Derbyshire Healthcare NHS Foundation Trust

PUBLIC BOARD MEETING
TUESDAY 17 JANUARY 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, declarations of interest	Selina Ullah
2.	9:35	Patient Story – *'My experience of being a service user with a diagnosis of autism spectrum disorder on an inpatient ward'*	Tumi Banda
3.	9:55	Minutes of Board of Directors meeting held on 1 November 2022	Selina Ullah
4.		Matters arising – Actions Matrix	Selina Ullah
5.		Questions from members of the public	Selina Ullah
6.	10:00	Chair's update	Selina Ullah
7.	10:10	Interim Chief Executive's update	Carolyn Green
STRATEGY, OPERATIONAL PERFORMANCE AND QUALITY ASSURANCE			
8.	10:25	Integrated Performance report	R Leyland / J Lowe / Tumi Banda / A Odunlade
9.	10:45	Assuring Quality Care	Becki Priest
11:00 B R E A K			
10.	11:15	Assurance of CQUIN progress	Tumi Banda
11.	11:25	Position Statement focussing on CQC domains – Responsive	Ade Odunlade
12.	11:40	Learning from Deaths Mortality report	Arun Chidambaram
13.	11:50	Guardian of Safe Working Report	Arun Chidambaram
14.	12:00	Infection Prevention and Control Annual Report including IPC Board Assurance Framework	Tumi Banda
GOVERNANCE			
15.	12:10	Board Committee assurance summaries of meetings held during November and December 2022	Committee Chairs
CLOSING MATTERS			
16.	12:20	- Identification of any issues arising from the meeting for inclusion or updating in the Board Assurance Framework - Meeting effectiveness	Selina Ullah
FOR INFORMATION			
Summary of Council of Governors meeting held 1 November 2022 Glossary of NHS Acronyms 2022/23 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 7 March 2023. It is anticipated that this meeting will be held digitally via MS Teams
Users of the Trust's services and other members of the public are welcome to observe the meetings of the Board.
Participation in meetings is at the Chair's discretion

Our vision

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

Our values

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

People first – we 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 2022/23		
NAME	**INTEREST DISCLOSED**	**TYPE**
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 Non-Executive Director	• Independent Member of Governing Council, University of Derby	(a)
Deborah Good Non-Executive Director	• Trustee of Artcore - Derby	(e)
Carolyn Green Deputy Chief Executive and Chief Nurse	• 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 Non-Executive 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)
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)

(a) Directorships, including non-executive directorships held in private companies or PLCs (with the exception of those dormant companies).
(b) Ownership or part ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS.
(c) Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS.
(d) A position of authority in a charity or voluntary organisation in the field of health and social care.

(e) Any connection with a voluntary or other organisation contracting for National Health Services or hold a position of authority in another NHS organisation or commercial, charity, voluntary, professional, statutory or any other body which could be seen to influence decisions you take in your NHS role (see conflict of interest policy -loyalty interests).

Derbyshire Healthcare NHS Foundation Trust

MINUTES OF A VIRTUAL MEETING OF THE BOARD OF DIRECTORS TUESDAY 1 NOVEMBER 2022

VIRTUAL MEETING VIA MS TEAMS

Commenced: 09.30 Closed: 12:53

PRESENT	Selina Ullah	Trust Chair
	Ralph Knibbs	Senior Independent Director
	Deborah Good	Non-Executive Director
	Ashiedu Joel	Non-Executive Director
	Geoff Lewins	Non-Executive Director
	Tony Edwards	Non-Executive Director
	Ifti Majid	Chief Executive
	Carolyn Green	Interim Deputy Chief Executive
	Rachel Leyland	Interim Director of Finance
	Ade Odunlade	Chief Operating Officer
	Tumi Banda	Interim Director of Nursing and Patient Experience
	Dr Arun Chidambaram	Medical Director
	Jaki Lowe	Director of People and Inclusion
	Vikki Ashton Taylor	Director of Strategy, Partnerships and Transformation
	Becki Priest	Interim Director of Quality and Allied Health Professionals
	Justine Fitzjohn	Trust Secretary
IN ATTENDANCE	Lynn Andrews	Non-Executive Director Designate
	Anna Shaw	Deputy Director of Communications and Engagement
For DHCFT2022/102	Samina Arfan	Head of Equality, Diversity and Inclusion
For DHCFT2022/094	Joe Thompson	Assistant Director of Clinical Professional Practice
For DHCFT2022/094	Simon	Patient Story
	Tamsin Hooton	Programme Director, Provider Collaborative Joined Up Care Derbyshire
APOLOGIES	Dr Sheila Newport	Non-Executive Director and Deputy Trust Chair
	Jas Khatkar	NExT Director
	Sue Turner	Board Secretary
OBSERVERS*	Andrew Beaumont	Public Governor, Erewash
	Denise Baxendale	Membership and Involvement Manager
	David Charnock	Appointed Governor, University of Nottingham
	Rachel Bounds	Appointed Governor, Derbyshire Voluntary Association
	Marie Hickman	Staff Governor, Admin
	Joanne Foster	Staff Governor, Nursing
	Jan Nicolson	Staff Governor, Allied Professions

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

DHCFT 2022/093	**CHAIR'S WELCOME, OPENING REMARKS, APOLOGIES FOR ABSENCE AND DECLARATION OF INTERESTS** Trust Chair, Selina Ullah welcomed everyone and opened the meeting which was held via Microsoft Teams public webinar. She extended a particular welcome to new members of the Board Dr Arum Chidambaram, Becki Priest, Tumi Banda and Rachel Leyland. Titles as listed in the attendance register. No declarations of interest were raised with any of the agenda items. Apologies were noted as listed. The Register of Directors' Interest was noted, with the inclusion of Ifti Majid's role as CEO Designate at Nottinghamshire Healthcare NHS Foundation Trust. The Board paused to reflect on the passing of Her Majesty Queen Elizabeth II since the last meeting. Selina stated this was Ifti Majid's last Board meeting as he would be leaving the Trust at the end of November. On behalf of the Board, Selina thanked Ifti for his transformative and positive influence on the Trust over the preceding years. This was attributed to his belief, drive and compassion, which made him stand out as a leader.
DHCFT 2022/094	**PATIENT STORY** Assistant Director of Clinical Professional Practice, Joe Thompson, introduced Simon, who shared his experience of receiving the Trust's services and the impact it had had in both positive and negative ways. Simon explained that he first accessed the Trust's mental health services over 25 years ago when he was in his twenties. He now uses these experiences in his current role with the Trust as the Lead EQUAL network advisor to ensure other service users' voices are heard. Selina reassured Simon this was a friendly space and expressed the Board's gratitude for taking the time to share his story with them. Simon first came to the Trust through its Community Mental Health Team and was admitted as an inpatient following a suicide attempt. He had accessed mental health services throughout his adult life, in particular through therapists and psychologists. This had helped him to understand how his experiences as an adult had been influenced by childhood experiences. Simon had been an inpatient on several occasions at Kingsway, the Radbourne Unit and an out of area placement in Yorkshire. Simon had undertaken several treatment pathways including medication, day patient support, group therapy, focused therapy and a Cognitive Behavioural Therapy (CBT) programme spanning two years. He reflected that some of his improvement and ability to manage his condition could be attributed to social changes, including ending difficult relationships and a change in employer. He recognised his mental health needs had probably been a contributory factor in difficulty maintaining a career, the breakdown of his marriage and estrangement from his children. Simon had suffered stigma due to his mental health needs. He reflected that his experiences of suffering with mental health and the treatments he has accessed have shaped who he is and through his lived experience he is able to influence the Trust's organisational learning and service delivery. Simon had been in full time employment with the Trust for the last six and half years, originally working in medical education with undergraduate students on medical placement, helping them access knowledge from people with a lived experience. Most recently Simon had become the network adviser for the Trust's patient and carer forum EQUAL. He was also a patient representative on the Royal College of Psychiatrists' Governing Council and worked on co-production projects around education and patient experience of digital psychiatry. He believes passionately in the benefits of co-production particularly as its origins stem from the civil rights movement and the principle of knowledge coming from many different places, for example, clinical training, managing systems, the lived experience. Simon

	recognised the strengths in looking at a situation through multiple lenses including those of the patient, to make the best decisions. As it had been eight years since Simon's last inpatient admission and four years since he had received direct support from a consultant psychologist Simon did not consider his experience current. However, he uses his knowledge to support systems to be the best that they can be and create spaces for patients and carers to be heard to affect change. Simon's current role as an EQUAL network adviser helps enable a direct feedback loop between those currently using the Trust's services and those who deliver them. Simon's view is that good mental health care is about relationships with people. He outlined the current challenges that he has observed, (i) a more organised carer's voice than patient voice, (ii) progressing beyond a feedback loop to collaborative decision making and (iii) joining lived experience into a vision of what involvement should look like. Peer support workers are good but was only one way for people with lived experience to be involved. Simon said that things are far better than in the past. He was privileged to help the Trust on their journey and was really pleased to have the opportunity to come to the Board and talk about the work he had been doing and the contribution he has made to the Trust's services. Dr Arun Chidambaram, Medical Director said how interested he was in the meta knowledge that Simon brought to the Trust and thanked him for his involvement in national workstreams. He reflected on how important the voice of the end user is in shaping services. In response to Carolyn Green, Interim Deputy Chief Executive, Simon articulated what success would look like for him from the Trust's and the Integrated Care System's (ICS) perspective. He recognised the huge opportunity that the ICS poses to shape services and said that success for him was about patient involvement rather than just engagement. He would like to see a clear pathway for lived experience practitioners through the organisation at all levels and a single person accountable for that progression strategy. The ICS is an opportunity to rework how services fit together across organisations and break down silo working, to embed the patient voice across the whole suite of system services, for example, joining up physical and mental health care. In response to a question from Vikki Ashton Taylor, Director of Strategy, Partnerships and Transformation about what digital technologies added most value, Simon recognised there was a future for digital services, but emphasised this needed to be part of a suite of access options. The point of access should be driven by patient need not by the service. The challenge was equity of access for those different types of services. The Chair thanked Simon for his story, for the contribution he was making to the Trust and the national picture through the passion he brings to his work. She expressed how good it was that it was some time since he had needed to access the Trust's crisis service. **RESOLVED: The Board of Directors noted Simon's story which provided the Executive with a challenge around patient voice being as strong as carers' voices to contribute to co-production of services. They also noted Simon's suggestion of a Patient Director.**
DHCFT 2022/095	**MINUTES OF THE BOARD OF DIRECTORS MEETING HELD ON 6 SEPTEMBER 2022** The minutes of the previous meeting held on 6 September 2022 were accepted as a correct record of the meeting.

DHCFT 2022/096	**ACTION MATRIX AND MATTERS ARISING** The Board reviewed and closed the completed actions. No actions remained outstanding.
DHCFT 2022/097	**QUESTIONS FROM MEMBERS OF THE PUBLIC** No questions had been submitted for a response ahead of the meeting. Selina reminded the Board that Governors represent the public and any questions raised with them by members of the public are taken to the Council of Governors under their holding to account role.
DHCFT 2022/098	**CHAIR'S UPDATE** Selina Ullah's report summarised her activity since the last Board meeting. She updated the Board on progress to appoint the next Chief Executive. She was delighted that more than 200 colleagues from across the organisation had engaged with the process to develop the job description and person specification, as well as the format for the interview and selection process. A summary of what colleagues valued and stated as key skills and attributes was included at Appendix 1 of the report. The process includes a comprehensive communication plan and the advertisement launched on 7 October 2022 with details available via https://derbyshire-futures.com/. Selina and Ifti as Chair and Chief Executive had continued to visit service areas, which most recently included the Radbourne Unit. Selina said she had gained valuable insight from her conversations with colleagues, patients, and carers and was an opportunity to triangulate the reports received by Committees and the Board. They had witnessed first-hand the prompt response by ward staff when a patient unexpectedly became physically unwell. She had been reassured by the speed, calmness, and compassionate professionalism of staff. They had also witnessed a patient being admitted under a Section 136 by the police and were reassured by the way staff calmly and compassionately dealt with an agitated patient. Selina said had been inspired by the passion and effort she witnessed on their visit to the Medical Annex where the training, development and education of junior doctors and nursing staff takes place. She was struck by the impact that a small team has on the Trust's services. The Trust's newest Non-Executive Directors (NEDs) were also beginning to visit services as part of their induction. Other matters covered in the Chair's report included: • Memorial Wreath laying service in tribute to HM Queen Elizabeth II • Details of the matters covered at the Annual Members Meeting on 21 September 2022 • The Chair's engagement with the Council of Governors' • Matters dealt with by the Governors' Nominations and Remunerations Committee • Board Activity with regard to the CE and Director of Finance appointment progress and the interim leadership arrangements post 1 December 2022. The Chair focussed her report on recent activity by the Council of Governors and the Trust Board as this was where energy and effort had been placed in order to maintain stability and ensure the Trust continues to be 'Well Led' and maintains strategic focus. Lynn Andrews, Non-Executive Director Designate commented she had been reassured by the Chair's report of her visit to the Radbourne Unit particularly in relation to the item later on the agenda on the Trust's response to the BBC Panorama programme findings.

	RESOLVED: The Board of Directors noted the content of the Chair's update.
DHCFT 2022/099	**CHIEF EXECUTIVE'S REPORT** Ifti Majid's CEO report provided the Board with a detailed update on local and national developments within the national and local Derbyshire health and social care sector over the last two months. As this was Ifti's last report to Board he had taken the opportunity to include his personal reflections on the last seven years. The following matters were highlighted: **National Context** The schedule for the UK COVID-19 Inquiry was outlined. It was anticipated that the Trust's involvement was likely to be part of the additional modules relating to the health care system which was likely include issues such as the care sector, the vaccination programme, test and trace, and PPE. The Corporate Services team was undertaking some pre-work in anticipation of any requests for information from the enquiry team, which would be coordinated through NHS England (NHSE). The Board was reminded of the inquiry focus, which was on challenges and best practice. As the Trust had demonstrated areas of national best practice, it was likely we would be asked to provide evidence to the inquiry. For example, our Trust was the only one that undertook a BME risk assessment process. The Board was asked to note new NHSE Operating Model. This important document had started to define the relationships and expectations of NHS provider organisations, Integrated Care Boards (ICBs) and the regional and national NHS team. Included in the CEO's report was a summary of the expectations on providers and those relevant to the Trust Board. The new model would be a matter for a Board Development session, as well as being involved in conversations through system meetings particularly, to manage risk of duplication and assurance routes within an emerging system approach. Ifti introduced Tamsin Hooton, in her new position as Provider Collaborative Programme Director who shared her first month activities which included her conducting a light touch stocktake of the Collaborative's development, reflecting on what had been achieved so far, as well as setting out some suggested areas for development. This would support the Provider Collaborative Leadership Board in agreeing next steps including a more formal delivery programme. Tamsin sought feedback from the Board on whether they would find an away day event helpful and include some Non-Executive Directors of the Provider Collaborate and sought an indication of how best to communicate and engage with the Board about the work of the collaborative in addition to a monthly update to the Chief Executives. **East Midlands Region and Derbyshire Context** The Joined Up Care Derbyshire newsletter for October 2022 had been included at Appendix 1 of the report. Ifti thanked all those involved in developing the new Dementia Strategy for Derbyshire (included at Appendix 2), noting that dementia diagnosis rates post COVID-19 were not where we would want them to be. **Within our Trust** Ifti reflected this was the first Board Meeting without Claire Wright who had retired as Director of Finance on 31 October 2022. The Board formally thanked Claire for her huge contribution to the Trust, the Derbyshire System and to improving the lives of residents. She spent much of her considerable career working in Derbyshire between Derby Hospitals and our Trust. She had led the Trust in consistently achieving its financial plan with compassion and integrity, always with a focus on people's experiences of using our services. Ifti echoed the comments made by the Chair in her report following their joint visit to the Radbourne Unit. He had been really pleased with the engagement he had received from patients and the contribution to fostering an open culture.

	He also commented on how fortunate he had been, along with Carolyn Green, to attend celebrations at one of the Child and Adolescent Mental Health Services (CAMHS) bases, organised in conjunction with young people from the CAMHS participation group. The event held at Temple House was sensational and an opportunity to meet and hear from a range of partners who support young people, increase understanding of the different components of the service. Over 150 visitors attended the day and as a direct outcome at least ten new collaborations had been planned to benefit young people. He was privileged to open the event with Derby's Youth Mayor, Omar Aslam, by whom he was very inspired. The Board noted the current COVID-19 rates, in terms of colleague absences which had shown a gradual increase and in patient cases, which remained low. The Infection Prevention and Control (IPC) team continued to review the Trust's use of PPE and makes changes to practice based on the Trust's data. Ifti took the opportunity to note the great work of the vaccination hub at Kingsway, in delivering COVID-19 and flu vaccinations to colleagues and patients. In conclusion, Ifti responded to the Board's tribute to him earlier in the meeting. He attributed the Trust's success to all the staff and commended the senior leadership team immediately below the Executive Leadership Team for their delivery of safe services. He thanked his Executive colleagues for their knowledge, wealth of experience and commitment to the Trust and the people of Derbyshire. Ifti expressed his confidence in Carolyn Green's interim leadership moving forward and wished the Board and the Trust every success. Executive colleagues responded with their own tribute and thanks. **RESOLVED: The Board of Directors scrutinised the report, noting the risks and actions being taken and accepted assurance around key issues raised.**
DHCFT 2022/100	**INTEGRATED PERFORMANCE REPORT** The Board was updated on key finance, performance and workforce measures at the end of September 2022. Executive Directors drew attention to the following sections within the report: **Operations** Chief Operating Officer, Ade Odunlade highlighted that the transition to SystmOne in had resulted in recording errors which affected some of the performance measures. The SystmOne project team had made good progress to address the issues. Performance summits had been held with the aim to deliver and coordinate across four workstreams: data optimisation, quality improvement, review of metrics and engagement. The report set out the key metrics for which focussed Recovery Action Plans (RAP) had been drafted or were in development for specific workstreams. The RAPs were being monitored via the Trust Operational Oversight Leadership group (TOOL) and reported to the system wide Mental Health Learning Disability and Autism Board. Ade was pleased to report significant improvement in reducing out of area acute inpatient placements which placed the Trust in the top three mental health Trusts. However, until the new build scheme for Psychiatric Intensive Care Unit (PICU) was commissioned all PICU patients will continue to be cared for out of area as there is no local provision in Derbyshire. An update on delayed transfers of care and waiting lists was given. Lynn Andrews said it was positive the Trust had been identified to pilot an initiative on waiting list improvements but asked whether the pilot could be successful given the Trust's vacancy rates. Ade clarified that the pilot would involve staff nationally using digital technologies and reported that in the last quarter over 100 new members of staff had joined the Trust each month. The Trust would be looking at innovative ways to redefine and substitute roles where possible to manage the hard to reach vacancy areas.

	In response to a question from the Chair regarding the Recovery Action Plans, Ade confirmed a progress trajectory was in place for each plan. **Finance** Interim Executive Director of Finance, Rachel Leyland reported that as at the end of September 2022, the overall year to date (YTD) position reflected a deficit of £1.0m compared to the £0.8m planned, a variance of £0.2m. The main driver for this variance related to the undelivered CIP which was being slightly offset by some additional income. The forecast remained a breakeven position in line with the plan. The risks to maintaining the breakeven position were included within the report and related in the main to agency staff spend and that the majority of the efficiencies identified (70%) were non-recurrent for subsequent years. Geoff Lewins, Non-Executive Director commented on the improved financial position due to reduced costs from COVID-19 and out of area placements but expressed concern over the increase in agency spending and asked about the NHSE controls that were in place. Rachel Leyland clarified NHSE were monitoring trusts through their relevant ICS. Director of People and Inclusion, Jaki Lowe summarised the action being taken at a local and system level to address agency staffing costs. Ade added that role design would be considered as part of an inpatient staffing summit being held at the end of November at a dedicated TOOL meeting. Tony Edwards, Non-Executive Director stressed that it was important for the Board to know if system constraints were impacting on the Trust's ability to improve service, e.g., reducing waiting times. He added that the Finance and Performance (F&P) Committee needs to be able to track progress with savings and efficiency initiatives and have line of sight of our ability to deliver the changes required quickly enough and have impact in the financial year. Carolyn asked Rachel to lead a quality improvement project for agency spend reduction, for which the Executive Leadership Team (ELT) would set targets in order to plan the recovery. She emphasised the need for this within the context of the Trust's risks relating to quality, safety and patient experience resulting from high levels of agency staff, which was as important as the financial challenge. In response to a question from the Chair, Rachel Leyland confirmed the Trust had a stable cash position in line with the levels of planned capital investment being delivered. **People performance** Jaki gave assurance that multi-disciplinary groups were in place for all the areas set out in the report requiring performance improvement. Accountability at a leadership, service and individual level was being given attention in order to affect performance.. Jaki referred to the agency spend earlier in the discussion and highlighted that some of that was attributable to delays before the recruitment process commences and an area of focus. She asked Board to note the uplift being seen in performance by the Trust's recruitment services and thanked Cathryn Taylor, Head of People Operations and Alex Dougall, Recruitment Services Manager at Derbyshire Community Health Services (DCHS) for their work on this. Updates on training, sickness absence, appraisals and exit interview compliance was given. Ralph Knibbs, Non-Executive Director added that Jaki's thanks for the work around recruitment should be extended to Rebecca Oakley, Acting Deputy Director People and Inclusion for her innovative ideas and connecting with managers for solutions. It was noted that a letter of thanks had been sent to all three colleagues.

	In response to Ralph's question about addressing the disconnect between the HR and Finance systems, Jaki responded that the Trust was working at system level with DCHS on workforce planning. NHSE funding had been secured for a system wide role to plan and triangulate data at a finance, people and operational level. Tony Edwards commented on the enthusiasm and energy with which Jaki had presented particularly around the recruitment and process changes. He hoped this was shared with colleagues in terms of action and the criticality for the success of recruitment. In response to a question from Tony around quality of induction and the effect this has on candidates, Jaki concurred with the importance of this and that the Trust's corporate induction was person centred, with all members of the Executive team in attendance each month. **Quality** Tumi Banda, Interim Director of Nursing and Patient Experience brought the following items from his report to the Board's attention. The proportion of patients whose care plans had been reviewed continued to be recorded as lower than expected and was on a downward trajectory. Work was taking place with Heads of Nursing in conjunction with the SystmOne implementation team to resolve the data quality issues and bring care plan recording into compliance. Regarding patients in employment and settlement data, around one third of patients have no employment or accommodation status recorded and coincides with data migration to SystmOne. However, the Individual Placement Support (IPS) Service was being monitored and continued to successfully support people into employment. The issue was therefore around data quality and not quality of service outcome. Tumi reported that the number of reported incidents of physical or prone restraint and patient seclusion continued to reduce and compared favourably against other Trusts with similar bed capacity. The Trust was seeing a reduction in restrictive practice through innovations like body worn cameras and a group had been established to focus on closed cultures, including the temporary staff workforce. Education around the use of medication and prone restraint practices was also in place to support reduction in restrictive practices. Formal complaints were below the Trust target and attributed to an increase in face-to-face contacts as services stand back up following COVID-19 restrictions. These were supported by video and telephone services to offer a varied range of service access. Deborah Good, Non-Executive Director stress the importance of maintaining focus and priority on patients in settled accommodation as it was a key determinant of future pathways and health prospects. **RESOLVED: The Board of Directors received positive assurance with the action taken to address performance issues but received limited assurance from current performance across the areas presented.**
DHCFT 2022/101	**<u>NEURODEVELOPMENTAL SERVICES – UPDATE IN RESPONSE TO PANORAMA AND DISPATCHES PROGRAMMES</u>** The Board received a system wide report giving assurance in response to the issues raised in the BBC Panorama programme featuring Edenfield and the Panorama and Channel 4 Dispatches programmes. The report focused on the importance of cross sector learning to continually improve services. Ade reminded the Board that the Quality and Safeguarding Committee and the Finance and Performance Committee receive regular reports on Neurodevelopmental Services, Learning Disability and Autism (LD&A) and Quality of Services.

	Carolyn said she had received significant assurance from the report and emphasised the importance of the Trust learning from occurrences at other organisations. She asked Tumi to pick up the residual system risks from the report around acute liaison nurses and the impact of bed closures from a patient quality and cost perspective, which leads to people with LD&A having to access acute mental health beds. Lynn was pleased to see the rapid reporting to Board on what the Trust was doing in response to the publication of these programmes and the clarity of the timing and areas of responsibility. She emphasised the patient voice should be heard as part of the Trust's safe and well checks. Ade responded these checks had been undertaken for all patients in May 2022 and scheduled again for January 2023 in line with NHSE guidance. As a system the Trust leads on the use of a patient categorisation tool in terms of right place, right care., thus prioritising patients either not receiving the right care or placed out of area. All stakeholders were involved, including patient and their carer(s). Ashiedu Joel. Non-Executive Director asked for an explanation on how the delayed transfer of care was impacting on patient needs being met in light of the issues raised in the documentaries. It was noted that the delayed transfer of care for patients with LD &A was due to capacity in the system from a facility originally built to support 6 patients but had only ever been able to support 3 patients. Carolyn commented that there were wider reasons why people with LD&A were not receiving the appropriate care, such as lack of suitable housing; a key reason why people who were medically fit for discharge cannot move into the community. This needs to be looked at strategically within systems. **RESOLVED: The Board of Directors:** **1) Noted the update and overview** **2) Asked ELT to extend its current LD&A work programme to include a strategic focus on housing.**
DHCFT 2022/102	**<u>WORKFORCE RACE EQUALITY STANDARD (WRES) AND WORKFORCE DISABILITY EQUALITY STANDARD (WDES) SUBMISSION RETROSPECTIVE SIGN OFF</u>** The Board welcomed Samina Arfan, Head of Equality, Diversity and Inclusion (EDI) to her first meeting of the Board. The report set out the progress on the WRES and WDES action plan. The Board had previously delegated authority to People and Culture Committee to review and sign off the submissions in time for the 31 October 2022 deadline and publication on the Trust's website. The Board noted a correction in the WRES action plan that for outcomes 6 and 7 the January 2022 dates should have been January 2023. Samina presented an overview of the WRES and WDES data for 2021/22 within the context of the Trust's public sector equality duty. The Trust's WDES action plan further strengthens the NHS as a workforce disability leader and addresses inequalities within Derbyshire. The key actions arising from the Messenger review were set out in the presentation, and included inclusive leadership practice, promotion of opportunities and fairness standards and an enhanced role by the CQC to ensure improvement in EDI outcomes. The WRES data indicators were presented under the areas below and the results set out in terms of areas of improvement and where deterioration had taken place: (i) Representation, recruitment, and progression (ii) Behaviours and discrimination (iii) Formal disciplinary (WRES) / capability (WDES) processes

	The Board noted that the Trust has a wide range of actions in place to address inequalities identified in the WRES and WDES data. Many of the actions sat within the system wide EDI strategy with four associated priorities. Samina added that addressing race provides an evidence based framework to demonstrate impact and could be scaled up for other groups with protected characteristics where the data was less extensive. Work was underway through the 'Above Difference' programme, allyship, targeted work with Bank staff, Junior Doctors and addressing incidents of bullying and harassment. Ashiedu thanked Samina for the in-depth granularity of the data presented in the report. Samina concurred with Ashiedu's comment on the importance of undertaking detailed mapping of the protected characteristics within the data sets in order to understand areas of intersectionality and target areas of focus. Carolyn commented on the great work that had been achieved against the previous targets but was cognisant that more needed to be done collectively on the outstanding or deteriorating areas. **RESOLVED: The Board of Directors resolved to:** **1) Ratify the WRES Report and Action Plan which had been previously approved by the People and Culture Committee on 20 September 2022 as published on the Trust's public-facing website.** **2) Note the engagement and development of the action plan with the Trust's BME Network** **3) Note the strategic implications of the WRES 2022/23 and asked for further work to be undertaken on understanding the intersectionality of the available data.**
DHCFT 2022/103	**<u>EQUALITY DIVERSITY AND INCLUSION (EDI) UPDATE</u>** The Board received an update of EDI work undertaken, ongoing and work planned this year, the key elements of which had been covered during the preceding item. It was noted that the People and Culture Committee had developed a forward plan of work. Jaki highlighted that a framework for inclusion was in development and would focus on the Trust's strategic outcomes for inclusion, being led by Samina with the involvement of partners in DCHS and University Hospitals of Derby and Burton. The inclusion framework would influence forthcoming recruitment changes around job design, job descriptions and advertising. The report included an overview of progress by the Staff networks. **RESOLVED: The Board of Directors noted the report.**
DHCFT 2022/104	**<u>GUARDIAN OF SAFE WORKING REPORT (GOSW)</u>** Dr Arun Chidambaram, Medical Director presented the GOSW report that provided data about the number of junior doctors in training and the Trust's compliance with the new junior doctor contract. The report detailed arrangements to ensure safe working within the Junior Doctor contract and arrangements in place to identify, quantify and remedy any risks to the organisation. Arun highlighted that the GOSW ensured junior doctors had a voice and could report by exception on any issues through the mechanism, which links with the Trust's Freedom to Speak Up arrangements. In response to a question from the Chair about whether there were any trends arising from the frequency, timing or nature of the fines, the Medical Director took an action to include this in the next report to the Board. Jaki asked Arun for his reflections on the experience of junior doctors and their levels of engagement. Arun responded that there was confidence the GOSW system works well along with the junior doctor forum, which also logs issues to ensure a good experience. The Trust is keen they become our consultants once qualified.

	ACTION: Trends arising from the frequency, timing or nature of the fines to be included in the next GOSW report. **RESOLVED: The Board of Directors** **1) Noted the quarterly update report.** **2) Asked for their thanks to be extended to Dr Smita Saxina, GOSW, for her report.**
DHCFT 2022/105	**LEARNING FROM DEATHS MORTALITY REPORT** The Board received its regular report on the requirement of the 'National Guidance on Learning from Deaths' for each Trust to collect and publish specified information on a quarterly basis. The report which covered the period 31 May to 31 July 2022 had also been reported to the Quality and Safeguarding Committee meeting in October 2022. Arun commented on the importance of learning from deaths for the Trust's ethos to foster an open culture. He highlighted the areas of learning from the latest report as well as other sources including incidents. The Trust proactively seeks information about deaths of all people who have received care from the Trust and among specific population groups, for example people with Learning Disability and Autism. **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 2022/106	**RECEIPT OF ANNUAL REPORTS** Tumi presented annual reports for Looked After Children and for Safeguarding Children and Adults at Risk. Both had been considered by the Quality and Safeguarding Committee in September 2022 and were recommended to the Board for approval. **Safeguarding Children and Adults at Risk Annual Report 2021/22** The annual production of the report was a governance requirement of both the Trust and the Safeguarding Children Partnership and Adult Safeguarding Boards. The Quality and Safeguarding Committee had received assurance that the Trust was meeting its legal and statutory performance and governance requirements in a consistent and reliable manner. **RESOLVED: The Board of Directors received the report with significant assurance the Trust was meeting its legal and statutory performance and governance requirements.** **Annual Looked After Children Report 2021/22** The report provided an overview of the progress, challenges, opportunities and future plans to support and improve the health and wellbeing of looked after children in Derby City. The Quality and Safeguarding Committee had received significant assurance from the work of the Trust in discharging its formal statutory duties to vulnerable children. The Board noted the higher morbidity rates in Looked After Children than in other groups and Arun explained that whilst the overall number of looked after children was lower than in previous years, the proportion of those under the age of 12 months were overrepresented in this group and a cause for concern. He highlighted that it would be important to monitor whether these children leave care, but more importantly the impact system partners could have on preventing children becoming looked after where there were opportunities to support the family. **RESOLVED: The Board of Directors received the report with significant assurance the Trust was discharging its formal statutory duties to vulnerable children.**

DHCFT 2022/107	**BOARD ASSURANCE FRAMEWORK ISSUE 3, 2022/23** Justine Fitzjohn, Trust Secretary presented the Board with the third issue of the Board Assurance Framework (BAF) for 2022/23. She highlighted, the Director of People and Inclusion had substantially rewritten the 'Great Place to Work' risks under strategic objective 2. All the risks and root causes had been reviewed and incorporated into two new risks 2C and 2D. Risks 2A and 2B had therefore been closed. The Board noted refinement of the quality aspects of the dormitory eradication programme related risks. Carolyn informed Board that the Quality and Safeguarding Committee had requested the inclusion of learning from external reviews in other organisations. This had been reflected within the BAF under strategic objective 1 'To provide Great Care in all our services'. **RESOLVED: The Board of Directors:** **1) Approved the third issue of the BAF for 2022/23 and received assurance the 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** **2) Agreed to continue to receive updates in line with the Board's forward plan.**
DHCFT 2022/108	**POLICY FOR ENGAGEMENT BETWEEN THE BOARD OF DIRECTORS AND THE COUNCIL OF GOVERNORS** The Board of Directors considered the proposed revisions to the above policy, noting that it continues to reflect the current Foundation Trust Code of Governance and is compliant with the Trust Constitution, Standing Orders and locally agreed protocols developed by the Council of Governors. The revised policy had been highlighted to show the following recommended changes: • Change of terminology to NHS England (NHSE) where appropriate. • References to the Integrated Care System. The statute which established the Integrated Care Systems on 1 July 2022 did not directly change the statutory duties of governors but the role of the governors within systems was likely to evolve over time and further guidance was expected. • The wording around governors asking questions at Public Board meetings. This remained an option, but governors supported reserving that time on the Board agenda for questions from members of the public. This was on the basis that Council of Governors meetings are also public meetings and submitting 'holding to account' questions demonstrated governors carrying out their statutory duties. The Trust Secretary informed the Board that the revised policy had been supported by the Governance Committee in October 2022. **RESOLVED: The Board of Directors approved the revised policy document.**
DHCFT 2022/109	**BOARD COMMITTEE ASSURANCE SUMMARIES** The Board Committee Assurance Summaries demonstrated the work of the committees since their last update to the Board. The Assurance Summaries were accepted and noted by the Board as a clear representation of the priorities that were discussed and will be taken forward in forthcoming meetings. The Assurance Summaries were noted without comment. 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 2022/110	**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 2022/111	**2022/23 BOARD FORWARD PLAN** The 2022/23 forward plan outlining the programme for the remainder of the year was noted and would be reviewed further by all Board members for the financial year ahead.
DHCFT 2022/112	**MEETING EFFECTIVENESS** The Board agreed that the meeting had been successfully conducted as a virtual meeting. The meeting had overrun mainly due to the length of the patient story, Selina stressed the importance of these stories but asked for additional support to help individuals tailor their presentations within the time allocation.
DHCFT 2022/113	**CHAIR'S CLOSING REMARKS** The Chair reiterated her personal thanks to the Chief Executive, Ifti Majid for his outstanding contribution to the Trust and for his support wisdom, insight, and friendship. He would be missed by his colleagues and friends, but the Board wished him well in the next chapter of his career at Nottinghamshire Healthcare.
The next meeting to be held in public session will be held at 09.30 on 17 January 2023.	

				BOARD OF DIRECTORS (PUBLIC) ACTION MATRIX - JANUARY 2023			
Date	**Minute Ref**	**Item**	**Lead**	**Action**	**Completion Date**	**Current Position**	
1.11.2022	DHCFT 2022/104	Guardian of Safe Working Report	Medical Director	Trends arising from the frequency, timing or nature of the fines to be included in the next GOSW report	17.1.2023	Captured in reporting.	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%**

Derbyshire Healthcare NHS Foundation Trust
Report to the Public Board of Directors – 17 January 2023

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 1 November 2022. The structure of this report reflects the role that I have as Trust Chair.

I would like to take this opportunity to wish members of the Board, our staff colleagues, Governors and all stakeholders a very happy new year. As a Trust, we have an exciting year ahead of us with some ambitious development programmes and a new CEO. The Board will be concentrating on developing a high performing organisation with soul, being people first and delivering for patients. Here is to 2023 being a year of positivity, improvement, good health and restoration for our patients, carers, colleagues, services and wider organisation.

Our Trust and Staff

1. On 3 November the staff conference took place at Pride Park, the first face to face staff conference since the pandemic. The theme of this year's conference 'inspiring and motivating each other during times of change'. Over 135 colleagues took part and heard from our guest speaker, former Olympic athlete, Derek Redmond.

Derek shared some fascinating insights into his sporting career – including how the four athletes selected for the 4 x 400m relay in the 1991 World Athletics Championships agreed between themselves to change the order of the legs, much to the upset of some of their coaching team at the time. Needless to say the team won the gold medal, even though as Derek said, the four athletes were not the four best runners in the world.

But they were the best team; they spent time with each other, knew each other well and this put them in a place where they were confident to take risks and push the boundaries. We were all thoroughly energised by Derek and his inspiring story.

2. I am very proud to report that the Trust was shortlisted in the 'Trust of the Year' award by the very prestigious Health Service Journal. The Awards evening took place on 17 November and the Trust was represented by a cross section of Trust colleagues including clinicians, administrative and frontline staff, including community and inpatient and exec colleagues, members of the comms team and myself. Although we did not win, it is a very high accolade to be shortlisted and noteworthy recognition for the Trust, the journey it has

travelled, our People First values and the immense work that we are doing to deliver great services for our patients and the people of Derbyshire.

3. Samina Arfan, our Head of Equality Diversity and Inclusion (EDI) organised a Lunch and Learn session on 21 November on Islamophobia for colleagues during Islamophobia Awareness week, which I attended. The session was informative and well received and sign posted the participants to resources. The session highlighted for me the need to continue to raise awareness and provide practical support for our colleagues to do their job in a sensitive, informed and effective way.

4. On 23 November we had our 2022 HEARTS Awards, which was the first face to face staff awards event since the pandemic began. The communications team did a fabulous job in turning our training room into a fitting space for a very enjoyable staff awards celebration event. It was wonderful to be able to recognise and celebrate our colleagues for all the inspiring work they have done over and above their day job.

5. Carolyn Green, Interim CEO and I undertook some service visits on 28 November. We visited the Neuro Development Services where Fiona Brettell, Service Manager gave us an overview of the service, the planned developments and recent successes with recruitment. We also visited, Temple House, Children's Services (Hayley Darn and Dom Pitter) where we met the parents support group who told us about their involvement. The group had helped them through challenging and difficult times with their children. Some of the parents now work for the Trust on a sessional basis. We also visited The Beeches, Mother and Baby Unit (Kerby Walker) and I was impressed with the developmental work being undertaken. I left the services with a strong sense of the ambition and passion that these managers had for their services. A big thank you to Fiona, Hayley, Dom and Kerby.

6. On 5 December I met with each of the Executive Team members to garner their views and suggestions for the forthcoming recruitment of the CEO. The consultation with executive members was very helpful to me and I very much value their objectivity and their vision and ambition for the Trust.

7. Sadly, we held a minutes silence for a colleague, Duncan McNiven, Nursing Assistant in our Older Adult Services, who passed away at home. Duncan was much loved by colleagues and patients and will be greatly missed. Our condolences to Duncan's family and friends. We have also been further

saddened by the death of our colleague, Marie White, a valued member of our Children's Services division. Marie worked in our health visiting services and had a long career with the Trust. We held a minutes silence for Marie on Thursday last week.

8. In true age old tradition on 13 December we had the judging of Christmas decorations across the Trust. Once again, colleagues and service users excelled in their creativity in bringing the festive atmosphere to our services and environments. The winners were:

    - Best overall inpatient display – Morton Ward, Hartington Unit
    - Best overall non inpatient display – South Derbyshire and Dales Adult Community Mental Health Team, Dale Bank View
    - Best patient participation – Cubley Court, Kingsway Hospital
    - Best diversity and inclusion – Ward 34, Radbourne Unit
    - Overall winner – High Peak Crisis Resolution and Home Treatment Team.

9. After a very robust process, the CEO recruitment process concluded on 21 December. I am pleased to report that we appointed Mark Powell. Mark has worked for the Trust previously from October 2016 to April 2021. Mark is currently the Deputy CEO at Leicester Partnership NHS Trust. I would like to thank Carolyn Green for her continued leadership of the Trust in her interim CEO capacity.

10. On 22 December I met with the Executive Directors to update them about the outcome of the CEO recruitment. I am grateful to Jaki Lowe, Director of People and Inclusion for the assistance she has provided me in this process and to Gill Lemmon and Alison Tuckley for the herculean task of organising the various meetings between candidates and Board members, Council of Governors, system leaders and the various stakeholder panels held on 19 December and 21 December.

11. I would like to recognise the Winter Wellbeing Campaign that ran through the month of December. My thanks to all colleagues who worked so hard behind the scenes to make this happen. This brought a strong focus for everyone on our own health and wellbeing.

12. Finally, I would like to thank all our colleagues for their on-going commitment and dedication shown to the Trust and our patients and service users at a time that continues to be evermore challenging internally and externally in the wider system.

Council of Governors

1. I meet regularly with the Lead Governor and Deputy Lead Governor. These meetings are an important way of building the relationship and understanding of the working of the Board and the Council of Governors. On 7 November I met with Susan Ryan, Lead Governor to update and inform her of issues and developments in the Trust as well as hear from her about any key issues the governors may have had raised with her or the Deputy Lead Governor. I am

grateful to our governors for all their work and for ensuring the needs of their constituents and all Derbyshire communities are at the forefront of our service planning and delivery.

2. We held a Governors and Non-Executive Directors 'getting to know each other' session on 7 December. We all felt that it was very useful to have this opportunity to share our experiences and why we were at Derbyshire Healthcare. The session was very affirming in understanding how closely our values were aligned and our joint interest in the work of the Trust.

3. I met with Staff Governors, Joanne Foster, Marie Hickman, Kel Simms, Varria Russel Grant and Jan Nicholson on 8 November. The staff governors provide a valuable way for me to hear about issues that impact colleagues and their suggestions for improvement are always very helpful.

4. The Governance Committee jointly chaired by Ruth Grice and Marie Hickman met on 13 December.

5. On 13 December Carolyn Green, Anna Shaw, Deputy Director of Communications and Engagement and I met with the Staff Governors to address the issues they had raised with me on 8 November. It was a very positive meeting and there was an agreement on how we could resolve some of the issues they had raised.

6. On 22 December, an extraordinary meeting of the Council of Governors was held to ratify the appointment of Mark Powell as CEO. I am grateful to the Governors for their involvement in the recruitment process and their continued support to the Board.

7. The next meeting of the Council of Governors will be on 6 March, following the Public Board meeting on that day. The next Governance Committee takes place on 7 February.

Board of Directors

1. We have begun to have a mixed approach to meetings; meeting in person for our development sessions when we can but also virtually using MS Teams. This enables Board members to keep connected whilst working remotely. We have continued to hold our public Board meetings virtually as we have found that we have had an increased attendance of members of the public and our staff observing the Board meetings this way.

2. On 29 November the Board held a diagnostic session to identify the Board development requirements to successfully deliver the Trust strategy. This was a good opportunity for the Board to work together face to face.

3. The Board took part in its second workshop as part of the Board Leadership for Inclusion Initiative (BLFII) on 14 December. This is part of a twelve month programme that the Board has embarked upon with the aim to focus on

addressing inequalities in access, experience and outcomes for our patients and staff colleagues.

4. On 30 November, following an all staff Question and Answer Session, we said goodbye to Ifti Majid, CEO after a long service to the Trust. We thanked him for his leadership of the Trust and wish him every success in his role as CEO at Nottinghamshire Healthcare NHS Foundation Trust.

5. I met with the Non-Executive Directors on 7 December to hear their views on the CEO appointment and their perspective on Board requirements. This was followed by a Confidential Board information sharing session.

6. On 22 December the Board Remuneration and Appointments Committee met to approve the decision made by the interview panel to appointment Mark Powell as the CEO and agree the terms and conditions of appointment.

7. I continue to meet with my Non-Executive Director colleagues on a quarterly basis to review their objectives, development needs and discuss their perspectives on how the Board and Trust is delivering Trust priorities. This quarter I met with Deborah Good and Ralph Knibbs.

8. The Board said goodbye to Dr Sheila Newport, Deputy Chair on 10 January 2023. Sheila has been an invaluable member of the Board and her insight, compassion and sharp analysis will be very much missed. Sheila is retiring and we wish her our best wishes for her retirement.

System Collaboration and Working

1. The four Derbyshire Provider Chairs continue to meet monthly with John MacDonald, Chair of the Integrated Care Board (ICB) /Joined Up Care Derbyshire (JUCD). This provides an opportunity for the system leaders to discuss and agree approaches to system issues affecting patients. At our meeting we discussed the finances and the financial outlook for the wider system.

2. 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, NHS Confederation and others

1. I attended the NHS Providers Board meeting on 9 November. We discussed the forthcoming changes at NHS Providers, the challenges being faced by Provider organisations and the impact of what is a rapidly changing political environment. The key concerns of NHS leaders e.g. winter pressures, system pressures and the likely industrial action by health workers was discussed.

2. On 15 and 16 November I attended the NHS Providers Conference in Liverpool, along with Ade Odunlade, Chief Operating Officer and Ashiedu Joel, Non-Executive Director. This event was well attended by NHS Chief

Executives, Executives, Chairs and Non-Executive Directors. We heard from both the Secretary of State for Health, Steve Barclay and Shadow Health Secretary, Will Streeting. They gave their political view on the NHS and their priorities going forward.

3. On 12 December I joined the NHS Confederation Chairs meeting. The key item for discussion was the Public Inquiry into the COVID-19 pandemic and specifically around Inquiry Rule 9 which entitles the Inquiry to send a written request for evidence which will usually direct the recipient i.e. the Trust, to the issues that need to be covered. The importance of legal representation at this stage was emphasised.

4. I have attended regular briefings from NHS England for the Midlands region, which has been essential to understand the impact of ongoing pandemic pressures on services, other system pressures e.g. ambulance waits, elective recovery, workforce issues, out of area placements of complex patients and waiting times in mental health and autism services and industrial action.

5. I have also joined the weekly calls established for chairs of mental health trusts hosted by the Mental Health Network in collaboration with the Good Governance Institute where support and guidance on the Board through the pandemic has been a theme. A number of the Non-Executive Directors (NEDs) have also attended weekly calls for NEDs on a range of useful topics.

8. On 13 January a number of Trust staff and I attended the national NHS APNA (Asian Professional National Alliance) Awards, as both Ifti Majid and I were nominated for an award.

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.	

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

Covered as part of the individual items.

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

This report reflects a wide range of activities across the Trust, and consideration relating to ensuring inclusion is embedded in operational work of the Trust. The specific services visited provide support to those with protected characteristics by the nature of their work. I have supported the work of the Trust in promoting an inclusive culture and an inclusive Board. I have instigated a board development programme on inclusion which will assist in developing the Board's understanding and response to the inclusion challenges faced by many of our staff.

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

Demonstrating inclusive leadership at Board level

As a Board member I have ensured that I am visible in my support and leadership on all matters relating to diversity and inclusion. I attend meetings to join in the debates and conversation and to challenge where appropriate, and also to learn

more about the challenges of staff from groups who are likely to be or seem to be disadvantaged. I ensure that the Non-Executive Directors are also engaged and involved in supporting inclusive leadership within the Trust.

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

Recommendations

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

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


East
Midlands
Alliance
for Mental Health and Learning Disabilities

East Midlands Alliance

for Mental Health and Learning Disabilities

Creating a blueprint for mental health partnership support

Case study: An innovative approach to improving services through alliance

East Midlands Alliance for Mental Health and Learning Disabilities

An innovative approach to improving services at St Andrew's Healthcare, the country's largest charitable mental health provider, is being delivered by the East Midlands Alliance for Mental Heath and Learning Disabilities.

The East Midlands Alliance for Mental Health and Learning Disabilities was established to strengthen joint working and support delivery of the NHS Long Term Plan, and is made up of six partner provider organisations:

- Derbyshire Healthcare NHS Foundation Trust
- Leicestershire Partnership NHS Trust
- Lincolnshire Partnership NHS Foundation Trust
- Northamptonshire Healthcare NHS Foundation Trust
- Nottinghamshire Healthcare NHS Foundation Trust
- St Andrew's Healthcare

Together the Alliance has taken a collective approach to give quality improvement focused support to St Andrew's, as the provider has embarked on a journey of change and quality improvement, in partnership with the five Trusts.

The improvement programme began in Autumn 2021 and focuses on best practice initiatives to support the needs of patients and staff, helping St Andrew's to focus on key areas raised by the CQC in relation to some of their services and governance.

What has been happening?

East Midlands Alliance
for Mental Health and Learning Disabilities

The support programme has been led by the alliance of partners and co-ordinated through a ‘buddy’ Trust, which has involved sharing ideas, listening and learning to drive forward positive change to benefit patients across the region.

The various elements of the programme are led by different members of the Alliance, and each workstream has an NHS lead and a St Andrew’s lead. Together they meet regularly to drive actions forward, to help St Andrew’s focus on the areas they need to make changes to.

This work has been carefully planned to manage capacity and focuses on best practice initiatives to support the needs of patients and staff.

One of the key benefits of the Alliance is that the region becomes responsible for the patient, so all involved partners play an important role in providing quality of care and appropriate specialised treatment.

NHS Derbyshire Healthcare NHS Foundation Trust
NHS Leicestershire Partnership NHS Trust
NHS Lincolnshire Partnership NHS Foundation Trust
NHS Northamptonshire Healthcare NHS Foundation Trust
NHS Nottinghamshire Healthcare NHS Foundation Trust
St Andrew’s HEALTHCARE

Alliance workstreams

East Midlands Alliance
for Mental Health and Learning Disabilities

- Began in Autumn 2021
- NHFT has been the lead 'buddy support'
- Sharing idea, listening, and learning to drive positive change forward
- Eight workstreams, each with an NHS and a St Andrew's lead

- Workforce safeguards – Northamptonshire
- Fundamentals of care – Derbyshire
- Patient safety strategy – Northamptonshire
- Appropriate use of Enhanced Observations – Derbyshire
- Embedding lessons learnt into practice – Lincolnshire
- Communications as an enabler – Northamptonshire & Leicestershire
- Quality Improvement as an enabler – Nottinghamshire
- 'Culture of patients' safety and high-quality care – Leicestershire

A ‘buddy’ relationship

East Midlands Alliance
for Mental Health and Learning Disabilities

The role that the ‘buddy trust’ (Northamptonshire Healthcare NHS Foundation Trust) played has also been very important in the process.

This went beyond the workstreams, and included a range of activities and arrangements to help deliver quality improvement and targeted support.

Key staff were supported to focus time on the development and delivery of the programme, and mentoring and supporting St Andrews staff.

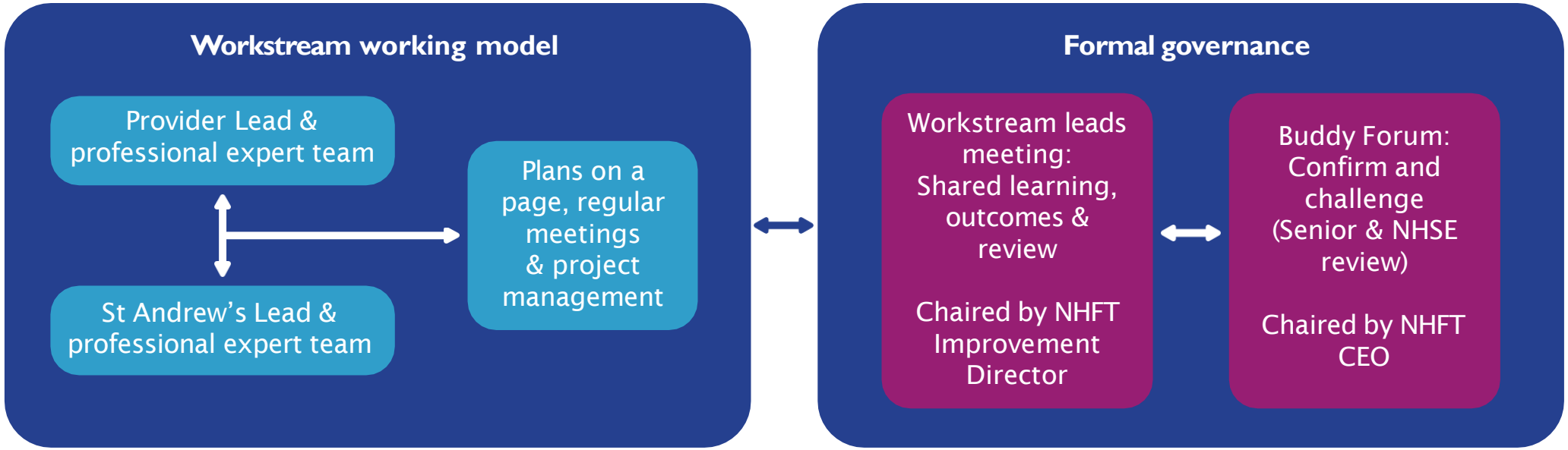
This included Julie Shepherd, NHFT Chief Nurse, taking the role of Improvement Director. Julie supported the project management of the relationship and enhancing a ‘Ward to Board’ framework to help ensure changes were being effectively implemented at all levels.

Strong focus on quality improvement-based governance

East Midlands Alliance for Mental Health and Learning Disabilities

Each alliance workstream benefited from a robust governance structure, which incorporated a two-way learning process and agreed aims and objectives.

An example of this structure is outlined below, which was replicated across each workstream.



Key improvements so far

East Midlands Alliance for Mental Health and Learning Disabilities

Through the work of the Alliance, St Andrew's has seen lots of productive and tangible changes:

- **CQC improvements – Women's and Men's Service**

  Following a re-inspection from the Care Quality Commission of its **Women's Service** in April and May 2022, St Andrew's ratings improved from Inadequate to Requires Improvement. The service has also been rated as 'Good' in the caring and responsive categories, as detailed in the chart below.

CQC Category	July / August 2021	April / May 2022
Safe	Inadequate	Requires improvement
Effective	Requires improvement	Requires improvement
Caring	Inadequate	Good
Responsive	Requires improvement	Good
Well-led	Inadequate	Requires improvement

Key improvements so far

A re-inspection of St Andrew's **Men's Service** by the Care Quality Commission took place in June 2022. While the overall rating remained at Requires Improvement, the service has also been rated as 'Good' in the caring and responsive categories.

CQC Category	July / August 2021	June 2022
Safe	Inadequate	Requires improvement
Effective	Requires improvement	Requires improvement
Caring	Requires improvement	Good
Responsive	Requires improvement	Good
Well-led	Requires improvement	Requires improvement

Key improvements so far

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- **e-Observations roll-out**
  St Andrew's is rolling out e-Observations, which can be used on mobile devices, such as a tablets and smartphones. This investment directly supports the Charity's strategic objective to improve the quality of care and patient outcomes by enabling clinical teams to respond swiftly; ensuring observation data is always up to date; providing up-to-date patient information at the point of care; reducing costs and ensuring staff time is better spent, to name but a few.

- **Appropriate language**
  St Andrew's has made significant improvements in the way staff talk and write about their patients. The organisation has developed a New Language Guidance document, co-designed with patients to ensure language gives hope and drives recovery.

Key improvements so far

East Midlands Alliance
for Mental Health and Learning Disabilities

- **MHOST staffing model**
  A new patient staffing model called MHOST – Mental Health Optimum Staffing Tool – has been introduced. The model bases staffing levels on patient numbers, and considers each patient's needs at specific times of the day. MHOST allows the organisation to make sure they have more staff on shift when they're needed, and fewer staff at quiet times of the day.

- **Review of Blanket Restrictions**
  St Andrew's has reviewed blanket restrictions in their LD/ASD, Medium Secure and Locked and Specialist Rehabilitation wards. Each ward ran a session with its patients to explore the rules that are currently in place. Following this, many wards successfully reduced and removed unnecessary blanket restrictions. Importantly, these co-produced sessions mean that patients now understand the purpose of rules and what needs to change for them to be removed.

- **Sustainability**
  A core focus of the alliance from the outset is maintaining a focus on ensuring the lasting impact of the buddy and quality improvement journey. This is achieved through accountability conversations, effective impact analysis and the development of a robust exit criteria.

"There's been lots of change; we now have a sensory room and better access to outside space, which is home to our new ward pet rabbit. These changes instantly made a big difference to our patient group."

Keira White, Nurse Manager, Silverstone Ward (a ward that cares for patients with Emotional Unstable Personality Disorder and disordered eating)

Key improvements so far

East Midlands Alliance
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- **Improvement in ward environments**
  The organisation has delivered improvements to wards, working closely with patients, who have been integral to the design process.
  Engagement through regular community meetings ensured that patient choice was at the forefront of decision making, and ward improvements include wall art, sensory rooms and new furniture.

- **Change Leaders**
  There are also now over 90 members of staff registered as Change Leaders in St Andrew's 'Lead the Change' programme, which focuses on their culture and listening to staff. It means that they have been able to find ways to empower staff and improve their well-being, which in turn means they will deliver better care to patients.

- **Supporting shared learning**
  All colleagues have had a strong focus on sharing best practice and are empowered to take learnings back into their own organisations.

What does this mean for future collaboration opportunities in mental health?

East Midlands Alliance for Mental Health and Learning Disabilities

For those in the Alliance this is a pioneering step that focuses on the delivery of high-quality care and the best interests of service users. It is not about organisational boundaries, so St Andrew's has been a partner in it from the outset.

No Trust or provider is an island, and as the national care model changes, it's important now more than ever, that we work collaboratively to ensure the best quality of care for people living with complex mental health conditions. This programme is a shining example of that.

The Alliance's work to support mental health service users across the East Midlands is an important signifier of the role and commitment of healthcare providers in driving positive change across regional footprints and providing care closer to home.

The model also allows providers to get on the front foot to improve service delivery standards and could help lay the foundations as a blueprint for further collaborations in mental health in the NHS.

"I feel supported and trusted as restrictions have reduced. I'm really happy with our new ward environment and having a tea station."

Patient, Oak Ward, St Andrew's Healthcare

The East Midlands Alliance for Mental Health and Learning Disabilities was established in 2019 and brings together the six largest providers of mental health, learning disability and autism services in the region:

- Derbyshire Healthcare NHS Foundation Trust
- Leicestershire Partnership NHS Trust Lincolnshire
- Partnership NHS Foundation Trust
- Northamptonshire Healthcare NHS Foundation Trust
- Nottinghamshire Healthcare NHS Foundation Trust St
- Andrew's Healthcare

The aims of the Alliance are to establish a more formal collective arrangement to strengthen joint working and support delivery of the NHS Long Term Plan; share learning across the East Midlands; undertake the strategic oversight of the Provider Collaboratives; develop a stronger collective East Midlands voice for mental health, learning disability and autism; and improve quality and patient experience across the region.

For further information please contact Simon Hughes, Head of Partnership Communications at Northamptonshire Healthcare NHS Foundation Trust (NHFT) at simon.hughes@nhft.nhs.uk

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2023/24 priorities and operational planning guidance

23 December 2022

Foreword from the NHS CEO

Thank you to you, and to your teams, for your continued extraordinary efforts on behalf of our patients – particularly over the past weeks as we have prepared for and managed periods of industrial action. There is no denying it has been an incredibly challenging year for everyone working in the NHS, and arguably tougher than the first years of the pandemic.

We have already made real progress towards many of our goals for 2022/23 – in particular in all but eradicating two year waits for elective care and delivering record numbers of urgent cancer checks. This was achieved alongside continuing to respond to the build-up of health needs during the pandemic, an ongoing high level of COVID-19 infection and capacity constraints in social care, increased costs due to inflation and reduced productivity due to the inevitable disruption caused by COVID-19.

2023/24 will also be challenging. Our planning approach therefore reflects both our new ways of working, as recently articulated in the NHS Operating Framework, and an acknowledgement of the continuing complexity and pressure you face.

We will support local decision making, empowering local leaders to make the best decisions for their local populations and have set out fewer, more focused national objectives. These align with our three tasks over the coming year:

- recover our core services and productivity;
- as we recover, make progress in delivering the key ambitions in the Long Term Plan (LTP), and;
- continue transforming the NHS for the future.

To assist you in meeting these objectives, we have set out the most critical, evidence-based actions that will support delivery - based on what systems and providers have already demonstrated makes the most difference to patient outcomes, experience, access and safety.

I look forward to continuing to work with and support you over the year ahead to deliver the highest possible quality of care for patients and the best possible value for taxpayers.

Amanda Pritchard

Our priorities for 2023/24

In 2023/24 we have three key tasks. Our immediate priority is to recover our core services and productivity. Second, as we recover, we need to make progress in delivering the key ambitions in the NHS Long Term Plan. Third, we need to continue transforming the NHS for the future.

The table below sets out our national objectives for 2023/24. They will form the basis for how we assess the performance of the NHS alongside the local priorities set by systems.

Recovering our core services and productivity

To improve patient safety, outcomes and experience it is imperative that we:

- improve ambulance response and A&E waiting times
- reduce elective long waits and cancer backlogs, and improve performance against the core diagnostic standard
- make it easier for people to access primary care services, particularly general practice.

Recovering productivity and improving whole system flow are critical to achieving these objectives. Essential actions include: reducing ambulance handovers, bed occupancy and outpatient follow-ups relative to first appointments; increasing day case rates and theatre utilisation; moving to self-referral for many community services where GP intervention is not clinically necessary and increasing use of community pharmacies. We must also increase capacity in beds, intermediate care, diagnostics, ambulance services and the permanent workforce. These actions are supported by specific investments, including those jointly with local authorities to improve discharge.

Our people are the key to delivering these objectives and our immediate collective challenge is to improve staff retention and attendance through a systematic focus on all elements of the NHS People Promise.

As we deliver on these objectives we must continue to narrow health inequalities in access, outcomes and experience, including across services for children and young people. And we must maintain quality and safety in our services, particularly in maternity services.

The NHS has an important role in supporting the wider economy and our actions to support the physical and mental wellbeing of people will support more people return to work.

Delivering the key NHS Long Term Plan ambitions and transforming the NHS

We need to create stronger foundations for the future, with the goals of the NHS Long Term Plan our 'north star'. These include our core commitments to improve mental health services and services for people with a learning disability and autistic people.

Prevention and the effective management of long-term conditions are key to improving population health and curbing the ever increasing demand for healthcare services. NHS England will work with integrated care systems (ICSs) to support delivery of the primary and secondary prevention priorities set out in the NHS Long Term Plan.

We need to put the workforce on a sustainable footing for the long term. NHS England is leading the development of a NHS Long Term Workforce Plan and government has committed to its publication next spring.

The long-term sustainability of health and social care also depends on having the right digital foundations. NHS England will continue to work with systems to level up digital infrastructure and drive greater connectivity- this includes development of a 'digital first' option for the public and further development of and integration with the NHS App to help patients identify their needs, manage their health and get the right care in the right setting.

Transformation needs to be accompanied by continuous improvement. Successful improvement approaches are abundant across the NHS but they are far from universal. NHS England will develop the national improvement offer to complement local work, using what we have learned from engaging with over 1,000 clinical and operational leaders in the summer.

Local empowerment and accountability

ICSs are best placed to understand population needs and are expected to agree specific local objectives that complement the national NHS objectives set out below. They should continue to pay due regard to wider NHS ambitions in determining

their local objectives – alongside place-based collaboratives. As set out in the recently published Operating Framework, NHS England will continue to support the local NHS [integrated care boards (ICBs) and providers] to deliver their objectives and publish information on progress against the key objectives set out in the NHS Long Term Plan.

Alongside this greater local determination, greater transparency and assurance will strengthen accountability, drawing on the review of ICS oversight and governance that the Rt Hon Patricia Hewitt is leading. We welcome the review which NHS England has been supporting closely, and we look forward to the next stage of the discussions as well as the final report. NHS England will update the NHS Oversight Framework and work with ICBs to ensure oversight and performance management arrangements within their ICS area are proportionate and streamlined.

Funding and planning assumptions

The Autumn Statement 2022 announced an extra £3.3 bn in both 2023/24 and 2024/25 for the NHS to respond to the significant pressures we are facing.

NHS England is issuing two-year revenue allocations for 2023/24 and 2024/25. At national level, total ICB allocations [including COVID-19 and Elective Recovery Funding (ERF)] are flat in real terms with additional funding available to expand capacity.

Core ICB capital allocations for 2022/23 to 2024/25 have already been published and remain the foundation of capital planning for future years. Capital allocations will be topped-up by £300 million nationally, with this funding prioritised for systems that deliver agreed budgets in 2022/23.

The contract default between ICBs and providers for most planned elective care (ordinary, day and outpatient procedures and first appointments but not follow-ups) will be to pay unit prices for activity delivered. System and provider activity targets will be agreed through planning as part of allocating ERF on a fair shares basis to systems. NHS England will cover additional costs where systems exceed agreed activity levels.

ICBs and NHS primary and secondary care providers are expected to work together to plan and deliver a balanced net system financial position in collaboration with other ICS partners. Further details will be set out in the revenue finance and contracting guidance for 2023/24.

Next steps

ICBs are asked to work with their system partners to develop plans to meet the national objectives set out in this guidance and the local priorities set by systems. To assist them in this, the annex identifies the most critical, evidence based actions that systems and NHS providers are asked to take to deliver these objectives. These are based on what systems and providers have already demonstrated makes the most difference to patient outcomes, experience, access and safety.

