# Derbyshire Healthcare NHS Foundation Trust
# Board of Directors

Conference Rooms A and B, Centre for Research and Development, Kingsway Hospital.
3 March 2020 09:30 - 3 March 2020 12:30

# INDEX

Derbyshire Healthcare NHS Foundation Trust

**NOTICE OF PUBLIC BOARD MEETING – TUESDAY 3 MARCH 2020**
**TO COMMENCE AT 9:30am**
**CONFERENCE ROOMS A & B, CENTRE FOR RESEARCH AND DEVELOPMENT, KINGSWAY, DERBY**

| | TIME | AGENDA | LED BY |
|---|---|---|---|
| **1.** | 9:30 | Chair's welcome, opening remarks, apologies and Register of Interests | Caroline Maley |
| **2.** | 9:35 | Patient Story | Carolyn Green |
| **3.** | 10:00 | Minutes of Board of Directors meeting held on 4 February 2020 | Caroline Maley |
| **4.** | | Matters arising – Actions Matrix | Caroline Maley |
| **5.** | | Questions from governors or members of the public | Caroline Maley |
| **6.** | 10:05 | Chair's Update | Caroline Maley |
| **7.** | 10:10 | Chief Executive's Update | Ifti Majid |
| **OPERATIONAL PERFORMANCE, QUALITY, STRATEGY AND GOVERNANCE** | | | |
| **8.** | 10:25 | Integrated Performance and Activity Report | C Wright/ C Stafford / C Green / M Powell |
| **9.** | 10:45 | Quality Report - Caring | Carolyn Green |
| **11:00 B R E A K** | | | |
| **10.** | 11:15 | Freedom to Speak Up Guardian Report (six month update) | Justine Fitzjohn/ Tamera Howard |
| **11.** | 11:35 | Public Sector Equality Duty (PSED)<br>Gender Pay Gap (GPG) and Inclusion Strategy for 2020 | Claire Wright |
| **12.** | 11:50 | Workforce Standards Formal Submission | C Green /J Sykes M Powell / C Stafford |
| **13.** | 12:00 | Fit and Proper Person Test Policy renewal | Justine Fitzjohn |
| **14.** | 12:10 | Board Committee Assurance Summaries and Escalations: Audit & Risk Committee 16 January, People and Culture Committee 28 January, Quality Committee 11 February 2020 *(minutes available upon request)* | Committee Chairs |
| **CLOSING MATTERS** | | | |
| **15.** | 12:25 | - Identification of any issues arising from the meeting for inclusion or updating in the Board Assurance Framework<br>- Meeting effectiveness | Caroline Maley |
| **FOR INFORMATION** | | | |
| Glossary of NHS Acronyms<br>2020/21 Forward Plan | | | |

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

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

**The next meeting will be held at 9.30am on 5 May 2020 in**
**Conference Rooms A & B, Centre for Research and Development, Kingsway, Derby DE22 3LZ**
*Users of the Trust's services and other members of the public are welcome to attend the meetings of the Board.*
***Participation in meetings is at the Chair's discretion***

Derbyshire Healthcare
NHS Foundation Trust

# Our vision

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

# Our values

As a Trust, we can only provide good quality services through our dedicated staff, working together with a common purpose. Our values reflect the reasons why our staff choose to work for the NHS and Derbyshire Healthcare.

Our Trust values are:

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

Derbyshire Healthcare
NHS Foundation Trust

| DECLARATION OF INTERESTS REGISTER 2019/20 | | |
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| **NAME** | **INTEREST DISCLOSED** | **TYPE** |
| **Margaret Gildea**<br>Non-Executive Director | • Director, Organisation Change Solutions Limited (mentoring client from First Steps (Eating Disorders) as part of Organisation Change Solutions) | (a, b)<br>(a) |
| **Gareth Harry**<br>Director of Director of Business Improvement & Transformation | • Chairman, Marehay Cricket Club<br>• Member of the Labour Party<br>• Mother is a member of Amber Valley Borough Council | (d)<br>(e)<br>(c, e) |
| **Ashiedu Joel**<br>Non-Executive Director | • Trustee at The Bridge (East Midlands) in Loughborough<br>• Director/Owner Ashioma Consults Ltd<br>• Director/Co-owner Peter Joel & Associates Ltd | (a) |
| **Geoff Lewins**<br>Non-Executive Director | • Director, Arkwright Society Ltd | (a) |
| **Ifti Majid**<br>Chief Executive | • Board Member NHS Confederation Mental Health Network<br>• Kate Majid (spouse) is Hospital Director, The Priory Group | (e)<br>(a, e) |
| **Mark Powell**<br>Chief Operating Officer | • Chair of Governors, Brookfield Primary School, Mickleover, Derby | (e) |
| **Amanda Rawlings**<br>Director of People and Organisational Effectiveness (DHCFT) | • Director of People and Organisational Effectiveness, Derbyshire Community Healthcare Services (DCHS)<br>• Co-optee Cross Keys Homes, Peterborough | (e)<br>(e) |
| **Dr Julia Tabreham**<br>Non-Executive Director | • Non-Executive Director, Parliamentary and Health Service Ombudsman<br>• Director of Research and Ambassador Carers Federation | (a)<br>(d) |
| **Dr John Sykes**<br>Medical Director | • Undertakes paid assessments of patients at the request of the local authorities under the Mental Health Act and Mental Capacity Act and acts likewise for solicitors representing patients | (e) |
| **Richard Wright**<br>Deputy Trust Chair and Non-Executive Director | • Chair Sheffield UTC Multi Academy Trust<br>• Board Member, National Centre of Sport and Exercise Medicine Sheffield<br>• Member of the Advisory Panel, Sheffield Hallam Business School<br>• Chair of the System Finance Oversight Group, Joined Up Care Derbyshire (JUCD) | (a)<br>(a)<br>(d)<br>(e) |

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

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

Derbyshire Healthcare
NHS Foundation Trust

# MINUTES OF A MEETING OF THE BOARD OF DIRECTORS

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

**Tuesday 4 February 2020**

**MEETING HELD IN PUBLIC**

Commenced: 9.30am Closed: 12.10pm

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| **PRESENT** | Caroline Maley | Trust Chair |
| | Margaret Gildea | Senior Independent Director and Non-Executive Director |
| | Asheidu Joel | Non-Executive Director |
| | Geoff Lewins | Non-Executive Director |
| | Dr Sheila Newport | Non-Executive Director |
| | Dr Julia Tabreham | Non-Executive Director |
| | Richard Wright | Deputy Trust Chair and Non-Executive Director |
| | Ifti Majid | Chief Executive |
| | Claire Wright | Deputy Chief Executive & Director of Finance |
| | Carolyn Green | Director of Nursing & Patient Experience |
| | Mark Powell | Chief Operating Officer |
| | Amanda Rawlings | Director of People Services & Organisational Effectiveness |
| | Gareth Harry | Director of Business Improvement & Transformation |
| | Justine Fitzjohn | Trust Secretary |
| **IN ATTENDANCE** | Perminder Heer | NExT Director |
| | Anna Shaw | Deputy Director of Communications & Involvement |
| | Celestine Stafford | Assistant Director, People and Culture Transformation |
| | Sue Turner | Board Secretary |
| | Stacey Wilson | Clinical Lead Nurse, Kedleston Unit |
| | Sara Johnson | Senior Nurse, Rehabilitation Services |
| **For DHCFT2020/002** | Vicki Baxendale | Head of Nursing, Adult Community and Specialist Services |
| **VISITORS** | Lynda Langley | Lead Governor and Public Governor, Chesterfield |
| | Julie Lowe | Public Governor, Derby City East |
| | David Charnock | Appointed Governor, University of Nottingham |
| | Jo Foster | Staff Governor, Nursing |
| | Christopher Williams | Public Governor, Erewash |
| | Helen Cooper | Deputy Director, People Services |
| | Tracey Piper | Observer |
| **APOLOGIES** | Dr John Sykes | Medical Director |

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| **DHCFT 2020/001** | **CHAIR'S WELCOME, OPENING REMARKS, APOLOGIES FOR ABSENCE AND DECLARATION OF INTERESTS**<br><br>The Trust Chair, Caroline Maley, welcomed everyone to the meeting. Introductions were made to Stacey Wilson, Clinical Lead Nurse, who shadowed Caroline and Sara Johnson, Senior Nurse, Rehabilitation Services who was shadowing Chief Executive, Ifti Majid. Assistant Director, People and Culture Transformation, Celestine Stafford shadowed Director of People and Organisational Effectiveness, Amanda Rawlings. A special welcome was made to two new Non-Executive Directors, Dr Sheila Newport and Ashiedu Joel who were attending their first Trust Board meeting.<br><br>Apologies for absence were noted from Medical Director John Sykes.<br><br>No declarations of interest were made with regard to the agenda items. Deputy Trust Chair, Richard Wright advised that he is no longer an Executive Director of Sheffield Chamber of Commerce. This entry on the Declarations of Interest Register is to be removed and updated to include his membership of the Advisory Panel, Sheffield Hallam Business School and his chairmanship of the System Finance Oversight Group, Joined Up Care Derbyshire (JUCD).<br><br>**ACTION: Declaration of Interests Register to be updated in respect of Richard Wright.** |
| **DHCFT 2020/002** | **PATIENT STORY**<br><br>Head of Nursing for Adult Community and Specialist Services, Vicki Baxendale joined the meeting to talk about the work of PARADE, a 22 week evidence based psycho education course for people with bipolar disorder and delivered by Community Mental Health Team (CMHT) Community Psychiatric Nurses (CPNs) and peer facilitators. People suffering from bipolar disorder represent 1% of the Derbyshire population and they make up a significant amount of CMHT case load. The course is being delivered in the north and the south and any service user with bipolar disorder can attend either course. Dedicated staff in the community are being trained to deliver the training and are working with volunteers to support them to learn new skills to deliver the course materials. Funding for this programme has been provided by East Midlands Academic Health Science Network and supports peer support facilitators to pass on their knowledge and experience to people with bipolar disorder. Evidence is beginning to show that this programme is likely to improve recovery, reduce bed days and the need for crisis intervention services.<br><br>Vicki highlighted some of the challenges that have arisen while running the programme. It is sometimes difficult for service users being able to commit to the 22 week course. Staffing and managing caseloads and clinics to enable CPNs to deliver the course has also proved difficult as has finding the right peer support workers to facilitate the course. Another challenge has been finding enough service users with bipolar to deliver the course to at the right stage of their recovery to achieve the greatest clinical benefit..<br><br>A video showing feedback from the Bolsover team highlighting positive experiences following recent education groups to support people with bipolar made it clear that the PARADE programme has been equally rewarding for our service users and colleagues.<br><br>Non-Executive Director (NED), Sheila Newport could see that the programme was having a positive effect and asked how the course was affecting health outcomes. Vicki informed her that although it is too early for this to have been evaluated due to small sample size. However, she knew that a community mental health team in Nottingham running a similar course has experienced positive outcomes such as reduced bed stay, a reduction in the |

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| | number of admissions and had seen positive discharge with people with bipolar, with their symptom control resulting in full discharge from services in their research trial.<br><br>Non-Executive Director, Julia Tabreham asked if there was any clinical evidence that has shown an improvement in the wellbeing of service users going through the programme. Vicki was pleased to report that results from questionnaires have shown that service users have seen an improvement in their health and wellbeing.<br><br>Director of Nursing and Patient Experience, Carolyn Green reported that she had spoken to some service users who felt nervous attending today's meeting to feedback on the programme. She had also heard how clinicians and medics have found it extremely rewarding running the course and have successfully worked their caseloads around the course.<br><br>Caroline Maley recognised how it might be difficult for peer support facilitators to commit time to the programme especially if they were working or seeking work and was interested to know if any payment could be offered to them. Carolyn advised that the Trust has revised its payment policy and is working with the People Services team to consider the viability of paying bank staff rates for people taking part in the programme. She was concerned that bipolar has always been a service that has been overlooked by mental health services and under invested. The Trust is currently working in line with NICE Guidelines to see how investment and implementing this practice can be continually improved.<br><br>Chief Executive, Ifti Majid wondered whether groups such as this could work within the Integrated Care System (ICS) or within the JUCD Place system or within local GP practices. Vicki outlined how the level of education involved in running such groups requires specialist knowledge generally found in secondary care around medication and psychology and teaching people how to cope with their life events and consequences of their mood.<br><br>The Board discussed how the primary care networks could develop the knowledge and skills to support people effectively so that in the future this type of work could be carried out in Place and with multi-disciplinary teams working within the Place system and hubs. It was thought that implementing a delivery plan could take around two years as there as there are a number of people with bipolar disorder in current secondary care settings to prioritise and work through this care offer. This is a secondary care intervention that can be physically delivered within Place and in the future delivered in a more integrated way.<br><br>Caroline Maley thanked Vicki for giving the Board an insight into the PARADE programme which is clearly proving to be a rewarding experience for both service users and colleagues. Ifti Majid felt it was good to hear the emerging evidence of how this programme impacts on people's lives and he looked forward to the Trust being able to implement this and receive feedback when the programme has worked with more people in this way. |
| **DHCFT 2020/003** | **<u>MINUTES OF THE BOARD OF DIRECTORS MEETING HELD ON 3 DECEMBER 2019</u>**<br><br>The minutes of the previous meeting, held on 3 December 2019, were accepted as a correct record of the meeting. |
| **DHCFT 2020/004** | **<u>ACTIONS MATRIX – MATTERS ARISING</u>**<br><br>The action to communicate the importance of receiving the flu vaccination to all staff was confirmed as closed. Director of People Services and Organisational Effectiveness, Amanda Rawlings was pleased to report that the current vaccination rate by front line staff stands at 72.4% and has exceeded the organisation's previous compliance rate. |

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| | Ifti Majid applauded the success of the Share Hope Not Flu campaign run by the Trust and the ongoing work of the peer vaccinators that has elevated the Trust to within the top 5% of performing national mental health trusts. The programme of vaccinations will continue with the aspiration of achieving the 80% compliance rate to protect our staff and community and qualify for the flu vaccination CQUIN payment.<br><br>Carolyn Green gave thanks to staff at the Hartington Unit for their use of infection control measures which prevented a flu outbreak on their wards. |
| **DHCFT 2020/005** | **QUESTIONS FROM GOVERNORS OR MEMBERS OF THE PUBLIC**<br><br>None received. |
| **DHCFT 2020/006** | **CHAIR'S UPDATE**<br><br>Caroline Maley's report provided the Board with a summary of her activity and visits to the Trust's services undertaken since the previous Board meeting in December.<br><br>Caroline thanked the Communications team for giving her a preview of the Trust's new intranet site that will be rolled out soon and for giving her an insight into how the team respond to media enquiries as well as Freedom of Information (FOI) requests and manage the quality of reporting about the Trust.<br><br>December was a month of festive celebrations. Caroline was honoured to have been invited to join the older people's services staff and service user Christmas buffet at Ward 1. This event coincided with the judging of the annual Christmas decoration competition which had engaged many staff across the Trust.<br><br>Celebrations continued into January when Caroline hosted with Ifti a tea party for staff who had 20, 30 and 40 years working for the NHS. This is the first time that the Trust has hosted a celebration of this type in marking these important milestones for our dedicated staff.<br><br>On 22 January Caroline visited the Dementia Rapid Response Team (DDRT) and took part in a visit to a local care home to see how the DRRT has been providing support with this service user and it gave her an insight into some of the challenges facing this innovative team.<br><br>Caroline referred to the Council of Governors meeting that she chaired on 7 January. This meeting was the last meeting attended by John Morrissey, former Lead Governor and Public Governor for Amber Valley, and Moira Kerr, Public Governor for Derby City West, and she thanked them for their years of service. Elections for new public governors are underway. New governors bring a wealth of skills and insight and Caroline looked forward to meeting newly elected governors at the next meeting of the Council on 3 March.<br><br>Caroline made thanks to former clinical Non-Executive Director, Dr Anne Wright who completed her term as a NED in December. Thanks were also made to Suzanne Overton-Edwards for her contribution during her placement as a NExT Director with the Trust and then as an interim NED.<br><br>Caroline also reported on system collaboration and working by including key messages noted from Joined Up Care Derbyshire Board (JUCDB) meeting held on 19 December attached as an appendix to her report and urged colleagues to attend these meetings whenever possible.<br><br>Carolyn Green responded to the item in Caroline's report concerning access to the |

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| | Miniature Insertable Cardiac Monitor (ICM) system which has been lost since the team upgraded to Windows 10. This is a multi-trust problem with regard to ICM which has come about through Windows 10 which is an expectation of all NHS organisations.<br><br>Carolyn Green referred to the item with regard to expanding the physical healthcare offer of staff working in older adults and how the care experience can be improved. Carolyn was supportive of this way of working but was mindful of disinvestment by commissioners in physical healthcare and payment for physical healthcare checks to GPs and that this has to be explored with these changes in mind. Carolyn confirmed that she and Medical Director, John Sykes are collaborating with acute trusts to ensure that the Trust has software that complies with the expected safety standards for 2020.<br><br>**RESOLVED: The Board of Directors noted the activities of the Trust Chair since the last meeting held on 3 December 2019.** |
| **DHCFT 2020/007** | **CHIEF EXECUTIVE'S UPDATE**<br><br>Ifti Majid's report gave a summary of the changes within the national health and social care sector, as well as an update on developments within the local Derbyshire health and social care community. The report also includes feedback from external stakeholders, such as commissioners, and feedback from staff.<br><br>The following issues were highlighted:<br><br>**National context**<br>The Queen delivered her speech to parliament on 19 December 2019 and presented the Government's plans for the coming session of parliament which reconfirmed the expectation to deliver in full the NHS Long Term Plan (LTP). As mentioned in Ifti's previous report to the Board the Health Service Safety Investigations branch can now be established to enhance patient safety and promote learning lessons. Other important plans include the implementation of a modern and fair points-based immigration system that will include a fast track NHS visa scheme. Proposals for the reform of long-term social care, including an opportunity for Councils to access a further £500m for adult social care and the reform of the Mental Health Act will also be brought forward.<br><br>Board members were aware from the LTP that the NHS has committed to significantly reducing waste. The Trust has signed up to the NHS Plastics Pledge to avoid using single-use plastic items. This was evident at today's meeting as no single use plastic items were used in catering for the refreshments.<br><br>**Local Context**<br>Ifti's report also provided an update on the recent public meeting of the Joined Up Care Derbyshire Board meeting held on 16 January. He was particularly pleased that during conversations about integrated care partnerships there was also a focus on Derbyshire's air quality strategy.<br><br>The meeting of the Derby City Health and Wellbeing Board also focused on wider determinants that impact on people's health. Some of the key matters discussed included their drink free days campaign in Derby. As a large employer Ifti asked the Communications team to link in with the alcohol education charity to look at how this can be promoted within our Trust.<br><br>Ifti made Board members aware of a discussion on the Derbyshire Clean Air Strategy held at Derby City Health and Wellbeing Board. This strategy exposed a significant differential in air quality between east and west of the county due to transportation networks. The strategy is to be circulated to all Board members after the meeting. |

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| | The JUCD Board Place Alliance Strategy *"Working Together Makes a Difference"* was included as an appendix to the report and set out how organisations involved within the system are working together to transform and prepare a service for the future that will connect and access people through a more communicative and coordinated service. This will improve their health and wellbeing, enhance quality of care, create flexibility and ensure system value, sustainability and equity. Ifti did not want the Place Strategy to be confused with the national descriptions of Place. He emphasised that this strategy is concerned with organisations and communities in Derbyshire working to develop in a variety of courageous ways that will push boundaries making Place the transformation engine that will move us forward.<br><br>Director of Business Improvement and Transformation, Gareth Harry had observed that the strategy showed a better consistency across partner organisations now that it was moving towards the implementation stage and will enable decisions to be taken by the Trust Board that will signify how the Trust is fully signed up to the transformation programme and will enable Place to be aligned within the Trust's own clinical strategies.<br><br>Discussion followed on how to develop people work streams and develop new roles across the Trust that can deliver system working by providing prevention and primary care in the community that will reduce the amount of acute care. It is hoped that by March 2021 the Trust will be in a better position to hold conversations at team leader and area manager level to understand how to make the best use of current capacity and establish new models of working that can deliver all components of the Place Strategy in the years ahead. As a result of this discussion Ifti undertook to feed back the Board's thinking on developing a structured people work stream at the next JUCD Board meeting.<br><br>Sheila Newport had noticed that much of today's discussions had involved physical healthcare and primary healthcare and felt it would be helpful for the Board to receive a document to demonstrate how commissioning is being considered to support colleagues in the Primary Care Networks in the future. Ifti advised that clarity on Primary Care Networks within the Integrated Care System is likely to be discussed at the next JUCD Board meeting in March and he would keep the Board updated with progress.<br><br>**Within our Trust**<br>The CQC completed their inspection of the Trust in January and Ifti gave thanks to all colleagues who were involved in the inspection. The initial feedback received from the CQC was attached to Ifti's report ahead of receiving a final report and more information will be shared when it becomes available. Although there were some areas to improve in the feedback received from the CQC Ifti wanted to celebrate the significant improvements that had been noted the CQC's feedback and thanked all colleagues involved in the inspection and for high level of engagement shown to the CQC inspectors.<br><br>The Trust is about the launch its Inclusion Strategy and this will be formally shared with the Board at the next meeting in March. As part of the development of this strategy, a short film signifying what inclusion means to Trust staff was played during the meeting.<br><br>Deputy Chief Executive and Director of Finance, Claire Wright referred to the meeting of the Staff Forum mentioned in Ifti's report when an open conversation was held about the menopause and how prepared the Trust was to be supportive of colleagues on whom it was impacting, particularly with regard to stigma, policies and opportunities for doing something differently. Claire reported that the session booked on 6 March to meet with Trust colleagues and the national lead for this initiative is to be rescheduled to accommodate a number of staff who do not work on Fridays.<br><br>**ACTION: The Board's thinking on developing a structured people work stream is to be fed back to the JUCD Board at their next meeting.** |

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| | **ACTION: Board to be updated on JUCD discussions on Primary Care Networks within the Integrated Care System**<br><br>**RESOLVED: The Board of Directors scrutinised the Chief Executive's update, noting the risks and actions being taken.** |
| **DHCFT 2020/008** | **INTEGRATED PERFORMANCE AND ACTIVITY REPORT**<br><br>The Integrated Performance Report (IPR) provided the Board of Directors with an overview of Trust performance at the end of December 2019.<br><br>**Quality and Operations**<br>The main areas of performance referred to by Chief Operating Office, Mark Powell highlighted the ongoing variability of out of area placements for adult inpatient mental healthcare. Plans for new ways of keeping people closer through the procurement of a number of beds at a centre in Kegworth that will keep people close to their local support network were outlined. Mark also reported on developments to provide a Psychiatric Intensive Care Unit (PICU) provision which is being addressed as part of the Trust's estate transformation project. This is a key deliverable in ensuring that if patients require intensive support they can be provided with the right level of care. The Trust is in the process of developing a business case for this work which will be brought to the Board as soon as possible.<br><br>NExT Director, Perminder Heer asked about the short term PICU out of area care being set up in Kegworth and asked what measures were in place for this is a short term solution. Mark Powell responded that it is a national mandate that no patients are placed out of area by March 2021. There are a multitude of projects that clinical and operational teams are taking forward that will have an impact on patient flow through our services that will avoid the need to admit people to hospital or spend less time in hospital. Assurance on this programme of work through to the Finance and Performance Committee.<br><br>A report containing an action plan to reduce waiting times in Child and Adolescent Mental Health Service (CAMHS) services was received by the Finance and Performance Committee in January. The Committee will continue to receive assurance reports on this programme of work.<br><br>**Finance:** Claire Wright gave an overview of the Trust's financial position and reported that for the end of December the Trust is ahead of plan by £19k. The forecast assumes that the year-end planned surplus of £1.8m can be achieved.<br><br>The 2019/20 Cost Improvement Programme (CIP) will be undelivered by £270k by the end of the financial year with a significant non-recurrent element. She was pleased to report that a partial payment of CQUIN will be made as over 60% compliance has now been achieved. Claire reported that a meeting is taking place on 5 February with executives to further establish next year's position around expected cost pressures. She also brought to the Board's attention that assumptions for out of area expenditure will further worsen.<br><br>Claire drew attention to the STP (Sustainable Transformation Programme) financial position and referred to conversations around evolving positions with system partners. This will impact on the new year and bring the need to create additional savings and efficiencies. She expected this to be discussed further during performance review meetings with the regulators at the end of the month and Claire will keep the Board updated when the position is made clearer.<br><br>Claire made further reference to the volatility of the out of area cost pressure and the fact that it may be compounded by work to eliminate the Trust's dormitory stock. |

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| | She also described discussions at the Mental Health Service Delivery Board concerning investment slippage.<br><br>In summarising, Claire highlighted that she is looking equally at the conclusion of the 2019/20 financial plan and also looking ahead to 2020/21. She referenced the Finance and Performance Committee Assurance Summary where the key risk for next year is the delivery of the required CIP. The progress of CIP had not been as hoped and this was therefore being escalated by the Committee to the Board today.<br><br>**Workforce:** Amanda Rawlings outlined how workforce performance metrics are showing an upward trajectory although this is not progressing yet as fast as she would like. Retirements continue to rise with the average now at 7.83 in December. The highest of number of retirees is being seen in children's and older adult services.<br><br>Mandatory training is being looked at to increase compliance particularly in the acute inpatient areas. Extra resources have been secured to improve certain elements of role specific training going forward to fill the gaps where facilitators have been unable to run courses due to lack of availability of trainers which is a nationwide concern.<br><br>The People and Culture Committee undertook a deep dive into sickness absence management and the support being provided to deliver a more person centred approach in managing attendance with the key aim of increasing employee attendance and productivity and reducing the cost of sickness absence.<br><br>**Quality**<br>Carolyn Green talked about quality aspects and workforce safeguards and stressed the need to ensure there continues to be a high level of compliance in safety training. The Trust is looking at how other organisations deliver mandatory training to establish how safety training can be reviewed to ensure it is carried effectively and with improved compliance.<br><br>Carolyn was mindful that more headway is needed to improve safer staffing in night shifts. She was aware of the high levels of retirement in children's and older adult services and advised of the need to take mitigating action. She thought that agency, bank and retention rates should be looked at and that there should be more flexible working arrangements that are family friendly to retain staff. Carolyn was concerned that from 2020 the workforce position will start to deteriorate in specific areas due to the number of staff able to retire and that current rates may start to deteriorate without a significant change to some of our practices.<br><br>Carolyn also escalated the limited impact of mitigation plans from a clinical perspective for autism services and waiting times. Carolyn also noted the deteriorating picture in CAMHS but was fully briefed on the mitigation plan to reduce this increased waiting time. The escalations from the Quality Committee in these areas will be included in the next iteration of the Board Assurance Framework (BAF).<br><br>Richard Wright referred to the increase in staff turnover and the high number of staff reaching retirement age. He was aware that people have a need to make lifestyle choices and had seen that the Trust's retire and return to work programme had been quite successful in maintaining recruitment rates. More schemes need to be brought in to make sure people stay working within the Trust so we can overcome the challenges being seen with our retirement profile. The Board discussed the importance of understanding the risks associated with the Trust's care services and the Place Strategy and JUCD work so that the Trust Strategy and workforce planning focuses on what is need now and in five years' time and in a Primary Care Network. Ifti Majid acknowledged the expectation that the Trust will continue to employ more people. He proposed that a report on wider staffing and what the future will look like be brought back to the Board at a timeline to be decided by the |

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| | Executive Team outside of the meeting. It was decided that BAF workforce risks will be broadened so they are linked with internal challenges associated with JUCD and the skill mix required of the workforce when the Board reviews the 2020/21 BAF on 19 February.<br><br>Ifti Majid had seen that the number of medication incidents had increased and asked if this was something the Board should be concerned about. Carolyn reported that improvement in pharmacy services coverage in the community had resulted in more matters being reported not just medication errors and that she was satisfied with the rationale of how and why reporting had increased. She was pleased to report that a paper on medication incidents is being taken to the Quality and Safeguarding Committee on 11 February.<br><br>It was concluded that there are number of financial, operational and quality challenges that the Executive Directors are dealing with. The Board was assured that the Board Committees are taking responsibility in a number of areas as mentioned above but in view of current performance limited assurance was obtained from the report.<br><br>**ACTION: Report on wider staffing and what the future will look like be brought back to the Board at a timeline to be decided by the Executive Team**<br><br>**ACTION: BAF workforce risks to be broadened so they are linked with internal challenges associated with JUCD and the skill mix required of the workforce during the review of the 2020/21 BAF on 19 February**<br><br>**RESOLVED: The Board of Directors received limited assurance on current performance across the areas presented.** |
| **DHCFT 2020/009** | **<u>BOARD ASSURANCE FRAMEWORK (BAF) (FIFTH ISSUE)</u>**<br><br>Trust Secretary, Justine Fitzjohn detailed the fifth issue of the BAF for 2019/20 which provides assurance on the process of identifying and mitigating risks to achieving the Trust's strategic objectives.<br><br>Revised risk ratings for two risks were presented since the fourth issue.<br><br>• Risk 1a *'There is a risk that the Trust will fail to provide standards for safety and effectiveness required by our Board'.* There is a risk that the Trust will fail to provide standards for safety and effectiveness required by our Board was agreed in November 2019 to be reduced from extreme to high due to the positive impact in acute care (with respect to supervision, appraisal and training targets) and overall delivery of the Acute Care Transformation programme. Consistent delivery of the seclusion pathway and patient experience of seclusion has been added as a gap in assurance in the risk. Following the 'deep dive' of the risk by Quality Committee in December 2019, it was agreed that the risk rating should remain rated as high.<br><br>• Risk 3b '*There is a risk that the Trust fails to influence external drivers (such as national policy and BREXIT) which could impact on its ability to effectively implement its Strategy'* was agreed in December 2019 to be reduced from high to moderate due to evidence of continuing take up of opportunities to lobby nationally around policy development and implementation and adherence to controls around potential impact of BREXIT.<br><br>Following review by the relevant Board Committees and scrutiny by the Audit and Risk Committee on 16 January it was proposed that the current risk rating for the following risks be reduced:<br><br>• Risk 1b *'There is a risk that the Trust estate does not comply with regulatory and legislative requirements'* be reduced from high to moderate following the deep dive of |

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| | the risk at the Finance and Performance Committee. The risk has therefore met its target risk rating and so is shown as 'accepted' in the risk appetite section of the BAF.<br><br>• Risk 2a '*There is a risk that the Trust will not be able to retain, develop and attract enough staff and protect their wellbeing to deliver high quality care'* be reduced from extreme to high due to the progress made toward closing the gaps in controls and assurances. It is recognised that there are still significant pathway specific risks particularly in relation to reducing sickness absence; delivering investment required by the Long Term Plan; and increasing staff diversity. These will be addressed going forward through review of the Workforce Improvement Plan to deliver more focused actions. Key gaps in control will be identified in the 2020/21 BAF. As the risk remains rated as high, the risk appetite continues to not be 'not accepted' by the Trust.<br><br>The Board was satisfied that the BAF had been thoroughly scrutinised by the Audit and Risk Committee and approved the fifth issue of the BAF and agreed to continue to receive quarterly updates of the 2020/21 BAF. Consideration of risks for the 2020/21 BAF have commenced and will be agreed at the Board Development session planned for 19 February.<br><br>**RESOLVED: The Board of Directors:**<br>**1) Approved the fifth issue of the BAF for 2019/20 and the significant assurance the paper provides of the process of the review, scrutiny and update of the BAF in seeking to identify and mitigate risks to achieving the Trust's strategic objectives**<br>**2) Agreed to continue receive a quarterly update of the 2019/20 BAF risks as outlined in the forward plan.** |
| **DHCFT 2020/010** | **<u>LEARNING FROM DEATHS MORTALITY REPORT</u>**<br><br>The 'National Guidance on Learning from Deaths' requires each Trust to collect and publish specified information on a quarterly basis. This report covers the period 1 July 2019 to 30 November 2019. This report was reviewed at the Quality committee on the 14th January 2020.<br><br>Carolyn Green reported that the Quality Committee had reviewed and scrutinised the data, the progress and the learning. The Mortality Group recommended to the Quality Committee that a learning review takes place of the Trust's approach to mortality reviews to establish further learning and wider improvements and this was supported by the Committee.<br><br>Sheila Newport as the lead NED for Mortality and Learning from Deaths considered that the process being taken with mortality reviews shows a good engagement of people and hoped that a multi-disciplinary approach taking account of physical healthcare will be included in the new and improved model. Carolyn assured the Board that the Mortality Group is on target to create a more sustainable and directed improvement review model that will take account of physical healthcare aspects.<br><br>Ifti Majid asked if the 7% nation-wide death rate of all ethnicity groups reflected the people within the Trust's services. Carolyn advised that auditing on ethnicity will be difficult to analyse until we have access to NHS Digital data. Until then this analysis can also be carried through in the Trust's reverse commissioning work.<br><br>Julia Tabreham recalled that a top level focus on death by ethnicity was carried out three years' ago. The Quality Committee received significant assurance at that time and suggested that this exercise be revisited. Julia was also pleased to note that further improvement work will be carried out on data reporting systems which will pay dividend when analysing death by sexual orientation. |

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| | The Board took assurance from the approach being taken to reviewing learning from deaths particularly due to the scrutiny applied to this procedure and agreed for the report to be published on the Trust's website in line with national guidance.<br><br>**RESOLVED: The Board of Directors:**<br>**1) Accepted this 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.**<br>**2) Noted that the Quality Committee endorsed the Mortality Group recommendation to audit the Trust's approach to mortality reviews. This consistent approach based on selecting cases through a 'red flag' system has provided assurance based on a lack of concern and appreciative learning and has not identified any 'problems in care'. An alternative approach (pending access to NHS Digital data) envisages casting a wider net to see if this generates different results.** |
| **DHCFT 2020/011** | **ELECTRONIC PATIENT RECORD TRANSFORMATION PROJECT MOBILISATION**<br><br>This report updated the Board as to the progress of the business change process that applies to the transformation of the Trust's core Electronic Patient Record (EPR) system to the TPP SystmOne Mental Health solution.<br><br>Due to purdah restrictions during the General Election period the Board agreed the business case to migrate from its current core clinical application EPR system for mental health the OnEPR system. This report confirmed the mobilisation of this programme of work. Over the course of this year through a phased approach the Trust will transition from the use of PARIS as the Trust's EPR system to OnEPR.<br><br>The Board discussed the progress made in transitioning to the new EPR and recognised the importance of proper completion of each electronic patient record to understand the people that that the Trust serve. The OnEPR system will significantly improve the ability to understand and respond accordingly to population needs. This is not just important from a patient experience but from a staff experience and will be to the benefit of how the Trust's inclusion work is described.<br><br>**RESOLVED: The Board of Directors reviewed and discussed the progress made to date with the transformation process around the SystmOne Mental Health solution as the Trust's core EPR.** |
| **DHCFT 2020/012** | **CLINICAL SERVICE STRATEGIES**<br><br>Due to purdah restrictions in December the Clinical Service Strategies created through the Clinically-Led Strategy Development (CLSD) were discussed and approved by the Board at the previous meeting held in confidential session on 3 December. These covered the Substance Misuse Service; Forensic and Rehab Service and Children's Mental Health Services and were now received in the public domain.<br><br>Gareth Harry highlighted how the clinical strategies have been developed by colleagues in frontline service delivery roles and have brought together a consistent approach. The service improvement plans include major projects such as forensic and rehabilitation services that are being developed to improve patient care and staff approach. The strategies include a vision of the future service, an outline of the development process, a summary of workforce, estate and information management and technology (IM&T) implications and a more detailed service improvement plan to deliver the strategies.<br><br>Carolyn Green reflected on the excellent clinical strategies, and she picked out a specific action from the Substance Misuse Group and their wishes to influence Place and primary care. She noted the limited focus on alcohol misuse and asked the Board to reflect upon how the strategies impact upon Place and the need for Place and primary care efforts to be |

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| | more focused on the public health risks of allied with alcohol and substance misuse when considering clinical information. She felt this should be a bigger focus within the Place Strategy, a particularly s a recent national publication has shown that nearly 60% of people who die by their own hand, have been active users of drugs and alcohol just prior to their death. The statistics of alcohol related admissions to both of our A&E departments for alcohol related admissions are significant outliers and are over represented at A&E.<br><br>Margaret Gildea added that if this was the case she hoped that any missed priorities within the Place Strategy could be developed further through JUCD. Gareth informed the Board that clinical strategy proposals are being taken through the JUCD governance system to propose extending this service currently commissioned by public health to work with primary care and other providers to look at reducing admission to hospital through better prevention of longer term conditions. Place and the Primary Care Networks are engaging with people who are high intensity service users who work with people who heavily misuse drugs and alcohol and are looking at how this can be further incorporated more within the Place Strategy.<br><br>Having noted the process undertaken to develop the strategies the Board approved the Clinical Service Strategies for Substance Misuse, Forensic and Rehab Services and Children's Mental Health Services.<br><br>**RESOLVED: The Board of Directors**<br>**1) Agreed the Clinical Service Strategies for Substance Misuse, Forensic and Rehab Services and Children's Mental Health Services**<br>**2) Noted the process undertaken to develop the strategies and the extent to which they have been developed by colleagues in frontline service delivery roles**<br>**3) Noted the need for working groups established at clinical service level, reporting to the Clinical Services Strategies Transformation Group, to lead implementation of the service development plans and the importance of leadership in this process of Clinical Directors, Clinical leads and other clinical leaders in delivering.** |
| **DHCFT 2020/013** | **<u>ESTATES STRATEGY</u>**<br><br>Mark Powell presented the Board of Directors with the Trust's Estates Strategy for 2020-2030 for approval. The strategy had been extensively reviewed and supported by the Board on 3 December due to the period of purdah and was presented today in the public domain for approval.<br><br>The strategy outlined the Trust's approach to its Estate to support delivery and implementation of the Trust's developing Clinical Strategy and associated strategic objectives. It also intends to further support and embed the Trust's vision and values, promoting staff engagement and developing a culture of open and transparent processes. The strategy focuses on a number of key programmes of work being planned for the next ten years 2020-2030, that are aligned to the Trust's strategic objectives; Great Care, Great Place to Work, Best Use of Money.<br><br>In addition, the strategy is aligned to the wider Joined Up Care Derbyshire Integrated Care System's Local Estates Strategy (LES). This further demonstrates the Trust's commitment to the national strategy, Placed Based Care and the wider system engagement inclusive of NHS, Social Care, Local Authority, NHS Property Services, NHSE and NHS Community Health Partnerships and associated Digital Strategies.<br><br>The Estates Strategy has been produced in accordance with national guidance and follows the format of the Department of Health's specification on 'Developing an Estate Strategy'. This has been further enhanced by employment of significant staff engagement through the help of DHCFT clinicians, service managers, Executive Directors, external stakeholders |

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| | and corporate support teams including Estates and Facilities.<br><br>Mark Powell informed the Board that the papers for today's meeting had been looked at on the Trust's website by local media. Radio Derby had run an item that was not entirely accurate and described the Trust as not meeting current guidelines across its estate in particular how we are looking to change our use of inpatient dormitory accommodation. He assured the Board that a response will be made to Radio Derby to ensure that their broadcast does not escalate disproportionately.<br><br>A considerable amount of time has been spent looking at what our estate should look like for today and the future in providing facilities for different needs and different groups of people making sure our estate is as efficient as possible. The key deliverables of the strategy are:<br><br>Caroline Maley thanked Mark and the Estates team for the extensive work involved in producing this ten year strategy. The Board acknowledged that the Estates Strategy had been well examined and scrutinised and supported by the Board on 3 December and by the Finance and Performance Committee and duly approved the Estates Strategy.<br><br>**RESOLVED: The Board of Directors approved the Estates Strategy.** |
| **DHCFT 2020/014** | **<u>BOARD COMMITTEE ASSURANCE SUMMARIES AND ESCALATIONS</u>**<br><br>The Board received assurance summary updates from recent meetings of the following Board Committees:<br><br>**People and Culture Committee:** A watching brief is being kept on sickness absence management. The building blocks are in place to deliver a more person centred approach in managing attendance. The Committee is expecting to see progress over the next three to six months and will receive a further report in order to obtain further assurance.<br><br>Margaret Gildea reported that a first look at the results of the staff survey showed positive engagement scores. The Committee took the opportunity to congratulate Amanda Rawlings on the work that has focussed on producing better data and reducing timescales to bring resolutions and outcomes to employee relations cases.<br><br>**Audit and Risk Committee:** An additional meeting of the Committee took place on 3 December and had been primarily convened to assess BAF risk 1a. Due to the Board reducing risk 1a from extreme to high, this risk was assessed by the Quality Committee on 10 December.<br><br>At the more recent meeting held on 16 January the Committee discussed how the impact that proposed changes in Accounting Standards will involve a significant amount of work for the Finance team and External Auditors, particularly for IFRS16 which is being planned for. A Deep Dive report on BAF 3a (financial plans) outlined the key controls and mitigating action that is in place, The Committee received significant assurance regarding the range of focus being applied to mitigate risk 3a. The Committee carried out its first review of its Equality Diversity and Inclusion objectives and found this to be a useful exercise. The Internal Audit report provided a good level of assurance on the way Datix is being used as an operational risk system. A review of JUCD Planning Process was seen as a useful piece of work.<br><br>**Mental Health Act Committee** held on 6 December saw a presentation made by Clinical Directors of restrictive practice. This included a case study that showed the process for monitoring Rapid Tranquilisation (RT) while a patient is in seclusion which evidenced the person centred approach and risk assessment that was taken. The Committee also received service user feedback on their lived experience while in seclusion which has |

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| | enabled a restrictive practice improvement plan to be developed that will be monitored by the Trust Management Team to ensure progress is made.<br><br>**Quality Committee:** A Deep Dive report on BAF risk 1a received at the meeting held on 10 December set out the progress that had been made in mitigating the risks but gaps in assurance relating to seclusion practice, physical healthcare and lack of Psychiatric Intensive Care Unit (PICU) provided the Committee with limited assurance and it was agreed that the risk rating of this risk would remain rated as high. The Committee recommended further management in key domains. These include an improvement plan in seclusion practice and record keeping of physical healthcare checks when a person refuses physical healthcare monitoring / post rapid tranquilisation.<br><br>The meeting on 14 January looked at the acute care transformation programme with the new NEDs on the Committee noting the significant progress that had been made in acute care and a commitment from staff to take these improvements forward. The Committee also reviewed the work programme looking at locked door rehabilitation in the low secure unit and saw a substantial improvement.<br><br>**Finance and Performance Committee:** Much of the meeting focussed on operational matters and financial risks that have been discussed earlier at today's meeting. Richard Wright emphasised the discussions that had taken place regarding the progress against an estimated Cost Improvement Programme (CIP) target of £7.8m for 2020/21.<br><br>It is expected that the Committee will hold an additional meeting to discuss the financial plan/CIP/contracting to assess credibility of a deliverable operational plan before final submission. This meeting will comprise the Trust Chair, Chief Executive, Chair of the Audit and Risk Committee, Chair of the Finance and Performance Committee Chair, Director of Finance and Deputy Director of Finance. The Board gave delegated authority to the individuals listed to scrutinise and approve the final operating plan before submission.<br><br>**RESOLVED: The Board of Directors:**<br>**1) Received and noted the Board Committee Assurance Summaries.**<br>**2) Gave delegated authority to the individuals listed above to scrutinise and approve the final operating plan before submission** |
| **DHCFT 2020/015** | **<u>IDENTIFICATION OF ANY ISSUES ARISING FROM THE MEETING FOR INCLUSION OR UPDATING IN THE BOARD ASSURANCE FRAMEWORK (BAF)</u>**<br><br>There were no additional items for inclusion or updating within the BAF. |
| **DHCFT 2020/016** | **<u>2019/20 BOARD FORWARD PLAN</u>**<br><br>The 2019/20 forward plan was noted and will continue to be reviewed further by all Board members. |
| **DHCFT 2020/017** | **<u>MEETING EFFECTIVENESS</u>**<br><br>The Board considered that effective discussions took place on the JUCD Place Strategy, the mobilisation of the new OnEPR project and the Estates Strategy. Due to the period of purdah at the end of 2019 these projects were discussed extensively within the Board Committees and other forums.<br><br>Colleagues shadowing Board members at today's meeting were invited to offer their comments. Celestine Stafford who had shadowed Amanda Rawlings found it particularly interesting hearing the Board discuss matters that impact on all staff across the Trust. Stacey Wilson who shadowed Caroline Maley found the scope of discussions assuring particularly during the Integrated Performance Report item which echoed the conversations |

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| | being held on the wards. Sara Johnson shadowing Ifti Majid agreed with Stacey and would be feeding back the discussions she had heard today to the operational management meetings. |
| The next meeting of the Board to be held in public session will take place at 9.30am on Tuesday 3 March 2020 in Conference Rooms A and B, Centre for Research and Development, Kingsway Hospital, Derby DE22 3LZ | |

| | | | | BOARD OF DIRECTORS (PUBLIC) ACTION MATRIX - MARCH 2020 | | | |
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| Date | Minute Ref | Item | Lead | Action | Completion Date | Current Position | |
| 4.2.2020 | DHCFT/ 2020/001 | Declaration of Interests | Board Secretary | Declaration of Interests Register to be updated in respect of Richard Wright | 3.3.2020 | Register updated | Green |
| 4.2.2020 | DHCFT/ 2020/007 | Chief Executive Update | Ifti Majid | The Board's thinking on developing a structured people work stream is to be fed back to the JUCD Board at their next meeting | 3.3.2020 | Fed into JUCD governance review and features in the draft governance proposal developed by John MacDonald | Green |
| 4.2.2020 | DHCFT/ 2020/007 | Chief Executive Update | Ifti Majid | Board to be updated on JUCD discussions on Primary Care Networks within the Integrated Care System | 3.3.2020 | As more definition is received around the developing role of Primary Care Networks this will be built into the CEO report to Board | Green |
| 4.2.2020 | DHCFT/ 2020/008 | Integrated Performance Report | Ifti Majid | Report on wider staffing and what the future will look like be brought back to the Board at a timeline to be decided by the Executive Team | 3.3.2020 | Proposed item for May Board meeting | Yellow |
| 4.2.2020 | DHCFT/ 2020/008 | Integrated Performance Report | Ifti Majid | BAF workforce risks to be broadened so they are linked with internal challenges associated with JUCD and the skill mix required of the workforce during the review of the 2020/21 BAF on 19 February | 3.3.2020 | Discussed at BAF Board assurance planning session and will be compiled at the Exec review of strategy building blocks that will then feed into revised 2020/21 BAF to be discussed at April Audit and Risk Committee | Green |

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

# Trust Chair's report to the Board of Directors

## Purpose of Report

This report is intended to provide the Board with the Trust Chair's reflections on activity with and for the Trust since the previous Board meeting on 4 February 2020. The structure of this report reflects the role that I have as Trust Chair.

