Derbyshire Healthcare
NHS Foundation Trust

Derbyshire Healthcare NHS Foundation Trust
Virtual meeting of the Board of Directors

To be live streamed via MS Live Events

1 September 2020 09:30 - 1 September 2020 12:00

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Derbyshire Healthcare
NHS Foundation Trust

NOTICE OF A VIRTUAL PUBLIC BOARD MEETING – TUESDAY 1 SEPTEMBER 2020
TO COMMENCE AT 9:30am

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 via Microsoft Teams technology

	TIME	AGENDA	LED BY
1.	9:30	Chair's welcome, opening remarks and apologies, declarations of interest	Caroline Maley
2.		Minutes of Board of Directors meeting held on 7 July 2020	Caroline Maley
3.		Matters arising – Actions Matrix	Caroline Maley
4.		Questions from governors or members of the public	Caroline Maley
5.		Chair's Update	Caroline Maley
STRATEGY AND OPERATIONAL PERFORMANCE			
6.	9:40	Chief Executive's Update - includes: - National context - Phase 3 letter and NHS People Plan - Local context – JUCD update - Trust update – pandemic response, pulse check, review of Trust strategy in light of lessons learnt and engagement	Ifti Majid
7.	10:20	Inclusion-related reporting requirements and leadership challenges	Claire Wright
8.	10:35	Integrated Performance and Activity Report	C Wright / C Stafford / C Green / M Powell
9.	10:55	Flu/COVID-19 Vaccination Programme	Jaki Lowe
GOVERNANCE			
10.	11:10	Workforce Race Equality Standard (WRES) Workforce Disability Equality Standard (WDES)	Claire Wright
11.	11:25	Freedom to Speak Up Guardian Report	Tam Howard
12.	11:40	Board Committee Assurance Summaries: Audit and Risk Committee held 2 July, Quality and Safeguarding Committee 14 July, Finance and Performance Committee 28 July 2020	Committee Chairs / Justine Fitzjohn
CLOSING MATTERS			
13.	11:50	- Identification of any issues arising from the meeting for inclusion or updating in the Board Assurance Framework - Meeting effectiveness	Caroline Maley
FOR INFORMATION			
Glossary of NHS Acronyms 2020/21 Forward Plan			

Questions that are applicable to the agenda, and at the Chair's discretion, can be sent by email to the Board Secretary up to 48 hours prior to the meeting for a response provided by the Board at the meeting. Email: sue.turner17@nhs.net
The Trust Chair may, under the Foundation Trust's Constitution, request members of the public to withdraw for the Board to conduct its remaining business in confidence as special reasons apply or because of information which is likely to reveal the identities of an individual or commercial bodies.

The next meeting will be held at 9.30am on 3 November 2020. It is anticipated that this meeting will be held digitally via MS Teams
Users of the Trust's services and other members of the public are welcome to attend the meetings of the Board.
Participation in meetings is at the Chair's discretion

Derbyshire Healthcare
NHS Foundation Trust

Our vision

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

Our values

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

Our Trust values are:

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

TEAM Derbyshire Healthcare

Making a positive difference

Derbyshire Healthcare
NHS Foundation Trust

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

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

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

Derbyshire Healthcare NHS Foundation Trust

MINUTES OF A LIVE STREAMED
MEETING OF THE BOARD OF DIRECTORS
TUESDAY 7 July 2020

MEETING LIVE STREAMED VIA MS LIVE EVENTS	
Commenced: 10.30am	Closed: 12.30pm

PRESENT	Caroline Maley	Trust Chair
	Richard Wright	Deputy Trust Chair and Non-Executive Director
	Margaret Gildea	Senior Independent Director and Non-Executive Director
	Ashiedu Joel	Non-Executive Director
	Geoff Lewins	Non-Executive Director
	Dr Sheila Newport	Non-Executive Director
	Ifti Majid	Chief Executive
	Claire Wright	Deputy Chief Executive & Director of Finance
	Mark Powell	Chief Operating Officer
	Carolyn Green	Director of Nursing & Patient Experience
	Gareth Harry	Director of Business Improvement & Transformation
	Justine Fitzjohn	Trust Secretary
IN ATTENDANCE	Dr Kathy McLean	Chair, University Hospitals of Derby and Burton NHS Foundation Trust (UDHB)
	Perminder Heer	NExT Director
	Anna Shaw	Deputy Director of Communications & Involvement
	Dr Mark Broadhurst	Deputy Medical Director
	Celestine Stafford	Assistant Director, People and Culture Transformation
	Sue Turner	Board Secretary
APOLOGIES	Dr Julia Tabreham	Non-Executive Director
	Dr John Sykes	Medical Director
VISITORS	Governors, members of staff, the public, representatives of the CQC via live streaming:	
	Lynda Langley	Lead Governor
	Cllr Jim Perkins	Appointed Governor, Derbyshire County Council
	Susan Ryan	Public Governor, Amber Valley
	Kevin Richards	Public Governor, South Derbyshire
	Marie Hickman	Staff Governor, Admin and Allied Support Staff
	Dr Deepak Sirur	Consultant Psychiatrist in Substance Misuse
	Stephen Jones	Chief Pharmacist
	Pete Henson	Head of Performance, Delivery and Clustering
	Laura Gee	Organisational Effectiveness Advisor
	Shirley Houston	Engagement Officer
	Yvonne Stevens	Programme Support Manager
	Zoe Bradley	Service Support Manager
	Stuart Clensy	Clinical Lead - Learning Disabilities
	Roksana Pszczolkowska	Performance Officer and Data Analysist
	Natalie Day	Service Manager
	Sarah Bennett	CQC Representative
	Surrinder Kaur	CQC Representative
	Nicola Spriggs	Deputy Performance Manager
	David Waldram	Member of the public

DHCFT 2020/050	**<u>CHAIR'S WELCOME, OPENING REMARKS, APOLOGIES FOR ABSENCE AND DECLARATION OF INTERESTS</u>** Due to the need for social distancing to help limit the spread of COVID-19, this was a virtual meeting held via MS Live Events. This was the first time that the Board had held one of its meetings in this way. The Trust Chair, Caroline Maley, welcomed everyone to the meeting, including those members of the public observing via live streaming, the Trust's Lead Governor, other Governors and members of staff. Caroline also took the opportunity to welcome representatives from the CQC who were observing the meeting as spectators and to Clinical Lead - Learning Disabilities, Stuart Clensy who was observing the meeting to shadow Director of Nursing and Patient Experience, Carolyn Green as part of his personal development. Caroline also welcomed Dr Kathy McLean, Chair, University Hospitals of Derby and Burton NHS Foundation Trust (UDHB) who would be joining the meeting as her guest. Apologies were noted as above. Medical Director, Dr John Sykes was represented by Deputy Medical Director, Dr Mark Broadhurst and was welcomed to the meeting. No declarations of interest declared, other than those already recorded on the formal register of Directors' interests.
DHCFT 2020/051	**<u>MINUTES OF THE BOARD OF DIRECTORS MEETING HELD ON 5 MAY 2020</u>** The minutes of the previous meeting, held on 5 May 2020, were accepted as a correct record of the meeting.
DHCFT 2020/052	**<u>ACTIONS MATRIX</u>** The Board agreed to close all completed actions. Updates were provided by members of the Board and noted on the actions matrix. All completed actions were scrutinised to ensure that they were fully complete. To allow greater focus on the critical issues related to COVID-19 the report on wider staffing and what the future will look like will brought to the Board when normal business is resumed. Chief Executive, Ifti Majid suggested that as the People and Culture Committee has been stood back up, the Committee will review the future of wider staffing in the first instance and report its findings to the Board. Assistant Director, People and Culture Transformation, Celestine Stafford and Board Secretary, Sue Turner undertook to work with the Committee to ensure this action is in place. **ACTION: Report on wider staffing and what the future will look like to be taken to the People and Culture Committee and reported to the Board.**
DHCFT 2020/053	**<u>QUESTIONS FROM GOVERNORS OR MEMBERS OF THE PUBLIC</u>** Three questions had been received from Public Governor, Andrew Beaumont. These were responded to by Ifti Majid as follows: 1) **Are the historical reasons for the Trust's lack of a psychiatric intensive care unit (PICU) purely financial?** This was not a purely financial decision it was also concerned with care pathways. Due to activity levels the Trust has been managing with an enhanced care ward at the Radbourne Unit. Owing to changes in service models a PICU is now required in Derbyshire as patient experience needs improving and a substantial amount of money is spent on placing patients in PICU out of area. 2) **What impact has COVID-19 had on people's early traumatic experiences?** Ifti

	responded that he had not seen any evidence that early traumatic experiences would give protection to trauma from the virus. The response to COVID-19 is very individual and we know that repeat trauma has a negative effect on people's mental health. If people's coping mechanisms are outside of the home they may be finding things difficult. 3) **Is 'Attend Anywhere' similar to 'Microsoft Teams'?** Attend Anywhere is similar to MS Teams and it is specifically designed to focus on clinical consultation.
DHCFT 2020/054	**<u>CHAIR'S UPDATE</u>** Caroline's report provided the Board with reflections on her activity in terms of her role as Trust Chair since the previous Board meeting on 5 May. As Chair, Caroline wished to record her thanks to all Trust staff, volunteers and stakeholders who have worked so hard to keep services up and running throughout this period. Many staff have had to work in different ways, or have been redeployed to support essential services. Many have changed location for work, including a large number working from home. Caroline has been inspired by the way that technology has been embraced in such a short period of time, and with the care and compassion shown in so many ways during such a difficult period. Caroline added she has been impressed by the numbers of staff taking part in the live engagement events that have been held. She was grateful for the open and honest feedback about how the past three months have been for members of staff. We may not have always got things right, but staff have appreciated the challenges that the Incident Management Team (IMT) and the Executive Leadership Team (ELT) have faced in leading the Trust through this phase of the pandemic. To have been able to engage with so many staff has been an honour and humbling experience. Caroline declared she was extremely proud of the Trust and its staff. **RESOLVED: The Board of Directors noted the content of the Chair's update.**
DHCFT 2020/055	**<u>GENERAL UPDATE ON THE IMPACT OF COVID-19 - RESTORATION AND RECOVERY</u>** This report presented by Ifti Majid provided the Board with feedback on some of the COVID–19 restoration and recovery activity in Derbyshire and reflects a wider view of the Trust's operating environment. Whilst there is much work underway within Derbyshire, discussion focused on the Mental Health, Learning Disability and Autism draft recovery cell work stream plan and lessons learnt feedback from colleagues within the organisation. Chief Operating Officer, Mark Powell summarised the position within the Trust from a workforce and operational perspective and assured the Board of the significant progress that has been made in continuing to safely deliver services throughout the pandemic. The key challenges are concerned with the workforce and in ensuring social distancing in inpatient wards. The Trust has now had COVID-19 free wards across all inpatient areas for four weeks. From a workforce perspective 65 colleagues are currently off work for COVID-19 related reasons. In the last two months this has reduced from 200 and an increasing number of staff are returning to the workplace. It was decided at the outset of the pandemic that the Trust would take a safety first approach and a number of colleagues in vulnerable categories were asked to work from home. The Trust is now assessing the risk of these colleagues returning to the workplace and has so far undertaken 400 health risk assessments. The outcome of these risk assessments is still on-going and a number of these colleagues are starting to return to a COVID-19 secure workplace. Every effort is being made to ensure everyone has the right equipment to carry out their roles and to ensure they are provided with a safe environment to return to work. The

Estates Team are working to ensure all buildings are secure to maintain social distancing and all buildings now meet appropriate guidelines. The Trust has a good supply of PPE for all colleagues across the Trust and will continue to have good deliveries of PPE. Protection control measures are being delivered throughout the pandemic in line with guidance from the government.

Ifti Majid talked about the initial findings from the COVID-19 staff survey and the draft recovery plan which forms part of the Derbyshire Health and Social Care system that will be vital for the Board to develop its strategy in line with COVID-19. He outlined how since the response phase began on 16 March the organisation had been in contact with all people open to the Trust's services and has continued with care and treatment reviews and focussed on repatriating patients, particularly those with learning disabilities (LD) and autism. The Trust will build on feedback received from service users and colleagues and will develop this within the recovery plan.

Gareth Harry as the programme lead for the Mental Health, Learning Disability (LD) and Autism recovery cell of Joined Up Care Derbyshire (JUCD) was invited to cover key points and answer any questions arising from the work stream COVID-19 recovery plan. He highlighted the recovery plan objectives that will re-establish the previous level of services and gave an overview of the lessons learned from colleagues and people who use mental healthcare services. There was a high correlation of positive experience from colleagues with regard to remote working and communication methods and people's experiences of redeployment and retention of service models and challenges they have met throughout the incident. There were also mixed views from service users around video communication as opposed to face to face consultation.

The System Recovery Cell Data Workstream is expecting a 7.5% increase in mental health activity from the direct and indirect impact of COVID-19 due to the down turn in the economy in the next 18 months. Gareth outlined how there is a need to work collaboratively across secondary care, primary care, IAPT providers and the voluntary sector to look at a joint and co-ordinated response to this increase in demand. A key piece of work will be the transition to mental health, LD and autism helpline model of provision that will act as a helpline support resource. This will require a difficult transition to be safely managed in order to operate in the new model of provision from October.

There are significant risks to the safe recovery of services as the workforce returns to work across all services. Recovery of services is highly dependent on the return to work of staff across all services before redeployed staff can return to other prioritised services. Waiting times and access across many services has worsened. The backlog clearance in the context of increased demand will take time and will present challenges in terms of workforce and estate capacity. This is a significant risk to recovery of services and is likely to take a long time and will need careful assessment for harm avoidance.

Having reflected on the need to re-establish services, Non-Executive Director, Geoff Lewins asked that reference be made to the Trust's strategy within the system recovery plan objectives. Senior Independent Director, Margaret Gildea echoed Geoff's request and would like to see evidence of staff lessons learned from the clinically led strategy work to ensure this embraces cross system working. Ifti Majid advised that work is already taking place on elements of work that need to be delivered this month. When the Trust Strategy is refreshed it will take account of the JUCD Mental Health, LD and Autism work stream.

Caroline Maley referred to the initial findings from the COVID-19 staff survey and asked for any comments to be taken on this document outside of the meeting and drew discussions to a close.

RESOLVED: The Board of Directors:
1) **Scrutinised the report, noting the risks and actions being taken.**
2) **Noted the JUCD Mental Health, LD and Autism work stream COVID-19 recovery plan.**
3) **Noted the initial findings from the COVID-19 staff survey.**

DHCFT 2020/056	**INTEGRATED PERFORMANCE AND ACTIVITY REPORT** This report updated the Board of Directors on the Trust's performance at the end of May 2020. The report focussed on key finance, performance and workforce measures during this extremely challenging period. Deputy Chief Executive and Director of Finance, Claire Wright reported that the Trust had accrued top up income to hit break even amounting to £564k for month 2 (May). An equivalent process for top ups is expected in order to break even up to month 4. With regard to NHS Financial arrangements beyond month 4, guidance is anticipated on how the payment arrangements will operate for month 5 (August) onwards. It is expected that more detailed discussion on how this will evolve will be covered at forthcoming meetings. In terms of capital the Trust has complied with requests for several capital submissions recently for current year and future expectations. The request for the Trust to submit a 2020/21 capacity plan submission for mental health specific requirements to help address capital that incorporated estimates for permanent dormitory eradication and a local Psychiatric Intensive Care Unit (PICU) was particularly noted. Mark Powell updated the Board on operational activity. The Board noted the significant reduction in the number of referrals coming into most of the Trust's services which is a similar position being seen by other providers. This will lead to a need to catch up in backlog activity and changes to referral rates that are expected over the coming months. Throughout the pandemic the Trust has adopted a stringent waiting well policy. Significant contact has been maintained with service users across a variety of services through telephone contact to ensure patients are safe and well. In terms of PICU provision there has been a small increase in patients being placed out of area as a result of the discharge initiative for COVID-19 response. From a workforce point of view a decision was taken to effectively pause appraisals and associated workforce measures. These are starting to be reinstated and the Executive Leadership Team (ELT) will decide when these measures are re-established within business as usual practice. Specific training programmes will be reinstated across all areas in line with how the pandemic progresses in order to keep service users as safe as possible. Carolyn Green was pleased to report that the Trust has recruited 27 aspirant band 4 nurses who came to work within the organisation as part of their final placement. Extremely constructive feedback has been received on how welcome they have been made to feel. This will have a positive impact on the vacancy rate and it is hoped that more nurses will be converted to join the acute and older adult inpatient pathway. Carolyn also reported that supervision rates through existing preceptorships have increased. Clinical reviews have also been undertaken to look at access waiting lists, equality and inclusivity standards and the Board was assured that all these measures are in place. Caroline Maley was pleased to hear that so many new nurses had been recruited and asked if the Trust was prepared for the predicted growth in demand for mental health services. Celestine Stafford advised that a significant amount of work has taken place to maintain staff across the organisation as part of recruitment cell in the Incident Management Team (IMT). A new reporting tool has been developed that gives operational managers and the recruitment team a clear picture of where recruitment is taking place as well as the levels of recruitment that need to be concentrated on. Innovative ways are also being developed for using social media to recruit to roles in the organisation, this includes student nurses and other professional roles. A significant amount of work is also taking place to refresh the workforce plan in anticipation of what the revised People Plan will look like. A great deal of work is concentrating on closing the gaps not just in the acute inpatients service but also in retaining staff across the organisation. Carolyn Green added she was pleased to report that 27 aspirant nurses have recently

	joined the Trust as part of their final placement. They have provided extremely positive feedback on how welcome they have been made to feel within the Trust and it is hoped that more student nurses will join the older adult inpatient pathway. Having reviewed and discussed the report, the Board agreed that limited assurance had been obtained from current performance across the Trust. It was also agreed that since the Finance and Performance and Committee and People and Culture Committee had been stepped down during this period the report provided assurance around, key elements of the report that would have been received through committee reporting. **RESOLVED: The Board of Directors:** **1) Received limited assurance on current performance across the areas presented.** **2) Agreed that the report incorporates the key elements of assurance to the Trust Board that would otherwise have come from Finance and Performance Committee and People and Culture Committee reporting.**
DHCFT 2020/057	**<u>STAFF SURVEY RESULTS SUMMARY REPORT</u>** Celestine Stafford's report provided the Board of Directors with information relating back to the 2019 NHS Staff Survey results and on the future plans for 2020. This paper was previously received by the People and Culture Committee on 23 June and was submitted to the Board for information and to provide assurance on future planning. Celestine pointed out that it had not been possible to progress with the original action plan due the pandemic and highlighted the proposal to review actions as part of the recovery process. The national NHS Staff Survey will recommence in September under a strong communication plan. Owing to the level of engagement achieved within the organisation over last few months through MS Teams engagement meetings and the Team Derbyshire Healthcare Facebook page she is anticipating a higher level of engagement in this year's staff survey. Ifti Majid reinforced the point that the Trust's response to the COVID-19 incident has been focussed on themes related to staff engagement, inclusion, safety, staff wellbeing and morale. Although it has not been possible to follow the original action plan the whole process followed has been in line with the culture created within the Trust prior to the pandemic. This has delivered the positive outcomes from the staff survey and the progress of these themes will continue to be supported by the Board throughout 2020/21. The Board also approved the proposed plan to prepare for the 2020 Staff Survey to establish survey champions and the development of a strong communications plan. It was noted that the organisation did not run a Pulse Check in Q1 due to the COVID-19 pandemic. Due to national guidance allowing postponements, the Pulse Check will recommence in Q4 and will run as planned in the next financial year 2021/22. **RESOLVED: The Board of Directors:** **1) Continued to support progress of the themes through the Trust's indirect work.** **2) Approved the proposed plan to spend the next two months preparing for the 2020 NHS Staff Survey – including structural work going to happen behind the scenes within ESR, establishing key contacts/champions in areas regarding paper distribution and developing a strong communications plan.**
DHCFT 2020/058	**<u>LEARNING FROM DEATHS MORTALITY REPORT</u>** The report presented by Deputy Medical Director, Mark Broadhurst included the 'National Guidance on Learning from Deaths' that requires each Trust to collect and publish specified information on a quarterly basis. This report covers the period 1 March to 29 May 2020. The report showed that during this period there have been 679 death notifications which were predominately in the older adult pathway. There is very little variation between male

	and female deaths. Mark offered assurance on the approach to learning from deaths and advised that mortality reviews had shown that no deaths were thought to have been due to practice in care. Clinical Non-Executive Director (NED), Sheila Newport who is also the Mortality and Learning from Deaths lead NED, recognised that mortality review work is in line with correct procedure and asked how learning issues that arise from the mortality reviews are embedded within the Trust. Mark summarised how learning is disseminated and advised that recommendations made from these reviews relate to whether things could have been done differently as shown in the examples set out in the paper. These recommendations are fed back to action leads to ensure they are undertaken. These recommendations are also broadcast through 'Blue Light' policies for wider learning. In response to Geoff Lewins questioning why the table on page six of the report showed that 88 deaths were reported and the third paragraph states that 43 were reported through Datix, Mark clarified that 88 was the total number of deaths reported during the period and 43 deaths were as result of COVID-19. Claire Wright observed how some of the tables in the document had significant gaps in data; labelled as 'blank' or 'unknown', which negatively impact on ascertaining any themes or trends relating to the data. She also emphasised how improving data capture was an important priority in the Trust's inclusion strategy. This observation would be fed back to the Mortality Group in order to improve reporting. **RESOLVED: The Board of Directors accepted this Mortality Report as assurance of the Trust's approach and agreed for the report to be published on the Trust's website as per national guidance.**
DHCFT 2020/059	**GUARDIAN OF SAFE WORKING REPORT** This report produced by the Guardian of Safe Working (GSOW) was provided to the Board to give assurance that the Trust is discharging its statutory duties regarding safe working for medical trainees and was presented in the context of COVID-19. The report showed that trainee doctors are always encouraged to report any concerns they have regarding safe working by a system of exception reporting. This has continued throughout the pandemic although Junior Doctors Forum meetings have been undertaken through MS Teams and no exception reports were raised in this period. Caroline Maley queried the table in item 7 relating to vacancies from March to September 2019. Mark explained how these differences accounted for junior doctors' change over and that vacancies are reported on a six monthly basis. He would have expected there to been a subsequent six months' worth of data and he would check whether this data is accurate to make sure it is correct in subsequent reports. Caroline noted the recent Junior Doctor Forum was well attended by the junior doctors in the north and asked if junior doctors in the south were also engaging in this forum. Mark responded that all junior doctors are encouraged to attend and those in the south will continue to participate. Ifti Majid reflected on the initial findings from the COVID-19 staff survey that shown that staff in general had shared no escalations and asked if any specific matters had been raised by trainees. Mark advised that the general themes that have arisen have been mainly about the different working practices of junior doctors who are on call, the hardship of working out of hours and having proper rest periods. These have been received through the GOSW process and resolutions have been found. Non-Executive Director, Ashiedu Joel noted that there had been an increase in the number of junior doctors working within the Trust from overseas and asked if issues regarding differences in participation or equality inclusion in medical practice were raised with the

	Freedom to Speak Up Guardian (FTSUG). Mark reported that this is approached through the Junior Doctors Forum. Escalations through the GOSW and the FTSUG are both methods for raising concerns and resolving any aspect of training or issues around ethnicity or equality or diversity. The system for escalation is for each trainee to escalate issues through their supervisor and this system is then escalated through GOSW. Supervisors are aware of this system and deal with these issues but issues can also be escalated through the FTSUG. The Board noted that the report had been received by the Quality and Safeguarding Committee and accepted this report from the Guardian of Safe Working as assurance of the Trust's approach regarding safe working for medical trainees. **RESOLVED: The Board of Directors received significant assurance from the report from the Guardian of Safe Working.**
DHCFT 2020/060	**ANNUAL RE-VALIDATION OF DOCTORS** Due to the impact of COVID-19 medical appraisal is currently on hold within the Trust. The report gave the Board an interim update prior to the reinstatement of medical appraisal processes. The Board acknowledged that the General Medical Council (GMC) has announced postponement of revalidation dates for all doctors due to revalidate before 16 March 2021 and the suspension of medical appraisal process is in keeping with regional and national guidance which is due for review this month. It is anticipated that these processes will be reinstated as soon as guidance and clinical pressures allow. Having read the report, Ifti Majid recognised that the Trust has robust processes in place for the carrying out of and review of medical appraisal. However, he questioned whether there were potentially less learning opportunities for BAME groups to receive constructive feedback during the appraisal process which would mean they would be less likely to develop. Ifti would like the Board to address this matter further and requested that a report focussing on inclusion within the revalidation process be produced for the next Board meeting to be held on 1 September. **ACTION: Report on the focus of inclusion within the revalidation process to be submitted to the next meeting in September.** **RESOLVED: The Board of Directors accepted this report as an interim update prior to the reinstatement of medical appraisal processes.**
DHCFT 2020/061	**BOARD ASSURANCE FRAMEWORK UPDATE** Trust Secretary, Justine Fitzjohn presented the Board with the second issue of the BAF for 2020/21. The development of the first issue of the BAF for 2020/21 coincided with the outbreak of the COVID-19 virus. This second issue of the BAF is an updated version of the 'COVID response' BAF that was developed outlining the key risks, assurances, controls, gaps and actions in relation to the immediate pandemic response. Justine pointed out that the Board would shortly be refreshing the building blocks of the Trust's strategic objectives which will enable a clear identification of BAF risks that will be submitted to the Board in September. As the Executive Director responsible for Infection Prevention and Control, Carolyn Green provided positive assurance to the Board in these exceptional times that the Trust is compliant with all national infection control standards and requirements. This compliance has previously been reported to the Board and the Quality and Safeguarding Committee.