System plans should be triangulated across activity, workforce and finance, and signed off by ICB and partner trust and foundation trust boards before the end of March 2023. NHS England will separately set out the requirements for plan submission.

National NHS objectives 2023/24

	Area	Objective
Recovering our core services and improving productivity	**Urgent and emergency care***	Improve A&E waiting times so that no less than 76% of patients are seen within 4 hours by March 2024 with further improvement in 2024/25
		Improve category 2 ambulance response times to an average of 30 minutes across 2023/24, with further improvement towards pre-pandemic levels in 2024/25
		Reduce adult general and acute (G&A) bed occupancy to 92% or below
	Community health services	Consistently meet or exceed the 70% 2-hour urgent community response (UCR) standard
		Reduce unnecessary GP appointments and improve patient experience by streamlining direct access and setting up local pathways for direct referrals
	Primary care*	Make it easier for people to contact a GP practice, including by supporting general practice to ensure that everyone who needs an appointment with their GP practice gets one within two weeks and those who contact their practice urgently are assessed the same or next day according to clinical need
		Continue on the trajectory to deliver 50 million more appointments in general practice by the end of March 2024
		Continue to recruit 26,000 Additional Roles Reimbursement Scheme (ARRS) roles by the end of March 2024
		Recover dental activity, improving units of dental activity (UDAs) towards pre-pandemic levels
	Elective care	Eliminate waits of over 65 weeks for elective care by March 2024 (except where patients choose to wait longer or in specific specialties)
		Deliver the system- specific activity target (agreed through the operational planning process)
	Cancer	Continue to reduce the number of patients waiting over 62 days
		Meet the cancer faster diagnosis standard by March 2024 so that 75% of patients who have been urgently referred by their GP for suspected cancer are diagnosed or have cancer ruled out within 28 days
		Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028
	Diagnostics	Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%
		Deliver diagnostic activity levels that support plans to address elective and cancer backlogs and the diagnostic waiting time ambition
	Maternity*	Make progress towards the national safety ambition to reduce stillbirth, neonatal mortality, maternal mortality and serious intrapartum brain injury
		Increase fill rates against funded establishment for maternity staff
	Use of resources	Deliver a balanced net system financial position for 2023/24
	Workforce	Improve retention and staff attendance through a systematic focus on all elements of the NHS People Promise
	Mental health	Improve access to mental health support for children and young people in line with the national ambition for 345,000 additional individuals aged 0-25 accessing NHS funded services (compared to 2019)
		Increase the number of adults and older adults accessing IAPT treatment
		Achieve a 5% year on year increase in the number of adults and older adults supported by community mental health services
		Work towards eliminating inappropriate adult acute out of area placements
		Recover the dementia diagnosis rate to 66.7%
		Improve access to perinatal mental health services
	People with a learning disability and autistic people	Ensure 75% of people aged over 14 on GP learning disability registers receive an annual health check and health action plan by March 2024
		Reduce reliance on inpatient care, while improving the quality of inpatient care, so that by March 2024 no more than 30 adults with a learning disability and/or who are autistic per million adults and no more than 12–15 under 18s with a learning disability and/or who are autistic per million under 18s are cared for in an inpatient unit
	Prevention and health inequalities	Increase percentage of patients with hypertension treated to NICE guidance to 77% by March 2024
		Increase the percentage of patients aged between 25 and 84 years with a CVD risk score greater than 20 percent on lipid lowering therapies to 60%
		Continue to address health inequalities and deliver on the Core20PLUS5 approach

**ICBs and providers should review the UEC and general practice access recovery plans, and the single maternity delivery plan for further detail when published;*

Annex

This annex sets out the key evidence based actions that will help deliver the objectives set out above and the resources being made available to support this. All systems are asked to develop plans to implement these. To assist systems in developing their plans a summary of other guidance, best practice, toolkits and support available from NHS England is available on the planning pages of FutureNHS.

1. Recovering our core services and productivity

1A. Urgent and emergency care (UEC)

Key actions:

- Increase physical capacity and permanently sustain the equivalent of the 7,000 beds of capacity that was funded through winter 2022/23
- Reduce the number of medically fit to discharge patients in our hospitals, addressing NHS causes as well as working in partnership with Local Authorities.
- Increase ambulance capacity.
- Reduce handover delays to support the management of clinical risk across the system in line with the November 2022 letter.
- Maintain clinically led System Control Centres (SCCs) to effectively manage risk.

In order to improve patient flow, we all agree we need to reduce bed occupancy to at least 92% (NHS review of winter), increase physical capacity in inpatient settlings to reflect changes in demographics and health demand [Projections: General and acute hospital beds in England (2018–2030)], as well as improve support for patients in the community. NHS England [working with the Department of Health and Social Care (DHSC) and the Department for Levelling Up, Housing and Communities (DLHUC)] will develop a UEC recovery plan with further detail and this will be published in the new year. Delivery of this plan and the objectives set out in this guidance are supported by:

- £1bn of funding through system allocations to increase capacity based on agreed system plans. NHS England anticipates that capacity will be focused on increasing G&A capacity, intermediate and step-down care, and community beds with an expectation that utilisation of virtual wards is

increased towards 80% by the end of September 2023. NHS England will continue share best practice across a range of conditions to support this.

- £600m provided equally through NHS England and Local Authorities and made available through the Better Care Fund in 2023/34 (and £1bn in 2024/25) to support timely discharge. In addition, a £400m ring-fenced local authority grant for adult social care will support discharge among other goals. Further detail will be set out in the revenue finance and contracting guidance for 2023/24.
- An increase in allocations for systems that host ambulance services to increase ambulance capacity.

1B. Community health services

Key actions:

- Increase referrals into urgent community response (UCR) from all key routes, with a focus on maximising referrals from 111 and 999, and creating a single point of access where not already in place
- Expand direct access and self-referral where GP involvement is not clinically necessary. By September 2023, systems are asked to put in place:
    - direct referral pathways from community optometrists to ophthalmology services for all urgent and elective eye consultations
    - self-referral routes to falls response services, musculo-skeletal physiotherapy services, audiology-including hearing aid provision, weight management services, community podiatry, and wheelchair and community equipment services.

Expanding direct access and self-referrals empowers patients to take control of their healthcare, streamlines access to services and reduces unnecessary burden on GP appointments.

NHS England will allocate core funding growth for community health services as part of the overall ICB allocation growth, with £77m of Service Development Funding maintained in 2023/24.

1C. Primary care

Key actions:

- Ensure people can more easily contact their GP practice (by phone, NHS App, NHS111 or online).

- Transfer lower acuity care away from both general practice and NHS 111 by increasing pharmacy participation in the Community Pharmacist Consultation Service.

NHS England will publish the General Practice Access Recovery Plan in the new year which will provide details of the actions needed to achieve the goals above. In addition, once the 2023/24 contract negotiations have concluded, we will also publish the themes we are looking to engage with the profession on that could take a significant step towards making general practice more attractive and sustainable and able to deliver the vision outlined in the Fuller Stocktake, including continuity of care for those who need it. The output from this engagement will then inform the negotiations for the 2024/25 contract.

Delivery of this plan and the objectives set out in this guidance is supported by funding for general practice as part of the five year GP contract, including funding for 26,000 additional primary care staff through the Additional Roles Reimbursement Scheme (ARRS). ICB primary medical allocations are being uplifted by 5.6% to reflect the increases in GP contractual entitlements agreed in the five-year deal, and the increased ARRS entitlements. Data on general practice appointments is being published, including at practice-level, and work is ongoing to improve the quality and use of the data.

1D. Elective care

Key actions:

- Deliver an appropriate reduction in outpatient follow-up (OPFU) in line with the national ambition to reduce OPFU activity by 25% against the 2019/20 baseline by March 2024
- Increase productivity and meet the 85% day case and 85% theatre utilisation expectations, using GIRFT and moving procedures to the most appropriate settings
- Offer meaningful choice at point of referral and at subsequent points in the pathway, and use alternative providers if people have been waiting a long time for treatment including through the Digital Mutual Aid System (DMAS)

The goals for elective recovery are set out in the 'Delivery plan for tackling the COVID-19 backlog of elective care'. These include delivery of around 30% more elective activity by 2024/25 than before the pandemic, after accounting for the impact of an improved care offer through system transformation, and advice and

guidance. Meeting this goal of course still depends on returning to and maintaining low levels of COVID-19, enabling the NHS to restore normalised operating conditions and reduce high levels of staff absence. We will agree targets with systems for 2023/24 through the planning round towards that goal on the basis that COVID-19 demand will be similar to that in the last 12 months. The contract default will be to pay for most elective activity (including ordinary, day and outpatient procedures and first appointments but excluding follow-ups) at unit prices for activity delivered.

ICBs and trusts are asked to update their local system plans, actively including independent sector providers, setting out the activity, workforce, financial plans and transformation goals that will support delivery of these objectives.

NHS England will allocate £3bn of ERF to ICBs and regional commissioners on a fair shares basis and continue to work with systems and providers to maximise the impact of the three-year capital Targeted Investment Fund put in place in 2022. Further details will be set out in the *Revenue finance and contracting guidance for 2023/24* and *Capital guidance update 2023/24.*

1E. Cancer

Key actions:

- Implement and maintain priority pathway changes for lower GI (at least 80% of FDS lower GI referrals are accompanied by a FIT result), skin (teledermatology) and prostate cancer (best practice timed pathway)
- Increase and prioritise diagnostic and treatment capacity, including ensuring that new diagnostic capacity, particularly via community diagnostic centres (CDCs), is prioritised for urgent suspected cancer. Nationally, we expect current growth levels to translate into a requirement for a 25% increase in diagnostic capacity required for cancer and a 13% increase in treatment capacity.
- Expand the Targeted Lung Health Checks (TLHC) programme and ensure sufficient diagnostic and treatment service capacity to meet this new demand.
- Commission key services which will underpin progress on early diagnosis, including non-specific symptoms pathways (to provide 100% population coverage by March 2024), surveillance services for Lynch syndrome, BRCA and liver; and work with regional public health commissioners to increase

colonoscopy capacity to accommodate the extension of the NHS bowel screening programme to 54 year olds.

The NHS is implementing one of the most comprehensive strategies on early diagnosis anywhere in the world. Cancer Alliances and the ICBs they serve will lead the local delivery of this NHS-wide strategy. NHS England is providing over £390m in cancer service development funding to Cancer Alliances in each of the next two years to support delivery of this strategy and the operational priorities for cancer set out above. As in previous years, the Cancer Alliance planning pack will provide further information to support the development of cancer plans by alliances and these, subject to ICB agreement, are expected to form part of wider local system plans.

1F. Diagnostics

Key actions:

- Maximise the pace of roll-out of additional diagnostic capacity, delivering the second year of the three-year investment plan for establishing Community Diagnostic Centres (CDCs) and ensuring timely implementation of new CDC locations and upgrades to existing CDCs
- Deliver a minimum 10% improvement in pathology and imaging networks productivity by 2024/25 through digital diagnostic investments and meeting optimal rates for test throughput
- Increase GP direct access in line with the national rollout ambition and develop plans for further expansion in 2023/24 (NHS England will publish separate guidance to support the increase GP direct access)

Timely access to diagnostics is critical to providing responsive, high quality services and supporting elective recovery and early cancer diagnosis. NHS England has provided funding to support the development of pathology and imaging networks and the development and rollout of CDCs. £2.3bn of capital funding to 2025 has also been allocated to support diagnostic service transformation, including to implement CDCs, endoscopy, imaging equipment and digital diagnostics.

1G. Maternity and neonatal services

Key actions:

- Continue to deliver the actions from the final Ockenden report as set out in the April 2022 letter as well as those that will be set out in the single delivery plan for maternity and neonatal services .
- Ensure all women have personalised and safe care through every woman receiving a personalised care plan and being supported to make informed choices
- Implement the local equity action plans that every local maternity and neonatal system (LMNS)/ICB has in place to reduce inequalities in access and outcomes for the groups that experience the greatest inequalities (Black, Asian and Mixed ethnic groups and those living in the most deprived areas).

NHS England will publish a single delivery plan for maternity and neonatal services in early 2023. This will consolidate the improvement actions committed to in Better Births, the NHS Long Term Plan, the Neonatal Critical Care Review, and reports of the independent investigation at Shrewsbury and Telford Hospital NHS Trust and the independent investigation into maternity and neonatal services in East Kent.

To support delivery including addressing the actions highlighted in the Ockenden report NHS England has invested a further £165m through the maternity programme for 2023/24. This is £72m above the £93m baselined in system allocations to support the maternity and neonatal workforce. That investment has increased the number of established midwifery posts by more than 1;500 compared to 2021.

1H. Use of resources

To deliver a balanced net system financial position for 2023/24 and achieve our core service recovery objectives, we must meet the 2.2% efficiency target agreed with government and improve levels of productivity.

ICBs and providers should work together to:

- Develop robust plans that deliver specific efficiency savings and raise productivity consistent with the goals set out in this guidance to increase activity and improve outcomes within allocated resources.
- Put in place strong oversight and governance arrangements to drive delivery, supported by clear financial control and monitoring processes.

Plans should include systematic approaches to understand where productivity has been lost and the actions needed to restore underlying productivity, including, but not be limited to, measures to:

- **Support a productive workforce** taking advantage of opportunities to deploy staff more flexibly. Systems should review workforce growth by staff group and identify expected productivity increases in line with the growth seen.
- **Increase theatre productivity** using the Model Hospital System theatre dashboard and associated GIRFT training and guidance, and other pathway and service specific opportunities.

Plans should also set out measures to release efficiency savings, including actions to:

- **Reduce agency spending** across the NHS to 3.7% of the total pay bill in 2023/24 which is consistent with the system agency expenditure limits for 2023/24 that are set out separately. NHS England has published toolkits to support this.
- **Reduce corporate running costs** with a focus on consolidation, standardisation and automation to deliver services at scale across ICS footprints. NHS England has published annual cost data benchmarking and a corporate service improvement toolkit .
- **Reduce procurement and supply chain costs** by realising the opportunities for specific products and services. Systems should work to the operating model and commercial standards and the consolidated supplier frameworks agreed with suppliers through Supply Chain Coordination Limited (SCCL). Systems should engage with the Specialised Services Devices Programme to leverage the benefits across all device areas.
- **Improve inventory management**. NHS Supply Chain will lead the implementation of an inventory management and point of care solution. National funding will support providers that do not have effective inventory management systems.
- *Purchase medicines at the most effective price point* by realising the opportunities for price efficiency identified by the Commercial Medicines Unit, and ensure we get the best value from the NHS medicines bill. National support to deliver efficiencies will continue to be available for systems through the National Medicines Value Programme.

2. Delivering the key NHS Long Term Plan ambitions and transforming the NHS

2A. Mental health

Key actions:

- Continue to achieve the Mental Health Investment Standard by increasing expenditure on mental health services by more than allocations growth.
- Develop a workforce plan that supports delivery of the system's mental health delivery ambition, working closely with ICS partners including provider collaboratives and the voluntary, community and social enterprise (VCSE) sectors.
- Improve mental health data to evidence the expansion and transformation of mental health services, and the impact on population health, with a focus on activity, timeliness of access, equality, quality and outcomes data.

As systems update their local plans, they are also asked to set out how the wider commitments in the NHS Mental Health Implementation Plan 2019/20–2023/24 will be taken forward to improve the quality of local mental healthcare across all ages in line with population need.

NHS England has allocated funding to grow the workforce and expand services to support delivery of the mental health NHS Long Term Plan commitments. In particular, NHS England will continue to support the growth in IAPT workforce by providing 60% salary support for new trainees in 2023/24. We will also support ICBs to co-produce a plan by 31 March 2024 to localise and realign mental health and learning disability inpatient services over a three year period as part of a new quality transformation programme.

2B. People with a learning disability and autistic people

Key actions:

- Continue to improve the accuracy and increase size of GP Learning Disability registers.
- Develop integrated, workforce plans for the learning disability and autism workforce to support delivery of the objectives set out in this guidance. (The workforce baselining exercise completed during 2022/23 will assist in the development of local, integrated, workforce plans to support delivery.)

- Test and implement improvement in autism diagnostic assessment pathways including actions to reduce waiting times.

NHS England has allocated funding of £120m to support system delivery against the objectives and will publish guidance on models of mental health inpatient care to support a continued focus on admission avoidance and improving quality.

2C. Embedding measures to improve health and reduce inequalities

Key actions:

- Update plans for the prevention of ill-health and incorporate them in joint forward plans, paying due regard to the NHS Long Term Plan primary and secondary prevention priorities, including a continued focus on CVD prevention, diabetes and smoking cessation. Plans should:
    - build on the successful innovation and partnership working that characterised the COVID vaccination programme and consider how best to utilise new technology such as home testing. NHS England will publish a tool summarising the highest impact interventions that can be – and are already being – implemented by the NHS.
    - have due regard to the government's Women's Health Strategy.
- Continue to deliver against the five strategic priorities for tackling health inequalities and:
    - take a quality improvement approach to addressing health inequalities and reflect the Core20PLUS5 approach in plans
    - consider the specific needs of children and young people and reflect the Core20PLUS5 – An approach to reducing health inequalities for children and young people in plans
    - establish High Intensity Use services to support demand management in UEC.

Funding is provided through core ICB allocations to support the delivery of system plans developed with public health, local authority, VCSE and other partners. The formula includes an adjustment to weight resources to areas with higher avoidable mortality and the £200m of additional funding allocated for health inequalities in 2022/23 is also being made recurrent in 2023/24.

2D. Investing in our workforce

In 2022/23 systems were asked to develop whole system workforce plans. These should be refreshed to support:

- Improved staff experience and retention through systematic focus on all elements of the NHS People Promise and implementation of the Growing Occupational Health Strategy, improving attendance toolkit and Stay and Thrive Programme.
- Increased productivity by fully using existing skills, adapting skills mix and accelerating the introduction of new roles (e.g. anaesthesia associates, AHP support workers, pharmacy technicians and assistants, first contact practitioners, and advanced clinical practitioners).
- Flexible working practices and flexible deployment of staff across organisational boundaries using digital solutions (e-rostering, e-job planning, Digital Staff Passport).
- Regional multi professional education and training investment plans (METIP) and ensure sufficient clinical placement capacity, including educator/trainer capacity, to enable all NHS England- funded trainees and students to maintain education and training pipelines.
- implementation of the Kark recommendations and Fit and Proper Persons (FPP) test.

NHS England is increasing investment in workforce education and training in real terms in each of the next two years.

2E. Digital

Key actions:

- Use forthcoming digital maturity assessments to measure progress towards the core capabilities set out in What Good Looks Like (WGLL) and identify the areas that need to be prioritised in the development of plans. Specific expectations will be set out in the refreshed WGLL in early 2023.
- Put the right data architecture in place for population health management (PHM).
- Put digital tools in place so patients can be supported with high quality information that equips them to take greater control over their health and care.

DHSC recently published strategic plans for digital, data and technology. Data saves lives and A plan for digital health and social care set out how digitised services can support integration and service transformation. NHS England will:

- Provide funding to help ICSs meet minimum digital foundations, especially electronic records in accordance with WGLL.
- Procure a Federated Data Platform, available to all ICSs, with nationally developed functionality including tools to help maximise capacity, reduce waiting lists and co-ordinate care.
- Roll out new functionality for the NHS App, to help people take greater control over their health and their interactions with the NHS, including better support to get to the right in-person or digital service more quickly, access to their patient records, improved functionality for prescriptions and improved support for hospital appointments and choice ahead of next winter.
- Accelerate the ambition of reducing the reporting burden on providers and addressing the need for more timely automated data through the Faster Data Flows (FDF) Programme.

Funding is allocated to meet minimum digital foundations (especially electronic patient records) and scale up use of digital social care records in accordance with WGLL.

2F. System working

2023/24 is the first full year for ICSs in their new form with the establishment of statutory ICBs and integrated care partnerships (ICPs). Key priorities for their development in 2023/24 include:

- Developing ICP integrated care strategies and ICB joint forward plans.
- Maturing ways of working across the system including provider collaboratives and place-based partnership arrangements.

Improving NHS patient care, outcomes and experience can only be achieved by embedding innovation and research in everyday practice. ICBs have a statutory duty to facilitate or otherwise promote research and the use of evidence obtained from research and to promote innovation, for example AI and machine learning which is driving efficiency and enabling earlier diagnosis.

NHS England will continue to support ICSs to draw on national best practice and peer insight to inform future development.

Joint forward plans

The National Health Service Act 2006 (as amended by the Health and Care Act 2022) requires ICBs and their partner trusts (the ICB's partner NHS trusts and foundation trusts are named in its constitution) to prepare five-year JFPs before the start of each financial year.

NHS England has developed guidance to support the development of JFPs with input from all 42 ICBs, trusts and national organisations representing local authorities and other system partners, including VCSE sector leaders.

Systems have significant flexibility to determine their JFP's scope as well as how it is developed and structured. Legal responsibility for developing the JFP lies with the ICB and its partner trusts. However, we encourage systems to use the JFP to develop a shared delivery plan for the integrated care strategy (developed by the ICP) and the joint local health and wellbeing strategy (JLHWS) (developed by local authorities and their partner ICBs, which may be through health and wellbeing boards) that is supported by the whole system, including local authorities and VCSE partners.

Delegated budgets

We are moving towards ICBs taking on population healthcare budgets, with pharmacy, ophthalmology and dentistry (POD) services fully delegated by April 2023 and appropriate specialised services delegated from April 2024. This will enable local systems to design and deliver more joined-up care for their patients and communities. NHS England will support ICBs as they take on commissioning responsibility across POD services from April 2023, supporting the integration of services.

Subject to NHS England Board approval, statutory joint committees of ICBs and NHS England will oversee commissioning of appropriate specialised services across multi-ICB populations from April 2023, ahead of ICBs taking on this delegated responsibility in April 2024.

ICBs are expected to work with NHS England through their joint commissioning arrangements to develop delivery plans. These should identify at least three key priority pathways for transformation, where integrated commissioning can support the triple aim of improving quality of care, reducing inequalities across communities and delivering best value. NHS England will provide ICBs with tools and resources to support transformation, and to further develop their understanding of specialised services and enable them to realise the benefits of integration.

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Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 17 January 2023

Interim Chief Executive's Report

Purpose of Report

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

Personal Reflections

This is the first CEO Board report I will write and present for Derbyshire Healthcare NHS Foundation Trust in my role as interim leader.

Trust Changes

I took up post on 1 December 2022 and all governance processes for transfer of statutory duties, including CQC Responsible Officer as the nominated individual, from 23 November 2022 – date of certificate. This is a temporary appointment until the permanent Chief Executive commences. This was named as Mark Powell on 23 December 2022, a former Director at Derbyshire Healthcare NHS Foundation Trust.

Industrial Action

This period has seen a period of significant change in the landscape of the NHS and a period of industrial unrest. Derbyshire Healthcare did not experience any formal direct industrial action in December 2022. However, our management team and Emergency Planning and Response teams continue to work in partnership with Staff Side to develop a shared plan for Derbyshire where safety is paramount, can be maintained and terms and derogations agreed. I am very grateful for our operational teams and Staff Side collaborations and their continued support in weekly planning. We now know that the first and second day of planned industrial action will occur in Derbyshire on Wednesday 18 January and Thursday 19 January 2023. The industrial action shall commence at the beginning of the day shift on both 18 and 19 January 2023 and will last until commencement of the night shift on both 18 and 19 January 2023 within 24 hours services. For services that are not 24 hours the industrial action shall commence at 08:00 hours on both 18 and 19 January 2023 and will last for 12 hours. The industrial action that will take place on both 18 and 19 January 2023 will be in the form of strike action.

Eradication of Dormitories

On 19 December 2022 we were delighted to receive the news from the national team of investment into our Dormitory eradication programme.

You may have seen the announcement in the 12 December 2022 Monday Musing email that the Trust's Making Room for Dignity programme team recently received confirmation of a financial commitment to funding from NHS England, enabling the Psychiatric Intensive Care Unit (PICU) construction works to begin at Kingsway Hospital in line with the new adult acute unit there.

Since then, there have been further developments, and I am delighted to notify you of confirmation of the additional investment required to complete the whole programme, compromising of:

- Northern Derbyshire Older Adults: 12-bed relocation (Hartington Unit to Walton Hospital)
- Radbourne Unit Acute: 34-bed refurbishment (female)
- Acute Plus: 8-bed refurbishment - Audrey House (female) – Initially as a 10-bed decant ward.

We hope you will agree that this is fantastic news for the Trust and the future of our services.

I re-iterate on behalf of the Board a thank you to everyone who has been involved with and supported the programme so far and secured this additional funding. These developments will transform the services we are able to offer locally, through providing private ensuite bedrooms for our acute patients of all ages and reducing our number of out-of-area placements.

My special thanks go to Andy Harrison and Geoff Neild for their personal leadership and contribution to achieve this outcome. I would also like to welcome Andy formally to the Trust, following his appointment as Senior Responsible Officer, Acute Care Capital Programme.

2023/24 Priorities and Operational Planning Guidance

In 2023/24 there are nationally three key tasks.
Our immediate priority is to recover our core services and productivity. Secondly, as we recover, we need to make progress in delivering the key ambitions in the NHS Long Term Plan. Thirdly, we need to continue transforming the NHS for the future.

ICBs are asked to work with their System partners to develop plans to meet the national objectives set out in this guidance and the local priorities set by Systems.

The most critical, evidence based actions that Systems and NHS providers are asked to take to deliver these objectives, are set out in page 7 of Appendix A.

Use of Resources - Deliver a balanced net system financial position for 2023/24 – **Trust Board and CEO**

To deliver a balanced net system financial position for 2023/24 and achieve our core service recovery objectives, must meet the 2.2% efficiency target agreed with government and improve levels of productivity.

Please note that any non-recurrent cost efficiency savings and existing non budgeted investments would need to be additionally taken into account in this financial year.

Modelling and planning has commenced with the Strategy and Finance Team on the impact and ramifications for the Trust.

ICBs and providers should work together to:

- Develop robust plans that deliver specific efficiency savings and raise productivity consistent with the goals set out in this guidance to increase activity and improve outcomes within allocated resources.

Workforce - Improve retention and staff attendance through a systematic focus on all elements of the NHS People Promise – **Director of People and Inclusion and executive colleagues**

Mental Health –

- Improve access to mental health support for children and young people in line with the national ambition for 345,000 additional individuals aged 0-25 accessing NHS funded services (compared to 2019).
- Increase the number of adults and older adults accessing IAPT treatment.
- Achieve a 5% year on year increase in the number of adults and older adults supported by community mental health services.
- Work towards eliminating inappropriate adult acute out of area placements.
- Recover the dementia diagnosis rate to 66.7%.
- Improve access to perinatal mental health services.
- **Trust board and CEO**

People with a Learning Disability and Autistic People

- Ensure 75% of people aged over 14 on GP learning disability registers receive an annual health check and health action plan by March 2024.
- Reduce reliance on inpatient care, while improving the quality of inpatient care, so that by March 2024 no more than 30 adults with a learning disability and/or who are autistic per million adults and no more than 12–15 under 18s with a learning disability and/or who are autistic per million under 18s, are cared for in an inpatient unit.
- **Trust Board, Chief Operating Officer and CEO as Senior Responsible Officer**

Prevention and Health Inequalities

- Increase percentage of patients with hypertension treated to NICE guidance to 77% by March 2024.
- Increase the percentage of patients aged between 25 and 84 years with a CVD risk score greater than 20 percent on lipid lowering therapies to 60%.
- Continue to address health inequalities and deliver on the Core20PLUS5 approach.
- **Trust Board, Executive Medical Director as Lead for Physical Health Care**

These are based on what Systems and providers have already demonstrated makes the most difference to patient outcomes, experience, access and safety.

System plans should be triangulated across activity, workforce and finance, and signed off by ICB and partner Trust and Foundation Trust Boards before the end of March 2023. NHS England will separately set out the requirements for plan submission.

For absolute clarity, any areas not noted as priority areas will not receive any additional funding to recover waiting times and must be recovered within existing expenditure.

COVID-19

In the last month we have seen a gradual increase in the number of colleagues away from work due to a COVID-19 based absence. At the time of reporting, this stood at around 40, which is double where we were at the last Board meeting. Since the last Board, we have had a couple of spikes of positive patients in our in-patient facilities in the South and, as I write the report, we are on an upward trajectory of 12 patients. This continued oscillation is absolutely in line with what we expect to see as we head into winter months and prepare for an expected steady increase in both COVID-19 and flu impacting on our patients and colleagues.

We have continually reviewed our use of PPE, including face masks and, whilst remaining rigorously compliant with national guidelines, we have not as yet returned to universal face mask wearing, though we do encourage colleagues to make a personal choice if they wish to wear a face covering in non-clinical settings.

Our vaccination hub continues to serve in delivering COVID-19 boosters and flu vaccinations to colleagues and patients and we continue to encourage all colleagues to make an appointment to receive their vaccinations. Although we are above the regional average, we are behind our performance of last year.

Service Visits

Since the last Board meeting I have been fortunate to visit the following teams:

- Radbourne Unit
- Hartington Unit
- Kingsway Hospital - all units
- High Peak Crisis Team
- South Derbyshire Dales community teams
- St Andrews House – Learning Disability Teams
- The Beeches inpatient unit

Becki Priest and Geoff Lewins kindly covered my visits to Children's services to enable me to attend an ICB Board Development session.

During the visits we were able to have conversations with many colleagues covering broad areas such as gaining a better understanding of the service, the challenges and importantly hearing about innovation and things colleagues were proud of. I was able to also thank colleagues for their fantastic collective efforts in the hotly contested Christmas Decoration competition. There were some truly

outstanding displays, which will have undoubtedly raised the spirits of colleagues, service users and carers.

After much debate, the Executive Team agreed that this year's winners are as follows:

- **Best overall inpatient display** – Morton Ward, Hartington Unit
- **Best overall non inpatient display** – South Derbyshire and Dales Adult Community Mental Health Team, Dale Bank View
- **Best patient participation** – Cubley Court, Kingsway Hospital
- **Best diversity and inclusion** – Ward 34, Radbourne Unit
- **Overall winner** – High Peak Crisis Resolution and Home Treatment Team

Congratulations to these teams!

Engagement Events

We have continued to hold regular all colleagues Q&A sessions during November and December. We have continued to have high levels of attendance with between 150 and 200 colleagues joining calls.

Key points we discussed included:

- Car parking - ideas and solutions
- Open sessions – all areas

Performance and Acting Upon Feedback

Our Children Services have shared that they often feel that their voice is not represented at Trust Board and concentration is on Mental Health and Learning Disability services.

To our whole Children's Division, while I am the interim CEO, I commit to spotlighting your practice and achievements. I am really sorry if this is your experience and how we made you feel.

<u>My first spotlight</u>
This is our Health Visiting service and their annual performance benchmarked against East Midlands and England.

<u>England/East Midlands/Derby performance</u>

	Qtr. 1 %	Qt2 %	Qtr. 3 %	Qtr.4 %
New-born	85.4/93.9/**99.45**	83.2/92.1/**98.52**	82.6/92.7/**99.19**	79.3/90.9/**98.8**
6-8 week	84.2/94.0/**99.27**	81.8/91.4/**99.05**	81.0/90.0/**98.98**	79.5/89.0/**99.42**
12 months	74.2/64.5/**96.11**	72.6/68.6/**96.36**	72.2/63.8/**96.29**	69.3/65.5/**92.07**
2/2.5 year (ASQ-3)_	87.9/83.2/**93.81**	89.1/83.7/**92.88**	92.0/86.4/**93.63**	92.4/91.1/**90.43**

Derby performance was better than both the England and the East Midlands performance for every measure across all quarters.

This is a phenomenal level of service to our community and to our organisation - in our Trust strategy we ask our people to do their best. On behalf of the Trust Board, I would like to express my sincere thanks for your continued support to mothers and families in Derby. I note that the operating framework has no targeted performance or operational requirements for Children's Services.

National Context

i. The Board has previously been alerted to the COVID-19 Inquiry. The UK COVID-19 Inquiry held a preliminary hearing on 4 October to look at the scope and procedures for the forthcoming public hearing. Derbyshire has been approached to contribute evidence for module 3.

   Module 3 will cover the health care system. Details about additional modules will be announced in the coming months, one of which is likely to be system issues (such as the care sector, the vaccination programme, test and trace, and PPE) and impact issues (such as health inequalities, children and young people, public services and other public sector bodies).

   The Board will be aware that as an organisation we may need to submit evidence under 'Rule 9' though it is expected that any NHS provider evidence call will be handled through NHS England. Derbyshire submitted evidence in December 2022.

ii. NHS England have committed to fund a total of 15 new clinics to provide specialist treatment for people with serious gambling problems by 2023/24. Derby has been identified to deliver the clinic for the East Midlands and on 14 December 2022, we were delighted to receive confirmation from NHS England's Mental Health Team, that the Trust's submission of a proposal to establish the new regional gambling harms service for the East Midlands, had been approved.

East Midlands Region and Derbyshire Context

The Joined Up Care Derbyshire System Delivery Board for Mental Health, Learning Disability and Autism continued to meet as a partnership. We continued focussing on preparation for winter and best use of the winter monies to support discharge and alternatives to hospital admission. We also noted plans linked to the

£2.37m of new money over three years to support the mental health urgent care pathway. I can confirm that the Derbyshire System did invest in Mental Health.

The Mental Health, Learning Disability and Autism Delivery Board continues to embed its approach, known as Recovery Action Planning, to ensure that all areas where we are not performing to the required level, have a clear plan with improvement milestones. During November and December, we continued to focus on access to Children and Young People's Eating Disorder services and our Perinatal Community services. We also spent time reviewing our work to reduce any delayed discharges or those assessed as clinically fit for discharge in the Learning Disability bedded care offers.

The Delivery Board received a further update on the Mental Health, Neurodiversity and Learning Disability Alliance Festival. The Alliance group met and agreed that in 2023, we would commit to two further community events in the Spring and Autumn period to build upon the great success of the first two events. The Provider Collaborative for Derbyshire continues to meet monthly. The Provider Collaborative Programme Director, Tamsin Hooton, has conducted a stocktake of the Collaborative's development and made recommendations for further improvements. The Mental Health, Learning Disability and Autism Delivery Board is significantly over committed and a challenge to the incoming CEO will be to set a balanced budget, as required by the System - a balanced net system financial position for 2023/24. As interim CEO, I have requested a named Non-Executive Director to be allocated by our Trust Chair to the Mental Health System Delivery Board when Sheila Newport, Non-Executive Director, departs the Trust after completing her term of office.

The NHS Executive continues to meet and continues to take oversight of the NHS contribution with the three main System Delivery Boards (which include the Mental Health, Autism and Learning Disability, Urgent, Emergency and Critical Care and Planned Care groups).

The East Midlands Alliance continues to act as a group collective and an example of our work supporting St Andrews is attached at Appendix B to share with the Trust Board and the public as an example of our regional collaboration.

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 its community that it serves
- Feedback from staff, people who use our services, and members of the public is being reported into the Board.

Consultation

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

Governance or Legal Issues

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

Public Sector Equality Duty 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.

The national COVID-19 Inquiry is going to be a vital plank in our understanding of health inequalities, what has worked and not worked prior to COVID-19.

The 2.2% efficiency target agreed with government and improved levels of productivity will require assessment of safety and quality impact assessments. The national investment model in Mental Health and Learning Disability services at the end of the mental health investment period will mean that commissioned services will be able to meet between 26% and 30% of population demand. This is set and pre-covid/cost of living levels – NHS Confederation and Centre for Mental Health - No wrong door December 2022.

Recommendations

The Board of Directors is requested to:

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

Report presented by: **Carolyn Green**
Interim Chief Executive

Report prepared by: **Carolyn Green**
Interim Chief Executive

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 17 January 2023

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 November 2022. The report focuses on key finance, performance and workforce measures.

Executive Summary

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

Operations

This chapter has been developed to provide a greater level of assurance to the Board 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. The chapter now also includes performance against the relevant NHS national long term plan priority areas. It is intended that future iterations of this chapter will include drivers in the quality improvement format.

A. Internal measures

<u>Waits for care coordination</u>
Waits are being impacted upon by staffing level challenges, increasing demand and staff fatigue. Actions being taken to improve the position include roll out of Living Well to improve flow; review of the CPA policy to reduce admin time and release more time to care; and proactive recruitment and review of skill mix to create new roles and development opportunities.

<u>Waiting list for adult autistic spectrum disorder (ASD) assessment</u>
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 November 2022 there were 1,964 adults waiting for adult ASD assessment, which is an increase of 11 on the previous month. A revised approach to waiting list management is being mobilised and should start to have an impact from quarter 4. A Recovery Action Plan has been developed and will be monitored by the Trust Operational Oversight Leadership Team.

Waits for psychological services
At the end of November 2022, 474 people across Derbyshire were waiting to be seen by psychological services with an average wait time of 350 days. The number of people waiting has continued to gradually reduce and the reduction is statistically significant.

Waits for Child and Adolescent Mental Health Services (CAMHS)
At the end of November 2022, 533 children were waiting to be seen with an average wait time of 29 weeks. A number of actions are now in place to improve the position, including redesign of the assessment team model and launch of a cores CAMHS team, which are expected to alleviate saturation across core teams and increase flow and specialist support to those who need it.

Waits for community paediatrics
At the end of November 2022 there were 1,656 children waiting to be seen, with an average wait time of 29 weeks. Waits are impacted upon by staffing levels, insufficient assessment capacity, a high level of demand and physical space for additional assessments. A detailed recovery plan is in place which is summarised in the main body of the report.

Outpatient appointments cancelled by the Trust
Over the 24-month period the level of cancellations has been above the 5% threshold for all but 1 month and has averaged around 8%. Recording accuracy needs to improve and so further training in the use of SystmOne has been arranged for those concerned.

Outpatient appointment did not attends
The level of defaulted appointments has remained within common cause variation for the majority of the time and in the current process the trust target of 15% or lower is likely to be consistently achieved.

B. NHS Operational Priorities 2022/23

There are a number of Integrated Care System NHS long term plan operational priorities towards which the Trust's activity contributes. Performance is monitored by NHS England mainly through the mental health services dataset submissions (MHSDS), and internally monitored by the Joined Up Care Derbyshire Mental Health Delivery Board. The measures for which the Trust is directly responsible are included in this report.

Discharges followed up within 72 hours
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 work is required to further improve the accuracy of recording.

Community mental health access 2 plus contacts
The Trust has been 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 is an increase of 14% on current performance. A recovery action plan is in place and summarised in the main body of the report.

Children and young people eating disorder waiting times
These standards focus on effective treatment at the earliest opportunity in order to improve outcomes, reduce rates of relapse and need for admission. 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%). A recovery action plan is in place which is being led by the Integrated Care System, as this service is delivered by two providers within the system who are experiencing similar issues..

Early intervention in psychosis waiting times
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.

Improving access to psychological therapies (IAPT) 6 week waits
Wait times have been increasing since the summer, both for referral to treatment and then first to second treatments. The main impact has been vacancies in our Step 2 team who do most of the assessments. There is a clear career progression from Step 2 to Step 3, via funded high intensity training, so we tend to lose Psychological Wellbeing Practitioners (PWPs) when the University courses start in September and March. A detailed action plan is in place and summarised in the main body of the report.

IAPT 1st to 2nd treatment >90 days
Various initiatives have been proposed to reduce waits. These included, wait list consolidation which has previously been successful, concentration on the longest waiters and monitoring of outliers more closely, broadening of the group offer, introduction of technology, spot purchasing of assessments and treatments via a 3rd party and online bookable appointments. A detailed action plan is in place and summarised in the main body of the report.

IAPT recovery rate
This is an annual target and year to date we are exceeding target. Up until the last 2 months the national standard has been achieved in month also. The dip in performance may be as an unintended consequence of implementing waiting list waiting well checks which include taking measures. We have amended this but the positive effects of this change may not take effect immediately.

Individual placement and support
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 on target to be achieved this financial year also.

Inappropriate adult acute out of area placements
The increase in patients with Covid-19 impacted on capacity as expected, and so currently there are 6 patients placed in Mill Lodge and 1 patient in an inappropriate out of area placement. This patient is on a pathway to be repatriated into a Derbyshire bed, however at the moment repatriation is not possible owing to

pressures elsewhere. University Hospitals of Derby & Burton and Chesterfield Royal Hospital are both continuing to declare critical incidents and overall the Derbyshire system is under increased pressure. Therefore, any requests received from these organisations for beds are our highest priority to ensure system flow.

Patients placed out of area in Psychiatric Intensive Care Units (PICU)
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. In addition, actions are in place to generate improved flow and admission capacity in adult acute inpatients, working closely with community teams and to create capacity to repatriate PICU patients when appropriate to do so.

Perinatal access
This is 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 support. An action plan is in place which is summarised in the main body of the report. The Trust Quality Improvement team have been engaged to monitor progress against trajectories.

Data quality maturity index
The level of data quality has been significantly better than expected for the last 7 months. It is expected that the national target will be consistently exceed.

Finance

At the end of November, the overall year to date (YTD) position is a deficit of £0.37m compared to the plan deficit of £1.04m, a favourable variance to plan of £0.67m. The forecast remains a breakeven position as per the plan.

However, there are areas of risk in and outside of that plan driven by the planning assumptions that have been followed, such as the delivery of the required 3% efficiencies, Agency expenditure and the containment of Covid costs.

Efficiencies
The full year plan includes an efficiency requirement of £6.0m phased equally across the financial year. There has been a particular focus on actions required to close the remaining efficiency gap which is required to achieve the overall breakeven plan. This has now been achieved and full plans have been developed.

Whilst the full requirement for efficiencies has now been identified the majority of the schemes are non-recurrent 68% and there is need to take action to ensure the costs are reduced to match the planned delivery.

Agency
Agency expenditure YTD totals £4.7m against a plan of £1.6m, an adverse variance to plan of £3.1m. The two highest areas of agency usage relate to Consultants mainly in CAMHS and Nursing staff.

Covid Costs
The financial plan assumes no expenditure for Covid after the end of May as per the planning guidance. There has been a significant reduction in covid related expenditure in recent months, November being the lowest month at £10k.

Out of Area Placements
Expenditure for adult acute out of area placements totals £2.0m to date. The forecast assumes 9 for December and 6 for remainder of year.

Capital Expenditure
Following the resubmission of the capital plan in June expenditure is slightly below plan at the end of November. In October NHSE/I requested that the forecast expenditure across the system was reduced to remove the 5% planning assumption that had been in previous months forecasts, the forecast is therefore reflecting an underspend of £0.3m.

Better Payment Practice Code (BPPC)
In November the target of 95% was missed on both value and volume.

Cash and Liquidity
Cash remains high at £46m at the end of November however this is expected to reduce in line with capital expenditure. The liquidity ratio has reduced in 2022/23 mainly driven by the timing of cash receipts related to the centrally funded Making Room for Dignity capital scheme.

People

Annual appraisals
Appraisal levels continue to be below our expectations. There is however a significant improvement over the last 10 months. A number of areas have been struggling with the recording of appraisals. As a result we now have dedicated sessions for teams in the accessing, using and recording of information. Compliance continues to be monitored at Divisional Achievement Reviews and via the Trust Operational Oversight Leadership Team.

Annual turnover
Turnover remains high and above the Trust target range of 8-12%. The new exit interview process is starting to provide further data on why colleagues are leaving the trust. This is being triangulated with other Trust data and a strategic action plan developed to address key areas such as career development and flexible working.

Compulsory training
Compulsory training continues to be a key focus and an ongoing recovery position for the Trust. Overall, the 85% target level has been achieved for the last 8 months. Immediate Life Support and Positive and Safe training compliance continues to improve. The mandatory training working group have been working to address key objectives to ensure compliance is achieved.

Staff absence
Sickness absence remains high and above the 5% target threshold. COVID absences dropped significantly however increases were seen in flu, cold and cough absences. The absence transformation programme will commence in

2023 and this will tighten our understanding of how all absences are being managed and any subsequent changes needed to policy and health and wellbeing support. The main reason for absence continues to be stress and anxiety and 2023 will see further investment in resources to support colleagues who are struggling at work and home.

Clinical and Managerial Supervision
The levels of compliance with the clinical and management supervision targets have remained low since the start of the pandemic. A review of the supervision policy is currently taking place and once this is finalised, clear communications will be issued around expectations on supervision. This is also being fed into corporate induction and the leadership induction.

Proportion of posts filled
Staffing levels continue to improve and gradual reductions in vacancy rate have continued with significant improvements in comparison to 6 months ago. Work continues on innovative ways of recruiting and attracting whilst we also focus on retention through intelligence gained from stay surveys, exit interviews and the national staff survey.

Bank staff
There was a small reduction in agency spend and an increase in overall fill rates though increased bank usage. Ongoing engagement sessions with bank colleagues are now taking place monthly. Agency spend on non-medical staffing has increased significantly over the last 12 months and work is now taking place to ensure correct usage and accountability is transparent for leaders and through divisional achievement reviews.

Quality

Compliments
The number of compliments continues to remain below the expected level on average. This is due to compliments mostly being received verbally and staff not accurately recording them. Action is being taken to address this. A project supporting the electronic patient survey will provide a further method of receiving compliments, complaints, and concerns. With an increase in accessibility, it is expected that a natural increase will occur over the next 6 months.

Complaints
The number of formal complaints received continues to be within common cause variation. The number of formal complaints is now below the Trust target. This could be due to the number of face-to-face contacts increasing as services stand back up and a previous theme identified as patients having difficulty in accessing services.

Delayed transfers of care
Although the number of delays has increased between September and November 2022, the number is still low when compared with the national picture and continues to be below the Trust target of 3.5%. The main barrier to discharge is identifying appropriate housing for service users. Work continues within the rapid review processes and clinical meetings. A Housing Officer

was recruited in May 22 to support the identification of placements for patients who are clinically ready for 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. This is likely due to care plans that have not yet been migrated over to SystmOne and data quality issues with how this information is being captured. The division are considering using additional resource with the aim of the aim of all teams having existing care plans migrated over by the end of December 2022.

Patients in employment
From September 2022 the number of patients recorded as in employment has increased and a report has been developed which informs teams if there are gaps in the Current Data Quality Maturity Index information recorded on referral. From January 2023, Ward and Service Managers have been asked to review this report weekly and action any gaps identified. The Individual Placement Support (IPS) Service continues to have success in supporting people into employment even during the pandemic and the service is currently expanding. As a result, the number of patients in employment is expected to improve over the six months.

Patients in settled accommodation
Around one third of patients have no accommodation status recorded and the decline in patients with a recorded settled accommodation status again coincides with the data migration to SystmOne. A report has been developed which informs teams if there are gaps in the Current Data Quality Maturity Index information recorded on referral. From January 2023, Ward and Service managers have been asked to review this report weekly and action any gaps identified.

Medication incidents
Medication incidents are monitored through both the feedback intelligence group report and the Medicines Management Operational Subgroup (MMOS). The majority of these incidents are graded as minor or insignificant. The MMOS is currently revising the medications error procedure, considering Trust values, and the Acute Inpatient Matrons and Head of Nursing are in the process of updating the relevant policies which will reduce the number of incidents. The pharmacy team have also identified some learning points which they plan to introduce from December 2022.

In October 2022 the Children's Division started electronic prescribing and medicines administration (EPMA) a solution which digitises the process of prescribing and recording medication administered to patients within the Division. This will be rolled out across the trust and should also help reduce the number of medication incidents over the next six months.

Incidents of moderate to catastrophic actual harm
The number of reported incidents of moderate to catastrophic harm has reduced from July and continue to be below the mean.

Duty of Candour

Duty of Candour reported incidents have been on a downward trajectory since April which coincides with the Patient Safety Team undertaking training with Service Managers and Heads of Nursing to support them in understanding and interpreting new national guidance. Training around accurately reporting continues. A review into the current process of quality assurance, auditing and reviewing of incidents is underway and due to these developments, as expected the number of incidents reported has stabilised.

Prone restraint

There are ongoing workstreams to support the continuing need to reduce restrictive practice. Furthermore, the Positive and Safe team have now re commenced attending inpatient wards to provide advice and support around de-escalating incidents that could lead to restrictive practice. The overall numbers of prone restraint are lower than the regional average per bed numbers and it is expected that incidents related to prone restraint will continue in this vein.

Physical restraint

The number of reported incidents involving restraint have remained within common cause variation throughout the reporting period. Common impacting factors to restrictive practice include increased use of bank staff, vacancies, increased sickness, staffing challenges and concerns relating to closed culture. A working group has been created to put together a working procedure for assessing closed cultures and what needs to be done where closed cultures are identified. This work aims to improve patient feedback along with reducing restrictive practice both in Inpatient and Community Services.

Seclusion

The use of seclusion has been above the mean common cause variation from October 2021 due to a small number of patients who had been placed in seclusion on more than one occasion. From July 2022 the number of seclusions was on a downward trajectory and is now below the Trust target. The Head of Nursing for Acute and Assessment Services is currently leading on a thematic review of seclusions to identify further learning.

Falls on inpatient wards

After an abnormal spike of incident in March 2022, A review of falls was commissioned and identified that a high number of falls were related to the same small number of patients. From this review a bi-weekly falls review meeting has been established to identify any specific needs for those patients falling regularly. A Physiotherapist has been allocated to support the inpatient wards in managing falls risks.

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 & Equality Impact Risk Analysis

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

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

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

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

Recommendations

The Board of Directors is requested to:

1) Confirm the level of assurance obtained on current performance across the areas presented. The proposed level is limited assurance.
2) Formally agree that this report incorporates the key elements of assurance to the Trust Board that would otherwise have come from Finance and Performance Committee and People and Culture Committee reporting.
3) Determine whether further assurance is required.
4) Provide feedback on the revised format of the Operations section of the main body of the report, in order to inform future iterations and to evolve the executive summary.

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

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

Faye Rice
Managing Director, Delivery, Performance & Transformation

Joanne Wilson
Acting Director of Finance

Rebecca Oakley
Acting Deputy Director, People & Inclusion

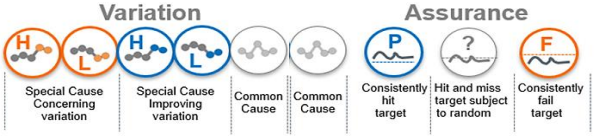
Joseph Thompson
Assistant Director of Clinical Professional Practice

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			43		16	31	23
1b	Waiting list - care coordination - number waiting at month end			109		35	74	54
2a	Waiting list - ASD assessment - average wait to be seen			73		64	69	67
2b	Waiting list - ASD assessment - number waiting at month end			1,964		1421	1635	1528
2c	ASD assessments			23	26	4	30	17
3a	Waiting list - psychology - average wait to be seen			50		37	50	43
3b	Waiting list - psychology - number waiting at month end			474		665	881	773
4a	Waiting list - CAMHS - average wait to be seen			29		13	22	17
4b	Waiting list - CAMHS - number waiting at month end			533		369	528	449
5a	Waiting list - community paediatrics - average wait to be seen			29		13	18	16
5b	Waiting list - community paediatrics - number waiting at month end			1,656		908	1229	1069
6	Outpatient appointments cancelled by the Trust			7%	5%	5%	11%	8%
7	Outpatient appointment "did not attends"			12%	15%	9%	14%	12%
B1	3 day follow-up			83%	80%	78%	99%	89%
D1	Community Mental Health Access (2 plus contacts)			8,570	10,044.0	8733	8975	8854
E1	Children & Young People Mental Health Access (1 plus contact)			2,935		2818	2997	2907
E4	Children & Young People Eating Disorder Waiting Time - Routine			62%	95%			82%
E5	Children & Young People Eating Disorder Waiting Time - Urgent			54%	95%			63%
G3	Early intervention 14 day referral to treatment - complete			100%	60%	67%	107%	87%
G3	Early intervention 14 day referral to treatment - incomplete			100%	60%	56%	114%	85%
G3	Early intervention 14 day referral to treatment - complete			100%	60%	67%	107%	87%
G3	Early intervention 14 day referral to treatment - incomplete			100%	60%	56%	114%	85%
H0	IAPT 6 week referral to treatment			60%	75%	79%	93%	86%
H1	IAPT 18 week referral to treatment			100%	95%	100%	100%	100%
H2	IAPT 1st to 2nd Treatment over 90 Days			15%	10%	2%	8%	5%
H7	IAPT patients completing treatment who move to recovery			45%	50%	46%	61%	54%
I1	Individual Placement and Support Access			235	343.0	103	323	213
K2	Total inappropriate out of area bed days			1,465		1347	1953	1650
K2	Average patients out of area per day - adult acute			4	0	-2	10	4
K2	Patients placed out of area - adult acute			5	0	-2	18	8
K2	Average patients out of area per day - PICU			11		6	20	13
K2	Patients placed out of area - PICU			15		11	32	22
L1	Perinatal Rolling 12 Months Access			4%	10%	3%	4%	3%
L2	Perinatal Access Year to Date			315	1,070.0	120	381	251
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

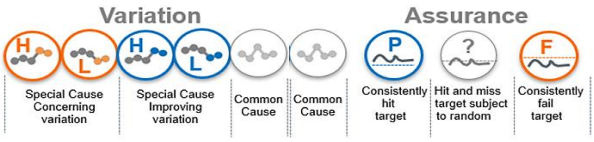
B. People

	Metric Name	Variation	Assurance	Latest Value	Target	Lower process limit	Upper process limit	Mean
1	Annual appraisals			77%	85%	72%	76%	74%
2	Annual turnover			13%	8-12%	12%	14%	13%
3	Compulsory training			87%	85%	83%	87%	85%
4	Staff absence			7%	5%	5%	8%	7%
5	Clinical supervision			71%	95%	69%	76%	72%
6	Management supervision			75%	95%	71%	78%	74%
7	Filled posts			95%	100%	87%	93%	90%
8	Bank staff use			6%	5%	5%	7%	6%

C. Quality

	Metric Name	Performance	Assurance	Latest Value	Target	Lower process limit	Upper process limit	Mean
1	Compliments received			102	119	59	136	98
2	Formal complaints received			9	13	5	29	17
3	Delayed transfers of care			2%	3.5%	-0.3%	1.9%	0.8%
4	CPA reviews			70%	95%	83%	93%	88%
5	Patients in employment			12%		10%	15%	12%
6	Patients in settled accommodation			41%		48%	59%	54%
7	Number of medication incidents			69		29	90	59
8	No. of incidents of moderate to catastrophic actual harm			31	48	16	77	47
9	No. of incidents requiring Duty of Candour			1	1	-4	11	3
10	No. of incidents involving prone restraint			5	12	-2	19	8
11	No. of incidents involving physical restraint			52	46	4	85	44
12	No. of new episodes of patients held in seclusion			10	14	0	31	15
13	No. of falls on inpatient wards			33	30	20	46	33

Key to symbols[1]:

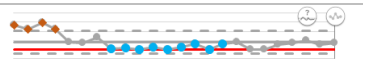
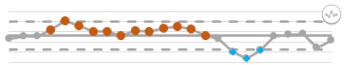
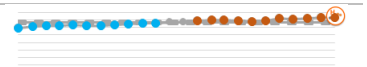
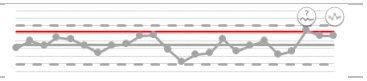
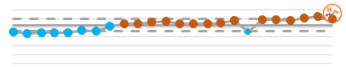
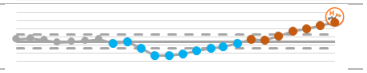
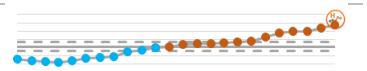
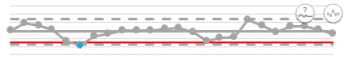


Blue dots indicate special cause variation, better than expected.

Orange dots indicate special cause variation, worse than expected.

[1]The rating symbols were designed by NHS Improvement

Operational Services Performance Summary by Division

Indicator	Target	Position Nov 2022	National benchmark	Divisional Breakdown[1] AA	AC	Ch	F&R	OP	Psy	SC	Run Chart
● 3-day follow-up	80%	93%	79%	91%			100%	100%		75%	
● Data quality maturity index	95%	97%	79%	91%	98%	85%	96%	98%	98%	98%	
● Early intervention 2-week referral to treatment	60%	100%	75%		100%						
● Early intervention current waits under 2 weeks	60%	100%	40%		100%						
● IAPT 18-week referral to treatment	95%	99.9%	98%							99.9%	
● IAPT 6-week referral to treatment	75%	60%	89%							60%	
● IAPT recovery rate	50%	46%	50%							46%	
● Adult acute out of area placements – daily average	0	4	7	4							
● PICU out of area placements – daily average	0	11	3	11							
● Adult ASD assessment average wait (weeks)	n/a	73	n/a							73	
● Adult ASD assessments	26	23	n/a							23	
● Psychological services average wait to be seen (weeks)	n/a	50	n/a							50	
● CAMHS average wait to be seen (weeks)	4[2]	29	n/a			29					
● Paediatrics average wait to be seen (weeks)	18	29	14			29					
● Outpatient appointment Trust cancellations	5%	7%	n/a		6%	7%		14%		5%	
● Outpatient appointments not attended (DNAs)	15%	12%	n/a		19%	4%		6%		11%	

[1] Key: AA Adult Acute Care, AC Adult Community Care, Ch Children's Services, F&R Forensic & Mental Health Rehabilitation, Psy Psychology and SC Specialist Care Services
[2] Proposed access standard (NHSE)

The measures above are covered in detail in the Operations section of the main body of the report.

Benchmarking Sources

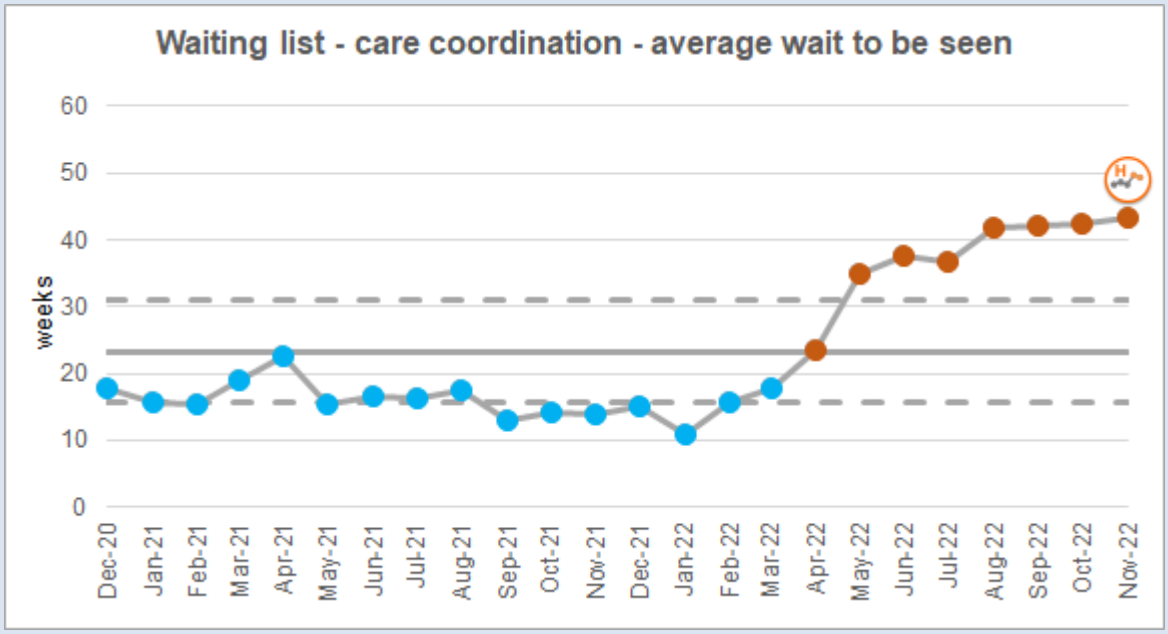
Measure	Data source	Date
3-day follow-up	Mental Health Statistics	October 22
Data quality maturity index	Data quality - NHS Digital	August 22
Early intervention 2-week referral to treatment	MHSDS Monthly Statistics	October 22
Early intervention current waits under 2 weeks	MHSDS Monthly Statistics	October 22
IAPT 18-week referral to treatment	Psychological Therapies: reports	September 22
IAPT 6-week referral to treatment	Psychological Therapies: reports	September 22
IAPT recovery rate	Psychological Therapies: reports	September 22
Adult acute out of area placements – daily average	Out of Area Placements	September 22
PICU out of area placements – daily average	Out of Area Placements	September 22
Paediatrics average wait to be seen (weeks)	Referral to Treatment Waiting	October 22

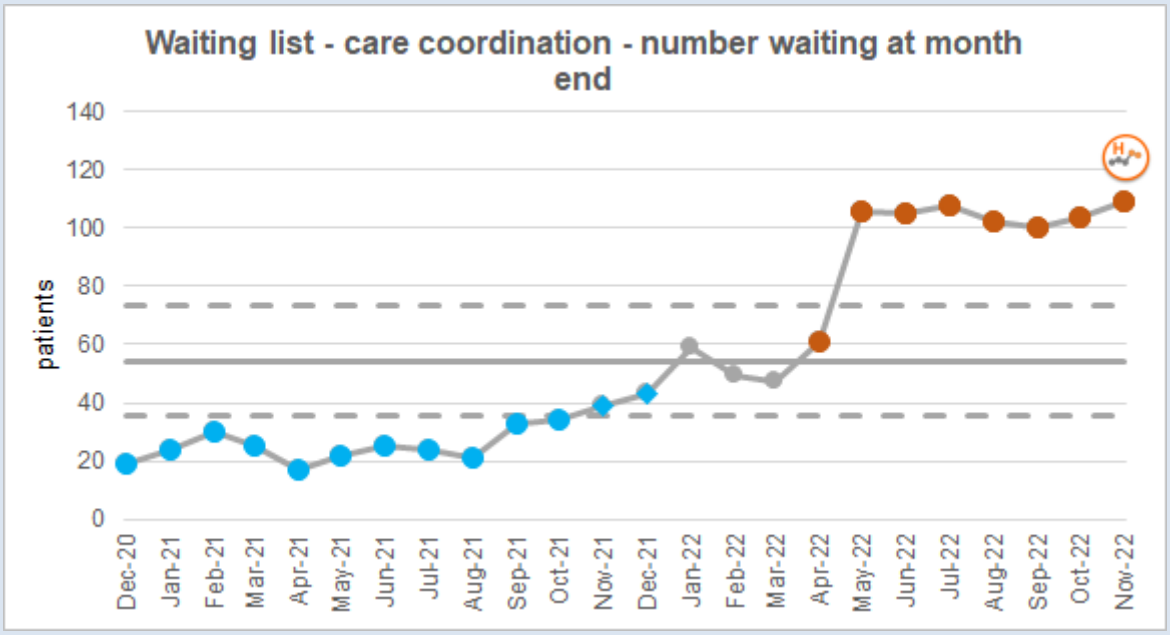
Operations

A. Internal measures

1. Waits for care coordination

Performance summary





There are a number of key factors impacting on waits:

- Some teams are in distress due to staffing challenges
- Migration to SystmOne has presented an ongoing challenge for staff, with some staff still struggling to use SystmOne
- As we came out of the pandemic, the number of referrals has steadily increased but there was no additional capacity created for Care Coordinators to take new cases (this explains the 7-point shift upwards)
- Staff fatigue (ongoing issue raised during and post pandemic)

Primary drivers/ change ideas/ rationales	
• Working more efficiently • Increasing staffing levels	• Reducing admin and waste • Exploring alternatives to address nursing recruitment challenges
Key actions	

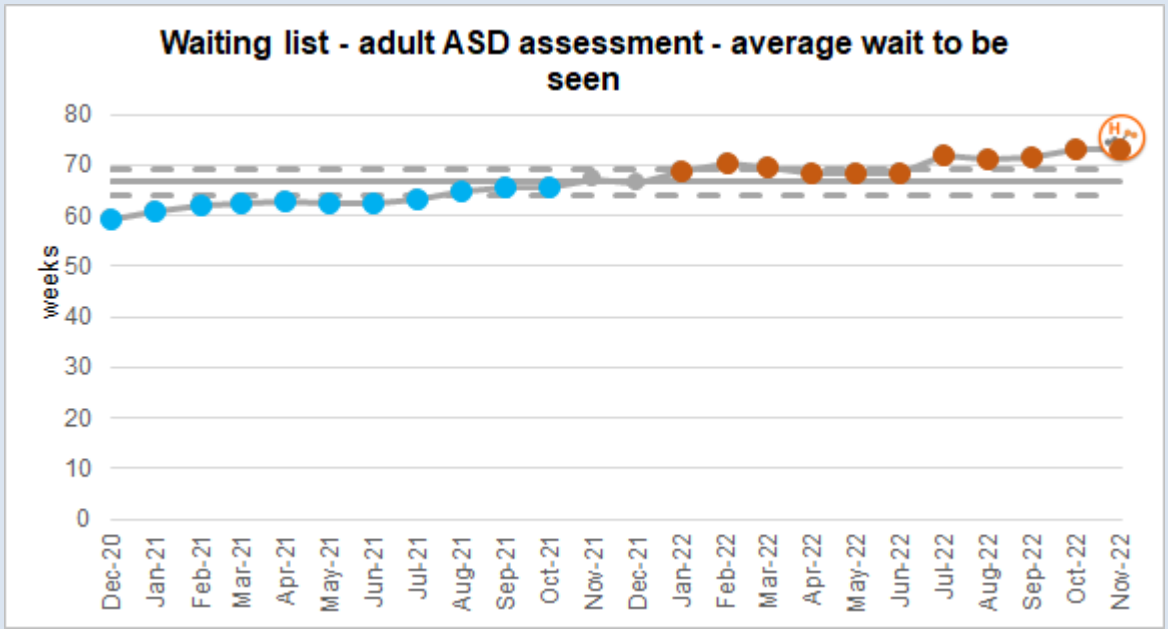
Description	Anticipated Benefit/ Outcome	Target	Completion Date
Roll out of Living Well	Improved flow of patients/ reduced waits	Reduction in waiting lists to meet the 4-week target for referral to treatment	31/3/2024
Review of the CPA policy to Care Principles & CPA	Reduction in admin time, releasing more time to care	Reduction in waiting lists. People being able to access the appropriate level of intervention at the point they need it	30/6/2023
Proactive recruitment and review of skill mix, creating new roles and development opportunities e.g., Nurse Associate, MH Practitioner (open to social workers and OTs), Band 5 to 6 development roles.	To bring a different skill set to facilitate multidisciplinary team working and address the nursing shortage	Reduction in turnover and vacancies	30/6/2023

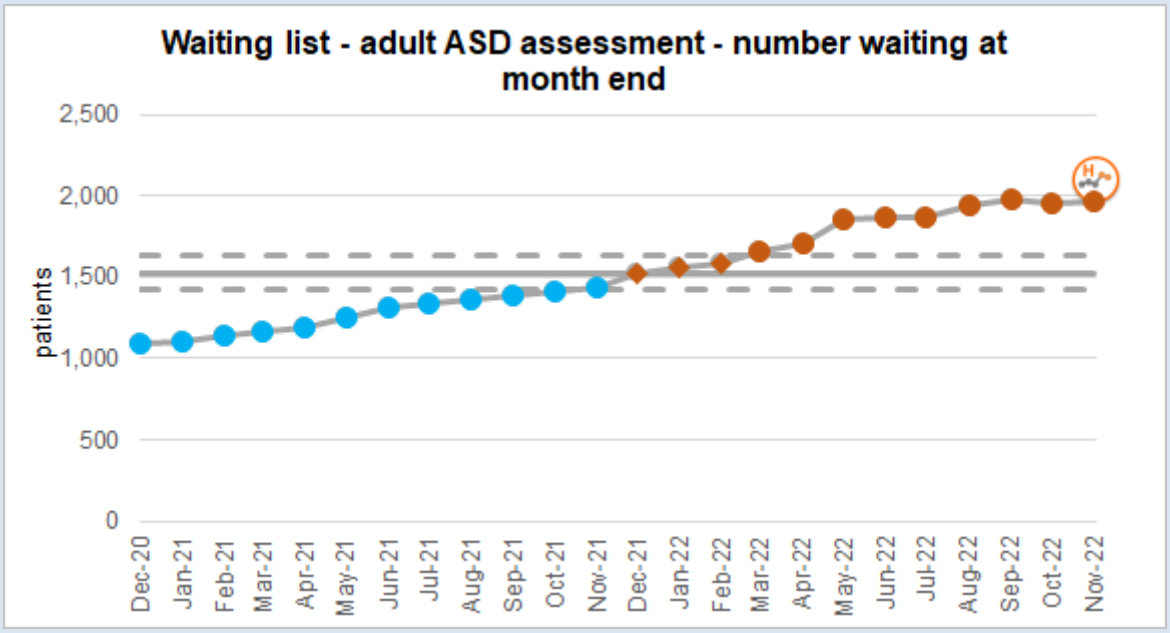
Progress and/or barriers to progress

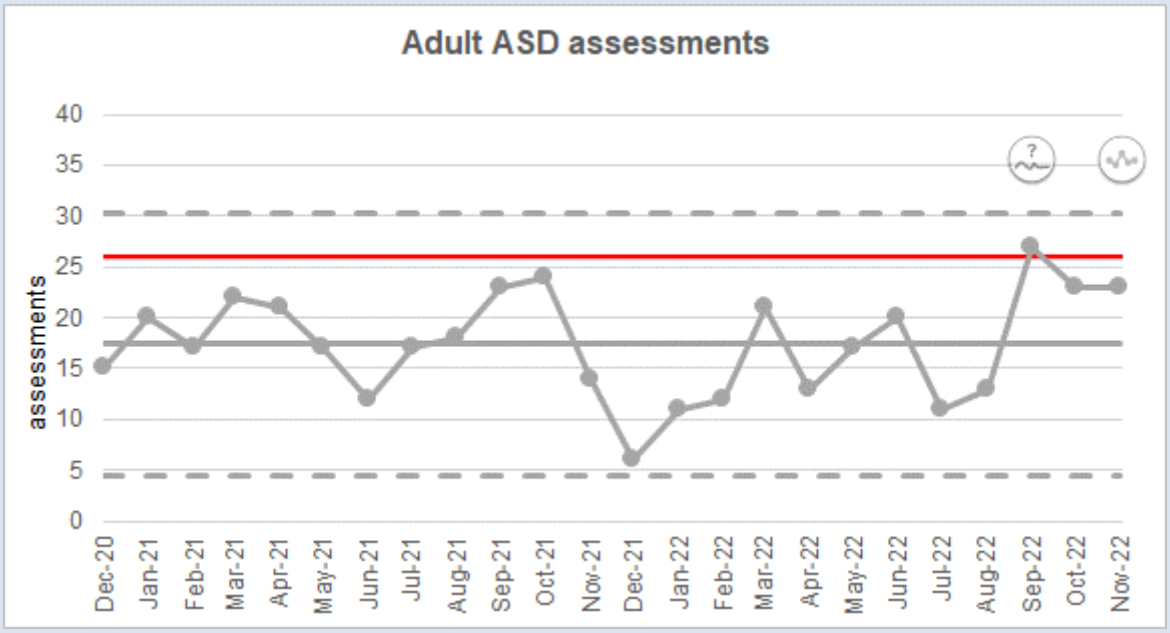
- The division is currently being supported by Faye Rice and Lee Doyle to undertake process mapping with the aim of increasing efficiency
- Prototype of Living Well in Derby City, which is taking cases from the waiting list

2. Waits for adult autistic spectrum disorder (ASD) assessment

Performance 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 November 2022 there were 1,964 adults waiting for adult ASD assessment, which is an increase of 11 on the previous month. A revised approach to waiting list management is being mobilised and should start to have an impact from quarter 4.

