Derbyshire Healthcare
NHS Foundation Trust

PUBLIC BOARD MEETING
TUESDAY 9 MAY 2023 TO COMMENCE AT 09:30
This will be a virtual meeting conducted via MS Teams

	TIME	AGENDA	LED BY
1.	9:30	Chair's welcome, opening remarks and apologies - 2023/24 Register of Interests - Annual review of 2022/23 declarations of interest	Selina Ullah
PATIENT STORY			
2.	9.35	Patient Story – *my experience of being a carer*	Carolyn Green
STANDING ITEMS			
3.	10.00	Minutes of Board of Directors meeting held on 7 March 2023	Selina Ullah
4.		Matters arising – Actions Matrix	Selina Ullah
5.		Questions from members of the public	Selina Ullah
6.	10:05	Chair's update	Selina Ullah
7.	10:15	Chief Executive's update	Mark Powell
STRATEGY, PERFORMANCE AND RISK			
8.	10:30	Integrated Performance report	A Odunlade/R Leyland/ J Lowe/C Green
10:55 B R E A K			
9.	11:05	Trust Strategy update	Vikki Ashton Taylor
10.	11:15	Trust Operational Plan update 2023/24	Vikki Ashton Taylor
11.	11:25	Position Statement - focus on "Caring" domain	Carolyn Green
12.	11:35	Making Room for Dignity programme update	Geoff Neild
13.	11.45	Board Assurance Framework (BAF) 2023/24 Issue 1	Justine Fitzjohn
GOVERNANCE AND COMPLIANCE			
14.	11:55	Corporate Governance Report: - NHS England Year-End Self-Certification - Audit & Risk Committee Year-end report and approval of Board Committee Terms of Reference - Trust Sealings (six monthly report for information)	Justine Fitzjohn
15.	12.00	Review and ratification of Standing Financial Instructions	Rachel Leyland
BOARD COMMITTEE ASSURANCE			
16.	12:05	Board Committee Assurance Summaries	Committee Chairs
REPORTS FOR APPROVAL ON ASSURANCE FROM BOARD COMMITTEES			
17.	12.20	Quality and Safeguarding Committee: - Learning From Deaths/Mortality Annual Report 2022/23 - Workforce Standards Formal Submission/Safer Staffing	Arun Chidambaram Carolyn Green
18.	12.25	People and Culture Committee: - Public Sector Equality and Gender Pay Gap Report - Modern Slavery Statement - 2022 Staff Survey Results	Jaki Lowe
CLOSING BUSINESS			
19.	12:30	Identification of issues arising from discussions for inclusion or updating in the BAF Meeting effectiveness	Selina Ullah
FOR INFORMATION			
Summary of Council of Governors meeting held 7 March 2023 Glossary of NHS Acronyms 2023/24 Forward Plan			

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

The next meeting will be held at 09.30 on 4 July 2023. It is anticipated that this meeting will be held in Conference Rooms A&B, Centre for Research and Development, Kingsway. The exact arrangements will be notified on the Trust website 7 days in advance of the meeting

Users of the Trust's services and other members of the public are welcome to observe meetings of the Board.

Participation in meetings is at the Chair's discretion.

Our vision

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

Our values

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

People first – we work compassionately and supportively with each other and those who use our services. We recognise a well-supported, engaged and empowered workforce is vital to good patient care.
Respect – we respect and value the diversity of our patients, colleagues and partners and for them to feel they belong within our respectful and inclusive environment.
Honesty – we are open and transparent in all we do.
Do your best – we recognise how hard colleagues work and together we want to work smarter, striving to support continuous improvement in all aspects of our work.

DECLARATION OF INTERESTS REGISTER 2023/24		
NAME	**INTEREST DISCLOSED**	**TYPE**
Lynn Andrews Non-Executive Director	• Trustee for Ashgate Hospice in Chesterfield	(e)
Vikki Ashton Taylor Director of Strategy, Partnerships and Transformation	• Magistrate covering mainly Derbyshire and Nottinghamshire Courts	(e)
Tumi Banda Interim Director of Nursing and Patient Experience	• Jabali Men's Network	(d)
Tony Edwards Deputy Trust Chair	• Independent Member of Governing Council, University of Derby	(a)
Deborah Good Non-Executive Director	• Trustee of Artcore – Derby • Director of Craftcore Derby	(e) (e)
Carolyn Green Director of Nursing and Patient Experience	• Midlands and East Regional Director, National Mental Health Nurse Directors Forum	(e)
Ashiedu Joel Non-Executive Director	• Director, Ashioma Consults Ltd • Director, Peter Joel & Associates Ltd • Director, The Bridge East Midlands • Director, Together Leicester • Lay Member, University of Sheffield Governing Council • Fellow, Society for Leadership Fellows Windsor Castle	(a) (a) (a) (a) (a) (a)
Ralph Knibbs Senior Independent Director	• Vice Chair, RFU Diversity & Inclusion Implementation Group, England Rugby Football Union	(e)
Geoff Lewins Non-Executive Director	• Director, Arkwright Society Ltd • Director, Cromford Mill Limited (wholly owned trading subsidiary of Arkwright Society)	(a) (a)
Jaki Lowe Director of People and Inclusion	• General Medical Council Associate	(e)
Ade Odunlade Chief Operating Officer	• Trusteeship African Council for Nursing & Midwifery • Research Lead on Observations for Ox e-Health • Chair, NHS Providers Chief Operating Officer Network • Governor of Eden Park High School, Beckenham, Kent • Member of the Advisory Board of XRT Therapeutics (digital compony helping people to overcome phobia and anxiety)	(d) (e) (e) (e) (e)
Mark Powel Chief Executive	• Treasurer, Derby Athletic Club	(d) (e)
Becki Priest Interim Director of Quality and Allied Health Professionals	• Has a consultancy called IPS support assisting health and care organisations to implement employment support or to review their practice. Regularly undertakes contracted work with IPS Grow which is part of social finance.	(b)
Selina Ullah Trust Chair	• Non-Executive Director, Solicitors Regulation Authority • Director/Trustee, Manchester Central Library Development Trust • Non-Executive Director, General Pharmaceutical Council • Non-Executive Director, Locala Community Partnerships CIC • Non-Executive Director, Accent Housing Group • Director, Muslim Women's Council • Trustee and Board member of NHS Providers representing Mental Health Providers	(a) (e) (e) (e) (e) (e) (e)

(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
Report to Board of Directors – 9 May 2023

Register of Directors' Interests

Purpose of Report

This report provides the Trust Board with the year-end 2022/23 Register of Directors' interests. This register will be published in the Annual Report for 2022/23. The register is updated with each new interest declared/removed and the revised version is then reported to each Public Board.

Executive Summary

- It is a requirement that the Chair and current Board members who regularly attend the Board should declare any conflict of interest that may arise in the course of conducting NHS business. Directorship and other significant interests held by NHS Board members should be declared on appointment and kept up to date.
- The Chair and Board members should declare any business interest, position of authority in a charity or voluntary body in the field of health and social care, and any connection with a voluntary or other body contracting for NHS services.
- For this reason each Director should make a continual declaration of any interests they have to the Board Secretary as they arise.
- To ensure openness and transparency during Trust business, the Register is included at the next meeting in the papers that are considered by the Board of Directors at each meeting.

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

Assurances

- Directors are asked to disclose to the meeting any changes to the Register of Directors' Interests during the course of the year

- When declaring an interest, each Board member has affirmed their agreement to comply with the NHS Codes of Conduct and Accountability, and the Seven Principles of Public Life (Nolan), and to state whether there is any relevant audit information of which the Trust's Auditors are unaware.

Governance or Legal Issues

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

Public Sector Equality Duty and Equality Impact Risk Analysis

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

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

Recommendations

The Board of Directors is requested to approve and record the declarations of interest as disclosed. These are recorded in the Register of Interests which is accessible to the public at the Trust Head Office and will be listed in the Trust's Annual Report for 2022/23.

Report presented by: **Selina Ullah**
Trust Chair

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

DECLARATION OF INTERESTS REGISTER 2022/23		
NAME	**INTEREST DISCLOSED**	**TYPE**
Lynn Andrews Non-Executive Director	• Trustee for Ashgate Hospice in Chesterfield	(e)
Vikki Ashton Taylor Director of Strategy, Partnerships and Transformation	• Magistrate covering mainly Derbyshire and Nottinghamshire Courts	(e)
Tumi Banda Interim Director of Nursing and Patient Experience	• Jabali Men's Network	(d)
Tony Edwards Deputy Trust Chair	• Independent Member of Governing Council, University of Derby	(a)
Margaret Gildea Senior Independent Director	• Director, Organisation Change Solutions Limited • Coaching and organisation development with First Steps Eating Disorders • Director, Melbourne Assembly Rooms • Designated Independent Non-Executive Member, NHS Derby and Derbyshire Integrated Care Board	(a) (e) (d) (d)
Deborah Good Non-Executive Director	• Trustee of Artcore – Derby • Director of Craftcore Derby	(e) (e)
Carolyn Green Director of Nursing and Patient Experience Deputy Chief Executive and Chief Nurse (Oct-Nov) Interim Chief Executive (Nov-Mar)	• Midlands and East Regional Director, National Mental Health Nurse Directors Forum	(e)
Gareth Harry Director of Director of Business Improvement and Transformation	• Chair, Marehay Cricket Club • Member of the Labour Party • Non-Executive Trustee, Derbyshire Cricket Foundation	(e) (e) (e)
Ashiedu Joel Non-Executive Director	• Director, Ashioma Consults Ltd • Director, Peter Joel & Associates Ltd • Director, The Bridge East Midlands • Director, Together Leicester • Lay Member, University of Sheffield Governing Council • Fellow, Society for Leadership Fellows Windsor Castle	(a) (a) (a) (a) (a) (a)
Ralph Knibbs **Senior Independent Director**	• Vice Chair, RFU Diversity & Inclusion Implementation Group, England Rugby Football Union • Head of HR, UK Athletics • Founding member and Steering Committee member, The Rugby Black List	(e) (e) (e)
Geoff Lewins Non-Executive Director	• Director, Arkwright Society Ltd • Director, Cromford Mill Limited (wholly owned trading subsidiary of Arkwright Society)	(a) (a)
Jaki Lowe Director of People and Inclusion	• General Medical Council Associate	(e)
Ifti Majid Chief Executive	• Co-Chair of NHS Confederation BME leaders Network • Chair of the NHS Confederation Mental Health Network • Trustee of the NHS Confederation • Spouse is Managing Director (North) Priory Healthcare	(d) (d) (d) (e)

Ade Odunlade Chief Operating Officer	• Trusteeship African Council for Nursing & Midwifery • Research Lead on Observations for Ox e-Health • Chair, NHS Providers Chief Operating Officer Network • Governor of Eden Park High School, Beckenham, Kent • Member of the Advisory Board of XRT Therapeutics (digital compony helping people to overcome phobia and anxiety)	(d) (e) (e) (e) (e)
Becki Priest Interim Director of Quality and Allied Health Professionals	• Has a consultancy called IPS support assisting health and care organisations to implement employment support or to review their practice and currently has a contract with IPS Grow which is part of social finance	(b)
Selina Ullah Trust Chair	• Non-Executive Director, Solicitors Regulation Authority • Director/Trustee, Manchester Central Library Development Trust • Non-Executive Director, General Pharmaceutical Council • Non-Executive Director, Locala Community Partnerships CIC • Non-Executive Director, Accent Housing Group • Director, Muslim Women's Council • Trustee and Board member of NHS Providers representing Mental Health Providers	(a) (e) (e) (e) (e) (e) (e)
Richard Wright Deputy Trust Chair and Non-Executive Director	• Non-Executive Director (Chair) Sheffield UTC Multi Academy Educational Trust • Designated Independent Non-Executive Member, NHS Derby and Derbyshire Integrated Care Board	(a)

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

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

Derbyshire Healthcare NHS Foundation Trust

MINUTES OF A VIRTUAL MEETING OF THE BOARD OF DIRECTORS TUESDAY 7 MARCH 2023

VIRTUAL MEETING VIA MS TEAMS WEBINAR

Commenced: 09.30 Closed: 12:40

PRESENT	Selina Ullah	Trust Chair
	Tony Edwards	Deputy Trust chair
	Ralph Knibbs	Senior Independent Director
	Lynn Andrews	Non-Executive Director
	Deborah Good	Non-Executive Director
	Geoff Lewins	Non-Executive Director
	Carolyn Green	Interim Chief Executive
	Ade Odunlade	Chief Operating Officer and Interim Deputy Chief Executive
	Dr Arun Chidambaram	Medical Director
	Rachel Leyland	Interim Director of Finance
	Tumi Banda	Interim Director of Nursing and Patient Experience
	Vikki Ashton Taylor	Director of Strategy, Partnerships and Transformation
	Justine Fitzjohn	Trust Secretary
IN ATTENDANCE	Mark Powell	Incoming Chief Executive
	Anna Shaw	Deputy Director of Communications and Engagement
	Rebecca Oakley	Deputy Director of People and Inclusion
	Joe Wileman	Head of Programme Delivery
For DHCFT2023/031	Kel Sims	Risk and Assurance Manager
For DHCFT2023/032	Tamera Howard	Guardian of Safe Working
	Sue Turner	Board Secretary
APOLOGIES	Jaki Lowe	Director of People and Inclusion
	Becki Priest	Interim Director of Quality and Allied Health Professionals
	Ashiedu Joel	Non-Executive Director
OBSERVERS	Pete Henson	Head of Performance
	Susan Ryan	Public Governor, Amber Valley
	Andrew Beaumont	Public Governor, Erewash
	Joanne Foster	Staff Governor, Nursing

The Board meetings are broadcast via a MS Teams webinar event. The names of observers might not be identifiable and may not be recorded as attendees

DHCFT 2023/021	**CHAIR'S WELCOME, OPENING REMARKS, APOLOGIES FOR ABSENCE AND DECLARATION OF INTERESTS** Trust Chair, Selina Ullah welcomed Board colleagues to the meeting including Governors, members of staff and members of the public who were observing this meeting today via Microsoft Teams public webinar. Head of Programme Delivery, Joe Wileman attended to present today's patient story and support the item on Continuous Quality Improvement. Apologies were noted as listed. Deputy Director of People and Inclusion, Rebecca Oakley deputised for Director of People and Inclusion, Jaki Lowe. No declarations of interest were raised with any of the agenda items. The Register of Directors' Interest was noted.
DHCFT 2023/022	**PATIENT STORY** Today's patient story was heard as an example of the Trust's quality improvement work which is covered in more detail under item 9. Continuous Quality Improvement: A Stocktake. Joe Wileman presented today's story on behalf of Jack who had given Joe permission to relay his experience of being in rehabilitation and rediscovering enjoyment of being outside and working with his hands. Jack is 21 years old and has schizophrenia and this was his first experience of being in hospital. Jack was admitted to the Hartington Unit after his illness deteriorated and was then transferred to Tansley Ward. He then spent time in the rehabilitation service on Cherry Tree close at Kingsway. When Jack was first admitted to Hartington Unit he found it stressful and felt uncomfortable with doors having to be locked. He enjoyed spending time in the hub where he could play pool whenever he wanted. When he was well enough to leave the ward Jack was transferred to a bungalow at Cherry Tree Close and found boredom a particular challenge. This was when Jack and his fellow residents took part with Trust staff and the Derbyshire Wildlife Trust in a pilot scheme into wild gardening that involved constructing and planting raised beds, building bird feeders and hedgehog houses situated in the grounds of Kingsway. Jack discovered how enjoyable it was to be outside using his hands and as soon as he is moved to a supported living placement he would like to develop his woodwork skills as he was proud of the bird boxes and bird table he built. Jack also came to realise the benefits that came from green space initiatives and recognised that working outside and using his hands has helped him in his recovery and would recommend this experience as therapy to other patients. Non-Executive Directors, Lynn Andrews and Tony Edwards were interested to know how this initiative had developed and how it can be operated in settings outside of Kingsway to overcome patients' feelings of boredom and isolation. Joe summarised how this pilot scheme ran in Cherry Tree Close for 12 weeks and formed part of the Quality Improvement (QI) initiative. The scheme aims to help patients recognise the benefits of green space and the impact on physical health and mental wellbeing and can be built into the community mental health framework. These activities have alleviated boredom and provided opportunities to develop skills and better health outcomes. Medical Director, Arun Chidambaram and Interim Director of Nursing and Patient Experience, Tumi Banda were mindful that the Trust is responsible for addressing boredom so patients can start to enjoy and participate in activities. They were pleased to hear that Jack was supported to identify his strengths as this is encouraged within patients' care planning.

	Board members noted the QI methodology that greatly benefitted Jack in his recovery and would continue to explore these meaningful activities in inpatient settings and make it a beneficial use of patient time. **RESOLVED: The Board of Directors noted QI methodology that was used to capture benefits to people in rehabilitation services.**
DHCFT 2023/023	**MINUTES OF THE BOARD OF DIRECTORS MEETING HELD ON 1 NOVEMBER 2022** The minutes of the previous meeting held on 17 January 2023 were accepted as a correct record of the meeting.
DHCFT 2023/024	**ACTION MATRIX** The Board reviewed and closed the completed actions. No actions remained outstanding. **MATTERS ARISING** The previous patient story containing recommendations for improvements to services was referenced by the Chair. Carolyn Green offered assurance that all patient story recommendations are dealt with individually and are reported back to the Board via a two year review of progress made with each case that evidences how learning has been embedded.
DHCFT 2023/025	**QUESTIONS FROM MEMBERS OF THE PUBLIC** No questions had been directly submitted for a response ahead of the meeting. Governors represent the population of Derbyshire and any questions raised with them by members of the public are taken to the Council of Governors.
DHCFT 2023/026	**CHAIR'S UPDATE** Selina gave a verbal update of her activity since the previous Board meeting covering the period between 18 January to 8 February after which she was on annual leave. The new Chief Executive, Mark Powell will take up his role with the Trust on Monday 3 April. Over recent weeks Selina has been familiarising Mark with the Trust's key priorities and has enjoyed getting to know him while discussing how to build on the strong foundations within the organisation, developing further the people first promise and continuous improvement work that will take the Trust to the next level by working collectively in delivering quality safe care for patients and the people of Derbyshire. As this was Carolyn Green's final meeting in her capacity as Interim CEO Selina gave thanks to Carolyn for her leadership, especially for navigating the organisation through some difficult challenges during the period of industrial action and for her work within the system which has left a strong legacy for Mark to develop. Selina summarised her involvement in system work over recent weeks especially within the Joined Up Care Derbyshire Provider collaborative and found it enlightening to discuss and take forward the principles of other providers. Within the Trust Selina recently attended the Trust's Operational Oversight Leadership (TOOL) meeting chaired by Chief Operating Officer, Ade Odunlade and was fascinated to see first-hand how operational performance and delivery is overseen. Selina has continued to meet with her Non-Executive Director colleagues. She took the opportunity to welcome new members to the Council of Governors and gave thanks to Ruth Grice for chairing the Governor's Governance Committee, which is a key function of the Council of Governors.

	Lastly, Selina thanked all staff for sustaining the challenges they are faced with on a day to day basis and keeping services running while experiencing huge pressures across the Derbyshire health and care system as a result of industrial action. **RESOLVED: The Board of Directors noted the content of the Chair's verbal update.**
DHCFT 2023/027	**INTERIM CHIEF EXECUTIVE'S REPORT** This was the final report from Carolyn in her role as interim CEO. The following points drew attention to recent strategical and national activities. **Industrial Action** Derbyshire Healthcare experienced formal industrial action in January. Carolyn expressed her gratitude to the management team and Emergency Planning and Response teams for their continued to work in partnership with Staff-side partners to deliver safe outcomes for patients. Although planned industrial action for nursing and allied health colleagues at the beginning of March has been paused subject to active pay negotiations, plans are in place for proposed industrial action with junior doctors. **Within our Trust** Members of the Board have been involved in a number of quality visits. These visits have given a better understanding of services and provided the opportunity to hear about the innovation and activities that will improve the lived experience of staff both working and for patients receiving care. Carolyn is the Senior Information Risk Owner (SIRO) for the System Delivery Board for Mental Health, Learning Disability and Autism. One of the highlights from the most recent meeting was the system-wide work to support and improve experiences of the deaf community in Derby by making reasonable adjustments to meet the demand and make sure that our services are accessible. The presentation slides from this meeting were included under Appendix A in the pack. **National Context** Carolyn referred to the former Health Secretary, Patricia Hewitt's independent review into how the oversight and governance of Integrated Care Systems (ICSs) can best enable them to succeed. This legislation will have an impact on the Trust strategy and will shape prevention and population health and resonates with Jack's story about how the Trust can influence work into promoting wellness and support prevention. Reference was made to the report issued by the National Audit Office (NAO) on NHS mental health services as it highlighted workforce pressures and struggles to meet targets. This continues to be a factor both nationally and in Derbyshire. Around one in six adults in England have a common mental health disorder. The proportion of young people estimated to have a mental disorder rose significantly following the COVID-19 pandemic. These national reflections connect to feedback across the workforce on how it feels to work at the front line. Over the next few years demand for mental health services will continue to outstrip provision putting pressures on patients, staff and people trying to access services. Tony Edwards referred to intent of the ICB strategy document to ensure joined up working and planning with other providers in the system for 2024 and asked if this was a significant change to the strategy. Carolyn summarised that this fundamental shift to towards prevention has been discussed over a number of years and is a long term requirement. There are constitutional targets that the Trust will be working to achieve within this alliance to enhance of 0 – 5 year old children's services, health visiting and school nursing services and for people with learning disabilities. The Trust will also be extending its contribution in physical healthcare, especially to those with cardiovascular disease. The Hewitt review makes clear the expectation for the ICBs which will also be another driver that will influence joined up care.

	Non-Executive Director, Deborah Good wanted to know what the plans were to mitigate the worst impact of the planned industrial action being taken by junior doctors from 13 to 16 March. Arun Chidambaram assured Deborah of the robust plans that have been devised for industrial action by junior doctors taking learning has been taken from how the Trust responded to the previous industrial action. The predominant risk is urgent mental health intervention which is primarily delivered by junior doctors. The Trust has met with the trade unions, the BMA and reached an agreement about how to manage and respect the right of junior doctors to take industrial action. Arun was pleased to report that there is an oversubscription of senior clinicians who are enthusiastic about taking on the role of junior doctors which will mitigate the risk to the urgent care pathway in mental health safely. **RESOLVED: The Board of Directors scrutinised the report, noting the risks and actions being taken and accepted assurance around key issues raised.**
DHCFT 2023/028	**<u>INTEGRATED PERFORMANCE REPORT</u>** The Board was updated on key finance, performance and workforce measures at the end of January 2023. Executive Directors drew attention to the following areas and responded to questions. **Operations** Ade Odunlade summarised the significant challenges around patient flow affecting delayed discharges and out of area placements, which are being ramped up across the whole organisation. Demand is also being felt due to re-admitters to acute wards by patients who have already had one or more admission in last six months. Challenges are also being seen with waiting times for adult Autistic Spectrum Disorder assessment, Child and Adolescent Mental Health Services, Paediatric outpatients and Improving Access to Psychological Therapies (IAPT) 6-week referral to treatment. Improvements are being seen in waiting times which have reduced month on month for the last ten months. The target has been achieved for Community mental health access 2 Plus contacts and with IAPT patients completing treatment who move to recovery. The Board joined Vikki Ashton Taylor in acknowledging the significant work of the operational teams to improve the position against the community mental health access target with the 2 Plus contacts because this particular target has been RAG rated red for a period of time and will be compliant moving into 2023/24. Deborah was interested in the new metrics around readmittance to acute wards asked how the community teams were supporting people once they were discharged. Ade clarified that this has been measured for some time. The measurement is part of the quality improvement process to see how well people are held in the community compared with other organisations in relation to readmission. Tony Edwards referred to the improvement in waiting lists but noticed that three out of four waiting lists were still a concern and asked if there was a timescale for when those areas would improve. Ade explained that there are considerable problems with flow into and throughout social care across the country. There has been a significant increase in demand for our services post COVID and it has become necessary to establish a better way to manage that demand utilising technology. This will not be resolved quickly but a significant reduction to waiting lists is anticipated in four to six months. **Finance** Interim Executive Director of Finance, Rachel Leyland reported that at the end of the January the overall year to date financial position saw a surplus of £1.6m compared to the plan deficit of £1.3m, a favourable variance to plan of £2.9m. This is a good position to be in as the forecast is now a surplus of £2.8m against the plan of breakeven. Following this improvement in the revenue position we have also secured additional capital funding for the new builds and refurbishments of the existing inpatient units. This

improved position enabled the Finance and Performance Committee to propose reducing the financial risk from extreme to moderate and was approved by the Audit and Risk Committee on 2 February.

The focus now is on the next financial year. Currently financial plans for 2023/24 both for revenue and capital expenditure are being developed as a system in readiness for a draft submission on 23 February 2023 and final submission at the end of March 2023. Due to the timing of submission the Board granted delegated authority to the Finance and Performance Committee to sign off the final plan on behalf of the Trust Board on 21 March.

Non-Executive Director, Geoff Lewins, Chair of the Audit and Risk Committee welcomed the good news that the financial position is performing better than plan, but he was concerned that the majority of the efficiencies were non-recurrent and hoped that the QI programme will produce more sustainable improvements. Having observed from the control charts that agency costs of 4.5% to 5% are significantly higher than this year's plan of 3.7%, Rachel clarified to Geoff that it is higher than plan but lower than the outturn. The original plan was based on a regulator ceiling that was set some years ago and was reduced to manage COVID pressures which is why the plan is lower than previous years.

Discussion focussed on transformation scheme plans to reach efficiency targets which are at a minimum requirement of 3% for next year, 2% of which is recurrent. The Board was made aware that there will be a split of transformation schemes and these are being taken forward by the Executive Leadership Team and Finance and Performance Committee. Draft plans are in place with 70% of transformation programs already supported by QI methodology and reducing waste through a bottom up approach with colleagues across the organisation. Work is also underway with operational teams and with the Mental Health Learning Disability and Autism Delivery Board to defer operational delivery plans for 2023/24.

People performance

Deputy Director of People and Inclusion, Rebecca Oakley reported that appraisal levels continue to be below expectation. There is inconsistency between teams and work is underway to increase appraisal rates. Overall, the 85% target level for mandatory training has been achieved for the last 10 months. Turnover remains high at 12.78% for January and key steps are being made to triangulate key people metric data and intelligence from key leads to ensure teams needing support takes place promptly to minimise staff leaving the teams. The retention plan will be enhanced from intelligence taken from the results of the Staff Survey.

Sickness absence in January of 6.2% was the lowest recorded for over a year. The main reason for absence continues to be stress and anxiety. A clinical psychologist is working to support colleagues who are experiencing anxiety, depression or trauma through work. 2023 will see further investment in resources to support colleagues who are struggling at work and home through a trauma informed approach to coaching that will be rolled out from May.

There has been an increase in agency spend which was predominantly due to the recent industrial action. The People and Inclusion team are continuing to work closely with bank colleagues and there has been some shift where bank colleagues have moved to substantive contracts. Rebecca was pleased to report that there is now increased engagement with bank staff. Staffing levels continue to improve with January seeing another increase. A targeted recruitment campaign for trainee healthcare support workers and Occupational Therapists (OTs) event recently took place and work continues implement learning from the cultural intelligence recruitment programme.

Senior Independent Director and Chair of the People and Culture Committee, Ralph Knibbs referred to the release of the Staff Survey results which are currently embargoed until 9 March and asked about of the timescales and the process of how the results would

	be shared across the organisation. Rebecca outlined that once the embargo is lifted the results will be worked on quite quickly. The Staff Survey is an important listening tool that identifies areas that can improved and make a difference to colleagues. A report outlining the results of the Staff Survey will be reported to the People and Culture Committee at the end of the March and reported to the Board in May. Tony Edwards was keen to ensure that staff can work flexibly and was keen to see that this is triangulated against the effectiveness of the organisation. He also wanted to know how data can help with the aim to improve diversity. Rebecca assured Tony that flexible working is operating well in some areas and team leaders are being empowered to reach the right approach that is right for their team. Equality Diversity and Inclusion (EDI) is an important element of the Staff Survey and is regularly reported in detail to the People and Culture Committee which helps give an understanding of how to ensure people can feel they can be themselves when they are in the workplace. The Board will receive an update on EDI at the November meeting. **Quality** Tumi Banda reported that a high number of compliments continue to be received from our patients, carers and families which is a testament to colleagues who are working extremely hard. Although there are challenges with flow, delays with transfer of care have reduced which is due to the work we are doing with our system partners. There continue to be challenges around compliance with care planning. The aim is for all service users to have a care plan and a deep dive is being undertaken this month by the Quality and Safeguarding Committee to look at solutions to improve care planning. There has been an increase in the use of restraint and teams are working to find ways of reducing restrictive practice while working with the high activity they are being faced with and a number of incidents have been able to be de-escalated by the use of trauma informed care. Seclusion is being managed under the Code of Practice and is terminated at the earliest point possible with patients being offered different ways of managing their distress. The Chair asked to receive assurance on targets that were prone to special cause variation. Tumi assured Selina that a triangulating approach is taken to analysing variation such as performance of flow, staff sickness etc. to establish the reasons allowing a close track of natural variations. Having thoroughly discussed all areas of performance, Selina thanked the executive leads for their updates and concluded that a level of limited assurance had been received from performance as it will be necessary to see further progress in the areas that have been reported. **RESOLVED: The Board of Directors:** **1) Delegated authority to the Finance and Performance Committee to sign off the operational financial plan for the final submission at the end of March** **2) Received limited assurance obtained on current performance across the areas presented** **3) Formally agreed that this report incorporates the key elements of assurance to the Trust Board that would otherwise have come from Finance and Performance Committee and People and Culture Committee reporting.**
DHCFT 2023/029	**<u>CONTINUOUS QUALITY IMPROVEMENT: A STOCKTAKE</u>** The Board was updated on progress in implementing the Trust's Quality Improvement (QI) Strategy. Since the launch of the QI Strategy in November 2021 14 actions were identified of which 11 have been completed. The priority is to deliver the three remaining actions and concentrate on the next phase of training that will focus on developing staff who are leading transformational schemes identified through the QI process across the organisation to increase opportunities for staff to put QI skills to use in delivering the

	Trust's strategic objectives of providing great care, being a great place to work, making the best use of resources and being a great system partner. The Board noted the positive progress that has been made and observed how a quality improvement initiative of green social prescribing progressed by QI trained colleagues using the Trust's QI infrastructure had benefitted Jack during today's patient story. The IPR also evidenced the hard work of the community mental health operational team who developed their own QI recovery action programme. There are now 373 colleagues trained across quality, service improvement and redesign (QSIR), and there is a strong plan in place to increase this to 1,000 trained by the end of next year. This level was challenged by Carolyn Green who recalled the goal was to train 1,500 people within two years. While discussing the benefits of QI work and the Trust's aspiration to be a mature QI organisation, it was accepted that although more QI initiatives will be created by training more staff it is more important to target people to be trained with a clear purpose in delivering a QI culture and having a resource that can embrace digital transformation as a key enabler to deliver QI value with more pace. Having noted the feedback from Board colleagues Vikki Ashton Taylor would take forward their suggestions to take QI forward into the next phase. The Board supported the benefits of QI work and asked that it be reiterated within the refreshed Trust Strategy for 2023/24 and looked forward to seeing continued progress being made in embedding a QI culture across the organisation. It was requested that the next report sets out the progress made with the next phase of QI work and articulates how system connections can be improved. **RESOLVED: The Board of Directors:** **1) Noted the content of the report and the progress of activities to date in delivery of the 2021-2024 Quality Improvement Strategy** **2) Supported existing and newly identified activities relating to delivery of remaining objectives within the current QI strategy and the development of the next iteration from 2024.**
DHCFT 2023/030	**<u>POSITION STATEMENT - FOCUS ON EFFECTIVE CQC DOMAIN</u>** Tumi Banda's report focussed on how to improve effectiveness and outcomes for people who use the Trust's services. The report also included an update on the continued good standards, the reduction in the use of out of area beds, improvement work to reduce restrictive practices and focus on making sure that people are admitted and cared for in a safe way that supports their sexual identity sexual safety. Carolyn Green considered that the report underpinned areas where the Trust is benchmarked and asked if there were any domains that could be highlighted to show how negative impacts were being monitored. The development of dashboards around people in areas of responsibility, how they are caring for patients and carers to ensure if there are any incidences of failure to be caring or compassionate so they are recorded was given by Tumi as an example of how negative impacts are managed. Another was the improved use of restrictive practice which is an area that has been particularly effective which can be seen from the continued low numbers of restraints. In response to Lynn Andrews challenging whether the report captured all Care Quality Commission (CQC) key lines of enquiry (KLOEs) to monitor effectiveness, Tumi assured Lynn that the report evidenced effectiveness in all domains and he was confident that the Trust can evidence its responsiveness to the CQC regarding incidences highlighted by the media, particularly in response to the Panorama programme exposing care at a secure unit elsewhere in the country in November 2022. There are various ways of measuring effectiveness which is monitored by the Quality and Safeguarding Committee. The Quality Visit process and the use of mock inspections enables clinical teams to showcase areas of improvement, on inpatient wards, and areas of positive

	practice and provides a chance to examine effectiveness from the public point of view. NICE guidance is also used to measure effectiveness. The CQC oversight meetings are used to evolve the learning taken from each domain. Having discussed and considered the information contained in the report the Board agreed that significant assurance had been obtained from all areas presented. **RESOLVED: The Board of Directors:** **1) Considered the current evidence in the domain of Effectiveness** **2) Considered and confirmed the levels of assurance as rated by the CQC as good** **3) Confirmed that significant assurance had been obtained on the areas presented.**
DHCFT 2023/031	**<u>BOARD ASSURANCE FRAMEWORK UPDATE</u>** Risk and Assurance Manager, Kel Sims presented the Board with an updated Board Assurance Framework (BAF), which focuses on key risks the organisation faces to achieve the Trust's strategic objectives during the 2023/24 financial year and how they are being mitigated. Three risks have reduced ratings and one (MS1) has an increased rating. One risk has moved from strategic objective 3 (to make best use of our resources) to objective 4 (to be a great partner) and a new risk has also been added to strategic objective 4. All were approved by the Audit and Risk Committee on 2 February. The Committee was also satisfied with the rationale to carry over risk 1D into the 2023/24 BAF *"There is a risk that the Trust's increasing dependence on digital technology for the delivery of care and operations increases the Trust's exposure to the impact of a major outage*". The Board agreed to include this risk in the 2023/24 BAF. The fourth issue of the BAF for 2022/23 was approved by the Board. Improvements made to the BAF by the Board at the Board Development session held in February were also approved. As pointed out by Carolyn Green, some risks and/or mitigations will be adapted as they progress particularly in view of the impact that Patricia Hewitt's independent review into the ICS might have on the Trust Strategy. The Risk and Assurance Manager assured the Board that she will continue to receive feedback from each of the Board Committees to ensure review/completion dates are established for all actions and will update the BAF Issue 1 2023/24 to reflect these points. **RESOLVED: The Board of Directors:** **1) Approved this fourth issue of the BAF for 2022/23 and the assurance the paper provides of the process of the review, scrutiny and update of the BAF in seeking to identify and mitigate risks to achieving the Trust's strategic objectives** **2) Reviewed all risks within the report to consider which should be carried forward to the 2023/24 BAF** **3) Agreed the implementation of the improvements identified at the BAF Board development session** **4) Agreed to continue to receive updates in line with the forward plan for the Trust Board.**
DHCFT 2023/032	**<u>FREEDOM TO SPEAK UP GUARDIAN REPORT</u>** Freedom to Speak Up Guardian (FTSUG), Tam Howard presented her update and shared an analysis of trends and actions being taken to improve speaking up culture. Today's report highlighted a significant decrease in instances of bullying and harassment being raised by staff. Emerging, or ongoing, themes are mainly concerned with culture and worker safety and wellbeing. A well-received Board development session was delivered by the FTSUG in November 2022 was themed around the contents of the

	FTSU Reflection and Planning Tool which is to be completed by the Board by January 2024. Board members also participated in terms of their responsibility for creating a safe culture and an environment in which workers can highlight problems and make suggestions for improvement. Carolyn Green commented that although great strides have been made within the Trust's FTSU culture one of the outcomes from the Board development session was the greater need for triangulation of FTSU data which will be taken forward by the People and Inclusion team. Carolyn wondered if there were individuals that might feel safe and willing to participate in staff stories. Rebecca Oakley assured the Board that the People and Inclusion team responds quickly to FTSU data and encourages the FTSUG's input. Intelligence is also collected from the different staff networks, staff side, trade union partners and divisional people leads. FTSU is also triangulated through staff stories heard by the People and Culture Committee. The most recent staff story illustrated how FTSU and people metric data is used to support teams. The FTSUG also produces a report for the People and Culture Committee that supports triangulation of data. The Board received significant assurance from the mechanisms that enable FTSU to improve speaking up culture within the Trust. It was noted that concerns raised by bank and agency staff are low. The FTSUG works closely with the Guardian of Safe Working and attends the Junior Doctor Forums and student meetings and bank staff engagement events to promote the FTSU process. Tony Edwards looked forward to seeing the results of the Staff Survey once the embargo is lifted and was pleased to hear that the FTSUG will produce a FTSU assessment once the results are released. **RESOLVED: The Board of Directors:** **1) Supported the current mechanisms and activities in place for raising awareness of the FTSU agenda** **2) Received significant assurance from the FTSU agenda within the Trust and that proposals made by the FTSUG promote a culture of open and honest communication to support staff to speak up** **3) Supported the development of the FTSU strategy as required by the National Guardian's Office** **4) Confirmed engagement with the process and completion of the FTSU Reflection and Planning Tool.**
DHCFT 2023/033	**<u>LEARNING FROM DEATHS MORTALITY REPORT</u>** The Board received a report from the Medical Director regarding learning from deaths covering the period 1 October to 31 December 2022. There have been zero deaths reported where the patient tested positive for Covid-19. The Trust received 643 death notifications of patients who had been in contact with our service within the six months prior to their death. There is little variation between male and female deaths; 309 male deaths were reported compared to 334 females. No inpatient deaths were recorded. A key development reported was the delegation of the role of reviewing deaths with the Royal College of Psychiatrists Care Review Tool to the multi-disciplinary clinical team. This process started on 1 March and is expected to be more efficient because the clinical team will know the patient. The Board noted the developments that have taken place since the previous report and agreed for the report to published on the Trust's website as per national guidance. **RESOLVED: The Board of Directors accepted the Mortality Report as assurance of the Trust's approach and agreed for the report to published on the Trust's website as per national guidance.**
DHCFT	**<u>GUARDIAN OF SAFE WORKING REPORT</u>**

2023/034	The report from Guardian of Safe Working (GoSW) report provided data about the Trust's Junior Doctors and arrangements in place to identify and remedy any risks to the organisation. Arun Chidambaram reminded the Board that the previous report showed there were delays in the payment of retrospective payments made due to some junior doctors through exception reports recording a breach of non-resident on call rest requirements. Arun was pleased to report that these payments have now been processed. He also highlighted that engagement from the GOSW during the preparedness for industrial action helped establish trust with junior doctors. The Board acknowledged that the GOSW has carried out a considerable amount of improvement work to ensure the voice of junior doctors is heard and is working with the FTSUG to support junior doctors to raise any concerns and noted that the report had provided the Quality and Safeguarding Committee with significant assurance on 14 February that the Trust is discharging its statutory duties in employing junior doctors on the 2016 contract. **RESOLVED:** **1) Noted the contents of this report.** **2) Noted that whilst the previous report outlined that the GOSW could not give assurances to the Trust that it was discharging its statutory duties in employing junior doctors on the 2016 contract, this is no longer the case.**
DHCFT 2023/035	**CORPORATE GOVERNANCE UPDATE** The Board received an update on Well Led including the review against the new Code of Governance for NHS Provider Trusts which will come into effect from 1 April 2023. Work is on-going to assess the leadership of the Board against the Well Led Framework both in terms preparing for the Board Well Led element of a CQC inspection but also commissioning an external development review. As a CQC inspection is not imminent it has been decided to commission the review in line with the NHSE guidance and best practise. Preparation of the Leaders' Pack will provide the Board with assurance of the Trust's key messages and position ready for the CQC inspection. The updated Code of Governance for NHS Provider Trusts will come into effect from 1 April 2023. This replaces the 2014 NHS Foundation Trust Code of Governance and sets out an overarching framework for the corporate governance of trusts, supporting delivery of effective corporate governance, understanding of statutory requirements where compliance is mandatory and provisions with which trusts must comply, or explain how the principles have been met in other ways. **RESOLVED: The Board of Directors:** **1) Noted the update on Board Well Led including the commissioning of an external development review** **2) Noted the update on the Code of Governance**
DHCFT 2023/036	**FIT AND PROPER PERSON POLICY** The Trust's Fit and Proper Persons Policy and Procedures document was ratified as recommended by the Trust Secretary who had reviewed the document and confirmed that it is still compliant with the guidance and regulations and no significant changes had been made to the policy since it was previously approved by the Trust Board in March 2020. **RESOLVED: The Board of Directors noted the update and approved the Fit and Proper Persons Policy and Procedures**

DHCFT 2023/037	**BOARD COMMITTEE ASSURANCE SUMMARIES** The Board Assurance summaries from recent meetings of the Trust Board Committees were accepted as a clear representation of the priorities that were discussed and will be taken forward in forthcoming meetings. The following points were brought to the attention of the Board by Committee Chairs: • Lynn Andrews made the Board aware that the Quality and Safeguarding Committee agreed an extension to the Patient Experience Strategy for a further 12 months to complete ongoing work and develop a comprehensive co-produced strategy for next year. • Tony Edwards proposed that a report be submitted to the Board at the next meeting in May on progress being made with the Making Room for Dignity Programme • An escalation made to the Board regarding the need for fully briefed representatives to deputise for Executive Directors in their absence at Board Committees **ACTION: Executive Leadership Team to ensure suitably briefed deputies represent Executive Directors if they are unable to attend meetings of the Board Committees** The Board was satisfied that it is within the Board Committees where much of the scrutiny and challenge takes place which is an important part of the Trust's governance requirements. **RESOLVED: The Board of Directors noted the Board Assurance Summaries.**
DHCFT 2023/038	**IDENTIFICATION OF ANY ISSUES ARISING FROM THE MEETING FOR INCLUSION OR UPDATING IN THE BOARD ASSURANCE FRAMEWORK (BAF)** No additional items were identified for inclusion in the BAF.
DHCFT 2023/039	**2022/23 BOARD FORWARD PLAN** The forward plan outlining the programme for 2023/24 was noted and would be reviewed further by all Board members for the financial year ahead. **ACTION: Forward Plan to include a progress update on the Making Room for Dignity Programme scheduled for May 2023**
DHCFT 2023/040	**MEETING EFFECTIVENESS** The Board agreed that the meeting had been successfully conducted as a virtual meeting.
The next meeting to be held in public session will be held at 09.30 on 9 May 2023.	

				BOARD OF DIRECTORS (PUBLIC) ACTION MATRIX - MAY 2023			
Date	**Minute Ref**	**Item**	**Lead**	**Action**	**Completion Date**	**Current Position**	
7.3.2023	DHCFT 2023/037	Board Committee Assurance Summaries	ELT	Executive Leadership Team to ensure suitably briefed deputies represent Executive Directors if they are unable to attend meetings of the Board Committees	9.3.2023	Action taken and completed by Executive Leadership Team	Green
7.3.2023	DHCFT 2023/039	Board Forward Plan	Board Sec	Forward Plan to include a progress update on the Making Room for Dignity Programme scheduled for May 2023	9.3.2023	Captured in forward plan and on agenda for meeting to be held on 9 May 2023	Green

Key:

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

Trust Chair's Report to the Board of Directors

Purpose of Report

This report is intended to provide the Board with the Trust Chair's reflections on activity with and for the Trust since the previous Board meeting on 7 March 2023. The structure of this report reflects the role that I have as Trust Chair.

Our Trust and Staff

1. I start my report with the wonderful news about our Making Room for Dignity programme. We held the ground-breaking ceremony for our Chesterfield facility and also our Kingsway facility on 22 March. This has been a much awaited development and one that will make a real difference in the quality of care and experience for our patients and their carers. I would like to thank everyone who has been involved in getting this much needed development to fruition. I am grateful to our system partners and NHSE colleagues for their support in difficult times and staying the course despite the many hurdles we faced. This is a real pivotal moment for our patients and our ambitions to provide excellent care.

2. On 3 April the Trust and I welcomed Mark Powell as he joined us in his new capacity as CEO.

I and the Board are very much looking forward to working with Mark in delivering the Trust strategy and maintaining our focus on becoming a high performing Trust with soul; building on our people first values while delivering for patients.

3. It has been a challenging time for our colleagues with two periods of industrial action for pay restoration by junior doctors. I am pleased to say that, in true Team Derbyshire spirit, everyone has worked together to ensure our patients are safe and to minimise any adverse impact on services and to support our colleagues and their right to take industrial action. I am immensely proud of our

staff colleagues and how they continue to deliver quality care in such difficult circumstances.

4. Sadly, on 16 March we held a one minute silence in memory for a much loved and respected colleague, Lauren Smyth. Lauren was a Health Visitor with our Children's Services. She will be much missed, and our deepest condolences go to her family, friends and colleagues.

5. I was invited by the Women's Network to be a speaker on Women in Leadership as part of the International Women's Day celebrations. The theme this year was on equity. It was very well attended, and I was humbled by the positive feedback from participants. My thanks to the network for all they have achieved in the one year since the inception of the Network under the leadership of Dr Chinwe Obinwa.

6. On 11 April I attended the BME Staff Network. We had a good discussion on the Trust's Equality Diversity and Inclusion (EDI) agenda, the Board's continued commitment to inclusion, and how we can ensure more co-production with the network. I also met with the Multi Faith Forum and Dawn the Disability Network on 4 and 5 May.

7. I was invited by our Chief Allied Health Professional, Becki Priest to the Allied Health Professionals (AHPs) AHP Network on 18 April. I was given an excellent presentation on the role of AHPs in the Trust and was impressed to hear that it is the third largest staff group and one of the fastest growing. AHPs play a vital role in the Trust and are critical to multi-disciplinary team working and to patient care.

8. I continue to join the live engagement events being hosted via MS Teams. These meetings are very useful to me in terms of understanding how staff are feeling and engaged with the Trust. I am pleased to note that several Non-Executive Directors (NEDs) also join these calls.

9. The results of the NHS Staff Survey have been published, the trend nationally has seen less staff engagement with the survey and our Trust was no exception. In respect of the Trust, we have seen a slight deterioration in some areas, although significantly less than our peer comparator trusts. Particularly pleasing was that we were above average on every indicator and this is a pattern that continues from previous years. We have seen a deterioration in relation to our staff who would recommend the Trust as a place to work; 66.5% from 72% last year and similarly 68% of staff would recommend a friend or relative who needed treatment with the standard of care provided by the Trust down from 72% last year. This is clearly disappointing for everyone, not least because we have high standards and continually strive to do our best. We recognise staff colleagues have been under considerable pressure and this is reflected in our staff survey results.

10. On 2 May I visited the Kedleston Unit, Radbourne Unit and the Undergrad Medical Education Team with Chief Executive, Mark Powell. It is always a learning experience and another aspect for triangulating assurance. It was very affirming to see the excellent care our colleagues deliver to our patients. We also received a tour of the plans for the new estates developments which will make a huge difference in the experience of care for our patients and their carers.

Council of Governors

11. Following the election of new Governors, I would like to welcome our three newest public governors: Tom Bladen (Derby City East), Christine (prefers Chris) Williamson (Derby City West) and Brian Edwards (High Peak and Derbyshire Dales) in photo order. I look forward to working with them all.

12. Our Governors have the key responsibilities of holding the Board to account, connecting the Trust with our communities, and bringing intelligence about how Derbyshire residents are experiencing our services. I have met with our new Governors on a one to one basis in order to get to know them better and hear about their concerns and ideas for the Trust.

13. The Council's Governance Committee met on 18 April, chaired by David Charnock, the new Chair of the Governance Committee. The Governance Committee will be jointly chaired by David Charnock and Marie Hickman.

14. The Governance Committee was followed by a session with Governors to gain their feedback on NEDs to complete the 360 degree appraisal process for each of the NEDs. It was heartening to see the level of attendance and participation from so many of our Governors at this meeting. I continue to be grateful to our Governors for their support for the Trust and their insight.

15. The Nominations and Remuneration Committee met on 25 April to receive my appraisal and those of the six NEDs (Geoff Lewins, Deborah Good, Lynn Andrews, Ashiedu Joel, Tony Edwards and Ralph Knibbs) and to gain assurance that the process outlined and agreed by the Council of Governors had been followed accordingly.

16. I am delighted that Susan Ryan has been elected as the Lead Governor and I look forward to continuing to meet and work with Sue. I met with Sue on 4 May as part of our monthly update meetings. The purpose of these meetings with the Lead Governors is to ensure that we are open and transparent around the challenges and issues that the Trust is dealing with. Regular meetings between the Lead Governors and Chair are an important way of building a relationship and understanding of the working of both governing bodies.

17. The next meeting of the Council of Governors will be on 9 May, following the Public Board meeting. The next Council of Governors meeting will then be on 5 September.

Board of Directors

18. On 8 March I met with Ralph Knibbs, Senior Independent Director (SID) for my annual appraisal. This is a robust process with 360 degree feedback sought from NEDs, Executive Directors, Governors, external colleagues and other internal colleagues. A report on the process and outcome of the appraisal is collated by the SID and presented to the Council's Nomination and Appointments Committee and the Council of Governors.

19. I too have undertaken NED appraisals during March and April. NED appraisals also follow a similar process to the Chair appraisal with 360 degree feedback, a review of the objectives set for the last 12 months, setting of new objectives for the next 12 months and identifying any development needs.

20. At the Remuneration and Appointments Committee on 15 March, the Committee undertook the annual review of Board composition and the Committee year end effectiveness report and terms of reference with some minor changes in line with recent policy guidance.

21. The following Board Development session focused on the CQC requirements and a sense check of where we are as an organisation and what we need to do further. This session was jointly led by Lynn Andrews, NED and Chair of the Quality and Safeguarding Committee and Justine Fitzjohn, Trust Secretary. A big thank you to Lynn and Justine for a very thought provoking session.

22. On 21 March I joined the Finance and Performance Committee as the Committee considered the financial plan and Trust operational delivery plan. The Board has some difficult decisions to make in the coming months given the very challenging financial position the wider system finds itself in.

23. I would also like to thank Jas Khatkar who joined the Board on 1 April 2022 as NExT Director, whose term ended on 31 March. Jas has been a valued member of the NED team. I held an exit interview with him on 11 April and identified a number of areas for learning based on his experience. I have agreed with him to continue to remain in contact and further use his knowledge to enhance relations and connections with the wider communities the Trust serves.

24. On 17 April, Mark Powell, CEO; Justine Fitzjohn and I met with the Office of Modern Governance who we have commissioned to undertake a Well Led Review. It has been some time since an independent review of the Trust's governance and assurance mechanisms has been undertaken. This review will provide me and the Board with confirmation and evidence of the robustness of our governance arrangements and where we may need to concentrate on further.

25. On 25 April the Remuneration and Appointments Committee met to review the status of mandatory training for the Board and to review several year-end processes ahead of the publication of the Annual Report and Accounts.

26. On 26 April a confidential Board meeting was held to consider matters related to the financial plan and the Trust operational delivery plan and to approve the final sign off, of the 2022/23 plan submission to NHS England.

27. The Board met on 3 May to continue the Board development programme 'Building Leadership for Inclusion Initiative' that we have commissioned as part of our commitment to inclusion and becoming an anti-racist organisation. There

is a growing recognition and acceptance that racial injustices and ingrained inequalities are apparent in society and in organisations and that this leads to differential experience, differential access to services and differential outcomes for particular groups e.g. higher numbers of Black men in secure mental health services, higher numbers of Black women who die in childbirth compared to other racial groups.

28. I have also continued to meet with all NEDs individually.

System Collaboration and Working

29. On 13 March I was involved in the appointment of the Integrated Care Board Quality NED.

30. 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.

Regulators, NHS Providers and NHS Confederation and others

31. I attend fortnightly briefings from NHS England and NHS Improvement (NHSE/I) for the Midlands region, which has been essential to understand the progress of the management of some considerable system challenges including plans for recovery, industrial action and financial plans and performance.

32. I have also joined, when possible, the weekly calls established for Chairs of Mental Health Trusts, hosted by the NHS Confederation Mental Health Network in collaboration with the Good Governance Institute, where support and guidance on the Board through the pandemic has been a theme, as well as the focus on recovery and stabilisation of services.

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

Assurances

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

Consultation

This report has not been to other groups or committees.

Governance or Legal Issues

None

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

This report reflects a wide range of activities across the Trust, and consideration relating to ensuring inclusion is embedded in operational work of the Trust. I have also continued to develop my own awareness and understanding of the inclusion challenges faced by many of our staff.

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

Demonstrating inclusive leadership at Board level

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

New recruitment for NEDs and Board members has ensured that we have a Board that is representative of the communities we serve.

Recommendations

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

Report prepared and presented by: **Selina Ullah**
Trust Chair

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 9 May 2023

Chief Executive's Report

Purpose of Report

This report provides an update on current local issues and national policy developments since the last Board meeting. The detail within the report is drawn from a variety of sources, including Trust internal communications, local meetings and information published by NHS England, Health Education England, NHS Providers, the NHS Confederation and Care Quality Commission (CQC).

The report is intended to be used by the Board of Directors to inform and support strategic discussion. The Board should note that the report reflects a wider view of the Trust's operating environment and serves to horizon scan for risks and opportunities that may affect the organisation.

National Context

The Hewitt Review

Patricia Hewitt's independent review of Integrated Care Systems (ICSs) was published on 4 April and draws on six key principles: collaboration, a limited number of shared priorities, giving local leaders space and time to lead, providing systems with the right support, balancing freedom with accountability and enabling timely, relevant, high-quality and transparent data. As the report reflects, while there will always be a range of views on some issues, fundamentally there is strong and broad agreement among senior leaders on the overall direction of her recommendations. These include fewer central targets, enabling a shift towards upstream investment in prevention, multi-year funding and payment mechanism flexibility.

The review was commissioned by the Secretary of State for Health and Care and the Chancellor of the Exchequer, so the recommendations are now for consideration by the Government, and they will decide whether they will be adopted. It would be prudent for the Board to consider the recommendations as part of a future Board development session.

2023/24 Operational Planning Round

The Trust submitted its operational and financial plan on 30 March. This formed part of the overall plan submitted by the Derbyshire system. Feedback was provided to all systems, particularly those that were showing a significant gap in terms of financial balance, of which Derbyshire was one. As we know individual NHS bodies have legal responsibilities to seek to deliver within the resources allocated to them by NHS England. We have therefore been working with partners to review our plan to ensure that it meets this requirement. All systems are expected to submit final plans by noon on 4 May. More detail on our plan is provided in a separate item on the agenda.

The Better Care Fund 2023-2025

The Better Care Fund (BCF) Policy Framework for 2023-25 and the Better Care Fund Planning Requirements for 2023-25 were published on 4 April, which set out the detailed requirements for Better Care Fund plans. This provides an extra £1.6 billion of funding to support hospital discharge.

It highlights that mental health, learning disability and autism continue to be an integral area of the BCF and should be considered on an equal footing to physical health, when planning the use of the funding.

Commissioned Review

Board members will be aware of the recent Employment Tribunal findings from Michelle Cox versus NHS England, in which NHS England was found to have treated Michelle unfavourably because of her race. The case highlighted unfair and unjust treatment of Michelle, a senior nurse who won her tribunal against NHSE.

The nature of this case presents a systemic issue of race discrimination and bias across the NHS which we must all address. There will be lessons for us in our policies, the development we provide, how we address concerns and the threshold and management of referral processes to professional bodies.

We have commissioned a review of the case and its findings which will be reported into the People and Culture Committee. The Committee will consider the findings and oversee the action plan coming out from the review.

Within the Trust

Industrial Action

Further industrial action has taken place during April and is planned into early May. The Trust's Incident Management Team, working together with staff side partners, continue to plan for this and at the time of writing we continue to cope and respond in a compassionate and managed way. It is important to state that NHS pay is a matter for the Government and unions, and we will continue to make robust preparations while periods of action continue.

I would like to personally offer my thanks to all colleagues who have been involved in supporting the Trust's Industrial action response.

Service and Team Visits

As part of my CEO induction, I have scheduled a number of service and team visits over the coming months. My intent is to use these to broaden my understanding of Trust services and to provide an opportunity to listen to colleagues across the Trust. During April I have had the opportunity to visit and speak to the following teams:

- Liaison and Crisis Resolution and Home Treatment team (North)
- Occupational Therapists at the Hartington Unit

- Management team at the Hartington Unit
- High Peak Adult Community Mental Health Team
- High Peak and North Dales Older Adult Community Mental Health Team
- Buxton and High Peak and Dales Dementia Rapid Response and Intensive Home Treatment Team
- Tissington ward

I also held my first CEO drop-in session on 21 April. Several colleagues dropped in to welcome me to the Trust, to offer their support and took the opportunity to raise a number of issues with me.

Overall, it has been pleasing to hear from colleagues about positive work that they are taking forward. This is alongside various issues and frustrations that they wanted me to hear. I intend to collate this feedback, seek to understand any themes and will add more detail to my report for July's Trust Board meeting.

Engagement Events

I held my first all staff engagement event on 4 April and it was pleasing to see many colleagues attend. It was an opportunity for me to introduce myself and to give a brief overview of how I, with the Executive Team, intend to approach the next few months. I have an extended presentation to the Council of Governors on 9 May to set out this approach, to support governors in their key role of representing our communities.

Medical Senate

I was pleased to be invited to the launch of Derbyshire Healthcare's Medical Senate at a face-to-face event in Higham. Our Trust employs around 130 doctors as Consultants and Staff grade colleagues in psychiatry and community paediatrics, many of whom have worked in our Trust for more than a decade.

The Medical Senate replaces the Trust's Medical Advisory Committee. Its purpose is to better use the collective expertise and wisdom of this experienced medical workforce, which is not always consistently harnessed and optimally deployed in how we embed transformation and strategy change in the organisation. The Medical Senate will also provide a forum to practise, and exercise distributed and collective medical leadership beyond the formal medical leadership roles.

The first meeting discussed important issues like the new draft Section 117 policy, Shared Care Record sharing agreements with system partners and a proposal for a Just and Learning Culture pilot with regulatory body the General Medical Council.

Service information

The new mental health street triage service was launched on 27 March, in partnership with Derbyshire Constabulary. Every day between 4pm and midnight, mental health professionals will travel in two police cars – one in the north of Derbyshire and one in the south – and provide support to people in emergency situations who appear to be in mental distress. The team will attend mental health-related incidents and provide on-scene assessments, ensuring people receive the right care as quickly as possible, including crisis alternatives where

appropriate; this should reduce the need to detain people unnecessarily. We are very proud to have this service and very grateful to colleagues who have worked so hard to make the service a reality – first with the pilot scheme last year, and now with the official launch.

Our Derby Drug and Alcohol Recovery Service, the NHS-led partnership to help Derby residents make positive changes in their drug or alcohol use, has been recommissioned by Derby City Council – with a greater focus on proactive working in order to reach out to more members of the community. The service has been recommissioned by Derby City Council's Public Health team, who have awarded a three-year contract starting on 1 April 2023. It will be run by the Trust along with national charities Phoenix Futures and Intuitive Thinking Skills.

Our Work Your Way Individual Placement and Support (IPS) service has received the national quality mark for IPS services as a result of a recent Fidelity Review. Congratulations to everyone who was involved in this achievement, I know it's not an easy process and that there was a lot of good practice identified in the review including the positive team culture, good communication, good employment support and a focus on continuous learning and collaboration. This achievement is particularly impressive given the service first launched in March 2020, in the height of COVID restrictions. Despite these initial challenges, the team has continued to grow and improve and support many local people into paid employment.

The Trust's Children's Universal service have successfully achieved Baby Friendly accreditation. This is an important accreditation from the World Health Organisation and UNICEF, aimed at supporting public services to better support families with feeding and developing close, loving parent-infant relationships, ensuring that all babies get the best possible start. To achieve this accreditation the team had to achieve a minimum score of 80% on every standard of care being assessed. The assessment team said it was clear pregnant women and new mothers receive a very high standard of care from our teams.

The Trust's Children in Care and Adoption Health team received excellent feedback from NHS Derby and Derbyshire Integrated Care Board (DDICB) for demonstrating good practice. The team, who are specially trained to offer confidential support and advice to children in care and their foster carers, were recognised by DDICB for their Children in Care Markers of Good Practice (MOGP) Action Plan for 2022/23 submission. In a letter from DDICB, the team were praised for demonstrating the organisation and team's commitment to meeting the needs of Children in Care at every stage of their journey in the care of the local authority and wider.

Joined up Care Derbyshire (JUCD) Developments

<u>Provider Collaborative Leadership Board Partnership (PCLB) Update</u>

Provider collaboratives are the vehicle for joining up the delivery of health care and vary in scale and scope. They are essential in the development of strong Integrated Care Systems (ICSs) as they can support and enable vertical integration (e.g. primary, community, local acute services) and horizontal integration (e.g. across multiple places or across multiple ICSs). The JUCD Provider Collaborative was established in early 2022 as part of the transition to the

ICS, reflecting national guidance that all mental health and acute providers should be members of at least one provider collaborative by April 2022.

The JUCD Provider Collaborative was initially constituted in 'shadow' form prior to the legislative enactment of Integrated Care Boards in July 2022. The JUCD Provider Collaborative Leadership Board incorporates Hospital Services (secondary, tertiary, networks), Mental Health, Community Services, Ambulance (999 and 111 / Urgent and Emergency Care) and General Practice (In and Out of Hours Primary Care). The JUCD PCLB is an executive group dedicated to driving forward the collaborations which it identifies as being required on behalf of the provider Boards and functions through engagement and discussion between its members. Direct accountability is to provider Boards.

The attached terms of reference (ToR) (Appendix A) does not seek to be binding, but instead sets out the principles and approach to working together to deliver seamless quality services for the people of Derby and Derbyshire, which meet the quadruple aim of JUCD of improving experience of care (quality and satisfaction), improving the health of the population, improving staff experience and resilience, and reducing the per capita cost of healthcare.

A Partnership Agreement and ToR for the collaborative are in place and were recently revised and approved by the PCLB in February 2023, to reflect the fact that we are no longer a 'shadow' Board and to include some agreed responsibilities such as oversight of the System Delivery Boards and Transformation Group. Previous versions of these documents reflecting the previous 'shadow' status of the collaborative were approved by Trust Boards in March 2022.

The Health Act 2022 provides a legislative framework for delegating statutory responsibilities to provider collaboratives from NHS providers and/or ICBs. The current governance position in Derby and Derbyshire is that the PCLB is directly accountable to provider Boards but does not have any delegated accountability and takes decisions through the executive accountability of its members.

Within JUCD we have not yet enacted any formal delegation to our provider collaboratives although there is an expectation that this will be done in time. As the Provider Collaborative starts to take on more formal responsibilities within the ICS structure, such as taking formal responsibility for delivery and transformation structures and establishing working arrangements for the collaborative delivery of clinical services such as Musculoskeletal (MSK), we are at the point that we now need to review the governance arrangements for the Provider collaborative.

A working group has recently been established to consider the merits of establishing a governance route for shared and formalised decision making as and when required, focussing on MSK as the first practical example. This group aims to underpin existing ways of working and provide a framework to build from, as necessary, to fulfil either the need, potential or ambition of JUCD Boards. The shape of any future shared governance needs to enable and reflect our ambition for change.

Other examples of opportunities for more formal delegation lie within mental health to enable governance of a more formal collaborative delivery vehicle with greater ability to take decisions about the commissioning and delivery of services for our

patients. The area of delegation to provider collaboratives raises many complex issues and is a relatively new one in terms of national policy and the assurance framework to support providers and ICBs in setting up new ways of working. We are working closely with regional colleagues and learning from other areas as we develop our thinking, but it is likely that we will require some external support prior to establishing any new formal governance structures.

The attached slide pack (Appendix B) summarises the Collaborative's vision, purpose, strategic priorities and progress to date, in the form of a joint presentation given with System Place leads to the ICB Board in March. The presentation also contains details of the collaborative's programme of work and 5-year plans including milestones and measures of success for each of the strategic areas of focus. The measures of success have been informed by the national maturity matrix for provider collaboratives.

I am pleased that we have set time aside in our Board development session in June to further develop our collective understanding of Place and Provider Collaborative development. The Board previously approved the PCLB ToR in March 2022 and have continued to receive progress updates through the CEO report.

The ToR have been updated to reflect the maturing relationship between partner organisations and I am asking the Board to approve the revised version.

Looking Ahead

Colleagues have started to make preparations to celebrate the 75th birthday of the NHS in July. Our Medical Director, Dr Arun Chidambaram, gave a talk to students at Shirebrook Academy in north-east Derbyshire in March, explaining about the many different careers that the NHS has to offer. Arun was the first speaker to mark the upcoming NHS birthday, as part of a new national partnership between Speakers for Schools and NHS England. The aim of the partnership is to help inspire young people to consider a career in the NHS.

Our Staff Networks are coming together to hold a joint conference, which will take place on 10 May. This will include a full day of discussions and activities to share the progress that all our Staff Networks have achieved over the last year and to provide a platform to gather information and support for our Networks for the future.

The Trust will be holding a free virtual information event to help those affected by dementia, on Wednesday 10 May from 6 to 8pm via Microsoft Teams. The free question and answer session is aimed at people experiencing memory problems or those diagnosed with dementia and their carers, as well as anyone who wishes to learn more about support.

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

Risks and Assurances

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

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

Consultation

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

Governance or Legal Issues

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

Public Sector Equality Duty and Equality Impact Risk Analysis

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

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

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

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

Recommendations

The Board of Directors is requested to:

1) Scrutinise the report and appendices, noting the risks and actions being taken.
2) Seek further assurance around any key issues raised.
3) Approve the ToR appended to this report.

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

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

Joined Up Care Derbyshire (JUCD)
Provider Collaborative Leadership Board Partnership (PCLB) document and Terms of Reference (ToR)

February 2023 – issue number 1.4

Development / Changes from the previous version

Updated for clarity and to take account of accountabilities in relation to Delivery Boards and system transformation.

Where reference is made to the Board this means the Provider Collaborative Leadership Board. The term provider Boards refers to the Boards of the providers which make up the PCLB.

1. Background

Provider collaboratives are the vehicle for joining up the delivery of health care and vary in scale and scope. They are essential in the development of strong Integrated Care Systems (ICSs) as they can support and enable vertical integration (e.g., primary, community, local acute services) and horizontal integration (e.g. across multiple places or across multiple ICSs).

Provider collaboratives support improved decision making and delivery across multiple organisations. Through collaborating at scale, they can effectively align strategic decision making and make quicker and more effective decisions including standardisation of approaches and delivery where variation is unwarranted. Through working together providers can make the best use of the resources available and support the strategic aim of reducing health inequalities.

This can be over local areas known as being ‘at Place’ but sometimes, many people will have more complex or acute needs, requiring specialist expertise which can only be planned and organised effectively over a larger area than Place. This may be because concentrating skills and resources in bigger sites improves quality or reduces waiting times; because it is harder to predict what smaller populations will need; or because scale working can make better use of public resources. Because of this, some services such as hospital, specialist mental health and ambulance needs to be organised through provider collaboration that operates at a whole-ICS area – or more widely where required.

The intention is that all people served by the ICS, and wider East Midlands collaborations are able to:

- Access a full range of high-quality acute hospital, mental health and ambulance services.
- Experience fair access to these services, based on need and not factors such as geography, race or socio-economic background.
- Optimise pathways of care to achieve best in class health and care outcomes for the people of Derby and Derbyshire

The JUCD Board has agreed that Provider Collaboratives will cover:

- Hospital Services (secondary, tertiary, networks)
- Mental Health
- Community Services
- Ambulance (999 & 111 / Urgent and Emergency Care)

- General Practice (In & Out of Hours Primary Care)

The scope will include a plan to modernise and develop services including on a wider area (at scale) and transformation to ensure the quality and sustainability of services. The scope will also explore the use of clinical networks, system level support and mutual aid arrangements between organisations to enhance resilience, together with fair and equal access to services across the ICS area, and East Midlands ICS network(s). It will also ensure collaboration in the delivery of health, social and economic development by improving provider productivity, efficiency and reduce unwarranted variation. The collaborative will also agree non-clinical areas of focus where a wider economy of scale would improve outputs, efficiency and effectiveness.

2. The providers

- Chesterfield Royal Hospital NHS FT
- Derbyshire Community Health Services NHS FT
- Derbyshire Healthcare NHS FT
- DHU Health Care C.I.C
- East Midlands Ambulance Service NHS Trust
- University Hospitals of Derby and Burton NHS FT

3. The Board and Governance Approach

The Board has been formed by the NHS provider organisations in the JUCD ICS as a single Provider Collaborative Leadership Board to manage the collective endeavours of the Derbyshire NHS Providers. The approach is in line with the requirements of the ICS Design Framework and the opportunities for different ways of working identified in the Health and Care Act.

The Board is an executive group dedicated to driving forward the collaborations which it identifies as being required on behalf of the provider Boards and will function through engagement and discussion between its members. Direct accountability is to provider Boards.

This document does not seek to be binding but instead sets out the principles and approach to working together to deliver seamless quality services for the people of Derby and Derbyshire which meet the quadruple aim of JUCD of:

- Improving experience of care (quality & satisfaction),
- Improving the health of the population,
- Improving staff experience and resilience, and
- Reducing the per capita cost of healthcare.

The providers acknowledge that arrangements will evolve and agree that the key to all collaboration is working together to build trust, and to begin with a streamlined governance structure and build as situations or emerging regulation require.

It is envisaged that in time the full Provider Collaborative Leadership Board may take the form of a joint committee made up of the constituent organisations with delegations from these bodies to enable it to make appropriate decisions on their behalf. The Board is established by the providers, each of which remains a separate legal entity accountable for the services they provide, to ensure a governance framework for the further development of collaborative working between the providers.

The Board gives the opportunity to determine the areas of interest which it will be appropriate for the provider collaborative to concentrate on and therefore clarity regarding any delegations will be determined as required.

The actions of the participants and bodies represented will:

- be driven by the interests of the people and communities served.
- Support each other to address barriers to system transformation.
- Design health, care and wellbeing services to meet the needs and wants of the people who use them, not the organisations who provide them.
- Ensure services are provided as close as possible to the places people live.

To ensure these aims in operating as a Board it will:

- Be guided by the approaches defined through the Provider Chairs and Chief Executives meeting.
- Function through engagement and discussion between its members. Any agreements reached at the Board will be enacted through the decision-making processes of the organisations involved.
- Seek to reach consensus in deciding its recommendations and making decisions on system matters. The Chair will actively seek to reach decisions by consensus. If consensus cannot be reached, views which oppose the majority view will be recorded and presented with the report/advice ensure transparency.

The Board is made up of willing partners and as such, any of the six member organisations can withdraw from the Board. This should be done in writing from the CEO and Chair of the organisation to the other Provider Collaborative Leadership Board members giving at least one months' notice. It should be noted that the legislation requires Acute and Mental Health providers (as a minimum) to be part of one or more provider collaboratives.

The work of the Board will be supported by a Programme Director who will work across the constituent bodies and be hosted by one of the provider organisations (currently Derbyshire Healthcare Foundation Trust).

4. Membership and Business

Membership and quoracy arrangements are set out in the terms of reference. Membership will reflect the need for a clear senior leadership driving collaborations and the need to bring in a wide range of expertise.

Core Members are:

- Accountable for contributing and taking personal responsibility for achieving the purposes set out in the Terms of Reference and taking forward relevant decisions to or on behalf of their organisations.
- Expected to act as facilitators, providing effective communication for the programme to engage their respective organisations in the developments, modelling collective leadership.
- Expected to provide information as necessary to support the undertaking of accurate analysis to inform developments.
- Responsible for keeping their organisational board or equivalent updated on the progress of the ICS and the provider collaborative and will take key items for approval ensuring timely decision making does not delay the work of the ICS development and delivery.
- Will confirm to all provisions regarding conflicts of interest detailed in the terms of reference. The approach to conflicts of Interest will also be guided by the approach identified in Section G of the document *'Interim Guidance on the functions and governance of the integrated Care Board'* (NHS August 2021) or any updated versions.

The ICB has members from two of the provider Boards which ensures a link between the ICB and the Provider Collaborative Leadership Board.

The work of the Board will involve:

- Advising on the collective approach to look at the scope of opportunities at scale in areas requiring a bigger footprint approach to provision. It is the sole purpose of the Board to work on these areas on the collective behalf of the providers and to engage meaningfully with the Health and Care partnerships to further influence change.
- Confirming what added value provider collaborations at scale will offer, and what will the respective approaches to collaboration at scale be in terms of configuration, functions, accountabilities and supporting infrastructure.
- Working closely with the Integrated Place Executive and the Place Partnership Boards and the system Delivery Boards/Place Alliances to collectively influence how the system operating model may need to change based on the outcomes of these JUCD programmes.
- Receiving updates from each of the providers in relation to the programme of work defined for delivery through provider collaboratives at scale.
- Overseeing the development and implementation of an annual work programme which reflects the agreed priorities of the Board and works towards the future operating model, responding to opportunities and shared challenges through collaborative work.
- Keeping the provider Boards and ICB appraised of its work and progress.
- Reviewing its effectiveness and approach at every meeting and reviewing progress against the agreed maturity matrix.

<u>In doing this the Board will:</u>

- Provide joint system leadership to transform and address provider quality and efficiency, working together at scale with a shared purpose and effective decision-making arrangements.
- Plan, deliver and transform services, address unwarranted variation and inequality in access, experience, and outcomes across wider populations, improve resilience and ensuring that specialisation and consolidation occur where this will provide better outcomes and value.
- Identify and agree opportunities and priorities for collaboration in line with strategic objectives
- Agree on deployment of local assets and resources for service recovery, restoration and transformation
- Agree management of risks and mitigations of each provider partner
- Agree the strategic plan for provider collaboration for recommendation to ICB Board

The agreed areas of focus for the Board are:

- Evolution and development of the JUCD Provider Collaborative
- Clinical pathway Redesign
- Clinical Pathway Enablers
- Monitoring the performance of our (provider) system
- Corporate Efficiency

5. Information Sharing and Confidential Information

It is essential to ensure full collaboration that relationships are built on mutual trust. Key to this is confidence that providers will share all information that is required in order to achieve the best outcome for the citizens of Derbyshire and that the information that is shared is treated appropriately.

As such whilst nothing in this document impacts on providers' regulatory or statutory obligations it is anticipated / expected that:

- Providers will make sure that they share information, and in particular competition sensitive information, in such a way that is compliant with competition and data protection law. The approach will be in compliance with the Provider Selection Regime which it is anticipated will be included within the Health and Care Act.
- All providers will keep in strict confidence all confidential Information it receives from another provider.
- Providers will only use confidential information received from another provider for the purpose of collaboration and not for any other purpose.

Terms of reference for the Provider Collaborative Leadership Board

1. Purpose

The Board provides the formal joint leadership for the collaborations to enable the delivery of a shared agenda. It provides oversight of the development and delivery of a robust, viable and deliverable sustainability and transformation plan and new ways of working which meet the healthcare needs of the citizens of Derby and Derbyshire

The Board will be responsible for the following key functions:

- Providing joint system leadership to transform and address provider quality and efficiency, working together at scale with a shared purpose and effective decision-making arrangements.
- Planning, delivering, and transforming services, to address unwarranted variation and inequality in access, experience, and outcomes across wider populations, improve resilience and ensure that specialisation and consolidation occur where this will provide better outcomes and value.
- Identifying and agreeing opportunities and priorities for collaboration in line with strategic objectives
- Agreeing the deployment of local assets and resources for service recovery, restoration and transformation
- Overseeing the management of risks and agreeing the mitigations of each provider partner
- Agreeing a strategic plan for collaboration for recommendation to ICB Board

2. Accountability

The Board is directly accountable to the provider Boards. The Chair represents the voice of the Provider Collaborative Leadership Board and provides regular reports (including but not limited to, risk management and delivery). In addition, an annual report will be provided to the ICB/ to include progress and a summary of key achievements. Wider oversight and accountability is provided through the provider organisations and the / ICP.

The Chair is responsible for proactively notifying the Chair of the ICB of any matters pertinent to the business of the Board. The Board will work closely with the Provider Collaborative at Place processes and individual organisations lead officers within the ICS.

The Provider Collaborative is accountable for overseeing the delivery and transformation programme on behalf of the ICS. The PCLB will set up appropriate governance structures to fulfil this responsibility, including the system Transformation Co-ordinating Group. The PCLB will receive regular reports on delivery, risks and escalations from the Transformation Co-ordinating Group (TCG) and consider this as a standing item on each agenda. The PCLB will ensure that reportsare shared with the Integrated Place Executive and NHS Executive in relation to the delivery and transformation programme, including reporting on risks and escalations that cannot be resolved within the PCLB.

3. Membership, attendance and responsibilities

The initial approach is to focus on a core membership which can be expanded as the Board matures. Any changes to Core members will require agreement by the Provider Boards with any changes to ‘Partner Members’ or those to be ‘In attendance’ agreed by the Board via amendment to the Terms of Reference.

The membership of the Board will be:

Core Members

Provider CEOs (6). If the CEO is not able to attend the CEO may designate their deputy CEO to attend or in exceptional circumstances a role of equivalent seniority – any designate must have the ability to make decisions on behalf of the relevant CEO at the meeting. The Executive Director of Strategy & Transformation EMAS will represent EMAS.

Partners

- Programme Director (SRO), Provider Collaborative
- Chair of Derbyshire GP Provider Board
- Representative from the Clinical Professional Leadership Group & SRO work stream leads for Delivery Boards
- Chief Digital Information Officer and Chief People Officer as appropriate
- Enablers System SRO for finance and estates and others as appropriate

In attendance

- By invitation – other partners / links from other systems
- Governance / finance / communications support (as needed)
- Specific individuals/roles supporting the development of the Provider Collaborative Leadership Board will also be invited to attend.

It is expected that members will prioritise meetings and make themselves available. Members, through notifying the Chair in advance of the meeting, may identify a deputy of sufficient seniority who will have delegated authority to make decisions on behalf of their organisation in accordance with the objectives set out in the Terms of Reference for this Board and relevant agenda items.

Members are expected to attend at least 75% of meetings held each calendar year to ensure consistency.

4. Quorum

The meeting will be quorate when four of the provider Chief Executives or their deputies are present.

If any member of the Board has been disqualified from participating in the discussion and/or decision-making for an item on the agenda, by reason of a declaration of a conflict of interest, then that individual shall no longer count towards the quorum for that part of the meeting.

5. Chairing arrangements

The meeting will be chaired by a NHS Provider CEO and will be chosen through the agreement of the core members. The term of office will be for 12 months unless otherwise agreed by a quorate meeting of the Board.

Should the Chair or vice not be present at a meeting the core members present will agree which of their number will take the chair for that meeting.

6. Meeting Process

The group will meet formally before every ICB Board meeting to ensure all information submitted to the Board has been properly scrutinised and to develop an agreed view on any future issues arising. The Chair may arrange extraordinary meetings at their discretion and if required to consider matters in a timely manner.

The meeting may be held, and meeting papers distributed, through electronic means. Where necessary, members will be required to respond to virtual electronic communications to consider issues.

The Chair will be responsible for agreeing the agenda; ensuring matters discussed meet the objectives as set out in these Terms of Reference and sent to members and attendees, unless by prior agreement, a minimum of two working days before the meeting. Additional items for the agenda will be taken by exception with the knowledge and agreement of the Chair in advance of the meeting commencing. Brief minutes of the meeting and a note of actions will be taken at the meeting.

The preparation and distribution of the agenda and meeting records will be supported by the provider organisation which takes the chair. The brief minutes and action notes will be circulated to members for approval at the next meeting.

There will be a standing agenda item at the end of each meeting to check the objectives have been met and review effectiveness of the discussions.

7. Delegated Authority

At this stage the Board has no formally delegated authority from the Boards of statutory organisations.

The seniority of individual members means that they are committing their respective organisations and making decisions within the scope of their own authority in tandem with other members of the group.

8. Urgent Decisions

The Board may be required to take urgent decisions. An urgent decision is one where the requirement for the decision to be made arises between meetings and in relation to which a decision must be made prior to the next scheduled meeting. Where an urgent decision is required, a supporting paper will be circulated to all members. To reach a consensus view or make a decision the members may meet either in person, via video / telephone conference or (where meeting in person or remotely is not possible) communicate by email to take an urgent decision. Requests for all urgent decision will be made by the chair (or in the chair's absence the vice chair) and administered through the provider organisation which takes the chair.

The quorum will be as described in section 4 and will require the participation of four of the Provider Chief Executives or their deputies. In such circumstances, a minute of the discussion and decision will be taken by the secretary and will be reported to the next meeting for formal ratification.

9. Conflicts of interest

As a Provider Collaborative Leadership Board not yet taking delegated decisions the requirements in relation to conflicts are less onerous, however it is felt important that good practice should be followed and therefore Members should adopt the following approach:

- That they continue to comply with relevant organisational policies/governance framework for probity and decision making.
- A register of interests will be recorded and maintained. This will be reviewed annually to ensure accuracy, in the intervening periods members should declare any unregistered interests pertinent to the agenda on an on-going basis. Members will be responsible for notifying the Chair of any changes to their respective declarations as and when they occur.
- In advance of any meeting, consideration will be given as to whether conflicts of interest are likely to arise in relation to any agenda item and how they should be managed. This may include steps to be taken prior to the meeting, such as ensuring that supporting papers for a particular agenda item are not sent to conflicted individuals
- The Chair will take overall responsibility for managing conflicts of interest pertinent to agenda items as they arise; any such declarations will be formally recorded in the minutes of the meeting
- The Chair will determine how declared interests should be managed, which is likely to involve one the following actions:
    I. Allowing the individual to participate in the discussion, but not the decision-making process.
    II. Allowing full participation in discussion and the decision-making process, as the potential conflict is not perceived to be material or detrimental to the decision-making arrangements.
    III. Requiring the individual to withdraw from the meeting for that part of the discussion if the conflict could be seen as detrimental to the discussions

In considering the approach to Conflicts of interest the Chair will take account of the guidance given in Section G of the document *'Interim Guidance on the functions and governance of the integrated Care Board'* (NHS August 2021) or any updated versions including the advice that

- It should not be assumed that members are personally or professionally conflicted just by virtue of being an employee, director, partner or otherwise holding a position with one of these organisations.
- Actions to mitigate Conflicts of Interest should be proportionate and should seek to preserve the spirit of collective decision-making wherever possible.
- ICBs should clearly distinguish between those individuals who should be involved in formal decision taking, and those whose input informs decisions, including shaping the ICB's understanding of how best to meet patients' needs and deliver care for their populations.

10. Review

The Board will review its effectiveness and approach to full status at every meeting and review progress against the maturity matrix.

In reviewing its effectiveness, the Board may amend its Partnership Document and Terms of Reference by resolution. The meeting will confirm whether the changes are substantive enough to require consideration by the provider Boards. Where this is indicated the changes will not take effect until the consultation has been undertaken. The revised Partnership Document and Terms of Reference will be shared with the ICB once confirmed.

These Terms of Reference will be reviewed at least annually to ensure good governance practice.

Joined Up Care Derbyshire

Place and Provider Collaborative Development: 5 year roadmap and next steps

Penny Blackwell and Stephen Posey

16th March 2023

Contents:

Joined Up Care Derbyshire

Place Vision and Purpose

Our Vision

Empowering people to live a healthy life for as long as possible through joining up health, care and community support for citizens and individual communities.

Our Purpose and function

- **Co-ordinate and integrate local services** built on a mutual understanding of the population and a shared vision;
- Take accountability for the delivery of coordinated, **high quality care and improved outcomes for the population;**
- Take on the **planning, management of resources, delivery, and performance** of a range of community-based health and care services, in line with the strategic requirements of the ICB and ICP.
- Deliver through **a social model that is outcome driven and strength based**; focussing on the assets of individuals and communities and developed with them through local leadership
- Progress towards our ambition for delegated responsibility and accountability to enable maximum impact from existing and enhanced structures
- **Co-ordinate and support delivery of the Integrated Care Strategy.**

Provider Collaborative Vision and Purpose

Our Vision

***Working together as providers to achieve tangible improvements to the way care is delivered*, supporting the Joined Up Care Derbyshire quadruple aim**

Our Purpose and function

To **add value** to the ICS and beyond by:

- developing and **delivering collaborative approaches to specific challenges** within providers' gift to resolve
- addressing **efficiency, productivity and sustainability** through collaborative working, integration or the consolidation of service delivery or corporate functions
- developing **partnership relationships**, strengthening communication between providers, sharing approaches to challenges and opportunities
- **reducing inequalities of access and unwarranted variation**, where provider collaboration can best achieve this
- taking on some **commissioning responsibilities** within the ICS where this will align better with operational delivery and transformation**, improve decision making and accelerate change**

Strategic Priorities/Areas of Focus

	Provider Collaborative	Place
Organisational development, governance, leadership	Growth and evolution of the provider collaborative	Developing Place Operating model
Integrated, sustainable model of care, Improved outcomes	Clinical pathway improvement	Integrating and transforming services
Workforce, digital, estates	Clinical Pathway Enablers	Enablers of integrated care
Improving outcomes and value	Corporate efficiencies	Improving Population Outcomes
Delegated functions within the ICS	Oversight of delivery and transformation programmes	Co-ordinating delivery of the integrated care strategy

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What has been achieved so far

Provider collaborative achievement so far

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Progress
in establishing PCLB, relationships and ways of working

5
Strategic Areas of focus agreed by the Provider Collaborative

Stocktake was undertaken in
Sept 22

Clinical Enablers
structures, priorities and leadership in place

Clinical priorities:
Phase 1 – MSK & orthopaedics referrals, and speech and language therapy. Phase 2 - fragile services and delivering the integrated care strategy

Collaborative has taken responsibility for delivery and transformation activities across the system

Collaborative areas of focus – progress and maturity

Area of Focus	Evolution and development of JUCD provider collaborative	Clinical pathway design	Clinical pathway enablers	Monitoring system performance, overseeing performance delivery and transformation	Corporate efficiencies
Confirmed Lead	Stephen Posey/Tamsin Hooton		Jim Austin/Amanda Rawlings	Tamsin Hooton	Simon Crowther
Governance/ Delivery groups					
Agreed Priorities			Digital People Services Estates/Other		
Plans in place			D3B and PS		
Maturity Level	Developing	Emerging	Developing	Developing	Emerging
Next steps	Confirm accountability arrangements with ICS, develop programme work. OD plan	Complete prioritisation process and confirm clinical priorities	Agree options for People services collab.	Finalise Transformation and Delivery governance, decision making and escalation. Embed e-PMO	Identify opportunities and priorities.
Overall Status					

What has been achieved so far? Place

Local Place Level

The top delivery priorities for Local Place Alliances include ensuring a range of services within the Team Up approach plus partnership development and addressing local needs, for example;

1. Set-up of acute home visiting services at scale by supporting PCNs through the planning, governance, implementation and delivery process.
2. Support implementation of a phased delivery programme of an integrated local access point for urgent community response involving DCHS, Social Care, home visiting and falls recovery services.
3. Continue to develop mental health working groups to support local mental health priorities and support the delivery of the Community Mental Health Framework and the development of Living Well Teams locally.
4. Continue to maintain, support and develop multi disciplinary team working at scale to support care homes.
5. Continue to maintain, support and develop connections across the wider Place between all partnerships
6. Continue current work on priorities based on local need as identified via local population health needs assessment and other local sources of intel/data/information.

System Level

- Transitioned to Partnership Boards and new structures.
- Pro-actively identifying the links between key strategies and place delivery (eg dementia care, end of life, personalisation, children's services, adult social care)
- Championing the use of insights to drive change including supporting community research.
- Driving an approach to identify sentinel markers that measure what matters and demonstrate the impact of place based approaches including integration indicators
- Oversight of discharge transformation and delivery.
- Identifying and resolving new and complex challenges around regulatory requirements and integrated provision.
- Modelling behaviours of distributed leadership and development of mutual accountability.
- Influencing infrastructure enablers to support integrated delivery across partners
- Championing collaborative working, prevention, early intervention and health inequalities in every Place project and workstream at local and system level.
- Initiated ambitious transformation programme – diagnostic phase amount to commence.

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5 year roadmap: priorities, milestones and measures of success

SEE APPENDICES FOR DETAILED ROADMAPS

Provider collaborative priorities and measures of success

Developing the JUCD Provider collaborative

Governance and delegation

Boards understand what decisions the collaborative can take; any schemes of delegation from boards to collaboratives are clear.

Leadership

Board members and NEDs have a clearly defined role and actively support collaboration

Resourcing and leadership

The collaborative is well-resourced to deliver benefits at scale. Shared provider leadership roles where this supports integration

Working with partners

Collaborative has strong relationships with partners and other collaborations

Clinical Pathways

Improving health outcomes and population health

Health inequalities in access, experience and outcomes are reduced via evidence informed, measurable actions that are frequently monitored

Clinically led programmes of change

Clinical input shapes transformation programmes, led by multi-disciplinary clinical leaders.

Sustainable clinical services

Effective systems to identify & address fragile services, with options implemented

Clinically and financially sustainable model of care

Collaborative has a clinical strategy aligned to wider ICS strategy

Provider collaborative priorities and measures of success

Clinical Pathways Enablers

Digital, Data and Technology

Shared digital solutions used where this achieves efficiencies, information sharing or joint working and regular evaluation of effectiveness and seeking out further opportunities.

Workforce/ People Services collaborative

Using resources and capacity flexibly where necessary. Staff of each collaborative member feel able to work collaboratively with partner organisations

Estates

Reduced total system sqm and numbers of premises. Health and care estate is fit for purpose and supports integrated care model.

Pharmacy

Pharmacy operations are integrated to make best use of resources, increase productivity and efficiency as demonstrated by benchmarking

Oversight of performance, delivery and transformation programmes

Improve outcomes, sustainability, productivity

Continuously innovating, contributing to the design & delivery of ICS objectives & design of the forward plan, with clear lines of accountability and regular performance reviews and routine support.

Efficiency & productivity through collaboration & at scale models

Financial risks & savings shared across members. Improved benchmarks of productivity/GIRFT/MHosp.

Corporate Efficiencies

Corporate efficiencies/back office functions

Clinical support and corporate functions are delivered jointly where efficient and savings are effectively reinvested

Place priorities and measures of success

Developing Place Operating model

Place Partnership Boards

Fully established Place Partnership Boards (City and County) with clear responsibilities in relation to IPE, local places, HWB structures and other partnership functions.

Integrated Place Executive

Driving the Integrated Care Strategy, successful delivery of population health improvements and integrated care

Local Place Alliances

Working to a shared partnership agenda Clear LPA scope and remit. Consistent of member input System enabler support provided. Delivering local improvements in services and outcomes

Resourcing and leadership

Success demonstrated by the fact that it becomes neither possible nor necessary to identify whether someone is working for 'place'

Integrating and transforming services

Team up (existing)

Full implementation of existing Team up programme

Team Up (expansion)

Improvements made across whole pathway of care supporting locally developed improved experience, outcomes and cost effectiveness.

Discharge Transformation

Positive discharge flow patient experience and outcomes delivered by matched capacity and demand and effective care processes. System confidence supporting reduced reliance on bedded care.

Provider Collaboration

Maximised opportunities to use resources flexibly and collaboratively between partners

End of Life

TCB

Strengths based approaches

TCB

Living well- CMHF

TCB

Role re Fuller response / implementation

TBC

Place priorities and measures of success

Enablers

Digital

Shared information on individuals to support care delivery (DSCR & DiSc) Digitally enabled care and technology enabled care readily available.

Business Intelligence

Data strategy and function effectively supports and delivers a population health management system to ensure care coordination and integration is informed by population health data and analytics

Workforce

Place based workforce strategy (including new skills / roles to support integrated care)
Maximise opportunities within place delivery of the 'one workforce' approach.

Estates

Place based estates strategy to serve places not organisations

.

Finance

Funding model and distribution of resources that supports population health Place based planning and integrated provision.
Delegated responsibility enacted

Population outcomes

Understanding need

Place (at all levels) is driven by a clear understanding of population health needs and its role in addressing those

Prevention

Maximising opportunities to increase prevention across place functions through integrated partnership working

Inequalities

Maximising opportunities to reduce inequalities across place functions through integrated partnership working

Working with communities

Stakeholder engagement is assured including with VCSE partners, embedding co-production with local service users and amplifying the voice of the least heard.

Integrated Care Strategy

Structure and approach

Clear mechanisms that enable oversight and support by the IPE to delivery of the strategy on behalf of ICP

Age well / die well Key Area of Focus (IPE responsible)

Delivery against agreed evaluation measure (to be determined in first phase)

Leadership, accountability, roles and responsibilities

Leadership and accountability: strategic direction

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- The ICB is a strategic commissioner and a facilitator of integration
- The PCLB along with Place design the operating model for integrated care, deliver operational performance and improvement/transformation and provide assurance on this to the ICB
- The provider collaborative takes an increasing role in overseeing collective planning and delivery of improvement and transformation activities across the system, delivery is led by providers and the place partnerships working in concert
- System Delivery and Programme Boards become more important as units of system planning and delivery
- Shift from a culture of individual organisations developing improvement and efficiency plans to more focus on system programmes of work, although the role that individual organisations play in delivering operational improvement and productivity as well as financial savings will still be key
- As place and the provider collaboratives progress to more formal accountability for the oversight of integrated care we will need to re-calibrate our relationship with one another and the ICB

System Roles

ICP Leads on:

- Integrated care strategy
- Population Health
- Prevention and wider determinants of health

ICB Leads on:

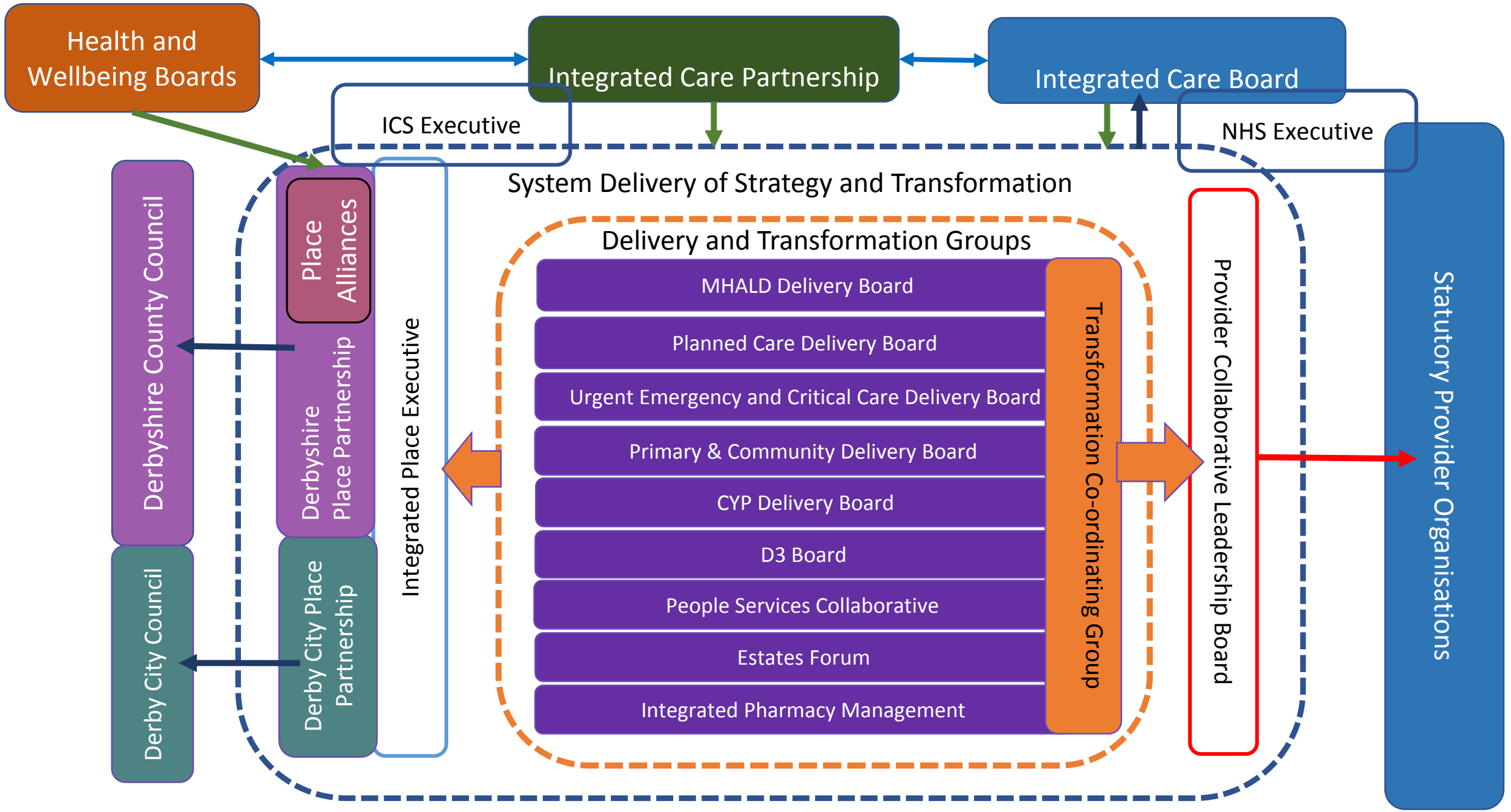
- Facilitating integrated care models
- Strategic commissioning (delegating budgets, setting outcomes)
- Assurance framework for place and provider collaborative
- Provider performance management
- System strategic and operating plan
- System financial plan including allocation of resources

Place leads on:

- Co-ordinating delivery of integrated care strategy
- Understanding and responding to population needs
- reducing health inequalities at the level of communities
- operating model for integrated care at place
- delivering improvement and transformation across places (e.g. Community Transformation)
- engaging communities and wider stakeholders including the VCSE and residents

Provider collaborative leads on:

- delivering sustainable, safe care
- reducing inequalities of access, improving outcomes along pathways
- operating model for integrated care at scale
- co-ordinating and overseeing improvement and transformation plans across system (host role)
- delivery of specific improvement and transformation priorities
- system financial efficiency



Governance diagram showing transformation and delivery function & relationship between PCLB, IPE & system groups

Summary Place Operating Model

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- One Integrated Place Executive (IPE) to co-ordinate and deliver the set of activities that are best done once. These include for example:
  - Identifying Place priorities from system strategic plans
  - Planning, and overseeing the integration and co-ordination of integrated health and care services.
  - Managing relevant whole system transformation programmes.
  - Interface with provider collaborative and delivery boards to determine the implications for local provision.
  - Hold delegated resources and accountability from the ICB
  - Identifying and addressing system / inter-agency barriers to integrated care.
- Two Place Partnership Boards (City & County) drawing priorities from, and influencing priorities in:
  - Integrated Care Strategy
  - Joint Health & Well-being Board Strategies
  - NHS Integrated Care Board plan
  - Joint Forward Plan
- Local Place Alliances responsible for the local co-ordination and delivery.

How place and provider collaboratives will work together

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- Neatly delineating responsibilities and lead areas between place and provider collaborative doesn't accurately describe the **overlap and interdependencies** between different roles.
- All providers are also place partners. Key is having the right work led by the right groups.
- Develop an approach **to population health management** which enables both place and provider collaborative groups to use data to identify issues that need to be addressed and develop appropriate plans in response to this, which jointly deliver against the objectives in the integrated care strategy and which are complementary and comprehensive. Co-ordinated by place.
- Maintain **oversight of system transformation and delivery programmes** through PCLB but recognise place leads on significant element of strategic transformation
- We will **co-ordinate decision** making using system programme and transformation groups and quarterly shared discussions between IPE/PCLB
- Principle of **subsidiarity** is important, **decision making should be delegated** as close to the work as possible
- Use NHS Executive Team/ICS Executive where required for **shared decision making** with ICB and/or local authorities

Leadership and resources to deliver

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- ICB funds and employs a number of roles supporting the place structures and Delivery Board programmes as well as place clinical leadership. Future resources and job roles need to reflect accountability and be aligned to place or provider structures and direction.
- Leadership is often an ‘add-on’ to operational roles for providers and this can hinder progress. We need sufficient resources to be able to release people to lead on our main change programmes, supported by sufficient project management capacity. Resourcing this needs to be done across the system, including the ICB’s contribution
- The provider collaborative will identify shared executive leads for collaborative work and over time develop substantive shared roles
- Provider boards and NEDs role within the collaborative should be enhanced alongside greater delegation to the collaborative
- Operational service managers at local place level should be formally supported to work together.

Delegation – live ‘case studies’

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Mental Health

- Current delegation to the MH Delivery Board is informal. Budgets and financial reporting are managed at ICB level. MHALDB has some decision-making around contracting decisions
- Exploring formal delegation of both commissioning and responsibility for delivery
- Potential models include ‘service integrator’ model in place in BSol ICB
- MH provider leads management of budget, performance and delivery providing assurance to ICB

Musculo-skeletal

- Build on existing service redesign to bring together acute and community triage, referral assessment and treatment models
- Multiple providers involved in pathway including independent sector
- Alliance model proposed
- Providers have delegated responsibility for manging single shared budget to meet patient needs
- Delegation of commissioning responsibilities to a joint committee of providers being explored with the ICB

Working with system partners including our ask of the ICB

Our ask of the ICB

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- **Review governance and delegation** across the ICS to support the direction of travel and ambition described here, co-producing pathway to delegation for providers and place
- develop clear **framework for assurance** & evaluation that recognises adaptive, **progressive approach in relation to roles and responsibilities** and sets out how the ICB will gain assurance on delivery of delegated functions
- **Align appropriate ICB resources** to support Place and Provider Collaborative responsibilities and workplan priorities
- **Develop commissioning strategy for primary care** to ensure that there is a sustainable model of general practice
- Lead work to **develop a financial framework** for devolving budgets and managing financial decision making across the system including budgets for programmes and at place level
- **Enhance collaborative commissioning approaches** to support delivery of integrated care

Working with partners

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- Place will lead on relationship with local authorities, communities and VCSE
- Provider collaboratives will identify specific areas where direct engagement is needed e.g., VCSE alliance input to pathways, service reconfigurations and maintain regular engagement with Health and Wellbeing Boards
- A commitment from **all partners to resource place and system work**, giving staff autonomy and mandate to give support to agreed programmes of work
- Develop and embed use of **community insights** in both place and provider work
- **'Zip up' Health and Wellbeing connectivity** from neighbourhood to Board.
- Strengthen the **roles and relationships of PCNs** within each local place.
- Strengthen the **roles and relationships of district and borough councils** within each local place.
- Provider collaborative will ensure strong **link to other collaboratives** e.g. EMAP, and regional specialised commissioning
- Requires **communication and engagement support** from both ICB and local authorities

Closing reflections

Closing reflections

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- Does the system support the operating model – integrating care through place, provider collaboration and programme?
- Are our delivery priorities and milestones ambitious enough?
- Do they represent the key changes required to develop an integrated care model?
- Is there appetite, energy and trust to support the strategic direction in relation to distributed system leadership and delegated accountability and resources?
- We propose some dedicated development time for ICB plus place, provider collaborative and programme leaders to co-produce the next steps.

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Appendices

Slides 28 - 34 PCLB work programme priorities and milestones to 2027
Slides 35 - 40 IPE work programme priorities and milestones to 2027

Provider collaborative priorities for delivery

See appendices for further detail in each area of focus

Area of Focus	Evolution and development of JUCD provider collaborative	Clinical pathway design	Clinical pathway enablers	Corporate efficiencies	Oversight of performance delivery and transformation
Short Term (6 months)	Clarify and confirm governance, accountability reporting to enable delivery of current priorities and responsibilities Engage with Boards, NEDs and governors Alignment with place as part of integrated care mandate	Initiation of first phase projects: MSK and orthopaedics & Speech and Language Therapy Evidence review and engagement to identify clinical priorities for years 2 and beyond, focus on fragile services Aligning clinical strategies across providers	Workforce Digital Established programme structures, priorities and workplans in place	Review benchmarking to identify opportunities for joint working to deliver efficiencies Reducing agency spend	Continue to develop Delivery Board and Transformation structures Lead transformation planning and contribute to Joint Forward Plan Address resource gaps in PMO and programme areas
Medium Term (2 years)	Enact delegation from ICB and provider boards as required to enable priorities. Communications and engagement with stakeholders and public Articulate medium – long term strategy as part of JFP iteration Shared provider leadership roles OD with Boards – risk and gain sharing	Workplan to address fragile clinical services (priorities and roadmap to be agreed) Agree shared strategy for clinical collaboration Second phase priorities agreed and in implementation phase First phase priorities show impact	Pharmacy Estates Workforce Digital ? Review pathology model	Agree operating model for corporate functions – in house/consolidated/outsourced Develop business cases and implement agreed changes Shared functions begin to deliver improved value	Provider collaborative workplan fully developed and reflected in DB and other plans Determine cross cutting and strategic transformations to deliver clinical strategy/sustainability Delivery Boards managing 'shadow' budgets and efficiency targets OD and skills development
Long Term 2025 - 2027	Play full part in delivering PHM approach, working alongside place Models of collaboration/integration/consolidation in place, driven by shared strategy	Second phase priorities show impact. Progress to deliver shared clinical strategy, including reconfigured clinical operating models Embedded ways of monitoring change programmes and developing rolling plans reflecting PHM approach	Estates strategy reflects integrated operating model and agreed areas of clinical collaboration/consolidation. Implementation is delivering efficiencies in the use of estate	Consolidated model of corporate services in place reflecting integrated operating model	Provider collaborative leads on system delivery including performance, accountability and assurance to ICB Transformation and delivery plans reflect shared clinical strategy and place programmes

Collaborative Priorities - Milestones and Measures of Success: Developing the JUCD Provider

	Measures of Success	Milestones – 6 months	Milestones 2 -3years	Milestones 2025-27
Governance and delegation	Boards have a clear understanding of what decisions the collaborative can take; any schemes of delegation from boards to collaboratives are clear.	Clarify & confirm governance, accountability reporting to enable delivery of current priorities & responsibilities. Explore modes of delegation e.g. service integrator model MHALD, Alliance model MSK. Align with place as part of integrated care mandate.	Approve provider collaborative roadmap and work programme for years 2-5. Implement formal delegation/models of collaboration as appropriate and amend PCLB partnership agreement. Agree assurance and accountability arrangements with ICB. Contribute to iterations of ICS Joint Forward Plan.	Governance and delegation are reviewed alongside the continued development of the collaborative and ICS architecture. Significant change to delivery and contracting models e.g. lead providers/service integrators in place to support PC objectives and ICS strategy.
Leadership	Board members and NEDs have a clearly defined role and actively support collaboration	Engagement with NEDs and Governors. Away time with Chairs and CEs to confirm collaborative ambition		
Resourcing and leadership	The collaborative is well-resourced to take timely decisions to deliver benefits at scale	Confirm resources required for year 2-3, agree business case/finding for agreed roles. Agree with ICB how existing roles can be reshaped to align to integrated care model/new ways of working.	OD to create multi-disciplinary teams to deliver workplan. Sufficient leadership in place to deliver on collaborative priorities, drawn from existing teams where possible	Staff in provider organisations are enabled to work collaboratively, with clear priorities and improvement approach in place.
Resourcing and leadership	Shared provider leadership roles where this supports the model for integration	Confirm ongoing core team resource requirements and funding.	Formalised shared leadership roles where these support operating model and change	

Collaborative Priorities - Milestones and Measures of Success: Clinical pathways

	Measures of Success	Milestones – 6 months	Milestones 2 - 3years	Milestones 2025-27
Improving health outcomes and population health	Provider Collaborative programmes demonstrably include evidence informed measurable actions to reduce health inequalities and prioritise prevention on access, experience and outcomes. The Collaborative has systems in place to frequently monitor and identify potential unwarranted variation	First phase priorities agreed MSK and SLT, project teams and PIDs in place. Benefits realisation mapped, Begin to engage on second phase priorities. Develop approach to PHM, Prevention and Health inequalities aligned to system approach	First phase priorities begin to deliver impact. Agree second phase priorities &programme plans including metrics. Develop approach to reviewing data to identify opportunities, quality and safety.	PHM and systematic approach to identifying areas for improvement embedded within PC.
Clinically led programmes of change	Clinical input shapes transformation programmes, l ed by multi-disciplinary clinical leaders.	Working with CPLG, engage of fragile services and other clinical priorities	Clear clinical priorities set out with delivery plans including metrics and impact	Second phase priorities show impact PCLB oversees clear change programme for clinical services
Sustainable clinical services	Collaborative has effective systems to identify and address fragile services. Collaborative has implemented options to address fragile services within the system	Workshop to identify fragile services. Agree priorities for collaborative solutions, develop clinically led proposals for change	Workplan to address fragile services developed and implemented, Work with ICB to align approach to quality and safety across the ICS.	Workplan fully implemented, further review of fragility and agreement of any more structural solutions to support resilience, quality and sustainability
Clinically and	Collaborative has a clinical strategy aligned to wider	Align clinical strategies to identify areas for	Develop medium/long term clinical strategy for	Clinical strategy reflected in transformed model of

Collaborative Priorities - Milestones and Measures of Success: Clinical pathway enablers

	Measures of Success	Milestones – 6 months	Milestones 2 -3years	Milestones 2025-27
Digital, Data and Technology	Shared digital solutions used where this achieves efficiencies, information sharing or joint working and regular evaluation of digital solution effectiveness and seeking out further opportunities.	**Digital** – infrastructure work programme completed and opportunities for efficiencies, collaboration and shared solutions identified. **Data** – shared analytics and data platforms to inform strategic and operational planning and delivery. **Technology** – digitally enabled tools and technology evidence based programme established to inform care delivery	Digital infrastructure programme priorities being implemented and organisational change process established. High quality, accessible data and intelligence tools to support surveillance and reduce unwarranted variation in health and wellbeing Evidence based decision making, backed by high quality data analysis, is seen as business as usual across the ICS. Evidence based digitally enabled care is embedded in service delivery across the ICS and supported through a digitally included process to address inequalities.	Digital infrastructure maturity being realised and collaborative approach ensuring continuous system development and improvement. ICS has a fit for purpose data architecture and reporting capability. Decision markers are informed and supported with evidence required to affect change and improve population health and wellbeing. Use of digital tools and technology widespread across the system. Innovation programme introduced to review new tools and technology to understand benefits to care delivery.

Collaborative Priorities - Milestones and Measures of Success: Clinical pathway enablers

	Measures of Success	Milestones – 6 months	Milestones 2 - 3years	Milestones 2025-27
Workforce/People Services collaborative	Collaborative is able to use member and partner resources and capacity flexibly where they are most needed, creating efficiencies and savings. Staff of each collaborative member feel safe, empowered and supported to work collaboratively with partner organisations	Accelerate recruitment collaboration, development of options Support Domiciliary Care International Recruitment Digital ESR roadmap agreed	Project Derbyshire Digital - ESR enhancement - Derbyshire digital road map Develop a Derbyshire approach to People Scaling for transactional efficiencies Shared recruitment option in place	People Scaling approach fully rolled out across JUCD Shared model of people services in place Staff enabled to work across collaborative partners
Estates	Reduced total system sqm and numbers of premises. Health and care estate is fit for purpose and supports integrated care model.	Estates group refreshed, linked in with review of clinical and back office services. Agree opportunities to reduce void space and exit leases	Shared estates strategy that reflects operating model and clinical strategy. Programme to release efficiencies in place with dedicated capacity to deliver	Estates strategy implemented, increasing efficiency of use, reflecting clinical strategy and shared delivery models
Pharmacy	Pharmacy operations are integrated to make best use of resources, increase productivity and efficiency as demonstrated by benchmarking	Identify opportunity using benchmarking and best practice evidence	Agree model for collaboration, business case and implementation including governance	Review impact of changed model and identify further opportunities for improvement

Collaborative Priorities - Milestones and Measures of Success: Corporate Efficiencies

	Measures of Success	Milestones – 6 months	Milestones 2 - 3years	Milestones 2025-27
Corporate efficiencies/back office functions	Clinical support and corporate functions are delivered jointly where this creates efficiencies and savings are effectively utilised to support wider population health objectives.	Establish working group. Review benchmarking. Identify opportunities within ICS and agree priorities.	Develop preferred model and business cases for agreed priorities. Implement agreed models for shared services (consolidation/joint venture/WOS/outsource)	Identify further opportunities for improvement, reflecting emerging integrated care and clinical model. Back office functions fully integrated where this releases benefits.

Collaborative Priorities - Milestones and Measures of Success: Oversight of performance, delivery and transformation programmes

Objective	Measures of Success	Milestones – 6 months	Milestones 2 - 3years	Milestones 2025-27
Design and deliver pathways that improve outcomes/improve sustainability/productivity	Collaborative continuously innovates and contributes to the design and delivery of ICS objectives and design of the forward plan.	Agreed process for transformation and delivery planning for 2023/2024. Driven by data and evidence, this forms part of JFP	Review of JFP. Ongoing use of data and benchmarking to inform and prioritise delivery board plans	Provider collaborative leads on system delivery including transformation plan
Design and deliver pathways that improve outcomes/improve sustainability/productivity	All members and partners understand lines of accountability in the PC; members feel able to hold each other to account. Collaborative regularly reviews performance & delivery, members act to disclose and address issues, members support each other to use best practice and improvement approaches.	Programme reporting process including escalation agreed and implemented, including PCLB, IPE and NHS ET Confirm and clarify governance and accountability arrangements relating to transformation and delivery .	Improvement plans across organisations aligned with delivery board and programmes of work to ensure co-ordinated approach to delivery across the system.	Clear accountability to ICB for performance and delivery. Transformation plans identified for 'at scale' changes that address system priorities
Improve efficiency and productivity through collaborative working and at scale models of clinical and corporate services	Financial risks and savings associated with specific programme delivery shared across members. Improved benchmarks of productivity/GIRFT/MHosp	Transformation plans are formulated to address productivity and cost savings	Plans implemented and begin to show impact on delivering better value services Risk and gain sharing approach agreed	Plans implemented and begin to show impact on delivering better value services

Place priorities for delivery

See appendices for further detail in each area of focus

Area of Focus	Operating Model	Integrating and Transforming Services	Enablers of Integrated Care	Population Outcomes	Co-ordinating delivery of Integrated Care Strategy
Short Term (6 months)	Partnership Boards up and running IPE focus shifting to co-ordination role and addressing barriers. Local Place Alliance functions reviewed and adjusted. Leadership roles confirmed Agreed role in relation to HWB plan / function delivery.	Prioritised response to care gaps (and operational place requirements) eg falls, anticipatory care Diagnostic completed and provides sound case for change Discharge funding plan to address pressures whilst transformation programme developed Clarity and alignment re Fuller	Increase understanding of existing enabler plans and implications / opportunities Framework for 'measuring what matters' finalised. Finance / workforce / digital working with Place to develop place based approach to enablers Shadow oversight of BCF	Clarify Place role re PHM with lead, DPHs and CMO Identify key actions that Place can take to respond to, and embed the insights framework approach. Ensure Partnership Board and IPE are giving space to the LPA messages from their communities.	Establish reporting / escalation process and agree approach to strategy evaluation. Ensure system build measures that give parity of attention to strategy alongside immediate pressures Implementation plan for Age Well / Die well lead by Place
Medium Term (2 years)	Delivery plans developed at Place Partnership Board and LPA level reflecting flow of priorities from system and local needs. Enabler priorities fully aligned to supporting Place objectives. Commissioning and finance strategies supporting Place delivery Increasing level of resource aligned to Place working	Comprehensive community transformation implementation programme underway driving resource allocation and providing tracked benefits. (including anticipatory care MDT working, fully integrated community crisis response and step up / step down capacity and flow)	Digital strategy fully informed by Place priorities and delivering impact. Place based workforce strategy (including new skills / roles to support integrated care) Place based estates strategy to serve places not organisations Increasing autonomy / flexibility across joint budgets	To be confirmed informed by Integrated Care strategy priorities, role of Place in relation to delivery of Health & Wellbeing priorities and learning from first 6 months.	Assess progress. Determine need to review Strategy (in light of any new JSNAs or national guidance.) Delivering against established measures and 'course correcting' as appropriate informed by views of public, users, staff and data metrics Maintain focus on 'how' effective integrated system working is (not just outputs)
Long Term 2025 - 2027	Review operating model – opportunities for alignment. Respond to any national changes and review.	Improvements made across whole pathway of care supporting locally developed improved experience, outcomes and cost effectiveness. Embedded approach to continuous evaluation and adaptation	Place based planning and integrated provision. Delegated responsibility enacted	Fully embedded population health approach – driven by data and insights and responded to though local integrated approaches.	Delivery of change for the 3 'key areas of focus from 23/24 have impacted on how JUCD routinely addresses population outcomes, care and resource gaps

Collaborative Priorities - Milestones and Measures of Success: Developing Place Operating model

	Measures of Success	Milestones – 6 months	Milestones 2 - 3years	Milestones 2025-27
Place Partnership Boards	Fully established Place Partnership Boards (City and County) with clear responsibilities in relation to IPE, local places, HWB structures and other partnership functions..	Both Partnership Boards operating to new Terms of Reference. Undertake development work to establish effective relationships. Agreed process for agenda setting between partnerships and IPE	Place Partnership Board Delivery plan developed reflecting flow of priorities from system and responding to place / neighbourhood needs.	Review operating model – opportunities for alignment. Respond to any national changes and review.
Integrated Place Executive	Functioning as a pivotal role in the ICS – driving the Integrated Care Strategy, creating the environment for successful delivery of population health improvements and integrated care	Adjust focus towards identifying and addressing system / inter-agency barriers to integrated care, interface with other components of ICS, supporting strategy delivery plans and overseeing the co-ordination of integrated services.	Increasing influence on enabler priorities and individual organisations' strategies and plans. Commissioning and finance strategies supporting Place delivery	
Local Place Alliances	Working to a shared partnership agenda Clear LPA scope and remit Consistent of member input System enabler support provided. Delivering local improvements in services and outcomes	New relationship established with Place Partnership Board, Local Operational Teams developed. Increased clarity of expectations.	Local Place Alliance delivery plan developed reflecting flow of priorities from system and addressing local place / neighbourhood needs	
Resourcing and leadership	Success demonstrated by the fact that it becomes neither possible nor necessary to identify whether someone is working for 'place'	Place is appropriately resourced with Place leadership / support roles plus staff in partner organisations are enabled to work collaboratively with time and resource; autonomy and mandate to give support to Place.	Increasing level of resource from all partners aligned to place working.	

Collaborative Priorities - Milestones and Measures of Success: Integrating and transforming services

	Measures of Success	Milestones – 6 months	Milestones 2 -3years	Milestones 2025-27
Team up (existing)	Full implementation of existing Team up programme	Prioritised response to care gaps (and operational place requirements) eg falls, anticipatory care	Integration within expanded Team Up programme	
Team Up (expansion)	Improvements made across whole pathway of care supporting locally developed improved experience, outcomes and cost effectiveness.	Newton diagnostic completed and provides sound case for change, prioritised interventions and assessment of readiness.	Comprehensive implementation programme underway driving resource allocation and providing tracked benefits.	Embedded approach to continuous evaluation, learning and adaptation.
Discharge Transformation	Positive discharge flow patient experience and outcomes delivered by matched capacity and demand and effective care processes. System confidence supporting reduced reliance on bedded care.	Agree funding plan for use of 'wrong' capacity to address pressures whilst transformation programme developed and implemented.	Progress made against transformation plan ambitions	No delays, capacity matching need and no 'failure demand'
Provider Collaboration	Maximised opportunities to use resources flexibly and collaboratively between partners	Develop proposals for change	Implemented changes and have increasing flexibility across pathways.	
Need to add End of life, strengths based approaches, living well- CMHF, role re Fuller response / implementation				

Collaborative Priorities - Milestones and Measures of Success: Population outcomes

	Measures of Success	Milestones – 6 months	Milestones 2 -3years	Milestones 2025-27
Understanding need	Place (at all levels) is driven by a clear understanding of population health needs and its role in addressing those	Clarify Place role re PHM with lead, DPHs and CMO Ensure relevant Place level data to support Partnership and local delivery plans	To be confirmed informed by Integrated Care strategy priorities, role of Place in relation to delivery of Health & Wellbeing priorities and learning from first 6 months.	Fully embedded population health approach – driven by data and insights and responded to though local integrated approaches.
Prevention	Maximising opportunities to increase prevention across place functions through integrated partnership working	Place role in response to strategy key area of focus and plan response.		
Inequalities	Maximising opportunities to reduce inequalities across place functions through integrated partnership working	Work with relevant leads to determine Place role in response to Core20 Plus5 priorities. Ensure informed delivery plans		
Working with communities	Stakeholder engagement is assured including with VCSE partners, embedding co-production with people who use our local services and amplifying the voice of the least heard.	Identify key actions that Place can take to respond to, and embed the insights framework approach. Ensure Partnership Board and IPE are giving space to the LPA messages from their communities.		

Collaborative Priorities - Milestones and Measures of Success: Enablers

	Measures of Success	Milestones – 6 months	Milestones 2 -3years	Milestones 2025-27
Digital	Shared information on individuals to support care delivery (DSCR & DiSc) Digitally enabled care and technology enabled care readily available.	Increase understanding of existing plans and implications / opportunities for integrated place based working	Digital strategy planning and implementation fully informed by Place priorities.	
Business Intelligence	The Data strategy and function effectively supports and delivers a population health management system to ensure care coordination and integration is informed by population health data and analytics	Framework of indictors 'measuring what matters' established and routinely reported against. BI link resource for Place identified.	Significantly strengthened and embedded BI support to Place. Places developed to self support where possible.	
Workforce	Maximise opportunities within place delivery of the 'one workforce' approach.	Understand existing plans and implications / opportunities for integrated place based working	Have mapped totality of place workforce. Influenced new skills / roles to support integrated care delivery.	
Estates	Place based workforce strategy (including new skills / roles to support integrated care)	Understand existing plans and implications / opportunities for integrated place based working	Place has role to review/ approve estates plans. Partners seek opportunities to utilise their own estate for Place benefit.	
Finance	Funding model and distribution of resources that supports population health Place based planning and integrated provision. Delegated responsibility enacted	Finance capacity working with Place to develop approach. Financial data reporting spend on a population basis. Shadow oversight of BCF, relevant SDF and Community Futures Fund. Mirrored by Public Health Grant.	Increasing autonomy across budgets. Make recommendations to the ICB for appropriate integrated / community services and joint commissioning budgets	

Collaborative Priorities - Milestones and Measures of Success: Integrated Care Strategy

	Measures of Success	Milestones – 6 months	Milestones 2 - 3years	Milestones 2025-27
Structure and approach	Clear mechanisms that enable oversight and support by the IPE to delivery of the strategy on behalf of ICP	Establish reporting / escalation process Agree approach to evaluation Ensure system build measures that give parity of attention to strategy alongside immediate pressures	Assess progress. Determine need to review Strategy (in light of any new Joint Strategic Needs Assessments or national guidance.)	
Age well / die well Key Area of Focus (IPE responsible)	Delivery against agreed evaluation measure (to be determined in first phase)	Develop implementation plan – incorporating 'actions from integrating and transformation services' priorities. Establish approach to hearing from staff, patients and carers	Delivering against established measures and 'course correcting' as appropriate informed by views of public, users, staff and data metrics	
Enablers		Assess ability of existing delivery plans to meet needs of the Key Areas of Focus	Maintain focus on 'how' effective integrated system working is (not just outputs)	

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 9 May 2023

Integrated Performance Report

Purpose of Report

The purpose of this report is to provide the Board of Directors with an update of how the Trust was performing at the end of March 2023. The report focuses on key finance, performance and workforce measures.

Executive Summary

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

Operational Performance

This chapter has been developed to provide a greater level of assurance on actions being taken to address areas of underperformance. The chapter includes performance against the relevant NHS national long term plan priority areas. This month includes a section on the transforming care programme, plus a section on the Friends & Family Test.

Most challenging areas:

- Waiting times for adult autistic spectrum disorder assessment
- Child and adolescent mental health services (CAMHS) waiting times
- Paediatric outpatients 18-week referral to treatment

Most improved areas:

- Psychological services waiting list reducing month on month for the last 11 months; Division of Psychology and Psychological Therapies now formed
- Target achieved for community mental health access 2 plus contacts and reflected in the latest national data

Key next steps:

1. The Health Inequality Programme board has now been established and going forward will start to report on key actions and metrics associated with reducing health inequalities for our patients.

2. The Productivity Programme board has been established and will develop a Trust-wide programme dedicated to improving productivity for the benefit of our patients.

Transforming Care Programme
The programme has three key aims: to improve quality of care for people with a learning disability and/or autism, to improve quality of life for people with a learning disability and/or autism, and to enhance community capacity, thereby reducing inappropriate hospital admissions and length of stay. Currently in Joined up Care Derbyshire there are 50 service users in bedded care, of whom 43 are in the right care setting for their current needs. Of the 7 service users not currently in the right care setting, 4 placements are locked door rehabilitation for complex care, with discharges planned between May and August 2023 with high confidence. one placement is mental health rehabilitation owing to the complexity of need not able to be supported in the community. One placement is adult mental health, not on the severe mental illness (SMI) register, and one placement is a child Psychiatric Intensive Care Unit (PICU) bed, with the service user recently turning 18. Work is ongoing to discharge these service users.

Friends & Family Test
In the latest data the Trust received a high level of positive feedback (92%) and ranked very highly in comparison with other providers.

Finance

At the end of the financial year the Trust delivered its forecasted surplus of £2.8m (adjusted after impairments) compared to the plan of breakeven. The surplus position has been driven by additional non recurrent income and one off pay and non-pay benefits.

The Board Assurance Framework (BAF) risk that the Trust fails to deliver its revenue and capital financial plans, was reduced in year from Extreme to Moderate.

Efficiencies
The full year plan included an efficiency requirement of £6.0m phased equally across the financial year. At the end of the financial year all plans delivered in full. However, the majority of the schemes are non-recurrent (68%) which is adversely impacting on 2023/24 financial plans.

Agency
Agency expenditure YTD totals £7.6m against a plan of £2.4m, an adverse variance to plan of £5.2m. The two highest areas of agency usage continue to be driven by Consultants mainly in CAMHS and nursing staff. There has been an increase in agency expenditure in February and March, which has been driven by the requirement to clinically support a complex admission.

Covid costs
The financial plan assumed no expenditure for Covid after the end of May as per the planning guidance for 2022/23. There has been a significant reduction in covid related expenditure since August and levels remains low.

Out of Area Placements
Expenditure for adult acute out of area placements totals £3.2m for the financial year along with £0.6m on stepdown beds. This has generated an overspend of £2.6m across both areas, which has been managed in the overall financial position.

Capital Expenditure
Capital expenditure had been below plan for most of the financial year, but started to exceed the plan in February and March in relation to the Making Room for dignity capital schemes and additional expenditure for other supported schemes in line with regional expectations.

Better Payment Practice Code (BPPC)
In March the target of 95% was exceeded by value but the volume was slightly below the target at 94.2%.

Cash and Liquidity
Cash remains high at £54m at the end of March due to the receipt of additional central funding for the Making Room for Dignity capital schemes. Due to the timing of these cashflows that has also impacted on the movements in the liquidity ratio during 2022/23

2023/24 financial plan

Currently financial plans for 2023/24 from a revenue perspective are still in the progress of being agreed as a Derbyshire system. The final submission is due on 4th May 2023.

People

Annual appraisals
Appraisal levels continue to be below our expectations, however positive progress has been made since the last report.

Key next steps:

- ***Divisional People Leads to work proactively with leaders to combat areas of low compliance.***
- ***Weekly monitoring of progress in Operational Services***

Annual turnover
March has seen a small reduction in turnover to within the target range of 8-12% and remains in line with national and regional comparators.

Compulsory training
Overall, the 85% target level has been achieved for the last 11 months.

Staff absence
In March 2023 sickness was 6.2% which is the lowest we have recorded for over a year. This is in a period where typically year on year we see absence increase. The main reason for absence continues to be stress and anxiety.

Key next steps:

- ***Staff Support clinical psychologist to commence in post from July 2023 to provide additional in-house support for colleagues suffering with stress, anxiety and trauma at work***
- ***To ensure that every absence under 3 weeks is effectively managed, and people supported to reduce absence length and recurrence.***

Proportion of posts filled
Staffing levels continue to improve with March seeing another increase. The recruitment team continue to work closely with divisions to develop targeted and bespoke campaigns. Work continues on implementing learning from the cultural intelligence recruitment programme. We are increasing physical presence at local and regional job and career fairs over the next 3 months. Divisional workforce plans are being finalised and will be fed into a workforce summit in June.

Bank and agency staff
March saw an increase in requests for shifts which was matched by an increase in fill rates. Agency spend is high across the system.

Key next steps:

- ***Reduce reliance on contingent workforce***
- ***Increase bank fill rate by 10%***
- ***Reduce agency utilisation by 40%***
- ***Reduce sickness absence by 0.5% by year end***

Supervision
The overall level of compliance with the clinical and management supervision targets has remained low since the start of the pandemic, however further improvements can be seen at a team level, with 107 teams now 100% compliant with management supervision and 76 teams now 100% compliant with management supervision.

Key next steps:

- ***Improvement plan in place in Operational Services, with weekly monitoring of progress***

Quality

Compliments
The number of compliments continues above the mean of 100 which would suggest that actions to improve recording of compliments has been impactful.

Complaints
The number of formal complaints received have been on a downward trajectory between January and March 2023 and is now below the Trust target of 12 per month.

Delayed transfers of care (DTOC)
Following a review of DTOC reporting it was found that some services were not recording some delays on SystmOne. This has now been resolved and the data is flowing through into the report. In addition, it was identified that the data warehouse was not pulling through all delays recorded on the SystmOne. This has also been corrected and as a result the numbers increased.

Key next steps:

- ***Twice weekly clinically ready for discharge meeting to continue to identify and address any barriers to discharge***

Care plan reviews

The proportion of patients whose care plans have been reviewed continues to be recorded as lower than expected and is currently on a downward trajectory.

Key Next Steps:

- ***Heads of Nursing are supporting services to develop team-based care plan compliance plans including identifying and protecting staff time for administration. The Adult and Older Adult teams have identified action plans to improve care plan compliance.***

Patients in employment and in settled accommodation

Around one third of patients have no employment status or accommodation status recorded at present.

Key Next steps:

- ***A report has been developed which informs teams if there are gaps in the current Data Quality Maturity Index. Ward and Service Managers to review this report weekly and action any gaps identified. Monitored via monthly service specific operational meetings.***

Medication incidents

Work continues to be underway to reduce numbers of medication incidents. Common variation continues to be within expected thresholds.

Key next steps:

- ***Implementation of electronic prescribing and medicines administration (EPMA), a solution which digitises the process of prescribing and recording medication administered to patients within the Divisions.***

Incidents of moderate to catastrophic actual harm

This data demonstrates the number of DATIX incidents occurring of moderate at catastrophic harm. There was a 68% increase in incidents between February and March 2023. This increase is attributed in part to the Mental Health Helpline who have increased reporting of DATIX incidents since recent training.

Duty of Candour

Duty of Candour (DoC) reported incidents appear to have increased, however on reviewing these incidents the number of incidents included in the data is inaccurate and there were only a total of 5 incidents between January and March. Therefore, DoC remains within expected thresholds.

Prone restraint

Prone restraint has increased by a total of 3 incidents between February and March 2023.

Key next steps**:**

- ***In-depth qualitative audit and thematic review of seclusion and restraint; simulation training including seclusion, self-harm and ligature simulation; training around alternative injection sites which should reduce the need for prone restraint.***

Physical restraint
Physical restraints have increased by 32% between February and March 2023. This is being reviewed within the Reducing Restrictive Practice Group. The Trust Positive and Safe Support Team continue to offer extra training sessions to improve training availability for staff.

Seclusion
Seclusions between February and March 2023 have increased by 100%. This is in part due to increased reporting on the organic older adult wards and to a single individual who was secluded on numerous occasions while waiting for a more appropriate environment and accounts for 26% of the total incidents. This person has now been discharged to an environment that can meet their needs.

Falls on inpatient wards
Between February and March 2023 falls have remained within common cause variation.

Care hours per patient day (CHPPD)
CHPPD is rolling data updated monthly, to show staffing levels in relation to patient numbers on an inpatient ward. In the latest published national data when benchmarked against other mental health trusts, our staffing levels continue to be below average.

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

Risks and Assurances

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

Consultation

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

Governance or Legal Issues

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

Public Sector Equality Duty and Equality Impact Risk Analysis

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

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

- This report reflects 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) Delegate authority to the Finance and Performance Committee to sign off the operational financial plan for the final submission at the end of March.
2) Confirm the level of assurance obtained on current performance across the areas presented. The proposed level is limited assurance.
3) 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.
4) Determine whether further assurance is required.

Report presented by: **Ade Odunlade**
Chief Operating Officer

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Head of Performance

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Integrated Performance Report Performance Key Insights

This section will evolve over time to provide the Board with insights into key areas of challenge identified within the main body of the report.

Adult community mental health services

- Demand dropped significantly at the start of the pandemic but has returned to pre-COVID levels. **The majority of referrals are received from primary care.**
- The adult community **caseloads are very high**: 53 patients per whole time equivalent clinician. The length of time patients are on caseload is also high and is increasing and varies across teams, ranging from 448 days to over 5 years. These factors, coupled with high levels of sickness and vacancies, are directly impacting on waiting times, and indirectly impacting on inpatient admissions: smaller caseloads would enable the teams to really focus on the high acuity patients, which would lead to reduced crisis presentations and reduced admissions, taking pressure off the front door. **This reduction in caseload of patients with a lower level of acuity should result from the roll out of Living Well over the next 12 months**.

Inappropriate out of area placements

- **Out of area placements are reducing.** To enable further reduction there needs to be bed capacity within the Trust, where currently most wards are experiencing high levels of occupancy. As well as the community caseload issues highlighted above, other factors impacting on bed capacity include **an increase in length of stay over time: 71% admitted under Mental Health Act Sections recently**, which suggests there is a higher level of acuity resulting in longer periods of inpatient treatment. There was also a sustained period of delayed discharges of people clinically ready for discharge. This has recently been resolved.

- Analysis of inpatient data indicates there has been a reduction in high readmission group patients, **which is positive, however there has been growth in admissions of people with personality disorder which is a negative trend as inpatient care is generally not considered appropriate for this patient** group unless for the management of crises involving significant risk to self or others that cannot be managed within other services, or for detention under the Mental Health Act https://www.nice.org.uk/guidance/cg78/chapter/1-Guidance#inpatient-services.

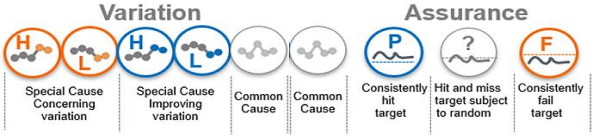
- Factors positively impacting on admissions are the Home Treatment teams and Mental Health Liaison teams, who are operating as effective alternatives to admission. **Home Treatment are currently supporting 65 patients stepped up from community and 41 patients stepped down from inpatients. The proportion of patients seen by Mental Health Liaison who are subsequently admitted is now fewer than 1 in 20.**

Assurance Summary

A. Operations

	Metric Name	Performance	Assurance	Latest Value	Target	Lower process limit	Upper process limit	Mean
1a	Waiting list - care coordination - average wait to be seen			54		20	37	28
1b	Waiting list - care coordination - number waiting at month end			149		50	92	71
2a	Waiting list - ASD assessment - average wait to be seen			79		66	72	69
2b	Waiting list - ASD assessment - number waiting at month end			2,025		1636	1843	1739
2c	ASD assessments			24	26	4	32	18
3a	Waiting list - psychology - average wait to be seen			38		42	51	47
3b	Waiting list - psychology - number waiting at month end			436		611	775	693
4a	Waiting list - CAMHS - average wait to be seen			25		14	24	19
4b	Waiting list - CAMHS - number waiting at month end			493		391	567	479
5a	Waiting list - community paediatrics - average wait to be seen			32		16	22	19
5b	Waiting list - community paediatrics - number waiting at month end			1,953		1289	1587	1438
6	Outpatient appointments cancelled by the Trust			9%	5%	4%	11%	7%
7	Outpatient appointment "did not attends"			11%	15%	9%	14%	12%
B1	3 day follow-up			86%	80%	78%	97%	88%
D1	Community Mental Health Access (2 plus contacts)			10,640	10,044.0	8549	9253	8901
E1	Children & Young People Mental Health Access (1 plus contact)					2851	3031	2941
E4	Children & Young People Eating Disorder Waiting Time - Routine			67%				79%
E5	Children & Young People Eating Disorder Waiting Time - Urgent			61%				60%
G3	Early intervention 14 day referral to treatment - complete			87%	60%	62%	111%	86%
G3	Early intervention 14 day referral to treatment - incomplete			85%	60%	57%	117%	87%
H0	IAPT 6 week referral to treatment			56%	75%	72%	87%	79%
H1	IAPT 18 week referral to treatment			99%	95%	100%	100%	100%
H2	IAPT 1st to 2nd Treatment over 90 Days			13%	10%	2%	12%	7%
H7	IAPT patients completing treatment who move to recovery			52%	50%	44%	61%	52%
I1	Individual Placement and Support Access			295	343.0	117	337	227
K2	Total inappropriate out of area bed days			1,115		1235	1861	1548
K2	Average patients out of area per day - adult acute			8	0	-3	8	3
K2	Patients placed out of area - adult acute			12	0	-4	15	6
K2	Average patients out of area per day - PICU			20		7	20	13
K2	Patients placed out of area - PICU			33		12	31	21
L1	Perinatal Rolling 12 Months Access			5%	10%	3%	4%	4%
L2	Perinatal Access Year to Date			435	1,070.0	139	408	273
N4	Data quality maturity index			98%	95%	98%	98%	98%

Key to symbols[1]:



Blue dots indicate special cause variation, better than expected.

Orange dots indicate special cause variation, worse than expected.