	The Board was satisfied with the key risks contained in this version of the BAF and approved the second issue of the BAF for 2020/21. **RESOLVED: The Board of Directors:** **1) Approved this second issue of the BAF for 2020/21 and received significant assurance from the process of the review and update of the BAF in seeking to identify and mitigate risks to achieving the Trust's strategic objectives, during this phase of response to the COVID-19 pandemic.** **2) Continue to receive updates in line with the forward plan for the Board.**
DHCFT 2020/062	**GOVERNANCE OVERVIEW** This report was prepared to assure the Board on the robustness of the Trust's Corporate Governance processes during COVID-19 and to seek approval of the following Governance documents: • **NHS Improvement Year-End Self-Certification** The aim of self-certification is for the Trust to assure itself and to self-certify that it is in compliance with NHS Provider conditions. The Board noted the declarations as outlined and confirmed it was satisfied that the Trust is compliant with its licence conditions. • **Fit and Proper Person Declaration (FPPR)** It is the Chair's responsibility at the end of every year to declare that processes are maintained for ensuring compliance with FPPR. The report confirmed that a robust process is in place to ensure that FPPR processes have been applied to all Board members and that this is recorded in Executive Directors' and NEDs' personal files. Caroline Maley declared that she was satisfied that all Directors of the Trust, including NEDs, and Executive Directors (including voting and non-voting) are deemed to be fit and that none meet any of the 'unfit' criteria. • **Modern Slavery Statement** The Board noted that the People and Culture Committee was assured that the Trust has met the criteria for the 2019/20 financial year when it considered the statement on 23 June and approved the revised Modern Slavery Statement. It was also agreed that the Chair's and the Chief Executive's electronic signatures would be used to approve the statement and for it to be published on the Trust's website. **RESOLVED: The Board of Directors** **1) Noted the summary contained within the Corporate Governance overview and confirm assurance that the Trust continues to have robust corporate governance processes in place.** **2) Approved the NHS Improvement Year-end Self-Certification.** **3) Received full assurance from the Chair's Fit and Proper Person's Test declaration that that all Directors meet the fitness test and do not meet any of the 'unfit' criteria.** **4) Approved the Modern Slavery Statement for 2019/20.**
DHCFT 2020/063	**BOARD COMMITTEE ASSURANCE SUMMARIES** In line with the 'Reducing the Burden' guidance received from NHSI/E verbal assurance and escalation updates from Board Committees have been recorded at Board meetings instead of the submission of written reports. A combined assurance summary covering the activity of the Board Committees held over recent weeks was received and highlights were provided by the respective Non-Executive Chair: **Audit and Risk Committee** Committee Chair, Geoff Lewins reported that a number of meetings had been held to oversee the approval of the Trust's Annual Report and Accounts 2020/21. The Committee also received updates on counter fraud, internal audit and external audit progress. It had

	been necessary to hold an additional meeting on 24 June for the Committee to assess the material valuation of the Trust's land and buildings and the treatment of deferred income in order to formally approve and adopt the Annual Accounts and Report for 2019-20 on behalf of the Trust Board. Geoff took the opportunity to commend the work of the Finance Team in preparing the accounts for sign off under such difficult circumstances. **Quality and Safeguarding Committee** Committee Chair, Margaret Gildea thanked the Incident Management Team (IMT) for providing assurance on quality, clinical and safety aspects of care provision since it commenced in March. She also applauded the approach being taken to infection control which had resulted in the Trust being COVID-19 free since 6 June. **Finance and Performance Committee** Chair of the Committee, Richard Wright outlined how discussions that took place at the June meeting on the Estates Strategy highlighted the affect that COVID-19 and social distancing will have on the strategy going forward. The Committee spent a great deal of time discussing the Trust's waiting well activity to ensure people are kept in contact to ensure they are safe and well when waiting for treatment. Significant assurance was received from the Emergency Preparedness, Resilience and Response (EPRR) report. It was clear that the procedures that the Trust had in place have successfully withstood the response to the COVID-19 incident. **Mental Health Act Committee** Committee Chair, Sheila Newport highlighted the flexibility of the Mental Health Act management team and the work of the Associate Hospital Managers who have had to change the way they have been working in order to produce positive outcomes. An increase has been seen in patients admitted with psychosis. The increase in seclusion and restraint practice is being closely monitored to ensure that improvement levels are maintained. The Committee received significant assurance that safeguards of the Mental Health Act are being appropriately applied within the Trust. **People and Culture Committee** Essential people services issues were reported through to the Committee in June. It was noted that the Committee's activity had been reported through the Integrated Performance Report. Due to the absence of Julia Tabreham, the Chair of the Committee, this Committee's activity was not discussed. The Board accepted the assurance and escalation update report as evidence of the work of the Board Committees. **RESOLVED: The Board of Directors noted the Board Assurance Summary report.**
DHCFT 2020/064	**IDENTIFICATION OF ANY ISSUES ARISING FROM THE MEETING FOR INCLUSION OR UPDATING IN THE BOARD ASSURANCE FRAMEWORK (BAF)** No additional items were considered for inclusion or updating within the BAF. However, Ifti Majid requested that the Board consider risks linked to the health inequalities of BAME colleagues who are at risk of developing severe symptoms if they were to catch COVID-19 so they can be included in the BAF for 2020/21. He proposed that a specific report is brought to the Board in September in response to the letters received from Public Health England and that the BAF be considered in line with inclusion and in assessing the Trust's priorities in delivering its strategic objectives at the July Board Development Session. **ACTION: Report in response to letters from Public Health England to be an agenda item at the September meeting.** **ACTION: BAF to be revised in line with health inequalities and inclusion and in assessing the Trust's priorities in delivering its strategic objectives at Board Development on 15 July.**

DHCFT 2020/065	**ANY OTHER BUSINESS** This was the final meeting that Perminder Heer would be attending under her placement with the Trust under the NHS Providers NExT Director scheme and was thanked for her participation in the work of the Trust during the past year.
DHCFT 2020/066	**2020/21 BOARD FORWARD PLAN** The 2020/21 forward plan outlining the programme for bi-monthly meetings was noted and will be reviewed further by all Board members throughout the financial year. It was understood that due to the COVID-19 pandemic, it had been necessary to defer some items of business. These have been tracked on the forward plan for decision making regarding how these would be managed.
DHCFT 2020/067	**MEETING EFFECTIVENESS** All Board members agreed that the meeting had been successfully conducted via MS Live Events and were pleased to note that number of those observing the meeting were members of staff. It was agreed that live streaming of Board meetings would be a positive step for the future. Thanks were extended to the technical skills of Alex Rose who produced the meeting. Dr Kathy McLean, Chair, UDHB thanked Caroline Maley for inviting her to attend today's meeting. She was pleased to hear the progress that the Trust was making and to observe a good level of system (JUCD) reporting and reference at the Board. She would be inviting Caroline to observe the UDHB Board at a later date.
The next meeting to be held in public session will take place at 10.30am on Tuesday 1 September 2020. Owing to the current coronavirus pandemic this meeting will be held digitally and will be live streamed via MS Live Events.	

				BOARD OF DIRECTORS (PUBLIC) ACTION MATRIX - SEPTEMBER 2020			
Date	**Minute Ref**	**Item**	**Lead**	**Action**	**Completion Date**	**Current Position**	
4.2.2020	DHCFT/ 2020/008	Integrated Performance Report	Ifti Majid	Report on wider staffing and what the future will look like is to be brought back to the Board at a timeline to be decided by the Executive Team	3.11.2020	Report on wider staffing and what the future will look like is to be taken to the September meeting of the People and Culture Committee and reported to the Board in November.	Amber
7.7.2020	DHCFT/ 2020/060	Annual Re-Validation Of Doctors	John Sykes	Report on the focus of inclusion within the revalidation process to be submitted to the next meeting in September	3.11.2020	Report will now be taken to the November meeting.	Yellow
7.7.2020	DHCFT/ 2020/064	Identification of any issues arising for inclusion or updating in the BAF	Ifti Majid	Report in response to letters from Public Health England to be an agenda item at the September meeting	1.9.2020	This is covered within the Inclusion-related reporting requirements and leadership challenges report under agenda item 7 at the September meeting.	Yellow
7.7.2020	DHCFT/ 2020/064	Identification of any issues arising for inclusion or updating in the BAF	ALL	BAF to be revised in line with health inequalities and inclusion and in assessing the Trust's priorities in delivering its strategic objectives at Board Development on 15 July	1.9.2020	Complete	Green

Resolved	**GREEN**	**1**	**25%**
Action Ongoing/Update Required	**AMBER**	**1**	**25%**
Action Overdue	**RED**	**0**	**0%**
Agenda item for future meeting	**YELLOW**	**2**	**50%**
		4	**100%**

Derbyshire Healthcare NHS Foundation Trust
Report to the Public Board of Directors – 1 September 2020

Trust Chair's report to the Board of Directors

Purpose of Report

This report is intended to provide the Board with the Trust Chair's reflections on my activity with and for the Trust since the previous Board meeting on 7 July 2020. The structure of this report reflects the role that I have as Trust Chair.

Our Trust and Staff

1. Given the on-going pandemic, I have agreed to discontinue my visits to teams across the Trust until such time as it is thought to be safe, both for staff and for myself, to visit. In the meantime, I have been attending as many of the team live engagement events being hosted via MS Teams. These meetings are very useful to me in terms of understanding how are staff are feeling and engaged with the Trust.

2. On 15 July I attended a Webinar hosted by the Royal College of Psychiatrists South Asian History Month: Current and future challenges. This was chaired by Subodh Dave, Teaching Fellow and Adult Consultant Psychiatrist from our Trust. Once again, the power of the personal experiences of being from a BAME background in this country were very moving and challenging to hear. I look forward to seeing how we as a Trust develop our Inclusion Strategy.

3. On 11 August I joined "Chat and Chai" with colleagues to reflect on South Asian History Month. Whilst I could not stay with the group for the full time of the conversation, I did watch the recording that was shared with all staff of the discussions. I learned much about the history of the area and gained insight into the origins of a number of our staff. Thank you for letting me join you.

4. I hope that many of our staff have been able to enjoy some time away from work over the summer period. I know how important it has been to take some time off to refresh and relax after the challenges of the past few months and in anticipation of a challenging winter period ahead. My thanks go to everyone for the continued commitment and dedication shown to the Trust and our service users, and to supporting each other in all that we do.

Council of Governors

5. We held a virtual joint Council of Governors / Board meeting on 7 July 2020 following the public Board in the morning. This meeting was extremely well attended by Governors, who have embraced the use of technology superbly well.

6. The Council of Governors also met in an extraordinary meeting on 7 July to deal with a number of statutory duties: Appointment of Mazars as our external auditors following the resignation of Grant Thornton; the appointment for a second term of three years of Geoff Lewins, Non-executive Director and Chair of the Audit and Risk Committee; and to agree an extension of my term of office by one year to September 2021. My thanks go to the Council for supporting these appointments.

7. The Governance Committee of the Council met on 11 August at which I gave them an oversight of the developments in the Trust and the wider system. This meeting was chaired by Julie Lowe, as Kelly Sims, Chair for this Committee remains on redeployment to supporting the PPE distribution in the Trust. I am grateful to our Governors for their support for the Trust at this time.

8. I have had regular meetings with Lynda Langley as Lead Governor to ensure that we were open and transparent around the challenges and issues that the Trust was dealing with. Regular meetings between the Lead Governor and Chair are an important way of building a relationship and understanding of the working of both governing bodies. I am pleased that Lynda has continued to work with other lead governors in the system over this period, helping to benchmark our processes for continued engagement with governors.

9. The next meeting of the Council of Governors will be on 1 September, following the Public Board meeting on that day. The next Governance Committee takes place on 8 October 2020.

Board of Directors

10. All meetings continue to be held as virtual meetings using MS Teams, enabling Board members to keep connected whilst working remotely. The first live streamed Board took place on 7 July and was observed by some 20 individuals (staff and governors).

11. On 24 June, the Audit and Risk Committee approved the Annual Report and Accounts on behalf of the Board. This has been now laid before Parliament and has enabled us to plan to host the Annual Members Meeting using MS Live Events on 1 September. I just want to formally recognise the staff who pulled together the Annual Report and Accounts under very challenging circumstances. My thanks go to them all.

12. The Non-Executive Directors (NEDs) have met regularly with Ifti Majid and me to ensure we have been fully briefed on developments as needed. I have continued to meet with NEDs individually over the past three months and I am grateful to them for the support and flexibility at this time.

13. On 15 July a virtual Board Development meeting took place giving consideration to our Trust Strategy and changes that need to be made to some of the detail supporting the strategy, given all that has happened in this year. Great progress was made, and I look forward to seeing how this shapes up following consultation with staff.

14. We have said farewell to Perminder Heer who was a NExT Director with the Trust on a placement up to the 31 July. Perminder has now been appointed an Associate Non-Executive Director at East Midlands Ambulance Service NHS Trust (EMAS) and we wish her well in her new role.

System Collaboration and Working

15. I have continued to meet regularly with the chairs of the East Midlands Alliance of mental health trusts, which has been a very useful source of sharing best practise and peer advice.

16. Joined Up Care Derbyshire (JUCD) met on 16 July using MS Teams. Attached as Appendix 1 are the key messages noted from this meeting.

17. I have supported the appointment of an Executive Lead for JUCD, joining a panel of NHS Provider Chairs, primary care and local authority leads to support an interim appointment. This is due to be announced shortly.

Regulators, NHS Providers and NHS Confederation and others

18. I have attended regular briefings from NHS England / NHS Improvement (NHSE / I) for the Midlands region, which has been essential to understand the progress of the management of the pandemic. This included a meeting with Sir Simon Stephens, Chief Executive Officer of the NHS and his team prior to the issue of the People Plan and the Phase 3 NHS response to COVID-19 letter which was issued on 31 July. These matters will be picked up within the Chief Executive report to the Board.

19. I have also joined the weekly calls established for Chairs of Mental Health Trusts hosted by Mental Health Network in collaboration with the Good Governance Institute where support and guidance on the Board through the pandemic has been a theme. A number of the NEDs have also attended weekly calls for NEDs on a range of useful topics.

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

Assurances

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

Consultation

This report has not been to other groups or committees.

Governance or Legal Issues

None

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

This report reflects a wide range of activities across the Trust, and consideration relating to ensuring inclusion is embedded in operational work of the Trust. The specific services visited provide support to those with protected characteristics by the nature of their work. I have supported the work of the Trust in carrying out the risk assessments for those from a BAME background, and with underlying health conditions. I have also continued to develop my own awareness and understanding of the inclusion challenges faced by many of our staff.

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

Demonstrating inclusive leadership at Board level

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

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

Recommendations

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

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

Appendix 1

Joined Up Care Derbyshire Board – 16 July 2020

Key Messages

Shared Care Records

Board heard about plans to introduce an improved shared care record across all JUCD partners in Derbyshire. This is being led in collaboration with the clinical community and will support COVID-19 operational and tactical management as the software includes specific functionality such as history taking, COVID-19 status and alerts.

There are additional medium and longer-term benefits that fit with our previously stated ambitions towards a single electronic patient record and better use of analytics for planning and service improvement. A 'proof of concept' will run initially, with a full business case presented to JUCD in early 2021 to support the agreement of a permanent solution.

JUCD People and Culture Board

People are one of the underpinning elements of the JUCD strategy, where we emphasise a greater focus on developing, sustaining and valuing our workforce. The JUCD People and Culture Board will bring together health and care organisations and key stakeholders to support the transformation ambitions and support the design the future state of health and care delivery in Derbyshire.

The Board will seek to act in the best interest of citizens, patients, our people and the system as a whole by providing innovative strategic solutions which will address the cultural changes that are necessary to build a workforce that befits a world-class 21st century integrated care system which is recognised as being the best place to work. The Board will meet for the first time in September 2020.

Discharge and Community Support in Derby

JUCD Board agreed in principle to work on improving the models of community support and discharge in Derby, in line with our ongoing strategy that has been deployed in north Derbyshire, Matlock, Belper and Ilkeston in recent years. In addition, our learning on discharge processes during the COVID-19 pandemic has added to our understanding of what can be achieved and strengthened the desire to capitalise on that for the benefit of patients and staff. A project group will form, draw in discussions with colleagues and patients to help inform the planning, and we would expect a formal public consultation in early 2021.

Future Meetings

The Joined Up Care Derbyshire Board will not meet in August, and from September will resume its meetings in public, meeting virtually initially. The Board will meet in public once every two months, with Board Development Sessions taking place in other months, starting in October.

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 1 September 2020

Chief Executive's Report to the Public Board of Directors

Purpose of Report

This report provides the Board of Directors with feedback on changes within the national health and social care sector, as well as providing an update on developments occurring within our local Derbyshire health and social care community. Given the COVID-19 pandemic, much of the content is influenced by the NHS response to the pandemic, and how to learn lessons from the response.

The report also updates the Board on feedback from external stakeholders, such as our commissioners, and feedback from our staff. The report should be used to support strategic discussion on the delivery of the Trust strategy. The Board should note that the report reflects a wider view of the Trust's operating environment and serves to horizon scan for risks that may affect the organisation. Risks identified are highlighted in the report and taken forward, to assess their operational and strategic impact. They are also recorded on operational risk registers or the Board Assurance Framework, as appropriate.

National Context

1. On 31 July Simon Stevens, NHS CEO and Amanda Pritchard, NHS Chief Operating Officer, wrote to all NHS CEOs and Chairs, outlining the next phase (phase 3) of our response to the COVID Pandemic. Quite rightly, the letter starts with a thank you to all NHS staff for their hard work and commitment in responding to the virus to date – a sentiment that I would want to echo and note in our Board for colleagues in our organisation. The response of our colleagues in the Trust has been outstanding from a flexibility, passion, drive and the "can-do" attitude shown by colleagues, over the whole Trust.

   The letter outlines 3 key priorities between now and the end of March 2021.

   - Accelerating the return to near-normal levels of non-COVID health services, making full use of the capacity available in the 'window of opportunity' between now and winter.
   - Preparation for winter demand pressures, alongside continuing vigilance in the light of further probable COVID spikes locally and possibly nationally.
   - Doing the above in a way that takes account of lessons learned during the first COVID peak; locks in beneficial changes; and explicitly tackles fundamental challenges including: support for our staff, and action on inequalities and prevention.

   In addition, the letter reduces the NHS Incident level from 4 (National) to 3 (Regional) with associated reduced demands on Trust and system incident management teams.

With respect to specific expectations on our services, I have listed some of them below for the Board to note:

Accelerating the return to near-normal levels of non-COVID health services

- Every CCG must continue to increase investment in mental health services in line with the Mental Health Investment Standard
- All systems to validate their existing NHS Long Term Plan (LTP) mental health service expansion trajectories for 2020/21. Further advice on this will be issued shortly. In the meantime:
    - Improving Access to Psychological Therapies (IAPT) services should fully resume
    - 24/7 crisis helplines for all ages, that were established locally during the pandemic, should be retained, developing this into a national service
    - Continue the transition to digital working
    - Maintain the growth in the number of children and young people accessing care
    - Proactively review all patients on community mental health teams' caseloads and increase therapeutic activity and supportive interventions, to prevent relapse or escalation of mental health needs, for people with severe mental illness (SMI) in the community
    - Ensure that local access to services is clearly advertised
    - Use £250 million of earmarked new capital to help eliminate mental health dormitory wards.
- Continue to reduce the number of children, young people and adults within a specialist Learning Disability or Autism inpatient setting by providing better alternatives and by ensuring that Care (Education) and Treatment Reviews always take place, both prior to, and following inpatient admission
- Complete all outstanding Learning Disability Mortality Reviews (LeDeR) by December 2020
- GP practices should ensure that everybody with a Learning Disability is identified on their register; that their annual health checks are completed; and access to screening and flu vaccinations is proactively arranged. (This is supported by existing payment arrangements and the new support intended through the Impact and Investment Fund to improve uptake.)

Preparation for winter demand pressures

- Sustain current NHS Staffing, capacity and beds, including the use of the independent sector and retained Nightingale Hospitals
- Deliver a very significantly expanded seasonal flu vaccination programme
- Expanding the 111 First offer to provide low complexity urgent care without the need for an A&E attendance
- Systems should maximise the use of 'Hear and Treat' and 'See and Treat' pathways for 999 demand
- Continue to make full use of the NHS Volunteer Responders scheme

- Continuing to work with local authorities, given the critical dependency of our patients – particularly over winter - on resilient social care services. Ensure that those medically fit for discharge are not delayed from being able to go home, as soon as it is safe for them to do so, in line with DHSC/PHE policies.

Takes account of lessons learned

- Deliver the expectations within the 2020/21 People Plan and deliver a local system-wide version of the people plan
- Work Collaboratively across local community to:
    - Protect the most vulnerable from COVID-19
    - Restore NHS services inclusively, so that they are used by those in greatest need
    - Develop digitally enabled care pathways in ways which increase inclusion
    - Accelerate preventative programmes which proactively engage those at greatest risk of poor health outcomes
    - Strengthen leadership and accountability, with a named executive Board member responsible for tackling inequalities, in place by September in every NHS organisation
    - Ensure datasets are complete and timely, to underpin an understanding of, and response to, inequalities.

The letter is clear about the expectations for systems to play a leading role in the ongoing response to the pandemic and in relation to future planning. While there is no mention of legislation change, the role of the system is clear in that each system will have:

- Single Sustainability and Transformation Partnership (STP) / Integrated Care System (ICS) Executive Lead and Independent Chair
- Developed Partnership Board
- Single ICS approach to Commissioning (no more than one CCG per ICS)
- Plan for developing and implementing full shared care record.

As a Board we need to consider our response in several different contexts. Our response as an organisation, led via our incident management team and specific action cells, overseen by the Executive Leadership Team (ELT). Our response as a specialist provider of Children's, Mental Health and Learning Disability Services, with a direct link to the East Midlands Alliance and the national programme, and as a member of a developing ICS with a developing infrastructure to plan, monitor and develop our ongoing response to the pandemic.

2. The NHS People Plan for 2020/21, '*We are the NHS'* was released on 30 July 2020 with a republished version released on 6 August. This document sets out what the people of the NHS can expect – from their leaders and from each other – for the rest of 2020 and into 2021. This plan sets out actions to support transformation across the whole NHS. It focuses on how we must all continue to look after each other and foster a culture of inclusion and belonging, as well as action to grow our workforce, train our people, and work together differently to deliver patient care.

There are several highlights in the people plan that we need to be considering as a Board, as a senior leadership team and discussing and receiving assurance on at our People and Culture Committee:

- The ‘living with COVID approach’ that comes through the plan does resonate with our ‘safety first’ and people focus
- We need to focus on the development of new roles across all services and support areas
- We need to embrace and support new ways of working including home and remote working
- We must appoint a Board wellbeing Guardian
- We must maintain free parking and develop/offer cycle to work schemes;
- Enhance role flexibility for all colleagues, who want that in the Trust
- Develop and promote our reliance on e-rostering
- Develop ways and methods of redeploying colleagues with support, as that is likely to be an ongoing feature of the pandemic response
- Expand e-learning to make it easy for colleagues to stay up to date with training.

In addition, workforce diversity is a very big focus of the people plan. In particular:

- Ensuring diversity gaps in recruitment and promotion are eradicated
- Ensuring diversity in leadership and decision making supports local communities in having confidence in healthcare providers
- Closing the disciplinary gap associated with diverse groups
- Speeding up actions to have an impact on the areas above
- Diversity and inclusion will form an increasing part of CQC well led inspections.

It is good to see that the two big workforce training priorities are Cancer and Mental Health, along with a continued drive around international recruitment.

The system focus in the Phase 3 letter is also reflected in the People Plan with recognition to ensure increased workforce mobility and increased system-based workforce planning.

At the same time as launching the People Plan, Our NHS People Promise was also launched. Board members are very aware that in our Trust we co-created a Team Derbyshire Healthcare Promise at the 2018 Staff Conference. It is not my intention to replace this promise, as it has great traction and recognition in our Trust, but we will look at the NHS People Promise to make sure that we have reflected the essence of it in our local version.

The NHS People Promise

Our People and Culture Committee will be having an initial conversation around the people plan in September, with a more detailed gap analysis and action plan being presented at the following meeting.

