Derbyshire Healthcare
NHS Foundation Trust

Derbyshire Healthcare NHS Foundation Trust
Board of Directors Meeting

To be held digitally via MS Teams

4 May 2021 09:30 - 4 May 2021 12:30

INDEX

Derbyshire Healthcare NHS Foundation Trust

PUBLIC BOARD MEETING
TUESDAY 4 MAY 2021 TO COMMENCE AT 9:30am
Following national guidance on keeping people safe during COVID-19 this will be a virtual meeting conducted via MS Teams

	TIME	AGENDA	LED BY
1.	9:30	Chair's welcome, opening remarks and apologies, declarations of interest - Register of Directors' Interests Report 2020/21	Caroline Maley
2.		Staff Wellbeing Story	Jaki Lowe
3.		Minutes of Board of Directors meeting held on 2 March 2021	Caroline Maley
4.		Matters arising – Actions Matrix	Caroline Maley
5.		Questions from members of the public	Caroline Maley
6.	10:00	Chair's Update	Caroline Maley
7.	10:10	Chief Executive's Update	Ifti Majid
STRATEGY, OPERATIONAL PERFORMANCE AND QUALITY ASSURANCE			
8.	10:25	Integrated Performance and Activity Report	C Wright/J Lowe/ C Green//L Doyle
9.	10.40	COVID-19 Update	Lee Doyle
10.	10:50	Guardian of Safe Working Report	Dr Smita Saxena/ Dr John Sykes
11:00 B R E A K			
11.	11.10	Workforce Safety Standards Formal Submission	C Green / J Sykes / J Lowe
12.	11.30	Workforce Resources Delivery Plan	Jaki Lowe
13.	11.20	Staff Survey Results	Jaki Lowe
GOVERNANCE			
14.	11.45	Corporate Governance Report: - NHS Improvement Year-End Self-Certification - Approval of Modern Slavery Statement 2020/21 - Year-end governance reporting from Board Committees and approval of ToRs - Trust Sealings (six monthly report - for information)	Justine Fitzjohn
15.	12.00	Board Assurance Framework Update	Justine Fitzjohn
16.	12:15	Board Committee Assurance Summaries	Committee Chairs
CLOSING MATTERS			
17.	12:30	- Identification of any issues arising from the meeting for inclusion or updating in the Board Assurance Framework - Meeting effectiveness	Caroline Maley
FOR INFORMATION			
Summary Report from the Council of Governors meeting held 2 March 2021 Glossary of NHS Acronyms 2021/22 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 6 July 2021. It is anticipated that this meeting will be held digitally via MS Teams
Users of the Trust's services and other members of the public are welcome to attend the meetings of the Board.
Participation in meetings is at the Chair's discretion

Our vision

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

Our values

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

Our Trust values are:

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

Derbyshire Healthcare NHS Foundation Trust
Report to Board of Directors – 4 May 2021

Register of Directors' Interests

Purpose of Report

This report provides the Trust Board with the year-end 2020/21 Register of Directors' interests. This register will be published in the Annual Report for 2020/21. The register is updated with each new interest declared/removed and the revised version is then reported to each Public Board. There is only one change between the attached register and the current 2021/22 register and to avoid having to include two versions in this paper the additional interest to note is:

Carolyn Green Director of Nursing and Patient Experience	Midlands and East Regional Director, National Mental Health Nurse Directors Forum	(e)

Executive Summary

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

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

Assurances

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

Governance or Legal Issues

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

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

Recommendations

The Board of Directors is requested to approve and record the declarations of interest as disclosed. These are recorded in the Register of Interests which is accessible to the public at the Trust Head Office and will be listed in the Trust's Annual Report for 2020/21.

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

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

Derbyshire Healthcare
NHS Foundation Trust

DECLARATION OF INTERESTS REGISTER 2020/21		
NAME	**INTEREST DISCLOSED**	**TYPE**
Margaret Gildea Non-Executive Director	• Director, Organisation Change Solutions Limited • Coaching and organisation development with First Steps Eating Disorders	(a) (e)
Gareth Harry Director of Director of Business Improvement and Transformation	• Chair of Marehay Cricket Club • Member of the Labour Party	(e) (e)
Ashiedu Joel Non-Executive Director	• Director Ashioma Consults Ltd • Director Peter Joel & Associates Ltd • Leicester Council of Faiths • The Bridge East Midlands	(a) (a) (a) (a)
Geoff Lewins Non-Executive Director	• Director, Arkwright Society Ltd	(a)
Jaki Lowe Director of People and Inclusion	• General Medical Council Associate	(e)
Ifti Majid Chief Executive	• Board Member of NHS Confederation Mental Health Network • Co-Chair of NHS Confederation BME Leaders Network • Spouse is Operations Director (North) at Priory Healthcare	(d) (d) (e)
Dr Julia Tabreham Non-Executive Director	• Research and Ambassador Carers Federation • Daughter's partner is Amit Pore – Team Lead for the NHS Passport. Amit is employed by Netcompany, working in collaboration with NHS Digital and NHSX (NHS joint organisation for digital, data and technology) • Daughter-in-Law is Dr Jacqueline Tsang – Consultant Obstetrician, Newham Hospital, London	(d) (e) (e)
Dr John Sykes Medical Director	• Undertakes paid assessments of patients at the request of the local authorities under the Mental Health Act and Mental Capacity Act and acts likewise for solicitors representing patients	(e)
Richard Wright Deputy Trust Chair and Non-Executive Director	• Non-Executive Director (Chair) of Sheffield UTC Multi Academy Educational Trust • Chair, System Finance Oversight Group, Joined Up Care Derbyshire	(a) (d)

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

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

Derbyshire Healthcare NHS Foundation Trust

MINUTES OF A VIRTUAL
MEETING OF THE BOARD OF DIRECTORS
TUESDAY 2 MARCH 2021

VIRTUAL MEETING VIA MS TEAMS
Commenced: 9.30am Closed: 12.15pm

PRESENT	Caroline Maley	Trust Chair
	Richard Wright	Deputy Trust Chair and Non-Executive Director
	Margaret Gildea	Senior Independent Director and Non-Executive Director
	Geoff Lewins	Non-Executive Director
	Dr Sheila Newport	Non-Executive Director
	Dr Julia Tabreham	Non-Executive Director
	Ashiedu Joel	Non-Executive Director
	Ifti Majid	Chief Executive
	Claire Wright	Deputy Chief Executive and Director of Finance
	Mark Powell	Chief Operating Officer
	Carolyn Green	Director of Nursing and Patient Experience
	Dr John Sykes	Medical Director
	Gareth Harry	Director of Business Improvement and Transformation
	Jaki Lowe	Director of People and Inclusion
	Justine Fitzjohn	Trust Secretary
IN ATTENDANCE	Anna Shaw	Deputy Director of Communications
	Sue Turner	Board Secretary
	Lee Doyle	Deputy Director of Operations
	Vicki Baxendale	Interim Assistant Director of Nursing Quality and Governance
	Dr Mohan Rathnaiah	Junior Doctor, Higher Trainee
OBSERVERS*	Lynda Langley	Lead Governor and Public Governor, Chesterfield
	Andrew Beaumont	Public Governor, Erewash
	Jodie Cook	Public Governor, Voluntary Sector (Derbyshire Mental Health Forum)
	Julie Lowe	Public Governor, Derby City East
	Valerie Broom	Public Governor, Amber Valley
	Marie Hickman	Library and Knowledge Manager and Staff Governor

* *The Board meetings are broadcast via a MS Teams Live event which does not currently record names of observers so the above list may not reflect the total numbers for the broadcast.*

DHCFT 2021/019	**CHAIR'S WELCOME, OPENING REMARKS, APOLOGIES FOR ABSENCE AND DECLARATION OF INTERESTS** Due to the need for social distancing to help limit the spread of COVID-19, this was a virtual meeting, held via MS Teams. Trust Chair, Caroline Maley, welcomed everyone to meeting including the Trust's Lead Governor, other Governors, Trust colleagues and the public observing via the live streamed feed. A warm welcome was extended to Lee Doyle, Deputy Director of Operations who attended to shadow outgoing Chief Operating Officer, Mark Powell along with Vicki

	Baxendale, Interim Assistant Director of Nursing Quality and Governance and Dr Mohan Rathnaiah who shadowed Director of Nursing and Patient Experience, Carolyn Green and Medical Director, John Sykes respectively. No declarations of interest were declared, other than those already recorded on the formal register of Directors' interests. Caroline extended her thanks to Ian Strange and Suzie Goodburn for providing the technical support enabling the meeting to be livestreamed so that members of the public, staff and governors could observe the Board. Since the last meeting took place on 13 January the third lockdown began. Caroline thanked staff for their flexibility and commitment and expressed her pride in how the Trust continues to respond to the pandemic. As this was Mark Powell's last Board meeting before he leaves to take up his new role as Deputy Chief Executive of Leicestershire Partnership NHS Trust, Caroline wished Mark every success in his new role and at the request of the Council of Governors read out their messages of thanks for the excellent work Mark has carried out for the Trust.
DHCFT 2021/020	**A PATIENT'S VIEW - WHY AM I LESS IMPORTANT THAN ANOTHER PERSON WITH ANOTHER CONDITION?** This anonymous story shared by Carolyn Green on behalf of service user, Mrs R gave an account of what it is like for an autistic person to be admitted to hospital. Mrs R suffers from agoraphobia, panic attacks and anxiety as well as autism which makes her think and see things differently. Her agoraphobia was caused by the extreme trauma she lived through as a child and her life has been severely damaged through her restrictions which has meant she has only left her home for medical emergencies. To help Mrs R with her treatment the Trust has provided her with a hospital passport which allows her to be accompanied by her husband who keeps her calm as meeting different doctors and nurses fills her with fear. The root of Mrs R's story centres around why there no-one to help people like her with autism when they are admitted to hospital. Having been admitted to hospital after for a second serious health incident Mrs R's needs set out in her treatment passport were not followed and there was no one specialised in autism to treat her. This resulted in her wanting to leave hospital even though her condition was life threatening as she could not cope in an unfamiliar environment where she feels everything is contaminated. She wanted to return to her home where she feels secure, where there will be no strangers, no dirt and no one touching her. Mrs R feels that people with autism die younger because there is a lack of understanding and adjustments made for them and they cannot get the treatment and care they need. She states that people with autism need adjustments made for them so they can have access to medical care that is essential to them. There are dedicated staff for people with other mental health issues including learning disabilities but no one specialised in treating autism was there to help Mrs R. Non-Executive Director, Sheila Newport as Chair of the Mental Health Act Committee and the Trust's Clinical Non-Executive was incredibly moved by Mrs R's story and highlighted the importance for NHS services to have the capacity to help patients with autism navigate NHS services. She was concerned that changes being made to the Mental Health Act (MHA) will mean that people like Mrs R might find it more difficult to access physical healthcare and hoped the Trust can influence services to be appropriate for people with autism so they can receive kindness. Deputy Chief Executive and Director of Finance Claire Wright echoed Sheila's comments and would use Mrs R's meaningful description of how it feels for people with autism to help the Trust design its estate be more appropriate for people with autism.

	The Board has previously discussed the need to develop commissioned services for people with autism and this is being taken to the Joined Up Care Derbyshire (JUCD) Board. Chief Executive, Ifti Majid emphasised that Mrs R's story should also influence the education, training and development of colleagues working in creating care within the physical care system and the importance of treating people holistically. Senior Independent Director, Margaret Gildea as Chair of the Quality and Safeguarding Committee hoped that autism services could be developed so that staff experienced in autism could also work in physical healthcare situations and be an advocate for people with autism in the same way that people with learning disabilities are assisted through their treatment and care. In terms of how people with autism are treated, Medical Director, John Sykes referred to the way learning disability (LD) services have evolved to give a more enlightened approach to people with LD and their human rights as they are not ill but they need certain enhancements to be able to access services like anyone else. John took the opportunity to relay how a formal Trust response to MHA public consultation; published on 13 January 2021 and with a closing date of 21 April 2021 is being compiled by the Trust relating to people with learning disability and autism and asked for the Board's response to the issues being raised as follows: • We propose to create a new duty on local commissioners (NHS and local government) to ensure adequacy of supply of community services for people with a learning disability and autistic people. The Board strongly agreed to this proposal. • We propose to supplement this with a further duty on commissioners that every local area should understand and monitor the risk of crisis at an individual level for people with a learning disability and autistic people in the local population through the creation of local at risk or support registers. The Board strongly agreed to this proposal. • The final question was what can be done to overcome any challenges around the use of pooled budgets and reporting on spend on services for people with a learning disability and autistic people? In response the Board emphasised the need for the provision of integrated care services and pooled budgets to be taken forward in line with latest White Paper recommendations, particularly in terms of commissioner responsibilities. The Board concluded that there is considerable learning to be taken from Mrs R's story to improve the Trust's physical healthcare pathway and for people with autism so they are treated as individuals as there are a number of people struggling with similar patters to Mrs R. **RESOLVED: The Board of Directors discussed and noted the difficulties experienced by Mrs R for taking forward to improve services for people with autism.**
DHCFT 2021/021	**MINUTES OF THE BOARD OF DIRECTORS MEETING HELD ON 13 JANUARY 2021** The minutes of the previous meeting held on 13 January 2021 were accepted as a correct record of the meeting.
DHCFT 2021/022	**ACTIONS MATRIX** The Board agreed to close all completed actions. Updates were provided by members of the Board and noted on the actions matrix. **MATTERS ARISING** A report on resourcing plans and how this is linked to the Long Term Plan had been due to be brought to the Board in March. Given that Board Committees have reverted to lighter governance measures in response to the third wave of the pandemic, the Board agreed in

	January to keep this matter under close review and was assured that this report would be brought to the next meeting on 4 May following a full review by the People and Culture Committee in April.
DHCFT 2021/023	**QUESTIONS FROM MEMBERS OF THE PUBLIC** No questions had been submitted for a response ahead of today's meeting.
DHCFT 2021/024	**CHAIR'S UPDATE** Caroline Maley's report provided the Board with reflections on her activity in her role as Trust Chair since the previous Board meeting held on 13 January and outlined virtual engagement with colleagues during the ongoing pandemic. Caroline reported that she was delighted to join a meeting with Ruby Wax arranged by IAPT (psychological therapy services), which was attended by 138 people. Ruby is an advocate for mental health services and talked about some of the work that she does in mental health, and the books she has written. Ruby also led a short mindfulness practice for all on the call. Caroline praised and thanked the IAPT team for engaging with her. It is hoped that virtual team visits which unfortunately have been delayed due to the latest wave of COVID-19 can recommence, and Caroline looks forward to reporting in future on these visits. In January the Council of Governors met with the Board. This was a productive meeting that covered good conversations about developments coming from the system wide Mental Health, LD and Autism Delivery Board, as well as discussions about some joint training and dialogue with Non-Executive Directors (NEDs). In February a well-attended and productive Governance Committee took place which covered some really important issues. Julie Lowe was welcomed as newly elected chair of this Committee, and Kelly Sims was thanked for her two years as chair. The notes from the Joined Up Care Derbyshire meeting held on 21 January were appended to the report and more detail is included in the Chief Executive's Update. **RESOLVED: The Board of Directors noted the content of the Chair's update.**
DHCFT 2021/025	**CHIEF EXECUTIVE'S REPORT** Ifti Majid's report provided the Board with feedback on changes within the national health and social care sector, and an update on developments occurring within the local Derbyshire health and social care community.as influenced by the NHS response to the pandemic, and how to learn lessons from the response. The Board noted that the report reflects a wider view of the Trust's operating environment and risks that may affect the organisation. These will be taken forward to assess their operational and strategic impact, and recorded on operational risk registers, or the Board Assurance Framework (BAF), as appropriate. Ifti first of all paid tribute to the way staff have been flexible in working from home and in unaccustomed ways since the outbreak of the pandemic and have had to withstand significant personal impact. He and the Board paused to think about the incredible stoic and can do attitude that colleagues have maintained in response the pandemic which has epitomised the Trust's values. During February the Trust enhanced its focus on the Trust's 'It's Not OK' Campaign. Through this campaign colleagues within the Trust and the wider community can be assured that any form of discrimination on the grounds of any protected characteristic (which includes race, gender, sexual orientation, disability, age, religion/belief, gender reassignment, marriage and civil partnership, pregnancy and maternity) is unacceptable. The Board is committed to supporting staff to take action against any discrimination.

	Monday 8 March is International Women's Day (IWD). Ifti encouraged the Board to take part in this global day celebrating all women in all roles across the health and care system. Several well attended live engagement events and question and answer sessions have been held in recent weeks to ensure colleagues receive correct information so they can make an informed decision about getting their COVID-19 vaccination. From a national context Ifti referred to the details released by the Secretary of State for Health from the White Paper relating to the future of health and care in England. The main impact is the demand of integrated service delivery and the different working relationships between health providers and local authority and the locality of Integrated Care Systems (ICSs) and opportunity for the use of committees in common and how we manage across the different care pathways. All these aspects will give a stronger legislative power and authority to the ICS and Board members are focussed on how this can be taken through the Derbyshire ICS. The Board will also be revisiting the White Paper to consider how this will affect funding and how the Trust will operate with local authorities and other providers. Claire Wright referred to information shared through social media outlets, particularly the Derbyshire Healthcare Facebook page around LGBT+ History Month. As the Trust's LBGT+ champion, Claire recently co-signed a letter with colleagues to the national LGBT+ network about the use of the rainbow in NHS imagery. Claire pointed out that this has caused confusion in the public about what the rainbow now represented which in turn created risk for, and concern among, LGBT+ colleagues and service receivers and she undertook to keep the Board updated on how progress. Non-Executive Director, Geoff Lewins referred to the White Paper and asked what would be the main areas that the Trust would need to focus on in preparation for working within the Derbyshire system as there is still a lot to understand in terms of the far-reaching impact of the White Paper. Ifti stressed the importance of having increased understanding around the collaboration with local authorities so the Trust can collaborate with all providers to deliver high quality, efficient pathways as well as LD and autism services across Derbyshire while working to improve health outcomes that are driven by housing, education etc. These are anchor institutions and Ifti is leading this work across the county working with the ICS to establish what committees there are in common. This work will emerge through interaction with the ICS Board, the Trust Board and NHS Governance. Chief Operating Officer, Mark Powell thanked Ifti for his comments about the way colleagues have been working over the last year and urged the Board to continue to think about capacity as we head into April, May and June when hopefully services can return to more normal levels because staff need to have rest and recuperation to deliver services. It is important to think about the type of services the Trust provides as a significant increase in the number of people who need to access our services is predictable in both adults and children. Mark reminded the Board that staffing levels will also need to increase over the next 12 to 24 months to meet demand. Director of Business Improvement and Transformation, Gareth Harry reiterated that the Trust has been working in a heightened state of NHS emergency planning for more than a year and agreed that the Trust must start to think about post pandemic working. Of key importance will be to put staff first and support their health and wellbeing through the next few months while services are re-established. This can only be carried out sustainably if staff and colleagues are put first. Deputy Trust Chair, Richard Wright and Chair of the Finance and Performance Committee was aware of the contribution that staff have made and was pleased that support is being offered to them. He welcomed the opportunity to deliver improved services in collaboration with a number of other bodies with responsibilities for housing and education but was concerned that he had not heard much from local government and DCLoG (Department of Communities and Local Government) in their position as partners in the ICSs. Ifti assured him that there had been responses to the White Paper from local government that make their position clear. He considered that the work taking place through anchor institutions will

	deliver increased benefit for the population of Derbyshire regardless of what is happening at a national level but there are still lessons to be learnt about how the Trust can work across government departments. The focus will be on local relationships and shared objectives working together as a group to bring about real change. Discussions concluded that a Board Development Session will be arranged at a suitable time to focus on the White Paper relating to the future of health and care and how this links to the themes in the NHS Long Term Plan. **ACTION: White Paper relating to the future of health and care and how this links to the themes in the NHS Long Term Plan to feature in the 2021/22 Board Development programme** **RESOLVED: The Board of Directors scrutinised and discussed the report, noting the risks and supported the actions being taken.**
DHCFT 2021/026	**PERFORMANCE AND ACTIVITY REPORT** This report updated the Board of Directors on the key finance, performance and workforce measures. Mark Powell described how performance reflected the outstanding effort of colleagues in maintaining delivery of services during the lockdown period in January. The Trust is operating at a stable position and maintaining a good level of performance. Looking forward there are some considerations to take account of children returning to school. So far community paediatrics have shown lower than normal referrals but there is now an increase in the number of referrals which is expected to continue. Inpatient services continue to be faced with challenges around capacity because of COVID-19 social distancing restrictions. This has had an impact on bed availability and some patients have had to be placed out of area. There is internal work taking place in response to demand for services and to ensure teams are ready to respond. The Trust continues to provide good services but there are clearly some significant challenges that will arise due to a rise in demand and from a staff health and wellbeing perspective. Claire Wright took the Board through the Trust's financial position. The forecast outturn position shows a deficit of £0.9m. This includes an estimate for additional accrued annual leave. This is a national issue requested by NHS England and NHS Improvement NHS Improvement England (NHSIE) to be part of month 9 submissions. Funding for the cost of the additional annual leave provision and some other year end matters are still subject to national discussion and associated guidance has not yet been issued. The forecast outturn for the second part of the year is expected to be better than originally planned. The Trust's financial position forms part of the overall financial position of JUCD which continues to show a favourable variance compared to the original planned outturn. The system as a whole expects to be able to manage costs overall within the fixed income allocation with no material variance at year end. The COVID-19 pandemic has had an impact on the ability to deliver services. Overall, the year-to-date costs have exceeded the Trust's COVID-19 allocation for the year by £70k. Included within these costs are out of area adult placements, which continue to be required because not all Trust beds are available for use due to the need to maintain a COVID-19 secure socially distanced inpatient environment. With regard to capital, confirmation of funding for the COVID-19 laptops has been received. Claire and the Finance team have re-examined other expectations for capital spend to year end and are forecasting an underspend on capital plan by £1.4m as a Trust and £4.3m as a system. This has been agreed with regulators. Discussions continue with regard to the dormitory irradiation programme and Psychiatric Intensive Care (PICU) developments.

	In terms of quality, Carolyn Green reported that performance is reasonably stable. Autism diagnosis waiting times are well placed and the need for a commissioned autism treatment service has been covered earlier during the patient story as well as the need for increased physical healthcare checks across all pathways. Physical healthcare and psychological health and wellbeing are now combined and thanks were extended to John Sykes and Vicki Baxendale for the improvements that have been made with this work. Safety training uptake is being focused on as well as improved management of clinical supervision. Carolyn was pleased to report that staff have said they feel supported in this area but recording of supervision needs to be improved. Director of People and Inclusion, Jaki Lowe updated the Board on people performance. Substantial headway is being made on recruitment and turnover rates are looking positive. Medical appraisal rates have increased this month and there is a slight increase in other employee appraisal rates. A decision was made at the start of this year which was supported nationally to include health and wellbeing conversations within appraisals which will incorporate key questions and can be reported through appraisal completion. This stance will continue and is a testament to line managers and People Services keeping people safe. Training programmes now have increased capacity and focus on key priority areas. Progress is monitored closely against training recovery plans and sustainability. The expected outcome is to ensure compliance targets are reached by the end of March 2021. Non-Executive Director, Julia Tabreham was pleased to see that the funding for additional laptops had been approved and that physical healthcare assessments have been increased. She asked what needs were being identified through these physical healthcare assessments and asked for reassurance that these services can be improved. John Sykes advised that general trends in healthcare assessments are mainly concerned with medication and side effects of medication and cardiovascular factors in general and whether this can be covered by primary care. Annual healthcare checks conducted by primary care have yet to be stood up and staff are identifying the problems of individual patients so their health needs can be met. Geoff Lewins saw that care programme approach (CPA) reviews were showing a downward trajectory. Autism has been covered in the patient story and he asked what action is being taken to improve this service. Carolyn Green assured Geoff that performance and gaps in CPA is responded to by patient services. Clinical standards are in place and 95% is the target for CPA reviews. Performance currently stands at 92 – 95% and operational performance management is in place to maintain these standards and required improvement. Geoff understood that patients who are at more serious risk must be kept in close contact. He was assured patients in the community are regularly kept in contact to ensure they maintain good health. It is important for community teams to have team members return from redeployed areas so they can return to performing with normal capacity. With regard to autism this has been laboured in the last two patient stories to Board regarding the gaps in the service. This is also well articulated in the Board Assurance Framework (BAF) as a gap in commissioning which has not been able to move forward. This has been referred to the Mental Health, LD and Autism Delivery Board (MHLDADB) but confirmation has not yet been received about the areas that will be prioritised for future investment. Non-Executive Director, Ashiedu Joel saw that supervision levels have not improved and asked how inclusive practice and leadership can be improved across the Trust. Jaki Lowe responded that a significant amount of engagement has taken place with supervision but this is sometimes not recorded correctly. Colleagues are being encouraged to have conversations that strip away some of the barriers. She was pleased to assure Ashiedu that early indications of improvement will be seen in the results of the staff survey which will be reviewed at the next Board meeting. Mark suggested that it would be advisable to look at the policy for the management of supervision to ensure good management can be improved as a result of recent lessons learnt during the Trust's response to the pandemic.

	In terms of inclusive practice, the Trust is far more inclusive than it has been previously. The role of the Incident Management Team and line managers have a very clear line of action in supporting people. There have also been a number of live engagement events using MS Teams held with the leadership team which has been valued by colleagues. Incredibly positive feedback has also been received from staff during Staff Forums. Cultural inclusivity will continue to be a key part of the culture programme this year. In conclusion the Board reflected on how the pandemic is starting to show a significant impact on increasing waiting lists, particularly with autism. Ifti added that at the last MHLDADB a final paper was received from Derbyshire Community Health Services NHS Trust (DCHS) about creating a joint health autism spectrum disorder support service. This has now been approved and a further paper is expected at the next Delivery Board. **RESOLVED: The Board of Directors confirmed that limited assurance had been obtained from current performance across the areas presented.**
DHCFT 2021/027	**COVID-19 UPDATE** The Board considered the update on the response to the COVID-19 Pandemic outlining the Incident Management Team (IMT) structure and cell function. It aims to supplement the daily communications and podcasts that colleagues have received. The Board noted the good progress being made with the delivery and the roll out of the COVID-19 Vaccination programme and was pleased that COVID-19 related absence has thankfully started to fall during February. Significant assurance was received from the Trust's IMT's coordinated response to the outbreak of the COVID-19. **RESOLVED: The Board of Directors received significant assurance of a coordinated response to the COVID-19 incident.**
DHCFT 2021/028	**ANNUAL GENDER PAY GAP REPORT FOR APPROVAL** The Annual Gender Pay Gap (GPG) Report was presented for approval by Jaki Lowe. The report also included a summary of the Trust's position in the latest Gender Pay Gap Report. The Trust's latest GPG report shares information about the difference between pay levels for men and women. Results were strong against similar trusts last year, and Jaki was pleased to report that the GPG for this year has reduced in terms of the Trust's median pay gap since reporting commenced in 2017. The Trust is fully committed to inclusion and will continue to work across the workforce and network groups to ensure the organisation is a place of work where everyone feels they can engage, participate and grow. The effort made over the last twelve months to accommodate remote working will benefit gender equality for the workforce. The impact that the pandemic has had on women has been significant over the last year and a local recovery plan is being looked at to support women in their careers in Derbyshire. The Trust will be using International Women's Day and the month of March to relaunch work on gender equality and develop internal communications to help raise awareness and understanding around gender equality and positive action to be taken. Julia Tabreham saw from the data that women are not faring as much as she would like. John Sykes recalled how he had previously spoken about how a number of women would like to take on extended roles but find it difficult because of their family commitments. The clinical excellence awards system has come to an end and John is waiting to see what will replace this nationally. Margaret Gildea pointed out that influence and history that takes time to make change. She saw from the data that men are earning more than women in nursing and midwifery.

	The Board accepted the report with limited assurance due to the work that remains in progress and approved the GPG report prior to forwarding to the Government Office and publishing on the Trust's external website. **RESOLVED: The Board of Directors:** **1) Approved the GPG report prior to forwarding to the Government Office and publishing on the Trust's external website** **2) Received limited assurance on the work in progress.**
DHCFT 2021/029	**ASSURANCE ON ADOPTING A JUST CULTURE APPROACH WITHIN THE DISCIPLINARY POLICIES AND PROCESSES** This report comes after an in-depth assessment by the People and Culture Committee (PCC) of the Trust's disciplinary policy for staff that fall under Agenda for Change terms and conditions and the Medical Disciplinary Policy. One of the things that is being promoted nationally is what is called a Just Culture approach which is about supportive ways of dealing with issues. This report provided an oversight to assure the Board that PCC have reviewed this in detail and is satisfied that the correct disciplinary policies in place within the Trust. The Board was also assured that the report has been taken through the employee relations teams and every case over previous months has been looked at to ensure they are moving forward and people have the right support in place to take investigations through appropriately. Jaki also confirmed that colleagues within Staff Side are supportive of this new process and are keen to work with the Employee Relations Team to take this forward in a very supportive way. Julia Tabreham as Chair of PCC confirmed that members of the Committee were satisfied with the changes that will be taken forward and assured the Board that this will remain an area of focus. The Medical Disciplinary policy has been reviewed by the Medical Local Negotiating Committee and changes agreed to be implemented. This policy is in line with the MHPS (Maintaining High Professional Standards in the NHS). A Patient Safety Incidence Response Framework for the investigation of incident investigations which follows the principles of Just Culture. Medical Staff and senior leaders have been trained on the new framework which adopts a more people centric approach. All formal processes are overseen by the Employee Relations function to ensure that investigations and actions are appropriate and proportionate, and that staff have appropriate management and welfare support. Carolyn Green welcomed this review which has been triggered into a national review following the death of a nurse who took their own life while under an investigative process. The suicide of any health professional is tragic and the way any disciplinary action is sensitively handled is critical. It is important carry the Just Culture forward and focus on psychological help being available to health professionals. She was pleased that the Trust is taking a people first approach and that the Trust's networks and unions are in support of the improvements that have been made to the Trust's policies and processes and in taking action with any cumulative risk. John Sykes added that investment has been made in patient safety framework training with regard to Serious Incident (SI) investigations. All individuals involved have taken part in this training and it is considered to have been a good investment. The Board was assured that examination of the Trust's policies and processes has been undertaken in line with the example of good practice and shared learning guidance contained in the national review and that that this work will carry on through the Trust values. The policy will be launched through a series of masterclasses to support line managers to adopt the new policy and processes. **RESOLVED: The Board of Directors:** **1) Noted the assurance received by the People and Culture Committee** **2) Agreed that this will remain an area of focus of People and Culture Committee.**
DHCFT 2021/030	**LEARNING FROM DEATHS MORTALITY REPORT**

	The 'National Guidance on Learning from Deaths' requires each Trust to collect and publish specified information on a quarterly basis. This report presented by John Sykes covered the period 20 October 2020 to 19 January 2021. During the COVID-19 pandemic, the learning from deaths process continued to be undertaken but slight changes to the process were initially made to allow for colleagues to undertake other duties. Activity has now resumed back to normal with weekly case note reviews and the daily reviewing and grading of all new deaths taking place. All deaths directly relating to COVID-19 are reviewed through the Learning from Deaths procedure unless they also meet a Datix red flag, in which case they will be reviewed under the Untoward Incident Report Reporting Policy and Procedure. Discussion took place on the breakdown of characteristics the Board requested previously. It was felt that the report did not capture crucial data on sexual orientation or identity and this will be improved in subsequent reports. The report will also be improved to take account of primary care and physical healthcare and John undertook to discuss these improvements separately with Sheila Newport in her role as Lead Non-Executive Director for Mortality. Having discussed the data, the Board accepted the report and agreed for it to be published on the Trust's website. **ACTION: Mortality Report to be improved by Medical Director (MD) to take account of primary care and physical healthcare. MD to discuss these improvements with the Lead NED for Mortality** **RESOLVED: The Board of Directors 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.**
DHCFT 2021/031	**<u>BOARD ASSURANCE FRAMEWORK UPDATE 2020/21 ISSUE 4</u>** The Board considered the fourth issue of the BAF for 2020/21 presented for approval by Trust Secretary, Justine Fitzjohn. Key changes to the risk ratings included a reduction from extreme to high in financial risk 3a *"There is a risk that the Trust fails to deliver its revenue and capital financial plans".* This was following month 9 financial results and associated forecasting and discussions with system partners. This rating change will be kept under review and may need to be re-escalated depending on factors such as any further changes to NHSIE treatment of annual leave provisions or any other issues that may adversely impact current forecast assumptions. In January the Audit and Risk Committee conducted a deep dive of extreme rated risk 2a "*There is a risk that we do not create a healthy vibrant culture and conditions to make DHCFT a place where people want to work, thrive and to grow their careers".* The Committee challenged whether the rating should still be extreme based on the progress against actions but was mindful that a number of risk factors that are COVID-19 specific could undermine the progress being made on the people agenda and supported keeping this at the current extreme risk rating for the time being. Justine was pleased to report that significant assurance was received from the Trust's Internal Auditors, 360 Assurance, after completion of their audit on the Development of Risks on the BAF. Margaret Gildea as Chair of the Quality and Safeguarding Committee advised that the Committee had discussed whether risk 1a "*There is a risk that the Trust will fail to provide standards for safety and effectiveness as required by our patients and our Board"* should be raised from high to extreme given its concerns about a future surge in demand. After thorough debate taking into account the Trust wide position, the Committee decided that risk 1a is not of an extreme level and agreed to maintain the high level rating of the risk as

	services remain in continuous monitoring. Risk 1a will articulate how the national predicted surge in demand in mental health services amid the pandemic could worsen. Having reviewed the risk mitigations, the Board was satisfied with the key risks articulated in this version of the BAF and approved the fourth issue of the BAF for 2020/21. It was noted that this version of the BAF will be rolled over into 2021/22 as most risks are still current and will continue to be revised over the next financial year. **RESOLVED: The Board of Directors:** **1) Approved this fourth issue of the BAF for 2020/21 and the assurance the paper provides of the process of the review, scrutiny and update of the BAF in seeking to identify and mitigate risks to achieving the Trust's strategic objectives** **2) Agreed to continue to receive updates in line with the forward plan for the Board.**
DHCFT 2021/032	**<u>FREEDOM TO SPEAK UP GUARDIAN REPORT</u>** Freedom to Speak Up Guardian (FTSUG) Tamera Howard presented the half yearly report to the Board to ensure the Board is aware of Freedom to Speak Up (FTSU) cases within the Trust. Total case numbers seen in this report to Board (July to December 2020) are slightly lower than case numbers seen in the previous report to Board (January to June 2020). The report also covers trends within the organisation and actions being taken. The report showed patient safety concerns were fairly low and there has also been a 22% reduction in bullying and harassment which may reflect the reduced level of relational contact through staff redeployment and staff working from home. The percentage of BAME staff responding to the process has dropped but there has been an increase in anonymous reporting which could be as a result of the FTSU visibility via FOCUS the Trust's staff intranet. It was noted that it is quite challenging to record ethnicity of workers approaching the FTSUG as some staff choose not to disclose their ethnicity or they raise concerns anonymously. Ifti Majid credited the hard work of the FTSUG in maintaining visibility across the Trust and reminded the Board that this report should be regarded as an overarching suite of measures that are being raised. It is clear that the FTSUG is effectively working with the lead NED for BAME workers and the lead NED for speaking up. The Board expressed thanks to Tam for her work and fully supported the continued process for speaking up within the Trust. It was agreed that the Speak Up, Listen Up, Follow Up National Guardian's e-learning programme will be rolled out across the Trust at an appropriate time. **RESOLVED: The Board of Directors:** **1) Supported the current mechanisms and activities in place for raising awareness of the FTSU agenda** **2) Received significant assurance of the Freedom to Speak Up agenda within the Trust and that the proposals made by the Freedom to Speak Up Guardian promote a culture of open and honest communication to support staff to speak up** **3) Supported the roll out of the Speak Up, Listen Up, Follow Up National Guardian's e-learning programme across the Trust at an appropriate time.**
DHCFT 2021/033	**<u>CORPORATE GOVERNANCE UPDATE</u>** Justine Fitzjohn assured the Board on the continued robustness of the Trust's Corporate Governance processes during the response to the COVID-19 pandemic and gave an overview of some national governance guidance. The Trust has adapted its Corporate Governance processes to release capacity to manage the pandemic. The report outlined how the Trust had responded to the first 'Reducing the Burden' letter from NHSEI and how it will be responding to the second letter. The Board was assured that the Trust had continued to respond to best practice from various sources,

	including NHSEI, NHS Providers, the Good Governance Institute and the Healthcare Financial Management Association (HMFA). The productive working relationship with the Council of Governors has continued throughout the pandemic. No face to face meetings with governors has been held since March but meetings and briefings have continued virtually and governors continue to connect with their communities. The production of the 2020/21 Annual Report and Accounts is underway and is being overseen by the Audit and Risk Committee. The Trust will not be required to include a Quality Report within the 2020/21 Annual Report and Accounts. The Trust will be required to produce a separate Quality Account and guidance is awaited on the content, including the submission timeline. The Quality and Safeguarding Committee will carry out the required consultation in advance of the confirmed submission date The change of Senior Information Risk Owner (SIRO) was highlighted. With immediate effect Justine Fitzjohn, Trust Secretary will be the Trust's SIRO taking over from Claire Wright, Deputy Chief Executive and Director of Finance. It was noted that the Trust's Corporate Governance Framework is due for renewal every three years. In line with streamlined governance Audit and Risk Committee members approved some minor updates at their January meeting. The Board accordingly ratified the action of the Committee in relation to approving the framework. **RESOLVED: The Board of Directors** **1) Noted the summary contained within the Corporate Governance update and confirmed assurance that the Trust continues to have robust corporate governance processes in place** **2) Ratified the action of the Audit and Risk Committee in relation to approving the Corporate Governance Framework** **3) Noted the change in Senior Information Risk Owner (SIRO).**
DHCFT 2021/034	**<u>BOARD COMMITTEE ASSURANCE SUMMARIES</u>** The Board Committee Assurance Summaries demonstrated the work of the committees since their last update to the Board and were accepted as a clear representation of the priorities that were discussed and will be taken forward in forthcoming meetings. **Finance and Performance Committee:** Richard Wright reported that the Committee is effectively operating to ensure resources are used correctly and continues to monitor the significant investments made within the Trust. The programme to eradicate dormitories within the organisation and install a Psychiatric Intensive Care Unit is progressing and will be of great benefit to the Trust when complete. Reducing the BAF financial risk 3a "*There is a risk that the Trust fails to deliver its revenue and capital financial plans"* from extreme to high gives a higher degree of confidence in improving the Trust's financial position at year end. A deep dive of risk 3b "*There is a risk that learning from the response to the COVID-19 outbreak, and transformation plans developed prior, does not lead to sustainable embedded transformation"* was due to have taken place at the March meeting of the Committee. This has now been delayed to May after the peak of the pandemic to ensure further learning can be embedded within the Trust's processes and has been agreed with the Chair of the Audit and Risk Committee. The updated Treasury Management Policy was approved. The Committee also agreed that key issues relating to the Dormitory and Psychiatric Intensive Care Unit (PICU) development were relayed by the Chair of the Committee following the most recent project board meeting **Audit and Risk Committee:** Geoff Lewins referred to the deep dive of extreme rated BAF risk 2a "*There is a risk that we do not create a healthy vibrant culture and conditions to make*

	DHCFT a place where people want to work, thrive and grow their careers". Committee members challenged whether the risk rating should still be extreme based on the progress against actions. The reasons for keeping the risk at extreme was due to current volatility, with workforce being at the centre of the pandemic response and despite good progress, performance was still below target in some key areas. The Committee also discussed risk 1a "*There is a risk that the Trust will fail to provide standards for safety and effectiveness as required by our patients and our Board"* and asked the Quality and Safeguarding Committee to assess whether this risk was appropriately rated. As mentioned by Margaret Gildea earlier, this risk will remain rated as high. The Committee also received an update on the level of overpayments and the progress of actions. An Overpayment Improvement Action group, to be led by the Director of People and Inclusion has been formed for recovering the overpayment in a sensitive and people focussed way. **People and Culture Committee:** Julia Tabreham described how the Committee has recently been holding shortened and more focussed meetings to enhance the capacity of Executive Director members. Following review of the extreme rated risk 2a by the Audit and Risk Committee, the Committee was asked to consider if the narrative of risk 2a correctly and sensitively captured the priorities relating to the complex symptoms that some staff are experiencing while responding to COVID-19. While staff health and wellbeing could be considered one of the biggest risks in the organisation, the Trust now has wide ranging health and wellbeing support package in place. This offer is having a positive impact on staff turnover and absence and recruitment rates are now closer to target than they have ever been. Encouraging progress was identified from the performance indicators contained in the dashboard. The Committee agreed to support the cultural development programme and this will be the focus of the Committee's work throughout the year. The Committee also supported the new disciplinary procedures and Just Culture approach that the Board discussed today. **Quality and Safeguarding Committee:** Margaret Gildea outlined how significant assurance had been obtained from the vaccination plans within the Trust and from the continued co-ordinated response to the pandemic and she commended the exceptional work had been carried out to ensure the hub was up and running. As reported earlier the Committee debated whether the risk rating of risk 1a should be judged on current demands or the trajectory of psychological demand that is predicted to surge because of the increasing effect that COVID-19 is having on the population's mental health. Taking into account the Trust wide position, it was agreed that risk 1a is not of an extreme level and will remain rated high level as services remain in continuous monitoring. The Board was assured that all committees remain accountable within current constraints and that appropriate processes and controls are in place. It was accepted that the level of governance at Board Committees will continue to be reviewed in order to increase the capacity of Executive Directors and reduce the demands made on services. **RESOLVED: The Board of Directors noted the Board Assurance Summaries.**
DHCFT 2021/035	**<u>STANDING FINANCIAL INSTRUCTIONS UPDATE</u>** Claire Wright confirmed to the Board the current Standing Financial Instructions (SFIs) changes that accommodate the emergency decision-making powers of the Incident Management Team, as reported to Audit and Risk Committee in January 2021. Since the Board made alterations to some financial processes to remove routine burden on staff delivering the COVID-19 response in April 2020 it had been hoped some processes

	would revert back to the original SFIs at the end of September 2020. This has now been extended to the end of March 2021 due to the current situation of the pandemic. It was noted that following a review of the temporary SFIs by the Audit and Risk Committee other temporary changes have been implemented around the budget setting process for 2021/22 and recovery of over-payments. **RESOLVED: The Board of Directors noted and approved the updates to the SFIs reflecting the Emergency decision-making powers of the Incident Management Team.**
DHCFT 2021/036	**IDENTIFICATION OF ANY ISSUES ARISING FROM THE MEETING FOR INCLUSION OR UPDATING IN THE BOARD ASSURANCE FRAMEWORK (BAF)** No new items were required for inclusion in the Board Assurance Framework (BAF). Physical healthcare will continue to be included in the BAF for 2021/22. The Quality and Safeguarding Committee is to consider whether the headway made in physical healthcare can reduce the mitigation level to moderate. 75% completion in the community needs to be achieved for this risk to be fully mitigated.
DHCFT 2021/037	**2021/22 BOARD FORWARD PLAN** The 2021/22 forward plan outlining the programme for the remainder of the year was noted and will be reviewed further by all Board members throughout the financial year.
DHCFT 2021/038	**MEETING EFFECTIVENESS** Board members agreed that the meeting had been successfully conducted as a live streamed meeting held in the public domain. Appropriate items had been placed on the agenda. Vicki Baxendale thanked the Board for the opportunity to attend the meeting as this had built on her experience after attending the Quality and Safeguarding Committee. Lee Doyle echoed Vicki's comments and found the meeting insightful and very informative. Dr Mohan Rathnaiah thought discussions had been particularly open and honest and had been of value to him as a trainee doctor.
The next meeting to be held in public session will be held at 9.30am on 4 May 2021. Owing to the current coronavirus pandemic this meeting will be held digitally and will be live streamed via MS Live Events.	

				BOARD OF DIRECTORS (PUBLIC) ACTION MATRIX - MAY 2021			
Date	**Minute Ref**	**Item**	**Lead**	**Action**	**Completion Date**	**Current Position**	
1.9.2020	DHCFT2020/075	Integrated Performance Report	DPI	People and Culture Committee to seek assurance from action plans to improve safer staffing levels to meet the requirements of the Long Term Plan. The Committee is to also obtain assurance from staff turnover levels and how the Trust can attract more people to the organisation	~~2.3.2021~~ 4.5.2021	People and Culture Committee have this matter under close review. Safer staffing and future resources will be the focus of the April PCC meeting prior to a report being taken to the Board in May. Workforce Resources Delivery Plan received at Board 4 May 2021	Green
2.3.2021	DHCFT2021/025	CEO Report	Trust Secretary	White Paper relating to the future of health and care and how this links to the themes in the NHS Long Term Plan to feature in the 2021/22 Board Development programme	4.5.2021	Scheduled in 2021/22 Board Development Programme for June	Green
2.3.2021	DHCFT2021/030	Learning From Deaths Mortality Report	MD	Mortality Report to be improved by Medical Director (MD) to take account of primary care and physical healthcare. MD to discuss these improvements with the Lead NED for Mortality	4.5.2021	Improvements have been agreed for next version of the Mortality Report.	Green

Key:	**Resolved**		**GREEN**	**3**	**100%**
	Action Ongoing/Update Required		**AMBER**	**0**	**0%**
	Action Overdue		**RED**	**0**	**0%**
	Agenda item for future meeting		**YELLOW**	**1**	**0%**
				4	**100%**

Trust Chair's report to the Board of Directors

Purpose of Report

This report is intended to provide the Board with the Trust Chair's reflections on activity with and for the Trust since the previous Board meeting on 2 March 2021. The structure of this report reflects the role that I have as Trust Chair.

Our Trust and Staff

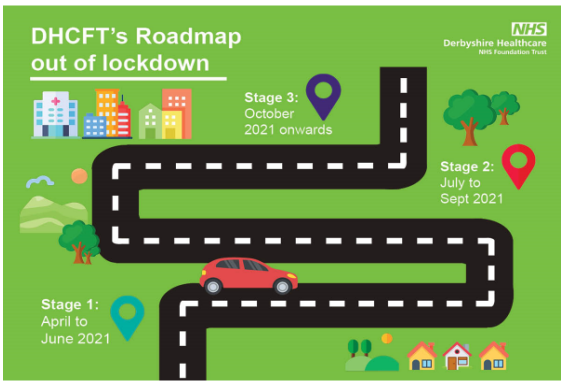
1. Given the on-going pandemic, I have agreed to discontinue my visits to teams across the Trust until such time as it is thought to be safe, both for staff and for myself, to visit. Virtual Non-Executive Director (NED) visits are set to commence by June 2021 having been paused during the latest wave of the pandemic. I am looking forward to reconnecting with staff, services and service users through this process.

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

3. On 7 April I had the privilege in taking part in the judging of the nominations for the Trust's HEARTS Awards. It was wonderful to see how many teams and staff members had been nominated for awards – and almost impossible at times to decide who was a worthy winner, as all had accomplished remarkable things. I look forward to the virtual awards ceremony which will take place in May.

4. I was pleased to hear how many of our staff had taken up the offer of a vaccination against COVID. My thanks go out to all who have been involved in this important process, and to all our staff for listening and taking well informed decisions. Whilst we know that it is likely that further boosters or annual vaccination programmes will be needed, this has been such an important step forward on the road to recovery.

5. At the beginning of April, we embarked on the Trust's RoadMap out of Lockdown. I welcome this as careful approach to recovery, with an emphasis in the first stage of building team resilience for all our staff. Thank you to all staff for your on-going commitment and dedication shown to the Trust and our service users over an extraordinary time. I know that we will all welcome a return to a more stable way of life but know that we will all need to work together to help this happen.



Council of Governors

6. We held a virtual joint Council of Governors meeting on 2 March 2021 following the public Board in the morning. We streamed this meeting for the public to watch. At this meeting I advised the Council of Governors that I would be standing down as Chair at the end of my term on 13 September 2021. The process led by the Governors to recruit my replacement has begun.

7. An extraordinary Council of Governors meeting was held on 1 April to approve an amendment to the Trust's public constituency boundaries and the related amendment to the Trust's Constitution.

8. The Council's Nominations and Remuneration Committee met on 18 March to receive the appraisals of myself and three NEDs (Margaret Gildea, Julia Tabreham and Richard Wright) and to discuss and agree the process for the recruitment of the new Chair of the Trust. The Committed met again on 21 April to receive the remaining NED appraisals (Sheila Newport, Geoff Lewins and Ashiedu Joel) and to continue planning the Chair recruitment.

9. The Governance Committee of the Council met on 1 April chaired by Julie Lowe. Once again it was heartening to see the level of attendance and participation from so many of our Governors at this meeting. I continue to be grateful to our Governors for their support for the Trust at this time.

10. Elections for new staff and public governors in several constituencies has begun. Nominations closed on 19 April, and election results will be announced at the end of May. I look forward to welcoming the new Governors to the Council from the beginning of June. Councillor Jim Perkins, our appointed Governor from Derbyshire County Council will not be standing at the County Council elections, and therefore will step down as a Governor. I wrote a letter of thanks to him for his four years of service as an appointed Governor. In due course I will advise you of a replacement for Jim on the Council.

11. I have had regular meetings with Lynda Langley as Lead Governor to ensure that we are open and transparent around the challenges and issues that the Trust was dealing with. 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 continued to work with other lead governors in the system over this period, helping to benchmark our processes for continued engagement with governors.

12. The next meeting of the Council of Governors will be on 4 May, following the Public Board meeting. An extraordinary Council meeting is expected to take place on 6 July to confirm the new Chair appointment. The next Council of Governors meeting will then be on 7 September. The next Governance Committee takes place on 15 June.

Board of Directors

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

14. In March I was pleased to support the recruitment process for our new Chief Operating Officer, and I am delighted that we will be welcoming Ade Odunlade on to the Board at the beginning of July.

15. On 6 April the Remuneration and Appointments Committee met to review the status of mandatory training for the Board and to review several year-end processes ahead of the publication of the Annual Report and Accounts.

16. On 6 April a confidential Board meeting was held to consider matters related to the development of our estate. An extraordinary Public Board meeting was also held on 6 April to approve an amendment to the Trust's public constituency boundaries and the related amendment to the Trust's Constitution.

17. The Non-Executive Directors (NEDs) have met regularly with Ifti Majid and me to ensure we have been fully briefed on developments as needed. I have also continued to meet with all NEDs individually and we have recommenced the informal NED meetings and Cross Committee Chair meeting which took place on 25 March. Since the last Board meeting appraisals have been carried out for Geoff Lewins, Sheila Newport and Ashiedu Joel.

System Collaboration and Working

18. Joined Up Care Derbyshire (JUCD) met on 18 March and 15 April using MS Teams. Attached as Appendix 1 and Appendix 2 are the key messages noted from this meeting. Regular monthly meetings are now in place for the Chairs of the NHS Provider Trusts, ICS and CCG to meet ahead of any JUCD Board meetings. Richard Wright deputised for me at the meetings for JUCD on 15 April. Apart from the formal meeting, there was a development session which was led by Ifti Majid around Derbyshire Anchor Institutions. This is important work and will be covered in the CEO report today.

19. I have agreed to chair the System Finance and Estates Committee with Richard Wright as my deputy. Richard has been chairing the System Finance group for about a year leading the thinking with the Directors of Finance and other NEDs on the challenge ahead on system finances. I have had several meetings with the Executive Directors in the system who lead on finance and estates to gain an understanding of the challenges and opportunities ahead.

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

21. I have also been joining the East Midlands Chairs Development network, which is sponsored by Prem Singh, Chair of Derbyshire Community Health Services NHS Foundation Trust and Councillor Sue Woolley, Chair of Lincolnshire Health and Wellbeing Board. The next meeting of this group will be on 27 May.

Regulators, NHS Providers and NHS Confederation and others

22. I attend fortnightly briefings from NHSE/I for the Midlands region, which has been essential to understand the progress of the management of the pandemic, the vaccination progress and plans for recovery and regional developments. It is also a forum to hear about progress from Midlands STAR (Strategic Transformation and Recovery) Board. These matters will be picked up within the Chief Executive's report to the Board.

23. I have also joined when possible the weekly calls established for chairs of mental health trusts hosted by the NHS Confederation Mental Health Network in collaboration with the Good Governance Institute where support and guidance on the Board through the pandemic has been a theme. A number of the NEDs have also attended weekly calls for NEDs on a range of useful topics.

24. On 16 March I attended a virtual Chief and Chairs meeting hosted by NHS Providers. We heard from Chris Hopson, CEO of NHS Providers, giving us a good perspective on the current situation and challenges ahead, as well as from Amanda Pritchard, COO of NHSE/I and Prerana Issar, Chief People Officer from NHSE/I. It is notable that there is an emphasis on allowing for recovery of staff ahead of recovery of services.

Strategic Considerations	
1) We will deliver **great care** by delivering compassionate, person-centred innovative and safe care	X
2) We will ensure that the Trust is a **great place to work** by 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. I have also continued to develop my own awareness and understanding of the inclusion challenges faced by many of our staff.

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

Demonstrating inclusive leadership at Board level

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

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

Recommendations

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

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

Appendix 1

Joined Up Care Derbyshire

Email: joinedupcarederbyhsire@nhs.net
www.joinedupcarederbyshire.co.uk

22 March 2021

Dear Colleague

Joined Up Care Derbyshire Board – March 2021 – Key Messages

The Joined Up Care Derbyshire Board met in public in Thursday 18th March 2021. We've outlined below the key messages from the meeting and all related papers are available at https://joinedupcarederbyshire.co.uk/about/our-board

Patient Story – Integrated Care
The Board received a patient story relating to joining up care in Chesterfield as part of the Ageing Well programme. The holistic model of care has been developed since 2017 through the place alliance, specifically supporting housebound patient across three cohorts:

- People requiring a same day response
- People living in care homes
- People living with moderate frailty as risk of deterioration (proactive care).

A multi-disciplinary team including Long Term Condition Nurses, a Community GP, social prescribers, pharmacists, ACPs and paramedics has developed the approach which pre-dates the NHS Long Term Plan. Through proactive care planning, the project has seen a reduced requirement for multiple clinician input, greater continuity of care and greater levels of assurance for both the patient and the family that they felt supported and listened to, as well as having confidence that they were talking to clinicians who immediately were familiar with the details of the care plan.

Learning from this and other programmes is shared through the Place Alliances Leadership meeting which takes place monthly, where approaches and barriers are discussed and able to be adopted where there may be benefit. It was agreed that we should consider how we might broaden this learning to include other partners and to capture more formally the good practice that Derbyshire is driving.

Vaccination Programme
The Board extended its thanks to everyone involved with the Covid-19 Vaccination Programme, including staff, volunteers and other partners who have worked tirelessly and brilliantly to deliver one of the most successful vaccination programmes in England.

Developing Our System
There has been significant progress in developing our system working at a time when there is such a focus on the pandemic. This was work in progress but has now been given increased focus through the recent publication of the Government White Paper on Health and Social Care.

Of note this month are:

- The progress in understanding how we accelerate provider collaboration at scale, working at system and pan system level to provide services for our patients, and at the same time building on significant progress in our place alliances by further developing collaboration at place for the benefit of local communities. Our existing eight place alliances will be known as
  'local place alliances' in the future, with two Place Partnerships - one for the City and one for the County – supporting.

- The development of our interim ICS governance arrangements, where the Board was updated on the iterative process being taken to quality, performance, finance and people assurance during this transition year, overseen by a new Transition Committee.
- The emergence of the Clinical and Professional Leadership Group will build on the existing Clinical and Professional Reference Group to lead the development and delivery of the clinical model across the system. The starting point is to build upon what works well now, what can be consolidated and what will need to change fundamentally considering other ICS developments. These developments are key dependencies in relation to the development of wider clinical and professional leadership and there is a need for stronger engagement and alignment across various programmes of work. This is a complex process with many unknowns at this time; genuinely building stronger collective clinical and professional leadership which is meaningful will take time to transition and embed.

People Plan

Our people plan continues to be guided by the three key assumptions that the health and social care system needs: • More staff

- Working differently
- In a culture that is more compassionate and inclusive

Progress has included:

- Consistent support to staff across the system during the pandemic, with primary care staff having access to the Thrive app, and resources available to all through the JUCD website.
- The recovery of our workforce given the importance of their health and wellbeing and the impact this has on our ability to deliver our restoration and recovery plans must be a key principle in our planning for 2021/22.
- We employed 100% of the suitable Bringing Back Staff returners that were available to our system, which provided resilience during times of system pressure.
- System partners have collaborated effectively to resource and deploy the staff required for the vaccination programme in a very challenging context.
- We have implemented a range of employment access schemes in support of the Anchor Institutions work. The second Step Into Work programme concluded on 29th January; nine from the total of twelve candidates who commenced the programme on 7th December successfully completed the accredited courses and gained both Level 1 and Level 2 qualifications.

Childhood Obesity Strategy

The Childhood Obesity Strategy was developed in response to persistent obesity rates in children in Derby and Derbyshire. Anecdotal evidence and emerging data suggests that rates of obesity in children have increased in the last 12 months, including an increase in those who are severely obese. Further data will be collected during 2021/22 which will enable a new baseline to be set and agreement of outcomes targets.

The strategy recommends that:

1. Derby and Derbyshire develop clear pathways and signposting to enable children who are already overweight or obese to access joined-up and long-term support. This includes

ensuring that there are robust systems in place to identify children who are overweight or obese and a commissioned service is available which provides effective support, in a multidisciplinary approach, to children and families.

2. Derby and Derbyshire develop preventative approaches for current and future generations and a whole systems approach to obesity which coordinates existing efforts, reveals gaps in provision and supports the efficient use of limited resources.

We look forward to seeing colleagues at the next Board Meeting to be held in public, on Thursday 20th May at 9am.

Yours faithfully,

John MacDonald
Independent Chair

Dr Chris Clayton
Executive Lead

Appendix 2

Joined Up Care Derbyshire

Email: joinedupcarederbyhsire@nhs.net
www.joinedupcarederbyshire.co.uk

16 April 2021

Dear Colleague

Joined Up Care Derbyshire Board – April 2021 – Key Messages

The Joined Up Care Derbyshire Board met in public in Thursday 15th April 2021. We have outlined below the key messages from the meeting and all related papers are available at https://joinedupcarederbyshire.co.uk/about/our-board

Linking with Health and Wellbeing Boards, towards a statutory Integrated Care System

The Board welcomed Cllr Carol Hart and Cllr Roy Webb as representatives of the aligned Derby and Derbyshire Health and Wellbeing Boards, to reflect the further collaboration on agendas between those Boards and the Integrated Care System, in line with the merging policy direction in the Health and Care Bill. Our development plan towards proposed statutory ICS status continues, reinforcing partnership working and understanding how the likely NHS ICS Board and Partnership Board will operate, and setting out a clear business plan and roadmap that the Board will follow to track progress. Works continues in earnest on the pillars of our development: the outline of our strategic intent; provider collaboration at scale; provider collaboration at place; and the JUCD role as an anchor institution.

