Derbyshire Healthcare
NHS Foundation Trust

Derbyshire Healthcare NHS Foundation Trust
Council of Governors' Meeting

Virtual MS Teams meeting

7 September 2021 14:00 - 7 September 2021 16:25

INDEX

Derbyshire Healthcare NHS Foundation Trust

COUNCIL OF GOVERNORS' MEETING – TUESDAY 7 SEPTEMBER 2021 FROM 2.00-4.25PM

Following national guidance on keeping people safe during COVID-19 all face to face meetings have been cancelled. This will be a virtual meeting conducted digitally.

AGENDA		LED BY	TIME
1.	Welcome, introductions and Chair's opening remarks Apologies and Declaration of Interests	Caroline Maley	2.00
2.	Submitted questions from members of the public	Caroline Maley	2.05
3.	Minutes of the previous meetings held on – 4 May and 6 July 2021	Caroline Maley	2.10
4.	Matters arising and actions matrix	Caroline Maley	2.15
5.	Chief Executive's update (verbal)	Ifti Majid	2.20
STATUATORY ROLE			
6.	Presentation of the Annual Report and Accounts 2020/21 and report from the External Auditors	Claire Wright, Geoff Lewins, external auditors	2.35
7.	Lead Governor role	Caroline Maley	2.50
HOLDING TO ACCOUNT			
8.	Non-Executive Directors Deep Dive (including Annual Report of Audit and Risk Committee)	Geoff Lewins	3.00
COMFORT BREAK			3.10
9.	Escalation items to the Council of Governors from the Governance Committee (verbal)	Caroline Maley	3.20
10.	Verbal summary of Integrated Performance Report (full report provided for information)	Non-Executive Directors	3.25
OTHER MATTERS			
11.	Mental Health, Autism and Learning Disabilities Board (verbal)	Ifti Majid	3.45
12.	Governance Committee Report – 15 June and 10 August 2021	Julie Lowe	4.05
13.	Any Other Business	Caroline Maley	4.15
14.	Review of meeting effectiveness and following the principles of the Code of Conduct	Caroline Maley	4.20
15.	Close of meeting	Caroline Maley	4.25
FOR INFORMATION			
16.	Minutes of the Public Board meetings held on 4 May 2021 and 6 July 2021*		
17.	Chair's Report as presented to Public Trust Board on 6 July 2021 and 7 September 2021*		
18.	Chief Executive's Report as presented to Public Trust Board on 6 July 2021 and 7 September 2021*		
19.	Governor meeting timetable 2020/21		
20.	Glossary of NHS terms		
Next Meeting: Tuesday 2 November 2021, from 2.00pm. This will be a virtual meeting.			

Please note that this meeting will be followed by a brief confidential Council of Governors to approve the minutes from the confidential Council of Governors held on 6 July 2021.

* These reports will be available to view on the Trust's website. Click on the 2021 drop down menu and select '7 September 2021 agenda and papers'.

Our vision

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

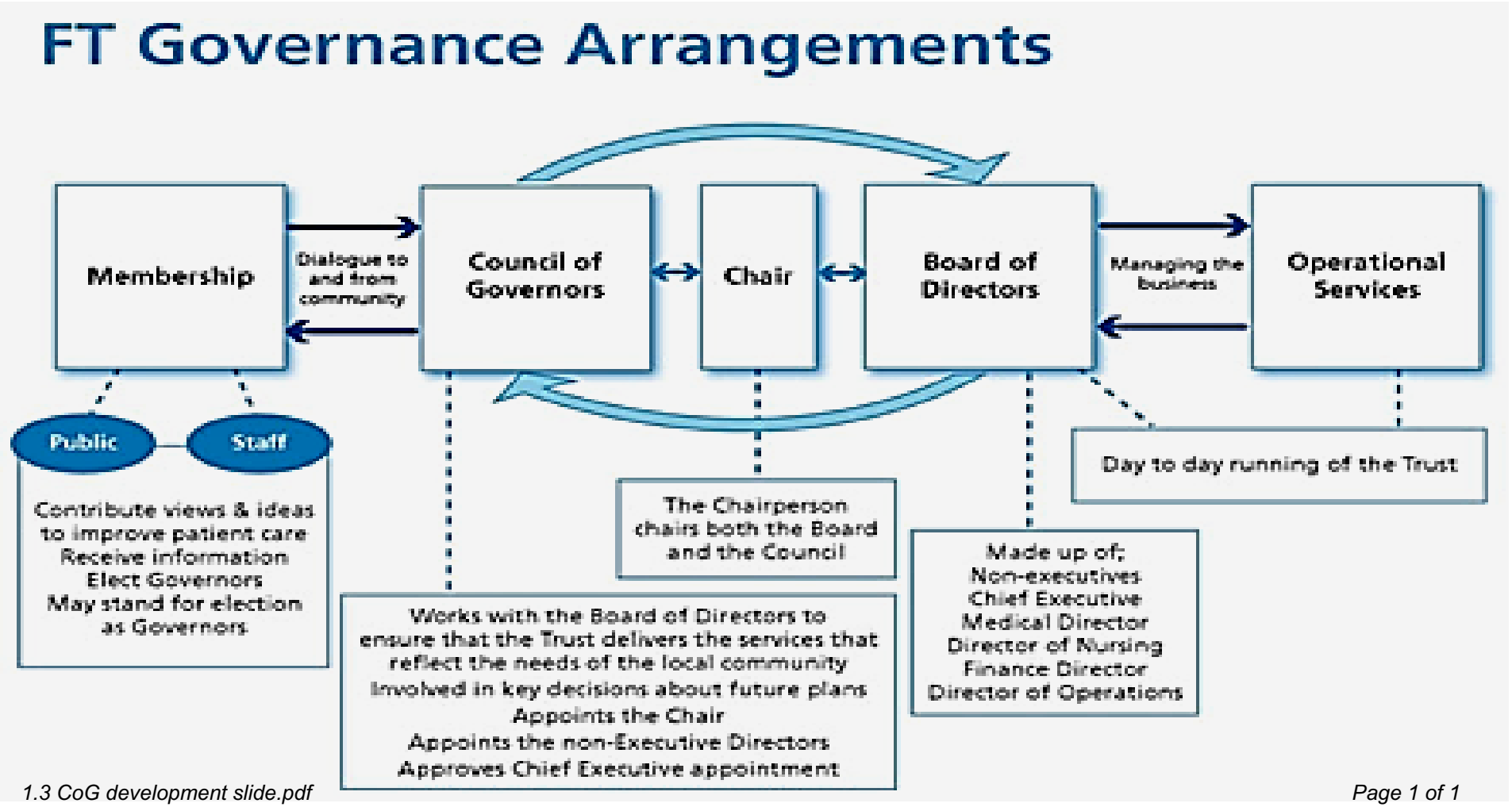
Our values

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.

Getting the balance right



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The implications for governors and 'holding to account'

- How are the Board complying with best practice – and obligations ?
- How are the Board reaching the right decisions ?
- How are the Board assuring themselves that the trust is delivering safe and effective care ?

❖ The performance of the Trust is the Board's concern;

❖ The performance of the Board is the Governors' concern !

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how do we ask effective questions?

Good questions

- Help us clarify, explore, open things up, see the whole picture
- Help us identify underlying causes, impacts and patterns
- Help us understand and empathise
- Help us gain fresh perspectives and new ways of seeing
- Help us get to the crux of an issue or problem and reframe it

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how do we ask effective questions?

Good questions

- Allow us to diverge and examine issues before we converge on an answer or solution
- Encourage us to listen and reflect
- Help us offer and get ideas and insights
- Help us learn and be more creative
- Help us hold to account
- Help us gain assurance
- Help us make a difference

Derbyshire Healthcare NHS Foundation Trust

MINUTES OF COUNCIL OF GOVERNORS MEETING HELD ON TUESDAY 4 MAY 2021, FROM 14.00-16.30 HOURS MEETING HELD DIGITALLY VIA MICROSOFT TEAMS

PRESENT	Caroline Maley	Trust Chair and Chair of Council of Governors
	Valerie Broom	Public Governor, Amber Valley
	Susan Ryan	Public Governor, Amber Valley
	Rob Poole	Public Governor, Bolsover and North East Derbyshire
	Lynda Langley	Public Governor, Chesterfield and Lead Governor
	Julie Lowe	Public Governor, Derby City East
	Carole Riley	Public Governor, Derby City East
	Stuart Mourton	Public Governor, Derby City West
	Orla Smith	Public Governor, Derby City West
	Andrew Beaumont	Public Governor, Erewash
	Christopher Williams	Public Governor, Erewash
	Julie Boardman	Public Governor, High Peak and Derbyshire Dales
	Kevin Richards	Public Governor, South Derbyshire
	Rosemary Farkas	Public Governor, Surrounding Areas
	Marie Hickman	Staff Governor, Admin and Allied Support Staff
	Kel Sims	Staff Governor, Admin and Allied Support Staff
	Jo Foster	Staff Governor, Nursing
	Dr Farina Tahira	Staff Governor, Medical
	Rachel Bounds	Appointed Governor, Derbyshire Voluntary Association
	Jodie Cook	Appointed Governor, Derbyshire Mental Health Forum
	Dr Stephen Wordsworth	Appointed Governor, University of Derby
	Cllr Roy Webb	Appointed Governor, Derby City Council
IN ATTENDANCE	Margaret Gildea	Non-Executive Director and Senior Independent Director
	Ashiedu Joel	Non-Executive Director
	Geoff Lewins	Non-Executive Director
	Julia Tabreham	Non-Executive Director
	Richard Wright	Non-Executive Director
	Ifti Majid	Chief Executive
	Carolyn Green	Executive Director of Nursing and Patient Experience
	Justine Fitzjohn	Trust Secretary
	Lee Doyle	Acting Director of Operations
(For Item 016 only)	John MacDonald	Independent Chair, Joined Up Care Derbyshire (JUCD)
(For Item 016 only)	Martin Whittle	Chair of JUCD Engagement Committee
	Denise Baxendale	Membership and Involvement Manager
APOLOGIES	Carol Sherriff	Public Governor, High Peak and Derbyshire Dales
	Al Munnien	Staff Governor, Nursing

ITEM	ITEM
DHCFT/GOV /2021/019	**WELCOME, INTRODUCTIONS, CHAIR'S OPENING REMARKS, APOLOGIES FOR ABSENCE & DECLARATION OF INTERESTS** Caroline Maley welcomed all to the meeting especially to John MacDonald and Martin Whittle. She reminded everyone that the meeting was being streamed for public viewing. The apologies were noted; and no interests were declared.
DHCFT/GOV /2021/020	**THE INTEGRATION WHITE PAPER – GOVERNANCE** John MacDonald, Independent Chair Joined Up Care Derbyshire (JUCD) and Martin Whittle, Chair of JUCD Engagement Committee delivered a presentation on exploring future opportunities for governors to influence JUCD Integrated Care

	System (ICS). He emphasised that the purpose of the ICS was for the people of Derby and Derbyshire to have the best start in life, to live well, age well and die well. John referred to the following: • JUCD is now officially designated as an ICS • The Government's recently published white paper on the future of ICS's which focuses on: - The health and social care system and the importance of transformation - Partnership working - Reducing bureaucracy and duplications - Strategic commissioning and strategic provision - The NHS's role in wider determinants of health. He explained that this will mean: • JUCD ICS will become a statutory body • Clinical Commissioning Group (CCG) statutory functions will transfer into the ICS • Establishment of an ICS NHS Board and a Health and Social Care Partnership • There will be no national blueprint. John also explained that the timescales are clear and the transition to become an ICS has already begun; with JUCD working in a shadow form from September 2021 and becoming a statutory authority in April 2022. He also emphasised the importance of JUCD building a strong link with governors and for governors to understand the wider system and the role of the Trust within it. He anticipated that there will not be a formal group of governors on ICS boards but a final definition on governance has not yet been published. Martin explained that it is a statutory requirement for the Chair of the system to engage with the community and statutory accountabilities will transfer to ICS. He reiterated that engaging with the community will be core and provide assurance to that things are being carried out correctly. It was noted that the national guidance should be taken and used to mould and fit to Derbyshire which covers all aspects of healthcare. Once the guidance is made available the partners in JUCD will be able to make further plans. Referring to engagement, Martin confirmed that the system has already established a Citizen's Panel with members being able to express an interest in particular issues/locations and this will help to ensure that views from members and the public are represented. Partners are also members of particular workstreams which align to their expertise for example Derbyshire Healthcare works specifically in the mental health workstream board which Ifti Majid leads on. Rosemary Farkas asked how the new system will take account of health inequalities and stigma. John explained that there will be the potential to form stronger relationships with Local Authorities and the ability for issues to be addressed at the wider board. Valerie Broom referred to the complexity of the ICS and suggested that governors will need training and support in understanding the system. It was noted that John hoped to see more joined up services and opportunities to bring greater collaboration, as already seen during the pandemic, in order to support the delivery of care. It was also noted that there will be a move away from contracting and the focus will be on planning and allocation. He reiterated that the intention of the ICS is to improve patents experience and reduce bureaucracy. The Chair thanked John and Martin for their update and also conveyed her appreciation to Kevin Richards and Carole Riley who have represented governors at JUCD Engagement Committee meetings.

	(John and Martin left the meeting at 14.29.)
DHCFT/GOV /2021/021	**SUBMITTED QUESTIONS FROM MEMBERS OF THE PUBLIC** No questions from members of the public had been received.
DHCFT/GOV /2021/022	**MINUTES OF THE COUNCIL OF GOVERNORS' MEETINGS ON THE 2 MARCH 2021 AND 1 APRIL 2021** ***Minutes of the previous meeting held on 2 March 2021*** The minutes of the meeting held on 2 March 2021 were accepted as a correct record. ***Minutes of the previous meeting held on 1 April 2021*** The minutes of the meeting held on 1 April 2021 were accepted as a correct record.
DHCFT/GOV /2021/023	**MATTERS ARISING AND ACTIONS MATRIX** All completed 'green' actions were scrutinised to ensure that they were fully completed. The Council of Governors agreed to close completed actions. There were no matters arising. **RESOLVED: The Council of Governors noted the completed actions and comments on the Action Matrix.**
DHCFT/GOV /2021/024	**CHIEF EXECUTIVE UPDATE** Ifti Majid provided the meeting with: • An update on the current situation regarding the COVID-19 pandemic. He confirmed that Derbyshire has a low transmission rate; and that no patients in the Trust's inpatient facilities have COVID-19; this is due to the Trust's strong infection prevention and control. Only 17 members of staff are currently off work due to COVID-19 related illnesses, the majority of which have had a reaction to the vaccines e.g. nausea and have been encouraged to stay off work. The Trust now has the facilities to vaccinate its staff and patients in its inpatient facilities. It was noted that Derbyshire is one of the best counties in terms of vaccination compliance; this also applies to colleagues. • System working – Ifti agreed to circulate his presentation to governors. • Staff survey – 61% of colleagues completed the survey during the second COVID-19 wave in September and October 2020. A high percentage of colleagues would recommend the Trust as a great place to work compared to 30% and 40% in 2015 and 2016 respectively. It was noted the Trust is above average in all 10 domains of the survey. Rob Poole congratulated the Trust on such positive results and asked if there are any plans to celebrate this achievement. Ifti explained that recognition will be given at the staff HEARTS Awards in May and at the Annual Members' Meeting in September. The Trust will also be celebrating being awarded a 'good' from the Care Quality Commission (CQC) which the Trust had been unable to celebrate due to the pandemic. Kevin Richards noted the increase in morale which should have a positive impact on absenteeism and retention and recruitment of staff. • Roadmap out of lockdown – Ifti presented the Trust's roadmap which is in three stages: April to June; July to September; and October onwards. Ifti outlined the first stage which focuses on colleagues and team resilience. • The Trust Strategy was refreshed in April 2021 and includes the Trust Vision, the four Trust values, three strategic objectives, building blocks and priority and actions. The building blocks explain what the Trust needs to do to improve; the vision and values remain the cornerstone of the Trust; and actions include eradicating dormitories, changing to a single electronic patient record (EPR), and great place to work priorities. • Integrated Care Systems – following on from John MacDonald's and Martin Whittle's presentation on the ICS, Ifti referred to the guidance 'Integrating care:

	Next steps to building strong and effective integrated care systems across England' which details how organisations will accelerate collaborative ways of working in future; and 'The NHS's recommendations to Government and Parliament for an NHS Bill' its purpose being to free up different parts of the NHS to work together and with partners more easily. The Bill will bring about the formality of the structure from April 2022; will remove barriers to integration through joint committees, collaborative commissioning approaches and joint appointments. • ICS and collaborative working – Ifti reiterated the importance of collaborative working e.g. with Local Authorities and other trusts. Roy Webb declared an interest in the collaborative work with Local Authorities. He explained that he is a member of JUCD Board and the proposal does not include a road map for social care; and expressed concern at the lack of addressing social care in the Bill. There appears to be no formalised process for social care (adults and children); social care is still on the annual funding process unlike health which is on a three-five year funding. However, there is an area of doubt and although JUCD are working around this it needs to be formalised in a better way. • Ifti referred to the 2021/22 priorities and operational planning guidance and in particular to: ICS's being required to set out their delivery and governance arrangements that will support the NHS Priorities; systems should begin their procurement of a shared care record so that a minimum viable product is live in September and roadmap for development to include wider data sources and use for population health is ready for April 2022. It was noted that the Trust is in the process of looking at joining up shared records across Derbyshire. *(Stuart Mourton left the meeting at 3.02pm.)* **RESOLVED: The Council of Governors noted the helpful information and explanations provided by Ifti Majid.** **ACTIONS:** • **Ifti Majid's presentation and documents mentioned will be sent to governors to read**
DHCFT/GOV /2021/025	**VERBAL SUMMARY OF INTEGRATED PERFORMANCE REPORT** The Integrated Performance Report (IPR) was presented to the Council of Governors by Ashiedu Joel, Non-Executive Director (NED). The focus of the report was on workforce, finance, operational delivery and quality performance. Ashiedu gave a summary of the Public Trust Board that took place this morning which included: a patient story from a Trust colleague; flexible approaches to work for colleagues; roadmap out of lockdown; keeping patients and staff safe. She also referred to the following: • The Board had conveyed their appreciation to Cllr Jim Perkins who has stood down as Appointed Governor for Derbyshire County Council. • Employment and access to work in the Trust – the Trust is in the process of implementing best practice and data intelligence in order to close the gaps • The Trust was £2.1 million in deficit at the end of this year. This was due to the pandemic and additional cost for moving over patient records from Paris to SystmOne. • NHS Improvement have agreed the Trust's dormitories eradication programme. • A focus on waiting lists and the impact the pandemic has had on them. The Trust is looking at how to address the increasing waiting list. During the pandemic some patients have opted to have appointments/assessments via digital means which have proved successful, • Due to the pandemic and lack of capacity, staff appraisals and mandatory training have been paused. A people plan is being developed to stand these up. • The reduction in staff absence is the lowest in a three year period,

	• Recruitment is ongoing. The Trust Chair thanked Ashiedu for the comprehensive summary of the Trust Board meeting. Julia Tabreham, NED and Chair, People and Culture Committee explained that during the pandemic meetings had been streamlined and are now back to full governance. The Committee has developed a dashboard which aligns with the strategy and system work which is working really well. The Committee has stopped using acronyms around black and ethnic minority groups and will instead look at specific communities to drive forward a better understanding of these communities. The Committee was fully compliant, and Julia expressed her appreciation to Sue Turner, Board Secretary for her continued support. She also noted that cross committee assurance is working well. Julia expressed her delight at the outcomes of the staff survey and acknowledged this was under Ifti's and Caroline's leadership. *(Rob Poole left the meeting at 4.16pm.)* Richard Wright, NED and Chair, Finance and Performance Committee sought to clarify the deficit mentioned by Ashiedu. He explained that this is the same amount as unspent annual leave provision monies which the Centre has agreed that the Trust can carry forward. This means that the Trust broke even and is not in deficit. He also explained that staff had not taken annual leave in 2020/21 due to the pandemic. He also explained that funding for the £80 million programme had been approved to eradicate all dormitories which will be replaced by single en-suite rooms. Richard confirmed that the Trust is required to carry out this work in a given time period, present outline and full business cases to other bodies, including the ICS, for approval. It was noted that this is in line with the Trust 'great care' objective to improve the Trust's estate. He also mentioned the development of a Psychiatric Intensive Care Unit (PICU) that the Trust will be part funding. **RESOLVED: The Council of Governors** **1) Noted the information provided in the IPR.** **2) Agreed that the NEDs have held the Executive Directors to account.**
DHCFT/GOV /2021/026	**<u>NON-EXECUTIVE DIRECTOR'S (NED) DEEP DIVE</u>** Margaret Gildea, Senior Independent Director (SID) and Chair of the Quality and Safeguarding Committee presented her Deep Dive to governors. It included a summary of her activities over the past year and the following was noted: • The responsibility as SID to carry out the Chair's appraisal. Margaret confirmed that the appraisal was very positive. • One of the statutory roles of the Council of Governors is to recruit a Chair; and as SID Margaret will be supporting the process of so that governors can be assured that it will be a fair and inclusive process. • Combining the Quality and Safeguarding Committees has been effective. Reporting has been shortened during the pandemic to minimise the workload for executive members of the Committee. The Committee has focused on assurance around physical healthcare, waiting lists, the Trust's response to COVID-19, serious incidents, patient and carer experience, medicines management, learning from deaths, safe working, safeguarding children and adults. She conveyed her appreciation to Sue Turner, Board Secretary for her continued support in the running of the Committee. • During lock down Quality Visits have been paused but the quality of reports has mitigated this loss. Margaret also gave a summary of her work as a member of the People and Culture Committee (PCC); Mental Health Act Committee; and Audit and Risk Committee.

	The Chair thanked Margaret for her comprehensive Deep Dive and also conveyed her appreciation to her for her work and great wealth of wisdom. *(Dr Farina Tahira left the meeting at 3pm.)* **RESOLVED: The Council of Governors received the Deep Dive Report from Margaret Gildea.**
DHCFT/GOV /2021/027	**ESCALATION ITEMS TO THE COUNCIL OF GOVERNORS FROM THE GOVERNANCE COMMITTEE** One item of escalation was received from the Governance Committee meeting held on 1 April 2021: How are the NEDs assured about the capacity in A&E through the Mental Health Liaison teams to support people with deteriorating mental health as a result of COVID, and in particular older adults and those with longer term conditions such as Bi Polar Disorder, who may have had other access to support in the community which they have not been able to access. The response to the question attached as Appendix 1 to these minutes, was read out at the meeting. **RESOLVED: The Council of Governors** **1) The Council of Governors was satisfied with the response.**
DHCFT/GOV /2021/028	**UPDATE ON THE FORTHCOMING ELECTIONS** Denise Baxendale gave an update on the public and staff governor elections. She explained that the Council of Governors have the following vacancies including seats for those governors whose term of office end on 1 June 2021: • Public governor vacancies: - Bolsover and North East Derbyshire (two vacancies) - Chesterfield (one vacancy) - High Peak and Derbyshire Dales (one vacancy) • Staff governor vacancies: - Admin and Allied Support (one vacancy) - Allied Profession (one vacancy) - Nursing (two vacancies). Activity to promote the vacancies and identify individuals interested in the governor vacancies had been intensive and a detailed list of the activities was provided in the report. Denise confirmed that nominations had closed on 19 April and the situation regarding the vacancies is as follows: • Bolsover and North East Derbyshire – uncontested (one vacancy stands) • Chesterfield – contested with two nominations • High Peak and Derbyshire Dales – contested with four nominations • Admin and Allied Support – uncontested • Allied Professions – contested with two nominations • Nursing – contested with four nominations She also confirmed that the notice of poll will be published on 7 May; the voting packs will be despatched on 10 May and elections close 5pm on 28 May with results being declared soon after. On behalf of the Council of Governors, the Chair conveyed her appreciation to Denise for her hard work and great outcomes. **RESOLVED: The Council of Governors**

	1) Noted the information provided on the election process.
DHCFT/GOV /2021/029	**REPORT FROM GOVERNORS NOMINATIONS AND REMUNERATION COMMITTEE – MEETINGS HELD ON 18 MARCH AND 21 APRIL 2021; AND THE COMMITTEE'S YEAR END REPORT 2020/21** The Caroline Maley declared an interest in this item as it includes the Chair's appraisal and the process for recruiting a new Trust Chair. Therefore Justine Fitzjohn, Trust Secretary presented the report and went through the key points in the paper which outlined the Trust Chair and six Non-Executive Directors (NEDs) appraisals as well as several year-end governance reports specifically: • Time commitment, balance of skills, committee membership and succession planning. • Annual collective performance review of the committee in accordance with its Terms of Reference. • Annual review of Terms of Reference before submission to the Council of Governors. • Review of the levels of remuneration for NEDs. • The Committee's year-end report 2020/21 and revised Terms of Reference. • Trust Chair recruitment process (it was noted that Margaret Gildea had included an overview of the recruitment process in her Deep Dive). *(Kevin Richards left the meeting at 16:10.)* Lynda Langley assured the Council that a robust process had been undertaken for the Chair and NEDs appraisals and conveyed her appreciation to Margaret Gildea and Justine Fitzjohn for their support. Caroline also conveyed her appreciation to Justine for producing the report and masterminding all the appraisals for her. **RESOLVED: The Council of Governors** **1) Noted the updated report from the two meetings of the Nominations and Remuneration Committee held 18 March and 21 April 2021** **2) Received assurance from the Committee that satisfactory appraisals have taken place for the Trust Chair and Non-Executive Directors** **3) Approved the four Chair objectives as set out in the report** **4) Noted the 28 June for the recruitment stakeholder groups in governor diaries** **5) Approved the annual collective performance review of the committee in accordance with its Terms of Reference** **6) Approved the Terms of Reference.**
DHCFT/GOV /2021/030	**COUNCIL OF GOVERNORS ANNUAL EFFECTIVENESS SURVEY (TO APPROVE)** Denise Baxendale presented the report to approve the process for this year's Governor Annual Effectiveness Survey. She explained that the Council of Governors carries out its annual effectiveness survey in line with best practice. The results are presented to the Governance Committee and then to the Council of Governors. There are 28 questions including three free text sections for capturing suggestions for training needs, suggestions for improvements and an overall assessment of effectiveness. Last year as in previous years the survey was undertaken in September, with the results being presented to the Governance Committee in October and the Council of Governors in November. It is recommended that the survey this year follows the same process: to be undertaken in September 2021, with the results being presented to the Governance Committee in October and the Council of Governors in November. The survey will be promoted widely in Governor Connect, via governor meetings, and emails encouraging governors to complete the survey.

	RESOLVED: The Council of Governors **1) Noted the information provided in the report** **2) Approved that the survey is undertaken in September 2021.**
DHCFT/GOV /2021/031	**GOVERNANCE COMMITTEE REPORT – 1 APRIL 2021** The Council of Governors received the report from the Governance Committee meeting which took place on 1 April 2021. Julie Lowe, Chair of the Committee referred to the following: • The Annual Members' Meeting will be held virtually on 9 September, the theme of which is 'Cohesion through COVID-19'. It will close with the announcement of the winners of the 'Finding my calm during COVID' writing competition. • Governors approved the draft Governor and Membership Section of the Annual Report 2020/21 • Governors reviewed their individual declarations of interest • A governor training and development session on the Integrated performance Report (IPR) is in the process of being arranged and an engagement session has been organised for 6 October • Governors were asked to consider the Lead Governor role. Denise Baxendale also referred to the Committee's suggestion that the Council of Governors give special dispensation to staff governors unable to attend meetings due to the pressures of the pandemic. Caroline confirmed that the Committee is going from strength to strength and conveyed her thanks to Denise for serving the Committee and to Julie Lowe for chairing the meetings. **RESOLVED: The Council of Governors** **1) Noted the information provided in the Governance Committee Report** **2) Approved special dispensation for staff governors unable to attend meetings during the pandemic.**
DHCFT/GOV /2021/032	**ANY OTHER BUSINESS** **Appointed Governor, Derbyshire County Council** It was noted that Cllr Jim Perkins has stood down as Appointed Governor representing Derbyshire County Council. Caroline Maley has sent Jim a letter of thanks and is looking forward to meeting the nominated representative who will be replacing him. Lynda Langley explained that Jim had contacted her and had requested that his appreciation to Denise Baxendale for her support in his governor role be conveyed to her. **News from the Trust's appointed governors' representation the voluntary sector** Jodie Cook, Appointed Governor, Derbyshire Mental Health Forum referred to the self-harm review commissioned by Public Health. It is envisaged that the self-harm review will be ready in the autumn. Jodie also referred to an event being organised by the Mental Health Systems on urgent care. This will be taking place on 12 October and will showcase and celebrate the mental health support and helpline and the Safe Haven in Derby. Caroline Maley thanked Jodie for the update and encouraged all governors to subscribe to the e-newsletters produced by Derbyshire Mental Health Forum and Derbyshire Voluntary Association. **IPR governor training and development session** Denise Baxendale confirmed that the session has been scheduled for 12 May from 2-3pm. It will take place virtually via Microsoft Teams. **Trust writing competition**

	Denise Baxendale confirmed that the Trust writing competition 'Finding my calm during Covid' is now open. Governors are encouraged to promote the competition with their families, friends, constituents and members of the public. **Lead Governor role** Lynda Langley, Lead Governor and the Chair informed the meeting that no expressions of interest for the Lead Governor role have been submitted. Both the Chair and Lynda are keen to work with the new Lead Governor before their terms finish in September 2021 and March 2022 respectively. Caroline encouraged governors to consider the role. **NHS Providers Governor Focus Conference showcase** The Council agreed to submit an application for the governors showcase at the NHS Providers Governors Focus Conference. The showcase is an opportunity for Council of Governors from across England to demonstrate to their peers how they are exercising their statutory duties. The deadline for submitting an application is 14 May. Julie Lowe, Lynda Langley, Carole Riley, Orla Smith and Christopher Williams agreed to support Denise Baxendale in the application process.
DHCFT/GOV /2021/033	**REVIEW OF THE MEETING EFFECTIVENESS AND FOLLOWING THE PRINCIPLES OF THE CODE OF CONDUCT** The Council of Governors agreed that: - Governors are adhering to the Code of Conduct - The meeting included a clear oversight of Integrated Care Systems - The meeting was efficiently chaired and finished early - The meeting covered all agenda items with enough time for discussion - Governors were assured that the NEDs are holding the Board to account.
DHCFT/GOV /2021/034	**CLOSE OF MEETING** Caroline Maley thanked all for their attendance and input. An extraordinary Council of Governors meeting will be held on **Tuesday 6 July** from 2.30-3.00pm to appoint the new Trust Chair. A Council of Governors meeting will be held on **Tuesday 7 September**, from 2.00pm. Governors were asked to note the following: • Trust Board and Council of Governors session on **Tuesday 6 July** from 3.10-4.45pm • Trust Annual Members' Meeting to be held on **Thursday 9 September** from 2.00pm. The meeting closed at 16:30 hours.

Appendix 1

Escalation items to the Council of Governors from the Governance Committee

Question One:

How are the NEDs assured about the capacity in A&E through the Mental Health Liaison teams to support people with deteriorating mental health as a result of COVID, and in particular older adults and those with longer term conditions such as Bi Polar Disorder, who may have had other access to support in the community which they have not been able to access.

Response:

We have two core 24 complaint mental health liaison teams. Core 24 is the national recommended configuration or make up of liaison teams. Activity is strong and teams remain in place. Our emergency response is supplemented by the mental health helpline, which as a 24 hour support system is an additional layer of support to people in our care who are impacted by COVID-19 and the pressures of the lockdown and the wider loss experienced in our communities. Our liaison teams in the north and south continue to have practitioners who specialise in older adults. Where additional care is needed our older adults team remain at full strength.

Our benchmarking of clinical activity remains strong. There is strong evidence of face to face, virtual and telephone support. Our activity of staying in contact is in the top 10% in the country.

However, we are very aware that third sector, social care and trust groups are paused or delayed, and this will have an impact on our people. The Trust teams have maintained a number of groups with a virtual offer, but this may not be a suitable alternative offer or a person's preference.

Overall an individual in our care is more likely to struggle through the pandemic and the changes to services will be experienced very differently across the spectrum of people we serve. Our clinical team are very mindful of this. We are not seeing a significant deterioration in relapse rates, more natural reactions to restriction and loneliness.

We are continuing at this time with our mixed offer of service and we will start to meet people in our care gradually. For some this will be meeting in a garden or a short walk in April, meeting in small cluster groups in May in less than groups of six outside for walking or horticultural groups and a gradual phased change to how we are working.

The national roadmap is a conservative path and incremental steps to more social/therapeutic contact. The Trust's steps will mirror this model.

Derbyshire Healthcare NHS Foundation Trust

MINUTES OF EXTRAORDINARY COUNCIL OF GOVERNORS MEETING HELD ON TUESDAY 6 JULY 2021, FROM 14:30-14:46HOURS MEETING HELD DIGITALLY VIA MICROSOFT TEAMS

PRESENT	Caroline Maley	Trust Chair and Chair of Council of Governors **(deferred chairing the meeting to the Lead Governor due to the business to be transacted)**
	Valerie Broom	Public Governor, Amber Valley
	Susan Ryan	Public Governor, Amber Valley
	Rob Poole	Public Governor, Bolsover and North East Derbyshire
	Ruth Grice	Public Governor, Chesterfield
	Lynda Langley	Public Governor, Chesterfield and Lead Governor – **Chair for the meeting**
	Carole Riley	Public Governor, Derby City East
	Orla Smith	Public Governor, Derby City West
	Andrew Beaumont	Public Governor, Erewash
	Christopher Williams	Public Governor, Erewash
	Julie Boardman	Public Governor, High Peak and Derbyshire Dales
	Chris Mitchell	Public Governor, High Peak and Derbyshire Dales
	Kevin Richards	Public Governor, South Derbyshire
	Jan Nicholson	Staff Governor, Allied Professions
	Marie Hickman	Staff Governor, Admin and Allied Support Staff
	Kel Sims	Staff Governor, Admin and Allied Support Staff
	Jo Foster	Staff Governor, Nursing
	Farina Tahira	Staff Governor, Medical
	Rachel Bounds	Appointed Governor, Derbyshire Voluntary Association
	Cllr Roy Webb	Appointed Governor, Derby City Council
	Stephen Wordsworth	Appointed Governor, University of Derby
	David Charnock	Appointed Governor, University of Nottingham
IN ATTENDANCE	Denise Baxendale	Membership and Involvement Manager
	Lee Doyle	Acting Director of Operations
	Justine Fitzjohn	Trust Secretary
	Carolyn Green	Executive Director of Nursing and Patient Experience
	Ifti Majid	Chief Executive
	Ade Odunlade	Chief Operating Officer
APOLOGIES	Jodie Cook	Appointed Governor, Derbyshire Mental Health Forum
	Rosemary Farkas	Public Governor, Rest of England
	Julie Lowe	Public Governor, Derby City East
	Stuart Mourton	Public Governor, Derby City West

ITEM	**ITEM**
DHCFT/GOV /2021/035	**WELCOME, INTRODUCTIONS, APOLOGIES FOR ABSENCE & DECLARATION OF INTERESTS** Lynda Langley, Lead Governor, took the chair and welcomed all to the meeting. She reminded everyone that the link to the meeting had been published on the Trust's website to allow public viewing. Lynda explained that this extraordinary Council of Governors meeting was convened in order discuss the recommendation from the Governors Nominations and Remuneration Committee to appoint the new Trust Chair who will replace Caroline Maley when she retires on 13 September 2021. The apologies were noted; and no interests were declared.