Local Context

3. The last Joined Up Care Derbyshire (JUCD) Board meeting was held online on 16 July. Key items discussed included:
   - We agreed to develop a proof of concept around a digital shared care record and analytics platform. We agreed to undertake an accelerated procurement process to select a strategic partner and develop a proof of concept between now and March 2021. We also agreed to use the proof of concept to complete a business case and create an implementation plan. This will be overseen by the Derbyshire Digital Board.
   - We signed off the setting up of a system People and Culture Board that would replace the previous Local Workforce Action Board.
   - We reviewed the approach used to support 'discharge to assess' within Derbyshire during the COVID response, to look to ensure we learn lessons and prepare for the winter pressure period.
   - A discussion around how Joined up Care Derbyshire fits with the wider non-health system, the socio-economic and infrastructure system in Derbyshire, and how through lessons learnt from COVID we can enhance a single approach to improving wellbeing for the Derbyshire population.

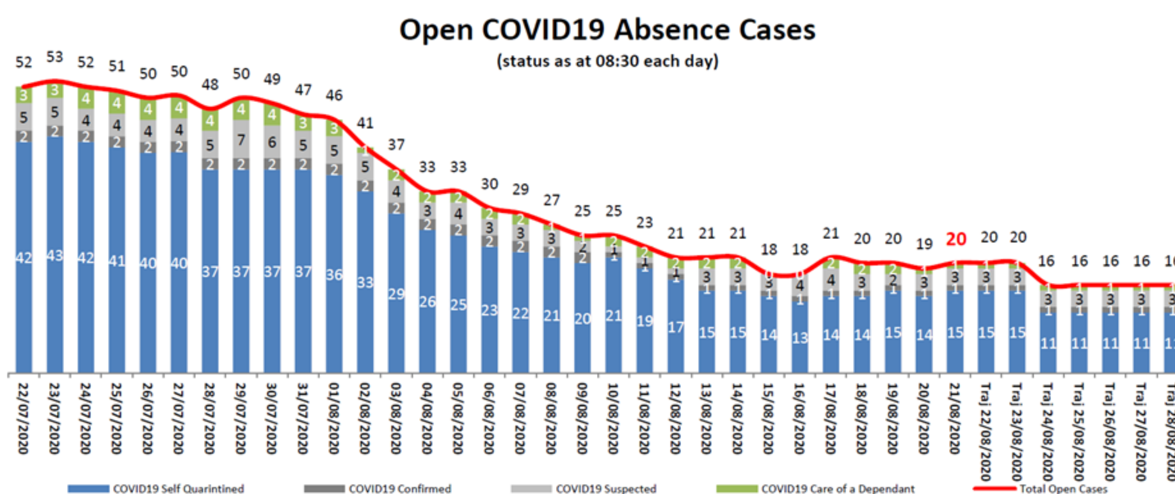
Within our Trust

4. I would like to formally welcome Jaki Lowe to our Board. Jaki joined us as Director of People and Inclusion on 17 August and will have a portfolio that covers People Services and Organisational Development, Inclusion and Communication and Engagement.

5. As this is my first formal Board report following the start of the pandemic response, I want to take the opportunity to say a massive thank you to all colleagues who work in our organisation. We have seen incredible compassion, flexibility and a real "can do" attitude from colleagues which has resulted in us being able to prioritise essential services and maintain very strict compliance with

infection control standards, which in turn has helped to keep very low numbers of COVID positive patients in our inpatient services.

It is noticeable that the numbers of staff who are away from work due to COVID related absence has reduced very significantly, from a high of over 200 at the peak, to less than 20 now. This was helped by the early decision the Trust made to support those colleagues with health vulnerabilities to work from home. We have now been through a rigorous health risk assessment process, which included a specific risk assessment conversation for our BME colleagues that has enabled many colleagues to return to the workplace in a controlled and supported manner. In March 100% of colleagues were involved in a discussion about their health risks, with all staff with a declared health risk then going to complete a specific risk assessment – on 17 August this number stood at 668. The Trust systems show we have 401 colleagues from BME communities, and we have completed 483 BME specific risk assessments. The reason for this number being above the 401 BME colleagues is because we took the decision to offer a specific risk assessment to white colleagues who were living with a member of our BME communities.



6. We have now received feedback from the NHS People Pulse Check from 20 July to 11 August. The NHS People Pulse is designed as a simple listening tool for both national and local leaders to use when designing and implementing further support during the Covid-19 pandemic.

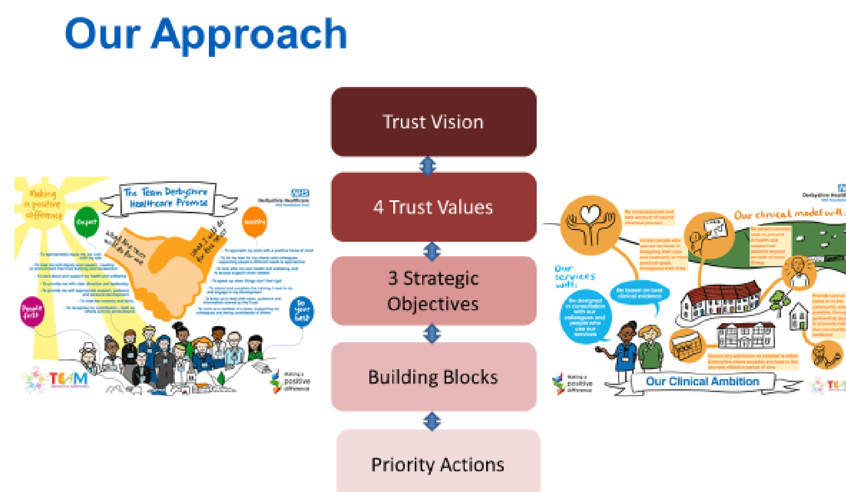
   Respondents were asked questions related to the pandemic based around support for colleagues and their mood. There were 148 respondents who took part from our Trust for the August 2020 period. The table below summarises our responses and shows them against the national averages:

Group	Question	Derbyshire Healthcare	NHS Overall
Colleague feedback	I feel confident in the approach that my local leaders are taking to manage the impact of the coronavirus	82%	66.6%
	In the current environment, I feel able to balance my work and my personal life in a way that works	67.2%	61.6%
	My organisation is keeping me informed about the impact of the coronavirus on my working life and safety	96.1%	84.4%
	My organisation is proactively supporting my health and wellbeing in the current environment	85.2%	68.4%
Colleague mood	Colleagues feeling anxious	56.7%	57.8%
	Colleagues feeling motivated	63.8%	51.8%
Practical support	Colleagues requiring details about any wellbeing/mental health services	8.7%	16.8%
	Colleagues requiring enhanced IT support	29.1%	22%
	Colleagues requiring greater clarity on the personal financial guidance available to employees	7.9%	7.5%
	Colleagues requiring greater clarity on what travel is/ isn't allowed	7.1%	6.6%
	Colleagues requiring greater flexibility to their working schedule/pattern	23.6%	27.7%
	Colleagues not requiring any additional support	29.1%	24.1%
	Colleagues requiring more frequent team huddles, virtual check-ins, or other ways to maintain team connection	27.6%	29.7%
	Colleagues requiring more updates on changing operations/ways of working	20.5%	31.2%
	Other (please specify)	18.1%	15.9%

This is something for our People and Culture Committee to use as external assurance when looking at the impact of leadership during COVID, but it does give strong assurance about the work of our senior managers/leaders and the incident management team during this period. We should note that the national percentages may alter a little as more work is done to validate the results nationally.

7. An important part of learning lessons from our response to the COVID pandemic is to review the Trust's organisational strategy, to understand if any of the components of the strategy need to be reviewed in light of those lessons learnt, or the changing national requirements.

Board colleagues are aware of the 5 tiers depicted below that make up our organisational strategy:



Initial conversations through July Board Development session give us the clear steer that the Trust Vision, values and strategic objectives remain relevant and are well understood and 'owned' by colleagues throughout the organisation. As we come to consider the more specific areas of focus, the building blocks and attendant priority action areas, we recognise are areas amendments are needed to reflect the expectations of the NHS Phase 3 letter, the new People Plan, changes to our environment from needing to plan to live with COVID into the longer term, and of course lessons from our initial response.

To this end, a revised set of building blocks and priority actions will be brought to the November Board meeting for formal sign off. In parallel with this and linked to the revisions of the building blocks and priority actions, a revised Board Assurance Framework is being developed that will be presented to the Audit and Risk committee on 1 October, and again presented to the November Board meeting.

8. Over the last two months we have held several 'Live' Divisional Engagement Events, chaired by myself with the aim of offering colleagues the chance to tell us as a senior leadership team how they are finding working in the Trust at present, along with an opportunity to ask questions, make suggestions and share innovations. Engagement sessions have been held with:

- Older Adults Acute Services
- Older Adult Community Services
- Adult Acute Services
- Adult Community Services
- Specialist Services
- Children's Services
- Corporate Services

In addition, we have held CEO question and answer sessions with each of our networks:

- LGBT+ Network
- BME Network
- Disability and Wellness Network
- Multi-faith Network
- Armed Forces Network.

These events have been very well attended, no doubt helped by the fact they were held on Microsoft Teams, for example the two events run for our Children's services each had more than 100 colleagues attending. Whilst the topics discussed have varied to some degree, depending on the group, there have been common themes some of which include:

- Estates and adjustments to be made due to COVID Secure
- The health and wellbeing impact of COVID on our diverse communities
- The Black Lives Matter movement acted as a catalyst for conversations about pace of change in our trust re: recruitment, decision making representation, the disciplinary gap and career progression
- Time off, leave and travel restrictions
- Risk assessments, returning to the workplace and reasonable adjustments;
- Positive feedback, reflecting the pulse check mentioned earlier, around communications and leadership approach
- Clinical contacts, how to maintain face to face provision where needed
- The risks of a loss of team identity due to remote working.

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

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

Assurances

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

Consultation

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

Governance or Legal Issues

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

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

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

As such implementation of national policy in our Trust would include a repeat Equality Impact Assessment, even though this will have been completed nationally. As the Trust is working on the data and action planning submissions linked to the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) and how this ties into feedback received from our staff networks it is clear we need to develop more proactive WRES/WDES reporting and we are not able to wait for nor rely on the 'after the fact' reports related to these national reports. The availability of this timelier data is a gap in control needing addressing urgently.

Both the People Plan and the NHS Phase 3 letter reference the appalling health inequalities exposed by the COVID pandemic and place a clear and unambiguous requirement on us as a healthcare organisation to take local action in support of addressing inequalities.

This paper demonstrates some strong features of good practice relating to inclusion and diversity. The approach we have taken to risk assessment, the inclusion of families and the drive to use the risk assessment to have an informed conversation

between employee and manager is best practice and the 100% compliance demonstrates how importantly managers and leaders see protecting and supporting colleagues.

The lessons learnt through the pandemic relating to health inequalities and the expectations of the People Plan and Phase 3 letter make to clear we need to review and extend our inclusion strategy and this is an action that Jaki Lowe, Director of People and Inclusion will develop over the next 6 months in full collaboration with our Networks and leaders.

Recommendations

The Board of Directors is requested to:

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

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

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

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 1 September 2020

Inclusion-related reporting requirements and leadership challenges

Purpose of Report

To provide a summary update to the Trust Board on inclusion reporting requirements to promote Board reflection on progress to date and future strategic priorities around the Inclusion agenda at Derbyshire Healthcare.

Executive Summary

This report summarises content from four recently received documents. These documents set out clear expectations for NHS Boards and senior leadership to more explicitly consider and challenge themselves on their strategic intent and delivery around a wide range of inclusion priorities, particularly with a view to those highlighted and made more pronounced by the COVID-19 pandemic.

The actions from the individual documents summarised below are of course sitting alongside the many actions and priorities described in '**WE ARE THE NHS: People Plan for 2020/21 - action for us all'.** This report does not attempt to summarise the specific actions set out in the People Plan (so as not to replicate the work on devising the local version of the People Plan) but the actions listed here are relevant to the inclusion priorities set out in the People Plan

1. Regional NHSIE letter

At the end of June 2020 CEOs and Chairs received a letter from Regional Director of NHSI/E asking Trusts to consider and to provide assurance (in both the shorter and longer term) that:

- BAME colleagues are fully supported during COVID-19 and beyond
- there is personal support from CEO/Chairs for real change in how we approach supporting BAME colleagues and their personal experience of working in NHS
- Trusts build on good practice and ensure consistency
- Trusts reinforce and ensure that change is not left to BAME colleagues and networks to lead; it is a leadership challenge/responsibility for all, Board, leaders and managers.

The detail included reference to risk assessment deadlines, Workforce Race Equality Standard (WRES) reporting requirements, use of Model Employer targets for BME representation, oversight of issues relating to bullying, harassment and discrimination, use of reverse mentoring, support for BAME networks (including a regional network), it also cited measures of equality in employment as being key priority.

2. 'CO617' - WRES briefing for Board and COVID-19 Emergency Preparedness, Resilience and Response (EPRR) membership

This document challenged NHS leadership to consider how they would better benefit from diversity of thought by improving representation in decision making. It also covered two specific areas of concerns:

- Understanding concerns and anxieties of staff and patients and identifying meaningful interventions to address them, and
- Protecting staff through effective redeployment of vulnerable staff groups, informing redeployment decision and having consistent guidance and access to PPE.

The document asked trusts to: consider best practice such as diversity advisory groups and the involvement of BAME networks in COVID-19 decision-making, to be explicit about seeking EPRR members from minority groups, to consider involving talent without prior experience in response structures, to enhance the reflective use of Equality Impact assessments, to use WRES Experts, to increase BAME representation at senior and Board level, to review the composition of EPRR structures and to act quickly when evidence of potential inequalities is identified

3. Public Health England – 'Beyond the Data' Recommendations

The Board are aware that this document followed the Public Health publication of COVID-19 Health Inequalities data.

The recommendations are copied in full below for the Board to consider:

- Mandate comprehensive and quality **ethnicity data collection and recording** as part of routine NHS and social care data collection systems, including the mandatory collection of ethnicity data at death certification, and ensure that data are readily available to local health and care partners to inform actions to mitigate the impact of COVID-19 on BAME communities
- Support **community participatory research**, in which researchers and community stakeholders engage as equal partners in all steps of the research process, to understand the social, cultural, structural, economic, religious, and commercial determinants of COVID-19 in BAME communities, and to develop readily implementable and scalable programmes to reduce risk and improve health outcomes
- Improve **access, experiences and outcomes of NHS, local government and integrated care systems commissioned services** by BAME communities including: regular equity audits; use of health impact assessments; integration of equality into quality systems; good representation of black and minority ethnic communities among staff at all levels; sustained workforce development and employment practices; trust-building dialogue with service users.
- Accelerate the development of **culturally competent occupational risk assessment tools** that can be employed in a variety of occupational settings and used to reduce the risk of employee's exposure to and acquisition of COVID-19, especially for key workers working with a large cross section of

the general public or in contact with those infected with COVID-19.

- Fund, develop and implement **culturally competent COVID-19 education and prevention campaigns**, working in partnership with local BAME and faith communities to reinforce individual and household risk reduction strategies; rebuild trust with and uptake of routine clinical services; reinforce messages on early identification, testing and diagnosis; and prepare communities to take full advantage of interventions including contact tracing, antibody testing and ultimately vaccine availability.
- Accelerate efforts to **target culturally competent health promotion and disease prevention programmes** for non-communicable diseases promoting healthy weight, physical activity, smoking cessation, mental wellbeing and effective management of chronic conditions including diabetes, hypertension and asthma.
- Ensure that **COVID-19 recovery strategies** actively **reduce inequalities caused by the wider determinants of health** to create long term sustainable change. Fully funded, sustained and meaningful approaches to tackling ethnic inequalities must be prioritised.

4. Implementing phase 3 of the NHS response to the COVID-19 pandemic 7 August 2020

As we know, COVID-19 has further exposed some of the health and wider inequalities that persist in our society. In their letter NHS Improvement and NHS England flag the need for collaborative work with local communities and partners to take the following eight urgent actions:

1. Protect the most vulnerable from COVID-19, with enhanced analysis and community engagement, to mitigate the risks associated with relevant protected characteristics and social and economic conditions; and better engage those communities who need most support.
2. Restore NHS services inclusively, so that they are used by those in greatest need. This will be guided by new, core performance monitoring of service use and outcomes among those from the most deprived neighbourhoods and from Black and Asian communities, by 31 October.
3. Develop digitally enabled care pathways in ways which increase inclusion, including reviewing who is using new primary, outpatient and mental health digitally enabled care pathways by 31 March.
4. Accelerate preventative programmes which proactively engage those at greatest risk of poor health outcomes; including more accessible flu vaccinations, better targeting of long-term condition prevention and management programmes such as obesity reduction programmes, health checks for people with learning disabilities, and increasing the continuity of maternity carers.
5. Particularly support those who suffer mental ill health, as society and the NHS recover from COVID-19, underpinned by more robust data collection and monitoring by 31 December.
6. Strengthen leadership and accountability, with a named executive board member responsible for tackling inequalities in place in September in every NHS organisation, alongside action to increase the diversity of senior leaders.

7. Ensure datasets are complete and timely, to underpin an understanding of and response to inequalities. All NHS organisations should proactively review and ensure the completeness of patient ethnicity data by no later than 31 December, with general practice prioritising those groups at significant risk of COVID-19 from 1 September.
8. Collaborate locally in planning and delivering action to address health inequalities, including incorporating in plans for restoring critical services by 21 September; better listening to communities and strengthening local accountability; deepening partnerships with local authorities and the voluntary and community sector; and maintaining a continual focus on implementation of these actions, resources and impact, including a full report by 31 March.

Progress against the issues and challenges set out in these documents

In terms of actions that were most urgent, early in the pandemic, the Board will be aware of the proactive 'safety-first' approach taken by Derbyshire Healthcare to work with Staff networks to devise a bespoke BME risk assessment as well as a bespoke wider health risk assessment to help protect colleagues who may be at greater risk from COVID-19. In addition staff wellbeing offers have been significantly enhanced.

Furthermore, the Board will be aware of many examples of Derbyshire Healthcare taking leading-edge inclusion actions over recent months and years, such as:

- the co-creation of the 'ReMEDI' reverse mentoring programme, expansion thereof overseen by ReMEDI Steering Group chaired by BME network members
- our suite of staff networks for BME, LGBT+, Disability and Wellness, Multi-faith and Armed Forces colleagues, all chaired by colleagues and supported by Executive Sponsors. Protected time is given to attend and networks are open to members of communities and allies.
- Recruitment Action Steering Group, chaired by BME network member that launched Recruitment Inclusion Guardians pilot
- The introduction of an employee relation equality checkpoint
- BME Risk Assessment Steering Group, chaired by the BME network chair
- Setting of our own 15% BME representation targets across AfC bands
- WRES action planning co-created at the BME conference in 2019
- Reverse Commissioning Group
- Our Inclusion Strategy
- We have a WRES Expert in-training and a trained WRES frontline rep
- Our CEO has a national and regional profile on race equality issues
- We have appointed a Director of People and Inclusion.
- We have BAME representation in Executive and Non-Executive roles and have had three BAME NeXT directors

These many successes and targeted actions have not made Derbyshire Healthcare immune to discrimination and inequalities and it is acknowledged that there continues to be improvement needed in outcomes and experience.

When the Workforce Race Equality Standard and Workforce Disability Equality Standard are finalised it will help the Trust to see where progress has been made and where further progress is needed in those two specific areas.

We are considering in our lessons learned cell how best to further increase representation in decision-making both for BME colleagues and colleagues with other protected characteristics and always bearing in mind the importance of intersectionality.

An area for improvement is in data capture and in declaration rates. In some areas data for BME colleagues is reasonably well known, whereas for some protected characteristics such as disability and long term conditions, or sexual orientation declaration rates are much lower. Too often Electronic Staff Records have lower levels of declarations than the staff survey. In addition, levels of 'not declared' remain too high.

As outlined in the most recent letter, data capture is also equally important for people who use our services and areas of under-capture must be addressed. This will be an important factor to gain assurance on in the roll out of the new Electronic Patient Record.

The areas highlighted in the Beyond the Data recommendations are wide ranging and multifactorial involving partners across systems to work together to deliver them. The Board will be aware of the Population Health management discussion at Joined Up Care Derbyshire. Our Reverse Commissioning group will be key part of improving commissioned services for BAME communities.

Culturally-competent COVID-19 education and prevention campaigns, as well as wider health promotion, will be important for Joined Up care Derbyshire in delivering 'phase 3' and beyond.

The summary above shows the wide range of actions and oversight being set out for all in the NHS to deliver on. These actions range from immediate risk reduction actions taken early in the pandemic to the near, medium and longer term requirements to improve the health and wellbeing of those most at risk and address system inequalities, some actions being organisation-specific and some being in partnership with the wider health and care system.

Whilst Derbyshire Healthcare is a leader in many inclusion areas, there is much work still to do, to build on successes and to address areas where inequalities are still prevalent, both for the workforce and for the communities we serve.

The Board is invited to consider these requirements, our current position, future challenges and the strategic direction of travel on key inclusion priorities for our workforce and the communities to whom we provide services.

Strategic Considerations	
1) We will deliver **great care** by delivering compassionate, person-centred innovative and safe care	x
2) We will ensure that the Trust is a **great place to work** by attracting colleagues to work with us who we develop, retain and support by excellent management and leadership	x

3) We will make the **best use of our money** by making financially wise decisions and will always strive for best value to make money go further	x

Assurances

- The People and Culture Committee is the assurance committee for the workforce issues outlined in this paper, the Quality Committee is a key assurance Committee for the Patient related inclusion issues.
- The Trust Board itself must be assured on the strategic direction of travel for inclusion in Derbyshire Healthcare.

Consultation

- A summary of the requirements contained in the first three documents were provided to the BME Staff network for their views and their input in the next steps
- The Executive Leadership Team have seen the same summary along with some examples of progress similar to those outlined in the executive summary.

Governance or Legal Issues

- WRES and WDES reporting is mandatory requirement of the NHS contract
- The issues outlined in the documents and the Board and leadership responses help us demonstrate commitment to Equality Act 2010 and Public Sector Equality Duty
- The reporting requirements more generally will be needed to provide assurance to NHSIE

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 very point of this paper is to consider a wide range of equality related factors as described at length above.

Recommendations

The Board of Directors is requested to:

1) Note the wide-ranging reporting requirements and signals on key inclusion priorities
2) Consider these in light of our current position, future challenges and the strategic direction of travel on key inclusion priorities for our workforce and the communities we serve

Report presented by: **Claire Wright**
Deputy CEO and Finance Director

Report prepared by: **Claire Wright**
Deputy CEO and Finance Director

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 1 September 2020

Performance Report

Purpose of Report

The purpose of this report is to provide the Board of Directors with a brief update of how the Trust is performing at the end of July 2020 during this extremely challenging period. The report focuses on key finance, performance and workforce measures.

Executive Summary

The report provides the Board of Directors with information that demonstrates how the Trust is performing against a suite of key targets and measures. Performance is summarised in an assurance summary dashboard with targets identified, where a specific target has been agreed. Where a specific target has not been agreed or specifically commissioned, colleagues will be able to track performance over time and discuss/challenge any specific variation that may be of concern or unusual. Further detailed statistical process control charts for the measures are included in appendix 2.

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

Finance

Revenue: In order to 'true-up' to breakeven we accrued top-up income amounting to £364k for July 2020. This brings the top ups that have been required in the first four months to a total of £1.5m.

Within the overall costs for the month we incurred £730k for COVID-19-related costs. For the four months including July our COVID-19-related costs have been £2.9m. Agency costs, particularly COVID-19-related, are quite high for the early part of the year which means that we have spent £1.2m on agency staff in the first four months against a pro rata agency ceiling of £1m. We expect agency to reduce as we increase substantive and bank employment.

For 'phase 3' planning, there are several templates being completed by multi-disciplinary teams along with commissioners and partners in the system. We expect these to be iterative to some extent. The templates incorporate planning and financial assumptions related to the standing up of services, the COVID-19 response and winter planning. They also specifically include delivery of Mental Health Investment Standard and relevant aspects of the Long Term Plan.

Our submissions necessarily include assertive recruitment outcome assumptions in order to deliver these requirements.

Our block income value will need to be increased in order to deliver the planned requirements and still achieve a position of break even by year end.

We have been notified that the current process of block and retrospective top up payments will continue for month 5 and 6. We have received indications of how financial arrangements may work after month 6 (likely to be fixed blocks), but these are not yet confirmed.

The next stages of financial and planning arrangements will be discussed at the Finance and Performance Committee.

Capital: We submitted a revised 'business as usual' capital plan as a Derbyshire system

that came within our STP capital envelope. We were also advised of some ear marked Critical Infrastructure Risk (CIR) funding for urgent backlog maintenance, for Derbyshire Healthcare this was in the region of £200k. The relevant submissions for these have been made.

Beyond the 'business as usual' capital requirements, the Board will be aware of our need for substantial refurbishment and new build in order to eradicate dormitories. At the last Finance and Performance Committee we discussed the details of these assumptions at length alongside the updated submission made for mental health dormitory eradication capital.

