Derbyshire Healthcare NHS Foundation Trust
Board of Directors

To be held digitally via MS Teams

2 November 2021 09:30 - 2 November 2021 13:00

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PUBLIC BOARD MEETING
TUESDAY 2 NOVEMBER 2021 TO COMMENCE AT 9:30am
Following national guidance on keeping people safe during COVID-19 this will be a virtual meeting conducted via MS Teams

	TIME	AGENDA	LED BY
1.	9:30	Chair's welcome, opening remarks and apologies, declarations of interest and Register of Directors' Interests	Selina Ullah
2.		Patient Story	Carolyn Green
3.		Minutes of Board of Directors meeting held on 7 September 2021	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	Chief Executive's Update - Approval of Green Plan - Revised RoadMap	Ifti Majid
STRATEGY, OPERATIONAL PERFORMANCE AND QUALITY ASSURANCE			
8.	10:25	Integrated Performance Report - Derbyshire TCP performance update	C Wright/J Lowe/ C Green/A Odunlade
9.	10:45	NHSI Financial Annual Plan Months 7-12 2021/22	Claire Wright
11:00 B R E A K			
10.	11:10	Strategic implications of the outcomes of the 2020/21 Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) submissions	Jaki Lowe
11.	11:35	Quality Position Statement – Effective (focus on CQC domains - Well Led CQC and NHSI as per Board forward plan schedule)	Carolyn Green
12.	11:50	Guardian of Safe Working Report	John Sykes
13.	12:00	Learning from Deaths Mortality Report	John Sykes
GOVERNANCE			
14.	12:10	Board Assurance Framework Update - Issue 3 2021/22	Justine Fitzjohn
15.	12:20	Approve Standard Financial Instructions	Claire Wright
16.	12:30	Quality and Safeguarding Committee receipt of Annual Reports 2020/21: - Safeguarding Children and Adults at Risk - Derby City Looked After Children Provision - Infection Prevention and Control	Carolyn Green
17.	12:40	Board Committee Assurance Summaries of meetings of Quality and Safeguarding, Mental Health Act, Finance and Performance and Audit and Risk Committees held during September and October 2021	Committee Chairs
CLOSING MATTERS			
18.	12:50	- Identification of any issues arising from the meeting for inclusion or updating in the Board Assurance Framework - Meeting effectiveness	Selina Ullah
FOR INFORMATION			
Trust Sealings (six monthly report) Summary of Council of Governors meetings Glossary of NHS Acronyms 2021/22 Forward Plan			

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

The next meeting will be held at 9.30am on 18 January 2022. It is anticipated that this meeting will be held digitally via MS Teams
Users of the Trust's services and other members of the public are welcome to attend the meetings of the Board.
Participation in meetings is at the Chair's discretion

Our vision

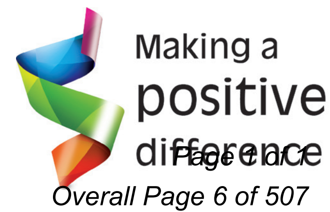
To make a positive difference in people's lives by improving health and wellbeing.

Our values

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

Our Trust values are:

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



DECLARATION OF INTERESTS REGISTER 2021/22

NAME	INTEREST DISCLOSED	TYPE
Margaret Gildea Senior Independent Director	• Director, Organisation Change Solutions Limited • Coaching and organisation development with First Steps Eating Disorders • Director, Melbourne Assembly Rooms	(a) (e) (d)
Carolyn Green Director of Nursing and Patient Experience	• Midlands and East Regional Director, National Mental Health Nurse Directors Forum	(e)
Gareth Harry Director of Director of Business Improvement and Transformation	• Chair, Marehay Cricket Club • Member of the Labour Party	(e) (e)
Ashiedu Joel Non-Executive Director	• Director, Ashioma Consults Ltd • Director, Peter Joel & Associates Ltd • Director, Leicester Council of Faiths • Director, The Bridge East Midlands • Director, Together Leicester • Lay Member, University of Sheffield Governing Council	(a) (a) (a) (a) (a) (a)
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	• Board Member of NHS Confederation Mental Health Network • Co-Chair, NHS Confederation BME Leaders Network • Spouse is Operations Director (North) at Priory Healthcare	(d) (d) (e)
Ade Odunlade Chief Operating Officer	• Director- CMC Foundation Christian Charity • Trusteeship African Council for Nursing & Midwifery • Research Lead on Observations for Ox e-Health • Director – Jonathan Davids Limited (currently converting to Dormant Company)	(a) (d) (e) (a)
Dr Julia Tabreham Non-Executive Director	• Research and Ambassador Carers Federation • Daughter's partner, Amit Pore is Team Lead for the NHS Passport. Amit is employed by Netcompany, working in collaboration with NHS Digital and NHSX (NHS joint organisation for digital, data and technology) • Daughter-in-Law, Dr Jacqueline Tsang is Consultant Obstetrician, Newham Hospital, London	(d) (e) (e)
Dr John Sykes Medical Director	• Undertakes paid assessments of patients at the request of the local authorities under the Mental Health Act and Mental Capacity Act and acts likewise for solicitors representing patients	(e)
Selina Ullah Trust Chair	• Non-Executive Director - Solicitors Regulation Authority • Director/Trustee, Manchester Central Library Development Trust (voluntary role) • Non-Executive Director, General Pharmaceutical Council • Non-Executive Director, Locala Community Partnerships CIC • Non-Executive Director, Accent Housing Group	(a) (a) (e) (e) (e)
Richard Wright Deputy Trust Chair and Non-Executive Director	• Non-Executive Director (Chair) of Sheffield UTC Multi Academy Educational Trust	(a)

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

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

MINUTES OF A VIRTUAL

MEETING OF THE BOARD OF DIRECTORS

TUESDAY 7 SEPTEMBER 2021

VIRTUAL MEETING VIA MS TEAMS	
Commenced: 09.30	Closed: 12.24

PRESENT	Caroline Maley	Trust Chair
	Richard Wright	Deputy Trust Chair and Non-Executive Director
	Margaret Gildea	Senior Independent Director
	Dr Sheila Newport	Non-Executive Director
	Geoff Lewins	Non-Executive Director
	Dr Julia Tabreham	Non-Executive Director
	Ashiedu Joel	Non-Executive Director
	Ifti Majid	Chief Executive
	Claire Wright	Deputy Chief Executive and Director of Finance
	Ade Odunlade	Chief Operating Officer
	Carolyn Green	Director of Nursing and Patient Experience
	Dr John Sykes	Medical Director
	Gareth Harry	Director of Business Improvement and Transformation
	Jaki Lowe	Director of People and Inclusion
IN ATTENDANCE	Anna Shaw	Deputy Director of Communications
	Sue Turner	Board Secretary
Item DHCFT2021/0	Hayley Darn	General Manager, Children's Services
Item DHCFT2021/0	Sarah Gray	Clinical Lead for Child and Adolescent Mental Health Services
APOLOGIES	Justine Fitzjohn	Trust Secretary
OBSERVERS*	Richard Eaton	Communications Manager
	Justine Fitzjohn	Trust Secretary
	Denise Baxendale	Membership and Involvement Manager
	Ian Strange	Technical Analyst
	Selina Ullah	Incoming Trust Chair
	Pete Henson	Head of Performance
	David Charnock	Appointed Governor, University of Nottingham
	Jo Foster	Staff Governor, Nursing
	Marie Hickman	Staff Governor, Admin and Allied Support Staff
	Julie Lowe	Public Governor, Derby City East
	Susan Ryan	Public Governor, Amber Valley
	Simon Rose	Lived Experience Educator
	Natalie Legg	Team Administrator
	Melanie Dyke	Derbyshire Community Health Services NHS Foundation Trust
	Georgina Mellor	Paediatric Physiotherapist
	Lynda Langley	Lead Governor and Public Governor, Chesterfield
	Leanne Walker	Chair of the LGBT+ Network
	Jan Nicholson	Paediatric Occupational Therapist
	Eddie Bisknell	Local reporter
	Rikesh Patel	

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

DHCFT 2021/075	**CHAIR'S WELCOME, OPENING REMARKS, APOLOGIES FOR ABSENCE AND DECLARATION OF INTERESTS** Due to the need for social distancing to help limit the spread of COVID-19, this was a virtual meeting, held via MS Teams and livestreamed to the public. Trust Chair, Caroline Maley, welcomed everyone to her final meeting as Trust Chair before Selina Ullah commences in post on 14 September. Apologies were received from Trust Secretary, Justine Fitzjohn. The Register of Directors' of Interest was noted. Non-Executive Director, Ashiedu Joel declared her additional interest as a Lay Member, University of Sheffield Governing Council to be included in the register. **ACTION: Ashiedu Joel's additional interest to be included in the Register of Directors' Interests.**
DHCFT 2021/076	**STAFF STORY** Hayley Darn, General Manager, Children's Services and Sarah Gray, Clinical Lead for Child and Adolescent Mental Health Services (CAMHS) joined the meeting and shared from their perspective within Children's services how the Trust's operational oversight had been taken through the pandemic by the Incident Management Team and how this had shaped the good practice "people first" approach. They also talked about the innovations carried through by the Children's and CAMHS management team and the impact this had on health and wellbeing support offered to colleagues. Hayley and Sarah were particularly proud of the way CAMHS adapted and upheld clinical activity with everyone open to their caseload through various waves of the pandemic, working with innovation and kindness taking a people first approach as the prime factor. The importance of effective communication and engagement was quickly identified alongside the need to provide colleagues with appropriate technology to work from home where necessary. Good levels of communication were maintained through virtual engagement with team members, no matter where or how they were working giving them a good sense of connection. They both commended the way their colleagues worked together and made sure patients continued to be at the forefront of their activity. Vulnerable staff working at home were assured that patients could be seen face to face by a less vulnerable member of staff. The Board discussed elements of learning taken during the pandemic and how with the benefit of hindsight, and knowledge of how long emergency procedures were in place it would be necessary to look more at the resilience of leaders within the organisation, and how new colleagues can be further supported when joining the Trust during the pandemic. The Board recognised the importance of ensuring that teams are robust and that colleagues can better deliver on rotation across teams. Other assumptions to be addressed were concerned with colleagues' equality with digital technological or their access to broadband. Having reflected on the importance of responsiveness and visible leadership during times of uncertainty and how services continue to balance the importance of people's mental health and physical healthcare needs, the Board thanked Hayley and Sarah for giving a clear insight into the of activity within the Children's Division and CAMHS. **RESOLVED: The Board of Directors noted the innovative activity within the Children's Division and CAMHS forming a collective COVID response**

DHCFT 2021/077	**MINUTES OF THE BOARD OF DIRECTORS MEETING HELD ON 6 JULY 2021** The minutes of the previous meeting held on 6 July 2021 were accepted as a correct record of the meeting.
DHCFT 2021/078	**ACTIONS MATRIX AND MATTERS ARISING** Reference was made to the action regarding improvements to be made to the Learning from Deaths Mortality Report received at the July meeting. It was agreed not to close this action until after the report is received at the November Board meeting to ensure that data relating to the different ethnicities and people with protected characteristics within Derbyshire have been included in the report to the satisfaction of the Board.
DHCFT 2021/079	**QUESTIONS FROM MEMBERS OF THE PUBLIC** No questions had been submitted for a response ahead of today's meeting.
DHCFT 2021/080	**CHAIR'S UPDATE** Caroline provided her last Trust Chair update to the Board on her activity since the previous Board meeting held in July. She offered her thanks to colleagues for their support and commitment and shared how she enjoyed spending time with teams over recent weeks. A special highlight for Caroline was the formal opening of the memorial garden, in memory of colleagues Gladys Mujajati and Ann Shepherd who succumbed to COVID in 2020. The garden also remembers other members of staff who have lost their lives over the years and has been wonderfully created by the Trust's Estates team as a place to sit and reflect. Engagement continued with the Council of Governors. Caroline highlighted the importance of the regular meetings she has with the Lead Governor in building an understanding of the working of both governing bodies. She was proud of the way governors showcased how the Trust and the Council had worked through the pandemic at a national conference with a presentation entitled "Meaningful Engagement through the COVID 19 Pandemic". The last few months have involved system meetings, regional meetings and national meetings. Caroline referenced the notes from the Joined up Care Derbyshire (JUICD) meeting held in July that were appended to her report; more details of which were included in Ifti Majid's Chief Executive report. She also shared a report that went to NHS England and Improvement (NHSEI) Board meeting by Claire Murdoch, National Director for Mental Health at NHS England which reassured her of the alignment of the Trust's priorities in Derbyshire with those set out in this report. Caroline took the opportunity to promote the Annual Members' Meeting (AMM) taking place on 9 September where the winner of the 'Finding my calm during COVID' writing competition will be announced. She thanked Denise Baxendale, Membership and Involvement Manager for her involvement in this important event, and for the support she provides to the Governors. Finally, Caroline wished the Board and her successor, Selina Ullah, all the best for the future and looked forward to seeing from her retirement the Trust continuing to go from strength to strength. **RESOLVED: The Board of Directors noted the content of the Chair's update.**
DHCFT 2021/081	**CHIEF EXECUTIVE'S REPORT** Ifti Majid's report provided the Board with an update on local and national developments within the national and local Derbyshire health and social care sector over the last two months.

National Context
Ifti provided an update on the Integrated Care System (ICS) design framework and outlined how the closer working between provider organisations will create opportunities to make clinical pathways more effective and efficient through these partnership arrangements.

Ifti was mindful that the Board will need to consider during Board Development in October the challenges emerging with capacity that are seen to be worsening for senior leadership teams within the Trust's involvement within the provider collaborates. Consideration will also be given to how the Trust will support the development of both a provider collaborative in Derbyshire and a Mental Health Learning Disability and Autism Alliance. The Board will also spend time exploring the emerging governance that it will have to be assured by and the that of the collaborative and how to reduce any duplication.

The government published its response to the Reforming the Mental Health Act White Paper consultation on 15 July 2021 following a 14-week public consultation that the Trust responded to. The Board noted that the Trust's Mental Health Act Committee and its operational sub-group is already in the process of reviewing and supporting expected changes to understand their impact and mitigations to allow for planning within the Trust.

Local Context
A Joined Up Care Derbyshire (JUCD) Board meeting was held on 15 July. Some of the key points from that meeting were covered in Ifti's report for the Board to note which included a reminder of a patient story about the importance of holding quality conversations and active listening which was reminiscent of the patient story heard at the previous Board meeting.

Ifti referred to a key clinical priority that has emerged from the Mental Health, Learning Disability and Autism Delivery Board by highlighting how the Transforming Care Programme (TCP) is working to reduce the number of people with a learning disability or autism cared for in a hospital setting. This is something that will require sustained system focus and leadership and Ifti thanked colleagues from the Trust who have been actively engaged in this development work. He proposed holding a more detailed discussion of the trajectory, achievement and risks associated with TCP at the next Board meeting, as part of the integrated performance report.

ACTION: Transforming Care Programme trajectory, achievement and risks to be discussed at the next Board meeting on 2 November as part of the IPR

Within the Trust
Ifti updated the Board on ongoing work to create two new acute units in Derby and Chesterfield, with the aim of replacing current dormitory style provision. Over the course of the next year he will share more detailed plans as they emerge as work progresses towards having the full business cases ready to present to the Board in June 2022.

Ifti has previously stated in public how amazed he has been by the ongoing resilience of colleagues in the organisation in responding to the COVID pandemic. Ifti and the Board thanked all Team Derbyshire Healthcare colleagues for their ongoing support and adherence to infection, prevention and control measures and acknowledged the pressure that services and staff continue be under responding to the pandemic and progressing the Trust's COVID recovery.

Approval of Derbyshire Anchor Charter
Ifti had previously spoken about the wider system based work he is leading with Andy Smith from Derby City Council, on the Anchor Partnership. The development of an Anchor Charter appended to his report described ways of securing commitment from each partner organisation that will make changes to benefit communities across the city and county.

The Board formally adopted the Anchor Charter, in recognition that the Charter will enhance and support the approach that the Board is already taking to benefit residents of Derbyshire and agreed to embed its principles within the Trust's Strategy and Vision and Values.

	Deputy Trust Chair, Richard Wright hoped there were plans to increase the number of organisations within the Anchor partnership and suggested that further education colleges be approached as the development of students will be critical to the economy. Ifti concurred and assured Richard that more organisations will be joining to ensure there is good engagement across the county. Richard also asked about the provider collaboratives and questioned how the system was going to rationalise this requirement. Ifti explained that the purpose of the provider collaboratives is to deliver change as laid down in the NHS long term plan to deliver the national priorities. The alignment with other Derbyshire foundation trusts, the Mental Health Alliance and the East Midlands Alliance is connected within this collaborative. Agreement will need to be reached about the approach to be taken with regards to capital and how to deliver the overall plan to best effect across local and regional levels. Non-Executive Director, Sheila Newport referred to Ifti's comment in his report regarding the current engagement with Place and asked if this was concerned with where people receive services. Ifti responded that the challenge is sometimes a lack of recognition that the Trust delivers universal services and was worried that the complex needs of the people who use these services get support where they need it within Place. Ifti felt that having Ade Odunlade on the Board as Chief Operating Officer will help the Trust's link with Place become operationally more acceptable. Ifti turned his focus on to Caroline because this was the last Board meeting she would chair before she retires. He considered that her legacy had left a positive impact on the lives of the people of Derbyshire and he gave thanks to her for her service to the Trust. The Board bid farewell to Caroline and thanked her for her service, leadership and support over the years and wished her a very long, happy and healthy retirement. **RESOLVED: The Board of Directors:** **1) Scrutinised the report, noting the risks and actions being taken** **2) Agreed to adopt the JUCD Anchor Charter** **3) Sought further assurance on key issues raised.**
DHCFT 2021/082	**PERFORMANCE AND ACTIVITY REPORT** This report updated the Board of Directors on the key finance, performance and workforce measures at the end at the end of July 2021. **Finance** Claire Wright summarised the current financial performance. With the first half of the financial year due to end in September the year to date position will be refreshed for the second half of the year and reported to the next Board meeting. Claire assured the Board that she is strongly focussed on the financial position in future years both internally and within the system. With regards to self-funded capital, the Trust is on plan at the end of month 4 and it is expected that the full capital plan will be committed by the end of the financial year. Claire mentioned that although the Trust will be receiving additional funding from the mental health investments this will have an impact on the Trust's financial plan due to slippage on recruitment. The lead executives will ensure that sound financial governance is taken forward within recruitment activity. Richard Wright asked Claire if she was expecting to see another long term efficiency improvement programme operating throughout the second half of the financial year and whether vacancies transferred through efficiency schemes carried out last year will restart removing the need to recruit to certain positions. Claire considered it was too early to make this judgement. The analysis that the Finance Team is looking at will determine if any previous cost improvement schemes are revisited and this will be discussed in depth within the Finance and Performance Committee and will be reported to the Board at the next meeting in November.

Operations

Chief Operating Officer, Ade Odunlade reported that performance has continued within expected levels and the number of out of area placements has been successfully reduced to zero. To date the Trust has consistently achieved the national standard for follow-up of discharged patients. Unfortunately, the waiting list for ASD assessment is slowly increasing as a steady number of referrals has led to a month on month increase

Ade and the Board thanked the 93% of Trust colleagues who are now fully vaccinated against COVID-19. Vaccinations will remain a central part of the Trust's ongoing pandemic response. COVID-19 recovery plans continue particularly in terms of identifying locations, timings and protocols for safe COVID-19 face to face appointments. Ade assured the Board that the Trust continues to have a good oversight of all elements of performance to ensure business continuity for patients and staff.

People performance

Director of People and Inclusion, Jaki Lowe reported that staff absence continues to be lower than average. Long term sickness absence has begun to reduce whilst short term absence has increased in line with relaxation of restrictions and increased infection rates.

The Trust is changing the focus on annual appraisals so that they concentrate on health and wellbeing conversations balancing this with conversations on awareness of objectives. In general appraisal completion is also beginning to improve where managers and staff are able to factor in that dedicated time. Recovery of appraisals will be the focus in coming months as we move out of the pandemic

Staff turnover within the Trust is reflecting the national picture. Retirements continue to add to the turnover rate although this is still in line with national predictions. Planning is in place to target recruitment by attracting people into the organisation.

Quality

Carolyn Green reflected on today's staff story and highlighted that feedback arising from virtual and non-virtual assessments is being assessed in relation to patients' use and capability with digital methodology. Choices are being offered in terms of virtual appointments to support people to be digitally confident to maximise the choices of patients, families, and carers.

Although the number incidents in the use of restraint and seclusion peaked in July, they remain under the upper control limit and have not resulted in an increase in the use of prone restraint. Carolyn saw this this as a positive indicator that reducing restrictive practice pilot work streams have been effective in providing alternatives to prone restraint. Carolyn assured the Board that the Clinical Directorship is closely managing the Trust's services under a tight monitoring brief to ensure colleagues and patients are kept safe while managing safer staffing levels.

Sheila Newport noted that care plan reviews had reduced and asked Carolyn what was being done to mitigate any clinical implications. Carolyn reported that although care plan reviews were necessary for a small group of patients, she was not unduly concerned and expects care plan reviews to increase to significantly higher numbers.

Caroline Maley asked if continued financial rigor is applied to ceilings set on locum and agency costs. Claire assured Caroline that operational and clinical decisions are taken to agree to the use of locums or agency workers. The Trust exceeded its ceiling last year and Claire expects it will be exceeded again this year. A significant amount of these costs is associated with the Trust's recovery from COVID-19. The use of locums has been necessary as has the use of agency workers used to augment the extra cleaning levels required to maintain satisfactory infection, prevention and control measures because of COVID. Medical Director, John Sykes added that locums cover for junior doctors who have to fill vacancy gaps as they arise. There are plans to recruit consultants to increase the number of senior trainees within the organisation but a lot of locum costs are due to the supply and demand as the Trust has recently lost consultants to the private sector and to other areas of the NHS.

	Having scrutinised and discussed performance within the Trust the Board agreed that limited assurance had been obtained on the areas presented. A progress update on the mental health urgent care helpline and response hub, which offers valuable mental health support 24/7 to people in Derbyshire, through a partnership approach was appended to the report for information. **RESOLVED: The Board of Directors received limited assurance from current performance across the areas presented.**
DHCFT 2021/083	**<u>WORKFORCE RACE EQUALITY STANDARD (WRES)</u>** **<u>WORKFORCE DISABILITY EQUALITY STANDARD (WDES)</u>** Jaki Lowe updated the Board on progress with the work taking place on the 2020/21 Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) submissions. She requested that the Board grant delegated authority for the People and Culture Committee to approve the submissions for 30 September and 31 October deadlines respectively at the meeting of the Committee. The Board discussed how adopting a shared ownership approach with all senior leaders across the organisation alongside engagement with staff networks will drive the actions set out in the 2020/21 WRES and WDES action plans that will be seen in the results this time next year. The Cultural Intelligence Programme is due to launch with the Board on 15 September. This is an exciting first step for the Trust to take part in an organisational programme to embrace and celebrate cultural difference. Senior Independent Director, Margaret Gildea noticed the passion with which Hayley and Sarah spoke during today's staff story about focussing on a people first approach and reiterated the importance of staff engagement at team level that will support the shared ownership approach to be taken. Ifti was conscious that while the people first approach remains the method to be taken for all colleagues, BME colleagues continue to have a poorer experience of working within our organisation in terms of their development and with disciplinary measures. More stringent action must be taken to improve their experience and he urged the Board to prioritise cultural intelligence work as this will be the key to the Trust's success in making a difference. Non-Executive Director, Ashiedu Joel questioned how the EDI (Equality, Diversity and Inclusion) approach can ensure fair treatment and opportunity can be flexed to make it more equitable and proposed that the Board must interrogate the WRES indicators and personalise them to the Trust in order to change behaviours. Delegated authority was granted to the People and Culture Committee to review and sign off the WRES and WDES October submissions on 21 September 2021. It was agreed that at the next Board meeting on 2 November, the Board will receive updates from the People and Culture Committee regarding the delivery of the WRES and WDES with key areas for improvement and approved action plans. **RESOLVED: The Board of Directors gave delegated authority to the People and Culture Committee on 21 September to review and sign off the 2020/21 WRES and WDES submissions.**
DHCFT 2021/084	**<u>2021/22 FLU VACCINATION PROGRAMME</u>** The Board considered an overview of the approach being taken to the Trust's flu campaign 2021/22. Jaki Lowe outlined the necessary steps to achieving the vaccination of frontline healthcare workers for Derbyshire Healthcare NHS Foundation Trust (DHCFT) to reach the minimum expectation of 100% offered and 85% vaccinated. The Board recognised that achieving the

	85% target will rely on an organised and efficient campaign and applauded the work led by Assistant Director of Public and Physical Healthcare, Richard Morrow. It was noted that the vaccination programme this year overlaps with the launch of the COVID booster campaign through the Kingsway Hospital hub. The Board was also pleased to note that the flu delivery programme will be jointly delivered by DHCFT and Derbyshire Community Health Services NHS Foundation Trust (DCHS) in a partnership working model using a Memorandum of Understanding to address some the specific events of the written instruction. This will enable both organisations to provide an optimised response and focus efforts and resources across Derbyshire in mutually advantageous way to deliver the vaccination programme. Non-Executive Director, Geoff Lewins asked Jaki to clarify how NHS England and Improvement (NHSEI) reporting requirement targets will be reached. Jaki confirmed that all Trust colleagues will be offered the vaccine. Achieving the target of expected minimum uptake of 85% is based on the vaccination of eligible frontline Heath Care Workers (HCWs). **RESOLVED: The Board of Directors:** **1) Received significant assurance about the programme being undertaken by the Trust and that the 'winter readiness' approach fits with the Trust's values and strategy** **3) Recognised that that costings for the campaign are unable to be determined at this time but include cost of bank staff, administration support, requirement for pharmacy support and transport / logistics** **4) Confirmed the NHS England and Improvement (NHSEI) reporting requirements (100% offered, 85% vaccinated healthcare workers)** **5) Recognised the potential impact that concomitant administration may have on the programme.** **6) Noted that the Memorandum of Understanding required to enable DCHS and DHCFT to work in partnership and vaccinate each other's staff is in planning but not yet confirmed between respective organisations.**
DHCFT 2021/085	**<u>RE-VALIDATION OF DOCTORS</u>** This report provided the Board with the necessary assurance that the Trust has fully achieved all the standards with the Statement of Compliance assurance for the statement of compliance to be signed on behalf of the Trust by the Chief Executive or Trust Chair. John Sykes provided the Board with assurance on the appraisal process for medical staff which continued throughout the COVID-19 pandemic. Assurance was also received on the key actions that have been completed over the course of the past twelve months in order to maintain compliance with the regulations. In terms of undertaking effective appraisals Sheila Newport asked if the Trust had adopted the Appraisal 2020 model where there is a reduced requirement for preparation by the doctor and a greater emphasis on verbal reflection and discussion in appraisal meetings. John confirmed that this model was now being used within the organisation. In addition to discussions covering the achievement of objectives a health and wellbeing evaluation is also undertaken. Learning from themes arising from doctors' appraisals are also being taken forward by the Medical Appraisal Lead. The Board agreed that significant assurance could be taken from the revalidation of the Trust's doctors and agreed that Ifti Majid would sign the statement of compliance for submission to NHS England and NHS Improvement (NHSEI). **RESOLVED: The Board of Directors:** **1) Received significant from the report.** **2) Agreed that the statement of compliance can be signed by the Chief Executive and submitted.**

DHCFT 2021/086	**GUARDIAN OF SAFE WORKING REPORT** This regular 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. 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. John Sykes was pleased to report that virtual meetings taking place with junior doctors have also been attended by members of the British Medical Association (BMA). Although the software for logging exception reports was continuing to be problematic, exception reports were being completed and closed and action is being taken to resolve the issue. The Board received significant assurance of the Trust's approach in discharging its statutory duties regarding safe working for medical trainees and paid tribute to work that medical trainees do for the Trust. Thanks were also extended to Carolyn Green for her work in harnessing the good working relations between junior doctors and clinical teams. **RESOLVED: The Board of Directors received significant assurance of the Trust's approach in discharging its statutory duties regarding safe working for medical trainees.**
DHCFT 2021/087	**WELL LED/GOVERNANCE INTERIM STATEMENT** Caroline Maley presented the report in the absence of Trust Secretary, Justine Fitzjohn and sought approval from the Board on the proposed approach to preparing for an external Well Led Development Review in light of the impact of the pandemic and in line with the Trust's roadmap. The Board recognised that maintaining a strong focus on being well led remains a continuous process across the Trust and within the system and approved the process of activities to assess against the Well Led framework's Key Lines of Enquiry (KLOEs) around: 1. Leadership capacity and capability 2. Vision and strategy 3. Culture and engagement 4. Governance 5. Risk and performance management 6. Information, data and reporting. Carolyn Green added she and Justine have discussed the additional capacity needed to be able to complete this work and she assured the Board that the Executive Leadership have approved this resource. **RESOLVED: The Board of Directors approved the proposed approach to preparing for an external Well Led Development Review.**
DHCFT 2021/088	**FREEDOM TO SPEAK UP GUARDIAN REPORT** The Trust's Freedom to Speak Up Guardian (FTSUG), Tamera Howard joined the meeting to present the Board with a half yearly report of Freedom to Speak Up (FTSU) cases within the organisation, an analysis of trends within the organisation and actions being taken. The Board noted that the total case numbers seen in this report have increased by 62.5% compared to cases reported in the Board in March which was seen as a positive indication of the change in the speaking up culture within the organisation. Patient safety concerns remain low but bullying and harassment cases have has increased from 18 to 22 in relation to the first half of this year which is much lower than the national average.

	In terms of emerging and ongoing FTSU themes, the effect that investigations have on staff health and wellbeing and the isolation and disconnection of being redeployed to another area as part of an investigation process and the impact of being unable to discuss these processes with supportive colleagues was seen as a concern. The perceived delays to the investigation process and receiving outcomes was seen as having a serious negative effect on staff wellbeing. Having been involved in managing investigations, Margaret Gildea suggested that the People and Culture Committee looks at how long investigations take and the impact that the investigation process has on staff wellbeing. Ifti Majid was interested to know if people raise a concern with the FTSUG have they already instigated a process that circumvents line manager responsibilities. If colleagues feel they need to dual report a process that is underway does this mean staff are not happy with the process? Ifti suggested that the People and Culture Committee include this in the analysis of FTSU activity. Julia Tabreham as the NED lead for FTSU assured Ifti that she and the FTSUG continue to meet on a regular basis and confirmed that FTSU data and themes emerging from the process are monitored by the People and Culture Committee through the People and Inclusion Dashboard. The Board acknowledged that the Trust's speaking up culture should be celebrated and supported the FTSU vision strategy. **ACTION: People and Culture Committee to the explore the impact that the investigation process has on staff wellbeing, length of time that investigations take and staff satisfaction with the process.** **RESOLVED: The Board of Directors:** **1) Supported the current mechanisms and activities in place for raising awareness of the FTSU agenda.** **2) Discussed the report and received significant assurance from the FTSU agenda at the Trust and that the proposals made by the FTSUG promote a culture of open and honest communication to support staff to speak up.** **3) Supported the development of an FTSU Vision Strategy for the Trust as recommended by the National Guardian's Office and FTSU Board Self Review guidance.**
DHCFT 2021/089	**<u>BOARD COMMITTEE ASSURANCE SUMMARIES</u>** The Board Committee Assurance Summaries demonstrated the work of the committees since their last update to the Board and were accepted as a clear representation of the priorities that were discussed and will be taken forward in forthcoming meetings. **Mental Health Act Committee:** This was a positive meeting where significant assurance was received on the governance that ensures safeguards of the MHA have been appropriately applied. The failure of the wi-fi connection at the Radbourne and Hartington Units was referred to the Finance and Performance Committee as this issue has ramifications on service delivery. **Audit and Risk Committee**: Good levels of assurance were received that the organisation's data quality is based on particularly solid foundations. Limited assurance received on clinical audit processes and how salary over payments were being recovered will be reported to the next meeting in October. External audit work on the Trust's Value for Money (VfM) arrangements provided assurance that the Trust has performed as an efficiently run organisation. The Committee was gratified that Mazars had worked to close the VfM work off in advance of the National Audit Office's September deadline which meant that the Trust had complied with statutory guidance. **Quality and Safeguarding Committee:** A paper outlining the clinical demand of the future pipeline of forensic patients and expansion of the service was discussed and will be further reported to the Committee in October. The Chief Pharmacist's report and concerns with not being able to undertake electronic prescribing was escalated to the Finance and

	Performance Committee. Themes emerging from the number of vacancies, staff turnover and integration within the medical teams was escalated to the People and Culture Committee to establish if how well medical staff are working within their teams. **Finance and Performance Committee:** The dormitory eradication and Psychiatric Intensive Care Unit (PICU) projects being monitored by the Committee are progressing well. Work within the estates strategy and extra cleaning required in response to COVID-19 has contributed to the excellent results in infection and prevention and control. The Board noted that upgrades to improve the wi-fi connection was discussed by the Committee and was pleased to note that a communication will be communicated to all staff informing them of the improvements being made to the wi-fi and the refurbishment work being carried out to the wards. **People and Culture Committee:** As a result of a referral from the Quality and Safeguarding Committee a commitment was made to undertake an analysis of the pulse check data of medical staff and provide feedback on the outcomes and action to be taken. The People and Inclusion Dashboard continues to add value to meetings and the increase in executive attendance at the July meeting was much appreciated. The Board was assured that FTSU data and themes is monitored by the Committee via the People Inclusion dashboard and that the issues raised in the FTSUG report, particularly the impact that investigations have on staff health and wellbeing will be carried through. The Committee discussed and agreed that BAF Risk 2a '*There is a risk that we do not sustain a healthy vibrant culture and conditions to make Derbyshire Healthcare Foundation Trust (DHCFT) a place where people want to work, thrive and to grow their careers'* is increased to extreme due to increased gaps in control that relate to resilience issues within the People Services team. The Board recognised that it is within the Board Committees where much of the scrutiny and challenge takes place which is such an important part of the Trust's governance requirements. **RESOLVED: The Board of Directors noted the Board Assurance Summaries**
DHCFT 2021/090	**IDENTIFICATION OF ANY ISSUES ARISING FROM THE MEETING FOR INCLUSION OR UPDATING IN THE BOARD ASSURANCE FRAMEWORK (BAF)** The following points were considered for inclusion in the next iteration of the BAF: • The Executive Leadership Team is to consider how TPC will be included in the BAF under risk 1a "*There is a risk that the Trust will fail to provide standards for safety and effectiveness as required by our patients and our Board"* and linked to the Corporate Risk Register under the Mental Health Learning Disability and Autism Mental Health LD and Autism Board. • Consideration will also be given to how the Trust will support the development of both a provider collaborative in Derbyshire and a Mental Health Learning Disability and Autism Alliance and how this should be reflected in the BAF. • Mitigating action relating to the increase in vacancy, staff turnover and sickness rates is to be strengthened in the BAF and the Executive Leadership Team (ELT) is to develop an improvement plan • ELT is to also consider how difficulties in recruiting people to the new work the Trust is being funded for is featured within the BAF. • Changes to access standards impacted by the new Mental Health Act should be subject to specific review connected to current performance as well as the Learning Disability and Autism Strategy and featured in the next iteration of the BAF. The next iteration of the BAF is due to be received by the Board on 2 November after being reviewed by the Audit and Risk Committee on 7 October.

DHCFT 2021/091	**2021/22 BOARD FORWARD PLAN** The 2021/22 forward plan outlining the programme for the remainder of the year was noted and will be reviewed further by all Board members throughout the financial year.
DHCFT 2021/092	**MEETING EFFECTIVENESS** Board members agreed that the meeting had been successfully conducted as a live streamed meeting held in the public domain with the correct items placed on a comprehensive agenda. Thanks were extended to all Board members for enabling the meeting to run to time. Consideration is to also be given to how discussions held within system board committees are brought to the attention of the Board. The ICS and implications this will have on sovereign boards will be covered at the October Board Development.
The next meeting to be held in public session will be held at 9.30am on 2 November 2021. Owing to the current coronavirus pandemic this meeting will be held digitally and will be live streamed via MS Live Events.	

				BOARD OF DIRECTORS (PUBLIC) ACTION MATRIX - NOVEMBER 2021			
Date	Minute Ref	Item	Lead	Action	Completion Date	Current Position	
6.7.2021	DHCFT 2021/068	Learning From Deaths Mortality Report	MD	Report to be enhanced to show different ethnicities within the Derbyshire communities. Blank entries relating to the count of people's sexual orientation will also be looked at to understand why it is often left blank. The idea of having a rolling data base of people with protected characteristics to ensure the data is complete is to be explored.	~~7.9.2021~~ 2.11.2021	Board members are to confirm at the November meeting that data relating to the different ethnicities and sexual orientation within Derbyshire have been included in the report to their satisfaction.	Yellow
6.9.2021	DHCFT 2021/075	Declaration of Interests	Board Secretary	Ashiedu Joel's additional interest as Lay Member, University of Sheffield Governing Council to be included in the Register of Directors' Interests	2.11.2021	Register of Directors' Interests has been updated to include Ashiedu Joel's additional declaration.	Green
6.9.2021	DHCFT 2021/078 1	CEO Report	CEO	Transforming Care Programme trajectory, achievement and risks to be discussed at the next Board meeting on 2 November as part of the IPR	2.11.2021	On November agenda. TCP Performance update included in IPR in Appendix 3	Green
6.9.2021	DHCFT 2021/88	Freedom to Speak Up Guardian Report	DPI	People and Culture Committee to explore the Impact that the investigation process has on staff wellbeing, length of time that investigations take and staff satisfaction with the process	18.1.2021	On the agenda of the People and Culture Committee for the next scheduled meeting on 23 November 2021	Yellow

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

Derbyshire Healthcare NHS Foundation Trust
Report to the Public Board of Directors – 2 November 2021

Trust Chair's report to the Board of Directors

Purpose of Report

This report is intended to provide the Board with the Trust Chair's reflections on my activity with, and for, the Trust since joining the Trust on 14 September 2021. The structure of this report reflects the role that I have as Trust Chair.

Our Trust and Staff

1. I attended the corporate induction, which is a revised format corporate induction and has been running for the last 6 months and delivered online. There were around 65-68 new starters. I found the induction stimulating and relevant with a good mix of sessions led by the Chief Executive and Executive Directors. The sessions covered Trust Values, expectations, Trust services, the populations served by the Trust/health inequalities, compassionate care/leadership, quality and continuous improvement, Equality, Diversity and Inclusion, and Freedom to Speak Up. The Trust Values and expectations of new inductees was clear and there was good interaction with inductees. The flow and scheduling of sessions were smooth and seamless. Overall, it was very positive and an energising experience.
2. I have met staff from different services via the live online Engagement Sessions; Adult Services, Older People's Community Services, Children's Community Services, Forensic and Rehabilitation Services and Corporate Services, all of which have provided a further line of insight into the organisation. These events have attracted on average upwards of 50 attendees. Staff have shared how they are delivering services, addressing waiting times, innovating, promoting wellbeing and some of the pressures they are facing. It has been inspiring listening to staff about their work.
3. With the assistance of Anna Shaw and Richard Eaton from the Communications Team I was able to introduce myself to Trust colleagues via a video.
4. I was able to see how the Trust Values are enacted when I met Tamera Howard; Freedom to Speak Up Guardian. Tam outlined the work she has been doing to promote a positive culture of Speaking Up and some of the planned activities for Freedom to Speak Up throughout the month of October.

Council of Governors

5. With the assistance of the Communications Team, I was able to introduce myself to the governors via a video. The link for the video was in Governors Connect, which is the regular e-newsletter for governors.
6. My first day was 14 September so I was not in post to report back on the Board and Council of Governors at the beginning of that month. The full minutes of the Board meeting are included on this agenda as well as a summary of business from the last Council of Governors.
7. I met with Lead Governor, Lynda Langley, Chair of Governance Committee, Julie Lowe and Denise Baxendale who supports the governors with their role.

8. I attended the Governance Committee held on 12 October and was very impressed with the engagement log that documents engagement activities that governors have undertaken. It also highlights the issues and concerns that they have picked up from the engagement activities and brought back to the Trust for further action.
9. The next meeting of the Council of Governors will be on 2 November, following the Public Board meeting that day. The next Governance Committee takes place on 8 December.

Annual Members Meeting (AMM)

10. On 9 September the Trust held the Annual Members Meeting on MS Teams. It was attended by 69 people: 11 public governors, 5 staff governors, 3 appointed governors, 7 Non-Executive Directors, 6 Executive Directors, 21 staff members, 4 Trust members, and 12 members of the public. The AMM closed with the announcement of the winners of the Trust's writing competition on the theme of 'finding my calm during COVID'. We hope that the 2022 meeting will be held as a face to face event.

Board of Directors

11. I have met with all of the Non-Executive Directors and the Executive Directors individually, which has been invaluable for me in understanding the progress made in delivering the strategic priorities of the Trust and some of the challenges the Trust is facing and working to address.
12. The Board has committed to developing Cultural Intelligence within its Senior Leadership Team. Board members took part in a self-assessment exercise and used this as a basis for discussion and development at a Board Development session on 15 September. The exercise highlighted that the Trust has a strong focus, drive and commitment to valuing difference and is in a good place to develop further.
13. A Board Development session took place on 13 October, which focused on the next steps in the development of the Derbyshire Integrated Care System (ICS).
14. The Non-Executive Directors have met with Ifti Majid and me to ensure we have been fully briefed on developments.

System Collaboration and Working

15. I have met with John MacDonald and Chris Clayton, Chair and Chief Executive respectively of Joined Up Care Derbyshire (JUCD). I attended the October JUCD Board meeting.
16. I also assisted in the recruitment of the substantive Chief Executive role for the Derbyshire system on 11 and 13 October.
17. The JUCD Board met on 16 September using MS Teams. It was highly informative and highlighted the progress made by the various work streams and the complexities and challenges of being an operational Integrated Care Board (ICB) on 1 April 2022.
18. I have been introduced to a number of Chairs forums and networks, including Mental Health Trust Chairs, NHS Providers Mental Health Chairs Network and East Midlands Chairs Alliance. Some of these meet weekly and others monthly, which has been a very useful source of sharing best practise and peer advice.
19. Members of the Board and I took part in the East Midlands Alliance Board Development event on 14 October, which was highly informative. Progress updates were provided about some of the work programmes which are under the umbrella of the Alliance.

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

Assurances

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

Consultation

This report has not been to other groups or committees.

Governance or Legal Issues

None

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

This report reflects a wide range of activities across the Trust, and consideration relating to ensuring inclusion is embedded in operational work of the Trust. The specific services visited provide support to those with protected characteristics by the nature of their work. I am developing my own awareness and understanding of the inclusion challenges faced by many of our staff.

With respect to working with governors, I will continue to support the approach taken by the Trust to work actively to encourage a wide range of nominees to Trust governor elections and strive that the Council of Governors is representative of the communities they serve. The Trust also provides 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

I will ensure that I am visible in my support and leadership on all matters relating to diversity and inclusion. I will provide support to Non-Executive Directors and ensure that the Non-Executive Directors are also engaged and involved in supporting inclusive leadership within the Trust.

We will continue to consider the skills and knowledge needed on the Board in terms of diversity and inclusion when recruiting new Board members building on the proactive approach taken to appoint people from protected characteristics, thereby trying to ensure that the Trust has a Board that is representative of the communities we serve.

Recommendations

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

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

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 2 November 2021

Chief Executive's Report to the Public Board of Directors

Purpose of Report

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

National Context

1. NHS England and NHS Improvement (NHSE/I) published priorities and operational planning guidance for October 2021 to March 2022 on 30 September 2021. The Board will remember in my briefing earlier in the year that six priority areas were identified for April to September and those have not changed for the latter half of the year:

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

    In addition, the guidance continues to focus on the five priority areas for tackling health inequalities and continues the focus on sustained long term plan delivery.

    The NHS will receive an extra £5.4bn to cover COVID-19 costs in the second half of the financial year. This includes £1.5bn for elective recovery, of which £500m is capital. There is an increased efficiency requirement in H2 compared to the first half of the financial year (H1).

    Specifically, in relation to our services:

    The guidance confirms that the NHS mental health implementation plan 2019/20 – 2023/24 remains the foundation for the mental health response to

COVID-19. Systems should continue to make use of the additional £500m funding made available for mental health at the beginning of 2021/22. Systems must also continue to meet the mental health investment standard (MHIS).

More detailed clarity is given in relation to those areas we must focus on in the second half of the year:

- Delivery against in-year integrated care system (ICS) workforce plans, making full use of new roles, and development of a multi-year mental health workforce plan.
- Accelerating the recovery of face-to-face care in community mental health services and submitting the re-categorisation of community mental health spend over autumn.
- Reducing out of area placements, long lengths of stay and long waits in emergency departments for mental health patients.
- Continuing to increase access to NHS-funded children and young people's community mental health services, talking therapies, individual placement support and specialist perinatal services.
- Advancing equalities, including delivering the target for physical health checks for people with severe mental illness and recovering the dementia diagnosis rate.
- Delivering actions to enable whole pathway commissioning for provider collaborative 'front runners' from April 2022.
- Ensuring digital capabilities are in place across services to drive interoperability and improvements in patient safety, supporting digitally enabled pathway redesign, and using digital services to improve access and personalisation of care is also encouraged.

Whilst not specifically mentioned in its own section, the expectation continues to be clear about long term plan delivery for Learning Disability and Autism Services.

Board members will note the synergy between the expectations in the planning guidance and in the Trust's own RoadMap for Quarter 3. As a Board it will be vital for us to think about how we increase our monitoring of long term plan achievement through our Board Committees and in conjunction with emerging system governance.

2. At the September Board meeting I spoke about the publication of the Integrated Care System (ICS) design framework (16 June) and the increasing detail emerging now about provider Collaborative at Scale and at Place. I thought it helpful to ensure the Board was sighted on the expected key timeline dates of ICS/ICB establishment between now and April 2022:

   NHSE/I set out some specific dates by which ICSs are expected to complete key actions in preparation for the creation of statutory ICBs on 1 April 2022, although all dates are indicative and assume the passage of legislation through Parliament. I have included below highlights of some of the key dates for our Board to be aware of, including the appointment of all ICB designate NEDs and executive board-level posts by 31 December, and a two-part consultation on the ICB constitution (including nomination process for the trust partner member) starting on 14 October.

It is expected that ICB appointments to Chair and CEO will be completed by mid-November with non-executive directors (NEDs) appointed by the end of December along with other ICB executive level posts.

The ICB constitution will be two-part and will start following appointment and discussion with the designate ICB chair. The first part will be focused on the board size and composition and will be completed by 17 November (and agreed with NHSE/I regional team 19 November). The second part will focus on the nomination process for GP, trust and local authority partner roles, and will be completed by 30 November. The final draft constitution submission must be submitted by the 18 March 2022.

18 March 2022 is the deadline for ensuring clarity around quality and safety systems including the implementation of the System Quality Groups in line with the National Quality Boards guidance. This is something we need to consider when reviewing the future role of internal Trust governance.

The middle of March 2022 is also the date when it is expected that all arrangements are in place for the formal launch of the Integrated Care Partnership Board with associated governance focussing on population health and reducing health inequalities.

It is important as an organisation that we take into account these developments as we review our strategy during the winter.

Local Context

3. A Joined Up Care Derbyshire Board meeting was held in public on 16 September 2021. Some of the key points from that meeting for our Board to note include:

    - Very familiar to colleagues on our Board of Directors was the patient story, which was focused on Autism, both diagnosis and post diagnostic support, as well as transition from Children's to Adult services. Not only did this lead to a conversation around current service plans and the new autism support service, it also led to a conversation about our role as Anchor Organisations in Derbyshire and how we could support employees who are neuro-diverse.
    - The system continues to be very busy with a high level of escalation and bed occupancy levels in all services above 95%. From a critical care perspective the system continues to be very busy above optimal capacity, mainly due to providing mutual aid to neighbouring ICSs.
    - We spoke of the timelines to Integrated Care Body establishment in April, as mentioned earlier in my report, agreeing and recognising the capacity pressures that we need to find ways of addressing to ensure both the transition, but as importantly, the opportunity for delivering new ways of working are not lost.
    - The Board had an in-depth conversation about the system's current financial status, including the ways we are addressing the underlying financial deficit within the NHS. It was noted that Derbyshire NHS currently allocates more money to its providers than it receives, resulting in an underlying financial deficit for the system. We spoke of the more strategic approach that we were developing in relation to financial

management as well as a system wide transformational plan with more details to be discussed at the next meeting.
- The Board heard updates on progress being made to understand the impact and ways of operating of both provider Collaborative at Scale (see next item) and Place.
- Something I felt really important was the agreement through the People and Culture Strategic Oversight Group to develop a set of shared leadership principles which would help to align our behaviours and aspirations as leaders in the Derbyshire system.

4. Board colleagues will recall I shared the latest guidance on Provider Collaborative development at the last Board meeting. I also spoke about the work that was underway within the Joined Up Care Derbyshire System. Appendix 1 is a paper that is being shared with all provider Boards in the Derbyshire System.

   The paper sets out the background to provider Collaborative at Scale covering some of the ground we spoke about at the last Board. The clarity on the national priority areas is positive and essential linked to the broader Joined Up Care Derbyshire (JUCD) strategy. The subcommittee tasked with defining a way forward are proposing the model of a single provider leadership board across JUCD.

   In terms of the emerging national requirement around a local mental health, learning disability and autism collaborative/alliance, I believe this proposal continues to support that approach and is something that we have discussed and agreed via the provider collaborative subgroup.

   We are asked as a Board to receive the briefing note in Appendix 1 and to formally agree our support for the direction of travel. At this point we are not being asked to formally agree to be a partner, nor to consider or agree to alter schemes of delegation, and so on.

5. As Board members are aware from the briefing last month, the Derbyshire ICS Building the Right Support Programme (formally transforming care programme), is currently not providing the level of assurance and performance in relation to the ambition set out in the plan and the NHSE monitoring process. In addition, the Derbyshire system has received feedback from Moorhouse Consulting, who have reviewed our Building the Right Support approach and made a number of recommendations around three specific areas:

   - Clinical interventions
   - System ownership
   - Core team capacity

One part of this response is to move the leadership and accountability for Building the Right Support from a commissioning organisation to more closely align to providers who can have direct impact on admissions. To this end, Ade Odunlade as our COO, will now become the lead officer for Building the Right Support, with the leadership of the core team that currently sits within the CCG, now moving to our organisation.

I am sure Board members would like to extend a warm welcome to those colleagues who now join our leadership team.

Within our Trust

6. Board members will be pleased to note (attached at Appendix 2) the draft Trust Green Plan. Our Green Plan is set within the context of, and aligns with, the NHS aim to reduce carbon emissions to 'net zero' outlined in the 2020 NHS report 'Delivering a 'Net Zero' National Health Service' (2020). That report recognises the NHS responsibility for around 4% of the nation's carbon emissions and its significance in the solution through its 1.3 million plus employees. The report's stated targets, to reduce directly controlled emissions to net zero by 2040 (80% by 2028-2032) and influenced emissions to net zero by 2045 (80% by 2036-2039) are targets that currently put the NHS on a trajectory to be the world's first 'net zero' emissions national health service.

   The plan demonstrates our commitment to:

   - Support the NHS-wide ambition to become the world's first healthcare system to reach net zero carbon emissions
   - Prioritise interventions which simultaneously improve patient care and community wellbeing while tackling climate change and broader sustainability issues
   - Support the organisation and Derbyshire system in planning and making prudent capital investments while increasing efficiencies.

   The delivery of this plan will help raise the profile of sustainability by providing robust leadership and direction. This will in turn provide the drive to ensure sustainability is embedded across the organisation. Sustainability will be considered in its wider sense; how it can contribute to reducing costs and providing high quality care, as well as tackling environmental concerns and reducing the Trust's carbon emissions and other greenhouse gases. The delivery of the plan will also provide a foundation for a comprehensive programme of engagement with staff, patients, partners and the wider community.

   The Board is asked to agree the draft plan and confirm monitoring of the associated Green Plan delivery programme through Finance and Performance Committee.

7. In each quarter of 2021/22, we have produced a 'RoadMap' that aligns with the Trust strategy and defines the priority areas for focus in the coming quarter. The quarter 3 RoadMap is attached in Appendix 3. Board colleagues will note a change in emphasis in the plan which, whilst it continues to focus on the need to protect colleagues and those using our services (through good infection prevention and control standards) and focus on the wellbeing of colleagues through our health and wellbeing assessments and support offers, it now starts to focus on how we increase recovery of key quality and performance metrics that have understandably slipped during the pandemic response.

   Board colleagues will also note that we are now supporting groups of less than 10 colleagues to meet inside where this is deemed the most effective way of carrying out the business of the meeting.

8. October is Black History Month, and the Trust's focus on the event started with a video from myself shared with colleagues, where I spoke about the significance of the annual event.

   Our Trust BME Network Chair, Sharon Rumin spoke very powerfully to colleagues about this year's theme 'Proud To Be': "It's been a challenging time for many BME staff and our allies with so much in the media about racism, inequality and injustice. The theme of Black History Month 2021 is to focus on celebrating being Black and working in collaboration with our allies; to inspire and share the pride people have in their heritage and culture – in their own way, in their own words.

   Colleagues including myself, Selina our Chair, Deep Sirrur (consultant Psychiatrist), Subodh Dave (Consultant Psychiatrist) and Chinwe Obinwa (Consultant Psychiatrist) have been involved in leading national and regional events celebrating Black History Month. In our Trust there have been a number of very well attended events including:

   - Guest speaker David Shosanya talks about allyship
   - Wear Red Day
   - Guest speaker Professor Cecile Wright from Black Community Matters Derby talks about Black Lives Matter (BLM)
   - Colleagues have also been invited to take part in a wall art competition in their teams throughout the month (COVID friendly of course!)
   - We have also been promoting teams, including those using our services, to create poems around the theme of Proud to Be.

   My thanks to everybody who has made this vital month of celebration such a success.

9. Many thanks to Anna Shaw, our Deputy Director of Communications, for the following update for Board on the activities of our Communications Team.

   It has been a busy couple of months for our Communications team, who continue to share updates and information through our external communication channels and respond to requests from local, regional and national media.

   Our external communications regarding the development of new mental health facilities in Derby and Chesterfield started in September, and a public questionnaire was available for six weeks, closing on 1 November. We will review the feedback received and continue to communicate and engage with people regarding these exciting developments. This will include focused consultation regarding changes to our older adult services, which will commence in December.

   In October we participated in a week-long health and social care feature on Radio Derby, talking about our COVID related challenges and priorities for the coming months, including Winter preparedness. This was well received, and enabled health and social care leads across Derbyshire to present a joined up, system-wide approach to our planning and conversations.

Also in October, we launched and promoted a new service in the city of Derby in October called Drinkwise Derby, aimed at providing information and advice to Derby residents on managing their alcohol use. The service, which is being run by the Derby Drug and Alcohol Recovery Service on behalf of Derby City Council's Public Health team, was featured on BBC East Midlands Today. The service's website is at www.drinkwisederby.org.uk

October is a time when we raise awareness of several key health and social issues. To coincide with this year's World Mental Health Day, we promoted the new information on Neurodiversity that has been launched on the Derby and Derbyshire emotional health and wellbeing website. We were also proud of the efforts of colleagues who promoted Black History Month and Speak Up Month both nationally and locally.

Going forwards we will be doing more work to showcase the positive news, developments and innovations from within the Trust, linked to our recruitment opportunities to join Team Derbyshire Healthcare. The 'work for us' pages on our website continues to be some of the most visited pages of the site, generating over 18,600 unique page views in the 90 days between 20 July and 17 October.

The Communications team continues to manage the website on behalf of the Trust, and during that same 90-day period there were over 250,000 page views. Our family health services in Derby and our talking therapies service, Talking Mental Health Derbyshire, were the most viewed service pages.

Internally we continue to keep colleagues informed and updated on COVID related guidance and developments and we have launched a 'working remotely Team Derbyshire Healthcare promise', which will form a sub-set of our wider staff promise. We are also starting to talk about other important non-COVID developments, and the team continue to prepare for our staff conference that is scheduled to take place later this month, featuring guest speaker Amar Latif.

Communications and engagement also remain a central aspect of the OnEPR transformation programme, to improve the way we record patient information. Following a successful transition to the SystmOne electronic patient record (EPR) system in our CAMHS, Learning Disabilities and Older Adult Mental Health Services, a great deal of work is being done to ensure that teams in our Working Age Adult Mental Health Services feel prepared for, and involved in, the move to SystmOne when it goes live in January 2022.

10. I know Board colleagues are committed to the benefits of creating an environment where colleagues feel empowered and enabled to tell us how it feels to work in the Trust and raise concerns around quality issues or other areas where they feel there are risks to our core values or expected outcomes. This is something we see regularly at the Board through our Freedom to Speak Up Guardian's report. October is Freedom to Speak up Month with a number of events and reminders about speaking up happening both in our Trust and at a regional and national level.

11. On 23 September we held a fantastic thank you ceremony on the balcony outside of the Ashbourne Centre coffee lounge to personally thank everybody who was involved in whatever role in the incident management team during the

last 20 months. It was fantastic to meet everybody personally, to share stories of their contributions and hear some reminiscing (believe it or not). We were able to present colleagues with a small token of our thanks and appreciation by way of a card and inscribed clock. I'm sure Board members would once again join me in thanking all colleagues involved in our incident management team as the amazing response our Trust undertook in terms of the pandemic wouldn't have happened without their dedication, passion and commitment.

12. I really valued meeting medical colleagues at both the Trust Medical Advisory Committee and The Trust Local Negotiating Committee during September and October. I notice that the use of MS Teams seems to have a positive impact on attendance with great coverage across the Trust at both meetings. There were some important discussions about the new Integrated Care System and the opportunities this gives us, leading to debate about population health and, in particular, outcomes of our local BME communities. We also spoke of the crisis pathway, updated on the Dormitory Eradication Programme and changes to the leadership of some services.

13. As Board colleagues are aware, the significance of the developments associated with the emerging Integrated Care System, simply can't be underplayed and so ensuring that colleagues in our Trust have the opportunity to understand more about how these changes will impact on themselves and their service, as well as the Trust, is really important. To that end, we have started a series of 'in conversation' events with key individuals from the system, such as Stephen Bateman talking to me about provider Collaboratives, Andy Smith talking about Children's Services across the system, Gavin Boyle about urgent care and Tracy Allen about Place, as well as a focussed session with our own Gareth Harry about the Mental Health, Learning Disability and Autism Delivery Board.

14. Over the last two months we have continued to hold several 'Live' Divisional Engagement Events, chaired by either myself, Ade as our COO, or indeed the Divisional General Manager or Executive lead, with the aim of offering colleagues the chance to tell us as a senior leadership team how they are finding working in the Trust at present, along with an opportunity to ask questions, make suggestions and share innovations. I have been pleased to welcome Non-Executive Directors to these sessions as well. Engagement sessions have been held with:

    - Forensic and Rehabilitation Services
    - Specialist Services
    - Adult Acute Services
    - Adult Community Services
    - Corporate Services
    - Older Adult Community Services
    - Admin and Clerical Staff
    - Specific session focussing on the Vaccinations, both Flu and the COVID Booster

    We adopted a different approach to these events, with them being hosted by the general manager, who invited colleagues to share their experiences normally through team managers or service managers. The general manager then invited me to provide a briefing and then we had a general question and

answer session. There was certainly more discussion and dialogue doing it this way without presentations.

This month we simply focussed around the Road Map and changes going into quarter 3 that were roundly supported by all the live engagement events.
In addition, I have been lucky to be able to attend and meet with our CAMHS leadership colleagues and attend the Kedleston Unit since the last Board meeting.

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

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

Assurances

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

Consultation

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

Governance or Legal Issues

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

Public Sector Equality Duty 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 focus on Black History Month I detail in the report is an important vehicle for increasing awareness around race equality issues and to reinforce our Trust anti-racism stance. It is particularly important to note the opportunities for celebration and learning we are putting on, have been developed by our Network. There is a risk that we must be mindful of as a Board, which relates to the need for active engagement, celebration and learning all year round, not just in October.

There is also a link with Freedom to Speak up Month, as we know that BME Colleagues make less use nationally of Freedom to Speak up routes.

The focus on improving public health and prevention as part of the more towards developing integrated care systems is a real opportunity to differentially intervene in those parts of Derbyshire where we know health outcomes are the poorest. It is vital our Board pushes in system engagement to ensure that this concept is further developed.

Our live engagement events continue to provide a helpful vehicle for speaking up.

Recommendations

The Board of Directors is requested to:

1) Scrutinise the report, noting the risks and actions being taken.
2) Agree to the direction of travel identified in Appendix 1
3) Support and sign off the green plan in Appendix 2
4) Seek further assurance around any key issues raised.

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

Paper to the Derby & Derbyshire NHS Provider Boards

Proposal from the Provider Collaboration at Scale Sub-Committee

October 2021

1. National and local background

NHS England and Improvements' paper on "Integrating care Next steps to building strong and effective integrated care systems across England" sets out clear ambition and guidance on the importance of "Provider Collaboratives at Scale", within the context of the formation of the new Integrated Care Systems across England.

This paper set out the background to provider collaboration at scale and the initial steps taken to develop a baseline of current collaboration in the following areas of national priority:

- Acute (UEC and Planned care)
- Mental Health
- 999/111
- Primary Care in/out of hours (at the request of the Joined Up Care Derbyshire ICS Board)

Within the Joined Up Care Derbyshire (JUCD) footprint, the approach taken to explore this request and produce a proposal has been to create a sub-committee and link in with the Place Partnership developments. Using the national guidance of the ICS design framework, the recently released 'Working together at scale' document and completing a local stakeholder mapping process has brought us to a place where an overarching direction of travel and proposal can be made in relation to the JUCD approach to Provider Collaboratives.

2. Sub-Committee membership and achievements

The Provider Collaborative at Scale sub-committee has been meeting since April 2021 monthly with the following core membership:

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Role	Name
Accountable Officer/111 lead	Stephen Bateman
Chair	Helen Phillips
SRO/999 lead	Will Legge
UHDB Rep/Urgent Care lead	Gavin Boyle
CRH Rep/Planned Care lead	Angie Smithson
Primary Care rep	Duncan Gooch
Mental Health Trust rep/MH,LD&A lead	Ifti Majid
DCHFT Rep/Place Partnerships lead	Tracy Allen
Finance lead	Claire Wright
CCG lead	Zara Jones
Public Health lead	Robyn Dewis
Programme resource	Claire Hinchley
Programme administration	Julie Stone

Additional members' e.g. Local authorities, CQC, deputies and guest speakers have attended meetings, with the following guest speakers providing significant support to development of thinking:

- Des Breen – Medical Director and Clinical Advisor to NHSEI System Transformation Workstream
- Louise Robson - Chief Executive Lead for Provider Collaboratives – NW, NE & Yorkshire

The sub-committee set out to deliver the following within Q1 to inform the Q2 plan:

Deliverables	Achievements
Finalise sub-group membership and workplan	**Complete.** Sub-committee meets monthly
Gather and document initial views on key areas of focus for collaboration and their current state, looking at next steps and support required to progress	**Complete.** Initial stakeholder engagement completed in April with delivery board leads and other relevant workstreams.
Seek to engage with Primary Care on In and Out of Hours provision, considering scale collaboration	**Complete.** Primary & Community Care collaboration board commenced in July 2021

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Discuss approach to ensuring links and co-development with 'at place' workstream	**Complete.** Membership and representation on both committees and sharing of ideas in place
Undertake mapping exercise of key focus areas against national key principles	**Complete.** Mapping exercise created a 'long list' of ideas for collaboration
Use mapping exercise to inform Q2 plan	See proposal
Assess impact of national published guidance, informing Q2 plan	See proposal
Quarter 2: Seek to develop collaborations and local population needs, in line with findings	See proposal

A task and finish group to support the sub-committee was in place temporarily however the release of draft national guidance provided a different approach and direction of thought within the sub-committee, therefore it was stood down whilst the national guidance was received and absorbed.

The sub-committee reports directly into the JUCD Board on a bi-monthly basis, providing updates on progress and receiving assurance from the board as to the direction of travel.

3. National guidance

Following from the release of the ICS Design Framework in June, NHSE&I released Working Together at Scale: guidance on provider collaboratives mid-August.

The guidance sets out three suggested models of delivery for provider collaboratives at scale that should be considered by local ICS to assess their suitability.

The three models are:

- Provider Leadership Board
- Lead Provider
- Shared Leadership

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The guidance includes direction on membership, accountability, form and governance.

It sets out the purpose of a provider collaborative and these key points and actions:

- Provider collaboratives will be a key component of system working, being one way in which providers work together to plan, deliver and transform services.
- By working effectively at scale, provider collaboratives provide opportunities to tackle unwarranted variation, making improvements and delivering the best care for patients and communities.
- Significant scope to deliver these benefits already exists within current legislation and, subject to its passage through Parliament, we expect the Health and Care Bill will provide new options for trusts to make joint decisions
- All trusts providing acute and mental health services are expected to be part of one or more provider collaboratives by April 2022.
- Community trusts, ambulance trusts and non-NHS providers should be part of provider collaboratives where this would benefit patients and makes sense for the providers and systems involved.
- ICS leaders, trusts and system partners, with support from NHS England and NHS Improvement regions, are expected to work to identify shared goals, appropriate membership and governance, and ensure activities are well aligned with ICS priorities.

4. <u>Proposal for a Joined Up Care Derbyshire Provider Collaborative</u>

At the July sub-committee meeting, a development session was held with partners to understand the three recommended models (taken from a draft version of the guidance) and how they could be localised across Derby and Derbyshire.

Following due consideration, debate and discussion, the model of a **<u>single</u>** Provider Leadership Board across JUCD was agreed to be a sensible approach for all providers to work together to deliver at scale benefits for areas of work that require collaboration across two or more partners, and where specific at scale areas of work that don't currently have a focus could be housed and delivered.

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The Provider Leadership Board model has the benefits of providing single authoritative place where members are empowered (through delegated authority and their local sovereign organisations schemes of delegation) to make binding decisions across the work areas of the Board. This fundamental difference to the prior ways of working is envisaged to fast-track strategic decision-making and ensure the pace of change is not hampered by over-burdening governance processes.

The diagram in Appendix A gives a brief overview of how this model would be envisaged to operate, albeit with only two organisations on the diagram. For clarity, it is proposed that in JUCD the initial member organisations of the Provider Leadership Board (and thus the Provider Collaborative) would be;

- Chesterfield Royal Hospital NHS Foundation Trust
- Derbyshire Community Health Services NHS Foundation Trust
- Derbyshire Healthcare NHS Foundation Trust
- DHU Health Care CIC
- East Midlands Ambulance Service NHS Trust
- University Hospitals of Derby and Burton NHS Foundation Trust

It is envisaged that this model will work for the overall provider collaborative, and that there are then opportunities for alliances and other sub-collaborative arrangements to be put in place where it is sensible to do so. Appendix B gives a graphical view of how this could operate. A good example of this is the Mental Health, Learning Disability and Autism collaborative working, which may move to a formal alliance arrangement sitting under the overarching JUCD Provider Collaborative.

This is a development process the delivery board is working through during the end of Summer and beginning of Autumn to finalise.

The development session generated lots of discussion from partners, of which a summary includes:

- The proposals have some advantages and are the right direction of travel in terms of simplification and decision making.
- Careful thought should be given to the Place/Provider Collaborative interface, linked to the transformation, decision making delegation (not just between

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ICS and Provider Collaborative but Provider Collaborative and other programmes). An initial view of this is shown in Appendix C.

- How the financial and commissioning framework evolves needs to be significantly influenced and co-designed with Place and Provider Collaboratives and that will be a challenge that all system partners will need to work together to achieve.
- We must not lose the gains already made and get in the way of those with any of the proposals that suggested.
- General practice must not feel that they are being side-lined and must be part of the system and are actively part of the development processes of the Provider Collaboration workstream.

For the proposed collaborative to progress, the next steps include setting out the form and governance of the collaborative and deciding upon the resource required to deliver this next phase.

The phases and timescales of delivery are to be agreed within the sub-committee but may include:

Phase	Task	Resource required	Timescales
1 – Design	• Statement and agreement of form and governance • Board development sessions • Agreement of membership	Senior level governance skill set	September 2021 to December 2021
2 – Set up	• Meetings in place • Roles and responsibilities agreed • Delegation of authority in place • Priorities set • Work programmes agreed • Resource aligned • Reporting arrangements in place • Comms and engagement delivered	Director level with strong knowledge and delivery of leading large scale change, programme management and governance	November 2021 to March 2022

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3 - Delivery	• Partnership delivery board meets • Work programmes commenced	• Director level as above • PMO • Work programme leads	April 2022 onwards

With regards to creating form and governance, the national guidance states (p23) 'Providers should determine and agree the form and governance of their collaborative, with help from ICS leaders and NHS England and NHS Improvement regions.

There is no one model that all collaboratives must adopt; it will be up to members to decide which arrangements will work best for them. The 'right' form and governance arrangements should flow from the shared purpose and objectives of the provider collaborative.

Providers will need to identify the functions and core capabilities necessary to deliver the expected benefits of scale and use governance arrangements that are proportionate.'

Within the guidance, a set of guiding principles are offered to determine the form and governance of the arrangement:

- Must be underpinned by a shared vision and commitment to collaborate to deliver benefits of scale and mutual aid, doing what is best for people and populations across places
- Should build on and enable existing successful governance arrangements; for some areas, arrangements may need to be strengthened rather than creating new arrangements from scratch
- Should enable providers to efficiently reach decisions, which each organisation is committed to upholding, on topics that are within the collaborative's remit
- Should provide strong mechanisms for provider members to hold each other to account to ensure that decisions are reached and carried out and benefits of scale are realised at pace

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- Should ensure the needs and voices of local communities are a key consideration in all decisions and clinical leadership is embedded in programme delivery
- Should make it clear how decisions are made, how disagreements are resolved, how funding flows to services within the collaborative's remit, and how the collaborative is resourced
- Should help streamline ways of working within and across systems; for instance, representatives of provider collaboratives are empowered to engage in conversations about services and transformations that are to be delivered at scale, rather than each individual provider needing to be consulted.

Local actions for review regarding the collaborative are included in the summary of the sub-committee meeting outlined above.

Further guidance regarding membership of the collaborative – including the role and value added for membership of local authorities, social care and the voluntary sector can be found within the national guidance document and this is part of the work of the future work of the sub-committee.

5. Next steps for the sub-committee to consider

The provider collaborative at scale sub-committee is tasked with debating and agreeing the following points:

- Debate the proposed phases, actions and timescales and amend/agree these
- Consider whether suitably skilled resource to achieve the next phase of progression is available within the current workforce and make nominations
- Consider the overall resource required to take the programme forwards and provide a recommended way to procced

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6. NHS Provider Organisation Considerations

Each provider is asked to receive this briefing note and support the overarching direction of travel articulated, in that there should be the formation of a single JUCD Provider Collaborative, with appropriate alliances, work plans and programmes that it leads and manages.

It should be noted that this agreement to the direction of travel is not a request at this stage to formally commit to becoming a member of the Provider Collaborative, or to alter delegated authorities or schemes of delegation. It should be seen as support of a direction, so further work can be progressed to provide a full proposal for each organisation to consider on formal membership, decision making, risk management and how the Provider Collaborative will operate.

Specifically, the ask of delegated authority and decision making is anticipated to need significant discussion and internal assurance in order to make it workable in a collaborative environment and this is fully understood. There are a set of questions which are helpful to outline now for consideration, but not for answering at this stage of the developments. These will, however, need addressing in due course.

Provider questions to consider;

- Identify the role of the organisational Chair in the collaborative space
- Identify development needs across the provider senior team
- Identify areas for streamlining – where can the system do something once and do it well, rather than doing it many times in many different places (PMO, governance, role of delivery boards)
- Identify how priorities and decision making in the collaborative space reach the provider board and staff groups in a timely manner
- Create a written record of how decisions are made within the provider board and within the provider leadership collaborative board
- Review current governance – does it work well now, will it work in the immediate transition period and beyond?
- Identify available resource to support the new governance and delivery arrangements

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7. **Recommendations**

The Board is recommended to;

1. Agree to the proposed Joined Up Care Derbyshire (JUCD) approach of having a single Provider Collaborative, working under a Provider Leadership Board model as an appropriate direction of travel for the JUCD system

2. Agree to continue to engage and support development of the proposed Provider Collaborative model

Appendix A – Provider Leadership Board Model

Joined Up Care
Derbyshire

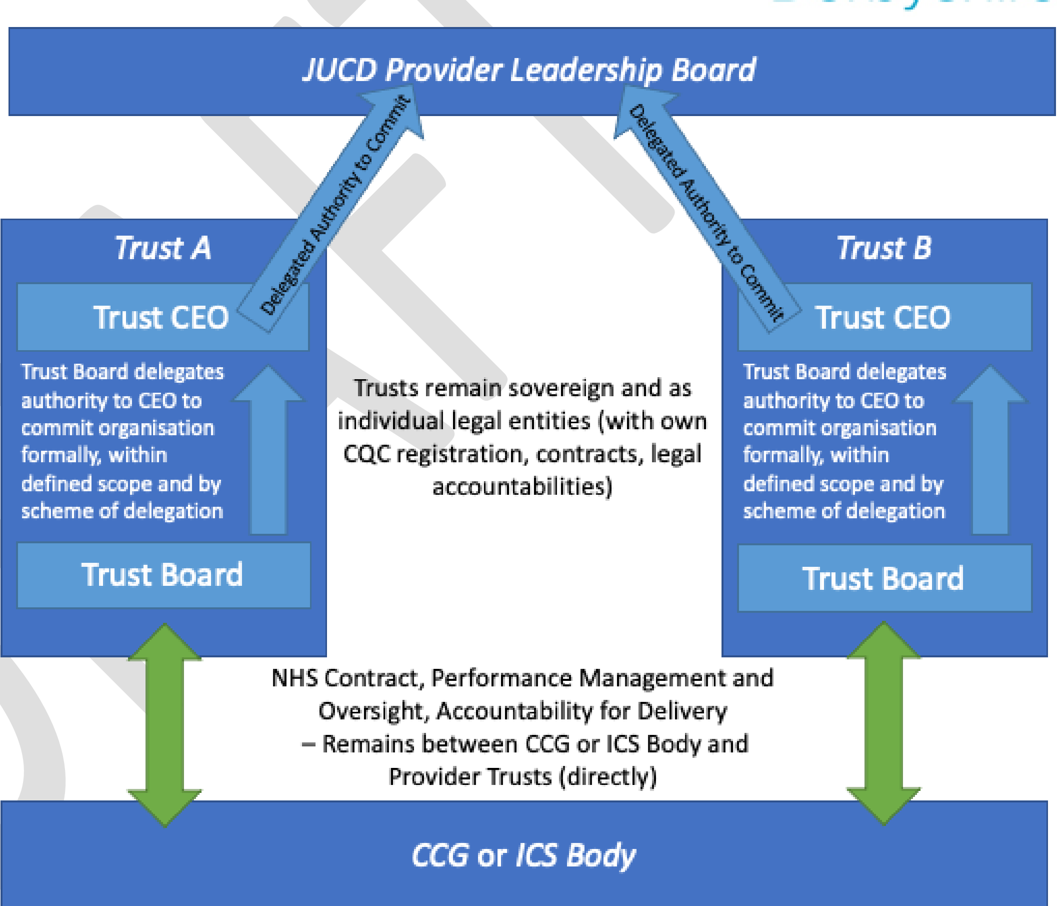
'Provider Leadership Board' Model

JUCD Provider Leadership Board has Collaborative member CEOs + others as required. Requires MoU / Alliance Agreement to define objectives and scope

JUCD Provider Leadership Board

- Has vision developed by members
- Rotating or independent chair
- Usually supported by PMO to aid delivery of core objectives
- Usually establishes subgroups, sponsored by exec SRO
- Advised by clinical advisory groups/steering groups on best practice / gaps in models
- Has a pre-defined (by it's members) decision-making approach

This model is not restricted to one sector per collaborative, however does operate at Trust level



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Appendix B – Provider Collaborative Workstream Model

Joined Up Care Derbyshire

Individual Provider Collaboratives may wish to establish a programme approach to lead workstreams around their common areas of activity/improvements

This would not replace the ICS accountability through the existing delivery boards established for the system

‘Provider Leadership Board’ Model

XYZ Provider Leadership Board

Decision-making & Authority

Provider Collaborative Programme

(could be supported by system PMO, for example)

- *Acute (Planned, UEC, Critical)*
- *Mental Health, LD and Autism*
- *Ambulance and 111*
- *In and Out of Hours Primary Care*

ICS Accountability

ICS Delivery Boards

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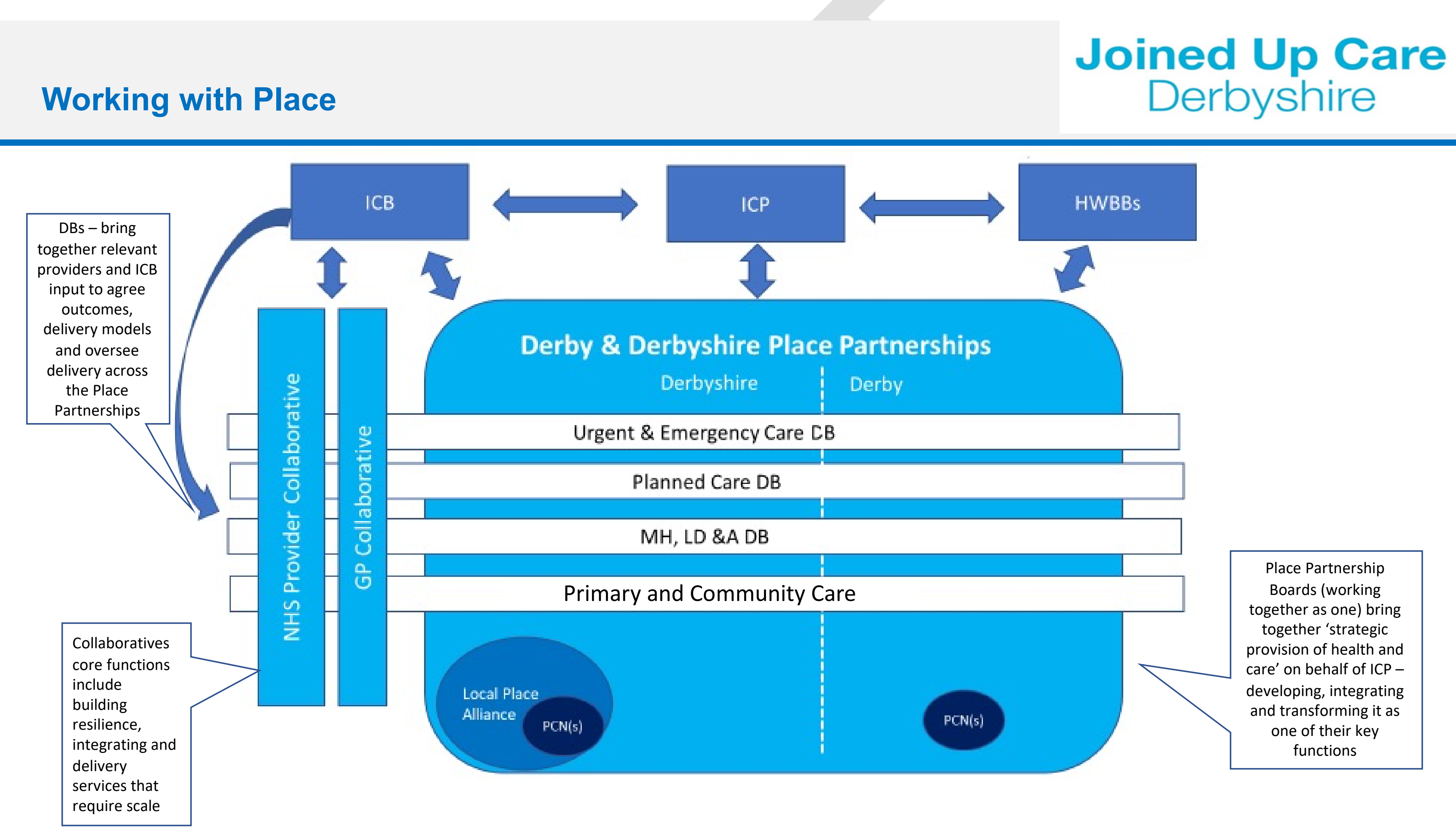
Appendix C – Place / Provider Collaborative Working



Derbyshire Healthcare NHS FT

Green Plan

for the cycle 2022 to 2025

A healthier environment through sustainable development

Version 1.0

21 September 2021

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1.0 Introduction

Derbyshire Healthcare NHS FT provides mental health, learning disabilities and substance misuse (drug and alcohol) services, as well as a wide range of children's services across Derby city and Derbyshire County. It employs more than 2,400 staff operating from a number of community bases across the whole of the county, serving a combined population of over one million people.

We are committed to demonstrating leadership in sustainability and have produced this Green Plan in order to:

- support the NHS-wide ambition to become the world's first healthcare system to reach net zero carbon emissions
- prioritise interventions which simultaneously improve patient care and community wellbeing while tackling climate change and broader sustainability issues
- support the organisation and Derbyshire system in planning and making prudent capital investments while increasing efficiencies

The delivery of this plan will help raise the profile of sustainability by providing robust leadership and direction. This will in turn, provide the drive to ensure sustainability is embedded across the organisation. Sustainability will be considered in its wider sense; how it can contribute to reducing costs and providing high quality care, as well as tackling environmental concerns and reducing the trust's carbon emissions and other greenhouse gases. The delivery of the plan will also provide a foundation for a comprehensive programme of engagement with staff, patients, partners and the wider community.

Our Green Plan is set within the context of, and aligns with, the NHS aim to reduce carbon emissions to 'net zero' outlined in the 2020 NHS report 'Delivering a 'Net Zero' National Health Service' (2020). That report recognises the NHS responsibility for around 4% of the nation's carbon emissions and its significance in the solution through its 1.3 million plus employees. The report's stated targets to reduce directly controlled emissions to net zero by 2040 (80% by 2028-2032) and influenced emissions to net zero by 2045 (80% by 2036-2039) are targets that currently put the NHS on a trajectory to be the world's first 'net zero' emissions national health service.

This green plan is for all of us and needs to be actively supported by each and every member of staff.

2.0 Organisational Vision

We aim to be an environmentally friendly trust. Our vision is for the creation of a healthier environment through the sustainable development of trust services. In achieving this, DHCFT will:

- embed opportunities in its day to day activities and across its workforce to reduce both the carbon emissions we control and the carbon emissions we influence
- build environmental sustainability into its planning and design processes for new and transformed services and estate
- embed sustainable models of care and support the local community to be well-connected, healthy, resilient, independent and managing their lives in a positive way
- establish local and system level partnerships and collaboration, including patient groups, to help local communities improve the resilience of services and estate in response to environmental and climatic changes

In this cycle of the plan (2022 to 2025), in recognition of existing and planned work, particular consideration is given to:

- new buildings and transformation of existing estate in line with capital investment for inpatient services
- ongoing development of the community mental health framework and its shaping of community service provision across all age groups

- transformation of services and estate relating to lessons learned from the Covid-19 pandemic and advance of digital solutions and greater flexible working

3.0 Areas of Focus

3.1 Workforce and system leadership

Making sure that staff are engaged with the sustainability agenda is essential for the delivery of sustainable healthcare. Every single member of staff has a role to play in delivering this strategy. Engaging staff to adopt sustainable practices will enable them to take ownership within their own areas of influence. Sustainability principles do not just apply at work; they apply at home, across our supply chain and beyond.

What we want to achieve	How we will measure it	How we will achieve it
Support staff to improve sustainability at work and home and empower them to make sustainable choices in their everyday lives.	Staff participation in sustainability programmes, training and the generation and progression of ideas through continuous improvement.	Provide awareness training and regular updates on the Green Plan and sustainability agenda. Develop and maintain a sustainability programme. Support the development and progression of sustainability initiatives through transformation and continuous improvement. Develop lower carbon options for staff. Build sustainability into job descriptions, plans and recruitment through WF&OD lead.

3.2 Sustainable models of care

We need to improve the environmental sustainability of care pathways, and better integrate healthcare services to improve efficiency. Delivering the best quality of care within the available environmental, social and economic resources is a growing challenge. Ensuring we have a healthcare system that is fit for the future is increasingly important as we are starting to face the effects of climate change. This will directly impact the way we care for patients and how diseases are spread.

What we want to achieve	How we will measure it	How we will achieve it
To deliver the best quality of care while being mindful of its social, environmental and financial impact and take a whole systems approach to the way it is delivered.	Staff surveys. Patient feedback. Level of patient groups and stakeholder involvement in service design. Quality visits. Trusted assessments.	Provision of care closer to home, also through digital means and promotion of video consultations where appropriate. Consideration and implementation of the digital agenda and utilisation of electronic as opposed to paper-based systems. Addressing health inequalities.

	Referral, admission and discharge data. Mileage claims and monitoring. Monitoring of contact type e.g. F2F, Virtual, Telephone. Staff absence and feedback.	Apply sustainability principles to new build and refurbished Estate to improve wellbeing and create a healing environment and support improved quality of care. Development of staff and patient groups and the enablement of patient and clinician led, lean service redesign. Greater joined up working with system partners. Collaborate with stakeholders to create a healthy environment for patients, including temperature, light and food choices. Take a proactive approach to identify the leading causes of staff sickness and implement a package of measures to address this.

3.3 Digital transformation

There is a clear connection between digital transformation and a net zero NHS. The digital agenda seeks to harness digital technology to streamline service delivery and improve the use of resources, reducing carbon emissions.

What we want to achieve	How we will measure it	How we will achieve it
Digital solutions and alternatives within clinical and operational practice that reduce carbon emissions.	Proportion of video consultations and meetings against agreed aims. Increased app-based referrer contact e.g. Consultant Connect Increased patient contact in non-face-to-face categorisation. Number of digital transcriptions. Reduced expenditure on paper, printing and postage, plus reduced storage capacity requirement.	Collaboration with teams in redesign of operational processes. Utilising new software and platforms e.g. Office 365, MS Teams OneDrive. Remote working and ability to access data from anywhere using OneDrive / Share point. Digital video consultation and meetings. Speech recognition software. Patient apps. Reduction of paper records, printing and postage.

3.4 Travel and transport

The transport of goods, services, staff, patients and visitors has a significant impact on local air quality, congestion and health. Delivering a robust Travel Plan and supporting staff, patients and visitors to use more active and sustainable travel methods will reduce the impact of these activities, leading to cost savings and health benefits.

What we want to achieve	How we will measure it	How we will achieve it
To encourage sustainable and active travel wherever possible and reduce the carbon and air quality impacts of our organisation and internal supply chain.	Reduced mileage claims. Electric vehicle infrastructure. Cycle to work infrastructure. Fewer face to face meetings. Increased uptake of bike and e-bike schemes. More joint working with system partners on walking, cycling and public transport initiatives.	Ensure all new trust vehicles are ultra-low emission and zero emission. Support electric vehicle uptake. Ensure staff have access to methods and training for video consultation to reduce business miles between sites and from attending external meetings. Appoint a cycling lead for the trust and support cycling and other non-car alternatives with facilities and system partnerships, and the appointment of a cycle-to-work lead.

3.5 Estates and facilities

Refurbishing and developing the Estate allows us to embed sustainability and efficiency using smart design and emerging technologies across our improvement works. This requires taking a whole life costing approach to projects by considering sustainability in design, construction, commissioning, operation and decommissioning, helping to future-proof our organisation.

Capital projects

We will focus on reducing the carbon emissions arising from the organisation's buildings and infrastructure, including

- improving energy efficiency and reducing energy usage
- decarbonising heating and hot water systems
- waste reduction and the circular economy
- building design and refurbishments

What we want to achieve	How we will measure it	How we will achieve it
To reduce the environmental impact of building works during design, refurbishment, construction, operation and decommissioning stages.	Energy and water consumption, including design and in-use performance. Scoring / standards / evaluation. New plans need to conform before go-ahead.	Ensure a sustainability philosophy is taken for all Capital Projects including major refurbishments, driving resource efficiency through the Estates Strategy. Inform staff how the heating, cooling, lighting and ventilation of

		their buildings operate, and how they can report any performance issues.

Asset management and utilities

Our activities are intensive and constant, with utilities representing a substantial cost and environmental impact to the organisation. It's essential that we accurately measure and reduce consumption to make sure we're getting the best value for money and minimising environmental impact. Embedding more efficient practices, new technologies and improving staff awareness will help to improve utility efficiency across everyday activities and as part of longer-term plans.

What we want to achieve	How we will measure it	How we will achieve it
To embed energy and water efficient technologies and practices throughout our Estate and services and deliver year-on-year reductions in consumption.	ERIC returns.	Monitor utility consumption across our Estate and deliver a programme of targeted energy and water efficiency schemes to manage and drive down use. Specify renewable energy when we enter new purchasing arrangements for electricity.

Green space and biodiversity

Nurturing and improving green space provide benefits for mental and physical wellbeing. It also leads to improved air quality, noise reduction, supports biodiversity and helps combat climate change. By collaborating with partners and local communities we will implement a clear strategy that helps us contribute to local biodiversity and make the best use of available green space.