[1]The rating symbols were designed by NHS Improvement

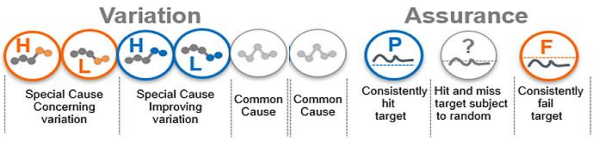
B. People

	Metric Name	Variation	Assurance	Latest Value	Target	Lower process limit	Upper process limit	Mean
1	Annual appraisals			80%	85%	73%	78%	75%
2	Annual turnover			12%	8-12%	12%	14%	13%
3	Compulsory training			89%	85%	84%	88%	86%
4	Staff absence			6%	5%	5%	8%	7%
5	Clinical supervision			76%	95%	72%	77%	75%
6	Management supervision			75%	95%	69%	77%	73%
7	Filled posts			96%	100%	88%	92%	90%
8	Bank staff use			7%	5%	4%	7%	6%

C. Quality

	Metric Name	Performance	Assurance	Latest Value	Target	Lower process limit	Upper process limit	Mean
1	Compliments received			113	119	67	140	103
2	Formal complaints received			12	13	5	29	17
3	Delayed transfers of care			3%	3.5%	1.8%	7.0%	4.4%
4	CPA reviews			50%	95%	76%	89%	83%
5	Patients in employment			12%		10%	14%	12%
6	Patients in settled accommodation			37%		45%	55%	50%
7	Number of medication incidents			83		33	93	63
8	No. of incidents of moderate to catastrophic actual harm			72	48	15	79	47
9	No. of incidents requiring Duty of Candour			1	1	-5	13	4
10	No. of incidents involving prone restraint			9	12	-2	20	9
11	No. of incidents involving physical restraint			73	46	21	90	56
12	No. of new episodes of patients held in seclusion			34	14	1	34	17
13	No. of falls on inpatient wards			32	30	19	48	34

Key to symbols[1]:



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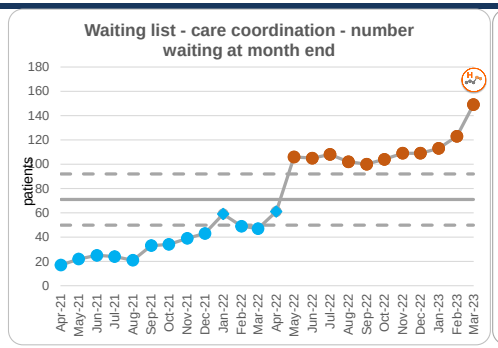
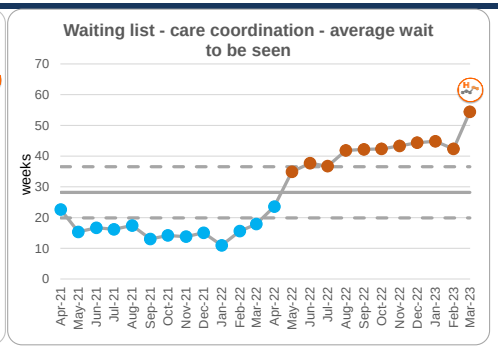
Derbyshire Healthcare
NHS Foundation Trust

Operations

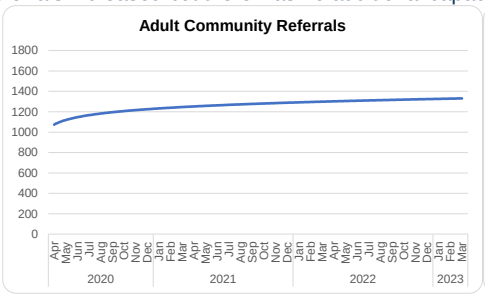
Operational Performance

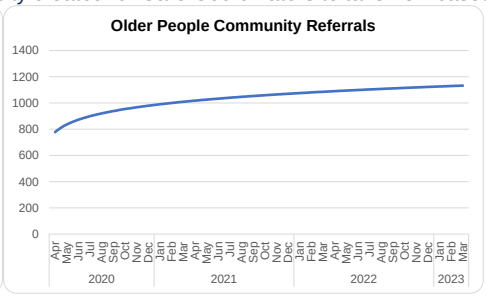




Summary

There are a number of key factors impacting on waits. As we came out of the pandemic, the number of referrals increased but there was no additional capacity created for Care Coordinators to take new cases:





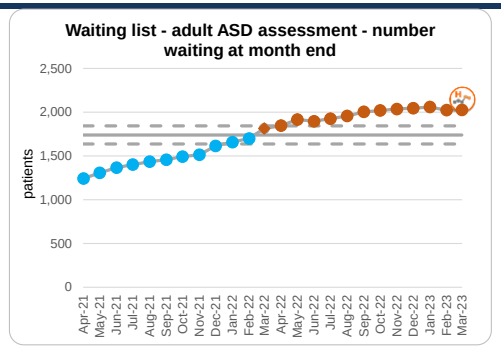
Staff are experiencing fatigue (ongoing issue raised during and post pandemic). Some teams are in distress owing to ongoing staffing challenges:

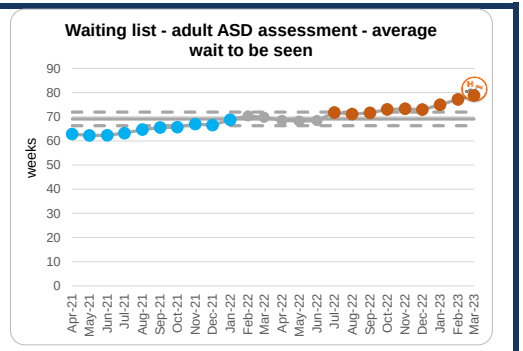
Adult Community	Turnover	Sickness	Vacancies
Bols + C C Adult CMHT	10%	6%	16%
Chesterfield C Adult CMHT	12%	1%	7%
High Peak Adult CMHT	34%	19%	10%
Killmsh + N C Adult CMHT	28%	15%	35%
North Dales Adult CMHT	10%	2%	11%
Amber Valley Adult CMHT	0%	4%	0%
El Nth	11%	0%	8%
El Sth + City	0%	14%	0%
Erewash Adult CMHT	5%	4%	5%
South Dales Adult CMHT	19%	23%	11%
Sth Derbyshire Adult CMHT	0%	3%	9%
Derby City B Adult CMHT	7%	4%	16%
Derby City C Adult CMHT	0%	13%	4%

Team	Turnover	Sickness	Vacancies
Amber Valley OA CMHT	22%	5%	14%
Bols + CC OA CMHT	0%	8%	0%
Chesterfield C OA CMHT	7%	8%	6%
County Elderly Service Medical	26%	1%	3%
Derby City OA CMHT	4%	1%	12%
Discharge Liaison Team OA	27%	10%	15%
Erewash OA CMHT	10%	0%	11%
H P + NDales OA CMHT	0%	21%	0%
Killmsh + N C OA CMHT	11%	3%	16%
Memory Assessment Service	5%	2%	7%
OA Day Services	24%	3%	8%
South + Dales OA CMHT	13%	0%	5%

Actions

- Roll out of Living Well to improve flow of patients and reduce waits, by 31/3/2024 – in progress
- Review of the CPA policy to Care Principles & CPA to reduce admin time and release more time to care, by 30/6/2023 – in progress
- Proactive recruitment and review of skill mix, creating new roles and development opportunities to bring a different skill set to facilitate multidisciplinary team working and address the nursing shortage by 30/6/2023 – in progress





Referrals

Year	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2016				18	15	20	23	28	31	26	27	18
2017	19	17	9	20	23	21	25	22	27	43	30	29
2018	29	34	32	41	47	40	62	41	45	54	48	22
2019	92	65	52	50	82	71	77	49	59	34	55	46
2020	83	32	28	45	20	46	17	27	14	48	77	74
2021	43	56	58	59	85	80	64	56	51	70	55	114
2022	62	62	141	74	100	97	50	70	88	65	70	52
2023	40	10	43									

Assessments

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2016				19	7	22	5	4	19	20	15	13
2017	35	37	47	22	22	18	30	16	24	34	30	12
2018	20	15	23	18	19	20	22	11	13	14	20	20
2019	33	24	25	24	19	18	15	11	26	30	34	15
2020	28	27	22	1	5	11	20	16	18	29	18	15
2021	20	17	22	22	17	12	14	14	24	24	15	6
2022	12	12	21	13	10	14	8	6	20	22	20	15
2023	22	29	25									

Summary

Demand for the service continues to outstrip capacity (commissioned to undertake 26 per month but currently receiving referrals 76 per month this financial year to date). At the end of March 2023 there were 2,025 adults waiting for adult ASD assessment, which is a reduction of 13 since the last report. A revised approach to waiting list management is being mobilised and should start to have an impact from quarter 4. Referrals peaked in April 2022 at 141 but have been gradually reducing since then. This calendar year we are staring to see an increase in monthly assessments completed.

Actions

- Increase workforce capable of assessment: 20 newly trained staff (pending ADOS licensing), by Feb 2024 – in progress.
- Introduce robust flagging system on EPR, accurate reporting data and consistency to operational processes, by Qtr2 2023.
- Clinical efficacies: Review clinical processes to increase screening success and increase the number of ASD assessments completed, in order to meet target for assessments by Qtr1 2023.

Benchmarking

Waits over 13 weeks with no appointment	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22
Derbyshire Healthcare NHS Foundation Trust	1125	1150	1165	1155	1190	1260	1275	1330	1440	1485	1570	1655	1690	1730	1795
Birmingham and Solihill NHS Foundation Trust	15	15	15	15	15	10	10	15	15	15	15	15	15	20	20
Central and North West London NHS Foundation Trust	235	250	280	300	310	330	350	365	390	400	520	450	460	480	485
Leicestershire Partnership NHS Trust	20	20	20	20	20	25	35	45	60	75	95	115	105	110	125
Lincolnshire Partnership NHS Foundation Trust	325	335	365	330	360	375	405	445	470	490	515	540	540	550	575
Midlands Partnership NHS Foundation Trust	410	410	405	395	395	395	390	400	410	435	480	495	530	540	560
North Staffordshire Combined Healthcare NHS Trust	15	15	20	145	155	195	220	270	305	345	385	405	430	460	485
Northamptonshire Healthcare NHS Foundation Trust	1515	1570	1550	1600	1655	1780	1900	1955	2050	2160	2245	2355	2450	2535	2485
Nottingham University Hospitals NHS Trust	395	400	400	365	365	370	370	370	370	370	370	370	370	375	375
Nottinghamshire Healthcare NHS Foundation Trust	85	85	85	120	120	120	120	120	120	120	120	120	120	120	120

Data source: Data source: NHS Digital

- Waiting lists are increasing significantly for the majority of providers.

Operational Performance

Psychology & Psychological Therapies

Introduction
This month has bought changes to psychology services. We have now formed the Division of Psychology and Psychological Therapies and future reports will include the whole divisional performance. This performance report focuses on around 40% of the division, which is based on the data currently accessible.

Workforce update
Division of Psychology and Psychological Therapies now formed. The systems team are currently working on a way to allow us to pull through all the psychology workforce data to be able to review in one place.

Morale is positive and recruitment has improved although there remains a national shortage of clinical psychologists. Retention remains high. We remain the most well recruited to psychology services as a whole across the midlands (as compared to Lincoln, Notts & Leicestershire)

New posts in CAMHS and gambling harm are currently preparing for recruitment.

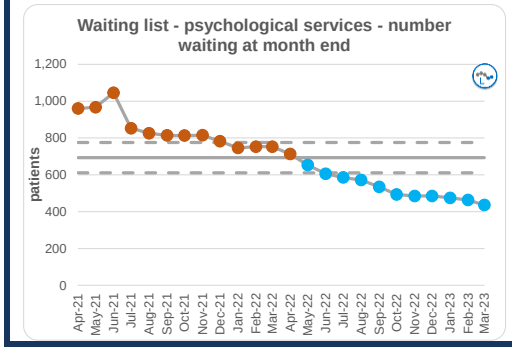
Friends & Family Test
Friends and Family Test, where reported, shows excellent feedback:

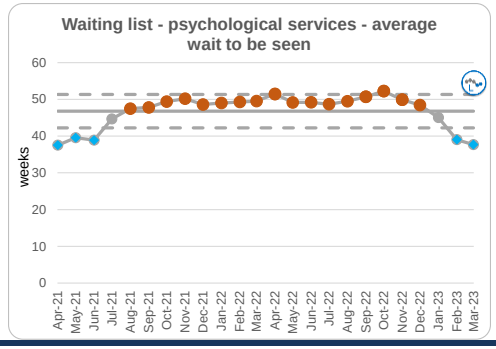
- CBT had 84 responses and 100% of them were positive
- Working age adult psychology received 96 responses and 97% were positive

Partnership and PLACE working
All teams are now exploring staff working in areas and places where the team had not traditionally offered care. These staff are working to integrate with living well teams and PLACE alliances as they develop.

We have built a positive relationship with the university of Nottingham which has resulted in employment of a Clinical Tutor for Derbyshire so we can increase the number of trainees we employ and increase our recruitment pool of qualified staff in the future.

Waiting lists and referrals
Referrals continue into services at a steady rate, however in some areas demand continues to outstrip delivery causing pockets of longer waits (for example Amber Valley working age adult psychology services). Overall waiting lists do however continue to reduce. At the end of March 2023, 436 people across Derbyshire were waiting to be seen by psychological services, with an average wait time of 38 weeks. The number waiting and waiting times are both continuing to reduce significantly. We aim, with the formation of the division to reduce these numbers further over the next 12 months.





Staff well-being
Psychologists are now supporting a number of teams through reflective practice. Working alongside People Services we have appointed a counselling psychologist to deliver a service to staff. She starts in July.

Supervision & appraisal
An action plan is being established to address Supervision and appraisal rates to ensure psychology as with other service provision lines is aiming to achieve 100% compliance. There is some inaccuracy in the data which is being scrutinised, possibly due to the new divisional formation.

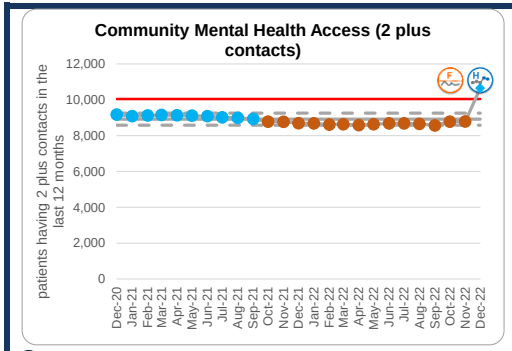
Increasing psychological awareness
As part of our ambition to be the most psychologically informed trust in the NHS, we have begun delivering twice monthly bite size psychology sessions for all to attend via MS Teams. This has been well attended to date. We have developed the Trauma informed conference to be delivered on the 5th May with 200 attendees.

Raising the profile of the Division
We have two members of staff applying for research funding which will increase publications in peer reviewed journals; we have a member of staff who is in Canada this month having been fully funded to be the key note speaker at an international conference (https://www.forensicpsychiatryinstitute.com/conference/agenda/)

Actions

- Current workforce continues to receive training in relation to psychological thinking as part of the upskilling plans. This remains ongoing.
- Continued push to recruit to hard to fill posts
- Teams within Psychology and Psychological Therapies supporting each other as patients are "everybody's business"
- Focus on removing boundaries between services and how formulation can improve this
- To complete the Division of Psychology and Psychological Therapies through finalising ESR and hierarchy – currently there are some inaccuracies which influence the data reported.
- Await completed structure from systems team to be able to gain the right intelligence for the division
- Continued work with systems team to improve accuracy of SystemOne reporting and data capture especially around wait lists where some individuals appear to have been recorded twice. Focus on data cleanse.
- Improve compliance with appraisals and supervision

Operational Performance

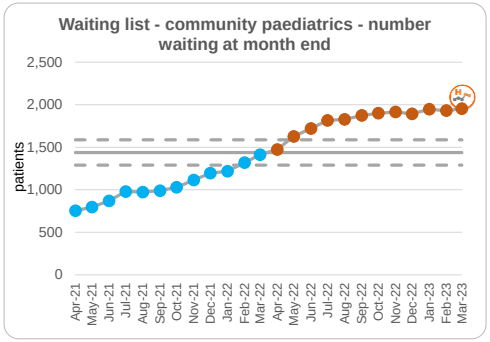


Summary

The Trust was set a very challenging target to increase the number of adults and older adults receiving 2 or more contacts in a year from community mental health services to 10,044 by the end of March 2023, which was an increase of 14% on current performance.

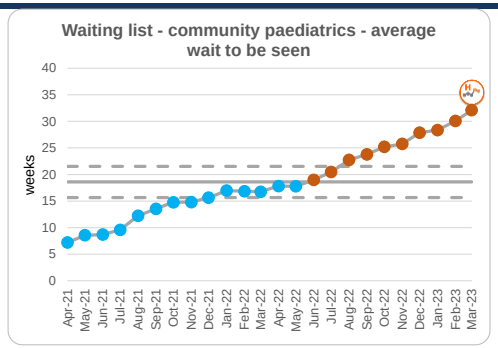
A recovery action plan was put in place and implemented, following which analysis of internal data indicated that the target level of activity was being achieved.

As the national data is a few months in arrears and the target is a rolling twelve months' target, this achievement took some time to be reflected in the national reporting, however the latest national data demonstrates that we are now exceeding target, which is a significant achievement.



Summary

At the end of March 2023 there were 1,953 children waiting to be seen. The average wait time was 32 weeks.



External factors contributing to increased demand on Community Paediatricians:

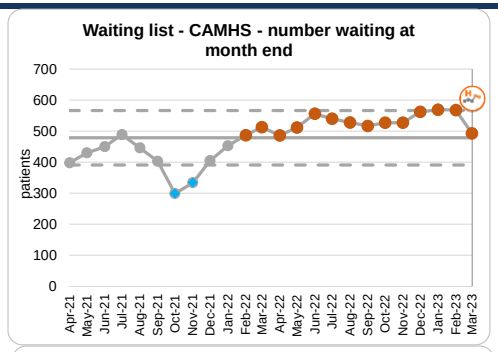
- ASD/ADHD demand for specialist assessment increased 400% from 2018 to 2023 (22/23 4575 referrals per annum) with maximum South Derbyshire system capacity to assess 1900 per year)
- Looked After Children rates increased during the pandemic
- Developmental delay referrals to community paediatricians increased following the pandemic
- Appointment duration has increased due to the increased complexity of CYP presenting needs post the pandemic.

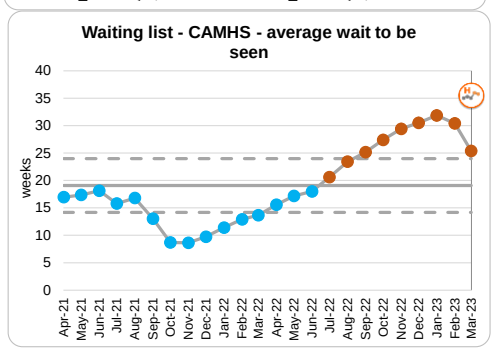
Internal factors:

- Challenges to recruitment- 2 Consultant vacancies
- Long term sickness in the team
- Access to clinical space

Mitigation:

- Neurodevelopmental (ND) business case 400k received January 2023 (75% less than proposed business case to address current demand) – mobilisation phase underway.
- Skill mix review ongoing
- Appointment of locums (to be reviewed)
- Increased work and flexibility (weekends/evening)
- 7% increase in activity over the past 6 months
- Quality Improvement – Children & Young People ND transformation (phase 1) starts May 2023
- Mobilisation of the VCSE Community hubs in May 2023 for pre and post assessment work.



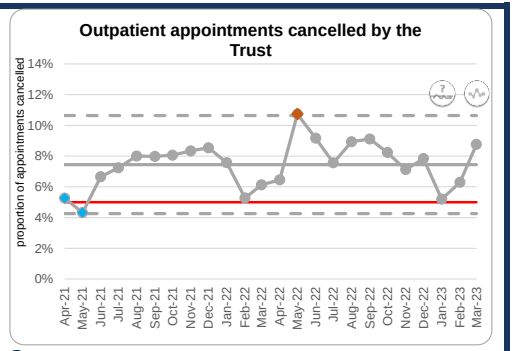


Summary

At the end of March 2023, 493 children were waiting to be seen with an average wait time of 25 weeks.

Actions

- The new triage element of the Triage and Assessment Service became operational in Feb 23. This has initially consisted of 2 lead practitioners with one day per week dedicated time, to focus solely on triaging. The number of practitioners will increase to 5 by the end of May, when new recruits start.
- The longest waits on the routine list have been prioritised.
- From Feb 23 to March 23, 410 triage calls have been made. 77 young people were discharged off the waiting list, signposted to more appropriate services, or provided with information, with 22 of the 410 people being expediated onto the priority assessment list. For those young people who did not answer the phone, opt in letters were sent, which have been well received.

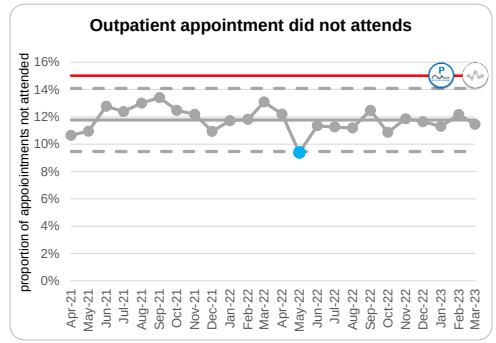


Summary

This indicator was introduced as a measure of patient inconvenience some years ago and when cancelling appointments, the administrators should identify whether or not the patient was aware of the appointment in order to enable differentiation between cancellation of virtual and actual appointments. Recording accuracy needs to improve and so further training in the use of SystmOne has been arranged for those concerned.

Actions

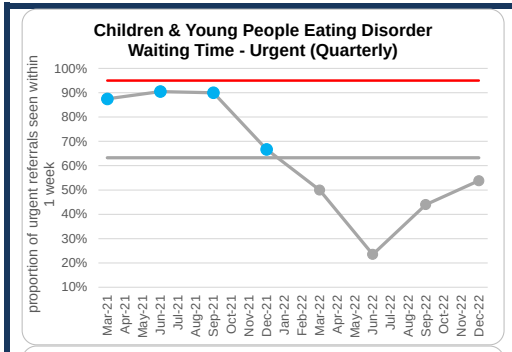
- Refresher training for admin staff
- Discussion in supervision with admin staff
- Professional Heads of Admin to distribute instructions regularly on how to cancel clinics correctly.

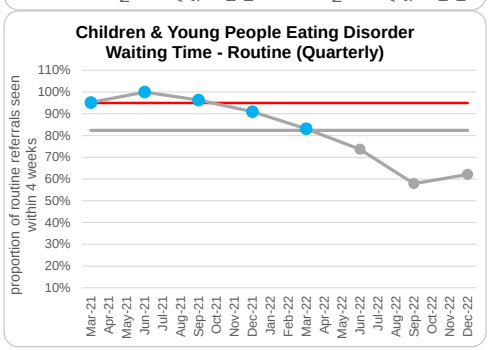


Summary

The level of defaulted appointments has remained within common cause variation, averaging just under 12% and in the current process the trust target of 15% or lower is likely to be consistently achieved.

Operational Performance

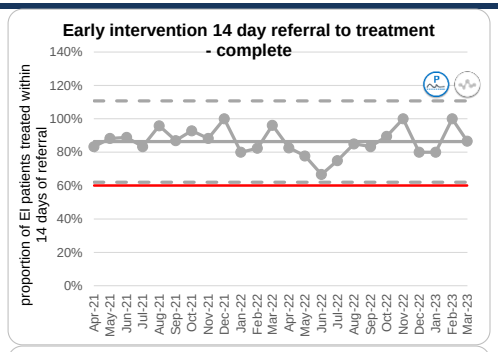


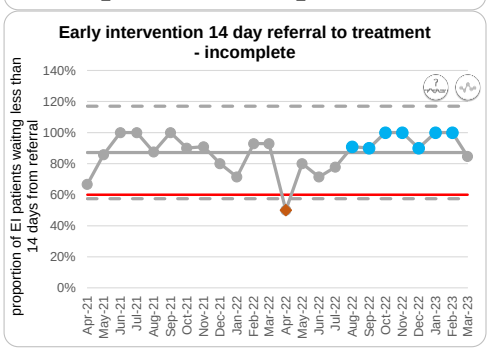


Summary

The two waiting time standards are that children and young people (up to the age of 19), referred for assessment or treatment for an eating disorder, should receive NICE-approved treatment with a designated healthcare professional within one week for urgent cases, and four weeks for every other case (target 95%). The Trust's Child & Adolescent Eating Disorder Service is achieving 100% for both standards, but unfortunately the national measure is not based on service, so anyone up to age 19 referred to any Trust service at all with a referral reason of eating disorder is counted in the overall calculation.

A revised action plan is currently being developed for 2023/24 in conjunction with Chesterfield Royal, who provide the service in the north of the County. Key actions from the plan will be detailed in this report from next time and progress will be monitored monthly by the Joined Up Care Derbyshire Mental Health & Learning Disability Delivery Board.

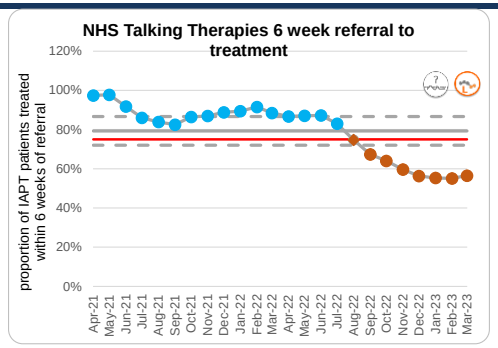




Summary

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

The service is generally very responsive and has exceeded the national 14-day referral to treatment standard of 60% or more people on the waiting list to have been waiting no more than 2 weeks to be seen in all but one month over the past 2 years.

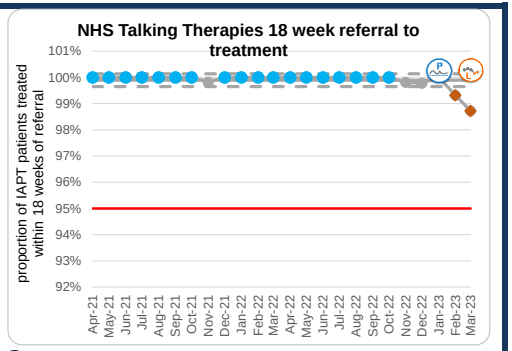


Summary

Wait times from referral to assessment/ treatment and 1st to 2nd treatment have been lengthening due to returns to near pre-pandemic levels (1200 referrals in March) of referral, difficulty in recruiting to Psychological Wellbeing Practitioner (PWP) qualified roles. This has seen a decline in the achievement of the 6-week referral to treatment up to January 2023, although this decline has slowed and improved from February to March. Additionally, attended appointments for assessments are lower than we would like and improving this should achieve some wait time gains. DNA's remain high for assessment slots but trialling of bookable appointments has commenced.

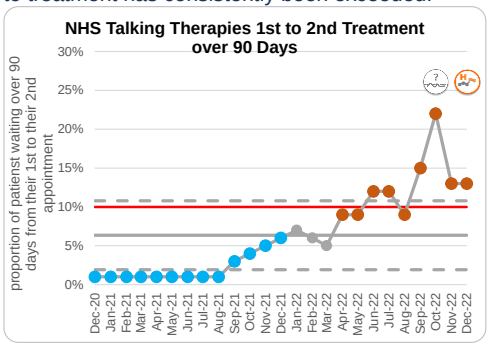
Actions

- Recruitment to the qualified PWP posts has improved with 2 being recruited against a WTE deficit of 5. One has started and the other is being cleared by recruitment.
- A booking clerk is in post to book short notice appointments into cancelled slots. A further monitoring of staff releasing DNA appointments has commenced to get a consistent amount of re-booking to increase activity at assessment.
- NHSE are funding bookable appointments which is being trialled with 3 PWPs.
- Spot purchasing of assessments to bring the referral to assessment waits down is in process.



Summary

The 95% standard for 18-week waits from referral to treatment has consistently been exceeded.



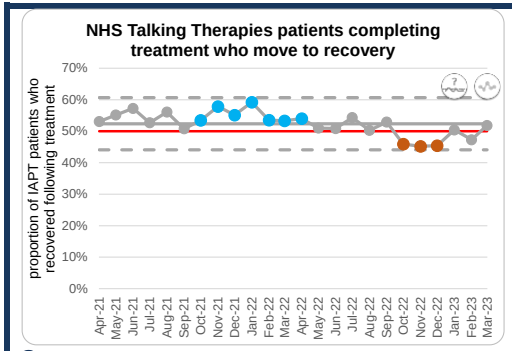
Summary

Waits have been significantly high for the last 9 months and above target for the last 4 months. The graph shows a stabilising picture up to December but quarter 4 is not available yet.

Actions

- Consolidate the waiting lists.
- Service Manager discussion over longest waiters monthly to reduce outliers. Standing agenda item
- Review productivity and average contacts to increase treatments and reduce wait times. Work ongoing to monitor individual and team performance, and to inform caseload management.
- Maintain a focus on attendance, which has improved into quarter 4 of 2022/23
- Review acceptance criteria to achieve more appropriate referrals.
- Introduce bookable appointments increasing available treatment slots.
- Ensure appropriate clients are referred into IESO who have some additional capacity.

Operational Performance

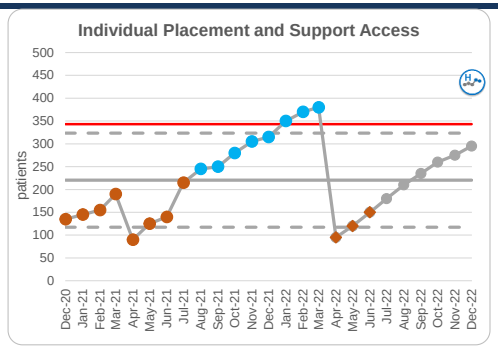


Summary

This is an annual target and full year performance is on target. The dip in performance in quarter 3 was likely to have been an unintended consequence of implementing waiting list waiting well checks, which included taking measures. This has been amended and the positive effects have now started to be reflected in the data, with higher recovery rate compliance achieved in January and March.

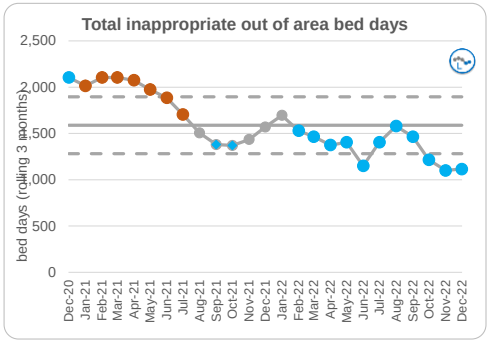
Actions

- Clarification and communication of referral criteria, for clinicians/ referrers and service users.
- Focus on productivity to reduce wait times and inform clinicians clearly of their own performance.
- Monitoring of clinician and service wide performance, development of individual performance reports.
- Continued monitoring of removal of outcome measures as part of waiting well appointments



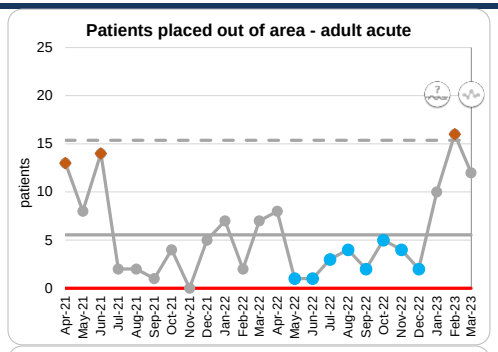
Summary

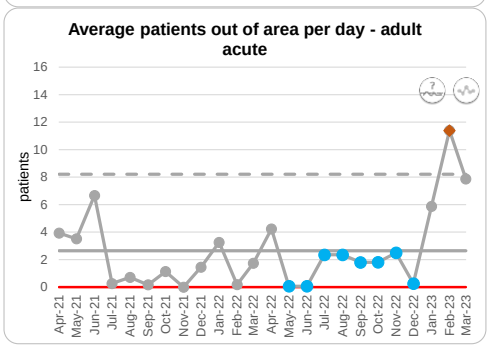
This is a year-end target for the number of new people accessing the individual placement and support services within the financial year. The target was achieved in 2021/22 and is currently on target to be achieved this financial year also.



Summary

This is a combination of inappropriate out of area adult acute placements and inappropriate out of area psychiatric intensive care unit placements, calculated on a rolling 3 months' basis. The actions being taking to improve the position of each placement type are detailed in the next 2 columns.



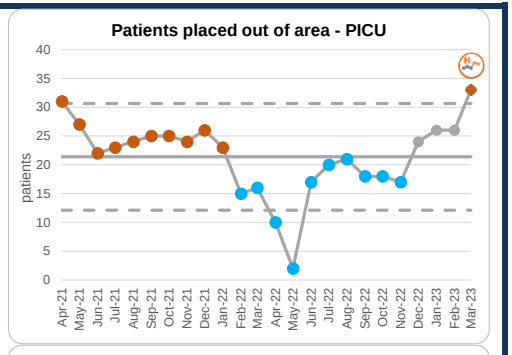


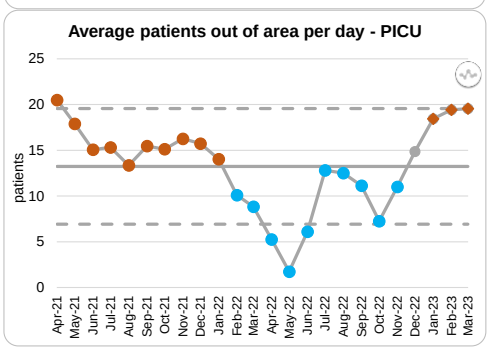
Summary

This continues to be impacted upon by persistently high levels of bed occupancy 100% plus. This is the result of utilising leave beds effectively and maximises bed availability. Clinically ready for discharge is monitored multiple times each week to ensure that flow is maintained and as a result numbers are significantly reduced. Average length of stay remains higher reflecting the higher levels of acuity within the inpatient wards at this time. However, the number of patients in out of area beds has reduced considerably over the last 6 weeks due to a number of actions that have been put in place. Today we have a total of 6 patients in acute out of area beds.

Actions

- Changes have been made to the authorisation protocol for out of area beds.
- Gatekeeping and Purposeful Admission protocols being developed
- Community based medication initiation being developed





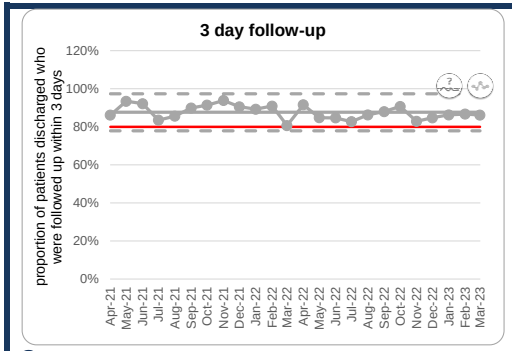
Summary

There is no local PICU provision, so anyone needing psychiatric intensive care must be placed out of area, however, work continues on the provision of a new build PICU in Derbyshire. As a result of actions there has been considerable reduction in PICU placements over the past 6 weeks and today there area total of 14 patients placed in PICU beds.

Actions

- Provision of a PICU in Derbyshire in order to be able to admit to a unit that forms part of a patient's usual local network of services in a location which helps the patient to retain the contact they want to maintain with family, carers and friends, and to feel as familiar as possible with the local environment
- To generate improved flow and admission capacity in adult acute inpatients, working closely with community teams, creating capacity to repatriate PICU patients when appropriate to do so and a reduction in requirement for psychiatric intensive care.

Operational Performance

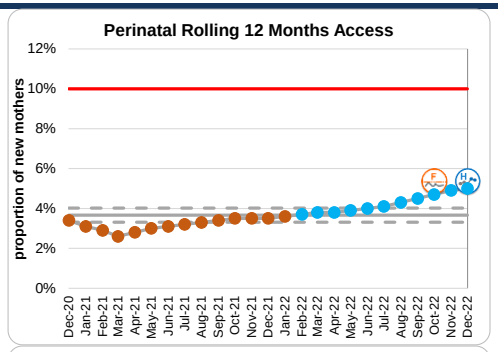


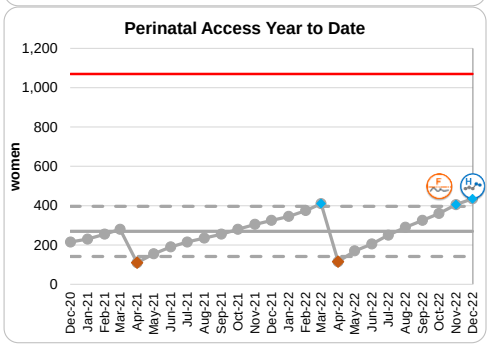
Summary

Patients are followed up in the days following discharge from mental health inpatient wards to provide support and ensure their wellbeing during the period when they are potentially at their most vulnerable. The national standard for follow-up has been exceeded throughout the 24-month period. Some ongoing recording issues have been experienced following the move to SystmOne, however these have now largely been addressed as people have become used to how to record on the new system.

Actions

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





Summary

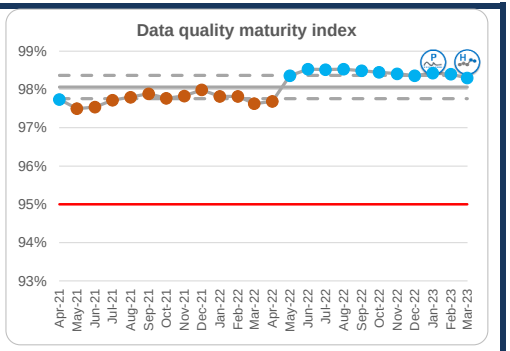
This is a measure of the number of women accessing services in the 12-month period as a percentage of Office for National Statistics (ONS) 2016 births (target 10%).

The number of live births in Derby & Derbyshire has been lower each subsequent year than when the target was set, which makes it more challenging to achieve as there are fewer mothers who potentially need perinatal mental health support:

Live Births	Derby	Derbyshire	Total	Difference v 2016
2021	2896	7366	10262	-852
2020	2908	7002	9910	-1204
2019	3009	7336	10345	-769
2018	3174	7416	10590	-524
2017	3184	7563	10747	-367
2016	3294	7820	11114	

Actions

- Data quality checks to verify recording of assessments working with Information Management Team, to aid monitoring of performance against target
- Increase capacity in teams to enable further assessments to be undertaken. Utilise focused assessments, joint antenatal clinics, workforce/recruitment planning. To result in reduced waits and increased access to the service
- Increase referrals: increase in assessments from maternal mental health service
- Target areas of low referrals, bespoke training to GP's and Health Visitors; increase communications regarding the advice line.
- Development of birth trauma and tokophobia pathways.
- Record assessments from the specialist midwives.
- Improved awareness of referral pathways
- The Trust Quality Improvement team have been engaged to monitor progress against trajectories and revise the step changes that were expected in quarter 4 of 2022/23
- Bespoke offer of support from the Perinatal Clinical Network
- Monthly operational meetings to discuss progress amongst Perinatal Teams, and to consider further actions, local targets set and monitored within teams/roles
- Quarterly updates shared by Managing Director to Delivery board, Targeted delivery from 31st March 2023



Summary

The level of data quality has been significantly better than expected for the last 9 months. It is expected that the national target will be consistently exceed.

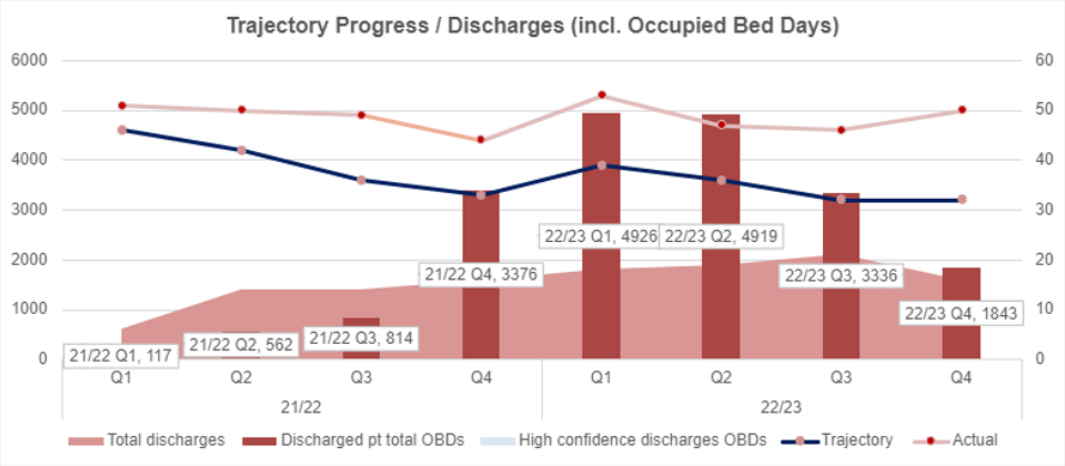
Transforming Care Programme

The Transforming Care programme aims to improve the lives of children, young people and adults with a learning disability and/or autism who display behaviours that challenge, including those with a mental health condition. The programme has three key aims: to improve quality of care for people with a learning disability and/or autism, to improve quality of life for people with a learning disability and/or autism, and to enhance community capacity, thereby reducing inappropriate hospital admissions and length of stay. With the services set out in the national service model it is expected that no local area will need non-secure inpatient provision (of which acute learning disability beds would be one type) for more than 10-15 inpatients with a learning disability and/or autism, per million population, at any one time. (NHS England, LGA, ADASS, Building the Right Support, 2015). Currently in Joined up Care Derbyshire there are 50 service users in bedded care.

Inpatient Performance Overview

Joined Up Care Derbyshire

Trajectory



	No of patients at 27/03/23	Quarter 4 Trajectory	current +/- against Trajectory
DDICB Beds Total	32	16	+16
Adult Spec Comm total	18	14	+4
Combined Adults	50	30	+20
CYP Spec Comm	5	3	+2

Cohorting: LoS & Care

50↑ in bedded care:

- 43↑ are in the right setting for current care needs
- 22↑ of are receiving care in the right geography
- 28 ↑are in the wrong geography and all of these are because the provision doesn't currently exist within the geography
- **6** ↓ are in the wrong setting, 6↓are in the wrong care↓
- 38% have a LoS of less than a year

LoS Group	Number of current inpatients	Number of discharged patients, group on discharge 22/23	% split of cohort per LoS group in 22/23
Less than a year	19	66	38%
1-3 years	11	5	22%
3-5 years	6	0	12%
more than 5 years	14	2	28%

Good News: Discharges

18 year old female – originating from Derbyshire

- Autism and ADHD diagnosis
- Was a Looked After Child placed in the community in Wolverhampton from Cygnet low secure unit in April 2022
- Presentation deteriorated whilst in the community and spent various periods of time in s136 suite whilst in the Black Country
- Repatriated to Derbyshire to be closer to home and admitted to AMH bed on 15th July 2022
- Supported by ND In-reach team whilst in hospital
- Discharged on 20th March 2023 back home to live with dad

Hillside Ward Long Stay Patient

Admitted Feb 2021

- Monday 27th March went on 2 weeks' leave to new placement in readiness for discharge
- Immediate environment changes in response to risks
- Despite challenges, staff stayed with her until she settled in including staying overnight on the first night to support.

Of the 7 service users not currently in the right care setting, 4 placements are locked door rehabilitation for complex care, with discharges planned between May and August '23 with high confidence. 1 placement is mental health rehabilitation owing to the complexity of need not able to be supported in the community. 1 placement is adult mental health, not on the SMI register, and 1 placement is a child PICU bed, with the service user recently turning 18. Work is ongoing to discharge these service users.

Operational Performance

Friends & Family Test

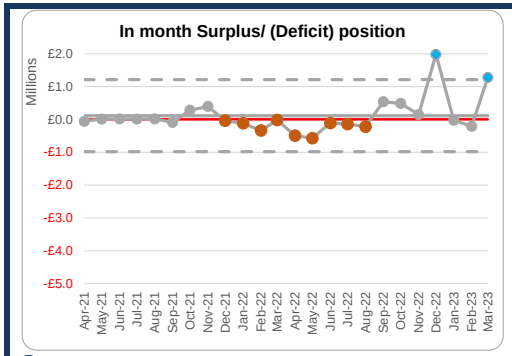
ICB Code	Trust Code	Trust Name	Total Responses	Total Eligible	Response Rate	Percentage Positive	Percentage Negative	Mode of Collection							
								Mode SMS	Mode Electronic Discharge	Mode Electronic Home	Mode Paper Discharge	Mode Paper Home	Mode Telephone	Mode Online	Mode Other
		England (excluding Independent Sector Providers)	18,851	772,364	2%	87%	6%	2,465	1,376	292	5,192	1,642	314	6,217	1,353
QHM	RR7	GATESHEAD HEALTH NHS FOUNDATION TRUST	17	131	13%	100%	0%	0	0	0	17	0	0	0	151
QSL	RH5	SOMERSET NHS FOUNDATION TRUST	14	165	8%	100%	0%	0	0	0	0	0	0	14	0
QH8	R1L	ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST	46	21,427	0%	98%	2%	0	0	0	7	0	0	39	0
QHM	R0B	SOUTH TYNESIDE AND SUNDERLAND NHS FOUNDATION TRUST	68	1,437	5%	97%	1%	0	0	0	43	0	0	25	0
QUA	TAJ	BLACK COUNTRY HEALTHCARE NHS FOUNDATION TRUST	196	17,169	1%	97%	1%	0	0	0	0	0	0	0	0
QNC	RLY	NORTH STAFFORDSHIRE COMBINED HEALTHCARE NHS TRUST	127	14,497	1%	97%	3%	5	0	0	0	105	0	17	0
QRL	R1F	ISLE OF WIGHT NHS TRUST	28	2,300	1%	96%	0%	0	0	0	0	28	0	0	0
QUA	RYK	DUDLEY INTEGRATED HEALTH AND CARE NHS TRUST	27	1,590	2%	96%	0%	0	0	0	0	0	0	0	0
QF7	TAH	SHEFFIELD HEALTH & SOCIAL CARE NHS FOUNDATION TRUST	97	6,738	1%	96%	0%	0	0	0	97	0	0	0	0
QHM	RTF	NORTHUMBRIA HEALTHCARE NHS FOUNDATION TRUST	47	904	5%	96%	2%	47	0	0	0	0	0	0	*
QHM	RX3	TEES, ESK AND WEAR VALLEYS NHS FOUNDATION TRUST	1,362	138,051	1%	94%	2%	120	287	0	907	0	0	48	22
QUE	RT1	CAMBRIDGESHIRE AND PETERBOROUGH NHS FOUNDATION TRUST	213	2,379	9%	93%	2%	3	58	0	0	80	0	70	0
QOP	RT2	PENNINE CARE NHS FOUNDATION TRUST	595	10,494	6%	93%	3%	124	0	0	280	0	7	184	0
QWO	RY6	LEEDS COMMUNITY HEALTHCARE NHS TRUST	43	626	7%	93%	2%	0	0	0	0	0	0	43	0
QJM	RP7	LINCOLNSHIRE PARTNERSHIP NHS FOUNDATION TRUST	466	4,687	10%	92%	2%	9	47	0	410	0	0	0	0
QJ2	RXM	DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST	260	15,839	2%	92%	3%	0	0	0	95	0	0	165	*
QOQ	RV9	HUMBER TEACHING NHS FOUNDATION TRUST	214	4,917	4%	92%	2%	0	0	0	214	0	0	0	*
QYG	RW4	MERSEY CARE NHS FOUNDATION TRUST	841	20,406	4%	92%	2%	0	477	0	325	0	0	39	315
QRL	RW1	SOUTHERN HEALTH NHS FOUNDATION TRUST	1,002	10,672	9%	92%	3%	0	0	0	514	224	0	264	24
QRL	R1C	SOLENT NHS TRUST	592	1,916	31%	91%	2%	52	0	0	496	0	0	44	0
QMJ	TAF	CAMDEN AND ISLINGTON NHS FOUNDATION TRUST	144	1,693	9%	90%	5%	0	8	0	0	24	0	112	0
QYG	RXA	CHESHIRE AND WIRRAL PARTNERSHIP NHS FOUNDATION TRUST	529	10,478	5%	90%	6%	486	0	0	43	0	0	0	0
QF7	RXE	ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST	88	19,470	0%	90%	7%	*	*	*	*	*	*	*	509
QHM	RX4	CUMBRIA, NORTHUMBERLAND, TYNE AND WEAR NHS FOUNDATION TRUST	560	33,653	2%	89%	5%	0	0	0	409	0	0	0	0
QWO	RGD	LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST	125	7,144	2%	89%	6%	0	0	0	0	40	0	85	0
QE1	RW5	LANCASHIRE & SOUTH CUMBRIA NHS FOUNDATION TRUST	1,459	31,502	5%	89%	7%	0	25	0	0	0	266	1,168	39
QMJ	RRP	BARNET, ENFIELD AND HARINGEY MENTAL HEALTH NHS TRUST	728	8,436	9%	89%	3%	0	37	0	0	0	0	691	0
QE1	RXL	BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST	137	969	14%	88%	1%	0	0	100	0	0	0	37	0
QXU	RXX	SURREY AND BORDERS PARTNERSHIP NHS FOUNDATION TRUST	262	9,190	3%	88%	4%	3	95	0	36	0	0	128	0
QVV	RDY	DORSET HEALTHCARE UNIVERSITY NHS FOUNDATION TRUST	219	6,055	4%	87%	8%	6	0	23	0	12	0	178	0
QOP	RXV	GREATER MANCHESTER MENTAL HEALTH NHS FOUNDATION TRUST	509	23,602	2%	87%	8%	0	0	0	0	0	0	0	0
QR1	RTQ	GLOUCESTERSHIRE HEALTH AND CARE NHS FOUNDATION TRUST	120	1,205	10%	87%	4%	0	0	0	0	0	0	120	0
QMJ	RV3	CENTRAL AND NORTH WEST LONDON NHS FOUNDATION TRUST	255	24,061	1%	86%	5%	0	4	0	47	0	0	204	0
QOX	RVN	AVON AND WILTSHIRE MENTAL HEALTH PARTNERSHIP NHS TRUST	501	5,833	9%	86%	5%	1	0	0	91	370	0	0	3
QNQ	RWX	BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST	449	22,475	2%	86%	8%	0	46	0	21	0	0	382	0
QMJ	RNK	TAVISTOCK AND PORTMAN NHS FOUNDATION TRUST	7	2,579	0%	86%	0%	*	*	*	*	*	*	*	0
QYG	RBS	ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	34	232	15%	85%	12%	34	0	0	0	0	0	0	196
QWO	RXG	SOUTH WEST YORKSHIRE PARTNERSHIP NHS FOUNDATION TRUST	518	12,481	4%	85%	8%	349	0	0	66	0	0	103	27
QKS	RXY	KENT AND MEDWAY NHS AND SOCIAL CARE PARTNERSHIP TRUST	584	13,810	4%	85%	3%	0	0	0	545	0	0	39	2
QPM	RP1	NORTHAMPTONSHIRE HEALTHCARE NHS FOUNDATION TRUST	284	6,450	4%	85%	8%	0	0	35	0	127	0	122	0
QU9	RNU	OXFORD HEALTH NHS FOUNDATION TRUST	185	10,781	2%	83%	9%	0	96	0	62	0	0	27	0
QHL	RXT	BIRMINGHAM AND SOLIHULL MENTAL HEALTH NHS FOUNDATION TRUST	311	17,172	2%	83%	7%	0	0	0	211	0	0	100	0
QWO	TAD	BRADFORD DISTRICT CARE NHS FOUNDATION TRUST	101	9,232	1%	82%	8%	0	69	0	5	0	20	7	0
QKK	RV5	SOUTH LONDON AND MAUDSLEY NHS FOUNDATION TRUST	318	37,818	1%	82%	4%	0	0	0	0	247	0	71	0
QNC	RRE	MIDLANDS PARTNERSHIP NHS FOUNDATION TRUST	304	22,108	1%	82%	14%	0	0	0	0	0	0	280	0
QMF	RAT	NORTH EAST LONDON NHS FOUNDATION TRUST	806	9,739	8%	81%	9%	0	0	0	0	0	0	806	0
QM7	RWR	HERTFORDSHIRE PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST	647	11,183	6%	81%	9%	*	*	*	*	*	*	*	0
QNX	RX2	SUSSEX PARTNERSHIP NHS FOUNDATION TRUST	105	11,872	1%	79%	10%	0	0	0	0	0	0	105	43
QKK	RPG	OXLEAS NHS FOUNDATION TRUST	632	9,057	7%	78%	9%	125	120	102	200	85	0	0	0
QRV	RKL	WEST LONDON NHS TRUST	63	7,473	1%	78%	13%	0	0	0	42	0	0	21	0
QWE	RQY	SOUTH WEST LONDON AND ST GEORGE'S MENTAL HEALTH NHS TRUST	268	19,497	1%	77%	16%	203	0	0	0	0	0	0	*
QT6	RJ8	CORNWALL PARTNERSHIP NHS FOUNDATION TRUST	24	4,287	1%	75%	4%	1	5	0	9	0	0	9	*
QT1	RHA	NOTTINGHAMSHIRE HEALTHCARE NHS FOUNDATION TRUST	88	14,025	1%	74%	11%	69	0	0	0	16	0	0	126
QMM	RMY	NORFOLK AND SUFFOLK NHS FOUNDATION TRUST	315	26,498	1%	73%	20%	0	0	0	0	0	0	0	0
QMF	RWK	EAST LONDON NHS FOUNDATION TRUST	382	31,300	1%	71%	18%	0	0	27	0	0	0	333	0
QK1	RT5	LEICESTERSHIRE PARTNERSHIP NHS TRUST	526	10,667	5%	65%	25%	474	2	0	0	0	21	29	0

In the latest national data, the Trust received a high level of positive feedback (92%) and performed highly in comparison with other Trusts. NHS England » Friends and Family Test data – February 2023 This is a slight increase of 1% compared with the previous month.

Derbyshire Healthcare
NHS Foundation Trust

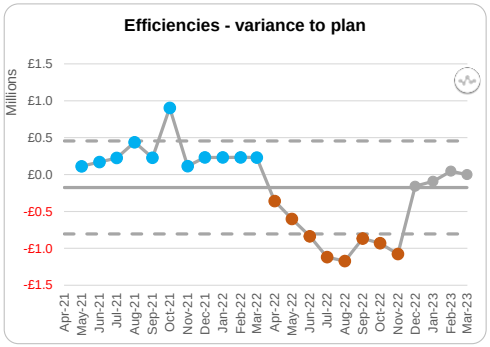
Finance

Financial Performance



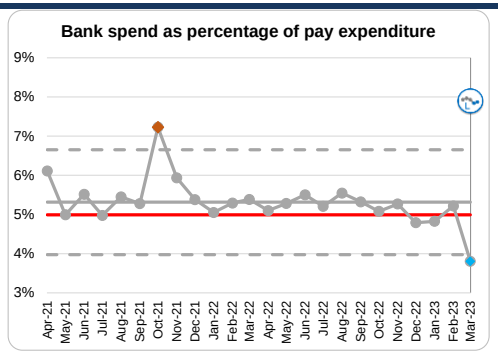
Summary

At the end of the financial year, the overall year to date (YTD) position is a surplus of £2.6m (adjusted to £2.8m after impairments) against a full year plan of breakeven. This outturn position is as per the previous forecast. The surplus position has been driven by additional non recurrent income and one off pay and non-pay benefits**.** The Board Assurance Framework (BAF) risk *that the Trust fails to deliver its revenue and capital financial plans,* was reduced in year from Extreme to Moderate.



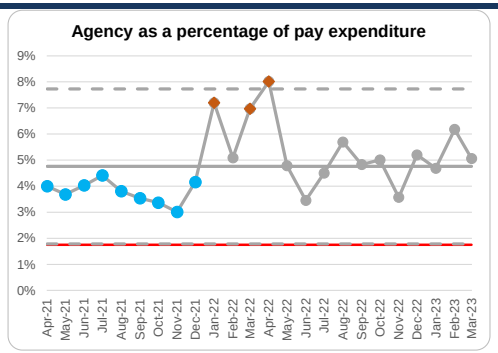
Summary

The full year plan included an efficiency requirement of £6.0m phased equally across the financial year. As at the end of the financial year the full £6.0m has been transacted in the ledger and all schemes delivered full. However, a considerable proportion of the efficiencies are non-recurrent in nature 68% which drives the underlying position and has an adverse impact on 2023/24 financial plans.



Summary

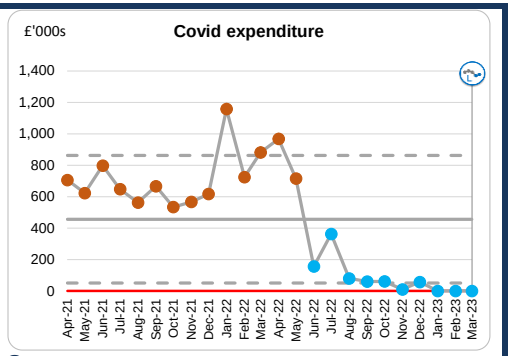
Bank staff expenditure YTD totals £7.5m against a plan of £6.8m with average spend of £0.6 per month, except for October 2021 where that increased to £0.8m. Like with the agency percentage reduction in March due to the pension cost impact, the same has been seen on bank, reducing down to 3.8% of total pay.



Summary

Agency expenditure year to date (YTD) totals £7.6m against a plan of £2.4m, an adverse variance to plan of £5.2m. The two highest areas of agency usage relate to Consultants and Nursing staff. Agency expenditure for March was £0.9m, an increase on the previous month. The peak in costs relates to additional agency costs that have been put in place to support a complex patient on one of the Acute Trust's wards.

The agency expenditure as a proportion of the total pay has reduced in percentage terms to 5.1% compared to the previous month despite the actual agency expenditure increasing in the month. This is due to £5.9m of additional pension costs, which is paid nationally, that requires reporting in the organisation's position at year end.

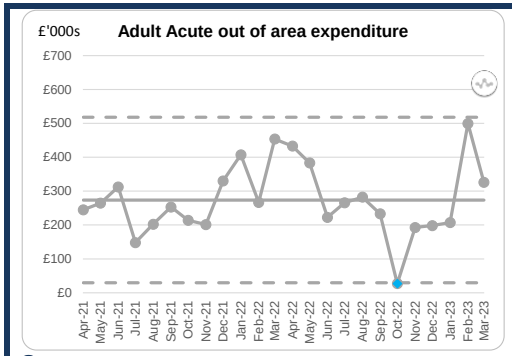


Summary

The Trust has an income allocation of £0.3m a month for the financial year for Covid-related expenditure. The financial plan assumes no expenditure after the end of May as per the planning guidance.

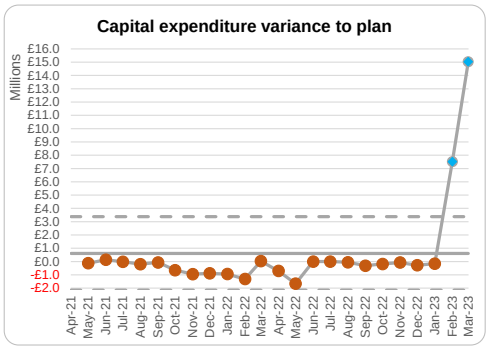
The above chart shows that expenditure has been reducing throughout this financial year with expenditure since August significantly lower than in previous months.

Financial Performance



Summary

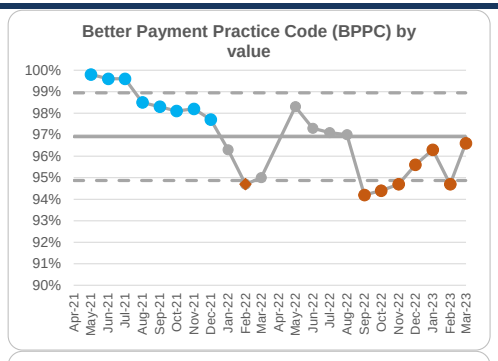
Expenditure for adult acute out of area placements including block purchased beds and cost per case beds had been reducing during 2022/23, however there has been a significant increase in February which has reduced slightly in March.

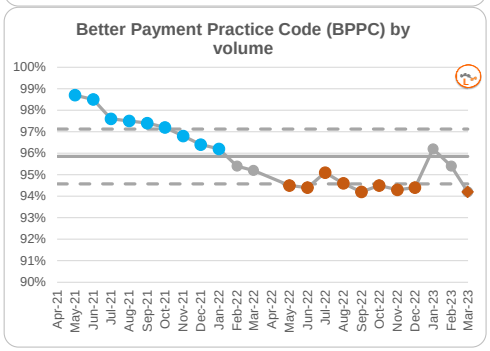


Summary

Capital expenditure was reporting behind plan in April and May, however that was against the April plan submission. The capital plan was resubmitted in June 2022 which changed the capital system allocation to reflect the requirement of the self-funded elements of the Making Room for Dignity project.

Capital expenditure has been above plan in the last two months of the financial year due to the additional capital expenditure related to the dorms project (which has come with additional funding that was not originally in the plan).

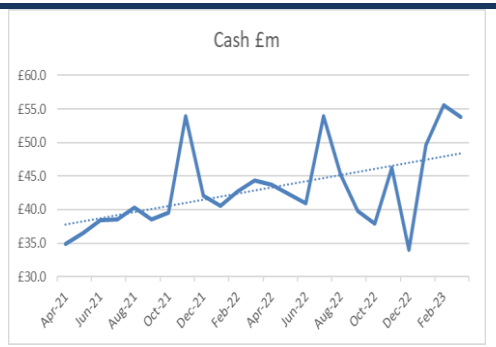




Summary

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

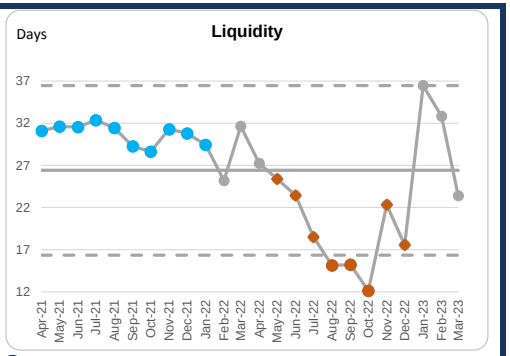
At the end of March, the value of invoices exceeded the target at 96.6%, however the volume of 94.2% was slightly below target.



Summary

The chart above shows the levels of cash over the last two years.

Cash increased in February and March due to the additional funding for the Dorms capital projects that has been drawn down.



Summary

The chart above shows the liquidity levels over the last two years. Liquidity levels were high in 2021/22.

In 2022/23 the liquidity reduced until the last quarter due to the timing of cash receipts related to the centrally funded capital schemes for the eradication of dorms. The PDC drawdown requests have caught up which has driven the increased level in January.

Planning 2023/24

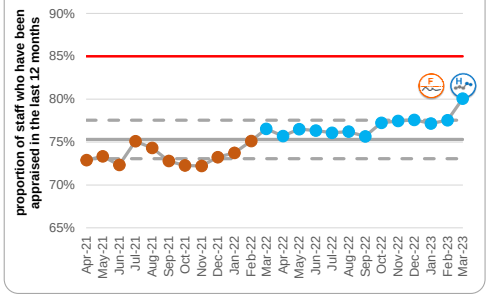
Currently financial plans for 2023/24 from a revenue perspective are still in the progress of being agreed as a Derbyshire system. The final submission is due on 4th May 2023.

Derbyshire Healthcare
NHS Foundation Trust

People

People Performance

Annual appraisals



Summary

There has been an increase across compliance of over 2% in March. Appraisal levels continue to be below our expectations with Operational Services currently at 81% and Corporate Services at 75%.

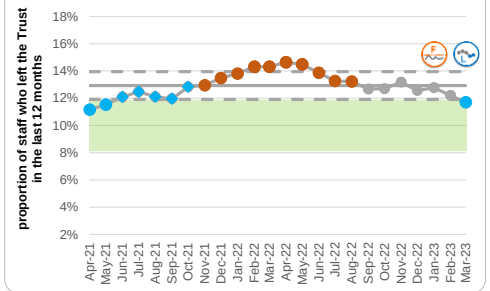
Actions

- Work has continued with increased support on using the Electronic Staff Record (ESR) to record an appraisal and the Divisional People Lead for each division is working with leaders to look at reasons for low compliance.
- Compliance also continues to be monitored at Divisional Achievement Reviews and via the Trust Operational Oversight Leadership Team (TOOL).
- Top areas in corporate services are People and Inclusion (100%) and Operational Support Team (98%). Medical Education (55%) and Nursing and Quality (56%) are both targeted an improvement of 10% by May 2023.

In Operational Services a recovery action plan has been put in place, with progress monitored weekly by the Chief Operating Officer. Key actions include:

- Managers to review the current reported position and inform correction of Electronic Staff Records (ESR) where any recording errors are found.
- Managers to book appraisal dates for all overdue appraisals and to schedule in appraisals for all their remaining team members, to take place a month before they are due to expire and share the yearly planner with their ASM for assurance
- Ongoing monitoring of compliance for appraisals in service line and divisional operational meetings

Annual turnover (target 8-12%)



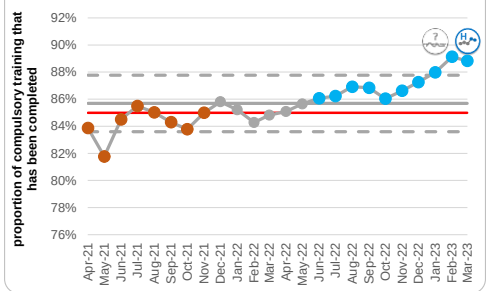
Summary

March has seen a small reduction in turnover to within the target range of 8-12% and remains in line with national and regional comparators.

Actions

- A triangulation of key people metric data and intelligence from key leads is now in place to ensure teams needing support takes place promptly to minimise staff leaving the teams.
- STAY surveys are being run with these teams and also teams requesting the survey to support the team to develop bespoke retention initiatives.
- Staff Survey results have been presented at divisional level and divisional action plans are being developed to address key actions and build on existing engagement plans.
- A strategic recruitment and retention lead is being recruited with a key focus on developing a retention strategy at organisational level and to work with divisions on bespoke retention initiatives.
- Top reason for leaving is retirement and the second highest known reason for leaving is work/life balance. A priority action is to develop our flexible working approach which is currently being reviewed and engagement taking place with colleagues for feedback on what would make a difference in our policy.
- Highest levels of turnover is in AHP roles and other clinical support services such as Health Care Support Assistants. These professional groups are being targeted as part of our STAY surveys and prioritised for retention strategies.

Compulsory training



Summary

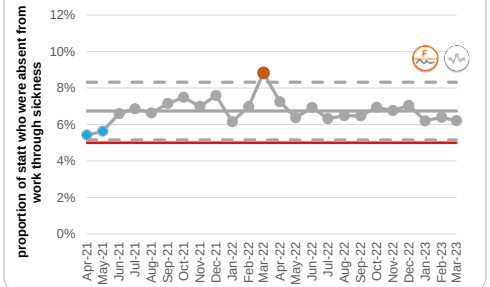
Overall, the 85% target level has been achieved for the last 11 months. Operational Services are currently 90% compliant and Corporate Services slightly lower at 83%.

Immediate Life Support (ILS) and Positive and Safe training compliance continue to remain in a stable position following targeted work to improve compliance last year. ILS is currently 84% compliance and positive and safe at 84% (breakaway) and 81% (teamwork).

Actions

- Priority actions are 1/2/3 being managed through mandatory training task and finish group continues to meet to focus on driving improvements to ESR data and training cleansing, embedding block week booking for clinical roles and ongoing review of compliance.

Staff absence



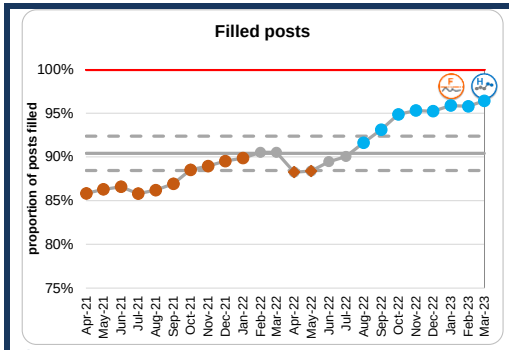
Summary

In March 2023 sickness was 6.2% which is the lowest we have recorded for over a year. This is in a period where typically year on year we see absence increase. In the latest national data, the average absence rate for mental health trusts was 5.8% and nationally the main reason for absence was stress and anxiety, accounting for over 22% of all absence. NHS Sickness Absence Rates, October 2022 - NDRS (digital.nhs.uk) Sickness has exceeded the 5% target threshold for the last 2 years.

Actions

- Staff Support clinical psychologist to commence in post from July 23 to provide additional in-house support for DHCFT colleagues suffering with stress, anxiety and trauma at work.
- Priority action is to ensure that every absence under 3 weeks is effectively managed, and people supported to reduce absence length and recurrence.

People Performance



Summary

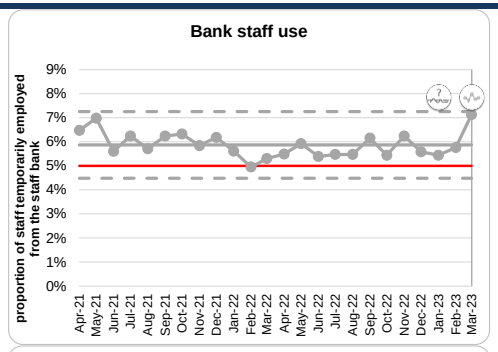
Staffing levels continue to improve with March seeing another increase and overall position of 91.07% and another reduction in vacancy rate which is now at 4.07%.

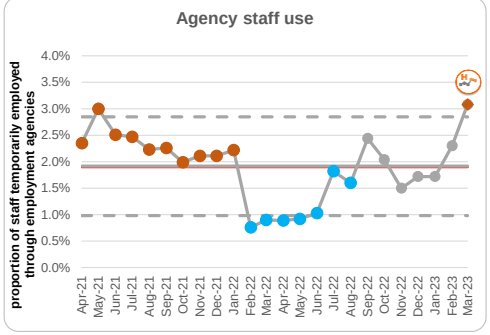
There is some variation across services, with Clinical Services management carrying 31% vacancies and Neurodevelopmental division overstaffed versus budget by 12%:

Adult Care Acute	86%
Adult Care Community	90%
Children's Services	88%
Clinical Services Management	69%
Forensic & Rehab & Specialist Services	91%
Neurodevelopmental	112%
Older People's Care	91%
Psychology	82%

Actions

- The recruitment team continue to work closely with divisions to develop targeted and bespoke campaigns.
- Work continues on implementing learning from the cultural intelligence recruitment programme and the first one-page job description will go live next month.
- We are increasing physical presence at local and regional job and career fairs over the next 3 months
- Divisional workforce plans are being finalised and will be fed into a workforce summit in June where actions and tracking will be agreed to support transformational work on hard to fill/recruit to posts.





Summary

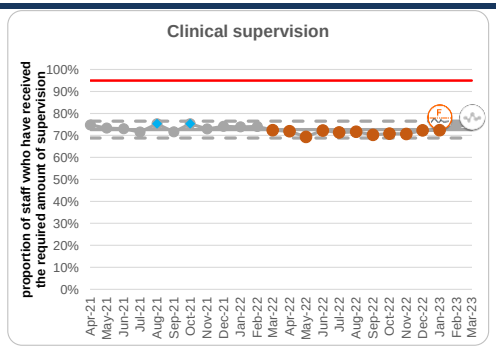
March saw an increase in requests for shifts which was matched by an increase in fill rates. The overall fill rate hit over 80% for the first time in a number of years. However, this was both an increase in bank and agency fill rates.
Thornbury use has decreased to 72 bookings, from 112 in Feb, 178 in Jan.

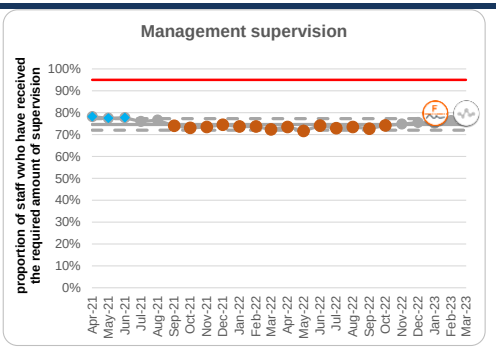
Agency spend is high across the system and a system plan is being developed to aid reduction

Actions

A robust and comprehensive delivery plan has been identified to underpin these 4 priorities

- Reduce reliance on contingent workforce
- Increase bank fill rate by 10%
- Reduce agency utilisation by 40%
- Reduce sickness absence by 0.5% by year end





Summary

As seen with compulsory training and appraisals, Operational Services continue to perform at a considerably higher level than Corporate Services for both types of supervision (management: 79% versus 61% and clinical: 77% versus 31%). The overall level of compliance with the clinical and management supervision targets has remained low since the start of the pandemic, however further improvements can be seen at a team level, with 107 teams now 100% compliant with management supervision and 76 teams now 100% compliant with management supervision.

Actions

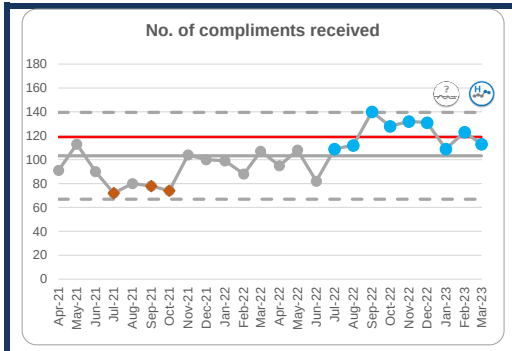
A recovery action plan is in place in Operational Services, with progress being monitored weekly by the Chief Operating Officer. The key actions in place are as follows:

- Data cleanse to take place to ensure all completed supervisions are recorded correctly and to ensure that all staff are aligned to the correct budget code and line manager within ESR
- Operational managers to ensure supervision tree structures are in place for each team, with identified clinical supervisors for all staff in a clinical facing role
- Ongoing monitoring of compliance in service line and divisional operational meetings for both management and clinical
- Review of criteria for clinical supervision for Operational Managers at Area Service Manager and above, and consider professional supervision as an alternative in line with the supervision policy
- All Adult Acute Care Service Managers to complete supervision tree to highlight managerial and clinical supervisors. Supervision tree to also highlight any use of groups/group supervision (primarily for clinical supervision). This will likely lead to further actions where supervisor recorded in error or missing will require correction or follow-up.
- Supervision report to highlight in red anyone where no supervision has been undertaken in past 3 months
- Children's Services Head of Nursing to offer group clinical supervision to Special Schools and LD community teams
- Staffing pressures in the smaller teams within Children's Services mean that the operational manager is regularly pulled into clinical care. Plan to review the leadership of these teams with change management proposals underway.
- Ongoing monitoring of supervision through regular monthly performance meetings with Area Service Managers and Operational leads - issues escalated to divisional operational meeting as needed

Derbyshire Healthcare
NHS Foundation Trust

Quality

Quality Performance

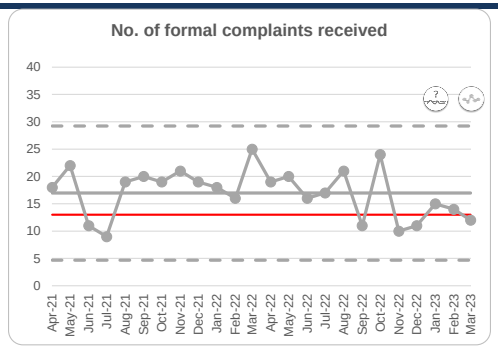


Summary
The number of compliments continues above the mean of 100 which would suggest that actions to improve recording of compliments has been impactful.

It is not possible to identify a specific reason for the fluctuation in compliments recorded as compliments are mostly received verbally and staff do not always accurately record them and there is no consistent process of recording them across the trust.

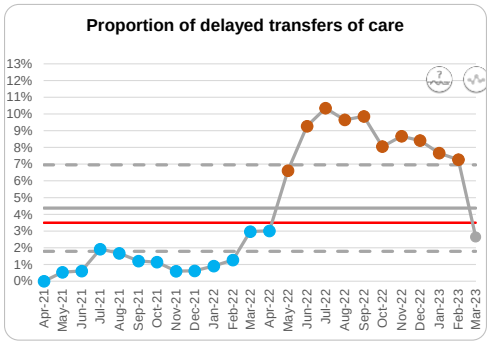
Actions
- The Heads of Nursing (HoN) have been asked to provide assurance that compliments are being accurately recorded and that a clear process is identified. This has been raised within the divisional Clinical reference groups to encourage staff to record compliments and for teams to consider the method of compliment recording. This is monitored through the quarterly Patient Experience Committee report.

- A project to implement an automated electronic patient survey will provide a further method of receiving compliments and concerns. With an increase in accessibility, it is expected that an increase in compliments, and concerns will occur over the next 6 months as the electronic patient survey is expected to go live across the Substance Misuse, Older Adult, Working Age Adult and Childrens divisions in April 2023 and then in the Neurodevelopmental Division by May 2023.



Summary
The number of formal complaints received have been on a downward trajectory between January and March 2023 and is now below the Trust target of 12 per month.

Actions
The complaints team are monitoring this, but no specific theme has been identified.

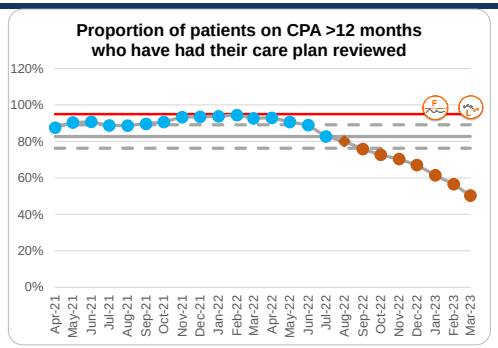


Summary

Following a review of DTOC reporting it was found that some services were not recording some delays on SystmOne. This has now been resolved and the data is flowing through into the report. In addition, it was identified that the data warehouse was not pulling through all delays recorded on the SystmOne. This has also been corrected and as a result the numbers increased.

Ward teams were also keeping their own excel spreadsheets and it has been agreed by the Managing Director and General Manager that this will stop and all delays will now be recorded on SystmOne.

Actions
- The Trust has a Twice weekly “Clinically ready for discharge” meeting where any barriers to discharge are identified and discussed and in March 2023 the numbers of DTOC have reduced back to 3%, below the trust target. This will continue to be monitored



Summary

The proportion of patients whose care plans have been reviewed continues to be recorded as lower than expected and is currently on a downward trajectory. In the Working Age Adult Community Mental Health teams, data has been affected by the migration from PARIS to SystmOne as some of the service users who had care plans in place on Paris have not yet had them migrated to the new EPR.

Due to staff vacancies, sickness, industrial action and patient acuity the current percentage of patients who have had their care plan reviewed and have been on CPA for over 12 months is 56%, a reduction of 5% between and January and March.

Actions

The Assistant Director of Clinical Professional Practice attended the Divisional operation meeting in February 2023 and the Heads of Nursing (HoN) are supporting services to develop team-based care plan compliance plans including identifying and protecting staff time for administration. This will be monitored through the divisional monthly COAT and the Monthly operational meeting.

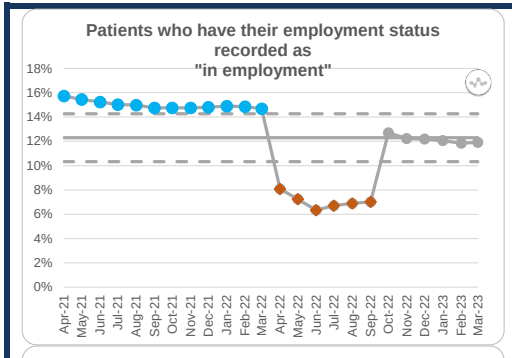
Furthermore, Compliance around CPA has been the subject of a commissioned 360 review by an external company and is part of an action plan to improve compliance.

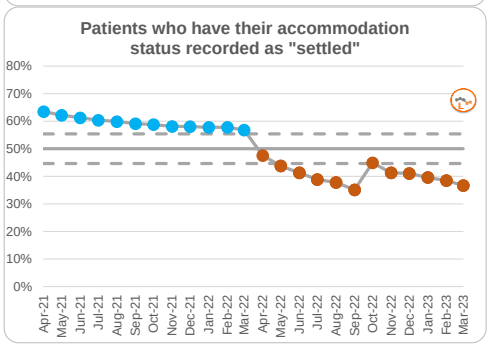
The Adult and Older Adult teams have identified action plans to improve care plan compliance, including:

- Compliance is monitored weekly with weekly dip audit and electronic reporting, with any themes emerging or barriers being reported and subsequent actions identified via the monthly divisional COAT meeting for monitoring and assurance.

With improved care plan compliance Is it expected that more timely reviews of CPA will follow. There is also a meeting scheduled to discuss the trust approach to CPA in April 2023.

Quality Performance



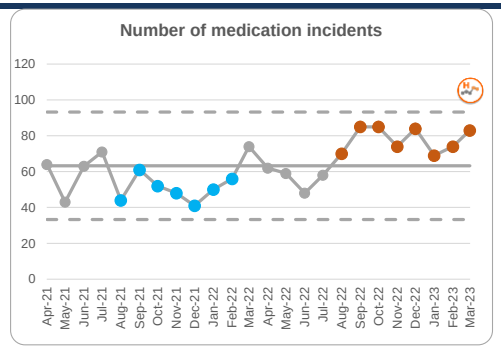


Summary

Around one third of patients have no employment status or accommodation status recorded at present and the decline in patients recorded as being in employment coincides with the data migration to SystmOne. There has been no change in the number of patients recorded as in employment between January and March. The number of patients who have their accommodation status recorded as settled has fallen by 2% between January and March.

Actions

- A report has been developed which informs teams if there are gaps in the current Data Quality Maturity Index information recorded on referral and from February 2023, Ward and Service Managers will be asked to review this report weekly and action any gaps identified. This will be monitored via monthly service specific operational meetings.



Summary

Work continues to be underway to reduce numbers of medication incidents. Common variation continues to be within expected thresholds.

Actions

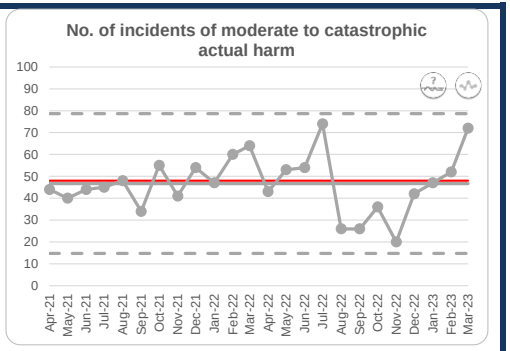
The number of medication incidents is reviewed via the monthly medication management subgroup and is reported on within the quarterly thematic “Feedback Intelligence Group” (FIG) report by the Heads of Nursing and is included in the Serious Incidents Bi-monthly report. Any actions identified are reviewed via the medicines management subgroup and the Serious Incidents Bi-monthly report is taken to Quality & Safety Committee (QSC) for assurance. Quarterly review

When looking into medication incidents, they take a variety of forms, from missed doses, wrong medication administration, missed fridge temperature recording, prescription error and documenting errors. This is monitored through both the feedback intelligence group report and the Medicines Management Operational Subgroup (MMOS) and the majority of these incidents are categorised as minor or insignificant.

The pharmacy team have identified some learning points including:

- Development of an agency ward folder where the medicine management e-learning is printed out as PDFs for reference. This is currently being trialled in the North with a plan to roll out in the South impatient wards if it is ratified in April.
- DHCFT Pharmacy are feeding back to ward managers on a quarterly basis about shared learning from meetings with Chesterfield Royal Hospital pharmacy.

As of Feb 2023 the community mental health services and Childrens services have implemented electronic prescribing and medicines administration (EPMA) a solution which digitises the process of prescribing and recording medication administered to patients within the Divisions. From May 2023 inpatient and assessment services will also implement EPMA. It is too early to see the impact of EPMA on medication incidents, but this will be monitored and reported upon in subsequent reports. A report on incidents is also reviewed within the Monthly COAT meeting for each division and as part of a quarterly medicine management assurance report



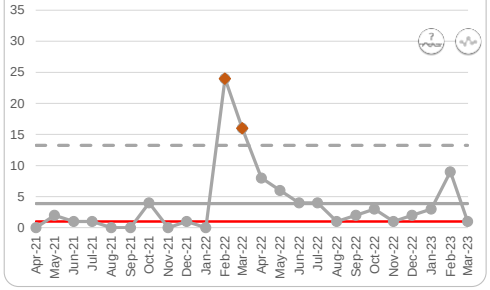
Summary

This data demonstrates the number of DATIX incidents occurring of moderate at catastrophic harm. There was a 68% increase in incidents between February and March 2023. This increase is attributed in part to the Mental Health Helpline who have increased reporting of DATIX incidents since recent training in February 2023.

The patient safety team and Head of Nursing team also review data for any patterns and the data will be split into physical harm and psychological harm-based incidents when the Learn from Patient Safety Events (LFPSE) reporting is started. this is currently on hold while DATIX is reconfigured to report on this. This issue with DATIX is affecting NHS Trusts nationally.

Quality Performance

No. of incidents requiring Duty of Candour



Summary

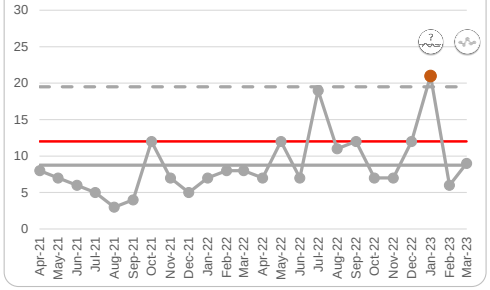
Duty of Candour (DoC) reported incidents appear to have increased between January and February 2023 however on reviewing these incidents with the family liaison officer who monitors DoC, the number of incidents included in the data is inaccurate and there were only a total of 5 incidents between January and March (one in January, 3 in February and 1 in March) therefore, DoC remains within expected thresholds.

Actions

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

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

No. of incidents involving prone restraint



Summary

Prone restraint has increased by a total of 3 incidents between February and March 2023.

Actions

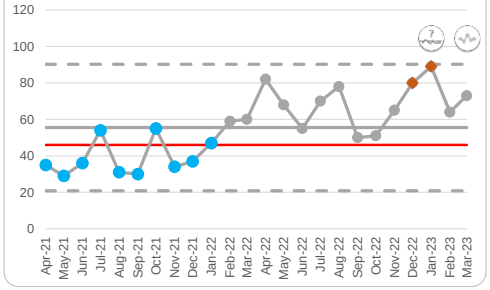
- The Head of Nursing for Acute and Assessment services is completing an in-depth qualitative audit and thematic review of seclusion and restraint and with the PSST. This has been delayed due to clinical pressures and end of year leave and is due to be completed by the end of May 2023.

- It should be noted that the overall numbers of prone restraint are lower than the regional average per bed number.

- Over the next six months there are plans for Simulation Training including seclusion, self-harm and ligature simulation. The process of recruiting a simulation lead and a simulation technician is currently underway.

- The PSST are also in the process of planning training around alternative injection sites which should reduce the need for prone restraint, and this should be ready for October 2023.

No. of incidents involving physical restraint



Summary

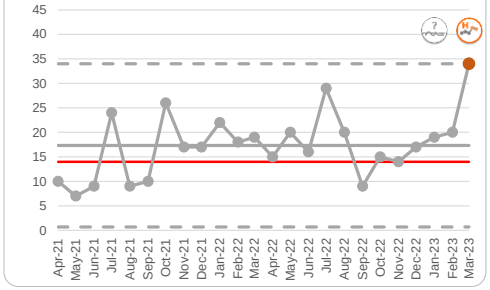
Physical restraints have increased by 32% between February and March 2023. This is being reviewed within the Reducing Restrictive Practice Group. The Trust Positive and Safe Support Team continue to offer extra training sessions to improve training availability for staff.

The increases in physical restraint appear to be related to the increased acuity of patients in inpatient settings and a high number of repeated incidents attributed to a small group of patients.

Actions

- The Trust Positive and Safe Support Team are placing extra training sessions to improve training availability for staff. Compliance with positive and safe training is increasing and is currently at 82% for teamwork and 82% for breakaway training. Furthermore, the PSST continue to spend time in clinical areas to support and train clinical staff, live during practice.

No. of new episodes of patients held in seclusion



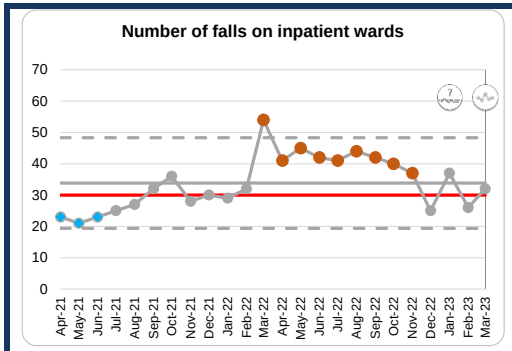
Summary

Seclusions between February and March 2023 have increased by 100%. This is in part due to increased reporting on the organic older adult wards and to a single individual who was secluded on numerous occasions while waiting for a more appropriate environment and accounts for 26% of the total incidents. This person has now been discharged to an environment that can meet their needs.

Actions

- Where there have been increased incidents of seclusion, reviews have been completed which have aligned peaks to specific patients that have either been secluded multiple times or held in seclusion for an extended period due to their risk. Furthermore, following a review by the positive and safe support team (PSST) it has been identified that there has been an increase in older adults with dementia recorded as seclusion and accurate reporting in older adult services continues to improve with the clinical lead now discussing seclusion as part of the induction for new staff. This will continue to be monitored through the monthly PSST DATIX meeting and the Reducing Restrictive Practise group.
- The Head of Nursing for Adult Acute and Assessment services is leading a task and finish group doing a qualitative audit and thematic review of seclusion and restraint supported by the PSST and inpatient clinical leads. Actions for this review will be presented and monitored through the Reducing Restrictive Practise Group.

Quality Performance



Summary

Between February and March 2023 falls have remained within common cause variation.

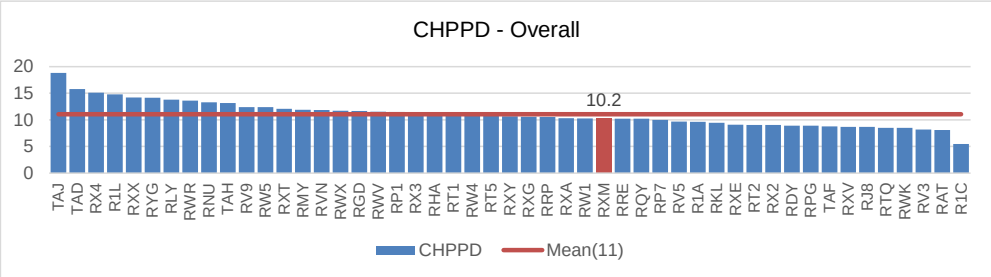
Actions

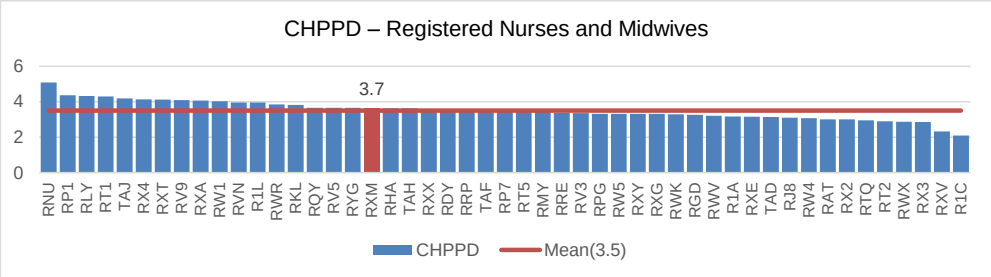
- This would suggest the bi-weekly falls review meeting, chaired by the Matron for Older Adult Services is having a positive impact and continues to identify any specific needs for those patients falling regularly. The impact and actions from this meeting are reported to the Divisional Clinical Reference Group for assurance. This will continue to be monitored over the next quarter.

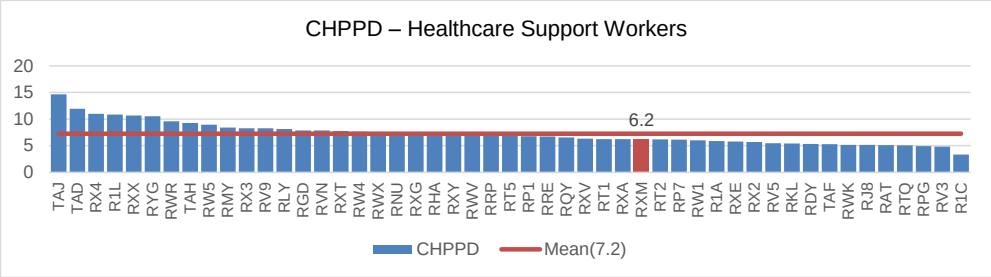
Care Hours per Patient Day (CHPPD)

CHPPD is rolling data updated monthly, to show staffing levels in relation to patient numbers on an inpatient ward. Every month, the hours worked during day shifts and night shifts by registered nurses and midwives and by healthcare assistants are added together. Each day, the number of patients occupying beds at midnight is recorded. These figures are added up for the whole month and divided by the number of days in the month to calculate a daily average. Then the figure for total hours worked is divided by the daily average number of patients to produce the rate of care hours per patient day.

The charts below show how we compared in the latest published national data when benchmarked against other mental health trusts. We were below average overall:





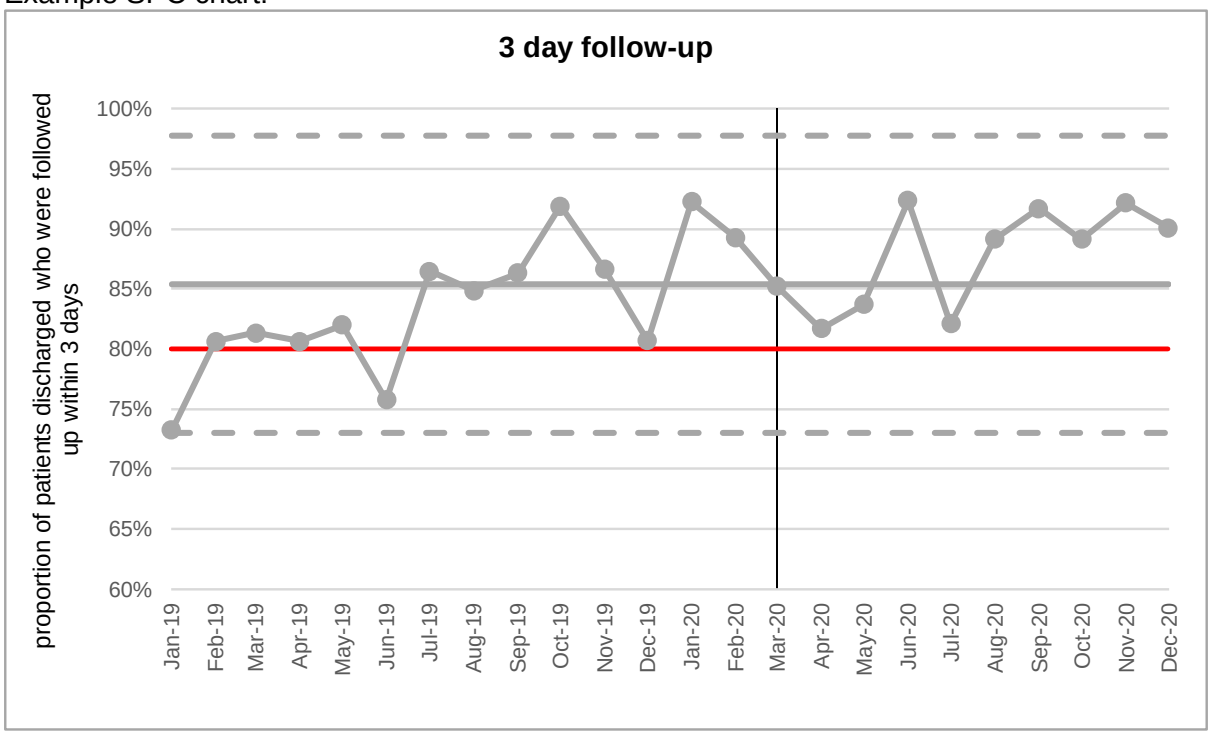


https://www.england.nhs.uk/publication/care-hours-per-patient-day-chppd-data/

Appendix 1

Statistical Process Control Chart (SPC) Guidance

Example SPC chart:



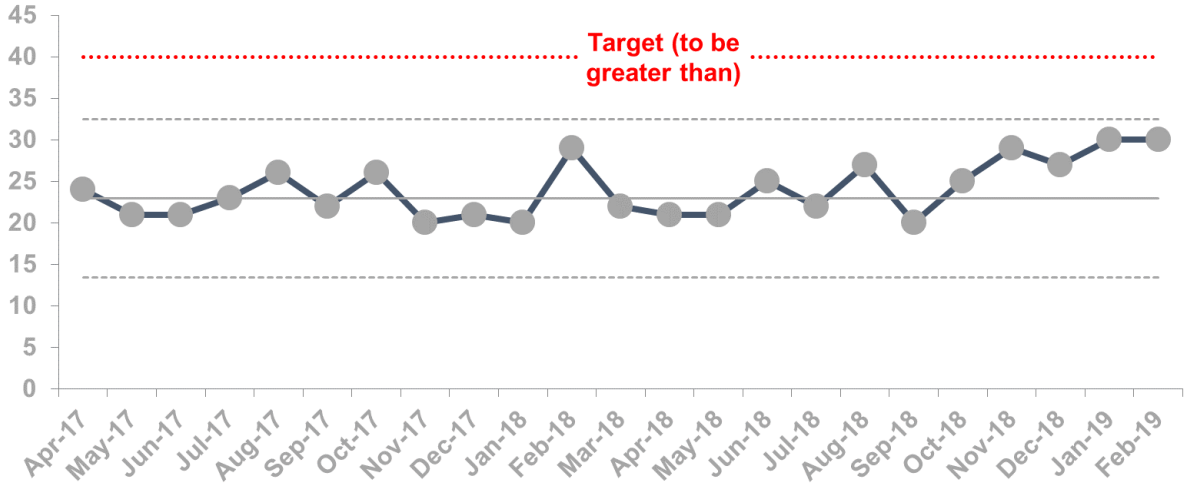
- The red line is the target.
- The grey dots are the actual performance each month. They are coloured grey as performance each month is normal in this example.
- The solid grey line is the average (mean) of all the grey dots.
- The grey dotted lines are called process limits, or control limits.

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

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

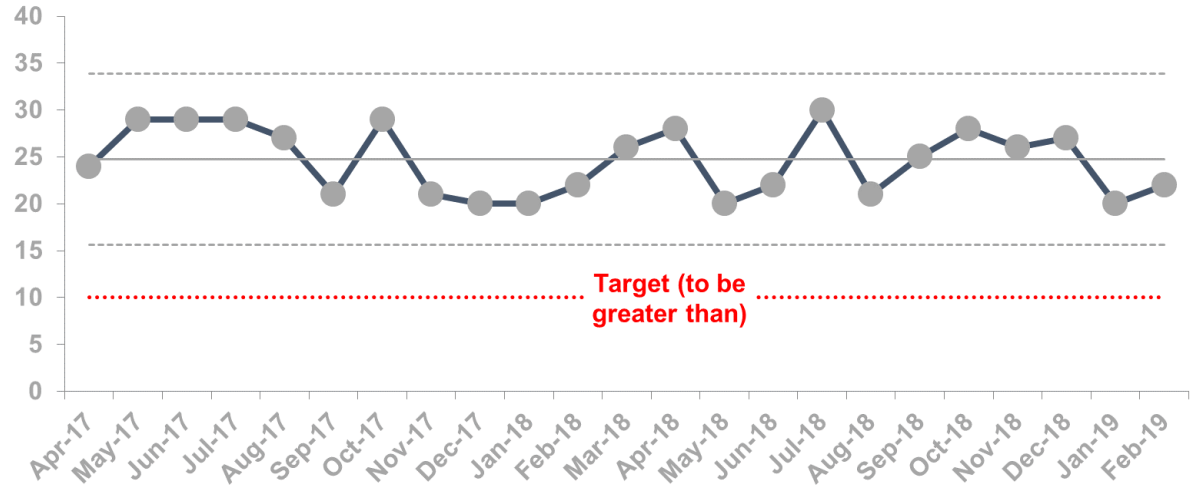
Things to look out for:

1. A process that is not working



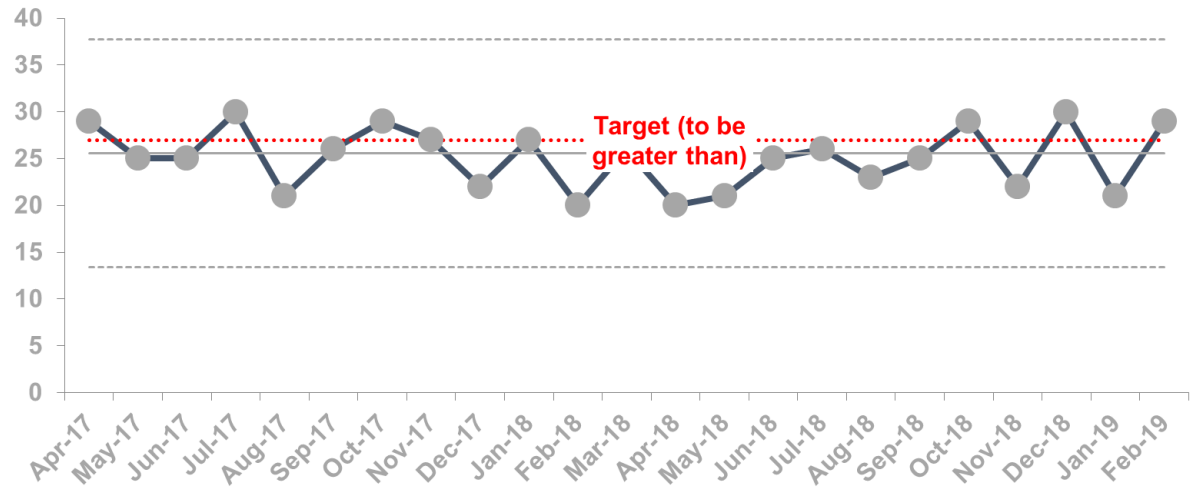
In this example the target is higher than the upper dotted grey line. This means that the target will never be achieved. To achieve the target, we need to change how we do things.

2. A capable process



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

3. An unreliable system

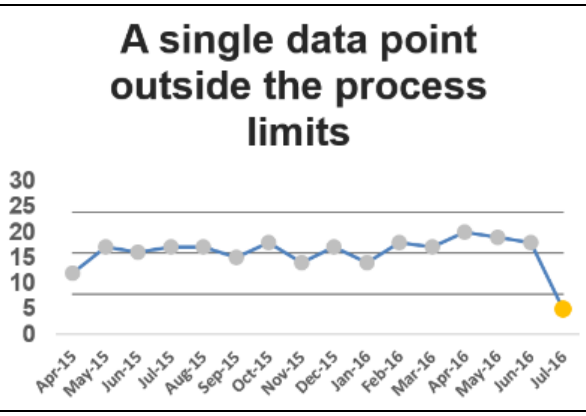


In this example the target line sits between the 2 grey dotted lines. As it is normal for the grey dots to fall anywhere between the 2 dotted grey lines, this means that it is entirely random as to whether or not the target will be achieved. So, this system is unreliable and needs to be redesigned if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

4. Unusual patterns in the data

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

There are four scenarios where this can happen:

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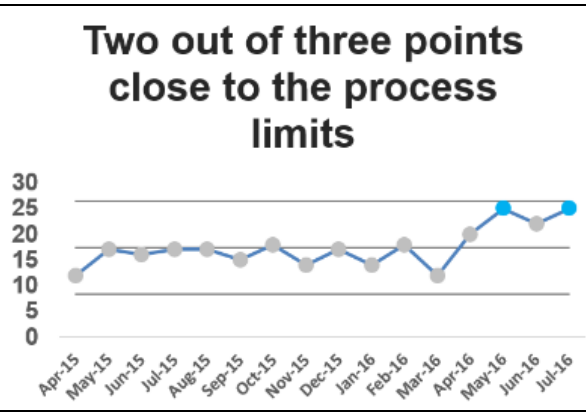
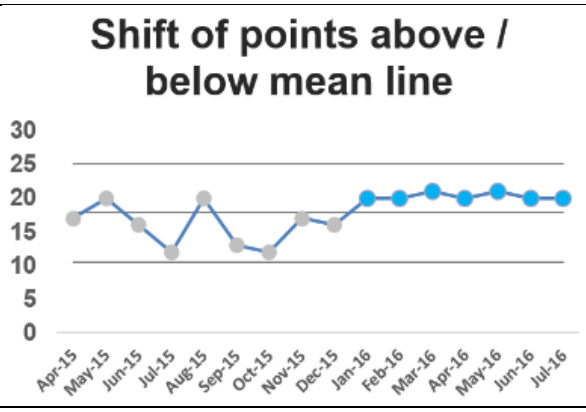
<td> 
</td>
</tr>
<tr>
<td>In this example the July 16 perfomance is significantly lower than expected and falls beneath the lower grey dotted line.</td>
<td>2 out of 3 points close to one of the grey dotted lines is statistically significant, in this case they are blue, indicating better than expected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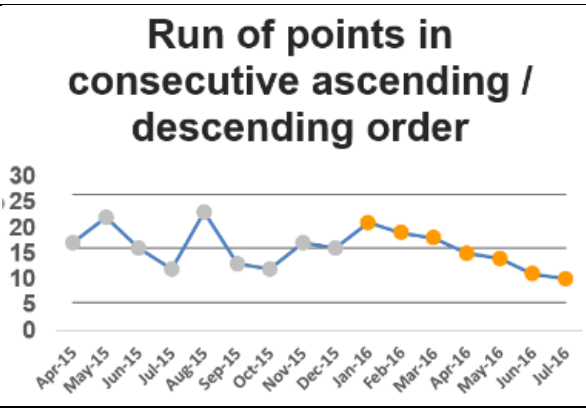
<td> 
</td>
</tr>
<tr>
<td>A run of 7 points above or below the average line is significant. In this example it might indicate that an improvement was made to the process in Jan 16 that has proven to be effective.</td>
<td>A run of 7 points in consecutive ascending or descending order is significant.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

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

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 9 May 2023

Trust Strategy 2022 – 2025: 2022/23 Quarter 4 Progress Report

Purpose of Report

To provide the Board with an update on progress in delivering the priority actions identified in the organisational strategy.

Executive Summary

The refreshed 2022 to 2025 Trust strategy was approved by the Board in July 2022 following an engagement process with staff.

The strategy was developed in the context of COVID recovery and an organisational focus on improving access, outcomes and experiences for our patients. All of which was underpinned by investment to improve the buildings from which we offer our acute mental health services, and investment to expand our service offer. The strategy was also developed in the context of an identified financial deficit.

At the heart of the strategy was, and continues to be, a collective commitment to continue improving our organisational culture, and to embedding new ways of working where our values and 'people first' approach are central to all we do. In addition, over the life of this strategy we continue to deliver our commitment to inclusion for our patients, our colleagues and our communities.

The refreshed strategy retained the previously agreed vision, values and strategic objectives, only adding GREAT Partner to the latter in recognition of the organisations increasing collaborative role both within Joined Up Care Derbyshire (JUCD) and beyond:

To enable delivery of the strategic objectives: Great Care, Best Use of Resources, Great Place to Work and Great Partner, a number of building blocks were identified that underpin delivery of each of the strategic objectives.

These building blocks set out the focused group of priorities under each strategic objective, called the Derbyshire Healthcare Eight Essentials, and in order to deliver these, a number of priority actions were identified. The Derbyshire Healthcare Eight Essentials are as follows:

1. Improve recruitment and retention
2. Maximise colleague wellbeing and attendance
3. Achieving our Long Term Plan performance requirements
4. Continue to develop our formal partnerships
5. The five quality areas
6. Embed and develop our electronic patient care record
7. Spending smarter, reducing waste and saving money
8. Making Room for Dignity Programme

The attached summary (appendix A) sets out the Derbyshire Healthcare Eight Essentials delivery position, and details progress against each of the contributing priority actions included in the strategy as at the end of quarter 4 (Q4) 2022/23.

Of the 24 priority actions, 11 had an expected completion date by end of Q4 2022/23 with 8 reporting as now completed. This includes the review of recruitment processes and training to build inclusive recruitment and selection practice, as well as improvements in the health and wellbeing and risk assessment processes across the organisation that support our staff. As a result we have seen improved recruitment KPIs with all 12 KPIs having moved to above target, including a reduction in overall time to recruit and reduction in readvertisements.

Also achieved, was the development of the Derby and Derbyshire Mental Health, Learning Disabilities and Autism Alliance and subsequent partnership agreement to support the evolving partnership working arrangements. This has resulted in improved networking and awareness of the service offer between NHS, Local Authorities and Voluntary Sector (VCSE) providers, as well as initiated a co-design and co-production approach to partnership working.

There are 3 undelivered priority actions due for completion by end Q4 2022/23:

1. The development of a workforce plan – this has been developed at organisational level as part of a system wide workforce plan, however the divisional level workforce plans have been delayed as a result of the 2023/24 planning round extending beyond the end of March. It is intended that the divisional plans will be completed once the system wide financial position is confirmed.
2. Improving processes and support for people experiencing matters that could cause stress reactions – the appointment of a Trust staff clinical psychologist to support staff experiencing high levels of stress and trauma commences in post July 2023.
3. Implement the East Midlands (EM) Perinatal Provider Collaborative – the Trust is currently operating as a lead provider in shadow form and has a well-established Clinical Professional Reference Group and strong involvement of experts by experience who have informed the consistent use of outcome measures within the mother and baby units. The formal go live has been

delayed until October 2023 (Q3) due to a national decision to align all go live dates.

There are a small number of priority actions where due dates are either not listed or noted as annual, where annual the assumed delivery date will be Q2 2023/24 to align to 12 months from the launch of the strategy. Progress updates will be provided in the next report to the Board.

Within the Derbyshire Healthcare Eight Essentials: Making Room for Dignity Programme, the priority action of seeking additional national capital funding sources to complete the programme has been delivered ahead of the Q1 2023/24 deadline, also delivered was the prioritisation of local business cases within the remaining local capital funding currently available, which was without a due date.

The current strategy will be updated to reflect the delivery achieved in year one (2022/23), see appendices B, and priority actions for year two (2023/24), see appendices C.

The Board is asked to note the 2022/23 quarter 4 progress in delivering the priority actions as set out in the Trust's 2022 – 2025 organisational strategy.

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

Risks and Assurances

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

Consultation

- Staff engagement at the launch of the refreshed strategy
- Approval of the refreshed strategy and priority actions at the July 2022 Board
- Ongoing staff engagement to enable and report delivery of individual priority actions.

Governance or Legal Issues

None identified.

Public Sector Equality Duty and Equality Impact Risk Analysis

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

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

Recommendations

The Board of Directors is requested to note the 2022/23 quarter 4 progress in delivering the priority actions as set out in the Trust's 2022 – 2025 organisational strategy.

Report presented by: **Vikki Ashton Taylor**
Director of Strategy Partnerships and Transformation

Report prepared by: **Vikki Ashton Taylor**
Director of Strategy Partnerships and Transformation

DHCFT Trust Strategy

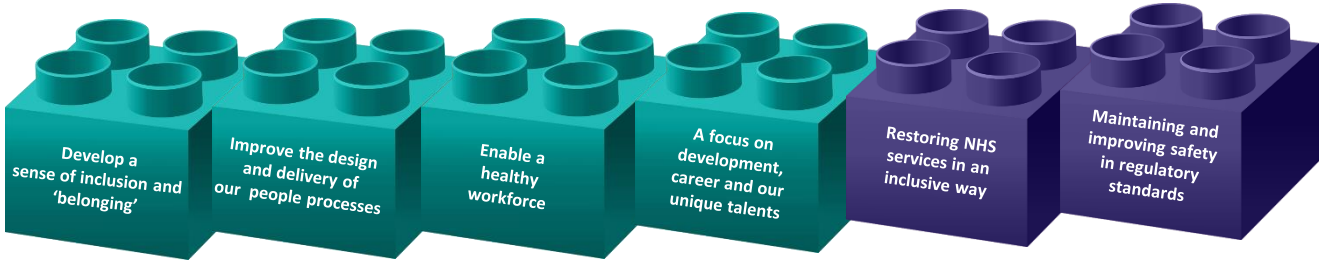
Progress Update Q4 2022/23

GREEN: DELIVERED
YELLOW: OFF TRACK BUT WILL DELIVER
RED: OFF TRACK WITH RISKS TO DELIVERY
GREY: COMPLETION DATE POST APRIL 2023

Improve recruitment and retention

Annual Priority 22/23	Improve recruitment and retention			
Priority action	**UPDATE**	**Action owner**	**Expected completion date**	**Outcomes**
Develop a workforce plan that delivers the operational plan, workforce and service transformations and creates a sustainable approach to volume and hard-to-recruit posts	Off track but will deliver Workforce plan developed at organisational level, divisional workforce plans being developed now with submission due by end of April – building on operational plan on a page and will feed into divisional people plans	Director of People and Inclusion	Q3 2022/23 Now revised to Q1 2023/24	Increased efficiency in recruitment processes for high-volume recruitment through cohorted processes Reduced vacancy rate as reducing reliance on posts where there are supply issues
Review recruitment processes and training to build in inclusive recruitment and selection practice	Delivered Review completed as part of system wide inclusive recruitment pilot and post and funding identified for inclusive recruitment lead to further develop best practice for DHCFT	Director of People and Inclusion	Q4 2022/23	Increased diversity in all applications and shortlists Reduce race disparity in Bands 7 and above Increased confidence from networks WRES and WDES data improves
Develop a consistent approach across the Trust to people-centred leadership embedding feedback, effective supervision, career progression, development and support	Completion date post April 2023 New system wide appraisal developed to support career progression across the system – launching April 23, talent management strategy developed and pilot commencing April23, feedback programme commissioned and due to launch summer 23	Director of People and Inclusion	Q1 2023/24	We maximise development of DHCFT people and careers and make the most of people's unique talents Reduce turnover of key professions and individuals Increased progression of BME staff into managerial positions

Category
A. Getting the basics right
B. Continuous improvement
C. Specific transformation programme



Maximise colleague wellbeing and attendance

Annual Priority 22/23	Maximise colleague wellbeing and attendance				
Priority action	**Category**	**UPDATE**	**Action owner**	**Expected completion date**	**Outcomes**
Improve the health and wellbeing and risk assessment processes so that they are being used dynamically and systematically across the Trust and meet the unique needs of all our people	A & B	Completed Health and Wellbeing conversations in place and rolled out, culture work underway, EDI steering group established, quality summit established, Professional Nursing Advocates in work place (restorative supervision), supervision policy reviewed. Review of all risk assessments with OH completed and alignment to health and wellbeing conversations.	Chief Operating Officer, Director of People and Inclusion, and Director of Nursing and Patient Experience	Q4 2022/23	Reduction in stress-related absence Culturally sensitive and appropriate conversations and support is in place Maintain staff survey results on health and wellbeing We are supporting people to be safe and well
Improve processes and support for people who are experiencing matters that could cause stress reactions inside and outside of work	B	Off track but will deliver New OH contract being reviewed with view to move closer to supporting stress absences. Appointment of DHCFT staff clinical psychologist now made – starting July 23 to support staff experiencing high levels of stress and trauma	Director of People and Inclusion and Chief Operating Officer	Q4 2022/23 Now revised to Q2 2023/24	Reduction in stress-related absence Reduced average length of stress-related absence Improved staff survey on staffing levels Reduction in agency and bank expenditure

Category
A. Getting the basics right
B. Continuous improvement
C. Specific transformation programme

Achieving our Long Term Plan performance requirements

Annual Priority 22/23	Achieving our Long Term Plan performance requirements				
Priority action	**Category**	**UPDATE**	**Action owner**	**Expected completion date**	**Outcomes**
Deliver a <32 days average length of stay on our acute MH wards through maintaining occupancy levels at <85%. Adult Crisis and Home Treatment Services provided in line with fidelity model	C	Completion date post April 2023 There has been a lot of work to date. Whilst we have not managed to deliver the outcomes, we have seen improvements that will ensure we achieve the objectives. More use of data, active team oversight, more scrutiny on flow will enable this.	Chief Operating Officer	Q1 23/24	Zero inappropriate out of area acute placements Improved care planning and smoother discharge arrangements Improved continuity of care Admissions avoided
Deliver perinatal community mental health access standard of 10% of prevalence	C	Completion date post April 2023 Recovery Action plan in place, revised assessment process implemented. Recruitment remains a pressure. Completion on track for Q1 2023/24	Director of Strategy, Partnerships and Transformation	Q1 23/24	Improved access to mothers and partners to specialist perinatal mental health services
Recover dementia diagnosis rates to national target of 67%	C	Completion date post April 2023 Current performance: 62.5%. At the end of March 2024, we expect to achieve a 65.5% dementia diagnosis rate. Whilst this is not compliant with the target set, this plan sees us improving the diagnosis rate. Refreshed Recovery Action Plan to achieve the 67% target in development	Director of Strategy, Partnerships and Transformation	Q1 23/24 Revised delivery date to be confirmed	Shorter waiting times Backlog clearance COVID 'missed referrals' found and services accessed

Category
A. Getting the basics right
B. Continuous improvement
C. Specific transformation programme

Continue to develop our formal partnerships

Annual Priority 22/23	Continue to develop our formal partnerships				
Priority action	**Category**	**UPDATE**	**Action owner**	**Expected completion date**	**Outcomes**
With colleagues from the statutory and voluntary sector, establish a formal Mental Health and Learning Disabilities Alliance in Derbyshire with a formal partnership agreement in place	C	Delivered. Mental Health and Learning Disabilities Alliance established. Partnership Agreement in place.	Director of Strategy, Partnerships and Transformation	Q3 22/23	Collaborative infrastructure established to support future cross-system work in co-production with experts by experience (EbE)
Successfully implement the provider collaborative for Perinatal inpatient services across the East Midlands with DCHFT as the lead provider	C	Off track but will deliver. Operating as lead provider in shadow form. Formal go live delayed from April 2023 until October 2023 due to national decision to align all go live dates. Revised delivery date Q3 2023	Director of Strategy, Partnerships and Transformation	Q4 22/23: model implementation - completed Q2 23/24: finance Now revised to Q3 2023/24	Collaborative infrastructure in place to enable provider-led collaboration over improvements in Perinatal inpatient services and joining up inpatient and community pathways
Work in partnership with DCHS to progress the harmonisation of Learning Disabilities and Autism services across the city and county	C	Completion date post April 2023. A lot of work has been done on this objectives which includes joint development, harmonisation of service, development of committee in common and potential realignment in the next few months	Chief Operating Officer		Single clinical and leadership responsibility for all services across Derbyshire. Improved quality of inpatient and community services

Category
A. Getting the basics right
B. Continuous improvement
C. Specific transformation programme

The five quality areas

Annual Priority 22/23	The five quality areas: a focus on solid assessment, risk or safety planning, effective planning, outcome measurement and or service specific improvement				
Priority action	**Category**	**UPDATE**	**Action owner**	**Expected completion date**	**Outcomes**
Each division will have its own specific quality requirement standards. The Clinical Director, Head of Nursing/Practice and lead AHP/ Psychologist/Therapist will lead the achievement of these core clinical practice standards	A	Completion date post April 2023 Quality dashboard established across the Trust, divisional CRG and COAT in place, Quality Summit established, quality visits, Transition from PARIS EPR to SystmOne including core assessments, QSC bi-monthly review, HoP divisional action plans, QI training established and projects underway, data triangulated with service users and EBE.	Director of Nursing and Patient Experience	Annual with quarterly achievement requirements	Recovering our clinical practice standards, ensures we provide safer care to our people An example would be in Substance Misuse: Assessment Plan of care Safety assessment Outcome measure Implementing the drug strategy
Focusing on the safety domain of practice and preparing for new changes in mental health legislation –Liberty Protection Safeguards and a new emergent Mental Health Act	C	Off track but will deliver Safety domain: Safety planning training sourced. Due to be implemented. However preparation for changes in mental health legislation – Liberty Protection Safeguards and new MHA – achieved all identified action although the implementation is delayed	Medical Director	Annual with quarterly achievement requirements	Improvements in the safety domain of our CQC registration Advance preparation for legislative changes for DHCFT and to support the ICS

Category
A. Getting the basics right
B. Continuous improvement
C. Specific transformation programme

Embed and develop our electronic patient care record

One team
One approach
One Derbyshire

Annual Priority 22/23	Embed and develop our Electronic Patient Record				
Priority action	**Category**	**UPDATE**	**Action owner**	**Expected completion date**	**Outcomes**
Finalise the Phase 3 and 4 implementation of the move to SystmOne electronic patient record (EPR) system	C	Delivered. SystmOne fully implemented	Director of Strategy, Partnerships and Transformation	Q2 22/23	All secondary care services across the Trust on SystmOne
Deliver electronic prescribing and the electronic transfer of prescriptions element of the OnEPR programme	C	Completion date post April 2023 EPMA is now live within: Adult and Neurodevelopment services (ANS) CAMHS, and Community Mental Health teams (CMHT) Scheduled go live dates: Inpatient services: 18 May 2023, Crisis services: 24 May 2023	Director of Strategy, Partnerships and Transformation	Q2 23/24	All services and prescribers able to write and transfer prescriptions electronically. Improved accuracy of prescribing and adherence to formulary
Optimise the use of SystmOne across the Trust, realising the benefits identified in the original business case	C	Completion date post April 2023 Ongoing training programme in place. Standard Operating Procedures agreed for service areas. Oversight of benefits realisation monitored through the Clinical Digital Board	Director of Strategy, Partnerships and Transformation	Q2 23/24	Quicker access for staff to the records they need Improved communication with other system partners, either directly through records or via the Derbyshire shared care record.

Category
A. Getting the basics right
B. Continuous improvement
C. Specific transformation programme

Spending smarter, reducing waste and saving money

Annual Priority 22/23	Spending smarter, reducing waste and saving money				
Priority action	**Category**	**UPDATE :**	**Action owner**	**Expected completion date**	**Outcomes**
Reduce waste and reduce budget for agreed in-year cost savings	A & B	Delivered Budget amended to reflect delivery.	Director of Strategy, Partnerships and Transformation	Q1 22/23	Delivery of first part of 3% efficiency plan assumed in 22/23 overall financial plan
Transformation and continuous improvement – spend smarter and contain costs to affordable levels	B & C	Delivered 2022/23 efficiency plan (1% recurrently and 2% non recurrently). Continuous quality improvement strategy rolled out including training programme. A number of quality improvement programmes are in train and will be a continuous process to achieve good quality and efficiency	Chief Operating Officer	Q2 22/23	Delivery of remainder of 3% efficiency plan assumed in 22/23 overall financial plan
Using 22/23 as year one, agree our 3-5 year financial plan	B & C	Off track but will deliver 23/24 financial plan still in draft and discussions on-going both internally and as a system.	Executive Finance Director	Q2- Q4 22/23 (in stages) Now revised to Q2 2023/24 (Recovery Plan)	Clear multi-year financial plan creating the return to break even/ sustainability (ditto system financial plan)

Category
A. Getting the basics right
B. Continuous improvement
C. Specific transformation programme

Making Room for Dignity Programme

Annual Priority 22/23	Making Room for Dignity programme				
Priority action	**Category**	**UPDATE**	**Action owner**	**Expected completion date**	**Outcomes**
Seek national approval of both Adult Acute Unit full business cases	C	Delivered: Adult Acute Unit full business cases approved nationally and construction commenced	Senior Responsible Officer (SRO) Acute Care Capital Programme	Q3 2022/23	Commence construction of Adult Acute Units at Kingsway Hospital and Chesterfield Royal Hospital
Seek JUCD approval of full business cases for Older Adult Service relocation, Radbourne refurbishment, PICU and Acute-Plus unit	C	Delivered: JUCD approved all four full business cases subject to identification of capital	Senior Responsible Officer (SRO) Acute Care Capital Programme	Q3 2022/23	Enable construction to commence immediately capital funds secured
Prioritisation of local business cases within remaining local capital funding available currently		Delivered: £25 million local approved to complete funding for AAUs and PICU	Senior Responsible Officer (SRO) Acute Care Capital Programme		Schedule construction and recruitment to prioritised schemes with capital available
Seek additional national capital funding sources to complete programme	C	Delivered: Additional £31 million national capital and construction of all builds scheduled	Senior Responsible Officer (SRO) Acute Care Capital Programme	Q1 2023/24	Schedule construction and recruitment of remaining schemes when capital available
Schedule recruitment to additional staff required for each scheme within programme	C	Revenue scheduled for recruitment, training and familiarisation of additional staff in advance of service go-live	Senior Responsible Officer (SRO) Acute Care Capital Programme	Q1 2023/24	Additional staff recruited, trained and familiarised with buildings by service commencement dates.

Category
A. Getting the basics right
B. Continuous improvement
C. Specific transformation programme

What we delivered - Year 1 roadmap

DELIVERED
Transformation and continuous improvement

DELIVERED
Improve the health and wellbeing and risk assessment processes

DELIVERED
With colleagues from the statutory and voluntary sector, establish a formal MHLD Alliance in Derbyshire with a formal partnership agreement in place

DELIVERED
Reduce waste and budget for agreed in-year cost savings

DELIVERED
Finalise the Phase 3 and 4 implementation of the move to SystmOne

DELIVERED
Review recruitment processes and training to build inclusive recruitment and selection practices

DELIVERED
Seek JUCD approval of full business cases for Older Adult Service Relocation, Radbourne Refurbishment, PICU and Acute-Plus

DELIVERED
Seek additional national capital funding sources to complete programme

DELIVERED
Prioritisation of local business cases within remaining local capital funding available currently

DELIVERED - YEAR 2 PRIORITY
Seek national approval of both Adult Acute Unit full business cases

YEAR 1 NOT FULLY DELIVERED
Improve processes for those experiencing stress in and out of work

YEAR 1 NOT FULLY DELIVERED
Develop a workforce plan

YEAR 1 NOT FULLY DELIVERED
Successfully implement and lead the provider collaborative for Perinatal inpatient services

What we will deliver - Year 2 roadmap

IN PROGRESS
Develop a consistent approach to people-centred leadership

YEAR 2 OBJECTIVE
Deliver electronic prescribing and transfer prescriptions element of the OnEPR programme

YEAR 2 OBJECTIVE
Work in partnership to progress the harmonisation of Learning Disabilities and Autism services

YEAR 2 OBJECTIVE
Schedule recruitment to additional staff required for each scheme within programme

IN PROGRESS
Agree our 3-5 year financial plan after year 1

IN PROGRESS
Focusing on the safety domain of practice and preparing for changes in mental health legislation

YEAR 2 OBJECTIVE
Deliver perinatal community MH access standard of 10% of prevalence

YEAR 2 OBJECTIVE
Deliver a <32 days average length of stay on our acute MH wards

YEAR 2 OBJECTIVE
Each division will have its own specific quality requirement standards

YEAR 2 OBJECTIVE
Optimise the use of SystmOne across the Trust

YEAR 2 OBJECTIVE
Recover dementia diagnosis rates to national target of 67%

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 9 May 2023

Operational Plan Report 2023/24

Purpose of Report

To provide the Board with an update on progress in the development of the 2023/24 operational plan.

Executive Summary

On 23 December 2022, NHS England (NHSE) published the 2023/24 national planning guidance. The guidance outlined three priority areas for the NHS: to recover core productivity; progress the aspirations in the long-term plan; and transform the health and care system for the future.

Joined Up Care Derbyshire (JUCD) is required to submit a system wide Operational Plan in response to the NHS National Planning Guidance. The development of the system wide Operational Plan is co-ordinated by the Derby and Derbyshire ICB with input from local NHS providers. NHS providers are required to contribute to the plans of local ICSs reflecting a systems focused mindset based on collaboration and cooperation. The planning submission has three elements: activity and performance, workforce, and finances. The draft JUCD Operational Plan was submitted 30th March 2023 although will require further updates in light of the ongoing planning requirements.

Activity and Performance

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

Priority	Compliant with NHS England target	Improvement on 2022/23?
Increase the dementia diagnosis rate		
Provide access for 28,294 people to receive IAPT in 23/24		Mirrors 22/23 levels
Increase the number of women accessing specialist perinatal services in 2023/24.		
Increase the number of children and young people accessing a mental health service.		
Increase the number of adults with a severe mental health illness receiving 2+ contacts with a community health service.		
Ensure that 75% of individuals listed on GP registers as having a learning disability will receive annual health check.		
Reduce the number of adults who are autistic, have a learning disability or both who are in beds commissioned by the ICB and NHSE.		
Reduce out of area placements		

Of the eight priority areas set out above, the Trust alongside system partners, plan to achieve the national targets set by NHS England. There remain challenges in

terms of delivering this plan, for example, resources, timescales, and uncertainties such as the operating environment.

There are three targets where the Trust and system partners have agreed that improvements on last year's performance can be made but that it is not possible to achieve the 2023/24 target, as follows:

- Increasing the Dementia Diagnosis Rate: The Trust is planning to improve its performance in relation to diagnosing dementia – moving from the average rate delivered in 2022/23 (63.7%) to 65.5% by the end of the March 2024. This will be achieved by recruiting workforce to establishment levels, establishing a late diagnosis offer into residential and nursing homes and improving data recording practice.

- Reduce the number of adults who are autistic, have a learning disability or both who are in beds: The Trust, alongside system partners are planning to reduce the number of adults, who are autistic, have a learning disability or both, in beds by March 2024. Whilst we do not anticipate achieving the target, it is improvement on the 2022/23 position. This will be achieved by additional in-reach support to inpatient wards to facilitate discharge, 'wrap round' support offer developed from NHS community service provision to work alongside individuals core care team supporting MDT review of care provision. For NHS England commissioned provision, we anticipate the target to be achieved.

- Reduce out of area placements: The Trust and system partners are planning to reduce the number of inappropriate out of area placement beds days by 40%, on the 2022/23 Q3 position, by the end of March 2024. This will be achieved by additional step down capacity contracted for individuals identified as medically fit for discharge, additional Crisis alternative service provision to be brought online during 2023/24, and a rolling recruitment program to fill current vacancies within inpatient teams and recruit to new posts required to support new build Adult Mental Health wards.

Finance
As a Trust, we are part of the Derbyshire system financial plan, which is currently highlighting a challenging financial position, however there is further work to be completed regarding mitigations and prioritisation. The system is required to submit a breakeven plan and therefore in order to support delivery of this all system partners have been required to achieve an efficiency target.

The Trust is developing a number of transformation schemes to enable this. Progress updates will be reported to future Board meetings and provide assurance on the development, delivery and monitoring of the efficiency and transformation programme. All schemes will be required to complete a Project Initiation Document (PID) and undertake Quality and Equality Impact Assessments.

Workforce
In recent years we have invested in our workforce, focusing on models of care which meet our populations health needs, and working in partnership with all providers across health and care. Growth in workforce between 2020/21 and 2022/23 was 385.44 whole time equivalent (WTE) posts. 72% of the workforce growth was linked to new investments. The balance of 28% growth was a

combination of job shares, skill mix, junior doctors, over recruitment to Health Care Assistants (HCAs) and recruitment to long standing vacancies.

Trust recruitment and retention continues, against a backdrop of known national and local workforce supply challenges. Currently acute inpatient and community mental health (adult and older adult) have large numbers of vacancies, related to nursing, occupational therapists, and support to clinical workforce posts, whilst the Children's and Young Peoples (CYP) workforce has significant medical and nursing vacancies. As a result, we often rely on the use of Agency and Locum staff, which have a greater cost.

Alongside partners, we are developing new ways of working through changes in practice, whilst recognising that doing this well requires significant time and resource to release staff to engage in co-production, co-design and prototyping activities. This approach is underpinned by our People First approach.

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

Although not a regulatory requirement, the Trust is developing an organisational Operational Plan to describe what we will be focusing on for the next 12 months in relation to Workforce, Activity and Finance, whilst ensuring a strong focus delivering quality services underpinned by our people first approach. The Trust Operational Plan will reflect the priorities set out in the Trust Organisational Strategy.

The Operational Divisions and Corporate functions have worked collaboratively to develop the Trust 2023/24 Operational Plan, and to contribute to the broader system plan. This work will be finalised once the financial position is confirmed. It is intended that the Divisional Operational plans are reviewed at the Finance and Performance Committee.

The evolving Trust Operational Plan aligns to our 2022 – 2025 Trust Strategy strategic objectives: delivering great care, making best use of resources, being a great place to work and a great partner. A number of the priority actions for the current year will directly contribute to enabling delivery of the Trust operational 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 creating a compassionate, skilled and empowered leadership, creating a vibrant culture where colleagues feel they belong, thrive and are valued.	
3) The Trust is a **great partner** and actively embraces collaboration as our way of working.	x

4) We will make the **best use of resources** by making financially wise decisions and avoiding wasting resources to ensure financial recovery and long term sustainability.	x

Risks and Assurances

- Non achievement of key targets and statutory responsibilities
- Impact on staff morale and ability to recruit and retain staff
- Across Derby and Derbyshire, NHS and Local Authority organisations are disinvesting in services
- EQIA assurance for all transformation programmes
- Board approval of 2023/24 financial plan
- Aligns with and seeks to deliver against the Trust's strategy.

Consultation

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

Governance or Legal Issues

None identified

Public Sector Equality Duty and Equality Impact Risk Analysis

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

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

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

Recommendations

The Board of Directors is requested to note the progress report on the 2023/24 Planning Process.

Report presented by: **Vikki Ashton Taylor**
Director of Strategy Partnerships and Transformation

Report prepared by: **Vikki Ashton Taylor**
Director of Strategy Partnerships and Transformation

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 9 May 2023

Quality Report – 'Caring'

Purpose of Report

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

Executive Summary

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

The key lines of enquiry (KLOE) for caring are presented with benchmarking evidence, independent evidence from surveys or externally verified information from the Care Quality Commission (CQC).

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

At the last Trust wide inspection, nine core services all were rated good and two services were rated. Our objective in 2022/23 was to maintain this good performance, wherever possible.

The Trust has achieved mixed feedback on the community survey benchmark information and full feedback on all of its services, but there continues to be some deterioration in the survey.

Since the last Caring report was submitted to the Board in June 2022, the Trust's strategy has been revisited; this now includes a more specific focus on patient experience and the introduction of a shared governance model for patients with the Carers Forum as a mirror image to the Staff Forum, which has been very well received and is growing. The 'Equal' forum is also fully operational and implementing the best practice evidence in co-production and emerging models of shared governance.

The organisation has additionally made solid progress headway in the Family and Friends Test Trust wide feedback. However, there are some areas, which require further additional attention to ensure completion of this survey, particular focus on care planning consistency and performance in the standards we have grown to expect from Derbyshire Healthcare services.

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

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

Assurances

- The consideration of the use of caring has positive assurances which are well evidenced.
- In the last report, gaps in controls in quality improvement were referenced, the Trust has an active Quality improvement strategy and is fully implementing its plan.

Consultation

The content of the report has been collected from the Quality and Safeguarding Committee information, Divisional Achievement reviews and additional Trust information.

Governance or Legal Issues

The NHS is founded on a common set of principles and values that bind together the communities and the people it serves – patients and public – and the staff who work for it. The NHS Constitution establishes the principles and values of the NHS in England. It sets out rights to which patients, public and staff are entitled, and pledges which the NHS is committed to achieve, together with responsibilities, which the public, patients and staff owe to one another to ensure that the NHS operates fairly and effectively. The Secretary of State for Health, all NHS bodies, private and voluntary sector providers supplying NHS services, and local authorities in the exercise of their public health functions are required by law to take account of this Constitution in their decisions and actions.

Public Sector Equality Duty and Equality Impact Risk Analysis

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

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

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

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

The Trust is working hard to improve these factors but there is still work to do to ensure the services are able to meet current or emerging national access targets. This is a substantial pressure for the services, when our teams are faced with significant and sustained increases in demand and referrals.

Recommendations

The Board of Directors is requested to:

1) Consider and confirm the levels of assurance as rated by the CQC as 'good.' Furthermore, consider the current priorities for quality improvement in the domain of Caring and achievements in this area.
2) Confirm the level of assurance obtained on the areas presented. It is suggested that significant assurance continues to be achieved. A gap in control is specifically noted with regard to dormitory accommodation with regard to privacy and dignity.

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

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

uality Report – Caring

1. Policy and regulatory context

The formal legal duties under this domain are as follows:

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

KLOE C1- Kindness, respect and compassion

The measures for this area are the Trust's training in equality and diversity and patient feedback on caring as per our community and in-patient survey and any questionnaires or service visits in our comprehensive inspection.

In addition, the Care Quality Commission (CQC) (2022/3) report noted that patients and carers said:

What patients told us

Patients were overwhelmingly positive about the staff. They described staff as helpful, approachable and friendly. They felt there was enough staff on duty to meet their needs. One patient told us staff take a 'holistic approach'. They felt they looked at the person as a whole including physical, mental and spiritual needs.

Patients were aware of their section 17 leave arrangements. They told us they had no issues utilising their leave. Patients used their leave for recreational purposes as well as rehabilitation. For example, patients told us they used their leave to go to the supermarket to purchase ingredients to enable them to self-cater. They felt this promoted their independence and in turn increased their self-confidence and self-esteem.

Patients were aware of who their named nurses were and told us they were involved in the development and review of their care plans.
Patients had a good understanding of their discharge plans. They told us what they had to achieve for discharge to take place. Patients felt included in discussions about the care, treatment and discharge planning.
Patients were aware of their treatment plans. They told us the doctors discussed medication with them and supported them to provide informed consent.
All the patients told us they felt safe on the unit. They told us they got along with their peers and staff were always present.

Care plans showed evidence of patient involvement. They were patient-centred and contained patients' views and wishes. We noted staff provided copies of care plans to patients.

What patients told us

Patients described staff as 'approachable, friendly and helpful'. One patient told us that 'staff genuinely care' about patients. However, they felt nursing staff spent a significant portion of their day in the nursing office. Patients told us the ward was kept clean and they were encouraged to keep their bed areas tidy.

All the patients told us they felt safe on the ward. However, some patients cited examples when peers made them feel unsafe. They told us staff managed incidents quickly and provided one-to-one support.

The majority of patients had a poor understanding of their care plans. None of the patients we spoke with had a copy of their care plans.

All the patients were aware of the responsible clinician (RC). They attended weekly ward rounds and described the RC as 'kind'. They told us they felt their views were considered during meetings.

Patients were aware of the observation levels they were on and understood the reasons. Patients could tell us about their section 17 leave arrangements.

What carers told us

Carers were overwhelmingly positive about the ward staff. Carers described staff as 'amazing' and said that they 'cannot fault them' or 'praise them enough'.
Carers were provided with contact details of the ward. They found it easy to contact the ward and told us staff were friendly and helpful.
Carers were invited to meetings such as ward rounds and discharge planning meetings. They felt involved in important decisions.
Face to face visits were taking place on the ward and where permitted carers could accompany patients off the ward. They were also able to maintain contact with patients on their mobile phones.

Focused improvement on Care planning and Patient Centred Care will continue until we have greater control of intermittent inconsistency in our clinical standards.

The Trust clinical team is focused on improving its processes relating to care planning and ensuring a patient centred approach to each person's care.

- Improved completion of care planning by clinicians and with patient involvement throughout
- Development of training and improved access to training for staff
- Improved use of technology for care planning in the community
- Improved use of psychoeducation to support the creation, development, and review of care plans with patients, carers, and their families
- Focused approach to formulation and its relation to effective and meaningful care planning
- Training and focus on ensuring health inequalities are understood by staff to support the most appropriate plan of care. This must include Serious Mental Illness (SMI) groups
- Engagement with wider services to create safe systems and trauma informed approaches for the best patient centred outcomes
- Ensuring that carefully focuses on the person and not just their mental health, including milestones and links with services
- Review of current technology and electronic systems to ensure they are fit for purpose and do not limit clinical outcome, this includes where we record, report and assure ourselves on care planning compliance to return to our more rigorous monitoring systems which we had achieved through the PARIS system and the data warehouse.

In 2022/23 this pattern has continued and our DEED scheme every week is overflowing with service user and carer feedback on Trust services, of which some are listed below:

Tissington Staff, Tissington House, Kingsway Hospital

"To all at Tissington: Thank you for the six weeks of awe-inspiring opportunities, friendly staff, fantastic protocols, and a delightful atmosphere, my first NHS placement will be one that I remember. An additional thank you is necessary to all staff; compassion is a skill none of you lack. I have felt reassured ad included throughout. You shall be missed tremendously."

General Manager, Specialist Services
"The Beeches currently has some extension work underway meaning that the area surrounding The Beeches was in need of a little TLC. On hearing this John came to tidy up the outskirts of the Beeches and plant some new plants to make it a little brighter. Thank you, John, for making The Beeches more welcoming for patients, families, and staff. Also thank you for always working hard behind the scenes to support The Beeches team."

Stanley Road Health Visiting Team, Children's Services
"Over the last eight months the team have offered their continued support and guidance and provided me with an invaluable experience to enable my career development within the 0-19 service. The care and compassion they demonstrate to children and their families is exceptional, which has been conducted alongside adapting to new service changes. You are all a huge credit to the service, thank you so much."

Early Discharge Team - Derby Crisis Team
"I want to recognise and thank the Early Discharge team for working collaboratively with the Specialist Autism Team in trying to resolve a tricky situation for a patient. The Early Discharge team have come together with the Specialist Autism Team and have worked rapidly and effectively. Laura has worked tirelessly throughout the ongoing challenges and ensured all professionals involved are updated. She has gone above and beyond to juggle the demands of her clinical role."

Service Manager/ Recruitment Inclusion Guardian, High Peak and North Dales, The Ritz
"Matt is a Recruitment Inclusion Guardian (RIG) for the Trust and stepped in at the very last minute for a day of six interviews which would not have been able to go ahead without a RIG present. Staffing has been an issue across the Early Intervention Service for some time and this recruitment day was essential for both North and South EI services.