DHCFT/GOV /2021/036	**APPROVAL OF THE APPOINTMENT OF THE NEW TRUST CHAIR** Lynda gave an outline of the recruitment process; and assured governors that the process was robust, open and transparent. Lynda also summarised how the preferred candidate, Selina Ullah, met the criteria for the role and their strengths and confirmed that the she has the right qualities to meet the job description. It was noted that the focus groups and interview panel found Selina to be warm, humble, informed and inspirational. It was noted that Selina had also undertaken extensive research into the Trust, Joined Up Care Derbyshire and other Trust partners and had spoken to a variety of people within Trust and with partner organisations. Lynda also confirmed that Selina, who lives in Bradford assured the interview panel that travel would not be an issue; and that visibility would be a priority for her. Susan Ryan who sat on the interview panel concurred with Lynda and explained that there were four strong candidates to interview. She also explained that Selina was incredibly informed and gave good examples of how she has used her skills and experience to change areas she has previously worked in. Kel Sims who participated in the shortlisting process and focus group also concurred with Lynda explaining that the focus group had most appreciated Selina's openness and approachability. Lynda outlined the Governors Nominations and Remunerations Committee recommendation to appoint Selina Ullah as the Trust Chair, on an annual fee of £45,100 for a three year term commencing on 14 September 2021 (on the expiry of Caroline Maley's term of office on 13 September 2021). The Council of Governors unanimously agreed with the Committee's recommendation to appoint Selina Ullah with the terms as outlined above. The Trust Secretary will inform Selina of the outcome. Lynda reiterated that the recruitment process was thorough, fair and balanced, and has led to the best outcome for the Trust. She also explained that all four candidates had commented that the values of the Trust had shone through at each stage of the interview process. Lynda conveyed her appreciation to all who participated in the recruitment process including the focus groups, interview panel, Justine Fitzjohn, Trust Secretary and Ali Tuckley, PA to the Trust Chair and Chief Executive. Caroline also conveyed her appreciation to everyone involved in the recruitment and expressed her delight at the appointment of Selina. Caroline added she would continue with her dedication to working with the Trust until her retirement in September. Justine Fitzjohn assured governors that there will be an opportunity for governors to say goodbye to Caroline. She also explained that a statement on the appointment of the new Trust Chair will be published tomorrow; and she is aware that Selina is really looking forward to joining the Trust; and building on the work that Caroline has accomplished. **RESOLVED: The Council of Governors:** **1) Approved the appointment of Selina Ulla as Trust Chair at an annual fee of £45,100 for a three year term commencing on 14 September 2021.** **2) Noted that all appointments to the Trust Board are subject to satisfactory completion of the Fit and Proper Persons Tests.** **ACTION: The Trust Secretary will contact Selina Ullah to inform her of the outcome.**

DHCFT/GOV /2021/038	**CLOSE OF MEETING** Lynda Langley thanked all for their attendance and input. A confidential extraordinary Council of Governors meeting is taking place after this meeting. The next Council of Governors meeting will be on **Tuesday 7 September 2021, from 2.00pm.** Both meetings will be held virtually. The meeting closed at 14:46 hours.

COUNCIL OF GOVERNORS ACTION MATRIX - AS AT 18 JUNE 2021								
Date of Minutes	**Minute Reference**	**Item**	**Lead**	**Action**	**Completion by**	**Current Position**		
04/05/2021	DHCFT/GOV/2021/024	Chief Executive Update	Denise Baxendale	The Trust will share Ifti Majid's presentation with governors		Presentation requested from Chief Executive on 25.5.21. Circulated to governors in Governor Connect 18.6.21. COMPLETE	Green	
04/05/2021	DHCFT/GOV/2021/024	Chief Executive Update	Denise Baxendale	The Trust will share documents mentioned by the Chief Executive for governors to read		Documents circulated to governors via Governor Connect dated 27.5.21. COMPLETE	Green	
06/07/2021	DHCFT/GOV/2021/036	Approval of the appointment of the new Trust Chair	Justine Fitzjohn	The Trust Secretary will contact Selina Ullah to inform her of the outcome.		Justine contacted Selina. COMPLETE	Green	

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

Presentation to the Council of Governors

Derbyshire Healthcare NHS Foundation Trust – year ended 31 March 2021

August 2021

Introduction

Mark Surridge

Key Audit Partner

John Pressley

Audit Manager

Introduction

Our responsibilities are defined by the Local Audit and Accountability Act 2014 and the Code of Audit Practice ('the Code') issued by the National Audit Office ('the NAO').

Scope of our work

- Opinion on the financial statements
- Value for Money arrangements
- Wider reporting responsibilities

Who we report to

Committee	
Audit and Risk Committee	We present an Audit Plan, and then regularly progress against that plan and our findings to the Audit and Risk Committee
Board	The Audit and Risk Committee uses our work to provide assurance to the Board. Occasionally, we may report directly to the Board, but have not needed to do that this year.
Governors	Annually, we issue a summary to the Governors (due September 2021)

Our work for 2020/21
Scope

Opinion on the financial statements

We carry out our audit in accordance with the requirements of the Code of Audit Practice and International Standards on Auditing (ISAs).

The purpose of our audit is to provide reasonable assurance to users that the financial statements are free from material error.

Value for money arrangements

We are required to consider whether the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

We report against the following criteria:

- **Financial sustainability** - How the Trust plans and manages its resources to ensure it can continue to deliver its services
- **Governance** - How the Trust ensures that it makes informed decisions and properly manages its risks
- **Improving economy, efficiency and effectiveness** - How the Trust uses information about its costs and performance to improve the way it manages and delivers its services

Wider reporting

The NHS Act 2006 provides auditors with specific powers where matters come to our attention that, in our judgement, require specific reporting action to be taken. We have the power to:

- issue a report in the public interest; and
- make a referral to the regulator.

We are also required to report if the governance statement does not comply with relevant guidance or is inconsistent with our knowledge and understanding of the Trust.

Our work for 2020/21
Outcomes

Opinion on the financial statements

✓

COMPLETE

Issued on 11 June 2021, we gave an unqualified opinion on the financial statements for the year ended 31 March 2021:

"In our opinion, the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2021 and of the Trust's income and expenditure for the year then ended;
- have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2020/21; and
- have been properly prepared in accordance with the requirements of the National Health Service Act 2006."

Value for money arrangements

✓

COMPLETE

The Guidance for this work was updated on 16 April 2021, giving a new reporting deadline of September 2021.

We shared the outcome of this work with the Audit and Risk Committee in July. Now this is completed, we are sharing our Auditors Annual Report with Governors.

Wider reporting

✓

COMPLETE

We have not needed to use any of our wider reporting powers.

We had no issues to report over the content or format of the Governance Statement

Mark Surridge

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Mazars is an internationally integrated partnership, specialising in audit, accountancy, advisory, tax and legal services*. Operating in over 90 countries and territories around the world, we draw on the expertise of 40,400 professionals – 24,400 in Mazars' integrated partnership and 16,000 via the Mazars North America Alliance – to assist clients of all sizes at every stage in their development.

*where permitted under applicable country laws.

Auditor’s Annual Report

Derbyshire Healthcare NHS Foundation Trust – year ended 31 March 2021

June 2021

Contents

01

Section 01:

Introduction

1. Introduction

Purpose of the Auditor's Annual Report

Our Auditor's Annual Report (AAR) summarises the work we have undertaken as the auditor for Derbyshire Healthcare NHS Foundation Trust ('the Trust') for the year ended 31 March 2021. Although this report is addressed to the Trust, it is designed to be read by a wider audience including members of the public and other external stakeholders.

Our responsibilities are defined by the Local Audit and Accountability Act 2014 and the Code of Audit Practice ('the Code') issued by the National Audit Office ('the NAO'). The remaining sections of the AAR outline how we have discharged these responsibilities and the findings from our work. These are summarised below.

Opinion on the financial statements

We issued our audit report on 11 June 2021. Our opinion on the financial statements was unqualified.

Wider reporting responsibilities

In line with group audit instructions issued by the NAO, on 11 June 2021, we reported that the Trust's consolidation schedules were consistent with the audited financial statements.

Value for Money arrangements

In our audit report we reported that we had not completed our work on the Trust's arrangements to secure economy, efficiency and effectiveness in its use of resources and had not issued recommendations in relation to identified significant weaknesses in those arrangements at the time of reporting. Section 3 confirms that we have now completed this work and provides our commentary on the Trust's arrangements.

Following the completion of our work we have issued our audit certificate which formally closes the audit for the 2020/21 financial year.

02

Section 02:

Audit of the financial statements

2. Audit of the financial statements

The scope of our audit and the results of our opinion

Our audit was conducted in accordance with the requirements of the Code, and International Standards on Auditing (ISAs).

The purpose of our audit is to provide reasonable assurance to users that the financial statements are free from material error. We do this by expressing an opinion on whether the statements are prepared, in all material respects, in line with the financial reporting framework applicable to the Trust and whether they give a true and fair view of the Trust's financial position as at 31 March 2021 and of its financial performance for the year then ended. Our audit report, issued on 11 June 2021 gave an unqualified opinion on the financial statements for the year ended 31 March 2021:

"In our opinion, the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2021 and of the Trust's income and expenditure for the year then ended;
- have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2020/21; and
- have been properly prepared in accordance with the requirements of the National Health Service Act 2006."

03

Section 03:

Commentary on VFM arrangements

3. VFM arrangements – Overall summary

Approach to Value for Money arrangements work

We are required to consider whether the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. The NAO issues guidance to auditors that underpins the work we are required to carry out and sets out the reporting criteria that we are required to consider. The reporting criteria are:

- Financial sustainability;
- Governance; and
- Improving economy, efficiency and effectiveness.

At the planning stage of the audit, we undertake work so we can understand the arrangements that the Trust has in place under each of the reporting criteria; as part of this work we may identify risks of significant weaknesses in those arrangements. Where we identify significant risks, we design a programme of work (risk-based procedures) to enable us to decide whether there is a significant weakness in arrangements. Although we describe this work as planning work, we keep our understanding of arrangements under review and update our risk assessment throughout the audit to reflect emerging issues that may suggest there are further risks of significant weaknesses.

Our assessment of what constitutes a significant weakness is a matter of professional judgement, based on our evaluation of the subject matter in question, including adequacy of the Trust's responses. The NAO's guidance states that a weakness may though be said to be significant if it:

- Exposes (or could reasonably be expected to expose) the body to significant financial loss or risk;
- Leads to (or could reasonably be expected to lead to) significant impact on the quality or effectiveness of service or on the body's reputation;
- Leads to (or could reasonably be expected to lead to) unlawful actions; or
- Involves a failure to take action to address a previously identified significant weakness, such as failure to implement or achieve planned progress on action/improvement plans.

Where our risk-based procedures identify actual significant weaknesses in arrangements, we are required to report these and make recommendations for improvement.

To arrive at our assessment, we performed a variety of work to obtain an understanding of the Trust's arrangements for each specified reporting criteria. This included performing a detailed risk assessment, drawing from a variety of sources, including, but not limited to:

- Meeting with management and reviewing management's self-assessment;
- Considering the views of the Audit and Risk Committee;
- Reviewing supporting guidance from the National Audit Office, including indicators of significant weaknesses;
- Considering our understanding of sector developments and any local issues;
- Reading and reviewing Board and Committee reports;
- Reviewing the Trust's Annual Governance Statement and Annual Report;
- Considering the outcomes from the work of internal audit;
- Reading risk registers and risk management reporting; and
- Considering the work of regulators and inspectorates.

3. VFM arrangements – Overall summary

Summary

The table below summarises the outcomes of our work against each reporting criteria.

Reporting criteria	Commentary page reference	Risks of significant weaknesses in arrangements identified?	Actual significant weaknesses in arrangements identified?
Financial sustainability: How the Trust plans and manages its resources to ensure it can continue to deliver its services	10	No	No
Governance: How the Trust ensures that it makes informed decisions and properly manages its risks	13	No	No
Improving economy, efficiency and effectiveness: How the Trust uses information about its costs and performance to improve the way it manages and delivers its services	16	No	No

3. VFM arrangements – Overall summary

Financial sustainability: how the Trust plans and manages its resources to ensure it can continue to deliver its services

Overall responsibilities for financial governance

We have reviewed the Trust's overall governance framework, including Board and Committee Reports, the Annual Governance Statement, and Annual Report and Accounts to confirm the Trust Board has a responsibility to make the best use of financial resources and deliver the services people need, to standards of safety and quality which are agreed nationally.

The Finance and Performance Committee oversees all aspects of financial management and operational performance on behalf of the Board. This includes:

- detailed oversight of financial performance, forward projections and the assumptions that underpin forward plans;
- scrutiny of reports on performance;
- workforce budgets;
- the cost-improvement programme;
- reviewing the Trust's capability and capacity to meet the commercial and marketing requirements of potential business opportunities; and
- assurance on health and safety and emergency planning.

Budget monitoring and control

We have reviewed the Trust's financial plans and supporting policies and procedures to confirm that the Trust's budget monitoring and control processes identify and incorporate significant pressures into the financial plan to ensure it remains achievable and realistic. Clear responsibilities are outlined for budget holders and the Trust's Standing Finance Instructions include specific provisions for the preparation and approval of the Annual Plan and budget.

At the start of the financial year the Director of Finance will, on behalf of the Chief Executive, prepare and submit revenue and capital expenditure start budgets for approval by the Board. Budgets are produced following discussion with appropriate budget holders and are linked to workforce plans where pay budgets are linked by Whole Time Equivalents. During the budgeting process, new requirements for the workforce are considered and included in the budget if applicable.

We read the Trust's Standing Financial Instructions and these include specific provisions for budgetary control and reporting and Finance Managers provide reports and support to budget holders and teams to support effective financial management of those component parts of Trust financial performance.

The 2020/21 financial year and medium-term financial planning for the Trust was severely disrupted by Covid-19, with both a change in NHS financing arrangements as well as the suspension and revision of the operational planning process for both 2020/21 and 2021/22. NHS Planning Guidance for 2020/21 was suspended and replaced with a new financial regime to support the NHS response to Covid-19. From April through to September 2020, NHS foundation trusts and NHS trusts were paid on a 'block contract' basis and made reimbursement claims for additional costs arising from Covid-19. For the second half of the year, each health system was given a financial envelope to achieve overall financial balance. This allowed individual organisations to deliver a surplus or deficit position by mutual agreement within the system.

We reviewed the system financial plan for Joined Up Care Derbyshire covering the period October 2020 to March 2021 was submitted on 5 October with an aggregate deficit of £43million. The system finance lead also summarised system level work on the potential mitigations to tackle the deficit amounting to £25million. Individual organisational plans were submitted on 22 October in line with that system plan, with the Trust planning an organisational deficit of £0.6million. The Trust's financial plan for October 2020 to March 2021 did not include any savings plans. We reviewed Trust's financial plan, Board report and the minutes of relevant meetings where the revised financial plan was considered. We confirmed that the reports were clear and concise and adequate scrutiny was evident at the approval meeting.

3. VFM arrangements – Overall summary

Financial sustainability: how the Trust plans and manages its resources to ensure it can continue to deliver its services

Financial performance in 2020/21

Our discussions with management and our review of committee reports confirms that throughout 2020/21, the Finance and Performance Committee and the Trust Board, through an Integrated Performance Report, have received regular reports on financial performance and planning. The Finance and Performance Committee oversees all aspects of financial management and operational performance on behalf of the Board. The reports include sufficient detail to identify and manage risks to financial resilience, including showing actual financial outturn and the forecast for the financial year. The Executive Leadership Team also monitors financial performance on a monthly basis and any unplanned pressures are considered against a contingency reserve. Each month, detailed forecasting analyses financial outturn against plan and forecast assumptions are reviewed and adjusted accordingly.

Where the Trust identifies a significant risk to achieve the target, it will update the Board Assurance Framework, including the controls and mitigating actions required to help the Board monitor and oversee risk management. The Board receives the Board Assurance Framework regularly, with an update up to the end of the 2020/21 financial year at the March 2021 Board meeting. Our review of the Board Assurance Framework includes a specific risk that the Trust may fail to deliver its revenue and capital financial plans that recognises the financial risks associated with the temporary NHS financial arrangements, including the need for funding clarity beyond October 2021.

As reported in the audited financial statements, Total Operating Income for 2020/21, as recorded in the Statement of Comprehensive Income, was £174million and Total Operating Expenses were £173million. As set out in Note 7 Operating Expenses, staff costs are the main cause for the increase, rising from £113million in the prior year to £126million in 2020/21. This ultimately resulted in an operating surplus for 2020/21 of £1.5million, compared to £6.1million in 2019/20 and, after taking account of finance costs, the Trust ended the year with a deficit of £2.1million.

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

We have reviewed performance reports and financial outturn and are satisfied that the Trust has proactively participated and contributed to system planning during 2020/21.

3. VFM arrangements – Overall summary

Financial sustainability: how the Trust plans and manages its resources to ensure it can continue to deliver its services

Financial planning for 2021/22

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. This included the details of the finance and contracting arrangements for the first half of 2021/22 (April to September). The financial arrangements are similar to the latter half of 2020/21, including:

- a financial envelope for the local health system based on the financial envelope for October to March 2021, adjusted for known pressures and policy changes;
- the continuation of block contract payments and no requirement for signed contracts between commissioners and providers;
- uplifting specialised and directly commissioned services from NHS England by 0.5%; and
- additional funding to support the delivery of the Mental Health Investment Standard and Long-Term Plan priorities.

Within the context of the temporary financial framework, the Trust is developing its savings programme with due regard to the financial envelope for Joined Up Care Derbyshire.

The Trust has an Operational Plan for 2021/22 and the strategic priorities have been considered by the Trust and by Joined Up Care Derbyshire. From our review of board reports and minutes, as well as discussions with management, the Trust's strategy and delivery priorities for 2021/22 have been considered and triangulated with financial, activity and workforce data, including considering the wider system plans of Joined Up Care Derbyshire.

We have considered the financial performance of the trust for the year ending 2020/21, including the level of debt within the Trust, being mainly made up of an outstanding PFI liability at 31 March 2021 of £23m. We have also considered the Trust's ongoing monitoring of financial performance and it is clear that the Trust is closely monitoring the progress against plan to date, is fully aware of where the gaps lie. We reviewed the system wide financial plan, both for October 2020 to March 2021 and for 2021/22, which shows there is a substantial system level gap, but this is driven by issues in the acute sector and not the Trust.

3. VFM arrangements – Overall summary

Governance: how the trust ensures that it makes informed decisions and properly manages its risks

Governance structure

We have reviewed the Trust's Board and Committee Reports during the year as well as key documents in relation to how the Trust ensures that it makes informed decisions and properly manages its risks. The Trust Board is accountable for the Trust's strategies, policies and performance actions as set out in the Codes of Conduct and Accountability issued by the Secretary of State. Each Executive Director is responsible for their specific area to ensure this occurs.

We read the Trust's Vision and Strategy and confirm this sets out the direction of travel and the things the Trust must do to achieve its vision and deliver its statutory responsibilities. The Trust translates this into an annual operating plan including the financial plans for enabling sustainable delivery of services. The annual operational planning cycle takes into account service priorities in the long-term plan and agreed developments with commissioners to deliver strategic priorities.

Our review of the Trust's governance framework confirms arrangements are in place, with the Trust Board being accountable for the Trust's strategies, policies and performance. The Trust has established committees with responsibility for specific areas, such as finance and performance, and the quality of care, including:

- Audit and Risk Committee;
- Finance and Performance Committee;
- Mental Health Act Committee;
- Quality and Safeguarding Committee; and
- Remuneration and Safeguarding Committee.

We consider the committee structure of the Trust is sufficient to provide assurance that decision making, risk and performance management is subject to appropriate levels of oversight and challenge.

We have also reviewed minutes and reports from the Council of Governors, who are responsible for representing the interests of the Trust's members, the public and partner organisations and for holding non-executive directors to account. The Trust has arrangements in place to review the performance of executive and non-executive directors. The appraisal of Executive Directors is overseen by the Remuneration and Appointments Committee; and the appraisal of Non-Executive Directors is overseen by the Nominations and Remuneration Committee of the Council of Governors. The Chair's performance is overseen by the Senior Independent Director using a process which is agreed by the Nominations and Remuneration Committee.

Our review of Board and Committee papers confirms that a template covering report is used for all Board Reports, ensuring the purpose, strategic context, governance issues, and recommendations are clear. Minutes are published and reviewed by the Board to evidence the matters discussed, challenge and decisions made.

We read the Care Quality Commission's most recent inspection report on the Trust from March 2020 who reported that "Governance processes operated effectively at the trust and operational, performance and risk were managed well" and "There was a good relationship between the trust board and council of governors. The council of governors held the non-executives to account."

3. VFM arrangements – Overall summary

Governance: how the trust ensures that it makes informed decisions and properly manages its risks

Board Assurance Framework

The Trust records strategic risks in the Board Assurance Framework and our review confirms it is sufficiently detailed to manage the Trust's key risks, identify controls, gaps in controls and obtain the assurance required to work towards a targeted risk score. Our review of reports as well as attendance at Audit and Risk Committee meetings confirms the Board Assurance Framework is regularly updated. Operational level risks are captured in "Datix", linked to the associated strategic risk and subject to regular review at Committees. The Trust also performs 'deep dives' on Strategic Risks to allow for additional layers of scrutiny and challenge.

Audit and Risk Committee

The Trust has an established Audit and Risk Committee that is responsible for establishing and maintaining an effective system of integrated governance, risk management and internal control across the organisation, in a way that supports the organisation's objectives. It achieves this by:

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

The Audit and Risk Committee considers the Board Assurance Framework, Annual Report, Quality Report, Annual Governance Statement and progress with internal and external audit plans. It also regularly receives updates on losses and compensation payments, single source tenders and waivers of Standing Financial Instructions.

We have reviewed supporting documents and confirmed the Audit and Risk Committee has agreed terms of reference, meets regularly and reviews its programme of work to maintain focus on key aspects of governance and internal control. In response to Covid-19, the Trust moved Board and Committee meetings on-line. Our attendance at Audit and Risk Committee has confirmed there is an appropriate level of effective challenge.

Internal Audit and Counter-Fraud

The Trust's Internal Audit and Counter-Fraud Service is provided by 360 Assurance, who provide a plan and regular progress reports to the Audit and Risk Committee. The Head of Internal Audit Opinion is reflected in the published Annual Governance Statement, where, in their view Internal Audit had Significant Assurance that there is a generally sound framework of governance, risk management and control designed to meet the organisation's objectives, and that controls are generally being applied consistently.

3. VFM arrangements – Overall summary

Governance: how the trust ensures that it makes informed decisions and properly manages its risks

Performance management

We have reviewed key reports issued by the Board and confirmed the Trust reports its performance in several different ways:

- an Integrated Performance Report to each Board meeting;
- the publication of the Annual Report, Annual Governance Statement and the Quality Report, which are reviewed by the Audit and Risk Committee before adoption by the Board; and
- dashboard reporting on the Trust website against key performance indicators, safer staffing levels, improvement plans and health risk assessments for at-risk staff.

The Integrated Performance Report covers Finance, Quality and Operations, and Workforce. Performance is summarised in an assurance summary dashboard, which shows performance against target and over time. Board members are also able to triangulate information from this report with the assurance summaries from each Committee, where more in depth reports are provided. Where the Trust identifies a significant risk to achieve the target, it will update the Board Assurance Framework, including the controls and mitigating actions required to help the Board monitor and oversee risk management. The Board receives the Board Assurance Framework regularly, with an update up to the end of the 2020/21 financial year at the March 2021 Board meeting

The Finance and Performance Committee oversees and gains assurance on all aspects of financial management and operational performance, including contract compliance, commercial decisions and cost improvement reporting. The Committee also oversees the Trust's business development, commercial strategies, estate strategy and workforce resource planning, prior to review by the People and Culture Committee.

Our review confirms, overall, that the Trust's reports are clearly laid out and sufficiently detailed to monitor performance and take corrective action where required, which may include updating the Board Assurance Framework.

Conduct

We have reviewed the Trust's suite of policies and procedures in place to maintain compliance with legislative/regulatory requirements and standards in behaviour, including conflicts of interest. These policies and procedures are subject to regular review by the Trust.

The Trust maintains a Register of Director's Interests, which is updated with each new interest declared/removed and the revised version is then reported to each Public Board. We confirmed the Register for 2020/21 was reviewed at the May 2021 Board meeting and published in the 2020/21 Annual Report.

We read the Care Quality Commission's most recent inspection report on the Trust from March 2020 who reported that "Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Staff supported patients to make decisions on their care for themselves. They understood the provider's policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity."

3. VFM arrangements – Overall summary

Improving VFM: how the Trust uses information about its costs and performance to improve the way it manages and delivers its services

Performance management

We have discussed arrangements with management to confirm the Trust is part of the national benchmarking club and reviews costs together with information about activity, workforce and quality. The Trust is part of the national benchmarking club and reviews costs together with information about activity, workforce and quality. The Trust also uses the national reference cost to compare its use of resources. Divisions have performance reviews with members of the Trust Management Team, where activity, targets and finance is presented, although these were paused during 2020/21 due to Covid-19. The Trust also uses the national reference cost to compare its use of resources. Divisions have performance reviews with members of the Trust Management Team, where activity, targets and finance is presented, although these were paused during 2020/21 due to Covid-19.

Our review of Board and Committee reports confirms that the Finance and Performance Committee and the Trust Board have continued to receive regular Integrated Performance Reports covering Finance, Quality and Operations, and Workforce. Performance is summarised in an assurance summary dashboard, which shows performance against target and over time. Board members are also able to triangulate information from this report with the assurance summaries from each Committee, where more in depth reports are provided. Our review confirms the reports provide sufficient detail to understand performance and published minutes demonstrate sufficient challenge from non-executive directors on the Trust's costs, performance and service delivery.

Our discussions with management confirm the Trust has performance standards set within contracts with commissioners and internally set performance standards. Performance against these standards is monitored across all areas through periodic (monthly) reporting. Where performance is below expectations, these reports highlight the action being taken to seek the required improvement. During 2020/21, performance standards have been modified to enable the Trust to respond to Covid-19.

We have read and reviewed the Trust's Annual Report and Quality Report, which set out its performance against key indicators and how it evaluates and assesses performance and improvement opportunities. We read the Care Quality Commission's most recent inspection report on the Trust from March 2020, who rated the Trust "Good" overall and the report includes the following comment: "Staff collected and analysed data about outcomes and performance and engaged actively in local and national quality improvement activities."

NHS Staff Survey

In June 2020, the People and Culture Committee reviewed the 2019 NHS Staff Survey and the planed responses for 2020. The Staff Survey Results for 2020 were reviewed at the May 2021 Trust Board, which showed the Trust performing above average in all areas and an improvement in all 10 themes.

3. VFM arrangements – Overall summary

Improving VFM: how the Trust uses information about its costs and performance to improve the way it manages and delivers its services

Joined Up Care Derbyshire

The Trust works in close partnership with other Health and Social Care organisations in the area, but notably with the Integrated Care System: Joined Up Care Derbyshire, whose Board is comprised of the region's main health and care senior executives and chairs. The Board has oversight of the whole system, sets the strategic direction and defines the outcomes the system should deliver. We have reviewed reports presented to the Trust's Board, Board Reports of Joined Up Care Derbyshire and other reports relating to the governance and performance of Joined Up Care Derbyshire, The Trust's objectives are aligned to Joined Up Care Derbyshire and our review of the Integrated Performance Report confirms it enables the Board to monitor the Trust's performance against national and local objectives.

The Trust's Council of Governors is responsible for representing the interests of the Trust's members, the public and partner organisations, in how the Trust is governed. It meets six times a year and consists of 16 elected public and staff governors, alongside 12 appointed governors from local partners and councils. The Council of Governors is supported by a monthly governance committee looking at key issues in greater depth: strategy and finance, governor development, membership development and quality.

NHSE/I maintains a Single Oversight Framework, which is designed to help NHS providers attain, and maintain, Care Quality Commission ratings of "Good" or "Outstanding". For 2020/21, the Trust has maintained a score of 2 in the framework, which is defined as "Providers offered targeted support: there are concerns in relation to one or more of the themes. We've identified targeted support that the provider can access to address these concerns, but which they are not obliged to take up."

The Care Quality Commission's most recent inspection report on the Trust is from March 2020, with the Trust given an overall "Good" rating, and included the following comment: "There was good systemic leadership within the local Sustainable Transformation Partnership, with board and service leaders engaged actively with other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population."

We read and reviewed an independent report produced by 360 Assurance (the Trust's internal auditor's) on System Shared Decision Making, issued in draft form in April 2021. The report did not highlight any significant concerns and noted that good progress had been made in the development of effective system wide decision making.

3. VFM arrangements – Overall summary

Improving VFM: how the Trust uses information about its costs and performance to improve the way it manages and delivers its services

Procurement

We read the Trust's Standing Financial Instructions and confirm these adequately set out the procedures, controls and the authorisation sign offs that are required for the commission or procurement of services. In 2020/21, to assist the management of the Trust's response to Covid-19, supported by the Cabinet Office's Procurement Policy Note (PPN 02/20) issued in March 2020, the Trust introduced temporary Standing Financial Instructions.

We reviewed the Trust's organisational structure and noted that the Trust's Director of Business Improvement and Transformation is supported by a Head of Strategic Procurement and Tendering. Discussions with management established that 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. All contracts and associated purchase orders are raised on the NHS Standard Terms and Conditions which suppliers are mandated to comply with. The Procurement Team upholds the Chartered Institute of Procurement and Supply (CIPS) Code of Professional Conduct.

Our attendance at the Audit and Risk Committee confirms it receives regular reports on any breaches of Standing Financial Instructions and Single Tender Waivers to assure the Board that the Trust is working in accordance with relevant legislation, professional standards and internal policies. Sufficient information is provided to enable an adequate level of review and we have observed an appropriate level of challenge from Committee members through the year.

04

Section 04:

Other reporting responsibilities

4. Other reporting responsibilities

Matters we report by exception

The NHS Act 2006 provides auditors with specific powers where matters come to our attention that, in their judgement, require specific reporting action to be taken. Auditors have the power to:

- issue a report in the public interest; and
- make a referral to the regulator.

We have not exercised any of these statutory reporting powers.

We are also required to report if, in our opinion, the governance statement does not comply with relevant guidance or is inconsistent with our knowledge and understanding of the Trust. We did not identify any matters to report in this regard.

Reporting to the NAO in respect of consolidation data

The NAO, as group auditor, requires us to report to them whether consolidation data that the Trust has submitted is consistent with the audited financial statements. We have concluded and reported that the consolidation data is consistent with the audited financial statements.

Mark Surridge

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B3 3AX

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*where permitted under applicable country laws.

Derbyshire Healthcare NHS Foundation Trust
Report to the Council of Governors – 7 September 2021

Lead Governor Role

Purpose of Report
To outline the importance of the Lead Governor role and request that the Council of Governors encourages eligible governors to submit a nomination for the Lead Governor role (and the Deputy Lead Governor role).

Executive Summary
It is a regulatory requirement for the Trust to have a Nominated Lead Governor. NHS Improvement (Monitor) guidance states that the role is intended to create one point of contact between NHS England/Improvement (Monitor) and the Council of Governors (CoG) (when necessary).

The above is the minimum requirement but in line with many other Trusts the role of Lead Governor at our Trust has been expanded to include greater responsibility and accountability which is outlined in the role description attached as Appendix A.

Lynda Langley, our current Lead Governor will be leaving the Trust when her office ends in March 2022, so it is important that her successor is in place before then. Ideally, we would have a period of shadowing.

We have been encouraging eligible Governors to consider the role for several months but to date no formal expressions of interest have been received. The requirement is now becoming pressing.

At the Governance Committee in August discussion took place on some of the possible barriers for Governors considering the role. This included the time commitment and also there is also a qualifying period that public governors need to be in post for before taking up the role. It was noted that there was some flexibility as each Lead Governor had made the role their own depending on their time commitments. Full support and training is available if required and the Lead Governor also has the support of the Deputy Lead Governor role, which also needs to be elected in time for when Carole Riley also leaves us in March 2022.

One suggestion is a public governor could try the role for 12 months rather than holding office for the remaining period they are public governors. The report includes an overview of current time commitments at Appendix B.

A recommendation was made to reduce the eligibility criteria down from 12 months to six months, matching that of Deputy Lead Governor. The Committee also re-stated the principle that the Lead Governor should be elected from the eligible Public Governors. This was primarily based on the fact that public governors have the majority representation on the Council of Governors.

The Council of Governors is asked to approve the change and confirm that the Lead Governor (and Deputy Lead Governor) will be a Public Governor.

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	

Assurances
This report takes into account Regulator guidance around the Lead Governor role.

Consultation
A review of the role of the Lead/Deputy Lead Governor was undertaken in 2019 and approved by the Council of Governors on 7 May 2019.

Governance or Legal Issues
Monitor's Code of Governance requires each NHS Foundation Trust to appoint or elect a Governor as Lead Governor and the role is described in the Code.

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:

Governors are fully supported by the Trust and reasonable adjustments implemented. Governors elected into the role will be offered on-going support and training.

Recommendations:
The Council of Governors is requested to:

1. Discuss the issues raised with a view to encouraging eligible public governors to submit a nomination for the role of Lead Governor (and Deputy Lead Governor).
2. Discuss and agree the proposed amendment to the role description/processes for the Lead Governor in relation to reducing the eligibility criteria to 6 months.

Report presented by: **Caroline Maley, Trust Chair**
Report prepared by: **Justine Fitzjohn, Trust Secretary**

Appendix A

LEAD GOVERNOR ROLE

Background

The Council of Governors (CoG) elects a Trust's Nominated Lead Governor, as required by NHSI (Monitor).

Although NHSI (Monitor) guidance states that the role is intended to create one point of contact between NHSI (Monitor) and the Council of Governors (CoG) (when necessary), best practice suggests that the role of the Lead Governor should be expanded to include greater responsibility and accountability.

Monitor guidance states that where NHS Foundation Trusts choose to broaden the Lead Governor's role, Directors and the Council of Governors should agree what it should and should not include. The Council of Governors should vote on or otherwise decide who the Lead Governor will be. Directors (including the Chair) should not be involved in this process. The Council of Governors will need to satisfy itself that whoever is appointed has the appropriate skills and experience.

Please note Monitor is part of NHS Improvement (NHSI) but remains referenced in this job description due to the regulatory requirements which directly related to Monitor.

Summary of roles and responsibilities

1. Direct link between the Governors and NHSE/I in situations where it would be inappropriate for NHSE/I to go through the Chair
2. Act as the point of contact between CoG and the Care Quality Commission (CQC)
3. In exceptional circumstances, chair Council of Governors meetings ~~in situations relating to CoG~~, when it is not appropriate for the usual Trust Chair or Deputy Chair to act into this role
4. Working with the Trust Chair, prioritise agenda items for CoG and ensure action plans are followed
5. Maintain regular communication with the Chair conducting regular reviews of the performance of the Trust
6. Member of the Nominations and Remuneration Committee
7. Member of the Governance Committee
8. Represent concerns that Governors may have (either as a body, or individually) to the Chair
9. Undertake appropriate action where non-compliance or any misconduct is alleged under the Governors' Code of Conduct, as set out in the Code, which could include, together with the Chair addressing inappropriate action by any Governor and raising the matter at the Governance Committee
10. Lead appraisal process for the CoG: facilitate CoG review of effectiveness, following completion of the CoG appraisal documents
11. Maintain close working relationship with the Senior Independent Director (SID) of the Board of Directors (BoD)
12. Together with the SID carry out the appraisal of the Chair

13. As representative of CoG establish and maintain working relationships with NEDs, BoD and forge links with external bodies such as CQC, and CoGs of other Foundation Trusts.
14. With the Chair, mutually agree with a Governor any formal time away from the role. The Lead Governor will then provide support following return of that governor from a leave of absence.