At the time of writing we have not heard an outcome. We are told that the size of our requirements mean that our submission will have a longer national approval process.

A verbal update will be provided to Board on any further feedback or progress on these matters.

Operations

Seven day follow-up of patients on CPA, up to March 2020, then three day follow-up of all patients, from April 2020

To date the revised standard has been achieved.

Data quality maturity index

Although the level of data quality fell below the lower control limit in July, the level of data quality is still well above target. As services are being restored and patient contact activity is increased we should start to see an improvement.

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

Talking Mental Health Derbyshire (TMHD) continues to exceed the national standard for 18 week referral to treatment, however the service has been lower than standard for six week referral to treatment for the last two months. This is owing to referrals to the Trust's element of the service being on hold during the pandemic, with the Trust's IAPT clinicians currently staffing the mental health helpline.

IAPT – people completing treatment who move to recovery

In July the target was not achieved for the first time in 18 months. The service continues to monitor recovery and reliable improvement and remains on target for both year-to-date.

Patients placed out of area – adult acute

The number of out of area acute placements has increased for the last two months. More recently the anticipated surge in activity has started to impact on bed use returning to levels experienced pre-COVID-19. The expected surge in emotional distress and economic downturn is likely to impact on bed usage even further. The COVID-19 guidance has resulted in a reduction in the usual bed base and we are operating with 19 fewer beds owing to a mixture of staffing levels and social distancing. However attempts to maintain reduced lengths of stay continue and these have been successful, enabling maximum utilisation of inpatient beds.

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

For the past two months the level of out of area PICU placements has been abnormally high. Derbyshire does not currently have any PICU beds within the county and therefore all admissions into PICU beds for Derbyshire patients will result in an out of area

admission. The Trust is working with commissioners and regulators to look at ways where care continuity can be maintained with commissioned PICUs in neighbouring Counties.

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

CAMHS continue to make good use of video and telephone as the vehicles for clinical contact, which is having a positive impact on the size of the waiting lists. The number of referrals received continues to be lower than normal, with the exception of the CAMHS Eating Disorder team who have seen an increase in referrals over the last two months.

Waiting list for community paediatrics

Further significant progress continues to be made in reducing waits and at the end of July the number of children on the waiting list was at the lowest level achieved to date.

Waiting list for autistic spectrum disorder (ASD) assessment

The ASD Assessment Service has been suspended from fully undertaking assessments since mid-March whilst the staff have been partially or fully redeployed across the Trust to Adult Eating Disorders, Hartington Unit and the Mental Health Helpline.

Waiting list for psychology

The average wait to be seen has increased further and is now higher than normal. Conversely the number of patients on the waiting list has been lower than normal for the past four months. The number of referrals received each month during the pandemic is below average. Where possible we are undertaking work remotely by phone or Attend Anywhere.

Admissions

We have seen a sustained level of acuity in both adult and older adult inpatients, which is reflected in the volume of admissions under the Mental Health Act and in the reasons for admission. This increased acuity means there is an increase in levels of activity, observations and clinical care. As far as alternatives to admission are concerned, the crisis teams have remained fully functioning (although initially severely impacted by staff absence owing to shielding workforce). Crisis teams' caseloads are now returning to numbers close to that pre COVID-19.

Phase 3 of the NHS response to the COVID-19 pandemic

To help address some of the wider health inequalities persisting in society that have been exposed by COVID-19, the NHS has been tasked with a number of actions. One of these is that all NHS organisations should proactively review and ensure the completeness of patient ethnicity data by no later than 31 December 2020.

Workforce

In order to reduce the burden and release capacity to manage the COVID-19 pandemic, all NHS organisations were instructed by Amanda Pritchard, Chief Operating Officer, NHS England and NHS Improvement, to suspend appraisals and revalidation and to reduce the volume of mandatory training as appropriate.

Annual appraisals

For the first month since the start of the pandemic we have seen an increase in the proportion of completed appraisals.

Turnover

Turnover continues to remain within the Trust target range of 8 - 12%.

Mandatory training

To enable the training team to deliver clinically essential training, the number of available training classes has been significantly reduced. This is reflected in the data, where promoting safer and therapeutic services - which is normally delivered in a classroom - has the lowest levels of compliance. Overall compliance has fallen month on month since the start of the pandemic and is likely to continue to deteriorate for those training courses that are delivered face-to-face. A partial recovery plan has been agreed by the Executive to ensure that key safety training continues to be delivered to front line staff.

Staff absence

COVID-19 absence has steadily fallen over the last few months and is no longer the most common reason for absence.

Supervision

The level of compliance with the clinical and managerial supervision targets is no longer falling and for the last few months has been stable, but at a level lower than normal.

Vacancies

The proportion of posts filled remained within normal variation.

Bank staff use

The proportion of temporary staffing employed remained within normal variation.

Quality

Incidents

The number of incidents of moderate to catastrophic harm were within normal variation and have been below average for the last two months.

Seclusion and restraint

The use of seclusion and restraint was within normal variation, although with a potentially reducing trend in physical restraint and prone restraint.

Patients in settled accommodation and patients in employment

Accommodation and employment will clearly be affected by the current pandemic and its financial consequences, so this data will be monitored closely.

Care plan reviews

The proportion of patients whose care plan has been reviewed has fallen again continues to be much lower than normal. This is to be expected as teams have been prioritising essential tasks, with reduced routine contact. We will monitor this over the coming months as teams restore services in line with national expectations.

Board Assurance Framework (BAF)

The BAF has been reviewed and a report based upon the interventions agreed through the Incident Management Team (IMT) and in accordance with the infection prevention and control guidelines and assurances requested by NHSI provided to the Board. The frequency of patient testing has increased. A detailed breakdown of patient testing procedures is contained within the main report.

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

Assurances

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

Consultation

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

Governance or Legal Issues

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

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

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

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

Recommendations

The Board of Directors is requested to:

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

Report presented by: **Mark Powell**
Chief Operating Officer

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

Claire Wright
Director of Finance/Deputy CEO

Darryl Thompson
Deputy Director of Nursing & Quality Governance

Richard Morrow
Assistant Director of Public and Physical Healthcare

1. Assurance Summary

Indicator	Rating[1]	Data Quality	Indicator	Rating[1]
Operational				
CPA 7 day follow-up to Mar 20, then 3 day follow-up all patients	?		Waiting list for care coordination – number waiting	See chart
Data Quality Maturity Index (DQMI) - MHSDS data score	P		Waiting list for care coordination – average wait	See chart
Early Intervention (EIP) RTT within 14 days - complete	P		Waiting list for ASD assessment – number waiting	See chart
EIP RTT within 14 Days - incomplete	P		Waiting list for ASD assessment – average wait	See chart
IAPT referral to treatment (RTT) within 18 weeks	P		Waiting list for psychology – number waiting	See chart
IAPT referral to treatment within 6 weeks	P		Waiting list for psychology – average wait	See chart
IAPT people completing treatment who move to recovery	?		Waiting list for CAMHS – number waiting	See chart
Patients placed out of area - PICU	See chart		Waiting list for CAMHS – average wait	See chart
Patients placed out of area - adult acute	See chart		Waiting list for community paediatrics – number waiting	See chart
			Waiting list for community paediatrics – average wait	See chart
Workforce				
Annual appraisals	F		Clinical supervision	F
Annual turnover	?		Management supervision	F
Compulsory training	?		Vacancies	F
Sickness absence	?		Bank staff use	?

[1]The rating symbols were designed by NHS Improvement

Key:

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

2. Detailed Narrative

Operations

A. Seven day follow-up of patients on CPA, up to Mar 2020, then three day follow-up of all patients, from April 2020

In line with the recommendations of the annual National Confidential Inquiries[1], which have consistently found that people are at most risk of self-harm or suicide in the first two to three days following discharge, from April 2020 the national standard for follow-up post discharge from inpatient wards was reduced from seven days to 72 hours and revised to include all patients, not just those on the Care Programme Approach (CPA). To date the revised standard has been achieved.

B. Data quality maturity index

Although the level of data quality fell below the lower control limit in July, the level of data quality is still well above target. As services are restored in line with national instruction[2] and patient contact activity is increased we should start to see an improvement.

C. IAPT 6 week referral to treatment

Talking Mental Health Derbyshire (TMHD) continues to exceed the national standard for 18 week referral to treatment, however the service has been lower than standard for six week referral to treatment for the last two months. This was owing to referrals to the Trust's element of the service being on hold during the pandemic, with the Trust's IAPT clinicians currently staffing the mental health helpline. The service re-opened to digital referrals on 6 July and continues to support the mental health helpline with several staff. There are transitional plans being introduced to reduce the commitment and increase capacity within the service, and it is planned for all staff to return to their substantive posts by 6 September.

D. IAPT – people completing treatment who move to recovery

In July the target was not achieved for the first time in 18 months. The service continues to monitor recovery and reliable improvement and remains green for both year to date.

E. Patients placed out of area – adult acute

The number of out of area acute placements has increased for the last two months and returned to within normal variation. Additional bed capacity was created as a result of the discharge initiative for COVID-19 response, however out of area placements are still expected to be required in order to maximise and appropriately prioritise Trust staffing resources.

From an acute out of area perspective there was a significant increase in bed use from October 2019 to January 2020. Attempts were made to address this which appeared to have an impact during the first few months of 2020 and the initial period of the COVID-19 pandemic. More recently the anticipated surge in activity has started to impact on bed use returning to levels experienced pre-COVID-19 and therefore this reduction has not been sustained. The economic downturn and expected surge in emotional distress is likely to impact on bed usage even further. However, attempts to maintain reduced lengths of stay continue and have been successful, enabling maximum utilisation of inpatient beds.

There is an expectation that DHCFT will eliminate out of area acute bed use by 1 April 2021. However given the current situation resulting from the COVID-19 pandemic this objective is being challenged. The COVID-19 guidance has resulted in a reduction in the usual bed base and we are operating with 19 fewer beds owing to a mixture of staffing levels and social distancing. The social

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[1] https://sites.manchester.ac.uk/ncish/reports/annual-report-2019-england-northern-ireland-scotland-and-wales/

[2] https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/07/Phase-3-letter-July-31-2020.pdf

distancing requirement is to have at least 2 metres between beds in the dormitory areas. Much of the acute inpatient bed base for DHCFT relies upon dormitory/bay accommodation. There is no indication at this stage that this guidance will be reviewed and therefore it is difficult to forecast when we would expect the re-opening of these beds. Prior to the COVID-19 pandemic we were entering a programme to move towards converting the dormitories to single rooms but this has been delayed. The programme of works to complete the adaptations was scheduled over a number of years and involved the temporary closure of beds whilst the works was completed. A further bid to fund an enhanced programme has been submitted which included a programme to build/convert alternative ward space.

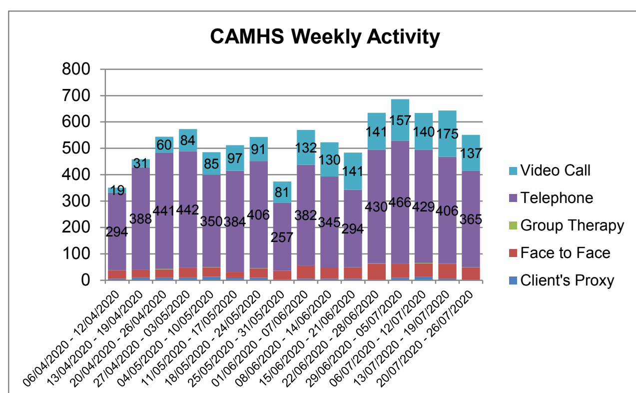
F. Patients placed out of area – Psychiatric Intensive Care Units (PICU)

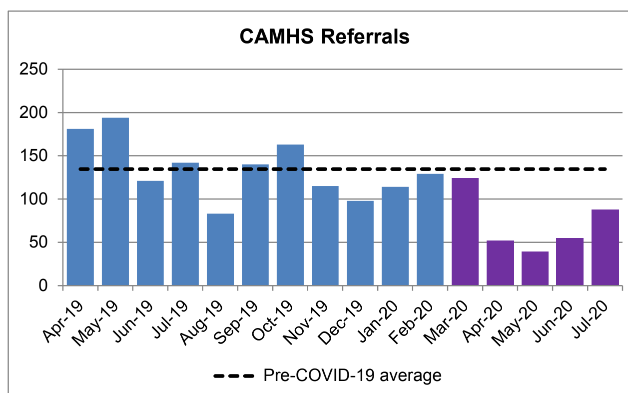
For the past two months the level of out of area PICU placements has been abnormally high. Derbyshire does not currently have any PICU beds within the County and therefore all admissions into PICU beds for Derbyshire patients will result in an out of area admission. The Trust is working with commissioners and regulators to look at ways where care continuity can be maintained with commissioned PICUs in neighbouring Counties. There is a sense that during the COVID-19 pandemic that the profile of patients admitted to hospital has changed and that there has been an increase in the level of distress and disturbance that patients are experiencing. Therefore the progress that had previously been made to reduce the number of PICU placements has been overturned and PICU admissions have returned to similar levels as 12 months ago. Enhanced case management for people placed in PICU has demonstrated effectiveness in driving down length of stay in PICU to an absolute minimum.

The commissioning of a PICU provision within Derbyshire is required as a first step in avoiding out of area PICU placements. The next challenge would be ensuring estate was available to facilitate the delivery of a PICU unit and it is expected that this is likely to be a new build in order to meet service specifications. This was included in the bid submission mentioned above.

G. Waiting list - Child and Adolescent Mental Health Services (CAMHS)

CAMHS continue to make good use of video and telephone as the vehicles for clinical contact, which is having a positive impact on the size of the waiting lists. The number of referrals received continues to be lower than normal, with the exception of the CAMHS Eating Disorder team who have seen an increase in referrals over the last two months.

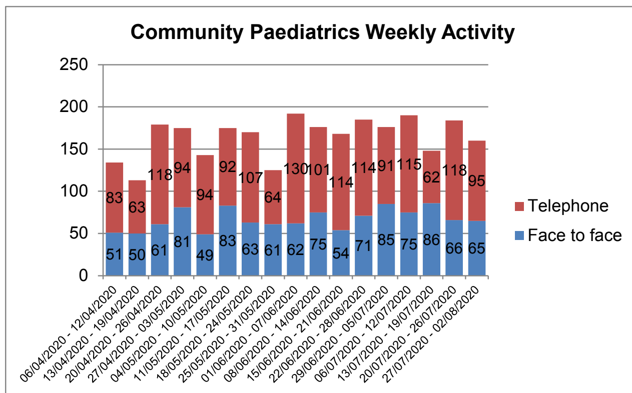


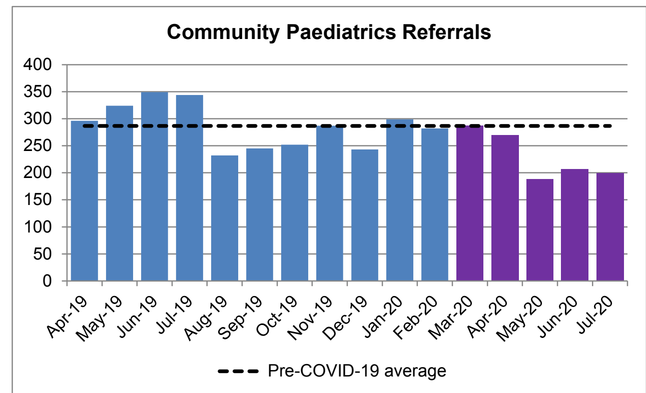


Following a period of 13 months where the waiting list was abnormally large, for the past two months the waiting list has returned to normal levels (Appendix 2, page 16).

H. Waiting list for community paediatrics

Further significant progress continues to be made in reducing waits and at the end of July the number of children on the waiting list was at the lowest level achieved to date. The number of referrals received has reduced currently as a result of the impact of school closure owing to COVID-19, and also the temporary closure of the neurodevelopmental pathway.



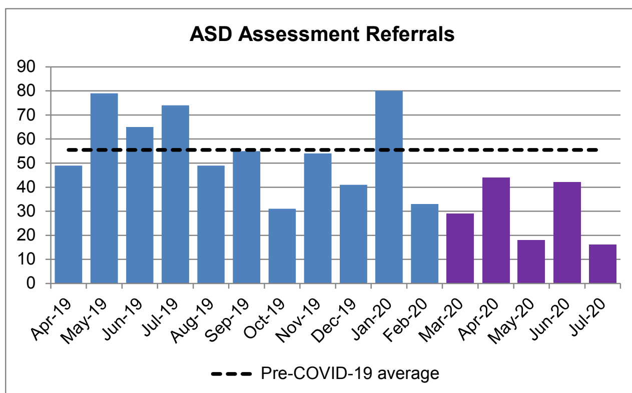


I. Waiting list for autistic spectrum disorder (ASD) assessment

The ASD Assessment Service has been suspended from fully undertaking assessments since mid-March whilst the staff have been partially or fully redeployed across the Trust to Adult Eating Disorders, Hartington Unit and the Mental Health Helpline). Referrals have continued in this time and have been processed remotely by the team administrator.

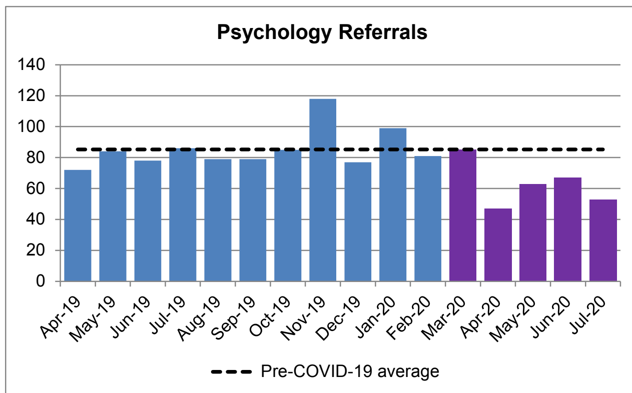
Since mid-May the team have been undertaking a limited pilot on the feasibility of using Attend Anywhere for ASD assessments alongside using a new DHCFT-designed ASD assessment tool. This has been undertaken with the next 40 patients on the waiting list to ensure fairness.

Over half of the team's capacity is currently within redeployed teams with ongoing planning on phased return and new models of working. The aim is to agree the feasibility of remote ASD assessments before re-starting the service. Face-to-face assessments will still be undertaken but estate impact will mean that it is anticipated that remote assessments should be prioritised.



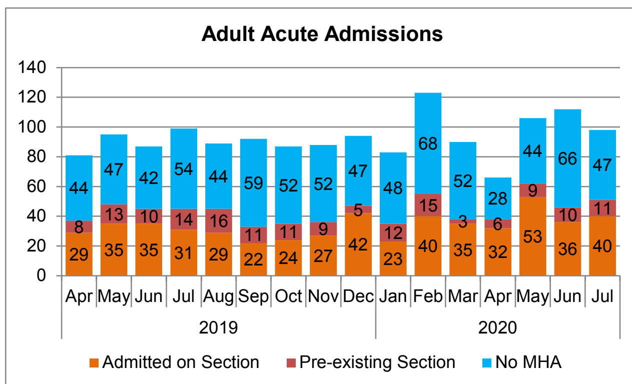
J. Waiting list for psychology

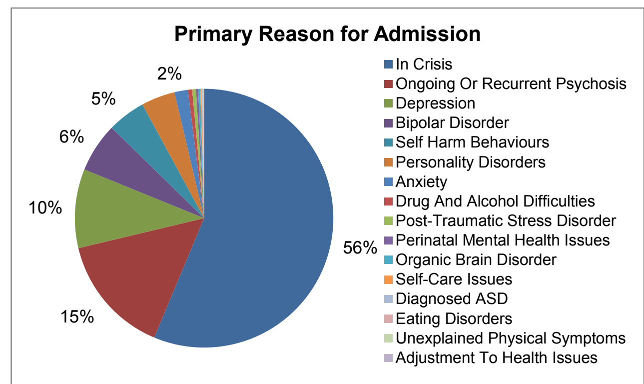
The average wait to be seen has increased further and is now higher than normal. Conversely the number of patients on the waiting list has been lower than normal for the past four months. The number of referrals received each month during the pandemic is below average. Where possible we are undertaking work remotely by phone or Attend Anywhere and we now have a structure that will sit under the new lead once they are in post (this comprises of three 12 month secondments of Consultant Clinical Psychologists to Adult Acute, Older People and Derby City and South County mental health teams). In particular within the community we will be giving a focus to consistent working across teams, recruiting to vacancies and reviewing working practices coming out of COVID-19 to maximise efficiency.

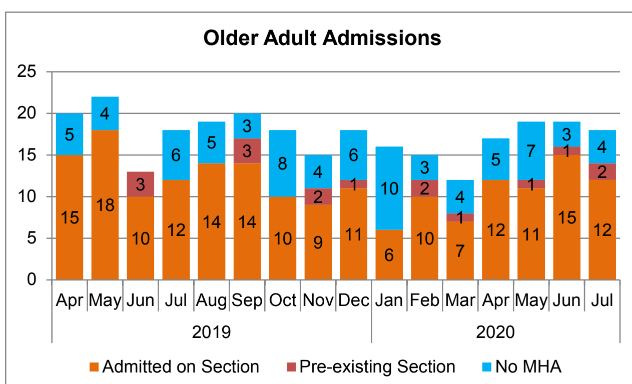


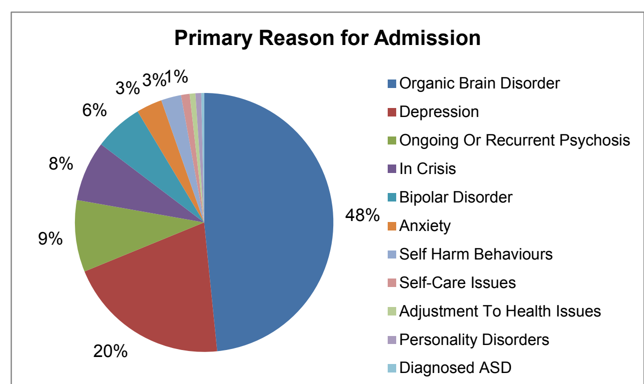
K. Admissions

We have seen a sustained level of acuity in both adult and older adult inpatients, which is reflected in the volume of admissions under the Mental Health Act and in the reasons for admission. This increased acuity means there is an increase in levels of activity, observations and clinical care. As far as alternatives to admission are concerned, the crisis teams have remained fully functioning (although initially severely impacted by staff absence owing to shielding workforce). Crisis teams' caseloads are now returning to numbers close to that pre COVID-19.







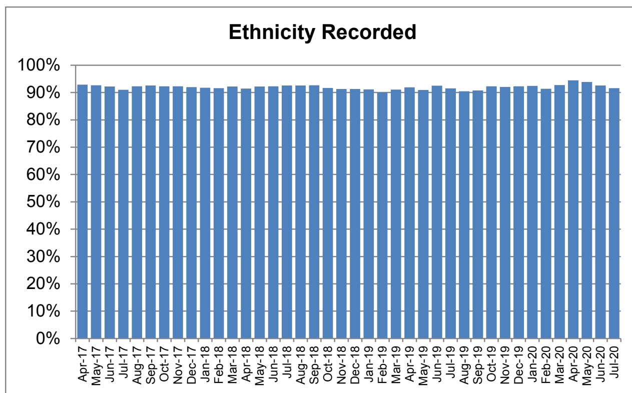


L. Phase 3 of the NHS response to the COVID-19 pandemic

To help address some of the wider health inequalities persisting in society that have been exposed by COVID-19, the NHS has been tasked with a number of actions[3]. One of these is that all NHS organisations should proactively review and ensure the completeness of patient ethnicity data by no later than 31 December 2020, with general practice prioritising those groups at significant risk of COVID-19 from 1 September 2020.

As a Trust, our level of data completeness has been consistently high:

[3] https://www.england.nhs.uk/wp-content/uploads/2020/08/implementing-phase-3-of-the-nhs-response-to-covid-19.pdf



The vast majority of patients for whom we do not have ethnicity recorded are those who have been referred to us but are yet to be seen. Up to now GPs have not been required to provide patient ethnicity when making referrals to mental health services and there is no option for the GP to provide ethnicity if they use the national electronic referral system. However from 1 September Primary Care will be required to start collecting protected characteristic data, which should help to further improve our data completeness.

An exception report is sent out weekly to the relevant teams to enable data quality improvement action to be undertaken and ensure the high level of data completeness is maintained.

Workforce

In order to reduce the burden and release capacity to manage the COVID-19 pandemic, all NHS organisations were instructed by Amanda Pritchard, Chief Operating Officer, NHS England and NHS Improvement[4], to suspend appraisals and revalidation and to reduce the volume of mandatory training as appropriate.

A. Annual appraisals

For the first month since the start of the pandemic we have seen an increase in the proportion of completed appraisals.

B. Turnover

Turnover continues to remain within the Trust target range of 8 - 12%.