(RIGs were introduced across the Trust in February 2020, helping to improve diverse representation in our Band 6 and above jobs to ensure the recruitment process is a fair process, encouraging a diverse workforce and ensure protected groups are given fair access.) Thank you, Matt, we could not have recruited our excellent new band 6 colleagues without you!! Early Intervention Service will soon be fully recruited after some time of real staffing issues and team pressures. Thank you, Matt, from the Countywide Early Intervention Service!"

Staff Nurse, Pleasley Ward, Hartington Unit
"Tracy started on the ward as a preceptee nurse. Within her first week she was working with another new starter and some agency nurses. Tracy has dug deep, done everything plus more that has been asked of her and she has done this with a smile on her face."

Neurodevelopmental Services - all teams
"We've just hosted two coproduction workshops for people with lived experience of learning disabilities and autism and their families and these workshops would not have gone ahead or gone so well if it wasn't for the commitment and energy of colleagues working across the many teams within Neurodevelopmental Services. I would like to thank everyone that took the time to be involved in the planning and delivery of the day, as well as the ongoing analysis and implementation of the recommendations found through the workshops. Thank you all!"

Health Hero - for an individual who has made a significant contribution to the NHS by making an outstanding difference in the community or have made a significant difference to health and wellbeing outcomes for the public and those in our care.
Well done to colleagues and volunteers nominated in this category:

Junior Doctor, Tissington House (Older People's Acute Inpatient)
"Jack has been with the team as a Junior Doctor for some weeks. He has delivered care sensitively and has continually gone above and beyond. He has acted quickly and recognised patients requiring additional support. He has spent time with family members explaining and reassuring them about various needs. Jack continues show commitment to learning and sharing his knowledge with the team. Having been able to provide one-to-one support to patients who have been in his care, they have shown their thanks by making a special effort to say goodbye to him. Jack has been able to step up and cover the ward medically with confidence. Thank you."

Dynamic Hospital Avoidance Lead, Adult Neurodevelopmental Services, Brooklands
"Karl participated in the two coproduction workshops recently hosted by Joined Up Care Derbyshire with people with lived experience of learning disabilities and autism and their families. Karl attended as one of the representatives of the Trust and went above and beyond, offering care and support to attendees at each workshop. Karl particularly supported attendees who were nervous about participating and sharing their stories and were very brave in attending. He offered a kind ear and shoulder to cry on and supported people to not only share their stories, but also to access support on the day and mobilised the colleagues needed. He was a real star and embodied the caring commitment of the Trust."

Patient / Carer / External nominations – for nominations received from service users, carers or external organisations for individuals or teams that have made a significant difference while delivering care. Well done to colleagues and volunteers nominated in this category:

Occupational Therapist and Lead Nurse, Dementia Rapid Response Team, Scarsdale Hospital
A carer says: "Emma and Debbie have both had compassion, finding time to research, listen, evaluate and act which is so rare these days. They have supported us to develop a plan to treat my wife's illness."

The care home says: "Emma and Debbie have been so supportive to our needs and the effect on residents in the home. They have also been understanding to the resident herself and put her and family members as a priority. They are an asset to your team."

Chesterfield Dementia Rapid Response Team, Scarsdale Hospital
Card received by patient's spouse: "You all came into my life when I was in need of friends who understood my situation. Well, you've certainly accomplished that. Each one of you that visited during the last few weeks have coloured my life. I can see a light at the end of the tunnel. Thank you all so much for your patience and support, an excellent service of which you should all be proud. Love and best wishes. People will forget what you said, people will forget what you did, but people will never forget how you made them feel."

Chesterfield Dementia Rapid Response Team, Scarsdale Hospital
"To the Dementia Rapid Response Team, thank you and a few chocolates isn't enough, but what else can we offer - not all heroes wear capes and that is exactly what you are in our eyes. You flew in and rescued us just at the right time. We were on our knees, but you put us right. We will be forever grateful. Thank you. xxx"

Occupational Therapist, Ward 36, Radbourne Unit
“From day one the support extended to me was immeasurable. He has been kind, wise and passionate about the work he does with not just me but with all the other patients, and he holds brilliant group sessions which are enjoyable and welcoming. In my case, he gave me a wake-up call when I needed it most. He supported me by getting me motivated to live my life. The knowledge and wisdom he shared with me and the other patients is invaluable and priceless and I cannot thank him enough.”

Nursing Assistant, Ward 35, Radbourne Unit
“During a stay on Ward 35, I had the delight of meeting a Nursing Assistant named Asher Cox. I am writing this because I would like Asher to receive the recognition which she very highly deserves, due to the very high qualities she has consistently shown since my admission. These are qualities which I believe are crucial to have when working with mental health. Asher is a very empathetic person and has always been very quick to de-escalate situations where negative emotions could lead to larger amounts of distress. For my own personal experience, she has always made time for all when they need it and has a very calming nature. I cannot put into words how fantastic she is at her job. She is an honest, confident, empathetic, passionate, reliable, and kind person who I appreciate very much, and I have so much gratitude towards her. I would love if she was able to see this and be aware that this is how a lot of the patients think about Asher and for management to give her praise and recognition.”

Ward 33, Radbourne Unit
“Throughout my stay on the ward all the nurses and nursing assistants were supportive and very caring. All the staff involved in my care (including those off the unit) approached delicate subject matters lightly and let me discuss these on my own terms and at my own pace.

Despite staff shortages, all staff always kept the ward a cheerful and safe place - however hard that may have been. Many staff I spoke to reminded me of my resilience, inner strength, sense of humour, and other personal qualities that I should draw upon when struggling - and will continue to draw upon throughout my recovery.”

Morton Ward, Hartington Unit
“Morton Ward have looked after me so well during my admission. They have made me strong again and enabled me to safely return back home. You're all a great team, thank you all so very much.”

Named Nurse and Ward OT, Morton Ward
“I wish to show my appreciation for my named nurse and ward OT on Morton ward. You have both played a huge part in my recovery which I will always remember and be grateful for. If it was not for you, I feel I would've given up. You have inspired me and made me want to change others’ lives the way you have changed mine. You bring brightness to the ward every day, thank you for everything, especially for allowing me to express myself.”

Everyone at the In-reach and Home Treatment Team South, Albany House, Kingsway Hospital
“I can't express fully in words how much you have all meant to me in the last few weeks. From feeling in the absolute pit of despair, when life meant nothing to me, to now where I feel optimistic and dare, I say it happy. I know how much pressure the mental health service is under, and I count my blessings that you were able to look after me. Each and every one of you who have either visited or i have spoken to on the phone have given me something to think and reflect on to get to where I am today. My anxiety levels have decreased and are more manageable. Thank you all, you are truly amazing.”

Morton Ward, Hartington Unit
"During my admission I have learned to regulate my own emotions, take responsibility for my own actions, build up a routine and also recognise my own strengths and weaknesses. The staff have helped me a lot through my good and bad moments, and I've learned to do things for myself, accept help and responsibility and become as independent as possible, working on my own physical and mental health problems. The staff have all done their best and I've appreciated all the groups I've tried. They have put up with a lot from me and it is working – I am finally starting to own my own recovery and appreciate how kind they have been to me. I am continuing to work on my own recovery – asking for help, being more patient, and the number of activities, talks etc and my level of understanding and patience leading me to understand further how much my family have done for me, and how much they are going through. I am thankful also for Chaplaincy, the dietician and how all the staff have helped me in the times I've needed help – to recognise I am able to do this. Thank you! I would highly recommend my journey as it has done me the world of good."

Crisis Team Nurses, Derby City and South Derbyshire Crisis Resolution and Home Treatment Team
"A patient open to the secondary care CBT team is a military veteran. He was in a personal crisis and needed urgent support from a variety of agencies. He said his contact with the Crisis team had 'restored his faith in humanity' when at a very low point, and that the team members he met went the 'extra mile' to help."

I have chosen some particular extracts to demonstrate the lived experience of our services. The number of service user and family feedback through the DEED scheme is increasing. This is a sustained change and is a great insight into our culture changes and how valued the feedback form people who experience our services is to our people working within our organisation.

This information correlates with the National Benchmarking information on the Trust's services, which at this time remain with solid performance.

Our Community Mental Health Survey 2022

1250 invited to take part
282 completed in Derbyshire Healthcare Foundation NHS Trust
23% response rate
21% average response rate for all trusts
30% response rate for your Trust last year

Comparison with other trusts
The number of questions at which your trust has performed better, worse, or about the same compared with all other trusts.

Much better than expected – 0	
Better than expected - 1	
Somewhat better than expected- 1	
About the same- 28	
Somewhat worse than expected- 0	
Worse than expected - 0	
Much worse than expected - 0	
Health and social care workers	Compared with other trusts - about the same
Patient Response 6.9 / out of10	
Organising care	Compared with other trusts
Patient Response 8.2 / out of10	About the same

Planning care	Compared with other trusts
Patient Response 7.0 / out of10	About the same
Reviewing care	Compared with other trusts
Patient Response 7.1 / out of10	About the same
Crisis care	Compared with other trusts
6.6 / out of10	About the same
Medicines	Compared with other trusts
Patient Response 7.3 / out of10	About the same
NHS talking therapies	Compared with other trusts
Patient Response 7.8 / out of10	About the same
Support and wellbeing	Compared with other trusts
Patient Response 4.9 / out of10	About the same
Feedback	Compared with other trusts
Patient Response 1.3 / out of 10	About the same
Overall views of care and services	Compared with other trusts
Patient Response 6.9 / out of10	About the same
Overall experience	Compared with other trusts
Patient Response 6.8 / out of10	About the same
Responsive care	Compared with other trusts
Patient Response 7.6 / out of10	About the same

This represents stable forward, with a reduction overall in line with Trust results in the post pandemic period. This performance is a worsened position compared to our pre pandemic experience of care.

NHS Benchmarking on Overall Patient Experience

This is a reduced level of performance for our organisation, however, it still within acceptable levels, if not at our previous level of exceptional performance in this area, where we were functioning at the third highest in the country.

Organisationally we will seek to recover our position as we exit the post pandemic period, this will be a challenge with the level of additional activity and a significant financial challenge.

Experience of care- Employment services

"I suffer from bipolar and mood disorder and have been unemployed for 5yrs when I was referred to IPS in January 2022. I used to have a high-power job as a strategic manager for a mining company for many years before falling ill. I now just want a purpose and a reason to get out of the house and I am willing to re locate. The support I have received from Diane has been excellent. She has contacted potential employers on my behalf and helped me gain 2 temporary posts and has also contacted another employer who is inviting me for a look around and an interview. My confidence has definitely improved, and I feel much more motivated since working with Diane."

"I have been in the mental health service for most of my life suffering from depression, anxiety, and hearing voice's. I have been out of work for 26 years but have now secured a

job as a school crossing patrol. Before I became ill the last time (1996), I was a soft drinks salesman I have also volunteered at a school in Derby from 2001 to 2013 as an IT technician and did general maintenances for them. I have been with Louise since December 2021. The support I have had from Louise has been great. Louise is very helpful and explains things in a down to earth way. I was very anxious on the first meeting with Louise which was one to one over the internet, but she soon helped me calm down and now I have a job

Benchmarking Network

Quality

	MH056	Mean	Median	National trend
Community Teams Patient Satisfaction Score	68%	68%	68%	
NHS Friends and Family Test (FFT) Patient Satisfaction Score	89%	85%	87%	

The CQC undertake surveys to explore the experience of people who receive care and treatment. One of these surveys covers community mental health teams and reports the proportion of people whose view was that overall they had a good experience of community mental health services. This year, the average position recorded was 68% a marginal reduction on the 2020/21 position of 70.4%.

The NHS Friends and Family Test was created to help service providers and commissioners understand whether their patients are happy with the service provided, and where improvements are needed. It includes a number of measures of satisfaction. The data shown for this metric relates to March 2022. The average position recorded was 85% which was also a marginal reduction on the 2020/21 position of 88.9%.

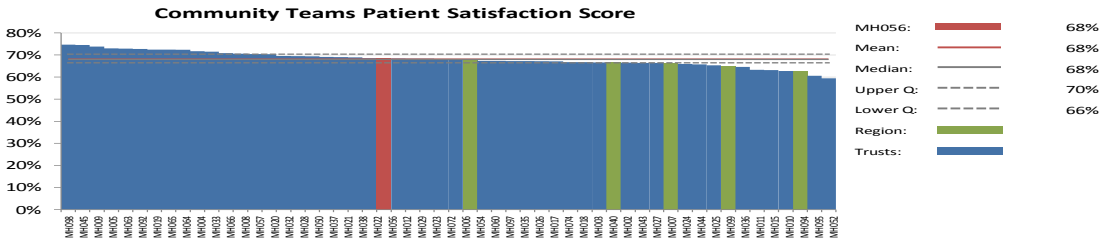
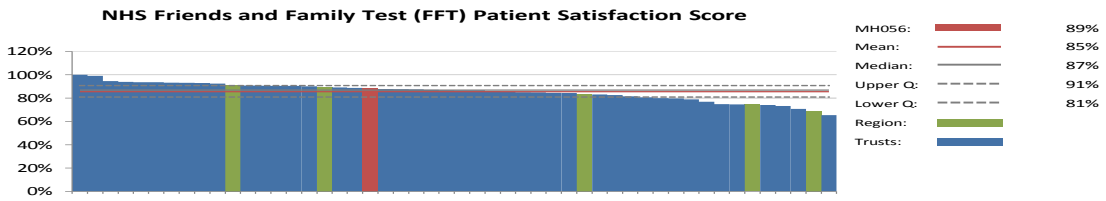


Figure 94



Other new developments related to feedback and Pt experience

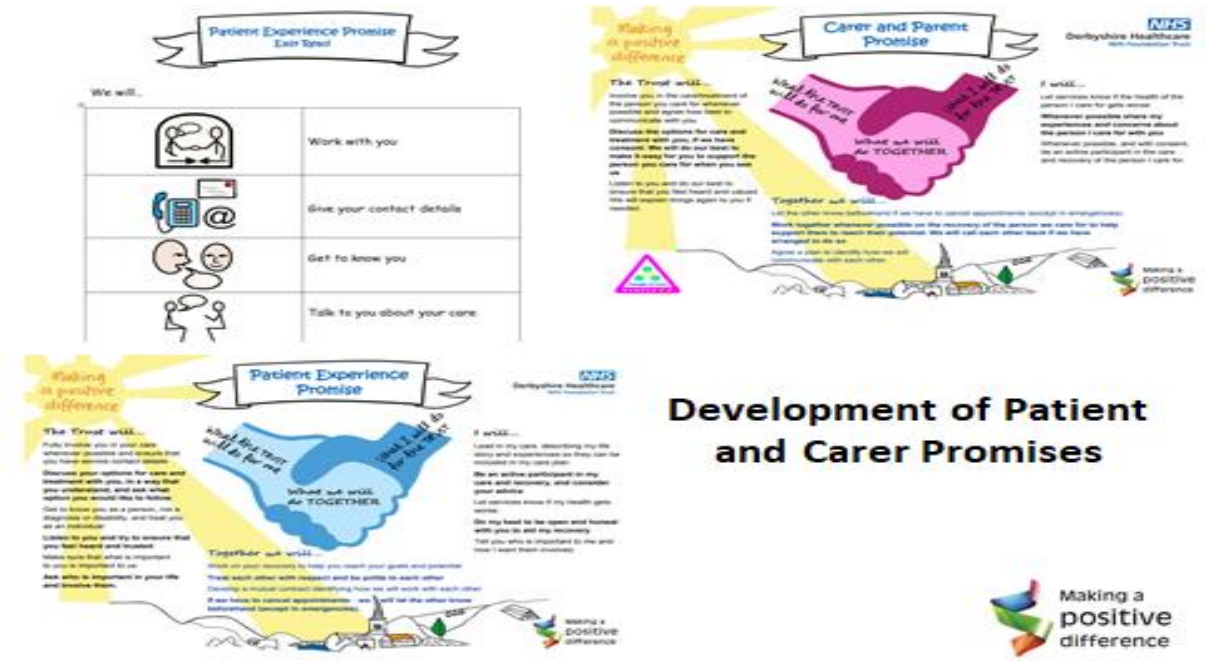
Embedding of the Mental Health helpline

The Mental Health Helpline continues to be very active and well regarded. The introduction of the helpline during the pandemic has supported the increase in patient acuity and activity. The Mental Health Helpline provides an additional tool for people to access alongside clinical care teams over the 24-hour, 7 day a week period and provides access to a variety of professionals. This service has supported people into services as well as reduce the waiting time people face in discussing their concerns and in turn prevent crisis occurring. Furthermore, for those already in our care, it has provided another service for them to access out of hours when their care team may not be available. This service remains very positively regarded and is actively used.

Overall, the Trust is rated as “good.” The feedback from the CQC was very positive “there was good management of complaints and there was an increase in compliments.” “There were clear responsibilities at every level in the Trust for the management, investigation and response to complaints.”

Responsiveness to complaints has reduced over this year and some late responses have occurred. It is clear that the operational pressures have impacted upon timely investigation. To combat this an investigation facilitator model has been piloted by acute and by community mental health areas of the Trust with great impact and success. Both Ruth Crawford and Natasha Baines have been a great asset to the operational services in improving the quality of their responses and responsiveness to experience and learning for the teams.

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



Patient Experience

The Patient Experience Strategy was published in 2020 and has been reviewed by the Quality and Safeguarding Committee in 2022/23. Significant progress continues and areas of improvement include:

- The EQUAL developments including feedback through 'Bright Ideas' leading to investments in ward-based activity
- Texting and feedback service
- Pathway specific tools such as the Helpline
- Self-referral to the Crisis team
- The community mental health survey
- Up-take and impact of Family and Friends Test

These are important areas to note and areas we have specifically required to improve due to feedback from people who use our services.

Feedback from Healthwatch – themes

Healthwatch fed back that the main theme is being frustrated around waiting for an Autism spectrum disorder (ASD) assessment. This is acknowledged by the Autism Assessment Service (AAS) and they are working proactively to improve communication with those on the waiting list. A specific Task and Finish group to address these issues was set up in February 2023; the aim of this group is to improve the referral and assessment process and reduce the waiting time for autism assessments. Since January 2023, the AAS have implemented a standardised process for enquiries that are made relating to the waiting list to support a consistent approach. Furthermore, there has been successful recruitment into the ASS and 20 clinicians have been trained across our Trust to undertake ASD assessments, which will reduce the need for them to be added to the ASS waiting list or removed if they are already on it.

Key areas for escalation from Carers Group and EQUAL:

Influencing and design of the new build

Living Well/Discharge - Representatives would like to know what happened with the work on the Discharge Policy they participated in and how this work is being incorporated in the new Living Well model:

The group was reassured that the work, that had been done in the Discharge Culture Task and Finish group in 2022, was being incorporated into the current discharge policy and that this would be brought to the Patient and Carer Experience meeting for review prior to ratification. The group were also assured that these principles would be applied to the new living well model and participants were given information on how they could get involved in living well related focus groups.

Mental Health Together – Representatives expressed concern for the loss of this service. They would like assurance that the remit and principles of this service, with its focus on Mental Health, will not be lost in an Integrated Care Board 'general' plan for involvement and engagement which relies too heavily on surveys and digital methods of communication and information gathering:

It was acknowledged by the group, that patient and carer representatives were concerned about the potential loss of this service, and it was agreed that these concerns would be passed on to the Quality and Safeguarding Committee. It was pleasing to note that the ICB have confirmed an extension to the contract,

Expectations on Service Users and Carers to be digitally enabled, active and skilled - Representatives feel these expectations are far and above what should be reasonably expected. Patients and Carers are expected to be connected to the internet, own appropriate technology (hardware and software) and be digitally skilled. Representatives feel Service Users and Carers can become further isolated and disengaged from services if they are not equipped in the way, that is now automatically expected. Questions were also raised about the digital expectations on volunteers in engagement and involvement work and the extra barriers this can create:

The group was assured that the Trust understood not all users of the service would be comfortable with using digital means of communication and that there were pockets of digital poverty across the Trust. It was also acknowledged that volunteers and groups may not have access to hardware and software, which would allow them to communicate effectively with service users and carers who may prefer these methods of communication. Along with the Assistant Director for Digital Clinical Practice, it was proposed to the group that a process would be created for consulting with patient and carer representatives and that a "Digital Library" would be developed to give access to Wi-Fi enabled tablets that could be loaned out to carer and service user representatives and patients and carers that they are working with. This will be supplemented with needs-based training and support via the Business intelligence team. The hardware is expected to be in place for April 2023.

In April 2023 the Executive Director of Nursing and Patient Experience undertook a visit to the North Derbyshire Carers main group and hub support groups across northern Derbyshire in Chesterfield.

Feedback was the groups were very pleased with the securing of financial support to redesign the wards and securing the finance for a new Psychiatric Intensive Care Unit which was very welcomed. Carers expressed thanks for this work. Their current concern is really centred around the disinvestment in the Third sector in the north of the County. In Chesterfield, Bolsover and Killamarsh all social recovery groups provided by Peer support, or third sector are either not occurring or diminishing. Concerns were expressed that despite large financial investment in large third sector organisations that money is being absorbed in large operators' overheads and staffing and not reaching the people who require peer support. The group expressed concerns this has worsened over the last 12 and 6 months.

We continue to be very grateful to the EQUAL Patient and Care Forum for their feedback and support of services to continually improve and feed this information into the ICB Mental Health and Learning Disability and Autism Board.

Compliments, Complaints and Concerns

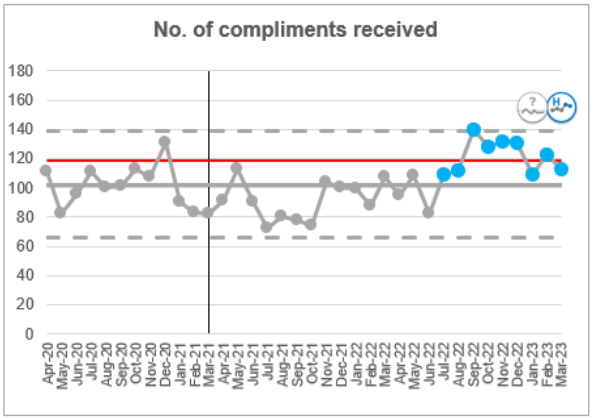
The Trust's Patient Experience Team is the central point of contact for people to provide feedback and raise concerns about the services provided by the Trust. The team sits within the Nursing and Patient Experience directorate. The team's aim is to provide a swift response to concerns or queries raised and to ensure a thorough investigation takes place when required, with complainants receiving comprehensive written responses including being informed of any actions taken.

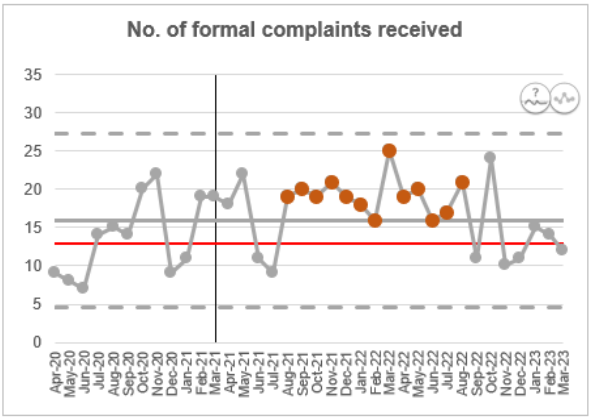
2022-2023 has been a challenging year due to changes in the Patient Experience Team's staffing and the pressures experienced by all teams across the Trust. The Patient Experience Team worked with people contacting their service and with operational teams and to ensure that the best outcomes have been achieved. It is recognised that the length of the investigation process could be improved, and work is ongoing to address this. Our progress throughout the year is monitored, and reported on, in quarterly reports to the Patient Experience Committee and Quality Committee.

Comparison of Contacts Through the Year

	2020-21	2021-22	2022-23	Total
Complaint	167	216	190	573
Compliment	1214	1102	1385	3701
Concern	481	516	444	1441
Enquiry	743	1421	1690	3854
Total	**2605**	**3255**	**3709**	**9569**

Complaints are issues that need investigating and require a formal written response from the Trust. Investigations are coordinated through the Patient Experience Team. Concerns can be resolved locally and require a less formal response. This can be through the Patient Experience Team or directly by staff at ward, or team, level within our services. The number of recorded concerns and complaints has dropped slightly from the previous year, this may have been due to an increase of Covid related issues the previous year. Enquiries made to the Trust have risen significantly during 2022/23, a high number were not related to Trust Services but people contacting our team with issues relating to GP practices and Accident and Emergency Departments and other issues not managed by our Trust. A number of enquiries relating to our Trust services were in relation to appointments and access to services. All enquiries are logged and responded to.





Parliamentary and Health Service Ombudsman

During the year, the Trust discussed nine cases with the Parliamentary and Health Service Ombudsman. 2 enquiries - no further action. 1 enquiry went to an assessment with no further action and 1 enquiry is still ongoing. 1 assessment - no further action. 1 assessment £300 paid in Remedy. 2 assessments and 1 investigation are ongoing.

Comparison of Concerns, Complaints and Compliments by Top Issues Raised

The most common form of concern and complaint raised in 2022-2023 was in relation to care planning, which was the same issue highlighted in 2021-22. Care planning is a broad subject covering a wide range of aspects of care. Discussions are ongoing to look at providing more clarity regarding this topic.

Top 3 issues raised in Concerns	
2020-21	247
Availability of Services / Activities / Therapies	105
Care planning	88
Other	54
2021-22	308
Care planning	134
Availability of Services / Activities / Therapies	117
Other	57
2022-23	196
Care planning	96
Appointments (e.g. delays and cancellations)	51
Availability of Services / Activities / Therapies	49
Total	**751**

Top 3 issues raised in Complaints	
2020-21	141
Care planning	76
Abruptness / Rudeness / Unprofessionalism	40
Availability of Services / Activities / Therapies	25
2021-22	220
Care planning	119
Abruptness / Rudeness / Unprofessionalism	52
Availability of Services / Activities / Therapies	49
2022-23	179
Care planning	92
Abruptness / Rudeness / Unprofessionalism	62
Medication	25
Total	**540**

Compliments

Themes from the 1385 compliments received reflect people's gratitude for the care provided and appreciation of the compassion shown by staff. The number of recorded compliments in 2022-23 has increased from the previous year.

	2020-21	2021-22	2022-23
Care	674	660	779
Compassion	500	489	619
Empathy	341	346	496
Environment	146	145	169
Facilities	121	113	130
General gratitude	875	775	983
Information/Advice	374	403	480
Kindness	563	567	690
Listening	449	439	586
Responsiveness	454	395	520
Support/Help	804	728	889
Other - see description	70	37	102
Total	5371	5097	6443

KLOE C2 - Involving people in decisions about their care

We were previously rated it as 'good' because:

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

Previously in the Trust not all patients were involved in their care plans or given copies of their care plans in the acute care service. Since 2020, we have improved this performance, but it is not fully resolved and improvement plans remain in place until there is sustained improvement in compliance.

In recent CQC mental health visits in 2022 and on audits in 2023- care planning has significantly improved, both in completion and quality.

Ward 33

Patients were aware of who their named nurses were and told us they had regular one-to-one sessions. They told us they were involved in developing their care plans and received copies.

However, at **Ward** 36 in 2023 this was intermittent at audit and at a Mental Health Act Inspection visit it was clear that wellness of patients in the service was a factor, however sustained evidence of active engagement is still required to ensure we are consistently meeting standards

The Trust has co-produced a patient experience strategy. This was designed drawing upon the evidence in safe wards and the concept of mutual expectations and a patient experience promise was implemented, which has been redesigned to be pathway specific.

The EQUAL People and Carers Forum is a live forum and influencing the Trust and wider partners. The EQUAL forum has set the agenda and defined the areas they wished to received assurance on which have included : autism, psychiatry, community working age adults care, stability in psychiatry, physical health care checks in the new wards, and community mental health care.

The model of **'Bright Ideas'**, based on People's 'Bright Ideas' was implemented and feedback of this model and impact is very positive. This continues to directly improve and impact on feedback from people in our care directly to a Peer support worker and feeds into the EQUAL Network Advisor.

KLOE C3 - Privacy and dignity

We have good indicators in our Community Mental Health. The Mental Health helpline feedback, sustained improvement in the Family and Friends survey and significant improvements in our level of compliments on the lived experience of our colleagues were all noted.

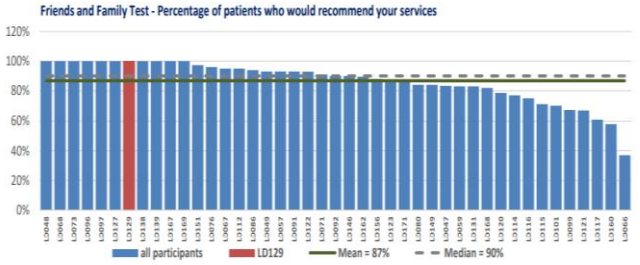
The specific measures in this area are listed as an appraisal of whether there is strong evidence in place to confirm compliance.

- Incidents of breaches of confidentiality (strong evidence), compliance with data protection requirements - Staff training in IG (Information Governance) (strong evidence).

- Healthwatch feedback (strong evidence and noted as a responsive organisation, number of complaints and compliments (strong evidence and patient privacy and confidentiality (strong evidence).

- Learning Disability services for Derbyshire Healthcare – Percentage of patients that recommend your service against all other Learning Disability organisations. (Strong evidence)

Source: NHS Staff Survey 2021



Source: NHS Friends and Family Test - test data 2020/21

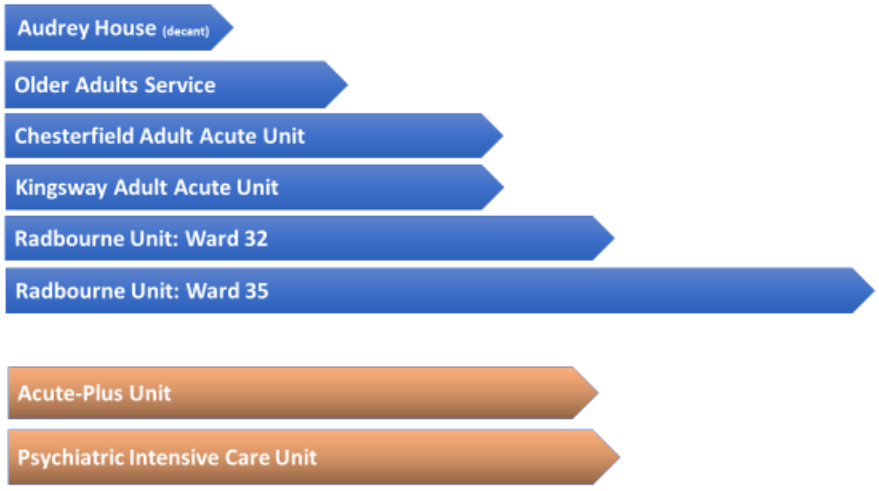
Caring, therapeutic environments

One aspect of Privacy and Dignity which also connects with the Safety Domain, is the use of dormitory accommodation. There is an extensive plan and building programme which will eradicate all dormitory accommodation in Derbyshire. This is one of the largest programmes in the country.

Drivers for Change

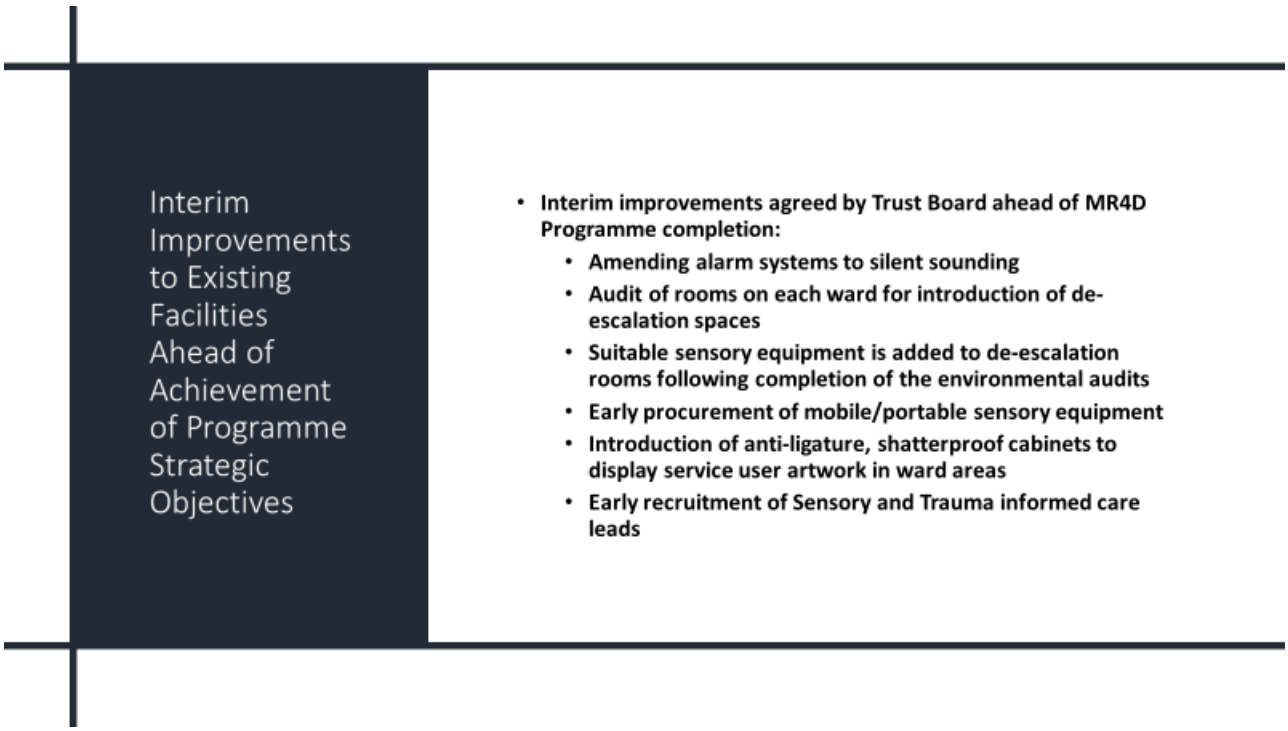
- Derbyshire is an outlier for the use of dormitory style accommodation with one of the highest levels in England
  - Negative impact on privacy and dignity and patient safety
  - Negative impacts on A&E and Acute Trust flow
  - Formal CQC requirement under regulation 15(1)c to eradicate the use of dormitories
- Derbyshire currently has mixed age groups within dormitory accommodation in the North of the County
- Derbyshire has no PICU capacity
  - leading to all Derbyshire patients being placed out of area
  - Stated aim under NHS 5 Year Forward View and Long Term Plan to end inappropriate out of area placements by March 2021
  - Leads to poor patient journey, lack of social, familial and environmental connections which are all known to aid recovery

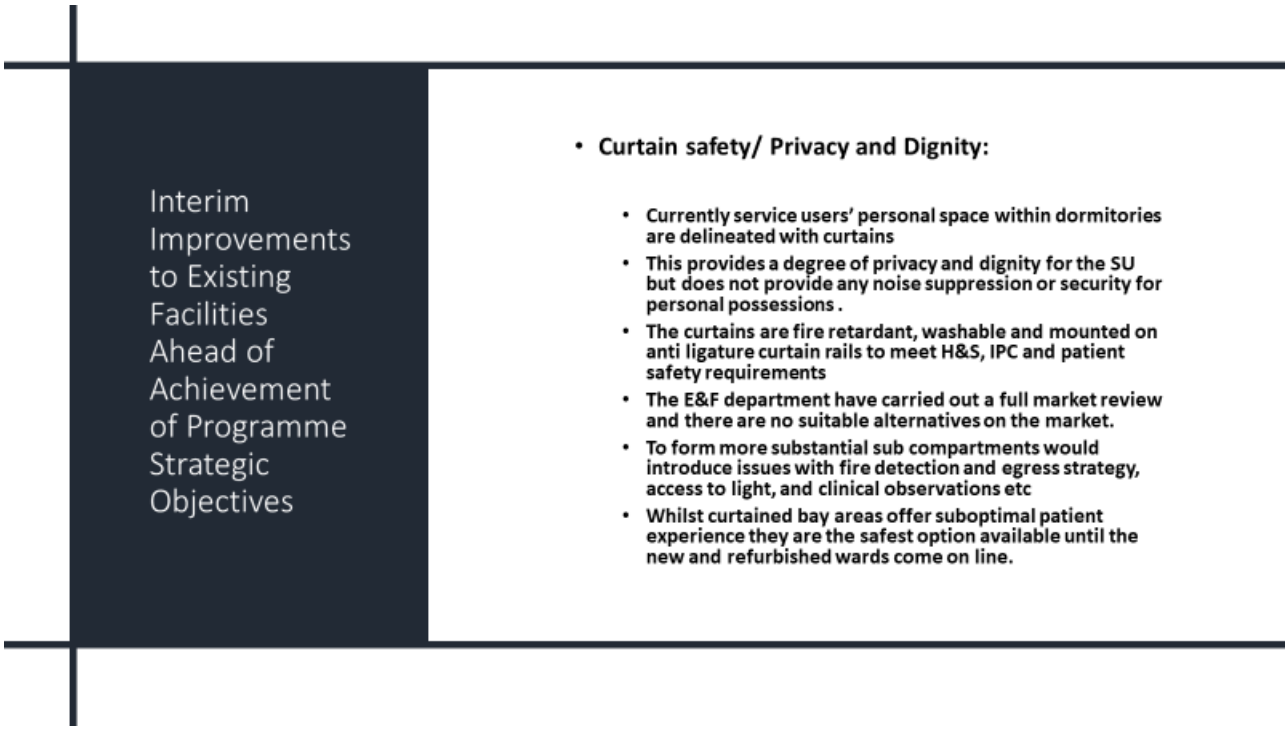
Making Room for Dignity Programme



Go-Live	Dorms Eradication
Nov 2023	
May 2024	29% (100% OA)
Nov 2024	40%
Nov 2024	78%
Mar 2025	89%
Apr 2026	100%
	Specialist Services
Feb 2025	36%
Mar 2025	100%

The Trust has continued to invest in the existing estate and how the clinical services operate to offer patient and carer choice of services in gender and use the single room bed stock to those with specific needs and requirements such as transgender, risks due to sexual safety and or victim of a crime or abuse.





Key improvement areas

1. Delivery of the Trust strategy on eradication of dormitory bed stock

2. Full recovery of patient experience Family Friends Test and wider feedback mechanisms – all services Trust wide.

Carolyn Green
Director of Nursing and Patient Experience

NHS Community Mental Health Survey Benchmark Report 2022

Derbyshire Healthcare NHS Foundation Trust

Contents

This work was carried out in accordance with the requirements of the international standard for organisations conducting social research (accreditation to ISO27001:2013; certificate number GB10/80275).

Background and methodology

This section includes:

- an explanation of the NHS Patient Survey Programme
- information on the Community Mental Health Survey
- a description of key terms used in this report
- navigating the report

Background and methodology

The NHS Patient Survey Programme

The NHS Patient Survey Programme (NPSP) collects feedback on adult inpatient care, maternity care, children and young people's inpatient and day services, urgent and emergency care, and community mental health services.

The NPSP is commissioned by the Care Quality Commission (CQC); the independent regulator of health and adult social care in England.

As part of the NPSP, the Community Mental Health Survey has been conducted almost every year since 2004. The CQC use the results from the survey in its assessment of mental health trusts in England.

To find out more about the survey programme and to see the results from previous surveys, please refer to the section on further information on this page.

Community Mental Health Survey

The survey was administered by the Survey Coordination Centre for Existing Methods (SCCEM) at Picker Institute.

The 2022 survey of people who use community mental health services involved 53 providers of NHS community mental health services in England. We received responses from 13,418 people, a response rate of 20.9%.

People aged 18 and over were eligible for the survey if they were receiving care or treatment for a mental health condition and were seen face-to-face at the trust, via video conference or telephone between 1 September 2021 and 30 November 2021. For more information on the sampling criteria for the survey, please refer to the sampling instructions detailed in the 'Further information' section. Fieldwork for the survey (the time during which questionnaires were sent out and returned) took place between February and June 2022.

Trend data

The Community Mental Health Survey is comparable back to the 2014 survey. Trend data is presented in this report for questions that have been asked in previous survey years.

Further information about the survey

- For published results for other surveys in the NPSP, and for information to help trusts implement the surveys across the NPSP, please visit the NHS Surveys website.
- To learn more about the CQC's survey programme, please visit the CQC website.

Key terms used in this report

The 'expected range' technique

This report shows how your trust scored for each evaluative question in the survey, compared with other trusts that took part. It uses an analysis technique called the 'expected range' to determine if your trust is performing about the same, better or worse compared with most other trusts. This is designed to help understand the performance of individual trusts and identify areas for improvement. More information can be found in the Appendix.

Standardisation

Demographic characteristics, such as age and sex, can influence service users' experience of care and the way they report it. For example, research shows that older people report more positive experiences of care than younger people. Since trusts have differing profiles of service users, this could make fair trust comparisons difficult. To account for this, we 'standardise' the results, which means we apply a weight to individual service user responses to account for differences in demographic profile between trusts. For each trust, results have been standardised by the age and sex of respondents to reflect the 'national' age-sex type distribution (based on all respondents to the survey).

This helps ensure that no trust will appear better or worse than another because of its profile, and enables a fairer and more useful comparison of results across trusts. In most cases this standardisation will not have a large impact on trust results.

Scoring

For each question in the survey, the individual (standardised) responses are converted into scores on a scale of 0 to 10. A score of 10 represents the best possible result and a score of 0 the worst. The higher the score for each question, the better the trust is performing. Only evaluative questions in the questionnaire are scored. Some questions are descriptive (for example Q1) and others are 'routing questions', which are designed to filter out respondents to whom the following questions do not apply (for example Q23). These questions are not scored. Section scoring is computed as the arithmetic mean of question scores for the section after weighting is applied.

National average

The 'national average' mentioned in this report is the arithmetic mean of all trusts' scores after weighting is applied.

Suppressed data

If fewer than 30 respondents have answered a question, no score will be displayed for that question (or the corresponding section the question contributes to).

Further information about the methods

For further information about the statistical methods used in this report, please refer to the survey technical document.

Using the survey results

Navigating this report

This report is split into five sections:

- **Background and methodology** – provides information about the survey programme, how the survey is run, and how to interpret the data.
- **Headline results** – includes key trust-level findings relating to the service users who took part in the survey, benchmarking, and top and bottom scores. This section provides an overview of results for your trust, identifying areas where your organisation performs better than the average and where you may wish to focus improvement activities.
- **Benchmarking** – shows how your trust scored for each evaluative question in the survey, compared with other trusts that took part; using the 'expected range' analysis technique. This allows you to see the range of scores achieved and compare yourself with the other organisations that took part in the survey. Benchmarking can provide you with an indication of where you perform better than the average, and what you should aim for in areas where you may wish to improve.
- **Change over time** – displays your trust score for each survey year. Where available, trend data will be shown from 2014 to 2022. Questions are displayed in a line chart with the trust mean plotted alongside the national average. Statistical significance testing is also shown between survey years 2022 vs 2021. This section highlights areas your trust has improved on or declined in over time.
- **Appendix** – includes additional data for your trust; further information on the survey methodology; and interpretation of graphs in this report.

How to interpret the graphs in this report

There are several types of graphs in this report which show how the score for your trust compares to the scores achieved by all trusts that took part in the survey. Additionally, line charts show your trust's trend data over time.

The two chart types used in the section 'Benchmarking' use the 'expected range' technique to show results. For information on how to interpret these graphs, please refer to the Appendix.

Other data sources

More information is available about the following topics at their respective websites, listed below:

- Full national results; technical document: http://www.cqc.org.uk/cmhsurvey
- National and trust-level data for all trusts who took part in the Community Mental Health Survey 2022 https://nhssurveys.org/surveys/survey/05-community-mental-health/. Full details of the methodology for the survey, instructions for trusts and contractors to carry out the survey, and the survey development report can also be found on the NHS Surveys website.
- Information on the NHS Patient Survey Programme, including results from other surveys: www.cqc.org.uk/content/surveys
- Information about how the CQC monitors hospitals: https://www.cqc.org.uk/what-we-do/how-we-use-information/using-data-monitor-services

Headline results

This section includes:

- information about your trust population
- an overview of benchmarking for your trust
- the best and worst scores for your trust

Who took part in the survey?

This slide is included to help you interpret responses and to provide information about the population of service users who took part in the survey.

1250 invited to take part

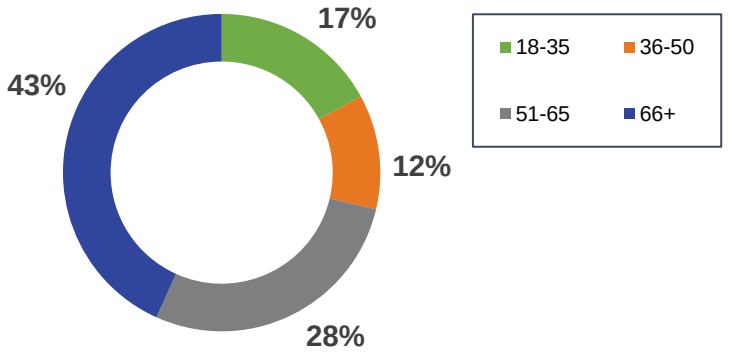
282 completed

23% response rate

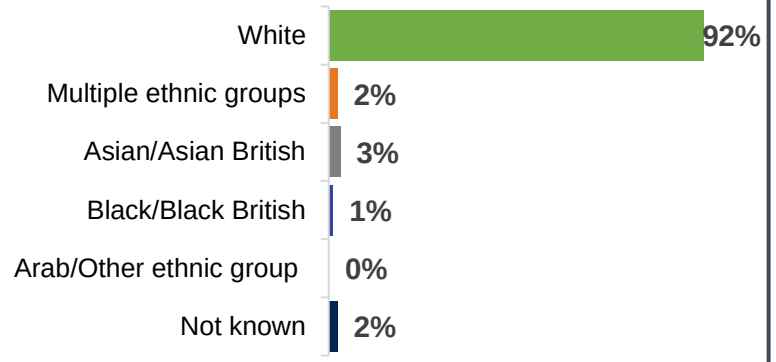
21% average response rate for all trusts

30% response rate for your trust last year

AGE



ETHNICITY



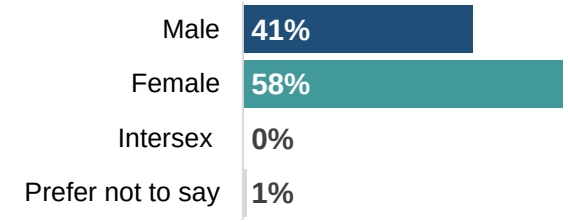
LONG-TERM CONDITIONS

95% of service users have a **physical or mental health condition or illness that has lasted or is expected to last for 12 months or more.**

Number of long-term conditions reported:

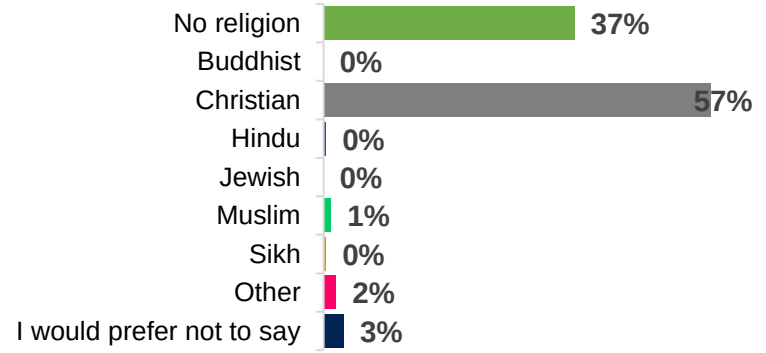
SEX

At birth were you registered as…



0% of service users said their **gender is different from the sex they were registered with at birth**.

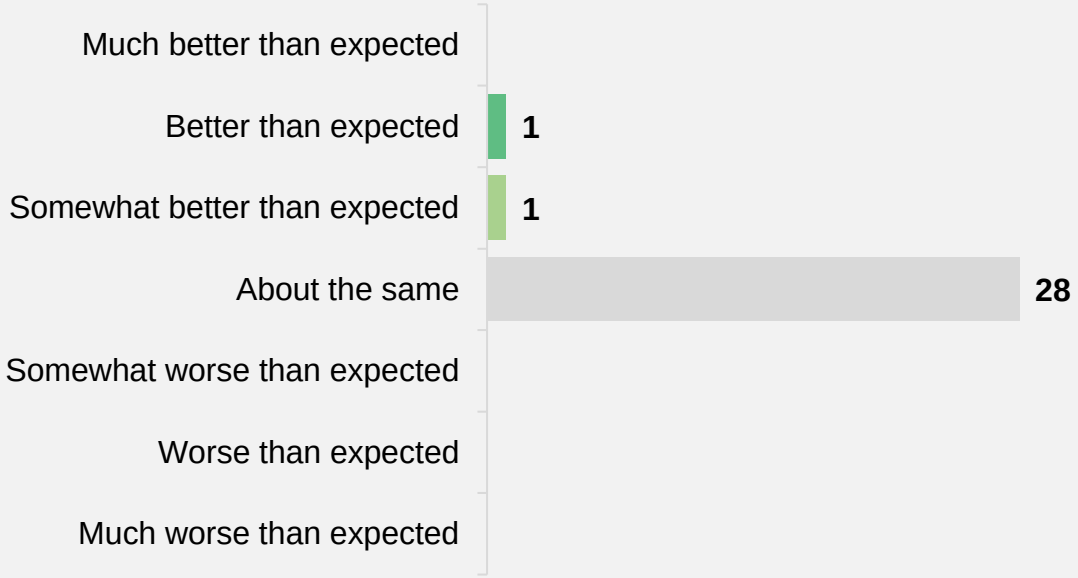
RELIGION



Summary of findings for your trust

Comparison with other trusts

The **number of questions** at which your trust has performed better, worse, or about the same compared with all other trusts.



Comparison with last year's results

The **number of questions** at which your trust has performed statistically significantly better, significantly worse, or no different than your result from the previous year, 2022 vs 2021.

For a breakdown of the questions where your trust has performed better or worse compared with all other trusts, please refer to the appendix section "your trust has performed much worse" , "your trust has performed worse" , "your trust has performed somewhat worse", "your trust has performed somewhat better", "your trust has performed better", "your trust has performed much better" .

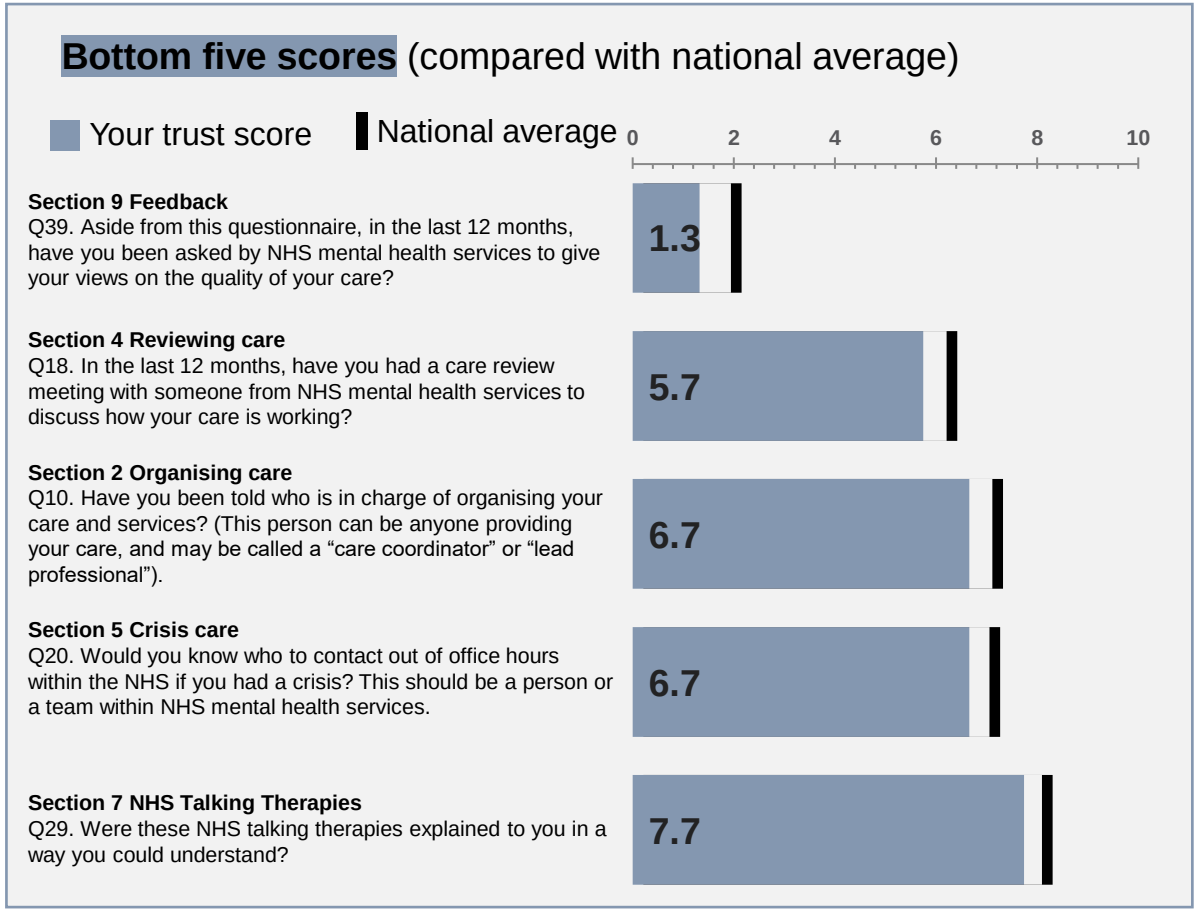
Best and worst performance relative to the national average

These five questions are calculated by comparing your trust's results to the national average.

- **Top five scores**: These are the five results for your trust that are highest compared with the national average. If none of the results for your trust are above the national average, then the results that are closest to the national average have been chosen, meaning a trust's best performance may be worse than the national average.
- **Bottom five scores:** These are the five results for your trust that are lowest compared with the national average. If none of the results for your trust are below the national average, then the results that are closest to the national average have been chosen, meaning a trust's worst performance may be better than the national average.

Top five scores (compared with national average)

Bottom five scores (compared with national average)



Benchmarking

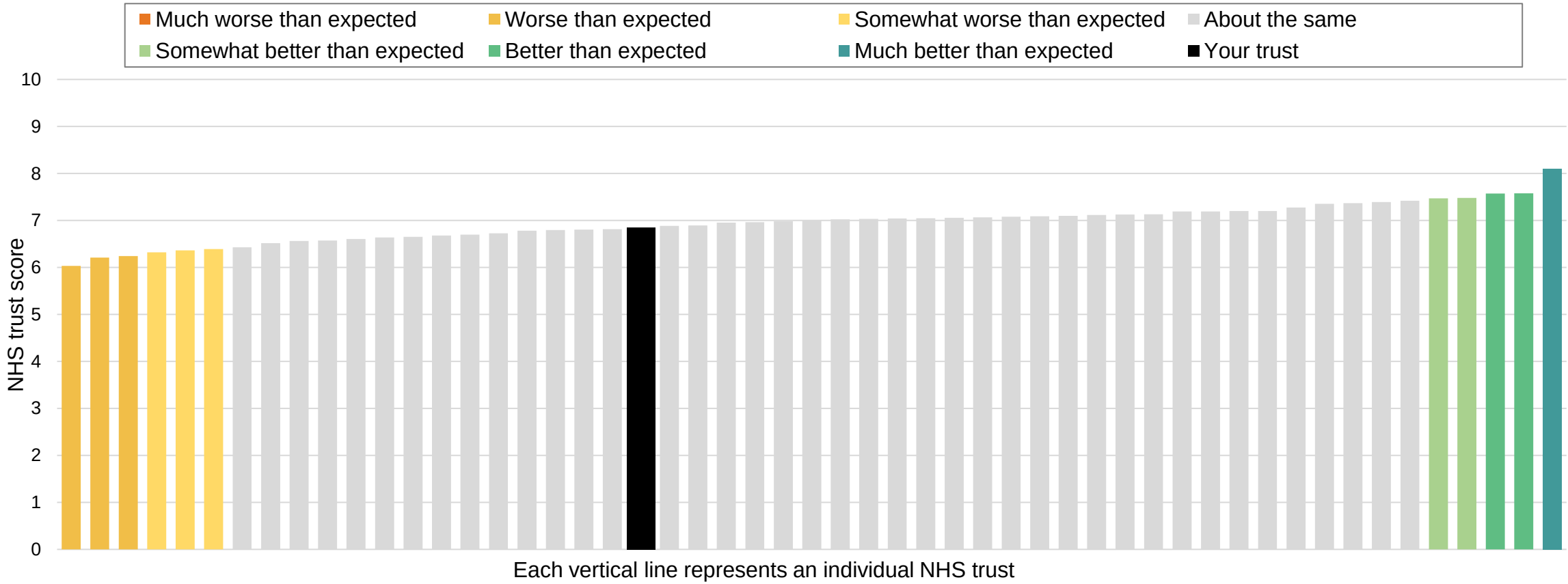
This section includes:

- how your trust scored for each evaluative question in the survey, compared with other trusts that took part.
- an analysis technique called the ‘expected range’ to determine if your trust is performing about the same, better or worse compared with most other trusts.

Section 1. Health and social care workers

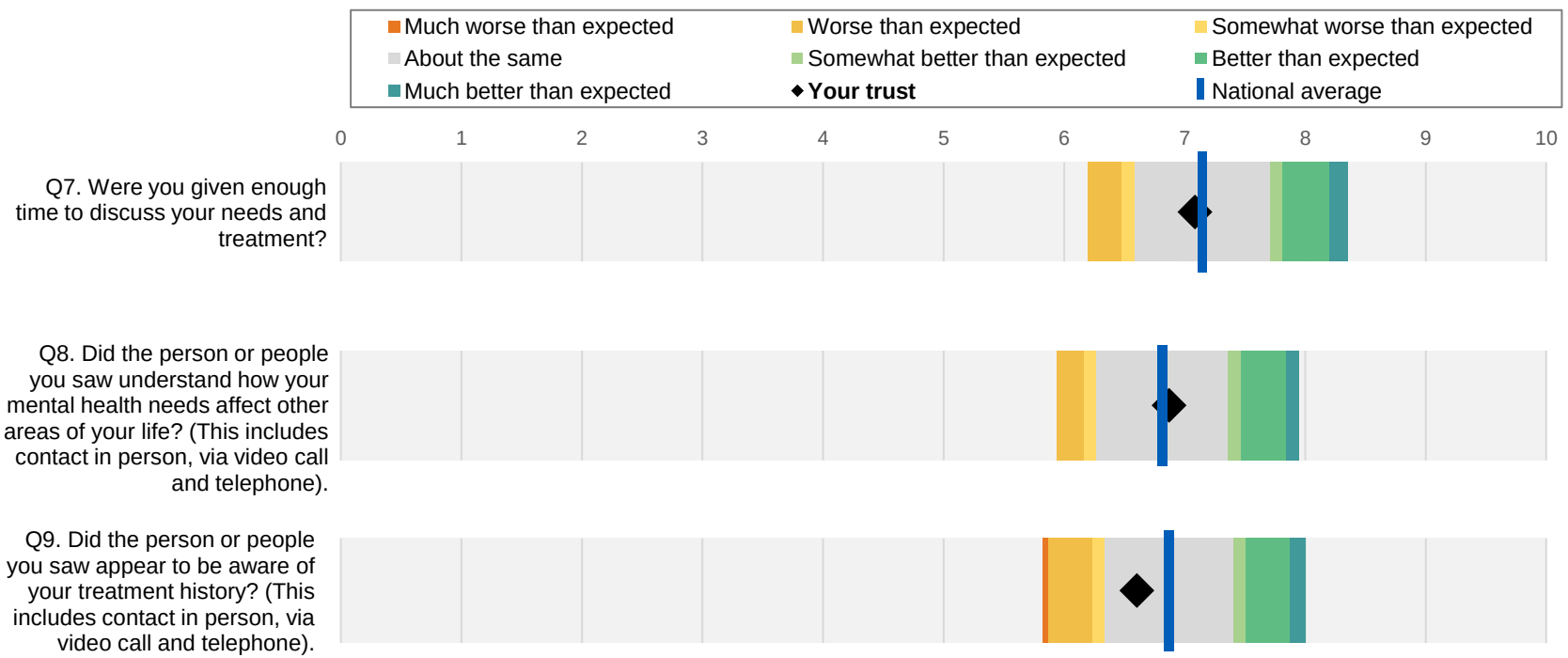
This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

Your trust section score = 6.9 About the same



Section 1. Health and social care workers (continued)

Question scores

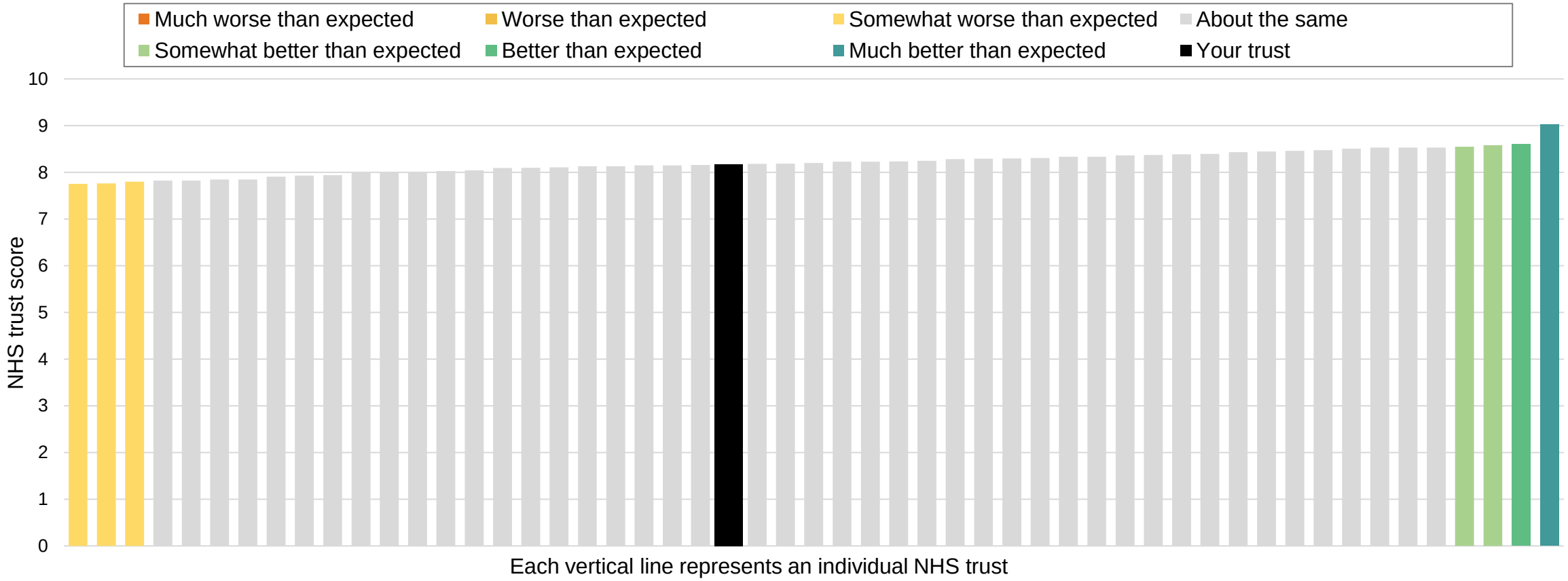


			All trusts in England		
	Number of respondents	Your trust	National average	Lowest score	Highest score
About the same	268	7.1	7.1	6.2	8.4
About the same	260	6.9	6.8	5.9	7.9
About the same	253	6.6	6.9	5.8	8.0

Section 2. Organising care

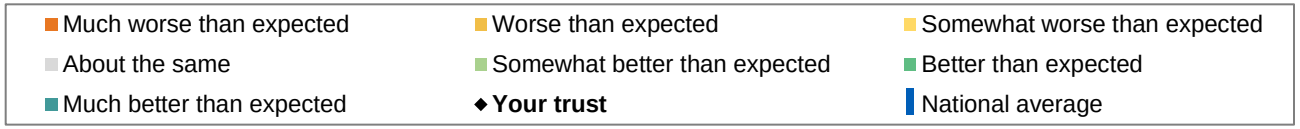
This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

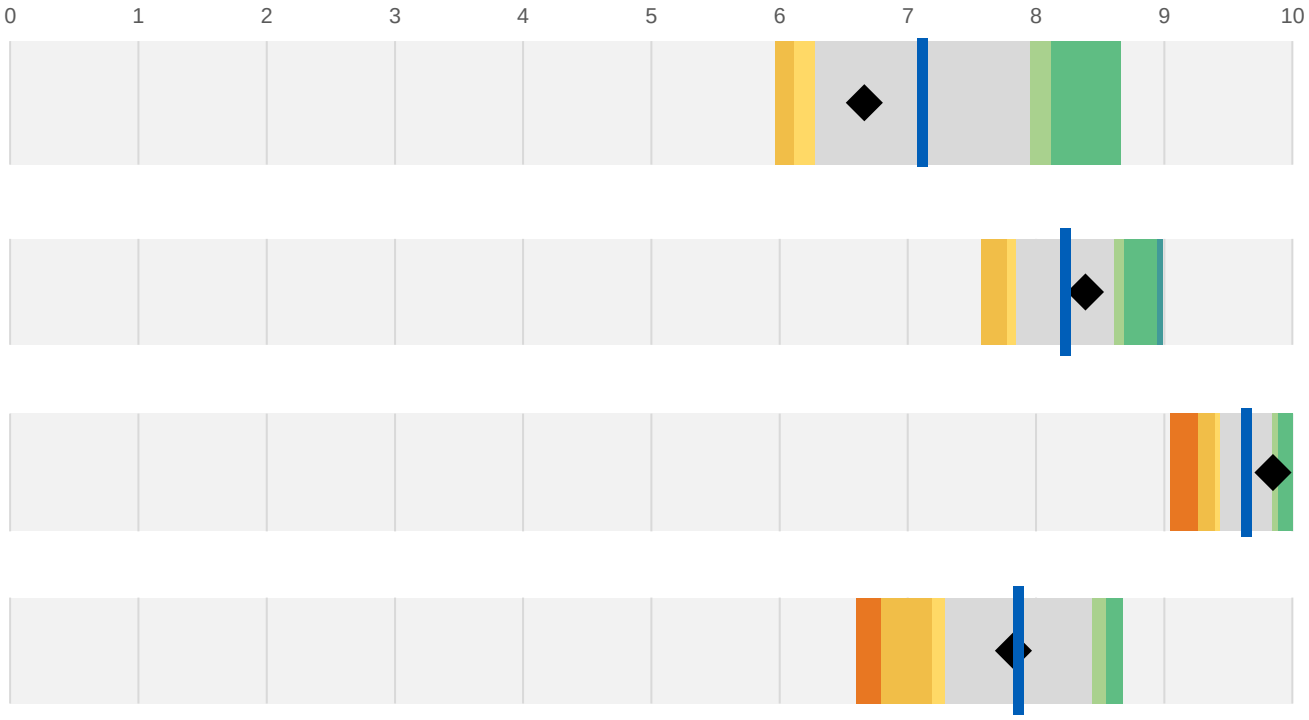
Your trust section score = 8.2 About the same



Section 2. Organising care (continued)

Question scores



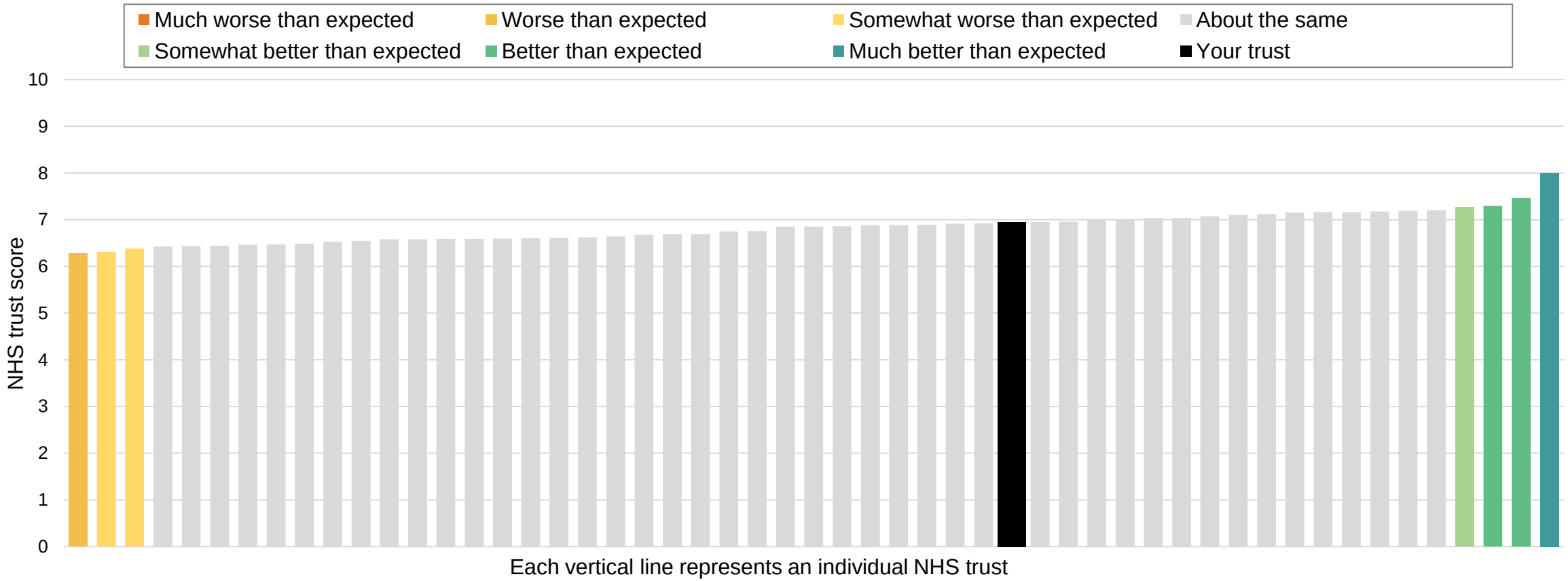


		All trusts in England				
	Number of respondents	Your trust	National average	Lowest score	Highest score	
Q10. Have you been told who is in charge of organising your care and services? (This person can be anyone providing your care, and may be called a "care coordinator" or "lead professional").	230	6.7	7.1	6.0	8.7	About the same
Q12. How well does this person organise the care and services you need?	130	8.4	8.2	7.6	9.0	About the same
Q13. Do you know how to contact this person if you have a concern about your care?	125	9.8	9.6	9.0	10.0	Somewhat better than expected
Q14. Thinking about the last time you contacted this person, did you get the help you needed?	123	7.8	7.9	6.6	8.7	About the same

Section 3. Planning care

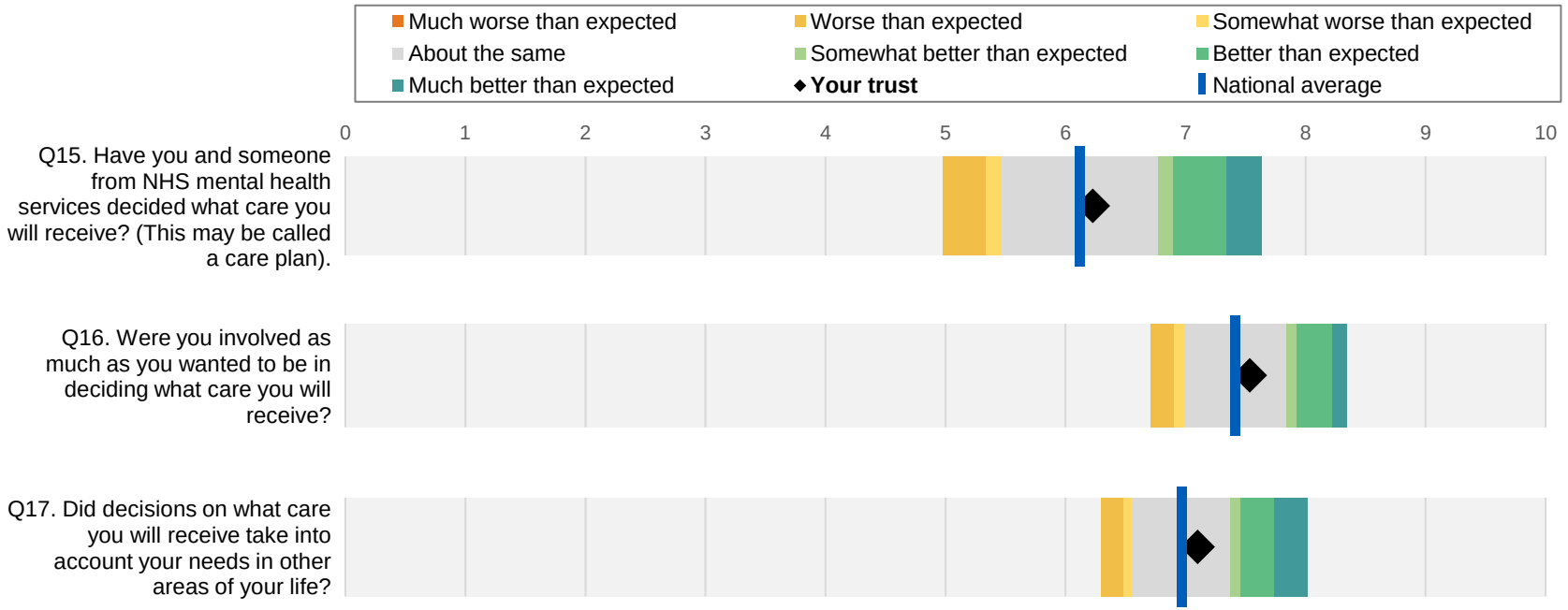
This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

Your trust section score = 7.0 About the same



Section 3. Planning care (continued)

Question scores

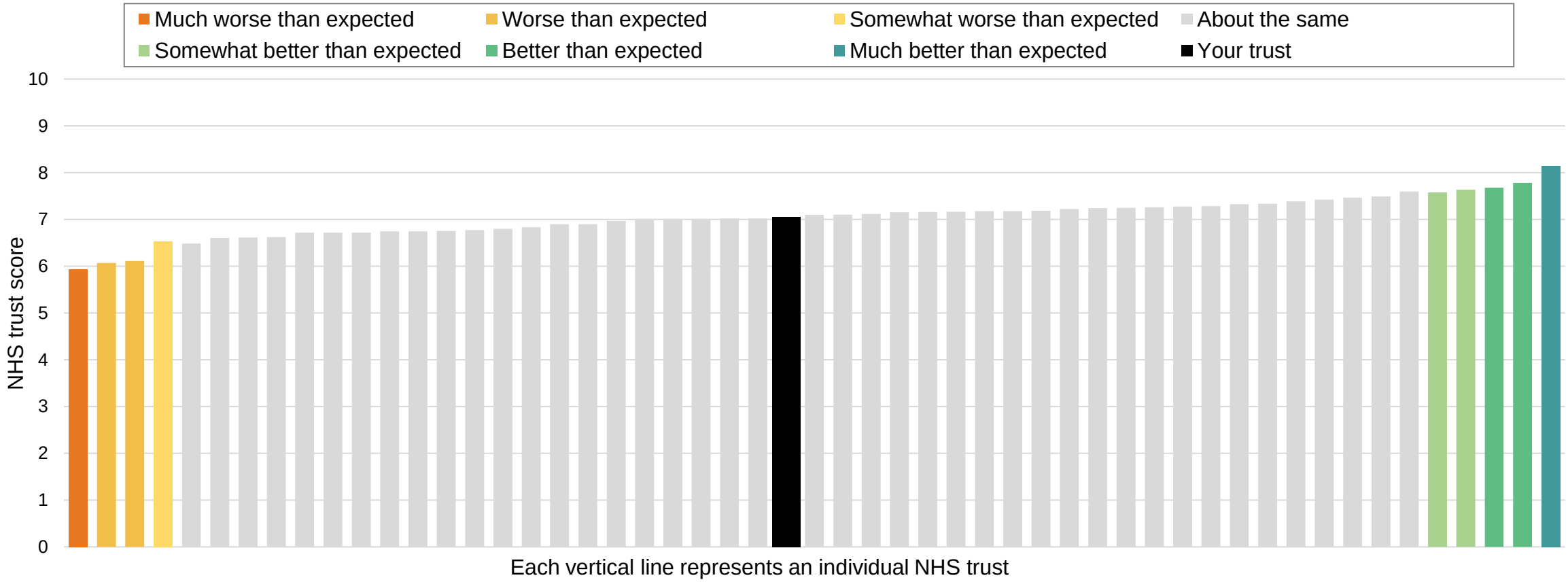


		All trusts in England		
Number of respondents	Your trust	National average	Lowest score	Highest score
About the same				
247	6.2	6.1	5.0	7.6
About the same				
187	7.5	7.4	6.7	8.3
About the same				
179	7.1	7.0	6.3	8.0

Section 4. Reviewing care

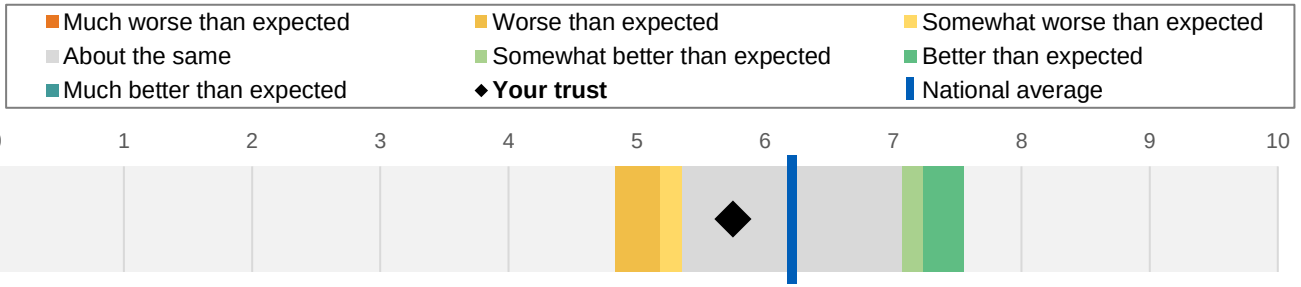
This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

Your trust section score = 7.1 About the same



Section 4. Reviewing care (continued)

Question scores

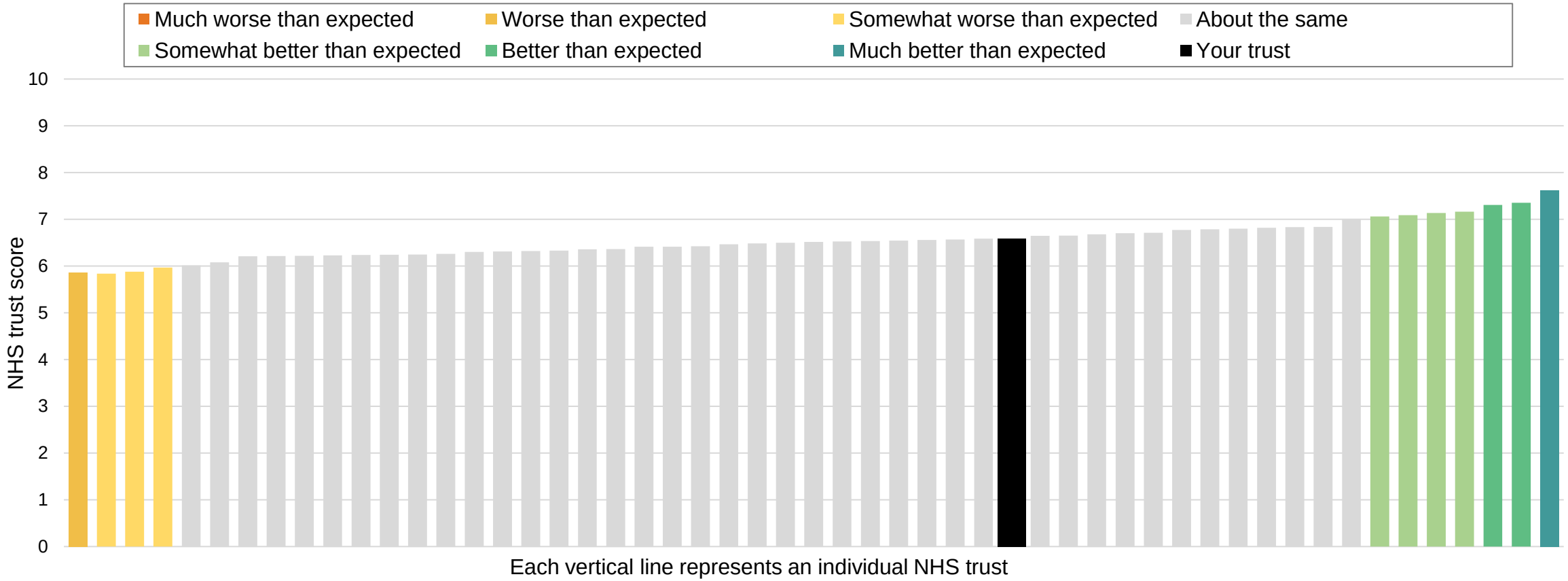


		All trusts in England		
Number of respondents	Your trust	National average	Lowest score	Highest score
Q18. In the last 12 months, have you had a care review meeting with someone from NHS mental health services to discuss how your care is working?				
211	5.7	6.2	4.8	7.6
About the same				
Q19. Did you feel that decisions were made together by you and the person you saw during this discussion? (This includes contact in person, via video call and telephone).				
119	8.4	7.9	6.7	8.9
About the same				

Section 5. Crisis care

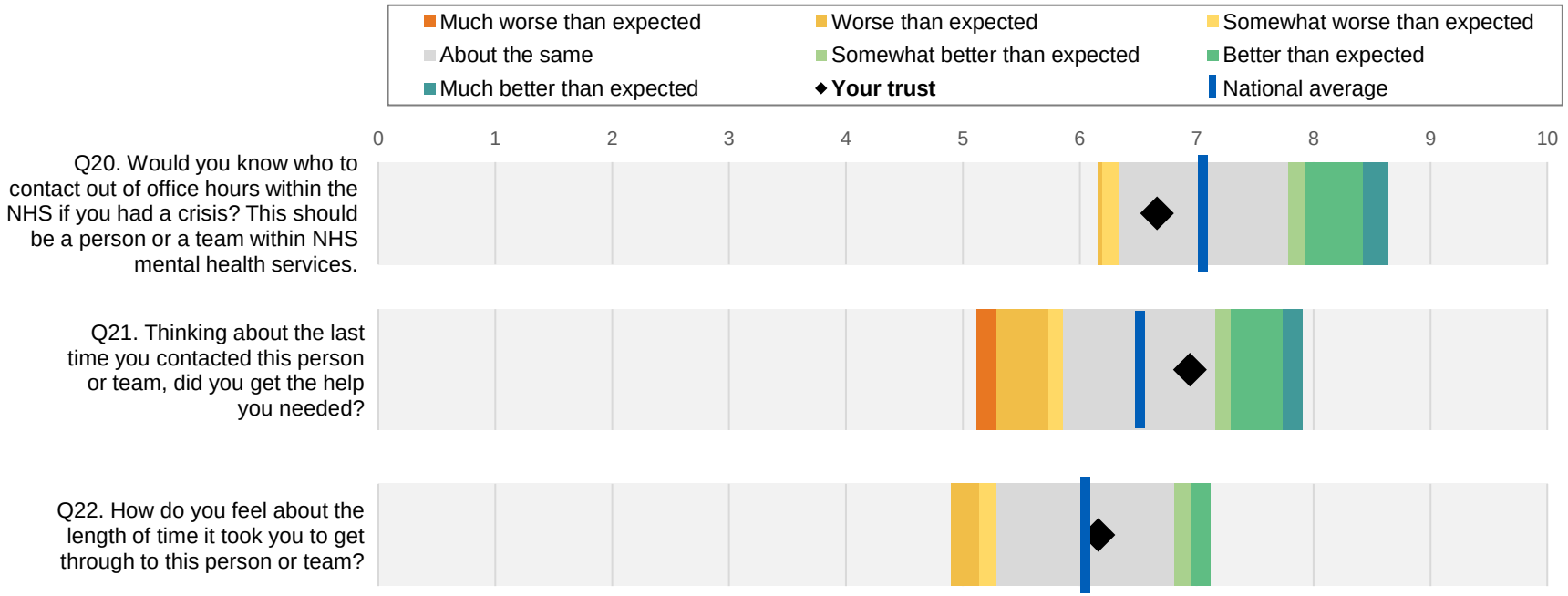
This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the ‘expected range’ analysis technique used, a trust could be categorised as ‘about the same’ whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

Your trust section score = 6.6 About the same



Section 5. Crisis care (continued)

Question scores



		All trusts in England		
Number of respondents	Your trust	National average	Lowest score	Highest score
242	6.7	7.1	6.2	8.6
120	6.9	6.5	5.1	7.9
113	6.2	6.0	4.9	7.1

About the same

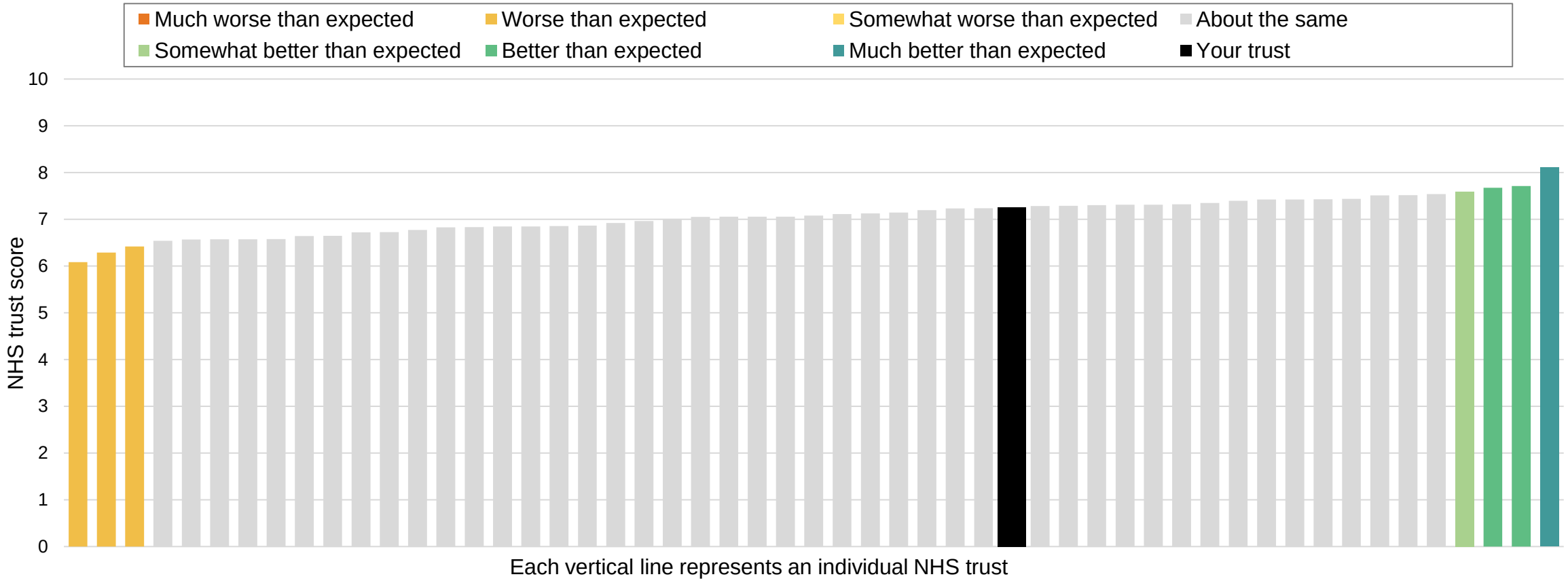
About the same

About the same

Section 6. Medicines

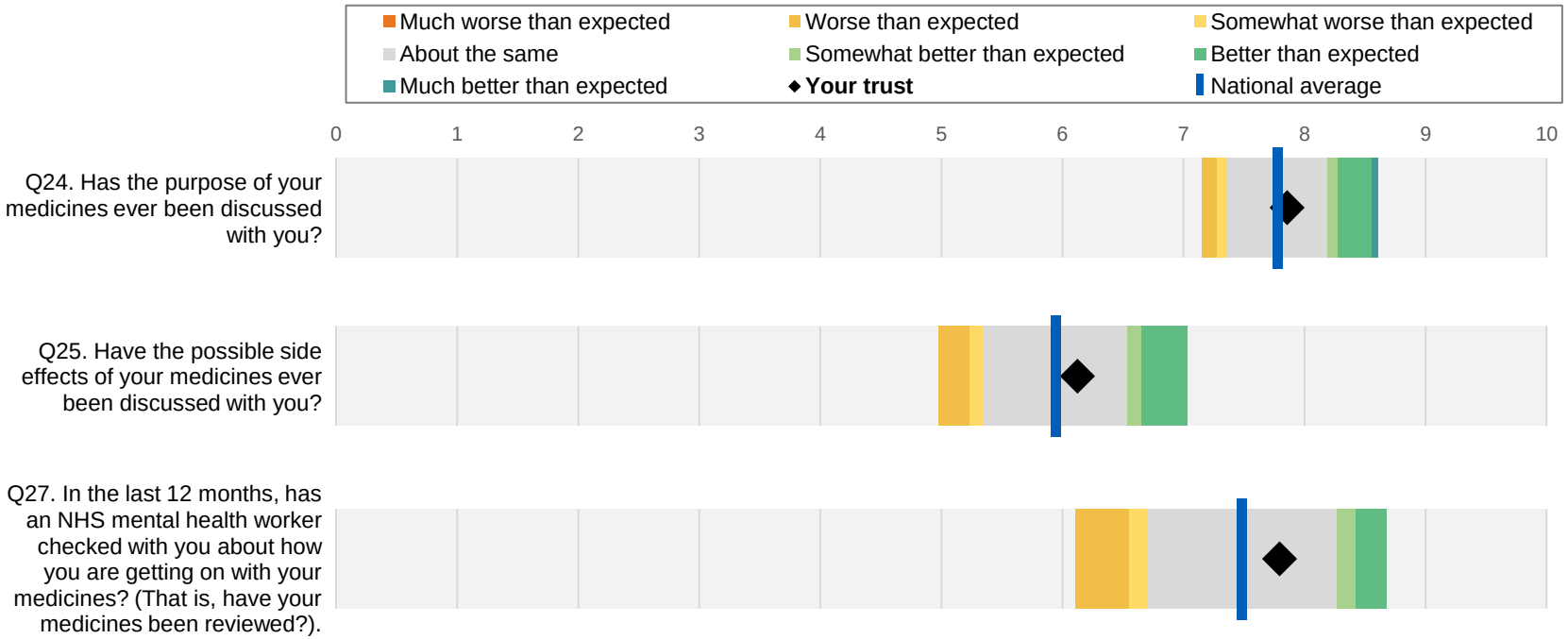
This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

Your trust section score = 7.3 About the same



Section 6. Medicines (continued)

Question scores

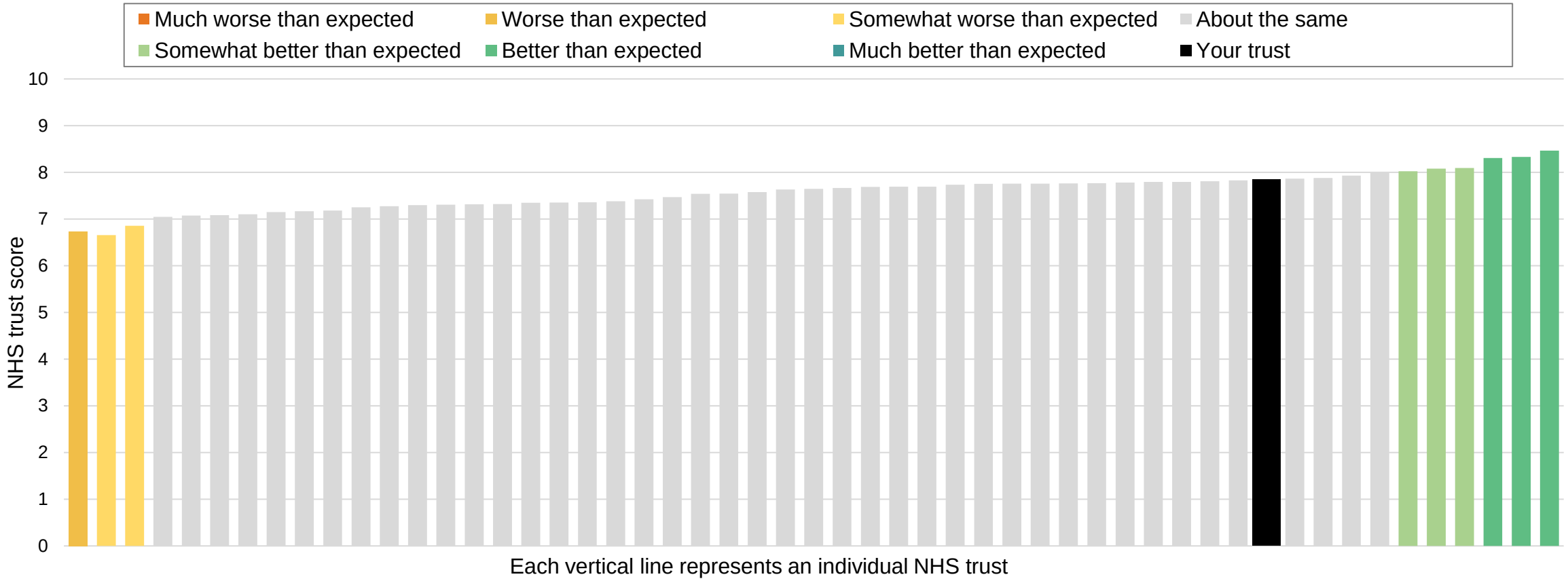


		All trusts in England				
	Number of respondents	Your trust	National average	Lowest score	Highest score	
Q24. Has the purpose of your medicines ever been discussed with you?	222	7.9	7.8	7.2	8.6	About the same
Q25. Have the possible side effects of your medicines ever been discussed with you?	213	6.1	5.9	5.0	7.0	About the same
Q27. In the last 12 months, has an NHS mental health worker checked with you about how you are getting on with your medicines? (That is, have your medicines been reviewed?).	174	7.8	7.5	6.1	8.7	About the same

Section 7. NHS Talking Therapies

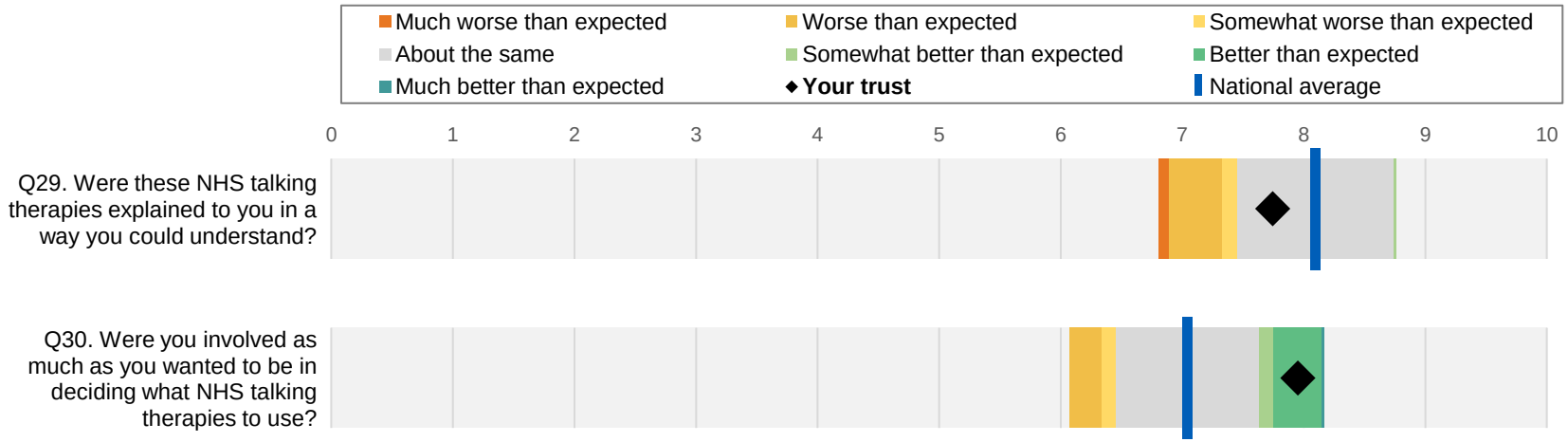
This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

Your trust section score = 7.8 About the same



Section 7. NHS Talking Therapies (continued)

Question scores



		All trusts in England		
Number of respondents	Your trust	National average	Lowest score	Highest score
75	7.7	8.1	6.8	8.8
67	7.9	7.0	6.1	8.2

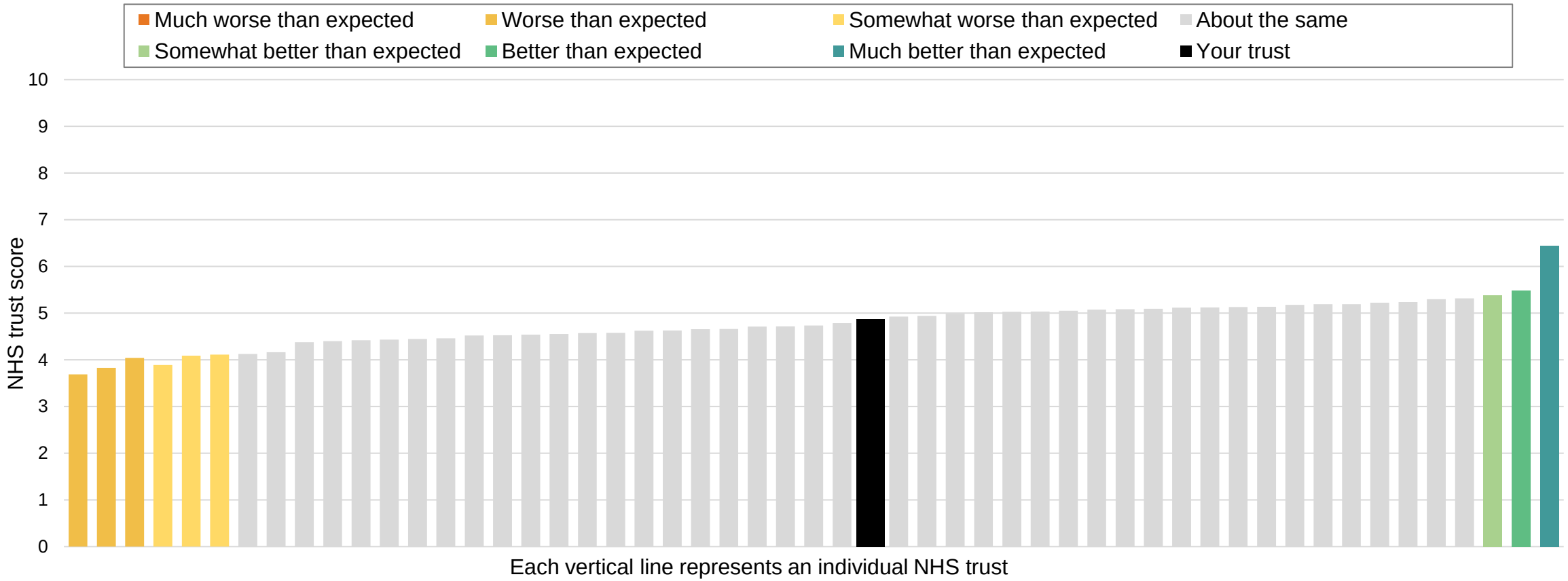
About the same

Better than expected

Section 8. Support and wellbeing

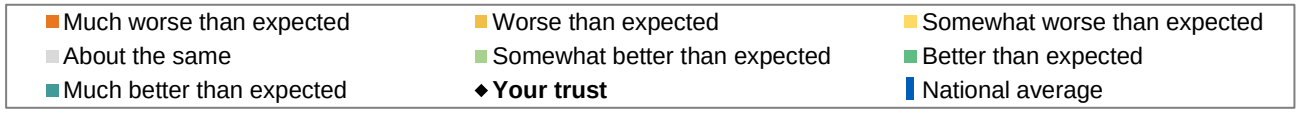
This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

Your trust section score = 4.9 About the same



Section 8. Support and wellbeing (continued)

Question scores

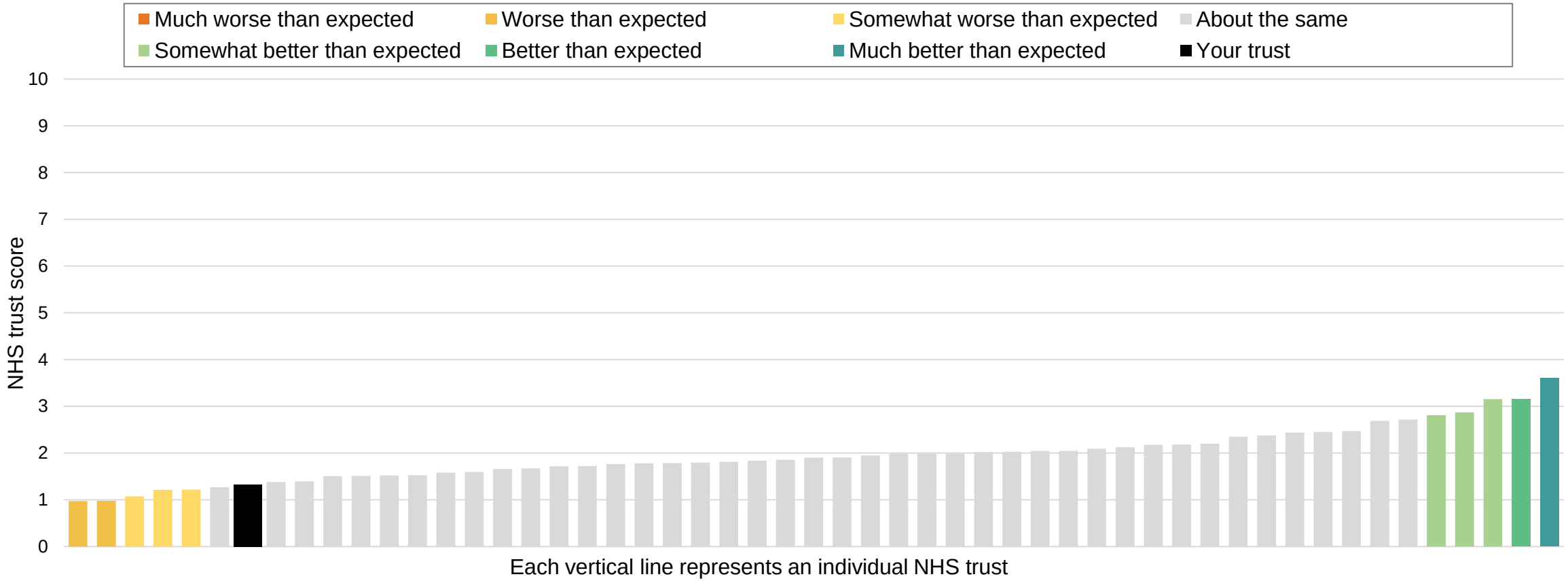


		All trusts in England				
		Number of respondents	Your trust	National average	Lowest score	Highest score
Q33. In the last 12 months, did NHS mental health services support you with your physical health needs (this might be an injury, a disability, or a condition such as diabetes, epilepsy, etc)?	About the same	152	4.8	4.7	3.3	6.8
Q34. In the last 12 months, did NHS mental health services give you any help or advice with finding support for financial advice or benefits?	About the same	147	3.8	3.8	2.7	5.3
Q35. In the last 12 months, did NHS mental health services give you any help or advice with finding support for finding or keeping work (paid or voluntary)?	About the same	62	4.4	3.9	2.6	5.7
Q36. Have NHS mental health services involved a member of your family or someone else close to you as much as you would like?	About the same	188	6.4	6.6	5.5	8.1

Section 9. Feedback

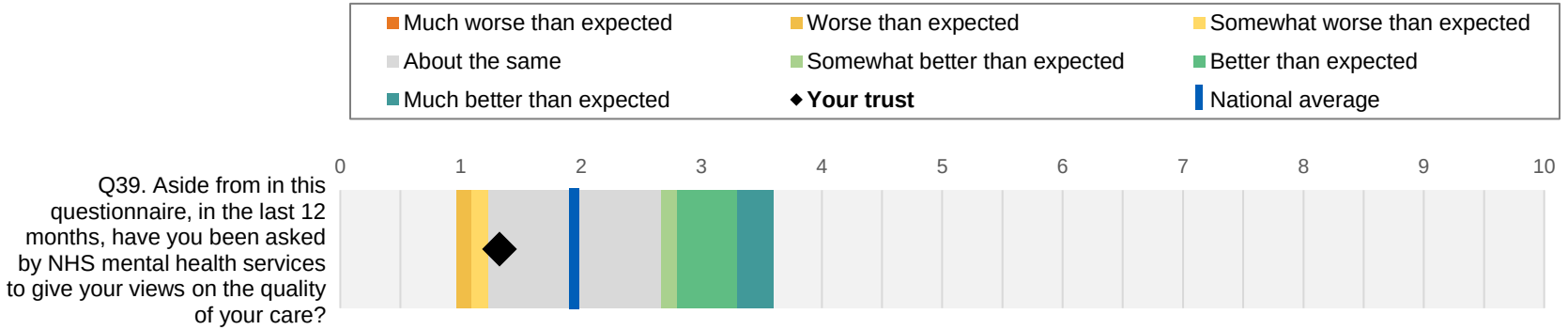
This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

Your trust section score = 1.3 About the same



Section 9. Feedback (continued)

Question scores

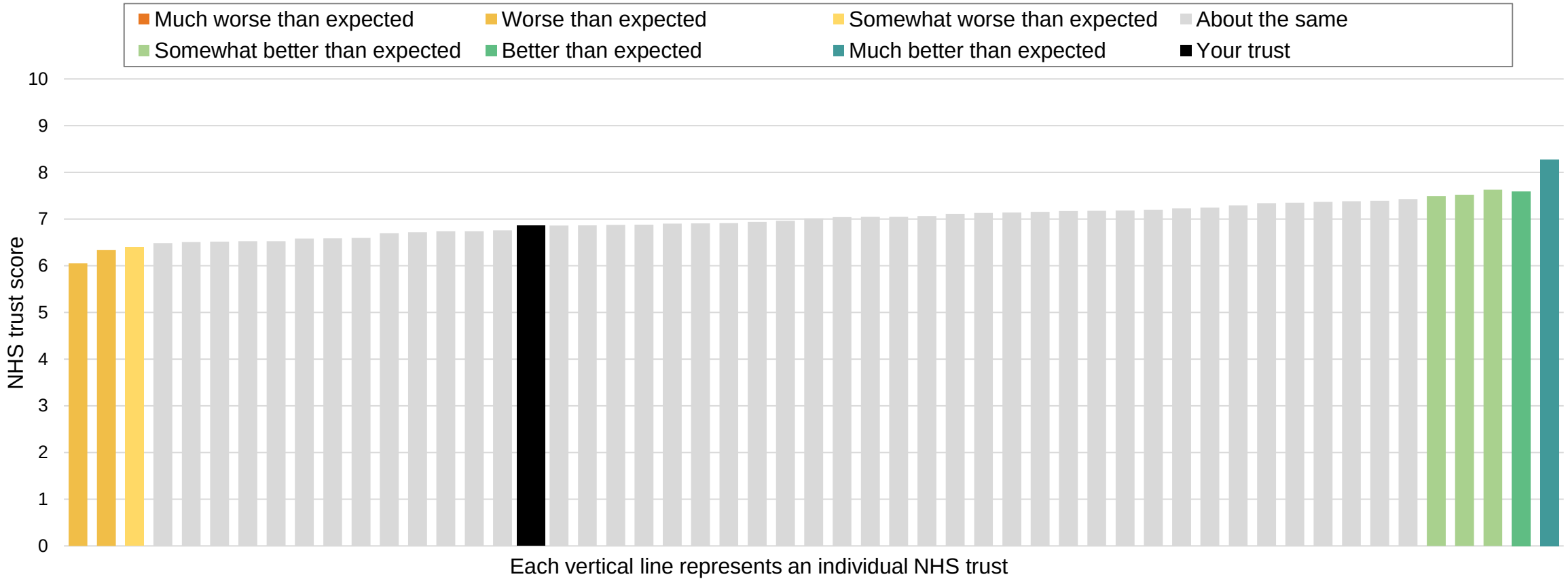


	All trusts in England			
Number of respondents	Your trust	National average	Lowest score	Highest score
234	1.3	1.9	1.0	3.6

Section 10. Overall views of care and services

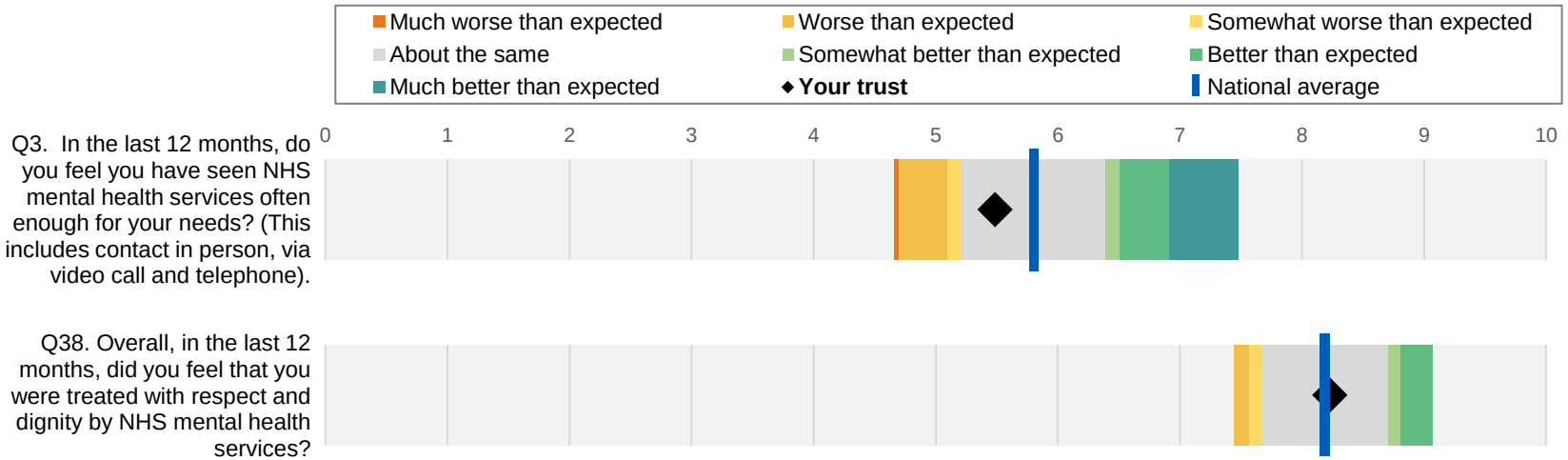
This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

Your trust section score = 6.9 About the same



Section 10. Overall views of care and services (continued)

Question scores



		All trusts in England			
	Number of respondents	Your trust	National average	Lowest score	Highest score
Q3. In the last 12 months, do you feel you have seen NHS mental health services often enough for your needs? (This includes contact in person, via video call and telephone).	265	5.5	5.8	4.7	7.5
Q38. Overall, in the last 12 months, did you feel that you were treated with respect and dignity by NHS mental health services?	270	8.2	8.2	7.4	9.1

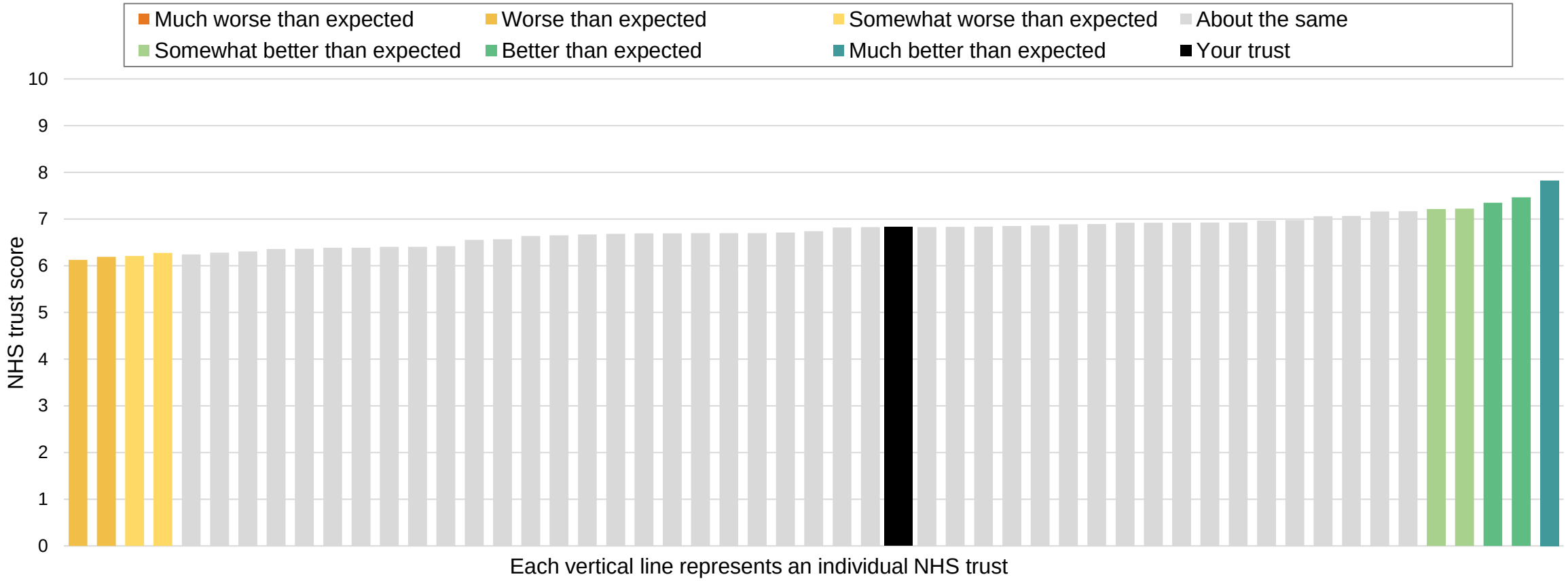
About the same

About the same

Section 11. Overall experience

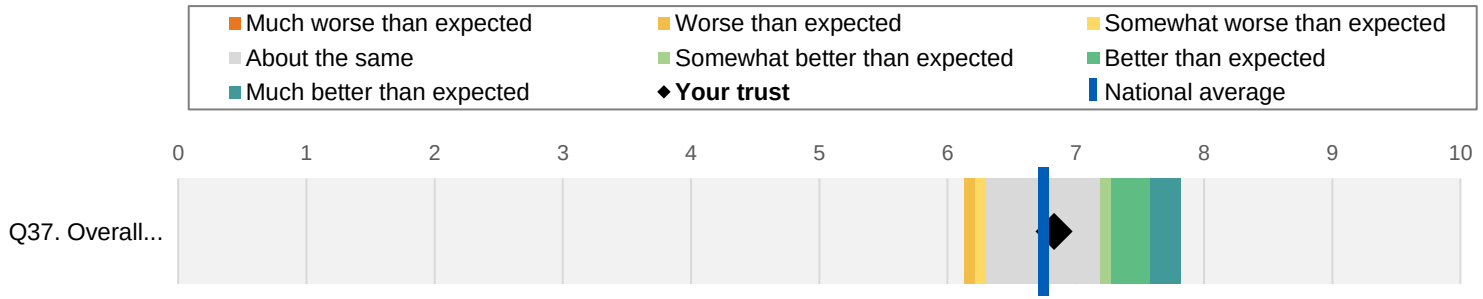
This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

Your trust section score = 6.8 About the same



Section 11. Overall experience (continued)

Question scores



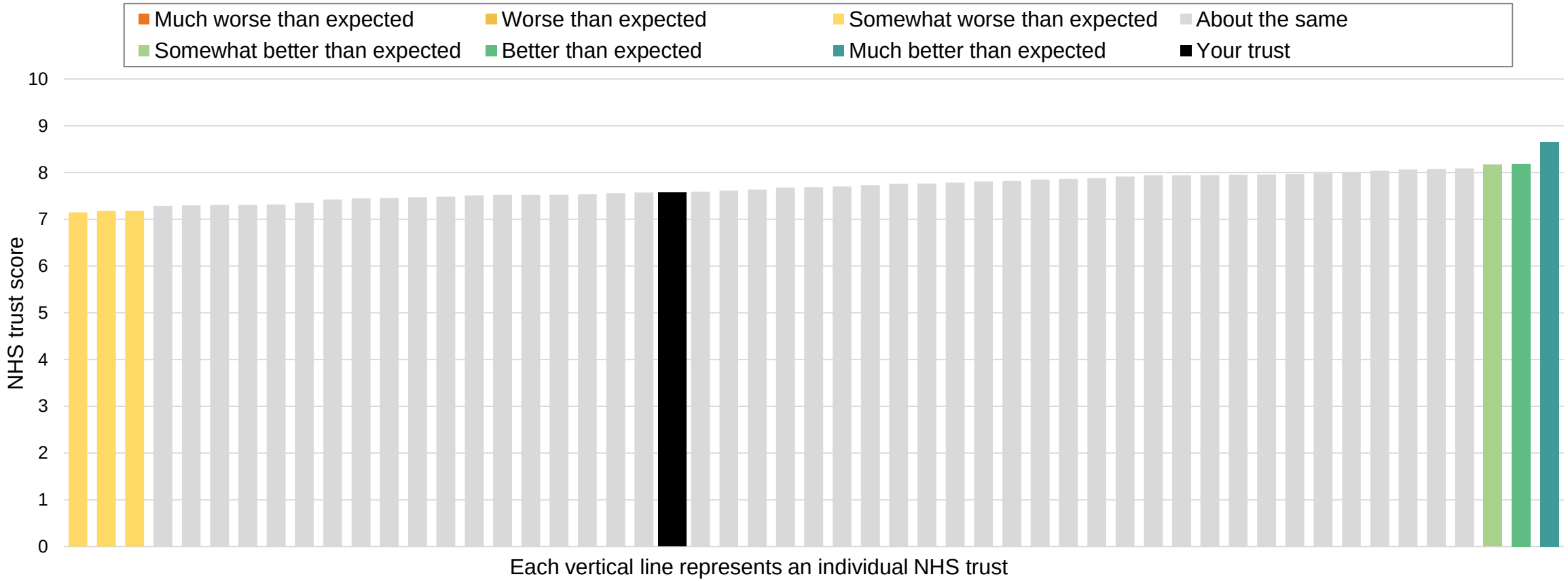
About the same

		All trusts in England		
Number of respondents	Your trust	National average	Lowest score	Highest score
255	6.8	6.7	6.1	7.8

Section 12. Responsive care

This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

Your trust section score = 7.6 About the same



Section 12. Responsive care

Question scores

		All trusts in England				
	Number of respondents	Your trust	National average	Lowest score	Highest score	
Q4. In the last 12 months, have you and someone from NHS mental health services agreed how your care and treatment will be delivered? (i.e. in person, via video call or telephone).	274	7.2	7.2	6.2	8.6	About the same
Q6. Have you received your care and treatment in the way you agreed?	192	8.0	8.2	7.4	8.8	About the same

Change over time

This section includes:

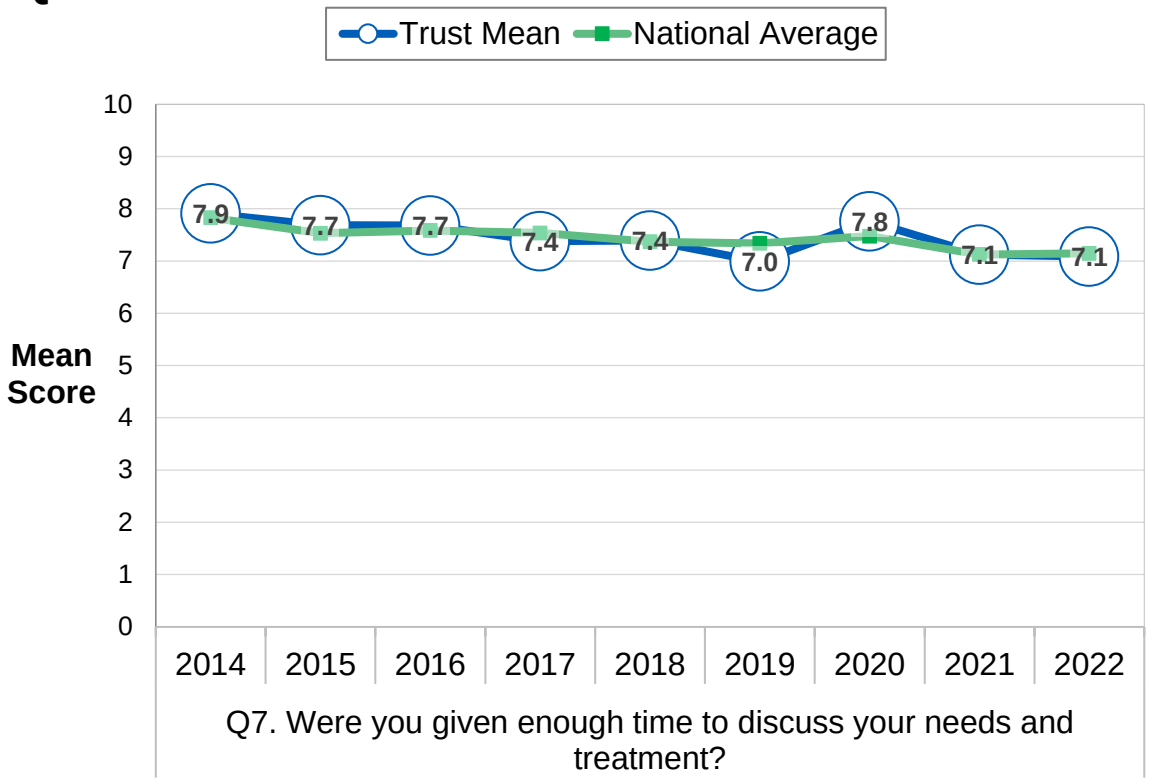
- a comparison to previous survey years scores for your trust for each question, including:
  - your trust's 2022 score compared with its scores from 2014 to 2021.

Please note;

- Section 3 planning care, appears missing from the change over time section as the questions that comprise the section score are non comparable to previous survey years and therefore do not display trends.
- If data is missing for a survey year, this is due to a low number of responses, or because the trust data was not included in the survey that year, due to sampling errors or ineligibility.

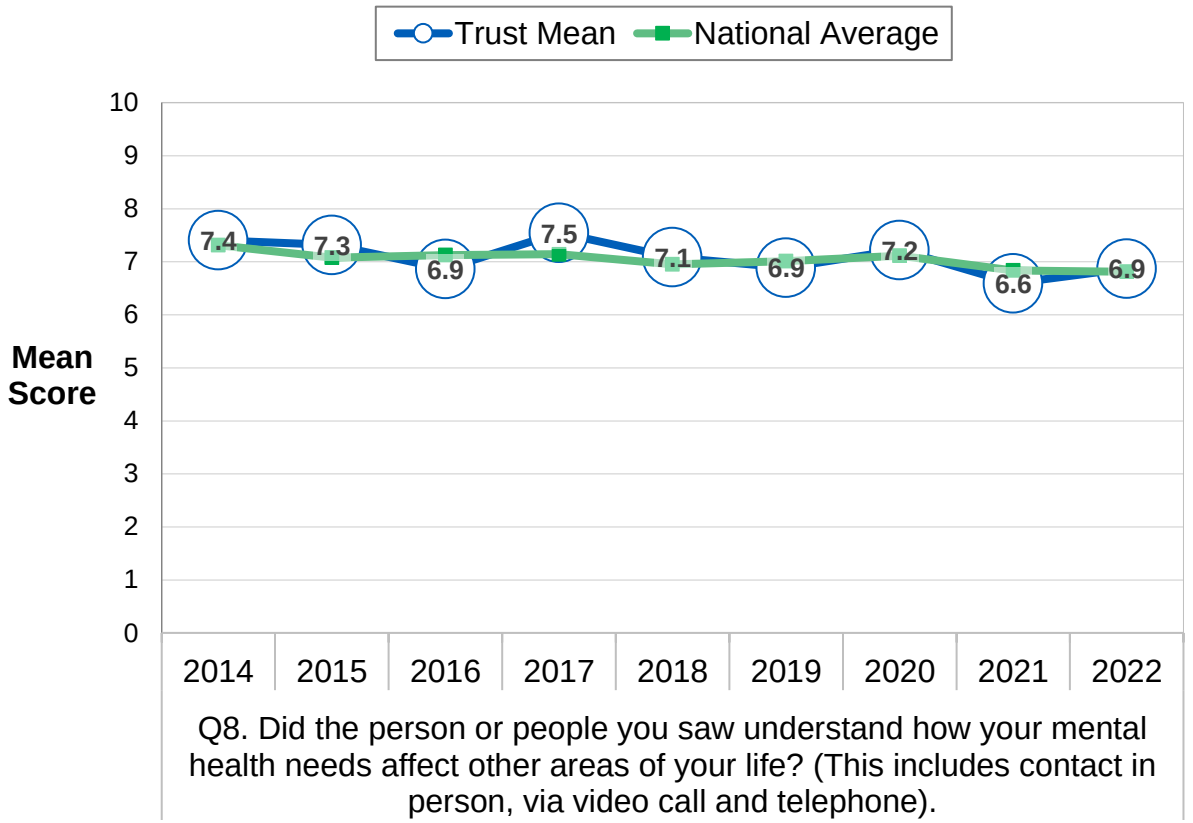
Section 1. Health and social care workers

Question scores



Significant change 2022 vs 2021	No change

Answered by all. Respondents who stated that they didn't know / couldn't remember have been excluded.
Number of respondents: 2014: 269; 2015: 235; 2016: 223; 2017: 205; 2018: 253; 2019: 267; 2020: 378; 2021: 337; 2022: 268

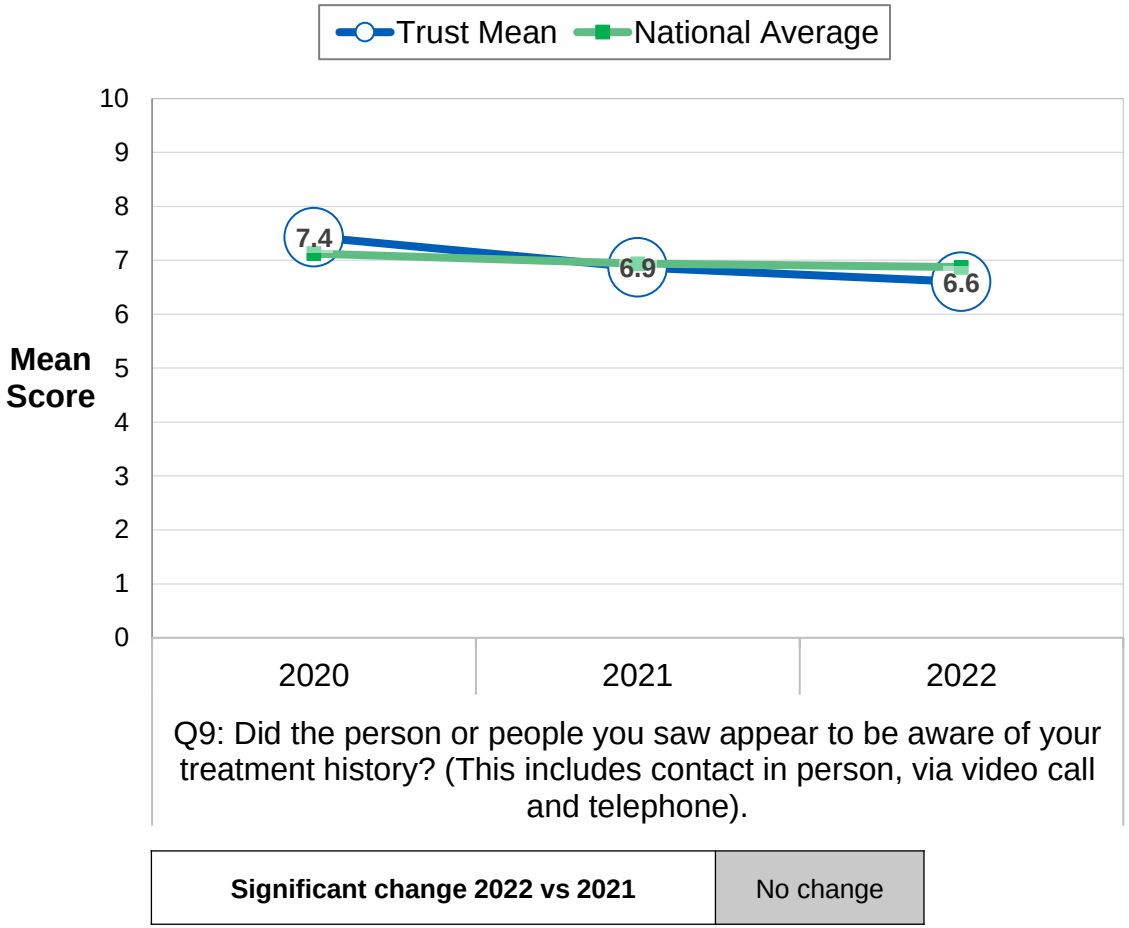


Significant change 2022 vs 2021	No change

Answered by all. Respondents who stated that they didn't know / couldn't remember have been excluded.
Number of respondents: 2014: 266; 2015: 231; 2016: 214; 2017: 199; 2018: 248; 2019: 260; 2020: 374; 2021: 332; 2022: 260

Section 1. Health and social care workers

Question scores

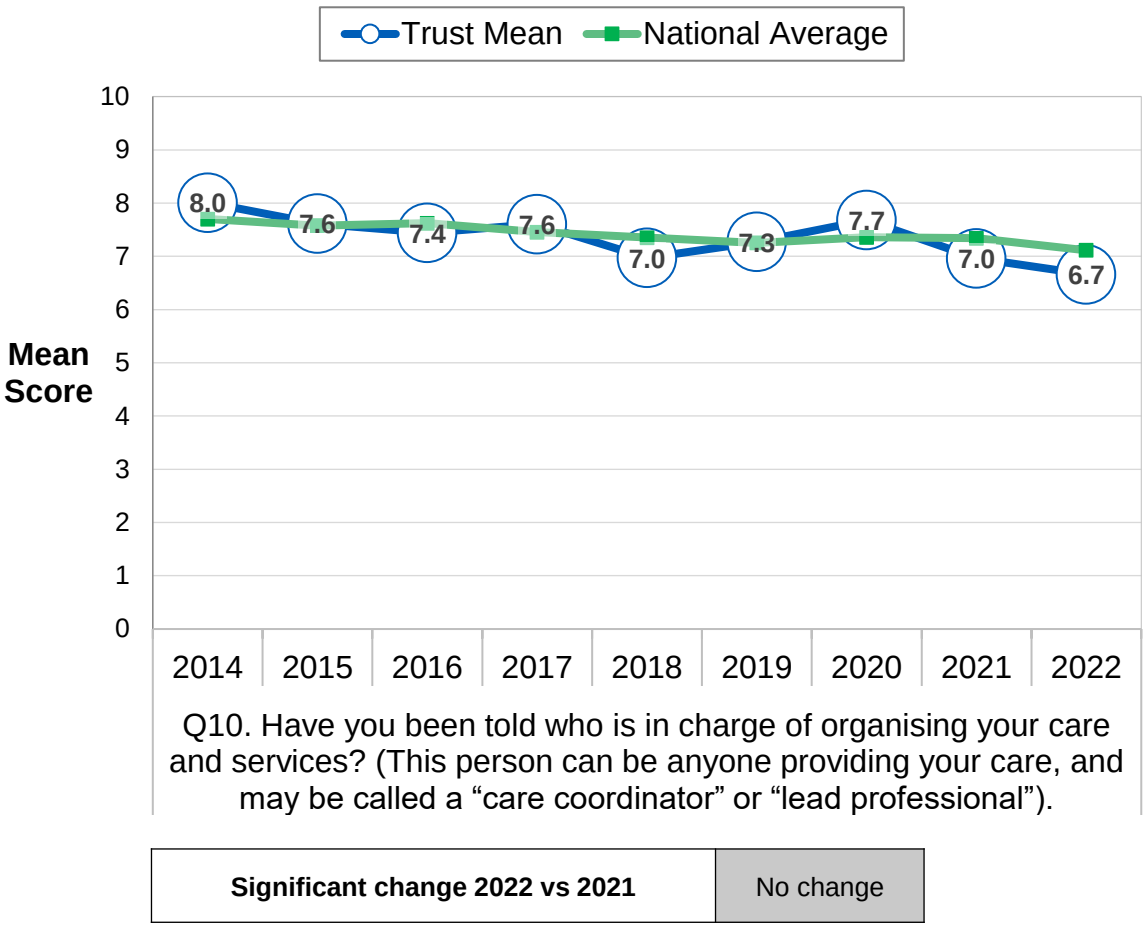


Significant change 2022 vs 2021	No change

Answered by all. Respondents who stated that they didn't know / couldn't remember or that they had no treatment prior to this have been excluded.
Number of respondents: 2020: 356; 2021: 326; 2022: 253

Section 2. Organising care

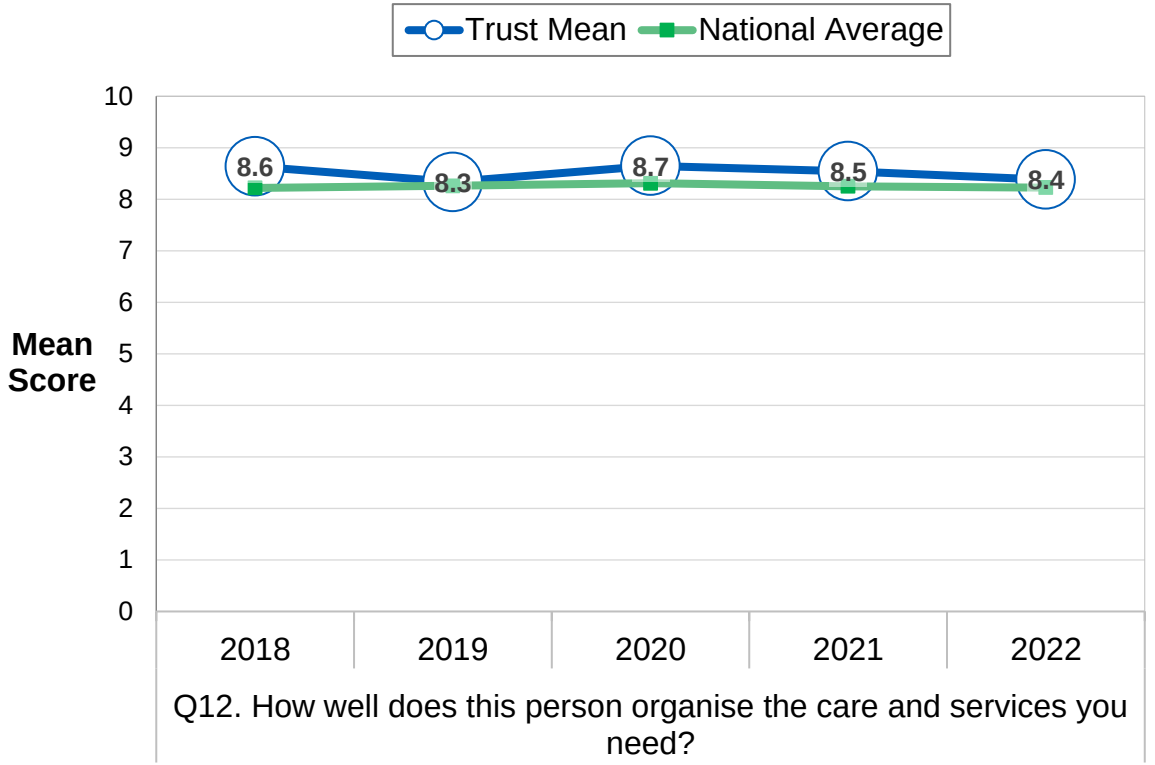
Question scores



Q10. Have you been told who is in charge of organising your care and services? (This person can be anyone providing your care, and may be called a “care coordinator” or “lead professional”).

Significant change 2022 vs 2021	No change

Answered by all. Respondents who stated that they weren’t sure have been excluded.
Number of respondents: 2014: 233; 2015: 216; 2016: 191; 2017: 170; 2018: 200; 2019: 232; 2020: 302; 2021: 281; 2022: 230



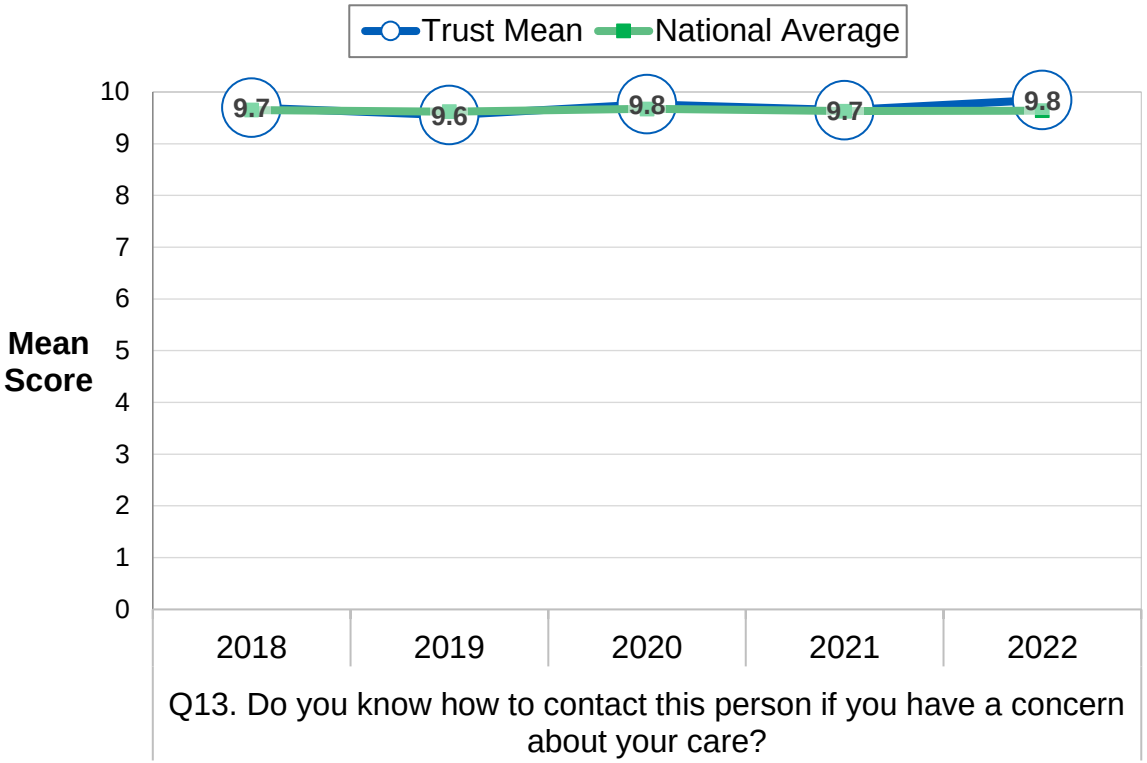
Q12. How well does this person organise the care and services you need?