Personal Specification/ Time Commitment

The Lead Governor should have the ability to demonstrate the following in the role:

1. excellent interpersonal skills including listening skills and the ability to exercise good judgement, compassion and objectivity
2. ability to deal with personal conflicts, ability to command respect, confidence and support of colleagues, committed to reflecting the views of the whole Council
3. being prepared to acquire detailed knowledge of Foundation Trust Governance and of the Trust.
4. being able to commit time to the role.

The Trust will take steps to provide reasonable adjustments as necessary to assist any Governor to fulfil the role.

Qualifying Period and term of office.

The Lead Governor will be a Public Governor and will have served a minimum of ~~12~~ six months as a Governor of the Trust before taking up the office of Lead Governor. They will then hold office as Lead Governor for the remaining period they are a Public Governor or before if the CoG decide to terminate the appointment at an earlier date. An initial investigation into a request to terminate the appointment the Lead Governor will be managed by the Governance Committee, which will make a recommendation to the Council of Governors.

Extract from the Trust's Constitution in relation to the Lead Governor (Annex 5)

10.1 *The Council of Governors shall nominate one of its Governors as the nominated lead Governor (the "Nominated Lead Governor").*

10.2 The Nominated Lead Governor shall provide their contact details to NHSI (Monitor) and continue to update NHSI (Monitor) with their contact details as and when they change.

10.3 The role of the Nominated Lead Governor is to facilitate direct communication between NHSI (Monitor) and the Council of Governors in the limited circumstances where it may not be appropriate to communicate through the normal channels.

10.4 The Nominated Lead Governor shall take steps to understand NHSI (Monitor)'s role, the available guidance and the basis on which NHSI (Monitor) may take regulatory action.

10.5 In the event that an individual Governor wishes to make contact with NHSI (Monitor), this contact will be through the Nominated Lead Governor.

DEPUTY LEAD GOVERNOR ROLE

The Trust will also have a Deputy Lead Governor to support the Lead Governor across their range of duties. The Council of Governors will vote or otherwise decide who the Deputy Lead Governor will be.

They will have served a minimum of six months as a Governor of the Trust before taking up the office of Deputy Lead Governor. They will then hold office as Deputy Lead Governor for the remaining period they are a Public Governor or before if the CoG decide to terminate the appointment at an earlier date. An initial investigation into a request to terminate the appointment the Deputy Lead Governor will be managed by the Governance Committee, which will make a recommendation to the Council of Governors.

Their role will be:

- To deputise for the Lead Governor in their absence through illness or other clashing commitments
- To cover for the Lead Governor, where the Lead Governor may have a conflict of interest in taking part in an activity
- To offer support alongside the Lead Governor in maintaining working relationships with external bodies as detailed in Point 14 of the Role Description.
- To familiarise themselves with the workings of the Trust, NHSI and any other agencies in order to carry out their role.

Nomination process for both roles

The role of Lead Governor/ Deputy Lead Governor shall be reviewed by the Council of Governors on the approach of the expiry of the current term of office of the Public Governor(s) appointed to the post(s).

Subject to the qualifying period described in this document nominations will be sought from all Public Governors eligible for appointment to the post(s) and, in the event of there being more than one nominee for each post; the appointment(s) will be determined by a ballot in which all Governors will vote. If the Public Governor who has served as Lead Governor or Deputy Lead Governor is re- elected as a Public Governor on expiry of their term of office, they will be eligible for consideration for re-appointment to the Lead Governor or Deputy Lead Governor subject to following the agreed nomination process.

The proposed procedures for appointment are:

- All Public Governors able to meet the required qualifying period are invited to

self-nominate

- Nominees must submit a brief statement (maximum 250 words) with their nomination setting out what they would bring to the role. This statement will be distributed to all Governors to help them choose which candidate to vote for. Support will be given to complete the statement if required.
- If more than one valid nomination is received for either post, all governors are issued with a ballot paper and the person who receives the most votes will be appointed as the Lead Governor/Deputy Lead Governor (as long as over 50% of all Governors vote). It is proposed that a simple majority is appropriate as all decisions, where a vote is requested, are passed on a simple majority
- If there is only one valid nomination for either post, all Governors will be asked to support the nomination and if this person receives the support of the majority of Governors they will be appointed as the Lead Governor/Deputy Lead Governor.

More details of the voting and timeline are shown in Appendix 1

Appendix 1

Timeline for appointment of the Lead Governor and Deputy Lead Governor

Date 1 Nomination forms, with covering letter are sent to all public governors from the Membership and Involvement Manager

Date 2 Nominations and nomination statement deadline

Date 3 Ballot papers issued to all governors

Date 4 Closing date for ballot

Date 5 Results declared

Voting

If the matter comes to a vote then each governor will be asked to mark their voting paper once for their preferred candidate, in 'first past the post' voting method.

Appendix B

Overview of time commitments/duties of current Lead Governor

Chair appraisal

- One meeting annually with SID to discuss outcomes

Nominations and Remuneration Committee membership

- Approx. 2 per year (additional if recruiting)

1-2-1 meetings with Trust Chair

- 1 hour monthly

Ad hoc meetings with Denise Baxendale

- c.1 hour monthly

Annual Members Meeting

- Presentation of Governor and membership slide – 10 minutes (slide prepared by Denise in consultation with Lead Governor)

Audit and Risk Committee

- Attend the Annual Report and Accounts sign off meeting – 1 hour

Pastoral role

- Occasional

Contacting new governors

- Check-in emails and offer of 1-2-1 meetings if suggested.

Public Board meetings

- Attendance not essential, but desirable – 3 hours – 6 times per year

Governance Committee/CoG

- Ideally can join meetings 15-30 minutes earlier in a meet and greet role

Derbyshire Healthcare NHS Foundation Trust
Report to the Council of Governors – 7 September 2021

Non-Executive Director (NED) Deep Dive – Geoff Lewins

Purpose of Report
This paper provides both a description of my activities during the year and information covering the Annual Report of the Audit and Risk Committee. The paper primarily covers the year from April 2020 to March 2021 but will also include activities since March where relevant.

Executive Summary
As Chair of the Audit and Risk Committee this paper is principally concerned with my activities in that role and the assurances gained through that Committee. This broadly falls into two parts:

1) The Audit and Risk Committee's work to oversee the production of the Annual Report and Accounts. Since this Council will already have had a presentation from the External Auditors and/or the Director of Finance giving an overview of finances in 2020/21, I have focused on the process undertaken and the assurances gained rather than the financial results themselves. In summary the process of preparing and auditing the report and accounts was made considerably more difficult by the COVID-19 emergency but all involved in the process performed admirably and the Audit and Risk Committee gained significant assurance in the end result.
2) The Audit and Risk Committee also carried out a significant amount of other work during the year reviewing the Trust's system of risk management. This included regular reviews of the Board Assurance Framework, specific areas within its own remit and annual reports on the activities of other board committees. Our Internal Auditors, 360 assurance, attended all meetings and provided assurance on Internal Audit and Counter Fraud.

Additionally as a NED I attend Board meetings, Board Development meetings and am a member of the Remuneration Committee and the Finance and Performance Committee. During the year I have supported the Trust project to develop a single Electronic Patient Record and have become increasingly involved in Derbyshire System activities.

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's system of Risk Management is adequate in identifying risks and allowing the Board to understand the appropriate management of those risks
- The Audit and Committee has reviewed and used the Board Assurance Framework and believes that it is fit for purpose.
- There are no outstanding areas of significant duplication or omission in the Trust's system of governance that have come to our attention.

Consultation

- This report was prepared specifically for the Council of Governors and has not been to other groups or committees.

Governance or Legal Issues

- Every NHS organisation is required to have an Audit Committee.

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 EDI objectives of the Audit and Risk Committee are included within its terms of reference. The Committee reviewed how well these objectives had been met and confirmed that papers considered by the Committee had, in large part, made relevant reference to equality, diversity and inclusion matters.

Recommendations

The Council of Governors is requested to consider the content of this report and to ask for any clarification or further information.

Report prepared and presented by: Geoff Lewins, Non-Executive Director

Council of Governors – 7 September 2021

NED Deep Dive – Geoff Lewins

Purpose of Report

This paper provides both a description of my activities during the year and information covering the Annual Report of the Audit and Risk Committee. The paper primarily covers the year from April 2020 to March 2021 but will also include activities since March where relevant.

Audit and Risk Committee

As chair of the Audit and Risk Committee this paper is principally concerned with my activities in that role and the Assurances gained through that Committee. This broadly falls into two parts.

1) The Audit and Risk Committee work to oversee the production of the Annual Report and Accounts. Since the Council of Governors will already have had a presentation from the External Auditors, supported by the Director of Finance I have focused on the process undertaken and the assurances gained rather than the financial results themselves. Governors have had some finance training during the year and receive regular finance performance updates within the Integrated Performance Report (IPR).
2) The Audit and Risk Committee also carried out significant amount of other work during the year reviewing the Trust's system of risk management.

Audit and Risk Committee work to oversee the production of the Annual Report and Accounts

From December onwards the Trust Secretary and the Director of Finance maintained a plan of activities necessary for production of the Annual Report and Accounts which was regularly reviewed by the Audit and Risk Committee. This plan was informed by a review of the prior year process to identify opportunities for improvement and a review of accounting policies and new technical requirements prepared by the Finance team. Additionally, during the 2020 audit the External Auditors raised concerns over the levels of deferred income reported in the accounts and this was reviewed by the Audit and Risk Committee during the year to avoid a similar issue arising in 2021.

As noted in last year's report the then External Auditors, Grant Thornton, resigned and were replaced by Mazars who took over in November 2020. During the year Grant Thornton or Mazars attended all meetings of the Audit and Risk Committee with the exception of confidential Audit and Risk Committee meetings. Since taking over the role as External Auditors Mazars have kept the Committee appraised of their audit plans and provided assurance that they were liaising with the Trust's Finance team to ensure a smooth process.

As happened last year the actual year end process had to be carried out during a period of COVID-19 restrictions requiring both Trust staff and Mazars to work remotely thus significantly increasing the difficulty of the process. It is a tribute to their hard work and the quality of the planning that the year end activity went so well.

The Committee continued to meet virtually throughout the year. In accordance with good practice the Lead Governor attended the meeting scheduled to sign off the accounts. At that meeting Mazars confirmed that they were able to sign off the accounts with an unqualified opinion which enabled timely submission of documents to NHS England and Improvement (NHSE/I).

In order to complete the 2021 statutory activity it was necessary to lay the Annual Report and Accounts before Parliament following which the Trust could publish the documents on our website and present them to the Council of Governors and the Annual Members Meeting. Before we could do this it was necessary for Mazars to complete some further work on 'Value for Money'.

Under normal circumstances this would have been completed at the same time as their work on the Annual Report and Accounts however some additional requirements were laid upon them by the National Audit Office which delayed this final sign off for most if not all Trusts. This was not due to any deficiencies in the work of Mazars or the Trust and this work was completed in time for the July 2021 Audit and Risk Committee and the Annual Report and Accounts were laid before Parliament as required.

Once again I would like to express my thanks for the exceptional work carried out by the Finance Team during this process.

Internal Audit

Our Internal Auditors, 360 Assurance, attend all Audit and Risk Committee meetings and, in addition to the Head of Internal Audit opinion in the Report and Accounts, provide regular reports on the Internal Control framework and on their Counter Fraud activity. The Audit and Risk Committee approves an Internal Audit plan and during the year a number of Internal Audit reports are produced in accordance with the plan. The Audit and Risk Committee reviews the reports and also monitors the action plan of agreed management actions arising from the Internal audit reports.

Board Assurance Framework (BAF)

The Audit and Risk Committee reviews the quarterly iterations of the BAF prior to its formal approval by the Board. Each of the items on the BAF is the responsibility of one of the Board Committees which will carry out a deep dive to confirm risk assessment and assess adequacy of mitigating actions. In addition, risks rated as extreme are subject to a deep dive at the Audit and Risk Committee. During the year the Director of People and Inclusion presented the Deep Dive on the extreme risk 20_21 2a (There is a risk that we do not create a healthy, vibrant culture and conditions to make Derbyshire Healthcare NHS Foundation Trust (DHCFT) a place where people want to work, thrive and grow their careers).

Year-End Effectiveness Reports from Board Committees

Board Committees represent key parts of the overall risk management framework of the Trust. At the end of the year each Committee prepares a report on its activities and how it has met its objectives. The Audit and Risk Committee reviews these reports as part of its overview of the risk management framework.

Other areas of Audit and Risk Committee responsibility

The Committee has responsibility, within its objectives, for a number of important areas of activity within the Trust. Reports on these areas are scrutinised during the year.

Data Security and Protection – this is an area of strength for the Trust where the team has performed well when benchmarked against other Trusts and when reviewed by Internal Audit. We cannot be complacent however as the risk of Cyber attacks remains high across the NHS. A new cyber risk was added to the BAF in 2021/22.

Standing Financial Instructions (SFIs) – an important part of the Trust control framework is a set of SFIs which govern how the Trust enters into Financial commitments. Occasionally it is not possible to follow these in which case there is a formal process of management review to waive them culminating in an Audit and Risk Committee review of the appropriateness of those waivers.

Freedom to Speak Up (FTSU) – enabling colleagues to speak up without fear if they feel the need is very important and responsibility for ensuring this process is working satisfactory is shared between the Audit and Risk Committee , which oversees the process in place, and the People and Culture Committee which focuses on the issues surfacing through the FTSU process.

Clinical Audit – similarly to FTSU, responsibility is shared between the Quality and Safeguarding Committee which reviews the findings of Clinical Audit Work and the Audit and Risk Committee which looks at the process including resourcing and effectiveness.

Data Quality – it is important that the Trust retains a high level of data quality to ensure that its decision making and reporting to regulatory authorities remains sound. This is a challenge facing all organisations and the Audit and Risk Committee receives reports from Management and Internal audit in this area.

Conflict of Interest – the Audit and Risk Committee receives reports on gifts and hospitality and secondary employment which could potentially lead to conflicts of interest. In addition there are exercises focused on Board members and Decision Making staff to ensure comprehensive coverage.

Other Activities Outside of the Audit and Risk Committee

In addition to attendance at Board meetings, Council of Governors and Board Development days I am a member of the Finance and Performance Committee which I find very interesting as I can draw on my previous experience in Finance, Process Improvement and information technology (IT).

During last year it became clear that there was opportunity to use the experience of myself and other NEDs to support projects both within the Trust and within the Derbyshire system.

I have become involved with the OnEPR project which will migrate the Trust from PARIS to SystmOne. This will bring significant patient and efficiency benefits by, amongst other things, enabling much improved data sharing with primary care. The first and second phases of the project successfully implemented in November 2020 and June 2021 respectively. Further phases are scheduled for September and November.

On a similar theme I am involved with the Derbyshire System in the implementation of a linked IT system – the 'shared care record'. This will enable sharing (subject to appropriate information security) of citizen records across NHS and social services which should provide further benefits in care across the county.

The Derbyshire System is continuing on its path to become an Integrated Care System (ICS) with increasing involvement of Trust NEDs in System Committees. I have recently joined the 'System Transition Assurance Sub-Committee' which is providing assurance on the transition activities to move towards ICS status.

I have continued to attend national briefings and peer to peer teams and zoom calls hosted by both the good governance institute and NHS digital.

Derbyshire Healthcare NHS Foundation Trust
Report to the Council of Governors – 7 September 2021

Integrated Performance Report

Purpose of Report

This paper provides Council of Governors with an integrated overview of performance at the end of July 2021. The focus of the report is on workforce, finance, operational delivery and quality performance.

The purpose of the report is to provide information to governors – a verbal summary of the Boards performance presented by the Non-Executive Directors. This provides governors with details of how the Non-Executive Directors seek assurance from the Board on strategy issues including holding Executive Directors to account through Board Committees.

Executive Summary

The report 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. 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

<u>Revenue</u>

Under the current financial regime set by NHSEI, there has only been a requirement to submit a half year (H1) plan. However, the Trust has also an internal plan for H2 generating a full year plan. The previous block income payments that were transacted in 2020/21 have continued into 2021/22.

Our financial position forms part of the overall financial position of Joined Up Care Derbyshire.

Month 4	**2021/22**					
	In month			**YTD**		
	Plan	**Actual**	**Variance**	**Plan**	**Actual**	**Variance**
Income	(14,690,250)	(13,877,783)	812,468	(58,455,898)	(57,270,730)	1,185,168
Pay	10,692,088	10,199,362	(492,726)	42,481,022	41,462,983	(1,018,039)
Non-Pay	3,986,744	3,667,025	(319,719)	15,997,578	15,830,553	(167,025)
Total	**(11,418)**	**(11,396)**	**22**	**22,702**	**22,806**	**104**
	H1 Forecast			**Month 1-12 FOT**		
	Plan	**Actual**	**Variance**	**Plan**	**Actual**	**Variance**
Income	(87,836,406)	(86,587,883)	1,248,523	(173,045,873)	(174,662,353)	(1,616,481)
Pay	63,865,193	62,515,571	(1,349,622)	126,865,008	128,466,310	1,601,303
Non-Pay	23,971,213	24,023,408	52,195	46,097,745	46,142,406	44,661
Total	**0**	**(48,905)**	**(48,905)**	**(83,120)**	**(53,637)**	**29,483**

The Trust's year to date position at the end of month 4 is a small surplus of £11k as per plan. The forecast for H1 (months 1-6) is a small surplus of £49k against a breakeven

plan. The full year forecast is a surplus of £54k against an internal planned surplus of £83k.

Income is currently behind plan due to slippage on recruitment related to some new investments such as the Community Mental Health Framework and CAMHS Crisis. This has offsetting expenditure underspends. However, Income is forecast to be above plan by £1.6m mainly due to the release of deferred income totalling £1.2m (with offsetting expenditure). The slippage on CMHF and CAMHS Crisis investments is mainly offset by the value of the new investments for LD Specialist Autism Team and Dementia.

We expect to receive additional funding from the mental health investments over and above the ones mentioned above – this is to be confirmed – regular meetings are taking place with commissioner colleagues linked to Delivery Board and a new approach to financial reporting is underdevelopment to support Delivery board to manage the total MH and LD programme spend and risks within it. The forecast will be updated to reflect and new agreements when they are made.

Efficiencies

The full year plan includes an efficiency require of £2.3m mainly phased in the second half of the financial year. The forecast at month 4 assumes that this will be delivered in full. The financial arrangements for H2 are not yet confirmed, but nationally (and regionally) it has been signalled that we should expect increased efficiency requirements likely to be around 3%.

Agency

At the end of month 4 agency expenditure is above the ceiling by £662k which equates to 66%. The two highest areas of agency spend relates to Medical staff and Ancillary staff (mainly domestics). The forecast assumes that agency costs will reduce slightly from month 8 but is still generating forecast spend of £4.6m which is above the ceiling by £1.6m (54%). The forecast does include a contingency of £120k for any unforeseen agency usage.

Out of Area Placements

Expenditure for adult acute out of area placements and stepdown placements is within budget year to date. The forecast assumes expenditure for the 11 block beds and no ‘inappropriate’ out of area placements for the remainder of the financial year.

Covid costs

The Trust has an allocation of £700k a month for months 1-6 for Covid-related expenditure. The year to date expenditure is currently within that allocation. The main costs are driven by pay at £1.8m with a further amount of £0.9m on non-pay expenditure.

Capital

With regards to self-funded capital, the Trust is on plan at the end of month 4 and it is expected that the full capital plan is committed by the end of the financial year.
The Trust has received additional PDC capital funding for the initial stages of the dormitory eradication programme, this is the year two element of the original MOU.
In April 2021 we received formal notification from NHSEI that we have been allocated a place on the dormitory eradication programme with allocations totalling £80m, however this is subject to successful business case processes to secure; Outline Business Cases are in train.

Cash

Cash is at £38.5m at the end of July which is in line with last month's cash levels. Cash is forecast to reduce down to £32.5m by the end of the financial year in line with capital expenditure, payment of PDC dividends in September and March along with the clearing of old invoices.
Cash will take on enhanced focus in the coming months and years due to the PICU and dorms capital requirements. It is essential that we maintain adequate working capital and cashflows to pay our workforce and suppliers as well as deliver the various capital programmes. Appropriate assurance and scrutiny on these matters will take place at Finance and Performance Committee.

Operations

Three-day follow-up of all discharged inpatients

To date we have consistently achieved the national standard for follow-up which came into effect from 1 April 2020.

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 benchmarked against other trusts our data quality is well above average.

Early intervention 14-day referral to treatment

We have seen common cause variation throughout the 24-month period, and we would expect to consistently exceed the national standard for referral to treatment.

Early intervention 14-day referral to treatment – incomplete (people currently waiting to be seen)

The target has been achieved throughout the 24-month period.

IAPT 18-week referral to treatment

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

IAPT 6-week referral to treatment

With staff back in post we would expect to consistently exceed the national standard.

IAPT patients completing treatment who move to recovery

For the last 12 months the national standard has been achieved, with common cause variation seen throughout the data period. This is an annual target and last financial year the full year target was achieved.

Patients placed out of area – adult acute

We currently operate with 10 Trust adult acute beds closed in order to facilitate social distancing and cohorting. Whilst these beds are closed, we commission 11 beds at Mill Lodge, Kegworth. These beds were eventually classified as "appropriate" out of area from April 2021 due to achieving continuity of care standards.

Patients placed out of area – Psychiatric Intensive Care Units

The PICU usage has remained within common cause variation for the last 9 months. There is currently no PICU provision in Derbyshire so anyone needing psychiatric intensive care needs to be placed out of area. Work is in progress to try and reach agreement for a Trust PICU.

Waiting list for care coordination

The average wait to be seen has been unusually low for the last 3 months and the number of people waiting to be allocated a care coordinator has been significantly low for the last 11 months.

Autistic spectrum disorder assessment

Unfortunately, the waiting list is slowly increasing. A steady number of referrals is leading to a compounding month on month increase. We are continuing with our COVID-19 recovery plans. We have identified locations, timings, protocols for safe COVID-19 face to face appointments. The team are also spending time preparing for the move to SystmOne which means spending time finalising our assessment tools – making sure they are fit for purpose based on the legal advice we were given. We have had the recent retirement of a member of the ASD diagnostic team. We are currently recruiting to that role. A number of plans are in place to respond to the waiting list challenge.

Waiting list for psychology

We can see the impact of the pandemic on waits, with the waiting list being significantly higher than expected for months, but in recent months waits have returned to normal. Many patients are still waiting due to the pandemic and the desire to be seen face to face. Referrals remain steady.

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

The average wait to be seen has returned to common cause variation for the last few months following a period of longer than expected waits from the start of the pandemic. The number of referrals received has been steadily increasing, with a corresponding increase in activity. From week commencing 27/09 until 29/10 we are carrying out a 'waiting list blitz'. We are aiming to undertake around 320 assessments during the time period which should reduce the longest wait on the waiting list to around 6 weeks.

Waiting list for community paediatrics

The number of children on the waiting list has returned to common cause variation levels for the last 4 months. The average wait to be seen continues to be significantly shorter than expected.

Outpatient appointments cancelled by the Trust

The proportion of cancelled appointments was significantly higher than expected from March 2020 owing to the pandemic but for the last 12 months has been significantly lower than expected, however in the current process the 5% target is unlikely to be achieved. There are recording and reporting issues to be addressed to improve the accuracy of reporting.

Outpatient appointment "did not attends"

The level of defaulted appointments has remained within common cause variation for the last 14 months and in the current process the trust target of 15% or lower is likely to be consistently achieved.

Other Operational Matters of Note

Health Protection Unit

The Health Protection Unit (HPU) was set up in May of this year, with the aim to coordinate matters relating to health protection and prevention. This includes, COVID-19 related issues, vaccinations, health promotion and prevention initiatives.

Vaccination status

93% of people working for the Trust have now been vaccinated.

Respiratory Syncytial Virus Infection (RSV) in infants and young children

RSV is a very common virus and almost all children are infected with it by the time they are 2 years old. Public Health England have reported a rise in respiratory infections in young children out of season. We have engaged with our acute hospital partner organisations to ensure that we support their ability to maintain flow.

People

Annual appraisals

The “wellbeing conversation” now supplements an alternative mini appraisal process. In general appraisal completion is also beginning to improve where managers and staff are able to factor in that dedicated time.

Annual turnover

The rate of turnover has been higher for the last 2 months; July turnover is 12.47% just above the Trust target range of 8-12%. Retirements continue to add to the turnover rate although this is still in line with national predictions due to an ageing workforce across the NHS.

Compulsory training

The 6 month pause on training at the beginning of the pandemic inevitably impacted hugely on compliance levels and it will take considerable time to recover the position. Improvements in compliance had begun to recover and it was expected to improve over coming months, however due to further rises in cases across Derbyshire, training attendance was reduced temporarily and will be stepped back up as the local situation improves.

Staff absence

Staff absence had been lower than average for most of the pandemic. Long term sickness absence has begun to reduce whilst short term absence has increased in line with relaxation of restrictions and increased infection rates.

Clinical and management supervision

The levels of compliance with the clinical and management supervision targets have remained low since the start of the pandemic.

Proportion of posts filled

Prior to the start of this financial year there were a number of factors that had in effect artificially lowered the vacancy rate prior to April 2021, however this has now been adjusted for at the start of this financial year, which is where we can see a significant drop in posts being filled.

Bank staff

Following a period of 7 months of unusually high bank staff use, in the past 3 months the position has returned to common cause variation.

Quality

Compliments

The number of compliments decreased in line with the emergence of COVID-19 and the significant changes to many of our clinical services. As a result of reduced face to face contact, there has been a drop in the number of compliments received. Work is underway to improve feedback from service users via an electronic survey received by text or email.

Complaints

The number of complaints increased with a particular theme around both concerns and complaints of access to services.

Delayed transfers of care

Delayed transfers of care remain within the expected parameters and remain low compared to national mean.

Care plan reviews

The proportion of patients whose care plan have 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.

Patients in employment

The Individual Placement Support (IPS) Service continues to have success in supporting people into employment even during the current pandemic and the service is currently expanding. The IPS service came into effect in January 2020 and the data demonstrates the impact they have had on levels of employment, even during a pandemic.

Patients in settled accommodation

There continue to be community nurses dedicated to working in a multi-agency environment supporting our homeless service users however, data presents below the lower control limits and so further investigation is required.

Medication incidents

The medicines management operational subgroup are currently revising the medications error procedure, taking into account Trust values.

Incidents of moderate to catastrophic actual harm

The number of reported incidents of moderate to catastrophic harm have remained within common cause variation throughout the reporting period.

Duty of Candour

There have been no instances of Duty of Candour in the last 5 months.

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 Heads of Nursing.

Physical restraint

The number of reported incidents involving restraint have remained within common cause variation throughout the reporting period. Although restraint and seclusion have peaked in July, they remain under the upper control limit and it has not resulted in an increase in prone restraint. This is a positive indicator that reducing restrictive practice pilots and work streams have been effective to provide alternatives to prone restraint.

Seclusion

The use of seclusion was within common cause variation, however, has increased in July. In further investigating this trend, there appears to be a linked to a small number of patients who have been placed in seclusion on more than one occasion. This data will be monitored for patterns and further support needs for individual areas.

Falls on inpatient wards

The number of reported falls has remained within common cause variation. April 2021 to July 2021 has remained below the mean line and demonstrates the effectiveness of ongoing falls reduction work being developed and implemented within Older adult services.

Care Hours Per Patient Day (CHPPD)

CHPPD is rolling data updated monthly, to show staffing levels in relation to patient numbers on an inpatient ward. When benchmarked against other mental health trusts we were slightly below average.

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 Council of Governors is requested to:

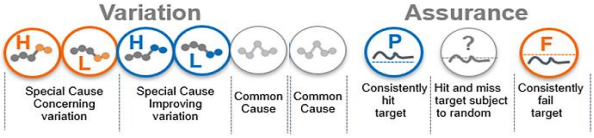
1) Consider the content of the paper as presented from the perspective of the Non-Executive Directors on how they have held the Executive Directors to account through their role.

Report presented by:	**Margaret Gildea, Non-Executive Director** **Ashiedu Joel, Non-Executive Director** **Geoff Lewins, Non-Executive Director** **Shelia Newport, Non-Executive Director** **Julia Tabreham, Non-Executive Director** **Richard Wright, Non-Executive Director**
Report prepared by:	**Ade Odunlade, Chief Operating Officer** **Claire Wright, Director of Finance/Deputy Chief Executive** **Carolyn Green, Director of Nursing and Patient Experience**

Assurance Summary

	Metric Name	Variation	Assurance	Latest Value	Target	Lower process limit	Upper Process limit	Mean
1	3 day follow-up			85%	80%	76%	101%	88%
2	Data quality maturity index			97%	95%	97%	98%	97%
3	Early intervention 14 day referral to treatment - complete			82%	60%	68%	108%	88%
4	Early intervention 14 day referral to treatment - incomplete			88%	60%	59%	112%	86%
5	IAPT 18 week referral to treatment			100%	95%	100%	100%	100%
6	IAPT 6 week referral to treatment			86%	75%	81%	97%	89%
7	IAPT patients completing treatment who move to recovery			53%	50%	47%	62%	54%
8a	Average patients out of area per day - adult acute			0		1	17	9
8b	Patients placed out of area - adult acute			2		4	29	16
9a	Average patients out of area per day - PICU			15		7	22	14
9b	Patients placed out of area - PICU			23		14	35	25
10a	Waiting list - care coordination - average wait to be seen			15		14	34	24
10b	Waiting list - care coordination - number waiting at month end			15		22	69	46
11a	Waiting list - ASD assessment - average wait to be seen			66		48	56	52
11b	Waiting list - ASD assessment - number waiting at month end			1,281		967	1081	1024
11c	ASD assessments			17	26.0	1	37	19
12a	Waiting list - psychology - average wait to be seen			29		23	28	26
12b	Waiting list - psychology - number waiting at month end			403		509	618	563
13a	Waiting list - CAMHS - average wait to be seen			18		17	22	20
13b	Waiting list - CAMHS - number waiting at month end			480		391	481	436
14a	Waiting list - community paediatrics - average wait to be seen			10		10	15	13
14b	Waiting list - community paediatrics - number waiting at month end			766		544	821	682
15	Outpatient appointments cancelled by the Trust			7%	5%	4%	19%	11%
16	Outpatient appointment "did not attends"			12%	15%	9%	15%	12%
17	Annual appraisals			75%	85%	72%	81%	77%
18	Annual turnover			12%	8-12%	10%	11%	11%
19	Compulsory training			86%	85%	83%	88%	86%
20	Staff absence			6%	5%	5%	8%	6%
21	Clinical supervison			72%	95%	74%	80%	77%
22	Management supervision			76%	95%	76%	81%	79%
23	Filled posts			86%	100%	88%	93%	90%
24	Bank staff use			6%	5%	5%	7%	6%
25	Compliments received			61	119	63	162	113
26	Formal complaints received			9	13	3	22	13
27	Delayed transfers of care			0%	3.5%	-0.6%	1.7%	0.5%
28	CPA reviews			89%	95%	90%	95%	93%
29	Patients in employment			10%		10%	11%	11%
30	Patients in settled accommodation			52%		58%	62%	60%

Key to symbols[1]:



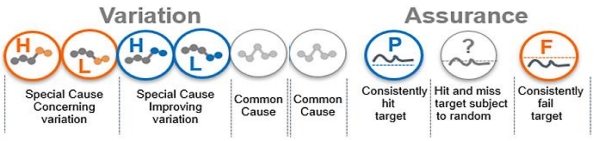
Blue dots indicate special cause variation, better than expected.

Orange dots indicate special cause variation, worse than expected.

[1]The rating symbols were designed by NHS Improvement

	Metric Name	Variance	Assurance	Latest Value	Target	Lower process limit	Upper process limit	Mean
31	Number of medication incidents			66		27	75	51
32	No. of incidents of moderate to catastrophic actual harm		P	67	48	13	81	47
33	No. of incidents requiring Duty of Candour		?	0	1	-1	3	1
34	No. of incidents involving prone restraint		?	5	12	-1	21	10
35	No. of incidents involving physical restraint		?	54	46	4	85	45
36	No. of new episodes of patients held in seclusion		?	21	14	3	28	15
37	No. of falls on inpatient wards		?	22	30	6	46	26

Key to symbols[1]:



Blue dots indicate special cause variation, better than expected.

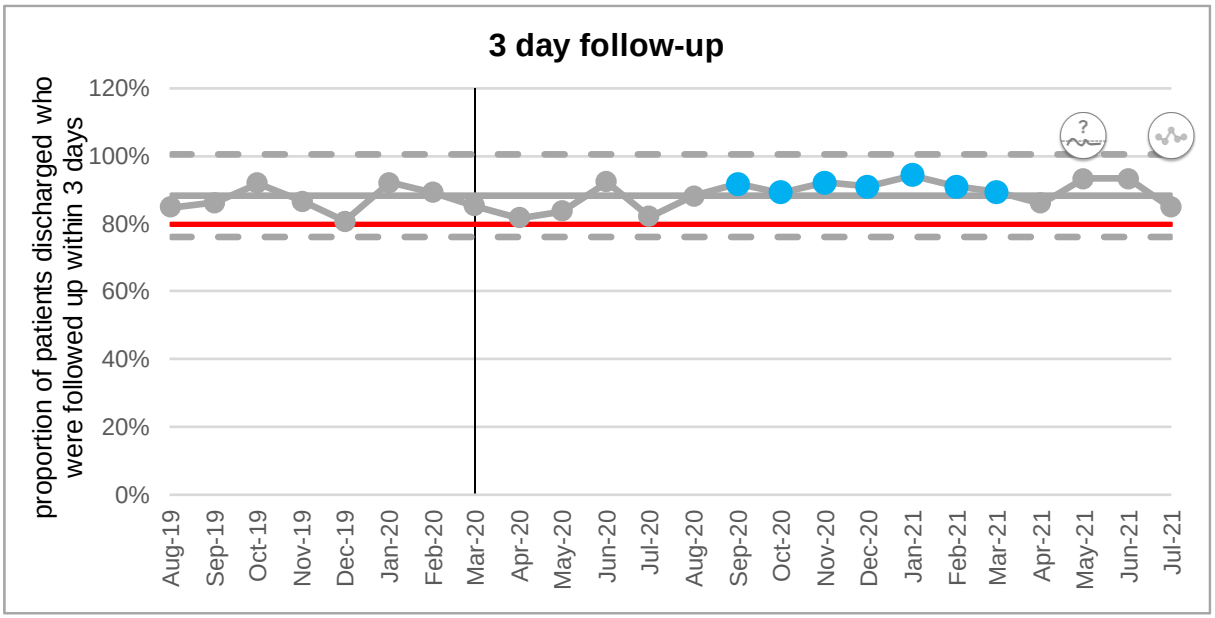
Orange dots indicate special cause variation, worse than expected.