Current System Position

Covid-19 cases continue to decline across Derby and Derbyshire. The number of daily GP appointments related to Covid-19 is currently at 72% of the peak volume seen in late April 2020, whilst the overall bed base occupied by confirmed COVID-19 patients is also improving. This stands at less than 2% across both Chesterfield Royal Hospital and University Hospitals of Derby and Burton, and 0% in Derbyshire Community Health Services and Derbyshire Healthcare). The Derbyshire system also continues to make good progress in delivering the rollout of the Covid-19 Vaccination Programme, with an average of 92% coverage for the over 60 year old age groups.

DERBYSHIRE County Council NHS Derby City Council

Whilst welcoming the further lifting of lockdown measures, the risk of a further wave and the impact of these changes will be monitored closely over the coming months. Staff welfare and staff absence levels remain concerning with 39% of hospital staff absences related to Covid-19. In addition, it is clear that the impact of the pandemic on the people of Derby and Derbyshire has been extensive and will continue to impact in future years, and we are working to understand how we can quantify this and plan for the recovery of waiting lists for operations and other services.

Understanding our priorities and finances

The planning guidance for 2021/22 was published in March and sets out the requirements of systems over the coming year, identifying the following key areas of focus for the first half of 2021/22:

- Supporting the health and wellbeing of staff and taking action on recruitment and retention
- Delivering the NHS COVID vaccination programme and continuing to meet the needs of patients with COVID-19
- Building on what we have learned during the pandemic to transform the delivery of services, accelerate the restoration of elective and cancer care and manage the increasing demand on mental health services
- Expanding primary care capacity to improve access, local health outcomes and address health inequalities
- Transforming community and urgent and emergency care to prevent inappropriate attendance at emergency departments (ED), improve timely admission to hospital for ED patients and reduce length of stay
- Working collaboratively across systems to deliver on these priorities

Important to our planning is creating a common understanding of the system financial position, given that we know there continues to be a significant underlying system financial pressure. The first six months of the year will operate under the existing pandemic funding regime, where costs pressures have been absorbed in support of delivering a pandemic response. From October, we will likely revert to traditional financial management and must understand where the system will stand financially at that time, and what we need to do about it in line with our transformation programme. Partners were clear that there must be a collective understanding of the root of the underlying financial challenge, and that it is a symptom of a broader issue and not the problem itself. The need to recover services whilst at the same time supporting staff who have worked tirelessly to tackle the pandemic for more than a year must be the context in which we understand how we balance the books.

Broadening the input of Governors

Our foundation trust governors have a very important role in holding Boards to account. The Derbyshire system recognises that the skills and knowledge of our governors can support the development of our transformation programme, especially in our communities at Place level. Discussion on this important step will continue with Governors to ensure that their primary assurance role is not compromised, and that Governors are supported appropriately to get involved where desired.

We look forward to seeing colleagues at the next Board Meeting held in public, on Thursday 20th May at 9am.

Yours faithfully,

John MacDonald

Independent Chair

Dr Chris Clayton

Executive Lead

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 4 May 2021

Chief Executive's Report to the 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. Colleagues will be aware that on 25 March 2021 NHS England and Improvement (NHSE/I) published the priorities and operational planning guidance for 2021/22. This overarching document sets out six priorities for the year ahead and asks systems to develop fully triangulated plans across activity, workforce and money for the next six months. These arrangements are supported by an additional £8.1bn of funding to reflect the ongoing impact of COVID-19.

   Those key six priority areas also include a range of sub requirements that are summarised below:

   - *Supporting the health and wellbeing of staff, and taking action on recruitment and retention*
     - This section talks about how colleagues should be supported to take leave, enabled to have health and wellbeing conversations and to be able to access appropriate support.
     - In addition, it talks about the use of e-rostering and supporting increased flexibility of staff with remote working plans and technology enhanced learning.
     - Enhancing clinical placements for students to ensure they qualify as planned.

   - *Delivering the NHS COVID vaccination programme and continuing to meet the needs of patients with COVID-19*
     - The need to respond to emerging Joint Committee on Vaccination and Immunisation (JCVI) requirements on continued vaccination and top up vaccination programmes.
     - NHSI/E undertaking a stocktake of critical care capacity.
     - Enhancement of COVID virtual ward concept.

- *Building on what we have learned during the pandemic to transform the delivery of services, accelerate the restoration of elective and cancer care, and manage the increasing demand on mental health services*. For our services, extra key points include:
    - Increasing children and young people's access to NHS-funded community mental health services.
    - Delivering physical health checks for people with Serious Mental Illness (SMI), particularly given that the Quality Outcomes Framework (QOF) indicators have changed.
    - Delivering the scale of workforce growth needed to meet the Long Term Plan (LTP) ambitions.
    - Investing fully in community mental health (funding will be provided to create new integrated models for SMI, Service Development Fund (SDF) funding, which will allow the expansion of services, and co-funding requirements across the NHS contract and GP contract will deliver additional Primary Care Network (PCN) posts. New metrics will also be introduced assessing people who access community mental health services).
    - Improving equalities across all programmes, noting actions and resources identified in the Advancing Mental Health Equalities Strategy.
    - Providers are also encouraged to advance the beneficial changes made throughout the pandemic, including (where clinically appropriate) 24/7 open access, staff wellbeing hubs, and crisis lines.
    - Reducing reliance on inpatient care for adults and children with learning disability, autism or both, supported by improved community capacity to expand personalised care, closer to home.
    - Improving accuracy of GP learning disability registers (with a particular focus on ensuring under-represented groups are recorded).
    - Continuing pilots and early adopter sites for keyworkers for children and young people with most complex needs.
    - Implementing the actions coming out of the Learning Disability Mortality (death) Review (LeDeR).
    - Programme to tackle inequalities.

- *Expanding primary care capacity to improve access, local health outcomes and address health inequalities*
    - Restoring and increasing access to primary care services.
    - Implementing health population management and personalised care approaches to improve health outcomes and address health inequalities.
    - Transforming community services and avoiding unnecessary hospital admissions and improving flow, in particular on the emergency pathway.

- *Transforming community and urgent and emergency care to prevent inappropriate attendance at emergency departments (ED), improve timely admission to hospital for ED patients and reduce length of stay*

- Every system is asked to set out plans to accelerate the roll out of the two-hour crisis community health response at home to provide consistent national cover (8am to 8pm, seven days per week) by April 2022.
- Continue with work underway to ensure the use of NHS 111 as the primary route to access urgent care and the timely admission of patients to hospital who require it from emergency departments (EDs).

- *Working collaboratively across systems to deliver on these priorities.*
  - Integrated Care Systems (ICSs) will be asked to confirm, by the end of Q1, delivery and governance arrangements to support delivery of the 2021/22 priorities. These must be set out in a memorandum of understanding (MoU), agreed with NHSE/I regional teams, and in line with the proposed new NHS system oversight framework. MoUs should also set out the oversight mechanisms and structures that reflect those delivery and governance arrangements, including the respective roles of the ICS and NHSE/I regional team.
  - Develop local priorities that reflect local circumstances and health inequalities.
  - Develop the underpinning digital and data capability to support population-based approaches.
  - Develop ICSs as organisations to meet the expectations set out in integrating care.
  - Implement ICS-level financial arrangements.

My sense is that this is a challenging and complex set of requirements that is clearly rooted in the ongoing delivery of the Long Term Plan and the more recent developments around Integrated Care Systems. It is really welcomed to see the focus on staff wellbeing, staff support and reducing health inequalities through engaging with both colleagues and local communities.

This is an exciting time for our services, all of whom are recognised in the planning guidance, with some real clarity around expectations.

The timescales are challenging as ever, the finance submission is due on 6 May and that is also the draft narrative plan and mental health workforce numerical submission deadline. Final plan submission is 3 June 2021.

Local Context

2. The Joined Up Care Derbyshire (JUCD) Board met formally in March and April as well as a development session in April. Some of the key areas being discussed included:

   - A patient story as part of the aging well programme that gave specific examples of how an integrated care approach really supported better patient outcomes.
   - How well the vaccination programme had gone in Derbyshire. The Board wanted us to thank all colleagues who had been involved – this of course applies to all our colleagues who have worked so hard in our Hospital Hub.

- Confirmation that going forward we would have two Places in Derbyshire, one City and one County, and our current eight Place Alliances would be known as local Place Alliances.
- A detailed conversation about our ICS People Strategy and some of the successes we had during the pandemic.
- We received the Childhood Obesity Strategy.
- The April Board was the first where we had representatives from the aligned Derby and Derbyshire Health and Wellbeing Board present. This is an important development as we start to think through how the NHS ICS Board and the ICS Partnership Board will work.
- We discussed the planning guidelines I mentioned above and the focus for the first six months of the year.
- I was particularly pleased that we had a conversation about the future role of Governors, their continued statutory role, but also the opportunity in Place Alliances and specialist provider alliances.

3. As a Derbyshire system we had our first experience of a Care Quality Commission (CQC) Provider Collaboration Review (PCR). The Focus of the review was on the provision of services for people who live with a learning disability in the community and consider how providers are working together to ensure the provision of learning disability services in light of COVID-19. Specifically, the aim of the PCR was to support providers across systems by sharing learning around the positive impact of partnership efforts, resulting in improved experiences and outcomes for those who have used services during the pandemic.

   During the review the CQC interviewed a range of providers from different parts of Derbyshire to inform their findings. They also interviewed representatives of people who use services. It was a different experience as not all providers and senior clinicians/managers were interviewed, just a cross section. The organisation, Choice Support, also conducted a range of interviews with people using learning disability services to listen to their experiences.

   The CQC looked at collaborative provision across systems, including access and flow, ensuring people using services received high quality safe care. This included the impact of new models we had in place. The review also included a focus on inequalities, particularly the impact on black and minority ethnic groups.

   A range of patient journeys were selected and followed through, with members of the care team, the individuals themselves, and their families being spoken to.

   We have had no requests for more information since the review finished. I would like to extend my thanks to all colleagues, both in our organisation and in the wider system, for their help and support with this process – it was new and challenging to co-ordinate being the first review across the system in this way.

   We understand that we will get some feedback and the published report will combine all seven Learning Disability PCR Reviews and will be anonymous. I am hoping to get some feedback around 17 May.

4. On 15 April I presented to JUCD Board the work I have led with Andy Smith from Derby City Council on Anchor Organisations. The first workshop was held on 26 February and was attended by colleagues representing:

    - JUCD Health Organisations
    - Derby City Council
    - Derbyshire County Council
    - University of Derby
    - Derby County Football Club
    - Rolls Royce

    The outcomes from the first meeting included:

    - An Anchor Executive Group will be formed, which in the first instance will be made up of those senior leaders who attended the workshop. Membership will be iterative and dynamic, meaning that it might change as work and understanding develops – for example, as work progresses it will be important to consider and agree where the Voluntary and Community Sector (VCS) fit in the system and establish clear links.
    - Based on the discussion and the initial high level data considered, the initial strategic focus or 'ask' will be in the area of workforce and employability. This is because of the significant impact arising from COVID on communities across Derbyshire in this area and the impact employment has on the health and wellbeing of communities. This means there will be a priority to spend in communities to support local businesses, employ local people and promote the consideration of social value into purchasing decisions, including the use of local suppliers wherever possible - putting Derbyshire first and keeping it local.
    - Each Anchor organisation will undertake a 'stocktake' on what is currently done in the area of employability and workforce; this will provide an overview of good practice, opportunities for sharing and/or scalability, system gaps and may also provide a pathway for involvement from the VCS. To ensure consistency in approach a template will be created and distributed.
    - I wanted to update the Board following the two recent patient stories we have had that spoke about the lack of an autism treatment service within Derbyshire. I am delighted to inform the Board that the Mental Health, Learning Disability and Autism Board has supported a proposal to implement a three tiered model for an autism support service, which will provide a crisis and hospital avoidance service, a multi-agency community support offer and an enhanced voluntary and community sector offer. We are anticipating the support service to be operational in part from August and the thing that I think is so positive is that this model not only addresses people's needs when in crisis, but takes a longer-term view of developing individual and community resilience.
    - Further data across Derby and Derbyshire in the area of workforce and employability (building on the high level data shared in the meeting) will be captured to inform future discussions. The city and county councils will take the lead in gathering this via their policy teams.

- There was a collective view that the system would benefit from the development of an 'Anchor Charter' as a way of securing commitment from individual organisations and provide a framework to make (the agreed) changes to benefit communities across the city and county. This will also include a communication strand, given the importance of this work across the system.
- There was recognition that the work of this group needed to link formally with JUCD and the two Health and Wellbeing Boards.

The initial draft Anchor Charter can be seen in appendix 2.

Within our Trust

5. I am delighted to share that we have appointed Ade Odunlade as our new Chief Operating Officer and that we look forward to welcoming Ade to Derbyshire Healthcare on 5 July.

   Ade joins us from Central and North West London NHS Foundation Trust, where he is currently the Managing Director of one of the Trust's three divisions. Ade leads a large service providing mental health, learning disability and perinatal services across a number of London Boroughs.

   Ade was also formerly the Associate Director of Operations for Coventry and Warwickshire Partnership NHS Trust. He has a wealth of operational experience across the NHS and within private healthcare.

   A Registered Mental Nurse by background, Ade has worked on acute inpatient wards, in community liaison teams, within a young offenders' institution and is a trained therapist. There will be a number of opportunities for colleagues to meet Ade before he formally starts in post and I will share these with you when they have been arranged.

6. Congratulations to all teams and colleagues who were nominated for a DEED award during 2020. This was undoubtedly one of the most difficult years the Trust has ever faced and the number of examples of colleagues going above and beyond the requirements of their role to support patients, their families and wider colleagues, has truly been amazing.

   Because these nominations are so impressive, they have formed the basis of our forthcoming Team Derbyshire Healthcare HEARTS Awards - alongside additional nominations that were made for our COVID Hero of the Year.

   The nominations were split across a range of different award categories with a panel having the incredibly difficult job of choosing a winner for each category.

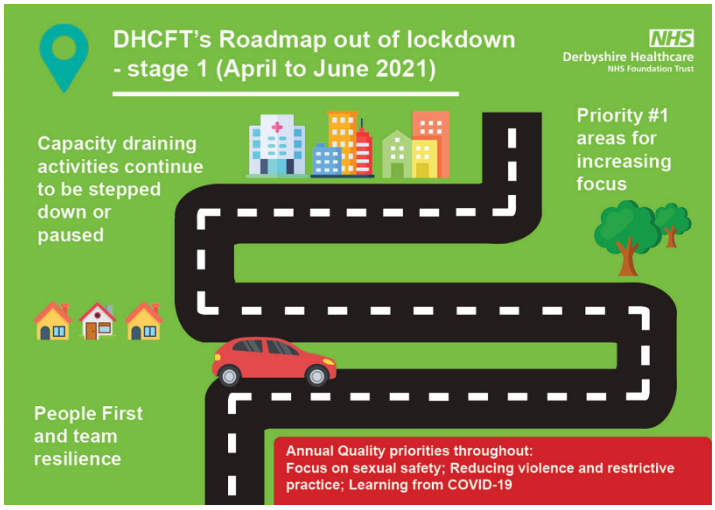
   This unenviable task was given to our awards panel, which included myself, Caroline Maley - Trust Chair, Bal Singh – Service Lead Breakout YP Substance Misuse Service, Becki Priest - Deputy Director of Practice and Transformation and Emily Elson - who has lived experience of our services.

   I must say that there was a very high standard of all the nominations and I wanted to share my congratulations to everyone who was shortlisted!

Our HEARTS finalists have now been selected and will be invited to attend a virtual awards ceremony on 26 May.

7. The COVID response continues in our Trust as we see transmission rates reducing across all our local communities in Derbyshire. We continue to have no positive patients being cared for in our inpatient wards (at the time of report submission) and very low numbers of staff away from work due to COVID related reasons. I am sure the Board will join me in thanking all our colleagues for the part they are all playing in keeping both patient and colleague levels so low. Something I regularly say on live engagement hours is that this doesn't happen by chance, it is good infection prevention and control measures that keep us in the unenviable position we are in.

   We have started to turn our attention to the next three and six months in terms of how we move forward and have developed a Road Map.



   The Road Map focusses on three time periods, the next three months, three to six months and then six months onwards. Its aim is to provide clarity to colleagues about our priorities during each time period, the things we agree should remain paused and which activities should be recommenced. The first three month period is very much a continuation of our 'people first' approach with a focus on enabling colleagues to take a rest period, to catch up with restorative activities, such as supervision and personal development, enabling teams to safely come together and based on learnings over the last year, agree our working pattern operating model and our clinical contact operating model.

8. On 22 April we held a landmark Staff Forum. At the Forum we discussed some core business including the Trust's Road Map mentioned above, how we can support our 'middle mangers' and the recent staff survey results. I always find that colleagues in our Staff Forum get the balance absolutely right between support, encouragement and challenge and the conversation is always people first in its nature and tone. This leads me to the landmark component. This meeting was the day we moved from an external facilitation and at this point I would like to formally note my thanks to Leslie Purcell, who has chaired the meeting from its inception, to the meeting being chaired by members of the group. I believe this shift in arrangements for chairing the meeting really demonstrates how very far the meeting has come over the years it has been meeting. My thanks and congratulations to everybody involved.

9. On 19 April I received a letter from the Clinical Research Network for the East Midlands thanking me for our contribution to research during this difficult time. Rather than share the whole letter, I wanted to share two sections that were more specific to our Trust:

   "As we enter the second year of the COVID-19 pandemic, we wanted to write to you to convey our thanks for the enormous effort and support that has gone into delivery research at your Trust during this time"

   "We also want to note the excellent research recruitment levels locally. Derbyshire Healthcare NHS Foundation Trust currently has the second highest recruitment amongst all NHS trusts in the mental health/community sector, which is testament to the hard work that has gone into continuing to deliver research throughout the pandemic"

   This is great recognition for a Trust our size and on behalf of the Board I would like to thank Head of Research and Development, Rubina Reza and her colleagues in our Research Department for their continued hard work and energy, both within our Trust, but in the wider health community too.

10. Board colleagues will recall that, before the second COVID wave in autumn, we updated the Trust Strategy. In particular we reviewed our 'Building Blocks', which are the key areas where we recognise we need to deliver improvement actions to achieve our strategic objectives, and therefore our vision. Much has changed since then in the environment we are working in; however the Vision, values, strategic objectives and building blocks remain as relevant today as when we signed them off last year. As an Executive Team we have however reviewed what we consider to be the priority actions under each building block – those things that if we deliver, we make a significant improvement in the building block and therefore the strategic objective that it supports.

    Appendix 1 gives a reminder to Board colleagues of the revised building blocks and now includes the priority actions against each building block.

11. Over the last two months we have held 'Live' Divisional Engagement Events, chaired by myself, with the aim of offering colleagues the chance to tell us as a senior leadership team how they are finding working in the Trust at present, along with an opportunity to ask questions, make suggestions and share innovations. I have been pleased to welcome Non-Executive Directors to these sessions as well. We have held the following events:

- Older Adults Community Services
- Specialist Services
- Adult Acute Services
- Corporate Services
- Forensic and Rehabilitation Services
- Adult Community Services
- All staff Event

These events have been very well attended, helped using a virtual format on Microsoft Teams. Whilst the topics discussed have varied to some degree, depending on the group, there have been common themes, some of which include:

- The Trust Roadmap and it was great to use these events to discuss the key areas and get feedback and ideas from colleagues
- Annual leave and the need to support colleagues getting a break
- Revising the process around health risk assessments
- The importance of teams and support from our teams we work with
- New investments
- Vaccinations and keeping ourselves safe

In addition, I am delighted to tell the Board I have started to visit services again in a COVID secure way and so far I have been along to:

- Cubley Court
- Bay Health House
- Hartington Unit

It has been fantastic to safely meet colleagues, see first-hand some of the innovation colleagues have been developing and deploying, both during our COVID response, and before. It was so great to hear about and see things like community Clozapine clinics and support for people with complex delirium. The other thing I was really impressed with was compliance with infection prevention and control measures, particularly on the Radbourne Unit and Cubley Court, as our inpatient services.

The feedback from these events has featured in our lessons learnt process and in turn fed into our strategy review. We will be continuing with this approach to engaging with colleagues, along with our new monthly ‘all staff team briefing session’.

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

Assurances

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

Consultation

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

Governance or Legal Issues

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

Public Sector Equality Duty & 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.

Our Trust Road Map focusses on colleagues and how we support and increase personal resilience; this is in line with the national people plan, but more importantly, it is about recognising the personal impact the last year has had on colleagues.

The use of technology to engage colleagues really demonstrates best practice in enabling us to hear more voices from colleagues, wherever they are working; this is a positively inclusive approach to learning.

During these two months colleagues from our Workforce Race Equality Group have continued to meet weekly with members of the Executive team in attendance. This is the group that has been very influential in helping develop our vaccination campaign.

Our live engagement events continue to provide a helpful vehicle for speaking up and it was great to see so much information shared through our social media outlets, in particular the staff Facebook page.

Recommendations

The Board of Directors is requested to:

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

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

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

NHS
Derbyshire Healthcare
NHS Foundation Trust

Refreshed Trust Strategy
April 2021

Our Approach

Trust Vision

4 Trust Values

3 Strategic Objectives

Building Blocks

Priority Actions

Our vision

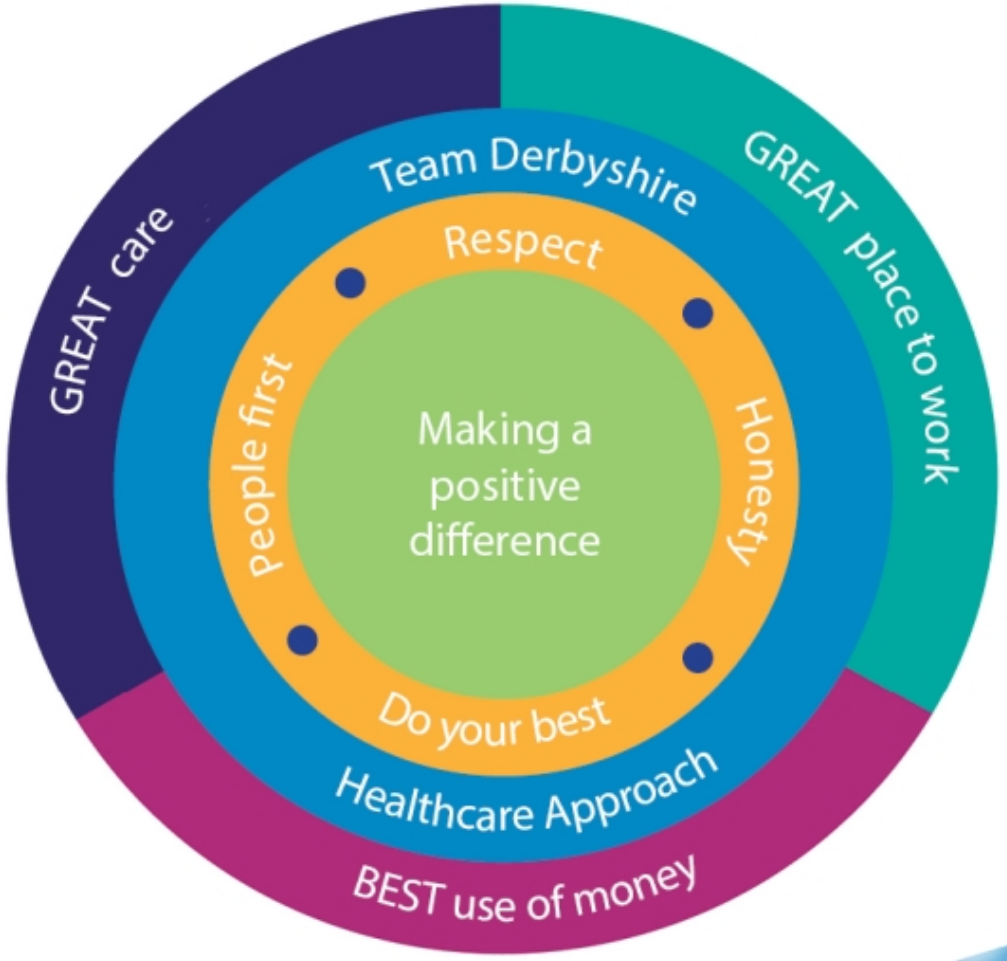
“ To make a positive difference in people’s lives by improving health and wellbeing”

Our Trust 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 Golden Circle



Making a positive difference

The building blocks to...

Making a positive difference

NHS Derbyshire Healthcare NHS Foundation Trust

GREAT place to work ● GREAT care ● Best use of money

Great Care Priority Actions #1

Improve our Estate (CW)		RM Action
Develop and deliver dormitory eradication programme of work	CW	Q1
Deliver a PICU in Derbyshire	CW	Q1
Maintain COVID secure workplace requirements ensuring colleagues feel safe. Review the key actions in the estate strategy building on learning from COVID response.	CW	Q1 Q3
Prioritise the backlog maintenance programme for years 2021/22 and 2022/23	CW	Q3

Embrace new Technology		RM Action
Maintain current use of Teams for both meetings and to optimise engagement	GH	Q1
Implement OnEPR programme including Electronic prescribing	GH	Q2 Q3
Ensure new build plans optimise use of “green” technology and optimise technological solutions in care delivery	GH	Q1

Improve Services for those most at risk of inequality (LD/AO)		RM Action
Develop a risk stratified waiting list reduction programme based on whole person need selecting a number of areas of focus ie Eating disorder, SMI	JS	Q2
Utilise MHIS and transformational monies to disproportionately invest in service provision in areas with greatest health inequalities. Start this in the CMHT framework work programme	LD/ GH	Q1

Great Care Priority Actions #2

Improve Psychological and Physical Safety (JS)		RM Action
Roll out Patient Safety Incident Response Framework (PSIRF) • Patient involvement in Patient Safety • Safety Partners to be trained by April 2022Patient Safety Syllabus April 2021	JS	Q1 Q3 Q3
Ensuring sexual safety for our people – implement the improvement plan	CG	Q1
Physical Health Care Establish the health Protection Unit	CG	 Q1
Reducing violence for our people – implementing the agreed improvement plan	CG	Q2

Enhance learning and innovation (CG)		RM Action
Explore opportunities to embed a learning culture- lessons learned approach to COVID and learning from our best practices (lessons learnt document)	CG/LD	Q1
Explore opportunities to trial simulation in practice	CG	Q3
Embed EQUAL learning and co-production across the Trust identifying initial priority areas eg Dorms	CG	Q1
Restore mandatory training to required level of compliance (initial focus on ILS/BLS/PSTS)	JL/LD	Q1
Review learning from COVID to support development of new clinical model for delivery reviewing ways of engaging with people who use our service (f2f/digital and choice) – framework agreed that ensures our use of technology doesn't exclude	JS/LD/CG	Q1
Review clinical and operational governance to ensure lessons are learnt from the COVID period, emerging best practice and that decision making forums are inclusive	JF/CW	Q1

Quality Priority

Great Place to Work Priority Actions

An inclusive Vibrant Culture for All (JL)		RM Action
Implement Cultural Intelligence starting with the Board and cascading through all leadership teams	JL	Q2
Pilot inclusive recruitment programme to support reviewing recruitment processes – linked to system	JL	Q1
Increase representation of BME staff in Band 6 and above roles Phase 1 Recruitment Inclusion Guardian (RIG) Phase 2 Introduction of Inclusion Guardian role Phase 3 Training for all colleagues	JL	 Q1 Q3 Q1

A Healthy Place to Work and Thrive (JL)		RM Action
Create a framework for recovery and renewal of our people and teams focus on the model for working in first instance – framework for working patterns agreed)	JL/LD	Q1
Support Teams to come together for specific team development to reconnect in a safe COVID secure way	JL/LD	Q1
Create and implement a framework for Healthy Teams	JL	Q3

People First Leadership (JL)		RM Action
Understand the many cultures across our organisation and collaboratively develop further our people first culture.	JL	Q3
Review and align people structures, systems, processes and delivery to our people first culture and our respect value. (product new policies)	JL	Q3
Review or development and training offer to align with our people first culture and respect value.	JL	Q3
Enhance visibility of Board and senior leaders as part of 'reconnecting (structure of Team visits live and virtual)	Board	Q1

A place where people are proud to work and grow (JL)		RM Action
Develop workforce plans that ensure we maximise skills and contribution of all staff	JL/GH	Q3
Implement an integrated success planning and talent management process	JL	Q3
Review our integrated people dashboards to ensure we provide information to all levels of the Organisation to support good decision making	JL	Q3
Reviewing the Trust recruitment process to ensure vacancies are filled as quickly as possible (revised process)	JL	Q1

Best Use of Money Priority Actions

Best Value (CW)		RM Action
Monitor the benefits realisation of new investment projects	**GH/CW**	**Q1**
Successful delivery of (business as usual) capital expenditure and revenue plans, working within JUCD system	**CW**	**Q1**
Delivery of efficiency requirements, working within JUCD system) Preparation Delivery	**GH**	 **Q1** **Q3**

Purposeful Partnerships (GH)		RM Action
Active participation in Wave 1 NCMs and Provider Collaboratives, building the future role of the East Midlands MH, LD&A Alliance .	**GH**	**Q1**
Prepare for Wave 2 NCMs and DHCFT role as lead provider for Perinatal Services	**GH**	**Q3**
Support our Teams to deliver NHS Long-term Plan objectives	**GH**	**Q1**

Sustainable Transformation (GH)		RM Action
Ensure planned benefits of OnEPR project are fully realised	**GH**	**Q4**
Refresh Trust Quality Improvement Strategy and deliver objectives which includes the design of a methodology for teams to flourish. This will include a framework for monitoring and evaluating impact	**GH/JL**	**Q2**
Ensure pipeline of projects and continuous improvement programmes deliver a future pipeline of efficiencies and reductions in the cost of providing services.	**GH/AO /LD**	**Q2**

Putting Derby/Derbyshire First & Keeping it Local

Draft Anchor Charter

We are **Anchor Institutions** because we are rooted in Derbyshire by our vision, histories, land, assets, and vitally our established local relationships. As a group of Anchor Institutions, we have a significant responsibility to enable and facilitate **Community Wealth Building**. This means we use the economic levers available to us to develop resilient, inclusive local economies within Derbyshire with more local spend and fair employment, as well as a larger and more diverse business base, ensuring that wealth is more locally owned and benefits the residents of Derbyshire.

Derbyshire Anchor Charter Mission Statement

To commit to long-term collaboration between Derbyshire Anchor Institutions, supporting shared Community Wealth Building goals to improve collective wellbeing and create a strong, resilient and inclusive Derbyshire economy.

We recognise as Anchor Institutions in Derbyshire we can have an impact in 5 key areas workforce/access to work, procurement, partnering in place, buildings and the environment.

Keeping it local – Our Charter:

As Derbyshire's Anchor Organisations we agree

- We will recognise our role in being a local anchor and commit to working with partners in the Anchor Executive to maximise the collective influence we have in addressing socio-economic and environmental determinants.
- We will embed this anchor Charter into our ethos through our organisational vision, values, culture, communications, behaviours, leadership, corporate planning and budgeting, we will seek to support inclusive, sustainable growth and the people and communities we are anchored within.

- We will listen to our communities to ensure that our mission addresses what matters most to them and work with them through our partnerships to make sure our influence supports positive change.
- We will work together through the Derby and Derbyshire Health and Wellbeing Boards and the Joined-Up Care Derbyshire ICS Board to seek and agree best practice, to measure impact and hold each other to account. We will share best practice and learning as an active Anchor Executive within the system and with wider partners.

As a Derbyshire Anchor Executive, we have agreed to initially focus our combined influence and actions on the following two impact areas:

Workforce and Access to Work ✓

Partnering in Place, Neighbourhoods and local communities

Procurement ✓

Buildings

The Environment

As members of Derbyshire's Anchor Executive, we recognise and will focus on the following areas of opportunity relating to the 2 initial impact areas:

Areas of Opportunity - Workforce & Access to Work

- **Recruitment**
  - We actively will address local employment issues by ensuring we are as open and accessible as possible in our recruitment processes and that we ensure our communities understand how we recruit and the opportunities that we have.
  - We will focus on supporting and increasing local employment opportunities to residents, actively targeting recruitment from within our most deprived communities. We will focus on providing more opportunities for inclusive employment, addressing both geographical areas and encouraging people who are furthest from employment, including residents with a mental health issue, learning, physical or sensory disability or who are care givers through focused outreach programmes to consider roles within health, care and our partner organisations.
- **Training, development and progression**
  - We will help and encourage local people to work within our Anchor Partners by ensuring that they are aware of the varied employment and careers we can offer. This will include delivering a targeted schools engagement programme, promoting apprenticeships and career programmes linking to Job Centre Plus, Further Education, local Adult Learning institutions and university partners. We will commit to supporting lower paid staff to reach their potential via inclusive personal and professional development, flexible working, transparent progression pathways and excellent management and mentorship.
- **Healthy Workplaces**
  - We will ensure all Derbyshire Anchor Executive Partner Organisations provide inclusive, healthy workplace wellbeing schemes that reach all staff especially those with highest needs. We will actively seek staff engagement to help us to ensure we address issues that are most important to our workforce. Where possible we will look to influence our partners to adopt these same practices.
- **Volunteering, work experience and mentorship**
  - We will increase opportunities for local people to volunteer in our organisations; this will help to support an understanding of the opportunities for people in Derbyshire and widen inclusion and diversity. We will work with local education providers to promote work experience opportunities and look to how we can support local people into health and care careers through an active mentorship scheme. We will encourage staff to volunteer in their communities and to act as “health career advocates” with local schools and exerting local influence where they can through these opportunities within their communities.

Areas of Opportunity - procurement

- **Local Supply Chains**
  - We will procure locally wherever possible, and it is deemed appropriate, from Small and Medium sized enterprises (SMEs) and microbusinesses.
  - We will actively work with other local anchor institutions to understand opportunity and promote these to local business through engagement channels. This will contribute towards indirect local employment and support economic, sustainable growth within the local area.
- **Social and Environmental Value**
  - We will build social value into our supply chain contracts, looking to increase 'additional value' from our providers that bring benefit to our communities.
  - Through the social value offer, we will look to support inclusive employment opportunities to local people and seek wider value to areas such as environment, climate action and zero carbon.

Signatories to the Anchor Charter and members of Derbyshire's founding Anchor Executive are:

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 4 May 2021

Performance Report

Purpose of Report

The purpose of this report is to provide the Board of Directors with a brief update of how the Trust was performing at the end of March 2021 during this extremely challenging period. The report focuses on key finance, performance and workforce measures.

Executive Summary

The report provides the Board of Directors with information that demonstrates how the Trust is performing against a suite of key targets and measures. Performance is summarised in an assurance summary dashboard with targets identified, where a specific target has been agreed. Where a specific target has not been agreed or specifically commissioned, colleagues will be able to track performance over time and discuss/challenge any specific variation that may be of concern or unusual. Further detailed statistical process control charts for the measures are included in appendix 2. The charts have been generated using an adaptation of a tool created by Karen Hayllar, NHS England & NHS Improvement, which enables much easier interpretation of how each process is performing. The main areas to draw the Board's attention to are as follows:

Finance

Revenue

This update is very summarised due to it being year-end and detail being available in due course in the annual report and accounts.

The Trust ended the year with a deficit of £2.1m at the end of month 12. This outturn includes costs for additional annual leave carried forward related to the pandemic, in line with NHS England and Improvement (NHSEI) requirements. Part of the reason we ended up with a larger deficit than previously forecast is that we incurred additional costs related to our patient record changes moving to SystmOne from Paris, we also accelerated depreciation to reduce the remaining asset life down to end date and we incurred some impairments. These additional year end costs were greater than forecast. Some of these extra costs however were offset by the release of some deferred income and the receipt of some additional income which created a benefit we had not previously forecast.

Our financial position forms part of the overall financial position of Joined Up Care Derbyshire (JUCD) and the system overall managed costs overall within the fixed income allocation with no material variance at year end.

Greater detail of the whole of the financial year that has just finished will be set out in the accounts and accompanying annual report.

Capital

With regard to capital, as previously outlined we underspent the capital plan as agreed. With regard to dormitory eradication; in April we received formal notification from NHSEI that we have been allocated a place on the dormitory eradication programme with allocations totalling £80m, this is subject to successful business case processes to secure.

Operations

Three day follow-up of all patients

To date we have consistently achieved the national standard for follow-up and the high level of performance seen over the last 8 months is statistically significant.

Data quality maturity index

Increasing waiting lists resulting from the pandemic continue to have a negative impact on data quality, however we have consistently exceeded the national target.

Improving Access to Psychological Therapies (IAPT) 18 week referral to treatment

The national target has been exceeded throughout the 24 month reporting period.

IAPT six week referral to treatment

Following a period of seven months of special cause variation as a result of staff being redeployed to support other services as the pandemic progressed, the staff returned to IAPT in November 2020 and for the last three months performance has returned to normal, achieving standard.

IAPT patients completing treatment who move to recovery

For the last seven months the national standard has been achieved.

Early intervention

The service continues to perform consistently well against the national 14 day referral to treatment standard.

Waiting list for care coordination

The number of patients waiting for care coordination has been significantly lower than normal for a number of months and the average wait to be seen has remained at normal levels.

Waiting list for psychology

The number of patients on the waiting list is within normal variation. The average wait to be seen was significantly higher than normal for a sustained period during the pandemic but in recent months has returned to normal.

Waiting list for Autistic Spectrum Disorder (ASD) assessment

We are currently planning our recovery to resume face to face assessments. There are approximately 60 people now at the top of the waiting list who have turned down video/phone assessments and are waiting for face to face appointments. These are the people who have been waiting the longest. Agreement has been reached to develop a Specialist Autism Team. The plan will be to consider how the ASD diagnostic team could support this team and vice versa.

Waiting list for Child and Adolescent Mental Health Services (CAMHS)

The use of telephone and Attend Anywhere as vehicles to support clinical contacts is having a positive impact on the size of the waiting list and for the last 10 months the waiting list has significantly reduced.

Waiting list for community paediatrics

The number of children on the waiting list has been significantly lower than normal for the past 10 months and for the last 6 months the average wait to be seen has been significantly lower than normal, however the expected increase in referrals is starting to impact on the waiting list, which at the time of writing has increased by almost 200 since last reported.

Patients placed out of area – adult acute

We continue to operate with 18 beds closed on the acute wards for adults of working age due to implementing social distancing. Use of out of area beds remains constantly lower than the number of closed beds.

As a result of working on the "continuity of care" principles, from 1 April 2021 any of our patients who are nursed at Mill Lodge are no longer regarded as "inappropriate" out of area placements. This will result in a significant reduction in the number of inappropriate placements in the future.

Patients placed out of area – Psychiatric Intensive Care Units (PICU)

PICU usage continues to be monitored closely with CCG and NHSE/I and all attempts are made to repatriate the patient to an acute bed once deemed appropriate to do so. Over the last few weeks we have noticed increased levels of acuity in patients on the acute wards which has resulted in increased use of PICU beds. However the case managers are working proactively with the PICU providers to ensure repatriation to an acute bed at the earliest opportunity.

People

Following the suspension of appraisals, revalidation and mandatory training, recovery plans are in place with weekly monitoring through the Executive Leadership Team (ELT).

Annual appraisals

The position had been deteriorating in many areas over the course of the pandemic. Medical Appraisal rates have increased this month and there is a slight increase in other employee appraisal rates. The Trust has agreed to pause for a further six months the formal appraisal process and in place the well-being conversation due to be rolled out shortly, will incorporate key questions and can be reported through appraisal completion on ESR by the line manager.

Annual turnover

The rate of turnover has been normal for the last 11 months and remains within the Trust target of 8-12%. The value of good retention rates such as ours can be seen in staff story completion rates and other forms of engagement and feedback across all services. This has been particularly evident during this time as we work through the pandemic.

Compulsory training

The Training Cell continues to meet weekly to support the Divisions with regards to improving the training position and focusing on key priority areas. A weekly training report is submitted to ELT for further assurance and scrutiny. Additional resources have supported the People Development team and compliance rates by chasing bookings and reminders for attendance which will reduce DNA's (did not attend).

Staff absence

It is a remarkable achievement that the Trust's absence figure has now fallen below our Trust target of 5%. The monthly absence for March is now at 4.84% which is extremely positive especially in this current climate. This is the lowest level seen since May 2018. It is of note that short term absence has improved significantly, this can be due to a number of factors : Increased uptake of the Flu Vaccination this year, less short term absence through home working and being able to manage long term conditions through working from home and less contact with people which reduces transmission of the normal coughs and colds etc at this time of the year.

Supervision

The levels of compliance with the clinical and managerial supervision targets have remained lower than normal since the start of the pandemic and for the last few months have been gradually worsening. This is now being addressed across all services.

Vacancies

The proportion of posts filled continues to be statistically higher than normal. There were record levels of vacancies posted in February which accounts for high volumes of recruitment activity across the Trust.

Bank staff use

Bank staff use has been rising and was statistically higher than normal this month which is likely to be a result of the increased demand in services managing sickness absence and annual leave.

Quality

Incidents

Incidents of moderate to catastrophic harm have increased in line with seasonal increase in deaths and the number of COVID-19 related deaths across all services.

Seclusion and restraint

The use of seclusion was within normal variation, although with a decreasing trend in physical restraint and prone restraint. There are ongoing work streams to support the continuing need to reduce restrictive practice.

Patients in settled accommodation and patients in employment

Accommodation and employment will clearly be affected by the current pandemic and its financial consequences, so this data will continue to be monitored closely. However, the Individual Placement Support service continues to have success in supporting people into employment even during the current pandemic.

Care plan reviews

The proportion of patients whose care plan has been reviewed continues to be lower than usual. Teams have been prioritising essential tasks, with reduced routine contact, and trying to engage with people who use our services in different ways, e.g. in virtual ways using Attend Anywhere. We will monitor this over the coming months as teams restore services in line with national expectations.

Complaints, concerns and compliments

The number of compliments decreased in line with the emergence of COVID-19 and the significant changes to many of our clinical services. The number of complaints increased with a particular theme around access to services.

Duty of Candour

In this report there were no instances of Duty of Candour.

Number of falls on inpatient wards

The number of reported falls remains withing normal variation.

Physical Health Assessments

There has been a steady increase in physical health assessments being initiated within adult and older adult services both inpatient and community services. Work continues to improve the compliance.

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

Assurances

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

Consultation

Versions of this 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. Proposed level is Limited Assurance
2) To formally agree that this report incorporates the key elements of assurance to the Trust Board that would otherwise have come from Finance and Performance Committee and People and Culture Committee reporting
3) Determine whether further assurance is required.

Report presented by:	**Lee Doyle** **Acting Director of Operations**
Report prepared by:	**Peter Henson** **Head of Performance**
	Claire Wright **Director of Finance/Deputy CEO**
	Celestine Stafford **Assistant Director People and Culture Transformation**
	Vicki Baxendale **Interim Assistant Director, Nursing, Quality & Governance**

Assurance Summary

Indicator	Rating[1]	Data Quality	Indicator	Rating[1]	Data Quality
Operational					
3 day follow-up all patients	?		Waiting list for care coordination – number	See chart	
Data Quality Maturity Index (DQMI) - MHSDS data score	P		Waiting list for care coordination – average wait	See chart	
Early Intervention (EIP) RTT within 14 days - complete	P		Waiting list for ASD assessment – number	See chart	
EIP RTT within 14 Days - incomplete	P		Waiting list for ASD assessment – average wait	See chart	
IAPT referral to treatment (RTT) within 18 weeks	P		Waiting list for psychology – number waiting	See chart	
IAPT referral to treatment within 6 weeks	P		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 - adult acute	See chart		Waiting list for CAMHS – average wait	See chart	
Patients out of area at month end - adult acute	See chart		Waiting list for community paediatrics – number	See chart	
Patients placed out of area - PICU	See chart		Waiting list for community paediatrics – average wait	See chart	
Patients out of area at month end - PICU	See chart				
People					
Annual appraisals	F		Clinical supervision	F	
Annual turnover	?		Management supervision	F	
Compulsory training	?		Vacancies	F	
Sickness absence	?		Bank staff use	?	

[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

Detailed Narrative

1. Operations

A. Three day follow-up of all patients

Patients are followed up in the days following discharge from mental health inpatient wards to provide support and ensure their wellbeing during the period when they are at their most vulnerable. To date we have consistently achieved the national standard for follow-up which came into effect from 1 April 2020 and the high level of performance seen over the last 8 months is statistically significant.

B. Data quality maturity index

Increasing waiting lists resulting from the pandemic continue to have a negative impact on data quality, however we have consistently exceeded the national target. When compared with other trusts our data quality is very good (Appendix 3).

C. IAPT 18 week referral to treatment

The national target has been exceeded throughout the 24 month reporting period.

D. IAPT 6 week referral to treatment

Following a period of 7 months of special cause variation as a result of staff being redeployed to support other services as the pandemic progressed, the staff returned to IAPT in November 2020 and for the last 3 months performance has returned to normal, achieving standard.

E. IAPT patients completing treatment who move to recovery

For the last 7 months the national standard has been achieved, with normal levels of performance seen throughout the data period.

F. Early intervention

The service continues to perform consistently well against the national 14 day referral to treatment standard and there is no evidence of the pandemic having any impact on performance.

G. Waiting list for care coordination

The number of patients waiting for care coordination has been significantly lower than normal for a number of months and the average wait to be seen has remained at normal levels despite the pandemic.

H. Waiting list for psychology

The number of patients on the waiting list is within normal variation. The average wait to be seen was significantly higher than normal for a sustained period during the pandemic but in recent months has returned to normal. The waiting list covers a large number of services and therefore in context the number waiting is quite small. Factors impacting on the waiting lists include:

- Patients requesting only face to face therapy and would rather wait – approximately 10-15%.
- Vacancies, maternity leave and secondment reducing capacity.
- Impact of provision of offer of psychological support – well-being plus staff support service reducing psychologist time
- Impact of school closures and limited places for childcare on families
- Some data quality issues

Our response to the waiting list challenges includes a focus on recruitment and a review and improvement of data quality. More staff time will become available once we move through the current COVID-19 crisis.

I. Waiting list for Autistic Spectrum Disorder (ASD) assessment

We are currently planning our recovery to resume face to face assessments. There are approximately 60 people now at the top of the waiting list who have turned down video/phone assessments and are waiting for face to face appointments. These are the people who have been waiting the longest. We have COVID safe assessment plans in place for Rivermead and Derby and are looking at availability in Bay Heath House, Chesterfield. We are aiming after Easter to trial offering 50% of our assessments via face to face. However, we are aware that these assessments may take longer as we may not be able to complete assessments in one day due to PPE - staff need to trial split assessments, cleaning time, PPE breaks for themselves and service users etc. Some decisions about timing are likely to need to be made on a case by case basis.

Green light today following board agreement to start recruitment to phase one of developing a Specialist Autism Team. The plan will be to consider how the ASD diagnostic team could support this team and vice versa. One of the challenges with recruitment and retention of the diagnostic team is that they only do diagnoses. This has led to clinicians leaving. With the new SAT we aim to potentially allow clinicians working in the diagnostic team to work across the SAT and provide some support and intervention which should increase clinicians' morale and improve staff retention.

J. Waiting list for Child and Adolescent Mental Health Services (CAMHS)

CAMHS continue to utilise telephone and Attend Anywhere as vehicles to support clinical contacts; face to face appointments are offered only when clinically indicated. This is having a positive impact on the size of the waiting list and for the last 10 months the waiting list has significantly reduced. The average wait to be seen continues to be significantly longer than normal.

K. Waiting list for community paediatrics

The number of children on the waiting list has been significantly lower than normal for the past 10 months and for the last 6 months the average wait to be seen has been significantly lower than normal, however the expected increase in referrals is starting to impact on the waiting list, which at the time of writing has increased by almost 200 since last reported. Referrals to the neurodevelopmental assessment pathway are now being received since the pathway re-opened, becoming fully open by January 2021. We are in negotiation with the CCG around this aspect of care to ensure that future commissioning and capacity reflect the demands and also the expected prevalence.

L. Patients placed out of area – adult acute

We continue to operate with 18 beds closed on the acute wards for adults of working age due to implementing social distancing. Use of out of area beds remains constantly lower than the number of closed beds.

It should be noted that we have experienced a COVID-19 outbreak on the Hartington Unit and the Radbourne Unit. These outbreaks restricted ability to admit further patients for a period of time. For a brief time this reduced admission and treatment capacity resulted in increased usage of out of area acute beds. However this increase was minimal.

As a result of working on the "continuity of care" principles, any of our patients who are nursed at Mill Lodge are no longer regarded as "inappropriate" out of area placements. This will result in a significant reduction in the number of "inappropriate" placements in the future.

M. Patients placed out of area – Psychiatric Intensive Care Units (PICU)

The PICU usage continues to be monitored closely with CCG and NHSE/I and all attempts are made to repatriate the patient to an acute bed once deemed appropriate to do so. Over the last few weeks we have noticed increased levels of acuity in patients on the acute wards which has resulted in increased use of PICU beds. However the case managers are working proactively with the PICU providers to ensure repatriation to an acute bed at the earliest opportunity.

2. People

In order to release capacity to manage the COVID-19 pandemic, all NHS organisations were instructed by Amanda Pritchard, Chief Operating Officer, NHS England and NHS Improvement[1], to suspend appraisals and revalidation and to reduce the volume of mandatory training as appropriate. This backlog of training and appraisals is now part of a number of recovery plans being worked through over the next few months.

A. Annual appraisals

A revised appraisal process will take place in the wellbeing conversation due to be rolled out shortly, full appraisals will be back in place in 6 months.

B. Annual turnover

The rate of turnover has been normal for the last 11 months and remains within the Trust target of 8-12%. Within month annual turnover decreased to 10.35% and a useful indicator in retirements shows a further decrease in numbers leaving the organisation.

C. Compulsory training

A Training Cell continues to meet weekly to support the Divisions with regards to improving the training position and focusing on key priority areas. The Cell continues to monitor progress against training recovery plans and sustainability.

The People Development team have been given additional administration resources who are proactively contacting people in an attempt to fill available training places. They are also contacting delegates to remind them of attendance in order to try and reduce the high number of DNA's. The Trust have provided a Marquee at Kingsway in order to provide a COVID-19 safe environment for the delivery of face to face training including Positive and Safe training and Adult & Paediatric Basic Life Support. External Immediate Life Support training delivery has also been commissioned.

Overall Statutory Mandatory training remains within target, attendance at training has been good but clinical pressures have impacted on the release of staff for the 5 day training programmes such as Positive and Safe training. Robust plans are in place with enough training places to meet demand. More trainers have been recruited to support delivery. Rosters are being monitored to ensure delegates are able to attend and that bank or agency can be booked in advance to ensure safe staffing levels are maintained.

D. Staff absence

Staff absence is now at the lowest level for 3 years This is really positive news particularly coming out of the pandemic and can be attributed to a number of factors :

- Different ways of working i.e. home working in particular which helps to support colleagues with long term conditions where short term sickness has been reduced.
- The high uptake of our flu vaccination programme has meant more colleagues are protected.

[1] https://www.england.nhs.uk/coronavirus/publication/reducing-burden-and-releasing-capacity-at-nhs-providers-and-commissioners-to-manage-the-covid-19-pandemic/

- Less contact because of the pandemic so less of the normal coughs cold and infections that can be transmitted when more people are working together so a decrease in short term episodic absences.
- Finally the introduction of the Health Risk Assessment and more individual monitoring and support may also be a factor.

E. Supervision

The levels of compliance with the clinical and managerial supervision targets have remained lower than normal since the start of the pandemic and for the last few months have been gradually worsening. This is being addressed at divisional and service level to improve across all areas.

F. Vacancies

Along with a higher than normal level of vacancies posted, the proportion of posts filled was statistically higher than normal for the first time. This may be an indicator of the positive team culture within the Trust and the different roles that are now being rolled out.

G. Bank staff use

Bank staff use has been rising and was statistically higher than normal this month which is likely to be a result of the increased level of staff taking annual leave and release for Mandatory training.

3. Quality

A. Incidents

Incidents of moderate to catastrophic harm have increased in line with seasonal increase in deaths and the number of COVID-19 related deaths across all services.

B. Seclusion and restraint

The use of seclusion was within normal variation, although with an decreasing trend in physical restraint and prone restraint. There are ongoing work streams to support the continuing need to reduce restrictive practice; including the introduction of body worn cameras, monitoring of restrictive practice within the “reducing restrictive practice forum” and monthly thematic reviews carried out by the Head of Nursing.

C. Patients in settled accommodation and patients in employment

Accommodation and employment will clearly be affected by the current pandemic and its financial consequences, so this data will continue to be monitored closely. However, the Individual Placement Support service continues to have success in supporting people into employment even during the current pandemic. This service is currently expanding. There continues to be community nurses dedicated to working in a multi-agency environment supporting our homeless service users.

D. Care plan reviews

The proportion of patients whose care plan has been reviewed continues to be lower than usual. Teams have been prioritising essential tasks, with reduced routine contact, and trying to engage with people who use our services in different ways, e.g. in virtual ways using Attend Anywhere. The planned restoration of services was interrupted by the second wave of the pandemic and further redeployment of community staff to support critical functions. We will monitor this over the coming months as teams restore services in line with national expectations, whilst continuing to be impacted by the COVID-19 situation and the ongoing need to prioritise essential tasks.

E. Complaints, concerns and compliments

The number of compliments decreased in line with the emergence of COVID-19 and the significant changes to many of our clinical services. The number of complaints increased with a particular theme around both concerns and complaints of access to services. Derbyshire Healthcare NHS Foundation Trust continues to work with Health Watch, including receiving regular feedback through governance structures and service user and carer surveys.

F. Duty of Candour

In this report there are no instances of Duty of Candour.

G. Number of falls on inpatient wards

The number of reported falls remains withing normal variation. However, there is a slight increased trend. This is likely to be as a consequence of enhanced reporting of falls from staff after promotion of good practice in this area and that nationally we are likely to see an increase in falls generally. This is as a result of people being de-conditioned from exercising less and not going out during the COVID-19 pandemic and resulting restrictions on movement.

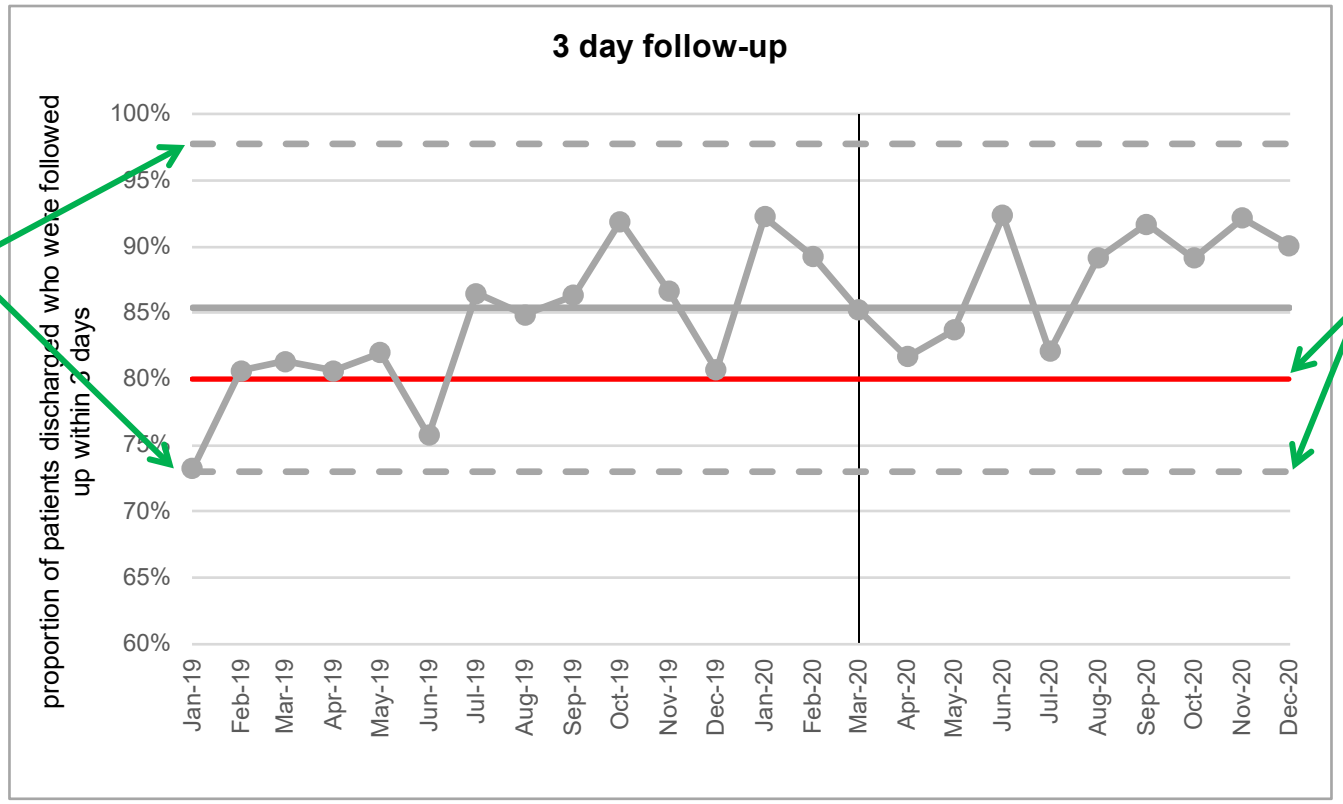
H. Physical Health Assessments

There has been a steady increase in physical health assessments being initiated within adult and older adult services both inpatient and community services. Work continues to improve the compliance.

Appendix 1

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"

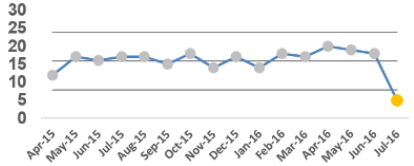


If the system is effective, the **lower** control limit will be above the target line (for targets where higher is better) or the **upper** control limit will be below the target line (for targets where lower is better). In that scenario we have nothing to worry about and can be assured our system is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

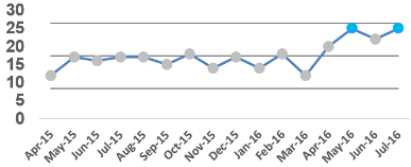
In this case the target line is above the lower control limit which indicates that the system is ineffective.