Significant change 2022 vs 2021	No change

Answered by those who have been told who is in charge of organising their care and services, and the person in charge is not a GP.
Number of respondents: 2018: 114; 2019: 133; 2020: 181; 2021: 148; 2022: 130

Section 2. Organising care

Question scores

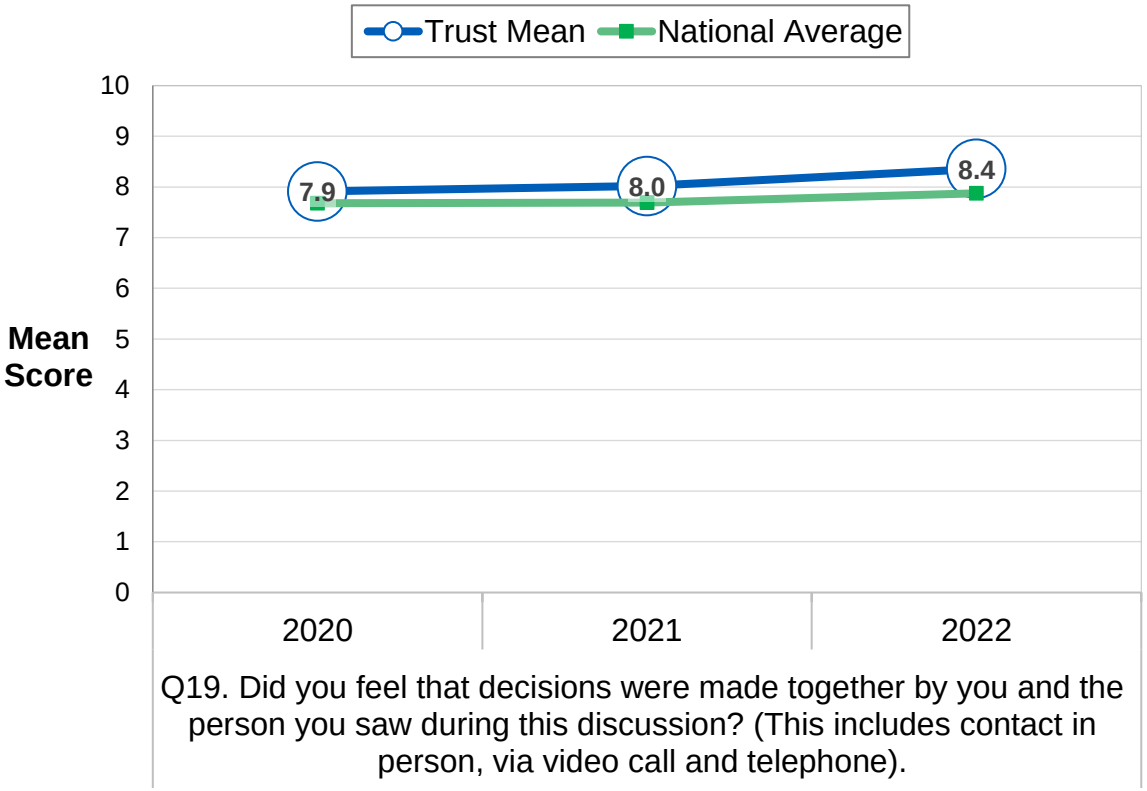


Significant change 2022 vs 2021	No change

Answered by those who have been told who is in charge of organising their care and services, and the person in charge is not a GP. Respondents who stated that they weren't sure have been excluded.
Number of respondents: 2018: 110; 2019: 130; 2020: 176; 2021: 143; 2022: 125

Section 4. Reviewing care

Question scores

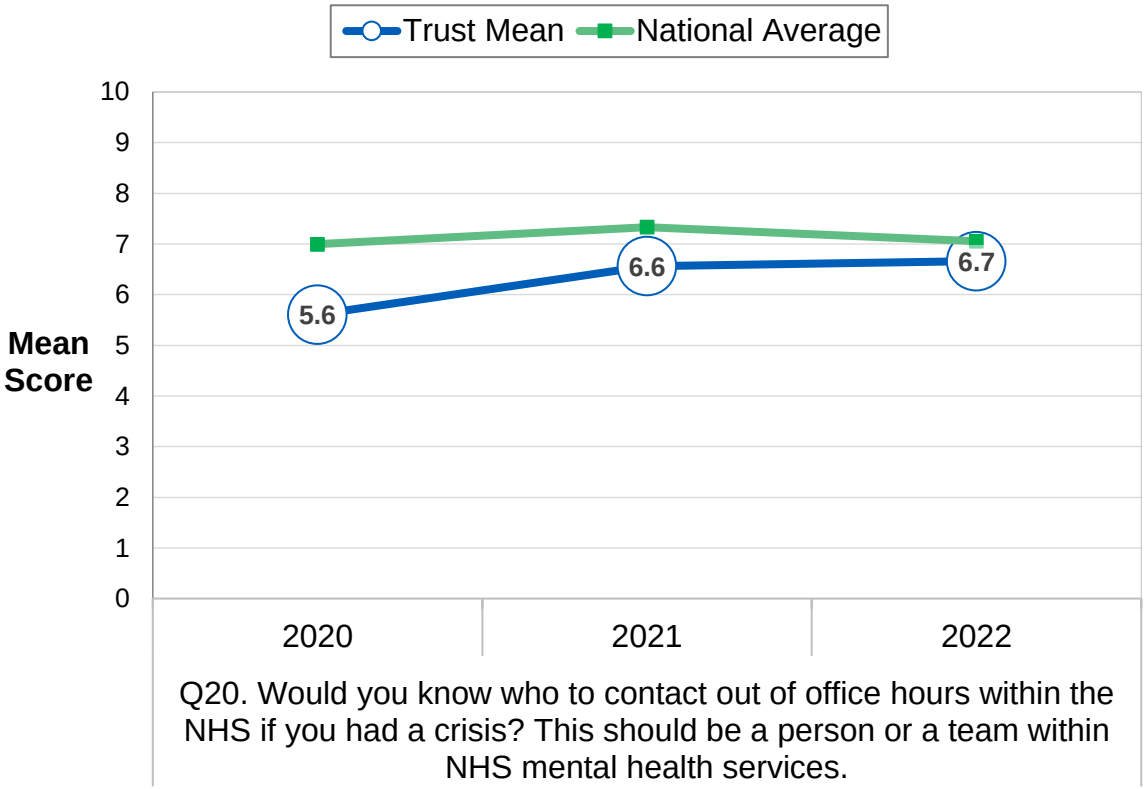


Significant change 2022 vs 2021	No change

Answered by those who felt that decisions were made together with the person they saw during this discussion. Respondents who stated that they didn't know / couldn't remember or did not want to be involved in making decisions have been excluded.
Number of respondents: 2020: 235; 2021: 164; 2022: 119

Section 5. Crisis Care

Question scores

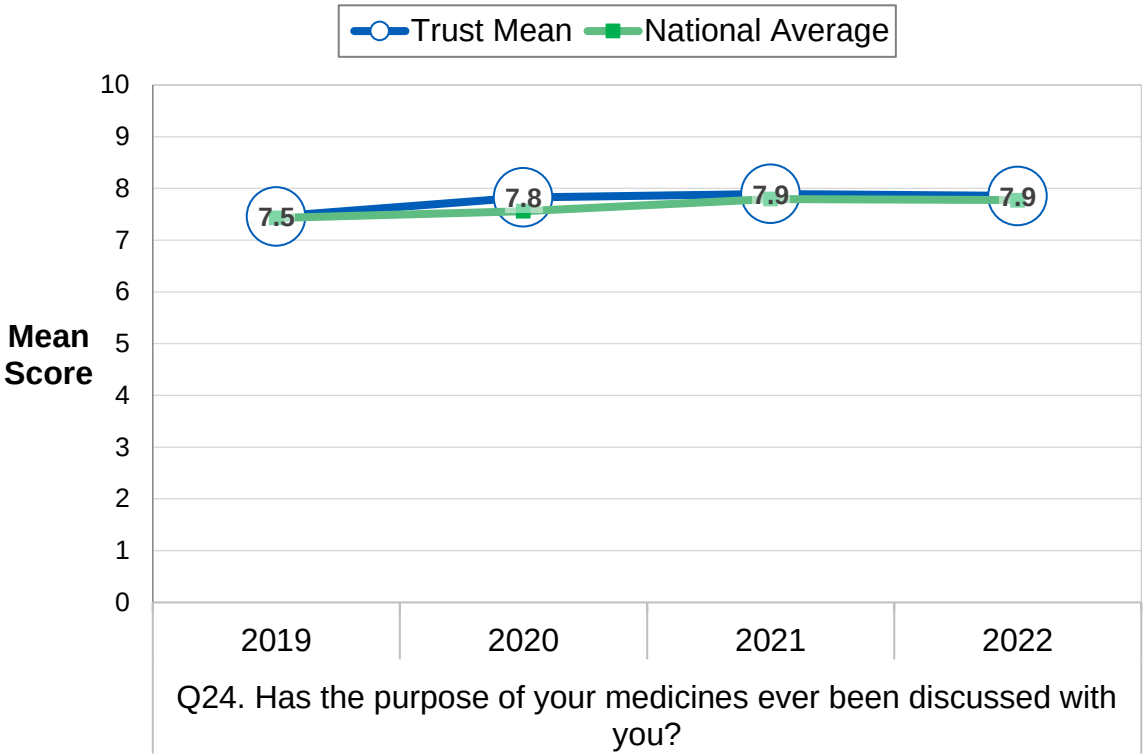


Significant change 2022 vs 2021	No change

Answered by all. Respondents who stated that they weren't sure have been excluded.
Number of respondents: 2020: 314; 2021: 302; 2022: 242

Section 6. Medicines

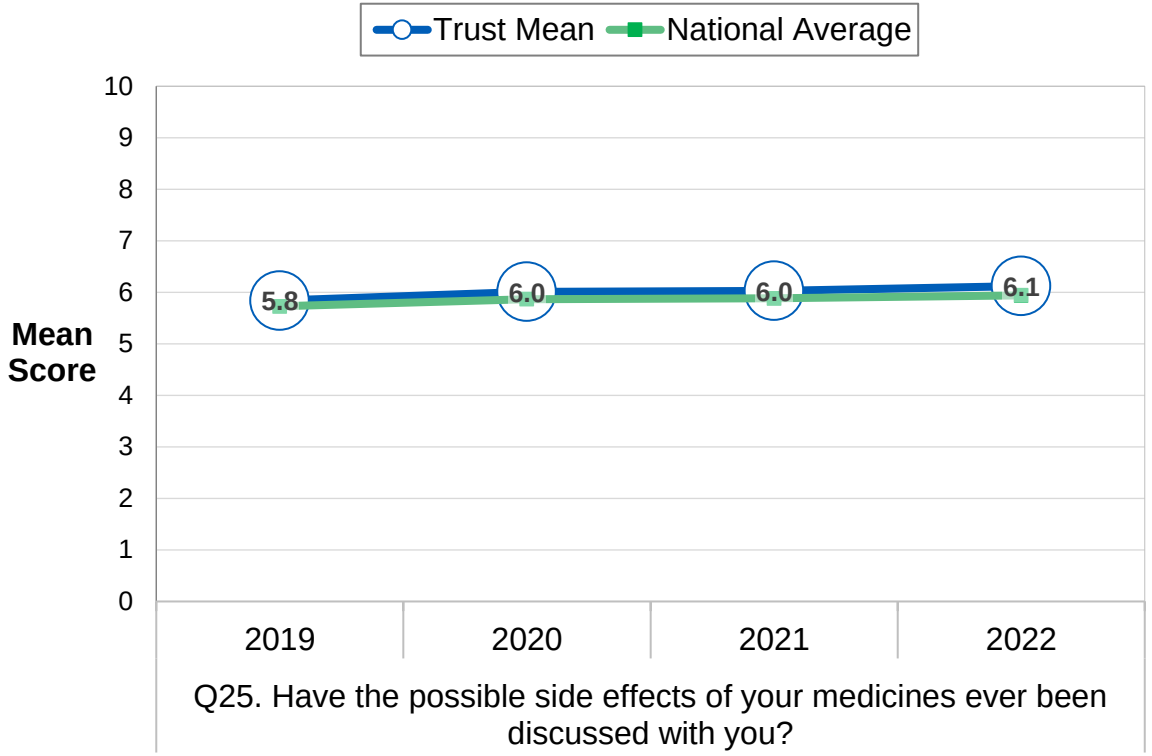
Question scores



Q24. Has the purpose of your medicines ever been discussed with you?

Significant change 2022 vs 2021	No change

Answered by those who have been receiving any medicines in the last 12 months for their mental health needs. Respondents who stated that they didn't know / couldn't remember have been excluded.
Number of respondents: 2019: 234; 2020: 309; 2021: 294; 2022: 222



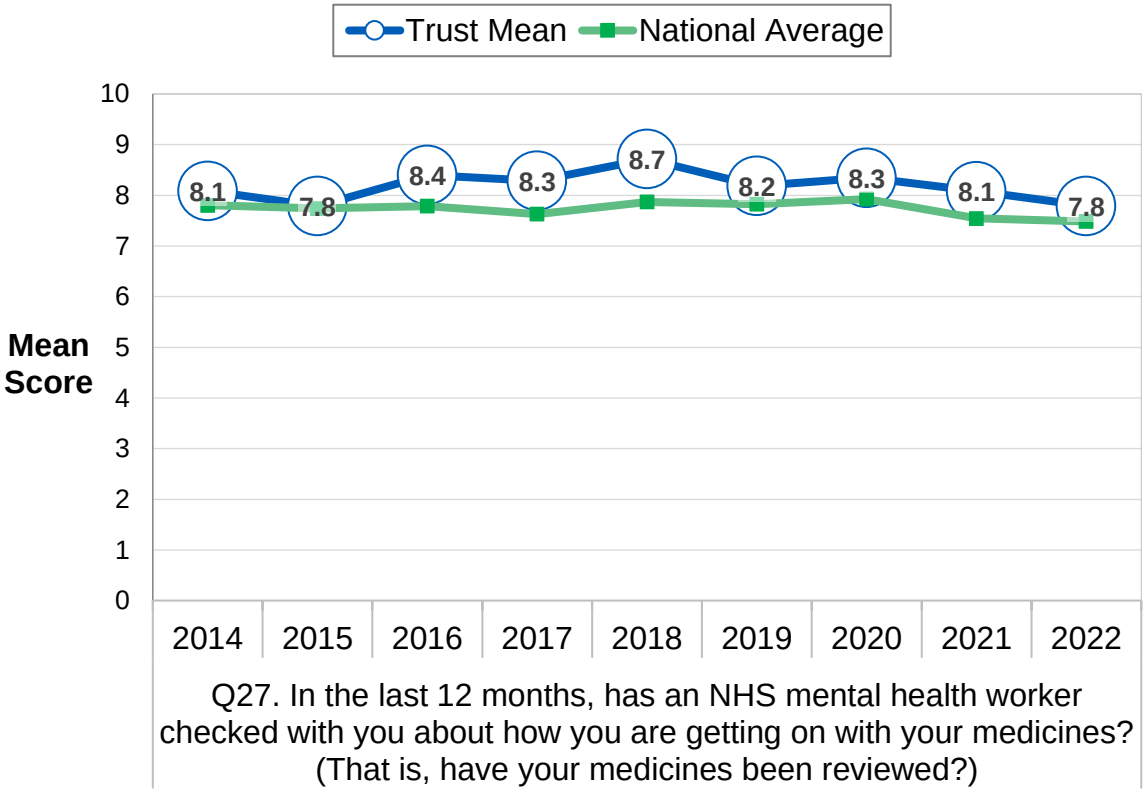
Q25. Have the possible side effects of your medicines ever been discussed with you?

Significant change 2022 vs 2021	No change

Answered by those who have been receiving any medicines in the last 12 months for their mental health needs. Respondents who stated that they didn't know / couldn't remember have been excluded.
Number of respondents: 2019: 236; 2020: 304; 2021: 291; 2022: 213

Section 6. Medicines

Question scores

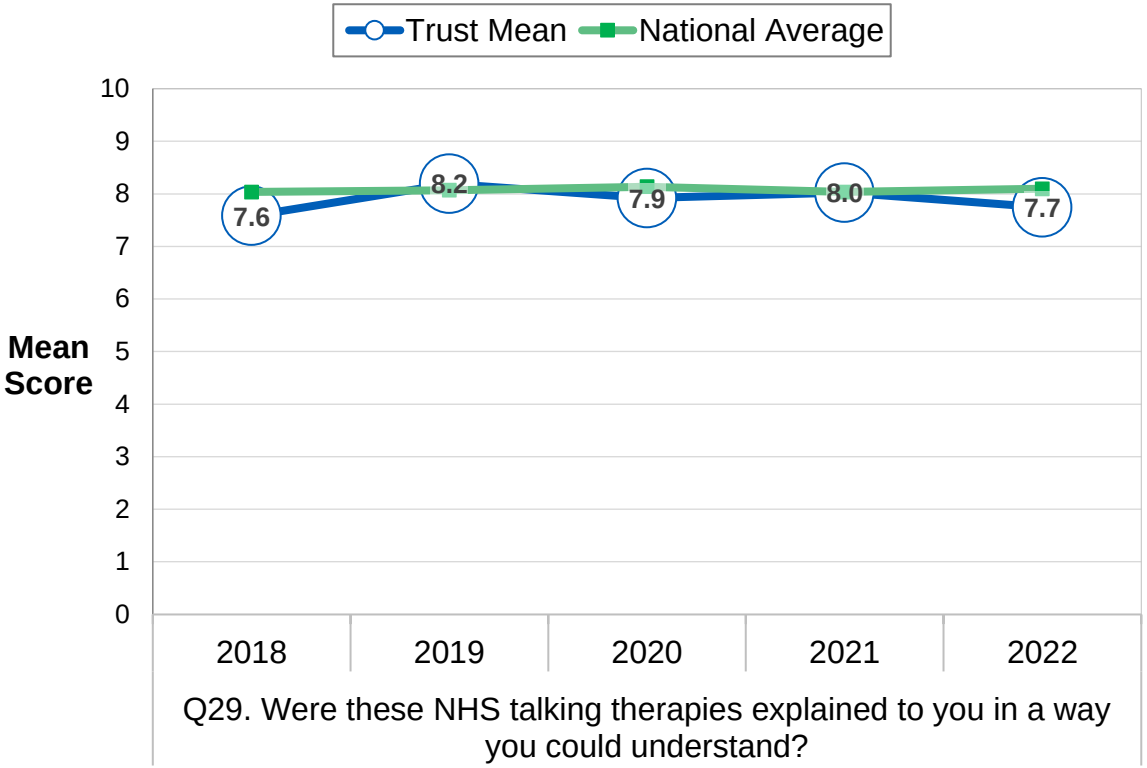


Significant change 2022 vs 2021	No change

Answered by those who have been receiving any medicines for 12 months or longer for their mental health needs. Respondents who stated that they didn't know / couldn't remember have been excluded. Number of respondents: 2014: 204; 2015: 180; 2016: 161; 2017: 141; 2018: 157; 2019: 191; 2020: 257; 2021: 240; 2022: 174

Section 7. NHS Talking Therapies

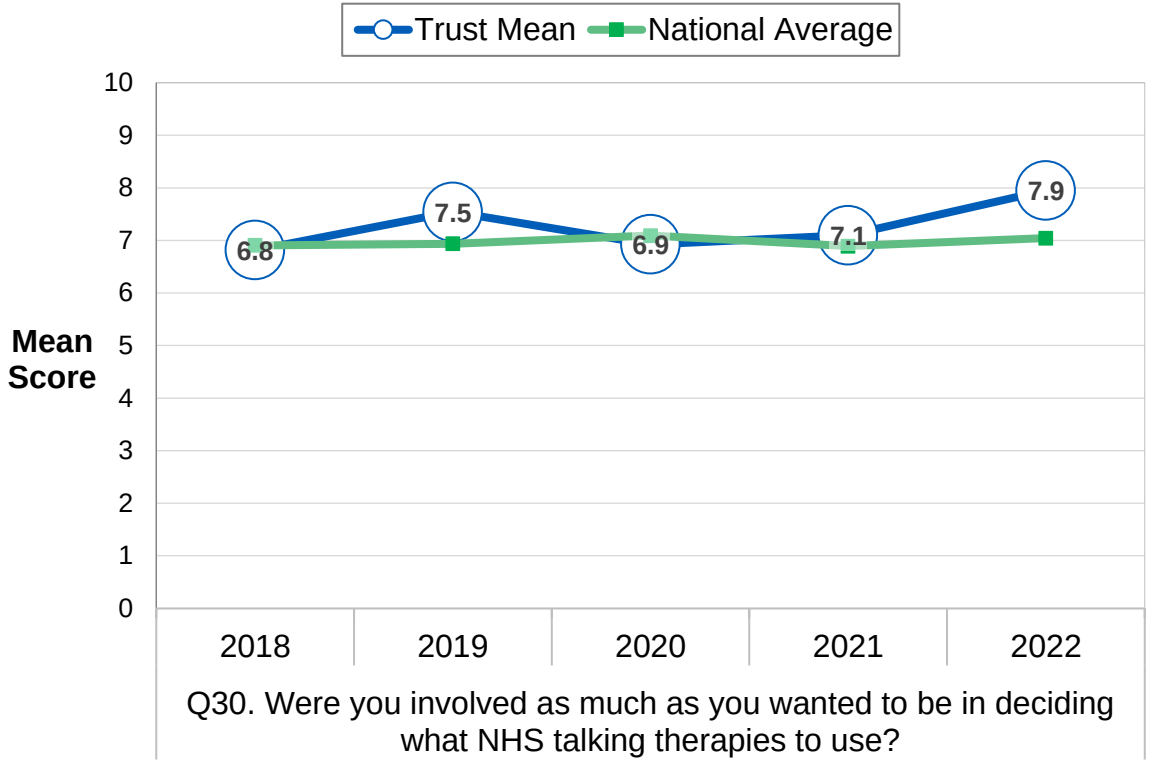
Question scores



Q29. Were these NHS talking therapies explained to you in a way you could understand?

Significant change 2022 vs 2021	No change

Answered by those who have received any NHS talking therapies in the last 12 months for their mental health needs. Respondents who stated that no explanation was needed have been excluded.
Number of respondents: 2018: 86; 2019: 89; 2020: 119; 2021: 84; 2022: 75



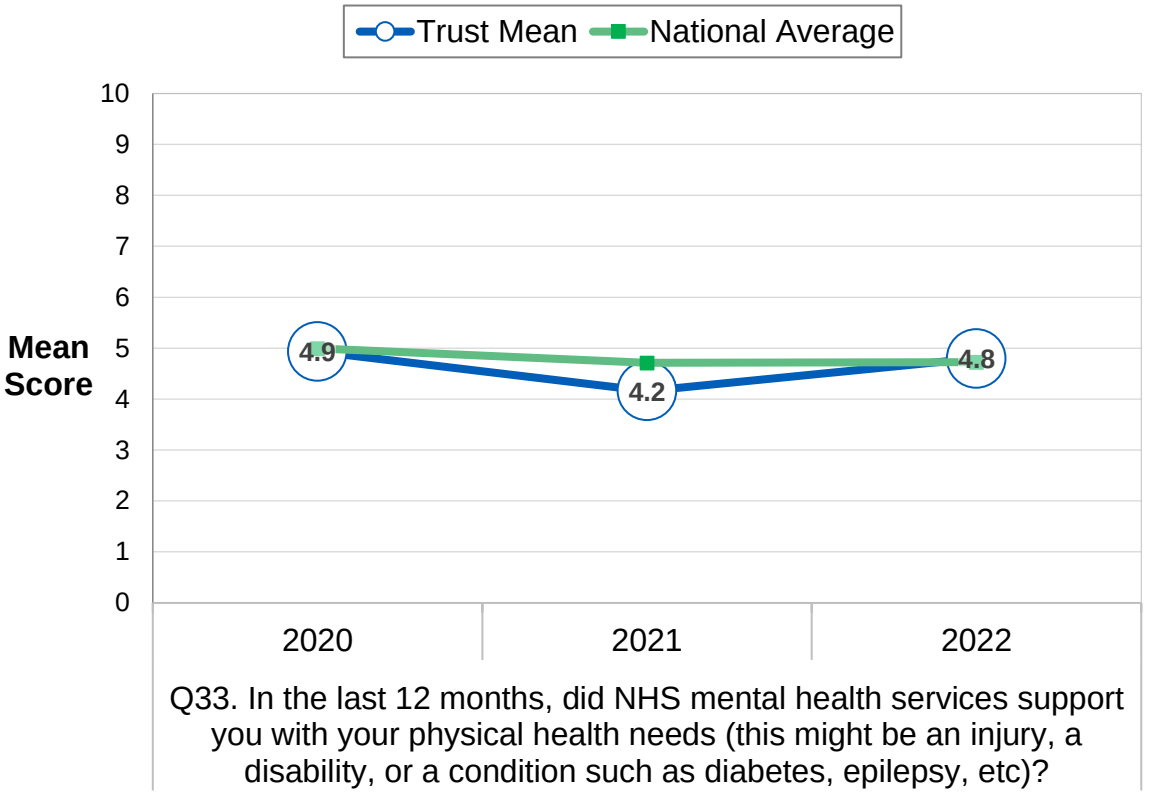
Q30. Were you involved as much as you wanted to be in deciding what NHS talking therapies to use?

Significant change 2022 vs 2021	No change

Answered by those who have received any NHS talking therapies in the last 12 months for their mental health needs. Respondents who stated that they didn't know / couldn't remember or did not want to be involved have been excluded.
Number of respondents: 2018: 83; 2019: 84; 2020: 110; 2021: 81; 2022: 67

Section 8. Support and wellbeing

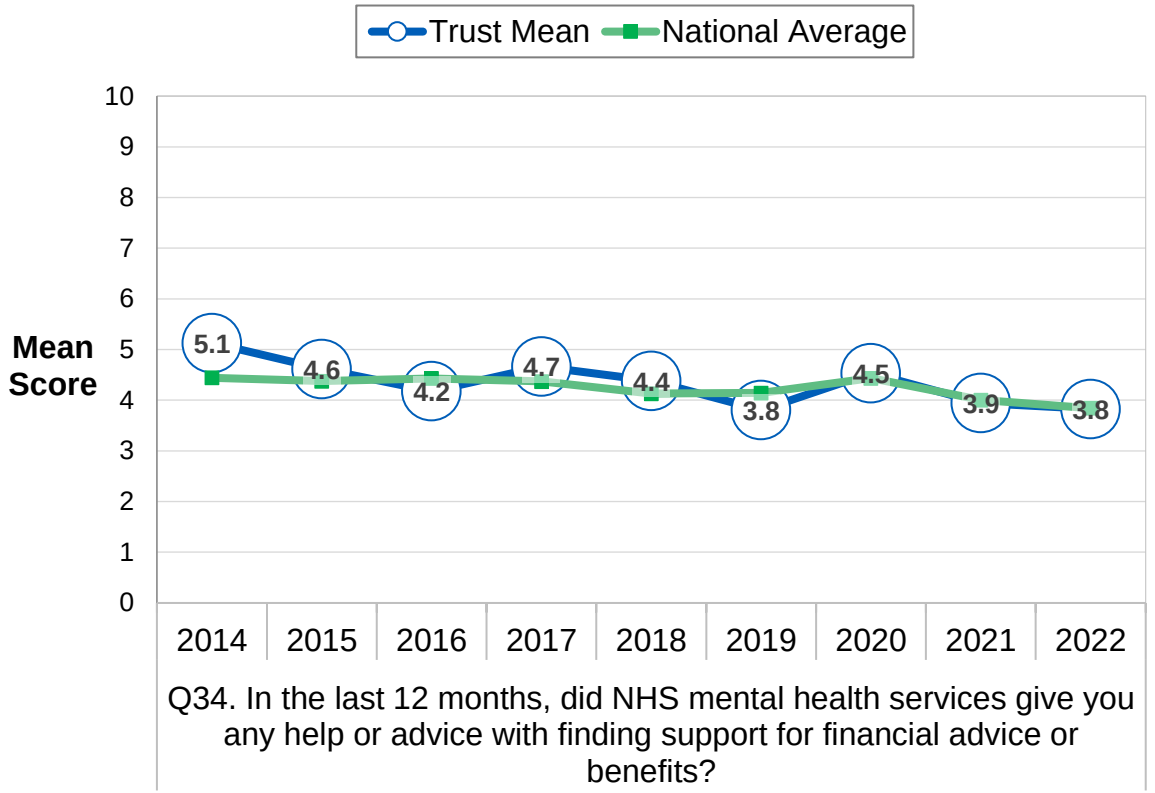
Question scores



Q33. In the last 12 months, did NHS mental health services support you with your physical health needs (this might be an injury, a disability, or a condition such as diabetes, epilepsy, etc)?

Significant change 2022 vs 2021	No change

Answered by all. Respondents who stated that they have support and did not need NHS mental health services to provide it, do not need support for this, or do not have physical health needs have been excluded. Number of respondents: 2020: 199; 2021: 170; 2022: 152



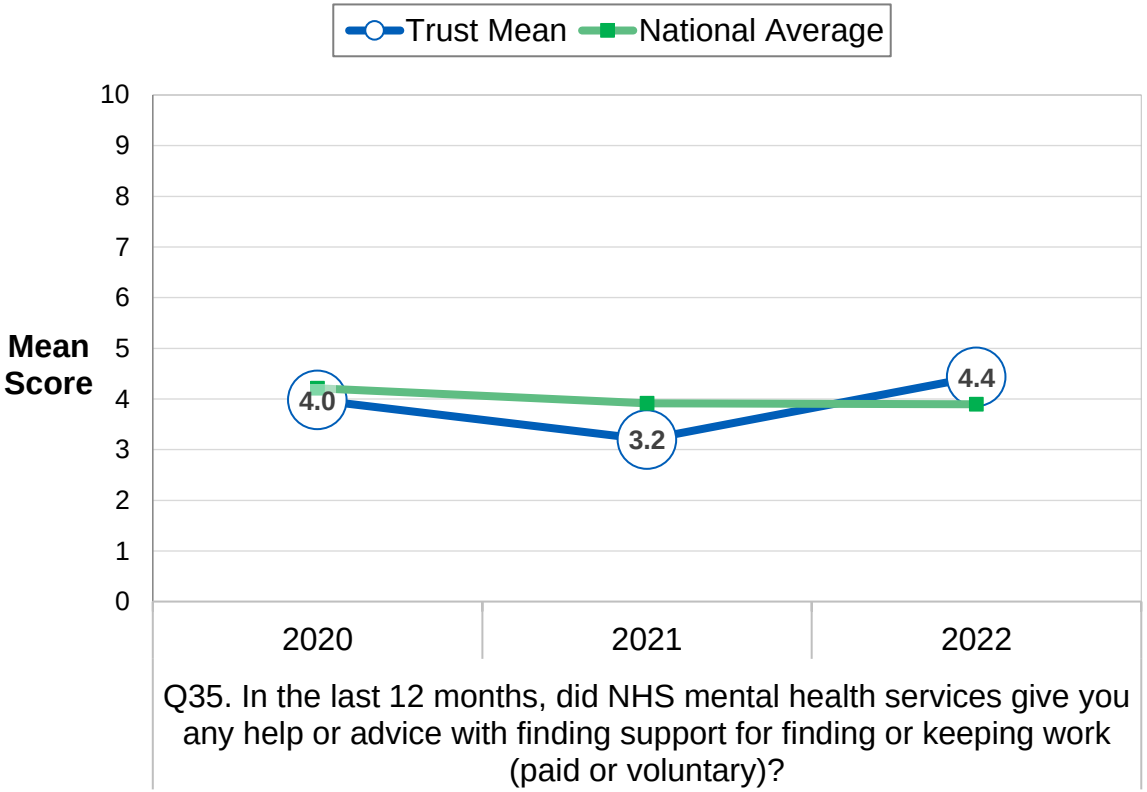
Q34. In the last 12 months, did NHS mental health services give you any help or advice with finding support for financial advice or benefits?

Significant change 2022 vs 2021	No change

Answered by all. Respondents who stated that they have support and did not need help / advice to find it, or do not need support for this have been excluded.
Number of respondents: 2014: 157; 2015: 142; 2016: 129; 2017: 115; 2018: 157; 2019: 165; 2020: 212; 2021: 171; 2022: 147

Section 8. Support and wellbeing

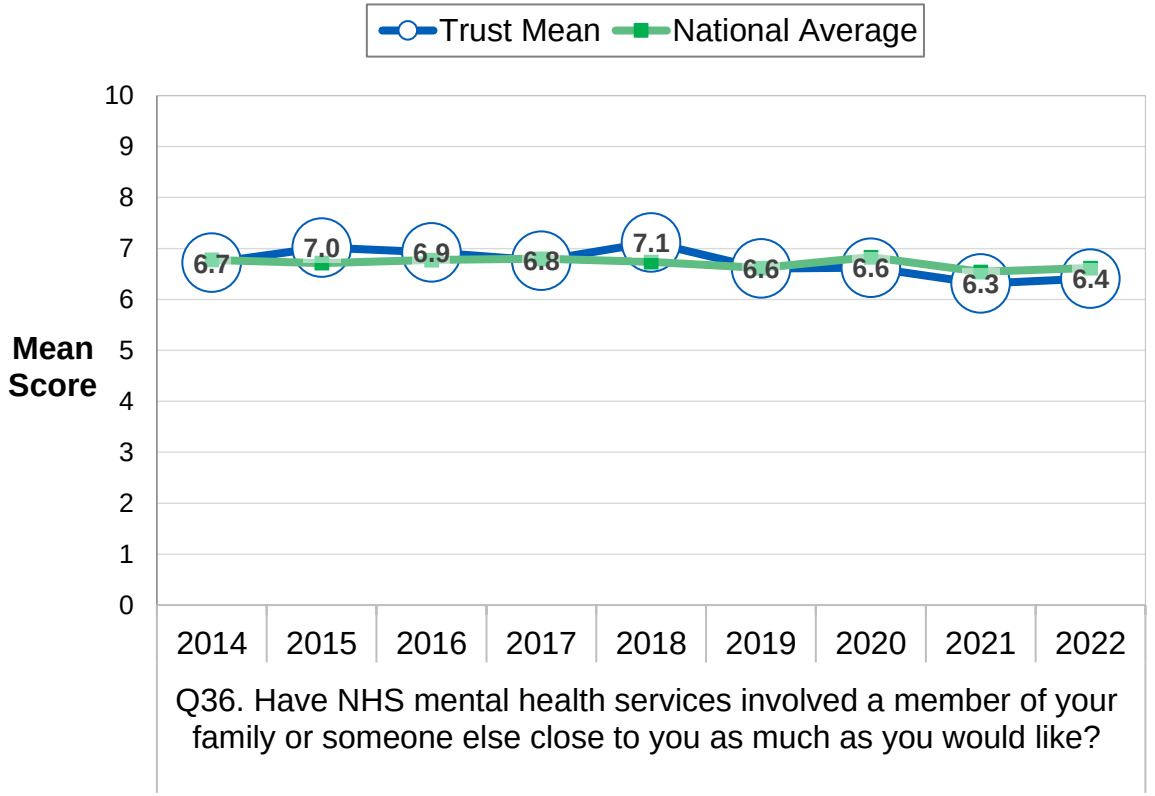
Question scores



Q35. In the last 12 months, did NHS mental health services give you any help or advice with finding support for finding or keeping work (paid or voluntary)?

Significant change 2022 vs 2021	No change

Answered by all. Respondents who stated that they have support and did not need help / advice to find it, do not need support for this, or are not currently in or seeking work have been excluded. Number of respondents: 2020: 79; 2021: 72; 2022: 62



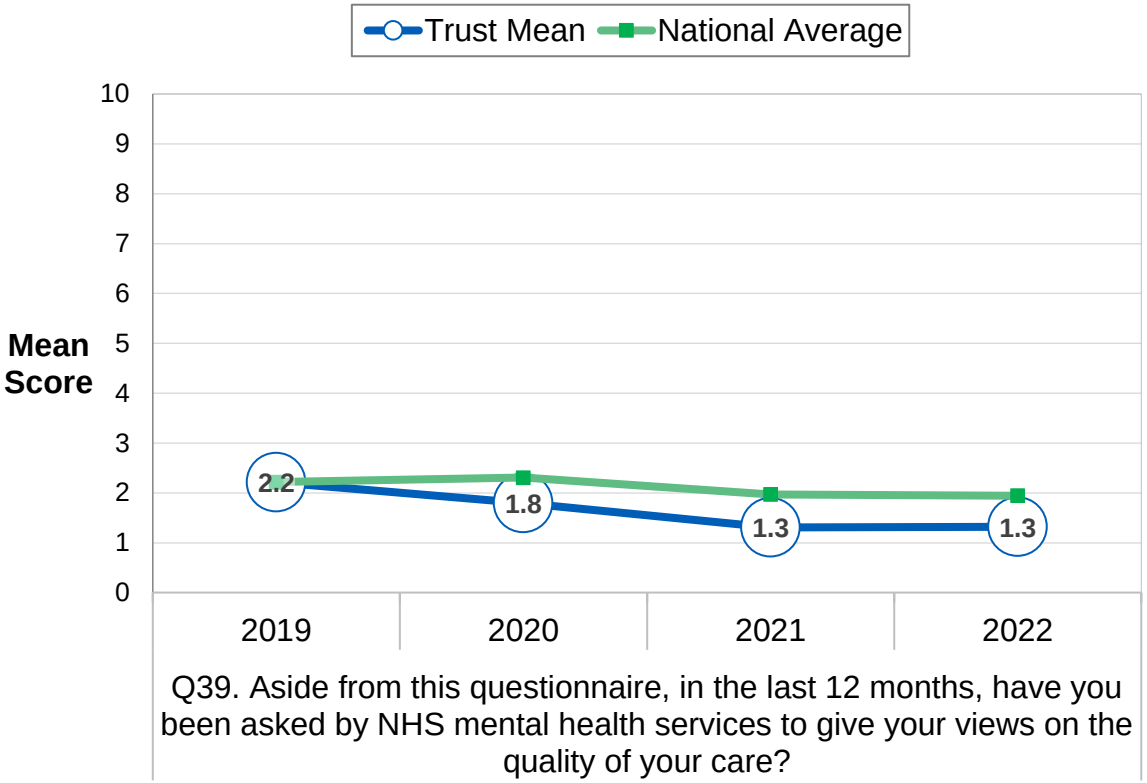
Q36. Have NHS mental health services involved a member of your family or someone else close to you as much as you would like?

Significant change 2022 vs 2021	No change

Answered by all. Respondents who stated that their friends or family did not want to be involved, did not want their friends or family to be involved, or that this does not apply to them have been excluded. Number of respondents: 2014: 187; 2015: 161; 2016: 158; 2017: 150; 2018: 179; 2019: 194; 2020: 255; 2021: 239; 2022: 188

Section 9. Feedback

Question scores

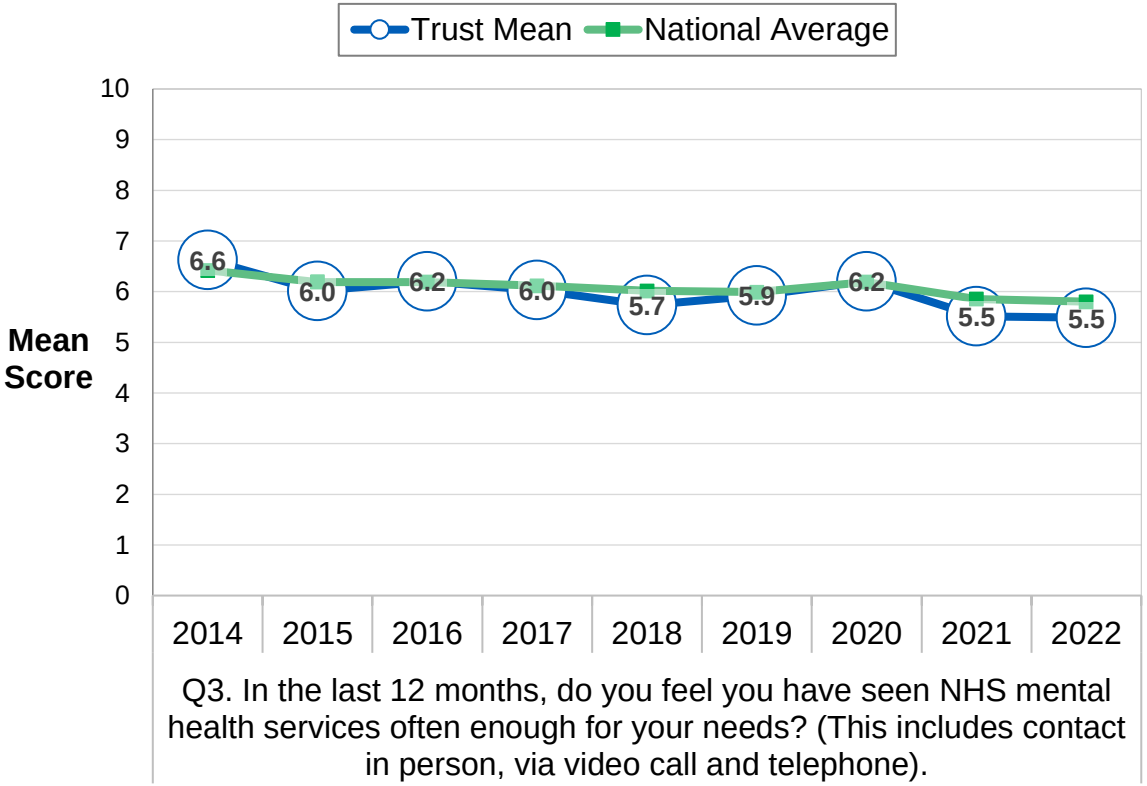


Significant change 2022 vs 2021	No change

Answered by all. Respondents who stated that they weren't sure have been excluded.
Number of respondents: 2019: 239; 2020: 329; 2021: 300; 2022: 234

Section 10. Overall views of care and services

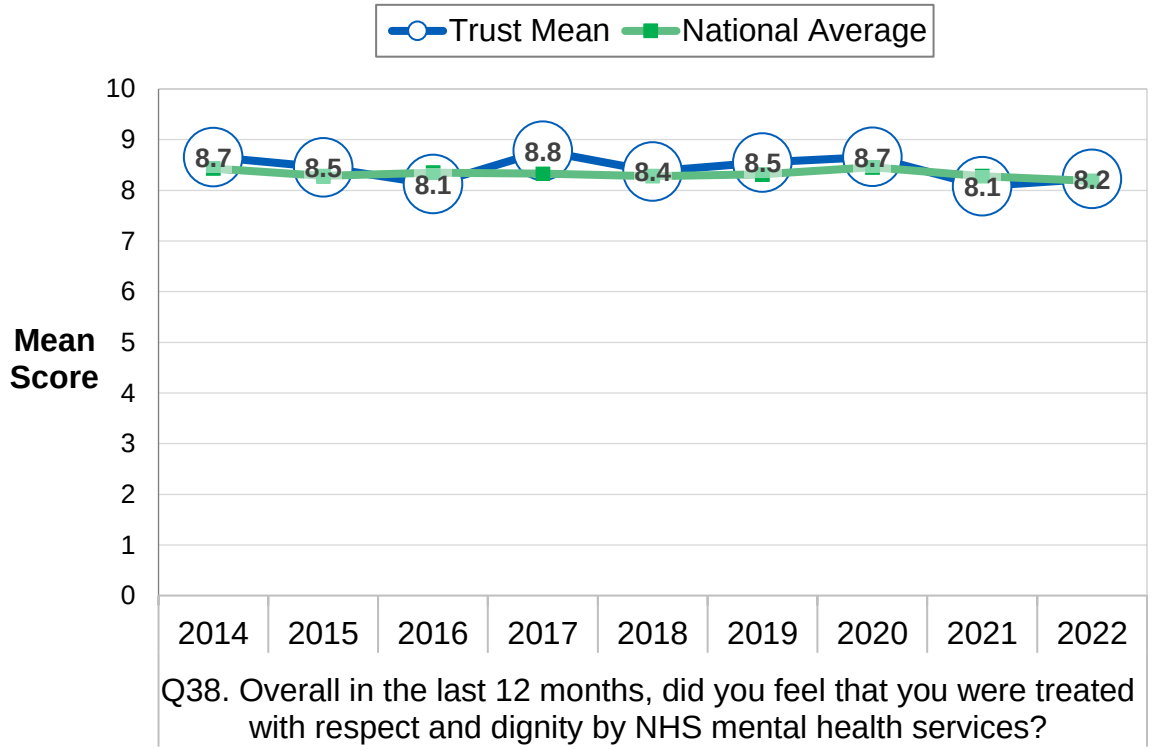
Question scores



Q3. In the last 12 months, do you feel you have seen NHS mental health services often enough for your needs? (This includes contact in person, via video call and telephone).

Significant change 2022 vs 2021	No change

Answered by all. Respondents who stated that they didn't know have been excluded.
Number of respondents: 2014: 271; 2015: 237; 2016: 221; 2017: 208; 2018: 255; 2019: 267; 2020: 381; 2021: 344; 2022: 265



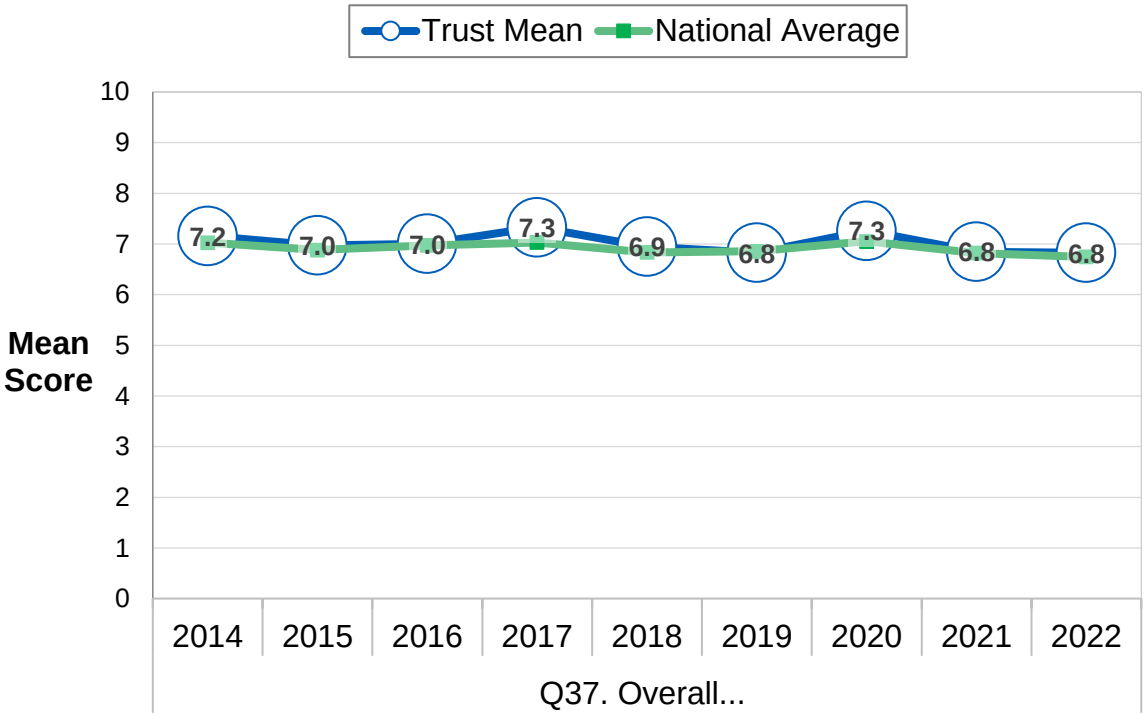
Q38. Overall in the last 12 months, did you feel that you were treated with respect and dignity by NHS mental health services?

Significant change 2022 vs 2021	No change

Answered by all.
Number of respondents: 2014: 267; 2015: 245; 2016: 225; 2017: 213; 2018: 262; 2019: 278; 2020: 385; 2021: 354; 2022: 270

Section 11. Overall…

Question scores



Significant change 2022 vs 2021	No change

Answered by all. Number of respondents: 2014: 251; 2015: 231; 2016: 223; 2017: 203; 2018: 247; 2019: 263; 2020: 361; 2021: 341; 2022: 255

Appendix

Comparison to other trusts: where your trust has performed much better

The questions at which your trust has performed much better when compared with all other trusts are listed below.
The questions where your trust has performed about the same compared with all other trusts have not been listed.

Much better than expected

- No questions for your trust fall within this banding.

Comparison to other trusts: where your trust has performed better

The questions at which your trust has performed better than compared with all other trusts are listed below.
The questions where your trust has performed about the same compared with all other trusts have not been listed.

Better than expected

- Q30. Were you involved as much as you wanted to be in deciding what NHS talking therapies to use?

Comparison to other trusts: where your trust has performed somewhat better

The questions at which your trust has performed somewhat better when compared with all other trusts are listed below.
The questions where your trust has performed about the same compared with all other trusts have not been listed.

Somewhat better than expected

- Q13. Do you know how to contact this person if you have a concern about your care?

Comparison to other trusts: where your trust has performed somewhat worse

The questions at which your trust has performed somewhat worse when compared with all other trusts are listed below.
The questions where your trust has performed about the same compared with all other trusts have not been listed.

Somewhat worse than expected

- No questions for your trust fall within this banding.

Comparison to other trusts: where your trust has performed worse

The questions at which your trust has performed worse compared with all other trusts are listed below.
The questions where your trust has performed about the same compared with all other trusts have not been listed.

Worse than expected

- No questions for your trust fall within this banding.

Comparison to other trusts: where your trust has performed much worse

The questions at which your trust has performed much worse when compared with all other trusts are listed below.
The questions where your trust has performed about the same compared with all other trusts have not been listed.

Much worse than expected

- No questions for your trust fall within this banding.

NHS Community Mental Health Survey

Results for Derbyshire Healthcare NHS Foundation Trust

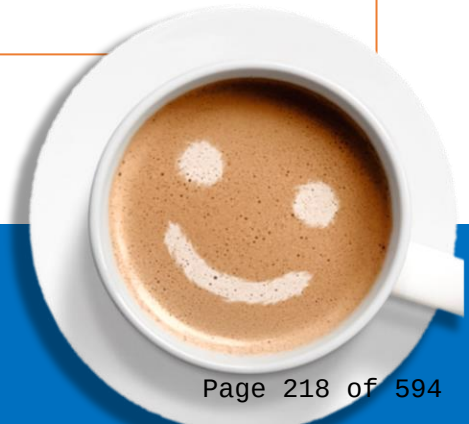
Where service user experience is best

- ✓ **NHS Talking Therapies:** service users being involved in deciding what NHS talking therapies to use
- ✓ **Support and well-being (Work):** service users being given help or advice with finding support for finding or keeping work
- ✓ **Involvement:** service users feeling that decisions were made together when reviewing care
- ✓ **Crisis care (care):** service users getting the help needed when they last contacted the crisis team
- ✓ **Medicines review:** NHS mental health services checking how service users are getting on with their medicines

Where service user experience could improve

- ○ **Views on quality of care:** NHS mental health services asking service users for their views on the quality of their care
- ○ **Care review:** service users had care review meeting in last 12 months
- ○ **Organisation of care:** service users being told who is in charge of organising their care and services
- ○ **Crisis care (access):** service users knowing who to contact out of hours in the NHS if they have a crisis
- ○ **NHS Talking Therapies:** staff explaining NHS talking therapies in a way service users can understand

These questions are calculated by comparing your trust's results to the national average. "Where service user experience is best": These are the five results for your trust that are highest compared with the national average. "Where service user experience could improve": These are the five results for your trust that are lowest compared with the national average.



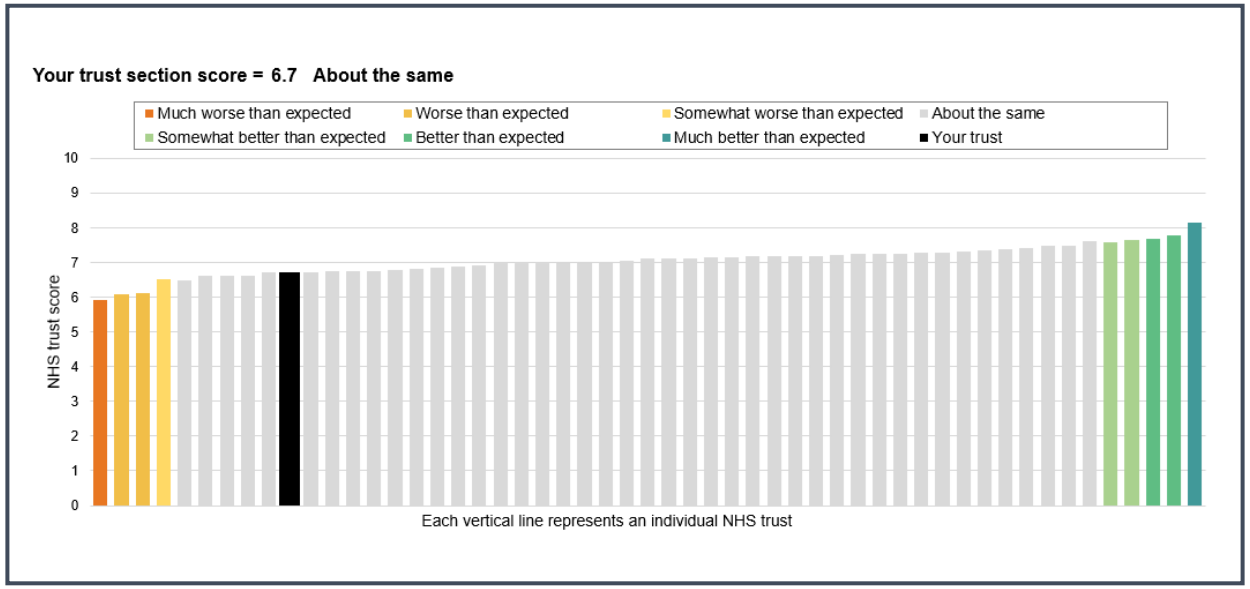
This survey looked at the experiences of people who were receiving care or treatment for a mental health condition and had been treated by the trust between 1 September 2021 and 30 November 2021. Between February and June 2022, a questionnaire was sent to 1250 recent service users. Responses were received from 282 service users at this trust. If you have any questions about the survey and our results, please contact [INSERT TRUST CONTACT DETAILS].

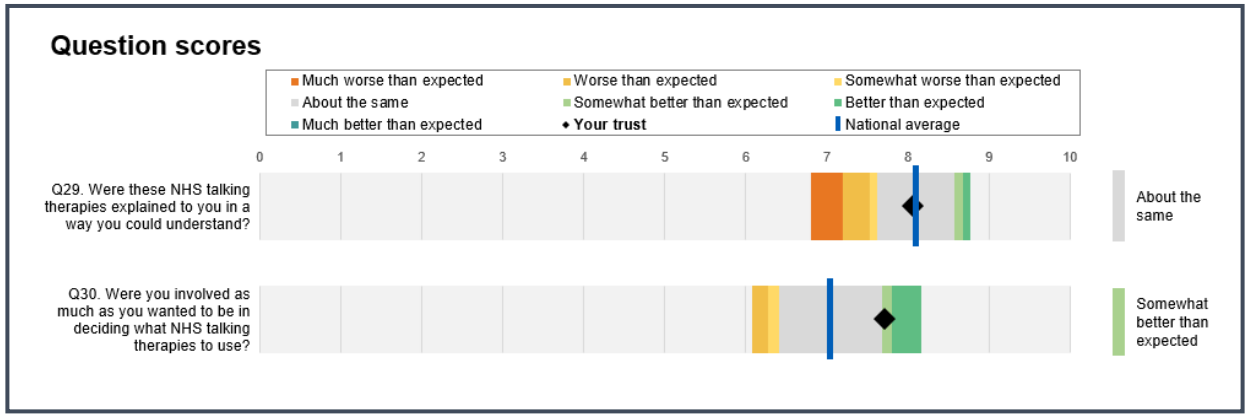
How to interpret benchmarking in this report

The charts in the 'benchmarking' section show how the score for your trust compares to the range of scores achieved by all trusts taking part in the survey. The black line shows the score for your trust. The graphs are divided into seven sections, comparing the score for your trust to most other trusts in the survey:

- If your trust's score lies in the **dark green section** of the graph, its result is 'Much better than expected'.
- If your trust's score lies in the **mid-green section** of the graph, its result is 'Better than expected'.
- If your trust's score lies in the **light green section** of the graph, its result is 'Somewhat better than expected'.
- If your trust's score lies in the **grey section** of the graph, its result is 'About the same'.
- If your trust's score lies in the **yellow section** of the graph, its result is 'Somewhat worse than expected'.
- If your trust's score lies in the **light orange** section of the graph, its result is 'Worse than expected'.
- If your trust's score lies in the **dark orange** section of the graph, its result is 'Much worse than expected'.

These groupings are based on a rigorous statistical analysis of the data termed the 'expected range' technique.





How to interpret benchmarking in this report (continued)

The ‘much better than expected,’ ‘better than expected’, ‘somewhat better than expected’, ‘about the same’, ‘somewhat worse than expected’, ‘worse than expected’ and ‘much worse than expected’ categories are based on an analysis technique called the ‘expected range’. Expected range determines the range within which a trust’s score could fall without differing significantly from the average, taking into account the number of respondents for each trust, to indicate whether the trust has performed significantly above or below what would be expected.

If it is within this expected range, we say that the trust’s performance is ‘about the same’ as other trusts. Where a trust is identified as performing ‘better’ or ‘worse’ than the majority of other trusts, the result is unlikely to have occurred by chance.

In some cases, there will be no shades of orange and/or green area in the graph. This happens when the expected range for your trust is so broad that it encompasses either the highest possible score for all trusts (no green section) or the lowest possible score for all trusts (no orange section). This could be because there were few respondents and/or a lot of variation in their answers.

In some cases, a trust could be categorised as ‘about the same’ whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

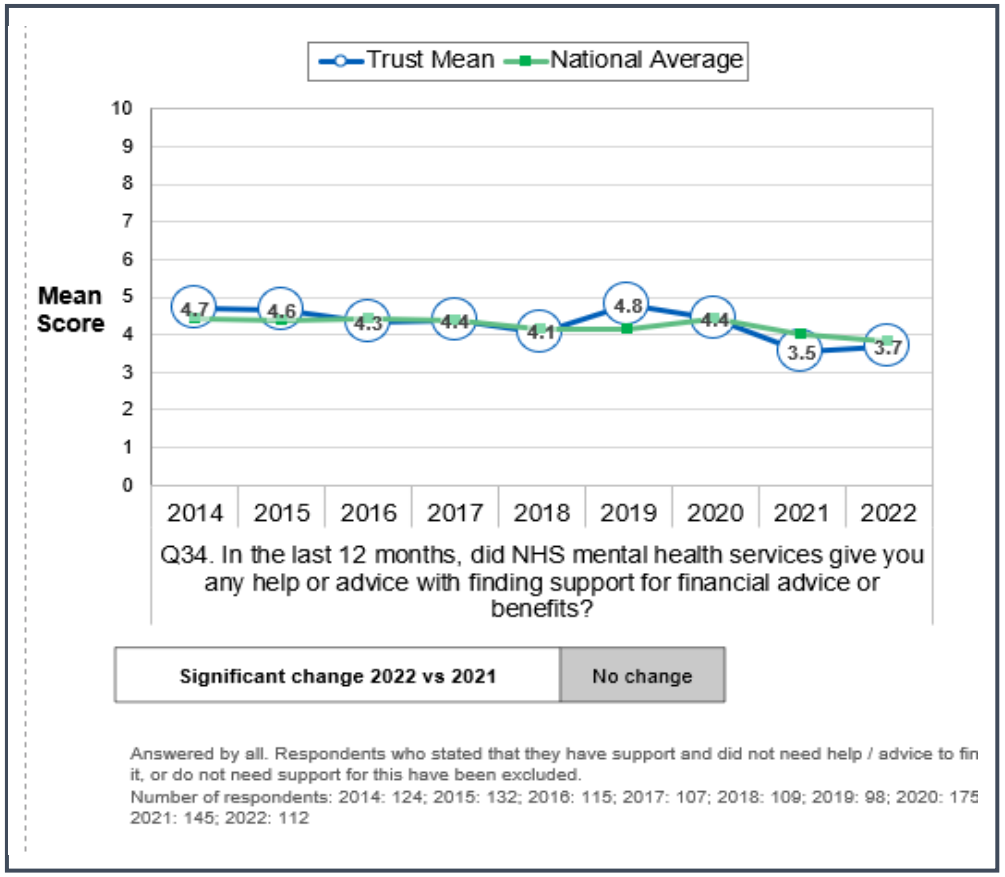
Additional information on the ‘expected range’ analysis technique can be found in the survey technical report on the NHS Surveys website.

How to interpret change over time in this report

The charts in the ‘change over time’ section show how your trust scored in each Community Mental Health survey iteration. Where available, trend data from 2014 to 2022 is shown. If a question only has one data point, this question is not shown. Questions that are not historically comparable, are also not shown.

Each question is displayed in a line chart. These charts show your trust mean score for each survey year (blue line). The national average is also shown across survey years, this is the average score for that question across all community mental health trusts in England (green line). This enables you to see how your trust compares to the national average. If there is data missing for a survey year, this is may be due to either a low number of responses, because the trust was not included in the survey that year, sampling errors or ineligibility.

Statistically significant changes are also displayed in tables underneath the charts, showing significant differences between this year (2022) and the previous year (2021). Z-tests set to 95% significance were used to compare data between the two years (2022 vs 2021). A statistically significant difference means it is unlikely we would have obtained this result if there was no real difference.



An example of scoring

Each evaluative question is scored on a scale from 0 to 10. The scores represent the extent to which the service user's experience could be improved. A score of 0 is assigned to all responses that reflect considerable scope for improvement, whereas a score of 10 refers to the most positive service user experience possible. Where a number of options lay between the negative and positive responses, they are placed at equal intervals along the scale. Where options were provided that did not have any bearing on the trust's performance in terms of service user experience, the responses are classified as "not applicable" and a score is not given. Similarly, where respondents stated they could not remember or did not know the answer to a question, a score is not given.

Calculating an individual respondent's score

The following provides an example for the scoring system applied for each respondent. For question 7 "Were you given enough time to discuss your needs and treatment?":

- The answer code "Yes, definitely" would be given a score of 10, as this refers to the most positive service user experience possible.
- The answer code "Yes, to some extent" would be given a score of 5, as it is placed at an equal interval along the scale.
- The answer code "No" would be given a score of 0, as this response reflects considerable scope for improvement.
- The answer code "Don't know / can't remember" would not be scored, as they do not have a clear bearing on the trust's performance in terms of service user's experience.

Calculating the trust score for each question

The weighted mean score for each trust, for each question, is calculated by dividing the sum of the weighted scores for a question by the weighted sum of all eligible respondents to the question for each trust. An example of this is provided in the survey technical document.

Calculating the section score

An arithmetic mean of each trust's question scores is taken to provide a score for each section.

Thank you.

For further information please contact the Survey Coordination Centre for Existing Methods:

mentalhealth@surveycoordination.com

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 9 May 2023

Making Room for Dignity Programme progress update

Purpose of Report

This report is to update the Board of Directors and provide assurance with progress on the Making Room for Dignity (MRfD) Programme.

Executive Summary

The MRfD Programme has three aims, to:

- eradicate dormitory wards for adult inpatient mental health provision;
- eradicate mixed age group wards for adult inpatient mental health provision; and
- eradicate the use of inappropriate Out of Area Psychiatric Intensive Care Unit (PICU) beds.

through delivery of six interdependent projects, phased over the next three years.

Revenue funding to support the MRfD Programme was approved by Derby and Derbyshire Integrated Care Board in May and June 2022:

- to support capital spend;
- for additional staff required to move from dormitory wards to single rooms; and
- to staff the two new specialist services.

The £9.7m p.a. revenue is a phased draw down, ahead of service go-live dates.

The MRfD Programme received final confirmation of full capital funding in December 2022. The total capital funding of £136m is split £111m national capital, and £25m Trust capital. Construction and refurbishment timelines and 'go-live' dates, for the whole Programme, have now been confirmed.

The refurbishment of Audrey House has commenced and is on target for a November 2023 go-live as a decant unit, enabling the refurbishment of the Radbourne Unit to commence. The Older Adult ward refurbishment commences August 2023 with a go-live date in April 2024. Construction of the new build units progresses well, with both sites up to first floor concrete frame, and on target for the adult acute units to go-live November 2024, and PICU March 2025.

Whilst the significant investment in new, modern and therapeutic mental health inpatient environments will facilitate and enable improvements in service provision, and enhancement of patient experience, increased safety and patient outcomes, it is our healthcare teams who provide care that will continue to deliver on our Trust's vision: *'To make a positive difference in people's lives by improving health and wellbeing.'* In total, 231 whole time equivalent staff are being recruited, with additional staff for existing services recruited 3.5 months before go-live, and new specialist service staff recruited 6 months before go-live. A 'branded' recruitment programme has been developed, in addition to employment and training of student nurses and nursing associates.

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

Risks and Assurances

- Construction contracts for the AAUs and PICU were signed in April 2023
- The capital construction costs are fully funded, with a number of cost pressures resulting from hyperinflation in construction market material costs, and cashflow, being managed by the MRfD Programme Delivery Team
- The Programme Delivery Team continue to pursue VAT abatement for the three new build construction projects.

Consultation

- There is a 'Making Room for Dignity Programme Board' on which a Non-Executive Director sits, alongside other Trust and stakeholder colleagues, which receives regular updates, considers key programme issues and receives updates from the associated workstreams in the programme
- Engagement in the programme activities is well developed and embedded into the Programme with our EQUAL patient and carer representation group advising on building design and equipment
- The project team meet with local, regional and national NHSEI colleagues on a regular basis and will continue to do so for the life of the Programme.

Governance or Legal Issues

- Completion of the MRfD Programme projects is fundamental to eradiation of dormitories and eradication of inappropriate out of area specialist placements, both of which are regulatory requirements by the CQC and NHS England policy.

Public Sector Equality Duty and Equality Impact Risk Analysis

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

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

Ensuring that Equality, Diversity and Inclusion (EDI) benefits are well thought-out and securely delivered in this wide-ranging programme of work will maximise the overall benefits to patient experience and outcomes and will be included throughout the programme.

EDI stakeholder engagement / inclusion in the programme activities are well developed and embedded into the Programme with our EQUAL patient and carer representation group and a dedicated People Division Lead for the Organisational Development and Change Management elements of the Programme.

Inclusion factors to take into account include, but are not limited to, those relating to:

- gender-related benefits or dis-benefits, including those for people with trans and non-binary gender identities
- physical and other disabilities; benefits or dis-benefits in accessibility, outcomes and/or experiences
- autism-friendly environments
- supporting religious or belief activities within inpatient facilities
- challenging hetero-normative assumptions in design and service delivery
- maximising the opportunity for new and flexible working considerations in transformational planning and service delivery.

Actions to Mitigate/Minimise Identified Risks

- Involvement of service users and EDI representation has helped ensure the Programme Delivery Team consider inclusion risks and consider how best to take action to mitigate them.
- Each project within the Programme has a detailed EQIA completed which has been reviewed and accepted by the JUCD EQIA panel with regular reviews for each scheduled in.

Recommendations

The Board of Directors is requested to note the progress to date and assurance on delivery of the MRfD Programme.

Report presented by: **Geoff Neild**
Programme Director
Making Room for Dignity Programme

Report prepared by: **Andy Harrison**
Senior Responsible Owner
Acute Care Capital Programme

Making Room for Dignity

NHS
Derbyshire Healthcare
NHS Foundation Trust

Making Room for Dignity

Programme Update May 2023

DHCFT @derbyshcft
www.derbyshirehealthcareft.nhs.uk

Making a positive difference

Making Room for Dignity Programme

Background

The MRfD Programme has three aims, to:

- **eradicate dormitory wards for adult inpatient mental health provision**
- **eradicate mixed age group wards for adult inpatient mental health provision**
- **eradicate the use of inappropriate Out of Area PICU beds.**

Making Room for Dignity

Making a positive difference

Making Room for Dignity Programme

The 3 aims are delivered through 6 projects:

Northern Derbyshire:

- ❑ **54-bed new build adult acute unit**
- ❑ **12-bed older adult refurbishment**

Southern Derbyshire:

- ❑ **54-bed new build adult acute unit**
- ❑ **34-bed adult acute refurbishment**

Derbyshire-wide:

- ❑ **14-bed new build Psychiatric Intensive Care Unit**
- ❑ **8-bed high acuity unit refurbishment**

Making Room for Dignity

Making a positive difference

Making Room for Dignity Programme

Revenue funding: £9.7 million p.a.

Approved by Derby and Derbyshire Integrated Care Board in May & June 2022

- **to support capital spend;**
- **for additional staff required in the move from dormitory to single room accommodation; and**
- **to staff the new specialist services.**

Making Room for Dignity

Making a positive difference

Making Room for Dignity Programme

Capital funding: £136 million (over 4 years)

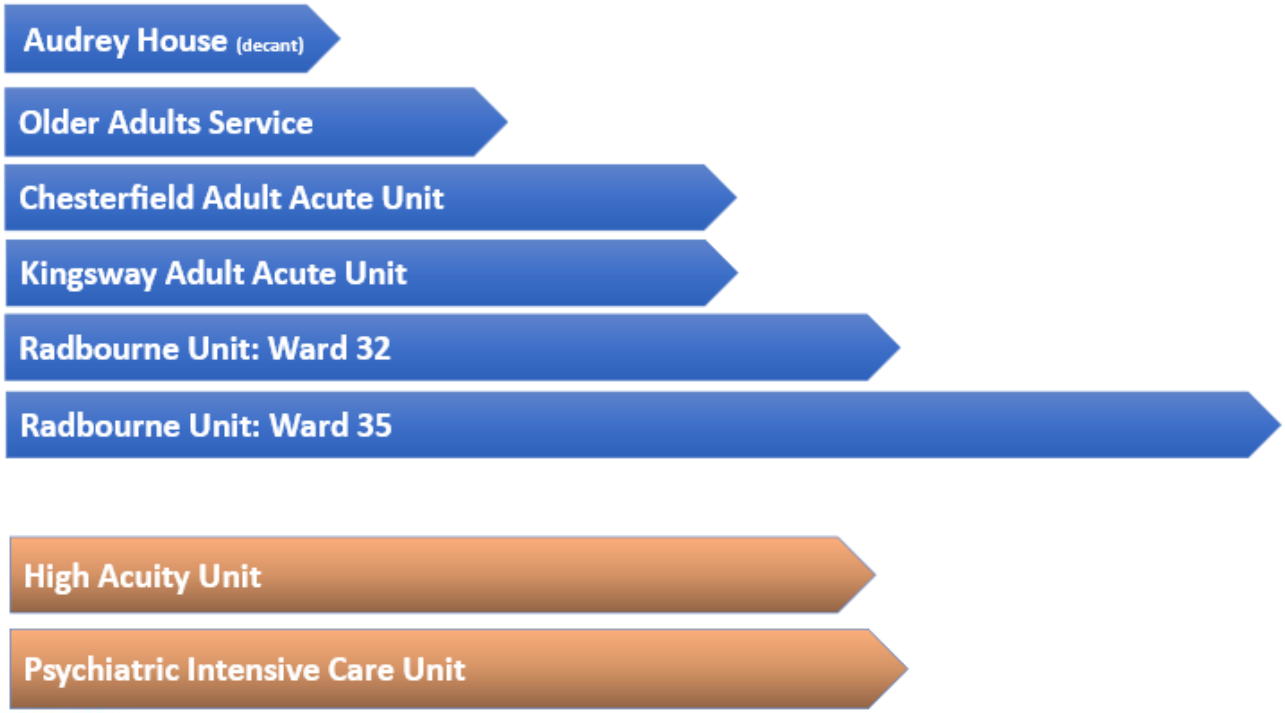
- Hyperinflation in construction materials costs in 2022, resulting from war in Ukraine
- Nationally funded capital, supplemented by Trust, approved Sept 2022: 2 new build AAUs
- Nationally funded capital, supplemented by Trust, approved Dec 2022: new build PICU
- Nationally funded capital for remaining 3 refurbishment projects late Dec 2022

Making Room for Dignity

Making a positive difference

Making Room for Dignity Programme

Construction & planned service 'go-live'



Go-Live	Dorms Eradication
Nov 2023	
April 2024	29% (100% OA)
Nov 2024	40%
Nov 2024	78%
Mar 2025	89%
Apr 2026	100%
	Specialist Services
Feb 2025	36%
Mar 2025	100%

Making Room for Dignity

Making a positive difference

Making Room for Dignity Programme

Building Programme Progress:

Chesterfield new build Adult Acute Unit:

April 2023

Making Room for Dignity

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Building Programme Progress:

Kingsway new build Adult Acute Unit and PICU:

April 2023

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Making a positive difference

Making Room for Dignity Programme

https://1drv.ms/v/s!AgvdayJ3ivZYhL5k6L0Tkmw5_U-ESA

Building Programme Progress:

Refurbishments:

- ❑ Audrey House
- ❑ Older Adults
- ❑ Radbourne Unit

Making Room for Dignity

Making a positive difference

Making Room for Dignity Programme

Staffing: 231 wte

- Additional staff for existing services are to be recruited 3.5 months before go-live
- New service staff teams are to be recruited 6 months before go-live
- Branded recruitment programme
- Training student nurses and nursing auxiliaries

Making Room for Dignity

Making a positive difference

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors - 9 May 2023

Board Assurance Framework (BAF)
Issue 1, 2023/24 – Version 1.3

Purpose of Report

To meet the requirement for Boards to produce an Assurance Framework. This report details the first issue of the BAF for 2023/24.

Executive Summary

Executive Director leads provided their updates to Issue 1 of the BAF for 2023/24 which was submitted for review by the Executive Leadership Team (ELT) on 11 April 2023 and approved by Audit and Risk Committee on 27 April. The BAF continues to be reviewed by the Board Committees at each meeting. Updates made to Issue 1 are summarised below.

Risk 1A – *There is a risk that the Trust will fail to provide standards for safety and effectiveness as required by our patients and our Board*
The action to close the key gap in control that *there is a risk that the Trust will fail to provide standards for safety and effectiveness as required by our patients and our Board* has been completed. The interim Director of Nursing provided the following rationale:

> *We have learnt as a result of Covid-19 that health inequalities amongst communities have been revealed by the effect of the pandemic. We are now using the health inequalities approach for our communities so the action is complete; we have learned from the monitoring of changes and patterns and negative impacts of Covid-19.*

ELT approved the closure of the action.

Risk 1D – *There is a risk that the organisation is in breach of essential standards for privacy and dignity in its acute bedded care facility as it has not fully completed its dormitory eradication programme. This may result in regulatory action if mitigation to improve safety does not occur:*
It was agreed at a confidential Board meeting in March 2023 that a new risk should be added under strategic objective 1, *to provide great care in all our services*. The addition is due to the slippages of the dormitory eradication programme.

Risk 3A – *There is a risk that the Trust fails to deliver its revenue and capital financial plans:*
The interim Director of Finance has thoroughly reviewed and updated all actions to close key gaps in controls and progress against them. The RAG rating of two of the actions has increased from amber to green, and the current overall risk rating has increased from moderate to extreme as the likelihood of the risk occurring has significantly increased.

Risk 4B – *There is a risk of reputational damage if the Trust is not viewed as a strong partner:*
The Director of Strategy, Partnerships and Transformation has provided comprehensive updates on the progress made on the actions to close the key

gaps in control. It's expected that improved RAG rating against some of the actions will be achieved throughout Quarter 1 of 2023/24.

Operational Risks
There are five Trust-wide operational risks rated as high linked to the Trust strategic objectives. Since the last BAF issue two operational risks have been removed from the BAF report and a new one has been added:

Risk 21586 Clinical-Other: *Wait times breaching ICB contract:*
Closed – Reviewed by the Risk Handler and General Manager and agreed that a new and refreshed risk needs to be raised with regards to Memory Assessment Services, given the impact of transformation works.

Risk 22838 Clinical-EPR: *Forced uninstall of IE11 - EMIS pharmacy computer system runs on 1E11:*
Closed – Patch now deployed to all but one computer in the department and EMIS software has been stable for users.

Risk 23009 Clinical-EPR: *Failure to follow Standard Operating Procedures (SOPs) causes inaccuracies in reported information - Risk to patient safety:*
New – Work is currently underway via a Business Change Project to encourage compliance; however some SOPs may need to be amended to reflect operational practice.

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

Risks and Assurances

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

Consultation

Executive Directors:

- Interim Chief Executive Officer
- Trust Secretary
- Deputy Directors
- Operational Leads
- Managing Directors
- General Managers
- Service Line Managers
- Operational Risk Handlers

Formal Reviews:

- Executive Leadership Team, Issue 1.1: 11 April 2023
- Audit and Risk Committee, Issue 1.2: 27 April 2023

Governance or Legal Issues

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

Public Sector Equality Duty and Equality Impact Risk Analysis

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

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

Recommendations

The Board of Directors is requested to:

1) **Review and Approve** this first issue of the BAF for 2023/24 and the assurance the paper provides of the process of the review, scrutiny and update of the BAF in seeking to identify and mitigate risks to achieving the Trust's strategic objectives
2) Agree to continue to receive updates in line with the forward plan for the Trust Board.

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

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

Board Assurance Framework 2023/24 – Issue 1 Board 09.05.23

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

Ref	Principal Risk	Director Lead	Rating (Likelihood x Impact)	Responsible Committee
Strategic Objective 1 - To Provide GREAT Care in all Our Services				
23-24 1A	There is a risk that the Trust will fail to provide standards for safety and effectiveness as required by our patients and our Board	Executive Director of Nursing (DON) / Medical Director (MD)	**HIGH (4x4)**	Quality and Safeguarding Committee
23-24 1B	There is a risk that the Trust does not deliver key regulatory and strategic requirements related to dormitory eradication and Psychiatric Intensive Care Unit (PICU) and that the Trust estate more generally is not maintained sufficiently well to comply with regulatory and legislative requirements	Chief Operating Officer (COO)	**HIGH (3X5)**	Finance and Performance Committee
23-24 1C	There is a risk that the Trusts increasing dependence on digital technology for the delivery of care and operations increases the Trusts exposure to the impact of a major outage	Chief Operating Officer (COO)	**MODERATE (3x4)**	Finance and Performance Committee
23-24 1D	There is a risk that the organisation is in breach of essential standards for privacy and dignity in its acute bedded care facility as it has not fully completed its dormitory eradication programme. This may result in regulatory action if mitigation to improve safety does not occur	Executive Director of Nursing (DON) / Chief Operating Officer (COO)	**MODERATE (3x4)**	Quality and Safeguarding Committee
Strategic objective 2 – To be a GREAT Place to Work				
23-24 2A	There is a risk that we are unable to create the right culture with high levels of staff morale	Director of People and Inclusion (DPI)	**HIGH (4x4)**	People and Culture Committee
23-24 2B	There is a risk that we do not have a diverse workforce with the right number of people with the right skills to support and deliver safe high-quality care	Director of People and Inclusion (DPI)	**HIGH (4x4)**	People and Culture Committee
Strategic Objective 3 – To Make BEST Use of Our Resources				
23-24 3A	There is a risk that the Trust fails to deliver its revenue and capital financial plans	Executive Director of Finance (DOF)	**EXTREME (4X5)**	Finance and Performance Committee

Board Assurance Framework 2023/24 – Issue 1 Board 09.05.23

Strategic Objective 4 – To be a GREAT Partner				
23-24 4A	Whilst there are significant benefits from the creation of the Integrated Care System (ICS) as an NHS body, there is a risk that the effects of the change may impact negatively on the cohesiveness of the Derbyshire health and care system	Director of Strategy, Partnerships and Transformation (DSPT)	**MODERATE (3x3)**	Trust Board
23-24 4B	There is a risk of reputational damage if the Trust is not viewed as a strong partner	Director of Strategy, Partnerships and Transformation (DSPT)	**HIGH (4x4)**	Trust Board

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

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

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

Root causes:

a) Workforce supply and lack of capacity to deliver effective care across hotspot areas, increasing risks in the medical workforce
b) Risk of substantial increase in clinical demand in some services
c) Changing demographics of population and substantial impacts of inequality within the deprived wards of the city and county
d) Intermittent lack of compliance with Care Quality Commission (CQC) standards specifically the safety domain
e) Lack of embedded outcome measures at service level
f) Known links between Serious Mental Illness (SMI) and other co-morbidities, and increased risk factors in population including inequality/ intersectionality, with escalating risks in alcohol consumption
g) Lack of compliance with physical healthcare monitoring in primary and secondary care, has improved but not at the required level for reductions in mortality
h) Restoration and recovery of access standards in autism and memory assessment services, due to demand
i) Lack of appropriate environment to support high quality care, i.e. single gender dormitories and PICU leading to out of area (OOA) bed use for PICU
j) Lack of capacity to meet population demand for community forensic team
k) Local NHS Trusts will offer Recruitment and Retention Premium to Consultant Psychiatrists in specialist services and other clinical staff due to competitive practices that destabilises Trust clinical services and leads to a deterioration in waiting time and potentially in safety
l) Due to the move in Electronic Patient Record (EPR) system and the transitional working arrangements there is potential that data quality could adversely affect patient safety
m) Violent crime in the community, sexual safety incidents and youth violent crime all increasing in Derby and Derbyshire
n) Health inequalities across the Derbyshire footprint. Initial insights show gaps in access to service, case load and worsening patient outcomes for our patients

BAF Ref: 23-24 1A	**Director Lead**: Tumi Banda (DON – Interim) / Dr Arun Chidambaram (MD)	**Responsible Committee**: Quality and Safeguarding Committee

Key Controls

Inherent Risk Rating			**Current Risk Rating**				**Target Risk Rating**			**Risk Appetite**		
High	Likelihood 4	Impact 4	High	Likelihood 4	Impact 4	Direction ⬌	Moderate	Likelihood 3	Impact 4	Accepted	Tolerated	Not Accepted

Board Assurance Framework 2023/24 – Issue 1 Board 09.05.23

Preventative – Quality governance structures, teams and processes to identify quality related issues; mandatory training; Duty of Candour processes; clinical audits and research; health and safety audits; risk assessments; physical health care screening and monitoring; monitoring and effective responses to infection and control guidance, EQUAL unannounced visits to services and anonymised bright ideas service improvement ideas. Feedback intelligence from independent advocacy, Director visits in and out of hours and Quality Visits
Detective – Quality dashboard reporting; quality visit programme/virtual clinical service contact visits; incident, complaints and risk investigation; Fire Safety Regulations (FSR) compliance checks; mortality review process; physical health care monitoring clinics pilots; safety check log; Head of Nursing and Matron compliance visits, reviewed model of announced and unannounced visits to service throughout the 24-hour period
Directive – Trust Strategy and commitments; Quality Improvement Strategy; Physical Health Care Strategy; Safeguarding Strategy; Suicide Reduction Strategy; clinical strategies; policies and procedures available via Trust intranet; Central Alerting System (CAS) alerts; Risk Management Strategy; clinical sub committees of the Quality and Safeguarding Committee

Assurances on controls (internal)	Positive assurances on controls (external)
Quality and Trust dashboards Scrutiny of Quality Account (pre-submission) by committees Programme of physical healthcare and other clinical audits and associated plans Infection Control Board Assurance Framework reported to NHS England Positive and Safe self-assessment reported to the East Midlands Head of Nursing/Practice and Matron compliance visits Quality visit programme and out of hours visits	National enquiry into suicide and homicide NHS Litigation Authority (NHSLA) scorecard demonstrating low levels of claims Safety Thermometer identifies positive position against national benchmark Mental Health Benchmarking data identifies higher than average qualified to unqualified staffing ratio on inpatient wards CQC comprehensive review 2020 Trust is rated Good; two core services rated outstanding, two rated as require improvement Identified Trust fully compliant with National Quality Board (NQB) Learning from Deaths guidance Transitional Monitoring Meetings with CQC (bi-monthly), no conditions Patient Safety Incident Response Framework (PSIRF) implementation

Key gaps in control	Key actions to close gaps in control	Impact on risk to be measured by	Expected completion date (Action review date)	Summary of progress on action	Action on track
Embedded learning from CQC regulatory actions, particularly in relation to improvement of training governance	Review operational governance of training compliance [ACTION OWNER: DPI] Develop and implement improvement plan to ensure sustained compliance with mandatory training [ACTION OWNERS: DPI/COO]	Embedded compliance with mandatory training and compliance rates. Reported to People and Culture Committee (PCC) Lack of recurrence of common themes regarding training compliance. Reported to PCC	30.06.23	Improved governance reporting to Board, PCC, ELT reintroduced through performance reviews on key metrics, i.e. Positive and Safe and Immediate Life Support (ILS) training compliance	GREEN

		and to be led by the operational leadership teams		Work continues to review the best way to deliver training that reduces the impact on the delivery of clinical services, which may include virtual opportunities All service lines continue to work to improve compliance with action plans. Mandatory training currently 92% compliant	
The Trust has not embedded a robust system of operational management and educational governance and has not learnt lessons from the 2016 and 2020 inspections	Review operational governance of training compliance [ACTION OWNERS: DPI/COO]	The Trust continues to have significant instability in training compliance and oversight of safety training The Trust management team need to move to a proactive oversight, projections of high-risk areas of safety training and advance management of risk Publication of ILS/ PSTS training as core risk areas in the Trust Board reporting until stability is achieved Sign-off of the outstanding CQC actions	30.06.23	Repeat variations in operational delivery and practice in educational governance. Focus remains in Acute Care and Older Adult Inpatients Services PCC receive a compliance report on all CQC outstanding actions, and a plan is presented against any actions that are not compliant. A trajectory is prepared to establish when the training will achieve the required compliance standard and signed off by PCC 06.03.23: ILS training was 89%. Positive and Safe is at 78% and monitoring is in place	GREEN

				Bi-monthly Training & Workforce Group now in place, chaired by the DPI CQC action signed off	
Inability to complete physical health checks for patients whose consultations remain undertaken virtually	Improvement plan to be developed and implemented to ensure required physical health care checks are completed [ACTION OWNER: MD]	Compliance with physical healthcare checks, reported in the Quality Dashboard A 360 audit has been commissioned to review whether these improvements are embedded	(30.06.23)	Revised metrics now form part of the quality dashboard and are reported regularly to the Quality and Safeguarding Committee Implementation of coaching and self-report pilot model of care in underway to improve compliance and patient empowerment via the Health Protection Unit Targeted actions are now in place across all service lines to improve on physical health checks to improve practice with an increased focus on adult inpatient services	AMBER
Implementation of revised priority actions for 'Good Care' which support the Trust strategy	Redesign improvement plans to align to revised building blocks which support the Trust Strategy [ACTION OWNER: DON]	Compliance with suite of metrics and reporting schedule detailed in quality dashboard	(30.06.23)	New strategy actions published and being reviewed in Quality Visit programme and in Divisional Achievement Reviews	AMBER
Insufficient investment in autism assessment and treatment services to meet demand. No commissioned treatment services Waiting time increased over COVID-19 period, exacerbated	Investment required by ICS to meet assessment and treatment demands [ACTION OWNERS: COO/DSPT]	Agreed funding allocation has occurred, recruitment to posts is active	30.06.23	Mental Health Learning Disability and Autism Delivery Board (MHLDA DB) agreed additional investment in a-new neuro diversity diagnostic pathway. Investment	AMBER

by underlying demand – ASD diagnostic waiting lists remain high				included in 2022/23 system operational plan. Additional in year funding to trial a new approach to assessment services for autism has been provided by the ICB – Progress is being monitored, and mobilisation has started but there continues to be insufficient long-term funding There continues to be insufficient long-term funding; it is hoped the new approach will demonstrate a case for future investment Associated recovery action plan in place (RAP) ASD contracted assessments per year have been achieved. Work continues to improve capacity to sustain compliance	
Six service areas assessed as 'Requires Improvement' by CQC in relation to safety	Develop and implement an improvement plan to enable all six service areas to reach 'Good' for safety in relation to the CQC standards [ACTION OWNER: DON]	CQC inspection and assessment	(30.06.23)	Significant improvement in all services. Plan to meet training compliance is not fully compliant There has been a programme of mock CQC inspections in hotspot areas namely inpatient areas and now moving to community services. A	AMBER

				thematic report will be presented to TOOL. The inspections have been received very positively by staff and are leading to identified areas of action for each team Six CQC actions remain open, training compliance targets to be met	
Gap in operating standards for acute and community mental health services	Enhanced monitoring of acute and community mental health services by the Nursing and Quality Directorate [ACTION OWNER: DON] Implement Royal College of Psychiatrists (RCP) Standards across Acute Services [ACTION OWNERS: MD/DON/COO] Implement Community Mental Health Framework [ACTION OWNER: DSPT]	Improvement in operating standards compliance. To be confirmed by external CQC inspection and assessment of at least 'Good' Implemented Acute Inpatient Mental Health Service Accreditation (RCP Standards) reported in Divisional Achievement Reviews and Quality Account Implemented Mental Health Community Framework to Quality and Safeguarding Committee	(30.06.23) (31.03.24) 31.03.24	Increased performance management scrutiny and unannounced site visits have been undertaken with compliance checks Mock inspections completed in acute services, there is support for the services on the areas requiring improvement Recruitment now underway. Given lack of medic availability (due to increased clinical demand) for PSII and mortality reviews, specific areas of need will be targeted in initial pilot Design of new fully integrated model completed Accreditation for Inpatient Mental Health Services (AIMS) to be completed	AMBER

				by end of Quarter 3 2023/24 Policy for Derbyshire Living Well and Derby Wellbeing Services to support with practice, delivery and governance is in draft Internal Trust programme Board in place to strengthen contribution and involvement in system-wide programme and delivery. Implementation underway in High Peak and Derby City. Next phase is Chesterfield and North-East Derbyshire early 2023/24	
Implementation of clinical governance improvements with respect to: - Outcome measures - Clinical service reviews including reduction in excess waiting times - Getting it Right First Time (GIRFT) reviews	Develop and implement an improvement plan to enable all governance improvement plans to be implemented [ACTION OWNERS: MD/DON/COO/DSPT]	Compliance with suite of metrics and reporting schedule	(30.06.23)	NICE guideline mapping established Agreed programme of work in place from Performance Summit focussing across four key workstreams to make improvements: Engagement; quality improvement and approach to management; review of metrics and data optimisation. All workstreams are progressing, wait times management underpinned by recovery action plans have been	AMBER

				developed and are being monitored via TOOL and the MHLDA DB	
Implementation of new quality priorities for: - Sexual safety - Implementing CQUINS and Clinical outcome measures - Recovering services – equally well - New Trust strategy and priorities - Dormitory eradication programme	Develop and implement an improvement plan to enable all quality priorities to be implemented [ACTION OWNER: DON]	Compliance with suite of metrics and reporting schedule	(30.06.23)	Reducing violence – Body worn camera investment in place Sexual safety – Improvement work (dashboard, preceptorship training and protocols) all commenced. Sexual safety on professional standards video launched Dormitory eradication programme in construction Plan for existing dormitory stock and a plan to maintain and improve dignity for active bed stock in design	GREEN
There is a risk that patients in our care in Derbyshire or commissioned services may receive poor care due to experiencing abuse or professional misconduct. Learning from other independent and national exposures of abuse	Revisit all assurances and scrutinise practice, gathering intelligence and implement an improvement plan to enable all services to provide the highest standard of care which would be expected [ACTION OWNERS: DON/MD]	Engagement and mobilisation of the organisation to discuss learning from recent exposes Discuss and activate colleagues to revisit what compassionate care means and actively encourage, inspire, reward – Supervision, reflective practice and asking for help Mobilise and re-emphasise expectations of standards of care and Freedom to Speak Up Revisit system and process of governance and using	(30.06.23)	There is a wide range of opportunities for colleagues to have conversations about care delivery and raise concerns, including Trust-wide and divisional engagements, Freedom to Speak Up processes, Schwartz Rounds Improvements in engagement of temporary staff have been identified Increasing visibility of senior staff through	AMBER

		intelligence to take oversight of services Inspire conversations re the risks of harm and closed cultures. Reset the culture and the tone of the requirement for professional scrutiny and all employee requirements to prevent harm and report poor care/ abuse Strengthen out of hours, weekends and night announced and unannounced visits. To promote access to multiple managers, relationships, so colleagues feel empowered to report any concerns Review Learning Disability physical health care access, provision access to acute liaison nurses and inspire acute and community colleagues in this area of safety for our community Professional leads are in place to ensure that registered professional staff practice in line with their professional codes Review reports and allegations in multi-disciplinary manner and include safeguarding and security specialist with effective recording and monitoring		Quality Visits, mock CQC inspections and out of hours visits Robust oversight of patient safety incidents, concerns, complaints, and compliments with scrutiny from independent partners, e.g. Healthwatch and experts by experience being core members of Patient and Carer Experience Committee External partnership working including Healthwatch, Advocacy services and statutory services within safeguarding and secure services. The Trust provides assurance and participates in external reviews alongside the ICB and Adult Safeguarding Board	

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

Record ID	Service Line	Title	Risk: Summary of Progress	Date Risk Created	Date of Next Review	Residual Risk Rating
3009	Learning Disabilities Services	Demand for Autism Spectrum Disorder (ASD) assessment Service far outstrips contracted activity	04.04.22: The team is still not commissioned to provide the number of assessments which are required for the region. Working with ~~CCG~~ICB to develop a long-term plan. Complaints and concerns have been raised 07.11.22: Diagnostic team and SAT team merged to provide additional resilience. Further training secured for other professionals to be able to assess people routinely. Specialist pool/bank being set up to offer opportunity for clinics to be had outside the main team	01.01.16	12.05.23	HIGH
22790	Corporate Services – Pharmacy	Prescribing Valproate to women of child-bearing potential: Failure to comply with regulations	24.06.22: Support for safe use of Valproate in compliance with MHRA in development 03.03.23: IT system (EPMA) now deployed to community teams and due for deployment to acute services in May. Awaiting updated national guidance. Awaiting guidance from Derbyshire Medicines Safety Officer network. No reported incidents of valproate-affected pregnancies in Derbyshire but there are still occurrences within England	28.02.22	27.06.23	HIGH
23009	Corporate Services – IM&T	Failure to follow SOPs causes inaccuracies in reported information - Risk to patient safety	Work is currently underway via Business Change to encourage compliance however some SOPs may need to be amended to reflect operational practice	10.03.23	01.05.23	HIGH

Board Assurance Framework 2023/24 – Issue 1 Board 09.05.23

Strategic Objective 1 – To Provide GREAT Care in all Services

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

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

Root causes:

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

BAF Ref: 23-24 1B	**Director Lead**: Ade Odunlade (COO)	**Responsible Committee**: Finance and Performance Committee

Key Controls

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

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

Assurances on controls (internal)	Positive assurances on controls (external)
IPC risk assessments Health and Safety Audits Premises Assurance Model System (PAMS) reporting providing updates on key priority areas Estates Strategy	Mental Health Capital Expenditure bidding process External authorised reports for statutory health and safety requirements 2020/21 Estates and Facilities Management internal audit (limited assurance)

Key gaps in control	Key actions to close gaps in control	Impact on risk to be measured by	Expected completion date (Action review date)	Progress against action	Action on track
Lack of adherence to emerging national guidance and policy requiring the elimination of mixed sex wards and dormitory style inpatient facilities	Deliver two new adult acute 54-bed units with ~~a~~ single room en-suite with additional staffing and new model of care VAT abatement appeal – Combined capital funding shortfall risk of £10.7m if appeal unsuccessful [ACTION OWNER: COO]	Delivery of approved business cases	(30.06.23)	Two new build adult acute unit FBCs nationally approved September 2022, funded by £80m national PDC and £18.6m CDEL. ICS supported and approved revenue funding Delay in national approval and redesign of foundations. Phased completion April 2024– March 2025 HMRC appeal on VAT abatement claim in process	AMBER
	Older Adult service relocation to refurbished ward with single room en-suite and gender segregation, with additional staffing and new model of care, by September 2024 to eradicate dormitories in Northern Derbyshire and avoid this 12-bed service being isolated in otherwise vacated wards, increasing service user safety issues National PDC capital funding approval [ACTIONS OWNER: COO]	Delivery of approved business case	(30.06.23)	Older Adult service relocation FBC and revenue funding approved by ICS National PDC capital funding approved by NHSE December 2022 Refurbishment scheduled June – December 2025. New unit live May 2024	AMBER
	Audrey House refurbishment as decant ward to enable Radbourne Unit dormitory eradication refurbishment. Dormitories cannot be fully eradicated without use of this decant ward National PDC capital funding approval [ACTIONS OWNER: COO]	Delivery of approved business case	(30.06.23)	National PDC capital funding approved by NHSE December 2022. Refurbishment scheduled January – October 2023. Live as decant ward November 2023 – October 2024. Further refurb	~~RED~~ AMBER

				scheduled November 2024. Live as Acute-Plus January 2025	
	Radbourne Unit dormitory eradication refurbishment to provide two 17-bed wards with single room en-suite, with additional staffing and new model of care, to complete dormitory eradication in Southern Derbyshire. Service users continue to receive care in non-compliant wards until this refurbishment is completed National PDC capital funding approval [ACTIONS OWNER: COO]	Delivery of approved business case	(30.06.23)	FBC and revenue funding approved by ICS. National PDC capital funding approved by NHSE December 2022. Following Audrey House refurb for decant, Radbourne Ward 32 refurb scheduled November 2023 – January 2025 and live March 2025. Refurb Ward 34 scheduled January 2025 – March 2026, live April 2026	AMBER
Lack of an accessible Derbyshire wide Psychiatric Intensive Care Unit (PICU)	Delivery of local PICU arrangements (new build and associated projects taking into account gender considerations) £3.5m national capital agreed November 2022. Derbyshire CDEL flexibility agreed for Trust to fund £10.9m remaining capital from cash reserves 2022/23 and 2023/24. VAT abatement risk £1.7m National PDC capital funding approval [ACTIONS OWNER: COO]	Agreed programme of work with capital funding to support it	(30.06.23)	FBCs approved by ICS in June 2022 for 14-bed male PICU and 8-bed Acute-Plus female facility PICU fully funded by national and Trust capital November 2022. HMRC appeal on VAT abatement claim in process – Capital funding shortfall risk of £1.7m for PICU if appeal unsuccessful. Practical completion expected November 2024, live March 2025. Acute-Plus national PDC capital funding approved by NHSE December 2022. Refurbishment following decant ward is scheduled November 2024. Live as Acute-Plus February 2025	AMBER

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

Board Assurance Framework 2023/24 – Issue 1 Board 09.05.23

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

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

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

Root causes:

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

BAF Ref: 23-24 1C	**Director Lead**: Ade Odunlade (COO)	**Responsible Committee**: Finance and Performance Committee

Key Controls

Inherent Risk Rating			**Current Risk Rating**				**Target Risk Rating**			**Risk Appetite**		
Moderate	Likelihood 3	Impact 4	Moderate	Likelihood 3	Impact 4	Direction ⟺	Moderate	Likelihood 2	Impact 4	Accepted	Tolerated	Not Accepted

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

Assurances on controls (internal)	**Positive assurances on controls (external)**
IM&T Strategy delivery update to F&P – Annual Embedded programme of software and hardware upgrades Live testing of business continuity plans	Templar Cyber Organisational Readiness Report (CORS) Annual external cyber review by Dynac (vulnerability scan) Data Security and Protection annual review by Internal Audit, weighted toward cyber security

		Compliance with Data Security and Protection Toolkit, including high levels of training compliance			
Key gaps in control	**Key actions to close gaps in control**	**Impact on risk to be measured by**	**Expected completion date (Action review date)**	**Progress against action**	**Action on track**
Business continuity plans reflect changes to service delivery such as increased phone and video contacts	All services to review business continuity plans to ensure they take account of the increased use of phone and video contacts for care provision and also use of video conferencing for operational delivery [ACTION OWNER: COO]	Reporting to the Divisional Achievement Reviews (DARs)	(30.06.23)	Emergency Planning and Business Continuity Manager is reviewing each business continuity plan to ensure that they are appropriate and consistent. April 2023 EPRR Steering Group meeting to receive update on service's business impact analysis, incorporating the increased use of technology	AMBER

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

Board Assurance Framework 2023/24 – Issue 1 Board 09.05.23

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

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

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

Root causes:

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

BAF Ref: 23-24 1D	**Director Lead**: Tumi Banda (DON – Interim) / Ade Odunlade (COO)	**Responsible Committee**: Quality and Safeguarding Committee

Key Controls

Inherent risk rating			Current risk rating				Target risk rating			Risk appetite		
Moderate	Likelihood 3	Impact 4	Moderate	Likelihood 3	Impact 4	Direction ⟺	Moderate	Moderate 3	High 4	Accepted	Tolerated	Not Accepted

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

Board Assurance Framework 2023/24 – Issue 1 Board 09.05.23

Assurances on controls (internal)	Positive assurances on controls (external)
Quality and Trust dashboards Bed Management processes Scrutiny of Quality Account (pre-submission) by committees Programme of physical healthcare and other clinical audits and associated plans Infection Control Board Assurance Framework reported to NHS England Positive and Safe self-assessment reported to the East Midlands Head of Nursing/Practice and Matron compliance visits Cleaning and maintenance schedules Infection Prevention and Control training Level 1 and 2 Trust targets of 85% compliance	Delivery of Same Sex Accommodation Guidance Safety Thermometer identifies positive position against national benchmark Mental Health Benchmarking data identifies higher than average qualified to unqualified staffing ratio on inpatient wards CQC comprehensive review 2020 Trust is rated Good; two core services rated outstanding, two rated as require improvement Internal audits: Risk management; data security and protection Estates and Facilities Management internal audit (limited assurance) Transitional Monitoring Meetings with CQC (bimonthly), no conditions Patient Safety Incident Response Framework (PSIRF) implementation Safe staffing guidance Monitoring of IPC standards compliance and reporting ICS IPC Team

Key gaps in control	Key actions to close gaps in control	Impact on risk to be measured by	Expected completion date (Action review date)	Progress against action	Action on track
Inpatients care is delivered in wards with dormitories, that compromise on patient dignity, privacy and effective IPC practice	Implement bed management process that ensure that admissions are screened to comply to gender, safety and IPC requirements Ensure that the environments are routinely check by clinicians, estates, and domestic staff Infection Prevention and Control monitoring, and training compliance Effective monitoring of the clinical environments by clinical, estates and domestic staff [ACTIONS OWNERS: DON/COO]	Monitor and report breaches of same sex admission breaches Monitoring of maintenance and cleaning schedules Head of Nursing and Matron environmental walk abouts Infection and Prevention and Control reports and monitoring of infections Individual screening of admissions to appropriate ward environments to ensure gender needs, safety needs and IPC needs are met Provision of other rooms for privacy and confidentiality	31.03.25	Fully funded programme of work in place 'Making Room for Dignity' Construction has started on the new builds in Chesterfield and Derby. The designs have been co-produced with construction experts, clinicians, carers, patients and people with lived experience The new or refurbished environments will require more staff and the recruitment of the staff is now under way with planning phase already started March 2023: Infection Prevention and Control Level 1 compliance is at 90% against a	AMBER

				target of 85%. Infection Prevention and Control Level 2 compliance is at 87% against a target of 85% Head of Nursing and Matron walkabouts are in place and conducted routinely	

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

Strategic Objective 2 – To be a GREAT place to work

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

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

Root causes:

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

BAF Ref: 23-24 2A	**Director Lead**: Jaki Lowe (DPI)	**Responsible Committee**: People and Culture Committee

Key Controls

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

Board Assurance Framework 2023/24 – Issue 1 Board 09.05.23

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

Assurances on controls (internal)	Positive assurances on controls (external)
National staff survey and reporting into board, ELT and divisions Quarterly pulse check and action planning process Staff survey analysis and reporting Exit interview analysis and reporting	Benchmarking in mental health and at system level Outstanding results from 2021 staff survey, identifying significant improvements across all themes

Key gaps in control	Key actions to close gaps in control	Impact on risk to be measured by	Expected completion date (Action review date)	Progress against action	Action on track
Lack of planned leadership development growth and stretch programmes and opportunities including coaching and mentoring	Review of system level leadership offer and impact Review and development of Trust leadership offer and impact Re-establish leadership forum Development of coaching access at local, system and national [ACTIONS OWNER: DPI]	Percentage of leaders with development plan as part of objectives Percentage of leaders attending local, system or national leadership programmes	(30.06.23) 31.05.23	Deputy Director of People is part of system leadership workstream to review current offer and develop 12-month plan on leadership offer – Draft proposal developed, to be finalised New leadership programme (aimed at band 8B staff) completed Leadership forum revised and first forum took place December 2022 with monthly forums now planned throughout 2023 – January, February and March delayed due to industrial action. First face to face forum will now take place April 2023	AMBER

Fully embedded person-centred culture of leadership and management	Review of policies and processes to support a person-centred approach to leadership and management Introduce just and restorative culture approach Review of leadership development offer Re-establish line manager development sessions Scrutiny of people data at divisional level [ACTIONS OWNER: DPI]	Reduced number of formal staff relations issues/cases reported in monthly people assurance report to ELT Staff survey results Reporting to TOOL	(30.06.23)	Just and restorative culture conference taken place Review of cases and case management reported to ELT in October 2022, continues every six months Deep dive on employment review cases and processes took place at PCC in February 2023 Civility and Respect policy approved, submitted for ratification in April 2023	AMBER
No operating framework through which to maximise the impact of staff networks	Collaboratively develop and Implement Staff Network Framework to provide consistency across the networks with clear framework, clarity of roles and objectives to increase engagement with under-represented staff Support to Bi-monthly network Chairs meetings through DPI, Head of EDI and EDI Manager [ACTIONS OWNER: DPI]	Engagement and buy-in by network Chairs Sign up to the framework by network Chairs and Executive Directors Annual updates by network Chairs of engagement undertaken to be included in annual reports	(30.06.23)	Discussions with network Chairs to progress New executive model implemented in December 2022. Draft framework now developed and engagement with key stakeholders commenced	AMBER

The current capacity and structure of the People and Inclusion directorate is not able to meet the Trust, system, regional and national demands alongside challenges from outsourcing key services via People Services in DCHS and UHDB	Review of current People and Inclusion structure to align to needs and priorities of Trust, identify gaps and develop plan to mitigate Review of gaps in services delivered by People Services or UHDB and develop accountability framework Formalise existing governance meetings to ensure clear processes in place for People and Inclusion Services contract and UHDB key service contracts Review of current communications and engagement and people priorities across the Trust and system [ACTIONS OWNER: DPI]	A People and Inclusion structure that can support the Trust to deliver against the people priorities Accountability dashboard presented to ELT quarterly Terms of reference in place and regular meetings A People and Inclusion structure that can support system-wide priorities People and Inclusion staff survey results	(30.06.23)	Contract review meetings established for Occupational Health and Payroll Services (UHDB) New governance structure to be developed to manage the Joint Venture – Early discussions commenced Monthly payroll contract meetings in place	RED
Lack of maturity of EDI framework	Produce and implement EDI framework with clear legislative, and mandated NHS national regional and local deliverables required for the EDI function and structure to deliver [ACTION OWNER: DPI]	Agree framework and capacity requirements to deliver Regular wider engagement with EDI Delivery Group, and divisional leads taking place Final presentation to PCC Roll out of framework Delivery against the People Performance Dashboard	(30.06.23)	Draft framework presented to ELT	AMBER
We have not engaged with our Bank staff to develop a strong sense of belonging, engagement and psychological contract with the Trust	Regular monthly engagement sessions Staff survey participation Clinical supervision and appraisal participation Alignment to Agenda for Change for pay and conditions	Staff survey participation response rates Staff survey engagement scores Attendance at engagement sessions	Complete (30.06.23) (30.06.23)	Engagement sessions booked virtually for October, November and December 2022, and face to face session for January 2023 Partaking in first national bank staff survey	GREEN

	[ACTIONS OWNER: DPI]			Aligned all bank staff bands 2, 3, 4 and 7 to Agenda for Change pay scales Started discussions with Staffside to review Bands 5 and 6 current spot rate with view to align to Agenda for Change	
Lack of visible and differential staff benefits and responsive support for staff that reflects current working conditions, e.g., cost of living crisis	Review of gaps in benefits to realign to staff needs Review of current reward and recognition framework Develop range of staff benefits that align to Trust values and 'people first' approach Develop the salary sacrifice offer to support colleagues with cost of living crisis [ACTIONS OWNER: DPI]	Staff survey engagement score Staff turnover Pulse check scores	(30.06.23)	Delivering Excellence Every Day awards (DEEDs) have been revised and relaunched Staff awards took place November 2022 System-wide discussions commenced with regards a system wide benefits package Mileage rates adjusted to reflect cost of living crisis	RED
Inconsistency in application of an in inclusive approach impact on developing and sustaining a sense of belonging	Embed an inclusive approach, promoting equality and ensuring diversity at all levels through learning and development, Schwartz Rounds, personal development reviews, mid-year reviews, rewards and awards, objective settings [ACTIONS OWNER: DPI]	Year on year change WRES/WDES, staff surveys and lived experience of staff through staff networks Data drawn from all engagement activities so we are able to identify impacts on staff experience and any inequalities that need to be closed	(30.06.23)	Work commenced	AMBER
Systematic planning and attendance of training	Training to be embedded in e-roster and designed to support safe staffing by minimising face to face sessions needed Progress the breaks and shift pattern change process [ACTIONS OWNER: DPI]	Full compliance with safer staffing levels in line with NHSI Workforce Safeguards Training compliance in line with CQC requirements	(30.06.23)	New reporting processes in place that feeds into TOOL, PCC and Board – Now embedded with triangulation on staffing/agency/bank to be included at PCC	AMBER

		Staff survey health and wellbeing scores Comprehensive system and trust level health and wellbeing offer Compliance with NHSI workforce safeguards requirements Staff are able to take breaks and access the right health and wellbeing support E-roster team appropriately resourced and supported		Shift and break consultation being planned, to commence early 2023 Training lead meeting regularly with all service managers to review staff training plans Meetings scheduled with neighbouring mental health Trusts to compare training offers and delivery modes	

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

Record ID	Service Line	Title	Risk: Summary of Progress	Date Risk Created	Date of Next Review	Residual Risk Rating
22961	Operational Services – management Team	Industrial action	Uncertainty around numbers of staff who would participate in industrial action, December 2022 onwards Weekly Strategy meeting with Managing Directors, Head of Organisational Effectiveness, Assistant Director for Clinical Professional Practice and EPRR Lead. Involvement of Staffside in planning group Risk under review for early May industrial action	28.11.22	30.04.23	HIGH

Strategic Objective 2 – To be a GREAT place to work

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

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

Root causes:

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

BAF Ref: 23-24 2B	**Director Lead**: Jaki Lowe (DPI)	**Responsible Committee**: People and Culture Committee

Key Controls

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

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

Assurances on controls (internal)	Positive assurances on controls (external)
People Performance Report in Tool, ELT and PCC People Dashboard in PCC PCC forward plan and deep dive plan Workforce plan Embedded recruitment and retention scheme	Healthcare Support Workers (HCSW) submissions System operational planning process Safe staffing report

Key gaps in control	Key actions to close gaps in control	Impact on risk to be measured by	Expected completion date (Action review date)	Progress against action	Action on track
An integrated workforce plan and planning process that feeds into pipeline plans and ensures we have the right people in the right place with the right skills	Develop a Trust Workforce Plan linking demand and capacity, workforce redesign to ensure a fully funded workforce Develop vacancy rate data and breakdown variances in vacancy data Establish a workforce transformation group to develop workforce development plans and ownership at divisional level [ACTIONS OWNER: DPI]	Vacancy rates Time taken to fill vacant posts Transformational posts, e.g. apprenticeships all identified Reduction in agency costs	(30.06.23)	High level Workforce Plan developed and presented to Board Workforce transformation group commenced December 2022 Divisional workforce plans being developed to support 2023/24 workforce plan System workforce conference took place February 2023 with key speakers from DHCFT	RED
We do not have an effective and embedded succession talent management processes	Develop a Talent Management Strategy Pilot career conversations for senior leaders and roll out career conversations for all colleagues	Career conversations taking place Internal appointments/promotions Turnover rate Key staff survey measures	(30.06.23)	Talent Strategy finalised Pilot launched for senior leaders in January 2023 – Phase one meetings with each executive taking place	AMBER

	Work as a system to develop system-wide approach to talent management and align where best for the Trusts [ACTIONS OWNER: DPI]			Deputy DPI system lead on talent management System appraisal developed to support system movements and talent management	
Lack of capacity, experience and plans for recruiting overseas	Develop International Recruitment (IR) plan and programme Appoint IR team to lead programme Engage with national IR support Access national IR funding Support Trust teams to prepare for IR arrivals [ACTIONS OWNER: DPI]	Number of IR appointments Retention rate of IR	(30.06.23)	IR pastoral support officer appointed and commenced in post Funding secured for four IRs Regular meetings established with national midlands IR lead System AHP IR bid successful Clinical Educator of IR in process of being recruited to	RED
Onboarding and Retention process and planning needs to be embedded	Understand the key retention issues for posts/teams/professions with the highest turnover Ensure 'stay conversations' form part of regular 1:1s Develop NHS retention framework for nursing [ACTIONS OWNER: DPI]	Improvements to turnover Staff survey engagement scores	(30.06.23)	'Stay' survey piloted with Allied Health Professionals and 1-2 year starters New starter survey completed with all started in six months and learning shared at Trust and divisional level Nursing retention framework self-assessment completed System retention lead appointed to support Trust level and system work	AMBER
Medical staffing team and role not sufficiently developed Workforce plan for medical staff not in place	Review existing medical staffing team and workforce support and identify gaps Develop new model to support and maximise the medical workforce	Engagement of medical workforce Reduction in agency spend	Complete (30.06.23)	Terms of reference agreed by MD and COO for review of existing medical staffing team and creation of a medical workforce plan	AMBER

	Develop medical agency model to ensure efficient usage Develop a medical staff workforce plan [ACTIONS OWNER: DPI]			Resources identified and funding agreed for the review by ELT First medical staffing workshop completed March 2023	
Lack of culturally competent recruitment processes	Completion and implementation of recommendations of the Above Difference recruitment and retention system pilot Wider engagement with recruiting managers, staff networks, clinical leads and operational leads Quartile monitoring of utilisation of Above Difference recruitment and retention tools Continuous improvement approach to implementing learning [ACTIONS OWNER: DPI]	WRES and WDES data shows year on year improvement, staff survey and lived experience of staff Increase the proportion of applications from ethnic minority groups, increase likelihood of shortlisting and reduce disparity in all areas	(30.06.23)	Recruitment leads across the system all trained through Above Difference programme Pilot nearing completion with six workstreams completing key learning to be shared at future system human resources meeting to agree actions and programme management to move forward at pace Examples of innovation already being trialled such as one page job description being piloted by two teams	RED
Effectiveness of recruitment policy, practice and processes	Review and develop existing recruitment Key Performance Indicators (KPIs) to ensure fit for purpose Where appropriate move away from TRAC to advertise jobs and use fast track processes, e.g. Indeed/MSforms Develop cohort recruitment for key posts Improve the multidisciplinary working (HR, communications and recruiting managers) to enable better planned and executed campaigns [ACTIONS OWNER: DPI]	Time to recruit Number of applicants applying and successfully shortlisted Campaign impact and reach Financial savings through cohort recruitment	(30.06.23)	KPI review commenced Indeed piloted for hard to fill posts in acute Cohort recruitment successfully piloted for Health Care Assistants and Human Resources apprenticeships System recruitment post approved with funding to pilot a cohort recruitment approach including writing inclusive adverts and job descriptions	AMBER

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

Record ID	Service Line	Title	Risk: Summary of Progress	Date Risk Created	Date of Next Review	Residual Risk Rating
22804	Corporate Services – Pharmacy	Pharmacy Staffing	There is a short-term deficit in our numbers of pharmacists and pharmacy technicians. Turnover has been increased by the growth of new posts within Primary Care Networks – Risk to pharmacy service provision 03.03.23: Staffing remains pressured. Likelihood is a 4-5 year trajectory to recover pharmacist staffing, with added pressure of PICU/Acute Plus, Blue Ward and expectation of increased pharmacist presence in CMHTs/Living Well/Perinatal/Crisis Teams. Anticipation is that EPMA deployment to inpatient wards will ease some capacity pressure. Recruitment efforts continue	18.03.22	01.06.23	HIGH

Strategic Objective 3 – To Make BEST use of Our Resources

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

Impact: Trust becomes financially unsustainable

Root causes:

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

BAF Ref: 23-24 3A	**Director Lead**: Rachel Leyland (DOF - Interim)	**Responsible Committee**: Finance and Performance Committee

Key Controls

Inherent Risk Rating			Current Risk Rating				Target Risk Rating			Risk Appetite		
Moderate	Likelihood 2	Impact 5	Extreme	Likelihood 4	Impact 5	Direction ↑	Moderate	Likelihood 2	Impact 5	Accepted	Tolerated	Not Accepted

Preventative – Integrated Care System (ICS) signed off and fully support ~~for~~ the dormitory eradication programme. Devoted and adequate team for Programme delivery. High quality business cases. Regular meetings with NHSIE on programme progress. Meaningful stakeholder engagement (internal and external). Robust cash flow forecasting and delivery. Multi-disciplinary development of financial plans for new programmes of work. System sign-off and appropriate governance arrangements for new programmes of work: Budget training, segregation of duties, management of commissioning risk through system engagement and leadership, mandatory counter fraud training and annual counter fraud work programme: Enhanced cash management and forecasting aligned to large capital and transformational programmes

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Detective – Risk logs and programme-reporting (capital/transformation) informs ongoing financial risk assessment: Audits (internal, external and in-house); scrutiny of financial delivery, bank reconciliations; continuous improvement including cost improvement planning (CIP) and efficiency / QI delivery; contract performance, local counter fraud scrutiny **Directive** – Business plans and templates set out clear financial plans and assumptions: Standing financial instructions; Treasury management procedures, budget control, delegated limits, recruitment approval processes; business case approval process; invest to save/Quality Improvement methodology and protocol and Plan Do Study Act. Risk and gain share agreements, Local Operating Procedure for Acute Capital Programme

Assurances on controls (internal)	Positive assurances on controls (external)
Dormitory eradication and PICU Programme monitoring and reporting. Urgent decision-making taking place and relevant meetings in place Appropriate monitoring and reporting of financial delivery – Trust overall and programme-specific including 'Use of Resources' reporting updates Assurance levels gained at Finance and Performance Committee Delivery of Counter fraud and audit work programme with completed and embedded actions for all recommendations Independent assurance via internal auditors including HFMA checklist, external auditors and counter fraud specialist that the figures reported are valid and systems and processes for financial governance are adequate Local Operating Procedure in operation for Acute Capital Programme Board and F&P oversight of Acute Capital Programme delivery	NHSE/I feedback throughout progress of dormitory eradication Programme and business cases in programme Systems Finance and Estates Committee/System Project Management Office/system DOF meetings etc. Internal Audits – Financial integrity and key financial systems audits External Audits – Strong record of high-quality statutory reporting with unqualified opinion National Fraud Initiative – No areas of concern Local Counter fraud work – Referrals show good counter fraud awareness and reporting in Trust and no material losses have been incurred. Use of risk-based activity in new counter fraud standards Information Toolkit rating – Evidencing strong cyber risk management (ref fraud/criminal financial risk) Programme Director, Senior Responsible Officer completed NHS Better Business Case Training

Key gaps in control	Key actions to close gaps in control	Impact on risk to be measured by	Expected completion date (Action review date)	Progress against action	Action on track
Trust cash and capital risks related to national funded acute capital programme: - Inflation cost risk - Risk-share	Risk share arrangements with PSCP Programme approach and engagement with all stakeholders. Close involvement with NHSE	Cash and capital reporting and forecasting evidence of plan delivery and/or indicates areas of required management action	31.03.24	Regular oversight of capital and cash position. Reporting to Trust Programme meetings and Committees on risks and mitigations	AMBER

- Cashflow timings and variability - VAT abatement appeal unsuccessful - Guaranteed Maximum Price exceeds national funding envelope (due to hyperinflation and other factors)	VAT abatement appeal in progress [ACTIONS OWNER: DOF]			Hyper-inflation cost risk remains is very high due to world events and economy National PDC capital funding approved by NHSE for two new builds and three refurbishment schemes, plus PICU year 1 HMRC appeal on VAT abatement claim in process – Combined capital funding shortfall risk of £10.7m if appeal unsuccessful	
System capital programme funding shortfall for self-funded Trust capital programme: System Capital Departmental Expenditure Limit (CDEL) inadequacy for system capital requirements	System capital draft planning assumes the final year of the self-funded element of the PICU build through system CDEL / Trust cash reserves VAT abatement appeal in progress Access any new national funding streams in year to maximise system capital plan in order to redirect CDEL capital for other schemes [ACTIONS OWNER: DOF]	Ongoing reporting will ascertain how and when the shortfall can be bridged by additional capital sources	31.03.24	System capital plan being finalised but will be limited to high priority schemes and includes year 2 of PICU from system CDEL	AMBER
Additional revenue not related to new builds, refurbishments and PICU not fully funded by System	Close partnership working with ICB and System partners. National funding for PDC revenue costs included in allocations for 2023/24 plan Early recruitment to staffing built into revenue plan of system [ACTIONS OWNER: DOF]	Monitoring and reporting of income allocations in year	31.03.24	ICB and DCHS partners contributing to OBC/FBC development Funding for PDC revenue from NHSE included in financial plan submission. Funding for early recruitment costs from ICB allocations included in the financial plan submission MHLDA DB agreed to oversee revenue delivery contained within programme spend	AMBER

Insufficient substantive staffing into vacancies and temporary staffing costs for bank and agency staff do not reduce	Additional management action and oversight [ACTION OWNER: DOF]	Enhanced bank and agency costs reported as part of wider financial and workforce reporting	31.03.24	Reports to ELT and F&P outlining current areas of pressure and required actions to be taken as part of the financial planning decision making process Quality Improvement (QI) process started and agency summit to be convened	RED
Non-delivery of required recurrent cost reduction and improved efficiency and Quality Improvement	Compilation and delivery of planned Trust efficiencies and quality improvements to deliver 2023/24 plan including recurrent long term cost reductions to return to breakeven Planning for 2023/24 assumes 3% recurrent delivery and 1% non-recurrent delivery (this is subject to further review and planning decisions) [ACTIONS OWNER: DOF]	Efficiency and QI reporting to Execs and F&P	31.03.24	Limited schemes identified at time of draft plan submissions. Area of urgent work as reported to ELT in order to identify full £8.7m requirement. Area of urgent work following discussions with F&P committee on reducing the current planned deficit position and F&P has closed the gap and schemes have been identified for the full £6m	RED
Financial cost pressures created both internally and by system first decisions leading to the requirement for mitigations to close both the internal gap and the system financial gap	Additional 'stretch' management action required to reduce other cost and mitigate impact to achieve overall financial position [ACTION OWNER: DOF]	Achievement is incorporated into most likely case forecast reported to ELT, F&P, and system reporting	31.03.24	The financial position for Derbyshire is a risk to the statutory duties for DHCFT to manage its financial position Financial plan for 2023/24 is being finalised. Plan assumes a level of inflationary cost uplift in line with national guidance	RED

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

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Strategic Objective 4 - To be a GREAT Partner

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

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

Root causes:

a) New senior management relationships across organisations, with potential new appointments in system leadership roles with the creation of the new ICS as an NHS body and the creation of provider collaboratives

b) Creation of mental health, learning disability and autism provider collaborative may destabilise some of the established relationships in place across Derbyshire

c) Creation of system level governance structures may impact on provider Foundation Trust governance arrangements and decision-making processes

d) ICB staff impacted by change, may lead to increased staff turnover in teams supporting the delivery of the Mental Health Long-Term Plan and subsequent loss of organisational memory

e) The Trust taking on additional lead-provider responsibilities at an ICS or regional level could impact on the quality, performance and financial risks faced by the organisation

BAF Ref: 23-24 4A	**Director Lead**: Vikki Ashton Taylor (DSPT)	**Responsible Committee**: Trust Board

Key Controls

Inherent Risk Rating			**Current Risk Rating**				**Target Risk Rating**			**Risk Appetite**		
High	Likelihood 4	Impact 4	Moderate	Likelihood 3	Impact 3	Direction ↓	Moderate	Likelihood 3	Impact 4	Accepted	Tolerated	Not Accepted

Preventative – Governance structures in place at a system and Delivery Board level. Ongoing close communication with NHSE/I, mental health and learning disability teams at a regional and national level. Assumed NHSE/I-led appointment process to new ICS Board positions

Detective – Early meetings to be put in place with all new appointees at an executive level. Continuing engagement in all Joined up Care Derbyshire governance from DHCFT representatives. Due diligence processes undertaken prior to accepting any lead provider responsibilities

Directive – Mental Health, Learning Disability and Autism System Delivery Board to engage widely across membership on the development of any provider collaborative with agreed plans and processes. Gateway process run by NHSE prior to agreement to establish the Trust as lead-provider in any regional collaborative

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Assurances on controls (internal)	Positive assurances on controls (external)
Regular reporting of position to Board by CEO Regular ELT updates and discussions NED Board members on JUCD committees and Board Board agreement required prior to undertaking of lead-provider responsibilities	Monthly Mental Health and Learning Disability assurance meetings with NHSE/I teams with DHCFT represented by DSPT Appointments/ assurance of new ICS Board (ICB) through NHSE/I processes Gateway process run by NHSE prior to agreement to establish a Trust as lead-provider in regional collaboratives

Key gaps in control	Key actions to close gaps in control	Impact on risk to be measured by	Expected completion date (Action review date)	Progress against action	Action on track
Maintenance of relationships with ICB colleagues during period of change and potential instability	Weekly meetings of wider MHLD system transformation team. Support and guidance provided from DHCFT Early meetings at DHCFT Board level with all new appointees into the ICB [ACTIONS OWNER: DSPT]	Staff turnover from wider transformational team, including ICB staff Positive working relationships formed with all new appointees in the Derbyshire system	(31.06.23)	Weekly meetings continuing ICB now formed and fully recruited to and great effort is being made on maintaining strong working relationships. However, there remains a potential risk around evolving ICB culture and required reductions in staffing numbers ICB governance and emerging provider collaborative governance	GREEN
Plan required for the development of the MHLDA DB to become a provider alliance	Plan to be developed in partnership with all other organisations in the alliance [ACTION OWNER: CEO]	Development and agreement of Mental Health, Learning Disability and Autism (MHLDA) Provider Alliance before December 2021	(31.06.23)	All Boards in the Derbyshire system have agreed their support for the direction of travel for a single provider collaborative across the system and sitting below that it is explicit that there will be a MHLDA Provider Alliance MHLDA Provider Alliance formally established partnership agreement	GREEN

				The JUCD Neurodiversity and LD Alliance Festival was formally launched in September 2022	
Increased decision-making at a system and/or provider alliance level may create conflicting accountabilities with the Trust-level governance structures which could result in an increased governance burden	Keep Trust structures under continuous review against the wider governance landscape, including the provider collaboratives and alliance arrangements – This in turn may lead to a formal change of DHCFT governance arrangements [ACTION OWNERS: CEO/Trust Secretary]	Board level confidence in new and emerging governance structures and ability to gain assurance on DHCFT risks and issues via system level governance regime	(31.12.23)	Ongoing review of Trust governance to ensure operational performance delivery of MHLDA constitutional standards that DHCFT is a lead or main provider of the performance. DHCFT CEO now a member of ICB Derbyshire Provider Collaborative Leadership Board have an agreed work programme as approved by ICB	AMBER

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

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Strategic Objective 4 - To be a GREAT partner

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

Impact:
May lead to poor experience and care for people accessing services within Place and communities

Root causes:

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

BAF Ref: 23-24 4B	**Director Lead**: Vikki Ashton Taylor (DSPT)	**Responsible Committee**: Trust Board

Key Controls

Inherent risk rating			Current risk rating				Target risk rating			Risk appetite		
High	Likelihood 4	Impact 4	High	Likelihood 4	Impact 4	Direction ⟺	Moderate	Likelihood 3	Impact 3	Accepted	Tolerated	Not Accepted

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

Assurances on controls (internal)	Positive assurances on controls (external)
Appointment to Managing Director roles Regular TOOL and ELT updates and discussions NED Board members on JUCD committees CEO on ICB	Monthly Mental Health and Learning Disability assurance meetings with NHSE Monthly reporting by County and City Places to JUCD Place Executive Patient surveys conducted by Healthwatch

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Key gaps in control	Key actions to close gaps in control	Impact on risk to be measured by	Expected completion date (Action review date)	Progress against action	Action on track
System partners report that some of its core constitutional targets were not being met and was failing to make progress, at pace and scale	New internal performance improvement group and clarity to Trust Board on which DHCFT constitutional standards are not being met and whether the DHCFT contribution is the lead or material and how performance will improve [ACTION OWNERS: COO/DSPT]	Improvement in performance in constitutional standards	(31.03.24)	The integrated Performance report has been to allow insight on key areas of improvement, for targeted actions and narrative around next steps. CQUIN, and Real World Health insights have been added to track on a monthly basis to ensure we improve performance and patient outcomes Recovery action plans underpinned by quality improvement (QI) methodology, developed for constitutional standards where DHCFT are non-compliant – Positive outcomes are already apparent, e.g., CMHT 2+ contacts Transforming care (LD & A patients) remains off trajectory and has a full recovery plan	RED
System partners report that DHCFT is inward looking and does not fully support PLACE developments	Managing Directors to design a communication and improvement plan, with 360 feedback that PLACE partners feel DHCFT support, data is provided and their support named Managing Director is accessible [ACTION OWNER: COO]	PLACE / PCN and GP Directors provide direct feedback to Managing Directors on their relationship, knowledge and impact of the additional leadership support. This includes examples of collaboration and the impact of this support	(30.06.23)	Managing Directors (MDs) actively engaging with Primary Care Networks (PCNs) MDs are now members of Derby City PLACE Board and equivalent County Board	RED

		Confirmation of frequency of contact, joint action / achievement log of issues raised and achieved Managing Directors reports to TOOL with summary of impact to ELT		CEO meeting with GP network monthly – Positive feedback on attitude and responsiveness	
Social care partners have reported that the lack of progress on autism diagnostic reductions is difficult and would like to see increased pace of improvements	Improvement plan for joint autism service [ACTION OWNER: COO]	Feedback from social care on awareness of the Autism Strategy and autism waiting times reduce across the interagency investment plan	(30.12.23)	Autism investment plan agreed within MHLDA spend in 2023. Autism waiting times have now been achieved for the 26 contracted assessments per month and we are on target to achieve for Quarter 1 2023. Work continues to improve capacity to sustain compliance	AMBER
GP networks and partners report they do not feel connected to the MHLDA DB and are not aware of strategic decisions that are made	Communication and engagement plan with GP networks [ACTION OWNER: DSPT]	Feedback form GP networks on connectivity to the MHLDA DB and DHCFT named leads, information supplied GP networks reflect that they are briefed and actively engaged	(30.06.23)	MD membership in PLACE Alliance Boards agreed in January Monthly GP and DHCFT engagement events established to receive feedback and answer any strategic or system questions on DHCFT and the MHLDA DB	AMBER
Police partners report they do not always feel supported by mental health services and are under pressure to respond to mental health crisis	Police Education, support, communication and improvement plan with MH Delivery Board and Trust Directors [ACTION OWNERS: DSPT/CEO]	Inter-agency meeting and review of a joint way forward in 2023 including • Police Training • Suicide prevention work • Joint co-produced outcomes Agreed outcomes are monitored and reported through the MHLDA DB with liaison with DHCFT Police Liaison group	(31.06.23)	Police now a formal member of the MHLDA DB and attending and contributing New national guidance in draft and collaborative approaches including staffing of 136 suites included in programme level investment	AMBER

Patient and carers groups report that they would like to see more progress in service user and carer involvement and moving from engagement to decision making	Peer support strategy and objectives for EQUAL and the Mental Health Engagement Group [ACTION OWNERS: DON/MD/CEO]	Peer support strategy Co-production in Patient and Carer Race Equality Framework (PCREF) requirements	(30.06.23)	EQUAL Group established to support service user and carer engagement. EQUAL has created several sub committees and informs future service improvements across the East Midlands Perinatal Mental Health Provider Collaborative	AMBER

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

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

Multiple System Strategic Risk

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

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

Root causes:

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

BAF Ref: 23-24 MS1	**Director Lead**: Ade Odunlade (COO)	**Responsible Committee**: Quality and Safeguarding Committee within DHCFT Quality and Performance Committee within the Derbyshire ICS Mental health, LD and Autism Board in terms of system operational delivery

Key Controls

Inherent Risk Rating			Current Risk Rating				Target Risk Rating			Risk Appetite		
High	Likelihood 4	Impact 4	High	Likelihood 4	Impact 4	Direction ⬌	Moderate	Likelihood 3	Impact 3	Accepted	Tolerated	Not Accepted

Preventative – Health and safety audits; risk assessments; investment in estates development; workforce plan covering recruitment and retention. Mental Health Act Code of Practice **Detective** – CQC inspection reports; quality visit programme/virtual clinical service contact visits; incident, complaints and risk investigations; safety check log; Head of Nursing and Matron compliance visits **Directive** – Trust Strategy and commitments; Quality Improvement Strategy; Physical Health Care Strategy; Safeguarding Strategy; policies and procedures available via Trust intranet					
Assurances on controls (internal)		**Positive assurances on controls (external)**			
Regional and national escalation process internal preparation		Advisory support provided by DHCFT to the system on bedded care standards for Learning Disability in-patient services Involvement of Local Government Association to deliver a peer review Involvement of external consultants – Two reports			
Key gaps in control	**Key actions to close gaps in control**	**Impact on risk to be measured by**	**Expected completion date (Action review date)**	**Summary of progress on action**	**Action on track**
The community Intensive Support Team and Learning Disability models require improved models of support	Review all models of support offered by the Intensive Support Team [ACTION OWNERS: COO/DON/MD]	Outcome of review – Improved models of support	(30.06.23)	Review outcome: Services brought together across the North and South under a single service manager. Establishment of a DHCFT Productivity Programme Board and an operational delivery review are underway. Clinical delivery audit is also underway supported by NHSE/I to further understand wicked issues Patient flow review via MADE events underway as Learning Disability beds are occupied by patients who are clinically fit for discharge	RED

Improvements are required in rapidly returning patients who access Learning Disabilities and Autism (LD&A) services to local care to enable them to live their lives in the least restrictive manner as close to home as possible	Continue to work on developed delivery improvement plan, owned by system partners, to improve position. This includes new cohort stratification approach that has been developed – key action to implement and fully embed approach to ensure focussed system action on existing inpatients who are place inappropriately and out of area [ACTION OWNER: COO]	Improvement plans developed and implemented resulting in a stabilised service and positive outcomes for patients working across partner systems Enhancing and reviewing Listening and Engagement Active Partnerships (LEAP) procedures Improvement plans in admission avoidance, crisis alternatives to admission and market stimulation and development, including improvement in the use of Dynamic Support Registers as a means of admission avoidance Make significant impacts on the number of stranded patients who have delayed discharges in units across the country resulting in the NHSE escalations	(30.06.23)	Full cross-system delivery plan developed and being actively driven and monitored by revised Neurodevelopmental Delivery Board Benefits realisation sessions took place in September 2022 – Attended by all system partners. Nine themed benefits for the neurodevelopmental programme identified – Submitted to align future reporting Review of ways of working for Intensive Support Team undertaken to address variation in service offer Full integrated operational pathway mapping workshops with all system partners completed with ~~and~~ action plan to meet fidelity of optimal pathway Coproduction workshops completed with service users, families and carers to shape delivery plan Improved oversight is in place but significant improvement in performance and outcome is required in returning	RED

				complex individuals with learning difficulties/autism and risks. Derbyshire ICS remain an outlier	
Current substantial staff vacancies are negatively impacting on safer staffing levels in a non-DHCFT Derbyshire bedded care facility	Compliance with NHS Improvement (NHSI) Workforce Safeguards requirements [ACTIONS OWNERS: COO/DON]	Full compliance with safer staffing levels in line with the NHSI Workforce Safeguards	(30.06.23)	Reviews of safer staffing and stabilisation in non-DHCFT Derbyshire bedded LD facility - Part stabilisation achieved Workforce issues including recruitment and retention, staff wellbeing and mitigations against use of agency staff considered. Ongoing commitment to working in an alliance with DCHS to support a resolution for future bedded care for LD&A services across Derbyshire	AMBER
Clinical care standards in a non-DHCFT Derbyshire bedded care facility including care plans, levels of incidents, restrictive practices including the use of long-term segregation are not compliant with clinical care standards	Develop an improvement plan for all Derbyshire in-patient LD&A services [ACTION OWNERS: COO/DON]	Full compliance with required care standards External review of Long-Term Segregation and review to end restrictive practices	(30.06.23)	External review of Long-Term Segregation and review to end restrictive practices complete Ward recruitment and management responsibility has returned to DCHS, they are considering their model on the unit. DHCFT General Manager supporting The Trust is working with JUCD on a strategic outline case for the future of bedded care for LD&A in Derbyshire	RED

				Some improvements in clinical standards Care plan work continues Strategic Outline Case for the future of bedded care for LD&A in Derbyshire cleared at System Delivery Board to take into Outline Business Case – Work ongoing	
Lack of adherence to national guidance and policy on in-patient care in a non-DHCFT Derbyshire bedded care facility	Deliver a single room en-suite delivery plan and programme of work [ACTION OWNER: COO/DON]	Delivery of approved business cases for development of single en-suite facilities, seclusion suite at specification standards and other improving the therapeutic and healing environment requirements Implementation of programme of work	(30.06.23)	Initial review and development of business plan to be undertaken Work to provide facilities that meet national standards to be completed – Expected completion date to be confirmed	AMBER

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

Board Assurance Framework 2023/24 – Issue 1 Board 09.05.23

Risk Rating
The full Risk Matrix, including descriptors, is shown in the Trust's Risk Management Strategy

RISK ASSESSMENT MATRIX						
The Risk Score is a multiplication of Consequence Rating X Likelihood Rating						
The Risk Grade is the colour determined from the Risk Assessment Matrix						
		CONSEQUENCE				
LIKELIHOOD		INSIGNIFICANT 1	MINOR 2	MODERATE 3	MAJOR 4	CATASTROPHIC 5
RARE	1	1	2	3	4	5
UNLIKEY	2	2	4	6	8	10
POSSIBLE	3	3	6	9	12	15
LIKELY	4	4	8	12	16	20
ALMOST CERTAIN	5	5	10	15	20	25

Risk Grade/Incident Potential
Extreme Risk
High Risk
Moderate Risk
Low Risk
Very Low Risk

Actions on Track for Delivery Against Gaps in Controls and Assurances	Colour Rating
Action completed	Blue
Action on track to completion within proposed timeframe	Green
Action implemented in part with potential risks to meeting proposed timeframe	Amber
Action not completed to original or formally agreed revised timeframe. Revised plan of action required	Red

Action Owners

CEO	Chief Executive Officer	COO	Chief Operating Officer
DOF	Director of Finance – Currently Interim	DON	Director of Nursing and Patient Experience
MD	Medical Director	DPI	Director of People and Inclusion
DSPT	Director of Strategy, Partnerships and Transformation		

Definitions

Preventative	A control that limits the possibility of an undesirable outcome
Detective	A control that identifies errors after the event
Directive	A control designed to cause or encourage a desirable event to occur
Corrective	A control to limit the scope for loss and reduce the extent of undesirable outcomes

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 9 May 2023

Corporate Governance Report

Purpose of Report

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

Executive Summary

Included are governance documents requiring Board approval. These are:

- NHS England Year-End Self-Certification – including an update on the new provider licence
- Terms of Reference (ToRs) for Board Committees

Assurance is provided from the Audit and Risk Committee on the year-end governance reporting from Board Committees. All the Board Committees reviewed their Terms of Reference during their 2022/23 year-end effectiveness reviews and are attached for the Board's approval. There are only minor changes proposed, mainly to ensure consistency across the Committees. Of note is the removal of the paragraphs relating to the emergency provisions around attendance and reporting adopted in response to the COVID-19 pandemic.

The year-end report for the Audit and Risk Committee is also presented to the Board which summarises how the Committee has discharged its remit during 2022/23 and is in addition to the assurance summary reports which have been presented to Board meetings throughout the year.

The Trust Sealings register is also attached for information.

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

Assurances

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

Consultation

The year-end governance reports and ToRs have been through the individual Board Committees and monitored through the Audit and Risk Committee.