Primary drivers/ change ideas/ rationales	
• Review workforce • Examine screening efficacies • Reduce unnecessary time spent on assessment • Operational governance	• Increase training opportunities • Review skill mix of diagnosticians • Review invest to save opportunities • Review the process of referrals • Criteria and screening efficacy • Increase access to more varied assessments • Increase access for clinical supervision • Review back office and administrative processes • Data accuracy review and operational fidelity of systems

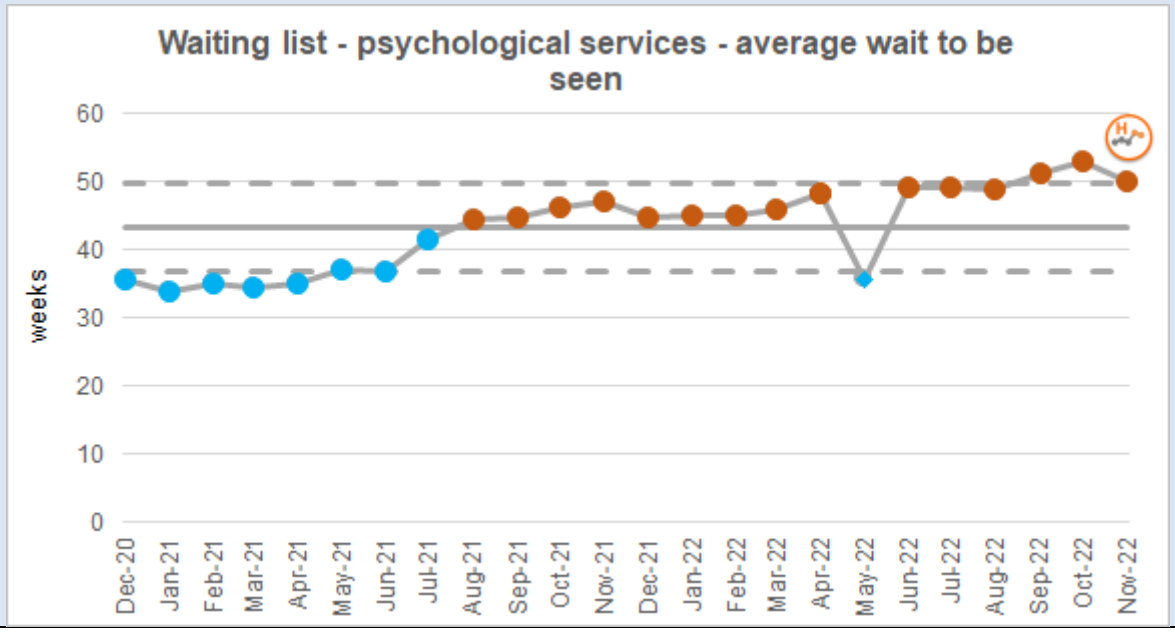
Key actions			
Description	**Anticipated Benefit/ Outcome**	**Target**	**Completion Date**
Training	Increased workforce capable of assessment	20 newly trained staff by Jan 2024 (pending ADOS licensing)	Feb 24
Review EPR system	Robust flagging system on EPR, accurate reporting data and consistency to operational processes	Due to whole system and whole Trust EPR challenges target to form optimisation work but needs to be factored into the existing demands across the Trust	Qtr2 2023
Clinical Efficacies	Reviewed clinical processes to increase screening success and increase the number of ASD assessments completed	Meet target for assessments	Qtr1 2023

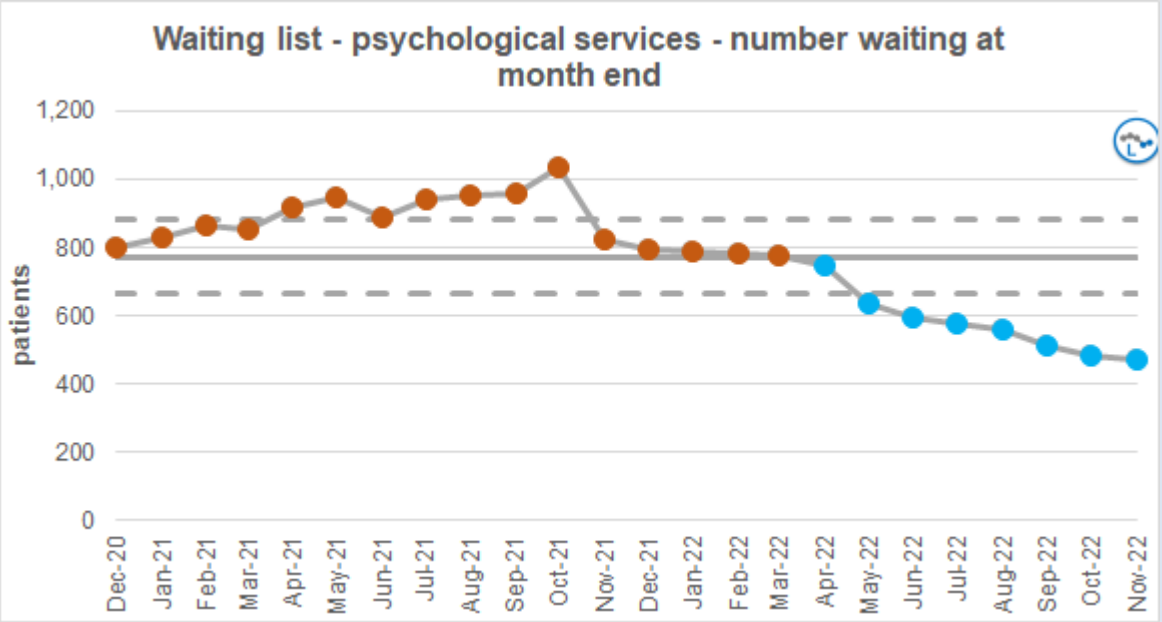
Progress and/or barriers to progress

- In progress

3. Waits for psychological services

Performance summary





At the end of November 2022, 474 people across Derbyshire were waiting to be seen by psychological services with an average wait time of 350 days. The number of people waiting has continued to gradually reduce and the reduction is statistically significant.

Primary drivers/ change ideas/ rationales

- Recruitment to over 80% of roles
- Improve efficiency of care delivery
- Develop new employment models
- Review, cleanse, and update data
- Training others to deliver psychological therapies
- Website & increasing visibility of DHCFT
- Flexible working
- Increasing administration support to Lead psychologists
- Review and reduce training on training passport
- Develop group treatments as first line offer
- Employ Digital Consultants
- Increase Assistant number
- Create role for other psychological professionals
- Waiting list review
- Optimise data
- Skilling up existing clinical roles to deliver moderate psychological interventions (e.g., EMDR delivery)
- Develop group work as first offer
- Pool resources across services/ specialisms, e.g., substance misuse

Key actions

Description	Anticipated Benefit/ Outcome	Target	Completion Date
Recruitment drive through internal website; easier to complete application forms, push through social media, flexible working, hybrid approach to working, digital consultants, developing other roles	Increased applicants and employment within the trust; increased workforce to deliver care and reduce waiting lists; increased diversity	To be 85% recruited & reduce the vacancy factor; employ 1 digital consultant as proof of concept; at least 1 CBT therapist in CMHT	Immediate
Upskilling of current workforce to deliver moderate intensity psychological interventions (e.g., EMDR delivery; skills groups,	To be able to offer trauma specific work by nursing and psychology professionals for	Greater offer of treatments (range and number); reduction in waiting list times	Mar-24 (because EMDR and other training

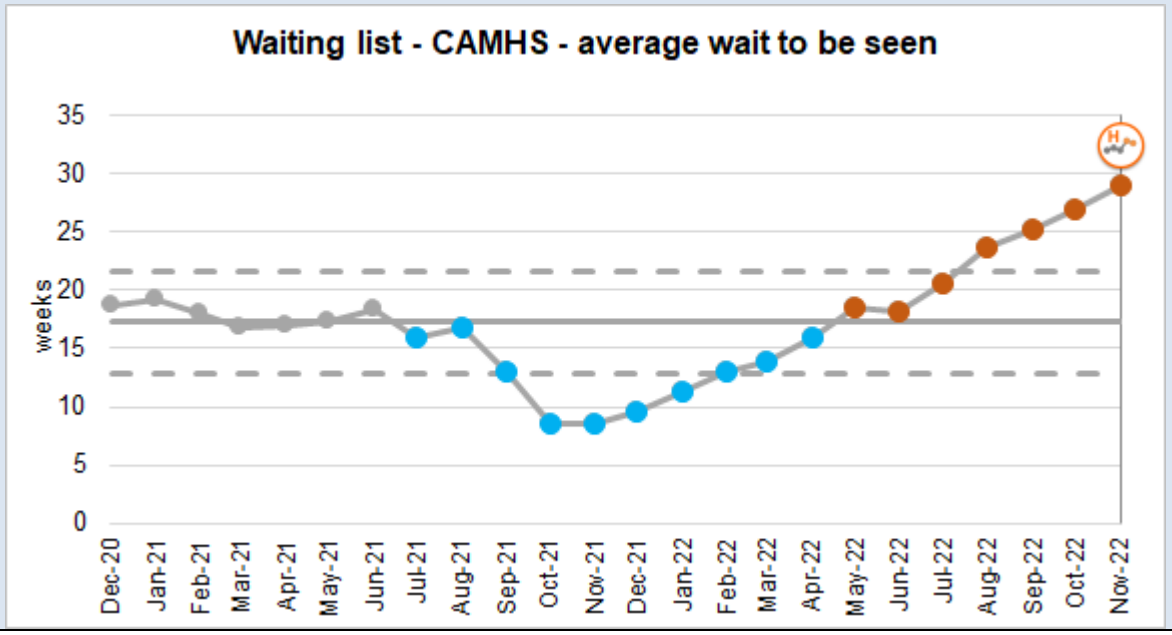
trauma stabilisation groups); increase group work offers	those on waiting list; increase availability of other treatment through group work		takes 2 years)
Creation of DPT to improve efficiency of delivery. Look to pool resources across the county to smooth out peaks and troughs and work with other teams; utilise population health data to understand needs in specific areas; make sure data is accurate.	Improved efficiency in delivery; ability to flex the resources; improve equitable care across county;	To have a plan for moves / changes in delivery to target high wait list areas. Links with a range of teams to deliver joined up care e.g., Subs misuse	Division creation planned for Jan – March 2023

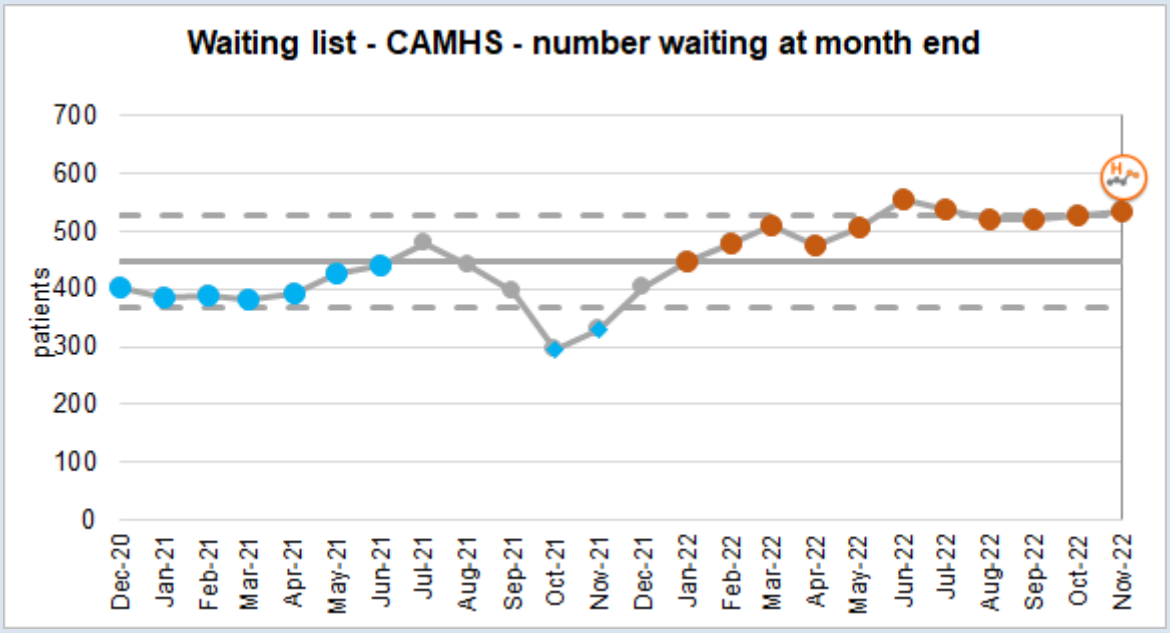
Progress and/or barriers to progress

- There remains a national shortage of qualified psychologists, with all Trusts struggling to recruit. We currently have less vacancies in psychological services than our regional colleagues. This position is unlikely to change until 2025 when those new places commissioned by Health Education England (HEE) for training output qualified staff. In the meantime, we are utilising other roles (as above) to try and plug our gap in delivery of psychological care. Whilst we have recruited to over 16 posts in the last 18 months, the increase in roles (through transformation of care) has maintained a vacancy factor.
- Focus is on meeting patient need. Barriers of movement between services remain high priority to remove. This work continues to develop as the Living Well transformation takes place and MDT and culture work takes shape.
- Future reports will report on the Division on Psychological Therapies which includes all psychological therapists and their deliver of care

4. <u>Waits for Child and Adolescent Mental Health Services (CAMHS)</u>

Performance summary





At the end of November 2022, 533 children were waiting to be seen with an average wait time of 29 weeks.

Primary drivers/ change ideas/ rationales

- Staffing of assessment capacity
- Referral pathways and management
- Lack of flow
- Sickness, vacancies and turnover
- Robust screening and triage
- Clear acceptance criteria
- Recovery and talking therapy capacity

Key actions

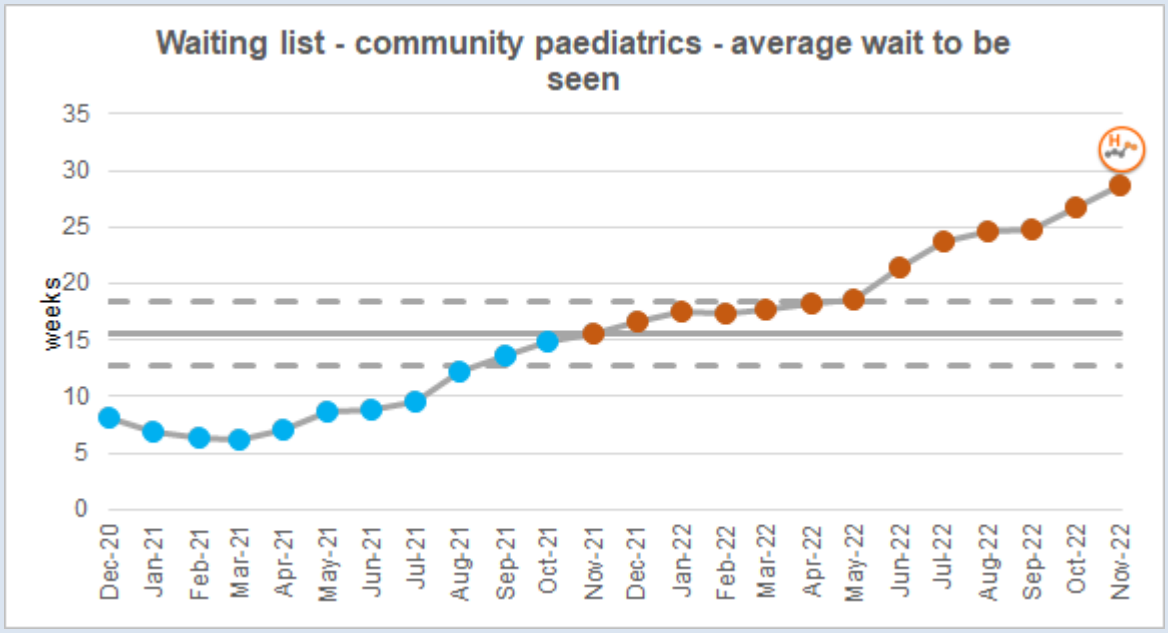
Description	Anticipated Benefit/ Outcome	Target	Completion Date
Priority assessments - RAG rate the priority wait list and ensure available assessment slots for the 'Priority' red cases.	No red waits, plan of care agreed for most urgent service users on the routine wait list	No red waits	Ongoing
Redesign Assessment Team Model	Restart routine assessments at earliest opportunity	Reduce wait time, mitigate risks that the old ASIST model posed	Start to mobilise mid January 2023
Launch a Core CAMHS Team - a place where all young people that need a service will go to while awaiting intervention/allocation elsewhere. Cases who no longer require direct care coordination can be transferred to the Hub as part of discharge planning. They will be monitored in clinics (approx. once every 6 weeks) and can be accessing therapy, groups, ND assessments, allocation in Recovery, Prescribing etc. It will operate on a shared caseload.	Alleviate saturation across core teams such as Recovery, Liaison, ASIST. Adhere to Waiting Safely Policy	Increase flow and specialist support/ intervention for those that require it	Start to mobilise mid January 2023

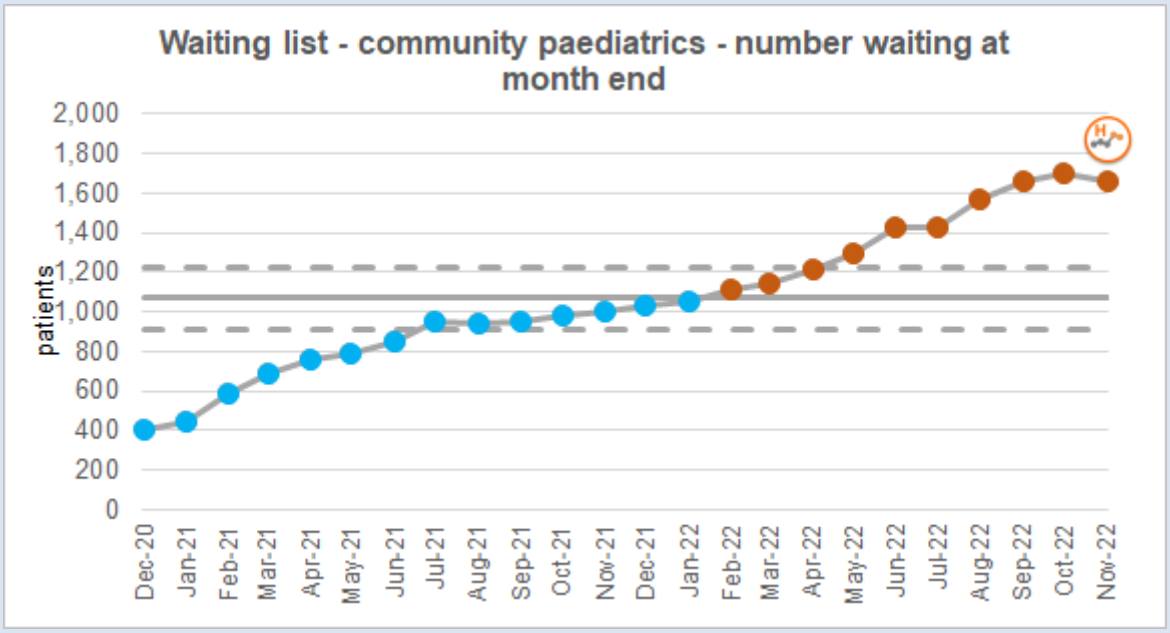
Progress and/or barriers to progress

- Progressing as planned

5. Waits for community paediatrics

Performance summary





At the end of November 2022 there were 1,656 children waiting to be seen, with an average wait time of 29 weeks.

Primary drivers/ change ideas/ rationales	
• Staffing • Assessment capacity • Referral management and lack of flow	• Physical space for additional assessment • Sickness and vacancy impact • Insufficient assessment capacity • Review referral criteria • Standardise follow-up requirements

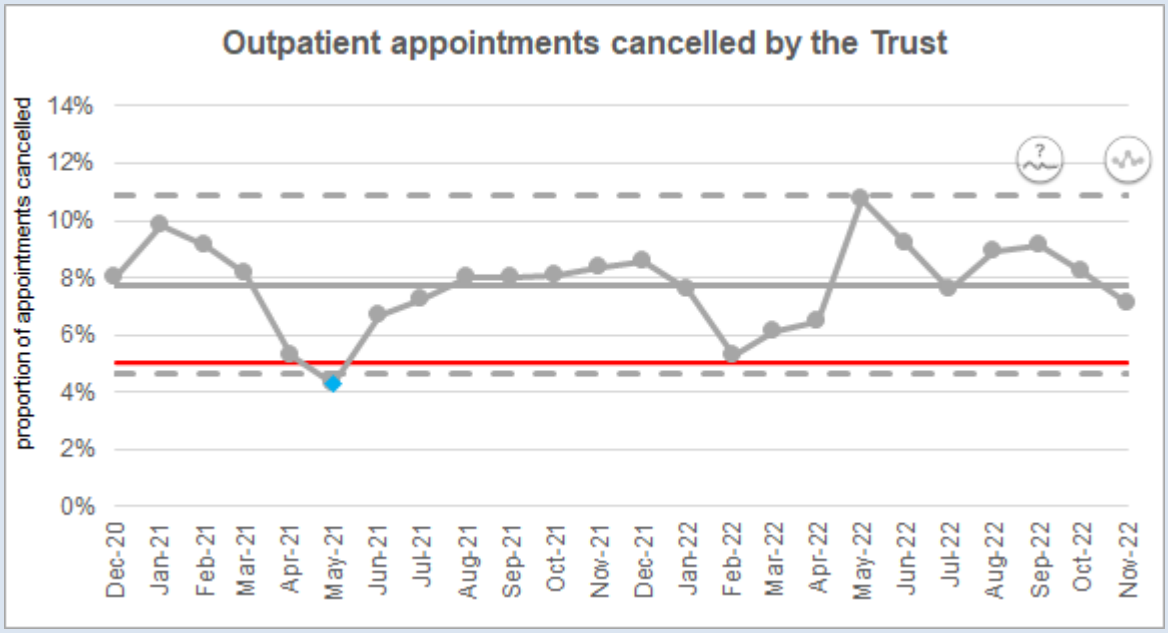
Key actions			
Description	**Anticipated Benefit/ Outcome**	**Target**	**Completion Date**
To increase available appointment slots. Consideration given to the setup of Saturday ADHD clinics	Increased number of clinical slots enabling more children to be seen and a reduction in waits	This will have limited impact on the waiting list to start with but will improve flow through the service	January 2023
Neurodevelopmental Development (Business case)	Business case has now been approved which will increase clinical time by appointment of Specialty Dr for ASD, also included in funds is NMP / Triage nurse, which will support earlier point on skill mix	Recruitment expected December 2022, appointment of these vacancies will depend on recruitment checks, interview dates etc.	Jan - March 2023
Review of waiting well across services, extensive review of Comm Paeds waiting list	To ensure the wellbeing of people on the waiting list while they are waiting	Information and signposting accessible to families and carers	Ongoing

Progress and/or barriers to progress

- Staff have been approached regarding Saturday clinics, but this will depend on the availability of budget and clinic rooms, which remains the biggest area of concern.

6. Outpatient appointments cancelled by the Trust

Performance summary



Over the 24-month period the level of cancellations has been above the 5% threshold for all but 1 month and has averaged around 8%. 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.

Primary drivers/ change ideas/ rationales

- To minimise patient inconvenience
- To ensure the standard for reasonable notice is adhered to
- To comply with Trust policy
- Re-education on trust policy
- Further training on SystmOne
- Improve recording
- Follow process

- Increased accuracy of recording

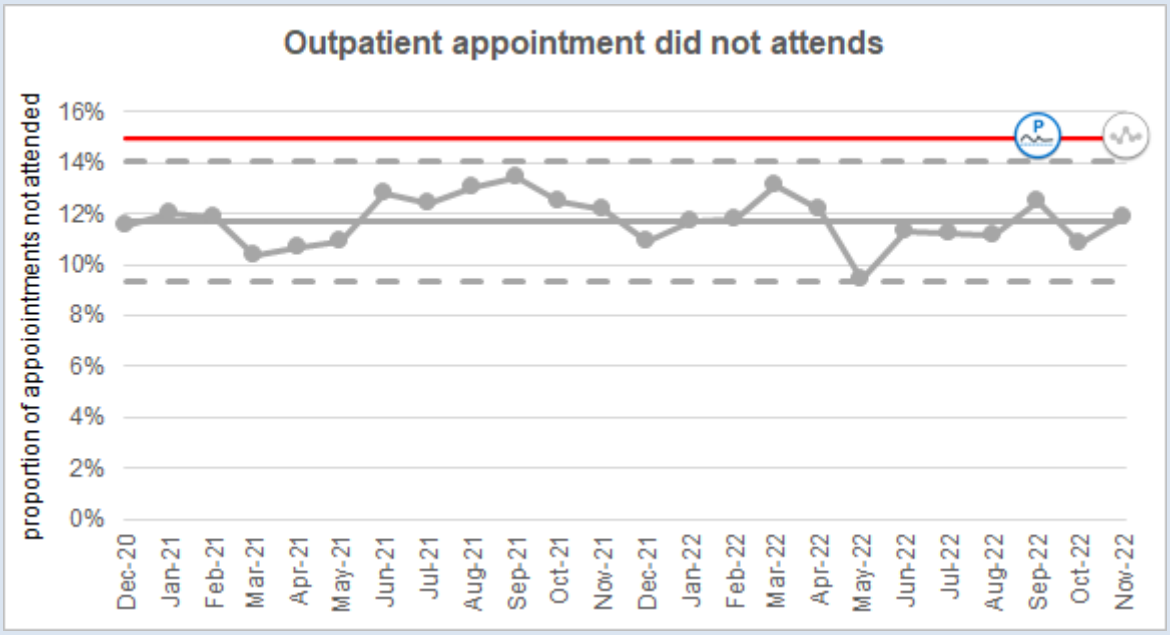
Key actions

Description	Anticipated Benefit/Outcome	Target	Completion Date
Refresher training for admin staff	To minimise cancellations	100% trained	28/02/2023
Discussion in supervision with admin staff	Regular review to ensure minimal cancellations	Within 5% threshold	Ongoing

Progress and/or barriers to progress

- Additional training is being arranged and attendance at training will be monitored

7. Outpatient appointment did not attends



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

B. NHS Operational Priorities 2022/23

There are a number of Integrated Care System NHS operational priorities towards which the Trust's activity contributes. Performance is monitored by NHS England through the mental health services dataset submissions (MHSDS), and internally monitored by the Joined Up Care Derbyshire Mental Health Delivery Board. The table below is the latest nationally published data for each applicable measure, which is published on the FutureNHS website:

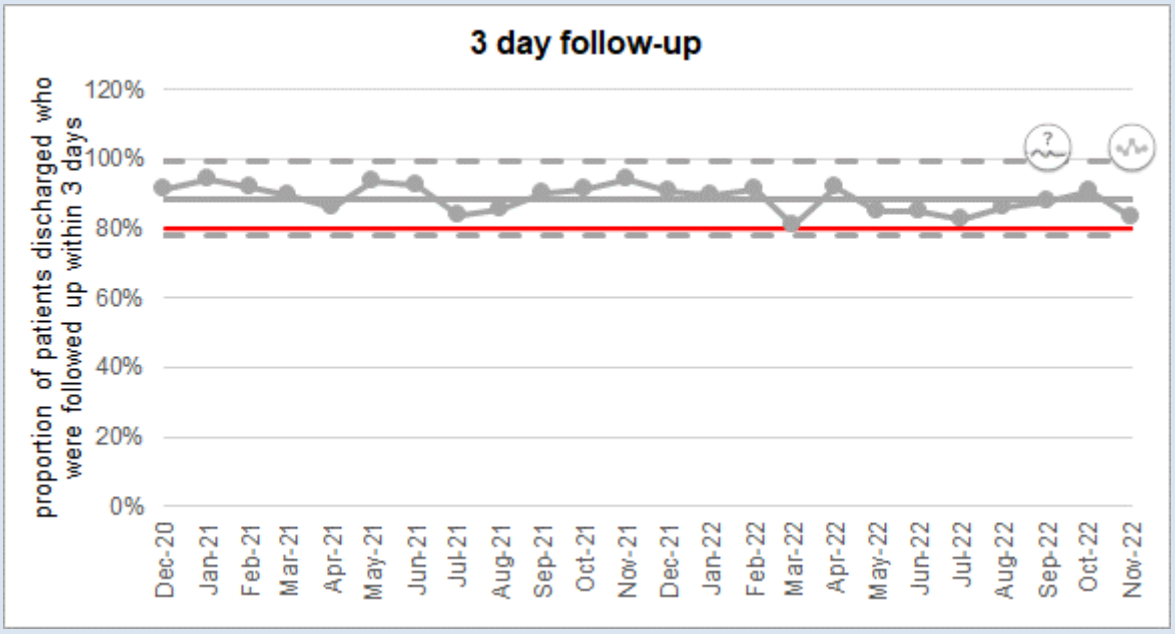
Measure	Trust Target	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
(B1) Discharges followed up within 72hrs	80%	80%	87%	83%	84%	82%	79%	78%	75%	63%	70%	79%	77%	83%
(D1) Community Mental Health access (2+ contacts)	10,044	8,935	8,775	8,765	8,695	8,680	8,620	8,635	8,585	8,630	8,680	8,685	8,655	8,570
(E1) CYP access (1+ contact) - system level indicator	N/A	2,865	3,035	3,070	3,085	3,100	3,095	3,065	3,075	3,075	3,040	3,030	2,980	2,935
(E4) CYP eating disorder waiting time - Routine	95%	91.0%			83.1%			73.7%			57.9%			62.1%
(E5) CYP eating disorder waiting time - Urgent	95%	66.7%			50.0%			23.5%			44.0%			53.8%
(G3) EIP waiting times - MHSDS	60%	45.8%	62.5%	55.4%	54.0%	66.2%	60.0%	64.6%	67.4%	70.0%	75.0%	66.7%	66.1%	79.2%
(H0) IAPT 6 week waits (monthly)	75%	87%	91%	93%	94%	94%	97%	94%	91%	93%	95%	90%	81%	71%
(H1) IAPT 18 week waits (monthly)	95%	100%	100%	100%	100%	99%	100%	100%	100%	100%	100%	100%	100%	99%
(H2) IAPT 1st to 2nd treatment >90 days (monthly) - system level indicator	10%	3%	4%	5%	6%	7%	6%	5%	9%	9%	12%	12%	9%	no data
(H4) IAPT access - all (monthly) - system level indicator	N/A	1,000	875	1,055	850	890	945	945	580	635	610	585	705	600
(H7) IAPT recovery rate - all (monthly)	50%	45%	45%	49%	45%	49%	46%	46%	49%	49%	50%	54%	51%	54%
(I1) Individual placement and support (cumulative year end target)	798	250	280	305	315	350	370	380	95	120	150	180	210	235
(K1) Percentage of inappropriate OAP days in period that are external	N/A	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
(K2) Number of inappropriate OAP days over the period - rolling 3 months	N/A	1,380	1,370	1,435	1,570	1,695	1,530	1,465	1,375	1,405	1,150	1,405	1,580	1,465
(L1) Perinatal access - rolling 12 months	N/A	365	365	370	365	380	390	405	385	365	430	420	470	480
(L2) Perinatal access - year to date	N/A	255	275	295	315	340	370	405	115	175	210	250	290	325
(N4) Data Quality - DQMI score	90%	96%	96%	96%	96%	96%	96%	96%	92%	92%	92%	96%	98%	no data

(Data source: https://future.nhs.uk/MHRH/view?objectID=26390480)

Recovery action plans are in place for the measures which are not currently achieving the required standard and progress against plans is being monitored by the Joined Up Care Derbyshire Mental Health Delivery Board. Below is a more detailed summary of the measures for which the Trust is directly responsible:

B1. Discharges followed up within 72 hours

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.

Primary drivers/ change ideas/ rationales

- Prevention of harm
- Supportive discharge
- Further training on SystmOne

Key actions

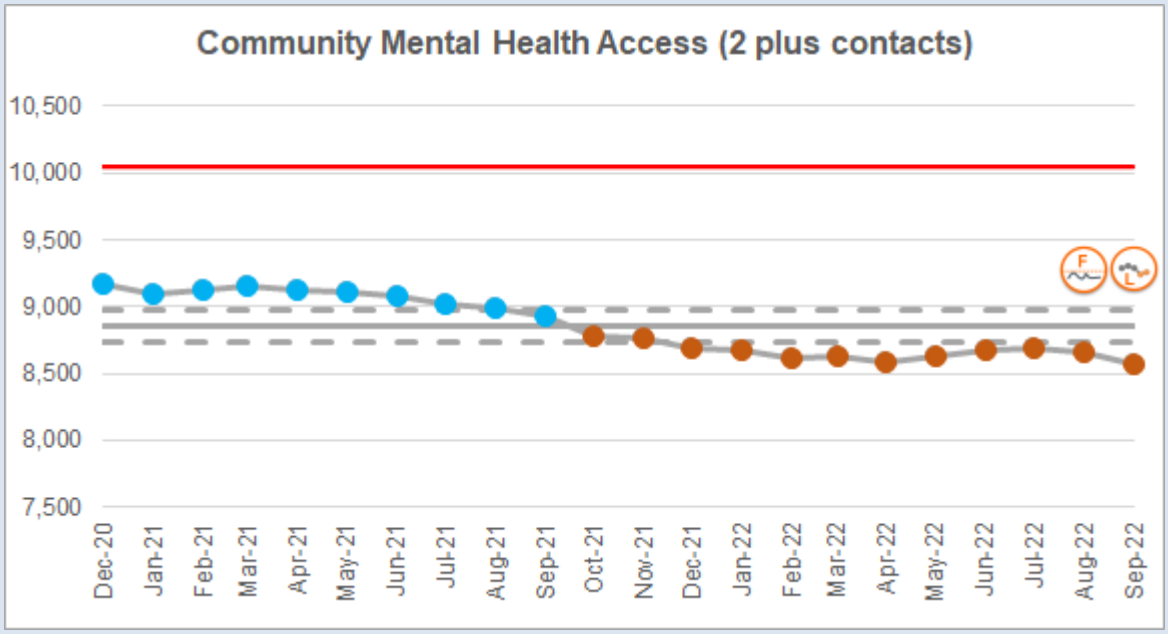
Description	Anticipated Benefit/ Outcome	Target	Completion Date
Regular audit of follow-ups to ensure improved accuracy of reporting	The true position to be reflected in the national data	Weekly review and feedback by Performance Analyst	Ongoing
Completion of breach reports for any follow-ups that were not achieved	Learning from breaches	Actual breaches kept to a minimum	Ongoing

Progress and/or barriers to progress

- 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.

D1. Community mental health access 2 plus contacts

Performance summary



The Trust has been 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 is an increase of 14% on current performance. A recovery action plan is in place, from which the key drivers and actions are summarised below.

Primary drivers/ change ideas/ rationales

- Reporting
- Delivery of community mental health framework
- Workforce
- Reduction in defaulted appointments
- SystmOne data
- Increase capacity in Living Well teams
- Model of care based on inclusivity
- Shortage of skilled workforce
- Staff retention
- Model of contact delivery
- Trust and patient expectations

Key actions

Description	Anticipated Benefit/ Outcome	Target	Completion Date
Roll out of Living Well	Improved flow of patients/ reduced waits	Reduction in waiting lists to meet the 4-week target for referral to treatment	31/3/2024
Review of the CPA policy to Care Principles & CPA	Reduction in admin time, releasing more time to care	Reduction in waiting lists. People being able to access the appropriate level of intervention at the point they need it	30/6/2023
Proactive recruitment and review of skill mix, creating new roles and development opportunities e.g., Nurse Associate, MH Practitioner (open to social workers and OTs), Band 5 to 6 development roles.	To bring a different skill set to facilitate multidisciplinary team working and address the nursing shortage	Reduction in turnover and vacancies	30/6/2023

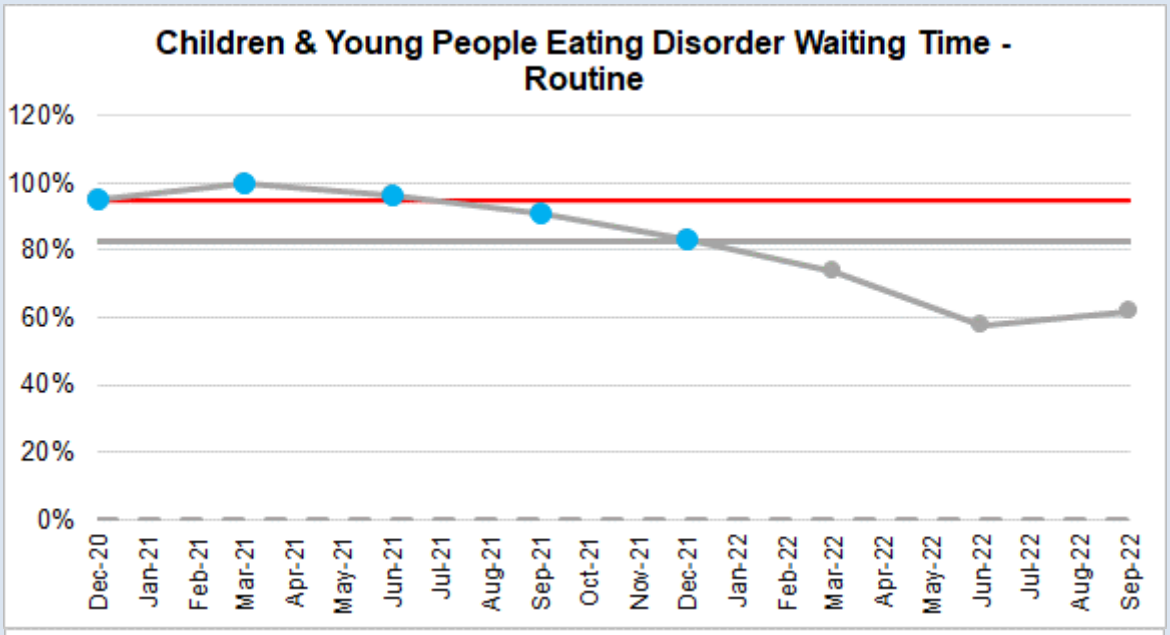
Progress and/or barriers to progress

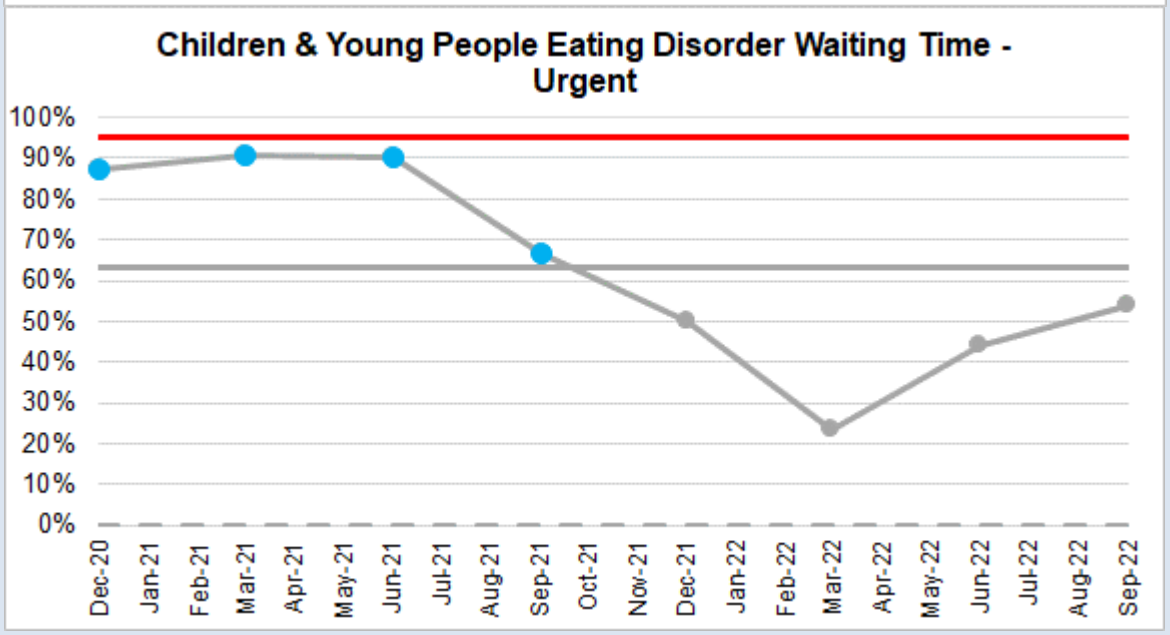
- The division is currently being supported by Faye Rice and Lee Doyle, Managing Directors, to undertake process mapping with the aim of increasing efficiency
- A prototype of Living Well is in place in Derby City, which is taking cases from the waiting list

- Activity completed by duty workers is no longer counted owing to the way SystmOne works, but would have counted when the target was set, as it was based on 2019/20 activity. This aspect is currently under review.
- Ongoing work around data cleansing for unreconciled appointments and data quality – ensuring that contacts are recorded correctly.

E4 & E5. Children and young people eating disorder waiting times

Performance summary





These standards focus on effective treatment at the earliest opportunity in order to improve outcomes, reduce rates of relapse and need for admission. 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%). A recovery action plan is in place which is being led by the Integrated Care System, as this service is delivered by two providers within the system who are experiencing similar issues. The key actions within the plan that are being taken, with an aim to achieving the objective by the end of March 2023, are summarised below.

Primary drivers/ change ideas/ rationales	
• Accurate reporting • Recruitment	• Data quality improvement • Increased capacity to see children more quickly

Key actions from the Integrated Care System Recovery Action Plan

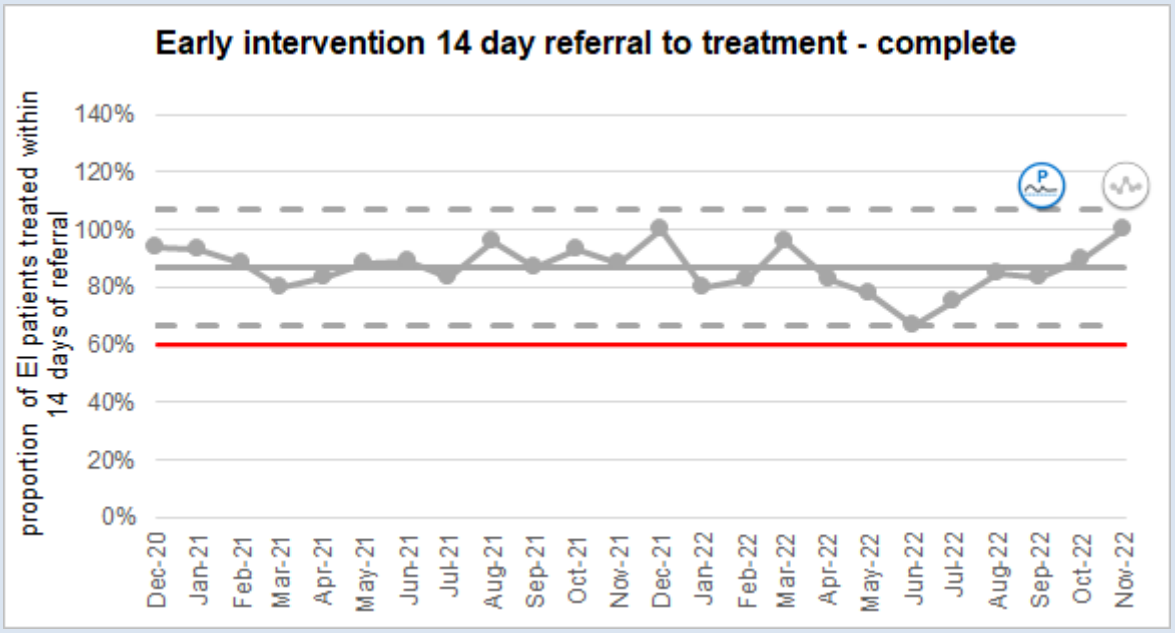
Description	Anticipated Benefit/ Outcome	Target	Completion Date
Development and implementation of recruitment strategy	Increased capacity within the teams supporting implementation of a new, more efficient approach to routine assessments	To achieve the 95% standards	31 March 2022
Improved accuracy of recording	Data will reflect actual waits	Design and implementation of a new 'Initial Contact' template on SystmOne that supports clearer, timely coding practice	Qtr 2 2022/23
Design and delivery of Derbyshire Avoidant Restrictive Food Intake Disorder pathway	Better, more efficient flow of referrals within the system; better coordination between teams; complex, multi-factor cases treated by teams most concordant with need		February 2023

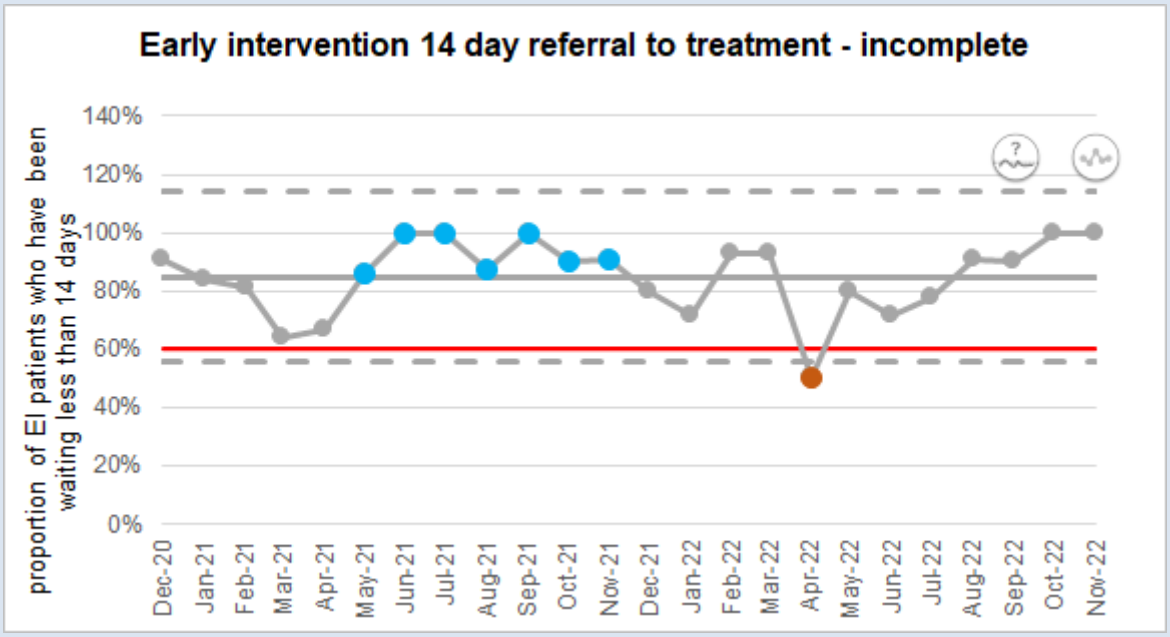
Progress and/or barriers to progress

- Accuracy of recording has improved but as the national measure is the rolling 12 months' position it will take some time to be reflected in the reported position
- An increased number of acutely unwell and urgent cases has necessitated prioritisation of urgent referrals which had a subsequent impact on routine referral wait times.
- Further exploration/analysis of capacity and demand is needed to better understand this complex issue. The aim is to outline what can realistically be expected to achieve with a full staff complement, given the rise in referrals, and what further is needed longer term in order to meet the access and wait time standards on an ongoing basis

G3. Early intervention in psychosis waiting times

Performance summary

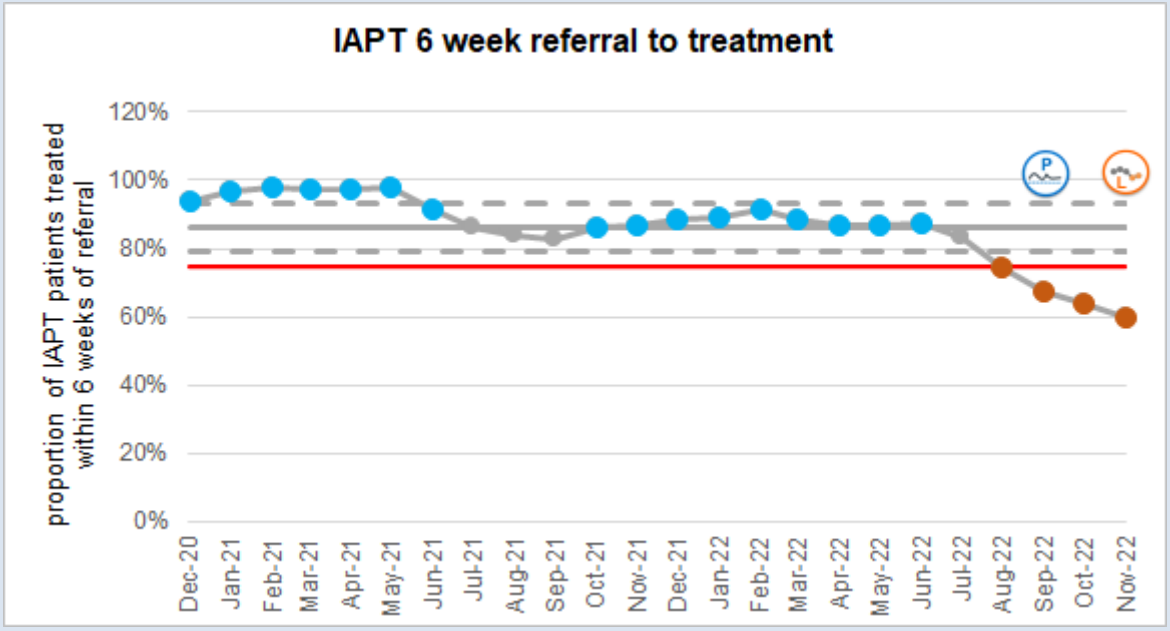




Patients with early onset psychosis are continuing to receive very timely access to the treatment they need. Occasionally delays result from difficulties contacting patients to arrange appointments, or patients not attending their planned appointments. The service is generally very responsive and has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

H0. Improving access to psychological therapies (IAPT) 6 week waits (monthly)

Performance summary



Wait times have been increasing since the summer, both for referral to treatment and then first to second treatments. For the above graph, the main impact for the 6-week referral to treatment increase in waits has been partly due to vacancies in our Step 2 team who do most of the assessments. As there is a clear career progression from Step 2 to Step 3, via funded high intensity training we tend to lose Psychological Wellbeing Practitioners (PWPs) when the University courses start in September and March. In previous years we have managed to maintain our staffing through a combination of qualifying trainees and recruitment, however Step 2 qualified clinicians are harder to recruit more recently. With longer wait lists from first to second treatment, PWPs have had the added pressure of booking in waiting well checks which also reduces their capacity to undertake assessments and Step 2 treatments.

Primary drivers/ change ideas/ rationales

- Longer wait lists reduce patient satisfaction, can increase risk, and increase treatment length.
- Longer wait times can decrease recovery rates and increase complaints and incidents.

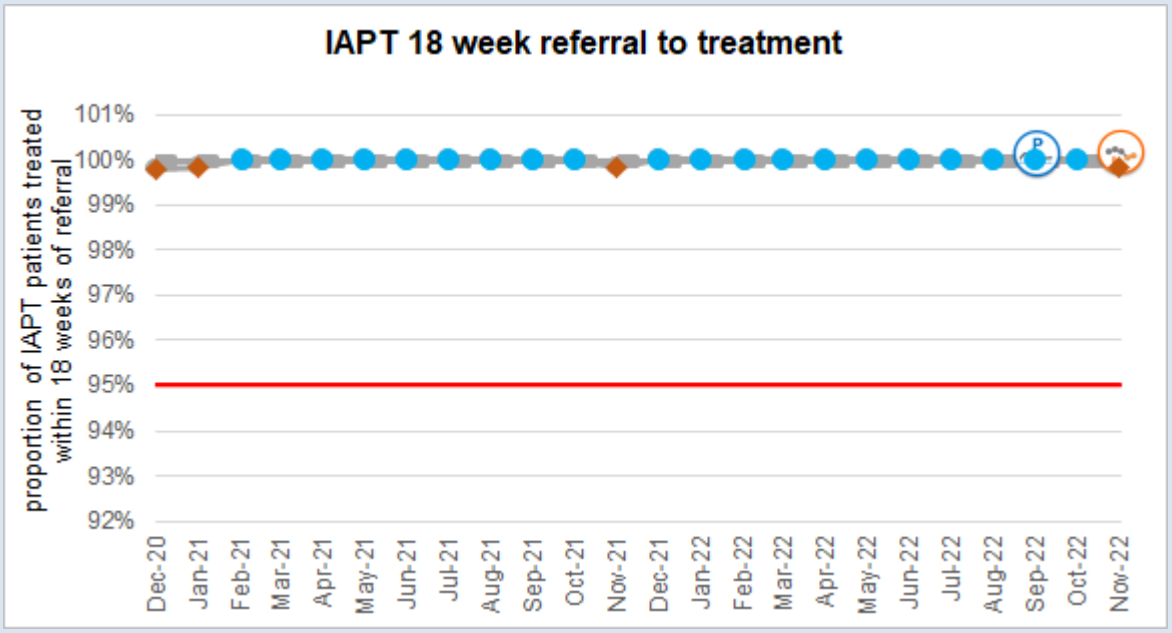
Key actions

Description	Anticipated Benefit/ Outcome	Target	Completion Date
Recruitment to the qualified PWP posts, complete the training of the 3 new PWP trainees, and revisit the use of agency staff as an interim measure.	Increased capacity	To be fully recruited, recruitment to re-commence Jan 2023 for the remaining establishment numbers	End Feb 2023
A booking clerk is in post to book short notice appointments into cancelled slots	To improve efficiency and reduce wait times.	To reduce wasted appointment slots to a minimum	Ongoing as the assessments are booked in with Step 2 and Step 3 staff.
To pilot an elective recovery module from NHS England and NHS Improvement to support waiting list improvements	Reduced waits.	To skill up the team to optimise waiting list management	End Feb 2023

Progress and/or barriers to progress
At the planning day on 12 December a range of options were considered for improving the wait times from referral to assessment. In addition to the ones above further avenues to explore are: • Exploring the funded addition with IAPTuS of bookable slots • Considering how assessments are structured and possible reductions in assessment times. • Possible screening tools and/ or assistive technology to support better information at referral. • Publishing average wait times on the Trust website. • Considering recruitment of PWPs via the apprentice route if unable to fill advertised vacancies

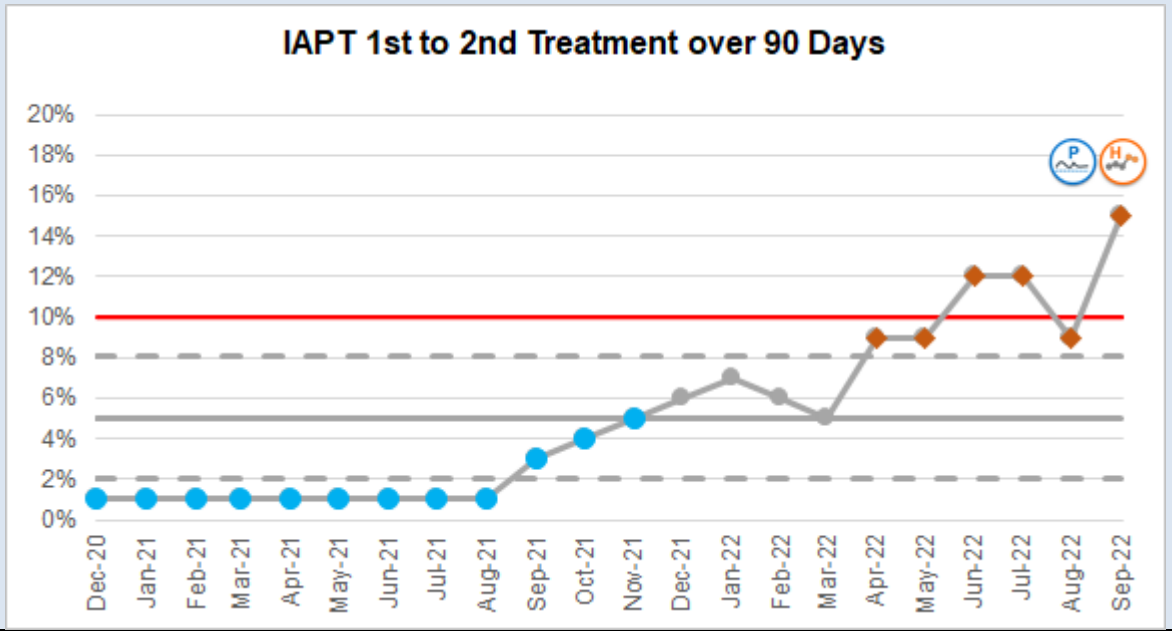
H1. IAPT 18 week waits (monthly)

Performance summary



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

H2. IAPT 1st to 2nd treatment >90 days (monthly)



Primary drivers/ change ideas/ rationales

- Longer wait lists reduce patient satisfaction, can increase risk, and increase treatment length.
- Longer wait times can decrease recovery rates and increase complaints and incidents.