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:

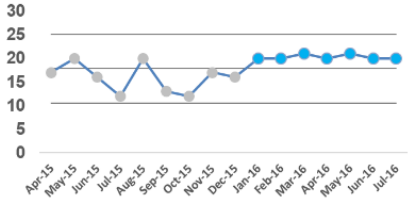
A single data point outside the process limits



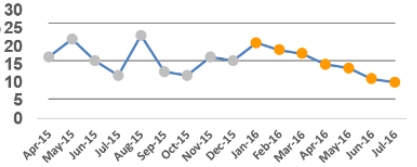
Two out of three points close to the process limits



Shift of points above / below mean line

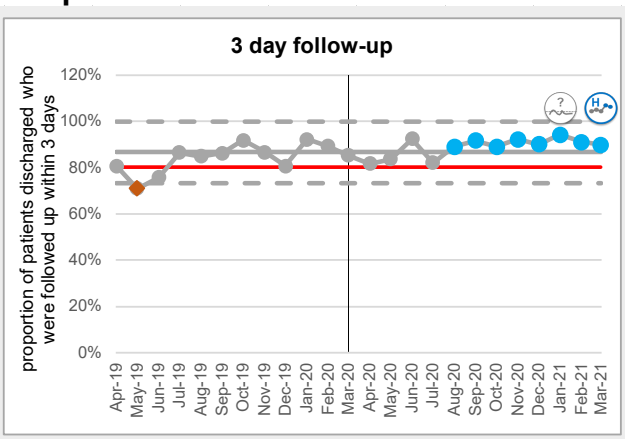


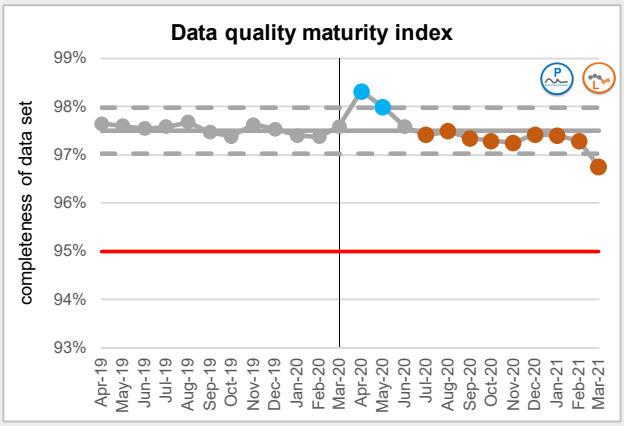
Run of points in consecutive ascending / descending order

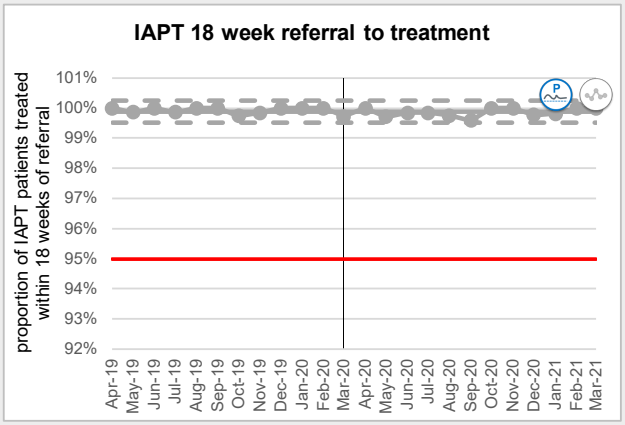


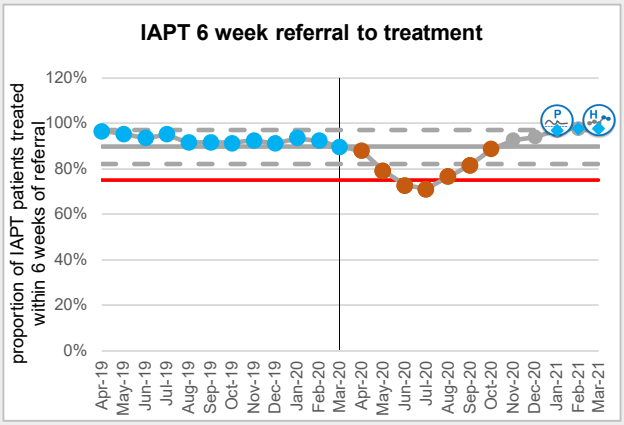
Appendix 2 – Charts

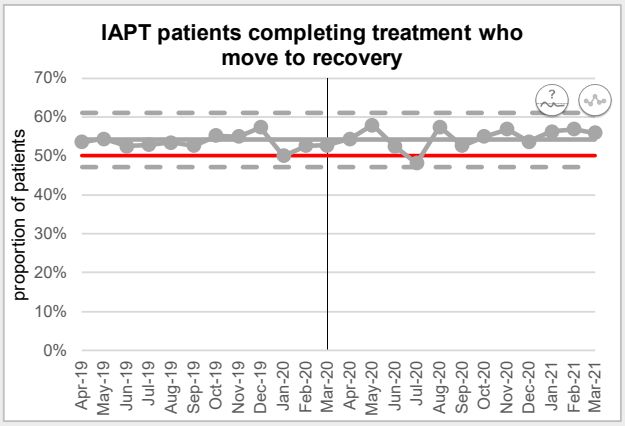
1. Operational Indicators

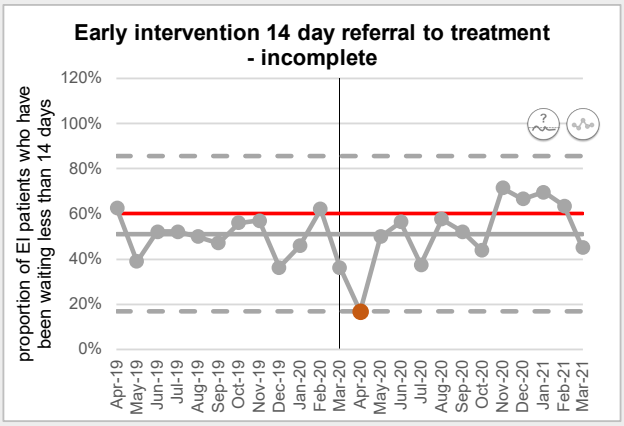


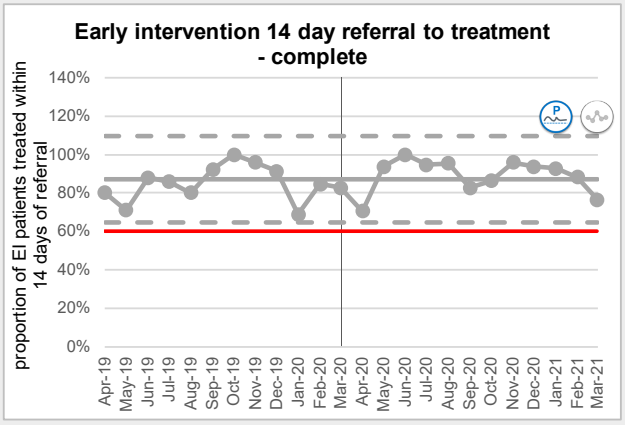


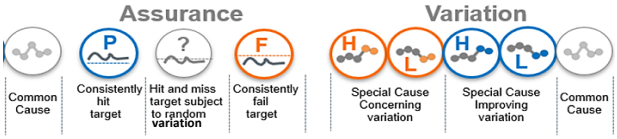


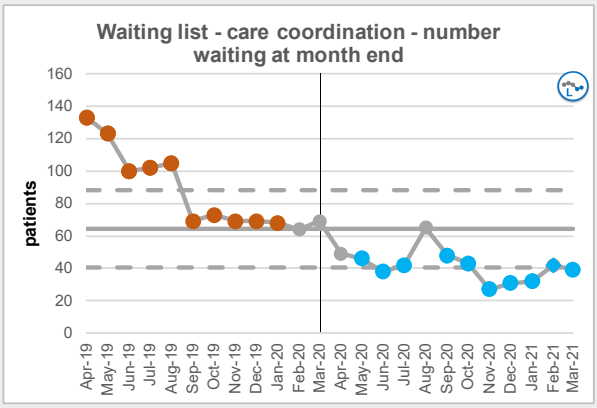


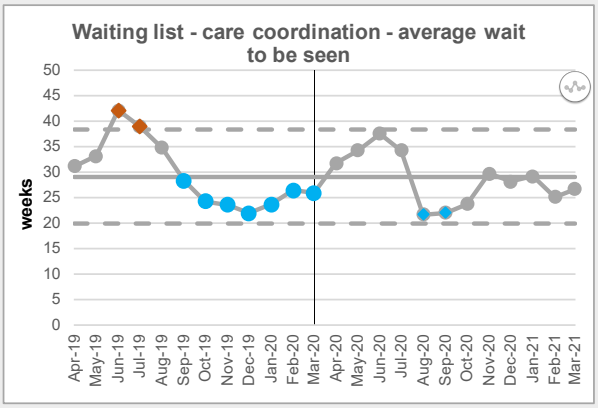


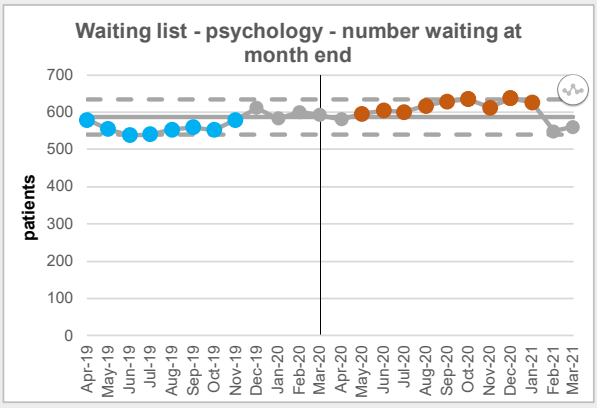


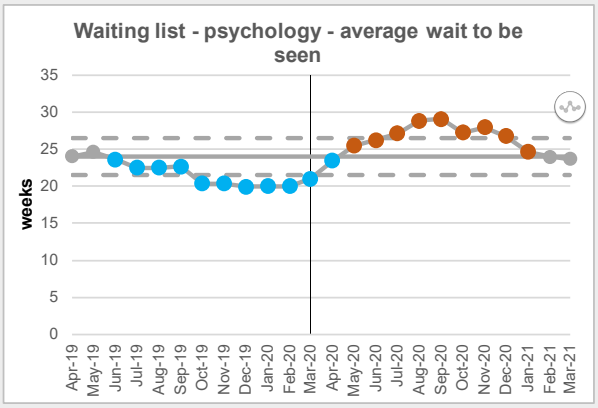


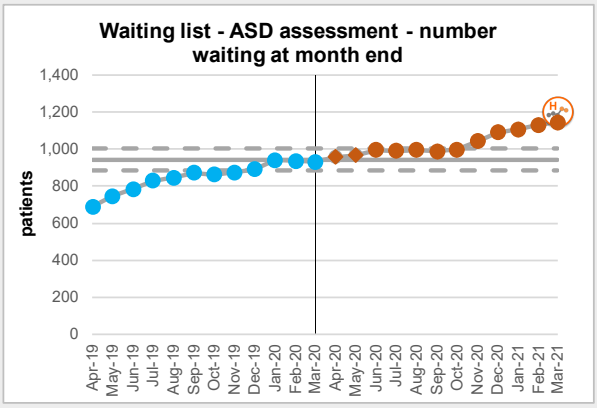


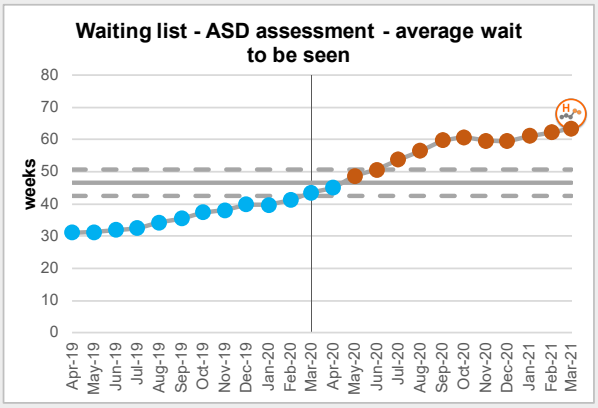

Waiting list - care coordination - number waiting at month end
patients
0
20
40
60
80
100
120
140
160
Apr-19 May-19 Jun-19 Jul-19 Aug-19 Sep-19 Oct-19 Nov-19 Dec-19 Jan-20 Feb-20 Mar-20 Apr-20 May-20 Jun-20 Jul-20 Aug-20 Sep-20 Oct-20 Nov-20 Dec-20 Jan-21 Feb-21 Mar-21

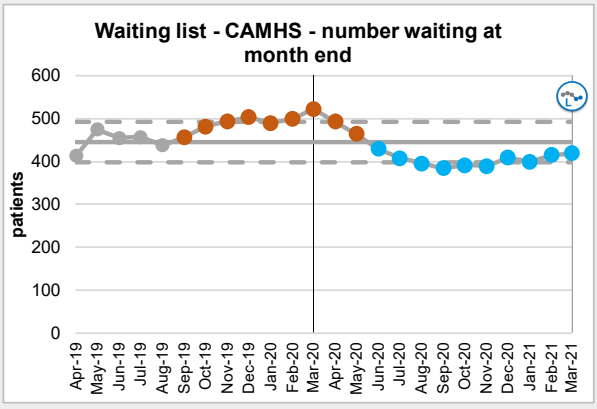

Waiting list - care coordination - average wait to be seen
weeks
0
5
10
15
20
25
30
35
40
45
50
Apr-19 May-19 Jun-19 Jul-19 Aug-19 Sep-19 Oct-19 Nov-19 Dec-19 Jan-20 Feb-20 Mar-20 Apr-20 May-20 Jun-20 Jul-20 Aug-20 Sep-20 Oct-20 Nov-20 Dec-20 Jan-21 Feb-21 Mar-21

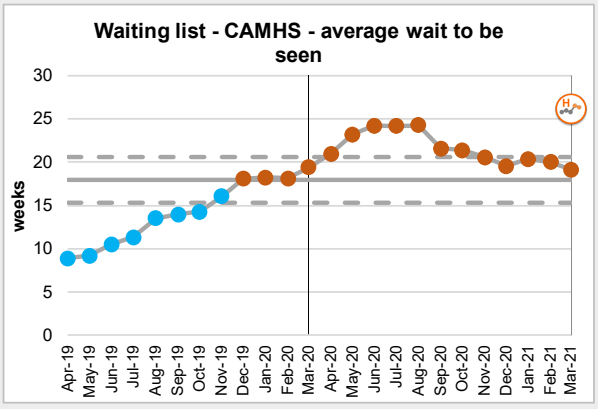

Waiting list - psychology - number waiting at month end
patients
0
100
200
300
400
500
600
700
Apr-19 May-19 Jun-19 Jul-19 Aug-19 Sep-19 Oct-19 Nov-19 Dec-19 Jan-20 Feb-20 Mar-20 Apr-20 May-20 Jun-20 Jul-20 Aug-20 Sep-20 Oct-20 Nov-20 Dec-20 Jan-21 Feb-21 Mar-21

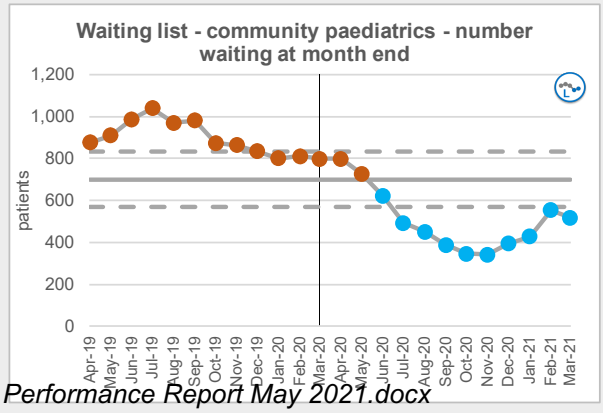

Waiting list - psychology - average wait to be seen
weeks
0
5
10
15
20
25
30
35
Apr-19 May-19 Jun-19 Jul-19 Aug-19 Sep-19 Oct-19 Nov-19 Dec-19 Jan-20 Feb-20 Mar-20 Apr-20 May-20 Jun-20 Jul-20 Aug-20 Sep-20 Oct-20 Nov-20 Dec-20 Jan-21 Feb-21 Mar-21

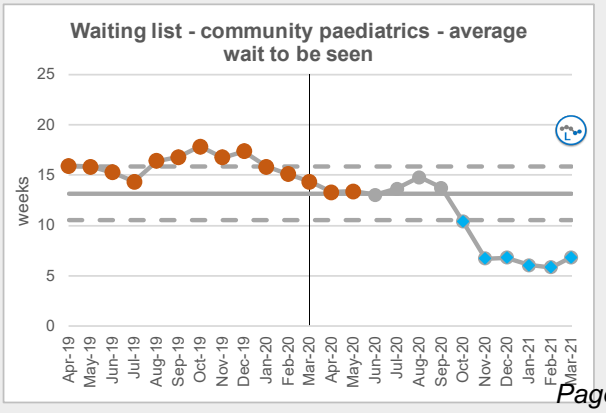

Waiting list - ASD assessment - number waiting at month end
patients
0
200
400
600
800
1,000
1,200
1,400
Apr-19 May-19 Jun-19 Jul-19 Aug-19 Sep-19 Oct-19 Nov-19 Dec-19 Jan-20 Feb-20 Mar-20 Apr-20 May-20 Jun-20 Jul-20 Aug-20 Sep-20 Oct-20 Nov-20 Dec-20 Jan-21 Feb-21 Mar-21

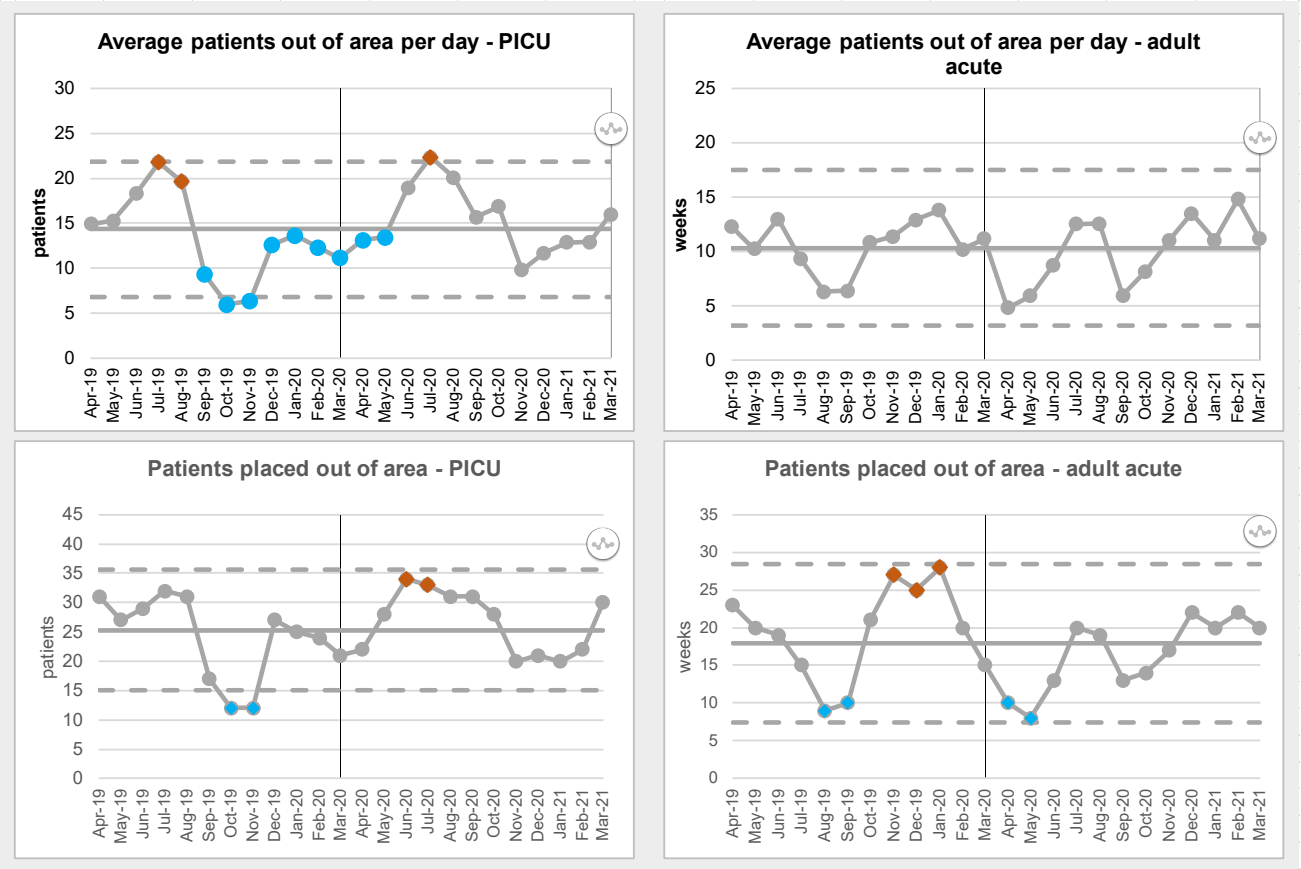

Waiting list - ASD assessment - average wait to be seen
weeks
0
10
20
30
40
50
60
70
80
Apr-19 May-19 Jun-19 Jul-19 Aug-19 Sep-19 Oct-19 Nov-19 Dec-19 Jan-20 Feb-20 Mar-20 Apr-20 May-20 Jun-20 Jul-20 Aug-20 Sep-20 Oct-20 Nov-20 Dec-20 Jan-21 Feb-21 Mar-21

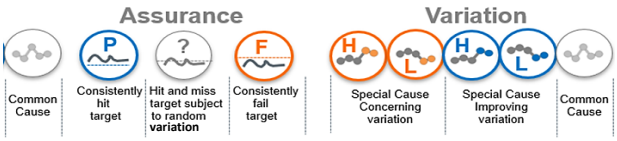

Waiting list - CAMHS - number waiting at month end
patients
0
100
200
300
400
500
600
Apr-19 May-19 Jun-19 Jul-19 Aug-19 Sep-19 Oct-19 Nov-19 Dec-19 Jan-20 Feb-20 Mar-20 Apr-20 May-20 Jun-20 Jul-20 Aug-20 Sep-20 Oct-20 Nov-20 Dec-20 Jan-21 Feb-21 Mar-21


Waiting list - CAMHS - average wait to be seen
weeks
0
5
10
15
20
25
30
Apr-19 May-19 Jun-19 Jul-19 Aug-19 Sep-19 Oct-19 Nov-19 Dec-19 Jan-20 Feb-20 Mar-20 Apr-20 May-20 Jun-20 Jul-20 Aug-20 Sep-20 Oct-20 Nov-20 Dec-20 Jan-21 Feb-21 Mar-21

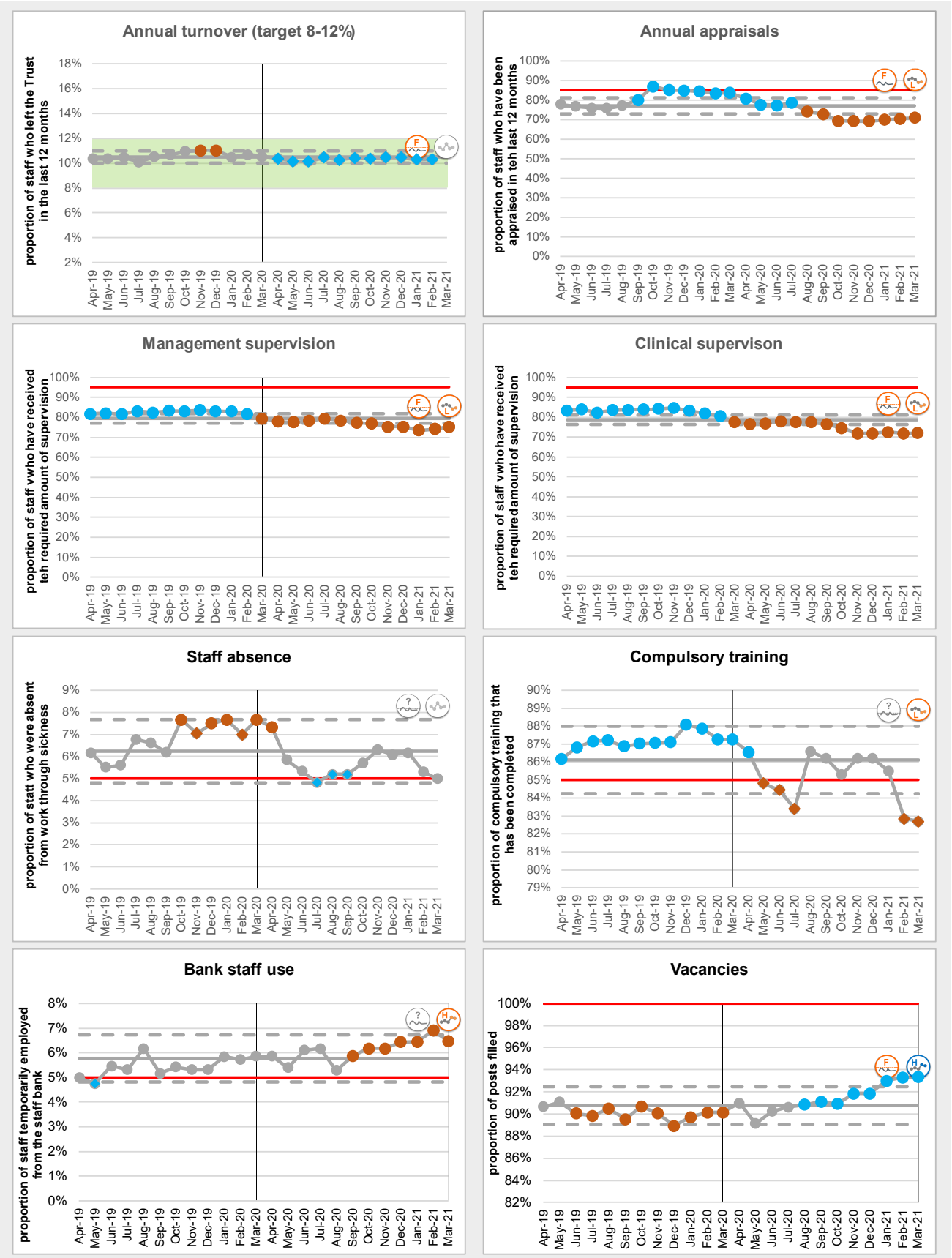

Waiting list - community paediatrics - number waiting at month end
patients
0
200
400
600
800
1,000
1,200
Apr-19 May-19 Jun-19 Jul-19 Aug-19 Sep-19 Oct-19 Nov-19 Dec-19 Jan-20 Feb-20 Mar-20 Apr-20 May-20 Jun-20 Jul-20 Aug-20 Sep-20 Oct-20 Nov-20 Dec-20 Jan-21 Feb-21 Mar-21


Waiting list - community paediatrics - average wait to be seen
weeks
0
5
10
15
20
25
Apr-19 May-19 Jun-19 Jul-19 Aug-19 Sep-19 Oct-19 Nov-19 Dec-19 Jan-20 Feb-20 Mar-20 Apr-20 May-20 Jun-20 Jul-20 Aug-20 Sep-20 Oct-20 Nov-20 Dec-20 Jan-21 Feb-21 Mar-21


Average patients out of area per day - PICU
patients
Average patients out of area per day - adult acute
weeks
Patients placed out of area - PICU
patients
Patients placed out of area - adult acute
weeks

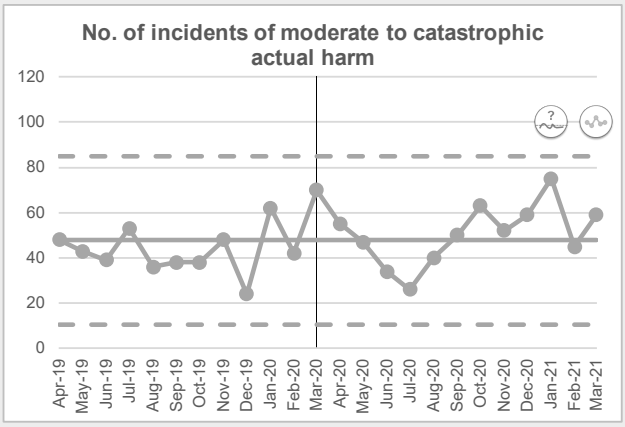

Assurance
Variation
Common Cause
Consistently hit target
Hit and miss target subject to random variation
Consistently fail target
Special Cause Concerning variation
Special Cause Improving variation
Common Cause

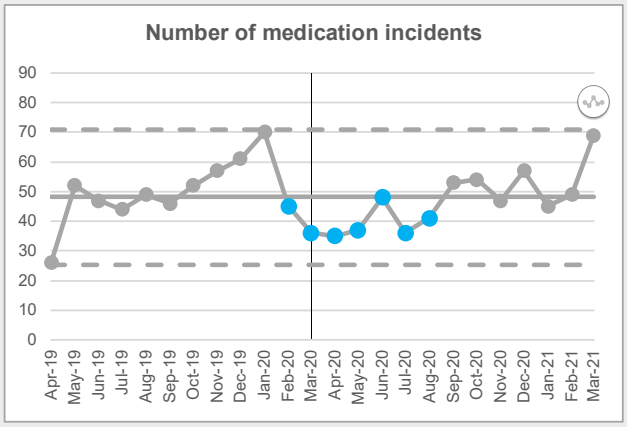
2. People Indicators

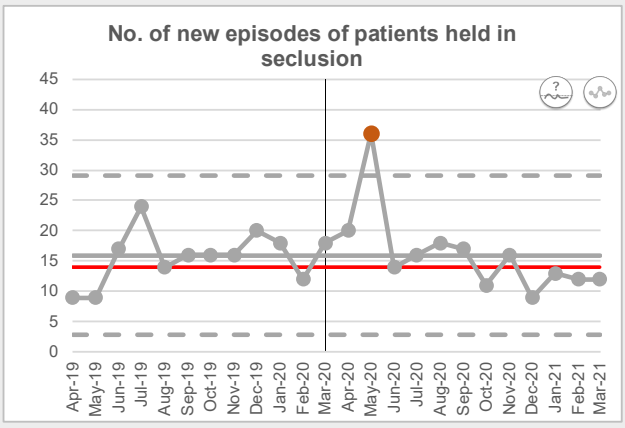


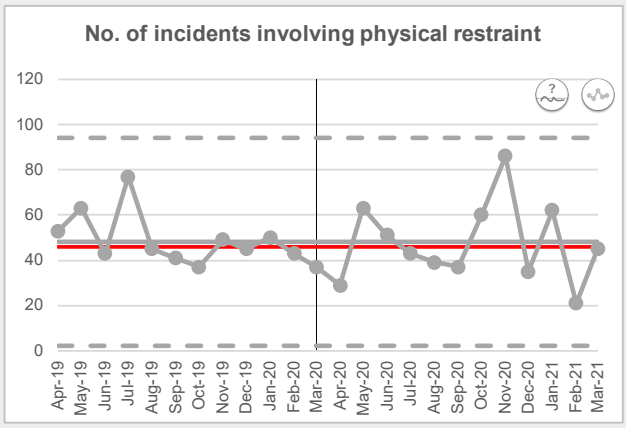
3. Quality Indicators

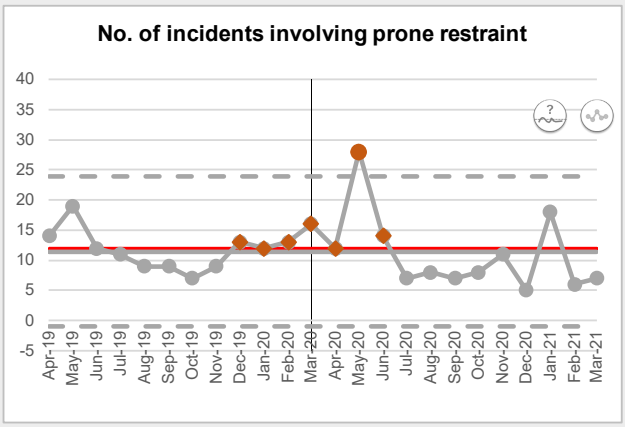
Safe

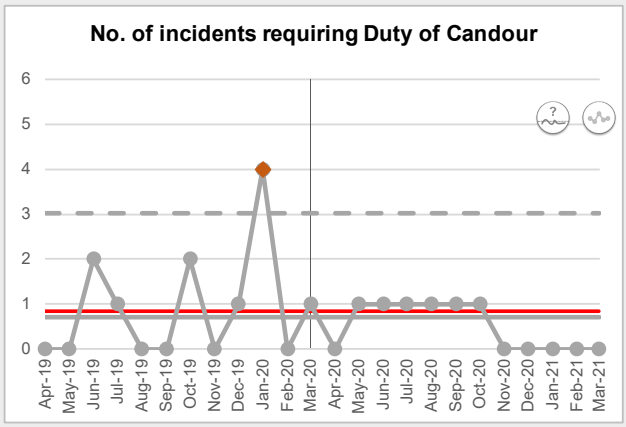


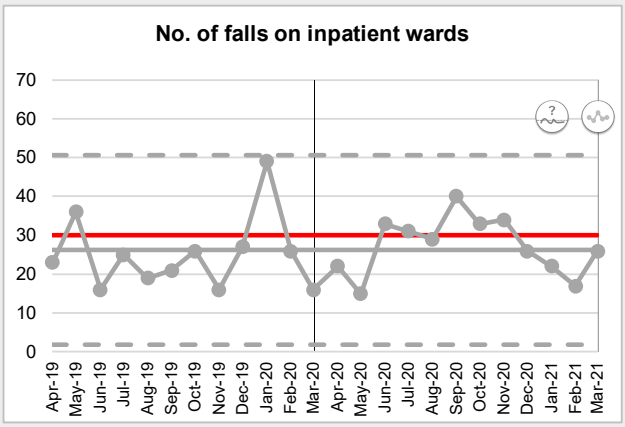


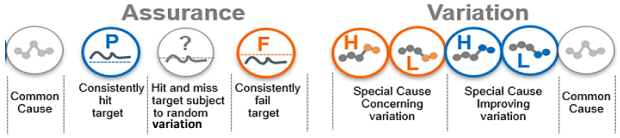




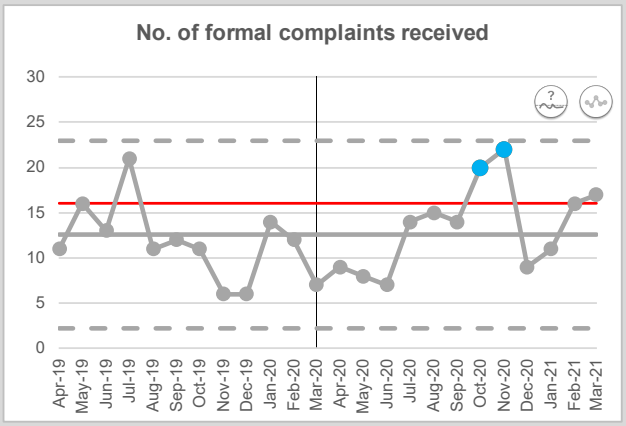


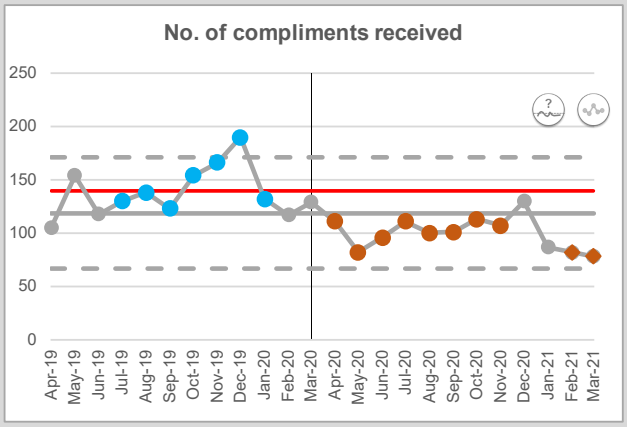




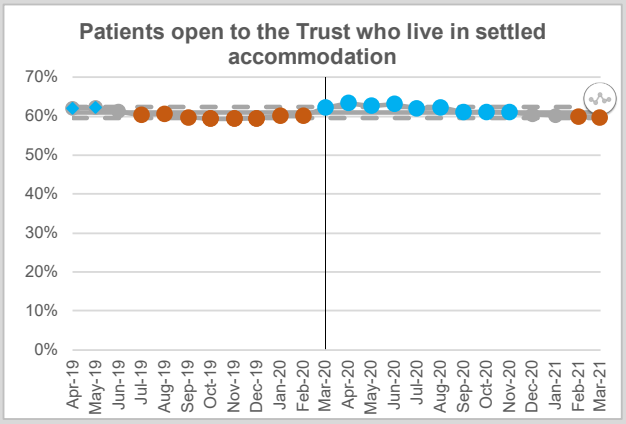


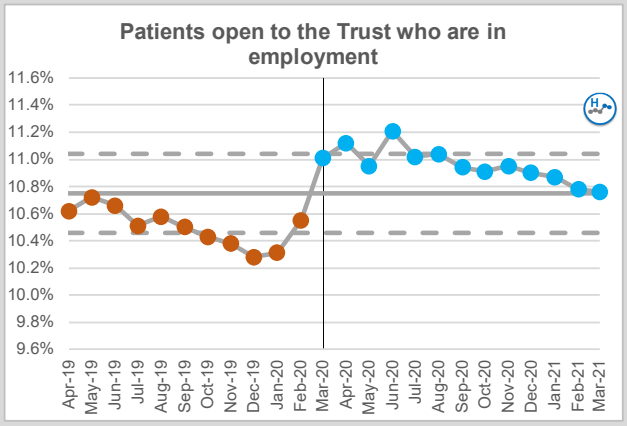
Caring



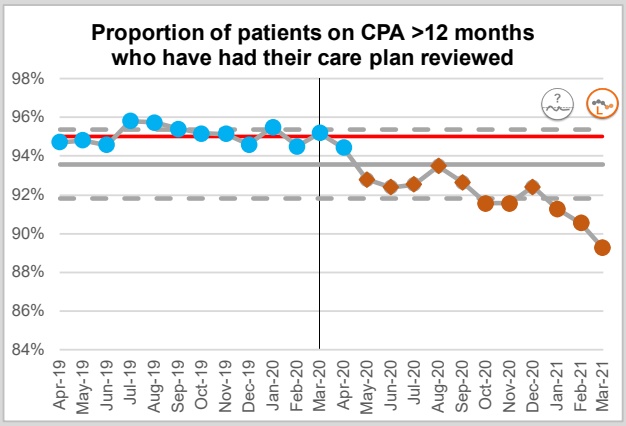


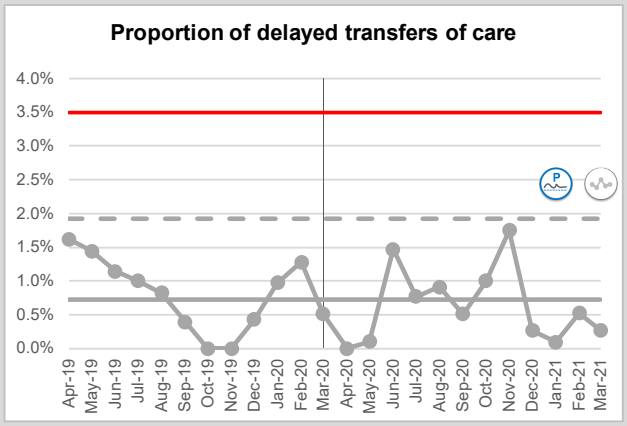
Effective

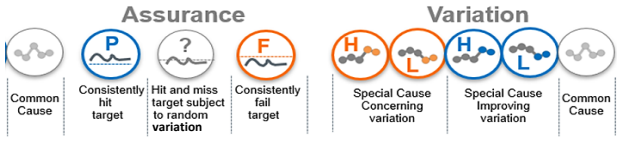


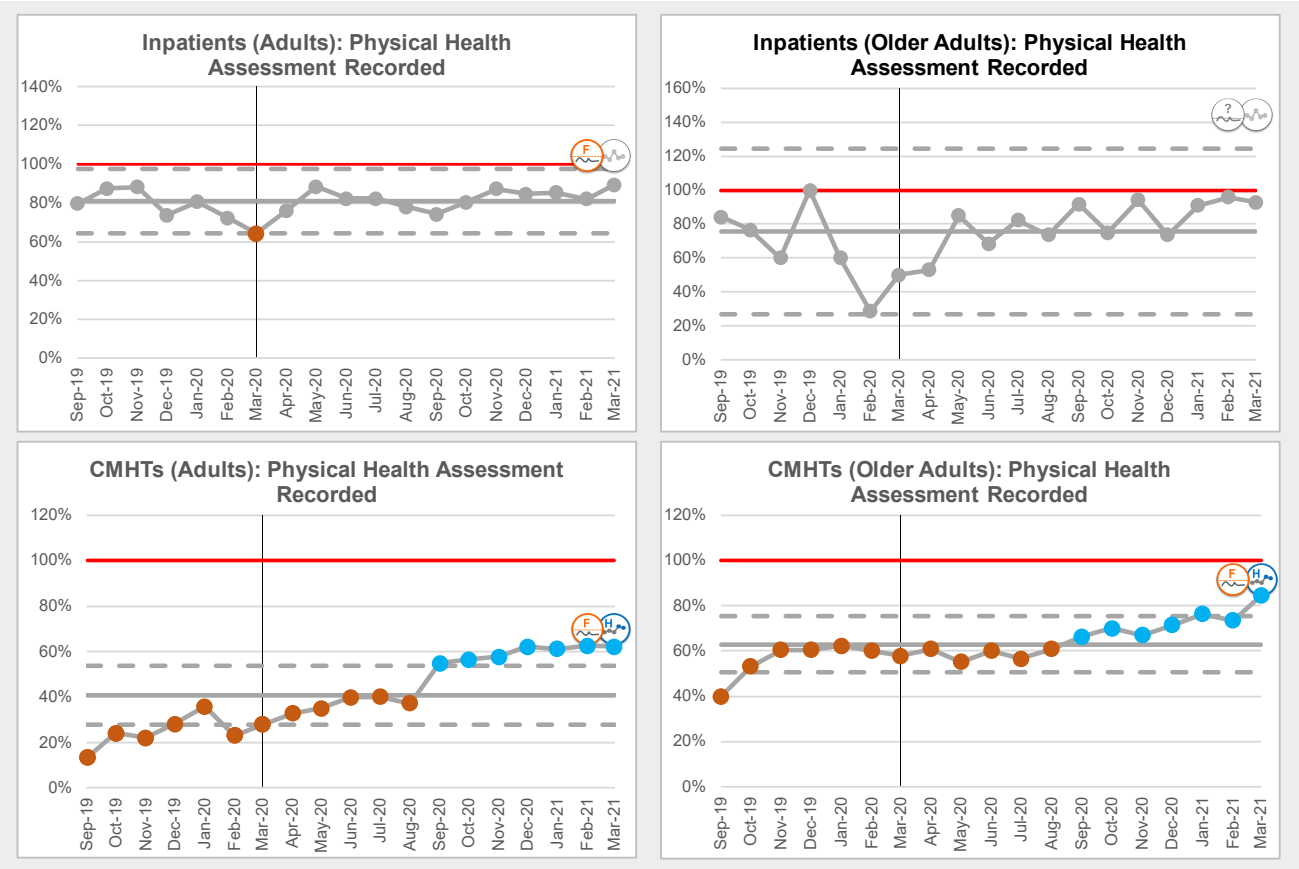


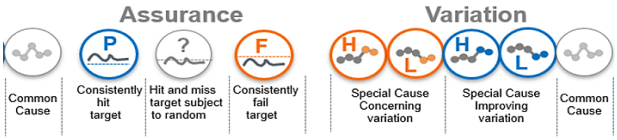
Responsive








Inpatients (Adults): Physical Health Assessment Recorded
Inpatients (Older Adults): Physical Health Assessment Recorded
CMHTs (Adults): Physical Health Assessment Recorded
CMHTs (Older Adults): Physical Health Assessment Recorded
Sep-19 Oct-19 Nov-19 Dec-19 Jan-20 Feb-20 Mar-20 Apr-20 May-20 Jun-20 Jul-20 Aug-20 Sep-20 Oct-20 Nov-20 Dec-20 Jan-21 Feb-21 Mar-21


Assurance
Common Cause
Consistently hit target
Hit and miss target subject to random
Consistently fail target
Variation
Special Cause Concerning variation
Special Cause Improving variation
Common Cause

Appendix 3 – Data Quality Maturity Index (DQMI) Benchmarking

PROVIDER NAME	December-2020	November-2020	October-2020	September-2020	August-2020
National Average	**81.7**	**84.4**	**80.9**	**81.0**	**83.0**
GREATER MANCHESTER MENTAL HEALTH NHS FOUNDATION TRUST	98.5	97.0	97.0	95.8	96.5
BIRMINGHAM AND SOLIHULL MENTAL HEALTH NHS FOUNDATION TRUST	98.3	98.4	98.4	98.5	98.5
NORTH STAFFORDSHIRE COMBINED HEALTHCARE NHS TRUST	98.2	98.0	97.9	98.0	98.1
TEES, ESK AND WEAR VALLEYS NHS FOUNDATION TRUST	98.2	98.1	98.1	98.0	98.0
HERTFORDSHIRE PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST	97.1	97.2	97.1	97.2	94.7
NORTHUMBRIA HEALTHCARE NHS FOUNDATION TRUST	97.0	96.9	96.8	95.7	97.3
SOUTH LONDON AND MAUDSLEY NHS FOUNDATION TRUST	96.9	95.0	95.0	95.1	95.0
DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST	96.5	96.5	96.6	96.5	96.7
NOTTINGHAMSHIRE HEALTHCARE NHS FOUNDATION TRUST	96.4	96.4	96.3	95.4	95.3
CAMBRIDGESHIRE AND PETERBOROUGH NHS FOUNDATION TRUST	96.3	95.3	94.2	96.7	97.1
LINCOLNSHIRE PARTNERSHIP NHS FOUNDATION TRUST	95.9	95.9	95.4	97.5	97.5
ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST	95.9	95.3	95.5	96.1	95.9
BARNET, ENFIELD AND HARINGEY MENTAL HEALTH NHS TRUST	95.8	95.4	93.2	95.6	95.4
TAVISTOCK AND PORTMAN NHS FOUNDATION TRUST	95.8	95.8	95.7	95.7	95.7
KENT AND MEDWAY NHS AND SOCIAL CARE PARTNERSHIP TRUST	95.7	95.5	95.5	95.3	95.5
NORFOLK AND SUFFOLK NHS FOUNDATION TRUST	95.1	94.8	94.9	95.0	95.2
CAMDEN AND ISLINGTON NHS FOUNDATION TRUST	94.9	92.5	92.5	94.9	95.0
SHEFFIELD CHILDREN'S NHS FOUNDATION TRUST	94.8	95.0	95.2	95.1	96.0
SUSSEX PARTNERSHIP NHS FOUNDATION TRUST	94.8	94.2	93.8	91.4	91.0
NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST	94.6	95.0	96.7	97.0	98.3
SOUTH WEST YORKSHIRE PARTNERSHIP NHS FOUNDATION TRUST	94.5	94.4	94.4	94.3	94.2
MIDLANDS PARTNERSHIP NHS FOUNDATION TRUST	94.3	94.4	94.6	94.5	94.5
NORFOLK COMMUNITY HEALTH AND CARE NHS TRUST	94.3	94.2	93.5	92.9	93.4
WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	94.1	94.5	94.4	94.5	96.6
WORCESTERSHIRE HEALTH AND CARE NHS TRUST	94.1	94.4	94.7	94.6	94.6
WEST LONDON NHS TRUST	94.0	94.4	93.8	93.8	93.9
ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST	93.9	93.1	93.6	93.6	93.8
SOMERSET PARTNERSHIP NHS FOUNDATION TRUST	93.8	94.1	94.5	94.6	97.3
CENTRAL AND NORTH WEST LONDON NHS FOUNDATION TRUST	93.7	93.8	93.8	94.1	94.1
CUMBRIA, NORTHUMBERLAND, TYNE AND WEAR NHS FOUNDATION TRUST	93.7	94.0	93.9	93.9	93.6
BRADFORD DISTRICT CARE NHS FOUNDATION TRUST	93.3	93.2	93.1	93.2	93.0
EAST LONDON NHS FOUNDATION TRUST	93.2	93.4	93.3	93.4	93.2
DEVON PARTNERSHIP NHS TRUST	93.1	89.1	89.3	89.1	89.1
LEEDS TEACHING HOSPITALS NHS TRUST	92.9	92.2	92.2	92.2	93.3
SOUTH WEST LONDON AND ST GEORGE'S MENTAL HEALTH NHS TRUST	92.8	91.9	92.1	92.5	92.5
SURREY AND BORDERS PARTNERSHIP NHS FOUNDATION TRUST	92.7	97.1	97.2	92.7	93.8
AVON AND WILTSHIRE MENTAL HEALTH PARTNERSHIP NHS TRUST	92.6	92.4	92.4	92.7	92.8
BIRMINGHAM WOMEN'S AND CHILDREN'S NHS FOUNDATION TRUST	92.6	91.2	91.4	90.3	89.8
OXLEAS NHS FOUNDATION TRUST	92.4	88.2	91.0	91.9	92.1
PENNINE CARE NHS FOUNDATION TRUST	92.4	92.3	92.4	92.3	92.1
NORTHAMPTONSHIRE HEALTHCARE NHS FOUNDATION TRUST	92.3	91.6	91.7	90.9	91.3
HOMERTON UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	92.1	92.4	92.6	92.7	92.5
ISLE OF WIGHT NHS TRUST	91.7	91.9	90.9	91.1	90.9
LEICESTERSHIRE PARTNERSHIP NHS TRUST	91.6	91.6	92.0	91.0	92.4
SOLENT NHS TRUST	91.5	91.8	92.1	92.2	92.3
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	91.3	90.8	91.0	90.8	91.9
BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST	91.3	90.9	86.8	90.0	92.5
WHITTINGTON HEALTH NHS TRUST	91.2	91.2	92.3	92.2	93.6
GATESHEAD HEALTH NHS FOUNDATION TRUST	90.8	92.1	92.1	92.3	94.3
BLACK COUNTRY PARTNERSHIP NHS FOUNDATION TRUST	90.6	91.1	91.4	91.5	91.7
FRIMLEY HEALTH NHS FOUNDATION TRUST	90.6	89.7	89.6	89.8	93.0
GLOUCESTERSHIRE HEALTH AND CARE NHS FOUNDATION TRUST	90.5	90.3	90.3	42.1	42.0
UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST	90.2	90.9	90.9	90.6	92.2
ISLE OF WIGHT YOUTH TRUST	90.1	86.4	91.4	66.7	66.7
CORNWALL PARTNERSHIP NHS FOUNDATION TRUST	89.9	89.9	89.5	89.5	89.7
LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST	89.8	86.8	86.9	87.6	88.1
SHEFFIELD HEALTH & SOCIAL CARE NHS FOUNDATION TRUST	89.7	89.7	89.0	89.3	89.8
WEST SUFFOLK NHS FOUNDATION TRUST	89.3	90.0	88.0	87.6	91.3
SOUTH TYNESIDE AND SUNDERLAND NHS FOUNDATION TRUST	89.2	89.8	89.7	88.7	92.0
TAMESIDE AND GLOSSOP INTEGRATED CARE NHS FOUNDATION TRUST	89.2	89.6	73.7	89.6	92.3
CHESHIRE AND WIRRAL PARTNERSHIP NHS FOUNDATION TRUST	89.0	89.0	89.2	86.2	86.1
SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST	88.9	89.5	93.8	93.8	98.4
DORSET HEALTHCARE UNIVERSITY NHS FOUNDATION TRUST	88.5	89.1	89.5	89.6	89.8
CHESTERFIELD ROYAL HOSPITAL NHS FOUNDATION TRUST	88.4	88.6	88.2	88.8	91.5
EAST LANCASHIRE HOSPITALS NHS TRUST	88.4	83.4	83.5	83.6	88.7
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	88.2	84.1	81.9	81.8	80.2
ROYAL FREE LONDON NHS FOUNDATION TRUST	88.0	89.1	88.9	88.5	90.9
GREAT ORMOND STREET HOSPITAL FOR CHILDREN NHS FOUNDATION TRUST	87.6	88.5	88.1	88.4	88.2
MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	87.4	88.4	88.5	76.4	75.2
SOUTHERN HEALTH NHS FOUNDATION TRUST	87.2	71.8	87.1	87.7	92.0
DERBYSHIRE COMMUNITY HEALTH SERVICES NHS FOUNDATION TRUST	86.3	86.2	86.5	86.2	88.3
COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	86.0	86.9	46.0	45.1	44.4
UNIVERSITY HOSPITALS OF DERBY AND BURTON NHS FOUNDATION TRUST	85.4	86.4	86.5	73.3	74.8
BRIDGEWATER COMMUNITY HEALTHCARE NHS FOUNDATION TRUST	84.5	84.0	82.8	80.8	87.1
MEDWAY NHS FOUNDATION TRUST	84.3	86.1	85.9	85.1	85.7
THE CELLAR TRUST	84.1	83.6	83.3	88.2	87.9
WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST	84.0	85.0	84.9	84.8	90.7
EPSOM AND ST HELIER UNIVERSITY HOSPITALS NHS TRUST	83.8	84.9	84.8	84.8	90.2
KENT COMMUNITY HEALTH NHS FOUNDATION TRUST	83.8	80.3	76.8	74.5	85.7
BIRMINGHAM COMMUNITY HEALTHCARE NHS FOUNDATION TRUST	83.3	82.8	55.6	55.6	55.7
OXFORD HEALTH NHS FOUNDATION TRUST	83.1	82.8	81.0	82.9	94.4
COVENTRY AND WARWICKSHIRE PARTNERSHIP NHS TRUST	82.9	82.9	83.0	82.6	82.2
HOUNSLOW AND RICHMOND COMMUNITY HEALTHCARE NHS TRUST	82.3	84.5	79.9	80.4	87.5
NORTHORPE HALL CHILD AND FAMILY TRUST	73.5	73.4	73.7	73.4	73.7
BRATHAY TRUST	68.0	63.6	63.8	-	-
NORTH EAST LONDON NHS FOUNDATION TRUST	67.6	67.6	66.9	66.5	68.5
HUMBER TEACHING NHS FOUNDATION TRUST	67.1	67.1	66.1	94.3	94.1
BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST	59.7	59.7	58.8	59.2	91.5
LANCASHIRE & SOUTH CUMBRIA NHS FOUNDATION TRUST	59.4	58.6	56.0	55.8	93.1
MERSEY CARE NHS FOUNDATION TRUST	50.5	92.9	48.8	49.1	56.8
NORTH WEST BOROUGHS HEALTHCARE NHS FOUNDATION TRUST	48.5	89.1	46.7	46.6	54.7
DUDLEY AND WALSALL MENTAL HEALTH PARTNERSHIP NHS TRUST	5.8	5.8	90.4	87.7	90.5

Data source: https://digital.nhs.uk/data-and-information/data-tools-and-services/data-services/data-quality#march-2021

Appendix 4 - 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.
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.

Data Quality Indicator	Definition	Not yet assessed	Sufficient	Insufficient
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 – 4 May 2021

COVID-19 Update Briefing

Purpose of Report

To provide an overview of the Trust's response to the ongoing COVID-19 Pandemic.

Executive Summary

This briefing provides an update on the response to the COVID-19 pandemic outlining the Incident Management Team (IMT) structure and cell function. It also captures an element of the EU Exit planning. It aims to supplement the daily communications and podcasts that colleagues have received.

The Incident Management Team is supported by a number of cells as shown below:

- Workforce and Estates
- Infection prevention and control
- Staff check and trace
- Flow and discharge
- Safer staffing
- COVID-19 vaccination
- Training
- Ethics and clinical governance
- Partnership working

The report provides additional narrative on the core areas of current work / actions within each cell.

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 provides assurance that the Trust Incident Management Team is maintaining a coordinated response to the outbreak of the COVID-19 and additional pressures including EU Exit, Winter preparedness and the COVID-19 Vaccination Programme.

Consultation

This paper has not been received at any other meeting.

Governance or Legal Issues

- Coronavirus Bill
- Changes to Mental Health Act and Care Act
- NHSE Emergency Preparedness Resilience and Response Framework

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:

As part of the ongoing response to COVID-19 the Incident Management Team are considering equality impacts through the various work streams. Examples of this include

- Making communications available through email and podcasts. The podcasts are transcribed to ensure we consider our deaf community.
- Easy read documents have been made available and shared with our learning disabilities service for wider cascade.
- We have been considering our older adult population during discussions around the potential for relocating patients as part of the wider system request and the impacts this would have on our patients and staff.
- We continue to provide the open access helpline which is available for our current cohort of patients and residents of Derby and Derbyshire.
- We widened the scope of the IMT: we sought expressions of interest for a BAME role and Disability and Wellness role. This was well received and volunteers provided additional depth to the response.

Recommendations

The Board of Directors is requested to:

1) Receive the report
2) Be assured of a coordinated response to the incident
3) Confirm and challenge as appropriate.

Report presented by: **Lee Doyle**
Acting Director of Operations

Report prepared by: **Peter Henson**
Head of Performance

COVID19 Pandemic Trust Board Briefing

Introduction

We are continuing to provide an incident response to COVID-19 and delivering the roll out of the COVID-19 vaccination programme. As a result of ongoing improvements and reduction in COVID-19-related activity nationally, from 26 April 2021 NHS Trust incident response functions were directed to reduce their operating hours to Monday to Friday from 9am to 5pm, excluding public holidays. Incident Management Team (IMT) meetings are currently held on Mondays and Fridays at 10am and 4pm.

Ensuring the safety of patients, staff and volunteers has continued to be the core of our response. We continue to use the cell approach to ensure all facets of the incident response are covered. This report gives a summary update of the functions of each cell and tasks that have been undertaken by the cell since the last report.

Workforce and Estates Cell

Workforce

Since March 2021 the number of confirmed cases of COVID-19 in the workforce has remained fairly stable at around a cumulative of 8. The roll-out of vaccination has resulted in a rise in absence for recovery following vaccination, this can be an absence of one to 3hree days and is recorded through Firstcare as in all absences. At the time of writing there are 22 staff absent from work for COVID-19 related reasons, of whom almost half are off for vaccination recovery. Overall sickness absence for all reasons is the lowest it has been for three years, currently sitting just below the Trust's 5% target at 4.8%.

Estates

Deep cleans continue and additional cleans have been completed in relation to outbreak management on wards and in clinical areas. The last outbreak occurred in February 2021. In response the Estates cell worked with other cells and key individuals to quickly repurpose Audrey House into a temporary COVID-19 ward, which proved extremely successfully as a tactic for managing the outbreak safely and minimising the risk of further spread of infection.