[1]The rating symbols were designed by NHS Improvement

Detailed Narrative

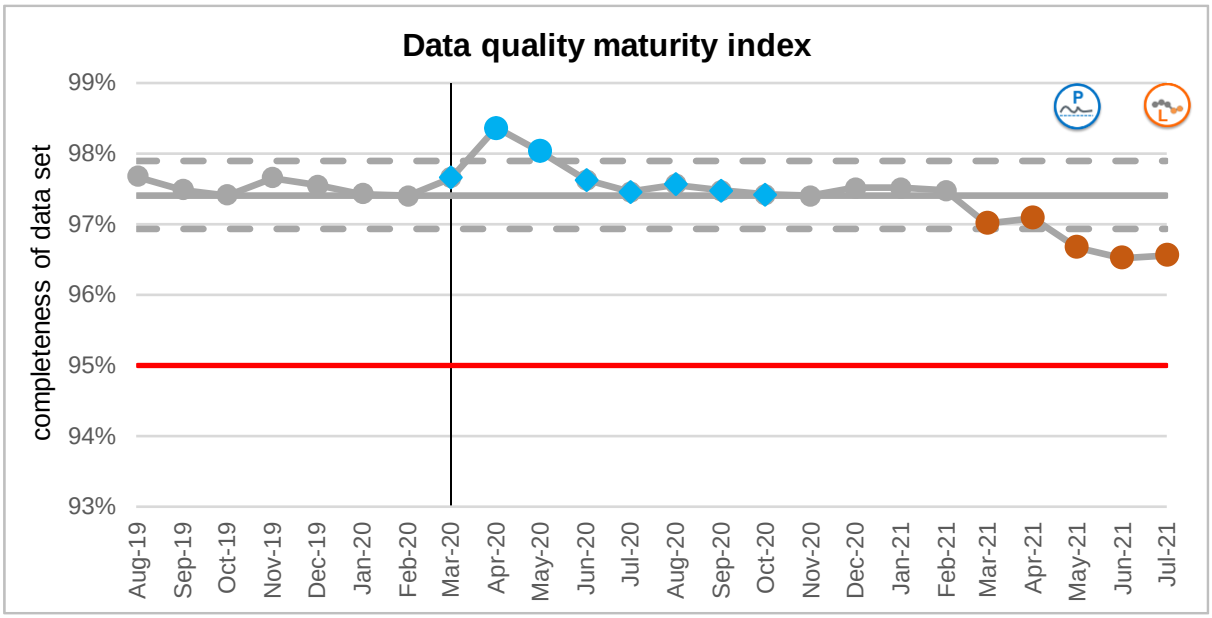
Operations

1. Three-day follow-up of all discharged inpatients



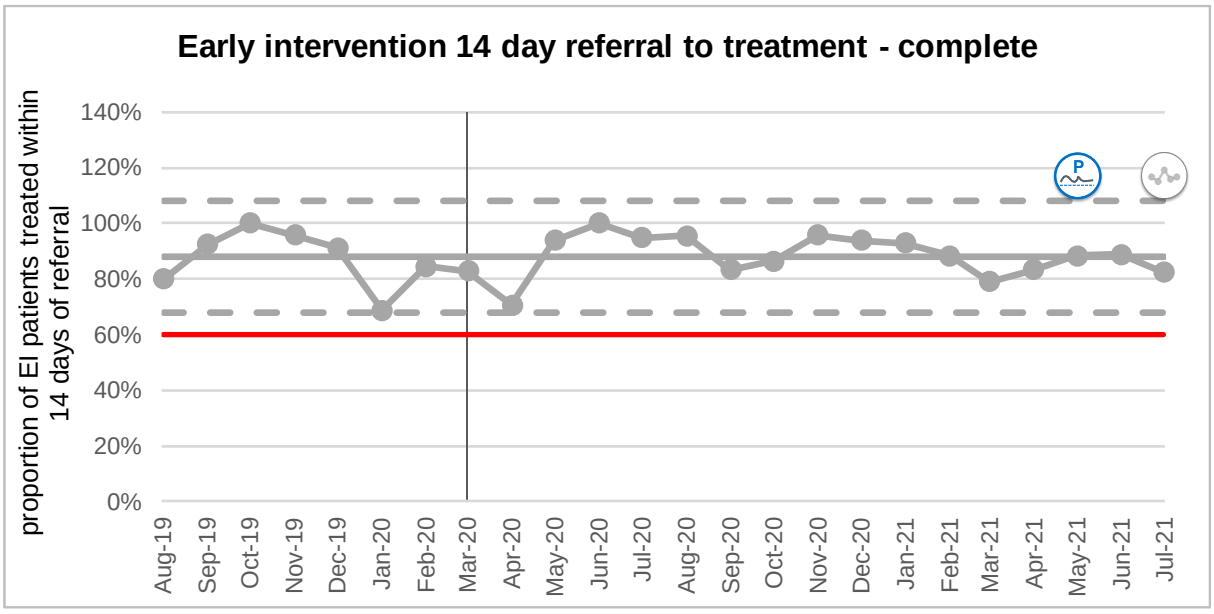
Patients are followed up in the days following discharge from mental health inpatient wards to provide support and ensure their wellbeing during the period when they are at their most vulnerable. To date we have consistently achieved the national standard for follow-up which came into effect from 1 April 2020. Despite this high level of performance, the process limits would suggest that we are as likely to pass or fail the target based on random variation.

2. Data quality maturity index



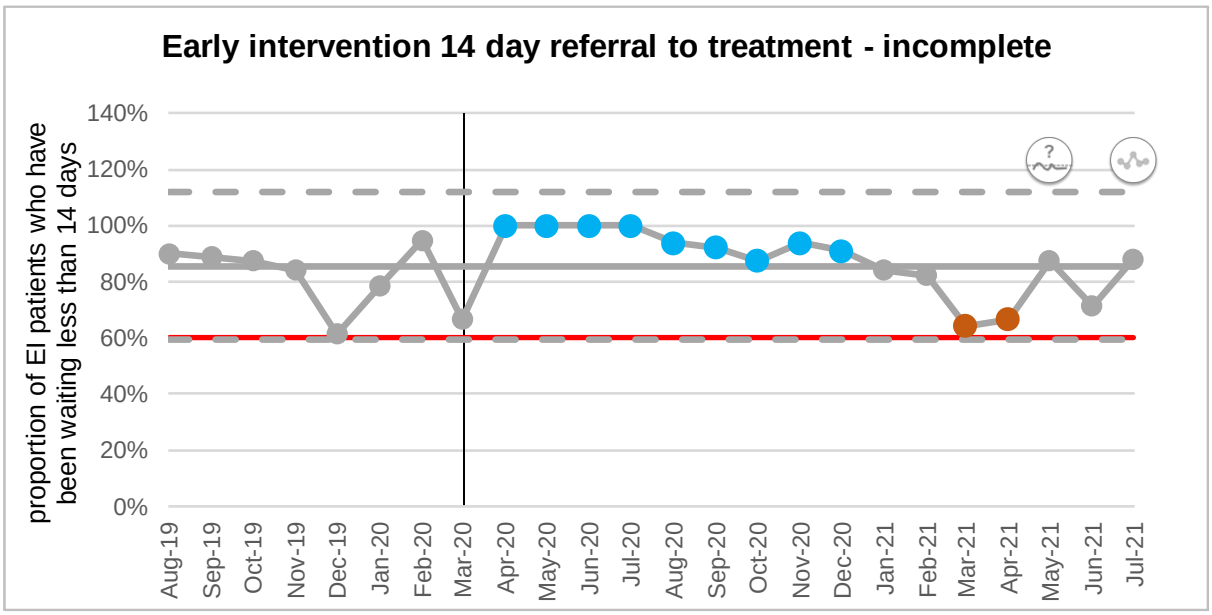
Increasing waiting lists resulting from the pandemic continue to have a negative impact on data quality, however we have consistently exceeded the national target. When benchmarked against other trusts our data quality is well above average (see Appendix 2).

3. Early intervention 14-day referral to treatment



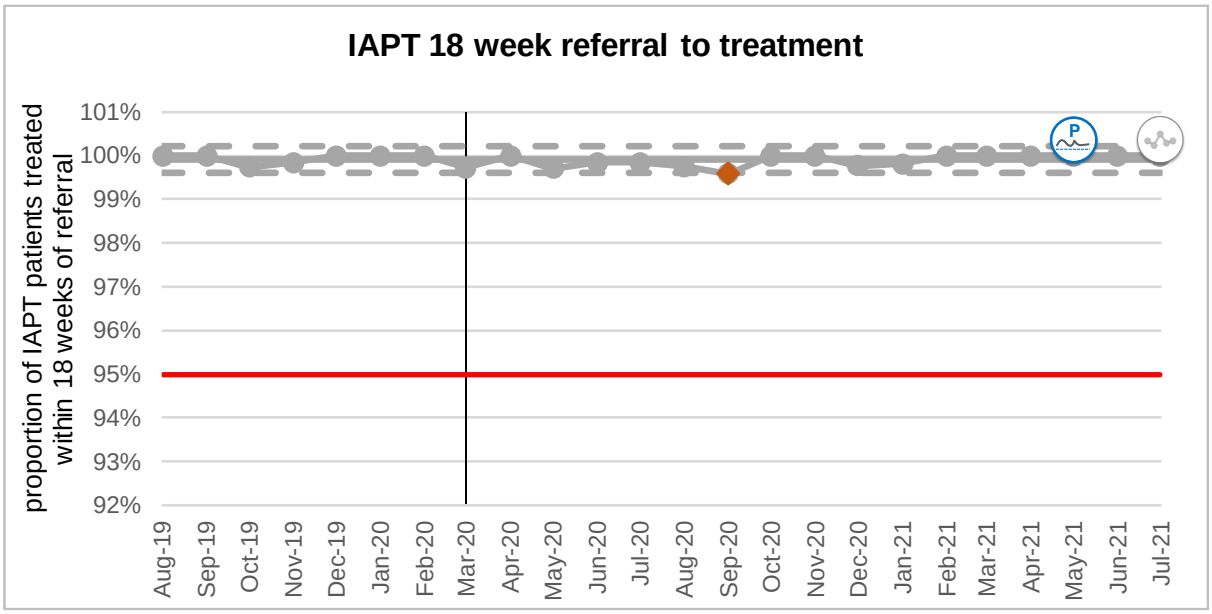
We have seen common cause variation throughout the 24-month period, and we would expect to consistently exceed the national standard for referral to treatment.

4. Early intervention 14-day referral to treatment – incomplete (people currently waiting to be seen)



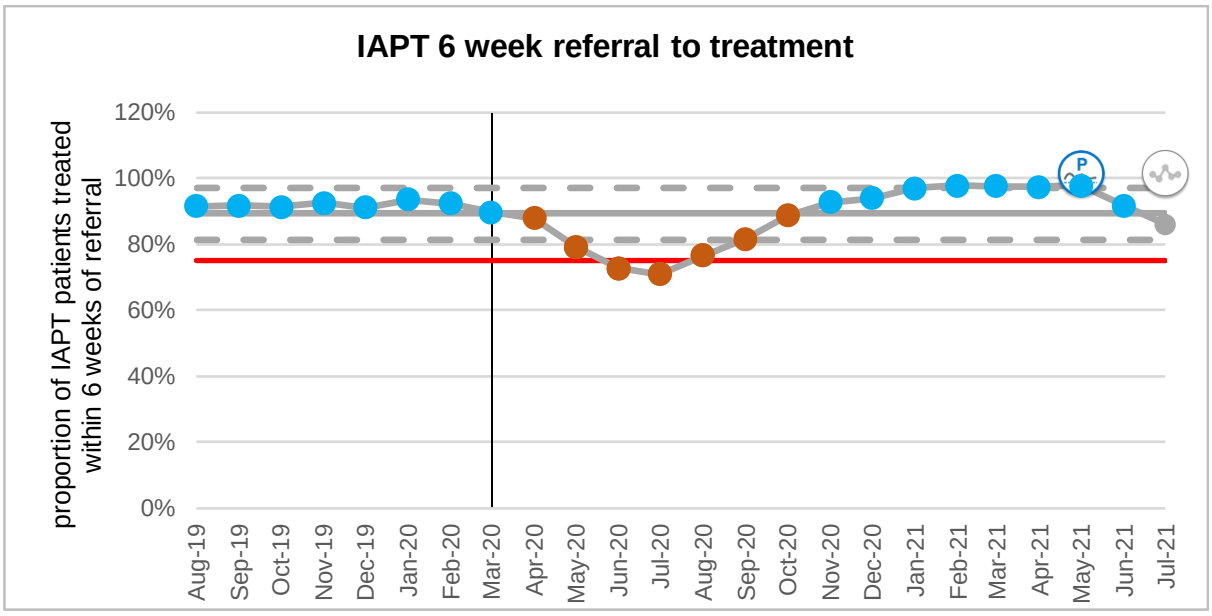
The service continues to perform consistently well against the national 14-day referral to treatment standard of 60% or more people on the waiting list to be have been waiting no more than 2 weeks to be seen. The target has been achieved throughout the 24-month period.

5. IAPT 18-week referral to treatment



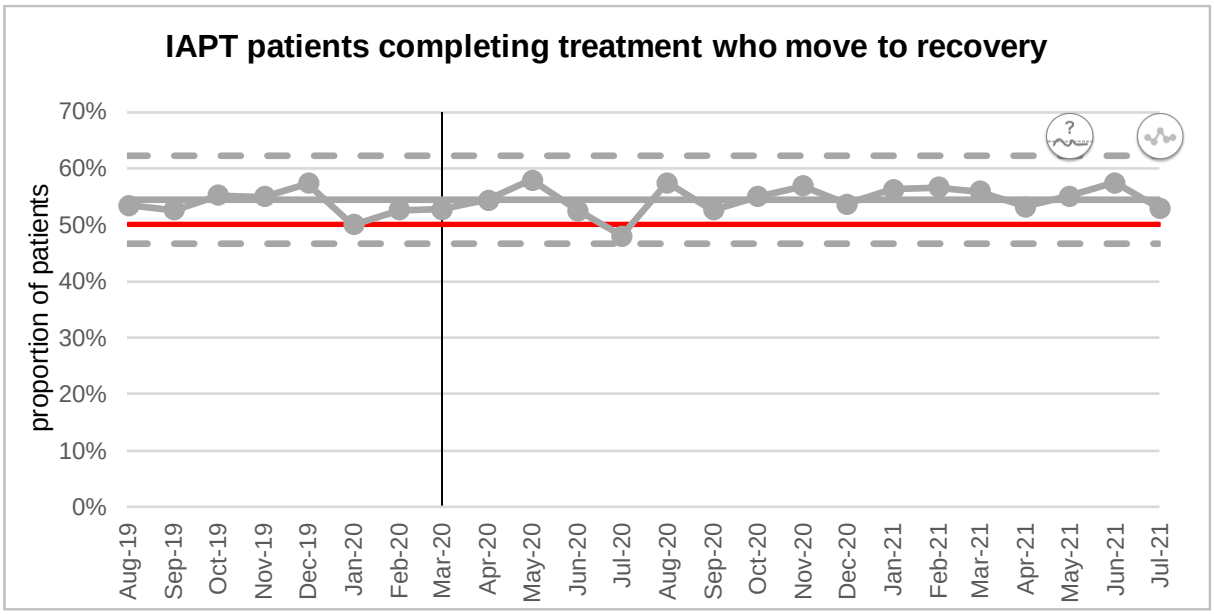
The national target has been exceeded throughout the 24-month reporting period. This is an example of a very tightly controlled process and we would expect to consistently exceed the 95% standard.

6. IAPT 6-week referral to treatment



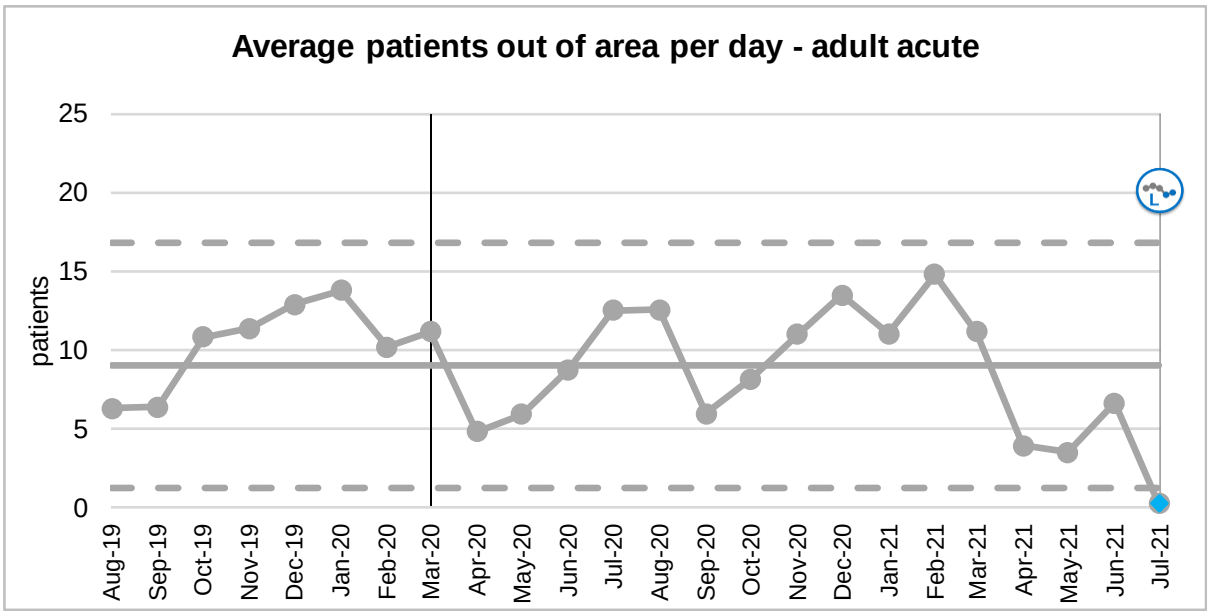
Following a period of 7 months of special cause concerning variation as a result of staff being redeployed to support other services as the pandemic progressed, the staff returned to IAPT in November 2020 and for 8 months performance was better than expected before returning to common cause variation last month. With staff back in post we would expect to consistently exceed the national standard.

7. IAPT patients completing treatment who move to recovery



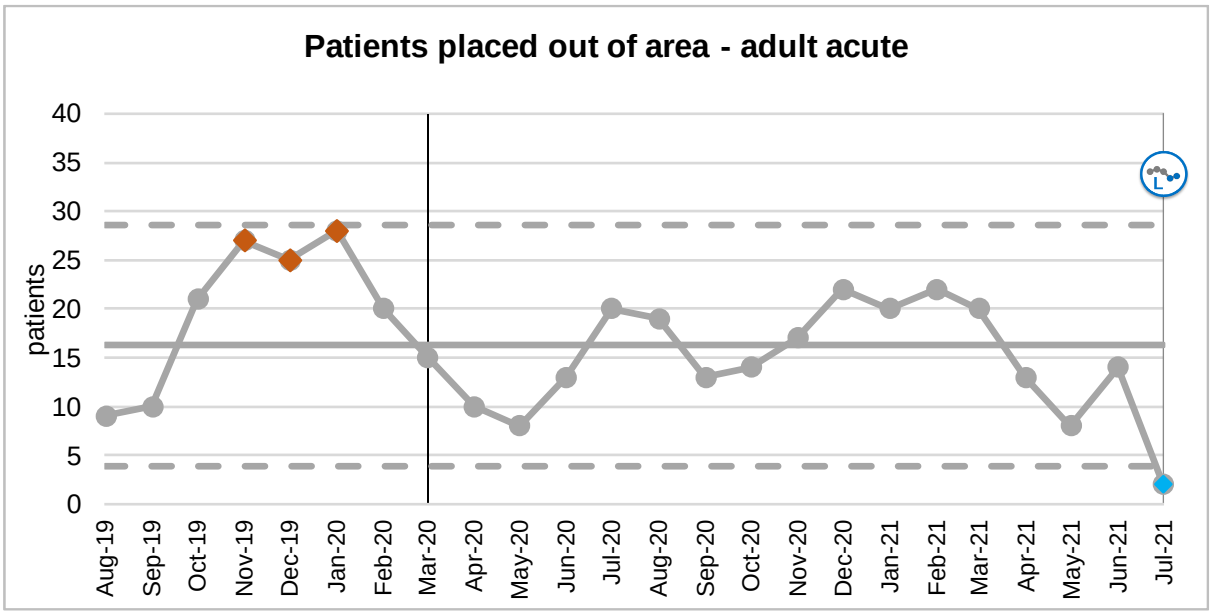
For the last 12 months the national standard has been achieved, with common cause variation seen throughout the data period. This is an annual target and last financial year the full year target was achieved.

8a. Average number of patients placed out of area per day – adult acute

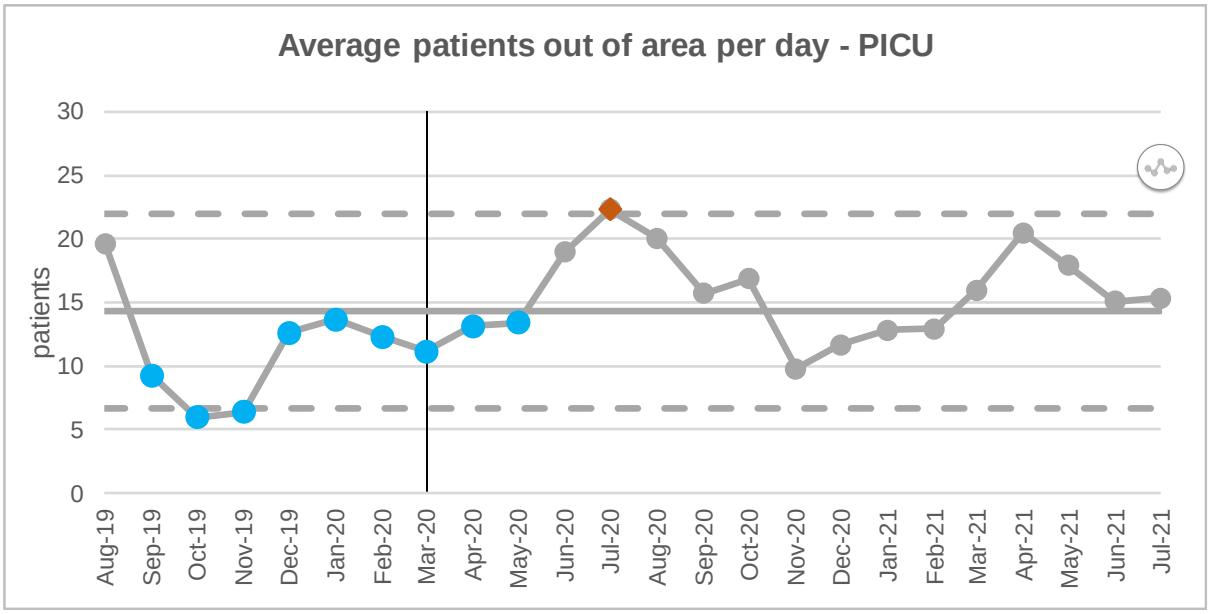


We currently operate with 10 Trust adult acute beds closed in order to facilitate social distancing and cohorting. Whilst these beds are closed, we commission 11 beds at Mill Lodge, Kegworth. These beds were eventually classified as “appropriate" out of area from April 2021 due to achieving continuity of care standards.

8b. Patients placed out of area per month – adult acute

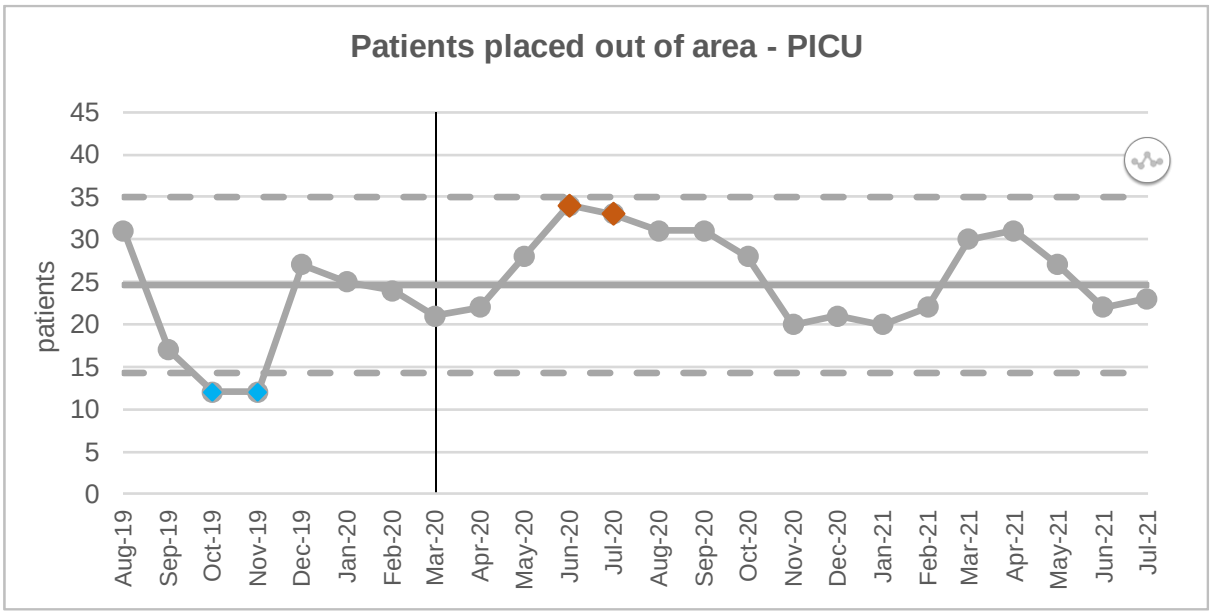


9a. Average number of patients placed out of area per day– Psychiatric Intensive Care Units

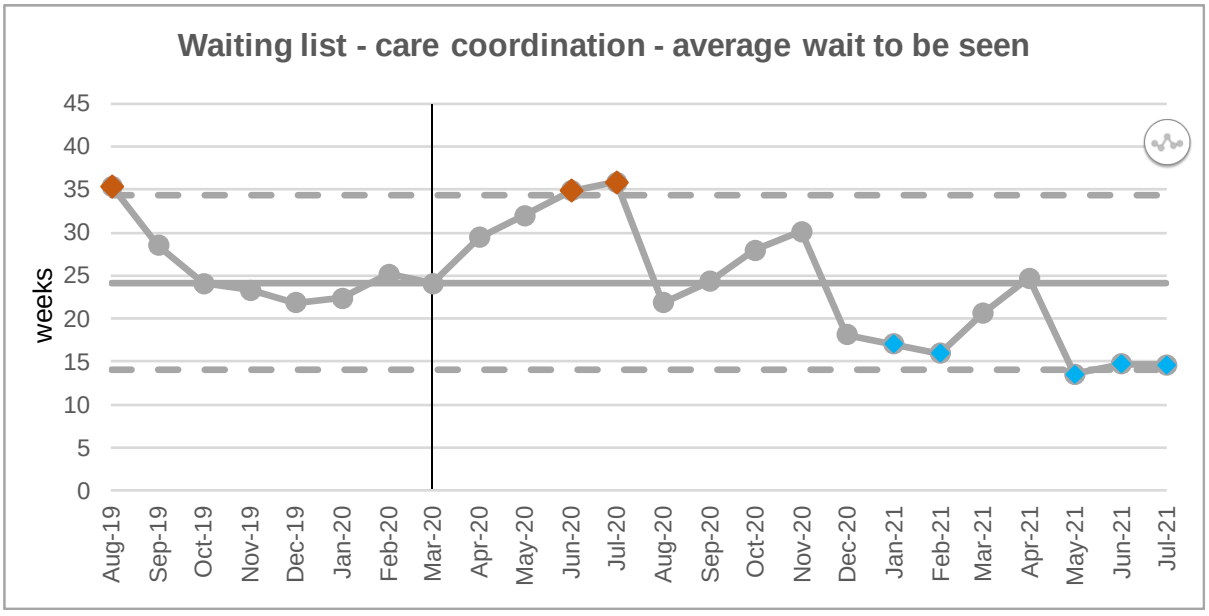


The PICU usage has remained within common cause variation for the last 9 months. There is currently no PICU provision in Derbyshire so anyone needing psychiatric intensive care needs to be placed out of area. Work is in progress to try and reach agreement for a Trust PICU.

9b. Patients placed out of area per month – Psychiatric Intensive Care Units (PICU)

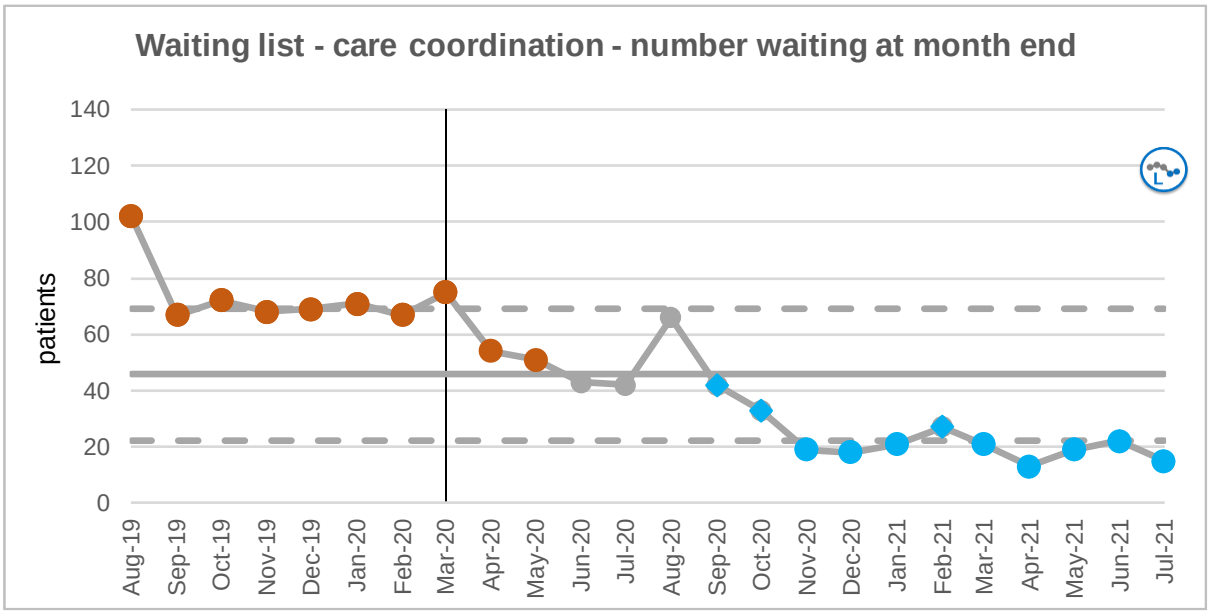


10a. Waiting list for care coordination – average wait



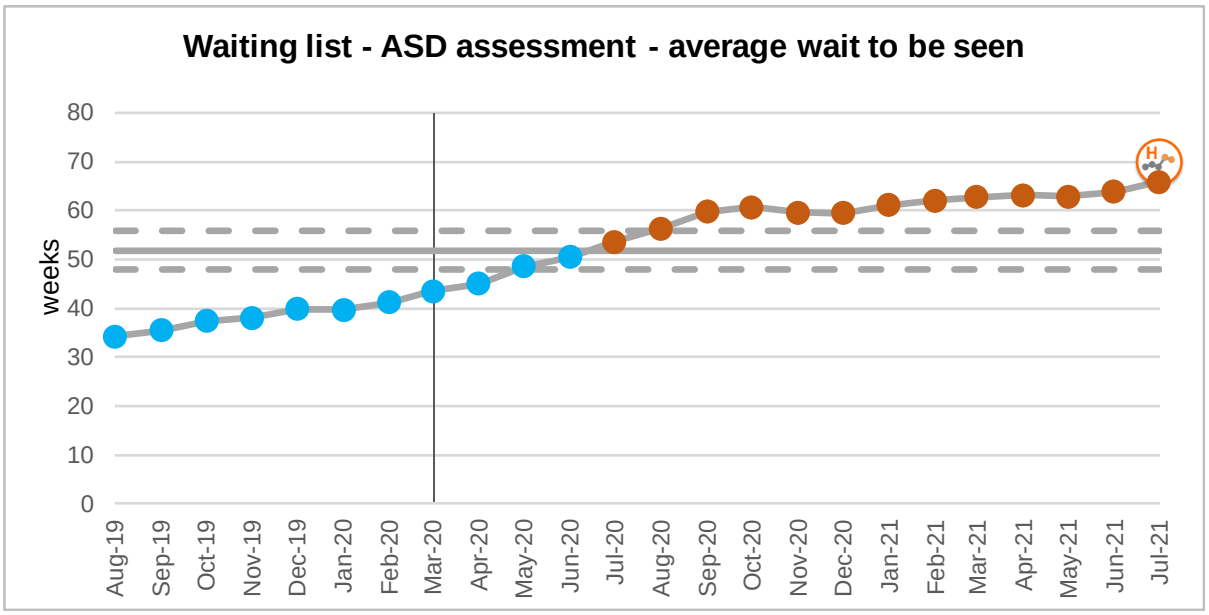
The average wait to be seen has been unusually low for the last 3 months.

10b. Waiting list for care coordination – number waiting

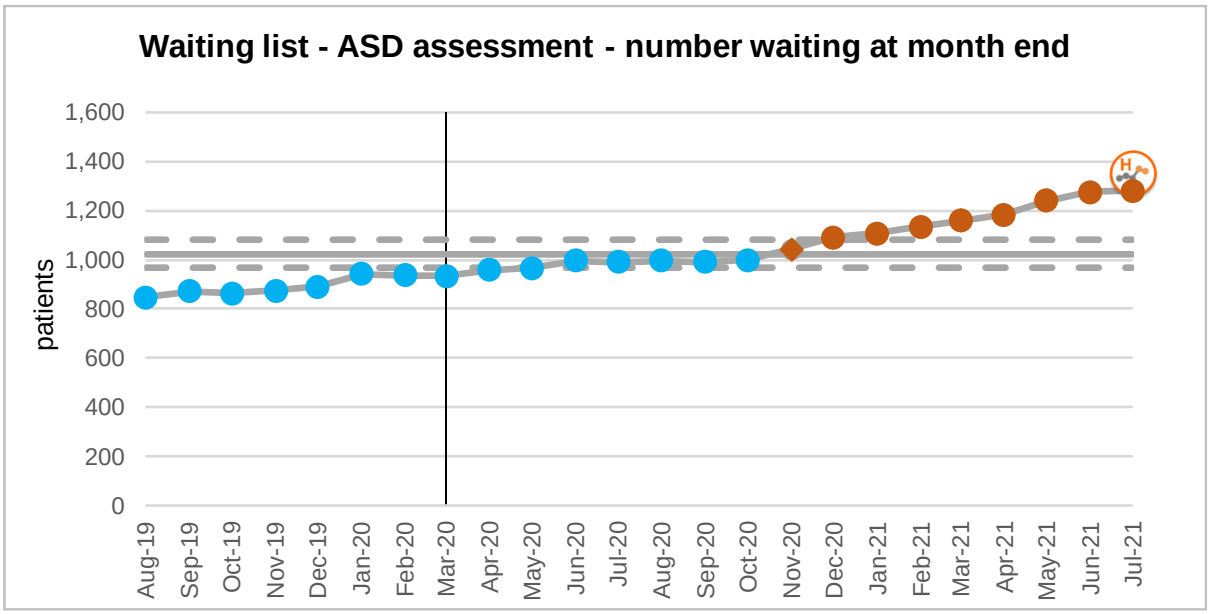


The number of people waiting to be allocated a care coordinator has been significantly low for the last 11 months.