Key actions

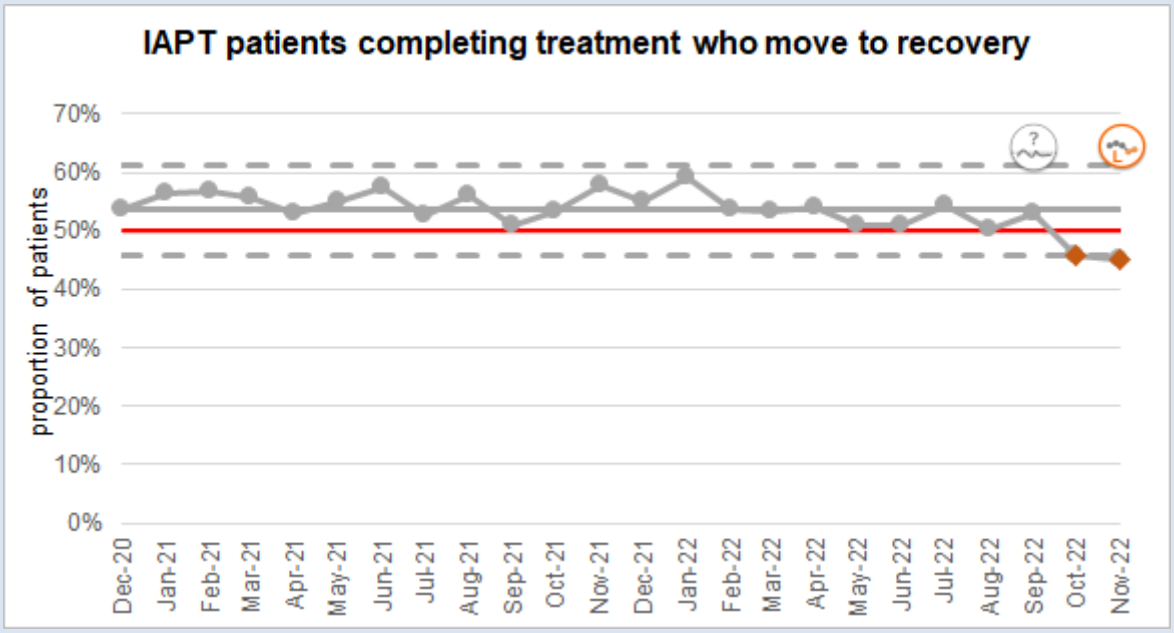
Description	Anticipated Benefit/ Outcome	Target	Completion Date
Reduce wait times from assessment/ treatment to second treatment. Consolidate the wait lists.	Reduction in wait times and ratification that wait lists are accurate.	Clarification amongst longer waiters that they wish to continue on wait lists/ haven't been treated by another provider.	Rolling monthly geographically so as not to overwhelm admin.
Review productivity and average contacts to increase treatments and reduce wait times.	Increase in discharges each month reducing wait times longer term.	Reduction in average contacts per treatment episode across the service to pre pandemic levels.	Introduction of clinician scorecard and clinician portals to increase staff engagement in improving wait times.
Introduction of supportive technology either at referral or to support treatment. Introduce bookable appointments increasing available treatment slots.	Reduction in average contacts per treatment.	Look into assistive technology to support decision making at assessment and better inform treatment. Introduce bookable appointments which aims to reduce DNAs and increase available treatment slots.	By end of March 2023

Progress and/or barriers to progress

At the planning day on 12 December wait lists were discussed. Various initiatives have been proposed. These included: wait list consolidation which has previously been successful; concentration on the longest waiters and monitoring of outliers more closely; broadening of the group offer; introduction of technology; spot purchasing of assessments and treatments via a 3rd party; and online bookable appointments.

H7. IAPT recovery rate - all (monthly)

Performance summary



This is an annual target and year to date we are exceeding target. Up until the last 2 months the national standard has been achieved in month also. The dip in performance may be as an unintended consequence of implementing waiting list waiting well checks which include taking measures. We have amended this but the positive effects of this may not take effect immediately.

Primary drivers/ change ideas/ rationales

- Long waiting lists
- Acceptance criteria
- Recovery rates declining
- Productivity
- Referral process may not support assessment waits
- Introduction of new technology
- Need for consistent definition of acceptance criteria
- Review of appointments and booking

Key actions

Description	Anticipated Benefit/ Outcome	Target	Completion Date
Planning day conducted 12 December 2022	Driver Diagram addressing areas for concentration.	To identify areas and to complete and circulate.	End December 2022
Clarification and communication of referral criteria, for clinicians/ referrers and service users.	Clarification over severity/ complexity with decision trees and further staff assessment training for consistency of assessments.	To have a consistent approach to assessment and information on our website for self-referral.	End Feb 2023
Focus on productivity to reduce wait times and inform clinicians clearly of their own performance.	Reduction in waits has a positive influence on outcomes, staff engaged in their own performance supports accountability and improved outcomes	Utilise clinician scorecards and/ or IAPTuS clinical portal for up-to-date information on performance. Wait list management and improvement initiatives incorporated into a driver diagram.	End of Feb 2023

Progress and/or barriers to progress

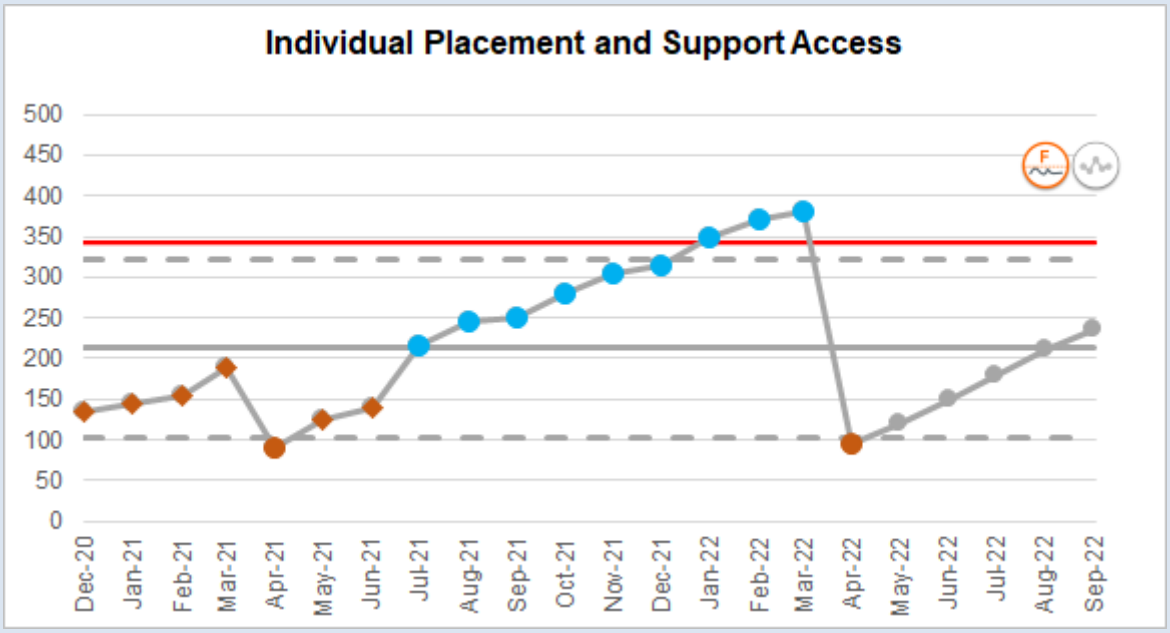
- The Planning Day including the management team took place on 12 December 2022 and used information from a staff survey and feedback requested at the service Away Day 2

weeks prior. From this a driver diagram has been created and working groups will be set up to explore the different initiatives.

- A Clinical Reference Group will be set up to oversee the clinical elements of improvement with clinicians from across the service in both step 2 and step 3.

I1. Individual placement and support

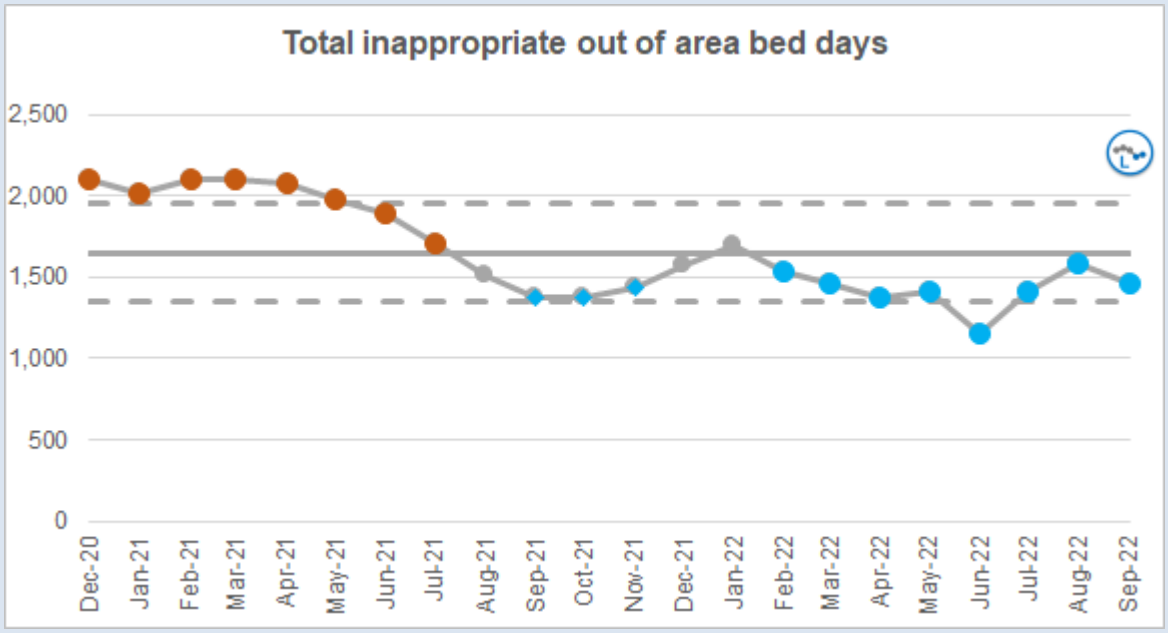
Performance summary



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 on target to be achieved this financial year also.

K2. Total number of inappropriate OAP days over the period - rolling 3 months

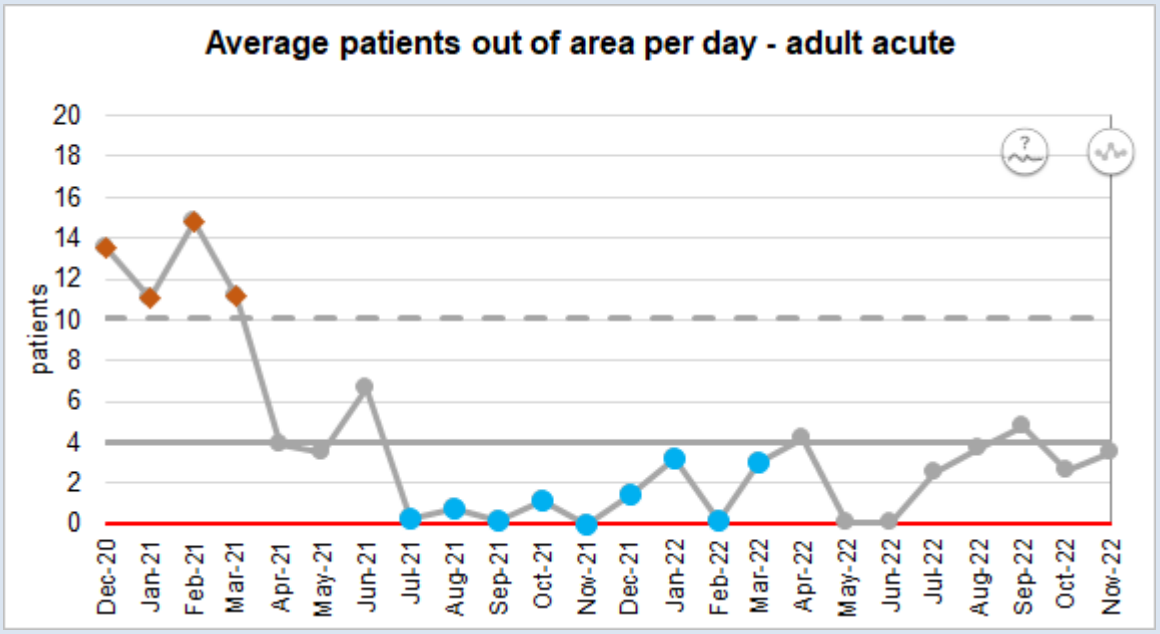
Performance summary

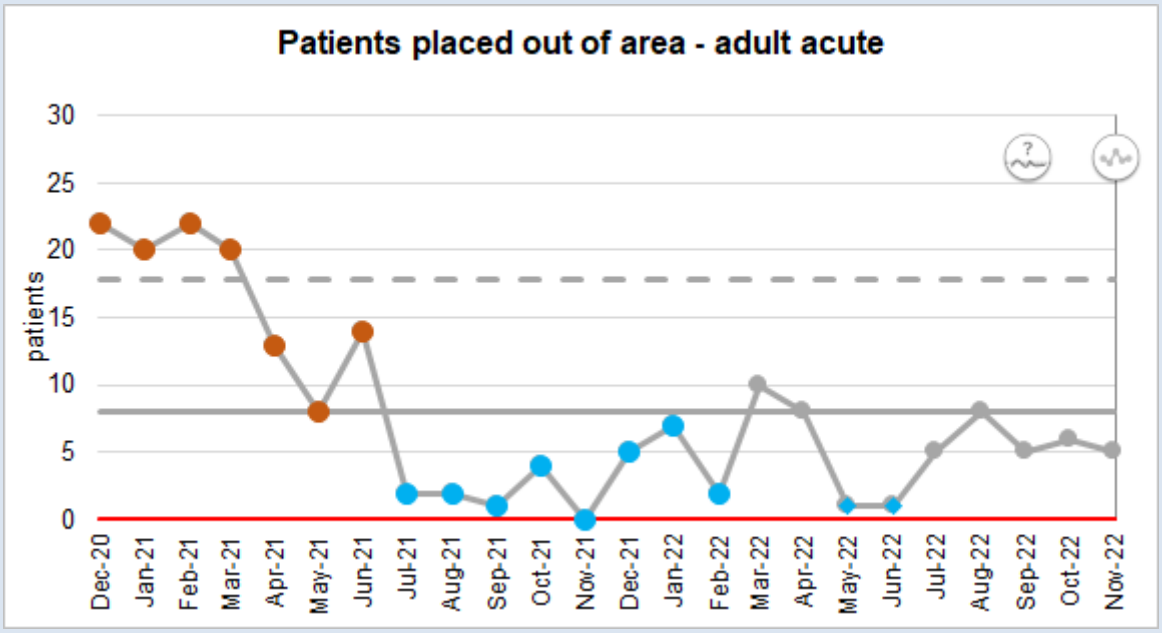


This is a combination of inappropriate out of area adult acute placements and inappropriate out of area psychiatric intensive care unit placements. The actions being taking to improve the position of each placement type are detailed below.

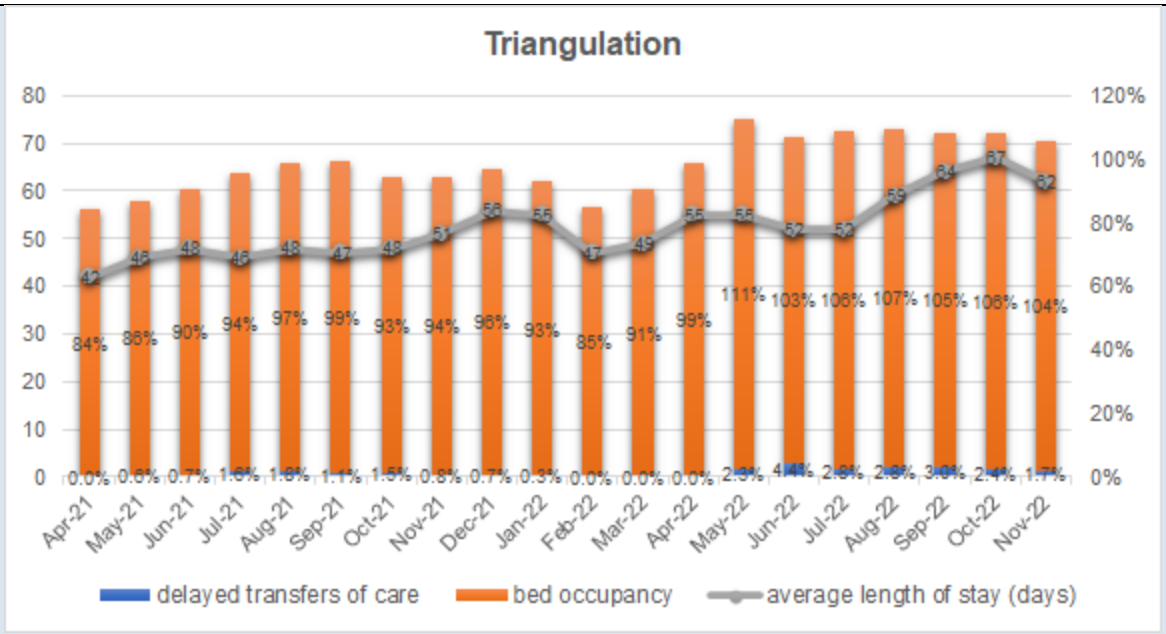
K2.1. Inappropriate adult acute out of area placements

Performance summary





The increase in patients with Covid-19 impacted on capacity as expected, and so currently there are 6 patients placed in Mill Lodge and 1 patient in an inappropriate out of area placement. This patient is on a pathway to be repatriated into a Derbyshire bed, however at the moment repatriation is not possible owing to pressures elsewhere. University Hospitals of Derby & Burton and Chesterfield Royal Hospital are both continuing to declare critical incidents and overall the Derbyshire system is under increased pressure. Therefore, any requests received from these organisations for beds are our highest priority to ensure system flow.



The level of inappropriate out of area acute placements continues to be impacted upon by persistently high levels of bed occupancy, delayed transfers of care and above average length of stay. In recent months there has been an increase in delayed transfers of care, and bed occupancy has exceeded 100% for the last 7 months: this is where patients have returned home for a period of trial home leave and their beds have been occupied by new admissions in the meantime. From queueing theory, to enable flow of patients through the system the Trust's adult acute bed occupancy level should not exceed 85% (the Erlang equation)[1]. The ultimate goal is 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.

Primary drivers/ change ideas/ rationales

- Create capacity for admissions
- Enable flow through the system
- Optimise length of stay
- Reduce delayed transfers of care

Key actions

Description	Anticipated Benefit/ Outcome	Target	Completion Date
To establish an internal acute transformational delivery board	To bring together improvement and transformation workstreams to enable further improvements in flow	To oversee the implementation of changes	To commence Nov 2022
Reduction in people clinically ready for discharge.	To generate improved flow and admission capacity	Below 10% (15 patients)	Ongoing
Reduction in length of stay	To generate improved flow and admission capacity	31 days	31/03/23

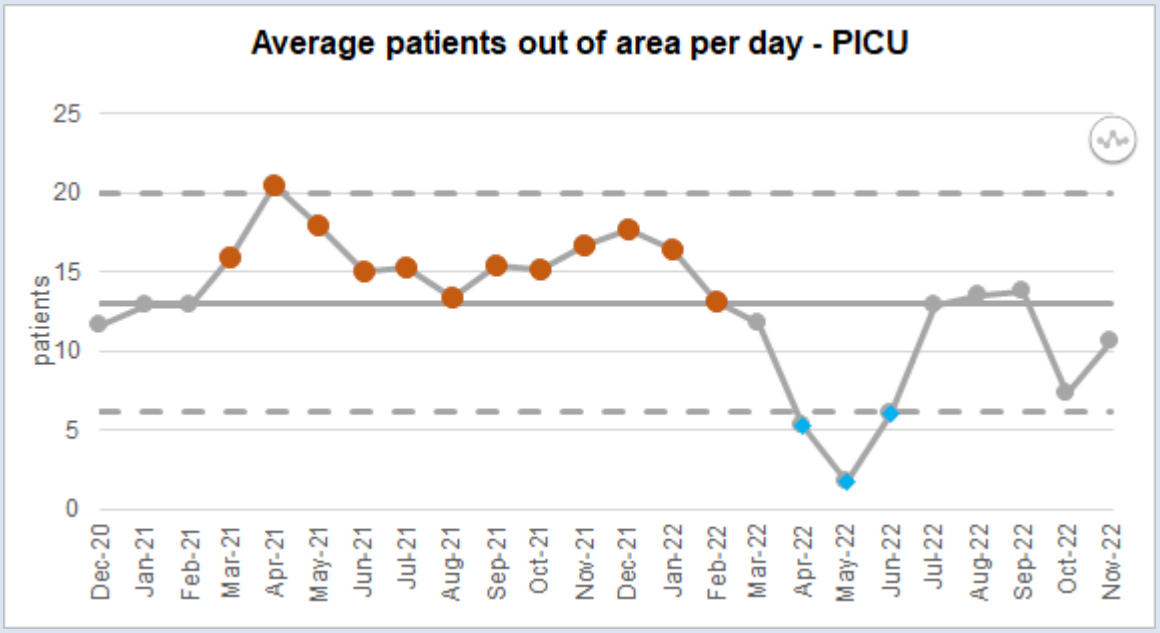
Progress and/or barriers to progress

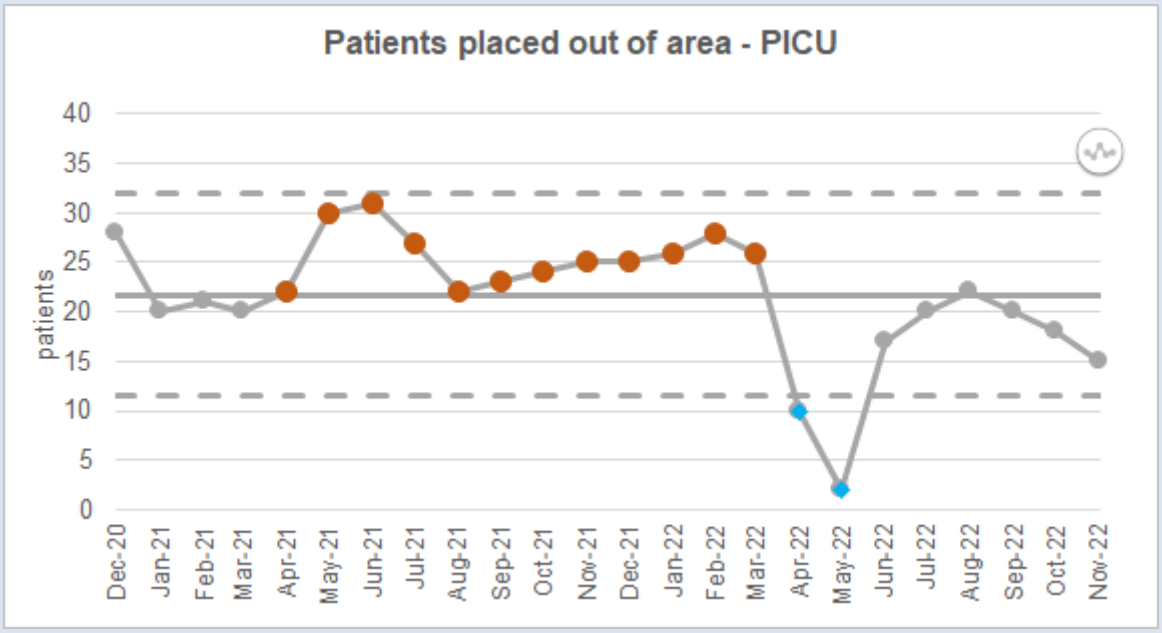
- The Acute Transformational Delivery Board has been established

[1] Jones R (2013) Optimum bed occupancy in psychiatric hospitals. Psychiatry On-line http://www.priory.com/psychiatry/psychiatric_beds.htm

K2.2. Patients placed out of area in Psychiatric Intensive Care Units (PICU)

Performance 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.

Primary drivers/ change ideas/ rationales

- Provision of a PICU in Derbyshire
- Repatriation from PICU placements into Trust acute beds when appropriate to do so

Key actions

Description	Anticipated Benefit/ Outcome	Target	Completion Date
Provision of a PICU in Derbyshire	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	0 out of area PICU placements	2024
To generate improved flow and	Capacity to repatriate PICU patients when appropriate to do so.	Reduction in PICU length of	March 2023

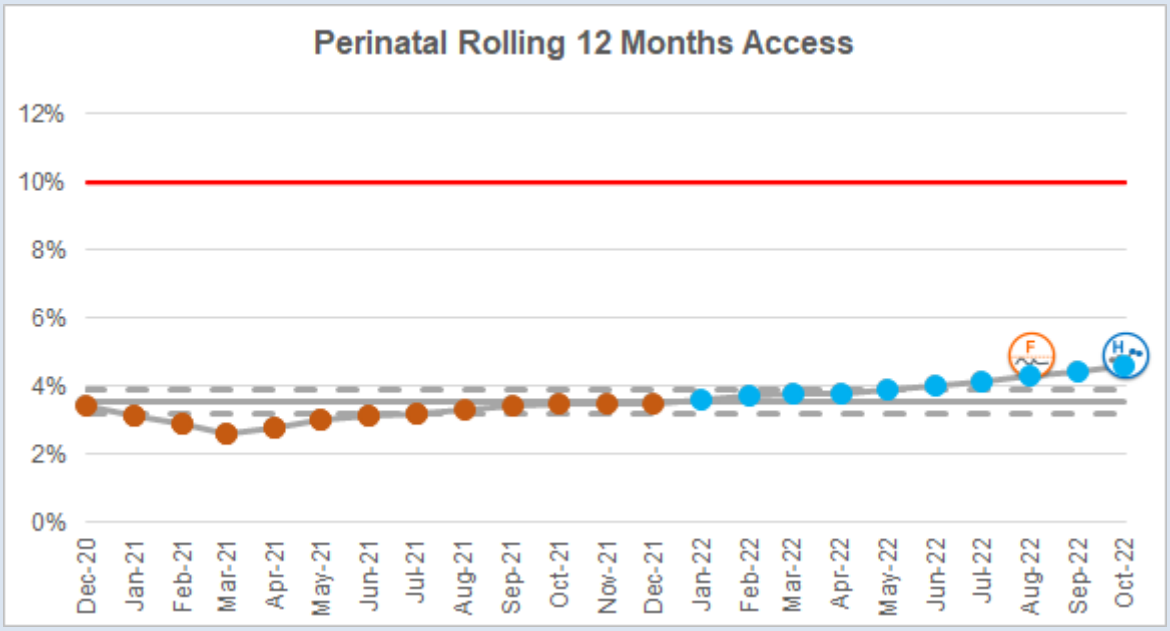
admission capacity in adult acute inpatients, working closely with community teams	Reduction in requirement for psychiatric intensive care.	stay and bed days	

Progress and/or barriers to progress

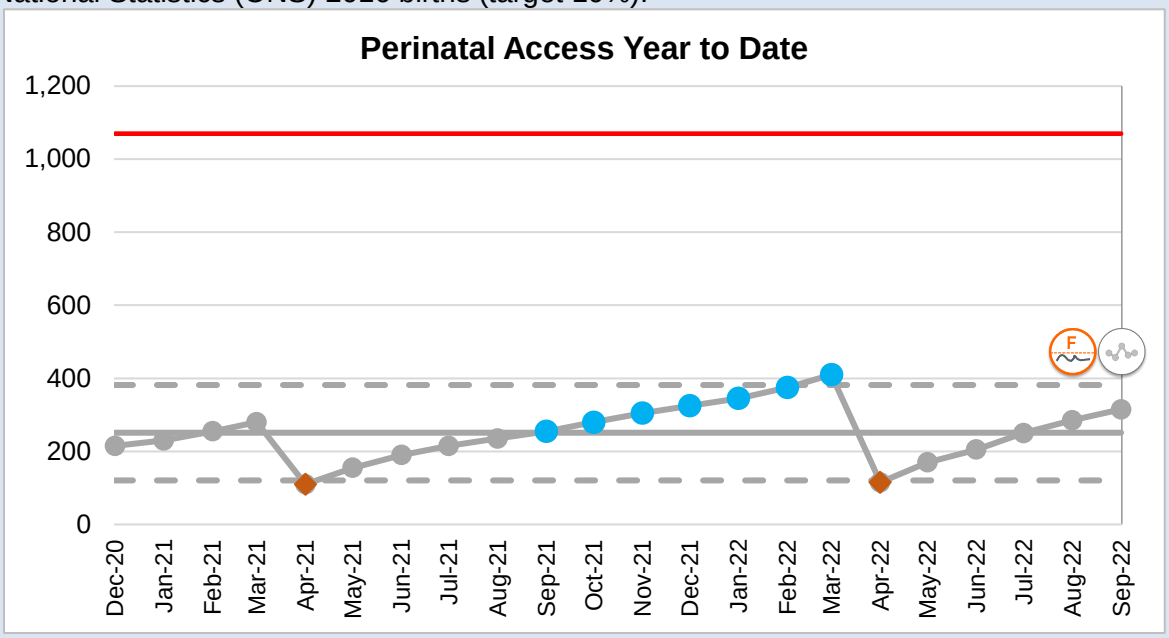
- Building works are progressing – see: https://www.derbyshirehealthcareft.nhs.uk/services/service-developments/refurbishment-project/latest-news-and-updates

L1. L2. Perinatal access

Performance summary



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



Primary drivers/ change ideas/ rationales

• Reduce defaulted appointments (DNAs) • Increase capacity for assessments • Increase number of referrals	• Reminder processes • More staff trained to complete assessments • Reduced length of assessment

• Improve recording of initial assessments	• Hard to reach groups/ Foston prison/ self-referrals/ reduce incomplete referrals • Internal reporting/ SystmOne data

Key actions

Description	Anticipated Benefit/ Outcome	Target	Completion Date
Verify and improve recording of assessments on SystmOne, working with Information Management and the training team	To aid monitoring of performance against target	Ensure consistency of recording of assessments	November 2022
Increase capacity to undertake assessments within the current teams and consider the impact of further recruitment later in the year	Reduced waits and increased access to the service	To increase access to 90 contacts per month by end of March 2023	November 2022
Increase referrals: • Increase in assessments from maternal mental health services • Target particular areas where referrals are lower than expected, such as Derby City and High Peak.	The expansion of Psychology into quarter 4 working with Birth trauma, Tokophobia (fear of childbirth) should significantly increase referrals and assessments	To increase access to 90 contacts per month by end of March 2023	November 2022

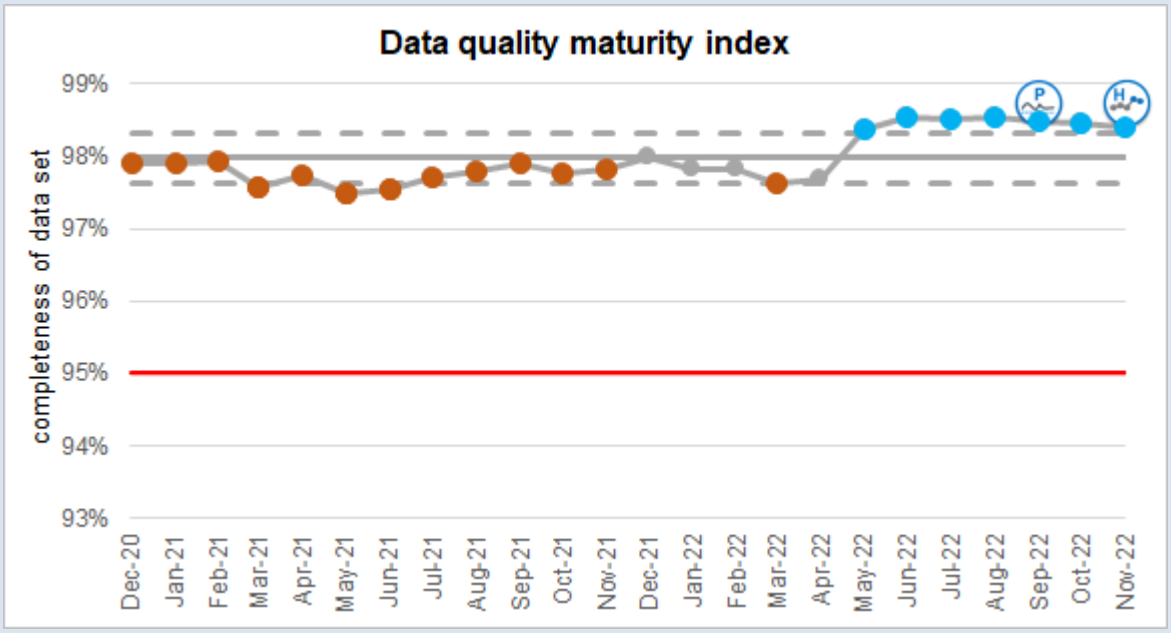
Progress and/or barriers to progress

- The Trust Quality Improvement team have been engaged to monitor progress against trajectories and the step changes that were expected into October and up to quarter 4 of 2022/23
- Monthly operational meetings to discuss progress amongst Perinatal Teams, and to consider further actions
- Quarterly updates shared by Managing Director to Delivery Board. Targeted delivery from 31st March 2023
- 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 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	

N4. Data quality maturity index

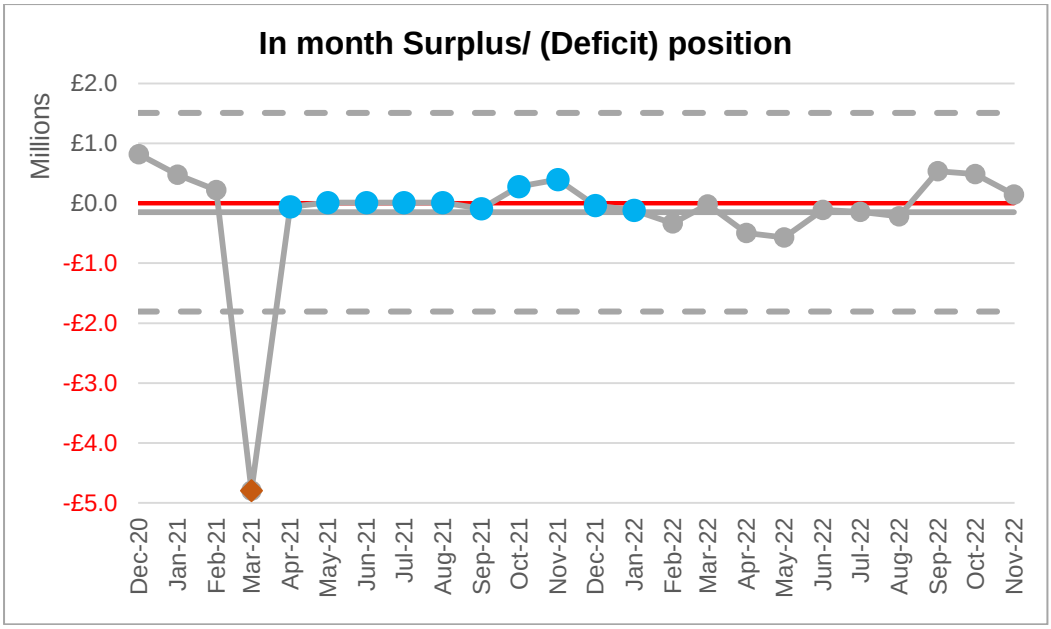
Performance summary



The level of data quality has been significantly better than expected for the last 7 months. It is expected that the national target will be consistently exceed.

Finance

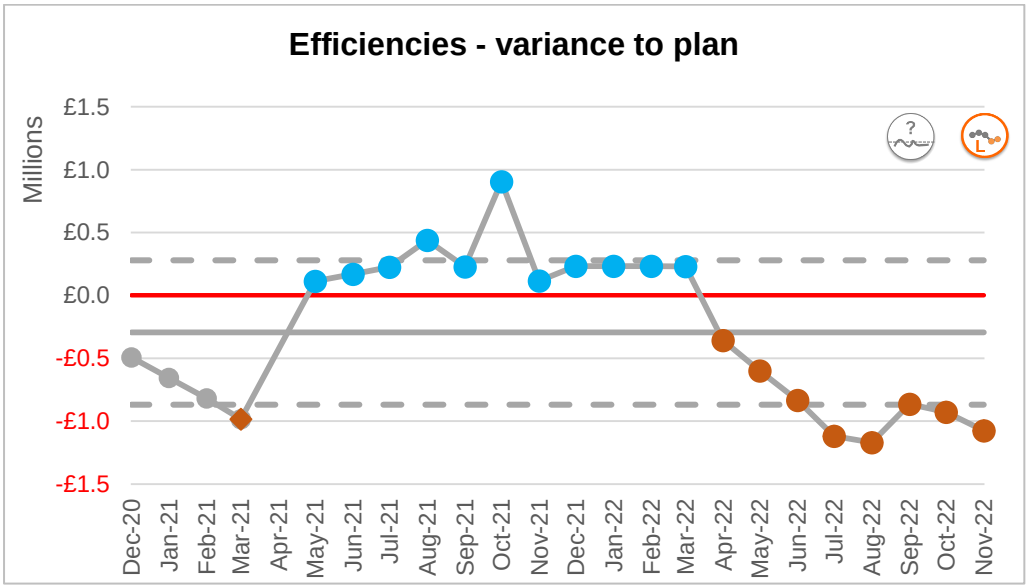
Overall Financial Position



At the end of November, the overall year to date (YTD) position is a deficit of £0.37m compared to the plan deficit of £1.04m, a favourable variance to plan of £0.67m. The forecast remains a breakeven position as per the plan.

However, there are significant areas of risk in and outside of that plan driven by the planning assumptions that have been followed, such as the delivery of the required 3% efficiencies, agency expenditure and reducing the risk around the containment of Covid costs, which are all shown below. Whilst the full requirement for efficiencies has now been identified the majority of the schemes are non-recurrent 68% and there is need to take action to ensure the costs are reduced to match the planned delivery.

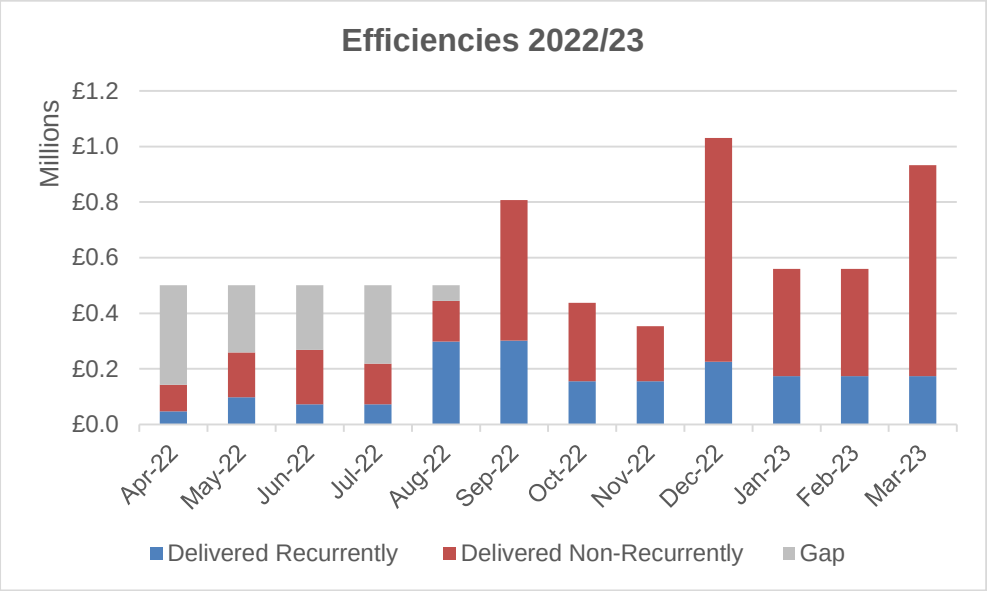
Efficiencies



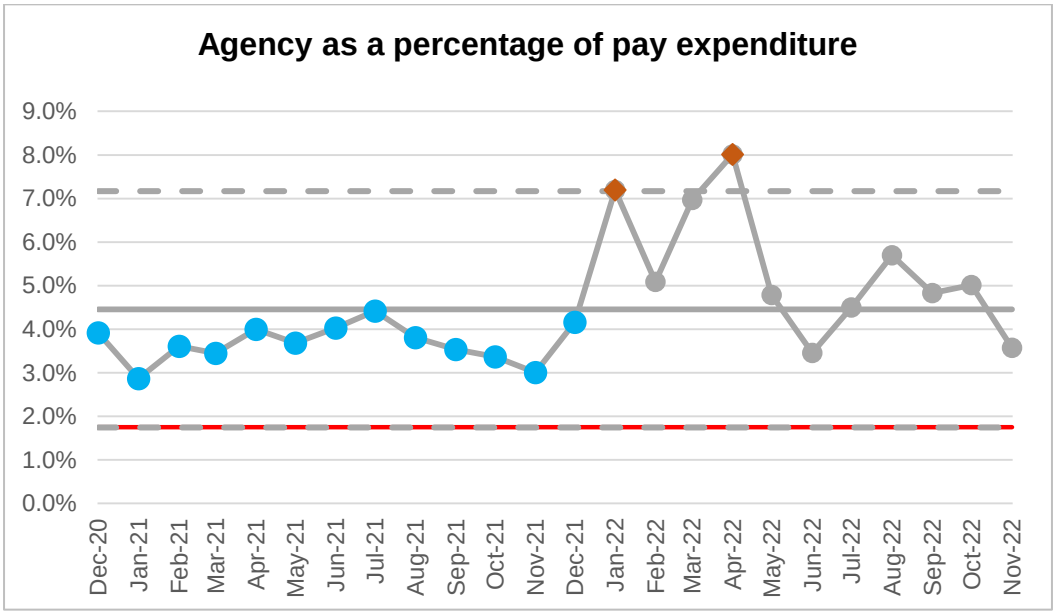
The full year plan includes an efficiency requirement of £6.0m phased equally across the financial year. At the end of November £2.9m had been transacted in the ledger leaving a

gap to delivery of £1.1m YTD. The remaining efficiency gap which is required to achieve the overall breakeven plan has now been achieved and full plans have been developed. However, a significant proportion of the efficiencies are non-recurrent in nature 68%.

The table below shows that the new schemes that have been identified will be transacted in the second half of the financial year.



Temporary Staffing

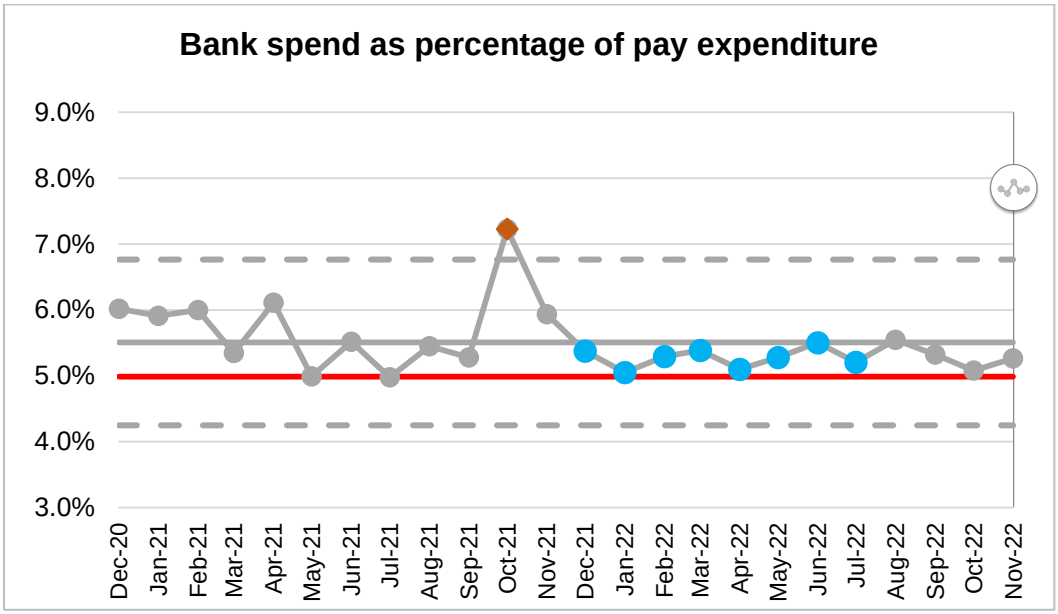


Agency expenditure year to date (YTD) totals £4.7m against a plan of £1.6m, an adverse variance to plan of £3.1m. The two highest areas of agency usage relate to Consultants mainly in CAMHS and Nursing staff on the wards. Agency expenditure for November was £0.4m.

Agency expenditure as a percentage of pay did reduce in September but that is driven by the increase in pay expenditure related to the backdated pay award being paid in September.

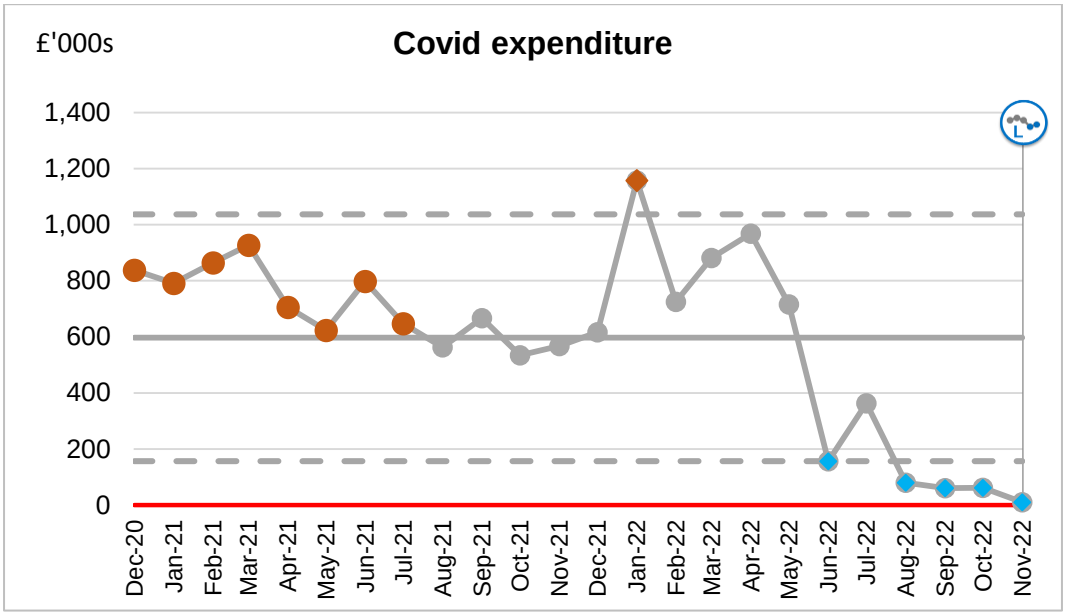
NHSE have confirmed that tighter agency controls will be introduced from September covering the following:

- establishing agency expenditure limits at system level with the JUCD limit confirmed at £22.462m
- reintroducing agency staffing performance and monitoring within the NHS Oversight Framework
- monitoring performance against existing requirements on agency shifts through on-framework providers and within national capped rates, allowing for existing 'break glass' rules
- implementing toolkits and resources to help systems and providers to better utilise substantive and bank staff.



Bank staff expenditure YTD totals £5.0m against a plan of £4.6m with average spend of £0.6 per month, except for October 2021 where that increased to £0.8m. The main areas of bank spend relates to Nursing on the wards along with Domestics.

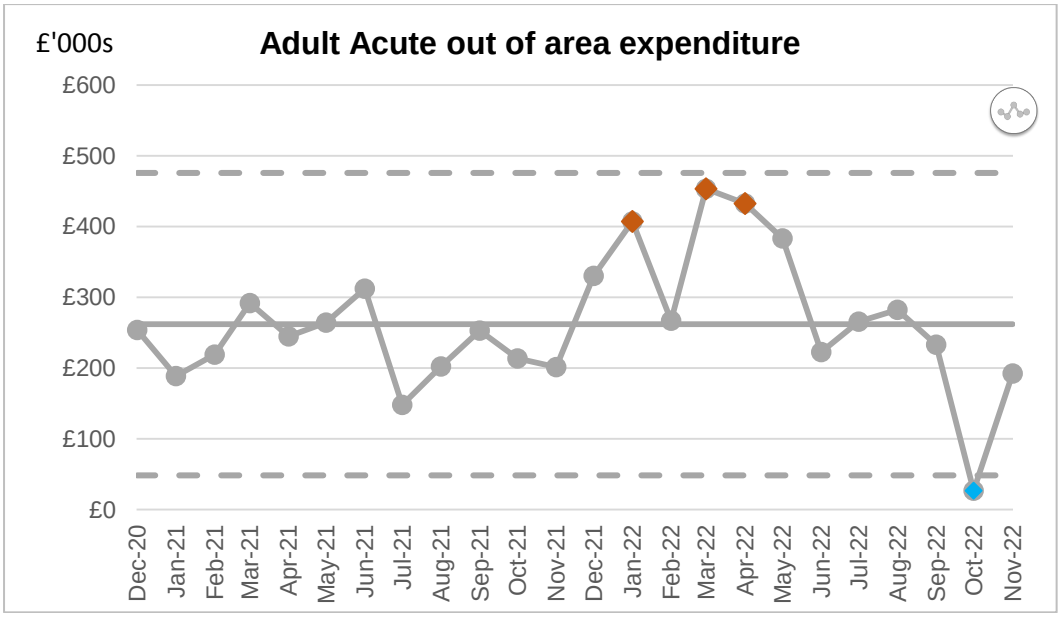
Covid Costs



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.

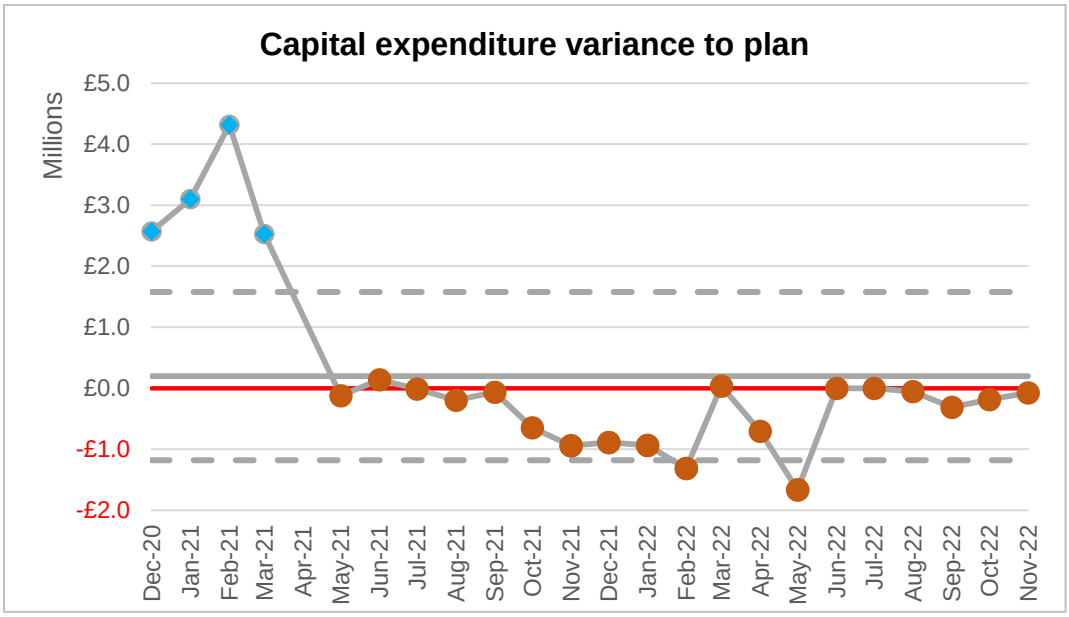
The above chart shows that expenditure has been reducing throughout this financial year with expenditure since August significantly lower than in previous months and November being the lowest at £10k.

Out of Area Placements



Expenditure for adult acute out of area placements including block purchased beds and cost per case beds has reduced compared to previous levels. YTD £2.0m has been spent on placements. The forecast assumes that there will be 9 out of area placements in December and 6 for the remainder of the year.

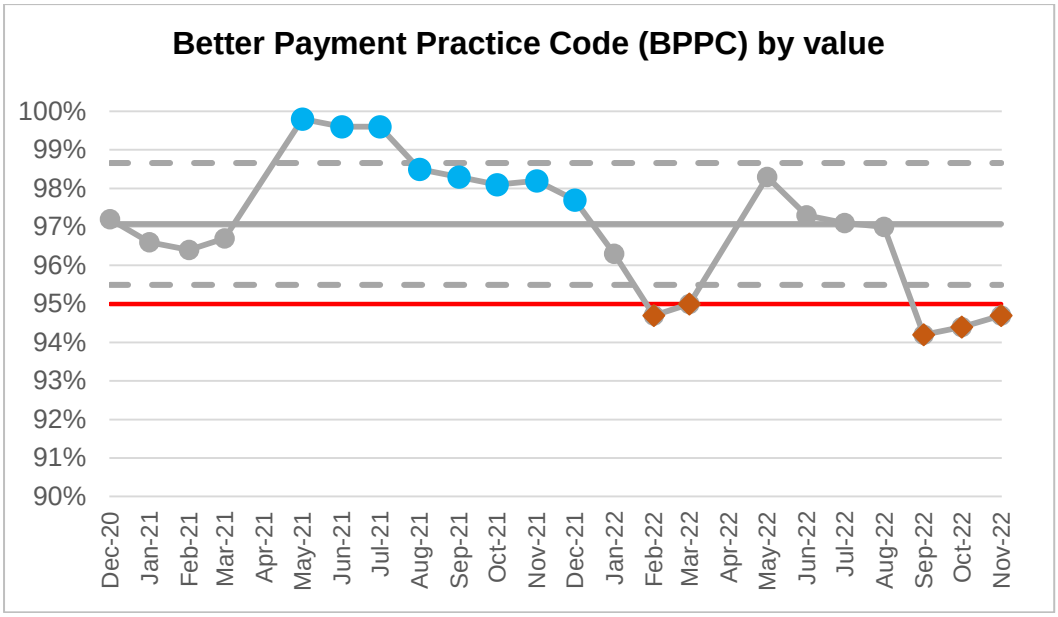
Capital Expenditure



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

Capital expenditure is slightly behind plan YTD but is forecast to achieve full planned spend by the end of the financial year.

Better Payment Practice Code (BPPC)

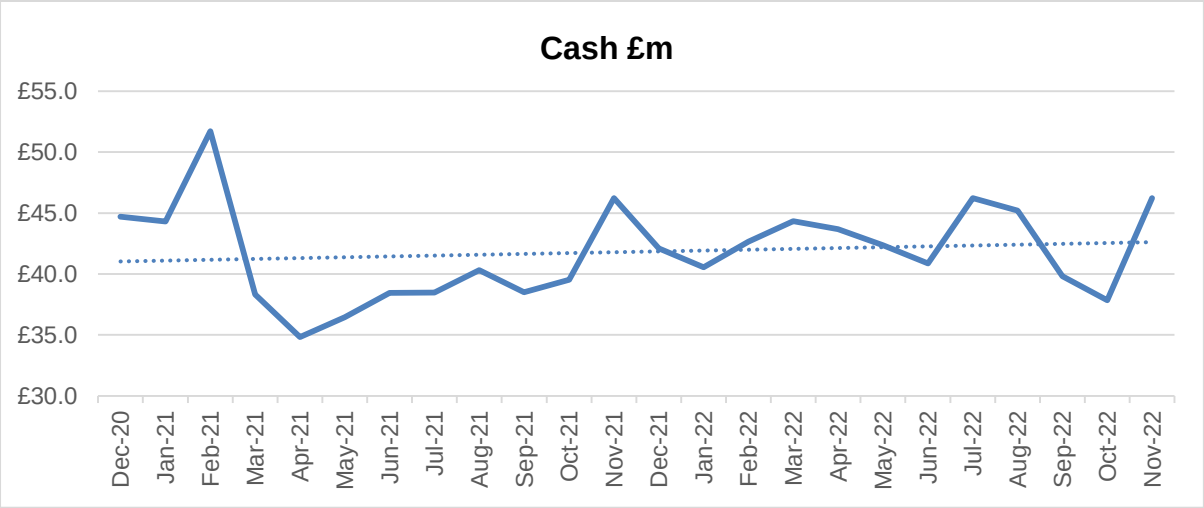


The Better Payment Practice Code sets a target for 95% of all invoices to be paid within 30 days. BPPC is measured across both invoice value and volume of invoices.
At the end of November by value 94.7% and volume 94.3% were both slightly below target.

Cash

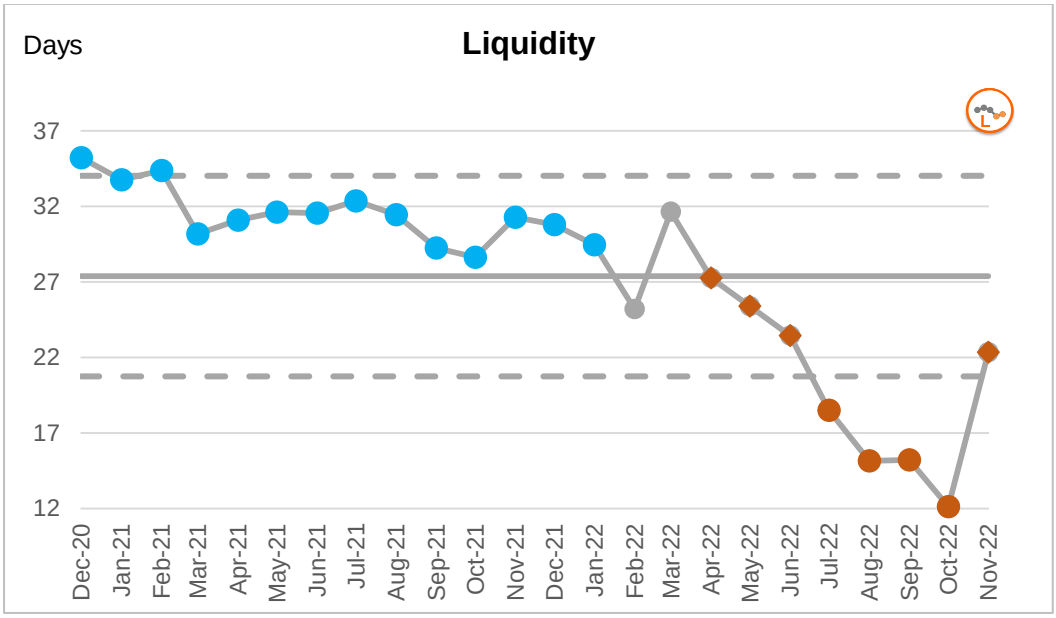
The chart below shows the levels of cash over the last two years. It is important to remember that in April 2020 CCGs paid the block contract amounts in advance, so 2 months were received in April 2020 and then no payment in March 2021 which brought the cash back down to the same level in March 2020. During 2021/22 cash slowly increased, however due to the deficits in each month since April 2022 this has driven the reduction in cash.

At the end of November cash is currently at £46m which is above plan by £25.5m. The cash forecast for the end of the financial year is £33m which reflects the use of cash reserves for the self-funded elements of the capital plan.



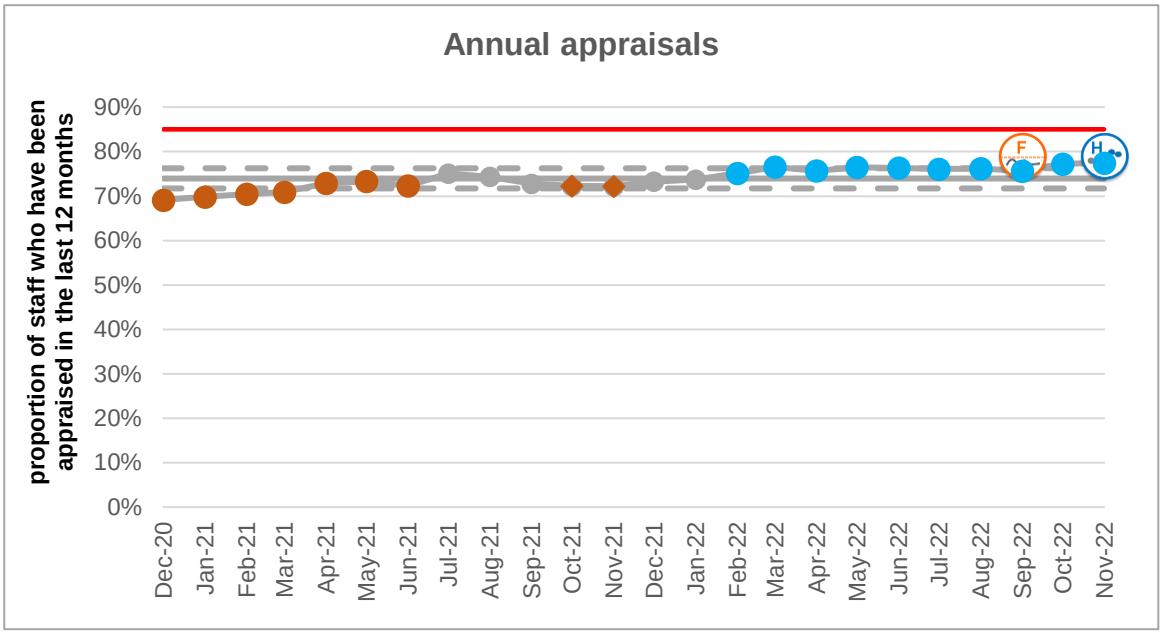
Liquidity

The chart below shows the liquidity levels over the last two years. Liquidity levels were high in 2020/21 and have started to reduce during 2021/22, which is due to two main factors, not making a surplus and the level of capital expenditure being above depreciation levels. The reason for the downturn in 2022/23 is due to the YTD deficit position and the timing of cash receipts related to the centrally funded capital schemes for the eradication of dorms. The PDC drawdown request for the early enabling works of £7.9m was processed but not receipted until 1st November and therefore shows an improvement from the prior month.



People

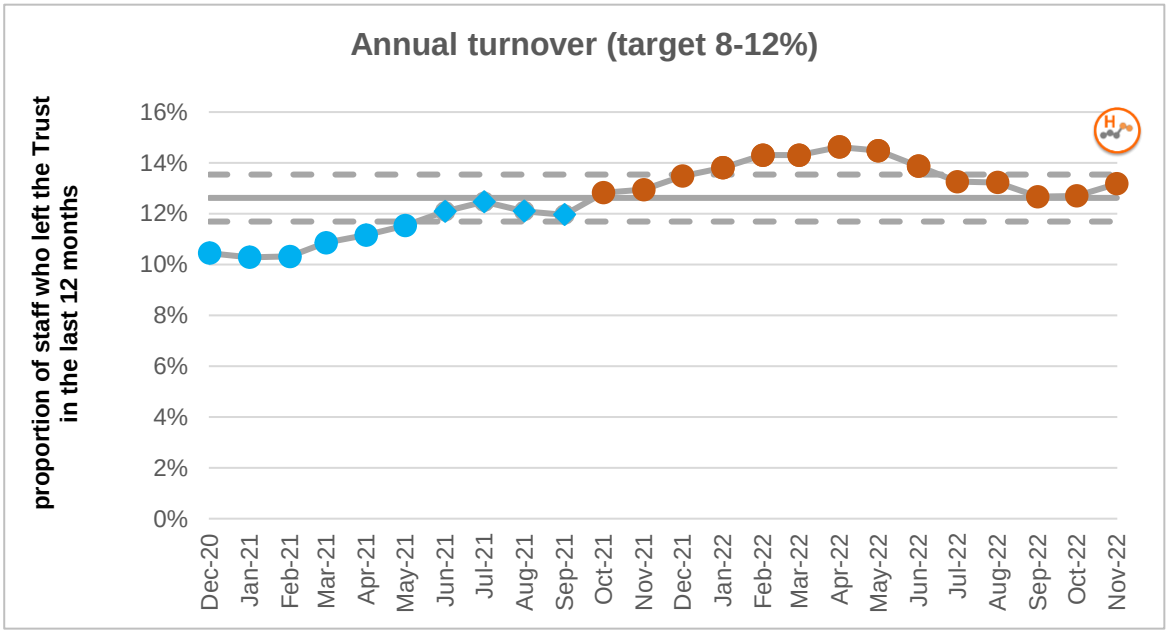
1. Annual appraisals



Appraisal levels continue to be below our expectations with Operational Services currently at 82% and Corporate Services at 56%. There is however a significant improvement over the last 10 months. We are aware that a number of areas have been struggling with the recording of appraisals due to the Electronic Staff Record (ESR). This has been fed into a recovery programme for the systems and workforce team who lead on ESR. As a result, we now have dedicated sessions for teams in Estates, ward colleagues and divisional leadership meetings to ensure there is confidence in accessing, using and recording information (including appraisals on ESR).

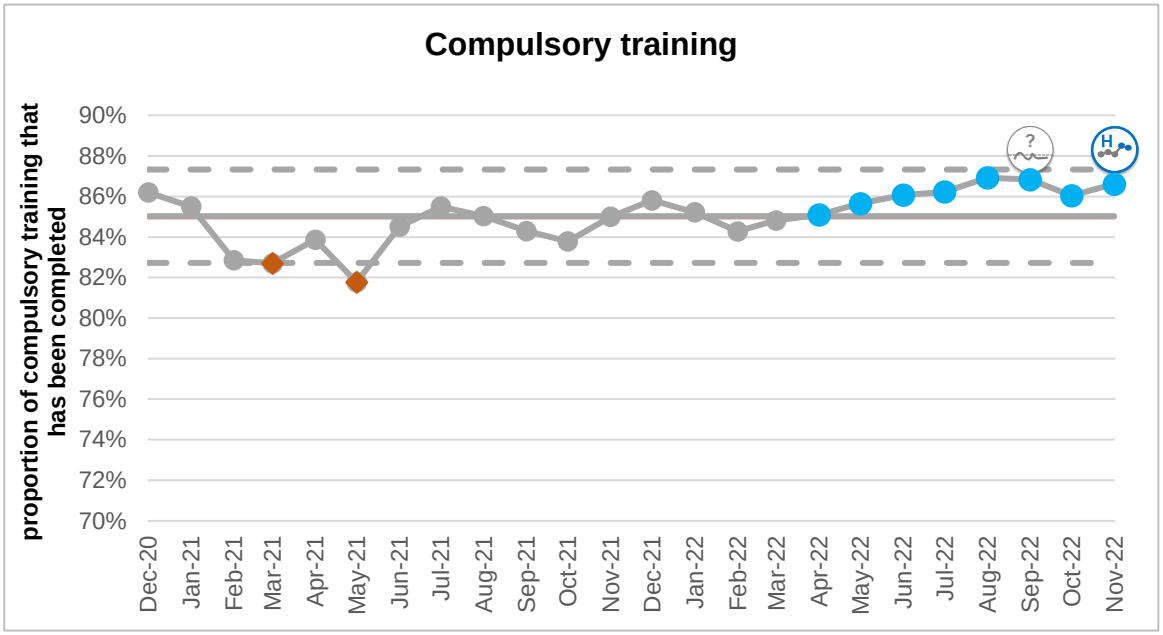
The corporate services compliance includes divisions such as Information Management & Technology and People and Inclusion who are at 100% compliance and services like Estates and Facilities who remain low on their compliance. The Divisional People Lead for these areas is now working with leaders to look at the reasons for the lower compliance and to understand how we adapt the process where it will be more effective and productive to do so. Compliance also continues to be monitored at Divisional Achievement Reviews and via the Trust Operational Oversight Leadership Team (TOOL).