Governance or Legal Issues

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

Public Sector Equality Duty and Equality Impact Risk Analysis

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

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

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

Recommendations

The Board of Directors is requested to:

1. Approve the NHS England Year-end Self-Certification (Appendix 1)
2. Approve the suite of Terms of Reference for Board Committees (Appendix 2)
3. Note the assurance received by the Audit and Risk Committee that all Board Committees have effectively carried out their role and responsibilities as defined by their Terms of Reference during 2022/23 and receive the year-end report of the Audit and Risk Committee (Appendix 3)
4. Note the Trust seal report (Appendix 4).

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

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

1. NHS England Year-end Self-Certification

NHS Foundation Trusts are currently required to annually self-certify whether or not they have complied with the conditions of the NHS provider licence, have the required resources available if providing commissioner requested services, and have complied with governance requirements. There is no longer a requirement to submit the results to NHS England (NHSE); however, these must be published on the Trust website and are subject to audit by NHSE on request.

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

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

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

The amended NHS provider licence which came into effect from 1 April 2023 has removed the requirement to publish the above declarations from the 2023/24 reporting year onwards.

New provider licence

The new provider licence came into effect on 1 April 2023 and aims to support effective system working; enhances the oversight of key services provided by the independent sector; address climate change; and makes a number of necessary technical amendments, including a reduction in future self-certification reporting requirements. The new licence conditions are available to view here PRN00191-nhs-provider-licence-v4.pdf (england.nhs.uk)

The new licence was received by the Interim Chief Executive on 29 March 2023

Recommendation:

The Board of Directors is asked to approve the NHS Improvement Year-end Self-Certification.

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

At its meeting on 27 April 2023, the Audit and Risk Committee received the full year end summaries for all of the Board Committees as well as their Terms of Reference (ToR).

All Board Committees have reviewed their activity during the past year and sought verbal confirmation from their members that they had fulfilled the key duties under their ToR and were operating effectively in providing assurance to the Trust Board.

The Audit and Risk Committee received assurance from the summary reports that the Committees have effectively carried out their role and responsibilities during 2022/23. All the Board Committees have developed a full future year's forward plan.

The suite of ToRs are included as Appendix 2.

The year-end report for the Audit and Risk Committee is also presented to the Board at Appendix 3 which summarises how the Committee has discharged its remit during 2022/23 and is in addition to the assurance summary reports which have been presented to Board meetings throughout the year.

Recommendation:

The Board of Directors is requested to:

- approve the suite of ToRs for the Board Committees and note the assurance received by the Audit and Risk Committee that all Board Committees have effectively carried out their role and responsibilities as defined by their ToR during 2022/23.
- receive the year-end report for the Audit and Risk Committee

3. Register of Trust Sealings

The six-monthly update on the authorised use of the Trust Seal since the last report to the Board on 1 November 2022 is attached for information at Appendix 4.

Recommendation:

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

Appendix 1

Condition G6

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

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

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

Proposed declaration:

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

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

2. Continuation of Services Condition 7

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

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

Primary evidence is contained in the Going Concern assessment which has been considered by the Audit and Risk Committee. This assessment is based solely on the anticipated future provision of our services in the public sector in line with current guidance. This decision will be reviewed each year in order to ensure that accounts are prepared on an appropriate basis given prevailing circumstances at the time. The Trust's financial management arrangements, overseen by Finance and Performance Committee. This is described in full along with mitigating actions in the 2021/22 Board Assurance Framework.

Proposed Declaration:

The Board declares that the licensee has a reasonable expectation that the licensee will have the required resources available to it after taking account

distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.

3. Condition FT4 Declaration

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

The Trust has robust governance structures in place to maintain a well-led organisation. There has been regular updates to the Board on the on-going management of corporate governance within the Trust. The Trust has effective Board and committee structures, reporting lines and performance and risk management systems. See attached Corporate Governance Statement for further information against each item.

Proposed declaration:

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

4. Certification on Training of governors

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

Governor training has been carried out throughout the year; sessions were held digitally. All new governors attend a bespoke induction and all governors were encouraged to attend the training and development sessions, areas for development included finance (led by a Trust Director); the Integrated Performance Report and engagement. Governors were also encouraged to attend virtual GovernWell sessions organised by NHS Providers, and the NHS Providers conference which gave governors the opportunity to network with governors from other Trusts and to share good practice.

Proposed declaration:

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

Corporate Governance Statement – 2022/23

1. The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	
Response	**Confirmed**
Risks and Mitigating actions The Trust has stood back up 'business as usual' in terms of its governance structures, having flexed them during the response to the pandemic, in line with the national 'reducing the burden' guidance. Our governance processes are set out in the Annual Report and Annual Governance Statement. The Trust received a 'Good' rating in the CQC Well Led inspection in 2020. Board Committees continue to review effectiveness with year-end reviews undertaken by each Committee during March 2023 for onwards scrutiny and oversight by the Audit and Risk Committee and then Trust Board.	
2. The Board has regard to such guidance on good corporate governance as may be issued by NHS England time to time	
Response	**Confirmed**
Risks and Mitigating actions The Trust has continued to embed good practice through self-assessment against the shared NHSE/ CQC well-led framework. The Trust had several areas of positive feedback on corporate governance elements of well-led following the CQC comprehensive inspection report.	
3. The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	
Response	**Confirmed**
Risks and Mitigating actions The Trust corporate governance framework has been implemented successfully in terms of Board and Board Committee responsibilities, delegation and escalation. There is a process for review of all Board Committees to reflect on their effectiveness.	
4. The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively;	

(b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations;

(c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions;

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

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

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

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

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

Response	**Confirmed**

Risks and Mitigating actions

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

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

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

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

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

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

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

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

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

Derbyshire Healthcare
NHS Foundation Trust

Appendix 2

Remuneration and Appointments Committee Terms of Reference

Purpose

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

1. Authority

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

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

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

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

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

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

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

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

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

2. Membership

2.1 The membership of the Committee shall consist of:

- Trust Chair
- All Non-Executive Directors.

2.2 The Trust Chair will chair the Committee.

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

3. Attendance

3.1 Meetings of the Committee may be attended by:

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

4. Quorum

4.1 A quorum shall be three members.

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

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

5. Frequency of Meetings

Meetings shall be held quarterly or as required.

6. Duties and Responsibilities

These terms of reference are based in part, on best practice as set out in the Code of Governance[1] and have been drafted referring to the provision in the code. The code states as two of its principles that;

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

" Appointments to the board of directors should follow a formal, rigorous and transparent procedure, and an effective succession plan should be maintained for board and senior management. Appointments should be made solely in the public interest, with decisions based on integrity, merit, openness and fairness. Both appointments and succession plans should be based on merit and objective criteria and, within this context, should promote diversity of gender, social and ethnic backgrounds, disability, and cognitive and personal strengths, Directors of NHS foundation trusts must be "fit and proper" to meet the requirements of the general conditions of the provider licence"

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

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

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

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

6.1 Appointments role

6.1.1 To be responsible for identifying and appointing candidates to fill all the executive director positions on the Board including the Chief Executive, voting and non-voting Directors. Non-Executive Directors are appointed through the Nominations and Remuneration Committee of the Council of Governors. Best practice is that the selection panel for a post should include at least one external assessor from NHS England and/or a representative from a relevant ICB, and the foundation trust should engage with NHS England to agree the approach.

6.1.2 Regularly review the structure, size and composition (including the skills, knowledge, experience and diversity) of the Board, making use of the output of the board evaluation process as appropriate, and make recommendations

[1] Code of governance for NHS provider trusts. This comes into effect from 1 April 2023 and replaces the 2014 Code of Governance

to the board, and nomination committee of the Council of Governors, as applicable, with regard to any changes.

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

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

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

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

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

6.2 Remuneration Role

6.2.1 Establish and keep under review a remuneration policy in respect of Executive Directors.

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

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

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

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

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

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

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

7. Minutes and Reporting

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

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

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

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

7.5 Agendas and papers will be distributed in accordance with deadlines agreed with the Committee Chair. Ideally this should be no less than three working days although flexibility will be maintained for extra-ordinary circumstances.

8. Terms of Reference Review

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

Approved by Remuneration & Appointments Committee	15 March 2023
To be approved by Audit & Risk Committee	27 April 2023
To be approved by Board of Directors	9 May 2023

Audit and Risk Committee Terms of Reference

Purpose

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

1. Authority

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

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

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

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

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

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

1.7 As a designated policy ratification group, (see 'Policy on Policy' document) the Audit and Risk Committee is operationally responsible for monitoring that the policy documents for which it is responsible comply with the policy. This includes monitoring that the style, content and format of the policy are compliant, including completion of

the Equality Impact Assessment (EIA) which forms part of the current policy template. All policy documents are allocated a policy ratification group as they are published on Connect.

2. Membership

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

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

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

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

3. Attendance

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

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

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

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

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

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

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

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

Access

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

4. Quorum

4.1 A quorum shall be two Non-Executive Directors.

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

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

5. Frequency of meetings

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

6. Duties and Responsibilities

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

Integrated governance, risk management and internal control

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

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

6.4 In particular to review the adequacy and effectiveness of:

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

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

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

- arrangements in place for preventing and countering fraud, bribery and corruption and managing security in compliance with the related NHS Protect Standards
- The Committee shall maintain an oversight of the Trust's general material control and risk management systems, including processes and responsibilities, the production and issue of any risk and control-related disclosure statements. The key record to guide the Committee's work will be the Board Assurance Framework (BAF).

6.5 As part of its integrated approach, the Committee will ensure appropriate information

flows, to the Committee from executive management and from and between other Board Committees, in relation to the Trust's overall internal control and risk management position.

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

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

Internal audit

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

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

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

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

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

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

External audit

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

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

6.15 To assess the External Auditor's work and fees each year and based on this assessment, to make the recommendation above to the Council of Governors with respect to the re-appointment or removal of the Auditor. This assessment should include the review and monitoring of the External Auditor's independence and

objectivity and effectiveness of the audit process in light of relevant professional and regulatory standards.

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

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

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

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

Annual accounts review

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

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

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

Speaking Up (Raising Concerns including Protected Disclosures)

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

Standing orders, standing financial instructions and standards of business conduct

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

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

6.25 To review the scheme of delegation.

Other

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

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

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

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

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

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

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

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

6.34 Responsibility for the oversight of data quality assurance.

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

7. Minutes and Reporting

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

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

the Committee shall present details to a meeting of the Board of Directors in addition to the assurance summary.

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

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

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

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

8. Administrative Support

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

- Agreement of the agenda with the Chair of the Committee and attendees
- Preparation, collation and circulation of connected papers in good time. The target is to send out the agenda packs 5 days in advance.
- Ensuring that those required to attend are invited to the meeting in good time
- Ensuring that the minutes are taken and keeping a record of matters arising and issues to be carried forward
- Manage the forward plan of the Committee's work
- Arranging meetings for the Chair with directors and advisers as necessary
- Advising the Committee as appropriate on pertinent issues/areas of interest/policy developments
- Enabling training and development of Committee members as appropriate
- Reviewing every decision to suspend the standing orders.

9. Review of Terms of Reference

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

Approved by Audit and Risk Committee	27 April 2023
To be approved by the Board of Directors	9 May 2023

Finance and Performance Committee Terms of Reference

Purpose

The prime purpose of the Committee is to gain assurance on all aspects of financial and operational performance, on behalf of the Board. The Committee also oversees and approves business developments as well as considering progress with commercial and contractual matters. The Committee is responsible for agreeing terms of reference and annual work programmes for its supporting sub-committees. It also receives agreed assurance and escalation reports as defined in the forward plan for the Committee.

1. Authority

1.1 The Committee oversees and approves business developments as well as considering progress with commercial and contractual matters.

The Committee may refer specific issues to the Board, Audit and Risk Committee and other Committees and make recommendations as appropriate. Matters formally delegated to the Finance and Performance Committee by the Board of Directors are:

- Continuous Improvement including CIP (Cost Improvement Programme) plan reporting
- Contractual compliance performance reporting
- Treasury Management – to approve policy, procedures, controls and monitoring of policy implementation
- Working Capital Facility – to approve (if applicable)
- Estate strategy delivery oversight including assurance on performance of the estates and facilities management function, on maintenance programmes and on statutory and regulatory compliance – twice yearly updates
- Indicative 5 year capital plan – approval
- Reference Costs: process - sign-off
- Emergency Preparedness, Resilience and Response (EPPR)
- Health and Safety Compliance Report

1.2 Aside from those specific matters listed, the Committee otherwise gains assurance on matters through reports and exceptions provided to it.

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

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

1.5 The Trust has a duty under the Equality Act 2010 to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good

relations between people from different groups. The Act protects against discrimination on grounds of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, gender and sexual orientation. The Finance & Performance Committee will ensure consideration has been given to equality impact related risks.

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

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

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

1.9 To receive assurance in relation to the fulfilment of the financial and performance aspects of the Trust's roles and responsibilities as Lead Provider of the East Midlands Perinatal Mental Health Provider Collaborative during the development and subsequent implementation of the provider collaborative, including the effective operation of Northamptonshire Healthcare Commissioning Hub support.

2. Membership

2.1 The membership of the Committee shall comprise:

Non-Executive Directors x 3 (one will be appointed as the Chair)
Director of Finance
Chief Operating Officer
Director of Strategy, Partnerships and Transformation

2.2 If the Chair is not present, one of the Non-Executive Directors will chair the meeting. Other staff may be required to attend, at the invitation of the Committee.

2.3 The Trust Chair will appoint the Chair of the Committee.

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

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

2.6 The Trust Board has delegated authority to any Non-Executive Director of the Trust to act as nominated deputy in the absence of any Non-Executive and this attendance will count towards the quorum.

3. Attendance

3.1 Other staff may be required to attend at the invitation of the Committee.

3.2 The Chief Executive Officer reserves the right to attend any meeting.

4. Quorum

4.1 A quorum shall normally be four members, including at least two Executive Directors and two Non-Executive Directors; noting that as a minimum the executive attendance must include both the Director of Finance and the Chief Operating Officer or their deputies acting as their direct representative.

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

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

5. Frequency

5.1 Meetings should be held bi-monthly with additional meetings if required.

6. Duties and Responsibilities

6.1 To monitor the development and delivery of financial and operational aspects of the Trust strategy through:

- Detailed oversight of current and future financial performance including financial risks
- Detailed oversight of current and future operational performance.

6.2 To monitor delivery of the continuous improvement programme including CIP.

6.3 To oversee progress on contractual negotiations.

6.4 To receive reports on business and commercial matters.

6.5 To consider outline business cases and proposals and to approve or make recommendations to Board accordingly.

6.6 To receive reports or referrals from committees and other meetings, relevant to the work of this Committee.

6.7 The agenda for the Committee will be informed by a forward plan of regular items but will also receive reports on relevant issues requiring additional scrutiny and assurance pertaining to actual and anticipated performance and/or when required by Trust Board or Audit and Risk Committee.

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

6.9 To conduct a self-effectiveness review of the performance of the Committee at the close of every meeting.

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

7. Minutes and Reporting

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

7.2 An assurance summary will be prepared and submitted to the Board of Directors and shall include details of any matters to be escalated in respect of which actions or improvements are needed.

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

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

7.5 Agenda and papers will be distributed in accordance with deadlines agreed with the Committee Chair. Ideally this should be no less than three working days although flexibility will be maintained for extra-ordinary circumstances.

8. Terms of Reference Review

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

Approved by Finance and Performance Committee	21 March 2023
To be approved by Audit and Risk Committee	27 April 2023
To be approved by Trust Board	9 May 2023

Derbyshire Healthcare
NHS Foundation Trust

Quality and Safeguarding Committee Terms of Reference

Purpose

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

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

1. Authority

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

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

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

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

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

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

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

1.8 To receive assurance in relation to the fulfilment of the quality aspects of the Trust's roles and responsibilities as Lead Provider of the East Midlands Perinatal Mental Health Provider Collaborative during the development and subsequent implementation of the provider collaborative, including the effective operation of Northamptonshire Healthcare Commissioning Hub support.

2. Membership

2.1 The membership of the Committee shall comprise:

- Non-Executive Directors x 3 (one will be appointed as the Chair)
- Director of Nursing and Patient Experience or a nominated deputy
- Medical Director or a nominated deputy
- Chief Operating Officer or a nominated deputy

2.2 The Trust Chair will appoint the Chair of the Committee

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3. Attendance

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

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

3.2 The following may also attend:

- Chief Executive Officer
- Trust Chair
- Director of Finance
- Director of People and Inclusion
- Director of Strategy, Partnerships and Transformation

- Trust Secretary

Any other attendees will be invited upon request.

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

3.4 The Trust Board has delegated authority to any Non-Executive Director of the Trust to act as nominated deputy in the absence of any Non-Executive and this attendance will count towards the quorum.

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

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

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

3.8 Nominated deputies for Executive members will contribute to attendance figures but will not contribute to quorum.

3.9 Other staff may be co-opted to attend meetings as considered appropriate by the Committee on an ad hoc basis.

4. Quorum

4.1 A quorum shall normally be three members, including at least one Executive Director and two Non-Executive Directors.

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

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

5. Frequency

5.1 Meetings shall be held ten times a year on a monthly basis except during January and August

6. Duties and Responsibilities

In respect of general governance arrangements:

6.1 To ensure that all statutory elements of operational risk and quality governance are adhered to within the Trust including the requirements of our regulators, NHS England and the Care Quality Commission (regulations).

6.2 To provide a clear link with the Trust's Strategy and Quality framework when agreeing quality governance priorities and monitor scrutinise these areas to provide

assurance and inform the Board on the strategic direction for Quality and monitor the performance of the clinical services.

6.3 To provide direction to the quality governance activities of the Trust's services and divisions. This will include setting strategy, delegating activities and monitoring clinical performance against this strategy or quality priorities.

6.4 To scrutinise, gain assurance and approve the Trust's Quality Governance Annual Reports before submission to the Board.

6.5 To have final sign off of the Trust Quality Account.

6.6 To approve the terms of reference and membership of its reporting sub-committees, the primary reporting committee will be the Executive chaired quality sub-group known as TOOL (Trust Operational Oversight Leadership). This is an operational delivery group but it will also scrutinise the clinical performance of the key sub-groups known as the Integrated Clinical Operational Assurance Teams at service level; and to oversee the work of those sub-committees and their clinical reference sub-groups, receiving reports from them, reviewing their work plans and clinical escalation issues. This will include oversight and escalation from the Divisional achievement reviews.

6.7 To scrutinise the work of the TOOL and receive assurance from the Chair of the group on quality performance issues and mitigating actions to ensure safe and effective services.

6.8 To agree to refer specific issues to the Board and other Board Committees where required and make recommendations as appropriate.

6.9 To receive and approve the annual Clinical Audit Programme consistent with the audit needs of the Trust and consistent with the Quality priorities.

6.10 To have oversight and gain assurance on the Trust's policies and procedures with respect to the use of clinical data and patient identifiable information to ensure that this is in accordance with all relevant legislation and guidance including the Caldicott Guidelines and the Data Protection Act 1998.

6.11 To make recommendations to the Audit and Risk Committee concerning the annual Internal Audit plan, to the extent that it applies to matters within these terms of reference; and to comply with any request from the Audit and Risk Committee for assurance in relation to the Board Assurance Framework and the Risk Register.

6.12 To have overview, responsibility and gain assurance for all regulations and standards as described by the Care Quality Commission as part of our responsibilities under the Care Quality Commission (Registration) Regulations 2009 and Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

6.13 To promote within the Trust a culture of open and honest reporting of any situation, including Duty of Candour, that may threaten the quality of patient care in accordance with the Trust's policy on Freedom to Speak Up and monitoring the implementation of that policy. This will include an approach that enables an open patient safety culture and gain assurance on its implementation.

6.14 To ensure that when matters of concern are raised during Committee business these are dealt with openly and transparently and scrutinised as appropriate. When issues

arise the Committee will undertake to challenge robustly and fairly in order to develop a culture of continuous improvement, openness and honesty.

6.15 To oversee the system within the Trust for obtaining and maintaining any licences relevant to clinical activity in the Trust.

6.16 To ensure that risks to patients are minimised through the application of a comprehensive risk management system including clinical risk registers, monitoring and learning from deaths and associated monitoring.

6.17 To oversee the process and gain assurance within the Trust to ensure that appropriate action is taken in response to adverse clinical incidents, mortality, complaints and litigation and those examples of good practice are disseminated within the Trust and beyond if appropriate.

6.18 To ensure a clear link with the Mental Health Act Committee on aspects of quality governance that are cross cutting clinical standards across mental health act or mental capacity act legislation that impacts upon clinical standards.

6.19 To maintain a forward plan of regular agenda items as identified by the scheme of delegation.

6.20 To ensure a clear link and be assured with the Commissioners Quality Assurance Group, and that escalated clinical concerns, gaps in commissioning and patient safety concerns are discussed and monitored through the joint commissioner and provider risk and issues log.

6.21 To gain assurance and monitor the work of the Trust-wide groups which report to the Quality and Safeguarding Committee, currently the Serious Incident Requiring Investigation (SIRI) group, the Physical Health Care Committee, Health and Safety Committee, Drugs and Therapeutics Committee, Patient Experience Group and any short term named task and finish groups established to design or develop Trust Clinical Strategy.

6.22 To co-operate with and assist the work of other Trust-wide groups which report or scrutinise the work of the Quality and Safeguarding Committee, e.g. governors' Governance Committee or the Council of Governors.

6.23 To receive assurance on how the Trust has developed and planned for all clinical service re-design with sign off of any associated clinical safety plans to mitigate any significant or material changes in service, which have been designed and developed by the Clinical Operational Assurance Teams. This includes all quality impact assessments of cost efficiency savings and any deficit reviews.

6.24 To conduct a self-effectiveness review of the performance of the Committee at the close of every meeting.

6.25 To oversee the development of an annual review of performance of the Committee against key areas of delegated authority and provide a check that all areas of governance and responsibility have been monitored.

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

6.27 To set the Safeguarding Quality Strategy, to provide quality governance and gain assurance to all aspects of the safeguarding agenda and lead the assurance process on behalf of the Trust for the following areas:

6.27.1 **Children's Act** has a statutory duty of care towards children (Children Acts 1989 and 2004) at risk of harm who are resident in Derby city and Derbyshire in our care. The committee will ensure as an organisation we have safeguards in place not only protects and promotes the welfare of vulnerable children, but that we have a significant impact on children in our care's health and well-being.

6.27.2 **The Care Act (2014)** Safeguarding adults at risk of abuse or neglect (Section 42 and named other relevant NHS legislation and NHS Safeguarding Adults policy and procedures.

6.27.3 **Counter Terrorism legislation** The Counter Terrorism and Security Bill, which is currently before Parliament (December 2014) at the time of writing, seeks to place duty on specified authorities (identified in full in Schedule 3 to the bill, and set out in this draft guidance) to have due regard to the need to prevent people from being drawn into terrorism through Prevent.

6.27.4 **A formal link to the area Safeguarding Children and Adults Boards** and provide systems leadership to our wider geographical and community safeguarding responsibilities and be the conduit for linking the community Safeguarding Board strategies with the Trust strategy.

6.27.5 **Promote a proactive and preventative approach** to safeguarding through our Flourishing Families agenda.

6.27.6 Ultimately to provide assurance to the Trust Board that the organisation is effectively discharging and fulfilling its statutory responsibility for safeguarding to ensure better outcomes for children and vulnerable adults.

6.27.7 Ensure the Trust workforce is appropriately trained in safeguarding children and adults to their appropriate level depending on their role and responsibility.

6.27.8 To determine strategic and operational development that will enable the Trust to integrate best practice in safeguarding across the Trust. The Committee has a responsibility to improve and develop Safeguarding practices consistent with national and local legislation, guidance and standards in safeguarding children and vulnerable people.

6.27.9 To ensure that the Trust embeds Think Family principles within all aspects of care and service developments to enable 'Flourishing Families'.

6.27.10 To provide rigorous and transparent assessment of performance and effectiveness and quality of practice for Safeguarding of Children and Family and Vulnerable Adults Services within the Trust.

6.27.11 To advise the Trust Board of national and local standards and Derby and Derbyshire Safeguarding Board arrangements.

6.27.12 The Committee will oversee Serious Case Reviews, Independent Learning Reviews, Domestic Homicide Reviews and all safeguarding major incidents and will advise service level directors and operational managers of recommendations, lessons learnt and compliance requirements.

6.27.13 The Committee will oversee and assure itself that all Safeguarding Boards for Children and Adults are appropriately represented and feedback from Boards to the Trust Board is in place

6.27.14 The Committee will oversee and assure itself on the Prevent and Channel: Supporting Individuals Vulnerable to Recruitment by Violent Extremists agenda. Establish or use existing mechanisms for understanding the risk of radicalisation. Communicate and promote the importance of the duty; as outlined in any counter terrorism legislation (2015) and ensure staff implement the duty effectively.

6.27.15 The Committee will oversee and assure itself on the Multi-Agency Public Protection Arrangements (MAPPA) with relevant agencies including the police. These processes ensure that the requirements for offenders in the community needs are met and duties to public safety are met fully.

6.27.16 The Committee will oversee and assure itself on the MARAC agenda, the Multi-Agency Risk Assessment Conference, that the trust is discharging its duty. The MARAC aims to share information to increase the safety, health and wellbeing of victims/survivors - adults and their children; improve agency accountability; and improve support for staff involved in high-risk domestic abuse cases

6.27.17 Have authority in the setting the quality standards, defining and monitoring of clinical practice in safeguarding children and vulnerable adult people through delegated duties to the Safeguarding Operational Group.

6.28 Safeguarding Adults Key Responsibilities:

6.28.1 Schedule 2 of the Care Act (2014). That Geographical links to the Safeguarding Adults Boards must have a clear, agreed understanding of the roles, responsibilities, authority and accountability of its member agencies, therefore the Trust should annually:

- Review suitable governance arrangements an effective infrastructure and adequate resources
- Deliver operational and strategic requirements
- Provide links to other boards and partnerships
- Provide links to other boards and partnerships
- Provide a person-centred, outcome focused safeguarding policy and procedures
- Ensure that there is awareness training for all health and social care staff and Police who work directly with people with care and support needs
- Ensure that there is a specialist training for all practitioners who have direct responsibilities for safeguarding work
- Develop and publish a Trust strategy specifying each service areas responsibilities

- Link with the wider community to inform its work and learn of the work of the Board
- Sign off the Safeguarding Adult Annual reports, detailing what the Trust and its members have achieved, including how they have contributed to the Board's objectives and what has been learned from and acted upon from the findings of Safeguarding Adults Reviews and Case Reviews and other Domestic Homicide reviews and associated audits
- Arrangements for the quality assurance of the effectiveness of safeguarding work.

6.29 Safeguarding Children Key Responsibilities:

- Scrutinise the Safeguarding Children Annual report, oversight of the Section 11 audit work and assurance that the Trust discharges its duty responsibly in line with national requirements
- Review suitable governance arrangements an effective infrastructure, adequate resources
- Deliver operational and strategic requirements
- Provide links to other boards and partnerships
- Provide a child centred, outcome focused safeguarding policy and procedures
- Ensure that there is training for all health and social care staff and Police who work directly with people with care and support needs
- Develop and publish a Trust strategy specifying each service areas' responsibilities
- Sign off the Children and Looked After Children Annual Reports, detailing what the Trust and its members have achieved, including how they have contributed to the board's objectives and what has been learned from and acted upon from the findings of Safeguarding Serious Case Reviews.

7. Minutes and Reporting

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

7.2 An assurance summary will be prepared and submitted to the Board of Directors and shall include details of any matters to be escalated in respect of which actions or improvements are needed.

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

7.4 Agendas and papers will be distributed in accordance with deadlines agreed with the Committee Chair. Ideally this should be no less than three working days although flexibility will be maintained for extra-ordinary circumstances.

8. Terms of Reference Review

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

Approved by Quality and Safeguarding Committee	18 April 2023
To be approved by Audit and Risk Committee	27 April 2023
To be approved by Trust Board	9 May 2023

Derbyshire Healthcare
NHS Foundation Trust

People and Culture Committee Terms of Reference

Purpose

The Committee supports the organisation to achieve a well-led, values driven and inclusive positive culture. The Committee is to provide assurance to the Board that the appropriate structures, processes and systems are in place to ensure an effective capable workforce to meet the Trust's current and future needs including workforce engagement and development.

1. Authority

1.1 The People and Culture Committee is constituted as a standing committee of the Foundation Trust's Board of Directors. Its constitution and Terms of Reference shall be as set out below, subject to amendment at future Board of Directors meetings. The People and Culture Committee shall not have executive powers in addition to those delegated in these terms of reference.

1.2 The Committee is authorised by the Board of Directors to obtain external legal or other independent professional advice and to secure the attendance of both internal and external officers with relevant experiences and expertise it if considers this necessary.

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

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

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

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

1.7 As a Committee of the Board, the People and Culture Committee has an important role to provide assurance on the progress and risks relating to the delivery of the Trust's strategic objectives which fall within the Committee's remit, this includes the delivery and implementation of the Trust's 3 year People Strategy.

2. Membership

2.1 The membership of the Committee will comprise:

- Non-Executive Directors x 3 (one will be appointed as the Chair)
- Director of People and Inclusion
- Medical Director
- Chief Operating Officer

The Deputy Medical and Managing Directors are to attend meetings as nominated deputies if the Medical Director or Chief Operating Officer are unable to attend.

In attendance as core attendees:

- Deputy Director of People and Inclusion
- Other team leaders may be invited to attend to present on specific agenda items or when relevant at the discretion of the Chair and Director of People and Inclusion

2.2 A quorum shall be three (not less than two non-executive directors and one executive director).

2.3 Members are expected to attend a minimum of four meetings per year.

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

3. Attendance

3.1 Only members of the Committee have the right to attend and vote at Committee meetings. The Committee may require other officers of the Trust, and other individuals to attend all or any part of its meetings as and when is necessary.

3.2 The Chief Executive Officer reserves the right to attend any meeting.

3.3 The Trust Chair will appoint the Chair of the Committee.

3.4 The Trust Board has delegated authority to any Non-Executive Director of the Trust to act as nominated deputy in the absence of any Non-Executive and this attendance will count towards the quorum.

4. Quorum

4.1 A quorum shall normally be three (not less than two Non-Executive Directors and one Executive Director).

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

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

5. Frequency

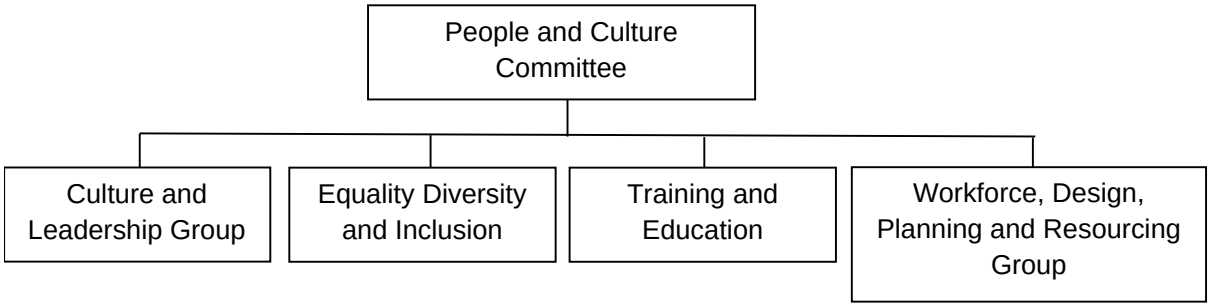
5.1 The Committee will meet on bi-monthly basis with additional meetings being called when necessary.

6. Duties and Responsibilities

6.1 The Committee will support the organisation to achieve a well led, values driven positive culture. The Committee is to provide assurance to the Board that the appropriate structures, processes and systems are in place to ensure an effective capable workforce to meet the Trusts current and future needs.

6.2 The Committee will monitor the implementation of the People Strategy and report progress to the Board by exception.

6.3 A number of supporting groups / forums will be accountable to the People and Culture Committee whilst not exhaustive; it is anticipated that the following groups will have a direct or indirect relationship and will be agreed within the Committee:



6.4 The Committee will oversee and monitor workforce performance.

6.5 The Committee review and monitor the Workforce metrics and Board Assurance Framework and ensure the Board is kept informed of any significant workforce risks.

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

6.7 The Committee is to be assured that mechanisms are in place to review and monitor the effectiveness and capability of the workforce across the whole Trust and that appropriate actions are taken to address issues of poor performance and bring about continuous quality improvement.

6.8 The Committee is to be assured that the Trust identifies lessons for improvement and implements these in all relevant areas.

6.9 The Committee is to be assured that National standards, guidance and best practice are systematically reviewed and embedded within the Trust.

6.10 The Committee is to be assured that the views of staff and appropriate others are systematically and effectively engaged in organisational development activities.

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

6.12 The Committee will oversee the leadership, training and education framework and monitor progress.

6.13 The Committee will monitor the implementation of agreed action plans in relation to organisational interventions and measure the effectiveness of change.

6.14 The Committee will review its effectiveness by self-assessment on an annual basis and at the end of each meeting. The annual review will be presented to the Audit and Risk Committee.

7. Minutes and Reporting

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

7.2 An assurance summary will be prepared and submitted to the Board of Directors and shall include details of any matters to be escalated in respect of which actions or improvements are needed.

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

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

7.5 Agendas and papers will be distributed in accordance with deadlines agreed with the Committee Chair. Ideally this should be no less than three working days although flexibility will be maintained for extra-ordinary circumstances.

8. Terms of Reference Review

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

Approved by People and Culture Committee	28 March 2023
To be approved by Audit and Risk Committee	27 April 2023
To be Approved by Trust Board	9 May 2023

Derbyshire Healthcare
NHS Foundation Trust

Mental Health Act Committee Terms of Reference

Purpose

The Committee monitors and obtains assurance on behalf of the Hospital Managers and the Trust as the detaining authority that the safeguards of the Mental Health Act are appropriately applied. It also monitors related statute and guidance and reviews the reports following Mental Health Act inspections by the Care Quality Commission.

1. Authority

1.1 The Board of Directors has approved the establishment of a Mental Health Act Committee as a Committee of the Board. The purpose of the Committee is to obtain assurance, on behalf of the "Hospital Managers" and the Trust as the detaining authority, that the safeguards and provisions of the Mental Health Act are appropriately applied; to take account of the provisions of related statute and guidance, such as Mental Capacity Act, Deprivation of Liberty Safeguards (DOLS) and Human Rights Act.

1.2 The Committee will exercise its responsibilities by fulfilling a scrutiny and monitoring role from receipt of regular activity data and inspection reports from an Operational Group; by obtaining assurance that best practice is deployed across the Trust.

1.3 As a Committee of the Board, the Mental Health Act Committee has an important role to provide assurance on the progress and risks arising relating to the delivery of the Trust's Strategic objectives which fall within the Committee's remit. It will consider any exceptions or risks escalating these to the Trust Board or referring to the Executive Leadership Team as necessary.

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

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

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

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

1.8 As a designated policy ratification group, (see 'Policy on Policy Documents) the Mental Health Act Committee is operationally responsible for monitoring that the policy documents for which it is responsible comply with the policy. These include policies in relation to the Mental Health Act and Code of Practice requirements, and the duties of Associate Hospital Managers, including the protocols for the hearing of appeals and reviews. It also includes monitoring that the style, content and format of the policy are compliant, including completion of the Equality Impact Assessment (EIA) which forms part of the current policy template. All policy documents are allocated a policy ratification group as they are published on Focus.

1.9 An operational subgroup will meet approximately one month before the full Committee to prepare assurances and highlight exceptions.

2. Membership

2.1 The membership of the Committee shall comprise:

- Non-Executive Directors x 3 (one will be appointed as the Chair)
- Medical Director or a nominated deputy
- Trust Secretary

2.2 The Trust Chair will appoint the Chair of the Committee.

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

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

3. Attendance

3.1 Additional attendees shall comprise:-

- Assistant Director of Legal, Governance and Mental Health Legislation
- Mental Health Act Manager
- Representative of Associate Hospital Managers
- Other senior management/professional leads may be invited at the discretion of the Committee Chair.

3.2 The Chief Executive Officer reserves the right to attend any meeting.

3.3 The Trust Board has delegated authority to any Non-Executive Director of the Trust to act as nominated deputy in the absence of any Non-Executive and this attendance will count towards the quorum.

4. Quorum

4.1 Quorum is normally a minimum of three members including at least two Non-Executive Directors and one Executive Director. If the Medical Director is unable to attend the Director of Nursing and Patient Experience will be required to attend instead in order to meet the quorum requirements.

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

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

5. Frequency

5.1 Meetings will be held quarterly.

6. Duties and Responsibilities

6.1 To receive compliance and assurance reports from the Operational Group regarding the number of patients subject to detention under each section of the Mental Health Act for the previous quarter as part of a rolling twelve month review to identify any variation or trends (including diversity data) and provide interpretation of data including an outline of actions arising as appropriate.

6.2 To consider matters of recommended good practice, and in particular the requirements of the Code of Practice (Revised): Mental Health Act (1983) and its Code of Practice as amended and approve policy changes to receive assurance on the steps taken to implement and embed recommended good practice relating to the requirements of the Mental Health Act, Mental Capacity Act and related legislation.

6.3 To receive assurance reports and scrutinise, as required, other activity reports from the Operational Group e.g. the use of seclusion, noting any exceptions and escalating concerns as necessary.

6.4 To receive assurance reports relating to the Care Quality Commission Inspection Reports and the implementation of the management response as defined by the Operational Group, providing scrutiny and challenge and noting exceptions and risks escalated by the operational group. With regard to Section 136, to oversee and receive assurance on the use of this section through the multi-agency Section 136 sub-committee.

6.5 To oversee the implications of related legislation, principally the Mental Capacity Act, (including Deprivation of Liberty), Human Rights Act guidance and other related legislation as appropriate, receiving assurance on impact, risk and effective implementation throughout the Trust.

6.6 To oversee that training needs are satisfactorily met to ensure compliance with legislative and best practice requirements, through assurance reporting and in general help promote awareness of the requirements of the Mental Health Act, Mental Capacity Act and associated legislation.

6.7 When receiving information on Mental Health Act activity and reports, the Committee will pay due regard to the Trust's Equality and Diversity Agenda.

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

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

6.10 To conduct a self-effectiveness review of the performance of the Committee at the close of every meeting.

6.11 To maintain a forward plan of regular agenda items to encompass the role and remit of the Committee as outlined in the Terms of Reference.

6.12 To oversee the development of an annual review of performance of the Committee against key areas as outlined within the Terms of Reference and confirm that all areas of governance and responsibility have been monitored.

6.13 Receive feedback from Associate Hospital Mangers and review any performance issues arising from mental health tribunals.

7. Minutes and Reporting

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

7.2 An assurance summary will be prepared and submitted to the Board of Directors and shall include details of any matters to be escalated in respect of which actions or improvements are needed.

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

7.4 Agendas and papers will be distributed in accordance with deadlines agreed with the Committee Chair. Ideally this should be no less than three working days although flexibility will be maintained for extraordinary circumstances.

8. Terms of Reference Review

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

Approved by Mental Health Act Committee	17 March 2023
Approved by Audit and Risk Committee	27 April 2023
Approved by Trust Board	9 May 2023

Appendix 3

Derbyshire Healthcare
NHS Foundation Trust

Board Committee Meeting Year-End Review 2022/23

Audit and Risk Committee

1. Purpose

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

It achieves this by:

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

Throughout the year, the Committee considers external audit reports, internal audit reports, and counter-fraud progress reports. All audit outcomes are overseen by monitoring the delivery of internal and external audit report recommendations.

The Committee considers the Board Assurance Framework, Annual Report and Annual Governance Statement and progress with internal and external audit plans. It also receives updates on losses and compensation payments, exit payments, conflicts of interest, tenders and waivers, debtors and clinical audit. The Committee also considers governance and compliance documents as well as oversight of the Trust's commercial insurances.

The Committee assesses the effectiveness of the external audit process by undertaking a self-assessment each year and by meeting with auditors in private. Auditors attend every meeting of the Committee, and the Trust's compliance with the audit plan approved by the Committee is monitored.

2. Authority

The Audit and Risk Committee has an important role to provide assurance on the progress and risks relating to the delivery of the Trust's strategic objectives. This includes identification, review and scrutiny of all relevant risks on the Board Assurance Framework (BAF) and reviewing of BAF management and reporting prior to formal reporting to the Trust Board.

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

The Committee is authorised by the Board of Directors to obtain external legal or other independent professional advice. The Committee is also authorised by the Board to request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary or expedient to the carrying out of its functions. The Committee did not identify the need to seek external legal advice or other independent professional advice during the year.

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

As a designated policy ratification group, (see Policy on Policy document) the Audit and Risk Committee is operationally responsible for monitoring that the policy documents for which it is responsible comply with the policy. This includes monitoring that the style, content and format of the policy are compliant, including completion of the Equality Impact Assessment (EIA) which forms part of the current policy template. The Claims Handling Policy and Procedures was revised and ratified by the Committee in July 2022. The Risk Management Strategy 2023 – 2025 was approved October 2022. The Committee agreed to the pausing of the annual review of Standard Financial Instructions (SFIs) to wait to see if any amendments were required following an audit of financial governance and best practice. A revised set of SFIs will be submitted to the April 2023 meeting for approval.

3. Membership of Audit and Risk Committee

The Audit and Risk Committee comprises independent Non-Executive Directors. Attendance during the year 2022/23 is listed below:

Name	Title
Geoff Lewins	Committee Chair, Non-Executive Director
Ashiedu Joel	Non-Executive Director
Deborah Good	Non-Executive Director

4. Attendance

An attendance log reflects attendance by members of the Committee, as well as the Trust Secretary and Director of Finance who are required to attend routine meetings of the

Committee to support the Chair and Committee members. The Trust Secretary is the nominated Lead Executive for the Committee. Other Executive Directors have attended by invitation to consider areas of risk or operation that are their responsibility.

The Chief Executive as Accountable Officer attended the June meeting at which the Annual Report and Accounts including the Annual Governance Statement were considered, as well as the opinion of the Head of Internal Audit which supports the conclusion within the Annual Governance Statement. The Trust Chair also attended the meeting to consider and approve the Annual Report and Accounts. The Lead Governor was invited to attended the meeting to observe the final approval of the Annual Report and Accounts but was unable to attend, the Committee Chair offered a follow up meeting.

The External Auditor was represented at all meetings. Internal Auditors attended all meetings of the Committee. A representative of the Counter Fraud Service attended the meetings when counter fraud reporting was scheduled.

Both the Internal and External Auditors had the opportunity to meet with the Audit and Risk Committee Chair in private (without Executives present) prior to Committee meetings.

5. Access

The Head of Internal Audit, representatives of External Audit and Counter Fraud Specialist have a right of direct access to the Chair of the Committee and are aware of the channels through which this can be achieved. In practice, this has been undertaken through the private meetings held prior to each Committee meeting.

6. Frequency of Meetings

The Committee met on six occasions throughout 2022/23 on 28 April, 26 May, 14 June, 7 July, 13 October and 2 February discharging its responsibilities as set out in the Terms of Reference.

7. Required frequency of attendance by members

According to the Committee's Terms of Reference, members should attend at least 80% of all meetings each financial year but should aim to attend all scheduled meetings. In 2022/23, the majority of members achieved in excess of 80% attendance at the meetings of the Committee. All meetings have been quorate.

8. Duties and Responsibilities

The Audit and Risk Committee has an annual plan of scheduled agenda topics, along with a range of specific issues which are subject to review. A rolling programme of actions is maintained and monitored. The following subheadings, shown in italics, are copied from the Duties and Responsibilities section of the Terms of Reference of the Audit and Risk Committee (attached). The commentary underneath each subheading is drawn from a review by the Trust Secretary of the minutes of all meetings and other relevant information.

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

9. Integrated governance, risk management and internal control

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

The Committee has a forward plan that maps out the periodic review of governance, risk and controls, internally and externally (via the audit plan and programmes).

The management of risk underpins the achievement of the Trust's Strategy and related objectives. The Trust's approach to Risk Management is set out in the Risk Management Strategy (a refresh for 2023-2025 was approved by the Committee in October 2022) which comprehensively brings together the Trust's risk management approach. The Committee received an annual summary of progress against the Risk Management Strategy on 7 October and approved the next version.

It was agreed that annual updates will continue to be received in order to measure progress against the Risk Management Strategy. The Committee accepted the inclusion of the system-based risk impacting on and mitigated by multiple system organisations as a stand-alone risk that is now included in the BAF report for scrutiny, but presented apart from risks specific to the Trust's strategic objectives.

A reporting plan for Operational Risk Management was signed off in October 2022 and the Committee started to receive this report quarterly from January 2023.

9.2 To consider the Board Assurance Framework and high-level risks, and to comply with any request for assurance in relation to the Board Assurance Framework and the Risk Register including deep dives of risks as appropriate.

The Committee has reviewed the format and content of the Board Assurance Framework four times during 2022/23 and has challenged the adequacy of the assurances that have been received. The BAF includes risks and mitigations developed in line with the objectives which support delivery of the Trust Strategy.

The Committee was assured that the Board Assurance Framework process was reviewed, scrutinised and updated in seeking to identify and mitigate risks to achieving the Trust's strategic objectives. There were no deep dives of risks in year due to de-escalation and also intense scrutiny by the Finance and Performance Committee relating to the finance risks.

9.3 In particular to review the adequacy and effectiveness of:

- ***all risk and control related disclosure statements (in particular the annual governance statement), together with any accompanying Head of Internal Audit Opinion, external audit opinion or other appropriate independent assurances.***

The Annual Governance Statement was subject to scrutiny and challenge by the Audit and Risk Committee to ensure it met the requirements as set out for the report. The Committee was assured that the report was balanced and fair.

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

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

The Committee has a process for receiving 'Deep Dive' which provides assurance over controls and gaps in assurance with a focus on action plans to manage risks. This approach informs and supports the overall review of the BAF prior to regular submission to the Trust Board. Significant clinical and corporate risks are identified and linked to the BAF risks as part of routine reporting. A six monthly report links corporate/operational risks to BAF risks.

- ***arrangements in place for preventing and countering fraud, bribery and corruption and managing security in compliance with the related NHS Counter Fraud Authority standards.***

The Trust's Counter Fraud Service was provided by 360 Assurance to the year end. Plans were designed to provide counter-fraud, bribery and corruption work across generic areas of activity in compliance with the latest guidance and standards.

In submitting its counter fraud annual report at the July 2022 meeting, 360 Assurance assured the Committee that that the Trust's counter fraud, bribery and corruption arrangements are embedded. There is a strong anti-fraud, bribery and corruption culture within the Trust and the counter fraud service delivered by 360 Assurance is efficient.

The Committee receives progress reports against delivery of the work plan including compliance against the comprehensive fraud risk assessment in line with the new methodology, introduced by the Government Counter Fraud Profession. This assessment is also recorded and managed in line with the organisation's risk management policy and included on the appropriate risk registers.

The Committee's Executive Lead and Trust Secretary has an additional role as the Trust's Counter Fraud Champion.

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

The BAF is a 'live' document and as such is regularly reviewed and updated. The Committee is responsible for reviewing the BAF to assure itself that the BAF appropriately addresses objectives and risks and also to ensure that newly arising risks are identified. The Committee has confirmed that it is satisfied that the BAF shows a

clear mapping across all risks identified by the Board of Directors and that good engagement has taken place with the Executive Directors in managing the overarching Risk Register.

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

The Audit and Risk Committee secures its oversight on assurance of effectiveness of other committees via each Committee's year-end report. Annual Effectiveness Reports relating to 2021/22 were received by the Committee in April 2022. For 2022/23 they are planned for review by the Committee in April 2023. The Trust has extended the lighter governance approach to its year end reporting 2022/23 as adopted under the reducing the burden principles from the pandemic, but this will be reviewed for 2023/24. Ongoing oversight was secured from the Committee assurance summaries presented monthly to the Trust Board. There have been escalations between Board Committees during the year.

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

The Corporate Governance Framework including all new/revised documents was uploaded to the policy framework after virtual approval by the Committee in January 2021. The Waiver of Standing Financial Instructions Register reports are received by the Committee every six months.

The annual review of Standing Financial Instructions (SFIs) has been delayed in 2022/23 but will be reported to the April 2023 meeting.

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

See items 9.2 - 9.3 above.

10. Internal audit

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

The Trust takes a risk based approach to developing the internal audit. The Committee has received assurance that sufficient work has been undertaken for the Head of Internal Audit opinion.

10.2 To oversee on an on-going basis the effective operation of internal audit in respect of:

- ***Adequate resourcing***
- ***Co-ordination with external audit***
- ***Meeting the Public Sector Internal Audit Standards***

- ***Providing adequate independent assurances***
- ***Having appropriate standing within the Trust***
- ***Reviewing and approving the internal audit plan ensuring that this meets the internal audit needs of the organisation.***

The Committee has a standing item on its agenda to receive a progress report from the Internal Auditors. The internal audit programme was regularly reviewed in year to ensure that it continued to meet the internal audit needs of the organisation.

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

Much of the work of the Committee is supported by the programme of work for internal audit services, provided by 360 Assurance. Services have been within an agreed work plan, prepared in consultation with the Executive Leadership Team and approved by the Committee, which seeks to ensure that reviews focus on areas of risk identified by the Trust.

The Internal Auditors progress report lists the outcomes of the completed reviews. Any Limited Assurance report is presented in full to the Committee, the Executive Director Lead is invited to attend the meeting to set out the management response and approach towards the agreed actions. Compliance against actions is monitored through the 'Pentana' system and reported in the Internal Audit Progress Report. The Committee has been notified of a drop in compliance during 2022/23.

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

360 Assurance's contract was renewed via direct award and commenced on 1 December 2022 – 31 March 2026 with a further 2 x 12 month periods.

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

Reviewed as part of the annual report presented to the Committee. 360 Assurance issues client satisfaction questionnaires.

11. External audit

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

Mazars were appointed on 1 September 2020 under a three year contract (with a two year renewal option) performing the external audit of the Trust from 2020/21 onwards.

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

Regular reporting to the Committee by the External Auditor as a standing agenda item encompasses updates on the nature and scope of the annual audit to be undertaken.

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

A report is presented annually to the Council of Governors on the work of the External Auditors. A positive response was received from the Trust on the annual client satisfaction survey performed issued by Mazar's.

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

See 11.1 and 11.2

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

Implementation of recommendations has been overseen as part of reporting to the Committee on internal and external audit review recommendations.

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

This policy is in place with the External Auditors.

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

See items above (11.2, 11.3 11.4) relating to the provision of the External Audit service.

12. Annual accounts review

12.1 To approve the Annual Report and Accounts and Annual Governance Statement on behalf of the Trust Board. In doing so the Committee will determine their completeness, objectivity, integrity and accuracy.

In preparation for approval of the Annual Report and Accounts, the Committee reviewed the relevant disclosure statements, in particular the Annual Governance Statement, together with the Head of Internal Audit Opinion, External Audit Opinion and considered that the Annual Governance Statement was consistent with its views on the Trust's systems of internal control.

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

The Committee agreed the draft accounting policies for annual accounts 2022/23 in February 2023.

13. Speaking Up (Raising Concerns)

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

The Committee receives updates on the implementation of the Freedom to Speak Up Policy within the Trust twice a year, in October and April (moved to April from 2022/23 due to the removal of the March meeting). The reports enable the Committee to review the robustness of policy and procedures.

A Board Development session was held in November 2022 and was dedicated to completing the Freedom to Speak Up Reflection and Planning Tool (launched June 2022 by NHS England), the National FTSU Guardian Jayne Chidgey-Clark also opened this session.

The Committee agreed significant assurance in 2022/23 with the adequacy of the Trust's arrangements by which Trust staff may, in confidence, speak up about possible improprieties in matters of financial reporting and control and related matters or any other matters of concern.

14. Standing orders, standing financial instructions and standards of business conduct

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

The Corporate Governance Framework was reviewed and approved by Board in March 2021. The framework itself will undertake a comprehensive review in October 2023 but elements of it will be revised more frequently, for example the annual review and approval of Committee Terms of Reference.

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

No significant issues were reported during the 2022/23 year. Reports of waiving of the Standing Financial Instructions and Standing Orders (where these have occurred) have been routinely reported to the Committee.

14.3 To review the scheme of delegation.

This forms part of the Corporate Governance Framework of the Trust and is reviewed periodically.

Other

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

Through reporting from the auditors, the Audit and Risk Committee remained appraised of the Trust's performance in financial indicators as benchmarked against other mental health foundation trusts and the wider NHS.

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

No actions have been referred to the Committee by the Board of Directors during the year.

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

Direct oversight of regulatory reviews carried out during the year, such as those undertaken by the CQC, have remained within the remit of the Trust Board itself.

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

The Committee received and reviewed the year-end summary reports for 2021/22 for the Finance and Performance, Mental Health Act, Quality and Safeguarding and Remuneration and Appointments Committees at its April 2022 meeting. 2022/23 year-end summaries for Board Committees are scheduled to be reviewed at the April 2023 meeting of the Committee.

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

Reports have been requested during the year including on the process for raising and addressing clinical risks and salary overpayments, a follow up report was requested on overpayments due to the initial limited assurance given. The Committee also received assurance on the overall 2021/22 Clinical Audit programme, its fitness for purpose and its delivery; and provided an initial view of the Clinical Audit Programme for 2022/23.

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

At the conclusion of every meeting the Committee discussed and agreed any necessary referrals to other Committees. These are noted on the assurance summary of the meeting presented to the Public Board meeting. Referrals are noted on the Committee's actions matrix and archived once evidence and assurance has been received that these are complete.

14.10 The Committee will receive assurance reports on Information Governance arrangements, particularly in respect to compliance with the Information Governance Toolkit and legislative compliance including the Data Protection Act and General Data Protection Regulation (GDPR).

An update on Data Security and Protection including cyber security and compliance with the Data Security and Protection Toolkit was received in April 2022 in line with the new national reporting timetable. Significant assurance was confirmed. Reporting will continue on bi- annual basis.

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

The Committee receives updates on compliance against the Conflicts of Interest Policy twice a year. A revised policy is due to be received in April 2023. This also includes reporting on gifts, hospitality, sponsorship and secondary employment in line with the Policy.

15. Feedback from Audit Committee Handbook survey

The Committee Chair co-ordinates members feedback to assess the Committee's performance against the requirements within the HFMA Audit Committee handbook (Checklist 2) . The handbook questionnaire covers Committee processes, effectiveness. In previous years the significant majority of responses were either 'strongly agree' or 'agree' in terms of positive response.

16. Objectives

In line with good governance and effective committee practice, objectives for the Audit and Risk Committee for 2022/23 were approved at the April 2022 meeting.

The Committee confirmed at the meeting held on 13 October that it was satisfied with the progress made against its 2022/23 objectives. The achievement of these objectives will be covered off in the year-end effectiveness report which was presented to the Committee in April 2023.

16.1 To ensure the internal audit programme is effectively implemented and reports signed off in a timely manner

Measured by adherence to agreed timelines for internal audit processes as reported through internal audit plan progress reports as standing item at all Committee meetings.

16.2 To promote best practice across all Board Committees, building upon embedded practice and seeking continuous improvement

Evaluated through end of year reports and ongoing discussion at Board Committee chairs meetings during the year. Best practice across all Board Committees is a core item of business at the Board Committee Chairs meetings. In 2022/23 there was a

consistent approach agreed across the Committees to lighten agendas with targeted priority items agreed between the Executive Lead and the Committee Chair.

16.3 Ensure continued engagement/governor involvement in external audit and related Committee matters

The Lead Governor is invited to observe the year end account sign off meeting but unfortunately could not make this in June 2022, the Chair offered a follow up meeting. Presentation of the Annual Report and Accounts and report from the External Auditors is reported to the Council of Governors in September every year.

16.4 To further embed oversight of risk within the Board Committee structure

The Committee has led focus on the BAF, including Deep Dives where required, to drive Board and Committee business to focus work towards the successful delivery of the Trust's strategic objectives.

This is measured through the year-end review of Committees (April annually) to confirm embeddedness of established process in this area. Assurance summaries from Committees to the Board operated well during the year to date in their role to provide the Board with assurance on key areas of Committee business and also to escalate risk issues.

16.5 To ensure that robust governance processes are in place, including oversight of effective implementation of any revised governance structure arising from Trust strategy review.

Evidenced through implementation of the framework of established activity in internal audit, external audit, assurance reporting on risk management and other internal/external reports which have given assurance to allow sign off of annual report and accounts including the Annual Governance Statement .

The Annual Governance Statement brings together all the detail on systems, controls and processes. A draft will be presented to the Committee in April 2023. The Committee has received staged reporting on the Head of Internal Audit Opinion.

16.6 To identify training needs of Audit and Risk Committee members and deliver appropriate training/support to enable members to be effective in their Committee role

The Committee chair and other members have attended networking events relating to their roles during the year. Additional training and support have been provided to the newest members of the Committee.

16.7 To review results from the annual Committee effectiveness report and develop actions (not covered by above) for delivery by the Committee to agreed timeframes.

See 10 above.

16.8 To clarify and implement effective reporting and oversight of Data Quality

The Committee has continued to seek periodic assurance from the IM&T lead that data continues to follow the rules of validation. An update report is presented every 6 months.

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

Although the Committee has not undertaken a specific review in 2022/23 report authors continue to complete the equality, diversity and inclusion section of the front sheets.

The following was included as additional objectives since 2021/22:

- **To ensure any gaps in assurance identified in the internal audit programme are adequately covered via alternative methods such as self-effectiveness or external review**

  This will be evaluated as part of the response to the 2022/23 Head of Internal Audit Opinion and will be considered as part of approval of the 2023/24 Internal Audit Plan. The External Well Led Review, which includes a self assessment, has been commissioned and regular updates will be reported through the Audit and Risk Committee.

17. Freedom to Speak Up

The Audit and Risk Committee is committed to the principles of Speaking Up and actively shaping the speaking up culture. To this end the Committee has considered in carrying out this review, that it has robustly challenged itself to improve patient safety, develop a culture of continuous improvement, openness and honesty. This can be specifically evidenced through the update reports on Freedom to Speak Up received by the Committee.

18. Ongoing Assurance – Governance Best Practice

The Committee has embedded the principles of the good governance best practice and continues to follow the process contained in its annual forward planning and review of effectiveness.

19. Minutes and Reporting

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

Each meeting is formally recorded and available to all Board members.

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

An assurance summary is reported to the public meeting of the Board of Directors after each meeting, which summarises discussions, details assurance and actions required, as well as decisions made and identification of any key risks. Items for escalation to the Board or for referral to other Board Committees are also contained within the assurance summary.

19.3 The Committee will report annually to the Board of Directors and the Council of Governors in respect of its work in support of the annual governance statement specifically commenting on:

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

The Board of Directors received the Committee's full Annual Report for 2021/22 in May 2022. The Committee Chair presented a summary of the Committee's Annual Report for 2021/22 to the Council of Governors in September 2022. The Trust's Annual Report and Accounts for 2021/22 were presented to the Council of Governors by Mazars, the Trust's External Auditors, in September 2022.

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

This report outlines how the Committee has addressed all elements of its Terms of Reference during the year. The work of the Committee is included within the Annual Report. The Board took significant assurance regarding the contents of the Annual Report and Accounts for the year ended 31 March 2022 as overseen by the Committee.

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

The Committee reflected upon its effectiveness at the end of each meeting, the appropriateness of papers and received suggestions for improvement. Overall, members have been satisfied with the way the Committee operates and have commented on good level of debate, challenge and participation of members and

attendees and chairing effectiveness. Papers have continued to improve with well-structured recommendations, contributing to holding Executive Directors to account. The Committee has continued to receive good levels of assurance and has been responsive to demand and priorities.

Board Committee Chairs discussed Committee effectiveness at their meetings held in year and were assured of key elements of governance, consistency and intelligence sharing across Committees.

20. Administrative Support

The Trust Secretary discharged her duties in support of the Audit and Risk Committee throughout the year.

21. Review of Terms of Reference

The Terms of Reference will be reviewed in April 2023 as part of the end of year reporting process and are appended to this report for further review.

22. Conclusion

The Audit and Risk Committee has continued to be a well-functioning effective Board Committee throughout 2022/23 and has provided appropriate assurance to the Board.

Appendix 4

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 9 May 2023

Register of Trust Sealings

Purpose of Report

This report provides the Trust Board with a six month update of the authorised use of the Trust Seal since the last report to the Board on 1 November 2022.

Executive Summary

The Trust's Standing Financial Instructions (point 8.18) state that every contract which exceeds £500,000 shall be executed under the Common seal of the Trust and be signed by the Trust Secretary and an Executive Director (voting or non-voting) duly authorised by the Chief Executive and not from the originating department.

These transactions will apply where the Board has previously approved the business through the Capital Expenditure Plan or the Estates Strategy. In accordance with the Standing Orders of the Board (section 12 point 6) a report of all sealing shall be made to the Trust Board twice a year. The report will contain details of the seal number, the description of the document and date of sealing. The register will be retained by the Trust Secretary.

A report on use of the seal was last made to the Board on 1 November 2022. Since the last report, the Trust Seal was used as follows (where the contract value for these transactions exceeded £500,000 or where the nature of the transaction required a seal, ordinarily property transactions such as deeds or leases)

- DHCFT87 28/10/2022: Deed of Surrender relating to Block B, Derbyshire Royal Infirmary, Litchurch Street, Derby
  (1) University Hospitals of Derby & Burton NHS Foundation Trust
  (2) Derbyshire Healthcare NHS Foundation Trust
- DHCFT88 28/10/2022: Lease of Suites C&D, St Paul's House, Jubilee Business Park
- DHCFT89 28/10/2022: Lease of St Mathew's House, Jubilee Business Park
- DHCFT90 28/10/2022: Lease of Suites A&B, St Paul's, House Jubilee Business Park
- DHCFT91 03/03/2023: Deed of Surrender relating to Suite D, St Paul's House, Jubilee Business Park
- DHCFT92 17/03/2023: Contract for provision of Children's Public Health Services
  (1) Derby City Council as authority
  (2) Derbyshire Healthcare NHS Foundation Trust as provider
- DHCFT93 17/03/2023: Contract for provision of Public Health Services Derby Integrated Drug and Alcohol Treatment and Recovery Services
  (1) Derby City Council as authority
  (2) Derbyshire Healthcare NHS Foundation Trust as provider
- DHCFT94 30/03/2023: NHS Contract Variation – Derbyshire Healthcare NHS Foundation Trust CV01 2022/23 National Insurance reduction and additional Perinatal PC costs

- DHCFT95 17/04/2023: Procure 22 Stage 4 Agreement – Derby and Chesterfield Pain/Gain Aggregation Agreement Deed
  (1) Sir Robert McAlpine Limited
  (2) Vinci Construction UK
  (3) Derbyshire Healthcare NHS Foundation Trust
- DHCFT96 17/04/2023: PO3 Northern Derbyshire Adult Acute 54 Bed Unit at Chesterfield Royal Hospital Stage 4 Contract
  (1) Sir Robert McAlpine Limited
  (2) Vinci Construction UK
  (3) Derbyshire Healthcare NHS Foundation Trust
- DHCFT97 17/04/2023: PO2 Southern Derbyshire Adult Acute Unit 54 Bed Unit and 14 Bed PICU Unit at Kingsway Hospital
  (1) Sir Robert McAlpine Limited
  (2) Vinci Construction UK
  (3) Derbyshire Healthcare NHS Foundation Trust

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

Assurances

Use of the Trust Seal has been undertaken in accordance with the Standing Financial Instructions and Standing Orders of the Board of Directors.

Consultation

N/A

Governance or Legal Issues

The affixing of the seal is consistent with the Board's responsibilities outlined within the Standing Financial Instructions and Standing Orders of the Board of Directors.

Public Sector Equality Duty and Equality Impact Risk Analysis

In compliance with the Equality Delivery System (EDS2), reports must identify equality-related impacts on the nine protected characteristics age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage and

civil partnership, and pregnancy and maternity (REGARDS people (Race, Economic disadvantage, Gender, Age, Religion or belief, Disability and Sexual orientation)) including risks, and say how these risks are to be managed.

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

Recommendations

The Board of Directors is requested to note the authorised use of the Trust Seal since the last report to the Board on 1 November 2022 and receive full assurance that this has been undertaken in accordance with the Standing Financial Instructions and Standing Orders of the Board of Directors.

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

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

Derbyshire Healthcare NHS Foundation Trust
Report to the Trust Board – 9 May 2023

Review of Standing Financial Instructions

Purpose of Report

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

Executive Summary

The SFIs were last update in November 2021 and are due for review. They have been reviewed by the Executive Leadership Team and agreed by the Audit and Risk Committee in April.

The following changes are being proposed:

General updates throughout the document for the following:

- change the name of NHS England and Improvement to NHS England
- Name changes to reflect the revised operational structure

3.2.2i Budgetary delegation
Proposed changes to the limits have been made. This is to reflect the increase in the size of the organisation and the growing value in the size of the revenue contracts.

7.9.4 – We no longer hold an Argos purchasing card therefore the reference to this has been removed.

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

The value to 'include' VAT – this is as per the Procurement Policy Note
Change the £10k to £25k requiring 3 written quotes to £10k to PCR 2015 limit requiring 3 written quotes.
Because of this change 8.8 and 8.9 are no longer required.

11.2.7 b) – reference to EU replaced with Public Contract Regulation (missed in last update)

11.2.7 diii – replaced Hospitality and Sponsorship Policy with Conflicts of Interest Policy

12.1.2 – Updates to reflect the changes in NHSE capital guidance.

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

Assurances

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

Consultation

- Senior staff within the Finance Department have updated the SFIs with input from the Head of Procurement.
- Counter Fraud have reviewed the SFIs and have not proposed any changes.
- Both the Executive Leadership Team and the Audit and Risk Committee have reviewed and agreed the proposed changes.

Governance or Legal Issues

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

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

Recommendations

The Board of Directors is requested to review the SFIs, agree the proposed changes and ratify the Standing Financial Instructions Policy and Procedure.

Report prepared and presented by: **Rachel Leyland**
Interim Director of Finance

Derbyshire Healthcare NHS Foundation Trust

Standing Financial Instructions

April 2023

CONTENTS

1. STANDING FINANCIAL INSTRUCTIONS

INTRODUCTION

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

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

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

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

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

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

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

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

Overriding Standing Financial Instructions

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

1.2 TERMINOLOGY

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

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

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

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

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

1.3 RESPONSIBILITIES AND DELEGATION

The Board of Directors

The Board exercises financial supervision and control by:

(a) formulating the financial strategy;

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

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

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

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

1.3.2 The Chair

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

1.3.3 The Chief Executive

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

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

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

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

1.3.6 The Director of Finance

The Director of Finance is responsible for:

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

The duties of the Director of Finance also include:

- the provision of financial advice to the Trust and its directors and staff;
- the design, implementation and supervision of systems of internal financial control; and
- the preparation and maintenance of such accounts, certificates, estimates, records and reports as the Trust may require for the purpose of carrying out its statutory duties.

1.3.7 All Board Members and Staff

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

- the security of the Trust's assets;
- avoiding loss;
- exercising economy and efficiency in the use of resources; and

- conforming with the requirements of Standing Orders, Standing Financial Instructions, Financial Procedures and the Scheme of Delegation.

1.3.8 Budget Holders

Have a responsibility to:

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

1.3.8 Contractors and their Staff

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

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

2. AUDIT

2.1 THE AUDIT AND RISK COMMITTEE

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

2.1.2 Where the Audit and Risk Committee feel there is evidence of ultra vires transactions, evidence of improper acts, or if there are other important matters that the Committee wish to raise, the Chair should raise the matter at a full meeting of the Trust Board. Exceptionally, the matter may need to be referred to the Department of Health or NHS England.

2.2 ROLE OF THE DIRECTOR OF FINANCE

2.2.1 The Director of Finance is responsible for:

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

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

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

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

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

d) explanations concerning any matter under investigation.

2.3 THE ROLE OF INTERNAL AUDIT

2.3.1 Internal Audit will review, appraise and report upon:

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

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

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

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

e) the extent to which the Trust's assets and interests are accounted for and safeguarded from loss of any kind, arising from:

(i) fraud and other offences,
(ii) waste, extravagance, inefficient administration,
(iii) poor value for money or other causes.

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

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

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

2.4 THE ROLE OF EXTERNAL AUDIT

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

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

2.5 External Auditors for non-Audit Services

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

2.5.2 Prohibited non-audit services

To ensure that the auditor's independence and objectivity is not impaired it is important the external auditors do not:

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

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

- Providing any services specifically prohibited by UK law or supporting guidance
- Work related to the accounting records and financial statements that will ultimately be subject to external audit
- Taxation assignments where there is no fixed fee or the fixed fee is greater than that allowed in this policy (see below)
- Internal audit services
- Design/implementation of financial information technology systems
- Valuations services where the valuation has a potentially material impact upon the Trust's financial statements
- Legal and litigation support or advice where the outcome could have a potentially material impact upon the Trust's financial statements
- Provision of senior recruitment services

2.5.3 Permitted non-audit services

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

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

- Advice on the preparation of financial information and the application of GAAP or training support for accounting projects and in relation to accounting standards
- Audit related services as defined in the APB Ethical Standard 5 (Revised)

- Assistance in tax compliance activities and advice on recent developments and/or complex or high-risk areas.

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

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

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

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

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

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

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

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

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

2.6 FRAUD and BRIBERY

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

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

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

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

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

2.6.1 Sanctions and Redress

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

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

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

2.7 SECURITY MANAGEMENT

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

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

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

3. BUSINESS PLANNING, BUDGETARY CONTROL

3.1 PREPARATION & APPROVAL OF OPERATIONAL FINANCIAL PLANS AND BUDGETS

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

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

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

- be in accordance with the aims and objectives set out in the operational plan;
- accord with workload and workforce plans;
- be produced following discussion with appropriate budget holders;
- be prepared within the limits of available funds;
- demonstrate the achievement of key financial targets such as strategic financial objectives of the Trust and the regulatory financial regime as advised by NHS England
- identify potential risks and mitigations.

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

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

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

3.2 BUDGETARY DELEGATION

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

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

3.2.1i From time to time NHS England may issue guidance or instructions regarding additional approval processes for certain types of Trust expenditure. Where Foundation Trusts are required to comply, NHS England's approval process, as defined by their guidance, will override the authority to authorise as laid out in the Trust standing financial instruction, only for the specific type of expenditure concerned

3.2.1ii In cases where compliance with any additional approval regime by NHS England is *voluntary*, the Chief Executive will determine the appropriate course of action for the Trust and will notify budget holders accordingly, with the support of the Director of Finance.

3.2.1iii In exceptional circumstances where large invoices are received which exceed the limits

set out on 3.2.2i, then the Chief Executive and Director of Finance can jointly approve.

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

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

3.2.2i With the exception of expenditure referred to in para 3.2.1i, 3.2.1ii and 3.2.2iii Authority to authorise any one revenue order shall be limited to:

£1,000,000 and above	*Board of Directors*
£500,000 to £999,999	*Chief Executive **and** Director of Finance.*
£200,000 to £500,000	*Chief Executive or Director of Finance.*
£50,000 to £200,000	*Deputy Chief Executive or Deputy Director of Finance*
£50,000 to £200,000	*Executive Directors voting and non-voting but not Non-Executive Directors*
£10,000 to £50,000	*Managing Directors and General Managers*
£1,000 to £10,000	*Heads of Operational Service Areas*
	(or lower limit for individual budget holders as set by the Chief Executive)

3.2.2ii With the exception of expenditure referred to in para 3.2.1i and 3.2.1ii Authority for planned expenditure of Capital Resources shall be limited to:
Expenditure on an individual project up to £100,000
- Approved by the Capital Action Team

Expenditure on an individual project up to £ 1,000,000
- Jointly approved by the Director of Finance and one other Executive Director

Project in excess of £1,000,000
- Board approval required

3.2.4 The general rules applying to delegation and reporting shall also apply to capital expenditure. (The particular applications relating to capital are contained in SFI 13).

3.2.5 The budgetary total or virement limits set by the Trust Board above must not be exceeded. Expenditure for which no provision has been made in an approved budget and which is not subject to funding under delegated powers of virement shall only be incurred after proper authorisation - i.e. by the Chief Executive or the Board of Directors as appropriate within delegated limits.

3.2.6 Unless approved by the Chief Executive, after taking the advice of the Director of Finance; budgets shall only be used for the purpose for which they were provided. Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive, subject to any authorised use of virement.

3.2.6 Non-recurring budgets shall not be used to finance recurring expenditure without the

authority in writing of the Chief Executive.

3.3 BUDGETARY CONTROL AND REPORTING

3.3.1 The Director of Finance will devise and maintain systems of budgetary control. These will include monthly financial information presented to the Trust Board in a form approved by the Trust Board.

a) Detailed financial information to Finance and Performance Committee covering but not limited to:
   i) Income and expenditure position for year to date and forecast year end position
   ii) Statement of Financial Position including any key exceptions
   iii) Cash levels and key drivers
   iv) Capital expenditure against plan.
   v) Agency performance against ceiling
   vi) Key financial risks and mitigations
b) the production of timely, accurate and comprehensive advice and financial reports to each budget holder, covering the areas for which they are responsible;
c) investigation and reporting of variances
d) monitoring of management action to correct variances;
e) arrangements for the authorisation of budget transfers;
f) on-going training and support to budget holders to enable them to manage successfully.

3.3.2 The Director of Finance shall keep the Chief Executive and the Board of Directors informed of the financial consequences of changes in policy, pay awards, and other events and trends, whether national, local or internal, affecting budgets and shall advise on the financial and economic aspects of future plans and projects.

3.3.3 All Budget Holders are responsible for ensuring that:
a) any likely overspending or reduction of income is not incurred without the prior consent of the Trust Board;
b) the amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised subject to the rules of virement; and
c) no permanent staff are appointed without the approval of the Chief Executive as per 10.3.1.ii other than those provided for in the budgeted establishment as approved by the Trust Board.
d) In the exceptional circumstance where a member of staff is engaged through terms deemed as 'off-payroll' by Her Majesty's Revenue and Customs (HMRC) and/ or NHS England, the relevant budget holder who is seeking to make these arrangements is responsible for ensuring compliance with HMRC rules and regulations and reporting, as informed by the Director of People and Inclusion. All off-payroll engagements should be approved by a Director before commencement
e) Where costs may be committed by a third party there must be appropriately authorised by a specific governance process defined by a local operating procedure.
f) Off-payroll arrangements will be reported to Executive Leadership Team and to Finance and Performance Committee on a regular basis in advance of the annual reporting requirements.

3.3.4 The Chief Executive or Director delegated by the Chief Executive is responsible for identifying and implementing cost improvements and value for money initiatives in accordance with the requirements of the Annual Plan and a balanced budget.

3.4 MONITORING RETURNS

3.4.1 The Chief Executive is responsible for ensuring that the appropriate monitoring forms are submitted, accurately and on time and in the required format, to the requisite Organisation.

4. ANNUAL ACCOUNTS AND REPORTS

4.1 The Director of Finance, on behalf of the Trust, will:

i. prepare and submit financial returns in such a form as directed by NHS England, with the approval of HM Treasury, specifically in accordance with International Financial Reporting Standards (as applied in the NHS England Annual Reporting Manual and the Department of Health Group Accounting Manual as well as HM Treasury's Financial Reporting Manual - FReM ;)
ii. lay audited accounts before Parliament and send a copy to NHS England in accordance with the Annual Reporting Manual.

4.2 The Trust's Annual Accounts must be audited by an auditor appointed by the Council of Governors. The Audited Annual Accounts must be presented to the Annual Public Meeting of the Trust.

4.3 The Trust will compile and publish an Annual Report in accordance with NHS England's Annual Reporting Manual.

5. BANKING ARRANGEMENTS

5.1 GENERAL

5.1.1 The Director of Finance shall monitor financial performance for working capital against budget and plan, periodically review them, and report to the Trust Board. All funds of the Trust shall be held in accounts in the name of the Trust. Only staff authorised by the Director of Finance may open a bank account in the name of the trust.

5.1.2 The Board shall approve the banking arrangements and agree (or delegate agreement on their behalf of) the Treasury Management Policy prepared by the Director of Finance.

5.1.3 Bank and Government Banking Service (GBS) Accounts

The Director of Finance is responsible for:

a) bank accounts and Government Banking Service accounts;

b) establishing separate bank accounts for the Trust's non-exchequer funds where appropriate;

c) ensuring payments made from bank or GBS accounts do not exceed the amount credited to the account except where arrangements have been made;

d) reporting to the Trust Board all arrangements made with the Trust's bankers for accounts to be overdrawn

e) reporting to Trust Board any proposals to draw down any or all of the Trust's working capital facility if such a facility is in place.

f) ensuring the Trust does not exceed the limit of its approved working capital facility if such a facility is in place

g) monitoring compliance with DH guidance on the level of cleared funds.

5.1.4 ONLY authorised signatories within the Financial Control Team may make changes to Trust banking mandates including Direct Debits. No other persons within the Trust should activate, deactivate or make any changes whatsoever to any Trust direct debit arrangements. Staff wishing to do so should contact the Financial Controller.

5.2 BANKING PROCEDURES

5.2.1 The Director of Finance will prepare financial procedures on the operation of bank accounts for the approval of the Board of Directors.

5.2.2 The Director of Finance must advise the Trust's bankers in writing of the conditions under which each account will be operated in accordance with approved procedures.

5.3 TENDERING AND REVIEW

5.3.1 Any commercial banking arrangements of the Trust should be reviewed at regular intervals to ensure they reflect best practice and represent best value for money by periodically seeking competitive tenders for the Trust's banking business.

5.3.2 Competitive tenders should be sought at least every 3 years. The results of the tendering exercise should be approved by the Board. This review is not necessary for GBS accounts.

6. INCOME, FEES AND CHARGES

6.1 INCOME SYSTEMS

6.1.1 The Director of Finance is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due. These systems shall include income due under contracts or extra-contractual arrangements for the provision of Trust services.

6.1.2 The Director of Finance is also responsible for the prompt banking of all monies received.

6.2 FEES AND CHARGES

6.2.1 The Trust shall refer to NHS England's Approved Costing Guidance in setting prices for contracts and services provided to other organisations, where applicable. However, pricing strategies will be determined by appropriate Trust Committees.

6.2.2 The Director of Finance is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the Department of Health or by Statute. Independent professional advice on matters of valuation shall be taken as

necessary.

6.2.3 All staff must inform the Director of Finance promptly of money due arising from transactions which they initiate or deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions. The Director of Finance and the Chief Executive shall approve all contracts for income.

6.3 DEBT RECOVERY

6.3.1 The Director of Finance is responsible for the appropriate recovery action on all outstanding debts. Income not received should be dealt with in accordance with losses procedures. This includes the use of external debt recovery agents.

6.3.2 Should any staff detect that an overpayment has been made they should report immediately to the Director of Finance in order that recovery procedures can be initiated. The Trust will follow the overpayment policy in recovering debt owed as a result of employee benefit overpayment.

7. SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS

7.1 The Director of Finance and/or the Director responsible for the cashier's service shall prescribe and is responsible for systems and procedures for any staff handling cash, pre-signed cheques and negotiable securities on behalf of the Trust, including:

i. approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable
ii. the security and control of any such stationery
iii. procedures for receiving and banking of cash, cheques and other forms of payment
iv. circumstances in which unofficial funds may be deposited in safes
v. prescribing systems and procedures for handling cash and negotiable instruments on behalf of the Trust. Where the Shared Services Organisation undertakes such issues as stated in 7.1, detailed requirements will be specified in a Service Level Agreement with the Shared Services Organisation.
vi. Issuing of High Street vouchers and the appropriate use of these vouchers.

7.2 Staff shall be informed in writing on appointment, of their responsibilities and duties for the collection, handling or distribution of cash, cheques, etc. Any staff whose duty it is to collect or hold cash shall be audited by the finance team to ensure the appropriate controls are in place for the safe keeping of the cash.

7.3 During the absence (e.g. on holiday) of the holder of a safe or cash-box key, the member of staff who acts in their place shall be subject to the same controls as the normal holder of the key. There shall be written discharge for the safe and/or cash-box contents on the transfer of responsibilities and the discharge document must be retained for inspection.

7.4 All cash, cheques and other forms of payment received by any other staff shall be passed immediately to the holder of a safe or cash-box key or to the cashier, from whom a signed receipt shall be obtained. No member of staff should keep Trust cash, cheques or other forms of payment, for whatever purpose, on Trust premises unless the Financial Controller is aware of the existence of such arrangements and can support and be assured on the systems and processes for the probity of such arrangements

7.5 Official money may never be used for the encashment of private cheques.

7.6 The opening of coin operated machines (including telephones) and the counting and recording of the takings shall be undertaken by two members of staff together, unless authorised in writing by the Director of Finance. The coin-box keys shall be held only by a nominated member of staff.

7.7 Any loss or shortfall of cash, cheques or other cash equivalents, however occasioned, shall be reported immediately to the Financial Control Team in accordance with the agreed procedure for reporting losses (see also Section 16 Disposals, Losses and Special Payments).

7.8 Petty Cash

7.8.1 All new floats or amendments to floats are authorised by the Director of Finance or Deputy Director of Finance, they will only be approved if they are essential to the service.

7.8.2 All Petty Cash Floats must be held in a secure place and remain under the control of the designated Float Holder/Accounting Officer. The float holders who are going off duty and coming on duty will both check the petty cash together and a formal record of the check will be documented.

7.8.3 Petty Cash disbursements should be for the purpose agreed when the float was established. All disbursements must be supported by receipt(s). In circumstances where staff require an advance of cash to make a purchase, a record must be kept of the details and amount issued to ensure that all cash can effectively be accounted for until receipts and unspent cash are returned within 24 hours. Advances of cash need to be authorised by either the Director of Finance, Deputy Director of Finance or the Financial Controller prior to the advance being issued.

7.8.4 Reimbursements will not be made unless both signatories provided match the authorised signatories that is held on record for the float

7.8.5 In exceptional circumstances Petty Cash above £50 may be issued with prior authorisation from the Director of Finance, Deputy Director of Finance or the Financial Controller.

7.9 Trust Credit Card

7.9.1 The Trust will hold a credit card in order to support the procurement process in allowing more flexibility to purchase goods but limited to exceptional circumstances. Standard procurement processes should be followed and suppliers set up through the usual procurement system to ensure good procurement governance. If the Trust credit card is used then the Trust's procurement processes will still need to be followed but the credit card will enable quicker payments to be made.

7.9.2 Access to the Trust credit card will be limited to Financial Control and Procurement. The card whilst not in use will be kept in a secure safe. Local procedures need to be in place to ensure the security of the credit card.

7.9.3 Fuel Purchasing Cards are held by the Estates Department, these should be kept in a secure place when not in use and documentation kept on usage.

7.9.4 Purchasing cards for PC World are held by the Financial Control Team. Local procedures need to be in place to ensure the security of these cards.

7.10 Chip and Pin machines

7.10.1 The Trust holds 5 chip and pin machines at various locations across the Trust.

7.10.2 The card holder is present when the card machine is in use and no payments are taken over the phone.

7.10.3 Local Procedures need to be in place to ensure the security of the machines.

8. TENDERING AND CONTRACTING PROCEDURE

8.1 **Duty to comply with Standing Orders** and Standing Financial Instructions

8.1.1 Every contract (other than for the delivery of Trust services delivered in accordance with the National Contract and commissioned by NHS or other Commissioners, (see 8.21) where made by the Trust, shall comply with these Standing Financial Instructions.

8.1.2 An exception from any of the following provisions of these Standing Financial Instructions may be made by the direction of the Trust or, in an emergency, by the Chair and Chief Executive, in accordance with SO 4.

8.1.3 Staff undertaking procurement activity should refer to the Trust Procurement Manual for further detailed information. The manual also includes reference to the 'No PO no pay' policy.

8.2 Bribery Act

All staff involved in tendering and contracting and other budget holder activities should be aware of the Bribery Act 2010 and should ensure that all dealings with other organisations and their staff do not bring them in breach of the Act. That could leave them open to criminal proceedings being commenced.

8.3 Public Contract Regulations 2015

On 1st January 2021 the OJEU regulations were transposed into English Law and our public procurement rules are governed under the Public Contract Regulations (PCR) 2015. Procedures for awarding all forms of contracts under PCR2015 shall have effect as if incorporated in these Standing Financial Instructions.

Any rules pertaining to public procurement under PCR2015 cannot be waived.

8.4 Investment approach

Any potential major investment decision must be guided by relevant current Foundation Trust guidance, which sets out governance processes for all major investments undertaken by NHS foundation trusts.

8.5 Tendering

All tendering activity must be compliant with the Procurement Transparency policy issued by the Department of Health dated March 2014 or any other such policy that may supersede it.

Formal Competitive Tendering

The standard method of procurement by the Trust shall be by way of competitive tender. The Trust shall ensure that such tenders are invited for the supply of goods, materials and manufactured articles and for the rendering of services including all forms of management consultancy services (other than specialised services sought from or provided by the DH); for the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens); and for disposals.

8.5.1 Tender and Quotation Limits

The procurement of all goods and services should be preceded by a requisition and official order. By exception, urgent and/or emergency situations may be reasons why this is not possible and in these cases confirmation orders should be raised.

8.5.2 General Position on Quotations and Tendering

Below £10,000 (inc VAT) good purchasing practice is necessary i.e. seeking the best value for money.

8.5.3 The Trust's Procurement Department must be consulted prior to the commencement of any of the processes listed below

- For purchases between £10,000 (inc VAT) and below PCR2015 limit three written quotations are required.
- Supplies and service contracts above the current PCR 2015 threshold require full compliance with the relevant PCR 2015 procedure
- In the event that purchases between £10,000 (inc VAT) and £25,000 (inc VAT) are procured through a compliant PCR 2015 framework there is no requirement to obtain additional quotations. For purchases above £25,000 (inc VAT) procured through a compliant PCR 2015 framework the Head of Procurement can recommend to Executives whether further competition is required. At all times value for money should be a prime consideration, even when procuring from a compliant framework.
- With regards to small works procurement (as defined by PCR 2015) these rules shall override any other obligation contained in these Standing Financial Instructions relating to tender and quotation requirements.

8.6 Formal tendering procedures may be waived by officers to whom powers have been delegated by the Chief Executive without reference to the Chief Executive except in (c) to (f) below where:

(a) The estimated expenditure or income does not, or is not reasonably expected to, exceed £25,000 (inc VAT) (in which case quotations process not tender process should be followed), or

(b) Where the supply is proposed under special arrangements negotiated by the DH or Regulator in which event the said special arrangements must be complied with;

(c) The timescale genuinely precludes competitive tendering. Failure to plan the work properly is not a justification for single tender;

(d) Specialist expertise is required and is available from only one source;

(e) The task is essential to complete the project, **and** arises as a consequence of a recently completed assignment and engaging different consultants for the new task would be inappropriate; this reason for waiver cannot be enacted if NHS England approval is required for management consultancy or other defined expenditure

(f) There is a clear benefit to be gained from maintaining continuity with an earlier project. However, in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering.

Requests for waiving formal tendering procedures should be in the form of a letter signed by the Chief Executive or their nominated deputy. These should then be entered in the waiver register and reviewed by the Audit and Risk Committee.

A waiver is not required for year two onwards of contracts that have already been through the procurement process that is outlined in these Standing Financial Instructions.

8.7 The limited application of the single tender rules should not be used to avoid competition or for administrative convenience or to award further work to a consultant originally appointed through a competitive procedure.

Where it is decided by the Chief Executive that competitive tendering is not applicable and should be waived by virtue of the above, the fact of the waiver and the reasons should be recorded in writing to the Chief Executive and documented in a register held by the Trust Secretary.

8.8 Tendering procedures are set out in the Appendix.

8.9 **Quotations** - are required where formal tendering procedures do not apply where expenditure is expected to exceed £10,000 (inc VAT).

8.10 Where quotations are required they should be obtained from at least three firms/individuals.

8.11 All quotations should be treated as confidential and should be retained for inspection.

8.12 The Chief Executive or their nominated officer should evaluate the quotations and select the one which gives the best value for money. If this is not the lowest then this fact and the reasons why the lowest quotation was not chosen should be in a permanent record.

8.13 Non-competitive quotations in writing may be obtained for the following purposes:

(a) the supply of goods/services of a special character for which it is not, in the opinion of the Chief Executive or their nominated officer, possible or desirable to obtain competitive quotations;

(b) the goods/services are required urgently

Instances of, and reasons for, non-competitive quotations are to be entered in the waiver register and reviewed by the Audit and Risk Committee

8.14 Where tendering or competitive quotation is not required:-

The Trust shall procure goods and services in accordance with procurement procedures approved by the Trust as laid out in the Trust Procurement Manual.

8.15 **Contracts** - The Trust may only enter into contracts within its statutory powers and shall comply with:

(a) its Establishment and Amendment Orders

(b) The Trust's Standing Orders

(c) The Trust's Standing Financial Instructions

(d) PCR 2015 and other statutory provisions

(e) any relevant directions from NHS England

(f) such of the NHS Standard Contract Conditions as are applicable.

Where appropriate contracts shall be in or embody the same terms and conditions of contract as was the basis on which tenders or quotations were invited.

8.16 All contract documents, up to the value of £100,000, shall be signed on behalf of the Trust by an Executive Director **(voting or non-voting)** or nominated officer. Documents above £100,000 shall be signed by the Director or Finance, Chief Executive or nominated officer with appropriate approval limit. Every contract the value of which exceeds £500,000 shall be executed under the Common seal of the Trust and be signed by the **Trust Secretary and an Executive Director (voting or non-voting)** duly authorised by the Chief Executive and not from the originating department.

8.17 In all contracts made by the Trust, the Board shall endeavour to obtain best value for money. The Chief Executive shall nominate an officer who shall oversee and manage each contract on behalf of the Trust.

8.18 **Personnel and Agency or Temporary Staff Contracts** - The Chief Executive shall nominate officers with delegated authority to enter into contracts of employment regarding staff, agency staff or temporary staff service contracts

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8.18.1 Where a member of staff is employed using such temporary arrangements the Director of People and Inclusion will ensure that up-to-date guidance is available to managers and that compliance with such guidance is appropriately monitored and enforced to ensure that the Trust is able to comply with regulatory requirements including those of NHS England and Her Majesty's Revenue and Customs (HMRC).

8.19 **Healthcare Services Agreements** – service agreements with commissioners for the supply of healthcare services, are subject to the separate and specific provisions of the

terms of authorisation of the Trust and must be in the form of legally binding contracts

8.20 Cancellation of Contracts – Except where specific provision is made in model forms of contracts approved for use within the NHS and in accordance with SFIs 8.18 and 8.19, every contract shall include a written clause empowering the Trust to terminate the Contract and to recover from the Contractor the amount of any loss resulting from such cancellation if the Contractor or any person employed by the Contractor or acting on behalf of the Contractor has offered, paid or given, directly or indirectly, any gift in money or any other form to any employee or agent of the Trust as an inducement or reward in connection with their behaviour in relation to the Contract, or appears to have committed any offence under the Bribery Act 2010 or other appropriate legislation.

8.21.1 Determination of Contracts for Failure to Deliver Goods or Materials – There shall be inserted in every written contract for the supply of goods or materials a clause to secure that, should the contractor fail to deliver the goods or materials or any portion thereof within the time or times specified in the contract, the Trust may without prejudice determine the contract either wholly or to the extent of such default and purchase other goods, or material of similar description to make good (a) such default, or (b) in the event of the contract being wholly determined the goods or materials remaining to be delivered. The clause shall further secure that the amount by which the cost of so purchasing other goods or materials exceeds the amount which would have been payable to the contractor in respect of the goods or materials shall be recoverable from the contractor.

8.22 The Chief Executive shall nominate officers with power to negotiate for the provision of healthcare services with purchasers of healthcare.

8.23 Contracts Involving Funds Held on Trust - shall do so individually to a specific named fund. Such contracts involving charitable funds shall comply with the requirements of the Charities Act.

9. NHS SERVICE AGREEMENTS AND CONTRACTS FOR PROVISION OF SERVICES

9.1 The Chief Executive, as the Accounting Officer, is responsible for ensuring the Trust enters into suitable contracts with service commissioners for the provision of health services. In discharging this responsibility, the Chief Executive shall take into account:

(a) The National Contract framework
(b) Local health service planning priorities
(c) The cost, price and volume of services to be provided and method of payment;
(d) The standards and detailed specifications for service quality expected;

The Trust will work with any partner agencies involved in both the delivery and the commissioning of the service required. The contract will apportion responsibility for mitigating any contractual risks and the financial arrangements should reflect this.

The Chief Executive, as the Accounting Officer, will need to ensure that regular reports are provided to the Trust Board detailing actual and forecast income from contracts, this responsibility has been delegated to the Executive Director of Finance.

This will include information on any costing arrangements subject to local currency agreements, including any changes to payment systems e.g. National Tariff Payment System

10. EMPLOYMENT TERMS AND CONDITIONS

10.1 REMUNERATION

10.1.1 The Board should formally agree and record in the minutes of its meetings, the precise terms of reference of the Remuneration and Appointments Committee, specifying which posts fall within its area of responsibility, its composition, and the arrangements for reporting. (The terms of reference of this committee are contained in the Scheme of Delegation).

10.1.2 Except where Agenda for Change rules apply, the Trust Board will approve proposals presented by the Chief Executive for the setting of remuneration and conditions of service for those staff not covered by the Committee.

10.1.3 The remuneration of the Chair and Non-executive Directors will be determined by the Council of Governors in accordance with the Foundation Trust Constitution.

10.2 FUNDED ESTABLISHMENT

10.2.1 The workforce plans incorporated within the annual budgets will form the funded establishment.

10.3 STAFF APPOINTMENTS

10.3.1 No Director or staff may engage, re-engage, or re-grade staff, either on a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration:

i) Unless within the approved budget and funded establishment limit and in accordance with appropriate guidance on such employment.
ii) In certain circumstances, following the consideration of an 'Invest to Save' Business Case at ELT, the Chief Executive and the Director of Finance may approve appointments to unfunded posts. These posts must have a return on investment over an agreed period of time. Any agreements that are made will be reviewed and evaluated on a regular basis in order to access the impact on delivering efficiencies laid out in the business case.

10.3.2 The Board will approve procedures presented by the Chief Executive for the determination of pay rates, conditions of service, etc., for staff.

10.4 PROCESSING OF PAYROLL

10.4.1 The Director of People and Inclusion is responsible for:

i) specifying timetables for submission of properly authorised time records and other notifications;
ii) making recommendations to the Director of Finance on the final determination of pay;
iii) making payment on agreed dates;
iv) agreeing methods of payment.
v) maintaining and enforcing a Trust under and overpayment policy and seeking to recover any overpayments in line with that policy.

10.4.2 The Director of Finance and the Director of People and Inclusion **will** as appropriate, issue instructions regarding:

ii) verification and documentation of data;
iii) the timetable for receipt and preparation of payroll data and the payment of staff;
iv) maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay;
v) security and confidentiality of payroll information;
vi) checks to be applied to completed payroll before and after payment;
vii) authority to release payroll data under the provisions of the Data Protection Act;
viii) methods of payment available to various categories of staff;
ix) pay advances and their recovery;
x) procedures for payment by cheque or bank credit:
xi) procedures for the recall of cheques or bank credits;
xii) maintenance of regular and independent reconciliation of pay control accounts;
xiii) separation of duties of preparing records and handling cash; and
xiv) a system to ensure the recovery from leavers of payments and property due to the Trust.
xv) A system to record and report specific employee costs as required by guidance for example “high-cost off-payroll” employee costs
xvi) Maintenance of an up to date authorised signatory list for pay

10.4.3 Nominated managers have delegated responsibility for:

i) Ensuring all members of staff with any secondary employment complete all required declarations in line with secondary employment policy or successor policy in place at the time
ii) Ensuring all staff absences are appropriately authorised. In the event of unauthorised absence the line manager is responsible for notifying payroll services to ensure payment for unauthorised absence is prevented or recovered
iii) submitting time records, and other notifications in accordance with agreed timetables;
iv) completing time records and other notifications in accordance with the instructions of and in the form prescribed by the Director of People and Inclusion or the Director of Finance.
v) submitting termination forms electronically immediately upon receiving confirmation of a member of staff’s resignation, termination or retirement. Where a member of staff fails to report for duty in circumstances that suggest they have left without notice, the Director of People and Inclusion must be informed at the earliest opportunity.
vi) Submitting all employee-related updates promptly to avoid over or under payment and to ensure that staff records are accurate and up to date for their area of responsibility. These requirements include but are not limited to new starters, change forms and leavers.
vii) An authoriser must ensure that timesheets, expense claims and other such notifications are appropriately checked and agreed as accurate before authorisation is given.
viii) Ensuring that all Rostering systems for their area of responsibility are accurately maintained, in accordance with Trust policy, to ensure correct and timely payments are made to appropriate staff

10.4.4 The Director of People and Inclusion and the Director of Finance shall ensure that the chosen method for providing the payroll service is supported by appropriate contracted terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of

these to appropriate bodies.

10.4.5 In terminating a contract through the use of severance payments, the affordability of the payment should be assessed by the Director of Finance before proceeding. The Director of People and Inclusion is responsible for ensuring all appropriate regulatory due process is followed for all types of termination payments. The proposed payment must be authorised by the Chief Executive via the use of the "Termination of Contract – Severance Payments Proforma". This document outlines the details and circumstances of the proposed severance payment. The Director of People and Inclusion must ensure this guidance is maintained in line with current regulatory requirements.

All exit packages must be within the contractual limits or less. Where the Director of People and Inclusion and the Remuneration and Appointments Committee proposes payment which exceeds contractual limits, appropriate approval must be sought from NHS England and the Treasury in line with regulatory policy.

In line with Freedom to Speak Up requirements the Chief Executive will personally review all settlement agreements that contain confidentiality clauses to ensure that such clauses are in the public interest
Such settlement agreements will be made available for inspection by the CQC as part of their assessment to determine if the organisation is well-led
If the settlement requires Treasury approval the Trust will demonstrate that the confidentiality clause is in the public interest in that particular case.

10.5 CONTRACT OF EMPLOYMENT

10.5.1 The Trust Board shall delegate responsibility to the Director of People and Inclusion for:

- ensuring that all staff are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation; and
- dealing with variations to contracts of employment; and
- dealing with termination of contracts of employment (except those cases subject to disciplinary rules and procedures) upon the advice of the Director of Finance on affordability.

11. NON-PAY EXPENDITURE

11.1 DELEGATION OF AUTHORITY

11.1.1 The Trust Board will approve the level of non-pay expenditure on an annual basis and the Chief Executive will determine the level of delegation to budget managers.

Budget holders so delegated, and others who the Budget Holders shall formally nominate shall be authorised to approve requisitions, invoices and petty cash, subject to appropriate segregation of duties and subject to the scope and limit(s) of their budget(s).

11.1.2 The Chief Executive shall set out procedures on the seeking of professional advice regarding the supply of goods and services.

11.2 CHOICE, REQUISITIONING, ORDERING, RECEIPT AND PAYMENT FOR GOODS AND SERVICES

11.2.1 Any member of staff authorised to requisition goods or services shall comply with procedures issued by the Director of Finance and**,** in choosing the item to be supplied or the service to be performed**,** shall always obtain the best value for money for the Trust. In so doing, the advice of the Procurement department shall be sought. Where this advice is not acceptable to the requisitioner, the Director of Finance and the Chief Executive shall be consulted.

11.2.2 The Director of Finance shall be responsible for the prompt payment of all properly authorised accounts and claims. Payment of contract invoices shall be in accordance with contract terms, or otherwise, in accordance with national guidance. Payment for goods and services shall only be made once the goods and services are received (except for prepayments as below). Such requirements will be specified in a Service Level Agreement with the Shared Services Organisation as appropriate.

11.2.3 Official orders must state the Trust's terms and conditions of trade and be consecutively numbered. They must only be issued to, and used by, those duly authorised by the Chief Executive and be in a form approved by the Director of Finance.

11.2.4 All goods, services, or works shall be ordered on an official order except works and services executed in accordance with a contract and purchases from petty cash. Verbal orders may only be issued very exceptionally - by a member of staff designated by the Chief Executive and only in cases of emergency or urgent necessity. These must be confirmed by an official order and clearly marked "Confirmation Order". Goods may not be taken on trial or loan in circumstances that could commit the Trust to a future uncompetitive purchase.

11.2.5 The Director of Finance will:

(a) advise the Board of Directors regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in standing orders and regularly reviewed.

(b) prepare procedural instructions where not already provided in the Scheme of Delegation or procedure notes for budget holders on the obtaining of goods, works and services incorporating the thresholds;

(c) be responsible for the prompt payment of all properly authorised accounts and claims;

(d) maintain a list of Directors/staff, authorised to certify invoices.

(e) be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall provide for:

i) Certification that:

- goods have been duly received, examined and are in accordance with specification and the prices are correct;
- work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct;
- in the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, the rates of

labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality, and price and the charges for the use of vehicles, plant and machinery have been examined;
- where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained;
- the account is arithmetically correct;
- the account is in order for payment.

ii) A timetable and system for submission to the Director of Finance of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment.

iii) Instructions to staff regarding the handling and payment of accounts within the Finance Department.

iv) Be responsible for ensuring that payment for goods and services is only made once the goods and services are received, (except as in SFI 11.2.6).

11.2.6 Prepayments are only permitted where exceptional circumstances apply. In such instances, where material (in excess of £10,000):

a) the appropriate Executive Director must provide, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the Trust if the supplier is at some time during the course of the prepayment agreement unable to meet their commitments;

b) the Director of Finance will need to be satisfied with the proposed arrangements before contractual arrangements proceed; and

c) the budget holder is responsible for ensuring that all items due under a prepayment contract are received and he must immediately inform the appropriate Executive Director or Chief Executive if problems are encountered, along with their Finance Manager who can ensure the correct accounting treatment is performed.

11.2.7 Managers must ensure that they comply fully with the guidance and limits specified by the Director of Finance and that:

a) all contracts (other than for a simple purchase permitted within the Scheme of Delegation or delegated budget), leases, tenancy agreements and other commitments which may result in a liability are notified to the Director of Finance and the Trust Secretary in advance of any commitment being made;

b) contracts above specified thresholds are advertised and awarded in accordance with Public Contract Regulation rules on public procurement;

c) where consultancy advice is being considered, the approval and procurement of such advice must be in accordance with current regulatory guidance for Foundation Trusts. When considering consultancy advice internal approval from the Director of Finance should be sought in line with delegated responsibility limits and always before any business case is sent for external approval from the Regulator. Wherever possible the preferred bidder should assist in the preparation of the required business case to the Regulator. The term consultancy advice is defined as the provision, to management, of objective advice and assistance relating to strategy, structure, management of operations of an organisation in pursuit of its purposes and objectives. Such

assistance will be provided outside the "business as usual" (BAU) environment when in-house skills are not available and will be of no essential consequence and time-limited. Services may include the identification of options with recommendations and/or assistance with (but not delivery of) the implementation of solutions. If in any doubt this is to be referred to the Director of Finance or Deputy for clarification.

d) no order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to Directors or staff, other than:

   i) isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars;

   ii) conventional hospitality, such as lunches in the course of working visits;

   iii) the Conflicts of Interest Policy must be adhered to in all cases.

e) no requisition/purchase order is to be placed for any item or items for which there is no budget provision unless authorised by the Director of Finance on behalf of the Chief Executive;

f) all goods, services, or works should be ordered on an official purchase order including wherever possible works and services executed in accordance with a contract but excluding purchases from petty cash;

g) verbal orders must only be issued very exceptionally - by a member of staff designated by the Chief Executive and only in cases of emergency or urgent necessity. These must be confirmed by an official order and clearly marked "Confirmation Order";

h) orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds or regulatory guidance;

i) goods are not taken on trial or loan in circumstances that could commit the Trust to a future uncompetitive purchase;

j) changes to the list of Directors/staff authorised to certify invoices are notified to the Director of Finance;

k) purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the Director of Finance; and petty cash records are maintained in a form as determined by the Director of Finance.

l) payments to local authorities and voluntary organisations made under the powers of the NHS Act shall comply with procedures laid down by the Director of Finance which shall be in accordance with these Acts.

12. EXTERNAL BORROWING AND INVESTMENTS

12.1 EXTERNAL BORROWING

12.1.1 The Director of Finance is responsible for ensuring that the sum of borrowing from all sources both short term and long term represents value for money, comply with any Regulatory limits and guidance and does not adversely impact on future cash flows.

12.1.2 Any application for a temporary loan or overdraft will only be made by the Director of Finance or by a member of staff so delegated by them and in any event a duly authorised signatory.

12.1.3 The Director of Finance must prepare detailed procedural instructions concerning applications for temporary loans and overdrafts.

12.1.4 All external borrowing must be consistent with the plans outlined in the current Business Plan and be recommended by Finance and Performance Committee to the Trust Board.

12.1.5 The Trust holds a separate Treasury Management Policy which covers both borrowings and investment in more detail.

12.2 INVESTMENTS

12.2.1 Foundation Trusts have discretion to invest surplus money for the purposes of, or in connection with, their functions. The Chief Executive, as accountable officer, is responsible for ensuring that surplus operating cash is invested in accordance with the Board of Directors' duty to safeguard and properly account for the use of public money.

12.2.2 The Director of Finance is responsible for advising the Trust Board on investment strategies for cash surpluses in accordance with best practice guidance and in line with NHS England's most current published guidance for Foundation Trusts.

13. CAPITAL EXPENDITURE AND PRIVATE FINANCE

13.1 CAPITAL INVESTMENT

13.1.1 All bids for Capital Investment should be approved by the Board of Directors (with due regard to the Trust's cash position and any associated investment strategies).

13.1.2 The Trust will follow NHS England's Cash and Capital Regime and where applicable approval will be sought for any investment and property business cases in line with the requirements of the guidance. See NHS England: 'Capital guidance update 2023/24' and NHS England 'capital investment and property business case approval guidance for NHS trusts and foundation trusts'.

13.1.3 The Trust will follow NHS England capital regime in relation to system sign off and working within CDEL limits set by the Regulator.

13.1.4 The Chief Executive is responsible for ensuring that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans.

13.1.5 The Trust shall appoint the Capital Action Team or other appropriate meeting structure whose responsibilities shall be:

a) the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost and meet their overall purpose; and

b) ensuring that capital investment is not undertaken without commissioner(s)/ partner(s) written support, where required, and the availability of resources to finance all revenue consequences and capital charges; and

c) to ensure that a robust financial appraisal is undertaken as appropriate for all business cases (which have been approved by the Trust's Finance and Performance committee as appropriate); and

d) to ensure that appropriate project management and control arrangements are in place; and

e) that the Director of Finance has certified professionally to the costs and revenue consequences detailed in business cases.

13.1.6 For capital schemes where the contracts stipulate stage payments, the Chief Executive will issue procedures for their management, incorporating the recommendations of "Estatecode". The Director of Finance shall issue procedures for the regular reporting of expenditure and commitment against authorised expenditure.

13.1.7 The approval of a capital programme shall not constitute approval for expenditure on any scheme. The Chief Executive shall issue to the manager responsible for any scheme (through the Capital Action Team):

- specific authority to commit expenditure;
- authority to proceed to tender or obtain quotations;
- approval to accept a successful tender or quotation and to place an order.

The Chief Executive will issue a scheme of delegation for capital investment management in accordance with "Estatecode" guidance and the Trust's Standing Orders.

13.1.8 The Director of Finance shall issue the capital investment framework and procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes.

13.1.9 Delegated limits for the signing-off of expenditure on capital monies are covered in these SFIs.

13.2.1 The section below covers the approval process before orders are placed

Expenditure on an individual project up to £100,000	Approved by the Capital Action Team
Expenditure on an individual project between £100,000 and £1,000,000	Jointly approved by the Director of Finance and one other Executive Director
Proposed expenditure on a project in excess of £1,000,000	Board approval required (and process to be in accordance with NHS England guidance)

13.2.2 The extent and progress of the manner in which Capital Investment monies are spent will be regularly reported to the Executive Leadership Team and Finance and Performance Committee. Any variation to the approved capital expenditure plan will require

appropriate authorisation, in accordance with the above limits and be appropriately reported to regulators.

14. ASSET REGISTERS AND SECURITY OF ASSETS

14.1 ASSET REGISTERS

14.1.1 The Chief Executive is responsible for ensuring that a system exists for the maintenance of registers of assets, taking account of the advice of the Director of Finance on the form of any register and the means of updating and arranging for a periodic physical check of assets against the asset register to be conducted.

The Trust shall maintain an asset register recording fixed assets. The composition of information to be held within these registers shall be specified in the Trust's capital accounting policies.

14.1.2 Budget holders must confirm to the Director of Finance any fixed asset additions within their remit. Additions to the asset register will be validated by reference to:

- properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties;
- stores, requisitions and wages records for own materials and labour with overheads; and
- lease agreements in respect of assets held under a finance lease and capitalised.

14.1.3 Budget holders must notify the Director of Finance where they propose that assets are to be sold, scrapped, or otherwise disposed of. Each disposal must be validated by reference to authorisation documents and invoices (where appropriate) and accounted for appropriately. (see disposals and condemnations section)

Budget holders must seek approval from the Trust Board to declare any land or buildings as surplus to NHS requirements and available for disposal and income.
Budget holders and service managers must notify the Financial Controller if assets are being transferred between buildings or otherwise relocated, to allow for the asset register to be updated.

If any assets remain in empty buildings, it is the exiting service manager that is responsible for those assets until the building has been handed over to a new service or to Estates.

No assets that have been identified to hold Commissioner Requested Services in accordance with the NHS England Licence Agreement are allowed to be sold without prior consultation and agreement with NHS England in line with current guidance and approval from the Board. The trust asset register includes a list of all assets which have been identified as being locations of Commissioner Requested Services

14.1.4 The value of owned buildings shall be indexed to current values and all assets shall be depreciated using methods and rates as specified by the appropriate accounting policies in use in the Trust. Periodically non-current assets will be subject to a formal revaluation exercise as described in the relevant Trust accounting policies. The Director of Finance shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.

14.1.5 The Director of Finance of the Trust shall calculate and pay capital charges as required.

14.2 SECURITY OF ASSETS

14.2.1 The overall control of assets is the responsibility of the Chief Executive.

14.2.2 Asset control procedures (including fixed assets, cash, cheques, and negotiable instruments, and also including donated assets) must be approved by the Director of Finance. This procedure shall make provision for:

- identification of additions and disposals;
- recording managerial responsibility for each asset;
- physical security of assets;
- periodic verification of the existence of, condition of, and title to, assets recorded;
- identification and reporting of all costs associated with the retention of an asset; and
- reporting, recording and safekeeping of cash, cheques and negotiable instruments.

14.2.3 All discrepancies revealed by verification of physical assets to fixed asset register shall be notified to the Director of Finance.

14.2.4 Whilst each member of staff has a responsibility for the security of property of the Trust, it is the responsibility of Directors and senior staff in all disciplines to apply such appropriate routine security practices in relation to NHS property as may be determined by the Board of Directors. Any breach of agreed security practices must be reported in accordance with instructions.

14.2.5 Any damage to Trust premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by Directors and staff in accordance with both security policies and the losses procedure.

14.2.6 The organisation will take all necessary steps to recover financial losses due to fraud, theft of, or criminal damage to, its assets on a case by case basis in a timely manner. The impact of the recovery of financial losses due to theft or criminal damage of its assets is regularly monitored and soundly evaluated by Executive Leadership Team and, where appropriate, improvements are made to the redress arrangements and the organisations approach to recovery.

14.2.7 IT assets and where practical Plant, Property and Equipment, should be marked as Trust property.

14.2.8 Where appropriate the Trust's assets should be covered by the NHS arrangements for the pooling of insurance**.**

14.2.9 Each member of staff has a responsibility for the security of property of the Trust whilst working remotely or from home, see separate Home Working Policy.

14.3 PARTNERING ARRANGEMENTS, LEASE ACQUISITIONS AND LEASE ASSIGNMENTS

14.3.1 Partnering arrangements involving the occupation of another party's property (NHS or non NHS) or allowing another party to occupy part of the Trust's property, even if no

financial consideration is involved, must be covered by formal agreement.

14.3.2 All arrangements where the Trust use or occupy a room, part or all of a building for any length of time must be covered by an appropriate written agreement.

14.3.3 Lease acquisition of properties must be covered by a formal lease arrangement.

14.3.4 The decision to sub-let a Trust property or to take on an assigned lease must be covered by a formal agreement or assignment.

14.3.5 The Trust Secretary must be consulted on the legal position and will advise on the need for lease or license agreement and its content.

14.3.6 The Head of Estates and Facilities is responsible for negotiating the heads of terms and will advise on matters of Health & Safety, rates, utilities, maintenance and insurance obligations.

14.3.7 The Director of Finance must be consulted to advise on the appropriate accounting treatment under IFRS.

14.3.8 The Trust Secretary is responsible for maintaining a full record of all agreements in a Trust-wide property database. This will include termination dates, break clause details, rent review dates, notice periods and financial commitments.

14.2 14.4 LEASE TERMINATIONS

14.4.1 The decision to vacate a Trust property must be covered by formal agreement.

14.4.2 The Trust Secretary must be consulted on the legal position and will advise on the notice to the landlord.

14.4.3 The Head of Estates and Facilities will facilitate the assessment of dilapidations and cancellation notifications e.g. rates, insurances, utilities.

14.4.4 The Director of Finance must be informed to ensure payments are cancelled in line with the agreement.

14.4.5 A full record of the agreement is to be maintained in the Trust wide property database.

14.5 RENT REVIEWS

14.5.1 As part of the responsibility for record management there is a need to ensure that rent reviews are carried out in accordance with the lease agreement, and that agreement is either concluded within 2 months of the review date, or that the Finance department are advised of the liability that the budget holder may face.

15. STORES AND RECEIPT OF GOODS

15.1 Stores, i.e. controlled stores and departmental stores for immediate use should be:

- kept to a minimum;
- subjected to annual stock take;

- valued in accordance with Trust accounting policy.

15.2 Subject to the responsibility of the Director of Finance for the systems of control, overall responsibility for the control of stores shall be delegated to a member of staff by the Chief Executive. The day-to-day responsibility may be delegated by the Chief Executive to departmental staff and stores managers/keepers, subject to such delegation being entered in a record available to the Director of Finance. The control of Pharmaceutical stocks shall be the responsibility of a designated Pharmaceutical Officer.

15.3 The responsibility for security arrangements and the custody of keys for all stores and locations shall be clearly defined in writing by the designated manager or Pharmaceutical Officer. Wherever practicable, stocks should be marked as health service property.

15.4 The Director of Finance shall set out procedures and systems to regulate the stores including records for receipt of goods, issues, and returns to stores, and losses.

15.5 Stocktaking arrangements shall be agreed with the Director of Finance and there shall be a physical check covering all material items in stock at least once a year.

15.6 Where a complete system of stock control is not justified, alternative arrangements shall require the approval of the Director of Finance.

15.7 The designated Manager/Pharmaceutical Officer shall be responsible for a system approved by the Director of Finance for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The designated Officer shall report to the Director of Finance any evidence of significant overstocking and of any negligence or malpractice (see also 16, Disposals and Condemnations, Losses and Special Payments). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

15.8 For goods supplied by NHS Supply Chain**,** the Chief Executive shall identify those authorised to requisition and accept goods from the store. The authorised person shall check receipt against the delivery note before forwarding this to the Director of Finance who shall satisfy himself that the goods have been received before accepting the recharge.

15.9 The Trust will follow any guidance issued by NHS England in relation to any centrally procured goods such as PPE.

16. DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

16.1 DISPOSALS AND CONDEMNATIONS

16.1.1 The Director of Finance must prepare detailed procedures for the disposal of assets including condemnations, and ensure that these are notified to managers. Every effort should be made by managers to maintain assets of property plant and equipment in good order.

16.1.2 When it is decided to dispose of a Trust asset, the head of department or authorised deputy will determine and advise the Director of Finance of the estimated market value of the item, taking account of professional advice where appropriate.

16.1.3 Surplus property, plant and equipment or any other Trust asset, which is in serviceable order, should not be disposed of. Due process must be followed whereby the surplus asset is reallocated within the Trust or temporarily stored appropriately. Requests to otherwise dispose of any serviceable asset must be approved by the head of department and notified to the Director of Finance.

16.1.4 All unserviceable articles shall be condemned or otherwise disposed of by a member of staff authorised for that purpose by the Director of Finance. The Condemning Officer shall record condemnation in a form approved by the Director of Finance, which will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second member of staff authorised for the purpose by the Director of Finance.

16.1.5 The Condemning Officer shall satisfy himself as to whether or not there is evidence of negligence in use and shall report any such evidence to the Director of Finance who will take the appropriate action.

16.2 LOSSES AND SPECIAL PAYMENTS

16.2.1 The Director of Finance must prepare procedural instructions on the recording of and accounting for condemnations, losses, and special payments. The Director of Finance shall maintain a Losses and Special Payments Register in which write-off action is recorded.

16.2.2 Any member of staff discovering or suspecting a loss of any kind must immediately inform their head of department, who must inform the Chief Executive and the Director of Finance at the earliest opportunity. Where a criminal offence is suspected, the Director of Finance must immediately inform the police if theft or arson is involved, but if the case involves suspicion of fraud, then the matter should be reported to the Local Counter Fraud Specialist for a criminal investigation. Consideration of police involvement will be discussed with the Local Counter Fraud Specialist. All security-related incidents must be reported to the Trust's Security Management Specialist

16.2.3 Whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a financial nature, the Trust's Local Counter Fraud Specialist must also be notified at the earliest opportunity.

16.2.4 The Board of Directors shall approve the writing-off of losses. This approval is delegated to the Chief Executive (or Director of Finance / Deputy Director of Finance) in accordance with the Scheme of Delegation. Write-offs will only be reported to Audit and Risk Committee on an exceptional basis by value.

16.2.5 The Director of Finance shall be authorised to take any necessary steps to safeguard the Trust's interests in bankruptcies and company liquidations.

16.2.6 For any loss, the Director of Finance should, in consultation with the Trust Secretary, consider whether an insurance claim can be made.

16.2.7 The Director of Finance shall maintain a Losses and Special Payments Register in which write-off action is recorded.

16.2.8 No special payments exceeding delegated limits shall be made without the prior approval of the relevant body

16.2.9 Losses and special payments will only be reported to the Audit and Risk Committee on an exceptional basis by value or volume if there becomes any issue with a certain area.

17 INFORMATION MANAGEMENT AND TECHNOLOGY

17.1 The Director with responsibility for Information Management and Information Technology, who is responsible for the accuracy and security of the computerised (including financial) data and information of the Trust, shall be responsible for devising and maintaining appropriate Information Management and Technology procedures and policies for the Trust.

17.2 The Director responsible for IM&T shall ensure that financial IM&T systems are developed and maintained in an appropriate manner, even in the event that the maintenance of such a system is outsourced.

17.3 The Director of Finance and the Director responsible for IM&T shall ensure that contracts for computer services for financial applications with another health organisation**,** any other agency or Shared Services Organisation shall clearly define the responsibility of all parties for the information governance, security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

17.4 Where another health organisation**,** any other agency or Shared Service Organisation provides a computer service for financial applications, the Director of Finance shall periodically seek assurances that adequate controls are in operation.

17.5 Where computer systems have an impact on corporate financial systems the Director of Finance shall satisfy themself that:

(a) systems acquisition, development and maintenance are in line with financial requirements
(b) data produced by financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists;

(c) Only appropriate persons shall have access to such data; and

(d) such computer audit reviews as are considered necessary are being carried out.

(e) Adequate business continuity/disaster recovery arrangements are in place

17.6 The Director of Finance shall ensure that financial risks to the Trust arising from the use of IM&T are effectively identified and considered and appropriate action taken to mitigate or control risk.

Freedom of Information

17.7 All Directors shall ensure that processes are in place and are subject to adequate control for the provision of information requests in line with The Freedom of Information (FOI) Act 2000.

18. PATIENTS' PROPERTY

18.1 The Trust has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in Trust property. Employees are required to follow the Trust Policy and Procedure for Service Users' Finance and Property

18.2 The Chief Executive is responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admission by;

a) notices and information booklets,
b) Trust admission documentation and property records,
c) the verbal advice of administrative and/or nursing staff responsible for admissions,

The Trust will not accept responsibility or liability for patients' property brought into Trust premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt.

18.3 The Chief Operating Officer must provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients. Due care should be exercised in the management of a patient's money in order to maximise the benefits to the patient.

18.4 Where Department of Health instructions require the opening of separate accounts for patients' monies, these shall be opened and operated under arrangements agreed by the Director of Finance.

18.5 In all cases where property of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates, Small Payments, Act 1965), the production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained.

18.6 Staff should be informed, on appointment, by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients.

18.7 Where patients' property or income is received for specific purposes and held for safekeeping the property or income shall be used only for that purpose, unless any variation is approved by the donor in writing.

19. CHARITABLE FUNDS

19.1 INTRODUCTION

19.1.1 Charitable funds are those gifts, donations and endowments held on trust for purposes relating to the Derbyshire Healthcare NHS Foundation Trust. They are administered on behalf of the Trust by the Directors of the Derbyshire Community Healthcare Services NHS Foundation Trust, acting as agents of the charitable fund.

19.1.2 The discharge of the DCHS's corporate trustee responsibilities is distinct from its responsibilities for exchequer funds and may not necessarily be discharged in the same manner, but there must still be adherence to the overriding general principles of financial regularity, prudence and propriety. Trustee responsibilities cover both charitable and non-charitable purposes. The Director of Finance shall ensure that each charitable fund is managed appropriately with regard to its purpose and to its requirements.

19.2 The Director of Finance shall periodically review the charitable funds in existence and shall make recommendations to the trustees regarding the potential for rationalisation of such charitable funds within statutory guidelines.

20. ACCEPTANCE OF GIFTS BY STAFF AND LINK TO STANDARDS OF BUSINESS CONDUCT

20.1 The Trust Secretary shall ensure that all staff are made aware of the Trust policy on acceptance of gifts and other benefits in kind by staff. Staff should be aware of and comply with the Trust's 'Conflict of Interest Policy'.

20.2 Staff should make themselves aware of, and comply with, the Bribery Act 2010, Code of Conduct for NHS Managers 2002, and the Code of Practice for the Pharmaceutical Industry 2012 relating to hospitality / gifts from pharmaceutical / external industry.

21. RETENTION OF DOCUMENTS

21.1 The Chief Executive shall be responsible for maintaining a Policy and Procedure for the Retention, Preservation and Destruction of Records which all employees must follow.

21.2 Any documents held in archives shall be capable of retrieval by authorised persons.

21.3 Documents held under the requirements of current directions shall only be destroyed at the express instigation of the Chief Executive, and records shall be maintained of documents so destroyed in accordance with the Policy and Procedure for the Retention, Preservation and Destruction of Records.

21.4 Associated policies which employees should be familiar with are: the Policy and Procedure for Offsite Records Storage, Policy and Procedure for Disposal of Confidential Information and the Information Lifecycle Management Policy and Procedure.

22. RISK MANAGEMENT AND INSURANCE

22.1 The Chief Executive shall ensure that the Trust has a programme of risk management, which will be approved and monitored by the Board of Directors. Employees must comply with the Trust Risk Management policies and procedures.

22.2 The programme of financial risk management shall include:

a) process for identifying and quantifying risks and potential liabilities

b) engendering among all levels of staff a positive attitude towards the control of risk

c) management processes to ensure all significant financial risks and potential liabilities are addressed, including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk

d) contingency plans to offset the impact of adverse events

e) audit arrangements including internal audit, clinical audit, health and safety review

f) arrangements to review the risk management programme

The existence, integration and evaluation of the above elements will provide a basis to make a statement on the effectiveness of internal control within the annual report and accounts.
The Trust Secretary shall ensure that insurance arrangements exist in accordance with the risk management programme.

Insurance arrangements with commercial insurers

22.3 There is a general prohibition on entering into insurance arrangements with commercial insurers. There are, however, three exceptions when the Trust may enter into insurance arrangements with commercial insurers. The exceptions are;

a) Trusts may enter commercial arrangements for insuring motor vehicles owned or leased by the Trust including insuring third party liability arising from their use.

b) where the Trust is involved with a contractual arrangement to lease a building and the landlord or Private Finance Initiative consortium in respect of the PFI contract require that commercial insurance arrangements are entered into.

c) Where income generation activities take place. Income generation activities should normally be insured against all risks using commercial insurance. If the income generation activity is also an activity normally carried out by the Trust for NHS purpose the activity may be covered in a risk pool. Confirmation of coverage on the risk pool must be obtained from the NHS Litigation Authority. In any case of doubt concerning a Trust's powers to enter into commercial insurance arrangements, the Director of Finance and Trust Secretary should consult the Department of Health.

APPENDIX 1

Tendering Procedure

1. Invitation to tender

(i) All invitations to tender shall state the date and time as being the latest time for the receipt of tenders.

(ii) All invitations to tender shall state that no tender will be accepted unless:

(a) submitted in a plain sealed package or envelope bearing a pre-printed label supplied by the Trust (or the word "tender" followed by the subject to which it relates) and the latest date and time for the receipt of such tender addressed to the Chief Executive or nominated Manager;

(b) that tender envelopes/ packages shall not bear any names or marks indicating the sender. The use of courier/postal services must not identify the sender on the envelope or on any receipt so required by the deliverer.

(c) It is submitted in accordance with the instructions issued via The Trust's electronic contract management system

(iii) Every tender for goods, materials, services or disposals shall embody such of the NHS Standard Contract Conditions as are applicable.

(iv) Every tender for building or engineering works (except for maintenance work, when Estmancode guidance shall be followed) shall embody or be in the terms of the current edition of one of the Joint Contracts Tribunal Standard Forms of Building Contract or Department of the Environment (GC/Wks) Standard forms of contract amended to comply with concode; or, when the content of the work is primarily engineering, the General Conditions of Contract recommended by the Institution of Mechanical and Electrical Engineers and the Association of Consulting Engineers (Form A), or (in the case of civil engineering work) the General Conditions of Contract recommended by the Institute of Civil Engineers, the Association of Consulting Engineers and the Federation of Civil Engineering Contractors. These documents shall be modified and/or amplified to accord with Department of Health guidance and, in minor respects, to cover special features of individual projects.

2. Receipt and safe custody of tenders

The Trust Secretary or their nominated representative will be responsible for the receipt, endorsement and safe custody of tenders received until the time appointed for their opening. In the case of tenders submitted by The Trust's electronic contract management, the tender maybe opened by the Head of Procurement.

The date and time of receipt of each tender shall be endorsed on the tender envelope/package.

3. Opening tenders and Register of tenders

(i) As soon as practicable after the date and time stated as being the latest time for the receipt of tenders, they shall be opened by two Directors usually the Trust Secretary and a Director who is not from the originating department. In the case of tenders submitted by the Trust's electronic contract management, the tender may be opened by the Head of Procurement. These tenders are held in a secure environment compliant with ISO27001 infrastructure and available as a CESG accredited HMG Impact Level 3 service which allows handling of "restricted documents" classification. In this case sub sections (ii), (vi) and (vii) do not apply.

(ii) A member of the Trust Board will be required to be one of the two approved persons present for the opening of tenders estimated above £400,000. The rules relating to the opening of tenders will need to be read in conjunction with any delegated authority set out in the Trust's Scheme of Delegation.

(iii) The 'originating' Department will be taken to mean the Department sponsoring or commissioning the tender.

(iv) The involvement of Finance Directorate staff in the preparation of a tender proposal will not preclude the Director of Finance from serving as one of the directors to open tenders. The involvement of estates staff in the preparation of a tender proposal will not preclude the Director of Estates from serving as one of the directors to open tenders.

(v) All Executive Directors will be authorised to open tenders regardless of whether they are from the originating department provided that the other authorised person opening the tenders with them is not from the originating department.

(vi) Every tender received shall be marked with the date of opening and initialled by those present at the opening.

(vii) A register shall be maintained by the Trust Secretary, or a person authorised by him, to show for each set of competitive tender invitations despatched, including those handled under the electronic contract management system (see 3 (i) above):

- the name of all firms individuals invited;
- the names of firms individuals from which tenders have been received;
- the date the tenders were opened;
- the persons present at the opening;
- the price shown on each tender;
- a note where price alterations have been made on the tender.

Each entry to this register shall be signed by those present.

A note shall be made in the register if any one tender price has had so many alterations that it cannot be readily read or understood.

(viii) Incomplete tenders, i.e. those from which information necessary for the adjudication of the tender is missing, and amended tenders i.e., those amended by the tenderer upon their own initiative either orally or in writing after the due time for receipt, but prior to the opening of other tenders, should be dealt with in

the same way as late tenders.

4. Admissibility

(i) If for any reason the designated officers are of the opinion that the tenders received are not strictly competitive (for example, because their numbers are insufficient or any are amended, incomplete or qualified) no contract shall be awarded without the approval of the Chief Executive.

(ii) Where only one tender is sought and/or received, the Chief Executive and Director of Finance shall, as far practicable, ensure that the price to be paid is fair and reasonable and will ensure value for money for the Trust.

5. Late tenders

(i) Tenders received after the due time and date, but prior to the opening of the other tenders, may be considered only if the Chief Executive or their nominated officer decides that there are exceptional circumstances i.e. despatched in good time but delayed through no fault of the tenderer.

(ii) Only in the most exceptional circumstances will a tender be considered which is received after the opening of the other tenders and only then if the tenders that have been duly opened have not left the custody of the Chief Executive or their nominated officer or if the process of evaluation and adjudication has not started.

(iii) While decisions as to the admissibility of late, incomplete or amended tenders are under consideration, the tender documents shall be kept strictly confidential, recorded, and held in safe custody by the Trust Secretary or their nominated officer.

6. Acceptance of formal tenders

(i) Any discussions with a tenderer which are deemed necessary to clarify technical aspects of their tender before the award of a contract will not disqualify the tender.

(ii) The most economically advantageous tender, if payment is to be made by the Trust, or the highest, if payment is to be received by the Trust, shall be accepted unless there are good and sufficient reasons to the contrary. Such reasons shall be set out in either the contract file, or other appropriate record.

It is accepted that for professional services such as management consultancy, the lowest price does not always represent the best value for money. Other factors affecting the success of a project include:

a) experience and qualifications of team members;
b) understanding of client's needs;
c) feasibility and credibility of proposed approach;
d) ability to complete the project on time.

Where other factors are taken into account in selecting a tenderer, these must be clearly recorded and documented in the contract file, and the reason(s) for not accepting the lowest tender clearly stated.

(iii) No tender shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these Instructions except with the authorisation of the Chief Executive.

(iv) The use of these procedures must demonstrate that the award of the contract was:

a) not in excess of the going market rate / price current at the time the contract was awarded;

b) that best value for money was achieved.

(v) All tenders should be treated as confidential and should be retained for inspection.

7. Tender reports to the Trust Board

Reports to the Trust Board will be made on an exceptional circumstance basis only.

8. List of approved firms

a) Responsibility for maintaining list

A manager nominated by the Chief Executive shall on behalf of the Trust maintain lists of approved firms from whom tenders and quotations may be invited. These shall be kept under frequent review. The lists shall include all firms who have applied for permission to tender and as to whose technical and financial competence the Trust is satisfied. All suppliers must be made aware of the Trust's terms and conditions of contract.

b) Building and Engineering Construction Works

(i) Invitations to tender shall be made only to firms included on the approved list of tenderers compiled in accordance with this Instruction or on the separate maintenance lists compiled in accordance with "Estmancode" guidance (Health Notice HN(78)147).

(ii) Firms included on the approved list of tenderers shall ensure that when engaging, training, promoting or dismissing staff or in any conditions of employment, shall not discriminate against any person because of colour, race, ethnic or national origins, religion or sex, and will comply with the provisions of the Equal Pay Act 1970, the Sex Discrimination Act 1975, the Race Relations Act 1976, the Disabled Persons (Employment) Act 1944 and Equality Act 2010 and any amending and/or related legislation.

(iii) Firms shall conform at least with the requirements of the Health and Safety at Work Act and any amending and/or other related legislation concerned with the health, safety and welfare of workers and other persons, and to any relevant British Standard Code of Practice issued by the British Standard Institution. Firms must provide to the appropriate manager a copy of its safety policy and evidence of the safety of plant and equipment, when requested.

c) Financial Standing and Technical Competence of Contractors

The Director of Finance may make or institute any enquiries he deems appropriate concerning the financial standing and financial suitability of approved contractors. The Director with lead responsibility for clinical governance will similarly make such enquiries as is felt appropriate to be satisfied as to their technical / medical competence.

9. Exceptions to using approved contractors

If in the opinion of the Chief Executive and the Director of Finance or the Director with lead responsibility for clinical governance it is impractical to use a potential contractor from the list of approved firms/individuals (for example where specialist services or skills are required and there are insufficient suitable potential contractors on the list), or where a list for whatever reason has not been prepared, the Chief Executive should ensure that appropriate checks are carried out as to the technical and financial capability of those firms that are invited to tender or quote.

An appropriate record in the contract file should be made of the reasons for inviting a tender or quote other than from an approved list.

Board Committee Assurance Summary Reports to Trust Board – 9 May 2023

The following summaries cover the meetings that have been held since the last public Board meeting held on 7 March and are received for information.

- Mental Health Act Committee 17 March
- Finance and Performance Committee 21 March
- Quality and Safeguarding Committee 24 March and 18 April
- People and Culture Committee 28 March

Mental Health Act Committee - key items discussed 17 March 2023
Mental Health Act Operational Group The Committee regularly receives the minutes of the above group for information only. They are presented by the Medical Director.
Mental Health Act Committee Year-end Effectiveness The Committee is required to review its activity and effectiveness for 2022/23, comparing its work with its Terms of Reference taking account of the quarterly meetings held from June 2022 to March 2023. The Committee considered its activity to be compliant against the Terms of Reference and the duties described. Agendas had been structured appropriately and no improvements need to be made. The terms of reference were reviewed and agreed with no changes considered necessary.
Mental Health Act (MHA) Manager's Report The report covered the analysis and assessment of the Mental Health Act Office activity covering the period from 1 October 2022 to 31 December 2022 The data contained in the report was comprehensively reviewed and provided significant assurance that the safeguards of the MHA have been appropriately applied within the Trust. Limited assurance was obtained in terms of data currently being extracted from the Trust's Electronic Patient Record (EPR) due to duplication of certain information. Manual reviews of data are taking place while the issue is being resolved.
Liberty Protection Safeguards (LPS) The Committee discussed the potential that LPS may not be implemented to replace Deprivation of Liberty Safeguards (DoLs) during the life cycle of this Parliament. As and when further updates become available these will be conveyed to the Committee. It was agreed that the standing item for the Liberty Protection Safeguards and the Mental Health Legislation will be removed from future agendas
Training Compliance The report provided an update on compliance for Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) as at 31 January 2023. The current training compliance level stands at 85% against the compliance target of 90%. Ongoing initiatives are in place to improve performance. This includes an increase in the threshold for cancelling training which is seen to be aiding training compliance levels. Reasons for staff not attending training continue to be caused by staffing pressures on the wards and sickness absence. It is anticipated that recent industrial action will have an impact on training compliance levels. Limited assurance was obtained from the report due to the 5% gap in training compliance.

Reducing Restrictive Practice, Restraint and Seclusion and locking of doors

A verbal briefing provided assurance that restrictive practice, restraint, and seclusion as well as the procedure for locked doors continues to be actively monitored. Progress is being made in reducing restrictive practices with enhancements being made with training and awareness.

Use of Section 136 suites

The report showed an upward trend in the use of S136, which is no different from other trusts. Over the last four months activity has been high which is thought to be linked to current economic difficulties. The Street Triage Project that went live in March following a pilot period is anticipated to reduce the number of Section 136 detentions as will the telephone helpline.

The Committee noted the current position and supported the continued ongoing work and improvements for the Section 135/136 Group.

Update from Associate Hospital Managers

Associate Hospital Managers (AHM) gave a verbal update on their activities. The resignation of an experienced AHM was recently reported with no issues being raised with the process for a replacement.

There have been few contested hearings in the last twelve months with one barring order. The review of Community Treatment Orders (CTO) are very complex, they are challenging cases. It is clear that the CTO are effective for patients.

Deprivation of Liberty Policy and Procedures

The review and update of the Deprivation of Liberty Policy and Procedures has been delayed in anticipation of the new Code of Practice and legislative changes. As these changes have not progressed through Parliament to date, the Committee approved the amended Policy until such time as the Code of Practice and legislative changes are formalised.

Joint Policy for Derbyshire on the Operation of Section 136 of the Mental Health Act Policy and Procedure

The policy sets out the procedure for multi-agency working relating to Section136 of the MHA 1983. The policy has been updated to ensure it is compliant with the Policing and Crime Act 2017 and was brought to the Committee for information.

Mental Capacity Act Policy

The Committee had previously extended the policy in anticipation for a new Code of Practice and legislative changes. As those changes have not progressed the policy was ratified such time as the Code of Practice and legislative changes are formalised.

Escalations to Board or other Committee(s): None
Next Meeting: 9 June 2023

Committee Chair: Ashiedu Joel	**Executive Lead: Arun Chidambaram, Medical Director**

Finance and Performance Committee - key items discussed 21 March 2023

Making Room for Dignity (MRfD) assurance on Estate Strategy

- Trust has received and returned the MOU for the funding of the three remaining projects
- The Trust is working with NHSE on the Acute Plus project as a condition laid out in the approval with it being a non-standard service model
- Energy supply at CRH remains a cost risk of £1.2m as further works and upgrades to the supply are now required
- VAT abatement – a barrister has been appointed to support the Trust with the case
- Contract prices for the 3 new builds have been agreed
- Heads of Terms for CRH and the lease for the blue ward are both moving forwards
- Key risks included in the programme board report relate to delays on completion of new builds due to late approval of the FBCs, cost pressures related to VAT abatement if unsuccessful, cost risk of energy supply and recruitment and retention of staff.

The Committee noted the updates and supported the next stage of the programme work.

Delivery of IM&T strategy and wider digital strategy

Significant progress has been made over the last 6 months, but emerging challenges have been highlighted to the committee.

- Significant progress with system One and implementation of E Prescribing
- Progressing the shared care record across the Derbyshire system
- Implementation of enhanced Wi-Fi
- IG completion continues to be a strength
- Challenges remain around recruitment and retention of technical staff and that may get worse with other organisation developing patient record systems and requiring additional resources

The Committee recognised the hard work and resilience of the IMT team and other teams that are feeding in as they have handled the challenges extremely well.

Operational Performance

The committee was provided an update on the performance at the end of January which was the same report presented to Trust Board. The Committee commented on the good progress made in developing the report.

Particular highlights presented were in relation to the readmission rate and caseloads and how these will link to the productivity work.

The Committee also noted a number of key areas that we report on but is more of a Derbyshire system issue such as Autism as we are meeting the target as an organisation but not as a system.

TCP proposal and update and LDA transition

The committee received an update on the current progress in relation to the Neurodevelopment services.

Focus has been on levels of supervision reported and compliance with required levels.

Some issues with the psychology service provision which is being delivered by another Provider which has reduced, and discussions are on-going with how this is delivered going forward. Discussion will need to be had with the ICB and more discussion will take place through the Committee in Common.

Business Environments update

- IMPACT provider collaborative update – discussions are taking place between IMPACT and the Trust in relation to future opportunities within the collaboration. Positive feedback that the Trust is working well within the collaborative. An informal review of all the Provider Collaboratives is taking place across the East Midlands.

- Perinatal provider collaborative update – Business case is being finalised and to be submitted early July with a formal assurance panel at the beginning of September. Good progress is being made. Work is focusing on the handover of the contract and associated roles.

Financial Governance and Plan delivery including CIP

The Committee received the Month 11 position reported against the breakeven plan. Month 11 is a favourable variance to plan. The forecast remains a surplus of £2.8m. This improvement has been driven by additional income for pay award, VAT rebate, slippage on investments, additional benefit from Dormitory revenue funding and a further stretch requirement. This £2.8m surplus is part of the reduced system deficit of £19m, which has now reduced to a £13m deficit.

Financial risks continue to reduce particularly related to the delivery of efficiencies and managing cost pressures however the risk of increasing temporary staffing costs particularly agency continues.

System updates: ICB Finance Committee / system DOF's

This item was covered as part of the planning agenda item.

Review and approval of Treasury Management Policy

The updated policy was presented and ratified by the committee with minor changes. Executive Leadership Team and Counter Fraud had also reviewed prior the Committee.