What we want to achieve	How we will measure it	How we will achieve it
To maximise the quality and benefits from our green spaces and reduce biodiversity loss by protecting and enhancing natural assets.	The value of natural capital.	Incorporate biodiversity and green space into our sustainability governance structure and work closely with our contractors to maximise the benefits. Raise awareness of the benefits of natural capital for physical and mental health and wellbeing by providing opportunities for staff to get involved in Trust-wide initiatives such as beekeeping and gardening schemes.

3.6 Medicines

The green agenda for pharmacy is being coordinated at a regional level (NHS Midlands for our trust) and it is an on ongoing agenda item for regional and Derbyshire Chief Pharmacists' meetings. This means progress against targets related to medicines can be met by aligning to these plans.

The targets within our regional plans primarily consider the reduced use of anaesthetic gases and metered dose inhalers. Neither of these are matters we would take the lead on, but we will support patients. We don't use anaesthetic gases in the Trust (in ECT we use injected anaesthetics); and we supply inhalers to patients based in their current prescriptions, which have been gradually changing from metered dose inhalers over the last decade and we expect will reduce further in future.

Reduction in single use plastic in packaging is a key aim and Pharmacy will support and contribute to the plans outlined in other parts of the trust green plan specifically related to plastics and procurement.

Reducing unnecessary waste is an ongoing consideration of our continuous improvement approach and we routinely monitor our dispensing to use ratios.

What we want to achieve	How we will measure it	How we will achieve it
Reduced use of anaesthetic gases and metered dose inhalers.	Local and regional monitoring.	We will support regional plans.
Reduced waste linked to non-used dispensed medicines.	Dispensing to non-use ratios.	Ongoing adaptation of prescribing processes.

3.7 Supply chain and procurement

The NHS supply chain accounts for approximately 62% of total carbon emissions and is a clear priority area for focus in every Green Plan.

What we want to achieve	How we will measure it	How we will achieve it
Source green energy.	Request REGO certificate on an annual basis.	The Trust already has a Power agreement that requires the supplier to provide a REGO certificate on an annual basis. This is part of a three Trust collaboration.
Procure recycled copier paper.	The Trust only purchases copier paper through Supply Chain and on an annual basis will review the types of paper procured.	The Trust has already advised staff that only recycled copier paper should be purchased through SOLO.
Identify product categories that could contribute in reducing the Trust's carbon emissions.	Compare the current carbon emissions for the product categories identified and then compare this to lower carbon mission alternatives.	Complete an analysis of the major spend by product category. Measure the total carbon emissions for major spend items and evaluate lower carbon emission alternatives.

3.8 Food and nutrition

We need to reduce the carbon emissions from the food made, processed or served within the organisation. This includes reducing overall food waste and ensuring the provision of healthier, locally sourced and seasonal menus high in fruits and vegetables, and low in heavily processed foods.

We generate large volumes of waste and have legal responsibilities to make sure that it is properly segregated, handled and disposed of. Procurement constitutes the largest proportion of our carbon footprint and we must reduce unnecessary use of resources across our organisational activities. By applying the waste hierarchy, rethinking traditional waste models and working closely with our staff and supply chain, we can move towards a circular economy approach and away from a throwaway culture.

What we want to achieve	How we will measure it	How we will achieve it
Minimisation of waste and disposal.	Waste streams and volumes.	Replace single use products with reusable alternatives where there is a viable and lower carbon option and be transparent when this is not feasible. Deliver initiatives to reduce food waste and ensure that it is treated in the most sustainable way. Segregate more waste streams at source to improve recycling rates. Use our purchasing power wisely, by working with suppliers to procure products that minimise packaging use and offer innovative solutions to waste reduction, including take back schemes. Provide healthy, informed and sustainable catering choices that meet and exceed national guidelines.

3.9 Adaptation

Climate change is one of the biggest public health threats and challenges that we face. Extreme weather conditions, such as flooding, and heat waves are increasing in severity and frequency and are now a visible reality. We must act now to adapt to a changing climate and mitigate the negative effects of past and future climate-altering actions. We need to embed climate change awareness and action into our entire infrastructure, our services, partners and colleagues to be prepared for climate change impact.

What we want to achieve	How we will measure it	How we will achieve it
Ensure our organisation is prepared to deal with the effects of climate change, particularly extreme weather events, and continue to invest in adaptation and mitigation measures.	Building evaluation. Green space evaluation and number of green space initiatives. Risk register.	Incorporate adaptation into our sustainability governance structure, corporate risk register and reporting processes. Maximise the quality and resilience of our greenspace to help mitigate the effects of climate change

4.0 Engagement, Communication and Delivery

Full and effective engagement and communication with trust staff, patients, system partners and members of our community will be key to the success of our vision to deliver a healthier environment through sustainable development.

The Green Plan will be delivered through a programme approach, segmented into the focus areas with leads for each based on particular capabilities, experience and interests. Each programme stream will adopt improvement methodology to evaluate its outcomes and refine plans and activities to deliver its objectives. Programme streams will be made up of staff and wider non-staff membership where appropriate, including patients, system partners and other stakeholders.

Communication and engagement of plans and activities will be coordinated by the trust communications team, utilising the trust internet and intranet spaces as well as surveys and questionnaires, market stall type events and social media.

Training will be sourced and provided in relation to the sustainability and green plan agenda and provided as required, as well as being recognised content within the staff induction process and organisational development programme.

Further details and activity in relation to engagement, communication and delivery can be found in the associated Green Plan Delivery Programme.

5.0 Minimum Foundations for the Green Plan (to be in Place by April 2022)

This plan has a three-year span from 2022 to 2025 but there are minimum expectations and requirements forming part of the foundations of the plan which need to be in place before publication of the Green Plan and before April 2022. These are:

As per the 2021/22 NHS Standard Contract:

1. The trust has a board member who is responsible for net zero targets and the Green Plan. Similarly, every ICS is asked to designate a board-level lead to oversee the development of their own Green Plan.
2. The trust purchases 100% renewable energy from April 2021, with supply contracts changing as soon as possible.
3. The trust reduces its use of desflurane in surgery to less than 10% of its total volatile anaesthetic gas use, by volume.
4. Every ICS develops plans for clinically appropriate prescribing of lower carbon inhalers.

As per *Delivering a net zero National Health Service*

5. The trust ensures that, for new purchases and lease arrangements, systems and trusts solely purchase lease cars that are ultra-low emissions vehicles (ULEVs) or zero emissions vehicles (ZEVs).
6. The trust Develops a green travel plan to support active travel and public transport for staff, patients and visitors.

As per the 2021/22 NHS planning guidance

7. Where outpatient attendances are clinically necessary, at least 25% of outpatient activity is delivered remotely, resulting in direct and tangible carbon reductions.

Work is ongoing ahead of April 2022 on these aspects and progress is monitored in the quarterly Greener NHS Data Collection (see appendix 1).

6.0 Governance

The trust Green Plan is led by a designated board-level net zero lead which is Chief Operating Officer, Ade Odunlade. It is supported with professional leadership from Andy Donoghue, Associate Director of Estates and Facilities, and programme support from Joe Wileman, Head of Programme Delivery.

The plan has senior, expert input from a broad range of disciplines and functions, including clinicians, estates and facilities, procurement, finance and human resources; and these individuals are informed by representative, well-supported sustainability colleagues, groups and networks from across the organisation and system. This group also makes up the core component of the programme delivery group which will meet regularly to drive the work and deliver the plan.

The plan is to be approved by the trust board and submitted to ICSs by 14 January 2022, to be consolidated into system-wide strategies. These, in turn, will be submitted to the relevant NHS England and NHS Improvement regional team for final peer review, ahead of publication.

Each region has received significant additional funding from the Greener NHS National Programme to recruit and run regional greener NHS teams to help co-ordinate and catalyse net zero progress within ICSs and trusts.

Progress against the approved Green Plan will be formally reported annually to the trust board and/or ICS governing body. Progress will also be reported formally to the relevant regional greener NHS team, in a format and frequency agreed with them.

While the approved Green Plan covers a three-year period, the trust will formally review and update the plans annually to consider:

- the progress made and the ability to increase or accelerate agreed actions
- new initiatives generated by staff or partner organisations
- advancements in technology and other enablers
- the likely increase in ambition and breadth of national carbon reduction initiatives and targets

At a national level, progress towards the NHS's net zero carbon emission targets is reported twice a year to the NHS public boards. The regional teams will hold ICSs to account on delivery of the latter's Green Plans, and ICSs will be tasked with holding organisations within their system to account in a similar fashion.

Authors:

Joe Wileman – Head of Programme Delivery
Andy Donoghue – Associate Director of Estates and Facilities

September 2021

APPENDIX 1 – Greener NHS Data Collection at June 2021

Question	Response
Does your organisation have an up-to-date board approved green plan in place which is aligned to the ambitions set out in *delivering a Net zero NHS ?*	In progress
Does your organisation have a board-level representative with Net zero work within their portfolio	Yes
Does your organisation purchase 100% of its electricity from renewable sources?	No
Has your organisation implemented the following actions to identify and address nitrous oxide waste? • A multi-disciplinary team is set up to adress the issue • A nitrous oxide waste review has been undertaken • Sources of nitrous oxide have been investigated • Solutions have been implemented to address waste • There is a 1/4ly review by the medical gas committee to minimise waste	 No No No No No
Does your organisation purchase or lease solely cars that are Ultra-Low Emission vehicles (ULEV) or zero emission vehicles (ZEV)?	No
Does your organisation purchase or lease solely, vans that are under 3.5 tonnes that are ULEV?	Yes - some
Does your organisation's salary sacrifice scheme for vehicles allow for the purchase of only ULEVs or ZEVs?	No
Does your organisation have a cycle-to-work lead?	No
Does your organisation have a salary sacrifice cycle-to-work scheme for staff?	Yes
What facilities does your organisation offer for people who arrive by a mode of active transport: Cycle parking/lockers/showers	Cycle parking
Does your organisation have access to a food waste technology installed in at least one of its sites to process food waste?	No
Does at least one of your sites have a digital meal ordering system installed? Yes (all) / Yes (some) / No (planning) / No	No
Does your organisation change menu regularly to use more seasonal ingredients? Yes (4 times/yr) / Yes (2 times/yr) Yes (1 time/yr) / no	Yes - once
Does your organisation have a plant-based menu that is readily available for patients and staff? Yes(patients) / Yes (staff) / Yes(both) / No	Yes – patients and staff
Does your organisation purchase only recycled paper? Yes(all) / yes(offices) / Yes(non-offices) / No (but planning)/No	Yes - all
Does your organisation have a walking aid refurbishment and reuse scheme?	Yes
How many overheating incidents triggered a risk assessment since the last snapshot date?	None
How many overheating assessments have triggered a risk assessment since the start of the financial year?	None
Does your organisation have a nominated lead who is accountable for adaption planning and management?	No
Does your organisation have a long-term climate change adaptation plan separate from your business continuity plan?	No

DHCFT's Roadmap out of lockdown

Stage 3:
November 2021 onwards

Stage 2:
July to October 2021

Stage 1:
April to June 2021

Images from Flaticon and Freepix

DHCFT's Roadmap out of lockdown - stage 3 (November 2021 onwards)

Keeping us and those who use our services safe

Getting the basics right and recovering our Trust standards

Connecting us

Annual Quality priorities throughout:
Focus on sexual safety; Reducing violence and restrictive practice; Learning from COVID-19

DHCFT's Roadmap out of lockdown - stage 3 (November 2021 onwards)

Keeping us and those who use our services safe:

- Continue to wear face coverings when in our buildings
- Maintain social distance, wash hands regularly, ensure ventilation in rooms
- Continue to undertake regular lateral flow tests
- Receive COVID Booster injections 6 months from dose 2
- Meetings of more than 10 people should normally be online – only in in exceptional circumstances will this be agreed
- Receive flu vaccination
- Recommence training opportunities and all colleagues to review our mandatory training compliance to ensure this is recovered, this is important to patient safety
- Continue to have regular health and wellbeing conversations at individual and team level and make adaptations where necessary
- Keep health risk assessments up to date as circumstances change and review working arrangements
- Increase face to face patient activity in a safe way.

DHCFT's Roadmap out of lockdown - stage 3 (November 2021 onwards)

Connecting us:

- Consider the most effective format for meetings – if face 2 face meeting, reduce to less than 10 people / or break into sub team groupings
- Teams to develop their local working patterns based on service need and conversations with individual colleagues as part of health and wellbeing meetings. This will clarify individual working patterns
- Team connectivity and morale is key to high functioning team – please consider ways of continuing to connect as a whole team
- Tell us what you think - complete our staff survey which is now out – your feedback really matters and has been instrumental in the improvements we have made over the last couple of years
- We will develop a plan of Board face-to-face engagement visits so you get to know all members of the Board and can share feedback and ideas for improvement.

DHCFT's Roadmap out of lockdown - stage 3 (November 2021 onwards)

Getting the basics right and recovering our Trust standards:

Working in a healthy culture and psychologically safe way – colleagues are tired and when this happens we can get fractious. We need to maintain a good working life balance. Lets support each other to:

- Take some annual leave
- Teams meetings mandated to 25 mins, 50 mins or 105mins to ensure breaks between meetings
- Not respond to emails or calls on non working days
- Catch up on restorative/supportive supervision

DHCFT's Roadmap out of lockdown - stage 3 (November 2021 onwards)

As the pandemic response is stabilising we do now need to start to concentrate on recovering our Trust standards where they have slipped:

- We will review our approach to recruitment to ensure Teams can recruit in a timely and effective way as we need to focus on filling vacant posts
- We need to work with all colleagues to understand what is driving increasing sickness levels and how we can do more to support colleagues health and wellbeing
- We now need to recover our clinical and operational performance as we are falling behind in some areas including increasing focus on what we are observing about a reduced patient experience over the past 18months and what we each can contribute to improving that
- We need to increase our focus on delivering the requirements of the long term plan both workforce expansion and meeting new service requirements
- We now need to increase our planning for financial sustainability, this is likely to include the use of a Trust efficiency programme.

DHCFT's Roadmap out of lockdown - stage 3 (November 2021 onwards)

As the pandemic response is stabilising we do now need to start to concentrate on recovering our Trust standards where they have slipped:

- We also want to enhance the development of our Continuous Quality Improvement Strategy which is linked but not the same as a Trust efficiency programme.
- We now need to finalise and complete any residual outstanding regulatory improvement actions and revisit and ensure our compliance in core regulatory performance this means we need to start in earnest our preparation for the next full compliance visit by the CQC
- We will develop innovations for reducing and safely managing waiting lists such as the CAMHS approach commenced end September

DHCFT's Roadmap out of lockdown - stage 3 (November 2021 onwards)

Ongoing actions from Quarter 1 and Quarter 2:

- Continue to cascade the cultural intelligence programme that has already started
- Continuing to ensure that lessons learnt from the pandemic response are built into service and governance developments
- Continue the work about development of our response to the Community Mental health Framework
- Continue the work about development of our response to the investment in our CAMHS service eg Crisis response
- Further develop our Dormitory Eradication Programme towards full business case submissions early in 2022/23
- Planning for Phase 3 and 4 of the OnEPR project

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 2 November 2021

Performance Report

Purpose of Report

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

Executive Summary

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

Three-day follow-up of all discharged inpatients
Patients are followed up in the days following discharge from mental health inpatient wards to provide support and ensure their wellbeing during the period when they are at their most vulnerable. To date we have consistently exceeded the national standard for follow-up which came into effect from 1 April 2020.

Data quality maturity index
Increasing waiting lists resulting from the pandemic continue to have a negative impact on data quality, however we would expect to consistently exceed the national target and we have seen a slight improvement in each of the last three months.

Early intervention 14-day referral to treatment
We have seen common cause variation throughout the 24-month period, and we would expect to consistently exceed the national standard for referral to treatment.

Early intervention 14-day referral to treatment – incomplete
The service continues to perform consistently well against the national 14-day referral to treatment standard of 60% or more people on the waiting list to be have been waiting no more than two weeks to be seen.

IAPT 18-week referral to treatment
The national target has been exceeded throughout the 24-month reporting period and for the last 8 months performance has been significantly better than expected.

IAPT 6-week referral to treatment
With staff back in post we expect to consistently exceed the national standard.

IAPT patients completing treatment who move to recovery
For the past 14 months the national standard has been achieved. This is an annual target and year to date we are exceeding target.

Average number of patients placed out of area per day – adult acute
There has been a statistically significant reduction in inappropriate out of area acute placements.

Patients placed out of area per month – adult acute
PICU usage has remained within common cause variation for the last 16 months.

Waiting list for care coordination
The average wait to be seen and number waiting have both remained significantly low in recent months.

Waiting list for adult autistic spectrum disorder (ASD) assessment
To meet demand, there would need to be between 54 and 67 assessments completed per month (65th to 85th percentile). Currently the service is funded to complete 26 assessments per month and is averaging 20 due to sickness and vacancies. Referrals are continuing to be received at the same rate. It is highly unlikely to see any significant change until there is a change to investment in the service.

Waiting list for psychology
We can see the impact of the pandemic on waits, with the waiting list being significantly higher than expected for months. Many patients are still waiting owing to the pandemic and a desire to be seen face to face. The average waiting time has risen slightly in the last two months. Referrals remain steady. For the last two months the number of people waiting has reduced significantly. Recruitment to a number of vacant and part time posts across adult services is in progress.

Waiting list for Child and Adolescent Mental Health Services (CAMHS)
The number of referrals received has been steadily increasing, with a corresponding increase in activity. On 27 September a waiting list initiative commenced which will progress until the end of October.

Waiting list for community paediatrics
The average wait to be seen continues to be significantly shorter than expected, however the number of children on the waiting list is now significantly high owing to the large increase in referrals for neurodevelopmental assessment which has been seen since January 2021.

Outpatient appointments cancelled by the Trust
The most common reason recorded for cancellation was “appointment brought forward”. This is when a patient needs to be seen more urgently and so is offered an earlier appointment. The second most common reason was cancellation owing to consultant sickness.

Outpatient appointment “did not attends”
The level of defaulted appointments has remained within common cause variation for the last 16 months and in the current process the trust target of 15% or lower is likely to be consistently achieved.

Other Operational Matters of Note

Health Protection Unit (HPU)
This next quarter for the HPU has seen its focus on the delivery of flu vaccination and COVID-19 vaccination, predominately boosters for staff and inpatients as well as primary and secondary doses for patients.

HPU are exploring doing some outreach work in providing vaccines to the severe mental illness (SMI) cohort and those that typically find accessing vaccines very difficult. A bid has gone in to access funding to support this.

Vaccination status
93% of people working for the Trust have received their first vaccination and 90% have now received both vaccinations. Booster vaccinations have commenced.

Finance

Revenue
Previously under the financial regime set by NHSEI, there was only a requirement to submit a half year (H1) plan. However, the Trust also produced an internal plan for H2 generating a full year plan. Planning guidance has recently been published setting out a requirement for a H2 plan (covering month 7-12) for 2021/22. The details of this are covered in a separate paper.

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

Month 6	**2021/22**					
	In month			**YTD**		
	Plan	**Actual**	**Variance**	**Plan**	**Actual**	**Variance**
Income	(14,690,250)	(15,731,997)	(1,041,746)	(87,836,398)	(87,471,845)	364,553
Pay	10,693,062	11,085,821	392,759	63,867,521	62,858,633	(1,008,888)
Non-Pay	3,985,389	4,734,960	749,571	23,968,361	24,712,796	744,435
Total	**(11,799)**	**88,784**	**100,584**	**(516)**	**99,584**	**100,100**
	H1 Forecast			**Month 1-12 FOT**		
	Plan	**Actual**	**Variance**	**Plan**	**Actual**	**Variance**
Income	(87,836,398)	(87,471,845)	364,553	(173,045,873)	(179,345,209)	(6,299,337)
Pay	63,867,521	62,858,633	(1,008,888)	126,875,811	130,675,706	3,799,895
Non-Pay	23,968,361	24,712,796	744,435	46,086,942	48,638,863	2,551,921
Total	**(516)**	**99,584**	**100,100**	**(83,120)**	**(30,640)**	**52,480**

Overall, the forecast for the end of the financial year remains on plan at breakeven. The income forecast for H2 has been based on the best intelligence at the time of forecasting and may change as income allocations are agreed for the second half of the financial year (H2) plan.

There are some large variances across income, pay and non-pay budgets which are driven by the following key assumptions summarised below.

AfC pay award back pay has been paid in September and income has been accrued based on the recent guidance. Budget has been allocated to Divisional budgets from reserves based on 3% of the £ budgets.

H2 allocations have been confirmed at a system level but at the time of finalising the month 6 forecast this had not been split at an organisational level. Therefore, assumptions have been made to the top-up income and Covid income. It has been assumed that the income will continue but at a lower level, for example a 5% reduction in Covid income.

No income reduction has been included in the forecast for the share of the £14m distance to target efficiency requirement, which would have required forecast cost reductions (cost out) to achieve the required break-even position.

The H2 plan is being presented to Trust Board (see separate paper) which will be at a point inf time, however due to timing of the meeting and the possibility of further changes to the plan up until the submission date of 16 November, any further changes will be presented to the Executive Leadership Team (ELT).

Covid costs were previously forecast to revert back to their original cost centres from the Covid cost centre at month 7. However due to the continuation of a Covid funding allocation costs are now forecast to remain against the Covid budget.

There is on-going monthly system reconciliations between Provider income and CCG expenditure and there has been a difference between our income assumptions and CCG expenditure related to the new investments because of slippage caused by recruitment delays. This is transparently discussed at System Delivery Board in order that plans can be agreed for the appropriate utilisation and reinvestment of slippage

Efficiencies

The full year plan includes an efficiency require of £2.3m mainly phased in the second half of the financial year. The forecast at month 6 assumes that this will be over delivered by £0.2m. The H2 planning guidance builds in an efficiency requirement to the allocations of 0.82%, totalling a requirement of 1.1% (0.28% in H1). However, depending on the overall system plan there may be a requirement for a higher level of efficiency.

Agency

At the end of month 6 agency expenditure is above the ceiling by £941k which equates to 62%. The two highest areas of agency spend relates to medical and ancillary staff (mainly domestics). The forecast assumes that agency costs will reduce slightly from month 10 but is still generating forecast spend of £4.7m which is above the ceiling by £1.7m (55%). The forecast does include a contingency of £100k for any unforeseen agency usage.

Out of Area Placements

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

Covid costs

The Trust has an allocation of £700k a month for months 1-6 for Covid-related expenditure. The year to date expenditure is currently within that allocation. The main costs are driven by pay at £2.6m with a further amount of £1.4m on non-pay

expenditure. It has been confirmed that a Covid allocation will continue into the second half of the financial year (H2).

Capital

With regards to self-funded capital, the Trust is slightly above plan at the end of month 6 and it is now forecast to be above plan by £0.6m by the end of the financial year. The above-plan forecast expenditure is related to the self-funded elements of the dormitory eradication programme and PICU, acute-plus plans and is therefore part of system discussions on capital prioritisation for use of system CDEL

The Trust has received additional PDC capital funding for the initial stages of the dormitory eradication programme, this is the year two element of the original MOU. Further funding has been agreed for the dormitory eradication programme with allocations totalling £80m over the next 3 years.

Cash

Cash is at £38.5m at the end of September which is in line with the cash balances for June and July. Cash is forecast to reduce down to £36.6m by the end of the financial year in line with capital expenditure and the payment of PDC dividends.

Cash is now subject to enhanced focus and oversight meetings due to the PICU and dorms capital requirements. It remains essential that we maintain adequate working capital and cashflows to pay our workforce and suppliers as well as deliver the various capital programmes. Appropriate assurance and scrutiny on these matters takes place at Finance and Performance Committee.

People

Annual appraisals

The appraisal process was reviewed at the end of October to agree reinstatement of full appraisals across all services. In the interim they continue to be paused replaced by a structured wellbeing conversation.

Annual turnover

The rate of turnover was higher than the Trust target range of 8-12% for 3 months but returned to within target range last month. Work is ongoing to develop a retire and return process which will encourage more retirees to return to substantive posts and support vacancy fill.

Compulsory training

A recovery plan continues to improve training compliance. Operational Services are currently above target at 86% compliant with compulsory training, with Corporate Services slightly lower at 77%.

Staff absence

Corporate Services are below the target threshold at 4.6%, with Operational Services currently sitting at 7.7%. General Managers and Area Service Managers have been tasked with compiling sickness action plans to address on a Divisional basis, reporting through the Trust Oversight Operational Leadership meeting (TOOL).

Supervision
The levels of compliance with the clinical and management supervision targets have remained low since the start of the pandemic and were significantly below target in September.

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

Bank staff
Following a period of 7 months of unusually high bank staff use, in the past 5 months the position has returned to common cause variation.

Quality

Compliments
The number of compliments decreased in line with the emergence of COVID-19 and the significant changes to many of our clinical services. Work is underway to improve feedback from service users via an electronic survey received by text or email.

Complaints
The number of complaints increased with a particular theme around both concerns and complaints of access to services. The recent results from the Mental Health Community Survey have presented similar themes, with service users and carers feeling they have struggled with the reduction in face to face contact with services during the COVID-19 Pandemic.

Delayed transfers of care
The increased number of care homes and care settings in outbreak and demonstrating staffing issues has resulted in high numbers of delays in transfers from inpatient settings, increasing the number of delayed transfers of care at times.

Care plan reviews
The proportion of patients whose care plans have been reviewed continues to be lower than usual. Teams have been prioritising essential tasks, with reduced routine contact, and trying to engage with people who use our services in different ways, e.g. in virtual ways using Attend Anywhere.

Patients in employment
The Individual Placement Support (IPS) Service continues to have success in supporting people into employment even during the current pandemic.

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

Medication incidents
When looking into medication incidents, they take a variety of forms: from missed doses, wrong medication administration, missed fridge temperature recording, prescription error and non-location of medication. The medicines management

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

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

Duty of Candour
There have been no instances of Duty of Candour in the last 3 months.

Prone restraint
There are ongoing work streams to support the continuing need to reduce restrictive practice; including the introduction of body worn cameras and monitoring of restrictive practice within the "reducing restrictive practice forum". Data analysis and review has shown that even where restraint and seclusion has increased, the use of prone restraint has continued to reduce.

Physical restraint
The number of reported incidents involving restraint have remained within common cause variation throughout the reporting period.

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

Falls on inpatient wards
April to July 2021 has remained below the mean line and demonstrates the effectiveness of ongoing falls reduction work being developed and implemented within Older adult services. However, August and September demonstrate an increased in falls. A further review is required to understand this pattern.

Care Hours Per Patient Day (CHPPD)

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

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

Assurances

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

Consultation

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

Governance or Legal Issues

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

Public Sector Equality Duty and Equality Impact Risk Analysis

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

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

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

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

Recommendations

The Board of Directors is requested to:

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

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

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

Rachel Leyland
Deputy Director of Finance

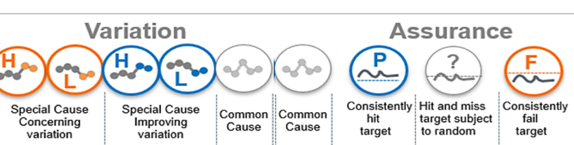
Amanda Wildgust
Assistant Director People Operations

Kyri Gregoriou
Assistant Director of Clinical Professional Practice

Assurance Summary

	Metric Name	Variation	Assurance	Latest Value	Target	Lower process limit	Upper Process limit	Mean
1	3 day follow-up			85%	80%	77%	100%	88%
2	Data quality maturity index			97%	95%	97%	98%	98%
3	Early intervention 14 day referral to treatment - complete			86%	60%	68%	109%	88%
4	Early intervention 14 day referral to treatment - incomplete			67%	60%	58%	111%	85%
5	IAPT 18 week referral to treatment			100%	95%	100%	100%	100%
6	IAPT 6 week referral to treatment			82%	75%	80%	97%	89%
7	IAPT patients completing treatment who move to recovery			51%	50%	46%	63%	54%
8a	Average patients out of area per day - adult acute			0		-1	17	8
8b	Patients placed out of area - adult acute			1		4	27	16
9a	Average patients out of area per day - PICU			15		9	21	15
9b	Patients placed out of area - PICU			25		16	33	25
10a	Waiting list - care coordination - average wait to be seen			10		13	32	23
10b	Waiting list - care coordination - number waiting at month end			31		21	61	41
11a	Waiting list - ASD assessment - average wait to be seen			69		50	59	54
11b	Waiting list - ASD assessment - number waiting at month end			1,312		1007	1121	1064
11c	ASD assessments			23	26.0	3	36	19
12a	Waiting list - psychology - average wait to be seen			30		23	28	26
12b	Waiting list - psychology - number waiting at month end			557		570	691	631
13a	Waiting list - CAMHS - average wait to be seen			21		16	24	20
13b	Waiting list - CAMHS - number waiting at month end			376		396	514	455
14a	Waiting list - community paediatrics - average wait to be seen			14		13	18	15
14b	Waiting list - community paediatrics - number waiting at month end			396		544	899	722
15	Outpatient appointments cancelled by the Trust			7%	5%	4%	19%	11%
16	Outpatient appointment "did not attends"			12%	15%	9%	15%	12%
17	Annual appraisals			75%	85%	72%	81%	77%
18	Annual turnover			12%	8-12%	10%	11%	11%
19	Compulsory training			86%	85%	83%	88%	86%
20	Staff absence			6%	5%	5%	8%	6%
21	Clinical supervison			72%	95%	74%	80%	77%
22	Management supervision			76%	95%	76%	81%	79%
23	Filled posts			86%	100%	88%	93%	90%
24	Bank staff use			6%	5%	5%	7%	6%
25	Compliments received			70	119	63	154	109
26	Formal complaints received			18	13	3	24	13
27	Delayed transfers of care			1%	3.5%	-0.6%	1.7%	0.5%
28	CPA reviews			90%	95%	90%	95%	92%
29	Patients in employment			10%		10%	11%	11%
30	Patients in settled accommodation			51%		57%	61%	59%

Key to symbols[1]:



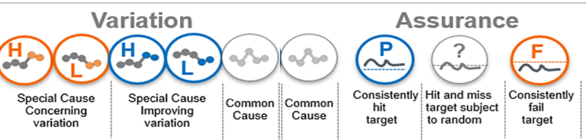
Blue dots indicate special cause variation, better than expected.

Orange dots indicate special cause variation, worse than expected.

[1]The rating symbols were designed by NHS Improvement

	Metric Name	Variance	Assurance	Latest Value	Target	Lower process limit	Upper process limit	Mean
31	Number of medication incidents			57		24	80	52
32	No. of incidents of moderate to catastrophic actual harm			56	48	14	82	48
33	No. of incidents requiring Duty of Candour			0	1	-2	3	1
34	No. of incidents involving prone restraint			3	12	-1	21	10
35	No. of incidents involving physical restraint			29	46	2	86	44
36	No. of new episodes of patients held in seclusion			9	14	1	29	15
37	No. of falls on inpatient wards			33	30	7	47	27

Key to symbols[1]:



Blue dots indicate special cause variation, better than expected.

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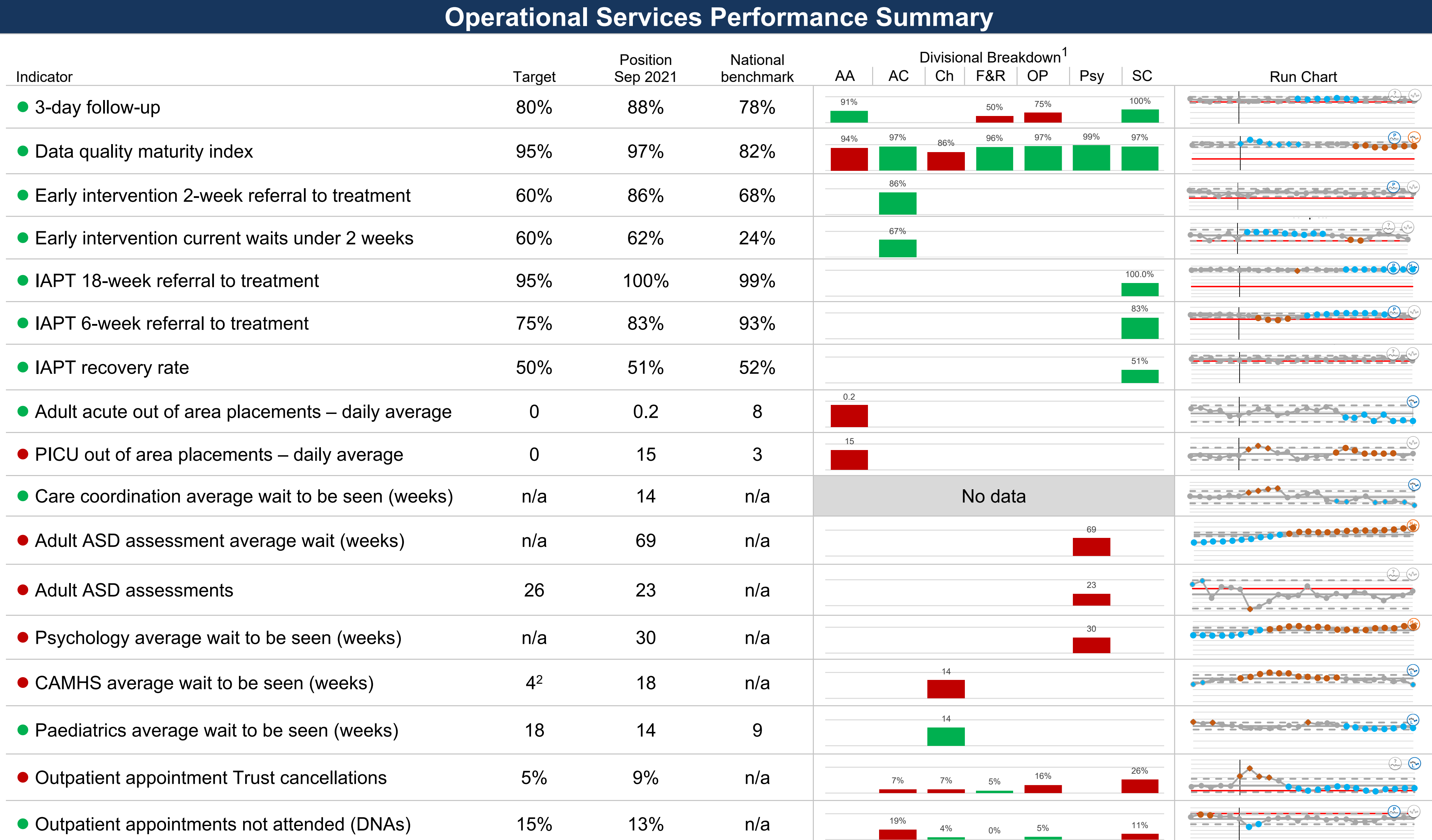


Operational Services Performance Summary

Indicator	Target	Position Sep 2021	National benchmark	Divisional Breakdown[1] AA	AC	Ch	F&R	OP	Psy	SC	Run Chart
3-day follow-up	80%	88%	78%	91%			50%	75%		100%	
Data quality maturity index	95%	97%	82%	94%	97%	86%	96%	97%	99%	97%	
Early intervention 2-week referral to treatment	60%	86%	68%		86%						
Early intervention current waits under 2 weeks	60%	62%	24%		67%						
IAPT 18-week referral to treatment	95%	100%	99%							100.0%	
IAPT 6-week referral to treatment	75%	83%	93%							83%	
IAPT recovery rate	50%	51%	52%							51%	
Adult acute out of area placements – daily average	0	0.2	8	0.2							
PICU out of area placements – daily average	0	15	3	15							
Care coordination average wait to be seen (weeks)	n/a	14	n/a	No data							
Adult ASD assessment average wait (weeks)	n/a	69	n/a						69		
Adult ASD assessments	26	23	n/a						23		
Psychology average wait to be seen (weeks)	n/a	30	n/a						30		
CAMHS average wait to be seen (weeks)	4[2]	18	n/a			14					
Paediatrics average wait to be seen (weeks)	18	14	9			14					
Outpatient appointment Trust cancellations	5%	9%	n/a		7%	7%	5%	16%		26%	
Outpatient appointments not attended (DNAs)	15%	13%	n/a		19%	4%	0%	5%		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)

Performance Summary

3-day follow up

The national standard for follow-up has been consistently achieved by all Divisions and is much higher than the national average. This process is tightly monitored by the Trust's Performance Analyst, who routinely chases up the relevant teams prior to any potential breaches. The move to SystmOne has caused some issues in older adults in terms of the teams not knowing how to record the follow-ups. This should improve over time as people get used to the new system. The SystmOne team have been asked to improve the training and guidance they provide in order to prevent a similar issue occurring when the other wards transfer over.

Data quality maturity index

Overall we perform consistently highly against this standard. The two Divisions who are being reported as below target are Adult Acute and Children's Services (CAMHS). A number of inaccuracies with the CAMHS reported position have been identified linked to SystmOne and the Information Management Team have been asked to investigate and resolve this issue, which will both improve the position and enable action to be taken to address the actual missing data once the true picture is known.

Adult acute inappropriate out of area placements

There continues to be a high level of demand for acute inpatient beds which has resulted in wards often operating at 100% capacity over a sustained period. A maximum occupancy of 85% would enable flow of patients through the system, eliminating the need for inappropriate out of area placements and protecting both patients and staff from untoward incidents arising from busyness https://www.priory.com/psychiatry/psychiatric_beds.htm.

PICU inappropriate out of area placements

Although these are classed as inappropriate according to the national definition, we are one of the few Trusts in the country without a PICU and so have no choice. The bid for a PICU new build in Derbyshire is progressing. The national standard for PICU length of stay is a maximum of 8 weeks (NMS-2014-final.pdf (napicu.org.uk) page 5). The National mean is 48 days (Mental Health Benchmarking Network (2020), *Inpatient and Community Mental Health Benchmarking*). The mean length of stay of Derbyshire patients discharged in the last 2 years from a PICU was 39 days so is better than nationally.

Adult ASD assessment

To meet demand, there would need to be between 54 and 67 assessments completed per month (65th to 85th percentile). Currently the service is funded to complete 26 assessments per month and is averaging 20. The current adult ASD waiting list is 1312. The longest wait is about 3 years, with the assessment hiatus in March-July having had a further negative impact on overall waiting times. Referrals are continuing to be received at the same rate.

Psychology waits

For the last 2 months the number of people waiting has reduced significantly. Recruitment to a number of vacant and part time posts across adult services is in progress. We have reviewed the waiting lists in line with trauma sensitive working in considering how we manage people on a waiting list and barriers of movement between services.

CAMHS waits

The number of referrals received has been steadily increasing, with a corresponding increase in activity. On 27/09/2021 a waiting list initiative commenced which will progress until the end of October. Staff within the ASIST team have paused all routine work to focus purely on assessments, with support from the rest of the CAMHS service. The goal is to undertake around 320 assessments during this period which should reduce the longest wait on the waiting list to around 6 weeks.

Outpatient cancellations

The proportion of cancelled appointments was significantly higher than expected from March 2020 owing to the pandemic but for the last 12 months has been significantly lower than expected, however in the current process the 5% target is unlikely to be achieved. The most common reason recorded for cancellation was “appointment brought forward”. This is when a patient needs to be seen more urgently and so is offered an earlier appointment. The 2nd most common reason was cancellation owing to consultant sickness.

Outpatient did not attends

The level of defaulted appointments has remained within common cause variation for the last 16 months and in the current process the trust target of 15% or lower is likely to be consistently achieved.

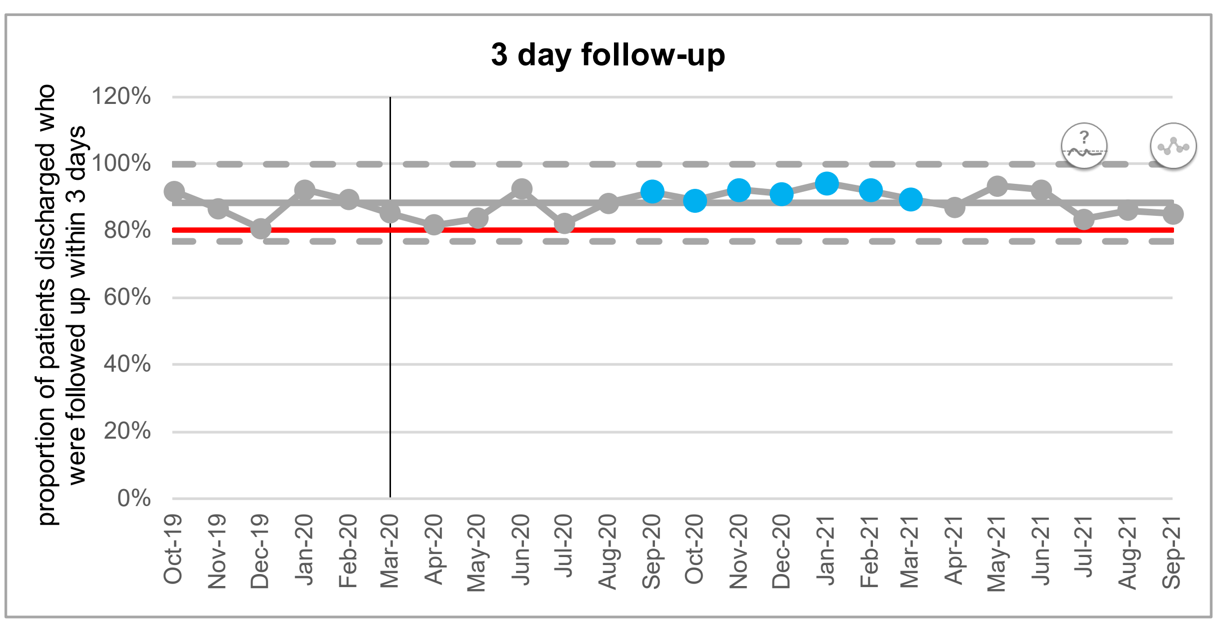
Benchmarking Sources

Measure	Data source	Date
3-day follow-up	Mental Health Statistics	July 21
Data quality maturity index	Data quality - NHS Digital	June 21
Early intervention 2-week referral to treatment	MHSDS Monthly Statistics	July 21
Early intervention current waits under 2 weeks	MHSDS Monthly Statistics	July 21
IAPT 18-week referral to treatment	Psychological Therapies: reports	June 21
IAPT 6-week referral to treatment	Psychological Therapies: reports	June 21
IAPT recovery rate	Psychological Therapies: reports	June 21
Adult acute out of area placements – daily average	Out of Area Placements	June 21
PICU out of area placements – daily average	Out of Area Placements	June 21
Paediatrics average wait to be seen (weeks)	Referral to Treatment Waiting	July 21

Detailed Narrative

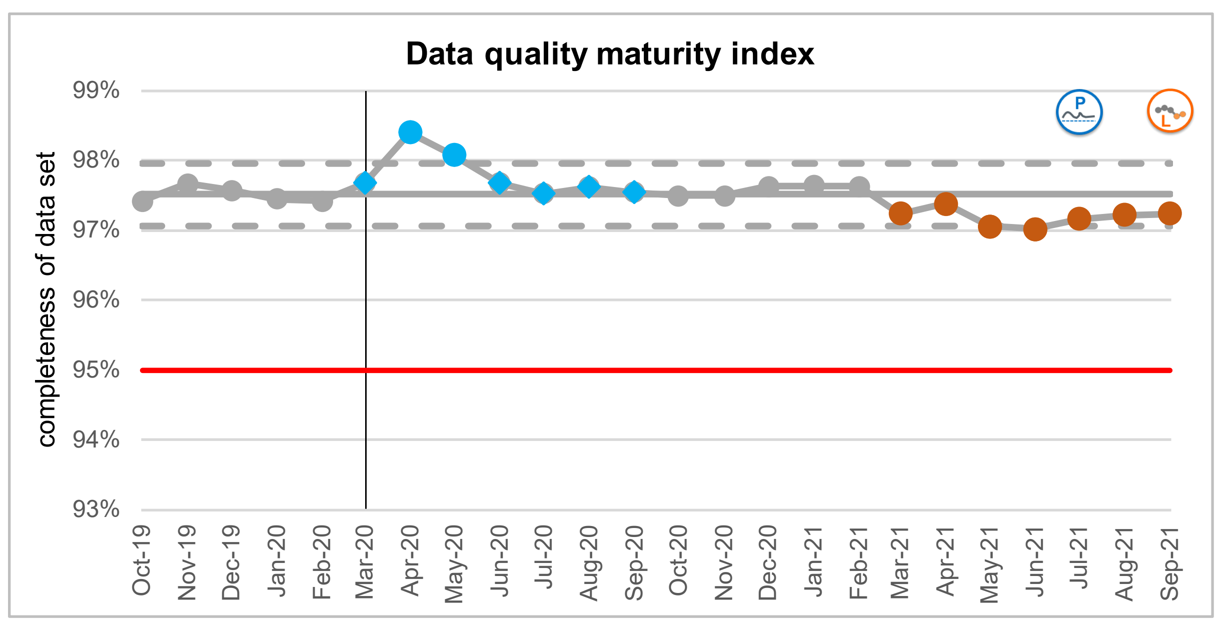
Operations

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



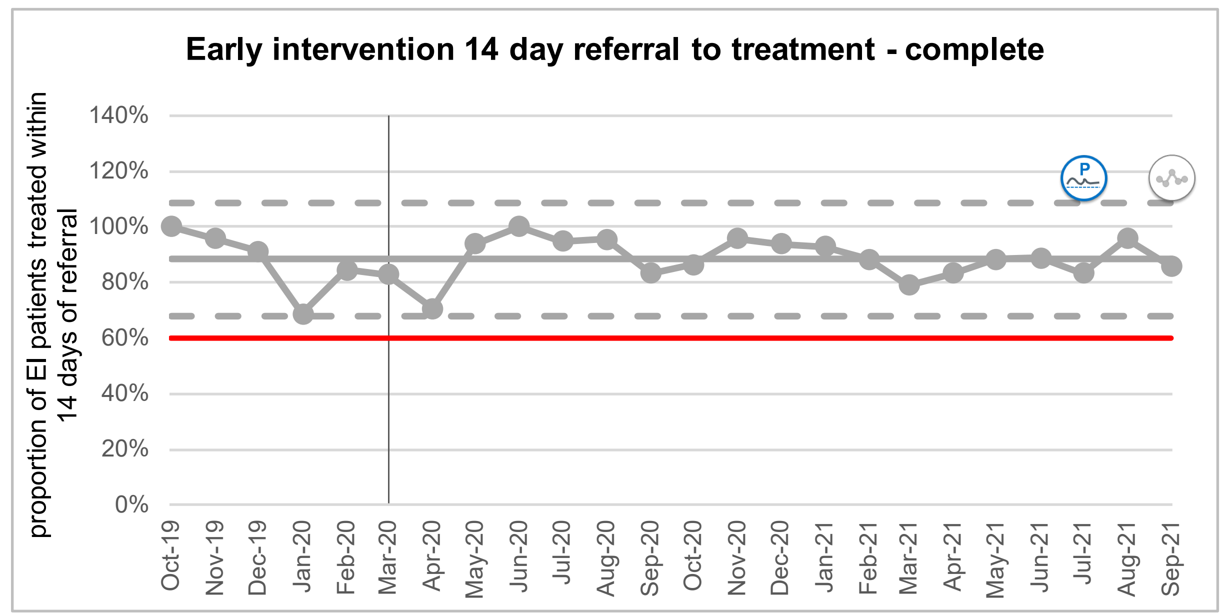
Patients are followed up in the days following discharge from mental health inpatient wards to provide support and ensure their wellbeing during the period when they are at their most vulnerable. To date we have consistently exceeded the national standard for follow-up which came into effect from 1 April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

2. Data quality maturity index



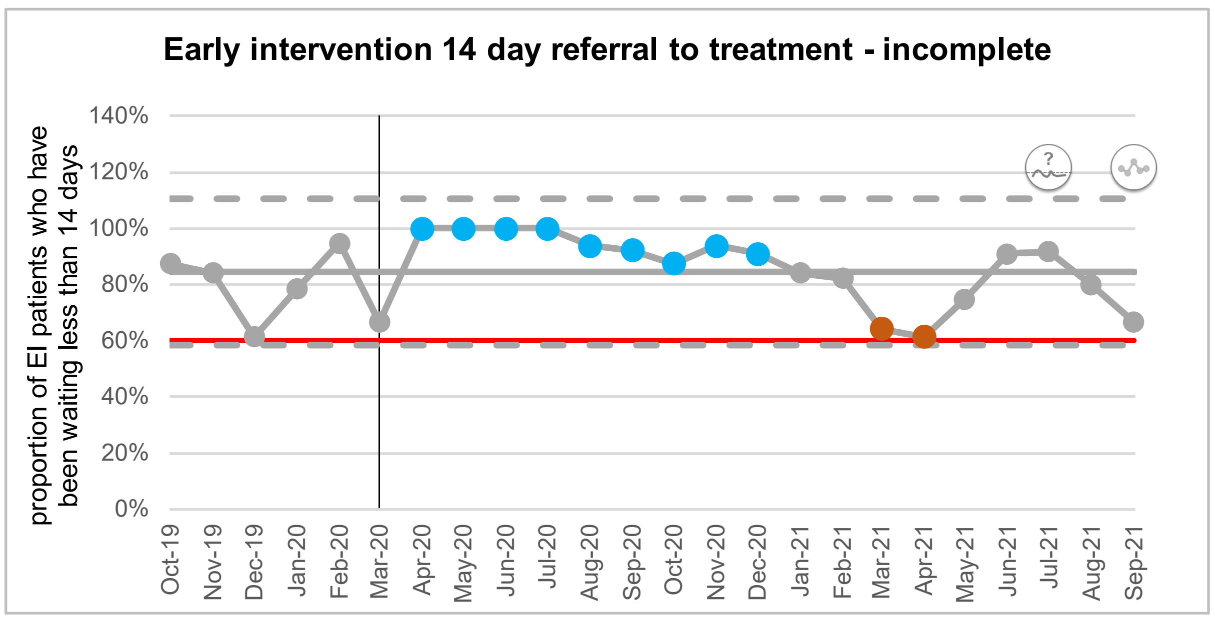
Increasing waiting lists resulting from the pandemic continue to have a negative impact on data quality, however we would expect to consistently exceed the national target and we have seen a slight improvement in each of the last 3 months.

3. Early intervention 14-day referral to treatment



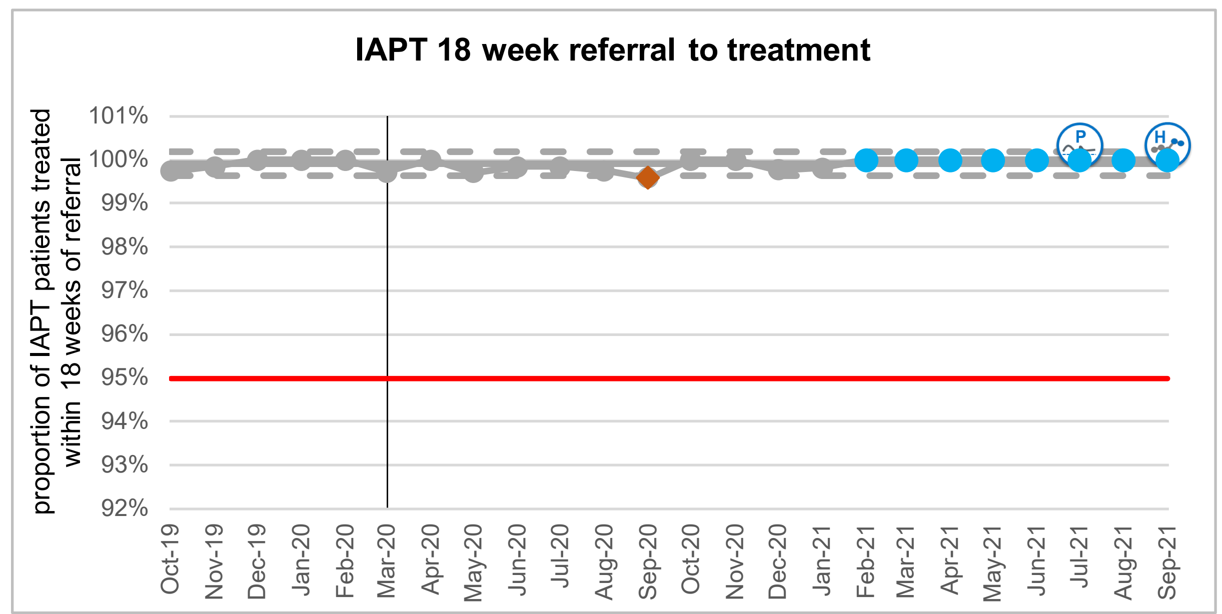
We have seen common cause variation throughout the 24-month period, and we would expect to consistently exceed the national standard for referral to treatment.

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



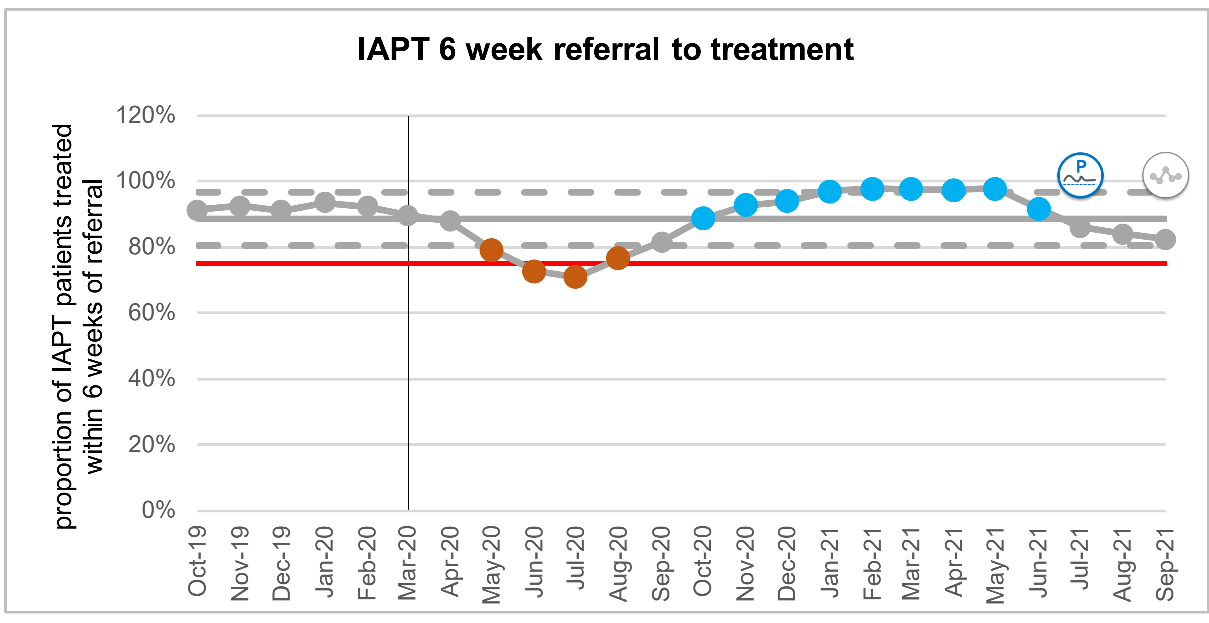
The service continues to perform consistently well against the national 14-day referral to treatment standard of 60% or more people on the waiting list to be have been waiting no more than 2 weeks to be seen. The target has been achieved throughout the 24-month period, and for the last 5 months we have seen common cause variation.

5. IAPT 18-week referral to treatment



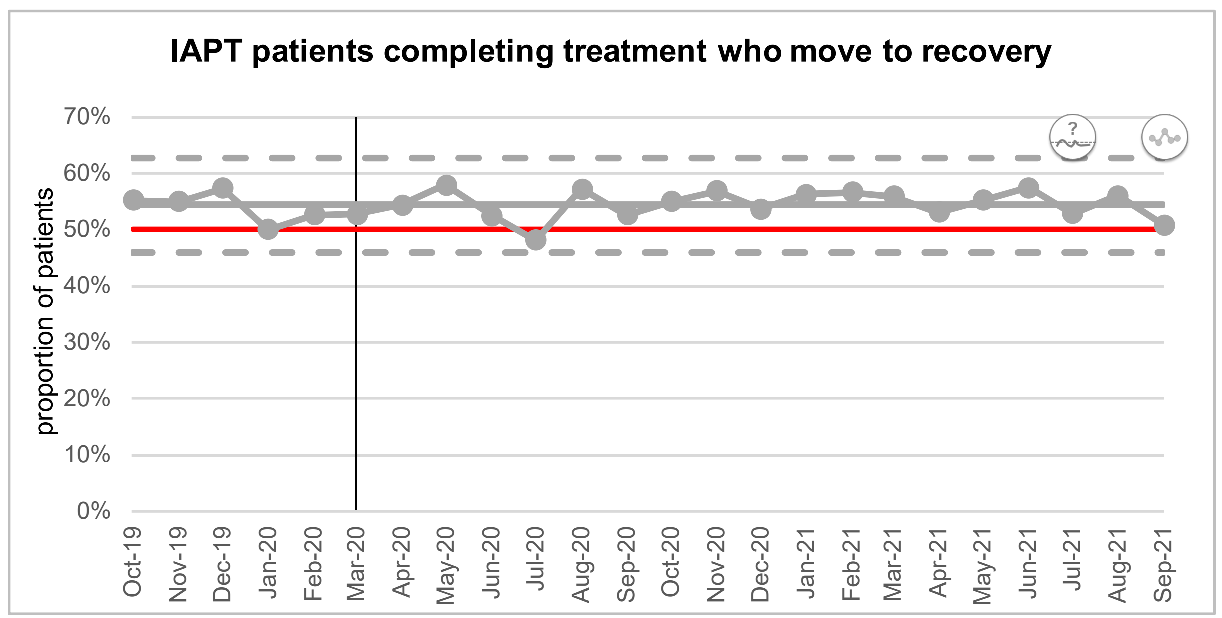
The national target has been exceeded throughout the 24-month reporting period and for the last 8 months performance has been significantly better than expected. This is an example of a very tightly controlled process and we would expect to consistently exceed the 95% standard.

6. IAPT 6-week referral to treatment



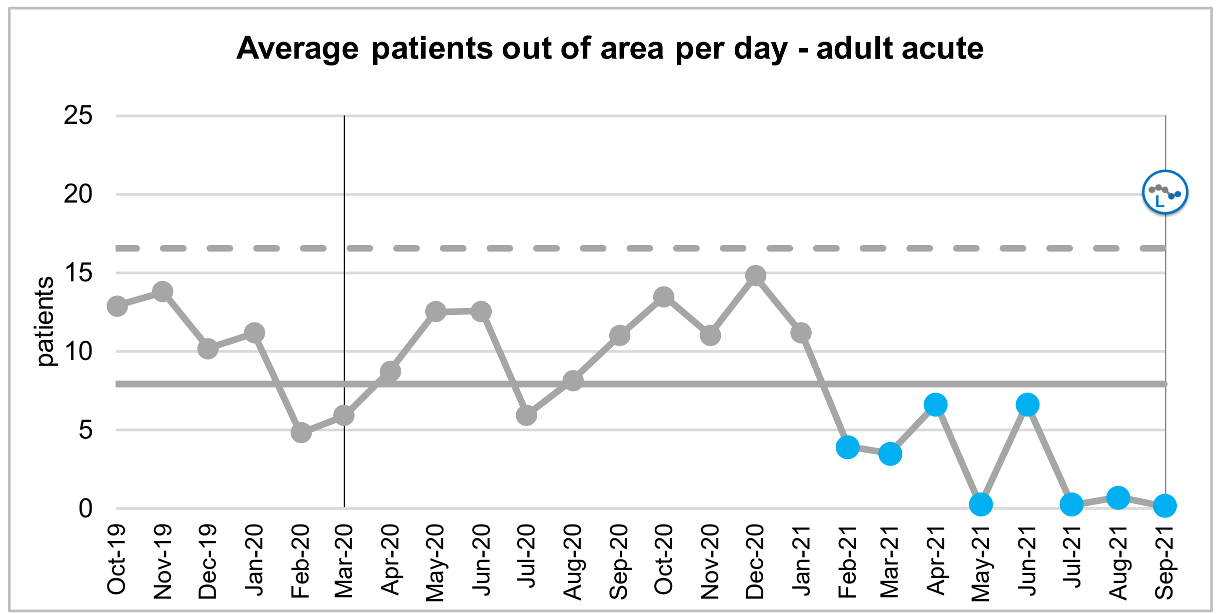
Following a period of 7 months of special cause concerning variation as a result of staff being redeployed to support other services as the pandemic progressed, the staff returned to IAPT in November 2020 and for 9 months performance was significantly better than expected before returning to common cause variation last month. With staff back in post we expect to consistently exceed the national standard.

7. IAPT patients completing treatment who move to recovery



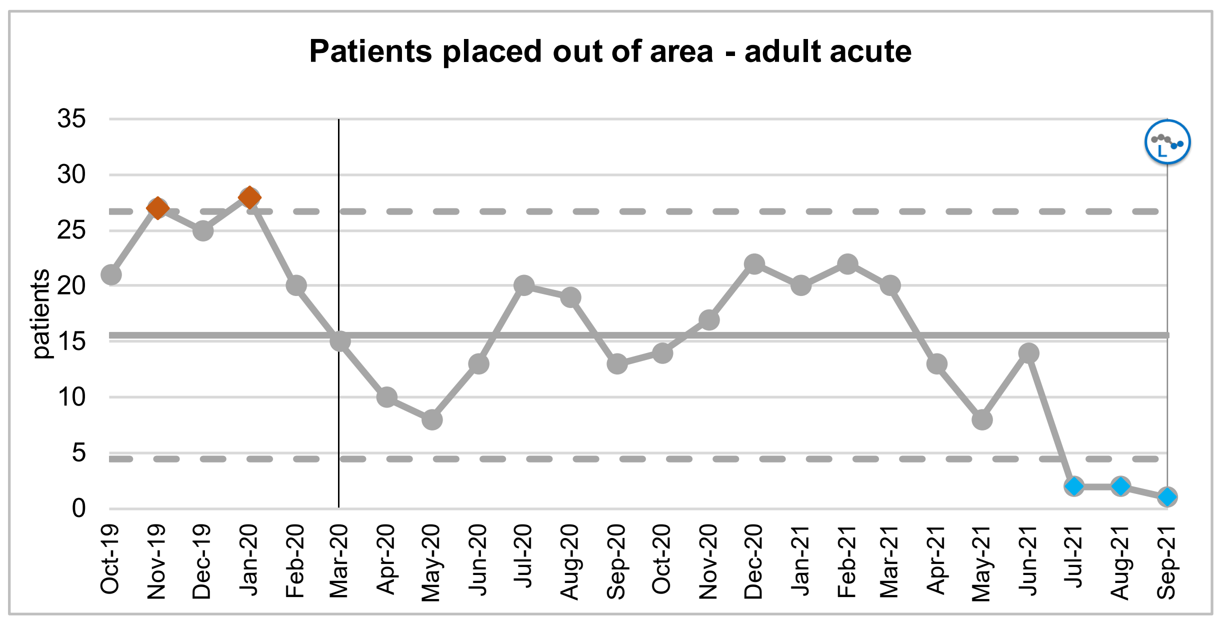
For the past 14 months the national standard has been achieved, with common cause variation seen throughout the data period. This is an annual target and year to date we are exceeding target.

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

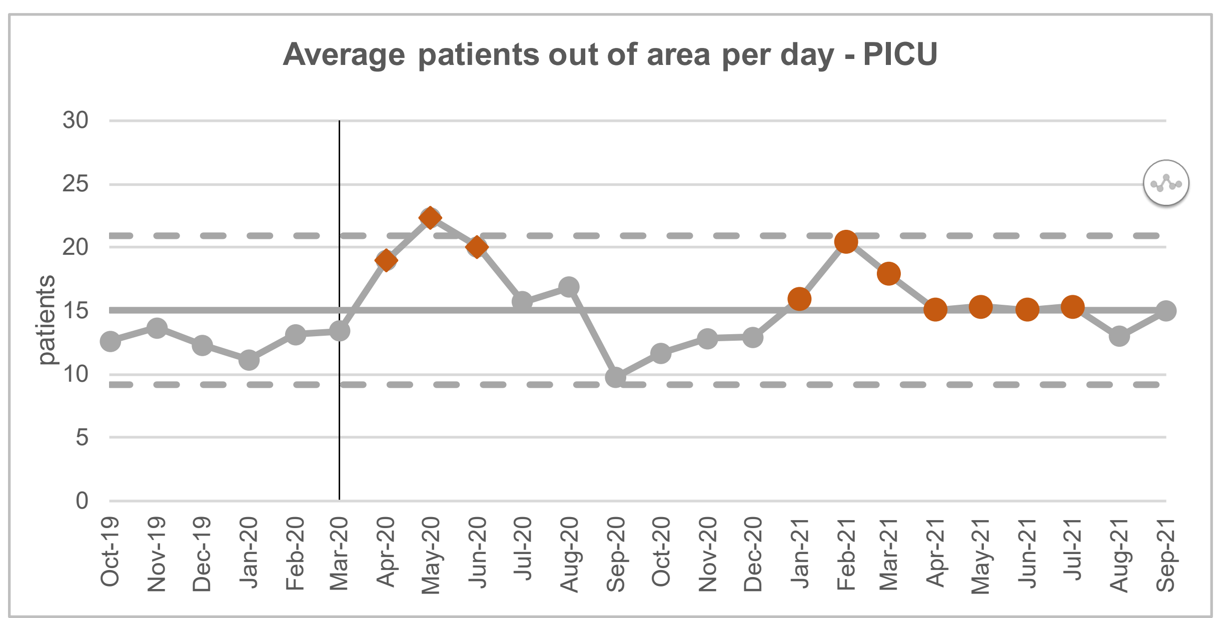


We currently operate with 10 Trust adult acute beds closed in order to facilitate social distancing and cohorting. Whilst these beds are closed, we commission 11 beds at Mill Lodge, Kegworth. These beds were eventually classified as “appropriate" out of area from April 2021 due to achieving continuity of care standards and being based within Derbyshire. There has been a statistically significant reduction in inappropriate out of area acute placements.

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

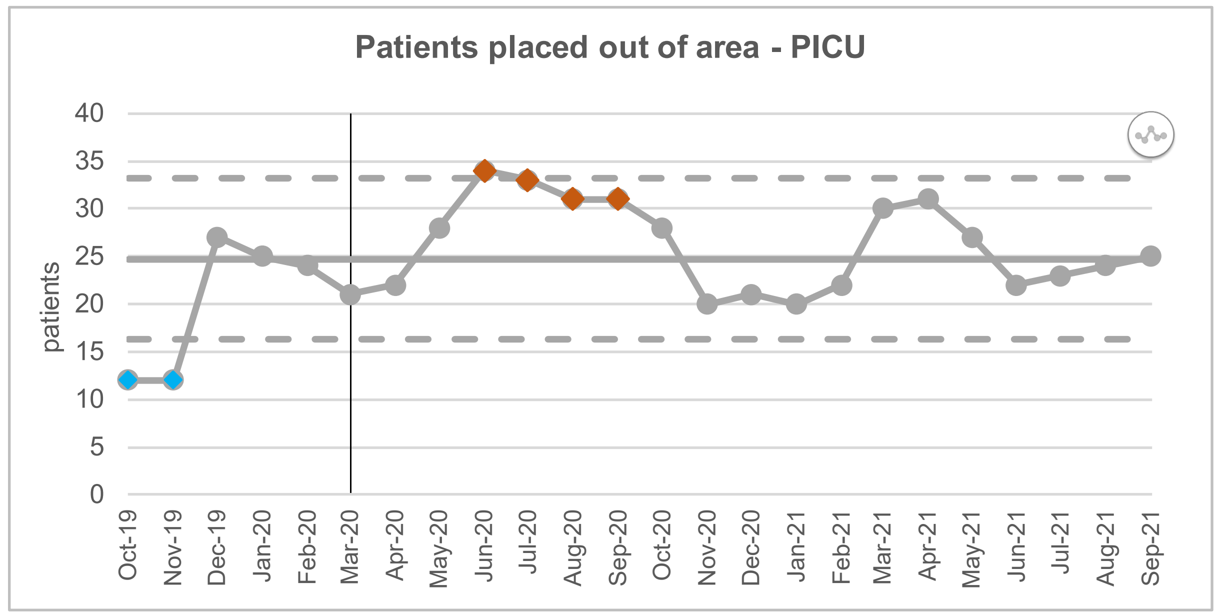


9a. Average number of patients placed out of area per day– Psychiatric Intensive Care Units

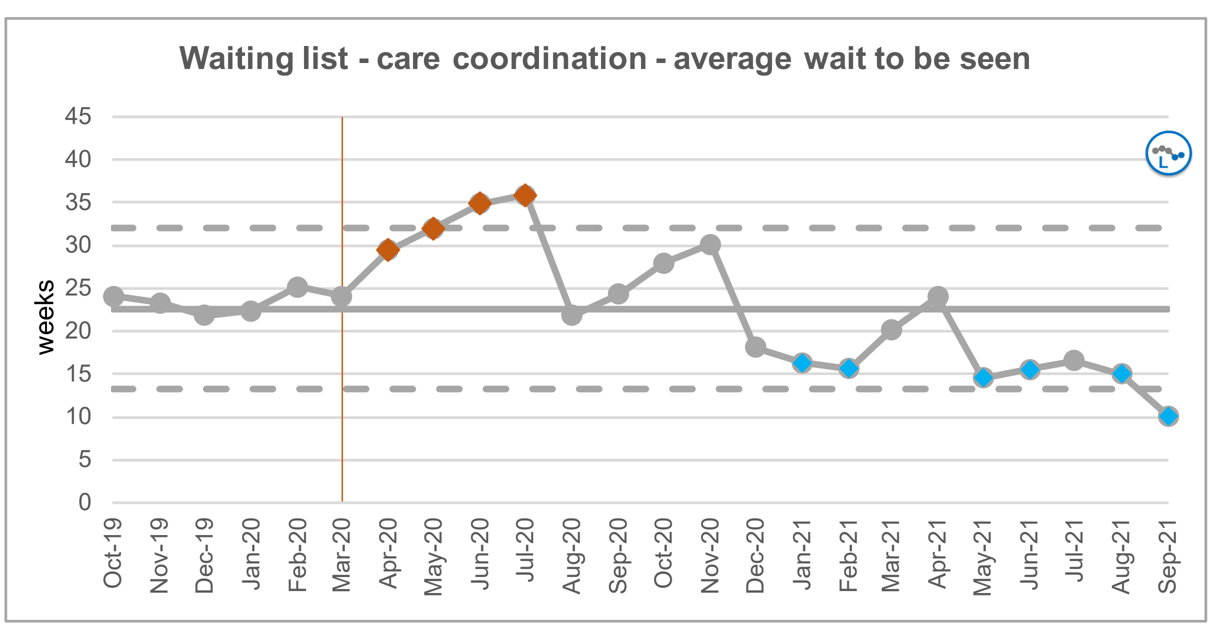


PICU usage has remained within common cause variation for the last 16 months. There is currently no PICU provision in Derbyshire so anyone needing psychiatric intensive care needs to be placed out of area. Work is progressing well towards obtaining agreement for the provision of a Trust PICU.

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

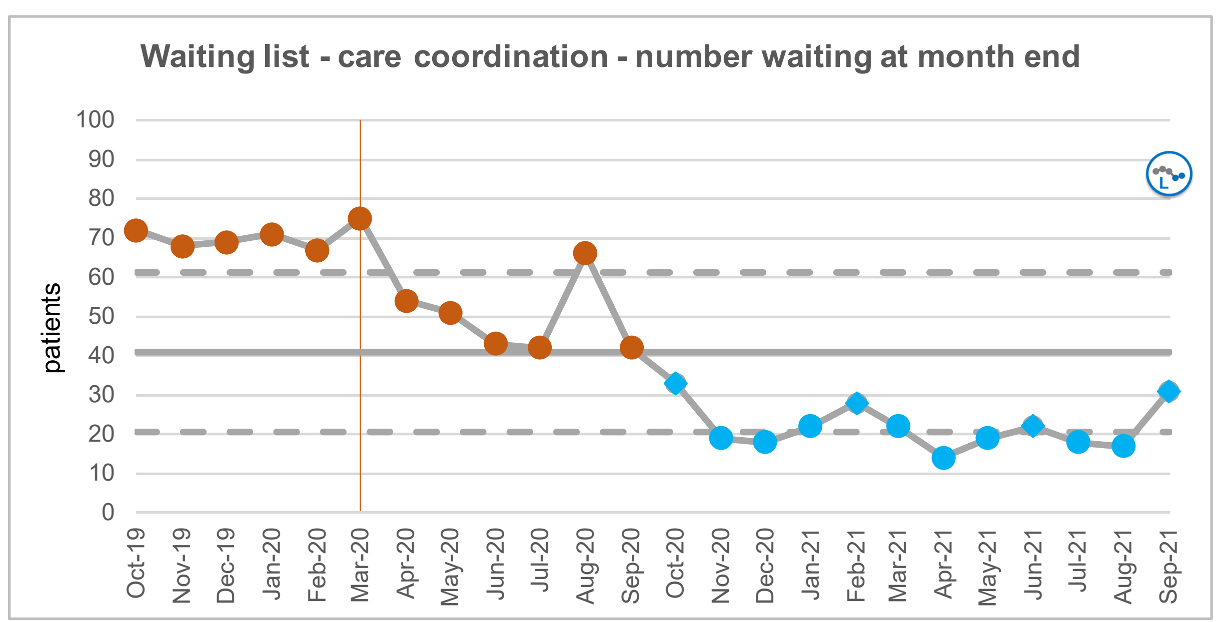


10a. Waiting list for care coordination – average wait



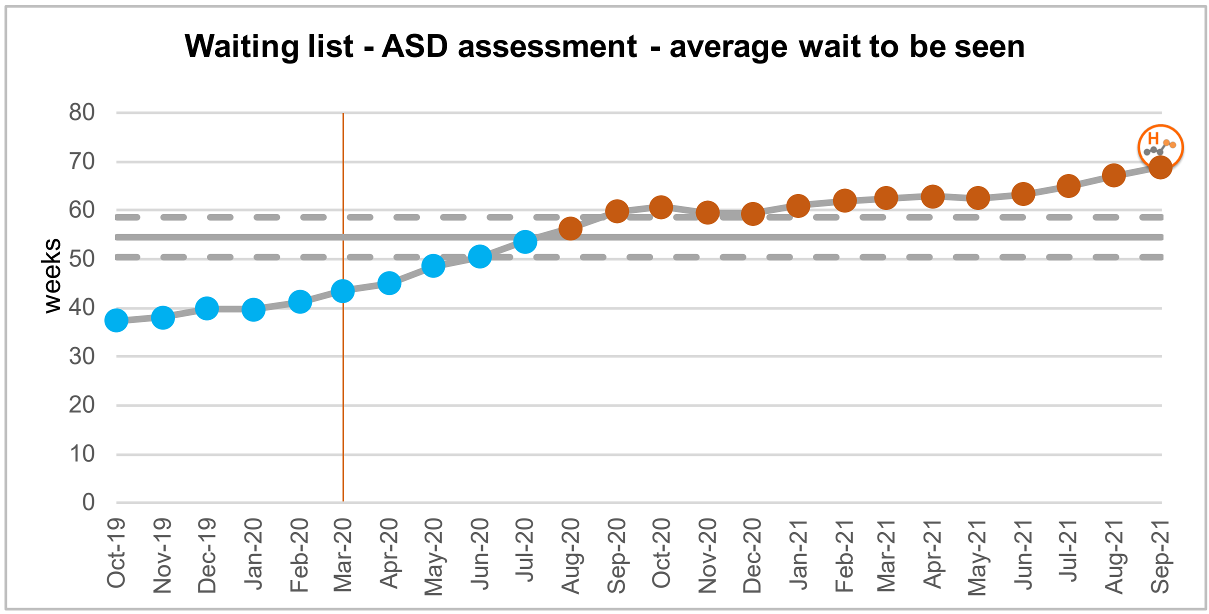
The average wait to be seen has remained significantly low in recent months.

10b. Waiting list for care coordination – number waiting

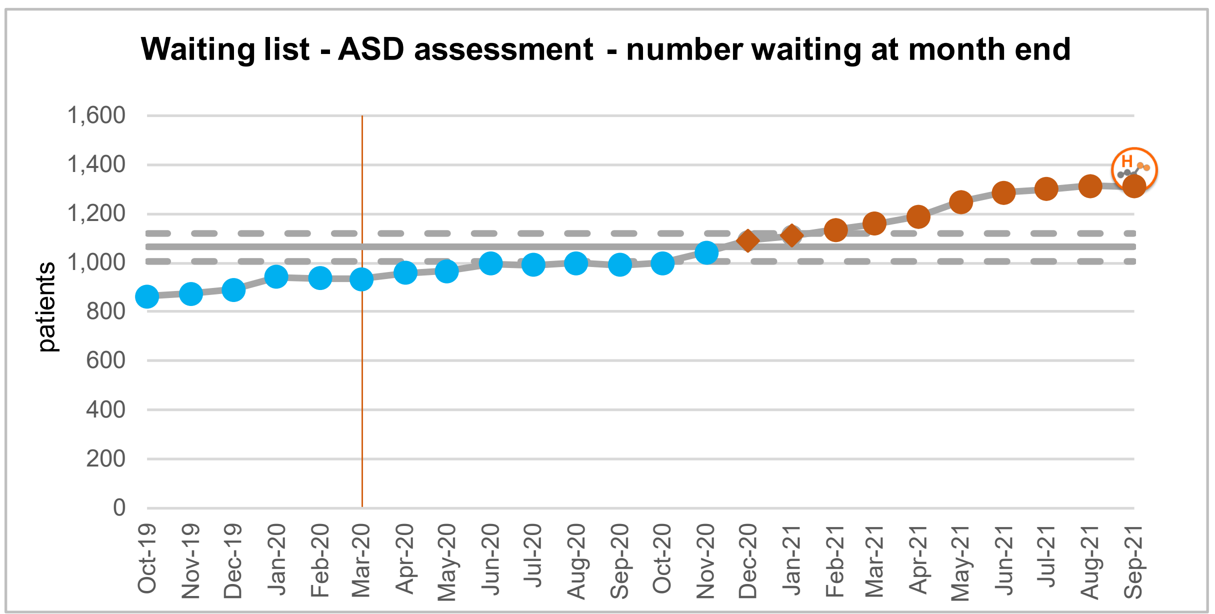


The number of people waiting to be allocated a care coordinator has been significantly low for the last 12 months.

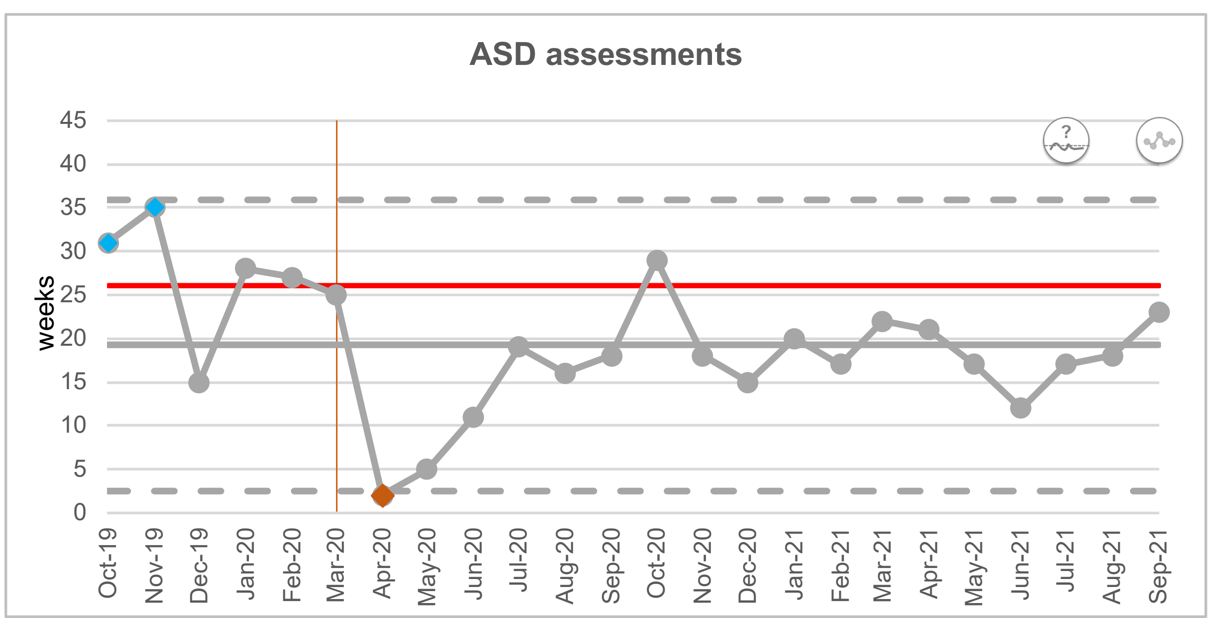
11a. Waiting list for autistic spectrum disorder (ASD) assessment – average wait



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



11c. Adult autistic spectrum disorder assessments per month



To meet demand, there would need to be between 54 and 67 assessments completed per month (65th to 85th percentile). Currently the service is funded to complete 26 assessments per month and is averaging 20 due to sickness and vacancies. The current adult ASD waiting list is 1312 people, with the longest wait of around 3 years, the assessment hiatus in March-July 2020 having had a further negative impact on overall waiting times. Referrals are continuing to be received at the same rate. It is highly unlikely to see any significant change until there is a change to investment in the service.

We are continuing with our COVID-19 recovery plans. We have identified locations, timings and protocols for safe COVID-19 face to face appointments. All team members are continuing to alternate between offering some face to face appointments and some online appointments.

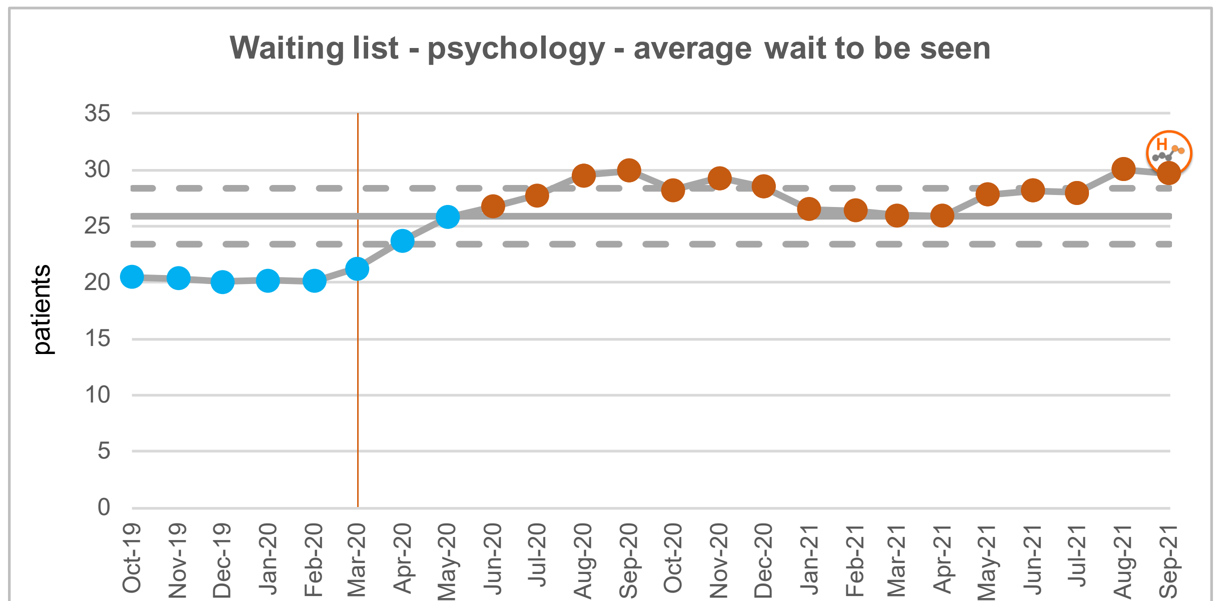
The team's capacity is being impacted upon by work required in preparation for the move to SystmOne.

Recruitment is progressing to fill the vacant post that resulted from the retirement of a member of the ASD diagnostic team.

As detailed previously, plans are in place to respond to the waiting list challenge as follows:

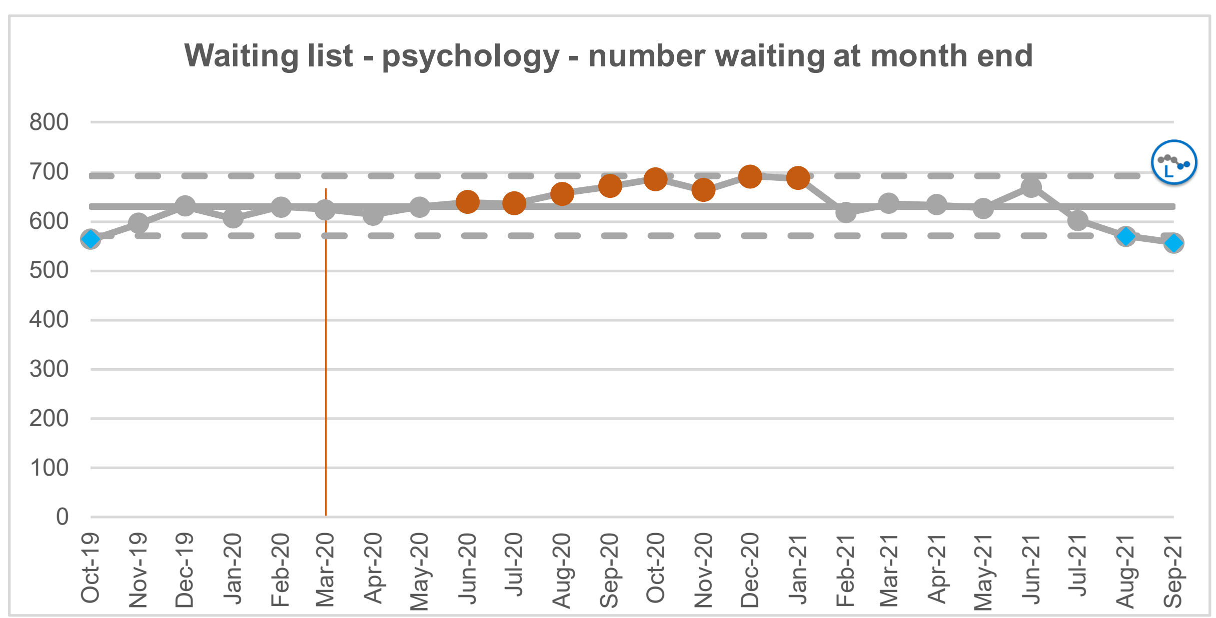
- Conducting a review of the evidence around diagnostic practices in the UK with Public Health Speciality Registrar, Dr. Joe Williams. So far this confirms that what we deliver is in line with the literature and other services Nationally.
- Review of our own delivery and consideration of whether something more efficient can be offered. This has a number of stages:
  - Academic review of the current literature and evidence for diagnostic assessments
  - Working with Dr Round to map what we deliver locally onto the evidence list
  - Considering different options for delivery of ASD diagnosis
  - Options appraisal and choice
- We have recruited to a 12-month assistant post to support scoring of questionnaires which in turn will support throughput of assessments
- We plan to increase admin time to support the assessment report writing process

12a. Waiting list for psychology – average wait



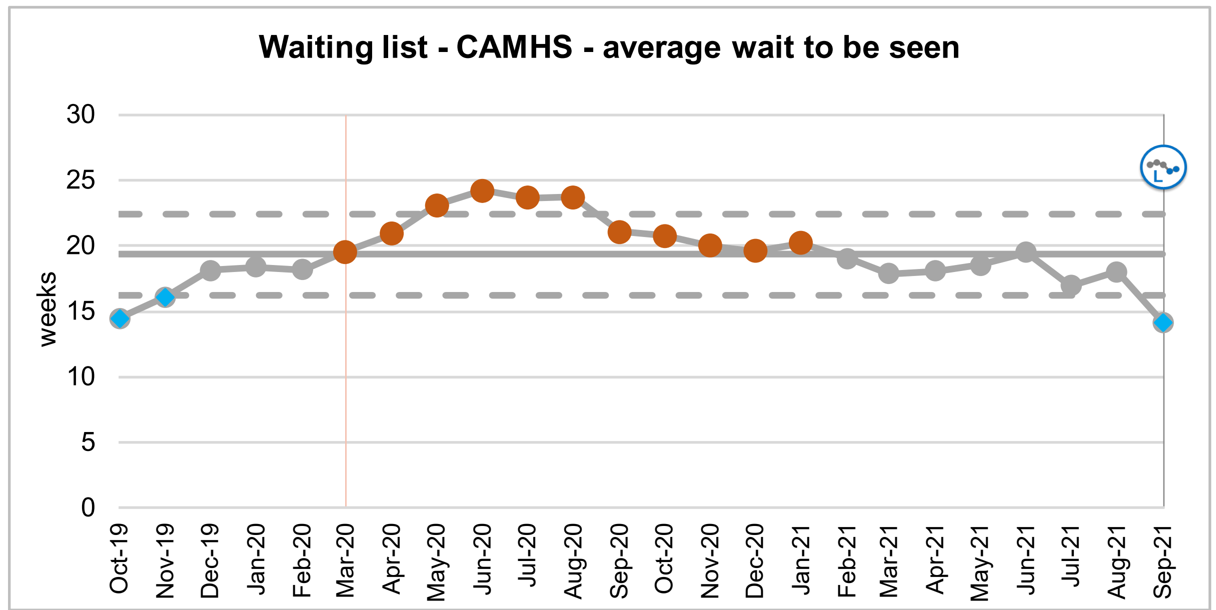
We can see the impact of the pandemic on waits, with the waiting list being significantly higher than expected for months. Many patients are still waiting owing to the pandemic and a desire to be seen face to face. The average waiting time has risen slightly in the last 2 months. Referrals remain steady.