Temporary use of Audrey House for COVID-19 patients has now ceased as case numbers have significantly reduced across the Trust. Deep clean activity is still ongoing as required and plans are in place to re-open the restaurant at Kingsway on 17 May (assuming national restrictions are lifted). Works to seven rooms at Kingsway are now complete to allow them to be used as bookable meetings spaces for teams across the Trust.

Infection Prevention and Control Cell

The cell continued to provide management oversight of small outbreaks within clinical areas when they occurred, working with the teams caring for patients with COVID-19 to ensure the safety of the patients and staff. Meetings were conducted in partnership with NHS England and NHS Improvement (NHSE/I), Public Health England and colleagues from the Clinical Commissioning Group (CCG). The cell has reviewed national guidance in relation to infection prevention and control and promoted best practice and supported communication through local teams and Trust

wide communications to share information and learning. Thankfully there have been no patient cases of COVID-19 since February 2021.

Staff Check and Trace Cell

The cell continues to monitor COVID-19 related staff absence and to manage the supply of and monitor the outcome of lateral flow testing across the Trust.

Since the trust started using the tests at the end of November 2020 over 2,100 kits have been registered to staff and these staff have submitted almost 38,000 test results. Of these 38,000 we have seen 97 positive lateral flows of which 17.5% have been false positives. The cell has also been able to use the results to identify potential COVID-19 breakouts in areas and worked alongside the trust track and trace team to minimise the spread of this. Staff are requested to complete tests every 3 or 4 days, even if they have been vaccinated.

Flow and Discharge Cell

The cell has continued to work on pathway development and inpatient length of stay reduction to optimise bed usage. This has been key as the number of inpatient beds has been reduced by 29 in order to create more physical space and enable social distancing and infection prevention and control measures.

The cell has escalated any delays in discharge in order to keep delays to a minimum.

The cell is working on transformation of adult mental health community services

Staffing, Workforce and Redeployment Cell

The majority of staff who were temporarily redeployed across operational services returned to their usual place of work at the end of March. The cell has developed a peripatetic bubble staffing model and has made recommendations for 2021/22. The cell is supporting the stand-up of Day Services from late May.

COVID Vaccine Cell

Over the last few months, the multi-professional cell has been instrumental in the successful establishment of a hospital hub vaccination centre at Kingsway Hospital. This has resulted in vaccination of staff, patients and carers in line with Government directive on vaccine prioritisation.

To support the hub to operate safely, effectively and in line with best practice and rapidly changing national guidance, the cell has developed and continues to maintain a policy including standard operating procedures.

Vaccines have primarily been administered within the hub, however subject to appropriate governance and the limitations of the product we have been able to meet specific patient needs by administering doses on our own wards and those of a private healthcare provider. We anticipate imminent deployment of vaccination in peoples' own homes on a small-scale for those with very specialist needs that prevent them from obtaining their protection in any other way.

Training Cell

The national directive to pause training in order to free up capacity to focus on managing the pandemic inevitably resulted in a backlog. The training cell is currently focusing on improving CQC statutory compliance, particularly around positive and safe teamwork training on the inpatient units. Improvement is monitored weekly and action taken to increase the number of training places filled.

Ethics and Clinical Governance Cell

This cell has continued to consider proposed changes to service delivery and/or clinical practice and the wider implications of the proposed changes. Papers are received and reviewed by the Director of Nursing and Medical Director, examples of which include standard operating procedures and guiding principles for supporting BAME staff during the COVID-19 pandemic.

Participation with the system and multi-agency partners

Participation has continued, as previously reported:

- Multi-agency strategic and tactical co-ordinating groups
- System Escalation Call and System Operational Resilience Group
- Mental Health work stream calls
- National NHS EPRR (Emergency Preparedness, Resilience and Response) response webinar
- National and Regional Medical Directors
- National and Regional Nurse Directors
- Safeguarding Boards recommenced and is restoring its function and this is elevating pressure on the safeguarding functions
- System flu group
- System COVID vaccine group

Requests for information

Although the volume of national reports required to be produced and submitted has remained high, there has been a reduction in frequency of submission recently, in some cases. The main national situation report (sitrep) continues to be completed daily. This provides the daily position regarding bed occupancy, bed closures, inpatients with COVID-19, patient swab test results awaited, staff absence and operational issues.

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 4 May 2021

Guardian of Safe Working Quarterly Report (Extended October 2020 - April 2021)

Purpose of Report

This is an extended report from the DHCFT Guardian of Safe Working which provides data about the number of junior doctors in training in the Trust, full transition to the 2016 Junior Doctor contract and any issues arising therefrom. The report details arrangements made to ensure Safe Working within the new contract and arrangements in place to identify, quantify and remedy any risks to the organisation.

Executive Summary

This extended report from the DHCFT Guardian of Safe Working (GOSW) provides data about the number of junior doctors in training in the Trust, full transition to the 2016 Junior Doctor contract and any issues arising therefrom. The report details arrangements made to ensure safe working within the new contract and arrangements in place to identify, quantify and remedy any risks to the organisation.

The Board of Directors is requested to note:

1) There are vacancies in higher trainee posts that reflect the national issue with recruitment in psychiatry. Trainees are being supported with exception reporting and these have been resolved in a timely fashion. There have been no exception reports during the last quarter.
2) The BMA fatigue and facilities charter for junior doctors is being carefully considered and recently issue with space for juniors in the south has been successfully resolved. We have nominated one junior doctor each from north and south to explore with other juniors about the use of allocated funds for this purpose.
3) There are issues with Allocate, the software-with logging ER or closing them which causes slight delay in the process. The company is not providing a good service anymore and we have had no contact with them recently despite messages left for them. This seems to be a national issue. Last year they did attend a Junior Doctor Forum (JDF) meeting.
4) During the COVID crisis, the junior doctors had previously raised issues about their work environment, situation with PPE and some training issues. The JDF has continued to provide them with a neutral platform to raise any such issues. They have felt supported and have been able to express their concerns freely. Some of the previous issues raised at JDF have been discussed with DME – Director Medical Education (DME)
5) DME, Associate Director Medical Education (ADME), Nursing Matron from Hartington unit and Freedom to speak up Guardian or signposted elsewhere. We have continued to hold JDF every 4-6 weeks and will be so for the rest of the year.
6) During COVID, the junior doctors have been risk assessed for potential complications due to COVID which may arise through existing health conditions or through being in the BAME group. The risks thus highlighted

have been addressed and suitably managed/ mitigated. The JDF has monitored this closely.

7) Junior doctors have successfully completed virtual induction and have given a positive feedback. There are connectivity issues at Hartington unit which remains unresolved.

8) The Freedom to speak up Guardian has recently met with junior doctors and explained her role to them.

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 extended report from the DHCFT Guardian of Safe Working provides data about the number of junior doctors in training in the Trust, full transition to the 2016 Junior Doctor contract and any issues arising therefrom. The report details arrangements made to ensure safe working within the new contract and arrangements in place to identify, quantify and remedy any risks to the organisation.

Consultation

- At the Junior Doctor Forum about relevant issues discussed in the report
- At the LNC discussions take place regarding the smooth running of consultant on call rota while we have so many vacancies on the higher trainee rota
- Discussions with DME, ADME regarding the concerns raised by Junior doctors
- Quality and Safeguarding Committee.

Governance or Legal Issues

- As the Guardian, I have been attending the local and national conferences to gain more knowledge and experience through discussions with other Guardians. More recently the meetings have been virtual, but the discussions have been helpful as a lot of similar issues affecting juniors elsewhere have been discussed
- I am also undertaking the role of a FTSU (Freedom to Speak up) Champion as I feel this will encourage juniors to use the Freedom to speak guardian whose role currently seems to be less understood by junior doctors.

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 clearly addresses the impact of COVID on BAME group amongst the junior doctors. NO other equality issues have been raised during this period.

Recommendations

The Board of Directors is requested to note the contents of the report as assurance of the Trust's approach in discharging its statutory duties regarding safe working for medical trainees.

Report presented by:	**Dr Smita Saxena** **Guardian of Safe Working**
`	**Dr John Sykes** **Medical Director**
Report prepared by:	**Dr Smita Saxena** **Guardian of Safe Working**

GUARDIAN OF SAFE WORKING QUARTERLY REPORT
(Extended October 2020 - April 2021)

1. Trainee data

Extended information supplied from 1 October 2020 to 1 April 2021.

Number of posts for doctors in training (numbers in post)

Grade	Number of posts for doctors in training (total)			
	NORTH		SOUTH	
CT1-3	8		11	
ST4-7	7		7	
GP Trainees	4		7	
Foundation	5		9	

2. Exception Reports (with regard to working hours)

There were one reports during this period. No fines were levied.

Exception Reports				
Location	No of exceptions carried over from last report	No of exceptions raised	No of exceptions closed	No of exceptions outstanding
North	0	0	0	0
South	0	1	1	0
Total	0	1	1	0

Exception Reports by Grade				
Location	No of exceptions carried over from last report	No of exceptions raised	No of exceptions closed	No of exceptions outstanding
CT1-3	0	0	0	0
ST4-7	0	1	1	0
GPVTS	0	0	0	0
Foundation	0	0	0	0
Total	0	1	1	0

Exception Reports by action				
	Payment	TOIL	Not agreed	No action required
North	0	0	0	0
South	0	1	0	0
Total	0	1	0	0

Response time				
Grade	**48 hours**	**7 days**	**Longer than 7 days**	**Open**
CT1-3	0	0	0	0
Foundation	0	0	0	0
ST4-6	0	0	1	0

The exception report above was resolved by TOIL in agreement with the trainee. The delay in responding was due to Allocate related issues.

3. Work schedule reviews

No formal work schedule reviews needed during this period.

4. Fines

No fines imposed.

5. Locum/Bank Bookings

North – 90 shifts totalling £33495.36
South – 67 shifts totalling £28925.24

The locum spend continues to remain high during this period due to COVID-19 related absence or junior doctors shielding and not being able to undertake their out of hours duties.

6. Agency Locum

South – 14 shifts totalling £10,054.50

7. Vacancies

	North Oct 20 – Mar 21	**South Oct 20 – Mar 21**
CT1-CT3	1 (maternity leave)	1
ST4-7	4	0
GP Trainees	0	0
Foundation	0	0

8. Qualitative information

The Junior Doctor Forum (JDF) has been meeting 6-8 weekly during COVID and this has been held virtually. As always, active representation is sought with each changeover of new doctors in accordance with JDF constitution.

This has been well attended by the juniors both in north and south. A representative from British Medical Association (BMA) has also been present on all occasions. The Freedom to Speak up Guardian was also present at the last meeting.

9. Issues arising

9.1 Compliance of Rota

Some trainees had previously raised concerns that the rest requirements for the on call rota were still not in line with the recent recommendations i.e. trainees to have 48 hours of rest after seven consecutive days of work.

Action completed: current rota is fully compliant since August 2020

9.2 During second wave there is adequate PPE availability.

The trainees have not reported any concerns.

9.3 Vacancies

As described Above. The DME and ADME (Director Medical Education and Associate Director Medical Education) are addressing the issues around higher trainee recruitment.

9.4 Induction for August 2021

Induction is being held virtually during COVID and the junior doctors have given a positive feedback.

One of the trainees queried about availability in the induction pack of information about the local services. The DME has suggested perhaps the previous trainees in each post could help to write an information folder about local services which can then be passed on to subsequent trainees as the services vary greatly in different areas and it would not be possible to include that information in generic induction.

The GOSW suggested that perhaps a local induction could be done jointly by the Clinical supervisors, admin staff and a member of team.

9.5 Fatigue and facilities

This is regularly visited at JDF. The trainee reps have asked for assurance that the budgets for fatigue and facilities (F&F) are ring fenced and kept rolling onwards.

The GOSW has encouraged trainees to find a representative each from North and South to take the initiative to liaise with other trainees about the budget spend in future.

The new trainees were made aware that there is still a substantial amount of money to be used from this fund and to forward their ideas.
The Wi-Fi connectivity at Hartington unit remains an ongoing issue due to local issues with the area.

Action(s) pending:

- **The F&F issue will be discussed at each JDF**
- **The JDF wants reassurance that the budget is ring fenced for the purpose and will be carried over to the subsequent financial years.**

Action completed: One trainee each from North and South have volunteered to have a discussion regarding F&F spend with other trainees.

9.4 Exception reports

Exception Reports are encouraged as usual so we can highlight areas of increased demand and impact of response during this period. No face to face contact needed unless we identify a risk that would benefit from this. A telephone discussion with educational supervisor is mandatory with usual information to be submitted on ALLOCATE (the software for logging exception reports) by the trainees and supervisors. Issues with ALLOCATE, have caused some delays in the process. This is a national issue and the GOSW and the Medical Director are looking at using a different system as the provider is not offering a good service.

As usual we propose a timely resolution of exception reports with either time off in lieu or where time off in lieu is not possible an overtime payment will be arranged as usual at some point in future as circumstances permit.

The timescales for taking action for junior doctors' exception reports have been relaxed by NHS employers.

Action complete: Trainees are encouraged at induction and JDF to use Exception Reporting

10. Other concerns raised with the GOSW

Following concerns raised by the trainees at the last JDF about issues relating to their relationships with nursing staff, the trainees have discussing these at other meetings such as – ADME meetings, with the tutors, within peer group/ reps. More recently the FTSU Guardian has spoken to the trainees about her role with such issues.

Action completed:

- **The Clinical Matron, Hartington Unit is meeting with trainees and works closely with nurses to address such issues**
- **Meeting held between the trainee reps and FTSU Guardian. Feedback will be given at next JDF**.

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors - 4 May 2021

Workforce Standards Formal Submission

Purpose of Report

In October 2018, NHS Improvement (NHSI) wrote to all trusts asking them to review their workforce safeguards and implement some formal recommendations effective from 1 April 2019. The purpose of this report is to ensure that the Trust is formally assessing its compliance. This is a self-assessment of the workforce safeguards and 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 2021 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. There has been some disruption in committee reporting due to the Level 4 emergency and the standing down of routine reporting in all areas apart from the Quality and Safeguarding Committee. The Executive Director of Nursing and Patient Experience has taken oversight of safer staffing in the Quality and Safeguarding Committee and in the Incident Management Team's Safer Staffing cell. This includes emergency safer staffing reviews, formal assessments in the Quality and Safety Committee and daily operational scrutiny of the services including over 7 days per week. It also includes direct scrutiny and oversight by the clinical leads over a 7-day week period.

In 2021 the People and Culture Committee, Executive Leadership Team and People Delivery Groups will resume oversight and assurance. The delivery groups will initiate a more inquisitive exploration of safer staffing. This will include continually updating the Trust's integrated workforce information to provide the Board with assurance of our compliance against these safer staffing recommendations at monthly intervals in the integrated performance report.

The self-assessment outlines that the Trust is compliant in this emergency period.

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 in normal operating periods. In the incident management period this has been directly managed by the Safer Staffing cell, the Ethics and Clinical Governance group and executive direct oversight in the Incident Management Team.

The Quality and Safeguarding Committee is assured that the Trust is compliant with the standards and has maintained the required standards. It has received staffing and caseload service specific reviews for services. This included emergency staffing and oversight.

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

- Medical staffing is provided by the Executive Medical Director and the Guardian of Safe Working Practices and reports have been submitted and reviewed by the Quality and Safeguarding Committee. The Guardian of Safe Working also reports through to the Board.
- 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 Executive Director of Nursing and Patient Experience has a deployment and risk management plan for Nursing Associates. The restricted and incremental roll out of this new role has remained successful in 2020.
- Given the day-to-day operational challenges, there is a requirement for 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. Safer staffing in a pandemic has been managed with direct control by the Executive Directors in the Incident Management Team.
- Should risks associated with staffing continue or increase and mitigations prove insufficient, there is a requirement for trusts to 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 and has been fully discharged through the pandemic with changes to wards, cohorting and staffing arrangements.

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

Assurances

- Mental health and other guidance is reviewed and is part of safer staffing reviews at Quality and Safeguarding Committee.
- Trusts must ensure the three components are used in their safe staffing processes, which include evidence based tools (where they exist) from the Mental Health Guide and professional judgement adopted, led by the Assistant Director of Clinical Professional Practice and Heads of Nursing / AHP (Allied Health Professional). This will include a dashboard, CHPPD (care hours per patient day) and e-roster – this is assured and in place and was submitted in December 2020.
- We have some gaps in assurance, and therefore have limited assurance in a revised reporting section due to sustained deficits in training compliance and operational management of this deficit. Recovery plans are in place and will become fully achieved early in the financial year 2021.We have ratified the workforce plan that requires further changes in 2020, based upon the continuous quality improvement work in our clinical strategy developments. The full workforce strategy improvement work has been reduced due to the pandemic.

Consultation

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

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 monthly. This monitoring has been discharged by the Incident Management Team with oversight by the Quality and Safeguarding Committee. Routine monitoring will return to the People and Culture Committee and the integrated performance report of the Trust Board.

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

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.

Recommendations

The Board of Directors is requested to:

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

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

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

John Sykes
Executive 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 and Patient Experience is Lead Director and NQB Mental Health and other guidance reviewed and part of safer staffing reviews at Quality Committee.	Assured and in place in 2020/21
2. Trusts must ensure the three components (see below) are used in their safe staffing processes:	Compliant	Compliant
– evidence-based tools (where they exist)	Mental Health Guide	The Quality and Safeguarding Committee has reviewed the Mental Health Guidance, benchmarked against this information and the required recommendations and this is in place. The mental health model hospital data is used to triangulate, and the Trust remains within national standards.
– professional judgement	Led by Assistant Director of Clinical professional practice and Heads of Nursing / Allied Health Professional (AHP). It includes a dashboard / CHPPD and E-roster dashboard. A full review of COVID-19 emergency staffing was undertaken and reviewed by the Quality and Safeguarding Committee. A workforce cell was established and reviewed emergency staffing and put in place full mitigation plans, and the use of redeployment.	Assured and in place for 2020/21
– outcomes.	Recommendations form clinical staff and Heads of profession are included in the skill mix review and have been implemented. This has occurred extensively throughout 2020/21.	Assured and in place for 2020/21

The NHSI standard	Trust response	Current performance and gap in assurance
We will check this in our yearly assessment.	Available for assessment	
3. We will base our assessment on the Annual Governance Statement, in which trusts will be required to confirm their staffing governance processes are safe and sustainable. https://www.cqc.org.uk/files/inspection-framework-nhs-trusts-foundation-trusts-trust-wide-well-led	In development with Annual Report process, for submission.	The Well-led review in 2020, including reviewing our safe staffing and skill mix review. There were no concerns re: our establishment. The concerns were for continual improvement in reducing our vacancy rate in core hot spot area, our Trust wide qualified vacancy rate is below the East midlands regional average. This has improved in 2020 and 2021, with an extensive reduction in vacancy rate in hotspot areas with an end of year position of a Trust wide vacancy rate of 6%. 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 2020/21 to ensure safe staffing. This can be externally verified by CQC mental health act and transitional monitoring which reported on the acute service in 2021 *"the trust had enough staff to deliver these services".*
4. We will review the Annual Governance Statement through our usual regulatory arrangements and performance management processes, which complement quality outcomes, operational and finance performance measures.	Revision to ensure all recommendation requirements are reviewed as per this guide and a standard operating framework for these required reports in a new model is implemented. COVID-19 arrangements have been in place and have impacted upon this work. This work has been achieved through the Incident Management Team, however in May 2021 a full return to integrated performance reporting on all aspects of safe staffing including fill rates should return to oversight and governance practice.	Assured and in place for 2020/21through Incident Management Team. The 2020/21 Annual Governance Statement contains a statement of compliance with the standards.
5. As part of this yearly assessment we will also seek assurance through the Single Oversight	Provided in integrated report, any further refinements as per recommendation 4, and was	Assured and in place for 2020 /2021 through

The NHSI standard	Trust response	Current performance and gap in assurance
Framework (SOF), in which a provider's performance is monitored against five themes.	enacted in March 2019.	Incident Management Team.
6. As part of the safe staffing review, the Executive Director of Nursing and Executive Medical Director must confirm in a statement to their board that they are satisfied with the outcome of any assessment that staffing is safe, effective and sustainable.	Available for Nursing and AHP in Quality and Safeguarding Committee papers. All service changes have a Quality Impact Assessment (QIA) and this has been externally assessed by the CQC in 2020 as meeting required standards. To ensure that medical staffing is safe, effective and sustainable: • Medical workforce monitoring for all grades including trainees in real time, reports at Medical Workforce Group every 2 weeks with exception reporting. Chaired by Executive Medical Director or his deputy with Operational and HR leads in attendance. • International and local recruitment (and retention) initiatives with engagement events led by Executive Medical Director, medical education leads and Clinical Directors. • Founder member of East Midlands Hub to control locum costs but these have spiralled upwards lately. • Executive Medical Director and HR lead member of national learning set to investigate best practice nationally. • Medical Workforce Group drafted first integrated workforce plan which is now expanded to include all clinical disciplines. There has been development of non-medical Approved Clinicians and prescribing roles. • Medical Director has presented workforce plan at People and Culture Committee.	Medical risks to delivery for safe staffing are reviewed Deep dive reports have been undertaken including benchmarking and detailed analysis Guardian of safer working reports have been scrutinised by the Quality and Safeguarding Committee and received by Trust committees Assured and in place for 2020/21 The nursing workforce review of the Beeches is required in 2021 to review the best practice and staffing levels against national guides. This work is commencing in May 2021.

The NHSI standard	Trust response	Current performance and gap in assurance
	Recruitment and retention performance is in advance of regional average. • E-job planning procured. To be fully operational in December 2021. • All training posts compliant with national contracts with reports from Guardian of Safe Working to the Quality and Safeguarding Committee. • Trust rated highly by GMC re medical training standards. • Alternative cover arrangements for physical healthcare after hours in place and utilised in event of absences of medical staff. • Group formed to explore gender/diversity issues in medical workforce including gender pay gap. Feedback given to Local Negotiating Committee who will agree action with management side. • the nursing workforce review of the Beeches is required in 2021 to review the best practice and staffing levels.	
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 is in line with the Trust business planning and the STP planning process was developed and signed off. However, the 2020 plan has been operationally delivered but requires further refinement. This work was assured and in place for 2019/20 and operational developments have been led by the Executive Team in the pandemic period. Examples include 'grow your own' approaches and apprenticeships for Nursing Assistants and eligible administration staff to enter into Nursing Associate or Registered nurse training positions.	Strategic Workforce Group has been impacted by the pandemic and has not fully overseen the delivery of the two-year plan. The executive team have taken direct oversight and direct action in the pandemic period. In this next phase of recovery in 2021 the Director of People will reactivate the workforce development and delivery architecture to recommence standard operating procedures and People services governance and assurances.

The NHSI standard	Trust response	Current performance and gap in assurance
	Specific priority areas with future workforce gaps have included Learning Disability Nursing and Mental Health Nursing, these schemes have been identified for the predicted expansion in Autism and Learning Disability services in line with long term plan investments in 2023/ 24. In addition, the expansion of trust services including Psychiatric Intensive Care Unit (PICU) and community framework again in this time period. Investment in additional medical training posts to reduce future workforce gaps. Use of the workforce levy for national apprenticeship schemes.	
8. They must ensure their organisation has an agreed local quality dashboard that cross-checks comparative data on staffing and skill mix with other efficiency and quality metrics such as the Model Hospital dashboard. Trusts should report on this to their Board every month.	The Integrated Performance Report provides this information. Alongside this other service specific reports are provided to both Quality and Safeguarding and People and Culture Committees.	Assured and in place for 2020/21, governance streamlined in line with national requirements to reduce the burden to release capacity to manage the pandemic governance. Deep dive reports and CQC review transition monitoring reports all contain mental health model hospital data per service line. The Executive Team have taken direct oversight and direct action in the pandemic period. Full reporting will recommence in 2021.
9. An assessment or re-setting of the nursing establishment and skill mix (based on acuity and dependency data and using an evidence-based toolkit where available) must be reported to the Board by ward or service area twice a year, in accordance with NQB guidance and NHS Improvement resources. This must also be linked to professional judgement and outcomes.	Available in Quality and Safeguarding Committee papers. This is reported to the Board through the Board Committee Assurance Summaries. There were no escalation issues to the Trust Board based upon these submissions.	The Executive Team have taken direct oversight and direct action in the pandemic period. This has been reviewed and signed off by the Executive Director of Nursing and Patient Experience and the Quality and Safeguarding Committee. Revise reporting model in 2020-21 to include direct board report in the Integrated Performance Report and People and Culture Committee and post Quality and Safeguarding Committee

The NHSI standard	Trust response	Current performance and gap in assurance
		submission twice per year in its Board Assurance summary.
10. There must be no local manipulation of the identified nursing resource from the evidence-based figures embedded in the evidence-based tool used, except in the context of a rigorous independent research study, as this may adversely affect the recommended establishment figures derived from the use of the tool	This is a statement – not a specific question to answer. We do not adapt any information.	Assured and in place for 2020/21
11. As stated in CQC's well-led framework guidance (2018) 6 and NQB's guidance7 any service changes, including skill-mix changes, must have a full quality impact assessment (QIA) review	We will refresh our QIA once we have the outcome of shift change consultation exercise. This did not occur in 2020/21. Additional supplementary staffing has been introduced including the staffing bubble to manage unexpected large scale changes in staffing. No reductions in staffing have occurred within the year.	Assured and in place for 2020/21
12. Any redesign or introduction of new roles (including but not limited to physician associate, nursing associates and advanced clinical practitioners – ACPs) would be considered a service change and must have a full QIA.	Compliant. Executive Director of Nursing has a deployment and risk management plan for nursing associates.	Assured and in place for 2020/21. 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 in the Incident Management Team. Datix is used to record risk, with an assessment of risk part of this.	Assured and in place for 2020/21 Example acute care, Health visiting caseloads in the pandemic. Review of Childrens services staff in the COVID-19 vaccination centre. Review of Audrey House 2020/21- activity and staffing Review of Cherry Tree Close 2020/21 – activity

The NHSI standard	Trust response	Current performance and gap in assurance
		and staffing.
14. Should risks associated with staffing continue or increase and mitigations prove insufficient, Trusts must escalate the issue (and where appropriate, implement business continuity plans) to the Board to maintain safety and care quality. Actions may include part or full closure of a service or reduced provision: for example, wards, beds and teams, re-alignment, or a return to the original skill mix	Staffing risks are identified in inpatient areas via a daily assurance process, whereby current and future risks are reviewed, and actions taken to minimise risk. Staffing huddle/ Safe staffing cell/ Escalation to Ethics and Clinical Governance cell as required. When appropriate escalation to Directors for service closure decisions are made.	Assured and in place for 2020/21 This occurred in 2020/21 for Audrey House due to significant reduction in clinical activity. This was reviewed at the Ethics and Clinical Governance cell by the Two Board level Clinical Directors (Director of Nursing and Medical Director).

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 4 May 2021

Workforce Resources Delivery Plan

Purpose of Report

To provide the Board of Directors with information and assurance on:

1. The workforce resourcing position in line with our organisational plans
2. Assurance that this plan is in accordance with the Trust's known service, workforce and financial intentions over the year
3. The plan supports the Joined-up Care vision, Mental Health investments and long-term plan and therefore has system alignment.

Executive Summary

Our workforce plan has been developed with input from services and supports the delivery of our overall organisational operational plan. The three-year Workforce Plan establishes how we will provide the right workforce, in the right place, delivering the right care for the population of Derbyshire. It also outlines how we will deliver the objectives of the NHS Long Term Plan, and the People Plan, to ensure that we can achieve the ambitious improvements we want to see for our patients. The plan establishes how we will overcome the challenges we face in terms of our workforce, including staff shortages against a backdrop of a growing demand for our services. The workforce plan supports innovative system-wide workforce transformation projects that is changing the way our services are delivered for the patients of Derbyshire. This work aims to radically transform healthcare services, making best use of our assets, our workforce, breaking down silos between services and reducing fragmentation in service delivery. For our workforce it means working in different ways, role transformation and improvements in quality of care and outcomes.

Within the NHS Long Term Plan (LTP) the Mental Health Implementation Plan provides a new framework setting out our commitment to deliver the most ambitious transformation of community mental health services and the wider mental healthcare workforce we have seen in the last 30 years.

The contents of this paper describe the current position and reporting against the plan, with key metrics and the future planning processes. It provides further detail on the workforce required to deliver the COVID-19 Pandemic Phase 3 Recovery Plan for the period September 2020 to March 2021. This further determines the plan that is required for submission for the year 2021/22 as part of the planning guidance published by NHS England and Improvement on 25 March 2021.

The draft plan is to be submitted on 6 May 2021 and following feedback, the Final Plan to be submitted on 3 June 2021. The submission will need to align to the 2021/22 Mental Health Finance and activity plans, being submitted on 6 May.

The Board is asked to note that dynamic nature of the plan which will be revised as it develops through system, regional and national processes.

The paper describes the levels of vacant posts that ware yet to be filled along with the increases in investments and new roles/service delivery that is already in progress. New models of service delivery and skill mix of existing roles will help to meet the target on our plan. The paper points to the increased use of the apprenticeship levy for new roles which will require a financial commitment for backfill.

Progress and achievements made over the last two years are noted in the paper along with key points of investment which will deliver new roles and new ways of working across a system wide delivery plan.

Crucial to this investment and the new roles and reshaping/development of services is the cultural transformational change which needs to be embedded in each stage of these developments. Further development of an inclusive culture which creates a sense of belonging for all our people within DHCFT (the Trust) will be our planned cultural intelligence programme and culture diagnostic process. These will seek to deliver this cultural change at across all teams of the organisation.

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 developments and actions summarised in the paper evidence how the Trust is aligning the strategic ambitions and plans in line with organisational regional and national workforce plans.

Consultation

- The plans have been developed in association with the Executive leadership Team and our system colleagues through Joined Up Care Derbyshire (JUCD).

Governance or Legal Issues

Delivery of the workforce plans will ensure that the Trust is compliant with:

- Monitoring and governance of the commitments as defined in the NHS LTP i.e. investments in both registered and non-registered parts of our workforce and their investments
- Monitoring and governance of the apprenticeship levy
- Safe Staffing Standards
- Financial Directives
- Working Time Directives 1998
- Equality Act 2010
- Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
- NHS Improvement's Agency Directives 2015
- National benchmarking
- NHSI weekly reporting for agency
- Monthly internal report from people resourcing for recruitment, bank and agency.

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

Our vision is to be an exemplar of good equalities practice. We are committed to advancing equality of opportunity and working productively with key stakeholders across the protected characteristics. We plan to attract, recruit and retain a wide range of staff from all sections of society to work in a positive, inclusive and nurturing environment. We also want to deliver, with dignity and respect, inclusive and accessible services that meet our patients' individual needs. We want to be the employer of choice for people living in the region, attracting local talent to work with us and for us, by recruiting a diverse, innovative, flexible and creative workforce.

The Trust has a legal requirement under the Equality Act (2010) to analyse and include equality considerations into day to day Trust business, including the design of policies, the delivery of services and employment. The law requires that we specifically respond to the three aims of the general equality duty. It is about identifying barriers and removing them before they create a problem, increasing the opportunities for positive outcomes for all groups, and using and making opportunities to bring different communities and groups together in positive ways. This is reflected throughout the workforce plan and its delivery.

Recommendations

The Board of Directors is requested to:

1) Note the contents of this paper and the key metrics
2) Note the planning preparation and key dates for submission of plans
3) Support the progress of the plan
4) Provide any further direction/comments on the delivery of the plan.

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

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

Gareth Harry
Director of Business Improvement and Transformation

Nancy Cooke
Workforce Planning & Development Lead

Faith Sango
Head of People Development

Serita Bonsignore
Assistant Director Equality Diversity & Inclusion

Workforce Resourcing Summary

Key Summary points to note

- The planned growth in the workforce required by the end of March 2021 was 46.40 whole time equivalents (WTE) which was primarily made up of nursing and medical vacancies. This figure has been reduced using bank and agency which is supporting the fill to vacancies across the Trust.
- The planned total staff in post at the end of March is 2,821.39 WTE
- The total staff in post as at the end of March is 2,641.93 WTE
- As at the end of March the plan and growth was not achieved and the distance to the plan was a shortfall of 179.46 WTE. This position is shown in more detail in the chart and table in the section below.
- The main staff groups that are below the planned position are Registered Nursing and the Medical workforce.

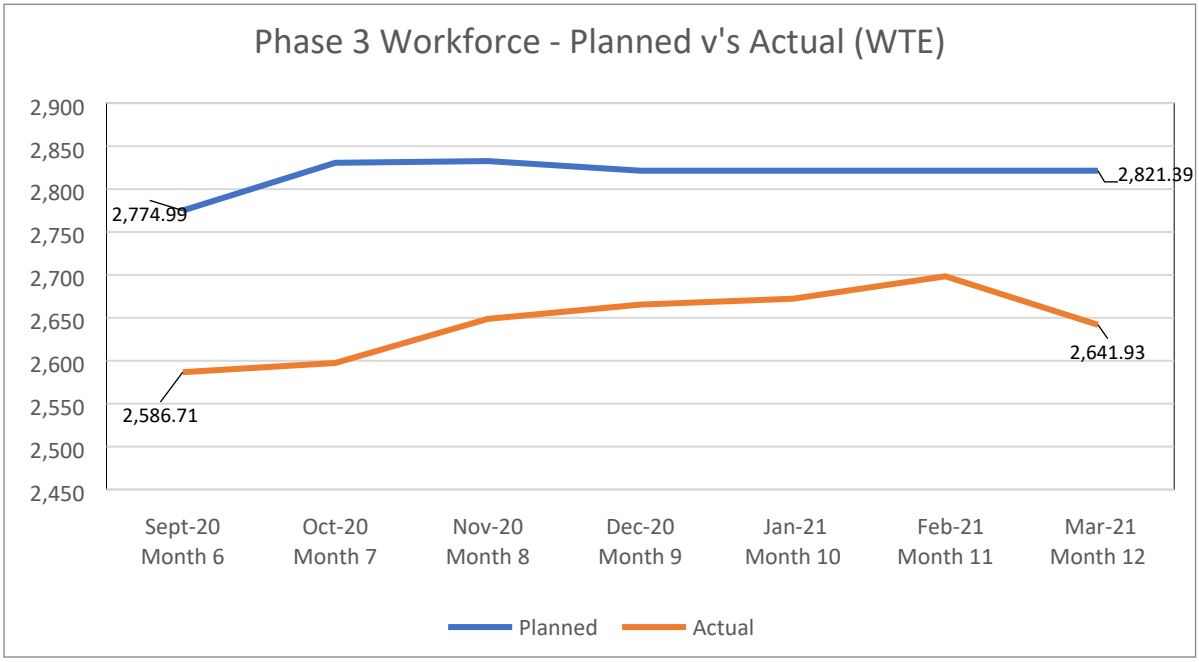
The total workforce growth for Derbyshire mental health services to deliver the LTP is to increase the staffing levels by 404.57 WTE by 2024. We are now in year 2 of the LTP and the workforce growth is 154.44 WTE. Detail breakdown of this is provided in the Workforce Plan for 2020-23.

The current position

In September 2021 the workforce plan for Mental Health services was submitted to NHS England and Improvement as part of the COVID-19 Phase 3 Recovery Plan, setting out how the priorities for the second half of 2020/21 would be achieved. This outlined the steps required to support the next phase of our COVID-19 response, recognising that mental health needs may increase significantly.

This chart shows the planned position against the actual position:

			Provider Workforce Return - Actuals								
Phase 3 Planning Return Workforce (WTE)	20/21 Year end Position Total	Growth Sept 20 - Mar 21	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Year to Date Position	Distance to meet Year End Position
Substantive	2,640.19	**46.40**	2,382.24	2,402.43	2,417.74	2,430.30	2,451.36	2,451.12	2,409.19	-231.00	-231.00
Bank	154.90	**0.00**	165.97	154.37	172.49	178.83	168.96	180.56	169.04	14.14	14.14
Agency	26.30	**0.00**	38.50	40.63	58.56	56.29	51.93	66.70	63.70	37.40	37.40
Total Provider Workforce (WTE)	2,821.39	**46.40**	**2,586.71**	**2,597.43**	**2,648.79**	**2,665.42**	**2,672.25**	**2,698.38**	**2,641.93**	**-179.46**	**-179.46**
Substantive by staff group											
Registered nursing, midwifery and health visiting staff	1,046.64	**27.90**	866.53	890.28	904.69	911.66	921.38	924.68	917.88	-128.76	-128.76
Allied health professionals	162.50	**0.80**								-162.50	-162.50
Other scientific, therapeutic and technical staff	183.48	**-0.27**	297.22	301.39	299.17	300.78	310.31	306.70	312.35	128.68	128.87
Health Care scientists	0.00	**0.00**								0.00	0.00
Qualified ambulance service staff	0.00	**0.00**								0.00	0.00
Support to nursing staff	312.84	**12.10**	668.27	650.49	647.22	653.66	647.69	645.19	639.75	326.91	326.91
Support to allied health professionals	37.17	**0.00**								-37.17	-37.17
Support to STT & HCS Staff	13.85	**0.47**	48.51	49.81	49.41	48.33	48.90	46.74	46.43	32.77	32.58
Support to Ambulance Staff	0.00	**0.00**								0.00	0.00
Total non-medical - Clinical staff substantive	1,756.48	**41.00**	1,880.53	1,891.97	1,900.49	1,914.43	1,928.28	1,923.31	1,916.41	128.29	135.49
Consultants (including Directors of Public Health)	84.60	**1.40**	77.84	81.26	80.51	80.48	80.56	82.01	79.91	-4.69	-4.69
Career/Staff grades	31.39	**0.00**	25.97	28.94	25.36	26.16	25.21	25.38	26.70	-4.69	-4.69
Trainee grades	62.75	**0.00**	55.31	55.00	57.56	58.14	57.66	63.82	59.29	-3.46	-3.46
Total medical and Dental Staff substantive	178.74	**1.40**	159.12	165.20	163.43	164.78	163.43	171.21	165.90	-13.54	-13.54
NHS Infrastructure support	704.97	**4.00**	336.59	339.26	347.82	345.09	353.65	350.60	320.88	-384.09	-384.09
Any Others	0.00	**0.00**	6.00	6.00	6.00	6.00	6.00	6.00	6.00	6.00	6.00
Total non-medical - non-clinical staff substantive	704.97	**4.00**	342.59	345.26	353.82	351.09	359.65	356.60	326.88	-361.71	-359.71



The plan is monitored monthly through the NHSE/I provider workforce returns. This return reported that at the end of March 2021 the actual staff in post is 2,641.93 WTE against the plan of 2,821.29 WTE, meaning that the plan was not achieved by 179.46 WTE. The reported position is further shown in the following table:

	Month 6 Sept-20	Month 7 Oct-20	Month 8 Nov-20	Month 9 Dec-20	Month 10 Jan-21	Month 11 Feb-21	Month 12 Mar-21
Planned	2,774.99	2,830.59	2,832.59	2,821.39	2,821.39	2,821.39	2,821.39
Actual	2,586.71	2,597.43	2,648.79	2,665.42	2,672.25	2,698.38	2,641.93
Distance to Plan	**-188.28**	**-233.16**	**-183.80**	**-155.97**	**-149.14**	**-123.01**	**-179.46**

The output of this analysis shows that we need to grow services, recruit staff and make the necessary changes to ensure we still meet the ambitions outlined in the NHS Long Term Plan (LTP). We know that we face ongoing staffing challenges including a high number of vacancies, staff turnover and previously high levels of sickness, noting that we have seen an improving trend in these areas. The following key metrics are observed: -

- Staff turnover is 10.86% - the national position for NHS MH Trusts is 11.95%
- Sickness absence is 4.84% (March 2021) - this has reduced significantly in recent months and is lower than the national position for MH Trusts which is over 6%
- A total of 179 WTE vacancies – 6.7% - the national position for MH Trusts is over 10% vacancy rate
- The key reason for the gap between current workforce levels and the targeted performance is our current vacancy levels.

Opportunities for reshaping the DHcFT workforce- progress to date

The NHS Long Term Plan renewed the commitment to pursue the most ambitious transformation of mental health care for 30 years The NHS Long-term Plan for Mental Health Implementation Plan provides a new framework to ensure we deliver on this commitment at the local level and increase and develop our workforce to deliver services.

Significant progress has been achieved in the first two years of the programme including: -

- The establishment of a 24/7 all ages MH, LD and Autism Helpline
- The expansion of our Mental Health Liaison Teams in RDH and CRH hospitals to comply with "Core 24" standards
- The expansion of our Adult Crisis and Home Treatment Teams and the creation of an Older Adult Crisis team in fidelity to national service models
- The creation of "Safe Havens" as alternatives to ED attendance or EMAS conveyance for people in mental health crisis.
- The expansion of school-based mental health services for children and young people.

We know there is still a lot of work to do to provide the right workforce to deliver mental health care for everyone who needs it, and to tackle inequalities in access, experience and outcomes. This includes: -

- Delivery of the Community Mental Health Framework and the transformation of Community Mental Health Teams and other allied community mental health services over the next three years (over 200 additional posts)
- Creation of Crisis and Home Treatment services for Children and Young People over the next two years
- Further expansion of "Safe Havens" across the County.
- Expansion of services for people with autism, starting with an expansion of Learning Disabilities (LD) Intensive Support Teams to be able to meet the needs of people with Autism

Creation of new Mental Health practitioner posts employed and clinically supervised by DHCFT but working in and directed by Primary Care Network multi-disciplinary teams (MDTs). Important to our planning is creating a common understanding of the system position in terms of workforce supply and demand, and we are now working towards systems solutions. For example, the newly transformed community services will include wider multidisciplinary teams than at present, integrating staff from primary care, statutory and voluntary sectors, physical and mental health and peer advisors. Each locality team will also link into a wider network including partners working across Primary Care Networks, Social Care, Housing and Voluntary Sector to support the delivery of care and support that wraps around the individual person. In support of this, we are introducing new roles including Peer Support Workers, Advanced Practitioners and Mental Health Pharmacists.

The work to develop our local response to the Community Mental Health Framework has included the prototyping of new roles and ways of working in the High Peak locality. These teams are pioneering and leading the way in working to transform practice on behalf of the wider system and will be replicated across the three years of the community programme as the service transforms, locality by locality.

The wider system plan for the delivery of the LTP for Mental Health includes the expansion of workforce across the whole system and not just for DHCFT as a key provider. This includes the expansion of workforce in roles such as peer support advisors, community development workers, and social workers employed and/ or commissioned by the local authorities and voluntary sector.

DHCFT are an active member of the Derbyshire system and working closely with stakeholders to ensure our plans for workforce transformation are aligned to the national, regional and local workforce plans. Locally, DHCFT will focus on the following:

- Taking advantage of the investments in Mental Health to transform our workforce and expand on plans to include introducing new roles to DHCFT. So far we have made a start on increasing the numbers of Non-Medical Prescribers and established the role of Nursing Associates across our services. Work is already underway to utilise the Mental Health investment in attracting and planning training for a new workforce to our community services.
- Ensuring that we are maximising our supply pipelines, i.e. expanding student placement in DHCFT in order to secure the future workforce. We have made changes to our recruitment process and are now able to guarantee students an employment offer on successful completion of their placements in DHCFT. Our aspiration is to recruit 100% of the nursing students training in Derby who will consider a role in Derbyshire. We recognise that some students come to Derby to study and go back home to work. We are utilising apprenticeship models to grow and develop our workforce, for example we are taking advantage of the clinical professional degree apprenticeships to “Grow our Own” as part of our retention strategy and also to contribute towards the 50,000 nurses national pledge.
- Investing in our existing staff and providing career pathways for HCSWs to become registered Nurses. We have recently invested in Nursing Apprenticeships for internal support staff and are now supporting a total of 29 HCSW on this model for Learning Disability and Mental Health Nursing Degrees. We plan to be in a position where we can support at least 15 trainees annually. This will help mitigate some of the issues we know we have with regards to our aging workforce as well provide an additional workforce supply pipeline.
- Moving away from historic ways of working; we are working very closely with education providers and Health Education England (HEE) to influence and shape curriculums for new roles and training to align with our service needs. The Nurse Associate curriculum although initially developed for acute adult care, is being delivered to ensure that this workforce is coming out with skills which are invaluable to our service delivery. This workforce has proven to add value to patient care in our Older Adults Services and is now being introduced to Acute care.
- Creating a more adaptable workforce to expand scope of practice whilst supporting our current workforce to work at the top of their licence. i.e. moving away from traditional models to ensure our workforce is upskilled to deliver

interventions within an expanded / advanced level of practice. We continue to grow our Non-Medical prescribers' workforce in this area and have Advanced Clinical Practitioners in training.
- Attracting a younger generation to DHCFT by being involved in activities that support our responsibilities as an Anchor organisation. This will ensure our support for the local community by creating new job pathways and making the NHS a more inclusive work environment and better employer for more people. i.e. plans are underway to work with the Princes Trust.
- As an NHS employer the Get into Healthcare programmes can help DHCFT to find the next generation of talent. This will mean widening access by targeting Derbyshire communities to ensure we raise the profile of NHS careers and support young people from a diverse background who are not in employment or education.
- Upskilling and equipping our leaders to be able to have quality well-being conversations.

Inclusive Transformational Change

DHCFT is committed to creating a great place to work and thrive for our employees, patients, carers, volunteers and communities. We recognise this transformational change is not only ambitious but an incredible opportunity to lead inclusively and advocate for tackling issues for marginalised groups that are affected by mental health inequalities and limited social mobility, both of which have been further compounded by the COVID-19 pandemic.

The EDI (equality, diversity and inclusion) team within the Trust are key stakeholders within the Change Programme and will work as partners:

- Review risks and address these as part of the Equality Impact Assessment process.
- Diversifying our recruitment process enabling better outreach to our communities and diverse applicants, instilling cultural sensitively and inclusive leadership behaviours in the key processes of attraction, selection and interview panels, which we aim to monitor and discuss regularly with the Executive Leadership Team (ELT).
- Share thought leadership in the area of 'designing inclusive mental health community services' ensuring that we take lessons learnt from others in benefits we can derive from design in patient services and community engagement.
- Use the governance of the EDI Delivery Group chaired by Jaki Lowe (Director of People and Inclusion) to engage key stakeholders who support and advocate EDI across the Trust in the change programme to ensure that critical issues can be addressed, and successful change is achieved.
- Ensure the positive impact that COVID-19 has enabled across our workforce are maintained for example agile working practices, compassionate leadership, well-being and overall psychological safety.
- Lead and embed the Cultural Intelligence programme across the Trust to enable a culture that is inclusive, and person centred for our employees, patients, carers, volunteers and communities.
- Creatively look at ways we can engage with potential employees using our disability confident employer status and our access to the apprenticeship levy.
- Use the career opportunities presented within the change programme to develop our talent, improve representation and performance with the

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

- Create an induction journey for new colleagues that sets a clear vision for inclusion within the Trust and propels them to use their courage and values to be Inclusion Allies and create a place where our employees, patients, carers, volunteers and communities belong.

Conclusions and Future Areas of Focus

Where there are activities to transform the workforce, there will always be a need for additional investment. As an organisation, DHCFT has adequate funds to upskill, develop and pay for training fees for our workforce utilising HEE and Apprenticeship Levy funds.

Our biggest challenges which impacts on a consistent and sustainable plan to grow our workforce through apprenticeships is funding to support salaries and backfill. When we utilise the Apprenticeship Levy, we often require a 100% backfill. We will consider the opportunities for investing in this in order to establish a sustainable Nursing Apprenticeships pipeline. This is a pipeline that we could easily maximise if recurrent funds were identified as available. Local intelligence tells us we have a group of experienced healthcare support workers (HCSWs) who aspire to be nurses and cannot afford to leave DHCFT to go and complete training. We also know that this group of staff are committed to working in DHCFT and will continue.

We still have a gap in growing the allied health professional (AHP) workforce through apprenticeships, and this will need investment to support salaries. The initial priority has been to plug the nursing gaps as this is where we have high turnover and most of our ageing workforce.

The Community Mental Health Framework (CMHF) investment will provide DHCFT an opportunity to narrow the gap in our clinical groups such as occupational therapists (OTs) and other AHP, with the initial investment funding 3 Band 6 WTE OTs, a Band 7 AHP Lead and 13 apprenticeships, with further scope to skill mix as required.

Significant issues continue with recruitment and retention of our Consultant Psychiatrist workforce. The Trust continues to develop new and innovative ways in which to attract and support medical recruitment through the flexible working and career opportunities. The continued national shortage in supply of both Consultant Psychiatrists and Trainee Psychiatrists has meant new skills and new roles are needed to fill this gap, we are increasing the numbers of Non-Medical Prescribers and Advanced Clinical Practitioners to enhance this medical model going forward.

We continue to support the national direction to increase the number of trainees creating more flexibility in undergraduate and postgraduate medical training and careers, supporting more options for doctors to step out and step back into the training pathway, expanding less-than-full-time training and expanding opportunities for portfolio careers. This will help promote fulfilling careers and encourage greater participation and greater diversity.

The next areas of focus will be to:

- Agree the approach to apprenticeship levy for new posts and provision of funding for that backfill
- Manage the emerging workforce plans and decision-making processes through the workforce planning resourcing and delivery group
- Manage the recruitment process to be able to track these new investments more clearly
- Establish the cultural intelligence programme to deliver a positive transformational change programme and monitor this through the Equality Diversity and Inclusion delivery group
- Work closely with our system colleagues to track progress on investments and new services as they come on board.

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 4 May 2021

2020 NHS Staff Survey – NHS England Results – Summary

Purpose of Report

The purpose of this paper is to update the Trust Board on the NHS Staff Survey – NHS England results, which show our position based on the 2020 all staff survey.

Executive Summary

This report for Derbyshire Healthcare NHS Foundation Trust contains results for themes and questions from the 2020 NHS Staff Survey, and historical results back to 2016, where possible.

As a reminder, please see below all of the key themes which cover areas of staff experience helping to present results in these areas in a clear and consistent way. All of the 10 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.

The themes are as follows:

- Equality, diversity and inclusion
- Health and wellbeing
- Immediate managers
- Morale
- Quality of care
- Safe environment – bullying and harassment
- Safe environment – violence
- Safety culture
- Staff engagement
- Team working

N.B. There is no longer a theme called ‘Quality of Appraisals’.

The 2020 results within each theme and question are presented in the context of the best, average and worst results for similar organisations where appropriate. Data in this report is weighted to allow for fair comparisons between organisations.

Key information:

- Derbyshire Healthcare NHS Foundation Trust is within the Combined Mental Health / Learning Disability and Community Trusts benchmarking group
- There are **52 organisations** in this benchmarking group
- Throughout the report – our organisation is seen on all graphs and charts in **navy blue**.

In summary of the 10 themes, compared to the other 51 organisations we are benchmarked against, we are:

- **Best in 2** (health and wellbeing) (morale)
- **Top scoring in 1** (immediate managers)
- Above average in 7 (equality, diversity and inclusion) (quality of care) (safe environment – bullying and harassment) (safe environment – violence) (safety culture) (staff engagement) (team working)
- Average in 0
- Below average in 0
- **Worst in 0**

Compared to last year, we are:

- **Better than 2019 in all 10 themes** (equality, diversity and inclusion) (health and wellbeing) (immediate managers) (morale) (quality of care) (safe environment – bullying and harassment) (safe environment – violence) (safety culture) (staff engagement) (team working)
- The same as 2019 in 0 themes
- **Worse than 2019 in 0 themes**

It is fantastic to see there has been an improvement in the scores in all 10 themes. This is in addition to 2 out of the 10 themes have come out as the best organisation and 1 as top scoring, when benchmarking against the 51 other Combined Mental Health / Learning Disability and Community Trusts for the 2020 NHS Staff Survey.

Based on the NHS England Staff Survey results, using the weighted data to benchmark nationally, this year we can also see that…

Our Staff Friends and Family Test (FFT) measures have both improved significantly again this year:

- Q18c: I would recommend my organisation as a place to work
  - 2019 – 56% to 2020 – 75% **(up 10%)**
- Q18d: If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation
  - 2019 – 66% to 2020 – 73% **(up 7%)**

Since consulting with colleagues and triangulating the findings it has now been confirmed that the 3 main areas of focus for the Trust will be:

- **Equality, diversity and inclusion** – the WRES and WDES data indicate there are still gaps in some of these key indicators – we will be looking at how we can decrease these gaps and build the results from the protected characteristics breakdown into the wider strategy and action plan.
- **1000 missing voices** – there are still approximately a thousand colleagues who didn't complete the survey in 2020. We need to understand which sections of the workforce didn't complete the survey and look at what is preventing colleagues from doing so; in order to increase participation in 2021 – whether this is because of the time it takes to complete the survey, concerns about confidentiality or getting the right mode (paper versus electronic).

- **How we sustain the positive results** – we have had such a positive set of results – the best year ever! However, we need to ensure we're retaining the positives and enhancing our support and care to colleagues and patients throughout 2021 and beyond. This will be linked to our NHS People Promise.

Lastly, this year the Trust are going to adopt a 3, 2, 1 approach to action planning to keep it simple and clear to all leaders and colleagues how their teams will feed into making improvements in both – the overall Trust focus areas and their own team level results. The Trust are focussing on 3 areas (as bulleted above), and we will be asking all directorates to pick 2 areas to focus on from their own results and all teams to pick 1 area of focus from their own results.

Next steps include:

- NHS Coordination Centre free text comments available – 30 April 2021
- Further work and analysis on WRES and WDES and protected characteristic data and linking EDI findings into wider strategy and action plan
- Further work and analysis on occupational group data
- Supporting leaders to understand and take account of the recently released directorate, department and team results
- Developing an action plan around response rate and sustaining the results (linked to the NHS People Promise)
- Reporting progress via the People and Culture Committee.

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

Assurances

From the 2020 NHS Staff Survey NHS England results we can see that:

- There has been an improvement in the scores in all 10 themes compared to 2019.
- 7 out of the 10 themes are above average and 2 themes scored as the best organisation and 1 as top scoring, when benchmarking against the 51 other Combined Mental Health / Learning Disability and Community Trusts for the 2020 NHS Staff Survey
- No themes saw either a decline in results compared to 2019, or were classed as 'below average' or 'worst' in our benchmarking group.

Consultation

- The NHS England results build on from the Quality Health results and are used to benchmark us nationally against all other NHS organisations which fit into our category in the NHS Staff Survey benchmarking of results.
- All information on our NHS Staff Survey results was shared via an email from Ifti, as part of our communications plan, with appropriate stakeholders and governors when the embargo was lifted on 11 March 2021.

Governance or Legal Issues

- CQC analyse the NHS Staff Survey results
- Some of our results are linked to the Health and Wellbeing CQUIN
- Staff FFT questions are reported and benchmarked nationally.

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

- All staff are given the opportunity to complete at least 1 Pulse Check or People Pulse survey and 1 NHS Staff Survey every year
- Our NHS Staff Survey results are be broken down by protected characteristics and further analysis is done by the Equality, Diversity and Inclusion Team in conjunction with all Staff Network Groups.

Recommendations

The Board of Directors is requested to receive and review the 2020 NHS Staff Survey – NHS England results and focus areas for 2021.

It is recommended that significate assurance should be given at this point based on:

- the consistent response rate, during a challenging year
- the fact that every one of our themes has improved compared the 2019 NHS Staff Survey – no theme saw a decline in results.

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

Report prepared by: **Clair Sanders, Engagement and OD Lead**

Laura Gee, Organisational Effectiveness Advisor

2020 NHS Staff Survey – NHS England Results – Summary Paper

Introduction

This report for Derbyshire Healthcare NHS Foundation Trust contains results for themes and questions from the 2020 NHS Staff Survey, and historical results back to 2016, where possible.

The results are divided into 10 key themes, see reminder below, which cover areas of staff experience helping to present results in these areas in a clear and consistent way. All of the ten 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.

The themes are as follows:

1. Equality, diversity & inclusion
2. Health & wellbeing
3. Immediate managers
4. Morale
5. Quality of care
6. Safe environment – bullying & harassment
7. Safe environment – violence
8. Safety culture
9. Staff engagement
10. Team working

N.B. There is no longer a theme called 'Quality of Appraisals'.

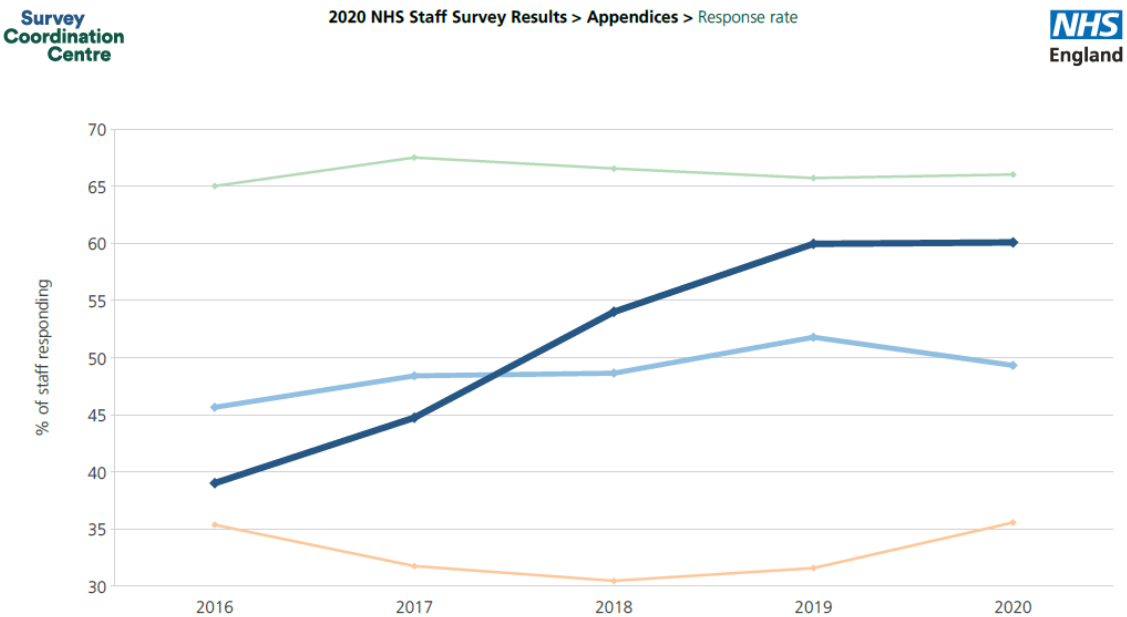
The new results within each theme and question are presented in the context of the best, average and worst results for similar organisations where appropriate. Data in this report is weighted to allow for fair comparisons between organisations.

Key information:

- Derbyshire Healthcare NHS Foundation Trust is within the Combined Mental Health / Learning Disability and Community Trusts benchmarking group
- There are **52 organisations** in this benchmarking group
- Throughout the report – our organisation is seen on all graphs and charts in **navy blue**.