Continuous Improvement update

Several updates have taken place over recent weeks including a Board development session and a stocktake at the March Trust Board.

Training continues and looking at targeting specific areas of skills deficits, development of the QI platform and aiming to use the full capacity of licences, scheduling in time to look at engagement and communication and finally evaluating the current strategy in year.

2023/24 System and Organisational Planning update and final submission sign off

The current position of the financial plan for 2023/24 was presented to the committee for review and sign off ahead of the 30 March 2023 submission.

Lots of work across the system and internally has taken place to get to the current position but there is more work required to further reduce the internal deficit and the system deficit before the final submission at the end of March.

Focus has been on the workforce plan and growth in staff numbers and cost.

The assumptions in the current position were shared: income allocations based on fair shares approach, efficiencies at 3%, inflationary uplifts based on national tariff adjustments. This generates a significant deficit position for the Trust. This is mainly driven by the underlying deficit position in 2022/23 where the forecast outturn of a surplus has been delivered through non-recurrent benefits. The underlying position is impacted by efficiencies in 2022/23 being delivered mainly through non-recurrent schemes along with other non-recurrent benefits, all driving the recurrent deficit into 2023/24.

There are already risks contained within this position mainly in relation to agency which the planned spend has been capped at 3.7% of the pay budget but spend in 2022/23 was in excess of

this, plans for the delivery of the efficiency programme requires significant work to develop robust plans and emerging costs pressures mainly around excess inflation.

Any planned deficits will impact on the levels of cash along with the capital expenditure in relation to self-funded schemes.

Next steps in trying to reduce the deficit are being explored mainly around recruitment assumptions, balance sheet benefits and removing any excess inflationary assumptions in the plan.

The Committee were not comfortable with the deficit position and would like to see options available to deliver the efficiencies and reduce the deficit position. This would require a list of options available and principles that we sign up to in order to make those difficult decisions.

Board Assurance Framework 2022/23 overview

The risks from 2022/23 are being rolled over into 2023/24 and Executive leads are in the process of providing updates on those risks.

Emergency Preparedness Resilience and Response (EPRR)

The committee was provided with an update on the work going on within the EPRR portfolio**.**

There have been many challenges this year and several incidents and events to deal with and it was acknowledged that the team had done a fantastic job in dealing with these.

Work has been on-going in relation to improve core standards compliance.

Training of staff has also been a focus.

The Committee acknowledge the excellent response in relation to the incidents and the planning and approach to the recent strikes.

Year-end review of F&P Committees effectiveness

The Committee felt it was in good shape from the activity covered and its effectiveness and agreed that it had covered most areas of their remit. The only exception would be the 5-year capital plan however it was noted that this has been covered in detail with regards the MRfD capital programme, but this has mainly been driven by a focus on a one year plan as part of the planning cycle.

The Committee does review the IT strategy and it should be formally added to the remit of the Committee.

It was agreed that any strategic contracts that require the Committee to sign off should come to the Committee as part of the business updates agenda item.

Committee Terms of Reference review

The TOR were discussed as part of the committee effectiveness agenda item

Escalations to Board or other Committees:
Board Assurance Framework: – key risks identified:
Next scheduled meeting: 23 May 2023

Committee Chair: Tony Edwards	**Executive Lead: Rachel Leyland, Interim Director of Finance**

Quality and Safeguarding Committee - key items discussed 24 March 2023 – this meeting was rescheduled from 14 March as a result of the recent industrial action by Junior Doctors

Summary of Board Assurance Framework (BAF) Risks

The Committee reviewed BAF risk 1a *"There is a risk that the Trust will fail to provide standards for safety and effectiveness as required by our patients and our Board"* it has oversight of in the context of discussions and the current work programmes.

The Committee was satisfied with the risk current ratings. It was understood that year-end financial planning and the recent industrial action will have a cumulative impact on the BAF, details of which will be included in the new iteration of the BAF for 2023/24 due to be reviewed by the Executive Leadership Team (ELT) and Audit and Risk Committee in April and approved by the Board of Directors on 9 May..

Outstanding CQC actions

Progress has been made on the majority of actions. Quality Improvement processes are progressing in areas of concern. Training compliance has improved but there remain some gaps particularly in acute services. Overall training compliance has reached the required level of 85%. Whilst training levels appear good overall a continued focus is being applied to all divisions to sustain compliance levels.

A mock CQC inspection programme has been completed and a thematic review has been submitted to the CQC Oversight group to ensure further action for improvement. Quality Summits are being implemented in three areas to support teams deemed to require short term intervention.

Limited assurance was obtained with regard to preparedness and progress towards completion of outstanding actions. The Committee was pleased to see there are now better processes in place and that actions are reviewed regularly with Managing Directors and Heads of Nursing responsible for the areas.

Neurodevelopmental services update

A key risk area discussed was the autism diagnosis waiting list which remains high with demand outstripping capacity. The target of completing 26 assessments a month is being achieved but the current rate of 76 referrals per month represents a significant shortfall in service demand.

The Committee recognised that autism waiting lists are meeting the commissioned number of places but meeting increased diagnostic targets will heighten the impact on those who are diagnosed. It is expected that the new service being modelled will allow a pathway into the service and that working with Voluntary Community and Social Enterprise (VCSE) partners will help serve as many individuals as possible to meet the new model of care.

Care Plan Performance

This performance deep dive provided an overview of the plans in place to improve care planning compliance across the Trust.

As of February 2023, 63% of patients have a care plan in place. This is an increase of 32% when compared with November 2022. The aim is for all service users to have a care plan however due to data quality issues the aim is to achieve 85%. The remaining 15% accounts for patients who have been discharged but not closed, patients on waiting lists, patients who would have a care plan recorded outside of the care plan template and patients who would not yet be expected to have a care plan. The Heads of Nursing and operational leads are working across all areas to specifically target interventions that

will improve the trajectory of care plan compliance. It is expected that month by month we will see accumulated progress.

This deep dive in care plan compliance provided a valuable opportunity to understand the issues impacting compliance. Despite the emphasis being placed on achieving better compliance rates limited assurance was received from plans to improve care planning compliance.

Patient Experience Quarterly Report

This report concerned themes and changes made to Trust services as a result of feedback from incidents and complaints made to the Patient and Carer Experience Committee and included an overview of the analysis of the data for Quarter 3 2022/23.

The ongoing work between the Carers Engagement Group, the EQUAL Forum and the Patient and Carer Experience Committee has resulted in good feedback. Work is underway to improve patient experience across the Trust and how patient and carer feedback is received, reviewed and actions created. Although returns from the Friends and Family Survey remain low in some areas, improved feedback formats will provide a variety of options for service users and carers including an electronic patient survey which has been co-produced with service user involvement.

Compliments showed an increase of 14% compared with Q2. All services would benefit from improving the recording of compliments as it is clear from the number of delivering everyday excellence (DEED) awards that are regularly nominated compliments are not accurately recorded. The Trust has responded well with escalations and in capturing learning from the HealthWatch reports during quarter 3.

The Committee received significant assurance from the report based on previous scrutiny by the Patient and Carer Experience Committee was pleased to see the involvement of the Carers Engagement Group and the EQUAL Forum and hoped to see key areas of escalation resolved in the next report.

Quality Visit findings and future plan for quality

Quality visits for season 11 will run until July 2023 and will realign with the Trust award process. Out of hours visits were formalised in November 2022 as a response to the Panorama programme exposing care at a secure unit elsewhere in the country. Visits have generally been well received by colleagues and have provided a reasonable level of assurance of service operation outside of the normal structured hours. These visits have highlighted areas for improvement, such as the Brigid App on inpatient wards, and areas of positive practice, for instance staff on the Enhanced Care Ward being positive about working within the Trust.

Discussion focussed on how the quality visit process provides an opportunity for teams to demonstrate areas of practice they are proud of as well as identifying areas where they need support from the Board. It was felt that teams are more prone to highlight issues that are not working well or the challenges they are faced with rather than highlighting their success. Teams are being encouraged to engage with the quality process and feel safe to speak up with the support of the Freedom to Speak up Guardian (FTSUG) in readiness for the CQC inspection.

The Committee noted the improvements made in arranging quality visits but received limited assurance until more confidence in the floor to Board Quality Visit process.

Safeguarding Children Assurance

This report provided significant assurance from safeguarding children activity in the Trust against statutory and legislative requirements. The report highlighted the continued high activity the Safeguarding Team is engaged in.

Challenges escalated to the Committee included the robust Business Continuity Plans put in place by the Safeguarding lead to ensure attendance at Multi-Disciplinary Meetings

(MDMs), safeguarding strategy meetings and partnership meetings to manage safeguarding incidents in line with legislative responsibilities and to continue to meet Public Protection duties.

CSPR (Child Safeguarding Practice Reviews) and internal investigations are on target. The media statements are in place for potential media interest with regard to CSPR both internally and from the Partnership agencies.

Concern was raised with Level 3 training which remains below the trajectory of 80%. Additional dates and spaces have been offered to address compliance needs. Compliance levels have increased following targeted work with non-compliant staff.

Safeguarding Adults' Assurance

The Committee reviewed adult safeguarding performance against statutory and legislative requirements and received significant assurance that statutory duties are being met

Clinical activity continues to be high with increasing complexity of safeguarding referrals and clinical cases. Actions from significant incidents are in progress or completed. Recent activity included providing assurance of 'Quality Care' to Derby City Adult Safeguarding Board and Derbyshire Safeguarding Quality Assurance Subgroup following the Panorama programme which identified poor and abusive care following undercover reporting in an NHS mental health secure service.

There has been a slight drop in adult safeguarding training compliance due to staff training passport requirements being updated. Bespoke training is being offered to areas where a need is identified. It was noted that the Quality Priority of Improving Sexual Safety is moving forward and remains a priority across all areas.

The number and type of alerts coming through to the Derby City Multi-Agency Safeguarding Hub (MASH) regarding safeguarding concerns with children in care have increased. All patients and staff involved have been supported.

Sexual safety and trauma - Sexual Safety Strategy

Significant assurance was received from Derbyshire Healthcare's Quality Priority of Improving Sexual Safety which is moving forward with regional links being made. The Trust is promoting sexual safety for people that use its services and staff to ensure that sexual safety is supported at every level. The Sexual safety Policy will be completed by April 2023 and will reflect how people can be kept safe from sexual harm.

Robust plans are in place to ensure that patients and staff feel supported and safe. Teams are being encouraged to have open conversations about sexual safety with people who use services and work within our services.

Tobacco Dependence Intervention and Support Policy

The Committee reviewed recent revisions and ratified the Policy

Board Assurance Framework – key risks identified: None
Escalations to Board or other committees: None
Next Meeting – 18 April 2023

Committee Chair: Lynn Andrews	**Executive Lead: Tumi Banda, Interim Director of Nursing and Patient Experience**

Quality and Safeguarding Committee - key items discussed 18 April 2023
Summary of Board Assurance Framework (BAF) Risks The Committee reviewed BAF risk 1a *"There is a risk that the Trust will fail to provide standards for safety and effectiveness as required by our patients and our Board"* it has oversight of in the context of discussions and the current work programmes. The risk that the Trust will be in breach of essential standards for privacy and dignity in its acute bedded care facility because we have not fully completed our dormitory eradication programme and may result in regulatory action if mitigation to improve safety does not occur will be articulated in the new version of the BAF.
Neurodevelopmental services update A verbal update provided assurance on progress being made with the new service being modelled to provide better care for service users across the county.
Outstanding CQC actions Progress has been made on the majority of actions. Limited assurance was obtained with regard to preparedness and progress towards completion of outstanding actions. Outstanding care planning based actions continue to have improvement work. Training trajectory continues to improve. A mock CQC Inspection Programme has been completed with areas of good practice and common themes reported with actions identified for improvement.
Quality Performance Dashboard This bi-monthly update on provided limited assurance from overall clinical performance. There has been an increase in seclusion which is attributed to a small number of individuals who were secluded multiple times who have now been discharged to an environment better suited to their needs. There was a spike in incidents of physical assault on staff related to multiple incidents involving a small number of patients. Incidents of self-harm via ligature have reduced by over 100% and continue on a downward trajectory. Care plan compliance continues to be challenging and is linked the migration of care plans from Paris EPR to SystmOne. This is being monitored through the divisional Clinical Operational Assurance Teams. It is anticipated that positive progress will be evident in the next issue of the dashboard.
Making Room for Dignity Programme Significant assurance was received from the progress being made to eradicate the use of dormitory accommodation for adult inpatient mental health provision and the programme to eradicate the use of inappropriate Out of Area PICU beds in Derbyshire.
Draft Quality Account 2022/23 The draft Quality Account for 2022/23 details the Trust's approach to quality over 2022/23 was received for review. The Quality Account highlighted the continued drive to deliver high quality and innovative care and the priorities being set for 2023/24. The final draft will be received for sign off at the May meeting.
Serious Incidents Annual report 2022/23 Limited assurance was received from information relating to all Patient Safety incidents, the process for review and developments occurring during 2022/23. The report showed areas identified for improvement and successes achieved over the preceding twelve month period. The investment of additional staff is now starting to show improvement in the flow particularly in terms of Case Record Review and quality of reporting.

Learning From Deaths / Mortality Annual Report 2022/23

There were no concerns with the findings of the report. All legal priorities have been completed with regard to the requirements of PSIRF. The Annual Mortality Report was accepted as assurance of the Trust's approach and would be received by the Board of Directors on 9 May and then published on the Trust's website as per national guidance.

Update on new MHA Bill

A briefing following the publication of the draft Mental Health Act Bill and a recent update on the Liberty Protection Safeguards ("LPS") outlined that the Department of Health and Social Care have confirmed that LPS which were to replace the Deprivation of Liberty Safeguards (DoLs) will not be progressed during the life cycle of this Parliament. The Trust will now standdown all preparations for the LPS.

It is anticipated the Mental Health Act (MHA) Bill will be introduced into Parliament in 2023. The number of patients detained under the MHA has doubled since it was last amended in 1983. The new amendments are intended to help reverse that trend. The Trust will continue to focus on service development, patient flow management and practice and investment in infrastructure especially the MHA Office and administrative support which will be monitored by the Mental Health Act Committee.

Clinical Audit Annual Report 2022/23

The annual review of effectiveness of the 2022/23 Clinical Audit Programme and the 2023/24 plan for Clinical Audit provided significant assurance from the prioritisation process to ensure we comply with the nationally mandated standards with limited assurance due to improvements that need to be made to learning and embedding change.

Quality and Safeguarding Committee Annual Effectiveness Report and annual review of Terms of Reference

The Committee considered the year-end report on its activity and effectiveness and confirmed that it had fulfilled its terms of reference during 2022/23. The report demonstrated the extensive matters covered and evidenced that the Committee had worked effectively. The terms of reference were reviewed and agreed.

Annual Special Educational Needs and Disabilities (SEND) Report 2022/23

This is a new requirement for 2022/23 to produce an annual SEND report, therefore this was the first annual report. The improvement in access and outcomes for children with Special Educational Needs and Disabilities in Education and Health was noted. Limited assurance was obtained from the report at this stage due to the new nature of the requirement to produce an annual report.

Board Assurance Framework – key risks identified: None
Escalations to Board or other committees: None
Next Meeting – 12 May 2023

Committee Chair: Lynn Andrews	**Executive Lead: Tumi Banda, Interim Director of Nursing and Patient Experience**

People and Culture Committee - key items discussed 28 March 2023

Summary of BAF Risks

The Committee reviewed BAF risk 2a it has oversight of in the context of discussions and the current work programmes. *"There is a risk that we do not sustain a healthy vibrant culture and conditions to make Derbyshire Healthcare Foundation Trust (DHCFT) a place where people want to work, thrive and to grow their careers."*

Progression was seen to have been made in a number of risk areas which will be captured Issue 1 of the 2023/24 BAF.

People and Inclusion Assurance Dashboard

The dashboard provided limited assurance from current performance due to the need to see improvement in a number of areas.

Turnover remains high. Action is taking place to increase retention. Vacancies continue to be stable. Sickness absence management have an improved focus due to additional resource. Clinical supervision remains an area that needs new focus. A recovery action plan to improve performance is being rolled out for teams to drive performance. Bank usage is active and holds healthy numbers. Work is underway to improve appraisal compliance with performance being monitored on a regular basis.

Modern Slavery Statement

The Committee was satisfied that the Modern Slavery Statement for 2022/23 reviewed by the Trust's safeguarding lead against the new Home Office guidance and recommended that the statement could be submitted to the Board on 9 May.

Workforce Plan 2023/24

The Committee received significant assurance from this cohesive workforce. It was noted that this year a more comprehensive process has produced a more consistent workforce plan than in previous years triangulated across finance, workforce and operations activity planning. The Committee also received assurance that preparation was on track to submit the workforce plan to the Board on 9 May.

Public Sector Equality Duty Reports including the Gender Pay Gap

The Public Sector Equality Duty Reports including the Gender Pay Gap and its role in helping satisfy the Trust's obligations under the Public Sector Equality Duty (PSED: section 149 of the Equality Act 2010) and national mandates were presented for approval prior to being published on the Trust's website by 31 March 2023.

The Gender Pay Gap Report provided information based on the six calculations an organisation is required to publish. Overall the report shows a variable picture that will be looked at further next year with regard to flexible working options and encouraging more men into the organisation.

The overview of the ethnicity rated between white and ethnic staff showed there is a small gap in the median hourly rate. Although the ethnicity pay gap is not currently mandated this will be looked at with regard to raising ethnicity in the workplace. Pay will also be looked at by ethnicity as well as disability to understand more about how the organisation is represented.

Health and Wellbeing Strategy 2023/24

Health and Wellbeing reporting regularly provides an update on staff health and wellbeing and innovations developed to ensure all colleagues are kept safe and well at work as well as support for those who are not well enough to be at work.

The strategy has been built around a national framework which gave a standardised view of good practice and includes needs and aspirations of staff that will be taken forward through wider engagement in order make it more bespoke to the Trust.

A number of additions were discussed that would feature more strongly within the strategy. These included initiatives that should be celebrated by the organisation such as Schwartz round work. Reference would also be made to muscular skeletal disorders, trauma linked through adverse childhood experiences as well as difficulties being experienced through the high cost of living and health inequalities in the deprived population.

Results of the 2022 National Staff Survey

There was a lower than usual response to the National 2022 Staff Survey which was thought to be caused by staff uncertainty as changes were being made within the Trust Board when the survey was released. Although limited assurance was received from the low response rate the Committee was significantly assured on the learning that will be taken forward to improve the response to next year's survey.

2022/23 Flu Campaign

The Committee received a high level summary of the lessons learnt from the 2022/23 Flu Campaign. The 2022/23 season saw a lower uptake than the previous year. DHCFT appears to have performed well, when compared to other mental health trusts.

Significant assurance was taken that these lessons learned from the 2022/23 campaign will be taken into the planning process for 2023/24.

Year-end Effectiveness Report and Review of Terms of Reference

All the Board Committees are required to review their activity and effectiveness, comparing the work of the Committee to its Terms of Reference (TOR).

Having reviewed the business carried out during 2022/23 the Committee was satisfied it had performed effectively throughout the year. Meetings had been well chaired performed under clear and structured agendas that were supported with well-informed reports. It was agreed that the Committee had developed enormously over the past year and would endeavour to further improve. The proposed revisions to the TORs were agreed as well as the addition of the requirement that agenda packs are to be issued five days in advance of each meeting.

Escalations to Board or other committees: None.

Board Assurance Framework – key risks identified: None
Next Meeting: 16 May 2023

Committee Chair: Ralph Knibbs	**Executive Lead: Jaki Lowe, Director of People and Inclusion**

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 9 May 2023

Learning from Deaths - Mortality Annual Report 2022/23

Purpose of Report

The 'National Guidance on Learning from Deaths' requires each Trust to collect and publish specified information on a quarterly basis. This report covers the period 1 April 2022 to 31 March 2023.

Executive Summary

All deaths directly relating to COVID-19 are reviewed through the Learning from Deaths procedure unless they also meet a Datix red flag, in which case they are reviewed under the Incident Reporting and Investigation Policy and Procedure.

- During 2022/23 there have been two deaths reported where the patient tested positive for COVID-19. These deaths were in the community.
- The Trust received 2302 death notifications of patients who had been in contact with our service in the last six months. There is very little variation between male and female deaths; 1124 male deaths were reported compared to 1176 females (2 not specified).
- Three inpatient deaths (expected), two patients died following transfer to the acute hospital for further treatment and three patients died whilst on leave from the ward (unexpected).
- The Mortality Review Group reviewed 46 deaths through a Stage 2 Royal College of Psychiatrists Care Review Tool These reviews were undertaken by a multi-disciplinary team, and it was established that of the 46 deaths reviewed, none were due to problems in care.
- The Trust has reported 23 Learning Disability deaths in the reporting timeframe and death of three patients with a diagnosis of autism.
- Medical Examiner Officers have been established at all Acute Trusts in England and their role will be extended to include deaths occurring in the community, including at NHS Mental Health and Community Trusts. The implementation of this process had been expected by April 2023 however due to the complexities involved in data sharing this has been paused Nationally for community-based services. The Patient Safety team will continue to work with Medical Examiners to ensure the Trust maintains momentum in this area.
- Good practice identified through case note reviews is fed back to clinicians involved as part of our appreciative learning.
- A process has been implemented within the patient Electronic Record which aids staff in identifying deaths which meet the threshold for DATIX reporting. This process fulfils stage one of the Learning from Deaths in that all deaths are considered for Red Flags as identified under the national Learning from Deaths procedure.

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

Assurances

This report provides assurance that the Trust is following recommendations outlined in the National Guidance on Learning from Deaths.

Consultation

Quality and Safeguarding Committee 11 April 2023.

Governance or Legal Issues

There are no legal issues arising from this report.

The Care Quality Commission Regulations - this report provides assurance as follows:

- Outcome 4 (Regulation 9) Care and welfare of people who use services
- Outcome 14 (Regulation 23) Supporting staff
- Outcome 16 (Regulation 10) Assessing and monitoring the quality of service provision
- Duty of Candour (Regulation 20)

Public Sector Equality Duty and Equality Impact Risk Analysis

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

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

- During 2022/23 there was very little variation between male and female deaths; 1,124 male deaths were reported compared to 1,176 female (two not specified).
- No unexpected trends were identified according to ethnic origin or religion.

Recommendations

The Board of Directors is requested to accept this Mortality Report as assurance of the Trust's approach and agree for the report to be published on the Trust's website as per national guidance.

Report presented by: **Dr Arun Chidambaram**
Medical Director

Report prepared by: **Rachel Williams**
Lead Professional for Patient Safety and Experience

Louise Hamilton & Nicola Burton
Safer Care Co-ordinator

Learning from Deaths - Mortality Report

1. Background

In line with the Care Quality Commission's (CQC) recommendations in its review of how the NHS investigates patient deaths, the National Quality Board published a framework for NHS Trusts - 'National Guidance on Learning from Deaths[1]'. The purpose of the framework is to introduce a more standardised approach to the way NHS trusts report, investigate, and learn from patient deaths, which should lead to better quality investigations and improved embedded learning.

To date the Trust has met all of the required guidelines.

The report presents the data for 1 April 2022 to 31 March 2023.

2. Current Position and Progress (including COVID-19 related reviews)

- Cause of death information is currently being sought through the Coroner offices in Chesterfield and Derby but only a very small number of cause of deaths have been made available. This will improve once Medical Examiners commence the process of reviewing the Trusts non-coronial deaths which has currently been put on hold nationally however the rust continues to meet with the Medical Examiners on a regular basis.

- Medic rotas for the north and south have been updated and a rota is in place until December 2023. 46 Case Note Review sessions were undertaken, where 46 incidents were reviewed. Unfortunately, 16 sessions did not take place due to lack of medic availability, 1 meeting was cancelled due to computer accessibility issues, 2 meetings were cancelled due to strike action and 5 sessions did not take place due to nurse availability.

- Regular audits continue to be undertaken to ensure compliance with policy and procedure and any necessary amendments made. This has included auditing complaint data against names of deceased patients to ensure this meets the requirements specified in the National guidance. The last audit was completed 16 January 2023.

- A process has been implemented within the patient Electronic Record which aids staff in identifying deaths which meet the threshold for DATIX reporting. This process fulfils stage one of the Learning from Deaths in that all deaths are considered for Red Flags as identified under the national Learning from Deaths procedure. This is a significant improvement in process and will release some capacity within the service to re-deploy into other priorities such as actions and high-profile incident management. The plan will also allow for more joined up working with Corporate and Legal services ensuring better sharing of information and identification of priorities for both services.

[1] National Guidance on Learning from Deaths. National Quality Board. March 2017

3. Data Summary of all Deaths

Note that inpatients and learning disability (LD) data is based upon whether the patient has an open inpatient or LD referral at time of death. The table below outlines information from 1 April 2022 to 31 March 2023.

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Total Deaths Per Month	181	189	174	210	168	147	229	178	242	223	176	185
LD Referral Deaths	4	2	2	1	1	3	3	1	1	1	1	3

Correct as of 5/4/2023

From 1 April 2022 to 31 March 2023, the Trust received 2302 death notifications of patients who have been in contact with our services.

Of these deaths 1,124 patients were male, 1,176 female, 1,714 were white British and 14 Asian/Asian British Pakistani. The youngest age was 0 years, the oldest age recorded was 105.

The Trust has reported 23 Learning Disability deaths in the reporting timeframe and death of three patients with a diagnosis of autism.

4. Review of Deaths

Total number of Deaths from 1 April 2022 to 31 March 2023 reported on Datix	219 “Unexpected deaths”; 2 COVID deaths 32 “Suspected deaths” 25 “Expected - end of life pathway”) NB some expected deaths have been rejected so these incidents are not included in the above figure Three inpatient deaths (expected), two patients died following transfer to the acute hospital for further treatment (unexpected) and three patients died whilst on leave from the ward (unexpected).
Incidents assigned for a review	271 incidents assigned to the operational incident group 6 did not meet the requirement 1 incident is to be confirmed

Only deaths which meet the criteria below are reported through the Trust incident reporting system (Datix) and these are also reviewed using the process of the *Untoward Incident Reporting and Investigation Policy and Procedure*; any patient open to services within the last six months who has died, and meets the following:

- Homicide – perpetrator or victim
- Domestic homicide - perpetrator or victim
- Suicide/self-inflicted death, or suspected suicide
- Death following overdose
- Death whilst an inpatient
- Death of an inpatient who died within 30 days of discharge from a DHCFT hospital

- Death following an inpatient transfer to acute hospital
- Death of patient on a Section of the Mental Health Act or Deprivation of Liberty Safeguards (DoLs) authorisation
- Death of patient following absconsion from an inpatient unit
- Death following a physical restraint
- Death of a patient with a learning disability
- Death of a patient where there has been a complaint by family/carer the Ombudsman, or where staff have raised a significant concern about the quality of care provision
- Death of a child (this will also be subject to scrutiny by the Child Death Overview Panel)
- Death of a patient open to safeguarding procedures at the time of death, which could be related to the death
- Death of a patient with historical safeguarding concerns, which could be related to the death
- Death where a previous Coroners Regulation 28 has been issued
- Death of a staff member whilst on duty
- Death of a child under the age of 18 of a current or previous service user who has died in suspicious circumstances
- Where an external organisation has highlighted concerns following the death of a patient whether they were open to the Trust at time of death or not.
- *Death of a patient with Autism*
- *Death of a patients who had a diagnosis of psychosis within the last episode of care*

The last two red flags have been added this year to ensure that the Trust meets the Learning from Deaths guidance and recent changes to the Learning Disability Mortality Review (LeDeR) reporting requiement of patients who have a diagnosis of autism.

5. Learning from Deaths Procedure

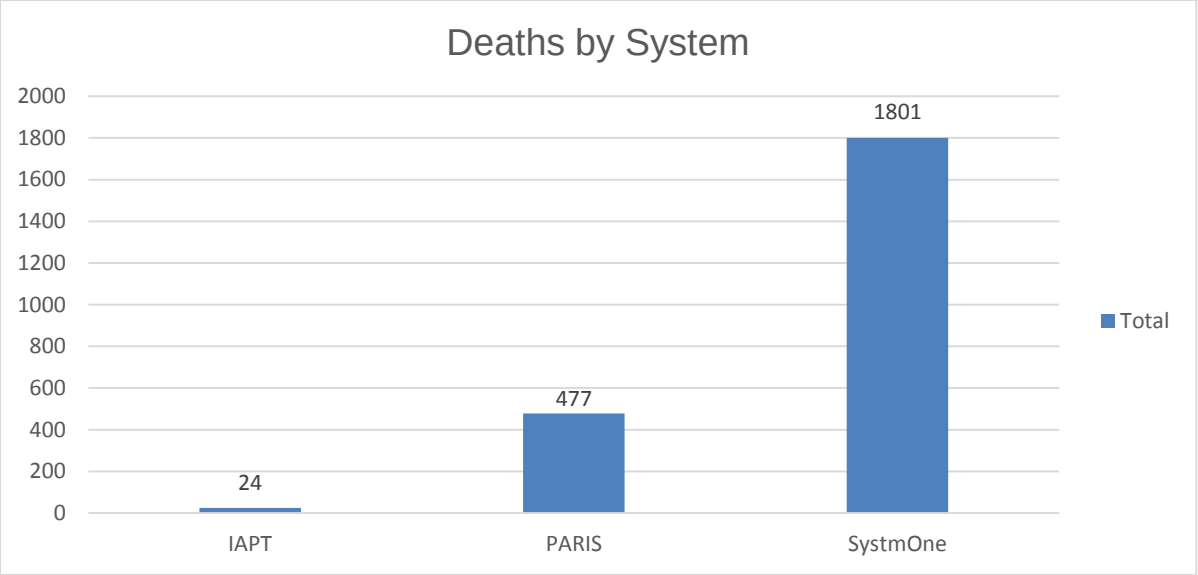
The Trust has now completed a move in terms of its mortality process, a process has been implemented within the patient Electronic Record which aids staff in identifying deaths which meet the threshold for DATIX reporting. This process fulfils stage one of the Learning from Deaths in that all deaths are considered for Red Flags as identified under the national Learning from Deaths procedure. This is a significant improvement in process and will release some capacity within the service to re-deploy into other priorities such as actions and high-profile incident management. The plan will also allow for more joined up working with Corporate and Legal services ensuring better sharing of information and identification of priorities for both services.

Th Mortality team are conducting random weekly audits of deaths against the Red Flags to provide assurance that the new process is working as intended and changes will be made accordingly.

During 2022/23 the Mortality Review Group reviewed 46 deaths through a Stage 2 Case Note Review. These reviews were undertaken by a multi-disciplinary team, and it was established that of the 46 deaths reviewed, 0 were not due to problems in care. Unfortunately, 16 sessions did not take place due to lack of medic availability, 1 meeting cancelled due to connection issues, 2 meetings cancelled due to strike action, and 5 sessions did not take place due to nurse availability. Unavailability of medics to attend these meetings remains a recurring problem.

6. Analysis of Data

6.1 Analysis of deaths per notification system since 1 April 2022 to 31 March 2023



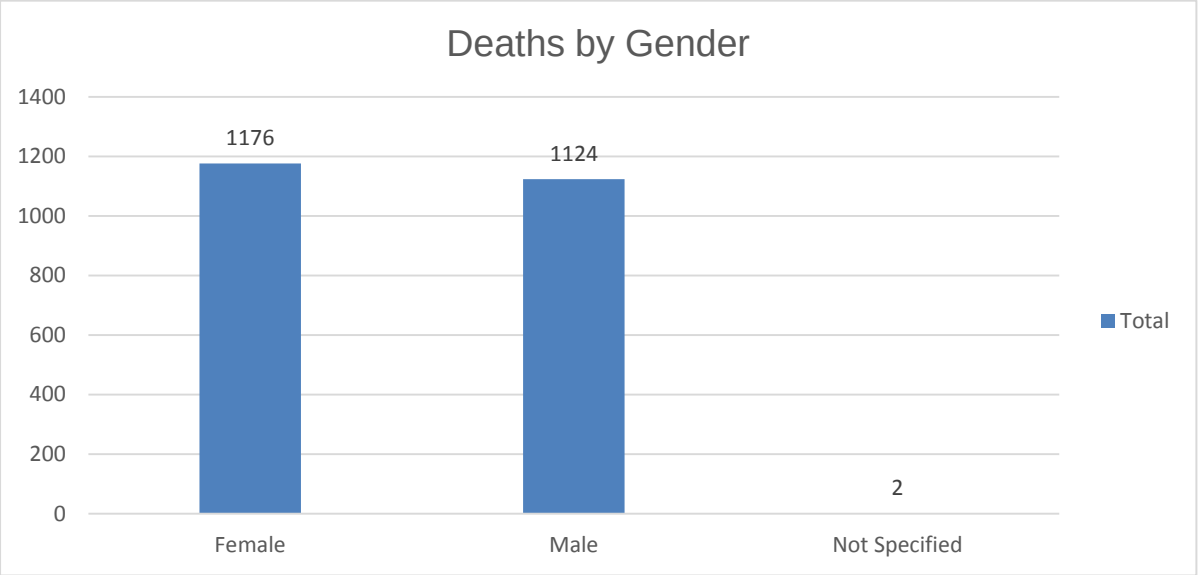
System	Number of Deaths
IAPT	24
PARIS	477
SystmOne	1801
Grand Total	**2302**

The data above shows the total number of deaths reported by each notification system. The majority of death notifications were predominately pulled from SystmOne. This clinical record system is aligned to our largest population of patients and a population at greatest risk of death due to the proportion of older people in our care.

From the 1 April 2022 to 31 March 2023 there have been 2 deaths reported where the patient tested positive for COVID-19. Of these deaths 2 patients both were female and from a White British background. And were within the community

6.2 Deaths by Gender

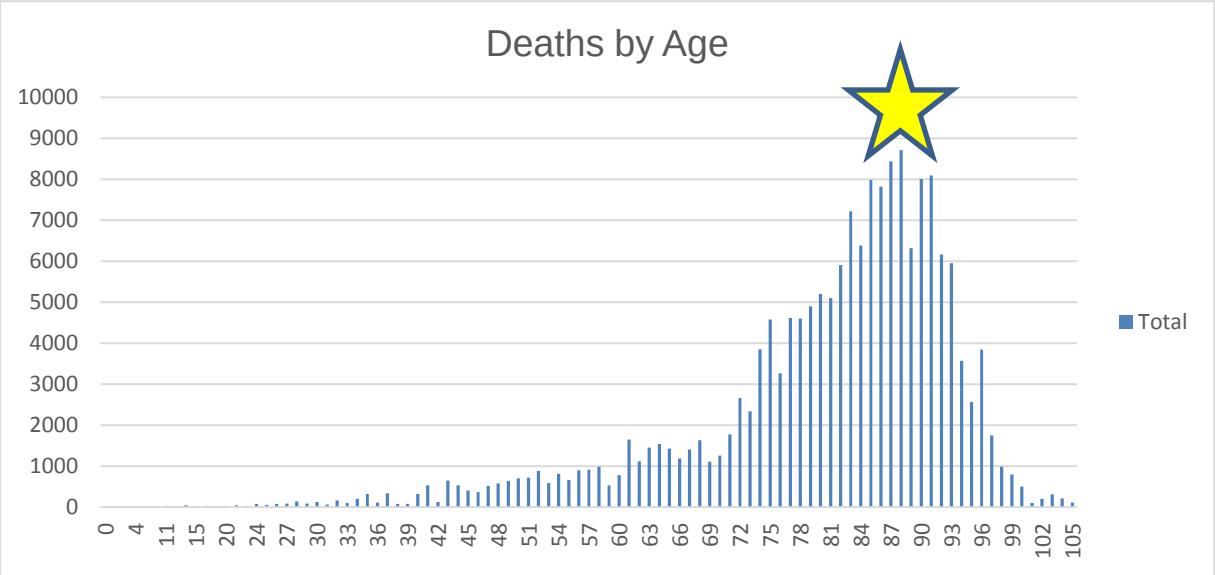
The data below shows the total number of deaths by gender 1 April 2022 to 31 March 2023. There is very little variation between male and female deaths;1176 female deaths were reported compared to 1124 males.



Gender	Number of Deaths
Female	1176
Male	1124
Not Specified	2
Grand Total	**2302**

6.3 Death by Age Group

The youngest age was classed as 0, and the oldest age was 105 years. Most deaths occurred within the 85 to 88 age groups (indicated by the star).



6.4 Learning Disability Deaths (LD)

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
LD Deaths	4	2	2	1	1	3	3	1	1	1	1	3
Autism	1	0	2	0	0	0	0	0	0	0	0	0

The Trust reviews all deaths relating to patients diagnosed with a Learning Disability. The Trust also currently sends all Learning Disability deaths that have been reported through the Datix system to the LeDeR programme. The Trust is currently awaiting the annual LeDeR report.

From 1 January 2022 the Trust has been required to report any death of a patient with autism to date three patients has been referred.

During 1 April 2022 to 31 March 2023, the Trust has recorded 23 Learning Disability deaths. The Trust now receives a quarterly update from LeDeR which highlights national good practice and identified learning; this is shared in the Mortality monthly meeting.

6.5 Death by Ethnicity

White British is the highest recorded ethnicity group with 1,714 recorded deaths, 130 deaths had no recorded ethnicity assigned, and 43 people did not state their ethnicity. The chart below outlines all ethnicity groups.

Ethnicity	Number of Deaths
Asian or Asian British – Any other Asian Background	1
Asian or Asian British – Indian	10
Asian or Asian British – Pakistani	14
Black or Black British – African	2
Black or Black British – Any other Black background	9
Black or Black British – Caribbean	4
Mixed – Any other mixed background	3
Mixed – White and Asian	2
Mixed - White and Black Caribbean	3
Not known	130
Not stated	43
Other Ethnic Groups - any other ethnic group	320
Other Ethnic Groups – Chinese	1
White – Any other White background	33
White – British	1714
White – Irish	13
Grand Total	**2302**

6.6 Death by Religion

Christianity is the highest recorded religion group with 958 recorded deaths, 915 deaths had no recorded religion assigned and 6 people refused to state their religion. The chart below outlines all religion groups.

Religion	Number of Deaths
Agnostic	5
Agnostic movement	2
Anglican	2
Atheist	4
Atheist movement	6
Baptist	2
Buddhist	2
Catholic religion	4
Catholic: non Roman Catholic	1
Catholic: Not Roman Catholic	1
Christian	958
Christian religion	14
Church Of England	79
Church of England, follower of	79
Church of Scotland	1
Church of Scotland, follower of	1
Congregationalist religion	1
Hindu	1
Islam	1
Jehovah's Witness	7
Methodist	17
Mormon	1
Muslim	10
Nonconformist	2
None	8
Not Given Patient Refused	6
Not Religious	36
Not stated	3
Pagan	1
Patient Religion Unknown	5
Pentecostalist	1
Quaker religion	1
Religion (other Not Listed)	1
Religion NOS	7
Roman Catholic	24
Sikh	8
Spiritualist	1
United Reform Church	1
Unknown	82
(blank)	915
Grand Total	**2302**

6.7 Death by Sexual Orientation

Heterosexual or straight is the highest recorded sexual orientation group with 887 recorded deaths. 1,345 have no recorded information available. The chart below outlines all sexual orientation groups:

Sexual Orientation	Number of Deaths
Bisexual	1
Female homosexual	1
Gay or lesbian	2
Heterosexual	798
Heterosexual or straight	89
Homosexuality NOS	1
Lesbian or gay	1
Not appropriate to ask	3
Not stated (declined)	2
Patient unsure	1
Person declined to disclose	2
Sexual orientation not given - patient refused	45
Sexual orientation unknown	1
Unknown	10
(blank)	1345
Grand Total	**2302**

6.8 Death by Disability

The table below details the top 8 categories by disability. Gross motor disability was the highest recorded disability group with 235 recorded deaths.

Disability	Number of Deaths
Learning Disability	6
Behaviour And Emotional	7
Physical	7
Other	7
Emotional Behaviour Disability	38
Hearing Disability	43
Intellectual Functioning Disability	107
Gross Motor Disability	235

There were a total of 511 deaths with a disability assigned and the remainder 1,791 were blank (had no assigned disability).

7. Recommendations and Learning

The table below outlines the current themes from incidents

Improvement issue	Actions required update
Transfer, Leave and Discharge	**Transfer of the deteriorating patient.** Internal investigations highlighted themes around the transfer and return of patients between inpatient services for the Trust and Acute providers. This includes handover of information, and the way patients are conveyed. A quality improvement project is underway between Derby Hospital and DCHFT. **Self-harm of patients whilst on leave from inpatient services and Section 17 leave arrangements.** A number of investigations have highlighted issues in relation to leave arrangements for inpatient services including follow up. A further thematic review was completed on conclusion of a cluster of inpatient suspected suicide incidents. An action plan has been developed. The Patient Safety Team are leading on the coordination of the review of the current processes and quality improvement actions. The works will include review of the pathway of communication and documentation (including risk assessments and care plan) between Crisis Resolution and Home Treatment/ Community teams and Inpatient Services when a patient is due to be on s17 leave/ discharged.
Suicide Prevention	The trust has identified the need to re-establish Suicide Prevention training across services, this is being led by the Trust Medical Director.
Training and awareness of Emotionally Unstable Personality Disorder	The trust will develop a training and awareness package for all services in relation to EUPD which is being led by the Trust Medical Director.
Family liaison and engagement	A considerable amount of work has been undertaken to ensure that the Trust is complaint with regulation 20. Operating procedures are now in place, template letters for family engagement, set timescales for family contacts, signposting to relevant support services, and helping family members identify coping mechanisms. Benchmarking against key guidance has been undertaken, Duty of Candour training has been developed including a bereavement leaflet and guidelines for operational staff Roll out of patient safety partners.
Falls prevention	A Trust Falls Group meets regularly to discuss improvements and themes arising from falls within inpatient services, a quality improvement plan is required to assure improvements.
Multi-agency engagement following incidents	It is known that patients are often known to multiple services both internally and externally. Works have been commissioned to consider agreements needed to enhance multi-agency working with partner agencies when an incident investigation has been commissioned to improve shared learning and enhance family liaison and support.
Improving Physical Healthcare monitoring	Quality improvement work in relation to improving physical healthcare management, observation, and care planning within Older Peoples services. Enhancement of wound care management and infection prevention and control investigation and follow up within inpatient services. Introduction of RESTORE2 into ILS training framework including review of current ILS provision.

Improvement issue	Actions required update
	Establish a physical health reporting working group to establish the new system one reporting frameworks to improve reports for assurance. Introduction of RESTORE2 into ILS training framework including review of current ILS provision. Notification of increased NEWS score via system one to senior colleagues to be reviewed.
MDT process improvements within CMHTs	Investigations have highlighted themes in relation to Multi-Disciplinary Team processes within Community Mental Health Trusts and works are currently underway to review the Electronic Patient Record and recording documentation and MDT process to ensure this is fit for purpose and being adhered to.
Observation levels	To continue commissioned working group to review handheld clinical devices and compliance with observations including physical health observations.
Dissemination of learning and service improvements following incidents	Work is underway to improve the way in which the trust learning and improves from incidents, this will include a revision to the processes in place in relation to internal investigation recommendations, Case Record Review learning, Incident Review Tool learning and the revised Trust Mortality process.
Inappropriate admission to inpatient adult ward	Investigations into high profile incidents of inappropriate admissions to Adult Mental Health inpatient services brought to attention an on-going issue in this area. Review of lower grade incidents and discussions with the service line have confirmed a long-standing theme in this area. A review of inappropriate admissions is currently underway.

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 9 May 2023

Workforce Standards Formal Submission 2023

Purpose of Report

In October 2018, NHS Improvement (NHSI) wrote to all trusts asking them to review their workforce safeguards and implement some formal recommendations effective from 1 April 2019. The purpose of this report is for the Board to receive assurance that the Trust is formally assessing its compliance and outlines the work undertaken for 2023/24. In addition, there is a self-assessment of the workforce safeguards for the year, and this is discussed further by the People and Culture Committee to scrutinise and review all workforce information, systems and process of staff deployment, rostering and skill mix of the Trust's services.

At DHCFT we aim to provide safe, high-quality care to our patients, and our clinical staffing levels are continually assessed to ensure we meet this aim.

Executive Summary

The report outlines compliance with national requirements, along with updated actions and recommendations.

The People and Culture Committee continues to take a lead in monitoring and reporting on standards. Further to the committee, the Trust has also created and embedded further assurance through reporting into the Trust Operational Oversight Leadership group (TOOL), Quality and Safeguarding Committee and further scrutiny through the Incident Management Team. The Executive Leadership Team and People Delivery Groups also continue to have oversight and assurance. This will include continually updating the Trust's integrated workforce information to provide the Board with assurance of our compliance against safer staffing in the Integrated Performance report.

The self-assessment outlines that the Trust was compliant in this emergency period and continues to be so.

The Quality and Safeguarding Committee is assured that the Trust is compliant with the majority of the standards and has maintained the required standards.

In 2022/23 we established the most comprehensive workforce plan to date comprising our approach to delivering the mental health delivery plan across Derbyshire and outlining the specific plan for Derbyshire Healthcare. The workforce plan for 2023/24 is in final draft format and triangulates activity with workforce and finance and will be presented and debated at the People and Culture Committee following its submission on 4 May. It has received staffing and caseload service specific reviews for services. This included emergency staffing and oversight.

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

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

Assurances

- Mental health and other guidance is reviewed and is part of safer staffing reviews at Quality and Safeguarding Committee.
- Trusts must ensure the three components are used in their safe staffing processes, which include evidence-based tools (where they exist) from the Mental Health Guide and professional judgement adopted, led by the Assistant Director of Clinical Professional Practice and Heads of Nursing / AHP (Allied Health Professional). This will include a dashboard, CHPPD (care hours per patient day) and e-roster.
- We have some gaps in assurance, and therefore have limited assurance in a revised reporting section due to sustained deficits in training compliance and operational management of this deficit. Recovery plans are in place and will become fully achieved early in the financial year 2022.

Consultation

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

Governance or Legal Issues

- To base our assessment on the annual governance statement, in which Trusts will be required to confirm their staffing governance processes are safe and sustainable, this will be in development with the Annual Report process.
- To ensure compliance is met with CQC Well Led Requirements.
- As part of the yearly assessment, the Trust will also seek assurance through the System Oversight Framework (SOF) in which a provider's performance is monitored against five themes. The NHS System Oversight Framework for 2021/22 replaces the NHS Oversight Framework for

2019/20, which brought together arrangements for provider and CCG oversight in a single document.

- Mental Health Staffing Framework mh-staffing-v4.pdf (england.nhs.uk) Mental Health Optimal Staffing Tool (MHOST) Shelford Group: Mental Health Optimal Staffing Tool (MHOST) (10 May 2019) - Mental health - Patient Safety Learning - the hub (pslhub.org)
- The Royal College of Nursing published their Nursing Workforce Standards (2021), developed as part of their safe staffing campaigns. The standards summarise the expectations in other national guidance and reiterates the importance of the Chief Nurse being responsible for setting nurse staffing levels based on service demand and user needs and the requirement to report directly to the Trust board. Self-assessment undertaken by the Lead Nurse for Workforce Nursing show DHCFT is compliant with these standards.
- To comply with the requirement for trusts to have an effective workforce plan that is updated annually and signed off by the Chief Executive and Executive Leaders. The Board should discuss the workforce plan in a Public Meeting.
- The Trust must ensure that it has an agreed local quality dashboard that cross-checks comparative data on staffing and skill mix with other efficiency and quality metrics such as the Model Hospital dashboard. Trusts should report on this to their Board monthly. Routine monitoring has returned to the People and Culture Committee and the integrated performance report of the Trust Board.

Public Sector Equality Duty and Equality Impact Risk Analysis

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

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

The risks are people related, so there are always adverse impacts (for example health). For the purposes of this paper it should be noted that the safeguards referred to are to improve clinical and workforce risks and it is the risks of not implementing these safeguards which have been taken into account, rather than the risk of implementing the required monitoring.

Leaders within the Trust are informed and knowledgeable about the impact of business decisions on a diverse workforce and the differing needs of the communities we serve.

Recommendations

The Board of Directors is requested to:

1) Receive and accept the Safe Staffing Report and self-assessment for the financial year 2022/2023.

2) The board is asked to confirm a level of assurance that processes are in place to monitor inpatient and community staffing levels and that actions are in place to try to mitigate the risks to patient safety and care quality.

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

Report prepared by: **Kyri Gregoriou**
Deputy Director of Nursing and Quality Governance

Rebecca Oakley
Deputy Director of People and Inclusion

Workforce Standards Formal Submission 2023

Nursing, AHP and Clinical Staffing

A self-assessment has been completed and is displayed in Appendix 3. This demonstrates assurance of safe, effective, and sustainable staffing, considering scheduled and unscheduled absences.

Figure 1 also shows the CHPPD values for the wards by month at the end of this report.

Figure 2 highlights the assessed and agreed safer staffing figures for all inpatient ward settings.

Clinical Staff on Maternity Leave as of March 2023:

Absences due to maternity leave were factored into the safer staffing reviews to ensure continuity of patient care.

Data is not available by proposed maternity return date as it is up to the individual how long they wish to be off for up to the maximum permitted under NHS Terms and Conditions.

Clinical

Staff Group	Headcount
Add Prof Scientific and Technic	4
Additional Clinical Services	7
Allied Health Professionals	10
Medical and Dental	2
Nursing and Midwifery Registered	25
Grand Total	48

Non Clinical

Staff Group	Headcount
Administrative and Clerical	8
Total	8

And by banding:

Clinical

Staff Group	AFC Banding	Headcount
Add Prof Scientific and Technic	Band 7	1
	Band 8A	2
	Band 8B	1
Additional Clinical Services	Band 3	4
	Band 4	2
	Band 5	1
Allied Health Professionals	Band 5	3
	Band 6	4
	Band 7	3
Medical and Dental	Other	1
	Other	1
Nursing and Midwifery Registered	Band 5	2
	Band 6	20
	Band 7	3
Total		48

Non Clinical

Staff Group	AFC Banding	Headcount
Administrative and Clerical	Band 3	1
	Band 4	2
	Band 5	2
	Band 6	2
	Band 9	1
Total		8

Sickness Absence

Again, absences due to sickness leave were factored into the safer staffing reviews to ensure continuity of patient care.

ff Group	Absence FTE %
Add Prof Scientific and Technic	5.43%
Additional Clinical Services	8.46%
Administrative and Clerical	5.65%
Allied Health Professionals	4.89%
Estates and Ancillary	8.61%
Medical and Dental	2.32%
Nursing and Midwifery Registered	6.94%
Students	1.09%
Grand Total	6.43%

Retention

Retention remains a priority for the Trust. Work has commenced to review the flexible working policy and processes to maximise the options available. System-wide work is proposed to improve access to flexible working opportunities is taking place. Over the last 12 months we have begun focused work on inclusive recruitment practices and this will continue to be implemented in 2023/24. The Trust's induction processes are being reviewed and the online induction process is being streamlined to make it easier to follow and access as part of our onboarding approach.

The Trust staff bank operates in a shared service arrangement continues to offer flexible staffing and continuity of service in its operations to the Trust services. The trust bank fill rates are monitored regularly, with oversight of the weekly fill rates by the Director of Nursing.

There is continued work to increase the pipeline of people entering nursing careers through alternative routes, as well as work to increase access to encourage career progression within the organisation. As part of the national nursing retention programme we are sharing learning across the Derbyshire system and focusing on the 5 impact action areas set out in the programme.

Using staff survey data and data from our in house STAY retention surveys we are starting to shape a bespoke retention strategy and approach. We are also recruiting to a Strategic Recruitment and Retention Lead to drive this work and provide support at divisional levels.

The Trust wide Health, Safety and Security team review safer staffing with a safety lens. this group is a partner with the senior union representatives to scrutinise and review safer staffing and any learning. this group gives an additional level of scrutiny of safe staffing and learning events.

Conclusion

The Trust continues to closely monitor staffing levels and comply with the recommendations outlined in the Developing Workforce Safeguards Guidance. Noting the staffing information detailed in this report, alongside the robust escalation and mitigation of short and long-term staffing shortfalls, it can be concluded that the Trust has in place sufficient processes and oversight of its staffing arrangements to ensure safe staffing is prioritised as part of its routine activities.

Health and wellbeing and staff engagement continue to be a top priority for the Trust, with a focus on ensuring easy and efficient access for all staff to support.

Recommendation

The Board is asked to note the report.

Appendix 1 - Figure 1

	% Fill Rate of CHPPD											
Ward	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Childbearing Inpatient	69.6	78.4	73.3	76.5	81.5	78.5	74.7	79.8	75.9	80.7	99.9	78.8
CTC Residential Rehabilitation	107.9	109.8	101.6	94	98.6	100.5	95.9	98.8	99.6	105.8	101.1	103.1
Enhanced Care Ward	106.6	92.9	88.5	86.3	83.9	97.8	88.2	89.8	89.6	93.7	89.6	83
Hartington Unit Morton Ward	104.4	118.8	88.4	95.7	86.7	111	108.6	87.1	96.5	100.4	94.3	108.1
Hartington Unit Pleasley Ward	76.4	75.8	74.3	80	73.9	83.2	66.1	70.9	68.5	73.7	88.8	80.8
Hartington Unit Tansley Ward	89.2	93	83.9	86.5	85.5	88.8	84	80.9	77	80.3	90	86.8
Kedleston Unit	98.5	100.1	93.4	96.7	93.8	86.9	91.7	91.6	109.8	101.7	93.6	97.4
Cubley Court – Female	98.2	105.2	89.5	91.5	86	86.2	93.8	86.6	70.3	90.9	82.1	80.6
Cubley Court – Male	67.6	58.6	57.1	48	58.8	55.3	60.2	59.1	59.2	60.1	83.2	120.9
Tissington Ward	92.1	90.9	98.4	101.9	106.8	103.1	103.8	103.8	104.9	103.9	116	103.8
Radbourne Unit – Ward 33	76.9	90.5	81.2	91.5	80.3	81.9	88	88	96.3	90.1	89.8	81.3
Radbourne Unit – Ward 34	105	97.7	95.4	79.2	78.9	86.2	91.1	98.2	90.6	92.1	89	85.2
Radbourne Unit – Ward 35	112	83.9	72.1	62.6	65.6	73.5	83.3	95.9	88.1	106.1	86.5	98.2
Radbourne Unit – Ward 36	101.8	132.7	104.7	94	81.9	84.3	96.3	102.5	111.2	106.6	106.8	110.5

The figures are all the CHPPD values for the ward by month. The total has been calculated based on the total number of care hours and patients, rather than being an average of the ward level totals.

Appendix 2 - Figure 2

	Morning Registered	Morning Unregistered	Morning Total	Afternoon Registered	Afternoon Unregistered	Afternoon Total	Night Registered	Night Unregistered	Night Total
Cubley Court Male	3	4	7	3	4	7	2	3	5
Cubley Court Female	3	4	7	3	4	7	2	3	5
Tissington Ward	3	3	6	3	3	6	2	2	4
The Beaches	2	2	4	2	2	4	1	1	2
Cherry Tree Close	2	3	5	2	3	5	2	1	3
Kedleston Unit	4	3	7	4	3	7	2	4	6
ECW	3	3	6	3	3	6	2	2	4
Ward 33	3	2	5	3	2	5	2	1	3
Ward 34	3	2	5	3	2	5	2	1	3
Ward 35	3	2	5	3	2	5	2	1	3
Ward 36	3	2	5	3	2	5	2	1	3
Pleasley Ward	3	2	5	3	2	5	2	1	3
Tansley Ward	3	2	5	3	2	5	2	1	3
Morton Ward	3	2	5	3	2	5	2	1	3

Figure 2 highlights assessed and agreed safer staffing levels for inpatient areas within Derbyshire Healthcare NHS Foundation Trust.

Appendix 3 - Clinical self-assessment against the recommendations:

The NHSI standard	Trust response	Current performance and gap in assurance
1. Trusts must formally ensure NQB's 2016 guidance is embedded in their safe staffing governance.	Executive Director of Nursing and Patient Experience is Lead Director and NQB Mental Health and other guidance reviewed and part of safer staffing reviews at Quality Committee.	Assured and in place in 2022/23 Safer staffing review continue to occur Reviews of emergency staffing have been maintained in the pandemic period
2. Trusts must ensure the three components (see below) are used in their safe staffing processes:	Compliant	Compliant
– evidence-based tools (where they exist)	Mental Health Guide	The Quality and Safeguarding Committee has reviewed the Mental Health Guidance, benchmarked against this information and the required recommendations and this is in place. The mental health model hospital data is used to triangulate, and the Trust remains within national standards.
– professional judgement	Led by Assistant Director of Clinical professional practice and Heads of Nursing / Allied Health Professional (AHP). It includes a dashboard / CHPPD* and E-roster dashboard. A full review of emergency staffing was undertaken and reviewed by the Quality and Safeguarding Committee. A workforce cell was established and reviewed emergency staffing and put in place full mitigation plans, and the use of redeployment.	Assured and in place for 2022/23 The trust has shared its model nationally of a three professionally qualified model of practice. (Two nurse registrants and a third registered professional model of practice). This model has received positive commentary on its use.

The NHSI standard	Trust response	Current performance and gap in assurance
	*See Figure 1 at end of report for monthly CHPPD figures.	
– outcomes.	Recommendations form clinical staff and Heads of profession are included in the skill mix review and have been implemented. This has occurred extensively throughout 2022/23.	Assured and in place for 2022/23
We will check this in our yearly assessment.	Available for assessment	
3. We will base our assessment on the Annual Governance Statement, in which trusts will be required to confirm their staffing governance processes are safe and sustainable.	In development with Annual Report process, for submission.	The Well-led review in 2020, including reviewing our safe staffing and skill mix review. There were no concerns re: our establishment. The concerns were for continual improvement in reducing our vacancy rate in core hot spot areas, our Trust wide qualified vacancy rate is below the East midlands regional average. We continue to deploy mitigation actions in our operational services to ensure the safety of our series in the acute service and we have made progress in 2022/23 to ensure safe staffing. This can be externally verified by CQC mental health act and transitional monitoring which reported on the acute service in 2021 *"the Trust had enough staff to deliver these services".*
4. We will review the Annual Governance Statement through our usual regulatory arrangements and performance management processes, which complement	Revision to ensure all recommendation requirements are reviewed as per this guide and a standard operating framework for these required reports in a new model is implemented.	Assured and in place for 2022/23 through Incident Management Team. The 2022/23 Annual Governance Statement contains a statement of compliance with the standards.

The NHSI standard	Trust response	Current performance and gap in assurance
quality outcomes, operational and finance performance measures.		
5. As part of this yearly assessment we will also seek assurance through the Single Oversight Framework (SOF), in which a provider's performance is monitored against five themes.	Provided in integrated report, any further refinements as per recommendation 4, and was enacted in March 2019.	Assured and in place for 2022/23.
6. As part of the safe staffing review, the Executive Director of Nursing and Executive Medical Director must confirm in a statement to their board that they are satisfied with the outcome of any assessment that staffing is safe, effective and sustainable.	Available for Nursing and AHP in Quality and Safeguarding Committee papers. All service changes have a Quality Impact Assessment (QIA) and this has been externally assessed by the CQC in 2020 as meeting required standards. To ensure that medical staffing is safe, effective and sustainable: • Medical workforce monitoring for all grades including trainees in real time reports to medical workforce group every 2 weeks with exception reporting. Chaired by Executive Medical Director or his deputy with operational HR leads in attendance. • International and local recruitment (and retention) initiatives are maximised with liaison with the Royal College of Psychiatrists and GMC. There are regular local engagement events to maximise local recruitment. • There is a focus on CAMHS recruitment and retention following an exodus of substantive	Medical risks to delivery for safe staffing are reviewed Deep dive reports have been undertaken including benchmarking and detailed analysis Guardian of safer working reports have been scrutinised by the Quality and Safeguarding Committee and received by Trust committees Assured and in place for 2022/23

The NHSI standard	Trust response	Current performance and gap in assurance
	consultants to Nottinghamshire local services have been maintained primarily through the procurement of locums. • Gap in assurance – job plans to attract new substantive consultants have not yet been formulated. • Locum costs have spiralled. This is an area of improvement that we must continue to progress • Gap in assurance – national and regional locum pay caps have been breached and are subject to ongoing pay inflation. It has been agreed regionally not to use recruitment and retention premiums but there is fierce competition from trusts using RRPs outside of the region to the North of the county and also one regional partner who did apply RRP's with significant impact upon our organisation staffing stability in one service. • Capital plan and the associated workforce plan includes medical staffing. • Review of medical leadership and medical structure is underway and is consistent with the proposed review of the operating management structure. • E-job planning software has been procured but cannot become fully operational without administrative support. Gap in assurance –	

The NHSI standard	Trust response	Current performance and gap in assurance
	need administrative support to become fully operational • All training posts compliant with national contracts with reports from Guardian of Safe Working to the Quality and Safeguarding Committee • Trust rated highly by GMC regarding medical training standards • Alternative cover arrangements for physical healthcare after hours in place and utilised in the event of absences of medical staff from rotas • A group formed to explore gender/diversity issues in medical workforce including the gender pay gap and suggestions have been proposed to the Medical Staff Committee and Local Negotiating Committee. Approved Clinicians and prescribing roles. • Medical Director has presented workforce plan at People and Culture Committee. Recruitment and retention performance is in advance of regional average. • A training cohort of Multi-professional Approved Clinicians have commenced their training. This development has been very well received. • Non-medical prescribing continues to expand in the Trust under the leadership of our	

The NHSI standard	Trust response	Current performance and gap in assurance
	Consultant Nurse and Non-medical prescribing lead Lisa Thomas. Advanced Clinical practitioners • Two senior nurses are now at an advanced stage of ACP for Physical healthcare training, and one will be joining the in-patient workforce this year in this new model of practice	
7. Trusts must have an effective workforce plan that is updated annually and signed off by the chief executive and executive leaders. The Board should discuss the workforce plan in a public meeting.	The workforce plan is due at the July Trust Board. The Executive Team in the pandemic period continued to activate some key new projects Examples include 'grow your own' approaches and apprenticeships for Nursing Assistants and eligible administration staff to enter into Nursing Associate or Registered nurse training positions. Specific priority areas with future workforce gaps have included Learning Disability Nursing with this group qualifying in 2022 and all of the group choosing DHCFT and our sister Trust as their preferred employer at completion. Mental Health Nursing, these schemes have been identified for the predicted expansion in Autism and Learning Disability services in line with long term plan investments in 2023/ 24. In addition, the expansion of trust services including Psychiatric Intensive Care Unit (PICU) and community framework again in this time period.	Strategic Workforce Group has been impacted by the pandemic and has not fully overseen the delivery of the two-year plan.

The NHSI standard	Trust response	Current performance and gap in assurance
	Investment in additional medical training posts to reduce future workforce gaps and the use of the workforce levy for national apprenticeship schemes continue in the organisation	
8. They must ensure their organisation has an agreed local quality dashboard that cross-checks comparative data on staffing and skill mix with other efficiency and quality metrics such as the Model Hospital dashboard. Trusts should report on this to their Board every month.	The Integrated Performance Report provides this information. Alongside this other service specific reports are provided to both Quality and Safeguarding and People and Culture Committees.	Assured and in place for 2022/23, governance streamlined in line with national requirements to reduce the burden to release capacity to manage the pandemic governance. Deep dive reports and CQC review transition monitoring reports all contain mental health model hospital data per service line. The Executive Team have taken direct oversight and direct action in the pandemic period in the Incident management team and safer staffing reports returned to TOOL in 2021/22. These continue through 2023/24 alongside reports into Quality Safeguarding Committee.
9. An assessment or re-setting of the nursing establishment and skill mix (based on acuity and dependency data and using an evidence-based toolkit where available) must be reported to the Board by ward or service area twice a year, in accordance with NQB guidance and NHS Improvement resources. This must also be linked to professional judgement and outcomes.	Available in Quality and Safeguarding Committee papers. This is reported to the Board through the Board Committee Assurance Summaries. There were no escalation issues to the Trust Board based upon these submissions.	The Executive Team have taken direct oversight and direct action in the pandemic period. This has been reviewed and signed off by the Executive Director of Nursing and Patient Experience and the Quality and Safeguarding Committee. The People and Culture Committee and Quality and Safeguarding Committee will continue to review a submission as a minimum twice per year and this is evidenced in its Board Assurance summary.

The NHSI standard	Trust response	Current performance and gap in assurance
10. There must be no local manipulation of the identified nursing resource from the evidence-based figures embedded in the evidence-based tool used, except in the context of a rigorous independent research study, as this may adversely affect the recommended establishment figures derived from the use of the tool	This is a statement – not a specific question to answer. We do not adapt any information.	Assured and in place for 2022/23
11. As stated in CQC's well-led framework guidance (2018) 6 and NQB's guidance7 any service changes, including skill-mix changes, must have a full quality impact assessment (QIA) review	We will refresh our QIA once we have the outcome of shift change consultation exercise. This did not occur in 2022/23 but the project has been restarted. Additional supplementary staffing has been introduced including the staffing known locally as the bubble to manage unexpected large scale changes in staffing. No reductions in staffing have occurred within the year. Any new services have a new clinical safer staffing model review and this includes drawing upon clinical models and evidence. This year a proposed new model of older people's care was undertaken and included a full skill mix review of the proposal	Assured and in place for 2022/23
12. Any redesign or introduction of new roles (including but not limited to physician associate, nursing associates and advanced clinical practitioners – ACPs) would be considered a service change and must have a full QIA.	Compliant. Executive Director of Nursing has a deployment and risk management plan for nursing associates.	Assured and in place for 2022/23. New roles have been proposed in the region from new monies associated with the Long term plan if these are adopted a full QIA of the new roles will be undertaken.

The NHSI standard	Trust response	Current performance and gap in assurance
13. Given day-to-day operational challenges, we expect trusts to carry out business-as-usual dynamic staffing risk assessments including formal escalation processes. Any risk to safety, quality, finance, performance and staff experience must be clearly described in these risk assessments.	Staffing in high risk service areas is reviewed on a daily basis with a formal process and monitoring system, which includes dynamic risk assessment. This is performed locally by Managers and their teams, with oversight by the Nursing and Quality team in the Incident Management Team. Datix is used to record risk, with an assessment of risk part of this.	Assured and in place for 2022/23 Example acute care, Health visiting caseloads in the pandemic, and a new hub model of practice.
14. Should risks associated with staffing continue or increase and mitigations prove insufficient, Trusts must escalate the issue (and where appropriate, implement business continuity plans) to the Board to maintain safety and care quality. Actions may include part or full closure of a service or reduced provision: for example, wards, beds and teams, re-alignment, or a return to the original skill mix	Staffing risks are identified in inpatient areas via a daily assurance process, whereby current and future risks are reviewed, and actions taken to minimise risk. Staffing huddle/ Safe staffing cell/ Escalation to Ethics and Clinical Governance cell as required. When appropriate escalation to Directors for service closure decisions are made.	Assured and in place for 2022/23.

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 9 May 2023

Public Sector Equality and Gender Pay Gap Report

Purpose of Report

The purpose of this report is to present to the Board the Public Sector Equality Duty Reports including the Gender Pay Gap (using data March 2022); and its role in helping satisfy DHCFT obligations under the Public Sector Equality Duty (PSED: section 149 of the Equality Act 2010) and national mandates.

This report is presented retrospectively due to the need to publish it on the Trust's external facing website by 31 March 2023.

Executive Summary

Derbyshire Healthcare NHS Foundation Trust as a public sector body, is governed by the Equality Act 2010 and the Public Sector Equality Duty (section 149 of the Equality Act 2010) in relation to its equality duties.

The specific duties under the Equality Act 2010 require the Trust to:

- Publish information to demonstrate compliance with the general equality duty. This information must include information relating to people who share a protected characteristic who are our employees or are people affected by our policies and practices. This includes the Gender Pay Gap
- Prepare and publish equality objectives to achieve any of the aims of the general equality duty.

The general duties are:

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

The Annual Public Sector Equality Duty Report provides an update for the following areas of work:

- Equality events
- Equality and diversity strategy and objectives
- Staff Networks
- Workforce Race Equality Standard
- Workforce Disability Standard
- Gender Pay Gap
- Equality Delivery System Domain 1
- Appendices with equality data for: Patients; Workforce; Membership.

In a year that has highlighted many inequalities, in the experience of services and the workplace for people with protected characteristics, and other underrepresented communities including the armed forces community this report showcases many examples of the leading-edge work that the Trust has done with equality, diversity and inclusion (EDI).

The Gender Pay Gap Report is based on data as at 31st of March 2022. The Report provides information based on the six calculations an organisation is required to publish. High-level overview of these calculations is provided in the table below:

Table: DHCFT Overall mean and median gender pay gap and bonus gap based on hourly rates of pay		
	DHCFT 2021	**DHCFT 2022**
Mean gender pay gap.	15.41%	16.51%
Median gender pay gap.	9.96%	10.39%
Mean bonus gender pay gap.	89.54%	87.62%
Median bonus gender pay gap.	88.93%	50.00%
Proportion of men and women receiving a bonus.	5.11%	4.20%
NB bonuses paid relate to clinical excellence awards which are for applicable consultants only rather than all employees (even though the calculation includes all staff)		
Proportion of females and males in each quartile band: DHCFT 2022		
Quartile	**Women**	**Men**
Top quartile	84.35%	15.65%
Upper Middle quartile	79.89%	20.11%
Lower Middle quartile	81.86%	18.14%
Lower quartile	71.94%	28.06%

In the absence of legislation, the Gender Pay Gap Report also provides a high-level overview of the Ethnicity Pay Gap looking at four calculations (excluding mean and median bonus ethnicity pay gap).

Ethnic Group	Average Hourly Rate	Median Hourly Rate
White	£17.87	£16.52
BME	£19.83	£15.44
Difference	-£1.96	£1.08
Pay Gap %	**-10.94%**	**6.53%**

Quartile	BME	White	BME %	White %
1	128	604	17.49	82.51
2	192	514	27.20	72.80
3	94	679	12.16	87.84
4	154	581	20.95	79.05

The PSED reports include:

- PSED Annual Report March 2023 reflect data April 2022 to date
- PSED Annual Workforce Report (with long report) reflecting data March 2022

- Gender Pay Gap Report reflecting data March 2022 and Action Plan 2023/24

Next Steps:

- Publishing on website by 31 March 2023
- Sharing widely internally with our staff and externally with our partners at JUCD

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

Risks and Assurances

- These reports are statutory requirements, failure to publish breaches the Equality Act 2010

Consultation

- Staff Network Chairs
- SMT
- ELT

Governance or Legal Issues

- Meets our requirements under the Equality Act 2010.

Public Sector Equality Duty and Equality Impact Risk Analysis

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

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

These reports provide information and analysis against REGARDs and EDS.

Recommendations

The Board of Directors is requested to note the information contained in the Public Sector Equality and Gender Pay Gap Report.

Report presented by: **Jaki Lowe and Samina Arfan**
Director of People and Inclusion and Head of EDI

Report prepared by: **Samina Arfan and Amany Rashwan**
Head of EDI and EDI Advisor

Derbyshire Healthcare
NHS Foundation Trust

Equality, Diversity, and Inclusion Annual Report 2022-23

Public Sector Equality Duty

March 2023

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FORWARD

We are pleased to present our Public Sector Equality Publication March 2023, reflecting our work over the past year.

We believe in creating an environment which fosters inclusion where individuals are respected and treated fairly, where diversity is celebrated and where everyone of all backgrounds are supported to reach their full potential.
Inclusion is at the heart of our Trust Strategy to create a strong sense of belonging in which people feel able to deliver great care. This report aims to provide a summary of the activity taking place across DHCFT against our joint equality objectives to improve service standards and outcomes for local people and our staff.

This past 12 months has been unlike any we have ever experienced. The impact of Covid-19 and global events has profoundly affected every aspect of our lives and the cost-of-living crisis has disproportionately affected already disadvantaged people and communities more than others.

We have a lot of pride in the way we are already working with our service users and carers and our colleagues. We are passionately developing new and pioneering ways to improve the way we work and the services we provide at place.

The things that are most important to us is living our key values, which were developed in partnership with our users, carers, colleagues, and wider partners:

Insert pic of CEO and Chair

Background

Our Trust

The Trust is passionate about making equality, diversity, and inclusion part of our DNA. We take pride in our **"People First Culture"** which creates a workplace where everyone feels a genuine sense of belonging, difference is celebrated, and people are comfortable to bring their whole selves to work.

We respect and value the diversity of our patients, colleagues and partners and support a respectful and inclusive environment throughout the work we do across the Trust for colleagues, patients, partners, and our wider community.

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

The Trust continues to work towards creating a compassionate and inclusive environment for receiving care and as a place to work.

This means we all play our part:

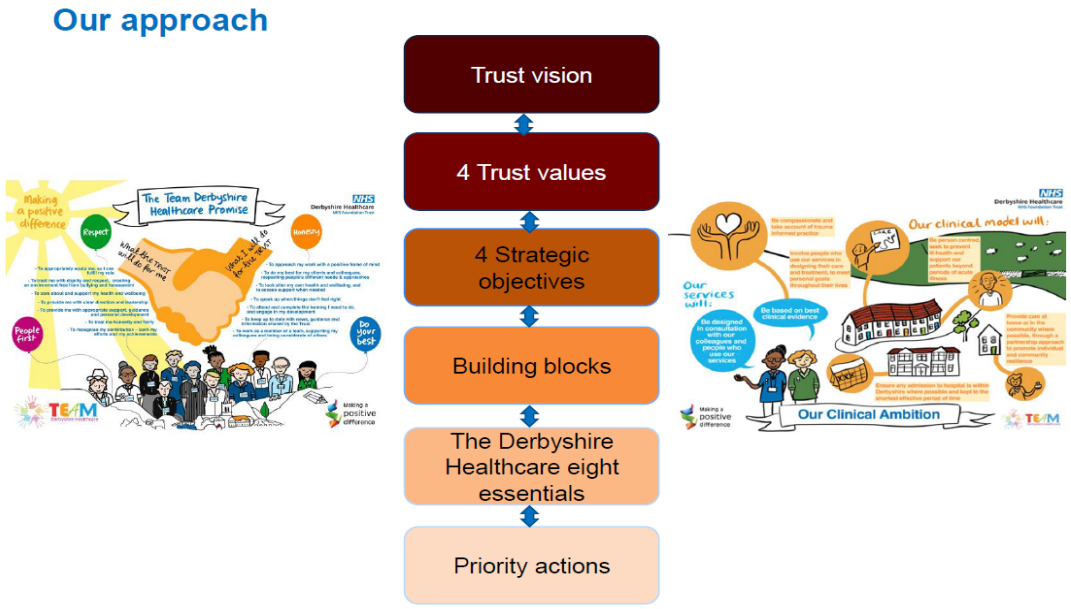
- To be a caring and progressive organisation that promotes equality, values and celebrates diversity and creates an inclusive and compassionate environment for receiving care and as a place to work.
- To ensure that our staff provide inclusive services that are equally good to all service users, which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

Please click here to hear our Team Derbyshire Healthcare colleagues describe what inclusion means to them

Our Vision and Values

- People first – We work compassionately and supportively with each other and those who use our services. We recognise a well-supported, engaged and empowered workforce is vital to good patient care
- Respect – We respect and value the diversity of our patients, colleagues and partners and for them to feel they belong within our respectful and inclusive environment
- Honesty – We are open and transparent in all we do
- Do your best – We recognise how hard colleagues work and together we want to work smarter, striving to support continuous improvement in all aspects of our work.

Our Approach



Our EDI Strategic Objectives

Great care

- Delivering compassionate, person-centred, innovative and safe care
- Choice, empowerment and shared decision-making is the norm.

Great place to work

- Attracting colleagues to work with us who we develop, retain and support by excellent management and leadership.
- An empowered, compassionate and inclusive culture that actively embraces diversity**.**

What we need to achieve –to deliver GREAT care

What we need to achieve –to be a GREAT place to work

Introduction

The purpose of this report is to provide information on how DHCFT met our legal and mandated duties related to equality, diversity, and inclusion over the period April 2021-March 2022.

What do we mean by workforce equality, diversity, inclusion, and fairness?

Equality, diversity, and inclusion can mean different things to different people. It is important that we are clear about what we mean when we talk about equality, diversity, and inclusion as well as an understanding of the legal context in which we operate.

- **Equality** means equal opportunities and fair treatment for our service users and carers and employees and job applicants regardless of any protected characteristics.
- **Diversity** is about recognising and reflecting difference, benefiting from having a range of perspectives in engagement, involvement and decision making and the workforce being representative of our residents.
- **Inclusion** is where people's differences are valued and used to enable everyone to thrive in our services and at work.
- **Fairness** does not mean treating everyone the same. It means treating people in line with their needs to ensure equality.

Our legal and Mandated Obligations

Legal Context: Equality Act 2010

As public bodies we are bound by the Public Sector Equality Duty (PSED). Our Inclusion strategy sets out how we will meet our statutory and mandatory obligations under this duty, which is defined within the Equality Act as: ***"A public authority must, in the exercise of its functions, have due regard to the need to:***

- Eliminate discrimination, harassment, victimisation, and any other conduct that is prohibited by or under this Act.
- Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it.
- Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

The Equality Duty is supported by specific duties the Equality Act, which stipulates that every public body is required to:

(a) Publish information annually to demonstrate its compliance with the general equality duty. This includes information relating to people who share a protected characteristic who are:
    - Employees (includes Gender Pay Gap)

- People (service users) affected by its policies and practices.

(b)Equality Objectives (specific and measurable) 4 yearly cycle

Protected Characteristics and Vulnerable Groups

These are individuals' characteristics protected by the Equality Act of 2010. Understanding these different characteristics can improve access, experience and outcomes of residents, patients, service users and staff.

There are 9 protected characteristics and 2 locally identified characteristics: age, disability, gender reassignment, race, religion and belief, sex, sexual orientation, marriage and civil partnership and pregnancy and maternity, carers, and Armed Forces Community.

We are committed to the Social Model of Disability, which sees the way society is organised and the organisational, physical, and attitudinal barriers it puts in place for disabled people as the problem, rather than the individual's impairment or difference.

Our National, regional, and local context

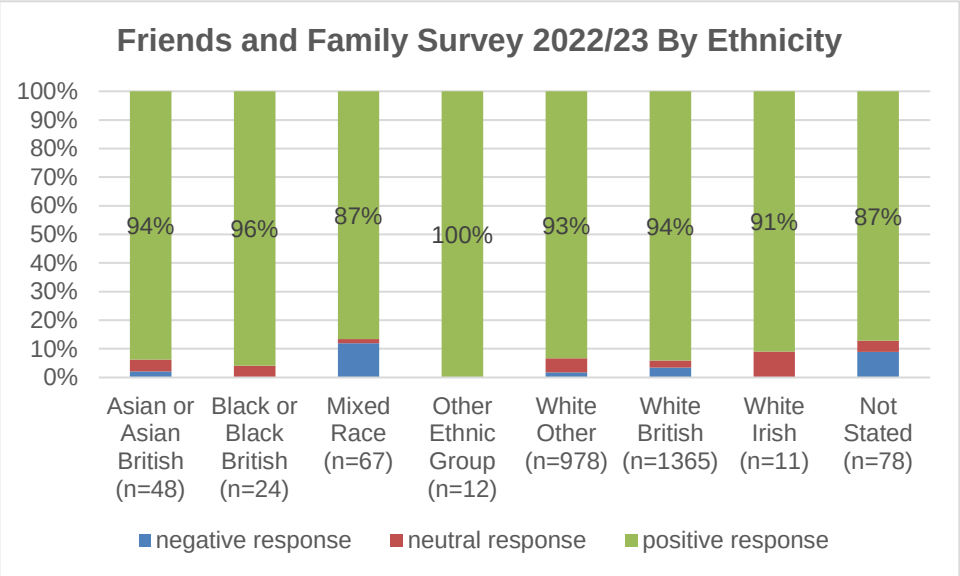
The table below sets out the national regional and local legal and mandated obligations related to EDI.

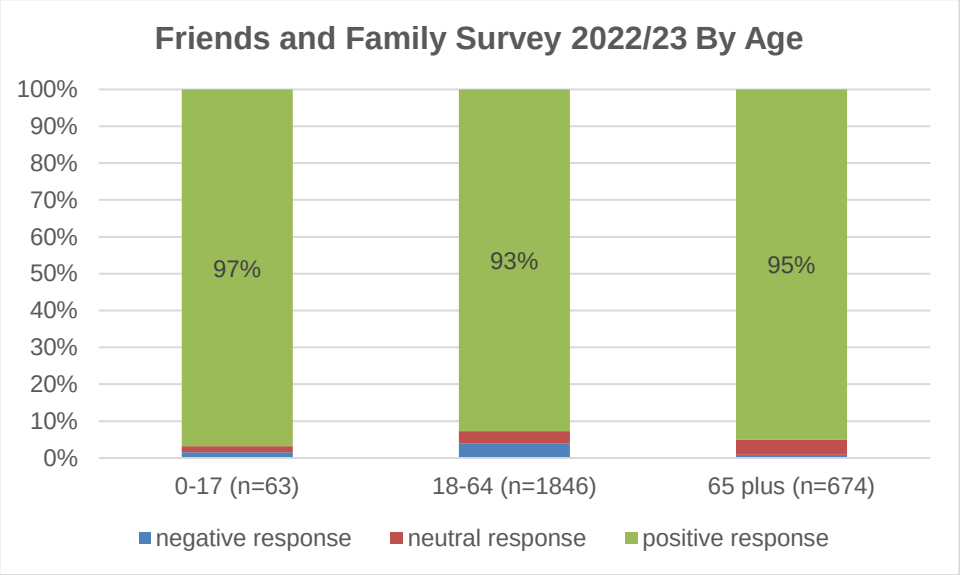
Promotion of equality in service delivery

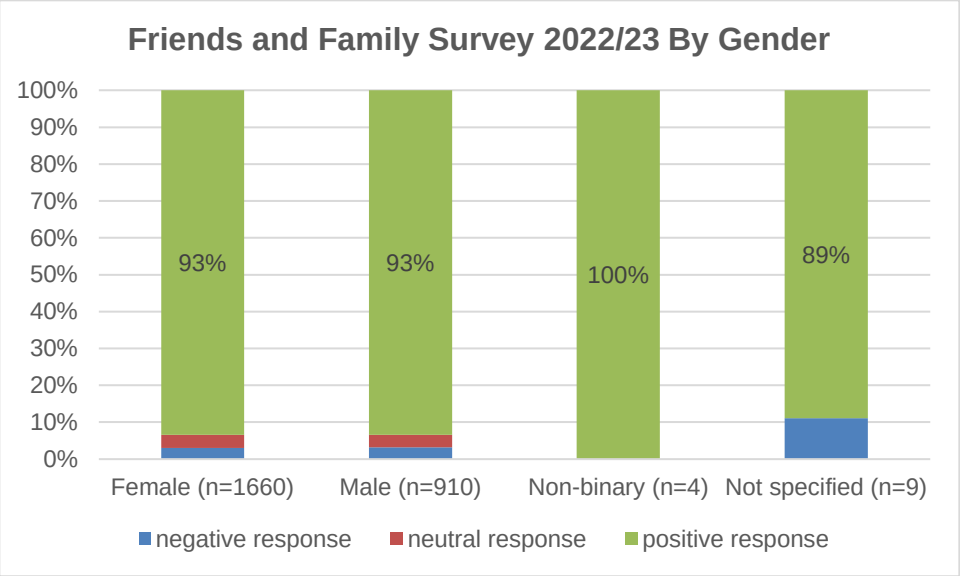
- **Customer satisfaction scores broken down by protected characteristics**

To measure customer satisfaction the Trust promotes the Friends and Family Test survey, and respondents are asked to provide their ethnicity, age, and gender.

Results for the financial year were as follows:







- **Performance against equality of service delivery key performance indicators**

Throughout the pandemic, we have continued to ensure the safety of our patients through adaptations of service provision. All inpatients have been clinically assessed. Individuals from black and minority ethnic backgrounds and who had underlying health conditions or were shielding were provided with additional support. All shielding inpatients and inpatients with vulnerabilities, including asthma, have been cared for in protected areas away from direct admissions. In addition, all shielded patients in the community were offered additional support from our mental health and community health teams and were also provided with information on the 24/7 mental health helpline.

In all of our community services we have continued to offer appointments by video, using *Attend Anywhere*, by telephone and also through face-to-face visits. This flexible approach has had a positive impact as it enabled maintenance of contact and level of interventions during the pandemic.

Clinically our mental health and learning disability services remained busy and continued to be operational. Our substance misuse services continued to provide a full service and experienced an increase in referrals and access related to alcohol and substance misuse. Our child health services - health visiting, safeguarding and child protection medical services continued to operate normally.

- **Explanations of activities the Trust is undertaking to promote equality of service delivery**

The Trust operates on a person-centred care planning basis. Each person is treated as an individual and their care plan takes into account all of their individual needs, which by default encapsulates equality of service delivery. Through the use of person-centred care planning, the Trust ensures that all patients are informed and supported to be as involved as they wish to be in decisions about their care. A care plan is devised jointly with the patient unless they are unwilling or unable to be involved. The principle of devising the care plan in conjunction with the patient, where possible, is consistently applied. In addition, for patients with a learning disability an accessible care plan has been devised which uses symbols to aid understanding and to enable participation in the production of the care plan.

The Trust activities and initiatives to promote Equality, Diversity, and Inclusion

The Trust continues to support promoting Equality, Diversity and Inclusion through various events, projects, initiatives and through marking and celebrating Awareness Days throughout the year via engagement sessions, Q&A sessions, and our social media platforms.

National spotlight on special clinics offered at our vaccination hub

Our Trust's vaccinations and Learning Disabilities (LD) team have received national attention for the way they have provided a welcoming environment at the Kingsway Hospital Hub for people requiring reasonable adjustments when getting vaccinated. The efforts of the vaccinators and LD team were showcased on a national webinar run by NHS England, where Marie Hooper (Non-Medical Prescriber, Learning Disabilities) represented the Trust and gave a presentation.

The Kingsway Hospital Hub has been setting aside one day a week for special clinic days with longer appointments, where individuals requiring more time and a calmer atmosphere can attend. Marie explained on the webinar how the vaccinators and LD team worked with individuals beforehand, preparing them and listening to their needs, and then did everything possible on the day to bring about the adjustments they had requested, working in partnership with carers and GPs.

Maire and the team were praised on the webinar for the team's "creativity" and one of the attendees described Marie's presentation as "fantastic".

Jess (pictured), who received her vaccination during one of the clinic days said: "I am pleased to have it just so that I can go out. I had my first jab in June, and it has been good to have it in the Kingsway Hub as I can bring Shadow (my dog) and there are lots of people around to make a fuss of her. It's really quiet here and that's been great."

The Trust's big sunflower project

Ahead of Mental Health Awareness Week (which took place from 10 – 16 May 2021) all colleagues received a pack of sunflower seeds to grow their own sunny flowers.

The theme of Mental Health Awareness Week was nature and we know there are strong links with positive mental health and nature.

Sunflowers are easy to grow and many people find the bright yellow blooms cheerful and uplifting.

The seeds can be planted inside or outdoors and garden vouchers were given to the three tallest sunflowers in September.

Colleagues were invited to share the height of their sunflowers and any experiences of potting and growing the seeds through our Team Derbyshire Healthcare Facebook page.

Many thanks to Legue of Friends for money for self-soothing bags

The Trust's League of Friends funded the service user project for self-soothing bags for the Older Adult In Reach and Home Treatment Team – High Peak and Dales.
The items purchased will greatly benefit patients and help the team to make self-soothing bags, to help patients to build on their self-management skills towards managing anxious situations. The bags provide the opportunity for service users to develop their coping skills and distraction techniques.

Self-soothing bags include a range of items, including creative items such as stress putty and colouring, centred on the five senses. As emotional tension happens during a stressful situation, it is important to know how to relax and regulate emotions effectively.

An instruction sheet is added into the bag to give the patient an understanding of how to use the items and what benefits each item gives. In addition, there is a feedback form to capture patient's experiences and the bag's usefulness.

Nike donation means Trust inpatients will be kitted out for sports sessions

Thanks to the generosity of Nike Direct, patients at the Trust's Hartington Unit can now be issued with a kit to take part in physical activity sessions at the unit.

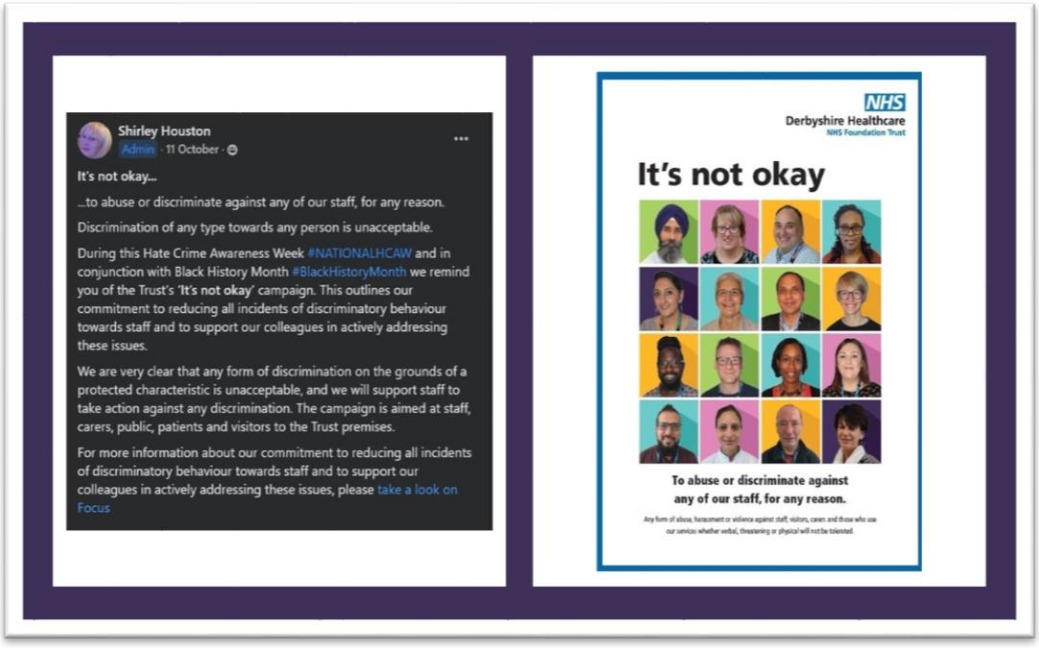
Many patients come into hospital without appropriate clothing or footwear to take part in physical activity sessions.

Physiotherapist Paula Manning got in touch with a local Nike store which offered to support the unit with donations of surplus staff uniforms. Paula, along with Recreation Coordinator Clare Farnsworth, liaised with Kim Wright, Operations Coach from Nike's Mansfield store, who kindly agreed that the work within the unit on physical activity is something they would be happy to support. Clare (front) and Paula are pictured with Kim and Dan from the Nike store and some of the kit.

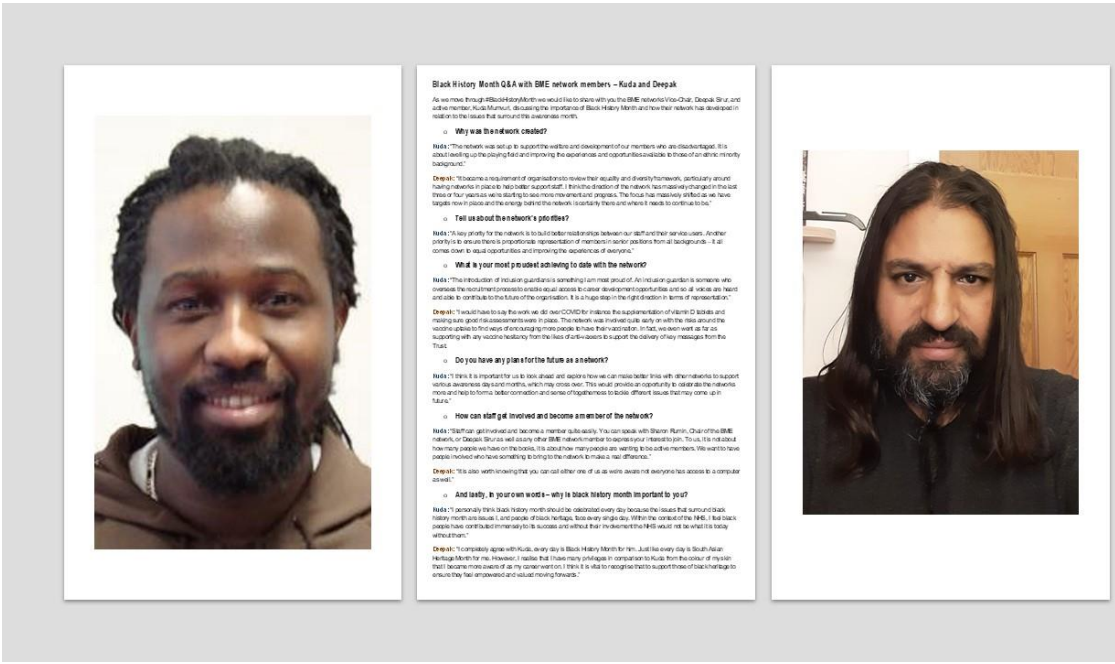
Clare said: "A huge thank you to our local Nike store for donating the gym wear to the Hartington Unit. The kits will be issued to patients that come into hospital with no sports clothing or footwear to support them to join in with physical exercise."

Wear Red Day – Show racism the Red Card – Friday 21 October 2022 #BlackHistoryMonth

Hate Crime Awareness Week



Black History Month Q&A with BME network members – Kuda and Deepak



Black History Month Q&A with BME network members – Kuda and Deepak

As we move through #BlackHistoryMonth we would like to share with you the BME networks Vice-Chair, Deepak Sirur, and active member, Kuda Munyuri, discussing the importance of Black History Month and how their network has developed in relation to the issues that surround this awareness month.

- **Why was the network created?**

Kuda: "The network was set up to support the welfare and development of our members who are disadvantaged. It is about leveling up the playing field and improving the experiences and opportunities available to those of an ethnic minority background."

Deepak: "It became a requirement of organisations to review their equality and diversity framework, particularly around having networks in place to help better support staff. I think the direction of the network has massively changed in the last three or four years as we're starting to see more movement and progress. The focus has massively shifted as we have targets now in place and the energy behind the network is certainly there and where it needs to continue to be."

- **Tell us about the network's priorities?**

Kuda: "A key priority for the network is to build better relationships between our staff and their service users. Another priority is to ensure there is proportionate representation of members in senior positions from all backgrounds – it all comes down to equal opportunities and improving the experiences of everyone."

- **What is your most proudest achieving to date with the network?**

Kuda: "The introduction of inclusion guardians is something I am most proud of. An inclusion guardian is someone who oversees the recruitment process to enable equal access to career development opportunities and so all voices are heard and able to contribute to the future of the organisation. It is a huge step in the right direction in terms of representation."

Deepak: "I would have to say the work we did over COVID for instance the supplementation of Vitamin D tablets and making sure good risk assessments were in place. The network was involved quite early on with the risks around the vaccine uptake to find ways of encouraging more people to have their vaccination. In fact, we even went as far as supporting with any vaccine hesitancy from the likes of some execs to support the delivery of key messages from the Trust."

- **Do you have any plans for the future as a network?**

Kuda: "I think it is important for us to look ahead and explore how we can make better links with other networks to support various awareness days and months, which may cross over. This would provide an opportunity to celebrate the networks more and help to form a better connection and sense of togetherness to tackle different issues that may come up in future."

- **How can staff get involved and become a member of the network?**

Kuda: "Staff can get involved and become a member quite easily. You can speak with Sharon Rumin, Chair of the BME network, or Deepak Sirur as well as any other BME network member to express your interest to join. To us, it is not about how many people we have on the books, it is about how many people are wanting to be active members. We want to have people involved who have something to bring to the network to make a real difference."

Deepak: "It is also worth knowing that you can call either one of us as we're aware not everyone has access to a computer as well."

- **And lastly, in your own words – why is black history month important to you?**

Kuda: "I personally think Black history month should be celebrated every day because the issues that surround black history month are issues I, and people of black heritage, face every single day. Within the context of the NHS, I feel black people have contributed immensely to its success and without their involvement the NHS would not be what it is today without them."

Deepak: "I completely agree with Kuda, every day is Black History Month for Him. Just like every day is South Asian Heritage Month for me. However, I realise that I have many privileges in comparison to Kuda from the colour of my skin that I became more aware of as my career went on. I think it is vital to recognise that to support those of black heritage to ensure they feel empowered and valued moving forwards."

The Trust's EQUAL Activities

Work has been continuing apace to establish and consolidate community-based groups that will feed into EQUAL, the Trust's patient and carer forum. As we move into 2023 new groups of service users and carers will be coming together in both Buxton and Chesterfield to create a feedback loop between service users and the Trust leadership team.

Other groups will be formed across the areas that the Trust provides services. By going 'to where people are' this work has equality, diversity, and inclusion at its heart - constantly seeking to engage the breadth of communities that the Trust serves. We seek to access the knowledge of those communities to help Trust services to be the best that they can be.

Members of EQUAL and the wider service user and carer community are an increasingly familiar sight across the Trust – taking part in recruitment panels for senior level Trust appointments, in Trust meetings and committees, in focus groups and so on as the Trust seeks to improve its performance by learning from the experiences of people who use its services.

Our Freedom to Speak-up Guardians' outreach activities

Our Freedom to Speak-up Guardian has been working tirelessly to promote the Freedom to Speak Up policy and procedure that aims to foster a positive culture of speaking up for all colleagues. Moreover, working across the Trust to advocate for raising concerns, speaking up, and acting as an active ally.

Some of the activities that took place throughout the year were:

- Monthly Freedom to speak-up champions check-in
- A2B Leadership Programme - Speaking Up for Leaders for DCHS and DHCFT Staff
- Freedom to Speak Up Guardian - (Junior Doctors - North & South)
- Monthly Trust Induction - FTSU promotion - New Trust staff
- Bank worker engagement session – Bank and Agency staff
- Attendance at Staff Networks meetings
- Promoting FTSU at various Staff meetings

Leadership, Training and Development

- **Cultural Intelligence (CQ Programme)**

The Trust's Above Difference Cultural Intelligence programme began with the Board on 15th September 2021. 24 senior leaders completed the programme, and 4 Facilitators have been trained to deliver the Programme to the wider Trust. 20 senior leaders completed the programme in June 2022. This has now been reviewed to increase facilitators and utilising the existing facilitators.

The Above Difference has been commissioned to support the systems work around cultural intelligence including DHCFT, with a view to interrupt bias across the recruitment pathway end to end. Five working groups have been set up to review process and look at good practice in line with the model employer and other frameworks in the following pathway areas:

1. Vacancies and advertising
2. Job descriptions
3. Interview process (interview questions and panel preparation)
4. Selection and shortlisting
5. Retention

- **Equity, Diversity, and Inclusion Workshops for Teams**

The Trust is committed to continuous learning and development to raise awareness about EDI and embed it as a practice in our day-to-day operations. The Trust has commissioned and started rolling out to teams training workshops about Equity, Diversity, and Inclusion in collaboration with Unleashed International Limited. The workshops deliver a comprehensive content that covers several EDI related themes that aim at:

- Raising people's self-awareness
- Understanding unconscious bias and how to mitigate this (Conscious Inclusion)
- Understanding equity, diversity, and inclusion (EDI)
- Understanding equity, diversity, and inclusion (EDI)
- Providing education on Discrimination, Allyship and Microaggressions
- Understanding how to be an effective Ally

- **EDI Training and sessions**

The EDI team continues to support colleagues across the Trust in raising awareness, building a wide knowledge base and encourage enlightening conversations about equality and inclusion, and facilitates the creation of a psychologically safe space for colleagues to have the confidence to bring their whole selves to work. Some of the activities the team is leading on are:

- delivering the EDI induction to all new starters as part of their Trust Induction on monthly basis.
- delivering 2 – 3 EDI Sessions per year to the Nursing and AHP students who are on placement with the trust.

- **Staff Networks' Chairs Development Programme**

One of the initiatives that aimed at supporting the Staff Networks by empowering their leadership teams and members is the Staff Networks' Development Programme that the Trust commissioned jointly with Derbyshire Community Health Services NHS Foundation Trust and was delivered between May and October 2022 with a celebration event held on 11 October 2022 where delegates shared their learnings, their feedback about the programme and aspiration for the futures of the network in both Trusts. The programme was developed by the Power of Staff Networks and comprised of different training series to equip delegates with tools and strategies for handling racial inequities, building their personal confidence, strengthening the networks and leadership skills in the NHS.

The programme was well attended, and the feedback was very positive.

- **The Organisational Inclusion Project**

The Trust has recently partnered with De Montfort university on an organisational Inclusion Project funded by NHS Charities together. Rubina Reza, the Trust's Head of Research & Development has taken the lead on this project for DHCFT, which is being done jointly with DCHS

The project will employ the established organisational diagnostic and change management methodology of Force Field Analysis within the Participatory Action Research approach. The project will develop an inclusive framework of inquiry across the whole organisation, identifying both challenges and the potential strategies which would overcome these challenges across all levels of the organisation, ensuring all voices are heard and solutions are acceptable and appropriate for all members.

The survey for the project closed on 30 November 2022. Preliminary analysis is underway. The research team will be holding workshops to build on survey findings in February 2023.

- **Inclusive Leadership Development Programme – Board Development**

The Trust has collaborated with the Leadership Academy who are delivering an Inclusive Leadership Programme for our Board members. The diagnostic exercise for which has taken place in June 2022 and the delivery of the programme is ongoing.

The programme is designed for leaders who govern organisations, systems, or a place. Board members will explore through the programme their leadership, how they lead individually and collectively. They will explore the way in which their leadership can impact more effectively on the organisation and its ambitions for equity, inclusion, and fairness.

We also applied for and became the first system to take this programme into the system and the diagnostic process for the ICS is currently taking place.

- **Supporting Board diversity**

In early 2022, Jas Khatkar was put forward by the Trust as for a placement under the NExT Directors scheme. He joined us in April 2022 for 12 months.

A Chartered Accountant by background, Jas is an experienced management consultant who specialises in finance transformation and business strategy. A former director with

Accenture, Jas has worked multiple industries, including telecoms, utilities, and pharmaceuticals. Jas also advices several Sikh community Non-Governmental Organisations (NGOs) and humanitarian charities working for equality and social justice.

The Trust has supported the NExT Director scheme for several years, and it aim is to increase the diversity of Board members across the NHS. Although NExT Directors are not members of the Board, they participate in Board and Committee meetings across the Trust, in addition to a wider range of other activities including service visits

Staff Networks

Derbyshire Healthcare has a number of Staff Networks to offer colleagues a safe space where they can receive support, advice and encouragement about work-related issues and provide an open forum to exchange views, experiences and raise concerns.

The Networks aim to improve working lives and promote diversity within the Trust.

All colleagues at Derbyshire Healthcare are welcome to join the Networks, and both members and allies get protected time to attend Network meetings.

Each Network also has an Executive Sponsor: a member of the Executive team, who actively champions the protected characteristic, attends Network meetings, and supports the Networks with their respective work programmes.

DHCFT Staff Networks

Staff Networks Highlights

Our staff networks have been working tirelessly throughout the year to support their members, colleagues at the Trust, The Trust leadership, and the wider community.

Armed Forces Community

The Armed Forces Community Staff Network has:

- Appointed a new Chair, Deputy Chair (veteran) and Executive Sponsor (family member).
- An increased membership of 30 members.
- Hosted the first remembrance event “Falklands 40”
- Achieved the silver award from Defence’s Employer Recognition Scheme.
- Started a monthly peer support session for its members.
- Been recognised as a “Veteran Aware” Trust by the VCHA.
- Facilitated a workshop at 103 REME Btn (Reserve Centre) on mental wellbeing.

Making a positive difference

BME Staff Network

The network continues its mission to drive positive changes within the workplace for the BME Community through:

- Having and supporting enlightening conversations
- Working in a collaborative way with colleagues from across the Trust to address any concern
- Acting as a critical friend and an inclusion champion
- Supporting the Trust in identifying priority areas for the WRES action plan
- Creating a psychologically safe space for everyone to express themselves
- Working on succession planning within the network, and talent management to address the challenges colleagues from a BME background are encountering
- The network is proud of its position within the Trust as a network where anyone can seek support as allied which is so important. The network is accredited by its members on the support it gives regarding the benefits of career progression weather inside the Trust or not. Encouragement and inspiration flourish throughout the network; and the network feels honoured when members feedback to us how we have encouraged them to feel empowered and progressed

Work plans for 2023

- The network will continue to focus on priorities local and regional as part of the WRES/MRES DATA. We are keen to work with EDI and other Trust steams to utilise relevant dash boards for live interrogation of various metrics to counter against any actionable inanely ways.

- The network reports into other networks space as a point of triangulation of assurances being achieved around health and to gauge the frontline impact of strategies and action being taken/ stalling and lacking accountability. The NHS People Plan and local integration/ICS linked to Networks.

- Continue to collaborate with the People and Inclusion Team to address any areas for development or concerns around Recruitment and escalation processes.

Network Highlights 2022

- The network was nominated this year for the Outstanding Network Award at the NHS Midlands Inclusion and Diversity Awards.

- The Network supported and collaborated with the Women's Network on the joint-venture to commission the Women of Colour in Leadership training programme which took place in July 2022 and was very well attended.

- Some of the network members have just finished the **Networks' Chairs Development programme** and the outcome is positive. Specially that the programme emphasised on the concept that networks members need to be active and participate.

D.A.W.N. Disability and Wellness Staff Network

Past Year

The D.A.W.N. Group has:

- Reasonable Adjustments Plan and accompanying Managers Guide has been reviewed and signed off by the Network – this will be requested to be incorporated into the leadership passport with attendance training etc by the Leadership Development team

- The promotional video has been recorded and will be circulated within the current membership as well as via Communications, weekly focus email and on the intranet

- Launched a video message on the International Day of Persons with Disabilities. To watch the video, click here

Video message from the Disability and Wellness Network, 2 December

Future Plans

- We are going to be providing a forum for people to tell their story of working with a disability/long term condition and how they felt, how they overcame any obstacles and what support was given - if any.

- We intend to use these to look at how the Trust provide support through different levels of staffing and different roles. We will be able to build a plan to see where the gaps in knowledge and support are within the Trust and look at how we are able to provide training and guidance to both staff and managers. We will be creating an action plan consisting of learning taken from these discussions and building this into possible future training and development opportunities

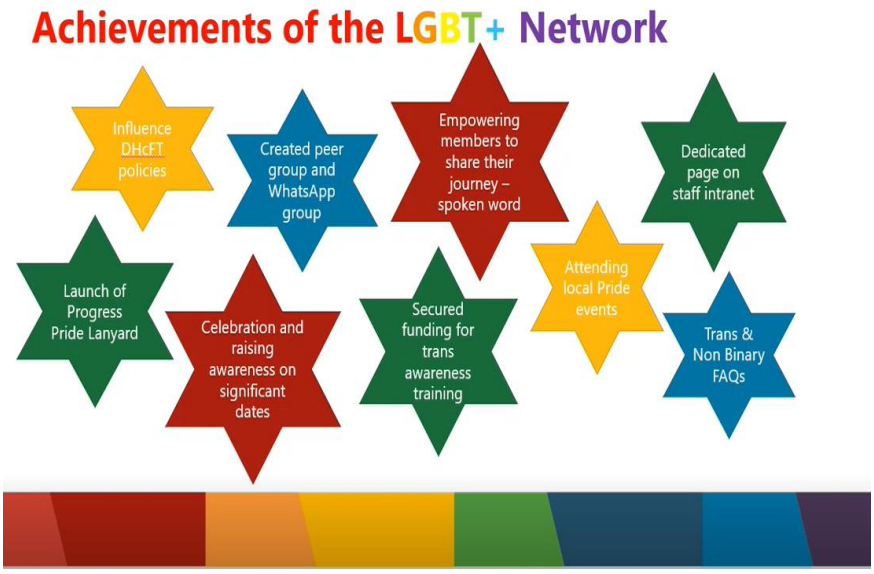
- We will be looking at ways to increase staff declarations regarding any disabilities/long term conditions when applying for positions within the Trust and for current staff that have not declared this, we will be looking at how mangers can provide a more inclusive culture to allow members of staff declare any disability/long term condition without the worry of a negative outcome

- We are going to be working with Recruitment and Selection to look at how we can improve the recruitment process for people with a disability/long term condition

- We are discussing including a brief section for promoting the Network during Induction and providing promotional information after the session

- We are looking to provide some products to promote the Network including wrist rests and mouse mats and ergonomic pens

LGBT+



- The LGBT+ network commissioned training for staff to attend about LGBT+ identities with a focus on gender identities. These sessions were well attended, and future sessions are being planned for 2023.
- We celebrate awareness days and events by creating infographics, hosting a quiz for LGBT+ History Month, an informative video and Q&A sessions for Pride Month, and inviting in an inspirational guest speaker to discuss their experience as an LGBT+ and BME person.
- We attended Chesterfield and Belper pride to meet our community and share some of the good work we do. At Belper pride we also created and distributed

a questionnaire about LGBT+ people's experience of mental healthcare to shape our aims for the next year.

- Other things we have done include sending out over 190 progressive pride flag lanyards, purchasing, and disseminating merchandise to make ourselves visible and supporting LGBT+ colleagues, other staff networks and staff who have questions about the LGBT+ community.

The Multi Faith Forum & The Christian Network

Multi Faith Forum

- Developing slowly. Quarterly meeting
- MFF survey in the summer (22 respondents). (Needs to be actioned)
  - Various people are interested in finding out more about faith / different faiths to support service users
  - Education to help develop knowledge and understanding leading to equality and dignity for all groups

Christian Network (Sub-Group of the Multi-Faith Forum)

- Small group continues to meet Wed am 8.30-9
- Easter reflection led by DHCFT but included DCHS & UHDB
- Monthly lunch time reflections continue (albeit small numbers)

Christian Christmas Reflection (Derbyshire Trusts- DHCFT, DCHS & UHDB)
15th December 2022
Reached 15 participants

Women's Network

We formally launched the Women's Network during International Women's Day in March 2022. We launched the network via a number of MS Teams events and a speaker who focused on:

- What the biases are that hold women back
- Why they occur
- Why the intersectionality identity of women matters
- What we can do to challenge bias in our daily work lives

Since then, we have formally held two Networks which have increased in numbers and focussed mainly on:

- Completing the Terms of Reference
- Identifying focus for the Network – questionnaires to be sent out to gather feedback to ensure the Network is representing the needs of female workforce
- Considering our visibility – raising awareness, marketing
- Building on awareness of current groups already working in the trust that align with the Women's Network aims to support them and not replicate work

Equality Delivery System (EDS2)

The Equality Delivery System (EDS) is a system that helps NHS organisations improve the services they provide for their local communities and provide better working environments, free of discrimination, for those who work in the NHS, while meeting the requirements of the Equality Act 2010. The NHS developed the EDS, taking inspiration from existing work and good practice.

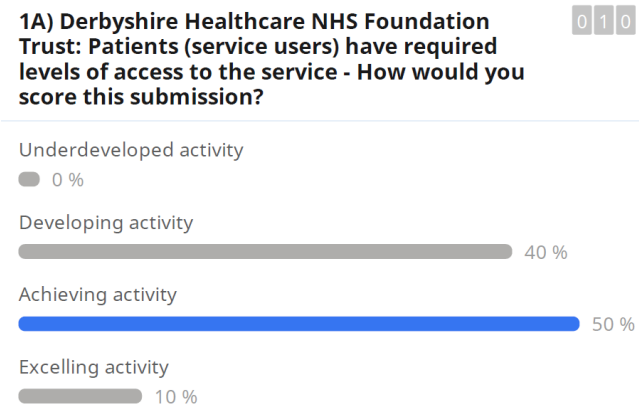
A review of the EDS2 was undertaken to incorporate system changes and take account of the new system architecture for Integrated Care Systems. Through collaboration and co-production and taking into account the impact of COVID-19, the EDS has now been updated and EDS 2022 is now available for live testing during 2022/23.

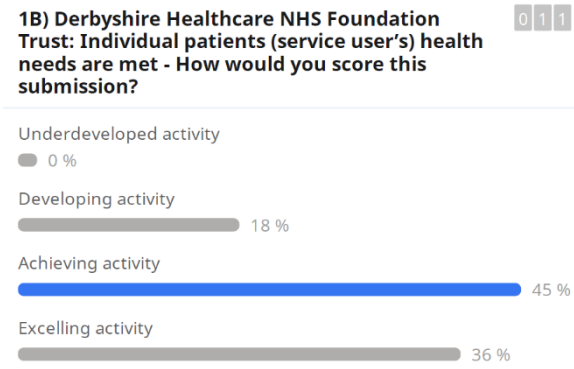
The main purpose of the EDS was, and remains, to help local NHS systems and organisations, in discussion with local partners and local populations, review and improve their performance for people with characteristics protected by the Equality Act 2010. By using the EDS 2022, NHS organisations can also contribute to delivering on the Public Sector Equality Duty.

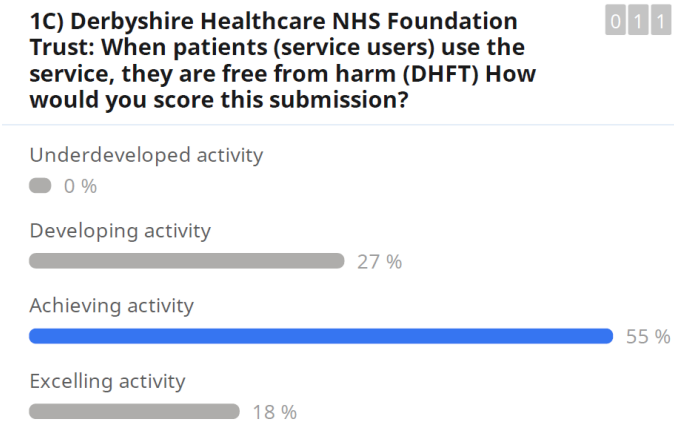
EDS 2022 is aligned to NHS England's Long-term Plan and its commitment to an inclusive NHS that is fair and accessible to all.

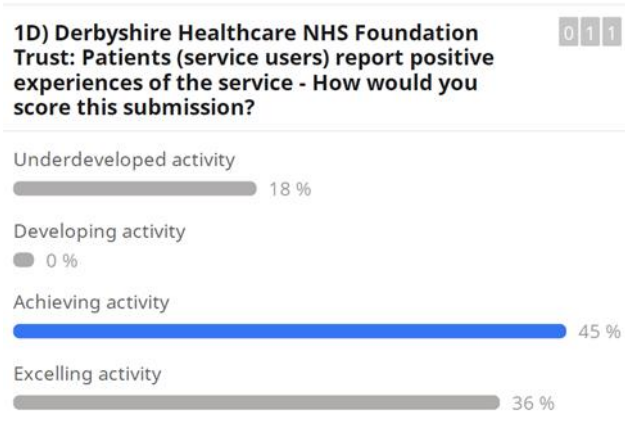
Domain 1: Commissioned or provided services	Domain 2: Workforce health and well-being	Domain 3: Inclusive leadership
1A: Service users have required levels of access to the service	2A: When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD and mental health conditions	3A: Board members, system leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities
1B: Individual service user's health needs are met	2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source	3B: Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed
1C: When service users use the service, they are free from harm	2C: Staff have access to support and advice when suffering from stress, abuse, bullying harassment and physical violence from any source	3C: Board members and system leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients
1D: Service users report positive experiences of the service	2D: Staff recommend the organisation as a place to work and receive treatment	

DHCFT's Perinatal team who held a positive EDS (Equality Delivery System) grading event in February 2023. This process was led by our commissioners and focused on our system-wide collaboration to ensure patients have required levels of access to the service, that individuals' health needs are being met and that people who use the service are free from harm. The tables below show the grading by the stakeholders against the four outcome areas, for more information please follow this link.









Workforce Race Equality Standard (WRES)

The Workforce Race Equality Standard (WRES) is an annual data collection exercise which highlights the experiences of Black, and Minority Ethnic (BME) compared to their white counterparts within an organisation. The standard is a requirement for all NHS health care providers through the NHS standard contract.

The WRES requires organisations to demonstrate progress against nine metrics specifically focused on race equality and suggests actions to address the disparities identified. The data and statistics used in this report reflect Workforce indicators, NHS staff survey Indicators and a Board representation indicator.

The WRES consists of 9 indicators which are themed in 3 areas below:

Representation, recruitment, and progression

- **Indicator 1** - Representation
- **Indicator 9** - voting Board membership
- **Indicator 2** - likelihood of appointment from shortlisting
- **Indicator 4** - access to non-mandatory training and CPD
- **Indicator 7** - fairness in career progression
- Disparity Ratio

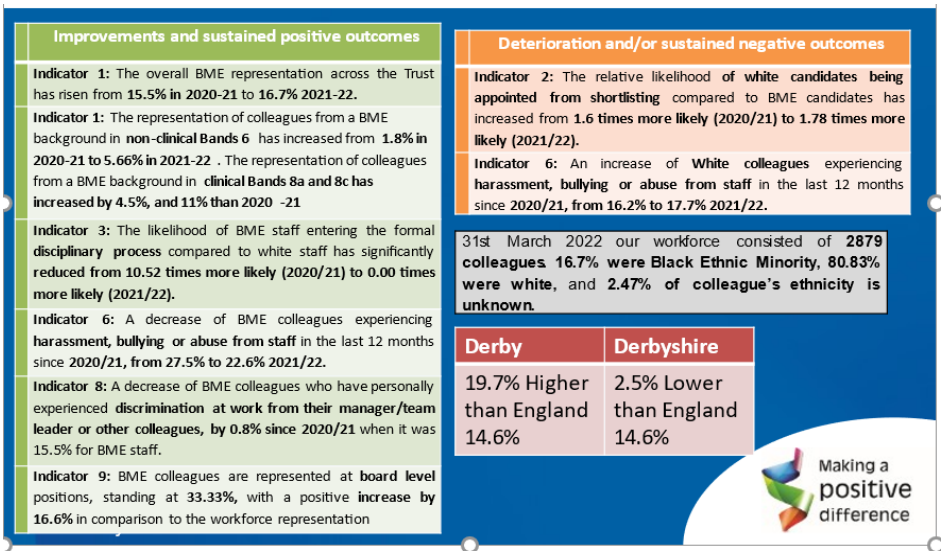
Behaviours and discrimination

- **Indicator 5** - bullying and harassment from the public
- **Indicator 6** - bullying and harassment from staff
- **Indicator 8** - experience of discrimination

Formal disciplinary processes

- **Indicator 3** - likelihood of entering the disciplinary process

The key headlines include:



Next steps include working with the relevant leads and BME Network to progress the action plan, this will require actions to be embedded into divisional people plans. To learn more about the WRES and the action plan, follow this link.

Workforce Disability Equality Standard (WDES)

The Workforce Disability Equality Standard (WDES) is an annual data collection exercise which highlights the experiences of disabled colleagues compared to their non-disabled counterparts within an organisation. The standard is a requirement for all NHS health care providers through the NHS standard contract.

The WDES requires organisations to demonstrate progress against the ten metrics specifically focused on disability equality and suggest actions to address gaps.

The data and statistics used in this report reflect Workforce indicators, NHS staff survey Indicators and a Board representation indicator.

The Workforce Disability Equality Standard (WDES) report provides an overview of the data from April 2020 to March 2021 and progress against the ten metrics of the WDES.

Our commitment as a Trust to improve the employee experience for colleagues with disabilities, the WDES will help foster a better understanding of the issues faced by disabled colleagues and the inequalities they experience and supports the Trust to take action to create an inclusive and diverse leadership, which is in line with Derbyshire Healthcare's mission to be 'positively inclusive'. It involves a continued approach to monitoring our attraction, recruitment and retention initiatives, eliminating unlawful discrimination, harassment and victimisation and to improve year-on-year the reported experience of Disabled colleagues. We will only then be a great place to work and a great place to be cared for.

Our Disability & Wellness Network (D.A.W.N) Staff Network continues to have executive sponsorship from the Director of People and OD. As a network, they have and will be instrumental in putting together the resulting action plan for 2022/23.

The WDES consists of 10 indicators which are themed in 3 areas below:

Representation, recruitment, and progression

- **Indicator 1:** Representation
- **Indicator 2:** Likelihood of appointment
- **Indicator 10:** Board voting membership
- **Indicator 5:** Fairness in career progression

Behaviours and discrimination

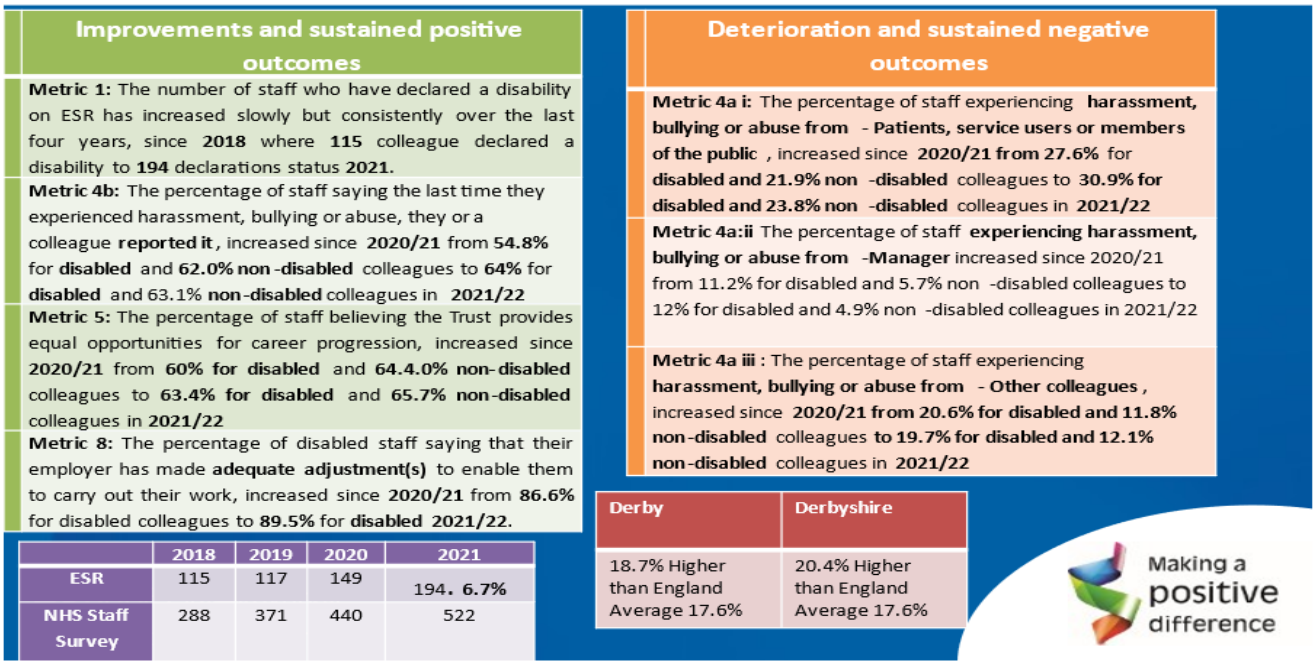
- **Indicator 4:** Bullying and harassment
- **Indicator 6:** Pressure to come into work

- **Indicator 7:** Feeling valued
- **Indicator 8:** Adequate adjustments
- **Indicator 9:** Colleague engagement

Formal capability processes

- **Indicator 3:** Likelihood of entering capability

The key headlines include:



Next steps include working with the relevant leads and D.A.W.N. network to progress the action plan, this will require actions to be embedded into divisional people plans. To learn more about the WDES and the action plan, follow this link.

Gender Pay Gap

The Gender Pay Gap is annual collection of data against six calculations an organisation is required to publish, which are listed in the table below:

Table 1: Gender Pay Gap reporting requirements.	
Mean gender pay gap	The difference between the average of men's and women's hourly pay.
Median gender pay gap	The difference between the midpoints in the ranges of men's and women's pay. All salaries in the sample are lined up separately for men and women in order from lowest to highest, and the middle salary is used. The figure is the difference of these two middle points.
Mean gender pay gap	The difference between the mean bonus payments made to relevant male employees and that paid to relevant female employees. For DHCFT this refers to local and national clinical excellence awards.
Median bonus gender pay gap	The difference between the median bonus payments made to relevant male employees and that paid to relevant female employees. For DHCFT this refers to local and national clinical excellence awards.
Proportion of males and females receiving a bonus.	The proportions of relevant male and female employees who were paid a bonus payment. For DHCFT this refers to local and national clinical excellence awards.
Proportion of males and females in each quartile band.	The proportions of male and female relevant employees in the lower, lower middle, upper middle and upper quartile pay bands.

We collected our data on 31st March 2022, when our workforce consisted of 2306 (18.10%) women, 573 (9.90%) men and 2879 in total.

In common with the whole NHS, our Trust is predominantly female. Given that over 80% of staff are women, it is also the case that women outnumber men at every quartile.

Table 2 below shows DHCFT's overall mean and median gender pay gap and bonus gap based on hourly rates of pay.

The table below shows an overview of our data, and the full report can read following this link.

Table 2: DHCFT Overall mean and median gender pay gap and bonus gap based on hourly rates of pay		
	DHCFT 2021	**DHCFT 2022**
Mean gender pay gap.	15.41%	16.51%
Median gender pay gap.	9.96%	10.39%
Mean bonus gender pay gap.	89.54%	87.62%
Median bonus gender pay gap.	88.93%	50.00%
Proportion of men and women receiving a bonus.	5.11%	4.20%
NB bonuses paid relate to clinical excellence awards which are for applicable consultants only rather than all employees (even though the calculation includes all staff)		
Proportion of females and males in each quartile band: DHCFT 2022		
Quartile	**Women**	**Men**
Top quartile	84.35%	15.65%
Upper Middle quartile	79.89%	20.11%
Lower Middle quartile	81.86%	18.14%
Lower quartile	71.94%	28.06%

Ethnicity Pay Gap

This year we also looked at the headline figures for the ethnicity pay gap EPG. The tables below show the mean and median EPG and the proportion of BME and

Ethnic Group	Average Hourly Rate	Median Hourly Rate
White	£17.87	£16.52
BME	£19.83	£15.44
Difference	-£1.96	£1.08
Pay Gap %	**-10.94%**	**6.53%**

Quartile	BME	White	BME %	White %
1	128	604	17.49	82.51
2	192	514	27.20	72.80
3	94	679	12.16	87.84
4	154	581	20.95	79.05

White staff in each quartile band as at March 2022. We plan to have a more detailed analysis next year

Appendix 1: Patient Equality Data

- **Patient Demographics (IAPT, PARIS, SystemOne) as of 31 March 2022**

The following tables show the available demographic information relating to patients open to the Trust as of March 2022 and is only intended as a general guide. The reporting categories between our electronic patient record systems (PARIS, SystemOne and IAPT), are different and when grouped, may not capture all of the information on our patients' demographics accurately at this high level.

Religion	%
Baha'i	0.00%
Buddhist	0.11%
Christian	13.23%
Declines to Disclose	0.12%
Hindu	0.26%
Invalid	0.30%
Jain	0.00%
Jewish	0.02%
Muslim	2.95%
None	3.59%
None - Atheist	0.19%
Not Stated	0.02%
Other	1.11%
Pagan	0.11%
Sikh	0.70%
Unknown	77.27%
Grand Total	**100.00%**

Ethnicity	%
Asian or Asian British - Any other Asian background	1.92%
Asian or Asian British - Bangladeshi	0.25%
Asian or Asian British - Indian	3.69%
Asian or Asian British - Pakistani	7.40%
Black or Black British - African	1.78%
Black or Black British - Any other Black background	0.65%
Black or Black British - Caribbean	0.46%
Mixed - Any other mixed background	1.30%

Mixed - White and Asian	1.13%
Mixed - White and Black African	0.70%
Mixed - White and Black Caribbean	1.91%
Not Known	3.62%
Not stated	2.43%
Other Ethnic Groups - Any other ethnic group	16.77%
Other Ethnic Groups - Chinese	0.33%
White - Any other White background	5.07%
White - British	50.40%
White - Irish	0.19%
Grand Total	**100.00%**

Marital Status	%
Divorced/Partnership Dissolved	0.85%
Divorced/Person whose Civil Partnership has been dissolved	0.17%
Invalid	0.00%
Married/Civil Partner	8.01%
Not Applicable	0.01%
Not disclosed	9.40%
Not Known	0.29%
Separated	0.53%
Single	33.10%
Unknown	46.77%
Widowed/Surviving	0.84%
Widowed/Surviving Civil Partner	0.04%
Grand Total	**100.00%**

Sexual Orientation	%
Bisexual	0.35%
Bi-Sexual	0.04%
Female homosexual	0.01%
Gay Or Lesbian	0.04%
Heterosexual	9.98%
Heterosexual Or straight	0.97%
Homosexual	0.05%
Homosexuality (& [lesbianism])	0.00%
Homosexuality NOS	0.04%
Lesbian or gay	0.16%
Male homosexual	0.01%
Not Appropriate to Ask	0.09%
Not Stated (declined)	0.05%
Other	0.09%
Other Sexual Ori Not Listed	0.01%
Patient unsure	0.06%
Person Asked and Does Not Know	0.03%
Person declined to disclose	0.17%
Sexual orientation not given - patient refused	0.31%
Sexual orientation unknown	0.10%

Unknown	87.45%
Grand Total	**100.00%**

Gender	%
Female	52.79%
Indeterminate	0.01%
Male	47.17%
Non-Binary	0.00%
Not Known	0.00%
Not specified	0.03%
Grand Total	**100.00%**

Disabled	%
No	96.98%
Yes	3.02%
Grand Total	**100.00%**

Appendix 1: Patient Equality Data

- **Interpretation and translations data**

Below is a list of the translation and interpretation services used from 1 April 2021 to 31 March 2022 across the Trust's services.