12b. Waiting list for psychology – number waiting

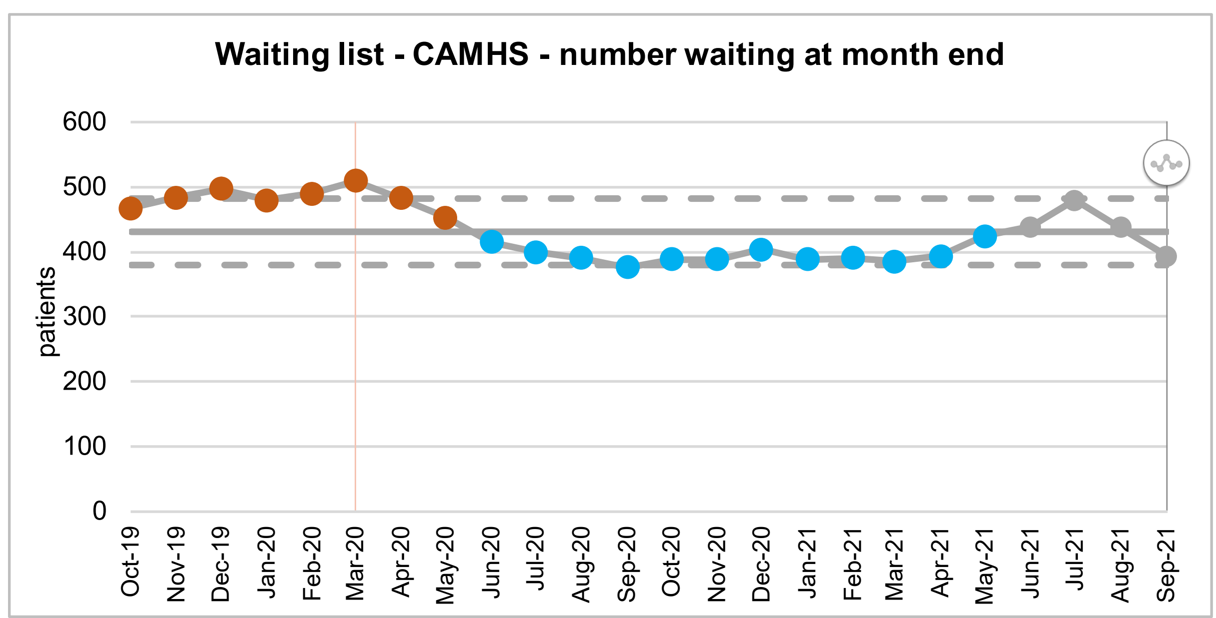


For the last 2 months the number of people waiting has reduced significantly. Recruitment to a number of vacant and part time posts across adult services is in progress. We have reviewed the waiting lists in line with trauma sensitive working in considering how we manage people on a waiting list and barriers of movement between services.

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

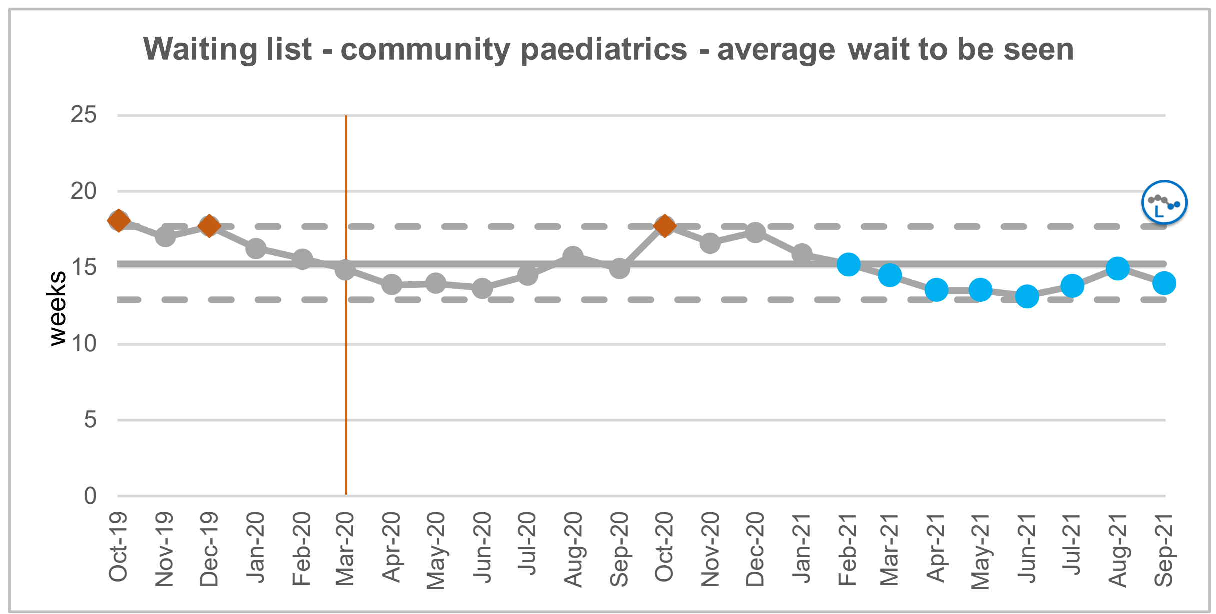


13b. Waiting list for Child and Adolescent Mental Health Services – number waiting

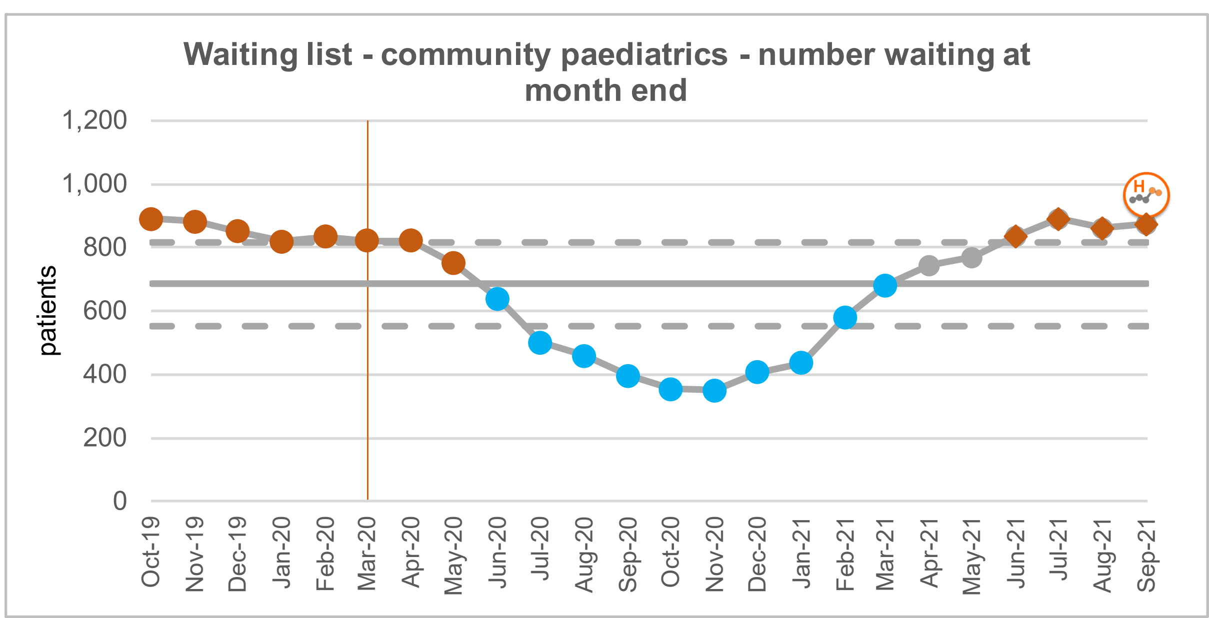


The number of referrals received has been steadily increasing, with a corresponding increase in activity. On 27/09/2021 a waiting list initiative commenced which will progress until the end of October. Staff within the ASIST team have paused all routine work to focus purely on assessments, with support from the rest of the CAMHS service. The goal is to undertake around 320 assessments during this period which should reduce the longest wait on the waiting list to around 6 weeks.

14a. Waiting list for community paediatrics – average wait

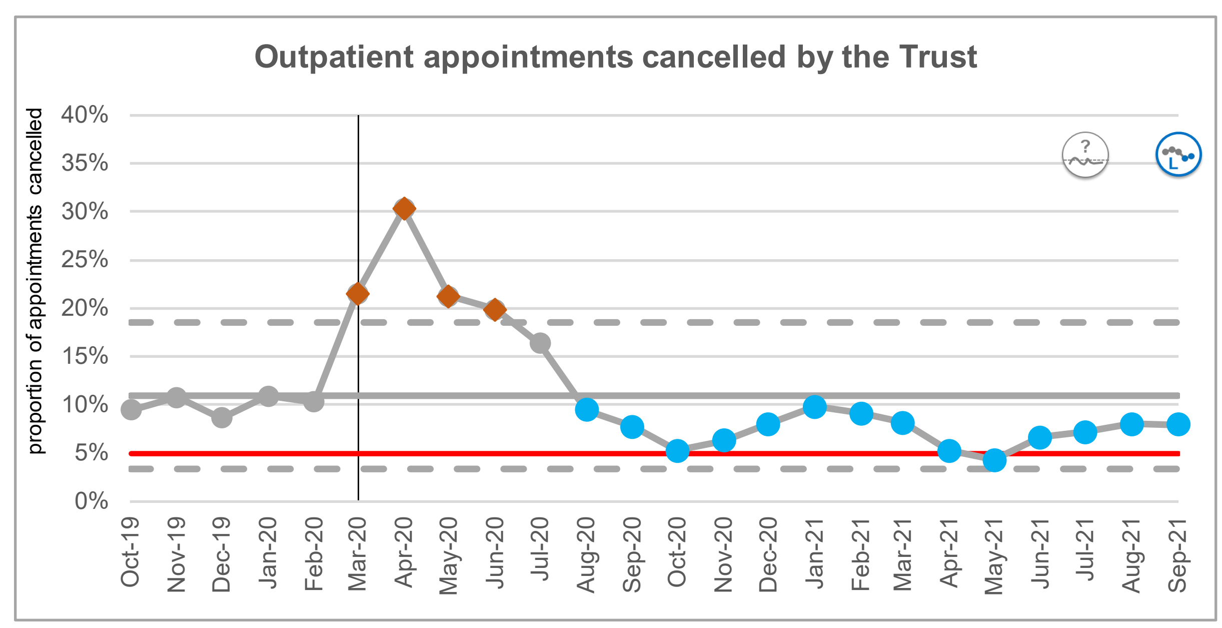


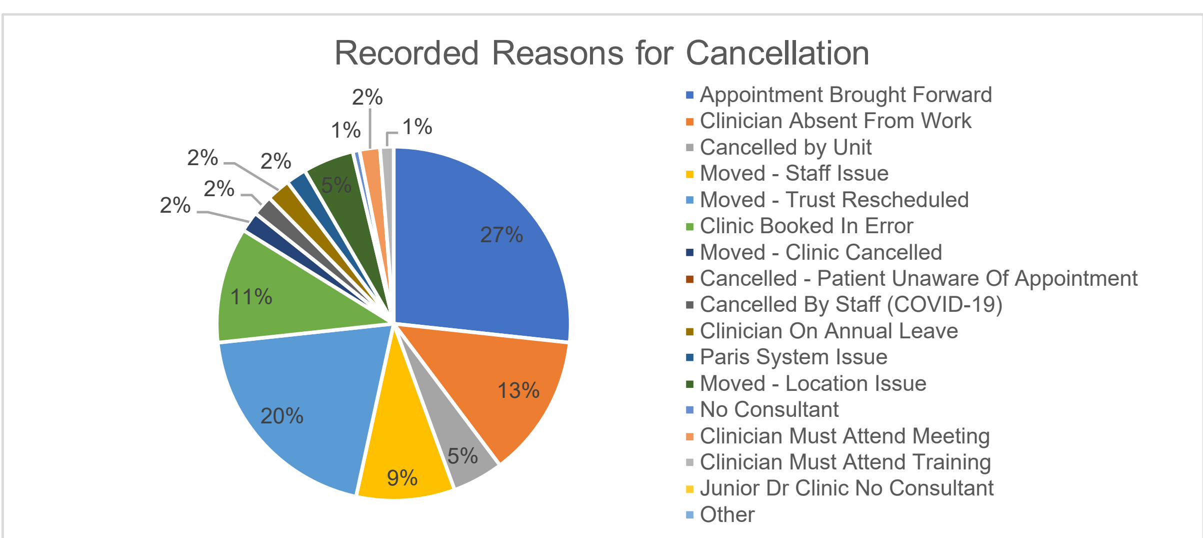
14b. Waiting list for community paediatrics – number waiting



The average wait to be seen continues to be significantly shorter than expected, however the number of children on the waiting list is now significantly high owing to the large increase in referrals for neurodevelopmental assessment which has been seen since January 2021.

15. Outpatient appointments cancelled by the Trust

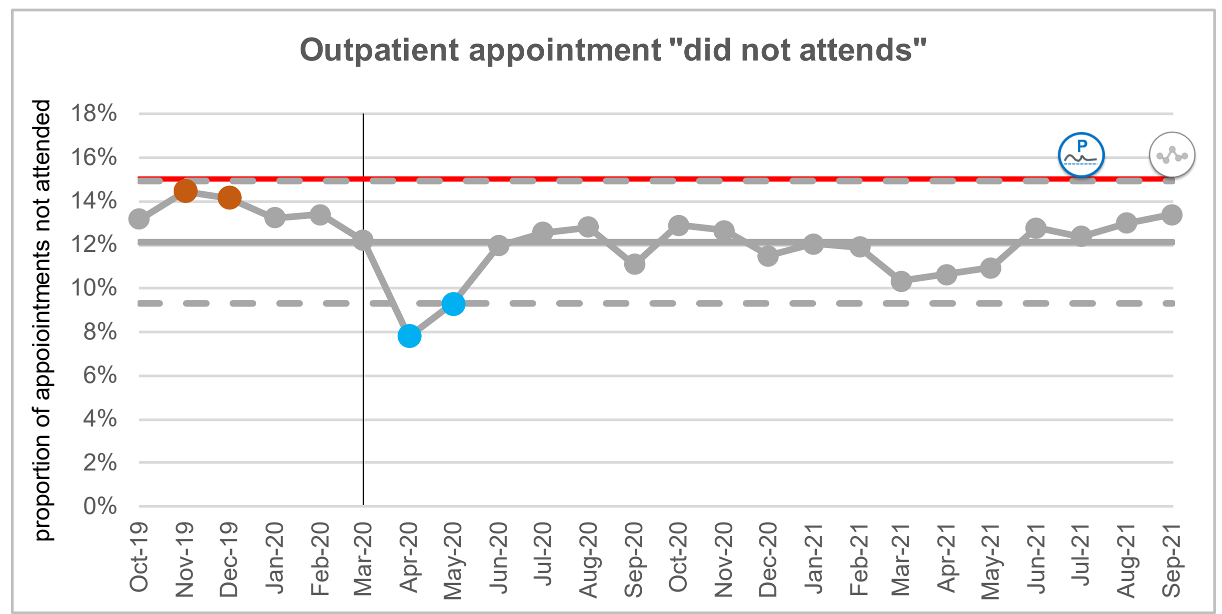




The proportion of cancelled appointments was significantly higher than expected from March 2020 owing to the pandemic but for the last 12 months has been significantly lower than expected, however in the current process the 5% target is unlikely to be achieved. The most common reason recorded for cancellation was “appointment brought forward”. This is when a patient needs to be seen more urgently and so is offered an earlier appointment. The 2nd most common reason was cancellation owing to consultant sickness.

The Trust operates a virtual clinic system with the aim of limiting the number of cancellations. The patient is unaware of the appointment until the appointment letter is sent out three weeks before the appointment date. The three weeks’ notice was introduced to reduce inconvenience to patients through cancellations and to bring us into line with the national standard for appointment notice.

16. Outpatient appointment "did not attends"



The level of defaulted appointments has remained within common cause variation for the last 16 months and in the current process the trust target of 15% or lower is likely to be consistently achieved.

Other Operational Matters of Note

A. Health Protection Unit

The Health Protection Unit (HPU) was set up in May of this year, with the aim to coordinate matters relating to health protection and prevention. This includes, COVID-19 related issues, vaccinations, health promotion and prevention initiatives. The HPU operates within Specialist Services and is managed by Interim Area Service Manager Fiona Brettell, along with Clinical Lead Catherine Martin and Health Protection and Promotion Advisor James Walker.

This next quarter for the HPU has seen its focus on the delivery of flu vaccination and COVID-19 vaccination, predominately boosters for staff and inpatients as well as primary and secondary doses for patients. The HPU continues to establish itself as an operational service, with a developed reporting, governance and supervision infrastructure as well as its own financial budget line. SOPs and the operational policy continue to be delivered.

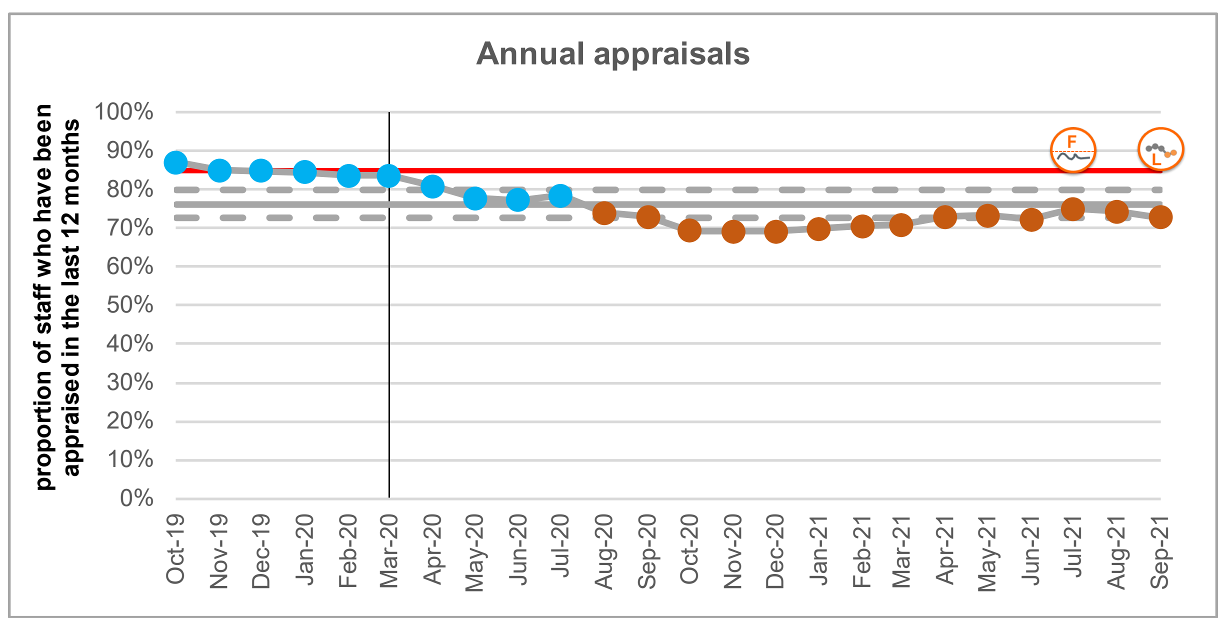
HPU are exploring doing some outreach work in providing vaccines to the severe mental illness (SMI) cohort and those that typically find accessing vaccines very difficult. A bid has gone in to access funding to support this.

B. Vaccination status

93% of people working for the Trust have received their first vaccination and 90% have now received both vaccinations. Booster vaccinations have commenced.

People

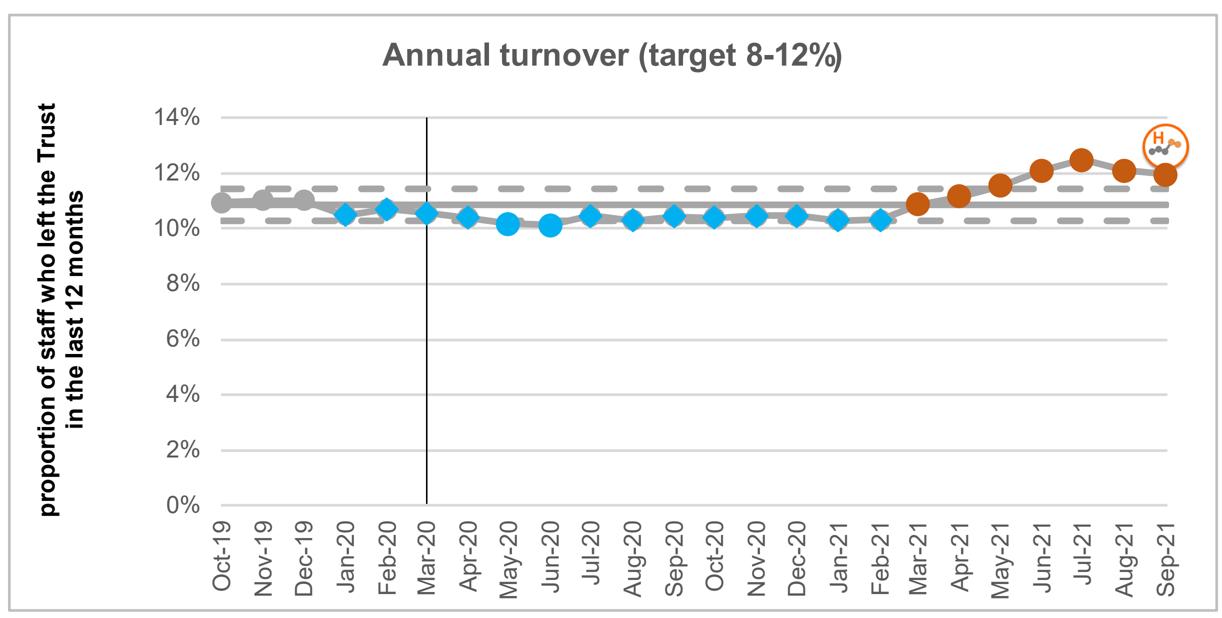
17. Annual appraisals



The "wellbeing conversation" now supplements an alternative mini appraisal process. The level of compliance has been significantly lower than expected for 14 months. Operational Services currently sits at 77% and Corporate Services at 55%.

The appraisal process will be reviewed at the end of October to agree reinstatement of full appraisals across all services. In the interim they continue to be paused replaced by a structured wellbeing conversation.

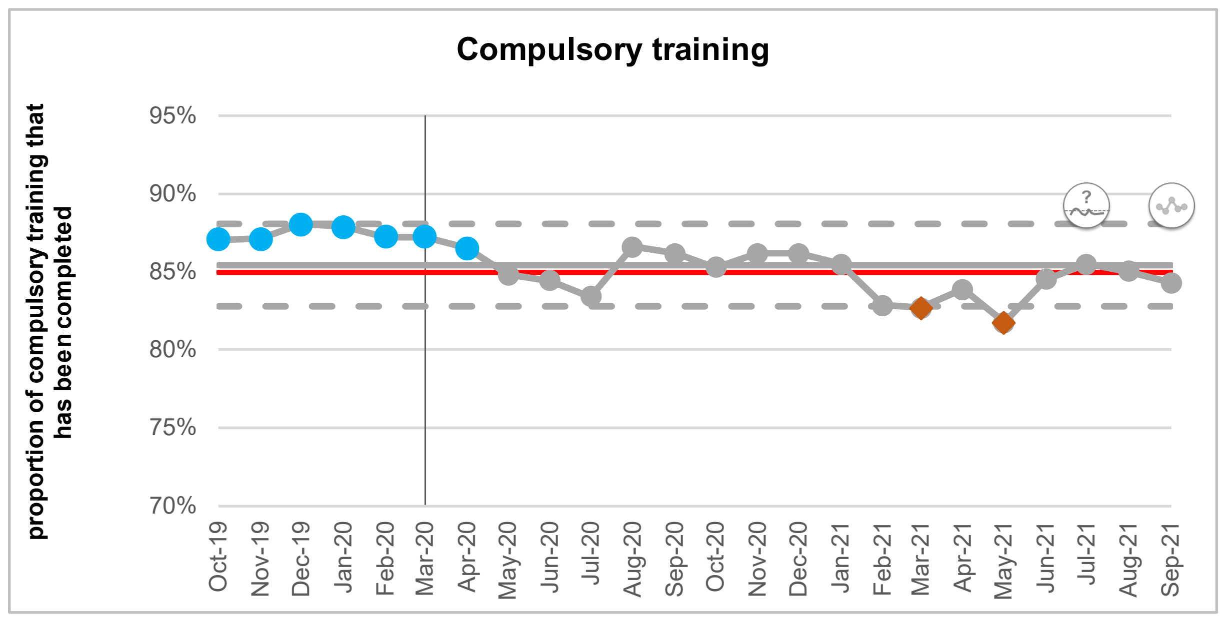
18. Annual turnover



The rate of turnover was higher than the Trust target range of 8-12% for 3 months but returned to within target range last month. Retirements continue to add to the turnover rate although this is still in line with national predictions due to an ageing workforce across the NHS. Work Is ongoing to develop a retire and return process which will encourage more retirees to return to substantive posts and support vacancy fill. Changes have been made to the termination process so that

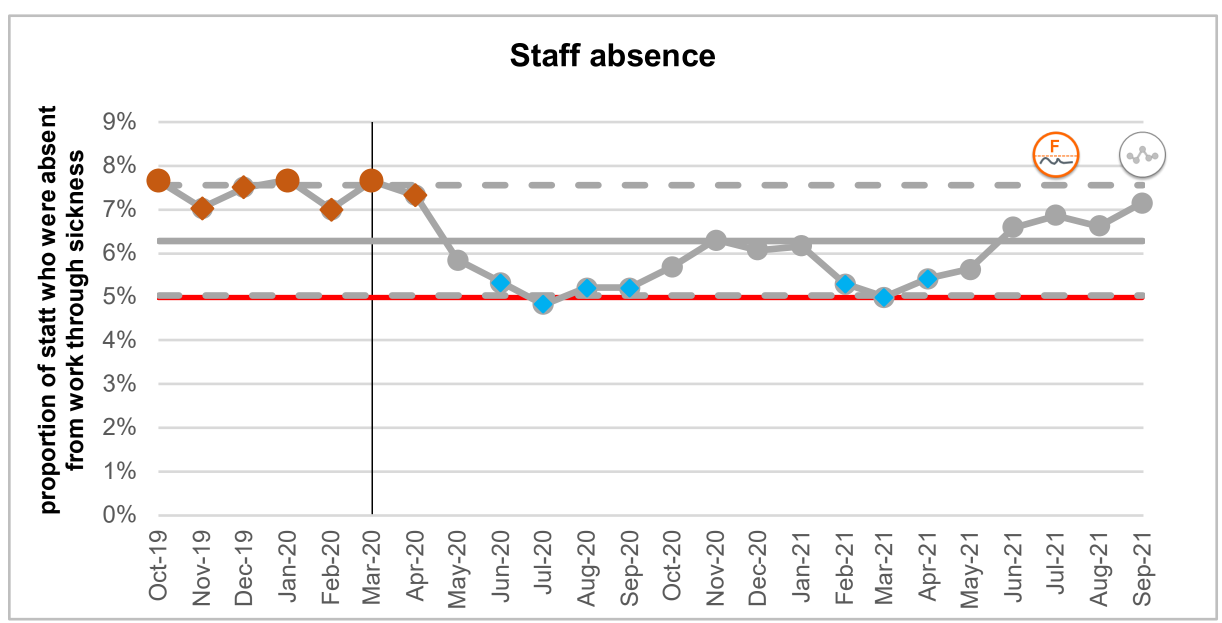
retirements are flagged at an earlier stage, this will support ongoing forecasting and workforce planning.

19. Compulsory training



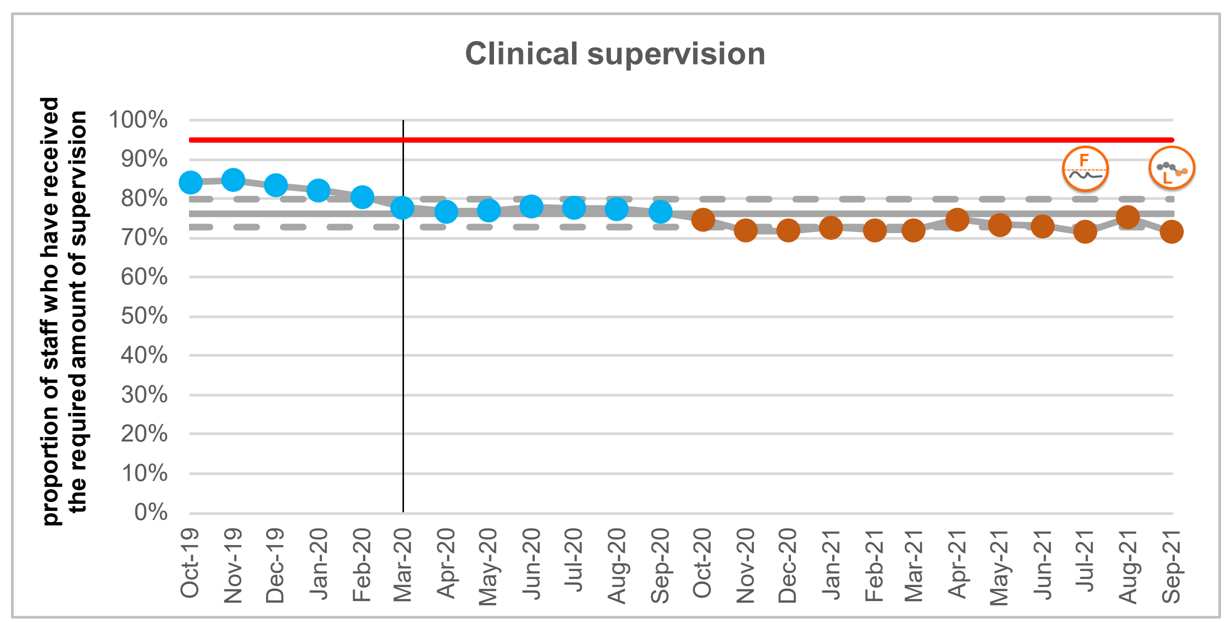
A recovery plan continues to improve training compliance. The full training requirement – compulsory training and role specific training – is around 70,000 attendances by our total workforce on over 70 courses, with just over 15,800 individual attendances to be completed. Operational Services are currently above target at 86% compliant with compulsory training, with Corporate Services slightly lower at 77%.

20. Staff absence

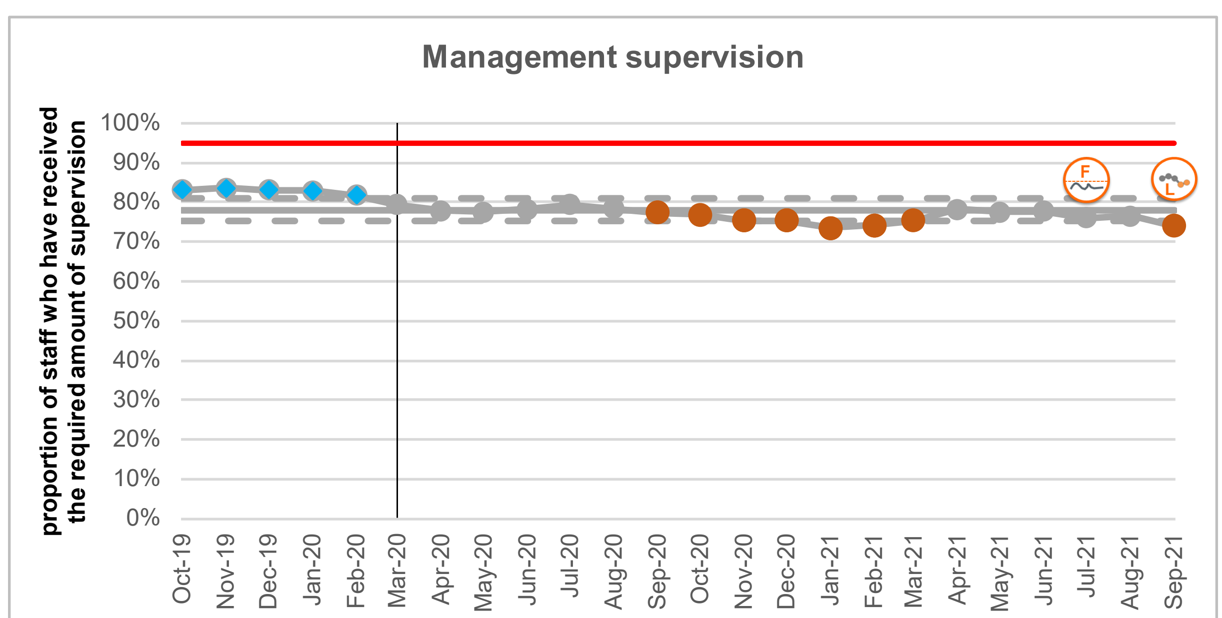


Corporate Services are below the target threshold at 4.6%, with Operational Services currently sitting at 7.7%. Our Systems and Information team in People Services have carried out a deep dive by Division and reintroduced the triangulation report which identifies hotspots (heat maps). General Managers and Area Service Managers have been tasked with compiling sickness action plans to address on a Divisional basis, reporting through the Trust Oversight Operational Leadership meeting (TOOL).

21. Clinical supervision

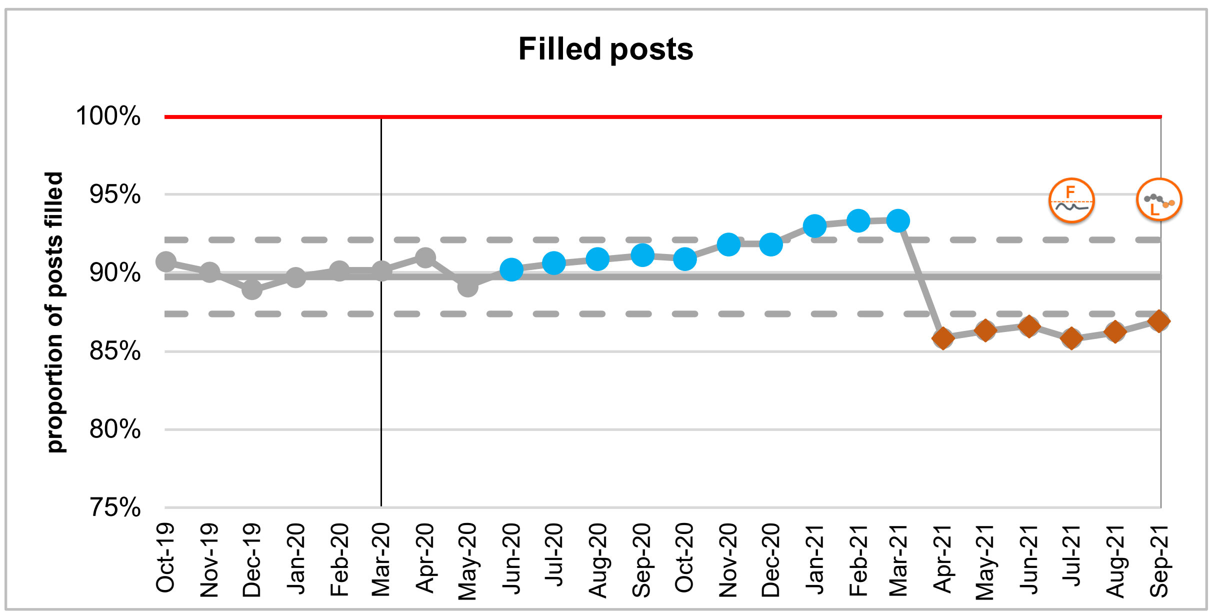


22. Management supervision



The levels of compliance with the clinical and management supervision targets have remained low since the start of the pandemic and were significantly below target in September. As seen with compulsory training and appraisals, Operational Services are also at a higher level than Corporate Services for both types of supervision (management: 76% versus 59% and clinical: 72% versus 35%).

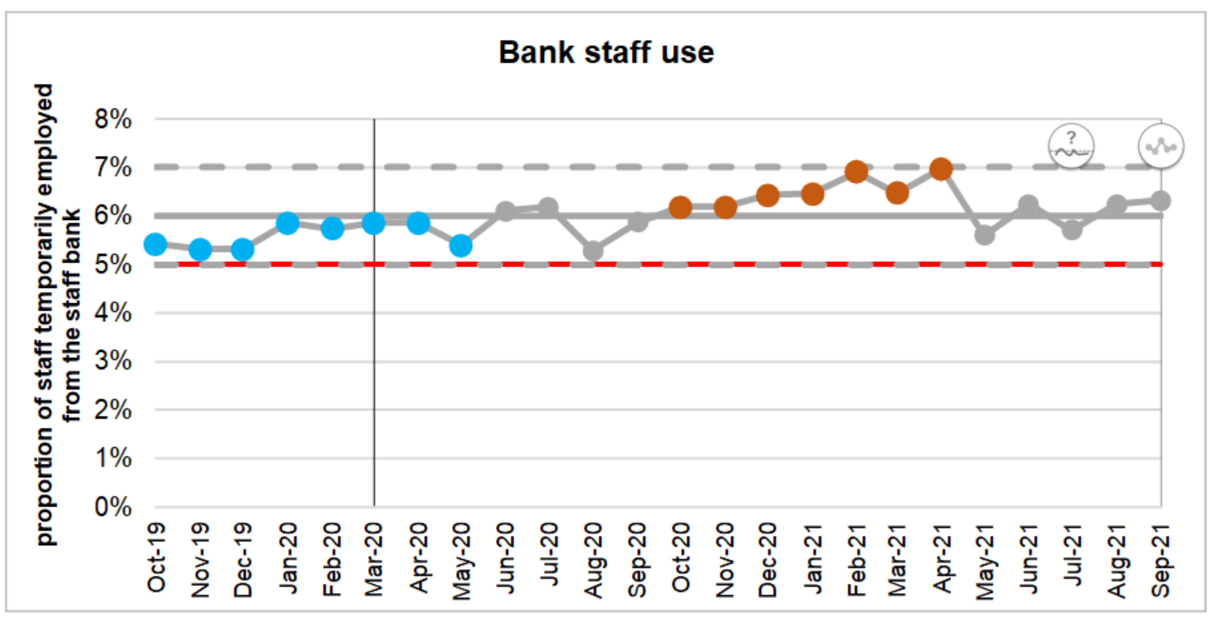
23. Proportion of posts filled



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

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

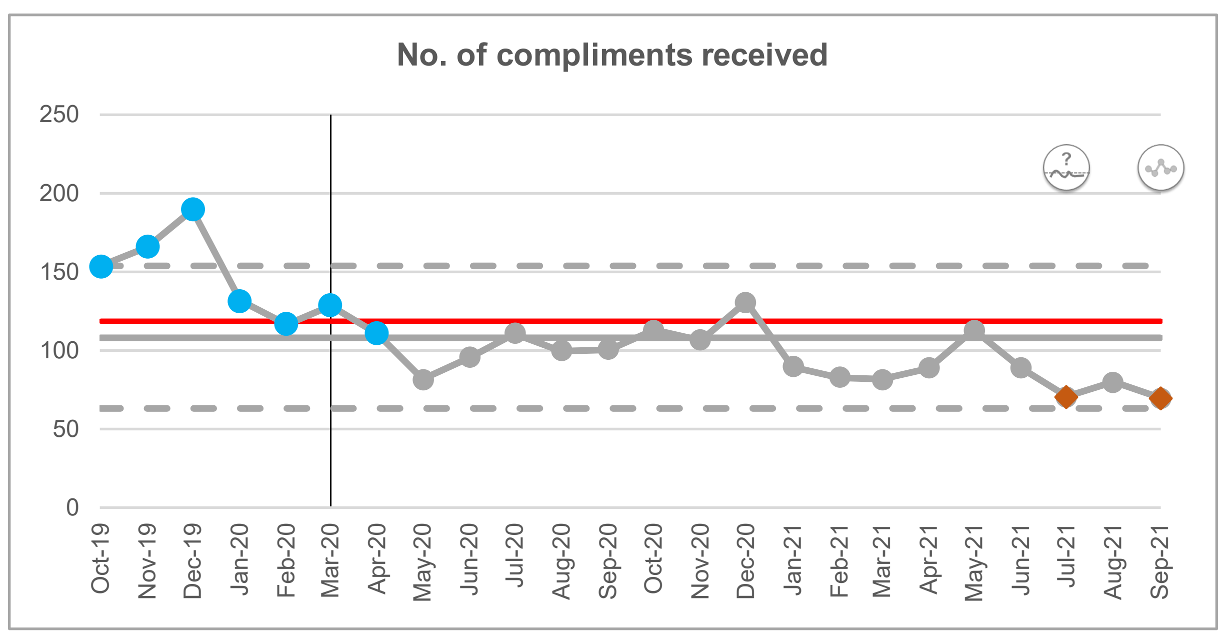
24. Bank staff



Following a period of 7 months of unusually high bank staff use, in the past 5 months the position has returned to common cause variation.

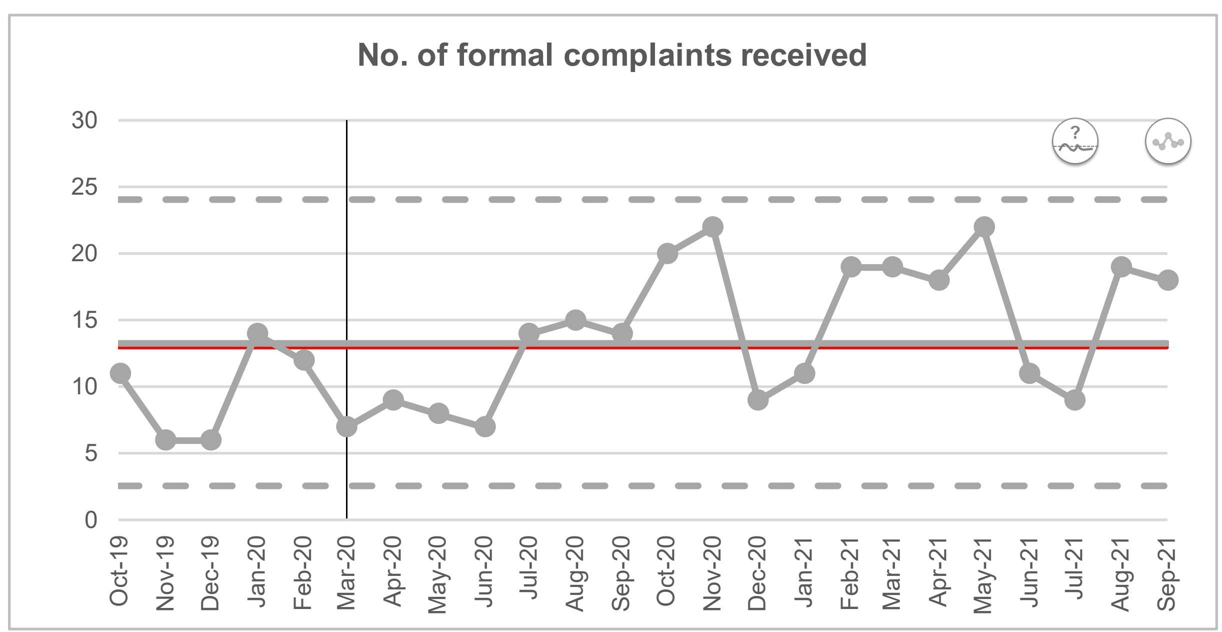
Quality

25. Compliments



The number of compliments decreased in line with the emergence of COVID-19 and the significant changes to many of our clinical services. A large number of compliments are received by staff during face to face contact and then entered by staff. As a result of reduced face to face contact, there has been a drop in the number of compliments received. This is below the expected target. Work is underway to improve feedback from service users via an electronic survey received by text or email. A pilot has commenced across crisis team services and a pilot is due to commence within the working age Erewash CMHT services on 11 October.

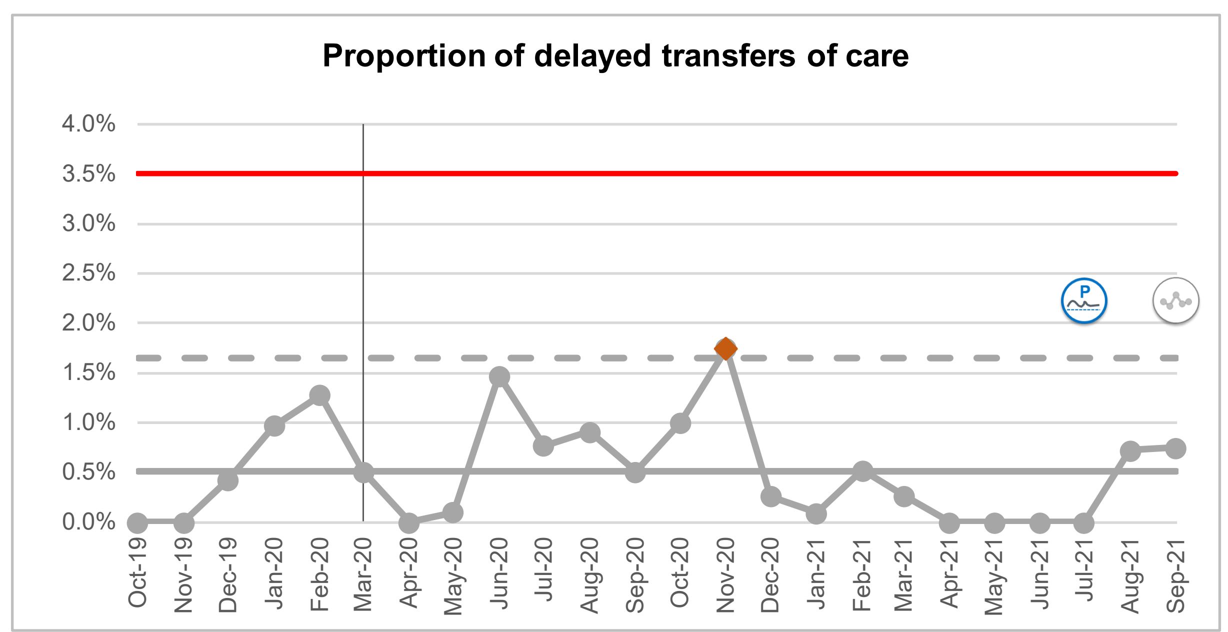
26. Complaints



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

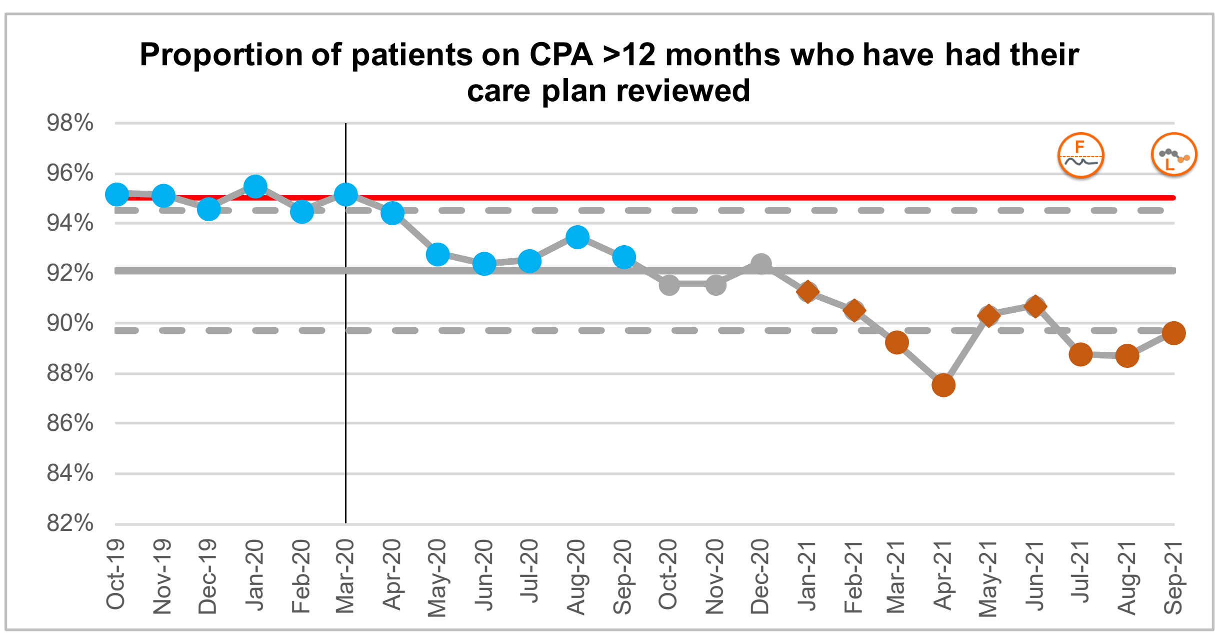
presented similar themes, with service users and carers feeling they have struggled with the reduction in face to face contact with services during the COVID-19 Pandemic.

27. Delayed transfers of care



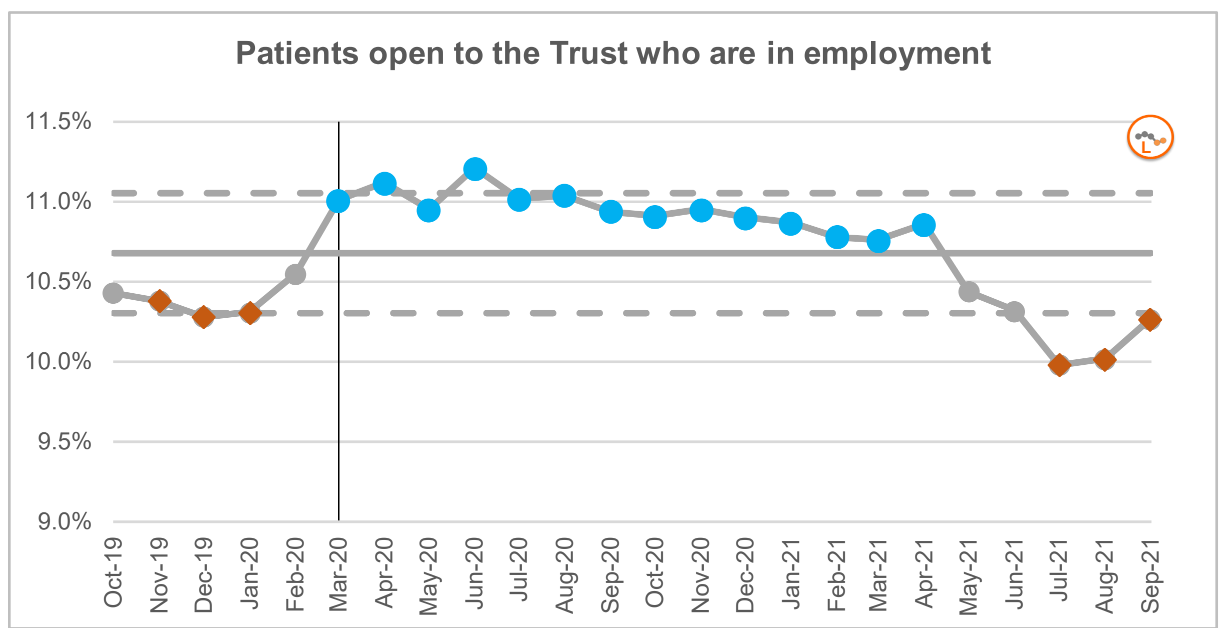
The increased number of care homes and care settings in outbreak and demonstrating staffing issues has resulted in high numbers of delays in transfers from inpatient settings, increasing the number of DTOCs at times. April to July 2021 have demonstrated no DTOCs. A review and support from Matrons have now improved processes and now increased the number of DTOCs in August and September.

28. Care plan reviews



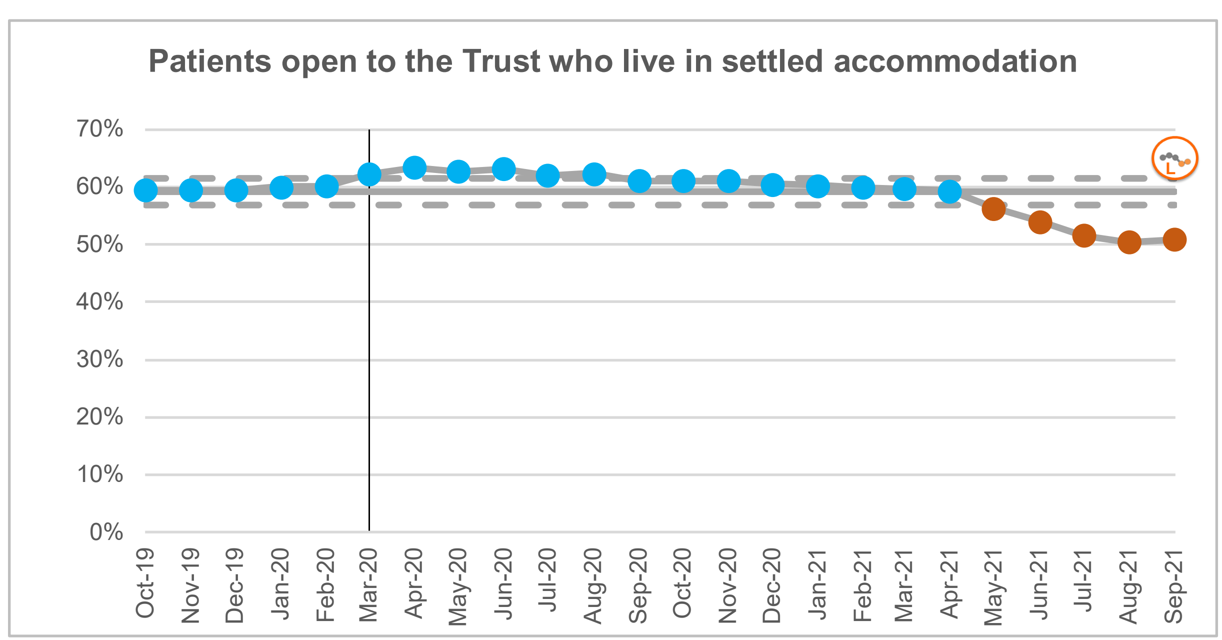
The proportion of patients whose care plans have been reviewed continues to be lower than usual. Teams have been prioritising essential tasks, with reduced routine contact, and trying to engage with people who use our services in different ways, e.g. in virtual ways using Attend Anywhere. As a result, an improvement in practice in May and June has been witnessed but then a drop in July as cases of COVID-19 have risen. As cases begin to once again stabilise and divisions establish ways to increase face to face contact, the trend appears to be improving.

29. Patients in employment



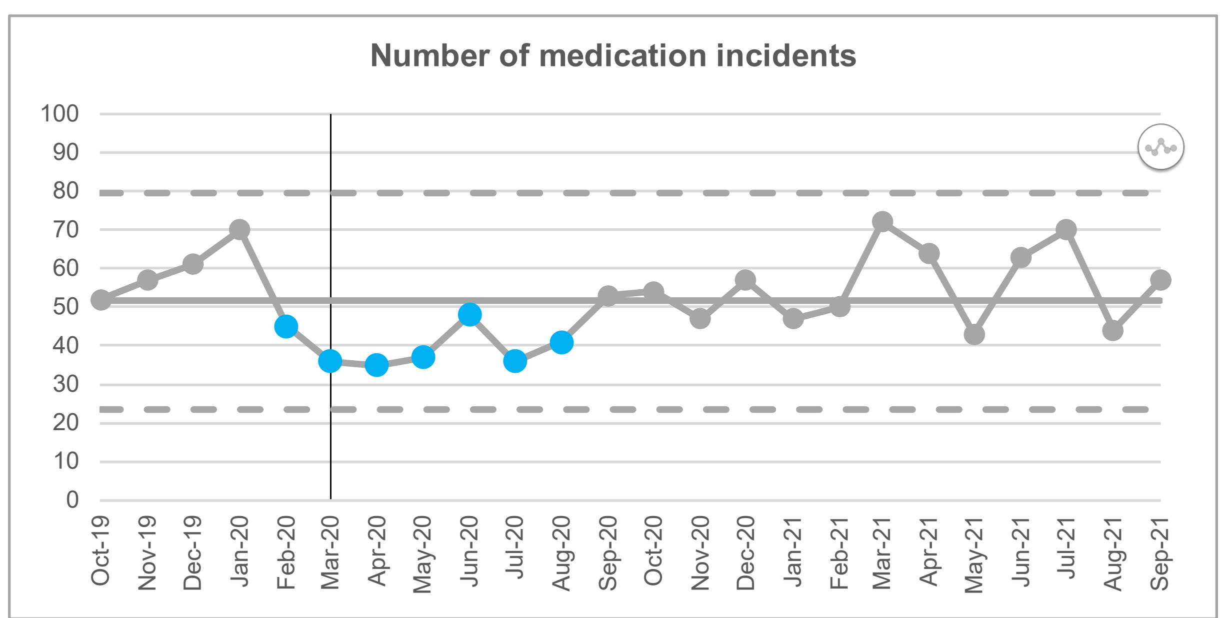
The Individual Placement Support (IPS) Service continues to have success in supporting people into employment even during the current pandemic and the service is currently expanding. The IPS service came into effect in January 2020 and the data demonstrates the impact they have had on levels of employment, even during a pandemic. As vacancies are being filled and ongoing development of the community mental health framework is underway data appears to be improving from July, however, remains below the lower threshold. This may also be linked to the current economy and availability of employment. As the country recovers from previous lockdowns, employment is becoming more available.

30. Patients in settled accommodation



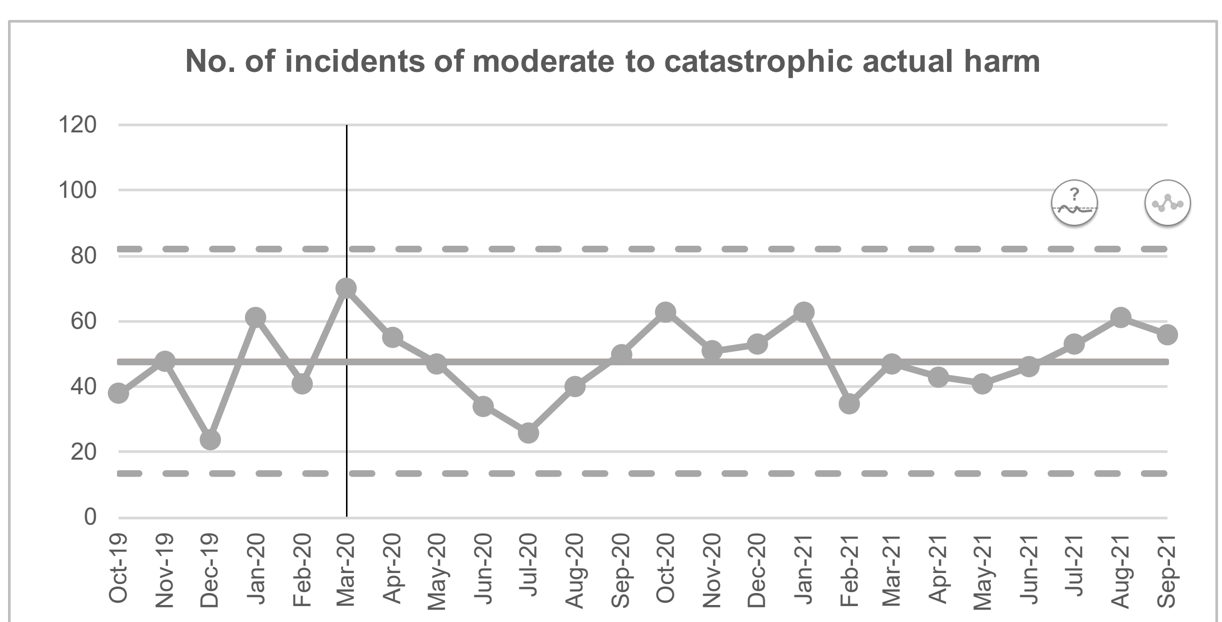
There continues to be community nurses dedicated to working in a multi-agency environment supporting our homeless service users however, data presents below the lower control limit and so further investigation is required into this.

31. Medication incidents



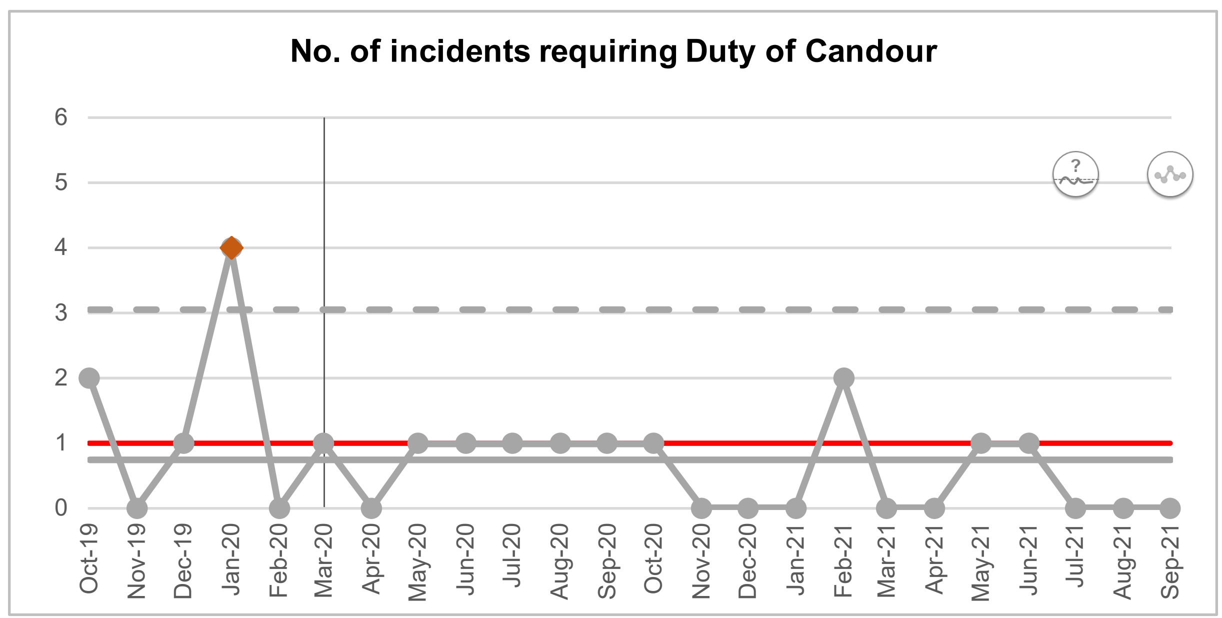
When looking into medication incidents, they take a variety of forms, from missed doses, wrong medication administration, missed fridge temperature recording, prescription error and non-location of medication. As a result, there are several factors that impact such as how busy the ward is, number of qualified staff, how the medication cabinet is organised and number of newly qualified staff. The medicines management operational subgroup are currently revising the medications error procedure, taking into account Trust values.

32. Incidents of moderate to catastrophic actual harm



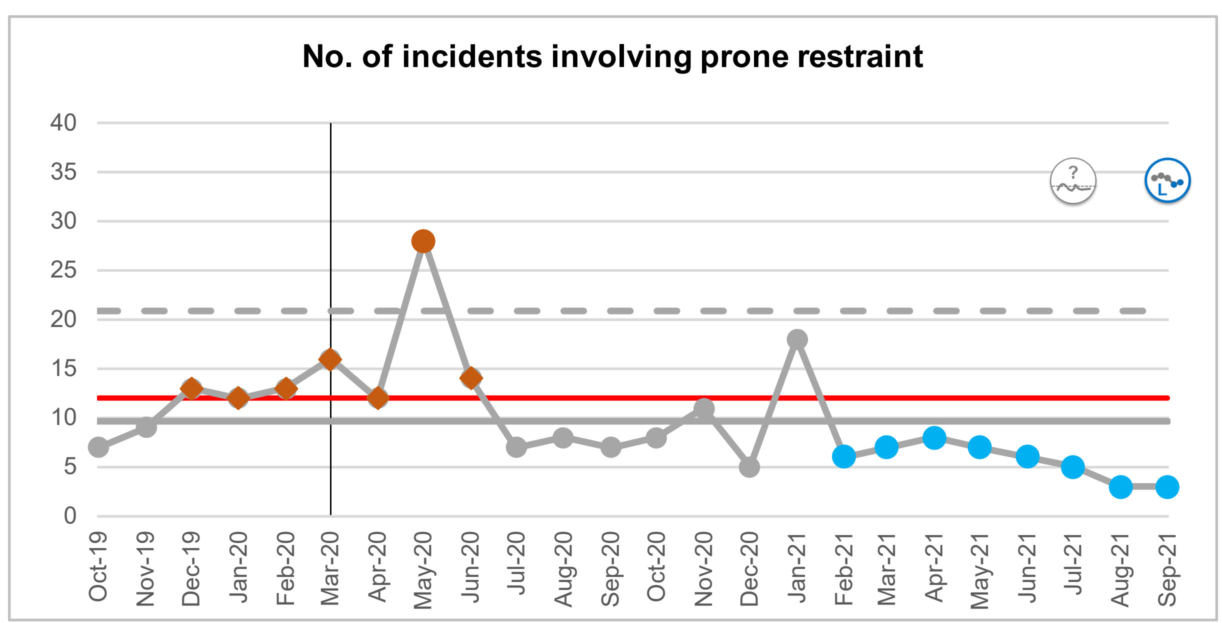
The number of reported incidents of moderate to catastrophic harm have remained within common cause variation throughout the reporting period. However, there has been a recent increase bringing the total above the mean line. This will continue to be monitored.

33. Duty of Candour



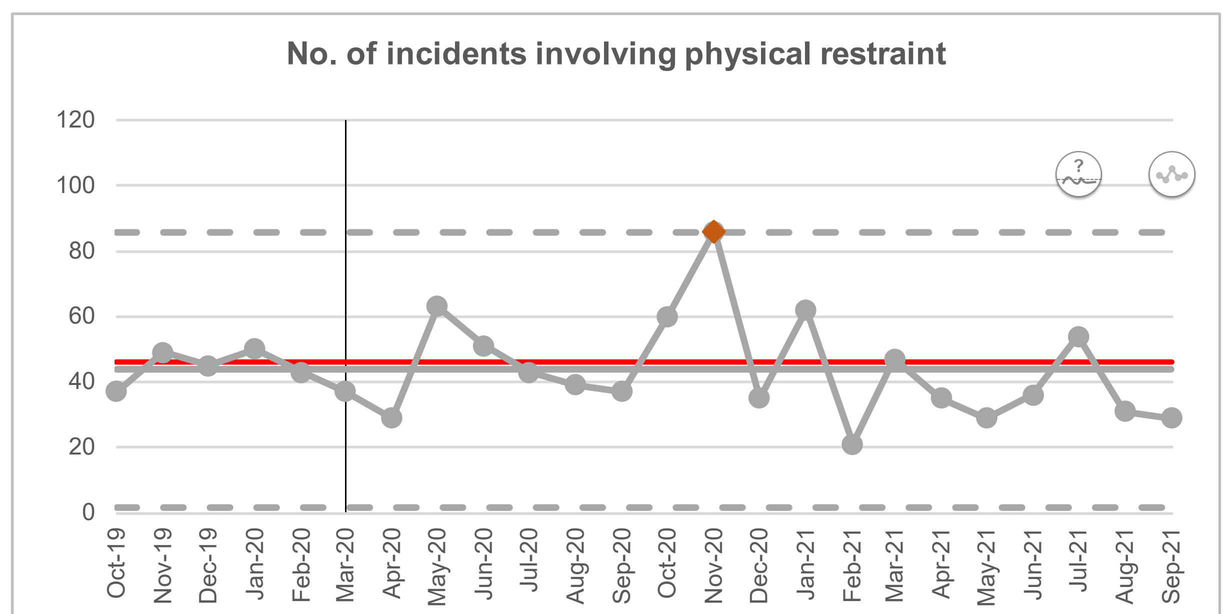
There have been no instances of Duty of Candour in the last 3 months.

34. Prone restraint



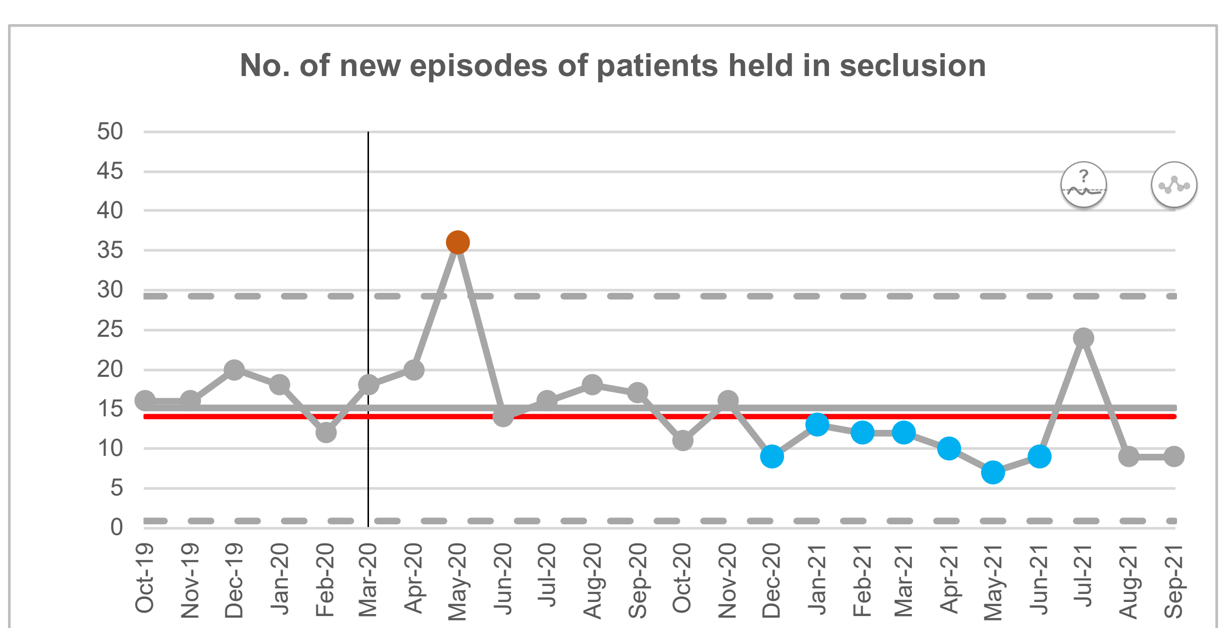
There are ongoing work streams to support the continuing need to reduce restrictive practice; including the introduction of body worn cameras, monitoring of restrictive practice within the “reducing restrictive practice forum”. As can be seen in May 2020 the increased point above the expected variance is in line with the increase in previous data relating to Seclusion. Apart from January 2021, targets relating to the numbers of prone restraint have been achieved. Data analysis and review has shown that even where restraint and seclusion has increased, the use of Prone restraint has continued to reduce. This appears to be a result of increased Positive and Proactive Support Training for staff, including the introduction of the “Anywhere But” approached, which uses the introduction of Safety Pods and alternative injection site training to prevent the need for prone restraint.

35. Physical restraint



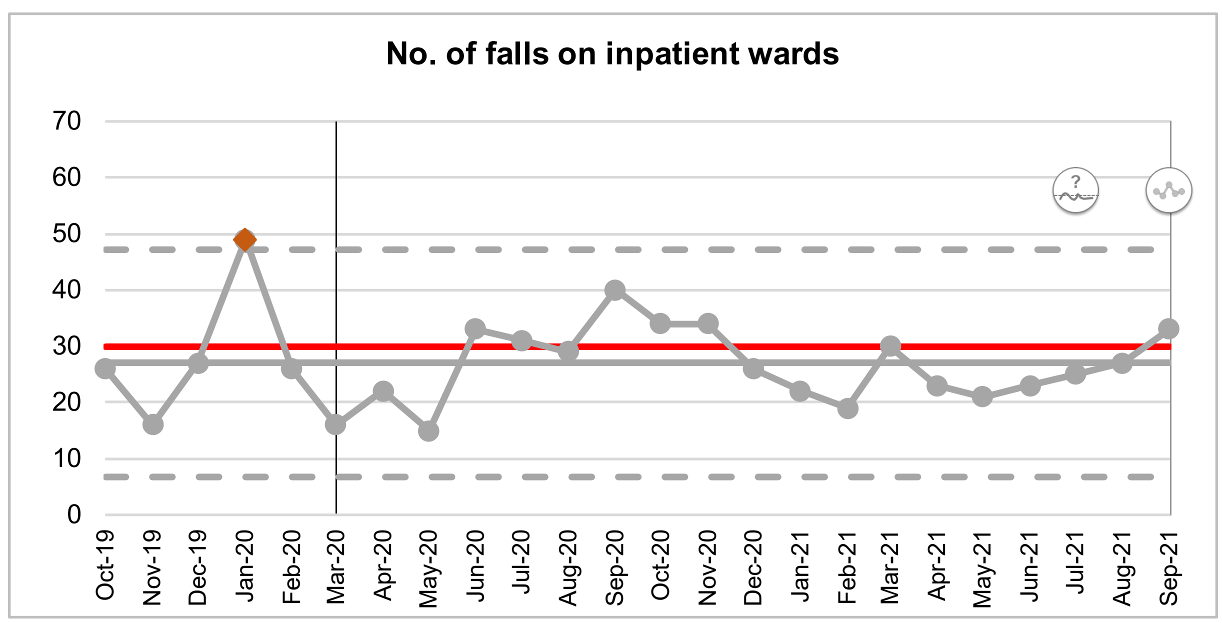
The number of reported incidents involving restraint have remained within common cause variation throughout the reporting period. The recent increase in July, bringing the data above the mean line shows a common variation, however, will continue to be monitored and discussed within appropriate forums. July's increase in physical restraint is linked to the increased use of Seclusion as demonstrated below and is liked to 3 specific patients on the Radbourne unit. A positive to take from this is that although restraint and seclusion have peaked in July, they remain under the upper control limits and has not resulted in an increase in prone restraint. This is a positive indicator that reducing restrictive practice pilots and work streams have been effective to provide alternatives to Prone restraint.

36. Seclusion



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

37. Falls on inpatient wards

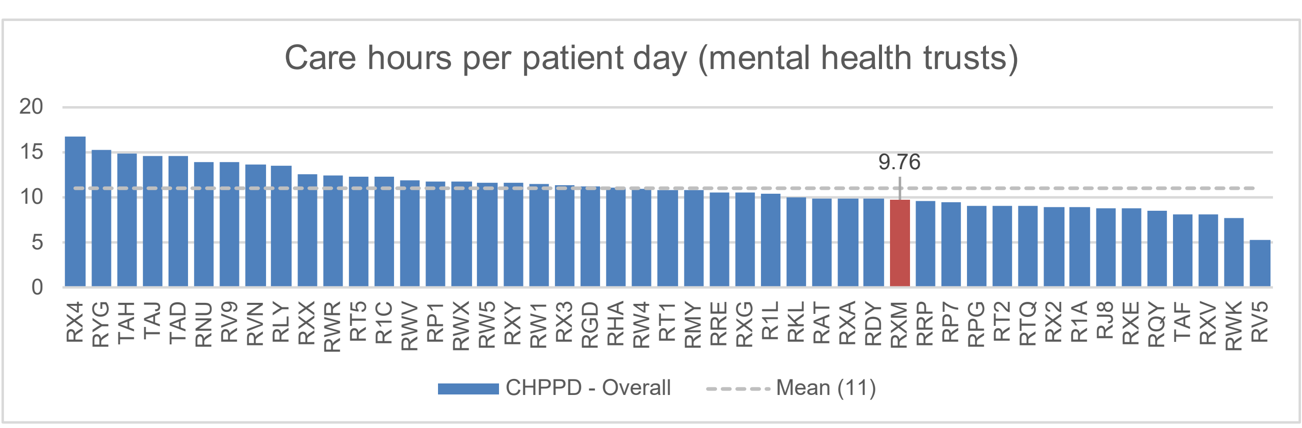


April 2021 to July 2021 has remained below the mean line and demonstrates the effectiveness of ongoing falls reduction work being developed and implemented within Older adult services. However, August and September demonstrate an increased in falls. A further review is required to understand this pattern.

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 chart below shows how we compared in the latest published national data (June 2021) when benchmarked against other mental health trusts. We were below average:

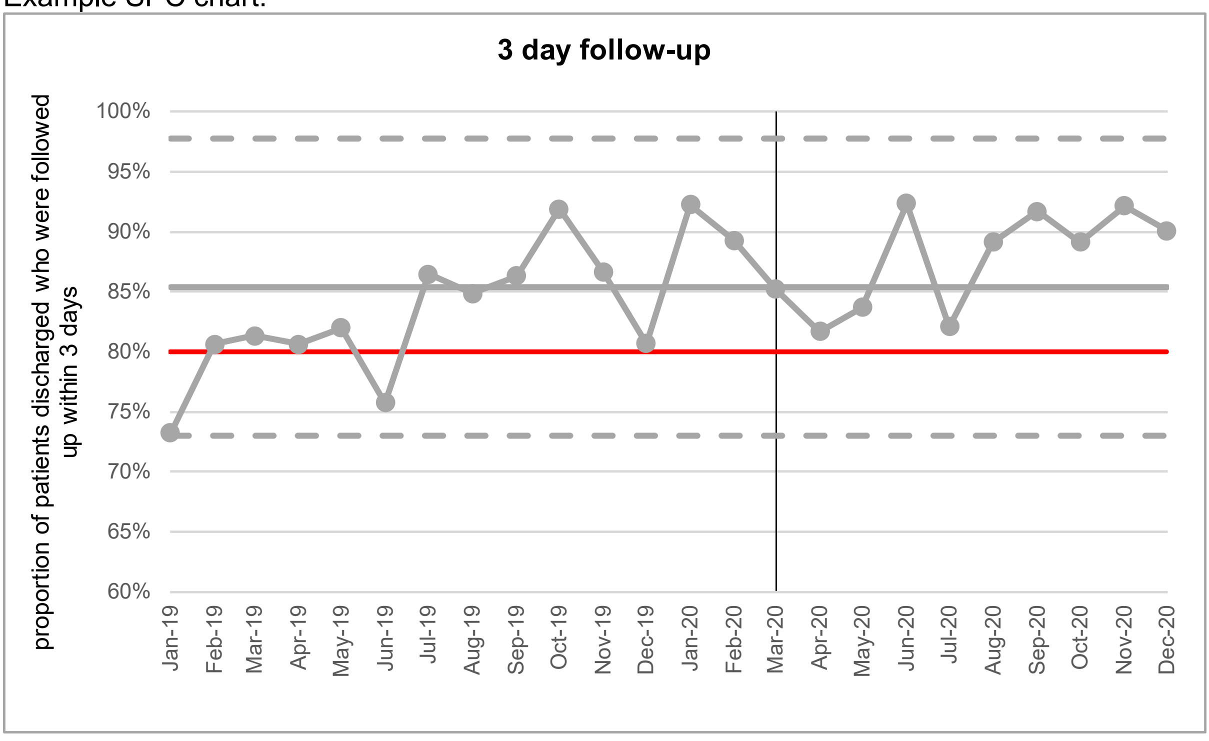


Data source: NHS England » Care hours per patient day (CHPPD) data

Appendix 1

Statistical Process Control Chart (SPC) Guidance

Example SPC chart:



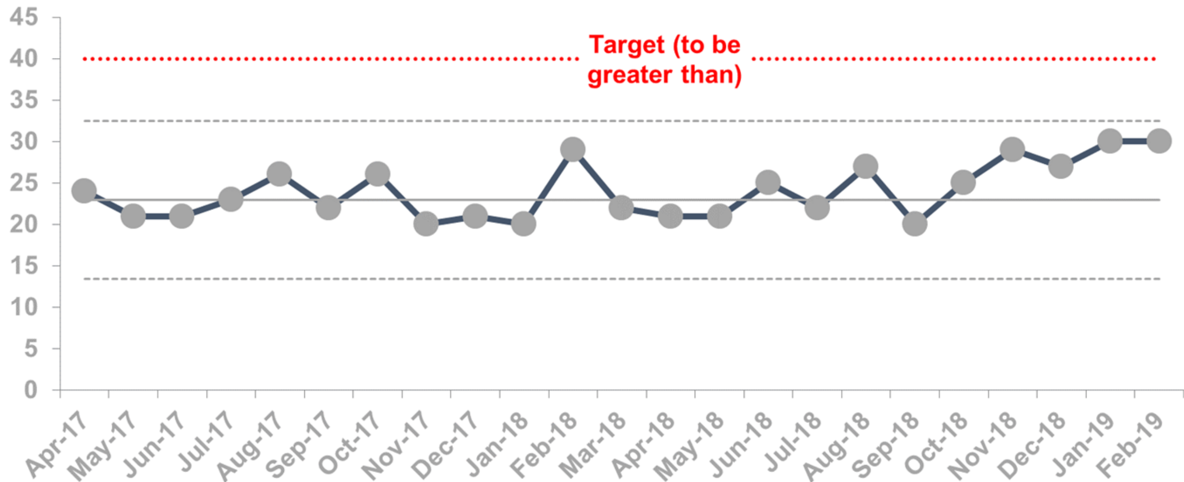
- The red line is the target.
- The grey dots are the actual performance each month. They are coloured grey as performance each month is normal in this example.
- The solid grey line is the average (mean) of all the grey dots.
- The grey dotted lines are called process limits, or control limits.

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

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

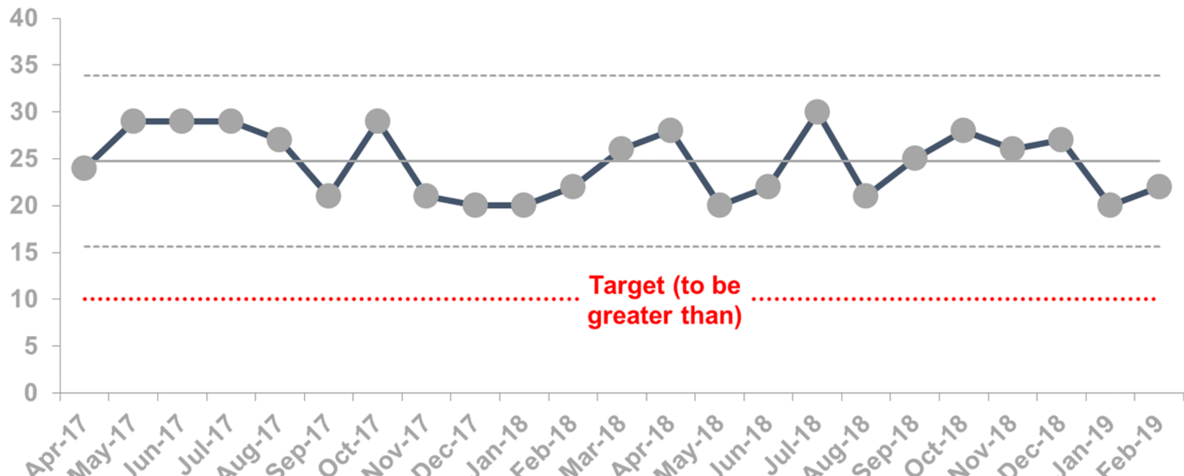
Things to look out for:

1. A process that is not working



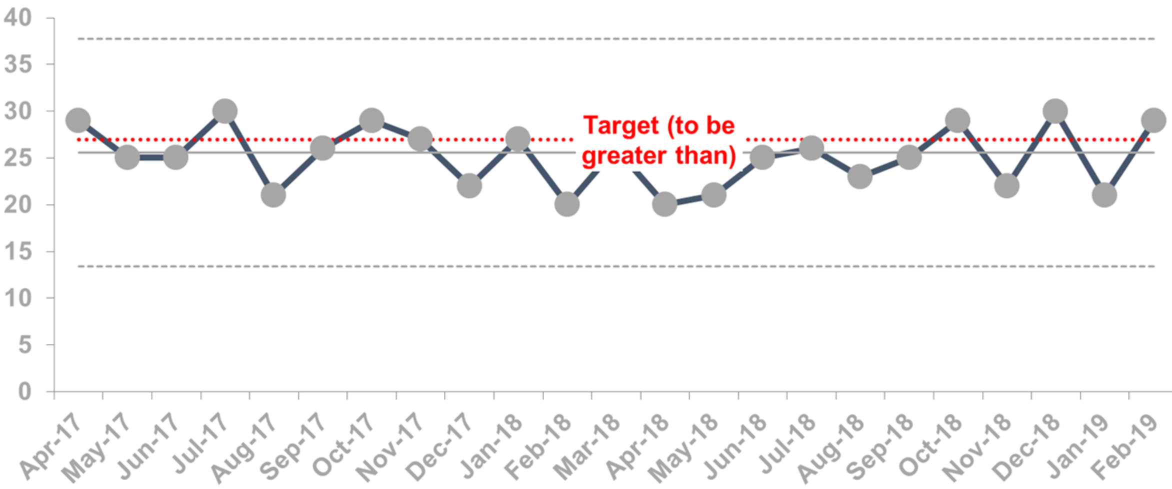
In this example the target is higher than the upper dotted grey line. This means that the target will never be achieved. To achieve the target, we need to change how we do things.