The results that follow are taken from the 2020 NHS England Staff Survey results. The survey was conducted between Monday 14 September and Friday 27 November 2020, with 1604 Derbyshire Healthcare employees completing the survey giving a 60.1% response rate (the trend for the past 5 years can be found in figure 1).

Figure 1: Response rate trends for Combined Mental Health / Learning Disability and Community Trusts



	2016	2017	2018	2019	2020
Best	65.0%	67.5%	66.5%	65.7%	66.0%
Your org	39.0%	44.7%	54.0%	60.0%	60.1%
Median	45.6%	48.4%	48.6%	51.8%	49.3%
Worst	35.4%	31.7%	30.5%	31.6%	35.6%

NHS England Reporting Themes

An overview of all 10 themes can be found in figure 2. We will go into each theme in detail – however in summary this tells us that, compared to the other 51 organisations we are benchmarked against, we are:

- **Best in 2** (health and wellbeing) (morale)
- **Top scoring in 1** (immediate managers)
- Above average in 7 (equality, diversity & inclusion) (quality of care) (safe environment – bullying & harassment) (safe environment – violence) (safety culture) (staff engagement) (team working)
- Average in 0
- Below average in 0
- **Worst in 0**

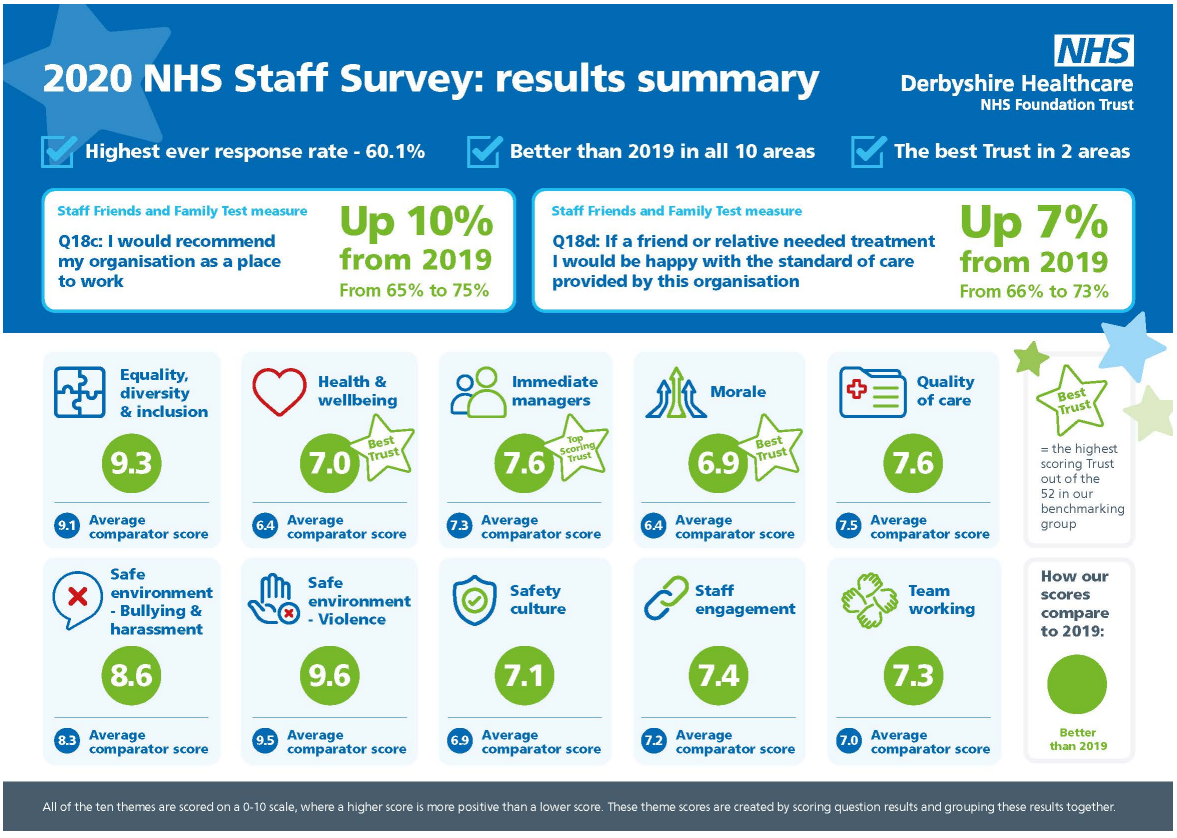
Compared to last year, we are:

- **Better than 2019 in all 10 themes** (equality, diversity & inclusion) (health & wellbeing) (immediate managers) (morale) (quality of care) (safe environment – bullying & harassment) (safe environment – violence) (safety culture) (staff engagement) (team working)
- The same as 2019 in 0 themes
- **Worse than 2019 in 0 themes**

Figure 2: Overview of all 10 themes for Combined Mental Health / Learning Disability and Community Trusts

	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement	Team working
Best	9.5	7.0	7.6	6.9	7.9	8.8	9.8	7.5	7.5	7.4
Your org	9.3	7.0	7.6	6.9	7.6	8.6	9.6	7.1	7.4	7.3
Average	9.1	6.4	7.3	6.4	7.5	8.3	9.5	6.9	7.2	7.0
Worst	8.2	5.9	7.0	6.1	6.8	7.6	9.1	6.1	6.6	6.6
Responses	1,590	1,601	1,598	1,591	1,384	1,593	1,596	1,599	1,600	1,576

We have devised the following infographic to summarise the key results to staff, including: how we score on each theme this year, how this compares to 2019 and to average. Full details can be found in Appendix 1.



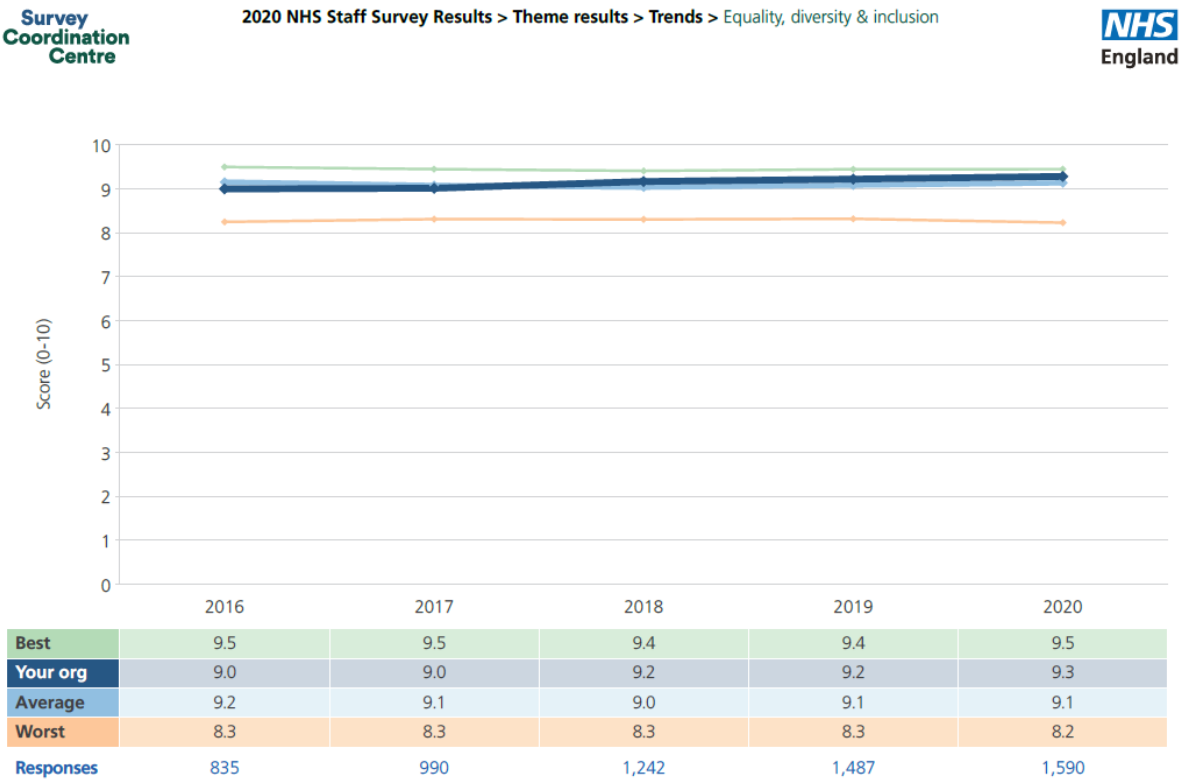
Each theme is now broken down and we can see the trends over the past 5 years (where available) and the individual question results that make up each theme.

1. Equality, diversity & inclusion

Questions that make up the theme: Q14, Q15a, Q15b and Q26b.

Key points to note:

- **Theme score above average compared to other 51 Combined Mental Health / Learning Disability and Community Trusts**
- **Improvement made on the overall theme score from last year**



	2016	2017	2018	2019	2020
Best	9.5	9.5	9.4	9.4	9.5
Your org	9.0	9.0	9.2	9.2	9.3
Average	9.2	9.1	9.0	9.1	9.1
Worst	8.3	8.3	8.3	8.3	8.2
Responses	835	990	1,242	1,487	1,590

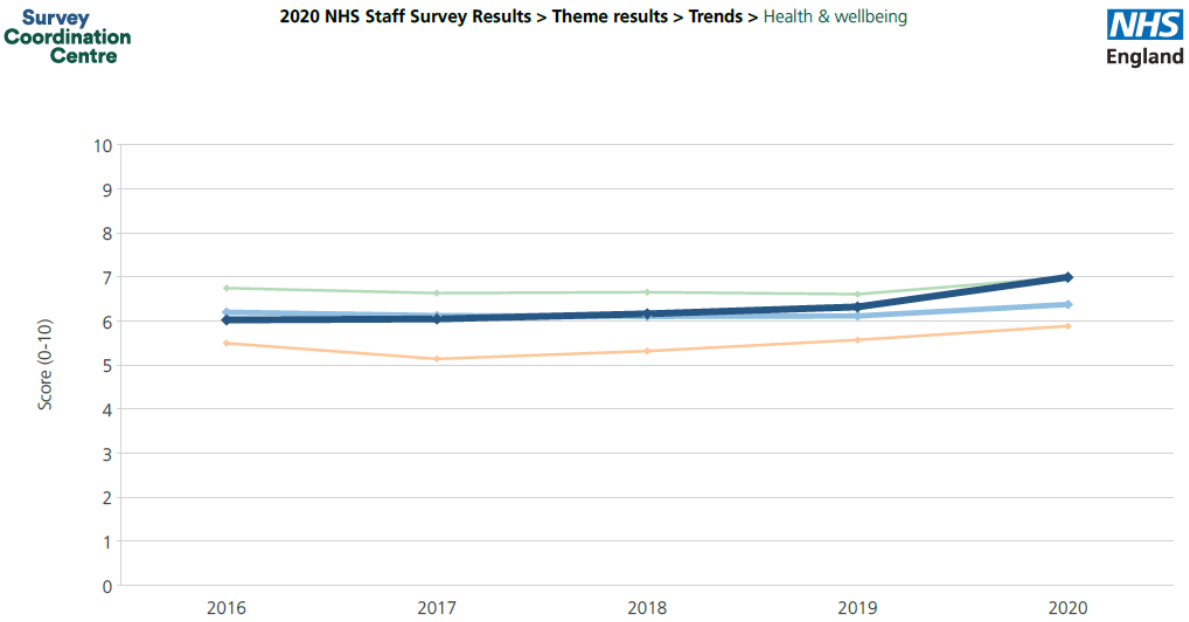
- Q14: Does your organisation act fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age?
  - Better than average, better than 2019
- Q15a: In the last 12 months have you personally experienced discrimination at work from patients / service users, their relatives or other members of the public?
  - Better than average, same as 2019
- Q15b: In the last 12 months have you personally experienced discrimination at work from manager / team leader or other colleagues?
  - Better than average, better than 2019
- Q26b: Has your employer made adequate adjustment(s) to enable you to carry out your work?
  - Better than average, better than 2019

2. Health & wellbeing

Questions that make up the theme: Q5h, Q11a, Q11b, Q11c and Q11d.

Key points to note:

- **Theme score the best organisation compared to other 51 Combined Mental Health / Learning Disability and Community Trusts**
- **Improvement on overall theme score from last year**



	2016	2017	2018	2019	2020
Best	6.8	6.6	6.7	6.6	7.0
Your org	6.0	6.1	6.2	6.3	7.0
Average	6.2	6.1	6.1	6.1	6.4
Worst	5.5	5.1	5.3	5.6	5.9
Responses	849	1,001	1,243	1,496	1,601

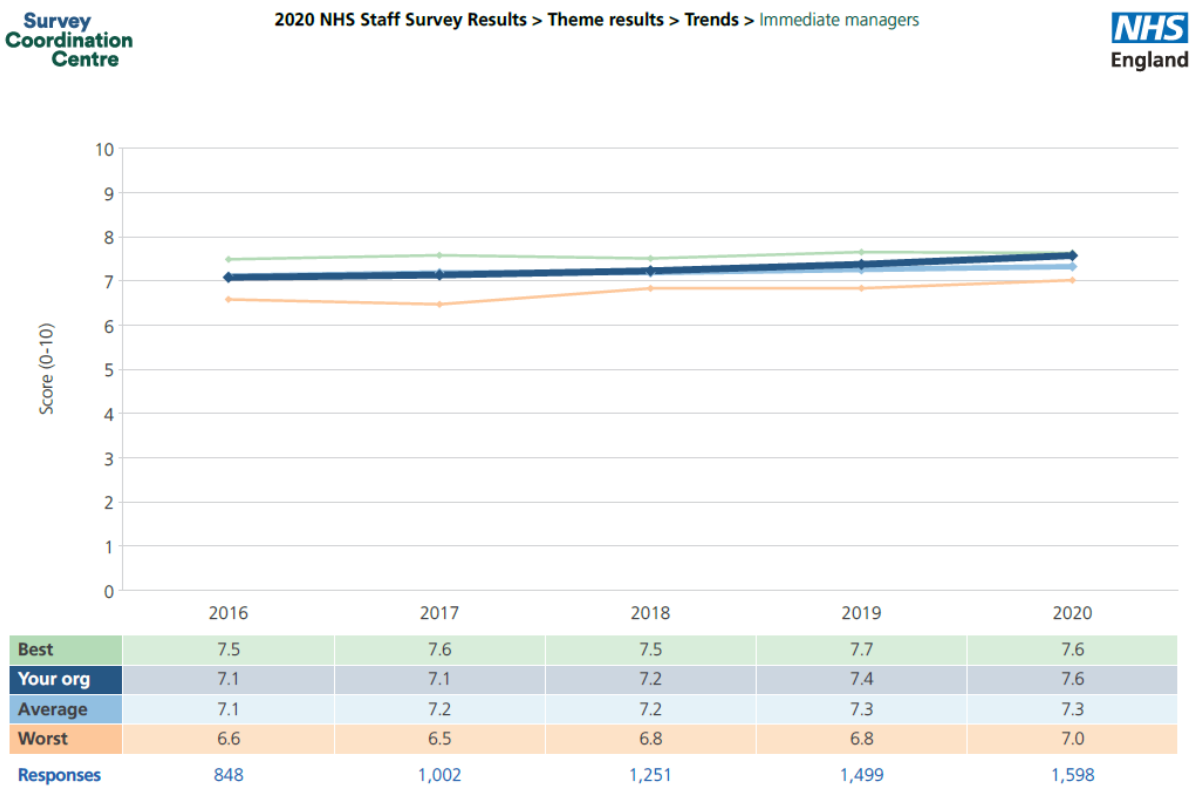
- Q5h: The opportunities for flexible working patterns
  - Better than average, better than 2019
- Q11a: Does your organisation take positive action on health and well-being?
  - **The best organisation,** better than 2019
- Q11b: In the last 12 months have you experienced musculoskeletal problems (MSK) as a result of work activities?
  - **The best organisation,** worse than 2019
- Q11c: During the last 12 months have you felt unwell as a result of work related stress?
  - **The best organisation,** better than 2019
- Q11d: In the last three months have you ever come to work despite not feeling well enough to perform your duties?
  - **The best organisation,** better than 2019

3. Immediate managers

Questions that make up the theme: Q5b, Q8c, Q8d, Q8f, Q8g.

Key points to note:

- **Theme score the best organisation compared to other 51 Combined Mental Health / Learning Disability and Community Trusts**
- **Improvement on overall theme score from last year**



	2016	2017	2018	2019	2020
Best	7.5	7.6	7.5	7.7	7.6
Your org	7.1	7.1	7.2	7.4	7.6
Average	7.1	7.2	7.2	7.3	7.3
Worst	6.6	6.5	6.8	6.8	7.0
Responses	848	1,002	1,251	1,499	1,598

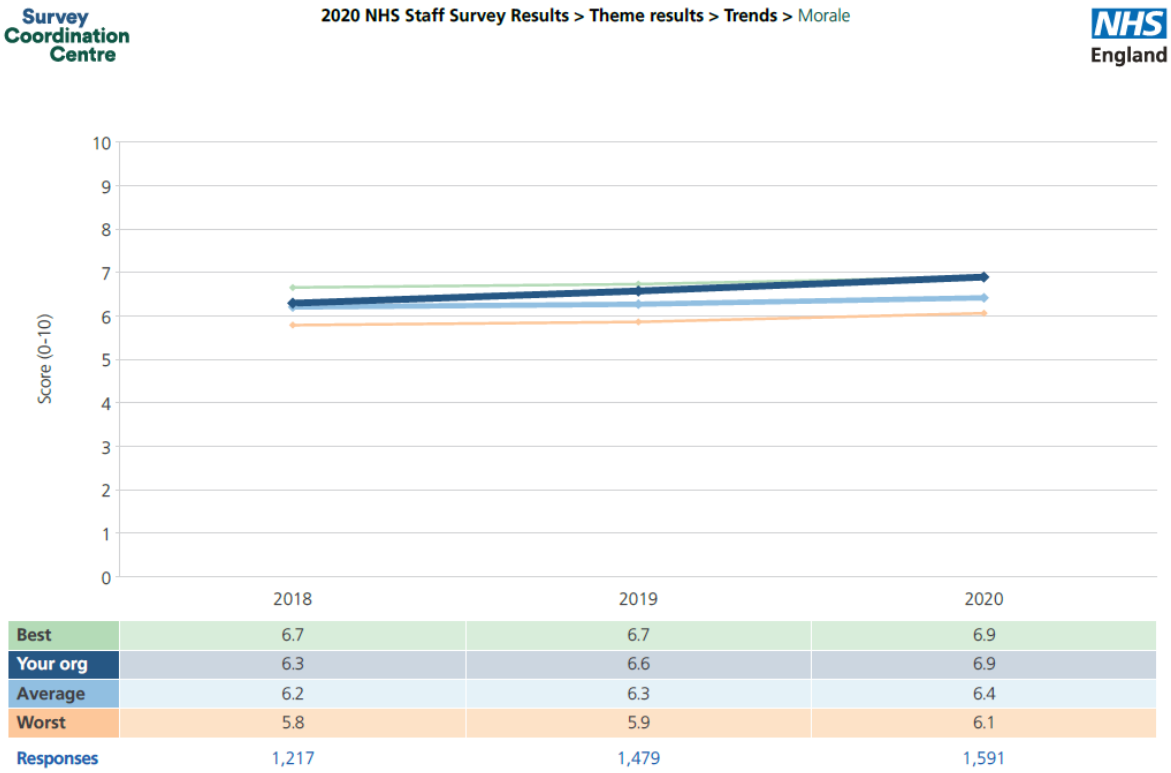
- Q5b: The support I get from my immediate manager
  - Better than average, better than 2019
- Q8c: My immediate manager gives me clear feedback on my work
  - Better than average, better than 2019
- Q8d: My immediate manager asks for my opinion before making decisions that affect my work
  - Better than average, better than 2019
- Q8f: My immediate manager takes a positive interest in my health and well-being
  - Better than average, better than 2019
- Q8g: My immediate manager values my work
  - Better than average, better than 2019

4. Morale

Questions that make up the theme: Q4c, Q4j, Q6a, Q6b, Q6c, Q8a, Q19a, Q19b and Q19c.

Key points to note:

- **Theme score the best organisation compared to other 51 Combined Mental Health / Learning Disability and Community Trusts**
- **Improvement on overall theme score from last year**



	2018	2019	2020
Best	6.7	6.7	6.9
Your org	6.3	6.6	6.9
Average	6.2	6.3	6.4
Worst	5.8	5.9	6.1
Responses	1,217	1,479	1,591

- Q4c: I am involved in deciding on changes introduced that affect my work area / team / department
  - **The best organisation**, better than 2019
- Q4j: I receive the respect I deserve from my colleagues at work
  - Better than average, better than 2019
- Q6a: I have unrealistic time pressures
  - **The best organisation**, better than 2019
- Q6b: I have a choice in deciding how to do my work
  - **The best organisation,** better than 2019
- Q6c: Relationships at work are strained
  - Better than average, better than 2019
- Q8a: My immediate manager encourages me at work
  - Better than average, better than 2019
- Q19a: I often think about leaving this organisation
  - **The best organisation,** better than 2019

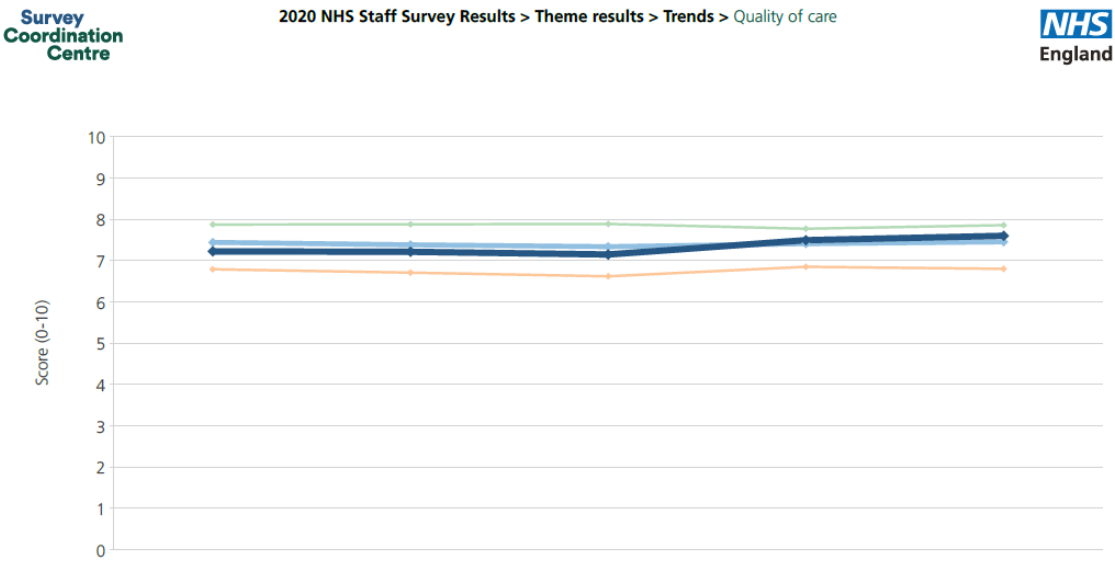
- Q19b: I will probably look for a job at a new organisation in the next 12 months
    - **The best organisation,** better than 2019
- Q19c: As soon as I can find another job, I will leave this organization
    - Better than average, better than 2019

5. Quality of care

Questions that make up the theme: Q7a, Q7b and Q7c.

Key points to note:

- **Theme score above average compared to other 51 Combined Mental Health / Learning Disability and Community Trusts**
- **Improvement on overall theme score from last year**



	2016	2017	2018	2019	2020
Best	7.9	7.9	7.9	7.8	7.9
Your org	7.2	7.2	7.2	7.5	7.6
Average	7.4	7.4	7.3	7.4	7.5
Worst	6.8	6.7	6.6	6.9	6.8
Responses	694	835	1,080	1,311	1,384

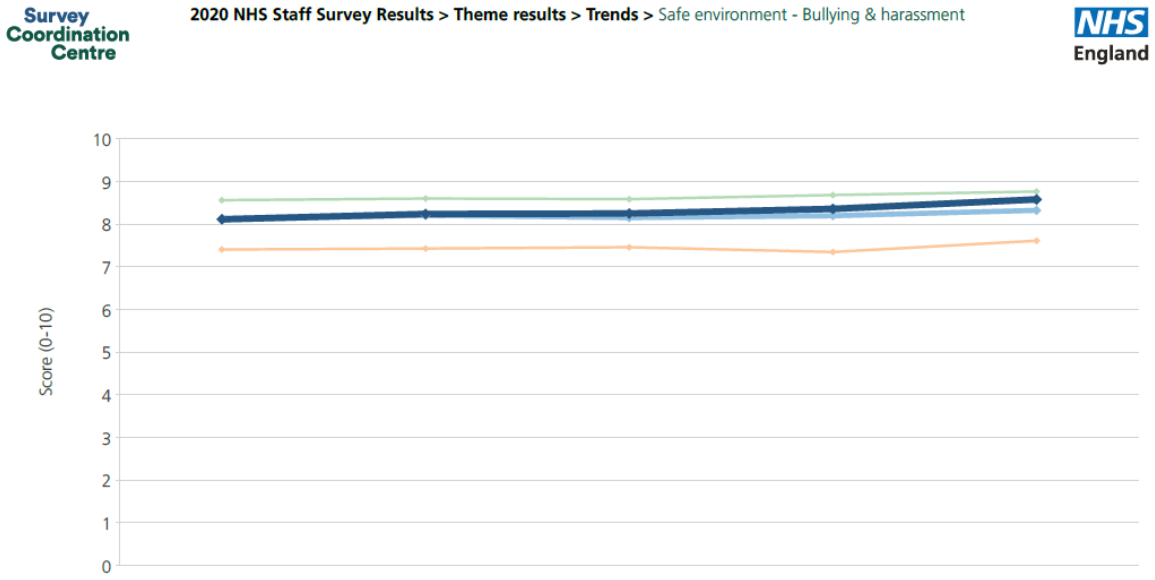
- Q7a: I am satisfied with the quality of care I give to patients / service users
    - Better than average, better than 2019
- Q7b: I feel that my role makes a difference to patients / service users
    - Better than average, better than 2019
- Q7c: I am able to deliver the care I aspire to
    - Better than average, better than 2019

6. Safe environment – bullying & harassment

Questions that make up the theme: Q13a, Q13b and Q13c.

Key points to note:

- **Theme score above average compared to other 51 Combined Mental Health / Learning Disability and Community Trusts**
- **Improvement on overall theme score from last year**



	2016	2017	2018	2019	2020
Best	8.6	8.6	8.6	8.7	8.8
Your org	8.1	8.2	8.3	8.4	8.6
Average	8.1	8.2	8.2	8.2	8.3
Worst	7.4	7.4	7.5	7.4	7.6
Responses	834	987	1,220	1,479	1,593

- Q13a: In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from patients / service users, their relatives or other members of the public?
  - Better than average, better than 2019
- Q13b: In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from managers?
  - Better than average, better than 2019
- Q13c: In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from other colleagues?
  - Better than average, better than 2019

7. Safe environment – violence

Questions that make up the theme: Q12a, Q12b and Q12c.

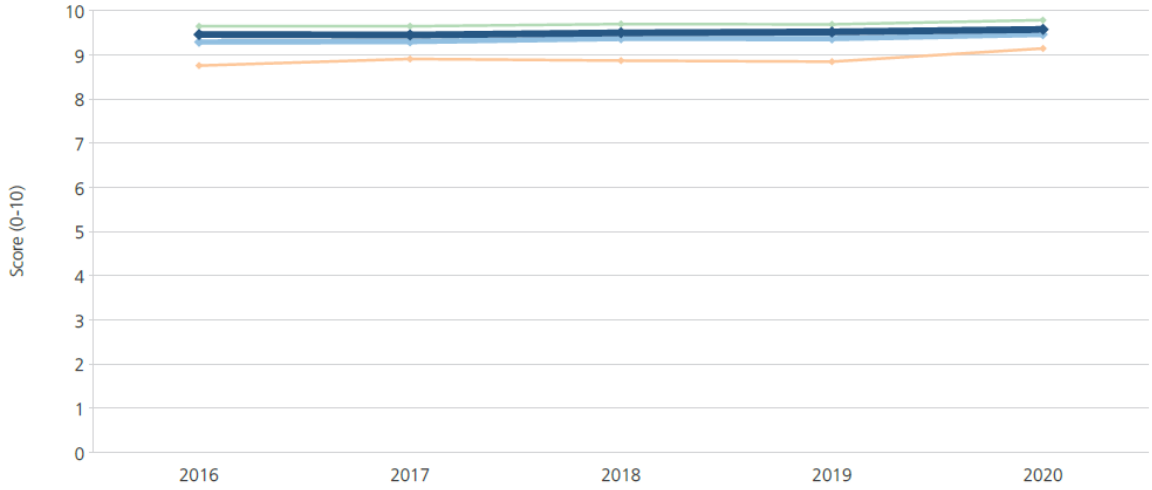
Key points to note:

- **Theme score above average compared to other 51 Combined Mental Health / Learning Disability and Community Trusts**
- **Improvement on overall theme score from last year**

Survey Coordination Centre

2020 NHS Staff Survey Results > Theme results > Trends > Safe environment - Violence

NHS England



	2016	2017	2018	2019	2020
Best	9.7	9.7	9.7	9.7	9.8
Your org	9.5	9.5	9.5	9.5	9.6
Average	9.3	9.3	9.4	9.4	9.5
Worst	8.8	8.9	8.9	8.9	9.1
Responses	835	980	1,220	1,486	1,596

- Q12a: In the last 12 months how many times have you personally experienced physical violence at work from patients / service users, their relatives or other members of the public?
  - Better than average, better than 2018
- Q12b: In the last 12 months how many times have you personally experienced physical violence at work from managers?
  - Better than average, same as 2019
- Q12c: In the last 12 months how many times have you personally experienced physical violence at work from other colleagues?
  - Better than average, better than 2019

8. Safety culture

Questions that make up the theme: Q16a, Q16c, Q16d, Q17b, Q17c and Q18b.

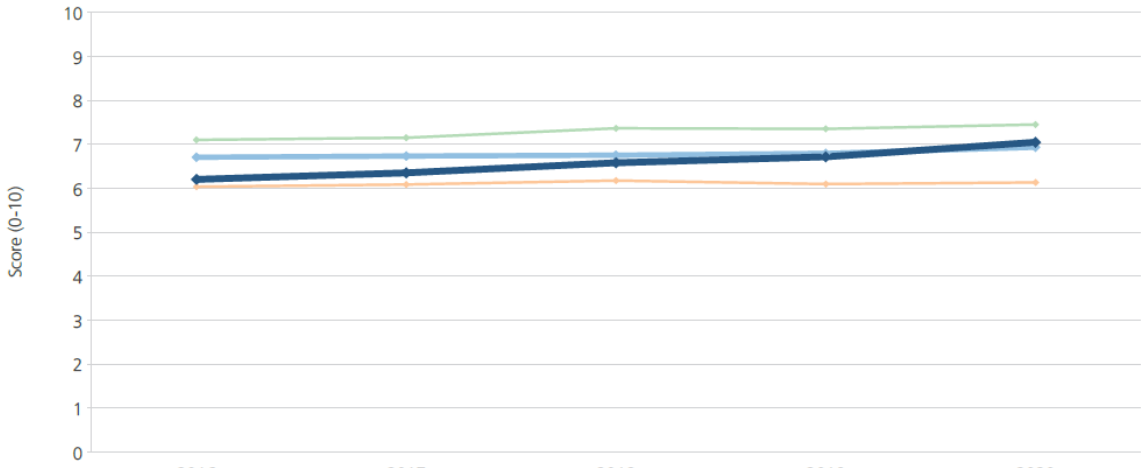
Key points to note:

- **Theme score above average compared to other 51 Combined Mental Health / Learning Disability and Community Trusts**
- **Improvement on overall theme score from last year**

Survey Coordination Centre

2020 NHS Staff Survey Results > Theme results > Trends > Safety culture

NHS England



	2016	2017	2018	2019	2020
Best	7.1	7.2	7.4	7.4	7.5
Your org	6.2	6.4	6.6	6.7	7.1
Average	6.7	6.7	6.8	6.8	6.9
Worst	6.0	6.1	6.2	6.1	6.1
Responses	843	1,001	1,230	1,486	1,599

- Q16a: My organisation treats staff who are involved in an error, near miss or incident fairly
  - Better than average, better than 2019
- Q16c: When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again
  - Better than average, better than 2019
- Q16d: We are given feedback about changes made in response to reported errors, near misses and incidents
  - Better than average, better than 2019
- Q17b: I would feel secure raising concerns about unsafe clinical practice
  - Better than average, better than 2019
- Q17c: I am confident that my organisation would address my concern
  - Better than average, better than 2019
- Q18b: My organisation acts on concerns raised by patients / service users
  - Better than average, better than 2019

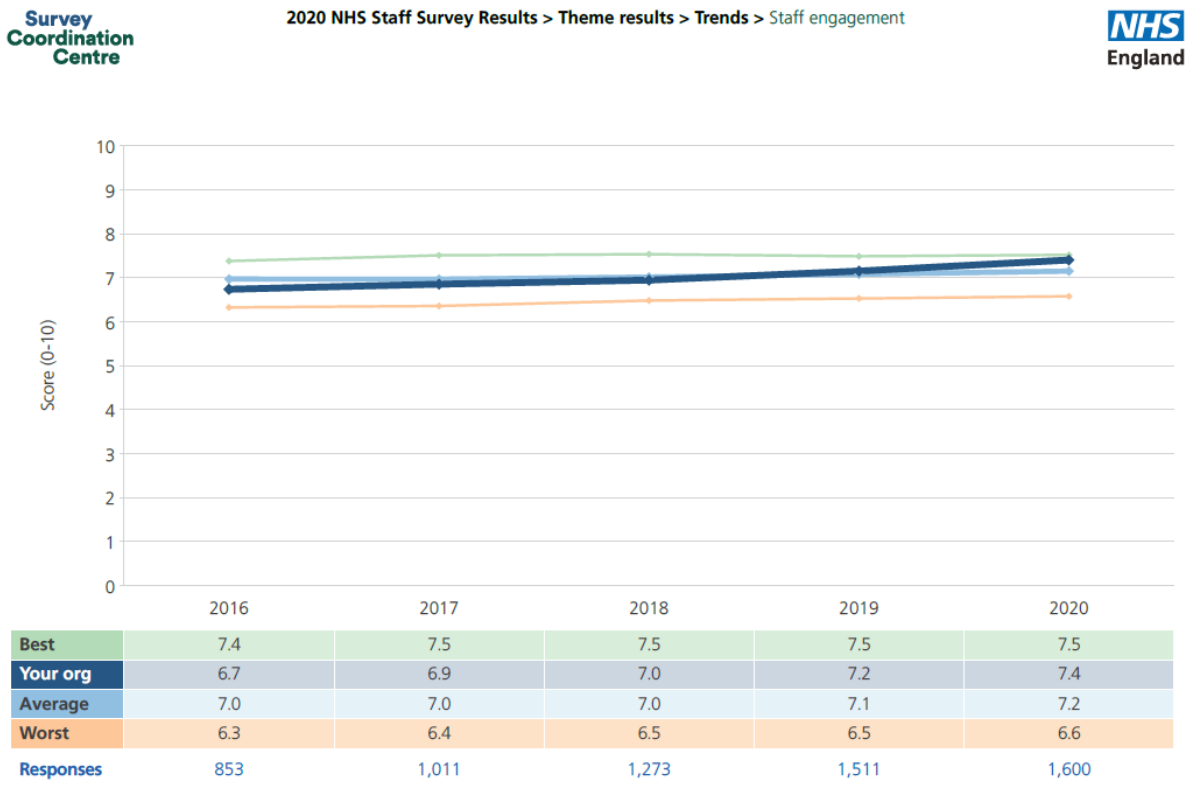
9. Staff engagement

Questions that make up the theme:

- Staff engagement - motivation: Q2a, Q2b and Q2c.
- Staff engagement - ability to contribute to improvements: Q4a, Q4b and Q4d.
- Staff engagement - recommendation of the organisation as a place to work/receive treatment: Q18a, Q18c and Q18d.

Key points to note

- **Theme score above average compared to other 51 Combined Mental Health / Learning Disability and Community Trusts**
- **Improvement on overall theme score from last year**



	2016	2017	2018	2019	2020
Best	7.4	7.5	7.5	7.5	7.5
Your org	6.7	6.9	7.0	7.2	7.4
Average	7.0	7.0	7.0	7.1	7.2
Worst	6.3	6.4	6.5	6.5	6.6
Responses	853	1,011	1,273	1,511	1,600

- Q2a: I look forward to going to work
  - Better than average, better than 2019
- Q2b: I am enthusiastic about my job
  - Better than average, worse than 2019
- Q2c: Time passes quickly when I am working
  - Worse than average, worse than 2019
- Q4a: There are frequent opportunities for me to show initiative in my role
  - Better than average, better than 2019
- Q4b: I am able to make suggestions to improve the work of my team / department
  - Better than average, better than 2019
- Q4d: I am able to make improvements happen in my area of work

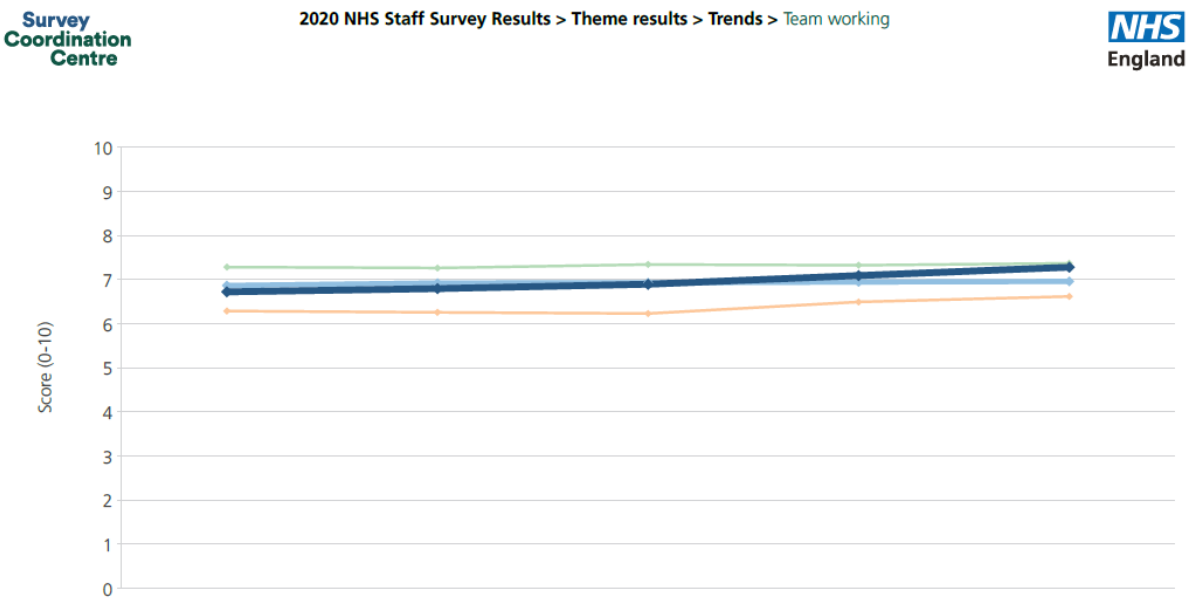
    - Better than average, better than 2019
- Q18a: Care of patients / service users is my organisation's top priority
    - Better than average, better than 2019
- Q18c: I would recommend my organisation as a place to work
    - Better than average, better than 2019
- Q19d: If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation
    - Better than average, better than 2019

10. Team Working

Questions that make up the theme: Q4h and Q4i

Key points to note:

- **Theme score above average compared to other 51 Combined Mental Health / Learning Disability and Community Trusts**
- **Improvement on overall theme score from last year**



	2016	2017	2018	2019	2020
Best	7.3	7.3	7.3	7.3	7.4
Your org	6.7	6.8	6.9	7.1	7.3
Average	6.9	6.9	6.9	6.9	7.0
Worst	6.3	6.3	6.2	6.5	6.6
Responses	845	1,001	1,258	1,485	1,576

- Q4h: The team I work in has a set of shared objectives
    - Better than average, better than 2019
- Q4i: The team I work in often meets to discuss the team's effectiveness
    - Better than average, better than 2019

Summary and focus areas in 2021

It is fantastic to see there has been an improvement in the scores in all 10 themes. This is in addition to 2 out of the 10 themes have come out as the best organisation and 1 theme is top scoring, when benchmarking against the 51 other Combined Mental Health / Learning Disability and Community Trusts for the 2020 NHS Staff Survey. See Appendix 2 for the themed score comparison with all 'Mental Health and Learning Disability and Mental Health, Learning Disability and Community Trusts'.

Based on the NHS England Staff Survey results, using the weighted data to benchmark nationally, this year we can see that…

Our Staff Friends and Family Test (FFT) measures have both improved significantly again this year:

- Q18c: I would recommend my organisation as a place to work
  - 2019 – 56% to 2020 – 75% **(up 10%)**
- Q18d: If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation
  - 2019 – 66% to 2020 – 73% **(up 7%)**

The following questions also came out as the best Trust within our whole benchmarking group:

- Q11a: Does your organisation take positive action on health and well-being?
  - 2020 – 53.1% of colleagues saying agree/strongly agree
- Q11b: In the last 12 months have you experienced musculoskeletal problems (MSK) as a result of work activities?
  - 2020 – 21% of colleagues stated yes
- Q11c: During the last 12 months have you felt unwell as a result of work related stress?
  - 2020 – 37.1% of colleagues stated yes
- Q11d: In the last three months have you ever come to work despite not feeling well enough to perform your duties?
  - 2020 – 39.6% of colleagues stated yes
- Q4c: I am involved in deciding on changes introduced that affect my work area / team / department
  - 2020 – 63.4% of colleagues saying agree/strongly agree
- Q6a: I have unrealistic time pressures
  - 2020 – 35.0% of colleagues saying rarely/never
- Q6b: I have a choice in deciding how to do my work
  - 2020 – 74.7% of colleagues saying often/always
- Q19a: I often think about leaving this organisation
  - 2020 – 17.8% of colleagues saying agree/strongly agree
- Q19b: I will probably look for a job at a new organisation in the next 12 months
  - 2020 – 13.1% of colleagues saying agree/strongly agree

As you're aware we were unable to prioritise the focus areas identified for 2020 because of the Covid-19 pandemic. However, despite this the Trust has gone from strength to strength.

Looking at the questions which scored 'red' (worse than average *and/or* worse than last year); there are only three questions out of the whole survey:

- Q2b: I am enthusiastic about my job
  - 78.3% of colleagues stated often/always (compared to 79.0% in 2019)
- Q2c: Time passes quickly when I am working
  - 78.3% of colleagues stated often/always (compared to 79.2% in 2019 and 78.5% average score)
- Q11b: In the last 12 months have you experienced musculoskeletal problems (MSK) as a result of work activities?
  - 21% of colleagues stated yes (compared to 19.5% in 2019)

The following questions stayed 'the same' as 2019:

- Q12b: In the last 12 months how many times have you personally experienced physical violence at work from managers?
  - 0.02% of colleagues experiencing at least one incident of violence
- Q15a: In the last 12 months have you personally experienced discrimination at work from patients / service users, their relatives or other members of the public?
  - 5.5% of colleagues stating yes

These results should be celebrated. There are extremely significant advances in the majority of questions and all theme areas. The top improvements are around our organisation taking positive action on health and wellbeing, which is up by 20% from last year and is 14% higher than the average comparator score. The challenge now is to keep up the momentum in these areas e.g. continue to support staff with all of the health and wellbeing initiatives that have been put in place during the pandemic, and develop further strategies linked to the recovery planning over the year ahead.

In 2019 the Trust endeavoured to enhance interventions to support Equality, Diversity and Inclusion. Whilst this theme is still above average and is scoring better than last year, we will continue to build on this and strengthen support in this area, over the next year. This would be in anticipation of seeing the knock-on effect over a two year period. A deeper dive into both the WRES and DRES information and our protected characteristics data has enabled us to see where tailored support is required.

Smaller key focus area work streams should continue around 'staff engagement', bearing in mind the results from questions 2b and 2c (enthusiasm about your job and time passing quickly when working) could be linked to the pandemic.

In addition to a deep dive into the data, question 11b - one of our 'best' questions against comparators, yet more colleagues than last year have said they have experienced musculoskeletal problems (MSK) as a result of work activities (21%). This figure again may be linked to the pandemic with more colleagues working from home in different environments, but it is worth exploring.

Smaller areas of work are required in both safe environment – bullying and harassment and safe environment – violence. Whilst both of these areas are scoring above average and better than 2019, thinking about question level data, it is really important that we continue to aspire to get the results of these questions as close to zero as possible. The aspiration is for no colleagues to experience bullying, harassment, abuse or violence – particularly from managers and colleagues.

Since consulting with colleagues and triangulating the findings it has now been confirmed that the 3 main areas of focus for the Trust will be:

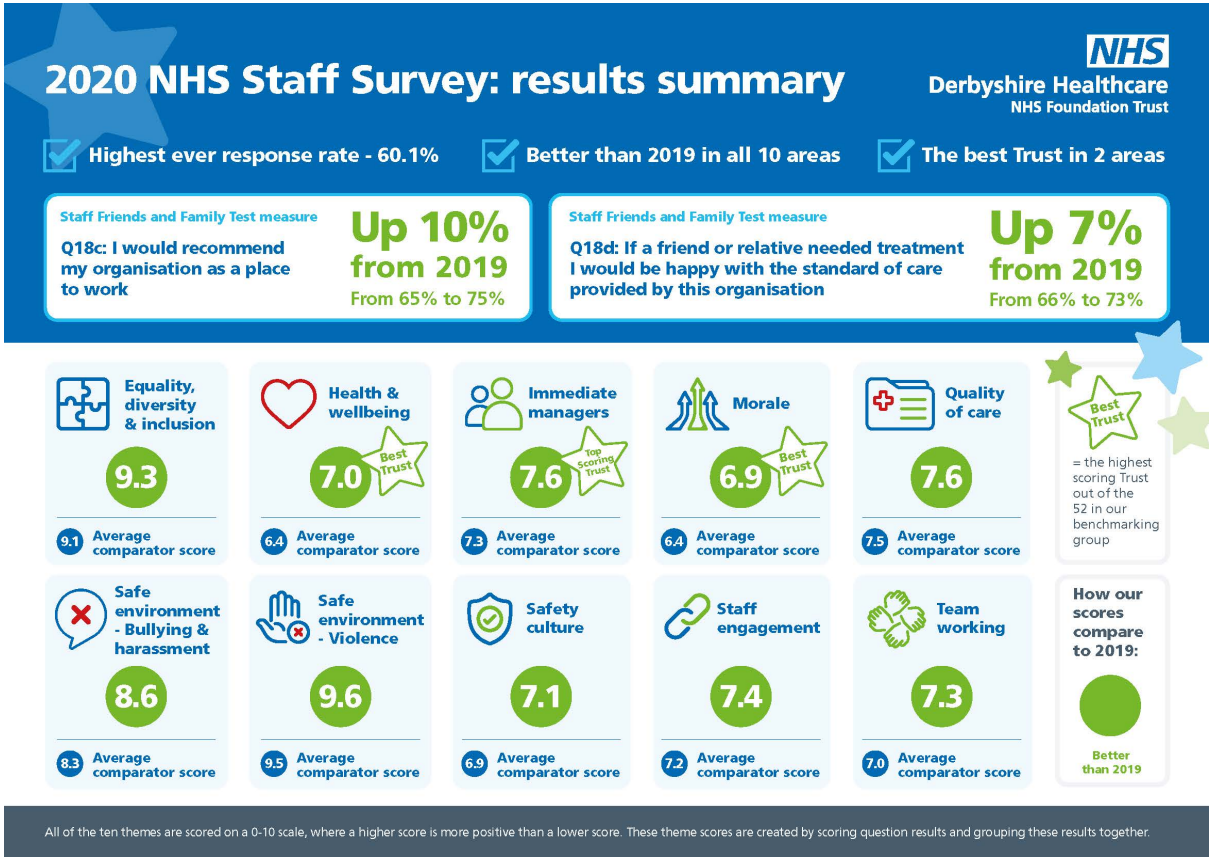
- **Equality, diversity and inclusion** – the WRES and WDES data indicate there are still gaps in some of these key indicators – we will be looking at how we can decrease these gaps and build the results from the protected characteristics breakdown into the wider strategy and action plan.
- **1000 missing voices** – there are still approximately a thousand colleagues who didn't complete the survey in 2020. We need to understand which sections of the workforce didn't complete the survey and look at what is preventing colleagues from doing so; in order to increase participation in 2021 – whether this is because of the time it takes to complete the survey, concerns about confidentiality or getting the right mode (paper versus electronic).
- **How we sustain the positive results** – we have had such a positive set of results – the best year ever! However, we need to ensure we're retaining the positives and enhancing our support and care to colleagues and patients throughout 2021 and beyond. This will be linked to our NHS People Promise.

Lastly, this year the Trust are going to adopt a 3, 2, 1 approach to action planning to keep it simple and clear to all leaders and colleagues how their teams will feed into making improvements in both – the overall Trust focus areas and their own team level results. The Trust are focussing on 3 areas (as bulleted above), and we will be asking all directorates to pick 2 areas to focus on from their own results and all teams to pick 1 area of focus from their own results.

Next steps

- NHS Coordination Centre free text comments available – 30 April 2021
- Further work and analysis on WRES and WDES and protected characteristic data and linking E,D & I findings into wider strategy and action plan
- Further work and analysis on occupational group data
- Supporting leaders to understand and take account of the recently released directorate, department and team results
- Developing an action plan around response rate and sustaining the results (linked to NHS People Promise)
- Reporting progress via the People and Culture Committee.

Appendix 1: 2020 NHS Staff Survey – Results Infographic



Appendix 2: Derbyshire Healthcare 2020 NHS Staff Survey Theme Score Comparison with all 'Mental Health & Learning Disability and Mental Health, Learning Disability and Community Trusts'

	Response Rate Percentage that responded from total recipients	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of care	Safe environment – bullying & harassment	Safe environment – violence	Safety culture	Staff engagement	Team Working
MH & LD and MH, LD & C TRUSTS (A-Z)	**%**	**out of 10**	**out of 10**	**out of 10**	**out of 10**	**out of 10**	**out of 10**	**out of 10**	**out of 10**	**out of 10**	**out of 10**
Comparator Average	49.3%	9.1	6.4	7.3	6.4	7.5	8.3	9.5	6.9	7.2	7.0
Avon and Wiltshire Mental Health Partnership NHS Trust	45.3%	9.0	6.2	7.2	6.2	6.9	8.0	9.4	6.6	6.8	6.7
Barnet, Enfield and Haringey Mental Health NHS Trust	44.1%	8.5	6.2	7.2	6.1	7.6	7.6	9.2	6.8	7.1	7.0
Berkshire Healthcare NHS Foundation Trust	60.4%	9.1	6.5	7.5	6.7	7.6	8.4	9.6	7.3	7.5	7.4
Birmingham and Solihull Mental Health NHS Foundation Trust	47.1%	8.5	6.1	7.3	6.4	7.5	7.7	9.2	6.6	7.1	6.7
Black Country Healthcare NHS Foundation Trust	53.3%	9.0	6.4	7.3	6.4	7.6	8.2	9.4	6.9	7.1	6.8
Bradford District Care NHS Foundation Trust	43.6%	9.0	6.3	7.3	6.4	7.4	8.4	9.6	6.9	7.0	7.7
Cambridgeshire and Peterborough NHS Foundation Trust	48.4%	9.1	6.2	7.2	6.3	7.3	8.4	9.6	6.9	7.0	6.9
Camden and Islington NHS Foundation Trust	64.2%	8.2	6.0	7.4	6.1	7.5	7.6	9.1	6.9	7.1	7.1
Central and North West London NHS Foundation Trust	43.5%	8.6	6.3	7.1	6.2	7.6	8.1	9.5	7.0	7.2	7.0
Cheshire and Wirral Partnership NHS Foundation Trust	51.0%	9.4	6.5	7.3	6.4	7.5	8.5	9.5	7.0	7.2	6.7
Cornwall Partnership NHS Foundation Trust	37.5%	9.2	5.9	7.0	6.3	7.3	8.1	9.5	6.7	7.0	6.6
Coventry and Warwickshire Partnership NHS Trust	41.3%	9.1	6.4	7.2	6.4	7.4	8.4	9.5	6.8	7.0	6.8
Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust	50.2%	9.3	6.6	7.5	6.7	7.5	8.4	9.3	7.2	7.3	7.2
Derbyshire Healthcare NHS Foundation Trust	60.1%	9.3	7.0	7.6	6.9	7.6	8.6	9.6	7.1	7.4	7.3

	Response Rate Percentage that responded from total recipients	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of care	Safe environment – bullying & harassment	Safe environment – violence	Safety culture	Staff engagement	Team Working
Devon Partnership NHS Trust	44.8%	9.2	6.2	7.4	6.5	7.0	8.1	9.4	6.8	7.0	6.9
Dorset Healthcare University NHS Foundation Trust	60.5%	9.4	6.7	7.4	6.7	7.5	8.6	9.7	6.0	7.3	7.1
East London NHS Foundation Trust	43.6%	8.5	6.3	7.4	6.3	7.7	7.8	9.3	7.0	7.3	7.0
Essex Partnership University NHS Foundation Trust	46.7%	9.0	6.4	7.3	6.4	7.6	8.0	9.5	6.9	7.2	6.9
Gloucestershire Health and Care NHS Foundation Trust	46.3%	9.3	6.4	7.2	6.5	7.4	8.3	9.6	7.0	7.2	6.7
Greater Manchester Mental Health NHS Foundation Trust	48.1%	9.0	6.2	7.4	6.3	7.3	8.1	9.2	6.8	7.0	6.8
Herefordshire and Worcestershire Health and Care NHS Trust	45.2%	9.3	6.4	7.2	6.5	7.3	8.4	9.5	7.0	7.1	6.7
Hertfordshire Partnership University NHS Foundation Trust	52.0%	8.9	6.6	7.4	6.6	7.7	8.2	9.3	7.3	7.4	7.1
Humber Teaching NHS Foundation Trust	43.1%	9.4	6.3	7.2	6.4	7.3	8.5	9.6	6.8	7.1	6.9
Isle of Wight NHS Trust (mental health sector)	64.5%	9.2	6.2	7.2	6.5	7.2	7.9	9.2	6.7	6.9	6.8
Kent and Medway NHS and Social Care Partnership Trust	61.1%	8.9	6.5	7.6	6.4	7.4	8.0	9.3	7.0	7.1	7.1
Lancashire and South Cumbria NHS Foundation Trust	43.3%	9.2	6.1	7.3	6.4	7.4	8.4	9.5	6.7	7.0	7.0
Leeds and York Partnership NHS Foundation Trust	47.0%	9.1	6.5	7.6	6.5	7.3	8.4	9.3	6.9	7.2	6.9
Leicestershire Partnership NHS Trust	52.5%	9.1	6.3	7.3	6.3	7.2	8.4	9.5	6.8	7.0	6.9
Lincolnshire Partnership NHS Foundation Trust	60.7%	9.3	6.7	7.5	6.8	7.6	8.4	9.4	7.1	7.4	7.3
Mersey Care NHS Foundation Trust	36.7%	9.2	6.5	7.4	6.5	7.6	8.4	9.5	7.2	7.2	7.0
Midlands Partnership NHS Foundation Trust	59.1%	9.4	6.6	7.4	6.6	7.6	8.5	9.6	7.1	7.3	7.1
Norfolk and Suffolk NHS Foundation Trust	46.0%	8.8	5.9	7.2	6.2	6.9	7.8	9.3	6.3	6.7	6.8

	Response Rate Percentage that responded from total recipients	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of care	Safe environment – bullying & harassment	Safe environment – violence	Safety culture	Staff engagement	Team Working
North East London NHS Foundation Trust	58.9%	9.0	6.4	7.4	6.4	7.8	8.4	9.7	7.1	7.3	7.1
North Staffordshire Combined Healthcare NHS Trust	60.7%	9.3	6.7	7.5	6.7	7.7	8.5	9.4	7.2	7.4	7.3
North West Boroughs Healthcare NHS Foundation Trust	35.6%	9.3	6.5	7.5	6.4	7.7	8.6	9.6	7.0	7.2	7.1
Northamptonshire Healthcare NHS Foundation Trust	59.4%	9.3	6.7	7.3	6.7	7.6	8.3	9.6	7.4	7.5	7.1
Nottinghamshire Healthcare NHS Foundation Trust	55.6%	9.1	6.3	7.2	6.4	7.4	8.2	9.4	6.9	7.1	6.8
Oxford Health NHS Foundation Trust	52.8%	9.2	6.4	7.4	6.4	7.3	8.3	9.5	7.1	7.2	6.9
Oxleas NHS Foundation Trust	42.9%	8.8	6.3	7.4	6.4	7.6	8.1	9.5	7.0	7.3	7.2
Pennine Care NHS Foundation Trust	38.3%	9.2	6.4	7.4	6.5	7.6	8.2	9.4	6.8	7.2	6.8
Rotherham Doncaster and South Humber NHS Foundation Trust	53.1%	9.5	6.7	7.3	6.6	7.7	8.6	9.6	7.0	7.2	6.9
Sheffield Health and Social Care NHS Foundation Trust	41.0%	8.8	6.0	7.1	6.1	6.8	7.9	9.3	6.1	6.6	6.7
Solent NHS Trust	66.0%	9.4	6.7	7.6	6.7	7.5	8.8	9.7	7.5	7.4	7.2
South London and Maudsley NHS Foundation Trust	51.9%	8.5	6.2	7.3	6.2	7.4	7.9	9.2	6.8	7.1	7.0
South West London and St George's Mental Health NHS Trust	61.1%	8.5	6.1	7.3	6.1	7.6	7.9	9.2	6.8	7.1	7.1
South West Yorkshire Partnership NHS Foundation Trust	42.7%	9.2	6.4	7.2	6.5	7.4	8.3	9.4	6.9	7.1	6.9
Southern Health NHS Foundation Trust	41.2%	9.2	6.5	7.4	6.4	7.4	8.3	9.6	7.0	7.2	7.0
Surrey and Borders Partnership NHS Foundation Trust	64.6%	9.2	6.7	7.6	6.6	7.7	8.4	9.5	7.1	7.4	7.3
Sussex Partnership NHS Foundation Trust	52.3%	9.1	6.3	7.4	6.5	7.0	8.0	9.3	6.9	7.2	6.9
Tavistock and Portman NHS Foundation Trust	62.6%	8.4	6.0	7.3	6.1	7.1	8.4	9.8	6.7	7.1	6.9

	Response Rate Percentage that responded from total recipients	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of care	Safe environment – bullying & harassment	Safe environment – violence	Safety culture	Staff engagement	Team Working
Tees, Esk and Wear Valleys NHS Foundation Trust	38.2%	9.3	6.4	7.2	6.4	7.4	8.3	9.4	6.9	7.1	6.9
West London NHS Trust	51.9%	8.5	6.5	7.6	6.4	7.9	7.9	9.2	6.9	7.3	7.1

	Our Trust
	Best Theme Score(s)
	Worst Theme Score(s)

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 4 May 2021

Corporate Governance Report

Purpose of Report
To seek approval of a number of Governance documents, note the assurance on Board Committee year end reporting and receive the Trust sealings report.