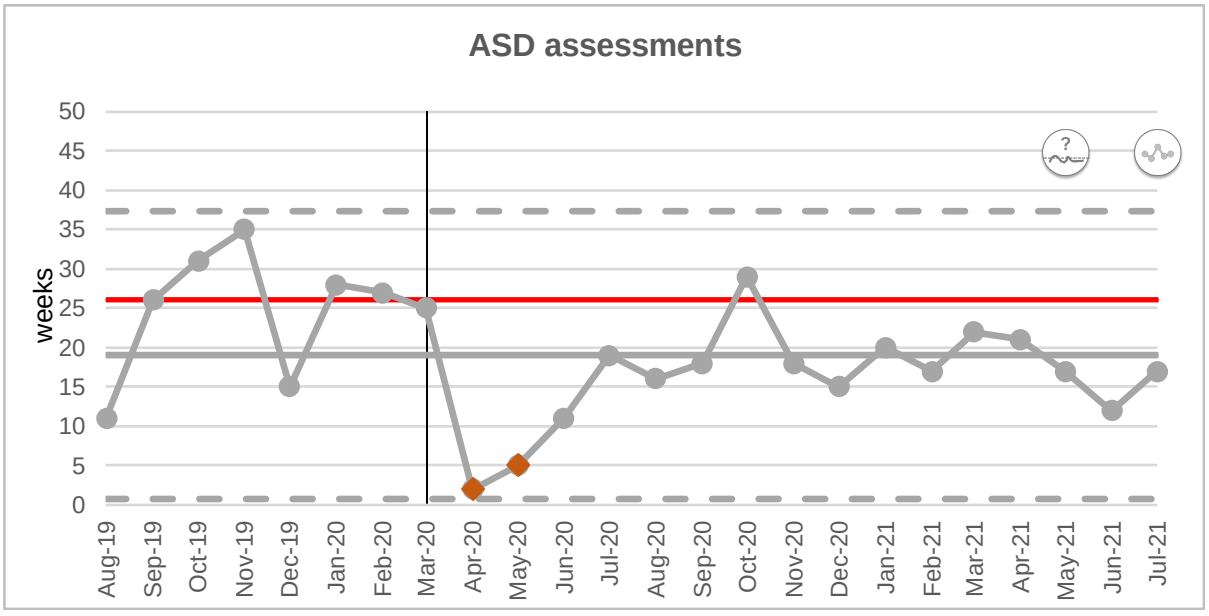
11a. Waiting list for autistic spectrum disorder (ASD) assessment – average wait



11b. Waiting list for autistic spectrum disorder assessment – number waiting



11c. Autistic spectrum disorder assessments per month



Unfortunately, the waiting list is slowly increasing as can be seen in the charts above. There have not been a greater number of referrals, just a steady number which is leading to a compounding month on month increase. Figure 11c also highlights the impact of the team being redeployed last year (see March to June).

There have been no changes to COVID management plans as per previous month: prior to the pandemic we were commissioned to provide 312 assessments per annum. We are continuing with our COVID-19 recovery plans. We have identified locations, timings, protocols for safe COVID-19 face to face appointments. All team members are alternating between offering some face to face appointments and some online appointments, balancing staff anxieties regarding returning to face to face appointments with limited access to rooms. Face to face appointments have gone well so far and have not impacted on our assessments as much as expected. However, it would be difficult to return to the ADOS clinic pilot until we no longer need PPE.

The team are also spending time preparing for the move to SystmOne which means spending time finalising our assessment tools – making sure they are fit for purpose based on the legal advice we were given. It also requires time at the LIGs in respect of this.

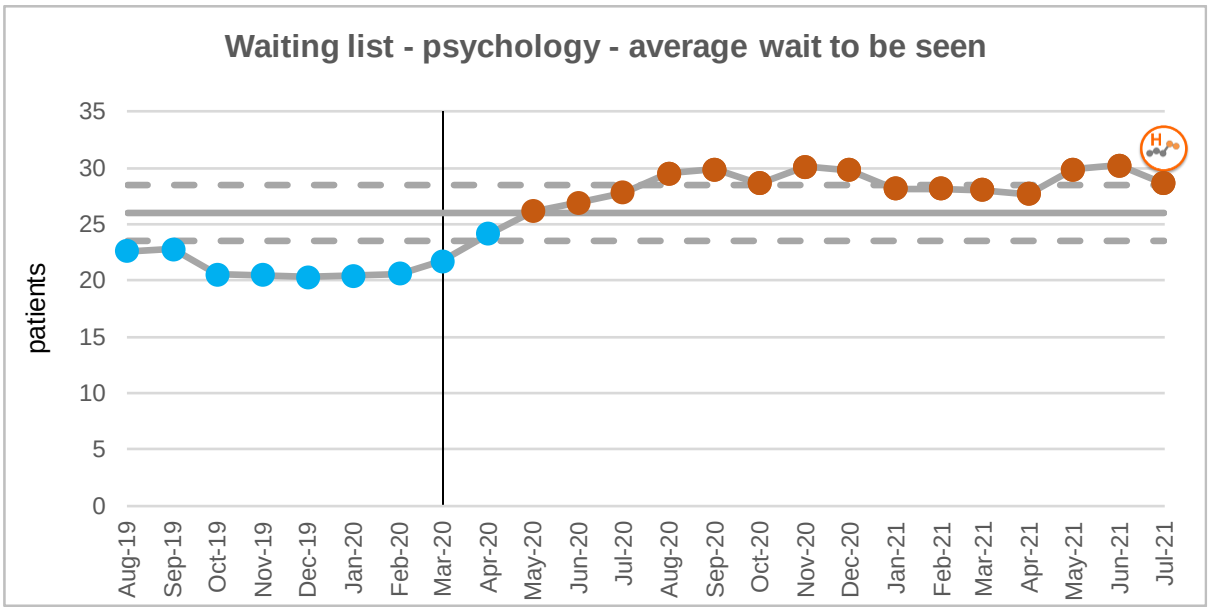
Dr Round is participating in the 'enhanced community autism workstream' commissioners are running looking at the development of pre and post diagnostic support provision in the voluntary sector and the interface between support and the diagnostic team. This workstream is planned for between now and March 2022.

We have had the recent retirement of a member of the ASD diagnostic team. We are currently recruiting to that role.

Plans to respond to waiting list challenge:

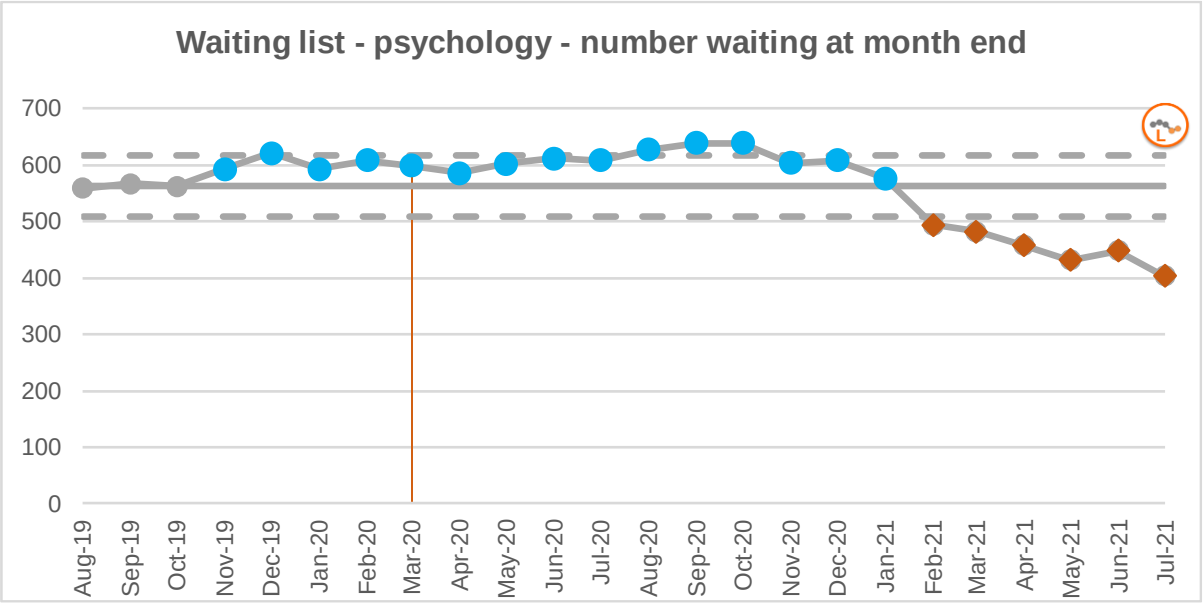
- We are working with a Public Health Speciality Registrar doing their placement in Derbyshire. Dr Joe Williams will be working alongside Dr Round and other members of the team to conduct a review of the evidence around diagnostic practices in the UK. We will be reviewing our own delivery and considering if we can offer something more efficient. This will have a number of stages:
    - Academic review of the current literature and evidence for diagnostic assessments
    - Working with Dr Round to map what we deliver locally onto the evidence list
    - Considering different options for delivery of ASD diagnosis
    - Options appraisal and choice
- We have plans to put in a 12-month assistant post to support scoring of questionnaires which in turn will support throughput of assessments
- We plan to increase admin time to support the assessment report writing process

12a. Waiting list for psychology – average wait



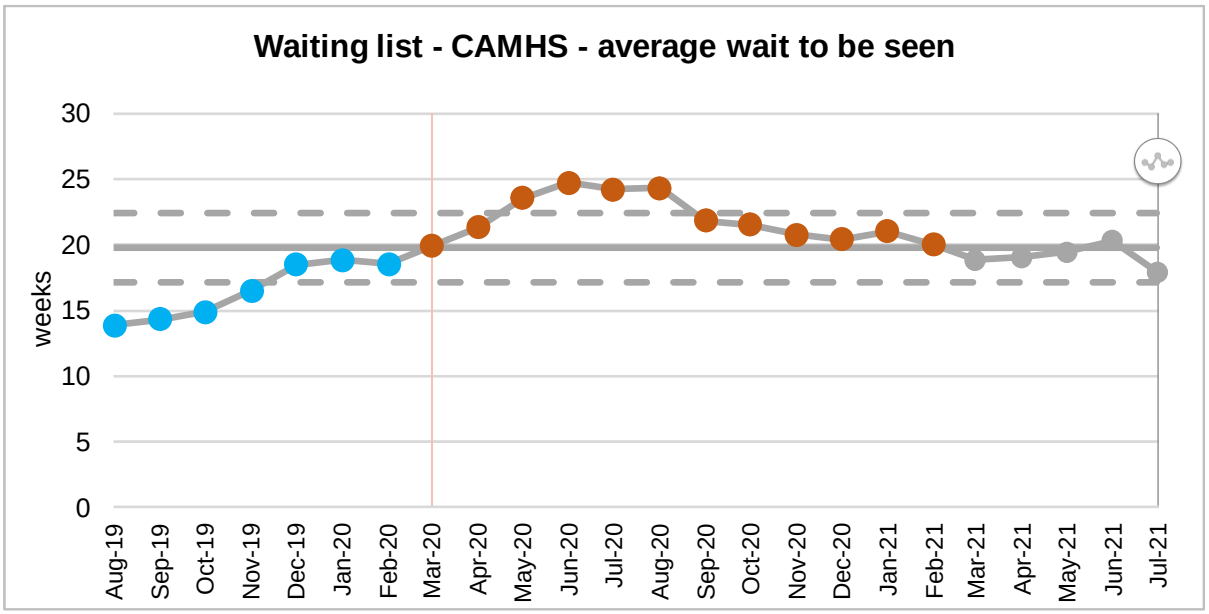
We can see the impact of the pandemic on waits, with the waiting list being significantly higher than expected for months, but in recent months waits have returned to normal, with a significantly lower than expected waiting list seen in May - July 21. Many patients are still waiting due to the pandemic and the request to be seen face to face. The average waiting time has dropped slightly but remains pretty much the same across the last 12 months (the period July 20 – July 21). Referrals remain steady.

12b. Waiting list for psychology – number waiting



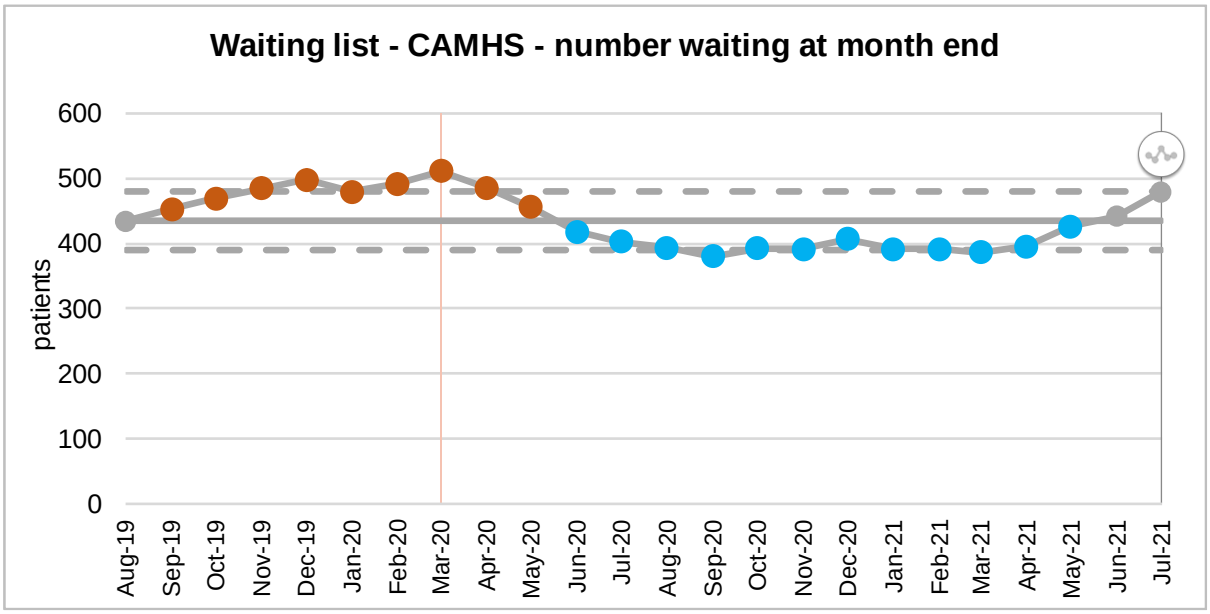
Factors which impact on waiting times include all those highlighted last month in relation to pandemic. We are now focussing on recruitment to a number of vacant and part time posts across adult services; trying some more creative and flexible possibilities including preceptorships; combining part time roles to make a more attractive whole time post; and considering the use of counselling psychologists where their skills are commensurate with service need. We are also reviewing the waiting lists in line with trauma sensitive working in considering how we manage people on a waiting list and barriers of movement between services.

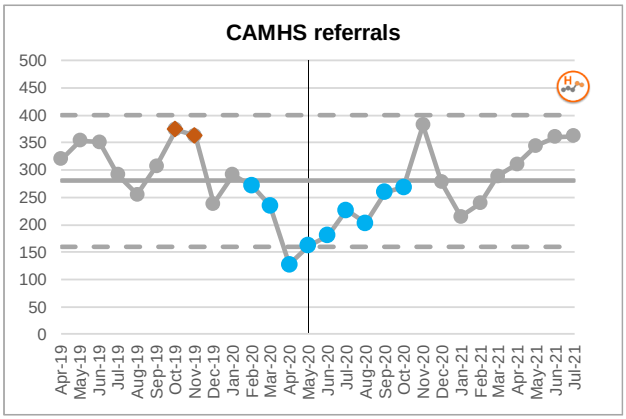
13a. Waiting list for Child and Adolescent Mental Health Services (CAMHS) – average wait

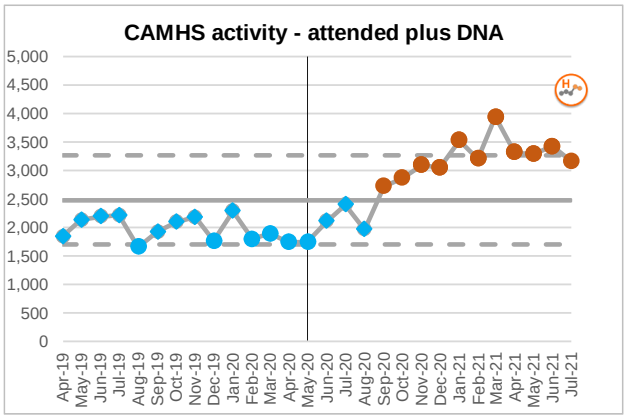


The average wait to be seen has returned to common cause variation for the last few months following a period of longer than expected waits from the start of the pandemic.

13b. Waiting list for Child and Adolescent Mental Health Services – number waiting



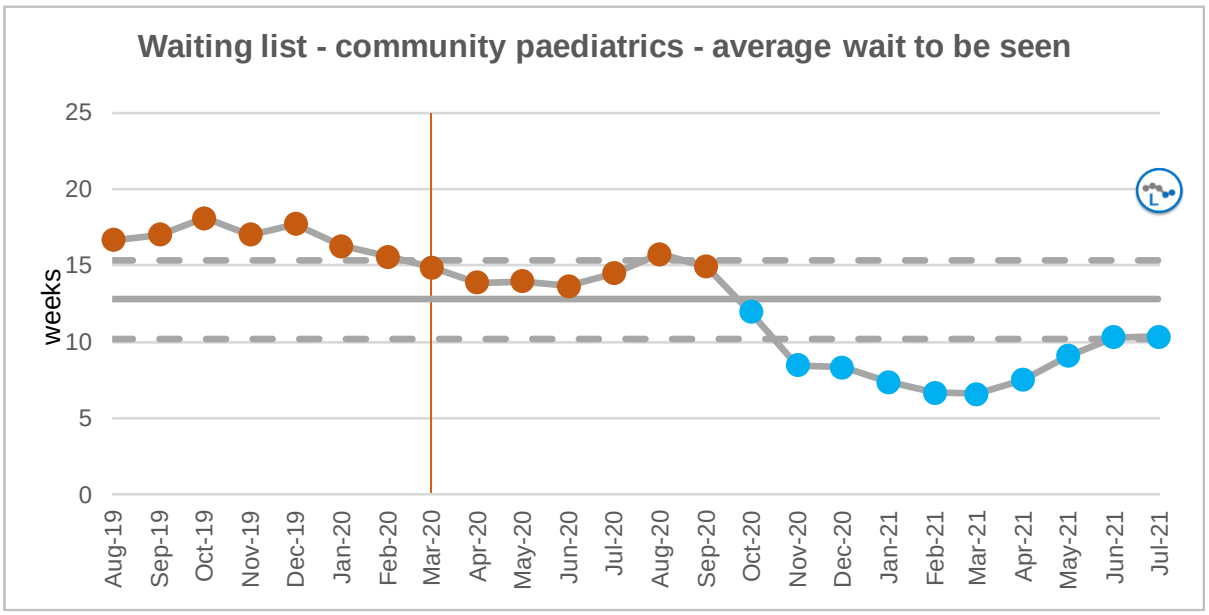




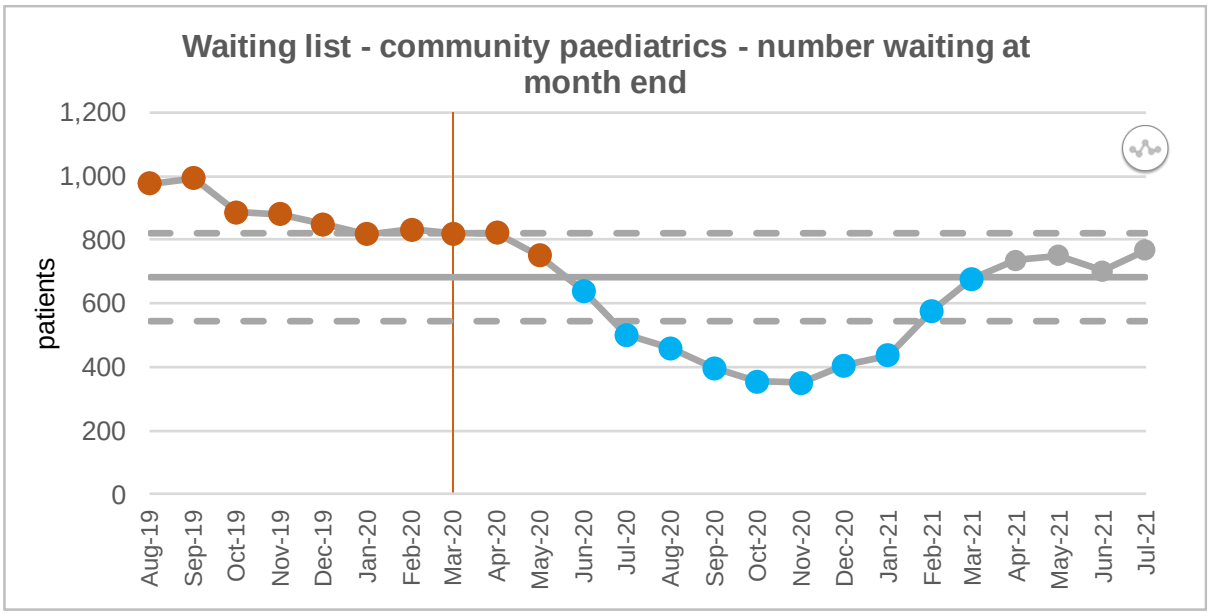
The number of referrals received has been steadily increasing, with a corresponding increase in activity. From week commencing 27/09 until 29/10 we are carrying out a 'waiting list blitz'. During

that time period (with one week's break in the middle) staff within the ASIST team will be pausing all routine work to focus solely on assessments, with support from the rest of the CAMHS service. We are aiming to undertake around 320 assessments during the time period which should reduce the longest wait on the waiting list to around 6 weeks.

14a. Waiting list for community paediatrics – average wait

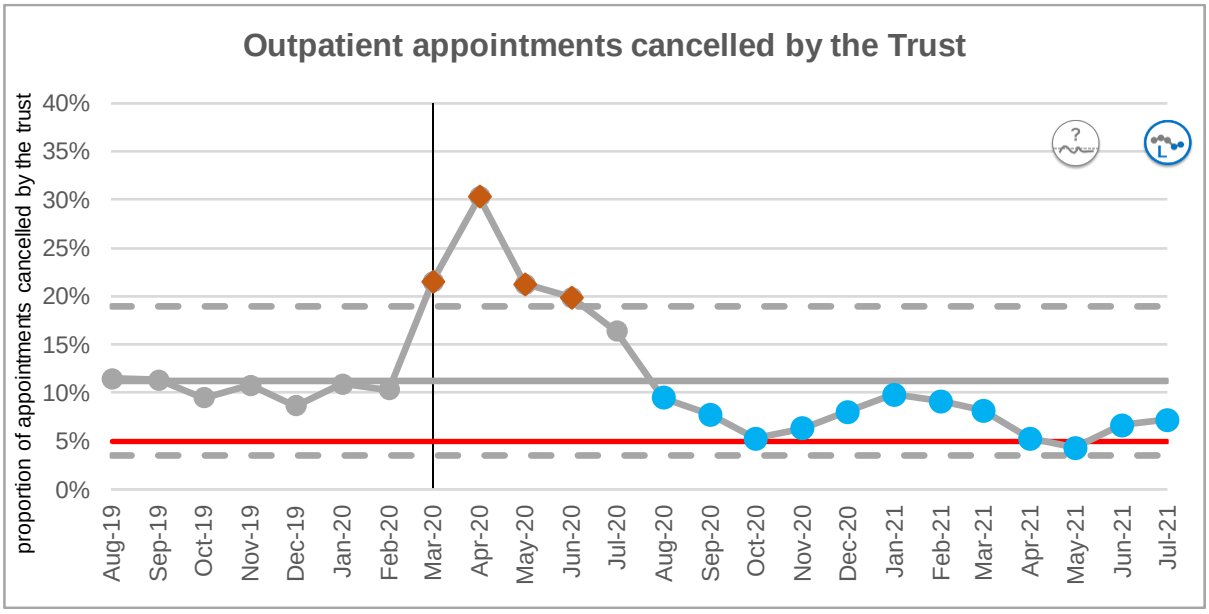


14b. Waiting list for community paediatrics – number waiting



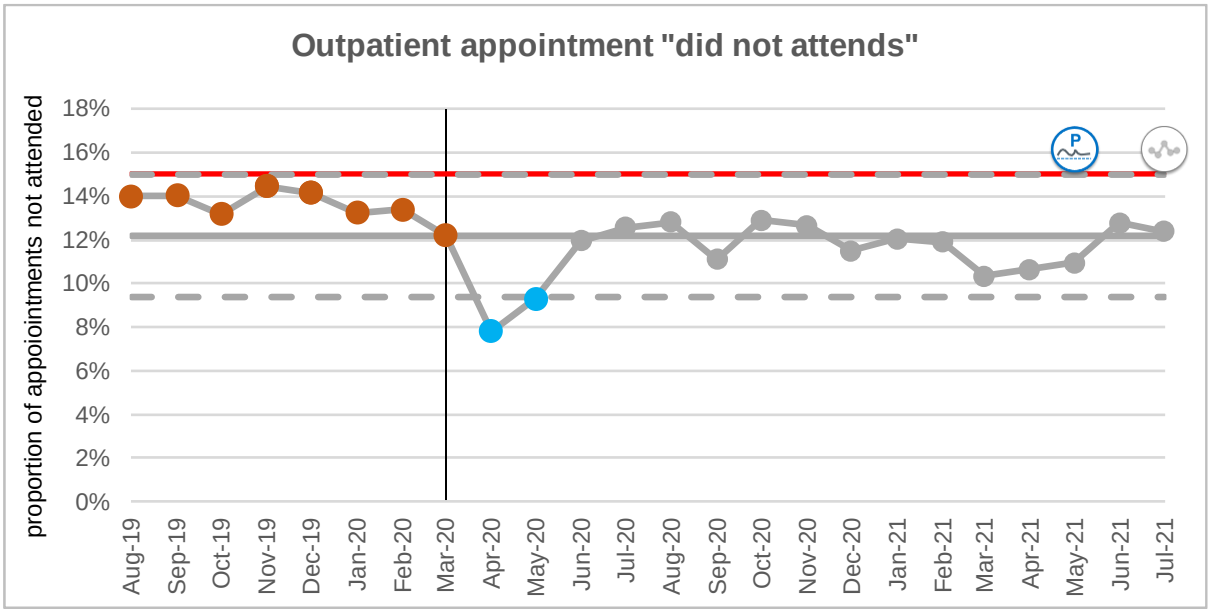
The number of children on the waiting list has returned to common cause variation levels for the last 4 months. The average wait to be seen continues to be significantly shorter than expected.

15. Outpatient appointments cancelled by the Trust



The proportion of cancelled appointments was significantly higher than expected from March 2020 owing to the pandemic but for the last 12 months has been significantly lower than expected, however in the current process the 5% target is unlikely to be achieved. The Trust operates a virtual clinic system with the aim of limiting the number of cancellations. The patient is unaware of the appointment until the appointment letter is sent out three weeks before the appointment date. This was introduced to reduce inconvenience to patients through cancellations and to bring us into line with the national standard for appointment notice. Some recording issues have been identified and Administrators have been reminded that when an appointment is cancelled or rearranged before the letter has been sent to the patient, the cancellation reason of “patient unaware” must be recorded on the record.

16. Outpatient appointment “did not attends”



The level of defaulted appointments has remained within common cause variation for the last 14 months and in the current process the trust target of 15% or lower is likely to be consistently achieved.

Other Operational Matters of Note

A. Health Protection Unit

The Health Protection Unit (HPU) was set up in May of this year, with the aim to coordinate matters relating to health protection and prevention. This includes, COVID-19 related issues, vaccinations, health promotion and prevention initiatives. The HPU operates within specialist services and is managed by Interim Area Service Manager Fiona Brettell, along with Clinical Lead Catherine Martin and Health Protection and Promotion Advisor James Walker. Recent recruitment includes admin support and 4 band 5 (2.8wte) Health Protection and Promotion Nurses. Working closely with Carolyn Green and Richard Morrow, and feeding regularly into the Incident Management Team and Communications, the HPU has begun over the last 4 weeks to improve its engagement with staff and patients, we are seeing more and more enquiries coming into the team around COVID-19 which is demonstrating the value of the new HPU in providing consistency in its messages, reassurance for staff as well as governance and assurance to the trust around COVID-19 related data.

B. Vaccination status

93% of people working for the Trust have now been vaccinated.

C. Respiratory Syncytial Virus Infection (RSV) in infants and young children

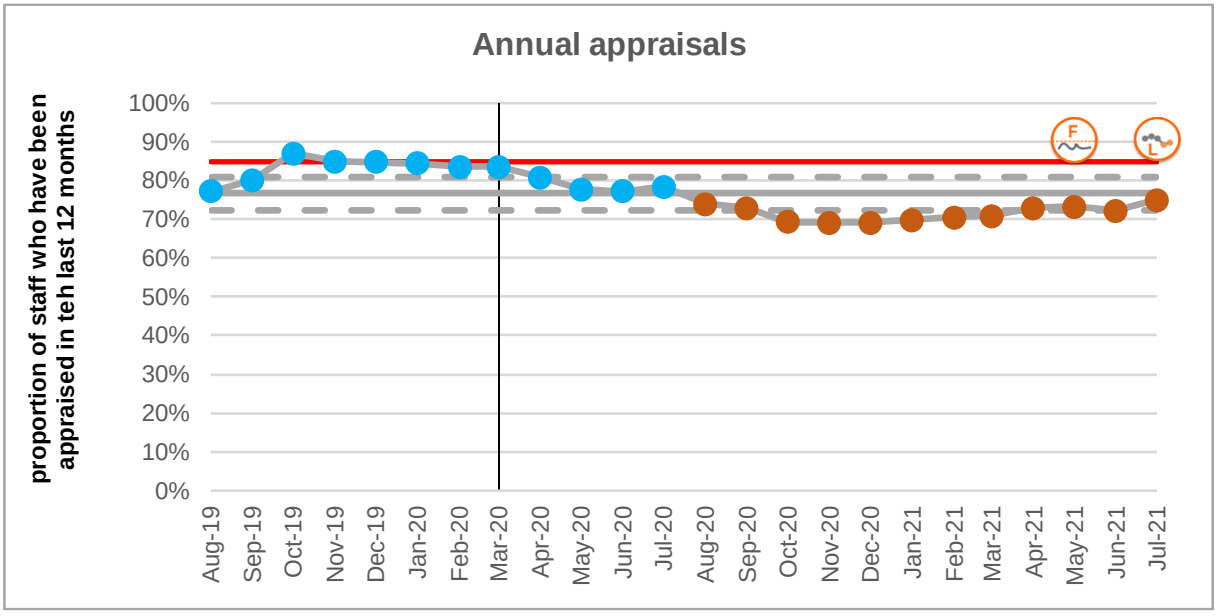
RSV is a very common virus and almost all children are infected with it by the time they are 2 years old. In older children and adults, RSV may cause a cough or cold. Public Health England have reported a rise in respiratory infections in young children out of season. Last winter, due to the various restrictions in place to reduce the spread of coronavirus (COVID-19), there were far fewer infections in younger people. This means many will not have developed immunity and so we may see more cases this year than in a typical season. For the majority of children, these illnesses will not be serious.

We have engaged with partner organisations, namely acute hospitals, to ensure that we support their ability to maintain flow. CAMHS are engaged in this planning to ensure we maintain a timely response in our liaison role.

People

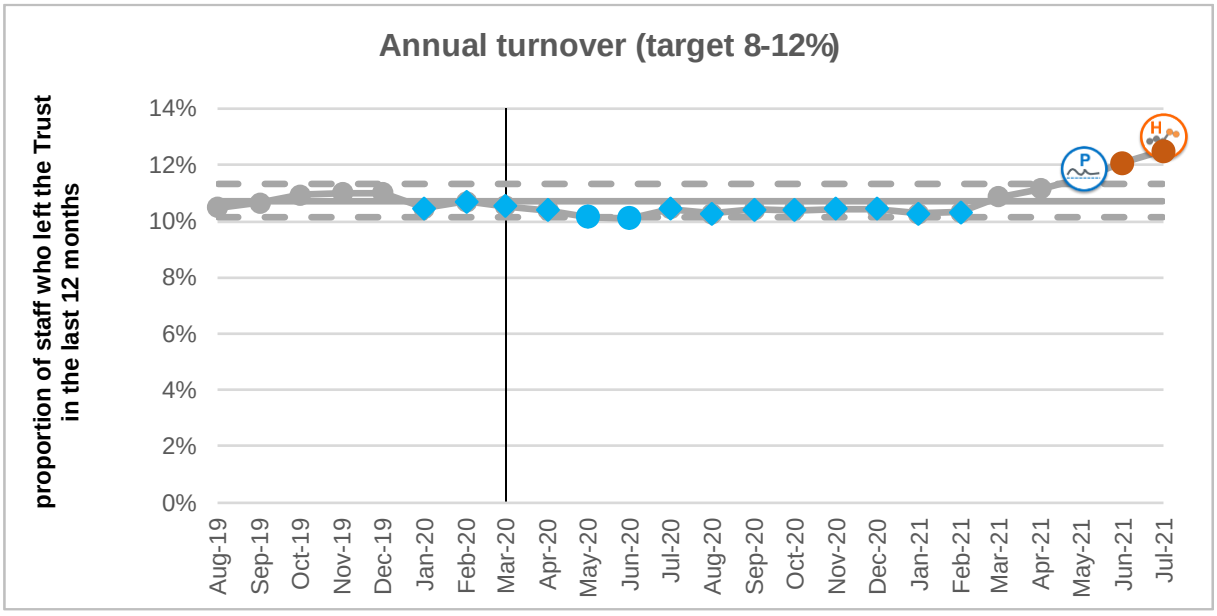
In order to release capacity to manage the COVID-19 pandemic, all NHS organisations were instructed by Amanda Pritchard, Chief Operating Officer, NHS England and NHS Improvement[1], to suspend appraisals and revalidation and to reduce the volume of mandatory training as appropriate. A recovery plan is in place to improve training compliance and appraisals continue to be paused replaced by a structured wellbeing conversation. Recovery of appraisals will be the focus in coming months as we move out of the pandemic.

17. Annual appraisals



The “wellbeing conversation” now supplements an alternative mini appraisal process. In general appraisal completion is also beginning to improve where managers and staff are able to factor in that dedicated time though this has been interrupted where services have come under increased pressure due to rising levels of COVID-19 in the community.

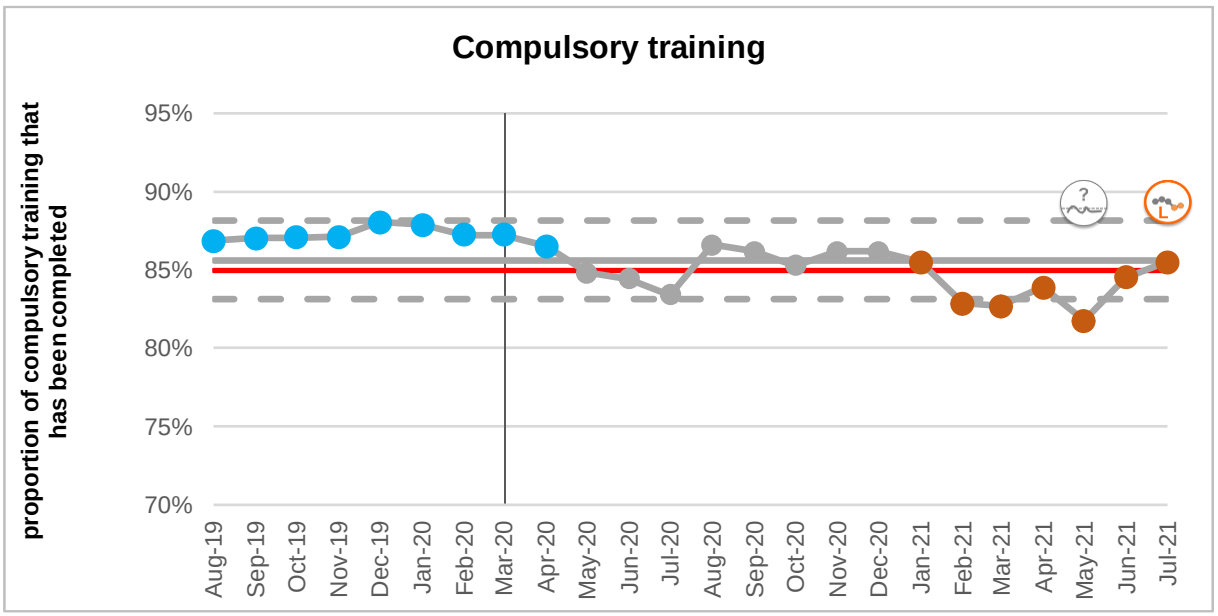
18. Annual turnover



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

The rate of turnover has been higher for the last 2 months; July turnover is 12.47% just above the Trust target range of 8-12%. Retirements continue to add to the turnover rate although this is still in line with national predictions due to an ageing workforce across the NHS. Work Is ongoing to develop a retire and return process which will encourage more retirees to return to substantive posts and support vacancy fill. Work is also ongoing to understand service by service what the predicted number of retirements will be, designed to support workforce planning and to encourage at an earlier stage the offer of a retire and return arrangement.