2. A capable process



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

3. An unreliable system

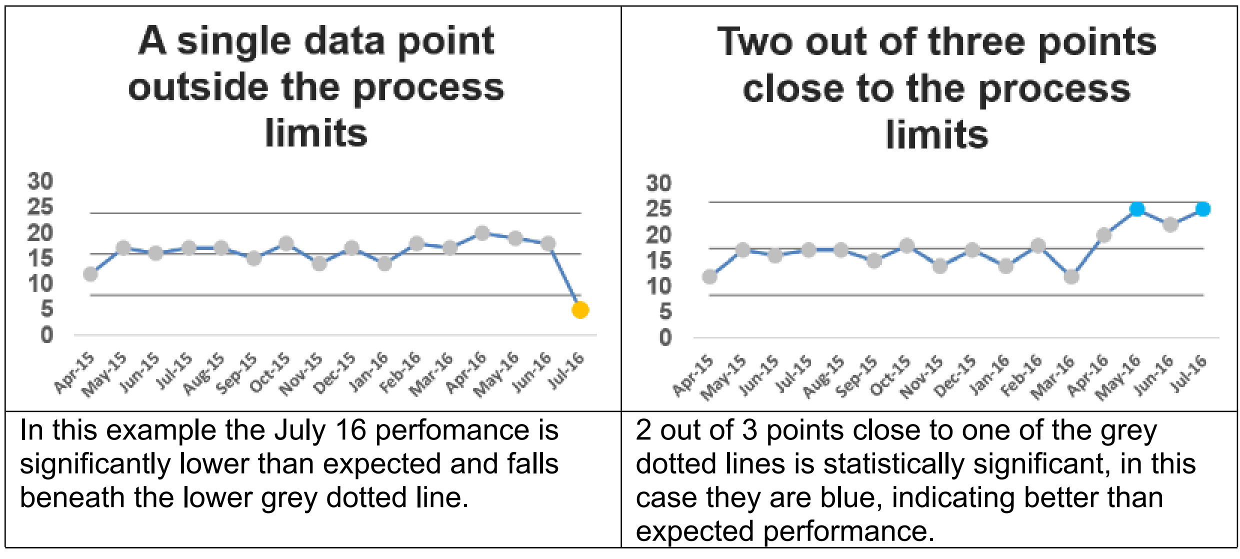


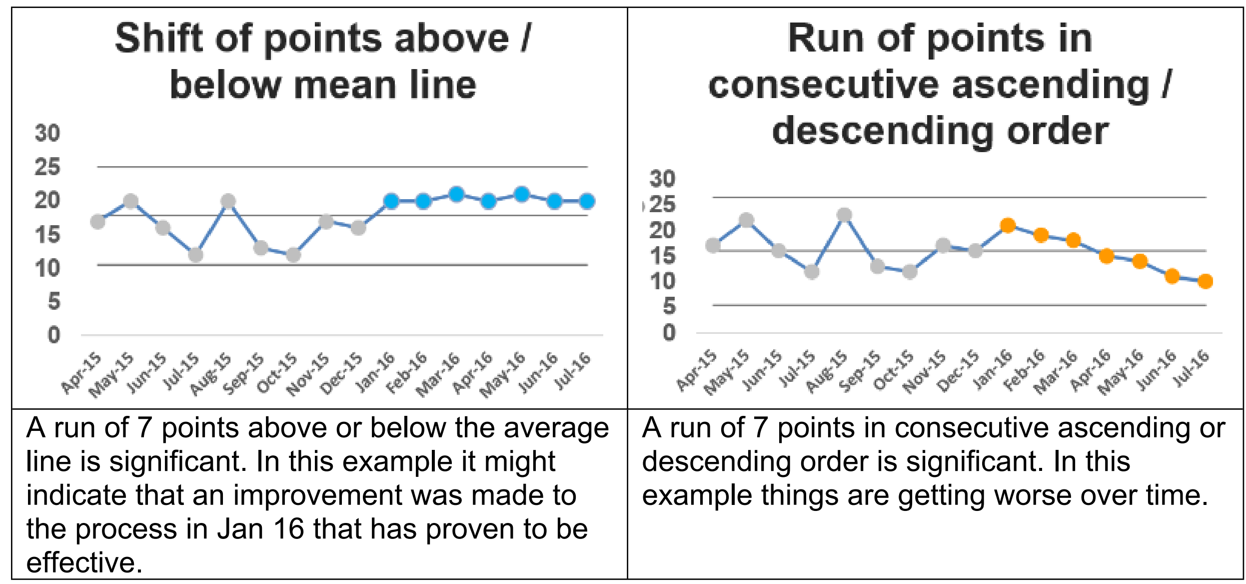
In this example the target line sits between the 2 grey dotted lines. As it is normal for the grey dots to fall anywhere between the 2 dotted grey lines, this means that it is entirely random as to whether or not the target will be achieved. So, this system is unreliable and needs to be redesigned if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

4. Unusual patterns in the data

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

There are four scenarios where this can happen:





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

Appendix 2 – Data Quality Maturity Index Benchmarking Data

	Jun-21	May-21	Apr-21	Mar-21	Feb-21
National Average	81.9	82.7	81.9	83.0	85.3
ROYAL PAPWORTH HOSPITAL NHS FOUNDATION TRUST	99.3	97.2	97.2	97.2	97.0
THE ROYAL MARSDEN NHS FOUNDATION TRUST	99.3	99.4	99.4	99.4	99.4
THE ROBERT JONES AND AGNES HUNT ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST	99.2	99.1	99.1	99.2	99.1
LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST	99.1	99.2	99.2	99.2	99.2
THE CHRISTIE NHS FOUNDATION TRUST	98.5	98.9	98.9	99.0	98.8
GREATER MANCHESTER MENTAL HEALTH NHS FOUNDATION TRUST	98.3	98.1	98.1	97.5	97.3
BIRMINGHAM AND SOLIHULL MENTAL HEALTH NHS FOUNDATION TRUST	98.2	97.8	97.3	98.6	98.6
TEES, ESK AND WEAR VALLEYS NHS FOUNDATION TRUST	98.1	98.1	98.3	98.3	98.1
NORTH STAFFORDSHIRE COMBINED HEALTHCARE NHS TRUST	97.9	97.9	97.9	98.1	98.0
NORFOLK AND NORWICH UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	97.3	97.8	97.9	96.9	96.1
ROYAL NATIONAL ORTHOPAEDIC HOSPITAL NHS TRUST	97.3	97.4	96.4	97.1	96.6
NORTHUMBRIA HEALTHCARE NHS FOUNDATION TRUST	97.1	97.3	97.3	97.2	97.3
LONDON NORTH WEST UNIVERSITY HEALTHCARE NHS TRUST	96.8	96.8	97.3	97.3	97.2
THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST	96.8	97.0	97.9	98.0	97.7
BARNET, ENFIELD AND HARINGEY MENTAL HEALTH NHS TRUST	96.7	96.4	95.5	96.4	96.4
CAMBRIDGESHIRE AND PETERBOROUGH NHS FOUNDATION TRUST	96.7	97.3	97.5	97.5	97.4
NOTTINGHAMSHIRE HEALTHCARE NHS FOUNDATION TRUST	96.4	96.4	96.1	96.8	96.5
TAVISTOCK AND PORTMAN NHS FOUNDATION TRUST	96.4	95.9	96.4	96.4	96.2
WESTERN SUSSEX HOSPITALS NHS FOUNDATION TRUST	96.3	96.4	95.8	96.0	96.0
DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST	96.2	96.5	96.5	96.6	96.4
OXFORD UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	96.2	96.6	96.6	96.5	96.4
IMPERIAL COLLEGE HEALTHCARE NHS TRUST	96.1	95.3	94.7	94.7	94.6
KENT AND MEDWAY NHS AND SOCIAL CARE PARTNERSHIP TRUST	96.1	96.1	95.9	95.8	95.8
UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST	96.1	96.6	96.5	96.0	96.0
ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST	96.0	96.0	96.1	95.8	96.3
STOCKPORT NHS FOUNDATION TRUST	95.9	96.5	96.5	96.5	96.4
KINGSTON HOSPITAL NHS FOUNDATION TRUST	95.7	96.5	96.3	96.4	95.8
LINCOLNSHIRE PARTNERSHIP NHS FOUNDATION TRUST	95.6	95.4	95.5	95.5	95.6
CAMDEN AND ISLINGTON NHS FOUNDATION TRUST	95.5	95.7	95.0	94.8	95.2
NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST	95.5	96.0	95.7	96.2	95.1
KETTERING GENERAL HOSPITAL NHS FOUNDATION TRUST	95.4	93.7	93.7	93.4	93.1
NORFOLK AND SUFFOLK NHS FOUNDATION TRUST	95.3	95.4	95.4	95.5	95.2
SOUTH WEST LONDON AND ST GEORGE'S MENTAL HEALTH NHS TRUST	95.3	92.5	93.0	92.3	92.7
HERTFORDSHIRE PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST	95.2	93.7	94.9	97.0	97.1
SHEFFIELD CHILDREN'S NHS FOUNDATION TRUST	95.1	94.4	94.3	94.2	94.3
THE QUEEN ELIZABETH HOSPITAL, KING'S LYNN, NHS FOUNDATION TRUST	95.1	95.6	95.8	95.7	95.7
SHREWSBURY AND TELFORD HOSPITAL NHS TRUST	95.0	93.9	93.9	95.0	94.9
SOMERSET PARTNERSHIP NHS FOUNDATION TRUST	94.9	95.2	95.3	95.4	94.7
SOUTH LONDON AND MAUDSLEY NHS FOUNDATION TRUST	94.9	93.9	93.7	93.3	93.6
UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST	94.8	95.6	95.4	95.3	95.1
NORFOLK COMMUNITY HEALTH AND CARE NHS TRUST	94.7	94.9	93.5	93.9	92.4
SOUTH WEST YORKSHIRE PARTNERSHIP NHS FOUNDATION TRUST	94.7	94.9	95.2	95.1	95.4
WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	94.6	95.0	95.1	94.8	94.6
ROYAL CORNWALL HOSPITALS NHS TRUST	94.5	95.4	95.3	96.3	96.4
SALISBURY NHS FOUNDATION TRUST	94.5	94.2	94.3	94.3	94.3
BRADFORD TEACHING HOSPITALS NHS FOUNDATION TRUST	94.3	94.1	93.9	94.0	94.0
CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST	94.3	94.9	94.6	94.7	94.5
UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST	94.3	94.0	93.9	93.7	93.6
FRIMLEY HEALTH NHS FOUNDATION TRUST	94.2	93.7	91.9	91.9	91.5
SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST	94.2	95.5	95.5	94.1	94.1
WORCESTERSHIRE HEALTH AND CARE NHS TRUST	94.2	94.2	94.6	94.4	94.4
EAST LONDON NHS FOUNDATION TRUST	94.1	91.5	91.7	91.7	93.2
ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST	94.0	93.9	94.0	93.7	93.2
NORTHERN LINCOLNSHIRE AND GOOLE NHS FOUNDATION TRUST	94.0	94.0	93.9	93.9	93.9
BARNSLEY HOSPITAL NHS FOUNDATION TRUST	93.8	95.0	93.4	94.3	92.9
CHELSEA AND WESTMINSTER HOSPITAL NHS FOUNDATION TRUST	93.8	94.9	94.3	96.7	96.5
UNIVERSITY HOSPITAL SOUTHAMPTON NHS FOUNDATION TRUST	93.8	93.9	94.0	94.0	94.0
HARROGATE AND DISTRICT NHS FOUNDATION TRUST	93.7	93.7	93.8	93.7	93.7
LEEDS TEACHING HOSPITALS NHS TRUST	93.7	93.3	93.3	93.2	93.1
MIDLANDS PARTNERSHIP NHS FOUNDATION TRUST	93.7	93.8	94.3	94.4	94.3
NORTH TEES AND HARTLEPOOL NHS FOUNDATION TRUST	93.7	94.4	94.2	94.7	71.6
PORTSMOUTH HOSPITALS NHS TRUST	93.7	93.0	92.3	92.9	93.8
CUMBRIA, NORTHUMBERLAND, TYNE AND WEAR NHS FOUNDATION TRUST	93.6	93.7	93.9	93.7	93.8
SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	93.6	93.3	93.4	93.3	93.4
LUTON AND DUNSTABLE UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	93.5	93.3	92.0	93.5	93.4
MID YORKSHIRE HOSPITALS NHS TRUST	93.5	92.3	92.3	93.1	93.1
MOORFIELDS EYE HOSPITAL NHS FOUNDATION TRUST	93.5	94.6	93.9	93.5	92.9
DONCASTER AND BASSETLAW TEACHING HOSPITALS NHS FOUNDATION TRUST	93.4	93.4	93.3	93.4	93.4
THE DUDLEY GROUP NHS FOUNDATION TRUST	93.4	93.4	93.3	92.5	94.3
BRADFORD DISTRICT CARE NHS FOUNDATION TRUST	93.3	93.1	93.3	93.2	93.2
SOUTH TEES HOSPITALS NHS FOUNDATION TRUST	93.3	93.1	93.0	93.1	92.9
UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST	93.3	93.4	93.3	18.7	18.0
WEST LONDON NHS TRUST	93.3	95.1	94.9	95.1	94.5

National Average	Jun -21	May -21	Apr -21	Mar -21	Feb -21
	81.9	82.7	81.9	83.0	85.3
THE HILLINGDON HOSPITALS NHS FOUNDATION TRUST	93.2	93.3	93.2	93.1	93.3
THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST	93.2	94.0	93.9	93.8	93.8
SURREY AND SUSSEX HEALTHCARE NHS TRUST	93.1	94.1	94.3	93.1	92.9
WARRINGTON AND HALTON TEACHING HOSPITALS NHS FOUNDATION TRUST	93.1	55.0	94.4	94.6	94.8
KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST	93.0	93.9	93.8	93.7	93.8
THE ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST	93.0	94.6	94.5	94.4	94.4
AVON AND WILTSHIRE MENTAL HEALTH PARTNERSHIP NHS TRUST	92.9	92.8	92.8	92.8	93.0
ROYAL BERKSHIRE NHS FOUNDATION TRUST	92.9	93.3	93.4	93.7	94.1
BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST	92.7	91.6	91.6	91.5	91.1
LEEDS COMMUNITY HEALTHCARE NHS TRUST	92.7	58.8	53.4	94.3	94.2
HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST	92.6	93.6	93.5	92.9	92.7
YORK TEACHING HOSPITAL NHS FOUNDATION TRUST	92.6	93.8	93.8	93.8	93.8
BIRMINGHAM WOMEN'S AND CHILDREN'S NHS FOUNDATION TRUST	92.5	90.7	89.0	90.0	92.5
BUCKINGHAMSHIRE HEALTHCARE NHS TRUST	92.4	93.3	93.3	93.5	93.4
PENNINE CARE NHS FOUNDATION TRUST	92.4	92.4	92.2	92.2	92.1
THE WALTON CENTRE NHS FOUNDATION TRUST	92.4	94.1	94.1	94.1	95.8
LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST	92.2	92.5	92.0	93.1	93.1
MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	92.2	93.3	93.0	93.2	92.8
ROYAL UNITED HOSPITALS BATH NHS FOUNDATION TRUST	92.2	93.4	93.2	93.1	92.9
AIREDALE NHS FOUNDATION TRUST	92.1	92.8	70.2	70.3	92.1
BARTS HEALTH NHS TRUST	92.1	93.1	92.9	69.5	91.7
ST GEORGE'S UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	92.1	89.6	89.7	89.9	90.0
ST HELENS AND KNOWSLEY TEACHING HOSPITALS NHS TRUST	92.1	92.2	92.2	91.1	90.9
LEICESTERSHIRE PARTNERSHIP NHS TRUST	92.0	91.4	91.5	91.4	91.3
NORTHAMPTON GENERAL HOSPITAL NHS TRUST	92.0	92.1	91.5	91.5	91.4
SURREY AND BORDERS PARTNERSHIP NHS FOUNDATION TRUST	92.0	96.2	97.3	92.3	93.9
CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	91.9	91.9	91.9	90.8	91.0
NORTHAMPTONSHIRE HEALTHCARE NHS FOUNDATION TRUST	91.8	91.9	36.5	91.5	92.8
OXLEAS NHS FOUNDATION TRUST	91.8	92.5	91.5	91.7	91.4
GEORGE ELIOT HOSPITAL NHS TRUST	91.7	93.4	92.4	92.0	90.8
GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST	91.6	92.5	67.3	92.5	92.8
UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST	91.6	91.2	91.1	90.6	90.9
PENNINE ACUTE HOSPITALS NHS TRUST	91.5	67.7	44.6	67.8	93.7
SOLENT NHS TRUST	91.4	90.1	90.4	91.5	91.4
UNIVERSITY HOSPITALS OF NORTH MIDLANDS NHS TRUST	91.4	92.6	92.7	92.7	92.6
EAST AND NORTH HERTFORDSHIRE NHS TRUST	91.3	92.5	92.6	92.7	92.6
THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST	91.3	90.5	90.5	90.7	90.7
CENTRAL AND NORTH WEST LONDON NHS FOUNDATION TRUST	91.2	93.2	92.0	93.4	68.0
WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST	91.2	92.4	92.5	92.8	92.7
BARKING, HAVERING AND REDBRIDGE UNIVERSITY HOSPITALS NHS TRUST	91.1	92.3	91.8	92.2	92.2
GATESHEAD HEALTH NHS FOUNDATION TRUST	91.1	91.4	91.7	91.7	91.7
LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	91.1	90.7	89.0	87.6	87.6
WEST HERTFORDSHIRE HOSPITALS NHS TRUST	91.1	92.4	92.6	93.7	93.7
HOMERTON UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	91.0	90.5	90.4	91.4	91.8
JAMES PAGET UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	91.0	91.9	91.9	92.0	91.3
ISLE OF WIGHT NHS TRUST	90.9	91.4	90.7	92.3	92.6
LANCASHIRE & SOUTH CUMBRIA NHS FOUNDATION TRUST	90.9	90.8	91.1	90.0	92.2
MILTON KEYNES UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	90.9	91.0	91.4	94.0	93.8
SUSSEX PARTNERSHIP NHS FOUNDATION TRUST	90.9	95.4	94.3	94.3	95.3
BLACK COUNTRY PARTNERSHIP NHS FOUNDATION TRUST	90.8	88.3	90.2	89.9	89.9
WEST SUFFOLK NHS FOUNDATION TRUST	90.7	91.5	91.6	91.6	91.6
HAMPSHIRE HOSPITALS NHS FOUNDATION TRUST	90.6	92.2	92.2	92.4	92.3
SHROPSHIRE COMMUNITY HEALTH NHS TRUST	90.5	84.6	88.0	84.7	83.8
SOUTHEND UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	90.5	91.9	91.7	91.7	91.7
YEOVIL DISTRICT HOSPITAL NHS FOUNDATION TRUST	90.5	89.5	89.6	89.5	89.2
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	90.4	91.0	91.2	91.2	91.3
CORNWALL PARTNERSHIP NHS FOUNDATION TRUST	90.3	90.2	89.9	89.2	89.7
UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST	90.3	91.1	91.2	91.3	91.2
DORSET COUNTY HOSPITAL NHS FOUNDATION TRUST	90.2	90.5	90.8	90.0	90.4
EAST SUFFOLK AND NORTH ESSEX NHS FOUNDATION TRUST	90.2	90.4	90.1	90.2	89.9
WYE VALLEY NHS TRUST	90.2	90.9	88.9	88.9	88.9
CHESTERFIELD ROYAL HOSPITAL NHS FOUNDATION TRUST	90.1	90.4	90.4	90.1	89.4
LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST	90.0	89.4	89.6	89.7	89.7
EAST SUSSEX HEALTHCARE NHS TRUST	89.7	89.8	89.8	90.1	90.1
LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	89.7	84.7	81.0	81.3	82.3
GLOUCESTERSHIRE HEALTH AND CARE NHS FOUNDATION TRUST	89.6	94.5	94.3	94.3	94.3
NORTH MIDDLESEX UNIVERSITY HOSPITAL NHS TRUST	89.5	90.9	91.1	90.1	91.1
NORTHERN DEVON HEALTHCARE NHS TRUST	89.5	88.7	88.3	88.2	87.9
SOUTH WARWICKSHIRE NHS FOUNDATION TRUST	89.5	90.9	90.7	90.6	90.7
COUNTY DURHAM AND DARLINGTON NHS FOUNDATION TRUST	89.4	89.8	91.1	91.0	90.9
SOUTH TYNESIDE AND SUNDERLAND NHS FOUNDATION TRUST	89.3	90.6	92.6	90.7	90.7
NORTH WEST ANGLIA NHS FOUNDATION TRUST	89.2	89.9	90.1	93.2	93.4
SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST	89.1	89.3	89.2	91.1	88.0
THE ROTHERHAM NHS FOUNDATION TRUST	89.1	67.6	67.5	67.6	67.5
SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST	89.0	90.5	90.4	90.1	90.0
DEVON PARTNERSHIP NHS TRUST	88.9	88.9	88.9	89.1	89.4
EAST LANCASHIRE HOSPITALS NHS TRUST	88.9	90.4	88.8	48.2	88.8

National Average	Jun -21	May -21	Apr -21	Mar -21	Feb -21
	81.9	82.7	81.9	83.0	85.3
SHEFFIELD HEALTH & SOCIAL CARE NHS FOUNDATION TRUST	88.9	89.1	89.4	89.7	89.2
LEWISHAM AND GREENWICH NHS TRUST	88.8	90.2	90.3	90.4	90.5
LINCOLNSHIRE COMMUNITY HEALTH SERVICES NHS TRUST	88.7	88.5	88.5	88.3	87.3
TAMESIDE AND GLOSSOP INTEGRATED CARE NHS FOUNDATION TRUST	88.7	90.2	90.1	90.3	90.4
GREAT WESTERN HOSPITALS NHS FOUNDATION TRUST	88.6	90.0	90.3	90.2	90.5
TORBAY AND SOUTH DEVON NHS FOUNDATION TRUST	88.6	88.3	88.1	88.3	88.2
WALSALL HEALTHCARE NHS TRUST	88.5	89.9	89.9	92.4	92.3
UNIVERSITY HOSPITALS PLYMOUTH NHS TRUST	88.4	89.9	89.9	91.4	91.3
DARTFORD AND GRAVESHAM NHS TRUST	88.3	89.4	89.2	89.2	89.2
ROYAL FREE LONDON NHS FOUNDATION TRUST	88.3	89.6	89.9	89.6	89.9
SOUTHERN HEALTH NHS FOUNDATION TRUST	88.2	87.4	88.7	88.5	88.2
THE ROYAL WOLVERHAMPTON NHS TRUST	88.2	89.6	89.2	89.7	90.2
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	88.1	89.3	89.3	89.1	88.3
UNITED LINCOLNSHIRE HOSPITALS NHS TRUST	88.1	88.8	88.8	88.7	88.7
DORSET HEALTHCARE UNIVERSITY NHS FOUNDATION TRUST	87.9	90.1	90.1	89.9	88.1
CHESHIRE AND WIRRAL PARTNERSHIP NHS FOUNDATION TRUST	87.8	87.8	88.0	88.6	88.8
ROYAL DEVON AND EXETER NHS FOUNDATION TRUST	87.8	88.4	86.8	86.6	85.8
WHITTINGTON HEALTH NHS TRUST	87.7	85.0	88.0	88.3	88.1
UNIVERSITY HOSPITALS OF DERBY AND BURTON NHS FOUNDATION TRUST	87.6	88.6	88.3	88.0	87.3
DERBYSHIRE COMMUNITY HEALTH SERVICES NHS FOUNDATION TRUST	87.2	87.8	87.1	87.3	87.1
EAST CHESHIRE NHS TRUST	86.9	88.6	88.7	88.5	88.5
GREAT ORMOND STREET HOSPITAL FOR CHILDREN NHS FOUNDATION TRUST	86.9	88.4	89.2	88.7	88.8
GUY'S AND ST THOMAS' NHS FOUNDATION TRUST	86.9	85.2	85.9	86.3	85.7
WESTON AREA HEALTH NHS TRUST	86.4	90.8	90.0	87.5	87.3
EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST	86.2	87.7	87.7	61.9	62.8
HOUNSLOW AND RICHMOND COMMUNITY HEALTHCARE NHS TRUST	86.0	82.1	85.6	86.4	82.1
NORTH CUMBRIA INTEGRATED CARE NHS FOUNDATION TRUST	86.0	87.1	87.5	87.3	88.8
COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	85.7	87.6	87.7	87.7	87.7
CENTRAL LONDON COMMUNITY HEALTHCARE NHS TRUST	85.6	85.6	83.7	79.2	79.3
BRIDGEWATER COMMUNITY HEALTHCARE NHS FOUNDATION TRUST	85.5	85.7	85.1	85.2	84.5
CROYDON HEALTH SERVICES NHS TRUST	85.5	85.4	84.9	85.1	84.8
MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST	85.3	89.7	89.9	90.8	90.8
NORTH EAST LONDON NHS FOUNDATION TRUST	85.2	85.0	84.8	85.3	84.8
COVENTRY AND WARWICKSHIRE PARTNERSHIP NHS TRUST	84.8	84.7	83.7	84.0	84.2
SUSSEX COMMUNITY NHS FOUNDATION TRUST	84.7	84.1	84.0	83.9	83.8
NORTH BRISTOL NHS TRUST	84.2	92.9	92.0	92.0	91.8
UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST	83.9	85.9	61.4	86.0	86.0
KENT COMMUNITY HEALTH NHS FOUNDATION TRUST	83.5	83.8	84.9	83.5	83.1
WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST	83.5	85.2	84.8	84.9	84.5
EPSOM AND ST HELIER UNIVERSITY HOSPITALS NHS TRUST	83.3	84.2	84.2	84.8	84.7
MEDWAY NHS FOUNDATION TRUST	83.2	84.5	89.5	84.7	85.7
OXFORD HEALTH NHS FOUNDATION TRUST	82.4	82.4	81.9	82.4	82.8
BOLTON NHS FOUNDATION TRUST	82.1	83.4	83.5	83.4	83.3
BIRMINGHAM COMMUNITY HEALTHCARE NHS FOUNDATION TRUST	82.0	83.4	84.7	56.3	55.3
ROYAL SURREY COUNTY HOSPITAL NHS FOUNDATION TRUST	81.3	85.0	85.2	83.9	83.7
QUEEN VICTORIA HOSPITAL NHS FOUNDATION TRUST	75.5	77.5	77.6	77.7	77.5
SALFORD ROYAL NHS FOUNDATION TRUST	66.9	91.0	91.3	91.3	90.7
BRIGHTON AND SUSSEX UNIVERSITY HOSPITALS NHS TRUST	62.7	77.9	77.9	94.0	93.5
MERSEY CARE NHS FOUNDATION TRUST	50.6	50.8	51.3	51.4	92.9
BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST	50.1	49.9	50.7	51.2	77.3
HUMBER TEACHING NHS FOUNDATION TRUST	46.2	93.8	67.8	93.4	93.2
ASHFORD AND ST PETER'S HOSPITALS NHS FOUNDATION TRUST	40.8	45.6	45.9	88.5	88.6
CAMBRIDGESHIRE COMMUNITY SERVICES NHS TRUST	39.4	39.5	39.6	39.6	13.9
HERTFORDSHIRE COMMUNITY NHS TRUST	23.4	23.4	23.4	23.4	54.4
WIRRAL COMMUNITY HEALTH AND CARE NHS FOUNDATION TRUST	6.4	6.3	6.3	6.3	82.2
DUDLEY AND WALSALL MENTAL HEALTH PARTNERSHIP NHS TRUST	5.6	5.6	4.8	5.7	5.8
NORTH WEST BOROUGHS HEALTHCARE NHS FOUNDATION TRUST	0.0	48.6	48.4	48.4	88.9
POOLE HOSPITAL NHS FOUNDATION TRUST	0.0	7.0	7.0	76.2	76.4
ROYAL BROMPTON & HAREFIELD NHS FOUNDATION TRUST	0.0	0.0	0.0	43.1	43.1
SOUTH WESTERN AMBULANCE SERVICE NHS FOUNDATION TRUST	0.0	0.0	0.0	0.0	-
THE ROYAL BOURNEMOUTH AND CHRISTCHURCH HOSPITALS NHS FOUNDATION TRUST	0.0	6.8	6.8	77.0	77.3

Data source: Data quality - NHS Digital

Appendix 3

Transforming Care Programme Performance Update Quarter 3 2021/22

Q3 2021/22 Current Bed Position:

Bed Type	Number of beds	End of Q3Trajectory	+/- against Q3 Trajectory
CCG	32	**21**	**+11**
Adult Spec Comm	18	**15**	**+3**
CYP Spec Comm	3	**3**	**On target**

Admission Avoidance

In the previous week there were:	Number on Adult DSR	Number undertaken	Admissions avoided	Number of admissions progressed	Comments
EMDT	4	4	4	0	
LAEP	1	1	1	0	
CCTR	1	1	1	0	
CETR	0	0	0	0	

Proactive admission avoidance work undertaken this week for **6** individuals, **non** of these resulted in an admission to a hospital bed.

In the previous week there were:	Admissions	Discharges
	1	**2**

Admissions									
Patient	**Admission date**	**Bed type**	**LD, LD/ASD or Autism only**	**On DSR**	**EMDTs CCTRs Dates**	**LAEP**	**MHA section (if relevant)**	**AT EDD**	**Comments**
A	05/10/21	AMH	Autism	Yes	-	23/09/21	S3	Q4	On inactive section of DSR. Not asked to be put back on Active list by MDT

Discharges								
Patient	**Discharge date**	**Bed type**	**LD, LD/ASD or Autism only**	**EDD Quarter**	**Conf level**	**Discharge destination**	**On DSR**	**Comments**
B	12/10/21	AMH	LD & Autism	Q3	Medium	Home	Yes	
C		Spec Comm	-	Q4	Medium	Home		Does not have a confirmed diagnosis

Inpatients

	Number of inpatients 18/10/21	Trajectory End of Quarter 3 2021/22	Current +/- Against End of Q3Traj	Forecast Best case End of Quarter 3	Forecast Most Likely End of Quarter 3	Forecast Worst case End of Quarter 3
CCG	32	21	**+11**	**17**	**22**	**31**
Adult Spec Comm	18	15	**+3**	**14**	**14**	**18**
Total Adults	**50**	**36**	**+14**	**31**	**36**	**49**

CYP Spec Comm	**3**	**3**	0	**3**	**3**	**3**

Forecasting

CCG patients
- Position at 31 March 2021 was **30** CCG inpatients
- Position at **18 October 2021** is **32** CCG inpatients
- **The forecast is 22 inpatients by the end of Quarter 3**

Adult Specialist Commissioning (SC)
- Position at 31 March 2021 was **19** Adult (SC) inpatients
- Position at **18 October 2021** is **18** Adult (SC) inpatients
- **The forecast is 14 inpatients by the end of Quarter 3**

Children Specialist Commissioning (SC)
- Position at 31 March 2021 was **3** Children SC inpatients
- Position at **18 October 2021** is **3** Children SC inpatients
- **The forecast is 3 inpatients by the end of Quarter 3**

Quarter 3 Planned Discharges and Confidence Levels

Toal CCG Cohort	Patients in Active treatment	Ready but delayed	Number delayed due to Covid	Reason for delay	Due to go by the end of Quarter 3
32	30	2	0	2 Accommodation	**15**

15 Patients due to be discharged by end Q3:

1 = High
9 = Medium
5 = Low

Winterbourne Cohort Update

Current position

Type of hospital	Number as of 11/10/21	Number of admissions	Planned Discharges this week	Actual discharges this week	Number as of 18/10/21
Locked Rehab	**18**	**0**	**0**	**0**	**18**
ATU	**4**	**0**	**0**	**0**	**4**
PICU	**2**	**0**	**0**	**0**	**1***

* Readjustment following deep dive

AMH Update

Current position

	Number as of 11/10/21	Number of admissions	Planned Discharges this week	Actual discharges this week	Number as of 18/10/21
Acute mental health hospitals	**8**	**1**	**1**	**1**	**9***

* Readjustment following deep dive

Diagnosis

9 patients in acute mental health wards requiring active treatment for mental illness:
5 patients with autism only
2 patients LD only
2 patients with LD and Autism

Accumulative Admissions/Discharges for Q3

	Admissions	Discharges
AMH	**2**	**2**
Locked Rehab	**0**	**0**
PICU	**0**	**0**
ATU	**0**	**0**
Spec Comm	**0**	**1**
CYP	**0**	**0**

LeDeR (Monthly Update)

As at 13 October 2021	
Total notifications received	**253**
Current reviews in progress	**17**
Complete and quality assured but waiting to be submitted	**0**
Complete and waiting for quality assurance	**2**
Current reviews not yet assigned to reviewer	**5**

Total reviews completed	224
Reviews on hold	5

LD Annual Health Checks (AHC)

Total Health checks carried out Q1-Q4 2020/21	4507
Percentage completed against LD register	78%
Total number on LD Register	5780

Totals: reported quarterly for 2021-2022						
	Apr-21	May-21	Jun-21	Total Q1 (April to June 21)	Jul-21	Aug-21
Health Checks carried out	184	163	191	538	235	198
Number of health checks declined	5	13	3	21	10	2
Number of DNAs	23	27	19	69	28	30

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 2 November 2021

Month 7-12 (H2) Financial Plan

Purpose of Report

To review and approve the current draft plan for month 7-12 (H2) of 2021/22 and to agree the method for the Trust Board's final sign off.

Executive Summary

The planning guidance was issued on 29th September by NHSE and requires a system submission and individual Provider plan submission by 16 November.

In line with the guidance the system has been allocated funding to cover H2 including inflationary uplift (including for the pay award), system top ups and Covid allocations.

Due to the timing of writing this report the current financial plan is draft and requires further refinement as the overall system financial position and assumptions are reviewed by Finance Directors.

The draft plan is based on an agreed block income allocation from the CCG. Other non-CCG income and expenditure included within the plan is based on the forecast position at month 6. No further efficiencies have yet been assumed above the previous 2.1% that was previously planned for H2.

The aggregate result of those assumptions generates a current draft deficit at year end of £1.8m. This deficit is being driven by the shortfall in funding for new investments, mainly CMHF and CAMHS Crisis, a shortfall in the pay award along with internal cost pressures which is partially offset by the benefit of the nominal Covid allocation being higher than the forecast costs.

During the calculation of this draft plan we have been notified of additional seasonal and discharge funding for Joined Up Care Derbyshire for mental health provision, which has not yet been incorporated.

Further discussions are to be had with the CCG related to the funding of new investments that have been included in the plan. We also need to agree with the CCG the treatment of any further investments to align plans from both provider and commissioner perspectives.

The Finance Directors are reviewing the overall system position and will be discussing next steps to bring the system and Providers in line with a breakeven position individually and in aggregate. This is likely to include an expectation of increased efficiency delivery.

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

Assurances

- This report should be considered in relation to the 2021/22 Board Assurance Framework.

Consultation

- Deputy Finance Directors have discussed the principles related to the CCG income allocations
- The expenditure plan is based on the forecast outturn at month 6 which has been reported to Executive Leadership Team
- Consultation will continue in the Joined Up Care Derbyshire system, as outlined in the document.

Governance or Legal Issues

- The draft plan has been informed by the planning guidance issued by NHSE and the system allocations calculated by NHSE.

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 financial plan for H2 of 2021/22 is currently draft and based on a set of assumptions contained within the month 6 forecast and does pick up on some specific protected characteristics. There are some requests for new internal investment which are included in the forecast at month 6 and therefore included in the H2 plan. There are also new investments included from Mental Health Investment Standard and also requirements included in the Long Term Plan.

Recommendations

The Board of Directors is requested to:

1) Note the assumptions contained in and approve the current draft financial plan for October 2021 to March 2022
2) Agree that a sub-group of the Trust Board's choosing, approves the final version of the H2 plan before submission.

Report presented by: **Claire Wright**
Deputy Chief Executive

Report prepared by: **Rachel Leyland**
Deputy Finance Director

Finance and Contracting arrangements for H2

Planning guidance – key points
This was issued on 29 September by NHSE.

The H2 (months 7-12) 2021/22 arrangements are broadly consistent with a continuation of the current H1 (month 1-6) framework, and are summarised as:

- System funding envelopes, containing adjusted CCG allocations, system top-up and COVID-19 fixed allocation, based on the H1 2021/22 envelopes adjusted for additional known pressures, such as the impact of the pay award, and increased efficiency requirement.
- Block payment arrangements remaining in place for relationships between NHS commissioners (comprising NHS England and CCGs) and NHS providers (comprising NHS foundation trusts and NHS trusts). Signed contracts between NHS commissioners and NHS providers are not required for the 2021/22 financial year and CQUIN is not in operation for 2021/22 (noting that the block payment values include full receipt of CQUIN value, none of which may be withheld by commissioners).

H1 and H2 will be treated as a single financial period. Where systems in aggregate, or their constituent organisations, are exiting H1 in a surplus position against H1 funding, this funding will be retained by the system into H2. Any surpluses generated in H1 should be utilised appropriately to manage winter demands and go further on elective recovery, while ensuring that the system and its constituent organisations are exiting 2021/22 with an affordable underlying run-rate and have taken action to recurrently deliver the necessary efficiencies. Where systems in aggregate, or their constituent organisations, are exiting H1 in a deficit position against H1 funding, they are expected to take action to deliver a balanced position for the full financial year.

In order to fund providers for the back-pay associated with the 3% pay deal, block payments for core services, and where appropriate distribution of top-up and Covid funding has been increased non-recurrently by 10.5% in M7. This uplift is equivalent to 6 months of the 1.75% pay pressure. CCG programme funding has been increased by 1.49% to fund the element of this which would be paid out of core allocations, along with any other system pressures associated with the pay rise.

For H2, growth on NHS provider block payments is an additional 1.16% on top of the H1 growth. This is the aggregate of inflationary growth of 1.98% and a general efficiency requirement of 0.82%.

The inflationary growth has been calculated considering pay (including the 3% uplift for H2), drugs, capital and other inputs over which providers have limited control. The calculation excludes CNST as this was funded through an organisation-specific funding adjustment in H1 rather than the general inflation factor. The CNST funding from H1 is recurrent in H2 envelopes.

The efficiency factor for H2 is 0.82%. This is calculated by reference to the 1.1% efficiency factor outlined in the 2021/22 NTPS proposals for consultation (the general efficiency of 0.28% in H1 plus 0.82% in H2 totals 1.1%).

This is shown in the table below:

Expenditure category	H2 assumption	Cost weight	Description	Back-pay for H1
Pay – consultants	3.0%	9.2%	In line with the 3% confirmed pay uplift.	3.0%
Pay – staff/career grades	3.0%	2.0%	In line with the 3% confirmed pay uplift.	3.0%
Pay – trainee grades	0.0%	4.8%	No further growth as trainee grades have confirmed pay deal in place for 2021/22 which has been assumed in the H1 values	n/a
Pay – agenda for Change	3.0%	47.6%	In line with the 3% confirmed pay uplift.	3.0%
Drugs	0.3%	8.2%	In line with the 2021/22 NTPS consultation notice, scaled to 50% to include growth over 6 months.	n/a
Capital	0.0%	2.6%	No further inflation in H2 as full year inflation assumed in H1	n/a
CNST	n/a	2.30%	Actioned as an organisation specific adjustment and therefore excluded from the general inflation calculation.	n/a
Other	0.9%	23.4%	In line with the 2021/22 NTPS consultation notice, scaled to 50% to include growth over 6 months.	n/a
NHS provider inflation factor	**1.98%**	**100.00%**		**1.75%**
Efficiency	(0.82%)		Refer to the efficiency explanation above.	
NHS provider growth factor	**1.16%**			

Local and national deadlines

The following deadlines have been agreed by the system in order to achieve sign off by submission on 16 November 2021.

5th November – Finance Director's approval

11th November – Planning cell approval

12th November - JUCD SLT approval

15th November – JUCD Board approval (virtual)

16th November – Submission to NHSEI

Therefore, at the time of writing this report, the current position presented in this report is the most up to date draft position, however it will need to be further updated before final submission. A verbal update will be given at the meeting on any key changes up to that point and **a request is made to Trust Board that a sub-set of the Trust Board's choosing to attend a specific planning meeting to appropriately scrutinise and sign off the final plan before submission.** This is likely to need to take place between 5 and 11 November (TBC).

Funding Allocations

The Derbyshire system has an allocation for H2 of £1,012m compared to the H1 envelope of £994m. The H2 allocation includes a reduction in Covid funding of £3.4m and a system efficiency requirement reflecting the Financial Improvement Target of £14.3m.

The allocations have been split across all organisations using the same principles as agreed in H1. All block contracts have been uplifted by the required inflationary uplifts.

The Covid allocations remain the same for the Providers apart from an adjustment for one of the Providers and the CCG have transacted the reduction in the overall allocation.

It has been agreed that the first draft of H2 plan will be based on these income allocation principles.

Therefore, our share of the system funding totals £73.196m for H2.
The other elements in our draft plan have been based on the forecast outturn reported at month 6 and is shown in the table below:

£'000s	H1	H2	Change
CCG income	(71,816)	(73,196)	(1,380)
Other Clinical Income	(11,720)	(11,770)	(50)
Other income	(3,936)	(4,986)	(1,050)
Total Income	(87,472)	(89,952)	(2,480)
Pay	62,858	67,817	4,959
Non-Pay	24,713	23,925	(788)
Total Expenditure	87,571	91,743	4,172
(Surplus) / Deficit	**99**	**1,790**	**1,691**

The CCG income change reflects the uplift for inflation less efficiencies. Other clinical income includes income from NHSE, Foundation Trusts and Local Authorities. It also includes the release of deferred income, reinvesting slippage on investments from H1 and the reversal of the pay award in month 6 that is funded in month 7 by the CCG.

Other income includes income related to Research and Development, Education and Training, income reported in the Operational budgets and the vaccine hub income.

Summary - Key drivers of the current draft position of deficit:

The increase in pay expenditure mainly relates to pay costs of the new service investments that had a part year effect in H1 along with some new investments agreed during the year that start in H2. However, the income allocation remains the same as H1 which also included a part year effect in H1. This is one of the drivers of the deficit in H2 and this is one of the elements that is expected to change as discussions with the CCG take place on applying the new investment funding for H2.

The current efficiencies assumed in H2 totals £2.0m which equates to 2.1% of planned expenditure for H2. No further efficiencies have been assumed to close the gap, at this draft stage. This may need to increase in order for us to reach breakeven.

The Board are reminded that in order to retain cash for capital requirements a breakeven or better position retains cash balances, a deficit is likely to result in a reduction to Trust cash reserves.

The current drivers of the draft deficit position of £1.8m are:

- Shortfall in funding for new investments £1.1m – being discussed with the CCG on 20 October
- Shortfall on the pay award funding of £1.0m
- New in year internal investments of £0.5m – funding sources need to be identified and could be funded NR from slippage in H2 – in discussion at Delivery Board and with Executives
- Deficit is partially offset by £0.8m benefit of the reduction on expected Covid spend compared to the nominal Covid allocation

Next Steps

- Discussions with the CCG regarding the level of funding required for new investments in H2 – scheduled for 20 October
- Add in further planned investments that were not included in the month 6 forecast outturn, once agreed with CCG on 20 October
- Inclusion of any additional funding assumptions (and associated costs) related to discharge support or seasonal funding
- Treatment of reinvesting slippage to be agreed with CCG on 20 October (reduction of cost and income with no impact on the bottom line)
- Validation of non-block income following discussions with the CCG – to be validated on 22 October
- Directors of Finance to review the draft system position on 22 October
- Discussions to be had across the system on the level of efficiencies currently assumed and any further requirements to close any gap
- Further actions as required depending on the position and the gap to close to breakeven.

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 2 November 2021

Workforce Race Equality Standard (WRES) 2020-21

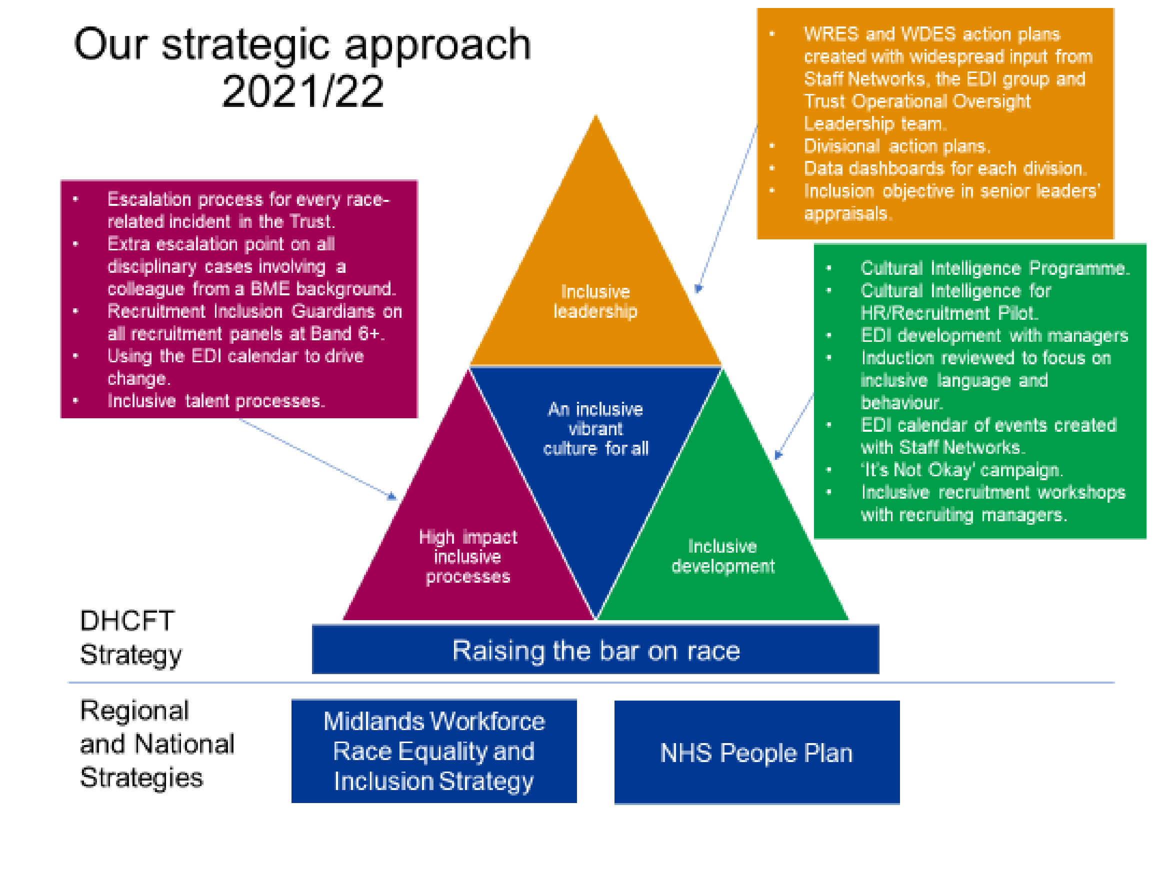
Purpose of Report
To update the Trust Board on progress with the work undertaken on the Workforce Race Equality Standard (WRES) 2020-21 for information and discussion.

Executive Summary

The WRES has nine evidence-based indicators focusing on the experience of Black and Minority Ethnic (BME) colleagues compared to white colleagues in the workplace. After seven years of the WRES, we have made some progress in areas that we focused on, but not nearly enough. A change of approach, focus and pace is required.

The WRES is a key strand in our strategic building block to create an inclusive vibrant culture for all. This year, we are looking for a fundamental shift in how we approach inclusion through embedding a distributed leadership approach in which we maximise our collective impact through leadership modelling and high engagement with those with lived experience.

We will build an inclusive culture and at the same time, focus on development and leadership while building trust with our staff through a number of high impact actions.



This year, as well as engaging with the BME Staff Network, we gained the involvement and commitment of wider colleagues and senior leaders in our planning to maximise our collective impact.

We are further embedding inclusive decision-making and taking our senior leaders on a Cultural Intelligence journey with Above Difference. Our ambition is to make development a priority for teams across the Trust. We are also leading a cultural review of recruitment processes as a national pilot at a system level.

At the same time, we will increase the impact of our Network groups and engage key people from these groups in the delivery of our inclusion agenda.

Developing our data capacity and availability has also been a key drive this year and moving into 2021/22. Dashboards are being developed to enable leaders to track and monitor the representation and retention of staff with protected characteristics within directorates. This data will support them to make localised decisions that affect their workforce and is further supported by the inclusion of colleagues' voices and lived experience in decision-making groups. We will also triangulate soft and hard data from multiple sources to draw better conclusions that underpin actions.

By embedding inclusive decision-making in our processes and facilitating those conversations with accurate and current data, we are ensuring that we learn from our colleagues' lived experience and adapting our systems, processes and decision making to reduce inequalities and improve experiences.

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

Assurances

- The Trust has submitted the WRES dataset to NHS England in line with 31 August 2021 deadline.
- The report with the action plan has also been published on the Trust's public-facing website in line with the 30 September 2021 deadline after being approved at the People and Culture Committee on 21 September 2021.
- Delivery against the action plan for the WRES is monitored by the Equality, Diversity and Inclusion Delivery group.

Consultation

- The WRES report and action plan has been created and finalised in collaboration with the Trust's BME Staff Network; the Equality, Diversity and Inclusion Delivery group, which includes representatives from Staff Networks, operational services, People Resources and the Trust's WRES Expert; members of the Trusts' Operational Oversight Leadership group; the Executive Leadership Team; and the People and Culture Committee.

Governance or Legal Issues

- WRES reporting is a mandatory requirement of the NHS Standard Contract. The Trust is required to submit the WRES dataset to NHS England by 31 August 2021 and publish the report and action plan on the public-facing website by 30 September 2021.
- Undertaking the WRES demonstrates the Trust's commitment to the Equality Act 2010 and Public Sector Equality Duty.

Public Sector Equality Duty and Equality Impact Risk Analysis

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

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

The WRES provides an overview of the workplace experiences for our Black and Minority Ethnic (BME) staff compared to white staff. The WRES looks at the experiences between BME staff and white staff and gives an idea of our overall workplace culture, including rates of bullying, harassment and abuse and perceptions of opportunities for career progression.

The national WRES data analysis for all NHS Trusts in England 2020 highlights:

- Just 40.7% of BME staff believed that their organisation provides equal opportunities for career progression of promotion compared to 88.3% for white staff.
- WRES indicators relating to perceptions of discrimination, bullying, harassment and abuse, and on beliefs regarding equal opportunities in the workplace, have not improved since the introduction of the WRES in 2016.
- There has been year on year fluctuation on the likelihood of appointment from shortlisting for BME and white staff, but no overall improvement.

  Source: WRES 2020 Data Analysis Report

Monitoring the WRES annually allows the Trust to assess the impact of targeted actions to create a more inclusive culture. This is achieved alongside further reporting requirements such as the Race Disparity Ratio that give a more in depth understanding of the workplace experience for BME staff, as well as progress

against the actions set out in the Midlands Workforce Race Equality and Inclusion Strategy.

The actions as part of the WRES action plan are further enhanced by the Trust's investment in the Cultural Intelligence programme which started in September 2021, as well as the system-wide pilot into developing culturally intelligent recruitment practices. This is also expected to have a positive impact on intersectional staff with other protected characteristics.

The WRES will also drive improvements for BME patients and their care, as it encourages the development of a more diverse, empowered and valued workforce, and a better understanding of race equality across the NHS workforce.

Recommendations

The Board of Directors is requested to consider and discuss the strategic implications of the WRES submission 2020/21.

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

Report prepared by: **Jaki Lowe**
Director of People and Inclusion

Clare Meredith
Equality, Diversity and Inclusion Advisor

Workforce Race Equality Standard (WRES)

Annual Report and Action Plan 2020/21

September 2021

What is the WRES?

The WRES is a set of nine mandatory indicators that enable the Trust to compare the workplace experiences of black and minority ethnic (BME) and white staff.

The WRES has four indicators specifically focusing on workforce data, four from the NHS Staff Survey, and one requiring organisations to ensure that their Boards are broadly representative of the overall workforce. It requires NHS organisations to close the gap between the workplace experience of BME and white staff for those indicators.

The main purpose of the WRES is to:

- Identify the gap in treatment and experience between white and BME staff
- Allow Trusts to make comparisons with similar organisations on levels of progress over time
- Enable NHS organisations to take remedial action on causes of ethnic disparities in WRES indicator outcomes.

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WRES Data 2020/21

Detailed below is the organisation's WRES data covering the period 1 April 2020 to 31 March 2021.

	2019/20	**2020/21**
Number of staff employed within the Trust as at 31 March 2020 and 31 March 2021.	2672	2795
Proportion of BME staff employed within Trust as at 31 March 2020 and 31 March 2021.	13.81% (369 people)	15.49% (433 people)
Indicator 1 Percentage of staff in each of the AfC Bands 1-9 and VSM compared with the percentage in the overall workforce	Please see table below	
Indicator 2 Relative likelihood of staff being appointed from shortlisting across all posts [A figure above "1" would indicate white candidates are more likely to be appointed from shortlisting]	2.02	1.60
Indicator 3 Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation [A figure above "1" would indicate BME staff are more likely to enter the formal disciplinary process]	1.43 [Note: Indicator based on data from a two-year rolling average of the current year and the previous year]	10.52 2019-20: 10 cases 2020-21: 3 cases [Note: Indicator based on data from current year only, in line with updated 2020/21 WRES guidance]
Indicator 4 Relative likelihood of staff accessing non-mandatory training and CPD	1.13	1.52

[A figure above "1" would indicate BME staff are less likely to access non-mandatory training and CPD]		
Indicator 5 Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or members of the public	**BME: 33.1%** (52 of 157 responses) **White: 23.7%** (304 of 1283 responses)	**BME: 28.0%** (53 of 189 responses) **White: 22.8%** (314 of 1375 responses)
Indicator 6 Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months	**BME: 22.8%** (37 of 162 responses) **White: 20.3%** (259 of 1278 responses)	**BME: 27.5%** (52 of 189 responses) **White: 16.2%** (223 of 1376 responses)
Indicator 7 Percentage believing that the Trust provides equal opportunities for career progression or promotion	**BME: 71.0%** (66 of 93 responses) **White: 87.8%** (770 of 877 responses)	**BME: 72.9%** (86 of 118 responses) **White: 90.6%** (909 of 1003 responses)
Indicator 8 Percentage of staff who have personally experienced discrimination at work from their manager/team leader or other colleagues in the last 12 months	**BME: 11.3%** (18 of 159 responses) **White: 5.4%** (68 of 1267 responses)	**BME: 15.5%** (28 of 181 responses) **White: 4.9%** (67 of 1370 responses)
Indicator 9 Percentage difference between the organisation's Board voting membership and the overall workforce	2.9% (Board Voting Membership from a BME background: 16.7% Overall workforce from a BME background: 13.81%)	1.2% (Board Voting Membership from a BME background: 16.7% Overall workforce from a BME background: 15.49%)

BME representation across the Trust broken down by banding

NON-CLINICAL							
	2019/20			2020/21			
Band	White % (#)	BME % (#)	Unknown % (#)	White % (#)	BME % (#)	Unknown % (#)	BME representation
Under Band 1	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	+ 0.0%
Band 1	54.5% (6)	18.2% (2)	27.3% (3)	40.0% (2)	20.0% (1)	40.0% (2)	+ 1.8%
Band 2	73.6% (142)	22.8% (44)	3.6% (7)	72.2% (135)	24.6% (46)	3.2% (6)	+1.8%
Band 3	89.6% (172)	9.9% (19)	0.5% (1)	90.3% (176)	8.7% (17)	1.0% (2)	-1.2%
Band 4	89.9% (107)	8.4% (10)	1.7% (2)	91.3% (115)	7.9% (10)	0.8% (1)	-0.5%
Band 5	80.7% (46)	14.0% (8)	5.3% (3)	85.5% (65)	11.8% (9)	2.6% (2)	-2.2%
Band 6	93.8% (45)	2.1% (1)	4.2% (2)	89.1% (49)	1.8% (1)	9.1% (5)	-0.3%
Band 7	94.7% (18)	0.0% (0)	5.3% (1)	84.6% (11)	7.7% (1)	7.7% (1)	+7.7%
Band 8a	94.4% (17)	5.6% (1)	0.0% (0)	100.0% (18)	0.0% (0)	0.0% (0)	-5.6%
Band 8b	87.5% (7)	12.5% (1)	0.0% (0)	88.9% (8)	11.1% (1)	0.0% (0)	-1.4%
Band 8c	100.0% (12)	0.0% (0)	0.0% (0)	84.6% (11)	15.4% (2)	0.0% (0)	+15.4%
Band 8d	83.3% (5)	16.7% (1)	0.0% (0)	85.7% (6)	14.3% (1)	0.0% (0)	-2.4%
Band 9	100.0% (1)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	+0.0%
VSM	83.3% (5)	16.7% (1)	0.0% (0)	87.5% (7)	12.5% (1)	0.0% (0)	-4.2%

CLINICAL		
	2019/20	2020/21

Band	White % (#)	BME % (#)	Unknown % (#)	White % (#)	BME % (#)	Unknown % (#)	BME representation
Under Band 1	0.0% (0)	0.0% (0)	0.0% (0)	62.5% (5)	37.5% (3)	0.0% (0)	+37.5%
Band 1	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	+0.0%
Band 2	70.4% (38)	25.9% (14)	3.7% (2)	66.0% (31)	27.7% (13)	6.4% (3)	+1.8%
Band 3	76.1% (232)	19.3% (59)	4.6% (14)	72.9% (221)	23.4% (71)	3.6% (11)	+4.1%
Band 4	85.7% (84)	11.2% (11)	3.1% (3)	86.9% (86)	11.1% (11)	2.0% (2)	-0.1%
Band 5	83.4% (277)	12.3% (41)	4.2% (14)	79.7% (278)	16.3% (57)	4.0% (14)	+4.0%
Band 6	88.9% (591)	8.4% (56)	2.7% (18)	88.3% (637)	8.9% (64)	2.8% (20)	+0.5%
Band 7	86.2% (232)	11.2% (30)	2.6% (7)	87.0% (247)	10.6% (30)	2.5% (7)	-0.6%
Band 8a	92.6% (75)	6.2% (5)	1.2% (1)	90.5% (76)	8.3% (7)	1.2% (1)	+2.1%
Band 8b	93.5% (29)	3.2% (1)	3.2% (1)	88.6% (31)	8.6% (3)	2.9% (1)	+5.4%
Band 8c	90.9% (10)	0.0% (0)	9.1% (1)	92.9% (13)	0.0% (0)	7.1% (1)	+0.0%
Band 8d	100.0% (3)	0.0% (0)	0.0% (0)	50.0% (1)	50.0% (1)	0.0% (0)	+50.0%
Band 9	0.0% (0)	100.0% (1)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	-100.0%
VSM	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	+0.0%
of which Medical & Dental							
Consultants	50.0% (39)	42.3% (33)	7.7% (6)	40.3% (31)	57.1% (44)	2.6% (2)	+14.8%
of which senior medical manager	100.0% (1)	0.0% (0)	0.0% (0)	100.0% (1)	0.0% (0)	0.0% (0)	+0.0%
Non-consultant career grade	29.0% (9)	58.1% (18)	12.9% (4)	31.3% (10)	65.6% (21)	3.1% (1)	+7.5%
Trainee grades	39.1% (9)	52.2% (12)	8.7% (2)	28.6% (8)	64.3% (18)	7.1% (2)	+12.1%
other	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	+0.0%

Action Plan

This action plan was produced in collaboration with our Black, Asian and Minority Ethnic (BME) Staff Network, operational leaders, and senior leadership over August and September 2021.

Please note that this action plan is a live document that will be updated and amended throughout the year to ensure that the actions and outcomes remain effective in closing the gaps in racial inequality in our Trust.

Indicator	Actions for 2021 (within 12 months)	Lead/s	Deadline	Position
Indicator 1 Percentage of staff in each of the AfC Bands 1-9 and VSM compared with the percentage in the overall workforce	The corporate WRES is to be updated each quarter to allow for more regular monitoring of the indicators. This will enable greater and more accurate monitoring of the effectiveness of targeted actions.		31 March 2022	In progress
	A data working group is to be established to develop a 6-monthly directorate WRES with dashboards to incorporate the WRES and WDES datasets, Staff Survey data etc. to have a more localised understanding of the workplace experiences of staff in directorates, rather than only an overview at corporate level.	Assistant Director of People Operations *with* EDI team, General Managers, and Systems and Information team.	31 March 2022	In progress
	Directorate engagement: directorates to agree their local response to their local directorate WRES. Action Plans to be interrogated by EDI Group.	General Managers *With* EDI Group	31 March 2022	Not started
	Mandatory inclusion objective in every senior leader's appraisal.			Not started
Indicator 2 Relative likelihood of staff being appointed from shortlisting across all posts	Cultural Intelligence HR/Recruitment National Pilot across the Derbyshire system with Above Difference to recruit and progress inclusively with Cultural Intelligence.	Director of People and Inclusion	31 March 2022	In progress

	Recruitment Inclusion Guardians (RIGS): RIGs were introduced to all shortlisting and interview processes at Band 6 and above in April 2021, from just interview panels at Band 7 and above since February 2020. A new RIG assurance process is to be introduced in 2021.	EDI team	31 December 2021	In progress
	Inclusive recruitment workshop with appointing managers. Pilot workshop already delivered.	EDI team	31 March 2022	In progress
Indicator 3 Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation	Introduce process for reviewing every race-related incident in the Trust. Task group from EDI Group to include operational, clinical and HR representatives will be organised to create a review pathway.	EDI Group	31 March 2022	Not started
	Introduce an extra escalation point on all cases involving BME staff to include Assistant Director of People Operations and Director of People and Inclusion.	Assistant Director of People Operations	31 October 2022	Not started
Indicator 4 Relative likelihood of staff accessing non-mandatory training and CPD	Deep dive survey across our BME workforce to understand whether career planning and development is taking place consistently. Review the development offer in place for BME staff.	Assistant Director of Organisational Development	31 March 2022	Not started
Indicator 5 Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or members of the public	Statement on hate crime to be sent out to all Trust staff.	Executive Director of Nursing and Patient Experience	30 September 2021.	Completed

Indicator 6 Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months	Refresh induction to focus on the impact of language, behaviour, bullying and harassment, and the difference between banter and harassment.	EDI Advisor	30 September 2021	Completed
	Written process for all to understand the reporting process for bullying, harassment and abuse of staff against staff to be added to the 'It's Not Okay' campaign on Focus.	EDI team	31 October 2021	Not started
Indicator 7 Percentage believing that the Trust provides equal opportunities for career progression or promotion	See action for non-mandatory training (Indicator 4) above.			
Indicator 8 Percentage of staff who have personally experienced discrimination at work from their manager/team leader or other colleagues in the last 12 months	Education/training for staff at higher/management grades on having productive conversations about race with colleagues (particularly when supporting BAME staff raising concerns about treatment in the workplace). Include the opportunity to take part in practice sessions and give/have feedback.			Not started
Indicator 9 Percentage difference between the organisation's Board voting membership and the overall workforce	See actions targeting recruitment (Indicator 2) and BME representation (Indicator 1) above.			

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 2 November 2021

Workforce Disability Equality Standard 2020/21

Purpose of Report
To present the Workforce Disability Equality Standard (WDES) 2020/21 submission for information and discussion.

Executive Summary

The WDES enables the Trust to better understand the experiences of staff living with disabilities or long-term conditions.

It has been consistently identified that the number of DHCFT staff who have declared a disability or long-term condition on ESR (electronic staff record) is lower than that of staff declaring a disability anonymously via the NHS Staff Survey. This trend is in line with other NHS Trusts: our disclosure rate for staff with disabilities or long-term conditions on ESR is 5.3% (as at March 2021), compared to 3.5% of NHS staff nationally (as at March 2020). This is much lower than the disclosure rate on the NHS Staff Survey, where 18.7% of NHS staff nationally and 27.8% of 1583 respondents at Derbyshire Healthcare disclosed a disability or long-term condition.

Actions to encourage disclosure of protected characteristics on ESR include engagement sessions with the Disability & Wellness Network and with wider Trust staff as part of a disclosure campaign, which is aimed at building trust as an employer with our current and future staff. The cultural review of recruitment processes as a national pilot with Above Difference at a system level will also support this objective. We will also aim to increase our impact using the next level of the Disability Confident standard.

An individualised approach is necessary to support staff to thrive at work. The actions embedded in the WDES action plan all form part of wider changes to create an inclusive culture where staff can feel safe to be themselves. Our Disability and Wellness Staff Network has been key in recommending reviews of our processes, including the Reasonable Adjustments Policy and Passport, and raising awareness of staff with disabilities and long-term conditions.

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

Assurances

- The Trust has submitted the WDES dataset to NHS England in line with 31 August 2021 deadline.
- The report and action plan have been published on the Trust's public facing website by the 30 October 2021 deadline, after being approved by the People and Culture Committee on 21 September 2021.
- Delivery against the action plan for the WDES is monitored by the Equality, Diversity and Inclusion Delivery group.
- The Trust has achieved Disability Confident Employer status (Level 2), which means it is recognised as going the extra mile to make sure staff with disabilities or long-term conditions get a fair chance.

Consultation

- Three engagement sessions were held for members of the Disability and Wellness Network to discuss the data and action plan for the 2020/21 submission. This forms part of ongoing engagement to ensure the actions in the action plan remain effective throughout the year.
- The WDES action plan has been created in collaboration with the Trust's Disability and Wellness Staff Network; the Equality, Diversity and Inclusion Delivery group, which includes representatives from Staff Networks, operational services and People Resources; members of the Trusts' Operational Oversight Leadership group; the Executive Leadership Team; and the People and Culture Committee.

Governance or Legal Issues

- Section 149 of the Equality Act sets out the Public Sector Equality Duty (PSED), which offers protection in relation to employment, as well as access to goods and services. The PSED strengthens the duty on employers to eliminate discrimination and advance equality of opportunity for staff with protected characteristics, including disability.
- Implementing the WDES assists DHCFT to ensure compliance with the provisions of the Equality Act 2010, and the aims of the PSED.

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 have been historic challenges for disabled people in accessing employment. As of December 2020, 8.4 million people of working age were identified as

disabled. This represents 20% of the working age population and is an increase of 327,000 from 2019.

Across the UK, 52.3% of disabled people were in employment, compared to 81.1% of non-disabled people. During the COVID-19 pandemic, the proportion of disabled people who are either unemployed or economically inactive has increased from 45.9% to 47.7%, and while non-disabled people have also seen an increase in the proportion who are either unemployed or economically inactive, the increase has been smaller (from 17.8% to 18.9%).

Source: 'Disabled people in employment', House of Commons Library.

The national WDES Data Analysis report for 2020 showed:

- 3.5% of staff working for NHS Trusts nationally have declared themselves as disabled on ESR compared to 18.7% of staff on the NHS Staff Survey.
- The reported levels of harassment, bullying or abuse of NHS staff has remained consistent over the last five years. This is true for both Disabled and non-disabled staff.
- The overall proportion of non-disabled staff experiencing presenteeism has reduced from 28.0% in 2016 to 23.5% in 2019. For Disabled staff, the percentage has fallen from 36.3% to 30.6%. Disabled staff were more likely to experience presenteeism across all regions, with higher levels in London (31.8%) and the Midlands (31.4%).

The 2020 data analysed in this report was from before and during the early days of the COVID-19 pandemic.

Source: 'WDES Data Analysis Report' 2020, WDES Implementation team. Published October 2021.

Implementing the WDES at a local level ensures targeted actions to improve the workplace experience for our workforce.

The WDES will also drive improvements for all of our staff with protected characteristics, as well as Disabled patients and their care, as it encourages the development of a more diverse, empowered and valued workforce, and a better understanding of disability equality across the NHS workforce.

Recommendations

The Board of Directors is requested to consider and discuss the strategic implications of the WDES 2020/21.

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

Report prepared by: **Jaki Lowe**
Director of People and Inclusion

Clare Meredith
Equality, Diversity and Inclusion Advisor

Workforce Disability Equality Standard (WDES)

Annual Report and Action Plan 2020/21

September 2021

Introduction

The WDES requires all NHS organisations to demonstrate progress against a set of ten indicators in order to assess the experiences of disabled and non-disabled staff. The aim of the WDES is to ensure employees who have a disability have equal access to opportunities and receive fair treatment in the workplace.

The standard has been implemented across all NHS Trusts in response to research that shows that disabled staff have poorer experiences in areas such as bullying and harassment, feeling pressure to come to work despite not feeling well enough and in access to opportunities for career progression when compared to their non-disabled colleagues.

The WDES will help foster a better understanding of the issues faced by disabled colleagues and the inequalities they experience, and supports Trusts to take action to create an inclusive and diverse leadership, which is in line with Derbyshire Healthcare's mission to be 'positively inclusive'.

WDES Data 2020/21

Detailed below is the organisation's WDES data covering the period 1 April 2020 to 31 March 2021.

	2019/20	**2020/21**
Number of staff employed within the Trust	2672	2795
Proportion of disabled staff employed within the Trust as at 31 March 2020 and 31 March 2021	4.4% (117 people)	5.3% (149 people)
Indicator 1 Percentage of staff in each of the AfC Bands 1-9 and VSM compared with the percentage in the overall workforce	Please see table below	
Indicator 2 Relative likelihood of non-disabled staff compared to disabled staff being appointed from shortlisting across all posts Note: A figure above "1" would indicate non-disabled candidates are more likely to be appointed from shortlisting	1.40	1.05
Indicator 3 Relative likelihood of disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure. Note: A figure above "1" would indicate that disabled staff are more likely to enter the formal capability process	0.00	0.00

Indicator 4a **Percentage of staff experiencing harassment, bullying or abuse from:** **i)** Patients, service users or members of the public **ii)** Manager **iii)** Other colleagues	**i) Disabled: 30.4%** (112 of 368 responses) **Non-disabled: 23.0%** (253 of 1098 responses) **ii) Disabled: 11.8%** (43 of 365 responses) **Non-disabled: 8.0%** (87 of 1090 responses) **iii) Disabled: 22.6%** (83 of 367 responses) **Non-disabled: 14.6%** (159 of 1091 responses)	**i) Disabled: 27.6%** (121 of 438 responses) **Non-disabled: 21.9%** (249 of 1135 responses) **ii) Disabled: 11.2%** (49 of 437 responses) **Non-disabled: 5.7%** (64 of 1130 responses) **iii) Disabled: 20.6%** (90 of 436 responses) **Non-disabled: 11.8%** (133 of 1127 responses)
Indicator 4b Percentage of staff saying the last time they experienced harassment, bullying or abuse, they or a colleague reported it	**Disabled: 53.6%** (82 of 153 responses) **Non-disabled: 51.2%** (169 of 330 responses)	**Disabled: 54.8%** (92 of 168 responses) **Non-disabled: 62.0%** (191 of 308 responses)
Indicator 5 Percentage of staff believing the Trust provides equal opportunities for career progression or promotion.	**Disabled: 81.2%** (203 of 250 responses) **Non-disabled: 87.6%** (642 of 733 responses)	**Disabled: 85.1%** (263 of 309 responses) **Non-disabled: 89.6%** (731 of 816 responses)
Indicator 6 Percentage of staff saying they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.	**Disabled: 16.4%** (40 of 244 responses) **Non-disabled: 12.3%** (69 of 563 responses)	**Disabled: 17.1%** (40 of 234 responses) **Non-disabled: 11.1%** (43 of 386 responses)

Indicator	2019/20	2020/21
Indicator 7 Percentage of staff saying they are satisfied with the extent to which the organisation values their work.	**Disabled: 43.9%** (161 of 367 responses) **Non-disabled: 54.1%** (596 of 1102 responses)	**Disabled: 50.3%** (219 of 435 responses) **Non-disabled: 59.2%** (672 of 1135 responses)
Indicator 8 Percentage of disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work.	**Disabled: 84.6%** (208 of 246 responses)	**Disabled: 86.6%** (252 of 291 responses)
Indicator 9a Staff engagement score for disabled staff, compared to non-disabled staff.	Disabled: 6.9 Non-disabled: 7.2	Disabled: 7.1 Non-disabled: 7.5
Indicator 9b Has your Trust taken action to facilitate the voices of disabled staff in your organisation to be heard? (yes/no)	Yes	Yes
Indicator 10 Percentage difference between the organisation's Board voting membership and its organisation's overall workforce.	+ 4% (8% of Board voting membership declared a disability compared to 4% of overall workforce)	+ 20 % (25% of Board voting membership declared a disability compared to 5% of overall workforce)

Representation of disabled and non-disabled staff broken down by banding:

NON-CLINICAL		
	2019/20	2020/21

Band	Disabled %	Non-disabled %	Unknown/ Null %	Disabled %	Non-disabled %	Unknown/ Null %	% of 'Unknown' 2020-2021
Cluster 1 (Bands <1 - 4)	4.7%	69.9%	25.4%	5.3%	71.5%	23.2%	-2.20%
Cluster 2 (Band 5 - 7)	3.2%	71.0%	25.8%	4.9%	70.8%	24.3%	-1.50%
Cluster 3 (Bands 8a - 8b)	3.8%	65.4%	30.8%	3.7%	66.7%	29.6%	-1.20%
Cluster 4 (Bands 8c - 9 & VSM)	8.0%	72.0%	20.0%	7.1%	64.3%	28.6%	+8.60%

CLINICAL							
	2019/20			2020/21			
Band	Disabled %	Non-disabled %	Unknown/ Null %	Disabled %	Non-disabled %	Unknown/ Null %	% of 'Unknown' 2020-2021
Cluster 1 (Bands <1 - 4)	2.8%	65.9%	31.3%	4.4%	65.9%	29.8%	-1.50%
Cluster 2 (Band 5 - 7)	5.2%	70.4%	24.4%	6.0%	71.0%	23.0%	-1.40%
Cluster 3 (Bands 8a - 8b)	4.5%	76.8%	18.8%	5.9%	76.5%	17.6%	-1.20%
Cluster 4 (Bands 8c - 9 & VSM)	0.0%	53.3%	46.7%	6.3%	68.8%	25.0%	-21.70%
Cluster 5 (Medical & Dental Staff, Consultants)	2.6%	57.7%	39.7%	3.9%	61.04%	35.06%	-4.64%

Cluster 6 (Medical & Dental Staff, Non-Consultants career grade)	0.0%	41.9%	58.1%	0.0%	50.0%	50.0%	-8.10%
Cluster 7 (Medical & Dental Staff, Medical and dental trainee grades)	0.0%	34.8%	65.2%	0.0%	50.0%	50.0%	-15.20%

WDES Action Plan

This action plan was produced in collaboration with our Disability and Wellness Staff Network, operational leaders, and senior leadership over August and September 2021.

Please note that this action plan is a live document that will be updated and amended throughout the year to ensure that the actions and outcomes remain effective in closing the gaps in disability inequality in our Trust.

Indicator	Actions for 2021 (within 12 months)	Lead/s	Deadline	Position
Indicator 1 Percentage of staff in each of the AfC Bands 1-9 and VSM compared with the percentage in the overall workforce	Mandatory inclusion objective in every senior leader's appraisal (Aligned to WRES Action Plan 2020/21)			Not started
	Disclosure campaign launched in May 2021 to address low rates of declaration. Campaign includes posters circulated virtually, and drop-in sessions with EDI team to highlight the importance of disclosing a disability or long-term condition.	EDI team	31 March 2022	Completed launch. Campaign ongoing until March 2022.

	Podcasts/videos with people talking about the difference declaring a disability can have.	Disability and Wellness Staff Network	31 March 2022	Not started
Indicator 2 Relative likelihood of non-disabled staff compared to disabled staff being appointed from shortlisting across all posts	Cultural Intelligence HR/Recruitment National Pilot across the Derbyshire system with Above Difference to recruit and progress inclusively with Cultural Intelligence. (Aligned to WRES Action Plan 2020/21)	Director of People and Inclusion	31 March 2022	In progress
	Recruitment Inclusion Guardians (RIGS): RIGs were introduced to all shortlisting and interview processes at Band 6 and above in April 2021, from just interview panels at Band 7 and above since February 2020. A new RIG assurance process is to be introduced in 2021. (Aligned to WRES Action Plan 2020/21)	EDI team	31 December 2021	In progress
	Deliver inclusive recruitment workshops with appointing managers. Pilot workshop has already been delivered. (Aligned to WRES Action Plan 2020/21)	EDI team	31 March 2022	In progress
Indicator 3 Relative likelihood of disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure.	0 staff have entered the formal capability process.			
Indicator 4a	Refresh induction to focus on the impact of language, behaviour, bullying and harassment, and the difference between banter and harassment.	EDI Advisor	30 September 2021	Completed

Percentage of staff experiencing harassment, bullying or abuse from: Patients, service users or members of the public Manager Other colleagues	Statement on hate crime to be sent out to all Trust staff. (Aligned to WRES Action Plan 2020/21)	Executive Director of Nursing and Patient Experience	30 September 2021	Completed
Indicator 4b Percentage of staff saying the last time they experienced harassment, bullying or abuse, they or a colleague reported it	Written process for all to understand the reporting process for bullying, harassment and abuse of staff against staff to be added to the 'It's Not Okay' campaign on Focus. (Aligned to WRES Action Plan 2020/21)	EDI team	31 October 2021	Not started
Indicator 5 Percentage of staff believing the Trust provides equal opportunities for career progression.				
Indicator 6 Percentage of staff saying they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.	Training for leaders to support people with disabilities, especially mental health.	EDI team	31 March 2022	Not started
	Line managers' booklet currently in development that focuses on leading inclusively and incorporates supporting staff with protected characteristics, including the need to support staff with disabilities/long term conditions.	EDI team	31 October 2021	In progress
Indicator 7 Percentage of staff saying they are satisfied with the extent to which the organisation values their work.				

Indicator 8 Percentage of disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work.	• Disability & Wellness Network reviewing Reasonable Adjustments Passport and guidance. • Task and finish group to be organised out of EDI Group on Reasonable Adjustments Passport and how to support people in line with the Trust values.	EDI Group *With* Disability and Wellness Staff Network	31 March 2022	In progress
Indicator 9a Staff engagement score for disabled staff, compared to non-disabled staff.				
Indicator 9b Has your Trust taken action to facilitate the voices of disabled staff in your organisation to be heard? (yes/no)				
Indicator 10 Percentage difference between the organisation's Board voting membership and its organisation's overall workforce.				

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 2 November 2021

Quality Position Statement - Effectiveness

Purpose of Report

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

Executive Summary

Derbyshire Healthcare as a Children's and Mental Health Trust has continued to maintain a 'Good' rating overall for its clinical services and at the last inspection achieved a 'Good' rating overall.

This paper is a review as well as a quality position statement on effectiveness and this paper is an analysis from a helicopter view of effectiveness of our services through a clinical lens, as well as considering the Effectiveness domain:

> *Effective. - By effective, CQC Health regulator we mean that people's care, treatment and support achieve good outcomes, promotes a good quality of life and is based on the best available evidence.*
>
> *In* addition *to the literal over the degree to which something is successful in producing a desired result; success.*

It is, by its nature a highlight report drawing our key clinical metrics or insights.

The evidence is drawn from multiple data sources, not all the information is available or live reportable, however it is a collection of data sources, partners' feedback, public health and community information to provide a helicopter view of our services, linked or connected to the Trust strategy, known clinical evidence, regulator evidence or feedback from agencies in particular areas of known risk.

The report also uses known clinical evidence of effectiveness, as outlined as issues and learning published in 2021 by The National Confidential Inquiry and into Suicide and Safety in Mental Health.

In addition, known evidence of services design or effectiveness have been included from either a regulator view of quality or known evidence in Children's services.

This report also includes some insights into the future directions of CQUINs and to give a future view of sexual safety and the future emerging clinical strategy.

The report has focused on clinical effectiveness. Effectiveness in the CQC domains also includes additionally the Mental Capacity Act, training, supervision and appraisal. These domains are already monitored within committee structures and will be included in any future review of effectiveness.

It should be noted that the Children's and Mental Health Services are growing in routine outcome measurement.

It is exciting and positive to see the Trust's services flourishing over 2020 and 2021. The next twelve months to two years are pivotal on the Trust's journey to routine outcome measurement, clinical improvement of standards and fully implementing the Quality Improvement Strategy on completion of its review in 2021.

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

Assurances

- This report is offered with significant assurance.

Consultation

- The evidence provided is a collection of known and new evidence, published through NHS Benchmarking, existing public health profiles and new information from the National Confidential Inquiry and into Suicide and Safety in Mental Health. There is clear clinical evidence this is a measure of effectiveness.

Governance or Legal Issues

- Health and Social Care Act 2008 (Regulated
- Activities) Regulations 2014 (Part 3) (as amended)
- Care Quality Commission (Registration)
- Regulations 2009 (Part 4) (as amended)

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 is a Trust wide helicopter view of effectiveness and impact through a clinical lens. The over-arching findings are a positive view of quality and effectiveness.
- Current safety priorities in investing in community forensic mental health services to improve public protection are noted as a residual risk as outlined in the Board Assurance framework.
- There is a continued risk to people in our care in sexual safety, which as an organisation we have prioritised as a quality priority to mitigate. There is an

adverse impact for women who use our services. We have improvement plans to mitigate these risks.

- There is a continued risk to people in our care in reducing in-patient and community suicide. Men are over-represented in this group.
- There is a continued risk to people in our care in our community to reduce the risk or actual incidents of Homicide and Domestic Homicide, which are very serious events. The highest risk groups are males with co-existing substance misuse and the highest risk group of potential victims are women.
- There is a continued risk that individuals, who are treated out of their area have worse clinical outcomes than those people in our care who are treated locally or with continuity of care principles in a close-proximity service. The Trust has mitigated this significantly and there is clear evidence of significant improvement.
- The quality position report is an assurance overview of the evidence and service provision rather than an executive action and mitigation report.
- Wider recommendations and evidence are used to give insights into services and the need to use the clinical evidence in service monitoring, service planning and service development to enable the Trust Board to consider the future strategy and evidence of our service provision.

Recommendations

The Board of Directors is requested to:

1) Consider and confirm the levels of assurance as rated by the CQC as good. Furthermore, consider the current evidence in the domain of Effectiveness.
2) Consider whether any additional information is to be included in the Integrated Performance Report or in the Quality Position Statement, either regularly or periodically.
3) Confirm the level of assurance obtained on the areas presented. It is suggested that there is significant assurance.
4) Give feedback into the suggested areas of further improvement in 2022 Quality priorities or exploration of wider system recommendations.

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

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

Quality Position Statement - Effectiveness

Derbyshire Healthcare as a Children's and Mental Heath Trust has continued to maintain a Good rating overall for its clinical services and at last inspection achieved a Good overall.

This paper is a review and a quality position statement on effectiveness and this paper is an analysis from a helicopter view of effectivenss of our services through a clinical lens.

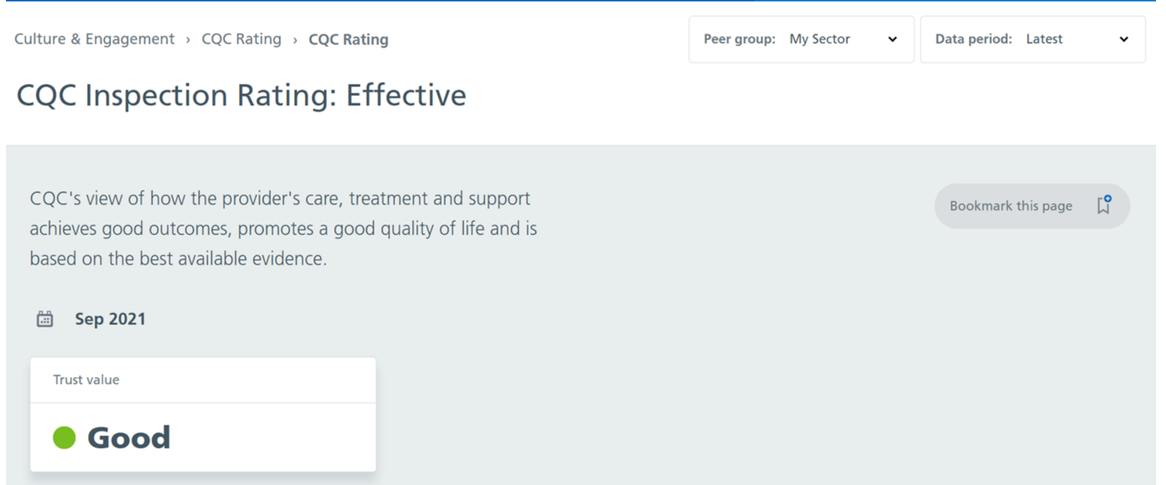
It is by its nature a highlight report.

The evidence is drawn form mulitple data sources, not all information is available is live reportable, however it is a collection of data sources, partners feedback, public health and community information to inform a helicopter view of our services linked or connected to the Trust strategy, known clinical evidence, regulator evidence or feedback from agencies in particualr areas of known risk.

The report also uses known clinical evidence of effectiveness as outlined as issues and learning published in 2021 by The National Confidential Inquiry and into Suicide and Safety in Mental Health.

In additon known evidence of services design or effectivenss have been included from either a regulator view of quality or known evidence in Children's services.

This report also includes some insights into the future directions of CQUINs and to give a future view of sexual safety and the future emerging clinical strategy.



The Trust strategy has been clear for several years, it is to improve the lived experience for staff who work in our services and by doing so have improved outcomes for patient care. The impact on patient care is not fully realised or not fully established as a causative factor. However, the Trust continues to make significant headway in compassion, inclusivity and inclusion. The table below is a national data extract of the impact of the Trust strategy and leadership.

People Promise › More | Peer group: My Sector | Data period: Latest

Overall Score	Data period	Trust value	Peer median	National median	Chart	Actions
Overall score on "We are compassionate and inclusive"	2020	7.7	7.4	7.4		
Inclusion	**Data period**	**Trust value**	**Peer median**	**National median**	**Chart**	**Actions**
Sub Score 1 - Inclusion	2020	7.8	7.6	7.4		
Quality of Care	**Data period**	**Trust value**	**Peer median**	**National median**	**Chart**	**Actions**
Sub Score 2 - Quality of Care	2020	7.5	7.3	7.3		

This is a significant improvement year on year for the last three years and is now above average and above peer medians in all areas in the staff survey from our staff/colleague feedback and perspective (2020).

Effectiveness – People first

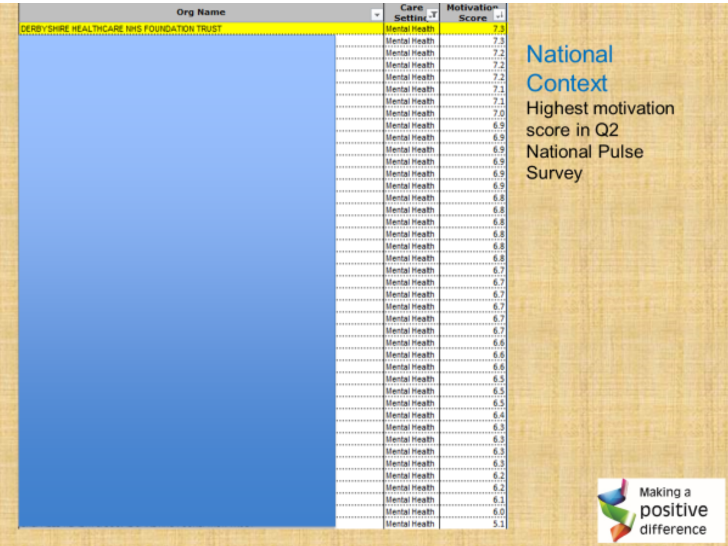
If we look after our people, our services to our people using our services and community will improve.

Highest motivation score in Q2 National Pulse Survey (2021)

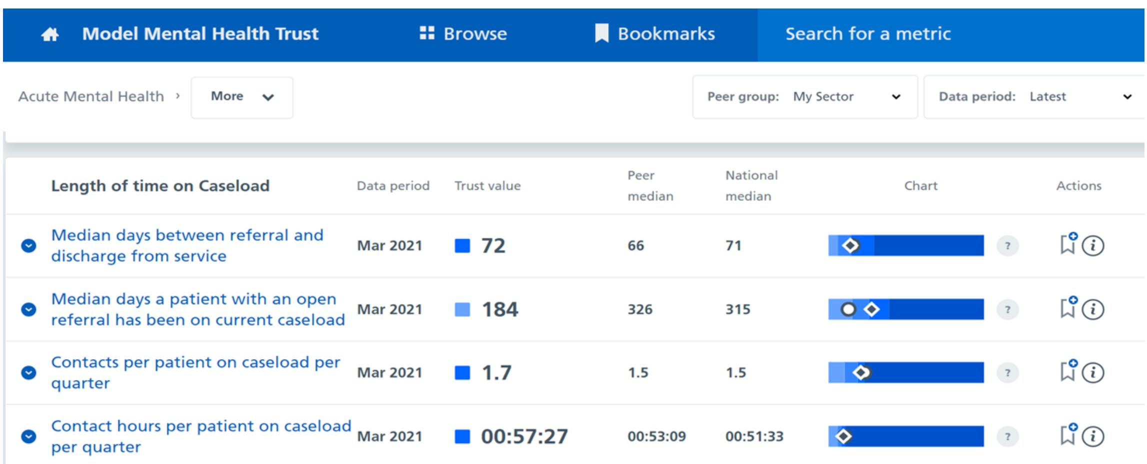
Intrinsic motivation is known to be a powerful driver of behaviours. Two different sources of motivation are identified: the satisfaction derived from undertaking actions that benefit other people or society (sometimes referred to as altruistic or prosocial motivation) and the interest or enjoyment of a task itself.

Evidence is emerging that intrinsically motivated providers display *desirable behaviours or attitudes towards patients.* Health education research in high income countries shows the importance and long-term benefits of selecting people with altruistic values, such as compassion or empathy, into the medical and clinical professions.

Insights into culture argue that generous clinicians provide better quality of care to patients However few interventions have rigorously explored the extent to which intrinsic motivation can be shaped or harnessed to motivate quality improvement. We are not able to establish, as yet, whether the People First policy is impactful on clinical effectiveness and outcomes. However, what we can be clear about is that the People First policy is having positive impacts upon staff motivation.



The staff survey is made up of staff feedback measures of perceived levels of quality of care. This is a good indicator, in addition when supplemented with activity data. This is another extract of the Model Mental Health Trust and this is used to triangulate activity, contact and evidence of thoroughness of approach to maintaining clinical engagement and intervention. These metrics are above national levels and give a further insight into positive outcomes of accessibility and contact. These measures are associated with high quality care.



Model Mental Health Trust | Browse | Bookmarks | Search for a metric

Acute Mental Health › More | Peer group: My Sector | Data period: Latest

Length of time on Caseload	Data period	Trust value	Peer median	National median
Median days between referral and discharge from service	Mar 2021	72	66	71
Median days a patient with an open referral has been on current caseload	Mar 2021	184	326	315
Contacts per patient on caseload per quarter	Mar 2021	1.7	1.5	1.5
Contact hours per patient on caseload per quarter	Mar 2021	00:57:27	00:53:09	00:51:33

The National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) has collected in-depth information on all suicides in the UK since 1996, with the overall aim of improving safety for all mental health patients.

The Inquiry provided crucial evidence to support service and training improvements, and ultimately, to contribute to a reduction in patient suicide rates and an overall decrease in the national suicide rate.

Based on our evidence from studies of mental health services, primary care and Accident and Emergency departments, we have developed a list of 10 key elements, as in diagram below, for safer care for patients. These recommendations have been shown to reduce suicide and are key to effectiveness.

DHCFT contribution to reducing suicide

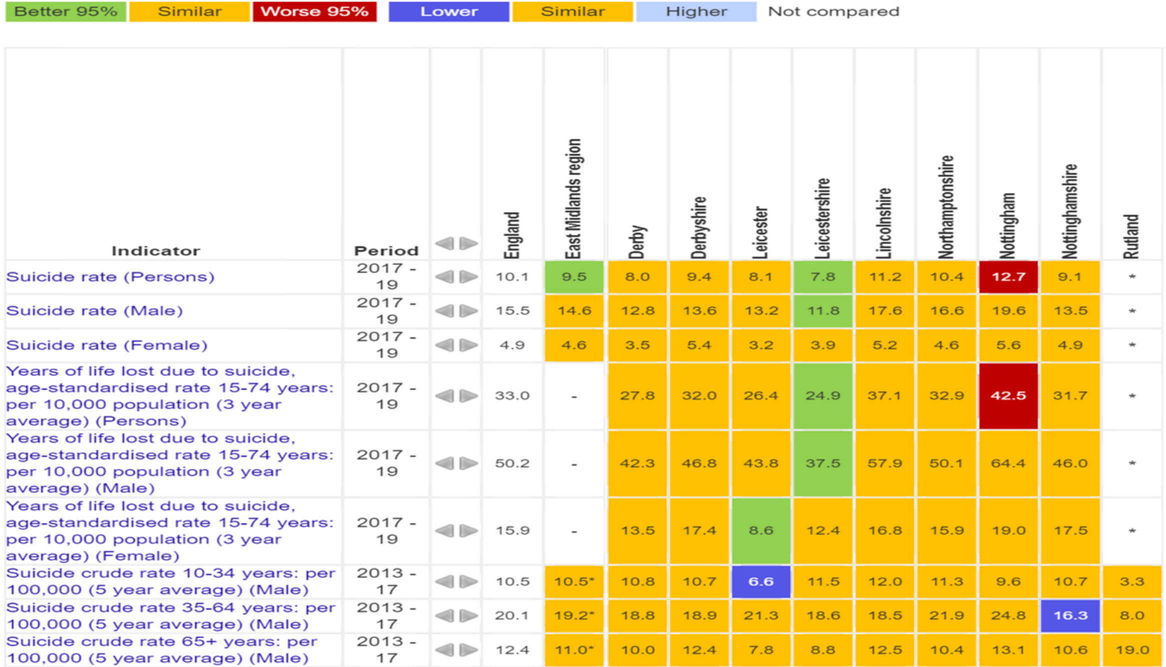
In 2020, there were 5,224 suicides registered in England and Wales, equivalent to an age-standardised mortality rate of 10.0 deaths per 100,000 people and statistically significantly lower than the 2019 rate of 11.0 deaths per 100,000.The decrease is likely to be driven by two factors; a decrease in male suicides at the start of the coronavirus (COVID 19) pandemic and delays in death registrations because of the pandemic.