## Our Trust and Staff

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

2. On 28 January I chaired a Quality Visit at Ilkeston to the Memory Assessment Service (MAS) and Memory Clinics. The team is small and serves all of the city and county. Demand for the services is high and waiting lists are managed well with most patients receiving a diagnosis within the required twelve weeks. However, it is evident that there have been more referrals than last year, and numbers already exceed those commissioned for the whole year. It is pleasing to hear the positive comments from patients about the service which is delivered in a caring and compassionate way and to see the very positive friends and family test results. One of the presentations was from the small admin team who are indeed the front line for these patients and their families at a time when they are concerned and worried, and it was great to see the way that our members of staff provide good listening skills and sign posting for patients. Examples were given of where they had gone the extra mile.

3. On 10 February I visited the Chesterfield Dementia Rapid Response team (DRRT), which is a relatively new team with new staff being appointed to permanent roles. I was able to join one of the support workers in a visit to a 91 year old patient in a care home. The purpose of the visit was to assist the staff at the care home with the management of this lady who was struggling with her dementia. It was once again great to see the care and compassion with which the patient was treated, and to see her obvious pleasure in seeing our staff member. I also attended the team's Multi-Disciplinary Team (MDT) meeting where all patients on the list were reviewed. It was clear to me that the staff worked well as a team, with all knowing and contributing to the discussions about the patients. Once again it was evident to me how important it is to ensure that the place of care for a patient is vital to their ability to lead a healthy and meaningful life. Dr Nick Long chaired the MDT meeting in a way that I believed reflected the culture of the Trust, starting the meeting with reading contributions from staff left in a positivity jar. I would like to see this being considered across the Trust as a meaningful way of hearing "stories".

4. On 18 February I attended the Reverse Commissioning meeting with Ashiedu Joel, Non-Executive Director (NED). The meeting was co-chaired by Carolyn Green, Director of Nursing and Patient Experience and Elsie Gayle, a community volunteer. This group has the opportunity to enhance our work in those communities where access to mental health support is more challenging

for citizens, and I look forward to seeing the difference that can be made in the lives of people through the changes that this group can help us make.

5. My thanks go out to all of the staff for making me so welcome during the many and varied activities and visits that I undertook, and also for being so open and honest with me about what they thought of the Trust and how we are doing in delivering services and putting our people first.

**Council of Governors**

6. Elections for new public governors and one staff governor closed on 31 January 2020. We are delighted to welcome to the Council of Governors Susan Ryan and Valerie Broom representing Amber Valley; Orla Smith representing Derby City West; Julie Boardman representing High Peak and Derbyshire Dales and Marie Hickman as a staff governor for Admin and Allied Support staff. I noted last month that Kevin Richards was re-elected unopposed for South Derbyshire. Our only constituency now with no Governor is Bolsover, but we continue to seek to promote the opportunity in that area. I would like to note the work that is done by Denise Baxendale, Membership and Involvement Manager in managing the election process and communications. We continue to review our election process to ensure that it is efficient and is best use of money. The Governors are being engaged in this process through the Governance Committee and the Council of Governors. Induction for new governors took place on 6 February and they were able to attend the Governance Committee as their first official meeting.

7. The Nominations and Remuneration Committee of the Council met on 11 February to receive the appraisal of two of the NEDs and to consider the outline objectives of two new NEDs and all NEDs as a group. The Committee considered the remuneration structure that has been published by NHS Improvement (NHSI) and will be making recommendations to the full Council of Governors meeting on 3 March 2020.

8. The Governance Committee also met on 11 February. The Committee agreed the process to be followed in the selection of the quality indicators for audit as part of the year end process, and also received information about the programme of quality visits. Planning for the Annual Members Meeting in September has also been set in motion. Kelly Sims has chaired this Committee well for the past twelve months. However, under its terms of reference, an election for a new Chair has been started. Julie Lowe has taken on the role of Deputy Chair for this Committee. The Committee also is considering the attendance requirements for Governors at a wider range of meetings to support the effective working of the Council and its Committees.

9. I have met with Lynda Langley as Lead Governor, and with Kelly Sims as Chair of the Governance Committee. Regular meetings between the Lead Governor and Chair are an important way of building a relationship and understanding of the working of both governing bodies. I am pleased that Lynda has been working at getting the Lead Governors of the four Derbyshire Foundation Trusts together in February to discuss the way that Governors might be engaged in the work of Joined Up Care Derbyshire (JUCD).

10. The next meeting of the Council of Governors will be on 3 March. The next Governance Committee takes place on 2 April.

**Board of Directors**

11. Board Development on 19 February 2020 saw the Board focus on the development of the Board Assurance Framework (BAF), and part of the morning was facilitated by 360 Assurance, our Internal Auditors. We were also given a demonstration of SystmOne as the Trust starts its implementation journey. We also spent some time considering the implications of becoming an Integrated Care System (ICS), and the emerging Integrated Care Partnerships (ICPs) which are being discussed at JUCD.

12. I note that Amanda Rawlings, our Director of People and Organisational Effectiveness will be leaving us shortly to take up her new role at the University of Derby and Burton Teaching Hospital (UDBH). We wish her well in her new role, and look forward to seeing her continue to lead some of the discussions at the system level on workforce. Recruitment for a new Director of People and Inclusion has commenced.

13. Since the last board meeting, I have met with Ashiedu Joel as part of her induction, and shared with her the objectives for her role. I have also had a quarterly meeting with Deputy Trust Chair, Richard Wright, at which we reviewed progress on his objectives for the year.

**System Collaboration and Working**

14. On 5 February I joined an East Midlands Chairs Development Network, which saw chairs of NHS trusts and local authority leaders come together to explore and share ideas and topics around integrated care. This is a new network and plans are being developed to meet quarterly. A major topic shared with the Network was the “Wigan Deal” illustrating the work that has been done in Wigan by health and social care joining forces around population health.

15. On 18 February I met with Dr Kathy Mclean, Chair of UDBH as part of her induction programme. It was good to share thoughts on our own roles as Chairs, and the work of our respective Councils of Governors. Working together is important in terms of the system and our leadership within it.

16. Joined Up Care Derbyshire (JUCD) Board met on 20 February, with main topics of discussion being the financial position of the system, and the development of the Integrated Care partnerships, which is being led by our Chief Executive, Ifti Majid. The patient story at the beginning of the meeting was presented by Dean Wallace, Director of Public Health, and focussed on a number of case studies where addressing prevention has a significant impact on the health of the population. Attached as Appendix 1 are the key messages noted from this meeting.

17. Meetings of JUCD are now taking place in public. The next meeting is on 19 March and takes place at The Hub, South Normanton, Off Shiners Way, Market Street, South Normanton, Alfreton DE55 2AA.

**Regulators; NHS Providers and NHS Confederation and others**

18. We have received our draft report from the CQC visit which took place in December and January 2020. We are currently undertaking factual accuracy checks and will be receiving the final report for publication in March.

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

**Assurances**

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

**Consultation**

This report has not been to other groups or committees.

**Governance or Legal Issues**

None

**Public Sector Equality Duty & Equality Impact Risk Analysis**

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

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

This report reflects a wide range of activities across the Trust, and consideration relating to ensuring inclusion is embedded in operational work of the Trust. The specific services visited provide support to those with protected characteristics by the nature of their work. In particular this month I note the work of the Reverse Commissioning group and the opportunity that this work enables to support those with mental health needs in communities which may not engage with services in the traditional ways.

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

**Demonstrating inclusive leadership at Board level**

Through the Trust's involvement in the NExT Director scheme we are supporting the development of those who may find it more difficult to be appointed as a NED in the NHS. Perminder Heer has a placement with us thereby continuing to support the system development of future potential NEDs from diverse backgrounds.

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

**Recommendations**

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

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

**Joined Up Care Derbyshire Board – key messages February 2020**

**Integrated Care Partnerships (ICPs)**

In their Making Sense of Integrated Care article published in 2018 the Kings Fund summarised ICPs as follows; *'Integrated care partnerships (ICPs) are alliances of NHS providers that work together to deliver care by agreeing to collaborate rather than compete. These providers include hospitals, community services, mental health services and GPs. Social care and independent and third sector providers may also be involved.'*

In Derbyshire we have developed a full cross system collaborative approach and ICP partners comprise acute trusts, community and mental health providers, local authorities (including social care and housing), education, primary care/Primary Care Networks (PCNs) and the independent and voluntary sectors.

Our health and care system has worked together since September 2019 and made some real progress including an agreement on the four ICP areas:

i) Chesterfield, North East Derbyshire and Bolsover
ii) Derby City
iii) South Derbyshire, Amber Valley and Erewash
iv) Derbyshire Dales and High Peak

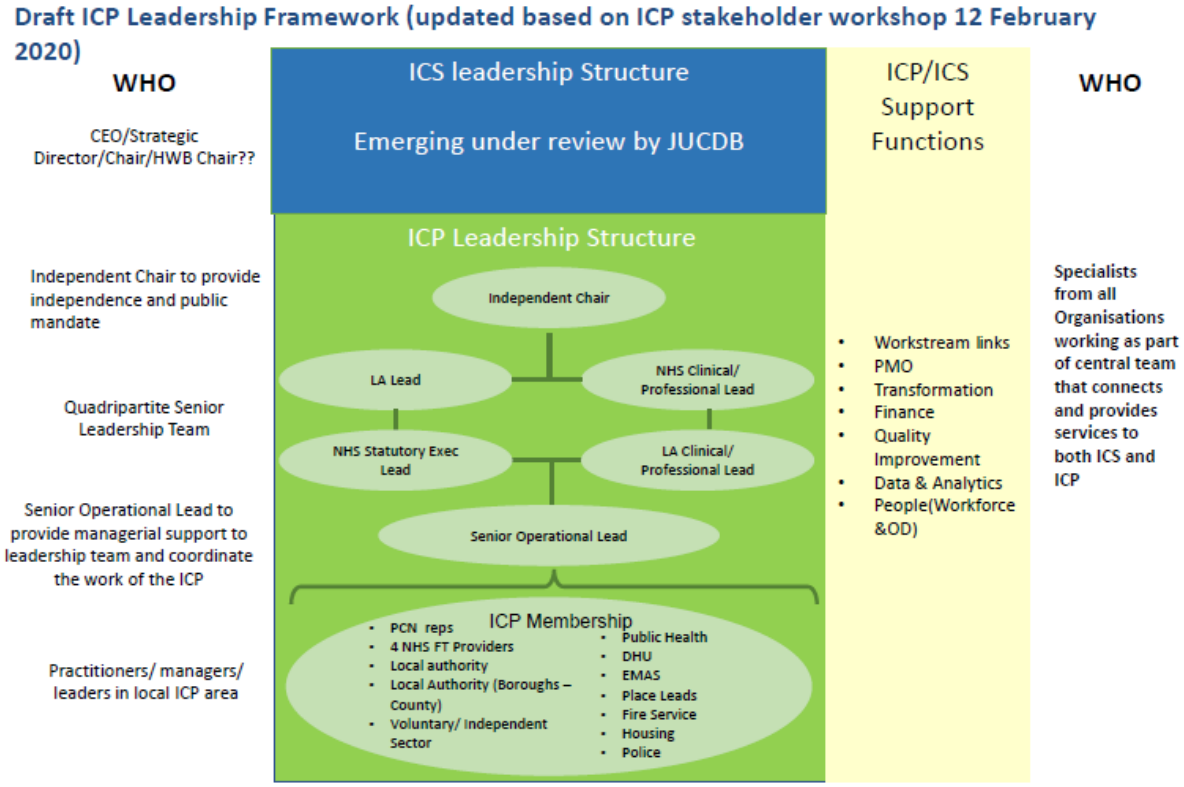
These areas are recognised by our local authorities and this helps to enable a focus on population health, prevention and ensure relevance to local populations. It is recognised that ICPs have a vital role to play although they should not be viewed as the panacea for our Derbyshire system.

The role of the Derbyshire ICPs has been agreed at headline level that they should customise and implement care pathways and support implementation of transformation programmes, build and maintain the 'supply chain' of providers and actively support PCNs. Key objectives include being inclusive and also lean through using existing resources innovatively with financial accountability representing around 25% of their overall roles.

At a more detailed level the ICP role needs to understand the local population health, wellbeing and social care needs and prioritise resources so that they can:

- Develop an approach that recognises the wider determinants of health as a key driver of health and wellbeing in the population
- Prioritise prevention across a person's life to encompass primary, secondary and tertiary health and care provision
- Customise and implement wellbeing and care pathways
- Lead local transformation and integration of agreed priorities
- Ensure focus on transformation of wellbeing and care models rather than clinical pathways and that ensure that these are both localised through Place and PCNs
- Manage resource/spend within agreed budgets (a challenge in year one)
- Reduce waste and duplication including estates and central functions
- Build workforce resilience, roles and recruitment and organisational development
- Integrate information and case management systems to give a holistic view of the person

An immediate priority is to build upon the work delivered so far by identifying leaders for each of the four ICPs including an independent chair for each, using the leadership model below. A process which is fair and transparent is in development and it is clear that these will not be new roles.




**Finance Update**

Financial performance up to month 9 (end December 2019):
At the end of month 9 the Derbyshire system is reporting being off plan and there continue to be a number of key risks associated with the year-end financial position. Key factors in this include the challenges for both acute trusts and specifically these are tariff change issues for Chesterfield Royal Hospital (CRH) and difficulty in delivering savings associated with the Service Benefit Reviews for University Hospital Derby and Burton UHDB).

**Savings plan performance:** The single savings plan for the whole Derbyshire system which incorporates the CCG overall financial performance continues to be reviewed and monitored by the Systems Savings Group. This offers significantly more visibility of the overall financial performance and savings requirements of the system. The 19/20 system financial challenge is now valued at £151m and the planned level of savings at the end of month 9 is £78.4m, although the actual recorded level of savings at the end of month 9 is £70.8m so there is a material shortfall in the recurrent savings forecast.

**Managing the end of year position:** A comprehensive recovery plan for the system is in place and this is being worked on intensively by colleagues across the Derbyshire system. Given the variances between the year to date performance and the year-end planned position it will not be possible for either CRH or UHDB to deliver within the Control Totals set by NHS Improvement. The Directors of Finance across the system have collectively agreed that each organisation will contribute to the recovery plan to ensure the delivery of the best system financial position that is possible.

**Working towards 2020/21:** The projected financial position for 2019/20 will impact upon 2020/21 in terms of a bigger financial performance and savings challenge. This makes it even more important that there is a dual focus in terms of managing the current year position to achieve the best outcome possible whilst planning ahead for the transformation of the way services are delivered next year to ensure that our shared financial targets are met.

**Workstream Review**

Between November 2019 and January 2020 the Independent Chair and STP Director met with each of the JUCD STP work-streams SRO and Leads with supporting colleagues. The purpose of the meetings was to provide an opportunity for the new Independent Chair to meet with key programme leaders and to understand better the transformational work, identified in the JUCD

STP Strategic Plan and the individual work-stream delivery plans, underway on behalf of the system.

The key themes emerging from the discussions noted were as follows:

- The need to focus on a smaller number of major transformation areas with significant resource directed towards these, with other work streams becoming business as usual. This was agreed as a principle by the Board.
- The need to optimise work-stream interdependencies.
- Opportunities to refine governance and progress reporting. Major transformation programmes will report to the Board quarterly and the business as usual work streams report six monthly, although escalation to the Board by exception will be encouraged outside of the agreed reporting framework where intractable issues required a system response or resolution. This will result in the Transformation Assurance Group being stood down which not only streamlines governance arrangements and reduces demand on peoples time, but will further reduce the division between transformation oversight and system savings oversight.

**Strengthening Clinical and Professional Leadership in JUCD**

Clinical and professional leadership for the Derbyshire system has to date come from the Joined Up Care Derbyshire Clinical & Professional Reference Group (CPRG) which was established in 2016/17 shortly after the publication of the original STP Plan.

A review of the terms of reference of CPRG has been undertaken aimed at strengthening the overarching clinical and professional leadership approach. This has resulted in a review of the leadership arrangements and future positioning of CPRG as we move towards becoming an ICS, to move CPRG into a stronger position to act as the clinical and professional voice for the system. In doing so, this will also put CPRG in a more prominent position within the STP governance arrangements.

**Derbyshire Healthcare NHS Foundation Trust**
Report to the Board of Directors – 3 March 2020

## Chief Executive's Report to the Public Board of Directors

### Purpose of Report

This report provides the Board of Directors with feedback on changes within the national health and social care sector, as well as providing an update on developments occurring within our local Derbyshire health and social care community. The report also updates the Board on feedback from external stakeholders, such as our commissioners, and feedback from our staff. The report should be used to support strategic discussion on the delivery of the Trust strategy. The Board should note that the report reflects a wider view of the Trust's operating environment and serves to horizon scan for risks that may affect the organisation. Risks identified are highlighted in the report and taken forward to assess their operational and strategic impact, and recorded on operational risk registers, or the Board Assurance Framework, as appropriate.

### National Context

1. The 2019 Workforce Race Equality Standard (WRES) has been released by the WRES Implementation Team. The WRES requires organisations employing the 1.4 million NHS workforce to demonstrate progress against nine indicators of staff experience; and supports continuous improvement through robust action planning to tackle the root causes of discrimination. This year saw a series of further national drives on this critical agenda; the NHS Long Term Plan included clear lines on the aspiration to improve black and minority ethnic representation at senior levels in the NHS, it also allocated additional resource to the WRES programme of work over the coming years.

   Having implemented the WRES for the last four years, many NHS organisations are now beginning to see continuous improvements across a range of WRES indicators – this is reflected in the latest national WRES data. However, at the same time, as a Board we know that embedding and sustaining continuous improvements in transforming the culture of an organisation takes time and focus. It requires organisations to approach this work with an open mind and an honest heart and as we discuss is best developed through openly hearing real stories from colleagues.

   The key findings this year include:

   - In 2019, 19.7% of staff working for NHS trusts and clinical commissioning groups (CCGs) in England were from a black and minority ethnic (BME) background; this has been increasing over time
   - Across all NHS trusts and CCGs, there were 16,112 more BME staff in 2019 compared to 2018.
   - The total number of BME staff at very senior manager (VSM) pay band has increased by 21, from 122 in 2018 to 143 in 2019, and is up by 30% since 2016
   - White applicants were 1.46 times more likely to be appointed from shortlisting compared to BME applicants; a similar figure to that reported in

2018, and an improvement on the 1.60 times gap in 2017 and 2016.
- The relative likelihood of BME staff entering the formal disciplinary process compared to white staff has reduced year-on-year, from 1.56 in 2016 to 1.22 in 2019
- WRES indicators relating to staff perceptions of discrimination, bullying, harassment and abuse, and on beliefs regarding equal opportunities in the workplace, have not changed for both BME and white staff
- The relative likelihood of white staff accessing non–mandatory training and continuous professional development (CPD) compared to BME staff was 1.15. This remained the same as last year
- 8.4% of board members in NHS trusts were from a BME background; an improvement from 7.4% in 2018 and 7.0% In 2017.
- The number of BME board members in trusts increased by 35 in 2019 compared to 2018 – an additional 18 executive and 17 non-executive board members
- In 2014, two-fifths of all NHS trusts in London had zero BME board members. As at 1 December 2019, all London trusts have at least one BME board member; a significant achievement. 14.7% of Very Senior Managers in London are now from a BME background.

The WRES data is very helpful in helping us to understand our progress against a national position. Whilst there is evidence of continuous improvement, those improvements are small, and we should not be self-congratulatory more we should be asking ourselves why we are not seeing a steeper improvement trajectory. As a Board we should remember that the data relates to the financial year 2018/19 and last year's staff survey results. As a Trust we continue to need to make very significant improvements across all eight indicators particularly indicator 2 - Relative likelihood of white applicants being appointed from shortlisting across all posts compared to BME applicants and indicator 3 - Relative likelihood of BME staff entering the formal disciplinary process compared to white staff. We will be discussing these results at both the BME Network and the Equalities Forum and I have asked for more up to date information from our People Services with respect to the two indicators mentioned above so we can see how we are currently performing given the actions we have taken since April 2019.

2. The Care Quality Commission (CQC) has published Monitoring the Mental Health Act in 2018/19, under its statutory duty to provide Parliament with an annual review of how health services in England apply the Mental Health Act (MHA). Key points include:

    - The Care Quality Commission (CQC) has identified the use of human rights principles and frameworks as a key area of concern. CQC state services must apply human rights principles and frameworks, and their impact on people should be continuously reviewed to make sure people are protected and respected.
    - CQC Mental Health Act (MHA) monitoring visits suggest that since 2015 the number of services meeting the basic expectations of the MHA code of practice have improved.
    - CQC has concluded it is difficult for patients, families, professionals and carers to navigate the complex laws around mental health and mental capacity.
    - Patient involvement needed to improve in 26% of care plans it reviewed in

2018/19.

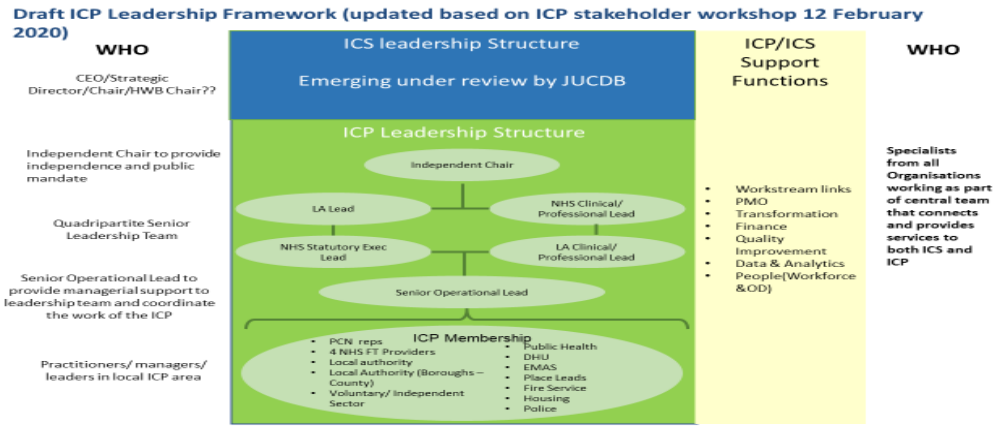
- Concern was also expressed about the pace of change in community services particularly relating to increasing capacity and responsiveness to compensate for in patient bed reductions.

The lessons learnt from this review should be considered by our Mental Health Act Committee to ensure that locally we learn lessons from these national trends.

**Local Context**

3. The Joined Up Care Derbyshire (JUCD) Board meeting was held in public on 20 February. Key items discussed included:

- In the last week of February NHS England (NHSE) / NHS Improvement (NHSI) had their regular System performance meeting attended by Claire Wright on my behalf, with a focus on in-year performance, system financial position, the journey to becoming an Integrated Care System (ICS) and compliance with the long term plan and local transformation
- It was very helpful to note the County Council Director of Public Health's annual independent report 'Stronger for Longer' looking at the health and wellbeing of our local population. The report is available from www.derbyshire.gov.uk/stronger
- The first draft of the annual system plan is due on the 5 March 2020 and work is ongoing to comply with this submission date. Following feedback from NHSI/E it is anticipated we will need to bring the plan to our Board meeting ahead of the April final submission date.
- We agreed the terms of reference for the Clinical and Professional Reference Group, the group that will provide clinical and professional oversight of transformational change, performance and innovation.
- The financial position of the system remains behind plan by £36.3m mainly driven by the two acute hospitals. The system savings requirement is also behind plan by circa £4 million.
- The board signed off the leadership model for Integrated Care Systems which had been arrived at through significant collaboration and consultation with key stakeholders.



**Within our Trust**

4. On 14 February the Trust received the draft comprehensive inspection report from the CQC. This report is embargoed whilst factual accuracy checks take place (ten days) and the publication date is agreed with the CQC. We expect this to be during March. As required all Board members have received a copy of the draft report. We will now begin to build up a theme-based response to the findings that will be monitored by the Executive Leadership Team and assurance provided to Board via the Quality and Safeguarding Committee.

5. This year's staff survey has now been released and I wanted to publicly thank all colleagues who participated in the 2019 staff survey. More colleagues than ever completed the survey that was undertaken late last year, and I'm delighted to say that the feedback provides a strong set of results.

   In comparison to the feedback received in 2018, the most recent survey results show we have significantly improved in approximately a third of all the areas surveyed – and we have not received lower scores on any of the themes.

   I am most pleased to share that the two Friends and Family Test questions that we ask throughout the year have seen marked improvement:

   - 64.6% of colleagues say they would recommend Derbyshire Healthcare as a place to work. *This is an improvement of 8.6%* compared to the response we received last year
   - 65.6% of colleagues said they would recommend the Trust as a place to receive care or treatment, which is an *increase of 4.6%* from last year and a 9% improvement when compared with the feedback we received in 2016.

   This analysis is also supported by noticeable improvements in each question that relates to the quality of care that we provide – all of which put us above average, when compared with the results received by other trusts that provide similar services to ourselves.

   Other highlights and positive feedback in the survey can be found on topics including:

   - Feedback from patients being used to inform decision making
   - Colleagues being treating fairly when they are involved in incidents or near misses
   - The Trust's values being discussed in appraisals
   - Management support to colleagues accessing training, learning or developments identified in appraisals
   - Adjustments being made to support colleagues with disabilities
   - Personal freedoms and responsibilities in deciding how to do work
   - Reduced instances of abuse, bullying and harassment from patients, their relatives and members of the public
   - Reducing the frequency of staff working additional, unpaid hours.

There are some areas where the survey shows we still have more to do and I am not complacent, we will continue to drive improvements in these areas. This includes:

- reducing any incidents of bullying and harassment,
- improving the quality of our appraisals
- clearly defining work objectives following appraisals or performance reviews.

I have attached an infographic at appendix 1 that visually summarises the results.

One of the lessons this year, even though we had the highest response rate ever, is how can we make it as easy as possible for colleagues to take part in the survey. We will be investing in paper copies for our acute care colleagues, to ensure they have a better opportunity to respond.

6. On 6 February myself and Claire Wright met some 50 of our preceptors from a range of professions including nurses, nurse associates and occupational therapists (OTs) to discuss the culture of the Trust and their role in maintaining and developing that culture. We were also able to spend some time discuss leadership in the NHS and sharing with our preceptors some of the messages we have been giving to leaders in our organisation. The session was well received, and I have agreed to do a focussed 'On the Road' session with our preceptors in August.

7. Building on the information we have discussed much as a Board and at Finance and Performance Committee over the past few months, we have commenced a process of updating colleagues in the organisation about the financial requirements for next year 2020/21. In line with our values and emerging culture approach to managing challenges we have done this through open and honest emails to colleagues in the organisation that both outline the level of the challenge as well as some important context and history. In addition, executive colleagues have met with Staff Side and our Staff Forum to both share the background and current detail as well as the process for development of plans for closing the gap. Feedback has generally been positive with respect to our aim of being open and transparent however as a Board we should be cognisant that regardless of assurances about job security information such as this can create anxiety and worry in colleagues and it is important, we continue to keep colleagues up to date with progress.

8. In terms of our media work, we are continuing to speak up about the importance of capital investment in the NHS, particularly in regards to inpatient (hospital) facilities. Following the publication of our Estates Strategy at the February Board, BBC East Midlands Today interviewed our Chief Operating Officer about our ambition to develop new acute mental health inpatient facilities with single, en-suite rooms, and to establish a psychiatric intensive care unit (PICU) within Derbyshire. I also spoke on behalf of the Trust in relation to an NHS Providers survey which showed that two thirds of NHS trusts providing mental health services will not receive the funding they need this year to invest in urgent repairs or upgrade their facilities. My comments were featured in publications including the Nursing Times.

6 February was Time To Talk Day, and I am pleased that the Trust marked the day with a range of activities, generating significant coverage on social media. Trust colleagues were able to find out about support available to them through a drop in session at the Ashbourne Centre on the Kingsway Hospital site. The Trust also co-organised a Run, Walk, Talk event at Markeaton Park in Derby which had significant reach on social media both on Time To Talk Day and in the days beforehand; Run, Walk, Talk has now become a fixture in the local calendar and is proving effective at bringing the community together and promoting a combined approach to improving physical and mental health. Run, Walk, Talk was nominated for a 'Towards an Active Derbyshire' award during February, in the innovation category, and was praised by one of our colleagues on the Victoria Derbyshire show on BBC2 this month during a piece about the importance of safety planning. Congratulations to Dr Subodh Dave and Jane Foulkes for making Run, Walk, Talk (#RunWalkTalk) such a success.

We continue to celebrate our fantastic, dedicated workforce. This year is WHO's Year of the Nurse and the Midwife and we will be sharing a profile of one nurse each month on social media. 21 February was also Mental Health Nurses Day, and several of our nursing colleagues were featured on our Facebook and Twitter pages.

Our 2019 Staff Survey results also generated media and social media interest, with lots of positive comments made about our improvement since 2018. Peak FM included our survey results infographic on their website.

9. During February I have met with two of our local MPs, Toby Perkins (Chesterfield) and Amanda Solloway (Derby North). These meetings are really helpful because not only do they provide an opportunity for me to receive feedback from our local MPs about issues their constituents are raising but it allows me to share some of the broader challenges we are wanting government to be aware of, for example the need for prioritised mental health capital, the transparency with which we see mental health investment hitting the frontline, challenges with ongoing and continuous tendering of services in particular our Children's and Substance Misuse services.

Since our last Board meeting I have attended 'On the Road' sessions at Corbar View, Buxton. Some of the key issues arising from these sessions included:

- Relationship with Stepping Hill and ability to access beds there for residents. Some helpful feedback that residents of the south High Peak were expressing a preference to be admitted to our Trust beds in Chesterfield
- Great presentation about the benefits of revamping our volunteer recruitment and management process
- Benefits of having a pharmacist attached to a community team
- Benefits of having a local non-medical prescriber.

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

**Assurances**

- Our strategic thinking includes national issues that are not immediately in the health or care sector but that could be of high impact.
- The Board can take assurance that Trust level of engagement and influence is high in the health and social care community.
- Feedback from staff, people who use our services, and members of the public is being reported into the Board.

**Consultation**

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

**Governance or Legal Issues**

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

**Public Sector Equality Duty & 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. The results of the Workforce Race Equality Standard (WRES) whilst demonstrating movement in the right direction do not, for me, demonstrate sustainable cultural change. As a Trust we must review the national findings and compare our internal progress to that as well as finding a way to gather and report data both relating to WRES and Workforce Disability Equality Standard (WDES) in a more timely way so we don't need to wait for the national reports to see our progress.

This paper demonstrates some strong features of good practice relating to inclusion and diversity. The opportunity to spend time talking to newly qualified colleagues about diversity and their role in challenging discrimination was invaluable.

**Recommendations**

The Board of Directors is requested to:

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

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

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

# 2019 NHS Staff Survey: results summary

NHS
Derbyshire Healthcare
NHS Foundation Trust

- Highest ever response rate - 60%
- 9 areas higher than 2018
- 2 areas the same as 2018

**Staff Friends and Family Test measure**

**Q21c: I would recommend my organisation as a place to work**

**Up 9% from 2018**
From 56% to 65%

**Staff Friends and Family Test measure**

**Q21d: If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation**

**Up 5% from 2018**
From 61% to 66%

### Equality, diversity & inclusion
Same score as 2018
**9.2**

### Health & wellbeing
Improvement on 2018
**6.3**

### Immediate managers
Improvement on 2018
**7.4**

### Morale
Improvement on 2018
**6.6**

### Quality of appraisals
Improvement on 2018
**5.6**

### Quality of care
Improvement on 2018
**7.5**

### Safe environment - Bullying & harassment
Improvement on 2018
**8.4**

### Safe environment - Violence
Same score as 2018
**9.5**

### Safety culture
Improvement on 2018
**6.7**

### Staff engagement
Improvement on 2018
**7.1**

### Team working
Improvement on 2018
**7.1**

**How our scores compare to the average Combined Mental Health/LD & Community Trust score:**

- Better than average
- The same as average
- Worse than average

All of the eleven themes are scored on a 0-10 scale, where a higher score is more positive than a lower score. These theme scores are created by scoring question results and grouping these results together.

**Derbyshire Healthcare NHS Foundation Trust**
Report to the Board of Directors – 3 March 2020

# Performance Report 2019/20

**Purpose of Report**

The purpose of this report is to provide the Board of Directors with an overview of Trust performance at the end of January 2020.

**Executive Summary**

The report provides the Board of Directors with information that shows how the Trust is performing against a set of key targets and measures.

Performance is summarised in an assurance summary dashboard with targets identified where a specific target has been agreed. Where a specific target hasn't been agreed or specifically commissioned, colleagues will be able to track performance over time and discuss/challenge any specific variation that may be of concern or unusual. Further detailed charts for the measures are included in appendix 2.

The main body of the report provides detail on a number of the key measures. Board members are also able to triangulate information from this report with the assurance summaries from each Committee, where more in depth reports have been provided for assurance.

The main areas to draw the Board's attention to are as follows:

**Finance**

The financial position for the end of January is slightly behind plan by £2k. The forecast assumes that the yearend (stretch) planned surplus of £1.8m can be achieved. However in order to achieve the stretch plan surplus the forecast assumes the reduction or avoidance of forecast expected costs totalling £0.8m (£1.0m last month).

In general terms, the financial risk is generated by unfunded cost pressures of £1.6m offset by contingency reserves of £750k leaving a net cost pressure of £0.9m.

Out of area (OOA) and Stepdown budget is now forecast to overspend by £0.5m due to the current overspend position at the end of January of £0.3m.This is an adverse movement of 0.3m compared to last month's forecast.

The forecast still assumes that 2019/20 cost improvement programme (CIP) is undelivered by £270k by the end of the financial year.

The forecast has been updated to reflect a partial payment for the Flu CQUIN of £173k for 72% achievement.

Agency forecast has reduced by £82k and still includes a level of contingency for any new requirements. There has been slippage on the recruitment to the Personality Disorder (PD) pathway which has reduced the expenditure forecast by £88k. These improvements have helped to offset the adverse movement in OOA and Stepdown forecast.

Sustainablity and Transformation Partnership (STP) financial position

As at month 9 (the most recent reported position) the STP position is off plan by £36.3m YTD. The two main drivers are Chesterfield Royal at £9.7m off plan due to tariff changes and University Hospitals of Derby and Burton (UHDB) off plan by £26.1m due to the impact of undelivered savings.

**Quality and Operations**

Care Programme Approach (CPA) seven day follow-up

In January two patients were not followed up within seven days post discharge. One patient was transferred to Royal Derby for end of life care and regular contact was maintained with the ward; the other patient initially refused to engage with services however the team liaised with their care workers to ascertain their wellbeing and successful contact with the patient was made on day 11.

Data quality maturity index

As reported previously, the reduction in data quality is a result of NHS England adding new items of data to be collected. Our data quality is higher than the national average. For more information see Appendix 4 in last month's report.

IAPT people completing treatment who move to recovery

Although statistically the reliable improvement target may pass or fail based on random variation, Talking Mental Health Derbyshire continues to exceed its performance targets for both recovery rates (target >50%) and reliable improvement (target >65%) in every month of 2019/20. Performance is very tightly monitored by the Area Service Manager.

Out of Area – Acute Placements

The Acute Services Management Team have systems and processes to ensure the flow of patients is planned to reduce the amount of time patients are out of area as much as possible and to optimise beds in the acute units, within the capacity and demand constraints as described above:

- Monday morning clinical meetings with ward based consultants, senior nurses, Local Authority social care workers and Assessment Services
- Daily ward rounds
- Daily senior nurse meetings to discuss patient flow
- Daily Assurance Calls with senior management team to discuss bed availability
- Weekly discussion with case managers, flow coordinators and senior managers

Waiting list for child and adolescent mental health services (CAMHS)

The waiting list and capacity to meet demand continue to be a challenge for CAMHS. Last month the Clinical Commissioning Group (CCG) released the agreed additional investment into CAMHS for this financial year, in advance of the CCG planning for next financial year. This should enable provision of some additional capacity and positively impact on the waiting list. Investment into the recovery pathway will support throughput within the service, free up capacity within ASIST and reduce waits.

Waiting list for community paediatrics

The waiting list has continued to reduce over the last 4 months. Waits below 52 weeks have been sustained for almost six months to date. Capacity and appointment managing centrally were initiated formally from 1 February 2020, the Waiting List Coordinator having now commenced in post. A review of the service specification with the CCG is progressing positively.

Waiting list for autistic spectrum disorder (ASD) assessment

As previously reported it is important to note that full commissioned capacity is not enough to meet the perennial and increasing levels of demand for this service. To meet demand, the service would need capacity to assess between 49 and 60 patients per month (the 65th to 85th percentile), whereas the service has averaged around 21 assessments per month, with 35 being the highest level ever achieved.

Waiting list for psychology

Work is ongoing to manage and reduce waiting times and numbers waiting across all community teams. Capacity has increased recently which will impact positively on waiting times. There continues to be difficulty in recruiting to all psychology posts.

Patients open to the Trust who are in settled accommodation

This has been a reducing trend but is beginning to show some improvement but will continue to be monitored.

Medication incidents

The trend for this measure seems to be stabilising. How incidents are classified, if they are Trust incidents or other provider incidents and our process of review is explained within the text of the paper.

Incidents of moderate to catastrophic actual harm

A recent increase is largely attributable to an increase in falls from a small number of patients, and assaults by patients on staff in older people's wards. The increase in falls is also covered in the text of the paper.

**Workforce**

Annual appraisals

The systems and Information team have now aligned the appraisal completion process for new starters, employees taking maternity leave or a career break and employees on long term sickness absence, the date is now extended to when the appraisal will be completed instead of showing as non-compliant from the start of that period. The completion rate has improved over the last 3 months.

Staff Attendance

Staff absence rates continue to cause concern across areas of the Trust. The top reason for absence remains to be anxiety/stress/depression and other psychiatric illnesses. Health and attendance training sessions for all line managers is progressing and to date 69% of managers have been trained. Further sessions for 2020 are now confirmed. The number of long term sickness cases is a key focus area for the employee relations team working with managers across the Trust to provide advice support and guidance in managing these cases effectively and sensitively.

Vacancies

Focus on inpatient areas to recruit and initiatives to recruit and retain are progressing. Recruitment rates are now beginning to show some progress although delays in parts of the recruitment process are still causing concern. Further operational support has been provided particularly in inpatient areas and it is expected that this will improve this stage of the process and fill vacancies at a faster rate.

Community staffing
This month's report includes information on community staffing levels.