2. Annual turnover



Turnover remains high and above the Trust target range of 8-12%. November saw a slight rise in turnover from the previous month (0.21% increase to 13.18%). The new exit interview process is starting to provide further data on why colleagues are leaving the trust. This is being triangulated with other Trust data and a strategic action plan developed to address key areas such as career development and flexible working.

3. Compulsory training

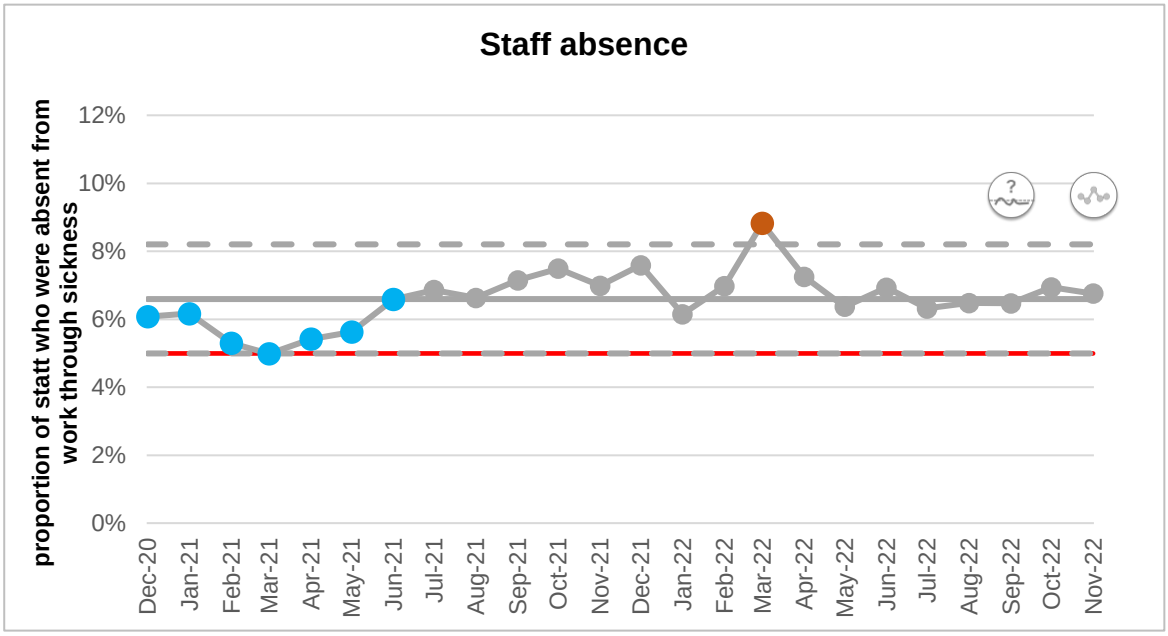


Compulsory training continues to be a key focus and an ongoing recovery position for the Trust. Overall, the 85% target level has been achieved for the last 8 months. Operational Services are currently 88% compliant and Corporate Services slightly lower at 81%.

Immediate Life Support (ILS) and Positive and Safe training compliance continues to improve. ILS hit 75% in November and positive and safe remained just below 70%. The mandatory training working group have been working to address key objectives to ensure compliance is achieved. This has included a focus on accountability for non-compliance with a personalised letter to all colleagues who as of 1st December were not compliant with either ILS or Positive and Safe and not

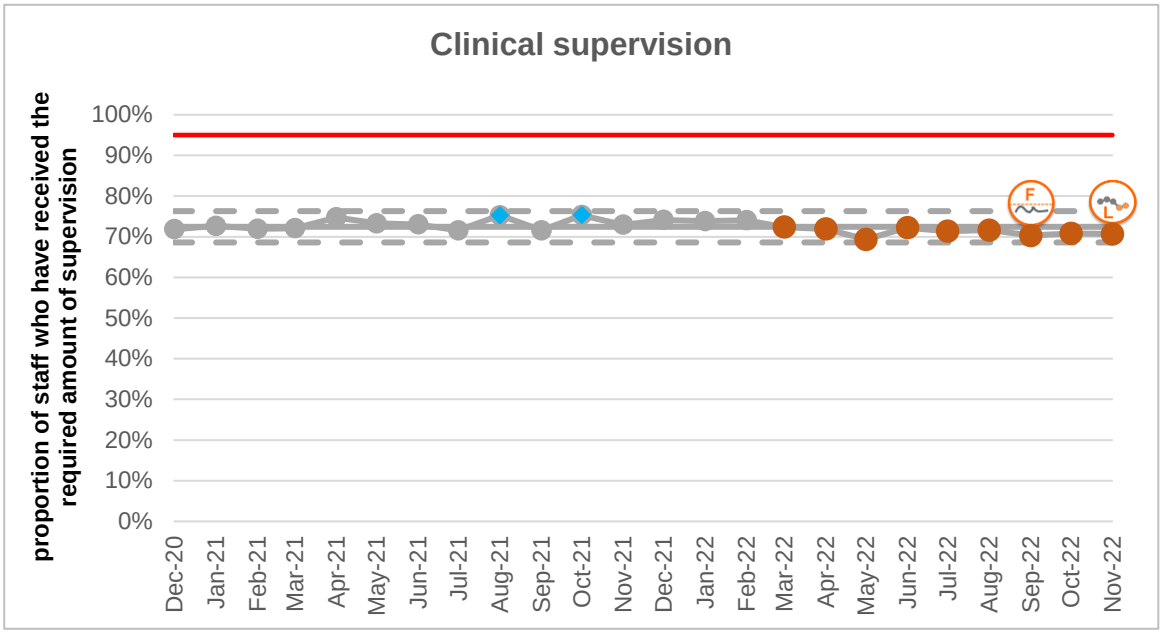
booked on a future training programme. This has resulted in 90 of the 110 non-compliant colleagues booking on a training session taking place in the next 8 weeks and the remaining 20 are being followed up by the General Manager for their area.

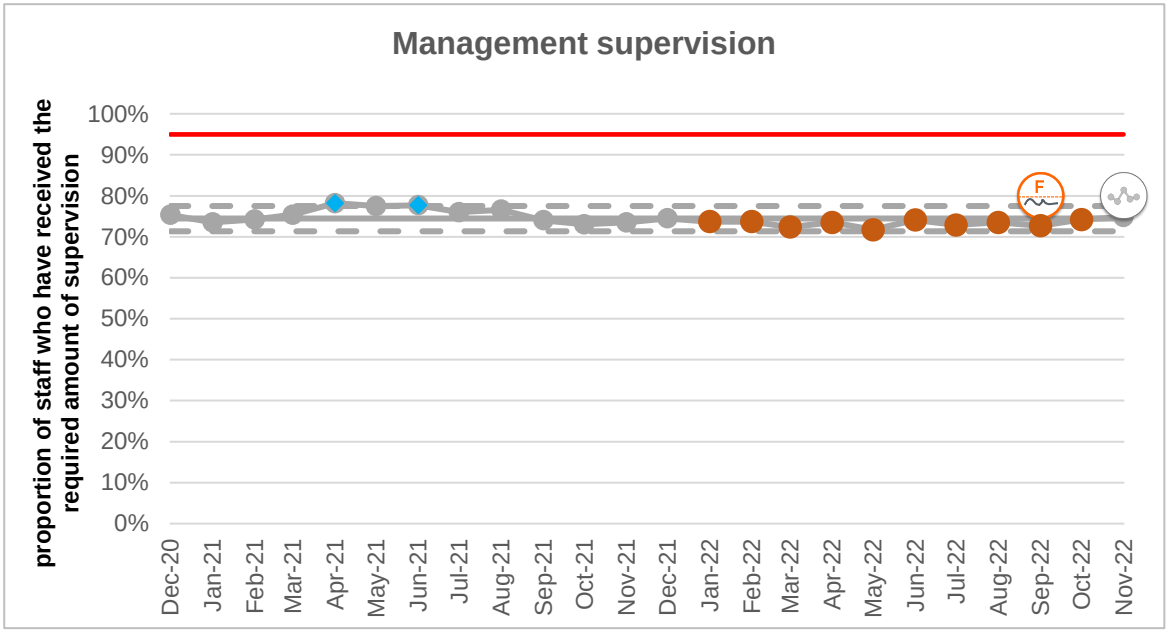
4. Staff absence



Sickness absence remains high and above the 5% target threshold. November sickness was 6.8%, this was a small reduction from October absence. COVID absences dropped significantly however increases were seen in flu, cold and cough absences. The absence transformation programme will commence in 2023 and this will tighten our understanding of how all absences are being managed and any subsequent changes needed to policy and health and wellbeing support. The main reason for absence continues to be stress and anxiety and 2023 will see further investment in resources to support colleagues who are struggling at work and home. This includes a staff support clinical psychologist and additional health and wellbeing resources.

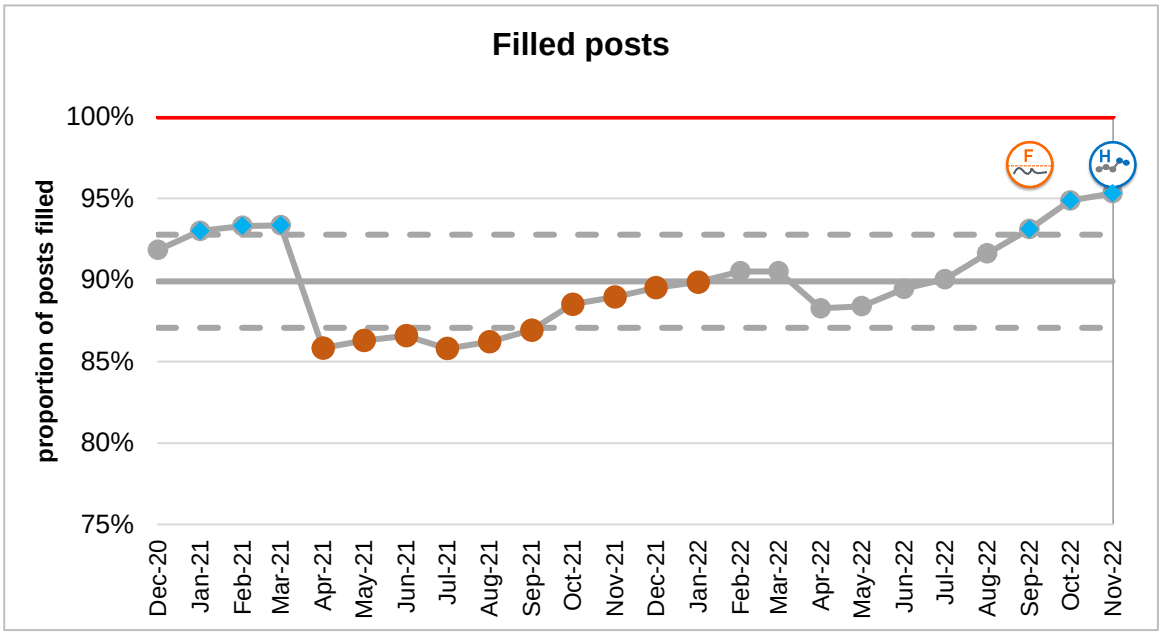
5. Clinical & managerial supervision





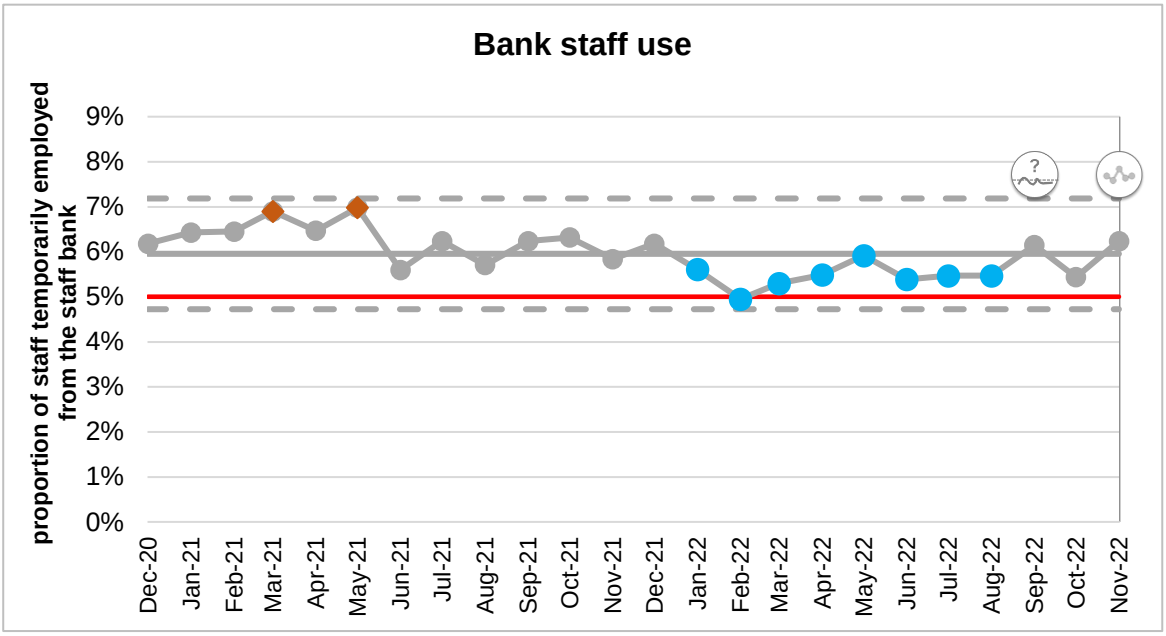
The levels of compliance with the clinical and management supervision targets have remained low since the start of the pandemic. As seen with compulsory training and appraisals, Operational Services continue to perform at a considerably higher level than Corporate Services for both types of supervision (management: 77% versus 61% and clinical: 75% versus 16%). As with the appraisal data, intelligence from divisional and team level indicates that management supervision is taking place, however recording it not always happening. A review of the supervision policy is currently taking place and once this is finalised, clear communications will be issued around expectations on supervision. This is also being fed into corporate induction and the leadership induction.

7. <u>Proportion of posts filled</u>



Staffing levels continue to improve and gradual reductions in vacancy rate have continued with significant improvements in comparison to 6 months ago where the vacancy rate was 6% higher. Work continues on innovative ways of recruiting and attracting whilst we also focus on retention through intelligence gained from stay surveys, exit interviews and the national staff survey. We are working with system colleagues on implementing learning from the cultural intelligence recruitment programme and this includes a one page job description, creative writing on adverts led by experts and cohort recruitment.

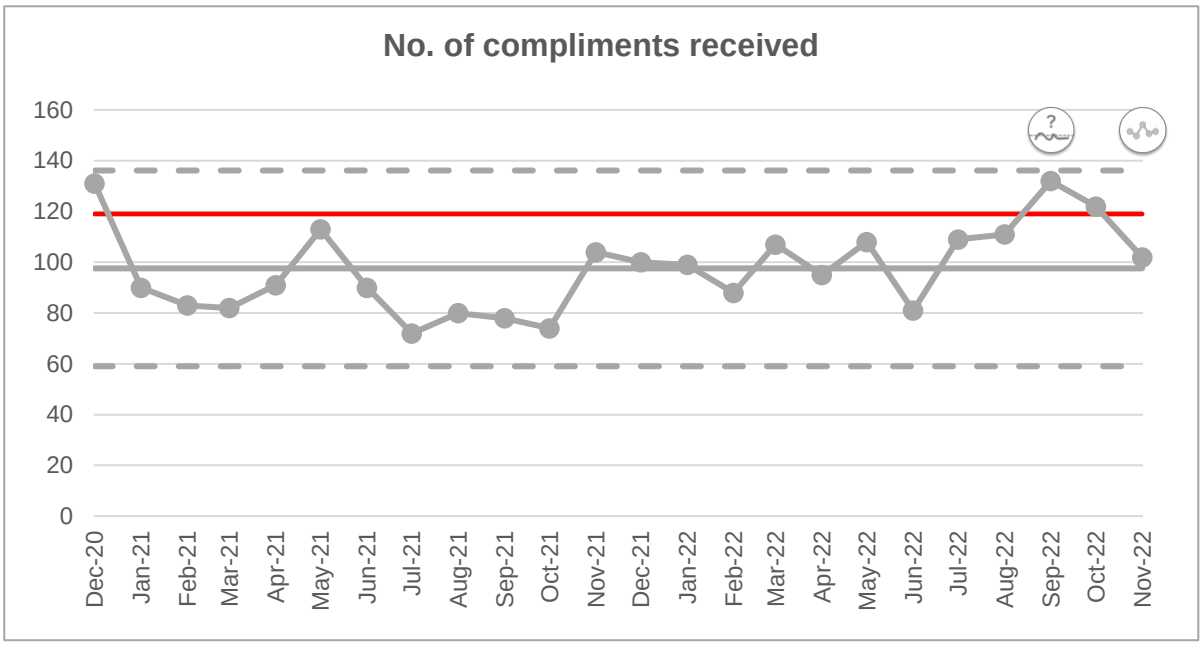
8. Bank staff



There was a small reduction in agency spend and an increase in overall fill rates though increased bank usage. Ongoing engagement sessions with bank colleagues are now taking place monthly and are well attended with a face-to-face session planned in January. Bank colleagues have been invited to join the staff networks and the Freedom to Speak Up Guardian has increased presence through the engagement sessions. A deep dive on agency spend was presented at the November People and Culture Committee and continues to be a focus through the strategic temporary workforce group. Agency spend on non-medical staffing has increased significantly over the last 12 months and work is now taking place to ensure correct usage and accountability is transparent for leaders and through divisional achievement reviews.

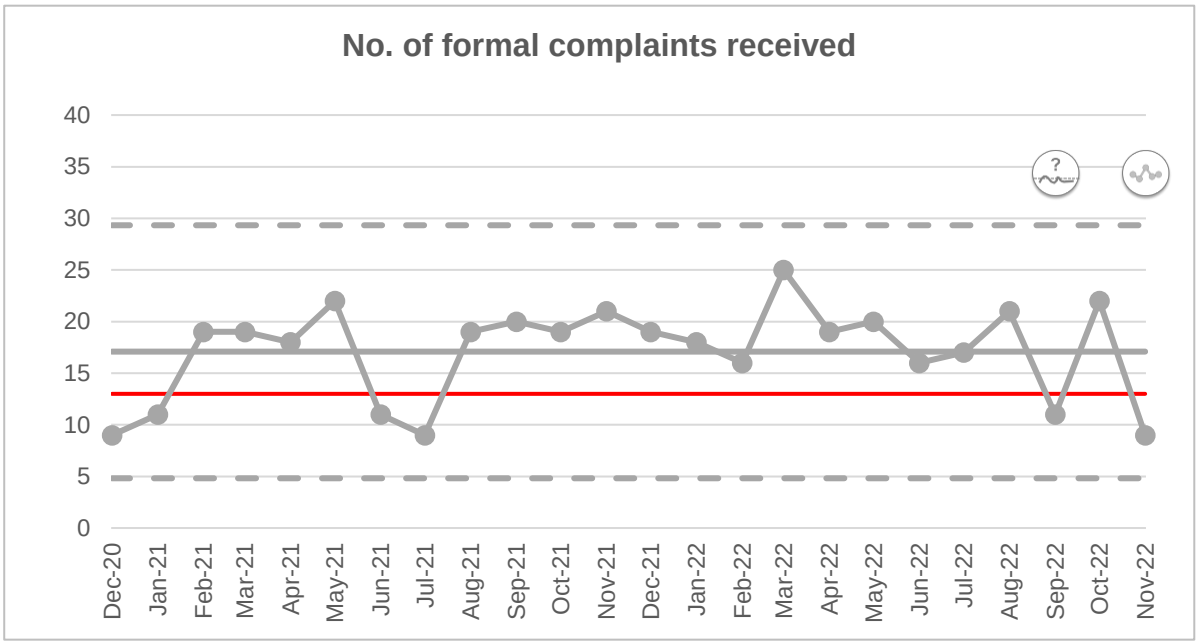
Quality

1. Compliments



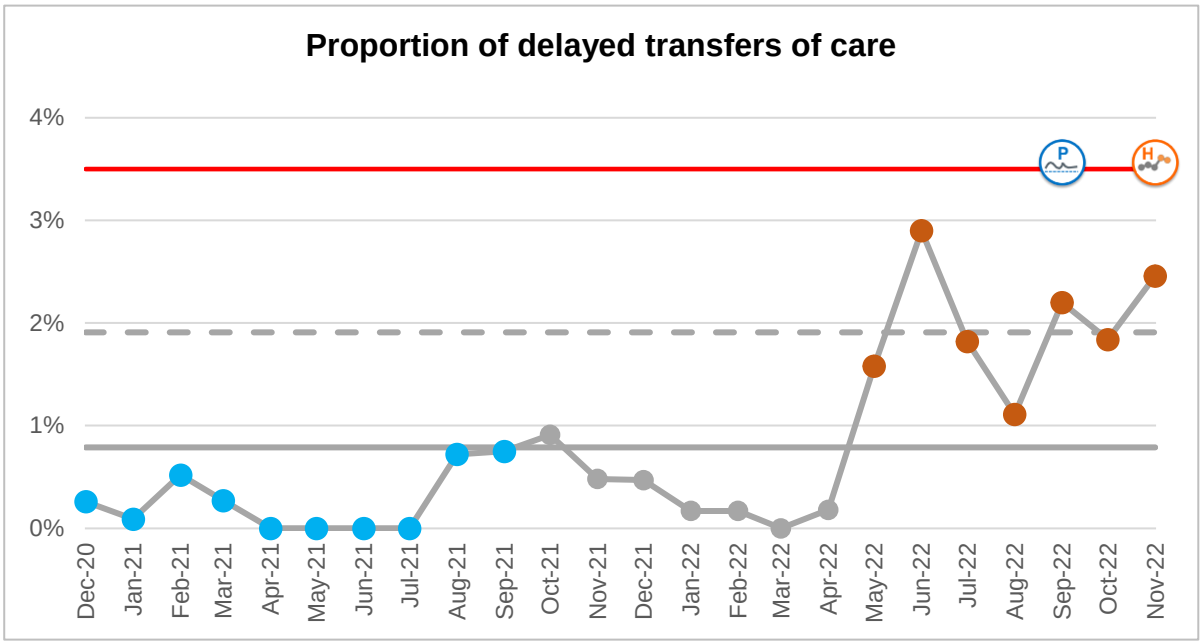
The number of compliments continues to remain below the expected level on average. This is due to compliments mostly being received verbally and staff not accurately recording them. The Heads of Nursing have been asked provide assurance that compliments are being accurately recorded and this has been raised within the divisional Clinical reference groups to encourage staff to record compliments and for teams to consider the method of compliment recording. This will be monitored through the quarterly patient experience committee report. A project supporting the electronic patient survey will provide a further method of receiving compliments, complaints, and concerns. With an increase in accessibility, it is expected that a natural increase in compliments, complaints 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 February 2023 and then in the Neurodevelopmental Division by April 2023.

2. Complaints



The number of formal complaints received continues to be within common cause variation in relation to the mean with a decline in the number recorded between August and September 2022. The number of formal complaints is now below the Trust target. This could be due to the number of face-to-face contacts increasing as services stand back up and a previous theme identified as patients having difficulty in accessing services. The implementation of the electronic patient survey should also give patients another way of feeding back without having to make a formal complaint. The number complaints recorded will continue to be monitored.

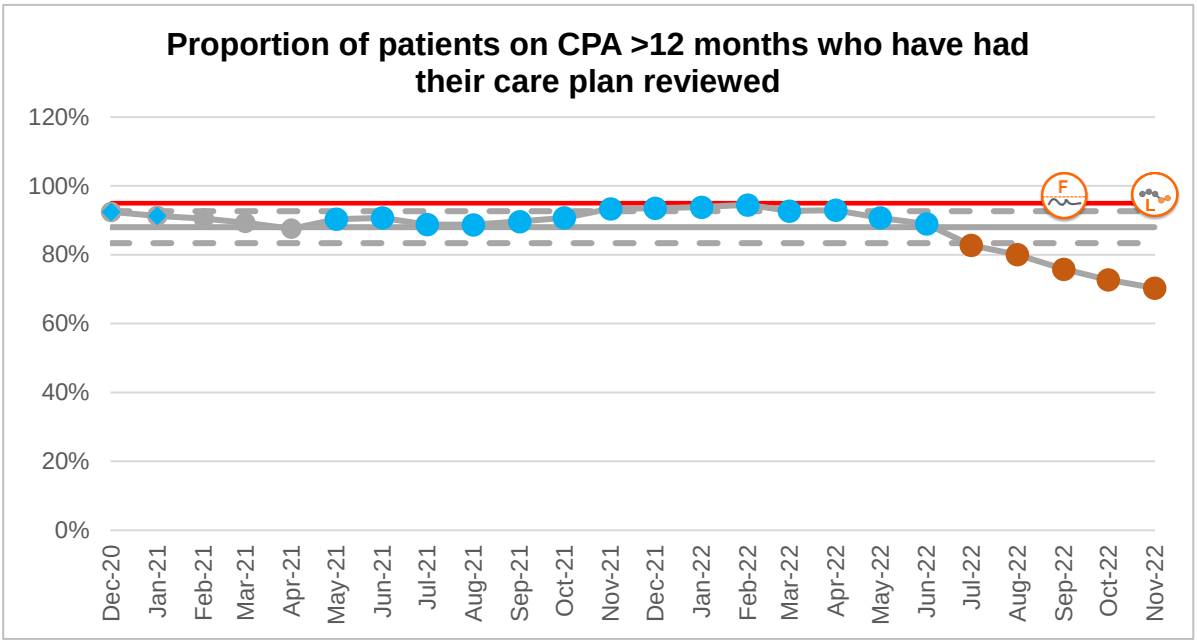
3. Delayed transfers of care (DTOC)



Although the number of DTOC has increased between September and November 2022, the number is still low when compared with the national picture and continues to be below the Trust target of 3.5%. The Flow Team have identified that the main barrier to discharge is identifying appropriate housing for service users. Work continues within the rapid review processes and clinical meetings. A Housing Officer was recruited in May 22 to support the identification of placements for patients who are clinically ready for discharge. This has achieved a shorter length of stay for those patients supported. The Trust has a twice weekly “clinically ready for discharge” meeting where patients identified as DTOC are reviewed and any barriers to discharge are identified and discussed. From November 2022 the Trust Flow Team have introduced a weekly, multi-agency discharge planning meeting that reviews and identifies any potential barriers for discharge and from this develops an action plan to prevent delay in discharges. It is too early to see the impact these meetings have had on DTOC; however, this will be monitored.

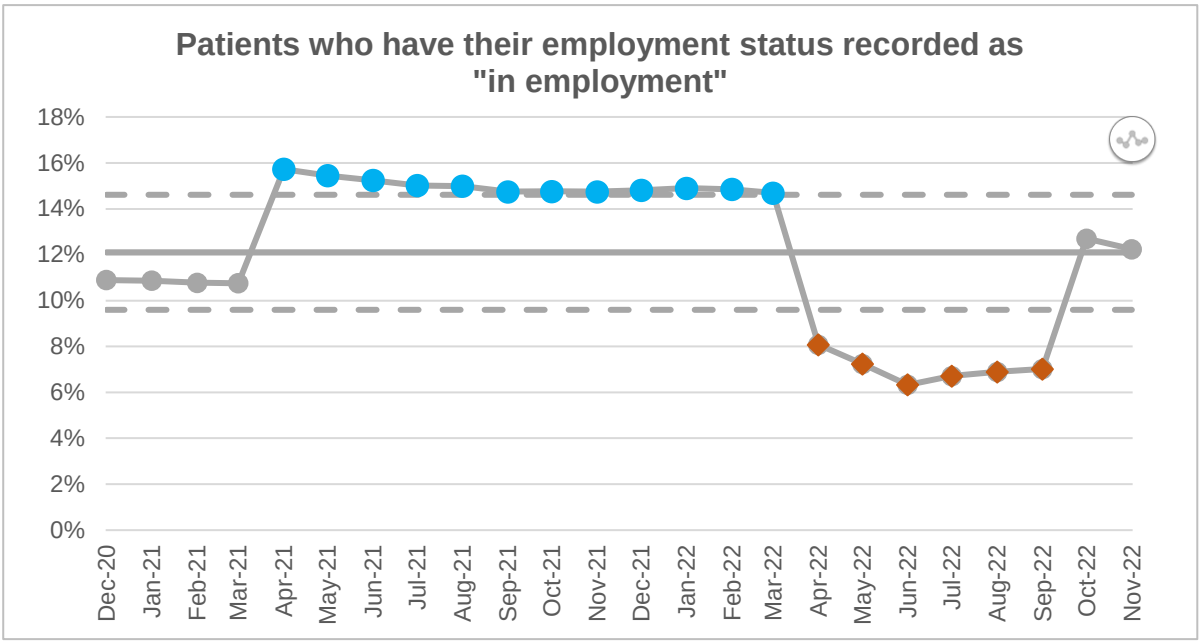
4. Care plan reviews

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. This is likely due to care plans that have not yet been migrated over to SystmOne and data quality issues with how this information is being captured. The Head of Nursing for Community services is monitoring progress on a weekly basis and is liaising with the CMHT Operational leadership team weekly to update. The division are considering using additional resource with the aim of the aim of all teams having existing care plans migrated over by the end of December 2022.



A programme of clinical quality audit is being implemented across the Trust divisions, led by the Heads of Nursing, which will help to identify those patients whose care plans require review. This is reported to the divisional Clinical and Operational Assurance Team meetings (COAT) for assurance, and we expect the trajectory to improve over the next six weeks.

5. Patients in employment

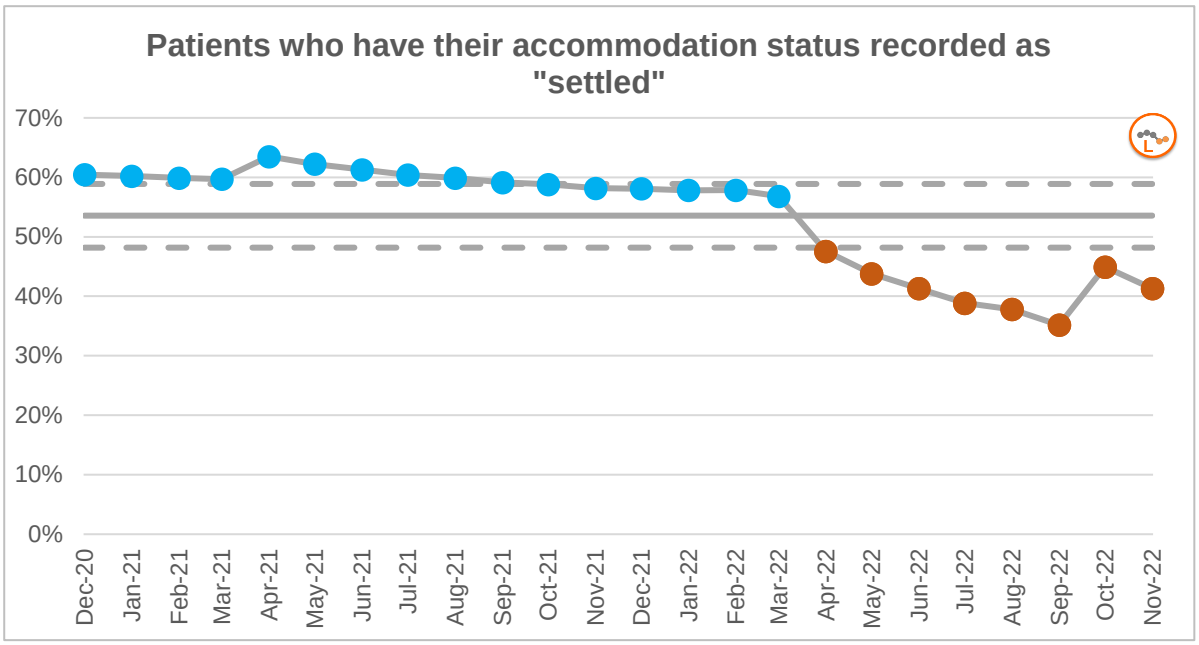


Around one third of patients have no employment status recorded at present and the decline in patients recorded as being in employment coincides with the data migration to SystmOne. From September 2022 the number of patients recorded as in employment has increased and a report has been developed which informs teams if there are gaps in the Current Data Quality Maturity Index information recorded on referral.

From January 2023, Ward and Service Managers have been asked to review this report weekly and action any gaps identified. The Individual Placement Support (IPS) Service continues to have success in supporting people into employment even during the pandemic and the service is currently expanding. They currently have 11 employment support workers, and this is planned to expand to 18 by March 2023 and to 23 by March 2024. The IPS Service has employed 4 peer

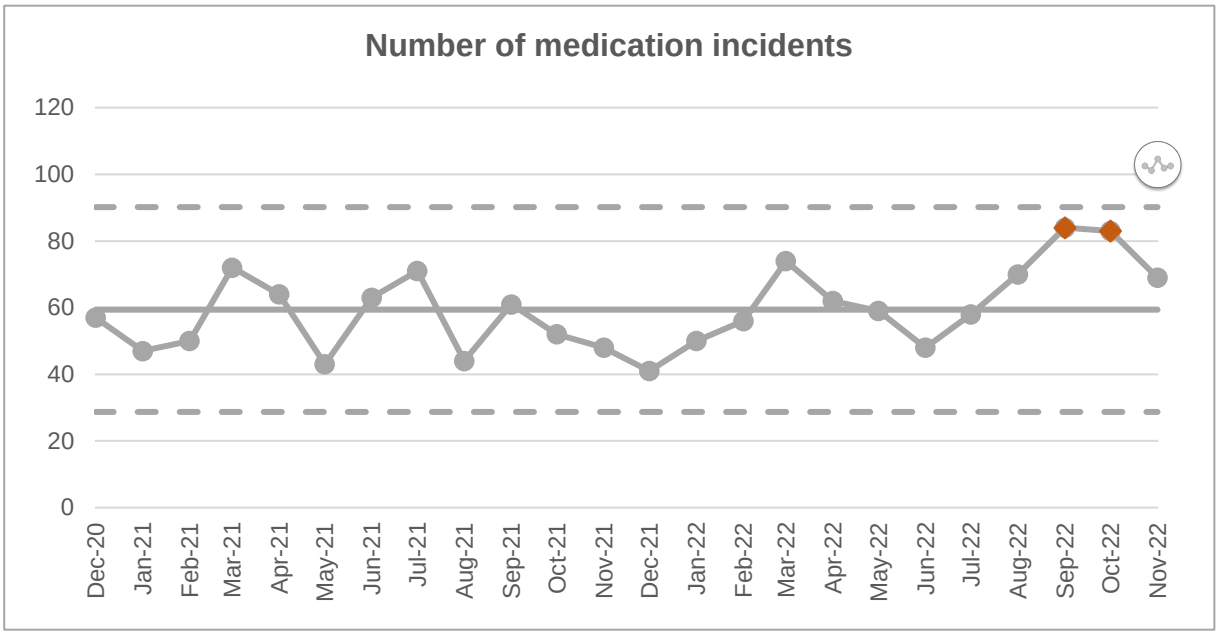
support workers to support service users back into work and to help them manage worries and anxieties and two team leaders have now been appointed. The Trust has also employed two experts by experience to focus on the implementation and management of Health Education England training in relation to Peer Support working and Apprentices. As a result, the number of patients in employment is expected to improve over the six months.

6. Patients in settled accommodation



Around one third of patients have no accommodation status recorded and the decline in patients with a recorded settled accommodation status again coincides with the data migration to SystmOne. Issues around inputting data have been identified and an improvement plan was implemented in the Older Adult Division in October including regular audit. A report has been developed which informs teams if there are gaps in the Current Data Quality Maturity Index information recorded on referral. From January 2023, Ward and Service managers have been asked to review this report weekly and action any gaps identified.

7. Medication incidents



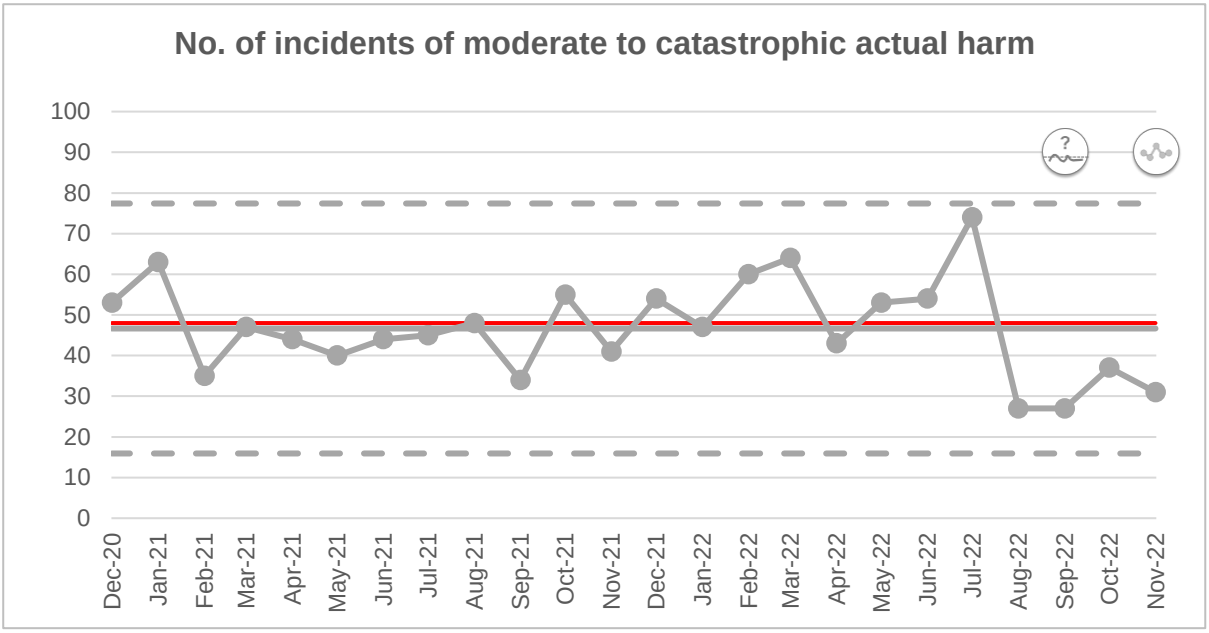
Although there is fluctuation with the number of medication incidents recorded, they are within the common cause variation in relation to the mean. When looking into medication incidents, they take a variety of forms, from missed doses, wrong medication administration, missed fridge temperature recording, 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 MMOS is currently revising the medications error procedure, considering Trust values, and the Acute Inpatient Matrons and Head of Nursing are in the process of updating the relevant policies which will reduce the number of incidents. This will go through the Medicines Management group for assurance.

The pharmacy team have also identified some learning points which they plan to introduce from December 2022:

- Development of an agency ward folder where the medicine management e-learning is printed out as PDFs for reference (the CD package was launched in December 2022 and the remaining packages are scheduled for January 2023).
- DHCFT Pharmacy to feed back to ward managers on a quarterly about shared learning from meetings with Chesterfield Royal Hospital pharmacy.
- Opportunity for the ward nursing staff to have an open medicine Q&A with Medicine Safety Officer when required.
- The Pharmacy is exploring ways to provide routine medicine updates to all staff via a medicine newsletter from January 2023

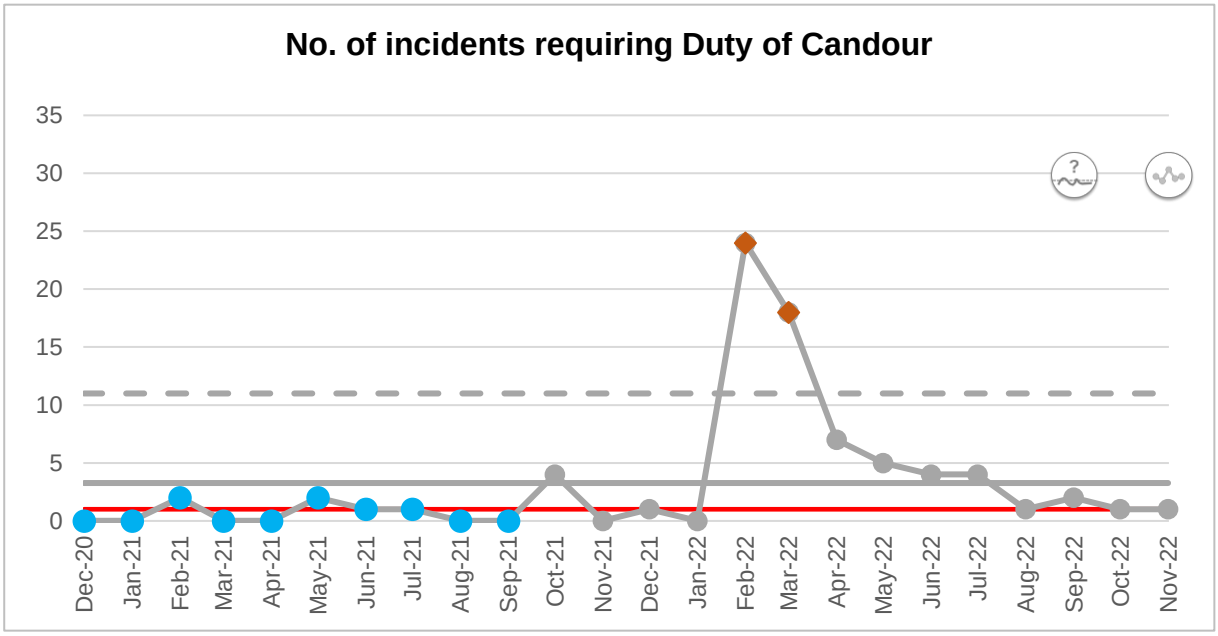
In October 2022 the Children's Division started electronic prescribing and medicines administration (EPMA) a solution which digitises the process of prescribing and recording medication administered to patients within the Division. This will be rolled out across the trust and should also help reduce the number of medication incidents over the next six months. It is too early to see the impact of EPMA on medication incidents put 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.

8. Incidents of moderate to catastrophic actual harm



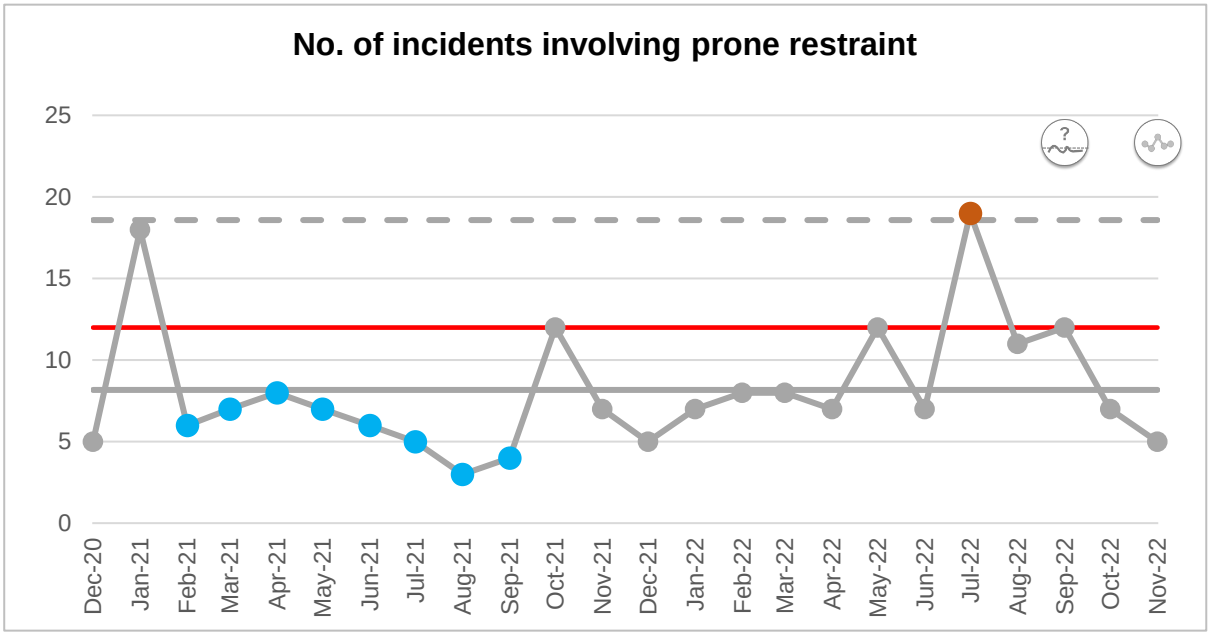
The number of reported incidents of moderate to catastrophic harm has reduced from July and continue to be below the mean. Incidents of moderate to catastrophic actual harm are monitored by the Head of Nursing team on a Quarterly basis and discussed within the divisional COAT meetings.

9. Duty of Candour



Duty of Candour reported incidents have been on a downward trajectory since April which coincides with the Patient Safety Team undertaking training with Service Managers and Heads of Nursing to support them in understanding and interpreting new national guidance related to DOC which has allowed for a more accurate and consistent approach to DOC and better adherence to policy. Training around accurately reporting DOC continues within clinical teams and the new Family Liaison Officer has now settled in his post and has support from another member of the patient safety team. A review into the current process of quality assurance, auditing and reviewing of incidents is underway and due to these developments, as expected the number of incidents reported requiring DOC has stabilised.

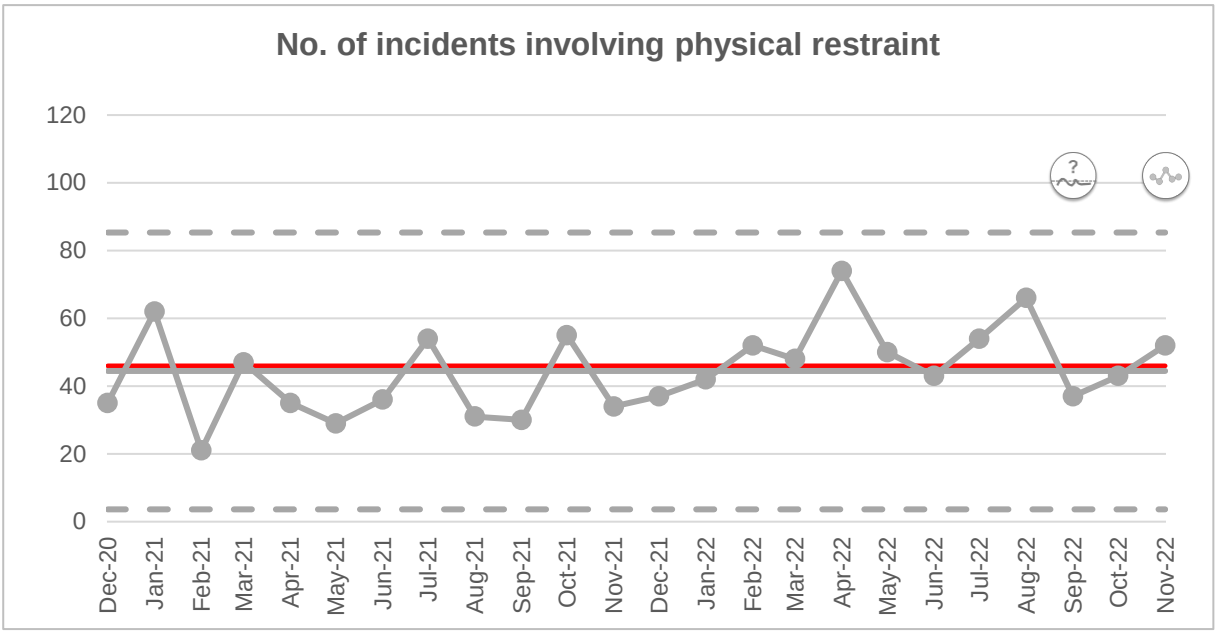
10. Prone restraint



There are ongoing workstreams to support the continuing need to reduce restrictive practice, such as the reducing restrictive practice group and a working group undertaking a thematic review of seclusion and rapid tranquilisation led by the Head of Nursing and supported by the inpatient clinical lead. Furthermore, the Positive and Safe team have now re commenced attending inpatient wards to provide advice and support around de-escalating incidents that could lead to restrictive practice.

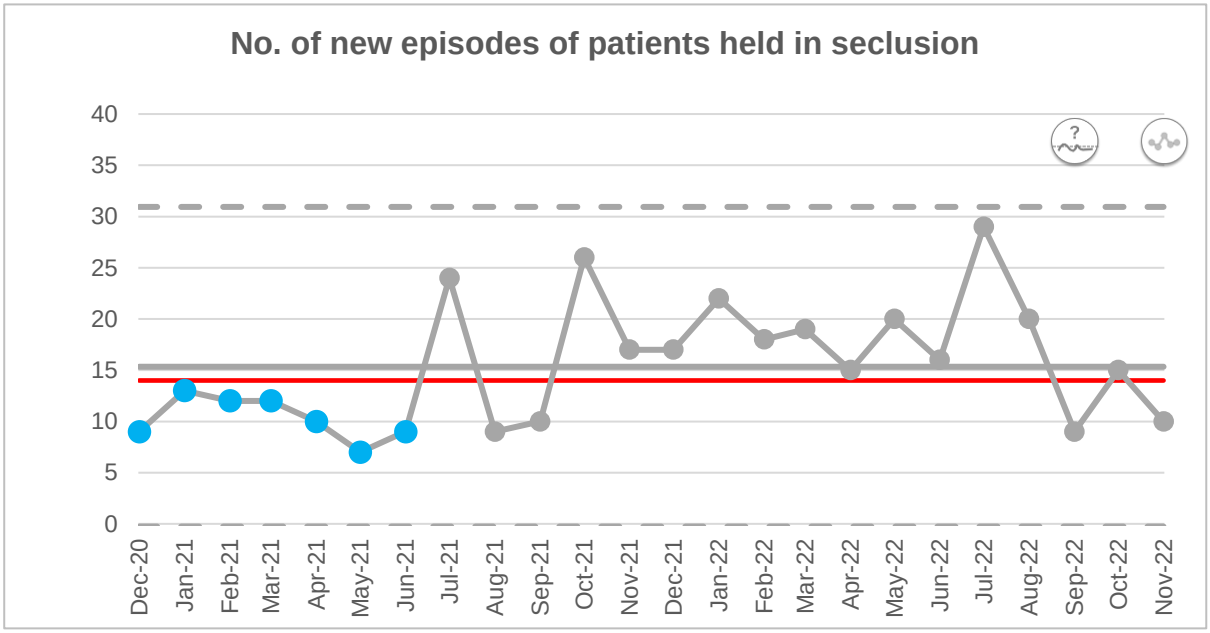
The monitoring of restrictive practice takes place within the Monthly Trust reducing restrictive practice group and data analysis and review has shown that incidents involving prone restraint have declined between September and October 2022. This is likely related to The Positive and Safe team's increased presence on the wards and they have changed the way staff are taught to support service users into seclusion. This means that prone restraint in these circumstances will no longer be necessary in all situations. The overall numbers of prone restraint are lower than the regional average per bed numbers and it is expected that incidents related to prone restraint will continue in this vein.

11. Physical restraint



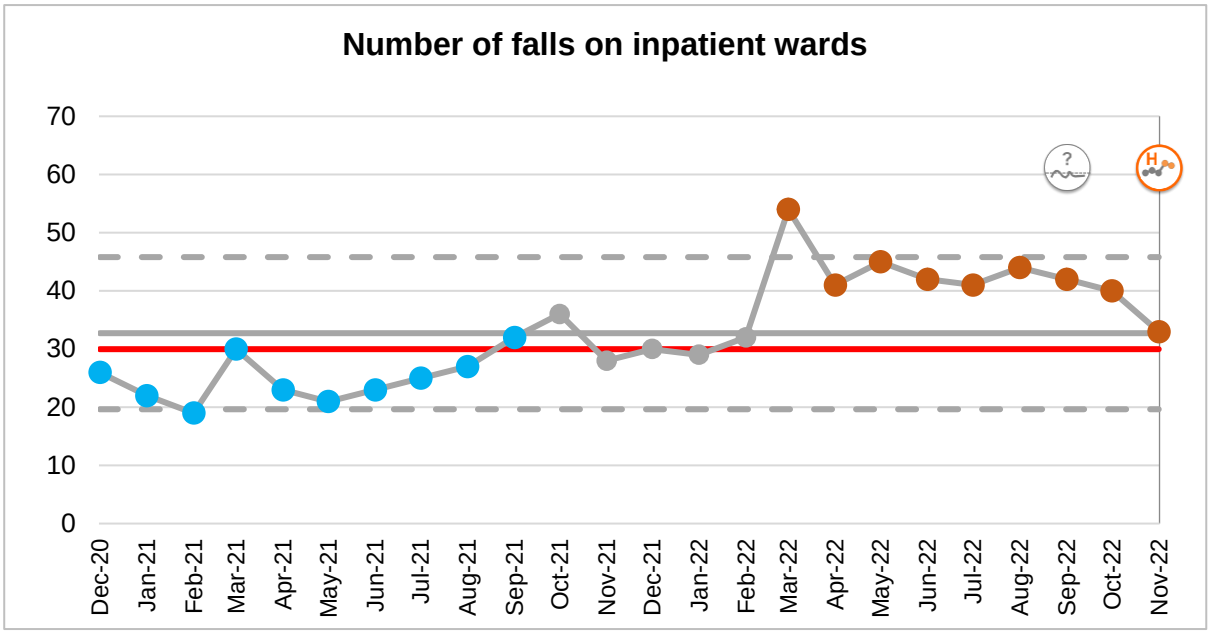
The number of reported incidents involving restraint have remained within common cause variation throughout the reporting period. The changes in numbers are linked to the data above relating to prone restraint and below relating to seclusion. Common impacting factors to restrictive practice include increased use of bank staff, vacancies, increased sickness, staffing challenges and concerns relating to closed culture. A working group has been created to put together a working procedure for assessing closed cultures and what needs to be done where closed cultures are identified. This work aims to improve patient feedback along with reducing restrictive practice both in Inpatient and Community Services. Over the last quarter the Positive and Safe team have increased their presence on inpatient wards to offer advice following incidents which will help staff to identify alternative ways of managing situations that could potentially involve physical restraint.

12. Seclusion



The use of seclusion has been above the mean common cause variation from October 2021 due to a small number of patients who had been placed in seclusion on more than one occasion on an acute ward and then the Enhanced Care ward. From July 2022 the number of seclusions was on a downward trajectory and is now below the Trust target. The Head of Nursing for Acute and Assessment Services is currently leading on a thematic review of seclusions to identify further learning.

13. Falls on inpatient wards

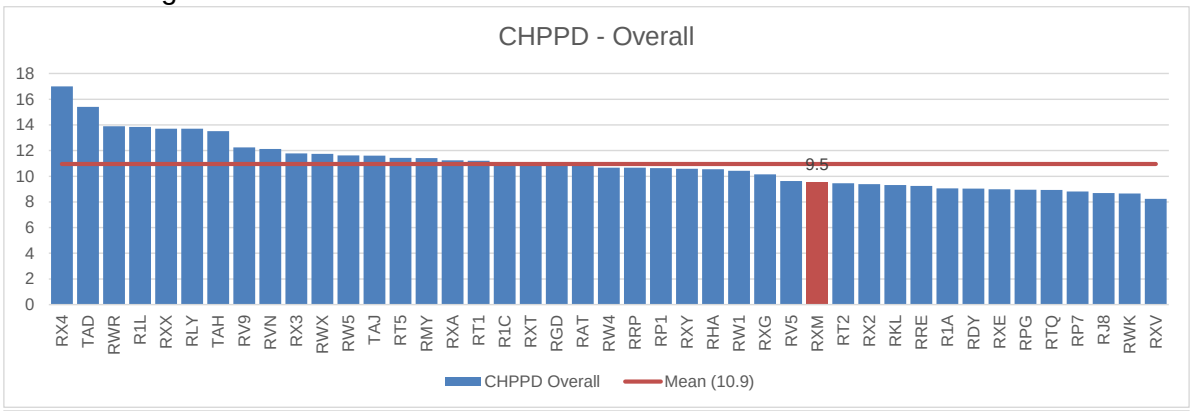


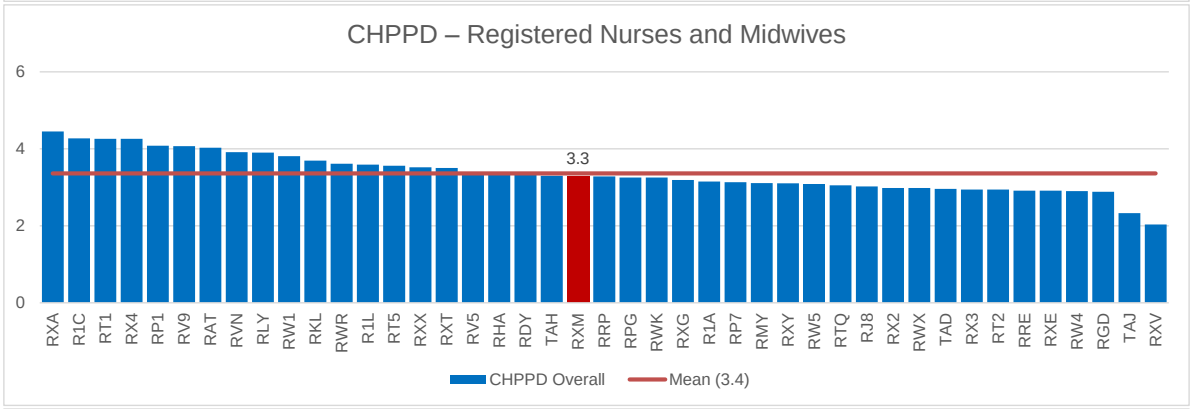
After an abnormal spike of incident in March 2022, A review of falls was commissioned and identified that a high number of falls were related to the same small number of patients. From this review a bi-weekly falls review meeting, chaired by the Matron for Older Adult Services, has been established to identify any specific needs for those patients falling regularly. The Head of Nursing has requested that the impact and actions from this meeting be reported to the Divisional Clinical Reference Group for assurance. The meeting appears to have had a positive impact with incidents related to falls reducing and continuing a downward trajectory between August and November 2022.

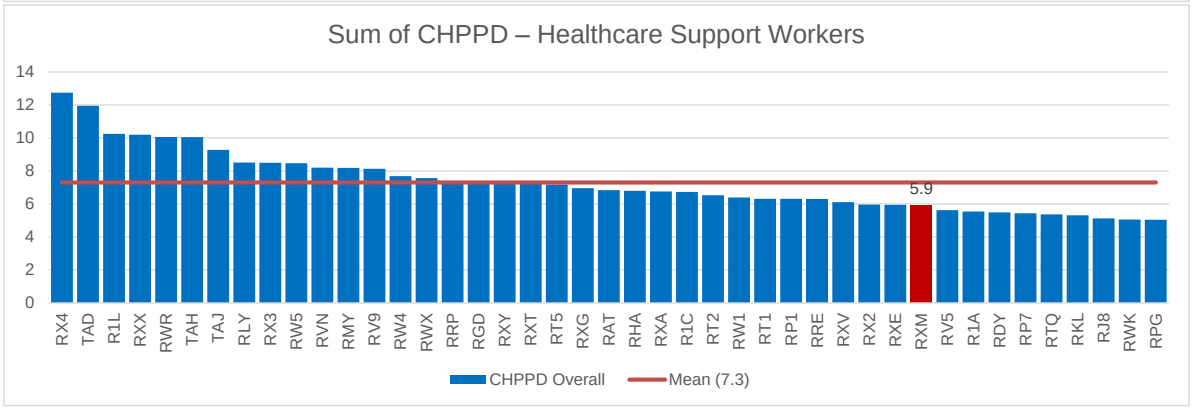
This will continue to be monitored over the next quarter. It was also identified that a Physiotherapist has been recruited to support the inpatient wards in managing falls risks but that they had been off sick for the last 12 months. A new Physiotherapist has now been allocated to this role from October 2022.