Around three-quarters of registered suicide deaths in 2020 were for men (3,925 deaths; 75.1%), which follows a consistent trend back to the mid-1990s. Males and females aged 45 to 49 years had the highest age-specific suicide rate (24.1 male and 7.1 female deaths per 100,000).

By English region, the highest age-standardised mortality rate (ASMR) was in the North East (13.3 deaths per 100,000 people) and has been the case in five out of the last 10 preceding years. The North East, Yorkshire and The Humber and the South West regions had statistically significantly higher ASMRs of suicide compared with the overall England ASMR (10.0 per 100,000).

Age-standardised suicide rates for English regions and Wales, deaths registered in 2020

Area name	Age-standardised rate Sep (2020)
England and Wales	10.0
North East	13.3
North West	10.1
Yorkshire and The Humber	11.5
East Midlands	9.3
West Midlands	10.7
East	9.5
London	7.0
South East	10.6
South West	11.2
Wales	10.3



Better 95% | Similar | Worse 95% | Lower | Similar | Higher | Not compared

Indicator	Period	England	East Midlands region	Derby	Derbyshire	Leicester	Leicestershire	Lincolnshire	Northamptonshire	Nottingham	Nottinghamshire	Rutland
Suicide rate (Persons)	2017 - 19	10.1	9.5	8.0	9.4	8.1	7.8	11.2	10.4	12.7	9.1	*
Suicide rate (Male)	2017 - 19	15.5	14.6	12.8	13.6	13.2	11.8	17.6	16.6	19.6	13.5	*
Suicide rate (Female)	2017 - 19	4.9	4.6	3.5	5.4	3.2	3.9	5.2	4.6	5.6	4.9	*
Years of life lost due to suicide, age-standardised rate 15-74 years: per 10,000 population (3 year average) (Persons)	2017 - 19	33.0	-	27.8	32.0	26.4	24.9	37.1	32.9	42.5	31.7	*
Years of life lost due to suicide, age-standardised rate 15-74 years: per 10,000 population (3 year average) (Male)	2017 - 19	50.2	-	42.3	46.8	43.8	37.5	57.9	50.1	64.4	46.0	*
Years of life lost due to suicide, age-standardised rate 15-74 years: per 10,000 population (3 year average) (Female)	2017 - 19	15.9	-	13.5	17.4	8.6	12.4	16.8	15.9	19.0	17.5	*
Suicide crude rate 10-34 years: per 100,000 (5 year average) (Male)	2013 - 17	10.5	10.5*	10.8	10.7	6.6	11.5	12.0	11.3	9.6	10.7	3.3
Suicide crude rate 35-64 years: per 100,000 (5 year average) (Male)	2013 - 17	20.1	19.2*	18.8	18.9	21.3	18.6	18.5	21.9	24.8	16.3	8.0
Suicide crude rate 65+ years: per 100,000 (5 year average) (Male)	2013 - 17	12.4	11.0*	10.0	12.4	7.8	8.8	12.5	10.4	13.1	10.6	19.0

The Trust contributes to suicide prevention and this work is closely monitored by Public Health and through the Trust's leads. This data is a proxy measure of the contribution of Trust services to this public health issue.

Effectiveness of planning and response - Follow Up Post Discharge

Percentage of patients having a first follow-up appointment within 3 days of discharge from in-patient care during - 2020/21

Early follow up post discharge has been identified as a key safety issue by The National Confidential Inquiry and into Suicide and Safety in Mental Health. There is clear clinical evidence this is a measure of effectiveness in Suicide prevention.

NHS Mental Health Benchmarking

MH - DHCFT	Mean	Median
90%	83%	85%

In England, there were 1,988 suicides within three months of discharge from in-patient care between 2008 and 2018. 15% of these post-discharge suicides occurred within the first week of leaving hospital, with the highest number occurring on the second full day after the day of discharge (22%). Nationally it is recommended all patients are followed up within 3 days of discharge from in-patient care. The NICE guidance of following up all discharged patients within 7 days was formally reviewed as part of the NHS Commissioning for Quality and Innovation (CQUIN) 2019/20 scheme.

NHSE/I have included 72 hour follow-up in the NHS Standard Contract 2020/21.

National clinical guidelines have been developed with reference to findings on suicide following discharge from in-patient care.

Every child or young person who dies by suicide is a precious individual and their deaths represent a devastating loss, leaving a legacy for families that can have an impact on future generations and the wider community. As with all deaths of children and young people, there is a strong need to understand what happened, and why, in every case. We must also ensure that anything that can be learnt to prevent future child suicide or young suicide is identified and acted upon.

This report, the second thematic report from the NCMD, looks at deaths that occurred or were reviewed by a child death overview panel between 1st April 2019 and 31st March 2020.

Effectiveness in child and adolescent mental health services (CAMHS)

The National Child Mortality Database (NCMD) identifies the common characteristics of children and young people who die by suicide, investigate factors associated with these deaths and pull out recommendations for service providers and policymakers. This was published in October 2021.

Key findings in brief

Services should be aware that child suicide is not limited to certain groups; rates of suicide were similar across all areas, and regions in England, including urban and rural environments, and across deprived and affluent neighbourhoods.

62% of children or young people reviewed had suffered a significant personal loss in their life prior to their death, this includes bereavement and "living losses" such as loss of friendships and routine due to moving home or school or other close relationship breakdown.

Over one third of the children and young people reviewed had never been in contact with mental health services. This suggests that mental health needs or risks were not identified prior to the child or young person's death.

16% of children or young people reviewed had a confirmed diagnosis of a neurodevelopmental condition at the time of their death. For example, autism spectrum disorder or attention deficit hyperactivity disorder. This appears higher than found in the general population.

Almost a quarter of children and young people reviewed had experienced bullying either face to face or cyber bullying. Most of the reported bullying occurred in school, highlighting the need for clear anti-bullying policies in schools.

The Derbyshire South rates of suicide have not deteriorated. However, further exploration of these key areas to reduce the risks to our children and young people to seek early help is required for them to have accessible services and reduce waiting times.

The Director of Nursing met with a cross cutting selection of GPs in October to provide a clinical overview to a Deep Dive in Mental health services with the Trust Chief Operating Officer. The feedback was that there was a clear marked improvement in Mental Health Services over the years. GP colleagues gave feedback they had no quality concerns with regards to the effectiveness or the quality of the service. Reservations were around the volume of children and young people with early help needs and emotional distress.

Further meetings to be held with colleagues to explore the early help offer and investment in non DHCFT services.

Community

	CAM115	Mean	Median	National Trend
Total CYPMHS: referrals received per 100,000 population (0-18)	1,599	3,325	3,218	
Total CYPMHS: proportion of referrals received marked urgent / emergency	29%	12%	11%	
Total CYPMHS: referrals accepted per 100,000 population (0-18)	1,593	2,699	2,488	
Total CYPMHS: referral acceptance rate	100%	81%	83%	
Total CYPMHS: proportion of referrals that were re-referrals	3%	16%	14%	

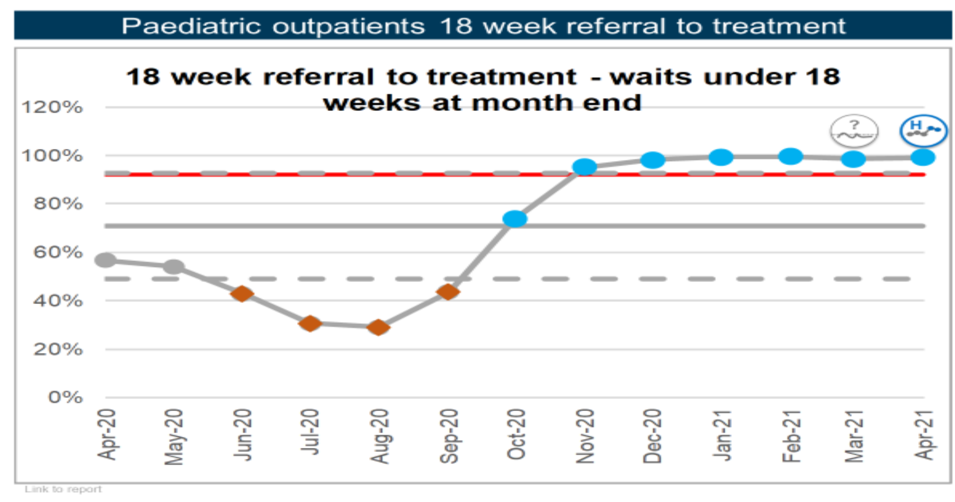
Effectiveness in Children's services

The National Child Mortality Database (NCMD) is used to identify the common characteristics of children and young people who die, investigate factors associated with these deaths and pull out recommendations for service providers and policymakers.

Over one third of the children and young people reviewed had never been in contact with mental health services. This suggests that mental health needs or risks were not identified prior to the child or young person's death.

16% of children or young people reviewed had a confirmed diagnosis of a neurodevelopmental condition at the time of their death. For example, autism spectrum disorder or attention deficit hyperactivity disorder. This appears higher than found in the general population.

Derbyshire Healthcare NHS Trust leads integrated CAMHS and Children's Services and has invested in clinical leadership, resources and time to fully transform safe paediatric management and early help. This is maintained and provides a key indicator of clinical effectiveness in reducing distress and offering early help to children not known to mental health services but who need specialist Paediatric assessment. The DHCFT model is novel nationally but it is a clinically effective model of care.



Children who are looked after children have significantly worst health outcomes without monitoring and clinical intervention.

Our children services maintain a solid and effective level of service and intervention. Children with Adverse Childhood Events have clinically worse outcomes in their adulthood, this service model and sustained level of intervention will disrupt the likelihood of worse outcomes in the future for our population.

Achieved in Derbyshire Healthcare NHS FT. April 2021

Looked after children

Children in Care Health Assessments Monthly Compliances

This report details percentage Compliance by month for Health Assessments against the targets (Under 5 = 6 months, 5 and over = 12 months).

The tables show the Compliance for Children open to the Service as at the last day of each month, and therefore does not include anyone who was discharged within that month.

Children Under 5

Compliance	Apr, 2020	May, 2020	Jun, 2020	Jul, 2020	Aug, 2020	Sep, 2020	Oct, 2020	Nov, 2020	Dec, 2020	Jan, 2021	Feb, 2021	Mar, 2021	Apr, 2021
Compliant	115	125	134	138	141	142	147	146	135	128	122	124	134
Non-Compliant	21	14	9	13	16	17	15	14	21	27	35	30	15
% Compliant	**84.6%**	**89.9%**	**93.7%**	**91.4%**	**89.8%**	**89.3%**	**90.7%**	**91.3%**	**86.5%**	**82.6%**	**77.7%**	**80.5%**	**89.9%**
Total	**136**	**139**	**143**	**151**	**157**	**159**	**162**	**160**	**156**	**155**	**157**	**154**	**149**

Children 5 and Over

Compliance	Apr, 2020	May, 2020	Jun, 2020	Jul, 2020	Aug, 2020	Sep, 2020	Oct, 2020	Nov, 2020	Dec, 2020	Jan, 2021	Feb, 2021	Mar, 2021	Apr, 2021
Compliant	413	418	420	430	428	431	434	432	429	432	434	452	459
Non-Compliant	54	45	53	49	56	53	45	55	55	56	62	46	52
% Compliant	**88.4%**	**90.3%**	**88.8%**	**89.8%**	**88.4%**	**89.0%**	**90.6%**	**88.7%**	**88.6%**	**88.5%**	**87.5%**	**90.8%**	**89.8%**
Total	**467**	**463**	**473**	**479**	**484**	**484**	**479**	**487**	**484**	**488**	**496**	**498**	**511**

SEND

LRRL13 SEND Process KPI

Letter Requests/Number of Plans	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21
Letter1	17	19	24	50	13	32	45	42	46	23	37	45	43
Letter2	123	48	95	82	49	47	50	80	99	89	92	79	116
EHCP Draft	61	54	53	51	31	32	35	29	28	40	66	43	46
EHCP	50	64	95	72	39	59	44	33	31	35	46	105	61

Response Times (by Month of Response) for Children Open in Reporting Year	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21
No. Letter 2 Responses with Preceding Letter 2	98	80	91	76	53	61	44	62	89	89	60	105	79
No. Letter 2 Responses within 42 Days	96	80	91	76	53	61	44	62	89	89	60	105	78
Letter 2 %	98%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	99%
No. Letter 2s where Response Date Deadline Falls in Month (42 days after Letter 2 Request)	68	104	83	92	72	63	46	41	61	119	74	83	98
No. Letter 2s Due where Response Recorded and Within 42 Days	66	104	83	92	72	63	46	41	61	119	74	83	97
% Letter 2s Due where Response Recorded and Within 42 Days	97%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	99%

A child or young person, who has special educational needs and disabilities, learning difficulty and/or a disability that means they need special health and education support, we shorten this to Special Educational Needs and Disabilities (SEND).

The SEND Code of Practice 2014 and the Children and Families Act 2014 gives guidance to health and social care, education and local authorities to make sure that children and young people with SEND are properly supported.

Why this is important?

1. Make sure that children and young people are at the heart of everything we do.
2. Improve the care and support that people get, to ensure that people's care and support is the same quality wherever they live.
3. Make sure that the right people know about SEND and education, health and care (EHC) plans.

Achieved and sustained in Derbyshire Healthcare NHS FT. April 2021

Children's service – 0-19

We support children and young people aged 0 to 18 through our family health services. Our health visitors work with families with young children, helping mums and dads to raise happy, healthy kids. Our school nurses and public health nurses work with older children and their families, carrying out health reviews and offering advice and information.

Early years - Outcomes	**Performance**
Antenatal contacts	Further improvement to meet 85%- agreed improvement plan
Coverage of new born visits	Further marginal improvement at 87% to 90%
Coverage 6-8 week check	90% +
Coverage 12 month review	90% +
Coverage 2- 2.5 year review	90% +

Clinical effectiveness in Children's services- our babies, children and families continue to be nourished and thrive.

In the context of community distress, becoming a parent in a pandemic and the context of elevated domestic violent throughout our community our Children's services are solid and successful.

Achieved and sustained in Derbyshire Healthcare NHS FT. April 2021

Effectiveness in Substance misuse services

In our Substance misuse services the challenges have been pressured. A number of our services have been maintained to provide continuity of care across the pandemic period. The stability in service offer has been significant.

1. The services have been stretched, but we have been able to secure Significant PHE Covid funding for 21/22. This has been allocated to both the city and county substance misuse services to maintain effectiveness.
2. County (DRP) – Funding will be allocated to a team of 10 staff in the county focussed on targeted criminal justice interventions, in line with changes in our community.
3. City (Derby Drug and Alcohol Service) have been allocated investment to improve accessibility to Alcohol Services including developing a new website and a promotional strategy within Derby City. Additionally, we will also be funding a Buvidal

(Buprenorphine depot injection) pilot for a small number of patients, with known improvement in effectiveness.

4. Stability in service with the formal confirmation of City Contract extension until 2023 and County contract extension until 2024.

Achieved and maintained in Derbyshire Healthcare in 2021

No out-of-area admissions

Very ill patients should be accommodated in a local inpatient unit. Being admitted locally means that patients stay close to home and the support of their friends and family and are less likely to feel isolated or to experience delayed recovery. Local admission should also result in simpler discharge care planning.

In England, 191 patients (10% of post-discharge deaths) died after being discharged from a non-local in-patient unit. This proportion increased to 13% (n=65) of those who died within two weeks of discharge. There has been a downward trend in the number of suicides by patients recently discharged from hospital in England and Scotland, and lower figures in Wales since a peak in 2013. In England, there were 149 post-discharge deaths in 2018 (20 in Scotland), down from 227 in 2011 (49 in Scotland).

Both the King's Fund Under Pressure report and the Independent Commission on Acute Adult Psychiatric Care referenced this recommendation in 2015, calling for an end to acute admissions out of area. National clinical guidelines have been developed with reference to our findings on suicide following discharge from in-patient care. See the NICE guidance on transition between in-patient mental health settings and community or care settings.

In the National Benchmarking in October 2021, the Trust length of stay was below average at 25 days. This achievement was prior to the Multi Agency Discharge Event (MADE) outcomes. The MADE which will enable further improvement to support improved patient flow across the system, recognise and unblock delays and challenge, improve and simplify complex discharge processes.

This approach draws upon the clinical and operational evidence to effective focused improvement.

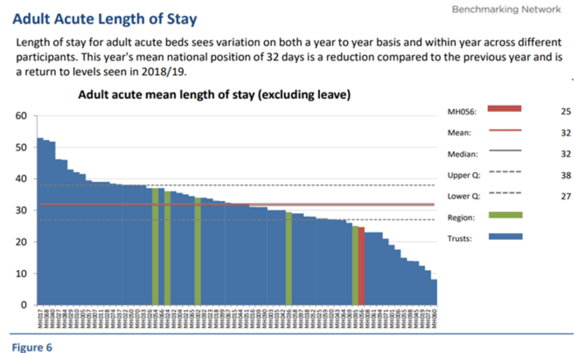


Figure 6

Achieved and maintained in Derbyshire Healthcare in 2021

24-hour crisis resolution/home treatment teams

Community mental health services should include a 24-hour Crisis Resolution/Home Treatment team (CRHT) with sufficiently experienced staff and staffing levels. CRHT's provide intensive support in the community to patients who are experiencing crisis, as an alternative to in-patient care. CRHT teams should be monitored to ensure that they are being

used safely. Contact time with CRHTs should reflect the specialist and intensive nature of that role.

The setting where suicide prevention can have the greatest impact is the crisis team; the main location where patients with acute illness are now seen. In England, there are on average 182 suicides per year by CRHT patients – over two times as many as under in-patient services. The introduction of a 24-hour CRHT appears to add to the safety of a service overall, with a reduction in suicide rates in implementing mental health services. In our study of the assessment of clinical risk in mental health services, both patients and carers emphasised the need for clarity about what to do and who to contact in a crisis.

Both the King's Fund Under Pressure report and the Independent Commission on Acute Adult Psychiatric Care referenced these recommendations in 2015 and emphasised the importance of CRHTs operating efficiently as intensive specialist community-based alternatives to in-patient care, and not simply as generic crisis teams. This recommendation is included in HM Government's Fourth progress report of the suicide prevention strategy for England. It is noted in the Fifth progress report of the suicide prevention strategy for England that by March 2021, all CRHT services will operate 24/7.

Achieved and maintained in Derbyshire Healthcare in 2021 – supplemented by the 24 hour Crisis line

Family involvement in 'learning lessons'

Working more closely with families could improve suicide prevention. Services should consult with families from first contact, throughout the care pathway and when preparing plans for hospital discharge and crisis plans. Staff should also make it easier for families to pass on concerns about suicide risk and be prepared to share their own concerns. This could help to ensure there is a better understanding of the patient's history and what is important to them in terms of their recovery and may support better compliance with treatment. There should be a multi-disciplinary review following all suicide deaths, involving input from and sharing information with families.

Staff told us that greater involvement of the family by the service would have reduced suicide risk in 18% of patients. One example of how clinicians think services can improve contact with families is by informing them when a patient does not attend an appointment. In only 27% of deaths by suicide, the service contacted the family when the patient missed the final appointment before the suicide occurred. Policies for multidisciplinary review and information sharing with families were associated with a 24% fall in suicide rates in implementing NHS Trusts, indicating a learning or training effect. Patients tell us they want their families to have as much involvement as possible in their assessment of clinical risk, including sharing crisis/safety plans with them. Clinicians tell us family involvement is vital to enhancing patient safety in mental health care settings

Achieved and maintained in Derbyshire Healthcare in 2021- we work towards our Triangle of care standards in 2022 and we maintain our Family liaison services and family involvement in learning.

Safer wards

Following NCISH recommendations, suicide using non-collapsible ligature points became an NHS 'never event' (a serious incident that is preventable) in 2009. This means that health services are required to monitor their incidence and are provided with advice to reduce the

risk. Since then suicide by mental health in-patients continues to fall; there were 74 suicides by in-patients in the UK (excluding Northern Ireland) in 2018. Between 2008 and 2018, around a third of in-patient suicides took place on the ward. Many of these deaths were by hanging/strangulation from low-lying ligature points. In our study of clinicians' views of good quality practice in mental healthcare, clinicians emphasised practices that improved safety in a ward environment such as observations conducted by trained staff

Achieved and maintained in Derbyshire Healthcare in 2021- we continue to make sure our hand held observations systems are fit for purpose, we will ensure in the new builds and refurbishments we will use the current evidence to reduce this risk to the lowest level we are able to.

Staff stability The National Confidential Inquiry into Suicide and Safety in Mental Health

There should be a system in place to monitor and respond to non-medical staff turnover rates. Non-medical staff are all other health staff except doctors.

Organisations with low turnover of non-medical staff had lower suicide rates than organisations where staff changed frequently. In addition, those services with low staff turnover saw a greater reduction in their suicide rates when they implemented NCISH recommendations that services with high staff turnover.

Derbyshire Healthcare is in the top five featuring at joint third in the nationally collected staff turnover and stability index.

		Mental Health	Mental Health and Learning Disabilit	All staff groups	4,265	46.4%	706	7.7%	90.5%
		Mental Health	Mental Health and Learning Disabilit	All staff groups	1,181	13.5%	869	9.9%	89.9%
		Mental Health	Mental Health and Learning Disabilit	All staff groups	706	17.1%	406	9.8%	89.8%
Derbyshire Healthcare NHS Foundation Trust	RXM	Mental Health	Mental Health and Learning Disabilit	All staff groups	315	11.5%	278	10.2%	89.8%

Clinical effectiveness of Leaning Disability services

Joined Up care Derbyshire had a recent 2021 collaboration review on people with a learning disability.

Our provider collaboration review was aimed to show the best of innovation across services and review national learning and improvement.

The CQC sought to find out more about the care for people with a learning disability who live in the community, and what impact the COVID-19 pandemic has had on them and the services they receive.

The CQC looked at:

1. Whether people with a learning disability still had access to the right care and support when they needed it during the pandemic. This includes how services have collaborated to keep people safe.
2. What the impact of the pandemic has been for people living independently in the community. This includes how well services have been planned and delivered to ensure continuity of care.
3. How providers have balanced the need to keep staff safe with continuing to provide people with a learning disability with the support they need.
4. How digital technology has supported or prevented services from being able to provide people with the care and support they need.

A model of good practice was the Mental Health and Learning Disability Hospital hub specific support service.

The mortality rates of individuals with COVID in South Derbyshire, who were open to DHCFT Learning disability services and who were lost to COVID, is very low against national benchmarks. (Quality account 2020/2021)

Achieved and maintained in Derbyshire Healthcare in 2021- Derbyshire Healthcare services did not have any trust specific actions

Effectiveness in the safe management of COVID

Derbyshire Healthcare has navigated the COVID pandemic successfully. There is evidence of significant clinical changes drawing upon the clinical evidence in Infection Prevention and Control. The full infection control Annual report and Quality Account 2020/21 has significant triangulated evidence of the positive clinical outcomes in colleague and patient safety. The COVID vaccination centre/ hospital hub and outreach model have had positive outcomes for people who used our services, and this was noted in the recent system inspection visit- Provider Collaborative Review for Learning Disability services.

Effectiveness in Older People's care

MH- DHCFT	Mean	Median
Older adult admissions per 100,000 weighted population 23.7	31.9	27.5
Older adult admissions per 100,000 weighted population 97.1	120.0	114.9
Older adult mean length of stay (excluding leave) 41.2	72.7	68.4
Older adult readmissions 3%	5%	5%

Overall, this picture of clinical effectiveness of Older people's care demonstrates a clinical pathway that is in balance. Effectiveness in older people's care would be accessible beds, admission beds enough to meet the population needs, hospital admission for lowest length of time with accessible community mental health care. Admission for the shortest amount of time but without a high level of re-admission.

All indicators demonstrate a clinical model in balance, this coupled with low complaints, positive patient and carer experience is a wider indicator of stability.

Key highlight - The impact and effectiveness of the community forensic team

– a Board Assurance Framework (BAF) red risk and one of our Trust Quality priorities is Sexual Safety.

The voice of partner organisations Multi-Agency Public Protection Arrangements (MAPPA) and Probation.

The Responsible Authority is the primary agency for MAPPA. This is the police, prison and Probation Trust in each area, working together. The Responsible Authority has a duty to ensure that the risks posed by specified sexual and violent offenders are assessed and managed appropriately.

The Criminal Justice Act 2003 (“CJA 2003”) provides for the establishment of MAPP) in each of the 42 criminal justice areas in England and Wales. These are designed to protect the public, including previous victims of crime, from serious harm by sexual and violent offenders. They require the local criminal justice agencies and other bodies dealing with offenders to work together in partnership in dealing with these offenders.

From 2014 concerns were raised by the MAPPA Strategic Board of the accessibility, commissioning and capacity of the community mental health teams to meet the demand of people who were required to have this level of public protection and co-ordination. Concerns were expressed with the lack of a specialist community forensic team and effectiveness of a generic community mental health team to meet the complexity and demand of risks posed by specified sexual and violent offenders.

Over the 12 months from 1 April 2019 to 31 March 2020 the number of registered sexual offenders (MAPPA Category 1) grew in Derbyshire by 3.6%, which is demonstrative of a return to the upward trend which has been seen in previous years.

Year Total Annual Increase RSO/100k

Year	Registered sexual offenders (MAPPA Category 1)	Annual Increase	RSO/100k
2019/20	1272	3.6%	135
2018/19	1228	0.5%	131
2017/18	1222	6.2%	132
2016/17	1151	4.1%	125
2015/16	1106	4.8%	121

The Derbyshire figure for RSOs per 100,000 population continues to be above the England and Wales average.

The number of violent offenders and other sexual offenders (MAPPA Category 2) increased over the course of the year and grew by 13.8%. Adult violent offenders are managed on post-release Licence by the National Probation Service whilst those aged under 18 years are supervised by the two Youth Offending Services. A very small number in this category are subject to social supervision by Derbyshire Healthcare Foundation NHS Trust (Mental Health Services) following discharge from a secure hospital unit.

The number of other dangerous offenders (MAPPA Category 3) included in the arrangements was identical to last year. The overall numbers of other dangerous offenders remain relatively low overall. Some of these offenders may previously have been included under one of the other categories.

A new service was set up, and the feedback is now as follows.

In 2021 this is the feedback from partners

Dear Carolyn

From a multi-agency perspective, I would say that our arrangements at MAPPA 3 have been ***significantly improved*** *by the community forensic team and in particular, the availability of both Psychologist and Psychiatrist input from the team. We have had complex cases, that hinged on clinical assessments of whether there was a Mental Health or Learning Disability need, or where behaviour linked more to Personality Disorder, and* ***the input from the Community Mental Forensic team staff has been vital.***

COVID has prevented us for working cases closely at practitioner level I suspect, and our co-location has not yet been realised, but the close liaison between the MAPPA unit and level 3 partners has been invaluable. I would like to see a focus now on practitioner links across the team and across to all our new probation staff.

Head of probation

Community Mental Forensic team (CFMHT) – Feedback from MAPPA team

The CFMHT have completed a number of psychological reports for MAPPA on cases being managed at Level 2 and 3. These reports have been most helpful in both informing our risk assessments and management plans, which are key to our purpose of protecting the public.

An assessment undertaken by the Psychologist in the CFMHT on a young female led to a diagnosis of post-traumatic stress disorder and personality disorder. This assessment, I believe was instrumental in facilitating her care.

- *The risks were significant - for arson endangering life, and for threats to kill. Attempts had the case had been managed both at MAPPA Level 2 and 3,*
- *I am not convinced that her care would have been as effective without the involvement of the CFMHT.*
- *A significant reduction in risk related behaviours and describe that she is making steady progress towards discharge.*

Specific identifying facts have been redacted.

The CFMHT were asked to complete another psychological assessment on a young person with Autism Spectrum Disorder (ASD) traits who had been convicted of committing touching offences.

There were concerns that the young man had a fascination with a TV drama where the lead character. There was also intelligence to indicate that the young man had thoughts to commit serious sexual offences. The young man and his family refused to engage with professionals.

Professionals working with the young man were struggling to assess his risk, which was complicated by the ASD traits. As a result of this the case was referred into MAPPA. A psychological report was commissioned from the CFMHT which has increased our understanding of the risks he presents and has informed how professionals now work with him. As a result of this assessment we have seen a marked improvement in the young man's motivation to engage with professionals involved in his management. This report has been key in informing both his risk assessment and risk management plan. He has now been discharged from MAPPA management.

Specific identifying facts have been redacted.

In another assessment completed by the Psychologist in the CFMHT it was recommended that a young man with a Learning Disability required specialist accommodation and psychological intervention.

The person had served a prison sentence for serious sexual offences, and a previous placement in an Approved Premises quickly broke down owing to an escalation in risk related behaviours following release. The report led to funding being secured through Adult Social Care and Health for a placement in a specialist unit.

Since the intervention and the team.

Probation records indicate no re-offending since release. He was assessed as a high risk of serious harm, and owing to the level of complexity in his case he had previously been managed at MAPPA Level 3. Without the psychological assessment by CFMHT I do not, that without suitable package of care and support he would have gone on to re-offend on release.

Specific identifying facts have been redacted.

Feedback from MAPPA team was requested to consider the clinical effectiveness and impact of the services. There are no quality metrics, national monitoring metrics, formal outcome measures, tools that can assess the quality of forensic care. The trust uses access, proxy measures and feedback from partners to assess

Feedback from neighbouring Mental Health Trust – Anonymous Consultant Psychiatrist

Thank you for sharing DHCFTs work in its community forensic team

I just wanted to say that since Wed, I have heard several colleagues comment on the inspirational work that you are doing in Derbyshire. I really hope that our Trust will be able to use your presentation as a catalyst for positive change.

The Trust is fully compliant.

Identify all offenders who meet the MAPPA eligibility criteria and fall within MAPPA through a mental health outcome	
Undertake a comprehensive risk assessment and assess the required level of MAPPA management and refer the offender for Level 2 and 3 management, where required.	
Complete the MAPPA required information and send it to the MAPPA Co-ordinator	
Provide data of the cases they manage for the MAPPA Annual Report.	

Effectiveness and planning for population health

Public protection and violence in Derbyshire for our community and for people who use our services

Derby is the most dangerous city in Derbyshire and is among the top 10 most dangerous overall out of Derbyshire's 279 towns, villages, and cities. The overall crime rate in Derby in 2020 was 107 crimes per 1,000 people. This compares poorly to Derbyshire's overall crime rate, coming in 31% higher than the Derbyshire rate of 73 per 1,000 residents. For England, Wales, and Northern Ireland as a whole, Derby is among the top 10 most dangerous cities, and the 399th most dangerous location out of all towns, cities, and villages.

The most common crimes in Derby are violence and sexual offences, with 12,768 offences during 2020, giving a crime rate of 48. This is 9% higher than 2019's figure of 11,580 offences and a difference of 4.48 from 2019's crime rate of 44. Derby's least common crime is theft from the person, with 295 offences recorded in 2020, a decrease of 42% from 2019's figure of 419 crimes.

Derby Crime Trends - Crime Rate Per 1,000 Residents

Crime	**2017**	**2018**	**2019**	**2020**	Trend
Anti-Social Behaviour	51	46	43	46	Safer
Bicycle Theft	2.1	2.5	2.4	2.4	Getting worse
Burglary	8	8	7	5	Safer
Criminal Damage and Arson	10	9	11	11	Getting worse
Drugs	3.5	3.8	3.7	4.3	Getting worse
Other Crime	1.4	1.8	2.4	2.5	Getting worse
Other Theft	9	9	9	7	Safer
Possession of Weapons	0.75	1.1	1.3	1.2	Getting worse
Public Order	2.6	3.8	9	12	Getting worse
Robbery (inc. mugging)	1.3	1.4	1.6	1.4	No change
Shoplifting	10	9	8	5	Safer
Theft from the person (including pickpocketing)	1.1	1.5	1.6	1.1	Safer
Vehicle Crime	8	6	6	5	Safer
Violence and Sexual Offences	22	26	44	48	Getting worse. Most dangerous area Cathedral Quarter and California (1,580)

What we know?

1. While the short-term effects of crime can be severe, most people don't suffer any long-term harm. Occasionally, people do develop long-term problems, such as depression or anxiety-related illnesses, and a few people have a severe, long-lasting reaction after a crime, known as post-traumatic stress disorder (PTSD).

2. The most startling findings show that people with mental health problems are:
   - three times more likely to be a victim of crime than the general population
   - five times more likely to be a victim of assault (rising to 10 times more likely for women)
   - more likely to be a repeat victim and experience different types of crime
   - far less likely to be satisfied with the service and support they receive.

3. McCann (2010) people with psychosis in CMHTs- aspire to have relationships, though those relationships tend to be abusive or exploitative; rarely (or never) discuss intimate relationships with their care coordinator.

4. Hughes et al (2016) systematic review of HIV, hepatitis B and C found people in psychiatric care had elevated rates of blood borne infections (far more than would be expected in the general population).

5. Khalifeh et al (2015)- 6- to 8-fold elevation in the odds of sexual assault among both men and women with a serious mental illness (SMI) compared with the general population.

6. Child sex abuse is a common experience amongst people with mental illness.

7. Increased rate of un-intended pregnancy and abortion (Simoila 2018).

8. Elkington 2010- sexual stigma has been identified as an issue for those with long term mental health problems and is linked to sexual risk taking and exploitation.

9. High levels of re-victimisation sexual assault and rape in people who use mental health services. 62% of women with severe mental illness reported being victims of sexual violence as adults (Institute of Psychiatry study Moran P).

10. Nearly 45% of people with severe mental illness reported experiencing crime in the last year (Institute of Psychiatry study Moran P).

Sexual safety inpatient wards- what do we know?

Foley and Cummings (2018)

- FOI to NHS trusts) between 2011 and 2015
- they identified 32 assaults (20 were women and 12 were male victims).
- 10 in patient’s bedroom; 13 in communal areas

All of this evidence and understanding will and has been used to informed our future clinical models and will be developed further to inform our metrics for the future to measure how we use the evidence and measure the impact.

Effectiveness in 2021/22/23

- We have a strong baseline of Education in our staff team.
- We have very clear boundaries for our staff, and they are very aware of professional boundaries and why.
- We are building a culture and therapeutic environment to predict sexual safety incidents, reduce their incidence (pre- and post-measures).
- We are building a culture and a physical environment which reduces sexual safety incidents (pre- and post-measures).
- We explore and measure the impact of talking to our people in our care of sexual safety.

Develop gender sensitive services and indicators in 22/23 +

- We are building an assessment model which is gender sensitive and explores relationships and relationships - Women – menstruation, sexuality, sexual safety and menopause.
- We are building an assessment model which is gender sensitive and explores relationships and relationships- Men – testicular health, sexuality, sexual safety and male sexual health also covers the prevention and treatment of sexually transmitted diseases.
- Exploring an effectiveness and collaboration strategy that looks to co-locate sexual health, women's and men's clinics with or co-aligned with Mental Health teams.
- Exploring an effectiveness and collaboration strategy that looks to co-locate – victim support services with Mental Health teams.
- How will Joined Up Cared Derbyshire review its psychological support offer to victims of violent and sexual crime, to review up-take and impact?
- How will we know - Joined Up Cared Derbyshire, that every person who is a victim of a violent or sexual violent crime, is offered psychological support?

How can we learn from other areas? Doing better for victims and witnesses with mental health problems in Kent www.victimsupport.org.uk
Tamar Dinisman and Ania Moroz October 2019

How and Why – the future?

1. Mental health staff are skilled at having conversations about sensitive topics.
2. These skills are transferable to sexual safety and sexual health. Is this a future priority for the Health Protection Unit?
3. The consequences of avoiding the topic are really significant.

Overall summary

We have made significant headway in the domain of effectiveness in our Mental Health and Learning Disability services. We have significant evidence of improvement and effectiveness.

There has not been a deterioration in our current practices.

We do have more areas to continue to improve.

We have further work to complete as we fully implement our Sexual Safety clinical improvement plan. We have ensured that our Substance Misuse and Alcohol services are inextricably interconnected into our clinical pathways. We have further work to complete on Dual diagnosis, now referred to as or co-existing Substance use to further reduce the risks of Homicide. Domestic Homicide and Suicide. This is an area where only a minority of patients who died by suicide between 2008 and 2018 were in contact with specialist substance misuse services, despite alcohol and drug misuse being a common antecedent of patient suicide in all UK countries (58% of all patient suicides UK-wide, higher in Scotland and Northern Ireland).

In England, there was a 25% fall in rates of suicide by patients in those NHS Trusts which had put in place a policy on the management of patients with co-morbid alcohol and drug misuse.

The specific key interventions that we will be exploring to ensure that this is the key areas of implantation and review of implementing NICE guidelines.

1. Specialist alcohol and drug services are available, with a protocol for the joint working with mental health services (including shared care pathways, referral and staff training).
2. There is a specific management protocol or written policy on the agreed
3. Protocols for managing self-harm patients who are under mental health care should highlight the short-term risk of suicide, especially where there is coexisting alcohol and drug misuse.
4. There is specific training in place for staff on substance misuse assessment.
5. There are specialist substance misuse clinicians within mental health services. This is an area of further exploration and development in acute mental health service pathways.

In 2022/23

NHS England are out to current consultation of the next years CQUINS and improvement areas.

1. Outcome measurement across specified mental health services
2. Use of anxiety disorder specific measures in IAPT. A part two implementation of an existing CQUIN.
3. Drawing learning from the 2019/20 IAPT CQUIN, the NHSE/I mental health team has been working with providers to extend the focus on outcomes measurement to adult community, children and young people (CYP) and perinatal mental health services.#
4. The data generated due to the recording of outcome measures will enable improved recording and evaluation of wider interventions, in line with commitments within the Long Term Plan.
5. There is detailed NICE guidance supporting the delivery of comprehensive biopsychosocial assessments for people who present to emergency departments due to self-harm. Mental health liaison services are now fully funded and rolled out across the country and this CQUIN draws attention to the benefits of ensuring an assessment is carried out on patients that have been referred from emergency departments. Through ensuring that all appropriate patients receive a comprehensive biopsychosocial assessment (research suggests that only 53% of people who self-harm and present to emergency departments receive a biopsychosocial assessment by specialist MH staff), this indicator will improve patient experience of MH in A&E (a 2015 CQC study found that only 36% report a positive experience), reduce repeat presentations to emergency departments and reduce the risk of suicide.
6. Supporting patients to manage a healthy weight in adult secure settings through interventions that culminate in service users having a ‘physical health passport’. Current literature indicates that the lives of people with severe mental illness are 10 to 25 years shorter than the general population. Obesity is one of the most significant

modifiable risk factors for premature mortality and chronic disease in individuals with mental illness. NICE guidelines suggest that service users should demonstrate an active engagement in diet, exercise and other lifestyle interventions to reduce weight before medical treatment is considered. This is very difficult to achieve in the secure services due to the severe, chronic nature of mental disorder, the treatments received, and the restrictions on freedom of movement.

7. Outcomes data can shed light on the effectiveness of interventions being delivered, supporting national objectives around developing the evidence base for specialised services and commissioning for outcomes. Access to routine clinical feedback has been demonstrated to improve outcomes for patients. Reviewing of individual outcome measures can aid clinical decision making and have a positive impact

8. Perinatal MH is a priority area of focus within the 5 Year Forward View for MH and within the Long-Term Plan (LTP). Supports LTP ambition to improve quality of care.

Our Children's services are solid and are responding exceptionally well to the clinical and contextual environments they find themselves navigating in.

1. Our Children's services will need to continue to explore with our women who are not vaccinated to make informed decisions.
2. Our Children services will need to maintain clinical standards in being sensitive to detect and alert family violence and community violence which is increasing in our city.

It is exciting and positive to see the Trusts services flourishing over 2020 and 2021.

The next 12 months to two years are pivotal on the trusts journey to routine outcome measurement, clinical improvement of standards and fully implementing the Quality Improvement Strategy on completion of its review in 2021.

Glossary and overview

MAPPA eligible offenders are identified by the police, probation, prison, youth offending or mental health services at the time they are sentenced.

Information about them can then be shared by the agencies in order to inform the risk assessments and risk management plans of those managing or supervising them.

In the majority of cases that is as far as MAPPA extend, but in some cases, it is assessed that structured multi agency management is required. In such cases there will be regular MAPPA meetings attended by relevant agency practitioners and managers.

There are three categories of MAPPA-eligible offenders:

Category 1

Registered sexual offenders (RSO) who are subject to the notification requirements of Part 2 of the Sexual Offences Act 2003, sometimes called the 'sex offender register'.

Category 2

Violent offenders (VO) sentenced to detention or imprisonment for 12 months or more, or who have been made subject to a Hospital or Guardianship Order under the Mental Health Acts. This category also includes a small number of offenders whose sexual offences do not come within scope of notification requirements.

Category 3

Other offenders (OO) who do not qualify under Categories 1 and 2 but who have previously acted in a way that demonstrates they may cause harm and are currently assessed as posing a serious risk which calls for structured multi agency management. No other persons can lawfully be included under the arrangements.

There are three management levels to ensure that time and resources are focused upon the cases where they are most needed; this is generally those involving a higher risk of serious harm or who present major grounds for concern.

Level 1	**Level 2**	**Level 3**
Is where the offender is managed by the lead agency with information exchange and multi-agency support as required but without regular MAPPA meetings.	Where the active involvement and resources of more than one agency is required to manage the offender or assure the safety of victims, but the risk management plans do not require a senior level of attendance for the commitment of resources.	Where senior oversight of the risk management plan or significant extra resources and scrutiny are required.

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 2 November 2021

Guardian of Safe Working Quarterly Report (October 2021)

Purpose of Report

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

Executive Summary

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

The Board of Directors is requested to note:

1) There are vacancies in higher trainee posts that reflect the national issue with recruitment in psychiatry. Trainees are being supported with exception reporting (ER) and these have been resolved in a timely fashion. There have been no exception reports during the last quarter.
2) The BMA fatigue and facilities charter for junior doctors is being carefully considered and recently issue with space for juniors in the south has been successfully resolved. We have nominated one junior doctor each from north and south to explore with other juniors about the use of allocated funds for this purpose.
3) There are continuing issues with Allocate, the software for logging of ERs or closing them which causes slight delay in the process. The company is not providing a good service anymore and we have had no contact with them recently despite messages left for them. This seems to be a national issue. More recently, the junior doctors have had problems logging in which is the main reason for delayed resolution of ERs.
4) During the COVID crisis, the junior doctors had previously raised issues about their work environment, situation with PPE and some training issues. The Junior Doctor Forum (JDF) has continued to provide them with a neutral platform to raise any issues. They have felt supported and have been able to express their concerns freely. Some of the previous issues raised at JDF have been discussed with DME – Director Medical Education (DME). There have been no new concerns raised recently at JDF.
5) DME, Associate Director Medical Education (ADME), Nursing Matron from the Hartington Unit and the Freedom to Speak Up Guardian have been signposted elsewhere. We have continued to hold JDF every four to six weeks and will be so for the rest of the year.

6) The existing vacancy in one of the inpatient wards in the south has concerned us. However, this seems to reflect the national issues with recruitment especially for inpatient areas. It has been difficult to recruit agency staff for similar reasons; fortunately, a speciality doctor has now been successfully recruited to this post, due to start on 1 November 2021.
7) Junior doctors have been successfully completing their virtual induction and have given a positive feedback.
8) The Freedom to Speak Up Guardian has been meeting up with junior doctors and explained her role to them. She has also attended the JDF and meets with the champions for Freedom to Speak Up on regular basis. Two of these champions are junior doctors.

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

Assurances

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

Consultation

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

Governance or Legal Issues

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

Public Sector Equality Duty and Equality Impact Risk Analysis

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

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

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

Recommendations

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

Report presented by: **Dr John Sykes**
Medical Director

Report prepared by: **Dr Smita Saxena**
Guardian of Safe Working

GUARDIAN OF SAFE WORKING QUARTERLY REPORT
(October 2021)

1. Trainee data

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

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

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

2. Exception Reports (with regard to working hours)

There have been 11 reports during this period. No fines were levied.

Exception Reports				
Location	No of exceptions carried over from last report	No of exceptions raised	No of exceptions closed	No of exceptions outstanding
North	0	0	0	0
South	0	11	11	0
Total	0	11	11	0

Exception Reports by Grade				
Location	No of exceptions carried over from last report	No of exceptions raised	No of exceptions closed	No of exceptions outstanding
CT1-3	0	4	4	0
ST4-7	0	2	2	0
GPVTS	0	0	0	0
Foundation	0	5	5	0
Total	0	11	11	0

Exception Reports by action				
	Payment	TOIL	Not agreed	No action required
North	0	0	0	0
South	11	0	0	0
Total	11	0	0	0

Response time				
Grade	**48 hours**	**7 days**	**Longer than 7 days**	**Open**
CT1-3	0	0	4	0
Foundation	0	0	5	0
ST4-6	0	1	1	0

The exception reports by the CT and FY trainee are on the same ward and due to the following issue:

- Absence of a middle grade doctor on the ward has generated extra work for both trainees.
- CT trainee has multiple other commitments – including attending their training and teaching and on call commitments which can sometimes leave extra work for the FY1 trainee
- Similarly the CT trainee has had to stay longer to do extra work when the FY trainee is not there.

The Director Medical Education, Clinical Supervisor and Clinical Director are all aware. Recruitment for an agency speciality doctor has been unsuccessful previously. The Clinical Supervisor / Consultant on the ward have been doing extra work to support trainees. More recently, a middle grade has been recruited however they are unable to start until 1 November. In the interim, the responsible professionals are all trying to support the trainees and the ward.

Following a discussion with the Clinical Supervisor and Director Medical Education, it has been agreed to make a payment in lieu for the extra hours carried out by both the trainees. It was felt appropriate to do so in order to make the trainees feel supported and to uphold the reputation of the trust amongst current and future trainees. The extra time done by both trainees individually varies between 45 minutes to an hour or up to an hour and half.

The exception report by higher trainee has been resolved through additional payment (as per the guidance for stepping down in the on call rota).

It has taken longer than seven days to resolve the exception reports due to Allocate related issues – logging in problems, non-visibility of exception reports on the GOSW dashboard, problems with e-mail generation informing the GOSW when Exception reports are logged in. We continue to discuss these issues with responsible persons at Allocate but this seems to be a national issue. We have asked the trainees to individually let the GOSW know about the exception reports through an e mail.

3. Work schedule reviews

No formal work schedule reviews needed during this period.

4. Fines

No fines imposed.

5. Locum/Bank Bookings

North – 68 shifts totalling £26,820.91
South – 70 shifts totalling £29,795.06

The locum spend remains high during this period due to vacancies, COVID-19 related absence and general sickness. A junior doctor has remained shielding and is not able to undertake their out of hours duties.

6. Agency Locum

South – 13 shifts totalling £8988.50

All attempts are made to cover the shifts by our own doctors, when this has not been possible we go to agency for cover.

7. Vacancies

	North **Nov 20 – Mar 21**	**South** **Nov 20 – Mar 21**
CT1-CT3	1	1
ST4-7	3	3
GP Trainees	0	0
Foundation	0	0

8. Qualitative information

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

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

9. Issues arising

9.1 Compliance of Rota

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

Action completed: current rota is fully compliant since August 2020

9.2 Currently there is adequate PPE availability.

The trainees have not reported any concerns.

9.3 Vacancies

As described Above. The DME and ADME are addressing the issues around higher trainee recruitment.

9.4 Induction for August 2021

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

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

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

9.5 Fatigue and facilities

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

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

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

Action(s) pending:

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

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

9.4 Exception reports

Exception Reports are encouraged as usual so we can highlight areas of increased demand and impact of response during this period. No face to face contact needed unless we identify a risk that would benefit from this. A telephone discussion with educational supervisor is mandatory with usual

information to be submitted on ALLOCATE (the software for logging exception reports) by the trainees and supervisors.

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

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

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

10. Other concerns raised with the GOSW

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

Action completed:

- **The Clinical Matron, Hartington Unit is meeting with trainees and works closely with nurses to address such issues**
- **Meeting held between the trainee reps and FTSU Guardian. Feedback will be given at next JDF**.
- **We continue to encourage trainees to speak up at the Junior Doctors Forum about any issues at place of work.**

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 2 November 2021

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 30 April to 22 July 2021.

Executive Summary

During the COVID-19 pandemic, the learning from deaths process continued to be undertaken but slight changes to the process were initially made to allow for colleagues to undertake other duties. Activity has now resumed back to normal with weekly case note reviews and the daily reviewing and grading of all new deaths taking place.

All deaths directly relating to COVID-19 are reviewed through the Learning from Deaths procedure unless they also meet a Datix red flag, in which case they are reviewed under the Untoward Incident Report Reporting Policy and Procedure.

- From 30 April to 22 July 2021 there have been zero deaths reported where the patient tested positive for COVID-19
- During this period the Trust received 385 death notifications of patients who had been in contact with our service in the last six months
- One inpatient death was recorded.
- The Mortality Review Group reviewed 28 deaths through a Stage 2 Case Note Review. These reviews were undertaken by a multi-disciplinary team and it was established that of the 28 deaths reviewed, 28 were not due to problems in care.
- During this period the Trust has reported 6 Learning Disability. There is very little variation between male and female deaths; 187 male deaths were reported compared to 207 females.
- 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 attracting colleagues to work with us who we develop, retain and support by excellent management and leadership	
3) We will make the **best use of our money** by making financially wise decisions and will always strive for best value to make money go further	

Assurances

This report provides assurance that the Trust is following recommendations outlined in the National Guidance on Learning from Deaths.

Consultation

This report was previously considered by the Quality and Safeguarding Committee and the Serious Incident Group.

Governance or Legal Issues

There are no legal issues arising from this report.

The Care Quality Commission Regulations - this report provides assurance as follows:

- Outcome 4 (Regulation 9) Care and welfare of people who use services
- Outcome 14 (Regulation 23) Supporting staff
- Outcome 16 (Regulation 10) Assessing and monitoring the quality of service provision
- Duty of Candour (Regulation 20)

Public Sector Equality Duty and Equality Impact Risk Analysis

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

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

- From 30 April to 22 July 2021 There is very little variation between male and female deaths; 187 male deaths were reported compared to 207 females.
- No unexpected trends were identified according to ethnic origin or religion.
- Further analysis is underway to examine if any trends can be detected by considering a larger data sample over an extended time frame.

Recommendations

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

Report presented by: **Dr John R Sykes**
Medical Director

Report prepared by: **Aneesa Akhtar-Alam**
Mortality Technician

Learning from Deaths - Mortality Report

1. Background

In line with the Care Quality Commission's (CQC) recommendations in its review of how the NHS investigates patient deaths, the National Quality Board published a framework for NHS Trusts - 'National Guidance on Learning from Deaths[1]'. The purpose of the framework is to introduce a more standardised approach to the way NHS Trusts report, investigate and learn from patient deaths, which should lead to better quality investigations and improved embedded learning.

To date the Trust has met all the required guidelines.

The report presents the data for 30 April to 22 July 2021.

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

- The Trust is still waiting to ascertain if Cause of death (COD) will be available through NHS digital and the national Medical Examiner System. Currently COD is been ascertained through the coroner officers in Chesterfield and Derby but only a very small number of COD have been made available.

- Medic rotas for the north and south have been updated. 28 Case Note Review sessions were undertaken, where 28 incidents were reviewed. Unfortunately, 3 sessions did not take place due to lack of medic availability.

- Regular audits continue to be undertaken to ensure compliance with policy and procedure and any necessary amendments made. This has included auditing complaint data against names of deceased patients to ensure this meets the requirements specified in the National guidance. The last audit was completed on 9 April 2021.

- The monthly Mortality review group meetings resumed in November 2020. These were put on hold during the initial COVID pandemic.

2. 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 30 April to 22 July 2021.

Month	2021-04-01	2021-05-01	2021-06-01	2021-07-01
1. Total Deaths Per Month	1	143	153	89
5. LD Referral Deaths	3	2	1	0

Correct as of 22 July 2021

178 patients were male, 207 females,297 were white British and 1 Asian/Asian British Pakistani. The youngest age was 0 years, the eldest age was 102 years old.

From 30 April to 22 July 2021, the Trust received 385 death notifications of patients who have been in contact with our services.

[1] National Guidance on Learning from Deaths. National Quality Board. March 2017

4. Review of Deaths

Total number of Deaths from 30 April to 22 July 2021 reported on Datix	38 unexpected deaths 0 COVID deaths 12 suspected deaths 3 expected (end of life pathway) 1 Inpatient death
Incidents assigned for a review	38 incidents assigned to the operational incident group 0 did not meet the requirement 6 incidents are to be confirmed

During 30 April to 22 July 2021 the Trust has recorded 1 Inpatient death.

Only deaths which meet the criteria below are reported through the Trust incident reporting system (Datix) and these are also reviewed using the process of the *Untoward Incident Reporting and Investigation Policy and Procedure*; any patient open to services within the last six months who has died, and meets the following:

- Homicide – perpetrator or victim
- Domestic homicide - perpetrator or victim
- Suicide/self-inflicted death, or suspected suicide
- Death following overdose
- Death whilst an inpatient
- Death of an inpatient who died within 30 days of discharge from a DHCFT hospital
- Death following an inpatient transfer to acute hospital
- Death of patient on a Section of the Mental Health Act or Deprivation of Liberty Safeguards (DoLs) authorisation
- Death of patient following absconsion from an inpatient unit
- Death following a physical restraint
- Death of a patient with a learning disability
- Death of a patient where there has been a complaint by family / carer / the Ombudsman, or where staff have raised a significant concern about the quality of care provision
- Death of a child (this will also be subject to scrutiny by the Child Death Overview Panel)
- Death of a patient open to safeguarding procedures at the time of death, which could be related to the death
- Death of a patient with historical safeguarding concerns, which could be related to the death
- Death where a previous Coroners Regulation 28 has been issued
- Death of a staff member whilst on duty
- Death of a child under the age of 18 of a current or previous service user who has died in suspicious circumstances
- Where an external organisation has highlighted concerns following the death of a patient whether they were open to the Trust at time of death or not.

5. Learning from Deaths Procedure

From 30 April to 22 July 2021, The Mortality Review Group reviewed 28 deaths through a Stage 2 Case Note Review. These reviews were undertaken by a multi-disciplinary team and it was established that of the 28 deaths reviewed, 28 were not due to problems in care.

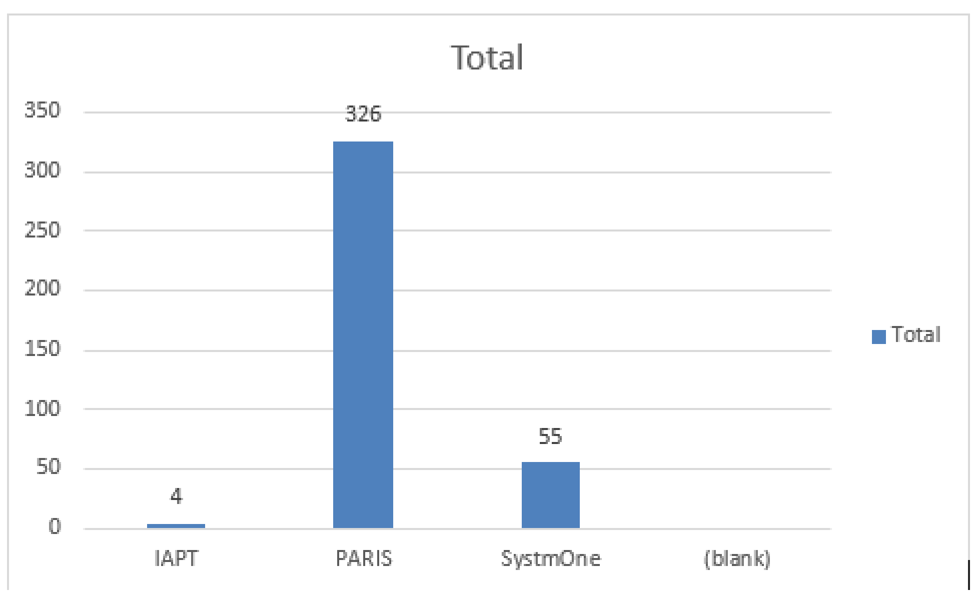
The Mortality Group review the deaths of patients who fall under the following 'red flags' as from 24 June 2020 these are as follows:

- Patient taking an anti-psychotic medication
- Death of a patient with a learning disability
- Patients with chronic pain
- Patients only open to outpatient services
- Patients with COVID19 (this is a temporary flag)

From 30 April to 22 July 2021 there has been 0 deaths reported where the patient tested positive for COVID-19.

6. Analysis of Data

6.1 Analysis of deaths per notification system since 30 April to 22 July 2021

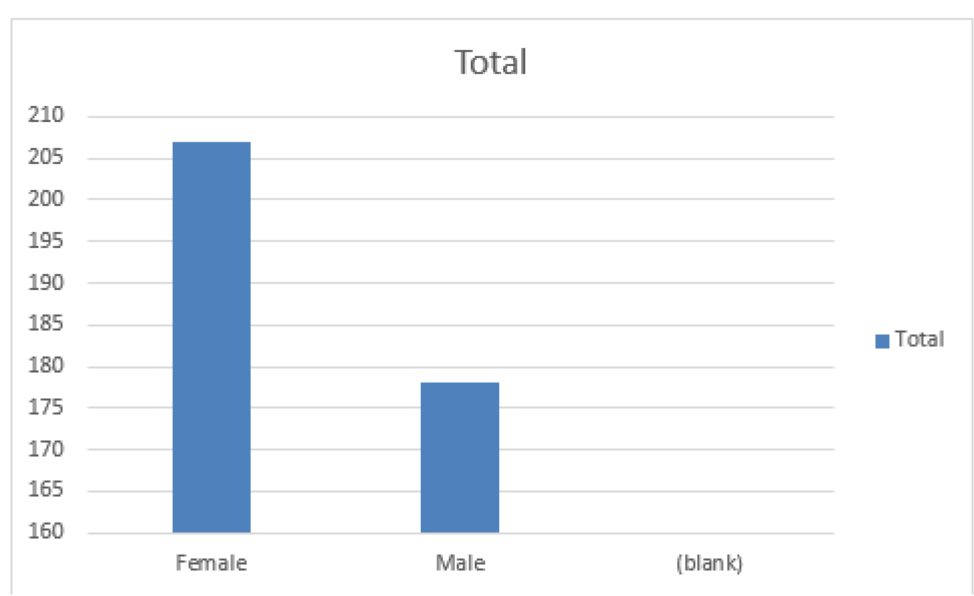


Row Labels	Count of Source System
IAPT	4
SystmOne	55
PARIS	326
Grand Total	385

The data above shows the total number of deaths reported by each notification system. Most death notifications were predominately pulled from PARIS. 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.

6.2 Deaths by Gender since 30 April to 22 July 2021

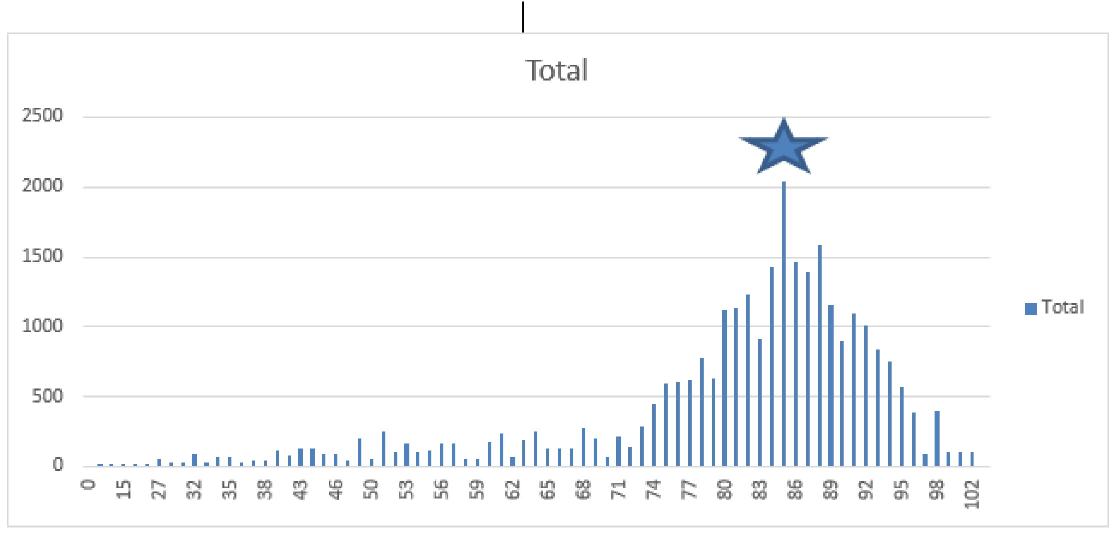
The data below shows the total number of deaths by gender. There is very little variation between male and female deaths; 178 male deaths were reported compared to 207 females.



Row Labels	Count of Gender
Female	207
Male	178
Grand Total	385

6.3 Death by Age Group since 30 April to 22 July 2021

The youngest age was classed as 0, and the oldest age was 102 years. Most deaths occurred within between the 85 years old age group (indicated by the star).



6.4 Learning Disability Deaths (LD) since 30 April to 22 July 2021

	April 2021	May 2021	June 2021	July 2021
LD Deaths	3	2	1	0

The Trust reviews all deaths relating to patients diagnosed with a Learning Disability. The Trust also currently sends all Learning Disability deaths that have been reported through the Datix system to the Learning Disabilities Mortality Review (LeDeR) programme. Due to challenges in reporting out from the LeDeR programme, we are unable to ascertain how many of our Trust's deaths have been reviewed through the LeDeR process. The Trust continues to share relevant information with LeDeR when requested which is used to inform their reviews.

Since 30 April to 22 July 2021, the Trust has recorded 6 Learning Disability deaths. The Trust now receives a quarterly update from LeDeR which highlights national good practice and identified learning; this is shared in the Mortality monthly meeting.

6.5 Death by ethnicity since 30 April to 22 July 2021

White British is the highest recorded ethnicity group with 297 recorded deaths, 59 deaths had no recorded ethnicity assigned, and 1 person did not state their ethnicity. The chart below outlines all ethnicity groups.

Row Labels	**Count of Ethnicity**
Mixed - White and Black Caribbean	1
Any other Black background	1
Black or Black British - African	1
Mixed - White and Black African	1
Not stated	1
Asian or Asian British - Pakistani	1
Indian	2
White - Irish	3
Mixed - Any other mixed background	3
Other Ethnic Groups - Any other ethnic group	6
White - Any other White background	9
Not Known	59
White - British	297
Grand Total	**385**

6.6 Death by religion 30 April to 22 July 2021

Christianity is the highest recorded religion group with 58 recorded deaths, 209 deaths had no recorded religion assigned and 5 people refused to state their religion. The chart below outlines all religion groups.

Row Labels	Count of Religion
Jewish	1
Atheist movement	1
Catholic: not Roman Catholic	1
Muslim	1
Greek Orthodox	1
Patient religion unknown	1
Christian religion	1
Religion (other not listed)	1
Sikh	1
Religion NOS	1
Church of England, follower of	2
None	2
Baptist	2
Jehovah's Witness	2
Methodist	4
Roman Catholic	5
Not given patient refused	5
Not religious	37
Church Of England	49
Christian	58
(blank)	209
Grand Total	**385**

6.7 Death by sexual orientation since 30 April to 22 July 2021

Heterosexual or straight is the highest recorded sexual orientation group with 114 recorded deaths. 262 deaths have no recorded information available. The chart below outlines all sexual orientation groups.

Row Labels	Count of Sexual Orientation
Bi-sexual	1
Not appropriate to ask	1
Gay or lesbian	1
Not Stated (declined)	6
Heterosexual or straight	114
Unknown	262
Grand Total	**385**

6.8 Death by disability since 30 April to 22 July 2021

The table below details the top 10 categories by disability. Behavioural and emotional problems were the highest recorded disability group with 11 recorded deaths.

Row Labels	Count of Disability
Hearing; other	2
Learning Disability (Dementia)	2
Behaviour and emotional; sight	2
Learning disability	3
Mobility and gross motor	3
Progressive (Lt) conditions	3
Hearing	3
Other	5
Physical disability	5
Behaviour and emotional	11
Grand Total	**43**

There was a total of 88 deaths with a disability assigned and the remainder 297 were blank (had no assigned disability).

Row Labels	Count of Disability
Hearing; learning disability (dementia); progressive (lt) conditions	1
Hearing; manual dexterity; learning disability (dementia); learning disability (dementia); mobility and gross motor	1
Hearing; mobility and gross motor	1
Behaviour and emotional; hearing; learning disability (dementia)	1
Hearing; progressive (lt) conditions	1
Behaviour and emotional; hearing; mobility and gross motor; sight	1
Hearing; speech	1
Behaviour and emotional; learning disability (dementia); learning disability (dementia)	1
Learning disability; manual dexterity	1
Behaviour and emotional; mobility and gross motor; sight; other	1
Learning disability (dementia); learning disability (dementia)	1
Behaviour and emotional; other; mobility and gross motor	1
Learning disability (dementia); mobility and gross motor	1
Behaviour and emotional; progressive (lt) conditions; other; mobility and gross motor; other	1
Manual dexterity	1
Disability - slight	1
Manual dexterity; learning disability	1
Gross motor disability	1
Manual dexterity; self care and continence; mobility and gross motor	1
Hearing; learning disability; mobility and gross motor; speech	1
Mobility and gross motor; behaviour and emotional	1

Row Labels	Count of Disability
Hearing; learning disability (dementia); learning disability (dementia); other; self-care and continence	1
Mobility and gross motor; hearing	1
Behaviour and emotional; dementia	1
Mobility and gross motor; other	1
Behaviour and emotional; learning disability (dementia)	1
Mobility and gross motor; self-care and continence	1
Behaviour and emotional; other	1
Mobility and gross motor; sight	1
Behaviour and emotional; self-care and continence	1
Mobility and gross motor; speech	1
Hearing; learning disability	1
Other; self-care and continence	1
Behaviour and emotional; behaviour and emotional; manual dexterity; learning disability	1
Progressive (lt) conditions; other; mobility and gross motor; other	1
Behaviour and emotional; manual dexterity; mobility and gross motor; perception of physical danger; other	1
Self-care and continence; learning disability	1
Emotional behaviour disability	1
Self-care and continence; mobility and gross motor; other	1
Behaviour and emotional; hearing; learning disability (dementia); perception of physical danger; self-care and continence	1
Self-care and continence; progressive (lt) conditions	1
Hearing; learning disability (dementia)	1
Sight	1
Behaviour and emotional; progressive (lt) conditions	1
Sight; sight	1
Hearing; other	2
Behaviour and emotional; sight	2
Hearing disability	2
Hearing; sight	2
Learning disability (dementia)	2
Learning disability	3
Hearing	3
Mobility and gross motor	3
Progressive (lt) conditions	3
Other	5
Physical disability	5
Behaviour and emotional	11
Unknown (blank)	297
Grand Total	**385**

Derbyshire Healthcare NHS Foundation Trust
Report to the Trust Board – 2 November 2021

Board Assurance Framework (BAF)
Issue 3, 2021/22

Purpose of Report

To meet the requirement for Boards to produce an Assurance Framework. This report details the third issue of the BAF for 2021/22.

Executive Summary

Issue 2 (version 2.3) of the BAF was presented to the Board on 6 July 2021. Each Director Lead has since reviewed their associated risks. Issue 3 (version 3.1) was then reviewed by the Executive Leadership Team (ELT) on 14 September and version 3.2 was reviewed by the Audit and Risk Committee on 7 October. Changes/updates to this issue of the BAF, compared with Issue 2, 2021/22, are indicated by blue text.

A change of ownership of BAF Risks 21_22 1b and 22_22 1d has been noted as the new Chief Operating Officer is in post and the risks have been transferred.

In the last issue there were nine operational risks rated as high or extreme on the corporate risk register that were aligned to the related BAF risks. Each of these has been reviewed by the risk owner and the Director Lead. There are now five operational risks from the corporate risk register that are aligned to the BAF, the changes are:

- Three operational risks aligned with Risk 21_22 2a have been reduced to moderate, so have been removed from the BAF
- Two operational risks previously aligned with Risk 21_22 2a are not on the corporate risk register but are on divisional risk registers, where they will continue to be monitored, so have been removed from the BAF
- One new operational risk has been added to the corporate risk register and rated as extreme; this has been aligned to Risk 21_22 1a

Since the Audit and Risk Committee reviewed Issue 3 of the BAF on 7 October there have been no changes in ratings of the related Trust-wide operational risks.

There is currently one BAF risk rated as extreme, risk 21-22 3a, which will require a 'deep dive' at the Audit and Risk Committee. It has been agreed that this will take place in January 2022. Should the risk rating of this risk be reduced, or the rating for other risks increase to extreme, this timetable will be revised. The risk has been thoroughly reviewed by the Director of Finance and one of the gaps in control has been reduced from red to amber (in addition to two other gaps in control that had their RAG rating reduced from red to amber in July).

The Director of People and Inclusion (DPI) is Lead on BAF Risk 21_22 2b *(There is a risk of continued inequalities affecting health and well-being of both staff and local communities)*. The DPI is Director Lead for staff related risks but not for those of community members and so suggested that the highlighted part of the risk title is removed. The DPI suggests that any key gaps in control with regard to community

members should be incorporated into Risk 21_22 1a with the Director of Nursing as Lead, under the umbrella of providing ‘standards for safety and effectiveness as required by our patients’. This was agreed by the Audit and Risk Committee on 7 October.

As requested by the Trust’s BME Network, ‘BAME’ has been replaced with ‘BME’ throughout the BAF (this is a request of the network for all Trust documents).

Since Issue 2, the ‘People Services’ directorate has changed names, to ‘People and Inclusion’, the BAF has been updated accordingly.

As with previous considerations of this paper, the content of the strategic risks reflected in the BAF represent the understanding of the risks as they currently stand at the time of writing.

Strategic Considerations

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

Assurances

- This paper details the current Board Assurance risks and provides assurance on the process of the review, scrutiny and update of the BAF in seeking to identify and mitigate risks to achieving the Trust’s strategic objectives.

Consultation

Board Committees:

- Quality and Safeguarding Committee: 14.09.21, 12.10.21
- Finance and Performance Committee: 28.09.21
- People and Culture Committee: 21.09.21

Formal Reviews:

- Executive Leadership Team, Issue 3.1: 14.09.21
- Audit and Risk Committee, Issue 3.2: 07.10.21

Governance or Legal Issues

- Governance or legal implications relating to individual risks are referred to in the BAF itself, where relevant.

Public Sector Equality Duty and Equality Impact Risk Analysis

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

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

Specific elements within each BAF risk and associated actions are addressed by the relevant lead Executive Director in taking forward.

Recommendations

The Board of Directors is requested to:

1) **Approve** this third issue of the BAF for 2021/22 and the assurance the paper provides of the process of the review, scrutiny and update of the BAF in seeking to identify and mitigate risks to achieving the Trust's strategic objectives
2) Continue to receive updates in line with the forward plan for the Trust Board.

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

Report prepared by: **Kelly Sims**
Risk and Assurance Manager

Summary Board Assurance Framework Risks 2021-22 – Issue 3.3 Board 2 November 2021

Ref	Principal Risk	Director Lead	Rating (Likelihood x Impact)	Responsible Committee
Strategic Objective 1. To provide GREAT care in all services				
21_22 1a	There is a risk that the Trust will fail to provide standards for safety and effectiveness as required by our patients and our Board	Executive Director of Nursing (DON)/Medical Director (MD)	**HIGH (4x4)**	Quality and Safeguarding Committee
21_22 1b	There is a risk that the Trust does not deliver key regulatory and strategic requirements related to dormitory eradication and Psychiatric Intensive Care Unit (PICU) and that the Trust estate more generally is not maintained sufficiently well to comply with regulatory and legislative requirements	~~Deputy Chief Executive Officer (CEO)/Executive Director of Finance (for dormitory eradication and PICU).~~ Chief Operating Officer (COO)	**HIGH (4x4)**	Finance and Performance Committee
21_22 1c	There is a risk that the Trust fails to maintain continuity of access to information to support effective patient care	Director of Business Improvement and Transformation (DBIT)	**MODERATE (3X4)**	Finance and Performance Committee
21_22 1d	There is a risk that the Trusts increasing dependence on digital technology for the delivery of care and operations increases the Trusts exposure to the impact of a major outage, i.e. cyber-attack, equipment failure	~~Director of Business Improvement and Transformation (DBI&T).~~ Chief Operating Officer (COO)	**MODERATE (3X4)**	Finance and Performance Committee
Strategic Objective 2. To be a GREAT place to work				
21_22 2a	There is a risk that we do not sustain a healthy vibrant culture and conditions to make Derbyshire Healthcare Foundation Trust (DHCFT) a place where people want to work, thrive and to grow their careers	Director of People and Inclusion (DPI)	**HIGH (3x5)**	People and Culture Committee
21_22 2b	There is a risk of continued inequalities affecting health and well-being of ~~both~~ staff ~~and local communities~~	Director of People and Inclusion (DPI)	**HIGH (4x4)**	Trust Board
Strategic Objective 3. To make BEST use of our money				
21_22 3a	There is a risk that the Trust fails to deliver its revenue and capital financial plans	Executive Director of Finance (DOF)	**EXTREME (4x5)**	Finance and Performance Committee
21_22 3b	There is a risk that learning from the response to the COVID-19 outbreak, and transformation plans developed prior, does not lead to sustainable embedded transformation	Director of Business Improvement and Transformation (DBIT)	**HIGH (4x4)**	Finance and Performance Committee
21_22 3c	Whilst there are significant benefits from the creation of the Integrated Care System (ICS) as an NHS body, there is a risk that the effects of the change on senior managers from across the system may impact negatively on the cohesiveness of the Derbyshire health and care system	Director of Business Improvement and Transformation (DBIT)	**HIGH (4x4)**	Trust Board

Summary Board Assurance Framework Risks 2021-22 – Issue 3.3 Board 2 November 2021

Strategic Objective 1. To provide GREAT care in all services

There is a risk that the Trust will fail to provide standards for safety and effectiveness as required by our patients and our Board

Impact: May lead to avoidable harm including increased morbidity and mortality; delays in recovery; and longer episodes of treatment; affecting patients, their family members, staff or the public

Root causes:

a) Workforce supply and lack of capacity to deliver effective care across hotspot areas
b) Risk of substantial increase in clinical demand in some services and COVID-19 related mental health surge
c) Changing demographics of population and substantial impacts of inequality within the deprived wards of the city and county
d) Intermittent lack of compliance with Care Quality Commission (CQC) standards specifically the safety domain
e) Lack of embedded outcome measures at service level
f) Known links between Serious Mental Illness (SMI) and other co-morbidities, and increased risk factors in population including inequality/ intersectionality
g) Lack of compliance with physical healthcare monitoring in primary and secondary care
h) Restoration and recovery of access standards in autism and memory assessment services, due to COVID-19 pandemic
i) New and emerging risks related to waves of COVID-19, excess deaths associated with winter, impact of substantial economic downturn
j) Increased safeguarding and domestic violence related investigations as a result of harm to our patients and their families related to the impact of lockdown
k) Lack of appropriate environment to support high quality care, i.e. single gender dormitories and PICU
l) Lack of capacity to meet population demand for community forensic team
m) Lack of Quality Improvement Strategy and full implementation plan

BAF Ref: 21_22 1a	**Director Lead**: Carolyn Green (DON) / Dr John Sykes (MD)	**Responsible Committee**: Quality and Safeguarding Committee

Key Controls

Inherent risk rating			Current risk rating				Target risk rating			Risk appetite		
HIGH	Likelihood 4	Impact 4	HIGH	Likelihood 4	Impact 4	Direction ⬌	MODERATE	Likelihood 3	Impact 4	Accepted	Tolerated	NOT ACCEPTED

Preventative – Quality governance structures, teams and processes to identify quality related issues; mandatory training; Duty of Candour processes; clinical audits and research; health and safety audits; risk assessments; physical health care screening and monitoring; investment in COVID-secure environments and cleaning
Detective – Quality dashboard reporting; quality visit programme/virtual clinical service contact visits; incident, complaints and risk investigation; Fire Safety Regulations (FSR) compliance checks; mortality review process; physical health care monitoring clinics pilots; safety check log; Head of Nursing and Matron compliance visits
Directive – Trust Strategy and commitments; Quality Improvement Strategy; Physical Health Care Strategy; Safeguarding Strategy; Suicide Reduction Strategy; clinical strategies; policies and procedures available via Trust intranet; Central Alerting System (CAS) alerts; clinical sub committees of the Quality and Safeguarding Committee; Information Management Team processes, including ethics governance cell
Corrective – Board committee structures and processes ensuring escalation of quality issues; six monthly skill mix review; CQC action plans; learning from incidents, complaints and risks; actions following clinical and compliance audits; workforce issues escalation procedures; reporting to commissioners on

compliance with quality standards; learning from other Trust experiences and national learning

Assurances on controls (internal)	Positive assurances on controls (external)
Quality and Trust dashboards Scrutiny of Quality Account (pre-submission) by committees Programme of physical healthcare and other clinical audits and associated plans COVID Board Assurance Framework reported to NHS England Positive and Safe self-assessment reported to the East Midlands Clinical Senate on Reducing Violence Head of Nursing and Matron compliance visits	National enquiry into suicide and homicide NHS Litigation Authority (NHSLA) scorecard demonstrating low levels of claims Safety Thermometer identifies positive position against national benchmark Mental Health Benchmarking data identifies higher than average qualified to unqualified staffing ratio on inpatient wards CQC comprehensive review 2020 Trust is rated Good; two core services rated outstanding, two rated as require improvement Identified Trust fully compliant with National Quality Board (NQB) Learning from Deaths guidance 2020/21 Internal audits: Risk management; data security and protection 2020/21 Estates and Facilities Management internal audit (limited assurance) Transitional Monitoring Meetings with CQC (bi-monthly), no conditions

Key gaps in control	Key actions to close gaps in control	Impact on risk to be measured by	Expected completion date (Action review date)	Summary of progress on action	Action on track
Embedded learning from CQC regulatory actions, particularly in relation to improvement of training governance	Review operational governance of training compliance [ACTION OWNER: DPI] Develop and implement improvement plan to ensure sustained compliance with mandatory training [ACTION OWNERS: DPI/COO]	Embedded compliance with mandatory training and compliance rates. Reported to People and Culture Committee (PCC) ~~and training cell of Incident Management Team (IMT)~~ Lack of recurrence of common themes regarding training compliance. Reported to PCC and to be led by the operational leadership teams	~~31.07.21~~ (31.10.21)	New reporting mechanism commenced~~ing~~ May 2021 with Positive and Safe and Immediate Life Support (ILS) training compliance reporting to Board ILS / Basic Life Support (BLS) / Safeguarding Adults / Children / Positive and Safe: All recovered. Next training recovery areas defined and being implemented	AMBER
Inability to complete physical health checks for patients whose consultations remain undertaken	Improvement plan to be developed and implemented to ensure required physical health care checks are completed	Compliance with physical healthcare checks, reported in the Quality Dashboard	~~31.07.21~~ (31.10.21)	Revised metrics included in Quality Dashboard reported to Quality and	AMBER

virtually	[ACTION OWNER: MD]			Safeguarding Committee. Maintenance to be monitored though dashboard data Remain under monitoring ~~expected trajectory for sustained improvement July 2021~~ New bid to region to implement a coaching and self-report pilot model of health care to improve compliance and patient empowerment	
Implementation of revised priority actions for 'Good Care' which support the Trust strategy	Redesign improvement plans to align to revised building blocks which support the Trust Strategy [ACTION OWNER: DON]	Compliance with suite of metrics and reporting schedule detailed in quality dashboard	31.03.22	Indicators are within agreed tolerance including revised requirements as outlined in the COVID recovery roadmap. Modest community survey results (2021) and positive staff survey results Health protection unit in place and active New quality dashboard launched June 2021	AMBER
Insufficient investment in Community Forensic Rehabilitation Team	Significant investment (est. £1m+) required by Clinical Commissioning Group (CCG) to meet demand as outlined in new national specification Learning from mental health homicide reviews and formal recommendation for Trust to review capacity of the community forensic team [ACTION OWNERS: COO/DBIT]	Agreed funding allocation	~~(31.05.21)~~ (31.10.21)	Escalated to CCG, in principle agreement in investment in August 2021. Clinical team developing information and analysis as they await the commissioner's final decision	RED
Insufficient investment in autism	Investment required by CCG to meet	Agreed funding allocation has	31.03.22	Mental Health and	AMBER

assessment and treatment services to meet demand. No commissioned treatment service Waiting time has increased over COVID-19 period, exacerbated by underlying demand	assessment and treatment demands [ACTION OWNERS: COO/DBIT]	occurred, recruitment to posts is active		Learning Disability and Autism Board (MHLD AB) agreed investment in principle into autism services. Proposal ratified Recruitment to Derbyshire Community Health Services (DCHS) - North Autism Intensive Support Team (IST) and South Autism IST service has commenced Reduction in autism assessment waiting list required	
Monitoring of changes and patterns in population need in relation in the potential deterioration due to impact of COVID-19	Continued monitoring and focus by the operations team and Divisional Achievement Reviews (DARs) [ACTION OWNERS: COO/MD/DON]	Monitoring of waiting list targets and implementation of mitigating actions. Reporting through DARs DON continues arm's length monitoring of monthly NHS benchmarking which continue to not follow the national trend	30.11.21	Safety standards remain in place for urgent referrals. Limited evidence of COVID related surge in demand. Robust oversight in place Community mental health team (working age) not having increase in referrals. Acuity and activity in existing patients is significant. Monitoring and team support in place	AMBER
Six service areas assessed as 'Requires Improvement' by CQC in relation to safety	Develop and implement an improvement plan to enable all six service areas to reach 'Good' for safety in relation to the CQC standards [ACTION OWNER: DON]	CQC inspection and assessment	(31.10.21)	Significant improvement in all services.~~, training remains self-assessed as below trajectory.~~ Plan to meet training compliance by 31.05.21 was achieved Further recovery of manual handling training requires further attention	AMBER
Gap in operating standards for	Enhanced monitoring of acute and	Improvement in operating	31.03.22	Increased performance	AMBER

acute and community mental health services	community mental health services by the Nursing and Quality Directorate [ACTION OWNER: DON] Implement Royal College of Psychiatrists (RCP) Standards across Acute Services [ACTION OWNERS: MD/DON/COO] Implement 2019 Community Mental Health Framework [ACTION OWNER: DBIT]	standards compliance. To be confirmed by external CQC inspection and assessment of at least 'Good' Implemented Acute Inpatient Mental Health Service Accreditation (RCP Standards) reported in Divisional Achievement Reviews and Quality Account Implemented Mental Health Community Framework to Quality and Safeguarding Committee	(estimated March 2022) (31.03.22)	management scrutiny and unannounced site visits have been undertaken with compliance checks Standards compliance work continues Plan for investment agreed with NHSE April 2021. Reported to Quality and Safeguarding Committee May 2021 Active recruitment now underway and named specific pilot areas in roll-out	
Implementation of clinical governance improvements with respect to: - Outcome measures - Clinical service reviews including reduction in excess waiting times - Getting it Right First Time (GIRFT) reviews - Patient Safety Incident Response Framework (PSIRF) implementation - Commissioning for Quality and Innovation (CQUIN) Framework - National Institute for Health and Care Excellence (NICE) guidelines	Develop and implement an improvement plan to enable all governance improvement plans to be implemented [ACTION OWNERS: MD/DON/COO/DBIT]	Compliance with suite of metrics and reporting schedule	(31.10.21)	Trust's COVID recovery roadmap outlines timescales for standing up of core clinical governance developments, commenced June 2021 PSIRF implementation continues – New processes in place and approval of revised incident policy NICE guideline mapping recommenced September 2021 Getting it Right First Time (GIRFT) reviews were held in July 2021, awaiting final agreed action plan post meeting feedback	AMBER

				Reduction in waiting times and analysis commence from September 2021	
Implementation of three new quality priorities for: - Reducing violence - Sexual safety - Learning from COVID-19 pandemic	Develop and implement an improvement plan to enable all quality priorities to be implemented [ACTION OWNER: DON]	Compliance with suite of metrics and reporting schedule	(31.10.21)	~~Implementation plans on hold until June 2021. All areas will be scheduled for a Quality and Safeguarding Committee report~~ Reducing violence - Body worn camera investment has commenced Sexual safety – Improvement work commenced (dashboard, preceptorship training and protocols) Learning from COVID - Review of learning commissioned and IMT event planned for September 2021	GREEN
Lack of Quality Improvement (QI) strategy and implementation plan may result in failure to achieve most effective quality improvement and reduce the quality of patient care	Develop and implement a QI strategy [ACTION OWNERS: DBIT]	Develop and implement an improvement plan in line with required standards for Well Led	31.10.21		FROM RED TO AMBER

Related operational high/extreme risks on the Corporate Risk Register:

Record ID	Service Line	Title	Risk: Summary of Progress	Date Risk Created	Date of Next Review	Residual Risk Rating

3009	Learning Disabilities Services	Demand for Autism Spectrum Disorder (ASD) assessment Service far outstrips contracted activity	[07/06/2021] Current waiting list is 1179 and there continues to be a significant wait for diagnosis. Systems for offering online assessments including short notice appointments for cancellations are working. Longest waits currently are for people who have informed us that they cannot access online assessments and require face to face appointments. We have started to offer a few face-to-face assessments in line with Trust COVID-safe policies and information collated from staff health risk assessments. It is anticipated that there will continue to be a disparity in wait times for those who need face to face appointments for some time to come	01.01.16	31.10.21	**HIGH**
21586	Community Care Services (Older People)	Wait times breaching CCG contract	[25/08/2021] Memory Assessment Service (MAS) continues to be in a recovery phase. Some of the temporary funding posts have been recruited to via the bank increasing the capacity within the team. The two extra medic PAs are also temporarily recruited to, increasing the number of diagnoses able to be undertaken Risk owner to quantify current wait time in weeks	12.12.18	25.11.21	**HIGH**
22154	Community Paediatrics Teams	Neurodevelopmental (ND) Assessment Pathway - operational delivery and capacity risks	[01/06/2021] Internal review shows Attention Deficit Hyperactivity Disorder (ADHD) diagnosis and management is the greatest risk. Short term funding also to be used to employ a short-term Specialty Doctor to help with the prescribing and oversight of this group Engaged in detailed demand and capacity modelling with the CCG. Estates impacting delivery. Specialty doctor recruited for 12 months fixed term contract	05.10.20	07.01.22	**HIGH**
21739	Operational Services	Emergency Preparedness, Resilience and Response (EPRR) Risks within Derbyshire	[20/08/2021] Measured controls in place. The incident management team response to the COVID pandemic has proactively managed disruptions in a safe, responsive way A recovery coordination programme has been set up to support the Trust Roadmap to Recovery The Recovery Oversight Group will support our EPRR recovery	23.07.19	19.11.21	**HIGH**
22677	Non-Trust	Bed availability across the Learning Disability and Autism (LD/A) secure regional pathway	There is pressure on female medium secure unit (MSU) beds in the region and at a national level. This is impacting on the ability to admit patients into appropriate beds for their needs [25/08/2021] The situation remains the same in particular for female LD/A beds, St Johns is to close and St Andrews in Northampton remains closed to admissions. Raised on the escalation call with regards to needing a solution - The risk remains in place two	12.08.21	31.10.21	**EXTREME**

			Derbyshire patients who need a female MSU bed, (one patient currently in Foston Hall prison and one in DCHS)			

Summary Board Assurance Framework Risks 2021-22 – Issue 3.3 Board 2 November 2021

Strategic Objective 1. To provide GREAT care in all services

There is a risk that the Trust does not deliver key regulatory and strategic requirements related to dormitory eradication and PICU and that the Trust estate more generally is not maintained sufficiently well to comply with regulatory and legislative requirements

Impact: Low quality care environment specifically related to dormitory wards
Crowded staff environment and non-compliance with COVID-secure workplace environments
Non-compliance with statutory care environments
Non-compliance with statutory health and safety requirements