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

**Assurances**

This report relates directly to the delivery of the Trust's strategy by summarising performance across the four key performance measurement areas. This report should be considered in relation to the relevant risks in the Board Assurance Framework.

As an integrated performance report the content provides assurance across several BAF risks related to workforce, operational performance, quality performance,

financial performance and regulatory compliance. The use of run charts will provide the Board with a more detailed view of performance over time as it enables the differentiation between normal and special cause variation.

**Consultation**

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

**Governance or Legal Issues**

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

**Public Sector Equality Duty & Equality Impact Risk Analysis**

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

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

This report reflects performance related to all of the Trust's service portfolio and therefore any decisions that are taken as a result of the information provided in this report is likely to affect members of those populations with protected characteristics in the REGARDS groups.

Any specific action will need to be relevant to each service and considered accordingly, so for example, as parts of the report relate specifically to access to Trust services; we will need to ensure that any changes or agreed improvements take account of the evidence that shows variable access to services from different population groups.

**Recommendations**

The Board of Directors is requested to:

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

| | |
|---|---|
| **Report presented by:** | **Mark Powell, Chief Operating Officer**<br>**Claire Wright, Director of Finance/Deputy CEO**<br>**Amanda Rawlings, Director of People and Organisational Effectiveness**<br>**Carolyn Green, Director of Nursing and Patient Experience** |
| **Report prepared by:** | **Karl Faulkner, Advanced Finance Analyst**<br>**Peter Henson, Head of Performance, Delivery & Clustering**<br>**Kathryn Lane, Deputy Director of Operational Services**<br>**Rachel Leyland, Deputy Director of Finance**<br>**Nadeem Mirza, Safety and Risk Systems Administrator**<br>**Catherine Pynegar, Business Intelligence Manager**<br>**Celestine Stafford, Assistant Director of People & Culture Transformation**<br>**Darryl Thompson, Deputy Director of Nursing & Quality Governance** |

## 1. Assurance Summary

| Indicator | Rating[1] | Data Quality | Indicator | Rating[1] | Data Quality |
|---|---|---|---|---|---|
| **Financial** | | | | | |
| Cumulative surplus / (deficit) | n/a | | Liquidity | | |
| Agency expenditure against ceiling | | | Cumulative cost improvement programme | n/a | |
| Agency costs as a proportion of total pay expenditure | | | Cumulative capital expenditure | n/a | |
| Out of area and step down expenditure | | | | | |
| **Operational** | | | | | |
| CPA 7 day follow-up | | | Waiting list for care coordination – number waiting | See chart | |
| Data Quality Maturity Index (DQMI) - MHSDS data score | | | Waiting list for care coordination – average wait | See chart | |
| Early Intervention (EIP) RTT within 14 days - complete | | | Waiting list for ASD assessment – number waiting | See chart | |
| EIP RTT within 14 Days - incomplete | | | Waiting list for ASD assessment – average wait | See chart | |
| IAPT referral to treatment (RTT) within 18 weeks | | | Waiting list for psychology – number waiting | See chart | |
| IAPT referral to treatment within 6 weeks | | | Waiting list for psychology – average wait | See chart | |
| IAPT people completing treatment who move to recovery | | | Waiting list for CAMHS – number waiting | See chart | |
| Patients placed out of area - PICU | See chart | | Waiting list for CAMHS – average wait | See chart | |
| Patients placed out of area - adult acute | See chart | | Waiting list for community paediatrics – number waiting | See chart | |
| | | | Waiting list for community paediatrics – average wait | See chart | |

[1]The rating symbols were designed by NHS Improvement

**Key:**

| | |
|---|---|
| P | The system is expected to consistently pass the target |
| ? | The system may achieve or fail the target subject to random variation |
| F | The system is expected to consistently fail the target |

| Indicator | Rating[1] | Data Quality | Indicator | Rating[1] | Data Quality |
|---|---|---|---|---|---|
| **Workforce** | | | | | |
| Annual appraisals |  | | Clinical supervision |  | |
| Annual turnover |  | | Management supervision |  | |
| Compulsory training |  | | Vacancies |  | |
| Sickness absence |  | | Bank staff use |  | |
| **Quality** | | | | | |
| **A. Safe** | | | | | |
| Incidents of moderate to catastrophic actual harm |  | | Medication errors |  | |
| Episodes of patients held in seclusion |  | | Incidents involving physical restraint |  | |
| Incidents involving prone restraint |  | | Incidents requiring duty of candour |  | |
| Falls on inpatient wards |  | | | | |
| **B. Caring** | | | | | |
| Formal complaints received |  | | Compliments received |  | |
| Staff friends and family test - recommended care |  | | | | |
| **C. Effective** | | | | | |
| Patients in settled accommodation | | | Patients in employment | | |
| **D. Responsive** | | | | | |
| Patients on CPA whose care plan has been reviewed |  | | Delayed transfers of care |  | |

[1]The rating symbols were designed by NHS Improvement

**Key:**

| | |
|---|---|
|  | The system is expected to consistently pass the target |
|  | The system may achieve or fail the target subject to random variation |
|  | The system is expected to consistently fail the target |

## 2. Detailed Narrative

**Finance**

The financial position at the end of January 2020 (month 10) is a surplus of £1.6m which is slightly behind plan year to date by £2k. The forecast assumes the achievement of the plan surplus of £1.8m. However in order to achieve the £1.8m surplus the forecast requires a cost reduction of £0.8m (£1.0m last month).

The position includes cost pressures totalling £0.9m after the use of contingency reserve. At the time of the plan submission it was assumed that some of these costs could be funded by Mental Health Investment Standard (MHIS) investment. However MHIS investment funded the overspend on Out Of Area (OOA) expenditure non-recurrently, with an agreement to reinvest any savings on OOA expenditure recurrently, which could then fund some of these related cost pressures.

The Cost Improvement Programme (CIP) is forecast to under deliver by £270k mainly due to the Wellbeing scheme having had no impact in lost days due to sickness absence as yet.

OOA and stepdown budget is forecasting an overspend of £0.5m due to the YTD overspend position of £0.3m. This is based on an assumption of 14 OOA and 9 Stepdown placements on average per month for the remainder of the financial year. This is an adverse movement of 30.3m compared to last month's forecast.

The forecast has been updated this month to reflect a partial payment for the Flu CQUIN of £173k for 72%.

Mitigations for cost reduction of £0.8m include the release of some balance sheet provisions along with not requiring the impairment for capital works completed at Tissington House in this financial year.

Comparing the actual expenditure on Agency to the ceiling we are below the ceiling value by £145k (6%) at the end of January. This generates a '1' on this metric within the finance score. Agency expenditure is forecast to be £2.87m which is below plan by £159k. This includes a contingency of £50k over the last two months.

Agency expenditure equates to 2.6% of total pay expenditure year to date and 2.9% forecast. Published on the Model Hospital is data for December 2019 which compares our percentage of agency costs of 2.69% against the peer median of 4.85% and National Median of 3.99%.

Capital is behind plan year to date. Original plans have been reviewed and replaced with new schemes that are phased towards the end of the financial year and that are related to CQC requirements and compliance. Therefore the forecast is to spend to the full plan of £5.2m.

STP Financial position:

As at month 9 STP position is off plan by £36.3m year to date, which is mainly due to: the Chesterfield Royal position continues to be off plan by £9.7m due to the complexities of the tariff change (year on year assessment and the move to the blended tariff for unscheduled care, in year) and the University Hospitals of Derby and Burton (UHDB) is now reporting an off-plan year to date performance of £26.1m, largely now due to the impact of undelivered savings including those associated with the Service Benefit Reviews. The forecast has changed at month 9 and the system is reporting to be off plan by £62.3m by the end of the financial year. The two main drivers are Chesterfield Royal at £11.5m behind plan and University Hospitals of Derby and Burton who are forecasting to be off plan by £51.4m.

The savings position for month 9 is collated at a detailed level by scheme. Of the total efficiency requirement of £151m, the forecast level of savings planned at month 9 is £101.9m, which is off plan by £49.1m.

**Operations**

A. Seven day follow-up

The purpose of seven day follow-up is to establish the wellbeing of patients and provide support during the period where they may be feeling most vulnerable during the first few days post discharge. In January there were two patients on CPA who were not followed up within seven days of discharge. One of the patients was transferred to Royal Derby Hospital for end of life care. The other patient initially refused to engage with services, however their wellbeing was established through discussion with their support workers and they were subsequently followed up directly on day 11.

From April 2020 the national standard for follow-up is likely to be reduced to 72 hours (see https://www.england.nhs.uk/wp-content/uploads/2019/12/1-NHSSC-20-21-consultation-document.pdf page 6).

B. Data quality maturity index

The number of items NHS England are monitoring has increased over time from 6 items to 36. This creates a challenge in terms of collecting the new data; however we continue to perform well when benchmarked against other organisations. For more information see appendix 4 in last month's report.

C. IAPT – people completing treatment who move to recovery

Despite the fact that statistically it is entirely random as to whether or not we pass or fail this target, Talking Mental Health Derbyshire have achieved the target every month to date. This is a result of the Area Service Manager tightly monitoring the position on a daily basis and reacting to address any deterioration. Performance is also monitored at regular contractual and operational meetings.

D. Patients placed out of area – PICU and adult acute

All patients placed out of area are visited by a DHCFT out of area care manager. Their role is to ensure that patients are receiving high quality, safe care while not being directly cared for by the Trust.

The use of clinically safe leave beds for admission is reviewed. A safe leave bed is one where a patient may have had two or more successful periods of home leave and may be on extended leave prior to discharge.

There is currently no local PICU provision, however this is being considered as part of the Estate transformation project.

28 patients were placed out of area in January owing to limited bed capacity in-house.

The Acute Services Management Team have systems and processes to ensure the flow of patients is planned to reduce the amount of time patients are out of area as much as possible and to optimise beds in the acute units, within the capacity and demand constraints as described above:

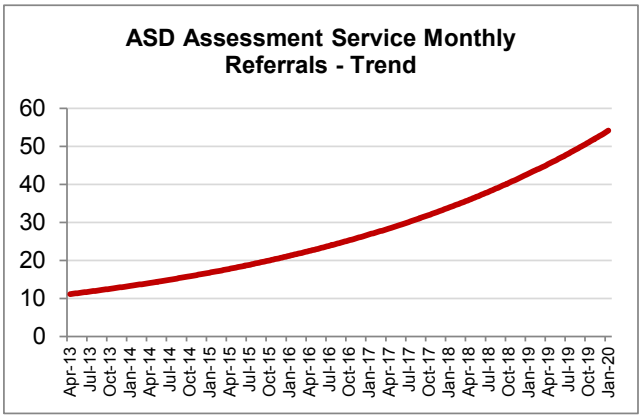
- Monday morning clinical meetings with ward based consultants, senior nurses, Local Authority social care workers and Assessment Services
- Daily ward rounds
- Daily senior nurse meetings to discuss patient flow
- Daily Assurance Calls with senior management team to discuss bed availability
- Weekly discussion with case managers, flow coordinators and senior managers

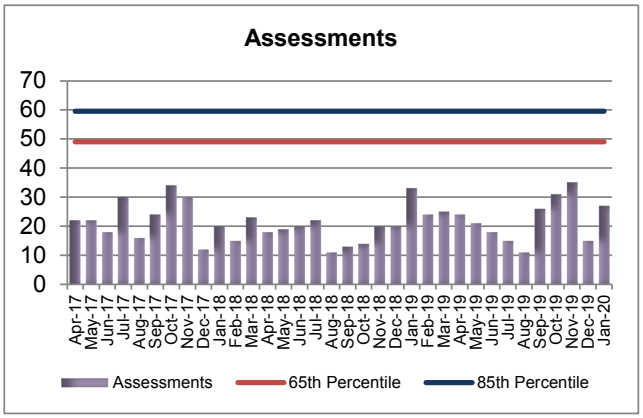
Focused work is in progress with regard to service improvement regarding optimising length of stay.

From previous analysis it was found that a significant proportion of bed capacity was filled by patients with a personality disorder. Establishment of a specialist personality disorder service in the community in the near future should result in a reduction in admissions and readmissions of patients with a personality disorder and in a better patient experience for this patient group, while also freeing up bed capacity.

E. Waiting list for autistic spectrum disorder (ASD) assessment

It is important to note that full commissioned capacity is not enough to meet the ongoing and increasing levels of demand for this service. To meet demand, the service would need capacity to assess between 49 and 60 patients per month, whereas the service has averaged around 21 assessments per month, with 35 being the highest level ever achieved. A paper has been submitted to the Executive Leadership Team which will be reviewed in March. This report proposes options to increase capacity; however this would have cost implications for commissioners.




F. Waiting times for psychology

The service continues to support 3 maternity leaves in Adult Services and 1 in Older People's Services. All areas have some psychological input with existing staff providing cover for absence or vacancy. Some appointments have been made to the developing personality disorder pathway and in time this is expected to have a positive impact on waiting list for DBT. There is ongoing work to define criteria and pathway for patients to ensure that the psychology service does not 'creep' into delivering a non-commissioned tier 4 service between IAPT and secondary care. A new waiting well leaflet for psychology services has been developed and will be integrated into the waiting list process early in 2020.

G. Waiting times for learning disability services

Changes to the way in which the Learning Disability Service operates have seen the introduction of a single point of access for Derby and for Derbyshire, with ongoing work to integrate these into one in the next few months. The piloting of a new referral matrix has supported with the prioritisation of referrals and supported consistency across the service. This review and focus has helped see an ongoing decrease in wait times and a reduction in the referral to treatment time.

H. Waiting times for physiotherapy

The mental health physiotherapy team continue to see fluctuating demand across the year. Despite challenges in recruitment to specialist physiotherapy roles the service has been able to maintain a high level of consistent performance. Ongoing work with the wards and a clear referral and prioritisation process enables the team to work effectively across the county.

I. Waiting times for substance misuse services

The national standard for substance misuse services is to see 95% of people within 3 weeks of referral. We continue to achieve this standard in both City and County. On the rare occasion when people wait over 3 weeks this is a result of pressure on slots and needing to prioritise those people who need prescribing.

J. Waiting times for community perinatal services

Staff sickness to key clinical roles has impacted on assessment and review capacity within the community team. However, proactive advances such as the piloting of antenatal clinics have meant that more women are seen at an earlier stage without the requirement for formal referral into Perinatal services. We aim to expand this provision in 2020/21 with potential NHSE early implementation funding.

K. Waiting times for eating disorder services

The Adult Eating Disorder Service continues to operate an effective prioritisation system to ensure service users with the highest level of risk are seen rapidly. Due to the small size of the specialist team there are impacts on waiting times at times of annual leave and sickness which are difficult to mitigate. The team is only able to work with the individuals with a BMI of 17 or below which limits the number of referrals they can take to those with the highest risk and need.

L. Waiting times for IAPT

IAPT board review the detail and escalate hotspots through normal performance reporting functions on a monthly basis; this includes highlighting geographic areas of concern in addition to the overall waiting times.

**Referral to treatment waiting list**

| Waiting range | n | % |
|---|---|---|
| 0-6 Weeks | 1259 | 90% |
| 6-12 weeks | 113 | 8% |
| 12-18 Weeks | 27 | 2% |
| 18+ Weeks | 0 | 0% |
| **Total** | **1399** | |
| **Average Weeks Waiting** | **3** | |

M. Waiting times for child & adolescent mental health services (CAMHS)

Context

The external waiting list continues to provide real challenge to the service. We are still managing the legacy of a doubling of referrals in quarter 1 owing to changes in commissioning. New starters to the assessment team are now in post, have completed their induction and are now picking up independent work. This effectively increased the capacity for new assessments from 20 per week to around 30 per week, as vacancy and short term sickness was affecting capacity. There is 1 vacancy at present, hence operating at 30 assessments per week, rather than at full capacity of 38.

Actions taken to date

The follow up groups referred to in the last report are now in place. Routine assessment clinics are now in place following the Christmas break, and the vacant clinical lead post is out to advert for substantive recruitment (currently covered by secondment). The weekly activity and trajectory are monitored, and recruitment using the funding from the mental health investment standard has commenced and is in a second round now to fill the remaining vacant posts. This follows a significant delay in release of the funding, which was not released by the CCG until December

2019. Approval for use of overtime did not result in additional capacity, however we now have an experienced member of staff who will do limited bank work to help create capacity.

Demand and capacity modelling is underway, with some initial work demonstrating the theoretical capacity is not enough to meet demand, but that actual capacity in the last 6 months (affected by turnover and short term sickness) has been significantly short.

Further demand and capacity modelling has demonstrated that when fully recruited Asist would have capacity but this does not take into account the substantial waiting list. In addition there has been further staff movement within the service due to new opportunities that has resulted in the following vacancies 2.0 WTE. Band 6, 1.0 wte band 5 and 0.6 wte maternity leave. These posts are currently out to advert.

Further actions to be taken

In order to address the significant challenge and legacy, an action-focused review was led by the General Manager in early January 2020, producing key actions and a revised action plan. This will result in a swift change to the appointment booking process (now offering a fixed assessment appointment rather than an invitation to call and book), review of assessment clinics to increase capacity (single practitioner assessments rather than double), new booking rules, recruitment of a waiting list coordinator (underway) and a revision to the administrative support to the process to streamline and reduce variation. A rapid review to establish whether other therapy capacity could be used to bring swifter family/ parenting intervention is also being scoped. An options appraisal was undertaken and the current assessment clinics offer 50% single practitioner assessment and 50% double this has provided an increase in capacity to 40 assessments per week. Current capacity is 15-18 per week due to the vacancy factor.

We continue to triage referrals via SPOA and signpost where clinically appropriate to other CCG funded services for assessment and follow up. Measures are in place to track the impact of the changes to check that progress is achieved and unintended consequence, for example a rise in DNA to change in appointment booking process, could be identified.

The changes proposed above will result in:

- Increased capacity by using single practitioners to undertake most assessments (previous staff used to undertake in pairs). This will increase the full capacity from the current 38 assessments per week (when fully staffed), with calculations being undertaken to assess the capacity gain.
- Better booking process, whilst noting that choice is reduced
- Recruitment of the waiting list co-ordinator will ensure we have grip on booking and will assist the operational managers to respond to demand better
- Recruitment to clinical posts will again increase capacity

Demand and capacity modelling is underway as above, and will be revised to reflect the changes to how the assessment process is to be undertaken.

It is important to note that working at pace in an assessment service can have an impact on staff wellbeing, with some of the turnover in the earlier part of the year attributable to this. Senior managers will ensure they maintain oversight of this concern. A longer term internal review of the construct of the assessment/short term intervention service will be undertaken during 2020/21.

Mitigations:

- Secured an experienced clinician to work (limited hours) on bank to support
- Clinical lead vacancy covered by secondment and in permanent recruitment
- Area Service Manager establishing a weekly situation report ‘sitrep’ to bring more stringent oversight
- Divisional Clinical Lead involved in review and oversight

A Service away day was held to look at the capacity across the service and there is an identified need to address the length of stay in order to improve flow across service to support the external waiting times. The risk associated with internal waits within service is of concern and increasing caseload size with children waiting for a service.

All new referrals for ASD/ADHD assessment to be discussed in MDT with medical oversight prior to referral for specialist assessment. Review of the existing waiting list for ASD/ADHD by all band 7. Development of an overtime clinic on Saturday to increase assessment diagnostics and report writing. Increase in caseload management and clinical supervision to ensure that children and young people are receiving the right care at the right time and increase throughput. The establishment of a 4 session discharge group to include wellbeing and sleep interventions.

N. Waiting times for community paediatrics

Progress continues to be made. Waits below 52 weeks have been sustained for 18 weeks. Capacity and appointment managing centrally will be initiated formally from 1 February 2020, the Waiting List Coordinator having now commenced in post. Work is progressing with IM&T to further enhance the TPP system of appointment booking. The process of reviewing the service specification with the CCG is well underway and positive.

O. Waiting times for memory assessment services

MAS wait times are well documented and Commissioners are aware. In the absence of this being a trust priority for additional funding we have asked for commissioners to tolerate longer waits. Given this position it is likely these waits will continue to grow, however monthly reporting and escalation will continue.

P. Waiting times for older people's community mental health services

| Referral to assessment average wait - weeks | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Team | Apr-19 | May-19 | Jun-19 | Jul-19 | Aug-19 | Sep-19 | Oct-19 | Nov-19 | Dec-19 | Jan-20 | Chart |
| Amber Valley | 3.4 | 3.9 | 4.0 | 3.6 | 2.2 | 2.6 | 2.2 | 3.1 | 3.3 | 4.0 | |
| Erewash | 4.9 | 4.1 | 4.8 | 3.9 | 3.7 | 5.1 | 3.5 | 4.1 | 3.1 | 4.9 | |
| South Derbys & South Dales | 2.7 | 4.2 | 3.7 | 3.0 | 3.0 | 4.2 | 4.4 | 4.2 | 3.4 | 6.2 | |
| Derby City | 2.6 | 2.3 | 3.6 | 2.6 | 4.1 | 3.6 | 4.0 | 5.5 | 5.0 | 5.5 | |
| Bolsover & Clay Cross | 1.9 | 10.2 | 1.7 | 3.1 | 1.8 | 3.6 | 2.6 | 2.8 | 3.6 | 3.6 | |
| Chesterfield Central | 2.4 | 2.0 | 3.3 | 1.8 | 2.1 | 2.9 | 2.3 | 1.8 | 0.9 | 2.1 | |
| High Peak & North Dales | 1.3 | 1.8 | 1.1 | 2.0 | 1.6 | 2.0 | 1.8 | 2.1 | 1.9 | 3.1 | |
| Killamarsh & N. Chesterfield | 4.8 | 3.1 | 2.1 | 2.8 | 4.5 | 2.4 | 3.0 | 2.5 | 2.9 | 3.9 | |

| Referral to treatment average wait - weeks | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Team | Apr-19 | May-19 | Jun-19 | Jul-19 | Aug-19 | Sep-19 | Oct-19 | Nov-19 | Dec-19 | Jan-20 | Chart |
| Amber Valley | 4.2 | 5.3 | 5.6 | 6.2 | 3.4 | 4.8 | 3.5 | 4.1 | 4.6 | 5.2 | |
| Erewash | 7.0 | 5.6 | 6.5 | 5.4 | 5.5 | 6.7 | 6.4 | 5.2 | 6.1 | 6.2 | |
| South Derbys & South Dales | 3.3 | 5.5 | 4.8 | 4.4 | 6.5 | 6.5 | 4.9 | 6.7 | 7.8 | 6.4 | |
| Derby City | 3.3 | 3.5 | 4.1 | 4.4 | 5.3 | 5.1 | 5.4 | 6.7 | 6.0 | 7.4 | |
| Bolsover & Clay Cross | 3.3 | 4.0 | 2.6 | 4.4 | 4.7 | 6.0 | 3.8 | 5.7 | 3.9 | 6.2 | |
| Chesterfield Central | 5.3 | 3.5 | 4.2 | 3.4 | 3.6 | 3.7 | 4.2 | 3.5 | 2.8 | 2.9 | |
| High Peak & North Dales | 3.6 | 3.6 | 2.5 | 4.1 | 4.4 | 3.0 | 2.9 | 4.2 | 4.4 | 4.5 | |
| Killamarsh & N. Chesterfield | 6.9 | 4.1 | 4.5 | 4.2 | 4.9 | 5.0 | 4.1 | 5.7 | 4.5 | 7.5 | |

The two areas with focused attention are Derby City and South Derbyshire & South Dales, compounded by reduced capacity due to registered nurse absences. January has seen a return of nurse resource which will improve wait times.

The consultant in older adult psychiatry in the Bolsover & Clay Cross locality is expecting to retire by the end of quarter 1 2020-21. Recruitment is underway with interviews early March.

Q. Waiting times for adult community mental health services

| Referral to assessment average wait - weeks | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Team | Apr-19 | May-19 | Jun-19 | Jul-19 | Aug-19 | Sep-19 | Oct-19 | Nov-19 | Dec-19 | Jan-20 | Chart |
| Amber Valley | 8.4 | 6.7 | 7.5 | 5.2 | 6.7 | 7.5 | 6.5 | 5.6 | 4.1 | 9.8 | |
| Erewash | 11.5 | 10.9 | 9.5 | 9.6 | 9.3 | 10.2 | 10.2 | 11.8 | 13.3 | 14.3 | |
| South Derbys & South Dales | 5.5 | 13.1 | 10.6 | 15.3 | 11.0 | 7.2 | 10.7 | 19.3 | 14.7 | 16.8 | |
| Derby City | 12.3 | 10.3 | 5.6 | 10.1 | 9.7 | 12.1 | 18.8 | 11.6 | 11.2 | 8.9 | |
| Bolsover & Clay Cross | 6.6 | 18.0 | 30.9 | 9.0 | 9.3 | 9.0 | 8.5 | 7.8 | 9.7 | 7.9 | |
| Chesterfield Central | 7.1 | 7.5 | 8.8 | 6.2 | 9.7 | 8.9 | 9.3 | 9.0 | 5.9 | 7.5 | |
| High Peak & North Dales | 3.6 | 2.8 | 4.1 | 5.4 | 5.0 | 3.7 | 4.3 | 4.1 | 5.4 | 5.7 | |
| Killamarsh & N. Chesterfield | 8.8 | 34.4 | 26.6 | 12.2 | 9.5 | 11.3 | 6.6 | 10.9 | 11.8 | 6.9 | |
| | | | | | | | | | | | |
| **Referral to treatment average wait - weeks** | | | | | | | | | | | |
| Team | Apr-19 | May-19 | Jun-19 | Jul-19 | Aug-19 | Sep-19 | Oct-19 | Nov-19 | Dec-19 | Jan-20 | Chart |
| Amber Valley | 9.6 | 9.7 | 10.0 | 8.4 | 7.2 | 10.1 | 8.3 | 7.3 | 4.7 | 11.4 | |
| Erewash | 12.6 | 15.2 | 11.4 | 12.1 | 13.5 | 13.2 | 13.2 | 14.2 | 14.2 | 14.7 | |
| South Derbys & South Dales | 10.8 | 13.6 | 7.8 | 18.5 | 11.5 | 18.9 | 9.2 | 17.1 | 26.8 | 23.5 | |
| Derby City | 13.8 | 12.4 | 8.5 | 10.6 | 14.4 | 12.6 | 18.7 | 17.6 | 9.9 | 14.2 | |
| Bolsover & Clay Cross | 10.4 | 14.5 | 52.3 | 21.8 | 17.9 | 15.7 | 11.1 | 14.1 | 15.9 | 11.7 | |
| Chesterfield Central | 10.3 | 9.8 | 7.4 | 11.6 | 10.6 | 14.8 | 11.4 | 15.4 | 12.6 | 9.6 | |
| High Peak & North Dales | 4.6 | 6.0 | 3.9 | 6.5 | 6.4 | 7.3 | 6.6 | 9.4 | 8.4 | 10.0 | |
| Killamarsh & N. Chesterfield | 14.3 | 18.0 | 47.4 | 27.7 | 21.6 | 14.6 | 13.8 | 12.9 | 21.6 | 12.5 | |

There is some variance month on month in average week waits from referral to assessment and referral to treatment. This is largely due to fluctuating capacity due to registered nurse absences and difficulties in obtaining cover for these gaps.

R. Waiting times for initial assessment and care coordination in adult community mental health services

| Team | Numbers waiting for Initial Assessment | Numbers Waiting for Care Coordination |
|---|---|---|
| Amber Valley | 43 | 0 |
| Erewash | 80 | 23 |
| South Derbys and South Dales | 54 | 26 |
| Derby City Team B | 67 | 47 |
| Derby City Team C | 62 | 46 |
| Bolsover and Clay Cross | 94 | 2 |
| Chesterfield Central | 90 | 12 |
| High Peak and North Dales | 54 | 0 |
| Killamarsh and N. Chesterfield | 63 | 32 |

Numbers for initial assessment remain fairly consistent across teams. However, these can increase due to unplanned staff absences.

Numbers waiting for care coordination have significantly reduced across all teams. This is as a result of new ways of working such as the Nurse Led Clinic, as well as an increase in group interventions.

Longest waiters are being reviewed by Area Service Managers with service managers. There is on-going data validation to ensure that the waiting lists are accurate and reflect the correct information on the Electronic Patient Record. There is divisional engagement with service managers to ensure regular review of waiting lists. Waiting lists are managed locally for the different interventions available.

All teams follow the waiting list policy and procedure, which ensures contact is made with those on the waiting list for a care coordinator. A new caseload management tool has recently been introduced which all teams are utilising to support flow through the service.

**Quality**

Particular measures of note are as follows:

A. Patients open to Trust in employment

This has been a deteriorating trend, but you will note some recent improvement. We are continuing to approach this via our IPS Service (Individual Placement Support). This is an evidence based approach utilising employment advisors who have been employed specifically to support our service users into employment. Five employment advisors have been recruited and started in January. We're also applying for further funding from NHS England to roll this initiative out more widely, and are working in partnership with South Yorkshire Housing for the IPS service to be delivered by them in some of the north areas of the county (Chesterfield Central and Killamarsh teams).

B. Patients open to Trust in settled accommodation

This has been a deteriorating trend, but you will note recent improvement. It continues to be reviewed by managers in the community in a bid to understand what might be driving this change, either in the accuracy of our reporting or in our patient population, and is also supported by recruitment of two part-time homeless specialist nurses in the community team in Chesterfield, and plans to recruit to this vacancy in Derby City.

C. Number of falls on inpatient wards

Further to our recent reducing trend we are noting a recent increase. On further exploration of this, there seems to be correlation with an increase in occupied bed days (greater occupation statistically increasing the risk of a recorded fall). Our records also show that there is a small number of patients across our older people's wards accounting for these falls, rather than a large number of people falling. We are also seeking to maintain a balance between encouraging mobility and maintaining a level of observation and proximity to the person that does not cause distress and confusion for the patient. Falls reduction continues as a local Commissioning for Quality and Innovation (CQUIN), and we continue to report our progress to commissioners each quarter.

D. Incidents of moderate to catastrophic actual harm

The increased in recorded moderate or above harm for Jan 2020 is aligned to the increase in recorded falls on our older people's wards, and also an increase in the acuity of this patient group and assaults of staff by patients.

E. Medication incidents

It is important to note that not all medication incidents are Trust incidents, the majority of specialist (and a good number of community, including older adults) are other agency incidents discovered by our staff, e.g. community pharmacy making dispensing errors, domiciliary care agencies making errors etc. Medication incidents are all reviewed quarterly by the Heads of Nursing. As a trend, this looks to be currently stabilising.

F. Number of incidents requiring Duty of Candour

The increase noted in the most recent month is as a result of data refresh.

**Workforce**

A. Annual appraisals

For the last 3 months the completion rate has been above the upper control limit, which indicates significant improvement. The appraisal paperwork has been streamlined and as part of the Leadership Development Programme all line managers are required to attend appraisal training. Both of these factors may be contributing to the improvement seen. The completion rate is around

10% higher than the same period last year. Divisional People Leads (DPLs) continue to monitor and support where there are low rates of completion.

B. Turnover

Turnover over the financial year to date has consistently been at Trust target level.

C. Mandatory training

Following a period of sustained improvement since June 2018, this financial year the level of mandatory training has been maintained above Trust target every month to date.

D. Staff attendance

Staff absence levels remain high. In the most recently published national data[1], the average sickness rate over 12 months for mental health trusts ranged from 2.3% (The Tavistock and Portman) to 7% (Mersey Care). At 6.1% our rate was 4th highest in the sample.

In Operational Services by far the greatest cause of sickness absence in the Trust is anxiety, stress, depression or other psychiatric illness, which accounted for just less than 10 thousand working days lost between February 2019 and January 2020:

| Working days lost - top 5 absence reasons | Jan 19 | Feb 19 | Mar 19 | Apr 19 | May 19 | Jun 19 | Jul 19 | Aug 19 | Sep 19 | Oct 19 | Nov 19 | Dec 19 | Jan 20 | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Anxiety/stress/depression/other psychiatric illnesses | 824 | 682 | 726 | 611 | 701 | 734 | 947 | 1027 | 865 | 968 | 879 | 923 | 923 | 9986 |
| Surgery | 246 | 184 | 192 | 243 | 183 | 124 | 274 | 211 | 212 | 217 | 287 | 240 | 327 | 2693 |
| Cold, Cough, Flu - Influenza | 343 | 286 | 213 | 241 | 139 | 131 | 99 | 28 | 117 | 343 | 346 | 276 | 340 | 2558 |
| Other musculoskeletal problems | 136 | 128 | 157 | 200 | 213 | 217 | 246 | 216 | 149 | 198 | 157 | 151 | 211 | 2241 |
| Gastrointestinal problems | 200 | 153 | 168 | 178 | 144 | 134 | 174 | 146 | 155 | 222 | 201 | 230 | 183 | 2087 |

Resolve continue to provide support to employees and feedback about this service has been very positive. Over the last 12 months long-term sickness has accounted for the greatest proportion of sickness absence (3.9%) compared with short-term absence (2.8%). The Employee Relations Team continues to provide targeted support for those long term sickness cases where a range of options is considered. The DPLs are continuing to work closely with Service Managers and the Employee Relations Team to provide support and advice.

Health and attendance training is progressing for all line managers and to date 69% of managers have been trained. Further sessions are scheduled for 2020.

E. Supervision

Supervision levels are closely monitored at performance reviews and monthly operational meetings.

F. Vacancies

The focus on recruiting to inpatient areas is maintained and initiatives to recruit and retain staff are in place. The effectiveness of these initiatives is being monitored. The recruitment team are working to speed up pre-employment checks.

[1] https://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates/july-2019-to-september-2019

## 3. Community Staffing Levels January 2020

It is an NHS England requirement that all Trusts publish their inpatient nursing staffing levels each day by ward area, showing the Trust's actual and planned staff fill rates. We are also going to now publish our community staffing figures to ensure that a full overview of staffing is provided to Board colleagues.

The table below shows staffing levels across all community facing teams.

| Service Line | Sub-Service Line | Cost Centre Code Desc | Funded WTE | Contract WTE | Worked WTE | Paid WTE | Vacancy WTE |
|---|---|---|---|---|---|---|---|
| Adult Care Community | County North | EI Nth | 15.41 | 14.97 | 15.40 | 15.40 | 0.44 |
| Adult Care Community | County North | Cnty N Early Int Medical | 1.10 | 1.77 | 1.77 | 1.77 | -0.67 |
| Adult Care Community | County North | Medic Adult Comm Nth | 12.32 | 9.47 | 10.87 | 10.87 | 2.85 |
| Adult Care Community | County North | Bols + C C Adult CMHT | 20.54 | 19.80 | 19.77 | 19.77 | 0.74 |
| Adult Care Community | County North | Chesterfield C Adult CMHT | 28.28 | 28.33 | 28.54 | 28.71 | -0.05 |
| Adult Care Community | County North | HP + N Dales Adult CMHT | 25.71 | 20.83 | 21.62 | 21.62 | 4.88 |
| Adult Care Community | County North | Killmsh + N C Adult CMHT | 21.27 | 21.99 | 22.64 | 22.64 | -0.72 |
| Adult Care Community | County South | EI Clin Specialist | 3.11 | 1.00 | 1.00 | 1.00 | 2.11 |
| Adult Care Community | County South | City+CountyS EI Medical | 1.70 | 1.00 | 1.00 | 1.00 | 0.70 |
| Adult Care Community | County South | Medic Adult Comm Sth | 7.98 | 7.59 | 7.99 | 7.99 | 0.39 |
| Adult Care Community | County South | Amber Valley Adult CMHT | 20.14 | 20.51 | 20.15 | 20.15 | -0.37 |
| Adult Care Community | County South | Erewash Adult CMHT | 17.98 | 17.57 | 19.88 | 19.88 | 0.41 |
| Adult Care Community | County South | South + Dales Adult CMHT | 21.20 | 19.89 | 22.04 | 22.04 | 1.31 |
| Adult Care Community | County South | EI Sth + City | 21.53 | 20.68 | 21.68 | 21.84 | 0.85 |
| Adult Care Community | Derby City | Outpatient Resource Ctre | 2.80 | 2.80 | 2.80 | 2.80 | 0.00 |
| Adult Care Community | Derby City | Eating Disorders Service | 5.53 | 4.84 | 5.17 | 5.17 | 0.69 |
| Adult Care Community | Derby City | Medic Eating Disorders | 1.10 | 0.60 | 0.60 | 0.60 | 0.50 |
| Adult Care Community | Derby City | Medic Adult Comm City | 8.98 | 9.38 | 9.20 | 9.20 | -0.40 |
| Adult Care Community | Derby City | Derby City B Adult CMHT | 29.68 | 27.05 | 27.03 | 27.21 | 2.63 |
| Adult Care Community | Derby City | Derby City C Adult CMHT | 29.53 | 28.76 | 29.76 | 29.76 | 0.77 |
| Adult Care Community | Derby City | Derby City D Adult CMHT | 1.00 | 0.00 | 0.00 | 0.00 | 1.00 |
| Children's Services | CAMHS | Early Access | 2.09 | 2.00 | 2.00 | 2.00 | 0.09 |
| Children's Services | CAMHS | Supported Care | 1.92 | 0.80 | 0.85 | 0.87 | 1.12 |
| Children's Services | CAMHS | CAMHS ID PSGY | 0.91 | 0.91 | 0.91 | 0.91 | 0.00 |
| Children's Services | CAMHS | CAMHS Medics | 10.95 | 5.83 | 8.23 | 8.23 | 5.12 |
| Children's Services | CAMHS | CAMHS EA Rise | 11.40 | 7.41 | 7.69 | 8.36 | 3.99 |
| Children's Services | CAMHS | CAMHS EA Assist | 9.10 | 10.97 | 10.97 | 10.97 | -1.87 |
| Children's Services | CAMHS | CAMHS EA PMHW | 1.95 | 2.48 | 1.80 | 1.80 | -0.53 |
| Children's Services | CAMHS | CAMHS EA YOS | 1.00 | 0.00 | 0.00 | 0.00 | 1.00 |
| Children's Services | CAMHS | CAMHS SC Eating Disorder | 7.00 | 4.20 | 4.49 | 4.54 | 2.80 |
| Children's Services | CAMHS | CAMHS SC ID | 2.75 | 3.30 | 3.30 | 3.30 | -0.55 |
| Children's Services | CAMHS | CAMHS SC Recovery | 9.35 | 11.70 | 11.12 | 11.24 | -2.35 |
| Children's Services | CAMHS | CAMHS SC Inspire | 7.44 | 6.25 | 6.25 | 6.25 | 1.19 |
| Children's Services | CAMHS | CAMHS CBT + EMDR | 8.50 | 5.00 | 5.00 | 5.00 | 3.50 |
| Children's Services | CAMHS | CAMHS Sensory Therapy | 1.50 | 0.60 | 0.60 | 0.60 | 0.90 |
| Children's Services | CAMHS | CAMHS Family Intervention | 6.15 | 3.95 | 3.95 | 3.95 | 2.20 |
| Children's Services | CAMHS | CAMHS DBT + RO DBT | 1.80 | 2.50 | 2.50 | 2.52 | -0.70 |
| Children's Services | CAMHS | CAMHS NMP | 0.95 | 1.15 | 1.15 | 1.15 | -0.20 |
| Children's Services | CAMHS | CAMHS EHSS | 3.96 | 4.51 | 3.80 | 3.80 | -0.55 |
| Children's Services | CAMHS | CAMHS SC Specialist Assmt | 1.20 | 0.55 | 0.55 | 0.55 | 0.65 |