Executive Summary
Included are several governance documents requiring Board approval. These are: • NHS Improvement Year-End Self-Certification • Modern Slavery Statement • Terms of Reference (ToRs) for Board Committees Assurance is provided from the Audit and Risk Committee on the year-end governance reporting from Board Committees All ToRs were made consistent to enable the Committees to act under emergency ToRs agreed in response to the COVID-19 pandemic. Additional revisions were as follows: Quality and Safeguarding: • Members' attendance at the Quality and Safeguarding Committee was strengthened to stipulate that if the Director of Nursing and Patient Experience could not be present, the Medical Director is to act as the Executive Lead. People and Culture Committee: • The first sentence revised to read that the Committee supports the organisation to achieve a well-led, values driven and inclusive positive culture • The reference to members' attendance was made stronger to specify that the Deputy Director of Operations and Deputy Medical Director are to be in attendance if the Medical Director or Chief Operating Officer is unable to be present • Section 6.3 was updated to show the new model of delivery through to the Committee. The Trust Sealings register report is included for information.

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

Assurances

The Trust has complied with national guidance and statutory duties. Each Committee or Committee Chair has been assured through their review that the Committees are working effectively and meeting the requirements of the Terms of Reference (ToR) as required per the Corporate Governance Framework.

Consultation

The Modern Slavery Statement has been considered by the People and Culture Committee. The year-end governance reports and ToRs have been through the individual Board Committees and monitored through the Audit and Risk Committee.

Governance or Legal Issues

The NHS Improvement Year-End Self-Certification is in compliance with the Trust's licence and the Modern Slavery Statement is mandated. The year-end governance reports are in line with governance best practice. The NHS Audit Committee Handbook advises that an Audit Committee, in line with best practice in other sectors, should prepare a report to the Board that sets out how the Committee has met its ToR. One of the general roles of the Board under the scheme of delegation is to agree the ToRs for Committees of the Board.

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

In relation to Modern Slavery Statement the Trust commits to the design and implementation of services, policies and measures that meet the diverse needs of services, the population and workforce, ensuring that none are placed at a disadvantage over others.

There is no direct impact on those with protected characteristics arising from other aspects this report. However, governance of the Trust includes broad consideration of equality and diversity issues for example as a key part of Board Committee business, and as an important element of governor training and development to ensure that decision making encompasses equality impact considerations. Each Board Committee has a specific.

Recommendations

The Board of Directors is requested to:

1. Approve the NHS Improvement Year-end Self-Certification
2. Approve the Modern Slavery Statement for 2020/21
3. Approve the suite of Terms of Reference for Board Committees.
4. Note the assurance received by the Audit and Risk Committee that all Board Committees have effectively carried out their role and responsibilities as defined by their Terms of Reference during 2020/21.
5. Note the Trust seal report.

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

Report prepared by: **Justine Fitzjohn, Trust Secretary**
Sue Turner, Board Secretary

1. NHS Improvement Year-end Self-Certification

NHS Foundation Trusts are required to annually self-certify whether or not they have complied with the conditions of the NHS provider licence (which itself includes requirements to comply with the National Health Service Act 2006, the Health and Social Care Act 2008, the Health Act 2009, and the Health and Social Care Act 2012, and have regard to the NHS Constitution), have the required resources available if providing commissioner requested services, and have complied with governance requirements.

Providers need to self-certify after the financial year end that, in relation to their NHS provider licence conditions:

- The provider has taken all precautions necessary to comply with the licence, NHS Acts and NHS Constitution; Condition G6(3)
- The provider has complied with required governance arrangements; Condition FT4(8
- If providing commissioner requested services, the provider has a reasonable expectation that required resources will be available to deliver the designated service Condition CoS7(3)
- Publication of condition G6(3) self certification ; condition G6(4)

The proposed declaration is included as Appendix 1 for Board approval. The declaration highlights key evidence and narrative to support the declarations.

Recommendation:

The Board of Directors is asked to approve the NHS Improvement Year-end Self-Certification. The declarations will then be posted on the Trust's web-site

2. Modern Slavery Statement

The Trust has to publish an annual statement setting out the steps they take to prevent modern slavery in their business and their supply chains. This is a requirement under Section 54 (Transparency in Supply Chains) of the Modern Slavery Act 2015. The statement must be updated every year and published on the Trust website within six months of the financial year-end.

Only very minor amendments were required to the Trust's statement when it was recently considered by the People and Culture Committee. The Committee was assured that the Trust has met the criteria for the 2019/20 financial year. The proposed statement for 2020/21 is attached at Appendix 2.

Recommendation:

The Board of Directors is requested to approve the Modern Slavery Statement for 2020/21, noting that once approved the statement will be uploaded to the Trust's website.

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

At its meeting on 27 April 2021, the Audit and Risk Committee received the full year end summaries for the following Committees as well as their Terms of Reference (ToR):

- Remuneration and Appointments Committee
- Finance and Performance Committee
- Audit and Risk Committee
- Quality and Safeguarding Committee
- People and Culture Committee
- Mental Health Act Committee

In April 2020 the Trust adapted a number of its governance structures in response to the NHSEI guidance letter 'reducing the burden and releasing capacity to manage the pandemic'. In relation to the Board and its Committees, emergency ToR were adopted which gave flexibility on quorum and membership and re-focused agendas as well as the mandate to hold meetings virtually.

The Board Committees reviewed their activity during the past year against the background of this lighter governance approach and sought verbal confirmation from their members that they had fulfilled the key duties under their ToR and were operating effectively in providing assurance to the Trust Board or escalating risks.

The Audit and Risk Committee received assurance from the summary reports that the Committees have effectively carried out their role and responsibilities during 2020/21. The suite of ToRs are included as Appendix 3.

Recommendation:

The Board of Directors is requested to approve the suite of ToRs for the Board Committees and note the assurance received by the Audit and Risk Committee that all Board Committees have effectively carried out their role and responsibilities as defined by their ToR during 2020/21.

4. Register of Trust Sealings

The six-monthly update on the authorised use of the Trust Seal since the last report to the Board on 3 November 2020 is attached for information at Appendix 4.

Recommendation:

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

Appendix 1

Condition G6

Condition G6(2) requires NHS foundation trusts to have processes and systems that:

- identify risks to compliance
- take reasonable mitigating actions to prevent those risks and a failure to comply from occurring

Providers must annually review whether these processes and systems are effective must publish their G6 self-certification within one month following the deadline for sign-off (as set out in Condition G6(4)).

Proposed declaration:

The Board declares that the Licensee continues to meet the criteria for holding a licence (Condition G6)

This declaration is supported by evidence as outlined in the Trust's Annual Governance Statement, Board Assurance Framework and through the work of the Board assurance Committees in ensuring management of risks and ongoing compliance. This has been supported through an internal audit carried out in year which provided significant assurance of our risk management processes and positive the CQC 'Good' rating from the 2020 Well Led inspection.

2. Continuation of Services Condition 7

Commissioner requested services (CRS) are services commissioners consider should continue to be provided locally even if a provider is at risk of failing financially and which will be subject to regulation by NHSI. Providers can be designated as providing CRS because:

- there is no alternative provider close enough
- removing the services would increase health inequalities
- removing the services would make other related services unviable.

Primary evidence is contained in the Going Concern assessment which has been considered by the Audit and Risk Committee. This assessment is based solely on the anticipated future provision of our services in the public sector in line with current guidance. This decision will be reviewed each year in order to ensure that accounts are prepared on an appropriate basis given prevailing circumstances at the time. The Trust's financial management arrangements, overseen by Finance and Performance Committee. This is described in full along with mitigating actions in the 2020/21 Board Assurance Framework.

Proposed Declaration:

The Board declares that the licensee has a reasonable expectation that the licensee will have the required resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.

3. Condition FT4 Declaration

NHS foundation trusts must self-certify under Condition FT4 (8) whether the governance systems achieve the objectives set out in the licence condition.

The Trust has flexed its governance structures to maintain a well-led organisation with robust governance in the context of wholly unprecedented challenges presented by COVID-19 was clear. There has been regular update to the Board on the on-going management of corporate governance within the Trust, the principles of which were approved by the Board in April 2020 and in light of NHSEI's most recent ' Reducing burden and releasing capacity to manage the COVID-19 pandemic' letter. The Trust has effective Board and committee structures, reporting lines and performance and risk management systems. See attached Corporate Governance Statement for further information against each item.

Proposed declaration:

The Board confirms that it complies with all elements of the Corporate Governance Statement (condition FT4)

4. Certification on Training of governors

Providers must review whether their governors have received enough training and guidance to carry out their roles.

Despite the COVID-19 pandemic governor training has been carried out throughout the year; sessions were held digitally. All governors were encouraged to attend the training and development sessions, areas for development included finance (led by a Trust Director); and mental health conditions which focused on anxiety and depression. Governors were also encouraged to attend virtual GovernWell sessions organised by NHS Providers, and the NHS Providers conference which gave governors the opportunity to network with governors from other Trusts and to share good practice.

Proposed declaration:

The Board is satisfied that during the financial year most recently ended the Licensee has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.

1. The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	
Response	**Confirmed**
Risks and Mitigating actions The Trust has been required to flex its governance structures but has following national guidance and best practise. The robustness of these processes are set out in the Annual Report and Annual Governance Statement. The Trust received a 'Good' rating in the CQC Well Led inspection in 2020. Board Committees continue to review effectiveness with year-end reviews undertaken by each Committee during February/March 2021 for onwards scrutiny and oversight by the Audit and Risk Committee and then Trust Board.	
2. The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	
Response	**Confirmed**
Risks and Mitigating actions The Trust has continued to embed good practice developed through self-assessment the NHSI and CQC well-led framework. The Trust had several areas of positive feedback on corporate governance elements of well-led following the CQC comprehensive inspection report received. The Trust has followed NHSEI's guidance as set out in the 'Reducing burden and releasing capacity to manage the COVID-19 pandemic' letters.	
3. The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	
Response	**Confirmed**
Risks and Mitigating actions The Trust corporate governance framework has been implemented successfully in terms of Board and Board Committee responsibilities, delegation and escalation. There is a process for review of all Board Committees to reflect on their effectiveness.	
4. The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee	

including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions;

(d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern);

(e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making;

(f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence;

(g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and

(h) To ensure compliance with all applicable legal requirements.

Response	**Confirmed**

Risks and Mitigating actions

The Board, via its Committees where relevant, oversees the Trust duties as listed. Items are escalated to the Trust Board from Committees to ensure key risks are addressed.

5. The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure:

(a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided;

(b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations;

(c) The collection of accurate, comprehensive, timely and up to date information on quality of care;

(d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care;

(e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and

(f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.

Response	**Confirmed**

Risks and Mitigating actions

Quality Leadership is overseen by the Trust Board and assurance on quality of care is provided through the Quality and Safeguarding Committee. Issues and risks are escalated to the Board as required. Working under Level 4 emergency procedures some compliance has been impacted by the pandemic response but essential quality and safety has been managed through the Incident Management Team, Executive Directors and the Quality and Safeguarding Committee. Quality is led on the Trust

Board jointly by the Medical Director and Director of Nursing and Patient Experience. We have continued to review and improve our integrated performance report to Trust Board to ensure robust oversight of operational performance, workforce, financial and quality issues.	
6. The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	
Response	**Confirmed**
Risks and Mitigating actions The Remuneration and Appointments Committee consider the composition of the Board to ensure that this is appropriate in terms of skill mix and qualifications. The Fit and Proper Persons Test Policy has been fully implemented and is embedded. Wider workforce issues are considered by the People and Culture Committee with risks and issues escalated to the Board as required and routinely through assurance summaries.	

Appendix 2

Derbyshire Healthcare NHS Foundation Trust

MODERN SLAVERY STATEMENT – 2020/21

INTRODUCTION

This Statement is made pursuant to section 54 of the Modern Slavery Act 2015 and sets out the steps that Derbyshire Healthcare NHS Foundation Trust (the Trust) has taken, and is continuing to take, to make sure that modern slavery or human trafficking is not taking place within our business or supply chain.

Modern slavery encompasses slavery, servitude, human trafficking and forced labour. The Trust has a zero-tolerance approach to any form of modern slavery. We are committed to acting ethically and with integrity and transparency in all business dealings and to put effective systems and controls in place to safeguard against any form of modern slavery taking place within our business or our supply chain.

AIM OF THIS STATEMENT

The aim of this statement is to demonstrate that the Trust follows good practice and all reasonable steps are taken to prevent slavery and human trafficking.

All members of staff have a personal responsibility for the successful prevention of slavery and human trafficking, with the Procurement Department taking the lead responsibility for compliance in the supply chain.

ABOUT THE ORGANISATION

The Trust is a provider of mental health, learning disability and children's services across the city of Derby and wider county of Derbyshire. We provide a variety of inpatient and community based services throughout the county. We also provide specialist services across the county including substance misuse and eating disorders services.

Successful partnership working is essential to the delivery of many of our services. The Trust works in close collaboration with our commissioners and fellow providers of local healthcare services, together with local authority colleagues at Derby City Council and Derbyshire County Council, and voluntary and community sector organisations. Derbyshire Healthcare is an active partner in Joined Up Care Derbyshire, an Integrated Care System of health and care organisations working collectively to address challenges and improve the level of joined up working within the local health and care economy.

The Trust provides services to a diverse population, including areas of wealth alongside significant deprivation. The Trust's catchment area includes both city and rural populations, with over 70 different languages being spoken.

We became a Foundation Trust in 2011 and we employ over 2,400 staff based in over 60 locations across the whole of Derbyshire. Across the county and the city, we serve a combined population of approximately one million people.

OUR POLICIES ON SLAVERY AND HUMAN TRAFFICKING

The Trust is aware of its responsibilities towards patients, service users, employees and the local community and expects all suppliers to the Trust to adhere to the same ethical principles. The Trust is committed to ensuring that there is no modern slavery or human trafficking in our supply chains or in any part of our business. Our internal policies replicate our commitment to acting ethically and with integrity in all our business relationships.

Currently all awarded suppliers sign up to our terms and conditions of contract which contain a provision around Good Industry Practice to ensure each supplier's commitment to anti-slavery and human trafficking in their supply chains; and that they conduct their businesses in a manner that is consistent with the Trust's anti-slavery policy.

The Trust policies, procedures, governance and legal arrangements are robust, ensuring that proper checks and due diligence are applied in employment procedures to ensure compliance with this legislation. We also conform to the NHS employment check standards within our workforce recruitment and selection practices. This strategic approach incorporates analysis of the Trust's supply chains and its partners to assess risk exposure and management on modern slavery.

We operate a number of internal policies to ensure that we are conducting business in an ethical and transparent manner. These include the following:

Recruitment and Selection policy and procedure: We operate a robust recruitment policy including conducting eligibility to work in UK checks for all directly employed staff. Other checks include checks of identity, evidence of qualifications, health clearance, employment history and in areas of safeguarding risk a Disclosure Barring Service criminal records check. External agencies are sourced through the NHS Improvement nationally approved frameworks and are audited to provide assurance that pre-employment clearance has been obtained for agency staff to safeguard against human trafficking or individuals being forced to work against their will.

Equal Opportunities: We have a range of controls to protect staff from poor treatment and/or exploitation which comply with all respective laws and regulations. These include provision of fair pay rates, fair terms and conditions of employment, and access to training and development opportunities.

Safeguarding Policies: We adhere to the principles inherent within both our Safeguarding Children and Adults policies and procedures. These provide clear guidance so that our employees are aware as to how to raise safeguarding concerns about how colleagues or people receiving our services are being treated, or about practices within our business or supply chain.

Freedom to Speak Up Policy: We operate a Speak Up policy so that all employees know that they can raise concerns about how colleagues or people receiving our services are being treated, or about practices within our business or supply chain, without fear of reprisals.

Standards of Business Conduct (within Standing Orders): This policy explains the manner in which we behave as an organisation and how we expect our employees and suppliers to act.

WORKING WITH SUPPLIERS

The Procurement Team ensures that due diligence is undertaken for all new and ongoing suppliers of goods and services to the organisation and their associated Supply Chains by sourcing through the following compliant routes:

1. Competitive OJEU (Official Journal of the European Union) procurements tendered in compliance with EU guidance which require suppliers to confirm they comply with the Modern slavery act. To support their response bidders are also required to state:

   a. *the organisation's structure, its business and its supply chains;*
   b. *its policies in relation to slavery and human trafficking;*
   c. *its due diligence processes in relation to slavery and human trafficking in its business and supply chains;*
   d. *the parts of its business and supply chains where there* is *a risk of slavery and human trafficking taking place, and the* steps *it* has *taken to* assess *and manage that risk;*
   e. *its effectiveness in ensuring that slavery and human trafficking* is *not taking place in its business or supply chains, measured against such performance indicators as it considers appropriate;*
   f. *the training and capacity building about slavery and human trafficking available to its staff.*

2. Procurement through EU compliant national government frameworks.

3. All contracts and associated purchase orders are raised on the NHS Standard Terms and Conditions which suppliers are mandated to comply with. These conditions state:

   10.1.28 it shall: (i) comply with all relevant Law and Guidance and shall use Good Industry Practice to ensure that there is no slavery or human trafficking in its supply chains; and (ii) notify the Authority immediately if it becomes aware of any actual or suspected incidents of slavery or human trafficking in its supply chains;

   10.1.29 it shall at all times conduct its business in a manner that is consistent with any anti-slavery Policy of the Authority and shall provide to the Authority any reports or other information that the Authority may request as evidence of the Supplier's compliance with this Clause 10.1.29 and/or as may be requested or otherwise required by the Authority in accordance with its anti-slavery Policy.

   The Procurement Team upholds the Chartered Institute of Procurement and Supply (CIPS) Code of Professional Conduct.

TRAINING

Advice and training about Modern Slavery and human trafficking is available to staff through our mandatory Safeguarding Children and Adults training programmes, our Safeguarding policies and procedures, and our Safeguarding Leads. It is also discussed at our compulsory staff induction training.

Awareness is also raised through information sharing on the Trust intranet and our public website.

Advice and training about Modern Slavery and human trafficking is available to staff through our Safeguarding Children and Adults training programme. The Trust is committed to and follow the Derbyshire and Derby Safeguarding Adults Policy and Procedures and the Derby and Derbyshire Safeguarding Children Partnership Procedures.

OUR PERFORMANCE INDICATORS

We will know the effectiveness of the steps that we are taking to ensure that slavery and/or human trafficking is not taking place within our business or supply chain if:

- No reports are received from our staff, the public, or law enforcement agencies to indicate that modern slavery practices have been identified.

BOARD OF DIRECTORS' APPROVAL

The Board of Directors has considered and approved this statement and will continue to support the requirements of the legislation.

This statement is made pursuant to Section 54(1) of the Modern Slavery Act 2015 and constitutes our organisation's modern slavery and human trafficking statement for the current financial year.

Signed on behalf of the Board of Directors:

Caroline Maley
Trust Chair

Ifti Majid
Chief Executive

Appendix 3

Derbyshire Healthcare
NHS Foundation Trust

Remuneration and Appointments Committee Terms of Reference

Purpose

The Committee is responsible for identifying and appointing candidates to fill Director positions on the Board including the Chief Executive, voting and non-voting Executive Directors. The Committee is also responsible for establishing and keeping under review a remuneration policy in respect of Executive Directors and to advise upon and oversee contractual arrangements for Executive Directors.

1. Authority

1.1 The Remuneration and Appointments Committee (the Committee) is constituted as a standing Committee of the Trust's Board of Directors. Its constitution and terms of reference shall be as set out below, subject to amendment at future Board of Directors meetings.

1.2 The Committee is authorised by the Board of Directors to act within its terms of reference. All members of staff are directed to co-operate with any request made by the Committee.

1.3 The Committee is authorised by the Board of Directors to obtain external legal or other independent professional advice. The Committee is authorised by the Board of Directors to request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary or expedient to the carrying out of its functions.

1.4 The Committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions.

1.5 As a Committee of the Board, the Remuneration & Appointments Committee has an important role to provide assurance on the progress and risks relating to the delivery of the Trust's strategic objectives which fall within the Committee's remit.

1.6 The Committee is authorised by the Board of Directors to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any member of staff and all members of staff are directed to co-operate with any request made by the Committee.

1.7 The Trust has a duty under the Equality Act 2010 to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations between people from different groups. The Act protects against discrimination on grounds of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, gender and sexual orientation. The Remuneration & Appointments Committee will ensure consideration has been given to equality impact related risks.

1.8 To actively consider the equality impact and evidence relating to all items of Committee business as part of the Committee's contribution to equality, diversity and inclusion

1.9 As a designated policy ratification group, (see 'Policy on Policy Documents) the Remuneration & Appointments Committee is operationally responsible for monitoring that the policy documents for which it is responsible comply with the policy. This includes monitoring that the style, content and format of the policy are compliant, including completion of the Equality Impact Assessment (EIA) which forms part of the current policy template. All policy documents are allocated a policy ratification group as they are published on Connect.

2. Membership

2.1 The membership of the Committee shall consist of:

- Trust Chair
- All Non-Executive Directors on the Board of Directors.

2.2 The Trust Chair will chair the Committee.

2.3 When appointing or removing the Chief Executive, the Committee shall be the committee described in Schedule 7, 17(3) of the National Health Service Act 2006 as amended by the Health and Social care Act 2012 (the Act) (that is all the non-executive directors). When appointing or removing the other executive directors the Committee shall be the committee described in Schedule 7, 17(4) of the Act (that is the Trust chair, the chief executive and the non-executive directors).

3. Attendance

3.1 Meetings of the Committee may be attended by:

- Chief Executive
- Director of People and Organisational Effectiveness
- Trust Secretary
- Any other person who has been invited to attend the meeting by the Committee so as to assist in deliberations.

4. Quorum

4.1 A quorum shall be three members.

4.2 Meetings may be held by conference call or by electronic means, by exception, so long as those present can hear each other and contribute simultaneously to the meeting.

4.3 If the meeting is not quorate the meeting can progress if those present determine. However, no business decisions shall be transacted and items requiring approval may be submitted to the next Trust Board meeting as an urgent item.

5. Frequency of Meetings

Meetings shall be held quarterly or as required.

6. Duties & Responsibilities

Monitor's Code of Governance (July 2014) - these terms of reference are based in part, on best practice as set out in that code and have been drafted referring to the provision in the code. The code states as two of its principles that;

"There should be a formal and transparent procedure for developing policy on executive remuneration and for fixing the remuneration packages of individual directors. No director should be involved in deciding his or her own remuneration."

"There should be a formal, rigorous and transparent procedure for the appointment of new directors to the board. Directors of NHS foundation trusts must be "fit and proper" to meet the requirements of the general conditions of the provider licence."

To be responsible for identifying and appointing candidates to fill all the executive director positions on the Board and for determining their remuneration and other conditions of service.

The Committee will ensure that when matters of concern are raised during Committee business these are dealt with openly and transparently and scrutinised as appropriate. When issues arise the Committee will undertake to challenge robustly and fairly in order to develop a culture of continuous improvement, openness and honesty.

To consider the Board Assurance Framework and high level risks, in particular as they relate to the remit of the Committee; and to comply with any request from the Audit and Risk Committee for assurance in relation to the Board Assurance Framework and the Risk Register including deep dives of risks as appropriate.

These terms of reference are intended to ensure that the Trust's procedure for the appointment of the chief executive and other directors (excluding Non-Executive Directors) to the Board of Directors reflect these principles.

6.1 Appointments role

6.1.1 To be responsible for identifying and appointing candidates to fill all the executive director positions on the board including the Chief Executive, voting and non-voting Directors. Non-executive Directors are appointed through the Nominations and Remuneration Committee of the Council of Governors.

6.1.2 Regularly review the structure, size and composition (including the skills, knowledge, experience and diversity) of the Board, making use of the output of the board evaluation process as appropriate, and make recommendations to the board, and nomination committee of the Council of Governors, as applicable, with regard to any changes.

6.1.3 Give full consideration to and make plans for succession planning for the Chief Executive and other executive board director roles taking into account the challenges and opportunities facing the trust and the skills and expertise needed on the Board in the future.

6.1.4 To advise upon and oversee contractual arrangements for executive directors, including but not limited to termination payments.

6.1.5 Ensure that a proposed executive director's other significant commitments (if applicable) are disclosed before appointment and that any changes to their commitments are reported to the Board as they arise.

6.1.6 Ensure that proposed appointees disclose any business interests that may result in a conflict of interest prior to appointment and that any future business interests that could result in a conflict of interest are reported.

6.1.7 Consider any matter relating to the continuation in office of any board executive director including the suspension or termination of service of an individual as an employee of the Trust, subject to the provisions of the law and their service contract. The Committee will oversee ongoing compliance with the Fit and Proper Person requirements of Directors.

6.2 Remuneration Role

6.2.1 Establish and keep under review a remuneration policy in respect of executive board directors.

6.2.2 Consult the Chief Executive about proposals relating to the remuneration of the other executive directors.

6.2.3 In accordance with all relevant laws, regulations and Trust policies, decide and keep under review the terms and conditions of office of the Trust's executive directors (voting and non-voting) on locally-determined pay in accordance with all relevant Foundation Trust policies, including:

- salary, including any performance-related pay or bonus
- provisions for other benefits, including pensions and cars
- allowances.

6.2.4 In adhering to all relevant laws, regulations and Trust policies:

- establish levels of remuneration which are sufficient to attract, retain and motivate executive directors of the quality and with the skills and experience required to lead the trust successfully, without paying more than is necessary for this purpose, and at a level which is affordable for the Trust

- use national guidance and market benchmarking analysis in the annual determination of remuneration of executive directors (both voting and non-voting) on locally-determined pay, while ensuring that increases are not made where Trust or individual performance do not justify them

6.2.5 Monitor, and assess the output of the evaluation of the performance of individual executive directors, and consider this output when reviewing changes to remuneration levels.

7. Minutes and Reporting

7.1 The minutes of all meetings of the Committee shall be formally recorded. These will be held confidentially by the Director of Corporate Affairs on behalf of the Trust Chair.

7.2 The Committee will report to the full Board of Directors after each meeting.

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

7.4 The Committee will report annually to the Audit and Risk Committee describing how the Committee has fulfilled its terms of reference and give details of any significant issues and how they have been addressed.

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

7.6 Agendas and papers will be distributed in accordance with deadlines agreed with the Committee Chair.

8. Terms of Reference Review

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

Approved by Remuneration & Appointments Committee	6 April 2021
Approved by Audit & Risk Committee	27 May
Approved by Trust Board	

Audit & Risk Committee Terms of Reference

Purpose

This is the principal Committee for seeking independent assurance on the general effectiveness of the Trust's internal control and risk management systems and for reviewing the structures and processes for identifying and managing key risks. It is responsible for reviewing the adequacy of all risk and control related statements prior to approval by the Board and for seeking assurances on these controls. In discharging its responsibilities the Committee takes independent advice from the Internal Auditor or seeks any other legal or professional advice as required to discharge its responsibilities.

1. Authority

1.1 The Audit and Risk Committee (the Committee) is constituted as a Committee of the Trust's Board of Directors. Its constitution and Terms of Reference are set out below, and are subject to amendment at future Board of Directors meetings. The Committee shall not have executive powers in addition to those delegated in these Terms of Reference.

1.2 As a Committee of the Board, the Audit and Risk Committee has an important role to provide assurance on the progress and risks relating to the delivery of the Trust's strategic objectives which fall within the Committee's remit. This includes identification, review and scrutiny of all relevant risks on the Board Assurance Framework.

1.3 The Committee is authorised by the Board of Directors to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any member of staff and all members of staff are directed to co-operate with any request made by the Committee.

1.4 The Committee is authorised by the Board of Directors to obtain external legal or other independent professional advice. The Committee is authorised by the Board of Directors to request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary or expedient to the carrying out of its functions.

1.5 The Trust has a duty under the Equality Act 2010 to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations between people from different groups. The Act protects against discrimination on grounds of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, gender and sexual orientation. The Audit and Risk Committee will ensure consideration has been given to equality impact related risks.

1.6 The Committee will actively consider the equality impact and evidence relating to all items of Committee business as part of the Committee's contribution to equality, diversity and inclusion

1.7 As a designated policy ratification group, (see 'Policy on Policy' document) the Audit and Risk Committee is operationally responsible for monitoring that the policy documents for which it is responsible comply with the policy. This includes monitoring that the style, content and format of the policy are compliant, including completion of the Equality Impact Assessment (EIA) which forms part of the current policy template. All policy documents are allocated a policy ratification group as they are published on Connect.

2. Membership

2.1 The Committee shall be composed of at least three independent non-executive directors, at least one of whom should have recent and relevant financial experience.

2.2 One of the members shall be appointed Chair of the Committee by the Board of Directors.

2.3 The Trust Chair shall not be a member of the Committee (but may attend by invitation as appropriate).

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

3. Attendance

3.1 Only members of the Committee have the right to attend meetings, but the Deputy Chief Executive & Director of Finance and Trust Secretary shall generally be invited to attend routine meetings of the Committee. Other Executive Directors and/or staff and executives shall be invited to attend those meetings in which the Committee will consider areas of risk or operation that are their responsibility and will be expected to attend as requested.

3.2 The Chief Executive, as accountable officer, may be invited to attend meetings and should discuss at least annually with the Committee the process for assurance that supports the governance statement. He/she should attend when the Committee considers the Annual Governance Statement and the annual report and accounts.

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

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

3.5 A representative of the local Service will attend at least two meetings of the Committee per year.

3.6 A governor representative may be invited to attend meetings of the Committee as an observer when the Committee considers the Annual Governance Statement and the annual report and accounts.

3.7 The Trust Secretary shall be the secretary to the Committee and will provide appropriate support and advice to the Chair and the Committee members.

3.8 At least once per year the Committee should meet privately with the external and Internal Auditors.

Access

3.9 The Head of Internal Audit, representatives of External Audit and Counter Fraud Specialist have a right of direct access to the Chair of the Committee.

4. Quorum

4.1 A quorum shall be two Non-Executive Directors.

4.2 Meetings may be held by conference call or by electronic means, by exception, so long as those present can hear each other and contribute simultaneously to the meeting.

4.3 If the meeting is not quorate the meeting can progress if those present determine.

However, no business decisions shall be transacted and items requiring approval may be submitted to the next Trust Board meeting as an urgent item.

5. Frequency of meetings

5.1 Meetings shall be held at least four times per year, the total number of meetings being determined by the assurance required by the Committee to discharge its responsibilities. The Board of Directors, Chief Executive, External Auditors or Head of Internal Audit may request an additional meeting if they consider that one is necessary.

6. Duties and Responsibilities

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

Integrated governance, risk management and internal control

6.2 To review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the Trust's activities, clinical and non-clinical, that supports the achievement of the Trust's objectives.

6.3 To consider the Board Assurance Framework and high level risks, including Deep Dives of risks as appropriate.

6.4 In particular to review the adequacy and effectiveness of:

- all risk and control related disclosure statements (in particular the Annual Governance Statement), together with any accompanying Head of Internal Audit Opinion, external audit opinion or other appropriate independent assurances

- the underlying assurance processes that indicate the degree of achievement of the Trust's objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements

- arrangements for the effective management of clinical and corporate risk to underpin the delivery of the Trust's strategic objectives

- arrangements in place for preventing and countering fraud, bribery and corruption and managing security in compliance with the related NHS Protect Standards

- The Committee shall maintain an oversight of the Trust's general material control and risk management systems, including processes and responsibilities, the production and issue of any risk and control-related disclosure statements. The key record to guide the Committee's work will be the Board Assurance Framework (BAF).

6.5 As part of its integrated approach, the Committee will ensure appropriate information flows, to the Committee from executive management and from and between other Board Committees, in relation to the Trust's overall internal control and risk management position.

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

6.7 To develop and use an effective assurance framework to guide the Committee's work. This will include utilising and reviewing the work of the internal audit, external audit and other assurance functions as well as reports and assurances sought from directors and managers and other investigatory outcomes so as fulfil its functions in connection with these Terms of Reference.

Internal audit

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

6.9 To oversee on an ongoing basis the effective operation of internal audit in respect of:

- Adequate resourcing
- Co-ordination with external audit
- Meeting the Public Sector Internal Audit standards 2019
- Providing adequate independent assurances
- Having appropriate standing within the Trust
- Reviewing and approving the internal audit plan ensuring that this meets the internal audit needs of the organisation.

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

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

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

External audit

6.13 To make a recommendation to the Council of Governors in respect of the appointment, re-appointment and removal of an External Auditor and related fees as applicable. To the extent that the recommendation is not adopted by the Council of Governors, this shall be included in the annual report, along with the reasons that the recommendation was not adopted.

6.14 To discuss with the External Auditor, before the audit commences, the nature and scope of the audit, and ensure co-ordination, as appropriate, with other External Auditors in the local health economy.

6.15 To assess the External Auditor's work and fees each year and based on this assessment, to make the recommendation above to the Council of Governors with respect to the re-appointment or removal of the Auditor. This assessment should include the review and monitoring of the External Auditor's independence and objectivity and effectiveness of the audit process in light of relevant professional and regulatory standards.

6.16 To oversee the conduct of a market testing exercise for the appointment of an auditor at least once every five years and, based on the outcome, make a recommendation to the Council of Governors with respect to the appointment of the Auditor.

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

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

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

Annual accounts review

6.20 To approve the Annual Report and Accounts including the Quality Report and Annual Governance Statement on behalf of the Trust Board. In doing so the Committee will determine their completeness, objectivity, integrity and accuracy. This review will cover but is not limited to:

- The meaning and significance of the figures, notes and significant changes
- Changes in, and compliance with the accounting policies, practices and estimation techniques
- Areas where judgment has been exercised
- Explanation of estimates or provisions having material effect
- Explanations for significant variances
- The schedule of losses and special payments
- Significant adjustments in the preparation of the financial statements and any unadjusted statements
- Any reservations and disagreements between the External Auditors and management which have not been satisfactorily resolved
- Changes in and compliance with guidance relating to the preparation of the Quality Report
- Compliance with the Annual Reporting Manual requirements for the content of the annual report as published by NHS Improvement.

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

Raising Concerns (Whistleblowing)

6.22 To review the adequacy of the Trust's arrangements by which Trust staff may, in confidence, raise concerns about possible improprieties in matters of financial reporting and control and related matters or any other matters of concern.

Standing orders, standing financial instructions and standards of business conduct

6.23 To review on behalf of the Board of Directors the operation of, and proposed changes to, the standing orders and standing financial instructions, the constitution, codes of conduct and standards of business conduct; including maintenance of registers.

6.24 To examine the circumstances of any significant departure from the requirements of any of the foregoing, and whether those departures relate to a failing, an overruling or a suspension.

6.25 To review the scheme of delegation.

Other

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

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

6.28 To consider the outcomes of significant reviews carried out by other bodies which include but are not limited to regulators and inspectors within the health sector and professional bodies with responsibilities that relate to staff performance and functions.

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

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

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

6.32 The Committee will receive assurance reports on Data Security and Protection arrangements, particularly in respect to compliance with the Data Security and Protection Toolkit and legislative compliance including the Data Protection Act and General Data Protection Regulations.

6.33 Audit and Risk Committee has a specific responsibility for overseeing the management of conflicts of interest and evaluating the Trust's response to implementing the Trust's Conflict of Interest Policy. The Committee is specifically cited in the national guidance in respect of consideration of any breaches.

6.34 Responsibility for the oversight of data quality assurance.

6.35 The Committee is committed to ensuring that when matters of concern are raised during Committee business these are dealt with openly and transparently and scrutinised as appropriate. When issues arise, the Committee will undertake to challenge robustly and fairly in order to develop a culture of continuous improvement, openness and honesty.

7. Minutes and Reporting

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

7.2 An assurance summary will be prepared and submitted to the Board of Directors and shall include details of any matters to be escalated in respect of which actions or improvements are needed. This will include details of any evidence of potentially *ultra vires*, otherwise unlawful or improper transactions, acts, omissions or practices or any other important matters. To the extent that such matters arise, the Chair of the Committee shall present details to a meeting of the Board of Directors in addition to the assurance summary.

7.3 The Committee will report annually to the Board of Directors and the Council of Governors in respect of its work in support of the Annual Governance Statement, specifically commenting on:

- The assurance framework and its fitness for purpose
- The effectiveness of risk management within the Trust
- The integration of and adherence to governance arrangements
- The appropriateness of the evidence that shows the organisation is fulfilling its regulatory requirements relating to its existence as a functioning business
- The robustness of the processes behind the quality accounts
- Any pertinent matters in respect of which the Committee has been engaged.

7.4 The Committee's annual report should also describe how the Committee has fulfilled its Terms of Reference and give details of any significant issues that the Committee considered in relation to the financial statements and how they were addressed. The Trust's annual report shall include a section describing the work of the Committee in discharging its responsibilities.

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

8. Administrative Support

8.1 The Committee shall be supported by the Trust Secretary whose duties in this regard include, but are not limited to:

- Agreement of the agenda with the Chair of the Committee and attendees
- Preparation, collation and circulation of connected papers in good time
- Ensuring that those required to attend are invited to the meeting in good time
- Ensuring that the minutes are taken and keeping a record of matters arising and issues to be carried forward
- Manage the forward plan of the Committee's work
- Arranging meetings for the Chair with directors and advisers as necessary
- Advising the Committee as appropriate on pertinent issues/areas of interest/policy developments
- Enabling training and development of Committee members as appropriate
- Reviewing every decision to suspend the standing orders.

9. Review of Terms of Reference

The Terms of Reference of the Committee shall be reviewed at least annually.

Approved by Audit & Risk Committee	18 March 2021
Approved by Trust Board	

Quality and Safeguarding Committee Terms of Reference

Purpose

The prime purpose of the Committee is to enable the Board to obtain assurance that high standards of care are provided by the Trust and, in particular, that adequate and appropriate governance structures, processes and controls are in place throughout the Trust to promote safety and excellence in patient care, Identify, prioritise and manage risk arising from clinical care, ensure the effective and efficient use of resources through evidence-based clinical practice; and protect the health and safety of Trust employees. The Quality and Safeguarding Committee is responsible for agreeing terms of reference and annual work programmes for its supporting sub-committees. It also receives agreed assurance and escalation reports as defined in the forward plan for the Committee.

The Committee is also responsible for setting the Safeguarding Quality Strategy, to provide quality governance and gain assurance on all aspects of the safeguarding agenda. The Committee's purpose is to provide assurance to the Trust Board that the organisation is effectively discharging and fulfilling its statutory responsibility for safeguarding to ensure better outcomes for children and vulnerable adults.

1. Authority

1.1 The Board of Directors has approved the establishment of a Quality and Safeguarding Committee as a Committee of the Board in accordance with standing orders.

1.2 As a Committee of the Board, the Quality and Safeguarding Committee has an important role to provide assurance on the progress and risks relating to the delivery of the Trust's strategic objectives which fall within the Committee's remit

1.3 The Committee is authorised by the Board of Directors to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any member of staff and all members of staff are directed to co-operate with any request made by the Committee.

1.4 The Committee is authorised by the Board of Directors to obtain external legal or other independent professional advice. The Committee is authorised by the Board of Directors to request the attendance of individuals and authorities from outside the trust with relevant experience and expertise if it considers this necessary or expedient to the carrying out of its functions

1.5 The Trust has a duty under the Equality Act 2010 to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations between people from different groups. The Act protects against discrimination on grounds of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, gender and sexual orientation. The Quality Committee will ensure consideration has been given to equality impact related risks.

1.6 The Committee will consider the equality impact and evidence relating to all items of Committee business as part of the Committee's contribution to equality, diversity and inclusion.

1.7 As a designated policy ratification group, (see 'Policy on Policy Documents) the Quality Committee is operationally responsible for monitoring that the policy documents for which it is responsible comply with the policy. This includes monitoring that the style, content and format of the policy are compliant, including completion of the Equality Impact Assessment (EIA) which forms part of the current policy template. All policy documents are allocated a policy ratification group as they are published on Connect.

1.8 A safeguarding operational subgroup is to meet quarterly and will report to the Committee to prepare assurances and highlight exceptions.

1.9 Minutes of meetings held by the Safeguarding Operational Group will be provided to the Quality and Safeguarding Committee.

1.10 To receive assurance reports and scrutinise, as required, other activity reports from the Safeguarding Operational Group, noting any exceptions and escalating concerns as necessary.

2. Membership

2.1 The membership of the Committee shall comprise:

- Non-Executive Director – Chair of the Committee
- Non-Executive Director (2)
- Director of Nursing and Patient Experience or a nominated deputy
- Medical Director or a nominated deputy
- Chief Operating Officer or a nominated deputy

3. Attendance

3.1 Attendees for specific agenda items at the request of the Committee:

- Deputy Director of Nursing and Quality Governance
- Lead professional for Patient Safety
- Chief Pharmacist
- Research and Clinical Audit Manager
- Risk and Assurance Manager
- Assistant Director of Clinical Professional Practice
- Health and Safety Manager
- Safeguarding Children Lead
- Safeguarding Adults Lead
- Chairs or Deputy Chairs of COATs (Clinical Operational Assurance Team) will be required to attend specific agenda items at the request of the Committee.

3.2 The following may also attend:

- Chief Executive Officer
- Trust Chair
- Director of People and Inclusion
- Director of Business Improvement and Transformation
- Trust Secretary

Any other attendees will be invited upon request.

3.3 If the Committee Chair is not present, the meeting shall be chaired by another Non-Executive Director.

3.4 Members of the Committee must attend at least 75% of all meetings each financial year but should aim to attend all scheduled meetings.

3.5 Executive Director members should aim to attend all scheduled meetings with fully briefed deputies to attend no more than one third of meetings on an exception basis.

3.6 The Committee's Executive Lead must be in attendance or the Medical Director will act as the Committee's Executive Lead.

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

3.8 Other staff may be co-opted to attend meetings as considered appropriate by the Committee on an ad hoc basis.

4. Quorum

4.1 A quorum shall normally be three members, including at least one Executive Director and two Non-Executive Directors This is in line with the use of emergency terms of reference that have been put in place for the delegation and purpose of carrying out the functions of the Trust during the COVID-19 pandemic. The quorum can be reduced to one Executive Director but this must be either the Director of Nursing or Medical Director and two Non-Executive Directors.

4.2 Meetings may be held by conference call or by electronic means, by exception, so long as those present can hear each other and contribute simultaneously to the meeting.

4.3 If the meeting is not quorate the meeting can progress if those present determine. However, no business decisions shall be transacted and items requiring approval may be submitted to the next Board of Directors meeting as an urgent item.

5. Frequency

5.1 Meetings shall be held monthly.

6. Duties and Responsibilities

In respect of general governance arrangements:

6.1 To ensure that all statutory elements of operational risk and quality governance are adhered to within the Trust including the requirements of our regulators, NHS Improvement and the Care Quality Commission (regulations).

6.2 To provide a clear link with the Trust's Strategy and Quality framework when agreeing quality governance priorities and monitor scrutinise these areas to provide assurance and inform the Board on the strategic direction for Quality and monitor the performance of the clinical services.

6.3 To provide direction to the quality governance activities of the Trust's services and divisions. This will include setting strategy, delegating activities and monitoring clinical performance against this strategy or quality priorities.

6.4 To scrutinise, gain assurance and approve the Trust's Quality Position Statements and Quality Governance Annual Reports before submission to the Board.

6.5 To have final sign off of the Trust Quality Account prior to Audit and Risk Committee approval.

6.6 To approve the terms of reference and membership of its reporting sub-committees, the primary reporting committee will be the Executive chaired Quality sub-group known as Trust Management Team (TMT). This group will scrutinise the clinical performance of the key sub-groups known as the Integrated Clinical Operational Assurance Teams at service level; and to oversee the work of those sub-committees and their clinical reference sub-groups, receiving reports from them, reviewing their work plans and clinical escalation issues.

6.7 To scrutinise the work of the Trust Management Team and receive assurance from the Chair of the group on quality performance issues and mitigating actions to ensure safe and effective services.

6.8 To agree to refer specific issues to the Board and other Board Committees where required and make recommendations as appropriate.

6.9 To receive and approve the annual Clinical Audit Programme consistent with the audit needs of the Trust and consistent with the Quality priorities.

6.10 To have oversight and gain assurance on the Trust's policies and procedures with respect to the use of clinical data and patient identifiable information to ensure that this is in accordance with all relevant legislation and guidance including the Caldicott Guidelines and the Data Protection Act 1998.

6.11 To make recommendations to the Audit and Risk Committee concerning the annual Internal Audit plan, to the extent that it applies to matters within these terms of reference; and to comply with any request from the Audit & Risk Committee for assurance in relation to the Board Assurance Framework and the Risk Register.

6.12 To have overview, responsibility and gain assurance for all regulations and standards as described by the Care Quality Commission as part of our responsibilities under the Care Quality Commission (Registration) Regulations 2009 and Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

6.13 To promote within the Trust a culture of open and honest reporting of any situation, including Duty of Candour, that may threaten the quality of patient care in accordance with the Trust's policy on Raising Concerns and monitoring the implementation of that policy. This will include an approach that enables an open patient safety culture and gain assurance on its implementation.

6.14 To ensure that when matters of concern are raised during Committee business these are dealt with openly and transparently and scrutinised as appropriate. When issues arise the Committee will undertake to challenge robustly and fairly in order to develop a culture of continuous improvement, openness and honesty.

6.15 To oversee the system within the Trust for obtaining and maintaining any licences relevant to clinical activity in the Trust.

6.16 To ensure that risks to patients are minimised through the application of a comprehensive risk management system including clinical risk registers, monitoring and learning from deaths and associated monitoring.

6.17 To oversee the process and gain assurance within the Trust to ensure that appropriate action is taken in response to adverse clinical incidents, mortality, complaints and litigation and those examples of good practice are disseminated within the Trust and beyond if appropriate.

6.18 To ensure a clear link with the Mental Health Act Committee on aspects of quality governance that are cross cutting clinical standards across mental health act or mental capacity act legislation that impacts upon clinical standards.

6.19 To maintain a forward plan of regular agenda items as identified by the scheme of delegation.

6.20 To ensure a clear link and be assured with the Commissioners Quality Assurance Group, and that escalated clinical concerns, gaps in commissioning and patient safety concerns are discussed and monitored through the joint commissioner and provider risk and issues log.

6.21 To gain assurance and monitor the work of the Trust-wide groups which report to the Quality and Safeguarding Committee, currently the Serious Incident Requiring Investigation (SIRI) group, the Physical Health Care committee, Health and Safety Committee, Drugs and Therapeutics Committee, Patient Experience Group and any short term named task and finish groups established to design or develop Trust Clinical Strategy.

6.22 To co-operate with and assist the work of other Trust-wide groups which report or scrutinise the work of the Quality and Safeguarding Committee, e.g. governors' Governance Committee or the Council of Governors.

6.23 To receive assurance on how the Trust has developed and planned for all clinical service re-design with sign off of any associated clinical safety plans to mitigate any significant or material changes in service, which have been designed and developed by the Clinical Operational Assurance Teams.

6.24 To conduct a self-effectiveness review of the performance of the Committee at the close of every meeting.

6.25 To oversee the development of an annual review of performance of the Committee against key areas of delegated authority and provide a check that all areas of governance and responsibility have been monitored.

6.26 To consider the Board Assurance Framework and high level risks, in particular as they relate to the remit of the Committee; and to comply with any request from the Audit and Risk Committee for assurance in relation to the Board Assurance Framework and the Risk Register including deep dives of risks as appropriate.

6.27 To set the Safeguarding Quality Strategy, to provide quality governance and gain assurance to all aspects of the safeguarding agenda and lead the assurance process on behalf of the Trust for the following areas:

6.27.1 **Children's Act** has a statutory duty of care towards children (Children Acts 1989 and 2004) at risk of harm who are resident in Derby city and Derbyshire in our care. The committee will ensure as an organisation we have safeguards in place not only protects and promotes the welfare of vulnerable children, but that we have a significant impact on children in our care's health and well-being.

6.27.2 **The Care Act (2014)** Safeguarding adults at risk of abuse or neglect (Section 42 and named other relevant NHS legislation and NHS Safeguarding Adults policy and procedures.

6.27.3 **Counter Terrorism legislation** The Counter Terrorism and Security Bill, which is currently before Parliament (December 2014) at the time of writing, seeks to place duty on specified authorities (identified in full in Schedule 3 to the bill, and set out in this draft guidance) to have due regard to the need to prevent people from being drawn into terrorism. PREVENT.

6.27.4 **A formal link to the area Safeguarding Children's and Adults Boards** and provide systems leadership to our wider geographical and community safeguarding responsibilities and be the conduit for linking the community Safeguarding Board strategies with the Trust strategy.

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

6.27.6 Ultimately to provide assurance to the Trust Board that the organisation is effectively discharging and fulfilling its statutory responsibility for safeguarding to ensure better outcomes for children and vulnerable adults.

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

6.27.8 To determine strategic and operational development that will enable the Trust to integrate best practice in Safeguarding across the Trust. The Committee has a responsibility to improve and develop Safeguarding practices consistent with national and local legislation, guidance and standards in Safeguarding children and vulnerable people.

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

6.27.10 To provide rigorous and transparent assessment of performance and effectiveness and quality of practice for Safeguarding of Children and Family and Vulnerable Adults Services within the Trust.

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

6.27.12 The Committee will oversee Serious Case Reviews, Independent Learning Reviews, Domestic Homicide Reviews and all Safeguarding major incidents and will advise service level Directors and operational managers of recommendations, lessons learnt and compliance requirements.

6.27.13 The Committee will oversee and assure itself that all Safeguarding Boards for Children's and Adults are appropriately represented and feedback from Boards to the Trust Board is in place

6.27.14 The Committee will oversee and assure itself on the PREVENT and Channel: Supporting Individuals Vulnerable to Recruitment by Violent Extremists agenda. Establish or use existing mechanisms for understanding the risk of radicalisation. Communicate and promote the importance of the duty; as outlined in any counter terrorism legislation (2015) and ensure staff implement the duty effectively.

6.27.15 The Committee will oversee and assure itself on the Multi-Agency Public Protection Arrangements (MAPPA) with relevant agencies including the police. These processes ensure that the requirements for offenders in the community needs are met and duties to public safety are met fully.

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

6.27.17 Have authority in the setting the quality standards, defining and monitoring of clinical practice in safeguarding children and vulnerable adults people through delegated duties to the Safeguarding operational group.

6.28 Safeguarding Adults Key Responsibilities

6.28.1 Schedule 2 of the Care Act (2014). That Geographical links to the Safeguarding Adults Boards must have a clear, agreed understanding of the roles, responsibilities, authority and accountability of its member agencies, therefore the Trust should annually

- Review suitable governance arrangements an effective infrastructure and adequate resources.
- Deliver operational and strategic requirements
- Provide links to other boards and partnerships
- Provide links to other boards and partnerships
- Provide a person-centred, outcome focused safeguarding policy and procedures
- Ensure that there is awareness training for all health and social care staff and Police who work directly with people with care and support needs
- Ensure that there is a specialist training for all practitioners who have direct responsibilities for safeguarding work
- Develop and publish a Trust strategy specifying each service areas responsibilities
- Link with the wider community to inform its work and learn of the work of the Board
- Sign off the Safeguarding Adult Annual reports, detailing what the Trust and its members have achieved, including how they have contributed to the Board's objectives and what has been learned from and acted upon from the findings of Safeguarding Adults Reviews and Case Reviews and other Domestic Homicide reviews and associated audits
- Arrangements for the quality assurance of the effectiveness of safeguarding work

6.29 Safeguarding Children Key Responsibilities

- Scrutinise the Safeguarding Children's Annual report, oversight of the Section 11 audit work and assurance that the Trust discharges its duty responsibly in line with National requirements.
- Review suitable governance arrangements an effective infrastructure, adequate resources
- Deliver operational and strategic requirements
- Provide links to other boards and partnerships
- Provide a child centred, outcome focused safeguarding policy and procedures
- Ensure that there is training for all health and social care staff and Police who work directly with people with care and support needs
- Develop and publish a Trust strategy specifying each service areas' responsibilities

- Sign off the Children's, Looked After Children Annual Reports, detailing what the Trust and its members have achieved, including how they have contributed to the board's objectives and what has been learned from and acted upon from the findings of Safeguarding Serious Case Reviews

7. Minutes and Reporting

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

7.2 An assurance summary will be prepared and submitted to the Board of Directors and shall include details of any matters to be escalated in respect of which actions or improvements are needed.

7.3 The Committee will report annually to the Audit and Risk Committee describing how the Committee has fulfilled its Terms of Reference and give details of any significant issues and how they have been addressed.

7.4 Agendas and papers will be distributed in accordance with deadlines agreed with the Committee Chair.

8. Terms of Reference Review

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

Approved by Quality and Safeguarding Committee	13 April 2021
Approved by Audit and Risk Committee	27 April 2021
Approved by Trust Board	

People & Culture Committee Terms of Reference

Purpose

The Committee supports the organisation to achieve a well-led, values driven and inclusive positive culture. The Committee is to provide assurance to the Board that the appropriate structures, processes and systems are in place to ensure an effective capable workforce to meet the Trust's current and future needs including workforce engagement and development.

1. Authority

1.1 The People and Culture Committee is constituted as a standing committee of the Foundation Trust's Board of Directors. Its constitution and Terms of Reference shall be as set out below, subject to amendment at future Board of Directors meetings. The People and Culture Committee shall not have executive powers in addition to those delegated in these terms of reference.

1.2 The Committee is authorised by the Board of Directors to obtain external legal or other independent professional advice and to secure the attendance of both internal and external officers with relevant experiences and expertise it if considers this necessary.

1.3 To consider the Board Assurance Framework and high level risks, in particular as they relate to the remit of the Committee; and to comply with any request from the Audit and Risk Committee for assurance in relation to the Board Assurance Framework and the Risk Register including deep dives of risks as appropriate.

1.4 The Committee is authorised by the Board of Directors to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any member of staff and all members of staff are directed to co-operate with any request made by the Committee.

1.5 The Trust has a duty under the Equality Act 2010 to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations between people from different groups. The Act protects against discrimination on grounds of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, gender and sexual orientation. The People & Culture Committee will ensure consideration has been given to equality impact related risks.

1.6 The Committee will actively consider the equality impact and evidence relating to all items of Committee business as part of the Committee's contribution to equality, diversity and inclusion.

1.7 As a designated policy ratification group, (see 'Policy on Policy Documents) the People & Culture Committee is operationally responsible for monitoring that the policy documents for which it is responsible comply with the policy. This includes monitoring that the style, content and format of the policy are compliant, including completion of the Equality Impact Assessment (EIA) which forms part of the current policy template. All policy documents are allocated a policy ratification group as they are published on Connect.

1.8 As a Committee of the Board, the People & Culture Committee has an important role to provide assurance on the progress and risks relating to the delivery of the Trust's strategic objectives which fall within the Committee's remit, this includes the delivery and implementation of the Trust's 3 year People Strategy.

2. Membership

2.1 The membership of the Committee will comprise:

- Non-Executive Directors x 3 (one will be appointed as the Chair)
- Director of People and Inclusion
- Medical Director
- Chief Operating Officer

The Deputy Medical and Operations Directors are to attend meetings as nominated deputies if the Medical Director or Chief Operating Officer are unable to attend.

In attendance as core attendees:

- Assistant Director People and Culture Transformation
- Deputy Director of Communications and Involvement will attend only when items to be discussed are relevant

2.2 A quorum shall be three (not less than two non-executive directors and one executive director).

2.3 Members are expected to attend a minimum of four meetings per year.

2.4 Executive Director members should aim to attend all scheduled meetings with fully briefed deputies to attend no more than one third of meetings on an exception basis.

3. Attendance

3.1 Only members of the Committee have the right to attend and vote at Committee meetings. The Committee may require other officers of the Trust, and other individuals may attend all or any part of its meetings as and when is necessary.

3.2 The Chief Executive Officer reserves the right to attend any meeting

3.3 The Trust Chair will appoint the Chair of the Committee

3.4 The Trust Board has delegated authority to any Non-Executive Director of the Trust to act as nominated deputy in the absence of any Non-Executive and this attendance will count towards the quorum.

3.5 The Board Secretary will be in attendance and provide administrative support.

3.6 A register of attendance will be maintained and reviewed by the Committee annually.

4. Quorum

4.1 A quorum shall normally be three (not less than two non-executive directors and one executive director) and is in line with the use of emergency terms of reference that have been put in place for the delegation and purpose of carrying out the functions of the Trust during the COVID-19 pandemic. The quorum can be reduced to one Executive Director and two Non-Executive Directors.

4.2 Meetings may be held by conference call or by electronic means, by exception, so long as those present can hear each other and contribute simultaneously to the meeting.

4.3 If the meeting is not quorate the meeting can progress if those present determine. However, no business decisions shall be transacted and items requiring approval may be submitted to the next Trust Board meeting as an urgent item.

5. Frequency

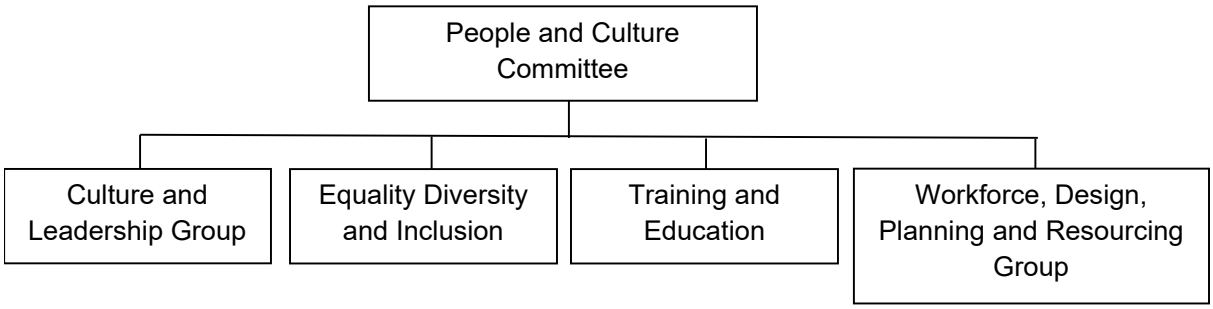
5.1 The Committee will meet on bi-monthly basis with additional meetings being called when necessary.