Root causes:

a. Long term under investment in NHS capital projects and estate
b. Limited opportunity for Trust large scale capital investment
c. Increasing expectations in care and working environments as national capital strategy and surrounding legislative and regulatory requirements evolve
d. National capital funding restrictions for business as usual capital programme for Trusts and Integrated Care Systems
e. Gaps in relation to the revised Premises Assurance Model (PAM)

BAF Ref: 21_22 1b	**Director Lead**: Ade Odunlade (COO)	**Responsible Committee**: Finance and Performance Committee

Key Controls

Inherent risk rating			Current risk rating				Target risk rating			Risk appetite		
HIGH	Likelihood 4	Impact 4	HIGH	Likelihood 4	Impact 4	Direction ⟷	MODERATE	Likelihood 3	Impact 4	Accepted	Tolerated	NOT ACCEPTED

Preventative – Routine environmental assessments for statutory health and safety requirements; environmental risk assessments reported through DATIX; COVID secure workplace risk assessments
Detective – Reporting progress against Premises Assurance Model (PAM) to ELT; IMT reporting against COVID secure workplace compliance
Directive – Capital Action Team (CAT) role in scrutiny of capital projects; IMT estates cell implementing all relevant COVID secure guidance; COVID secure workplace policy and procedure
Corrective – Short term investment agreed to support key risk areas including provision of equipment to ensure COVID secure workplace environments

Assurances on controls (internal)

- COVID secure workplace assessments
- Health and Safety Audits
- Premises Assurance Management System (PAMS) reporting providing updates on key priority areas

Positive assurances on controls (external)

- Mental Health Capital Expenditure bidding process
- External authorised reports for statutory health and safety requirements
- 2020/21 Estates and Facilities Management internal audit (limited assurance)

Key gaps in control	Key actions to close gaps in control	Impact on risk to be measured by	Expected completion date (Action review date)	Progress against action	Action on track
Estates Strategy delivery recommendations will need to be updated for ongoing COVID secure requirements	Review of Estates Strategy delivery recommendations to ensure compliance with ongoing COVID secure guidance [ACTION OWNER: COO]	Revised COVID compliant delivery recommendations	During 2021/22 financial year – Depending on pandemic evolution	Unable to review until during 2021/22 financial year as strategy needs to be considered post-COVID or when and how 'living-with COVID' is ascertained	AMBER
Lack of adherence to emerging national guidance and policy requiring the elimination of mixed sex wards and dormitory style inpatient facilities	Deliver a single room en-suite delivery plan and programme of work [ACTION OWNER~~S~~: ~~DOF for dormitory eradication programme and~~ COO ~~for wider estate strategy delivery~~]	Delivery of approved business cases and surrounding associated schemes for dormitory eradication	(31.03.24) Hard deadline for national funding of March 2024	Allocation of £80m confirmed Application for funding in place for new PICU and other hospital buildings, with a new plan in place once funding is approved, which would mean total eradication of dormitories	AMBER
Lack of an accessible Derbyshire wide Psychiatric Intensive Care Unit (PICU)	Delivery of local PICU arrangements (new build and associated projects taking into account gender considerations) [ACTION OWNER: ~~DOF~~ COO]	Agreed programme of work with capital funding to support it	(31.03.24) PICU delivery date aligned to dorms new build and interim CCG contract dates	~~PICU discussion ongoing with mix of male new build and alternative female provision~~ Application for funding in place for new PICU and other hospital buildings, with a new plan in place once funding is approved, which would mean total eradication of dormitories	AMBER
Internal Audit recommendations highlighted the need for evidence of assurance on estate maintenance and wider governance for estate compliance with statutory legislation	Deliver Internal Audit report recommendations in full Premises Assurance Model (PAM) assessment to be completed [ACTION OWNER: COO ~~(DOF in interim)~~]	Completion of agreed recommendations and management actions Reporting to Finance and Performance Committee twice yearly and any exceptions in between	~~Per dates in audit – Range from April to end Sept 2021~~ ~~31.07.21~~ ~~31/05/21~~ 31.03.22	~~Meetings have been set up.~~ Plan for reporting of suite of assurance for estates delivered at ELT September 2021 outlining the timeline and process/Outline Business Cases (three in total) –	AMBER

	Review of current estates and facilities governance structures [ACTION OWNER: COO ~~(DOF in interim)~~]	Governance structure in place		These should be completed in November 2021 ~~is in development. Reporting will be to ELT for delivery confirmation and May and July Finance and Performance Committee (F&P) for assurance~~ Internal governance structure in place and meeting monthly Management audit undertaken by internal auditors Quarter 4 2020/21 Governance reporting will include audit recommendation response and delivery	

Related operational high/extreme risks on the Corporate Risk Register: None

Strategic Objective 1. To provide GREAT care in all services

There is a risk that the Trust fails to maintain continuity of access to information to support effective patient care

Impact: Inability of staff to access patient records from the right place at the right time

Root causes:

a. Transfer to new electronic patient record provider
b. Inefficient access to clinical information in current system
c. Interoperability of systems with partner organisations
d. Current significant number of forms and processes resulting in issues regarding the consistency of recording of information

BAF Ref: 21_22 1c	**Director Lead**: Gareth Harry (DBIT)	**Responsible Committee**: Finance and Performance Committee

Key Controls

Inherent risk rating			Current risk rating				Target risk rating			Risk appetite		
MODERATE	Likelihood 3	Impact 4	MODERATE	Likelihood 3	Impact 4	Direction ⟺	LOW	Likelihood 2	Impact 3	Accepted	TOLERATED	Not accepted

Preventative – Local Implementation Groups (LIG) and overarching Clinical Design Authority (CDA) ensuring all forms and processes have been rigorously tested and signed off by representatives of the clinical services
Detective – Non-Executive Director (NED) Board member on OnEPR (one electronic patient record) Programme Delivery Board (PDB) providing project expertise and direct link to Board
Directive – OnEPR PDB governance oversight with respect to delivery of the new EPR with secured expert and experienced third party provider; fully resourced project management team within the third party provider and DHCFT; reporting on progress to Finance and Performance Committee and fortnightly updates to ELT; rapid escalation of issues to ELT
Corrective – Phased approach to delivery (four phases over 18-month project delivery plan); 'Go/No Go' rationale agreed and measures for decision making, ahead of each delivery phase. Weekly 'Go/No Go' meeting in 10 week run up to 'Go Live' date for each phase of implementation

Assurances on controls (internal)	Positive assurances on controls (external)
- Weekly project update report and wider project progress report highlighting current position against delivery plan	

Summary Board Assurance Framework Risks 2021-22 – Issue 3.3 Board 2 November 2021

Key gaps in control	Key actions to close gaps in control	Impact on risk to be measured by	Expected completion date (Action review date)	Progress against action	Action on track
Capacity within the IM&T Team to support programme delivery to the level required by the project plan	Identify and agree priorities and release of staff [ACTION OWNER: COO]	Compliance with the agreed resource plan for the project	~~30.09.21~~ 31.01.22	Fully resourced plan agreed with Channel 3 for the remainder of the programme. Gateway review dates agreed with Channel 3 for the release of their resource as required ELT agreed to amalgamate phase 3 and 4 within the plan with a go live of 24.01.22. This includes a fully resourced capacity plan	GREEN
Maintenance of staff well-being (in particular IM&T and Channel 3 staff) during final implementation of each delivery phase	Build in plans and expectations of working arrangements for IM&T and Channel 3 staff from phase 2 implementation onward [ACTION OWNER: DBIT]	Feedback from staff	~~30.09.21~~ 31.01.22	Staff wellbeing considered on deciding to delay phase 2 go live to 28.06.21 and was an active influence on the judgement made to amalgamate phase 3 and 4 with revised go live date	AMBER
Adherence to the project delivery plan due to unforeseen circumstances	Close monitoring of the project risk register and issues log/regular updates with potential to adjust phasing of 'go live' decisions for each phase [ACTION OWNER: COO]	Adherence to the project delivery plan, which includes a range of clear measurable criteria against key milestones	~~30.09.21~~ 31.01.22	~~ELT agreed further delay of phase 2 implementation - Due to issues with data migration and wellbeing of staff~~ ELT agreed to amalgamate phase 3 and 4 with a go live date of 24.01.22. Plan included fully resourced capacity plan	AMBER

Related operational high/extreme risks on the Corporate Risk Register: None

Summary Board Assurance Framework Risks 2021-22 – Issue 3.3 Board 2 November 2021

Strategic Objective 1. To provide GREAT care in all services

There is a risk that the Trust's increasing dependence on digital technology for the delivery of care and operations increases the Trust's exposure to the impact of a major outage i.e. cyber-attack, equipment failure

Impact: This could lead to the disruption in the provision of services with risk to patient safety

Root causes:

a. Increasing reliance on a single electronic patient record
b. Increasing use of video software for the direct provision of care and operational purposes
c. Increased staff home working
d. Increasing electronic collaboration across health and social care partners
e. Increasing global instability and risk from state supported cyber attacks
f. Increase in locally developed system solutions to support DHCFT and partner operations and performance, i.e. COVID vaccination, health risk assessments, COVID flow testing, flu

BAF Ref: 21_22 1d	**Director Lead**: Ade Odunlade (COO)	**Responsible Committee**: Finance and Performance Committee

Key Controls

Inherent risk rating			Current risk rating				Target risk rating			Risk appetite		
MODERATE	Likelihood 3	Impact 4	MODERATE	Likelihood 3	Impact 4	Direction ⟺	MODERATE	Likelihood 2	Impact 4	Accepted	TOLERATED	Not accepted

Preventative – Trust utilises NHS provided solutions as widely as possible i.e. Office 365, NHS Mail to ensure compliance with mandated requirements. Use of the secure Health and Social Care Network (HSCN) specified by NHS Digital. Staff training on data security and protection. Regular all staff communications regarding safe ways of working and phishing emails. Contract with Arden GEM provides information governance and security services, includes review of risks and addressing of vulnerabilities. Subscription with NHS Digital Care Certification Programme highlights cyber vulnerabilities and monitors Trust's compliance against them
Detective – Cyber essentials framework: NHS Digital encourage all organisations to comply. Advanced Threat Protection (ATP) monitors every server and device to highlight threats and software vulnerabilities
Directive – Compliance with NHS Digital requirements. Monthly rigor review meeting with Arden GEM to identify software solutions which require upgrading to ensure supported. Data Security and Protection Policies and Procedures. Business continuity plan and procedure
Corrective – Timely actions undertaken in response to vulnerabilities identified through controls/processes outlined above

Assurances on controls (internal)	Positive assurances on controls (external)
IM&T Strategy delivery update to F&P – September 2021	- Templar Cyber Organisational Readiness Report (CORS) - Annual external cyber review by Dynac (vulnerability scan) - Data Security and Protection annual review by Internal Audit, weighted toward cyber security - Compliance with Data Security and Protection Toolkit, including high levels of training compliance

Key gaps in control	Key actions to close gaps in	Impact on risk to be	Expected	Progress against	Action

Summary Board Assurance Framework Risks 2021-22 – Issue 3.3 Board 2 November 2021

	control	measured by	completion date (Action review date)	action	on track
Business continuity plans reflect changes to service delivery such as increased phone and video contacts	All services to review business continuity plans to ensure they take account of the increased use of phone and video contacts for care provision and also use of video conferencing for operational delivery [ACTION OWNERS: ~~DBIT/~~COO]	Reporting to the Divisional Achievement Reviews (DARs)	30.11.21	Due to start in Quarter 2 following development of division level plans	AMBER
Limited resource within organisation dedicated to cyber	Consider development of a business case to increase cyber support [ACTION OWNERS: ~~DBIT/~~COO]	Increased capacity to support cyber risk management	~~(30.06.21)~~ (31.12.21)	Head of cyber security and team in post at NHS Arden and Greater East Midlands Commissioning Support Unit. DHCFT is working with their team and ~~monthly meetings are established~~ maintaining communication through regular meetings	AMBER
Embedded programme of software and hardware upgrades	Prioritise work alongside organisational requirements and developments [ACTION OWNER: ~~DBIT~~COO]	Information Technology Strategy (IT Strategy) 6-month update to ~~Board~~ Finance and Performance Committee	(30.11.21)	Embedded programme of software and hardware upgrades routinely reviewed in monthly meetings with NHS Arden and Greater East Midlands Commissioning Support Unit	GREEN
Live testing of business continuity plans	Desktop incident response exercise on IT failure to be completed [ACTION OWNERS: ~~DBIT/~~COO]	Exercise evaluation report to Finance and Performance Committee	28.02.22	~~Update requested from Deputy Director of Operational Services~~ The Emergency Planning and Business Continuity Manager will be working with IM&T on the testing of the business continuity plans	AMBER
Some gaps identified in Cyber Operational Readiness Support (CORS) review undertaken by Templar	Consideration of recommendations in relation to asset owners and policies. Trust to develop own actions in response [ACTION OWNER: ~~DBIT~~COO]	Response to CORS recommendations report to Data Security and Protection Committee	30.11.21	Progress report planned for presentation at F&P Committee September 2021	AMBER

Related operational high/extreme risks on the Corporate Risk Register: None

Strategic Objective 2. To be a GREAT place to work

There is a risk that we do not sustain a healthy vibrant culture and conditions to make DHCFT a place where people want to work, thrive and to grow their careers

Impact: Risk to the delivery of high-quality clinical care
Inability to deliver transformational change
Exceeding of budgets allocated for temporary staff
Loss of income

Root causes:

a. National shortage of key occupations and registered professions
b. Future commissions of key posts insufficient for current and expected demand
c. Sufficient funding to deliver alternative workforce solutions
d. Retention of staff in some key areas
e. Overdependence on registered professions
f. Impact of COVID-19 pandemic
g. Increase in mental health demand and associated funding
h. Increase in use of technology
i. Consistent person-centred culture not fully embedded

BAF Ref: 21_22 2a	**Director Lead**: Jaki Lowe (DPI)	**Responsible Committee**: People and Culture Committee

Key Controls

Inherent risk rating			Current risk rating				Target risk rating			Risk appetite		
EXTREME	Likelihood 4	Impact 5	HIGH	Likelihood 4	Impact 5	Direction ↓	MODERATE	Likelihood 2	Impact 5	Accepted	Tolerated	Not accepted

Preventative –Workforce plan covering wide range of recruitment channels including targeted campaigns, 'Work For Us' internet page, leadership development, new role and skill mix changes, leadership development programme, increased well-being support, system workforce hub
Detective – Performance report identifying specific hotspots and interventions to increase recruitment and retention, Freedom to Speak Up Guardian role, Peoples Services Leadership Team meeting to oversee delivery of the People Agenda. Health risk assessments. Health and wellbeing conversations and well-being action plans. Black, Asian, and Minority Ethnic (~~BAME~~BME) risk assessments
Directive – Wellbeing Strategy, infrastructure and programmes to support staff health and wellbeing. Workforce plan to grow and develop the workforce. Assurance reports on delivery of People Strategy to People and Culture Committee. Leadership support sessions. Staff engagement forums
Corrective – Leadership and Management Strategy and development programmes to build inclusive and engaging leadership and management. Leadership Programme – Core Leaders. Occupational health contract monitoring meeting

Assurances on controls (internal)	Positive assurances on controls (external)
Workforce Performance Report to Executive Leadership Team monthly Bimonthly People Dashboard to People and Culture Committee, includes recruitment tracker and deep dives ELT rolling programme of deep dives of strategic building blocks ~~Twice weekly Recruitment tracker report to Incident Management Team~~	Outstanding results from 2020 staff survey, identifying significant improvements across all themes Safe staffing reports and Care Hours Per Patient Day (CHPPD) reporting (planned versus actual staff) Workforce Race Equality Standard (WRES), Workforce Disability Equality

~~(IMT) to monitor recruitment progress across organisation~~ Employee relations assurance report to ELT Deep dive review of the risk to Audit and Risk Committee (January 2021)	Standard (WDES) and gender pay gap reporting 2020/21 Internal Audit: WRES and WDES data quality (significant assurance) Reduction in employee relations cases No employment tribunal cases

Key gaps in control	Key actions to close gaps in control	Impact on risk to be measured by	Expected completion date (Action review date)	Progress against action	Action on track
Effective recruitment and retention plan to all posts Time taken to recruit to new and vacant posts	Recruitment plans in place for workforce requirements related to capital projects and mental health investment plans (relating to PICU plans and dormitory eradication) [ACTON OWNER: DPI]	Vacancy rates, time to recruit data within performance report to Board. People dashboard to PCC and monthly people assurance report to ELT Diversity in appointments. Target of 20% of workforce as ~~BAME~~BME	~~(30.09.21)~~	Recruitment processes working well. Plans in place for all new posts are being dynamically managed – Operational and 'business as usual' (BAU)	FROM AMBER TO GREEN
Embedded flexible workforce arrangements in place	Implementing the learning from flexible working arrangement in response to the COVID-19 pandemic, i.e. home working Review of policies/processes and contracts of employment to embed flexible working [ACTONS OWNER: DPI]	Sickness absence rate reported in performance dashboards as outlined above Staff survey responses Pulse and people pulse check responses Percentage of people working on flexible contracts with respect to hours and location (reporting metric to be developed)	~~(30.09.21)~~	~~Flexible working in place as a result of COVID-19 with many working from home. Continuing to review and adapt response as learning continues~~ ~~Flexible working policies and contracts in process of being reviewed~~ DHCFT Promise for flexible working in place. Working from home and flexible working policy updated. Guidance and advice for managers has been produced and focus groups on flexible working have been undertaken Pulse and people pulse checks ~~to be~~ commenced and will take place quarterly – Operational and BAU	FROM AMBER TO GREEN
Fully embedded person-centred culture of leadership and management	Review of policies and processes to support a person-centred approach to leadership and management	Reduced number of formal staff relations issues/cases. Reported in monthly people assurance	(31.10.21)	'People First - Supporting colleagues fairly through workplace situations' in place	AMBER

	Review of leadership development offer [ACTONS OWNER: DPI]	report to ELT		and disciplinary and incident polices reviewed in line with approved proposal with 'Above Difference' to review cultural intelligence - Started with Board session on 15.09.21 External review of workforce policies ongoing	
Development of a funded Workforce Plan that delivers on new role development	Develop and implement 2021/22 of the Workforce Delivery Plan (WDP) [ACTON OWNER: DPI]	Vacancy rate of registered posts reported in performance dashboards as outlined above and recruitment report to IMT No of new roles in place, metric to be developed. Apprenticeship student nurse uptake reported to Workforce Delivery Plan Group	~~(30.06.21)~~ Ongoing	Delivery of plan being monitored though Workforce Planning Delivery Group, through to ELT and PCC. Initial WDP reported to Board May 2021 Medical Workforce Project Group review of all vacancies, recruitment and agency spend fortnightly	AMBER
People and Inclusion Directorate ~~People Services~~ shaped to deliver against future needs of the organisation	Review of Peoples Services model and plans Identify resources required to shape culture locally Develop performance framework to support delivery of revised model [ACTONS OWNER: DPI]	~~Implemented performance framework~~ Service line agreements KPIs	(31.12.21) Deferred to 2021/22	~~Statement on joint venture way forward from DHCFT and DCHS Directors presented to both Boards March 2021. Cultural discovery programme starting Quarter 3~~Negotiations almost complete with DCHS. New schedule of service agreed. New service level agreements and KPIs to be finalised. Performance management arrangements to be established Recruitment to two Assistant Director Posts in People and Inclusion complete and one underway. More formal service oversight meetings will be established in October with both Assistant Directors	FROM AMBER TO RED

Consolidate health and wellbeing provision and infrastructure, ensuring learning from COVID-19 pandemic is incorporated	Align well-being offer to local Sustainability and Transformation Plan (STP) and national offers Updating well-being offer, in particular mental health interventions Roll out of health and wellbeing plans for all staff Review management of change policy to incorporate health and well-being discussions Similar review of appraisal policy and processes [ACTONS OWNER: DPI]	Maintain sickness absence rates to below 5% or below Reduction in sickness absence as a result of anxiety and stress Percentage uptake of health and well- being plans Published policies	~~(30.06.21)~~ ~~30.09.21~~ 31.12.21	~~Review target with ELT~~ Local, regional and national offer published via Trust intranet Increase uptake of health risk assessments Wellbeing offer has been reviewed. Health & Wellbeing Framework has been rolled out Review RESOLVE contract to increase capacity for referrals Consider a reflective practice offer	AMBER
	Roll out of flu vaccination plan for autumn 2021 ~~and any subsequent COVID-19 vaccine~~ [ACTON OWNERS: DPI/DON]	Increased uptake of staff flu vaccination by 30.11.21 ~~Continued roll out of COVID-19 vaccine in line with national guidance~~	(30.11.21) ~~As per guidance~~	Planned delivery in place. No outstanding actions/risks. Suggest removing this gap in control from the BAF ~~COVID-19 vaccinations well underway (92% front line staff vaccinated at June)~~	GREEN
Training compliance in key areas below target set by the Trust	Recovery being implemented Mandatory training to be rostered [ACTION OWNERS: DPI/COO]	Percentage of compliance with mandatory training reported to ELT~~, training cell in IMT~~ and bimonthly to Board as part of performance report Forward planning for training compliance	~~(30.06.21)~~ (31.12.21)	Recovery plan implemented, particularly in relation to ILS and Positive and Safe training. Forward plans to include rostering of training to be developed Significant impact of COVID-19 on release of staff – Extra resource given to support the Training and Development Team to improve attendance at training, but changes to training and education have been paused until a further business case and risk mitigation is received	AMBER

Evidence of safer staffing levels of suitably qualified staff	Compliance with NHS Improvement (NHSI) Workforce Safeguards requirements [ACTION OWNER: DPI]	Full compliance with safer staffing levels in line with the NHSI Workforce Safeguards	~~31.07.21~~ 31.12.21	Plan to be presented to PCC July 2021 – Complete New reporting process started to incorporate ward level reporting – Reporting from ward managers is the current gap, work in progress	AMBER

Related operational high/extreme risks on the Corporate Risk Register: None

Strategic Objective 2. To be a GREAT place to work

There is a risk of continued inequalities affecting health and well-being of ~~both~~ staff ~~and local communities~~

Impact: Risk to the delivery of high-quality clinical care
Inability to attract, recruit and retain a motivated and diverse workforce
Risk to the health and wellbeing of our staff
Risk to patients and communities having access to the right services
Escalation in formal cases impacting on individuals and teams
Reduced confidence by our communities in our Trust

Root causes:

a. Commissioning of services does not meet the need of diverse communities
b. Change management and transformation programmes lead to deterioration in experience
c. Processes and policies have inbuilt bias
d. Processes for advocacy and raising issues not clear or dealt with well
e. Gaps in cultural competence of leaders and managers

BAF Ref: 21_22 2b	**Director Lead**: Jaki Lowe (DPI)	**Responsible Committee**: Trust Board

Key Controls

Inherent risk rating			Current risk rating				Target risk rating			Risk appetite		
HIGH	Likelihood 4	Impact 4	HIGH	Likelihood 4	Impact 4	Direction ⟺	MODERATE	Likelihood 3	Impact 4	Accepted	Tolerated	NOT ACCEPTED

Preventative – Freedom to Speak Up Guardian (FTSUG) self-assessment and six monthly reports; annual review of people development plan commissioned through People and Inclusion Directorate ~~People Services~~; provision of information through induction processes for new staff; staff engagement sessions; Equality, Diversity and Inclusion (EDI) Delivery Group meeting; supported networks for diverse staff groups and allies; Health and Well-being Network; workforce planning design meeting; Culture and Leadership Delivery Group; Training and Education Delivery Group
Detective – Weekly recruitment report to IMT; EDI updates to ELT, monthly performance report to Board; Reverse Commissioning Project Group; Reverse Commissioning Steering Group; Equality Forum; attendance management monitoring; take up of Reasonable Adjustment Passports; updating of Electronic Staff Record (ESR) regarding disability and long-term conditions
Directive – People Strategy; Inclusion Strategy; Joined Up Care Derbyshire (JUCD) People Strategy
Corrective – Leadership and management development strategy ensuring inclusion is at the heart of all development; exit interview feedback

Summary Board Assurance Framework Risks 2021-22 – Issue 3.3 Board 2 November 2021

Assurances on controls (internal)	Positive assurances on controls (external)
Executive Leadership Team rolling programme of deep dives on strategic building blocks	2020 staff survey results Gender pay gap annual assessment and report Assessment and report annually for Equality Delivery System (EDS2) WRES and WDES annual report 2020/21 Internal Audit WRES/Disability Worker Exclusion Scheme (DWES) data quality (significant assurance)

Key gaps in control	Key actions to close gaps in control	Impact on risk to be measured by	Expected completion date (Action review date)	Progress against action	Action on track
Develop an Equality, Diversity and Inclusion Strategy (EDI Strategy)	Establish approach for refreshing and expanding the strategy Establish a steering group to oversee refresh of the strategy Complete review of cultural intelligence Refreshed strategy completed Launch events for the Equality, Diversity and Inclusion Strategy Development of directorate equality dashboards [ACTIONS OWNER: DPI]	Improved position regarding staff motivation in staff survey and pulse checks Freedom to Speak Up Index to People and Culture Committee and Board Inclusion Recruitment report Positive Friends and Family Test Percentage of exit interviews completed Metrics within the employee relations report	~~(30.09.21)~~ 31.12.21	~~Steering group in place to develop strategy~~ Strategy has been developed, engagement/embeddedness to be reviewed. EDI delivery group will oversee delivery of the strategy ~~Dashboard developed for PCC focused on cross cutting themes from hotspot areas, i.e. FTSUG, WRES, WDES~~EDI delivery group now stood up to full operating expectations and will oversee delivery of the strategy	AMBER
Refresh and expand engagement plans. Include lessons learnt from response to COVID pandemic	Establish approach for refreshing and expanding the engagement plan and a group to oversee the refresh Refresh 12-month engagement plan Develop a cultural sensitivity approach to health and wellbeing discussions [ACTIONS OWNER: DPI]	Improved staff survey results Positive Friends and Family Test Positive pulse check	~~(30.09.21)~~ 31.12.21	Engagement plan for next 12 months to be developed, in line with Trust COVID recovery roadmap	AMBER
Gaps in the cultural competence of leaders and	~~Diagnostic exercise to identify gaps around culture and identify how to build~~	~~Metrics within the employee relations report~~	~~(30.09.21)~~ 31.03.22	~~Relaunch of health risk assessment underway in line~~	AMBER

managers resulting in staff reporting being disadvantaged due to their protected characteristics	~~on current approaches~~ Roll out of cultural competence training to equip leaders and managers to be able to lead and support staff and provide the best experience for service users ~~BAME and health risk assessments offered for all staff, including new starters~~ [ACTION OWNER: DPI]	~~Metrics within the Freedom to Speak Up report~~ ~~Annual publication of Workforce Race Equality Standard data, identifying an improved position~~ Live WRES monitoring at corporate and directorate level ~~to ensure consistent capture and monitoring of data~~		~~with vaccination programme~~ Health risk assessment has been revisited and is now a dynamic process. Roll out of master classes for cultural intelligence start September 2021. Cultural workshops undertaken in areas of need (on disparity ratio of BME staff at Band 7 and above)	
Unequal experience of people with protected characteristics through recruitment process	~~Review of recruitment strategy and plans~~ Review of assurance framework that inclusion and recruitment guardians will use [ACTION OWNER: DPI]	Improved BME recruitment process outcomes Improved disparity ratios	~~31.12.21~~ 28.02.22	~~Recruitment inclusion guardians to support all recruitment of posts Band 6 and above from advert stage. In process of agreeing recruitment pilot for cultural intelligence across Derbyshire health system. DHCFT leading approach starting Quarter 3~~ Increased the number of inclusion guardians to 50+ System wide pilot on reviewing recruitment process has commenced and will conclude in February 2022 Senior appointments at the most senior level have also improved the disparity	AMBER

Related operational high/extreme risks on the Corporate Risk Register: None

Strategic Objective 3. To make BEST use of our money

There is a risk that the Trust fails to deliver its revenue and capital financial plans

Impact: Trust becomes financially unsustainable

Root causes:

a) Financial detriment (revenue, cash and/or capital) resulting from large capital development programme, in particular dormitory eradication and associated capital schemes and patient record investment
b) Non approval of business case for national funding
c) Insufficient capital envelope for JUCD system that inhibits Trust capital spend requirements for the self-funded projects within the dormitory eradication and PICU programme
d) Organisational financial detriment created by commissioning decisions or wider 'system-first' decisions including enactment of risk-sharing agreement in partnership arrangements or changes in NHS financial arrangements during and beyond the pandemic
e) Non-delivery of expected financial benefits from transformational activity
f) Non-delivery of standard or additional financial efficiency requirements
g) Lack of sufficient cash and working capital
h) Loss due to material fraud or criminal activity
i) Unexpected income loss or non-receipt of expected transformation income (e.g. long-term plan (LTP) and Mental Health Investment Standard (MHIS) without removal of associated costs
j) Costs to deliver services exceed the Trust financial resources available, including contingency reserves.

BAF Ref: 21_22 3a	**Director Lead**: Claire Wright (DOF)	**Responsible Committee**: Finance and Performance Committee

Key Controls

Inherent risk rating			Current risk rating				Target risk rating			Risk appetite		
HIGH	Likelihood 3	Impact 5	EXTREME	Likelihood 4	Impact 5	Direction ↑	MODERATE	Likelihood 2	Impact 5	Accepted	Tolerated	NOT ACCEPTED

Preventative – Integrated Care System (ICS) sign off and support for dormitory eradication work. Devoted and adequate team for Programme delivery. High quality business cases. Regular meetings with NHSIE on programme progress. Meaningful stakeholder engagement (internal and external). Robust cash flow forecasting and delivery
Multi-disciplinary development of financial plans for new programmes of work. System sign-off and appropriate governance arrangements for new programmes of work: Budget training, segregation of duties, management of commissioning risk through system engagement and leadership, mandatory counter fraud training and annual counter fraud work programme: Enhanced cash management and forecasting aligned to large capital and transformational programmes
Detective – Risk logs and programme-reporting (capital/transformation) informs ongoing financial risk assessment: Audits (internal, external and in-house); scrutiny of financial delivery, bank reconciliations; continuous improvement including cost improvement planning (CIP) and delivery; contract performance, local counter fraud scrutiny
Directive – Business plans and templates set out clear financial plans and assumptions: Standing financial instructions; budget control, delegated limits, recruitment approval processes; business case approval process; invest to save/Quality Improvement methodology and protocol - Plan Do Study Act. Risk and gain share agreements

Summary Board Assurance Framework Risks 2021-22 – Issue 3.3 Board 2 November 2021

Corrective – Risk mitigation activity and oversight at ICS system/other partnership level. Proactive reporting and forecasting of capital and wider transformation programme progress enabling remedial activity to take effect. General corrective management action; Use of contingency reserve; Disaster recovery plan implementation; Performance reviews and associated support/ in-reach	
Assurances on controls (internal)	**Positive assurances on controls (external)**
- Dormitory eradication and PICU Programme monitoring and reporting. Urgent decision- making taking place and relevant meetings in place. - Appropriate monitoring and reporting of financial delivery – Trust overall and programme-specific including 'Use of Resources' reporting updates - Assurance levels gained at Finance and Performance Committee - Delivery of Counter fraud and audit work programme with completed and embedded actions for all recommendations - Independent assurance via internal auditors, external auditors and counter fraud specialist that the figures reported are valid and systems and processes for financial governance are adequate	- NHSI/NHSE feedback throughout progress of dormitory eradication programme - Internal Audits – Financial integrity and key financial systems audits - External Audits – Strong record of high-quality statutory reporting with unqualified opinion - National Fraud Initiative – No areas of concern - Local Counter fraud work – Referrals show good counter fraud awareness and reporting in Trust and no material losses have been incurred. Use of risk-based activity in new counter fraud standards Information Toolkit rating – Evidencing strong cyber risk management (ref fraud/criminal financial risk)

Key gaps in control	**Key actions to close gaps in control**	**Impact on risk to be measured by**	**Expected completion date (Action review date)**	**Progress against action**	**Action on track**
Dormitory eradication and PICU programme team not yet fully in place	Recruitment to project manager and project officer Secure and backfill relevant internal Trust staff into programme [ACTION OWNER: ~~DOF~~ Senior Responsible ~~R~~Officer (SRO)]	Full team in place and operational	~~30.06.21 And quarterly thereafter~~ Quarterly - Ongoing	Programme Director in role. New Senior Responsible Officer in place. New governance structure in place. Delivery/status reporting ongoing ~~Recruitment process started for project managers and officer. Internal team to be backfilled needs identifying and securing~~ Team required at this stage is in place	FROM RED TO AMBER
Fixed Cash flow timing for national funding presents risk for cashflow management and working capital as the full suite of all Trust capital projects progress over forthcoming years and in particular as cash reserves are utilised	Enhanced cashflow monitoring, oversight, forecasting and reporting Prompt and effective cashflow management if required [ACTION OWNER: DOF]	Accurate cash forecasting and maintenance of sufficient cash flow balances	~~Quarterly reviews 30/06/21 onwards~~ (31.03.22)	Augmented reporting and processes in train. Internal finance team supported by external expert cost advisors	AMBER

in later stages					
'Best Value' building block - Extant Use of Resources priorities to be revisited post COVID 1. Increase wellbeing and reduction in sickness absence 2. Inclusive leadership/retention 3. Deliver e roster and e job planning 4. Eliminate out of area placements 5. Optimise digital technology 6. Medicines optimisation and e prescribing 7. Streamline access to services 8. Optimise use of estate 9. Consider size and function of corporate services 10. Improve administration and communication	Revisit the previous 'Use of Resources (UoR)' Top Ten priorities incorporating transformational gains achieved during pandemic [ACTION OWNER: DBIT]	Improvement in UOR related metrics as reported to: - Board - Finance and Performance Committee - People and Culture committee	~~(30.09.21)~~ (31.03.22)	Impact of COVID continues Sickness levels adversely impacted due to COVID-19 pandemic Leadership development adversely impacted due to COVID-19 pandemic E-Roster – Specific programme changes are on hold – Will now be affected by dormitory eradication programme Out of area placements – Linked to eradication of dormitory accommodation and COVID secure environment Digital – Attend Anywhere in place, Microsoft Teams in place – Rapid digital transformation achieved during COVID-19 – Needs maintaining and enhancing Medicine optimisation ongoing, E-Prescribing part of OnEPR Access – lessons learned/business as usual. Waiting lists impacted by COVID Estate – Impacted by: Social distancing requirements, remote working and home working, dorms eradication work Corporate services – Some STP work (e.g. payroll) moved to University Hospitals Derby and	AMBER

				Burton (UHDB) as of April 2021. Admin and communications – Engagement and communications are of high focus and success	
Delivery of planned benefits of specific change programmes	Delivery of planned benefits realisation for change programmes in particular: - Dormitory eradication programme - Delivery of OnEPR programme - Delivery of enhanced E-Roster and e job planning informed by dorms programme - Delivery of planned MHIS/LTP service changes [ACTION OWNERS: DOF/COO]	Achievement of planned benefits of change programmes as reported to Programme Boards and Finance and Performance Committee at key milestone points (and by exception)	~~Most are Multi-year and not all set out yet (quarterly – TBC)~~ Next review: After first half of year	- OnEPR phases 3 and 4 timeframe reviewed due to COVID ~~is on track to new timeframe (amended by 3 weeks)~~ - Measurables: expected benefits reported to F&P Committee - Dormitory eradication - Updates to Board include identification of measurable critical success factors - E-Roster is in place, but changes were not enacted and consultation to be revisited. On hold for dorms work - E-Job planning has re-commenced - MHIS, service development funding (SDF) and recovery funding recruitment is proceeding in line with submitted cases and funding notified in April 2021	AMBER
Need to secure £80m national funding for dormitory eradication through business case approval	Develop suitable business cases and all surrounding actions All programme activities to be delivered Successful engagement [ACTION OWNER: SRO ~~DOF/COO~~]	Approved business cases delivered to time scope and cost Risk log of programme to be maintained and mitigated	~~(30/06/2021)~~ 31.03.24 Ongoing reviews in line with programme timelines	~~In development~~ Two Outline Business Cases submitted to national gateway. Regular reporting to F&P and Trust Board	AMBER
Unknown **capital** requirement for requirements over and above the national funded projects	Urgent decisions on best clinical delivery models for buildings outside of new build facilities to be costed up [ACTION OWNER: DOF]	Defined costs produced to eliminate the unknown Confirmation that that value is affordable from internal cash	(31.03.22) 31.03.24	Clinical model determined and additional requirements estimated for refurbishments. Cash affordable from internal reserves	BLUE

		reserves Confirmation that the cash and capital expenditure is supported and include in the signed-off JUCD capital programme		~~The unknown aspect is known and now closes this risk.~~ The residual cash and local sign off for Capital Departmental Expenditure Limit (CDEL) requirements are covered in local system capital line below – Action complete	
Revenue requirements for all new models and configuration of services exceed funding	Revenue requirements in business cases and associated financial planning achieves system and commissioner sign off and is affordable [ACTION OWNERS: DOF/SRO]	Approved financial and contractual arrangements to incorporate new ways of service delivery	~~30.06.21 (initial business case)~~ Next reviews in line with programme timelines 31.03.24 (contracted delivery)	Revenue costings for outline business cases are complete with letters of support. Revenue costings for other parts of acute capital programme are underway and suite of business cases being developed with system partners	AMBER
Local system **capital** envelopes are limited and may not allow sufficient capital expenditure to self-fund 100% dormitory eradication and provide PICU	Cash constrained, minimal capital plan to retain sufficient internal cash Discussion with regulators as to how Foundation Trusts with sufficient cash can spend on larger schemes that exceed 'normal' levels of system CDEL [ACTION OWNER: DOF]	Signed off capital programme sufficient to fund requirements ICS Department of Finance letters of support for Outline Business Cases (OBCs) Letters of support for Full Business Cases (FBCs)	31.03.24	CDEL allocations for future years not available Net cash requirement and affordability for aggregate acute capital programme needs confirmation Support for and approval within ICS CDEL limit needs confirming for beyond OBC support OBC Department of Finance letters of support expected System development of suite of business cases for acute capital programme with expert advice on appropriate VAT treatment	AMBER
Changing and unknown future NHS financial arrangements, including those for provider alliances	Assimilation of new guidance and arrangements when received System Financial oversight, planning and governance	Agreed financial arrangements being enacted and achievement of planned financial outturns, as measured by reporting and KPIS	Quarterly	System Department of Finance and Deputies are working to current guidance	AMBER

and integrated care systems ICS evolution into statutory body – Unknown impact on providers and system ways of working	arrangements [ACTION OWNERS: DOF/DBIT/CEO]	such as surplus or deficit in period and forecast. For trust and wider system in aggregate Visibility of progress reported to ELT, F&P and Board as appropriate		System financial meetings take place regularly to scrutinise planning and forecasting assumptions System finance reporting is underway New guidance for ICS and financial framework was issued for H1 only ~~is expected in May/June 2021 (not yet issued)~~	

Related operational high/extreme risks on the Corporate Risk Register: None

Strategic Objective 3. To make BEST use of our money

There is a risk that learning from the response to the COVID-19 outbreak, and transformation plans developed prior, does not lead to sustainable embedded transformation

Impact: Improvements in the quality of care, working lives and service efficiencies are lost

Root causes:

a) Impact of the COVID-19 pandemic and adherence to directives including COVID secure environments
b) Increased use of clinical consultations and interventions using virtual technology in response to COVID-19
c) Increased use of videoconferencing for clinical and corporate meetings in response to COVID-19
d) Closer relationships between community teams and inpatient services developed as a result of working within COVID-19 guidance
e) Less miles travelled miles on trust business due to greater use of virtual technology and videoconferencing
f) Flexible working arrangements for colleagues increased in response to COVID-19
g) Understanding of factors which have led to the reduction in sickness and absence of colleagues
h) Historical reliance on staff based in trust estate
i) Limited team autonomy to make local improvements at pace
j) Improvements to acute pathway length of stay during the pandemic are lost

BAF Ref: 21_22 3b	**Director Lead**: Gareth Harry (DBIT)	**Responsible Committee**: Finance and Performance Committee

Key Controls

Inherent risk rating			Current risk rating				Target risk rating			Risk appetite		
HIGH	Likelihood 4	Impact 4	HIGH	Likelihood 4	Impact 4	Direction ⟺	MODERATE	Likelihood 3	Impact 4	Accepted	Tolerated	NOT ACCEPTED

Preventative – Adherence to national and local guidance in relation to responding to the COVID-19 pandemic
Detective – Lessons Learnt Cell of IMT; EQUAL Forum; regular reporting to Finance and Performance Committee on pipeline to include future transformation; home working and COVID secure policies and procedures
Directive – Estates Cell of the Incident Management Team has established principles for home working and estates optimisation; Quality Improvement Strategy; clinical strategies
Corrective - Fortnightly System Restoration Cell focused on joint plans; restoration plans in line with Phase 3 national planning; evidence of local improvements at team level, i.e. risk stratification of caseloads, discharge processes

Assurances on controls (internal)	Positive assurances on controls (external)
- Regular reporting of impact of measures taken to IMT	- Patient surveys for patients with learning disabilities and Serious Mental Illness (SMI) conducted by Healthwatch

Key gaps in control	Key actions to close gaps in control	Impact on risk to be measured by	Expected completion date	Progress against action	Action on track

			(Action review date)		
Implementation of the Estates Strategy in relation to community and corporate estate	Conduct estates optimisation work for community and corporate services [ACTION OWNER: COO]	Freeing up corporate estate to be utilised for clinical space	~~30.09.21~~ 31.12.21	Work ongoing in line with Trust Roadmap (Phase 1) Consideration of short-term estates changes to support service recovery (at Phase 2 onwards) and medium/longer term issues post COVID Full implementation of the Estates Strategy will be ongoing throughout 2021/22 as we still don't fully understand what any long-term COVID mitigations might remain/be needed	GREEN
Embedding of current ways of working in a post COVID environment	Maintain directives on virtual meetings and non-patient facing activities to support new ways of working [ACTION OWNER: DBIT]	Less miles travelled on trust business compared to a pre COVID baselines More hours working from home compared to a pre COVID baselines	~~30.09.21~~ 31.12.21	The organisation is continuing to operate under COVID-secure guidelines. Further work being undertaken at team, divisional and organisational level during phase 1 of the roadmap (Quarter 1) to look at medium-term operational models Ahead of phase 2 of the roadmap a shift in approach to face-to-face operational meetings based on risk assessments rather than Trust-wide directives will take place. The ambition to retain use of Teams for non-developmental meetings at a team and individual level remains	AMBER
Consistency of application with respect to use of videoconferencing software for patient consultations vs face to face in person consultations	Agreed protocol for when face to face in person appointments are necessary for patient safety with the understanding all other contacts would be via video or phone [ACTION OWNERS: DON/MD]	Percentage use of video/phone contacts with patients in line with the agreed protocol	~~30.09.21~~	Further work ~~planned~~ undertaken at team, divisional and organisational level during first phase of the roadmap to look at medium-term operational models and ongoing use of	FROM GREEN TO BLUE

				video contacts – Action Complete	
Learning from COVID-19 pandemic outbreak Pulse checks/staff survey - check	Review learning from colleagues [ACTION OWNER: COO]	Positive staff feedback on learning from COVID-19	~~30.09.21~~ 31.03.22	Live staff engagement sessions continued throughout pandemic. Learning the Lessons surveys/focus groups undertaken, reported to Board Pulse checks restarted in July 2021. Staff survey 2020 results shared and learning taken, including regarding the impact of COVID-19	GREEN
Implemented clinical strategies and Quality Improvement (QI) strategies and sign off all actions	Refresh Quality Improvement strategy and implementation plan Build in prioritised actions from clinical improvement strategies into divisional business plans [ACTIONS OWNER: DBIT]	Increase in no of people trained and supported to undertake Quarter 1 actions at a local team level Delivery against the divisional business plans	~~30.09.21~~ 31.12.21	Roadmap outlines resumption of strategic work later in 2021/22. A cross-organisational group has been meeting since May 2021 to refresh the Trust QI strategy and implementation plan. Drafts to be considered at ELT and Quality & Safeguarding Committee in Quarter 3 Planning sessions with divisions/teams postponed due to focus on COVID response. The Transformation Team are regularly meeting with divisional colleagues around 2021/22 and 2022/23 plans	RED
Improvements to acute pathway length of stay during pandemic are reversed	Fortnightly out of area monitoring meetings Work on flow cell continuing, led by Medical Director Crisis team expansion and crisis alternatives to admissions in place and continuing to be developed. Social worker input on wards being sustained	~~Average acute Length of stay less than 32 days~~ Bed occupancy being managed at less than 85%	31.12.21	Average acute length of stay worsened in July 2021 due to delayed discharging of a number of long stay patients. The COO is instigating a new approach to the management of acute flow focusing on delivery of 85% bed occupancy rather than length of stay. New mechanisms are being	AMBER

	Transformational change postponed by pandemic restarted [ACTIONS OWNER: DBIT]			implemented for patient reviews and discharge coordination	

Related operational high/extreme risks on the Corporate Risk Register: None

Strategic Objective 3. To make BEST use of our money

Principal risk: Whilst there are significant benefits from the creation of the Integrated Care System (ICS) as an NHS body, there is a risk that the effects of the change on senior managers from across the system may impact negatively on the cohesiveness of the Derbyshire health and care system

Impact: Financial position of the Derbyshire Health and Care system worsens; working relationships across the system deteriorates; loss of confidence from regulators in the Derbyshire system

Root causes:

a) New senior management relationships across organisations, with potential new appointments in system leadership roles with the creation of the new ICS as an NHS body and the creation of provider collaboratives
b) Creation of mental health, learning disability and autism provider collaborative may destabilise some of the established relationships in place across Derbyshire
c) Creation of system level governance structures may impact on provider Foundation Trust governance arrangements and decision-making processes
d) CCG staff impacted by change, may lead to increased staff turnover in teams supporting the delivery of the Mental Health Long-Term Plan and subsequent loss of organisational memory

BAF Ref: 20_21 3c | **Director Lead**: Gareth Harry (DBIT) | **Responsible Committee**: Trust Board

Key Controls

Inherent risk rating			Current risk rating				Target risk rating			Risk appetite		
HIGH	Likelihood 4	Impact 4	HIGH	Likelihood 4	Impact 4	Direction ⟺	MODERATE	Likelihood 3	Impact 4	Accepted	Tolerated	NOT ACCEPTED

Preventative – Governance structures in place at a system and Delivery Board level. Ongoing close communication with NHSE/NHSI, mental health and learning disability teams at a regional and national level. Assumed NHSE/NHSI-led appointment process to new ICS Board positions
Detective – Early meetings to be put in place with all new appointees at an executive level. Continuing engagement in all Joined up Care Derbyshire governance from DHCFT representatives
Directive – Mental Health, Learning Disability and Autism System Delivery Board to engage widely across membership on the development of any provider collaborative with agreed plans and processes
Corrective - Weekly meetings of wider system transformation team to continue, providing support and advice to colleagues across the system

Assurances on controls (internal)	Positive assurances on controls (external)
- Regular reporting of position to Board by CEO - Regular ELT updates and discussions - NED Board members on JUCD committees and Board	- Monthly Mental Health and Learning Disability assurance meetings with NHSEI teams with DHCFT represented by Director of Business Improvement and Transformation - Appointments/ assurance of new ICS board through NHSE/NHSI processes

Key gaps in control	Key actions to close gaps in control	Impact on risk to be measured by	Expected completion	Progress against action	Action on

Summary Board Assurance Framework Risks 2021-22 – Issue 3.3 Board 2 November 2021

			date (Action review date)		track
Maintenance of relationships with CCG colleagues during period of change and potential instability	Weekly meetings of wider MHLD system transformation team. Support and guidance provided from DHCFT DBIT Early meetings at DHCFT Board level with all new appointees into the ICS Board [ACTION OWNER: DBIT]	Staff turnover from wider transformational team, including CCG staff Positive working relationships formed with all new appointees in the Derbyshire system	~~(30.06.21)~~ Ongoing ~~30.09.21~~ 31.12.21	Weekly meetings continuing A permanent ICS Chair was appointed in July 2021. The CEO advert was published on 01.09.21	AMBER
Ensuring DHCFT board members are represented in positions of responsibility in JUCD governance structures	DHCFT Non-Executive Directors representing the organisation on a range of JUCD system governance committees and groups [ACTION OWNER: CEO]	DHCFT Board oversight of JUCD system and levels of confidence in system working and decision-making (measured in Board development sessions)	~~(30.06.21)~~ (31.12.21)	Non-Executive Directors including the Chair are now represented on JUCD governance Boards/committees	GREEN
Plan required for the development of the Mental Health, Learning Disability and Autism System Delivery Board (MHLD SDB) to become a provider collaborative	Plan to be developed in partnership with all other organisations in the collaborative [ACTION OWNER: CEO]	Development and agreement of Mental Health, Learning Disability and Autism Provider Collaborative before December 2021	~~(30.06.21)~~ (31.12.21)	Draft Terms of Reference for expanded SDB being considered. Accountability framework for delivery groups reporting to MHLD SDB is in development. System-wide provider collaborative approach is in development System support for MHLD&A SDB to be fast tracked on development of provider collaborative	AMBER
Increased decision-making at a system and/or provider collaborative level may impact on Trust-level governance structures becoming obsolete without regular review and change	Review of trust governance arrangements to be conducted in response to creation of ICS as an NHS Body with Non-Executive and Executive Director representation on the Board and the creation of a provider collaborative for Mental Health, Learning Disability and Autism [ACTION OWNER: CEO/Trust Secretary]	Board level confidence in new and emerging governance structures and ability to gain assurance on DHCFT risks and issues via system level governance regime	31.12.21	NHS England and NHS Improvement (NHSE/I) published several integrated care system (ICS) guidance documents and accompanying resources on 19.08.21 to support systems' transition into statutory Integrated Care Boards (ICBs) by 01.04.22. This document summarises these resources and provides	AMBER

				detailed commentary on the ICB functions and governance guidance, model constitution and ICS people guidance. A new series has been launched internally to help our colleagues understand the new ICS. The CEO is updating the Council of Governors on the MHLD SDB	

Related operational high/extreme risks on the Corporate Risk Register: None

Summary Board Assurance Framework Risks 2021-22 – Issue 3.3 Board 2 November 2021

Risk Rating

The summary score for determining the risk ratings for each risk is shown below. The full Risk Matrix, including descriptors, is shown in the Trust's Risk Management Strategy

RISK ASSESSMENT MATRIX					
The Risk Score is simply a multiplication of the Consequence Rating x the Likelihood Rating The Risk Grade is the colour determined from the Risk Assessment Matrix below					
	CONSEQUENCE				
LIKELIHOOD	INSIGNIFICANT 1	MINOR 2	MODERATE 3	MAJOR 4	CATASTROPHIC 5
RARE 1	1	2	3	4	5
UNLIKELY 2	2	4	6	8	10
POSSIBLE 3	3	6	9	12	15
LIKELY 4	4	8	12	16	20
ALMOST CERTAIN 5	5	10	15	20	25

Risk Grade/Incident Potential
Extreme Risk
High Risk
Moderate Risk
Low Risk
Very Low Risk

Action Progress

The colour ratings are based on the following descriptors:

Actions on Track for Delivery Against Gaps in Controls and Assurances	Colour Rating
Action completed	Blue
Action on track to completion within proposed timeframe	Green
Action implemented in part with potential risks to meeting proposed timeframe	Amber
Action not completed to original or formally agreed revised timeframe. Revised plan of action required	Red

Action Owners:

CEO	Chief Executive Officer	COO	Chief Operating Officer
DOF	Deputy Chief Executive and Executive Director of Finance	DON	Executive Director of Nursing and Patient Experience
MD	Medical Director	DPI	Director of People and Inclusion
DBIT	Director of Business Improvement and Transformation		

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 2 November 2021

Review of Standing Financial Instructions (SFIs)

Purpose of Report

SFIs have been reviewed and updated and are presented to the Board to be ratified.

Executive Summary

The SFIs have not been updated since 2019 due to the emergency response where temporary SFIs have been in place.

The following changes have been made:

General updates throughout the document for the following:

- change the name of NHS Improvement to NHS England and Improvement
- the term 'manpower' replaced by workforce
- the term 'People Services' replaced with 'People and Inclusion'
- 'his/her/herself' replaced with 'their/them/themselves'

Section 8 Tendering and Contracting has been updated to reflect EU changes to the 'EU Directives Governing Public Procurement' to the 'Public Contract Regulations 2015'.

Detailed updates are contained in the table below:

1.3.9	Senior Assurance Support meeting, Trust Management Team meeting' replaced with 'operational meetings'
2.6	Added: 'The Trust has in place a Counter Fraud Champion who is currently the Trust Secretary'
3.1, 3.1.1	Annual Plans' replaced with 'operational financial plans'
3.1.2	Financial ratings metric' replaced with 'financial regime'
3.1.2	Added: 'and mitigations'
3.2.1iii	Added: 'in exceptional circumstances'
3.2.1iii	Removed: 'if they relate to an agreed Service Level Agreement and / or contract'
3.2.2ii	replaced 'signed' with 'approved'
3.3.1	dashboards' replaced with 'information' and removed the list of contents
3.3.1	removed: ' performance against current NHS Improvement Finance score
3.3.3	Added: 'Off-payroll arrangements will be reported to Executive Leadership Team and to Finance and Performance Committee on a regular basis in advance of the annual reporting requirements'
7.9.1	Added: 'but limited to exceptional circumstances. Standard procurement processes should be followed and suppliers set up through the usual procurement system to ensure good procurement governance. If the Trust credit card is used then.'
7.9.4	Added: 'Purchasing cards for Argos and PC World are held by the

	Financial Control Team. Local procedures need to be in place to ensure the security of these cards.'
7.10	Added: 'Chip and Pin machines 7.10.1 The Trust holds 5 chip and pin machines at various locations across the Trust. 7.10.2 The card holder is present when the card machine is in use and no payments are taken over the phone. 7.10.3 Local Procedures need to be in place to ensure the security of the machines.
8.1.3	Added: 'The manual also includes reference to the 'No PO no pay' policy.'
12.1.5	Added: 'The Trust holds a separate Treasury Management Policy which covers both borrowings and investment in more detail.'
13.1.2	Added: 'See NHS Improvement: 'Capital regime, investment and property business case approval guidance for NHS trusts and foundation trusts'.'
13.1.3	Added: 'The Trust will follow NHS England and Improvement capital regime in relation to system sign off and working within CDEL limits set by the Regulator.'
13.2.1	replaced 'signed' with 'approved'
14.2.9	Added: 'Each member of staff has a responsibility for the security of property of the Trust whilst working remotely or from home, see separate Home Working Policy.'
15.9	Added: 'The Trust will follow any guidance issued by NHS England and Improvement in relation to any centrally procured goods such as PPE.'
16.2.4	Added: 'Deputy Director of Finance'
16.2.4	Added: 'Write-offs will only be reported to Audit and Risk Committee on an exceptional basis by value.'
16.2.9	Added: 'on an exceptional basis by value or volume if there becomes any issue with a certain area.'

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

Assurances

These Standing Financial Instructions identify the financial responsibilities which apply to everyone working for the Trust. They have been updated to clarify procedures that should be followed to ensure Trust's financial transactions are carried out in accordance with the law and with Government policy.

Consultation

- Senior staff within the Finance Department have updated the SFIs with input from the Head of Procurement.
- Counter Fraud have been sent the policy to review and have no updates.
- ELT have reviewed and have no further updates
- Audit and Risk Committee reviewed on 7 October 2021.

Governance or Legal Issues

These Standing Financial Instructions detail the financial responsibilities, policies and procedures adopted by the Trust. They are designed to ensure that the Trust's financial transactions are carried out in accordance with the law and with Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness.

Public Sector Equality Duty and Equality Impact Risk Analysis

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

The nature and remit of this document means that it has no impact on equality, diversity or inclusion and therefore does not impact those with protected characteristics.

Recommendations

The Board of Directors is requested to ratify the SFIs.

Report presented by: **Claire Wright**
Deputy Chief Executive and Director of Finance

Report prepared by: **Rachel Leyland**
Deputy Director of Finance

Derbyshire Healthcare NHS Foundation Trust

Standing Financial Instructions

October 2021

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1. STANDING FINANCIAL INSTRUCTIONS

INTRODUCTION

1.1 Who Should Read These Standing Financial Procedures (SFIs)?

These Standing Financial Instructions detail the financial responsibilities, policies and procedures adopted by the Trust. They are designed to ensure that the Trust's financial transactions are carried out in accordance with the law and with Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness.

These Standing Financial Instructions identify the financial responsibilities which apply to everyone working for the Trust. They do not provide detailed procedural advice and should be read in conjunction with the detailed departmental and financial procedure notes.

You should read these SFIs and be aware of their relevance to you as you discharge your responsibilities if you are:

- A Director of the Trust
- A Service Manager
- A Senior Manager in a support function
- A budget holder
- Involved in placing orders for goods/services on behalf of the Trust
- Involved in negotiating contracts/other arrangements for the provision of goods/services
- Involved with the handling and safe custody of patients' monies and valuables
- Involved in the administration of Charitable Funds

ALL staff must be made aware of section 11 Standards of Business Conduct within the Standing Orders of the Board of Directors and Standards of Business Conduct.

Should any difficulties arise regarding the interpretation or application of any of the SFIs then the advice of the Director of Finance MUST BE SOUGHT BEFORE YOU ACT. The user of these Standing Financial Instructions should also be familiar with and comply with the provisions of the Trust's Standing Orders.

The failure to comply with Standing Financial Instructions and Standing Orders can in certain circumstances be regarded as a disciplinary matter that could result in dismissal.

Overriding Standing Financial Instructions

If for any reason these Standing Financial Instructions are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance shall be reported to the next formal meeting of the Audit and Risk Committee for referring action or ratification. All members of the Board and staff have a duty to disclose any non-compliance with these Standing Financial Instructions to the Director of Finance as soon as possible.

1.2 TERMINOLOGY

1.2.1 Any expression to which a meaning is given in Health Service Acts, or in the Financial Directions made under the Acts, shall have the same meaning in these instructions; and:

"Trust" means the Derbyshire Healthcare NHS Foundation Trust;
"Board" means the Board of Directors of the Trust;
"Budget" means a resource, expressed in financial terms and whole time equivalent (WTE) terms, proposed by the Trust for the purpose of carrying out, for a specific period, any or all the functions of the Trust;
"Chief Executive" means the Chief Officer of the Trust;
"Director of Finance" means the Chief Financial Officer of the Trust, who is also the Director of Finance;
"Budget Holder" means the Director or member of staff with delegated authority to manage finances (Income and Expenditure, Revenue and Capital) for a specific area of the Trust;
"Legal Advisor" means the Trust appointed person properly qualified to provide legal advice.

1.2.2 Wherever the title Chief Executive, Director of Finance, or other nominated officer is used in these instructions, it shall be deemed to include such other directors or staff who have been duly authorised to represent them.

1.2.3 Wherever the term "staff" is used it shall be deemed to include staff of third parties contracted to the Trust when acting on behalf of the Trust.

1.2.4 Words importing the masculine gender only shall include the feminine gender; words importing the singular shall import the plural and vice-versa.

1.3 RESPONSIBILITIES AND DELEGATION

The Board of Directors

The Board exercises financial supervision and control by:

(a) formulating the financial strategy;

(b) requiring the submission and approval of budgets within approved allocations/overall income;

(c) defining and approving essential features in respect of important procedures and financial systems (including the need to obtain value for money);

(d) defining specific responsibilities placed on members of the Board and staff as indicated in the Scheme of Delegation document.

1.3.1 They may delegate executive responsibility for the performance of operational functions to the Chief Executive in accordance with the Trust's approved Scheme of Delegation.

1.3.2 The Chair

The Chair is responsible for leading the Board and for ensuring that it successfully discharges its overall responsibility for the organisation as a whole.

1.3.3 The Chief Executive

Within these SFIs it is acknowledged that the Chief Executive is ultimately accountable to the Board and it is the duty of the Chief Executive to:

- Implement the financial policies of the Board in order to ensure that the Board meets its obligations to perform its functions within the available resources.
- Ensure all staff are notified of the requirements of the Standing Financial Instructions.
- Delegate the management of resources to officers of the Trust in accordance with the Trust's approved Scheme of Delegation.
- Ensure that the Trust's financial obligations and targets are met.
- Take responsibility for the Trust's system of internal control.

1.3.4 In performing these duties the Chief Executive will take due consideration of the advice given by the Director of Finance.

1.3.5 It is a duty of the Chief Executive to ensure that members of the Board and, staff and all new appointees are notified of, and put in a position to understand, their responsibilities within these Instructions.

1.3.6 The Director of Finance

The Director of Finance is responsible for:

- implementing the Trust's financial policies and for co-ordinating any corrective action necessary to further these policies;
- maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions;
- ensuring that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Trust at any time.

The duties of the Director of Finance also include:

- the provision of financial advice to the Trust and its directors and staff;
- the design, implementation and supervision of systems of internal financial control; and
- the preparation and maintenance of such accounts, certificates, estimates, records and reports as the Trust may require for the purpose of carrying out its statutory duties.

1.3.7 All Board Members and Staff

All members of the Board and staff of the Trust have a responsibility for:

- the security of the Trust's assets;
- avoiding loss;

- exercising economy and efficiency in the use of resources; and
- conforming with the requirements of Standing Orders, Standing Financial Instructions, Financial Procedures and the Scheme of Delegation.

1.3.8 Budget Holders

Have a responsibility to:

- Monitor activities to ensure resources are utilised in an effective and efficient manner;
- Ensure activities are conducted within the constraints of budgets;
- Provide all information and explanations required by the Director of Finance to ensure financial control, enacted through the business of the operational meetings, Executive Leadership Team, Finance and Performance Committee and the Trust Board
- Ensure the security of Trust Assets including property, equipment and cash

1.3.8 Contractors and their Staff

Any contractor or staff of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income shall be covered by these instructions. It is the responsibility of the Chief Executive to ensure that such persons are made aware of this.

1.3.11 For all members of the Board and any staff who carry out a financial function, the form in which financial records are kept and the manner in which members of the Board and staff discharge their duties must be to the satisfaction of the Director of Finance.

2. AUDIT

2.1 THE AUDIT AND RISK COMMITTEE

2.1.1 In accordance with Standing Orders, the Board shall formally establish an Audit and Risk Committee, with clearly defined terms of reference (which are contained in the Scheme of Delegation) and following guidance from the NHS Audit Committee Handbook, which will provide an independent and objective view of internal control including financial control.

2.1.2 Where the Audit and Risk Committee feel there is evidence of ultra vires transactions, evidence of improper acts, or if there are other important matters that the Committee wish to raise, the Chair should raise the matter at a full meeting of the Board. Exceptionally, the matter may need to be referred to the Department of Health or NHS England and Improvement.

2.2 ROLE OF THE DIRECTOR OF FINANCE

2.2.1 The Director of Finance is responsible for:

- ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control including the establishment of an effective internal audit function
- ensuring an internal audit service exists to review, evaluate and report on the effectiveness of internal financial control to meet mandatory audit standards;

- ensuring that an annual audit report is prepared by Internal Audit and External Audit and as required by the Audit and Risk Committee and the Board in accordance with current Department of Health and NHS England and Improvement guidance.

2.2.2 The Director of Finance or designated auditors are entitled without necessarily giving prior notice to require and receive:

a) access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;

b) access at all reasonable times to any land, premises or staff of the Trust;

c) the production of any cash, stores or other property of the Trust under a member of staff's control;

d) explanations concerning any matter under investigation.

2.3 THE ROLE OF INTERNAL AUDIT

2.3.1 Internal Audit will review, appraise and report upon:

a) Internal Audit shall independently verify the Annual Governance Statement and other declarations in accordance with guidance from the Department of Health.

b) the extent of compliance with, and the financial effect of, relevant established policies, plans and procedures;

c) the adequacy and application of financial and other related management controls;

d) the suitability of financial and other related management data;

e) the extent to which the Trust's assets and interests are accounted for and safeguarded from loss of any kind, arising from:

(i) fraud and other offences,
(ii) waste, extravagance, inefficient administration,
(iii) poor value for money or other causes.

2.3.2 Whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the Director of Finance must be notified immediately, who shall in turn notify the Trust's Local Counter Fraud Specialist.

2.3.3 The Head of Internal Audit will normally attend Audit and Risk Committee meetings and has a right of access to all Audit and Risk Committee members, the Chair and Chief Executive of the Trust.

2.3.4 The Head of Internal Audit shall report to the Director of Finance who shall refer audit reports to the appropriate officers designated by the Chief Executive.

2.4 THE ROLE OF EXTERNAL AUDIT

2.4.1 The Trust's external auditor is appointed by the Council of Governors and is paid for by the Trust. The Auditor must comply with the principles set out in the Audit Code for NHS Foundation Trusts

2.4.2 The Governors must ensure that a cost-effective external audit service is provided and periodically review arrangements in conjunction with the Audit and Risk Committee.

2.5 External Auditors for non-Audit Services

2.5.1 The independence and objectivity of the external auditors is an important element supporting good governance within the Trust. The auditor should be, and should be seen to be, impartial and independent. Accordingly, the auditor should not carry out any other work for an audited body if that work would impair their independence in carrying out any of their statutory duties or might reasonably be perceived as doing so.

2.5.2 Prohibited non-audit services

To ensure that the auditor's independence and objectivity is not impaired it is important the external auditors do not:

- Audit their own work
- Make management decisions on behalf of the Trust
- Undertake activities which (potentially) result in conflicts of interest
- Act as advocates for the Trust
- Creating any threat to their independence

Therefore, the Trust will apply the following prohibitions on non-audit work by the external auditor:

- Providing any services specifically prohibited by UK law or supporting guidance
- Work related to the accounting records and financial statements that will ultimately be subject to external audit
- Taxation assignments where there is no fixed fee or the fixed fee is greater than that allowed in this policy (see below)
- Internal audit services
- Design/implementation of financial information technology systems
- Valuations services where the valuation has a potentially material impact upon the Trust's financial statements
- Legal and litigation support or advice where the outcome could have a potentially material impact upon the Trust's financial statements
- Provision of senior recruitment services

2.5.3 Permitted non-audit services

Where the work is not disallowed under the previous paragraph the external auditors may be considered for individual assignments. In the majority of cases such assignments will be subject to formal tendering procedures held in accordance with the Trust's SFIs.

In certain circumstances the external auditors' detailed understanding of the Trust's business may result in a recommendation from the Director of Finance to the Audit and

Risk Committee for the external auditors to be retained to undertake a permitted non-audit exercise, rather than undertake a formal tendering procedure. This may be, e.g., for reasons of efficiency, confidentiality or expert understanding of the Trust's position. These could include:

- Advice on the preparation of financial information and the application of GAAP or training support for accounting projects and in relation to accounting standards
- Audit related services as defined in the APB Ethical Standard 5 (Revised)
- Assistance in tax compliance activities and advice on recent developments and/or complex or high-risk areas.

Secondments between the external auditors and the Trust will also be acceptable for lower (sub-Board) positions.

2.5.4 There is no financial limit in any one financial year relating to non-audit assignments secured by external audit through competitive tendering procedures. Nonetheless, the potential for the compromising of independence and objectivity must always be considered. Therefore, it will be the duty of the Director of Finance to draw the attention of the Audit and Risk Committee if the external auditor is awarded non-audit work to a value equal to or greater than the value of the external audit contract in any one financial year.

There will be a strict limit applied to any assignment awarded directly to the external auditor without a competitive tendering process. The value of any one assignment must not exceed £10,000 and there can be no more than two such assignments in any one financial year.

2.5.5 For awards made to the external auditor through a competitive tendering process – the approval will follow existing SFI requirements and will be reported by the Director of Finance to the next Audit and Risk Committee.

For awards made to the external auditor directly, without a competitive tendering process – a written request will be submitted to the Audit and Risk Committee. The Committee will give its consent either at a scheduled meeting or by written consent (as appropriate) based upon a submission which covers:-

- The service to be provided
- An explanation of the rationale for appointing the external auditor
- The safeguards in place to mitigate the threat to auditor independence (e.g., the application of 'Ethical Walls' by the audit firm)
- Estimate of fees and expenses
- An analysis of the expected total proportion of fees earned by the external auditors in the year which will be earned by non-audit work

The Audit and Risk Committee will need to provide approval on a formal, recorded, basis.

2.5.6 For the avoidance of doubt the phrase 'external auditor' in this policy covers not only the audit partner signing-off the Trust's accounts, nor the audit section or department undertaking the external audit but also the firm providing the audit.

2.5.7 Adherence to this policy will be monitored by the Audit and Risk Committee.

2.6 FRAUD and BRIBERY

In line with their responsibilities the Trust Chief Executive and Director of Finance shall ensure compliance with Secretary of State guidelines on fraud and bribery.

The Trust shall nominate an accredited individual to carry out the duties of the Local Counter Fraud Specialist (LCFS) as specified by the NHS Counter Fraud Authority. The Trust has in place a Counter Fraud Champion who is currently the Trust Secretary.

The LCFS shall report to the Trust Director of Finance and work alongside NHS Counter Fraud Authority to ensure there is a zero-tolerance approach to Fraud and Bribery within the Trust.

The LCFS will provide a written report, at least annually, detailing the counter fraud work within the Trust which will be presented to the Audit and Risk Committee.

In accordance with the Trust Fraud and Bribery Policy, any suspicions involving financial crime must be reported to the Local Counter Fraud Specialist, and / or the Executive Director of Finance or via the NHS Fraud Reporting Line. All reported concerns will be treated in the strictest confidence and professionally investigated in accordance with the Fraud Act 2006 and Bribery Act 2010. Where evidence of Fraud and / or Bribery is identified all available sanctions will be pursued against offenders. This may include internal and professional body disciplinary sanctions, criminal prosecution and civil action to recover identified losses.

2.6.1 Sanctions and Redress

The Trust is committed to pursuing and / or supporting NHS Counter Fraud Authority in pursuing the full range of available sanctions (criminal, civil and disciplinary) against those found to have committed fraud and / or bribery.

The Trust seeks to recover, and / or support NHS Counter Fraud Authority in seeking to recover NHS funds that have been lost or diverted through fraud and / or bribery.

The Trust publicises cases that have led to successful recovery of NHS funds.

2.7 SECURITY MANAGEMENT

In line with their responsibilities, the Trust Chief Executive will monitor and ensure compliance with Directions issued by the Secretary of State for Health on NHS security management.

The Trust shall nominate a suitable person to carry out the duties of the Local Security Management Specialist (LSMS) as specified by the Secretary of State for Health guidance on NHS security management.

The Trust shall nominate a Non-Executive Director to ensure security has a high profile and is considered appropriately in the Trust's strategic direction.
The Chief Executive has overall responsibility for security management. Key responsibilities are delegated to the Security Management Director (SMD) and the appointed Local Security Management Specialist (LSMS).

3. BUSINESS PLANNING, BUDGETARY CONTROL

3.1 PREPARATION & APPROVAL OF OPERATIONAL FINANCIAL PLANS AND BUDGETS

3.1.1 The Chief Executive will compile and submit to the Board an operational financial plan in accordance with current NHS England and Improvement guidelines with due regard to the views of Council of Governors. The operational financial plan will include:

- In accordance with NHS England and Improvement annual plan guidance, statements of the significant assumptions on which the plan is based;
- details of major changes in workload, service delivery or resources to achieve the plan;
- any other relevant information as required by the regulator's guidance issued for the planning submission.

3.1.2 At the start of the financial year the Director of Finance will, on behalf of the Chief Executive, prepare and submit revenue and capital expenditure start budgets for approval by the Board. Such budgets will:

- be in accordance with the aims and objectives set out in the operational plan;
- accord with workload and workforce plans;
- be produced following discussion with appropriate budget holders;
- be prepared within the limits of available funds;
- demonstrate the achievement of key financial targets such as strategic financial objectives of the Trust and the regulatory financial regime as advised by NHS England and Improvement
- identify potential risks and mitigations.

3.1.3 The Director of Finance shall monitor financial performance against budget and plan, and report financial performance to the Board and subsequently to NHS England and Improvement as required, in the appropriate templates issued by NHS England and Improvement.

3.1.4 All budget holders must provide information as required by the Director of Finance to enable budgets to be compiled. This will be enacted through the business of appropriate meetings with managers and the Trust Board.

3.1.5 The Director of Finance has a responsibility to ensure that adequate training is delivered on an on-going basis to budget holders to help them manage successfully.

3.2 BUDGETARY DELEGATION

3.2.1 The Chief Executive may delegate the management of a budget to permit the performance of a defined range of activities. This delegation must be in writing with a clear definition of:

- the amount of the budget and the purpose(s) of each budget heading;
- achievement of planned levels of service and individual or group responsibilities;
- the provision of regular reports and authority to exercise virement.

3.2.1i From time to time NHS England and Improvement may issue guidance or instructions regarding additional approval processes for certain types of Trust expenditure. Where Foundation Trusts are required to comply, NHS England and Improvement's approval process, as defined by their guidance, will override the authority to authorise as laid out in the Trust standing financial instruction, only for the specific type of expenditure concerned

3.2.1ii In cases where compliance with any additional approval regime by NHS England and Improvement is *voluntary*, the Chief Executive will determine the appropriate course of action for the Trust and will notify budget holders accordingly, with the support of the Director of Finance.

3.2.1iii In exceptional circumstances where large invoices are received which exceed the limits set out on 3.2.2i, then the Chief Executive and Director of Finance can jointly approve.

3.2.2 Authority for virements between budgets relating to a particular service or function shall be limited to:

over £500,000	Countersigned by relevant Executive Director / Director of Finance
£100,000 to £500,000	Countersigned by Deputy Director of Operations /General Manager / Head of Service
Up to £100,000 *	Budget holder (* or total budget if less than £100,000)

3.2.2i With the exception of expenditure referred to in para 3.2.1i, 3.2.1ii and 3.2.2iii Authority to authorise any one revenue order shall be limited to:

over £500,000	Board of Directors
£200,000 to £500,000	Chief Executive or Director of Finance.
£50,000 to £200,000	Deputy Chief Executive or Deputy Director of Finance
£30,000 to £50,000	Executive Directors voting and non-voting but not Non-Executive Directors
£10,000 to £30,000	Deputy Director of Operations and General Managers
£1,000 to £10,000	Heads of Operational Service Areas

(or lower limit for individual budget holders as set by the Chief Executive)

3.2.2ii With the exception of expenditure referred to in para 3.2.1i and 3.2.1ii Authority for planned expenditure of Capital Resources shall be limited to:
Expenditure on an individual project up to £100,000
- Approved by the Capital Action Team

Expenditure on an individual project up to £ 1,000,000
- Jointly approved by the Director of Finance and one other Executive Director

Project in excess of £1,000,000
- Board approval required

3.2.4 The general rules applying to delegation and reporting shall also apply to capital expenditure. (The particular applications relating to capital are contained in SFI 13).

3.2.5 The budgetary total or virement limits set by the Board above must not be exceeded. Expenditure for which no provision has been made in an approved budget and which is not subject to funding under delegated powers of virement shall only be incurred after

proper authorisation - i.e. by the Chief Executive or the Board of Directors as appropriate within delegated limits.

3.2.6 Unless approved by the Chief Executive, after taking the advice of the Director of Finance; budgets shall only be used for the purpose for which they were provided. Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive, subject to any authorised use of virement.

3.2.6 Non-recurring budgets shall not be used to finance recurring expenditure without the authority in writing of the Chief Executive.

3.3 BUDGETARY CONTROL AND REPORTING

3.3.1 The Director of Finance will devise and maintain systems of budgetary control. These will include monthly financial information presented to the Board in a form approved by the Board.

a) Detailed financial information to Finance and Performance Committee covering but not limited to:
   i) Income and expenditure position for year to date and forecast year end position
   ii) Statement of Financial Position including any key exceptions
   iii) Cash levels and key drivers
   iv) Capital expenditure against plan.
   v) Agency performance against ceiling
   vi) Key financial risks and mitigations
b) the production of timely, accurate and comprehensive advice and financial reports to each budget holder, covering the areas for which they are responsible;
c) investigation and reporting of variances
d) monitoring of management action to correct variances;
e) arrangements for the authorisation of budget transfers;
f) on-going training and support to budget holders to enable them to manage successfully.

3.3.2 The Director of Finance shall keep the Chief Executive and the Board of Directors informed of the financial consequences of changes in policy, pay awards, and other events and trends, whether national, local or internal, affecting budgets and shall advise on the financial and economic aspects of future plans and projects.

3.3.3 All Budget Holders are responsible for ensuring that:

a) any likely overspending or reduction of income is not incurred without the prior consent of the Board;
b) the amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised subject to the rules of virement; and
c) no permanent staff are appointed without the approval of the Chief Executive as per 10.3.1.ii other than those provided for in the budgeted establishment as approved by the Board.
d) In the exceptional circumstance where a member of staff is engaged through terms deemed as 'off-payroll' by Her Majesty's Revenue and Customs (HMRC) and/ or NHSI, the relevant budget holder who is seeking to make these arrangements is responsible for ensuring compliance with HMRC rules and regulations and reporting,

as informed by the Director of People and Inclusion. All off-payroll engagements should be approved by a Director before commencement

e) Where costs may be committed by a third party there must be appropriately authorised by a specific governance process defined by a local operating procedure.

f) Off-payroll arrangements will be reported to Executive Leadership Team and to Finance and Performance Committee on a regular basis in advance of the annual reporting requirements.

3.3.4 The Chief Executive or Director delegated by the Chief Executive is responsible for identifying and implementing cost improvements and value for money initiatives in accordance with the requirements of the Annual Plan and a balanced budget.

3.4 MONITORING RETURNS

3.4.1 The Chief Executive is responsible for ensuring that the appropriate monitoring forms are submitted, accurately and on time and in the required format, to the requisite Organisation.

4. ANNUAL ACCOUNTS AND REPORTS

4.1 The Director of Finance, on behalf of the Trust, will:

i. prepare and submit financial returns in such a form as directed by NHS England and Improvement, with the approval of HM Treasury, specifically in accordance with International Financial Reporting Standards (as applied in the NHS England and Improvement Annual Reporting Manual and the Department of Health Group Accounting Manual as well as HM Treasury's Financial Reporting Manual - FReM ;)

ii. lay audited accounts before Parliament and send a copy to NHS England and Improvement in accordance with the Annual Reporting Manual.

4.2 The Trust's Annual Accounts must be audited by an auditor appointed by the Council of Governors. The Audited Annual Accounts must be presented to the Annual Public Meeting of the Trust.

4.3 The Trust will compile and publish an Annual Report in accordance with NHS England and Improvement's Annual Reporting Manual.

5. BANKING ARRANGEMENTS

5.1 GENERAL

5.1.1 The Director of Finance shall monitor financial performance for working capital against budget and plan, periodically review them, and report to the Board. All funds of the Trust shall be held in accounts in the name of the Trust. Only staff authorised by the Director of Finance may open a bank account in the name of the trust.

5.1.2 The Board shall approve the banking arrangements and agree (or delegate agreement on their behalf of) the Treasury Management Policy prepared by the Director of Finance.

5.1.3 Bank and Government Banking Service (GBS) Accounts

The Director of Finance is responsible for:

a) bank accounts and Government Banking Service accounts;

b) establishing separate bank accounts for the Trust's non-exchequer funds where appropriate;

c) ensuring payments made from bank or GBS accounts do not exceed the amount credited to the account except where arrangements have been made;

d) reporting to the Board all arrangements made with the Trust's bankers for accounts to be overdrawn

e) reporting to Board any proposals to draw down any or all of the Trust's working capital facility if such a facility is in place.

f) ensuring the Trust does not exceed the limit of its approved working capital facility if such a facility is in place

g) monitoring compliance with DH guidance on the level of cleared funds.

5.1.4 ONLY authorised signatories within the Financial Control Team may make changes to Trust banking mandates including Direct Debits. No other persons within the Trust should activate, deactivate or make any changes whatsoever to any Trust direct debit arrangements. Staff wishing to do so should contact the Financial Controller.

5.2 BANKING PROCEDURES

5.2.1 The Director of Finance will prepare financial procedures on the operation of bank accounts for the approval of the Board of Directors.

5.2.2 The Director of Finance must advise the Trust's bankers in writing of the conditions under which each account will be operated in accordance with approved procedures.

5.3 TENDERING AND REVIEW

5.3.1 Any commercial banking arrangements of the Trust should be reviewed at regular intervals to ensure they reflect best practice and represent best value for money by periodically seeking competitive tenders for the Trust's banking business.

5.3.2 Competitive tenders should be sought at least every 3 years. The results of the tendering exercise should be approved by the Board. This review is not necessary for GBS accounts.

6. INCOME, FEES AND CHARGES

6.1 INCOME SYSTEMS

6.1.1 The Director of Finance is responsible for designing, maintaining and ensuring

compliance with systems for the proper recording, invoicing, collection and coding of all monies due. These systems shall include income due under contracts or extra-contractual arrangements for the provision of Trust services.

6.1.2 The Director of Finance is also responsible for the prompt banking of all monies received.

6.2 FEES AND CHARGES

6.2.1 The Trust shall refer to NHS England and Improvement's Approved Costing Guidance in setting prices for contracts and services provided to other organisations. However, pricing strategies will be determined by appropriate Trust Committees.

6.2.2 The Director of Finance is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the Department of Health or by Statute. Independent professional advice on matters of valuation shall be taken as necessary.

6.2.3 All staff must inform the Director of Finance promptly of money due arising from transactions which they initiate or deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions. The Director of Finance and the Chief Executive shall approve all contracts for income.

6.3 DEBT RECOVERY

6.3.1 The Director of Finance is responsible for the appropriate recovery action on all outstanding debts. Income not received should be dealt with in accordance with losses procedures. This includes the use of external debt recovery agents.

6.3.2 Should any staff detect that an overpayment has been made they should report immediately to the Director of Finance in order that recovery procedures can be initiated. The Trust will follow the overpayment policy in recovering debt owed as a result of employee benefit overpayment.

7. SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS

7.1 The Director of Finance and/or the Director responsible for the cashier's service shall prescribe and is responsible for systems and procedures for any staff handling cash, pre-signed cheques and negotiable securities on behalf of the Trust, including:

i. approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable
ii. the security and control of any such stationery
iii. procedures for receiving and banking of cash, cheques and other forms of payment
iv. circumstances in which unofficial funds may be deposited in safes
v. prescribing systems and procedures for handling cash and negotiable instruments on behalf of the Trust. Where the Shared Services Organisation undertakes such issues as stated in 7.1, detailed requirements will be specified in a Service Level Agreement with the Shared Services Organisation.
vi. Issuing of High Street vouchers and the appropriate use of these vouchers.

7.2 Staff shall be informed in writing on appointment, of their responsibilities and duties for the collection, handling or distribution of cash, cheques, etc. Any staff whose duty it is

to collect or hold cash shall be audited by the finance team to ensure the appropriate controls are in place for the safe keeping of the cash.

7.3 During the absence (e.g. on holiday) of the holder of a safe or cash-box key, the member of staff who acts in their place shall be subject to the same controls as the normal holder of the key. There shall be written discharge for the safe and/or cash-box contents on the transfer of responsibilities and the discharge document must be retained for inspection.

7.4 All cash, cheques and other forms of payment received by any other staff shall be passed immediately to the holder of a safe or cash-box key or to the cashier, from whom a signed receipt shall be obtained. No member of staff should keep Trust cash, cheques or other forms of payment, for whatever purpose, on Trust premises unless the Financial Controller is aware of the existence of such arrangements and can support and be assured on the systems and processes for the probity of such arrangements

7.5 Official money may never be used for the encashment of private cheques.

7.6 The opening of coin operated machines (including telephones) and the counting and recording of the takings shall be undertaken by two members of staff together, unless authorised in writing by the Director of Finance. The coin-box keys shall be held only by a nominated member of staff.

7.7 Any loss or shortfall of cash, cheques or other cash equivalents, however occasioned, shall be reported immediately to the Financial Control Team in accordance with the agreed procedure for reporting losses (see also Section 16 Disposals, Losses and Special Payments).

7.8 Petty Cash

7.8.1 All new floats or amendments to floats are authorised by the Director of Finance or Deputy Director of Finance, they will only be approved if they are essential to the service.

7.8.2 All Petty Cash Floats must be held in a secure place and remain under the control of the designated Float Holder/Accounting Officer. The float holders who are going off duty and coming on duty will both check the petty cash together and a formal record of the check will be documented.

7.8.3 Petty Cash disbursements should be for the purpose agreed when the float was established. All disbursements must be supported by receipt(s). In circumstances where staff require an advance of cash to make a purchase, a record must be kept of the details and amount issued to ensure that all cash can effectively be accounted for until receipts and unspent cash are returned within 24 hours. Advances of cash need to be authorised by either the Director of Finance, Deputy Director of Finance or the Financial Controller prior to the advance being issued.

7.8.4 Reimbursements will not be made unless both signatories provided match the authorised signatories that is held on record for the float

7.8.5 In exceptional circumstances Petty Cash above £50 may be issued with prior authorisation from the Director of Finance, Deputy Director of Finance or the Financial

Controller.

7.9 Trust Credit Card

7.9.1 The Trust will hold a credit card in order to support the procurement process in allowing more flexibility to purchase goods but limited to exceptional circumstances. Standard procurement processes should be followed and suppliers set up through the usual procurement system to ensure good procurement governance. If the Trust credit card is used then the Trust's procurement processes will still need to be followed but the credit card will enable quicker payments to be made.

7.9.2 Access to the Trust credit card will be limited to Financial Control and Procurement. The card whilst not in use will be kept in a secure safe. Local procedures need to be in place to ensure the security of the credit card.

7.9.3 Fuel Purchasing Cards are held by the Estates Department, these should be kept in a secure place when not in use and documentation kept on usage.

7.9.4 Purchasing cards for Argos and PC World are held by the Financial Control Team. Local procedures need to be in place to ensure the security of these cards.

7.10 Chip and Pin machines

7.10.1 The Trust holds 5 chip and pin machines at various locations across the Trust.

7.10.2 The card holder is present when the card machine is in use and no payments are taken over the phone.

7.10.3 Local Procedures need to be in place to ensure the security of the machines.

8. TENDERING AND CONTRACTING PROCEDURE

8.1 Duty to comply with Standing Orders and Standing Financial Instructions

8.1.1 Every contract (other than for the delivery of Trust services delivered in accordance with the National Contract and commissioned by NHS or other Commissioners, (see 8.21) where made by the Trust, shall comply with these Standing Financial Instructions.

8.1.2 An exception from any of the following provisions of these Standing Financial Instructions may be made by the direction of the Trust or, in an emergency, by the Chair and Chief Executive, in accordance with SO 4.

8.1.3 Staff undertaking procurement activity should refer to the Trust Procurement Manual for further detailed information. The manual also includes reference to the 'No PO no pay' policy.

8.2 Bribery Act

All staff involved in tendering and contracting and other budget holder activities should be aware of the Bribery Act 2010 and should ensure that all dealings with other organisations and their staff do not bring them in breach of the Act. That could leave them open to criminal proceedings being commenced.

8.3 Public Contract Regulations 2015

On 1st January 2021 the OJEU regulations were transposed into English Law and our public procurement rules are governed under the Public Contract Regulations (PCR) 2015. Procedures for awarding all forms of contracts under PCR2015 shall have effect as if incorporated in these Standing Financial Instructions.

Any rules pertaining to public procurement under PCR2015 cannot be waived.

8.4 Investment approach

Any potential major investment decision must be guided by relevant current Foundation Trust guidance, which sets out governance processes for all major investments undertaken by NHS foundation trusts.

8.5 Tendering

All tendering activity must be compliant with the Procurement Transparency policy issued by the Department of Health dated March 2014 or any other such policy that may supersede it.

Formal Competitive Tendering

The standard method of procurement by the Trust shall be by way of competitive tender. The Trust shall ensure that such tenders are invited for the supply of goods, materials and manufactured articles and for the rendering of services including all forms of management consultancy services (other than specialised services sought from or provided by the DH); for the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens); and for disposals.

8.5.1 Tender and Quotation Limits

The procurement of all goods and services should be preceded by a requisition and official order. By exception, urgent and/or emergency situations may be reasons why this is not possible and in these cases confirmation orders should be raised.

8.5.2 General Position on Quotations and Tendering

Below £10,000 (ex VAT) good purchasing practice is necessary i.e. seeking the best value for money.

8.5.3 The Trust's Procurement Department must be consulted prior to the commencement of any of the processes listed below

- For purchases between £10,000 (ex VAT) and £25,000 (ex VAT) three written quotations are required.
- For purchases above £25,000 (ex VAT) and below PCR 2015 limit formal tenders are sought. All tender opportunities and contract awards in excess of £25,000 and below the PCR 2015 threshold will be published on Contracts Finder,

- Supplies and service contracts above the current PCR 2015 threshold require full compliance with the relevant PCR 2015 procedure

- In the event that purchases between £10,000 (ex VAT) and £25,000 (ex VAT) are procured through a compliant PCR 2015 framework there is no requirement to obtain additional quotations. For purchases above £25,000 (ex VAT) procured through a compliant PCR 2015 framework the Head of Procurement can recommend to Executives whether further competition is required. At all times value for money should be a prime consideration, even when procuring from a compliant framework.
- With regards to small works procurement (as defined by PCR 2015) these rules shall override any other obligation contained in these Standing Financial Instructions relating to tender and quotation requirements.