C. Compulsory training

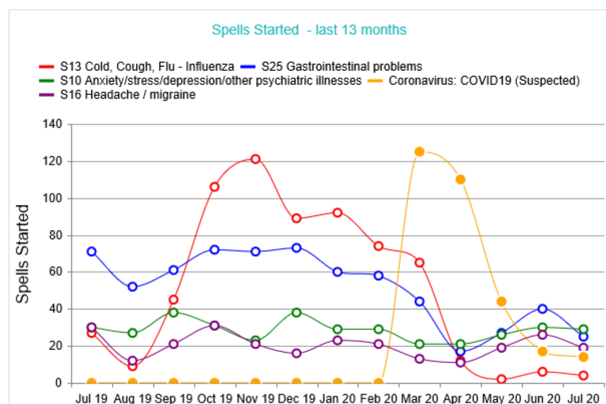
To enable the training team to deliver clinically essential training, the number of available training classes has been significantly reduced. This is reflected in the data, where promoting safer and therapeutic services - which is normally delivered in a classroom - has the lowest levels of compliance. Overall compliance has fallen month on month since the start of the pandemic and is likely to continue to deteriorate for those training courses that are delivered face-to-face.

Competence Name	Cohort	Compliance (%)
383|LOCAL|C Data Security & Protection (Previously IG) (Annual)|	2638	84%
383|LOCAL|C Equality, Diversity and Human Rights - Level 1 (3 yearly) All Staff|	2638	87%
383|LOCAL|C Fire Safety - Level 1 (2 Yearly) All Staff|	2638	86%
383|LOCAL|C Fraud Awareness (3 yearly)|	2363	92%
383|LOCAL|C Health, Safety & Welfare (3 Yearly) All Staff|	2638	85%
383|LOCAL|C Moving & Handling Level 1 (3 yearly)|	2638	82%
383|LOCAL|C Promoting Safer & Therapeutic Services Clinical Staff (3 yearly)|	1746	56%
383|LOCAL|C Promoting Safer & Therapeutic Services Non-Clinical Staff (3 yearly)|	616	58%
383|LOCAL|C Safeguarding - Adults Level 1 (Non Clinical) (3 Yearly)|	609	88%
383|LOCAL|C Safeguarding - Adults Level 1+2 (All Clinical) (3 yearly)|	1755	78%
383|LOCAL|C Safeguarding - Children - Level 1 (Annual)|	543	80%
383|LOCAL|C Safeguarding - Children Level 1 (once only)|	1820	98%

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

D. Staff absence

COVID-19 absence has steadily fallen over the last few months and is no longer the most common reason for absence:



E. Supervision

The level of compliance with the clinical and managerial supervision targets is no longer falling and for the last few months has been stable, but at a level lower than normal.

F. Vacancies

The proportion of posts filled remained within normal variation.

G. Bank staff use

The proportion of temporary staffing employed remained within normal variation.

Quality

A. Incidents

The number of incidents of moderate to catastrophic harm were within normal variation and have been below average for the last two months.

B. Seclusion and restraint

The use of seclusion and restraint was within normal variation, although with a potentially reducing trend in physical restraint and prone restraint. This might be in line with pieces of work that have been ongoing with regards to reducing restrictive practices.

C. Patients in settled accommodation and patients in employment

There are some slight variances in this data, but the very small range on the vertical axis of the graph means that the significance of visible change needs to be approached with some caution. Accommodation and employment will clearly be affected by the current pandemic and its financial consequences, so this data will be monitored closely.

D. Care plan reviews

The proportion of patients whose care plan has been reviewed has fallen again continues to be much lower than normal. This is to be expected as teams have been prioritising essential tasks, with reduced routine contact. We will monitor this over the coming months as teams restore services in line with national expectations.

E. Board Assurance Framework (BAF)

The BAF has been reviewed and a report based upon the interventions agreed through the Incident Management Team (IMT) and in accordance with the infection prevention and control guidelines and assurances requested by NHSI provided to the Board.

In regard to patient testing:

- For inpatients we have evolved the process as guidance has changed and local testing capacity has allowed us to increase the frequency of testing. We have a report generated from our clinical care records reporting into the IMT every day to provide oversight and assurance related to patient testing and results.

- Currently we test all unplanned admissions (the significant majority) at the point of admission to hospital. We retest at 5 - 7 days as per NHS guidelines. We also test patients upon return from leave and if we move them to another clinical area or repatriate them from another clinical setting.

- If a patient were to become symptomatic or unwell then a COVID-19 test would be undertaken as part of the diagnostic exploration. If we have a patient who refuses to be tested then they are isolated as though they are a confirmed case. We continue to offer a test and will engage an advocate to try and support the person to access a swab and navigate their other treatment needs. Public Health England will also provide support and advice for patients who are refusing to support a clinically appropriate decision to manage their admission.

- Any confirmed cases will be nursed in isolation or cohort nursed with other confirmed cases as per the standard operating procedures for each of the clinical areas.

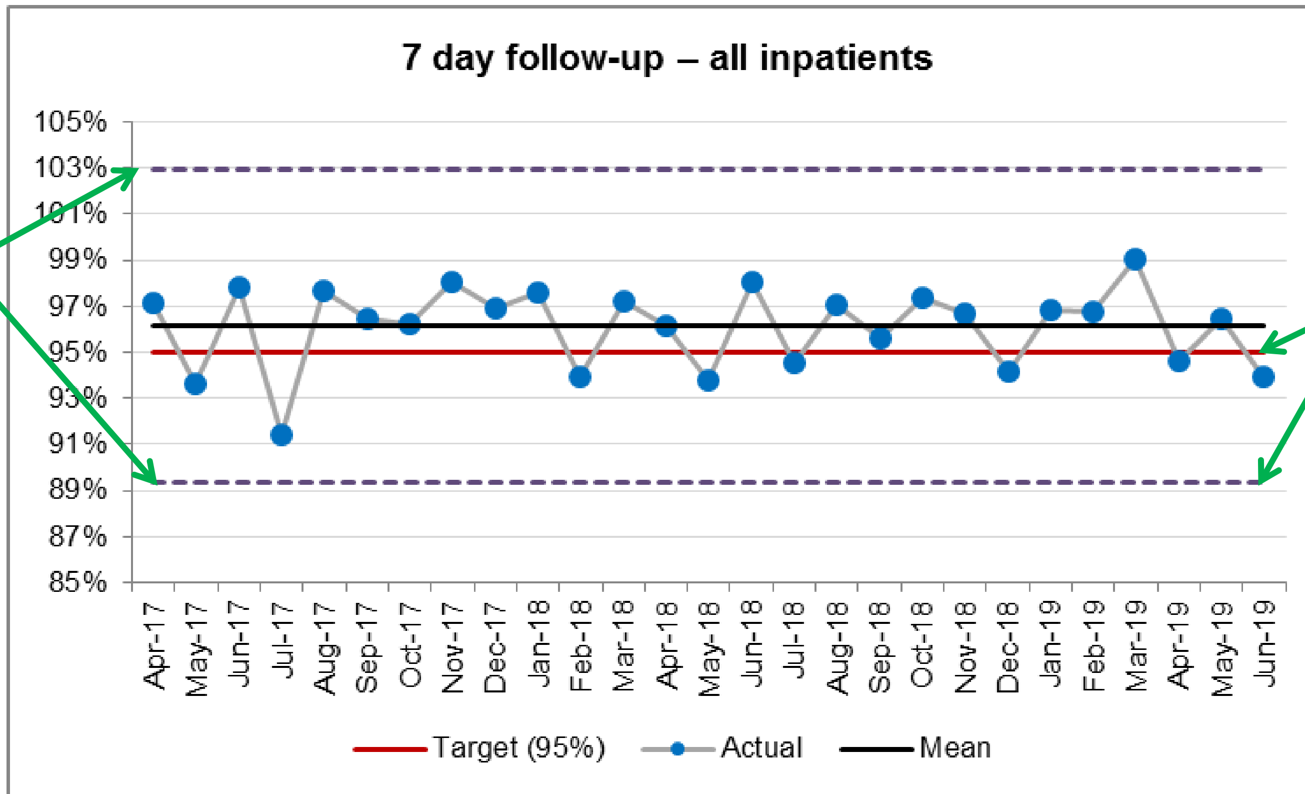
- For people being admitted electively (Clozapine initiation, ECT commencement) we aim to swab test 72 hours before admission, if this cannot be arranged or the person is not able to access agreeable, we would swab as an emergency admission.

- We have cohorting arrangements in place for new admissions to enable them to be supported in isolation until the swab test result has been confirmed. The shielded patients are nursed in designated ward spaces. The inpatient areas have standard operating procedures in place which are reviewed and signed off by the IMT as guidance or clinical demand changes. There are cohorting pans in place for an outbreak if this occurs. These have been deployed previously.

Appendix 1

How to Interpret a Statistical Process Control Chart (SPC)

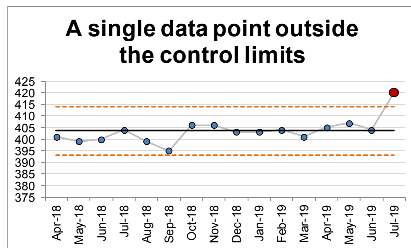
The dotted lines are the "control limits". Any performance between these 2 lines is normal for the current system. This is known as "normal variation"

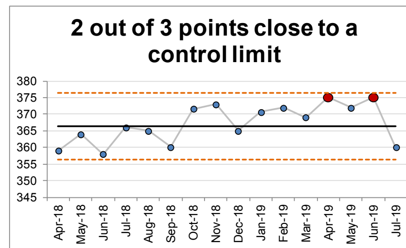


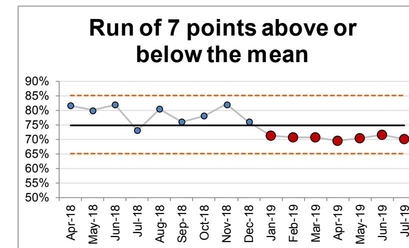
If the system is effective, the **lower** control limit will be above the target line (for targets where higher is better) or the **upper** control limit will be below the target line (for targets where lower is better). In that scenario we have nothing to worry about and can be assured our system is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

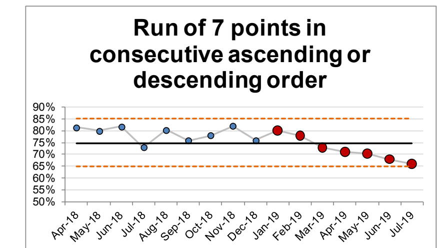
In this case the target line is above the lower control limit which indicates that the system is ineffective.

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



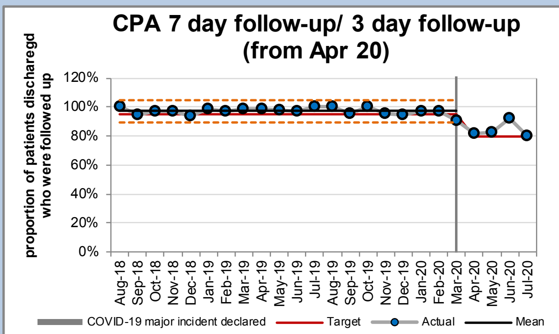


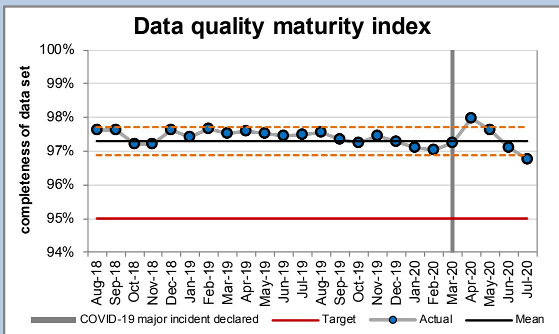


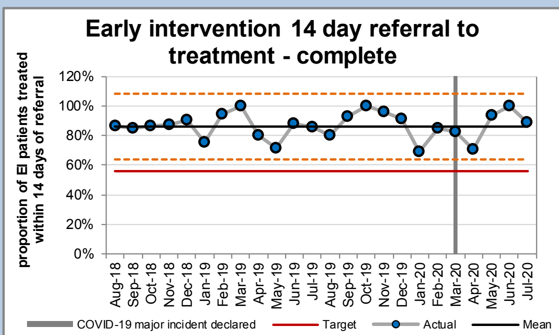


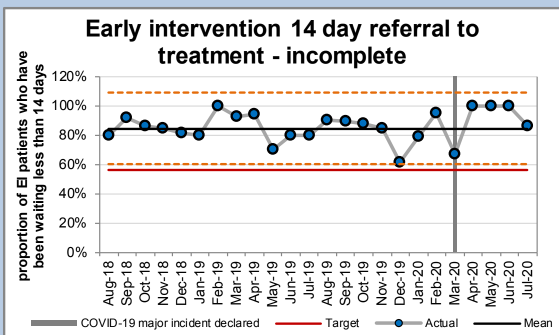
Appendix 2 – Charts[5]

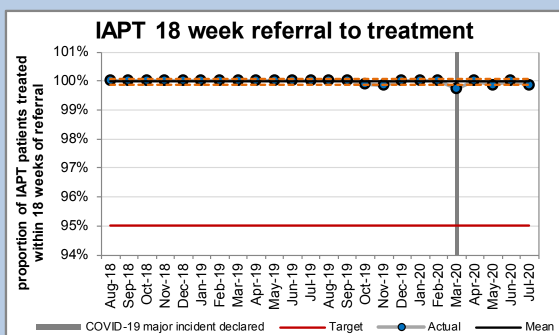
Operational indicators

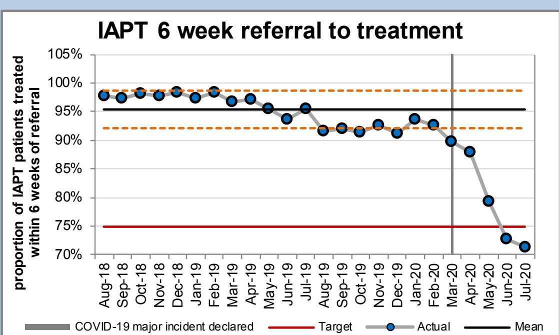


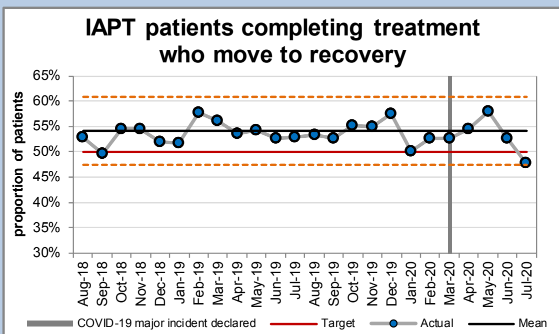


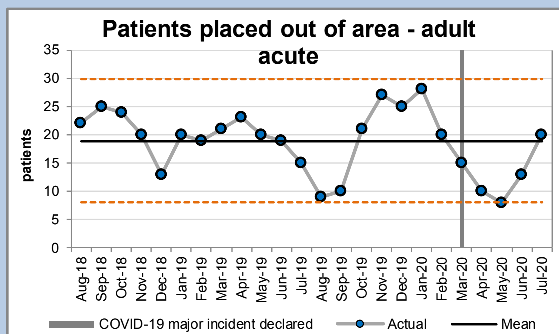


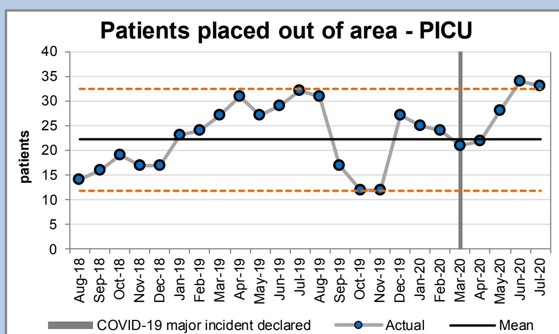






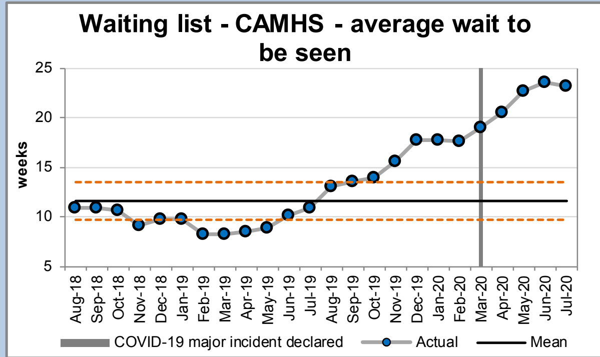


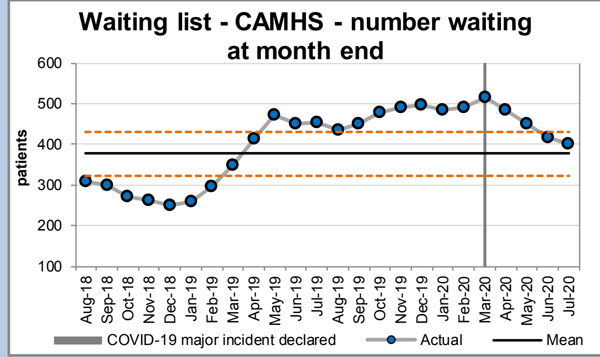


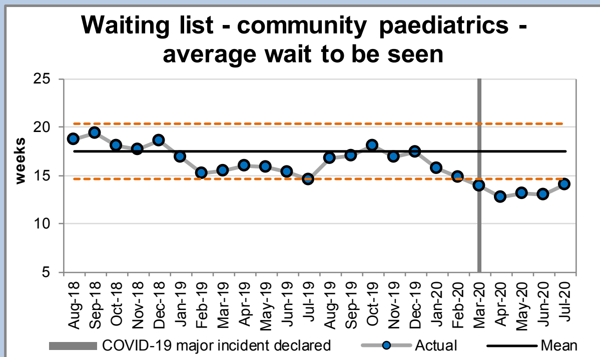


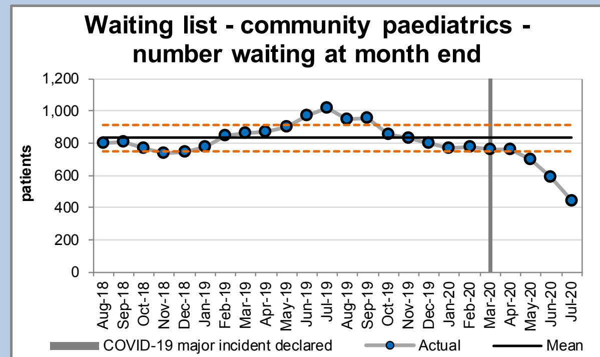
[5] The control limits have been fixed at pre-COVID-19 levels to enable tracking of performance against the norm during the pandemic.