6. Duties and Responsibilities

6.1 The Committee will support the organisation to achieve a well led, values driven positive culture. The Committee is to provide assurance to the Board that the appropriate structures, processes and systems are in place to ensure an effective capable workforce to meet the Trusts current and future needs.

6.2 The Committee will monitor the implementation of the People Strategy and report progress to the Board by exception

6.3 A number of supporting groups / forums will be accountable to the People and Culture Committee whilst not exhaustive; it is anticipated that the following groups will have a direct or indirect relationship and will be agreed within the Committee:



6.4 The Committee will oversee and monitor workforce performance.

6.5 The Committee review and monitor the Workforce metrics and Board Assurance Framework and ensure the Board is kept informed of any significant workforce risks.

6.6 To consider the Board Assurance Framework and high level risks, in particular as they relate to the remit of the Committee; and to comply with any request from the Audit and Risk Committee for assurance in relation to the Board Assurance Framework and the Risk Register including deep dives of risks as appropriate.

6.7 The Committee is to be assured that mechanisms are in place to review and monitor the effectiveness and capability of the workforce across the whole Trust and that appropriate actions are taken to address issues of poor performance and bring about continuous quality improvement.

6.8 The Committee is to be assured that the Trust identifies lessons for improvement and implements these in all relevant areas.

6.9 The Committee is to be assured that National standards, guidance and best practice are systematically reviewed and embedded within the Trust.

6.10 The Committee is to be assured that the views of staff and appropriate others are systematically and effectively engaged in organisational development activities.

6.11 The Committee is committed to ensuring that when matters of concern are raised during Committee business these are dealt with openly and transparently and scrutinised as appropriate. When issues arise the Committee will undertake to challenge robustly and fairly in order to develop a culture of continuous improvement, openness and honest.

6.12 The Committee will oversee the leadership, training and education framework and monitor progress.

6.13 The Committee will monitor the implementation of agreed action plans in relation to organisational interventions and measure the effectiveness of change.

6.14 The Committee will review its effectiveness by self-assessment on an annual basis and at the end of each meeting. The annual review will be presented to the Audit and Risk Committee.

7. Minutes and Reporting

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

7.2 An assurance summary will be prepared and submitted to the Board of Directors and shall include details of any matters to be escalated in respect of which actions or improvements are needed.

7.3 The Committee will report annually to the Audit and Risk Committee describing how the Committee has fulfilled its Terms of Reference and give details of any significant issues and how they have been addressed.

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

7.5 Agendas and papers will be distributed in accordance with deadlines agreed with the Committee Chair.

8. Terms of Reference Review

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

Approved by People and Culture Committee	12 April 2021
Approved by Audit and Risk Committee	27 April 2021
Approved by Trust Board	

Mental Health Act Committee Terms of Reference

Purpose

The Committee monitors and obtains assurance on behalf of the Hospital Managers and the Trust as the detaining authority that the safeguards of the Mental Health Act are appropriately applied. It also monitors related statute and guidance and reviews the reports following Mental Health Act inspections by the Care Quality Commission.

1. Authority

1.1 The Board of Directors has approved the establishment of a Mental Health Act Committee as a Committee of the Board. The purpose of the Committee is to obtain assurance, on behalf of the "Hospital Managers" and the Trust as the detaining authority, that the safeguards and provisions of the Mental Health Act are appropriately applied; to take account of the provisions of related statute and guidance, such as Mental Capacity Act, Deprivation of Liberty Safeguards (DOLS) and Human Rights Act.

1.2 The Committee will exercise its responsibilities by fulfilling a scrutiny and monitoring role from receipt of regular activity data and inspection reports from an Operational Group; by obtaining assurance that best practice is deployed across the Trust.

1.3 As a Committee of the Board, the Mental Health Act Committee has an important role to provide assurance on the progress and risks arising relating to the delivery of the Trust's Strategic objectives which fall within the Committee's remit. It will consider any exceptions or risks escalating these to the Trust Board or referring to the Executive Leadership Team as necessary.

1.4 The Committee is authorised by the Board of Directors to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any member of staff and all members of staff are directed to co-operate with any request made by the Committee.

1.5 The Committee is authorised by the Board of Directors to obtain external legal or other independent professional advice. The Committee is authorised by the Board of Directors to request the attendance of individuals and authorities from outside the trust with relevant experience and expertise if it considers this necessary or expedient to the carrying out of its functions

1.6 The Trust has a duty under the Equality Act 2010 to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations between people from different groups. The Act protects against discrimination on grounds of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, gender and sexual orientation. The Mental Health Act Committee will ensure consideration has been given to equality impact related risks.

1.7 The Committee will actively consider the equality impact and evidence relating to all items of Committee business as part of the Committee's contribution to equality, diversity and inclusion.

1.8 As a designated policy ratification group, (see 'Policy on Policy Documents) the Mental Health Act Committee is operationally responsible for monitoring that the policy documents for which it is responsible comply with the policy. These include policies in relation to the Mental Health Act and Code of Practice requirements, and the duties of Associate Hospital Managers, including the protocols for the hearing of appeals and reviews. It also includes monitoring that the style, content and format of the policy are compliant, including completion of the Equality Impact Assessment (EIA) which forms part of the current policy template. All policy documents are allocated a policy ratification group as they are published on Connect.

1.9 An operational subgroup will meet approximately one month before the full Committee to prepare assurances and highlight exceptions.

2. Membership

2.1 The membership of the Committee shall comprise:-

- Non-Executive Director – Chair of the Committee
- Non-Executive Director (2)
- Medical Director or a nominated Deputy
- Director of Nursing and Patient Experience or a nominated Deputy

2.2 Members of the Committee must attend at least 75% of all meetings each financial year but should aim to attend all scheduled meetings

2.3 If the Committee Chair is not present, the meeting shall be chaired by another Non-Executive Director.

3. Attendance

3.1 Additional attendees shall comprise:-

- Trust Secretary
- Mental Health Act Manager
- Representative of Associate Hospital Managers
- Other senior management/professional leads may be invited at the discretion of the Committee Chair.

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

4. Quorum

4.1 Quorum is normally a minimum of three members including at least two Non-Executive Directors. The use of emergency powers by the Chair and CEO have been put in place for the delegation and purpose of carrying out the functions of the Trust during the COVID-19 pandemic reducing the quorum to one Executive Director and two Non-Executive Directors.

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4.2 Meetings may be held by conference call or by electronic means, by exception, so long as those present can hear each other and contribute simultaneously to the meeting.

4.3 If the meeting is not quorate the meeting can progress if those present determine. However, no business decisions shall be transacted and items requiring approval may be submitted to the next Trust Board meeting as an urgent item.

5. Frequency

5.1 Meetings will be held quarterly.

6. Duties and Responsibilities

6.1 To receive compliance and assurance reports from the Operational Group regarding the number of patients subject to detention under each section of the Mental Health Act for the previous quarter as part of a rolling twelve month review to identify any variation or trends (including diversity data) and provide interpretation of data including an outline of actions arising as appropriate.

6.2 To consider matters of recommended good practice, and in particular the requirements of the Code of Practice (Revised): Mental Health Act (1983) and its Code of Practice as amended and approve policy changes to receive assurance on the steps taken to implement and embed recommended good practice relating to the requirements of the Mental Health Act, Mental Capacity Act and related legislation.

6.3 To receive assurance reports and scrutinise, as required, other activity reports from the Operational Group e.g. the use of seclusion, noting any exceptions and escalating concerns as necessary.

6.4 To receive assurance reports relating to the Care Quality Commission Inspection Reports and the implementation of the management response as defined by the Operational Group, providing scrutiny and challenge and noting exceptions and risks escalated by the operational group. With regard to Section 136, to oversee and receive assurance on the use of this section through the multi-agency Section 136 sub-committee.

6.5 To oversee the implications of related legislation, principally the Mental Capacity Act, (including Deprivation of Liberty), Human Rights Act guidance and other related legislation as appropriate, receiving assurance on impact, risk and effective implementation throughout the Trust.

6.6 To oversee that training needs are satisfactorily met to ensure compliance with legislative and best practice requirements, through assurance reporting and in general help promote awareness of the requirements of the Mental Health Act, Mental Capacity Act and associated legislation.

6.7 When receiving information on Mental Health Act activity and reports, the Committee will pay due regard to the Trust's Equality and Diversity Agenda.

6.8 To ensure that when matters of concern are raised during Committee business these are dealt with openly and transparently and scrutinised as appropriate. When issues arise the Committee will undertake to challenge robustly and fairly in order to develop a culture of continuous improvement, openness and honesty.

6.9 To consider the Board Assurance Framework and high level risks, in particular as they relate to the remit of the Committee; and to comply with any request from the Audit and Risk Committee for assurance in relation to the Board Assurance Framework and the Risk Register including deep dives of risks as appropriate.

6.10 To conduct a self-effectiveness review of the performance of the Committee at the close of every meeting.

6.11 To maintain a forward plan of regular agenda items to encompass the role and remit of the Committee as outlined in the Terms of Reference.

6.12 To oversee the development of an annual review of performance of the Committee against key areas as outlined within the Terms of Reference and confirm that all areas of governance and responsibility have been monitored.

6.13 Receive feedback from Associate Hospital Mangers and review any performance issues arising from mental health tribunals.

7. Minutes and Reporting

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

7.2 An assurance summary will be prepared and submitted to the Board of Directors and shall include details of any matters to be escalated in respect of which actions or improvements are needed.

7.3 The Committee will report annually to the Audit and Risk Committee describing how the Committee has fulfilled its Terms of Reference and give details of any significant issues and how they have been addressed.

7.4 Agendas and papers will be distributed in accordance with deadlines agreed with the Committee Chair.

8. Terms of Reference Review

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

Approved by Mental Health Act Committee	12 March 2021
Approved by Audit and Risk Committee	27 April 2021
Approved by Trust Board	

Appendix 4

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 4 May 2021

Register of Trust Sealings

Purpose of Report

This report provides the Trust Board with a six month update of the authorised use of the Trust Seal since the last report to the Board on 3 November 2020.

Executive Summary

In July 2019 Section 8.18 of the Standing Financial Instructions and Standing Orders of the Board of Directors was amended and the contract value for when the Trust seal is required was increased from £100,000 to £500,000. Therefore, every contract which exceeds £500,000 shall be executed under the Common seal of the Trust and be signed by the Trust Secretary and an Executive Director (voting or non-voting) duly authorised by the Chief Executive and not from the originating department (as set out in the Board's Standing Financial Instructions point 8.18).

These transactions will apply where the Board has previously approved the business through the Capital Expenditure Plan or the Estates and Agile Working Strategy. In accordance with the Standing Orders of the Board (section 12 point 6) a report of all sealing shall be made to the Trust Board twice a year. The report will contain details of the seal number, the description of the document and date of sealing. The register will be retained by the Trust Secretary.

A report on use of the seal was last made to the Board on 3 November 2020. Since the last report, the Trust Seal was affixed once as follows (the contract value for this transaction was valued at over £500,000):

DHCFT73: Lease of Suite 4, Cromwell Business Centre, High Street, Chapel-en-le-Frith, Derbyshire SK23 OHD (Christopher Michael Sizeland and Kathleen Sizeland as general trustees to the Frith Estates Pension Scheme.

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

Assurances

Use of the Trust Seal has been undertaken in accordance with the Standing Financial Instructions and Standing Orders of the Board of Directors.

Consultation

N/A

Governance or Legal Issues

The affixing of the seal is consistent with the Board's responsibilities outlined within the Standing Financial Instructions and Standing Orders of the Board of Directors.

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

Recommendations

The Board of Directors is requested to note the authorised use of the Trust Seal since November 2020 and receive full assurance that this has been undertaken in accordance with the Standing Financial Instructions and Standing Orders of the Board of Directors.

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

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

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 4 May 2021

Board Assurance Framework (BAF)
First issue for 2021/22

Purpose of Report

To meet the requirement for Boards to produce an Assurance Framework. This report details the first issue of the BAF for 2021/22.

Executive Summary

The first two issues of the BAF for 2020/21 focused on the risks faced by the organisation in response to the COVID-19 pandemic. Issues 3 and 4 were more fully developed to reflect the wider Trust Strategy and the NHS Long Term Plan.

A Board Development session focused on the BAF priorities took place on 24 February 2021 to consider the risks to delivery of the strategic objectives for 2021/22. The Board agreed that the seven risks already identified in issues 3 and 4 for 2020/21 should continue, and that two further risks be added for 2021/22. These are in relation to:

- The increasing dependence on digital technology and risk of a major outage due to a cyber-attack or equipment failure (Risk 21_22 1d), and
- Risk associated with the accompanying organisational change connected with the development of the Integrated Care System (ICS) in Derbyshire (Risk 21_22 3c)

In addition, Risk 21_22 1b regarding regulatory compliance of the Trust's estate has been expanded to include the risks associated with dormitory eradication and development of a new psychiatric intensive care unit (PICU), and Risk 21_22 3a extended to include gaps in assurance around Trust and system capital, and revenue requirements . Prior to the commencement of the new Chief Operating Officer in July 2021, Risks 21_22 1b and 21_22 1d have been assigned an interim director lead.

Following feedback from the Trust's internal auditors, 360 Assurance, further work has been completed in order to identify how the actions taken to reduce gaps in controls and assurances will be measured. As a result, and wherever possible, reference to the relevant dashboard or reporting mechanism has been articulated in the 'impact on risk to be measured by' column of each risk.

Changes/updates to this Issue of the BAF, compared with Issue 4 2020/21 are highlighted in blue.

There are seventeen operational risks rated as high or extreme, updated as of 16 04 2021. These have been aligned to the related BAF risk.

There is currently one risk rated as extreme, Risk 21-22 3a, which will require a 'deep dive' to the Audit and Risk Committee. It is proposed this take place in January 2022. Should the risk rating of this risk be reduced, or the rating for other

risks increase to extreme, this timetable will be revised.

Deep Dive timetable for 2021/22		
Risk 21_22 3a. There is a risk that the Trust fails to deliver its revenue and capital financial plans.	Director of Finance	Audit and Risk Committee January 2022.

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

Assurances

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

Consultation

- Board Development – 24 February 2021
- Executive Directors – March/April 2021
- Executive Leadership Team – 20 April 2021
- Audit and Risk Committee – 27 April 2021

Governance or Legal Issues

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

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

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

Recommendations

The Board is requested to:

1) Approve this first issue of the BAF for 2021/22 and the assurance the paper provides of the process of the review, scrutiny and update of the BAF in seeking to identify and mitigate risks to achieving the Trust's strategic objectives
2) Continue to receive updates in line with the forward plan for the Board

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

Report prepared by: **Rachel Kempster**
Risk and Assurance Manager

Summary Board Assurance Framework Risks 2021_22. Issue 1 Board May 2021

Ref	Principal risk	Director Lead	Rating (Likelihood x Impact)	Responsible Committee
Strategic Objective 1. To provide GREAT care in all services				
21_22 1a	There is a risk that the Trust will fail to provide standards for safety and effectiveness as required by our patients and our Board	Executive Director of Nursing/Medical Director	HIGH (4x4)	Quality and Safeguarding Committee
21_22 1b	There is a risk that the Trust does not deliver key regulatory and strategic requirements related to dormitory eradication and PICU and that the Trust estate more generally is not maintained sufficiently well to comply with regulatory and legislative requirements	Deputy CEO/Executive Director of Finance (for dormitory eradication and PICU). COO (on appointment) for wider delivery of estates strategy	HIGH (4x4)	Finance and Performance Committee
21_22 1c	There is a risk that the Trust fails to maintain continuity of access to information to support effective patient care	Director of Business Improvement and Transformation	MODERATE (3X4)	Finance and Performance Committee
21_22 1d	There is a risk that the Trusts increasing dependence on digital technology for the delivery of care and operations increases the Trusts exposure to the impact of a major outage i.e. cyber-attack, equipment failure	Director of Business Improvement and Transformation. COO (on appointment)	MODERATE (3X4)	Finance and Performance Committee
Strategic Objective 2. To be a GREAT place to work				
21_22 2a	There is a risk that we do not sustain a healthy vibrant culture and conditions to make DHCFT a place where people want to work, thrive and to grow their careers	Director of People and Inclusion	HIGH (3x5)	People and Culture Committee
21_22 2b	There is a risk of continued inequalities affecting health and well-being of both staff and local communities	Director of People and Inclusion	HIGH (4x4)	Trust Board
Strategic Objective 3. To make BEST use of our money				
21_22 3a	There is a risk that the Trust fails to deliver its revenue and capital financial plans	Executive Director of Finance	EXTREME (4x5)	Finance and Performance Committee
21_22 3b	There is a risk that learning from the response to the COVID-19 outbreak, and transformation plans developed prior, does not lead to sustainable embedded transformation	Director of Business Improvement and Transformation	HIGH (4x4)	Finance and Performance Committee
21_22 3c	Whilst there are significant benefits from the creation of the ICS (Integrated Care System) as an NHS body, there is a risk that the effects of the change on senior managers from across the system may impact negatively on the cohesiveness of the Derbyshire health and care system	Director of Business Improvement and Transformation	HIGH (4x4)	Board

Summary Board Assurance Framework Risks 2021_22. Issue 1 Board May 2021

Strategic Objective 1. To provide GREAT care in all services

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

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

Root causes:

a) Workforce supply and lack of capacity to deliver effective care across hotspot areas
b) Risk of substantial increase in clinical demand in some services and COVID-19 related mental health surge
c) Changing demographics of population and substantial impacts of inequality
d) Intermittent lack of compliance with CQC standards specifically the safety domain
e) Lack of embedded outcome measures at service level
f) Known links between SMI and other co-morbidities, and increased risk factors in population including inequality/ intersectionality
g) Lack of compliance with physical healthcare monitoring in primary and secondary care
h) Restoration and recovery of access standards in autism and memory assessment services, due to COVID-19 pandemic
i) New and emerging risks related to waves of COVID-19, excess deaths associated with winter, impact of substantial economic downturn
j) Increased safeguarding and domestic violence related investigations as a result of harm to our patients and their families related to the impact of lockdown
k) Lack of appropriate environment to support high quality care i.e. single sex dormitories and PICU
l) Lack of capacity to meet population demand for community forensic team

BAF ref: 21_22 1a	**Director Lead**: Carolyn Green, Executive Director of Nursing/ Dr John Sykes, Medical Director	**Responsible Committee**: Quality and Safeguarding Committee

Inherent risk rating:			**Current risk rating:**				Target risk rating:			Risk appetite:		
Rating HIGH	Likelihood 4	Impact 4	Rating HIGH	Likelihood 4	Impact 4	Direction ⇔	Rating MODERATE	Likelihood 3	Impact 4	Accepted	Tolerated	Not accepted

Key controls:

Preventative – Quality governance structures, teams and processes to identify quality related issues; mandatory training; 'Duty of Candour' processes; clinical audits and research; health and safety audits; risk assessments; physical health care screening and monitoring; investment in COVID secure environments and cleaning
Detective – Quality dashboard reporting; quality visit programme/virtual clinical service contact visits ; Incident, complaints and risk investigation; FSR compliance checks; mortality review process; physical health care monitoring clinics pilots; Safety check log; Head of Nursing and Matron compliance visits
Directive – Trust Strategy and commitments; Quality Improvement Strategy; Physical Health Care Strategy; Safeguarding Strategy; Suicide Reduction Strategy; Clinical strategies; Policies and procedures available via Trust intranet; CAS alerts; Clinical Sub Committees of the Quality and Safeguarding Committee; Information Management Team processes, including ethics governance cell
Corrective – Board committee structures and processes ensuring escalation of quality issues; six monthly skill mix review; CQC action plans; learning from incidents,

complaints and risks; actions following clinical and compliance audits; workforce issues escalation procedures; reporting to commissioners on compliance with quality standards; learning from other Trust experiences and national learning					
Assurances on Controls (internal):		**Positive assurances on Controls (external):**			
Quality and Trust dashboards Scrutiny of Quality Account (pre-submission) by committees Programme of physical healthcare and other clinical audits and associated plans COVID Board Assurance Framework reported to NHSE Positive and Safe self-assessment reported to the East Midlands Clinical Senate on Reducing Violence Head of Nursing and Matron compliance visits		National enquiry into suicide and homicide NHLSA Scorecard demonstrating low levels of claims Safety Thermometer identifies positive position against national benchmark Mental Health Benchmarking data identifies higher than average qualified to unqualified staffing ratio on inpatient wards CQC comprehensive review 2020 trust is rated Good; two rated outstanding, two remaining core services rated as require improvement; Identified Trust fully compliant with NQB Learning from Deaths guidance. 2020/21 internal audits: Risk Management; Data Security and Protection 2020/21 Estates and Facilities Management internal audit (limited assurance) Transitional Monitoring Meetings with CQC (bi-monthly), no conditions			
Key gaps in control:	**Key actions to close gaps in control:**	**Impact on risk to be measured by:**	**Expected completion date./(Action review date):**	**Summary of progress on action:**	**Action on track:**
Embedded learning from CQC regulatory actions, particularly in relation to improvement of training governance	Review operational governance of training compliance [ACTION OWNER: DPI] Develop and implement improvement plan to ensure sustained compliance with mandatory training [ACTION OWNER: DPI/COO]	Embedded compliance with mandatory training and compliance rates. Reported to PCC and training cell of IMT Lack of recurrence of common themes regarding training compliance. Reported to PCC and training cell of IMT	31/05/2021	New reporting mechanism commencing May 2021 with positive and safe and ILS training compliance reporting to Board. Weekly reporting to ELT to continue until minimum compliance met. ILS achieved, PSTS to be achieved by 31/05/2021	
Inability to complete physical health checks for patients whose consultations remain undertaken virtually	Improvement plan to be developed and implemented to ensure required physical health care checks are completed [ACTION OWNER: MD]	Compliance with physical healthcare checks, reported in the Quality Dashboard	30/06/2021	Revise metrics included in Quality Dashboard reported to Quality and Safeguarding Committee. Significant improvement on SPC charts. Maintenance to be monitored though dashboard data.	
Implementation of revised priority actions for 'Good Care' which support the trust strategy	Redesign improvement plans to align to revised building blocks which support the Trust Strategy	Compliance with suite of metrics and reporting schedule detailed in quality dashboard	30/06/2021	Overall, indicators are within agreed tolerance including revised	

	[ACTION OWNER: DON]			requirements as outlined in the COVID recovery roadmap. Positive community survey results and positive staff survey results.	
Insufficient investment in Community Forensic Rehabilitation Team	Significant investment (est. £1m+) required by CCG to meet demand as outlined in new national specification. Learning from Mental Health Homicide reviews and formal recommendation for Trust to review capacity of the community forensic team [ACTION OWNER: DBI&T, COO]	Agreed funding allocation	(31/05/2021)	Escalated to CCG, awaiting response re next steps. Clinical team have been developing information and analysis as they await the commissioner input	
Insufficient investment in autism assessment and treatment services to meet demand. No commissioned treatment service. Waiting time has increased over COVID- 19 period, exacerbated by underlying demand	Investment required by CCG to meet assessment and treatment demands. [ACTION OWNER: COO/DBI&T]	Agreed funding allocation	30/04/2021	MHLD and Autism Board agreed investment in principle into autism services. Awaiting formal ratification April 2021.	
Monitoring of changes and patterns in population need in relation in the potential deterioration due to impact of COVID-19	Continued monitoring and focus by the ethics cell of the IMT and Divisional Achievement Reviews (DAR) [ACTION OWNER: COO/MD/DON]	Monitoring of waiting list targets and implementation of mitigating actions. Reporting through Divisional Achievement Reviews.	30/06/2021	Safety standards remain in place for urgent referrals. Currently limited evidence of COVID related surge in demand. Robust oversight in place.	
Key gaps in assurance:	**Key actions to close gaps in assurances:**	**Impact on risk to be measured by:**	**Expected completion date./(Action review date):**	**Summary of progress on action:**	**Action on track:**
Six service areas assessed as 'Requires Improvement' by CQC in relation to safety	Develop and implement an improvement plan to enable all six service areas to reach 'Good' for safety in relation to the CQC standards [ACTION OWNER: DON]	CQC inspection and assessment	30/06/2021	Significant improvement in all services, training remains self-assessed as below trajectory. Plan to meet training compliance by 31/5/2021. Other elements of plan to be achieved by	

				30/06/2021.	
Gap in operating standards for acute and community mental health services	Enhanced monitoring of acute and community mental health services by the Nursing and Quality Directorate [ACTION OWNER: DON] Implement Royal College of Psychiatrists (RCP) Standards across Acute Services [ACTION OWNER MD/DON/COO] Implement 2019 Community Mental Health Framework [ACTION OWNER: DBI&T]	Improvement in operating standards compliance. To be confirmed by external CQC inspection and assessment of at least 'Good' Implemented Acute Inpatient Mental Health Service Accreditation (RCP Standards) reported in Divisional Achievement Reviews and Quality Account Implemented Mental Health Community Framework to Quality and Safeguarding Committee	31/05/2021 (date tbc) (31/05/2021)	Increased performance management scrutiny and unannounced site visits have been undertaken with compliance checks Standards compliance work continues. Accreditation process remains paused due to COVID-19 Plan for investment agreed with NHSE April 2021. Report planned for Quality and Safeguarding Committee May 2021.	
Implementation of clinical governance improvements with respect to: - Outcome measures - Clinical service reviews including reduction in excess waiting times - Getting it Right First Time (GIRFT) reviews - PSIRF implementation - CQUIN - NICE guidelines	Develop and implement an improvement plan to enable all governance improvement plans to be implemented [ACTION OWNERS MD/DON/COO/DBI&T]	Compliance with suite of metrics and reporting schedule	(30/09/2021)	Trusts COVID recovery roadmap outlines timescales for standing up of core clinical governance developments, commencing June 21 onwards. PSIRF implementation continues with new processes in place and approval of revised incident policy.	
Implementation of three new quality priorities for: - Reducing violence - Sexual safety - Learning from COVID 19 pandemic	Develop and implement an improvement plan to enable all quality priorities to be implemented [ACTION OWNERS: DON]	Compliance with suite of metrics and reporting schedule	(30/09/2021)	Implementation plans on hold until June 2021	

Related operational high/extreme risks:

Operational Risks, status as of 16 04 2021

Summary Board Assurance Framework Risks 2021_22. Issue 1 Board May 2021

Record ID	Service Line	Title	Risk: Summary of progress	Date risk created	Date of next review
3009	Learning Disabilities Services	Demand for ASD assessment Service far outstrips contracted activity	[11/01/2021] Current waiting list is 1071 - continues to be a significant wait for diagnosis and service has been unable to offer assessments at normal levels due to changing service demands related to COVID. Service was closed for 4 months in line with the first lock down. Online assessment affects assessment capacity and individuals who cannot use video/telephone appointments have an extended wait. Current situation with regards to COVID and current national lockdown means continued uncertainty as face to face appointments are limited to high risk, and some staff are redeployed for some of their working hours. Service has not been asked to close so is expecting to continue offering an online service with smaller capacity.	01/01/2016	30/04/2021
21189	Management (Specialist Services)	Admission criteria to Eating Disorders Service	[18/09/2020] Request made to General manager to seek an update on the current progress of discussions with the CCG. Inequity of provision of the adult eating disorders service in Derbyshire compared to of the geographical areas.	14/11/2017	30/06/2021
21586	Community Care Services (Older People)	Wait times breaching CCG contract	[30/03/2021] MAS from a staffing perspective is back to 100% following a temporary period of redeployment. It is currently going through a process of review and recovery due to Covid-19. This review will take into consideration the wait times and breach of contract	12/12/2018	30/06/2021
22154	Community Paediatrics Teams	ND Assessment Pathway - operational delivery & capacity risks	[16/02/2021] Project role established to provide oversight, analysis and planning. Some recovery commenced, in CAMHS. 2 weekly oversight meeting in Division. Some internal changes to NDMDM being made. In discussion with CCG re business case for investment, not finalised yet	05/10/2020	30/04/2021
21739	Operational Services	Emergency Preparedness, Resilience and Response (EPRR) Risks within Derbyshire	[03/01/2021] The Trust is currently responding to the national COVID19 Pandemic, due to this and the ongoing nature of the incident; the risk has been increased to 20 (Extreme Risk). The implications of the incident have had a significant impact upon how we run our Trust. We have been required to pause services, redeploy staff into critical services and create a COVID Secure Environment for staff to work within. We have also lost two colleagues during this incident. The longevity of the incident has also caused a significant level of fatigue and work pressures due to decisions/actions taken at the beginning of the incident. Whilst we have utilised the major incident plan and the pandemic influenza plan there have been a number of actions identified to further prepare the Trust for future events of this scale.	23/07/2019	30/04/2021

Summary Board Assurance Framework Risks 2021_22. Issue 1 Board May 2021

Strategic Objective 1. To provide GREAT care in all services

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

Impact: Low quality care environment specifically related to dormitory wards
Crowded staff environment and non-compliance with COVID secure workplace environments
Non-compliance with statutory care environments
Non-compliance with statutory health and safety requirements

Root causes:

a. Long term under investment in NHS capital projects and estate
b. Limited opportunity for Trust large scale capital investment
c. Increasing expectations in care and working environments as national capital strategy and surrounding legislative and regulatory requirements evolve
d. National capital funding restrictions for business as usual capital programme for Trusts and Integrated Care Systems
e. Gaps in relation to the revised Premises Assurance Model (PAM)

BAF ref: 21_22 1b	**Director Lead**: Claire Wright, Deputy CEO and Executive Director of Finance	**Responsible Committee**: Finance and Performance Committee

Inherent risk rating:			**Current risk rating:**				Target risk rating:			Risk appetite:		
Rating HIGH	Likelihood 4	Impact 4	Rating HIGH	Likelihood 4	Impact 4	Direction ⟷	Rating MODERATE	Likelihood 3	Impact 4	Accepted	Tolerated	Not accepted

Key controls:

Preventative – Routine environmental assessments for statutory health and safety requirements; Environmental risk assessments reported through Datix; COVID secure workplace risk assessments
Detective – Reporting progress against Premises Assurance Model (PAM) to ELT; IMT reporting against COVID secure workplace compliance
Directive – Capital Action Team role in scrutiny of capital projects; IMT Estates Cell implementing all relevant COVID secure guidance; COVID secure workplace policy and procedure
Corrective – Short term investment agreed to support key risk areas including provision of equipment to ensure COVID secure workplace environments

Assurances on Controls (internal):	Positive assurances on Controls (external):
- COVID secure workplace assessments - Health and Safety Audits - Premises Assurance Management System (PAMS) reporting providing updates on key priority areas	- Mental Health Capital Expenditure bidding process - External authorised reports for statutory health and safety requirements - 2020/21 Estates and Facilities Management internal audit (limited assurance)

Key gaps in control:	Key actions to close gaps in control:	Impact on risk to be measured by:	Expected completion date./(Action	Progress against action:	Action on track:

			review date):		
Estates Strategy delivery recommendations will need to be updated for ongoing COVID secure requirements .	Review of Estates Strategy delivery recommendations to ensure compliance with ongoing COVID secure guidance [ACTION OWNER COO]	Revised COVID compliant delivery recommendations	During 2021/22 financial year – depending on pandemic evolution	Unable to review until during 2021/22 financial year as strategy needs to be considered post COVID or when and how 'living-with' Covid is ascertained.	
Key gaps in assurance:	**Key actions to close gaps in assurances:**	**Impact on risk to be measured by:**	**Expected completion date./(Action review date):**	**Progress against action:**	**Action on track:**
Lack of adherence to emerging national guidance and policy requiring the elimination of mixed sex wards and dormitory style inpatient facilities.	Deliver a single room en-suite delivery plan and programme of work [ACTION OWNER: DOF for dormitory eradication programme and COO for wider estate strategy delivery]	Delivery of approved business cases and surrounding associated schemes for dormitory eradication	(31/03/2024) Hard deadline for national funding of March 2024	Letter received 08/04/2021 confirming allocation of £80m. Outline Business case development in train.	
Lack of an accessible Derbyshire wide Psychiatric Intensive Care Unit (PICU)	Delivery of local PICU arrangements (new build and associated projects taking into account gender considerations) [ACTION OWNER: DOF]	Agreed programme of work with capital funding to support it	(31/03/2024) PICU delivery date aligned to dorms new build and interim CCG contract dates	PICU discussion ongoing with mix of male new build and alternative female provision.	
Internal Audit recommendations highlighted the need for evidence of assurance on estate maintenance and wider governance for estate compliance with statutory legislation	Deliver Internal Audit report recommendations in full Premises Assurance Model (PAM) assessment to be completed [ACTION OWNER: COO (DOF in interim)] Review of current estates and facilities governance structures [ACTION OWNER: COO (DOF in interim)]	Completion of agreed recommendations and management actions Reporting to Finance and Performance Committee twice yearly and any exceptions in between Governance structure in place	Per dates in audit – range from April to end Sept 2021 31/07/2021 31/05/2021	Meetings have been set up. Plan for reporting of suite of assurance for estates is in development. Reporting will be to ELT for delivery confirmation and July F&P for assurance Internal governance structure in place and meeting monthly. Management audit undertaken by internal	

				auditors Q4 20/21. Governance reporting will include audit recommendation response and delivery	

Related operational high/extreme risks:

Record ID	Service Line	Title	Risk: Summary of progress	Date risk created	Date of next review
22109	Estates & Facilities Management	Failure to maintain Systems and Equipment at the Hartington unit	[05/11/2020] Evidence of request provided to AD Estates and Facilities who is investigating. On-going.	22/07/2020	30/04/2021
21467	Acute Inpatient Services (Older People)	Workplace Health, Safety and Welfare-DRRT overcrowded office space	[23/02/2021] Update from AB. The risk hasn't changed, whilst we don't remain over crowded due to Covid. Our office space remains Covid secure but this does mean we don't have enough desk space for all the team and they are having to work remotely which isn't ideal for a crisis team.	09/01/2020	31/05/2021
21783	Estates & Facilities Management	Fire Door Inspection Programme & Required PPM	[05/11/2020] Works on-going. Capital & revenue funds have now been made available. Contractor to visit site in November to quote for remedial works as per H&S audit. Head of Estates and Facilities aware.	07/10/2019	30/04/2021
2295	Estates & Facilities Management	Sheets within the Trust do not currently meet the requirements set out within HTM05:03	[07/04/2021] Risk raised from low to high March 20221 following review by H&S Manager. Laundering company cannot guarantee the washing regime with our sheets meets crib 5 as must be replaced after a number of washes not exceeding 60 degrees. Increased to a red risk due to gap in assurance against litigation for non-compliance with a MH standard. The minimum standard for all bedding in MH is crib 7, crib 5 in general hospitals.	01/01/2016	11/08/2021

Summary Board Assurance Framework Risks 2021_22. Issue 1 Board May 2021

Strategic Objective 1. To provide GREAT care in all services

Principal risk: There is a risk that the Trust fails to maintain continuity of access to information to support effective patient care

Impact: Inability of staff to access patient records from the right place at the right time

Root causes:

a. Transfer to new electronic patient record provider
b. Inefficient access to clinical information in current system
c. Interoperability of systems with partner organisations
d. Current significant number of forms and processes resulting in issues regarding the consistency of recording of information

BAF ref: 21_22 1c	**Director Lead**: Gareth Harry, Director of Business Improvement and Transformation	**Responsible Committee**: Finance and Performance Committee

Inherent risk rating:			**Current risk rating:**				Target risk rating:			Risk appetite:		
Rating	Likelihood	Impact	Rating	Likelihood	Impact	Direction	Rating	Likelihood	Impact	Accepted	Tolerated	Not accepted
MODERATE	3	4	MODERATE	3	4	⟺	LOW	2	3			

Key controls:

Preventative – Local Implementation Groups (LIG) and overarching Clinical Design Authority (CDA) ensuring all forms and processes have been rigorously tested and signed off by representatives of the clinical services
Detective – NED Board member on OnEPR Programme Delivery Board (PDB) providing project expertise and direct link to Board
Directive – OnEPR PDB governance oversight with respect to delivery of the new EPR with secured expert and experienced third party provider; Fully resourced project management team within the third party provider and DHCFT; Reporting on progress to Finance and Performance Committee and fortnightly updates to ELT; rapid escalation of issues to ELT;
Corrective – Phased approach to delivery (four phases over 18 month project delivery plan); 'Go/No Go' rationale agreed and measures for decision making, ahead of each delivery phase. Weekly 'Go/No Go' meeting in 10 week run up to 'Go Live' date for each phase of implementation

Assurances on Controls (internal):	Positive assurances on Controls (external):
- Weekly project update report and wider project progress report highlighting current position against delivery plan	-

Key gaps in control:	Key actions to close gaps in control:	Impact on risk to be measured by:	Expected completion date./(Action review date):	Progress against action:	Action on track:
Capacity within the IM&T Team to support programme delivery to the level required by the	Identify and agree priorities and release of staff [ACTION OWNER: COO]	Compliance with the agreed resource plan for the project	30/06/2021	Fully resourced plan agreed with C3 for the remainder of the programme. IM&T posts	

project plan				now filled. Gateway review dates agreed with C3 for the release of their resource as required	
Maintenance of staff well-being (in particular IM&T and Channel 3 staff) during final implementation of each delivery Phase	Build in plans and expectations of working arrangements for IM&T and Channel 3 staff from Phase 2 implementation onward [ACTION OWNER: DBI&T]	Feedback from staff	30/06/2021	Pace of project had negative impact on the well-being of staff during Phase 1 implementation. Lessons learnt and plans in place with respect to Phase 2 roll out.	
Key gaps in assurance:	**Key actions to close gaps in assurances:**	**Impact on risk to be measured by:**	**Expected completion date./(Action review date):**	**Progress against action:**	**Action on track:**
Adherence to the project delivery plan due to unforeseen circumstances	Close monitoring of the project risk register and issues log/regular updates with potential to adjust phasing of 'go live' decisions for each phase [ACTION OWNER: COO]	Adherence to the project delivery plan, which includes a range of clear measurable criteria against key milestones.	30/06/2021	ELT agreed delay of Phase 2 implementation to 07/06/21 due to ongoing COVID priorities.	

Summary Board Assurance Framework Risks 2021_22. Issue 1 Board May 2021

Strategic Objective 1. To provide GREAT care in all services

Principal risk: **There is a risk that the Trusts increasing dependence on digital technology for the delivery of care and operations increases the Trusts exposure to the impact of a major outage i.e. cyber-attack, equipment failure**

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

Root causes:

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

BAF ref: 21_22 1d	**Director Lead**: Gareth Harry, Director of Business Improvement and Transformation	**Responsible Committee**: Finance and Performance Committee

Inherent risk rating:			**Current risk rating:**				Target risk rating:			Risk appetite:		
Rating	Likelihood	Impact	Rating	Likelihood	Impact	Direction	Rating	Likelihood	Impact	Accepted	Tolerated	Not accepted
MODERATE	3	4	MODERATE	3	4	New risk	MODERATE	2	4			

Key controls:

Preventative – Trust utilises NHS provided solutions as widely as possible i.e. Office 365, NHS Mail to ensure compliance with mandated requirements. Use of the secure HSCN (Health and Social Care Network) specified by NHS Digital. Staff training on data security and protection. Regular all staff communications regarding safe ways of working and phishing emails. Contract with Arden Gem provides information governance and security services, includes review of risks and addressing of vulnerabilities. Subscription with NHS Digital Care Certification Programme highlights cyber vulnerabilities and monitors Trust's compliance against them

Detective – Cyber essentials framework - NHS Digital encourage all organisations to comply. Advanced Threat Protection (ATP) monitors every server and device to highlight threats and software vulnerabilities.

Directive – Compliance with NHS Digital requirements. Monthly rigor review meeting with Arden Gem to identify software solutions which require upgrading to ensure supported. Data Security and Protection Policies and Procedures. Business continuity plan and procedure

Corrective – Timely actions undertaken in response to vulnerabilities identified through controls/processes outlined above.

Assurances on Controls (internal):	Positive assurances on Controls (external):
- IT Strategy 6 month update to Board	- Templar Cyber Organisational Readiness Report (CORS) - Annual external cyber review by Dynac (vulnerability scan) - Data Security and Protection annual review by Internal Audit, weighted toward cyber security - Compliance with Data Security and Protection Toolkit, including high levels of

	training compliance				
Key gaps in control:	**Key actions to close gaps in control:**	**Impact on risk to be measured by:**	**Expected completion date./(Action review date):**	**Progress against action:**	**Action on track:**
Business continuity plans reflect changes to service delivery such as increased phone and video contacts	All services to review business continuity plans to ensure they take account of the increased use of phone and video contacts for care provision and also use of video conferencing for operational delivery [ACTION OWNER: DBI&T/COO]	Reporting to the Divisional Achievement Reviews	30/09/2021		
Limited resource within organisation dedicated to cyber	Consider development of a business case to increase cyber support [ACTION OWNER: DBI&T/COO]	Increased capacity to support cyber risk management	(30/06/2021)		
Embedded programme of software and hardware upgrades	Prioritise work alongside organisational requirements and developments [ACTION OWNER: DBI&T]	IT Strategy 6 month update to Board	(30/09/2021)		
Key gaps in assurance:	**Key actions to close gaps in assurances:**	**Impact on risk to be measured by:**	**Expected completion date./(Action review date):**	**Progress against action:**	**Action on track:**
Live testing of business continuity plans	Desktop incident response exercise on IT failure to be completed. [ACTION OWNER: DBI&T/COO]	Exercise evaluation report to Finance and Performance Committee	28/02/2022		
Some gaps identified in Cyber Operational Readiness Support (CORS) review undertaken by Templar	Consideration of recommendations in relation to asset owners and policies. Trust to develop own actions in response. [ACTION OWNER: DBI&T]	Response to CORS recommendations report to Data Security and Protection Committee	30/09/2021		

Summary Board Assurance Framework Risks 2021_22. Issue 1 Board May 2021

Strategic Objective 2. To be a GREAT place to work

Principal risk: There is a risk that we do not sustain a healthy vibrant culture and conditions to make DHCFT a place where people want to work, thrive and to grow their careers

Impact: Risk to the delivery of high quality clinical care
Inability to deliver transformational change
Exceeding of budgets allocated for temporary staff
Loss of income

Root causes:

a. National shortage of key occupations and registered professions
b. Future commissions of key posts insufficient for current and expected demand
c. Sufficient funding to deliver alternative workforce solutions
d. Retention of staff in some key areas
e. Overdependence on registered professions
f. Impact of COVID-19 pandemic
g. Increase in mental health demand and associated funding
h. Increase in use of technology
i. Consistent person centred culture not fully embedded

BAF ref: 21_22 2a	**Director Lead**: Jaki Lowe, Director of People and Inclusion	**Responsible Committee**: People and Culture Committee

Inherent risk rating:			**Current risk rating:**				Target risk rating:			Risk appetite:		
Rating EXTREME	Likelihood 4	Impact 5	Rating HIGH	Likelihood 4	Impact 5	Direction ↓	Rating MODERATE	Likelihood 2	Impact 5	Accepted	Tolerated	Not accepted

Key controls:

Preventative –Workforce Plan covering wide range of recruitment channels including targeted campaigns, 'Work For Us' internet page, leadership development, new role and skill mix changes, leadership development programme, increased well-being support, system workforce hub.
Detective – Performance report identifying specific hotspots and interventions to increase recruitment and retention, Freedom to Speak Up Guardian role, Peoples Services Leadership Team meeting to oversee delivery of the People agenda. Health risk assessments. Health and Wellbeing conversations and well-being action plans. BAME risk assessments.
Directive – Wellbeing Strategy, infrastructure and programmes to support staff health and wellbeing. Workforce plan to grow and develop the workforce. Assurance reports on delivery of People Strategy to People and Culture Committee. Vaccination engagement sessions. Leadership support sessions. Staff engagement forums.
Corrective – Leadership and Management Strategy and development programmes to build inclusive and engaging leadership and management. Leadership Programme– Core Leaders. Occupational health contract monitoring meeting.

Assurances on Controls (internal):	Positive assurances on Controls (external):
Workforce Performance Report to Executive Leadership Team monthly Bi Monthly People Dashboard to People and Culture Committee, includes recruitment tracker and deep dives	Outstanding results from 2020 staff survey, identifying significant improvements across all themes Safe staffing reports and CHPPD reporting (planned v's actual staff)

Summary Board Assurance Framework Risks 2021_22. Issue 1 Board May 2021

ELT rolling programme of deep dives of strategic building blocks Twice weekly Recruitment tracker report to Incident Management Team (IMT) to monitor recruitment progress across organisation Employee relations assurance report to ELT Deep dive review of the risk to Audit and Risk Committee (Jan 2021)	WRES, WDES and Gender pay gap reporting 2020/21 Internal Audit: WRES and WDES Data Quality (significant assurance).

Key gaps in control:	Key actions to close gaps in control:	Impact on risk to be measured by:	Expected completion date./(Action review date):	Progress against action:	Action on track:
Effective recruitment and retention plan to all posts Time taken to recruit to new and vacant posts	Recruitment plans in place for workforce requirements related to capital projects and MH investment plans [ACTON OWNER:DPI]	Vacancy rates, time to recruit data within performance report to Board. People dashboard to PCC and monthly people assurance report to ELT Diversity in appointments. Target of 20% of workforce as BAME.	(30/09/2021)	Recruitment processes working well. Plans in place for all new posts are being dynamically managed	
Embedded flexible workforce arrangements in place	Implementing the learning from flexible working arrangement in response to the COVID-19 pandemic, i.e. home working, redeployment [ACTON OWNER:DPI] Review of policies/processes and contracts of employment to embed flexible working [ACTON OWNER:DPI]	Sickness absence rate reported in performance dashboards as outlined above Staff survey responses Pulse and people pulse check responses % of people working on flexible contracts with respect to hours and location (reporting metric to be developed)	(30/06/2021)	Flexible working in place as a result of COVID-19 with many people working from home. Continuing to review and adapt response as learning continues. Flexible working policies and contracts in process of being reviewed Pulse and people pulse checks to be commenced.	
Fully embedded person centred culture of leadership and management	Review of policies and processes to support a person centred approach to leadership and management [ACTON OWNER:DPI] Review of leadership development offer [ACTON OWNER:DPI]	Reduced number of formal staff relations issues/cases. Reported in monthly people assurance report to ELT	(30/06/2021)	"People First - Supporting colleagues fairly through workplace situations" in place and disciplinary and incident polices reviewed in line with approach Approved proposal with 'Above Difference' to review cultural intelligence.	

Development of a funded Workforce Plan that delivers on new role development	Develop and implement 2021/22 of the Workforce Delivery Plan [ACTON OWNER:DPI]	Vacancy rate of registered posts reported in performance dashboards as outlined above and recruitment report to IMT, No of new roles in place, metric to be developed. Apprenticeship student nurse uptake reported to Workforce Plan Delivery Group	(30/06/2021)	Delivery of plan being monitored though the Workforce Plan Delivery Group Medical Workforce Project Group review of all vacancies, recruitment and agency spend fortnightly	
People services shaped to deliver against future needs of the organisation	Review of Peoples Services model and plans [ACTON OWNER:DPI] Identify resources required to shape culture locally [ACTON OWNER:DPI] Develop performance framework to support delivery of revised model [ACTON OWNER:DPI]	Implemented performance framework	(30/06/2021) Deferred to 2021/22	Statement on joint venture way forward from DHCFT and DCHS Directors presented to both Boards March 2021.	
Consolidate health and wellbeing provision and infrastructure, ensuring learning from COVID-19 pandemic is incorporated	Align well-being offer to local STP and national offers [ACTON OWNER:DPI] Updating well-being offer, in particular mental health interventions Roll out of health and wellbeing plans for all staff [ACTON OWNER:DPI] Review management of change policy to incorporate health and well-being discussions. Similar review of appraisal policy and processes [ACTON OWNER:DPI]	Maintain sickness absence rates to below 5% or below Reduction in sickness absence as a result of anxiety and stress % uptake of health and well- being plans. % uptake of health risk assessments Published policies	(30/06/2021) 30/09/2021	Review target with ELT Local, regional and national offer published via Trust intranet Increase uptake of health risk assessments	
	Roll out of flu vaccination plan for autumn 2021 and any subsequent COVID-19 vaccine [ACTON OWNER:DPI/DON]	Increased uptake of staff flu vaccination by 30/11/2021 Continued roll out of COVID-19 vaccine in line with national guidance	As per guidance	COVID-19 vaccinations well underway	
Key gaps in assurance:	**Key actions to close gaps in assurances:**	**Impact on risk to be measured by:**	**Expected**	**Progress against action:**	

			completion date./(Action review date):		
Training compliance in key areas below target set by the Trust	Recovery plan to be implemented. Mandatory training to be rostered. [ACTION OWNER: DPI/COO]	% compliance with mandatory training reported to ELT, training cell in IMT and bimonthly to Board as part of performance report. Forward planning for training compliance	(30/06/2021)	Recovery plan has been implemented, particularly in relation to ILS and positive and safe training. Forward plans to include rostering of training to be developed. Significant impact of COVID-19 on release of staff	
Evidence of safer staffing levels of suitably qualified staff	Compliance with NHSI Workforce Safeguards requirements [ACTION OWNER DPI]	Full compliance with safer staffing levels in line with the NHSI Workforce Safeguards	31/05/2021	Plan to be presented to PCC May 21	

Related operational high/extreme risks:

Record ID	Service Line	Title	Risk: Summary of progress	Date risk created	Date of next review
21222	Peoples Services	Compliance - Resus Training(ILS & BLS)	[06/07/2020] APBLS was paused over the COVID pandemic initial months resulting in only APBLS for new inductees occurring. From 7th of July 2020 all APBLS session are open for staff to book onto. In March service areas were asked to send the names of staff to book onto APBLS. Not all service areas replied. For those who did a place has been secured, although in light of social distancing, places have been reduced to enable this to occur. During the COVID pandemic, ILS has continued to be delivered, although those allowed to attend has been restricted due to social distancing. The resuscitation lead and people development lead highlighted that some medical staff potential were allocated the incorrect level of resuscitation, i.e. ILS rather than APBLS. Awaiting an update from deputy medical director to support this. Once completed ESR will be amended to reflect the level.	19/02/2018	30/04/2021

21510		Delivery of Positive and Safe and Training Compliance	[01/10/2020] The team JD has been agreed and to be advertised. It is anticipated to have the team fully inducted by March 2020, should the positions be appointed to in the first scheduled interviews. Currently the two trainers are being supported by a fixed term contract until March 2021 and during this time each positive and safe update is accommodating 15 learners and this is why an external venue is being used to safely maximise within social distancing rules the number which the team can accommodate. But there needs to be 100 % attendance to ensure that the compliance begins to be achieved. This has been raised to ELT. Each ward manager has been contacted to inform of the new method of delivery and liaising is constant to ensure all staff are gaining a place on Positive and Safe.	22/10/2018	30/04/2021
1569	Community Care Services - County South	Work related stress	[14/03/2021] NMP recruitment successful. Consultant staffing remains challenging with current advert our for post. Possibility of x 2 higher trainees to join during 2021 as Acting Consultants - being supported by Medical Director and Exec team. Clinical director leading this. Consultant / medical staffing remains challenging and identified as a priority for 2021/22 in Divisional plan. On call rota remains covered.	14/10/2020	31/08/2021
2772	Child and Adolescent Mental Health Services (CAMHS)	Insufficient resources CAMHS workforce	[02/11/2020] Recruitment to consultant vacancy remains challenging, long term agency cover for 2.6 wte. vacancies. NMP trainee has now completed the course. NMP post out to recruitment. Consultant group offering a mixture of remote and FTF working during the pandemic using attend anywhere and telephone to support assessments and reviews.	01/01/2016	31/03/2021
22266	Universal 0-19 Services- Enhance HV Team	Staffing	[09/04/2021] Staff currently following the Covid delivery action plan and are not offering the full service at present. Any vulnerable families that they are unable to allocate are discussed with clinical lead and action plan agreed	24/11/2020	30/06/2021
22365	Community Care Services - County North	Medic Cover	[09/02/2021] Ongoing discussions about increased short term resource to manage the service gaps and large caseloads. Agency request approved and currently trying to fill Post out to advert for permanent recruitment.	16/12/2020	30/04/2021
22450	Child and Adolescent Mental Health Services (CAMHS)	Clinical concerns raised as a result of insufficient staffing levels in the Recovery Team	[25/02/2021] Clinical risk are increased due to unfilled Vacancies and re-deployment of Staff. There are 4 Band 6 vacancies to fill in Erewash/Swadlincote (DBV) localities, leaving only 1.6 Band 6's and 2 Band 5's picking up cases from Erewash and DBV. The other Recovery Team localities are also struggling. Insufficient Staffing levels has meant we are unable to re-allocate some of the active cases from Staff who have been re-deployed. This situation continues to have impact on Staff well-being and delay in allocation of new referrals coming in	02/02/2021	30/04/2021

			from other parts of the service. The ASM has tried to support by putting in a request for Agency staff 2 weeks ago		
22588	Perinatal Services	Risk to service due to lack of Qualified Nurses	[12/03/2021] 0.6 Qualified WTE Vacancies Currently have 5.6 WTE nurses (1WTE is a preceptee). No margin for further absence. Staff and manager doing over hours to cover. Not currently meeting staffing standards set by RCPSYCH needed for accreditation – should be working on a minimum of 2 qualified nurses per shift . Most shifts are working below the safer staffing levels. Specialist skills needed for safe and effective care	12/03/2021	30/04/2021

Strategic Objective 2. To be a GREAT place to work

Principal risk: There is a risk of continued inequalities affecting health and well-being of both staff and local communities

Impact: Risk to the delivery of high quality clinical care
Inability to attract, recruit and retain a motivated and diverse workforce
Risk to the health and wellbeing of our staff
Risk to patients and communities having access to the right services
Escalation in formal cases impacting on individuals and teams
Reduced confidence by our communities in our Trust

Root causes:

a. Commissioning of services does not meet the need of diverse communities
b. Change management and transformation programmes lead to deterioration in experience
c. Processes and policies have inbuilt bias
d. Processes for advocacy and raising issues not clear or dealt with well
e. Gaps in cultural competence of leaders and managers

BAF ref: 21_22 2b	**Director Lead**: Jaki Lowe, Director of People and Inclusion	**Responsible Committee**: Trust Board

Inherent risk rating:			**Current risk rating:**				Target risk rating:			Risk appetite:		
Rating HIGH	Likelihood 4	Impact 4	Rating HIGH	Likelihood 4	Impact 4	Direction ⇔	Rating MODERATE	Likelihood 3	Impact 4	Accepted	Tolerated	Not accepted

Key controls:

Preventative – Freedom to Speak Up Guardian (FTSU) self-assessment and 6 monthly reports; annual review of people development plan commissioned through People Services; provision of information through induction processes for new staff; staff engagement sessions; EDI Delivery Group meeting; supported Networks for diverse staff groups and allies; Health and Well-being Network; Workforce planning design meeting; Culture and Leadership Delivery Group; Training and Education Delivery Group.

Detective – Weekly recruitment report to IMT; EDI updates to ELT, monthly performance report to Board; Reverse Commissioning Project Group; Reverse Commissioning Steering Group; Equality Forum; Attendance management monitoring; Take up of Reasonable Adjustment Passports; Updating of ESR regarding disability and long term conditions

Directive – People Strategy; Inclusion strategy; Joined Up Care Derbyshire People Strategy

Corrective – Leadership and management development strategy ensuring inclusion is at the heart of all development; Exit interview feedback

Assurances on Controls (internal):	Positive assurances on Controls (external):

Executive Leadership Team rolling programme of deep dives on strategic building blocks	2020 staff survey results Gender Pay Gap annual assessment and report Assessment and report annually for EDS2 WRES and WDES annual report 2020/21 Internal Audit WRES/DWES data quality (significant assurance)

Key gaps in control:	Key actions to close gaps in control:	Impact on risk to be measured by:	Expected completion date./(Action review date):	Progress against action:	Action on track:
Develop an Equality, Diversity and Inclusion Strategy	Establish approach for refreshing and expanding the strategy Establish a steering group to oversee refresh of the strategy Complete review of cultural intelligence Refreshed strategy completed Launch events for the Equality, Diversity and Inclusion Strategy [ACTION OWNER FOR ABOVE: DPI]	Improved position regarding staff motivation in Staff Survey Freedom to Speak Up Index to People and Culture Committee and Board Pulse Check Inclusion Recruitment report Positive Family and Friends Test % of exit interviews completed Metrics within the employee relations report	(30/09/2021)	Steering group in place to develop strategy. Dashboard developed for PCC focused on cross cutting themes from hotspot areas (i.e. FTSU, WRES, WDES.	
Refresh and expand engagement plans. Include lessons learnt from response to COVID pandemic	Establish approach for refreshing and expanding the engagement plans Establish a group to oversee refresh of the engagement plan Refresh 12 month engagement plan [ACTION OWNER FOR ABOVE: DPI]	Improved Staff survey results Positive Family and Friends Test Positive Pulse Check	(30/09/2021)	Engagement plan for next 12 months to be developed, in line with Trust COVID recovery roadmap.	
Gaps in the cultural competence of leaders and managers	Diagnostic exercise to identify gaps around culture and identify how to build on current	Metrics within the employee relations report	(30/09/2021)	Relaunch of health risk assessment underway in line	

resulting in staff reporting being disadvantaged due to their protected characteristics	approaches Roll out of cultural competence training to equip leaders and managers to be able to lead and support staff and provide the best experience for service users [ACTION OWNER: DPI] BAME and health risk assessments offered for all staff, including new starters [ACTION OWNER: DPI]	Metrics within the Freedom to Speak Up report Annual publication of Workforce Race Equality Standard data, identifying an improved position Live WRES monitoring to ensure consistent capture and monitoring of data		with vaccination programme	
Key gaps in assurance:	**Key actions to close gaps in assurances:**	**Impact on risk to be measured by:**	**Expected completion date./(Action review date):**	**Progress against action:**	**Action on track:**
Unequal experience of people with protected characteristics through recruitment process	Review of recruitment strategy and plans [ACTION OWNER: DPI]	Improved BME recruitment process outcomes	30/06/2021	Recruitment inclusion guardians to support all recruitment of posts Band 6 and above from advert stage. In process of agreeing recruitment pilot for cultural intelligence across Derbyshire health system. DHCFT leading approach.	

Strategic Objective 3. To make BEST use of our money

Principal risk: There is a risk that the Trust fails to deliver its revenue and capital financial plans

Impact: Trust becomes financially unsustainable

Root causes:

a) Financial detriment (revenue, cash and/or capital) resulting from large capital development programme, in particular dormitory eradication and associated capital schemes and patient record investment
b) Non approval of business case for national funding
c) Insufficient capital envelope for JUCD system that inhibits Trust capital spend requirements for the self-funded projects within the dormitory eradication and PICU programme
d) Organisational financial detriment created by commissioning decisions or wider 'system-first' decisions including enactment of risk-sharing agreement in partnership arrangements or changes in NHS financial arrangements during and beyond the pandemic
e) Non-delivery of expected financial benefits from transformational activity
f) Non-delivery of standard or additional financial efficiency requirements
g) Lack of sufficient cash and working capital
h) Loss due to material fraud or criminal activity
i) Unexpected income loss or non-receipt of expected transformation income (e.g. LTP and MHIS) without removal of associated costs
j) Costs to deliver services exceed the Trust financial resources available, including contingency reserves.