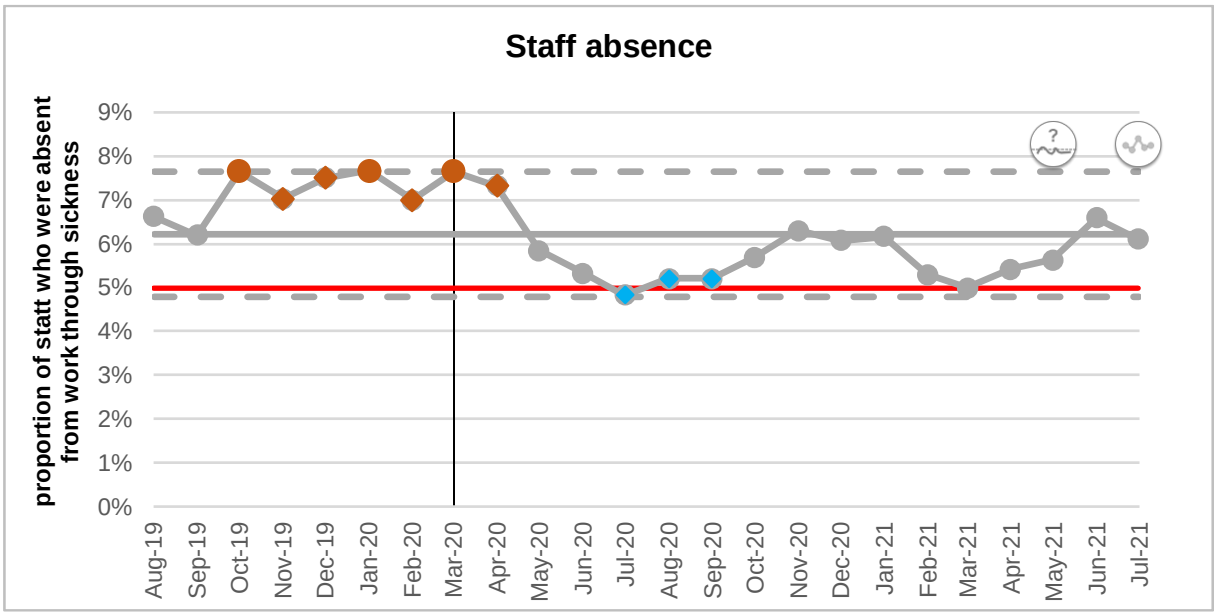
19. Compulsory training



The 6 month pause on training at the beginning of the pandemic inevitably impacted hugely on compliance levels and it will take considerable time to recover the position. The full training requirement – compulsory training and role specific training – is around 70,000 attendances by our total workforce on over 70 courses, with just over 15 thousand individual attendances to be completed. Operational Services are currently 87% compliant with compulsory training and Corporate Services slightly lower at 78%.

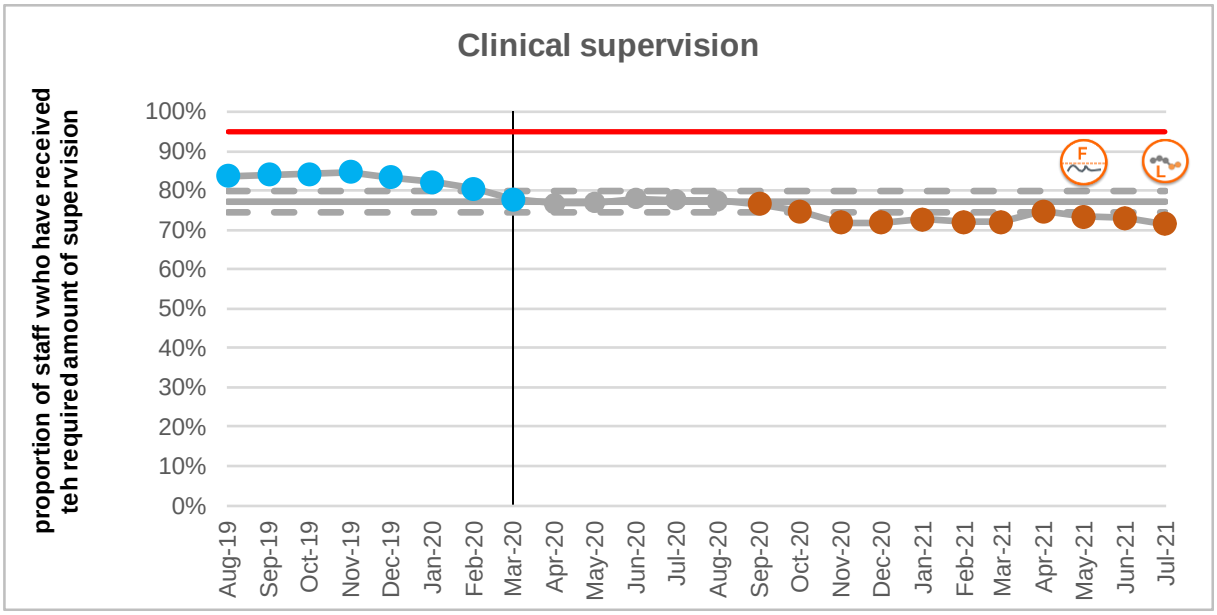
The Training Cell now meets on a monthly basis to support Operational Services with regards to improving the training position and to monitor progress against training recovery plans and sustainability. Operational Services are currently focusing on key priority areas. It is important to note that these key priority areas are generally role-specific rather than compulsory training for example basic and immediate life support, positive and safe teamwork and safeguarding adults and children level 3 therefore this should not impact on the compulsory training position. Improvements in compliance had begun to recover and it was expected to improve over coming months. However due to further rises in cases across Derbyshire, training attendance was reduced temporarily and will be stepped back up as the local situation improves.

20. Staff absence

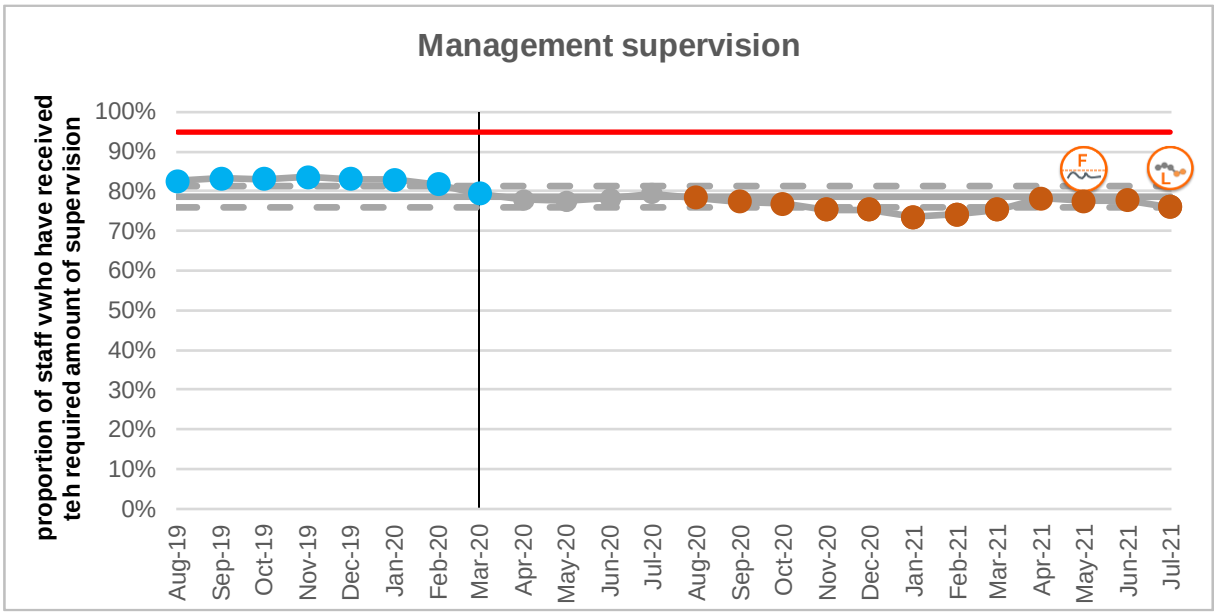


Staff absence had been lower than average for most of the pandemic. This was attributed to different ways of working i.e. home working which helps to support colleagues with long term conditions where short term sickness has been reduced, higher uptake of our flu vaccination programme meaning more colleagues are protected, less contact because of the pandemic so less of the normal coughs, colds and infections that can be transmitted when more people are working together and the introduction of the Health Risk Assessment with more individual monitoring and support. However as Government restrictions were relaxed we have seen a rise in COVID-19 and other infections and as such a rise in sickness absence generally. Sickness rates for June (6.65%) and July 2021 (6.62%) have now increased again further. Long term sickness absence has begun to reduce whilst short term absence has increased in line with relaxation of restrictions and increased infection rates.

21. Clinical supervision

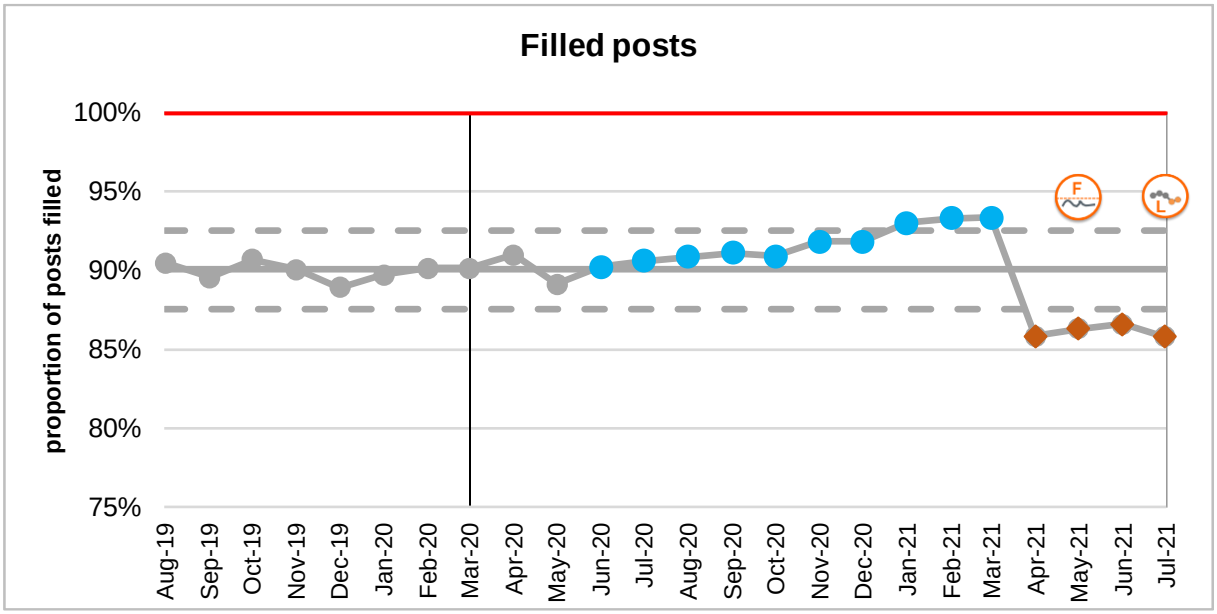


22. Management supervision



The levels of compliance with the clinical and management supervision targets have remained low since the start of the pandemic. As seen with compulsory training, Operational Services are at a higher level than Corporate Services for both types of supervision (management: 80% versus 62% and clinical: 75% versus 38%).

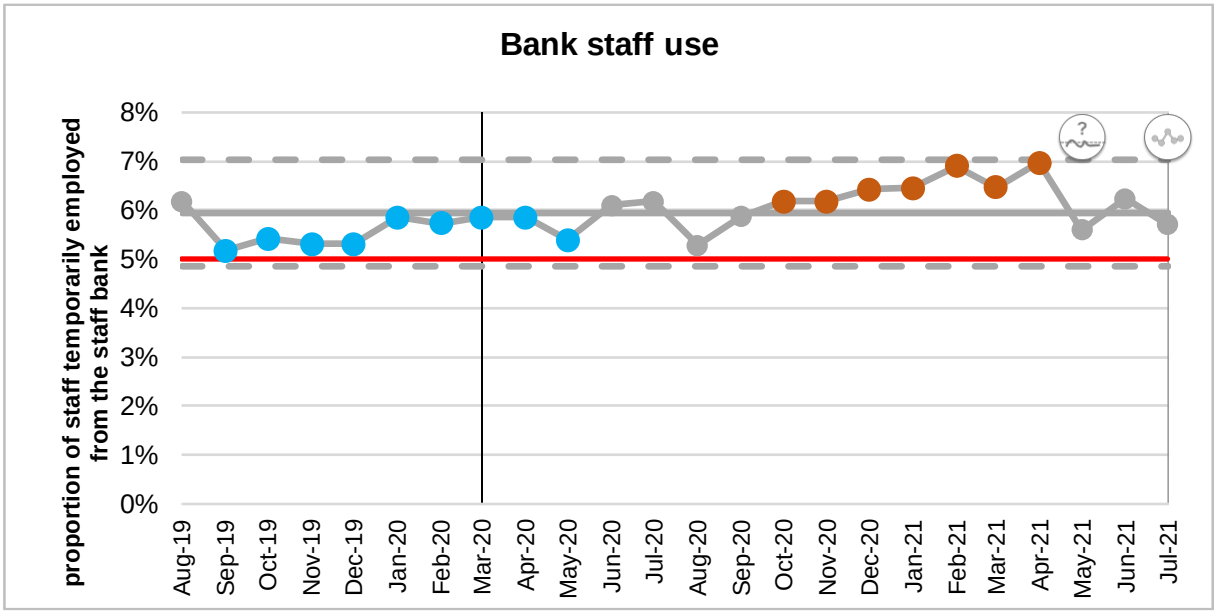
23. Proportion of posts filled



Prior to the start of this financial year there were a number of factors that had in effect artificially lowered the vacancy rate prior to April 2021, however this has now been adjusted for at the start of this financial year, which is where we can see a significant drop in posts being filled. An increased number of vacancies in 2021/22 budgets are due to the following comparative changes in establishments:

- Cost improvement programme (CIP) for 2020/21 would have reduced the funded whole time equivalent (wte) by approximately 100 wte. Owing to the pandemic this CIP was not enacted and as such these posts are back in the system to be filled.
- 2020/21 new development posts and 'cost pressure' posts – 59 wte who were in post for 2020/21 but not within the funded wte – again this effectively produced a lower vacancy rate.
- 2021/22 new developments, new cost pressure posts and skill mix increases – 40 new wte.

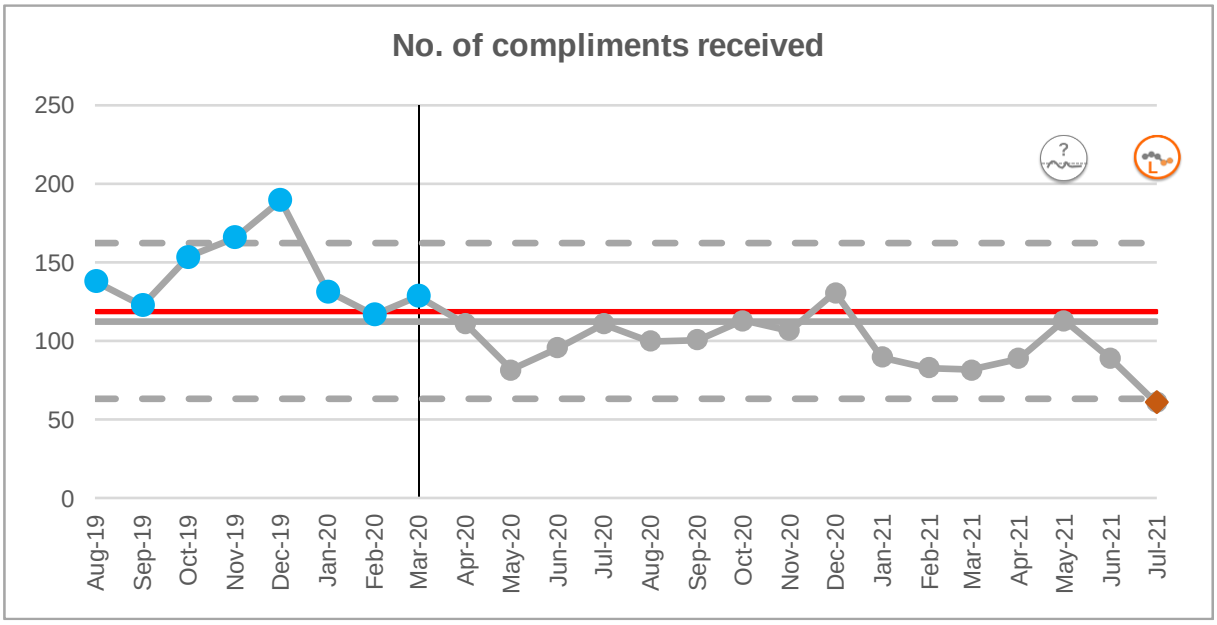
24. Bank staff



Following a period of 7 months of unusually high bank staff use, in the past 3 months the position has returned to common cause variation.

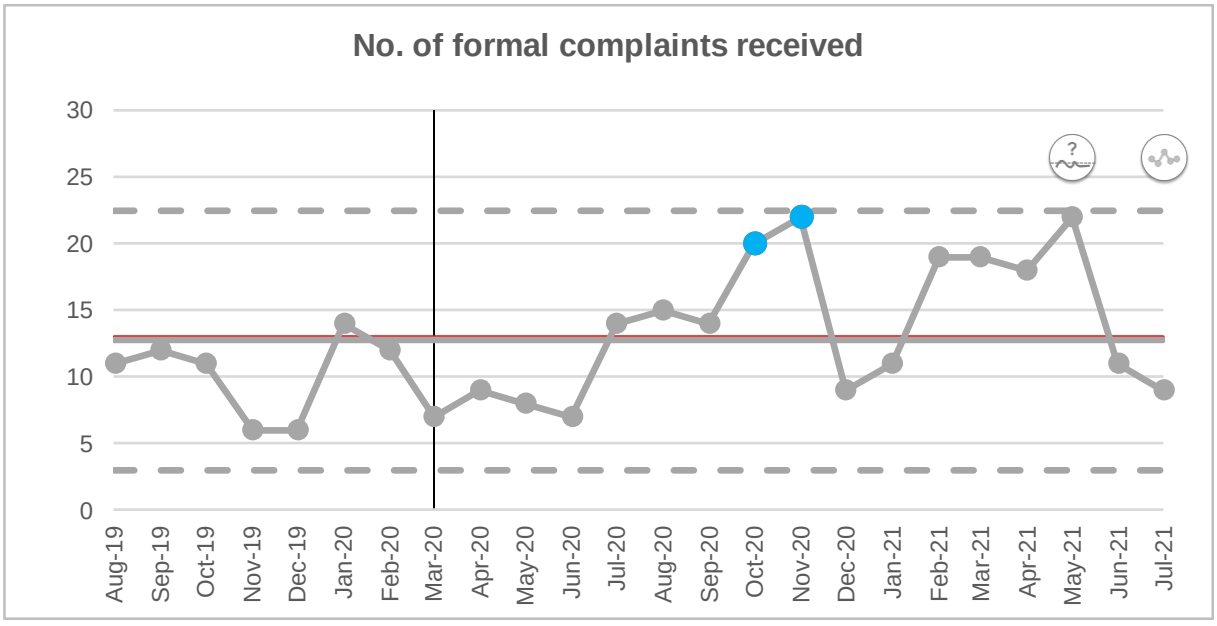
Quality

25. Compliments



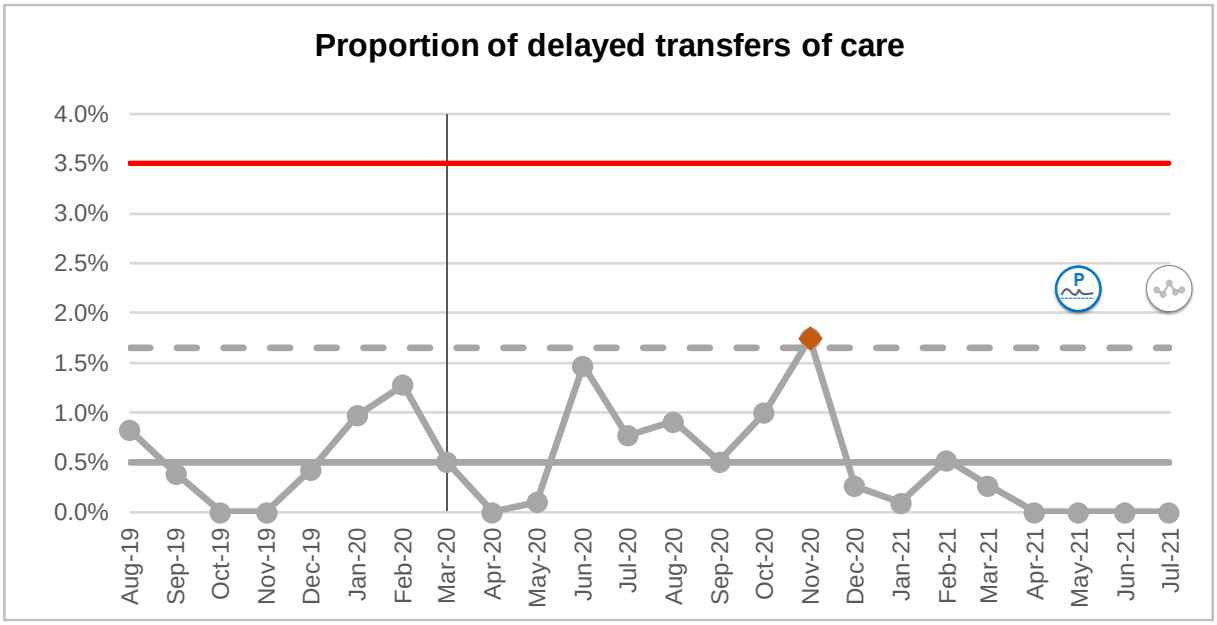
The number of compliments decreased in line with the emergence of COVID-19 and the significant changes to many of our clinical services. A large number of compliments are received by staff during face to face contact and then entered by staff. As a result of reduced face to face contact, there has been a drop in the number of compliments received. This is below the expected target. Work is underway to improve feedback from service users via an electronic survey received by text or email. A pilot is due to commence within a CMHT team and crisis team services.

26. Complaints



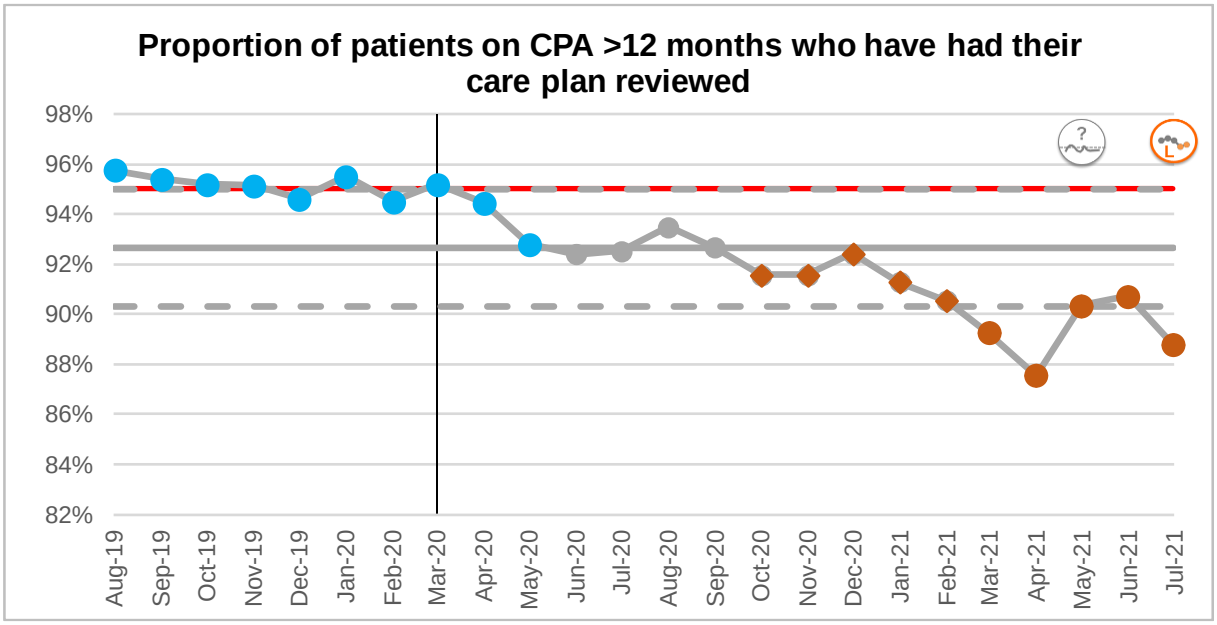
The number of complaints increased with a particular theme around both concerns and complaints of access to services. Derbyshire Healthcare NHS Foundation Trust continues to work with Health Watch, including receiving regular feedback through governance structures and service user and carer surveys. As identified above an electronic patient survey is due to be piloted. These surveys are expected to pick up areas of concern from service users and carers prior to them getting to the point of becoming a complaint.

27. Delayed transfers of care



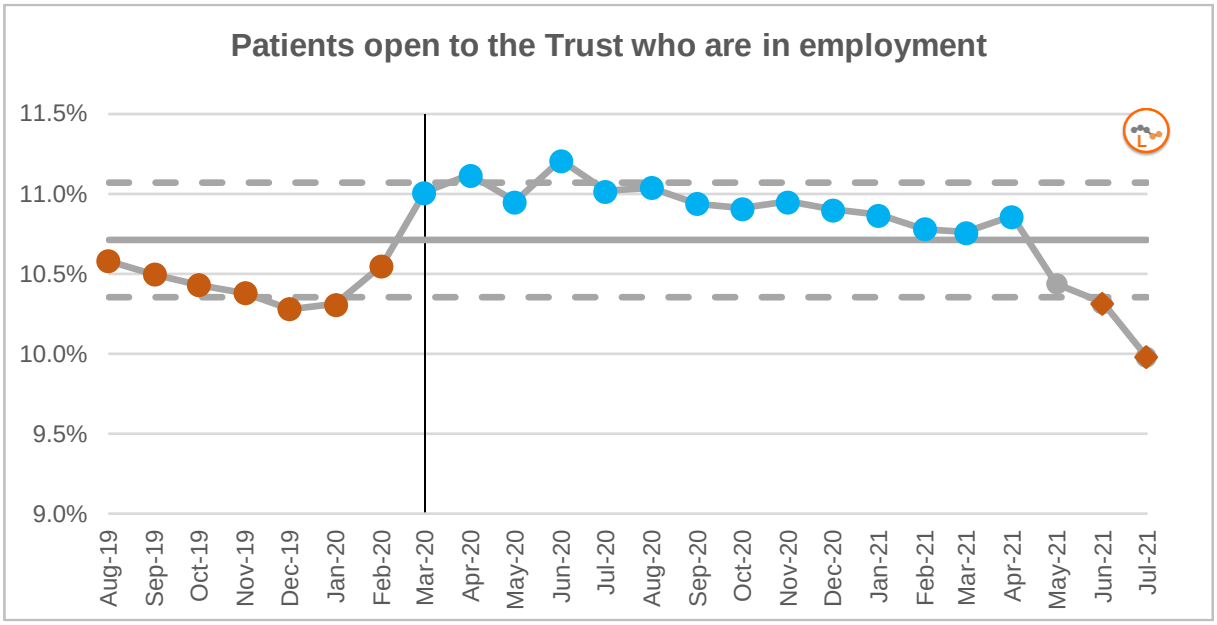
Delayed transfers of care (DTOC) remain within the expected parameters and remain low compared to national mean. However, COVID-19 has demonstrated changing trends. As restrictions increased, funding committees stood down resulting in faster responses to funding requests to accommodation and care settings, which reduced the number of DTOCs. On the other hand, however, the increased number of care homes and care settings in outbreak resulted in high numbers of delays in transfers from inpatient settings, increasing the number of DTOCs at times. April to July 2021 have demonstrated no DTOCs. A review of current inpatient settings will need to be carried out to ensure this data is correct and there is not a data recording issue.

28. Care plan reviews



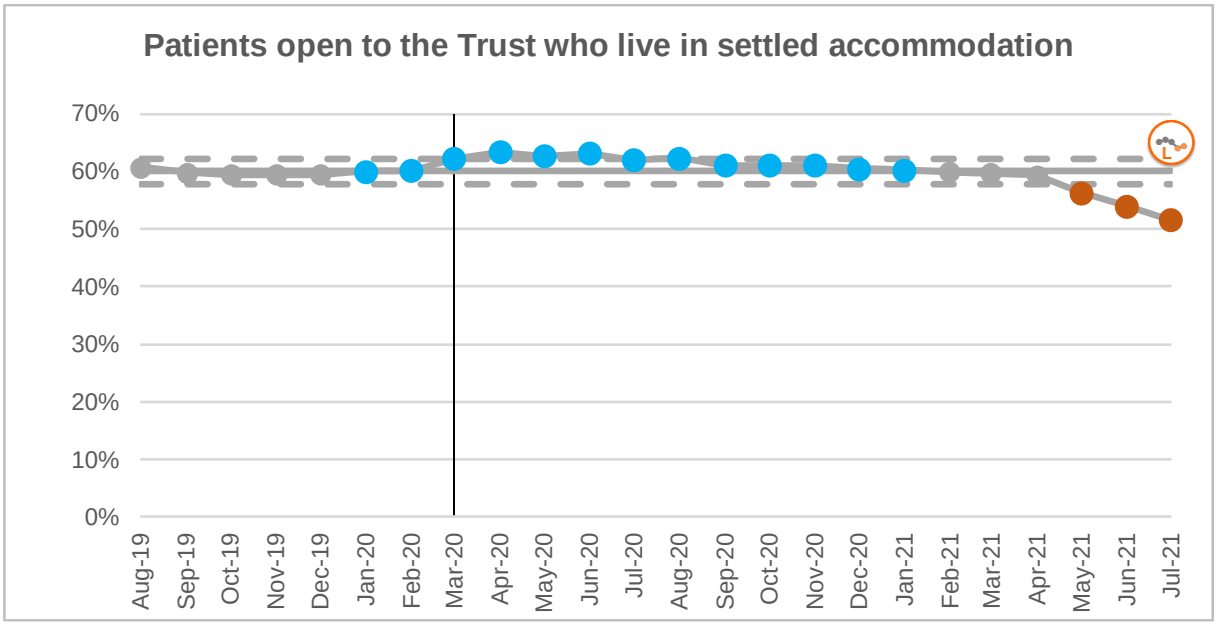
The proportion of patients whose care plans have been reviewed continues to be lower than usual. Teams have been prioritising essential tasks, with reduced routine contact, and trying to engage with people who use our services in different ways, e.g. in virtual ways using Attend Anywhere. As teams began to increase face to face contact and services begun to stand back up, an increase in COVID-19 rates and isolation rates has resulting in increased staff being off work. As a result an improvement in practice in May and June has been witnessed but then a drop in July as cases have risen.

29. Patients in employment



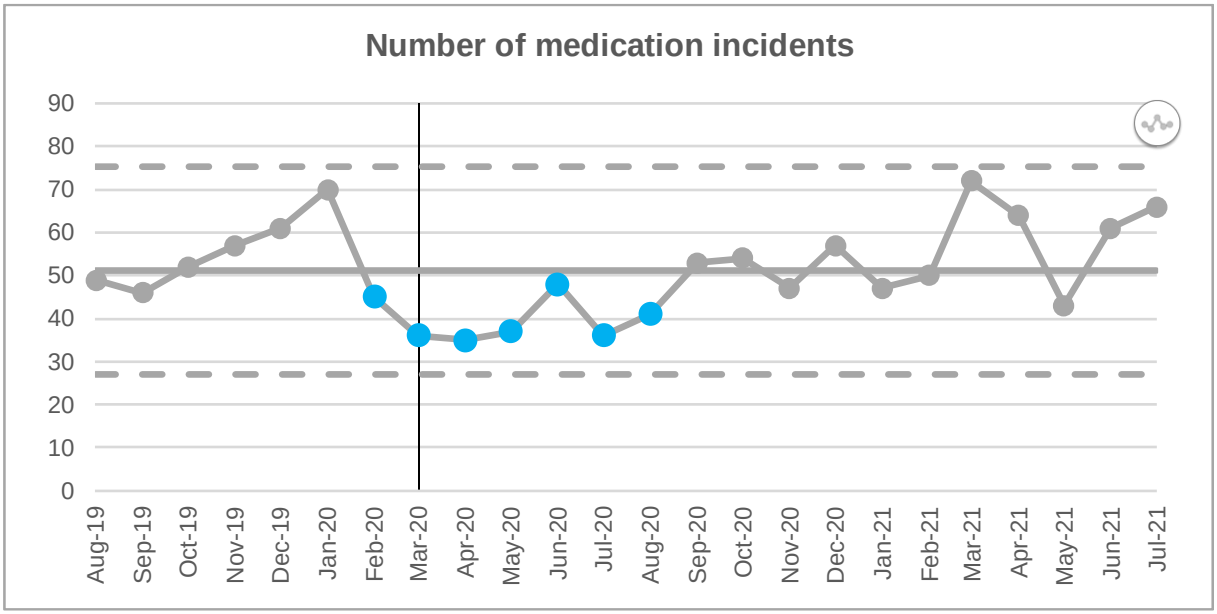
The Individual Placement Support (IPS) Service continues to have success in supporting people into employment even during the current pandemic and the service is currently expanding. The IPS service came into effect in January 2020 and the data demonstrates the impact they have had on levels of employment, even during a pandemic. The drop in May 2021 is likely linked to recent vacancies within the team. These posts are currently being recruited into. Drops in the data continue to be witnessed which brings the data below the lower control limit. As staff fill vacant posts, the data should improve.

30. Patients in settled accommodation



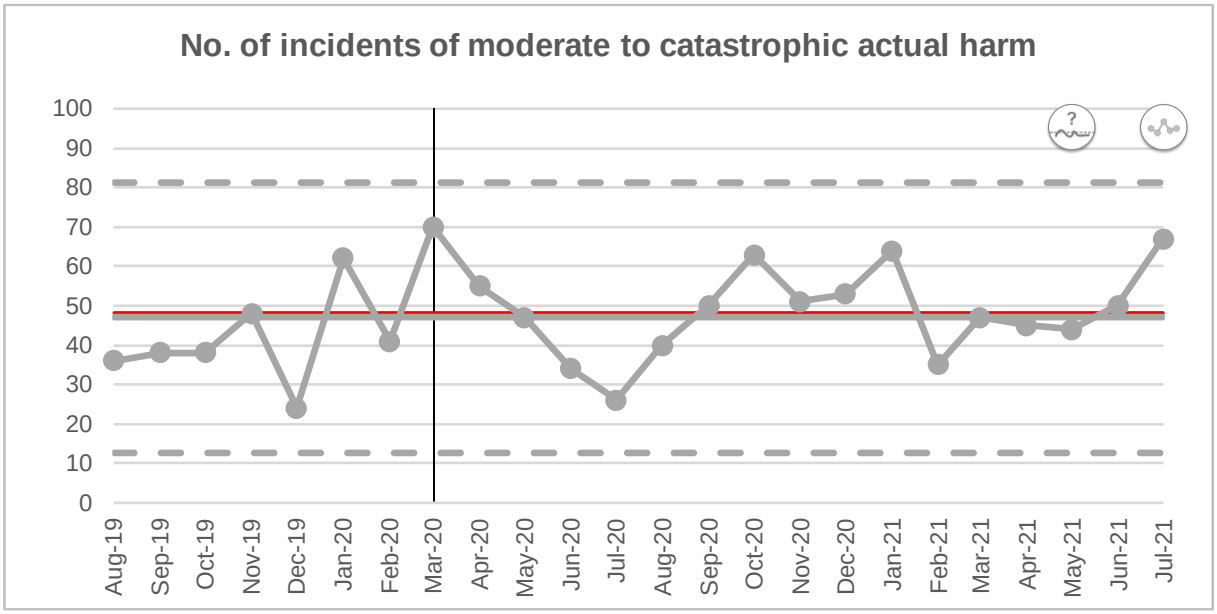
There continues to be community nurses dedicated to working in a multi-agency environment supporting our homeless service users however, data presents below the lower control limit and so further investigation is required into this.