| Service Line | Sub-Service Line | Cost Centre Code Desc | Funded WTE | Contract WTE | Worked WTE | Paid WTE | Vacancy WTE |
|---|---|---|---|---|---|---|---|
| Children's Services | Children's Care Mgt | IPS Com Mental Health | 5.40 | 5.40 | 5.22 | 5.22 | 0.00 |
| Forensic + MH Rehab | Complex Care | Liaison + Diversion | 26.82 | 23.00 | 20.94 | 21.80 | 3.82 |
| Older Peoples Care | Older Peoples Acute Care | DRRT Sth | 27.69 | 26.12 | 25.24 | 26.19 | 1.57 |
| Older Peoples Care | Older Peoples Acute Care | Discharge Liaison Team OA | 3.73 | 3.60 | 3.60 | 3.60 | 0.13 |
| Older Peoples Care | Older Peoples Acute Care | Inreach + HT OA Sth | 17.13 | 12.68 | 12.64 | 13.44 | 4.45 |
| Older Peoples Care | Older Peoples Acute Care | DRRT Chesterfld + NED + B | 25.33 | 21.00 | 20.88 | 21.87 | 4.33 |
| Older Peoples Care | Older Peoples Comity Care | Memory Assessment Service | 16.23 | 16.21 | 17.61 | 17.62 | 0.02 |
| Older Peoples Care | Older Peoples Comity Care | Medic OA Comm | 8.78 | 10.35 | 10.40 | 10.40 | -1.57 |
| Older Peoples Care | Older Peoples Comity Care | Amber Valley OA CMHT | 17.44 | 17.97 | 17.20 | 17.20 | -0.53 |
| Older Peoples Care | Older Peoples Comity Care | Bols + CC OA CMHT | 12.04 | 11.50 | 11.50 | 11.50 | 0.54 |
| Older Peoples Care | Older Peoples Comity Care | Chesterfield C OA CMHT | 10.16 | 10.26 | 10.02 | 10.02 | -0.10 |
| Older Peoples Care | Older Peoples Comity Care | Derby City OA CMHT | 23.77 | 22.78 | 20.12 | 20.12 | 0.99 |
| Older Peoples Care | Older Peoples Comity Care | Erewash OA CMHT | 15.22 | 14.70 | 12.98 | 12.98 | 0.52 |
| Older Peoples Care | Older Peoples Comity Care | H P + NDales OA CMHT | 14.03 | 13.84 | 13.90 | 13.90 | 0.19 |
| Older Peoples Care | Older Peoples Comity Care | Killmsh + N C OA CMHT | 11.30 | 8.80 | 8.80 | 8.80 | 2.50 |
| Older Peoples Care | Older Peoples Comity Care | South + Dales OA CMHT | 16.06 | 15.39 | 15.76 | 15.78 | 0.67 |
| Older Peoples Care | Older Peoples Comity Care | OA Day Services | 20.77 | 16.10 | 16.11 | 16.11 | 4.67 |
| Psychology | Heads of Psgy X | Eating Disorders PSGY | 3.21 | 3.22 | 3.22 | 3.22 | -0.01 |
| Psychology | Heads of Psgy X | CBT Service | 11.00 | 9.20 | 9.20 | 9.20 | 1.80 |
| Psychology | Heads of Psgy X | Psychotherapy Service | 12.45 | 7.63 | 7.63 | 7.63 | 4.82 |
| Psychology | Heads of Psgy X | Medic Psychotherapy | 0.50 | 0.53 | 0.53 | 0.53 | -0.03 |
| Psychology | Heads of Psgy X | Amber Valley OA PSGY | 0.67 | 0.67 | 0.67 | 0.67 | 0.00 |
| Psychology | Heads of Psgy X | Bolsover + CC OA PSGY | 0.90 | 0.20 | 0.20 | 0.20 | 0.70 |
| Psychology | Heads of Psgy X | CfldCentral OA PSGY | 2.10 | 1.30 | 1.30 | 1.30 | 0.80 |
| Psychology | Heads of Psgy X | Derby City OA PSGY | 2.60 | 2.80 | 2.80 | 2.80 | -0.20 |
| Psychology | Heads of Psgy X | Erewash OA PSGY | 0.60 | 0.60 | 0.00 | 0.00 | 0.00 |
| Psychology | Heads of Psgy X | HP+Nth Dales OA PSGY | 1.17 | 1.17 | 1.17 | 1.17 | 0.00 |
| Psychology | Heads of Psgy X | KillNthCfld OA PSGY | 0.20 | 0.20 | 0.20 | 0.20 | 0.00 |
| Psychology | Heads of Psgy X | Sth DD OA PSGY | 0.60 | 1.40 | 1.29 | 1.29 | -0.80 |
| Psychology | Heads of Psgy X | Amber Valley Adult PSGY | 3.80 | 2.80 | 1.28 | 1.28 | 1.00 |
| Psychology | Heads of Psgy X | Bolsover + CC Adult PSGY | 2.05 | 1.20 | 1.20 | 1.20 | 0.85 |
| Psychology | Heads of Psgy X | CfldCentral Adult PSGY | 1.80 | 3.10 | 2.50 | 2.50 | -1.30 |
| Psychology | Heads of Psgy X | Derby City B Adult PSGY | 0.90 | 1.00 | 1.00 | 1.00 | -0.10 |
| Psychology | Heads of Psgy X | Derby City C Adult PSGY | 1.60 | 1.00 | 1.00 | 1.00 | 0.60 |
| Psychology | Heads of Psgy X | Erewash Adult PSGY | 1.00 | 1.60 | 1.60 | 1.60 | -0.60 |
| Psychology | Heads of Psgy X | HP+Nth Dales Adult PSGY | 1.20 | 1.20 | 1.20 | 1.20 | 0.00 |
| Psychology | Heads of Psgy X | KillNthCfld Adult PSGY | 2.05 | 1.90 | 1.90 | 1.90 | 0.15 |
| Psychology | Heads of Psgy X | Sth DD Adult PSGY | 1.90 | 1.30 | 1.30 | 1.30 | 0.60 |
| Psychology | Heads of Psgy X | El Nth PSGY | 1.14 | 0.64 | 0.64 | 0.64 | 0.50 |
| Psychology | Heads of Psgy X | El Sth + City PSGY | 2.00 | 2.00 | 2.00 | 2.00 | 0.00 |
| Psychology | Heads of Psgy Y | Perinatal PSGY | 1.33 | 1.16 | 1.16 | 1.16 | 0.17 |
| Psychology | Heads of Psgy Y | Spec Therapy PSGY | 1.00 | 1.00 | 1.00 | 1.00 | 0.00 |
| Psychology | Heads of Psgy Y | LD PSGY | 10.55 | 8.35 | 7.65 | 7.65 | 2.20 |
| Psychology | Heads of Psgy Y | Adult Acute HU PSGY | 1.80 | 1.80 | 1.80 | 1.80 | 0.00 |
| Psychology | Heads of Psgy Y | Adult Acute RU PSGY | 2.90 | 2.90 | 2.90 | 2.90 | 0.00 |
| Psychology | Heads of Psgy Y | Trainee PSGY | 10.00 | 10.00 | 9.00 | 9.00 | 0.00 |
| Psychology | Heads of Psgy Y | PSGY Y VF | 1.00 | 1.00 | 1.06 | 1.08 | 0.00 |
| Psychology | Heads of Psgy Y | Perinatal RU PSGY | 0.50 | 0.24 | 0.24 | 0.24 | 0.26 |
| Psychology | Heads of Psgy Y | Kedleston Kway PSGY | 2.80 | 2.50 | 2.50 | 2.50 | 0.30 |
| Psychology | Heads of Psgy Y | Rehab CTC Kway PSGY | 1.20 | 0.60 | 0.60 | 0.60 | 0.60 |
| Psychology | Heads of Psgy Y | Rehab Audrey Kway PSGY | 0.40 | 0.20 | 0.20 | 0.20 | 0.20 |
| Specialist Care Services | Adult IAPT Services | IAPT | 67.84 | 68.57 | 63.75 | 63.75 | -0.73 |

| Service Line | Sub-Service Line | Cost Centre Code Desc | Funded WTE | Contract WTE | Worked WTE | Paid WTE | Vacancy WTE |
|---|---|---|---|---|---|---|---|
| Specialist Care Services | Learning Disabilities | LD Intensive Support | 22.13 | 15.84 | 15.84 | 16.18 | 6.29 |
| Specialist Care Services | Learning Disabilities | Trust wide CLDT Nursing | 20.39 | 13.49 | 13.09 | 13.09 | 6.90 |
| Specialist Care Services | Learning Disabilities | Trust wide CLDT Physio | 10.28 | 6.50 | 5.55 | 5.55 | 3.78 |
| Specialist Care Services | Learning Disabilities | Trust wide CLDT OT | 10.64 | 7.99 | 9.79 | 9.79 | 2.65 |
| Specialist Care Services | Learning Disabilities | Trust wide CLDT SALT's | 9.24 | 6.62 | 6.28 | 6.30 | 2.62 |
| Specialist Care Services | Learning Disabilities | LD Medics | 5.20 | 2.20 | 2.20 | 2.20 | 3.00 |
| Specialist Care Services | Learning Disabilities | LD Forensic Team | 4.53 | 4.78 | 4.90 | 4.90 | -0.25 |
| Specialist Care Services | Perinatal | Perinatal Inpatient RU | 19.94 | 17.82 | 19.87 | 23.52 | 2.12 |
| Specialist Care Services | Perinatal | Perinatal Community | 15.78 | 16.42 | 15.30 | 15.30 | -0.64 |
| Specialist Care Services | Specialist Care Medical | Perinatal Medics | 3.20 | 3.40 | 3.40 | 3.40 | -0.20 |
| Specialist Care Services | Specialist Care Mgt | Dietetics Inpatient | 4.20 | 4.00 | 4.00 | 4.00 | 0.20 |
| Specialist Care Services | Specialist Care Mgt | OT Professional Leads | 1.24 | 1.00 | 1.00 | 1.00 | 0.24 |
| Specialist Care Services | Specialist Care Mgt | Physiotherapy | 7.11 | 5.44 | 4.84 | 4.84 | 1.67 |
| Specialist Care Services | SubsMis | Derby Substance Misuse | 16.00 | 14.36 | 13.36 | 13.36 | 1.64 |
| Specialist Care Services | SubsMis | DerbyshireSubstanceMisuse | 21.78 | 21.30 | 20.80 | 20.80 | 0.48 |
| Specialist Care Services | SubsMis | GRID | 1.00 | 1.00 | 1.00 | 1.00 | 0.00 |
| | | | **1,073.89** | **958.76** | **959.74** | **978.19** | **115.13** |

## 4. Safer Staffing

It is an NHS England requirement that all Trusts publish their inpatient nursing staffing levels each day by ward area, showing the Trust's actual and planned staff fill rates. This is in response to the Francis Report (2013), where a commitment was made that all NHS Trusts with inpatient areas would publish full staffing data (by month, by ward area) from May 2014, and then on an ongoing monthly basis. The intention is to show how Trusts across the NHS ensure the safety of their staffing levels and skill mix. The data is routinely published on the Trust's website.

Table 1 compares the planned staffing levels on each ward with the actual staffing levels for the latest reported month.

Table 2 gives the care hours per patient day (CHPPD) for the latest reported month. CHPPD was developed by NHS Improvement to provide a single, consistent and nationally comparable way of recording and reporting deployment of staff on inpatient wards. (for more information, see: https://improvement.nhs.uk/documents/5604/Care_hours_per_patient_day_CHPPD_guidance_for_all_inpatient_trusts.pdf).

Table 2 also gives the average fill rates on each ward. The fill rate is the extent to which rota hours were filled by registered nurses and unregistered care staff.

## Table 1. Ward Staffing Levels – Actual versus Planned (January 2020)

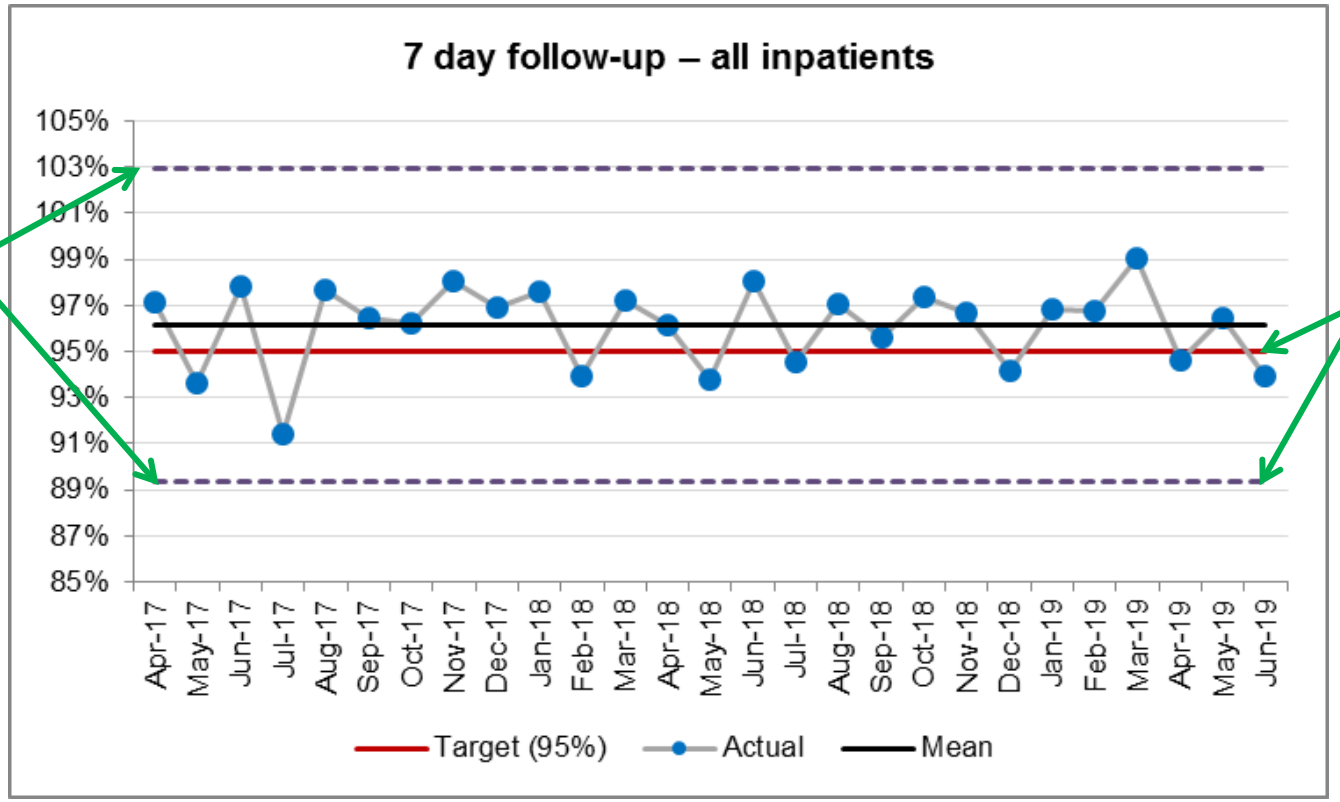
| Ward name | Main 2 Specialties on each ward | | Day | | | | Night | | | | Allied Health Professionals | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Registered Nurses/Midwives | | Non-registered Nurses/Midwives (Care Staff) | | Registered Nurses/Midwives | | Non-registered Nurses/Midwives (Care Staff) | | Registered allied health professionals | | Non-registered allied health professionals | |
| | Specialty 1 | Specialty 2 | Total monthly planned staff hours | Total monthly actual staff hours | Total monthly planned staff hours | Total monthly actual staff hours | Total monthly planned staff hours | Total monthly actual staff hours | Total monthly planned staff hours | Total monthly actual staff hours | Total monthly planned staff hours | Total monthly actual staff hours | Total monthly planned staff hours | Total monthly actual staff hours |
| AUDREY HOUSE RESIDENTIAL REHABILITATION | 314 - REHABILITATION | | 929.48 | 712.89 | 807.5 | 624 | 651 | 388.5 | 0 | 294 | 0 | 0 | 0 | 0 |
| CHILD BEARING INPATIENT | 710 - ADULT MENTAL ILLNESS | | 930 | 726.47 | 930 | 730.49 | 325.5 | 325.5 | 325.5 | 389.57 | 0 | 0 | 0 | 0 |
| CTC RESIDENTIAL REHABILITATION | 314 - REHABILITATION | | 931.51 | 917.77 | 1738.45 | 1441.43 | 658.75 | 333.25 | 325.5 | 662.14 | 0 | 0 | 0 | 0 |
| ENHANCED CARE WARD | 710 - ADULT MENTAL ILLNESS | | 1379.5 | 1138 | 1388 | 1599.17 | 651 | 484.5 | 651 | 1134.67 | 0 | 0 | 0 | 144.5 |
| HARTINGTON UNIT - MORTON WARD ADULT | 710 - ADULT MENTAL ILLNESS | | 1403.25 | 1227 | 1374.75 | 1402.5 | 573.5 | 310.41 | 573.5 | 765.65 | 472.75 | 167 | 0 | 0 |
| HARTINGTON UNIT - PLEASLEY WARD ADULT | 710 - ADULT MENTAL ILLNESS | 715 - OLD AGE PSYCHIATRY | 1586 | 1048.75 | 1418.25 | 1172 | 573.5 | 271.25 | 573.5 | 632.5 | 461 | 260 | 0 | 0 |
| HARTINGTON UNIT - TANSLEY WARD ADULT | 710 - ADULT MENTAL ILLNESS | | 1585.5 | 1274.39 | 1416 | 1391.47 | 582.41 | 361.99 | 581.75 | 721.26 | 945.5 | 98.32 | 0 | 0 |
| KEDLESTON LOW SECURE UNIT | 712 - FORENSIC PSYCHIATRY | | 1919 | 1627.66 | 2291.5 | 1854.49 | 635.5 | 635.5 | 1271 | 1323.92 | 0 | 0 | 0 | 7.5 |
| KINGSWAY CUBLEY COURT - FEMALE | 715 - OLD AGE PSYCHIATRY | | 1373.8 | 1307.76 | 1930.58 | 2343.2 | 645.73 | 490.31 | 1291.77 | 1882.22 | 465 | 45 | 0 | 0 |
| KINGSWAY CUBLEY COURT - MALE | 715 - OLD AGE PSYCHIATRY | | 1637.83 | 1041.95 | 2470.5 | 2847.26 | 645.73 | 543.38 | 947.75 | 1778.05 | 195 | 37.5 | 0 | 0 |
| LONDON ROAD COMMUNITY HOSPITAL - WARD 1 OP | 715 - OLD AGE PSYCHIATRY | | 1661.25 | 1229.63 | 1469.5 | 1297.68 | 632.73 | 570.6 | 645.73 | 921.98 | 0 | 0 | 0 | 0 |
| RADBOURNE UNIT - WARD 33 ADULT ACUTE INPATIENT | 710 - ADULT MENTAL ILLNESS | | 1364.05 | 1166.82 | 923 | 1325.75 | 640.5 | 403.67 | 322.75 | 901.75 | 460 | 81.82 | 0 | 0 |
| RADBOURNE UNIT - WARD 34 ADULT ACUTE INPATIENT | 710 - ADULT MENTAL ILLNESS | | 1389.5 | 1180.5 | 924 | 1064.57 | 651 | 450.5 | 325.5 | 619.5 | 463 | 127.5 | 0 | 0 |
| RADBOURNE UNIT - WARD 35 ADULT ACUTE INPATIENT | 710 - ADULT MENTAL ILLNESS | | 1373 | 896 | 887 | 920 | 651 | 304.5 | 325.75 | 688.75 | 461.5 | 438 | 0 | 0 |
| RADBOURNE UNIT - WARD 36 ADULT ACUTE INPATIENT | 710 - ADULT MENTAL ILLNESS | | 1373.5 | 1242.95 | 1341 | 1031.01 | 651 | 494.5 | 325.5 | 742.25 | 461 | 72.5 | 0 | 0 |

## Table 2. Ward Care Hours Per Patient Day & Average Fill Rates (January 2020)

| | Care Hours Per Patient Day (CHPPD) | | | | | | | | Day | | | | Night | | | | Allied Health Professionals | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Ward name | Cumulative count over the month of patients at 23:59 each day | Registered Nurses/ Midwives | Non-registered Nurses/ Midwives | Registered Nursing Associates | Non-registered Nursing Associates | Registered allied health professionals | Non-registered allied health professionals | Overall | Average fill rate - Registered Nurses/ Midwives (%) | Average fill rate - Non-registered Nurses/ Midwives (care staff) (%) | Average fill rate - Registered Nursing Associates (%) | Average fill rate - Non-Registered Nursing Associates (%) | Average fill rate - Registered Nurses/ Midwives (%) | Average fill rate - Non-registered Nurses/ Midwives (care staff) (%) | Average fill rate - Registered Nursing Associates (%) | Average fill rate - Non-Registered Nursing Associates (%) | Average fill rate - registered allied health professionals (AHP) (%) | Average fill rate - non-registered allied health professionals (AHP) (%) |
| AUDREY HOUSE RESIDENTIAL REHABILITATION | 283 | 3.9 | 3.2 | 0.0 | 0.0 | 0.0 | 0.0 | 7.1 | 76.7% | 77.3% | | | 59.7% | - | | | - | - |
| CHILD BEARING INPATIENT | 127 | 8.3 | 8.8 | 0.0 | 0.0 | 0.0 | 0.0 | 17.1 | 78.1% | 78.5% | | | 100.0% | 119.7% | | | - | - |
| CTC RESIDENTIAL REHABILITATION | 1120 | 1.1 | 1.9 | 0.0 | 0.0 | 0.0 | 0.0 | 3.0 | 98.5% | 82.9% | | | 50.6% | 203.4% | | | - | - |
| ENHANCED CARE WARD | 273 | 5.9 | 10.0 | 0.0 | 0.0 | 0.0 | 0.5 | 16.5 | 82.5% | 115.2% | | | 74.4% | 174.3% | | | - | - |
| HARTINGTON UNIT - MORTON WARD ADULT | 540 | 2.8 | 4.0 | 0.0 | 0.0 | 0.3 | 0.0 | 7.2 | 87.4% | 102.0% | | | 54.1% | 133.5% | | | 35.3% | - |
| HARTINGTON UNIT - PLEASLEY WARD ADULT | 569 | 2.3 | 3.2 | 0.0 | 0.0 | 0.5 | 0.0 | 5.9 | 66.1% | 82.6% | | | 47.3% | 110.3% | | | 56.4% | - |
| HARTINGTON UNIT - TANSLEY WARD ADULT | 577 | 2.8 | 3.7 | 0.0 | 0.0 | 0.2 | 0.0 | 6.7 | 80.4% | 98.3% | | | 62.2% | 124.0% | | | 10.4% | - |
| KEDLESTON LOW SECURE UNIT | 380 | 6.0 | 8.4 | 0.0 | 0.0 | 0.0 | 0.0 | 14.3 | 84.8% | 80.9% | | | 100.0% | 104.2% | | | - | - |
| KINGSWAY CUBLEY COURT - FEMALE | 530 | 3.4 | 8.0 | 0.0 | 0.0 | 0.1 | 0.0 | 11.4 | 95.2% | 121.4% | | | 75.9% | 145.7% | | | 9.7% | - |
| KINGSWAY CUBLEY COURT - MALE | 498 | 3.2 | 9.3 | 0.0 | 0.0 | 0.1 | 0.0 | 12.5 | 63.6% | 115.3% | | | 84.1% | 187.6% | | | 19.2% | - |
| LONDON ROAD COMMUNITY HOSPITAL - WARD 1 OP | 497 | 3.6 | 4.5 | 0.0 | 0.0 | 0.0 | 0.0 | 8.1 | 74.0% | 88.3% | | | 90.2% | 142.8% | | | - | - |
| RADBOURNE UNIT - WARD 33 ADULT ACUTE INPATIENT | 534 | 2.9 | 4.2 | 0.0 | 0.0 | 0.2 | 0.0 | 7.3 | 85.5% | 143.6% | | | 63.0% | 279.4% | | | 17.8% | - |
| RADBOURNE UNIT - WARD 34 ADULT ACUTE INPATIENT | 555 | 2.9 | 3.0 | 0.0 | 0.0 | 0.2 | 0.0 | 6.2 | 85.0% | 115.2% | | | 69.2% | 190.3% | | | 27.5% | - |
| RADBOURNE UNIT - WARD 35 ADULT ACUTE INPATIENT | 536 | 2.2 | 3.0 | 0.0 | 0.0 | 0.8 | 0.0 | 6.1 | 65.3% | 103.7% | | | 46.8% | 211.4% | | | 94.9% | - |
| RADBOURNE UNIT - WARD 36 ADULT ACUTE INPATIENT | 552 | 3.1 | 3.2 | 0.0 | 0.0 | 0.1 | 0.0 | 6.5 | 90.5% | 76.9% | | | 76.0% | 228.0% | | | 15.7% | - |

# How to Interpret a Statistical Process Control Chart (SPC)

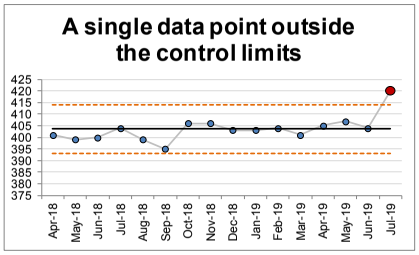
The dotted lines are the "control limits". Any performance between these 2 lines is normal for the current system. This is known as "normal variation"

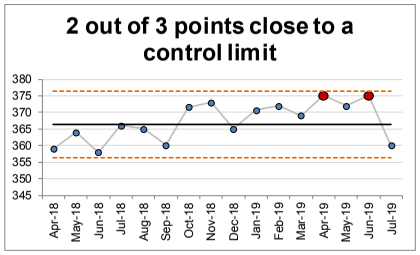


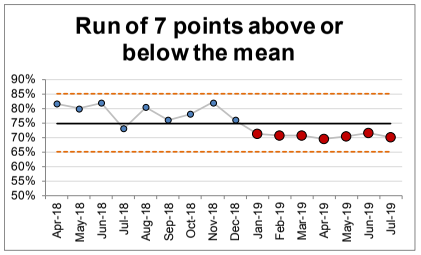

If the system is effective, the **lower** control limit will be above the target line (for targets where higher is better) or the **upper** control limit will be below the target line (for targets where lower is better). In that scenario we have nothing to worry about and can be assured our system is performing well.

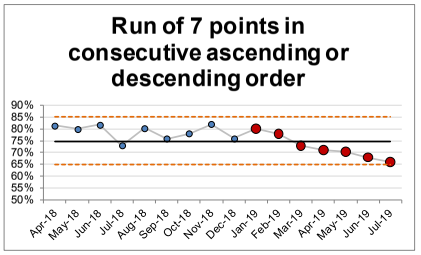
In this case the target line is above the lower control limit which indicates that the system is ineffective.

A run chart also enables us to see when something unusual has happened in the system. This is known as "special cause variation". This can be seen in 4 ways:



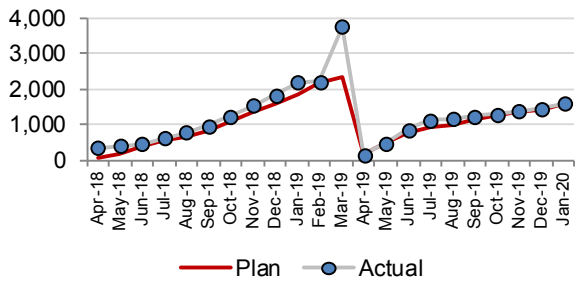



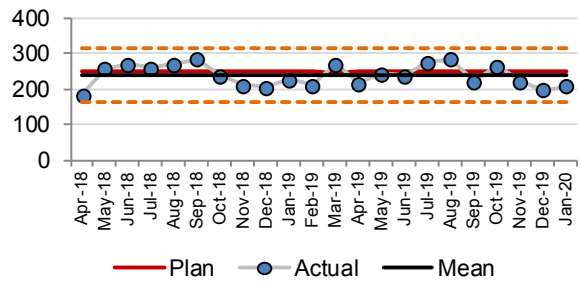



## Financial Indicators

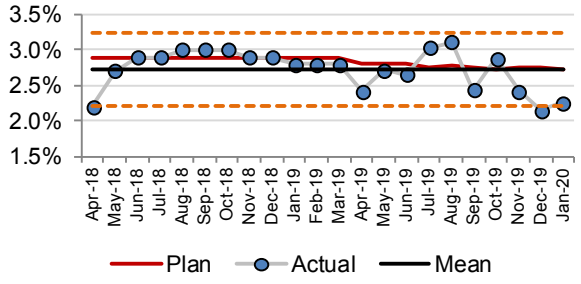
### Cumulative Surplus / (Deficit)