- **Face to Face Interpretation**

Total amount spent: 2021-22 = £62,782

Derby Healthcare NHS Foundation Trust: £42,391

Derby Healthcare FT – CCG Children's: £20,227

2,627 requests in the period FY 2021-22

Derby Healthcare NHS Foundation Trust: 1,595

Derby Healthcare FT – CCG Children's: 1,032

Language	Jobs
Slovak	533
Urdu	285
British Sign	274
Arabic (Modern Standard)	161
Czech	157
Polish	267
Kurdish (Sorani)	157
Punjabi, Eastern (India)	135
Romanian	119
Punjabi, Western (Pakistan)	81
Farsi	67
Vietnamese	39
Portuguese	37
Arabic (Classical/North African)	28
Russian	27
Latvian	24
Bengali	25
Mandarin	24

Cantonese	23
Spanish	15
Turkish	14
Hindi	11
Italian	11
French	10
Hungarian	9
Tamil	9
Albanian	8
Mirpuri	8
Lithuanian	7
Tigrinya	7
Kurdish (Kurmanji)	6
Indonesian	5
Japanese	5
Sudanese Arabic	5
Pashto (Afghanistan)	4
Amharic	3
Pashto (Pakistan)	3
Roma	3
Swahili	3
Albanian (Kosovo)	2
Bosnian	2
Oromo (Central)	2
Sylheti	2
Aramaic	1
Bahasa Indonesian	1
Bulgarian	1
Deafblind (BSL Hands on/hand-under-hand)	1
English (Pidgin)	1
Filipino	1
German	1
Greek	1
Portuguese (Brazil)	1
Potowari (Pahari)	1

- **Telephone interpretation**

Total amount spent: 2021-22 = £155

Languages Used below	**Number of bookings**
	2021-22 = 18

Language	**Count**

Chinese Mandarin	6
Polish	2
Punjabi	2
Arabic (Sudanese)	1
Hindi	1
Latvian	1
Lithuanian	1
Mandarin	1
Romanian	1
Russian	1
Urdu	1

- **Document translation**

Total amount spent: 2021-22 = £6,003

Derby Healthcare NHS Foundation Trust: £5,827

Derby Healthcare FT – CCG Children's: £176

109 Requests in the period FY 2021-22

Derby Healthcare NHS Foundation Trust: 106

Derby Healthcare FT – CCG Children's: 3

Language	Requests
Slovak (Slovakia)	36
Polish (Poland)	17
Urdu	16
Latvian (Latvia)	6
Punjabi (India)	4
Arabic Modern Standard	10
Chinese (Simplified)	3
Czech (Czech Republic)	3
French (France)	2
Kurdish (Sorani)	2
Romanian (Romania)	2
Arabic Classical	1
Swahili	2
Hungarian (Hungary)	1
Pashto (Afghanistan)	1
Punjabi (Pakistan)	1
Portuguese (Portugal)	1
Turkish (Turkey)	1

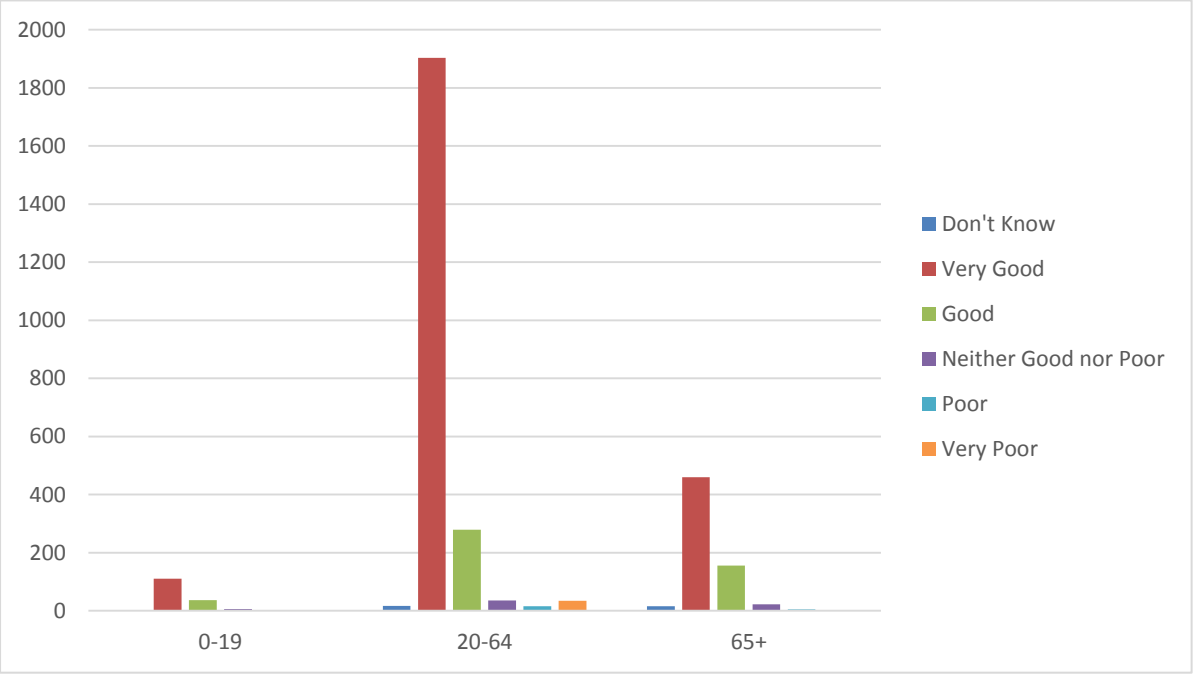
- **Face to face interpretation**

	2021-22
Average bookings per month	218
Average length of time of booking (mins)	45
Average fulfilment rate	94%
Average cost spent per month	£5,231
Total spend	£62,782

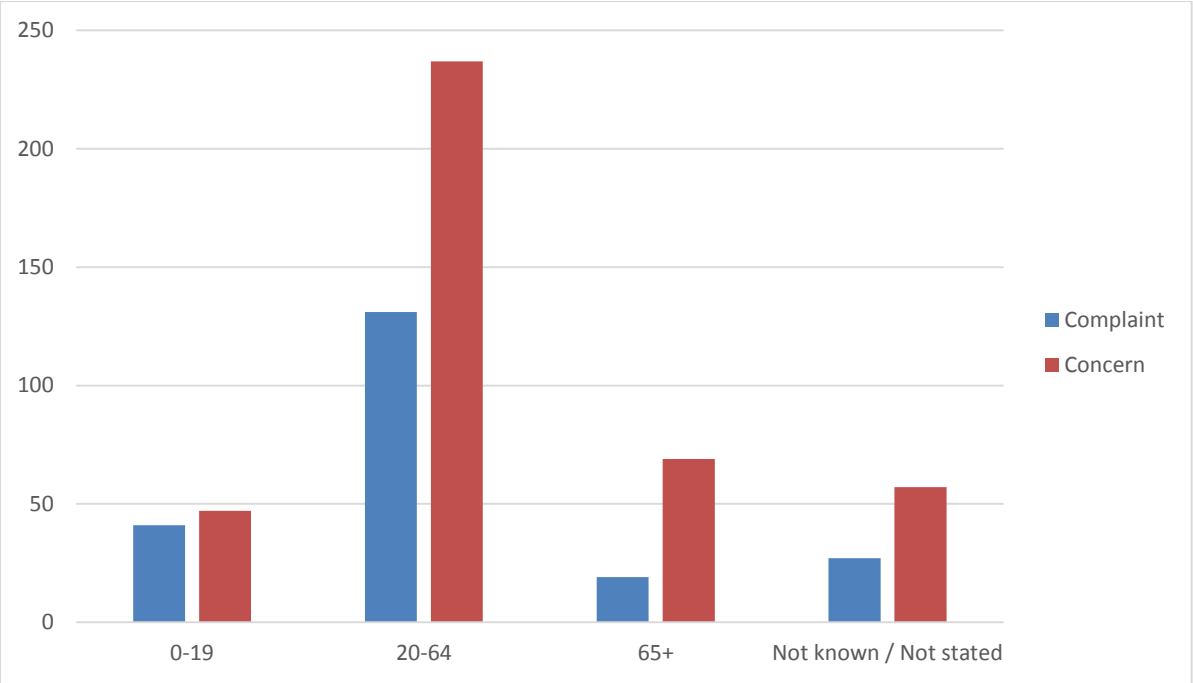
Appendix 1: Patient Equality Data

- **Patient Experience data (Reporting period 1 April 2021 – 31 March 2022)**

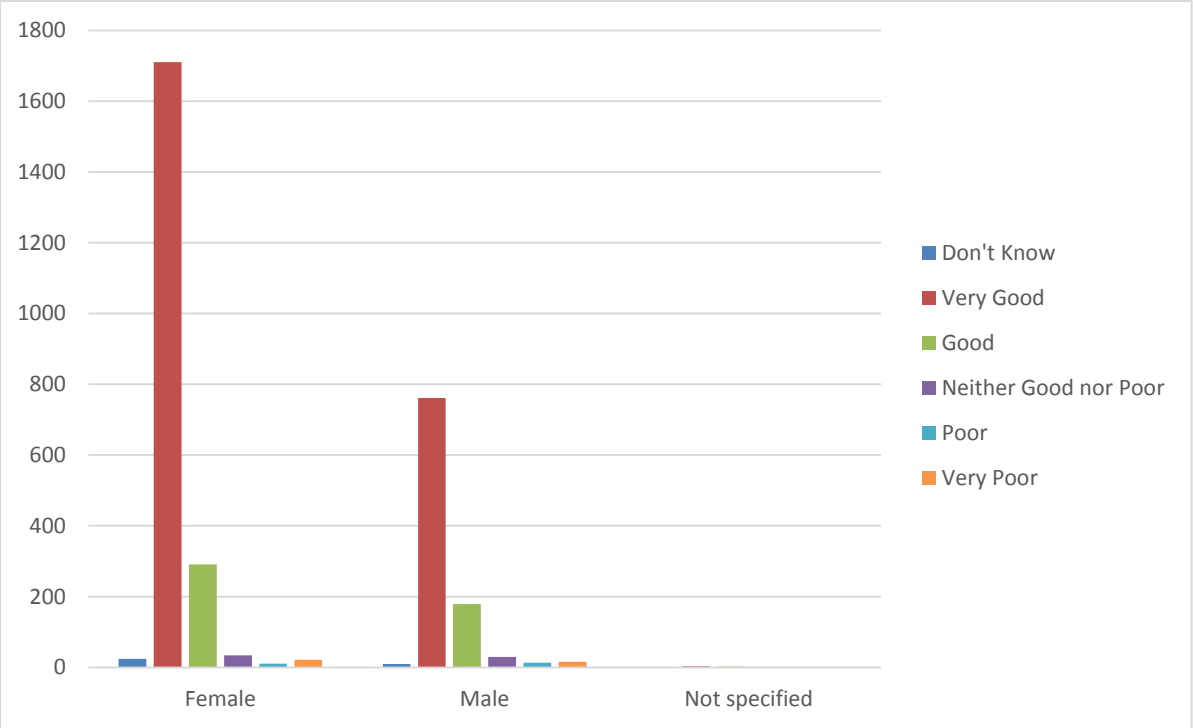
1. Age Profile of Friends and Family Test results



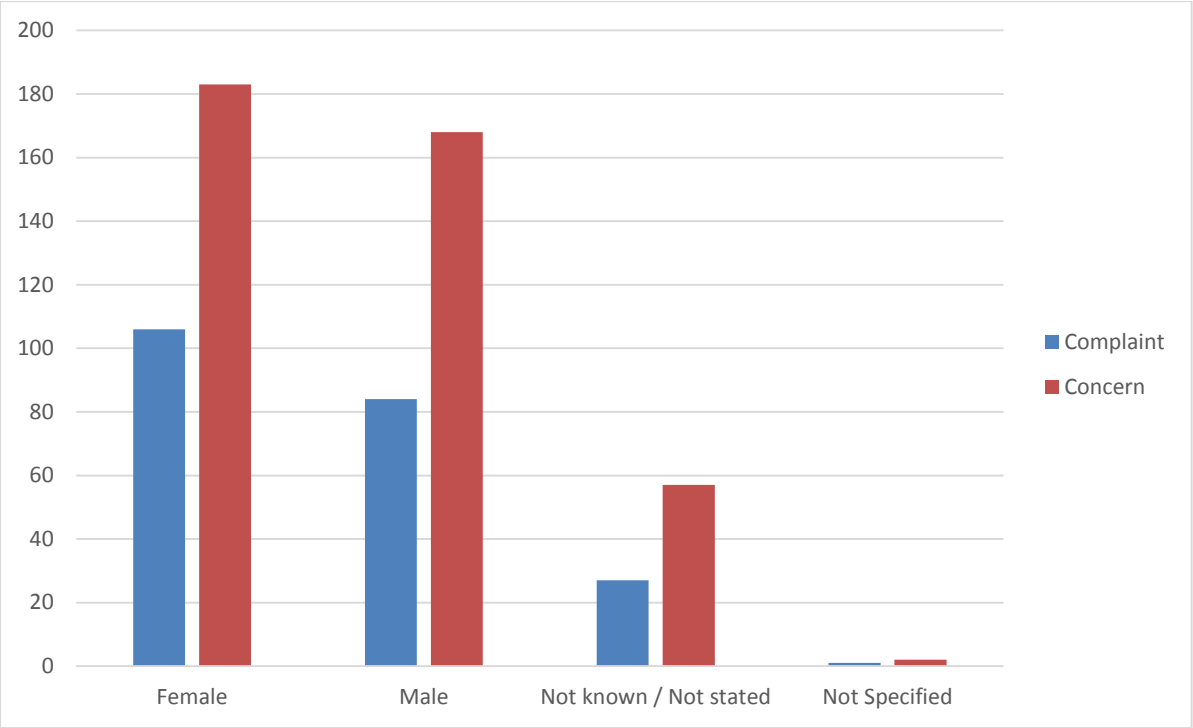
2. Age Profile of Patients/Service Users involved in concerns/complaints



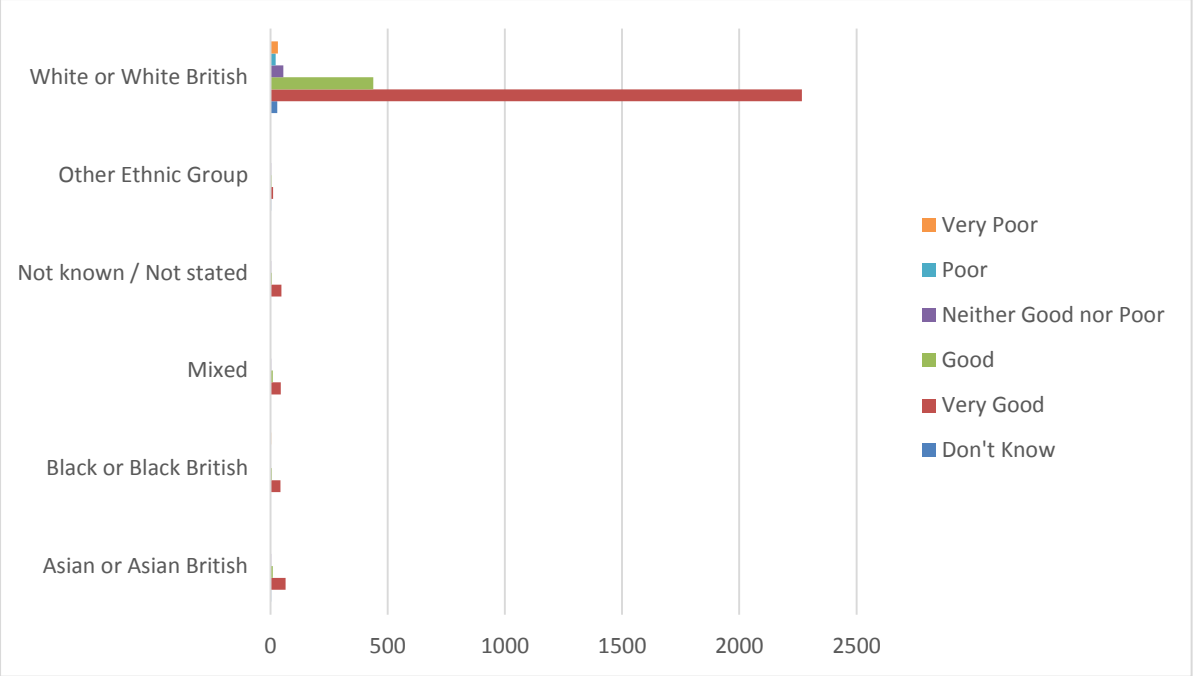
3. Gender Profile of Friends and Family Test results



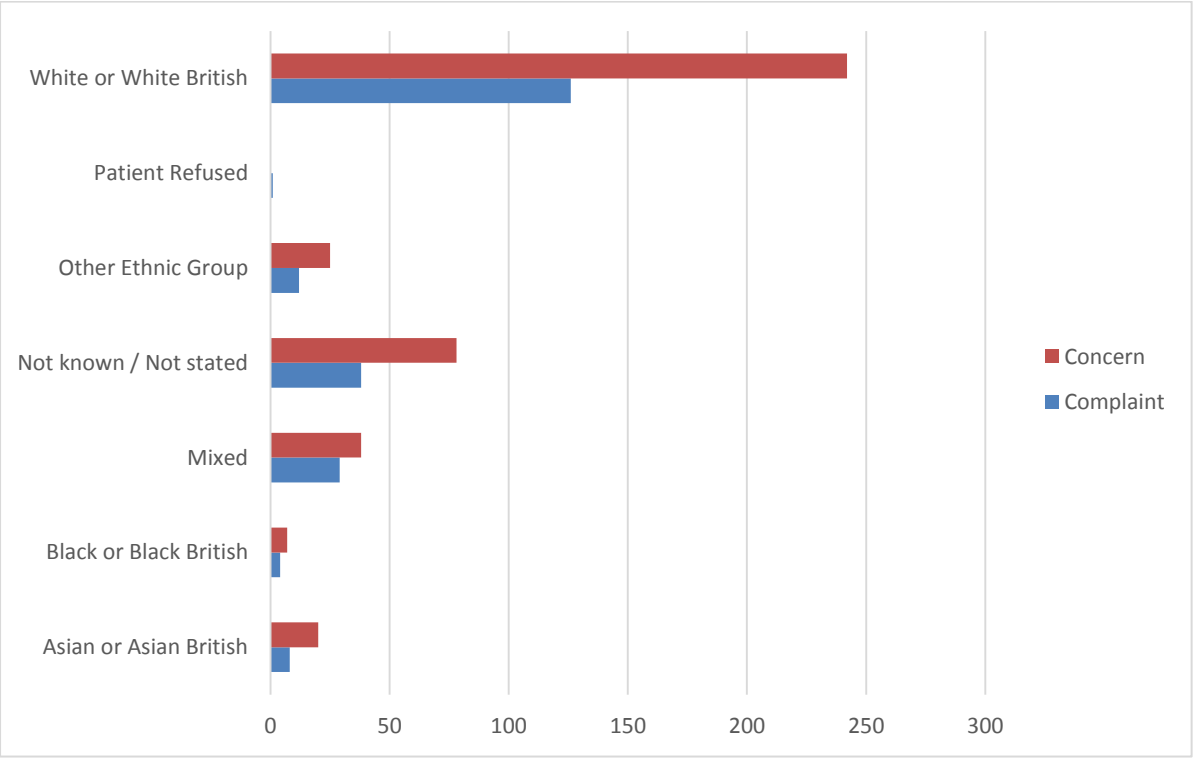
4. Gender Profile of Patients/Service Users involved in concerns or complaints


200
180
160
140
120
100
80
60
40
20
0
Female
Male
Not known / Not stated
Not Specified
Complaint
Concern

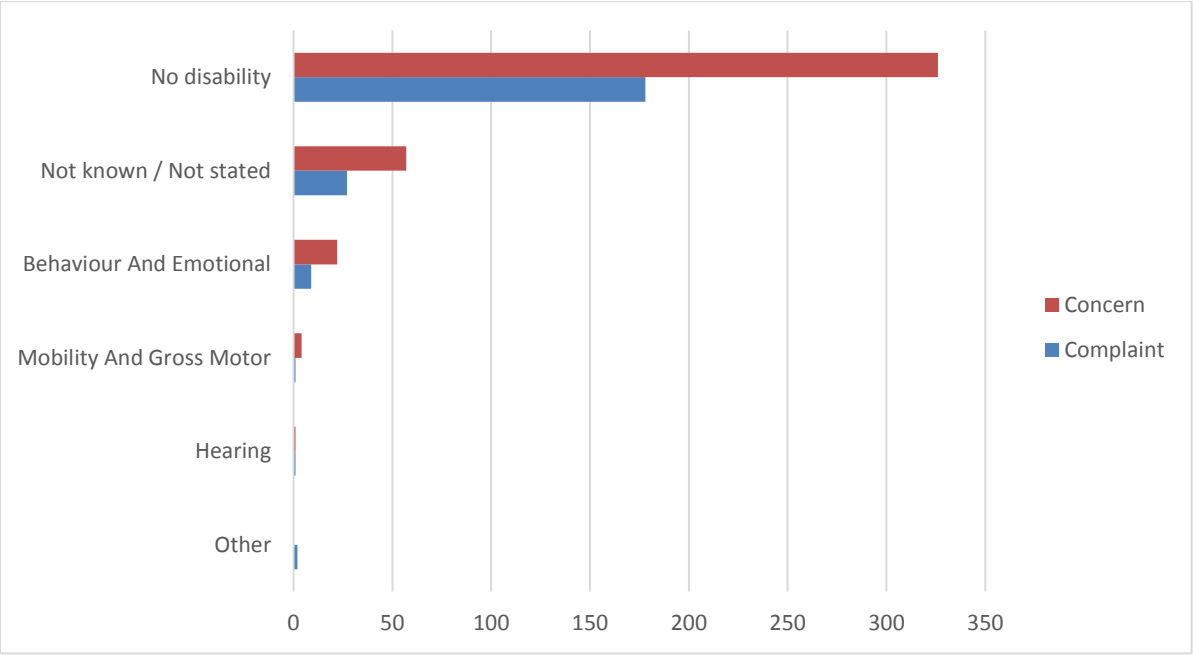
5. Ethnicity Profile of Friends and Family Test results



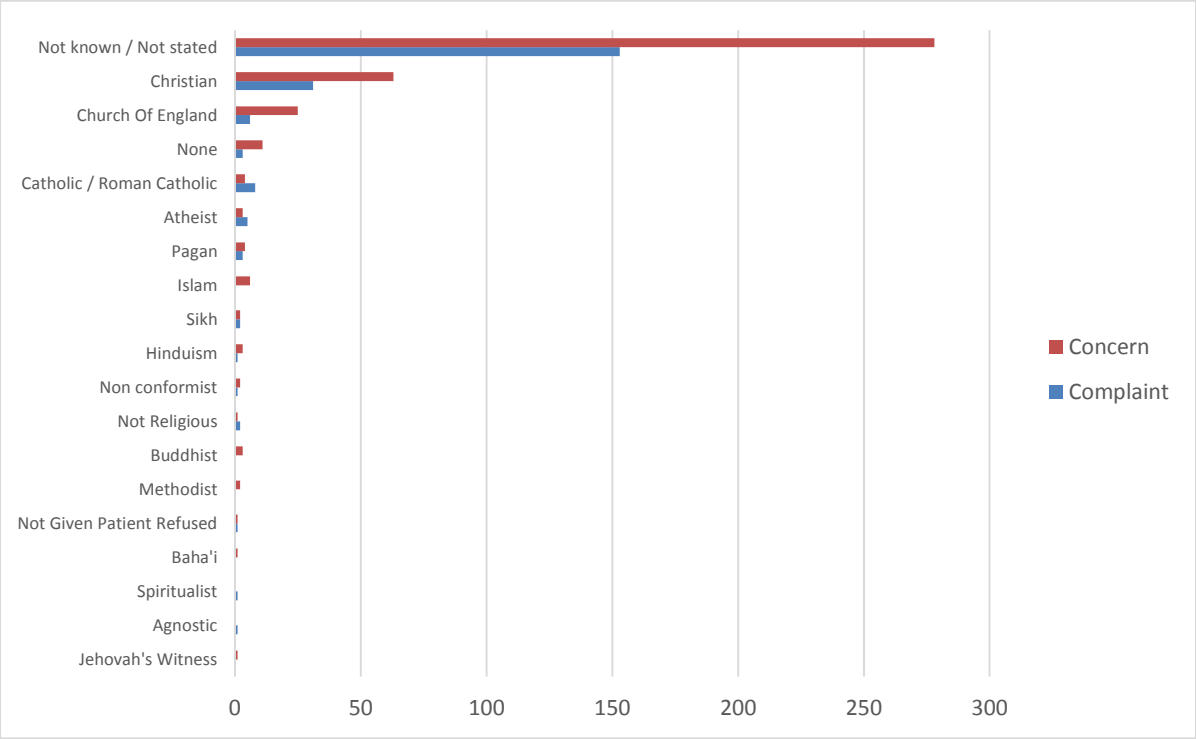
6. Ethnicity Profile of Patients/Service Users involved in concerns or complaints



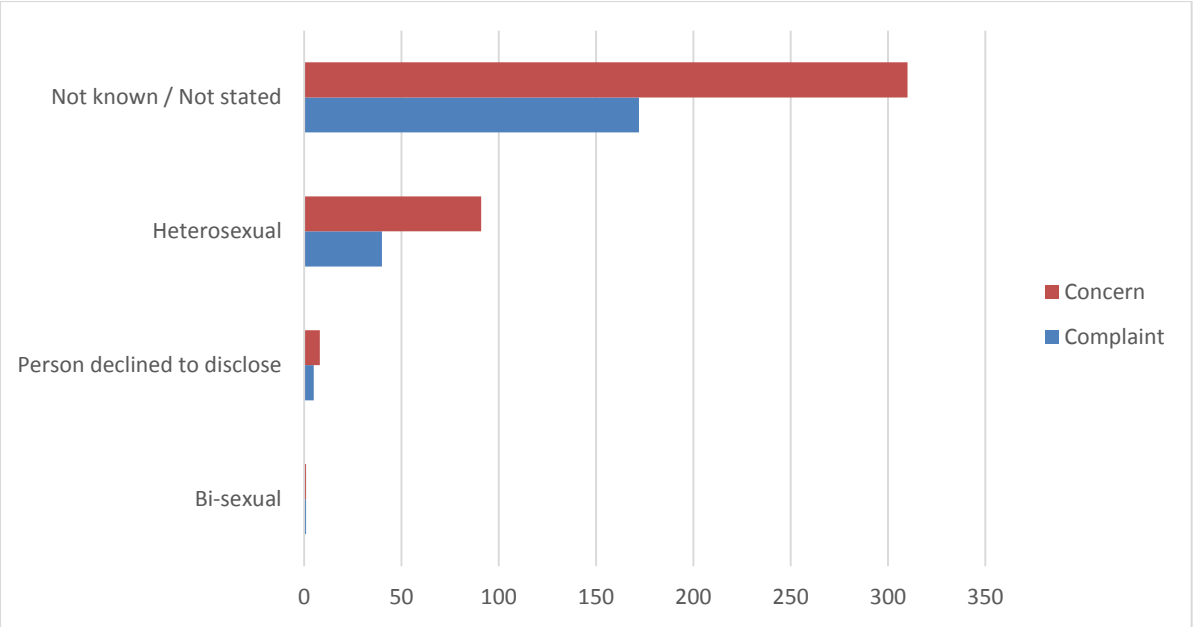
7. Disability Profile of Patients/Service Users involved in Concerns or Complaints



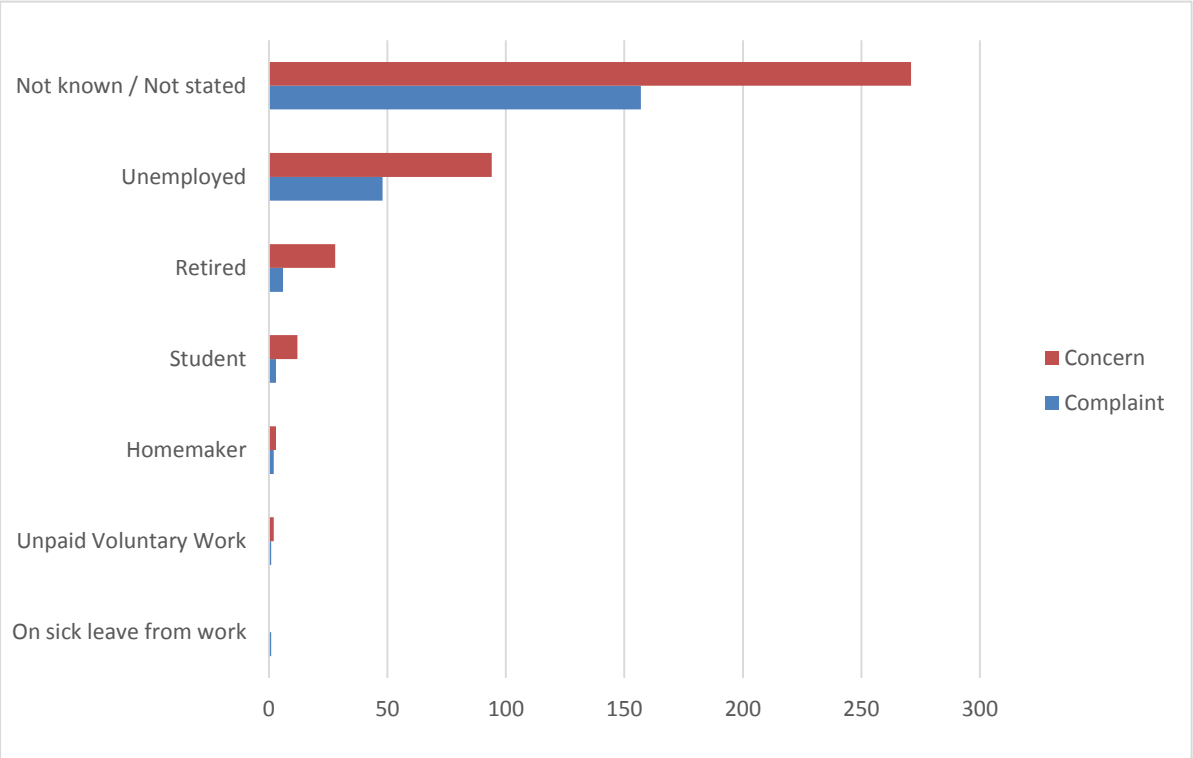
8. Religion or Belief Profile of Patients/Service Users involved in concerns or complaints



9. Sexual Orientation Profile of Patients/Service Users involved in concerns or complaints



10. Economic disadvantage Profile of Patients/Service Users involved in concerns or complaints



Appendix 2: Workforce Equality Data

The table below provides a snapshot of our workforce profile as of March 2022. For our full workforce report please follow this link.

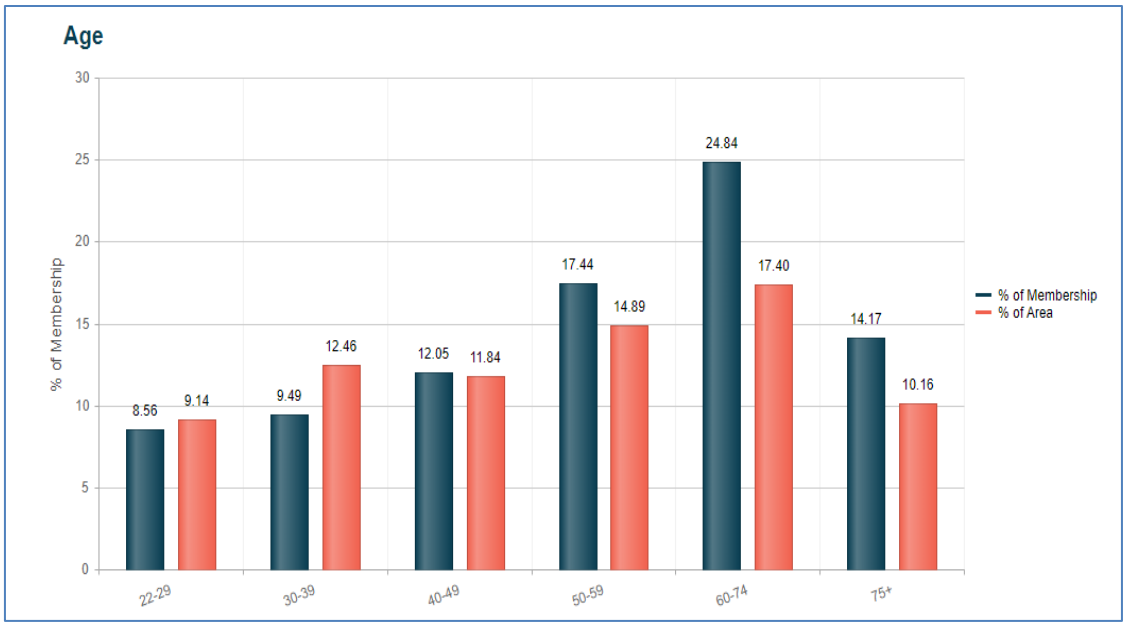
	Headcount	FTE	Workforce %
Employees	2879	2514.95	-
Ethnicity			
White	**2327**	**2017.46**	**80.83%**
White - British	2212	1916.12	76.83%
White - Irish	27	21.66	0.94%
White - Any other White background	59	53.13	2.05%
White Northern Irish	3	2.67	0.10%
White Unspecified	19	17.28	0.66%
White English	4	3.6	0.14%
White Gypsy/Romany	1	1	0.03%
White Other European	2	2	0.07%
Mixed Race	**65**	**58.13**	**2.26%**
Mixed - White & Black Caribbean	28	25.13	0.97%
Mixed - White & Black African	4	3.48	0.14%
Mixed - White & Asian	19	16.82	0.66%
Mixed - Any other mixed background	14	12.7	0.49%
Asian or Asian British	**226**	**202.88**	**7.85%**
Asian or Asian British - Indian	147	132.48	5.11%
Asian or Asian British - Pakistani	60	54.18	2.08%
Asian or Asian British - Bangladeshi	4	2.73	0.14%
Asian or Asian British - Any other Asian background	11	10.25	0.38%
Asian Punjabi	3	2.24	0.10%
Asian Tami	1	1	0.03%
Black or Black British	**169**	**156.77**	**5.87%**
Black or Black British - Caribbean	59	53.19	2.05%
Black or Black British - African	98	92.71	3.40%
Black or Black British - Any other Black background	9	8.67	0.31%
Black Nigerian	1	0.8	0.03%
Black British	2	1.4	0.07%
Other Ethnic Backgrounds	**21**	**19.14**	**0.73%**
Chinese	5	4.75	0.17%
Any Other Ethnic Group	14	12.39	0.49%
Vietnamese	1	1	0.03%
Filipino	1	1	0.03%
Not Stated	**71**	**60.56**	**2.47%**
Total BME 16.7%			

	Headcount	FTE	Workforce %
Trust Employees	2879	2514.95	-
Gender			
Female	2306	1984.15	80.10%
Male	573	530.8	19.90%
Religious Belief			
Atheism	474	423.69	16.46%
Buddhism	19	17.03	0.66%
Christianity	1166	1014.52	40.50%
Hinduism	32	29.46	1.11%
Not stated	726	617.71	25.22%
Islam	70	62.93	2.43%
Jainism	2	2	0.07%
Judaism	6	5.8	0.21%
Other	326	292.5	11.32%
Sikhism	58	49.31	2.01%
Sexual Orientation			
Lesbian, Gay & Bisexual	104	96.62	3.61%
Heterosexual or straight	2196	1930.24	76.28%
Undecided	4	3.6	0.14%
Other not listed	2	1.8	0.07%
Not Stated	573	482.68	19.90%
Disability			
Yes	194	171.38	6.74%
No	2081	1837.99	72.28%
Prefer not to Answer	3	2.05	0.10%
Not Declared	601	503.52	20.88%
Age			
16-20	3	2.44	0.10%
21-30	413	390.33	14.35%
31-40	658	569.44	22.86%
41-50	796	706.13	27.65%
51-60	782	674.25	27.16%
61-70	216	165.01	7.50%
71 & above	11	7.35	0.38%
Marriage & Civil Partnership			
Married & Civil Partnership	1498	1272.13	52.03%
Other	1237	1117.41	42.97%
Not stated	144	125.41	5.00%

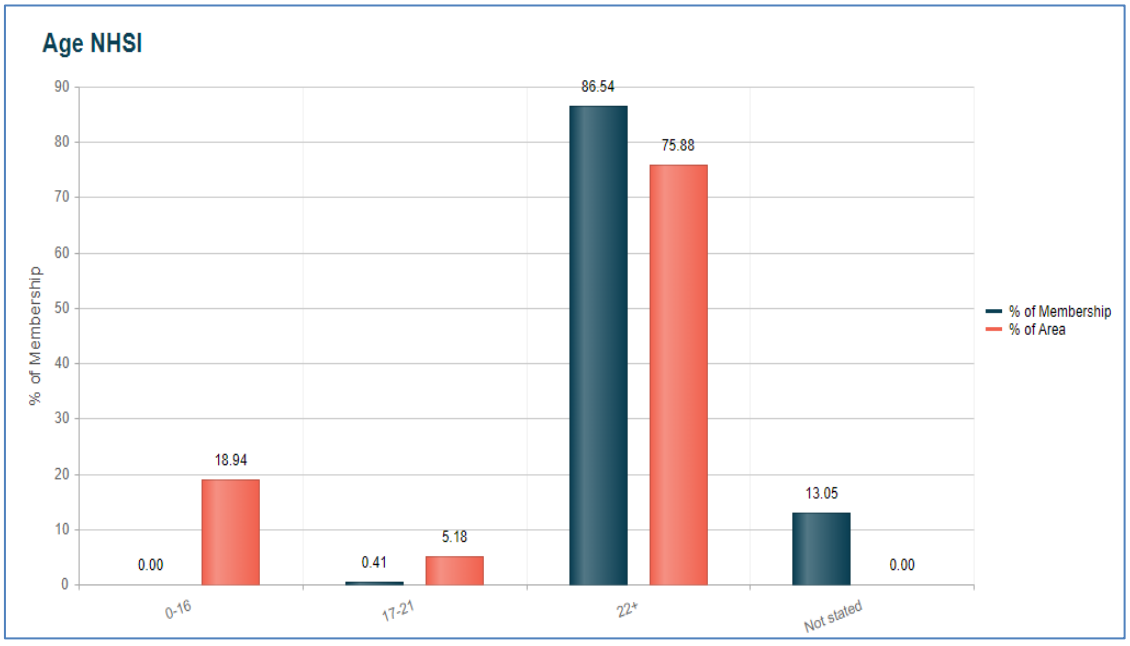
Appendix 3: Membership data

As of 31 March 2022, the Trust had **5,786 public members** who have chosen to join the Trust as a member.

Age



Note the following graph which denotes members aged between 17 and 21:

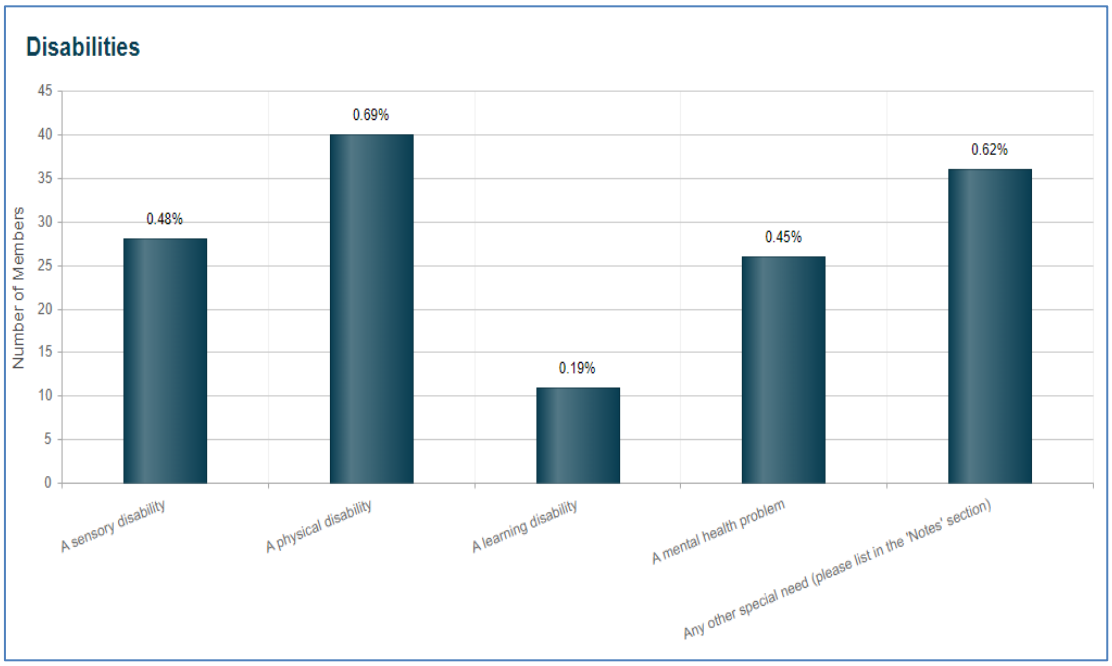


The table below shows how many members we have for each age category:

	Public	% of Membership	Base	% of Area
Age	**5,786**	**100.00**	**1,074,436**	**100.00**
0-16	0	0.00	203,499	18.94
17-21	24	0.41	55,692	5.18
22+	5,007	86.54	815,245	75.88
Not stated	755	13.05	0	0.00
Age	**5,007**	**86.54**	**815,245**	**75.88**
22-29	495	8.56	98,199	9.14
30-39	549	9.49	133,832	12.46
40-49	696	12.03	127,160	11.84
50-59	1,009	17.44	159,951	14.89
60-74	1,438	24.85	186,908	17.40
75+	820	14.17	109,195	10.16

Note: anyone over the age of 16 years is welcome to become a member of the Trust.

Disability



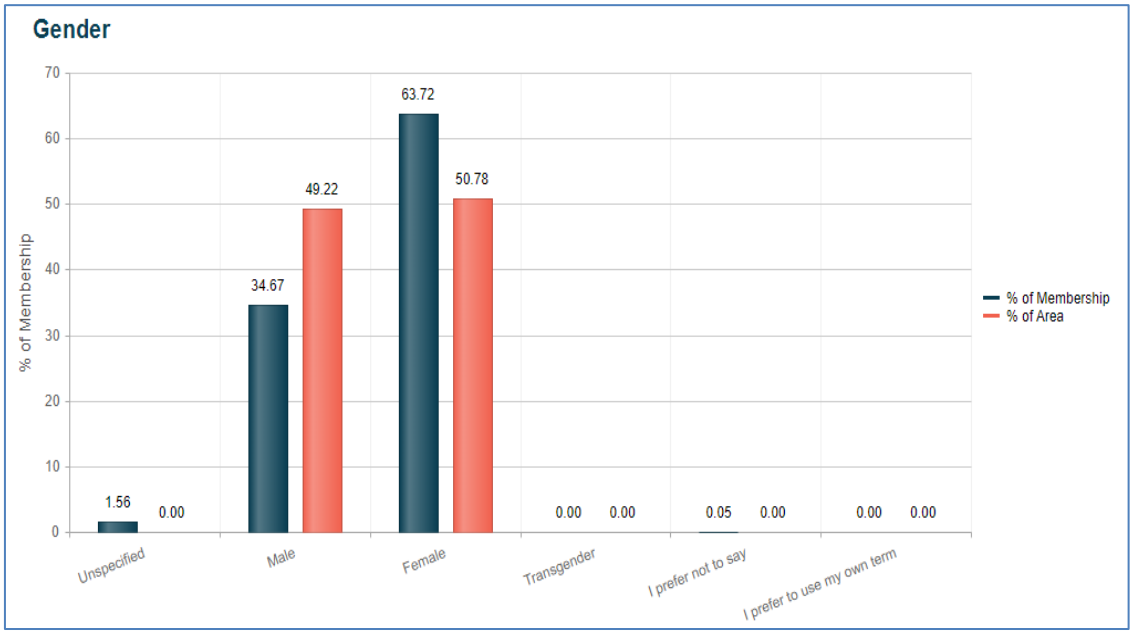
Disabilities	Number of Members	Percentage of Members

A sensory disability	28	0.48
A physical disability	40	0.69
A learning disability	11	0.19
A mental health problem	26	0.45
Any other special need (please list in the 'Notes' section)	36	0.62

Gender re-assignment

The Trust does not collect data on gender re-assignment from its membership.

Gender



Gender	Number of Members	Percentage of Members
Unspecified	90	1.56
Male	2,006	34.67
Female	3,687	63.72
I prefer not to say	3	0.05

NB. The Trust reviewed and updated the data it collects for gender – and since the beginning of January 2019 now includes: 'Transgender' and 'I prefer to use my own term'.

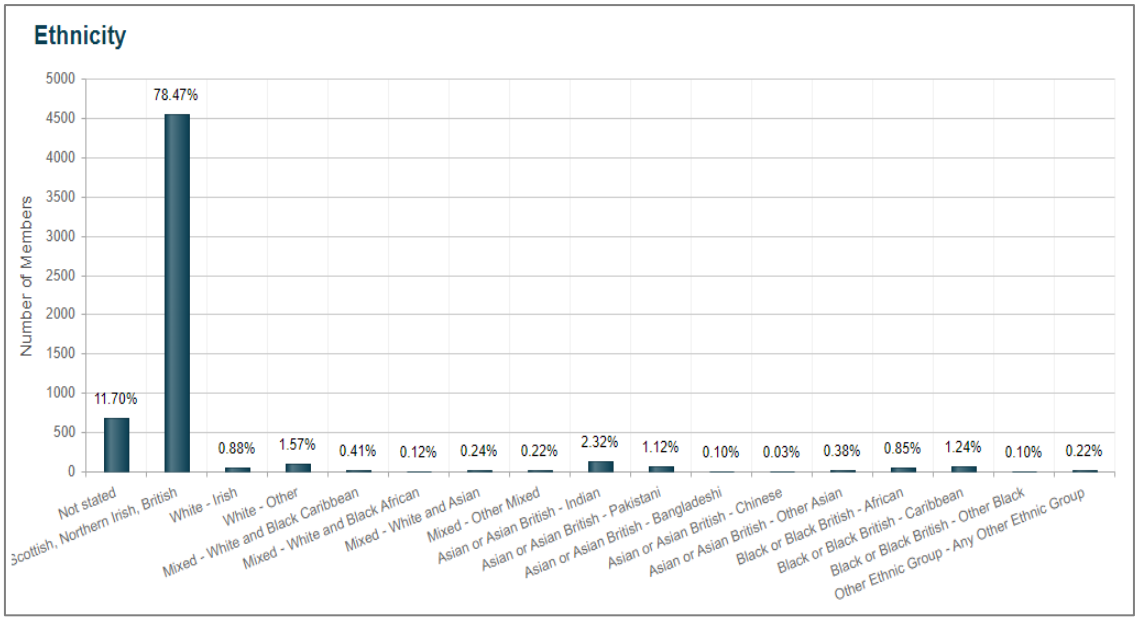
Marriage and civil partnership

Data on this protected characteristic is not collected for membership.

Pregnancy and maternity

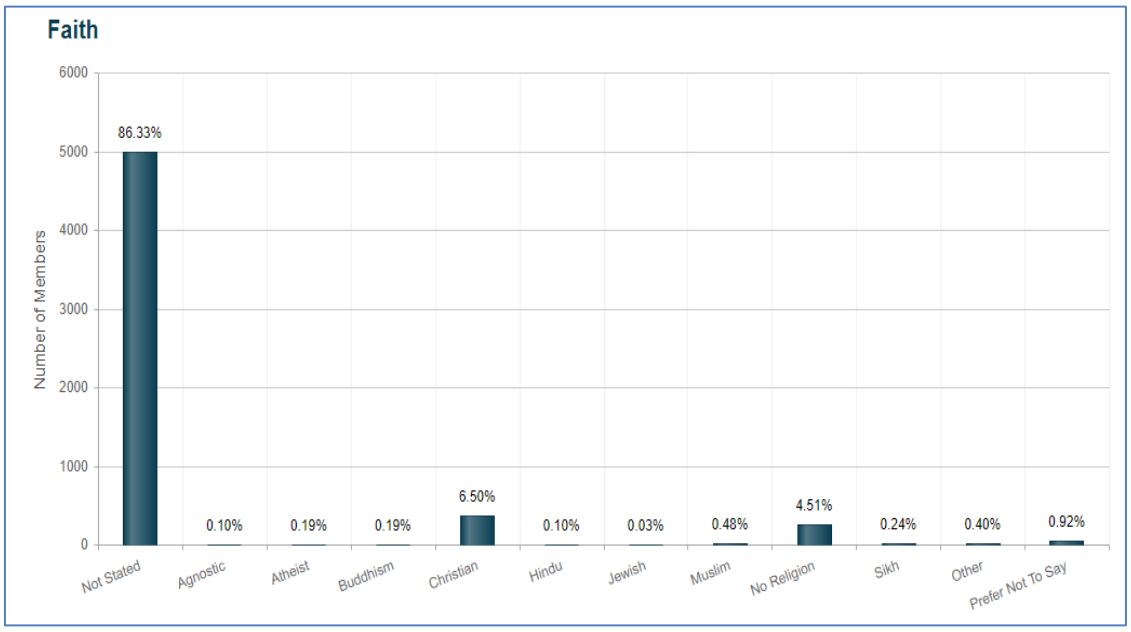
Data on this protected characteristic is not collected for membership.

Race



Ethnicity	Number of Members	Percentage of Members
Not stated	677	11.70
White - English, Welsh, Scottish, Northern Irish, British	4,540	78.47
White - Irish	51	0.88
White - Other	91	1.57
Mixed - White and Black Caribbean	24	0.41
Mixed - White and Black African	7	0.12
Mixed - White and Asian	14	0.24
Mixed - Other Mixed	13	0.22
Asian or Asian British - Indian	134	2.32
Asian or Asian British - Pakistani	65	1.12
Asian or Asian British - Bangladeshi	6	0.10
Asian or Asian British - Chinese	2	0.03
Asian or Asian British - Other Asian	22	0.38
Black or Black British - African	49	0.85
Black or Black British - Caribbean	72	1.24
Black or Black British - Other Black	6	0.10
Other Ethnic Group - Any Other Ethnic Group	13	0.22

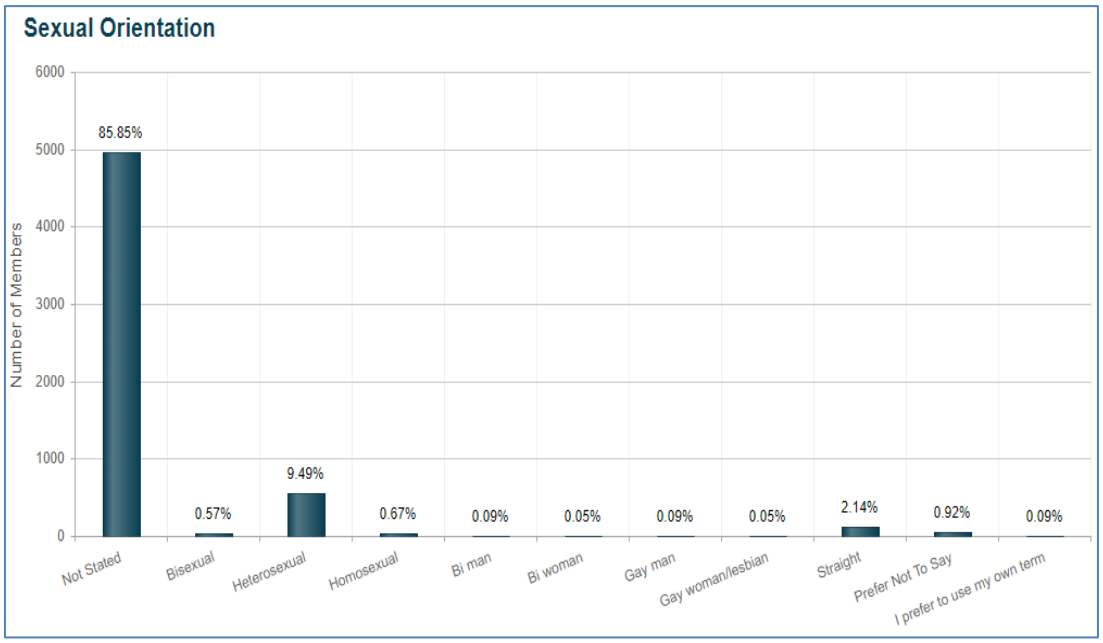
Religion and belief



Faith	Number of Members	Percentage of Members
Not Stated	4,995	86.33
Agnostic	6	0.10
Atheist	11	0.19
Buddhism	11	0.19
Christian	376	6.50
Hindu	6	0.10
Jewish	2	0.03
Muslim	28	0.48
No Religion	261	4.51
Sikh	14	0.24
Other	23	0.40
Prefer Not to Say	53	0.92

NB. The Trust reviewed and updated the data it collects for faith – and since the beginning of January 2019 now includes: ‘agnostic’, ‘atheist’ and ‘pagan’.

Sexual orientation



Sexual Orientation	Number of Members	Percentage of Members
Not Stated	4,967	85.85
Bisexual	33	0.57
Heterosexual	549	9.49
Homosexual	39	0.67
Bi man	5	0.09
Bi woman	3	0.05
Gay man	5	0.09
Gay woman/lesbian	3	0.05
Straight	124	2.14
Prefer Not to Say	53	0.92
I prefer to use my own term	5	0.09

NB. Prior to January 2019, the Trust collected the following data on sexual orientation: heterosexual, homosexual, bisexual, prefer not to say. The Trust reviewed and updated the data it collects on its membership form and since the beginning of January 2019 collects data on bi man, bi woman, gay man, gay woman/lesbian, straight, I prefer to use my own term, and I prefer not to say. This could explain the high percentage of members who have not stated their sexual orientation.

Derbyshire Healthcare
NHS Foundation Trust

Equality, Diversity, and Inclusion

Workforce Monitoring Information Report

Data: April 2021-March 2022

Public Sector Equality Duty

March 2023

Contents

Introduction

Derbyshire Healthcare NHS Foundation Trust (DHCFT) is an NHS anchor institution and strive to be reflective of the population we serve, to better understand our communities and address inequalities. As part of the requirement of the PSED, organisations with over 150 employees are required to annually publish information relating to their employees. Our understanding of who are our colleagues are important so that we can seek to further understand the experience of different groups of colleagues and identify areas where we can improve colleague experience.

A high-level summary is outlined in this report which will be followed by the full report, providing an overview for the organisation and a breakdown by staff groups and service area and based on colleagues who have joined us, remained with us, and left us during 2021/2022.

You can find more information, including metrics specific to colleague experience, in our other annual reports which are published each year on our website.

- Workforce Disability Equality Standard
- Workforce Race Equality Standard
- Gender Pay Gap

Key Workforce Facts

This Workforce Monitoring Information Report is for the period April 2021 to March 2022 and has been produced to provide an analysis of our workforce by protected characteristics:

- Race
- Disability
- Gender
- Age
- Sexual orientation
- Religion or belief
- Marriage and Civil partnerships
- Gender identity
- Pregnancy and maternity

BME is an acronym (Black, and Minority Ethnic) used in this report to refer to all ethnic groups except White British as this is a required monitoring terminology for this statutory reporting. The acronym, however, can be problematic because it offers an assumption that all non-white people exist as a homogeneous group without appreciation of the uniqueness of individual ethnicities. We acknowledge that these homogenising terms do not help in the quest to root out systemic racism.

Headcount

As of March 2022, DHCFT, employed 2879 colleagues and. Our approach is to review and monitor workforce data through our internal reporting mechanisms.

High level Summary

2.1 AGE

LARGEST AGE GROUP			
TRUST OVERALL	**51-55**	**TRUST OVERALL**	**51-55**
SERVICES		**STAFF GROUP**	
Adult Care Acute	46-50	Add Prof Scientific and Technic	46-55
Adult Care Community	46-50	Additional Clinical Services	51-55
Children's Services	51-55	Administrative and Clerical	51-55
Clinical Services Management	46-50	Allied Health Professionals	36-40
Forensic & Mental Health Rehab	51-55	Estates and Ancillary	51-55
Neuro Developmental	36-40	Medical and Dental	46-50
Older Peoples Care	46-55	Nursing and Midwifery Registered	46-50
Performance Delivery Clustering		Students	41-45

Psychology	36-40		
Specialist Care Services	46-50		
Corporate	51-55		

2.2 DISABILITY

DISABLED: % DECLARED			
TRUST OVERALL	**6.74%**	**TRUST OVERALL**	**6.74%**
SERVICES		**STAFF GROUP**	
Adult Care Acute	6.05%	Add Prof Scientific and Technic	7.53%
Adult Care Community	6.08%	Additional Clinical Services	6.22%
Children's Services	5.80%	Administrative and Clerical	7.42%
Clinical Services Management	7.14%	Allied Health Professionals	9.85%
Forensic & Mental Health Rehab	5.67%	Estates and Ancillary	3.50%
Neuro Developmental	9.01%	Medical and Dental	2.14%
Older Peoples Care	8.41%	Nursing and Midwifery Registered	6.85%
Performance Delivery Clustering		Students	6.67%
Psychology	5.66%		
Specialist Care Services	9.50%		
Corporate	6.29%		

2.3 ETHNICITY * *Data presented based on majority group*

ETHNICITY: % WHITE*			
TRUST OVERALL	**80.83%**	**TRUST OVERALL**	**80.83%**
SERVICES		**STAFF GROUP**	
Adult Care Acute	76.61%	Add Prof Scientific and Technic	82.85%
Adult Care Community	84.81%	Additional Clinical Services	75.54%
Children's Services	86.96%	Administrative and Clerical	89.04%
Clinical Services Management	85.71%	Allied Health Professionals	88.18%
Forensic & Mental Health Rehab	61.70%	Estates and Ancillary	62.94%
Neuro Developmental	84.68%	Medical and Dental	39.29%
Older Peoples Care	84.38%	Nursing and Midwifery Registered	84.79%
Performance Delivery Clustering		Students	73.33%
Psychology	91.51%		
Specialist Care Services	83.71%		
Corporate	74.29%		

2.4 RELIGON AND BELIEF ** Data presented based on majority group*

RELIGON: % CHRISTIANITY*			
TRUST OVERALL	**40.50%**	**TRUST OVERALL**	**40.50%**
SERVICES		**STAFF GROUP**	
Adult Care Acute	38.31%	Add Prof Scientific and Technic	35.98%
Adult Care Community	35.64%	Additional Clinical Services	38.41%
Children's Services	46.38%	Administrative and Clerical	45.36%
Clinical Services Management	21.43%	Allied Health Professionals	43.35%
Forensic & Mental Health Rehab	41.84%	Estates and Ancillary	32.87%
Neuro Developmental	41.44%	Medical and Dental	24.29%
Older Peoples Care	45.91%	Nursing and Midwifery Registered	42.44%
Performance Delivery Clustering		Students	36.67%
Psychology	23.58%		
Specialist Care Services	42.99%		
Corporate	38.29%		

2.5 MARITAL STATUS

MARITAL STATUS: % MARRIED/CIVIL PARTNERSHIP			
TRUST OVERALL	**52.03%**	**TRUST OVERALL**	**52.03%**
SERVICES		**STAFF GROUP**	
Adult Care Acute	44.96%	Add Prof Scientific and Technic	54.39%
Adult Care Community	47.79%	Additional Clinical Services	46.78%
Children's Services	63.56%	Administrative and Clerical	55.48%
Clinical Services Management	78.57%	Allied Health Professionals	50.52%
Forensic & Mental Health Rehab	46.10%	Estates and Ancillary	48.95%
Neuro Developmental	50.45%	Medical and Dental	63.57%
Older Peoples Care	49.04%	Nursing and Midwifery Registered	51.36%
Performance Delivery Clustering		Students	43.33%
Psychology	52.83%		
Specialist Care Services	54.57%		
Corporate	53.52%		

2.6 SEXUAL ORIENTATION

SEXUAL ORIENTATION: %LGB+			
TRUST OVERALL	**3.61%**	**TRUST OVERALL**	
SERVICES		**STAFF GROUP**	
Adult Care Acute	4.44%	Add Prof Scientific and Technic	2.93%
Adult Care Community	5.52%	Additional Clinical Services	4.51%
Children's Services	2.07%	Administrative and Clerical	3.71%
Clinical Services Management	0%	Allied Health Professionals	2.96%
Forensic & Mental Health Rehab	1.42%	Estates and Ancillary	1.40%
Neuro Developmental	2.70%	Medical and Dental	0%
Older Peoples Care	6.49%	Nursing and Midwifery Registered	4.32%
Performance Delivery Clustering		Students	0%
Psychology	2.83%		
Specialist Care Services	1.35%		
Corporate	2.66%		

2.7 GENDER* *Data presented based on majority group*

GENDER: FEMALE*			
TRUST OVERALL	**80.10%**	**TRUST OVERALL**	**80.10%**
SERVICES		**STAFF GROUP**	
Adult Care Acute	76.81%	Add Prof Scientific and Technic	77.82%
Adult Care Community	79.28%	Additional Clinical Services	77.90%
Children's Services	95.45%	Administrative and Clerical	84.15%
Clinical Services Management	71.43%	Allied Health Professionals	91.63%
Forensic & Mental Health Rehab	63.12%	Estates and Ancillary	65.03%
Neuro Developmental	76.58%	Medical and Dental	58.57%
Older Peoples Care	84.13%	Nursing and Midwifery Registered	81.88%
Performance Delivery Clustering		Students	83.33%
Psychology	71.70%		
Specialist Care Services	83.71%		
Corporate	72.00%		

Equality Monitoring Data

The following workforce statistics has been compiled from data taken from the DHCFT's ESR system. The following workforce information shows data as at the end of March 2022.

It is split into the following tables:

- Table 1: DHCFT Workforce
- Table 2: Recruitment
- Table 3: Working Pattern
- Table 4: CPD Training
- Table 5: Completion of Mandatory Training
- Table 6: Breakdown of ER Casework Data
- Table 7: Breakdown of Leavers
- Table 8: Breakdown of Local Area - Census 2011 (awaiting census 2021 data)

Table 1 DHCFT Workforce

	Headcount	FTE	Workforce %
Employees	2879	2514.95	-
Ethnicity			
White	**2327**	**2017.46**	**80.83%**
White - British	2212	1916.12	76.83%
White - Irish	27	21.66	0.94%
White - Any other White background	59	53.13	2.05%
White Northern Irish	3	2.67	0.10%
White Unspecified	19	17.28	0.66%
White English	4	3.6	0.14%
White Gypsy/Romany	1	1	0.03%
White Other European	2	2	0.07%
Mixed Race	**65**	**58.13**	**2.26%**
Mixed - White & Black Caribbean	28	25.13	0.97%
Mixed - White & Black African	4	3.48	0.14%
Mixed - White & Asian	19	16.82	0.66%
Mixed - Any other mixed background	14	12.7	0.49%
Asian or Asian British	**226**	**202.88**	**7.85%**
Asian or Asian British - Indian	147	132.48	5.11%
Asian or Asian British - Pakistani	60	54.18	2.08%
Asian or Asian British - Bangladeshi	4	2.73	0.14%
Asian or Asian British - Any other Asian background	11	10.25	0.38%
Asian Punjabi	3	2.24	0.10%
Asian Tami	1	1	0.03%
Black or Black British	**169**	**156.77**	**5.87%**
Black or Black British - Caribbean	59	53.19	2.05%
Black or Black British - African	98	92.71	3.40%
Black or Black British - Any other Black background	9	8.67	0.31%
Black Nigerian	1	0.8	0.03%
Black British	2	1.4	0.07%
Other Ethnic Backgrounds	**21**	**19.14**	**0.73%**
Chinese	5	4.75	0.17%
Any Other Ethnic Group	14	12.39	0.49%
Vietnamese	1	1	0.03%
Filipino	1	1	0.03%
Not Stated	**71**	**60.56**	**2.47%**
Total BME 16.7%			

	Headcount	FTE	Workforce %
Trust Employees	2879	2514.95	-
Gender			
Female	2306	1984.15	80.10%
Male	573	530.8	19.90%
Religious Belief			
Atheism	474	423.69	16.46%
Buddhism	19	17.03	0.66%
Christianity	1166	1014.52	40.50%
Hinduism	32	29.46	1.11%
Not stated	726	617.71	25.22%
Islam	70	62.93	2.43%
Jainism	2	2	0.07%
Judaism	6	5.8	0.21%
Other	326	292.5	11.32%
Sikhism	58	49.31	2.01%
Sexual Orientation			
Lesbian, Gay & Bisexual	104	96.62	3.61%
Heterosexual or straight	2196	1930.24	76.28%
Undecided	4	3.6	0.14%
Other not listed	2	1.8	0.07%
Not Stated	573	482.68	19.90%
Disability			
Yes	194	171.38	6.74%
No	2081	1837.99	72.28%
Prefer not to Answer	3	2.05	0.10%
Not Declared	601	503.52	20.88%
Age			
16-20	3	2.44	0.10%
21-30	413	390.33	14.35%
31-40	658	569.44	22.86%
41-50	796	706.13	27.65%
51-60	782	674.25	27.16%
61-70	216	165.01	7.50%
71 & above	11	7.35	0.38%
Marriage & Civil Partnership			
Married & Civil Partnership	1498	1272.13	52.03%
Other	1237	1117.41	42.97%
Not stated	144	125.41	5.00%

Table 2: Recruitment

	Applications	%	Shortlisted	%	Interview Attended	%	Appointments	%
Employees	**8773**		**3208**		**2056**		**615**	
Ethnicity								
White	4658	53.09%	2289	71.35%	1491	72.52%	491	79.84%
BME	3986	45.43%	871	27.15%	531	25.83%	105	17.07%
Not Stated	129	1.47%	48	1.50%	34	1.65%	19	3.09%
Gender								
Female	6817	77.70%	2640	82.29%	1699	82.64%	519	84.39%
Male	1926	21.95%	560	17.46%	350	17.02%	95	15.45%
Not stated	30	0.34%	8	0.25%	7	0.34%	1	0.16%
Religious Belief								
Atheism	1427	16.27%	688	21.45%	432	21.01%	135	21.95%
Buddhism	91	1.04%	38	1.18%	28	1.36%	9	1.46%
Christianity	4250	48.44%	1441	44.92%	945	45.96%	275	44.72%
Hinduism	245	2.79%	49	1.53%	28	1.36%	2	0.33%
Not stated	19	0.22%	18	0.56%	16	0.78%	12	1.95%
Islam	785	8.95%	158	4.93%	86	4.18%	24	3.90%
Jainism	5	0.06%	0	0.00%	0	0.00%	0	0.00%
Judaism	18	0.21%	2	0.06%	2	0.10%	0	0.00%
Other	883	10.06%	380	11.85%	272	13.23%	91	14.80%
Sikhism	170	1.94%	68	2.12%	34	1.65%	7	1.14%
Do not wish to Disclose	880	10.03%	366	11.41%	213	10.36%	60	9.76%
Sexual Orientation								
Lesbian, Gay & Bisexual	394	4.49%	147	4.58%	95	4.62%	18	2.93%
Heterosexual	7955	90.68%	2895	90.24%	1859	90.42%	561	91.22%
Undecided	19	0.22%	6	0.19%	4	0.19%	0	0.00%
Other not listed	40	0.46%	16	0.50%	8	0.39%	2	0.33%
Not Stated	20	0.23%	19	0.59%	17	0.83%	13	2.11%
Do not wish to Disclose	345	3.93%	125	3.90%	73	3.55%	21	3.41%
Disability								
Yes	607	6.92%	298	9.29%	205	9.97%	53	8.62%
No	7995	91.13%	2822	87.97%	1783	86.72%	521	84.72%
Prefer not to Answer	139	1.58%	57	1.78%	39	1.90%	17	2.76%
Not Declared	32	0.36%	31	0.97%	29	1.41%	24	3.90%

	Applications	%	Shortlisted	%	Interview Attended	%	Appointments	%
Employees	**8773**		**3208**		**2056**		**615**	
Age								
Under 20	112	1.28%	25	0.78%	17	0.83%	2	0.33%
20-24	1328	15.14%	355	11.07%	178	8.66%	58	9.43%
25-29	1961	22.35%	516	16.08%	320	15.56%	104	16.91%
30-34	1573	17.93%	471	14.68%	299	14.54%	100	16.26%
35-39	1180	13.45%	443	13.81%	297	14.45%	88	14.31%
40-44	795	9.06%	378	11.78%	232	11.28%	72	11.71%
45-49	728	8.30%	413	12.87%	303	14.74%	94	15.28%
50-54	525	5.98%	301	9.38%	209	10.17%	53	8.62%
55-59	421	4.80%	230	7.17%	147	7.15%	26	4.23%
60-64	122	1.39%	65	2.03%	46	2.24%	14	2.28%
65+	28	0.32%	11	0.34%	8	0.39%	4	0.65%
Marriage & Civil Partnership								
Married & Civil Partnership	3531	40.25%	1334	41.58%	909	44.21%	272	44.23%
Other	5080	57.90%	1815	56.58%	1115	54.23%	333	54.15%
Not stated	162	1.85%	59	1.84%	32	1.56%	10	1.63%

Table 3: Working Pattern

	Full Time	Workforce %	Part Time	Workforce %
Employees	1759	61.10%	1120	38.90%
Ethnicity				
White	1387	59.60%	940	40.40%
BME	335	69.65%	146	30.35%
Not Stated	37	52.11%	34	47.89%
Gender				
Female	1296	56.20%	1010	43.80%
Male	463	80.80%	110	19.20%
Religious Belief				
Atheism	314	66.24%	160	33.76%
Buddhism	12	63.16%	7	36.84%
Christianity	699	59.95%	467	40.05%
Hinduism	23	71.88%	9	28.13%
Not stated	410	56.47%	316	43.53%
Islam	46	65.71%	24	34.29%
Jainism	2	100.00%		0.00%
Judaism	5	83.33%	1	16.67%
Other	216	66.26%	110	33.74%
Sikhism	32	55.17%	26	44.83%
Sexual Orientation				
Lesbian, Gay & Bisexual	78	4.43%	26	2.32%
Heterosexual	1363	62.07%	833	37.93%
Undecided	3	75.00%	1	25.00%
Other not listed	1	50.00%	1	50.00%
Not Stated	314	54.80%	259	45.20%
Disability				
Yes	133	68.56%	61	31.44%
No	1295	62.23%	786	37.77%
Prefer not to Answer	2	66.67%	1	33.33%
Not Declared	329	54.74%	272	45.26%
Age				
16-20	1	33.33%	2	66.67%
21-30	337	81.60%	76	18.40%
31-40	394	59.88%	264	40.12%
41-50	485	60.93%	311	39.07%
51-60	447	57.16%	335	42.84%
61-70	93	43.06%	123	56.94%
71 & above	2	18.18%	9	81.82%
Marriage & Civil Partnership				
Married & Civil Partnership	808	45.94%	690	61.61%
Other	861	48.95%	376	33.57%
Not Stated	90	5.12%	54	4.82%

Table 4: CPD Training

	Headcount	Workforce %
Employees	428	
Ethnicity		
White	327	76.40%
BME	92	21.50%
Not Stated	9	2.10%
Gender		
Female	360	84.11%
Male	68	15.89%
Religious Belief		
Atheism	92	21.50%
Buddhism	2	0.47%
Christianity	170	39.72%
Hinduism	3	0.70%
Not stated	87	20.33%
Islam	9	2.10%
Jainism	0	0.00%
Judaism	2	0.47%
Other	51	11.92%
Sikhism	12	2.80%
Sexual Orientation		
Lesbian Gay & Bisexual	21	4.91%
Heterosexual	344	80.37%
Undecided	1	0.23%
Other not listed	0	0.00%
Not Stated	62	14.49%
Disability		
Yes	35	8.18%
No	337	78.74%
Prefer not to Answer	0	0.00%
Not Declared	56	13.08%
Age		
16-20	0	0.00%
21-30	75	17.52%
31-40	135	31.54%
41-50	128	29.91%
51-60	85	19.86%
61-70	5	1.17%
71 & above	0	0.00%
Marriage & Civil Partnership		
Married & Civil Partnership	200	46.73%
Other	208	48.60%
Unknown	20	4.67%

Table 5: Completion of Mandatory Training

	%
Employees	85.39%
Ethnicity	
White	87.11%
BME	78.61%
Not Stated	74.62%
Gender	
Female	80.73%
Male	86.59%
Religious Belief	
Atheism	87.16%
Buddhism	92.63%
Christianity	87.11%
Hinduism	81.33%
Not stated	81.25%
Islam	78.09%
Jainism	90.00%
Judaism	88.33%
Other	88.42%
Sikhism	79.24%
Sexual Orientation	
Lesbian, Gay and Bisexual	90.39%
Heterosexual	86.90%
Undecided	92.50%
Other not listed	95.00%
Not Stated	78.65%
Disability	
Yes	87.73%
No	86.82%
Prefer not to Answer	100.00%
Not Declared	79.66%
Age	
16-20	100.00%
21-30	87.11%
31-40	86.10%
41-50	87.50%
51-60	84.17%
61-70	76.73%
71 & above	77.27%
Marriage & Civil Partnership	
Married and Civil Partnership	90.02%
Other	85.98%
Unknown	78.76%

Table 6: Breakdown of Employee Relations Casework Data

	Disciplinaries	%	Grievance	%	Dignity at Work	%
Employees	4		15		12	
Ethnicity						
White	4	100.00%	11	73.33%	8	66.67%
BME	0	0.00%	3	20:00%	4	33.33%
Not Stated	0	0.00%	1	6.67%	0	0.00%
Gender						
Female	1	25.00%	10	66.67%	6	50.00%
Male	3	75.00%	5	33.33%	6	50.00%
Unknown	0	0.00%	0	0.00%	0	0.00%
Religious Belief						
Atheism	0	0.00%	3	20.00%	2	16.67%
Buddhism	0	0.00%	0	0.00%	0	0.00%
Christianity	0	0.00%	5	33.33%	4	33.33%
Hinduism	0	0.00%	0	0.00%	0	0.00%
Not stated	3	75.00%	5	33.33%	2	16.67%
Islam	0	0.00%	0	0.00%	1	8.33%
Jainism	0	0.00%	0	0.00%	0	0.00%
Judaism	0	0.00%	0	0.00%	0	0.00%
Other	1	25.00%	2	13.33%	3	25.00%
Sikhism	0	0.00%	0	0.00%	0	0.00%
Sexual Orientation						
Lesbian Gay and Bisexual	0	0.00%	1	6.67%	1	8.33%
Heterosexual	1	25.00%	12	80.00%	10	83.33%
Undecided	0	0.00%	0	0.00%	0	0.00%
Other not listed	0	0.00%	0	0.00%	0	0.00%
Not Stated	3	75.00%	2	13.33%	1	8.33%
Disability						
Yes	0	0.00%	2	13.33%	2	16.67%
No	1	25.00%	11	73.33%	8	66.67%
Not Stated	3	75.00%	2	13.33%	2	16.67%
Age						
16-20	0	0.00%	0	0.00%	0	0.00%
21-30	0	0.00%	3	20.00%	1	8.33%
31-40	0	0.00%	2	13.33%	2	16.67%
41-50	0	0.00%	2	13.33%	5	41.67%
51-60	3	75.00%	4	26.67%	3	25.00%
61-70	1	25.00%	3	20.00%	1	8.33%
71 & above	0	0.00%	1	6.67%	0	0.00%
Marriage & Civil Partnership						

Married & Civil Partnership	2	50.00%	6	40.00%	6	50.00%
Other	2	50.00%	9	60.00%	5	41.67%
Unknown	0	0.00%	0	0.00%	1	8.33%

Table 7: Breakdown of Leavers

	Headcount	Workforce %
Employees	**405**	**-**
Ethnicity		
White	**327**	**80.74%**
White - British	312	77.04%
White - Irish	3	0.74%
White - Any other White background	7	1.73%
White Northern Irish	0	0.00%
White Unspecified	5	1.23%
White English	0	0.00%
White Gypsy/Romany	0	0.00%
White Other European	0	0.00%
Mixed Race	**5**	**1.23%**
Mixed - White & Black Caribbean	1	0.25%
Mixed - White & Black African	0	0.00%
Mixed - White & Asian	2	0.49%
Mixed - Any other mixed background	2	0.49%
Asian or Asian British	**33**	**8.15%**
Asian or Asian British - Indian	22	5.43%
Asian or Asian British - Pakistani	8	1.98%
Asian or Asian British - Bangladeshi	3	0.74%
Asian or Asian British - Any other Asian background	0	0.00%
Asian Punjabi	0	0.00%
Asian Tami	0	0.00%
Black or Black British	**26**	**6.42%**
Black or Black British - Caribbean	2	0.49%
Black or Black British - African	19	4.69%
Black or Black British - Any other Black background	74	18.27%
Black Nigerian	1	0.25%
Black British	0	0.00%
Other Ethnic Backgrounds	**2**	**0.49%**
Chinese	0	0.00%
Any Other Ethnic Group	2	0.49%
Vietnamese	0	0.00%
Filipino	0	0.00%
Not Stated	**12**	**2.96%**
Gender		
Female	323	79.75%
Male	82	20.25%
Religious Belief		
Atheism	54	13.33%
Buddhism	4	0.99%
Christianity	163	40.25%

Hinduism	6	1.48%
Not stated	121	29.88%
Islam	10	2.47%
Jainism	0	0.00%
Judaism	1	0.25%
Other	36	8.89%
Sikhism	10	2.47%
Sexual Orientation		
Lesbian Gay and Bisexual	6	1.48%
Heterosexual	294	72.59%
Undecided	0	0.00%
Other not listed	0	0.00%
Not Stated	105	25.93%
Disability		
Yes	21	5.19%
No	277	68.40%
Not Declared	107	26.42%
Age		
16-20	0	0.00%
21-30	80	19.75%
31-40	79	19.51%
41-50	75	18.52%
51-60	116	28.64%
61-70	53	13.09%
71 & above	2	0.49%
Marriage & Civil Partnership		
Married and Civil Partnership	8	1.98%
Other	200	49.38%
Unknown	13	3.21%

Table 8: Breakdown of Local Area - Census 2011

	Derby City	Derby County	Derbyshire Population	DHCFT	Variance (DHCFT vs Derbyshire)
Race	-	-	-	-	-
Asian or Asian British	12.50%	1.14%	3.92%	7.85%	3.93%
Black or Black British	2.94%	0.36%	0.99%	5.87%	4.88%
Mixed	2.91%	0.92%	1.41%	2.26%	0.85%
Other Ethnic Group	1.35%	0.12%	0.42%	0.73%	0.31%
White	80.30%	97.45%	93.26%	80.83%	-12.43%
Not Stated	0.00%	0.00%	0.00%	2.47%	2.47%
Gender	-	-	-	-	-
Female	50.53%	50.79%	50.70%	80.10%	29.40%
Male	49.47%	49.21%	49.30%	19.90%	-29.40%
Religious Belief					
Buddhist	0.33%	0.20%	0.23%	0.66%	0.43%
Christian	52.71%	63.62%	60.96%	40.50%	-20.46%
Hindu	0.88%	0.18%	0.35%	1.11%	0.76%
Jainism	0.00%	0.00%	0.00%	0.07%	0.07%
Jewish	0.04%	0.05%	0.05%	0.21%	0.16%
Muslim	7.64%	0.29%	2.08%	2.43%	0.35%
No religion	27.61%	27.95%	27.87%	16.46%	-11.41%
Other religion	0.40%	0.38%	0.38%	11.32%	10.94%
Sikh	3.57%	0.30%	1.10%	2.01%	0.91%
Not stated	6.81%	7.04%	6.98%	25.22%	18.24%
Sexual Orientation					
Bisexual	-	-	0.50%	1.32%	0.82%
Gay or Lesbian	-	-	0.80%	2.29%	1.49%
Heterosexual	-	-	94.60%	76.28%	-18.32%
Not Stated	-	-	0.40%	19.90%	19.50%
Other not Listed	-	-	0.00%	0.07%	0.07%
Person asked but does not know	-	-	3.40%	0.14%	-3.26%
Disability					
Long term health problem or disability	-	-	19.98%	6.74%	-13.24%
Age					
15-19	8.32%	7.34%	7.57%	0.07%	-7.50%
20-29	19.03%	12.75%	14.25%	12.05%	-2.20%
30-39	16.55%	14.08%	14.67%	22.16%	7.49%
40-49	17.71%	18.98%	18.68%	26.99%	8.31%
	Derby City	**Derby County**	**Derbyshire Population**	**DHCFT**	**Variance (DHCFT vs Derbyshire)**
50-59	13.42%	16.09%	15.45%	29.35%	13.90%
60-70	11.31%	15.41%	14.43%	9.00%	-5.43%
71+	13.67%	15.35%	14.95%	0.38%	-14.57%

Marriage & Civil Partnership					
Divorced/Partnership Dissolved	8.99%	9.86%	9.70%	7.61%	-2.09%
Married/Civil Partner	44.89%	50.70%	49.30%	52.03%	2.73%
Separated	2.66%	2.42%	2.50%	1.18%	-1.32%
Single	36.46%	29.28%	31.00%	33.24%	2.24%
Widowed/Surviving Civil Partner	7.00%	7.75%	7.60%	0.94%	-6.66%
Not Stated	0.00%	0.00%	0.00%	5.00%	5.00%

Derbyshire Healthcare
NHS Foundation Trust

Gender Pay Gap Report

2022/23 (data extract as of 31 March 2022)

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1. Introduction

Derbyshire Healthcare NHS Foundation Trust is a specialist provider of mental health, learning disability, substance misuse and children's services across Derbyshire. Derbyshire is a county that covers 1000 square miles with a population of about one million people. The rural, semi-rural and urban landscape gives rise to a mixture of affluent and seriously deprived areas. The city of Derby is a vibrant place where over 300 languages are spoken.

Equality, diversity and inclusion are key priorities for DHCFT and explicitly exist in the Trust strategy. It is recognised that the gender balance actions will be dependent on the Trust culture and the equity of policies and processes applied (removing any un-necessary element that introduce bias).

Our aim is to achieve gender parity at all levels and ensure that any gap is down to personal choice rather than a result of any direct or indirect discrimination. Gender pay gap reporting is a useful tool for monitoring equality in the workplace, gender participation and objective and fair talent management.

It is expected that the Trust will have improvements year on year as we continue to embed our inclusive culture.

This is our sixth year of publishing the gender pay gap report is this report based on data as at 31st of March 2022. This report is in line with the Equality Act 2010 regulations. 2879 employees' data was categories as "relevant employees" and used in reporting the gender ay pay and the hourly pay gap statistics. 80.10% of the workforce in DHCFT have identified their sex as females, compared to 19.90% of males.
Currently the ESR data only records sex by male and females and does not other binary, non-binary or trans categories. Though we are unable to provide this local data, research by Stonewall shows that trans individuals are subject to high levels of bias, discrimination and abuse in the workplace. It is reasonable to assume that these individuals would also be subject to pay inequality.

2. Background

Legislation has made it a statutory obligation for organisations to report annually on their gender pay gap. NHS organisations are covered by the Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017 which came into force on 31 March 2017. These regulations underpin the Public Sector Equality Duty and require Employers with 250 employees and over need to publish the following information annually for all employees who are employed under a contract of employment, a contract of apprenticeship or a contract personally to do work. This will include those under Agenda for Change terms and conditions, medical staff and very senior managers. All calculations are made relating to the pay period in which the snapshot day falls.

What is the gender pay gap?

- The gender pay gap is the difference between the average earnings of men and women, expressed relative to men's earnings.
- The mean pay gap is the difference between average hourly earnings of men and women.
- The median pay gap is the difference between the midpoints in the ranges of hourly earnings for men and women.

What about equal pay?

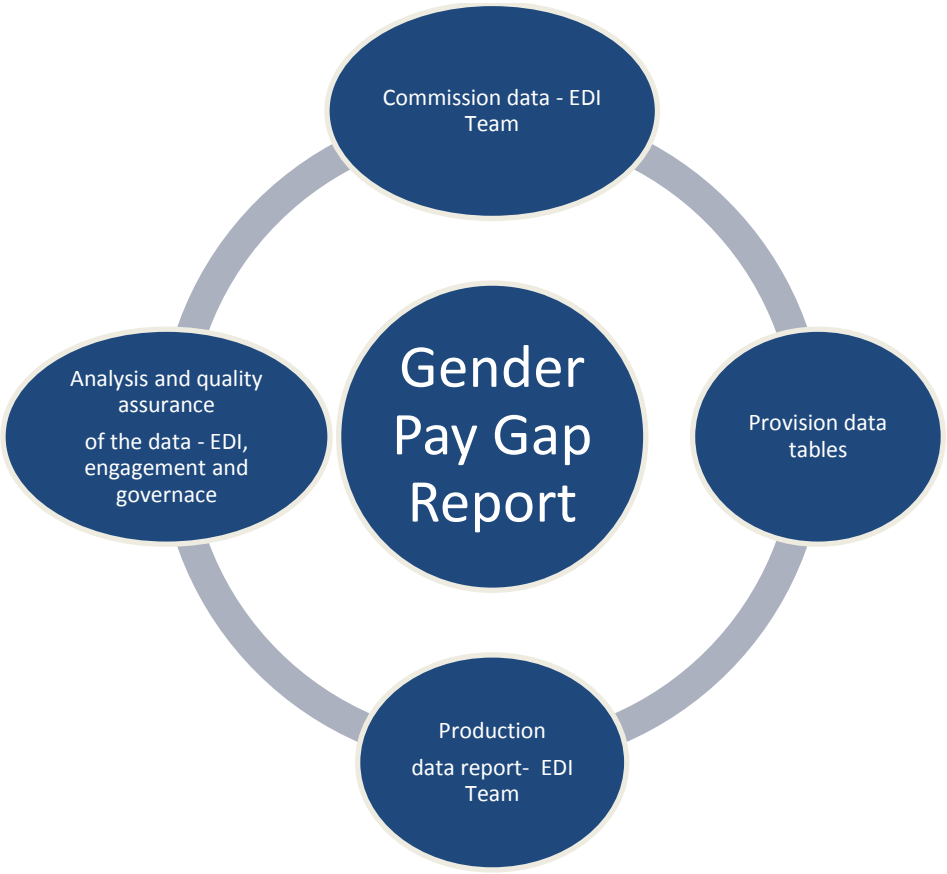
Equal pay deals with the pay differences between men and women who carry out the same or similar jobs. It has been a statutory entitlement since the Equal Pay Act was introduced in 1970.

Paying men and women differently for the same or like work is unlawful, however it is possible to have pay equality at the same time as having a gender pay gap.
The gender pay gap differs from equal pay as it is concerned with the differences in the average pay between men and women over a period of time no matter what their role is.

The national NHS terms and conditions ‘Agenda for Change’ pay system introduced in October 2004 ensures that pay in the NHS is consistent with the requirements of equal pay law. This covers 94.08% of the workforce at DHCFT. The remaining 5.53% of the workforce is covered by the NHS Medical contract, and the NHS Very Senior Managers contract, which also adhere to the principles of equal pay.

How is the report produced?

The production of the Report is an iterative process as illustrated in the diagram below. The process starts with commissioning the core data, which is used to compile the report. The data report is then analysed to understand the reasons for the Gender Pay Gap and identify lines of enquiry requiring further data as well as sense checking the accuracy of the data and calculations. This process of analysis, exploration and quality assurance happens multiple times before the first draft report is completed.



3. Reporting requirements

There are six calculations an organisation is required to publish, which are listed in the table below:

Table 1: Gender Pay Gap reporting requirements.	
Mean gender pay gap	The difference between the average of men's and women's hourly pay.
Median gender pay gap	The difference between the midpoints in the ranges of men's and women's pay. All salaries in the sample are lined up separately for men and women in order from lowest to highest, and the middle salary is used. The figure is the difference of these two middle points.
Mean gender pay gap	The difference between the mean bonus payments made to relevant male employees and that paid to relevant female employees. For DHCFT this refers to local and national clinical excellence awards.
Median bonus gender pay gap	The difference between the median bonus payments made to relevant male employees and that paid to relevant female employees. For DHCFT this refers to local and national clinical excellence awards.
Proportion of males and females receiving a bonus.	The proportions of relevant male and female employees who were paid a bonus payment. For DHCFT this refers to local and national clinical excellence awards.
Proportion of males and females in each quartile band.	The proportions of male and female relevant employees in the lower, lower middle, upper middle and upper quartile pay bands.

Technical guidance

Ordinary pay includes:

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

It does not include:

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

The relevant pay period means the pay period within which the snapshot date falls, which for monthly-paid staff would be the month in which the date is included.

Bonus pay relates to performance, productivity, incentive, commission or profit-sharing, but excludes:

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

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

What employers need to publish

The information outlined above will need to be published within one year of the date for the 2022 snapshot (publishing deadline of 30 March 2023 for data as of 31 March 2022).

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

In addition, employers have the option to provide narrative that will help people to understand why a gender pay gap is present and what the organisation intends to do to close it.
During the first publication employers will have already registered with the Government online reporting service to submit their GPG results.
Colleagues from the Electronic Staff Record (ESR) continue to refine the tool that helps organisations nationally to calculate their GPG data.

4. Summary of Data March 22

We collected our data on 31st March 2022, when our workforce consisted of 2306 (18.10%) women, 573 (9.90%) men and 2879 in total.

In common with the whole NHS, our Trust is predominantly female. Given that over 80% of staff are women, it is also the case that women outnumber men at every quartile.

Table 2 below shows DHCFT's overall mean and median gender pay gap and bonus gap based on hourly rates of pay.

Table 2: DHCFT Overall mean and median gender pay gap and bonus gap based on hourly rates of pay		
	DHCFT 2021	**DHCFT 2022**
Mean gender pay gap.	15.41%	16.51%
Median gender pay gap.	9.96%	10.39%
Mean bonus gender pay gap.	89.54%	87.62%
Median bonus gender pay gap.	88.93%	50.00%
Proportion of men and women receiving a bonus.	5.11%	4.20%
NB bonuses paid relate to clinical excellence awards which are for applicable consultants only rather than all employees (even though the calculation includes all staff)		
Proportion of females and males in each quartile band: DHCFT 2022		
Quartile	**Women**	**Men**
Top quartile	84.35%	15.65%
Upper Middle quartile	79.89%	20.11%
Lower Middle quartile	81.86%	18.14%
Lower quartile	71.94%	28.06%

DHCFT's results show that at the snapshot date of 31st March 2022, that the mean hourly pay for women is 16.51% less than the male mean and 10.39%% less than the male median. (If the mean gap is larger than the median gap it indicates the presence of a small number of top end outlier payment values favouring men, in relation to average hourly or bonus pay).

The tables below shows the average mean and median hourly rate for men and women and the pay gap as of March 2022. And the average mean and median salary for men and women.

Gender	Average Mean Hourly Rate	Median Hourly Rate
Male	£21.02	£18.44
Female	£17.55	£16.52
Difference	£3.47	£1.92
Pay Gap %	16.51%	10.39%

Gender	Average Mean Annual Salary	Median Annual Salary
Male	£41,106.69	£36,052.09
Female	£34,320.20	£32,305.26

The table below shows the proportion of Agenda for Change staff, medical and other.

Banding	Female	%	Male	%	Grand Total	%
AFC	2211	81.29%	509	18.71%	2720	94.48%
Non-AFC - Medical	82	58.57%	58	41.43%	140	4.86%
Non-AFC - Other	8	72.73%	3	27.27%	11	0.38%
NON-AFC - VSM	5	62.50%	3	37.50%	8	0.28%
Grand Total	2306	-	573	-	2879	-

The table below shows the proporation men and women in each quartile as of March 2022.

Quartile	Female	Male	Female %	Male %
1	636	118	84.35	15.65
2	580	146	79.89	20.11
3	650	144	81.86	18.14
4	546	213	71.94	28.06

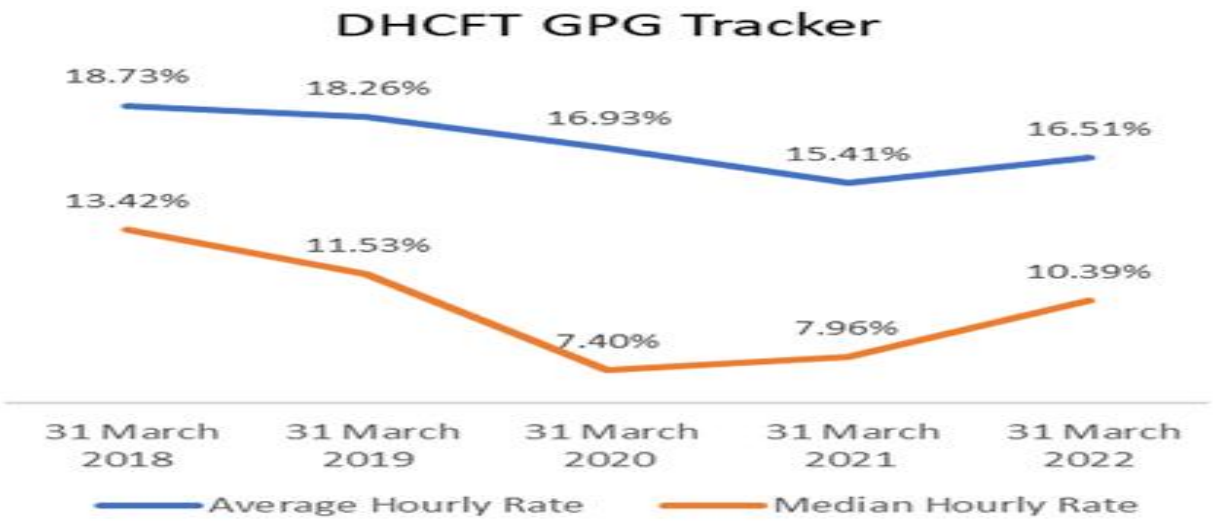
The tables below show the Gender Pay Gap comparative results for DHCFT for March 2021 and March 2022.

31 March 2021		
Gender	Average Mean Hourly Rate	Median Hourly Rate
Male	£20.06	£17.27
Female	£16.97	£15.90
Difference	£3.09	£1.37
Pay Gap %	**15.41%**	**7.96%**

31 March 2022		
Gender	Average Mean Hourly Rate	Median Hourly Rate
Male	£21.02	£18.44
Female	£17.55	£16.52
Difference	£3.47	£1.92
Pay Gap %	**16.51%**	**10.39%**

Variation	
Average Mean Hourly Rate	Median Hourly Rate
£0.96	£1.16
£0.58	£0.62
£0.38	£0.54
1.10%	**2.43%**

This graph shows the annual comparative mean and median gender pay gap since 2018.



The tables below show the proportion men and women in each quartile as of March 2021 and March 2022.

31 March 2021				
Quartile	Female	Male	Female %	Male %
1	608	118	83.75	16.25
2	557	132	80.84	19.16
3	618	159	79.54	20.46
4	522	211	71.21	28.79

31 March 2022				
Quartile	Female	Male	Female %	Male %
1	636	118	84.35	15.65
2	580	146	79.89	20.11
3	650	144	81.86	18.14
4	546	213	71.94	28.06

Variation	
Female %	Male %
0.60	-0.60
-0.95	0.95
2.33	-2.33
0.72	**-0.72**

5. Understanding the Gap

The differences in average pay between men and women occur for several reasons:

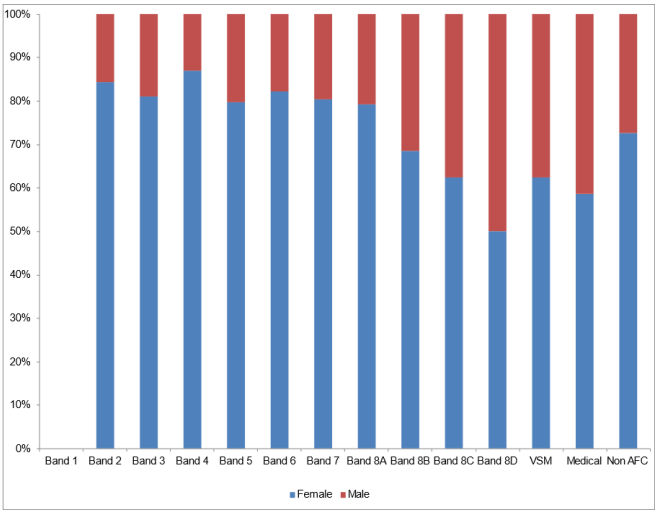
- The types of jobs people do
- Their tenure at work
- Natural variance
- Education and qualifications

A lower gender pay gap does not directly correlate to being a better organisation, however it is necessary to ensure that discrimination (direct or indirect) is not a factor.

DHCFT Challenges

The GPG can be explained in the fact that the proportion of females employed by the Trust is significantly higher than males. There are more women represented at all banding levels than men, (which reduces the average hourly rates for women overall).

Breakdown of proportion of females and males in each banding



Pay Band	Female	Male
Band 1	[illegible]	[illegible]
Band 2	84.32%	15.68%
Band 3	81.14%	18.86%
Band 4	86.96%	13.04%
Band 5	79.80%	20.20%
Band 6	82.19%	17.81%
Band 7	80.47%	19.53%
Band 8A	79.25%	20.75%
Band 8B	68.63%	31.37%
Band 8C	62.50%	37.50%
Band 8D	50.00%	50.00%
VSM	62.50%	37.50%
Non AFC	72.73%	27.27%

If there were balance across all the quartiles compared to the Trust overall, there would be 80/20 ratio of women to men at all banding levels. The higher ratios of women to men exist at bands 2 – 7 and. There are fewer than 80% female at bands 8a-8-d, VSM and non -AfC.

As the proportion of men increases through the quartiles, it influences the gap in the median hourly rates. The most significant differential is at the upper middle quartile where there are 79.89% women to 20.11% men and lower quartile where there are 71.94% women to 28.06% men. There is an opportunity to take focused activities to attract men into posts in the lower and upper middle quartile agenda for change roles and continue to support women into senior management positions.

Further exploration of looking at the intersect of gender and age will help understand better barriers working aged women face across the organisation including childcare, flexible working etc.

The table below show the working pattern of men and women as of March 2022

Working pattern	Full Time	Workforce %	Part Time	Workforce %
Employees	1759	61.10%	1120	38.90%
Gender				
Female	1296	56.20%	1010	43.80%
Male	463	80.80%	110	19.20%

Average Hourly Rate and Mean Gap by Staff Group

Average Hourly Rate	Gender			
Staff Group	Male	Female	Diff	Gap
Add Prof Scientific and Technic	£24.37	£22.34	£2.02	8.30%
Additional Clinical Services	£12.97	£12.50	£0.47	3.64%
Administrative and Clerical	£20.93	£14.30	£6.63	31.69%
Allied Health Professionals	£19.98	£18.96	£1.03	5.15%
Estates and Ancillary	£12.84	£11.28	£1.56	12.16%
Medical and Dental	£48.41	£39.25	£9.16	18.93%
Nursing and Midwifery Registered	£20.37	£19.65	£0.73	3.56%
Students	£10.24	£11.07	-£0.84	-8.19%

Average Hourly Rate and Mean Gap by Service area

Average Hourly Rate	Gender			
Service Line	Male	Female	Diff	Gap
Adult Care Acute	£23.29	£17.66	£5.63	24.18%
Adult Care Community	£22.00	£18.69	£3.31	15.04%
Business Improvement + Transformation	£39.13	£18.27	£20.86	53.31%
Children's Services	£19.70	£17.07	£2.63	13.36%
Clinical Serv Management	£29.85	£26.68	£3.16	10.60%
Corporate Central	£18.95	£17.30	£1.65	8.71%
Estates + Facilities	£14.37	£11.98	£2.39	16.65%
Finance Services	£20.54	£20.42	£0.13	0.61%
Forensic + MH Rehab	£16.70	£17.54	-£0.84	-5.03%
Med Education & CRD	£19.55	£17.63	£1.91	9.79%
Neuro Developmental	£18.23	£17.07	£1.15	6.32%
Nursing + Quality	£21.35	£21.58	-£0.23	-1.05%
Older Peoples Care	£22.94	£16.33	£6.61	28.83%
Ops Support	£20.91	£15.74	£5.16	24.69%
People + Inclusion	£15.08	£16.79	-£1.72	-11.38%
Performance Delivery Clustering	£0.00	£15.09	-£15.09	0.00%
Psychology	£26.25	£24.30	£1.95	7.44%
Specialist Care Services	£27.39	£19.09	£8.30	30.32%

Bonus Pay Gap

There is a gap in bonus payments at DHCFT. To gain a clearer understanding, bonuses have then broken down to illustrate the difference in Doctors' clinical excellence awards and long service awards.

Gender	Average Mean Bonus Pay	Median Bonus Pay
Male	£6,767.60	£400.00
Female	£837.69	£200.00
Difference	£5,929.90	£200.00
Pay Gap %	87.62%	50.00%

31 March 2021

Gender	Average Mean Bonus Pay	Median Bonus Pay
Male	£8,350.38	£1,807.46
Female	£873.47	£200.00
Difference	£7,476.91	£1,607.46
Pay Gap %	89.54%	88.93%

31 March 2022

Gender	Average Mean Bonus Pay	Median Bonus Pay
Male	£6,767.60	£400.00
Female	£837.69	£200.00
Difference	£5,929.90	£200.00
Pay Gap %	87.62%	50.00%

Variation

Average Mean Bonus Pay	Median Bonus Pay
-£1,582.79	-£1,407.46
-£35.77	£0.00
-£1,547.01	-£1,407.46
-1.92%	-38.93%

Clinical excellence and long service awards

The bonus table below relates exclusively to the Clinical Excellence Awards (CEAs) available to medical consultants. CEA is a national programme to recognise and reward medical consultants who demonstrate achievements in developing and delivering high quality patient care over and above the standard expected of their role, with a commitment to the continuous improvement of the NHS. They are determined locally, following a nationally agreed criterion.

31 March 2022

Gender	Average Mean Bonus Pay	Median Bonus Pay
Male	£14,588.71	£9,048.00
Female	£4,775.33	£3,619.20
Difference	£9,813.38	£5,428.80
Pay Gap %	67.27%	60.00%

Long Service Awards

There are currently two schemes in operation within Derbyshire Healthcare NHS Foundation Trust. One is an 'in-service' award scheme which is only available to staff who transferred in from North Eastern Derbyshire PCT in 2004. The other is a scheme whereby individual employees receive a long service award on retirement if they have had 20 years or more continuous NHS service. The employee receives this automatically as part of the retirement process.

31 March 2022

Gender	Average Mean Bonus Pay	Median Bonus Pay
Male	£250.00	£200.00
Female	£236.00	£200.00
Difference	£14.00	£0.00
Pay Gap %	5.60%	0.00%

Long-service awards are considered as one of the most important forms of recognition, as it rewards staff for loyalty to the business and enhances staff's feeling of being valued by the organisation.

The Long Service Award Scheme recognises employees' loyalty and continuous service within the NHS on the anniversary of 10, 20-, 30-, 40- and 50-years continuous service Continuous Service.

Clinical Excellence Awards

	31 March 2021		31 March 2022		Variation	
Gender	Average Mean Bonus Pay	Median Bonus Pay	Average Mean Bonus Pay	Median Bonus Pay	Average Mean Bonus Pay	Median Bonus Pay
Male	£16,447.82	£12,063.96	£14,588.71	£9,048.00	-£1,859.11	-£3,015.96
Female	£4,820.99	£5,358.94	£4,775.33	£3,619.20	-£45.66	-£1,739.74
Difference	£11,626.83	£6,705.02	£9,813.38	£5,428.80	-£1,813.45	-£1,276.22
Pay Gap %	**70.69%**	**55.58%**	**67.27%**	**60.00%**	-3.42%	4.42%

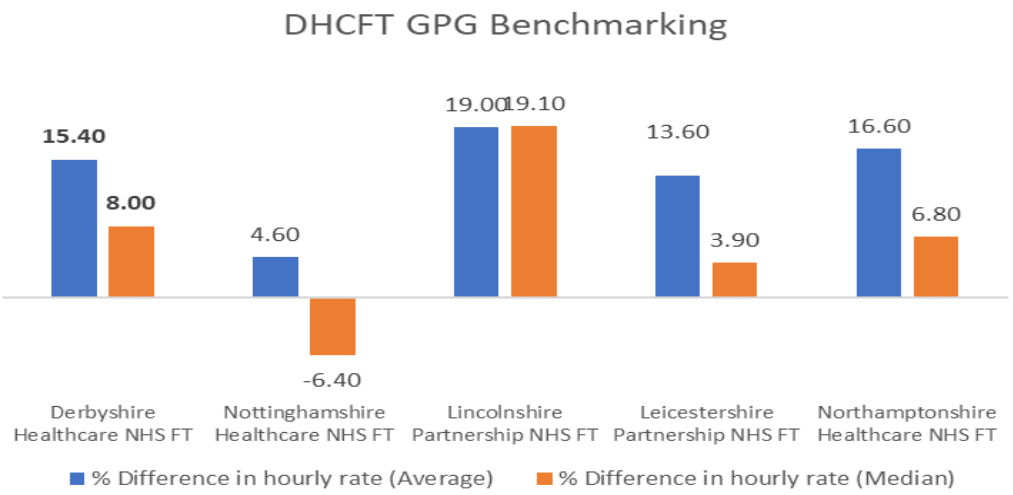
Long Service Awards

	31 March 2021		31 March 2022		Variation	
Gender	Average Mean Bonus Pay	Median Bonus Pay	Average Mean Bonus Pay	Median Bonus Pay	Average Mean Bonus Pay	Median Bonus Pay
Male	£252.94	£200.00	£250.00	£200.00	-£2.94	£0.00
Female	£245.45	£200.00	£236.00	£200.00	-£9.45	£0.00
Difference	£7.49	£0.00	£14.00	£0.00	£6.51	£0.00
Pay Gap %	**2.96%**	**0.00%**	**5.60%**	**0.00%**	2.64%	0.00%

Benchmarking (latest available benchmarking data 31 March 2021):

Employer	% Difference in hourly rate (Average)	% Difference in hourly rate (Median)	% Women in lower pay quartile	% Women in lower middle pay quartile	% Women in upper middle pay quartile	% Women in top pay quartile	% Who received bonus pay (Women)	% Who received bonus pay (Men)	% Difference in bonus pay (Mean)	% Difference in bonus pay (Median)
Derbyshire Healthcare NHS FT	**15.40**	**8.00**	83.80	80.80	79.50	71.20	75.00	25.00	89.50	50.00
Nottinghamshire Healthcare NHS FT	**4.60**	**-6.40**	73.80	69.00	76.40	73.70	33.90	42.30	13.40	33.30
Lincolnshire Partnership NHS FT	**19.00**	**19.10**	88.00	81.00	80.00	67.00	0.30	3.10	19.00	19.10
Leicestershire Partnership NHS FT	**13.60**	**3.90**	85.00	82.10	84.80	75.40	0.20	2.10	38.60	57.50
Northamptonshire Healthcare NHS FT	**16.60**	**6.80**	77.50	86.20	82.90	88.50	100.00	100.00	67.60	12.50

Source: *GOV.UK*



Ethnicity Pay Reporting

In the absence of legislation, DHCFT has voluntarily compiled the below ethnicity pay gap reporting, as part of the organisation's approach to improve inclusion and tackle inequality in the workplace. The tables below provide a snapshot of the ethnicity pay gap, which is reflective of where BME staff are positioned in DHFCT, further work will be required to understand the detail.

The table below shows the average mean and mean hourly rate for ethnicity and the pay gap as of March 2022.

Ethnic Group	Average Hourly Rate	Median Hourly Rate
White	£17.87	£16.52
BME	£19.83	£15.44
Difference	-£1.96	£1.08
Pay Gap %	**-10.94%**	**6.53%**

The table below shows the proportion Black and Minority Ethnic and White colleagues in each quartile as of March 2022.

Quartile	BME	White	BME %	White %
1	128	604	17.49	82.51
2	192	514	27.20	72.80
3	94	679	12.16	87.84
4	154	581	20.95	79.05

6. Progress and the Gender Balance Action Plan

Over the last 2 years in the aim towards gender parity, actions taken have been in line with the Government equalities office evidence-based publication[1] and the Advisory, Conciliation and Arbitration Service (Acas). These have included:

- Monitoring of gender characteristics success through the recruitment pipeline (Shortlisting, interview, selection).
- Women of Colour in Leadership workshop commissioned and organised as a joint venture between the BME and Women's Staff networks in 2022.
- Encouraging flexible working for all staff.
- An active women's network with an executive sponsor.
- Extensive Health and Wellbeing Offer for staff.

Wider targeted investment in initiatives at DHCFT that may help to close the gap in terms of evidence include:

- Above Difference Cultural Intelligence (CQ) Programme.
- Building leadership for inclusion Leadership development (covering inclusive leadership competencies).

5. Conclusions and Additional Focus to Address the Gap

There is a gender pay gap (GPG) that exists for DHCFT, but the mean GPG is narrowing. Some of the pay gap exists by choice (individuals choosing the jobs that they do). Going forward Government guide will be applied to assist in examining whether the GPG is caused by employee choice, or lack of opportunity. The key areas to be further monitored are:

- Equity versus lack of career progression (and barriers)
- Gender balance in promotion
- Gender balance of leavers
- Starting salaries by gender
- Part time employee career progression
- Supporting carers responsibilities

There are higher percentages of women employed in all quartiles than the percentage of women in the UK population. To reduce the GPG as defined by the government would therefore suggest that as well as supporting and encouraging female applicants into senior posts, that advertising and attraction campaigns should consider how to increase the representation of men into bands lower and middle quartile salary ranges.

[1] https://gender-pay-gap.service.gov.uk/public/assets/pdf/Evidence-based_actions_for_employers.pdf

DHCFT has been working in partnership to target more apprenticeship schemes and will be doing as part of the ongoing recruitment action plan.

The Trust strategy has been refreshed which include our values and behaviours to further embed the desired culture and will monitor the feedback and experiences of all staff as part of this programme.

In support of the wider Equality Diversity and Inclusion EDI agenda the Trust will continue to check equality in opportunities for selection, development and promotion in the organisation and parity across the whole employee lifecycle.

Through the new EDI Steering Group DHFCT will set specific goals for GPG and monitor these with other KPIs such as the Workforce Race/Disability Equality Standards to apply fairness of opportunity and parity. We know that sustained improvements will take time but have confidence in the targeted actions being applied.

Appendix 1: Action Plan

The action plan below has been developed with the Women's staff network, with a focus on improving gender parity. Improvements in these areas should impact on the overall engagement, experience and feelings of value for colleagues.

Appendix 1: Gender Pay Gap Action Plan 2023/24				
	Outcome	Actions	Leads and collaborators	Timescales
1	Additional Data Analysis	• Equity versus lack of career progression (and barriers) • Gender balance in promotion • Gender balance of leavers • Starting salaries by gender • Part time employee career progression • Supporting carers responsibilities • Detailed Ethnicity pay Gap • Age and Disability pay gap	Data team EDI Team	March 2024
1.b	Carry out an Equal Pay Audit for roles that fall under the Administrative and Clerical Positions and audit the following:	• AFC bandings against the roles and positions held. • Job titles o Job descriptions (roles and responsibilities) • Start date against the spine point for the AFC • Are these posts' part time? Flexible hours? Job shares? • Additional resources will be required to carry out the audit and a development of a tool that will capture this data on a quarterly basis to explore the problem areas.	ESR, data team	
2	Recruitment and selection	• Provide career coaching for staff and self-confidence sessions	Recruitment Lead and EDI team	March 2024

Appendix 1: Gender Pay Gap Action Plan 2023/24				
		• Introduce values-based recruitment for all roles and provide objective assessment training for all hiring managers to support consistency and fairness • Review the use of assessment tests in the interview process to improve objectivity beyond the competency-based interview • Work with schools and colleges to promote the NHS for male and female careers		
3	Career Development Promotion and Talent	• Promote cohorts of reverse mentoring to support and sponsor women in their career development / returning to work after maternity • Develop a talent management and succession planning process and include a self-nomination process as part of this • Offer career coaching for all staff and training for managers in their role in talent management	Leadership and EDI Women's Network	March 2024
2	Support, Awareness and Education	• Bias • Continue to roll out unleashed • EIA Training	EDI team	March 2024
3	Policies	• Menopause policy • Review safety on sight	Policy authors and Women's Network	March 2024
4	Wider Cultural Activities and Health and well being	• CQ Facilitators train the trainer • Wellbeing offers champions	CQ Facilitators and well being leads	March 2024

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 9 May 2023

Modern Slavery Statement

Purpose of Report

To present the Trust's Annual Modern Slavery Statement for 2022/23 for approval.

Executive Summary

The Trust's Annual Modern Slavery Statement for 2022/23 is attached. This statement was considered and supported by the People and Culture Committee on 28 March to assess whether the Trust has met the criteria for the preceding financial year. The Board is requested to approve the Annual Modern Slavery Statement and this will be uploaded to the Trust's website, replacing the previous version.

The Trust's safeguarding lead has reviewed this statement against the new Home Office guidance and confirmed that no changes were required.

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

Assurances

The Board receives assurance that the Trust is discharging its statutory duties regarding the modern slavery statement through the statement which it approves on an annual basis.

Consultation

People and Culture Committee 28 March 2023.

Governance or Legal Issues

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

Public Sector Equality Duty and Equality Impact Risk Analysis

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

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

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

Recommendations

The Board of Directors is requested to approve the revised Modern Slavery Statement for 2022/23 for publishing on the Trust's website, replacing the previous version.

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

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

Derbyshire Healthcare
NHS Foundation Trust

MODERN SLAVERY STATEMENT – 2023/23

INTRODUCTION

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

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

AIM OF THIS STATEMENT

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

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

ABOUT THE ORGANISATION

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

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

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

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

OUR POLICIES ON SLAVERY AND HUMAN TRAFFICKING

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

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

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

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

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

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

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

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

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

WORKING WITH SUPPLIERS

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

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

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

2. Procurement through compliant national government frameworks. The Trust purchases large amounts of products from third party distributors such as NHS Supply Chain and utilises framework agreements from national framework providers such as Crown Commercial Services (CCS) which include specific questions around the Modern Slavery in their procurement documentation and any breaches of labour laws which result in disqualification of unsuitable organisations.

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

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

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

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

TRAINING

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

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

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

OUR PERFORMANCE INDICATORS

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

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

BOARD OF DIRECTORS' APPROVAL

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

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

Signed on behalf of the Board of Directors:

Selina Ullah
Trust Chair

Mark Powell
Chief Executive Officer

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 9 May 2023

National NHS Staff Survey 2022

Purpose of Report

The purpose of this paper is to update the Public Trust Board on the NHS Staff Survey – NHS England results, which show our position based on the 2022 all staff survey.

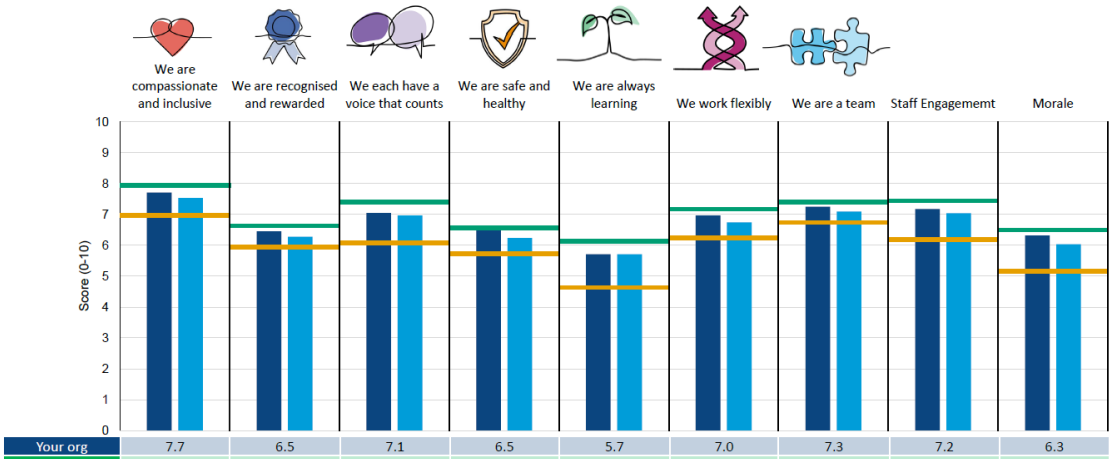
Executive Summary

The paper provides a summary of the results from the National NHS Staff Survey 2022 conducted between September and November 2022. This report has been shared and discussed at the People and Culture Committee.

The results are compared against 51 organisations in our benchmarking group - Combined Mental Health / Learning Disability and Community Trusts.

These results are presented in the context of best, average and worst results for similar organisations where appropriate. Data in this report is weighted to allow for fair comparisons between organisations. A small number of questions are not weighted or benchmarked because these questions ask for demographic or factual information.

The results are divided into the People Promise themes, which cover areas of staff experience helping to present results in these areas in a clear and consistent way. All of the themes are scored on a 0-10 scale, where a higher score is more positive than a lower score. These theme scores are created by scoring question results and grouping these results together.



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagememt	Morale
Your org	7.7	6.5	7.1	6.5	5.7	7.0	7.3	7.2	6.3
Best	7.9	6.6	7.4	6.6	6.1	7.2	7.4	7.4	6.5
Average	7.5	6.3	7.0	6.2	5.7	6.7	7.1	7.0	6.0
Worst	7.0	5.9	6.1	5.7	4.6	6.2	6.7	6.2	5.2
Responses	1408	1411	1400	1403	1343	1405	1408	1409	1411

A breakdown of all of the results within each theme is presented in the paper. All results have now been provided. Divisions have now received detailed analysis. An organisation wide engagement process will commence this month so that all staff have opportunity to talk about the challenges and opportunities and determine priority actions for each division based on the results and what people say.

Analysis has been completed on the inclusion aspects of the survey and discussed and debated at the new EDI Steering Group and actions being agreed.

The following are areas of focus for the Trust:

Priority	Improvements	How will we know when we get there?
Improving Staff Engagement	• Strengthen and standardise divisional lead engagement • Co-developed next steps for the next 12 months • Review of current reward and recognition programme	• Staff Engagement scores for staff survey • Successful completion of local action plans • Increased Staff Survey Participation
Improving the way we deal with concerns raised	• Design a framework that provides clarity on the different ways to raise a concern, clear accountability and what happens with the concern • Improve the way we triangulate our data to be able to identify areas of concerns before staff need to raise them • Develop new and innovative ways of speaking out e.g. anonymous forms/online submissions	• Increased confidence for raising concerns • Staff survey results improve for this area • Decrease in escalations
Growth and Development	• The launch of a career conversation toolkit to support career discussions and connecting colleagues with the range of opportunities available. • Improving the Appraisal Process • Increasing the accessibility and awareness of the options available to colleagues to grow, stretch and develop • Ensuring that informal stretch, role and development opportunities are open to all • Working as a Derbyshire system on informal and formal growth and development opportunities	• Appraisal KPI's being met in all teams • Staff survey results show increased scores for this area • Reduction in disparity ratio's
Health & Wellbeing	• Review and develop a new Flexible working approach and policy • Launch of a health and wellbeing strategy and increased focus on ensuring we have sufficient health and wellbeing services to meet colleagues needs • Mainstreaming the health and wellbeing conversation • Ensuring consistent approach to team engagement to work on priorities, clarity of roles and supporting each other	• Staff retention rates • Pulse survey responses • Staff survey results • Reduction of work related absence

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

Risks and Assurances

- There is a risk that the reduction in response rate does not provide survey results for a number of teams
- Learning has been taken from the reduced response rate and plans already put in place to support the approach with the 2023 survey

Consultation

- All staff were invited to participate in the National NHS Staff Survey

Governance or Legal Issues

- The CQC analyse the NHS Staff Survey results
- Staff FFT questions are reported and benchmarked nationally

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

Our NHS Staff Survey results are be broken down by protected characteristics and further analysis is done by the Equality, Diversity and Inclusion Team in conjunction with all Staff Network Groups.

Recommendations

The Board of Directors is requested to receive the National 2022 Staff Survey results and note a full discussion has taken place in People and Culture Committee.

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

Report prepared by: **Rebecca Oakley**
Deputy Director of People and Inclusion

2022 NHS Staff Survey Summary Paper

NHS England Results

Introduction

This report for Derbyshire Healthcare NHS Foundation Trust contains results from the 2022 NHS Staff Survey from the NHS England Staff Survey including themes and questions.

The results are also compared against **51 organisations** in our benchmarking group - Combined Mental Health / Learning Disability and Community Trusts.

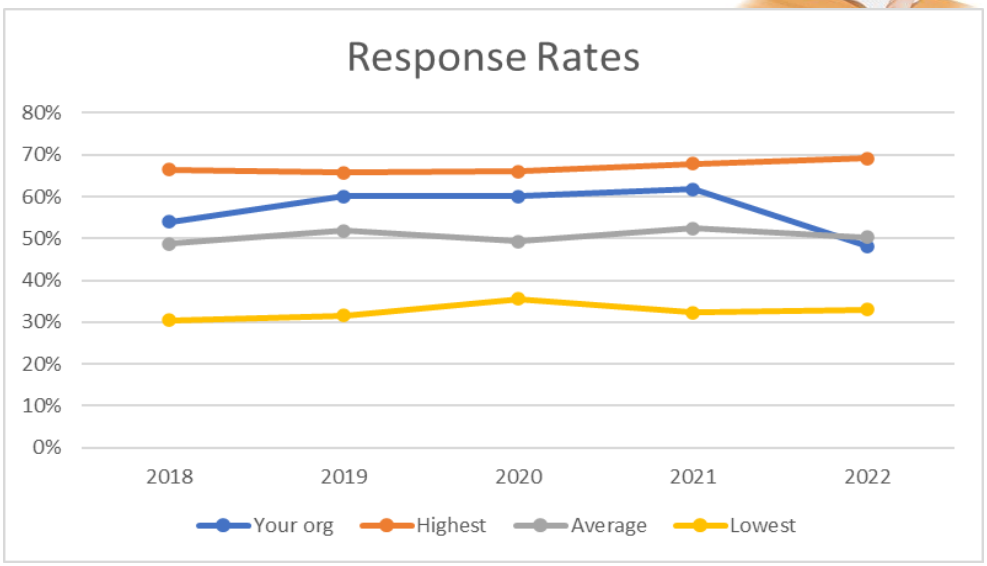
These results are presented in the context of best, average and worst results for similar organisations where appropriate. Data in this report is weighted to allow for fair comparisons between organisations. A small number of questions are not weighted or benchmarked because these questions ask for demographic or factual information.

The results are divided into the **People Promise themes** below, which cover areas of staff experience helping to present results in these areas in a clear and consistent way. All of the themes are scored on a 0-10 scale, where a higher score is more positive than a lower score. These theme scores are created by scoring question results and grouping these results together.

For the 2021 survey onwards the questions in the NHS Staff Survey are aligned to the People Promise. This sets out, in the words of NHS staff, the things that would most improve their working experience, and is made up of seven elements:

In support of this, the results of the NHS Staff Survey are measured against the seven People Promise elements and against two of the themes reported in previous years (Staff Engagement and Morale). The reporting also includes sub-scores, which feed into the People Promise elements and themes.

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



	2018	2019	2020	2021	2022
Your org	54.0%	60.0%	60.1%	61.8%	48.2%
Highest	66.5%	65.7%	66.0%	67.9%	69.2%
Average	48.7%	51.8%	49.3%	52.4%	50.3%
Lowest	30.5%	31.6%	35.6%	32.3%	33.0%
Responses	1284	1515	1604	1703	1412

NHS England Reporting Themes

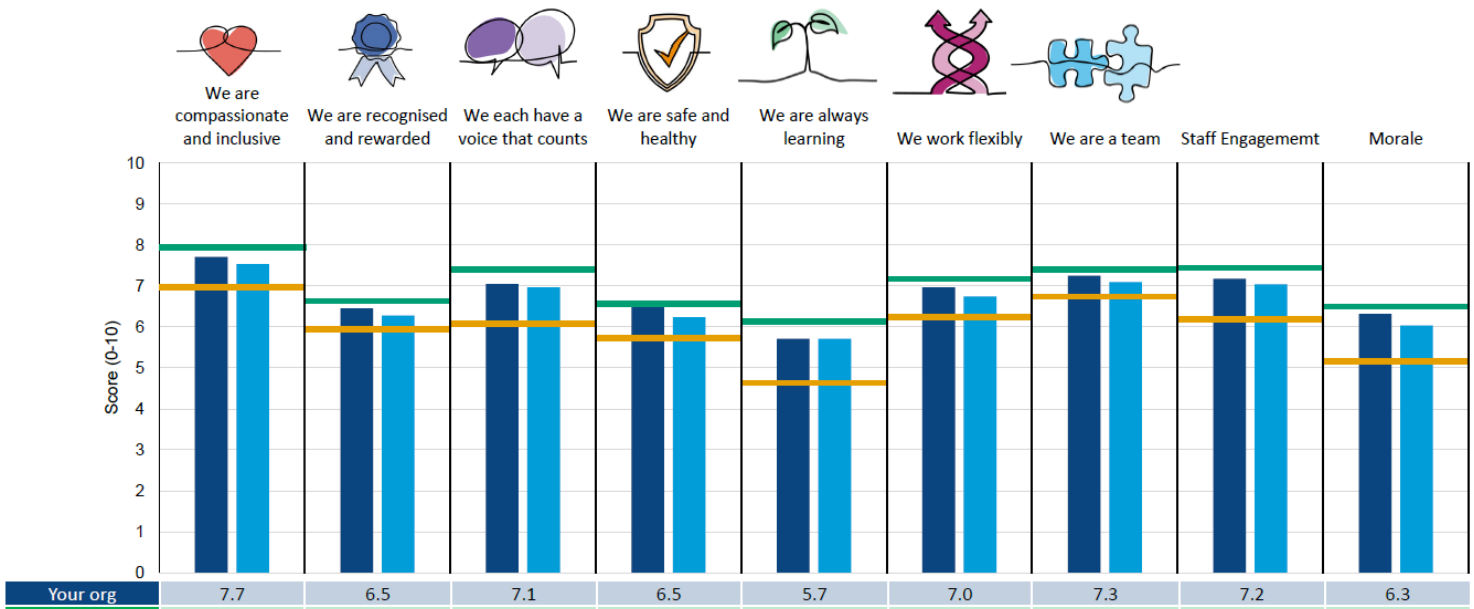
An overview of all people promise elements can be found in figure 2. We will go into each theme in detail – however in summary this tells us that, compared to the other 50 organisations we are benchmarked against, we are:

The best	0
Above average	8
Average	1
Below average	0
Lowest	0

Compared to 2021:

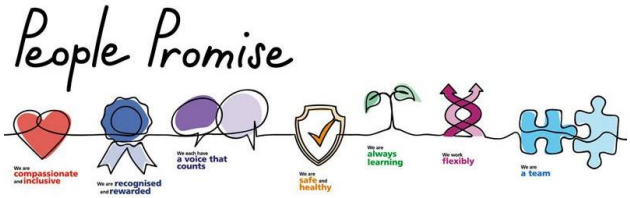
The best	3
Above average	6
Average	0
Below average	0
Lowest	0

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



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagememt	Morale
Your org	7.7	6.5	7.1	6.5	5.7	7.0	7.3	7.2	6.3
Best	7.9	6.6	7.4	6.6	6.1	7.2	7.4	7.4	6.5
Average	7.5	6.3	7.0	6.2	5.7	6.7	7.1	7.0	6.0
Worst	7.0	5.9	6.1	5.7	4.6	6.2	6.7	6.2	5.2
Responses	1408	1411	1400	1403	1343	1405	1408	1409	1411

We have devised an infographic to summarise the key results to share with staff, including how we scored on each theme this year against comparitors, example below, the full graphic is in Appendix 1.



Each theme is broken down and we can see the trends over the past 5 years (where available) and the individual question results that make up each theme giving us a good overview of our results against other organisations and previous years.

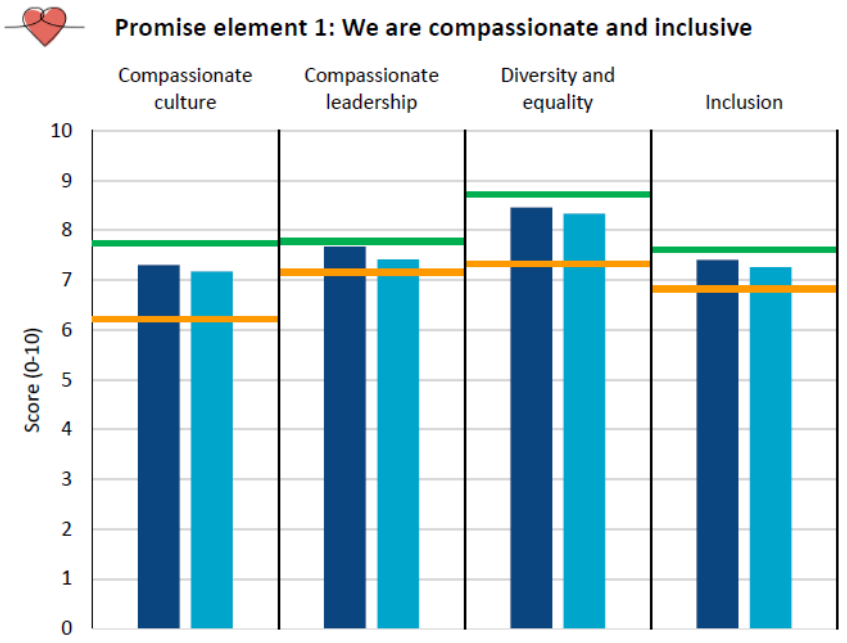
Theme 1 - We are compassionate and inclusive

Questions that make up the theme are below:

People Promise Elements	Sub-scores	Questions
	Compassionate culture	Q6a, Q23a, Q23b, Q23c, Q23d
	Compassionate leadership	Q9f, Q9g, Q9h, Q9i
	Diversity and equality	Q15, Q16a, Q16b, Q20
	Inclusion	Q7h, Q7i, Q8b, Q8c

Key points to note:

- **Theme score above average compared to other 50 Combined Mental Health / Learning Disability and Community Trusts**
- **There are 4 sub scores within this theme (above)**
- **Scores have declined by 0.1 of a point since last year.**
- **Large scores decrease in recommending a friend/relative**
- **Increase in positive management questions**

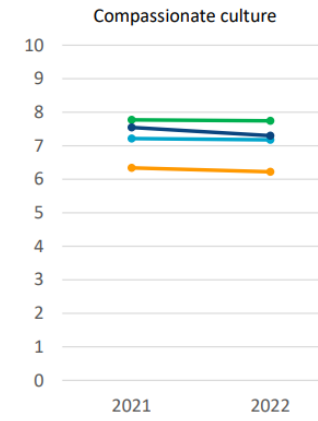


	Compassionate culture	Compassionate leadership	Diversity and equality	Inclusion
Your org	7.3	7.7	8.5	7.4
Best	7.7	7.8	8.7	7.6
Average	7.2	7.4	8.3	7.3
Worst	6.2	7.2	7.3	6.8
Responses	1402	1410	1407	1407

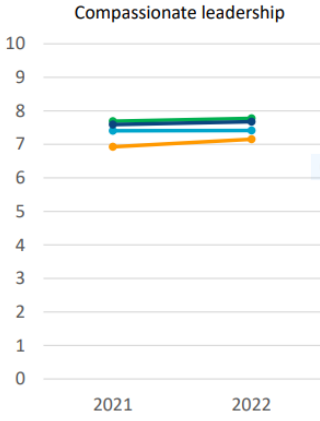
As you can see from the table above we score well above average for each subscore within the 'We are compassionate and Inclusive' People Promise Element.

The tables below shows that we have a declining score from last year on 2 subscores, **Compassionate Culture** and **Compassionate Leadership** and staying the same on the other 2 subscores. More detail into each question is in Appendix 2.

Promise element 1: We are compassionate and inclusive

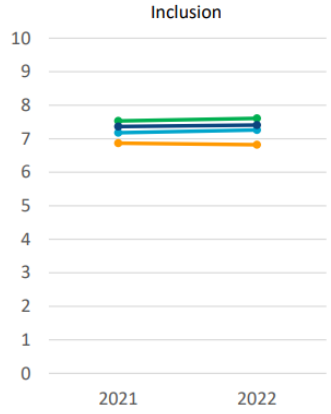


	2021	2022
Your org	7.5	7.3
Best	7.8	7.7
Average	7.2	7.2
Worst	6.3	6.2
Responses	1700	1402



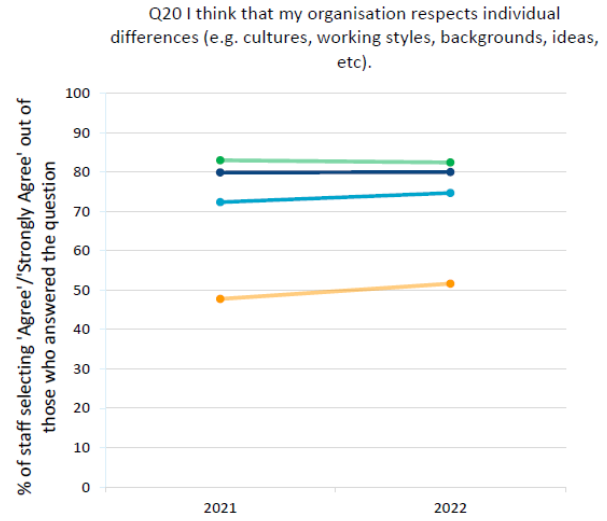
	2021	2022
Your org	7.6	7.7
Best	7.7	7.8
Average	7.4	7.4
Worst	6.9	7.2
Responses	1696	1410

	2021	2022
Your org	8.5	8.5
Best	8.7	8.7
Average	8.3	8.3
Worst	7.2	7.3
Responses	1689	1407

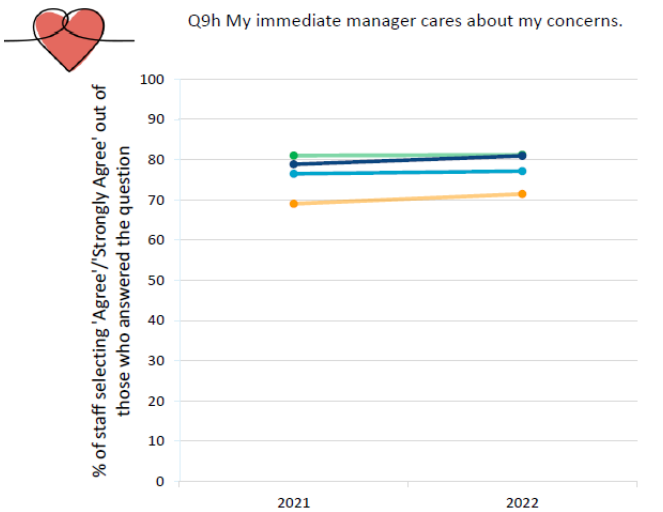


	2021	2022
Your org	7.4	7.4
Best	7.5	7.6
Average	7.2	7.3
Worst	6.9	6.8
Responses	1688	1407

The two questions below indicate an increase from last year.



	2021	2022
Your org	79.9%	80.0%
Best	83.0%	82.5%
Average	72.4%	74.7%
Worst	47.8%	51.7%
Responses	1692	1408



	2021	2022
Your org	78.8%	80.9%
Best	81.0%	81.2%
Average	76.5%	77.1%
Worst	69.0%	71.4%
Responses	1690	1410

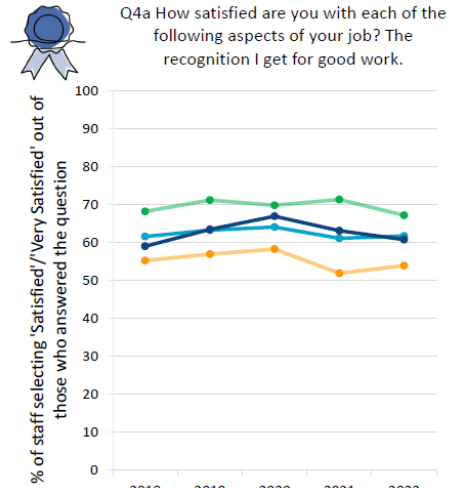
Theme 2 – We are Recognised and Rewarded

Questions that make up the theme are below:

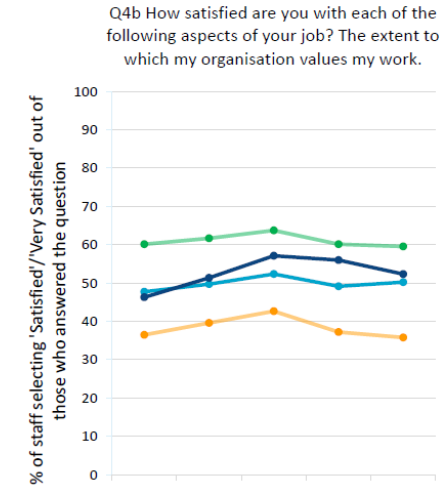
People Promise Elements	Sub-scores	Questions
We are recognised and rewarded	No Sub score	Q4a, Q4b, Q4c, Q8d, Q9e

Key points to note:

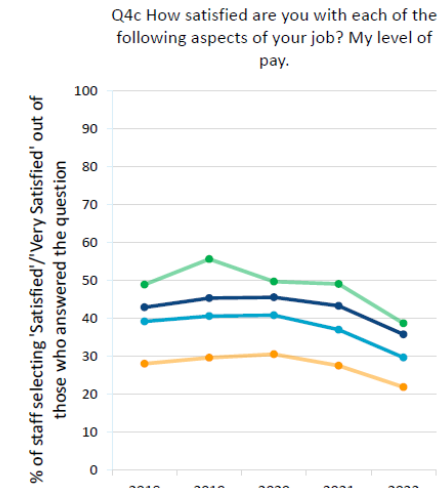
- **Theme score above average compared to other 50 Combined Mental Health / Learning Disability and Community Trusts**
- **Themes score was 0.1 point from being 'The Best' Score.**
- **There are no sub scores and 5 questions.**



	2018	2019	2020	2021	2022
Your org	59.0%	63.4%	66.9%	63.1%	60.7%
Best	68.1%	71.1%	69.8%	71.3%	67.1%
Average	61.5%	63.2%	64.1%	61.1%	61.7%
Worst	55.2%	56.9%	58.2%	51.9%	53.9%
Responses	1256	1503	1596	1688	1407



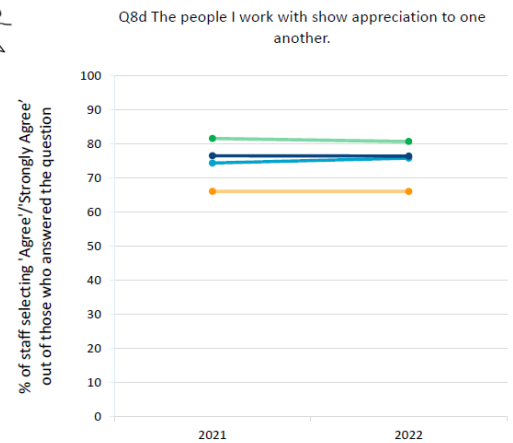
	2018	2019	2020	2021	2022
Your org	46.3%	51.4%	57.1%	56.0%	52.3%
Best	60.1%	61.7%	63.7%	60.1%	59.5%
Average	47.7%	49.7%	52.4%	49.1%	50.2%
Worst	36.5%	39.6%	42.6%	37.2%	35.8%
Responses	1249	1502	1590	1682	1407



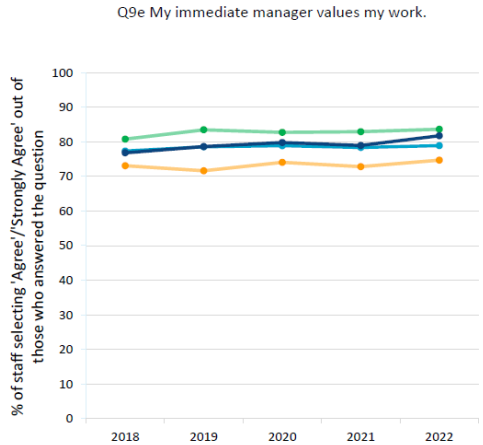
	2018	2019	2020	2021	2022
Your org	42.9%	45.3%	45.5%	43.3%	35.8%
Best	48.9%	55.6%	49.7%	49.0%	38.7%
Average	39.2%	40.6%	40.8%	37.0%	29.7%
Worst	28.1%	29.6%	30.5%	27.5%	21.9%
Responses	1251	1503	1592	1684	1410

As you can see from the qraphs above this score has had a decline compared to last year however this is still above average in most questions aside from Q4a which sits just below average.

The highlight in this theme is Q9e, this was our best result from 2018- 2022 with **81.8% stating that their immediate manager values their work**.



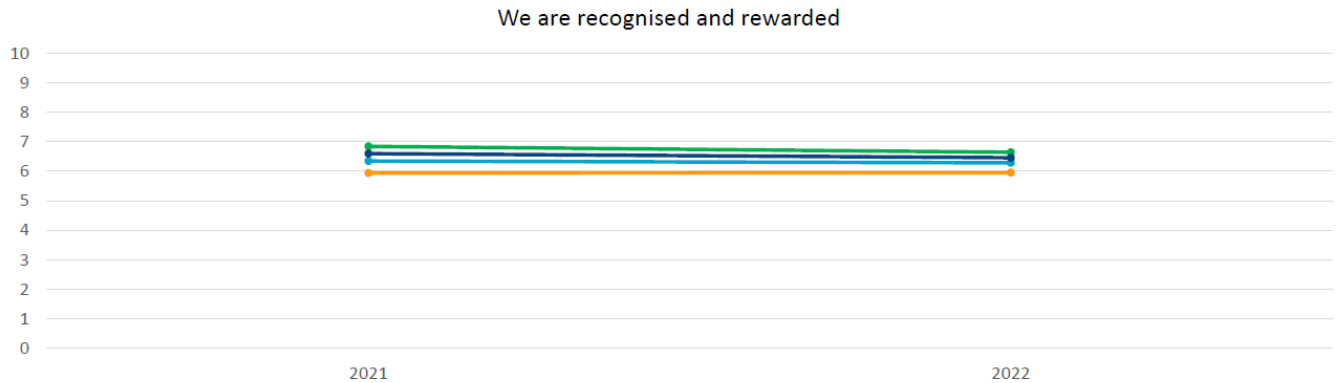
	2021	2022
Your org	76.4%	76.3%
Best	81.5%	80.6%
Average	74.3%	75.7%
Worst	66.0%	66.0%
Responses	1691	1409



	2018	2019	2020	2021	2022
Your org	76.8%	78.6%	79.8%	79.0%	81.8%
Best	80.8%	83.5%	82.7%	82.9%	83.7%
Average	77.3%	78.6%	78.9%	78.4%	78.9%
Worst	73.1%	71.6%	74.1%	72.8%	74.7%
Responses	1249	1493	1594	1696	1407

The table below shows that even though we have declined from last years score we are still only 0.1 point from best and well **above average** for this theme.

Promise element 2: We are recognised and rewarded



	2021	2022
Your org	6.6	6.5
Best	6.8	6.6
Average	6.3	6.3
Worst	5.9	5.9
Responses	1691	1411

Reward and Recognition is also a common theme being displayed in our free text data provided from the survey.

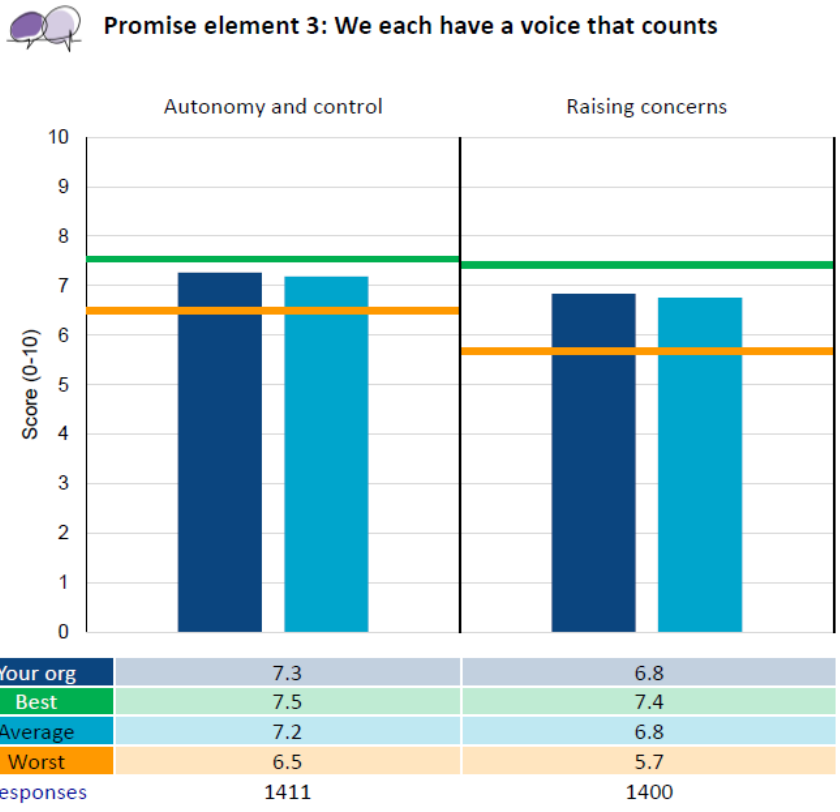
Theme 3 – We each have a voice that counts

Questions that make up the theme are stated below.

People Promise Elements	Sub-scores	Questions
People Promise We each have a voice that counts	Autonomy and control	Q3a, Q3b, Q3c, Q3d, Q3e, Q3f, Q5b
	Raising concerns	Q19a, Q19b, Q23e, Q23f

Key points to note:

- **Theme scores average compared to other 51 Combined Mental Health / Learning Disability and Community Trusts**
- **Decline on overall theme score from last year**
- **Includes 2 sub scores and 11 questions.**
- **We increased last years score for feeling safe to speak up**

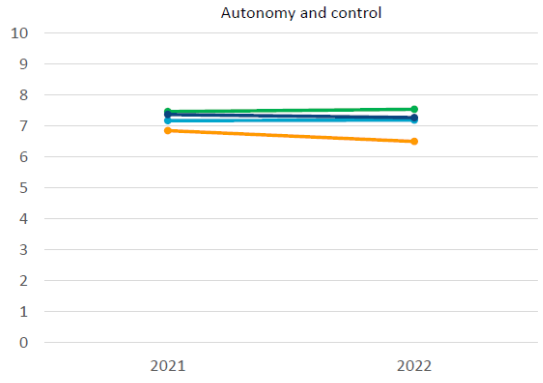


	Autonomy and control	Raising concerns
Your org	7.3	6.8
Best	7.5	7.4
Average	7.2	6.8
Worst	6.5	5.7
Responses	1411	1400

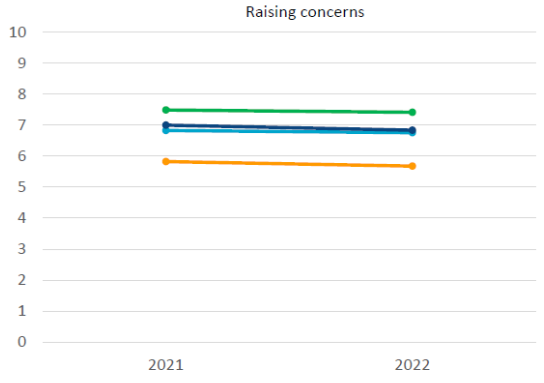
From the graph above you can see we are just hitting the score for average which is a steep decline from last years above average score.

The Graph below shows a decline from last years score on both sub scores however ‘Autonomy and control’ is **above average** in isolation.

Promise element 3: We each have a voice that counts



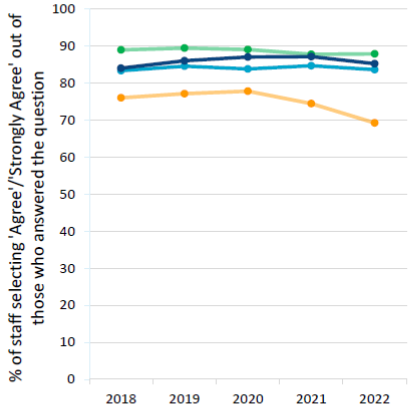
	2021	2022
Your org	7.4	7.3
Best	7.5	7.5
Average	7.2	7.2
Worst	6.8	6.5
Responses	1700	1411



	2021	2022
Your org	7.0	6.8
Best	7.5	7.4
Average	6.8	6.8
Worst	5.8	5.7
Responses	1689	1400

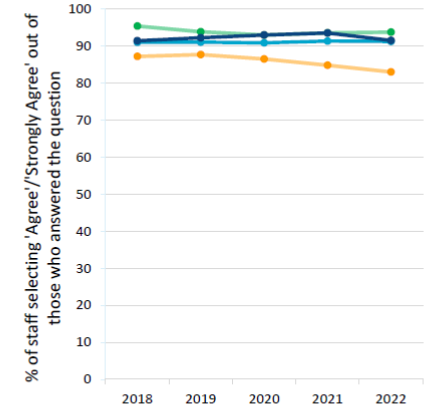
Below is a summary of each question that sits under this theme.

Q3a I always know what my work responsibilities are.



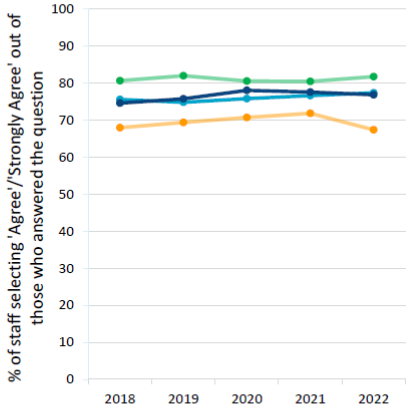
	2018	2019	2020	2021	2022
Your org	83.9%	85.9%	86.9%	87.0%	85.1%
Best	88.8%	89.3%	88.9%	87.7%	87.8%
Average	83.3%	84.4%	83.7%	84.6%	83.5%
Worst	75.9%	77.0%	77.7%	74.4%	69.2%
Responses	1271	1509	1593	1698	1410

Q3b I am trusted to do my job.