8.6 Formal tendering procedures may be waived by officers to whom powers have been delegated by the Chief Executive without reference to the Chief Executive except in (c) to (f) below where:

(a) The estimated expenditure or income does not, or is not reasonably expected to, exceed £25,000 (ex VAT) (in which case quotations process not tender process should be followed), or

(b) Where the supply is proposed under special arrangements negotiated by the DH or Regulator in which event the said special arrangements must be complied with;

(c) The timescale genuinely precludes competitive tendering. Failure to plan the work properly is not a justification for single tender;

(d) Specialist expertise is required and is available from only one source;

(e) The task is essential to complete the project, **and** arises as a consequence of a recently completed assignment and engaging different consultants for the new task would be inappropriate; this reason for waiver cannot be enacted if NHS England and Improvement approval is required for management consultancy or other defined expenditure

(f) There is a clear benefit to be gained from maintaining continuity with an earlier project. However, in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering.

Requests for waiving formal tendering procedures should be in the form of a letter signed by the Chief Executive or their nominated deputy. These should then be entered in the waiver register and reviewed by the Audit and Risk Committee.

A waiver is not required for year two onwards of contracts that have already been through the procurement process that is outlined in these Standing Financial Instructions.

8.7 The limited application of the single tender rules should not be used to avoid competition or for administrative convenience or to award further work to a consultant originally appointed through a competitive procedure.

Where it is decided by the Chief Executive that competitive tendering is not applicable and should be waived by virtue of the above, the fact of the waiver and the reasons should be

recorded in writing to the Chief Executive and documented in a register held by the Trust Secretary.

8.8 Except where SFI 8.1, or a requirement under SFI 8.6, applies, the Trust shall ensure that it follows the Procurement Transparency Policy and that full procurement must be followed for contracts in excess of £25k and not limited competition

8.9 The Board shall ensure that normally the firms/individuals invited to tender (and where appropriate, quote) are among those identified within the Procurement Framework. Where in the opinion of the Director of Finance it is desirable to seek tenders from firms not on the approved lists, the reason shall be recorded in writing to the Chief Executive.

8.10 Tendering procedures are set out in the Appendix.

8.11 **Quotations** - are required where formal tendering procedures do not apply where expenditure is expected to exceed £10,000 (ex VAT).

8.12 Where quotations are required they should be obtained from at least three firms/individuals.

8.13 All quotations should be treated as confidential and should be retained for inspection.

8.14 The Chief Executive or their nominated officer should evaluate the quotations and select the one which gives the best value for money. If this is not the lowest then this fact and the reasons why the lowest quotation was not chosen should be in a permanent record.

8.15 Non-competitive quotations in writing may be obtained for the following purposes:

(a) the supply of goods/services of a special character for which it is not, in the opinion of the Chief Executive or their nominated officer, possible or desirable to obtain competitive quotations;

(b) the goods/services are required urgently

Instances of, and reasons for, non-competitive quotations are to be entered in the waiver register and reviewed by the Audit and Risk Committee

8.16 Where tendering or competitive quotation is not required:-

The Trust shall procure goods and services in accordance with procurement procedures approved by the Trust as laid out in the Trust Procurement Manual.

8.17 **Contracts** - The Trust may only enter into contracts within its statutory powers and shall comply with:

(a) its Establishment and Amendment Orders

(b) TheTrust’s Standing Orders

(c) The Trust’s Standing Financial Instructions

(d) PCR 2015 and other statutory provisions

(e) any relevant directions from NHS England and Improvement

(f) such of the NHS Standard Contract Conditions as are applicable.

Where appropriate contracts shall be in or embody the same terms and conditions of contract as was the basis on which tenders or quotations were invited.

8.18 All contract documents, up to the value of £100,000, shall be signed on behalf of the Trust by an Executive Director **(voting or non-voting)** or nominated officer. Every contract the value of which exceeds £500,000 shall be executed under the Common seal of the Trust and be signed by the **Trust Secretary and an Executive Director (voting or non-voting)** duly authorised by the Chief Executive and not from the originating department.

8.19 In all contracts made by the Trust, the Board shall endeavour to obtain best value for money. The Chief Executive shall nominate an officer who shall oversee and manage each contract on behalf of the Trust.

8.20 **Personnel and Agency or Temporary Staff Contracts** - The Chief Executive shall nominate officers with delegated authority to enter into contracts of employment regarding staff, agency staff or temporary staff service contracts

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8.20.1 Where a member of staff is employed using such temporary arrangements the Director of People and Inclusion will ensure that up-to-date guidance is available to managers and that compliance with such guidance is appropriately monitored and enforced to ensure that the Trust is able to comply with regulatory requirements including those of NHS England and Improvement and Her Majesty's Revenue and Customs (HMRC).

8.21 **Healthcare Services Agreements** – service agreements with commissioners for the supply of healthcare services, are subject to the separate and specific provisions of the terms of authorisation of the Trust and must be in the form of legally binding contracts

8.22 **Cancellation of Contracts** – Except where specific provision is made in model forms of contracts approved for use within the NHS and in accordance with SFIs 8.18 and 8.19, every contract shall include a written clause empowering the Trust to terminate the Contract and to recover from the Contractor the amount of any loss resulting from such cancellation if the Contractor or any person employed by the Contractor or acting on behalf of the Contractor has offered, paid or given, directly or indirectly, any gift in money or any other form to any employee or agent of the Trust as an inducement or reward in connection with their behaviour in relation to the Contract, or appears to have committed any offence under the Bribery Act 2010 or other appropriate legislation.

8.23 **Determination of Contracts for Failure to Deliver Goods or Materials** – There shall be inserted in every written contract for the supply of goods or materials a clause to secure that, should the contractor fail to deliver the goods or materials or any portion thereof within the time or times specified in the contract, the Trust may without prejudice determine the contract either wholly or to the extent of such default and purchase other goods, or material of similar description to make good (a) such default, or (b) in the event of the contract being wholly determined the goods or materials remaining to be delivered. The clause shall further secure that the amount by which the cost of so purchasing other goods or materials exceeds the amount which would have been payable to the contractor in respect of the goods or materials shall be recoverable from the contractor.

8.24 The Chief Executive shall nominate officers with power to negotiate for the provision of healthcare services with purchasers of healthcare.

8.25 **Contracts Involving Funds Held on Trust** - shall do so individually to a specific named fund. Such contracts involving charitable funds shall comply with the requirements of the Charities Act.

9. NHS SERVICE AGREEMENTS AND CONTRACTS FOR PROVISION OF SERVICES

9.1 The Chief Executive, as the Accounting Officer, is responsible for ensuring the Trust enters into suitable contracts with service commissioners for the provision of health services. In discharging this responsibility, the Chief Executive shall take into account:

(a) The National Contract framework
(b) Local health service planning priorities
(c) The cost, price and volume of services to be provided and method of payment;
(d) The standards and detailed specifications for service quality expected;

The Trust will work with any partner agencies involved in both the delivery and the commissioning of the service required. The contract will apportion responsibility for mitigating any contractual risks and the financial arrangements should reflect this.

The Chief Executive, as the Accounting Officer, will need to ensure that regular reports are provided to the Board detailing actual and forecast income from contracts, this responsibility has been delegated to the Executive Director of Finance.

This will include information on any costing arrangements subject to local currency agreements, including any changes to payment systems e.g. National Tariff Payment System

10. EMPLOYMENT TERMS AND CONDITIONS

10.1 REMUNERATION

10.1.1 The Board should formally agree and record in the minutes of its meetings, the precise terms of reference of the Remuneration and Appointments Committee, specifying which posts fall within its area of responsibility, its composition, and the arrangements for reporting. (The terms of reference of this committee are contained in the Scheme of Delegation).

10.1.2 Except where Agenda for Change rules apply, the Board will approve proposals presented by the Chief Executive for the setting of remuneration and conditions of service for those staff not covered by the Committee.

10.1.3 The remuneration of the Chair and Non-executive Directors will be determined by the Council of Governors in accordance with the Foundation Trust Constitution.

10.2 FUNDED ESTABLISHMENT

10.2.1 The workforce plans incorporated within the annual budgets will form the funded

establishment.

10.3 STAFF APPOINTMENTS

10.3.1 No Director or staff may engage, re-engage, or re-grade staff, either on a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration:

i) Unless within the approved budget and funded establishment limit and in accordance with appropriate guidance on such employment.
ii) In certain circumstances, following the consideration of an 'Invest to Save' Business Case at ELT, the Chief Executive and the Director of Finance may approve appointments to unfunded posts. These posts must have a return on investment over an agreed period of time. Any agreements that are made will be reviewed and evaluated on a regular basis in order to access the impact on delivering efficiencies laid out in the business case.

10.3.2 The Board will approve procedures presented by the Chief Executive for the determination of pay rates, conditions of service, etc., for staff.

10.4 PROCESSING OF PAYROLL

10.4.1 The Director of People and Inclusion is responsible for:

i) specifying timetables for submission of properly authorised time records and other notifications;
ii) making recommendations to the Director of Finance on the final determination of pay;
iii) making payment on agreed dates;
iv) agreeing methods of payment.
v) maintaining and enforcing a Trust under and overpayment policy and seeking to recover any overpayments in line with that policy.

10.4.2 The Director of Finance and the Director of People and Inclusion **will** as appropriate, issue instructions regarding:

ii) verification and documentation of data;
iii) the timetable for receipt and preparation of payroll data and the payment of staff;
iv) maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay;
v) security and confidentiality of payroll information;
vi) checks to be applied to completed payroll before and after payment;
vii) authority to release payroll data under the provisions of the Data Protection Act;
viii) methods of payment available to various categories of staff;
ix) pay advances and their recovery;
x) procedures for payment by cheque or bank credit:
xi) procedures for the recall of cheques or bank credits;
xii) maintenance of regular and independent reconciliation of pay control accounts;
xiii) separation of duties of preparing records and handling cash; and
xiv) a system to ensure the recovery from leavers of payments and property due to the Trust.

xv) A system to record and report specific employee costs as required by guidance for example “high-cost off-payroll” employee costs
xvi) Maintenance of an up to date authorised signatory list for pay

10.4.3 Nominated managers have delegated responsibility for:

i) Ensuring all members of staff with any secondary employment complete all required declarations in line with secondary employment policy or successor policy in place at the time
ii) Ensuring all staff absences are appropriately authorised. In the event of unauthorised absence the line manager is responsible for notifying payroll services to ensure payment for unauthorised absence is prevented or recovered
iii) submitting time records, and other notifications in accordance with agreed timetables;
iv) completing time records and other notifications in accordance with the instructions of and in the form prescribed by the Director of People and Inclusion or the Director of Finance.
v) submitting termination forms electronically immediately upon receiving confirmation of a member of staff’s resignation, termination or retirement. Where a member of staff fails to report for duty in circumstances that suggest they have left without notice, the Director of People and Inclusion must be informed at the earliest opportunity.
vi) Submitting all employee-related updates promptly to avoid over or under payment and to ensure that staff records are accurate and up to date for their area of responsibility. These requirements include but are not limited to new starters, change forms and leavers.
vii) An authoriser must ensure that timesheets, expense claims and other such notifications are appropriately checked and agreed as accurate before authorisation is given.
viii) Ensuring that all Rostering systems for their area of responsibility are accurately maintained, in accordance with Trust policy, to ensure correct and timely payments are made to appropriate staff

10.4.4 The Director of People and Inclusion and the Director of Finance shall ensure that the chosen method for providing the payroll service is supported by appropriate contracted terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

10.4.5 In terminating a contract through the use of severance payments, the affordability of the payment should be assessed by the Director of Finance before proceeding. The Director of People and Inclusion is responsible for ensuring all appropriate regulatory due process is followed for all types of termination payments. The proposed payment must be authorised by the Chief Executive via the use of the “Termination of Contract – Severance Payments Proforma”. This document outlines the details and circumstances of the proposed severance payment. The Director of People and Inclusion must ensure this guidance is maintained in line with current regulatory requirements

All exit packages must be within the contractual limits or less. Where the Director of People and Inclusion and the Remuneration and Appointments Committee proposes payment which exceeds contractual limits, appropriate approval must be sought from NHS England and Improvement and the Treasury in line with regulatory policy.

In line with Freedom to Speak Up requirements the Chief Executive will personally review

all settlement agreements that contain confidentiality clauses to ensure that such clauses are in the public interest

Such settlement agreements will be made available for inspection by the CQC as part of their assessment to determine if the organisation is well-led

If the settlement requires Treasury approval the Trust will demonstrate that the confidentiality clause is in the public interest in that particular case.

10.5 CONTRACT OF EMPLOYMENT

10.5.1 The Board shall delegate responsibility to the Director of People and Inclusion for:

- ensuring that all staff are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation; and
- dealing with variations to contracts of employment; and
- dealing with termination of contracts of employment (except those cases subject to disciplinary rules and procedures) upon the advice of the Director of Finance on affordability.

11. NON-PAY EXPENDITURE

11.1 DELEGATION OF AUTHORITY

11.1.1 The Board will approve the level of non-pay expenditure on an annual basis and the Chief Executive will determine the level of delegation to budget managers.

Budget holders so delegated, and others who the Budget Holders shall formally nominate shall be authorised to approve requisitions, invoices and petty cash, subject to appropriate segregation of duties and subject to the scope and limit(s) of their budget(s).

11.1.2 The Chief Executive shall set out procedures on the seeking of professional advice regarding the supply of goods and services.

11.2 CHOICE, REQUISITIONING, ORDERING, RECEIPT AND PAYMENT FOR GOODS AND SERVICES

11.2.1 Any member of staff authorised to requisition goods or services shall comply with procedures issued by the Director of Finance and, in choosing the item to be supplied or the service to be performed, shall always obtain the best value for money for the Trust. In so doing, the advice of the Procurement department shall be sought. Where this advice is not acceptable to the requisitioner, the Director of Finance and the Chief Executive shall be consulted.

11.2.2 The Director of Finance shall be responsible for the prompt payment of all properly authorised accounts and claims. Payment of contract invoices shall be in accordance with contract terms, or otherwise, in accordance with national guidance. Payment for goods and services shall only be made once the goods and services are received (except for prepayments as below). Such requirements will be specified in a Service Level Agreement with the Shared Services Organisation as appropriate.

11.2.3 Official orders must state the Trust's terms and conditions of trade and be consecutively numbered. They must only be issued to, and used by, those duly authorised by the Chief

Executive and be in a form approved by the Director of Finance.

11.2.4 All goods, services, or works shall be ordered on an official order except works and services executed in accordance with a contract and purchases from petty cash. Verbal orders may only be issued very exceptionally - by a member of staff designated by the Chief Executive and only in cases of emergency or urgent necessity. These must be confirmed by an official order and clearly marked "Confirmation Order". Goods may not be taken on trial or loan in circumstances that could commit the Trust to a future uncompetitive purchase.

11.2.5 The Director of Finance will:

(a) advise the Board of Directors regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in standing orders and regularly reviewed.

(b) prepare procedural instructions where not already provided in the Scheme of Delegation or procedure notes for budget holders on the obtaining of goods, works and services incorporating the thresholds;

(c) be responsible for the prompt payment of all properly authorised accounts and claims;

(d) maintain a list of Directors/staff, authorised to certify invoices.

(e) be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall provide for:

i) Certification that:

- goods have been duly received, examined and are in accordance with specification and the prices are correct;
- work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct;
- in the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, the rates of labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality, and price and the charges for the use of vehicles, plant and machinery have been examined;
- where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained;
- the account is arithmetically correct;
- the account is in order for payment.

ii) A timetable and system for submission to the Director of Finance of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment.

iii) Instructions to staff regarding the handling and payment of accounts within the Finance Department.

iv) Be responsible for ensuring that payment for goods and services is only made once the goods and services are received, (except as in SFI 11.2.6).

11.2.6 Prepayments are only permitted where exceptional circumstances apply. In such instances, where material (in excess of £10,000):

a) the appropriate Executive Director must provide, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the Trust if the supplier is at some time during the course of the prepayment agreement unable to meet their commitments;

b) the Director of Finance will need to be satisfied with the proposed arrangements before contractual arrangements proceed; and

c) the budget holder is responsible for ensuring that all items due under a prepayment contract are received and he must immediately inform the appropriate Executive Director or Chief Executive if problems are encountered, along with their Finance Manager who can ensure the correct accounting treatment is performed.

11.2.7 Managers must ensure that they comply fully with the guidance and limits specified by the Director of Finance and that:

a) all contracts (other than for a simple purchase permitted within the Scheme of Delegation or delegated budget), leases, tenancy agreements and other commitments which may result in a liability are notified to the Director of Finance and the Trust Secretary in advance of any commitment being made;

b) contracts above specified thresholds are advertised and awarded in accordance with EU rules on public procurement;

c) where consultancy advice is being considered, the approval and procurement of such advice must be in accordance with current regulatory guidance for Foundation Trusts. When considering consultancy advice internal approval from the Director of Finance should be sought in line with delegated responsibility limits and always before any business case is sent for external approval from the Regulator. Wherever possible the preferred bidder should assist in the preparation of the required business case to the Regulator. The term consultancy advice is defined as the provision, to management, of objective advice and assistance relating to strategy, structure, management of operations of an organisation in pursuit of its purposes and objectives. Such assistance will be provided outside the "business as usual" (BAU) environment when in-house skills are not available and will be of no essential consequence and time-limited. Services may include the identification of options with recommendations and/or assistance with (but not delivery of) the implementation of solutions. If in any doubt this is to be referred to the Director of Finance or Deputy for clarification.

d) no order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to Directors or staff, other than:

i) isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars;

ii) conventional hospitality, such as lunches in the course of working visits;

iii) the Hospitality and Sponsorship Policy and relevant conflicts of interest policy must be adhered to in all cases.

e) no requisition/purchase order is to be placed for any item or items for which there is no budget provision unless authorised by the Director of Finance on behalf of the Chief Executive;

f) all goods, services, or works should be ordered on an official purchase order including wherever possible works and services executed in accordance with a contract but excluding purchases from petty cash;

g) verbal orders must only be issued very exceptionally - by a member of staff designated by the Chief Executive and only in cases of emergency or urgent necessity. These must be confirmed by an official order and clearly marked "Confirmation Order";

h) orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds or regulatory guidance;

i) goods are not taken on trial or loan in circumstances that could commit the Trust to a future uncompetitive purchase;

j) changes to the list of Directors/staff authorised to certify invoices are notified to the Director of Finance;

k) purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the Director of Finance; and petty cash records are maintained in a form as determined by the Director of Finance.

l) payments to local authorities and voluntary organisations made under the powers of the NHS Act shall comply with procedures laid down by the Director of Finance which shall be in accordance with these Acts.

12. EXTERNAL BORROWING AND INVESTMENTS

12.1 EXTERNAL BORROWING

12.1.1 The Director of Finance is responsible for ensuring that the sum of borrowing from all sources both short term and long term represents value for money, comply with any Regulatory limits and guidance and does not adversely impact on future cash flows.

12.1.2 Any application for a temporary loan or overdraft will only be made by the Director of Finance or by a member of staff so delegated by them and in any event a duly authorised signatory.

12.1.3 The Director of Finance must prepare detailed procedural instructions concerning applications for temporary loans and overdrafts.

12.1.4 All external borrowing must be consistent with the plans outlined in the current Business Plan and be recommended by Finance and Performance Committee to the Trust Board.

12.1.5 The Trust holds a separate Treasury Management Policy which covers both borrowings and investment in more detail.

12.2 INVESTMENTS

12.2.1 Foundation Trusts have discretion to invest surplus money for the purposes of, or in connection with, their functions. The Chief Executive, as accountable officer, is responsible for ensuring that surplus operating cash is invested in accordance with the Board of Directors' duty to safeguard and properly account for the use of public money.

12.2.2 The Director of Finance is responsible for advising the Board on investment strategies for cash surpluses in accordance with best practice guidance and in line with NHS England and Improvement's most current published guidance for Foundation Trusts.

13. CAPITAL EXPENDITURE AND PRIVATE FINANCE

13.1 CAPITAL INVESTMENT

13.1.1 All bids for Capital Investment should be approved by the Board of Directors (with due regard to the Trust's cash position and any associated investment strategies).

13.1.2 The Trust will follow NHS England and Improvement's Capital Regime and where applicable approval will be sought for any investment and property business cases in line with the requirements of the guidance. See NHS Improvement: 'Capital regime, investment and property business case approval guidance for NHS trusts and foundation trusts'.

13.1.3 The Trust will follow NHS England and Improvement capital regime in relation to system sign off and working within CDEL limits set by the Regulator.

13.1.4 The Chief Executive is responsible for ensuring that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans.

13.1.5 The Trust shall appoint the Capital Action Team or other appropriate meeting structure whose responsibilities shall be:

a) the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost and meet their overall purpose; and

b) ensuring that capital investment is not undertaken without commissioner(s)/ partner(s) written support, where required, and the availability of resources to finance all revenue consequences and capital charges; and

c) to ensure that a robust financial appraisal is undertaken as appropriate for all business cases (which have been approved by the Trust's Finance and Performance committee as appropriate); and

d) to ensure that appropriate project management and control arrangements are in place; and

e) that the Director of Finance has certified professionally to the costs and revenue consequences detailed in business cases.

13.1.6 For capital schemes where the contracts stipulate stage payments, the Chief Executive will issue procedures for their management, incorporating the recommendations of "Estatecode". The Director of Finance shall issue procedures for the regular reporting of expenditure and commitment against authorised expenditure.

13.1.7 The approval of a capital programme shall not constitute approval for expenditure on any scheme. The Chief Executive shall issue to the manager responsible for any scheme (through the Capital Action Team):

- specific authority to commit expenditure;
- authority to proceed to tender or obtain quotations;
- approval to accept a successful tender or quotation and to place an order.

The Chief Executive will issue a scheme of delegation for capital investment management in accordance with "Estatecode" guidance and the Trust's Standing Orders.

13.1.8 The Director of Finance shall issue the capital investment framework and procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes.

13.1.9 Delegated limits for the signing-off of expenditure on capital monies are covered in these SFIs.

13.2.1 The section below covers the approval process before orders are placed

Expenditure on an individual project up to £100,000	Approved by the Capital Action Team
Expenditure on an individual project between £100,000 and £1,000,000	Jointly approved by the Director of Finance and one other Executive Director
Proposed expenditure on a project in excess of £1,000,000	Board approval required (and process to be in accordance with NHS England and Improvement guidance)

13.2.2 The extent and progress of the manner in which Capital Investment monies are spent will be regularly reported to the Executive Leadership Team and Finance and Performance Committee. Any variation to the approved capital expenditure plan will require appropriate authorisation, in accordance with the above limits and be appropriately reported to regulators.

14. ASSET REGISTERS AND SECURITY OF ASSETS

14.1 ASSET REGISTERS

14.1.1 The Chief Executive is responsible for ensuring that a system exists for the maintenance of registers of assets, taking account of the advice of the Director of Finance on the form of any register and the means of updating and arranging for a periodic physical check of

assets against the asset register to be conducted.

The Trust shall maintain an asset register recording fixed assets. The composition of information to be held within these registers shall be specified in the Trust's capital accounting policies.

14.1.2 Budget holders must confirm to the Director of Finance any fixed asset additions within their remit. Additions to the asset register will be validated by reference to:

- properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties;
- stores, requisitions and wages records for own materials and labour with overheads; and
- lease agreements in respect of assets held under a finance lease and capitalised.

14.1.3 Budget holders must notify the Director of Finance where they propose that assets are to be sold, scrapped, or otherwise disposed of. Each disposal must be validated by reference to authorisation documents and invoices (where appropriate) and accounted for appropriately. (see disposals and condemnations section)

Budget holders must seek approval from the Trust Board to declare any land or buildings as surplus to NHS requirements and available for disposal and income.

Budget holders and service managers must notify the Financial Controller if assets are being transferred between buildings or otherwise relocated, to allow for the asset register to be updated.

If any assets remain in empty buildings, it is the exiting service manager that is responsible for those assets until the building has been handed over to a new service or to Estates.

No assets that have been identified to hold Commissioner Requested Services in accordance with the NHS England and Improvement Licence Agreement are allowed to be sold without prior consultation and agreement with NHS England and Improvement in line with current guidance and approval from the Board. The trust asset register includes a list of all assets which have been identified as being locations of Commissioner Requested Services

14.1.4 The value of owned buildings shall be indexed to current values and all assets shall be depreciated using methods and rates as specified by the appropriate accounting policies in use in the Trust. Periodically non-current assets will be subject to a formal revaluation exercise as described in the relevant Trust accounting policies. The Director of Finance shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.

14.1.5 The Director of Finance of the Trust shall calculate and pay capital charges as required.

14.2 SECURITY OF ASSETS

14.2.1 The overall control of assets is the responsibility of the Chief Executive.

14.2.2 Asset control procedures (including fixed assets, cash, cheques, and negotiable

instruments, and also including donated assets) must be approved by the Director of Finance. This procedure shall make provision for:

- identification of additions and disposals;
- recording managerial responsibility for each asset;
- physical security of assets;
- periodic verification of the existence of, condition of, and title to, assets recorded;
- identification and reporting of all costs associated with the retention of an asset; and
- reporting, recording and safekeeping of cash, cheques and negotiable instruments.

14.2.3 All discrepancies revealed by verification of physical assets to fixed asset register shall be notified to the Director of Finance.

14.2.4 Whilst each member of staff has a responsibility for the security of property of the Trust, it is the responsibility of Directors and senior staff in all disciplines to apply such appropriate routine security practices in relation to NHS property as may be determined by the Board of Directors. Any breach of agreed security practices must be reported in accordance with instructions.

14.2.5 Any damage to Trust premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by Directors and staff in accordance with both security policies and the losses procedure.

14.2.6 The organisation will take all necessary steps to recover financial losses due to fraud, theft of, or criminal damage to, its assets on a case by case basis in a timely manner. The impact of the recovery of financial losses due to theft or criminal damage of its assets is regularly monitored and soundly evaluated by Executive Leadership Team and, where appropriate, improvements are made to the redress arrangements and the organisations approach to recovery.

14.2.7 IT assets and where practical Plant, Property and Equipment, should be marked as Trust property.

14.2.8 Where appropriate the Trust's assets should be covered by the NHS arrangements for the pooling of insurance**.**

14.2.9 Each member of staff has a responsibility for the security of property of the Trust whilst working remotely or from home, see separate Home Working Policy.

14.3 PARTNERING ARRANGEMENTS, LEASE ACQUISITIONS AND LEASE ASSIGNMENTS

14.3.1 Partnering arrangements involving the occupation of another party's property (NHS or non NHS) or allowing another party to occupy part of the Trust's property, even if no financial consideration is involved, must be covered by formal agreement.

14.3.2 All arrangements where the Trust use or occupy a room, part or all of a building for any length of time must be covered by an appropriate written agreement.

14.3.3 Lease acquisition of properties must be covered by a formal lease arrangement.

14.3.4 The decision to sub-let a Trust property or to take on an assigned lease must be covered by a formal agreement or assignment.

14.3.5 The Trust Secretary must be consulted on the legal position and will advise on the need for lease or license agreement and its content.

14.3.6 The Head of Estates and Facilities is responsible for negotiating the heads of terms and will advise on matters of Health & Safety, rates, utilities, maintenance and insurance obligations.

14.3.7 The Director of Finance must be consulted to advise on the appropriate accounting treatment under IFRS.

14.3.8 The Trust Secretary is responsible for maintaining a full record of all agreements in a Trust-wide property database. This will include termination dates, break clause details, rent review dates, notice periods and financial commitments.

14.2 14.4 LEASE TERMINATIONS

14.4.1 The decision to vacate a Trust property must be covered by formal agreement.

14.4.2 The Trust Secretary must be consulted on the legal position and will advise on the notice to the landlord.

14.4.3 The Head of Estates and Facilities will facilitate the assessment of dilapidations and cancellation notifications e.g. rates, insurances, utilities.

14.4.4 The Director of Finance must be informed to ensure payments are cancelled in line with the agreement.

14.4.5 A full record of the agreement is to be maintained in the Trust wide property database.

14.5 RENT REVIEWS

14.5.1 As part of the responsibility for record management there is a need to ensure that rent reviews are carried out in accordance with the lease agreement, and that agreement is either concluded within 2 months of the review date, or that the Finance department are advised of the liability that the budget holder may face.

15. STORES AND RECEIPT OF GOODS

15.1 Stores, i.e. controlled stores and departmental stores for immediate use should be:

- kept to a minimum;
- subjected to annual stock take;
- valued in accordance with Trust accounting policy.

15.2 Subject to the responsibility of the Director of Finance for the systems of control, overall responsibility for the control of stores shall be delegated to a member of staff by the Chief Executive. The day-to-day responsibility may be delegated by the Chief Executive to departmental staff and stores managers/keepers, subject to such delegation being

entered in a record available to the Director of Finance. The control of Pharmaceutical stocks shall be the responsibility of a designated Pharmaceutical Officer.

15.3 The responsibility for security arrangements and the custody of keys for all stores and locations shall be clearly defined in writing by the designated manager or Pharmaceutical Officer. Wherever practicable, stocks should be marked as health service property.

15.4 The Director of Finance shall set out procedures and systems to regulate the stores including records for receipt of goods, issues, and returns to stores, and losses.

15.5 Stocktaking arrangements shall be agreed with the Director of Finance and there shall be a physical check covering all material items in stock at least once a year.

15.6 Where a complete system of stock control is not justified, alternative arrangements shall require the approval of the Director of Finance.

15.7 The designated Manager/Pharmaceutical Officer shall be responsible for a system approved by the Director of Finance for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The designated Officer shall report to the Director of Finance any evidence of significant overstocking and of any negligence or malpractice (see also 16, Disposals and Condemnations, Losses and Special Payments). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

15.8 For goods supplied by NHS Supply Chain**,** the Chief Executive shall identify those authorised to requisition and accept goods from the store. The authorised person shall check receipt against the delivery note before forwarding this to the Director of Finance who shall satisfy himself that the goods have been received before accepting the recharge.

15.9 The Trust will follow any guidance issued by NHS England and Improvement in relation to any centrally procured goods such as PPE.

16. DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

16.1 DISPOSALS AND CONDEMNATIONS

16.1.1 The Director of Finance must prepare detailed procedures for the disposal of assets including condemnations, and ensure that these are notified to managers. Every effort should be made by managers to maintain assets of property plant and equipment in good order.

16.1.2 When it is decided to dispose of a Trust asset, the head of department or authorised deputy will determine and advise the Director of Finance of the estimated market value of the item, taking account of professional advice where appropriate.

16.1.3 Surplus property, plant and equipment or any other Trust asset, which is in serviceable order, should not be disposed of. Due process must be followed whereby the surplus asset is reallocated within the Trust or temporarily stored appropriately. Requests to otherwise dispose of any serviceable asset must be approved by the head of department and notified to the Director of Finance.

16.1.4 All unserviceable articles shall be condemned or otherwise disposed of by a member of staff authorised for that purpose by the Director of Finance. The Condemning Officer shall record condemnation in a form approved by the Director of Finance, which will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second member of staff authorised for the purpose by the Director of Finance.

16.1.5 The Condemning Officer shall satisfy himself as to whether or not there is evidence of negligence in use and shall report any such evidence to the Director of Finance who will take the appropriate action.

16.2 LOSSES AND SPECIAL PAYMENTS

16.2.1 The Director of Finance must prepare procedural instructions on the recording of and accounting for condemnations, losses, and special payments. The Director of Finance shall maintain a Losses and Special Payments Register in which write-off action is recorded.

16.2.2 Any member of staff discovering or suspecting a loss of any kind must immediately inform their head of department, who must inform the Chief Executive and the Director of Finance at the earliest opportunity. Where a criminal offence is suspected, the Director of Finance must immediately inform the police if theft or arson is involved, but if the case involves suspicion of fraud, then the matter should be reported to the Local Counter Fraud Specialist for a criminal investigation. Consideration of police involvement will be discussed with the Local Counter Fraud Specialist. All security-related incidents must be reported to the Trust's Security Management Specialist

16.2.3 Whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a financial nature, the Trust's Local Counter Fraud Specialist must also be notified at the earliest opportunity.

16.2.4 The Board of Directors shall approve the writing-off of losses. This approval is delegated to the Chief Executive (or Director of Finance / Deputy Director of Finance) in accordance with the Scheme of Delegation. Write-offs will only be reported to Audit and Risk Committee on an exceptional basis by value.

16.2.5 The Director of Finance shall be authorised to take any necessary steps to safeguard the Trust's interests in bankruptcies and company liquidations.

16.2.6 For any loss, the Director of Finance should, in consultation with the Trust Secretary, consider whether an insurance claim can be made.

16.2.7 The Director of Finance shall maintain a Losses and Special Payments Register in which write-off action is recorded.

16.2.8 No special payments exceeding delegated limits shall be made without the prior approval of the relevant body

16.2.9 Losses and special payments will only be reported to the Audit and Risk Committee on an exceptional basis by value or volume if there becomes any issue with a certain area.

17 INFORMATION MANAGEMENT AND TECHNOLOGY

17.1 The Director with responsibility for Information Management and Information Technology, who is responsible for the accuracy and security of the computerised (including financial) data and information of the Trust, shall be responsible for devising and maintaining appropriate Information Management and Technology procedures and policies for the Trust.

17.2 The Director responsible for IM&T shall ensure that financial IM&T systems are developed and maintained in an appropriate manner, even in the event that the maintenance of such a system is outsourced.

17.3 The Director of Finance and the Director responsible for IM&T shall ensure that contracts for computer services for financial applications with another health organisation**,** any other agency or Shared Services Organisation shall clearly define the responsibility of all parties for the information governance, security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

17.4 Where another health organisation**,** any other agency or Shared Service Organisation provides a computer service for financial applications, the Director of Finance shall periodically seek assurances that adequate controls are in operation.

17.5 Where computer systems have an impact on corporate financial systems the Director of Finance shall satisfy themself that:

(a) systems acquisition, development and maintenance are in line with financial requirements

(b) data produced by financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists;

(c) Only appropriate persons shall have access to such data; and

(d) such computer audit reviews as are considered necessary are being carried out.

(e) Adequate business continuity/disaster recovery arrangements are in place

17.6 The Director of Finance shall ensure that financial risks to the Trust arising from the use of IM&T are effectively identified and considered and appropriate action taken to mitigate or control risk.

Freedom of Information

17.7 All Directors shall ensure that processes are in place and are subject to adequate control for the provision of information requests in line with The Freedom of Information (FOI) Act 2000.

18. PATIENTS' PROPERTY

18.1 The Trust has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in Trust property. Employees are required to follow the Trust Policy and Procedure for Service Users' Finance and Property

18.2 The Chief Executive is responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admission by;

a) notices and information booklets,
b) Trust admission documentation and property records,
c) the verbal advice of administrative and/or nursing staff responsible for admissions,

The Trust will not accept responsibility or liability for patients' property brought into Trust premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt.

18.3 The Chief Operating Officer must provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients. Due care should be exercised in the management of a patient's money in order to maximise the benefits to the patient.

18.4 Where Department of Health instructions require the opening of separate accounts for patients' monies, these shall be opened and operated under arrangements agreed by the Director of Finance.

18.5 In all cases where property of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates, Small Payments, Act 1965), the production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained.

18.6 Staff should be informed, on appointment, by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients.

18.7 Where patients' property or income is received for specific purposes and held for safekeeping the property or income shall be used only for that purpose, unless any variation is approved by the donor in writing.

19. CHARITABLE FUNDS

19.1 INTRODUCTION

19.1.1 Charitable funds are those gifts, donations and endowments held on trust for purposes relating to the Derbyshire Healthcare NHS Foundation Trust. They are administered on behalf of the Trust by the Directors of the Derbyshire Community Healthcare Services

NHS Foundation Trust, acting as agents of the charitable fund.

19.1.2 The discharge of the DCHS's corporate trustee responsibilities is distinct from its responsibilities for exchequer funds and may not necessarily be discharged in the same manner, but there must still be adherence to the overriding general principles of financial regularity, prudence and propriety. Trustee responsibilities cover both charitable and non-charitable purposes. The Director of Finance shall ensure that each charitable fund is managed appropriately with regard to its purpose and to its requirements.

19.2 The Director of Finance shall periodically review the charitable funds in existence and shall make recommendations to the trustees regarding the potential for rationalisation of such charitable funds within statutory guidelines.

20. ACCEPTANCE OF GIFTS BY STAFF AND LINK TO STANDARDS OF BUSINESS CONDUCT

20.1 The Trust Secretary shall ensure that all staff are made aware of the Trust policy on acceptance of gifts and other benefits in kind by staff. Staff should be aware of and comply with the Trust's 'Conflict of Interest Policy'.

20.2 Staff should make themselves aware of, and comply with, the Bribery Act 2010, Code of Conduct for NHS Managers 2002, and the Code of Practice for the Pharmaceutical Industry 2012 relating to hospitality / gifts from pharmaceutical / external industry.

21. RETENTION OF DOCUMENTS

21.1 The Chief Executive shall be responsible for maintaining a Policy and Procedure for the Retention, Preservation and Destruction of Records which all employees must follow.

21.2 Any documents held in archives shall be capable of retrieval by authorised persons.

21.3 Documents held under the requirements of current directions shall only be destroyed at the express instigation of the Chief Executive, and records shall be maintained of documents so destroyed in accordance with the Policy and Procedure for the Retention, Preservation and Destruction of Records.

21.4 Associated policies which employees should be familiar with are: the Policy and Procedure for Offsite Records Storage, Policy and Procedure for Disposal of Confidential Information and the Information Lifecycle Management Policy and Procedure.

22. RISK MANAGEMENT AND INSURANCE

22.1 The Chief Executive shall ensure that the Trust has a programme of risk management, which will be approved and monitored by the Board of Directors. Employees must comply with the Trust Risk Management policies and procedures.

22.2 The programme of financial risk management shall include:

a) process for identifying and quantifying risks and potential liabilities

b) engendering among all levels of staff a positive attitude towards the control of risk

c) management processes to ensure all significant financial risks and potential liabilities are addressed, including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk

d) contingency plans to offset the impact of adverse events

e) audit arrangements including internal audit, clinical audit, health and safety review

f) arrangements to review the risk management programme

The existence, integration and evaluation of the above elements will provide a basis to make a statement on the effectiveness of internal control within the annual report and accounts.
The Trust Secretary shall ensure that insurance arrangements exist in accordance with the risk management programme.

Insurance arrangements with commercial insurers

22.3 There is a general prohibition on entering into insurance arrangements with commercial insurers. There are, however, three exceptions when the Trust may enter into insurance arrangements with commercial insurers. The exceptions are;

a) Trusts may enter commercial arrangements for insuring motor vehicles owned or leased by the Trust including insuring third party liability arising from their use.

b) where the Trust is involved with a contractual arrangement to lease a building and the landlord or Private Finance Initiative consortium in respect of the PFI contract require that commercial insurance arrangements are entered into.

c) Where income generation activities take place. Income generation activities should normally be insured against all risks using commercial insurance. If the income generation activity is also an activity normally carried out by the Trust for NHS purpose the activity may be covered in a risk pool. Confirmation of coverage on the risk pool must be obtained from the NHS Litigation Authority. In any case of doubt concerning a Trust's powers to enter into commercial insurance arrangements, the Director of Finance and Trust Secretary should consult the Department of Health.

APPENDIX 1

Tendering Procedure

1. Invitation to tender

(i) All invitations to tender shall state the date and time as being the latest time for the receipt of tenders.

(ii) All invitations to tender shall state that no tender will be accepted unless:

(a) submitted in a plain sealed package or envelope bearing a pre-printed label supplied by the Trust (or the word "tender" followed by the subject to which it relates) and the latest date and time for the receipt of such tender addressed to the Chief Executive or nominated Manager;

(b) that tender envelopes/ packages shall not bear any names or marks indicating the sender. The use of courier/postal services must not identify the sender on the envelope or on any receipt so required by the deliverer.

(c) It is submitted in accordance with the instructions issued via The Trust's electronic contract management system

(iii) Every tender for goods, materials, services or disposals shall embody such of the NHS Standard Contract Conditions as are applicable.

(iv) Every tender for building or engineering works (except for maintenance work, when Estmancode guidance shall be followed) shall embody or be in the terms of the current edition of one of the Joint Contracts Tribunal Standard Forms of Building Contract or Department of the Environment (GC/Wks) Standard forms of contract amended to comply with concode; or, when the content of the work is primarily engineering, the General Conditions of Contract recommended by the Institution of Mechanical and Electrical Engineers and the Association of Consulting Engineers (Form A), or (in the case of civil engineering work) the General Conditions of Contract recommended by the Institute of Civil Engineers, the Association of Consulting Engineers and the Federation of Civil Engineering Contractors. These documents shall be modified and/or amplified to accord with Department of Health guidance and, in minor respects, to cover special features of individual projects.

2. Receipt and safe custody of tenders

The Trust Secretary or their nominated representative will be responsible for the receipt, endorsement and safe custody of tenders received until the time appointed for their opening. In the case of tenders submitted by The Trust's electronic contract management, the tender maybe opened by the Head of Procurement.

The date and time of receipt of each tender shall be endorsed on the tender envelope/package.

3. Opening tenders and Register of tenders

(i) As soon as practicable after the date and time stated as being the latest time for the receipt of tenders, they shall be opened by two Directors usually the Trust Secretary and a Director who is not from the originating department. In the case of tenders submitted by the Trust's electronic contract management, the tender may be opened by the Head of Procurement. These tenders are held in a secure environment compliant with ISO27001 infrastructure and available as a CESG accredited HMG Impact Level 3 service which allows handling of "restricted documents" classification. In this case sub sections (ii), (vi) and (vii) do not apply.

(ii) A member of the Trust Board will be required to be one of the two approved persons present for the opening of tenders estimated above £400,000. The rules relating to the opening of tenders will need to be read in conjunction with any delegated authority set out in the Trust's Scheme of Delegation.

(iii) The 'originating' Department will be taken to mean the Department sponsoring or commissioning the tender.

(iv) The involvement of Finance Directorate staff in the preparation of a tender proposal will not preclude the Director of Finance from serving as one of the directors to open tenders. The involvement of estates staff in the preparation of a tender proposal will not preclude the Director of Estates from serving as one of the directors to open tenders.

(v) All Executive Directors will be authorised to open tenders regardless of whether they are from the originating department provided that the other authorised person opening the tenders with them is not from the originating department.

(vi) Every tender received shall be marked with the date of opening and initialled by those present at the opening.

(vii) A register shall be maintained by the Trust Secretary, or a person authorised by him, to show for each set of competitive tender invitations despatched, including those handled under the electronic contract management system (see 3 (i) above):

- the name of all firms individuals invited;
- the names of firms individuals from which tenders have been received;
- the date the tenders were opened;
- the persons present at the opening;
- the price shown on each tender;
- a note where price alterations have been made on the tender.

Each entry to this register shall be signed by those present.

A note shall be made in the register if any one tender price has had so many alterations that it cannot be readily read or understood.

(viii) Incomplete tenders, i.e. those from which information necessary for the adjudication of the tender is missing, and amended tenders i.e., those amended by the tenderer upon their own initiative either orally or in writing after the due

time for receipt, but prior to the opening of other tenders, should be dealt with in the same way as late tenders.

4. Admissibility

(i) If for any reason the designated officers are of the opinion that the tenders received are not strictly competitive (for example, because their numbers are insufficient or any are amended, incomplete or qualified) no contract shall be awarded without the approval of the Chief Executive.

(ii) Where only one tender is sought and/or received, the Chief Executive and Director of Finance shall, as far practicable, ensure that the price to be paid is fair and reasonable and will ensure value for money for the Trust.

5. Late tenders

(i) Tenders received after the due time and date, but prior to the opening of the other tenders, may be considered only if the Chief Executive or their nominated officer decides that there are exceptional circumstances i.e. despatched in good time but delayed through no fault of the tenderer.

(ii) Only in the most exceptional circumstances will a tender be considered which is received after the opening of the other tenders and only then if the tenders that have been duly opened have not left the custody of the Chief Executive or their nominated officer or if the process of evaluation and adjudication has not started.

(iii) While decisions as to the admissibility of late, incomplete or amended tenders are under consideration, the tender documents shall be kept strictly confidential, recorded, and held in safe custody by the Trust Secretary or their nominated officer.

6. Acceptance of formal tenders

(i) Any discussions with a tenderer which are deemed necessary to clarify technical aspects of their tender before the award of a contract will not disqualify the tender.

(ii) The most economically advantageous tender, if payment is to be made by the Trust, or the highest, if payment is to be received by the Trust, shall be accepted unless there are good and sufficient reasons to the contrary. Such reasons shall be set out in either the contract file, or other appropriate record.

It is accepted that for professional services such as management consultancy, the lowest price does not always represent the best value for money. Other factors affecting the success of a project include:

a) experience and qualifications of team members;
b) understanding of client's needs;
c) feasibility and credibility of proposed approach;
d) ability to complete the project on time.

Where other factors are taken into account in selecting a tenderer, these must

be clearly recorded and documented in the contract file, and the reason(s) for not accepting the lowest tender clearly stated.

(iii) No tender shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these Instructions except with the authorisation of the Chief Executive.

(iv) The use of these procedures must demonstrate that the award of the contract was:

a) not in excess of the going market rate / price current at the time the contract was awarded;

b) that best value for money was achieved.

(v) All tenders should be treated as confidential and should be retained for inspection.

7. Tender reports to the Trust Board

Reports to the Trust Board will be made on an exceptional circumstance basis only.

8. List of approved firms

a) Responsibility for maintaining list

A manager nominated by the Chief Executive shall on behalf of the Trust maintain lists of approved firms from whom tenders and quotations may be invited. These shall be kept under frequent review. The lists shall include all firms who have applied for permission to tender and as to whose technical and financial competence the Trust is satisfied. All suppliers must be made aware of the Trust's terms and conditions of contract.

b) Building and Engineering Construction Works

(i) Invitations to tender shall be made only to firms included on the approved list of tenderers compiled in accordance with this Instruction or on the separate maintenance lists compiled in accordance with "Estmancode" guidance (Health Notice HN(78)147).

(ii) Firms included on the approved list of tenderers shall ensure that when engaging, training, promoting or dismissing staff or in any conditions of employment, shall not discriminate against any person because of colour, race, ethnic or national origins, religion or sex, and will comply with the provisions of the Equal Pay Act 1970, the Sex Discrimination Act 1975, the Race Relations Act 1976, the Disabled Persons (Employment) Act 1944 and Equality Act 2010 and any amending and/or related legislation.

(iii) Firms shall conform at least with the requirements of the Health and Safety at Work Act and any amending and/or other related legislation concerned with the health, safety and welfare of workers and other persons, and to any relevant

British Standard Code of Practice issued by the British Standard Institution. Firms must provide to the appropriate manager a copy of its safety policy and evidence of the safety of plant and equipment, when requested.

c) Financial Standing and Technical Competence of Contractors

The Director of Finance may make or institute any enquiries he deems appropriate concerning the financial standing and financial suitability of approved contractors. The Director with lead responsibility for clinical governance will similarly make such enquiries as is felt appropriate to be satisfied as to their technical / medical competence.

9. Exceptions to using approved contractors

If in the opinion of the Chief Executive and the Director of Finance or the Director with lead responsibility for clinical governance it is impractical to use a potential contractor from the list of approved firms/individuals (for example where specialist services or skills are required and there are insufficient suitable potential contractors on the list), or where a list for whatever reason has not been prepared, the Chief Executive should ensure that appropriate checks are carried out as to the technical and financial capability of those firms that are invited to tender or quote.

An appropriate record in the contract file should be made of the reasons for inviting a tender or quote other than from an approved list.

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 2 November 2021

Safeguarding Children and Adults Annual Report 2020/21

Purpose of Report

The annual production of this report is a governance requirement of both the Trust and the Safeguarding Children and Adults Boards. It provides assurance that the Trust is meeting its legal and statutory performance and governance requirements in a consistent and reliable manner.

Executive Summary

- The Trust has had a successful year and continues to fully discharge its statutory safeguarding duties.
- The Trust officers have discharged the duties as set in legislation and requirements outlined by the Health Regulator, the Care Quality Commission (CQC). The annual report includes how the Trust has been independently scrutinised and assessed. The positive findings have been included in the report and provide significant independent assurance from Clinical Commissioning Group specialists in children's and adult named and designated staff.
- The report describes the challenges faced in the year of the COVID-19 pandemic and the mitigation plans for the unprecedented times for all services.
- The report monitors trends in activity and analyses the themes from this activity and use the referral information and helpline activity to adapt training, plan clinical audits or develop policy and procedure from learning reviews.
- Safeguarding Unit including Multi Agency Safeguarding Hub (MASH) health activity over the year 2020-21 and the learning from this activity to incorporate this into Trust developments.
- The report provides quantitative, qualitative and narrative evidence of the scope and extent of work undertaken within the year and how the Safeguarding Unit assures itself that it is meeting its duties.
- The year ended with COVID-19 Contingency and Business Continuity Plans that have continued into the current year and will be reported on in future Children and Adults Reports.
- Audit activity and audit and inspection visit results are included in the report. A programme of audit has been included in the report to provide evidence on the internal governance process and how the Unit provides quality improvement of practice.
- This report provided significant assurance to the Quality and Safeguarding Committee on the Trust's systems, governance, learning and improvement of standards of practice. The Committee considered that report demonstrates a robust system of scrutiny and a commitment to sound practice.

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

Risks and Assurances

- The team seeks to actively mitigate and manage risk. Where necessary risks are escalated to the Committee as part of the reporting process from the Safeguarding Children and Safeguarding Adults Operational Groups.
- The Quality and Safeguarding Committee obtained assurance on 14 September that the Safeguarding Unit, including MASH Health, Section 11 Audit and the SAFF, is meeting its legal and statutory duties and obligations.

Consultation

The team has consulted internally and with partners throughout the year as appropriate to specific areas of activity, for example, policy development, public protection developments, refining processed within the MASH.

Governance or Legal Issues

The Trust meets statutory obligations and legal duties with regard to: Mental Health Act [1983]; Mental Capacity Act [2005]; The Care Act [2014]; Children and Families Act [2014]; Human Rights Act [1998] Domestic Violence, Crime and Victims Act [2004] and our internal systems, structures and processes are joined up and effective.

Statutory guidance issued under Section 29 Of The Counter-Terrorism And Security Act 2015
Section 26 of the Counter-Terrorism and Security Act 2015 (the Act) places a duty on certain bodies ("specified authorities" listed in Schedule 6 to the Act), in the exercise of their functions, to have "due regard to the need to prevent people from being drawn into terrorism". This guidance is issued under section 29 of the Act. The Act states that the authorities subject to the provisions must have regard to this guidance when carrying out the duty.

Health Specified Authorities
80 - The Health specified Authorities in Schedule 6 to the Act are as follows:

NHS Trusts
NHS Foundation Trusts

- NHS England has incorporated 'Prevent' into its safeguarding arrangements, so that Prevent awareness and other relevant training is delivered to all staff who provide services to NHS patients. These arrangements have been

effective and should continue.

- The Chief Nursing Officer in NHS England has responsibility for all safeguarding and a Safeguarding Lead, working to the Director of Nursing, is responsible for the overview and management of embedding the Prevent programme into safeguarding procedures across the NHS. This is replicated in our Trust.

Section 325 to 327B of the Criminal Justice Act 2003 (CJA) established multi-agency public protection arrangements (MAPPA) in each of the 42 criminal justice areas of England and Wales. These arrangements are designed to protect the public, including victims of crime, from serious harm by sexual or violent and other dangerous offenders. MAPPA are the statutory arrangements for managing sexual and violent offenders. MAPPA is not a statutory body in itself but is a mechanism through which agencies can better discharge their statutory responsibilities and protect the public in a co-ordinated manner.

The Trust meets the required standards for our regulators and our professional regulatory bodies Codes of Practice i.e. Safe, Caring, Effective, Responsive, Well-led and Safeguarding are one of the gold threads that runs throughout. We apply national guidelines and evidence based best practice e.g. NICE, DoH, National Statistics.

The Trust contributes as an equal partner in Multi-Agency forums e.g. MAPPA; MARAC; Channel; Child and Adult Safeguarding Boards and sub-groups and takes part in peer assessment, benchmarking and self-assessment and assurance.

The Trust invests in staff across multiple agencies and services to ensure high levels of competence and confidence and achieve consistently good practice that is constantly updated and refreshed within a culture of learning from both successful and adverse situations.

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 re-assignment, race, religion or belief, sex, sexual orientation, marriage and civil partnership, and pregnancy and maternity (REGARDS people (Race, Economic disadvantage, Gender, Age, Religion or belief, Disability and Sexual orientation), including risks, and say how these risks are to be managed.

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

The field of safeguarding adults at risk of abuse is underpinned by the following six key principles:

- **Empowerment** - of the individual to make decisions.
- **Protection** - support and representation for those in need.
- **Prevention** - of abuse / neglect as well as helping the person to reduce the risks of harm and abuse that are unacceptable to them.
- **Proportionality -** responses should be least restrictive to the person's rights.
- **Partnerships -** working collaboratively to prevent, identify and respond to harm.
- **Accountability** - and transparency in delivering safeguarding. Safeguarding is intended to support those most vulnerable to being at risk of abuse, many

of whom have protected characteristics relating to age, gender, disability, religion and sexual orientation. The intention of safeguarding governance and due diligence is to recognise the vulnerability to abuse of people engaging with Trust services and apply the principles to all aspects of safeguarding practice.

The Trust cannot mitigate all of the population health outcomes for children and adults in our community. However, it can influence the wider system and put in place preventative or detective measures to reduce preventable harms.

The Trust cannot stop abuse, but it can assess, engage, offer early detection and intervene to reduce the impact of abuse and monitor the harms associated with being at risk of harm.

Recommendations

The Board of Directors is requested to:

1) Receive and approve the Safeguarding Children and Adults Annual Report.
2) Receive the report which is offered by the Executive Lead with significant assurance from the report regarding the fulfilment of legal and statutory duties.

Report presented by: **Carolyn Green**
Director of Nursing and Patient Experience and Executive Lead of the Quality and Safeguarding Committee

Report prepared by: **Members of the Safeguarding Unit including MASH Health and the Operational Team members**

Safeguarding Children and Adults at Risk

Annual Report

2020/21

INTRODUCTION

The year began with significant intensity as the COVID-19 pandemic took hold and, in common with our multi-agency partners, DHCFT Safeguarding Unit implemented its Business Continuity Plan and this has continued to be applied throughout the reporting year.

The Team, including MASH Health Advisors moved rapidly to working from home or working to a more blended model in line with Trust policy and COVID secure settings. Information Technology support needs were identified and met promptly enabling staff members to work comfortably and effectively from home. The Trust adopted Microsoft Teams as the chosen medium for the majority of meetings and Safeguarding Strategy meetings for children and adults moved over so rapidly that we are able to give assurance that this adaptation to practice occurred smoothly and with no known adverse impacts such as non- attendance at strategy meetings.

Individual COVID-19 risk assessments were conducted with all staff and their agreed working patterns agreed accordingly to meet service needs and keep everyone safe. A schedule of essential meetings was agreed within the Trust and across the safeguarding children and adult partnership. Supervisions and essential meetings have continued to take place, staff support has been paramount and the Safeguarding unit would like to report that the Trust Incident Management Team have provided excellent leadership throughout to guide and support the effective management of the unit.

The safeguarding of all our patients, both adults and children remains a high priority for DHCFT. Safeguarding and ‘Think Family’ is the ‘Golden Thread’ throughout the care standards and practice reviews and analysis provided. The purpose of this report is to provide a review and analysis of the year’s safeguarding activity and an update of safeguarding developments across the Trust and the progress against the Trust Safeguarding Strategy.

This report sets out the work of DHCFT in relation to safeguarding and the necessary frameworks in place to continue to learn, develop and refine the service. The Trust continues to work in partnership with statutory and voluntary partners across Derbyshire and bordering localities to discharge its responsibilities in relation to safeguarding children and adults at risk - We have had a busy 12 months characterised by high levels of activity, increased complexity of calls for advice and referrals and many areas of development, which we use to inform our learning and to form our organisational development and growth.

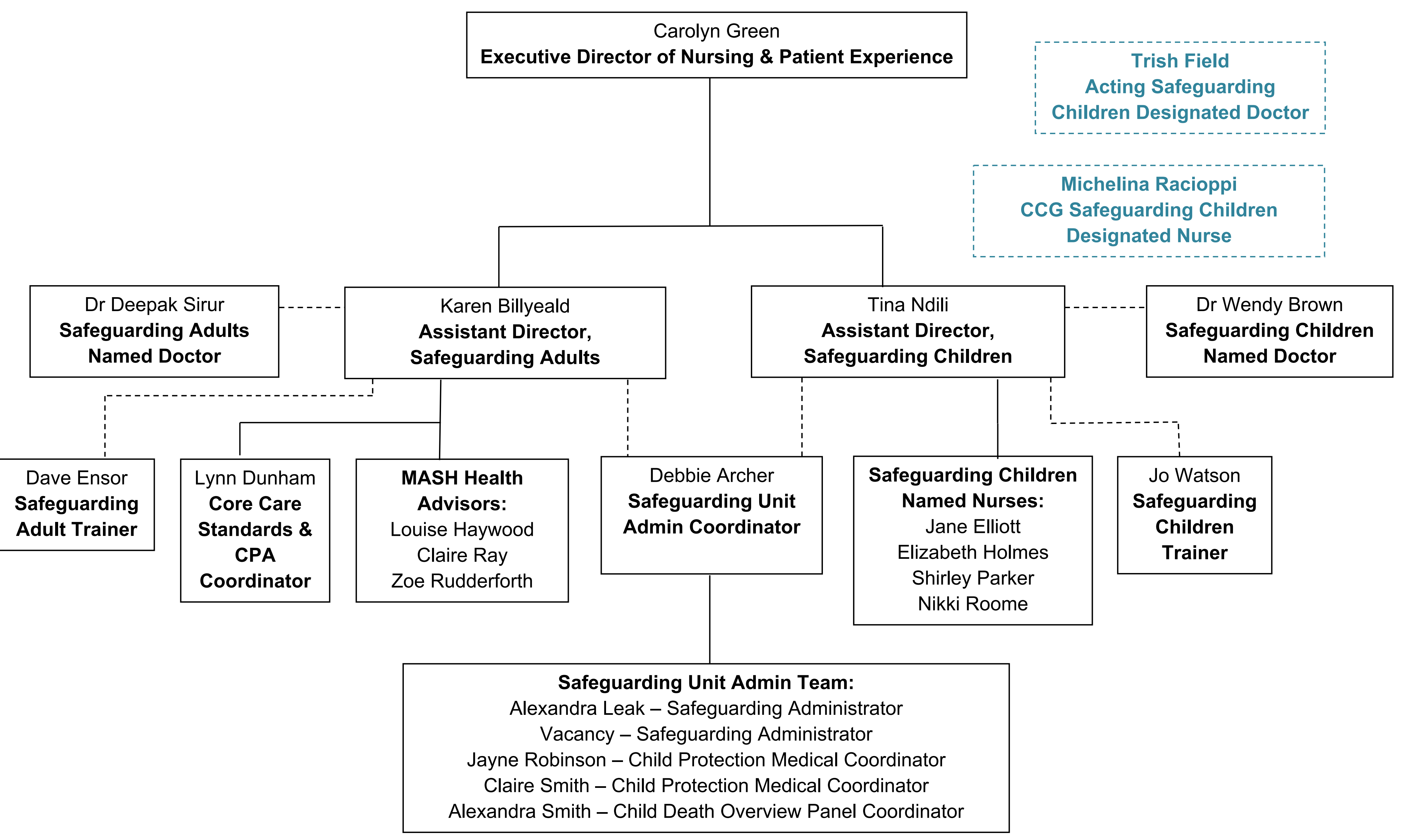
SAFEGUARDING UNIT REPORTING STRUCTURE

During the year the Trust reviewed its internal governance structure and aligned Committees across the Organisation. Safeguarding Children and Adults Operational Groups report on a quarterly basis to the Quality and Safeguarding Committee which reports directly to the Trust Board.

DHCFT is committed to partnership working to discharge its statutory duties with Derby City AND Derbyshire Safeguarding Children and Adult Boards. There is Trust representation and attendance at all sub-group and multi-agency meetings. Effective safeguarding relies on strong partnerships within the Trust and with other agencies and the Safeguarding Boards in a culture of consistent, respectful cooperation.

The Safeguarding Unit prepare a monthly report that is issued to all Clinical Operational Assurance Team (COAT) meetings for the Trust which includes Specialist, Children's, Neighbourhood, Forensic and Campus Divisions. The leads provide organisational scrutiny, guidance and learning and includes points for action for the Division's representatives as well as points for information. Both Safeguarding Operational Groups can escalate matters that require executive or committee consideration / inclusion in the Trust Risk Register but, equally, can escalate good news stories, lessons learned to share across the organisation.

SAFEGUARDING UNIT STRUCTURE

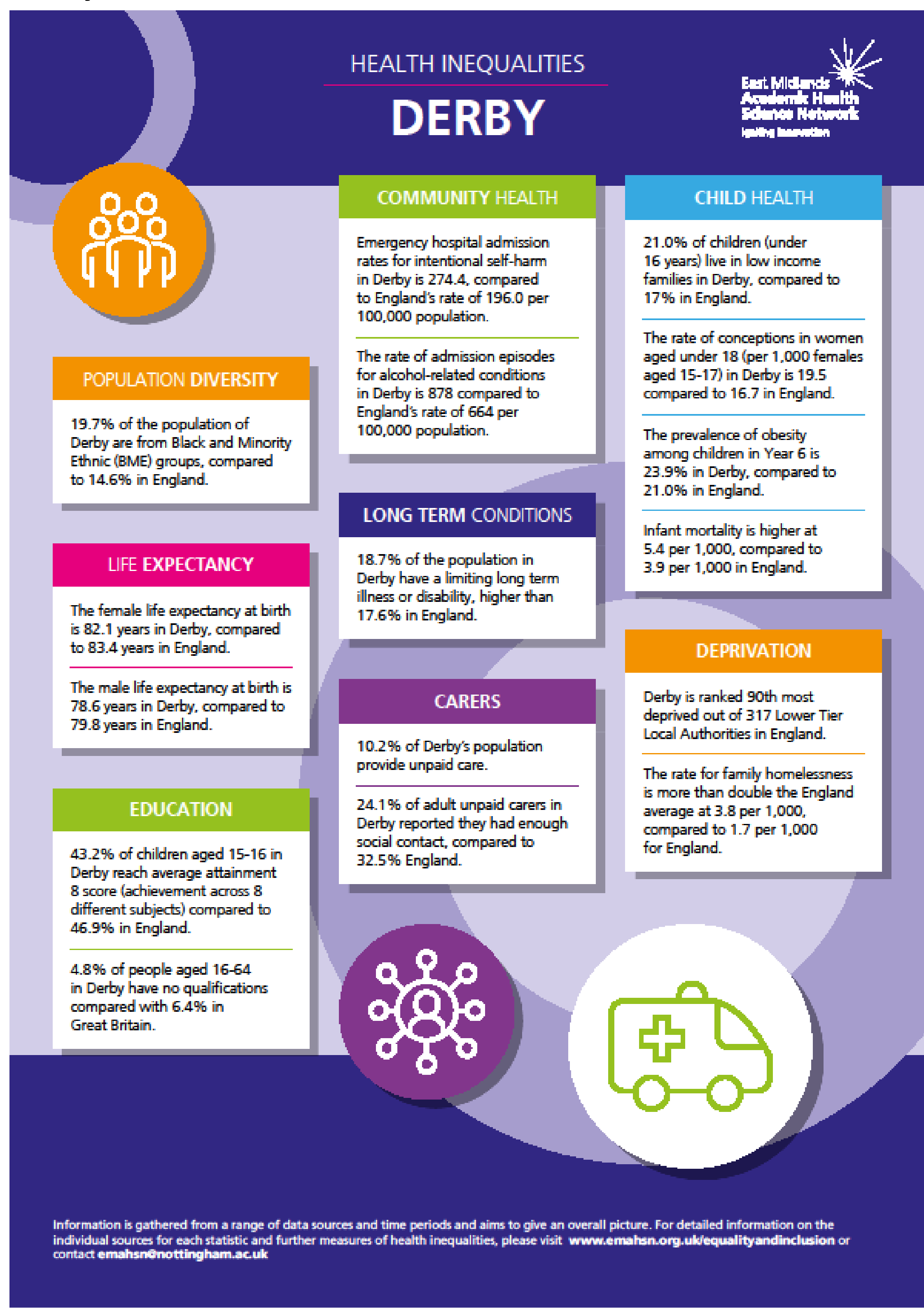


The period covered by this report saw the following changes to the Safeguarding Unit structure and responsibilities:

- September 2020 - Appointment of Safeguarding Adult Trainer, Dave Ensor
- December 2020 – Appointment of Child Death Overview Panel Coordinator, Alexandra Smith
- December 2020 – Appointment of Child Protection Medical Coordinator, Claire Smith
- January 2021 – Appointment of Safeguarding Administrator, Alexandra Leak

Derby/Derbyshire health inequalities summary:

Derby:



Derbyshire:

HEALTH INEQUALITIES

DERBYSHIRE

POPULATION DIVERSITY

2.5% of the population of Derbyshire are from Black and Minority Ethnic (BME) groups, compared to 14.6% in England.

LIFE EXPECTANCY

The female life expectancy at birth is 83.0 years in Derbyshire, compared to 83.4 years in England.

The male life expectancy at birth is 79.6 years in Derbyshire, compared to 79.8 years in England.

EDUCATION

46.3% of children aged 15-16 in Derbyshire reach average attainment 8 score (achievement across 8 different subjects) compared with 46.9% in England.

38.8% of the population in Derbyshire have higher qualifications (NVQ level 4 and above), compared with 42.8% in England.

COMMUNITY HEALTH

64.2% of adults are classified as overweight or obese in Derbyshire, compared to 62.3% in England.

The rate of admission episodes for alcohol-related conditions in Derbyshire is 775 compared to England's rate of 664 per 100,000 population.

Chesterfield has the highest rate of admission episodes for alcohol-related conditions in the East Midlands at 1,015 per 100,000 population.

LONG TERM CONDITIONS

20.4% of the population in Derbyshire have a limiting long term illness or disability, higher than 17.6% in England.

CARERS

12.1% of the population in Derbyshire provide unpaid care, compared with 10.2% in England.

67% of unpaid carers in Derbyshire are female.

29.4% of adult unpaid carers in Derbyshire reported they had enough social contact, compared to 32.5% England.

CHILD HEALTH

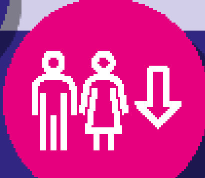
15.3% of children (under 16 years) live in low income families in Derbyshire, compared to 17% in England. Bolsover and Chesterfield have a higher percentage (19%).

42.7% of 5-16 year olds are physically active, compared to 46.8% in England.

Hospital admissions for substance misuse amongst those aged 15-24 are 110 per 100,000, higher than England's average of 83.1 per 100,000.

DEPRIVATION

Derbyshire is ranked the 103rd most deprived out of 151 Upper Tier Local Authorities in England. Chesterfield and Bolsover Districts are more deprived than other parts of Derbyshire.



Information is gathered from a range of data sources and time periods and aims to give an overall picture. For detailed information on the individual sources for each statistic and further measures of health inequalities, please visit **www.emahsn.org.uk/equalityandinclusion** or contact **emahsn@nottingham.ac.uk**

SAFEGUARDING CHILDREN'S PERFORMANCE DASHBOARD

	Metric	Quarter 1 2020/21	Quarter 2 2020/21	Quarter 3 2020/21	Quarter 4 2020/21
1	Number of advice calls received and reported	264	248	297	278
2	Number of supervision/group sessions	129	124	119	120
3	Number of attendance at MDMs/team meetings/ward rounds	28	57	29	46
4	Number of MASH sessions covered by the safeguarding children's team	0	0	0	0
5	Number of strategy discussions/meetings	108	147	118	140
6	Number of safeguarding meetings attended by the safeguarding team	9	2	1	7
7	Number of safeguarding children's training/workshops delivered	1	2	0	0
8	Number of child protection medical - suspected NAI	21	23	22	27
9	Number of CHANNEL referrals	0	8	12	10
10	Number of MARAC cases with children discussed at MARAC	203	181	208	240
11	Number of referrals to CSC	27	11	10	16
12	CIC Caseload - Born In Lives In	200	206	208	206
	CIC Caseload - Born In Lives Out	400	421	427	435
	CIC Caseload - Born Out Lives In	2	5	5	2
	Total CIC Caseload	602	632	640	643
13	Number of Child Deaths	1	7	3	4
14	Number of children referred for risk of FGM	0	1	0	1
15	Number of children on a child in need plan	698	724	675	412
16	Distinct count of children affected by DV during the Quarter	1063	1055	746	799
17	Number of children in an adult bed	0	0	1	0

	Metric	Quarter 1 2020/21	Quarter 2 2020/21	Quarter 3 2020/21	Quarter 4 2020/21
18	Number of young carers	6	6	7	6
19	Number of children on a child protection plan	512	522	576	594

Analysis of the main features within the safeguarding children dashboard:

- Supervision figures show compliance remains stable.
- Increase in S47s and strategy meetings which contributes to the pressure on the resources of the Safeguarding Children Nursing Team.
- MARAC cases and children impacted by Domestic Abuse continue to be at a consistently high level.
- Channel Referrals show a significant increase in Q2, this was partly attributable to a specific piece of work. These patterns are indicative of continued improved knowledge of this agenda and the collaboration and joint working with clinical teams on vulnerability assessments and subsequent action plans.

SAFEGUARDING ADULTS PERFORMANCE DASHBOARD – 2020/21

The safeguarding adults dashboard has become established over the past year and, whilst, ambitious in some of the data it seeks to capture that may not currently be achievable, it reflects the expected performance requirements of commissioners and some aspirational targets for data in the future.

METRIC		DEFINITION OF METRIC	TARGET GROUP	TARGET	QTR1	QTR2	QTR3	QTR4	NOTES
1	**Adult Safeguarding Level 1 Training (3 yearly)**	Adult Protection training allows staff to be able to identify early any safeguarding risks and to know what actions to take	Q1: 598 Q2: 624 Q3: 638 Q4: 667	85%	90.74%	89.76%	89.65%	89.40%	Target group = **Average** staff number required to complete training over the 3 month period
2	**Safeguarding Adults Level 1 + 2 (3 yearly)**	Adult Protection training allows staff to be able to identify early any safeguarding risks and to know what actions to take	Q1: 1770 Q2: 1824 Q3: 1881 Q4: 1954	85%	81.35%	78.25%	79.52%	78.56%	Target group = **Average** staff number required to complete training over the 3 month period
3	**Safeguarding Level 3 (3 yearly)**	Enquirers training in order to be compliant with Care Act and Derbyshire Adult Safeguarding Policy and Procedures	Q1: 137 Q2: 124 Q3: 119 Q4: 128	85%	69.76%	68.20%	67.19%	73.49%	Target group = **Average** staff number required to complete training over the 3 month period
4	**Number of urgent DoLS authorised -** Urgent DoLS are authorised by the Trust on the day we request an assessment (as we are the managing authority)	Accurate recording of number of DoLS applications ensures compliance and appropriate application of legislation	N/A	N/A	0	4	3	3	

	METRIC	DEFINITION OF METRIC	TARGET GROUP	TARGET	QTR1	QTR2	QTR3	QTR4	NOTES
5	**Number of standard DoLS applied for to the LA**	Accurate recording of number of DoLS applications ensures compliance and appropriate application of legislation	N/A	N/A	0	4	3	3	
6	**Number of people with an authorised DoLS granted by Supervisory body as at end of quarter**	Accurate records and monitoring of numbers ensures good governance and compliance with legislation	N/A	N/A	0	0	4	0	
7	**Number of referrals to coroner for people who have passed away and have an authorised DoLS granted by Supervisory body as at end of quarter**	Accurate records and monitoring of numbers ensures good governance and compliance with legislation	N/A	N/A	0	0	4	0	
8	**DoLS training for frontline / clinical staff**	DoLS awareness ensures compliance with legislation in relation to people who lack capacity to make decisions at appropriate time	Q1: 952 Q2: 954 Q3: 1092 Q4: 1038	85%	88.58%	88.23%	85.52%	81.28%	Target group = **Average** staff number required to complete training over the 3 month period
9	**Compliance with CQC requirements, Regulation 13, (Safeguarding people who use services from abuse)**	All providers are required to reach compliance with CQC Essential Standards of Quality and Safety in all Areas of the Service	N/A	0	0	0	0	0	
10	**The provider will complete SSASPB Safeguarding Adults Self-Assessment and share actions with the CCGs**	To support Health Services to meet Safeguarding Adult responsibilities and to demonstrate improved outcomes in preventing harm	N/A	N/A	N/A	N/A	N/A	N/A	Filed separately
11	**Number of adult safeguarding referrals made where allegation is within their own service**	Numbers of referrals from health staff to Social Care. Some providers beginning to collect this. Reliable source data is LA. However this is not currently broken down into health providers	N/A	N/A	N/A	N/A	N/A	N/A	Currently neither local authority separates health data by provider

	METRIC	DEFINITION OF METRIC	TARGET GROUP	TARGET	QTR1	QTR2	QTR3	QTR4	NOTES
12	**Number of adult safeguarding referrals made by staff where allegation relates to other care providers**	Numbers of referral from health staff to Social Care. Some providers beginning to collect this. Reliable source data is LA. However this is not currently broken down into health providers	N/A	N/A	N/A	N/A	N/A	N/A	Currently neither local authority separates health data by provider
13	**Numbers of staff referred to their professional body due to safeguarding concerns**	Total number staff referred due to concerns about their ability to practice safely	N/A	N/A	0	2	1	0	
14	**Triangle of Care – Training compliance / numbers trained in quarter**	Compliance with the Carer's Trust accreditation scheme	N/A	N/A	N/A	N/A	N/A	N/A	Not on training passports
15	**Triangle of Care - % of teams with completed self-assessments**		N/A	N/A	N/A	N/A	N/A	N/A	Not on training passports
16	**Positive and Safe – Training compliance for PACE & SCIP and Positive and Safe**		Q1: 453 Q2: 424 Q3:435 Q4: 459	85%	57.84%	42.33%	31.66%	41.77%	Target group = **Average** staff number required to complete training over the 3 month period
17	**Provider has a fully resourced and authorised PREVENT Lead**	Provider identify name of lead	N/A	N/A	KB	KB	KB	KB	Karen Billyeald is lead
18	**Number of staff who have received induction / basic awareness in Prevent (Level 1, 3 yearly)**	All staff should have a basic awareness of Prevent	Q1: 608 Q2: 624 Q3: 638 Q4: 669	85%	91.32%	89.33%	89.76%	85.99%	Target group = **Average** staff number required to complete training over the 3 month period

	METRIC	DEFINITION OF METRIC	TARGET GROUP	TARGET	QTR1	QTR2	QTR3	QTR4	NOTES
19	**Prevent Wrap Training to be delivered to all front-line staff (Level 3, 3 yearly)**	Number of identified staff group who require WRAP training from an accredited WRAP facilitator	Q1: 1744 Q2: 1768 Q3: 1810 Q4: 1972	85%	85.12%	81.56%	79.10%	77.57%	Target group = **Average** staff number required to complete training over the 3 month period
20	**EPRR Silver Command Training – compliance in quarter**	EPPR requirements for compliance with national core standards	N/A	N/A	N/A	N/A	N/A	N/A	
21	**EPRR Gold Command Training – compliance in quarter**	EPPR requirements for compliance with national core standards	N/A	N/A	N/A	N/A	N/A	N/A	
22	**Full attendance at MARAC meetings (fortnightly)**	Fulfilling our Public Protection responsibilities alongside partner agencies	N/A	100%	See notes	See notes	See notes	See notes	Under review
23	**Full attendance at MAPPA 3 meetings (monthly)**	Fulfilling our Public Protection responsibilities alongside partner agencies	N/A	100%	100%	100%	100%	100%	
24	**Full attendance at DSAB, City and County**	Fulfilling our responsibilities as full and equal members	N/A	100%	See notes	See notes	See notes	See notes	City: 100% County: N/K
25	**The number of Adult Safeguarding information sharing requests for Health received**	Evidence to be gathered to ascertain demand for and effectiveness of this partnership initiative to present to Commissioners	N/A	N/A	777	938	968	917	
26	Monitor the number and type of requests for information coming through to the Derby City MASH Health team from Children Social Care	Record of number of request for information for children and young people	N/A	N/A	67	99	86	120	
27	Time to conduct research (mins)	Record of the time taken to gather information / analysis	N/A	N/A					Not recorded

METRIC		DEFINITION OF METRIC	TARGET GROUP	TARGET	QTR1	QTR2	QTR3	QTR4	NOTES
28	Monitor the number of strategy discussions for safeguarding children	Record of the number of strategy discussions pertaining to children and young people	N/A	N/A	66	97	85	118	
29	How many children, young people, parents/ carers were discussed	Record of the number of children, young people and parents discussed	N/A	N/A	281	506	437	607	
30	Time in strategy meetings (mins)	Record of time in strategy meetings	N/A	N/A					Not recorded
31	Number of professionals liaised with	Record of the number of professionals liaised with for the strategy discussions / meetings	N/A	N/A	12	36	29	31	
32	Number of complex strategy meetings that involve both children and adults	Requested for 2018/19 onwards	N/A	N/A					Not recorded
33	Time to conduct research (mins)	Record of the time taken to gather information / analysis	N/A	N/A					Not recorded
34	Monitor the number of strategy discussions for adults at risk	Record of the number of strategy discussions pertaining to adults at risk	N/A	N/A	12	44	28	50	
35	How many adults were discussed	Record of the number of adults at risk discussed	N/A	N/A	49	106	53	98	
36	Time in strategy discussion/ meetings (mins)	Record of time in strategy discussion /meetings	N/A	N/A					Not recorded
37	Number of professionals liaised with	Record of the number of professionals liaised with for the strategy discussions / meetings	N/A	N/A	272	309	386	399	
38	Number of domestic violence standard cases discussed at triage	Record of the number of *standard* domestic violence discussed	N/A	N/A	Not complete during COVID-19	Not comple te during COVID-19	Not complete during COVID-19	Not complete during COVID-19	

	METRIC	DEFINITION OF METRIC	TARGET GROUP	TARGET	QTR1	QTR2	QTR3	QTR4	NOTES
39	Number of domestic violence medium cases discussed at triage	Record of the number of *medium* domestic violence discussed	N/A	N/A	384	407	307	300	
40	Number of hours spent in domestic violence triage meetings	Record of time spent in domestic violence triage meetings	N/A	N/A					Not recorded
41	Time taken to conduct research for domestic violence cases (mins)	Record of the time taken to gather information / analysis for domestic violence cases	N/A	N/A					Not recorded
42	Training, shadowing, supervision (hours)	Number of hours for training, shadowing and supervision	N/A	N/A	61.5	52.5	48	32	
43	Tasks received from DHCFT safeguarding service	Number of hours for processing tasks from DHCFT	N/A	N/A					Not recorded
44	Number of times when the Safeguarding Health advisor / Named Nurse was not available within the MASH Service (hours)	Number of hours that the MASH service did not have face to face presence in the MASH Service	N/A	0	0	0	0	0	
45	**Number of DBS risk assessments carried out**	Target group includes all new starters/routine checks each month Data to include all DBS checks for new staff and (separately recorded) all DBS checks for existing staff. Exceptions reporting required if any non-standard checks are made	Q1: 73 Q2: 61 Q3: 60 Q4: 55	100%	68	60	58	55	Q1:4 retire and return in progress, 1 exempt due to COVID19 Q2:1 Retire and return in progress Q3:1 Retire and Return in Progress 1 Waiver in Place
46	**Stories, feedback, early indicators of potential abuse, trends, application of best practice, good news stories**		N/A	N/A	See notes	See notes	See notes	See notes	KB to generate these from logs

Over time this data will have further analysis and will be continually developed so benchmarking with other Organisation can be explored to further consider trends and patterns to enable the Trust to plan and predict levels of care needed.

Analysis

The performance dashboard continues to provide data that offers a level of assurance to the Trust regarding safeguarding activity, trends and areas of challenge.

We successfully recruited to the Safeguarding Adults Trainer post and, between COVID-19 lockdowns, significant effort has been invested in addressing compliance challenges.

MASH Health Advisors continue to consistently meet Key Performance Indicators as part of Trust contracted activity.

The performance and narrative evidence provided in this annual report demonstrates that we have continued to meet our statutory and public protection duties throughout the pandemic and also reflects the key strategic priorities of the Derby and Derbyshire Safeguarding Adult Boards, Prevention: Making Safeguarding Personal and Quality Assurance.

DHCFT SAFEGUARDING ADULTS – TRAINING POSITION

This provides an update to the safeguarding adults training provision, compliance and action plan in the Trust as 31 March 2021.

Compliance report for Safeguarding Adults as of 31 March 2021:

Training Name	Target Group	Compliant	Non Compliant	Compliant %
Safeguarding - Adults Level 1 (3 Yearly)	665	598	67	89.92%
Safeguarding - Adults Level 1+2 (3 yearly)	1918	1510	408	78.73%
Safeguarding - PREVENTing Radicalisation - Level 1 (3 yearly)	667	565	102	84.71%
Safeguarding - PREVENTing Radicalisation/WRAP Level 3 (3 yearly)	1937	1503	434	77.59%
Safeguarding - Adults Level 3 (3 Yearly)	127	100	27	78.74%

This year has seen the on-going delivery of face to face sessions for all levels of safeguarding training. E-Learning is currently available for Levels 1 and 2 learners for Safeguarding Adults, MCA and DoLs.

A new Safeguarding Adults Trainer started in September 2020, and Level 3 training was resumed on 2 November. The course is 383 Safeguarding Adults Level 3 (Including Levels 1 and 2), plus Mental Capacity Act (MCA), Deprivation of Liberty Safeguards (DoLS), and Prevent/WRAP (three yearly). Due to the pandemic, the Trust Board cancelled all Safeguarding training (without consultation) in January and recommenced on 22 February 2021. There were ten full day classes delivered to 181 attendees in total.

It was also identified that a large target group of staff with specialist/senior roles being out of compliance with their training requirements. A number of half day classes designed specifically around Safeguarding Adults only, were proactively (and enthusiastically) advertised via 'bcc' emails to a large number of staff. Access requirements was that Prevent was undertaken via e-Learning. However take up was rather disappointing, resulting in 3 classes delivered to a total of 11 staff. Therefore a total of 192 attendees in the report period have accessed Safeguarding Adults Level 3 training at a minimum.

Staff who require training continue to be targeted each month by email reminders and guidance. There are some staff out of compliance for either Levels 1, 2 or 3 Safeguarding Adults. The length of expiry will be reviewed by the Executive team by exception to rectify this gap.

Action plan for 2021 – 2022:

To proactively target any staff that are out of date by over one year. They will be sent recorded 'read' emails and politely asked about any learning or training challenges they face, and whether they have any solutions that we can collaboratively implement to support them in achieving their mandatory compliance.

Mandatory training is linked to yearly appraisals, and, ability to access external training and potential promotion. Mandatory training is part of role and duties and constitutes Continuous Professional Development.
Operational leadership and diligence to this standard will be revisited.

DHCFT SAFEGUARDING CHILDREN TRAINING POSITION

Compliance data for Safeguarding Children Training as of 31/03/2021

Training Name	Target Group	Compliant	Non Compliant	Compliant %
C Safeguarding Children Level 1 Annual	601	407	194	67.72%
C Safeguarding Children Level 1 once only	1985	1929	56	97.18%
R Safeguarding - Children Level 2 three yearly	495	428	67	86.46%
R Safeguarding - Children Level 2 once only	1459	1417	42	97.12%
R Safeguarding - Children Level 3 three yearly	1111	778	333	70.03%
R Safeguarding - Children Level 3 Annual	346	272	74	78.61%
R Safeguarding - Children Level 4 Annual	8	8	0	100.00%

This last year has seen a change in the training programme due to the COVID-19 pandemic, with all face to face training being cancelled since 23 March 2020. Level 1 and 2 training has been via E-Learning since this date and continues to be delivered in this way.

Level 3 training was suspended from 23 March to 21 July 2020 and again from 11 January to 21 February 2021 due to redeployment of the trainer and Incident Management Team (IMT) decisions regarding the COVID-19 pandemic to ensure a safe service.

Level 3 training outside of these dates has been delivered via Microsoft Teams.

The Executive Leadership Team (ELT) have provided evidence of this decision to the Trust Board and Quality and Safeguarding Committee and the impact of this the suspended training and additional training dates are being made available for staff to access. This risk-based decision was made transparently and was proportionate to the level of risk in the organisation. The impact on training compliance is noted but has not been material.

There are some bespoke training dates being planned for staff groups at increased risk of not being able to access training.

Managers have been communicated with to update on training changes and to support staff in accessing their training. It is still noted that not all spaces are being booked by staff whose training competencies have expired. These staff are being targeted with emails asking them to arrange training and support with facilitating this is being offered where necessary and as part of good governance to ensure compliance monitoring.

Training packages have been developed to complement the new style of training, and this will involve ongoing evaluation and adjustments as deemed necessary. The evaluations and feedback have been on the whole very positive to this delivery style.

SECTION 11 AUDIT

Section 11 of the Children Act 2004 places duties on a range of organisations, agencies and individuals to ensure their functions, and any services that they contract out to others, are discharged having regard to the need to safeguard and promote the welfare of children. The CCG discharges its duties through the Section 11 audit.

The DHCFT Safeguarding Children Team submitted their Section 11 self-assessment on 19 March 2021. The information and evidence were provided from Trust staff at a period of high pressure due to COVID-19 pandemic. I would like to that all who took part in the self-assessment process. A quality visit led by NHS Derby and Derbyshire Clinical Commissioning Group (DDCCG) and Derby and Derbyshire Safeguarding Children Partnership (DDSCP) will be arranged to look at the audit and evidence provided to assure themselves that the Trust are meeting all the fully discharging their Statutory functions.

Looked After Children (LAC) Markers of Good Practice (MOGP)

The Markers of Good Practice is a self-assessment tool for Children in Care within Derby City. The Markers of Good Practice tool, which is 'RAG' rated, provides the Children in Care Team with a productive opportunity to showcase their service to the Clinical Commissioning Group and Designated Professionals. With the submission of evidence and 'RAG' rating, the tool supports the Children in Care team highlight progress, any gaps or improvements that are required to assure the commissioners our service is working towards a 'gold standard' delivery and that the needs of the Children in Care are being met and identified in line with the statutory guidance.

For 2020/21 it was agreed by DDCCG that the Children in Care Team submit the action plan developed in 2020 with updated evidence over the year 2020/21 rather than the full Markers of Good Practice Assurance Tool due to the COVID-19 Pandemic. Following the MOGP submission, representatives from the Clinical Commissioning Group and Designated Professionals completed the feedback in written format due to the COVID-19 pandemic. Strengths and challenges were identified, agreed by both parties and a further action plan will be developed for the provider to work through within the year 2021/22 to achieve compliance in the areas that were not yet rated as green.

DDCCG agreed on all the RAG rating areas that were identified by the provider to be green. Some areas that the provider had identified to be amber were changed by DDCCG to be RAG rated green, whilst the other areas were agreed by the provider and DDCCG to be RAG rated as amber as shown below:

Number of MOGP Standard	Number of assurances required	Number of actions required	Number of RAG rated Green agreed by DHCFT and DDCCG	Changes Number of RAG rated changed from Amber to Green by DDCCG	Number of RAG rated Amber agreed by DHCFT and DDCCG
8	16	27	10	4	13

All feedback from DDCCG will be fed back to the Safeguarding Children's Committee by the Head of Safeguarding Children's Service and at the Safeguarding Operational Leads meeting held by the organisation by the Named Nurse Children in Care. The action plan developed for 2021/22 will continually be discussed at the Safeguarding Operational Leads Meeting and with the Designated Nurse for Looked after Children.

For 2020/21 the Clinical Commissioning Group have been assured that the Children in Care service provision is overall at a good standard and the Health provider is working in partnership in all areas that have been identified as requiring further progression or improvement.

SAFEGUARDING ADULTS ASSURANCE FRAMEWORK (SAAF)

Following a very successful assessment visit in 2018 we received a follow-up review of our Action Plan on 30 September 2019. Our Action Plan was approved we were congratulated on the strategic and operational work of the Safeguarding Unit in safeguarding children, adults and families.

Safeguarding Children Assessment and Analysis Framework (SAAF) follow up visit feedback

The Safeguarding Adults Team had a virtual visit by the CCG Safeguarding Adult Leads on 16 February 2021.

Areas discussed included the impact of COVID-19, changes to practice, operational and referral themes and trends. The leads concluded that The Trust continues to work effectively to protect patients from abusive behaviour and practice. Both the Assistant Director and the Named Doctor are skilled and respected members of the inter-agency community and effectively support the work of the Safety Alert Bulletins (SABs). They have worked hard to ensure that the Trust has met its statutory responsibilities during testing times.

AREAS OF CONCERN/CHALLENGE OR PREVIOUS CHALLENGE AND SUCCESS

Challenges of reduction in children and vulnerable adults not being seen and the Safeguarding Teams scrutiny.