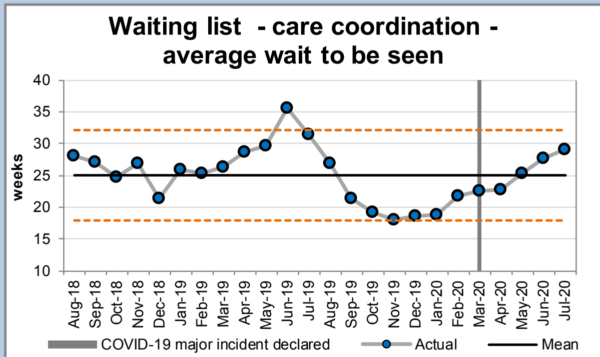
Operational indicators

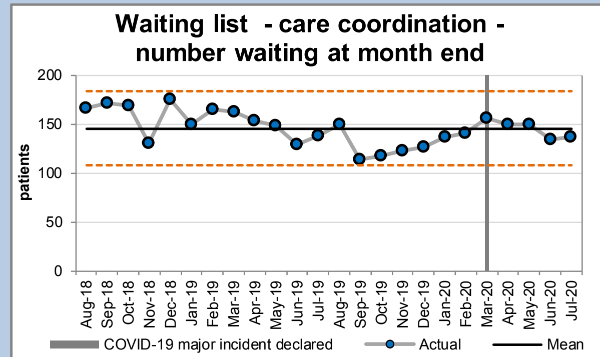


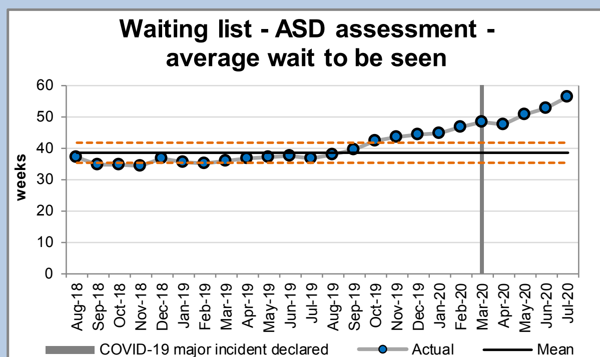


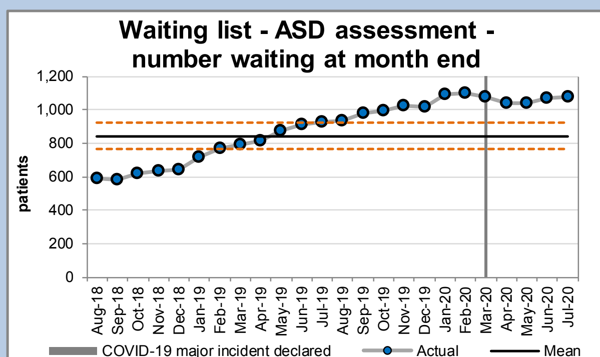


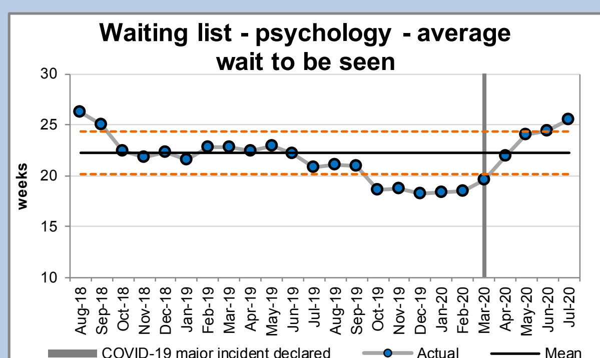


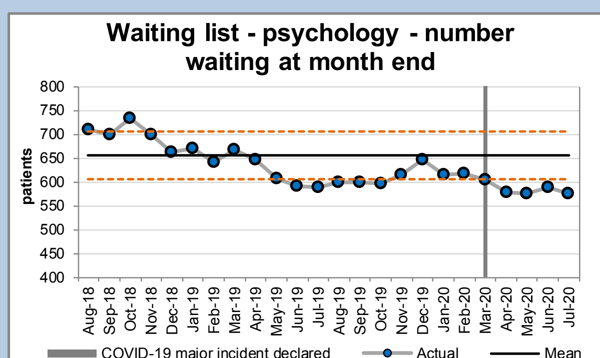




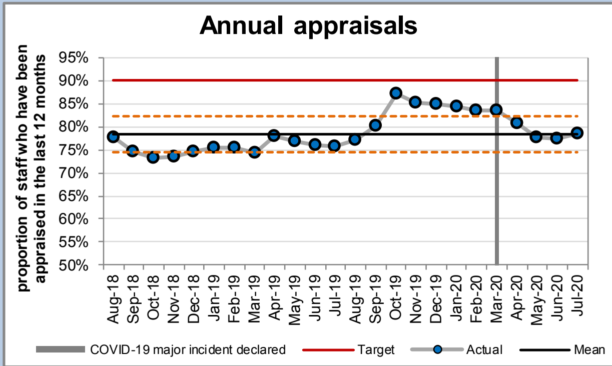


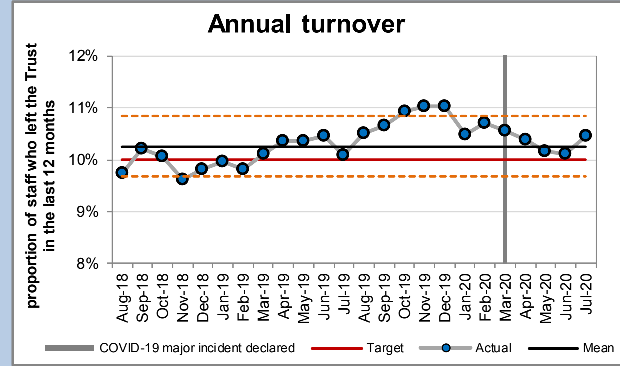


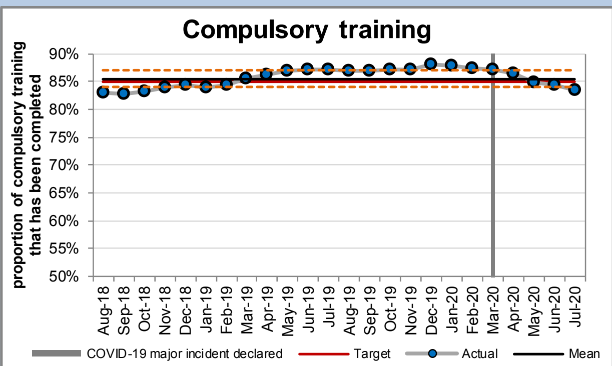


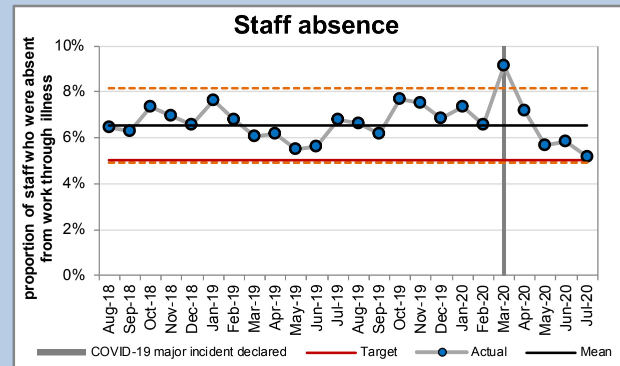


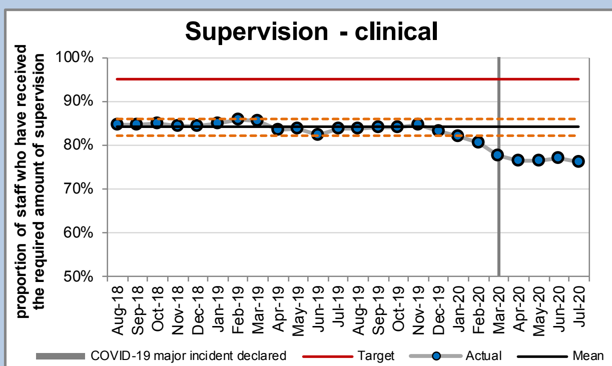
Workforce indicators

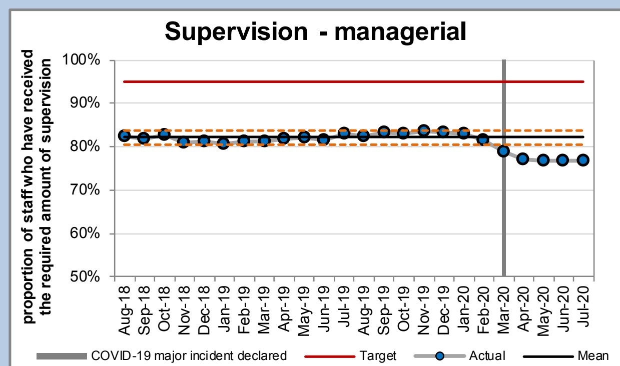


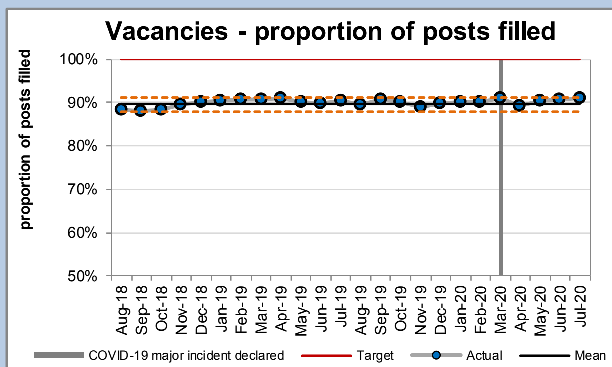


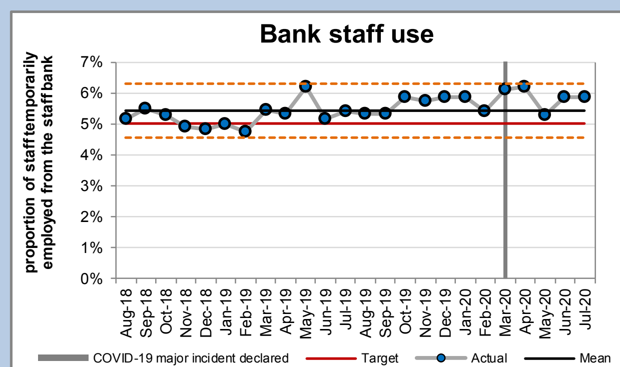








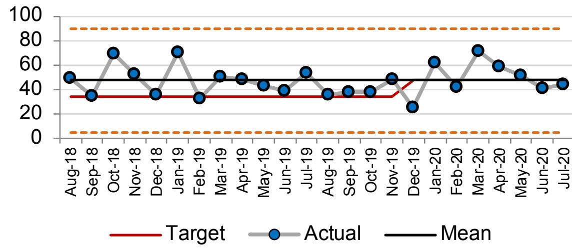




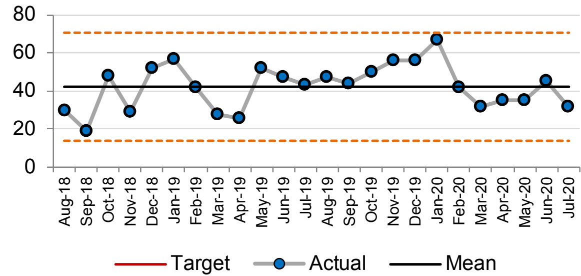
Quality Indicators

Safe

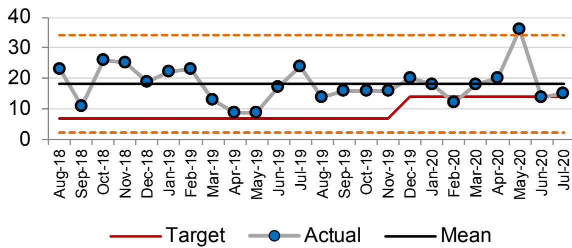
No of incidents of moderate to catastrophic actual harm



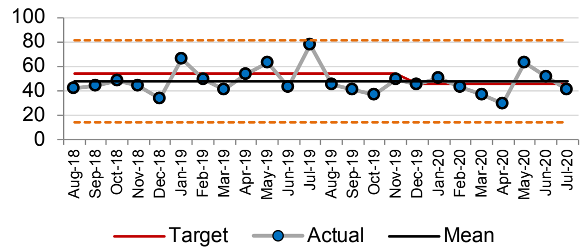
Number of medication incidents



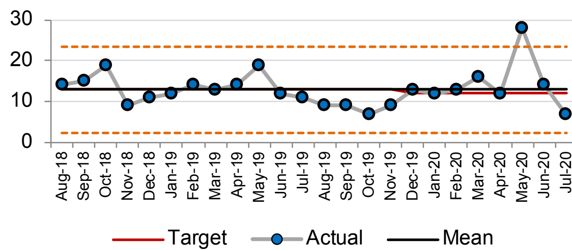
No of new episodes of patients held in seclusion



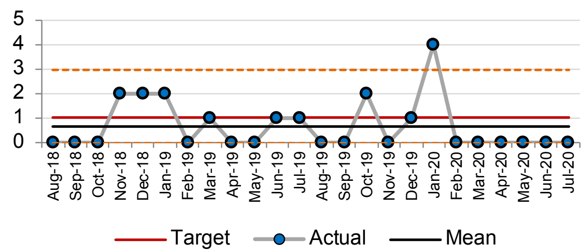
No of incidents involving physical restraint



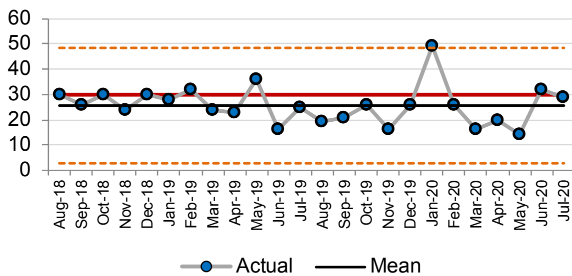
No of incidents involving prone restraint



No of incidents requiring Duty of Candour

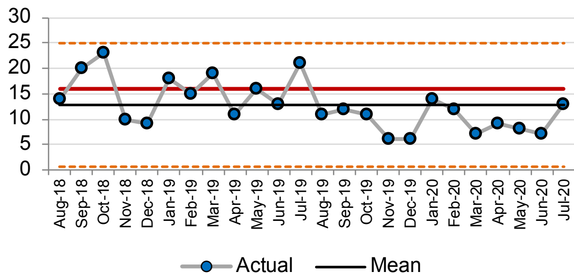


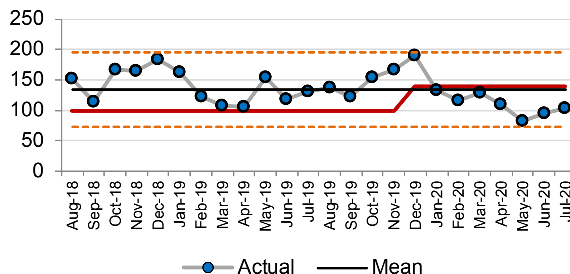
No of falls on in-patient wards

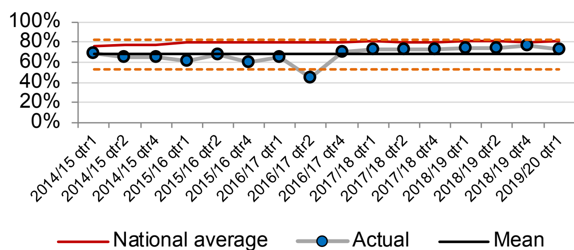


Quality Indicators

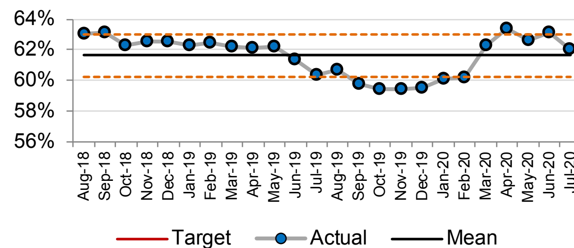
Caring

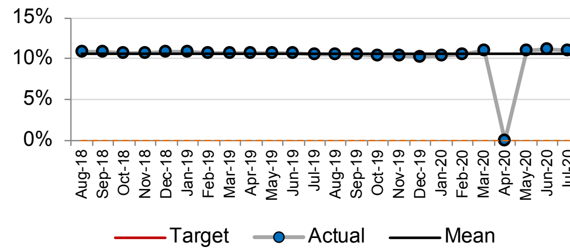




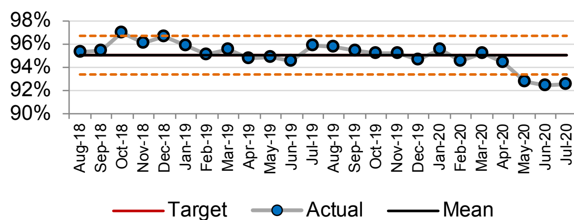


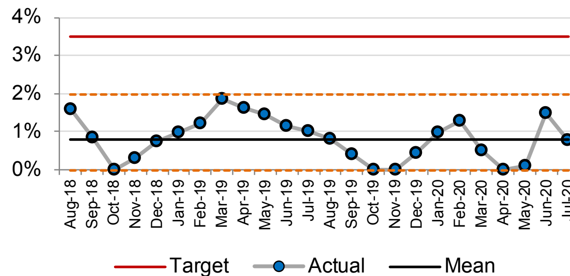
Effective





Responsive





Appendix 3 – Data Quality Kite Mark

Background

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

Approach

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

Data Quality Indicator	Definition	Not yet assessed	Sufficient	Insufficient
Timeliness	Is the data the most up to date and validated available from the system?	Not yet assessed	The data is the most up to date available.	Data is not available for the current month due to the time taken to extract / prepare from the system.
Audit	Has the system or processes used to collect the data been subject to audit (Internal Audit/ External Audit / self-audit) in the last 12 months?	Not yet assessed	The system and processes involved in the collection, extraction and analysis of the data have been audited and presented to the oversight committee.	No formal audit has taken place in the last 12 months. Exceptions have been identified and corrective action has not yet been implemented.
Source	Is the source of the data fully documented and understood?	Not yet assessed	All users understand how to extract the data in line with the indicator definition. The data source is well documented in the event that there is a change in personnel producing the indicator.	The data source is poorly documented and could be inconsistently extracted.

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

KPI Data Quality Reviews

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

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 1 September 2020

Flu 2020 vaccination programme update and COVID vaccine preparedness report

Purpose of Report

The report is to provide an overview of the plans and preparation to deliver the trusts comprehensive flu vaccination programme commencing in September 2020. In addition the trust has been engaging and contributing to national and regional plans to prepare for a COVID vaccination programme.

Executive Summary

The flu delivery programme has evolved significantly this year and incorporates significant learning from the delivery of antibody and antigen testing programmes.

Derbyshire Healthcare NHS Foundation Trust (DHCFT) achieved a 71.9% vaccination rate in 2019/20, whilst this was an improvement on the previous year (up from 54%) it was below the Trust’s ambition. This year we are in a position to offer every staff member a vaccine.

This year’s approach has been developed in partnership with Derbyshire Community Health Services NHS Trust (DCHS) and we are sharing a platform developed by the DHCFT Information Management and Technology team to reduce physical touch points, improve planning and efficiency and give a clear reporting framework from booking through to administration.

The flu programme for 2020/21 is designed to;

- Ensure every colleague within DHCFT has access to a Flu vaccine
- Ensure that COVID infection prevention and control (IPC) measures are of the highest standard and incorporated into all aspects of the programme
- Ease of access and use has been developed with the added benefit of reducing touch points from an IPC point of view
- Increased cold storage and forward planning of allocation of vaccines have been included to support management of medicines and reduce waste
- E-learning programme developed to enable COVID secure training can be delivered to assure colleagues competency
- Additional staffing resource is being sourced to support delivery and minimise impact on business as usual services
- Ensuring model supports requirements of COVID vaccination programme
- Sharing learning and overcoming barriers to STP delivery approach within the local health system.
- Working closely with partners in DCHS where the medicine code allows, and escalating aspects which need national framework review through regional system calls.

Vaccination for our high risk client;

- Mental Health patients are not an identified at risk group targeted by Public Health campaigns
- DHCFT has purchased 1000 vaccines to support identified high risk users in substance misuse services, Acute Adult and Older Adult services and Clozapine and Depot clinics.

The potential COVID vaccination programme;

- DHCFT is partaking in the national and regional planning meetings
- Flu preparedness and rapid delivery of vaccination programme are integral to COVID vaccination planning
- Emerging detail and timescales are being factored into local system plans
- Deep cold storage will be required and facilitated at a regional level (-70 degree Celsius)
- Trust working to contribute to administration programme as more details emerge
- Several vaccines are under development and at various stages of clinical trial approval – details of the proposed programme are still emerging.

Strategic Considerations	
1) We will deliver **great care** by delivering compassionate, person-centred innovative and safe care	Y
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	Y
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	Y

Assurances

- Compliance with COVID-19 IPC guidance and staff safety are core to model
- Ambition is to vaccinate all staff (we have vaccine capacity to do this)
- Systematic approach being taken and transparent reporting of those booked in and those who have attended
- Cold store issues and medicines management integral to model to avoid waste and efficiency
- Regular updates using Assurance tool are being submitted to STP Flu Cell monthly.

Consultation

- Colleagues through the anti-body and antigen testing models provided valuable feedback regarding approach and learning
- Review of previous season's performance and opportunities for improvement.
- Discussions with colleagues at DCHS
- Guidance and support from Pharmacy department
- Discussions with people services and contracting team in regards to collegiate working and legislative challenges.

Governance or Legal Issues

- Adherence to the Medicines Act legislation
- Green Book Immunisation guidance
- COVID-19 Infection prevention Control guidance
- Trust strategy 2020.

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

- In light of the high level of concern related to COVID-19 transmission risk the approach to flu planning has been underpinned by IPC guidance compliance. In addition the respective needs of all staff have been considered and the ability to access clinics which are socially distanced, IPC compliant, able to offer time and one to one support for those with significant health concerns vulnerabilities if required (longer appointment etc) have been factored in
- The team have consulted with a cross section of the Trust who have attended for anti-body and antigen testing, this has included a diverse range of staff demographically and professionally, their observation and comments have informed the approach being taken
- The IPC guidelines are intentionally rigid in order to protect all people within our community. Our clinic sites are in access able ground floor sites with adjacent parking / transport links. There are opportunities ahead of booking or attendance to speak to someone about specific requirements and these will be accommodated wherever possible or a suitable alternative explored (egg free vaccine is a known challenge).

Recommendations

The Board of Directors is requested to:

1) Review the contents and approach being undertaken by the Trust.
2) Comment in regards to whether assurance that adequate protection has been considered
3) Review progress against trajectory at November Board meeting.

Report presented by:	**Jaki Lowe** **Director of People and Inclusion**
Report prepared by:	**Richard Morrow** **Assistant Director of Public and Physical Healthcare**

Flu Campaign and COVID Vaccination preparedness 2020/21 DHCFT

The 2020/21 campaign is set to run between September 2020 and February 2021 with a National aspiration to vaccinate 90% of the NHS workforce across all sectors. DHCFT achieved 71.9% in 2019/20 having increased uptake from 54% the previous year. In addition there are preparations to enable deployment a COVID vaccine being worked through regionally and nationally.

CCG5: Staff flu vaccinations NHS

Scope
Services: Acute, community, mental health, ambulance.
Period: Q1 Q2 Q3 Q4

Payment basis
Minimum: 70%
Maximum: 90%
Calculation: Whole period %

Accessing support
NHSE&I policy lead
Doug Gilbert
england.uecdeliverypmo@nhs.net

Supporting documents
ImmForm Guidance
Green Book
NICE Guideline NG103

Data reporting & performance
Monthly provider submission (between September and March) to PHE via ImmForm. See: Guidance
Data will be made publicly available approximately 6 weeks after each quarter.

Performance basis: Whole Period. Quarterly reporting not suitable due to cumulative nature of measure. See section 3 for details about the basis for performance and payment.

Description
Achieving an 90% uptake of flu vaccinations by frontline staff with patient contact.

Numerator
Of the denominator, those who receive their flu vaccination.

Denominator
Total number of front line healthcare workers between 1 September 2020 and February 28th 2021.

Exclusions
- Staff working in an office with no patient contact.
- Social care workers.
- Staff out of the provider for the whole of the flu vaccination period (e.g. maternity leave, long term sickness).

www.nhs.uk 21

The Flu reporting period will begin in Q3 and run into Q4. In light of the National Pandemic response to COVID-19 and significantly increased health concerns about respiratory disorders and illness it is assumed that everyone who works for the trust (all colleagues groups) will want and have access to a vaccine. We have ordered 2625 vaccines for 2639 colleagues. We have to date been unable to obtain egg free vaccines as these are not currently available to order, this appears to be a regional challenge. Occupational Health services are unable to provide these so we will be referring these colleagues to their GP.

The delivery schedule for Quadrivalent Vac's was confirmed on 18/7/2020 as;

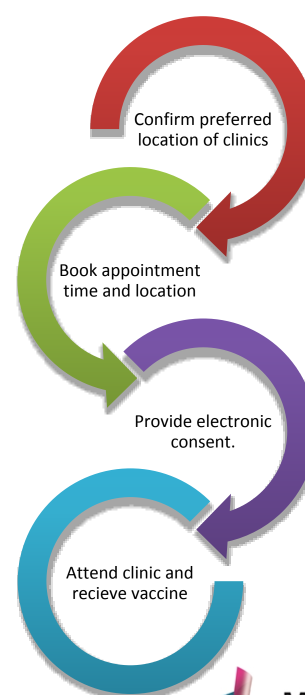
Date	18/9/2020	22.09/2020	9/10/2020	23/10/2020	6/11/2020
Quantity	630	125 – Trivalent for over 65's	500	630	740
%	25%	100%	20%	25%	30%

We expect to have vaccinated 90% of the team at DHCFT by 20/11/2020.

The method
The experience gained during the national level 4 incident in regards to antigen and antibody testing clinics has seen rapid learning to realise IPC compliant and efficient clinic models which:

- Identify likely numbers per location via an online survey – Being rolled out (21/08/20)
- Pre-book appointments to allow clinics to match demand. In development for launch early September.
- Virtual registration and consent process to manage IPC concerns / streamline process.
- Allocated vaccine awaiting colleagues on attendance. Clinics starting as vaccines arrive.
- Support vaccinators to manage capacity and demand and rapid administration of vaccines.

The clinics will utilise a locally developed system of booking, administration, logistics oversight and internal reporting which are adapted to suit a flu clinic approach. This gives opportunity to deliver high turnover clinics with minimal contact points. **DHCFT are working**



closely with DCHS to develop a collegiate delivery programme for colleagues across both organisations.

The model from our Occupational Health Provider (UDHB) is limited compared to previous years. It is anticipated that they will be supporting those with specific health requirements such as needle phobia, we have also agreed a support package with THRIVE via the Health and wellbeing team as well as for those who are in a high risk category.

All clinics will have access to full PPE for administrators and vaccinators and those attending the clinics will have access to face masks as per IPC guidelines. Enhanced cleaning and products to wipe down and maintain cleanliness will be available, alongside enhanced cleaning of the areas prior to and following the clinics.

This is a key focus of this year's approach and whilst IPC considerations have been at the forefront of previous years peer vaccinator approaches, this year we have taken additional steps to make sure that all colleagues will feel safe to attend. In order not to make the clinics impersonal we will be seeking to ensure that colleagues know who the 'people behind the mask' are as part of our Communications strategy. The Flu campaign is committed to ensuring that the trusts **People First** commitment is core to all messages.

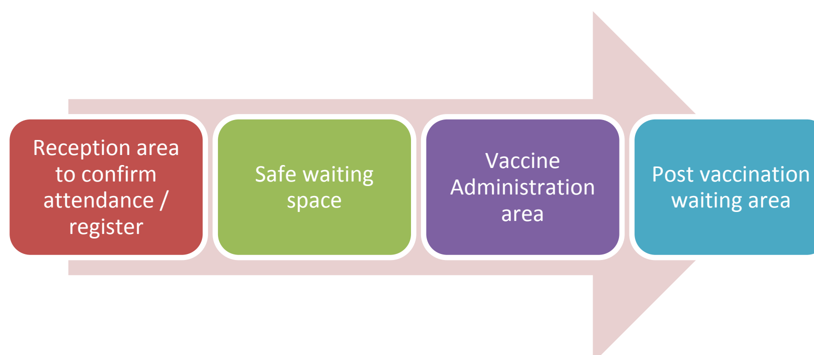
We have already begun to develop a Frequently Asked Questions (FAQ's) based upon initial questions and feedback from colleagues and we will evolve this as the programme develops. Colleagues are interested in the relationship between the Flu and COVID-19, the potential association with future COVID-19 vaccination programme and also the perceived risk that the Flu vaccine may increase the potential for colleagues to contract COVID-19.

Communications

The trust will utilise its social media platforms (Facebook, Twitter, LinkedIn) and communications team to ensure colleagues are aware of how and when to book into clinics. We have already initiated Comm's alerting colleagues to the plan to enable access as widely and easily as possible and have we are responding to comments from colleagues raised through social media or direct feedback and adapting the FAQ's as we go.

The communication strategy for 202/21 is intentionally simple; the focus is on ease of access, safe attendance and administration – the visual campaign is simply the arm of a health care worker ready to receive their vaccine. From a people first perspective we are seeking to be inclusive and additionally want to focus on the people behind the masks in subsequent communications to colleagues to reaffirm the importance of IPC, but also not to lose the compassionate reasons that underpin why we are seeking to vaccinate everyone. As in previous years, colleague's stories will be a key part of the communication strategy and will be shared along the way.

Clinic settings



Currently we have a number of sites across Derbyshire which have been vetted for suitability. This is being explored jointly with DCHS. A questionnaire has been launched to confirm where colleagues are likely to attend to match capacity and demand to clinic locations.

- The clinic settings provide a clean room in line with COVID-19 IPC clinical guidance for the administration of vaccines and account for privacy and dignity requirements.
- As the clinics will be operating a high throughput model there needs to be sufficient room for people to wait in a socially distanced and comfortable manner.
- Separate access and egress points and flow have also been provided.
- The clinics will have adequate cold storage capacity for the flu vaccines and fridges will be temperature checked and monitored in accordance with the medicines code.
- Anticipating that a COVID vaccine may be approaching release the database of vaccinated colleagues will be able to indicate when someone had their flu vaccine so that any mandated time periods between Flu vaccine and COVID vaccine administration can be accounted for.
- The model DHCFT have developed and shared alongside DCHS would be applicable to other vaccination programmes and utilises a method that can be easily adapted to suit.

Resources

The approach utilises some peer vaccinators (released from usual duties) and some bank nursing colleagues who are being recruited for the sole purposes of providing clinic support. The vaccinators will be released for attendance at the bookable clinics and matched to the capacity requirements of the clinic. This is to enable the clinics to be accessible, efficient, IPC compliant and minimise disruption to service delivery.

The option for colleagues to attend in an ad hoc fashion (drop in or pop up) is also available so that we do not limit the opportunity for people to attend but in order to manage the IPC challenge of large unregulated attendances this will be mitigated through comm's and the offer of ease of attendance through the booking system. In-Patient colleagues will have on site vaccinators able to facilitate vaccines in pop up clinics; we will have similar provision for trust induction.