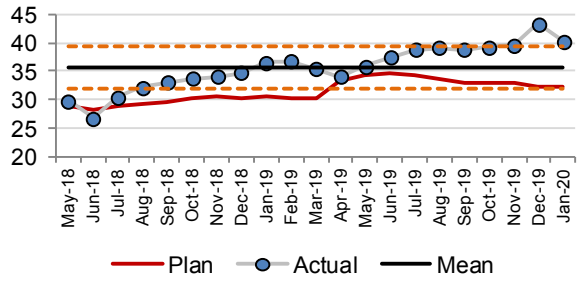

### Agency expenditure against ceiling



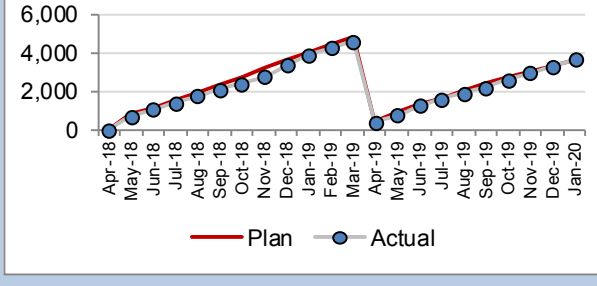

### Agency as percentage of pay expenditure



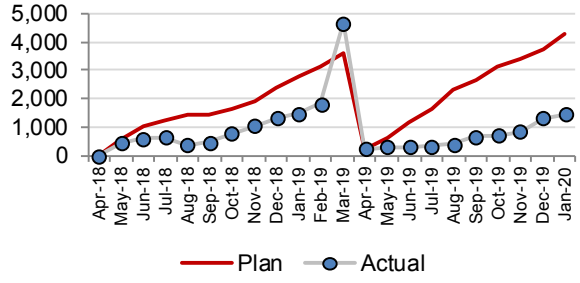

### Liquidity



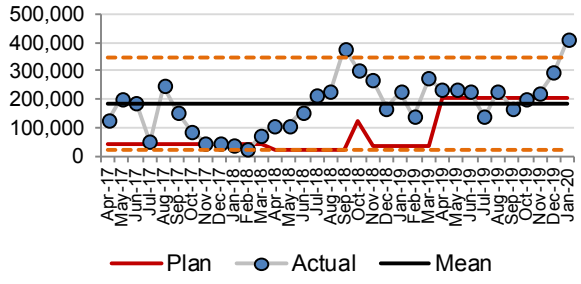

### Cumulative cost improvement programme (CIP)




### Cumulative capital expenditure

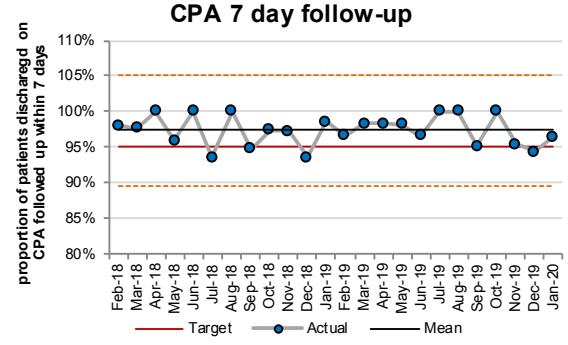



### Out of area and stepdown expenditure

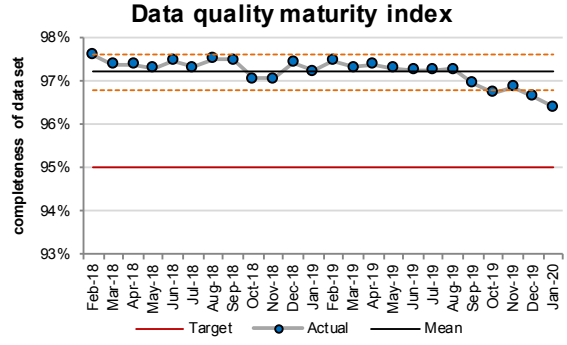


## Operational indicators

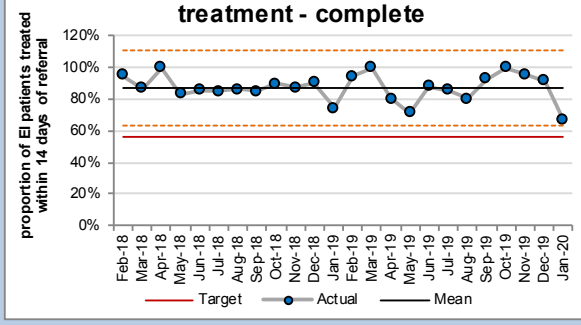
### CPA 7 day follow-up



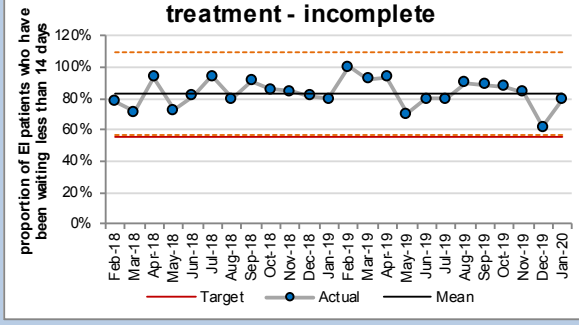

### Data quality maturity index



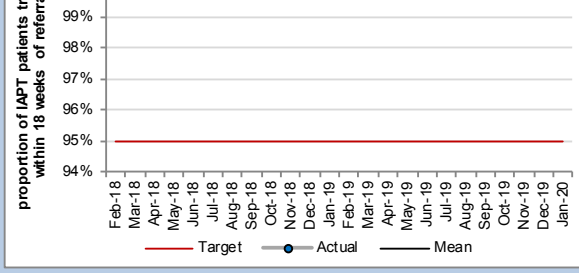

### Early intervention 14 day referral to treatment - complete



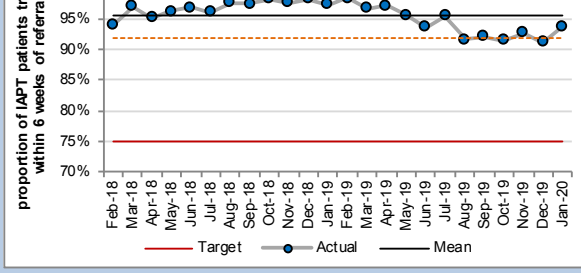

### Early intervention 14 day referral to treatment - incomplete



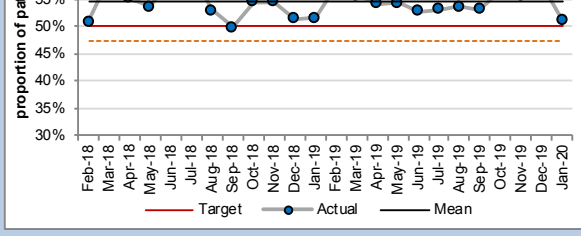

### IAPT 18 week referral to treatment



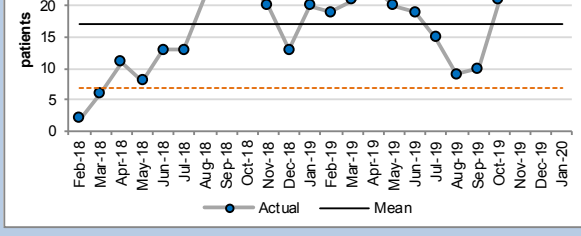

### IAPT 6 week referral to treatment



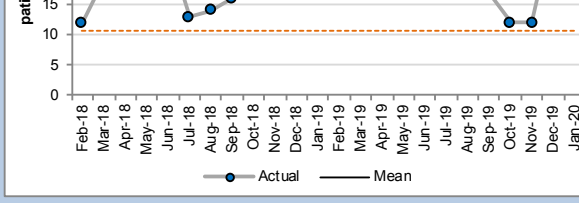

### IAPT patients completing treatment who move to recovery



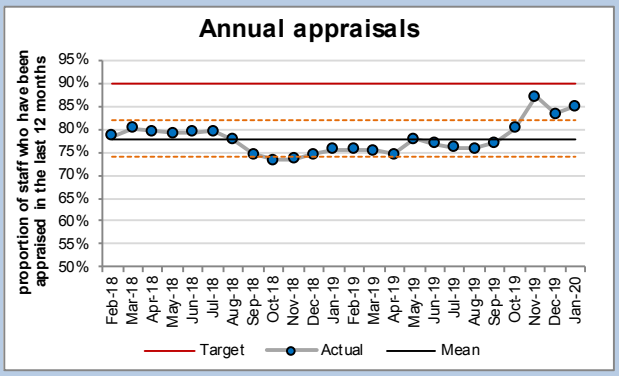

### Patients placed out of area - adult acute

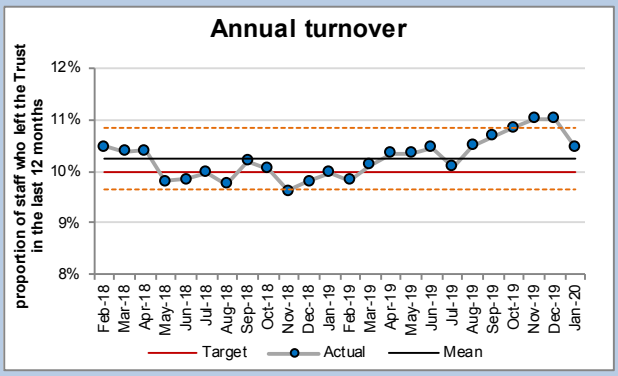


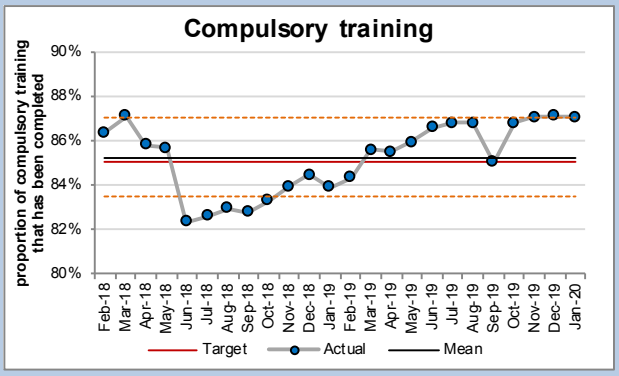

### Patients placed out of area - PICU

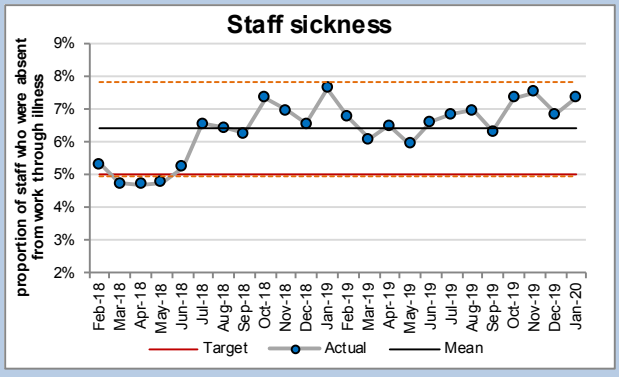


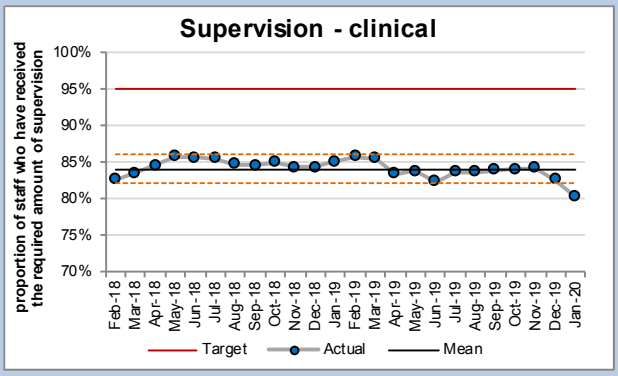
## Workforce indicators

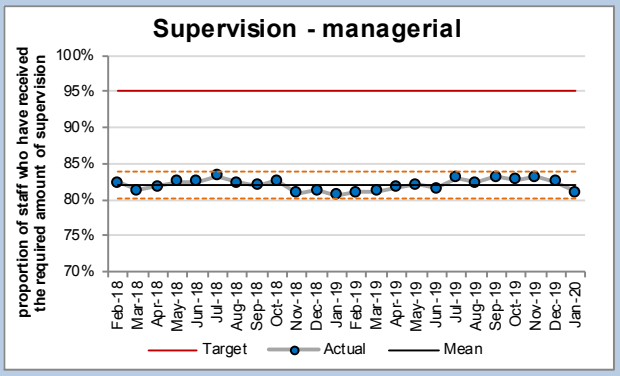


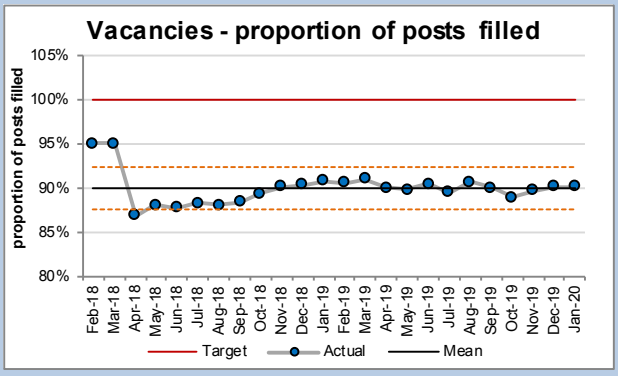



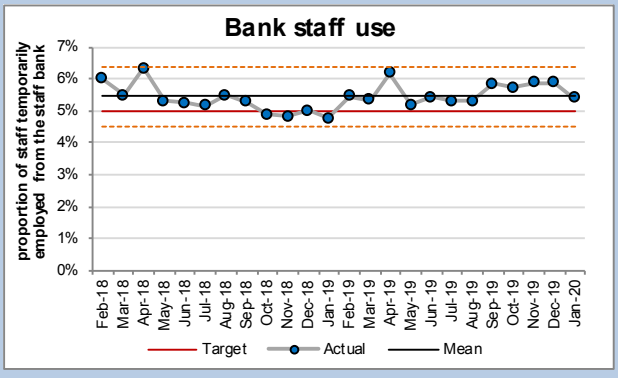



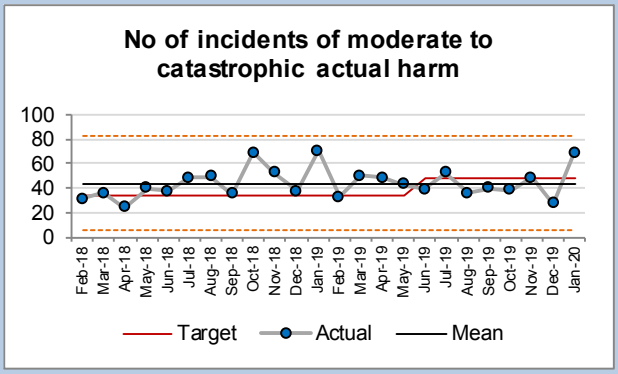



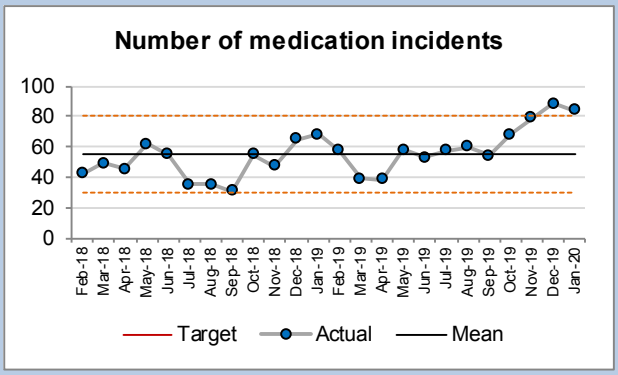



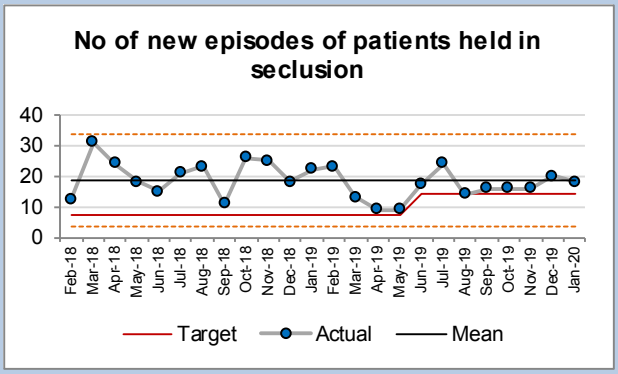



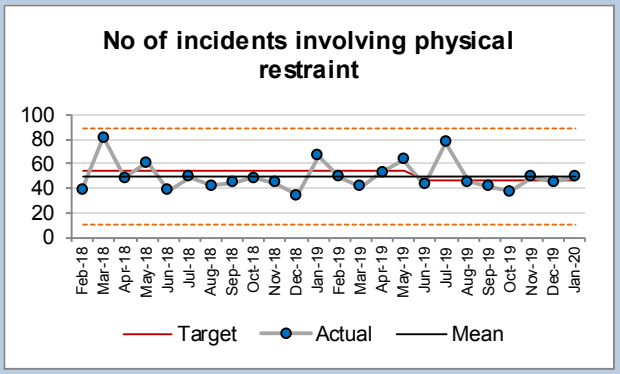
## Quality Indicators

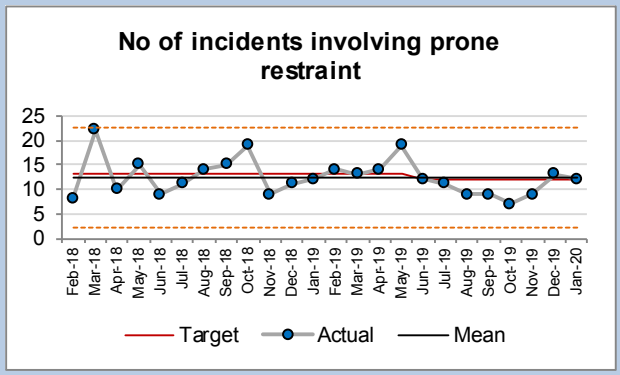
### Safe

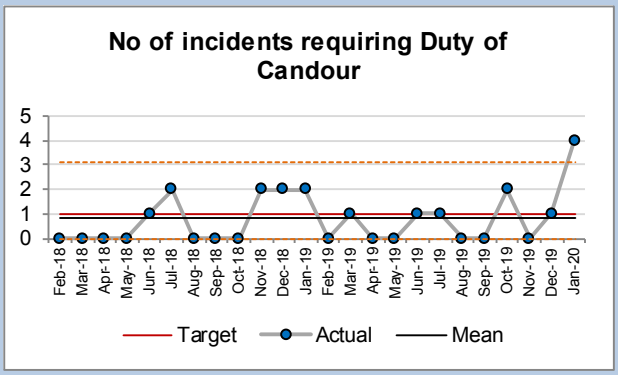


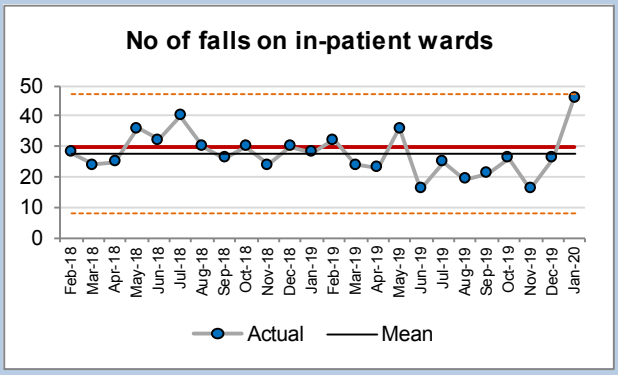



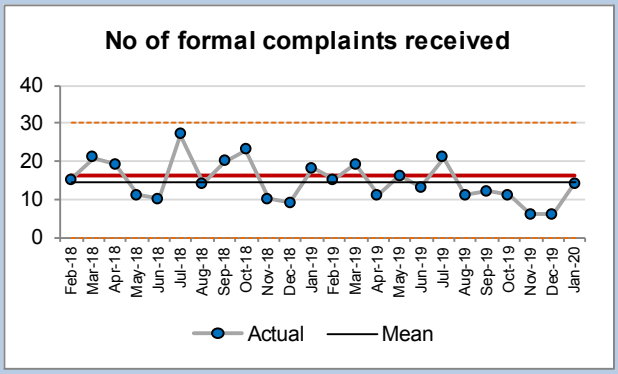



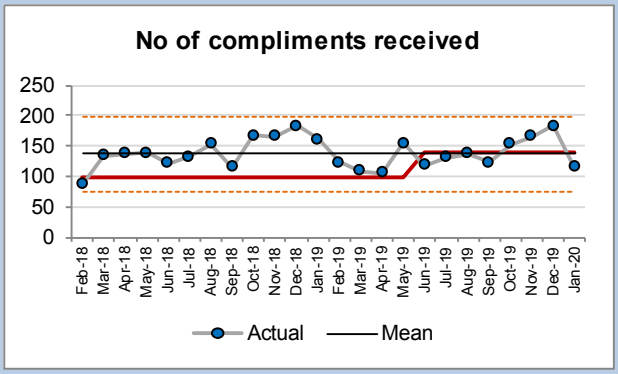



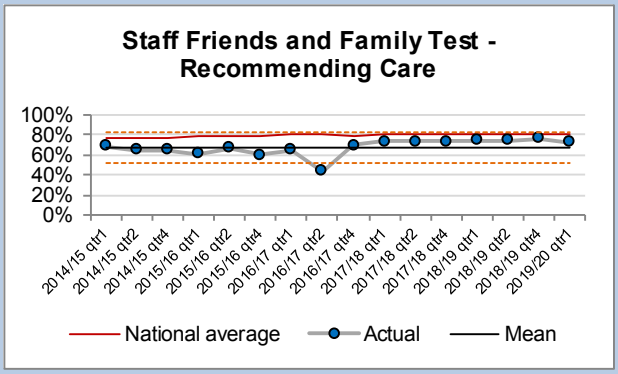



## Quality Indicators

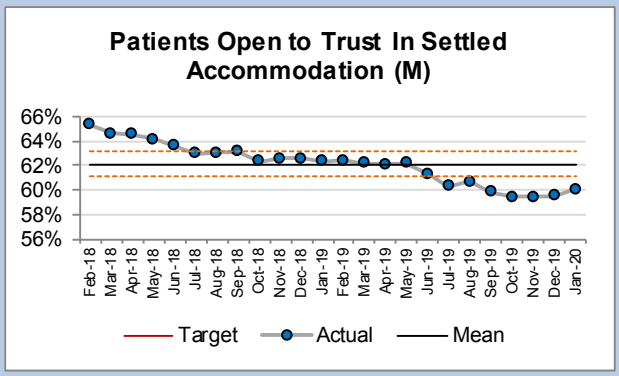
### Caring

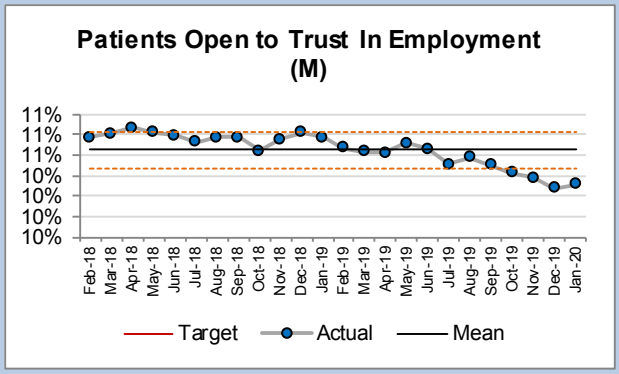


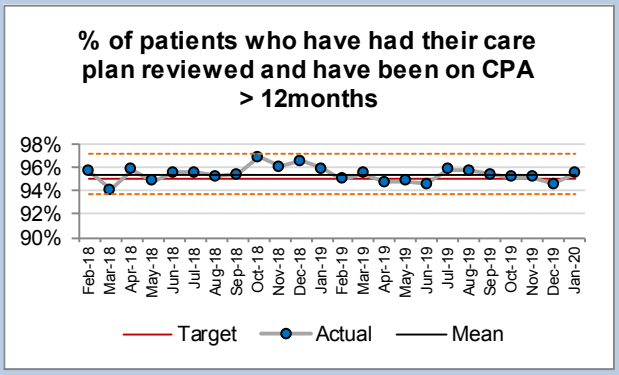



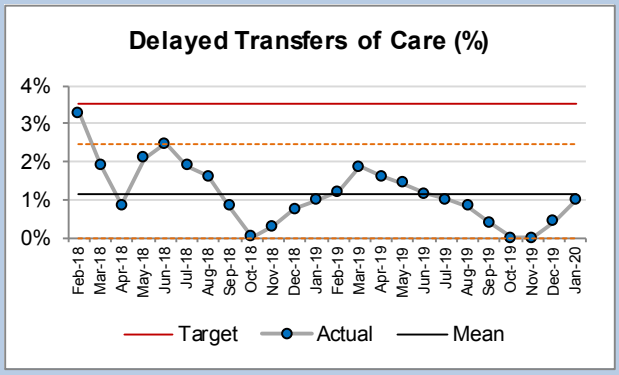

### Effective



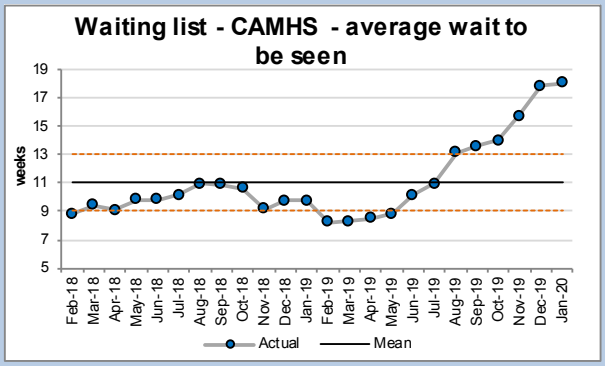



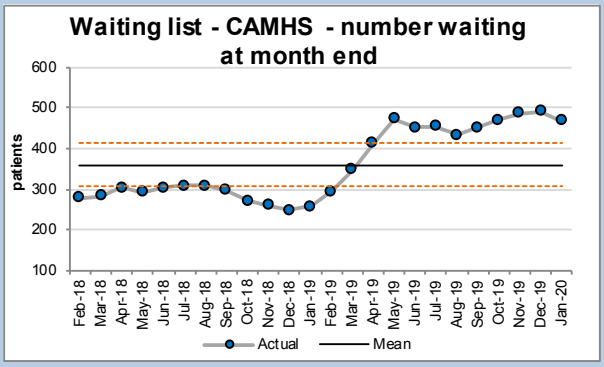

### Responsive

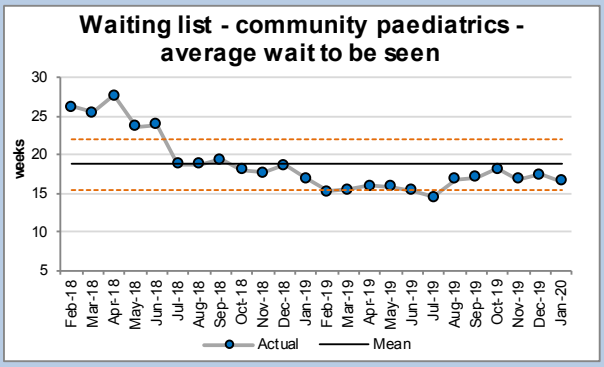


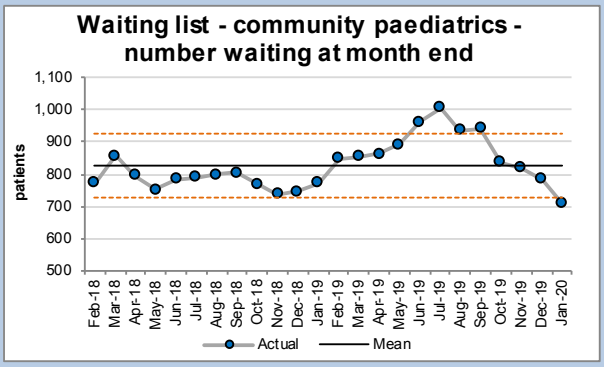



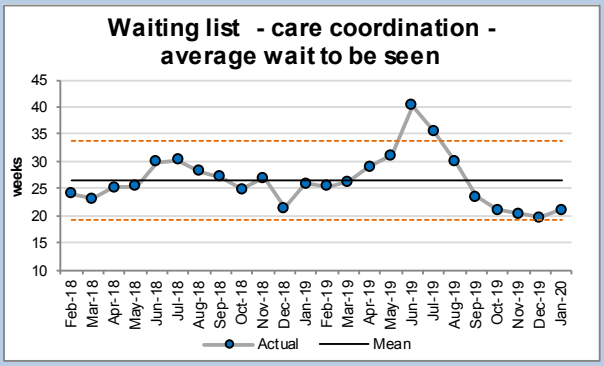
## Operational indicators

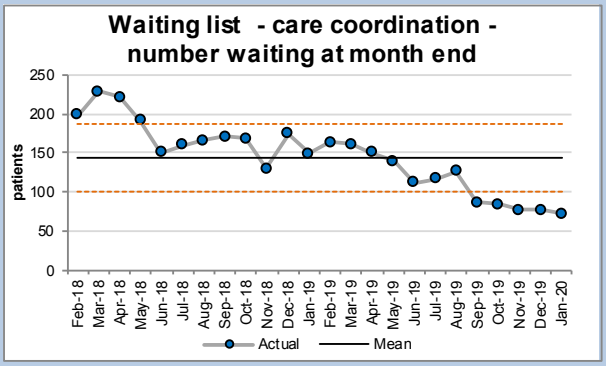


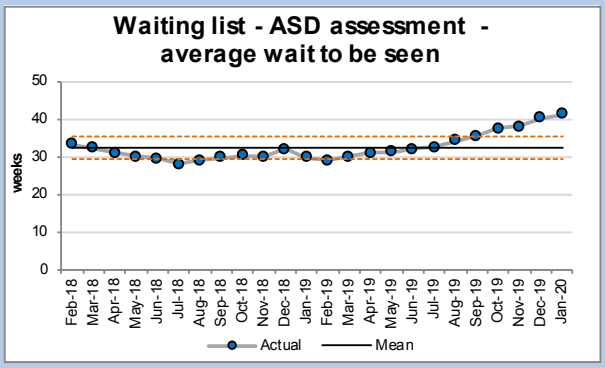



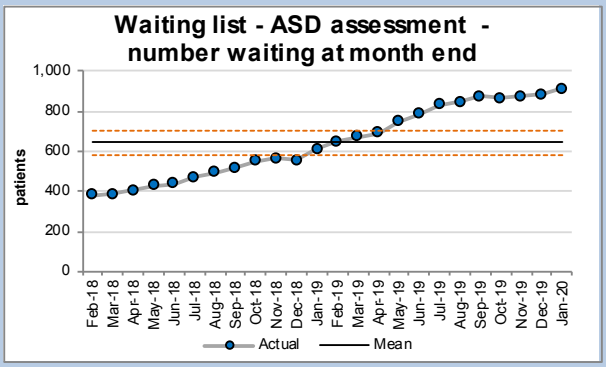



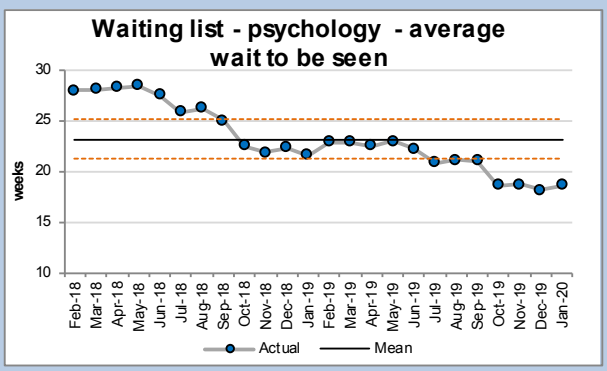



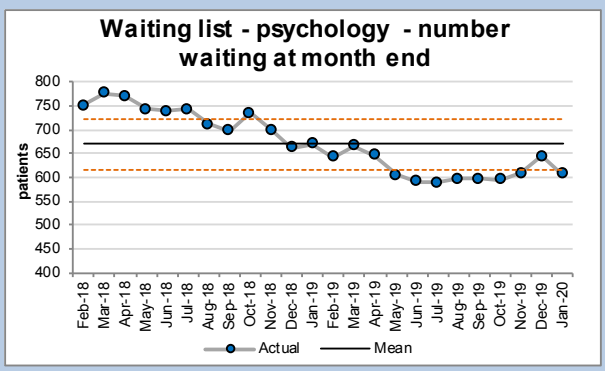



**Appendix 3**

## Data Quality Kite Mark

### Background

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

### Approach


Assessment of each domain will be based on the following criteria:

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

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

**KPI Data Quality Reviews**

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

**Derbyshire Healthcare NHS Foundation Trust**
Report to the Board of Directors – 3 March 2020

# Quality Report – 'Caring'

## Purpose of Report

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

## Executive Summary


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

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

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

At the last Trust wide inspection nine core services were rated good or outstanding and one core service was rated as requires improvement. Our objective in 2020 was to improve this performance and have all core services reporting at least a good in this domain, early indications are that this aspiration has been achieved in our last 2020 inspection.

The Trust has achieved solid community survey benchmark information and feedback on all of its services. All community services are rated as good or outstanding in this domain.

Since the last caring report was submitted to the Board in June 2019, the Trust's strategy has been revisited and now includes more specific focus on patient experience and the introduction of a shared governance model for patients with the Carers Forum as a mirror image to the Staff Forum which has been very well received and is growing. The 'Equal' forum is fully operational and we are now implementing the best practice evidence in co-production and emerging models of shared governance.

The Trust has reached a strong performance in benchmarking, in responsiveness and in acceptance of feedback at above the national average. This has been maintained again his year and the organisation has additionally made significant headway in the Family and Friends Test Trust wide feedback.

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

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

**Assurances**

The consideration of the use of caring has positive assurances which are well evidenced.

The quality improvements and or quality improvement strategy areas for further growth which were suggested in 2019 are outlined in the paper with progress.

**Consultation**

This paper has not been formally considered by other meetings, but has been shared with Executive colleagues. The content has been reviewed within the Trust's internal structure meetings.

**Governance or Legal Issues**

There are no other legal or governance issues impacted on by this paper other than the regulatory requirements of CQC and NHSI as described.

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

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

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

**Recommendations**

The Board of Directors is requested to:

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

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

# Quality Report – Caring

## 1. Policy and regulatory context

**The formal legal duties under this domain are as follows:**

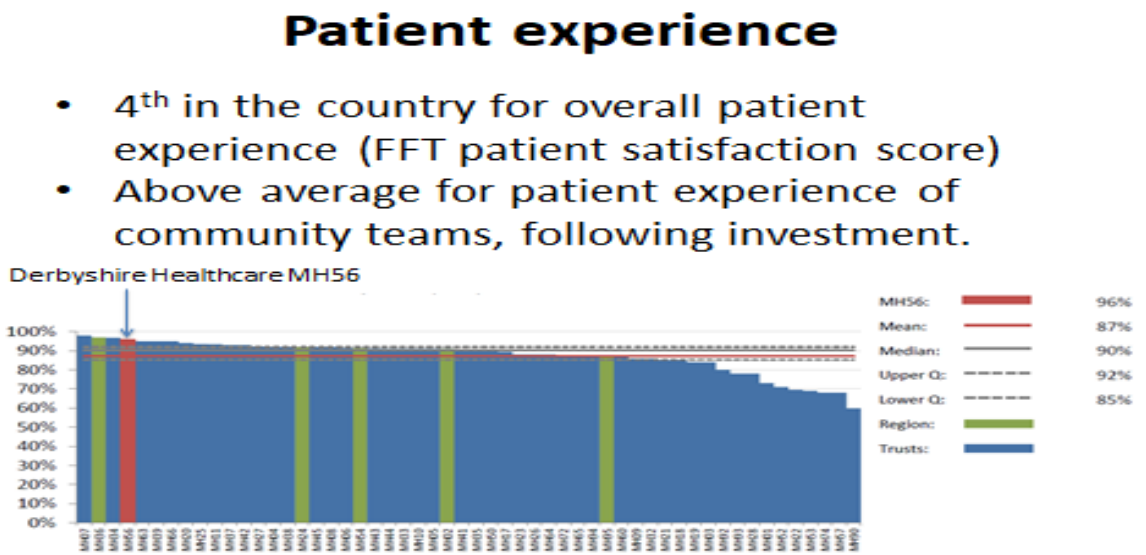
Caring covers a wide range of measures. The key lines of enquiry (KLOE) for caring are:

**KLOE C1- Kindness, respect and compassion**

The measures for this area are the Trust's training in equality and diversity and patient feedback on caring as per our community and in-patient survey and any questionnaires or service visits in our comprehensive inspection. In addition CQC (2018) patients and carers said "staff were compassionate, caring and kind. Staff listened and treated patients with dignity and respect. Staff knew their patients and patients gave positive feedback on the quality of care."

This correlates with the National Benchmarking information on the Trust's services, which at this time remain a very solid performance, where in 2018 we were at a very similar level in the community survey out of all MH Trusts and in 2019. Our regional counterparts are included in green to enable benchmarking.

New national data on the Trust's Friends and Family Test has been received and data shows a 300% increase in our response rate and significantly improved performance. Emerging feedback form people who use our service as part of recent regulatory feedback shows significant improvement in feedback in Child Health, Learning Disability, Crisis and Community mental health. Residual areas of improvement that all crisis patients always have a copy of their care plan and the experience of people who use our service in our acute service in the south of Derbyshire in seclusion.




Overall, two key pieces of evidence are considered with regard to patient experience. The Trust is the fourth in the country for the FFT for patient feedback for Mental Health Trusts.

The Trust's community survey published at the end of November 26 November 2019, the CQC received responses from 12,551 people who received community mental health services. Responses were received from 289 people at Derbyshire Healthcare NHS Foundation Trust and demonstrated and confirms this position with improved practice in all areas bar one. This is significantly different to a number of higher performing Mental Health Trusts that have seen a significant deterioration in their performance key improvement areas.

## Community Mental Health

Benchmarking Network

### Quality

While productivity and cost are important considerations, the safety and quality of services remains of central importance as a benchmarking theme. A wide range of quality metrics are available in the mental health benchmarking toolkit, and providers may find it useful to consider the findings in this section of the tool.

The score for community patient satisfaction comes from the National CQC survey, results of which are published on its website. The question asks *"Overall view of mental health services - feeling that overall they had a good experience"*. This metric has ranged from 69% to 73% in recent years. This year's position is 70.1%.

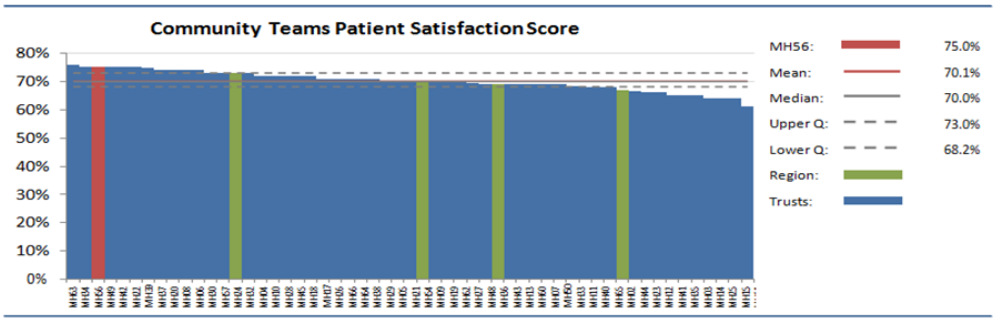



Figure 106

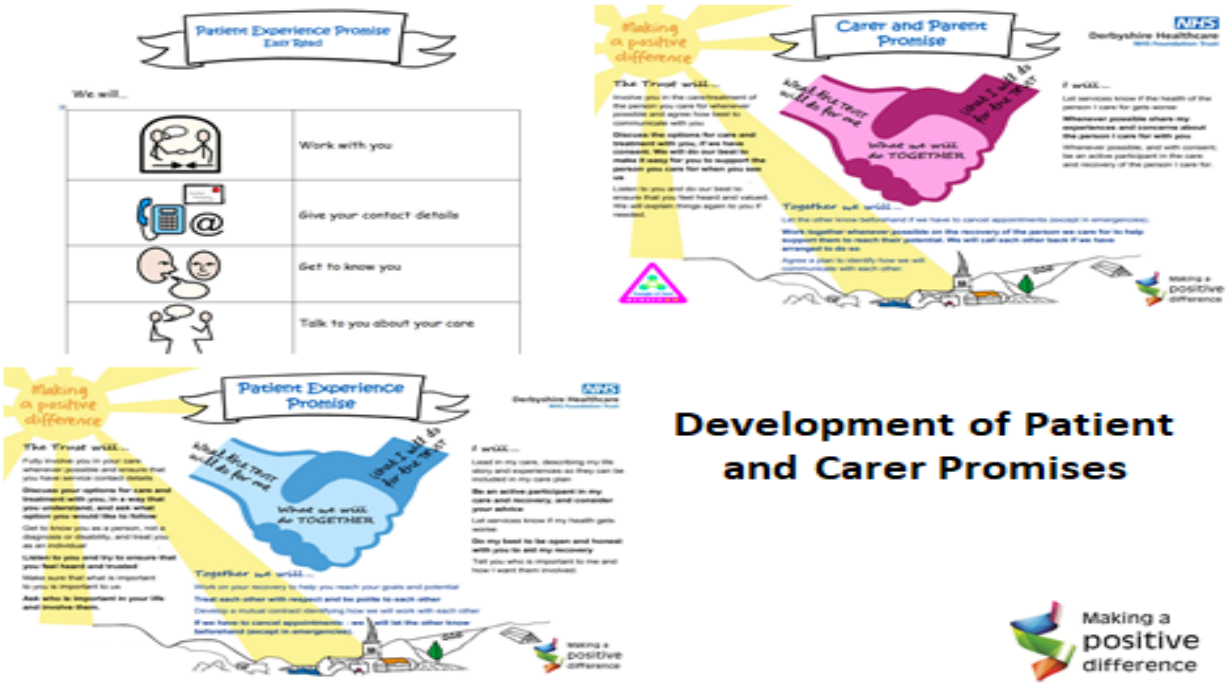
An alternative measure newly introduced to mental health providers is the NHS Friends and Family Test. This question asks *"How likely are you to recommend to friends and family if they needed similar care or treatment?"*

The average position this year was 85.3% would be likely or extremely likely to recommend.

| Community survey domain | Rating | Compared to other Trusts |
|---|---|---|
| Health and Social Care workers | 7.0/10 | About the same |
| Organising care | 8.4/10 | About the same |
| Planning care | 6.8/10 | About the same |
| Reviewing care | 7.6/10 | About the same |
| Crisis care | 7.0/10 | About the same |
| Medicines | 7.1/10 | About the same |
| NHS Therapies | 7.9/10 | About the same |
| Support and wellbeing | 4.3/10 | About the same |
| Feedback | 2.2/10 | About the same |
| Overall views of care and services | 7.2/10 | About the same |
| Overall experience | 6.8/10 | About the same |

Overall the Trust is rated as “good.” The feedback from the CQC (2018) was very positive “there was good management of complaints and there was an increase in compliments.” “There were clear responsibilities at every level in the Trust for the management, investigation and response to complaints.” Early evidence demonstrates this has been achieved and improved.

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



During the year the following contact has been made:

| | 2019/20 | 2018/19 | 2017/18 | 2016/17 | 2015/16 |
|---|---|---|---|---|---|
| Compliments | Full year not available | 1684 ↑ | 1222 | 1,215 | 1,016 |
| Concerns | Full year not available | 475 ↑ | 451 | 420 | 352 |
| Complaints | Full year not available | 197 ↑ | 191 | 146 | 115 |

Complaints are issues that need investigating and require a formal response from the Trust. Investigations are co-ordinated through the Patient Experience Team. Concerns can be resolved locally and require a less formal response; this can be through the patient experience team or directly by staff at ward or team level within our services and the desired outcome is to achieve an open culture where we talk about concerns and resolve issues. A service with fewer complaints is not always a positive sign. High performing Trusts are open cultures that accept where they have areas to improve and model and improvement culture.

When comparing quarterly reports the emerging data is a further significant increase in compliments.

**2. Accessible information**

Previously our implementation of the accessible information standards had been an area of improvement in our 2016 feedback. This was assessed as fully complaint in 2018 and an adaptation to communication aids was noted as an example of outstanding practice. This remains unchanged at the time of writing the report. Evidence of accessible information and use of interpreters continue to have significant prevalence.

**KLOE C2 - Involving people in decisions about their care**

We rated it as good because:

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

However, we continued to find that not all patients were involved in their care plans or given copies of their care plans in the acute care service. Over 2019, we have significantly improved this performance.

We reported in 2019 that we continued to have inconsistent and variable levels of care planning, person centred care and involvement. This remains a quality priority and in the newly designed Trust strategy is a core area of focus, and emerging evidence shows this is now a residual area of improvement in one core service area.

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

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

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

The final check to the new electronic text messaging and feedback model from individuals who use our service is going live in quarter four. A set of specialist feedback questionnaires are in design to send to all individuals who have been treated in an out of area bed to receive patient feedback on their experience again in quarter four of 2019/20.

1. Re-design and focus of clinical compliance staff in Nursing and Quality to have redesigned job description to include clinical practice improvement facilitation and key outcomes for care planning. This will be using the same methodology that we have successfully used in the Mental Capacity Act development and using coaching principles practice improvement facilitators (Q2 2019) - implemented, with clinical performance management focus. Matrons and ASMs in acute settings now routinely measure this and prioritise this area.
2. Dashboard developments for care planning for all services on whether a care plan was co-produced and whether a copy has been shared (Q2/3 2019). This will be recommended as a core objective for all acute senior Nurses and their Consultant Psychiatry colleagues. Implemented in acute, further work in crisis services.
3. Final review of the East London Foundation Trust core model of a CPA / care plan including relapse prevention and fast roll out of this recommended good practice (Q2 2019). Significant improvement in community mental health practice in this area.
4. Developing a model of EQUAL self-assessment of good practice in involvement and care planning and all acute ward senior nurses having coaching from an expert by experience of the lived experience of their ward.(Q3 2019) not achieved. However EQUAL forum modelling expert by experience f3edback through bright ideas and ward visits.
5. Evaluation of the expert by experience include borderline arts training and impact upon staff and individuals when focusing upon positive approaches to borderline personality issues and understanding Trauma (Q3/4 2019/20). Positive impact and evaluation.

**KLOE C3 - Privacy and dignity**

We have stability in our Community Mental Health and feedback re improvements in our acute in-patient survey.

The specific measures in this area are listed as an appraisal of whether there is strong evidence in place to confirm compliance. Incidents of breaches of confidentiality (strong evidence), compliance with data protection requirements - Staff training in IG (Information Governance) (strong evidence). Healthwatch feedback (strong evidence and noted as a responsive organisation, number of complaints and compliments (strong evidence and patient privacy and confidentiality (strong evidence).

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

Key improvement areas

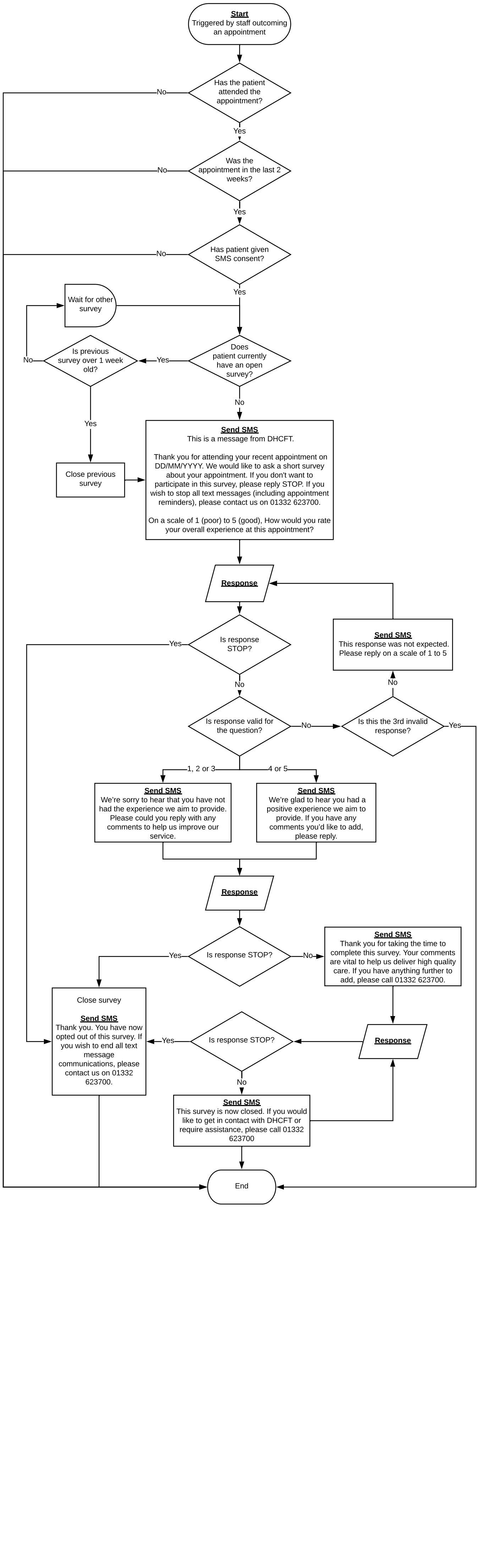
1. Redesign and refocus of the Safeguarding and Trust strategy on eradication of dormitory bed stock.

In my last report:

I confirmed that we would be developing a 'Patient and Carer Experience Strategy' that develops a systematic quality improvement and feedback improvement loop. The strategy has been ratified and the feedback model into services is incorporated into the Trust's IT development plan. We have struggled to convert the idea of a 'Trip Advisor' model into a reality and we have adjusted that model into a text messaging and an email service that will go live in March 2020 in line with Trust and national GDPR requirements. It will give access to 7000 text messages to receive feedback on our services and will gradually roll out Trust wide from April 2020.

This has been a solid year in improving performance and making headway on service improvements.

**Carolyn Green**
**Director of Nursing and Patient Experience**


Start
Triggered by staff outcoming an appointment
Has the patient attended the appointment?
No
Yes
Was the appointment in the last 2 weeks?
No
Yes
Has patient given SMS consent?
No
Yes
Wait for other survey
Does patient currently have an open survey?
Yes
Is previous survey over 1 week old?
No
Yes
Close previous survey
No
Send SMS
This is a message from DHCFT.
Thank you for attending your recent appointment on DD/MM/YYYY. We would like to ask a short survey about your appointment. If you don't want to participate in this survey, please reply STOP. If you wish to stop all text messages (including appointment reminders), please contact us on 01332 623700.
On a scale of 1 (poor) to 5 (good), How would you rate your overall experience at this appointment?
Response
Is response STOP?
Yes
No
Send SMS
This response was not expected. Please reply on a scale of 1 to 5
No
Is this the 3rd invalid response?
Yes
No
Is response valid for the question?
No
1, 2 or 3
4 or 5
Send SMS
We're sorry to hear that you have not had the experience we aim to provide. Please could you reply with any comments to help us improve our service.
Send SMS
We're glad to hear you had a positive experience we aim to provide. If you have any comments you'd like to add, please reply.
Response
Is response STOP?
Yes
No
Send SMS
Thank you for taking the time to complete this survey. Your comments are vital to help us deliver high quality care. If you have anything further to add, please call 01332 623700.
Response
Is response STOP?
Yes
No
Close survey
Send SMS
Thank you. You have now opted out of this survey. If you wish to end all text message communications, please contact us on 01332 623700.
Send SMS
This survey is now closed. If you would like to get in contact with DHCFT or require assistance, please call 01332 623700
End

**Derbyshire Healthcare NHS Foundation Trust**
Report to the Board of Directors – 3 March 2020

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

## Purpose of Report

This paper is a half yearly report to the Foundation Trust Board of Directors to ensure the Board is aware of Freedom to Speak Up (FTSU) cases within the Trust, an analysis of trends within the organisation and actions being taken.

## Executive Summary

This report sets out the number and types of cases and concerns raised in the last six months with the FTSUG. There has been an increase in the number of cases (individuals) approaching the FTSUG in the last six months compared to the previous six months.

A number of emerging themes include:

- Culture - inclusivity of recruitment process: concerns have been raised around the inclusivity of the Trust's recruitment processes. The development and training of Recruitment Inclusion Guardians will enable the Trust to support the diversity of the workforce and inclusivity of the recruitment process.
- Culture - valuing of a specific role and profession: concerns raised around workers feeling that their skills are not being effectively utilised and valued in some areas of the Trust.

The report also contains a comprehensive list of actions taken to improve visibility and promote FTSU to ensure that the FTSU Culture is continuously improved.

The development of the FTSU champions network 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 attracting colleagues to work with us who we develop, retain and support by excellent management and leadership | X |
| 3) We will make the **best use of our money** by making financially wise decisions and will always strive for best value to make money go further | |

**Risks and Assurances**

Reporting on concerns raised is presented to the Trust Board six monthly and to the Audit and Risk Committee six monthly going forwards to provide assurance on progress made. The People and Culture Committee also receive the issues as part of the wider staff feedback.

The Board undertook a self-review of FTSU using the NHSI toolkit in 2018. The areas for development are monitored by the Audit and Risk Committee. The toolkit provides a benchmark and assurance that work to promote and respond to raising concerns and speaking up at work is progressing. The toolkit was revised in July 2019 and the Board will carry out a self-review again in May 2020.

There are a number of 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** - none

**Governance or Legal Issues**

Trusts are required to have a FTSUG as part of 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 report discusses issues around culture faced by BME workers who have approached the FTSUG in relation to the inclusivity of recruitment processes.

**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) Support the use of a rolling improvement / action plan for Speaking Up which feeds into Trust's wider improvement strategy
3) Support the development of a Speaking Up Strategy during 2020/21 which will be shared with key stakeholders, discussed and agreed by the Board, and is linked to or embedded within other relevant strategies.

**Report presented by: Tamera Howard, Freedom to Speak Up Guardian**
**Report prepared by: Tamera Howard, FTSUG with support from Justine Fitzjohn, Trust Secretary**

# Freedom to Speak Up Report

## 1. Introduction

1.1 The Freedom to Speak Up Guardian (FTSUG) is part of a culture of speaking up and also acts to enable cultures where safety concerns are identified and addressed at an early stage.

1.2 Freedom to Speak Up has three components: improving and protecting patient safety, improving and supporting worker experience and visibly promoting learning cultures that embrace continual development.

1.3 The Care Quality Commission assesses a Trust's speaking up culture under the Well-Led domain of its inspections.

1.4 The report covers Quarters 2 and 3 of 2019/20. 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 and types of cases being dealt with by the FTSUG and themes identified from July to December 2019
- Information on what the Trust has learnt and what improvements have been made because 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

## 3. Summary of concerns raised

3.1 Concerns are categorised in accordance with NGO guidance. The NGO requires concerns relating to Patient Safety, Bullying and Harassment, anonymous concerns and those suffering detriment as a result of speaking up to be recorded.

3.2 Table 1 shows that the FTSUG has seen an increase in number of cases (individuals) approaching in Q2 (45 cases) and Q3 (52 cases) in comparison to Q1 (28 cases) and this has continued into January and February of Q4 with 45 cases. In Q3 of 2019/2020, the NGO reported that nationally there were 634 more cases raised in Q3 compared to Q2 and nearly 1000 more than in Q1. Q3 also saw the highest numbers of reporting of cases of any quarter with around 4200 across all Trusts in England.

3.3 The table also shows the increases in concerns reported through the FTSUG, including 80 logged in Q3, higher due to a management of change process which involved large numbers of workers approaching the FTSUG. This

includes logging the concerns of all attendees at a large team meeting in line with NGO guidance.

**Table 1: FTSU Data Q2 and Q3 2019/20**

| Types of Concerns 2019/2020 | Q2<br>Jul - Sep 2019 | Q3<br>Oct – Dec 2019 |
|---|---|---|
| Attitude & Behaviours | 25 | 29 |
| Culture | 6 | 3 |
| Policies, Processes and Procedures | 18 | 16 |
| Health and Safety | 4 | 0 |
| Staff Safety | 7 | 6 |
| **Bullying & Harassment** | **20** | **14** |
| **Patient Safety and Quality** | **8** | **6** |
| Availability of Managers | 3 | 3 |
| Performance | 0 | 2 |
| Fraud or Criminal Offence - potential | 2 | 1 |
| **Total Cases reported to FTSUG** | **45** | **52** |
| **Public Interest Disclosure Act concerns** | **30** | **21** |
| **Reportable to NGO: Bullying and Harassment / Patient Safety** | **28** | **20** |
| **Total number of concerns*** | **65** | **80** |
| **Anonymous** | **6** | **5** |
| **Suffering a detriment as a result of speaking up** | **0** | **1** |
| **Number of cases that have received feedback from FTSUG** | **11** | **43** |

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

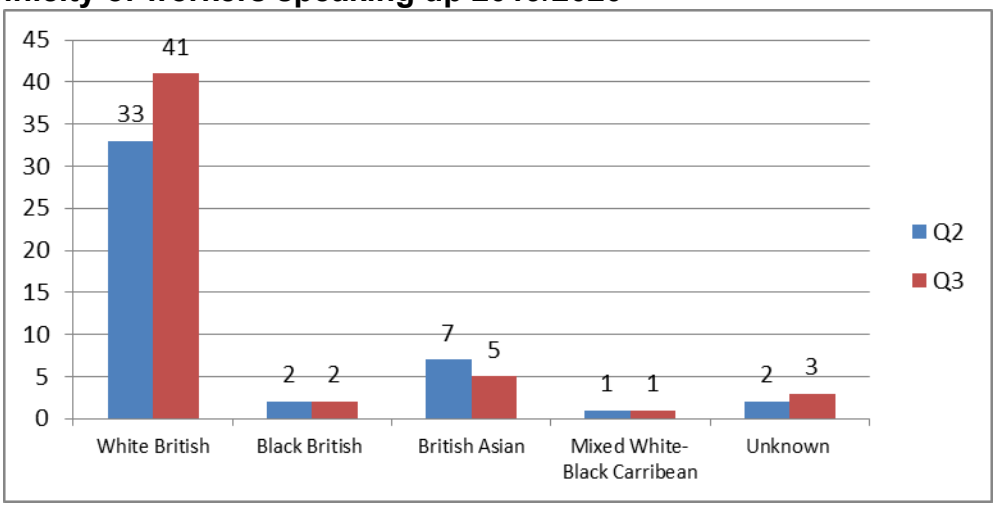
3.4 **Professional groups:** 32% of cases are from Administrative and Clerical workers in the Trust and this is double the 16% seen across NHS Trusts in England as reported by the NGO for 2018/2019. Medics are not currently approaching the FTSUG. The Guardian attended a Junior Doctors forum (South) and will attend the Junior Doctors forum (North) in early March to raise the profile of speaking up. The FTSUG has also met with the Trust's Guardian of Safeworking to promote Speaking Up.

**Table 2: Cases raised per professional group for Q2 and Q3 2019/2020**

| Professional Group | National Comparators (NGO Survey 2018/19) | DHCFT |
|---|---|---|
| Nurses | 30% | 32% |
| Admin & Clerical | **16%** | **32%** |
| Allied Health Professions | 14% | 7% |
| Others / Unknown | 12% | 7% |
| Healthcare Assistants | 9% | 13% |
| Doctors | **7%** | **0%** |
| Corporate | 5% | 0.5% |
| Estates & Facilities | 4% | 5% |
| Pharmacists | 1% | 4% |
| Board Members | 0% | 0% |

3.4 **Ethnicity of workers:** Of workers approaching the FTSUG in Q2 and Q3, 19% identified as BME and 76% identified as White British. The latest Workforce Race Equality Standards (WRES) figures for the Trust suggests that 17.17% of our workforce identify as BME and 82.83% as White British.