BAF ref: 21_22 3a	**Director Lead**: Claire Wright, Deputy CEO and Executive Director of Finance	**Responsible Committee**: Finance and Performance Committee

Inherent risk rating:			**Current risk rating:**				Target risk rating:			Risk appetite:		
Rating HIGH	Likelihood 3	Impact 5	Rating EXTREME	Likelihood 4	Impact 5	Direction ↑	Rating MODERATE	Likelihood 2	Impact 5	Accepted	Tolerated	Not accepted

Key controls:

Preventative – Integrated Care System (ICS) sign off and support for dormitory eradication work. Devoted and adequate team for Programme delivery. High quality business cases. Regular meetings with NHSIE on programme progress. Meaningful stakeholder engagement (internal and external) . Robust cash flow forecasting and delivery

. Multi-disciplinary development of financial plans for new programmes of work. System sign-off and appropriate governance arrangements for new programmes of work: Budget training, segregation of duties, management of commissioning risk through system engagement and leadership, mandatory counterfraud training and annual counterfraud work programme: Enhanced cash management and forecasting aligned to large capital and transformational programmes

Detective – Risk logs and programme-reporting (capital/transformation) informs ongoing financial risk assessment: Audits (internal, external and in-house); Scrutiny of financial delivery, bank reconciliations; Continuous improvement including CIP planning and delivery; Contract performance, Local counterfraud scrutiny.

Summary Board Assurance Framework Risks 2021_22. Issue 1 Board May 2021

Directive – Business plans and templates set out clear financial plans and assumptions: Standing financial instructions; budget control, delegated limits, recruitment approval processes; Business case approval process; Invest to save/Quality Improvement methodology and protocol- Plan Do Study Act. Risk and gain share agreements.
Corrective – Risk mitigation activity and oversight at ICS system/other partnership level. Proactive reporting and forecasting of capital and wider transformation programme progress enabling remedial activity to take effect. General corrective management action; Use of contingency reserve; Disaster recovery plan implementation; Performance reviews and associated support/ in-reach.

Assurances on Controls (internal):	Positive assurances on Controls (external):
- Dormitory eradication and PICU Programme monitoring and reporting. Urgent decision- making taking place and relevant meetings in place. - Appropriate monitoring and reporting of financial delivery – Trust overall and programme-specific including 'Use of Resources' reporting updates - Assurance levels gained at Finance and Performance Committee - Delivery of Counterfraud and audit work programme with completed and embedded actions for all recommendations - Independent assurance via internal auditors, external auditors and counterfraud specialist that the figures reported are valid and systems and processes for financial governance are adequate	- NHSIE feedback throughout progress of dormitory eradication programme - Internal Audits– Financial integrity and key financial systems audits - External Audits – strong record of high quality statutory reporting with unqualified opinion - National Fraud Initiative – no areas of concern - Local Counterfraud work – Referrals show good counterfraud awareness and reporting in Trust and no material losses have been incurred. Use of risk-based activity in new counterfraud standards Information Toolkit rating – evidencing strong cyber risk management (ref fraud/criminal financial risk)

Key gaps in control:	Key actions to close gaps in control:	Impact on risk to be measured by:	Expected completion date./(Action review date):	Progress against action:	Action on track:
Dormitory eradication and PICU programme team not yet fully in place	Recruitment to Project managers and project officer. Secure and backfill relevant internal Trust staff into programme [ACTION OWNERS: DOF]	Full team in place and operational	30/06/2021	Programme Director in role, on secondment. New governance structure in development. Delivery/status reporting has commenced Recruitment process started for project managers and officer. Internal team to be backfilled needs identifying and securing	
'Best Value' building block - Extant Use Of Resources priorities to be revisited post Covid 1. Increase wellbeing and reduction in sickness absence 2. Inclusive leadership/retention 3. Deliver e roster and e job	Revisit the previous 'Use of Resources (UoR)' Top Ten priorities incorporating transformational gains achieved during pandemic [ACTION OWNERS: DBIT]]	Improvement in UOR related metrics as reported to - Board - Finance and Performance Committee - People and Culture committee	(30/09/2021)	Sickness levels adversely impacted due to COVID-19 pandemic Leadership development adversely impacted due to COVID-19 pandemic E roster – specific programme changes are on hold – will now be affected by dormitory eradication programme Out of area placements – linked to eradication of dormitory accommodation and Covid secure	

planning 4. Eliminate out of area placements 5. Optimise digital technology 6. Medicines optimisation and e prescribing 7. Streamline access to services 8. Optimise use of estate 9. Consider size and function of corporate services 10. Improve administration and communication				environment. Digital – Attend Anywhere in place, MS Teams in place - rapid digital transformation achieved during COVID-19 – needs maintaining and enhancing Medicine optimisation ongoing, E prescribing part of OnEPR Access – lessons learned/business as usual. Waiting lists impacted by Covid Estate – Impacted by: social distancing requirements, remote working and home working, dorms eradication work Corporate services – some STP work (e.g. payroll moved to UHDB as of April 2021) Admin and communications – engagement and communications – are of high focus and success	
Delivery of planned benefits of specific change programmes	Delivery of planned benefits realisation for change programmes in particular: - Dormitory eradication programme - Delivery of OnEPR programme - Delivery of enhanced E-Roster and e job planning informed by dorms programme - Delivery of planned MHIS/LTP service changes [ACTION OWNERS: DOF/COO]	Achievement of planned benefits of change programmes as reported to Programme Boards and Finance and Performance Committee at key milestone points (and by exception)	Most are Multi-year and not all set out yet (quarterly – tbc)	- OnEPR is on track to new timeframe - Measurables: expected benefits reported to F&P Committee - Dormitory eradication - Updates to Board include identification of measurable critical success factors - E roster is in place but changes were not enacted and consultation to be revisited. On hold for dorms work - E job planning has re-commenced - MHIS, SDF and Recovery funding recruitment is proceeding in line with submitted cases and funding notified in April 2021.	
Key gaps in assurance:	Key actions to close gaps in assurances:	Impact on risk to be measured by:	Expected completion date./(Action review date):	Progress against action:	Action on track:
Need to secure £80m national funding for dormitory eradication through business case	Develop suitable business cases and all surrounding actions All programme activities to be delivered	Approved business cases delivered to time scope and cost Risk log of programme to be maintained and mitigated	(30/06/2021) 31/03/2024	In development	

approval	Successful engagement [ACTION OWNERS: DOF/COO]				
Unknown **capital** requirement for requirements over and above the national funded projects	Urgent decisions on best clinical delivery models for buildings outside of new build facilities to be costed up [ACTION OWNERS: DOF]	Defined costs produced to eliminate the unknown. Confirmation that that value is affordable from internal cash reserves Confirmation that the cash and capital expenditure is supported and include in the signed-off JUCD capital programme	(31/03/2022) 31/03/2024	Not yet possible to quantify requirements due to ongoing clinical discussion on model options	
Revenue requirements for all new models and configuration of services exceed funding	Revenue requirements in business cases and associated financial planning achieves system and commissioner sign off and is affordable [ACTION OWNERS: DOF]	Approved financial and contractual arrangements to incorporate new ways of service delivery	30/06/2021 (initial business case) 31/03/2024 (contracted delivery)	Not yet possible to quantify requirements due to ongoing clinical discussion on model options	
Local system **capital** envelopes are limited and may not allow sufficient capital expenditure to self-fund 100% dormitory eradication and provide PICU	Cash constrained, minimal capital plan to retain sufficient internal cash Discussion with regulators as to how FTs with sufficient cash can spend on larger schemes that exceed 'normal' levels of system CDEL [ACTION OWNERS: DOF]	Signed off capital programme sufficient to fund requirements	31/03/2024	Allocations for future years not issued	
Changing and unknown future NHS financial arrangements, including those for provider alliances and integrated care systems ICS evolution into statutory body – unknown impact on providers and system ways of working	Assimilation of new guidance and arrangements when received System Financial oversight, planning and governance arrangements [ACTION OWNERS: DOF/DBIT/CEO]	Agreed financial arrangements being enacted and achievement of planned financial outturns, as measured by reporting and KPIS such as surplus or deficit in period and forecast. For trust and wider system in aggregate. Visibility of progress reported to ELT, F&P and Board as appropriate	Quarterly	System DoF and Deputies are working to current guidance. System Financial meetings take place regularly to scrutinise planning and forecasting assumptions System finance reporting is underway New guidance for ICS and financial framework is expected in new calendar year	

Summary Board Assurance Framework Risks 2021_22. Issue 1 Board May 2021

Strategic Objective 3. To make BEST use of our money

Principal risk: There is a risk that learning from the response to the COVID-19 outbreak, and transformation plans developed prior, does not lead to sustainable embedded transformation

Impact: Improvements in the quality of care, working lives and service efficiencies are lost

Root causes:

a) Impact of the COVID-19 pandemic and adherence to directives including COVID secure environments
b) Increased use of clinical consultations and interventions using virtual technology in response to COVID-19
c) Increased use of videoconferencing for clinical and corporate meetings in response to COVID-19
d) Closer relationships between community teams and inpatient services developed as a result of working within COVID-19 guidance
e) Less miles travelled miles on trust business due to greater use of virtual technology and videoconferencing
f) Flexible working arrangements for colleagues increased in response to COVID-19
g) Understanding of factors which have led to the reduction in sickness and absence of colleagues
h) Historical reliance on staff based in trust estate
i) Limited team autonomy to make local improvements at pace

BAF ref: 21_22 3b	**Director Lead**: Gareth Harry, Director of Business Improvement and Transformation	**Responsible Committee**: Finance and Performance Committee

Inherent risk rating:			**Current risk rating:**				Target risk rating:			Risk appetite:		
Rating HIGH	Likelihood 4	Impact 4	Rating HIGH	Likelihood 4	Impact 4	Direction ⟺	Rating MODERATE	Likelihood 3	Impact 4	Accepted	Tolerated	Not accepted

Key controls:

Preventative – Adherence to national and local guidance in relation to responding to the COVID-19 pandemic
Detective – Lessons Learnt Cell of the Incident Management Team; EQUAL Forum; Regular reporting to Finance and Performance Committee on pipe line to include future transformation; Home Working and COVID Secure policies and procedures
Directive – Estates Cell of the Incident Management Team has established principles for home working and estates optimisation; Quality Improvement Strategy; Clinical Strategies
Corrective - Fortnightly System Restoration Cell focused on joint plans; restoration plans in line with Phase 3 national planning; Evidence of local improvements at team level i.e. risk stratification of caseloads, discharge processes

Assurances on Controls (internal):	Positive assurances on Controls (external):
- Regular reporting of impact of measures taken to IMT	- Patient Surveys for patients with learning disabilities and SMI conducted by HealthWatch

Key gaps in control:	Key actions to close gaps in control:	Impact on risk to be measured by:	Expected completion	Progress against action:	Action on

			date./(Action review date):		track:
Implementation of the Estates Strategy in relation to community and corporate estate	Conduct estates optimisation work for community and corporate services [ACTION OWNER: COO]	Less corporate estate	30/06/2021	Further work planned at team, divisional and organisational level during first phase of Trust Roadmap to look at medium-term estate requirements.	
Embedding of current ways of working in a post COVID environment	Maintain directives on virtual meetings and non-patient facing activities to support new ways of working [ACTION OWNER: DBI&T]	Less miles travelled on trust business compared to a pre COVID baselines More hours working from home compared to a pre COVID baselines	30/06/2021	Organisation is continuing to operate under COVID secure guidelines. Further work planned at team, divisional and organisational level during first phase of Roadmap to look at medium-term operational models.	
Consistency of application with respect to use of videoconferencing software for patient consultations vs face to face in person consultations	Agreed protocol for when face to face in person appointments are necessary for patient safety with the understanding all other contacts would be via video or phone [ACTION OWNER: DON/MD]	% use of video/phone contacts with patients in line with the agreed protocol	30/06/2021	Further work planned at team, divisional and organisational level during first phase of Roadmap to look at medium-term operational models and ongoing use of video contacts.	
Key gaps in assurance:	**Key actions to close gaps in assurances:**	**Impact on risk to be measured by:**	**Expected completion date./(Action review date):**	**Progress against action:**	**Action on track:**
Learning from COVID-19 pandemic outbreak against available self-assessments	Undertake self-assessment using recommended rating tools , and review learning from staff feedback [ACTION OWNER: COO]	Positive staff feedback on learning from COVID-19. Completed actions identified through self-assessment	30/06/2021	Live staff engagement sessions continued throughout pandemic. Learning the Lessons surveys/focus groups undertaken, reported to Board members. Self-assessment underway	
Implemented clinical strategies and quality improvement strategies and sign off all actions	Refresh quality improvement strategy and implementation plan. [ACTION OWNER: DBI&T]	Increase in no of people trained and supported to undertake QI actions at a local team level	30/06/2021	Roadmap outlines resumption of strategic work later in 21/22.	

	Build in prioritised actions from clinical improvement strategies into divisional business plans	Delivery against the divisional business plans	30/06/2021	Planning sessions with divisions/teams postponed due to focus on COVID response.	

Summary Board Assurance Framework Risks 2021_22. Issue 1 Board May 2021

Strategic Objective 3. To make BEST use of our money

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

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

Root causes:

a) New senior management relationships across organisations, with potential new appointments in system leadership roles with the creation of the new ICS as an NHS body and the creation of provider collaboratives
b) Creation of mental health, learning disability and autism provider collaborative may destabilise some of the established relationships in place across Derbyshire
c) Creation of system level governance structures may impact on provider FT governance arrangements and decision-making processes.
d) CCG staff impacted by change, may lead to increased staff turnover in teams supporting the delivery of the MH Long-Term Plan and subsequent loss of organisational memory.

BAF ref:	**Director Lead**: Gareth Harry, Director of Business Improvement and Transformation	**Responsible Committee**: Board
20_21 3c		

Inherent risk rating:			**Current risk rating:**				Target risk rating:			Risk appetite:		
Rating	Likelihood	Impact	Rating	Likelihood	Impact	Direction	Rating	Likelihood	Impact	Accepted	Tolerated	Not accepted
HIGH	4	4	HIGH	4	4	New risk	MODERATE	3	4			

Key controls:

Preventative – Governance structures in place at a system and Delivery Board level. Ongoing close communication with NHSEI, Mental Health and Learning Disability teams at a regional and national level. Assumed NHSEI-led appointment process to new ICS Board positions.
Detective – Early meetings to be put in place with all new appointees at an Executive level. Continuing engagement in all Joined up Care Derbyshire governance from DHCFT representatives
Directive – Mental Health, Learning Disability and Autism System Delivery Board to engage widely across membership on the development of any provider collaborative with agreed plans and processes.
Corrective - Weekly meetings of wider system transformation team to continue, providing support and advice to colleagues across the system

Assurances on Controls (internal):	Positive assurances on Controls (external):
- Regular reporting of position to Board by CEO. - Regular ELT updates and discussions - NED Board members on JUCD committees and Board	- Monthly Mental Health and Learning Disability assurance meetings with NHSEI teams with DHCFT represented by Director of Business Improvement and Transformation - Appointments/ assurance of new ICS board through NHSEI processes

Summary Board Assurance Framework Risks 2021_22. Issue 1 Board May 2021

Key gaps in control:	Key actions to close gaps in control:	Impact on risk to be measured by:	Expected completion date./(Action review date):	Progress against action:	Action on track:
Maintenance of relationships with CCG colleagues during period of change and potential instability	Weekly meetings of wider MH&LD system transformation team. Support and guidance provided from DHCFT DBI&T, Early meetings at DHCFT board level with all new appointees into the ICS Board [ACTION OWNER: DBI&T]	Staff turnover from wider transformational team, including CCG staff Positive working relationships formed with all new appointees in the Derbyshire system	(30/06/2021) 30/09/2021		
Ensuring DHcFT board members are represented in in positions of responsibility in JUCD governance structures	DHCFT NEDs representing the organisation on a range of JUCD system governance committees and groups [ACTION OWNER: CEO]	DHCFT Board oversight of JUCD system and levels of confidence in system working and decision-making (measured in Board development sessions)	(30/06/2021)		
Plan required for the development of the Mental Health, Learning Disability and Autism System Delivery Board to become a provider collaborative.	Plan to be developed in partnership with all other organisations in the collaborative [ACTION OWNER: CEO]	Development and agreement of Mental Health, Learning Disability and Autism Provider Collaborative before December '21.	(30/06/2021)		
Key gaps in assurance:	**Key actions to close gaps in assurances:**	**Impact on risk to be measured by:**	**Expected completion date./(Action review date):**	**Progress against action:**	**Action on track:**
Increased decision-making at a system and/or provider collaborative level may impact on trust-level governance structures becoming obsolete without regular review and change.	Review of trust governance arrangements to be conducted in response to creation of ICS as an NHS Body with Non-Executive and Executive Director representation on the Board and the creation of a provider collaborative for Mental Health, Learning Disability and Autism [ACTION OWNER: CEO/Trust Secretary]	Board level confidence in new and emerging governance structures and ability to gain assurance on DHCFT risks and issues via system level governance regime.	31/12/2021		

Summary Board Assurance Framework Risks 2021_22. Issue 1 Board May 2021

Risk Rating:

The summary score for determining the risk ratings for each risk is shown below. The full Risk Matrix, including descriptors, is shown in the Trusts Risk Management Strategy

Risk Assessment Matrix					
The Risk Score is simply a multiplication of the Consequence Rating x the Likelihood Rating. The Risk Grade is the colour determined from the Risk Assessment Matrix below.					
LIKELIHOOD	**CONSEQUENCE**				
	INSIGNIFICANT 1	**MINOR 2**	**MODERATE 3**	**MAJOR 4**	**CATASTROPHIC 5**
RARE 1	1	2	3	4	5
UNLIKELY 2	2	4	6	8	10
POSSIBLE 3	3	6	9	12	15
LIKELY 4	4	8	12	16	20
ALMOST CERTAIN 5	5	10	15	20	25

Risk Grade/ Incident Potential
Extreme Risk
High Risk
Moderate Risk
Low Risk
Very Low Risk

Action progress:

The colour ratings are based on the following descriptors.

Actions on track for delivery against gaps in controls and assurances:	Colour rating
Action completed	Blue
Action on track to completion within proposed timeframe	Green
Action implemented in part with potential risks to meeting proposed timeframe.	Amber
Action not completed to original or formally agreed revised timeframe. Revised plan of action required.	Red

Action owners:

CEO	Chief Executive Officer	COO	Chief Operating Officer
DOF	Deputy Chief Executive and Executive Director of Finance	DON	Executive Director of Nursing and Patient Experience
MD	Medical Director	DPI	Director of People and Inclusion
DBI&T	Director of Business Improvement and Transformation		

Board Committee Assurance Summary Reports to Trust Board – 4 May 2021

The following summaries cover the meetings that have been held since the last public Board meeting held on 2 March.

Finance and Performance Committee - key items discussed 16 March 2021
IMPACT partnership update Covered progress with East Midlands partnerships and the last three months' discussions.
OnEPR Programme update Discussion on timeframe adjustments for the programme where robust plan was agreed, Committee discussion of the good breadth of clinical engagement with Local Implementation Groups and Clinical Design Authority. Staff resilience as a priority fully supported
Operational Performance Discussion focussed on roadmap of recovery and staff wellbeing. Will be standing up Divisional Achievement meetings to oversee and support performance delivery. Discussed autism assessments, community paediatric referrals, staff redeployments. Non-recurrent CCG funding to clear backlog in children's services that may also help adult pathway (14-25 year old). Discussion of the impact of other partners and what might have the biggest impact quickest. Reviewed content of Integrated Performance Report. Limited Assurance
Update on 24/7 Helpline Discussed the growing evidence of data and feedback. Staff turnover an issue to understand more fully. Data breakdown by additional EDI factors required by Committee. Excellent evidence in data of S136 and admission avoidance and excellent impact demonstrated of the calls being beneficial to staff and callers. Need a view going forward of when to reach 'steady state' and the impact that this will have. Subsequent reporting on helpline which may also blend into Integrated Performance Report content.
Financial governance and plan delivery Discussed month 11 forecasts in paper, in the context of additional recent notifications for annual leave and Flowers provision from NHSIE. Discussion of run rate analysis being done in the system by finance professionals to understand the impact into next year of the current level of COVID expenditure set against levels of fixed 'top up' this year. Focus on cash reporting will be increasing, welcomed by Committee. Discussion of capital this year into next year, Committee supported a cash-retaining approach to business-as-usual capital planning (with safety override) in order to retain as much cash as possible to support unfunded requirements. Discussed estates planning in the system and its inclusion in the expanded role of System Finance Committee

Given the current forecast the Committee were of the opinion that the 2020/21 finance risk was probably more moderate than high, given it was two weeks prior to year-end, but to merely note as opposed to transact in 20/21's BAF.

Board Assurance Framework risk overview

Committee noted the 2020/21 closing BAF, noting that the finance risk would in effect be rated 'moderate', albeit briefly. And that the Committee expected all of its current risks to roll forward, in some form, into the 2021/22 BAF.

Update on Risk 3b including CIP and continuous improvement

This discussion took place instead of a deep dive, given the current financial regime. Focus of discussion was on the benefits we wish to retain post-COVID – e.g. use of technology, (Attend Anywhere, MS Teams) and reduced travel, especially in light of mixed economy of working from home and returning to base. Discussion about importance of sustaining length of stay improvements.

Year-end Review of Committee Effectiveness and review of Terms of Reference

Committee discussed its effectiveness at length i.e. discussion of appropriate matters, proportionate agenda, in light of exec capacity during COVID response and the national guidance on reduced bureaucracy during pandemic response.

Quality of reporting is very good, conversations are inclusive, F&P seen as a model Committee with high quality discussion and papers.

Well-chaired and well-attended and delivered robust assurance. Both Execs and NEDs excellent. Noted that it was helpful that finance is so well managed that allows greater focus on wider factors like operations.

Quality of challenge agreed to be strong and appropriate.

Agreed that objectives were met, noting that for 2021/22 there should be wider discussions for digital strategy more broadly beyond OnEPR, and similar for Estates strategy beyond dormitory eradication and PICU.

Terms of reference updated under emergency powers were accepted.

Forward Plan for 2020/21 and proposed for 2021/22

2021/22 forward plan agreed, subject to Inclusion of reference to digital strategy assurance and inclusion of additional objective to understand the impact of ICS progression on the committee's agenda and vice versa.

Escalations to Board or other Committee(s)

None

Key risks identified

None

Next Meeting: 25 May 2021

Committee Chair: Richard Wright	**Executive Lead: Claire Wright, Deputy Chief Executive / Director of Finance**

Audit and Risk Committee - key items discussed 18 March 2021

Draft Annual Report and Accounts

A progress report was given on the draft Annual Report and Accounts. Mirroring the previous financial year, the requirements had been slimmed down for example a full Quality Report was not required. There were some new requirements mainly around Equality, Diversity and Inclusion. The audit work will start at the end of April, the sign off meeting of 9 June for a submission date of 15 June.

Board Operational Indicators Data Validation

As part of the Committee's monitoring role, it received the Board Operational Indicators Data Validation report which outlined the work that takes place to ensure data quality is maintained at the Trust. The performance indicators are audited every six months through a rolling programme.

The Committee agreed that it is imperative that the information used to manage the Trust is an accurate reflection of the activities undertaken. The information generated is used by all services from Board to Ward and also outside the Trust by NHS England (NHS/E) and the Clinical Commissioning Groups (CCG's) for monitoring.

The internal audit review on Data Quality, programmed into the Internal Audit Plan in Quarter 1 2021/22 will complement the work the Trust already carries out in this area.

Six Monthly Freedom to Speak Up (FTSU) update

The report set out the compliance with the FTSU Policy by listing current FTSU activity, analysis, emerging or ongoing themes, responsiveness, evaluation and training. The FTSU Guardian also gave an overview of the actions taken to improve FTSU culture and addressing barriers to speaking together with an update on the FTSU strategy, the development of which has been placed on hold due to the pandemic.

Committee year-end effectiveness review

The Committee confirmed it had worked effectively with its Terms of Reference and that business had been completed comprehensively. The objectives going forward were felt to be realistic. No changes were required to the Terms of Reference.

Access to Legal Advice Policy and Procedure

The amended Access to Legal Advice Policy and Procedure was ratified. Only minor changes were required, and the policy was drafted in line with current laws and national policy guidance. The Committee noted the legal advice budget was managed well as the Legal Services Manager has oversight of process with an escalation process for spend on complex matters through to the Trust Secretary.

Waiver of Standing Financial Instructions Register

The Committee received the Waiver of Standing Financial Instructions Register for Quarters 2 and 3 of the 2020/21 financial year. There is a robust approval process for the waivers.

Internal Audit Progress Report

The report provides the Committee with updates on progress with the agreed Internal Audit Plan. The 2020/21 Internal Audit Plan is nearing completion. One report had been published on Risk Management providing significant assurance. The Committee received the Head of Internal Audit Opinion Stage Two report and noted that the Stage Three report was underway. The Board Assurance Framework (BAF) benchmarking report was included in the papers which linked to some of the recommendations in the Risk Management report. An update was given on the development of 2021/22 Internal Audit Plan along with the 2021/22 Internal Audit Charter.

<u>Counter Fraud, Bribery and Corruption Progress Report and Draft 2021/22 Counter Fraud Plan</u>

The above report was considered and included information on the new framework for Counter

Fraud.

External Audit Progress Report

Since the Committee last met, Mazars had undertaken additional planning work for the 2020/21 audit, including completing their review of the predecessor's audit file and liaison with key officers. They had also undertaken interim audit work which included documenting systems and controls; completing walkthroughs of key systems, updating the IT risk assessment and undertaken controls testing. The audit was on plan and the audit team would start the audit at the end of April.

Assurance/lack of assurance obtained

- The Committee was assured on the systems the Trust has in place to ensure good quality data is maintained and agreed that the Board can have confidence in the information contained within the reports they receive.
- Assurance obtained around the adequacy of the Trust's arrangements by which Trust staff may, in confidence, speak up about possible improprieties in matters of financial reporting and control and related matters or any other matters of concern.
- Significant assurance provided regarding the discharging of the Committee's duties under its Terms of Reference.
- Significant assurance on the process followed to approve and record waivers.
- Significant assurance through the Head of Internal Audit Opinion Stage Two report.

Decisions made

- Board Operational Indicators Data Validation will be reported to the Committee twice a year.
- Year-end effectiveness to be reported to the Trust Board and agreement of the Committee objectives for 2021/22
- Approval of the Access to Legal Advice Policy and Procedure
- Approval of the 2021/22 Internal Audit Plan and Counter Fraud Plan

Forward Plan

A number of changes to the draft forward plan 2021/22 were noted.

Escalations to Board or other Committee(s)

None identified for this meeting.

Key risks identified

None identified for this meeting.

Next Meeting: 27 April 2021

Committee Chair: Geoff Lewins	**Executive Leads: Claire Wright, Deputy Chief Executive / Director of Finance and Justine Fitzjohn, Trust Secretary**

Quality and Safeguarding Committee - key items discussed 9 March 2021	
Board Assurance Framework (BAF) The Committee reviewed BAF Risk 1a *"There is a risk that the Trust will fail to provide standards for safety and effectiveness as required by our patients and our Board"* and was mindful of emerging risks associated with the commissioning gap in Autism Spectrum Disorder (ASD) Service and was mindful that the previous two patient stories presented to the Board concerned lack of services for Autism. The expectation of what the system can deliver on ASD still needs to be established and taken forward. Clinical recommendation is being obtained from learning from serious incidents and analysis of avoidable admissions. The good headway being made with physical healthcare checks was noted. Physical healthcare will continue to be included in the BAF for 2021/22.	
COVID-19 briefing and COVID vaccination centre governance assurance and COVID-19 Vaccination Policy The Committee was briefed on the number of COVID-19 specific quality and safety items. The position remains stable and significant assurance was received from the vaccination plans within the Trust and from the continued co-ordinated response to the pandemic. Good progress is being made with staff vaccinations. A significant number of patients have now been vaccinated. LD patients are being provided with extra support for vaccination. Staff sickness absence rates have reduced.	
Patient and Carer Experience Report Significant assurance was received from the Patient and Carer Experience Report. That care planning is taking place. The therapeutic relationships involved in care planning is being progressed by enhancing relationships between patients, family and staff.	
Safeguarding Adults Assurance Report Activity has remained high throughout the pandemic and concern was raised about the increase in the type of adult safeguarding referrals and cases that are being dealt with by the team. A significant level of assurance was received that emerging themes are being detected and acted upon to pursue more preventative measures in the future The report also provided significant assurance that statutory requirements continue to be met and there is a safe and appropriate business continuity plan in place for the Safeguarding Unit as we move towards the next phase of the national COVID-19 recovery.	
Safeguarding Children Assurance Report The Safeguarding Children Team has continued to maintain current levels and continues to support CAMHS and children's services in safeguarding case work. The team is on target for completing serious case reviews. Significant assurance was received around Safeguarding Children activity, systems and controls with limited assurance received from current gaps in training. Recovery plans are in place now training has recommenced.	
Key risks identified Risks associated with lack of investment for an Autism Spectrum Disorder (ASD) treatment service.	
Escalations to Board or other committees None	
Next Meeting –13 April 2021	
Committee Chair: Margaret Gildea	**Executive Lead: Carolyn Green, Director of Nursing and Patient Experience**

Quality and Safeguarding Committee - key items discussed 13 April 2021
Board Assurance Framework (BAF) The Committee considered its allocation of BAF risks Board Assurance Framework (BAF) risks and agreed that BAF Risk 1a "*There is a risk that the Trust will fail to provide standards for safety and effectiveness as required by our patients and our Board"* is correctly rated as high.
Risk Register Escalation Assurance Quarterly Report This quarterly report summarised the outline progress with the project, now almost completed, to reduce the number of risk assessments recorded and managed though Datix. The report also provided a summary of the current status of 'red' risks within the context of the project outlined above and included an update on compliance rates for the tiered risk management training programme currently in place, in context of the current restrictions to delivering training. The Committee commended the excellent work undertaken by the Risk and Assurance Manager and Health, Safety and Security Manager to ensure risk management controls are in place and for simplifying the process. The Committee was satisfied that the number of extreme risks identified by operational services remains relatively stable. Significant assurance was received from the report and from the delivery of risk management training over the past year throughout COVID-19 pandemic.
Risk Assessment Procedure The procedure has been significantly updated to reflect the revised model to manage and escalate risks resulting from the project led by the Risk and Assurance Manager and Health, Safety and Security Manager to reduce the number of risk assessments recorded and managed though Datix. The Committee was satisfied that the procedure meets the statutory and national guidance for the Trust to maintain a risk register, supporting appropriate escalation and management. Procedure ratified.
Incident Reporting and Investigation Procedure The updated Incident Reporting and Investigation Procedure ensured the policy is in line with the National Patient Safety Strategy 2019. Its focus is on safety culture and systems, and the people first approach of 'Just Culture'. Policy ratified.
COVID-19 briefing There continue to be no positive COVID-19 cases or outbreaks within community teams or inpatients. General feedback from NHS England (NHSE) has indicated they are pleased with the way the Trust has managed outbreaks and kept them to a minimum. Public Health England has also praised the Trust's good practice in ensuring patients and staff are well cared for.
Thematic Review into Community COVID-19 Deaths 2020-21 The Committee considered a thematic review into COVID-19 deaths within the community from March 2020 to March 2021. The data has been reviewed with specific focus on demographic, location, teams and patient demographic. The Committee had no concerns in relation to the current process and was assured that the Trust is not an outlier. Significant assurance was obtained from the issues highlighted.
Quality Performance Dashboard The Dashboard provided a summary of highlights and challenges through the use of high level quality indicators, identified in line with the quality elements of the Trust Strategy and the Trust's Quality Priorities. The dashboard also provided an update with regards to current CQC actions that require a response.

The Committee took significant assurance that indicators contained in the dashboard are showing positive results.

Remodelling of the Trust's Services in the Community Framework

A verbal briefing updated the Committee on the programme of work to remodel the Trust's services in the community framework. It was understood that the clinical governance of different partner organisations is being looked at in order to establish the most efficient processes as well as a common policy.

The Committee noted that the new community mental health framework offers a unique opportunity to tackle diversity issues involving different organisations in the delivery of mental health provision and looked forward to a full report being brought to the next meeting in May.

Serious Incidents (SI) Bi-Monthly Report

The Committee considered that the SI review system to be well managed and received significant assurance from the report.

Quality Account

The purpose of the Quality Account (QA) is to ensure continuing public accountability for how safety and quality of care issues are managed by the Trust.

The draft QA was issued to Committee members for comment prior to the QA going out to a 30 day consultation with stakeholders including CCG, HealthWatch, service users and the EQUAL Forum. Working on the assumption that the submission date will be 30 June, a final version of the QA will be taken to the June meeting of the Committee for sign off on behalf of the Board.

Report from the Trust's Guardian of Safe Working (GOSW)

This extended report from the Trust's GOSW provides data about the number of junior doctors in training in the Trust, full transition to the 2016 Junior Doctor contract and any issues arising. The report details arrangements made to ensure safe working within the new contract and arrangements are in place to identify, quantify and remedy any risks to the organisation.

The report showed a promising position and was approved for submission to the Trust Board on 4 May.

Chief Pharmacist's Report

This was an interim report on the current status of Medicines Optimisation and the Pharmacy Department and enabled review of any impact of the pandemic. Areas of concern included:

- Functionality with implementation of electronic prescribing and medicines administration (ePMA) as part of the OnEPR project: The Committee considered that given time the system will be fit for purpose. It will not affect the roll out of the system but it will affect electronic prescribing. Feedback from the Director of Business Improvement and Transformation, who is leading OnEPR is to be provided to the Committee at the next meeting in May.

- There remains a persistently low uptake of required medicines-related training across the Trust. This echoes the overall training position during the pandemic and will be addressed by the Medicines Safety and Practice sub-committee of the Medicines Management Committee as the pressures of the pandemic ease. A drive to improve the persistently low uptake of required medicines-related training is to be prioritised. The Medical Director assured the Committee that strict medicine management protocols are in place for avoiding incidents, this ensures minor lapses are avoided and prevents major incidents occurring. The Medical Director is to look at the link between training and incidents and will bring a report to the next meeting in May that will assess whether the number of medicine incidents per month are an issue that need to be declared.

Special Educational Needs and Disability (SEND) internal action plan update

The Special Educational Needs and Disability (SEND) internal action plan update developed as a response to the Derby City Council – Written Statement of Action (WSOA) was received for consideration. The long standing issues with capacity in children's services (waiting times in CAMHS and Community Paediatrics) and capacity in 0-19 services previously discussed by the Committee were noted as a persistent concern. Despite the significant work currently being carried out around workforce planning in SEND services it was acknowledged that much of the delivery responsibility lies with the local authority and the CCG who commission the health services and their support is key to improving access.

Overall, this is a worrying situation that needs to be monitored. It is hoped that the workforce development and support from local authorities will improve the position. The Committee received limited assurance from the update report and action plan and requested that the Director of Nursing and Patient Experience provides a report for the June meeting outlining how access to SEND services can develop to a satisfactory level going forward.

Quality and Safeguarding Committee Year-End Review and Review of its Terms of Reference

The Committee reviewed and discussed its activity and effectiveness, comparing the work of the Committee to its Terms of Reference (ToR) taking account of the Committee's monthly meetings held during 2020/21.

Although a lighter approach had been taken to governance throughout the COVID-19 pandemic in order to ease the burden on Executive Directors, activity throughout the year has been thorough and has substantially met the commitments of the forward plan. All meetings have been quorate and were effectively held through the use of MS Teams. Papers supporting agenda items have improved and are more concise and focused and have been well scrutinised and honestly debated. Actions have been taken forward and assurance has been received as to their completion.

Meetings have been an efficient use of Executive Director time and have been well chaired. Combining the Safeguarding agenda within the Quality agenda has worked well. Overall, the Committee was satisfied it had met its obligations and key responsibilities.

The Committee also considered and agreed revisions to its ToR. Of note this year has been the flexibility for the Committee to act under emergency ToRs and state that either the Executive Lead, DON or MD must be in attendance.

Policy Review

The Safeguarding Adults Policy and Procedures and the Central Alert System Policy and Procedure were both reviewed and ratified.

Key risks identified

None

Escalations to Board or other committees

The People and Culture Committee is to provide assurance of mitigating action to be taken to improve training compliance for Immediate Life Support and Conflict Resolution

Next Meeting – 11 May 2021

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

People and Culture - key items discussed 12 April 2021

Attendance at this meeting was restricted to the Committee's Executive Lead, and Non-Executive Directors to enable other Executive Directors to attend essential operational meetings in response to the second wave of the pandemic.

Board Assurance Framework (BAF)

The summary of Board Assurance Framework (BAF) risks assigned to the People and Culture Committee was noted.

It was agreed at the previous meeting that risk 2a "*There is a risk that we do not create a healthy vibrant culture and conditions to make DHCFT a place where people want to work, thrive and to grow their careers"* would remain rated extreme because the Trust is still responding to the pandemic and the recovery processes. The Committee mindful that due to a number of risk factors that are COVID-19 specific risk 2a should remain rated as extreme.

People and Inclusion Performance Dashboard

This new and improved People and Inclusion Performance Dashboard was linked to the strategic building blocks and showed encouraging progress identified from the performance indicators. Strategically focussed discussion highlighted areas for further investigation and deep dives. This included women's experience in recruitment. Also, the need to refrain from using acronyms such as BAME. The Committee requires specific reporting at individual community level for all future reports.

Escalation from the Quality and Safeguarding Committee

In response to the Quality and Safeguarding Committee asking for assurance of mitigating action to be taken to improve training compliance for Immediate Life Support and Conflict Resolution a report from the Head of People Development showed that significant improvements are evidenced by current compliance:

- Immediate Life Support (target 75%) current compliance at March 2021 82.95%
- Conflict Resolution (target 75%) current compliance March 2021 70.76%

Evidence of improvement will be fed back to the Quality and Safeguarding Committee in May.

Escalation from the Mental Health Act Committee

At the March meeting of the Mental Health Act Committee discussion took place on how positive action can be taken to ensure staff are given time to recover from intensive work responding to COVID-19 and be given the ability to leave their regular clinical work and attend training sessions. The idea that training and development can be used as part of the recovery plan was escalated to the People and Culture Committee. The Committee discussed this approach and it will be taken through restorative activities such as supervision and personal development and will also be taken forward the training programme across the Trust.

The Mental Health Act Committee will be updated on the approach to be taken in June.

Future Resources

The report provided the Committee with an outline plan on mobilising the Community Mental Health Framework (CMHF) and other associated funding in line with the NHS Long Term Plan for investments in Mental Health Services and gave an overview of the recruitment plan. This has been demonstrated in the Workforce Resources Delivery Plan submitted to the Board on 4 May outlining how the Trust will deliver the objectives of the NHS Long Term Plan, and the People Plan while supporting the system-wide workforce transformation projects.

2020 Staff Survey Results

Having reviewed the results the Committee received significant assurance from the 2020 NHS Staff Survey – NHS England results based on the consistent response rate, during a challenging

year and the fact that every one of the themes has improved compared the 2019 NHS Staff Survey – no theme saw a decline in results.

Health and Wellbeing Update

The Committee received a verbal briefing on the new health risk assessment being relaunched across the Trust. New guidance provided to line managers has been made more comprehensive and itemises the available resources for staff when completing a health risk assessment.

Strategic Priorities for People

Slides setting out the strategic priorities for people highlighted the national priorities and solid platform from which to build outstanding and excellence through People and Inclusion.

Some of the next steps will include establishing a clear operating model at system level, ensuing that wellbeing plans at individual and team level are in place and thematic issues identified, support for teams to embed and/or develop new ways of working, support of transformation programmes and a continued management of the pandemic risk and response.

Modern Slavery Statement for 2020/21

The proposed version of the Trust's Annual Modern Slavery Statement for 2020/21 satisfied the Committee that the Trust has met the criteria for the preceding financial year. The Annual Modern Slavery Statement was accepted for submission to the Board for approval at the next meeting on 4 May for uploading to the Trust's website, replacing the previous version.

Year-End Effectiveness Review and review of Terms of Reference

The Committee reviewed its activity and effectiveness, comparing the work of the Committee to its Terms of Reference (ToR) taking account of the Committee's bi-monthly meetings held during 2020/21. The Committee was satisfied that it had discharged its responsibilities and noted the significant extent of the work it has monitored throughout the year. All meetings have been quorate despite attendance having been restricted to the Committee's Executive Lead, and Non-Executive Directors to enable Executive Director members to attend essential operational meetings in response to the pandemic.

The ToR that had been revised under emergency powers were accepted.

Escalations to Board or other Committees

None

Key risks identified

None

Next Meeting – 24 May 2021

Committee Chair: Julia Tabreham	**Executive Lead: Jaki Lowe, Director of People and Inclusion**

Mental Health Act Committee - key items discussed 12 March 2021

Mental Health Act (MHA) Report

The report contained an analysis and assessment based on a twelve month period and was considered section by section. The report had also been extensively covered by the MHA Operational Group on 15 February.

Attention was drawn to legal aspects concerning remote MHA assessments as it has been confirmed that MHA assessments should generally not be conducted virtually although second opinion appointed doctor (SOAD) assessments can be. In terms of conducting face to face MHA assessments it was confirmed that the Trust is entirely compliant. Remedial action has been taken with any patients who previously have been virtually assessed in keeping with these guidelines. Doctors have been provided with written guidance so they are aware of how assessments and renewals are to be completed under the different sections and CTOs (Community Treatment Orders).

The Committee received significant assurance from the report and considered that the MHA Office has good control of the processes it has in place.

White Paper on the Mental Health Act

Following an independent review of the MHA in 2017 the government is consulting on the subsequent White Paper. The Committee discussed the planned consultation process and how the Trust can respond individually and through the System Delivery Board and NHS Providers by 21 April.

The Trust will be consulting widely with two local authorities and service user groups and a report will be taken to the Executive Leadership Team (ELT) in order to decide on the Trust's collective response once engagement with Associate Hospital Managers (AHMs), governors and the BAME and LGBT+ networks has taken place and feedback has been received from the JUCD Delivery Board. The final response will be received at the next Committee meeting in June.

Section 135/136 Update

The Committee considered the update on the CQC action plan for the Health Based Places of Safety at the Radbourne and Hartington Unit and the work plan for the Section 135/136 MHA Group.

Prior to the COVID-19 pandemic a slight upward trend in Section 136 detentions was evident within Derbyshire, particularly in the south of the county. The steady increase of detentions is a national picture. When 'lockdown' commenced in April 2020 there was a sharp increase of S136 detentions, for the Trust, carrying on through to October. November saw figures closer to that of pre-lockdown but this was short lived with December and January's figures raising again.

It is clear that the Covid-19 pandemic has had a significant impact on people's lives. This has resulted in a further increase of detentions on top of the already gradual national increase. The Committee noted that number of repeat admissions were due to drug and alcohol problems and most of these individuals were already known to mental health services. This has resulted in some extremely aggressive patients or intoxicated patients being brought to 136 Suites.

The report provoked a very interesting discussion on all the factors that have fed into 136 detentions and implications for estate development. The Committee noted the current position of the ongoing work in the Section 136/136 Group and received limited assurance with the work completed so far with the CQC action plan. The reasons behind S136 figures are complex. A deep dive review of all these factors is underway and will be brought to the next meeting in June.

Training Compliance Update

As a result of COVID-19, all non-essential training had been paused so that services could concentrate on the immediate task of supporting vital areas of service. A significant amount of training is now being delivered through Level 3 Safeguarding training. E-learning on other modules is included in Safeguarding Levels 1 and 2 via MS Teams.

The report was brought to the Committee so that the depth of work taking place to improve compliance levels can be appreciated. There is now a focus on catching up with training now that services are recovering from the pandemic.

Discussion took place on how positive action can be taken to ensure staff are given time to recover from intensive work responding to COVID-19 and be given the ability to leave their regular clinical work and attend training sessions. The idea that training and development can be used as part of the recovery plan is to be escalated to the People and Culture Committee.

The Committee took limited assurance from the report. It was accepted that the CQC will not accept COVID-19 as an excuse for any lapses. It will be important to give evidence that the Trust has a training recovery plan. This will be escalated to the People and Culture Committee for discussion at the next meeting in April so that training and development can be built into the recovery plan for staff.

Year-End Effectiveness Review and review of Terms of Reference

The Committee reviewed its activity and effectiveness, comparing the work of the Committee to its Terms of Reference (TOR).

Taking account of the priorities and focus undertaken across the quarterly meetings held from June 2020 to March 2021 the Committee confirmed it was satisfied that it had fulfilled its responsibilities in obtaining assurance on behalf of the Hospital Managers and the Trust as the detaining authority that the safeguards of the Mental Health Act (MHA), Mental Capacity Act (MCA), Deprivation of Liberty Safeguards (DOLS) and Human Rights Act have been appropriately applied.

It was agreed that all meetings have been an efficient use of Executive Director time and have been well chaired. The opportunity to work flexibly throughout the year via MS Teams was appreciated. Activity throughout the year included regular review of the use of restrictive practice and seclusion activity and use of Section 135 and 136 detentions in Derbyshire. At each quarterly meeting the Committee has reviewed operational activity reported through its sub-group the Mental Health Act Operational Group. The Committee has also monitored related statute and guidance following Mental Health Act inspections by the Care Quality Commission.

The revised Terms of Reference that had been updated under emergency powers in response to the COVID-19 pandemic were considered and approved.

Escalations to Board or other Committee(s)

The idea that training and development can be used as part of the recovery plan is to be escalated to the People and Culture Committee.

Key risks identified

None

Next Meeting – 11 June 2021

Committee Chair: Dr Sheila Newport, Non-Executive Director	**Executive Lead: Dr John Sykes Medical Director**

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 4 May 2021

Report from the Council of Governors meetings held on 2 March 2021 and 1 April 2021

The Council of Governors has met twice since the last report. The first meeting was held on 2 March 2021 followed by an extraordinary meeting that was convened on 1 April 2021. Following national guidance on keeping people safe during COVID-19 and the need for social distance, both meetings were conducted digitally via Microsoft Teams.

Council of Governors meeting held on 2 March 2021

Chief Executive Update

Ifti Majid provided the meeting with an update on the current situation regarding the COVID-19 pandemic which included:

- The third wave levels are decreasing
- National measures to take England out of lockdown begin on 8 March; but the pandemic continues to be a risk
- The number of people dying from COVID-19 has significantly decreased
- The vaccination programme is going well. Over 20 million people have received the first dose and over 70,000 have received the second dose
- The R number in the West Midlands ranges between 0.6 and 0.9 – the vaccination programme should help to reduce these figures
- Incident rates are decreasing across England with 176 per 100,000 people in Derbyshire – but there are variations across Derby City
- 13 patients have COVID-19 on the wards; Audrey House has been stood up to house these patients. Staff are continuing to be vigilant and complying with measures to reduce the impact of COVID-19 (i.e. following the robust infection, prevention and control procedures)
- Staff absence due to COVID-19 has reduced to 2%
- 80% of colleagues have now received the vaccination and the Trust's own vaccination hub for colleagues and patients is now up and running. The vaccination hub has received very positive feedback
- Frontline colleagues continue to carry out lateral flow tests twice a week. These are followed up with a PCR test if colleagues test positive.

Non-Executive Director Deep Dive Report

Julia Tabreham, Chair of the People and Culture Committee (PCC) and Non-Executive (NED) Lead for Freedom to Speak Up (FTSU) presented her Deep Dive to governors. It included a summary of her activities over the past year.

Update on the Trust's 24/7 Mental Health Support Line

The Area Service Manager, Assessment Services, delivered a presentation on the Trust's 24/7 mental health support line and was supported by the Service Manager from the Hartington Wing; and colleagues from the P3 charity who co-produced the service.

Escalation of items to the Council of Governors
Four items of escalation were received from the Governance Committee meetings held on 10 December 2020 and 9 February 2021:

Question one:
Governors, in carrying out their engagement work, are continuing to hear issues about the transition from Child and Adolescent Mental Health Service (CAMHS) to adult services. How are Non-Executive Directors (NEDs) assured that changes are being made to help service users through the transition to adult services? Can NEDS confirm whether this is also being addressed through the Joined Up Care Derbyshire (JUCD) Mental Health System Delivery Board? Has the promised review of the age to 24 under the Long Term Plan for transition been implemented?

Question two:
How are the NEDS assured that services provided to children and young people are meeting current needs of children and young people (particularly in the 16 – 18 year group) where there is an increase in self-harm and mental health issues reported by schools?

Question three:

How are the NEDs assured that the JUCD Integrated Care System and the Trust is planning for and able to meet the current and future increasing demand for mental health services, at both System and Trust level?

Question four:

How are the NEDs assured that SystmOne and shared care records programmes are being successfully delivered and what improvements in the care of services users will be expected to be seen?

The responses were tabled at the meeting.

Summary Integrated Performance Report
The Integrated Performance Report (IPR) was presented to the Council of Governors to provide an overview of the performance of the Trust. The NEDs reported on how the report had been used to hold Executive Directors to account in their respective Board Committees for areas with regards to workforce, finance, operational delivery and quality performance.

Update on the Forthcoming Elections
Reference was made to NHS Improvement's (NHSI) recently updated reducing the burden letter to release capacity in the NHS to deal with the pandemic which included the opportunity for Trust's to pause governor elections if necessary. After some discussion the Council of Governors agreed that elections will take place because they were paused last year. The following seats will be promoted in the elections:

- Public Governor – Bolsover and North East Derbyshire (two seats)
- Public Governor – Chesterfield (one seat)
- Public Governor – High Peak and Derbyshire Dales (one seat)
- Staff Governor – Admin and Allied Support (one seat)
- Staff Governor – Allied Professions (one seat)

- Staff Governor – Nursing (two seats)

The Council were informed of the election timescale as follows:

- Nominations open – 31 March and close 19 April
- Notice of poll published 7 May and voting packs despatched 10 May
- Close of elections – 28 May and results declared 31 May new terms of office begin 2 June.

Governance Committee Report
Julie Lowe, Deputy Chair of the Governance Committee presented a report of the meetings held on 10 December 2020 and 9 February 2021. The meetings were attended by 52% and 72% of the Council of Governors respectively. The theme for the Annual Members' Meeting has been approved by the Chief Executive; the Governor Code of Conduct has been reviewed; the Governors Annual Effectiveness Survey will be carried out in September 2021; the Engagement Task and Finish Group met to review the 2018-2021 Membership Strategy, recommending that it is fit for purpose until 2024; and Julie Lowe has been elected Chair of the Governance Committee.

Council of Governors extraordinary meeting held on 1 April 2021

Proposal to Amend the Trust's Public Constituency Boundaries and Related Amendment to The Trust's Constitution
The Council agreed to approve the Trust Board's proposal:

- To extend the boundaries of the Trust's current 'surrounding areas' public constituency to create a 'Rest of England' public constituency and;
- To make the required amendments to the Trust Constitution as detailed above.

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
ACP	Advanced Clinical Practitioner
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
ARC	Audit and Risk Committee
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
BME	Black Minority Ethic
BAME	Black, Asian & Minority Ethnic
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

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Term / Abbreviation	**Terms in Full**
CQI	Clinical Quality Indicator
CQUIN	Commissioning for Quality and Innovation
CRB	Criminal Records Bureau
CRG	Clinical Reference Group
CRHT	Crisis Resolution and Home Treatment Teams
CRS	(NHS) Care Records Service
CRS	Commissioner Requested Services
CSF	Commissioner Sustainability Fund
CTO	Community Treatment Order
CTR	Care and Treatment Review
D	
DAT	Drug Action Team
DBS	Disclosure and Barring Service
DBT	Dialectical Behavioural Therapy
DfE	Department for Education
DCHS	Derbyshire Community Health Services NHS Foundation Trust
DDCCG	Derby and Derbyshire Clinical Commissioning Group
DHCFT	Derbyshire Healthcare NHS Foundation Trust
DIT	Dynamic Interpersonal Therapy
DNA	Did Not Attend
DH	Department of Health
DoLS	Deprivation of Liberty Safeguards
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
EDI	Equality, Diversity and Inclusion
EDS2	Equality Delivery System 2
EHIC	European Health Insurance Card
EHC	Education, Health and Care (plans)
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
EPRR	Emergency Preparedness, Resilience and Response
EPR	Electronic Patient Record
ERIC	Estates Return Information Collection
EQAL	Forum where we can seek patient engagement
ESR	Electronic Staff Record
EUPD	Emotionally Unstable Personality Disorder
EWTD	European Working Time Directive

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Term / Abbreviation	**Terms in Full**
F	
FBC	Full Business Case
FFT	Friends and Family Test
FOI	Freedom of Information
FRRT	Functional Rapid Response Team
FSR	Full Service Record
FT	Foundation Trust
FTE	Full-time Equivalent
FTN	Foundation Trust Network
FTSU	Freedom to Speak Up
FTSUG	Freedom to Speak Up Guardian
F&P	Finance and Performance
5YFV	Five Year Forward View
G	
GDPR	General Data Protection Regulation
GGI	Good Governance Institute
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
IMT	Incident Management Team
OOA	Outside of Area
IPC	Integrated Personal Commissioning
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

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Term / Abbreviation	**Terms in Full**
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
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
MHAC	Mental Health Act Committee
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
NGO	National Guardians Office
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
OPMH	Older People Mental Health
OP	Out Patient
OSC	Overview and Scrutiny Committee
OT	Occupational therapy
P	
PAB	Programme Assurance Board

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Term / Abbreviation	**Terms in Full**
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
PCC	People and Culture Committee
PDSA	Plan, Do, Study, Act
PEEP	Personal Emergency Evacuation Plan
PHE	Public Health England
PICU	Psychiatric Intensive Care Unit
PID	Project Initiation Document
PiPoT	People in Positions of Trust
PLACE	Patient Led Assessments of Care
PLIC	Patient Level Information Costs
PMLD	Profound and Multiple Disability
PPE	Personal Protective Equipment
PPI	Patient and Public Involvement
PPT	Partnership and Pathway Team
PREM	Patient Reported Experience Measure
PROMS	Patient Reported Outcome Measure
PSF	Provider Sustainability Fund
PSIRF	Patient Safety Incident Review Framework
Q	
QAG	Quality Assurance Group
QC	Quality Committee
QIA	Quality Impact Assessment
QIPP	Quality, Innovation, Productivity Programme
QSC	Quality and Safeguarding Committee
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
RIDDOR	Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013
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 Incident(s)
SID	Senior Independent Director
SIRI	Serious Incident Requiring Investigation
SLA	Service Level Agreement
SLR	Service Line Reporting

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Term / Abbreviation	**Terms in Full**
SMI	Serious Mental Illness
SOAD	Second Opinion Appointed Doctor
SOC	Strategic Options Case
SOF	Single Operating Framework
SPL	Shielded Patient List
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	
VO	Vertical Observatory
W	
WDES	Workforce Disability Equality Standard
WRES	Workforce Race Equality Standard
WSoA	Written Statement of Action
WTE	Whole Time Equivalent
Y	
YTD	Year to Date

2020-21 Board Annual Forward Plan

Exec Lead	Item	4 May 21	6 Jul 21	7 Sep 21	2 Nov 21	18 Jan 22	1 Mar 22
	Paper deadline	**27 Apr**	**29 Jun**	**31 Aug**	**26 Oct**	**11 Jan**	**22 Feb**
Trust Sec	Declaration of Interests	X	X	X	X	X	X
DOM	Patient Story	X	X	X	X	X	X
CHAIR	Minutes/Matters arising/Action Matrix	X	X	X	X	X	X
CHAIR	Board review of effectiveness of meeting	X	X	X	X	X	X
CHAIR	Board Forward Plan (for information)	X	X	X	X	X	X
CHAIR	Summary of Council of Governors meeting (for information)	X	X	X	X	X	X
CHAIR	Chair's Update	X	X	X	X	X	X
CEO	Chief Executive's Update	X	X	X	X	X	X
STRATEGIC PLANNING AND CORPORATE GOVERNANCE							
COO/DOF	NHSI Financial Annual Plan Month 7-12 2021/22				X		
DPI	Staff Survey Results	X					Headlines
DPI	Annual Gender Pay Gap Report for approval						X
DPI	Workforce Race Equality Standard (WRES) prior to submission end Oct 2021			X			
DPI	Workforce Disability Equality Standard (WDES) prior to submission end Oct 2021						X
DPI	2021/22 Flu Campaign	Summary result of 2020/21 campaign		X			
DPI	People Plan Annual Report						A
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	Annual Approval of Modern Slavery Statement	X					
Committee Chairs	Board Committee Assurance Summaries (following every meeting	X	X	X	X	X	X
COO	Annual Emergency Planning Report (EPPR)					X	
DBI&T	Business Plan Monitoring close down of 2020/21 (May) Proposal for 2021/22 (Jul)	X	X				
DBI&T	Learning Disabilities Clinical Strategy	X					
DBI&T	Mental Health, Learning Disability and Autism Annual summary	X					
DBI&T/CEO	Trust Strategy Review (incorporated within CEO Report)	X			X		
OPERATIONAL PERFORMANCE							
DON/DOF/ DPI/COO	Integrated performance and activity report to include Finance, People, performance and Quality Dashboard	X	X	X	X	X	X
DPI	Workforce Race Equality Standard (WRES) Workforce Disability Equality Standard (WDES)						X
DON/COO/DPI	Workforce Standards Formal Submission/Safer Staffing (prior to going on website)	X					

Exec Lead	Item	4 May 21	6 Jul 21	7 Sep 21	2 Nov 21	18 Jan 22	1 Mar 22
QUALITY GOVERNANCE							
	Quality Position Statement Report - focus on CQC domains (Well Led CQC & NHSI (Trust Sec) as per schedule - Caring led by DON to go to April 2022		Safety MD	Well Led Trust Sec	Effective DON & DPI	Use of Resources DOF	Responsive COO
MD	Learning from Deaths Mortality report (quarterly publication) (Jul/Nov/Jan/Mar)		X		X		
MD	Guardian of Safe Working Report	X			X		X
MD	NHSE Return on Medical Appraisals sign off - delayed for 2020/21						
DON	Control of Infection Report			A			
MD	Re-validation of Doctors			X			
DON	Receipt of Annual Reports: - Annual Looked After Children - Safeguarding Children and Adults at Risk				X		
DON	Outcome of Patient Stories - every two years					X	
POLICY REVIEW							
DOF	Standing Finance Instructions Policy and Procedures						X
Trust Sec	Engagement between the Board of Directors and CoG (Nov 2022)						
Trust Sec	Fit and Proper Person Policy						X