Care Hours Per Patient Day (CHPPD)

CHPPD is rolling data updated monthly, to show staffing levels in relation to patient numbers on an inpatient ward. Every month, the hours worked during day shifts and night shifts by registered nurses and midwives and by healthcare assistants are added together. Each day, the number of patients occupying beds at midnight is recorded. These figures are added up for the whole month and divided by the number of days in the month to calculate a daily average. Then the figure for total hours worked is divided by the daily average number of patients to produce the rate of care hours per patient day. Work is underway to implement processes relating to staffing levels and how they are recorded in line with CHPPD and patient acuity. This will be in the form of the MHOST reporting system and SafeCare module within E-Roster. The Trust held MHOST training organised in October, with participants identified from all inpatient areas. The Trust has also employed an e-roster manager who came into post in July 2022. 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:







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

Appendix 1 – Long Term Plan Measures Benchmarking

Children and young people with an eating disorder waiting times qtr3 2021/22 to qtr2 2022/23

Provider Level Data

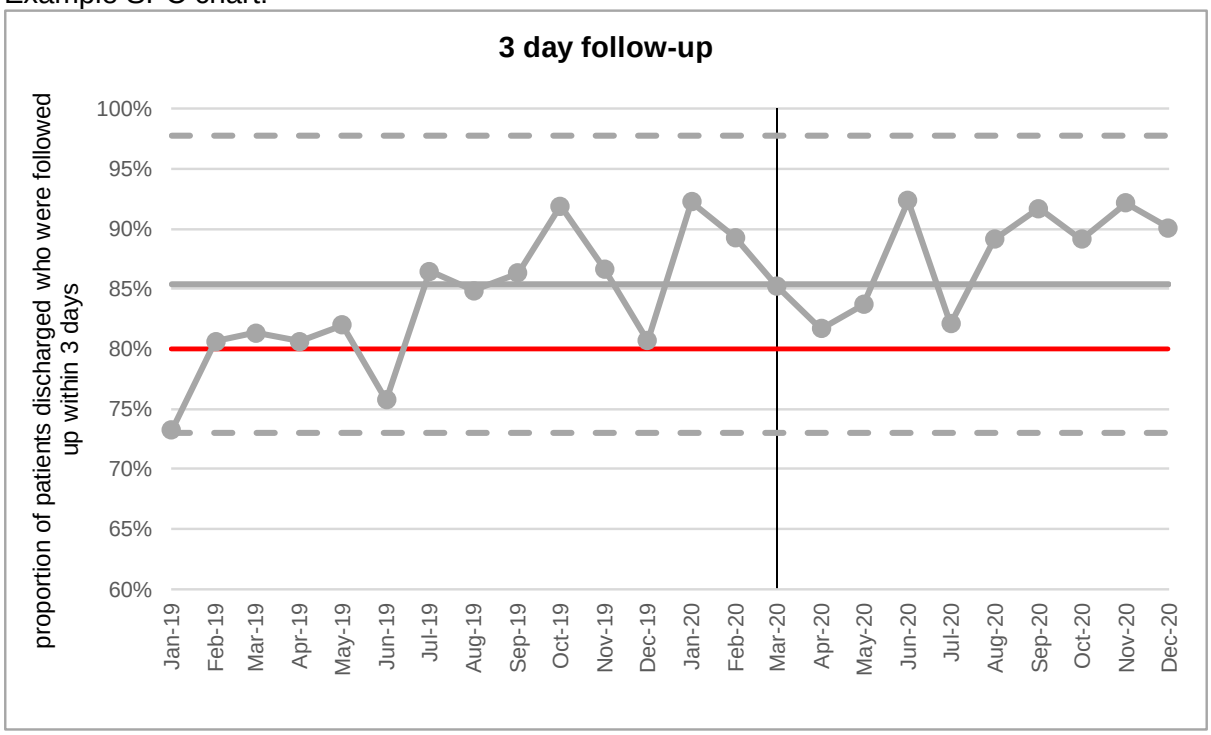
Provider Code	Provider Name	Urgent Cases: The number of patients started treatment by week since referral						Routine Cases: The number of patients started treatment by week since referral					
		>0-1 week	>1-4 weeks	>4-12 weeks	12 plus	Total number of completed pathways (all	% within 1 week	>0-1 week	>1-4 weeks	>4-12 weeks	12 plus	Total number of completed pathways (all	% within 4 weeks
RQ3	BIRMINGHAM WOMEN'S AND CHILDREN'S NHS FOUNDATION TRUST	8	-	-	-	8	100.0%	25	70	8	-	103	92.2%
RXA	CHESHIRE AND WIRRAL PARTNERSHIP NHS FOUNDATION TRUST	1	-	-	-	1	100.0%	21	45	23	12	101	65.3%
NR5	LIVEWELL SOUTHWEST	5	-	-	-	5	100.0%	8	31	8	-	47	83.0%
R0A	MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	34	-	-	-	34	100.0%	67	166	-	-	233	100.0%
RW4	MERSEY CARE NHS FOUNDATION TRUST	1	-	-	-	1	100.0%	220	32	-	-	252	100.0%
RLY	NORTH STAFFORDSHIRE COMBINED HEALTHCARE NHS TRUST	43	-	-	-	43	100.0%	31	23	1	-	55	98.2%
RTF	NORTHUMBRIA HEALTHCARE NHS FOUNDATION TRUST	7	-	-	-	7	100.0%	1	41	5	-	47	89.4%
RKL	WEST LONDON NHS TRUST	1	-	-	-	1	100.0%	120	16	21	14	171	79.5%
R1A	WORCESTERSHIRE HEALTH AND CARE NHS TRUST	10	-	-	-	10	100.0%	28	55	3	2	88	94.3%
TAJ	BLACK COUNTRY HEALTHCARE NHS FOUNDATION TRUST	46	1	-	-	47	97.9%	157	42	4	2	205	97.1%
RAT	NORTH EAST LONDON NHS FOUNDATION TRUST	169	4	-	-	173	97.7%	139	444	20	-	603	96.7%
RXX	SURREY AND BORDERS PARTNERSHIP NHS FOUNDATION TRUST	42	1	-	-	43	97.7%	49	93	5	-	147	96.6%
RHA	NOTTINGHAMSHIRE HEALTHCARE NHS FOUNDATION TRUST	27	1	-	-	28	96.4%	3	88	14	1	106	85.8%
RY6	LEEDS COMMUNITY HEALTHCARE NHS TRUST	25	1	-	-	26	96.2%	13	76	31	1	121	73.6%
RVN	AVON AND WILTSHIRE MENTAL HEALTH PARTNERSHIP NHS TRUST	19	1	-	-	20	95.0%	224	101	12	4	341	95.3%
RX4	CUMBRIA, NORTHUMBERLAND, TYNE AND WEAR NHS FOUNDATION TRUST	32	1	-	1	34	94.1%	52	94	64	4	214	68.2%
RW5	LANCASHIRE & SOUTH CUMBRIA NHS FOUNDATION TRUST	32	2	-	-	34	94.1%	43	94	22	66	225	60.9%
RT2	PENNINE CARE NHS FOUNDATION TRUST	16	1	-	-	17	94.1%	15	159	19	-	193	90.2%
RV3	CENTRAL AND NORTH WEST LONDON NHS FOUNDATION TRUST	70	2	4	-	76	92.1%	86	34	16	10	146	82.2%
RT5	LEICESTERSHIRE PARTNERSHIP NHS TRUST	49	6	1	-	56	87.5%	16	27	56	10	109	39.4%
RXT	BIRMINGHAM AND SOLIHULL MENTAL HEALTH NHS FOUNDATION TRUST	6	-	1	-	7	85.7%	16	46	-	-	62	100.0%
RBS	ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	26	5	-	-	31	83.9%	25	68	134	4	231	40.3%
RXG	SOUTH WEST YORKSHIRE PARTNERSHIP NHS FOUNDATION TRUST	56	11	-	-	67	83.6%	130	132	26	6	294	89.1%
RH5	SOMERSET NHS FOUNDATION TRUST	16	4	-	-	20	80.0%	33	50	13	1	97	85.6%
TAD	BRADFORD DISTRICT CARE NHS FOUNDATION TRUST	13	4	-	-	17	76.5%	2	20	39	7	68	32.4%
RP7	LINCOLNSHIRE PARTNERSHIP NHS FOUNDATION TRUST	13	2	1	1	17	76.5%	4	48	39	2	93	55.9%
RX3	TEES, ESK AND WEAR VALLEYS NHS FOUNDATION TRUST	56	14	4	1	75	74.7%	37	146	89	13	285	64.2%
RV5	SOUTH LONDON AND MAUDSLEY NHS FOUNDATION TRUST	17	6	-	-	23	73.9%	8	102	164	50	324	34.0%
RWV	DEVON PARTNERSHIP NHS TRUST	8	3	-	-	11	72.7%	23	51	42	71	187	39.6%
RRE	MIDLANDS PARTNERSHIP NHS FOUNDATION TRUST	13	3	2	-	18	72.2%	3	53	34	9	99	56.6%
8J589	OAKWOOD PSYCHOLOGY SERVICES	5	2	-	-	7	71.4%	5	22	-	-	27	100.0%
RWK	EAST LONDON NHS FOUNDATION TRUST	7	3	-	-	10	70.0%	206	123	62	11	402	81.8%
RNU	OXFORD HEALTH NHS FOUNDATION TRUST	35	12	2	2	51	68.6%	62	149	172	76	459	46.0%
RFS	CHESTERFIELD ROYAL HOSPITAL NHS FOUNDATION TRUST	8	2	2	-	12	66.7%	1	31	11	-	43	74.4%
RCU	SHEFFIELD CHILDREN'S NHS FOUNDATION TRUST	2	1	-	-	3	66.7%	11	59	8	-	78	89.7%
R1C	SOLENT NHS TRUST	8	5	-	-	13	61.5%	29	81	8	-	118	93.2%
RWX	BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST	56	25	9	4	94	59.6%	62	23	19	9	113	75.2%
RXV	GREATER MANCHESTER MENTAL HEALTH NHS FOUNDATION TRUST	17	6	4	2	29	58.6%	27	47	12	8	94	78.7%
RQY	SOUTH WEST LONDON AND ST GEORGE'S MENTAL HEALTH NHS TRUST	28	20	3	-	51	54.9%	12	43	10	6	71	77.5%
RAL	ROYAL FREE LONDON NHS FOUNDATION TRUST	20	14	3	-	37	54.1%	1	21	58	1	81	27.2%
RXM	DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST	14	8	4	-	26	53.8%	14	50	38	1	103	62.1%
RV9	HUMBER TEACHING NHS FOUNDATION TRUST	16	11	3	-	30	53.3%	22	70	12	-	104	88.5%
RDY	DORSET HEALTHCARE UNIVERSITY NHS FOUNDATION TRUST	17	13	2	-	32	53.1%	-	18	21	16	55	32.7%
RMY	NORFOLK AND SUFFOLK NHS FOUNDATION TRUST	61	32	15	9	117	52.1%	55	114	114	24	307	55.0%
RXE	ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST	15	13	1	-	29	51.7%	28	112	73	3	216	64.8%
R1F	ISLE OF WIGHT NHS TRUST	1	1	-	-	2	50.0%	7	44	2	-	53	96.2%
RW1	SOUTHERN HEALTH NHS FOUNDATION TRUST	3	3	-	-	6	50.0%	57	20	21	11	109	70.6%
RX2	SUSSEX PARTNERSHIP NHS FOUNDATION TRUST	109	72	38	11	230	47.4%	29	132	84	106	351	45.9%
RT1	CAMBRIDGESHIRE AND PETERBOROUGH NHS FOUNDATION TRUST	40	32	12	3	87	46.0%	17	107	100	23	247	50.2%
RP1	NORTHAMPTONSHIRE HEALTHCARE NHS FOUNDATION TRUST	31	37	2	-	70	44.3%	10	31	131	32	204	20.1%
TAH	SHEFFIELD HEALTH & SOCIAL CARE NHS FOUNDATION TRUST	3	4	-	-	7	42.9%	17	21	16	6	60	63.3%
RJ8	CORNWALL PARTNERSHIP NHS FOUNDATION TRUST	1	2	-	-	3	33.3%	6	17	33	42	98	23.5%
RWR	HERTFORDSHIRE PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST	22	49	15	-	86	25.6%	18	46	46	64	174	36.8%
RYG	COVENTRY AND WARWICKSHIRE PARTNERSHIP NHS TRUST	9	22	9	-	40	22.5%	4	11	40	59	114	13.2%
RTQ	GLOUCESTERSHIRE HEALTH AND CARE NHS FOUNDATION TRUST	12	62	54	53	181	6.6%	3	12	5	17	37	40.5%

Statistics » Children and Young People with an Eating Disorder Waiting Times (england.nhs.uk)

Appendix 2

Statistical Process Control Chart (SPC) Guidance

Example SPC chart:



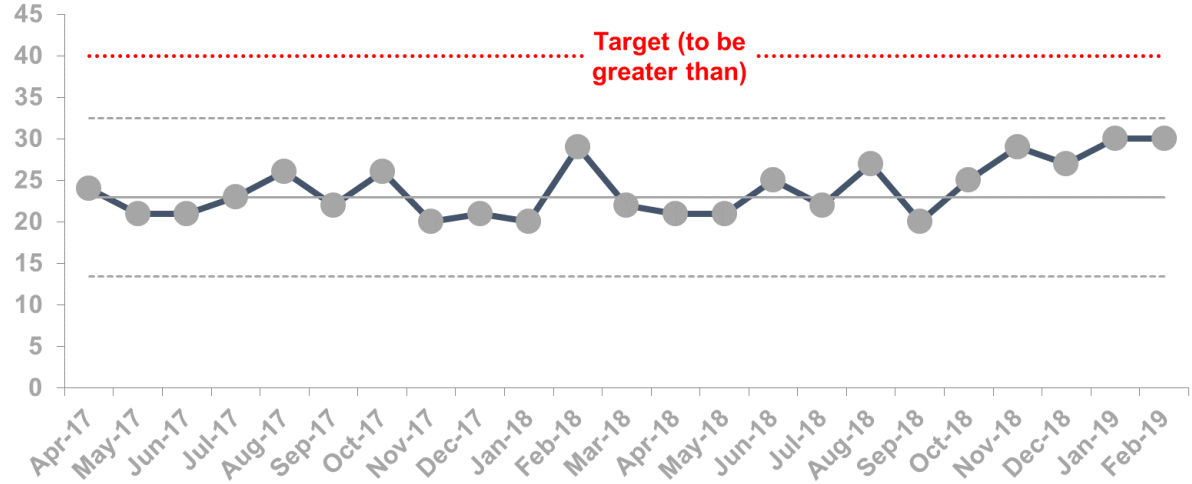
- The red line is the target.
- The grey dots are the actual performance each month. They are coloured grey as performance each month is normal in this example.
- The solid grey line is the average (mean) of all the grey dots.
- The grey dotted lines are called process limits, or control limits.

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.

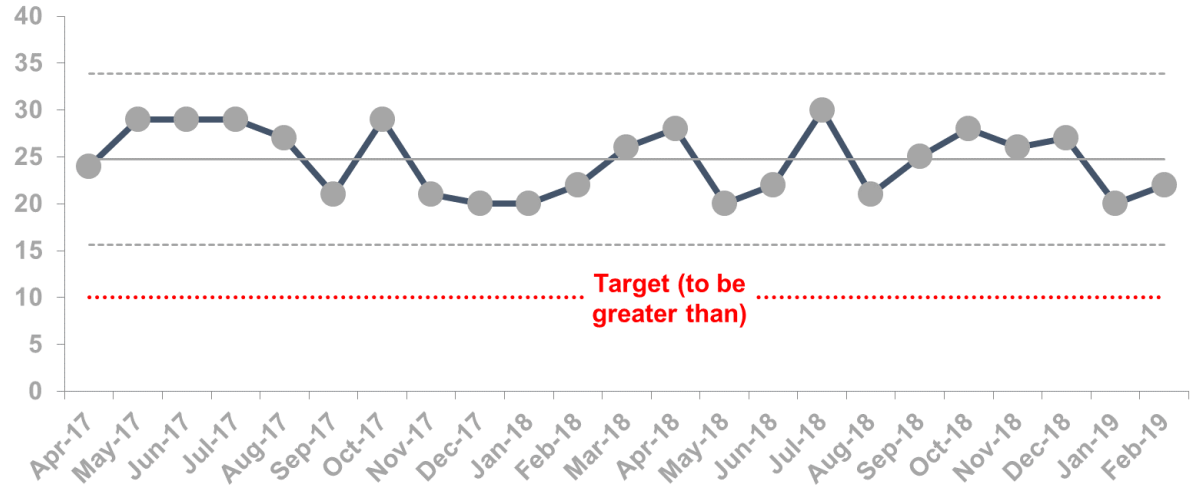
Things to look out for:

1. A process that is not working



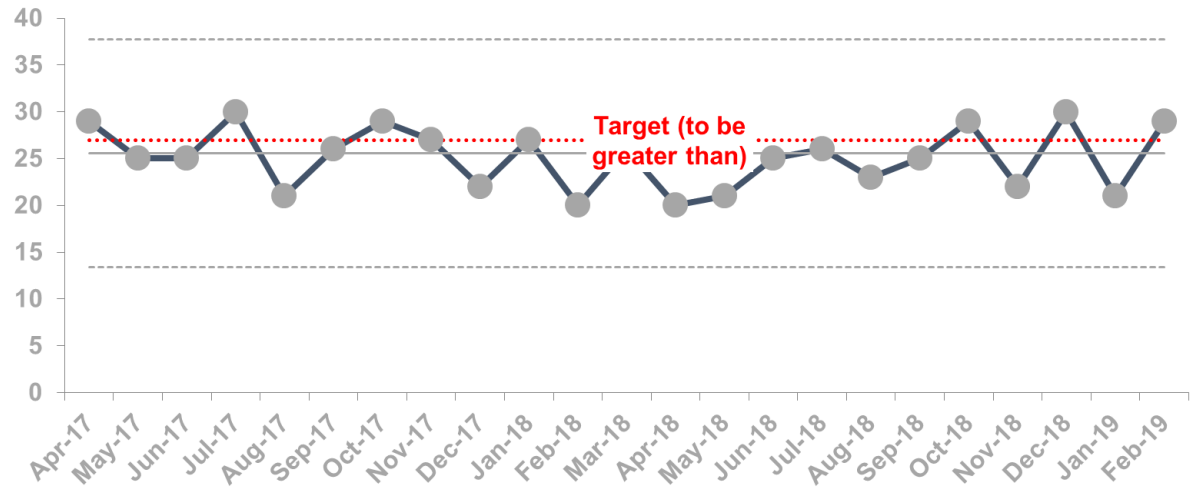
In this example the target is higher than the upper dotted grey line. This means that the target will never be achieved. To achieve the target, we need to change how we do things.

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

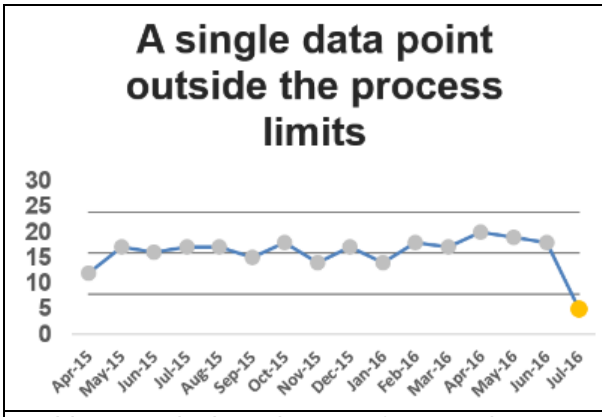


In this example the target line sits between the 2 grey dotted lines. As it is normal for the grey dots to fall anywhere between the 2 dotted grey lines, this means that it is entirely random as to whether or not the target will be achieved. So, this system is unreliable and needs to be redesigned if 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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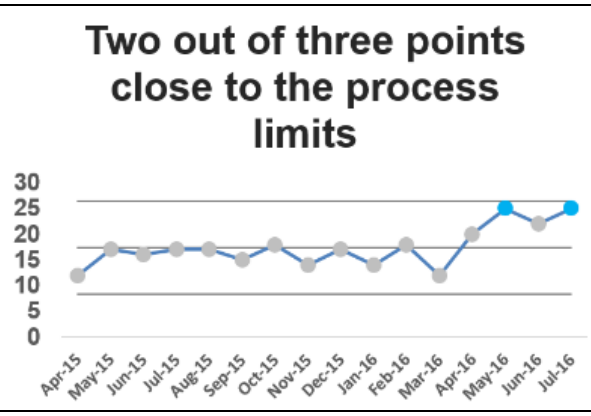
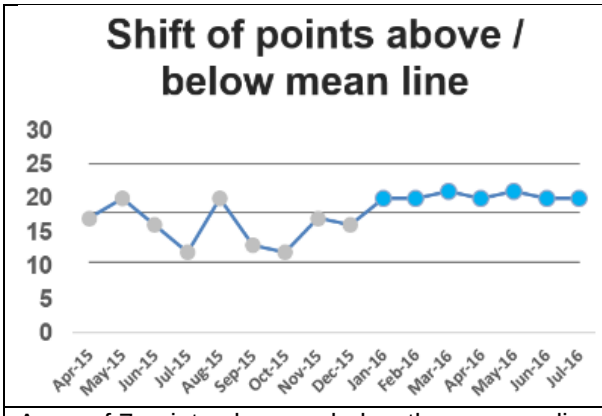
<td> 
</td>
</tr>
<tr>
<td>In this example the July 16 perfomance is significantly lower than expected and falls beneath the lower grey dotted line.</td>
<td>2 out of 3 points close to one of the grey dotted lines is statistically significant, in this case they are blue, indicating better than expected performance.</td>
</tr>
<tr>
<td> 
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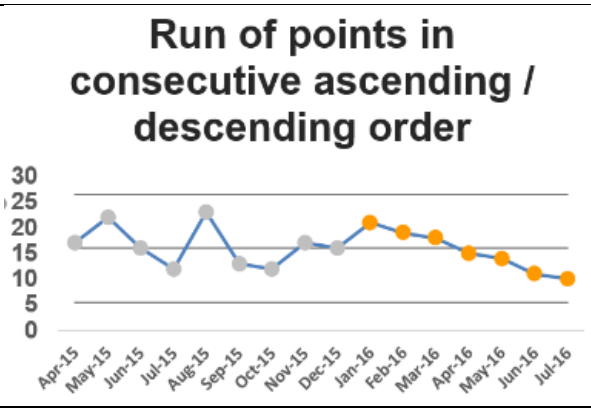
<td> 
</td>
</tr>
<tr>
<td>A run of 7 points above or below the average line is significant. In this example it might indicate that an improvement was made to the process in Jan 16 that has proven to be effective.</td>
<td>A run of 7 points in consecutive ascending or descending order is significant. 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 – 17 January 2023

Assuring Quality Care

Purpose of Report

In a recent Panorama documentary: *undercover report findings of poor and abusive care in NHS mental health secure services*, poor care, abuse - physical and verbal assault and negative cultures were captured and reported on. As a result, Claire Murdoch (National Director for Mental Health) has formally requested that all NHS Services collectively investigate their own areas to *identify, eradicate and prevent this kind of abuse from happening.*

As a result of the request for assurance, this report demonstrates current practice and further improvements to ensure full assurance that high quality care occurs in Derbyshire Healthcare NHS Foundation Trust (DHCFT).

Executive Summary

This report provides assurance to support the request from Claire Murdoch and identifies gaps and actions to further reinforce the assurance.

- There is a wide range of opportunities for colleagues to have conversations about care delivery and raise concerns, these include, reflective discussions, trust wide and divisional engagements, Freedom To Speak Up processes, Schwartz Rounds.
- During this process an improvement to engagement of temporary staff has been identified and a solution is being explored with temporary staffing and Clinical and Quality directorate colleagues.
- Increasing visibility of senior staff through the mechanism of Service Visits, recommencement of the Quality Visits programme, mock CQC inspections and out of hours visits
- Robust oversight of patient safety incidents, concerns, complaints, and compliments with scrutiny from independent partners – for example Healthwatch and Experts by Experience being core members of Patient and Carer Experience Committee.
- The Trust welcomes external partnership working including Healthwatch, Advocacy services and statutory services within the safeguarding arena and secure services.
- The Trust has strong service user engagement with some direct reporting to the Director of Nursing and Patient Experience.
- The Trust has processes to support people with a Learning Disability or Autistic people who are admitted to our acute and secure services.
- The Trust welcomes the opportunity to provide assurance and participate in external reviews alongside the Integrated Care Board (ICB) and Adult Safeguarding Board to which information has been submitted.
- The Trust is a member of National Mental Health Nurse Directors Forum and has shared its actions with this organisation who have produced an

analysis of what actions organisations are taking to set a culture of compassion and safe care.

- This report has been submitted to Quality and Safeguarding Committee where assurance was received and shared with Trust Operational Oversight Leadership meeting for information sharing and cascade to colleagues.
- Assurance has been provided to the System Quality Group and shared with Integrated Care System (ICS) Chief Nurses

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

- Assurance is provided regarding oversight of care and the wide variety of opportunities for colleagues to gain support and raise any concerns regarding care delivery.
- Assurance that work continues regarding developing an open culture across the Trust.

Consultation

- Executive Leadership Team (ELT).

Governance or Legal Issues

- This is in response to a request from Claire Murdoch for assurance regarding closed cultures, abuse of patients and poor care with the enquiring approach of “could this happen here”

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:

- DHCFT cares for people from a range of backgrounds and cultures and people who at times are vulnerable. Assurance that good quality care is in place is an essential part of equality impact. The report highlights how assurance is gained.

Recommendations

The Board of Directors is requested to receive assurance of oversight and continuous improvement to develop and maintain an open culture.

Report presented by: **Becki Priest**
Director of Quality & Therapies

Report prepared by: **Kyri Gregoriou**
Deputy Director of Nursing & Quality Governance

Vicki Baxendale
Deputy Director Regulated Practice & Special Projects

Assuring Quality Care

Introduction

In a recent Panorama documentary; *undercover report findings of poor and abusive care in NHS mental health secure services*, poor care, abuse and negative cultures were captured and reported on. As a result, Claire Murdoch (National Director for Mental Health) has formally requested that all NHS Services providing Mental Health, Learning Disability and Autism services collectively investigate their own areas to *identify, eradicate and prevent this kind of abuse from happening.*

The aim of the request is to prevent abuse by:

- Registered staff taking accountability for theirs and other actions
- Trusts having an open culture
- Teams regularly reviewing the quality of their care
- Leaders who support, challenge and role model
- Senior clinicians and managers who have an open-door creating environment for people to speak up about poor care
- Boards who have sight of intelligence including walking the patch.

As a result of the request for assurance, the below demonstrates current practice and further improvements to ensure full assurance that high quality care occurs in Derbyshire Healthcare NHS Foundation Trust (DHCFT).

Engagement, Discussion, Clinical Connection, and Reflection

Part of Claire Murdoch's letter has highlighted the need for Trust to take the approach "this could happen here". Considering this, it is essential for DHCFT to review and recognise ways in which it engages, discusses, connects, and reflects with staff around care provided, cultures, concerns, improvements, and innovations. In doing this a focus is to create an open, responsive, and positive culture.

Examples of this come in the form of clinical and operation teams meeting regularly to review and assess learning to ensure lessons are planned and implemented. In doing so scrutiny and assurance of our own practice occurs frequently.

Our lead psychologist has led on developing and implementing a forum for colleagues to engage in conversations around issues, empowering an open culture. This has focused on enabling staff to talk about how they feel about the recent Panoramas, encouraging reflection and learning. Within these sessions some of the words used by staff have been: "shame", "disgust", "upset" and "anger".

DHCFT has taken pride in its establishment and promotion of Schwartz rounds. These forums allow staff to reflect in an open forum about their experiences and encourage an open discussion within groups. A Patient based Schwartz round is also in development, encouraging inpatient discharged patients to return to tell their story and experience with teams.

Further to groups and reflective discussions, it is also important that staff have the opportunity for 1:1 time with their leaders and others. DHCFT has a high focus on ensuring that colleagues receive their yearly appraisal with their line manager and acknowledges how important good quality supervision is in preventing closed cultures. The Trust is focused on ensuring all staff have access to supervision, and from this a true opportunity to reflect, learn and improve their practice as well as raising concerns and support needs. It is important to also acknowledge that this is also important for Bank staff within the Trust and team leaders are invested in bringing in Bank staff as if they are regular, permanent staff. Reflective practice discussions take place weekly in acute inpatient settings with colleagues independent of the ward. This provides a safe space for staff to learn from incidents and raise concerns around practice.

DHCFT also has a Freedom to Speak Up Guardian in post, who actively spends time in different areas of the Trust. Offering time to staff, for them to have the opportunity to anonymously raise concerns or complaints. The Freedom to Speak Up Guardian (FTSUG) has direct contact with Senior Leads, Heads of Practice and Executive Directors and where concerns are raised, action must be taken. Freedom to Speak Up Guardian reports six monthly to Trust Board and a robust Freedom to Speak Up Policy is in place. There have been no vacancies in this area for a number of years and there is high visibility of contact details and posters around the Trust premises that staff will see and easily be able to take note of. There are also Freedom to Speak Up champions in teams across the Trust. The FTSUG has continued to promote the speaking up role on social media as well as writing a blog for Focus (staff intranet). The FTSUG continues to present at Trust inductions. The FTSUG has also presented tailored FTSU training sessions to the Junior Doctor network and to preceptees within the Trust as well as at team meetings and on request.

It is recognised that within services and due to national reductions of staff, bank and agency staff are used across clinical services. It has been recognised by DHCFT that without appropriate mechanisms in place to engage, support and hear feedback from this group of staff, there will be fundamental gaps in feedback. By engaging bank and agency staff, we have the opportunity to gain feedback from staff who are not tied to a specific team or area and so incorporates a critical friend approach. As well as Freedom to Speak Up procedures continuing to be available for bank and agency staff, DHCFT has also implemented regular live engagement events for bank and agency staff. These sessions provide time and space for staff to discuss their experiences of working within the Trust and raise any potential concerns around cultures. However, there remains further requirement to improve options for feedback from bank and agency staff and work is underway to widen the scope of feedback. Bank and agency colleagues can be a vital, independent ‘set of eyes’ in our inpatient areas. The Clinical & Quality team will explore with temporary staffing how we can specifically engage more with this cohort of colleagues.

As well as engagement with staff within DHCFT, it is also essential that we have processes in which we engage with patients and families. As well as the engagement through our family liaison officer and the patient experience team, Patients and Families are encouraged and supported to take part and engage with our EQUAL forums and other groups such as the Carers forum. These groups allow for conversations, engagement and escalations with the Trust Board to occur. The development of an electronic process is also due for roll out which will increase anonymous feedback from patients and families.

Engagement events

Further to local support and engagement, it is essential that for DHCFT to truly have oversight of its services, there is a requirement for further engagement with services. The Trust has several opportunities to engage groups to ensure feedback occurs and actions taken. Examples of these are:

- Trust Medical Advisory Committee – a group where our medical colleagues meet to reflect and discuss learning. A reflection within this group in relation to the recent panorama was “it’s all of our responsibilities to hold and challenge the culture of our organisation”.
- Administration engagement – administration staff are frequently offered time to talk about their experiences and learning. DHCFT highlights the importance of engaging all staff, both clinical and non-clinical. A recent engagement event with executive directors allowed time for administration staff to reflect and highlight their experience within the Trust.
- Trust induction – the Trust induction provides not only essential training before someone starts within their roles. But also, an opportunity to truly demonstrate the Trusts Culture, Visions and Values and embed them into all staff coming into the Trust. Within the Trust induction all staff have the opportunity to meet the Chief Executive and hear about the Trust Visions and Values. But also, time with the Director of Nursing and Patient Experience, to reflect on the importance of inclusion and understanding diversity challenges across the Derbyshire. Also within the Trust induction the Trust Director of People and Inclusion meets staff to talk about the important of psychological safety and how important the Trust Values are in keeping this for all. The Trust induction also has a strong focus on creating an environment that is safe for everyone and following an equality, diversity and inclusion strategy.
- Senior managers – along with junior and local staff, it is important that senior managers are given the opportunity to meet, reflect and discuss challenges within the Trust. Several forums occur where this occurs and allows for learning, engagement across divisions and support to be offered in resolving challenge. This also provides a forum for senior managers to learn from each other and ensure a cohesive approach.
- Students – further to employed staff within the Trust, DHCFT recognises the importance of hearing from students. The Trust recognises that is important to instil a positive culture before staff are employed and regular reflection and opportunities to hear students experiences of the Trust highlight learning. These forums also offer the opportunity to highlight potential closed cultures, allowing leaders to action.
- Clinical Quality Directorate – DHCFT is proud of its Clinical Quality Directorate. This directorate houses the Trust Heads of Nursing/Practice, Clinical Experts, Experts by Experiences and Lead Allied Health Professionals. This group of staff are focused on gaining local and Trust intelligence, which is then converted into quality improvement projects and focus groups. The forefront of this directorate is to provide and improve care in order for it to be the best it can be, while promoting and instilling a positive culture, resulting in positive patient outcomes.

- The Trust is currently in the process of developing and implementing a new role. This will be an Expert by Experience Feedback and Engagement lead. This role will focus on engaging with clinicians and service users across all services to gain live feedback and intelligence, observe practice and challenge any concerns, feedback to board, engage in improvement working groups, support the provision of expert by experience members into working groups and prepare clinical areas for increased peer support worker colleagues.
- Historically, DHCFT has taken pride in the level of direct contact and engagement executives and senior staff have had with clinical and frontline staff. This has continued through the COVID-19 pandemic and remains to the current date. Within staff surveys and feedback, there is positive feedback about this engagement and the open and transparency of the Trust executive team. As a result, this culture has created a forum where staff feel able to speak up and raise concerns and also engage with improvement plans. This engagement has supported staff during challenging times and has also heavily supported a positive morale and culture. An example of this is during the COVID-19 pandemic, where senior leaders regularly visits clinical areas and through this engagement implemented support offers such as free food, uniform support and pop up testing sites. DHCFT has also taken pride in its thank you to staff through gestures such as a hand written Christmas card from the Chief Executive to every staff member and a personalised chocolate bar to all. These have all supported positive morale during challenging periods.

Unannounced visits and announced

The Clinical Quality directorate frequently use regional intelligence to design review tools, that gain assurance and evidence for evening, weekend, and night visits. DHCFT has taken a 24-hour service review approach and acknowledged that this is an area where organisations need to strengthen oversight and scrutiny. Multiple levels of the organisation are involved in this, to reduce the risk of a top-down process. Teams across the Trust, within several different roles and professions have been brought together and planned and will be deployed, repeatedly and regularly. This process will continue and will enable further reflection and conversation, ensuring DHCFT keeps its Visions and Values and the forefront of its approach.

In addition to these visits, the Trust is also invested in a range of approaches that focus on assessing governance, assurance and also promoting good practice and innovation. For several years DHCFT have taken an innovation approach to Quality Visits, where teams are able to demonstrate practice, they are proud of, meeting senior leads and executives, while also having the opportunity to raise areas of concerns. This provides them a direct route to board, creating a ‘floor to board’ approach and encourages a speaking up culture.

Announced and unannounced visits have also commenced across all areas of the Trust. These allow for a range of professionals to see the practice of clinicians first-hand and provides an opportunity to engage with staff, for leaders to role model and to challenge any practice that does not fit with Trust Values or patient experience and safety.

A critical friend approach has also been implemented through Mock CQC visits. Our Deputy Director of Regulated Practice and Special Projects has been leading on a timetable of Mock CQC visits that explores patient care and practice to truly understand the experience of patients. Through this teams are assessed in line with the CQC Key Lines of Enquiry and any findings are placed within an action plan for completion. All actions plans are then held with divisional Clinical and Operation Assurance Team (COAT) meetings to ensure a strong level of governance. This creates a critical friend approach to improvement. As well as these visiting processes, DHCFT has recently created an Out of Hours Visit plan. DHCFT recognises that services are 24/7 and all staff need access to senior leadership. To ensure all have the opportunity to meet and speak with senior staff and for senior staff to understand the challenges within our services at different times. An out of hours rota will support unannounced visits to teams by leaders.

Development of Intelligence, Evidence and Assurance

DHCFT understands and acknowledges, that internal evidence and assurance is not always enough to truly have oversight of services and the care people are receiving. In order to gain this, there is a requirement for openness, transparency and responsiveness through other means and forums. There must be an opportunity for staff and patients to speak up, raise concerns and complain without the fear of repercussions. There needs to be confidence that an appropriate response and action will occur when items are raised.

DHCFT has a robust Complaints, Concerns and Compliments process in place and a quarterly intelligence report in relation to themes is held by each divisional COAT meeting, along with an escalation report to Quality and Safeguarding Committee. Complaints concerns and compliments are reviewed by Heads of Practice and reported to the Patient and Carers Experience Committee, this has core membership from within the Trust, carers and service users and Healthwatch which supports challenge from people who use our service regarding quality and culture. Where complaints are received, DHCFT takes a supportive and learning approach with service users, family, and carers. All complaints are signed off by and responded to by the Chief Executive with oversight and learning cascading through the divisions. DHCFT recognises that through complaints, comes learning opportunity and focus on improving services.

If allegations of abuse are made against staff then this will go through a safeguarding process, if required they will follow the local authority Person In Position Of Trust (PIPOT) process, this will entail an open and transparent multi agency approach, usually involving both police and social care.

Further to this, a twice weekly incident review meeting occurs where Heads of Practice, General Managers, Heads of Patient Safety and Experience, Medical Director, Director of Nursing and Legal/Mental Health leads review incidents that have occurred. Quickly identifying actions to take, learning and review and investigation processes.

The Trust has also been praised for above and beyond practice in relation to its Safeguarding team by the CQC. Highlighting a passion and willingness to improve care and experience. The Safeguarding team has taken a keen focus on Person In Positions of Trust (PIPOT) processes, ensuring that any concerns are quickly identified and investigated, promoting safety. The team also utilise these examples

to create training and learning for others. The Safeguarding team also works closely with external partners that allows scrutiny of practice within our teams including quality audits of cases, and partnership working both operationally and strategically.

Across services, there is also a strong emphasis on the engagement of Advocacy services. A recent improvement project across inpatient acute care wards has seen patient community meetings being reviewed and moved from weekends to weekdays. This has been done in order for advocacy services to be present at all and for senior managers to be present where appropriate. Advocacy services are provided to all of our inpatient areas, advocates attend regularly and are provided private spaces to speak to people in our care.

Alongside advocacy and engagement meetings, DHCFT has taken pride in its engagement with Healthwatch. Implementing a monthly art group that allows patients to engaging in positive therapeutic activities, and the opportunity to feedback on the care they are receiving away from staff. Encouraging an open and transparent culture. From these, our Healthwatch colleagues provide a report to our Heads of Practice, who then feed into Clinical Reference Groups and team meetings to create action plans with clear time frames of improvement that are fed back to Healthwatch. These actions are then followed up within future art groups to ensure they have been improved. Healthwatch also complete six monthly visits to our areas.

Expert by Experience feedback is recognised as a valuable asset to ensuring outstanding care. DHCFT is proud of its EQUAL group, which is filled with Experts, Carers and Volunteers who complete announced and unannounced visits, in all areas to provide further intelligence and feedback. EQUAL is chaired by our Director of Nursing and Patient Experience . Feedback is also provided via the Carers Engagement Group.

We have a peer support worker in place that visits our inpatient areas, talks to people in our care, collects patient generated ‘Bright Ideas’ on improvement, they report directly to the Director of Nursing and Patient Experience . All of our inpatient areas hold at least weekly ‘community meetings’ with people in our care, these discuss upcoming activities, and provide space for feedback to be given on the ward environment and the care received.

Training can provide an independent space for colleagues to raise concerns or challenge practice, particularly safeguarding or positive and safe training. When staff raise concerns within these sessions feedback is provided to the appropriate manager. Mandatory training across the Trust is currently 80% for all services and all training. There are some areas that do not meet the target of 75% across all their training. Managing Directors are working with teams to support the release of staff and the training team are reintroducing block training sessions, these were suspended during the pandemic and have historically improved compliance in training.

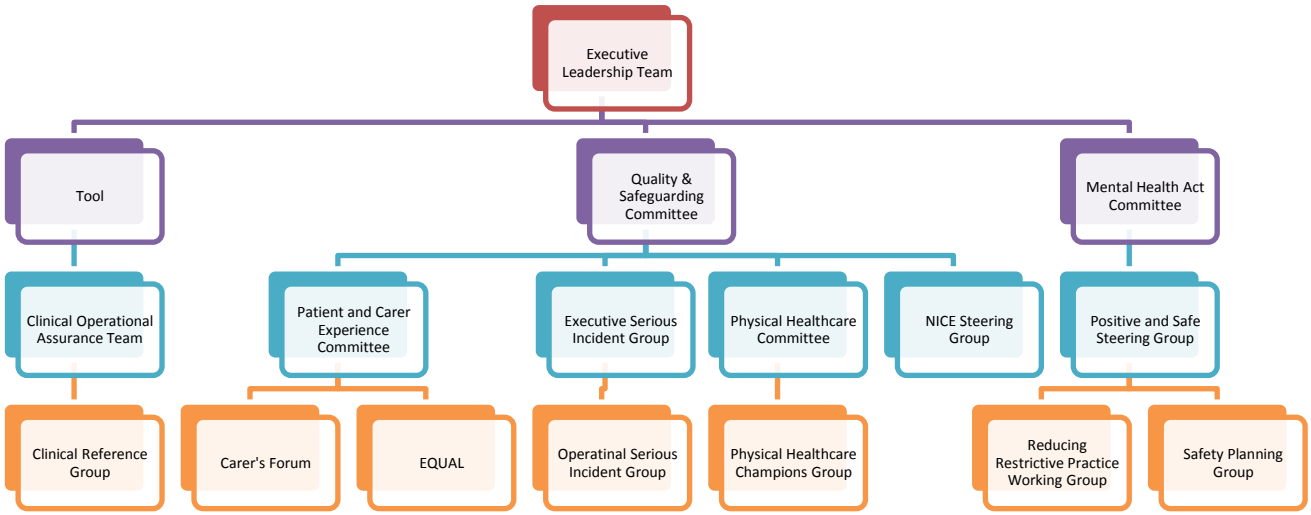
All colleagues have access to supervision and appraisals, below are the rates for all clinical services. These rates are currently lower than we would like and are regularly reviewed with leaders within clinical services.

	Actual	Target
Appraisal	82%	90%
Clinical Supervision	71%	95%
Managerial Supervision	75%	95%

Along with clinical assurance-based checks, DHCFT is also invested in checking its environment and engagement with catering, domestic and estates services. In order to create a level of assurance, annual PLACE visits are completed in all inpatient settings. These visits aim to review cleanliness of services, quality of food, maintenance of buildings and repair and upkeep of settings. This visit is completed with Domestic, Catering and Estates managers, Heads of Services, Heads of Infection Prevention and Control, Carers and Experts by Experience.

Accreditation is a positive way for clinical areas to demonstrate a high level of clinical performance, governance, and assurance. DHCFT is signed up to and invested in several Royal College of Psychiatry Accreditation schemes for this reason. Further to providing benchmark and expectation for clinical staff, they also provide a critical friend and peer approach to review and improvement. With these programs, teams are able to review their peers, provide support and learning for each other and also through an accreditation process receive critical friend feedback. This provides a level of openness and transparency.

Internally, it is important that DHCFT has a clear and robust governance structure which provides floor to board assurance, along with board to floor communication. This comes in the form of a clear meeting structure linking clinical reference group, Clinical Operational Assurance teams, Trust Operational Oversight Leadership, Quality and Safeguarding Committee and Executive Leadership team all together. Providing a clear forum for oversight and communications up and down.



Learning Disability services - Acute care

It is important that where patients with a learning disability or neurodevelopmental disorder identified are admitted into an inpatient acute setting, there is appropriate oversight, discussion and multi-disciplinary team working. DHCFT has a well-established process for managing admissions into acute inpatient care beds. Where a patient is identified as needing an admission, before this can accrue a Local Area Emergency Protocol (LAEP) meeting must occur. This meeting can be held 24 hours a day, an admission cannot occur without this. Through this process a Care and Treatment Review (CTR) is organised and implemented, and a 12-point discharge plan put in place to ensure appropriate in reach and outreach of each patient. An identified member of the case management team is allocated to every patient admitted and they work closely with teams to facilitate safe and appropriate discharge. This team along with the Intensive Support Team (IST) support and

facilitate training and supervision of staff to ensure the most appropriate care and practice is in place.

Systems are in place for the management of CTR across all areas, included an in reach team based around managing them. This team will link in with inpatient staff, along with community staff and will focus on ensuring the most appropriate settings and care packages are in place for patients.

Where external providers are part of a person care, DHCFT has robust process in place for monitoring practice and escalating concerns to ensure full assurance over care provision. DHCFT work closing with the Integrated Care Board (ICB) quality team where concerns are raised and a clear escalation process is in place. DHCFT staff also work alongside care providers to support and where appropriate offer training. The Trust Safeguarding team is also heavily focused and invested in managing concerns and providing learning.

Low secure unit

Our Low secure unit, Kedleston, has low levels of seclusion and nationally a lower length of stay accompanied with a low readmission rate. We are active partners within the regional provider collaborative who commission the beds. The provider collaborative has the responsibility to monitor the quality and safety of care within their sphere of responsibility and as such have case managers that visit Kedleston on a regular basis.

Kedleston manage a variety of people with very complex needs that require support from other services thus strengthening an open culture. A recent example of this is a gentleman with Learning Disabilities being cared for with support from the Forensic Learning Disability team.

Since the airing of the Panorama programme (related to mental health secure care) the General Manager that has responsibility for Kedleston has arranged a reflective session including operational and quality colleagues to discuss the culture within Kedleston and promote an open culture.

External reviews

Further to internal review and assessment, DHCFT is fully investing in an open culture and engagement with its local ICB. In collaboration with the local ICB an assurance report was submitted at the end of November 2022. DHCFT is part of an assurance visit and report alongside the Safeguarding Adults Board. This is with the request of reviewing DHCFT evidence for assurance.

Assurance has been provided to the System Quality Group and shared with Integrated Care System (ICS) Chief Nurses

DHCFT is also working alongside the ICB in the development of a regional Board Assurance Framework. Working as a system to improve system-based risk.

Conclusion

DHCFT takes pride in his Visions and Values as a Trust. There is a heavy focus on people first and part of this is taking the time to step back and think when issues and concerns present themselves to ensure that the approach taken is fair, supportive, trauma informed and results in a positive outcome. This approach has encouraged staff, service users and carers to feel comfortable to come forward, speak up and raise concerns when they are presented. Executive leaders take pride in the level of

engagement they have with those using our services and those working within it. Where national or system challenges have presented themselves, DHCFT has followed its Vision and Values and at times has with confidence taken a different approach to neighbouring Trusts, knowing that their approach will have a more positive outcome. This approach has strengthened DHCFT's approach to equality and improved staff morale. It is felt that this has supported people to speak up, to be open and honest, to feel able to challenge poor practice and to raise when they feel they are unable to manage it themselves. This approach is seen throughout the Trust at all levels.

This report has been submitted to Quality and Safeguarding Committee where assurance was received and shared with Trust Operational Oversight Leadership meeting for information sharing and cascade to colleagues. It has also been included on the Board Assurance Framework to enable continued oversight.

Derbyshire Healthcare NHS Foundation Trust
Report to the Public Trust Board – 17 January 2022

CQUIN Update and progress report

Purpose of Report

To provide the Board with an update and assurance around Derbyshire Healthcare NHS Foundation Trust (DHCFT) progress against the CQUINs (Commissioning for Quality and Innovation) for 2022/23 and to outline the CQUINs for 2023/24.

Executive Summary

This report provides an update with regards to DHCFT progress around the 2022/23 CQUIN achievement up to Quarter 2 and outlines the preparation for the 2023/24 CQUIN schedule.

As per the Integrated Care Board (ICB) agreement there is no payment attached to the 2022/23 CQUINs and there is no indication of a change to payment related reporting for the 2023/24 CQUINs.

2022/23 CQUIN update

- Staff flu vaccinations
  52% of staff have received their flu vaccine as of December 2022. Regular communications are being sent out to staff and clinics are set up in locations across the trust to enable staff to access vaccinations more easily

- Cirrhosis and fibrosis tests for alcohol dependent patients
  This CQUIN is fully achieved as of Quarter 2

- Routine outcome monitoring in Children and Young People (CYP) mental health and perinatal mental health services
  As of Quarter 2, DHCFT are not currently achieving this CQUIN, action plans are in place supported by the leads

- Routine outcome monitoring in community mental health services
  This CQUIN is fully achieved as of Quarter 2

- Use of anxiety disorder specific measures in Improving Access to Psychological Therapies (IAPT). (This CQUIN applies to the Talking Mental Health Contract)
  This CQUIN is being partially achieved as of Quarter 2. There have been data quality issues which have now been resolved

- Biopsychosocial assessments by mental health liaison services
  This CQUIN is fully achieved as of Quarter 2

- Outcome measurement in perinatal inpatient services
  As of Quarter 2, DHCFT are not currently achieving this CQUIN, monitoring of outcomes for patients and a monthly audit is in place to monitor progress against the CQUIN.

2023/24 CQUIN Schedule

The CQUINs for 2023/24 are:

- CQUIN 01 – Staff Flu Vaccination
  This CQUIN is a continuity of the previous year however, there has been a change in the threshold expectation and the upper threshold has been reduced to 80% from 90%

- CQUIN 15a - Routine outcome monitoring in community mental health services
  This CQUIN is a continuity of the 2022/23 CQUIN CCG10b with a change of parameters to 20%-50% from 10%-40%. There is a specific request for 2%-10% PROMs pairing.

- CQUIN 15b - Routine outcome monitoring in Children and Young People (CYP) and community perinatal mental health services
  This CQUIN is a continuity of the 2022/23 CQUIN CCG10a with a change of parameters to 20%-50% from 10%-40%.

- CQUIN 15c - Routine outcome monitoring in inpatient perinatal mental health services
  This CQUIN is a continuity of the 2022/23 CQUIN PSS8 with the same parameters in place.

- CQUIN 17 - Reducing the need for restrictive practice in adult/older adult settings
  This is a new CQUIN for 2023/24.

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.	

Risks and Assurances

The report provides evidence of progress towards the achievement of DHCFT CQUINs and assurance that we are working towards our aspiration to fully achieve them while delivering evidence-based person-centred care.

Consultation

- Divisional CQUIN Leads
- Deputy Director of Nursing and Quality

Governance or Legal Issues

Outcome 16 (Regulation 10 Assessing and Monitoring the Quality of Service Provision)

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 are potential adverse effect(s) on people with protected characteristics (REGARDS). Details of potential variations /inequalities in access, experience and outcomes are outlined below, with the appropriate action to mitigate or minimise those risks.

Recommendations

The Board of Directors is requested to:

1) Note the contents of the report
2) Comment on progress against actions
3) Receive assurance on the issues highlighted.

Report presented by: Tumi Banda
Director of Nursing and Patient Experience

Report prepared by: Joseph Thompson
Assistant Director for Clinical and Professional Practice

CQUIN Update

CQUIN 2022/23

Progress Update

CCG1 - Flu vaccinations for frontline healthcare workers

The vaccination uptake for health care workers was at 52% by end of December 2023. This was a reduction from the same period last year. DHCFT is in the mid-range and there is reduced uptake in the region and the country. There has been increased vaccination fatigue, hesitance and it may be that staff are concerns about other issues such as cost of living. It is anticipated that the set target of 90% will not be reached by the end of the flu campaign 2022/23.

CCG9: Cirrhosis and fibrosis tests for alcohol dependent patients

The set targets are being met in this CQUIN. There have been various initiatives implemented in the Q1 and Q2 which saw improvement in testing. The working group continues to monitor the initiatives and share learning.

CCG10a: Routine outcome monitoring in Children and Young People (CYP) and perinatal mental health services

The set targets for this CQIUN have not been met in Q1 and Q2. Various initiatives have been put in place to ensure that there are improvements in this CQUIN. There has been increased trained offer to Routine Outcome measures (ROMs), on Teams. Divisional CQUIN lead attended managers meeting, encouraged discussion around their use within staff supervision.

CCG10b: Routine outcome monitoring in community mental health services

To date the paired outcome target for Community is being achieved, currently 48%, further improvements are expected as other initiatives are embedded.

CCG11: Use of anxiety disorder specific measures in IAPT

The has been improvement in the CQUIN between Q1 and Q2, compliance has been adversely affected by reporting and coding to capture the required data. There are plans to resolve this compliance now stands was at 61% in Q2 against a target of 65%.

CCG12: Biopsychosocial assessments by Mental Health Liaison services

In Quarter 2, 96% of service users were offered a biopsychosocial assessment and 80% received a biopsychosocial assessment, the CQUIN target is 80%.

Of those service users who did not receive an assessment, the main reasons for this was because the patient absconding for refusing an assessment after being referred (60%).

PSS8: Outcome measurement in perinatal inpatient services

The CQUIN targets are not met, monthly audits are in place on the Unit which monitor the completion of the Patient Reported Outcome Measures (PROMs) and Clinician Reported Outcome Measures (CROMs). The audits are used to feedback into the team and ensure consistent use of outcome measures.

An additional challenge with this is that several discharges had been on extended periods of leave prior to discharge which caused difficulties in completing PROM on discharge. The team have made changes to ensure the PROM is completed prior to leave if completing on discharge might become a challenge.

The leads and working group have been identified the challenges and have plans in place that are being monitored in the divisions' governance meetings.

The CQUINs are be monitored through the divisional meetings and at the Trust Operational Oversight Leadership group (TOOL) led by the Assistant Director for Clinical and Professional Practice. The CQUNs will be on the Quality and Safeguarding Committee agenda in February 2023 and the new schedule of CQUINs will follow same process of monitoring.

CQUIN 2023/24
The CQUINs for 2023/24 will be reported to the Trust Quality and Safeguarding Committee and submitted to TOOL for assurance quarterly outlining how the trust is performing against the specific Threshold measures as per the table below. An action plan will also be submitted identifying any barriers or areas that require improvement with a goal-based plan identifying both what being done and what is required to achieve the upper threshold. There will be a monthly meeting for CQUIN leads to report on their progress and request support or escalation.

2023/24 summary table CCG CQUINs							
CQUIN	Topic	Lower Threshold	Upper Threshold	Q1	Q2	Q3	Q4
CQUIN01	Staff flu vaccinations:	75%	80%				
CQUIN15a	Routine outcome monitoring in community mental health services: Achieving 50% of adults and older adults accessing select Community Mental Health Services (CMHSs), having their outcomes measure recorded at least twice. Separately, achieving 10% of adults and older adults accessing select Community Mental Health Services, having their patient-reported outcomes measure (PROM) recorded at least twice.	Paired overall Min: 20%	Paired overall Max: 50%				
		Paired PROMs Min: 2%	Paired PROMs Max: 10%				
CQUIN15b	Routine outcome monitoring in CYP and community perinatal mental health services: Achieving 50% of children and young people and women in the perinatal period accessing mental health services, having their outcomes measure recorded at least twice.	20%	50%				
CQUIN15c	Routine outcome monitoring in inpatient perinatal mental health services: Achieving 55% of inpatients in specialist perinatal mental health services having the same patient-reported outcomes measure (PROM) recorded at least twice and 95% of patients having the same clinician-reported outcomes measure (CROM) recorded at least twice.	75% CROM	95% CROM				
		35% PROM	55% PROM				
CQUIN17	Reducing the need for restrictive practice in adult/older adult settings: Achieving 90% of restrictive interventions in adult and older adult inpatient mental health settings recorded with all mandatory and required data fields completed.	75%	90%				

CQUIN 01 – Staff Flu Vaccination
This CQUIN is a continuity of the previous year however, there has been a change in the threshold expectation and the upper threshold has been reduced to 80% from 90%

CQUIN 15a - Routine outcome monitoring in community mental health services
This CQUIN is a continuity of the 2022/23 CQUIN CCG10b with a change of parameters to 20%-50% from 10%-40%. There is a specific request for 2%-10% PROMs pairing.

CQUIN 15b - Routine outcome monitoring in CYP and community perinatal mental health services
This CQUIN is a continuity of the 2022/23 CQUIN CCG10a with a change of parameters to 20%-50% from 10%-40%.

CQUIN 15c - Routine outcome monitoring in inpatient perinatal mental health services
This CQUIN is a continuity of the 2022/23 CQUIN PSS8 with the same parameters in place.

CQUIN 17 - Reducing the need for restrictive practice in adult/older adult settings
This is a new CQUIN for 2023/24. As a result of this, the CQUIN will placed as a standard agenda for the Reducing Restrictive Practice meeting staring from January in order to commence work now in preparation for the CQUIN starting in March 2023. This will allow for audits, systems, and clinical practice to be put in place early.

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 17 January 2023

Responsiveness Update

Purpose of Report

This paper provides Trust Board with an update on the responsiveness of our services. The report is intended to provide an overview of performance in this domain and to prompt a strategic discussion about our approach and help to identify whether any further development or focus may be needed.

Executive Summary

This report presents information relating to one of the five key questions which the Care Quality Commission (CQC) considers when reviewing and inspecting services: are they responsive to people's needs?

There are a number of standards for access to care and treatment. This paper describes these standards and provides an assessment of how the Trust's services are performing against these standards.

The Trust continues to be responsive across many of the services it provides, achieving the majority of existing standards and proposed standards. However, there remain a number of services where being responsive continues to be a significant challenge. Recovery action plans are in place and progress reported in the Integrated Performance Reports to Trust Board.

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 relates directly to the delivery of the Trust's strategy on providing responsive services.
- This report should be considered in relation to the relevant risks in the Board Assurance Framework (BAF).
- The content of the report provides assurance across several BAF risks related to service delivery and regulatory compliance.

Consultation

This paper has not been considered by any other Committee, however responsiveness measures form part of the Integrated Performance Report to Trust Board and are also routinely monitored by other internal and external committees.

Governance or Legal Issues

Information supplied in this paper is consistent with the Trust's responsibility to deliver the requirements set out by the CQC.

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 note the contents of this report.

Report presented by: Ade Odunlade
Chief Operating Officer

Report prepared by: Peter Henson
Head of Performance

Lee Doyle
Managing Director

Responsiveness Update

1. Introduction

There are a number of existing and proposed standards for timely access to care and treatment. This paper describes these standards and provides an assessment of how the Trust's services are performing against these standards. For areas requiring improvement, recovery action plans are in place which are summarised in the Integrated Performance Report, with progress against implementation to be provided at future Board meetings.

2. Access standards

The majority of standards are outlined in the Handbook to the NHS Constitution for England[1]. The applicable standards are as follows:

The right to start consultant-led treatment within a maximum of 18 weeks from referral for non-urgent conditions.

- A maximum 3 day wait for follow-up after discharge from psychiatric inpatient care (revised from 7 days in April 2020)
- 75% of people referred to the improving access to psychology therapies (IAPT) programme should begin treatment within six weeks of referral and 95% of people referred to the IAPT programme should begin treatment within 18 weeks of referral.
- 60% of people experiencing a first episode of psychosis will start treatment within a NICE-recommended package of care with a specialist early intervention in psychosis service within two weeks of referral (this increased from 56% in 2020[2])

In addition to the above, the following access standards were introduced this financial year as NHS long term plan priorities for Integrated Care Systems:

- IAPT 1st to 2nd treatment waits over 90 days: target <=10%
- Children and young people referred to an eating disorders service should been seen within 1 week (urgent) or 4 weeks (routine)

NHS England also proposed the following mental health standards[3]:

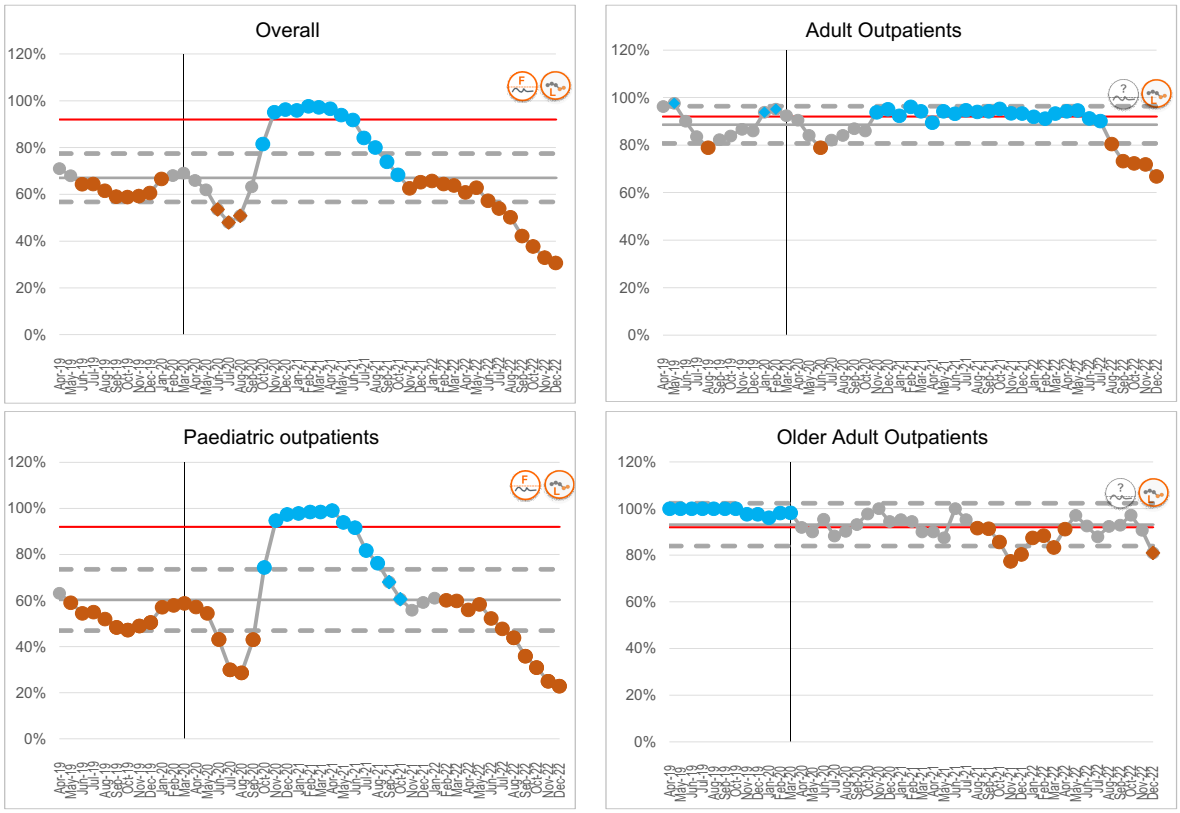
- For an 'urgent' referral to a community based mental health crisis service, a patient should be seen within 24 hours from referral, across all ages
- For a 'very urgent' referral to a community based mental health crisis service, a patient should be seen within four hours from referral, for all age groups
- Patients referred from Accident and Emergency should be seen face to face within one hour, by mental health liaison or children and young people's equivalent service
- Children, young people and their families/carers presenting to community-based mental health services, should start to receive care within four weeks from referral
- Adults and older adults presenting to community-based mental health services should start to receive help within four weeks from referral.

[1] https://www.gov.uk/government/publications/supplements-to-the-nhs-constitution-for-england/the-handbook-to-the-nhs-constitution-for-england
[2] https://www.england.nhs.uk/wp-content/uploads/2016/07/fyfv-mh.pdf
[3] https://www.england.nhs.uk/publication/mental-health-clinically-led-review-of-standards/

3. Trust performance against access standards

Consultant-led treatment

The national access standard is that 92% or more of the patients currently on the waiting list for a consultant-led outpatient service must have been waiting less than 18 weeks.
The Trust dropped below the national standard during the pandemic and the position has continued to deteriorate. This is mainly linked to the significant increase in referrals to paediatric outpatients for neurodevelopmental assessment, which has been evident since January 2021 and has been reported regularly to the Trust Board, however waits have also increased for adult and older adult mental health outpatients in recent months. At the time of writing 196 people across all outpatients services have been waiting over 18 weeks, of whom currently 54% have appointments booked in January and 80% between now and the end of February. The recovery action plan for paediatric outpatients is summarised in the Integrated Performance Report to Trust Board this month.



Delivering a personalised outpatient model[4]

The NHS 2022/23 operational planning guidance asked providers and systems to reduce outpatient follow-ups by a minimum of 25% against 2019/20 activity levels by March 2023 *where clinically appropriate and beneficial*, and going further where possible.

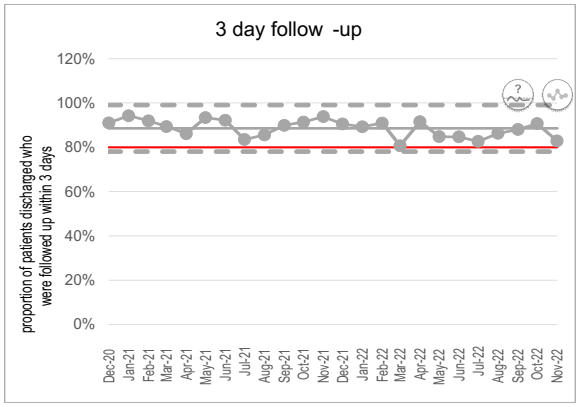
In the Trust, mental health consultant led outpatient follow-up appointments have reduced by 9%, however the volume of paediatric outpatient follow-up appointments has increased; this is linked to the significant and enduring increase in paediatric referrals since 2021:

Consultant Outpatient Follow up Appts	2019/20	2022/23 (Forecast)	Change
Mental Health	25,756	23,337	-9%
Paediatrics	7,259	8,563	18%

Follow-up after discharge from psychiatric inpatient care

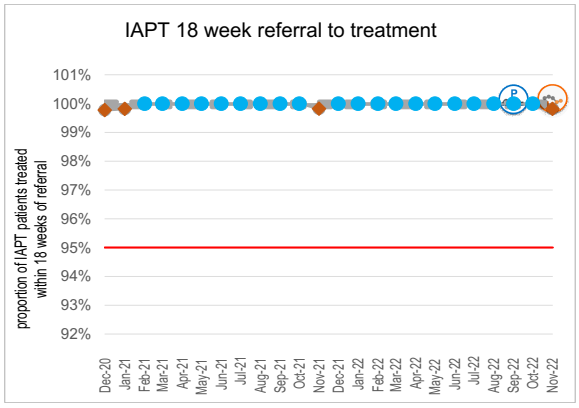
[4] B1388_i_principles-and-approach-to-deliver-a-personalised-outpatient-model_300322.pdf (england.nhs.uk)

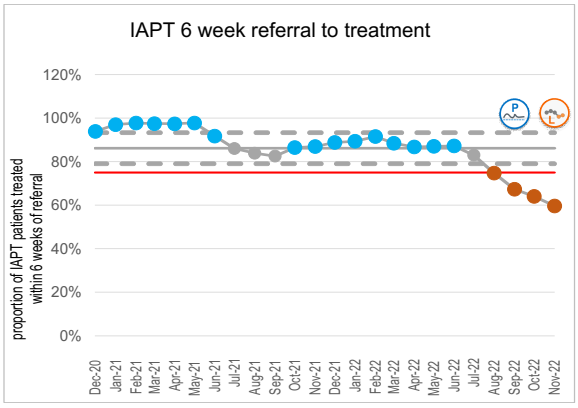
To date we have consistently exceeded the national standard for follow-up which came into effect from 1 April 2020.

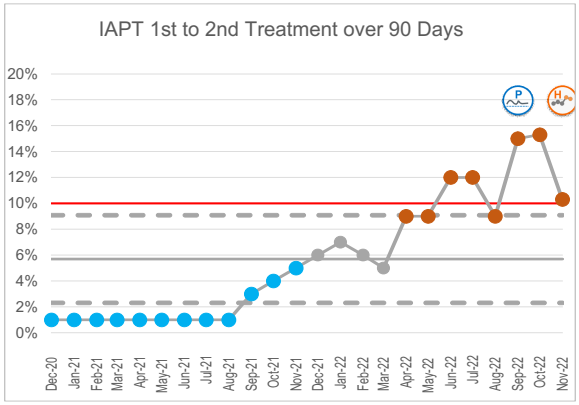


IAPT referral to treatment

The national standard for 18-week referral to treatment (standard = 95%) has been exceeded throughout the reporting period. Wait times have been increasing since the summer, both for 6-week referral to treatment and then first to second treatments. The main impact for the 6-week referral to treatment increase in waits has been owing to vacancies in the Step 2 team who do most of the assessments. As there is a clear career progression from Step 2 to Step 3, via funded high intensity training, Psychological Wellbeing Practitioners (PWPs) tend to be lost when the University courses start in September and March. In previous years our staffing levels have been maintained through a combination of qualifying trainees and recruitment, however more recently it has become harder to recruit Step 2 qualified clinicians. With longer wait lists from first to second treatment, PWPs have had the added pressure of booking in waiting well checks which also reduces their capacity to undertake assessments and Step 2 treatments.