**Fig 1: Ethnicity of workers speaking up 2019/2020**



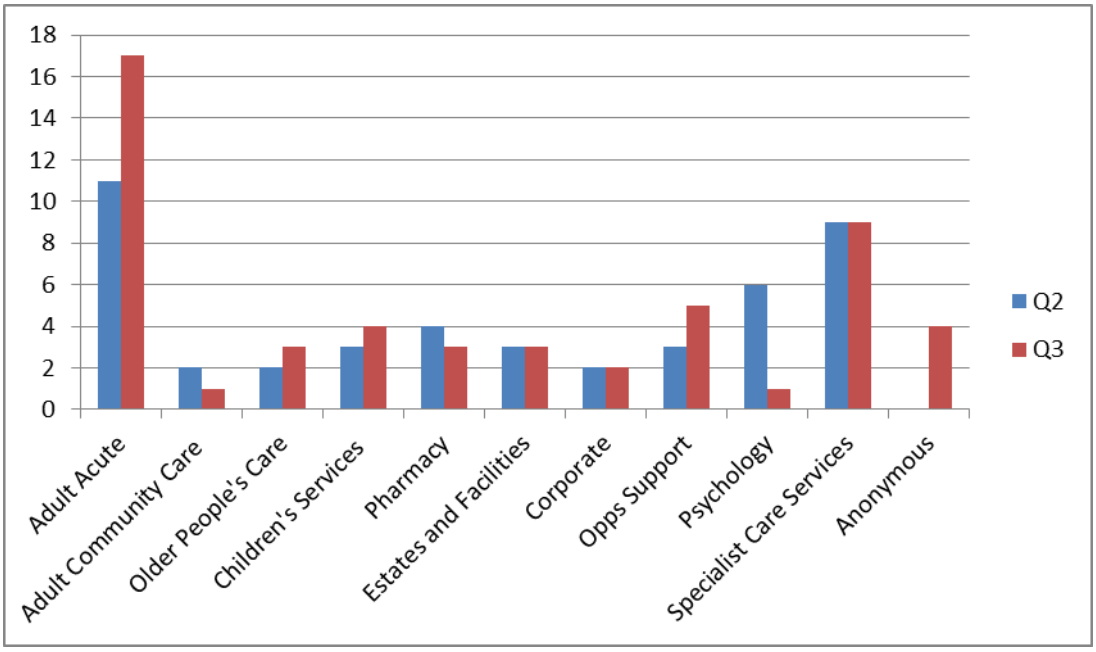

3.5 **Patient safety and quality issues:** Patient safety concerns in Q2 and Q3 were limited to 14 cases. In comparison to acute Trusts, Mental Health Trusts have far fewer patient safety concerns. All patient safety concerns are directed to the Director of Nursing and Patient Experience and/or to the Medical Director. Anonymised details of these concerns are now shared with the Risk and Assurance Manager to more effectively triangulate data.

3.6 **Bullying and Harassment:** Perceived bullying and harassment concerns represented 44% of the total concerns raised in Q2. In Q3 this had decreased to 27%. This is a positive outcome but a reduced or downward trend needs to continue in order to show an improvement. The National Guardian's Office (NGO) has seen a drop in bullying and harassment reporting from 45% in 2017/18 to 41% in 2018/2019. The FTSUG continues to positively promote the Trust's Dignity at Work policy and the Bullying and Harassment booklet to all workers. The FTSUG hopes to merge the role of FTSU Champion with that of a bullying and harassment champion and further training for Champions will need to be developed to cover this area.

3.7 **Detriment:** one individual reported suffering a detriment and this was logged in Q3. The individual has not yet given their consent to look further into this detriment which was discussed in confidence but the FTSUG is continuing to work with this individual.

3.8 **Concerns raised by areas:** In Q2 and Q3, Adult Care provided the greatest number of cases at 29% of the total, followed by Specialist Care Services with 18%.

**Fig 3: Division areas for Q2 and Q3 2019/20**




## 4. Emerging or ongoing themes and actions taken

4.1 It is important to note that many of the concerns workers bring to the FTSUG do not enter into a formal process and that categorisation of themes reflects the worker's perspective.

4.2 **Bullying and Harassment:** Workers continue to speak up about situations where they feel that Trust values of dignity and respect are not always upheld during interactions. These instances have taken place between workers and between workers and managers and were reported to have taken place in one-to-ones, during team meetings, on the ward and in a range of other contexts. Some of the concerns involved managers not responding effectively to resolve Bullying and Harassment issues.

**Action:** The FTSUG continues to support workers who identify concerns related to bullying and harassment by directing to the relevant support including policies and our bullying and harassment guide.

4.3 **Culture: admin and clerical function**
32% of cases have come from administrative and clerical workers and involve a range of concerns which have been logged and escalated appropriately.

**Action:** Concerns relating to admin culture in some areas of the Trust were shared with the Executive Leadership Team (ELT) in January 2020. The FTSUG has escalated concerns on an ongoing basis and some of the concerns have been supported by organisational effectiveness.

4.4 **Culture: inclusivity of recruitment process**

A number of concerns have been raised from BME workers in relation to being treated differently and some of these related to concerns around the inclusivity of the recruitment process. It is also important to note that some BME workers may choose not to progress their specific concerns around diversity and inclusion.

**Action:** One of the ideas that came out of the 2019 BME Staff Conference was to 'disrupt' the way the Trust recruits to become more inclusive. The Recruitment Steering Group is running a pilot project to increase diversity across the workforce. Recruitment to all posts Band 7 and above now include a Recruitment Inclusion Guardian in the shortlisting and as a panel member. Workers who would like to become Recruitment Inclusion Guardians are being signposted to the training for this process.

4.5 **Culture: in relation to valuing of role**

A group of workers in specific roles have raised concerns in relation to feeling that their skills are not being effectively utilised and valued in some areas of the Trust.

**Action:** concerns have been raised with ELT and a senior leader and are being considered.

## 5. Improving Speaking Up Culture

5.1 **Freedom to Speak Up Policy:** in order to reflect best practice and NHSI guidance the Freedom to Speak Up Policy was renewed. The policy was ratified by the Audit and Risk Committee in January 2020. The renewed speaking up policy was also taken to the Policy Review Group and JNCC. The Freedom to Speak Up policy is available on the intranet. It was also reviewed by some of the FTSU Champions.

5.2 **Improving visibility and networking:** The FTSUG has taken a number of actions to improve visibility and promote speaking up and these are detailed in **Appendix 1**. The FTSUG continues to network and meet regularly with Executive leads, People Services leads, Unions as other staff. These relationships are positive and supportive and facilitate the Speaking Up process.

5.3 **Addressing barriers to speaking up:** the FTSUG has attended Estates and Facilities team meetings to meet with workers who may not regularly access emails or electronic information. The FTSUG holds regular meetings with the Head of Estates and Facilities to discuss opportunities for development and improvement of speaking up culture. The FTSUG also regularly engages with the Equality, Diversity and Inclusion Service to address issues of inclusivity for all diverse groups.

5.4 **Network of FTSU Champions**: The FTSUG has recruited 29 Speaking Up Champions across the Trust. Several of these champions have brought cases to the FTSU and Champions have presented directly to teams and forums on Speaking Up. Speak Up Champions attended a day's training in October 2019.

5.5 **October 2019 Speak Up month:** The training of Speaking Up Champions coincided with the NGO's Speaking Up month. During Speaking Up month a joint DCHFT, UHDB and DCHS staff was also held for workers at London Road Community Hospital.

5.6 **Non-Executive Director:** Julia Tabreham took over the NED speaking up role from September 2019. Julia attended the Champions training. The Trust Secretary and FTSUG met with Julia in Q4 to discuss FTSU within the Trust.

## 6. Learning and improvement in relation to Speaking Up Culture

6.1 **CQC feedback on FTSUG:** During the latest CQC inspection, FTSU processes were assessed under Well Led and informally received very positive feedback. It is expected that formal feedback will demonstrate progress from the last inspection.

In the CQC report into acute services dated 4 June 2019, most staff knew how to use the speaking up process, who the FTSUG was and what their role was. However, not all student nurses were aware of this role. The Student Placement Facilitator and two Practice Placement Facilitators Preceptors are FTSU champions and actively promote speaking up to preceptors and students. The FTSUG also promotes the Speaking Up role to MSc Mental Health and Adult Nursing Students at Derby University on a regular basis.

6.2 **Evaluation feedback on Speaking Up:** A short evaluation form for individuals who have spoken up is sent and responses received have been positive around the support provided for FTSU. In Q2 and Q3, 85% of respondents said 'yes, they would speak up again' and 15% said 'maybe'.

Evaluation feedback has included: '*To be able to speak up to someone like Tam or her champions allows you to put things in perspective and consider what is happening and getting support at the level you require. The support provided by the F2SUG meant that I could work through the issue at my own pace; this support bolstered my confidence and I was able to deal with the issue myself. Tam has been incredibly supportive and will go the extra mile for people.'*

6.3 **Triangulation of data** has improved around patient safety with sharing of anonymised information with the Head of Risk and Assurance and the Lead for Patient Safety and Experience to make sure that patient safety concerns are effectively documented by the FTSUG. The FTSUG has also had a discussion with the Communications Team around the data held in relation to the Chief Executive's 'On the Road' sessions and workers who may flag up concerns through this process.

6.4 **Speaking up training:** The NGO intends to release Health Education England (HEE) eLearning for workers in the new financial year 2020/21. The FTSUG will meet with Trust training leads to discuss roll out of this e-learning programme. The FTSUG continues to present on Trust inductions and this has resulted in the recruitment of further Champions and also involved newly recruited staff speaking up about concerns.

6.5 **Showcasing speaking up to Board:** Recent NGO guidance suggested inviting workers who have spoken up to come and talk to the Board about their experience is valuable. The FTSUG is discussing a programme for this to be scheduled for 2020/21.

6.6 The FTSUG has developed a **rolling improvement action plan**, with the approval of the Executive Lead for speaking up, which they hope will enable the Trust to reflect on their speaking up culture as part of their overall improvement strategy and create a coherent narrative for patients, workers and oversight bodies.

6.7 **100 voices case study:** The FTSUG submitted a comprehensive case study around a worker in the service who spoke up about the lack of perceived equality around retire and return. The policy was recently amended following this worker's persistence and the work of the FTSUG and staff forum. The NGO said, *'wonderful that they have managed to change the policy and benefit the member of staff so significantly. You should take a lot of credit for your persistence, and the person who spoke up should similarly take credit for not letting it go. Great result.'*

6.8 The FTSUG successfully completed all of the actions required for the 360 Assurance Freedom to Speak Up Audit.

## 7 National Guardian's Office Developments & related National Changes

7.1 **National FTSU Case Reviews:** Two FTSU case reviews were published by the National Guardians office (NGO) for Brighton and Sussex University Hospitals (June 2019) and the Northwest Ambulance Service NHS Trust (September 2019). The NGO make specific recommendations for how both Trusts can improve the support they provide to their staff.

**What this means at DHCFT** – The case review recommendations have been reviewed by the FTSUG and shared with the Equality Diversity and Inclusion (EDI) Lead and Chief Executive to explore whether there is learning which could benefit the Trust.

7.2 **Difficult conversations** - The BSUH case review recommends all people who are involved with FTSU are adequately trained in holding difficult conversations. Our Trust provides training in Courageous Conversations and also in Quality Conversations. It is hoped that FTSU Champions will also attend a similar style of training around quality conversations and basic coaching techniques.

7.3 **Vulnerable workers** – The BSUH case review recommends that the reach of FTSU extends to workers who may be at risk of exclusion within the Trust. In the past year the FTSUG has attended EDI networks and engages with the EDI Lead and Network Chairs. Further attendance is scheduled for 2020. EDI forums could also enable staff to present their lived experiences of 'speaking up' in a way that further enables learning. The FTSUG also attends Estates and Facilities meetings and meets regularly with the Head of Estates and Facilities to discuss promotion of the FTSU role.

7.4 **FTSU Champion roles -** The North West Ambulance review concerned the handling of two speaking up cases where information indicated that the response to speaking up had not been in accordance with good practice. The case review made eight recommendations and one recommendation pointed out that FTSU Champions should not act as advocates. The FTSU Champions at DHCFT have a clear outline for their 'role' and complete an application form which is approved by their Line Manager.

7.5 In January 2020, The NGO released: 'Speaking Up in the NHS in England 2018/19'. The report provided a summary of speaking up data from 2018/19 for NHS Trusts and Foundation Trusts. The report showed that there was a 73% rise in the number of cases reported to Guardians in 2018/19 in comparison to 2017/2018. It also showed more than 1 in 10 staff raised concerns anonymously and that 5% of cases feared suffering a detriment.

7.6 The NGO's recently published 'Freedom to Speak Up Index' report, based upon a subset of questions in the NHS staff survey, shows that NHS Trusts with the highest index score are rated as good or outstanding by CQC . The Trust achieved 77% in the FTSU 2018 Index which was the same as Nottinghamshire Healthcare NHS Foundation Trust.

## 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 vital that the Trust learns from concerns that workers raise to continue to build an environment where workers know their concerns and feedback are taken seriously and welcomed as an opportunity to guide service improvement and transformation.

8.2 Freedom to Speak Up is a rapidly developing area as reflected through increases in numbers of cases both locally and nationally. It is clear from looking at the national averages of FTSU numbers that the Trust process has a higher profile than many and continues to gain momentum.

8.3 The Board needs to capitalise on this momentum and focus on driving the recommendations from this report forward with some 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) Support the use of a rolling improvement / action plan for Speaking Up which feeds into Trust's wider improvement strategy
3) Support the development of a Speaking Up Strategy during 2020/21 which will be shared with key stakeholders, discussed and agreed by the Board, and is linked to or embedded within other relevant strategies.

**Tamera Howard**
**Freedom to Speak up Guardian**

**Appendix 1**

**Promotion of FTSU role through communications, networking, meetings and visits during July to December 2019**

- **Communications:** promotion of FTSU on Connect, Screen Savers and through paper posters and leaflets as well as communications information including Making a Positive Difference
- **Induction:** secured a regular presentation slot at monthly Trust inductions – new workers have spoken up following induction

**Meetings and presentations promoting FTSU:**

- Three Away Days
- 13 Team Meetings / Ops Meetings
- Three Practice Development Sessions
- One Junior Doctors Forum (South). Attending JD Forum (North) on 6 March 2020.
- Regularly attend Staff Forum
- Presented to MSc MH and Adult Nursing Students at Derby University - ongoing work

**Support Network**

- Attend regular meetings with a range of senior leaders including Executive Lead for Speaking Up, Director of Operations, Deputy Director of Operations, Director of Nursing and Patient Experience and Director of People, Culture and Transformation, Head of Employee Relations and Head of Estates and Facilities
- Attend regular supportive meetings and telephone conversations with FTSUG buddies at UHDB, DCHS and Leicester Partnership Trust (LPT)
- Attend monthly supervision for support and development within role.
- Attend 121s with Line Manager

**National Guardian's Office and FTSU Midlands network**

- Engaging with NGO on regular basis through calls/emails/webinars.
- Part of Midlands FTSUG network and attended first meeting on 30 October 2019. Two further meetings scheduled for March 2020.
- Keeping up-to-date with NGO developments, guidelines and case reviews.
- Submitted NGO 100 voices case study in December 2019.

**Derbyshire Healthcare NHS Foundation Trust**
Report to the Board of Directors – 3 March 2020

# Public Sector Equality Duty (PSED), Gender Pay Gap (GPG) and Inclusion Strategy for 2020

## Purpose of Report

This complies with our mandatory reporting requirements for Public Sector Equality Duty, Gender Pay Gap and includes a new GPG action plan. It also includes the Inclusion Strategy that incorporates some of our Equality objectives.

## Executive Summaries

### 1. PUBLIC SECTOR EQUALITY DUTY (PSED)

This section of the report summarises content from a much fuller report presented to the Equality Forum and executives that showcases many examples of the leading edge work that the Trust has done with equality, diversity and Inclusion (EDI) such those highlighted in the Inclusion Strategy. It looks back on a fantastic year of successes and it includes a great deal of detail about workforce and patients. It also incorporates Equality Delivery System updates completed to date. This part of the document today serves more as a statement of compliance with public sector equality duty. It does not attempt to present all the relevant evidence in one place.

In considering how well the Trust has considered its public sector equality duty today, Board members will be aware of many examples of the required considerations, not least the PSED section itself that is included in all papers that are presented to Board and Board Committees

### 2. GENDER PAY GAP (GPG)

**The context**

It is International Women's Day (IWD) on Sunday 8 March with a theme of #EachforEqual. Last year IWD research showed that equal pay comes up as the main issue for women in the UK, followed by sexual harassment and domestic abuse.

As one of the UK's largest employers, improvement in the NHS gender pay gap should make a significant contribution to addressing the equal pay priorities of women.

For our Trust this is important for our People First and Respect values, our Inclusion Strategy as well as our overall staff satisfaction and employee retention (80% of our workforce is female).

The attached report (in the format generated by Electronic Staff Record (ESR)) shows some small overall improvement in some comparator areas for March 2019 data compared to March 2018 data. Whilst there is some improvement there is not enough: The Deputy CEO, after discussions with the Gender Network, is proposing a Gender Pay Gap Action plan for endorsement by the Board today.

The report also includes some additional analysis by staff group and service line which will be built on by the data analysis action area. The action plan covers six action areas:

1. Data Analysis
2. Branding communication and transparency
3. Recruitment and promotion processes
4. Policy review including maternity, paternity and parental leave
5. Wellbeing and Retention
6. Supporting Female Staff

**The results**

GPG mandatory reporting covers four areas: two type of average pay figures (mean and median), the gender distribution across quartiles and a subset of pay called 'bonus'

- Our median gender pay gap is now 11.53% (this compares *favourably* with prior year figures where the difference was 13.52%)
- Our mean pay gap is slightly *better* 18.26% (18.7% prior year)
- Our bonus gap is *worse* at 93.63% (92.89% prior year) (this is mainly driven by clinical excellence awards in our Trust)
- Gender distribution is slightly *better*: women occupy 70.96 % (69.6% prior year) of the highest paid jobs and 85.48% (85.37% prior year) of the lowest paid jobs.

For awareness it is anticipated that GPG headlines will described in the following way:

- *In this organisation, women earn 88p for every £1 that men earn when comparing median hourly wages. Their median hourly wage is 11.53% lower than men's.*
- *When comparing mean hourly wages, women's mean hourly wage is 18.3% lower than men's.*
- *In this organisation, women earn 6p for every £1 that men earn when comparing median bonus pay. Their median bonus pay is 93.6% lower than men's*
- *In this organisation, women occupy 70.96% of the highest paid jobs and 85.5% of the lowest paid jobs.*

## 3. INCLUSION STRATEGY

Our Inclusion Strategy defines how inclusion is at the heart of Derbyshire Healthcare; from our vision and values to granular examples of our day-to-day inclusion activities and priorities.

This simple strategy highlights what 'being you' in Derbyshire Healthcare means with some examples of recent celebrations and activities. It then summarises the key inclusion priorities for 2020; explaining why they matter and what impact they will have.

These priorities build on successes we have already achieved and they also seek to improve the areas where further progress is needed. In particular data capture for example; it is hard to reliably measure or change what we do not know.

We have chosen to have a mini-strategy for one year in order to be able to regularly reflect and refresh and to further expand on our next aims and ambitions as a result of learning from the last. This is a dynamic approach in order to enable an evolving, responsive and appropriately focussed strategy year-in-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 attracting colleagues to work with us who we develop, retain and support by excellent management and leadership | x |
| 3) We will make the **best use of our money** by making financially wise decisions and will always strive for best value to make money go further | x |

**Assurances**

- This issue relates to all board assurance framework risks affected by staff.

**Consultation**

- The Annual Equality Diversity and Inclusion Report that has informed the PSED report was discussed at ELT and Equality Forum.
- The Inclusion Strategy was discussed at Team Brief was circulated to all staff in Weekly Connect and was updated following comments. It has also been discussed at Staff Networks, Executive Leadership Team and Equality Forum.
- Our gender pay gap information has been discussed at Executive Leadership Team, Equality Forum and at our new Gender Network.

**Governance or Legal Issues**

- PSED requirements are to publish information to demonstrate compliance with the general equality duty. This information must include information relating to people who share a protected characteristic who are the Trust's employees or are people affected by the Trust's policies and practices. This does not have to be in a separate report. There is no prescribed format. Public bodies must demonstrate they have consciously thought about the three aims of the Equality Duty as part of the process of decision making. Every report that includes our PSED section demonstrates this.
- PSED also requires that we prepare and publish one or more equality objectives to achieve any of the aims of the general equality duty.
- We are required by the Government Equalities Office to report our Gender Pay Gap report by the deadline of 30 March 2020 using data taken from 31 March 2019. The GPG report has been compiled in line with guidance issued
- It is not a requirement to devise or publish a GPG action plan, but it is best practice.
- To have an Inclusion Strategy is not a legal requirement, but having one supports the delivery of some legal requirements related to Equality, Diversity and Inclusion and incorporates our Equality objectives as required by the PSED

**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 whole purpose of this report is the strategic consideration of inclusion in its widest sense and is therefore written in order to bring about change across many equality, diversity and inclusion priorities, as described in the report
- The PSED section of this report specifically relates to the general equality duty set out, that the public functions must have due regard to the need to:

    1. Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act.
    2. Advance equality of opportunity between people who share a protected characteristic and those who do not.
    3. Foster good relations between people who share a protected characteristic and those who do not.

- The primary protected characteristic associated with the gender pay gap is

gender but this is not the only characteristic GPG reporting touches on.

- The GPG action plan also proposes analysis across protected characteristics to see if that gives us better insights into the drivers of the gap and where differences may be more pronounced. Intersectionality is an important consideration for addressing our gender pay gap.
- Improvement in the breadth of our workforce data capture will help us focus in the right places. Therefore the inclusion priorities for 2020 about greater data capture for workforce are crucial in support of this agenda
- By closing our gender pay gap we will positively impact on those with protected characteristics (and hopefully not just gender) because it will help us to identify and remove barriers, provide positive outcomes for groups and bring groups together in positive ways, in line with the aims of the Equality Act
- The inclusion strategy is equally applicable to people who may have one or more protected characteristics. Intersectionality is an important consideration.
- The strategy is applicable to colleagues and to people who use our services.

**Recommendations**

The Board of Directors is requested to:

1) Discuss and agree compliance with the Public Sector Equality Duty
2) Discuss the gender pay gap information including its movement from prior year
3) Endorse the GPG action plan and commit to receive updates
4) Discuss and formally approve the Inclusion Strategy and commit to receive updates.

**Report presented by:** **Claire Wright**
**Deputy CEO**

**Report prepared by:** **Claire Wright**
**Deputy CEO**

**Liam Carrier**
**Assistant Head of Systems and Information (People Services)**

**Clare Meredith**
**Equality Diversity and Inclusion Advisor (People Services)**

**SECTION 1**
**Public Sector Equality Duty Report 2019**

Our Trust is committed to ensuring equality, diversity, inclusion and human rights are central to the way we deliver healthcare services to our service-users and how we support our staff.

This means we all play our part:

- To be a caring and progressive organisation that promotes equality, values and celebrates diversity and has created an inclusive and compassionate environment for receiving care and as a place to work;
- To ensure that our staff provide inclusive services that are equally good to all service users, which meet their needs and are delivered with kindness, dignity and respect;
- To ensure that all our team members are engaged, valued and treated equally with kindness, dignity and respect.

The Public Sector Equality Duty Report 2019 will be updated to reflect further developments.

**Public Sector Equality Duty (PSED)**

The public sector equality duty is made up of a general equality duty supported by specific duties. The general equality duty is set out in section 149 of the Equality Act 2010.

The **general equality duty** sets out that the public functions must have due regard to the need to:

1. Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act.
2. Advance equality of opportunity between people who share a protected characteristic and those who do not.
3. Foster good relations between people who share a protected characteristic and those who do not.

The **specific duties** require the Trust to:

- Publish information to demonstrate compliance with the general equality duty. This information must include information relating to people who share a protected characteristic who are the Trust's employees or are people affected by the Trust's policies and practices.
- Prepare and publish one or more equality objectives to achieve any of the aims of the general equality duty.

In the NHS Standard Contract, the Trust is required to publish information on the Equality Delivery System 2 (EDS2), the Workforce Race Equality Standard (WRES) and the Workforce Disability Equality Standard (WDES).

## Equality Strategy and Objectives

We want 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. Understanding our diverse patients and communities helps us to focus on inequalities and ensures that our services are targeted, used and effective.

Equality fits within the overall Trust Strategy to become a 'great place to work' and to 'deliver great care'. The building blocks reflect our work focused on inclusion for all of the protected characteristics.

## Inclusion Strategy 2020

The Trust is publishing its Inclusion Strategy alongside this report today and in it are set out our main inclusion objectives for the year ahead

## Summary of learning and actions from 2019/20:

Based on the past year, there have been several areas where the equality agenda will be focusing efforts to develop and improve upon, including:

- Reverse Mentoring for Equality, Diversity and Inclusion: The success of the first cohort means the launch of the second at the end of 2019 and a third to be launched in 2020. There will be a greater focus on the evaluation of the programme to understand the impact on our staff and services. More details on the programme can be found on page 23.

- Workforce Race Equality Standard (WRES): The WRES Improvement Action Plan was co-produced with our BME Staff Network and will be improved upon throughout the year to ensure that the actions are effective and impactful to address the gaps in workplace experience between BME and white colleagues. The BME Network is monitoring progress and will hold the Trust to account. More details and the link to the Action Plan can be found on page 35.

- Workforce Disability Equality Standard (WDES): The WDES Improvement Action Plan was co-produced with our Disability & Wellness Network and is updated to improve the experience of staff living with disabilities and long term conditions in the Trust. A particular focus is on highlighting the importance of declaring protected characteristics in the Trust. More details on the WDES and the link to the Action Plan can be found on page 40.

- Equality Delivery System (EDS2): Based on the feedback from the stakeholder grading events held in February 2020, the Kedleston Unit will be taking on actions to further improve the experiences of staff and patients at the unit, and will produce a 'You said, we did' report to demonstrate their progress to stakeholders over the coming year.

- Staff Networks: The Trust will continue to support the Networks to develop and thrive as a voice and champion for staff with protected characteristics. The Staff Networks have a great impact on the culture of the organisation and in creating an open and honest environment to drive improvement in the Trust.

As well as examples of the considerations of information on the Equality Delivery System 2 (EDS2) here with Kedleston, the Workforce Race Equality Standard (WRES) and the Workforce Disability Equality Standard (WDES) have taken place throughout the year. The Trust Board has received WRES and WDES reports and has discussed associated action plans.

The full EDI annual report from which this report is informed has been considered by Equality forum and Executive Leadership Team and will also be discussed at People and Culture committee to further explore EDI aspects featured in the report such as:

- Patient Equality Data: Information on patient equality data compared to wider demographic information for Derbyshire concludes that analysis of the available data would indicate that there are no evident barriers to accessing services as the patient demographic is broadly in line with that of the local population. However, the Improving Services for BME People through Reverse Commissioning Project is an initiative designed to better engage with our local BME communities to identify ethnic health inequalities in the Trust's provision of services. The project endeavours to close these gaps by influencing the commissioning of services to make a difference to the lives and outcomes for BME people

- Workforce Equality Data will be set out across the protected characteristics where we have data. To provide the most effective services for our patients and service users, we need to recruit, grow and engage with people from diverse backgrounds. Having a fuller picture of our staff profile also highlights areas of underrepresentation and to ensure that all groups' needs are taken into account in the Trust's decision-making. Monitoring of our workforce's protected characteristics is also used in the Trust's annual Staff Survey. It is a measure of our Trust's culture as it allows us to better understand the lived experience of our staff and identify issues, so that we can take steps to ensure people feel safe to be themselves and they are able to raise concerns.

- Membership Data: Our public membership is very important to the Trust. It allows us to have regular dialogue with our local communities, including people who use our services and their families and friends, local residents and people who have an interest in the services we provide. Through these conversations and relationships we can work together to improve the local NHS services we provide across Derbyshire and to ensure the Trust is responsive to the needs of our local communities. Breaking down the membership into protected characteristics is important to ensure that every community is represented and has a voice. The membership team frequently engage with the local community, for example, they attended Pride events with our Trust's LGBT+ Staff Network at Belper, Derby and Chesterfield in 2019 to appeal to members of the LGBT+ community to become public members of DHCFT. Currently the Trust has 6,140 public members who have chosen to join the Trust as a member.

**Equality Delivery System 2 (EDS2)**

The EDS2 helps the Trust to meet and respond to the Public Sector Equality Duty as set out in the Equality Act 2010. Giving 'due regard' is a legal duty – it means proactively and consciously engaging and considering the impact of our decision – which helps to improve outcomes for diverse groups. It will assist to meet the general duty to eliminate discrimination, harassment and victimisation; advance equality of opportunity; and foster good relations.

All four of the EDS2 goals and their associated outcomes are outlined below:

**The goals and outcomes of *EDS2***

| Goal | Number | Description of outcome |
|---|---|---|
| **Better health outcomes** | 1.1 | Services are commissioned, procured, designed and delivered to meet the health needs of local communities |
| | 1.2 | Individual people's health needs are assessed and met in appropriate and effective ways |
| | 1.3 | Transitions from one service to another, for people on care pathways, are made smoothly with everyone well-informed |
| | 1.4 | When people use NHS services their safety is prioritised and they are free from mistakes, mistreatment and abuse |
| | 1.5 | Screening, vaccination and other health promotion services reach and benefit all local communities |
| **Improved patient access and experience** | 2.1 | People, carers and communities can readily access hospital, community health or primary care services and should not be denied access on unreasonable grounds |
| | 2.2 | People are informed and supported to be as involved as they wish to be in decisions about their care |
| | 2.3 | People report positive experiences of the NHS |
| | 2.4 | People's complaints about services are handled respectfully and efficiently |

**Continued on next page**

**The goals and outcomes of *EDS2* *(continued)***

| | | |
|---|---|---|
| **A representative and supported workforce** | 3.1 | Fair NHS recruitment and selection processes lead to a more representative workforce at all levels |
| | 3.2 | The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their legal obligations |
| | 3.3 | Training and development opportunities are taken up and positively evaluated by all staff |
| | 3.4 | When at work, staff are free from abuse, harassment, bullying and violence from any source |
| | 3.5 | Flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives |
| | 3.6 | Staff report positive experiences of their membership of the workforce |
| **Inclusive leadership** | 4.1 | Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations |
| | 4.2 | Papers that come before the Board and other major Committees identify equality-related impacts including risks, and say how these risks are to be managed |
| | 4.3 | Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination |

In order to grade the service against the EDS2 goals, the following grading system is used:

| How well do people from protected groups fare in comparison with people overall? | |
|---|---|
| **Excelling (purple)** | Evidence shows that the majority of people in all 9 protected groups fare well |
| **Achieving (green)** | Evidence shows that the majority of people in 6-8 protected groups fare well |
| **Developing (amber)** | Evidence shows that the majority of people in 3-5 protected groups fare well |
| **Undeveloped (red)** | Evidence shows that the majority of people in only 2 or less protected groups fare well |

The Trust has carried out its annual EDS2 rating for the Trust's workforce (to fulfil Goal 3) and is also focusing on the Kedleston Unit, the low secure male mental health service, to fulfil all four Goals, and Goal 4 with regards to demonstrating inclusive leadership via independent audit of Board Papers for equality related risks, carried out by EQUAL members over January 2020.

The Equality, Diversity and Inclusion Service carried out a self-assessment of the Trust's workforce in partnership with People Services. The grading of the self-assessment took place with the Heads of People Services on 21st June 2019, and the Executive Leadership Team on 14th October for scrutiny and to add additional content prior to validation by stakeholders (staff).

Please see the below table for the grading:

| **Goal 1: Better health outcomes** (Healthy living & results for all nine protected characteristics (PCs)) | **Grading** | |
|---|---|---|
| 1.1 Services are commissioned, procured, designed and delivered to meet the health needs of the local communities. | | |
| 1.2 Individual people's health needs are assessed and met in appropriate and effective ways. | | |
| 1.3 Transitions from one service to another, for people on care pathways, are made smoothly with everyone well-informed. | | |
| 1.4 When people use NHS services their safety is prioritised and they are free from mistakes, mistreatment and abuse. | | |
| 1.5 Screening, vaccination and other health promotion services reach and benefit all local communities. | | |
| **Goal 2: Improved patient access and experience** (Nine PCs getting, using and experiencing our services) | | |
| 2.1 People, carers and communities can readily access hospital, community health or primary care services and should not be denied access on unreasonable grounds. | | |
| 2.2 People are informed and supported to be as involved as they wish to be in decisions about their care. | | |
| 2.3 People report positive experiences of the NHS. | | |
| 2.4 People's complaints about services are handled respectfully and efficiently. | | |
| **Goal 3: A representative and supported workforce** (The Trust is a good and fair employer for all nine PCs) | Workforce grading | Kedleston Unit grading |
| 3.1 Fair NHS recruitment and selection processes lead to a more representative workforce at all levels. | | |
| 3.2 The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their legal obligations. | | |
| 3.3 Training and development opportunities are taken up and positively evaluated by all staff. | | |
| 3.4 When at work, staff are free from abuse, harassment, bullying and violence from any source. | | |

| | | |
|---|---|---|
| 3.5 Flexible working options are available to all staff consistent with the needs of the service and the way people leas their lives. | | |
| 3.6 Staff report positive experiences of their membership of the workforce. | | * |
| **Goal 4: Inclusive leadership and governance** (Leaders responding and engaging with the needs of diverse communities) | Workforce grading | Kedleston Unit grading |
| 4.1 Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations. | | |
| 4.2 Papers that come before the Board and other major Committees identify equality-related impacts including risks, and say how these risks are to be managed. | ** | |
| 4.3 Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination. | | |

* The red rating reflects a period of time at the Kedleston Unit where staff were speaking up with regards to issues that concerned them and they felt that they were not being heard and felt unsupported. The Area Service Manager, Unions and Peoples Services met with the staff to hear their concerns, from this an action plan was implemented to ensure that issues raised were addressed. The team had further support from the Freedom to Speak Up Guardian. This ensured that that staff had the right support in place to air their concerns in a safe environment.

** EQUAL stakeholder service user group graded one paper on 29 January 2020. The group agreed next steps will include a paper to Equality Forum on 25 March with recommendations on the accountable officer's presence at the grading and a quarterly engagement meeting to ensure stakeholder engagement is embedded.

Phase 2: The Kedleston Unit's self-assessment has been completed by the General Manager of Forensic Services, Area Service Manager for Forensic Services, Senior Nurse and the Clinical Lead for the Kedleston Unit on 27 November 2019. The stakeholder grading took place on 5 February 2020 and will be sent electronically to stakeholders that were not able to attend. A 'You said, we did' report will be produced by the Kedleston Unit following analysis of the grading and the stakeholders' recommendations for the service.

EDS2 Implementation Plan:

| **Action** | **Subject Lead with EDI Team support** | **Position February 2020** |
|---|---|---|
| Stage 1 : Preparing for self-assessment | | |
| EDS2 training and planning Meeting with senior team | EDI Team<br>General Manager (TH)<br>Senior Nurse (RM) | Completed<br>18 Jun 2019 |
| Process map pathway onto EDS2<br>Goals/outcomes to aid deep dive via protected characteristics | EDI Team<br>General Manager (TH)<br>Senior Nurse (RM) | Completed<br>16 Aug 2019 |
| Kedleston Unit Self-assessment and EDS2 Template/dashboard<br>Quality assurance by EDI Team | Senior Nurse (RM)<br>General Manager (TH) | Completed 27 Nov 2019 |
| Share at Equality Forum | Senior Nurse (RM) and General Manager (TH) | Presented at Equality Forum on 11 Dec 2019 |
| Share at Trust Management Team Meeting | General Manager (TH) | To be tabled |

| Action | Subject Lead with EDI Team support | Position February 2020 |
|---|---|---|
| Stage 2: Grading by stakeholders | | |
| Identify stakeholders and plan Stakeholder grading event | Stakeholder grading event to take place on 5 February 2020 | 5 Feb 2020: Training Room 1 from 9.00-17.00. Grading report also to be shared electronically with stakeholders. |
| Stage 3: EDS2 Grading | | |
| EDS2 Dashboard and 'You, said, we did' Report<br><br>Share with Commissioners | Senior Nurse (RM) and General Manager (TH) | Due Quarter 1-2 of 2020 after stakeholder grading and recommendations have been completed and analysed. |
| EDS2 Dashboard and 'You, said, we did' Report – annual update | Senior Nurse (RM) and General Manager (TH) | 2020/21 |

**SECTION 2**
**Gender Pay Gap Report 2019/20 (data extract as at 31 March 2019)**

## Background

Since the Equality Act 2010 (Specific Duties) Regulations 2011 (SDR) came into force on 10 September 2011, there has been a duty for public bodies with 150 or more employees to publish information on the diversity of their workforce. Although the SDR did not require mandatory GPG reporting, the Government Equalities Office (GEO) and the Equality and Human Rights Commission (EHRC) provided guidance that made it clear that employers should consider including GPG information in the data they already publish. It was evident that not all employers did this, so the government made GPG reporting mandatory by amending the SDR so that all public sector employers with more than 250 employees have to measure and publish their gender pay gaps.

Employers with 250 employees and over need to publish the following information annually for all employees who are employed under a contract of employment, a contract of apprenticeship or a contract personally to do work. This will include those under Agenda for Change terms and conditions, medical staff and very senior managers. All calculations are made relating to the pay period in which the snapshot day falls. For this third year of publication, it will be the pay period including 31 March 2019.

Employers will need to:

- calculate the hourly rate of ordinary pay relating to the pay period in which the snapshot day falls
- calculate the difference between the mean hourly rate of ordinary pay of male and female employees, and the difference between the median hourly rate of ordinary pay of male and female employees
- calculate the difference between the mean (and median) bonus pay paid to male and female employees
- calculate the proportions of male and female employees who were paid bonus pay
- calculate the proportions of male and female employees in the lower, lower middle, upper middle and upper quartile pay bands by number of employees rather than rate of pay.

Ordinary pay includes:

- basic pay
- paid leave, including annual, sick, maternity, paternity, adoption or parental leave (except where an employee is paid less than usual or nothing because of being on leave)
- area and other allowances
- shift premium pay, defined as the difference between basic pay and any higher rate paid for work during different times of the day or night
- pay for piecework.

It does not include:

- remuneration referable to overtime.
- remuneration referable to redundancy or termination of employment
- remuneration in lieu of leave
- remuneration provided otherwise than in money.

The relevant pay period means the pay period within which the snapshot date falls, which for monthly-paid staff would be the month in which the date is included. Bonus pay relates to performance, productivity, incentive, commission or profit-sharing, but excludes:

- remuneration referable to overtime
- remuneration referable to redundancy
- remuneration referable to termination of employment.

Doctors' clinical distinction/excellence awards will be regarded as bonus pay, as well as any other payments above the level of ordinary for performance or expertise such as performance related pay for very senior managers, long service awards and others. The relevant period means the period of 12 months ending with the snapshot date.

**Calculating the quartiles**

Determine the hourly rate of pay and then rank the relevant employees in rank order from the lowest to the highest.

Divide those employees into four sections, each comprising an equal number of employees to determine the lower, lower middle, upper middle and upper quartile pay bands.

Show the proportion of male and female employees in each band as a percentage of the total employees in each band.

**What employers need to publish**

The information outlined above will need to be published within one year of the date for the 2019 snapshot (publishing deadline of 30 March 2020 for data as at 31 March 2019).

The information must be published on a website that is accessible to employees and the public free of charge. The information should remain on the website for a period of at least three years beginning with the date of publication.

In addition employers have the option to provide narrative that will help people to understand why a gender pay gap is present and what the organisation intends to do to close it.

During the first publication employers will have already registered with the Government online reporting service to submit their GPG results.

Colleagues from the Electronic Staff Record (ESR) continue to refine the tool that helps organisations nationally to calculate their GPG data.