The written instruction has been reviewed ahead of the vaccination programme and new and existing vaccinators will be inducted to assure competency and awareness of the systems and processes to allow safe and effective administration. A revised training package has been devised using a blended learning model of e-learning, MSM TEAMS group calls for questions and clarification of expectations and small group sessions for those who need additional information or support.

Patient vaccinations

We are targeting Flu vaccination for our known high risk patients this year. This includes our high risk service users in substance misuse services, those who attend the Depot and Clozapine clinics and our Older Adult and Adult Acute inpatient services. We encourage all care coordinators to advocate for their patients to access a flu vaccine through their local GP and Community Pharmacy services. PHE do not currently identify SMI or specific mental health conditions within the at risk groups.

COVID vaccine programme

There is significant national planning and infrastructure work to ensure the NHS is able to deliver a widespread vaccination programme when a COVID vaccine is released for clinical use. The trust is liaising at National and regional level to ensure we are part of those preparations. At this stage the Flu programme work is underpinning regional efforts to become system ready for a mass administration programme. DHCFT are part of the discussions, work and exploration to remove barriers which may inhibit a rapid and widespread roll out. The information is evolving rapidly as vaccines are at various stages of clinical efficacy trials currently. Whilst specific details are emerging the trust is fully engaged and working to ensure we are ready alongside system providers.

IT system support and external reporting

DHCFT's Information management and reporting team have been instrumental to delivering the proposed model and enabling an efficient, user friendly and most importantly a minimum touch point system from an IPC

perspective. We are confident we can meet the reporting requirements in a timely, transparent and clear manner.

The regional Flu vaccination group are meeting weekly currently and have a reporting format in place to support organisations to demonstrate progress and escalate any local challenges. DHCFT have worked closely with DCHS and are sharing learning within the cell to ensure that we learn from and contribute to system wide learning.

Challenges
The specific challenges around the legislation of the Falsified Medicines Directive, the Medicines Act Wholesalers Dealers Licence and the Authority to administer legislation have been escalated to NHSI/E. Despite a best intent to work through these issues we are mindful of the limitations in place as we approach the September start date so have agreed with DCHS that we will share IT platform and clinic spaces and support each other wherever else we can.

Local leadership
The programme has DHCFT Executive leadership from Jaki Lowe (Director of People and Inclusion) and is supported by;

- the Infection Prevention and Control team,
- Information Management and technology team,
- Peoples services,
- Pharmacy department,
- Communications Team,
- the Peer vaccinators,
- Flu clinic administration team
- and working in partnership with colleagues in DCHS.

Thank you for taking the time to read this paper and we look forward to updating you on the progress we have made to have vaccinated 90% of our colleagues by 20/11/20.

Report prepared by Richard Morrow – Assistant Director of Public and Physical Health Care, 27th August 2020.

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 1 September 2020

WRES 2019-20 and WDES 2019-20 update

Purpose of Report

To update the Trust Board on progress with the work on the 2019-20 Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) submissions.

To request Board delegated authority for People and Culture Committee meeting on 22 September to approve the October submissions.

Executive Summary

The WRES has nine evidence-based indicators focusing on the experience of Black and Minority Ethnic (BME) colleagues in the workplace. The WDES has ten evidence-based indicators to compare experiences of disabled/non-disabled staff. (For ease of reference these are listed alongside each other at the end of the report.)

NHS organisations must initially submit the relevant WRES and WDES datasets to NHS England by 31 August 2020. Subsequently, the data must be published on our external website by 31 October 2020 and shared with commissioners as part of the quality schedule.

For the October deadline alongside the data on our website we will publish our action plans (which are currently being updated by the BME Network and the Disability and Wellness Networks).

We will also produce infograms to communicate the performance for each indicator within the WRES and WDES and how they compare to the previous year's information.

In terms of progress to date: First drafts of the WRES and WDES reports, their associated action plans and infograms have been prepared. Iterations have been discussed with BME and Disability and Wellness Staff Networks, the Executive Leadership Team and the Equality Forum. The final iterations will go to People and Culture Committee on 22 September for approval, before submission in time for 31 October deadline.

At the 3 November meeting, the Board will then receive updates from the 22 September People and Culture Committee meeting regarding the 2019-20 WRES and WDES indicators highlighting the key areas of improvement and areas for further improvement along with the actions plans and infograms.

This will enable the Board to reflect further on what the data reported tells us about the relative experiences of our BME and disabled workforce colleagues within Team Derbyshire Healthcare when compared to our vision, values, our inclusion strategy and wider inclusion ambitions as well as the NHS People Plan.

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

WRES and WDES oversight and delivery is overseen by the Equality Forum and Executives.

Consultation

Consultation to date: Relevant staff networks, the Equality Forum and the Executive Leadership Team.

Governance or Legal Issues

- WRES and WDES reporting is mandatory requirement of the NHS contract
- Demonstrates commitment to Equality Act 2010 and Public Sector Equality Duty.

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 WRES and WDES are an important and wide-ranging set of indicators related to the protected characteristics concerning race and disability. The importance of intersectionality must also never be forgotten.

The indicators themselves help us to understand if and where there are differences in experience and the associated risks and inequalities that need to be addressed. The ability to know the levels of completeness in declarations/data capture is also an important indicator of how strongly our people feel confident to be their true selves in Team Derbyshire Healthcare.

The movement over time in the indicators illustrates trends and assists in us considering whether the actions we are taking to date are having a positive impact.

Although the WRES and WDES are specific to two protected characteristics they are arguably created by everybody in Team Derbyshire Healthcare whatever their race or dis/ability. Understanding and improving WRES and WDES explicitly help us meet our Equality Act duties of:

- identifying barriers and removing them before they create a problem,
- increasing the opportunities for positive outcomes for all groups and
- using and making opportunities to bring different communities and groups together in positive ways.

Recommendations

The Board of Directors is requested to:

1) Give delegated authority to People and Culture Committee on 22 September to review and sign off the 2019/20 WRES and WDES submissions
2) At the November Board meeting, to consider the strategic implications of the outcomes of the 2019-20 WRES and WDES indicators and their action plans in light of the Trust vision, values and inclusion priorities and People Plan.

Report presented by: **Claire Wright**
Deputy CEO and Finance Director

Report prepared by: **Claire Wright**
Deputy CEO and Finance Director

The indicators are described below:

WRES INDICATORS	WDES INDICATORS
1. Overall BME representation in our workforce and across the bands 2. White candidates are x times more likely to be appointed from shortlisting compared to BME candidates 3. BME staff are x times more likely to enter the formal disciplinary process compared to white staff. 4. White staff are x times more likely to access non-mandatory training and CPD compared to BME staff 5. The percentage of BME staff experiencing harassment, bullying or abuse from patients, relatives or the public 6. The percentage of BME staff experiencing harassment, bullying or abuse from staff 7. The percentage of staff believing that the organisation provides equal opportunities for career progression 8. Percentage of BME staff experiencing discrimination at work from manager/team leader or other colleagues in the last 12 months 9. The difference between our voting Board and overall workforce is x%	1. Representation of disabled staff in our overall workforce and across the bands 2. Non-disabled staff are x times more likely to be appointed from shortlisting compared to disabled staff 3. Disabled staff are x times more likely to enter the formal capability process compared to non-disabled staff 4. Percentage of staff saying the last time they experienced harassment, bullying or abuse, they or a colleague reported it 5. Percentage of staff believing the Trust provides equal opportunities for career progression 6. Percentage of staff saying they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties 7. Percentage of staff saying they are satisfied with the extent to which the organisation values their work 8. Percentage of disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work 9. Staff Engagement score - NHS Staff Survey results 10. The difference between our voting Board and overall workforce is x%

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 1 September 2020

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

Purpose of Report

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

Executive Summary

This report sets out the number and types of cases and concerns raised in the last six months with the FTSUG. There has been a decrease in the number of cases (individuals) approaching the FTSUG in the last six months compared to the previous six months. This is fall in cases has been seen by some FTSUGs during the pandemic.

A number of emerging themes include:

- **COVID-19 related staff safety and wellbeing:** 17% of all concerns (recording from mid-March onwards) related to the coronavirus pandemic and staff safety and wellbeing. Workers spoke up about redeployment, PPE regulations, self-isolation and social distancing, working from home, the safety of, and risk to, others in the home and risks to Black Minority Ethnic (BME) staff.
- **Inclusion:** BME workers in particular spoke up about a wide range of concerns including wanting to see greater diversity amongst more senior roles in our Trust. Some workers have felt that the pace of change within the NHS is too slow and this has been further highlighted following the Black Lives Matters demonstrations.

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

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

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

Risks and Assurances

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

The Board will be carrying out a refresh of a previous self-review of FTSU based on the updated NHSI toolkit issued in July 2019. Although this review has been delayed, the Audit and Risk Committee continues to monitor the progress of the FTSU action plan. The toolkit provides a benchmark and assurance that work to promote and respond to speaking up at work is progressing.

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

Consultation

Executive Leadership Team.

Governance or Legal Issues

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

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

The report discusses issues around workers with protected characteristics who have approached the FTSUG in relation to the inclusivity of recruitment processes.

Recommendations

The Board of Directors is requested to:

1. Support the current mechanisms and activities in place for raising awareness of the FTSU agenda.
2. Discuss the report and determine whether it sufficiently assures the Board of the Freedom to Speak Up agenda at the Trust and that the proposals made by the Freedom to Speak Up Guardian promote a culture of open and honest communication to support staff to speak up.
3. Support the development of a more interactive and accessible communications route for Speaking Up through the use of a Trust Speaking Up App for workers.

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

Derbyshire Healthcare NHS Foundation Trust
Freedom to Speak Up Report

1. Introduction

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

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

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

1.4 The report covers Quarters 4 of 2019/20 and Q1 of 2020/21. Reporting to Board is on a six-monthly basis.

2. Aim

2.1 This report aims to provide the Board with:

- Information on the number and types of cases being dealt with by the FTSUG and themes identified from January to June 2020.
- Information on what the Trust has learnt and what improvements have been made because of workers speaking up
- Actions taken to improve FTSU culture in the Trust, including progress in the promotion of the FTSUG role and addressing barriers to speaking up
- updates from the National Guardians Office (NGO)
- Key recommendations

3. Summary of concerns raised

3.1 Concerns are categorised in accordance with NGO guidance. The NGO requires concerns relating to patient safety, bullying and harassment, anonymous concerns and those suffering detriment as a result of speaking up to be recorded.

3.2 Table 1 shows that the FTSUG has seen a significant drop in number of cases (individuals) approaching in Q4 2019/20 (75 cases) in comparison to Q1 2020/21 (26 cases). There could be a number of explanations for this reduction:

- Q4 included a team of individuals Speaking Up (logged as 22 cases) which escalated reporting numbers from the more usual 50 cases.
- altered working conditions for workers with reduced face-to-face contact and therefore possibly less relational workplace issues with workers redeployed or working from home.

- a surge in information sharing/communication with workers during the pandemic, including through the staff Facebook page where staff have regularly raised issues and generally received a prompt response.
- 4 week absence of the FTSUG. Staff were signposted to the Trust Secretary and through the FTSU champions.
- FTSUG working from home during Q1 and unable to promote the role in the usual face-to-face settings which is of particular importance for more vulnerable groups less likely to use electronic communications methods.

Cases have remained similar to Q1 in Q2 with 20 cases recorded by mid-August 2020.

Table 1: FTSU Data Q4 2019/20 and Q1 2020/2021

Types of Concerns	**Q4 2020 Jan – March**	**Q1 2020 April – June**
Attitude and behaviours	27	9
Culture	28	8
Policies, processes and procedures	21	7
Health and safety	1	0
Staff safety and wellbeing	15	10
Bullying and harassment	**13**	**7**
Patient safety and quality	**7**	**1**
Availability of managers	0	1
Performance	1	0
Fraud or criminal offence	0	0
Total cases reported to FTSUG*	**75**	**26**
Public Interest Disclosure Act concerns	**20**	**8**
Reportable to NGO: Bullying and Harassment / Patient Safety	**20**	**8**
Anonymous	**0**	**0**
Person indicates suffering a detriment as a result of speaking up	**0**	**0**
Number of cases that have received feedback	**73**	**25**

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

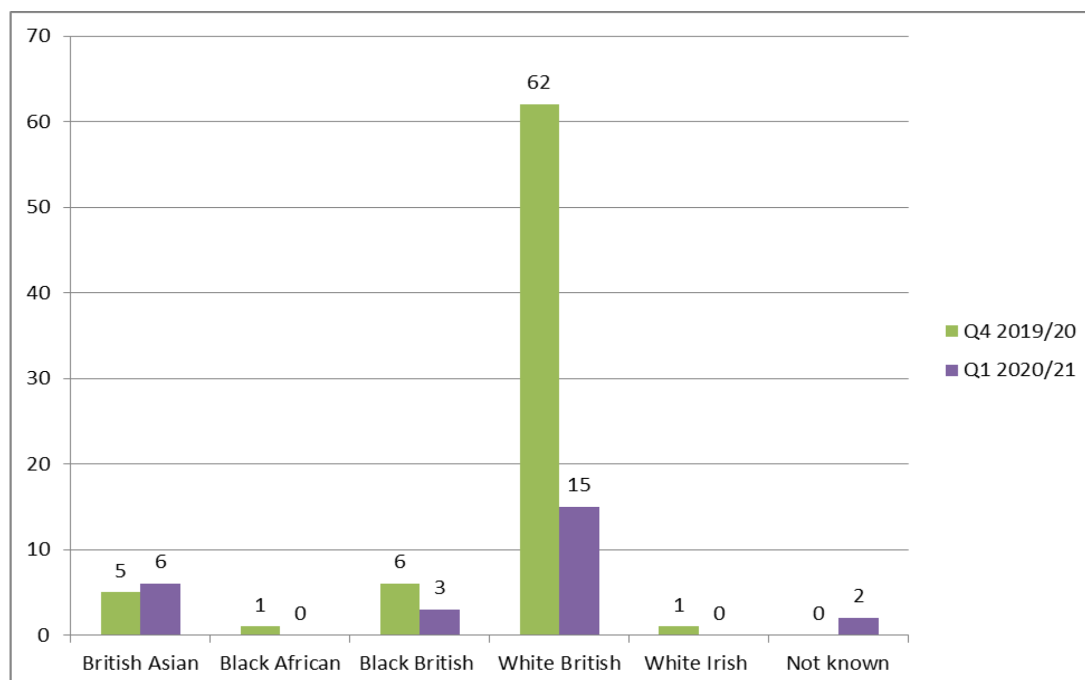
3.3 **Professional groups:** Across Q4 and Q1, 21% of cases are from Administrative and Clerical workers in the Trust and this is higher than the 16% seen across NHS Trusts in England as reported by the NGO for 2018/2019. In Q4, Administrative and Clerical cases were at 32% which is double the national average. Estates and Facilities workers have not approached the FTSUG in Q1 and this may be due to the face-to-face contact that is normally used to engage with workers in these areas which did not take place in Q1 due to COVID-19. In Q1, Medics have approached Senior Leaders and these concerns have been logged through the FTSUG. This is the first time that medics have been logged with the FTSUG.

Table 2: Cases raised per professional group for Q4 2019/20 and Q1 2020/21

Professional Group	Q4 2019/20 No of Cases	Q1 2020/21 No of Cases	Total percentage Q4 and Q1	NGO 2018/19 %
Administrative/clerical staff	14	7	21%	16%
Allied Healthcare Professionals	14	5	19%	14%
Board members	0	0	0	0
Cleaning/catering/maintenance/ancillary	4	0	4%	4%
Corporate services	0	0	0	0
Doctors	0	2	2%	7%
Healthcare assistants	12	3	15%	9%
Nurses	27	6	33%	30%
Pharmacists	1	3	4%	--
Other (includes anon)	3	0	3%	1%

3.4 **Ethnicity of workers:** Of workers approaching the FTSUG in Q4 (2019/20) and Q1 (2020/21), 21% identified as BME (an increase of 2% from Q2 and Q3 of 2019/20) and 77% identified as White British/European/Other. The latest Workforce Race Equality Standards (WRES) figures for the Trust indicated that 17% of our workforce identify as BME. In Q1, 35% of workers approaching the FTSUG came from a BME background and in Q4, this was 16%.

Fig 1: Ethnicity of workers speaking up Q4 2019/20 and Q1 2020/21



3.5 **Patient safety and quality issues:** Patient safety concerns during Q4 and Q1 were limited to 8 cases. In comparison to FTSU data for Acute Trusts, Mental Health Trusts have far fewer patient safety concerns. Patient safety concerns are directed to the Director of Nursing and Patient Experience and/or to the Medical Director. Anonymised details of these concerns are shared with the Risk and Assurance Manager to more effectively triangulate data.

3.6 **Bullying and Harassment:** Perceived bullying and harassment concerns represented 17% of the total concerns raised in Q4 (2019/20). In Q1 this rose to 27% which reflects Q3 (2019//20) levels. This was not expected by the FTSUG given the reduced level of relational contact through staff redeployment and staff working from home. However, on a positive note, Bullying and Harassment levels are lower than the NGO average at 41% (2018/19 FTSUG Survey data) and the FTSUG continues to positively promote the Trust's Dignity at Work policy and the Bullying and Harassment booklet sending electronic copies to all workers who require the information when speaking up. It is still hoped that a specialist course around workplace bullying and harassment will be developed and delivered to all Speaking Up Champions during Q3 of 2020/21.

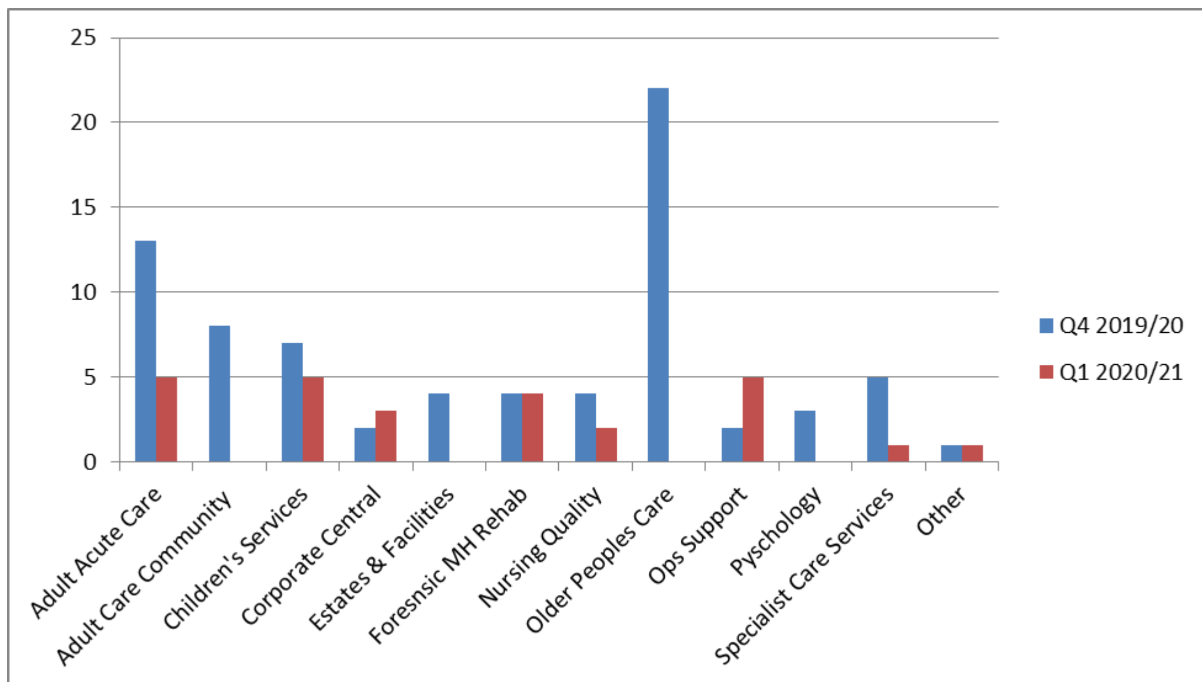
3.7 **Anonymity:** No workers spoke up anonymously directly to the FTSUG, although several asked to preserve their confidentiality when raising issues and this is often because they feel they could suffer a detriment for speaking up. A few cases were also logged with the FTSUG where the identity was known to the senior leader providing the concerns so these have been recorded as confidential as opposed to anonymous where identity is not known.

3.8 **Detriment:** No workers have reported that they have suffered a detriment for speaking up although some have expressed that they fear suffering a detriment. The NGO are looking more closely at fear and detriment and how this might be recorded more effectively.

3.9 **Why do workers approach the FTSU?** 90% of workers had raised their concerns elsewhere across the Trust with Line Managers or senior leaders and were looking for further support and advice and to escalate issues further. In 29% of cases this was because they had already escalated the issues but had not got the outcome they had hoped for.

3.10 **Concerns raised by areas:** During Q4 (2019/20 and Q1 (2020/21), Older Adult Care provided the greatest number of cases at 22% of the total, followed by Adult Care Acute with 18%. The increased numbers from Older Adult Care was due to the logging of a team speaking up in Q4 – teams must be logged by numbers according to NGO guidance.

Fig 2: Division areas for Q4 2019/20 and Q1 2020/2021



4. Emerging or ongoing themes with learning points

4.1 **Rolling Action Plan:** The FTSUG has produced a rolling action plan which documents current themes, actions taken and any outcomes. Ownership is held by the Executive Lead for Speaking Up, The FTSUG with oversight from other senior leaders including the Director of People and Inclusion.

The Director of People and Inclusion, Trust Secretary and FTSUG will meet in September to discuss the rolling action plan in greater detail.

4.2 COVID-19 related staff safety and wellbeing: 17% of all concerns (recording from mid-March onwards) related to the coronavirus pandemic and staff safety and wellbeing. Workers spoke up about redeployment, PPE, self-isolation and social distancing, working from home, the safety of, and risk to, others in the home and risks to BME staff.

Learning point: all COVID-19 concerns have been addressed as a matter of urgency by senior leaders through the Incident Management Team (IMT). Concerns were excellently handled with evident empathy. Staff also had the opportunity to use the Team Derbyshire Healthcare Facebook page (50% of the workforce are members) as a forum to raise concerns and again these were promptly handled.

4.3 Inclusion concerns:

Predominantly BME workers have been speaking up about a number of concerns around:

- perceived lack of progression pathways in relation to development opportunities for BME staff within the Trust
- impact of relationships with non BME managers in relation to carrying out the COVID-19 related BME staff risk assessment
- lack of BME staff in senior leadership positions
- inclusivity of the recruitment process
- concept of 'white allies' and what this means and might look like in the Trust.
- perceived slow pace of change within the NHS particularly in light of the Black Lives Matters demonstrations.
- disproportionate impact of coronavirus on BME workers.
- apparent lack of representation at IMT from staff networks and within restoration and resolution.

Learning points: BME risk assessments in relation to COVID-19- concerns were raised and were already being addressed by the Trust's BME network in conjunction with the Chief Executive. Supportive letters were sent out to all BME staff across the Trust who were asked to complete a risk assessment with their Line Manager, or other supportive leader, in order to identify any impact on their wellbeing and levels of risk. Managers and leaders were also invited to attend an online training session around the risk assessment. Derbyshire Healthcare was the first NHS Trust to produce a risk assessment for BME staff and have actively shared this document and associated good practice with other Trusts. The FTSUG has also engaged with the NGO webinars on COVID-19 and its impact on BME staff.

The BME conference of Autumn 2019 created a comprehensive set of actions including the introduction of Recruitment Inclusion Guardians (RIG) to the recruitment process for posts band 7 and above. This is to help increase diversity across the workforce. All Band 7 posts now include a RIG in the shortlisting and as a panel member. Guardians act as critical friends to the organisation's equality, diversity and inclusion recruitment process. They have been trained to take an active part in the recruitment and selection process and to offer challenge and reflection to recruiters and share learning. The impact of the actions of the RIG will be considered at the Trust's BME conference.

The Trust has also recently launched a draft Inclusion Strategy and produced an Inclusion video.

The FTSUG holds regular meetings with some BME staff network members as well as the Trust's Workforce Race Equality Standards (WRES) expert. On 15 June 2020, Dr Henrietta Hughes sent a joint letter with the NHS WRES Team urging leaders in health to assure themselves that all workers feel free to speak up within their organisations, especially given the impact of COVID-19 on BAME workers. The joint letter suggested that WRES leads and experts should work together and the Trust's FTSUG and WRES expert have responded to this and now meet regularly to discuss and develop this. Below is a quote from the letter.

‘It is vital you are confident that all staff feel free to speak up within your organisation. At local level, we will be supporting WRES experts and Freedom to Speak Up Guardians to work together in partnership so that all staff, and in particular our BME staff, feel safe to speak up, knowing that the right actions will be taken.’

This has been identified and the FTSUG has asked the BME network to discuss what support the network needs.