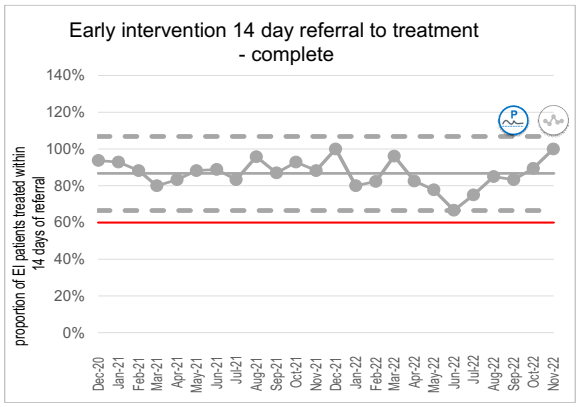


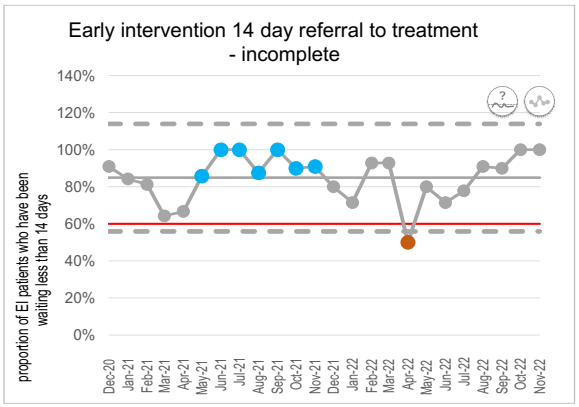




Early intervention in psychosis

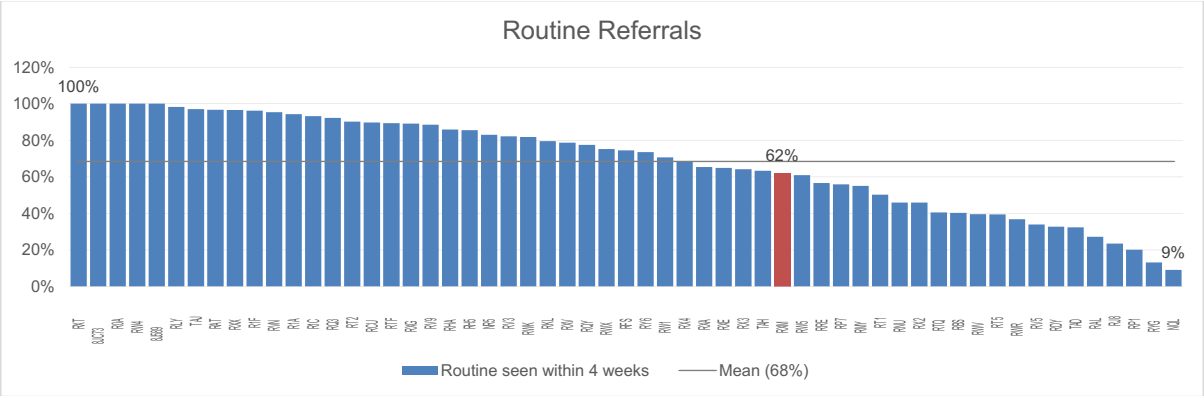
Patients with early onset psychosis are continuing to receive very timely access to the treatment they need. Occasionally delays result from difficulties contacting patients to arrange appointments, or patients not attending their planned appointments. The service is generally extremely responsive and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



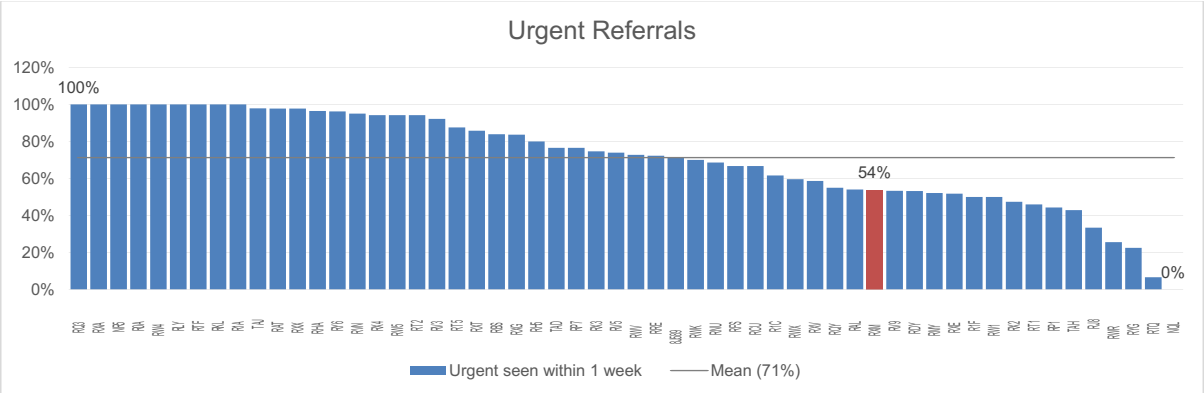


Children and young people referred for assessment or treatment for an eating disorder

In the latest published national data (quarter 2 – 2022/23) 62% of routine referrals were seen within four weeks of referral, which is below the national standard of 95% and the national average of 68%.



In the latest published national data (quarter 2 – 2022/23) 54% of urgent referrals were seen within one week of referral, which is below the national standard of 95% and the national average of 71%.

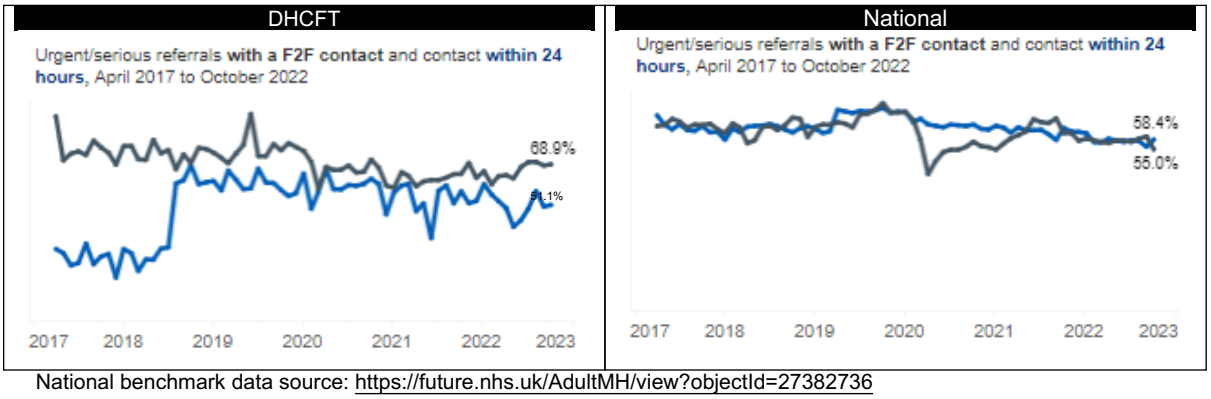


Data source: Statistics » Children and Young People with an Eating Disorder Waiting Times (england.nhs.uk)

A recovery action plan is in place which is being led by the Integrated Care System as this service is delivered by two providers within the system who are experiencing similar issues. Key actions and progress are summarised in the Integrated Performance Report to Board.

Referral to community based mental health crisis services – indicative position

The national data would suggest that for adult urgent referrals the Trust's responsiveness is below average for urgent response within 24 hours but above average for face-to-face contact. Caveat: NHS Digital have advised that the data is subject to data quality improvement and therefore it should be taken as indicative only.

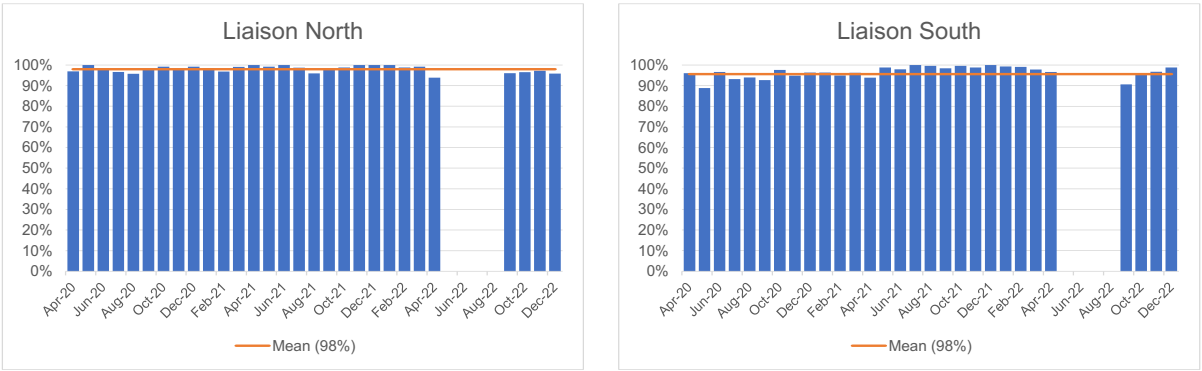


National benchmark data source: https://future.nhs.uk/AdultMH/view?objectId=27382736

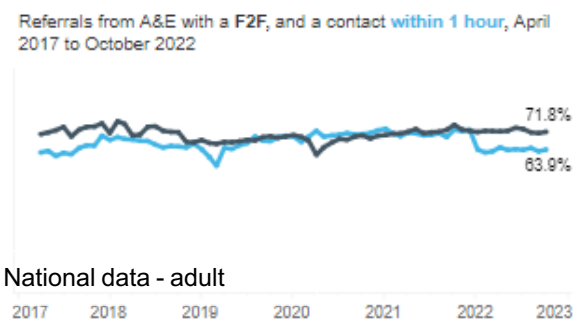
Patients referred from Accident and Emergency Departments (A&E)

On average 96% of adult referrals from A&E were seen within one hour of referral by Liaison South and 98% by Liaison North. This is considerably higher than the national benchmark of 64% and shows a high level of responsiveness.

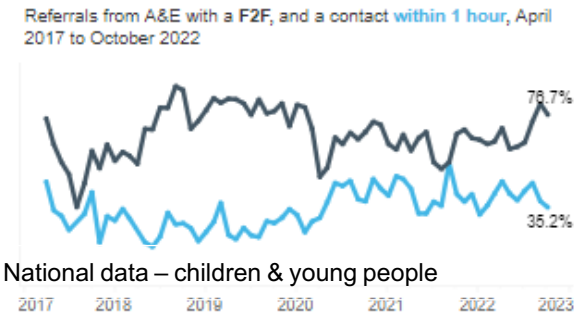
Data regarding children and young people is currently only available at national level and the latest position was that nationally only 35% of children and young people were seen within one hour of referral.



NB the gap in the charts above relates to the transition period from Paris to SystmOne. During that time significant data quality and reporting issues were experienced which took a few months to resolve.



National data - adult

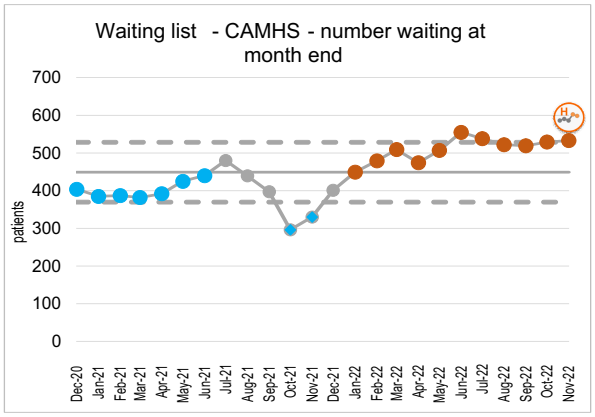


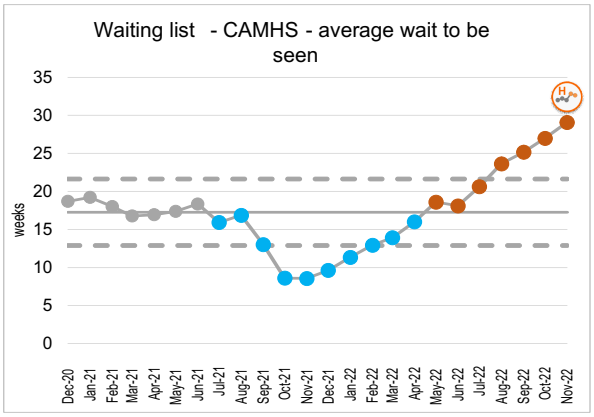
National data – children & young people

F2F = face to face
National benchmark data source: https://future.nhs.uk/AdultMH/view?objectId=27382736

Children, young people and their families/carers presenting to community-based mental health services

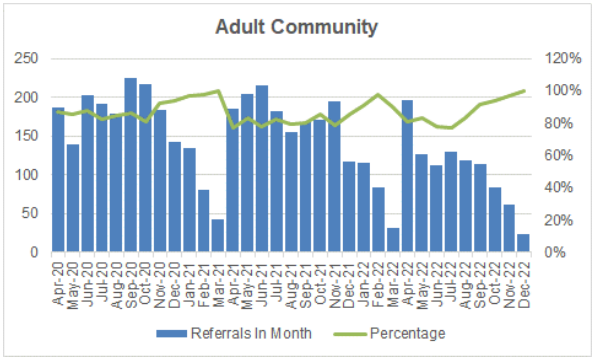
A year ago the average wait to be seen stood at 10 weeks, but since then waits have been steadily increasing, with a significant increase seen over the last 7 months. At the end of November 2022, 533 children were waiting to be seen with an average wait time of 29 weeks. A number of actions are now in place to improve the position, including redesign of the assessment team model and launch of a core CAMHS team, which are expected to alleviate saturation across core teams and increase flow and specialist support to those who need it.

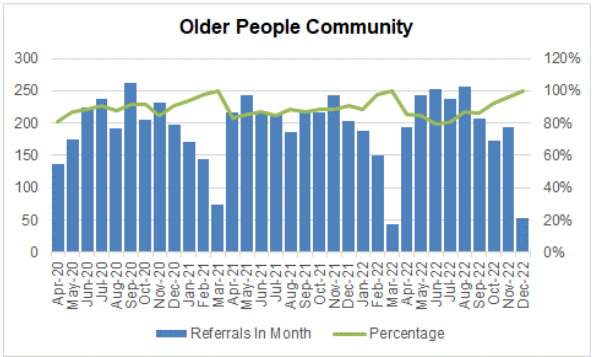




Adults and older adults presenting to community-based mental health services

Generally, community mental health services are very responsive, with adult services seeing an average of 89% of routine referrals within 4 weeks over the last 12 months, and older people seeing 90%.





A number of initiatives have been or are being undertaken in order to increase capacity and improve responsiveness, including multiagency discharge events, process mapping, and utilising the NHS England mental health elective recovery programme methodology.
A number of initiatives are in place in adult acute inpatient services in order to enable flow through service, create capacity and reduce wait times:

- The new NHS England principles for delayed discharge - changing medically fit for discharge (seen as too acute-focused) to clinically ready for discharge - which included feedback from carers groups to NHSE to make them more holistic.
- Twice weekly multi-agency clinically ready for discharge escalation meeting
- Weekly unit multidisciplinary team-based discharge planning meetings
- New use of leave beds guidance approved

The Waiting Well policy has been reviewed by the Head of Nursing with input from people with lived experience and the revised policy is now in place in order to improve responsiveness and manage risks for those on the waiting lists.

As reported last time, the community mental health framework[5] transformation and roll out of the Living Well model will help to improve both access and responsiveness, with a 'no wrong door' approach and collaboration with primary care, social care and voluntary, community and social enterprise (VCSE) organisations in meeting individual's needs at the time when they need it. Living Well roll-out is in progress, with a pilot currently in place to inform further implementation.

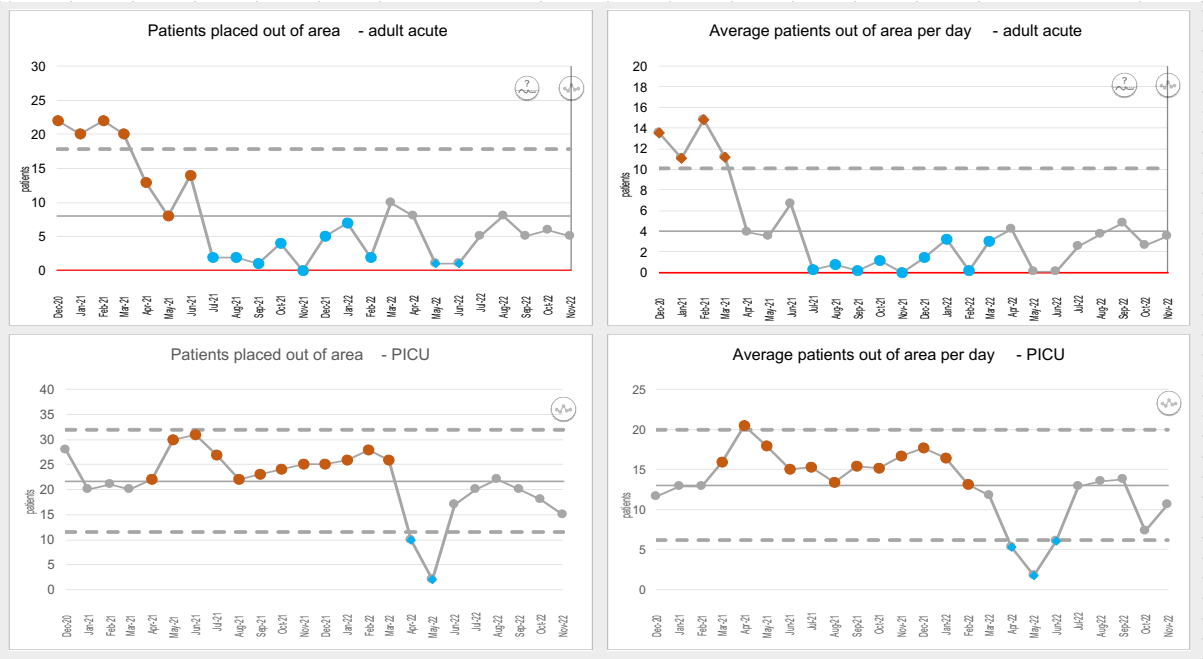
4. Other Considerations

Inappropriate out of area placements

Significant work has been ongoing since April 2021 to keep inappropriate out of area acute placements to a minimum in line with the objective of the Five Year Forward View for Mental Health (The Mental Health Taskforce, 2016) which was to eliminate inappropriate out of area placements for acute mental health care for adults by 2020/21 (including Psychiatric Intensive Care Unit (PICU) placements). Inpatients with Covid-19 have impacted on capacity at times during the pandemic. There are also significant pressures within the Derbyshire health system currently, with University Hospitals of Derby & Burton and Chesterfield Royal Hospital both continuing to declare critical incidents, and so any requests received from these organisations for beds need to be the highest priority to ensure system flow, which means at the moment it may take longer to repatriate out of area patients to Trust beds.

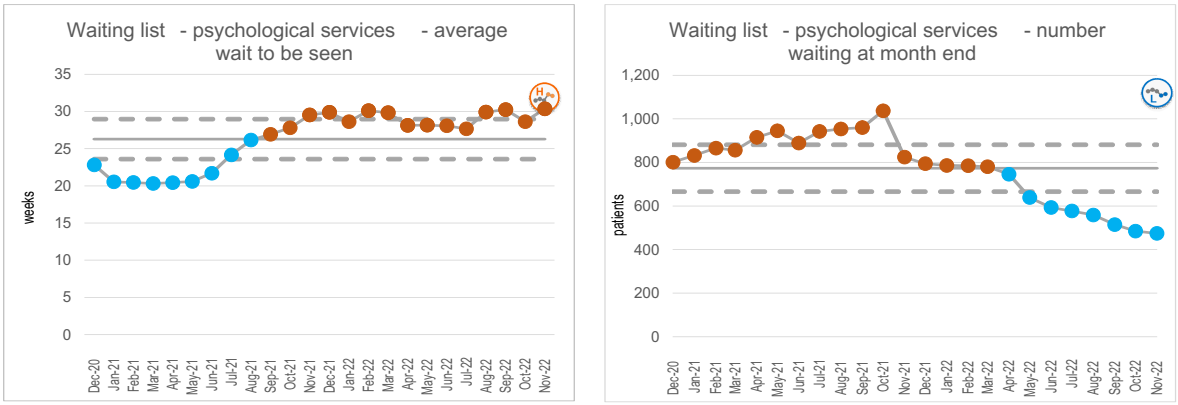
There is no local PICU provision, so anyone needing psychiatric intensive care must be placed out of area, however work continues on the provision of a new build PICU in Derbyshire. In addition, actions are in place to generate improved flow and admission capacity in adult acute inpatients, working closely with community teams and to create capacity to repatriate PICU patients when appropriate to do so.

[5] https://www.england.nhs.uk/publication/the-community-mental-health-framework-for-adults-and-older-adults/



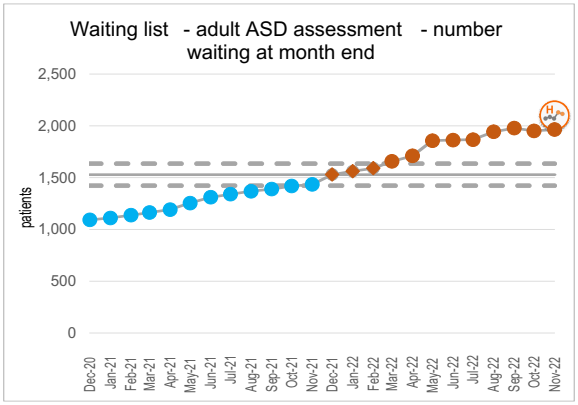
Waiting times for psychological services

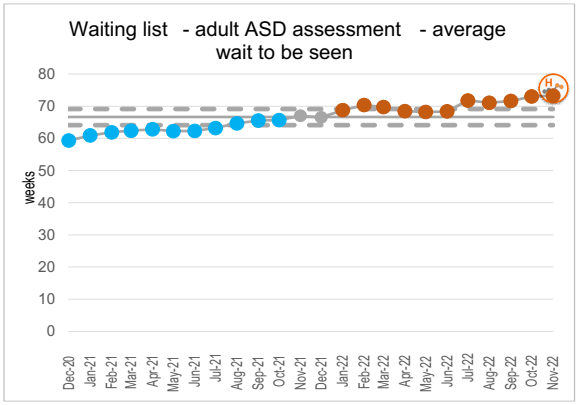
Although there is no national or local access standard, there continues to be a significant challenge with respect to waiting times for psychological support. At the end of November 2022, 474 people across Derbyshire were waiting to be seen by psychological services with an average wait time of 350 days. A recovery action plan is in place, which is summarised in the Integrated Performance Report to Trust Board. Positive progress is being made and for the last 8 months there has been a significant reduction in the number of people waiting to be seen.



Adult Autistic Spectrum Disorder (ASD) Assessment Service

Although there is also no national or local access standard, access to ASD assessment continues to be a significant challenge, with demand for the service continuing to outstrip capacity over an extended period of time. The service is commissioned to undertake 26 assessments per month but receives 76 referrals per month. At the end of November 2022 there were 1,964 adults waiting for adult ASD assessment. A recovery action plan has been developed, which is summarised in the Integrated Performance Report to Trust Board, and will be monitored by the Trust Operational Oversight Leadership Team. A revised approach to waiting list management is also being mobilised and should start to have an impact from quarter 4.





5. Conclusion

The Trust continues to be responsive across many of the services it provides, achieving the majority of existing standards and proposed standards. However, there remain a number of services where being responsive continues to be a significant challenge. The various recovery action plans noted in this report should positively impact on responsiveness. Updates on progress with implementation of these plans will be provided to the Trust Board in future Integrated Performance Reports.

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 17 January 2023

Learning from Deaths - Mortality Report

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 August to 30 September 2022.

Executive Summary

- All deaths directly relating to COVID-19 are reviewed through the Learning from Deaths procedure unless they meet an additional Incident Red Flag in which case they are reviewed under the Incident Reporting and Investigation Policy and Procedure. From 1 August to 30 September 2022 there has been zero deaths reported where the patient tested positive for COVID-19.
- The Trust received 317 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; 146 male deaths were reported compared to 171 females.
- No inpatient deaths were recorded.
- The Mortality Review Group reviewed 10 deaths through a Stage 2 Royal College of Psychiatrists Care Review Tool. These reviews were undertaken by a multi-disciplinary team, of the 10 deaths reviewed none were due to problems in care. Since January 2022 there has been a total of 94 meetings scheduled, 37 of these were attended, 43 sessions were not able to proceed due issues affecting attendance, 8 were cancelled.
- The Trust has reported four Learning Disability (LD) deaths in the reporting timeframe and no patients with a diagnosis of Autism Spectrum Disorder (ASD).
- Discussions with the Regional Medical Examiners have taken place to discuss the successful implementation of the Medical Examiner process within our Trust. It is hoped this process will commence on 1 February 2023.
- Good practice identified through case note reviews is fed back to clinicians involved as part of our appreciative learning.

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.

Governance or Legal Issues

There are no legal issues arising from this report.

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:

- 1 August to 30 September 2022. There is very little variation between male and female deaths; 146 male deaths were reported compared to 171 females
- No unexpected trends were identified according to ethnic origin or religion.

Recommendations

The Board of Directors requested to accept this Mortality Report as assurance of the Trust's approach and agree for it to be published on the Trust's website as per national guidance.

Report presented by: **Arun Chidambaram**
Medical Director

Report prepared by: **Rachel Williams**
Lead Professional for Patient Safety and Experience

Louise Hamilton and Aneesa Akhtar-Alam
Mortality Technicians

Learning from Deaths - Mortality Report

1. Background

In line with the CQC's 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 the required guidelines. The report presents the data for 1 August to 30 September 2022.

2. Current Position and Progress (including COVID-19 related reviews)

- Meetings with the Chesterfield Royal Hospital and University Hospital of Derby and Burton Regional Medical Examiners have taken place to discuss the implementation of the Medical Examiner process within our Trust. It is hoped following development of a standard operating procedure that the Medical Examiners will commence reviewing the Trusts non-coronial deaths and Trust Incident Red Flag deaths from 1 February 2023.

- 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. It is hoped that this will improve once Medical Examiners commence the process of reviewing the Trusts non-coronial deaths.

- During 1 August to 30 September 2022 10 Case Record Review sessions have been undertaken in relation to deaths which meet the incident criteria. Unfortunately, 6 sessions did not take place due to lack of medic availability and one session did not take place due to a lack of admin.

- Since January there has been a total of 94 meetings scheduled, of these 37 scheduled sessions took place however 43 sessions failed due to issues such as attendance and 8 were cancelled. The mortality team are currently awaiting a new schedule outlining the medics who will be attending Case Record Review sessions in 2023.

- 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 in October 2022.

[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 for 1 August to 30 September 2022.

	August	September
Total Deaths Per Month	169	148
LD Referral Deaths	1	3
ASD referral to LeDeR	0	0
Inpatient Deaths	0	0

Correct as of 20 October 2022

146 patients were male, 171 were female, 224 were white British, 50 were any other ethnic group and 19 had no known ethnicity assigned. The youngest age was 0 years, the eldest age was 103.

From 1 August to 30 September 2022, the Trust received 317 death notifications of patients who have been in contact with our services.

4. Review of Deaths

Total number of Deaths from 1 August 2022 to 30 September 2022 reported on Datix	19 “Unexpected deaths” 0 COVID-19 deaths 2 “Suspected deaths” 4 “Expected - end of life pathway” NB some expected deaths have been rejected so these incidents are not included in the above figure 0 Inpatients deaths
Incidents assigned for a review	24 incidents assigned to the operational incident group 0 did not meet the requirement 1 incident is to be confirmed

Only deaths which meet Trust Red Flags are reported through the Trust incident reporting system (Datix) and are reviewed through the Untoward Incident Reporting and Investigation Process. These Red Flags apply to any patient open to services within the last six months prior to their death:

- 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.

5. Learning from Deaths Procedure

The mortality team review all applicable non DATIX reported deaths against the Trust Red Flags and those outlined in the Royal College of Psychiatrists Care Review Tool, these are:

- All patients where family, carers or staff have raised concerns about the care provided

- All patients with a diagnosis of psychosis or eating disorders during their last episode of care, who were under the care of services at the time of their death or have been discharged within six months prior to their death

- All patients who were an in-patient in a mental health unit at the time of death or who had been discharged from in-patient care within the last month

- All patients who were under a Crisis Resolution and Home Treatment Team (or equivalent) at the time of death.

All deaths including community deaths are reviewed to ascertain if they meet the criteria above. Those patient deaths which meet these ‘red flag’ criteria above should be subject to a review process if they are not already under the incident process. At the stage of determining if a death meets the criteria for reporting as an incident, teams are required to review all deaths against the Trust Incident ‘Red Flags’. Previously under mortality the Trust was reviewing community deaths against locally defined flags in addition to what is required but had over committed its resources in this area and a redesign of the process was undertaken as learning was limited from these reviews.

The form based on section one of the Royal College of Psychiatrists Care Review Tool for mortality reviews remains under development, the intention is that this form will be added to the Electronic Patient Record. It is important to note that clinical teams already assess each death when determining if a DATIX incident is required. This will release capacity within the Patient Safety team and allow for greater return

on the Case Record Review process. It is hoped that the form will be available on SystmOne in the new year as it has now been developed.

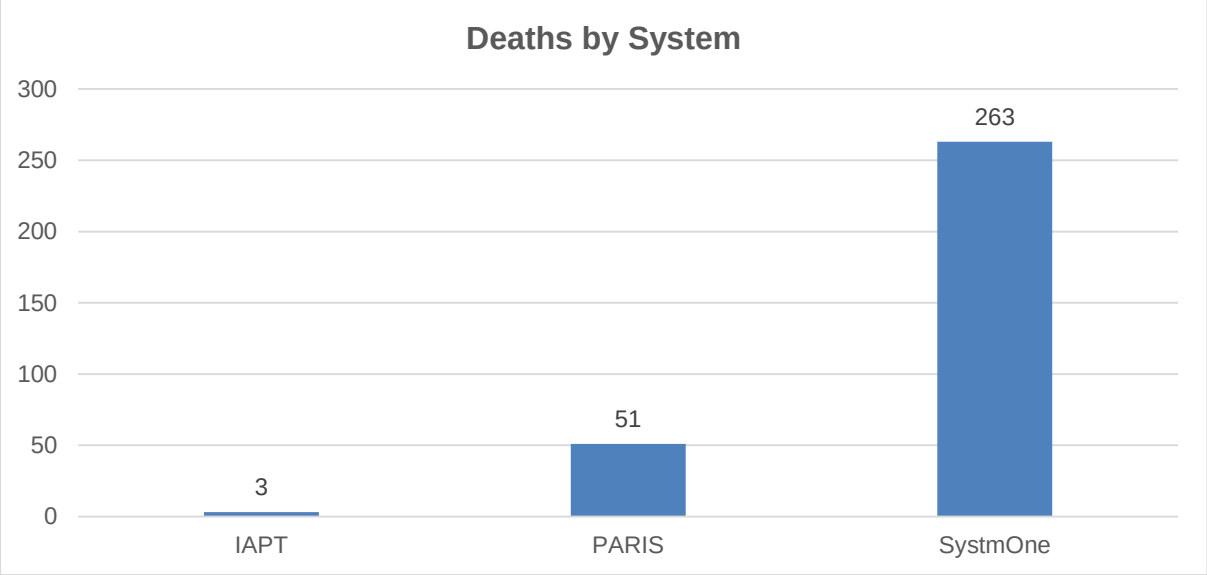
For the period 1 August to 30 September 2022, the Mortality Review Group reviewed 10 deaths through a Stage 2 Case Record Review. These reviews were undertaken by a multi-disciplinary team, and it was established that of the 10 deaths reviewed, none were due to problems in care.

From the 1 August to 30 September 2022 there has been no deaths reported where the patient tested positive for COVID-19.

Head of Clinical Quality from NHS Derby and Derbyshire Integrated Care Board / Joined Up Care Derbyshire was invited by the Lead Professional for Patient Safety/Experience to undertake an independent review of the Trust Incident Process to ascertain if any improvements could be made. No actions were required and there was satisfaction that the Trust had robust systems in place for monitoring incidents.

6. Analysis of Data

6.1 Analysis of deaths per notification system since 1 August to 30 September 2022

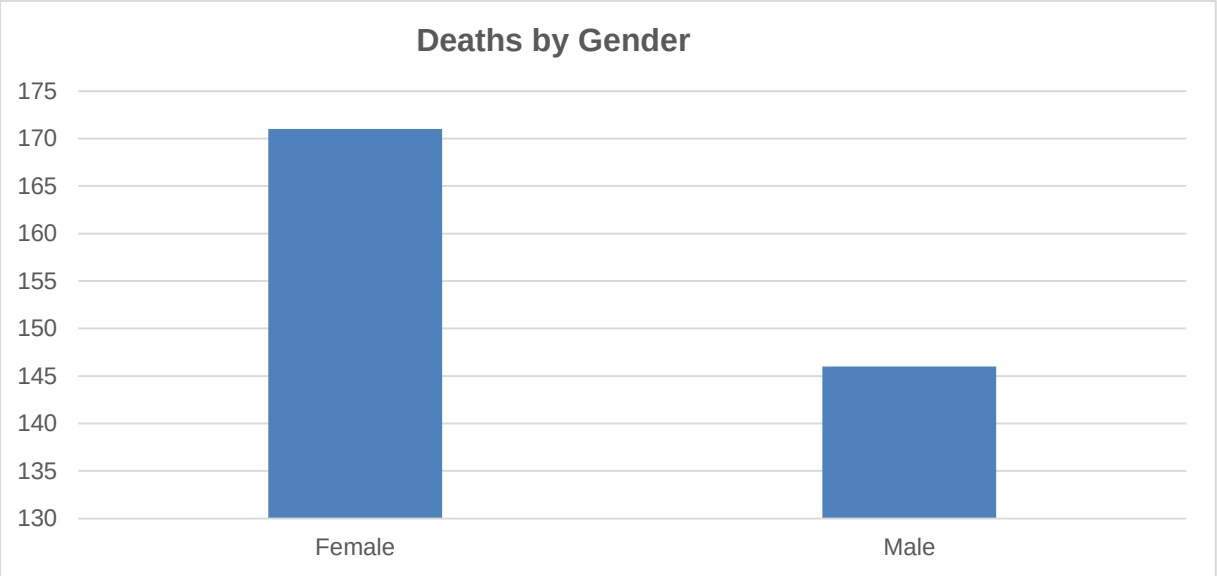


System	Number of Deaths
IAPT	3
PARIS	51
SystmOne	263
Grand Total	**317**

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. This data will no longer be utilised moving forward as all teams have now moved to one EPR with System1 fully rolled out across the Trust.

6.2 Deaths by Gender

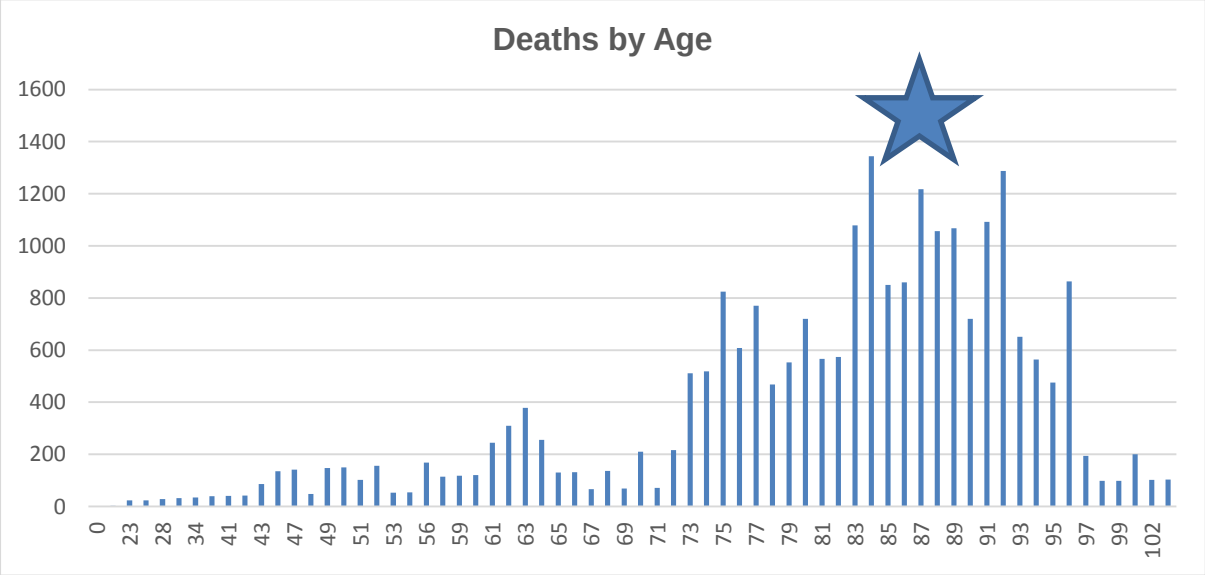
The data below shows the total number of deaths by gender for 1 August to 30 September 2022. There is very little variation between male and female deaths; 146 male deaths were reported compared to 171 females.



Gender	Number of Deaths
Female	171
Male	146
Grand Total	**317**

6.3 Death by Age Group

The youngest age was classed as zero, and the oldest age was 103 years. Most deaths occurred within the 83 to 92 age groups (indicated by the star).



6.4 Learning Disability Deaths (LD)

	August	September
LD Deaths	1	3

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 Learning Disabilities Mortality Review (LeDeR) programme. The Trust has received the recent LeDeR themes by provider for reviews completed between the 01 April and 30 September 2022, these will be shared in the Executive Incident group.

During 1 August to 30 September 2022, the Trust has recorded four 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.

The Trust also is required from 1 January 2022 to report deaths of patients who have a diagnosis of Autism Spectrum Disorder (ASD) for this reporting period the Trust has reported no deaths.

6.5 Death by Ethnicity

White British is the highest recorded ethnicity group with 224 recorded deaths, 19 deaths had no recorded ethnicity assigned, and seven people did not state their ethnicity. The chart below outlines all ethnicity groups.

Ethnicity	Number of Deaths
Mixed - White and Asian	1
Black or Black British - African	1
Black or Black British - Any other Black background	2
Asian or Asian British - Indian	3
Asian or Asian British - Pakistani	3
White - Irish	3
White - Any other White background	4
Not stated	7
Not Known	19
Other Ethnic Groups - Any other ethnic group	50
White - British	224
Grand Total	**317**

6.6 Death by Religion

Christianity is the highest recorded religion group with 128 recorded deaths, 125 deaths were (blank) with no recorded religion assigned. The chart below outlines all religious groups.

Religion	Number of Deaths
Jehovah's Witness	1
Quaker religion	1
Church of Scotland, follower o	1
Religion (other Not Listed)	1
Anglican	1
Spiritualist	1
Muslim	2
Christian religion	2
None	2
Not Given Patient Refused	2
Agnostic	2
Atheist movement	2
Roman Catholic	2
Sikh	3
Methodist	4
Not Religious	4
Unknown	10
Church Of England	11
Church of England, follower of	12
Christian	128
(Blank)	125
Grand Total	**317**

6.7 Death by Sexual Orientation

Heterosexual or straight is the highest recorded sexual orientation group with 148 recorded deaths. 156 have no recorded information available. The chart below outlines all sexual orientation groups.

Sexual Orientation	Number of Deaths
Gay Or Lesbian	1
Not Stated (declined)	1
Unknown	1
Not Appropriate To Ask	2
Sexual orientation not given - patient refused	8
Heterosexual	148
(blank)	156
Grand Total	**317**

6.8 Death by Disability

The table below details the top five categories by disability. Gross motor disability was the highest recorded disability group with 34 recorded deaths.

Disability	Number of Deaths
Physical disability	5
Hearing disability	7
Emotional behaviour disability	7
Intellectual functioning disability	18
Gross motor disability	34
Grand Total	**71**

There was a total of 83 deaths with a disability assigned and the remainder 234 were blank (had no assigned disability).

7. Medical Examiners

Medical Examiner officers have been established at all Acute Trusts in England. The role of these officers is now being extended to also cover deaths occurring in the community, including at NHS Mental Health and Community Trusts. Medical Examiners are to provide independent scrutiny of deaths not taken at the outset for coroner investigation. They will carry out a proportionate review of medical records and give families and next of kin an opportunity to ask questions and raise concerns. This process will inform learning to improve care for future patients, or, in a smaller number of cases, may be referred to others for further review. Their involvement will also provide reassurance to the bereaved.

Overall Medical Examiners will seek to answer the following three questions:

- What caused the death of the deceased?
- Does the coroner need to be notified of the death?
- Was the care before death appropriate?

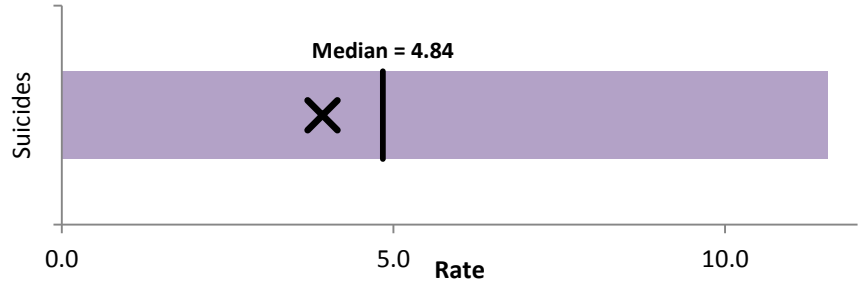
Discussions with the Regional Medical Examiners have taken place to discuss the implementation of the Medical Examiner process within our Trust. A standard operating procedure will be developed between Chesterfield Royal Hospital and University Hospital of Derby and Burton. It is hoped that the new process of the medical examiner reviewing all non-coronial deaths will hopefully commence on 1 February 2023.

8. National Confidential Inquiry into Suicide and Safety in Mental Health Safety Score Card

The NCISH safety scorecard was developed as a request of the Healthcare Quality Improvement Partnership (HQIP) as a way to support Trusts to implement quality improvement where appropriate. The data also allows Trusts to compare themselves to other Trusts, allowing some benchmarking.

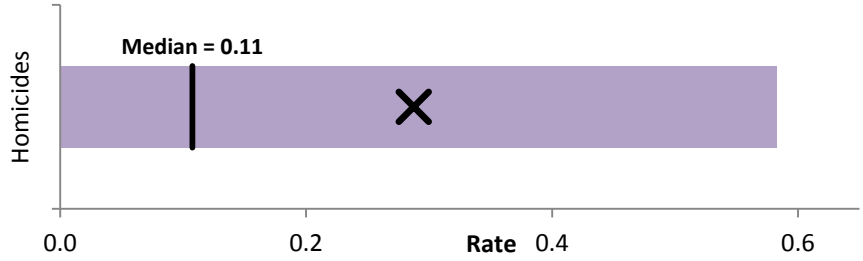
The data within the figures below show information from a range of results for mental health providers across England, based on the most recent available figures: 2017-2019 for suicides and homicides, 31 October 2020 – 31 October 2021 for non-medical staff turnover and January 2018 to February 2022 for trust questionnaire response rates. 'X' marks the position of your trust. Rates have been rounded to the nearest 2 decimal places and percentages to whole percentage numbers. These data sets were chosen has within research they have demonstrated contribution to risk increase.

The NCISH Safety Scorecard consists of 4 indicators that relate to the work of NCISH: suicide rate and homicide rate, non-medical staff turnover, and NCISH suicide questionnaire response rate.



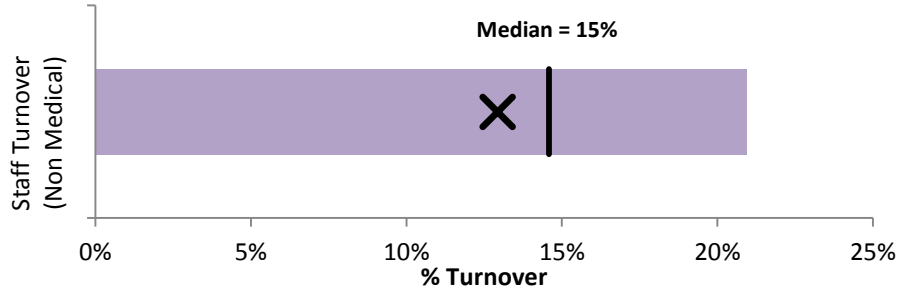
Suicide rate

The suicide rate in your Trust was 3.93 (per 10,000 people under mental health care) from 2017-2019



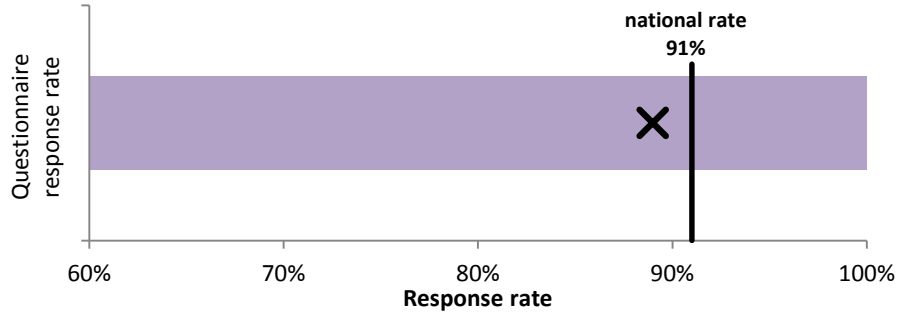
Homicide rate

The homicide rate was 0.29 (per 10,000 people under mental health care) from 2017-2019.



Staff Turnover

Non-medical staff turnover was 13% between October 2020 and October 2021.



NCISH questionnaire response rate

You have returned 89% of NCISH questionnaires between January 2018 and February 2022.

9. Recommendations and Learning

Following the findings of the ‘Analysis of Inpatients Deaths 2019-2022’ the following recommendations have been made:

- A review of the pathway of communication and documentation (including risk assessments and careplan) between the Crisis Team, ward areas and CMHT when a patient is due to be on section 17 leave / discharged
- To develop training on Emotionally Unstable Personality Disorder for all clinical staff
- To continue to raise the profile of referring patients who are high risk at discharge or complex to the complex risk panel
- An audit of DNA/CPR /respect forms to be undertaken on the older adult acute inpatient wards
- A focus group to be implemented in collaboration with the Acute Trusts to improve the admissions / transfers process when a patient is physically deteriorating (this work is underway, and a focus group is currently being established with the Royal Derby Hospital Medical Directorate to take this work forward)
- Establish a physical health reporting working group to establish the new SystmOne reporting frameworks to improve reports for assurance
- Introduction of RESTORE2 into ILS training framework including review of current ILS provision
- Review the Acute Inpatient Mental Health Services for Adults of Working Age Policy and Procedures and Discharge, Transfer, Transitions and leave policy
- Develop a ‘Learning the lessons from Incidents’ forum.

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 17 January 2023

Guardian of Safe Working Quarterly Report (December 2022)

Purpose of Report

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

Executive Summary

The Board is requested to note:

1) Dr Smita Saxena has stepped down as the Guardian of Safe Working (GoSW) with effect 30 November 2022. Dr Kaanthan Jawahar is the new GoSW with effect 1 December 2022.
2) The regional GoSW network suggests annual reports are done at the end of the financial and not calendar year. It is suggested we move to this. Accurate annual data could therefore be presented to the Board in July, and Q&S in June.
3) Owing to lack of availability of key attendees, a Junior Doctor Forum (JDF) meeting has not taken place in this quarter. JDF meetings are being arranged on a bi-monthly basis from January 2023, meaning two JDF meetings occur per 4 month junior doctor rotation.
4) Only one exception report was submitted during the period covered by this report. This is resulting from breaching rest requirements on a non-resident on call shift by a higher specialty trainee (HST) doctor. This will generate payment to the doctor, as well as a fine levied against the trust.
5) The lack of submission of exception reports is notable in this period. The new GoSW is prioritising addressing this through a combination of rolling induction sessions, visibility through 'Deputy Director of Medical Education (DME) drop in sessions', re-instigating regular JDF meetings, drawing on the remit of his related role as Deputy Local Negotiating Committee (LNC) Chair, and supporting a junior doctor colleague in carrying out a junior doctor wellbeing initiative, which will also look at the exception reporting system.
6) Retrospective payments to doctors, as well as fines levied against the Trust, have been calculated owing to a review of historic exception reports between November 2021 and May 2022. These exception reports also relate to breaching minimum rest requirements on non-resident on call shifts for ST doctors. The initial handling of these exception reports rightly covered reasons for occurrences and ensured compensatory rest was taken, however there appears to have been an oversight with contractually required payments/fines.
7) Payments/fines are delayed owing to a lack of a cost code for the GoSW to hold funds for the JDF from fines levied, as well as authorisation being required through medical education budget holders. The GoSW has raised

this with the medical staffing manager and the medical director as barriers to delivering the role, and is requesting the removal of the authorisation line (as the GoSW is required to be contractually independent of trust management structures) and the creation of a dedicated cost code.

8) Personalised work schedules are a contractual requirement in the 2016 junior doctor contract. Junior doctor representatives have approached the GoSW to help improve the use of personalisation and optimise its quality.

9) Exception reporting training for supervisors has been delivered by the GoSW as part of his Deputy LNC Chair role. This will be built upon further by looking to develop guidance for supervisors to further embed the exception reporting process.

10) There is a current consultation ongoing that is looking to create an HST tier non-resident on call rota in the south of the trust on the psychiatry rota. The outcome of this consultant will be discussed at the December Joint Local Negotiating Committee (JLNC) meeting in December 2022, the JDF in January 2023 and then a vote thereafter for the affects HST doctors on whether or not to accept the proposal. If accepted the rota will be implemented as soon as practicable. If rejected the trust can still impose the rota from August 2023. From a GoSW perspective, the main risk with this rota with be breaching minimum rest requirements for non-resident on call shifts, generating payment/fines, and compensatory rest affecting HST presence in core hours (service and training implications).

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

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

Consultation

Consultation would normally take place with the JDF, LNC, DME and junior doctors within the trust, however owing to the change in GoSW and short lead-in time to create this report, such consultation has not been possible on this occasion. Headlines however have been shared at the staff LNC meeting on 24/11/22, including with the core trainee and higher specialty trainee LNC representatives. The latter two have also had sight of the draft report.

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.

No equality issues have been raised during this period concerning the content of this report.

Recommendations

The Board of Directors is requested to note the contents of the report. At this stage the GoSW is unable to give assurance of the Trust's approach in discharging its statutory duties regarding safe working for doctors employed on the 2016 junior doctor contract, however a strategy and plan has been developed, which is realistic to deliver and thus provide the assurances required in due course. The GoSW requests the Board to support this strategy and plan.

Report presented by: **Dr Arun Chidambaram**
Medical Director

Report prepared by: **Dr Kaanthan Jawahar**
Guardian of Safe Working

GUARDIAN OF SAFE WORKING QUARTERLY REPORT
(December 2022)

1. Trainee data

Extended information supplied from 1 September to 25 November 2022

Numbers in post for doctors in training

Numbers of doctors in post WTE	North	South
FY1	3	5
FY2	2	4
GP ST	4.8 (headcount 5)	6.6 (headcount 7)
CT	10.6 (headcount 12)	11.8 (12 headcount)
HSTs	3	7.2 (8 headcount)
Paediatrics ST		0.8 ST3, 0.4 ST4 & 0.6 ST5 (headcount 3)

Key
CT = Core trainee years 1-3
FY1/FY2 = Foundation year trainee (years 1 and 2)
HST = Specialty trainee (ST) years 4-7
GP ST = General practice specialty trainee
Paediatrics ST = Paediatrics specialty trainee (year 4+)

2. Exception Reports (working hours)

Covering the period 1 September to 30 November 2022

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

Grade	No of exceptions carried over from last report	No of exceptions raised	No of exceptions closed	No of exceptions outstanding
CT1-3	0	0	0	0
ST4-7	0	1	1	0
GP	0	0	0	0
Foundation	0	0	0	0
Total	0	0	0	0

Action taken

Location	Payment	TOIL	Not agreed	No action required
North	0	0	0	0
South	1	1	0	0
Total	0	0	0	0

Response time

Grade	48 hours	7 days	Longer than 7 days	Open
CT1-3	0	0	0	0
Foundation	0	0	0	0
ST4-7	0	0	1	0

The one exception report submitted is from an ST4+ doctor for breaching minimum rest requirements on a non-resident on call shift. The time liable to payment/fine is 25 minutes.

The exception report outcome was finalised > 7 days after submission. The supervisor did not appear to receive notification via the Allocate software – reasons for this are being looked into.

3. Work schedule reviews

No formal work schedule reviews during this period.

4. Fines

A fine will likely be levied for the exception report described above.

Retrospective fines have been/are to be levied as follows:

- An ST4+ doctor in February had a particularly busy non-resident on call shift, needing to work continuously through to 7am. This meant they did not get the minimum rest requirement of 5 hours continuous rest between 10pm and 7am. This has resulted in payment to the doctor being £283.40, and a fine levied against the trust of £472.30.

- An ST4+ doctor submitted 4 exception reports between November 2021 and May 2022. All were for breaching minimum rest requirements during non-resident on call shifts. These vary in length between 30 minutes and 2 hours. The total payment due to the doctor is £175.87, and the fine to be levied against the Trust is £293. These payments have not yet been made.

5. Locum/Bank Shifts covered

North 23 shifts; total cost £10234.45
South 19 shifts; total cost £9836.27

6. Agency Locum

No agency locum spend.

7. Vacancies

	North Sept – Dec 22	South Sep – Dec 22
CT1-CT3	0.4	0
ST4-7	0	0
GP Trainees	0.2	1.0
Foundation	0	0

In the North of the Trust:

- Two CT2 doctors work 80% FTE, with the vacant on call shifts filled by locums
- One GP trainee doctors works 80% FTE, with the vacant on call shifts filled by locums

In the South of the Trust:

- One GP vacancy is back filled by a locally employed doctor on an ‘F3’ basis

Locum/bank shifts covered in section 5 are largely the results of these rota gaps.

ST4-7 doctor ‘vacancy’ numbers must be interpreted within the context of them being supernumerary.

8. Qualitative information

Owing to lack of availability of key members, no JDF meeting has taken place in this quarter. Going forwards, JDF meetings will be arrange bi-monthly so that two meetings occur per four month junior doctor rotation. These will begin from January 2023.

The regional GoSW network suggests annual reports are completed at the end of the financial and not calendar year. It is suggested the Trust moves to this schedule. Accurate data could therefore be presented to the Board in July, and Quality and Safeguarding Committee in June.

Only one exception has been submitted in this period, and informal feedback suggests a lack of engagement with exception reporting. Some of this will be reticence on the part of the junior doctor, however efforts can and should be made to improve engagement with the process. The new GoSW suggests the following:

- Attendance at north and south deputy DME drop in sessions (monthly) to improve visibility of the GoSW amongst rotating junior doctors.
- Bi-monthly JDF meetings as already outlined.
- Utilising remit as Deputy LNC Chair to drive forward the relevant items pertaining to junior doctor safe working and wellbeing.
- Supporting a junior doctor colleague in carrying out a junior doctor wellbeing project, which includes exception reporting within its remit.

The new GoSW was approached by two HST doctors that have since rotated out of the Trust. They asked for their previous exception reports to be reviewed (see section 4). At the time of the exception reports there was due consideration given to compensatory rest and similar, however breaching non-resident on call requirements contractually generates payment to the doctor and a fine against the Trust – these did not appear to be considered at the time.

There is a delay in paying the affected doctors and levying fines against the trust. This is owing to a lack of a dedicated cost code for holding funds for the JDF, as well as an authorisation line through medical education. The GoSW has raised this with the medical staffing manager and medical director. In order to effectively carry out the GoSW role and provide the necessary statutory assurances, the GoSW requests:

- A dedicated cost code where monies are held for fines levied
- Reporting lines within medical education are removed as, contractually, the GoSW must be independent of trust management structures

Work schedules should be personalised as set out in the 2016 junior doctor contract, however this has been highlighted to the GoSW by junior doctors as an area that requires improvement. The GoSW will work with and support junior doctor LNC representatives to optimise the use and quality of personalised work schedules for rotating junior doctors.

Exception reporting guidance for supervisors will be developed to build on training delivered earlier in the year by the GoSW as part of his related role as Deputy LNC Chair.

The Trust is proposing the creation of an HST doctor tier below the on call psychiatry consultants (non-resident on call). A consultation is underway, and the results of this will be discussed at the upcoming JLNC meeting (December 2022) and the JDF (January 2023). If this rota comes into being there is likely to be an increase in instances of HST doctors breaching their non-resident on call minimum rest requirements. Exception reports submitted for this will incur payments to the doctors and fines levied against the trust.

9. Compliance of rotas

Current work schedules are compliant with the 2016 junior doctor contract.

10. Other concerns raised with the Guardian of Safe Working (GoSW)

None that are not already covered in section 8.

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 17 January 2023

Physical Health Care and Infection Prevention Control update

Purpose of Report

To describe progress since the Annual report provided last year and update against recent changes to the Infection Prevention Control Guidelines and Board Assurance Framework.

Executive Summary

Progress since last report:

- The Board Assurance Framework Document was updated in September 2022 and is submitted alongside this report
- Organisational risk assessment and flexibility to move between standard infection control principles and transmission-based infection control principles in response to infection rates is the focus of approach
- FFP3 mask guidance unchanged. DHCFT have reviewed our approach and we are consistent with neighbouring and similar organisations.
- Air exchange rates have been reviewed. ECT suite upgrade has been completed, otherwise no significant changes required
- Case rates have increased in recent weeks in correlation with other providers, the trust continues to have comparably low rates of infections and spread
- Risk of serious illness remains low at present time
- Audit and oversight remain in place with a healthy learning culture to maintain and adapt practice
- The Board Assurance Framework has been reviewed by the Quality and Safeguarding Committee and is recommended to be accepted by the Board as providing assurance that we are compliant with current standards and expectations.

Strategic Considerations	
1) We will deliver **quality** in everything we do providing safe, effective and service user centred care	x
2) We will develop strong, effective, credible and sustainable **partnerships** with key stakeholders to deliver care in the right place at the right time	x
3) We will develop our **people** to allow them to be innovative, empowered, engaged and motivated. We will retain and attract the best staff.	x
4) We will **transform** services to achieve long-term financial sustainability.	x

Assurances

- Regular updates and discussion through Physical Health and Infection Prevention Control Executive Group
- Oversight of outbreaks through structured outbreak management meetings with external oversight and scrutiny when required
- Reporting through national outbreak portal and local forum
- Trust Infection Prevention and Control (IPC) lead is an active participant of regional Infection Prevention Control Strategic Assurance Group (IPCSAG).

Consultation

- The PHCIC Committee membership has been broadened to increase clinical/operational involvement. There is now an executive group
- There are regular meetings with ICS and ICB regional partners at all levels.

Governance or Legal Issues

Improving PHCIC and integration with other providers in the ICB framework is a key strategic objective.

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:

Those with mental health problems often die at an earlier age than those without. This is recognised in the Mental Health Act Review and is the subject of a major national quality improvement initiative and addressed by the Trust's Infection prevention Control strategy.

Recommendations

The Board of Directors is requested to:

1) Note progress since last update
2) Consider the level of assurance received
3) The Quality and Safeguarding Committee recommend that the Board accepts the up to date Board Assurance Frameworks as evidence of compliance with National IPC framework standards and expectations.

Report presented by: **Tumi Bandu – Director of Nursing**

Report prepared by: **Richard Morrow**
Assistant Director of Public and Physical Healthcare

Infection Prevention Control Update for Trust Board (January 2023)

In April the United Kingdom Health and Security Agency (UKHSA) wrote to the trust to advise of further changes to the Infection Prevention Control (IPC) guidelines and the introduction of the National Infection Prevention Control Manual (NIPCM).

These changes have moved us to utilise structured local risk assessments to determine the necessary interventions to maintain good IPC standards and minimise spread of infection. The guidelines focus upon a broader range of respiratory illnesses. The hierarchy of control approach has shifted towards a clear and considered use of Standard Infection Control Principles (SICP), which serve as a constant baseline, and a process to determine when to escalate to Transmission-Based Precautions (TBPs) in the event of an Outbreak or significantly increased risk.

The vaccination programme is a core mitigating factor and maintaining vaccination levels for colleagues and service receivers is part of the individual and collective risk assessment for both staff and patient resilience.

The guidelines implemented on 1 June 2022 build upon the assessment of risk factors to identify appropriate levels of intervention to appropriately mange the risks for the client group and setting. The infection rates, community case rates, testing status, history and vaccination status of the patient and staff group are used to determine the level of Infection Prevention Control measures and the use of Personal protective Equipment required.

To aid colleagues through the transition and mindful of regional and national concerns about the pace of changes and the potential for confusion amidst ongoing infection rates the Trust has produced a Standard Operating Procedure (SOP) which reflects the current approach and is tailored towards the services we provide, notably for inpatient areas.

The national Board Assurance framework (BAF) was updated on 28 September 2022, the national team had initially indicated there would be no revisions until the next version of the NIPCM is released in early 2023. The BAF is included as an appendix (1) to this paper.

- Organisations are requested to ensure they have robust triage, case tracking and recognition processes and oversight of mitigation to inform a risk assessment-based approach.

- The guidance recommends that focus upon symptomatic presentations for testing should be maintained.

- The guidance encourages organisations to maximise flow opportunities and prioritise the delivery of face to face and routine appointments to reduce access and waiting lists concerns.

- Universal use of face masks for staff and face masks/ coverings for all patients/visitors to remain as a key IPC measure within health and care settings over the winter period as an elective intervention, in response to symptomatic or confirmed cases or as a pre-emptive measure in the event of significant rise in case rates. This is part of the TBP’s outlined in the NIPCM.

- Screening, triaging, and testing for SARS-CoV-2 should continue over the winter period. Testing for other respiratory pathogens will depend on the health and care setting according to local and country specific testing strategies, frameworks, and data.

Training

The Trust's current training rates for level 1 and 2 training in all service areas are;

	Does not meet requirement		Meets requirement		Total	Total %
Competency		**%**		**%**		
NHS|CSTF|Infection Prevention and Control - Level 1 - 3 Years|	352	12%	2512	88%	2864	100%
NHS|CSTF|Infection Prevention and Control - Level 2 - 3 Years|	153	13%	995	87%	1148	100%
Grand Total	**505**	**13%**	**3507**	**87%**	**4012**	**100%**

The Trust is maintaining good compliance with IPC training amidst pressure within various service areas. There remains a focus to maintain and improve this level of compliance.

Face masks

Face masks remain a key element of the management of COVID and other respiratory illness. During outbreaks Healthcare workers as per the guidelines, are required to wear masks. At all times colleagues and patients are supported to wear masks electively if they wish. DHCFT continues to ensure that a ready supply of Type 2 r masks is available in all our bases and areas for both service users and Trust colleagues. Assurance checks take place if / when there are known cases, and these are facilitated by the Heads of Profession and IPC colleagues to ensure compliance is maintained.

FFP3 respirator masks

The trust has a reasonable quantity of FFP3 respirator masks which are in date and meet the requirements of our staff group (largely reserved for resuscitation incidents). The Trust has focussed efforts on ensuring that clinical staff working in In-Patient areas and areas where Aerosol Generating procedures (AGPs) are undertaken are fit tested as a priority and maintain a register for governance and assurance purposes. It should be noted that the current guidance indicates a respirator mask is required when attending to a known COVID positive or symptomatic patient, when undertaking an AGP procedure.

Fit Testing

The Trust employs a part-time fit tester on a 12-month fixed term contract to ensure that there is capacity to fit test newly recruited medical, nursing, and allied health professional colleagues in our in-patient areas and ensure that new respirator masks are correctly fit tested for existing colleagues. The use of Respiratory Protective Equipment (RPE) is relatively low in the trust, ensuring that colleagues are correctly fit tested requires flexibility and coordination. Having a dedicated person is helping to

maintain assurance that our colleagues have access to and are accessing fit testing where and when required.

Air exchange rates

DHCFT have been liaising with regional partners to provide collective assurance and consistency of approach, the air exchange rates across the Trusts inpatient areas have been reviewed again. Ventilation continues to be promoted as a critical element of SICP.

Outbreaks have not seen significant lateral spread once identified and individuals supported to manage in isolation. We have low cross infection rates and air exchange rates have not been identified in any of the Trusts outbreaks as a potential or likely source of transmission.

The ECT suite at Radbourne Unit had its air management system upgraded following a proposal put forwards to the Capital Action Team in November 2021 and works were completed in March 2022. The air exchange and filtrations system meet current HTM standards.

This approach is driven by the COVID IPC risk assessment, and the Standard Operating Procedure developed in partnership with UHDB anaesthetist and recovery nurses to ensure the suite is optimised for safe delivery and future proofed against any future outbreak or legislative concerns.