The 2019 Gender Pay Gap (GPG) results for Derbyshire Healthcare NHS FT are detailed below:

## GPG results as at 31 March 2019:

| Gender | Avg. Hourly Rate | Median Hourly Rate |
|---|---|---|
| Male | 19.40 | 16.30 |
| Female | 15.86 | 14.42 |
| Difference | 3.54 | 1.88 |
| Pay Gap % | **18.26** | **11.53** |

| Quartile | Female | Male | Female % | Male % |
|---|---|---|---|---|
| 1 | 571 | 97 | 85.48 | 14.52 |
| 2 | 531 | 137 | 79.49 | 20.51 |
| 3 | 542 | 125 | 81.26 | 18.74 |
| 4 | 474 | 194 | 70.96 | 29.04 |

*Q1 = Lowest, Q4 = Highest*

## GPG Bonus results as at 31 March 2019:

| Gender | Avg. Bonus Pay | Median Bonus Pay |
|---|---|---|
| Male | 8,282.73 | 3,141.64 |
| Female | 1,220.45 | 200.00 |
| Difference | 7,062.28 | 2,941.64 |
| Pay Gap % | **85.27** | **93.63** |

A comparison of 2018 v 2019 Gender Pay Gap results for Derbyshire Healthcare NHS FT are detailed below:

## GPG comparison 31 March 2018 v 31 March 2019:

| 31 March 2018 | | | 31 March 2019 | | | Variation | |
|---|---|---|---|---|---|---|---|
| Gender | Avg. Hourly Rate | Median Hourly Rate | Gender | Avg. Hourly Rate | Median Hourly Rate | Variation | Variation |
| Male | 19.00 | 16.18 | Male | 19.40 | 16.30 | *0.40* | *0.12* |
| Female | 15.44 | 13.99 | Female | 15.86 | 14.42 | *0.42* | *0.43* |
| Difference | 3.56 | 2.19 | Difference | 3.54 | 1.88 | *-0.02* | *-0.31* |
| Pay Gap % | **18.73** | **13.52** | Pay Gap % | **18.26** | **11.53** | *-0.47* | *-1.99* |

| 31 March 2018 | | | | | 31 March 2019 | | | | | Variation | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Quartile | Female | Male | Female % | Male % | Quartile | Female | Male | Female % | Male % | Female % | Male % |
| 1 | 560 | 96 | 85.37 | 14.63 | 1 | 571 | 97 | 85.48 | 14.52 | 0.11 | -0.11 |
| 2 | 527 | 129 | 80.34 | 19.66 | 2 | 531 | 137 | 79.49 | 20.51 | -0.85 | 0.85 |
| 3 | 531 | 125 | 80.95 | 19.05 | 3 | 542 | 125 | 81.26 | 18.74 | 0.31 | -0.31 |
| 4 | 457 | 200 | 69.56 | 30.44 | 4 | 474 | 194 | 70.96 | 29.04 | 1.40 | -1.40 |
| Total | **2625** | | | | Total | **2671** | | | | | |

## GPG Bonus comparison 31 March 2018 v 31 March 2019:

| 31 March 2018 | | | 31 March 2019 | | | Variation | |
|---|---|---|---|---|---|---|---|
| Gender | Avg. Bonus Pay | Med. Bonus Pay | Gender | Avg. Bonus Pay | Med. Bonus Pay | Avg. Bonus Pay | Median Bonus Pay |
| Male | 9,104.90 | 4,220.38 | Male | 8,282.73 | 3,141.64 | -822.17 | -1,078.74 |
| Female | 1,485.36 | 300.00 | Female | 1,220.45 | 200.00 | -264.91 | -100.00 |
| Difference | 7,619.54 | 3,920.38 | Difference | 7,062.28 | 2,941.64 | -557.26 | -978.74 |
| Pay Gap % | **83.69** | **92.89** | Pay Gap % | **85.27** | **93.63** | **1.58** | **0.74** |

## Further GPG Hourly Rate analysis as at 31 March 2019 by Staff Group and Service Area

### By Staff Group

| Avg. Hourly Rate | Gender | | | |
|---|---|---|---|---|
| Staff Group | Male | Female | Diff | Gap |
| Add Prof Scientific and Technic | 22.41 | 19.86 | 2.55 | 11.38 |
| Additional Clinical Services | 11.92 | 11.57 | 0.36 | 2.99 |
| Administrative and Clerical | 18.71 | 12.54 | 6.17 | 32.98 |
| Allied Health Professionals | 15.95 | 17.34 | -1.39 | -8.70 |
| Estates and Ancillary | 11.29 | 10.22 | 1.07 | 9.50 |
| Medical and Dental | 45.06 | 40.35 | 4.71 | 10.46 |
| Nursing and Midwifery Registered | 18.51 | 17.77 | 0.74 | 3.99 |
| Students | | 13.26 | | |

### By Service Line

| Avg. Hourly Rate | Gender | | | |
|---|---|---|---|---|
| Service Line | Male | Female | Diff | Gap |
| Adult Care Acute | 19.19 | 16.04 | 3.15 | 16.41 |
| Adult Care Community | 26.19 | 16.70 | 9.49 | 36.25 |
| Children's Services | 19.78 | 16.00 | 3.78 | 19.13 |
| Clinical Serv Management | 29.29 | 25.29 | 4.00 | 13.66 |
| Corporate Services | 16.10 | 14.40 | 1.70 | 10.56 |
| Forensic + MH Rehab | 15.21 | 14.97 | 0.23 | 1.54 |
| Neighbourhood | 22.23 | 18.30 | 3.92 | 17.66 |
| Older Peoples Care | 16.44 | 14.24 | 2.20 | 13.38 |
| Psychology | 22.26 | 23.10 | -0.84 | -3.77 |
| Specialist Care Services | 23.31 | 16.96 | 6.34 | 27.22 |

## Latest benchmarking data available (31 March 2018):

| | Pay Gap % | |
|---|---|---|
| | **Average** | **Median** |
| Lincolnshire Partnership NHS FT | **20.0%** | **20.1%** |
| Leicester Partnership NHS FT | **15.4%** | **6.3%** |
| Nottinghamshire Healthcare NHS FT | **8.7%** | **-3.4%** |
| Northamptonshire NHS FT | **20.1%** | **6.4%** |

***Liam Carrier – Assistant Head of Systems & Information***

## Our Gender Pay Gap (GPG) Action plan endorsed by Derbyshire Healthcare Trust Board

In the actions areas there is a range of expected outcomes all of which have the same impact: to narrow our pay gap (and eventually close it)
We know that by achieving success in addressing the drivers of this particular action area we will also have positive outcomes and impacts for our wider inclusion activities.

| Area and objective | Action | Lead | Timescales | Resources | Outcome |
|---|---|---|---|---|---|
| Data Analysis | 1. Greater scrutiny of GPG data - reviewing differences in:<br>a) Departments<br>b) Services<br>c) Occupations<br>2. Overlay analysis by age, disability, race and other protected characteristics<br>3. Analyse staff survey results with particular focus on women's experiences | Deputy CEO in conjunction with Director of People Inclusion and Engagement | By end May 2020 | • Executive Leadership Team<br>• Trust Leadership<br>• People Services | • Better understanding of the drivers in order to target the actions most effectively |
| Branding communication and transparency | 1. Data analysis across the recruitment path (being application, shortlisting and appointment)<br>2. Use of action planning guide* to focus on areas identified<br>3. Promotion of ambitions and successes | Deputy CEO in conjunction with Director of People Inclusion and Engagement | Bi-annual review | • Gender Network<br>• Recruitment Action Steering Group<br>• Communications team<br>• Recruitment team<br>• Trust Leadership | • Improved visibility of focus areas and enhanced areas for support<br>• Improved representation balance across bandings |
| Recruitment and promotion processes | 1. Regular reporting on male/female profile across: Recruitment path, occupations and working patterns<br>2. Review of recruitment practices and consideration of target setting and disruptive processes<br>3. Continued Review of Clinical Excellence Awards process and Award Round results (including the impact of changes made to differential weighting of domains in scoring)<br>4. Review of output from the Government Equalities Office project exploring gender bias in Clinical Excellence Awards** | Deputy CEO in conjunction with Director of People Inclusion and Engagement | Bi-annual review | • Gender Network<br>• Recruitment Action Steering Group<br>• People Services<br>• Local Negotiating Committee<br>• Output from Government Equalities Office<br>• Trust Leadership | • Improved visibility and oversight of progress<br>• Improved representation balance across bandings<br>• 'Bonus' component of GPG improved |

| Area and objective | Action | Lead | Timescales | Resources | Outcome |
|---|---|---|---|---|---|
| Policy review including maternity, paternity and parental leave | 1. Review policies for inclusivity and encourage shared parental leave<br>2. Share and promote success stories | Deputy CEO in conjunction with Director of People Inclusion and Engagement | Bi-annual review | • Executive Leadership Team<br>• Policy groups<br>• Communication team<br>• Trust Leadership | • Improved visibility and oversight of progress<br>• Improved representation balance across bandings |
| Wellbeing and Retention | 1. Increased promotion of flexible working for new and existing employees<br>2. Share success stories and role models | Deputy CEO in conjunction with<br>Director of People Inclusion and Engagement | Bi-annual review | • Executive Leadership Team<br>• Policy groups<br>• Communication team<br>• Trust Leadership | • Improved wellbeing<br>• Improved balance of recruitment and retention<br>• Greater uptake of flexible working (for males and females) |
| Supporting Female Staff | 1. Expansion of DHCFT gender network agenda in response to regular review of progress, shared stories and insight<br>2. Encourage use of coaching and mentoring<br>3. Review of maternity policy for most effective use of keep in touch days and returning experience<br>4. Menopause support | Deputy CEO in conjunction with<br>Director of People Inclusion and Engagement | Bi-annual review | • Gender Network<br>• Reverse Mentoring Steering Group<br>• Communication Team<br>• People Services<br>• Trust Leadership | • Improved wellbeing<br>• Improved retention<br>• Improved staff satisfaction and experience |

*This action plan has been compiled with reference to the: 'Addressing Your Gender Pay Gap – A Guide for Employers' produced by Health and Care Women Leaders Network and NHS Employers

**In 2019 we participated in a research project funded by the Government Equalities Office, conducted by the Gender and Behavioural Insights programme team, examining whether there is any gender bias in Clinical Excellence Awards. For this evaluation, Derbyshire Healthcare provided pseudonymised data on our consultant population and CEA applications and awards, to help understand any gender disparity in local award schemes and why it may be occurring. The results of this analysis are forthcoming.

**SECTION 3**

**Inclusion Strategy 2020**

# Inclusion Strategy 2020

## **Inclusion** at the heart of Derbyshire Healthcare

Making a positive difference

# **Inclusion** at the heart of Derbyshire Healthcare

**OUR VISION**

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

**We cannot do this if we don't know the whole person and don't take time to know what's important to them!**


**OUR VALUES**

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

**OUR STRATEGIC OBJECTIVES**

1. **Great care** - Delivering compassionate, person-centred, innovative and safe care where Choice, empowerment and shared decision-making is the norm
2. **Great place to work** - Attracting colleagues to work with us who we develop, retain and support by excellent management and leadership in an empowered, compassionate and inclusive culture that actively embraces diversity
3. **Best use of money** - Making financially wise decisions.

## BEING 'YOU' IN TEAM DERBYSHIRE HEALTHCARE

"What matters to you, matters to us"

Everyone in Team Derbyshire Healthcare should be **confident to be themselves** and work in a welcoming and supportive team that **celebrates difference and diversity**.

You can **get on with being you,** focusing on co-creating both a **great place to work** and to **receive care.**

"Together we can"

Examples of some recent celebrations and inclusive actions:

- ✓ **Annual Members Meeting** 2019 – recognising and celebrating the progress of our inclusion networks
- ✓ **Reverse Mentoring Steering Group** - for progressing the next stages of our Reverse Mentoring programme – scaling up to three times the original size in the second cohort.
- ✓ Our biggest yet **BME Conference** - brought together BME and non-BME colleagues to co-produce actions to address our Workforce Race Equality Standard action areas
- ✓ Our **LGBT+ network** represented us at all Derby and Derbyshire Prides and have issued hundreds of rainbow lanyards throughout our workforce
- ✓ Growth to **four inclusion networks** (BME, LGBT+, Disability and Wellness and Armed Forces).

**Active inclusion** means don't merely treat everyone the same: Treat everyone as individuals.

"*There is nothing so unfair as the equal treatment of unequal people"* Aristotle.

# In 2020 we will:

- ✓ Progress our **Recruitment Action Steering Group** and introduce **recruitment inclusion guardians** – WHY- to create disruptive change in our recruitment practices in order to increase representation across our workforce

- ✓ Grow our **Reverse Commissioning project** – WHY - to better understand how to provide services to communities that are underrepresented

- ✓ Have more **inclusion conversations** – WHY – for us all to be part of the change to make a positive difference

- ✓ Grow our **inclusion networks** – WHY - to help us to support each other better

- ✓ Establish a **Gender steering group** – WHY – to understand gender issues and close our gender pay gap

- ✓ Continue to scale up our **Reverse mentor programme** and evaluate its impact – WHY – to create a change movement through individual journeys and organisational change - to make a positive difference to our workforce, our Trust and our communities in Derbyshire

- ✓ Celebrate more through **inclusion events** – WHY - to celebrate achievements, to say thank you and to inform and challenge us to deliver even greater success

- ✓ Support and empower our **WRES expert and frontline representatives** – WHY – to help us deliver change by using the very best expert knowledge to help us continually improve and achieve our goals.

- ✓ Review our **Board Committees' inclusion objective to**: "… *actively consider the equality impact and evidence relating to all items of Committee business as part of the Committee's contribution to equality, diversity and inclusion."* - WHY – to continue to consider inclusion in the everyday business to keep driving improvements in staff and patient experience

## INCLUSION IS EVERYBODY'S BUSINESS: What can you do today?

- Watch our 'what inclusion means to me' **video** and talk about it in your team
- Talk to your manager and teammates to think through how **you can actively champion inclusion in your team - to improve your local staff and patient experience.**
- We need to know more **inclusion information about those who use our services** – we need you all to ask **actively inclusive** questions to people in your services and don't forget to record it on our electronic patient record systems! It could make the biggest difference in the world to your person-centred relationship with those who use our services
- We need to know more about you! – Log into Electronic Staff Record (ESR) and **update your personal information**, making sure to include your protected characteristics. If we don't know about our all workforce we can't properly understand where we are or where we get to and we won't achieve all we can. We need your help
- Why not **check out our networks and inclusion activities** – don't forget you get protected time to attend!
- **Spread the word** to your friends and communities to come and join Derbyshire Healthcare
- Let us know what you think and continue to **share your tips and examples of active inclusion and challenge us if we aren't getting it right.**

***Remember: Active inclusion is all about being person-centred in your leadership and in your practice every day.***

***Be yourself and empower those around you to be their whole self too.***

**Derbyshire Healthcare NHS Foundation Trust**
Report to the Board of Directors – 3 March 2020

# Workforce Standards Formal Submission

## Purpose of Report

In October 2019, NHS Improvement (NHSI) wrote to all trusts asking them to review their workforce safeguards and implement some formal recommendations. The purpose of this report is to ensure that the Trust is formally assessing its compliance. This is a self-assessment of the workforce safeguards and this is delegated to the People and Culture Committee to scrutinise and review all workforce information, systems and process of staff deployment, rostering and skill mix of our services.

This is the Trust's 2020 formal submission.

## Executive Summary

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

We will continue to refine the reporting and monitoring of these standards through the People and Culture Committee. This will include continually updating the Trust's integrated workforce information to provide the Board with assurance of our compliance against these recommendations.

The self-assessment outlines that the Trust is compliant.

The workforce standards and the governance are overseen by the People and Culture Committee with all of the metrics being overseen and managed through that assurance and operational delivery structure.

The Quality Committee is compliant with the standards. It has received staffing and caseload service specific reviews for Children's and Learning Disability services.

The Quality Committee receives the National Quality Required Standards twice a year to review the safety aspects of this requirement:

- Medical staffing is provided by the Medical Director and the Guardian of Safe Working Practices and these have been submitted and reviewed by the Quality Committee.

- As stated in the CQC's well led framework guidance (2018) 6 and National Quality Board's (NQB) guidance 7, any service changes, including skill mix changes, must have a quality impact assessment (QIA) review. This is in place.

- Any re-design or introduction of new roles (including, but not limited to Physician Associate, Nursing Associates and Advanced Clinical Practitioners (ACPs) would be considered a service change and must have a full QIA. The Director of Nursing has a deployment and risk management plan for Nursing Associates. The restricted and incremental roll out of this new role has been successful.

- The proposed developments for changing the rostering system, will not progress to consultation until a QIA has been completed has been maintained.

- Given the day-to-day operational challenges, we expect trusts to carry out business as usual dynamic staffing risk assessments including formal escalation processes. Any risk to safety, quality, finance, performance and staff experience must be clearly described in these risk assessments. A daily system of monitoring staffing and making active deployment to ensure staff safety is in place. Feedback on improvements has been noted in staff response in Working Age Adult's Community Mental Health Services, Acute Care, Crisis, Child Health and Learning Disability Services. This feedback has been triangulated with model hospital data on caseload size and has been confirmed.

- Should risks associated with staffing continue or increase and mitigations prove insufficient, trusts must escalate the issue (and where appropriate, implement business continuity plans) to the Board to maintain safety and care quality. Actions may include part or full closure of a service or reduced provision – for example; wards, beds and teams, re-alignment or a return to the original skill mix. This is in place.

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

**Assurances**

- Mental health and other guidance is reviewed and is part of safer staffing reviews at Quality Committee.
- Trusts must ensure the three components are used in their safe staffing processes, which include evidence based tools (where they exist) from the Mental Health Guide and professional judgement adopted, led by the Assistant Director of Clinical Professional Practice and Heads of Nursing / AHP (Allied Health Professional). This will include a dashboard, CHPPD (care hours per patient day) and e-roster – this is assured and in place.
- We have gaps in assurance, and therefore have limited assurance in a revised reporting section. We have ratified the workforce plan that requires further changes in 2020, based upon the continuous quality improvement work in our clinical strategy developments.

**Consultation**

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

**Governance or Legal Issues**

- To check on a yearly basis that the three components are used in the safe staffing processes
- To base our assessment on the annual governance statement, in which Trusts will be required to confirm their staffing governance processes are safe and sustainable, this will be in development with the Annual Report process
- To ensure compliance is met with https://www.cqc.org.uk/files/inspection-framework-nhs-trusts-foundation-trusts-trust-wide-well-led
- As part of the yearly assessment, the Trust will also seek assurance through the Single Oversight Framework SOF in which a provider's performance is monitored against five themes
- Trusts must have an effective workforce plan that is updated annually and signed off by the Chief Executive and Executive Leaders. The Board should discuss the workforce plan in a Public Meeting.
- The Trust must ensure that it has an agreed local quality dashboard that cross-checks comparative data on staffing and skill mix with other efficiency and quality metrics such as the Model Hospital dashboard. Trusts should report on this to their Board on a monthly basis.

**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 risks are people related, so there are always adverse impacts, however these safeguards are to improve clinical and workforce risks and it is the risks of not implementing these safeguards rather than the risk of implementing these required monitoring requirements.

There are risks to equality and delivery which are geographical in nature. Changes to trainee recruitment will switch from South Yorkshire/Sheffield rotation to Nottingham/Derby being imposed by HEEM/School of Psychiatry in Nottingham and not QIA. Potential risk to services in North Derbyshire including inpatient units in Chesterfield. This will be monitored and briefed to the Executive Leadership Team.

**Recommendations**

The Board of Directors is requested to:

1) Review the self-assessment and the briefing on this paper.
2) Be apprised of the compliance areas and the key areas of significant assurance.

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

**Report prepared by:** **Celestine Stafford**
**Assistant Director of People and Culture Transformation**

**Mark Powell**
**Chief Operating Officer**

**Carolyn Green**
**Director of Nursing and Patient Experience**

**John Sykes**
**Medical Director**

This is a self-assessment against the recommendations:-

| The NHSI standard | Trust response | Current performance and gap in assurance |
|---|---|---|
| 1. Trusts must formally ensure NQB's 2016 guidance is embedded in their safe staffing governance. | Executive Director of Nursing is Lead Director and NQB Mental Health and other guidance reviewed and part of safer staffing reviews at Quality Committee | Assured and in place in 2019/20 |
| 2. Trusts must ensure the three components (see Figure 1 below) are used in their safe staffing processes: | Compliant | |
| – evidence-based tools (where they exist) | Mental Health Guide | The Quality Committee have reviewed the Mental Health Guidance, benchmarked against this information and the required recommendations and this is in place.<br>The mental health model hospital data is used to triangulate and the Trust remains within national standards. |
| – professional judgement | Led by Assistant Director of Clinical professional practice and Heads of Nursing / AHP. It includes a dashboard / CHPPD and E-roster | Assured and in place for 2019/20 |
| – outcomes. | Recommendations form clinical staff and Heads of profession are included in the skill mix review and have been implemented | Assured and in place for 2019/20 |
| We will check this in our yearly assessment. | Available for assessment | |
| 3. We will base our assessment on the annual governance statement, in which trusts will be required to confirm their staffing governance processes are safe and sustainable. https://www.cqc.org.uk/files/inspection-framework-nhs-trusts-foundation-trusts-trust-wide-well-led | In development with Annual Report process, for submission | The Well-led review in 2018, including reviewing our safe staffing and skill mix review.<br>There were no concerns re our establishment. The concerns were for continual improvement in reducing our vacancy rate in core hot spot area, our Trust wide qualified vacancy rate is below the East midlands regional average.<br>We continue to deploy mitigation actions in our operational services to ensure the safety of our series in the acute service and we have made progress in 2019/20 |

| The NHSI standard | Trust response | Current performance and gap in assurance |
|---|---|---|
| 4. We will review the annual governance statement through our usual regulatory arrangements and performance management processes, which complement quality outcomes, operational and finance performance measures | Revision to ensure all recommendation requirements are reviewed as per this guide and a standard operating framework for these required reports in a new model is implemented | Assured and in place for 2019/20 |
| 5. As part of this yearly assessment we will also seek assurance through the SOF, in which a provider's performance is monitored against five themes | Provided in integrated report, any further refinements as per recommendation 4, and was enacted in March 2019 | Assured and in place for 2019/20 |
| 6. As part of the safe staffing review, the Executive Director of Nursing and Medical Director must confirm in a statement to their board that they are satisfied with the outcome of any assessment that staffing is safe, effective and sustainable | Available for Nursing and AHP in Quality Committee papers. All service changes have a QIA and this has been externally assessed by CQC in 2018 as meeting required standards<br>To ensure that medical staffing is safe, effective and sustainable:<br>• Medical workforce monitoring for all grades including trainees in real time, reports at Medical Workforce Group every 2 weeks with exception reporting. Chaired by Medical Director or his deputy with Operational and HR leads in attendance.<br>• International and local recruitment (and retention) initiatives with engagement events led by Medical Director and medical education leads.<br>• Founder member of East Midlands Hub to control locum costs.<br>• Medical Director and HR lead member of national learning set to investigate best practice nationally.<br>• Medical Workforce Group drafted first integrated workforce plan which is now expanded to include all clinical disciplines.<br>• Medical Director has presented workforce plan at People and Culture Committee<br>• E-job planning being procured. | Medical risks to delivery for safe staffing are reviewed.<br>Deep dive reports have been undertaken including benchmarking and detailed analysis<br>Guardian of safer working reports have been scrutinised by the Quality committee and received by Trust Board<br>Assured and in place for 2020/21 |

| The NHSI standard | Trust response | Current performance and gap in assurance |
|---|---|---|
| | • All training posts compliant with national contracts with reports from Guardian of Safe Working reporting to Quality Committee.<br>• Trust rated highly by GMC re medical training standards.<br>• Alternative cover arrangements for physical healthcare after hours being worked into business case for QIA. Includes hospital at night models.<br>• Workforce plan to deliver Physical Healthcare Strategy in development to feed into overall integrated workforce plan.<br>• Group formed to explore gender/diversity issues in medical workforce including gender pay gap.<br>• Recent conference with national lead exploring issues of 'generational' workforce development and fitness of purpose re NHS 10 year plan.<br>• Alternative models of CAMHS on call under development (shortage specialty) which will be subject to QIA. | |
| 7. Trusts must have an effective workforce plan that is updated annually and signed off by the chief executive and executive leaders. The board should discuss the workforce plan in a public meeting | The 2019/20 plan in line with the Trust business planning and the STP planning process was developed and signed off | Strategic Workforce Group has overseen the delivery of the two year plan. Assured and in place for 2019/20 |
| 8. They must ensure their organisation has an agreed local quality dashboard that cross-checks comparative data on staffing and skill mix with other efficiency and quality metrics such as the Model Hospital dashboard. 4 Trusts should report on this to their Board every month | The Integrated Performance report provides this information. Alongside this other service specific reports are provided to both Quality and People and Culture Committee. | Assured and in place for 2019/20<br>Deep dive reports and CQC review reports all contain mental health model hospital data per service line |
| 9. An assessment or re-setting of the nursing establishment and skill mix (based on acuity and dependency data and using an evidence-based toolkit where available) | Available in Quality Committee papers/ Board Level Committee. This is reported to the Board through the Board level summaries. There were no escalation issues to the Trust Board based upon these submissions | Revise reporting model in 2019-20 to include direct board report, post Quality Committee submission twice per year in the QC summary. |

| The NHSI standard | Trust response | Current performance and gap in assurance |
|---|---|---|
| must be reported to the board by ward or service area twice a year, in accordance with NQB guidance and NHS Improvement resources. This must also be linked to professional judgement and outcomes | | Assured and in place for 2019/20 |
| 10. There must be no local manipulation of the identified nursing resource from the evidence-based figures embedded in the evidence-based tool used, except in the context of a rigorous independent research study, as this may adversely affect the recommended establishment figures derived from the use of the tool | This is a statement – not a specific question to answer.<br>We do not adapt any information. | Assured and in place for 2019/20 |
| 11. As stated in CQC's well-led framework guidance (2018)6 and NQB's guidance7 any service changes, including skill-mix changes, must have a full quality impact assessment (QIA) review | We will refresh our QIA once we have the outcome of shift change consultation exercise. | Assured and in place for 2019/20 |
| 12. Any redesign or introduction of new roles (including but not limited to physician associate, nursing associates and advanced clinical practitioners – ACPs) would be considered a service change and must have a full QIA. | Compliant. Executive Director of Nursing has a deployment and risk management plan for nursing associates. Deployment is two staff and occurs in April 2019, subject to successful achievement of registration and qualification | Assured and in place for 2019/20. Example Nursing associate |
| 13. Given day-to-day operational challenges, we expect trusts to carry out business-as-usual dynamic staffing risk assessments including formal escalation processes. Any risk to safety, quality, finance, performance and staff experience must be clearly described in these risk assessments. | Staffing in high risk service areas is reviewed on a daily basis with a formal process and monitoring system, which includes dynamic risk assessment. This is performed locally by Managers and their teams, with oversight by the Nursing and Quality team. Datix is used to record risk, with an assessment of risk part of this. | Assured and in place for 2019/20<br>Example acute care, Health visiting caseloads. |
| 14. Should risks associated with staffing continue or increase and mitigations prove insufficient, Trusts must escalate the issue | Staffing risks are identified in inpatient areas via a daily assurance process, whereby current and future risks are | Assured and in place for 2019/20 |

| The NHSI standard | Trust response | Current performance and gap in assurance |
|---|---|---|
| (and where appropriate, implement business continuity plans) to the Board to maintain safety and care quality. Actions may include part or full closure of a service or reduced provision: for example, wards, beds and teams, re-alignment, or a return to the original skill mix | reviewed and actions taken to minimise risk.<br>When appropriate escalation to Directors for service closure decisions are made. | |

**Derbyshire Healthcare NHS Foundation Trust**
Report to the Board of Directors – 3 March 2020

# Fit and Proper Persons Policy and Procedures renewal

## Purpose of Report

For the Board to ratify the renewal of the Trust's Fit and Proper Persons Policy and Procedures.

## Executive Summary

The Trust's Fit and Proper Persons Policy and Procedures document is due for renewal. The Trust Secretary has reviewed the document and confirms that it is still compliant with the guidance and regulations but requires some very minor changes.

These are:

- Changing references throughout the document from Director of Corporate Affairs to Trust Secretary
- Correcting a name of a linked policy.

It is proposed that this policy be renewed every three years in line with other Trust policies (from the current two years).

The Board will continue to receive the annual declaration from the Chair on compliance of the Policy.

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

## Assurances

The policy and its indexes reflect latest guidance issued by NHS Providers and also to reflect updated guidance from CQC.

## Consultation

The policy was previously approved by the Trust Board in March 2018.

**Governance or Legal Issues**

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 requires all trusts to ensure that all executive and non-executive director posts (or anyone performing similar or equivalent functions) are filled by people that meet the requirements of the Fit and Proper Persons Requirement (FPRR). The definition of directors includes those in permanent, interim or associate roles, irrespective of their voting rights at board meetings. These regulations were introduced in November 2014 and the fundamental standards came into force in April 2015.

It is a requirement of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 that NHS bodies undertake a 'fit and proper person test'.

The regulations have been integrated into the CQC's registration requirements, and falls within the remit of their regulatory inspection approach.

**Public Sector Equality Duty & 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 Policy is applied to all Non-Executive and Executive Directors.

**Recommendations**

The Trust Board is requested to note the update and minor amendmentsrequired and approve the renewal of the policy for three years.

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

Derbyshire Healthcare
NHS Foundation Trust

# Fit and Proper Persons Policy and Procedure

| See also: | Located in the following policy folder on the Trust Intranet |
|---|---|
| Disciplinary Procedure for Medical Staff Policy and Procedures | Workforce & OD Policies and Procedures |
| Disciplinary Policy & Procedure | Workforce & OD Policies and Procedures |
| Disclosure and Barring Service (DBS) Policy and Procedures | Workforce & OD Policies and Procedures |
| Recruitment and Selection Policy and Procedures | Workforce & OD Policies and Procedures |
| Freedom to Speak Up Policy and Procedures | Workforce & OD Policies and Procedures |

| Service area | Issue date | Issue no. | Review date | |
|---|---|---|---|---|
| Trust wide | March 201820 | 12 | March 20230 | |
| **Ratified by** | **Ratification date** | **Committee/Group responsible for review:** | | |
| Board of Directors | March 202018 | Trust SecretaryDirector of Corporate Affairs | | |

Document published on the Trust Intranet under: Workforce & OD Policies and Procedures

**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.

# Checklist for Fit and Proper Persons Policy

| **Summary (Plain English)** Summarise the main points of the policy below in a style that is clear and easy to understand. Ensure the whole policy is written in plain English, using simple language where possible and avoiding convoluted sentences and obscure words. The resulting policy should be easy to read, understand and use, |
|---|
| The purpose of the Fit and Proper Persons Policy is to hold Trust Board members to account in relation to their conduct and performance and also to instil confidence in the public that the individuals leading the Trust are suitable to hold their position, in line with the requirements of the Fit and Proper Persons Regulations introduced in November 2014. |

| | | |
|---|---|---|
| **Name / Title of policy/procedure** | Fit and Proper Persons Policy | |
| **Aim of Policy** | To ensure all Executive and Non-Executive Director posts (or anyone performing equivalent/similar functions) are filled by people that meet the requirements of the Fit and Proper Persons Regulations. | |
| **Sponsor (Director lead)** | Trust Secretary~~Director of Corporate Affairs~~ | |
| **Author(s)** | Trust Secretary~~Director of Corporate Affairs~~<br>Director of Nursing & Patient Experience | |
| **Name of policy being replaced** | Fit and Proper Persons Policy and Procedure ~~Not applicable~~ | **Version No of previous policy: ~~N/A~~1** |

| | |
|---|---|
| **Reason for document production:** | Renewal of ~~R~~required policy |
| **Commissioning individual or group:** | Trust Board |

| **Individuals or groups who have been consulted:** | **Date:** | **Response** |
|---|---|---|
| Executive Leadership Team | 24/2/2020 | Agreed |

**Version control (for minor amendments)**

| Date | Author | Comment |
|---|---|---|
| ~~March 2018~~ | ~~Sam Harrison~~ | ~~Amendments to appendices 2 & 3, list of other relevant policies and associated documents added, additional information added to update the policy following the issue of NHS Providers Guidance on What Providers Need to Know. Updated with amended guidance regarding enhanced DBS checks.~~ |

# Fit and Proper Persons Policy

## Table of Contents

# Fit and Proper Persons Policy

## 1. Introduction

### 1.1 Purpose

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 introduced a 'fit and proper persons test' for all NHS bodies. This policy outlines how the Trust will meet the requirements placed on the NHS which came into force on 1 October 2014 for all NHS bodies and for all providers on 1 April 2015.

Under the regulations, all provider organisations must ensure that Director level appointments meet the Fit and Proper Persons Test and the regulations place a duty on NHS providers not to appoint a person or allow a person to continue to be an Executive Director or equivalent or Non-Executive Director under given circumstances.

The regulations have been integrated into the Care Quality Commission's (CQC's) registration requirements, and falls within the remit of their regulatory inspection approach.

### 1.2 Scope

This policy applies to all Board appointments, ie Executive and Non-Executive Directors and those senior managers which are formally recognisszed as part of the Trust's Executive Leadership Team (ELT). This includes permanent, interim and associate positions. It also includes those individuals who are acting up in Board level positions.

## 2. Requirements

The introduction of the Fit and Proper Persons Requirements (FPPR) requires the Trust Chair to:

- Confirm to the CQC that the fitness of all new Directors has been assessed in line with the regulations; and
- Declare to the CQC in writing that they are satisfied that they are fit and proper individuals for that role both on appointment and an ongoing basis and do not meet any of the 'unfit' criteria.

The Trust will make every reasonable effort to assure itself about existing post holders and new applicants and to make specified information about board Directors available to the CQC on request.

Individuals who fall into the categories above must satisfy the Trust Chair they:

- Are of good character

- Hold the required qualifications and have the competence, skills and experience required for the relevant office for which they're employed
- Are able, by reason of their physical and mental health, after any required reasonable adjustments if required, capable of properly performing their work
- Can supply relevant information as required by schedule 3 of the act, i.e. documentation to support the FPPR
- Not have been responsible for or privy to, contributed to, or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on regulated activity (or providing a service elsewhere which if provided in England would be a regulated activity).

In accordance with schedule 4 part 1 of the act a person is deemed "unfit" if:

- The person is an undischarged bankrupt or a person whose estate has had sequestration awarded in respect of it and who has not been discharged
- The person is the subject of a bankruptcy restrictions order or an interim bankruptcy restrictions order or an order to like effect made in Scotland or Northern Ireland
- The person is a person to whom a moratorium period under a debt relief order applies under Part VIIA (debt relief orders) of the Insolvency Act 1986
- The person has made a composition or arrangement with, or granted a trust deed for, creditors and not been discharged in respect of it
- The person is included in the children's barred list or the adults' barred list maintained under section 2 of the Safeguarding Vulnerable Groups Act 2006, or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland
- The person is prohibited from holding the relevant office or position, or in the case of an individual from carrying on the regulated activity, by or under any enactment

## 2.1 Good character

In accordance with part 2 of the Act a person will fail the good character test if they:

- Have been convicted in the United Kingdom of any offence or been convicted elsewhere of any offence which, if committed in any part of the United Kingdom would constitute an offence
- Have been erased, removed, struck off a register of professionals maintained by a regulator of health care of social work professionals.

Whilst there is no statutory guidance on what constitutes 'good character', the CQC names the following features that are 'normally associated' with good character that trusts should take into account when assessing an individual under FPPR, in addition to matters specified in part 2 of schedule 4:

- Honesty
- Trustworthiness

- Integrity
- Openness
- Ability to comply with the law
- A person in whom the public can have confidence prior employment history, including reasons for leaving
- If the individual has been subject to any investigations or proceedings by a professional or regulatory body
- Any breaches of the Nolan principles of public life
- Any breaches of the duties imposed on directors under the Companies Act
- The extent to which the director has been open and honest with the trust
- Any other information which may be relevant, such as disciplinary action taken by an employer.

### 2.2 Serious mismanagement or misconduct

In consideration of any instances of misconduct or mismanagement, consideration will be given to relevant guidance issued by the CQC, as set out below. Providers will have to reach their own decision as to whether any facts that are alleged reach the threshold of being "serious misconduct or mismanagement".

- "Misconduct" means conduct that breaches a legal or contractual obligation imposed on the director. It could mean acting in breach of an employment contract, breaching relevant regulatory requirements (such as mandatory health and safety rules), breaching the criminal law or engaging in activities that are morally reprehensible or likely to undermine public trust and confidence.

- "Mismanagement" means being involved in the management of an organisation or part of an organisation in such a way that the quality of decision making and actions of the managers falls below any reasonable standard of competent management. For example, failing to interpret data appropriately, failing to learn from incidents or complaints, and failing

## 3. Trust Procedure

### 3.1 Pre-Employment

The CQC expects senior leaders to set a tone and culture of the organisation that leads to staff adopting a caring and compassionate attitude. Therefore, it is important that in making appointments boards take into account the values of the organisation and the extent to which candidates provide good fit with those values. Values-based interviews, or values-based questions in other interviews, will be used.

All new appointments to the applicable posts will have the following recruitment checks in accordance with NHS Employment Check Standards issued by NHS employers, including:

- Proof of identity and right to work in the UK
- Proof of qualifications
- Professional registration and qualification check
- Full employment history and at least two detailed reference checks, one of which must be the most recent employer. Specifically this includes validating a minimum of three years continuous employment
- Occupational health assessment
- Disclosure and Barring Scheme (DBS) check (where appropriate to the role)
- Search of registers e.g. disqualified directors, bankruptcy and insolvency
- Google, news and social media searches

The standards that the Trust will follow at the recruitment stage, the assurance process to follow and evidence required is outlined in Appendix 2.

### 3.2 Declaration

Appointees will be asked to complete a declaration to include:

- Confirmation of their reasonable health after reasonable adjustments are made of properly performing tasks related to their role (subject to the relevant provisions of the Equality Act 2010)
- Any criminal and/or regulatory investigations
- Any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying out regulated activity
- Any undischarged bankruptcy, disqualification, debt relief orders etc
- Any inclusion on the Children's or Adults barred lists
- Any prohibition from holding relevant position or office under any law

### 3.3 External Recruitment Consultancy

Where the Trust engages recruitment consultants to asset with appointments, it may ask the consultants to carry to out some or all of the process, but the Trust will gain all necessary documentation to evidence that the checks have been carried out.

### 3.4 Ongoing Assurance

On an annual basis all relevant office holders will be asked to complete the fit and proper persons declaration (See Appendix 1).

The Trust will review the checks carried out on appointment, every three years or annually as appropriate (See Appendix 3).

With regard to the requirement for the Trust to be satisfied as to the post-holders, competence, skills and knowledge necessary for the post in which they are employed the following will be relied upon:

- Documented 360 Appraisals
- Provision of adequate training opportunities to include both individual and collective development.

### 3.5 Process to be followed on an issue or concern being raised

3.5.1 As set out above, some criteria are pass/fail, i.e. the Trust cannot appoint or have in place an individual in a relevant position if they do not satisfy the specific test. Other, particularly the tests of good character and any association with serious misconduct or responsibility for failure in a previous role, require the Trust to make a reasonable assessment as to fitness.

3.5.2 If, either at the time of appointment or later, it becomes apparent that circumstances exist or have arisen whereby a person may not be considered to meet all the requirements of a fit and proper person, the Director of Corporate Affairs shall inform the Chair (or if the person is the Chair, the Senior Independent Director). The Trust must take appropriate action to investigation and rectify the matter.

3.5.3 The Chair (SID) shall, acting reasonably and having regard to guidance issued by the CQC or Monitor, determine whether the person meets the said requirements.

The Chair leads on addressing these concerns on a case by case basis and will need to consider whether an investigation is necessary or appropriate given the allegation. The Chair may choose to consult with the Senior Independent Director and the Director of People and Organisational Effectiveness to determine the appropriate process to follow and action to take.

The Chair will consider the guidance as issued by NHS Providers, Fit and Proper Persons Regulations in the NHS, namely the Fit and Proper Persons Investigation Ten Step Guide, which covers:

| | |
|---|---|
| Step 1 | Receiving concerns in relation to a director |
| Step 2 | Deciding whether an investigation is necessary |
| Step 3 | Choosing who should carry out the investigation |
| Step 4 | Deciding the remit of the investigation |
| Step 5 | Deciding who to engage in the investigation |
| Step 6 | Agreeing any interim action |
| Step 7 | Gathering evidence |
| Step 8 | Managing competing factors in the investigation |
| Step 9 | Making a final decision |
| Step 10 | Managing the effects of the outcome |

3.5.4 Should the Chair consider the individual to be suitable, despite existence of information relevant to issues identified in Schedule 4, Part 2, the Chair's reasons should be recorded for future reference and made available.

3.5.5 If the Chair (SID) determines that the person does not or no longer meets the said requirements, that person may not be appointed, or appropriate disciplinary action be followed in line their tenure of office shall be terminated and that person shall cease to act as a Director.

3.5.6 The Chair should keep the Council of Governors informed throughout any investigation into a Non-Executive Director. However, the tension between confidentiality and transparency may lead to the Chair involving only the Lead Governor.

3.5.7 If action is taken against an Executive Director as an outcome of the hearing because of the failure to comply with Fit and Proper Persons Policy then the right to appeal will apply in accordance with existing Trust Policy & Procedures. In relation to Non-Executive Directors any appeal will be overseen by the Council of Governors. The criteria for removing Non-Executive Directors/Chairman are set out in the Trust's Constitution.

### 3.6 Implementation

It is the ultimate responsibility of the Trust Chair to discharge the requirement placed on the Trust, to ensure that all Directors meet the fitness test and do not meet any of the 'unfit criteria'. The ~~Director~~ Trust Secretary ~~of Corporate Affairs~~ is responsible for ensuring consistent application of the policy during the appointment process and for ensuring that all appropriate documentation is complete, retained and available. The Trust Secretary ~~Director of Corporate Affairs~~ will support the Trust Chair in preparing the annual declaration for the Trust Board. The Trust Secretary may delegate responsibility for maintaining the records of completed Fit and Proper Persons declarations, initially to the ~~-~~PA to the Chief Executive. ~~is responsible for maintaining the records of completed Fit and Proper Persons declarations~~.

The Council of Governors' Nominations & Remuneration Committee will receive a report to confirm the outcome of the Fit and Proper Person Checks regarding new Non-Executive Director appointments. The Trust Board's Remuneration & Appointments Committee will receive a report to confirm the outcome of the Fit and Proper Person Checks regarding Executive Director/Board appointments.

## 4. Associated Documents and References

Care Quality Commission, (2018). Regulation 5: Fit and proper persons: directors, Guidance for providers and CQC inspectors.
Available at: https://www.cqc.org.uk/sites/default/files/20180119_FPPR_guidance.pdf

Care Quality Commission, Regulation 5: Fit and proper persons: directors.
https://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-5-fit-proper-persons-directors

NHS Employment Standards.

http://www.nhsemployers.org/your-workforce/recruit/employment-checks

NHS Improvement (2017), Fit and proper persons requirements.
https://improvement.nhs.uk/resources/fit-and-proper-persons-requirements

NHS Improvement (2017), Guidance on senior appointments in NHS trusts.

https://improvement.nhs.uk/documents/784/senior_appointments_guidance_final.pdf

NHS Providers, NHS Confederation and NHS Employers (2014), Fit and proper persons test guidance.
http://nhsproviders.org/resource-library/briefings/fit-and-proper-persons-test-guidance

NHS Providers (2018), Fit and Proper Persons Regulations in the NHS: What do providers need to know?
http://nhsproviders.org/fit-and-proper-persons-regulations-in-the-nhs

## 5. Dissemination and Implementation

This policy will be made available on the intranet.

Awareness of this policy will be raised in the Statement of Main Terms and Conditions of Employment and local induction for relevant posts and a summary will be published on the HR section on the intranet.

## 6. Consultation and Approval

The Joint Consultative Committee (JCC) reviewed the first version of the policy and the Executive Leadership Team (ELT) agreed the policy, which was ratified by the Trust Board. The 2020 renewal of the policy required very minor amendments and was therefore did not require further consultation.

## 7. Equality and Diversity

The Trust is committed to ensuring that, as far as is reasonably practicable, the way we treat staff reflects their individual needs and does not discriminate against individuals or groups on any grounds.

## 8. Monitoring Compliance with this Policy

| Standard/ Process | Monitoring & Audit | | |
|---|---|---|---|
| | By | Committee | Frequency |
| Instances of non- | Trust Secretary ~~Director of Corporate Affairs~~ | Remuneration & | Annually |

| | | | |
|---|---|---|---|
| compliance with policy | | Appointments Committee and the Governors Nominations & Remuneration Committee | |
| Pre-employment checks | Trust Secretary ~~Director of Corporate Affairs~~ | Remuneration & Appointments Committee and the Governors Nominations & Remuneration Committee | Upon completion of process |
| Annual Review | Trust Secretary~~Director of Corporate Affairs~~ | Trust Board | Annually |

# Appendix 1 - Pre-employment and annual declaration for Executive Directors, Non-Executive Directors and Director Equivalent Posts

## Fit and Proper Persons Declaration

1 It is a condition of employment that those holding Director and Director equivalent posts provide confirmation in writing, on appointment and thereafter on demand, of their fitness to hold such posts. Your post has been designated as being such a post. Fitness to hold such a post is determined in a number of ways, including (but not exclusively) by the Trust's provider licence, the Health and Social Care Act 2008 (Regulated Activities) Regulations 2008 ("the Regulated Activities Regulations") and the Trust's Constitution.