	2018	2019	2020	2021	2022
Your org	91.3%	92.1%	92.9%	93.4%	91.4%
Best	95.3%	93.7%	92.9%	93.4%	93.6%
Average	90.9%	90.9%	90.7%	91.2%	91.1%
Worst	87.1%	87.6%	86.4%	84.7%	82.9%
Responses	1260	1508	1591	1695	1411

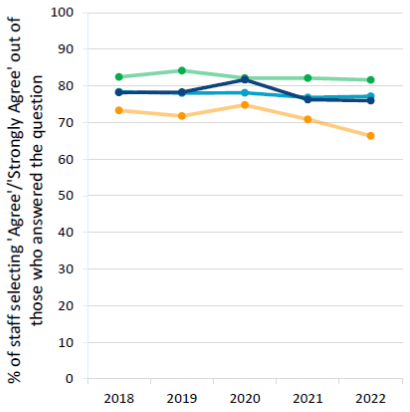
Q3c There are frequent opportunities for me to show initiative in my role.



	2018	2019	2020	2021	2022
Your org	74.5%	75.7%	77.9%	77.5%	76.8%
Best	80.5%	81.9%	80.4%	80.4%	81.6%
Average	75.5%	74.7%	75.7%	76.5%	77.3%
Worst	67.9%	69.3%	70.6%	71.7%	67.3%
Responses	1271	1510	1599	1695	1407

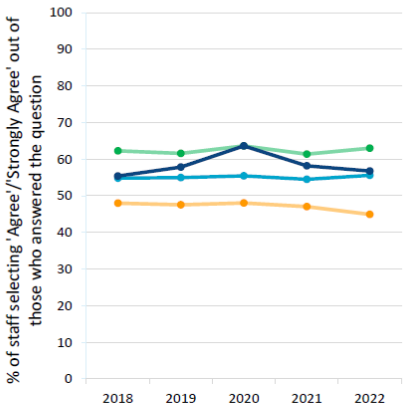
Q3A and Q3b are above average whilst Q3c is below average, all have decreased compared to last year

Q3d I am able to make suggestions to improve the work of my team / department.



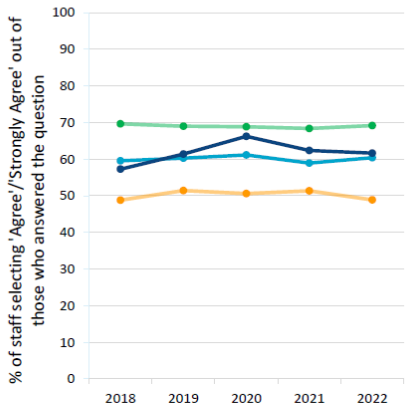
	2018	2019	2020	2021	2022
Your org	78.2%	78.3%	81.7%	76.2%	75.9%
Best	82.4%	84.2%	82.1%	82.1%	81.6%
Average	78.3%	78.0%	78.1%	76.8%	77.1%
Worst	73.3%	71.7%	74.8%	70.9%	66.3%
Responses	1267	1508	1595	1696	1409

Q3e I am involved in deciding on changes introduced that affect my work area / team / department.



	2018	2019	2020	2021	2022
Your org	55.4%	57.8%	63.6%	58.2%	56.7%
Best	62.3%	61.6%	63.6%	61.3%	63.0%
Average	54.8%	55.0%	55.4%	54.5%	55.6%
Worst	48.0%	47.5%	48.0%	47.0%	44.9%
Responses	1272	1503	1593	1693	1411

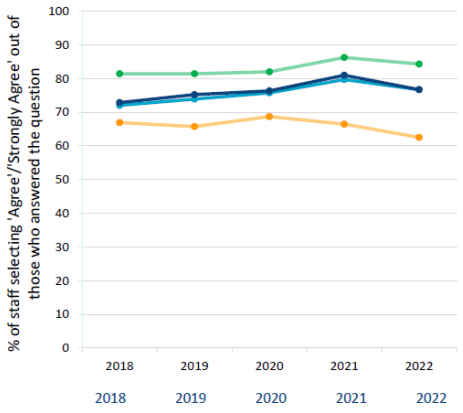
Q3f I am able to make improvements happen in my area of work.



	2018	2019	2020	2021	2022
Your org	57.3%	61.4%	66.2%	62.3%	61.6%
Best	69.6%	69.0%	68.8%	68.4%	69.1%
Average	59.5%	60.3%	61.1%	58.9%	60.4%
Worst	48.8%	51.4%	50.6%	51.3%	48.9%
Responses	1269	1507	1591	1687	1408

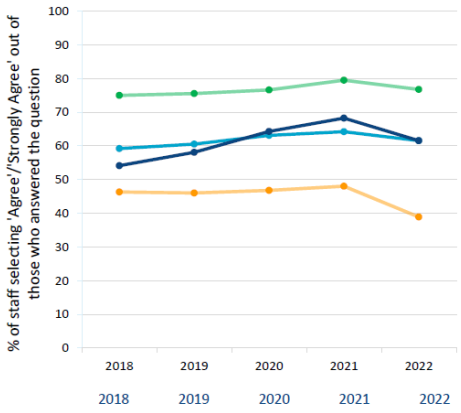
The graphs above indicate that Q3e and Q3f are above average whilst Q3d is below average, all have had a decrease in score.

Q19a I would feel secure raising concerns about unsafe clinical practice.



	2018	2019	2020	2021	2022
Your org	72.8%	75.2%	76.3%	80.9%	76.7%
Best	81.4%	81.4%	82.0%	86.2%	84.3%
Average	72.0%	73.9%	75.7%	79.7%	76.7%
Worst	66.9%	65.7%	68.7%	66.4%	62.5%
Responses	1230	1481	1593	1689	1406

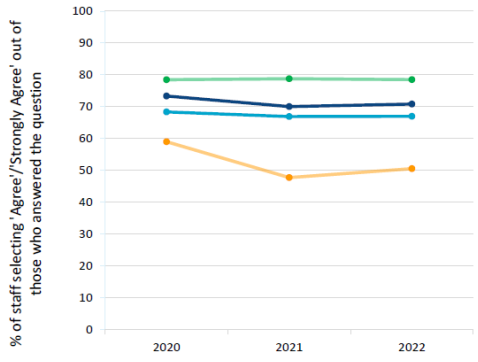
Q19b I am confident that my organisation would address my concern.



	2018	2019	2020	2021	2022
Your org	54.1%	58.1%	64.3%	68.2%	61.5%
Best	75.0%	75.5%	76.6%	79.5%	76.7%
Average	59.2%	60.5%	63.1%	64.2%	61.5%
Worst	46.3%	46.0%	46.8%	48.0%	38.9%
Responses	1225	1480	1592	1690	1406

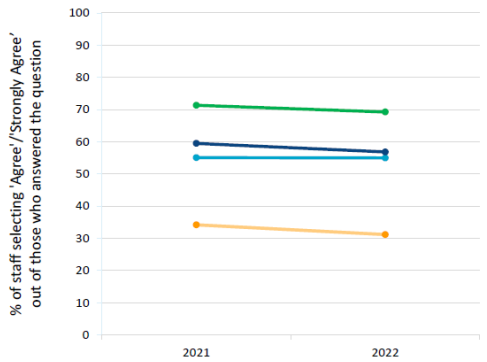
The above two questions are a decrease from last year and have moved from above average to average.

Q23e I feel safe to speak up about anything that concerns me in this organisation.



	2020	2021	2022
Your org	73.3%	70.0%	70.8%
Best	78.5%	78.8%	78.5%
Average	68.3%	66.9%	67.0%
Worst	59.0%	47.7%	50.5%
Responses	1594	1696	1403

Q23f If I spoke up about something that concerned me I am confident my organisation would address my concern.



	2021	2022
Your org	59.5%	56.8%
Best	71.3%	69.2%
Average	55.0%	55.0%
Worst	34.2%	31.1%
Responses	1694	1403

The above two questions are a **decrease** from last year and are still **above average.**

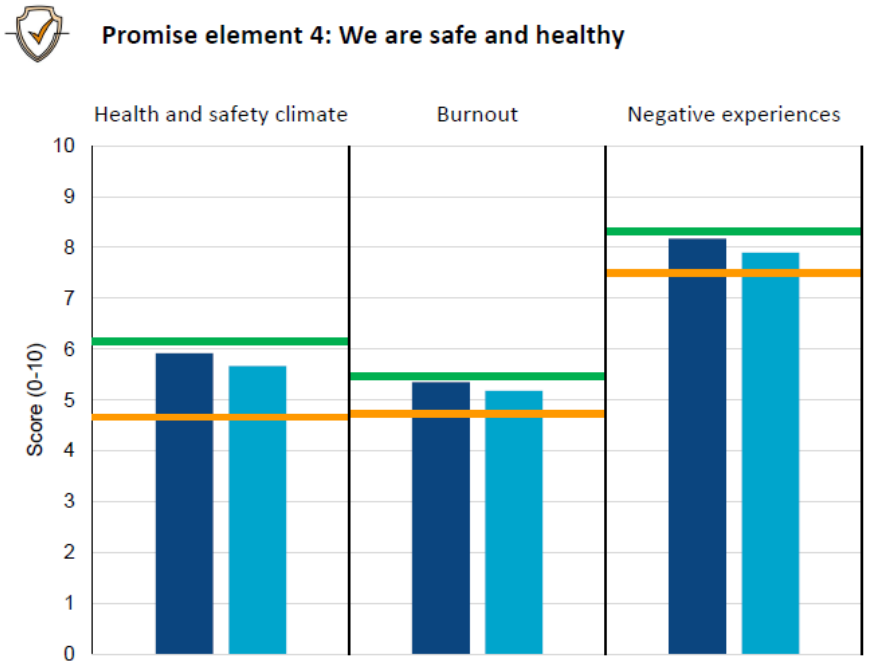
Theme 4 – We are safe and Healthy

Questions that make up the theme are below:

People Promise Elements	Sub-scores	Questions
We are safe and healthy	Health and safety climate	Q3g, Q3h, Q3i, Q5a Q11a, Q13d, Q14d
	Burnout	Q12a, Q12b, Q12c, Q12d, Q12e, Q12f, Q12g
	Negative experiences	Q11b, Q11c, Q11d, Q13a, Q13b, Q13c, Q14a, Q14b, Q14c

Key points to note:

- **Theme score above average compared to other 51 Combined Mental Health / Learning Disability and Community Trusts**
- **Decrease on overall theme score from last year**
- **Increased positive score on 'Negative Experiences'**

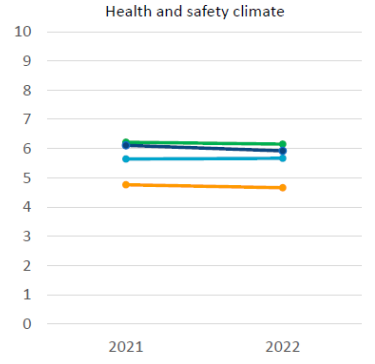


	Health and safety climate	Burnout	Negative experiences
Your org	5.9	5.3	8.2
Best	6.2	5.5	8.3
Average	5.7	5.2	7.9
Worst	4.7	4.7	7.5
Responses	1411	1409	1406

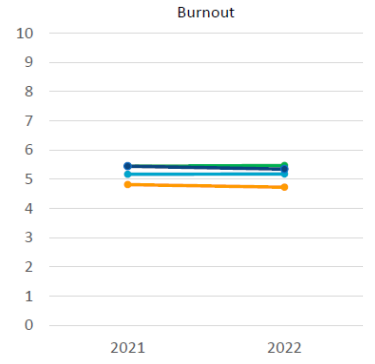
The graph above shows all sub scores from this People Promise element are above average with **'Negative Experiences'** close to best.

The analysis below shows the scores compared to 2021 for each element, the largest decrease being **'Health and safety climate'**.

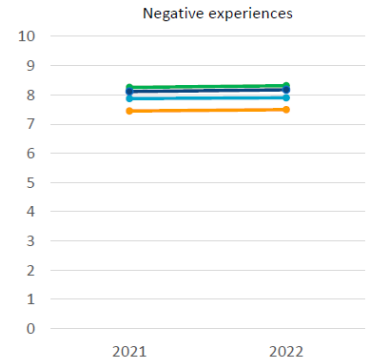
Promise element 4: We are safe and healthy



	2021	2022
Your org	6.1	5.9
Best	6.2	6.2
Average	5.6	5.7
Worst	4.8	4.7
Responses	1699	1411

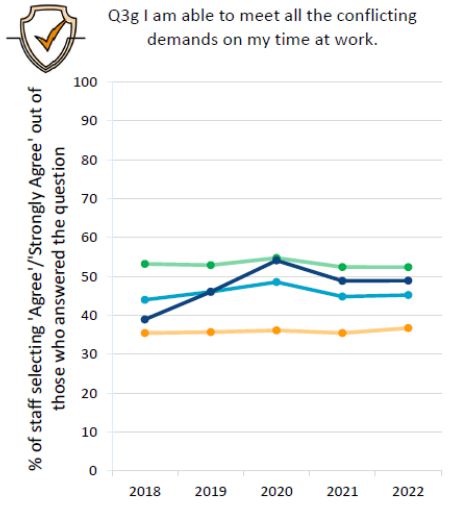


	2021	2022
Your org	5.4	5.3
Best	5.4	5.5
Average	5.2	5.2
Worst	4.8	4.7
Responses	1695	1409

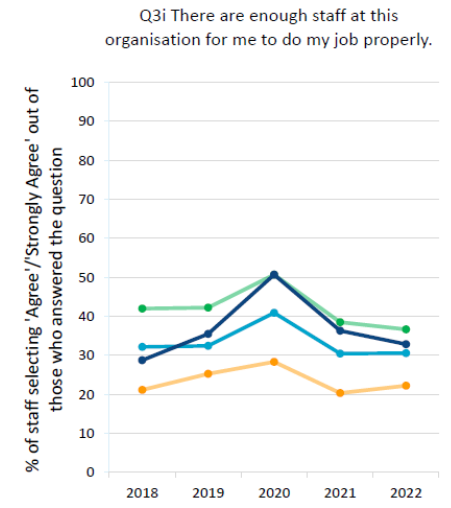


	2021	2022
Your org	8.1	8.2
Best	8.3	8.3
Average	7.9	7.9
Worst	7.4	7.5
Responses	1692	1406

The questions below are highlighted as a strong positive or strong negative, the full list of questions and responses are available in Appendix 3.



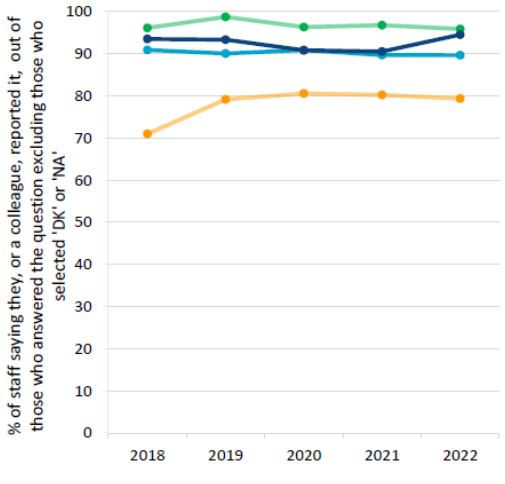
	2018	2019	2020	2021	2022
Your org	38.9%	46.0%	54.1%	48.8%	48.9%
Best	53.2%	52.9%	54.8%	52.4%	52.4%
Average	44.0%	46.0%	48.6%	44.8%	45.2%
Worst	35.4%	35.7%	36.1%	35.4%	36.7%
Responses	1269	1504	1589	1691	1408



	2018	2019	2020	2021	2022
Your org	28.7%	35.5%	50.7%	36.3%	32.8%
Best	42.0%	42.2%	50.7%	38.5%	36.6%
Average	32.1%	32.4%	40.9%	30.4%	30.5%
Worst	21.1%	25.2%	28.3%	20.3%	22.2%
Responses	1269	1505	1593	1696	1410

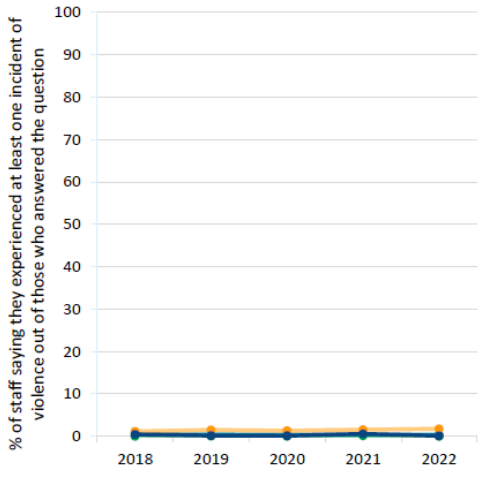
Q3g shows an increase from last year and Q3i shows a large decline from last year.

Q13d The last time you experienced physical violence at work, did you or a colleague report it?



	2018	2019	2020	2021	2022
Your org	93.5%	93.3%	90.8%	90.5%	94.5%
Best	96.1%	98.7%	96.3%	96.8%	95.9%
Average	90.9%	90.0%	90.9%	89.7%	89.6%
Worst	71.0%	79.2%	80.5%	80.2%	79.4%
Responses	159	187	199	193	145

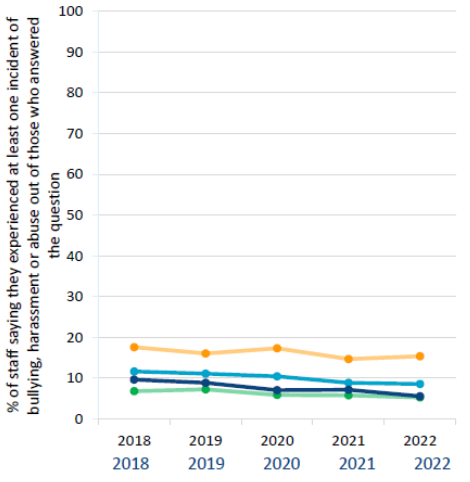
Q13b In the last 12 months how many times have you personally experienced physical violence at work from...? Managers.



	2018	2019	2020	2021	2022
Your org	0.4%	0.2%	0.2%	0.6%	0.1%
Best	0.0%	0.1%	0.0%	0.1%	0.0%
Average	0.5%	0.4%	0.4%	0.4%	0.4%
Worst	1.2%	1.5%	1.3%	1.6%	1.8%
Responses	1216	1481	1591	1689	1370

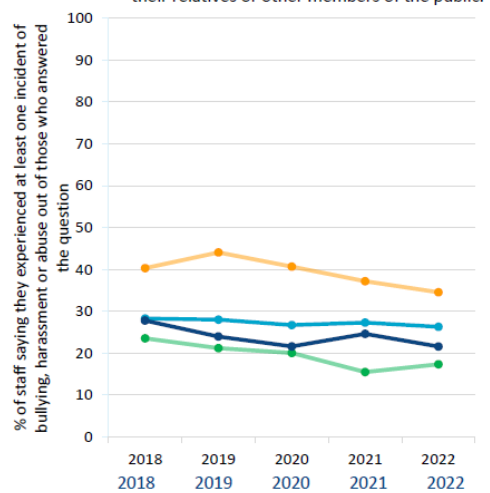
Q13d shows the most positive score we have had between 2018-2022 for reporting experiencing physical voilence at work. Q13b shows the **lowest level of physical violence** from managers.

Q14b In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from...? Managers.



	2018	2019	2020	2021	2022
Your org	9.6%	8.8%	7.0%	7.1%	5.5%
Best	6.8%	7.2%	5.8%	5.8%	5.2%
Average	11.6%	11.1%	10.4%	8.8%	8.5%
Worst	17.6%	16.0%	17.3%	14.7%	15.3%
Responses	1210	1474	1586	1673	1389

Q14a In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from...? Patients / service users, their relatives or other members of the public.



	2018	2019	2020	2021	2022
Your org	27.8%	23.9%	21.6%	24.6%	21.6%
Best	23.5%	21.2%	20.0%	15.5%	17.3%
Average	28.3%	28.0%	26.7%	27.3%	26.3%
Worst	40.3%	44.0%	40.6%	37.2%	34.5%
Responses	1236	1486	1593	1688	1399

Q14b and Q14a show the **lowest scores recorded** for bullying/harassment at work from managers for 2018-2023.

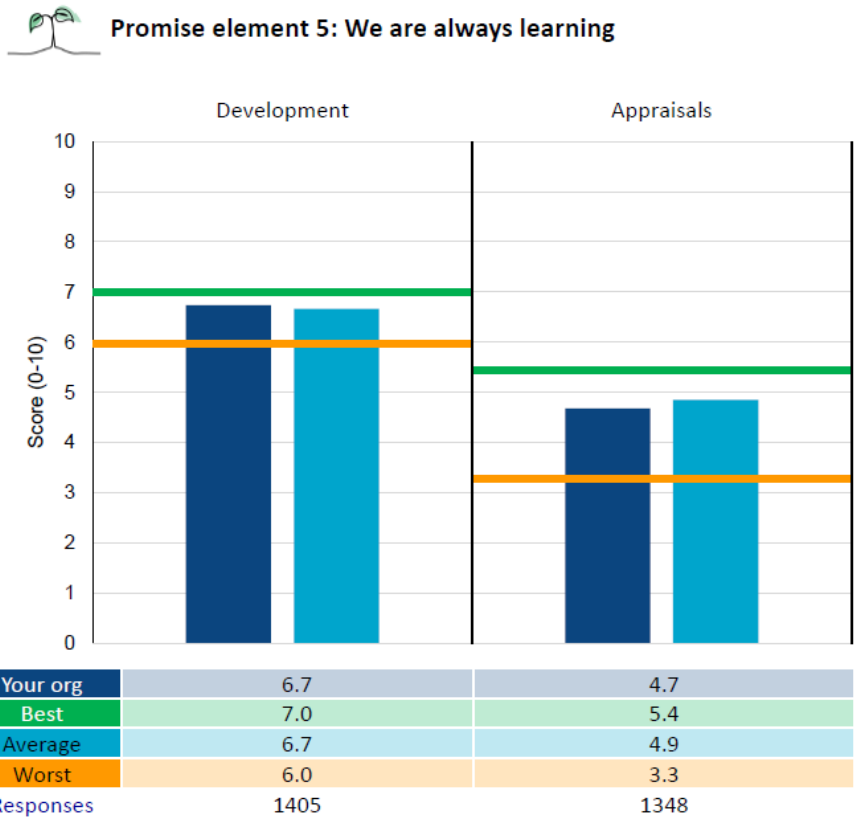
Theme 5 – We are always learning

Questions that make up the theme are below:

People Promise Elements	Sub-scores	Questions
	Development	Q22a, Q22b, Q22c, Q22d, Q22e
	Appraisals	Q21a*, Q21b, Q21c, Q21d *Q21a is a filter question and therefore influences the sub score without being a directly scored question.

Key points to note:

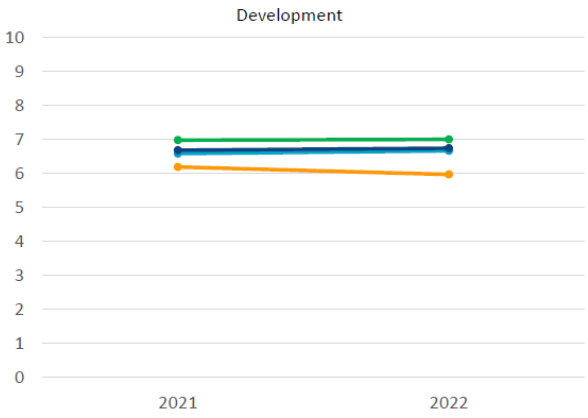
- **Theme score is average compared to other 51 Combined Mental Health / Learning Disability and Community Trusts**
- **Decline on overall theme score from last year**
- **No scores have seen improvement in this theme.**



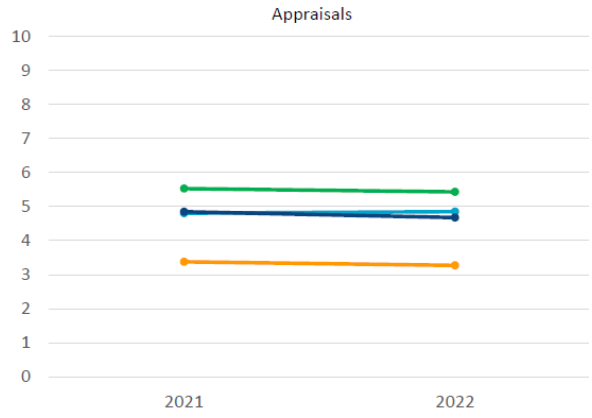
	Development	Appraisals
Your org	6.7	4.7
Best	7.0	5.4
Average	6.7	4.9
Worst	6.0	3.3
Responses	1405	1348

Development is average and Appraisals are below average looking at the results above.

Promise element 5: We are always learning

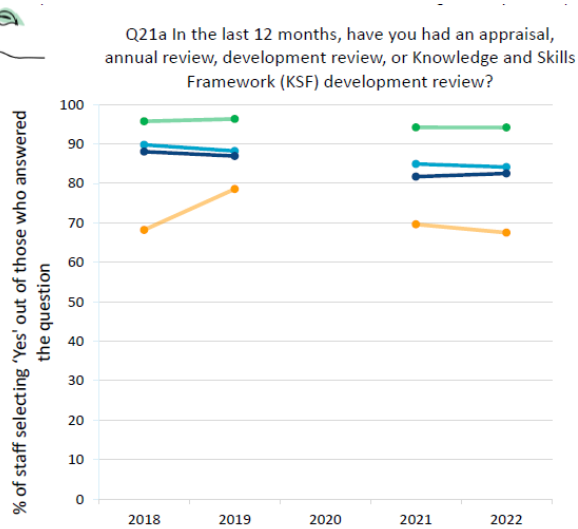


	2021	2022
Your org	6.7	6.7
Best	7.0	7.0
Average	6.6	6.7
Worst	6.2	6.0
Responses	1698	1405

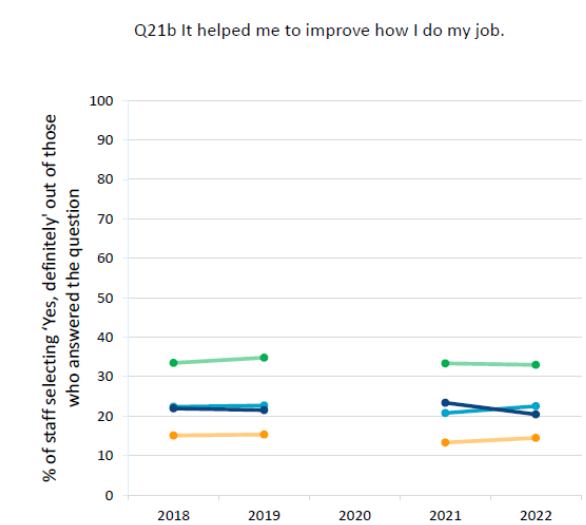


	2021	2022
Your org	4.8	4.7
Best	5.5	5.4
Average	4.8	4.9
Worst	3.4	3.3
Responses	1599	1348

Development has stayed the same score however the average this year is higher putting us at average for this sub score, Appraisals have had a decline this year which means this sits **below average**.



	2018	2019	2020	2021	2022
Your org	88.1%	86.9%	-	81.7%	82.5%
Best	95.7%	96.3%	-	94.2%	94.2%
Average	89.8%	88.2%	-	84.9%	84.1%
Worst	68.2%	78.6%	-	69.6%	67.5%
Responses	1224	1482	-	1688	1400



	2018	2019	2020	2021	2022
Your org	21.9%	21.5%	-	23.4%	20.4%
Best	33.5%	34.8%	-	33.4%	33.0%
Average	22.4%	22.7%	-	20.8%	22.5%
Worst	15.1%	15.3%	-	13.3%	14.5%
Responses	1058	1281	-	1375	1152

Q21a shows an increase from last year for appraisals but is still a low score compared to 2018/19, 21b has shown a steep decline from last year and the **lowest score recorded.**

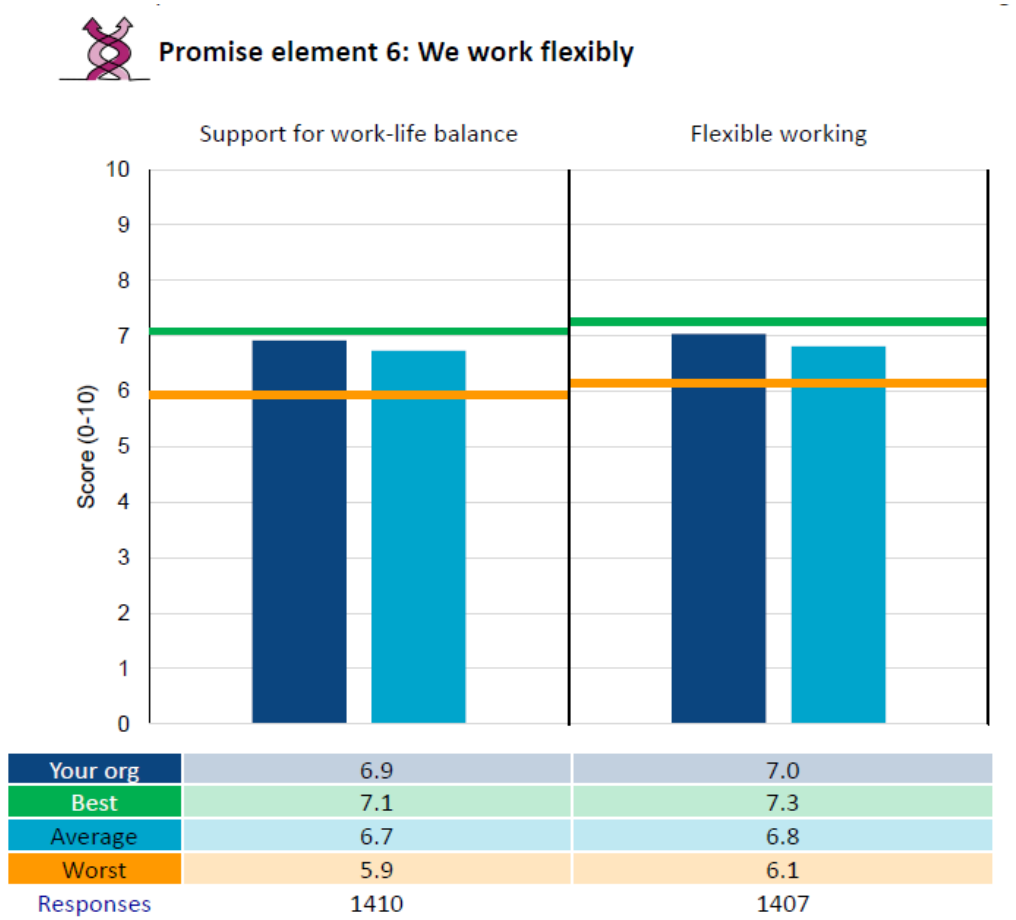
Theme 6 – We work Flexibly

Questions that make up the theme are stated below:

People Promise Elements	Sub-scores	Questions
We work flexibly	Support for work life balance	Q6b, Q6c, Q6d
	Flexible working	Q4d

Key points to note:

- **Theme score above average compared to other 51 Combined Mental Health / Learning Disability and Community Trusts in both sub scores.**
- **Decline on overall theme score from last year**

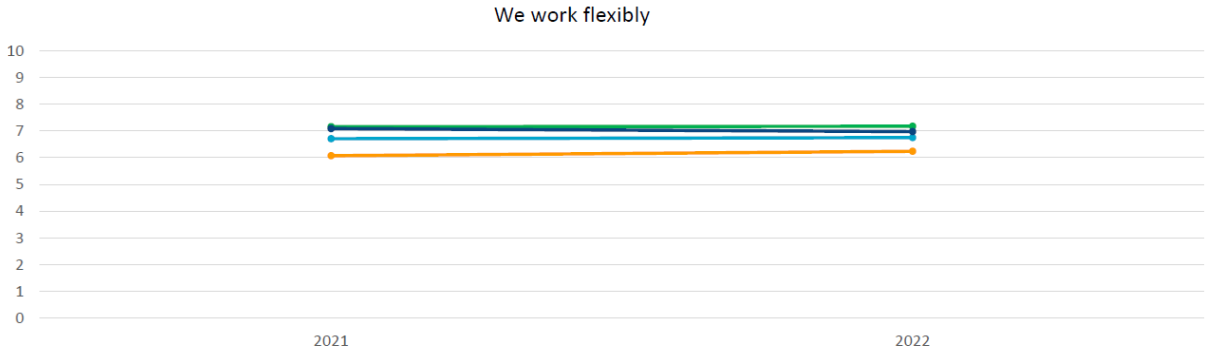


	Support for work-life balance	Flexible working
Your org	6.9	7.0
Best	7.1	7.3
Average	6.7	6.8
Worst	5.9	6.1
Responses	1410	1407

We are above average on our scores for both elements of 'We work flexibly'

Overall score for ‘We work flexibly’ is don’t by 0.1 points from last years results, we are still comfortably **above average**.

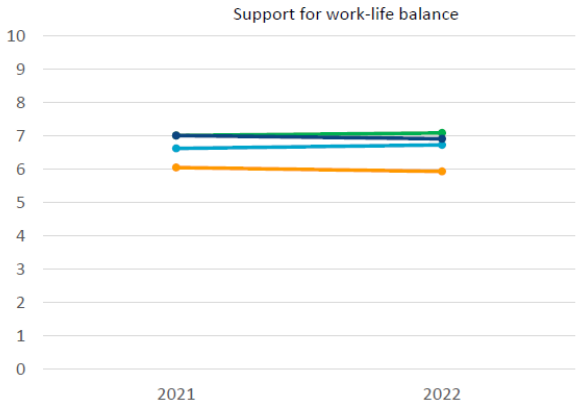
Promise element 6: We work flexibly



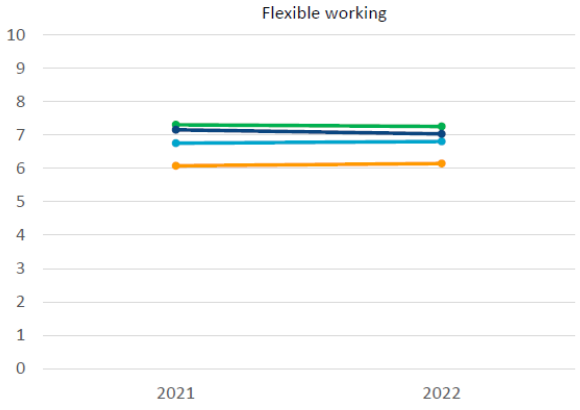
	2021	2022
Your org	7.1	7.0
Best	7.2	7.2
Average	6.7	6.7
Worst	6.1	6.2
Responses	1681	1405

The graphs below show the individual sub score results.

Promise element 6: We work flexibly



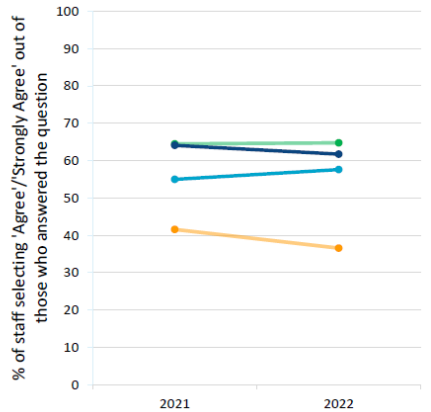
	2021	2022
Your org	7.0	6.9
Best	7.0	7.1
Average	6.6	6.7
Worst	6.0	5.9
Responses	1698	1410



	2021	2022
Your org	7.2	7.0
Best	7.3	7.3
Average	6.8	6.8
Worst	6.1	6.1
Responses	1684	1407

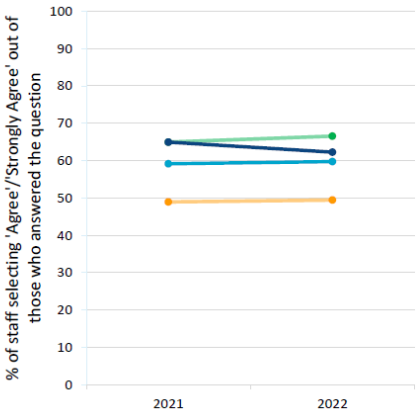
The graphs below show the individual scores for each question that contributes to the overall score.

Q6b My organisation is committed to helping me balance my work and home life.



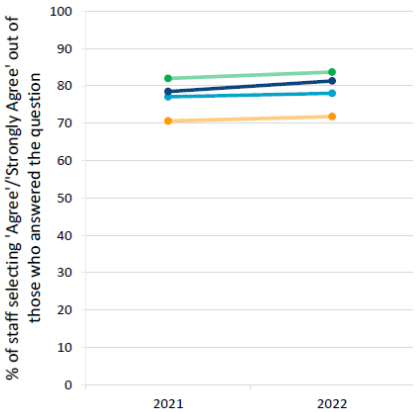
	2021	2022
Your org	64.1%	61.7%
Best	64.5%	64.7%
Average	55.0%	57.6%
Worst	41.5%	36.6%
Responses	1697	1409

Q6c I achieve a good balance between my work life and my home life.



	2021	2022
Your org	64.9%	62.2%
Best	64.9%	66.5%
Average	59.1%	59.7%
Worst	48.9%	49.4%
Responses	1691	1410

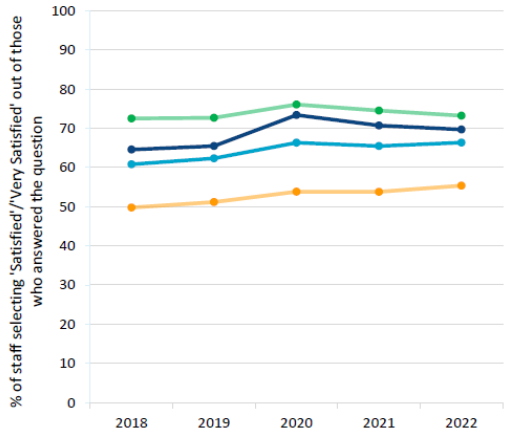
Q6d I can approach my immediate manager talk openly about flexible working.



	2021	2022
Your org	78.5%	81.3%
Best	82.0%	83.7%
Average	77.1%	78.0%
Worst	70.6%	71.8%
Responses	1696	1409

Q6b and Q6c have decreased scores whilst still being above average, Q6d has **increased in score from last year by 1.8%.**

Q4d How satisfied are you with each of the following aspects of your job? The opportunities for flexible working patterns.



	2018	2019	2020	2021	2022
Your org	64.6%	65.4%	73.4%	70.7%	69.7%
Best	72.5%	72.7%	76.1%	74.5%	73.2%
Average	60.8%	62.3%	66.3%	65.5%	66.3%
Worst	49.8%	51.2%	53.8%	53.8%	55.4%
Responses	1256	1503	1589	1684	1407

Q4d shows a decrease from last year but still above average.

Theme 7 - We are a team

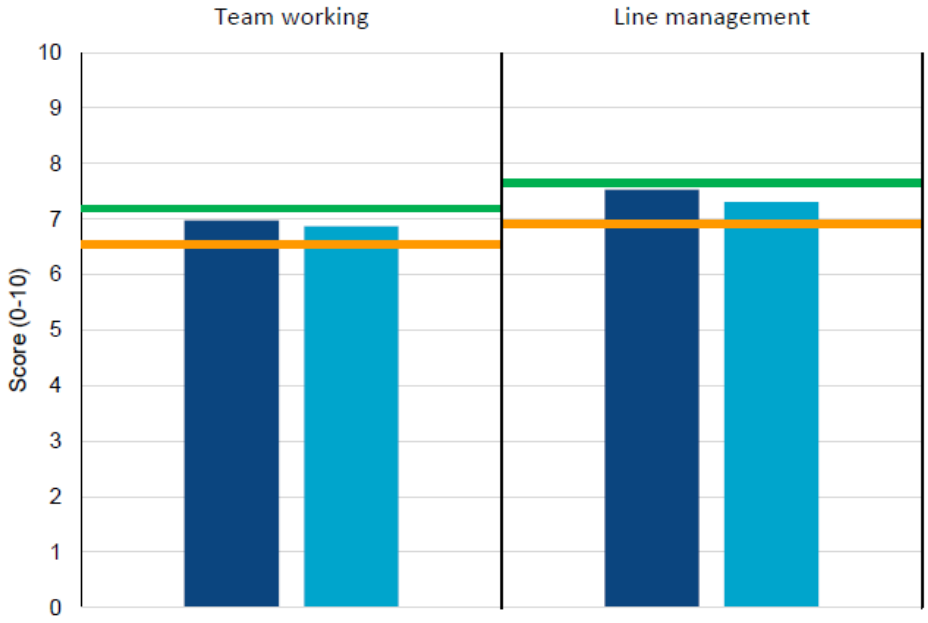
Questions that make up the theme are below:

People Promise Elements	Sub-scores	Questions
	Team working	Q7a, Q7b, Q7c, Q7d, Q7e, Q7f, Q7g, Q8a
	Line management	Q9a, Q9b, Q9c, Q9d

Key points to note:

- **Theme score above average compared to other 51 Combined Mental Health / Learning Disability and Community Trusts**
- **No Increase or Decrease on overall theme score from last year**
- **Decrease in sub scores**

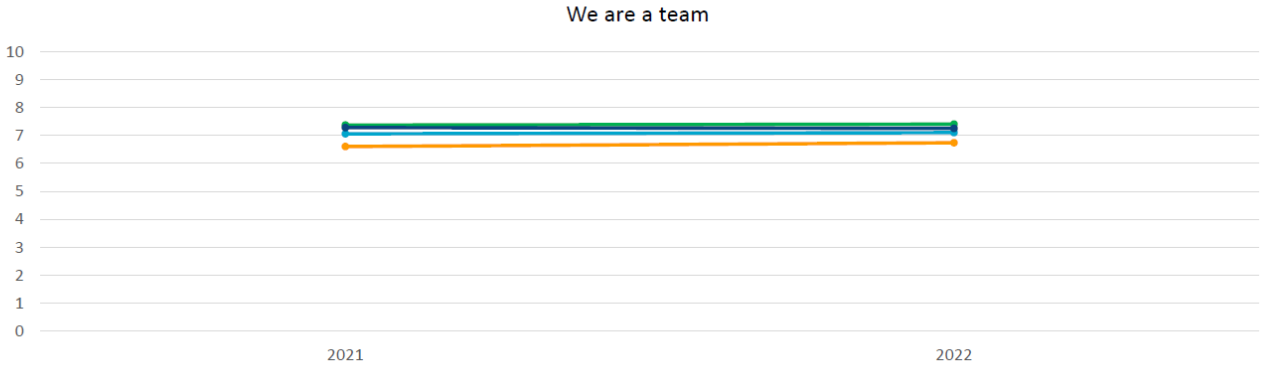
Promise element 7: We are a team



	Team working	Line management
Your org	7.0	7.5
Best	7.2	7.7
Average	6.9	7.3
Worst	6.5	6.9
Responses	1410	1409

As you can see from the above both sub scores are above average.

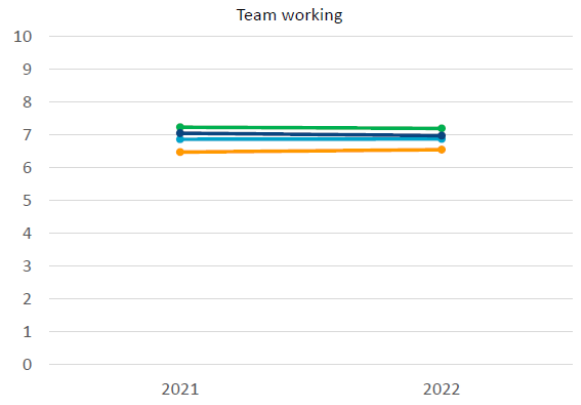
Promise element 7: We are a team



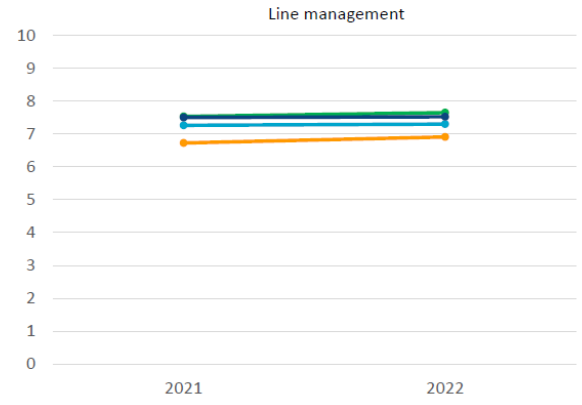
	2021	2022
Your org	7.3	7.3
Best	7.4	7.4
Average	7.1	7.1
Worst	6.6	6.7
Responses	1691	1408

The graph above shows that there hasn't been an **increase or decrease** of the 'We are a team 'People promise element.

Promise element 7: We are a team



	2021	2022
Your org	7.0	7.0
Best	7.2	7.2
Average	6.9	6.9
Worst	6.5	6.5
Responses	1694	1410

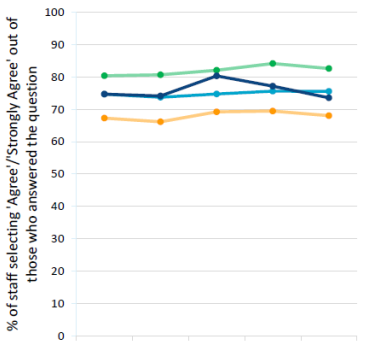


	2021	2022
Your org	7.5	7.5
Best	7.5	7.7
Average	7.3	7.3
Worst	6.7	6.9
Responses	1696	1409

No change in sub scores.

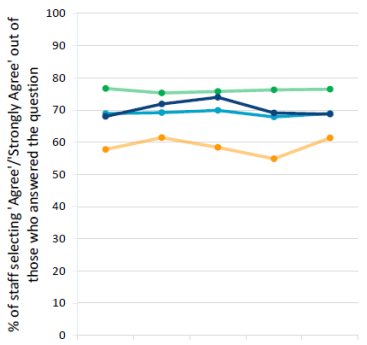
The graphs below show the results for the individual questions that sit under the 'We are a team' People Element.

Q7a The team I work in has a set of shared objectives.



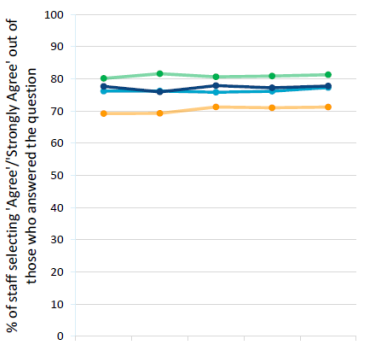
	2018	2019	2020	2021	2022
Your org	74.7%	74.1%	80.3%	77.1%	73.5%
Best	80.3%	80.6%	82.0%	84.1%	82.6%
Average	74.7%	73.7%	74.7%	75.6%	75.5%
Worst	67.3%	66.1%	69.2%	69.4%	68.0%
Responses	1263	1486	1587	1690	1407

Q7b The team I work in often meets to discuss the team's effectiveness.



	2018	2019	2020	2021	2022
Your org	68.0%	71.9%	74.0%	69.1%	68.7%
Best	76.7%	75.3%	75.8%	76.3%	76.5%
Average	68.9%	69.2%	69.9%	67.9%	68.9%
Worst	57.7%	61.4%	58.4%	54.9%	61.3%
Responses	1267	1506	1585	1690	1405

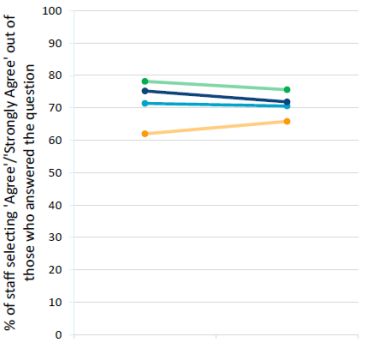
Q7c I receive the respect I deserve from my colleagues at work.



	2018	2019	2020	2021	2022
Your org	77.7%	76.0%	77.9%	77.2%	77.8%
Best	80.2%	81.6%	80.6%	80.9%	81.3%
Average	76.2%	76.2%	75.8%	76.1%	77.3%
Worst	69.2%	69.3%	71.3%	71.0%	71.2%
Responses	1270	1509	1588	1689	1406

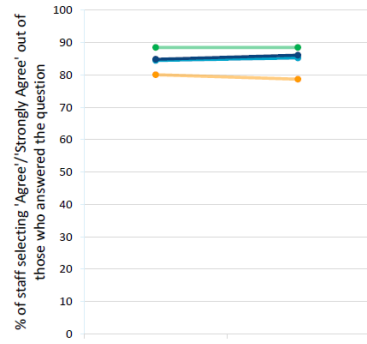
Q7a and Q7b show a decline from last year and below average and Q7c shows an **increase**.

Q7d Team members understand each other's roles.



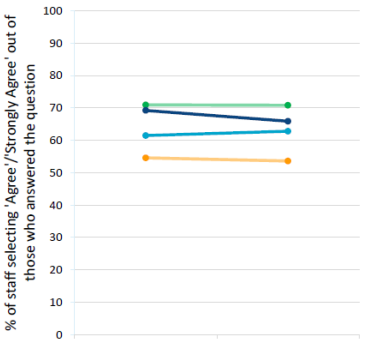
	2021	2022
Your org	75.2%	71.8%
Best	78.2%	75.6%
Average	71.4%	70.6%
Worst	62.0%	65.8%
Responses	1690	1410

Q7e I enjoy working with the colleagues in my team.



	2021	2022
Your org	84.8%	86.1%
Best	88.5%	88.5%
Average	84.4%	85.2%
Worst	80.0%	78.7%
Responses	1686	1407

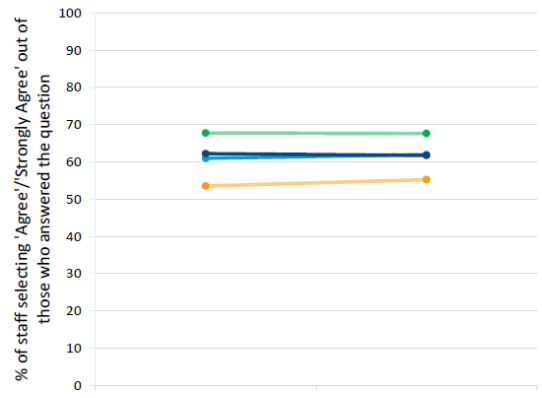
Q7f My team has enough freedom in how to do its work.



	2021	2022
Your org	69.2%	65.9%
Best	70.9%	70.8%
Average	61.5%	62.8%
Worst	54.6%	53.6%
Responses	1684	1407

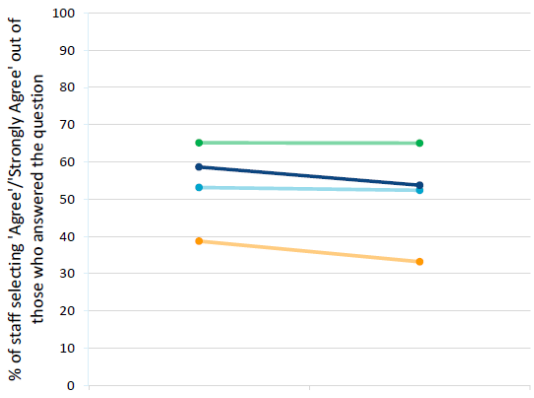
Q7d and Q7f show a decrease from last year and Q7e shows an increase **'I enjoy working with the colleagues in my team'.**

Q7g In my team disagreements are dealt with constructively.



	2021	2022
Your org	62.2%	61.7%
Best	67.8%	67.6%
Average	61.0%	62.0%
Worst	53.5%	55.2%
Responses	1686	1409

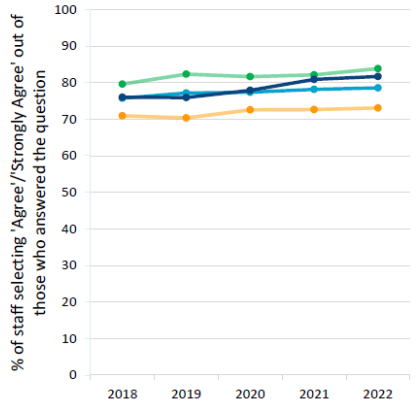
Q8a Teams within this organisation work well together to achieve their objectives.



	2021	2022
Your org	58.6%	53.7%
Best	65.1%	65.0%
Average	53.1%	52.4%
Worst	38.7%	33.2%
Responses	1694	1409

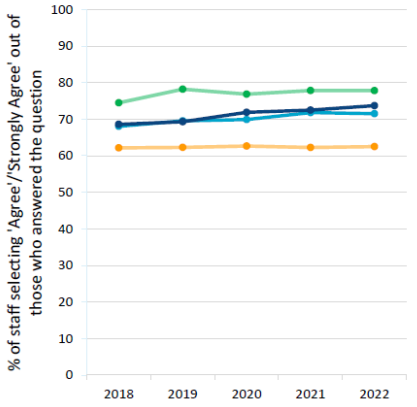
Both questions display a decline from last year, Q7g is below average '**disagreements are dealt with constructively**' and Q8a is above average.

Q9a My immediate manager encourages me at work.



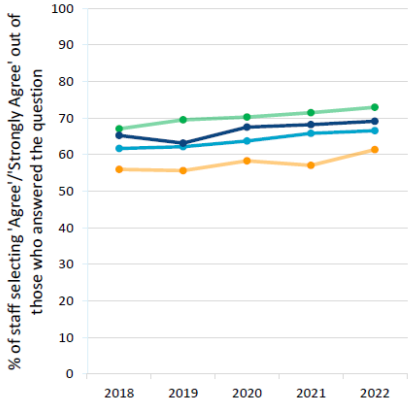
	2018	2019	2020	2021	2022
Your org	76.0%	75.9%	77.9%	80.9%	81.7%
Best	79.6%	82.3%	81.6%	82.1%	83.8%
Average	75.7%	77.1%	77.4%	78.1%	78.5%
Worst	70.9%	70.3%	72.5%	72.6%	73.1%
Responses	1247	1497	1597	1696	1409

Q9b My immediate manager gives me clear feedback on my work.



	2018	2019	2020	2021	2022
Your org	68.6%	69.3%	71.9%	72.5%	73.7%
Best	74.5%	78.2%	76.8%	77.8%	77.8%
Average	68.0%	69.5%	69.9%	71.8%	71.5%
Worst	62.1%	62.3%	62.6%	62.3%	62.5%
Responses	1246	1495	1593	1694	1406

Q9c My immediate manager asks for my opinion before making decisions that affect my work.



	2018	2019	2020	2021	2022
Your org	65.2%	63.1%	67.5%	68.2%	69.1%
Best	67.0%	69.5%	70.3%	71.5%	72.9%
Average	61.7%	62.2%	63.7%	65.8%	66.6%
Worst	56.0%	55.6%	58.3%	57.0%	61.3%
Responses	1247	1497	1594	1696	1407

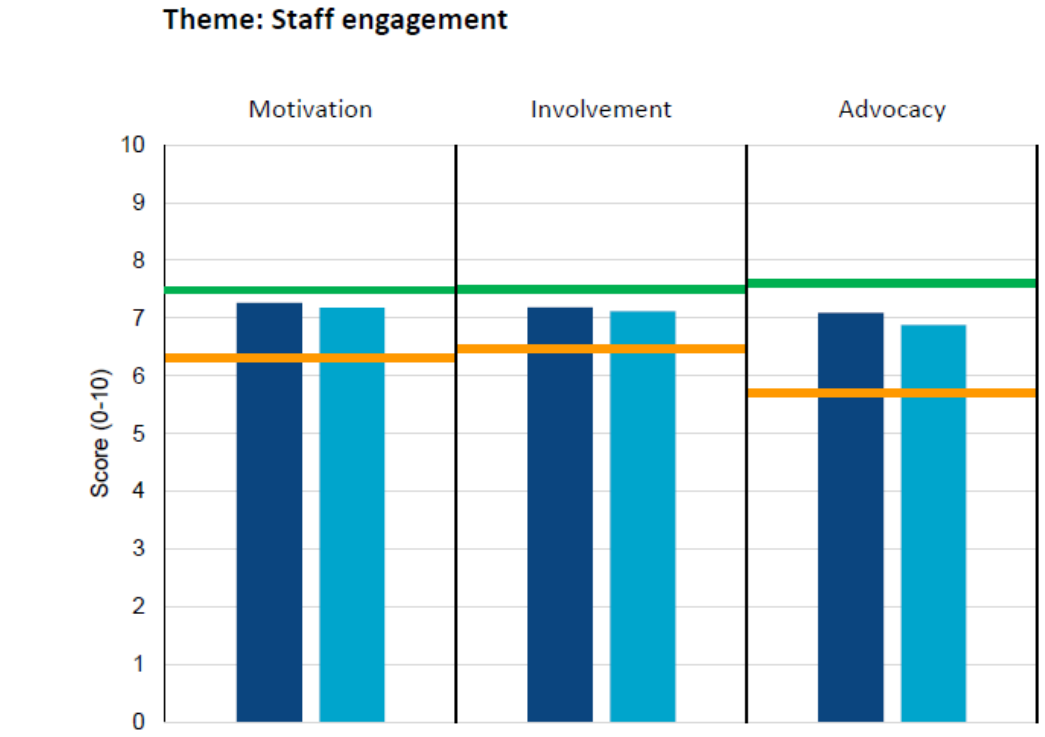
Staff engagement

Questions that make up the theme are below:

People Promise Elements	Sub-scores	Questions
	Motivation	Q2a, Q2b, Q2c
	Involvement	Q3c, Q3d, Q3f
	Advocacy	Q23a, Q23c, Q23d

Key points to note:

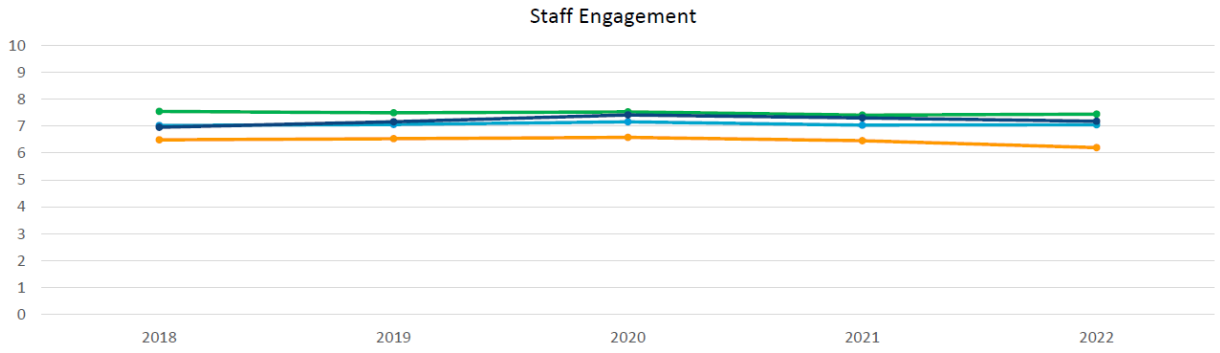
- **Theme score above average compared to other 51 Combined Mental Health / Learning Disability and Community Trusts**
- **Overall above average on all sub scores**
- **Score has reduced since last year's results**



	Motivation	Involvement	Advocacy
Your org	7.3	7.2	7.1
Best	7.5	7.5	7.6
Average	7.2	7.1	6.9
Worst	6.3	6.5	5.7
Responses	1396	1411	1403

The above graphs show **above average scores** for all elements of the Staff engagement theme.

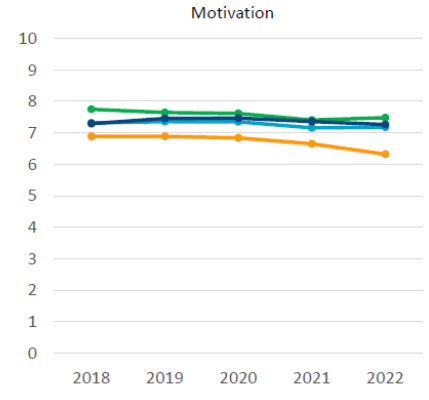
Theme: Staff Engagement



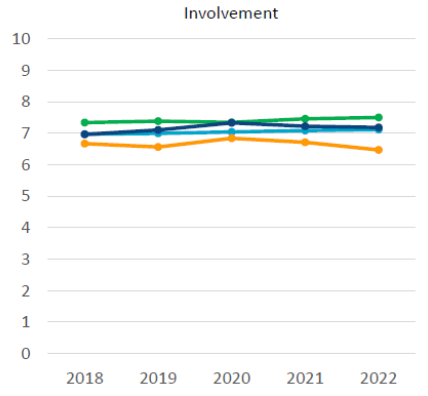
	2018	2019	2020	2021	2022
Your org	7.0	7.2	7.4	7.3	7.2
Best	7.5	7.5	7.5	7.4	7.4
Average	7.0	7.1	7.2	7.0	7.0
Worst	6.5	6.5	6.6	6.5	6.2
Responses	1273	1511	1600	1700	1409

The overall score for staff engagement has decreased from last year however is not the lowest score received between 2018-23.

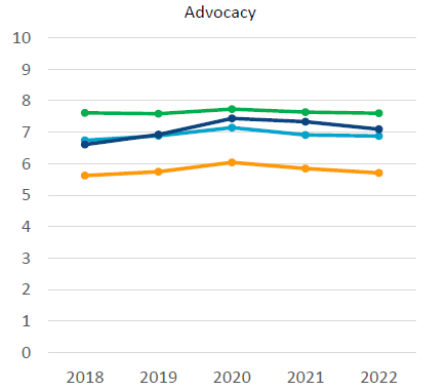
Theme: Staff Engagement



	2018	2019	2020	2021	2022
Your org	7.3	7.5	7.5	7.4	7.3
Best	7.7	7.6	7.6	7.4	7.5
Average	7.3	7.4	7.3	7.2	7.2
Worst	6.9	6.9	6.8	6.6	6.3
Responses	1257	1498	1589	1685	1396



	2018	2019	2020	2021	2022
Your org	7.0	7.1	7.3	7.2	7.2
Best	7.3	7.4	7.3	7.5	7.5
Average	7.0	7.0	7.0	7.1	7.1
Worst	6.7	6.6	6.8	6.7	6.5
Responses	1272	1510	1598	1697	1411

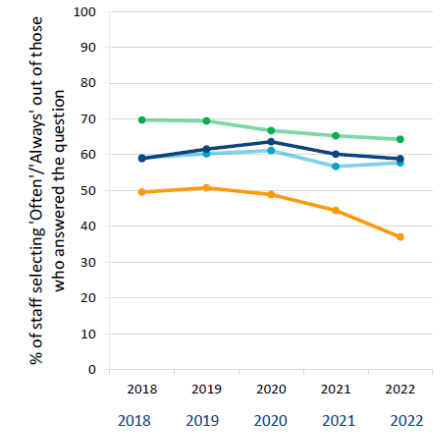


	2018	2019	2020	2021	2022
Your org	6.6	6.9	7.4	7.3	7.1
Best	7.6	7.6	7.7	7.6	7.6
Average	6.7	6.9	7.1	6.9	6.9
Worst	5.6	5.7	6.0	5.8	5.7
Responses	1222	1479	1599	1700	1403

As you can see from above the scores for ‘Motivation’ have decreased from last year but **on par with the results from 2018.** ‘Involvement’ has stayed the same as last year and is above average and ‘Advocacy’ has decreased however this is still higher than engagement levels in 2019.

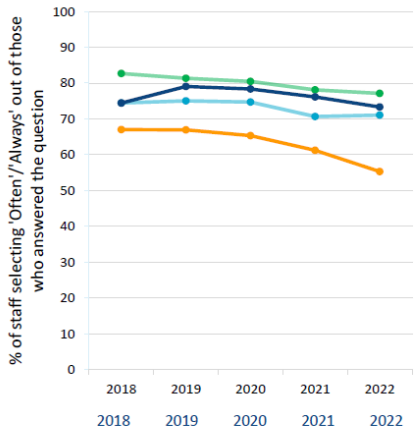
The graphs below show the individual results of the questions asked that feed into the overall Engagement score.

Q2a I look forward to going to work.



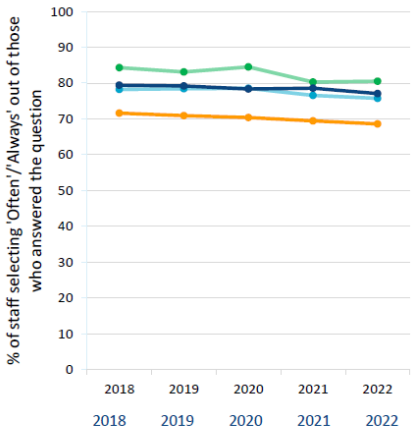
	2018	2019	2020	2021	2022
Your org	58.9%	61.5%	63.6%	60.1%	58.9%
Best	69.7%	69.4%	66.7%	65.3%	64.3%
Average	59.1%	60.2%	61.1%	56.7%	57.8%
Worst	49.5%	50.7%	48.9%	44.4%	37.0%
Responses	1269	1501	1591	1692	1401

Q2b I am enthusiastic about my job.



	2018	2019	2020	2021	2022
Your org	74.4%	79.1%	78.3%	76.1%	73.3%
Best	82.7%	81.3%	80.5%	78.1%	77.1%
Average	74.5%	75.0%	74.7%	70.7%	71.1%
Worst	67.0%	66.9%	65.3%	61.2%	55.3%
Responses	1257	1502	1586	1687	1400

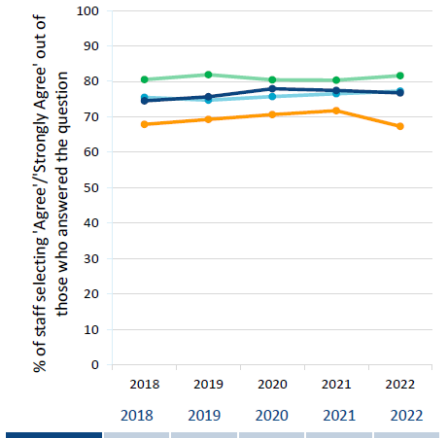
Q2c Time passes quickly when I am working.



	2018	2019	2020	2021	2022
Your org	79.4%	79.2%	78.3%	78.6%	77.1%
Best	84.3%	83.1%	84.5%	80.3%	80.5%
Average	78.2%	78.4%	78.6%	76.6%	75.7%
Worst	71.6%	70.9%	70.4%	69.4%	68.6%
Responses	1255	1501	1593	1688	1398

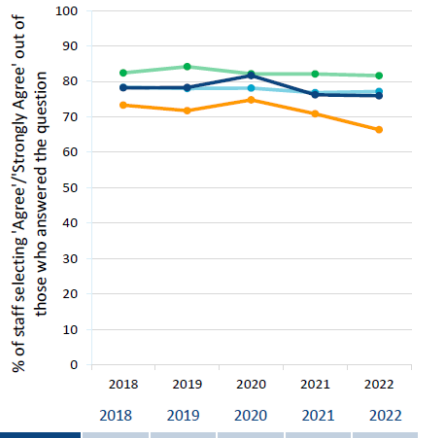
Q2a, 2b and 2c have all decreased and **above average**.

Q3c There are frequent opportunities for me to show initiative in my role.



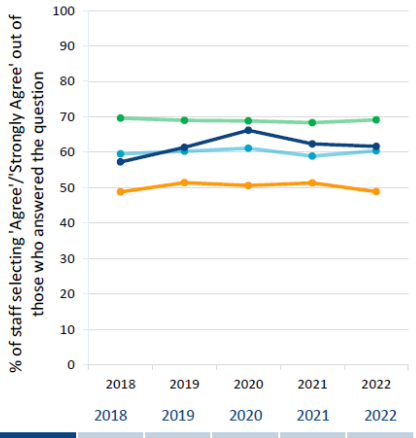
	2018	2019	2020	2021	2022
Your org	74.5%	75.7%	77.9%	77.5%	76.8%
Best	80.5%	81.9%	80.4%	80.4%	81.6%
Average	75.5%	74.7%	75.7%	76.5%	77.3%
Worst	67.9%	69.3%	70.6%	71.7%	67.3%
Responses	1271	1510	1599	1695	1407

Q3d I am able to make suggestions to improve the work of my team / department.



	2018	2019	2020	2021	2022
Your org	78.2%	78.3%	81.7%	76.2%	75.9%
Best	82.4%	84.2%	82.1%	82.1%	81.6%
Average	78.3%	78.0%	78.1%	76.8%	77.1%
Worst	73.3%	71.7%	74.8%	70.9%	66.3%
Responses	1267	1508	1595	1696	1409

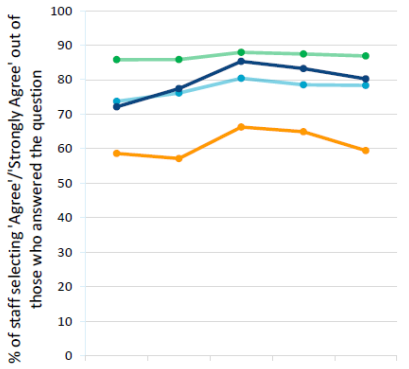
Q3f I am able to make improvements happen in my area of work.



	2018	2019	2020	2021	2022
Your org	57.3%	61.4%	66.2%	62.3%	61.6%
Best	69.6%	69.0%	68.8%	68.4%	69.1%
Average	59.5%	60.3%	61.1%	58.9%	60.4%
Worst	48.8%	51.4%	50.6%	51.3%	48.9%
Responses	1269	1507	1591	1687	1408

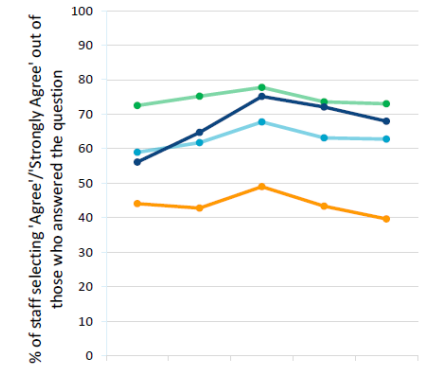
All scores have decreased however 3c (frequent opportunities to show initiative) and 3d (able to make suggestions to improve the work) are **below average.**

Q23a Care of patients / service users is my organisation's top priority.



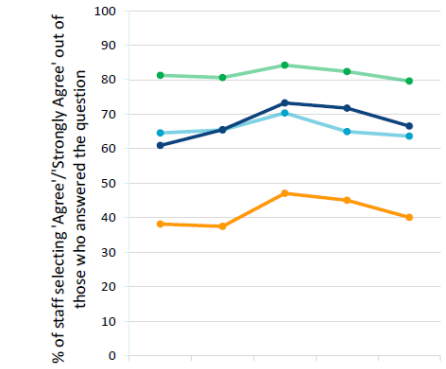
	2018	2019	2020	2021	2022
Your org	72.1%	77.4%	85.3%	83.2%	80.2%
Best	85.8%	85.9%	87.9%	87.5%	86.9%
Average	73.7%	76.1%	80.4%	78.5%	78.3%
Worst	58.6%	57.2%	66.3%	64.9%	59.5%
Responses	1222	1477	1596	1700	1400

Q23c I would recommend my organisation as a place to work.



	2018	2019	2020	2021	2022
Your org	56.1%	64.7%	75.2%	72.1%	68.0%
Best	72.5%	75.2%	77.8%	73.6%	73.0%
Average	59.0%	61.8%	67.8%	63.1%	62.8%
Worst	44.1%	42.8%	49.0%	43.3%	39.6%
Responses	1220	1478	1599	1699	1399

Q23d If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation.



	2018	2019	2020	2021	2022
Your org	60.9%	65.5%	73.3%	71.7%	66.5%
Best	81.3%	80.6%	84.2%	82.4%	79.6%
Average	64.6%	65.4%	70.4%	64.9%	63.6%
Worst	38.2%	37.5%	47.1%	45.0%	40.1%
Responses	1218	1478	1598	1697	1404

Decrease in all scores however still **above average.**

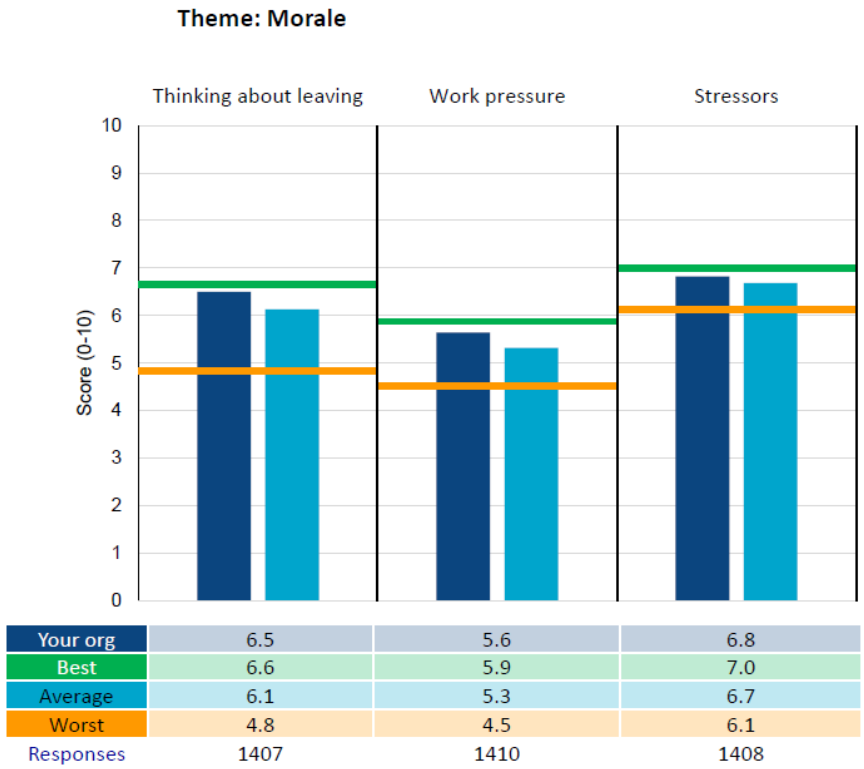
Morale

Questions that make up the theme are below:

People Promise Elements	Sub-scores	Questions
	Thinking about leaving	Q24a, Q24b, Q24c
	Work pressure	Q3g, Q3h, Q3i
	Stressors	Q3a, Q3e, Q5a, Q5b, Q5c, Q7c, Q9a

Key points to note:

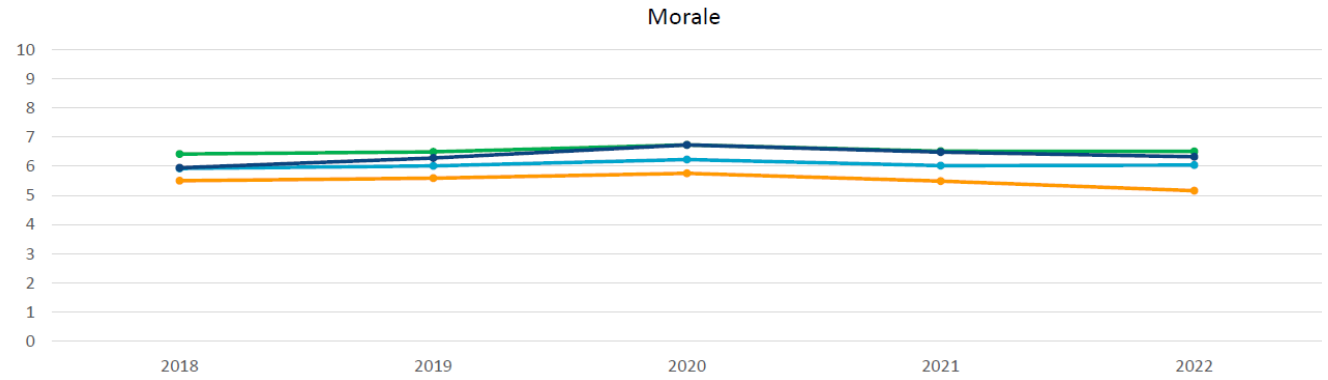
- **Theme score above average compared to other 51 Combined Mental Health / Learning Disability and Community Trusts**
- **Decrease on overall theme score from last year**
- **All sub scores decreased from last year**
- **Staff considering leaving has increased**



	Thinking about leaving	Work pressure	Stressors
Your org	6.5	5.6	6.8
Best	6.6	5.9	7.0
Average	6.1	5.3	6.7
Worst	4.8	4.5	6.1
Responses	1407	1410	1408

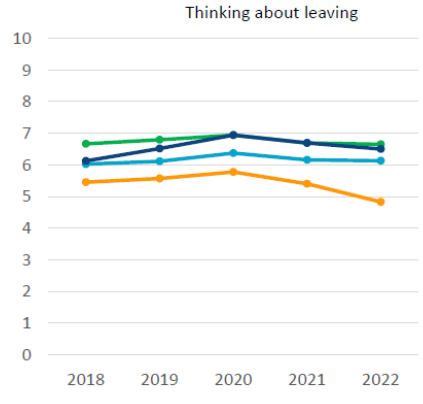
The above graphs show the scores for all sub scores within this theme, they are all above average with **'Work pressures' being the lowest.**

Theme: Morale

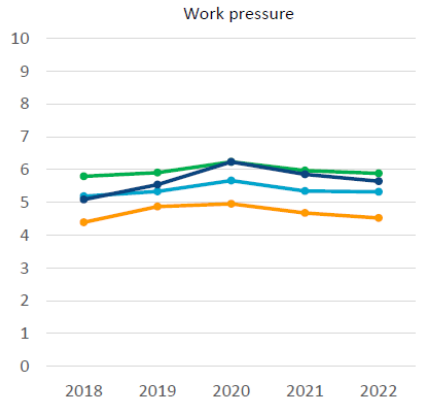


	2018	2019	2020	2021	2022
Your org	5.9	6.3	6.7	6.5	6.3
Best	6.4	6.5	6.7	6.5	6.5
Average	5.9	6.0	6.2	6.0	6.0
Worst	5.5	5.6	5.8	5.5	5.2
Responses	1263	1506	1599	1700	1411

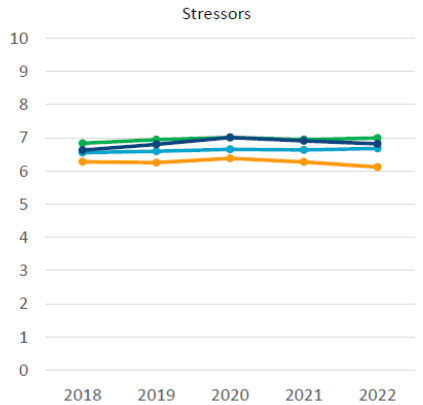
The score this year is the same as it was in 2019 with the lowest score being in 2018. The score is comfortably **above average.**



	2018	2019	2020	2021	2022
Your org	6.1	6.5	6.9	6.7	6.5
Best	6.7	6.8	6.9	6.7	6.6
Average	6.0	6.1	6.4	6.2	6.1
Worst	5.5	5.6	5.8	5.4	4.8
Responses	1218	1480	1596	1698	1407



	2018	2019	2020	2021	2022
Your org	5.1	5.5	6.2	5.9	5.6
Best	5.8	5.9	6.2	6.0	5.9
Average	5.2	5.3	5.7	5.3	5.3
Worst	4.4	4.9	5.0	4.7	4.5
Responses	1273	1509	1596	1698	1410

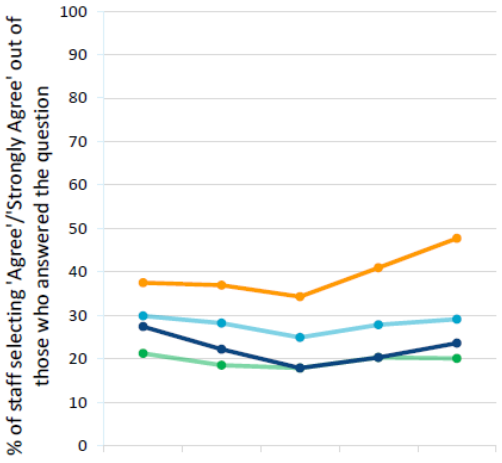


	2018	2019	2020	2021	2022
Your org	6.6	6.8	7.0	6.9	6.8
Best	6.8	6.9	7.0	6.9	7.0
Average	6.6	6.6	6.7	6.6	6.7
Worst	6.3	6.3	6.4	6.3	6.1
Responses	1258	1502	1591	1696	1408

The individual sub scores have all **reduced** compared to last year with results similar to 2019.

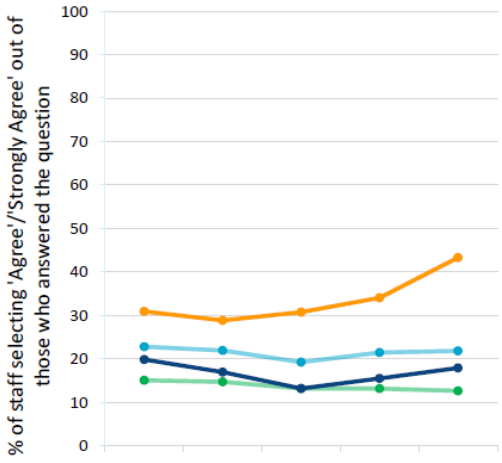
The questions included in this theme will be fully displayed in Appendix 5, some of the highlight areas are below.

Q24a I often think about leaving this organisation.



	2018	2019	2020	2021	2022
Your org	27.4%	22.2%	17.9%	20.3%	23.6%
Best	21.2%	18.5%	17.9%	20.3%	20.1%
Average	29.9%	28.2%	24.9%	27.8%	29.1%
Worst	37.5%	36.9%	34.3%	41.0%	47.7%
Responses	1219	1478	1597	1699	1407

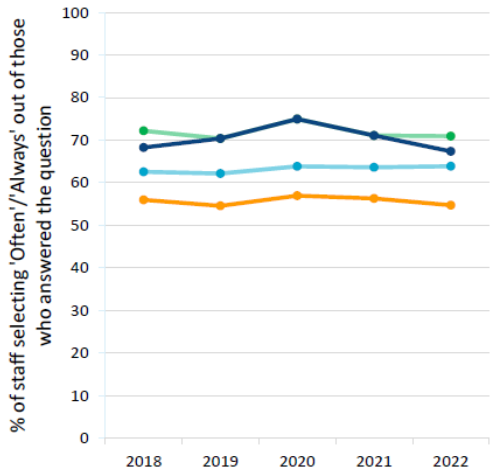
Q24b I will probably look for a job at a new organisation in the next 12 months.



	2018	2019	2020	2021	2022
Your org	19.8%	16.9%	13.1%	15.5%	17.9%
Best	15.0%	14.7%	13.1%	13.1%	12.6%
Average	22.8%	21.9%	19.2%	21.4%	21.8%
Worst	30.9%	28.8%	30.7%	34.0%	43.3%
Responses	1217	1480	1592	1696	1408

Staff thinking about leaving the organisation has **increased by 3.3%** from last year and is the highest it has been since 2018. Staff looking for a new job has also increased.

Q5b I have a choice in deciding how to do my work.



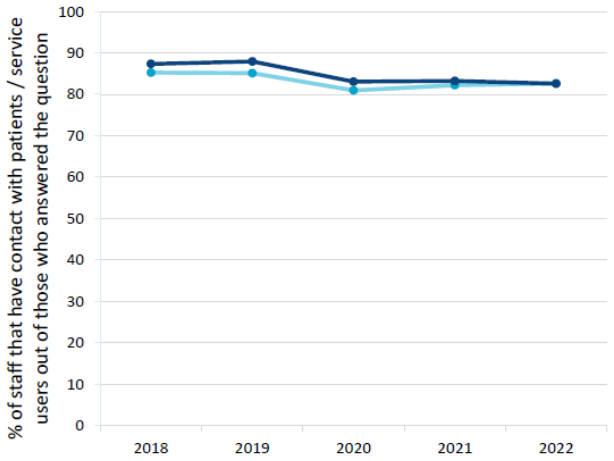
	2018	2019	2020	2021	2022
Your org	68.3%	70.4%	75.0%	71.1%	67.4%
Best	72.2%	70.4%	75.0%	71.1%	70.9%
Average	62.6%	62.1%	63.8%	63.6%	63.9%
Worst	56.0%	54.6%	56.9%	56.3%	54.7%
Responses	1254	1500	1589	1688	1409

Q5b has **decreased** to the lowest it has been between 2018-2022.

Additional Questions

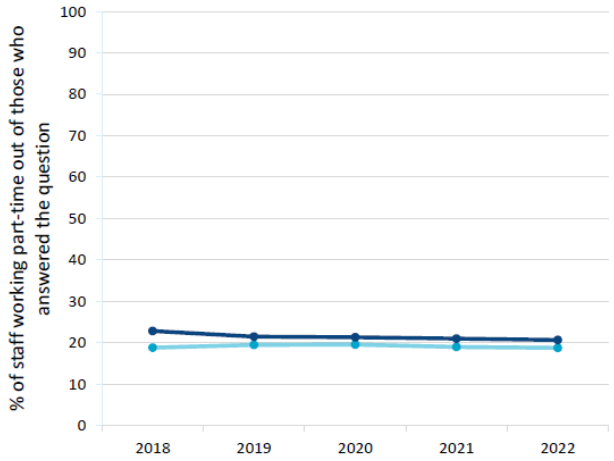
Some questions included in the staff survey were not linked to any People Promise elements or themes, the questions included are below:

Q1 Do you have face-to-face, video or telephone contact with patients / service users as part of your job?



	2018	2019	2020	2021	2022
Your org	87.3%	87.9%	83.1%	83.2%	82.6%
Average	85.2%	85.1%	80.9%	82.2%	82.6%
Responses	1216	1510	1594	1688	1395

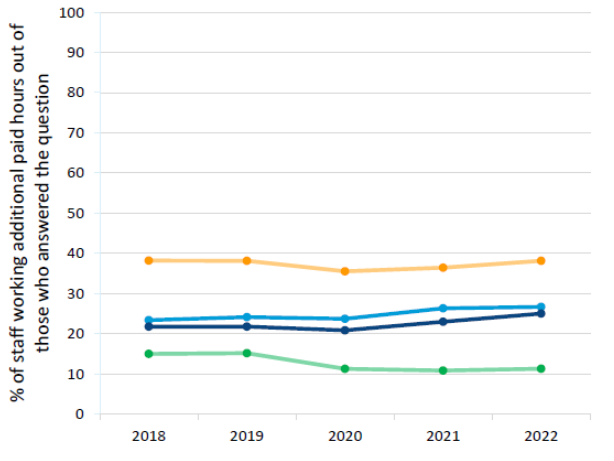
Q10a How many hours a week are you contracted to work?



	2018	2019	2020	2021	2022
Your org	22.8%	21.4%	21.3%	21.0%	20.6%
Average	18.8%	19.5%	19.5%	19.0%	18.7%
Responses	1228	1478	1483	1598	1381

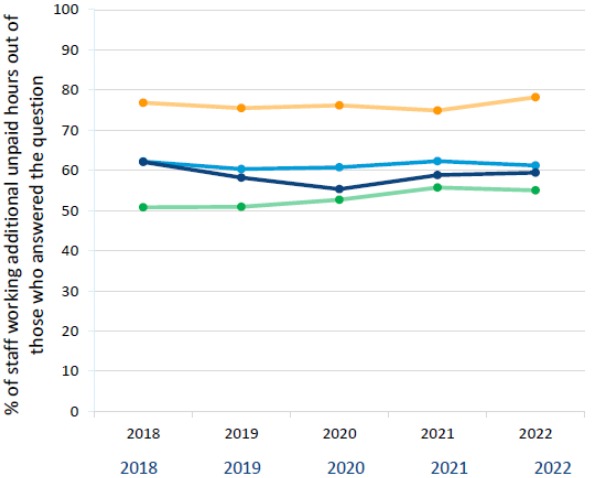
Q1 shows the **lowest score for patient contact** and Q10a shows a decrease in staff working part time vs full time.

Q10b On average, how many additional PAID hours do you work per week for this organisation, over and above your contracted hours?



	2018	2019	2020	2021	2022
Your org	21.7%	21.8%	20.8%	23.0%	25.0%
Lowest	15.0%	15.2%	11.2%	10.8%	11.3%
Average	23.4%	24.1%	23.7%	26.3%	26.7%
Highest	38.2%	38.1%	35.5%	36.4%	38.1%
Responses	1188	1477	1547	1615	1394

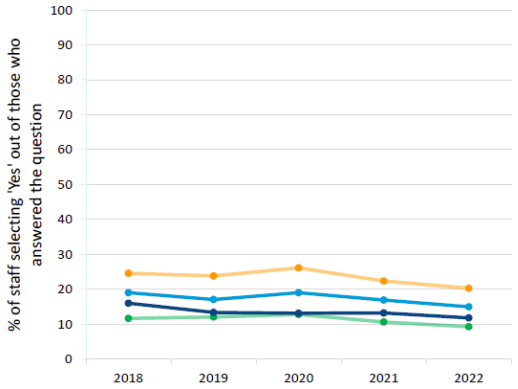
Q10c On average, how many additional UNPAID hours do you work per week for this organisation, over and above your contracted hours?



	2018	2019	2020	2021	2022
Your org	62.1%	58.2%	55.3%	58.8%	59.4%
Lowest	50.8%	50.9%	52.7%	55.7%	55.0%
Average	62.2%	60.3%	60.8%	62.3%	61.2%
Highest	76.8%	75.5%	76.2%	74.9%	78.2%
Responses	1203	1478	1554	1645	1395

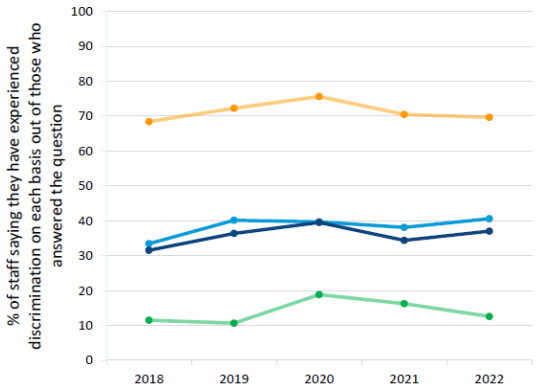
The two questions above highlight staff undertaking more **paid overtime** hours than previous years and an increase in unpaid hours worked**.**

Q11e Have you felt pressure from your manager to come to work?



	2018	2019	2020	2021	2022
Your org	16.0%	13.3%	13.1%	13.2%	11.8%
Best	11.6%	12.0%	12.7%	10.6%	9.2%
Average	19.0%	17.0%	19.0%	16.9%	14.9%
Worst	24.6%	23.8%	26.1%	22.3%	20.2%
Responses	682	821	629	777	700

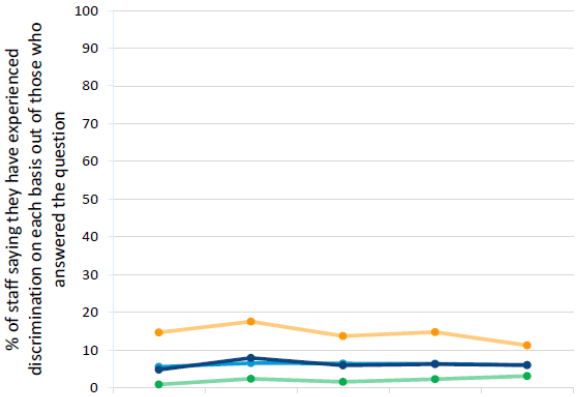
Q16c.1 On what grounds have you experienced discrimination? - Ethnic background.



	2018	2019	2020	2021	2022
Your org	31.5%	36.4%	39.5%	34.4%	37.0%
Best	11.5%	10.6%	18.8%	16.3%	12.6%
Average	33.4%	40.1%	39.7%	38.1%	40.6%
Worst	68.4%	72.2%	75.6%	70.5%	69.6%
Responses	132	155	168	185	153

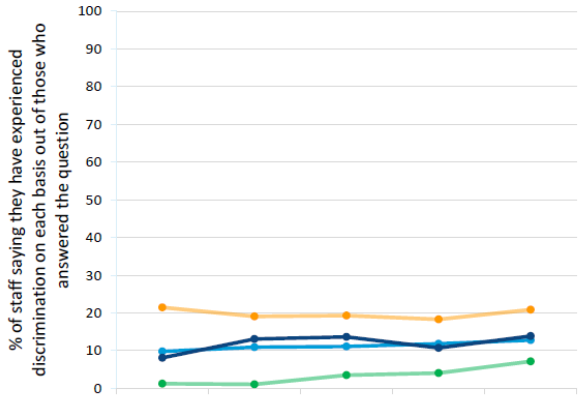
Questions above show a **decrease** in pressure felt from managers to come to work when off sick and a sharp increase in **ethnic background discrimination.**

Q16c.4 On what grounds have you experienced discrimination? – Sexual orientation.



	2018	2019	2020	2021	2022
Your org	4.8%	7.9%	5.9%	6.2%	6.0%
Best	0.8%	2.4%	1.5%	2.2%	3.1%
Average	5.5%	6.5%	6.4%	6.4%	6.0%
Worst	14.6%	17.5%	13.7%	14.7%	11.2%
Responses	132	155	168	185	153

Q16c.5 On what grounds have you experienced discrimination? – Disability.



	2018	2019	2020	2021	2022
Your org	8.1%	13.1%	13.7%	10.7%	13.9%
Best	1.2%	1.1%	3.5%	4.1%	7.2%
Average	9.8%	10.9%	11.1%	11.8%	12.8%
Worst	21.5%	19.1%	19.3%	18.3%	20.9%
Responses	132	155	168	185	153

Sexual Orientation discrimination has decreased and Disability related has increased from last year. More questions can be found in Appendix 6.

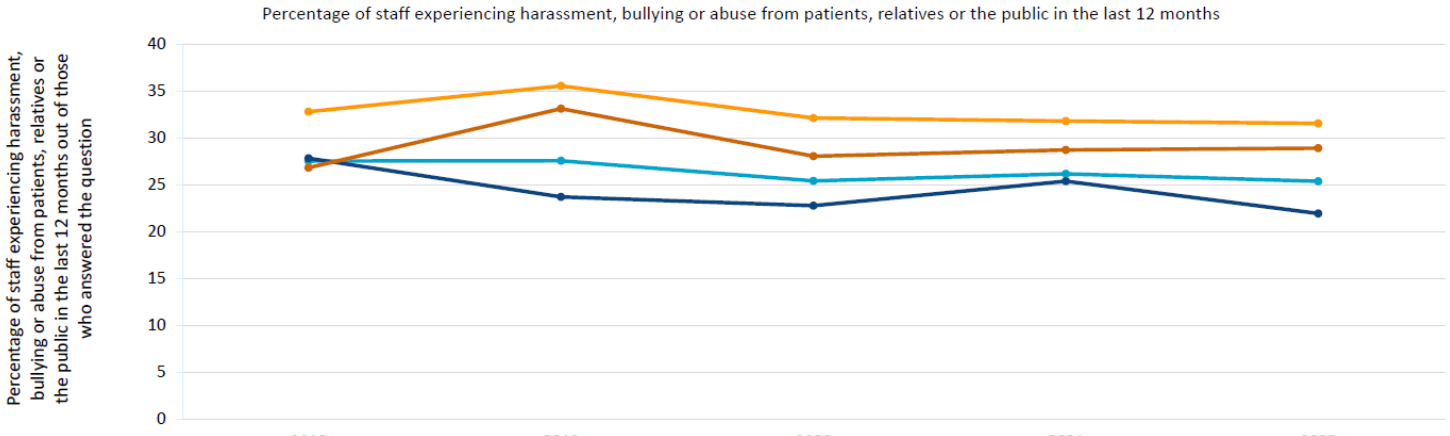
Workforce Equality Standards

This section contains data required for the staff survey indicators used in the Workforce Race Equality Standard (WRES) and Workforce Disability Equality

The questions included in this are below:

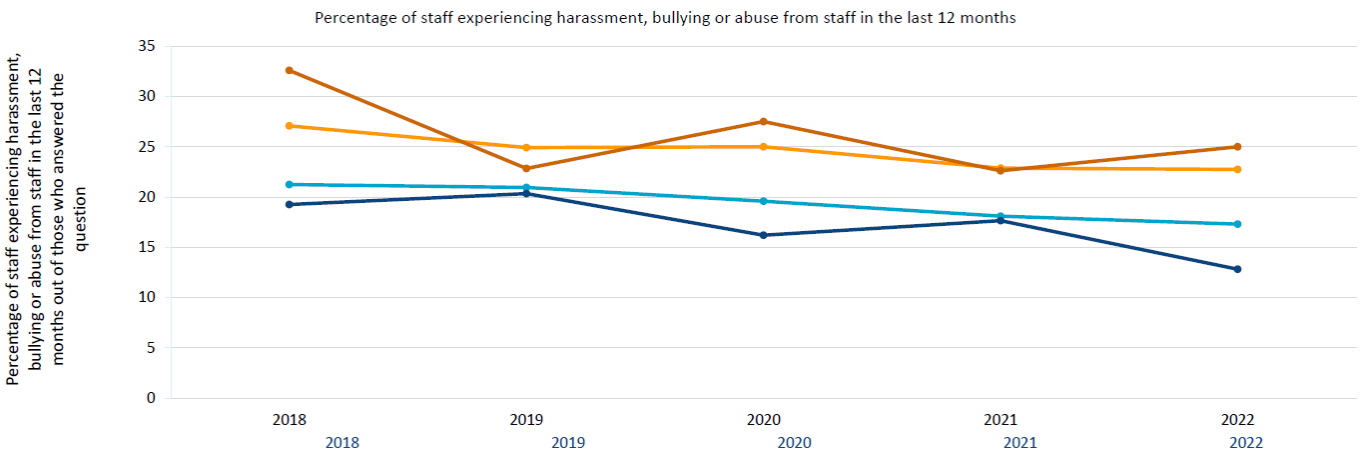
Workforce Equality Standard	Questions
Workforce Race Equality Standard	14a, 14b, 14c, 15, 16b
Workforce Disability Equality Standard	14a, 14b, 14c, 14d, 15, 9e, 4b, 30b

WRES



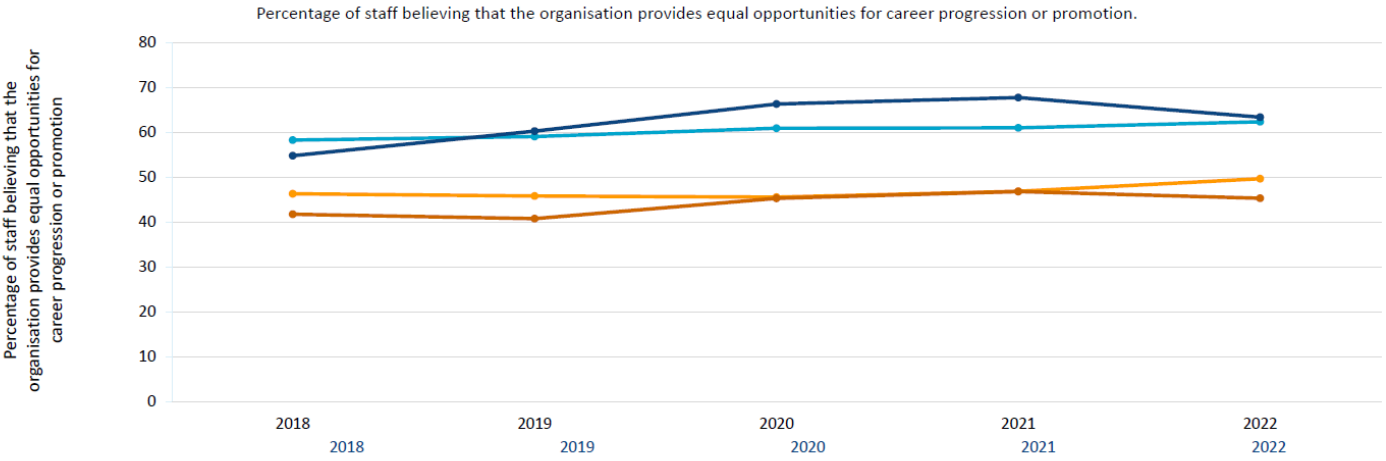
	2018	2019	2020	2021	2022
White staff: Your org	27.8%	23.7%	22.8%	25.4%	21.9%
All other ethnic groups*: Your org	26.8%	33.1%	28.0%	28.7%	28.9%
White staff: Average	27.5%	27.6%	25.4%	26.2%	25.4%
All other ethnic groups*: Average	32.8%	35.5%	32.1%	31.8%	31.5%
White staff: Responses	1064	1283	1375	1466	1213

Staff experiencing discrimination from patients, relatives or public that are white has decreased and **other ethnic groups has increased slightly**.



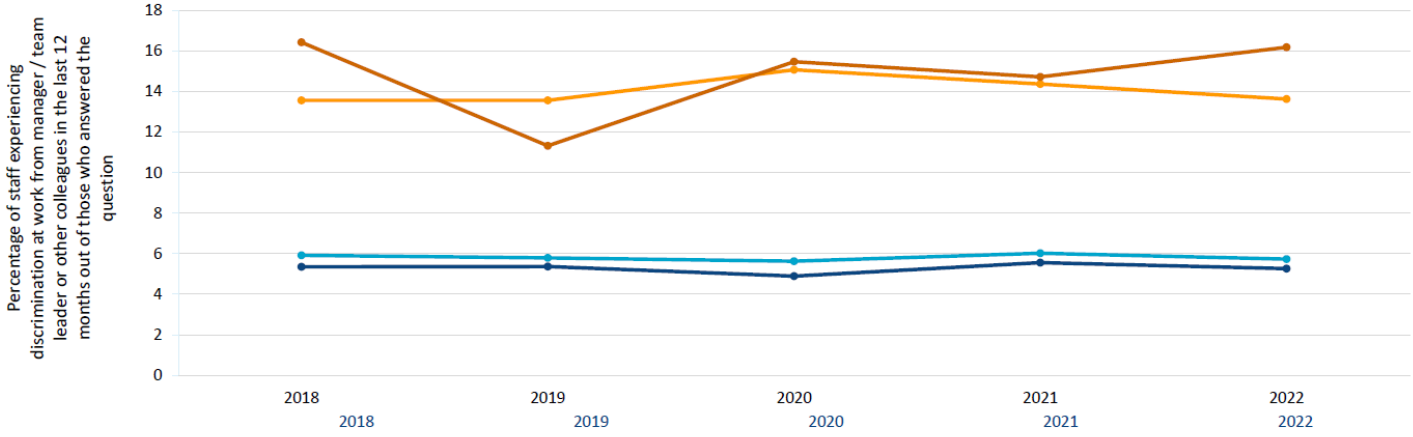
	2018	2019	2020	2021	2022
White staff: Your org	19.3%	20.3%	16.2%	17.7%	12.8%
All other ethnic groups*: Your org	32.6%	22.8%	27.5%	22.6%	25.0%
White staff: Average	21.2%	21.0%	19.6%	18.1%	17.3%
All other ethnic groups*: Average	27.1%	24.9%	25.0%	22.9%	22.8%

The percentage of staff experiencing bullying or abuse from staff has decreased drastically from last year in white staff but has **increased for other ethnic groups**, it is above average vs other organisations.



	2018	2019	2020	2021	2022
White staff: Your org	54.8%	60.3%	66.3%	67.7%	63.4%
All other ethnic groups*: Your org	41.7%	40.7%	45.3%	46.8%	45.3%
White staff: Average	58.3%	59.0%	60.9%	61.0%	62.3%
All other ethnic groups*: Average	46.3%	45.8%	45.5%	46.8%	49.6%

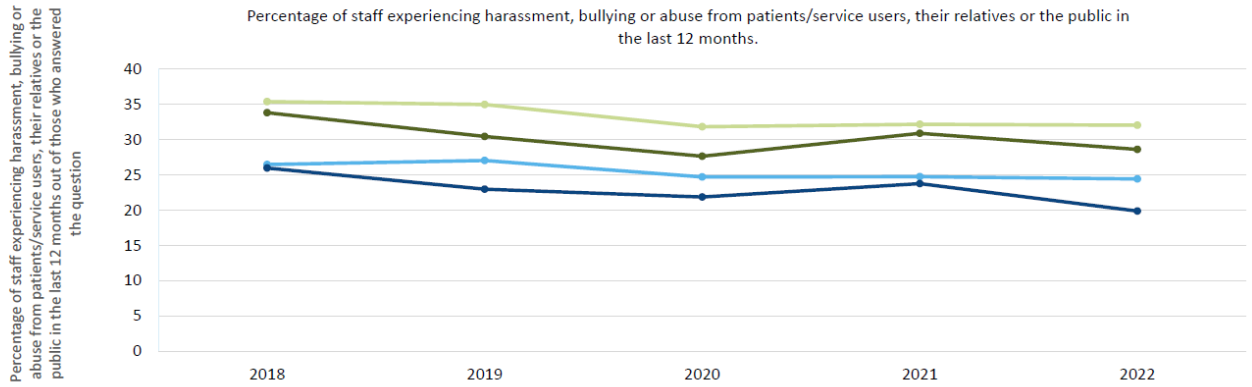
The percentage of staff believing in equal opportunities for career progression has **decreased in both groups**, this has stayed above average for white staff but has gone below average for all other ethnic groups.



	2018	2019	2020	2021	2022
White staff: Your org	5.4%	5.4%	4.9%	5.6%	5.3%
All other ethnic groups*: Your org	16.4%	11.3%	15.5%	14.7%	16.2%
White staff: Average	5.9%	5.8%	5.6%	6.0%	5.7%
All other ethnic groups*: Average	13.6%	13.6%	15.1%	14.4%	13.6%

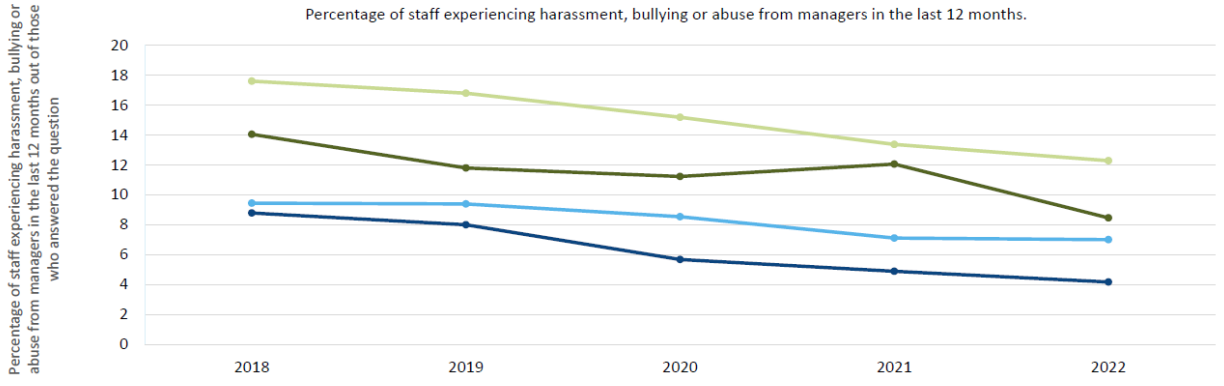
Staff experiencing discrimination from manager or colleagues has decreased for white staff being below average, for other ethnic groups this has **increased this year and is above average.**

WDES



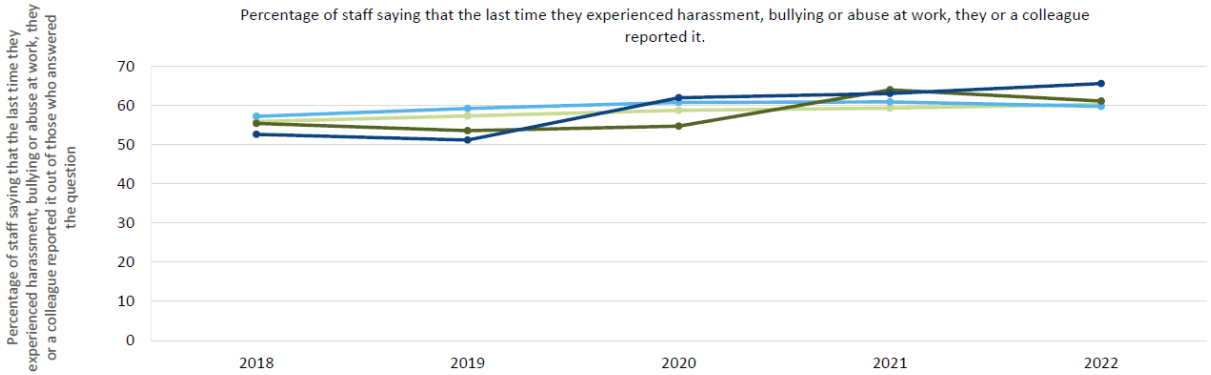
	2018	2019	2020	2021	2022
Staff with a LTC or illness: Your org	33.8%	30.4%	27.6%	30.9%	28.6%
Staff without a LTC or illness: Your org	26.0%	23.0%	21.9%	23.8%	19.9%
Staff with a LTC or illness: Average	35.4%	35.0%	31.8%	32.2%	32.0%
Staff without a LTC or illness: Average	26.5%	27.0%	24.7%	24.7%	24.4%
Staff with a LTC or illness: Responses	281	368	438	518	444
Staff without a LTC or illness: Responses	909	1098	1135	1162	942

Results show that staff with a disability have reported higher rates of abuse from patients compared to staff without a disability, both are below average.



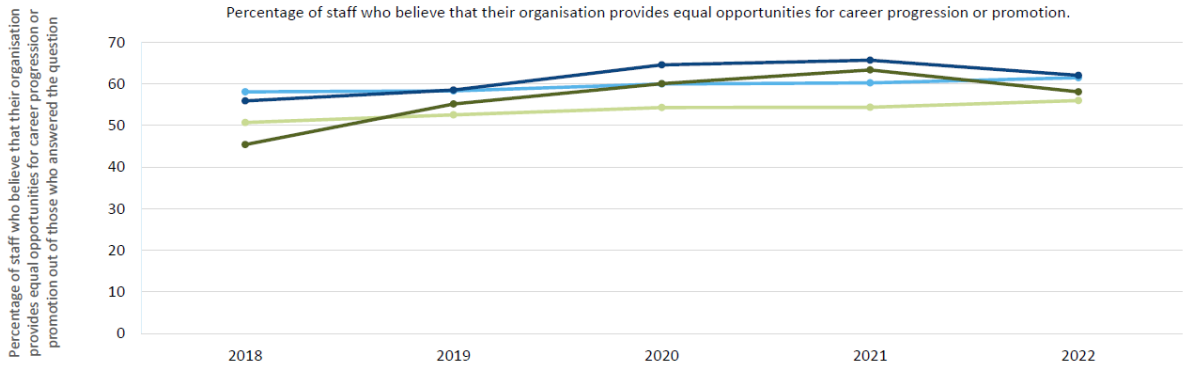
	2018	2019	2020	2021	2022
Staff with a LTC or illness: Your org	14.0%	11.8%	11.2%	12.0%	8.4%
Staff without a LTC or illness: Your org	8.8%	8.0%	5.7%	4.9%	4.2%
Staff with a LTC or illness: Average	17.6%	16.8%	15.2%	13.4%	12.3%
Staff without a LTC or illness: Average	9.4%	9.4%	8.5%	7.1%	7.0%
Staff with a LTC or illness: Responses	278	365	437	515	438
Staff without a LTC or illness: Responses	889	1090	1130	1149	938

Both are below average but **staff with a disability reported experiencing abuse from managers more often.**



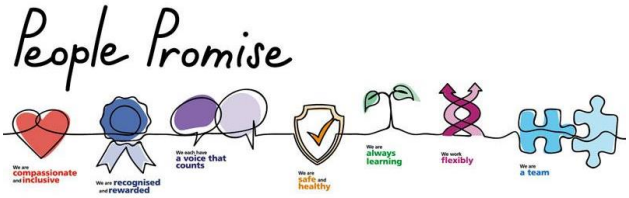
	2018	2019	2020	2021	2022
Staff with a LTC or illness: Your org	55.5%	53.6%	54.8%	64.0%	61.2%
Staff without a LTC or illness: Your org	52.7%	51.2%	62.0%	63.1%	65.6%
Staff with a LTC or illness: Average	55.9%	57.4%	58.8%	59.4%	60.3%
Staff without a LTC or illness: Average	57.3%	59.3%	60.8%	61.0%	59.8%
Staff with a LTC or illness: Responses	119	153	168	203	152
Staff without a LTC or illness: Responses	281	330	308	317	227

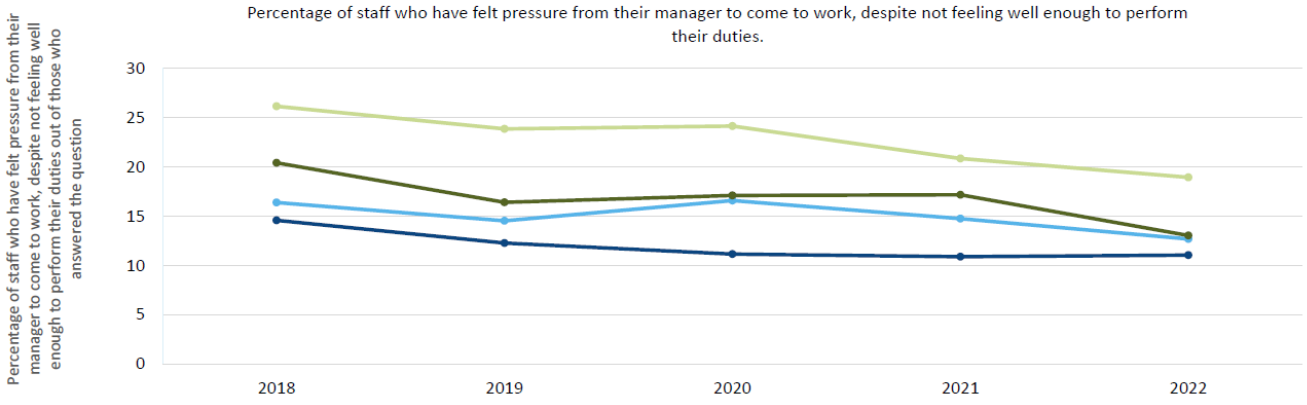
Our rate of reporting for bullying, harassment or abuse is above average and higher rates for staff without a disability.



	2018	2019	2020	2021	2022
Staff with a LTC or illness: Your org	45.4%	55.2%	60.0%	63.4%	58.1%
Staff without a LTC or illness: Your org	55.9%	58.5%	64.6%	65.7%	62.0%
Staff with a LTC or illness: Average	50.7%	52.5%	54.3%	54.4%	56.0%
Staff without a LTC or illness: Average	58.1%	58.3%	60.0%	60.2%	61.5%
Staff with a LTC or illness: Responses	282	368	438	513	439
Staff without a LTC or illness: Responses	905	1097	1132	1163	935

Both staff groups are above average, there was a decrease compared to last year.



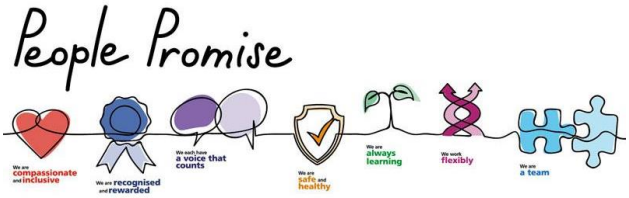


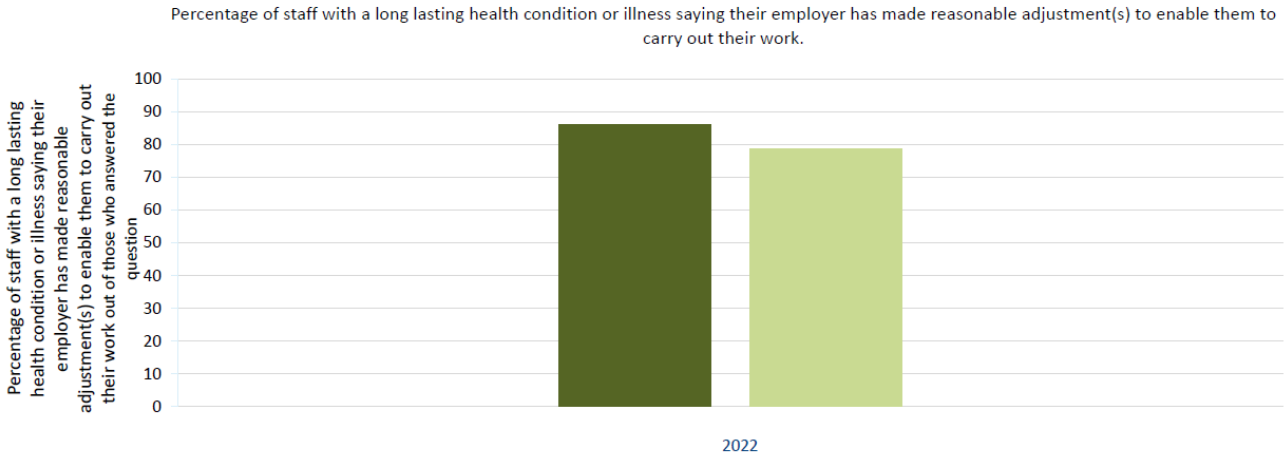
	2018	2019	2020	2021	2022
Staff with a LTC or illness: Your org	20.4%	16.4%	17.1%	17.2%	13.0%
Staff without a LTC or illness: Your org	14.6%	12.3%	11.1%	10.9%	11.0%
Staff with a LTC or illness: Average	26.2%	23.9%	24.1%	20.8%	18.9%
Staff without a LTC or illness: Average	16.4%	14.5%	16.6%	14.7%	12.7%
Staff with a LTC or illness: Responses	196	244	234	303	284
Staff without a LTC or illness: Responses	453	563	386	469	408

Both staff groups are below average however staff with a disability are **more likely to feel pressure** from their manager to attend work.

	2018	2019	2020	2021	2022
Staff with a LTC or illness: Your org	37.2%	43.9%	50.3%	51.4%	42.8%
Staff without a LTC or illness: Your org	48.9%	54.1%	59.2%	58.1%	56.4%
Staff with a LTC or illness: Average	38.5%	41.6%	44.6%	43.6%	44.0%
Staff without a LTC or illness: Average	50.2%	52.9%	55.2%	51.5%	53.2%
Staff with a LTC or illness: Responses	282	367	435	516	446
Staff without a LTC or illness: Responses	904	1102	1135	1157	947

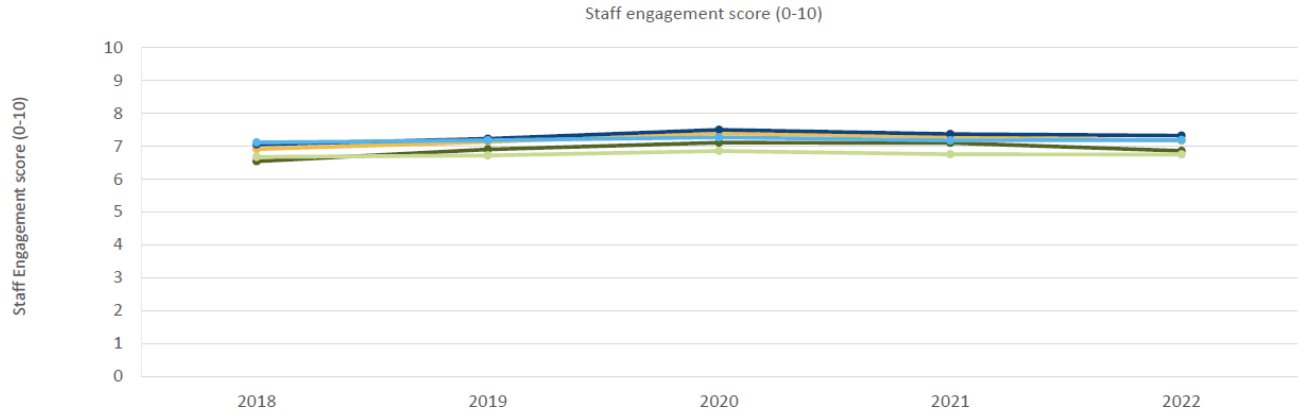
Staff with a disability are **below average** for feeling satisfied with the extent to which the organisation values their work.





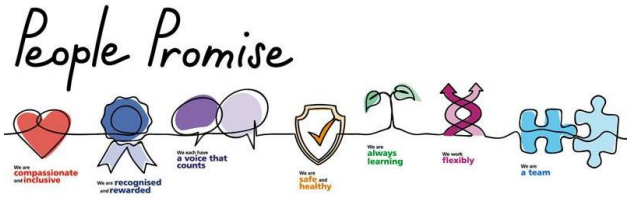
	2022
Staff with a LTC or illness: Your org	86.1%
Staff with a LTC or illness: Average	78.8%
Staff with a LTC or illness: Responses	287

The percentage was higher than the average for staff with a long-term condition or illness when discussing reasonable adjustments.



	2018	2019	2020	2021	2022
Organisation average	6.9	7.1	7.4	7.3	7.2
Staff with a LTC or illness: Your org	6.5	6.9	7.1	7.1	6.8
Staff without a LTC or illness: Your org	7.0	7.2	7.5	7.4	7.3
Staff with a LTC or illness: Average	6.7	6.7	6.8	6.7	6.7
Staff without a LTC or illness: Average	7.1	7.2	7.3	7.2	7.2
Staff with a LTC or illness: Responses	285	369	438	521	448
Staff without a LTC or illness: Responses	911	1105	1141	1170	948

Staff engagement score is higher than average in both groups but staff with a disability scored lower than staff without.



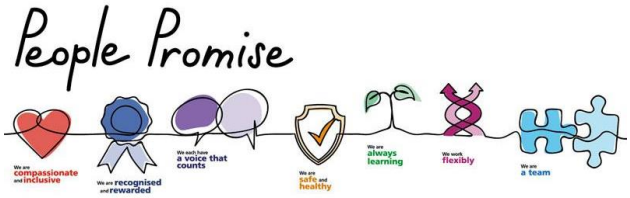
Summary

At an organisational level the below areas have been identified, based on the results as priority areas of focus.

Priority	Improvements	How will we know when we get there?
Improving Staff Engagement	• Strengthen and standardise divisional lead engagement • Co-developed next steps for the next 12 months • Review of current reward and recognition programme	• Staff Engagement scores for staff survey • Successful completion of local action plans • Increased Staff Survey Participation
Improving the way we deal with concerns raised	• Design a framework that provides clarity on the different ways to raise a concern, clear accountability and what happens with the concern • Improve the way we triangulate our data to be able to identify areas of concerns before staff need to raise them • Develop new and innovative ways of speaking out e.g. anonymous forms/online submissions	• Increased confidence for raising concerns • Staff survey results improve for this area • Decrease in escalations
Growth and Development	• The launch of a career conversation toolkit to support career discussions and connecting colleagues with the range of opportunities available. • Improving the Appraisal Process • Increasing the accessibility and awareness of the options available to colleagues to grow, stretch and develop • Ensuring that informal stretch, role and development opportunities are open to all • Working as a Derbyshire system on informal and formal growth and development opportunities	• Appraisal KPI's being met in all teams • Staff survey results show increased scores for this area • Reduction in disparity ratio's
Health & Wellbeing	• Review and develop a new Flexible working approach and policy • Launch of a health and wellbeing strategy and increased focus on ensuring we have sufficient health and wellbeing services to meet colleagues needs • Mainstreaming the health and wellbeing conversation • Ensuring consistent approach to team engagement to work on priorities, clarity of roles and supporting each other	• Staff retention rates • Pulse survey responses • Staff survey results • Reduction of work related absence

Through the People and Culture Committee the above priority areas will be monitored and progress reported.

At a divisional level, with the support of the DPLs, key actions and priorities are being identified and these will be fed into the Divisional Achievement Reviews for ongoing traction and monitoring.


People Promise
We are compassionate and inclusive
We are recognised and rewarded
We each have a voice that counts
We are safe and healthy
We are always learning
We work flexibly
We are a team


TEAM
Derbyshire Healthcare

2022 NHS Staff Survey
Results Summary

People Promise

NHS
Derbyshire Healthcare
NHS Foundation Trust

The national NHS Staff Survey presents feedback from colleagues aligned to the seven themes of the NHS People Promise. These themes are areas that are central to improving colleagues' experiences at work. Our Trust results are presented across these themes below, in addition to the Trust's overall scores for staff engagement and morale.

48% response rate

We are compassionate and inclusive
7.7
Higher than the average comparator score: ▼7.5

We are recognised and rewarded
6.5
Higher than the average comparator score: ▼6.3

We each have a voice that counts
7.1
Higher than the average comparator score: ▼7.0

We are safe and healthy
6.5
Higher than the average comparator score: ▼6.2

We are always learning
5.7
Equal to the average comparator score: ▶5.7

We work flexibly
7.0
Higher than the average comparator score: ▼6.7

We are a team
7.3
Higher than the average comparator score: ▼7.1

Staff engagememt
7.2
Higher than the average comparator score: ▼7.0

Morale
6.3
Higher than the average comparator score: ▼6.0

Colleagues feedback

Thank you to everyone who completed the NHS Staff Survey in 2022. The Trust is committed to making ongoing improvements in response to the feedback we have received from colleagues. Whilst many of our results have seen a slight reduction in the last year, your feedback continues to rate the Trust higher than average when benchmarked against other comparable organisations. Divisions will receive a breakdown of local results, in order for teams to identify priority areas to progress in the coming year. We will also work with colleagues to identify key Trust-wide priorities, including increasing our overall response rate in 2023.

Staff Friends and Family Test Scores

68%
'I would recommend my organisation as a place to work'

66.5%
'If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation'

Higher on both than the sector average!

We have scored each element compared to the average from the 51 other organisations in our benchmarking group

All elements are scored on a 0-10 scale, where a higher score is more positive than a lower score. The People Promise scores are generated by grouping the results from each question into sub-themes.

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 9 May 2023

Report from the Council of Governors meeting

The Council of Governors has met one since the last report, on 7 March 2023, and the meeting was conducted digitally via Microsoft Teams.

Update on care plans

The Interim Director of Nursing and Patient Experience, gave an update on care plans following a previous 'holding to account' question at the Council of Governors.

It is a priority to improve completion rates for care plans and this will be monitored regularly at the Quality and Safeguarding Committee. Challenges have been data quality and staffing vacancies.

Chief Executive update

The update was given by Carolyn Green, Interim Chief Executive on current issues affecting the Trust. Areas covered were:

- forward planning for activity, which included finances within the programme spend and the national and constitutional targets.
- industrial action impact
- waiting list update
- the importance of how we continue to work with all partners in the alliance to hear voices that are very rarely heard.

Overview of Forward / Annual Planning

The Trust's Director of Strategy, Partnerships and Transformation and the Interim Director of Finance gave a presentation on the NHS planning round.

The presentation set out a number of performance targets the Trust is required to deliver and the financial and workforce summaries and what that means in terms of activity. Governors asked questions on how the planning works in practice across the Derbyshire System and about the system financial deficit and the levels of efficiency savings built into the plan.

The planning processes have changed over the last few years, but the statutory position is that the Trust must have due regard to the views of the governors on the Annual Plan.

Non-Executive Directors (NEDs) Report

Two of the NEDs presented their overview reports on their role and activities at the Trust and within the Joined Up Care Derbyshire system.

Escalation Items to the Council Of Governors from the Governance Committee

Governors received a response to a holding to account question to the NEDs around their levels of assurance that the Trust has plans in place to respond to the challenges in service provision in South Derbyshire, including the staffing issues and caseload for all staff including consultant cover. Assurance was given that the Trust had line of sight around the issues and on the performance.

Verbal Summary Integrated Performance Report

The Integrated Performance Report (IPR) was presented to the Council of Governors to provide an overview of the performance of the Trust. The NEDs reported on how the report had been used to hold Executive Directors to account in their respective Board Committees for areas with regards to workforce, finance, operational delivery and quality performance.

Governor election update

A summary report on the 2022/23 elections was given. Inductions have been completed for the three new governors. There is still one vacancy for the seat in Erewash. The Council of Governors supported the appointments of Susan Ryan as Lead Governor and Hazel Parkyn as Deputy Lead Governor.

Governance Committee Report

The Committee Chair presented a report of the meetings held on 7 February 2023.

RECOMMENDATION

The Trust Board is asked to note the summary report from the Council of Governors meeting held on 7 March 2023.

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
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
BME	Black,& Minority Ethnic group
BoD	Board of Directors
C	
CAMHS	Child and Adolescent Mental Health Services
CASSH	Care and Support Specialised Housing
CBT	Cognitive Behavioural Therapy
CCG	Clinical Commissioning Group (defunct from 1 July 2022)
CCT	Community Care Team
CDMI	Clinical Digital Maturity Index
CE	Chief Executive
CEO	Chief Executive Officer
CGA	Comprehensive Geriatric Assessment
CHPPD	Care Hours Per Patient Day
CIP	Cost Improvement Programme
CMDG	Contract Management Delivery Group
CMHF	Community Mental Health Framework
CMHT	Community Mental Health Team
CNST	Clinical Negligence Scheme for Trusts
COAT	Clinical Operational Assurance Team
COF	Commissioning Outcomes Framework
CoG	Council of Governors
COO	Chief Operating Officer
CPA	Care Programme Approach
CPD	Continuing Professional Development
CPN	Community Psychiatric Nurse
CPR	Child Protection Register

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Term / Abbreviation	**Terms in Full**
CQC	Care Quality Commission
CQI	Clinical Quality Indicator
CQUIN	Commissioning for Quality and Innovation
CRG	Clinical Reference Group
CRH	Chesterfield Royal Hospital
CRHT	Crisis resolution and home treatment
CRS	(NHS) Care Records Service
CRS	Commissioner Requested Services
CSF	Commissioner Sustainability Fund
CTO	Community Treatment Order
CTR	Care and Treatment Review
D	
DAR	Divisional Assurance Review
DAT	Drug Action Team
Datix	Trust's electronic incident reporting system of an event that causes a loss, injury or a near miss to a patient, staff or others
DBS	Disclosure and Barring Service
DBT	Dialectical Behavioural Therapy
DfE	Department for Education
DCHS	Derbyshire Community Health Services NHS Foundation Trust
DDCCG	Derby and Derbyshire Clinical Commissioning Group
DHCFT	Derbyshire Healthcare NHS Foundation Trust
DIT	Dynamic Interpersonal Therapy
DNA	Did Not Attend
DoH	Department of Health
DoLS	Deprivation of Liberty Safeguards
DRRT	Dementia Rapid Response Team
DSPT	Director of Strategy, Partnerships and Transformation
DOF	Director of Finance
DON	Director of Nursing
DPI	Director of People and Inclusion
DPS	Date Protection and Security
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

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Term / Abbreviation	**Terms in Full**
ELT	Executive Leadership Team
EMDR	Eye Movement Desensitising & Reprocessing Therapy
EMR	Electronic Medical Record
EPR	Electronic Patient Record
ERIC	Estates Return Information Collection
ESR	Electronic Staff Record
EUPD	Emotionally Unstable Personality Disorder
EWTD	European Working Time Directive
F	
FBC	Full Business Case
FFT	Friends and Family Test
FOI	Freedom of Information
FSR	Full Service Record
FT	Foundation Trust
FTE	Full-time Equivalent
FTN	Foundation Trust Network
FTSU	Freedom to Speak Up
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
GIRFT	Getting it Right First Time
GMC	General Medical Council
GP	General Practitioner
GPFV	General Practice Forward View
H	
HCA	Healthcare Assistant
H1	First half of a fiscal year (April through September)
H2	Second half of a fiscal year (October through the following March)
HEE	Health Education England
HES	Hospital Episode Statistics
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
ICB	Integrated Care Board
ICM	Insertable Cardiac Monitor
ICS	Integrated Care System
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)
IMT	Incident Management Team

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Term / Abbreviation	**Terms in Full**
IM&T	Information Management and Technology
IRHTT	In-reach Home Treatment Team
IPP	Imprisonment for Public Protection
IPR	Integrated Performance Report
IPT	Interpersonal Psychotherapy
J	
JNCC	Joint Negotiating Consultative Committee
JTAI	Joint Targeted Area Inspections
JUCB	Joined Up Care Board
JUCD	Joined Up Care Derbyshire
K	
KLOE	Key Lines of Enquiry (CQC)
KPI	Key Performance Indicator
KSF	Knowledge and Skills Framework
L	
LA	Local Authority
LCFS	Local Counter Fraud Specialist
LD	Learning Disabilities
LD/A	Learning Disability and Autism
LHP	Local Health Plan
LHWB	Local Health and Wellbeing Board
LOS	Length of Stay
LPS	Liberty Protection Safeguards
LTP	Long Term Plan
M	
MADE	Multi-agency Discharge Event
MARS	Mutually Agreed Resignation Scheme
MAU	Medical Assessment Unit
MAS	Memory Assessment Service
MAPPA	Multi-agency Public Protection Arrangements
MARAC	Multi-agency Risk Assessment Conference (meeting where information is shared on the highest risk domestic abuse cases between representatives of local police, probation, health, child protection, housing practitioners, Independent Domestic Violence Advisors (IDVAs) and other specialists from the statutory and voluntary sectors.
MASH	Multi-Agency Safeguarding Hub
MCA	Mental Capacity Act
MD	Medical Director
MDA	Medical Device Alert
MDM	Multi-Disciplinary Meeting
MDT	Multi-Disciplinary Team
MFF	Market Forces Factor
MHA	Mental Health Act
MHAC	Mental Health Act Committee
MHIN	Mental Health Intelligence Network
MHIS	Mental Health Investment Standard
MHLT	Mental Health Liaison Team

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Term / Abbreviation	**Terms in Full**
MHRT	Mental Health Review Tribunal
MSC	Medical Staff Committee
MSK	Musculoskeletal (conditions)
MSU	Medium secure unit
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
NHSEI	NHS England and NHS Improvement
NIHR	National Institute for Health Research
O	
OBC	Outline Business Case
ODG	Operational Delivery Group
OOA	Outside of Area
OPMO	Older People's Mental Health Services
OP	Outpatient
OSC	Overview and Scrutiny Committee
OT	Occupational therapy
P	
PAB	Programme Assurance Board
PAG	Programme Advisory Group
PALS	Patient Advice and Liaison Service
PAM	Payment Activity Matrix
PARC	Psychosis and the reduction of cannabis (and other drugs)
PARIS	This is an electronic patient record system
PbR	Payment by Results
PCC	Police & Crime Commissioner
PCC	People and Culture Committee
PCN	Primary Care Networks
PDSA	Plan, Do, Study, Act
PHE	Public Health England
PICU	Psychiatric Intensive Care Unit
PID	Project Initiation Document
PiPoT	People in Positions of Trust
PLIC	Patient Level Information Costs
PMLD	Profound and Multiple Disability
PPE	Personal Protection Equipment
PPI	Patient and Public Involvement
PPT	Partnership and Pathway Team
PREM	Patient Reported Experience Measure
PROMS	Patient Reported Outcome Measure
PSF	Provider Sustainability Fund
PSIRF	Patient Safety Incident Review Framework
Q	
QAG	Quality Assurance Group

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Term / Abbreviation	**Terms in Full**
Q&SC	Quality and Safeguarding Committee
QIA	Quality Impact Assessment
QIPP	Quality, Innovation, Productivity Programme
R	
RAID	Rapid Assessment, Interface and Discharge
RCGP	Royal College of General Practitioners
RCI	Reference Cost Index
REGARDS	Race, Economic disadvantage, Gender, Age, Religion or belief, Disability and Sexual orientation
RTT	Referral to Treatment
S	
SAAF	Safeguarding Adults Assurance Framework
SBARD	Situation, Background, Assessment, Recommendation and Decision (SBARD) tool
SBS	Shared Business Services
SEND	Special Educational Needs and Disabilities
SFI	Standing Financial Instructions
SI	Serious Incidents
SID	Senior Independent Director
SIRI	Serious Incident Requiring Investigation
SLA	Service Level Agreement
SLR	Service Line Reporting
SMI	Severe Mental Illness
SOC	Strategic Options Case
SOF	Single Operating Framework
SPOA	Single Point of Access
SPOE	Single Point of Entry
SPOR	Single Point of Referral
STEIS	Strategic Executive Information System
STF	Sustainability and Transformation Fund
STP	Sustainability and Transformation Partnership
SUI	Serious (Untoward) Incident
SystmOne	Electronic patient record system
T	
TARN	Trauma Audit and Research Network
TCP	Transforming Care Partnerships
TCS	Transforming Community Services
TDA	Trust Development Authority
TMT	Trust Management Team
TUPE	Transfer of Undertakings (Protection of Employment) Regulations 1981
TMAC	Trust Medical Advisory Committee (now Medical Senate)
TOOL	Trust Operational Oversight Leadership
U	
UDBH	University Hospitals of Derby and Burton
UEC	Urgent and emergency care
V	
VARM)	Vulnerable Adult Risk Management

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

(updated 14 June 2022)

2023/24 Board Annual Forward Plan

Exec Lead	Meeting date	9 May 23	4 Jul 23	5 Sep 23	7 Nov 23	18 Jan 24	5 Mar 24
	Paper deadline	**2 May**	**26 Jun**	**29 Aug**	**30 Oct**	**8 Jan**	**26 Feb**
Trust Sec	Declaration of Interests	X	X	X	X	X	X
DON	Patient/Staff Story	X	X	X	X	X	X
CHAIR	Minutes/Matters arising/Action Matrix	X	X	X	X	X	X
CHAIR	Board review of effectiveness of meeting	X	X	X	X	X	X
CHAIR	Board Forward Plan (for information)	X	X	X	X	X	X
CHAIR	Summary of Council of Governors meeting (for information)	X	X		X	X	X
CHAIR	Chair's Update	X	X	X	X	X	X
CEO	Chief Executive's Update	X	X	X	X	X	X
STRATEGIC PLANNING AND CORPORATE GOVERNANCE							
DSPT	Trust Strategy update	X					
DPI	Staff Survey Results (following assurance at PCC)	X					
DPI	Annual Gender Pay Gap Report for approval (following assurance at PCC)	X					
DPI	Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) request for Board delegated authority for People and Culture Committee meeting on 19 September to approve the October submissions			X			
DPI	Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) Strategic implications/retrospective sign off after PCC on 20 September				X		
DPI	Workforce Plan for 2023/24			X			
DPI	Annual Approval of Modern Slavery Statement (following assurance at PCC)	X					
DPI	2023/24 Flu Campaign			X			
Trust Sec	Corporate Governance Report	X					
Trust Sec	NHS Improvement Year-End Self-Certification (within Corp Gov Report)	X					
Trust Sec	Year-end governance reporting from Board Committees and approval of ToRs (within Corp Gov report)	X					
Trust Sec	Trust Sealings (six monthly - for information) within Corp Gov report	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	Board Effectiveness Report				X		
Trust Chair	Fit and Proper Person Declaration		X				
DPSPT/DoF	Operational/ Financial Plan	X					
Committee Chairs	Board Committee Assurance Summaries	X	X	X	X	X	X
OPERATIONAL PERFORMANCE							
DON/DOF/ DPI/COO	Integrated performance and activity report to include Finance, People performance and Quality	X	X	X	X	X	X
DSPT	ICB Joint Forward Plan		X				
DPI	Equality Diversity and Inclusion (EDI) update				X		
COO	Emergency Preparedness, Resilience and Response (EPRR) Core Standards			X			
COO/Prog Director	Making Room for Dignity progress	X					
DON/COO/ DPI	Workforce Standards Formal Submission/Safer Staffing (prior to publishing on website) following assurance at PCC	X					

Exec Lead	Meeting date	9 May 23	4 Jul 23	5 Sep 23	7 Nov 23	18 Jan 24	5 Mar 24
QUALITY GOVERNANCE							
EXEC	Position Statement - focus on CQC domains (Well Led CQC & NHSI) as per schedule	Caring DON	Well Led Trust Sec	Safe MD	Responsive COO	Effective DON MD & DPI	
MD	Learning from Deaths Mortality report (quarterly publication) (Jul/Nov/Jan/Mar)	AR	X	X	X	X	X
MD	Guardian of Safe Working Report		AR		X	X	X
DSPT	Continuous Quality Improvement: A Stocktake						X
DON	Infection Prevention and Control Annual Report and BAF					AR	
MD	Re-validation of Doctors Compliance Statement		X				
MD	Mental Health Bill			X			
DON	Assuring Quality Care					X	
DON	Receipt of Annual Reports: - Annual Looked After Children - Safeguarding Children and Adults at Risk				X		
DON	Outcome of Patient Stories - every two years - due March 2024						X
POLICY REVIEW							
DOF/ Trust Sec	Standing Finance Instructions Policy and Procedures Review (May 2023)	X					