31. Medication incidents



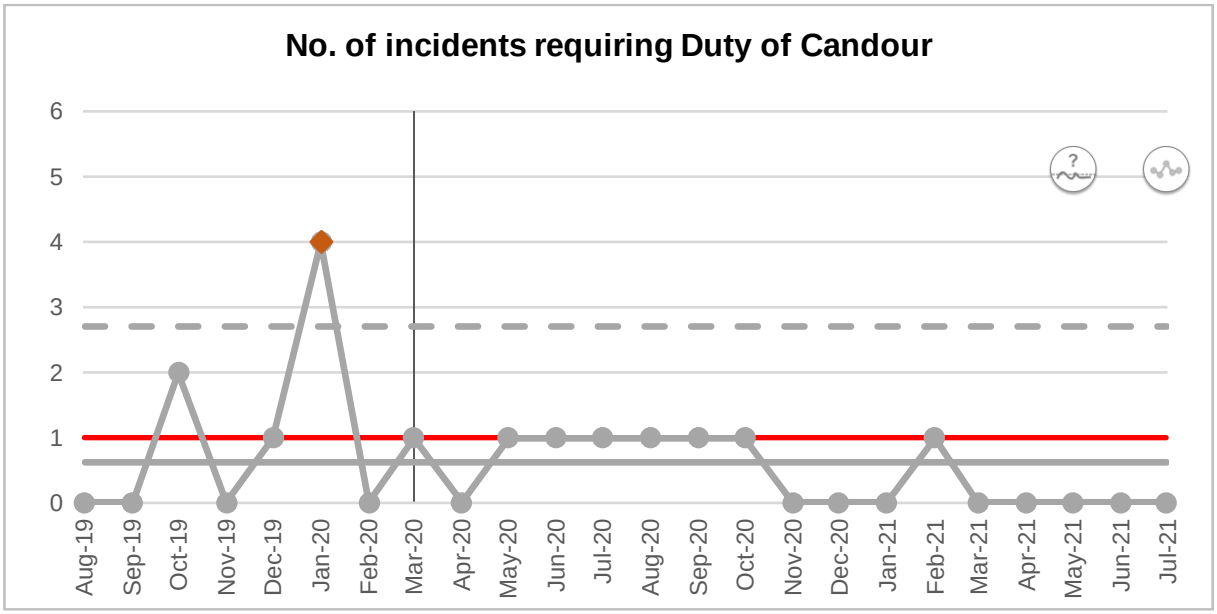
June 2021 demonstrates a rise above the expect mean. This is likely linked to the mental health "surge" following reduction in COVID-19 restrictions that began in March 2021 nationally. The last occasions of this occurring are presented in January 2020 where, winter pressures began, and bed pressures increased. When looking into Medication Incidents, they take a variety of forms, from missed doses, wrong medication administration, missed fridge temperature recording, prescription error and non-location of medication. As a result there are several factors that impact such as how busy the ward is, number of qualified staff, how the medication cabinet is organised and number of newly qualified staff. The medicines management operational subgroup are currently revising the medications error procedure, taking into account Trust values.

32. Incidents of moderate to catastrophic actual harm



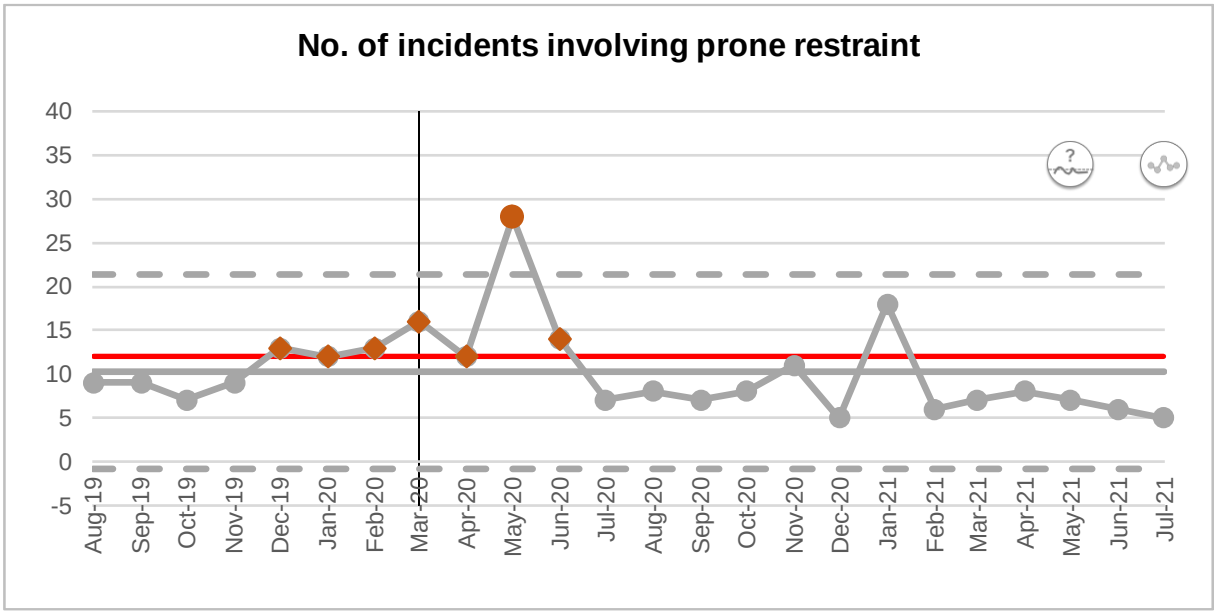
The number of reported incidents of moderate to catastrophic harm have remained within common cause variation throughout the reporting period. However, there has been a recent increase bringing the total above the mean line. This will continue to be monitored.

33. Duty of Candour



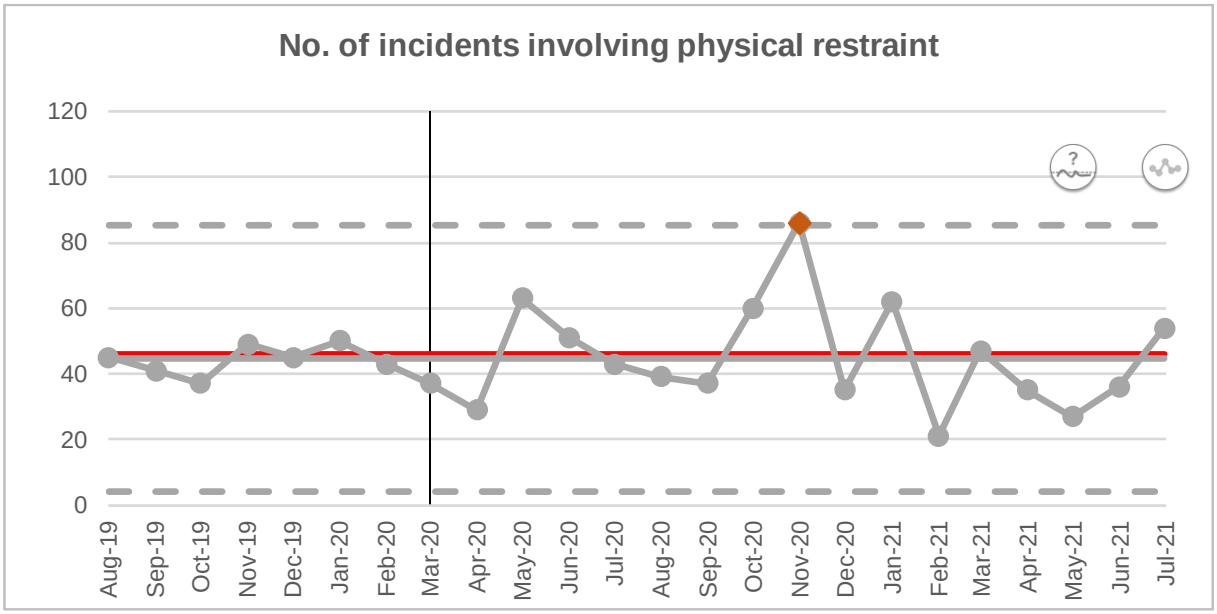
There have been no instances of Duty of Candour in the last 5 months.

34. Prone restraint



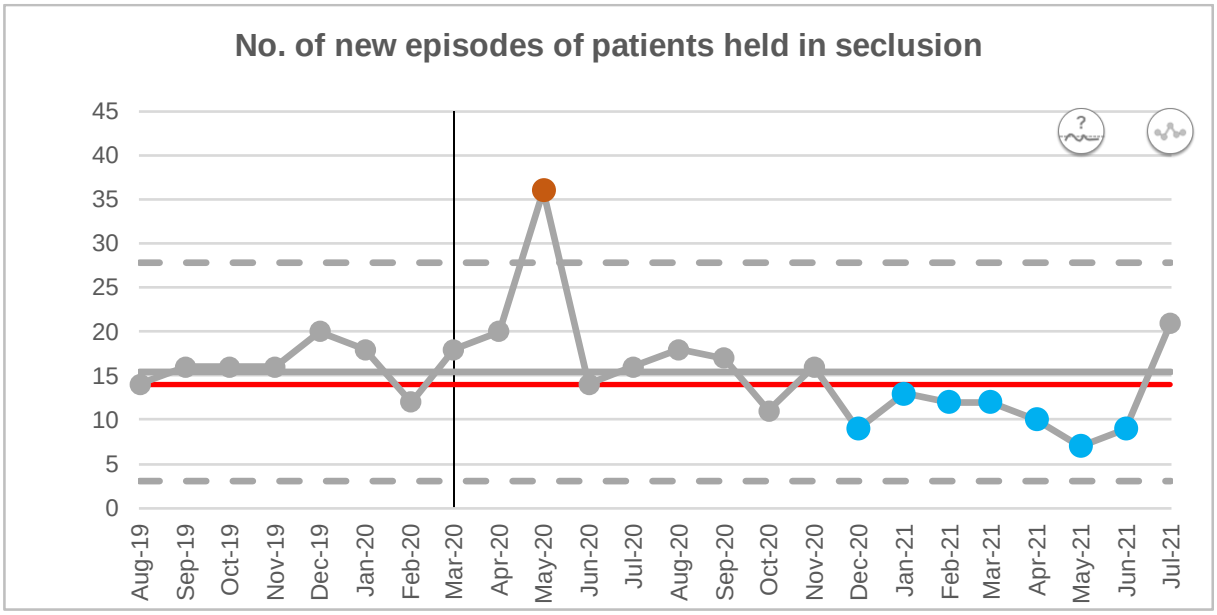
There are ongoing work streams to support the continuing need to reduce restrictive practice; including the introduction of body worn cameras, monitoring of restrictive practice within the "reducing restrictive practice forum" and monthly thematic reviews carried out by Heads of Nursing. As can be seen in May the increased point above the expected variance is in line with the increase in previous data relating to Seclusion. Apart from January 2021, targets relating to the numbers of prone restraint have been achieved. Further investigation has also identified a reduction in the last quarter in the number of aggression and abusive patient to staff incidents which may be linked to the introduction of the body worn cameras across inpatient services and reduced the need for prone restraint as incidents are de-escalated more effectively.

35. Physical restraint



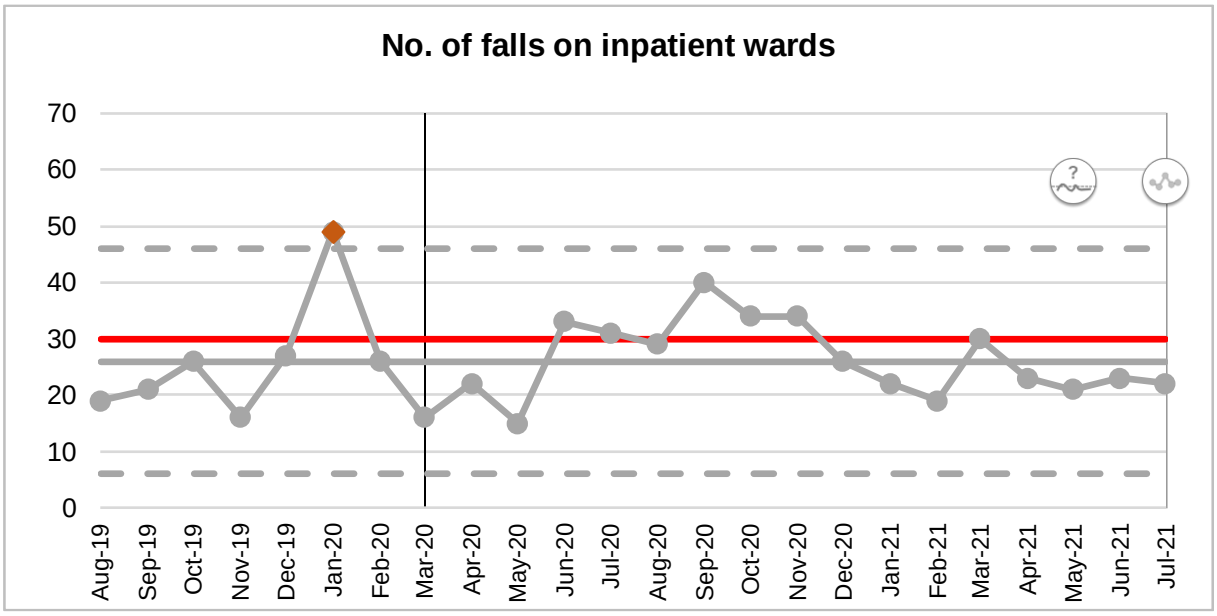
The number of reported incidents involving restraint have remained within common cause variation throughout the reporting period. The recent increase in July, bringing the data above the mean line shows a common variation however, will continue to be monitored and discussed within appropriate forums. July's increase in physical restraint may be linked to the increased use of seclusion as demonstrated below. A positive to take from this is that although restraint and seclusion have peaked in July, they remain under the upper control limits and has not resulted in an increase in prone restraint. This is a positive indicator that reducing restrictive practice pilots and work streams have been effective to provide alternatives to Prone restraint.

36. Seclusion



The use of seclusion was within common cause variation, however, has increased in July. In further investigating this trend, there appears to be a linked to a small number of patients who have been placed in seclusion on more than one occasion. This data will be monitored for patterns and further support needs for individual areas.

37. Falls on inpatient wards

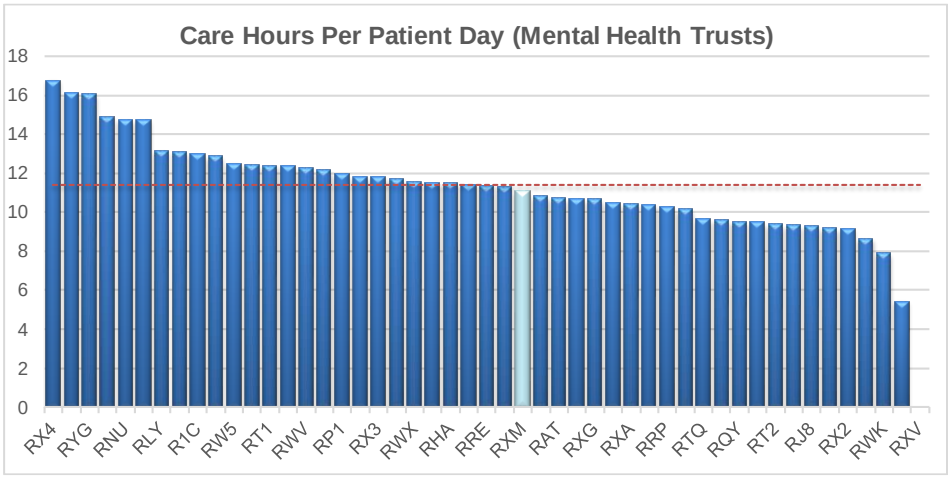


The number of reported falls has remained within common cause variation. June 2020 to December 2020 demonstrated an increase in the number of falls above the mean linked to an increase in patients presenting with delirium as services within the Derby Royal Hospital for delirium patients were stood down and moved into the community resulting in a higher number of admissions to the Cubley wards with a dual diagnosis of dementia and delirium. April 2021 to July 2021 has remained below the mean line and demonstrates the effectiveness of ongoing falls reduction work being developed and implemented within Older adult services.

Care Hours Per Patient Day (CHPPD)

CHPPD is rolling data updated monthly, to show staffing levels in relation to patient numbers on an inpatient ward. Every month, the hours worked during day shifts and night shifts by registered nurses and midwives and by healthcare assistants are added together. Each day, the number of patients occupying beds at midnight is recorded. These figures are added up for the whole month and divided by the number of days in the month to calculate a daily average. Then the figure for total hours worked is divided by the daily average number of patients to produce the rate of care hours per patient day. Work is underway to implement processes relating to staffing levels and how they are records in line with CHPPD and patient acuity. This will be in the form of the MHOST reporting system and SafeCare module within E-Roster.

The chart below shows how we compared in the latest published national data (April 21) when benchmarked against other mental health trusts. We were slightly below average:

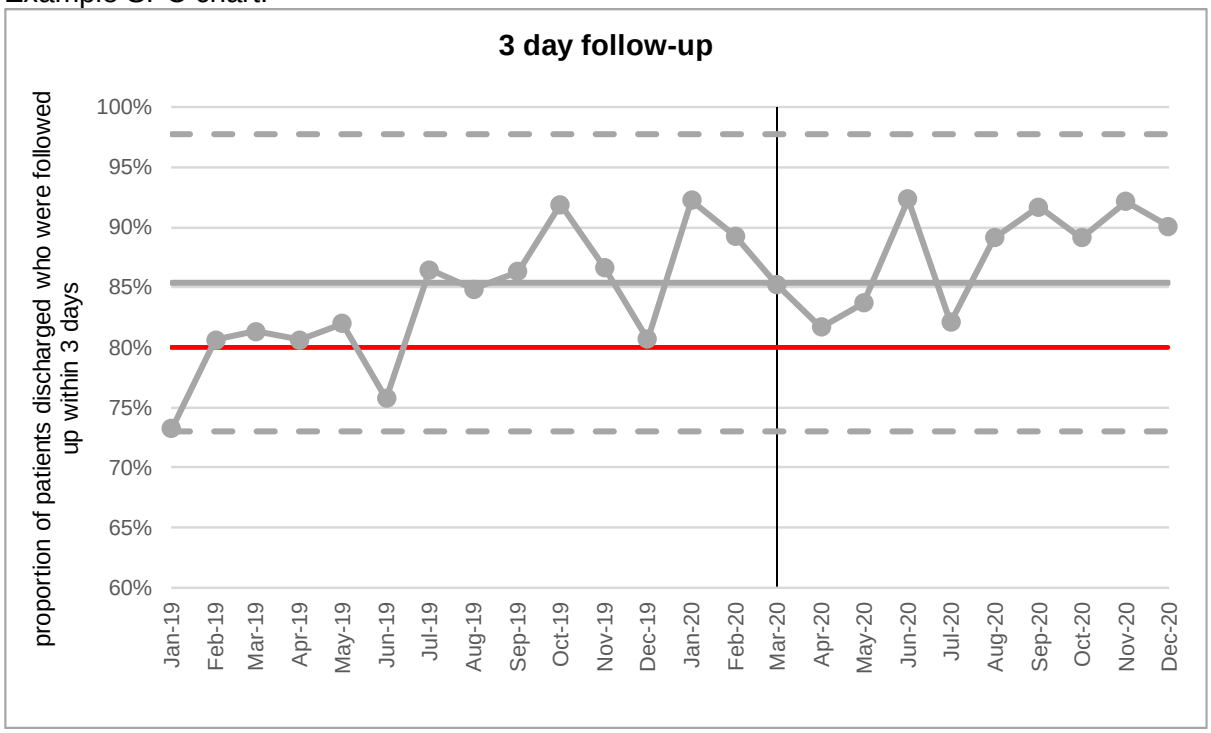


Data source: NHS England » Care hours per patient day (CHPPD) data

Appendix 1

Statistical Process Control Chart (SPC) Guidance

Example SPC chart:



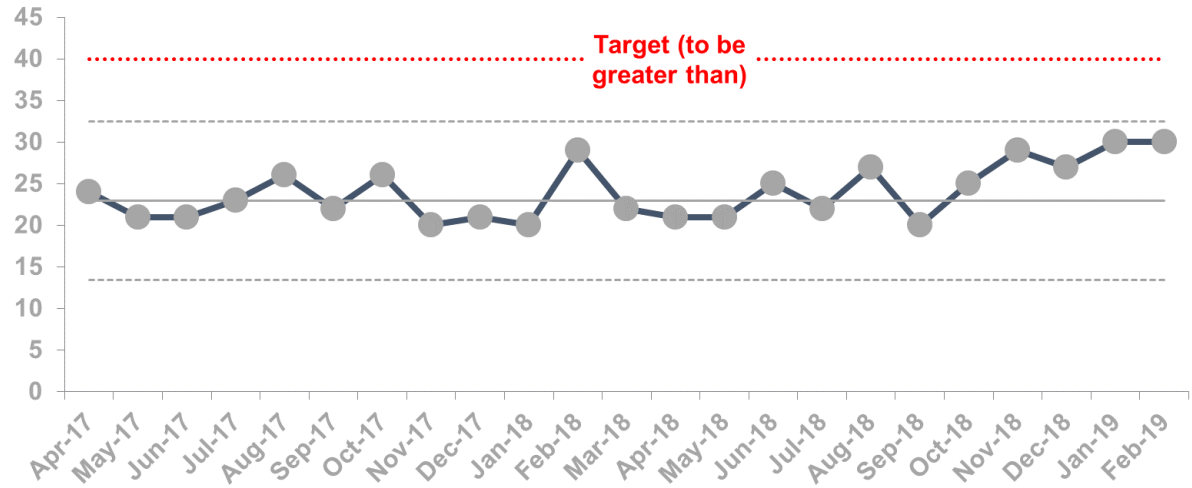
- The red line is the target.
- The grey dots are the actual performance each month. They are coloured grey as performance each month is normal in this example.
- The solid grey line is the average (mean) of all the grey dots.
- The grey dotted lines are called process limits, or control limits.

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

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

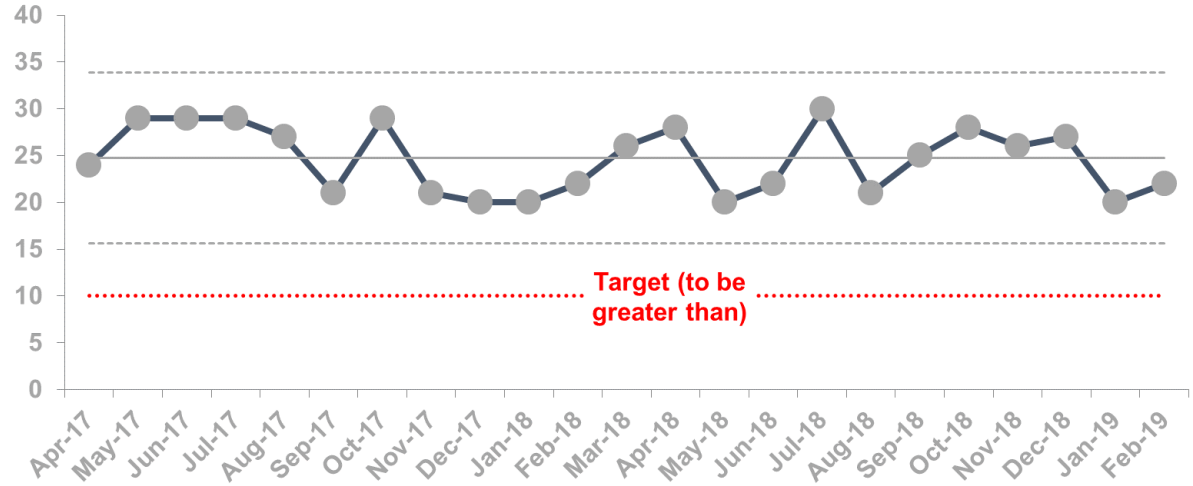
Things to look out for:

1. A process that is not working



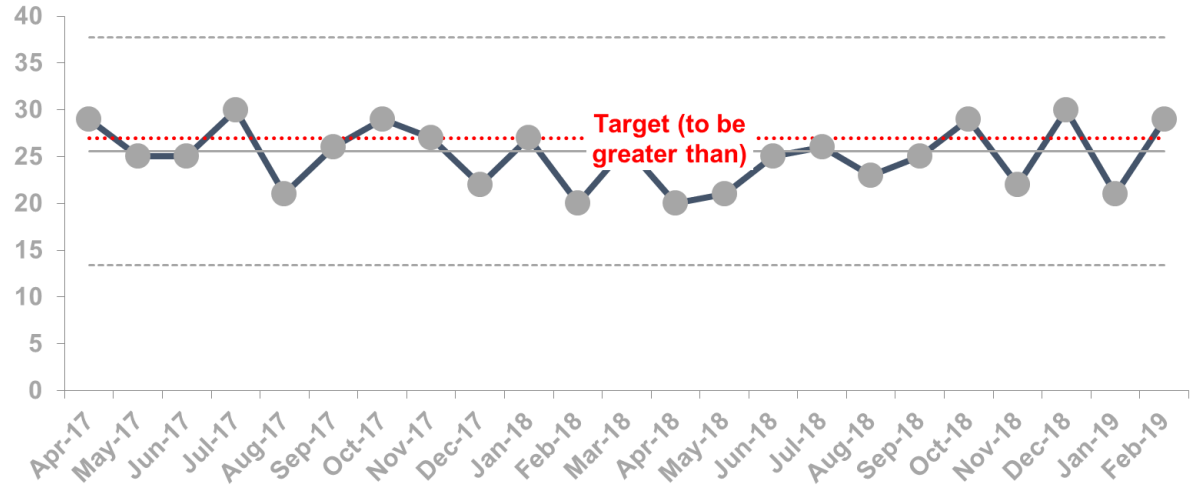
In this example the target is higher than the upper dotted grey line. This means that the target will never be achieved. To achieve the target, we need to change how we do things.

2. A capable process



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

3. An unreliable system

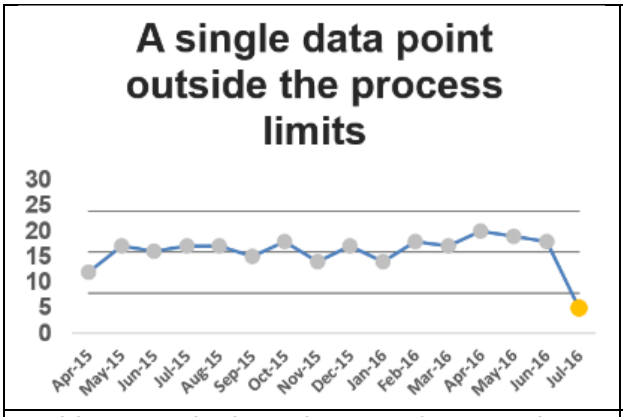
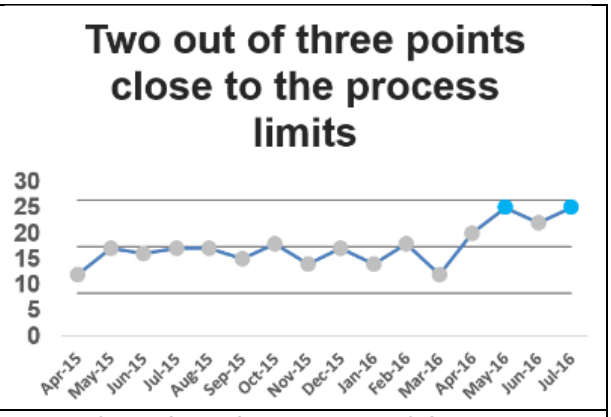


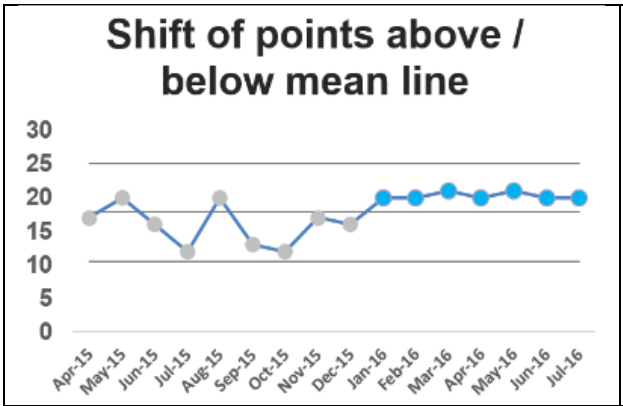
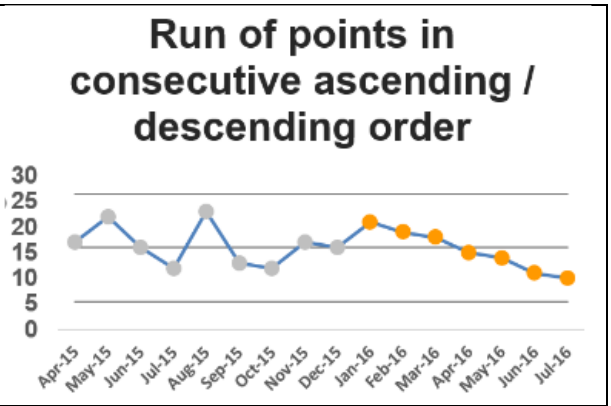
In this example the target line sits between the 2 grey dotted lines. As it is normal for the grey dots to fall anywhere between the 2 dotted grey lines, this means that it is entirely random as to whether or not the target will be achieved. So, this system is unreliable and needs to be redesigned if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

4. Unusual patterns in the data

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

There are four scenarios where this can happen:

	
In this example the July 16 perfomance is significantly lower than expected and falls beneath the lower grey dotted line.	2 out of 3 points close to one of the grey dotted lines is statistically significant, in this case they are blue, indicating better than expected performance.

	
A run of 7 points above or below the average line is significant. In this example it might indicate that an improvement was made to the process in Jan 16 that has proven to be effective.	A run of 7 points in consecutive ascending or descending order is significant. In this example things are getting worse over time.