Resuscitation

The New and Emerging Respiratory Virus Threats Advisory Group (NERVTAG) confirmed that they have risk assessed the risks related to resuscitation and found that chest compressions do not meet the threshold for an Aerosol Generating Procedure. NERVTAG advise that trusts should follow their local protocols and procedures. DHCFT continue to be advised by the Resus Council and follow their guidance regarding the correct equipment and procedures when undertaking resuscitation.

DHCFT advocate for staff to have access to level 3 PPE gowns, FFP3 masks and face / eye shields for the duration of Immediate Life Support interventions in In-Patient areas where COVID +ve cases or symptomatic cases are being managed. Significantly NERVTAG advise that whilst “Healthcare organisations may choose to advise their clinical staff to wear FFP3 respirators, gowns, eye protection and gloves when performing chest compressions but we strongly advise that there is no potential delay in delivering this life saving intervention”. The current standards are identified in the SOP and also covered in annual refresher training.

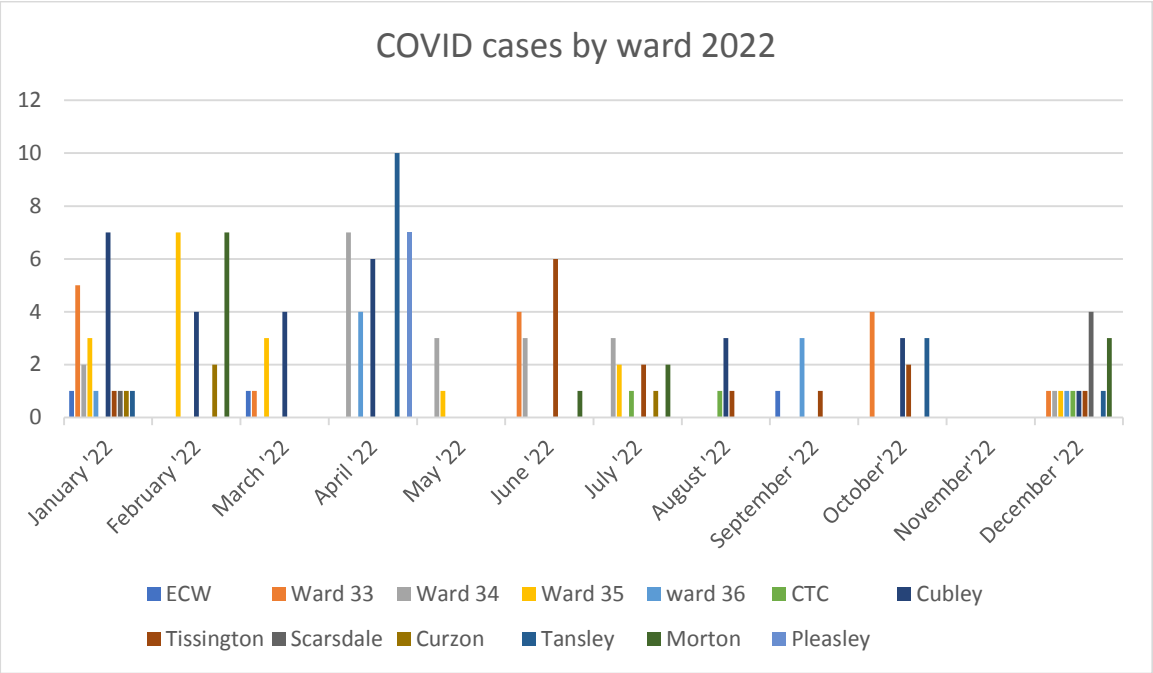
Cleaning

The Trust has successfully implemented the National Standards of Healthcare Cleanliness 2021 guidance across our areas with no deficits identified. The wards are all rated in the highest category and oversight during Outbreaks has shown consistent and very high standards of cleaning using structured scoring and assessment in all areas.

Deep clean teams continue to be available and responsive to ensure that ward and team bases remain operational with minimal delays, and this has greatly helped patient flow be maintained when bed demand has been high.

Outbreaks

Since the last update there have been several cases across the trust of COVID (see table below). These have been episodic and reflective of local increases in rates of infection. As the societal controls have been removed the trust is adopting a recognise and respond approach to contain cases if they arise. Recognising that the ability to prevent COVID entering our facilities is challenging when people are moving between work and home with no restrictions or controls beyond healthcare settings. The risk of serious illness has significantly reduced, and this has given confidence to the national team UKHSA, NHSE to advocate for this approach.



Symptomatic presentations have been the trigger for discovery and when we have tested more broadly found asymptomatic cases although this has reduced. No patients have had to be transferred to acute hospital for reasons directly linked to having COVID.

The Trust proactively tracks patient vaccination status and the Health Protection Unit (HPU)team regularly visit the inpatient areas to vaccinate patients who need initial or booster doses of vaccine. It remains the case that most hospitals do not have the facility to vaccinate patients following admission, particularly in the mental health sector. In addition, we continue to operate a proactive outreach model for all stages of vaccination to our most vulnerable Learning Disability and Serious Mental Illness service users, this is sponsored by the Integrated Care Board and in partnership with the Derbyshire Vaccine Inequalities Group. The HPU team were recognised at the regional NHSE awards and nationally for a parliamentary award for their work in this area.

High Consequence Infectious Diseases

There have been two HCIDs of concern since the pandemic moved into a restoration phase, namely Monkey Pox and more recently concerns about Ebola rates. The trust is an active part of the Joined-Up Care Derbyshire, regional IPC and NHSE Mental Health IPC forums. We have developed responses in partnership with other providers and monitor rates and guidance through these forums, providing assurance that we have appropriate guidance, communications, and strategies both in partnership and internally.

Other Infections diseases

The Trust continues to monitor other infectious agents and the rates of other pathogens within partner organisations for learning and tend analysis. We continue to have low levels of infection for MRSA, Flu, E-Coli etc. There has been a rise nationally within acute providers of E-Coli and this is an area we are working with regional partners to better understand and respond to.

Hand hygiene and glove use in health care settings are a key focus from an IPC measures point of view. The hand hygiene audit developed with NHSE Midlands group is being trialled within the trust and feedback provided to the national team as well as responded to internally. This is in part because the pandemic focussed upon responsive measures (TBPs) rather than proactive and adaptive measures SICPs and the transition is unfamiliar to many staff who started with us during the pandemic.

Vaccination

The Trust has a programme to support the vaccination of In-Patients for COVID and FLU. We operate a robust outreach model for Community LD and SMI clients.

The trust has a vaccination programme for staff members and we are working towards the CQUIN target of 70 – 90% uptake. This is monitored and tracked. The Autumn programmes have tailed off more quickly than expected locally, regionally, and nationally across all groups and sectors. NHSE have reduced the ambition for JUCD. Whilst multi-factorial, vaccination fatigue post pandemic is a significant contributing factor alongside existing health inequalities barriers.

DHCFT continues to provide a flexible offer of static and mobile clinics and pop ups. The Health Protection Unit are a core component of the approach with a dedicated support role for Trust clinicians.

Summary

Activity has been high in recent weeks as increased rates of infection have been present, we continue to compare favourably with other providers with comparatively low case rates and outbreaks being well managed and contained approaches.
The method of early detection and management has iteratively evolved during the Pandemic. We believe there are areas where we have a proven and reliable method.

- Cleaning and sanitisation standards have been a key focus from the beginning, and we continue to make sure our wards and communal areas are rigorously and routinely cleaned

- Professional approach to IPC. Trust staff continue to wear uniforms n clinical areas, follow IPC standards, and maintain PPE compliance we constantly raise this into consciousness

- Maintaining the message that if colleagues are poorly, they should not come into work. This reduces spread and avoids presenteeism which damages morale and capacity

- Learn from mistakes and embrace a compassionate approach to incidents where practice standards have slipped. Teams share their reflections with each other as a powerful learning aide.

The Trust has moved into a different phase and the changes to guidance reflect the shift to organisations identifying the correct measures to maintain staff and patient safety, whilst enabling contact and capacity to see those who require face to face support. IPC guidance is part of that shift with more focus being given to supporting teams with service and individual risk assessments to enable this.

Report prepared by Richard Morrow
Assistant Director of Public and Physical Health Care

Report presented by Tumi Banda
Director of Nursing and Director of Infection prevention and Control (DiPC)

Classification: Official

Publication reference: C1695

Infection prevention and control board assurance framework

21 September 2022 V1.11

Updates from November 30th V1.8 highlighted

Foreword

NHS staff should be proud of the care being provided to patients and the way in which services adapted and responded during the COVID-19 pandemic.

Effective infection prevention and control must continue and to support service recovery we have updated this board assurance framework (BAF) to support all healthcare providers to effectively self-assess their compliance with the National Infection Prevention and Control Manual (NIPCM) https://www.england.nhs.uk/publication/national-infection-prevention-and-control/ and other related infection prevention and control guidance to identify risks associated with infectious agents and provide an additional level of assurance to the Board. The general principles can be applied across all settings; acute and specialist hospitals, community hospitals, mental health and learning disability, and locally adapted.

The framework can be used to assure directors of infection prevention and control, medical directors, and directors of nursing by assessing the measures taken in line with the NIPCM or existing local policies whilst the NIPCM is being implemented. It can be used to provide evidence and as an improvement tool to optimise actions and interventions. The framework can also be used to assure trust boards.

Using this framework is not compulsory, however its use as a source of internal assurance will help support organisations to maintain quality standards.

Ruth May
Chief Nursing Officer for England

1. Introduction

The application of Infection Prevention and Control (IPC) measures has been key in the response to the SARS-CoV-2 pandemic.

The UKHSA guidance was archived at the end of April 2022, the proposal is that NIPCM combined with this version of the Board Assurance Framework (BAF) will support this transition.

This will continue to ensure organisations can respond in an evidence-based way to maintain the safety of patients, services users, and staff.

The update of the BAF helps providers to assess against the NIPCM as a source of internal assurance. It will also identify any areas of risk and the corrective actions required in response. The BAF provides assurance to trust boards that organisational compliance has been systematically reviewed.

The BAF is intended to support local organisations with decision making and be used by directors of infection prevention and control, medical directors, and directors of nursing if required unless alternative internal assurance mechanisms are in place.

2. Legislative framework

The legislative framework is in place to protect service users and staff from avoidable harm in a healthcare setting. We have structured the framework around the existing 10 criteria set out in the Code of Practice on the prevention and control of infection which links directly to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
The Health and Safety at Work Act 1974 places wide-ranging duties on employers, who are required to protect the 'health, safety and welfare' at work of all their employees, as well as others on their premises, including temporary staff, casual workers, the self-employed, clients, visitors and the general public. The legislation also imposes a duty on staff to take reasonable care of health and safety at work for themselves and for others, and to co-operate with employers to ensure compliance with health and safety requirements.

Risk assessment processes are central to protecting the health, safety and welfare of patients, service users and staff under both pieces of legislation. Where it is not possible to eliminate risk, organisations must assess and mitigate risk and provide safe systems of work. Local risk assessments should be based on the measures as prioritised in the hierarchy of controls https://www.england.nhs.uk/publication/national-infection-prevention-and-control/ . In the context of infectious agents, there is an inherent level of risk for NHS staff who are treating and caring for patients and service users and for the patients and service users themselves in a healthcare setting. All organisations must therefore ensure that risks are identified, managed, and mitigated effectively.

Infection Prevention and Control board assurance framework

1. Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks their environment and other users may pose to them

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
Systems and processes are in place to ensure that: • A respiratory plan incorporating respiratory seasonal viruses that includes: ○ point of care testing (POCT) methods for infectious patients known or suspected to have a respiratory infection to support patient triage/placement according to local needs, prevalence, and care services ○ segregation of patients depending on the infectious agent considering those most vulnerable to infection e.g., clinically immunocompromised. ○ A surge/escalation plan to manage increasing patient/staff infections. ○ a multidisciplinary team approach is adopted with hospital leadership, operational teams, estates & facilities, IPC teams and clinical and non- clinical staff to assess and plan for creation of adequate isolation rooms/cohort units as part of the plan. • Organisational /employers risk assessments in the context of managing infectious agents are: ○ based on the measures as prioritised in the hierarchy of controls.	The trust has COVID LFD testing kits available in all inpatient areas. Flu and other respiratory agents can be tested utilising the laboratories at RDH and CRH. PCR tests for patients being discharged to acre homes are organised through UHD and CRH pathology services as per guidelines. There are isolation and cohorting options depending upon the number of cases ranging from side rooms to cohort nursing if multiple cases are identified, this approach is broadly applicable to any respiratory contagion and can be adapted in the event of dual pathogens being present. Where cases are detected the local team with support from the Health Protection Unit and estates and facilities team will	The trust currently utilises a small range of RPE FFP3 masks. This is a challenge as the pandemic has seen a significant number of masks come in and out of availability. As the incidents of use of FFP3 masks is low within our settings this meant that we do not carry a wide	The trust maintains a database of the type of masks fitted and to whom. We currently have masks available with a use by date of 2025 to safeguard against limited range. The mitigation is logged on the trust risk register.

○ applied in order and include elimination; substitution, engineering, administration and PPE/RPE. ○ communicated to staff. ○ further reassessed where there is a change or new risk identified eg. changes to local prevalence. • the completion of risk assessments have been approved through local governance procedures, for example Integrated Care Systems. • risk assessments are carried out in all areas by a competent person with the skills, knowledge, and experience to be able to recognise the hazards associated with the infectious agents. • ensure that transfers of infectious patients between care areas are minimised and made only when necessary for clinical reasons. • resources are in place to monitor and measure adherence to the NIPCM. This must include all care areas and all staff (permanent, flexible, agency and external contractors). • the application of IPC practices within the NIPCM is monitored e.g. 10 elements of SICPs • the IPC Board Assurance Framework (BAF) is reviewed, and evidence of assessments are made available and discussed at Trust board level. • the Trust Board has oversight of incidents/outbreaks and associated action plans. • the Trust is not reliant on a single respirator mask type and ensures that a range of predominantly UK made FFP3 masks are available to users as required.	coordinate a local plan to manage and mitigate risk. These plans are overseen by the Assistant Director of Public and Physical Health Care and the Director of Infection Prevention and Control (DIPC). The regional IPC team and national NHSE team and UKHSA will also be consulted for support and critical friend challenge. Any identified incidents of respiratory illness are reported through the DATIX system and the electronic patient record is routinely scrutinised for new aces. The path labs will also ensure that new cases are communicated to the wards and HPU as a failsafe. The trust has level 1 and level 2 infection control training packages in place to ensure that understanding of IPC measures is present in all areas. The Trust has guidelines for the ongoing managemnt using Standard Infection Control Principles (SCIP) and when to implement Transmission Based Precautions (TBP's) including enhanced PPE and Cleaning regimens.	range as the demand is limited.	

	The trust monitors compliance with the 10 elements of SICP compliance. There are 10 elements of SICPs: 1. patient placement/assessment of infection risk (clinical oversight and review) 2. hand hygiene (audit) 3. respiratory and cough hygiene (audit) 4. personal protective equipment (audit) 5. safe management of the care environment (audit) 6. safe management of care equipment (audit) 7. safe management of healthcare linen (audit) 8. safe management of blood and body fluids Audit and policy) 9. safe disposal of waste (including sharps) (audit) 10. occupational safety/managing prevention of exposure (including sharps) (audit and incident review / learning) Any transfer or movement of patients is coordinated through the HPU with oversight and escalation to IMT via AD of public and Physical Health Care.		

	The Trust shares its IPC plans and is represented at the regional IPC meetings (IPCSAG) we also attend the regional mental health IPC meetings as well with NHSE. Oversight of outbreaks and measures to contain them is currently held within the Incident managemnt team as part of the national post pandemic response, this is attended, and any escalations of case rate increases are made through the nominated director or deputy in attendance.		
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure that: • the Trust has a plan in place for the implementation of the National Standards of Healthcare Cleanliness and this plan is monitored at board level. • the organisation has systems and processes in place to identify and communicate changes in the functionality of areas/room • cleaning standards and frequencies are monitored in clinical and non-clinical areas with actions in place to resolve issues in maintaining a clean environment. • enhanced/increased frequency of cleaning should be incorporated into environmental decontamination protocols for	The trust has implemented the national Standards of health care cleanliness and the ward scores are reviewed as part of outbreak oversight. All areas display their star rating in accordance with the guidance. The trust has no areas with a below 5-star cleaning score. Manufacturer's guidance is adhered to in accordance with specifications.		

patients with suspected/known infections as per the NIPCM (Section 2.3) or local policy and staff are appropriately trained. • manufacturers' guidance and recommended product 'contact time' is followed for all cleaning/disinfectant solutions/products. • For patients with a suspected/known infectious agent the frequency of cleaning should be increased particularly in: ○ patient isolation rooms ○ cohort areas ○ donning & doffing areas – if applicable ○ 'Frequently touched' surfaces e.g., door/toilet handles, chair handles, patient call bells, over bed tables and bed/trolley rails. ○ where there may be higher environmental contamination rates, including: ▪ toilets/commodes particularly if patients have diarrhoea and/or vomiting. • The responsibility of staff groups for cleaning/decontamination are clearly defined and all staff are aware of these as outlined in the National Standards of Healthcare Cleanliness • A terminal clean of inpatient rooms is carried out: ○ when the patient is no longer considered infectious ○ when vacated following discharge or transfer (this includes removal and disposal/or laundering of all curtains and bed screens). ○ following an AGP if clinical area/room is vacated (clearance of infectious particles after an AGP is dependent on the ventilation and air change within the room). • reusable non-invasive care equipment is decontaminated:	Deep clean and terminal cleans are available and coordinated with support from the estates and facilities team. Enhanced cleaning will be provided during times of enhanced surveillance or increased cases. Staff teams are clear on their respective responsibilities regarding fluid, bodily fluids etc as outlined in the National Standards of HealthCare Cleanliness. Terminal cleans are carried out when isolation period is discontinued. Air exchange rates are monitored and AGP procedures reviewee against NERVTAG guidance, currently only in ECT suite and for patients who have a thorough and contemporaneous infection risk assessment and are asymptomatic. Cleaning schedules and regimes are monitored. Ventilation assessments have been completed and improvements made to ECT suite as part of pandemic response.		

○ between each use ○ after blood and/or body fluid contamination ○ at regular predefined intervals as part of an equipment cleaning protocol ○ before inspection, servicing, or repair equipment. • compliance with regular cleaning regimes is monitored including that of reusable patient care equipment. • ventilation systems, should comply with HBN 03:01 and meet national recommendations for minimum air changes https://www.england.nhs.uk/publication/specialised-ventilation-for-healthcare-buildings/ • ventilation assessment is carried out in conjunction with organisational estates teams and or specialist advice from the ventilation group and/ or the organisations, authorised engineer and plans are in place to improve/mitigate inadequate ventilation systems wherever possible. • where possible air is diluted by natural ventilation by opening windows and doors where appropriate	Ventilation is an ongoing focus of IPC communications and site visits.		
3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and process are in place to ensure that: • arrangements for antimicrobial stewardship (AMS) are maintained and a formal lead for AMS is nominated • NICE Guideline NG15 https://www.nice.org.uk/guidance/ng15 is implemented – Antimicrobial Stewardship: systems and processes for effective antimicrobial medicine use • the use of antimicrobials is managed and monitored:	Trust is a low consumer of antimicrobials. Regular reviews of usage are undertaken and overseen by Medicines managemnt committee with attendance and escalation to medical director		

○ to optimise patient outcomes ○ to minimise inappropriate prescribing ○ to ensure the principles of Start Smart, Then Focus https://www.gov.uk/government/publications/antimicrobial-stewardship-start-smart-then-focus are followed • contractual reporting requirements are adhered to, and boards continue to maintain oversight of key performance indicators for prescribing including: ○ total antimicrobial prescribing. ○ broad-spectrum prescribing. ○ intravenous route prescribing. adherence to AMS clinical and organisational audit standards set by NICE: https://www.nice.org.uk/guidance/ng15/resources ○ • resources are in place to support and measure adherence to good practice and quality improvement in AMS. This must include all care areas and staff (permanent, flexible, agency and external contractors).	and Assistant Director of public and physical health care. Trust attends regional AMR delivery group and contribute to regional strategy as well as monitor changes with other providers and indicators of changes in use / risk etc.		
4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion.			
• **Key lines of enquiry**	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure that: • IPC advice/resources/information is available to support visitors, carers, escorts, and patients with good practices e.g., hand hygiene, respiratory etiquette, appropriate PPE use	Review of IPC advice and display materials undertaken on regular adults. Ensuring appropriate PPE is available and in situ for visitors	Hand hygiene and bare below the elbow challenges have increased since step change in	Implementation and use of regionally developed hand hygiene audit tool with NHSE

• visits from patient's relatives and/or carers (formal/informal) should be encouraged and supported whilst maintaining the safety and wellbeing of patients, staff, and visitors • national principles on inpatient hospital visiting and maternity/neonatal services will remain in place as an absolute minimum standard. national guidance on visiting patients in a care setting is implemented. • patients being accompanied in urgent and emergency care (UEC), outpatients or primary care services, should not be alone during their episode of care or treatment unless this is their choice. • restrictive visiting may be considered by the incident management team during outbreaks within inpatient areas This is an organisational decision following a risk assessment and should be communicated to patients and relatives. • there is clearly displayed, written information available to prompt patients' visitors and staff to comply with handwashing, respiratory hygiene, and cough etiquette. The use of facemasks/face coverings should be determined following a local risk assessment. • if visitors are attending a care area to visit an infectious patient, they should be made aware of any infection risks and offered appropriate PPE. • Visitors, carers, escorts who are feeling unwell and/or who have symptoms of an infectious illness should not visit. Where the visit is considered essential for compassionate (end of life) or other care reasons (e.g., parent/child) a risk assessment may be undertaken, and mitigations put in place to support visiting. • Visitors, carers, escorts should not be present during AGPs on infectious patients unless they are considered essential following a risk assessment e.g., carer/parent/guardian. • implementation of the supporting excellence in infection prevention and control behaviours Implementation Toolkit has	with disposal points at convenient and safe locations. Trust monitors national visiting guidelines and local variance through NHSE and IPC SAG meetings. Patient support is provided for those attending other hospital provider settings. Advice is supported by local protocols and policy. Signage and in advance communication protocols in place for anyone visiting an unwell or infectious patient. Pre-attendance advice is provided and a request to delay visto if feeling unwell. Compassionate visits for relatives feeling unwell or patients who are unwell are facilitated with a managed plan. Excellence in Implementation IPC toolkit is utilised by the HPU team as part of their IPC support role. Current audit framework is under review in line with national concerns about clarity of standards, quality of application. First principles approach regarding hand hygiene, bare	national guidance, this is national issue.	and regional colleagues.

been adopted where required C1116-supporting-excellence-in-ipc-behaviours-imp-toolkit.pdf (england.nhs.uk)	below the elbow and glove usage being revisited.		
5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure that: • all patients are risk assessed, if possible, for signs and symptoms of infection prior to treatment or as soon as possible after admission, to ensure appropriate placement and actions are taken to mitigate identified infection risks (to staff and other patients). • signage is displayed prior to and on entry to all health and care settings instructing patients with symptoms of infection to inform receiving reception staff, immediately on their arrival (see NIPCM). • the infection status of the patient is communicated prior to transfer to the receiving organisation, department or transferring services ensuring correct management /placement • triaging of patients for infectious illnesses is undertaken by clinical staff based on the patients' symptoms/clinical assessment and previous contact with infectious individuals, the patient is placed /isolated or cohorted accordingly whilst awaiting test results. This should be carried out as soon as possible following admission and a facemask worn by the patient where appropriate and tolerated. • patients in multiple occupancy rooms with suspected or confirmed respiratory infections are provided with a surgical facemask (Type II or Type IIR) if this can be tolerated. • patients with a suspected respiratory infection are assessed in a separate area, ideally a single room, and away from other	Symptomatic and history assessment undertaken on arrival in hospital. POCT testing if symptoms or concerns evident. Appropriate care setting identified and accessed if isolation or precautionary concerns are evident as per current SOP. Signs are displayed when infectious patients are identified upon a ward or clinical area. Communication to partner organisations is made in the event of known infection or in accordance with planned testing protocols (e.g., care homes). Patients who wish to wear or are advised to wear a mask due to infection or prevention concerns are routinely offered and these are available across all clinical settings.		

patients pending their test result and a facemask worn by the patient where appropriate and tolerated (unless in a single room/isolation suite). • patients with excessive cough and sputum production are prioritised for placement in single rooms whilst awaiting test results and a facemask worn by the patient where appropriate and tolerated only required if single room accommodation is not available. • patients at risk of severe outcomes of infection receive protective IPC measures depending on their medical condition and treatment whilst receiving healthcare e.g., priority for single room protective isolation • if a patient presents with signs of infection where treatment is not urgent consider delaying this until resolution of symptoms providing this does not impact negatively on patient outcomes. • The use of facemasks/face coverings should be determined following a local risk assessment. • patients that attend for routine appointments who display symptoms of infection are managed appropriately, sensitively, and according to local policy. • Staff and patients are encouraged to take up appropriate vaccinations to prevent developing infection • Two or more infection cases linked in time, place and person trigger an incident/outbreak investigation and are reported via reporting structures.	Triage and managemnt of patients sensitive to their needs and ensuring their dominant care need is not overshadowed is key to the trust approach. Patient movements, cohorting, PPE, support and communication underpin our approach to manage this sensitively and proportionately. The trust operates a Hospital Hub for vaccination of both patients and staff for Flu and COVID and has evolved tracking systems and outreach approaches for vulnerable groups. Outbreaks are communicated / reported through the recognised communication pathways where a clear link in place time and person is identified.		
6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**

Systems and processes are in place to ensure that:
• IPC education is provided in line with national guidance/recommendations for all staff commensurate with their duties.
• training in IPC measures is provided to all staff, including: the correct use of PPE
• all staff providing patient care and working within the clinical environment are trained in hand hygiene technique as per the NIPCM and the selection and use of PPE appropriate for the clinical situation and on how to safely put it on and remove it (NIPCM);
• adherence to NIPCM, on the use of PPE is regularly monitored with actions in place to mitigate any identified risk
• gloves and aprons are worn when exposure to blood and/or other body fluids, non-intact skin or mucous membranes is anticipated or in line with SICP's and TBP's.
• hand hygiene is performed:
  ○ before touching a patient.
  ○ before clean or aseptic procedures.
  ○ after body fluid exposure risk.
  ○ after touching a patient; and
  ○ after touching a patient's immediate surroundings.
• the use of hand air dryers should be avoided in all clinical areas. Hands should be dried with soft, absorbent, disposable paper towels from a dispenser which is located close to the sink but beyond the risk of splash contamination (NIPCM)
• staff understand the requirements for uniform laundering where this is not provided for onsite.
	IPC training is part of the standard training passport for all staff the level required is contingent upon scope of responsibility and part of assessed framework of competency.
	
	Lightboxes and hand hygiene awareness have been part of outbreak managemnt actions and videos and information resources are regularly circulated in support of refresher and new staff.
	
	SICP and TBP approaches are included in current SOP and observed during walk rounds and audits.
	
	Paper towels are utilised in all clinical areas.
	
	Uniform washing instructions have been circulated during the pandemic and are an integral part of uniform policy.
			IPC training.
			
			Level 1 – 86%
			
			Level 2 – 86%

7. Provide or secure adequate isolation facilities			

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
Systems and processes are in place to ensure: • that clear advice is provided; and the compliance of facemask wearing for patients with respiratory viruses is monitored (particularly when moving around the ward or healthcare facility) providing it can be tolerated and is not detrimental to their (physical or mental) care needs. • patients who are known or suspected to be positive with an infectious agent where their treatment cannot be deferred, care is provided following the NIPCM. • patients are appropriately placed i.e.: infectious patients are ideally placed in a single isolation room. If a single/isolation room is not available, cohort patients with confirmed respiratory infection with other patients confirmed to have the same infectious agent. • standard infection control precautions (SIPC's) are applied for all, patients, always in all care settings • Transmission Based Precautions (TBP) may be required when caring for patients with known / suspected infection or colonization	Advice and support from and to clinical teams regarding patients access and use of masks is routinely provided. Care is provided in accordance NIPCM through a specific SOP to assist staff as we step between SICP and TBP measures in response to any identified infectious cases. Cohorting and isolation procedures are reviewed in conjunction with IPC / HPU support to teams and moves facilitated to accommodate individual needs wherever possible. Efforts to balance the treatment needs and risks of exposure are explored through vaccination status and clinical vulnerability. SIPC's are always in pace. TBP's are introduced when infectious agent is suspected or confirmed until situation has resolved.		Communication strategy and all review / discussion meetings have reinforced that the decision to wear a face mask is a positive IPC measure and is to be encouraged and facilitated for both colleagues and service users.
8. Secure adequate access to laboratory support as appropriate			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**

There are systems and processes in place to ensure: • Laboratory testing for infectious illnesses is undertaken by competent and trained individuals. • patient testing for infectious agents is undertaken promptly and in line with national guidance. • staff testing protocols are in place for the required health checks, immunisations, and clearance • there is regular monitoring and reporting of the testing turnaround times, with focus on the time taken from the patient to time result is available. • inpatients who go on to develop symptoms of infection after admission are tested/retested at the point symptoms arise. **COVID-19 Specific** • patients discharged to a care home are tested for SARS-CoV-2, 48 hours prior to discharge (unless they have tested positive within the previous 90 days), and result is communicated to receiving organisation prior to discharge. Coronavirus (COVID-19) testing for adult social care services - GOV.UK (www.gov.uk) • for testing protocols please refer to: COVID-19: testing during periods of low prevalence - GOV.UK (www.gov.uk) C1662_covid-testing-in-periods-of-low-prevalence.pdf (england.nhs.uk)	Laboratory testing is undertaken by colleagues at RDH / CRH / national infectious Disease centre if HCID cautions are in place. POCT for COVID / FLU etc is available and utilised. Clinical systems have been configured to capture and report results, these re routinely checked for oversight and governance. Retesting and review is caried out in accordance with guidance. Patients being discharged to care homes are tested in accordance with curet testing protocols.	The Trust follows national testing guidance with an active encouragement that clinical curiosity and exploration of differential diagnosis in atypical cases should be maintained.

9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**

Systems and processes are in place to ensure that • resources are in place to implement, measure and monitor adherence to good IPC and AMS practice. This must include all care areas and all staff (permanent, flexible, agency and external contractors). • staff are supported in adhering to all IPC and AMS policies. • policies and procedures are in place for the identification of and management of outbreaks of infection. This includes the documented recording of an outbreak. • all clinical waste and infectious linen/laundry used in the care of known or suspected infectious patients is handled, stored and managed in accordance with current national guidance as per NIPCM • PPE stock is appropriately stored and accessible to staff when required as per NIPCM	The organisation has a bridging policy to support staff as we exit the pandemic, and a new IPC policy is being developed in accordance with the NICPM (expected to be reviewed and refreshed 02/2023) Wate and safe disposal polices, and procedures are adhered to. PPE is located within units with reserve stocks in case of escalation /deterioration of clinical safety.		
10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure that: • staff seek advice when required from their occupational health department/IPCT/GP or employer as per their local policy. • bank, flexible, agency, and locum staff follow the same deployment advice as permanent staff. • staff understand and are adequately trained in safe systems of working commensurate with their duties. • a fit testing Programme is in place for those who may need to wear respiratory protection.	OH support is a universal offer for all staff. IPC level 1 (all staff) training is monitored by team leads and overseen by Physical Health and Infection Control Committee (PHICC). Level 2 training is also overseen at this group. RPE fit tester and porta count machine employed by the organisation and an up-to-date		Work underway to move IPC audit framework onto an online platform (partial currently).

• where there has been a breach in infection control procedures staff are reviewed by occupational health. Who will:
  ○ lead on the implementation of systems to monitor for illness and absence**.**
  ○ facilitate access of staff to treatment where necessary and implement a vaccination Programme for the healthcare workforce as per public health advice.
  ○ lead on the implementation of systems to monitor staff illness, absence, and vaccination.
  ○ encourage staff vaccine uptake.
• staff who have had and recovered from or have received vaccination for a specific respiratory pathogen continue to follow the infection control precautions, including PPE, as outlined in NIPCM.
• a risk assessment is carried out for health and social care staff including pregnant and specific ethnic minority groups who may be at high risk of complications from respiratory infections such as influenza or severe illness from COVID-19.
  ○ A discussion is had with employees who are in the at-risk groups, including those who are pregnant and specific ethnic minority groups**.**
  ○ that advice is available to all health and social care staff, including specific advice to those at risk from complications**.**
  ○ Bank, agency, and locum staff who fall into these categories should follow the same deployment advice as permanent staff**.**
  ○ A risk assessment is required for health and social care staff at high risk of complications, including pregnant staff.
• testing policies are in place locally as advised by occupational health/public health.
	register of staff and their requirements available.
	
	OGH support for staff affected by respiratory illness is accessed and maintained.
	
	All staff follow IPC measures (SICP and TBP) irrespective of vaccination status.
	
	Vulnerable Worker risk assessment process and Health and wellbeing review processes are in place for all employees and advice line support for managers who may need assistance clarification is provided by OH or via HR.
	
	Testing protocols in the event of outbreak etc. are discussed and enacted with support from PHE / UKHSA and enacted by HPU internally.
	
	FFP3 register and support provided by RPE fit tester and supported by HPU. Fit testing is undertaken by an accredited tester using a porta count machine which is calibrated and serviced in accordance with manufacturers specifications.		

• NHS staff should follow current guidance for testing protocols: C1662_covid-testing-in-periods-of-low-prevalence.pdf (england.nhs.uk) • staff required to wear fit tested FFP3 respirators undergo training that is compliant with HSE guidance and a record of this training is maintained by the staff member and held centrally/ESR records. • staff who carry out fit test training are trained and competent to do so. • fit testing is repeated each time a different FFP3 model is used. • all staff required to wear an FFP3 respirator should be fit tested to use at least two different masks • those who fail a fit test, there is a record given to and held by employee and centrally within the organization of repeated testing on alternative respirators or an alternative is offered such as a powered hood. • that where fit testing fails, suitable alternative equipment is provided. Reusable respirators can be used by individuals if they comply with HSE recommendations and should be decontaminated and maintained according to the manufacturer's instructions • members of staff who fail to be adequately fit tested: a discussion should be had, regarding re deployment opportunities and options commensurate with the staff members skills and experience and in line with nationally agreed algorithm. • a documented record of this discussion should be available for the staff member and held centrally within the organisation, as part of employment record including Occupational health. • boards have a system in place that demonstrates how, regarding fit testing, the organisation maintains staff safety and provides safe care across all care settings. This system should			

include a centrally held record of results which is regularly reviewed by the board. • staff who have symptoms of infection or test positive for an infectious agent should have adequate information and support to aid their recovery and return to work.			

Derbyshire Healthcare
NHS Foundation Trust

Board Committee Assurance Summary Reports to Trust Board – 17 January 2023

The following summaries cover the meetings that have been held since the last public Board meeting held on 1 November 2022 and are received for information:

- Quality and Safeguarding Committee 8 November and 13 December
- Mental Health Act Committee 16 December
- People and Culture Committee 30 November
- Finance and Performance Committee 24 November

Quality and Safeguarding Committee - key items discussed 8 November 2022
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 risks relating to the BBC Panorama programme findings (28 September 2022), had been included in the BAF at the Committee's request.
Outstanding CQC actions A more targeted paper was requested for future meetings; setting out the action taken, any issues affecting progress and the level of assurance. Concern was expressed that in one case the action around training was showing a deterioration in progress in some services. Attendees indicated limited assurance from the approach being taken to establish compliance with the outstanding recommendations.
Quality Performance Dashboard The new format presented data in line with the CQC Key Lines of Enquiry and included linked data to relevant legislation. The following issues were highlighted: • Inclusion of inpatient data relating to incidents of self-harm due to ligatures • Incidents of assault from patients to staff • Number of incidents of absconsion • Number of outstanding actions following complaint investigations Work is in hand to align the Medical Director's bi-monthly incident report with the data included in the quality performance dashboard**.** There is a plan to include staffing incidents in the dashboard due to the risk posed to patient safety and quality. Discussion took place on the potential conflict between trying to reduce the number of incidents of absconsion whilst at the same time implementing a reduction in restrictive practise. An executive summary would be included for future reports to help the Committee focus on the areas requiring greater assurance.
Patient Experience Strategy – six month update An overview of the Patient Experience Strategy Workplan was provided with the actions taken against its 3 pledges: Pledge 1: We will promote shared values in respect of a positive patient experience – this was now complete and had been maintained Pledge 2: We will introduce a range of ways patients and carers can give feedback about their experience.

Pledge 3: We will use the feedback we gather to improve our services

Attendees indicated significant assurance in terms of the actions and processes being undertaken about patient experience but limited assurance on outcomes due to the delays in completion and requirement to review the strategy.

Bi-Monthly Incident Report

The report provided a 'snapshot' of activity and how it is managed at different levels and the alignment against the Patient Safety Incident Response Framework (PSIRF). Concern was raised about the length of time the Serious Incident (SI) process takes and the current number of overdue investigations which risk of delaying inquests. One of the biggest drivers for the overdue investigation had been the covid backlog but this was being worked through and staff were being supported through initiatives such as the Schwartz rounds. Time taken to complete investigations was also under-estimated so a project was underway to look at back-fill and include in job planning.

Attendees indicated significant assurance that actions are in place and that they are beginning to take hold.

Skill Mix and Safer Staffing

The Trust has a statutory obligation to maintain safer staffing levels within in-patient settings and a report was presented that demonstrated the Trust was performing comparatively well in terms of its staffing levels and favourably against national benchmarks. The Trust remained within acceptable levels regarding the number of staff per 10 beds and had safe staffing levels across all the working age groups.

The actions and initiatives being taken to respond to skill mix and staffing concerns were presented together with an outline of the further action that would be taken to support staffing and patient safety against national benchmarking standards. Attendees indicated significant assurance from the report and the work to address vacancy levels.

Assuring Quality Care

The report had been prepared in response to a formal request by Claire Murdoch (National Director for Mental Health) that all NHS Services providing Mental Health, Learning Disability and Autism services collectively investigate their own areas to identify, eradicate and prevent abuse from happening. Ms Murdoch's request had come following findings by the BBC's Panorama programme (28 September 2022), which exposed unsafe and abusive care in an NHS Mental Health Trust.

The Trust's current practice against each of the items identified from the BBC investigation was highlighted and offered further improvements to ensure full assurance that high quality care occurs within Derbyshire Healthcare NHS Foundation Trust.

The existing leadership visit schedules had been enhanced with out of hours visits and unannounced drop ins and then bringing together the findings and feedback from those staff and patient contacts to the relevant Committees of the Board. There had been significant communication and engagement with staff following the BBC programme and staff were encouraged to talk about and reflect on their response to the piece and compare it with their own experiences.

Attendees gained significant assurance of the Trust's processes with regard to communication and creating an open culture. A further report would be received by the Committee in February 2023 meeting on progress with the next steps in response to the National Director for Mental Health's request, following meetings with the ICB's Safeguarding Board and NHS England.

Chief Pharmacist's Quarterly Update

An update on progress made against the Trust's current strategies for Pharmacy and Medicines Optimisation was received.

The following sections were highlighted:

- The escalations from the Medicine Management Committee

- Implementation of electronic Prescribing and Medicines Administration (ePMA)
- Leadership role within medicines optimisation – associated with recruitment difficulties
- Rapid tranquiliser monitoring, review and debrief requirements
- Medicines expenditure associated with acuity in some services

Attendees indicated significant assurance from the content and detail of the report and the processes in place, but limited assurance relating to the specific matters highlighted by the Medical Director in his presentation.

CAS Alert Briefing

The Central Alerting System (CAS) briefing related to changes to food standards and the allergy monitoring framework following the inception of Natasha's law into legislation in October 2021. Attendees did not support reducing the aspirational figure of training compliance from 85% to 80% and requested a monthly update until the agreed threshold was achieved.

Quality Improvement Strategy 2021 – 2024 Annual Update

The Trust's Director of Strategy, Partnerships and Transformation joined the meeting and presented the report which provided progress on the Quality Improvement (QI) capability training programme plan to embed QI into the organisation in 2022-23, and associated aspects of infrastructure to support opportunities and application of QI methodology.

Neurodevelopmental Services Update

This a regular item on the Committee's agenda and this month's report provided an update on

- Acute Mental Health Admissions
- Audits and CQC (Care Quality Commission) Readiness
- Derbyshire Neurodevelopmental (ND) bedded care update

Following discussion and noting that the risk of closed beds continues, it was agreed that the Board Assurance Framework (BAF) should continue to reflect the risks and unfolding actions being taken.

Board Assurance Framework – key risks identified: None
Escalations to Board or other committees: None
Next Meeting – 13 December 2022

Committee Chair: Lynn Andrews	**Executive Lead: Tumi Banda, Interim Director of Nursing and Patient Experience**

Quality and Safeguarding Committee - key items discussed 13 December 2022

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 BAF is currently being reviewed by the Executive leads and appointed risk managers in preparation for the next version to be taken to ELT and the Audit and Risk Committee. All leads are aware that a number of operational risks have been identified around risk 1a that are due to be reviewed in this period. The revised BAF will then brought to the next meeting of the Committee on 14 February.

Risk escalation and assurance report includes monitoring of risk management training compliance

This report outlined the process of the risk register reviews, provided an update on the annual risk management audit, a summary of the current status of extreme/high level Trust-wide operational risks, together with update on compliance rates for the tiered risk management training programme.

The Trust's Internal Auditor carries out work to testing the Trust's risk processing which is reported to and monitored by the Audit and Risk Committee. Due to the limited assurance gained from the report, the Committee asked for quarterly reporting to continue until the Committee feels more confident with the process of risk management and escalation.

Outstanding CQC actions

The Committee received assurance on progress towards completion of outstanding CQC actions.

Quality visit findings and future plan for quality visits – verbal update

There had been some operational challenges in delivery the quality visit schedule. The format is being reviewed so that quality visits fit the purpose they are intended for. In addition to quality visits Executive Directors and Senior Leaders continue to make regular visits to services.

The Committee hoped that the report due at the March meeting would provide a better level of assurance on the plan for quality visits.

Patient and carer experience quarterly report

This report provided an update on the themes and changes made to Trust services as a result of feedback on incidents and complaints made to the Patient and Carer Experience Committee during Quarter 2 of the financial year 2022/23.

The Committee was assured that each division is learning and acting on the feedback received and was pleased that the quality of information contained in the report is being worked on to reduce the amount of detail and make it more helpful by benchmarking the divisions.

As shown in previous reports, returns of the Friends and Family Survey remain low in some areas. Staff are continuing to encourage people to provide their feedback and it is anticipated that returns will improve as a result of the roll out of better options for service user involvement.

Physical Healthcare and Infection Prevention Control update (including IPC BAF)

Having reviewed and discussed the report it was agreed that the level of assurance was split between IPC and physical healthcare. Significant assurance was obtained from IPC with limited assurance from the outcomes of physical healthcare checks. Although progress has been made there remain opportunities for improvement.

Care planning and person-centred care agenda – six monthly report

Work has continued to focus on developing processes that improve the quality of care plans, safety planning, person-centred practice and trauma informed care planning. Audits continue to be carried out within divisions and services to monitor both the presence and quality of care plans and safety plans. A clear process is being developed to embed this in usual clinical practise.

The Committee concluded that limited assurance had been obtained from the care planning process due to the challenges being experienced with data migration and access.

Guardian of Safe Working (GoSW) quarterly report

The report details arrangements made to ensure safe working of junior doctors and arrangements in place to identify, quantify and remedy any risks to the organisation.

The GoSW would be addressing the lack of submission of exception reports. An update was received on the fines, with assurance given by the GoSW that the Trust is discharging its statutory duties regarding safe working.

Annual update on professional strategies - Allied Health Professional therapies and psychological therapies

Key themes across all AHP (Allied Health Professionals) staff groups were noted as being:

- Lack of mental health training and / or student placements in professions not traditionally associated with mental health provision. This is being tackled through the Higher Education Institutions (HEIs)
- ESR (Electronic Staff Record) inability to report on staff in generic roles, which is being addressed nationally.

There is a plan to establish a Division of Psychological Therapies that will bring together all the psychological therapists and psychologists in the Trust with a newly appointed Chief psychologist / MDT (multi-disciplinary team) lead, three deputies and an ASM (Assistant Service Manager).

The Committee noted there have been many successes including engagement form psychological therapists; enthusiasm to develop different roles and new ways of working; growth in the provision of psychological therapies across Derbyshire and a reduction in the vacancy rate. However, there are still challenges around waiting lists for which we have developed a Recovery Action Plan (RAP) for Working Age Adults (WAA).

Learning from deaths / mortality report

The Committee accepted this Mortality Report as significant assurance of the Trust's approach and agreed for the report to be considered by the Trust Board of Directors and then published on the Trust's website as per national guidance.

Neurodevelopmental Services Update

The report provided an update on safeguarding incidents for the Trust in the last quarter, Neurodevelopmental (ND) System Delivery Plan, reducing health inequalities and recruitment and retention. The update also includes the Learning Disabilities Position Statement - LD standards.

Safeguarding children quarterly assurance report

The Committee reviewed safeguarding children activity in the Trust against statutory and legislative requirements.

Significant assurance was gained around Safeguarding Children activity, systems, and controls within the Trust with the Committee recognising the areas where risks and pressures are identified around predicting future demand.

Safeguarding adults quarterly assurance report

The Committee reviewed safeguarding adults activity in the Trust against statutory and legislative requirements.

Full assurance was accepted that statutory duties are being met and the Committee noted the Quality Priority of Improving Sexual Safety is moving forward with regional links being made and work in progress and that the actions from significant incidents are in progress or completed.

Special educational needs and disabilities (SEND) update Assurance was taken from the report with the Committee supporting the initial consideration of the SEND reforms, pending publication of response and that the Trust had strong compliance and developments underway with revised reporting proposals.
Policy Review The following policies were approved: Equality Impact Risk Analysis Policy and Procedures Care Principles and Care Programme Approach (CPA) Policy and Procedure
Board Assurance Framework – key risks identified: None **Escalations to Board or other committees:** None **Next Meeting – 14 February 2023**

Committee Chair: Lynn Andrews	**Executive Lead: Tumi Banda, Interim Director of Nursing and Patient Experience**

Mental Health Act Committee - key items discussed 16 December 2022
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 (MHA) Manager's Report The report covered the analysis and assessment of the Mental Health Act Office activity for the 12 month rolling period focusing on 1 July – 30 September 2022. There had been multiple uses of the holding power on one particular ward but these were reviewed by the MHA Office and deemed to be appropriate. One patient had been placed on a Section 5(4) on 4 occasions, the circumstances will be reviewed by the MHA Manager and the Ward Manager for learning and reflection. 10 files had been audited at random on the use Section 62 Urgent Treatment Requests and one consent to treatment form appears to have been put in place at the expiry of the 3-month rule. The data contained in the report was comprehensively reviewed and the Committee accepted partial assurance from the report that the data does not identify any specific matters of concern and that the safeguards of the MHA have been appropriately applied within the Trust.
Mental Health Act Bill This is a standing item – there was nothing to update on from the previous meeting.
Liberty Protection Safeguards and update on status of Code of Practice This is a standing item – there was nothing to update on from the previous meeting.
Report on complaints from patients detained under the Mental Health Act The Committee received the comparison data for complaints received during Q1 and Q2 of 2022/23 and complaints received regarding people on a Section of the Mental Health Act 1983. Data from complaints is also included in the Patient Experience Report that is reported to the Quality and Safeguarding Committee with assurance provided regarding the themesand changes made to Trust services as a result of feedback from complaints. The report provides assurance in line with CQC's fundamental standards under Regulations 16 and 17.

Deep Dive report on the use of Section 136

A Deep Dive report into the use of Section 136 suites/ Section 135/136 Nov 2021- October 2022 2022 was presented. Key issues highlighted were:

- The Section 135/136 MHA group continues to meet monthly with representation from Police and Social Care.
- The work plan is largely centred around embedding and sustaining progress, made in terms of the CQC action plan 2020.
- Training - e-learning packages and breakaway sessions for staff.
- The capacity of the Helpline has been increased with a view to reducing the in-appropriate use of Section 136s.
- Physical healthcare audits are being monitored and shared monthly with an upward trajectory.
- There has been a reviewing of over 5 years' worth of data which shows a variation of detentions in Section 136.
- A flow chart has been designed for the specific professions/facilitators including doctors.
- Risk registers have been reviewed and updated
- Estate works have commenced within the Section 136 suite North (Hartington Unit).
- Accessible information leaflets have been produced
- The Trust's stance on the acceptance of Section 136 out of area has been clarified and has been included in the Joint Policy reviews.
- The Family and friends test is to be given to patients and families on exit from the suites re: Section136 experience. Since July 2022 there has also been a smart survey to collect information used to monitor themes and trends, alongside audit requirements for CQC purposes, and for best standards.
- 136 Facilitators Trust wide were shortlisted for the "unsung hero" Trust Hearts Awards.

Training Compliance

The report provided an update on compliance for Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) in the Trust August – October. MCA/DoLS total compliance was 83.70% against a target of 90%. The Committee was disappointed with the position that had worsened since the last update. Other training rates have lower compliance rates and a range of initiatives are in place to improve performance.

Reducing Restrictive Practice, Restraint and Seclusion and Locking of Doors report – including trend update

The Committee received an update on progress made regarding implementation of the positive and safe strategy. The report identified some areas of improvement and actions have been identified, along with some data cleansing and analysis. The 90% or above competition rate is not currently being achieved and the reasons behind this are being explored and work is underway by the Head of Nursing team and Digital practise team to improve the situation.

There has been an increase in the use of restrictive practise but a decrease in seclusion across the inpatient ward settings. Locked doors remain the largest area of restrictive practice use. The data showed that restrictive practice appears to be reducing giving evidence that a closed culture is not presented, in line with the findings of the CQC closed culture report. The Committee accepted assurance in the issues highlighted.

Update from Associate Hospital Managers

Associate Hospital Managers (AHM) gave a verbal update on their activities. An experienced AHM has recently resigned which is a great loss to the team and would put pressure on the others to cover the work.

Escalations to Board or other Committee(s): None
Next Meeting: 17 March 2023

Committee Chair: Ashiedu Joel	**Executive Lead: Arun Chidambaram, Medical Director**

People and Culture Committee - key items discussed 30 November 2022

Summary of Board Assurance Framework (BAF) Risks

The Committee reviewed the two BAF risks it has oversight of in the context of discussions and the current work programmes. The new governance structure sitting below the Committee is now in place and reflected in the Committee's forward plan and aligned with the BAF with gaps in control identified.

People and Inclusion Assurance Dashboard

The data within the dashboard was noted with discussion centred around the process developed for appraisals being recorded in the ESR system and how this area is being targeted for improvement. There were also updates on the training compliance levels along with vacancy rates. Vacancy rates were now 5.13% which is a significant improvement. A new exit interview process has been initiated. The dashboard will be refined to include more granular data on staffing levels to allow a focus on areas where there are recruitment issues including agency usage.

Mandatory Training Compliance

The report provided an update on training compliance and action being taken to support staff to achieve and maintain training compliance. A considerable amount of work continues to be carried out to ensure there is enough capacity to deliver training especially in terms of compliance against CQC action areas relating to training. A cleansing exercise has been carried on the Training Passport within ESR and escalation was in place for staff who are non-compliant. The Committee received limited assurance on the progress being made against the plans in place to increase compliance for key training.

Systems Update

The Committee receives regular updates on the work of the Integrated Care Board's equivalent People and Culture Committee (PCC). A meeting is proposed for the PCC Chairs and HR Directors to discuss shaping the delivery environment and the assurance environment over the next 12 months. An update was received on the Industrial Action response.

Employee Relations Update

This update covered People Services risks and issues and current work being carried out in the Joint Venture.

Absence Management

Due to the increased levels of absence, action plans were put in place and a task and finish group was set up which had led to a reduction. Managers were being supported to manage long term sickness. A business case has been put together for support with a HR Transformation

Programme to shift the absence management. The Committee took full assurance that there is a comprehensive improvement plan to improve sickness absence.

Temporary Workforce (and agency spend) – Deep Dive

A task and finish group had been set up to deal with Agency Spend and there are increased levels of targets and scrutiny at system level. The Trust is looking at ways to maximise its E-Roster system and maximising the recruitment and retention of Bank Staff.

A Bank Staff Listening Events and a Bank Staff Survey will be introduced for the first time this year. System discussions are going to come around a collaborative Bank workforce.

The Committee took full assurance on the understanding and awareness of the usage of temporary workforce at Trust level but received limited assurance on the reduction of agency spend.

Escalations to Board or other committees: None

Board Assurance Framework – key risks identified: The Committee recommended that the training element of the BAF has an increased risk applied.

Next Meeting: 31 January 2023

Committee Chair: Ralph Knibbs	**Executive Lead: Jaki Lowe, Director of People and Inclusion**

Finance and Performance Committee - key items discussed 24 November 2022

Making Room for Dignity (MRfD) assurance on Estate Strategy

The Committee received the following updates:

- Psychiatric Intensive Care Unit (PICU) progress supported regionally with an element of cash backed funding but there remains the requirement to use the Trust's own cash reserves for a significant proportion of the costs (circa £11m). The Committee was in support of progression on this basis and noted the impact on cash and plans required to manage cash levels going forward. Due to the diversion of Trust cash and the knock-on risk for wider capital requirements such as estate and IM&T strategy delivery and risk mitigation; continued efforts to source any additional funding remains crucial for the remaining schemes.
- Affordability issues related to new build due to hyperinflation, there are plans in place to mitigate these additional costs pressures. The Committee was assured on the programme of work.
- VAT abatement outcome has been received and an appeal process being taken forward. The Committee in support of progressing with the programme.

Following the discussion on the programme the Board Assurance Framework (BAF) risk will be reviewed and updated and programme updates would continue to be reported to confidential Board meetings.

Operational Performance

Performance to end of September 2022 was scrutinised with the following issues highlighted:

- Reporting issues affecting measurement across a number of key areas. Various Recovery Action Plans in place which include actions, trajectories and risks to delivery.
- Autism Spectrum Disorder (ASD) assessments exceeded commissioned levels for the first time, concerns remain for the numbers still waiting. Psychology recruitment drive has had some positive results.
- Dip in Improving Access to Psychological Therapies (IAPT) performance due to staff moving through training and into other roles, action is being taken to recruit into vacancies. DNAs (did not attend) consistently below 15% but still an area of focus.

Harmonisation of Learning Disabilities and Autism (LDA) Services update

The alliance for working in partnership is progressing. Committees in Common (CiC) are in place for both Trusts; Derbyshire Community Health Services and Derbyshire Healthcare and the first two meetings have been held. Options are being looked at to expand the CiC to cover other services. The Committee received an overview of the issues discussed which included increased admissions, leading to a surge in escalation planning. A good news story was shared relating to admissions avoidance. In terms of the community offer, the model will align alongside the Trust's services to ensure effective use of resources and best outcomes.

Regional provider collaboratives update

The Committee noted that the interim business case had been submitted to NHS England and positive feedback received. There had been progress with the Perinatal Lead Provider programme of work. Operational go live was 1 October and a Memorandum of Understanding (MOU) was in place. Contract go live is expected in April 2023. The detailed financial information is still awaited and expected December. The Committee was assured on progress to date.

Laundry Tender

The award of the five plus two-year contract based on the outcomes of a mini competition exercise using a compliant framework was approved. Assurance was received that value for money had been achieved through a Derbyshire ICB collaborative procurement process.

Financial plan update

The Committee received the Month 7 position reported against the breakeven plan. Month 7 is a favourable variance to plan of £0.4m, mainly driven by the recently identified efficiency schemes that have been transacted. The forecast assumes breakeven including full delivery of £6m efficiencies. However, there is an unmitigated system forecast deficit of £35.4m. This requires the Trust to deliver a stretch surplus of £1.4m, which can be achieved from additional funding, VAT rebate and slippage on recruitment.

Financial risks are starting to reduce, however the risk of increasing temporary staffing costs particularly agency continues. The risk of reduced cash levels will be updated following the requirement to self-fund the PICU build. This will be reflected in the next update of the Board Assurance Framework.

The Committee expressed concern related to the high agency and bank expenditure and the actions being taken forward.

Continuous Improvement update

Month 7 position reported against the breakeven plan. Month 7 favourable variance to plan of £0.4m, mainly driven by the recently identified efficiency schemes that have been transacted. Forecast assumes breakeven including full delivery of £6m efficiencies. However, there is an unmitigated system forecast deficit of £35.4m. This requires us to deliver a stretch surplus of £1.4m, which can be achieved from additional funding, VAT rebate and slippage on recruitment.

Financial risks are starting to reduce, however the risk of increasing temporary staffing costs particularly agency continues. The risk of reduced cash levels will be updated following the requirement to self-fund the PICU build. This will be reflected in the next update of the Board Assurance Framework.

The Committee expressed concern about the high agency and bank expenditure and noted the actions being taken forward.

Board Assurance Framework (BAF) 2022/23 overview

The Committee has three risks, two of which are extreme. Following discussion on the PICU build and usage of cash reserves the next iteration of Finance risk on the BAF will reflect these risks.

Health and Safety Report

The report covered Fire, Health and Safety and Security Management for April to September 2022. The Committee received assurance that delivery was doing well considering the impact of the pandemic on working arrangements. The Trust was confident in achieving the 95% training compliance by the end of the financial year. A different approach has been required for Fire Wardens and First Aiders due to the impact of hybrid working.

Escalations to Board or other Committees: Confidential Board meeting to update on issues around system LDA risks
Board Assurance Framework: – key risks identified: PICU build and usage of cash reserves will be included in the next iteration of Finance risk on the BAF.
Next scheduled meeting: 24 January 2023

Committee Chair: Tony Edwards	**Executive Lead: Rachel Leyland, Interim Director of Finance**

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 17 January 2023

Report from the Council of Governors meeting

The Council of Governors has met one since the last report, on 1 November 2022, and the meeting was conducted digitally via Microsoft Teams.

Chief Executive update

The update was jointly given by Ifti Majid, Chief Executive and Carolyn Green, Interim Deputy Chief Executive and Chief Nurse. They had been working side by side, co-attending a number of improvement meetings, to ensure a smooth handover for when Ifti leaves the Trust on 30 November. Updates included the current situation regarding COVID-19 and flu; recovering waiting times and services, how complaints have reduced, the current financial situation and system working. Governors were also briefed on the Trust's response to the findings from the Panorama and Dispatches documentaries which focused on concerns relating to the treatment of service users in some mental health trusts, and the lessons being learnt. Governors were assured that the case studies in the documentary did not reflect how the Trust treats its patients and service users.

Presentation on the Derby and Derbyshire Emotional Health and Wellbeing Website

This included:

- How the website is set up
- What it is about – it is centralised signposting website with information on mental health and wellbeing.
- Who it is for – it is for everyone in Derby City and Derbyshire County
- Key dates
- Content process
- Accessibility

Report from the Governors' Nominations and Remuneration Committee

The Council of Governors agreed an increase to the remuneration of the Trust's Non-Executive Directors (NEDs) to bring the levels in line with the £13,000 per annum set out in the national guidance. This brings the rates in line with other provider trusts in the Derbyshire system; noting that the current rates has not been increased since 2013. The supplementary payments paid to the Deputy Trust Chair, Senior Independent Director (SID) and the Audit and Risk Committee Chair were also reviewed with no changes proposed for current postholders.

One of the Trust's NEDs, Ashiedu Joel, was re-appointed for a second three year term of office. Assurance was given that all the Fit and Proper Persons checks have been completed for Tony Edwards and Lynn Andrews the latest NED appointments. Governors also agreed to adjustments to the Chair's appraisal process for 2022/23.

Update on CQC Board Well Led

A CQC Well Led governor task and finish group has been set up and the aim of the group is to help governors understand the framework and prepare them for the role they play in the Well Led Inspection.

One of the areas in Well Led is leadership and governors received an update on the Chief Executive recruitment and re-outlined the continuity plans the Trust has in place to ensure stability in the interim period.

Council of Governors Annual Effectiveness Survey

This survey is carried out yearly in line with best practice. The positive response rate remains high and some additional actions have been developed in response to the survey feedback to further enhance the effectiveness of the Council of Governors.

Lead Governor/Deputy Lead Governor Roles

The current Lead Governor and Deputy Lead Governor's terms of office end in January and governors were asked to consider expressing an interest in the roles.

Non-Executive Directors Deep Dive (including annual report of the Audit And Risk Committee)

Ralph Knibbs, Chair of the People and Culture Committee, presented the Deep Dive, which included an update on staff retention. This included an overview of:

- How managers are encouraged to support staff
- The new 'stay' process
- The new exit questionnaire and process
- The introduction of hybrid and flexible working initiatives
- Staff wellbeing
- Upskilling staff and expanding capabilities
- Succession planning and talent management approaches

Escalation of items to the Council of Governors

One item of escalation was received from the Governance Committee meeting held on 12 October 2022:

Regarding Care Plans governors seek assurance that:

1. *All service users receive a copy of their care plan*
2. *The technical side of the migration from Paris to SystmOne is robust and a process is in place for support*

The response to the question was read out at the meeting and would be included in the published minutes.

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.

Annual Members Meeting (AMM) feedback

This was sent out after the meeting. A working group would be set up to plan the 2023 AMM.

Governor elections

The 2023 round of elections is underway. Full details are available on the Trust's website.

Governance Committee Report

The Committee Chair presented a report of the meetings held on 10 October 2022.

Thanks and Goodbye to Ifti Majid

Governors conveyed their appreciation to Ifti and wished him well in his future endeavours.

RECOMMENDATION

The Trust Board is asked to note the summary report from the Council of Governors meeting held on 1 November 2022.

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	
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
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
ELT	Executive Leadership Team
EMDR	Eye Movement Desensitising & Reprocessing Therapy

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Term / Abbreviation	**Terms in Full**
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
IM&T	Information Management and Technology
OOA	Outside of Area

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Term / Abbreviation	**Terms in Full**
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
MHRT	Mental Health Review Tribunal
MSC	Medical Staff Committee

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Term / Abbreviation	**Terms in Full**
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
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
Q&SC	Quality and Safeguarding Committee
QIA	Quality Impact Assessment
QIPP	Quality, Innovation, Productivity Programme

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Term / Abbreviation	**Terms in Full**
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
TOOL	Trust Operational Oversight Leadership (replaced IMT)
U	
UDBH	University Hospitals of Derby and Burton
UEC	Urgent and emergency care
V	
VARM)	Vulnerable Adult Risk Management
VO	Vertical Observatory
W	

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

(updated 14 June 2022)

2022-23 Board Annual Forward Plan

Exec Lead	Meeting date	10 May 22	5 Jul 22	6 Sep 22	1 Nov 22	17 Jan 23	7 Mar 23
	Paper deadline	**25 Apr**	**27 Jun**	**29 Aug**	**24 Oct**	**9 Jan**	**27 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							
DPI	Staff Survey Results	X					
DPI	Annual Gender Pay Gap Report for approval						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 20 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 2022/23			X			
DPI	2022/23 Flu Campaign			X			
Trust Sec	NHS Improvement Year-End Self-Certification	X					
Trust Sec	Year-end governance reporting from Board Committees and approval of ToRs	X					
Trust Sec	Corporate Governance Report	X					
Trust Sec	Review SOs, SFIs, SoD plus review/ratify SFI Policy (as Policy Review section below)						Amendment SFI
Trust Sec	Trust Sealings (six monthly - for information)	X			X		
Trust Sec	Annual Review of Register of Interests	X					
Trust Sec	Board Assurance Framework Update	X		X	X		X
Trust Sec	Freedom to Speak Up Guardian Report (six monthly)			X			X
Trust Chair	Fit and Proper Person Declaration		X				
Trust Sec	Annual Approval of Modern Slavery Statement	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 Dashboard	X	X	X	X	X	X
DPI	Equality Diversity and Inclusion (EDI) update				X		
COO	Emergency Preparedness, Resilience and Response (EPRR) Core Standards			X			
DON/COO/ DPI	Workforce Standards Formal Submission/Safer Staffing (prior to publishing on website)	X					

2022-23 Board Annual Forward Plan

Exec Lead	Meeting date	10 May 22	5 Jul 22	6 Sep 22	1 Nov 22	17 Jan 23	7 Mar 23
QUALITY GOVERNANCE							
EXEC	Position Statement - focus on CQC domains (Well Led CQC & NHSI) as per schedule - Use of Resources (DOF) deferred to April 2023	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
MD	Guardian of Safe Working Report - AR will be July from 2022/23		AR - see note		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	Draft Mental Health Bill			X			
DON	Assuring Quality Care					X	
DON	Receipt of Annual Reports: - Annual Looked After Children - Safeguarding Children and Adults at Risk				AR AR		
DON	Outcome of Patient Stories - every two years - next due March 2024						
POLICY REVIEW							
COO	Emergency Incident Response Plan and Procedures prior to expiry 01/10/2022			X			
Trust Sec	Policy for Engagement between the Board of Directors and the CoG				X		
DOF/ Trust Sec	Standing Finance Instructions Policy and Procedures Review						X
Trust Sec	Fit and Proper Person Policy prior to expiry 31/03/2023						X