2 By signing the declaration below, you are confirming that you do not fall within the definition of an "unfit person" or any other criteria set out below, and that you are not aware of any pending proceedings or matters which may call such a declaration into question.

## Provider Licence

3 Condition of Derbyshire Health NHS Foundation Trust's Provider Licence ("The Licence") provides that the Licensee shall not appoint as a Director any person who is an unfit person, except with the approval in writing of NHS Improvement.

4 The Licence condition requires the Licensee to ensure that its contracts of service with its Directors contain a provision permitting summary termination in the event of a Director being or becoming an unfit person. The Licence also requires the Licensee to enforce that provision promptly upon discovering any Director to be an unfit person, except with the approval in writing of NHS Improvement.

5 An "unfit person" is defined within the Licence as:

(a) An individual:

(i) who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged; or

(ii) who has made a composition or arrangement with, or granted a trust deed for, his creditors and has not been discharged in respect of it; or

(iii) who within the preceding five years has been convicted in the British Islands of any offence and a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was

imposed on him; or

(iv) who is subject to an unexpired disqualification order made under the Company Directors' Disqualification Act 1986; or

(b) a body corporate, or a body corporate with a parent body corporate:

(i) where one or more of the Directors of the body corporate or of its parent body corporate is an unfit person under the provisions of sub-paragraph (a) of this paragraph, or

(ii) in relation to which a voluntary arrangement is proposed under section 1 of the Insolvency Act 1986, or

(iii) which has a receiver (including an administrative receiver within the meaning of section 29(2) of the 1986 Act appointed for the whole or any material part of its assets or undertaking; or

(iv) which has an administrator appointed to manage its affairs, business and property in accordance with Schedule B1 to the 1986 Act; or

(v) which passes any resolution for winding up; or

(vi) Which becomes subject to an order of a Court for winding up.

**Regulated Activities Regulations**

6 Regulation 5 of the Regulated Activities Regulations states that the Trust must not appoint or have in place an individual as a Director, or performing the functions of or equivalent or similar to the functions of, such a Director, if they do not satisfy all the requirements set out in paragraph 3 of that Regulation.

7 The requirements of paragraph 3 of Regulation 5 of the Regulated Activities Regulations are that:

(a) The individual is of good character.

(b) The individual has the qualifications, competence, skills and experience which are necessary for the relevant office or position or the work for which they are employed.

(c) The individual is able by reason of their health, after reasonable adjustments are made, of properly performing tasks which are intrinsic to the office or position for which they are appointed or to the work for which they are employed.

(d) The individual has not been responsible for, privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity.

(e) That none of the grounds of unfitness specified in Part 1 of Schedule 4 apply to the individual.

8 The grounds of unfitness specified in Paragraph 1 of Schedule 4 to the Registered Activities Regulations are:

(a) The person is an undischarged bankrupt or a person whose estate has had sequestration awarded in respect of it and who has not been discharged.

(b) The person is the subject of a bankruptcy restrictions order or an interim bankruptcy restrictions order or an order to like effect made in Scotland or Northern Ireland.

(c) The person is a person to whom a moratorium period under a debt relief order applies under Part VIIA (debt relief orders) of the Insolvency Act 1986.

(d) The person has made a composition or arrangement with, or granted a Trust deed for creditors and not been discharged in respect of it.

(e) The person is included in the children's barred list or the adults' barred list maintained under section 2 of the Safeguarding Vulnerable Groups Act 2006, or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland.

(f) The person is prohibited from holding the relevant office or position, or in the case of an individual carrying on the regulated activity, by or under any enactment.

**Trust's Constitution**

9 The Trust's constitution places a number of restrictions on an individual's ability to become or continue as a Director. A person may not become or continue as a Director of the Trust if:

(a) They have been adjudged bankrupt or their estate has been sequestrated and in either case they have not been discharged.

(b) They have made a composition or arrangement with, or granted a

Trust deed for their creditors and have not been discharged in respect of it.

(c) They have within the preceding five years been convicted in the British Islands of any offence and a sentence of imprisonment (whether suspended or not) for a period of three months or more (without the option of a fine) was imposed on them.

(d) In the case of a Non-Executive Director they no longer satisfy the relevant requirements for appointment

(e) They are a person whose tenure of office as a Chairman or as a Member or Director of a Health Service body has been terminated on the grounds that his/her appointment is not in the interests of public service, for non-attendance at meetings, or for non-disclosure of a pecuniary/non-pecuniary interest.

(f) They have within the preceding two years been dismissed, otherwise than by reason of redundancy, by the coming to an end of fixed term contract or through ill health, from any paid employment with a health service body;

information revealed by a Criminal Records Bureau check is such that it would be inappropriate for him to become or continue as a Director on the grounds that this would adversely affect public confidence in the Trust or otherwise bring the Trust into disrepute;

(g) They have had their name removed, by a direction under section 46 of the 1977 Act from any list prepared under Part II of that Act, and has not subsequently had their name included in such a list.

(h) They have been placed on the registers of Schedule 1 offenders pursuant to the Sexual Offences Act 2003 (as amended) and/or the Children and Young Person's Acts 1933 to 1969 (as amended) and his or her conviction is not spent under the Rehabilitation of Offenders Act 1974;.

(i) They fail to abide by the Constitution.

(j) They are under 16 years of age.

I acknowledge the extracts from the provider licence, Regulated Activities Regulations and the Trust's constitution above. I confirm that I do not fit within the definition of an "unfit person" as listed above and that there are no other grounds under which I would be ineligible to continue in post. I undertake to notify the Trust immediately if I no longer satisfy the criteria to be a "fit and proper person" or other grounds which I would be ineligible to continue in post come to my attention.

Name: _____ Signed: _____

Position: _____ Date: _____

## Appendix 2 - Table of requirements for complying with the regulations at the recruitment stage

Below are standards that the Trust will follow at the recruitment stage, the assurance process to follow and evidence required.

| Standard | | Assurance Process | Evidence |
|---|---|---|---|
| 1. | The Trust should make every effort to ensure that all available information is sought to confirm that the individual is of good character as defined in Schedule 4, Part 2 of the regulations. The fit and proper persons 'test' must be applied before an individual is appointed to a position. | Recruitment checks in accordance with NHS Employment Check Standards issued by NHS Employers, including:<br>• Proof of identity and right to work in the UK<br>• Proof of qualifications<br>• Professional registration and qualification check<br>• Full employment history and at least two detailed reference checks, one of which must be the most recent employer. Specifically this includes validating a minimum of three years continuous employment<br>• Occupational health assessment<br>• Disclosure and Barring Scheme (DBS) check (where appropriate to the role)<br>• Search of registers e.g. disqualified directors, bankruptcy and insolvency<br>• Google, news and social media searches | • References<br>• Outcome of other pre-employment checks<br>• DBS check certificate where appropriate<br>• Register and internet search results<br>• List of referees and sources of assurance for Freedom of Information Act (FOIA) purposes |
| 2. | Where the Trust deems the individual suitable despite not meeting the characteristics outlined in Schedule 4, | • Report and debate at the nominations committee(s) | • Record that due process was followed for FOIA purposes |

| | | | |
|---|---|---|---|
| | Part 2 of these regulations, the reasons should be recorded and information about the decision should be made available to those that need to be aware. | • Report and recommendation at the council of governors (for NEDs) or the board of directors (for executive directors) for foundation trusts, reports to the board for NHS trusts<br>• Decisions and reasons for decisions recorded in minutes<br>• External advice sought as necessary | |
| 3. | Where specific qualifications are deemed by the Trust as necessary for a role, the Trust must make this clear and should only employ those individuals that meet the required specification, including any requirements to be registered with a professional regulator. | • Requirements included within the job description for all relevant posts<br>• Proof of qualifications checked as part of the pre-employment checks | • Person specification<br>• Recruitment policy and procedure |
| 4. | The Trust should have appropriate processes for assessing and checking that the individual holds the required qualifications and has the competence, skills and experience required, to undertake the role; these should be followed in all cases and relevant records kept.<br><br>N.B. While this provision most obviously applies to executive director appointments in terms of qualifications, skills and experience will be relevant to | • Recruitment checks including a candidate's qualifications and employment references<br>• Recruitment processes including qualitative assessment and values-based questions<br>• Decisions and reasons for decisions recorded in minutes | • Recruitment policy and procedure<br>• Values-based questions<br>• Minutes of council of governors<br>• Minutes of board of directors |

| | | | |
|---|---|---|---|
| | NED appointments. | | |
| 5. | In addition to 4. above, the Trust may consider that an individual can be appointed to a role based on their qualifications, skills and experience with the expectation that they will develop specific competence to undertake the role within a specified timeframe. | • Discussions and recommendations by the nominations committee(s)<br>• Discussion and decision at board of directors or council of governors meeting<br>• Reports, discussion and recommendations recorded in minutes of meetings<br>• Follow-up as part of continuing review and appraisal | • Minutes of committee, board and or council meetings.<br>• NED appraisal framework<br>• NED competence framework<br>• Notes of executive director appraisals |
| 6. | When appointing relevant individuals the Trust has processes for considering a person's physical and mental health in line with the requirements of the role, all subject to equalities and employment legislation and to due process. | • Self-declaration of past health issues subject to clearance by occupational health as part of the pre-employment process<br>• Offer of appointment should be subject to this health screening<br>• If a health issue is raised, should consider if it falls within definition of disability and if it does, consider whether reasonable adjustments in compliance with the Equality Act 2010 can be made. | • Occupational health clearance |
| 7. | Wherever possible, reasonable adjustments are made in order that an individual can carry out the role. | • Self-declaration of adjustments required<br>• Check steps taken are in line with requirements to make reasonable adjustments for employees under the Equality Act 2010<br>• NHS Employment Check Standards<br>• Board/council of governors decision. | • Minutes of board meeting/council of governors meeting |

| | | | |
|---|---|---|---|
| 8. | The Trust has processes in place to assure itself that the individual has not been at any time responsible for, privy to, contributed to, or facilitated, any serious misconduct or mismanagement in the carrying on of a regulated activity; this includes investigating any allegation of such potential behaviour and making independent enquiries. Where the individual is professionally qualified, it may include fitness to practise proceedings and professional disciplinary cases. | • Same checks set out in 1, ie. past employment history in accordance with NHS Employers pre-employment check standards including a self-declaration of fitness in which candidates provide an explanation of past conduct/character issues where appropriate<br>• Clear consequences of false, inaccurate or incomplete information included in recruitment packs | • NED Recruitment Information pack<br>• Reference request for executive directors and NEDs |
| 9. | The Trust must not appoint any individual who has been responsible for, privy to, contributed to, or facilitated, any serious misconduct or mismanagement (whether lawful or not) in the carrying on of a regulated activity; this includes investigating any allegation of such potential behaviour. Where the individual is professionally qualified, it may include fitness to practise proceedings and professional disciplinary cases.<br><br>N.B. CQC accepts that trusts will use reasonable endeavours in this instance. The existence of a compromise | • Clear consequences of false, inaccurate or incomplete information included in recruitment packs<br>• Core HR policies for appointments and remuneration<br>• Checks set out in 1 above<br>• Included in reference requests<br>• Check publicly available information including serious case reviews | • Executive and non-executive Recruitment Information packs<br>• Core HR policies<br>• Reference request for executive directors and NEDs |

| | | | |
|---|---|---|---|
| | agreement does not indemnify the new employer and trusts will need to ensure that their Core HR policies address their approach to compromise agreements. | | |
| 10. | A person who will be acting in a role that falls within the definition of a "regulated activity" as defined by the Safeguarding Vulnerable Groups Act 2006 must be subject to an enhanced DBS check.<br><br>N.B. CQC recognises that it may not always be possible for trusts to access a DBS check as an individual may not be eligible. | • Where an executive director or NED meets the eligibility criteria, trusts should apply for an enhanced DBS check<br>• If the director's role falls within the definition of a "regulated activity", the DBS check will establish whether the person is on the children's and/or adults' safeguarding barred list and whether they are prohibited from holding the office in question under other laws such as the Companies Act or Charities Act. | • DBS policy<br>• Enhanced DBS checks for eligible post-holders |
| 11. | As part of the recruitment/appointment process, trusts should establish whether the Individual is eligible for the relevant DBS check. | • Eligibility for DBS checks will be assessed for each vacancy arising<br>• OR<br>• All postholders will undergo an enhanced DBS check | • DBS policy |

## Appendix 3 – Complying with the regulations on an ongoing basis

Below are standards that the Trust will follow throughout the course of an individual's employment, the assurance process to be followed and the evidence to be produced.

| | Standard | Assurance Process | Evidence |
|---|---|---|---|
| 1. | The Trust should regularly review the fitness of directors to ensure that they remain fit for the role they are in; the trust should determine how often fitness should be reviewed based on the assessed risk to business delivery and/or the service users posed by the individual and/or role. | • Assessment of continued fitness to be undertaken each year as part of the appraisal process<br>• Checks of insolvency and bankruptcy register and register of disqualified directors to be undertaken each year as part of the appraisal process<br>• Board/Council of Governors to review, checks and agree the outcome<br>• Regular DBS checks<br>• Regular checks of relevant<br>• professional regulator's register<br>• Ensure there is an ongoing<br>• obligation in employment contracts to declare any criminal and/or regulatory investigations as soon as reasonably practicable | • Continued assessment as part of appraisal process<br>• Register checks if necessary<br>• Board/council minutes record that process has been followed |
| 2. | If the Trust discovers information that suggests an individual is not of good character after they have been appointed to a role, the trust must take appropriate and timely action to investigate and rectify the matter. | • Core HR policies provide for such investigations<br>• Revised contracts allow for termination in the event of non-compliance with regulations and<br>• other requirements<br>• Contracts (for executive directors , and director-level equivalents) and agreements (for NEDs) | • Core HR polices<br>• Contracts of employment (for executive directors and director-level equivalents)<br>• Service agreements or equivalent (for NEDs) |

| | | | |
|---|---|---|---|
| | The Trust has arrangements in place to respond to concerns about a person's fitness in relation to Regulation 5(3) and (4) after they are appointed to a role whether identified by the trust itself or others – and these are adhered to. | incorporate<br>• maintenance of fitness as a contractual requirement | |
| 3. | The Trust investigates, in a timely manner, any concerns about a person's fitness or ability to carry out their duties, and where concerns are substantiated, proportionate, timely action is taken; the trust must demonstrate due diligence in all actions. | • Core HR policies include the necessary provisions<br>• Action taken and recorded as required | • Core HR policies |
| 4. | Where a person's fitness to carry out their role is being investigated, appropriate interim measures may be required to minimise any risk to service users. | • Core HR policies | • Managerial action taken to backfill posts as necessary |
| 5. | The Trust informs others as appropriate about concerns/findings relating to a person's fitness; for example, professional regulators, CQC and other relevant bodies, and supports any related enquiries/ investigations carried out by others. | • Core HR policies | • Referrals made to other agencies if necessary |

# Equality Impact Analysis form for Fit and Proper Persons Policy

## REGARDS EIRA: Assessing Equality Relevance (Stage 1)

1. Name of the service / policy / project or proposal (give a brief description):

**Fit and Proper Persons Policy and Procedure**

2. Answer the questions in the table below to determine equality relevance:

| | Yes | No | Insufficient data / info to determine |
|---|---|---|---|
| Does the project / proposal affect service users, employees or the wider community, and potentially have a significant effect in terms of equality? | | x | |
| Is it a major project / proposal, significantly affecting how functions are delivered in terms of equality? | | x | |
| Will the project / proposal have a significant effect on how other organisations operate in terms of equality? | | x | |
| Does the decision/ proposal relate to functions that previous engagement has identified as being important to particular protected groups? | | x | |
| Does or could the decision / proposal affect different protected groups differently? | | x | |
| Does it relate to an area with known inequalities? | | x | |
| Does it relate to an area where equality objectives have been set by our organisation? | | x | |

3. On a scale of high, medium or low assess the policy in terms of equality relevance.

| | Tick below: | Notes: |
|---|---|---|
| High | | If ticked all 'Yes' or 'Insufficient data' |
| Medium | | If ticked some 'Yes' and / or 'Insufficient data' and some 'No' |
| Low | x | If ticked all 'No' |

**EIRA completed by:** Trust Secretary

**Date:** 24 February 202011 May 2018

Derbyshire Healthcare NHS Foundation Trust

# Board Committee Summary Report to Trust Board
# Audit & Risk Committee – Meeting held 16 January 2020

**Key items discussed**

- Review Board Assurance Framework (BAF)
- BAF Risk 3a "There is a risk that the Trust fails to deliver its financial plans"
- Half year Review of Audit & Risk Committee Equality, Diversity and Inclusion (EDI) Objectives
- SFI Waiver Report (six monthly)
- Accounting Standards and IFRS 16 Update
- Annual Reporting and Planning Timetable
- External Audit Plan and Progress
- Internal Audit Progress Report
- JUCD 2019/20 Operational Planning Process Review
- Freedom to Speak Up Policy
- Identification of any issues arising from the meeting for inclusion or updating in the Board Assurance Framework

**Assurance/lack of assurance obtained**

- The BAF paper provided significant 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.
- The Deep Dive report on BAF 3a '*There is a risk that the Trust fails to delivery its financial plan'* outlined the key controls and mitigating action that is in place, including assurances of continuous improvement through the Cost Improvement Programme and the Use of Resources reports to the Trust Board. These reports were seen as evidence of the strategic approach being taken to the effective use of resources and measurement of progress. The Committee received significant assurance regarding the range of focus being applied to mitigate risk 3a.
- The deep dive programme will be developed for 2020/21 and will be captured in relevant Board Committee forward plans.
- Part assurance was received around the mid-year review of compliance against the Equality, Diversity and Inclusion (EDI) objective. It is excellent inclusion practice for the Board and Board Committees to explicitly consider EDI throughout their everyday business but there is more work to do with report authors on how to improve their reporting on aspects relating to EDI and this will be a focus of all the Board Committees.
- Significant assurance received on the process followed to approve and record waivers and the updated assurance in respect of the anti-ligature report, and associated waiver process, presented to the Committee in October 2017.
- Assurance that the accounting policies follow the Group Accounting Manual issued by the Department of Health.
- Full assurance received on the project management arrangements for producing the 2019/20 Annual Report, including Quality Report and Annual Accounts
- The internal audit recommendations tracker report gave assurance on the actions identified as

completed and the trajectory for completion of the remaining open actions.

- Significant Assurance had been given for the review of Datix Risk Management review with confirmation that the Trust's Datix system is being used appropriate.
- The Joined Up Care Derbyshire (JUCD) 2019/20 Operational Planning Process Review was seen as a successful piece of work and would be helpful in assessing demand and capacity within the system.

**Key risks identified**

- Consideration would be given to including a BAF risk relating to the transition and implementation of the new EPR system and an updated Brexit related risk would be considered when the BAF for 2020/21 is reviewed at Board Development on 19 February.
- Financial benefits from a reduction in Out of Area (OOA) placements have not yet been seen and saw this as a main cost pressure risk. The Committee was also concerned about the variation of sickness absence management. This is also shared by the People and Culture Committee and they have asked for a drill down report on managing attendance at the January meeting.
- Impact of the proposed changes in Accounting Standards, particularly for IFRS16. Work is still being undertaken to establish the effect the standard will have.
- The External Auditor's main area of focus would be the presumed risk of achieving patient care income and revenue recognition. The financial sustainability of the Trust and its governance arrangements and partnership arrangements will also be taken into account as part of the external audit.

**Decisions made**

- Approved the fifth issue of the BAF for 2019/20 and the significant assurance that 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.
- Agreed BAF risk 3a will remain rated at 'extreme' likelihood 4, impact 5.
- Agreed to consider the opportunities for further improvement in EDI reporting and how best to further evolve reporting to best suit Committee EDI objectives.
- Agreed the draft accounting policies for annual accounts 2019/20.
- Ratified the Freedom to Speak Up Policy and Procedure.

**Escalations to Board or other Committee**

- No items were considered necessary for escalation to the Board or any of the Board Committees from this meeting.

| | |
|---|---|
| **Committee Chair: Geoff Lewins<br>Non-Executive Director** | **Executive Lead: Justine Fitzjohn,<br>Trust Secretary** |

Derbyshire Healthcare
NHS Foundation Trust

# Board Committee Assurance Summary Report to Trust Board
# People & Culture Committee – Meeting held 28 January 2020

**Key items discussed**

**People and Culture Committee BAF Risks**

- Discussion and agreement that the BAF risks need to be refreshed in line with strategic priorities

**Strategic Workforce Report**

- Report showed a clear set of behaviours as to how leaders behave, lifelong learning programme to be developed nationally.
- Appraisal process for Executives is pending alongside the People Plan and central development for leaders.
- Pension update outlined that courses are being offered to all staff.
- Flu update showed positive results at 68.5% as at 24 January 2020 - expected to achieve 70% by end of January 2020 which is a huge achievement.

**Managing Attendance Deep Dive**

- Limited assurance obtained.
- Building blocks are in place to deliver a more person centred approach in managing attendance.
- Committee would like to see progress over the three to six months levels of absence
- Report will be brought back to next meeting to provide further assurance

**Workforce Performance Report**

- Limited assurance obtained.
- Discussion took place around attendance, training compliance and recruitment and retention
- Focus is shifting to other divisions regarding recruitment and retention in particular children's services, older adult inpatients and specialist services showing increasing levels of retirements.

**Staff Survey Results**

- First look shows very positive engagement scores putting DHCFT in the most improved in mental health trusts
- Full report will be received at June meeting

**Workforce Plan Update**

- Significant assurance given with the exception of mandatory training which needs further work

**Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES)**

- Discussed key actions and their progress
- Received significant assurance
- Tracking whether intervention to close the gaps is making a difference across the WRES indicators.
- Considerable improvement has been made with regards to anecdotal feedback from BAME colleagues, further evidence will be captured. Request to list tangible measurables as part of the workforce performance dashboard e.g. when staff survey results are analysed .at the June meeting so as to measure this at six monthly intervals.
- Noted that the WRES staff indicator metrics need to be reported in the corporate staff survey action plan to evidence this is being embedded and becomes business as usual

**Employee Relations Assurance Report**

- Report showed significant improvement.
- Significant assurance received.
- Ongoing work focussed on reducing timescales to bring resolutions and outcomes to employee relations cases.

**Communications Strategy Update**

- Significant assurance received
- Excellent evidence contained in the paper with real improvements in place to all parts of the Communications Strategy and plans for 2020.

Meeting effectiveness

- Good level of understanding by committee members with great discussion about key issues in the Trust.

**Assurance/lack of assurance obtained**

- See above

**Key risks identified**

- Identified risks arising from the meeting for inclusion or updating in the BAF – mandatory training, pension and tax risk of losing clinicians and if staff are aware.

- Recruitment, sickness, mandatory training improving leadership to be included in refreshing the BAF through the Trust Board development session.

**Escalations to Board or other committee –** none

| **Committee Chair: meeting chaired by Margaret Gildea on behalf of regular chair Julia Tabreham** | **Executive Lead: Amanda Rawlings, Director of People Services & Organisational Effectiveness** |
|---|---|

Derbyshire Healthcare NHS Foundation Trust

# Board Committee Assurance Summary Report to Trust Board
# Quality and Safeguarding Committee meeting held 11 February 2020

**Key items discussed**

**Summary of BAF Risks for Quality and Safeguarding Committee**
- Reviewed and discussion on current, existing and emerging safeguarding risks.

**Safeguarding Overview**
- Verbal overview to benefit members who weren't members of the stand-alone Safeguarding Committee.
- Included a history of the Safeguarding Committee model.

**SEND Internal Action Plan**
- Limited assurance on progress and improvement.
- Significant areas of gaps are CAMHS waiting time, Autism and Education Health and Care (EHC) plans, Health Visitors and improvement.
- Oversight and triangulation and with an operations report of improvement to ensure improved performance.
- Improvements to equality issues to be expanded on impact and measurements and any specific issues or concerns regarding protected characteristics.

**Assurance report/minutes from Safeguarding Operational Group**
- The new meeting structure and model of the Safeguarding Operational Group operational group was outlined.

**Safeguarding Adults Assurance Report**
- Limited assurance obtained due to low compliance rates in safeguarding training.
- Report on the independent investigation into the care and treatment of a mental health service user in Derbyshire and action plan for improvement agreed and PICU and residual risks of a non NHS was reviewed and discussed.

**Safeguarding Children Assurance report**
- Significant assurance received on practice.
- From a system perspective, there are significant risks and factors outside of our control.

**Dual Diagnosis Improvement Plan**
- A review of practice with recommendations
- Dual Diagnosis Improvement Plan six month update report showing outcomes and focus will be received in September

**Management of Patients with Eating Disorders**
- Presentation of the risks and clinical risk issues and implementing a pathway of exploration with the STP.
- Risks and gaps in control due to capacity and ways of working.

**Serious Incident Bi-monthly Report**
- Report received significant assurance.

**Chaperone Policy**

- Reviewed and ratified.

**Trust allegations against Staff, Carers and Volunteers Policy and Procedures**

- Reviewed and ratified.

**Consideration of any items affecting the BAF –**

- BAF 1a to include:
  - lack of PICU
  - learning from independent investigation in care and treatment of Mr N
  - Eating disorders gap in control
  - Safeguarding adult training less than 75% and the increase in training profile and mitigation plans.

**Assurance/Lack of Assurance Obtained**

- Gap in assurance - SEND Internal Action Plan.
- Safeguarding Adults Assurance Report - limited assurance.
- Safeguarding Children Assurance report - significant assurance.
- Management of Patients with Eating Disorders - risk based issue for BAF.
- Serious Incident bi-monthly report - significant assurance.

**Meeting Effectiveness**

- Effective meeting and improvement plans for any gaps in control.

**Decisions made**

- Review of Board Assurance Framework and specific risk based gaps in controls reviewed.
- Chaperone Policy - ratified.
- Trust Allegations against Staff, Carers and Volunteers Policy and Procedures – ratified.

**Escalations to Board or other Committee**

- Escalation to People and Culture Committee to consider both gaps in rotas highlighted in the Guardian of safe working report and the gaps in safeguarding adults training compliance and expansion of the target group.
- Escalation to Trust Board of BAF1a risk changes to include lack of PICU, learning from Mr N learning. Eating Disorders gap in control, safeguarding adult less than 75% and the increase in training profile and mitigation plans.

| **Committee Chair: Margaret Gildea** | **Executive Lead: Carolyn Green, Director of Nursing & Patient Experience** |
|---|---|

# GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS

| NHS Term / Abbreviation | Terms in Full |
|---|---|
| **A** | |
| A&E | Accident & Emergency |
| ACCT | Assessment, Care in Custody & Teamwork |
| ACE | Adverse Childhood Experiences |
| ACP | Accountable Care Partnership |
| ACS | Accountable Care System (now known as ICS) |
| ADHD | Attention Deficit Hyperactivity Disorder |
| AfC | Agenda for Change |
| AHP | Allied Health Professional |
| AIMS | Royal College of Psychiatrists Accreditation for Inpatient Mental Health Services Standards |
| ALB | Arms-length body such as NHS Improvement (NHSI) and NHS England (NHSE) |
| AMM | Annual Members' Meeting |
| AMHP | Approved Mental Health Professional |
| ANP | Advanced Nurse Practitioner |
| AO | Accountable Officer |
| ASD | Autism Spectrum Disorder |
| ASM | Area Service Manager |
| **B** | |
| BAF | Board Assurance Framework |
| BLS | Basic Life Support (ILS Immediate Life Support) |
| BMA | British Medical Association |
| BAME | Black, Asian & Minority Ethnic group |
| BoD | Board of Directors |
| **C** | |
| CAMHS | Child and Adolescent Mental Health Services |
| CASSH | Care & Support Specialised Housing |
| CBT | Cognitive Behavioural Therapy |
| CCG | Clinical Commissioning Group |
| CCT | Community Care Team |
| CDMI | Clinical Digital Maturity Index |
| CE | Chief Executive |
| CEO | Chief Executive Officer |
| CGA | Comprehensive Geriatric Assessment |
| CIP | Cost Improvement Programme |
| CMDG | Contract Management Delivery Group |
| CMHT | Community Mental Health Team |
| CNST | Clinical Negligence Scheme for Trusts |
| COAT | Clinical Operational Assurance Team |
| COF | Commissioning Outcomes Framework |
| CoG | Council of Governors |
| CPA | Care Programme Approach |
| CPD | Continuing Professional Development |
| CPN | Community Psychiatric Nurse |
| CPR | Child Protection Register |
| CQC | Care Quality Commission |
| CQI | Clinical Quality Indicator |
| CQUIN | Commissioning for Quality and Innovation |
| CRB | Criminal Records Bureau |

| GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS | |
|---|---|
| **NHS Term / Abbreviation** | **Terms in Full** |
| CRG | Clinical Reference Group |
| CRS | (NHS) Care Records Service |
| CRS | Commissioner Requested Services |
| CSF | Commissioner Sustainability Fund |
| CTO | Community Treatment Order |
| CTR | Care and Treatment Review |
| **D** | |
| DAT | Drug Action Team |
| DBS | Disclosure and Barring Service |
| DBT | Dialectical Behavioural Therapy |
| DfE | Department for Education |
| DCHS | Derbyshire Community Health Services NHS Foundation Trust |
| DHCFT | Derbyshire Healthcare NHS Foundation Trust |
| DIT | Dynamic Interpersonal Therapy |
| DNA | Did Not Attend |
| DH | Department of Health |
| DoLS | Deprivation of Liberty Safeguards |
| DNA | Did not attend |
| DPA | Data Protection Act |
| DRRT | Dementia Rapid Response Team |
| DTOC | Delayed Transfer of Care |
| DVA | Derbyshire Voluntary Action (formerly North Derbyshire Voluntary Action) |
| DWP | Department for Work and Pensions |
| **E** | |
| ECT | Enhanced Care Team |
| ECW | Enhanced Care Ward |
| ED | Emergency Department |
| EDS2 | Equality Delivery System 2 |
| EHIC | European Health Insurance Card |
| EHR | Electronic Health Record |
| EI | Early Intervention |
| EIA | Equality Impact Assessment |
| EIP | Early Intervention In Psychosis |
| ELT | Executive Leadership Team |
| EMDR | Eye Movement Desensitising & Reprocessing Therapy |
| EMR | Electronic Medical Record |
| EPR | Electronic Patient Record |
| ERIC | Estates Return Information Collection |
| ESR | Electronic Staff Record |
| EUPD | Emotionally Unstable Personality Disorder |
| EWTD | European Working Time Directive |
| **F** | |
| FBC | Full Business Case |
| FFT | Friends and Family Test |
| FOI | Freedom of Information |
| FSR | Full Service Record |
| FT | Foundation Trust |
| FTE | Full-time Equivalent |
| FTN | Foundation Trust Network |
| FTSU | Freedom to Speak Up |

| GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS | |
|---|---|
| **NHS Term / Abbreviation** | **Terms in Full** |
| FTSUG | Freedom to Speak Up Guardian |
| F&P | Finance and Performance |
| 5YFV | Five Year Forward View |
| **G** | |
| GDPR | General Data Protection Regulation |
| GGI | Good Governance Institute |
| GMC | General Medical Council |
| GP | General Practitioner |
| GPFV | General Practice Forward View |
| **H** | |
| HCA | Healthcare Assistant |
| HEE | Health Education England |
| HES | Hospital Episode Statistics |
| HoNOS | Health of the Nation Outcome Scores |
| HSCIC | Health and Social Care Information Centre |
| HSE | Health and Safety Executive |
| HWB | Health and Wellbeing Board |
| **I** | |
| IAPT | Improving Access to Psychological Therapies |
| ICM | Insertable Cardiac Monitor |
| ICS | Integrated Care System (formerly ACS) |
| ICT | Information and Communication Technology |
| ICU | Intensive Care Unit |
| IDVAs | Independent Domestic Violence Advisors |
| IG | Information Governance |
| ILS | Immediate Life Support (BLS – Basic Life Support) |
| IM&T | Information Management and Technology |
| OOA | Outside of Area |
| IPP | Imprisonment for Public Protection |
| IPR | Individual Performance Review |
| IPT | Interpersonal Psychotherapy |
| **J** | |
| JNCC | Joint Negotiating Consultative Committee |
| JTAI | Joint Targeted Area Inspections |
| JUCB | Joined Up Care Board |
| JUCD | Joined Up Care Derbyshire |
| **K** | |
| KPI | Key Performance Indicator |
| KSF | Knowledge and Skills Framework |
| **L** | |
| LA | Local Authority |
| LCFS | Local Counter Fraud Specialist |
| LD | Learning Disabilities |
| LHP | Local Health Plan |
| LHWB | Local Health and Wellbeing Board |
| LOS | Length of Stay |
| **M** | |
| MARS | Mutually Agreed Resignation Scheme |
| MAS | Memory Assessment Service |

| GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS | |
|---|---|
| **NHS Term / Abbreviation** | **Terms in Full** |
| MAU | Medical Assessment Unit |
| MAS | Memory Assessment Service |
| MAPPA | Multi-agency Public Protection Arrangements |
| MARAC | Multi-agency Risk Assessment Conference (meeting where information is shared on the highest risk domestic abuse cases between representatives of local police, probation, health, child protection, housing practitioners, Independent Domestic Violence Advisors (IDVAs) and other specialists from the statutory and voluntary sectors. |
| MASH | Multi-Agency Safeguarding Hub |
| MCA | Mental Capacity Act |
| MDA | Medical Device Alert |
| MDM | Multi-Disciplinary Meeting |
| MDT | Multi-Disciplinary Team |
| MFF | Market Forces Factor |
| MHA | Mental Health Act |
| MHIN | Mental Health Intelligence Network |
| MHIS | Mental Health Investment Standard |
| MHRT | Mental Health Review Tribunal |
| MSC | Medical Staff Committee |
| MSK | Musculoskeletal (conditions) |
| **N** | |
| NCRS | National Cancer Registration Service |
| NED | Non-Executive Director |
| NICE | National Institute for Health and Care Excellence |
| NHS | National Health Service |
| NHSE | National Health Service England |
| NHSI | National Health Service Improvement |
| NIHR | National Institute for Health Research |
| **O** | |
| OBC | Outline Business Case |
| ODG | Operational Delivery Group |
| OP | Out Patient |
| OSC | Overview and Scrutiny Committee |
| OT | Occupational therapy |
| **P** | |
| PAB | Programme Assurance Board |
| PAG | Programme Advisory Group |
| PALS | Patient Advice and Liaison Service |
| PAM | Payment Activity Matrix |
| PARC | Psychosis and the reduction of cannabis (and other drugs) |
| PARIS | This is an electronic patient record system |
| PbR | Payment by Results |
| PCC | Police & Crime Commissioner |
| PCN | Primary Care Networks |
| PDSA | Plan, Do, Study, Act |
| PHE | Public Health England |
| PICU | Psychiatric Intensive Care Unit |
| PID | Project Initiation Document |
| PiPoT | People in Positions of Trust |
| PLIC | Patient Level Information Costs |
| PMLD | Profound and Multiple Disability |

| GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS | |
|---|---|
| **NHS Term / Abbreviation** | **Terms in Full** |
| PPI | Patient and Public Involvement |
| PPT | Partnership and Pathway Team |
| PREM | Patient Reported Experience Measure |
| PROMS | Patient Reported Outcome Measure |
| PSF | Provider Sustainability Fund |
| PSIRF | Patient Safety Incident Review Framework |
| **Q** | |
| QAG | Quality Assurance Group |
| QC | Quality Committee |
| QIA | Quality Impact Assessment |
| QIPP | Quality, Innovation, Productivity Programme |
| **R** | |
| RAID | Rapid Assessment, Interface and Discharge |
| RCGP | Royal College of General Practitioners |
| RCI | Reference Cost Index |
| REGARDS | Race, Economic disadvantage, Gender, Age, Religion or belief, Disability and Sexual orientation |
| RTT | Referral to Treatment |
| **S** | |
| SAAF | Safeguarding Adults Assurance Framework |
| SBARD | Situation, Background, Assessment, Recommendation and Decision (SBARD) tool |
| SBS | Shared Business Services |
| SEND | Special Educational Needs and Disabilities |
| SI | Serious Incidents |
| SID | Senior Independent Director |
| SIRI | Serious Incident Requiring Investigation |
| SLA | Service Level Agreement |
| SLR | Service Line Reporting |
| SOC | Strategic Options Case |
| SOF | Single Operating Framework |
| SPOA | Single Point of Access |
| SPOE | Single Point of Entry |
| SPOR | Single Point of Referral |
| STEIS | Strategic Executive Information System |
| STF | Sustainability and Transformation Fund |
| STP | Sustainability and Transformation Partnership |
| SUI | Serious (Untoward) Incident |
| **T** | |
| TARN | Trauma Audit and Research Network |
| TCP | Transforming Care Partnerships |
| TCS | Transforming Community Services |
| TDA | Trust Development Authority |
| TMT | Trust Management Team |
| TUPE | Transfer of Undertakings (Protection of Employment) Regulations 1981 |
| TMAC | Trust Medical Advisory Committee |
| **U** | |
| UDBH | University Hospitals of Derby and Burton |
| **V** | |

| GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS | |
|---|---|
| **NHS Term / Abbreviation** | **Terms in Full** |
| VO | Vertical Observatory |
| **W** | |
| WDES | Workforce Disability Equality Standard |
| WRES | Workforce Race Equality Standard |
| WTE | Whole Time Equivalent |
| **Y** | |
| YTD | Year to Date |

# 2020-21 Board Annual Forward Plan

| Exec Lead | Item | 5 May 20 | 7 Jul 20 | 1 Sep 20 | 3 Nov 20 | 13 Jan 21 | 2 Mar 21 |
|---|---|---|---|---|---|---|---|
| | **Paper deadline** | **27 Apr** | **29 Jun** | **24 Aug** | **28 Oct** | **4 Jan** | **22 Feb** |
| Trust Sec | Declaration of Interests | X | X | X | X | X | X |
| CG | Patient Story | X | X | X | X | X | X |
| CM | Minutes/Matters arising/Action Matrix | X | X | X | X | X | X |
| CM | Board review of effectiveness of meeting | X | X | X | X | X | X |
| CM | Board Forward Plan (for information) | X | X | X | X | X | X |
| CM | Summary of Council of Governors meeting (for information) | X | | X | X | X | X |
| CM | Chair's Update | X | X | X | X | X | X |
| IM | Chief Executive's Update | X | X | X | X | X | X |
| **STRATEGIC PLANNING AND CORPORATE GOVERNANCE** | | | | | | | |
| MP/CW | NHSI Annual Plan - timing to be confirmed | | | | X | | |
| CS | Staff Survey Results (headlines in May, summary in July) | X | X | | | | |
| CS | Equality Delivery System2 (EDS2) update | | | | | | X |
| CS | Annual Gender Pay Gap Report for approval | | | | | | X |
| CS | Workforce Race Equality Standard (WRES) | | | X | | | |
| CS | Workforce Disability Equality Standard (WDES) | | | X | | | |
| CS | Flu Campaign (summary of 2019/20 (May) progress update on 2020/21 (Nov)) | 19/20 Summary | | | 20/21 update | | |
| CS | Workforce Plan | | X | | | | |
| Trust Sec | NHS Improvement Year-End Self-Certification | X | | | | | |
| Trust Sec | Year-End Governance Reporting from Board Committees and approval of ToRs | X | | | | | |
| Trust Sec | Corporate Governance Framework | X | | | | | |
| Trust Sec | Review SOs, SFIs, SoD plus review/ratify SFI Policy (as Policy Review section below) | | X | | | | |
| Trust Sec | Trust Sealings (six monthly - for information) | X | | | X | | |
| Trust Sec | Annual Review of Register of Interests | X | | | | | |
| Trust Sec | Board Assurance Framework Update | X | X | | X | | X |
| Trust Sec | Freedom to Speak Up Guardian Report (six monthly) | | | X | | | X |
| Trust Sec | Fit and Proper Person Declaration | | X | | | | |
| Trust Sec | Board Effectiveness Survey Report | X | | | | | |
| Trust Sec | Annual Approval of Modern Slavery Statement | | | | X | | |
| Committee Chairs | Board Committee Assurance Summaries (following every meeting) - Audit & Risk, Finance & Performance, Mental Health Act, Quality & Safeguarding, People & Culture | X | X | X | X | X | X |
| MP | Annual Emergency Planning Report (EPPR) | | | | X | | |
| GH | Business Plan Monitoring close down of 2019/20 (May) Proposal for 2020/21 (Jul) 2020/21 Update (Nov) | X | | | X | | |
| GH | Learning Disabilities Clinical Strategy | X | | | | | |
| GH | Trust Strategy Review | X | | | X | | |

| Exec Lead | Item | 5 May 20 | 7 Jul 20 | 1 Sep 20 | 3 Nov 20 | 13 Jan 21 | 2 Mar 21 |
|---|---|---|---|---|---|---|---|
| **OPERATIONAL PERFORMANCE** | | | | | | | |
| CG/CW/CS/ MP | Integrated performance and activity report to include Finance, Workforce, performance and Quality Dashboard | X | X | X | X | X | X |
| CG/MP/CS | Workforce Standards Formal Submission/Safer Staffing (prior to going on website) | | | | | | X |
| **QUALITY GOVERNANCE** | | | | | | | |
| Execs | Quality Position Statement Report - focus on CQC domains (Well Led CQC & NHSI (Trust Sec) as per schedule | Safety JS | Responsive MP | Well Led JF | Effective CG &CS | Use of Resources CW | Caring CG |
| JS | Learning from Deaths Mortality report (quarterly publication of information on death) (Jul/Nov/Jan/Mar) | | X | | X | | |
| JS | Guardian of Safe Working Report | X | | X | X | | X |
| JS | NHSE Return on Medical Appraisals sign off | | | X | | | |
| CG | Control of Infection Report | | | A | | | |
| JS | Re-validation of Doctors | | A | | | | |
| CG | Receipt of Annual Reports:<br>- Annual Looked After Children<br>- Safeguarding Children and Adults at Risk | | | | X | | |
| CG | Outcome of Patient Stories | | | | X | | |
| **POLICY REVIEW** | | | | | | | |
| CW | Standing Finance Instructions Policy and Procedures | | X | | | | |
| JF | Engagement between the Board of Directors and CoG | | | X | | | |