The FTSUG is working with the Communications team to showcase the range and diversity of FTSU Champions in October 2020 during Speaking Up month. This maybe particularly important where colleagues from BME backgrounds feel they need to speak to a BME community members about their concerns as opposed to the FTSUG who is non BME.

The FTSUG also hopes to support training for Speaking Up Champions in Equality, Diversity and inclusion (EDI) Development and Cultural Competency.

The FTSUG is also working with another mental health trust the Black Country Healthcare Trust to consider the use of a web based reporting platform and app which will hopefully support more staff to engage with the speaking up process.

The FTSUG attends, when possible, a range of staff networks and the staff forum to engage with Equality, Diversity and Inclusion.

4.4 **Occupational Therapists** (OTs) have continued to express concerns regarding their role identity and assigned tasks particularly in acute ward settings and the impact this has on their wellbeing and also as professionals in being able to deliver effective care for patients. This is an ongoing theme as similar concerns were also raised in Q3. Concerns raised by Allied Healthcare Professionals (AHPs) in Q4 (18.7%) have increased relative to Q3 (9.6%). In Q1 these concerns were reduced due to reduced numbers of cases under the pandemic.

Learning point: There is ongoing work in place to look at OT concerns once services begin to restore and recover. The FTSUG meets regularly with the Trust’s OT lead. There is also a recognition that some universities now offer nursing skills within their OT training and that some of the tasks OTs are encouraged to carry out as part of their roles is reflective of the ‘new norm’.

4.5 **Culture: admin and clerical function**

21% of cases have come from administrative and clerical workers and involve a range of concerns which have been logged and escalated appropriately. Concerns were at 32% in Q4 but have dissipated during Q1 and lowered reporting due it is thought to the COVID-19 pandemic and reduced office based working. Nationally, the level of administrative and clerical workers approaching Guardians is 16%.

Action: Concerns relating to admin culture in some areas of the Trust were shared with the Executive Leadership Team (ELT) in January 2020. The

FTSUG has escalated concerns on an ongoing basis and some of the concerns have been supported by organisational effectiveness.

In September 2020, there will be a Microsoft Teams live engagement event for administrative and clerical staff which the FTSUG will attend to offer support for workers.

5. Improving Speaking Up Culture

5.1 **Impact of COVID-19 on speaking up:** the pandemic has had an impact on numbers of workers Speaking Up with individuals approaching the FTSUG reducing over Q1 and Q2 of 2020/21. Numbers of staff directly in the workplace decreased during the pandemic. The FTSUG has not had a regular face-to-face presence during the pandemic which enables engagement with teams and workers in harder to reach areas. The FTSUG was also absent for personal reasons throughout June which could also have impacted on numbers.

5.2 **Improving visibility and networking:** During the pandemic period, the FTSUG has promoted the speaking up role on the Trust's staff Facebook page and attended largescale MS Teams engagement events which have enabled the promotion of speaking up to large numbers of workers. On a positive note, these methods of staff engagement, have also allowed workers to raise concerns which have been promptly handled and responded to by senior leaders.

5.3 **Addressing barriers to speaking up:** In Q4, the FTSUG attended an Estates and Facilities team meeting to meet with workers who may not regularly access emails or electronic information. The FTSUG held regular meetings with the previous Head of Estates and Facilities to discuss opportunities for development and improvement of speaking up culture.

The FTSUG regularly engages with the Equality, Diversity and Inclusion Service including the WRES lead to address issues of inclusivity for all diverse groups.

In Q1, medics have spoken up – not directly to the FTSUG - but through senior leaders, who have brought concerns to be logged with the FTSUG. This is the first time that the FTSUG has been able to log medics concerns which is a positive result. The FTSUG continues to engage with and present at the Junior Doctor forums and will also present to Junior Doctors and medics on speaking up in October.

The NGO has run a series of webinars and a recent one, 'Engaging with Trainees', recognised that Junior doctors and trainees are one of the groups of workers which Freedom to Speak Up guardians often identify as a 'vulnerable group' – people who face additional barriers to speaking up because of perceived or actual repercussions for their career. Although trainees may be affected by hierarchies in an organisation, their "fresh pair of eyes" may also bring insight into ways to improve patient care and ways of working. During the webinar, Dr Henrietta Hughes was joined by

four Clinical Fellows from the Health Education England (HEE) National Medical Director's Clinical Fellow Scheme. They shared the findings of a focus group held with healthcare trainees and their perspectives as trainees in trusts and primary care on the barriers to speaking up. They discussed ideas on how to improve engagement between trainees and FTSUGs.

5.4 **Network of FTSU Champions**: The FTSUG has established fortnightly catch up meetings with Speaking Up Champions to share good practice, support any concerns or issues and to share NGO information. The FTSUG will be promoting the range and diversity of the Champions on the new Focus Intranet with a photo page and info about where the Champions are based.

5.5 **October 2020 Speak Up month:** The FTSUG is working with the Communications Team to discuss promotion of the role during this period.

5.6 **Non-Executive Directors:** the FTSUG is excellently supported by the Non-Executive Director (NED) lead for Speaking Up, Julia Tabreham and also from NED, Ashiedu Joel. The FTSUG has held meetings with both these NEDs and will continue to hold meetings with the NEDs and share FTSUG practice and areas for support and development.

6. Learning and improvement in relation to Speaking Up Culture

6.1 **CQC feedback on FTSUG:** During the latest Well led CQC inspection (January 2020), FTSU processes were assessed and received positive feedback.

The CQC report recorded that staff they spoke with *knew how to use the whistle blowing process. The Trust had a raising concerns policy and most staff felt able to raise concerns without fear of retribution.*

6.2 **Evaluation feedback on Speaking Up:** A short evaluation form for individuals who have spoken up is sent and responses received have been positive around the support provided for FTSU. In Q4 and Q1, 90% of respondents said 'yes, they would speak up again' and 10% said 'maybe'. One worker whose case was logged in Q1 has said informally in Q2 that they might choose not to speak up again due to their perception that their case has been handled slowly by management and Employee Relations. However, there is an understanding that many processes were put on hold during the COVID-19 period.

6.3 **Triangulation of data** has improved around patient safety with sharing of anonymised information with the Head of Risk and Assurance and the Lead for Patient Safety and Experience to make sure that patient safety concerns are effectively documented by the FTSUG.

6.4 **Speaking up training:** The NGO will release Health Education England (HEE) eLearning for workers at some point in 2020/21 – this has been placed on hold due to COVID-19. The FTSUG continues to present on Trust inductions. The FTSUG is also liaising with Derbyshire Community Health Services (DCHS)

eLearning who have developed a Speaking Up eLearning resource which they are keen to share with our Trust.

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

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

7 National Guardian's Office and related National Changes

7.1 **National FTSU Case Reviews**: The National Guardian's Office (NGO) has undertaken a case review of the handling of two speaking up cases referred to it by two workers from Whittington Health NHS Trust. The NGO undertook a review because the workers' referral information indicated the Trust's response to their speaking up had not been in accordance with its policies and procedures, or good practice. The office decided a review could provide potentially important learning for both the organisation and other NHS trusts.

What this means at Derbyshire Healthcare NHSFT (DHCFT); the case review recommendations have been reviewed by the FTSUG and shared with People Services Leads.

The report highlighted a number of issues including thanking people for speaking up. The DCHFT FTSUG always thanks workers for speaking up and uses the evaluation request email to re-thank workers so that this is documented.

The case review flagged up a number of issues around grievances and the learning from these has been discussed with People Services.

The case review also looked at Exit Interviews. At Whittington Health, one of the workers who spoke up about a range of matters and who raised a grievance about how the trust had responded to the matters they had raised was not offered an exit interview before they left the trust. This did not give them an opportunity to speak up and provide feedback about the trust's working culture, or the distress they experienced. All DCHFT workers are offered Exit Interviews and have the opportunity to the complete this form on line. In addition the Exit Interview Form also signposts to FTSUG support if it is needed.

7.2 The NGO's recently published Freedom to Speak Up Index, based upon a subset of questions in the NHS staff survey, shows that NHS Trusts with the highest index score are predominantly rated as good or outstanding by CQC . The Trust achieved 78.8% in 2019/20 and 77% in the FTSU 2018/19 Index which represents a slight increase. However, it should be noted that many FTSUGs have raised with the NGO how heavily reliant the index is on the NHS staff survey data. The NGO also writes, 'Measuring the effect of culture change can be difficult. The acid test is the view of workers. The NHS Annual Staff

Survey can help to give some indication as to whether Freedom to Speak Up is embedded within Trusts detailing whether staff feel knowledgeable, encouraged and supported to raise concerns and if they agree they would be treated fairly if involved in an error, near miss or incident.’

8. Conclusion

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

8.2 The Board needs to capitalise on this momentum and focus on driving the recommendations from this report forward with some meaningful and visible responses to Trust wide concerns.

9. Recommendations

The Trust Board is asked to:

1. Support the current mechanisms and activities in place for raising awareness of the FTSU agenda.
2. Discuss the report and determine whether it sufficiently assures the Board of the Freedom to Speak Up agenda at the Trust and that the proposals made by the Freedom to Speak Up Guardian promote a culture of open and honest communication to support staff to speak up.
3. Support the development of a more interactive and accessible communications route for Speaking Up through the use of a Trust Speaking Up App for workers.

Tamera Howard
Freedom to Speak up Guardian
Derbyshire Healthcare Foundation Trust

Derbyshire Healthcare
NHS Foundation Trust

Board Committee Assurance Summary Reports to Trust Board – 1 September 2020

The following summaries cover the meetings that have been held since the last Public Board meeting.

Audit and Risk Committee - key items discussed 2 July 2020
Review of Board Assurance Framework (BAF) The second issue of the BAF for 2020/21 was presented. The BAF will be refreshed as part of the Board's review of the strategic building blocks, extending the BAF beyond the current 'COVID response' format. The rationale around correcting some of the inherent risk ratings was explained. Discussions covered; an overview of the support being given to the Freedom to Speak Up Guardian role during the pandemic and the increase in previously unknown individuals accessing the Trust's services since the start of the pandemic. This was impacting admissions and there had also been an increase in seclusion and restraint. Both these issues were being looked at by the Medical Director and the broader implications would be considered by both the Quality and Safeguarding Committee and the People and Culture Committee.
Standing Financial Instructions (SFI) Waiver Report The Waiver Register report for quarter 4 2019/20 and quarter 1 2020/21 was presented. Additional information was sought on two individual waivers.
Internal Audit Progress Report The Internal Audit Progress Report was presented by 360 Assurance. The impact of the pandemic had delayed the initial delivery of the 2020/21 Internal Audit plan and these would be reviewed to ensure they are reflective of the current circumstances and remain risk based and meet assurance needs. The Committee considered a list of potential COVID-19 reviews in relation to governance, finance, clinical quality, performance and information, HR and IM&T. For the 2020/21 Head of Internal Audit Opinion, 360 Assurance will need to include an assessment on the Trust's governance, risk management and control arrangements in a period where there has been a global pandemic. The Committee summarised that the priority for 2020/21 is to have a core Internal Audit plan and ensure there are not any areas of exposure.
External Auditor's Annual Audit Letter Grant Thornton submitted the External Auditor's Annual Audit Letter which set out the unqualified opinion on the Trust's financial statements. Grant Thornton would work in handover to the Trust's new external auditors.
External Audit Contract This item was classed as commercial in confidence.
Key risks identified There would be a delay in revising the BAF but assurance was given that both the Incident Management Team and Board Committee continue to have oversight on the key strategic risks.

Decisions made

- Approval of the second issue of the BAF for 2020/21
- Agreement that the waiver report provided significant assurance on the process followed to approve and record waivers
- Noting of the external audit letter
- Agreement of a recommendation to the Council of Governors to appoint Mazars LLP as the Trust's external auditor from 1 September 2020.

Escalations to Board or other Committee

- None.

Next meeting – 1 October 2020

Committee Chair: Geoff Lewins	**Executive Leads: Claire Wright, Deputy Chief Executive and Director of Finance and Justine Fitzjohn, Trust Secretary**

Quality and Safeguarding Committee - key items discussed 14 July 2020

Board Assurance Framework (BAF)

The Committee regularly monitors the BAF risks allocated to it and considers them in the context of Committee discussions and work programme.

COVID-19 Summary Update

The report provided an update on specific quality, clinical and safety aspects of care provision. Areas covered were staff absences, use of 'Attend Anywhere' software for e-consultations, staffing and recruitment and the potential surge in cases of COVID-19, particularly amongst younger people. An increased demand for mental health services is currently being experienced and also emerging issues concerned with domestic violence.

A letter from the CQC reporting on the exemplary practice of the care and treatment of patients detained under the Mental Health Act (MHA) during the COVID-19 outbreak at Cubley Court was appended to the report which provided the Committee with full assurance of COVID-19 management at Cubley Court.

The Committee obtained significant assurance from the response being made to the pandemic with regard to ethical decision making.

Risk Register Escalation Assurance Quarterly Report

The report provided a summary of Trust wide/corporate risks and significant operational risks currently identified by service areas and teams. Although there had been a gap in formal reporting of risks to the Committee due to the lean governance in place following the response to the COVID-19 pandemic, oversight of the extreme/high risks had continued through the Chief Operating Officer and Deputy Director of Operations. The Committee agreed to reinstate quarterly reporting and considered that limited assurance had been obtained from the report due to gaps in formal escalation.

Serious Incidents Bi-Monthly Report

The report provided information relating to all Serious Incidents (SIs) occurring during 1 April to 29 June 2020.

Discussion took place on the significant amount of work to be undertaken to clear the accumulation of reportable incident investigation reports. It was acknowledged that a backlog is inevitable as a result of responding to COVID-19 emergency measures. This is being managed and will be absorbed in the coming months.

Significant assurance was received from the process of reporting. Limited assurance was obtained due to the small gaps in control related to overdue actions.

Ligature Risk Reduction - Six Month Summary Report The report updated the Committee with regards the safe management of anchor points and assurance of ligature risk reduction throughout the Trust and improvements that had been made. Trust procedures are well embedded. The assurance of a robust system and completion of actions are now in place. Some small delays have been experienced as a result of the COVID-19 pandemic and are being remedied. Significant assurance was received on improved procedures with limited assurance on the completion of the programme of actions. Therefore the ligature report will return to the Committee in three months as part of ongoing business as usual risk assessments.	
Annual Inquest And Claims Report The report detailed the number of inquests the Trust has had some level of involvement in during the last financial year and the number of Prevention of Future Death Reports ("PFD") for the Trust, benchmarked against all other mental health trusts. The Committee applauded the way that the Legal Service Manager takes a personal approach to supporting staff through what can be a stressful process. Statements are being requested at a much quicker rate and a surge in requests is anticipated following the recruitment of ten coroners for Derbyshire. Owing to the impact that COVID-19 will have on the court's listing and schedule, it is not known when this surge in demand may occur. The continued trend in coronial law to view PFD Reports was seen as a positive tool to improve patient safety. The Trust has been incredibly successful in its very low rate. It has been fed back that the Trust reports remain high quality and often identify their own learning, therefore preventing PFD by the nature of the Trust's learning. The Committee received significant assurance from the investigation process but was concerned that finding the resource to clear investigations will be extremely challenging as this is another burden for teams that are already overstretched.	
Escalations to Board or other Committee The People and Culture Committee will look at gaps in control in training and address the monthly targets to be set in recruitment.	
Next Meeting – 8 September 2020	
Committee Chair: Margaret Gildea	**Executive Lead: Carolyn Green, Director of Nursing and Patient Experience**

Finance and Performance Committee - key items discussed 28 July 2020
Assurance on Estate Strategy This report gave an update about the current situation with the dormitories and what is happening nationally and locally due to capital money being made available for the eradication of dormitories in mental health. The required resubmission will consider what work can be brought forward into 20/21. There will also be significant revenue cost and operational impacts to be further determined should the bid succeed.
Operational Performance This paper provided the Committee with an overview of operational performance up to the end of May 2020 using statistical process charts. Discussions focussed on factors relating to demand and capacity, both current and anticipated. The Committee confirmed the level of assurance to be limited based on current performance across the areas presented.

Financial Governance This report focusses on Financial Governance oversight including both revenue and capital and the financial impact of Incident Management Team decisions. There was particular focus on COVID-19 related costs which were the highest yet in month, including the impact of COVID-secure adjustments to inpatient provision and the resultant need for out of area placements. The Committee took significant assurance that appropriate financial governance is in operation under challenging circumstances. The Committee took limited assurance that the funding requested in the form of capital and / or revenue will be approved which could then present a risk if we have costs that are not funded.	
CIP and Continuous Improvement The report gave an update on the impact of the COVID-19 Incident Response on our existing and future Continuous Improvement, Transformation and Cost Improvement Programmes. The Committee noted the expectation that phase 3 planning guidance would arrive imminently. The Committee noted the extent to which previous improvement plans, business plans and the NHS long-term plan for mental health has influenced transformations delivered through the response phase and planned for the recovery phase.	
Discussion on Charitable Funds Position The Committee was asked to seek a view on whether to maintain status quo on arrangements with charitable funds or consider an alternative approach. It was agreed that in the context of the current situation with COVID-19 it was felt that this was important but could not be given greater resource or higher priority. The Committee therefore agreed to maintain the status quo with regard to charitable fund arrangements and to increase the visibility and reporting of the use of the funding we have received.	
Health and Safety Annual Report This report provided the members of the Committee with an Annual Health and Safety Report. The report outlines the activities and achievements in fire, health and safety, moving and handling and security management from 1 April 2019 to 31 March 2020. The Committee received significant assurance from the content of this report.	
Escalations to Board or other Committee None	
Committee Chair: Richard Wright	**Executive Lead: Claire Wright, Deputy Chief Executive / Director of Finance**

There have been no meetings of the Mental Health Act Committee or the People and Culture Committee to report on since the July Board. Their next meetings are 11 and 22 September respectively.

Derbyshire Healthcare NHS Foundation Trust

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS

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

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Term / Abbreviation	**Terms in Full**
CRG	Clinical Reference Group
CRHT	Crisis Resolution and Home Treatment Teams
CRS	(NHS) Care Records Service
CRS	Commissioner Requested Services
CSF	Commissioner Sustainability Fund
CTO	Community Treatment Order
CTR	Care and Treatment Review
D	
DAT	Drug Action Team
DBS	Disclosure and Barring Service
DBT	Dialectical Behavioural Therapy
DfE	Department for Education
DCHS	Derbyshire Community Health Services NHS Foundation Trust
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
EPRR	Emergency Preparedness, Resilience and Response
EPR	Electronic Patient Record
ERIC	Estates Return Information Collection
ESR	Electronic Staff Record
EUPD	Emotionally Unstable Personality Disorder
EWTD	European Working Time Directive
F	
FBC	Full Business Case
FFT	Friends and Family Test
FOI	Freedom of Information
FSR	Full Service Record
FT	Foundation Trust
FTE	Full-time Equivalent

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Term / Abbreviation	**Terms in Full**
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	Individual Performance Review
IPT	Interpersonal Psychotherapy
J	
JNCC	Joint Negotiating Consultative Committee
JTAI	Joint Targeted Area Inspections
JUCB	Joined Up Care Board
JUCD	Joined Up Care Derbyshire
K	
KPI	Key Performance Indicator
KSF	Knowledge and Skills Framework
L	
LA	Local Authority
LCFS	Local Counter Fraud Specialist
LD	Learning Disabilities
LHP	Local Health Plan
LHWB	Local Health and Wellbeing Board
LOS	Length of Stay
M	

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

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Term / Abbreviation	**Terms in Full**
PLIC	Patient Level Information Costs
PMLD	Profound and Multiple Disability
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
RIDDOR	Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013
RTT	Referral to Treatment
S	
SAAF	Safeguarding Adults Assurance Framework
SBARD	Situation, Background, Assessment, Recommendation and Decision (SBARD) tool
SBS	Shared Business Services
SEND	Special Educational Needs and Disabilities
SI	Serious Incidents
SID	Senior Independent Director
SIRI	Serious Incident Requiring Investigation
SLA	Service Level Agreement
SLR	Service Line Reporting
SMI	Serious Mental Illness
SOAD	Second Opinion Appointed Doctor
SOC	Strategic Options Case
SOF	Single Operating Framework
SPL	Shielded Patient List
SPOA	Single Point of Access
SPOE	Single Point of Entry
SPOR	Single Point of Referral
STEIS	Strategic Executive Information System
STF	Sustainability and Transformation Fund
STP	Sustainability and Transformation Partnership
SUI	Serious (Untoward) Incident
T	
TARN	Trauma Audit and Research Network
TCP	Transforming Care Partnerships
TCS	Transforming Community Services
TDA	Trust Development Authority
TMT	Trust Management Team

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Term / Abbreviation	**Terms in Full**
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

2020-21 Board Annual Forward Plan

Exec Lead	Item	5 May 20	7 Jul 20	1 Sep 20	3 Nov 20	13 Jan 21	2 Mar 21
	Paper deadline	**27 Apr**	**29 Jun**	**24 Aug**	**28 Oct**	**4 Jan**	**22 Feb**
Trust Sec	Declaration of Interests	X	X	X	X	X	X
CG	Patient Story	X	X	X	X	X	X
CM	Minutes/Matters arising/Action Matrix	X	X	X	X	X	X
CM	Board review of effectiveness of meeting	X	X	X	X	X	X
CM	Board Forward Plan (for information)	X	X	X	X	X	X
CM	Summary of Council of Governors meeting (for information)	X		X	X	X	X
CM	Chair's Update	X	X	X	X	X	X
IM	Chief Executive's Update	X	X	X	X	X	X
STRATEGIC PLANNING AND CORPORATE GOVERNANCE							
MP/CW	NHSI Annual Plan - timing to be confirmed				X		
CS	Staff Survey Results (summary in July)		X				
CS	Equality Delivery System2 (EDS2) update						X
CS	Annual Gender Pay Gap Report for approval						X
CS	Workforce Race Equality Standard (WRES) prior to submission 31.10.20			X			
CS	Workforce Disability Equality Standard (WDES) prior to submission 31.10.20			X			
CS	Flu Campaign (summary of 2019/20 due in May will now be a progress update on 2020/21 in Nov)	19/20 Summary			20/21 update		
CS	Workforce Plan		X				
Trust Sec	NHS Improvement Year-End Self-Certification	X					
Trust Sec	Year-End Governance Reporting from Board Committees and approval of ToRs	X					
Trust Sec	Corporate Governance Framework						X
Trust Sec	Review SOs, SFIs, SoD plus review/ratify SFI Policy (as Policy Review section below)		X				
Trust Sec	Trust Sealings (six monthly - for information - defer to November due to Covid-19)	X			X		
Trust Sec	Annual Review of Register of Interests	X					
Trust Sec	Board Assurance Framework Update	X	X		X		X
Trust Sec	Freedom to Speak Up Guardian Report (six monthly)			X			X
Trust Sec	Fit and Proper Person Declaration		X				
Trust Sec	Annual Approval of Modern Slavery Statement				X		
Committee Chairs	Board Committee Assurance Summaries (following every meeting) - Audit & Risk, Finance & Performance, Mental Health Act, Quality & Safeguarding, People & Culture (due to Covid-19 Board Assurance Summaries are suspended)	X	X	X	X	X	X
MP	Annual Emergency Planning Report (EPPR)				X		
GH	Business Plan Monitoring close down of 2019/20 (May) Proposal for 2020/21 (Jul) 2020/21 Update (Nov)	X	X		X		
GH	Learning Disabilities Clinical Strategy	X					
GH	Trust Strategy Review	X			X		

2020-21 Board Annual Forward Plan

Exec Lead	Item	5 May 20	7 Jul 20	1 Sep 20	3 Nov 20	13 Jan 21	2 Mar 21
OPERATIONAL PERFORMANCE							
CG/CW/CS/ MP	Integrated performance and activity report to include Finance, Workforce, performance and Quality Dashboard	X	X	X	X	X	X
CG/MP/CS	Workforce Standards Formal Submission/Safer Staffing (prior to going on website)						X
QUALITY GOVERNANCE							
Execs	Quality Position Statement Report - focus on CQC domains (Well Led CQC & NHSI (Trust Sec) as per schedule	Safety JS	Responsive MP	Well Led JF	Effective CG &CS	Use of Resources CW	Caring CG
JS	Learning from Deaths Mortality report (quarterly publication of information on death) (Jul/Nov/Jan/Mar)		X		X		
JS	Guardian of Safe Working Report	X	X		X		X
JS	NHSE Return on Medical Appraisals sign off - delayed for 2020/21			X			
CG	Control of Infection Report			A			
JS	Re-validation of Doctors		Update re delay		Update on inclusion		
CG	Receipt of Annual Reports: - Annual Looked After Children - Safeguarding Children and Adults at Risk				X		
CG	Outcome of Patient Stories				X		
POLICY REVIEW							
CW	Standing Finance Instructions Policy and Procedures		X				
JF	Engagement between the Board of Directors and CoG			X			
JF	Fit and Proper Person Policy						X

Key: Items deferred/cancelled to allow greater focus on the critical issues related to COVID-19