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

Appendix 2 – Data Quality Maturity Index Benchmarking Data

		April-2021	March-2021	February-2021	January-2021	December-2020
	National Average	81.0	83.0	85.3	83.0	82.3
RPY	THE ROYAL MARSDEN NHS FOUNDATION TRUST	99.4	99.4	99.4	99.4	99.2
RGM	ROYAL PAPWORTH HOSPITAL NHS FOUNDATION TRUST	99.3	97.2	97.0	96.9	97.1
RL1	THE ROBERT JONES AND AGNES HUNT ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST	99.3	99.2	99.1	99.3	99.2
RBQ	LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST	99.1	99.2	99.2	99.3	99.2
RBV	THE CHRISTIE NHS FOUNDATION TRUST	98.5	99.0	98.8	98.8	98.7
RX3	TEES, ESK AND WEAR VALLEYS NHS FOUNDATION TRUST	98.3	98.3	98.1	98.2	98.2
RXV	GREATER MANCHESTER MENTAL HEALTH NHS FOUNDATION TRUST	98.1	97.5	97.3	97.4	98.5
RLY	NORTH STAFFORDSHIRE COMBINED HEALTHCARE NHS TRUST	97.9	98.1	98.0	97.6	98.2
RT1	CAMBRIDGESHIRE AND PETERBOROUGH NHS FOUNDATION TRUST	97.5	97.5	97.4	96.7	96.3
RM1	NORFOLK AND NORWICH UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	97.5	96.9	96.1	96.2	96.6
RXT	BIRMINGHAM AND SOLIHULL MENTAL HEALTH NHS FOUNDATION TRUST	97.3	98.6	98.6	98.4	98.3
RXX	SURREY AND BORDERS PARTNERSHIP NHS FOUNDATION TRUST	97.3	92.3	93.9	97.0	92.7
RTF	NORTHUMBRIA HEALTHCARE NHS FOUNDATION TRUST	97.2	97.2	97.3	97.1	97.2
REN	THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST	97.1	98.0	97.7	97.8	97.8
R1K	LONDON NORTH WEST UNIVERSITY HEALTHCARE NHS TRUST	96.9	97.3	97.2	96.7	97.0
RXM	DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST	96.5	96.6	96.4	96.5	96.5
RNK	TAVISTOCK AND PORTMAN NHS FOUNDATION TRUST	96.4	96.5	96.2	96.6	95.8
RYR	UNIVERSITY HOSPITALS SUSSEX NHS FOUNDATION TRUST	96.4	96.0	96.0	95.9	97.2
RTH	OXFORD UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	96.2	96.5	96.4	96.1	96.4
RHA	NOTTINGHAMSHIRE HEALTHCARE NHS FOUNDATION TRUST	96.1	96.8	96.5	96.2	96.4
RXE	ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST	96.1	95.8	96.3	96.1	95.9
RWJ	STOCKPORT NHS FOUNDATION TRUST	96.0	96.5	96.4	96.4	96.5
RXY	KENT AND MEDWAY NHS AND SOCIAL CARE PARTNERSHIP TRUST	95.9	95.8	95.8	95.6	95.7
RAN	ROYAL NATIONAL ORTHOPAEDIC HOSPITAL NHS TRUST	95.9	97.1	96.6	95.7	97.1
RWE	UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST	95.9	96.0	96.0	96.1	96.0
RAX	KINGSTON HOSPITAL NHS FOUNDATION TRUST	95.7	96.4	95.8	92.8	93.2
RRP	BARNET, ENFIELD AND HARINGEY MENTAL HEALTH NHS TRUST	95.5	96.4	96.4	96.4	95.8
RP7	LINCOLNSHIRE PARTNERSHIP NHS FOUNDATION TRUST	95.5	95.4	95.6	96.0	95.9
RMY	NORFOLK AND SUFFOLK NHS FOUNDATION TRUST	95.4	96.1	95.2	95.3	95.1
RHQ	SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST	95.4	94.1	94.1	94.1	93.1
RYJ	IMPERIAL COLLEGE HEALTHCARE NHS TRUST	95.2	94.7	94.6	94.6	94.7
RX1	NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST	95.2	95.4	95.1	95.1	95.1
RXG	SOUTH WEST YORKSHIRE PARTNERSHIP NHS FOUNDATION TRUST	95.2	95.1	95.4	95.4	94.5
RCX	THE QUEEN ELIZABETH HOSPITAL, KING'S LYNN, NHS FOUNDATION TRUST	95.1	95.7	95.7	95.5	95.6
TAF	CAMDEN AND ISLINGTON NHS FOUNDATION TRUST	95.0	93.6	95.2	94.5	94.9
RCU	SHEFFIELD CHILDREN'S NHS FOUNDATION TRUST	95.0	94.2	94.3	93.8	95.2
RV5	SOUTH LONDON AND MAUDSLEY NHS FOUNDATION TRUST	95.0	93.3	93.6	94.1	95.1
RWR	HERTFORDSHIRE PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST	94.9	97.0	97.1	96.8	97.1
RH5	SOMERSET NHS FOUNDATION TRUST	94.9	95.4	94.7	94.1	94.3
RKL	WEST LONDON NHS TRUST	94.9	95.1	94.5	94.6	94.0
R1A	HEREFORDSHIRE AND WORCESTERSHIRE HEALTH AND CARE NHS TRUST	94.6	94.4	94.4	94.2	94.1
REF	ROYAL CORNWALL HOSPITALS NHS TRUST	94.6	96.3	96.4	96.3	96.4
RNZ	SALISBURY NHS FOUNDATION TRUST	94.6	94.3	94.3	94.1	95.4
RKB	UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST	94.6	95.3	95.1	95.0	95.1
RBL	WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	94.6	94.8	94.6	94.5	94.6
8JE99	ISLE OF WIGHT YOUTH TRUST	94.5	93.4	93.0	92.3	90.1
RHM	UNIVERSITY HOSPITAL SOUTHAMPTON NHS FOUNDATION TRUST	94.5	94.0	94.0	93.9	93.9

		April-2021	March-2021	February-2021	January-2021	December-2020
	National Average	81.0	83.0	85.3	83.0	82.3
RTQ	GLOUCESTERSHIRE HEALTH AND CARE NHS FOUNDATION TRUST	94.3	94.3	94.3	90.3	90.5
RRE	MIDLANDS PARTNERSHIP NHS FOUNDATION TRUST	94.3	94.4	94.3	94.2	94.3
RX2	SUSSEX PARTNERSHIP NHS FOUNDATION TRUST	94.3	94.3	95.3	94.1	94.8
RCD	HARROGATE AND DISTRICT NHS FOUNDATION TRUST	94.2	93.7	93.7	93.7	93.8
RXW	THE SHREWSBURY AND TELFORD HOSPITAL NHS TRUST	94.2	95.0	94.9	94.8	94.8
RA7	UNIVERSITY HOSPITALS BRISTOL AND WESTON NHS FOUNDATION TRUST	94.2	93.7	93.6	93.8	94.0
RAE	BRADFORD TEACHING HOSPITALS NHS FOUNDATION TRUST	94.1	94.0	94.0	93.4	93.4
R1L	ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST	94.0	93.7	93.2	93.6	93.9
RWY	CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST	93.9	94.7	94.5	94.3	93.6
RX4	CUMBRIA, NORTHUMBERLAND, TYNE AND WEAR NHS FOUNDATION TRUST	93.9	93.8	93.8	93.9	93.7
RNQ	KETTERING GENERAL HOSPITAL NHS FOUNDATION TRUST	93.9	93.4	93.1	92.9	92.7
RJL	NORTHERN LINCOLNSHIRE AND GOOLE NHS FOUNDATION TRUST	93.9	93.9	93.9	93.9	93.6
RR8	LEEDS TEACHING HOSPITALS NHS TRUST	93.6	93.2	93.1	48.0	92.6
RVY	SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	93.6	93.3	93.4	94.1	94.1
RXF	MID YORKSHIRE HOSPITALS NHS TRUST	93.5	93.1	93.1	93.1	93.9
RY3	NORFOLK COMMUNITY HEALTH AND CARE NHS TRUST	93.5	93.9	92.4	93.4	94.3
RQM	CHELSEA AND WESTMINSTER HOSPITAL NHS FOUNDATION TRUST	93.4	96.7	96.5	95.6	87.7
RP5	DONCASTER AND BASSETLAW TEACHING HOSPITALS NHS FOUNDATION TRUST	93.4	93.4	93.4	94.3	95.2
RVW	NORTH TEES AND HARTLEPOOL NHS FOUNDATION TRUST	93.4	94.7	71.6	94.2	93.4
RTP	SURREY AND SUSSEX HEALTHCARE NHS TRUST	93.4	93.1	92.9	93.7	94.1
RWW	WARRINGTON AND HALTON TEACHING HOSPITALS NHS FOUNDATION TRUST	93.4	94.6	94.8	94.6	94.7
TAD	BRADFORD DISTRICT CARE NHS FOUNDATION TRUST	93.3	93.2	93.2	93.3	93.3
RVJ	NORTH BRISTOL NHS TRUST	93.3	92.0	91.8	84.1	94.0
RTR	SOUTH TEES HOSPITALS NHS FOUNDATION TRUST	93.3	93.1	92.9	93.0	92.9
RAS	THE HILLINGDON HOSPITALS NHS FOUNDATION TRUST	93.3	93.1	93.3	93.9	94.0
R0D	UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST	93.3	18.7	18.0	2.9	2.9
RHW	ROYAL BERKSHIRE NHS FOUNDATION TRUST	93.2	93.7	94.1	94.0	69.6
RJZ	KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST	93.1	93.7	93.8	93.7	92.9
RTE	GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST	93.0	92.5	92.8	92.3	92.4
RHU	PORTSMOUTH HOSPITALS UNIVERSITY NATIONAL HEALTH SERVICE TRUST	93.0	92.9	93.8	93.8	95.0
RQY	SOUTH WEST LONDON AND ST GEORGE'S MENTAL HEALTH NHS TRUST	93.0	92.2	92.7	92.6	92.8
RQW	THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST	93.0	93.8	93.8	93.7	93.2
RCB	YORK TEACHING HOSPITAL NHS FOUNDATION TRUST	93.0	93.8	93.8	93.7	93.7
RFF	BARNSLEY HOSPITAL NHS FOUNDATION TRUST	92.9	94.3	92.9	93.8	93.6
RRJ	THE ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST	92.9	94.4	94.4	94.5	94.1
RVN	AVON AND WILTSHIRE MENTAL HEALTH PARTNERSHIP NHS TRUST	92.8	92.7	93.0	92.7	92.6
RP6	MOORFIELDS EYE HOSPITAL NHS FOUNDATION TRUST	92.8	93.5	92.9	92.5	93.2
RXL	BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST	92.6	91.5	91.1	91.0	91.3
RWA	HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST	92.6	92.9	92.7	92.5	92.4
RXQ	BUCKINGHAMSHIRE HEALTHCARE NHS TRUST	92.5	93.5	93.4	94.0	94.2
RNA	THE DUDLEY GROUP NHS FOUNDATION TRUST	92.4	92.5	94.3	94.2	94.0
RT2	PENNINE CARE NHS FOUNDATION TRUST	92.2	92.2	92.1	92.3	92.4
RD1	ROYAL UNITED HOSPITALS BATH NHS FOUNDATION TRUST	92.2	93.1	92.9	93.9	93.9
RBN	ST HELENS AND KNOWSLEY TEACHING HOSPITALS NHS TRUST	92.2	91.1	90.9	90.7	90.9
R1H	BARTS HEALTH NHS TRUST	92.1	69.5	91.7	91.6	91.7
RC9	BEDFORDSHIRE HOSPITALS NHS FOUNDATION TRUST	92.1	93.5	93.4	91.2	93.3
RDU	FRIMLEY HEALTH NHS FOUNDATION TRUST	92.1	91.5	91.5	91.1	90.9
RBT	MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	92.1	93.2	92.8	92.5	88.7
RET	THE WALTON CENTRE NHS FOUNDATION TRUST	92.1	94.1	95.8	96.1	95.8
RGT	CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	92.0	90.8	91.0	90.5	90.2

		April-2021	March-2021	February-2021	January-2021	December-2020
	National Average	81.0	83.0	85.3	83.0	82.3
RV3	CENTRAL AND NORTH WEST LONDON NHS FOUNDATION TRUST	92.0	93.4	68.0	93.4	93.7
RCF	AIREDALE NHS FOUNDATION TRUST	91.9	70.3	92.1	92.4	91.3
RWK	EAST LONDON NHS FOUNDATION TRUST	91.7	91.8	93.2	93.2	93.2
R0B	SOUTH TYNESIDE AND SUNDERLAND NHS FOUNDATION TRUST	91.7	90.7	90.7	90.5	90.1
RJE	UNIVERSITY HOSPITALS OF NORTH MIDLANDS NHS TRUST	91.7	92.7	92.6	92.6	92.6
RR7	GATESHEAD HEALTH NHS FOUNDATION TRUST	91.6	91.7	91.7	90.4	91.6
RT5	LEICESTERSHIRE PARTNERSHIP NHS TRUST	91.5	91.5	91.3	91.1	91.6
RPG	OXLEAS NHS FOUNDATION TRUST	91.5	91.7	91.4	92.1	92.4
RWG	WEST HERTFORDSHIRE HOSPITALS NHS TRUST	91.5	93.7	93.7	93.4	93.8
RKE	WHITTINGTON HEALTH NHS TRUST	91.5	88.3	88.1	87.8	89.7
RNS	NORTHAMPTON GENERAL HOSPITAL NHS TRUST	91.4	91.5	91.4	91.7	90.3
RTD	THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST	91.4	90.7	90.7	90.6	90.6
RTX	UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST	91.4	90.6	90.9	91.0	92.1
RWH	EAST AND NORTH HERTFORDSHIRE NHS TRUST	91.3	92.7	92.6	92.6	92.6
RD8	MILTON KEYNES UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	91.3	94.0	93.8	93.3	93.6
RWP	WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST	91.3	92.8	92.7	92.5	92.4
RBS	ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	91.2	91.2	91.3	89.4	91.2
RM3	SALFORD ROYAL NHS FOUNDATION TRUST	91.2	91.3	90.7	66.8	90.2
RXP	COUNTY DURHAM AND DARLINGTON NHS FOUNDATION TRUST	91.1	91.0	90.9	91.6	92.8
RLT	GEORGE ELIOT HOSPITAL NHS TRUST	91.1	92.0	90.8	90.5	90.6
RW5	LANCASHIRE & SOUTH CUMBRIA NHS FOUNDATION TRUST	91.1	90.0	92.2	58.2	59.4
RN5	HAMPSHIRE HOSPITALS NHS FOUNDATION TRUST	90.9	92.4	92.3	92.3	92.3
RGP	JAMES PAGET UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	90.9	92.0	91.3	95.1	95.0
RWF	MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST	90.8	90.8	90.8	90.9	91.9
RBD	DORSET COUNTY HOSPITAL NHS FOUNDATION TRUST	90.7	90.0	90.4	90.8	91.0
RXN	LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST	90.7	93.1	93.1	93.2	93.0
RJ7	ST GEORGE'S UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	90.7	89.9	90.0	90.4	90.6
RGR	WEST SUFFOLK NHS FOUNDATION TRUST	90.7	91.6	91.6	90.6	90.2
RA4	YEOVIL DISTRICT HOSPITAL NHS FOUNDATION TRUST	90.7	89.5	89.2	88.7	90.2
RF4	BARKING, HAVERING AND REDBRIDGE UNIVERSITY HOSPITALS NHS TRUST	90.6	92.2	92.2	92.1	92.1
RAJ	MID AND SOUTH ESSEX NHS FOUNDATION TRUST	90.4	91.7	91.7	92.2	92.1
R1C	SOLENT NHS TRUST	90.4	91.5	91.4	91.8	91.5
TAJ	BLACK COUNTRY HEALTHCARE NHS FOUNDATION TRUST	90.2	89.9	89.9	90.2	90.6
RFS	CHESTERFIELD ROYAL HOSPITAL NHS FOUNDATION TRUST	90.2	90.1	89.4	88.9	88.6
RRK	UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST	90.2	91.3	91.2	90.9	91.0
RJ8	CORNWALL PARTNERSHIP NHS FOUNDATION TRUST	89.9	89.2	89.7	88.9	89.9
RDY	DORSET HEALTHCARE UNIVERSITY NHS FOUNDATION TRUST	89.8	89.9	88.1	89.6	89.8
RAP	NORTH MIDDLESEX UNIVERSITY HOSPITAL NHS TRUST	89.8	90.1	91.1	91.4	91.5
RDE	EAST SUFFOLK AND NORTH ESSEX NHS FOUNDATION TRUST	89.7	90.2	89.9	90.5	90.8
R1F	ISLE OF WIGHT NHS TRUST	89.7	92.3	92.6	92.3	92.3
RGN	NORTH WEST ANGLIA NHS FOUNDATION TRUST	89.7	93.2	93.4	93.3	92.9
RQX	HOMERTON UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	89.6	91.4	91.8	92.3	92.6
RGD	LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST	89.6	89.7	89.7	87.0	89.8
RA3	WESTON AREA HEALTH NHS TRUST	89.6	87.5	87.3	87.6	87.5
RXC	EAST SUSSEX HEALTHCARE NHS TRUST	89.5	90.1	90.1	89.9	90.7
TAH	SHEFFIELD HEALTH & SOCIAL CARE NHS FOUNDATION TRUST	89.4	89.7	89.2	88.7	89.7
RJC	SOUTH WARWICKSHIRE NHS FOUNDATION TRUST	89.4	90.6	90.7	90.6	90.4
RPA	MEDWAY NHS FOUNDATION TRUST	89.3	84.7	85.7	86.2	84.9
RFR	THE ROTHERHAM NHS FOUNDATION TRUST	89.2	67.6	67.5	67.9	69.6
RK5	SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST	89.1	89.7	90.0	89.8	90.1

		April-2021	March-2021	February-2021	January-2021	December-2020
	National Average	81.0	83.0	85.3	83.0	82.3
8J084	THE CELLAR TRUST	89.1	85.3	83.9	83.8	84.1
RWV	DEVON PARTNERSHIP NHS TRUST	88.9	89.2	89.4	89.3	93.1
RN3	GREAT WESTERN HOSPITALS NHS FOUNDATION TRUST	88.9	90.2	90.5	90.1	90.5
RJ2	LEWISHAM AND GREENWICH NHS TRUST	88.9	90.4	90.5	90.5	90.3
RMP	TAMESIDE AND GLOSSOP INTEGRATED CARE NHS FOUNDATION TRUST	88.9	90.3	90.4	90.2	71.2
RBZ	NORTHERN DEVON HEALTHCARE NHS TRUST	88.8	88.2	87.9	88.2	89.0
RAL	ROYAL FREE LONDON NHS FOUNDATION TRUST	88.8	89.8	89.9	89.6	89.0
RA9	TORBAY AND SOUTH DEVON NHS FOUNDATION TRUST	88.7	88.3	88.2	88.3	89.0
RQ3	BIRMINGHAM WOMEN'S AND CHILDREN'S NHS FOUNDATION TRUST	88.6	90.0	92.5	92.4	92.3
RK9	UNIVERSITY HOSPITALS PLYMOUTH NHS TRUST	88.6	91.4	91.3	91.7	91.4
RBK	WALSALL HEALTHCARE NHS TRUST	88.6	92.4	92.3	92.2	92.1
RY5	LINCOLNSHIRE COMMUNITY HEALTH SERVICES NHS TRUST	88.5	88.3	87.3	87.5	88.5
RLQ	WYE VALLEY NHS TRUST	88.5	88.9	88.9	88.7	89.3
RXR	EAST LANCASHIRE HOSPITALS NHS TRUST	88.4	48.2	88.8	88.7	88.6
R0A	MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	88.2	89.2	88.3	88.0	88.2
RXA	CHESHIRE AND WIRRAL PARTNERSHIP NHS FOUNDATION TRUST	88.0	88.6	88.8	88.6	89.0
RJ1	GUY'S AND ST THOMAS' NHS FOUNDATION TRUST	88.0	86.3	85.7	85.1	85.8
R1D	SHROPSHIRE COMMUNITY HEALTH NHS TRUST	88.0	84.7	83.8	84.1	84.1
RP4	GREAT ORMOND STREET HOSPITAL FOR CHILDREN NHS FOUNDATION TRUST	87.9	88.7	88.8	88.9	88.6
RL4	THE ROYAL WOLVERHAMPTON NHS TRUST	87.8	89.7	90.2	90.6	90.2
RXK	SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST	87.7	91.1	88.0	89.4	88.5
RW1	SOUTHERN HEALTH NHS FOUNDATION TRUST	87.5	88.5	88.2	87.9	88.2
RN7	DARTFORD AND GRAVESHAM NHS TRUST	87.4	89.2	89.2	89.2	88.8
REP	LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	87.3	87.6	87.6	87.5	87.2
RWD	UNITED LINCOLNSHIRE HOSPITALS NHS TRUST	87.3	88.7	88.7	89.3	89.3
RY8	DERBYSHIRE COMMUNITY HEALTH SERVICES NHS FOUNDATION TRUST	87.1	87.3	87.1	88.1	86.3
RJN	EAST CHESHIRE NHS TRUST	87.1	88.5	88.5	88.7	88.4
RTG	UNIVERSITY HOSPITALS OF DERBY AND BURTON NHS FOUNDATION TRUST	86.8	88.1	87.3	86.9	87.0
RVV	EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST	86.1	61.9	62.8	62.1	63.7
RH8	ROYAL DEVON AND EXETER NHS FOUNDATION TRUST	86.1	86.6	85.8	84.7	84.3
RJR	COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	86.0	87.5	87.7	87.6	87.5
RNN	NORTH CUMBRIA INTEGRATED CARE NHS FOUNDATION TRUST	85.9	87.3	88.8	55.6	90.1
RY9	HOUNSLOW AND RICHMOND COMMUNITY HEALTHCARE NHS TRUST	85.6	86.4	82.1	82.0	82.3
RY2	BRIDGEWATER COMMUNITY HEALTHCARE NHS FOUNDATION TRUST	85.1	85.2	84.5	81.5	84.5
RYY	KENT COMMUNITY HEALTH NHS FOUNDATION TRUST	84.9	83.5	83.1	83.2	83.8
RAT	NORTH EAST LONDON NHS FOUNDATION TRUST	84.8	85.3	84.8	84.8	67.6
RYW	BIRMINGHAM COMMUNITY HEALTHCARE NHS FOUNDATION TRUST	84.7	56.3	55.3	38.9	83.3
RA2	ROYAL SURREY COUNTY HOSPITAL NHS FOUNDATION TRUST	84.2	83.9	83.7	83.7	41.8
RJ6	CROYDON HEALTH SERVICES NHS TRUST	84.0	85.1	84.8	83.9	82.1
RDR	SUSSEX COMMUNITY NHS FOUNDATION TRUST	84.0	83.9	83.8	82.5	84.8
RRV	UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST	83.9	86.0	86.0	86.0	85.5
RYX	CENTRAL LONDON COMMUNITY HEALTHCARE NHS TRUST	83.7	79.2	79.3	80.2	79.7
RYG	COVENTRY AND WARWICKSHIRE PARTNERSHIP NHS TRUST	83.7	84.0	84.2	84.2	82.9
REM	LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	83.4	81.3	82.3	85.4	61.2
RVR	EPSOM AND ST HELIER UNIVERSITY HOSPITALS NHS TRUST	83.1	84.4	84.7	84.6	85.4
RRF	WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST	83.1	84.9	84.5	83.8	85.4
RMC	BOLTON NHS FOUNDATION TRUST	82.4	83.4	83.3	83.4	83.0
RNU	OXFORD HEALTH NHS FOUNDATION TRUST	81.9	82.4	82.8	82.8	83.1
AAH	TETBURY HOSPITAL TRUST LTD	81.7	80.3	80.9	81.6	82.3
RPC	QUEEN VICTORIA HOSPITAL NHS FOUNDATION TRUST	75.5	77.7	77.5	77.6	77.0

		April-2021	March-2021	February-2021	January-2021	December-2020
	National Average	81.0	83.0	85.3	83.0	82.3
RXH	BRIGHTON AND SUSSEX UNIVERSITY HOSPITALS NHS TRUST	74.5	94.0	93.5	94.1	94.4
8JH27	NORTHORPE HALL CHILD AND FAMILY TRUST	73.8	74.9	73.6	73.6	73.5
8KM02	BRATHAY TRUST	70.5	70.1	66.5	68.1	68.0
RV9	HUMBER TEACHING NHS FOUNDATION TRUST	67.8	93.4	93.2	67.0	67.1
RW6	PENNINE ACUTE HOSPITALS NHS TRUST	60.9	67.8	93.7	80.1	94.6
8JJ35	THE CLD TRUST	55.7	55.7	56.2	55.5	55.4
8KF34	THE TOBY HENDERSON TRUST LTD	53.9	53.8	53.0	0.0	0.0
A344	BRIGHTON HOUSING TRUST	53.4	50.8	52.8	52.9	53.2
RY6	LEEDS COMMUNITY HEALTHCARE NHS TRUST	53.4	94.3	94.2	58.7	58.7
RW4	MERSEY CARE NHS FOUNDATION TRUST	51.3	51.4	92.9	51.1	50.5
RWX	BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST	50.7	51.2	77.3	77.6	59.7
RTV	NORTH WEST BOROUGHS HEALTHCARE NHS FOUNDATION TRUST	48.4	48.4	88.9	48.3	48.5
RTK	ASHFORD AND ST PETER'S HOSPITALS NHS FOUNDATION TRUST	41.0	88.5	88.6	45.5	45.3
RYV	CAMBRIDGESHIRE COMMUNITY SERVICES NHS TRUST	39.6	39.6	13.9	39.7	39.8
RP1	NORTHAMPTONSHIRE HEALTHCARE NHS FOUNDATION TRUST	36.5	91.5	92.8	92.8	92.3
RY4	HERTFORDSHIRE COMMUNITY NHS TRUST	23.4	23.0	54.4	23.4	23.3
RY7	WIRRAL COMMUNITY HEALTH AND CARE NHS FOUNDATION TRUST	6.3	6.3	82.2	6.3	6.3
RYK	DUDLEY INTEGRATED HEALTH AND CARE NHS TRUST	4.8	5.7	5.8	5.6	5.8
RD3	POOLE HOSPITAL NHS FOUNDATION TRUST	0.0	76.2	76.4	77.3	76.2
RT3	ROYAL BROMPTON & HAREFIELD NHS FOUNDATION TRUST	0.0	43.1	43.1	47.7	49.9
RYF	SOUTH WESTERN AMBULANCE SERVICE NHS FOUNDATION TRUST	0.0	0.0	-	0.0	0.0
RDZ	THE ROYAL BOURNEMOUTH AND CHRISTCHURCH HOSPITALS NHS FOUNDATION TRUST	0.0	77.0	77.3	77.1	76.1

Data source: Data quality - NHS Digital

Derbyshire Healthcare NHS Foundation Trust
Report to the Council of Governors – 7 September 2021

Report from the Governance Committee

Purpose of Report

The Governance Committee of the Council of Governors (CoG) has met twice since its last report to the Council of Governors in May. This report provides a summary of the meetings including actions and recommendations made.

Executive Summary

Since the last summary was provided in May the Governance Committee has met twice on 15 June and 10 August 2021. Following national guidance on keeping people safe during the COVID-19 pandemic, both meetings were conducted digitally using Microsoft Teams.

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

Assurances

- The Council of Governors can receive assurance that the Committee is well established and discussing key areas of governor business
- Items for decision or approval will be brought to the full Council of Governors as appropriate
- An update of discussions at each meeting is regularly reported to the Council of Governors
- Effectiveness of the meeting is discussed regularly
- The work plan is reviewed at each meeting and changes made as and when required
- The Governance Committee escalates items to the Council of Governors as and when required.

Consultation

- No formal consultation is required for this update, although the Governance Committee has been established with a consultative approach and this continues to be reflected through the items discussed.

Governance or Legal Issues

- The Governance Committee, as part of its work, will review key governance documents including the governors' Code of Conduct and will oversee Trust Constitution amendments prior to presenting to the Council of Governors.

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

Although there are no specific issues raised in the report which impact on individuals with protected characteristics, the Governance Committee is committed to ensure that governors who may require additional support and/or adjustments are provided with this to ensure that they can carry out their role. This includes provision of support workers where required and working with individual governors to ensure they have access to information in a preferred format (for example, in hard copy rather than email). Governors are also supported to attend meetings where they have disability and/or access issues.

Recommendations

The Council of Governors is requested to note the report made of the Governance Committee meetings held on 15 June and 10 August 2021.

Report presented by: **Julie Lowe,**
Deputy Chair of the Governance Committee

Report prepared by: **Denise Baxendale**
Membership and Involvement Manager

Report from the Governance Committee – 15 June 2021

16 governors (61.53% of the Council of Governors) attended this meeting held on 15 June 2021.

Lead Governor role

- Governors were again encouraged to consider expressing an interest in this role.

Feedback from governor engagement activities including themes / issues arising / topics of conversation relating to the trust

- Governors agreed to simplify the governor engagement log. All engagement activities will continue to be logged but only those with any issues/concerns will be presented to the Committee. Outcomes will also be recorded.

Review progress of Governors Membership Engagement Action Plan

- This has been reviewed by the Governor Engagement Task and Finish Group and circulated to all governors.

Update on NHS Providers Governor Focus Conference

- NHS Providers had chosen the Trust's submission 'Meaningful engagement through the COVID-19 pandemic' to showcase at their conference on 8 July.

Consideration of holding to account questions to council of governors

- One question regarding the Trust's psychiatric services was escalated to the Council of Governors (CoG) – a response will be provided on 7 September.

External audit provision across Joined Up Care Derbyshire

- The Committee supported the recommendation that CoG approves the proposal to undertake a Derbyshire wide procurement process for external auditors.

Report from the Governance Committee – 10 August 2021

14 governors (53.84% of the Council of Governors) attended this meeting held on 10 August 2021.

Lead Governor role

- It was noted that no governor has expressed an interest in the Lead Governor and Deputy Lead Governor role. It was agreed that this will be discussed further at the Council of Governors on 7 September.

Annual Members Meeting

- Governors were asked to promote the event within their communities
- Governors were encouraged to attend the Annual Members Meeting.

Feedback from governor engagement activities including themes / issues arising / topics of conversation relating to the Trust

- Derby and Derbyshire Clinical Commissioning Group (DCCG) and Joined Up Care Derbyshire (JUCD) Engagement Committee – governors were asked to consider representing the Council of Governors on this group now that Kevin Richards has resigned from his governor role. Carole Riley who supported Kevin if he was unable to attend meetings will continue in the supportive role.

Governor engagement opportunities

- Regarding engagement opportunities governors were encouraged to sign up to the voluntary sectors e-newsletters Derbyshire Mental Health Forum News and Derbyshire Voluntary Action's e-bulletin.

Annual Review of the Governance Committee terms of reference

- The Terms of Reference was reviewed by the Committee who recommended that the wording 'nominated memberships champion' under the membership section be removed.
- Amended Terms of Reference to be presented to the Council of Governors on 7 September for approval (see appendix 1).

Process for Governors Annual Effectiveness Survey

- The survey is ready to launch
- All governors are encouraged to complete the survey
- The results of the survey will be presented to the Governance Committee in October and to the Council of Governors in November.

Governors Nominations and Remuneration Committee

- There is a vacancy for a Public Governor on the Committee now that Kevin Richards has resigned.

Derbyshire Healthcare
NHS Foundation Trust

Terms of Reference of the Governance Committee

Authority
The Council of Governors Governance Committee is constituted as a Committee of the Council of Governors. The Governance Committee will review key governance documents including the governors' Code of Conduct and will oversee Trust Constitution amendments prior to presenting to the Council of Governors.

1. Role
The Council of Governors Governance Committee shall be responsible for advice and support on:

1.1 Code of Conduct
1.1.1 Maintaining an overview of governor attendance and contribution in line with the Governors' Code of Conduct and best practice, ensuring effective processes are in place to deal with any non-compliance, behaviour or conduct issues.
1.1.2 Annual review of the Governors' Code of Conduct.

1.2 Membership & Engagement
1.2.1 Ensure governors have an agreed approach to member engagement and recruitment and that the Council of Governors' responsibilities are met in this respect.
1.2.2 To assist in creating opportunities to engage with governors constituents and to create new members and engage with existing members.
1.2.3 To assist in the recruitment of governors and in preparing them to fulfil their responsibilities.
1.2.4 Regularly review the Trust's membership data.
1.2.5 Maintain an oversight of governor involvement in Trust activities, ensure that those activities are coordinated and reported back to the Council of Governors.
1.2.6 Advise on arrangements for the Annual Members' Meeting.

1.3 Quality
1.3.1 To consider the Trust's Quality Account and support the coordination of the governors' statement.

1.4 Holding to Account
1.4.1 Oversee engagement activities with Non-Executive Directors.
1.4.2 Make proposals for the Council's forward work programme, including items related to holding the board to account.

1.5 Training & Development
1.5.1 To consider the learning and development needs of the Council of Governors required to enable governors to undertake their role and responsibilities efficiently and effectively.
1.5.2 To reflect upon the training and development undertaken and review feedback received from governor development sessions.

1.6 Governance
1.6.1 Give due consideration to laws and regulations and the provisions of the NHS Foundation Trust Code of Governance.
1.6.2 Ensure the Council of Governors' annual effectiveness review is undertaken and outcomes presented to the Council of Governors with any required recommendations to discharge its role.
1.6.3 Review of any proposed changes to the Trust's constitution, making recommendations as required.

2. The Council of Governors shall not delegate any of its powers to the Governance Committee and the Governance Committee shall not exercise any of the powers of the Council of Governors.

3. Membership of the Committee
3.1 The Governance Committee shall comprise of elected Public Governors, Staff Governors and Appointed Governors.
3.2 The following are also invited to attend:
- Trust Chair (Chair of Council of Governors)
- Deputy Trust Chair in the absence of the Chair
- Trust Secretary
- Membership & Involvement Manager
- ~~Nominated Membership Champion~~

4. Quorum
A Quorum shall comprise:

a) Six governors
b) One member of Trust staff, aside from Staff Governors

5. Frequency of Meetings
5.1 The Committee shall meet bi-monthly and report regularly to the Council of Governors.

6. Planning & Administration of Meetings
6.1 Yearly the Committee shall elect from its membership, a governor to serve as Chair of the Committee who will be eligible for re-election after the term has expired.
6.2 The Committee shall elect from its membership, a governor to serve as a Deputy Chair.
6.3 The Membership & Involvement Manager will support the planning and administration of the Committee.
6.4 A suitably qualified member of staff should attend each meeting.

7. Review
7.1 The terms of reference of the Committee shall be reviewed by the Governance Committee annually and changes submitted to the Council of Governors for approval.

Governor Meeting Timetable – March 2022

DATE	TIME	EVENT	LOCATION/COMMENTS
7/9/21	9.30am onwards	Trust Board Meeting	This will be a virtual meeting
7/9/21	2.00pm onwards	Council of Governors meeting	This will be a virtual meeting
9/9/20	4.00-6.00pm	Annual Members' Meeting	This will be a virtual meeting
6/10/21	2.00-4.00pm	Governor Training and Development Session – governor engagement	This will be a virtual meeting
12/10/21	10.00am-12.30pm	Governance Committee	This will be a virtual meeting
2/11/21	9.30am onwards	Trust Board Meeting	This will be a virtual meeting
2/11/21	2.00pm onwards	Council of Governors meeting	This will be a virtual meeting
8/12/21	10.00am-12.30pm	Governance Committee	This will be a virtual meeting
18/1/22	9.30am onwards	Trust Board Meeting	Conference Rooms A&B, Ashbourne Centre, Kingsway Hospital Site, Kingsway, Derby DE22 3LZ
18/1/22	2.00pm onwards	Council of Governors and Trust Board development session	Conference Rooms A&B, Ashbourne Centre, Kingsway Hospital Site, Kingsway, Derby DE22 3LZ
8/2/22	10.00am-12.30pm	Governance Committee	Rooms 1&2, Ashbourne Centre, Kingsway Hospital Site, Kingsway, Derby DE22 3LZ
1/3/22	2.00pm onwards	Council of Governors meeting	Conference Rooms A&B, Ashbourne Centre, Kingsway Hospital Site, Kingsway, Derby DE22 3LZ
1/3/22	9.30am onwards	Trust Board Meeting	Conference Rooms A&B, Ashbourne Centre, Kingsway Hospital Site, Kingsway, Derby DE22 3LZ

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

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
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
EDS2	Equality Delivery System 2
EHIC	European Health Insurance Card
EHR	Electronic Health Record
EI	Early Intervention
EIA	Equality Impact Assessment
EIP	Early Intervention In Psychosis
ELT	Executive Leadership Team
EMDR	Eye Movement Desensitising & Reprocessing Therapy
EMR	Electronic Medical Record
EPR	Electronic Patient Record
ERIC	Estates Return Information Collection
ESR	Electronic Staff Record
EUPD	Emotionally Unstable Personality Disorder
EWTD	European Working Time Directive
F	
FBC	Full Business Case
FFT	Friends and Family Test

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

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Term / Abbreviation	**Terms in Full**
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
MAU	Medical Assessment Unit
MAS	Memory Assessment Service
MAPPA	Multi-agency Public Protection Arrangements
MARAC	Multi-agency Risk Assessment Conference (meeting where information is shared on the highest risk domestic abuse cases between representatives of local police, probation, health, child protection, housing practitioners, Independent Domestic Violence Advisors (IDVAs) and other specialists from the statutory and voluntary sectors.
MASH	Multi-Agency Safeguarding Hub
MCA	Mental Capacity Act
MDA	Medical Device Alert
MDM	Multi-Disciplinary Meeting
MDT	Multi-Disciplinary Team
MFF	Market Forces Factor
MHA	Mental Health Act
MHIN	Mental Health Intelligence Network
MHIS	Mental Health Investment Standard
MHRT	Mental Health Review Tribunal
MSC	Medical Staff Committee
MSK	Musculoskeletal (conditions)
N	
NCRS	National Cancer Registration Service
NED	Non-Executive Director
NICE	National Institute for Health and Care Excellence
NHS	National Health Service
NHSE	National Health Service England
NHSI	National Health Service Improvement
NIHR	National Institute for Health Research
O	
OBC	Outline Business Case
ODG	Operational Delivery Group
OP	Out Patient
OSC	Overview and Scrutiny Committee
OT	Occupational therapy
P	
PAB	Programme Assurance Board
PAG	Programme Advisory Group
PALS	Patient Advice and Liaison Service
PAM	Payment Activity Matrix
PARC	Psychosis and the reduction of cannabis (and other drugs)

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Term / Abbreviation	**Terms in Full**
PARIS	This is an electronic patient record system
PbR	Payment by Results
PCC	Police & Crime Commissioner
PCN	Primary Care Networks
PDSA	Plan, Do, Study, Act
PHE	Public Health England
PICU	Psychiatric Intensive Care Unit
PID	Project Initiation Document
PiPoT	People in Positions of Trust
PLIC	Patient Level Information Costs
PMLD	Profound and Multiple Disability
PPE	Personal Protection 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
R	
RAID	Rapid Assessment, Interface and Discharge
RCGP	Royal College of General Practitioners
RCI	Reference Cost Index
REGARDS	Race, Economic disadvantage, Gender, Age, Religion or belief, Disability and Sexual orientation
RTT	Referral to Treatment
S	
SAAF	Safeguarding Adults Assurance Framework
SBARD	Situation, Background, Assessment, Recommendation and Decision (SBARD) tool
SBS	Shared Business Services
SEND	Special Educational Needs and Disabilities
SI	Serious Incidents
SID	Senior Independent Director
SIRI	Serious Incident Requiring Investigation
SLA	Service Level Agreement
SLR	Service Line Reporting
SMI	Severe Mental Illness
SOC	Strategic Options Case
SOF	Single Operating Framework
SPOA	Single Point of Access
SPOE	Single Point of Entry
SPOR	Single Point of Referral
STEIS	Strategic Executive Information System
STF	Sustainability and Transformation Fund

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Term / Abbreviation	**Terms in Full**
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
WTE	Whole Time Equivalent
Y	
YTD	Year to Date

(updated 26 April 2021)