‘Stay Home’ that’s the Government message: Not ALL will be Safe

Due to the ‘Stay Home’, ‘protect the NHS’, ‘Save Lives’ Campaign, The safeguarding team early on anticipated that there would be a potential increase in Domestic Abuse, Child Sexual Exploitation, Emotional Abuse, Physical Abuse and Neglect, specifically with respect to children, young people and vulnerable adults. The team were concerned - What would be going on behind closed doors due to people having to have long periods of isolation due to the COVID-19 (Coronavirus) restrictions currently in place, children spending more time unsupervised on-line.

The risks and potential danger of under reporting/referrals as children and young people are not in education/nurseries and in the eye of professionals who normally identify abuse and neglect.

The Safeguarding team recognised that that COVID-19 would have a serious impact on the lives of women, children and men who are experiencing domestic abuse with likely increases in cases. Family stressors would increase because off financial worries due to loss of jobs, school and business closure and working from home will add to familial pressures.

Feelings of self-isolation and loneliness may lead to an increase in self-harm and suicide within all age groups and the increase in self and actual neglect.

Physical health issues for children, young people and adults from lack of activity, exercise and fresh air and a delay in routine health care.

The Safeguarding Team recognised that society/professionals needed to be more vigilant, to see, hear and report concerns, be curious in all situations, ask for advice and support from statutory agencies were necessary.

This was our message to the employees of the Trust, both in their personal and professional lives. The Safeguarding Team highlighted these risks at every opportunity and presented a few safeguarding bulletins with this message. The bulletins were circulated as part of the daily bulletins that the risk management team and communications teams issued.

As a Trust ‘Safeguarding being everybody’s business’ remained business as usual, even though meeting arrangements, systems and processes were slightly different.

Support for COVID-19 vaccination hub and training

The Trust had the responsibility to ensure delivery of COVID vaccine to staff and patients – through partner organisations and Hospital hub application. The Named Nurses for Safeguarding Children and the MASH Team were given the opportunity to be redeployed into the hub one day per week to support the Trusts vaccination hub. The Team rose to this challenge in various roles and responsibilities and those unable to be part of the programme supported their colleagues in alternative ways and this was remunerated to mitigate the impact on the service.

The Safeguarding Named Nurses were commended for their contribution.

COVID-19 Contingency Plans

At the end of February the national pandemic of COVID-19 emerged and was constantly changing. We as a Trust continue to access national advice. All departments were instructed to draw up service contingency plans for the prolonged period ahead of extraordinary and unprecedented times. The Safeguarding Unit had its plans in place very quickly which has been updated as need arose. Core functions and activity continued virtually with staff working at home and meetings, supervision and the advice

line continuing with a combination of phone calls and virtual meetings via Microsoft teams.

Safeguarding Department's Prioritised Activities:

- Membership of safeguarding partnership meetings.
- Specialist advice to the Trust.
- Full MASH activity
- Section 47 Strategy Discussions:
- Adult Strategy Discussions
- Safeguarding Children Advice Duty Rota
- On Call Consultant Community Paediatrician 24/7 Rota
- Child Protection Medicals – NAI
- Domestic Violence Triage
- Safeguarding Adult Advice
- MAPPA/MARAC/PREVENT/CHANNEL
- Court advice/Court support for Care Proceedings
- Safeguarding Children Supervision

The Safeguarding Children Partnership also required evidence of children services which were submitted to give Partnership assurance.

Safeguarding training was temporarily postponed, and competency extensions were given for up to four months, then a period of recovery was commenced to enable the return to required standards.

Safeguarding Challenges for Children's Services

The main challenge for the team over the last year was not being able to see the children face to face like they are used to, especially in the early lockdown. Many children with complex needs were not in school, some families did not want home visits as they were really worried about the COVID-19 risk in the community. We do not know if there were safeguarding cases that we might have picked up had we seen the children more and heard their voices more. Attend Anywhere was used but that was more challenging with children who used alternatives means of communication to speech.

The Safeguarding Unit continue to undertake compliance checks and are regularly checking data on records. There is some further work and diligence in record keeping to be undertaken as some teams have noticed the status of the child is not always up to date. This means we do not always know if the child is still on a plan or not. This compliance check is always feedback to the team to ensure standards are adhered to.

Sharing of child health record, in one of the Children's Teams the Neuro-Developmental Team did not always get invited to strategy meetings / conference or receive minutes.

This learning has been feedback and the Committee can be assured the Safeguarding Unit act upon their findings to improve these issues with partner agencies.

Children's Specialist Services

Services across the Divisional have experienced high demand and a very challenging year. The pandemic response had provided both times of great challenge but also of some opportunity, leading us to evaluate how we deliver care. The impact of reduction of some of our services in the pandemic period, some partner services and in particular schools cannot be underestimated in terms of the impact on families lives, which will adapt how we work for some time. The impact of national policy decisions will have outcomes on Children in their Educational achievement and in the psychological well-being of Children and Young people.

All services are now seeing an increase in activity, with rising referrals and delayed presentations now a feature across CAMHS, Universal and Specialist Therapy services. Recovery plans have been made and have commenced. We retain a number of high level operational and clinical risks which include staffing – related to sickness, vacancy and a difficulty in recruiting against key roles (Medical, Nursing, Health Visiting and School Nursing). Although these gaps in roles are substantially below the national and regional level, any level of vacancy is experienced as an additional burden to our committed colleagues who work in our services. We have developed contingency plans and regularly review the risks. We also work collaboratively with partner organisations to see what system mitigation we can generate.

During the challenge of the COVID response, we redeployed some staff to support some other Trust services but were relatively quick to recall back into the service at the end of wave 1 (August 2021) to lessen the impact of this. The services always retained critical functions across all services. Some specific colleagues in the Children's Division 0-19 teams supported the COVID vaccination effort in the winter of 2020/21, and all have been back in role since April 2021 for this time limited intervention for less than 10% of the workforce.

We have developed a number of initiatives in the backdrop of the pandemic response – attracting investment into Child and Adolescent Mental Health Services (CAMHS) Eating Disorders (in line with the NHS Long Term Plan), a specialist service for families in the city seeking asylum, and a specialist system role to work with complex cases who present to acute services, CAMHS or social care. These are all significant positive outcomes for our community.

CAMHS Waiting Lists

Over the past twelve months there has been continued change across the system as a whole, cuts and changes to access thresholds across the local authority (Multi Agency Team (MAT) and social care), education academies and spot purchasing commissioning. There is a need for whole system thinking to reduce the impact on CAMHS, 0-19 services, Occupational Therapy (OT), Special Educational Needs

(SEND) etc. There is a potential risk that health is filling the gaps of disinvestment and creating additional work in the health sector and this could lead to a detraction from key priorities and health needs of children and young people.

We have seen an increase in waiting times in CAMHS across both Derbyshire providers DHCFT and Chesterfield Royal Hospital (CRH). With regard to actions to mitigate this and reduce waiting lists we have been actively recruiting and sought central support to promote working for CAMHS via social media and trust website. We have also been successful in gaining CCG funding for 6.6 additional posts at band 5 and band 6 and have recruited a waiting list coordinator to support the management of the waiting lists to increase rapid access. Derbyshire Healthcare's waiting list and access is one of the few CAMHS organisations to be managing the capacity and demand. Compared to previous performance the CAMHS service is operating and a deteriorated level of performance. Overall it has significant improvement against national standards and benchmarking. We have developed a CAMHS specific induction programme, Continuing Professional Development (CPD) sessions, and supervision to support staff retention and the rapid equipping of our staff with the requisite knowledge. A Clinical review panel has been developed, and has proven effective around safe discharge and complex cases and in the support it provides for staff in CAMHS and other agencies when they are involved in the discussions. All of these actions are against the backdrop of a national shortage of trained staff.

Childhood obesity

In 2018 the Trust Safeguarding Children Team were made aware of a young person who was significantly overweight and there was no formal pathway to appropriate services to support them and their family.

There were also concerns that the family were neglecting the young person's health needs by not providing an adequate diet or healthy lifestyle.

Concerns were raised regarding the availability of treatment services for overweight and obese children to the Clinical Commissioning Groups and the Director of Public Health and attempted to escalate to Children's Social Care, but at the time obesity was not recognised as a child protection concern.

Derby and Derbyshire Safeguarding Children Partnership (DDSCP) then conducted a serious incident learning review of a child death attributed to obesity for a sperate incident.

Following the Learning Review, they identified two key actions:

1. To develop clear pathways of care for overweight and obese children
2. To develop a whole system approach to the prevention and early intervention of childhood obesity.

Health implications

Being overweight or obese can lead to chronic and severe medical conditions including type 2 diabetes, fatty liver disease, heart disease, stroke, certain cancers and psychological and psychiatric morbidities and have substantial long term economic, wellbeing and social costs.

Data

Obesity in children is defined as a BMI at or above the 95th percentile for children and teens of the same age and gender (CDC, 2018). Nationally, 22.6% of children are overweight or obese when they start school and 34.3% of children are overweight or obese by Year 6.

By the same measurement, children in Derby are above the national average at both Reception (24.7%) and Year 6 (37.2%). (PHOF, 2019).

Making a difference

A multi-agency strategic group was formed, and the beginning of a strategy was developed.

Due to the COVID-19 Pandemic this has been significantly delayed. The Childhood Obesity: Time for Action in Derby and Derbyshire Ten Year Plan: 2020 - 2030 was completed and signed off March 2021.

This provides an overarching vision for a reduction in prevalence of childhood overweight and obesity over a ten-year period.

The strategy is evidence based and driven by local need to focus on child health outcomes. It applies a whole systems approach to outline preventative and treatment interventions which are recommended across the region and applicable throughout childhood.

Summary

Obese children are ill more often, experience more day-to-day health issues (e.g. breathlessness, discomfort, fatigue), have greater school absence, healthcare attendances and hospital admissions.

Being overweight or obese in childhood has both short-term and longer-term consequences for health, with greatly increased risks of disability, chronic ill-health and premature death. Moreover, once severe, obesity is very difficult to treat effectively.

If we can identify early on where neglect is a factor, implement preventative and treatment interventions we will give these children a better life chance. Our Safeguarding unit and services will continue to focus on outcomes for Children and learning.

INNOVATIONS AND GOOD PRACTICE

Amalgamation of Children and Adults Safeguarding Teams

A closer alignment and amalgamation of our Safeguarding Service Teams has been designed and continue to work collaboratively and creatively where safeguarding concerns are across families with complex needs. There have been some very complex cases where the cross working of the sub sections of our teams has achieved better outcomes. The Named Nurse for Safeguarding Children job description has been updated to incorporate the new responsibilities and training requirements and is now in the process of consultation and implementation.

Domestic Abuse and Older People Task and Finish Group

In November 2020 a multi-agency task and finish group was established in response to a cluster of admissions of older men to a local inpatient mental health services where their declining mental health, due to dementia, had contributed to an escalation of behavioural changes and a raised level of violence within their most intimate relationships.

The phenomenon of domestic abuse in the intimate relationships of older people has been in evidence for many years and, whilst there is a general lack of research-based evidence by comparison with other fields of safeguarding interest and activity. However it is by no means less severe in impact.

The evidence that does exist supports generational-based characteristics, a “just get on with it” attitude and genuine fears that loved ones will be taken into care all contribute to the reluctance of older partners who are carers to disclose abuse within their relationships.

The task and finish group focused its initial endeavours in the following priority areas:

- Sharing useful resources
- Exploring the patterns and incidence
- Produce a piece of Professional Guidance for partner and the Trust workforce to go on the Safeguarding Adult Board websites
- Develop a communications plan for raising awareness in multi-agency, cross-care sector services.

The group originally planned to develop a bespoke risk screening tool similar to the CAADA-DASH [Domestic Abuse, Stalking, Harassment and Honour-Based Abuse], however, this is a nationally recognised and validated tool widely used in safeguarding work. therefore on reflection, it was acknowledged that the tool can be used with older people and that referrals to Derby and Derbyshire Multi Agency Risk Assessment Conference (MARAC) can be made based on Professional Judgement if thresholds are not met by using the scoring system in the tool.

It was also recognised by the group that awareness of elder abuse in intimate relationships is not consistently factored-in to risk assessment processes in care pathways. Staff members in care services do not always give a name to what they observe or hear in the context of the relationships of the older people they support. Learning and Development programmes offered by Derbyshire County Council and partners have now been enhanced to increase awareness of safeguarding, domestic abuse and older people.

The group focussed efforts on redefining the pathway into MARAC and discussions have taken place to enhance the MARAC response to referrals of domestic abuse in older people.

Individual group members carried out their own research to contribute to a bank of resources, research articles, useful hints and tips and professional guidance.

The group concluded its work in June 2021 with a piece of professional guidance to be included, as a resource, on the Safeguarding Adults Board websites.

Safeguarding Team Training on Level 4 Supervision Training:

Due to the Trust implementing a cascade model of Safeguarding Children Supervision supervisors were changing intermittently this highlighted the need to ensure all supervisors were trained to the highest standard and updated accordingly.

The Assistant Director for Safeguarding Children commissioned specialist training to key members of the Trust who had a supervisory responsibility. Details of the training:

Name: Safeguarding Supervision Skills: A Two Day Workshop.
Facilitated by: Richard Swann, Independent Consultant and Trainer.

Introduction:
"Evidence from a range of sources has identified that although practitioners are good at gathering information about children and families, they find it challenging analysing complex information in order to make judgments about whether a child is suffering, or is likely to suffer, significant harm." (DoE, 2011).

This two day course focused on the link between effective supervision and improved outcomes for vulnerable children. This course was focused to identify the core qualities of effective supervisors helping staff in making critical judgments when safeguarding children and young people.

Learning objectives were:

- Describe the elements of effective child protection supervision and how it can contribute to good outcomes for children.
- Use supervision to enable supervisees to critically appraise their own child protection practice.
- Understand the link between impact of the work and effective child protection practice.
- Positively manage the impact of protecting children, enabling emotions to be used to enrich thinking and support safe practice,
- Promote the effective analysis of information throughout the assessment and planning process.

Key aims were:

- Explore and understand key issues in contemporary safeguarding practice and their implications for the health and wider safeguarding systems in Derbyshire
- Identify priority development areas for the wider health and safeguarding system and the contribution which can be made by Safeguarding staff.
- Identify practical actions to take forward a response to these issues, individually, in teams and across the system.
- Explore how to take forward issues in a way which promotes compassionate and resilient practice, management and leadership.

The training received excellent evaluations and has continued to be commissioned by the Trust as required.

Resilience Training

The COVID-19 Pandemic brought challenges like never before, staff anxiety and resilience became a key feature. Staff sickness and complex demand were prevalent. Practitioners were at risk of burn out, ill health and unintentionally missing opportunities to see early warning signs and take action.

The Safeguarding Team has commissioned resilience training from an external source which received excellent evaluation, therefore was recommended to other teams and front-line staff. This was taken up by various teams especially within the Children's Division and was received extremely well by all. The training was delivered via Microsoft Teams.

Contents included:

- Towards another normal
- Resilience: Taking stock and moving forward
- Supporting staff, the organisation and wider system.
- Connecting to services we support and the wider system.
- Key impacts on our resilience.
- Coping with Compassion for ourselves and others, impact, intentions and intelligent action.
- Resilience The buffet table approach.

Six courses of Resilience:

- Self-compassion and self-expression
- Growth and grit mindsets
- Having choice and taking control
- Emotional intelligence and resilience
- Safety and belonging
- Physical, mental and emotional wellbeing

Contemporary developments and challenges for safeguarding in the wider health community

The training received excellent evaluations. Key aims were:

- Explore and understand key issues in contemporary safeguarding practice and their implications for the health and wider safeguarding systems in Derbyshire
- Identify priority development areas for the wider health and safeguarding system and the contribution which can be made by Safeguarding staff.
- Identify practical actions to take forward a response to these issues, individually, in teams and across the system.
- Explore how to take forward issues in a way which promotes compassionate and resilient practice, management and leadership.

SAFEGUARDING CHILDREN ADVICE THEMES

We continue to analyse the calls for advice into the Unit. Domestic Violence, Parenting Skills and Neglect continue to be the top five themes. We have seen an increase in Emotional Abuse and Child's Mental Health which has now put them into the themed analysis which has changed the profile compared to last year's, removing Physical Injury/Abuse and Sexual Abuse/Exploitation.

Top Five Advice Themes:

	2020/21	2019/20
1	Domestic Violence	Physical Injury/Abuse
2	Parenting Skills/Capacity/Basic Care	Neglect
3	Neglect	Domestic Violence
4	Emotional Abuse	Sexual Abuse/Exploitation
5	Child's Mental Health	Parenting Skills/Capacity/Basic Care

SAFEGUARDING ADULTS ADVICE THEMES

The Safeguarding Team at Derbyshire Healthcare Foundation Trust receive requests for advice regarding safeguarding concerns, referrals and ongoing cases. Requests are received in several different ways and from various sources. All of the adult related requests are logged and remain open to the Safeguarding Advisor/s until resolved. The Assistant Director for Safeguarding Adults leads this work.

From 1 April 2020 to 31 March 2021, **218** requests were logged, which is a 33% increase on the previous year; data analysis has been completed on them and is presented in this report.

This does not include workstreams that have been developed in response to particular phenomena, e.g. the majority of specific requests for agency information from the PREVENT Counter-Terrorism Team.

The overall number of advice requests has significantly increased, from 145 in 2019/20 to 218 in 2020/21. The advice requests are generally regarding cases that are of a much greater intensity than in previous years, and the majority of cases include multiple victims and perpetrators and types of concern. All requests for advice were responded to by the Assistant Director for Safeguarding Adults.

How are requests received?

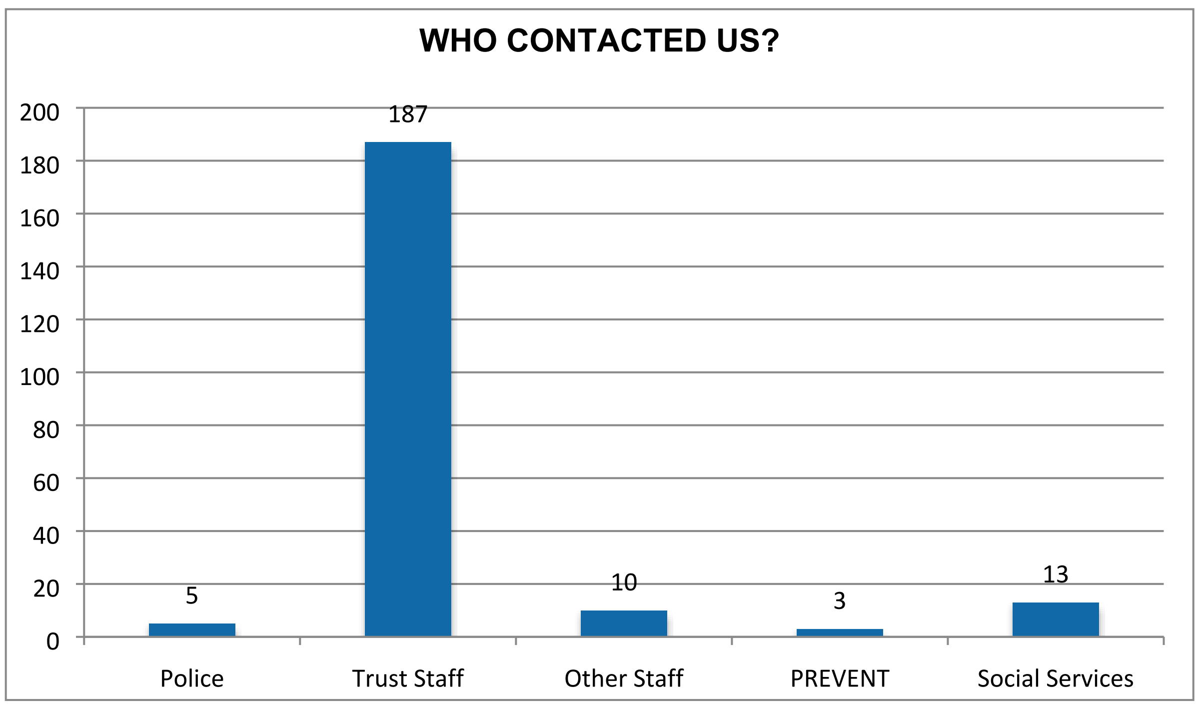
The method of contact for requests is usually via Trust staff. Third parties may approach staff who then log the request, or staff themselves often request advice for patients, service users, carers and family members that they are working with and have concerns for.

The majority of cases that the MASH Team receive are not included in this log as that would be a duplication of the number of concerns raised. However, there are a small number of advice requests that the MASH Team have requested advice on from the Assistant Director of Safeguarding Adults, these are included in the total number of requests for advice by 'Trust Staff'.

Requests are also received from sources external to the Trust such as other NHS Trusts, independent providers or St John's Ambulance. Previously, requests from Social Services were included in the 'Other Staff' category but this year they have been separated as there is a significant increase in contacts by Social Services seeking advice.

There has been an increase in the number of requests for advice from the Police, from one in 2019/20 to five in the last year. This is a testament to ever-improving partnership working in raising concerns and the strengthening relationship between the Trust and the Police in addressing the concerns.

In previous years there have been concerns raised by the CCG and the CQC, but in 2020/21 there were none logged from these sources.



What are the requests about?

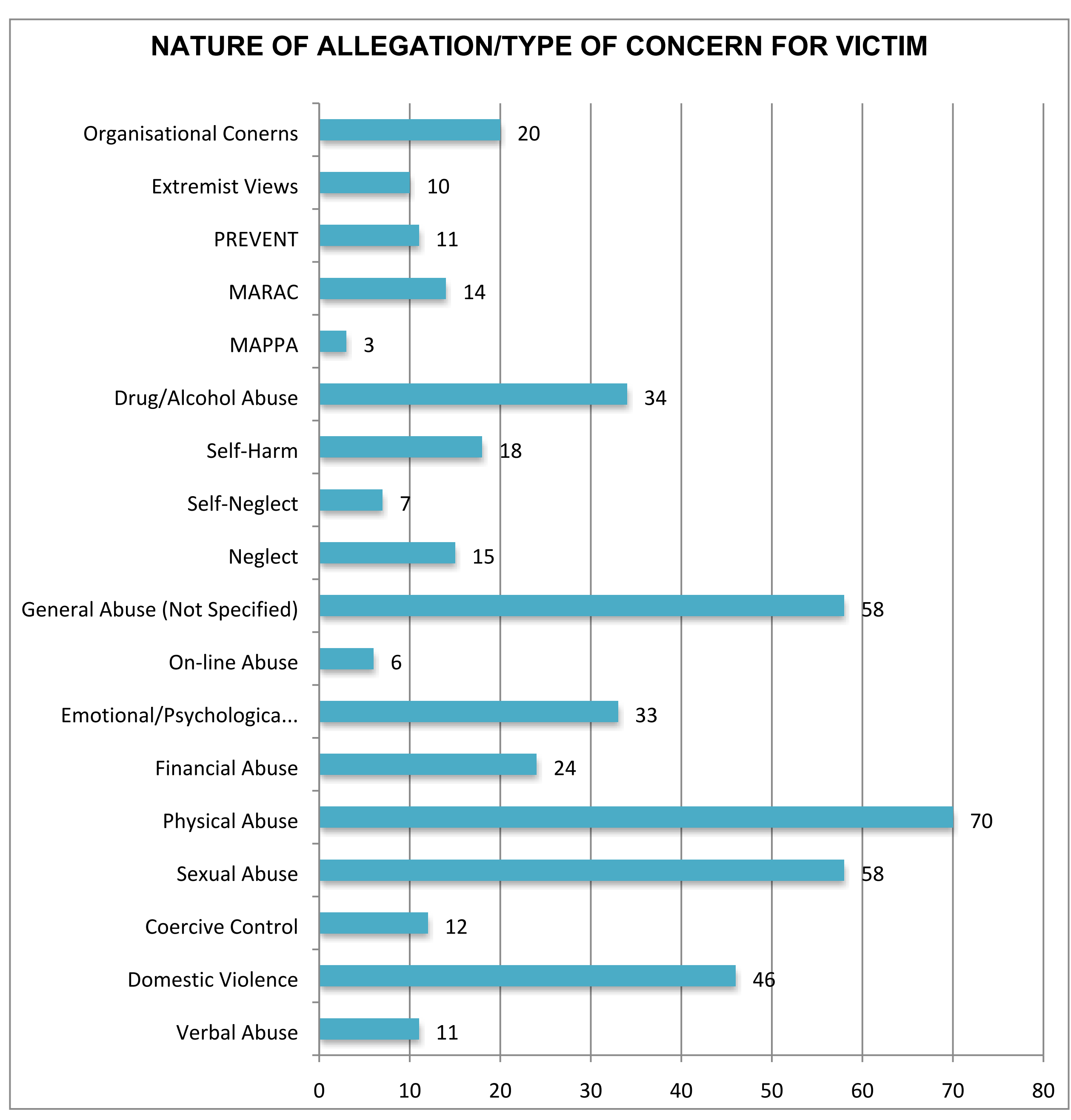
Advice is sought on all aspects of safeguarding. There may be more than one reason for concern in each request. For example, one request for advice might be made for one client, but that client might be experiencing domestic violence, sexual abuse and financial abuse, so all three of these issues would be logged – One request, three types

of concern. So, the total number in the chart below exceeds the total number of cases within the analysis period.

In some cases the type of concern raised has not been clearly noted. For example, there may be reference to 'General Abuse' but the nature of the abuse has not been identified/recorded.

Some requests are for general advice about process and there are also several data requests logged. These are generally received by external agencies such as the Police or other NHS Trusts.

The chart below indicates the nature of the concerns raised for the 218 requests logged in 2020/21.



Almost all types of concern have increased compared to previous years, a reflection of the increased number of requests for advice.

For the last few years sexual abuse has the most common type of concern but in the last year this has been surpassed by physical abuse. Domestic violence and drug/alcohol abuse also remain as some of the most common concerns.

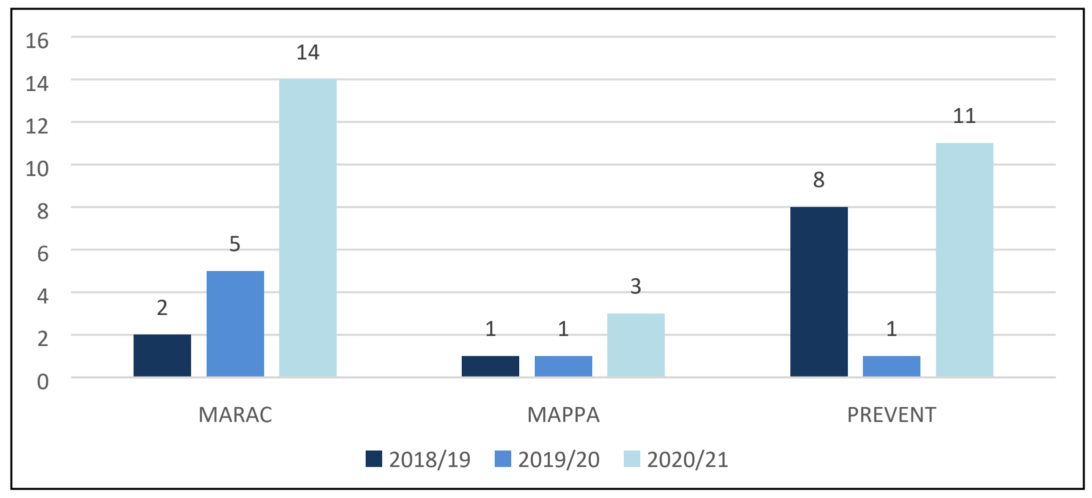
The table below shows this year's top five identified areas of concern and how the statistics compare with previous years. Although 'General Abuse' was one of the categories most logged this hasn't been included in the table as many of the cases didn't specify a type of abuse, so to include this category could possibly skew the analysis.

	No. of Concerns Raised			
Type of Concern	**2018/19**	**2019/20**	**2020/21**	**Comparison to Last Year**
Physical Abuse	35	28	70	60% increase in last year
Sexual Abuse	54	51	58	12% increase in last year
Domestic Violence	9	12	46	74% increase in last year
Emotional/Psychological Abuse	26	11	33	66% increase in last year
Drug/Alcohol Abuse	14	25	34	26% increase in last year

In 2020/21 there have also been some significant increases in requests for advice on the following:

- Extremist views – Doubled compared to the previous year
- Self-harm – Doubled compared to the previous year
- Neglect – Three times more concerns than the previous year
- Online abuse – Five times more concerns than the previous year

MARAC, MAPPA and PREVENT cases on which advice was sought have also increased:



Who are the requests about?

Information is recorded about those that concerns are about, referred to here as 'victims', and also those that are of risk to others, referred to here as 'perpetrators.

There are a growing number of cases with multiple victims and perpetrators – of the 208 requests for advice:

- Cases with multiple victims = 51
- Cases with multiple perpetrators = 33

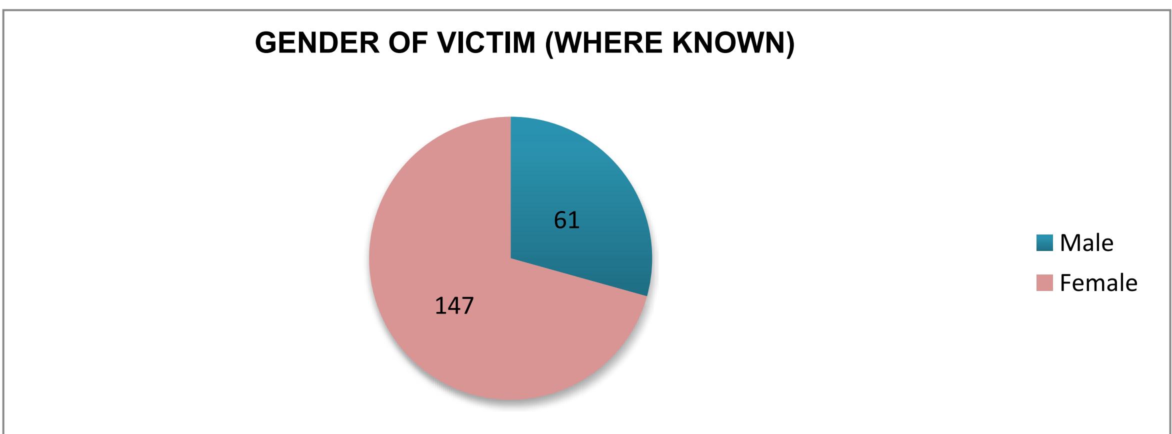
Also, in many cases the individuals identified are both victims and perpetrators.

Who are the victims?

The victims of individual perpetrators (not organisations) are most commonly family members or partners/spouses of the perpetrators.

There are often several victims identified within one request for advice; it is common that in a case there may be one perpetrator who has targeted several victims, especially in the cases that involve family members.

The gender of victims isn't always recorded in advice requests, but where the records specify, which was the case for 208 victims, the data has been included in the chart below.

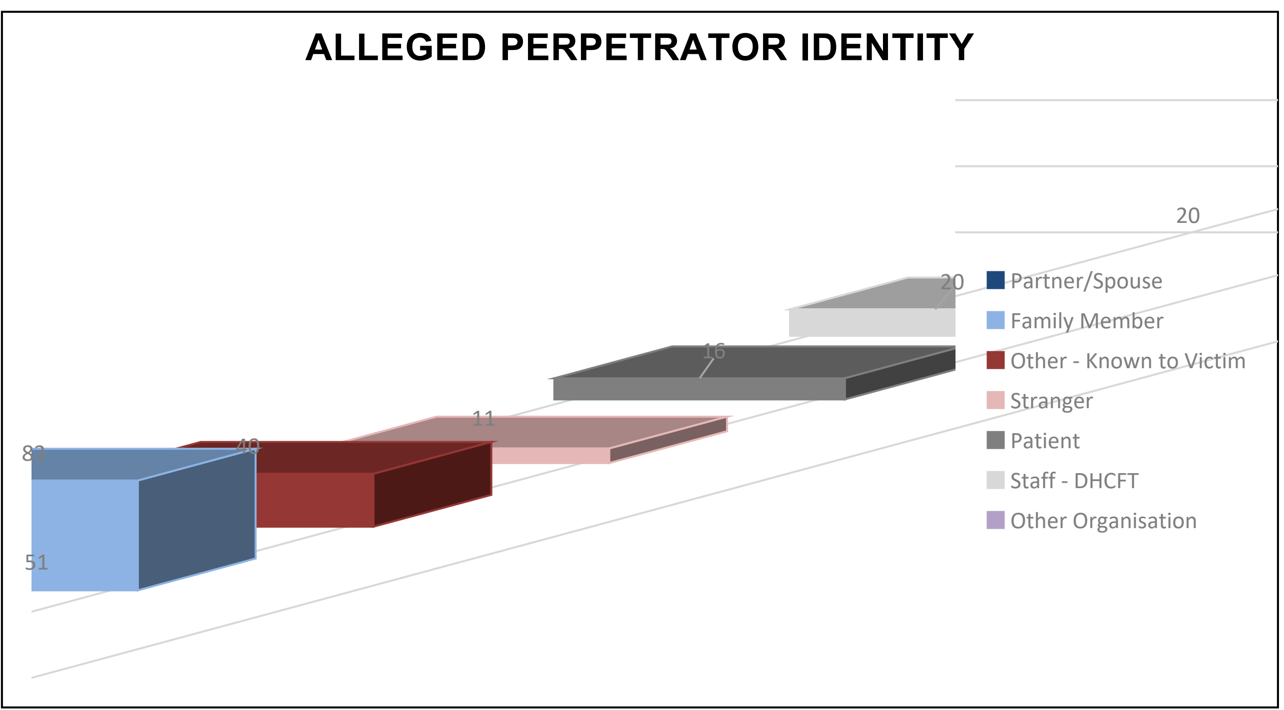


The percentage split of male/female is similar to previous years, but there has been a slight decrease in the number of male victims this year, from 32% in 2019/20 to 29% in 2020/21.

Who are the alleged perpetrators?

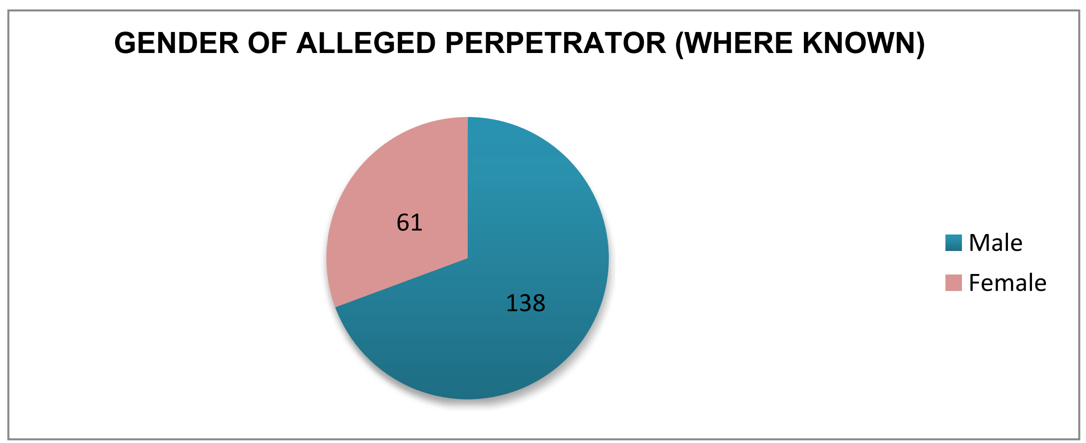
Where recorded, the data shows that the majority of the alleged perpetrators are family members or partners/spouses of the victims. Individual Trust staff, patients, staff members of other organisations, strangers and others known to the victim have also been recorded as being alleged perpetrators. Concerns have also been raised about other organisations as a whole, e.g. safety standards at a specific care home.

There were 241 perpetrators identified within the 208 requests for advice. Where known, the alleged perpetrator identities are shown in the chart below.



This year there has been a noticeable increase in neighbours being identified as perpetrators. Neighbours were mentioned in 12 of the 208 cases and are included in the ‘Other – Known to Victim’ category.

In the 218 requests for advice the gender of 199 individual alleged perpetrators was recorded.



The percentage split of male/female has shifted compared to previous years. In the two previous years there was a slight increase in the number of male perpetrators, from 82% in 2018/19 to 86% in 2019/20. However, in 2020/21 69% of the perpetrators were recorded as male and there was a significant increase in the number of female perpetrators identified. It should be noted though that genders were not always recorded so this could skew the analysis.

Summary of Findings

This last twelve months of data demonstrates activity in all areas of safeguarding including Public Protection and Counter-Terrorism.

The types of concern are of an ever-increasing complexity and intensity. Partnership working in raising and addressing these concerns is continually strengthening. One example of this heightened awareness is the increase in concerns raised about organisations and the standards of service, safety and care they offer.

In the 2019/20 report it was anticipated that there would be an increase in the number of domestic violence cases due to COVID-19 and national lockdowns. This was founded, there was an increase in the cases of domestic violence (74% increase on the previous year) and of physical abuse (60% increase on the previous year). COVID-19 was specifically cited in 11 of the 208 cases but it is likely that it impacted on a greater number in reality.

There has been a steady increase of sexual abuse cases year on year – There was a 12% increase in 2020/21 compared to the previous year. The Trust's safeguarding objectives for the following year include:

- Developing and undertaking the 'Safeguarding Inpatient Audit' as a key component of the Trust's focus on sexual safety
- Implementing and improving sexual safety in Trust services

The Trust's Quality Priorities for the next year also directly map to the findings in this report and the safeguarding objectives:

Recommendations

- The established process of data collection and analysis to be continued annually in the same format so that direct comparisons of findings can continue to be reviewed
- Parents to be separated from the 'Family Member' category when recording the identity of perpetrators – There is a noticeable increase in parents being identified as perpetrators so this would allow for more thorough review of the trend
- Neighbours to be separated from the 'Other – Known to Victim' category. This would allow direct comparison in future reports so as to identify if the increase in perpetrators of this category is an ongoing trend
- To benchmark against nationally collected data from the Local Authorities of England regarding trends and local phenomena

DHCFT SAFEGUARDING PRIORITIES

Sexual Safety

In anticipation of next year's quality priorities including sexual safety, work has began around strengthening our culture of sexual safety. This work has focused on Trust in-patient services and is guided by CQC Sexual Safety on Mental Health Wards published in 2018.

The Assistant Director and the Named Doctor have focused efforts on supporting a small working group that has, so far, achieved work towards development of a policy and a guidance leaflet for patients. This work will maintain a strong focus next year.

Predicting demand and work around referrals

In light of the unprecedented impact of the COVID 19 pandemic, consideration was needed of the levels of current and future demand for services across Derby and Derbyshire to ensure that the Partnership helped and protected vulnerable children and their families at the right time and in the right way in the future .The Safeguarding Children – Effective Demand Management Group was developed and chaired by the Chair of the Safeguarding Children Partnership, developing a

partnership approach to identifying and responding to changes in future demand for safeguarding services for children and families in Derby and Derbyshire.

The partnership meeting is held on a monthly basis in order for partners to keep up with the ever increasing demand and to discuss mitigation plans. Within Children Services, a Community Strategy Recovery Group is in place with a representative from DHCFT on the membership and the Trust has been fully engaged throughout from the Safeguarding Children Unit.

Activities were:

- To identify future demand and its content/priorities.
- Explore and develop practical understanding and appropriate application by all agencies of the partnership threshold document to ensure the right agency intervention at the right time for the right children and their families.
- Clarify data trends and indicators/predictors of demand, including any anticipated changes to national policy and practice
- Consider new identification points of risk and needs of children at home and in their communities
- Explore visibility of and access to children and the implications for the impact of hidden harm
- Signal to strategic leaders across the Partnership any identified service changes, resource reallocations or adaptations required to meet the needs of children in the future.

DDSCP Quality Assurance

DDSCP Quality Assurance Priorities which will also be included within the Trust priorities:

At the Quality Assurance Subgroup in October 2020, partners were asked to prioritise the pre-identified themes on a scale of 1 (highest priority) to 5 (lowest priority). These were then collated and the average (mean) calculated in order to rank them from highest to lowest combined priority. The priorities were linked to finding of Child Safeguarding Practice Reviews across the city and county.

Priorities identified by the partnership:

Safety of babies: Neglect: Child Sexual Abuse: Domestic abuse: Escalation: Think Family: Quality of assessment: Management Oversight and Supervision: Agency Contribution to Strategy Meetings: Early Help:

Next Steps

- Discussion of priorities across the partnership:
    - Are there any to add from single agency priorities that could be appropriate for a multi-agency or incorporated into one of the audit events?
    - Are there any items/issues that are in the audit template to be checked each time or that need to be in the audit template?
    - Do any require activity prior to audit (such as the investigative work around injuries in babies)?
- Agree priorities and multi-agency audit schedule (how many per year, which to be done in 2021?)
- Discuss links to individual priorities and where these can be combined or used to create a fuller picture
- Clarify which items can be moved to the performance framework as regular monitoring (e.g. monitoring related to statutory returns)
- Agree which of the single agency priorities need to be reported back into the QA Subgroup and which might link to/inform other agency priorities

DRIVE OVERVIEW REPORT FOR JOINT SAFEGUARDING ANNUAL REPORT

DHCFT along with other Derbyshire agencies are supporting the DRIVE pilot. Planning began in November 2020 with a Task and Finish group to set up the project which included stakeholders from the Trust with other statutory and non-statutory agencies.

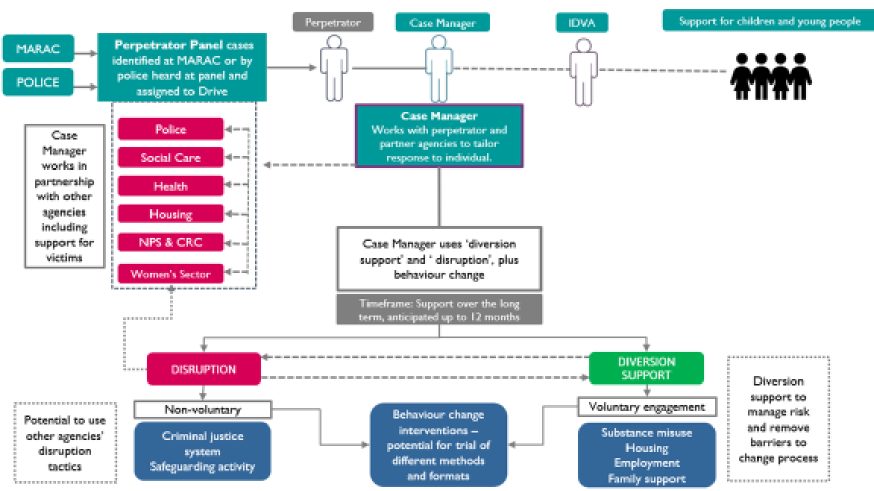
DRIVE is a new response to domestic abuse that aims to reduce the number of child and adult victims of domestic abuse by disrupting and changing perpetrator behaviour. It implements a whole-system approach through an intensive individual case management intervention alongside a co-ordinated multi-agency response to drive perpetrators to change their behaviour. DRIVE focuses on increasing victim safety alongside the crucial protective work of victims' services. The service has been developed to knit together existing services, complementing and enhancing existing interventions. DRIVE focuses on priority high-risk or serial perpetrators, both male and female, aged 16 and over. By addressing perpetrators' behaviour, DRIVE targets the root cause of domestic abuse to improve outcomes for victims and children.

The work of the perpetrator panel is overseen by the multi-agency DRIVE operational Group whose work is in turn scrutinised and assured by the DRIVE Implementation Panel, representation on which includes Trust safeguarding and operational representatives. Output and performance of the pilot are reviewed on a regular basis and following evaluation a full report will be presented at the end of the project period.

The outcomes of this work will be reported on fully in the 2021 report

Glow, the commissioned Drive Service Provider is required to follow a set of Drive policies and procedures to maintain adherence to Data Protection regulations and requirements. To ensure compliance the Service Provider shall has in place a qualified, trained or competent Data Protection or Compliance Officer. The Provider ensures that their entry with the Register of Data Controllers is maintained.

The Drive model



Only proportionate, accurate information that is directly relevant to the threat of harm by the perpetrator should be shared by the attending agencies.
Information sharing at Perpetrator Panels is strictly limited to the aims of the meeting and attendees should sign a declaration to the effect at the start of each meeting.
Agencies should ensure that the information they share is:

- adequate – sufficient to properly fulfil your stated purpose;
- relevant – has a rational link to that purpose; and
- limited to what is necessary – you do not share (or hold) more than you need for that purpose.

VARM OVERVIEW ANNUAL REPORT 20-21

Since 2013 the VARM (Vulnerable Adult Risk Meeting) process has been used in Derbyshire to support adults who have mental capacity and who are at risk of serious harm or death through self-neglect, risk taking behaviours or refusal to engage with service providers. VARM does not operate in Derby City where risk strategy meetings are advised for those not meeting Safeguarding criteria.

For a VARM to be called 4 criteria must be met:

- The adult has the mental **capacity** to make decisions and choices about their life;
- There is a risk of **serious harm** (physical or psychological) which is life-threatening and/or traumatic and which is viewed to be imminent or very likely to occur, **or death** by self-neglect, fire, deteriorating health condition, non-engagement with services, or where an adult is targeted by the local community, is the victim of hate crime or anti-social behaviour or the victim of sexual violence and they do not meet the criteria for a safeguarding referral;
- There is a **public safety interest**;
- There is a **high level of concern from partner agencies**.

The DSAB multi-agency VARM working group was established in February 2017 with the initial purpose of looking at the VARM operational and administrative processes to ensure that they were fit for purpose. Quarterly VARM Working Group meetings took place during 2019/20. It was agreed that the VARM Working Group would continue to meet in 2020/21 in order to continue to review and assess the impact of VARM.

Previous – Activity 19-20	**Top 5 Primary Referral**
165 VARM referrals 19 cases were found to not meet the VARM criteria.	Poor housing/hoarding 28% Substance misuse including alcohol 10%
146 Meetings were therefore recorded as VARM and given a case number	Antisocial behaviour, self-neglect fire risk 9%
88.5% conversion from referral to meeting	County lines 8%

Current reporting year Activity 2020-21	**Changes**
181 VARM referrals	Increase (165 to 181)
158 Meetings were recorded. Though some were rejected, some are outstanding with meetings carrying through to the next quarter at time of writing.	Marginal Increase (146 – 158)
87.3% conversion rate from referral to meeting though this may increase when outstanding meetings are taken into account.	Learning and themes will be developed by the partnership and shared with inter-agency partners

Quality Assurance

A Quality Assurance Audit was undertaken in quarter 4 2020-21. The draft findings and recommendations have been provisionally reviewed by the Interagency VARM working Group and awaiting Derby and Derbyshire Safeguarding Adult Board for ratification at time of writing this report.
This process continues to be seen as a valuable multidisciplinary engagement tool which centres making safeguarding personal and is an effective way to maximise attendance.

Key Challenges and Learning

Case numbers and meetings are increasing year on year as this process is increasingly embedded into interagency safeguarding practice.

There is some concern which does warrant further exploration that the VARM process is being used as a default option where other multiagency meetings could perform the function and this is a potential improvement area. this will be explored with interagency partners in 2021.

The inter-agency feedback of the process is that there are continued challenges of key attendees predominantly senior inter-agency health providers, GP and police being unable to attend through competing urgent commitments in this pandemic period.

Annual report for MASH Health Advisors 2020/21

The aim of this report is to reflect on the MASH Health Advisors activity from 1 April 2020 to 31 March 2021.

MASH Health consists of two whole time equivalent posts and three advisors:

The MASH during the COVID-19 Pandemic

The normal working environment of the MASH was significantly impacted due to the COVID-19 outbreak. The core principles of bringing agencies together for timely information sharing and safeguarding was disrupted by agencies working from home or different bases to protect staff. Consequently, Derby City MASH has had to evolve and adapt to ensure the service has continued to work effectively and continue to safeguard Children, Adults and families in Derby City. The impact was minimised by each partner activating their Business Continuity Plans and ensuring staff members had remote access to IT equipment, electronic patient records and meetings were held via telephone conference calls, Microsoft Teams etc.

Throughout the period MASH Health Advisors, Police and Social Care have generally worked remotely. Children's Social Care have had some practitioners working within the Council House on a rota basis, the Police have worked remotely throughout. MASH

Health Advisors have attended the Council House for one day a week between national lockdowns. Initially at the beginning of this period, Strategy discussions for both children's and adults took place via phone, however, as Multi-agency IT departments put systems in place this quickly evolved to all agencies in the MASH being able to partake in discussions via video link on Microsoft Teams.

All agencies have endeavoured to ensure the multi-agency approach and general ethos of the MASH has been maintained during these difficult times and effective multi-agency working relationships maintained. There does not appear to have been any adverse effects of the pandemic on the MASH team's ability to respond to and hold strategy meetings within the time frames set out by our policies and procedures. We have noted during the COVID-19 pandemic increasing numbers of safeguarding referrals being made and some influence on the category of safeguarding concerns being received into the MASH.

MASH Adult

Approximately 3600 referrals were received for Information Exchange during the year via an Information Exchange Form (IEF); this is around a 60% increase from last year. Over 1350 other health colleagues, mostly GPs were liaised with during this year.

134 strategy meetings were attended by MASH Health; when MASH Health could not attend research, information was submitted and any actions followed up by the Safeguarding unit.

MASH Social Care continue to send through the initial referral, requesting information and then re-sending the completed form. Although this is felt best practice, so all information can be gathered prior to a safety plan being developed, this continues to create an increase in referrals received for health advisors. However, it is worth noting that the receipt of completed safeguarding referrals into MASH Health Advisors has reduced in this period which is likely due to the general increase of workload/referrals being received into Adult MASH during this period.

Data collection is currently completed by a Health Advisor physically counting how many emails have been received on a weekly basis; it is therefore currently not feasible to breakdown which referrals are a duplicate of those already received. Furthermore, work is completed by Health Advisors for every email, whether it is to share information or liaise with other professionals. The data, therefore, is in relation to referrals received for further work and not for general referrals to MASH.

Further break down of the referrals received into MASH Health advisors and a comparison with last year's data has been beneficial in identifying key themes. As previously identified, there has been an increase of 60% of Adult Safeguarding referrals received from last year's data. When this is analysed it identifies that the following categories of abuse have increased significantly within this period.

There has been an 81% increase in referrals relating to Self-Neglect, it is not clear how much of this is related to inappropriate referrals being categorised as Self-Neglect, for example a mental health or self-harm being categorised as Self-Neglect or just a general increase of Self-Neglect due to the impact of COVID-19 on mental health. Referrals relating to Neglect and Acts of Omission have more than doubled (125% increase) during this period, this is a significant increase and may be in part due to instability of staff working in care settings.

There has been a 50% increase in referrals relating to Domestic Abuse and a 62% increase in referrals relating to Financial and Material Abuse. Referrals relating to Organisational Abuse have tripled in this period. Referrals relating to cuckooing have also tripled, although figures remain generally low. This analysis will support our Trust and partners to better understand the impact of the COVID-19 Pandemic on Adult Safeguarding and may benefit from further longitudinal analysis.

There was a significant Police operation in this period relating to the exploitation of vulnerable adults which increased the number of information requests and strategy discussions held as it involved individuals from the homeless community.

Health Advisors have continued to note an increase in safeguarding referrals that do not meet the threshold for adult safeguarding but are being progressed for formal information exchange. This remains under review as it is recognised that unmet needs may be identified that are not specific to safeguarding concerns. Health Advisors envisage a more robust triage screening, similar to that of children's services, where referrals can be signposted if they are not of a safeguarding concern. MASH Health Advisors continue to assess requests for information on a case by case basis, highlight those requests to Adult MASH that do not meet the statutory safeguarding criteria and share information as appropriate according to the MASH information sharing agreement and local and national policy and procedures relating to the sharing of information.

MASH Children

There were 372 section 47 referrals to MASH and of these, 367 Strategy Meetings were held. This is a very slight increase on the previous year (approximately 7% increase). Further analysis of these figures identifies a 17% increase in Strategy discussions relating to physical abuse, these figures did increase in the second half of this period and may have been due to more children returning to Educational settings.

Strategy discussions relating to neglect increased by 64%, which similar to Adult MASH referrals may reflect the impact of the COVID-19 pandemic on the mental health of Children, Adults and families. Unlike the statistics for Adult MASH, Strategy discussions held regarding High Risk Domestic Abuse was down 40 % on last year's figures. This is likely to have been impacted by COVID-19 restrictions/lockdowns and Domestic Abuse occurrences being under reported by victims. It was noted across the partnerships for Domestic Abuse Medium Risk Triage that there appeared to be an increase of

Domestic Abuse being reported by members of the public, such as neighbours and also the children involved in the occurrences rather than the Education or statutory sector.

Referrals relating to sexual abuse increased by 8% on last year's figures – this is likely due to a general increase in sexual abuse related to the internet and also an ongoing Police operation relating to the downloading of indecent images of children,. This Police operation continues and will likely affect the figures for 2021/2022 data. Data has been collected by MASH Health Advisors in relation to this Police operation and will not be detailed further within this annual report as it spans both the 2020/21 and 2021/22 period. It is relevant to note that the majority of children discussed in relation to this Police operation did not have contact with the perpetrators and Section 17 action was agreed for the majority.

Thematic Analysis for Adult and Children MASH (Think Family/Family Focused approach)

Within Strategy Meetings, 2140 individuals were discussed; for both adults and children. This is a 21% increase on figures for the previous year. These were either victims, perpetrators or family members in the home or others involved in the safeguarding. Thematic analysis of these figures has been provided in a previous section.

Despite the requirement for remote working during this difficult period, discussions between children and adult services remain a frequent occurrence to ensure all those that meet criteria are safeguarded from harm, although it would be naive to state that the MASH team's ability to have open discussions regarding cases will not have been affected by remote working.

The MASH is an excellent resource to ensure timely information sharing, providing a coordinated response and enabling all agencies to work together as one team. All agencies involved in the MASH are looking forward to the future with positivity when we can be reunited again under one roof. In the meantime, the MASH Health Advisors continue to foster positive working relationships with our multi-agency colleagues remotely, via daily discussions, and the MASH Operational meetings.

Domestic Abuse (DA)

There were approximately 1400 medium risk domestic abuse incidents discussed in triage. This is only a slight increase on the figures for the previous year.

Medium risk domestic abuse triage has continued to take place twice weekly to ensure notifications are reviewed in a timely manner. Medium triage has continued to consist of a Social Care Senior Practitioner, Education and a MASH Health Advisor. Medium Risk Triage has taken place remotely via Microsoft Teams. The Police have been unable to attend triage during the COVID-19 Pandemic due to workforce capacity issues.

However, they have made themselves readily available to answer any queries or the need for further information in relation to cases.

A strength-based approach has been adopted to ensure children are safeguarded from witnessing domestic abuse, to minimise Adverse Childhood Events (ACE's) and to ensure parents are protecting the children from harm. Initially, during the first lockdown it was acknowledged that due TO COVID-19 restrictions, Early Help Assessments and Single Assessments were more difficult to agree due to protection of staff and public from the virus. Moreover, most children were not in school/nursery and therefore protecting children and families from domestic abuse was a challenge. However, as agencies became accustomed to the new 'norm' and ways of working, this challenge decreased and agreed actions from triage have been undertaken and completed appropriately by all agencies.

It must be noted that domestic abuse figures are only in relation to the households in which children are named on the DASH risk screening. Moreover, medium risk triage is only for those children not already open to services (either early help or social care). The Police figures for domestic abuse in Derby City will therefore be significantly higher than that collected by Health Advisors.

Standard risk incidents are now no longer triaged within the MASH. This was discussed within the Multi-agency forum and it was agreed that all Standard risk referrals would be accepted at the point of contact from Police and entered within patient/agency records.

This decision was influenced by COVID-19, however, on review of the data, it was identified that between 80-90% of standard referrals were already being accepted at point of triage. It was therefore felt by all, that accepting all Standard referrals would be beneficial in building a bigger picture for families and promoting a good standard of practice.

Other

Advice calls
Health advisors received 144 calls for advice; 70 % of these were in relation to adults, 25 % in relation to adults and children and 5 % for child concerns. These percentages were expected as the Safeguarding unit continue to receive the calls in relation to children.

Data collection
Data continues to be collated to monitor activity levels. Health Advisors produce a quarterly report and submit monthly raw data as part of the Trust's performance reporting framework. The data is designed to reflect the activity of Health Advisors and does not evidence activities for MASH as a wider multi-agency team.

314 emails / calls for checks between MASH agencies were received which have been invaluable in ensuring relevant information is shared. This is reciprocated with MASH colleagues and Health Advisors will also request information from colleagues when required. Due to COVID-19 measures, these requests were completed via email or phone.

Professional development and wider improvement activity
Continuing Professional Development activity has continued to be accessed during COVID-19 with the appropriate adaptation to delivery. MASH Health Advisors attended the Level 4 Safeguarding Workshop They have also had access to Level 4 Safeguarding Supervision Programme and Consultancy.

MASH Health have been involved in the development of a Sexual Safety Leaflet for patients in Trust inpatient settings.

One of the MASH Health Advisors has delivered safeguarding supervision to School Nurses and will continue to do this on a regular basis as she wishes to maintain skills in this area.

MASH Health Advisors have also developed a flow chart for Social Care colleagues in relation to obtaining information for health agency checks.

One of the MASH Health Advisors is an Approved Mental Health Professional and continues to work both within the MASH team and in her respective role in the Trust Crisis team.

Testimonies

It’s been a challenging year for key workers over the last 12 months and professionals within the MASH have been required to adapt to increasing caseloads, new ways of working (remotely) to ensure the focus remains child centred and concerns responded to in a timely manner.

The MASH Health Advisors have been assiduous in their focus on solving problems during the coronavirus outbreak and the complexity/severity of new cases post lockdown, coupled with increase in referrals fuelled in part by the rise in domestic violence reports during lockdown, has provided additional challenges for the MASH. However, rather than the pandemic hindering partnership working strategy meetings and information sharing have become more efficient and streamlined with the commitment and dedication of the MASH Health Advisors.

LEARNING FROM REVIEWS

Child Safeguarding Practice Reviews (CSPR) Exception Report

There has been many Child Safeguarding Practice Reviews being worked upon during 2020/21 all at varying stages' actions are on target. Learning briefs have been developed by the Partnership to disseminate the learning throughout the Trust. The normal process of cascading learning via workshops has been on hold due to COVID-19. The Trust is and has been fully engaged with all child safeguarding practice review processes.

The Safeguarding Partnership has a process/multi agency meeting in place to look at the CSPR action plans of Derby/Derbyshire. This gives assurance across the partnership that actions are complete or give a progress position and enable agency challenge as necessary.

Work is addressed around agency assurance to identify the inter-relationship between the learning themes and what do we do about and ensure learning/change in practice happens. Evidence must be provided.

The latest four CSPRs methodology is being addressed in a new way: A Named Nurse and Specialist safeguarding Practitioner take the lead in each review to support staff and the process.

Methodology

The reviews will be completed in a proportionate way that enables the partnership to learn from the experiences of the family, practitioners involved in the case and relevant managers and promote a positive learning culture. The detail of the methodology will be linked to the key theme and explained below:

- Learning events will be held with front line practitioners involved in the cases.
- At the learning events a series of exploratory questions linked to the themes and will draw out learning from these cases to improve how the partnership supports services work together.
- Learning events will be held with managers involved in the cases and strategic managers as needed.
- Parents will be invited to participate in the review and be interviewed by the overview author.
- Reports may be commissioned from agencies to provide specific additional information not included in the Rapid Review. The specific requests for information may be identified following the practitioners' meeting. There may be generic points for clarification and specific requests for individual agencies.

A child safeguarding practice review report will be completed to provide:

- A brief overview of what happened and the key circumstances of the lived experience for each subject child in a way that does not identify them and is sufficient to understand the context for the learning and recommendations;
- A critique of how agencies worked together and analysis of good practice and systemic areas for development;
- Analysis of what would need to be done differently to prevent harm occurring to a child in similar circumstances; and,
- What needs to happen to ensure that agencies learn from this case?

Safeguarding Adults Homicide Reviews and Safeguarding Adult Reviews (SARs)

The Trust has been actively involved in five Adult Homicide / Domestic Homicide Reviews this year and two Safeguarding Adult Reviews. The Assistant Director for Safeguarding Adults is a member of the County Safeguarding Adults Board Safeguarding Adults Review Panel.

Learning from SARs and Homicide Reviews is shared with the workforce via the Safeguarding Adults Link Worker Network, the Trust Clinical and Operational Assurance Teams (COATS), in safeguarding supervision and in learning and development activities.

The Trust has contributed to the continued development of the Derbyshire approach to SARs and learning events are occurring earlier in the process with good effect. Close working relationships have developed between the Safeguarding Unit and the newly established Community Forensic Mental Health Team.

AUDITS

We are currently working on the following audits on behalf of the Trust:

TITLE	AIMS/OBJECTIVES
Safeguarding Review of Section 37/41 (MHA) in the Community (re-audit)	A safeguarding review of all Section 37/41 patients currently in the community was requested in 2017 following a number of serious incidents in the community. This is a re-audit as part of the audit cycle, it is being led by the Forensic and Rehabilitation Division leadership with support from the safeguarding team.
Proactive Approach to Threshold Implementation July 2020	Purpose of the audit to seek support and commitment to improving the effective use and implementation of the Partnership Threshold arrangements, revised and reissued in November 2020. Despite wide circulation of and training of the Thresholds document within agencies, there remained a high percentage of contacts and referrals from agencies which, after consideration and investigation by the staff at Starting Point (Derbyshire) and MASH (Derby City), are classed as 'No Further Action' (NFA)/'Threshold Not Met' (TNM) respectively. Both local authorities continued to audit the decision-making on receipt of contacts and referrals and scrutinised the application of thresholds internally. The DDSCP will review evidence of their assurance through the work of the QA Group. DHCFT and other partners were asked to undertake a dip-sample of five referrals made by your agency that have resulted in NFA or TNM. This was undertaken and returned. Considerable work with staff has been undertaken within training, supervision and advice giving in order to improve the situation. Messages have been circulated and good referral guidance has been used within training.
Use of Online Referral Form to Children's Social Care May 2020	Purpose of the was to establish how health staff were finding the use of the online referral form to Derby City Children's Social Care. Method was analysis was completed asking 30 staff from across DHCFT including the 0 to 19 Integrated Family Health Service, Specialist Health Services, CAMHS and Adult Mental Health teams. Questions asked, was it easy to find? was it easy to use? did you receive an email receipt? Where did you find the referral form? Who was the referral made by? The online referral form appears to have been well received by DHCFT staff.

TITLE	AIMS/OBJECTIVES
	A recommendation was made the addition of an option to save and be able to return to later to complete the form as it can be lengthy to complete if there are a number of family members to include and to consider how feedback is given to the referrer as not all cases were made aware of the outcome.
Re-audit of s47 Strategy Requests/Discussions – May 2020	Purpose of the audit was to re-audit following a previous audit in November 2019 Section 47 (s47) strategy discussions between DHCFT Safeguarding Health Team and Children's Social Care. This was following a request for six cases to be made available for CQC showing examples of s47 strategy discussions. Method, analysis was completed using a sample size of 30 cases from the 0 to 19 Integrated Family Health Service. Questions asked were, was the request completed on the Information exchange form. Was the health research used? Were the details correct on the IEF? Was the strategy discussion recorded? Was the discussion held within the timeline? The recommendations were to follow up the findings with the Head of Service for Childrens Social Care. If s47 requests arrive and are found to be for other services, children in care or the child has moved out of area, then Named Nurses should record in the EPR that the information has been received and acted upon.

The safeguarding Children Internal Audit plan has been on hold during this year due to the COVID-19 pandemic, however this has recommenced

Care Quality Commission (CQC)

Due to the COVID-19 pandemic the CQC adopted a transitional approach to inspection of services to assure safety and quality. This entailed the provision of information at division level and meetings with divisional leadership, the CQC and supported by the Clinical and Quality Directorate. This approach did not involve the Safeguarding Team directly, however assurances and data was requested from the Safeguarding Team to support the information provided to the CQC on its review of the Child Health Service.

NEW INITIATIVES/OBJECTIVES 2021/22

Led by the operational group and assurance on progress provided to the Quality and Safeguarding Committee.

Objective / Initiative	
1.	To continue to develop and integrate the Children's and Adults Safeguarding Team within the Trust.
2.	To ensure that succession planning, develop expertise within the workforce and consider talent management and support development.
3.	To continue to build resilience in the workforce and support staff around complex work, especially around COVID-19 pandemic, the challenges to safeguarding work that brings and the recovery phase. To provide leadership post 'lockdown'.
4.	To continue to work in partnership with all agencies around the challenges of working with emerging and new communities, ensuring work is done specifically with the Safeguarding Team around cultural competence.
5.	To complete and embed the Trusts, Domestic Abuse and the Elderly Policy, Allegation Policy and the Trust Domestic Abuse Policy for victims, perpetrators and their families.
6.	To develop Safeguarding relationships with the Freedom to Speak Up Guardian.
7.	To ensure the Think Family remains a key clinical safeguarding standard and the established 'think family think tank' will continue to function maintaining links with clinical practice.
8.	To continue to undertake a joint City / County Section 11 and SAFF, and provide effective evidence of the Trust compliance. To ensure any recommendations are acted upon.
9.	To make further developments in assuring Sexual Safety within Trust services and produce a Sexual Safety Standard Operating procedure to accompany our leaflet for people using our inpatient services, in line with this being a Trust Quality priority.
10.	Children and Obesity Strategy to cascade and implementation throughout the Trust.
11.	To continue to support the Trust's intention to move to one Electronic Patient Record [EPR]. This work involves both Assistant Directors.
12.	To commission training around large families and the impact on Safeguarding Children.
13.	To contribute to a multi-agency review of the Survivor Strategy and Professional Guidance
14.	To contribute to the Trust's endeavours to ensure readiness for the Liberty Protection Safeguards that will replace Deprivation of Liberty Safeguards and require a new set of arrangements and responses.
15.	To update the Safeguarding Audit Plan.

OVERALL

As the year ended, although we were implementing COVID-19 measures, we are able to reflect on what has been another highly successful year and we will continue to be committed to setting and providing the very best standards of clinical and safeguarding practice that as a team we can deliver.

We offer this report with significant assurance to the Quality and Safeguarding committee on our systems, governance, learning and improvement of standards of practice. We believe as a collection of health professionals that this report demonstrates a robust system of scrutiny and a commitment to sound practice.

REPORT PREPARED BY:

Tina Ndili, Assistant Director Safeguarding Children
Karen Billyeald, Assistant Director Safeguarding Adults (now retired)
Vicki Baxendale, Assistant Director Safeguarding Adults
Debbie Archer, Safeguarding Unit Administrative Coordinator
Zoe Rudderforth, MASH Health Advisor
Louise Haywood, MASH Health Advisor
Claire Ray, MASH Health Advisor
Jane Elliott, Safeguarding Children Named Nurse
Jo Watson, Safeguarding Children Trainer
Dave Ensor, Safeguarding Children Trainer
Dr Deepak Sirur, Named Doctor for Safeguarding Adults
Kelly Sims, CQC and Governance Coordinator/Staff Governor
Dominic Pitter, Area Service Manager CAMHS
Hayley Darn, General Manager Children's Services
Carolyn Green, Director of Nursing and Patient Experience

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 2 November 2021

Children in Care Annual Report 2020/21

Purpose of Report

This report has been produced to provide the Board with 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. This assurance report provided the Quality and Safeguarding Committee with scrutiny of how this service is discharging its legal duties and clinical standards requirements.

Executive Summary

- The report includes all cohorts of looked after children that Derby City Local Authority are responsible for, no matter where they live.
- The report provides significant assurance on the provision, screening and outcomes for children in the service. All health screening has been maintained and exceeded the levels set to ensure outcomes for our children which is commended in such a difficult year.
- One gap in assurance is the impact on dental checks due to disrupted primary care dental services. This will be recovered and is not within the full control of the service due to COVID restictions.
- The Quality and Safeguarding Committee scrutinised the report on 14 September to ensure the Trust has discharged its formal statutory duties to vulnerable children.
- It is known that looked after children are at elevated risk of worse health outcomes. Health screening services are in place to reduce and mitigate this risk. The health outcomes for our community in Derby are above our regional comparator and demonstrate above average performance and good outcomes. We note the increase in children who are looked after.
- It is recognised that the looked after children health team have core competencies, specialist skills, knowledge and attitudes to act as advocates, undertake health assessments and identify and manage health needs.
- The report describes the challenges faced in the year of the COVID-19 Pandemic and the mitigation plans for the unprecedented times for the service.

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

Assurances

- The Trust will assure measures are put into place in accordance of the service specification
- Maintain working relationships with other partner agencies/services
- The statutory timescales will be monitored, and evidence is provided and scrutinised in order to achieve outcomes
- Training compliance will be scrutinised to ensure competency of staff to the right level.

Consultation

- This report has been developed by the Named Nurse for Children in Care with information that is held by both provider and local authority
- Various members of the wider Children in Care team have contributed to the report
- A child friendly Annual Report will be developed in a leaflet form.

Governance or Legal Issues

The Trust meets statutory obligations and legal duties with regard to: Mental Health Act [1983]; Mental Capacity Act [2005]; The Care Act [2014]; Children and Families Act [2014]; Human Rights Act [1998] Domestic Violence, Crime and Victims Act [2004] and our internal systems, structures and processes are joined up and effective.

The Trust meets the required standards for our Regulators and our Professional Regulatory bodies Codes of Practice i.e. Safe, Caring, Effective, Responsive, Well-led and Safeguarding are one of the gold threads that runs throughout. We apply national guidelines and evidence based best practice e.g. NICE, DoH, National Statistics.

The Trust contributes as an equal partner in Multi-Agency forums e.g. MAPPA; MARAC; Channel; Child and Adult Safeguarding Boards and sub-groups and takes part in peer assessment, benchmarking and self-assessment and assurance.

The Trust invests in staff across multiple agencies and services to ensure high levels of competence and confidence and achieve consistently good practice that is constantly updated and refreshed within a culture of learning from both successful and adverse situations.

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:

- Empowerment - of the individual to make decisions
- Protection - support and representation for those in need
- Prevention - of abuse / neglect as well as helping the person to reduce the risks of harm and abuse that are unacceptable to them
- Proportionality - responses should be least restrictive to the person's rights
- Partnerships - working collaboratively to prevent, identify and respond to harm
- Accountability - and transparency in delivering safeguarding.

Recommendations

The Board of Directors is requested to:

1) Receive the report which is offered with significant assurance of the work within the Trust around looked after children and young people and the continued partnership working to ensure the best outcome is achieved for this vulnerable group of children and young people.
2) Accept the annual report and agree on the key priorities set for 2020/21.

Report presented by:	**Carolyn Green** **Director of Nursing and Patient Experience and Executive Lead, Quality and Safeguarding Committee**
Report prepared by:	**Kelly Thompson** **Named Nurse Children in Care**

ANNUAL REPORT FOR DERBY CITY LOOKED AFTER CHILDREN PROVISION

Year 2020/21

Contributors:

Kelly Thompson (Named Nurse for Children in Care – DHcFT)

Dr Corina Teh (Designated Doctor for Looked after Children – DHcFT)

Dr A Marudkar (Medical Advisor for Children in Care – DHcFT)

Dr V Kapoor (Medical Advisor for Children in Care – DHcFT)

Emma Fennell (Specialist Nurse for Children in Care – DHcFT)

Nicola Robbins (Specialist Nurse for Children in Care – DHcFT)

Satvieer Dutton (Specialist Nurse for Children in Care – DHcFT)

Kirsty Annable (Administrator Coordinator – DHcFT)

Section 1: Introduction and context

1.1. The purpose of this report is to provide Derbyshire Healthcare NHS Foundation Trust (DHcFT) 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. This includes all cohorts of looked after children that Derby City Local Authority are responsible for, no matter where they live (see section 10 for explanation of the differing cohorts).

1.2. The report will outline how Commissioners, Designated Professionals, Local Authority and Health Providers have worked together in partnership to meet the health needs of children in care in Derby City; in line with the statutory guidance 'Promoting the health and wellbeing of looked after children' (DH, 2015).

It will summarise key improvements, service performance; along with setting out the objectives and priorities for the next financial year (2021/22) for looked after children in Derby City.

1.3. This report has been compiled in partnership with the Named Nurse for Children in Care; Designated Doctor for Looked after Children, the Medical Advisors and Specialist Children in Care Nurses and admin.

1.4. Within all national and local policies and guidance the service is known as Looked after Children, however within Derbyshire Healthcare NHS Foundation Trust the service is known as Children in Care.

Context

1.5. **Definition of a looked after child/ child in care**

A child that is being looked after by the Local Authority; they might be living with:

- foster parents
- at home with their parents under the supervision of Children's Social Care
- in Local Authority or private residential children's homes
- other residential settings such as schools or secure units.

They might have been placed in care voluntarily by parents struggling to cope, or Children's Social Care may have intervened because a child was at significant risk of harm.

Health and wellbeing of looked after children

1.6. It is well recognised that children's early experiences have a significant impact on their development and future life chances. As a result of their experiences and blended effects of poverty, poor parenting, chaotic lifestyles, abuse and neglect, looked after children often are at greater risk and have poorer health than their peers (DfE, DH, 2015).

Ref: Promoting the health and wellbeing of looked-after children, March 2015, Department for Education and Department of Health

1.7. The Royal College of Paediatrics and Child Health (2020) states that looked after children and young people have greater mental health problems, along with developmental and physical health concerns such as speech and language problems, bedwetting, coordination difficulties and sight problems. Furthermore, the Department for Education and Department of Health (2015) argue that almost half of children in care have a diagnosable mental health disorder and two thirds have special educational needs. When there are delays in identifying or meeting the emotional and mental health needs this can have a detrimental effect on all aspects of their lives leading to unhappy unhealthy lives as adults.

Ref: Promoting the health and well-being of looked-after children, March 2015, Department for Education and Department of Health

Ref: Looked after children: Knowledge, skills and competencies of health care staff, Intercollegiate Role Framework, December 2020, Royal College of Paediatrics and Child Health

Section 2: Statutory Framework, Legislation and Guidance

The statutory guidance focused around Looked after Children is in abundance; the key documents and legislation are outlined as follows:

2.1 Children Act (1989)

Under this Act a child is defined as being 'looked after' by the local authority if the child or young person is in their care for a continuous period of more than 24 hours by the authority.

There are four main groups:

- **Section 20** children who are accommodated under a voluntary agreement with their parents
- **Section 31 and 38** children who are subject to an interim care order or care order
- **Section 44 and 46** children are subject to emergency orders
- **Section 21** children who are compulsory accommodated including children remanded to the care of the local authority or subject to criminal justice supervision with a residence requirement.

2.2 Adoption and Children Act (2002)

This Act modernised the law regarding adoptive parenting in the UK and international adoption. It also enabled more people to be considered by the adoption agency as prospective adoptive parents. This Act also places the needs of the child being adopted above all else.

2.3 Children and Young People's Act (2008)

The purpose of the Act is to extend the statutory framework for children in care in England and Wales and to ensure that such young people receive high quality care and services which are focused on and tailored to their needs

2.4 Children and Families Act (2014)

This Act strengthens the timeliness of processes in place to ensure children are adopted sooner. Due regard is given to the greater protection of vulnerable children including those with additional needs

2.5 Promoting the health and wellbeing of looked after children (March 2015)

This guidance was issued by the Department of health and Education. It is published for Local Authorities, Clinical Commissioning Groups, Service Providers and NHS England.

2.6 Looked after children: Knowledge, skills and competences of health care staff intercollegiate role framework (December 2020)

This document sets out specific knowledge skills and competencies for professionals working in dedicated roles for looked after children

2.7 The Children and Social Work Act (2017)

Improves decision making and support for looked after and previously looked after children in England and Wales

- Improve joint work at local level to safeguard children and enabling enhanced learning to improve practice in child protection
- Enabling the establishment of new regulatory regime for the social work profession
- Improve the provision of relationship and sex education in schools

Section 3: Looked after children data and profile

National and local data

3.1 The number of looked after children has increased steadily over the past eight years. There were 80,080 looked after children on 31 March 2020, an increase of 2%, compared to 31 March 2019. (Department for Education DfE, Department of Health DH, 2020).

3.2 Number of children looked after in England at 31 March 2015 to 2020

2015	**69,540**
2016	**70,440**
2017	**72,670**
2018	**75,420**
2019	**78,150**
2020	**80,080**

Ref: Data made available from Derby City Local Authority Informatics Department

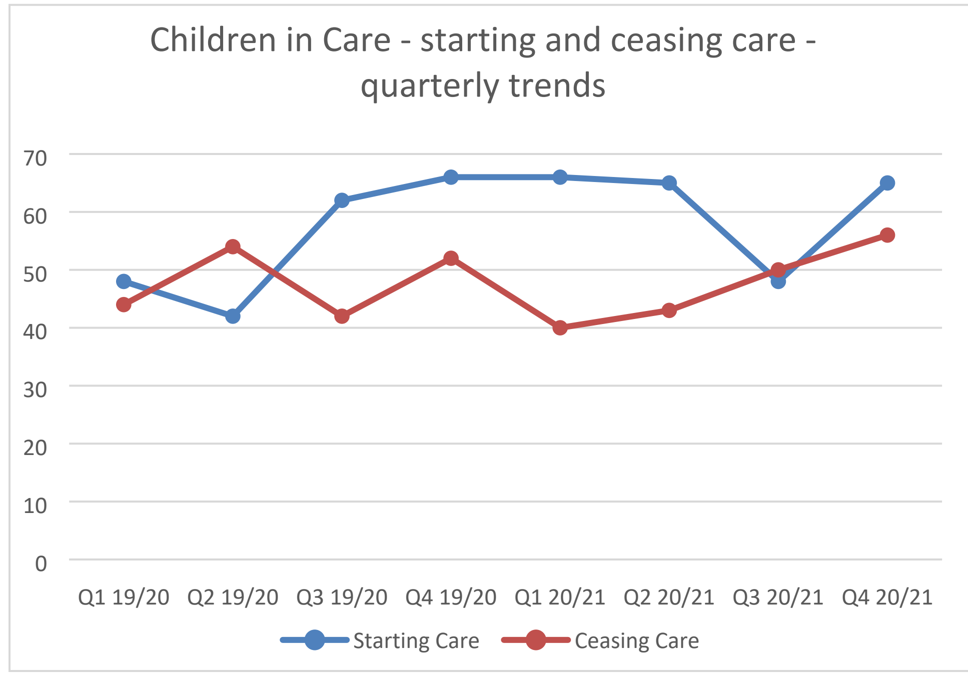
3.3 Number of children looked after in Derby at 31 March 2015 to 31 March 2021

2015	470	5% increase from 2014
2016	452	4% decrease from 2015
2017	448	0.8% decrease from 2016
2018	491	8% increase from 2017
2019	562	12% increase from 2018
2020	588	4.6% increase from 2019
2021	643 (provisional)	9.4% increase from 2020

Ref: Data made available from Derby City Local Authority Informatics Department

3.4 Children in Care - starting and ceasing care - quarterly trends

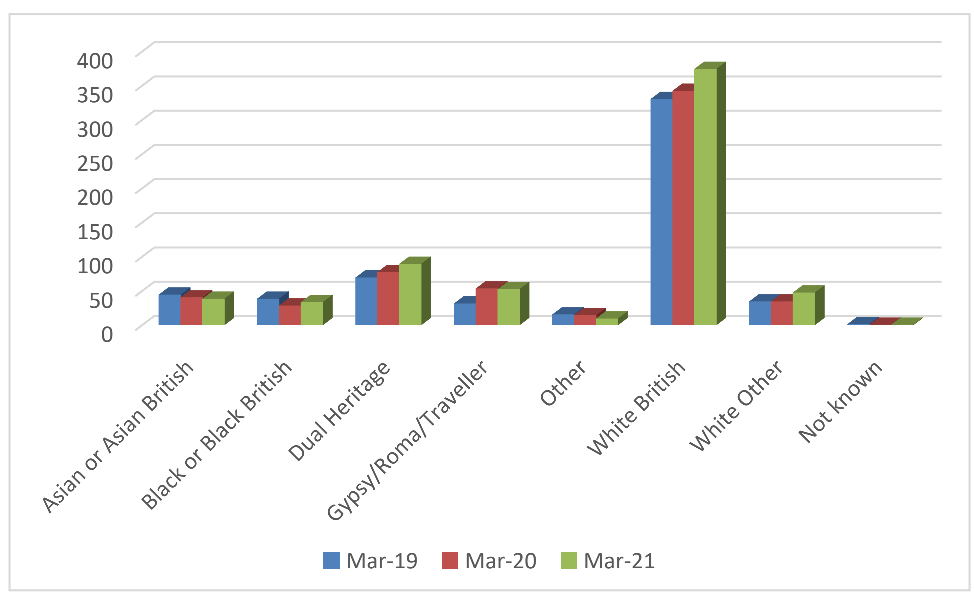
The number of Children in Care increased by 8 cases during Q4 to 643. This is an increase of 55 cases compared to twelve months ago (31 March 2020) where we had 588 cases. This equates to an increase of 9.4%.



We had 48 new entrants into care during Q3 2020-21. On average we have around 62 new entrants per quarter so this is lower than the current quarterly average. Quarter 3 saw an increase in the number of exits compared to the previous quarter. During Q4 2020-21 56 children ceased care compared to 50 in the previous quarter. The quarterly average for children exiting care during 2019-20 was 48 per quarter so we're over the average with 56.

Profile of looked after children in Derby City

3.5 Ethnicity comparisons over the last three years:



Ref: Data made available from Derby City Local Authority Informatics Department

The Children in Care team acknowledge adapt and respond to the change in demographics that children from different ethnicities is changing. The Children in Care team are not able to impact upon this finding; however, we must ensure that the care offered is culturally adapted and offer a culturally competent service

The placement team try to match ethnicity/culture where they can, however this is not always possible due to the balancing of availability and timings. Culture and identity are always discussed at Looked after Children reviews and plans are put in place to ensure the child's needs are being met.

The Designated Nurse for Looked after Children developed some unaccompanied asylum seeking children UASC leaflets (gender specific and general health) which is available in different languages.

Derby City Local Authority are linked to the East Midlands Migration group and the team manager attends the meetings. Any relevant information is distributed to the Designated Nurse for Looked after Children and shared with the Children in Care Team.

The Local Authority have employed a specific UASC team, in order to support the continuity and cultural compatibility.

The Children in Care team will use the Kent UASC Health website when required for UASC.

The Review Health Assessment pre-checklist has a section to prompt the nurses to confirm the ethnicity and to consider if care offered is culturally adapted and offers a culturally competent service

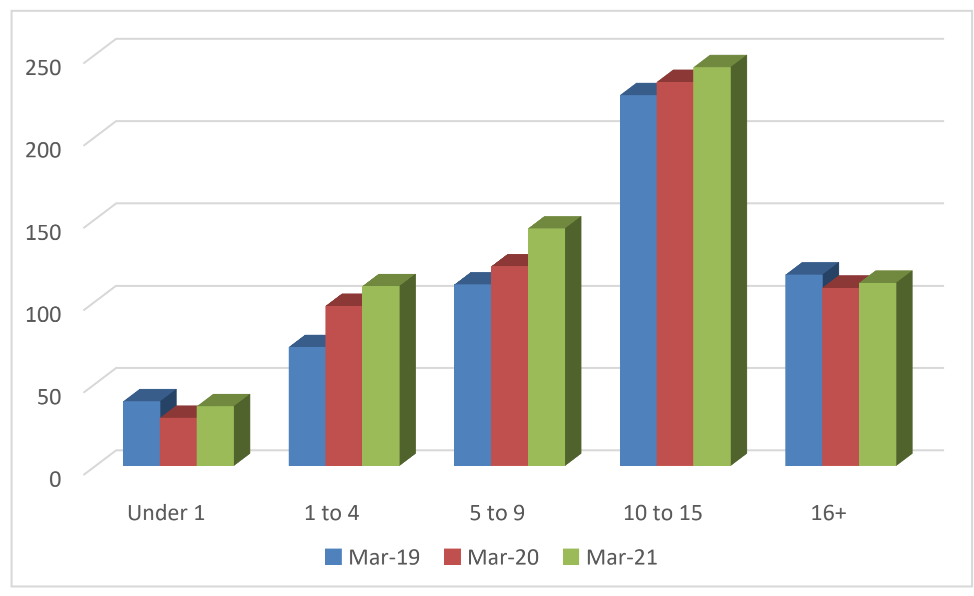
3.6 Gender of looked after children in March 2021

Gender	
Male	53%
Female	47%

Ref: Data made available from Derby City Local Authority Informatics Department

This data indicates that the gender split has narrowed compared to a year ago when we had 54% male and 46% female.

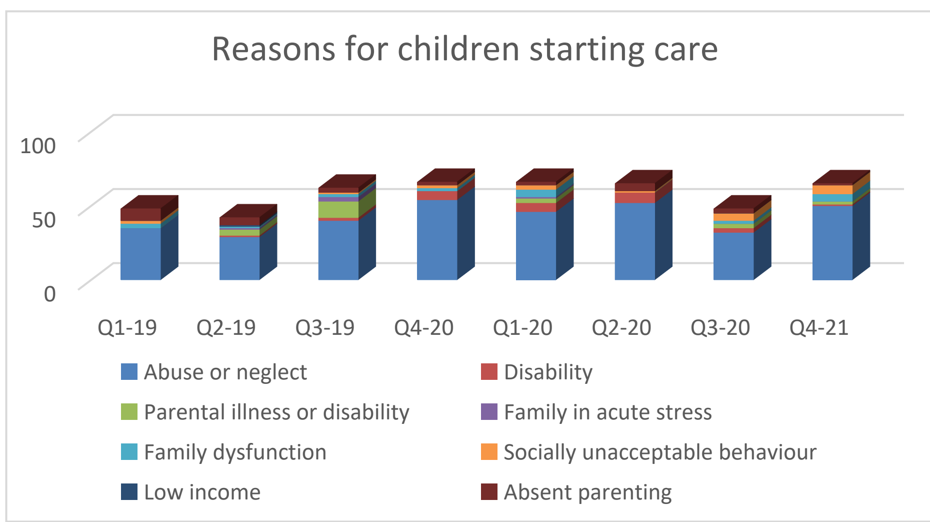
3.7 Age comparisons over the last three years:



Ref: Data made available from Derby City Local Authority Informatics Department

In comparing the data for the past three years, the 10 to 15-year-old age group consistently remain the highest number of children/young people coming into care. It is difficult to determine the definitive reasons for this but it may be linked to the increase in socially unacceptable behaviour, abuse/neglect, acute stress within the family home vocalised by children/young people and family dysfunction identified as a reason for coming into care. There is a slight decrease in the number of 16+ age group, this may be due to the decrease in unaccompanied asylum seeking children (UASC) over the past two years. There is an increase in all other age groups which reflects the increase in numbers of children entering care during 2020/21.

3.8 Reasons for children coming into care – comparison per quarter over the last two years:

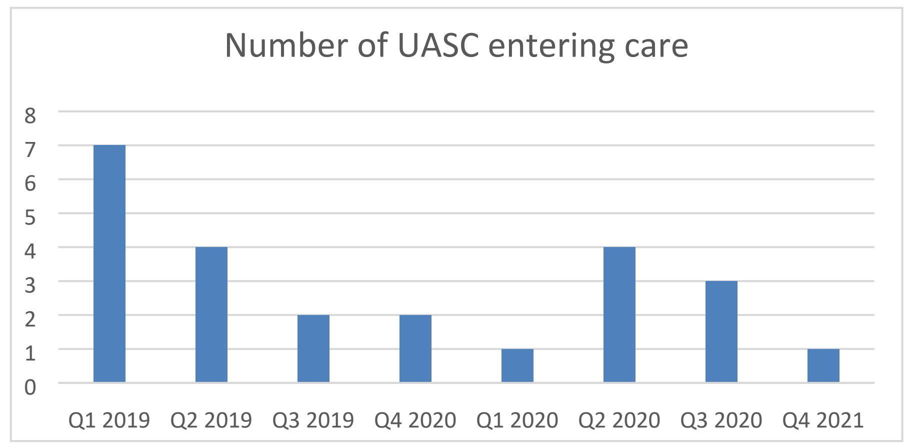


Ref: Data made available from Derby City Local Authority Informatics Department

Abuse or neglect remains the most dominant reason for children/young people coming into care, with the percentages remaining relatively stable in reason categories reflected in the above data. At the start of 2020 there was an increase in children coming into care due to Child Disability, this decreased towards the end of 2020/21. There has been an increase in children entering care due to Socially Unacceptable Behaviour. On average we have two new entrants into care, per quarter, due to Socially Unacceptable Behaviour. Some of the reasons are due to Anti-Social Behaviour / Offending, Disorderly / Risk Taking Behaviour and Violence by child towards parent/carer.

3.9 Unaccompanied Asylum Seeker Children 2020/21

Derby City Local Authority have developed a new team to support Unaccompanied Asylum Seeking Children. When the local dispersal centre opened in 2018 there was an increase of Unaccompanied Asylum Seeking Children coming into care, however the numbers slowed down during the latter part of 2019/20 and have continued to stay low during 2020/21 as shown in the table below.



Ref: Data made available from Derby City Local Authority Informatics Department

Section 4: DHcFT service provision for Looked after Children

4.1 The DHcFT Children in Care health team have core competencies, specialist skills, knowledge and attitudes to act as advocates, undertake health assessments, identify and manage health needs and provide support/training to Foster Carers and Children's homes (in line with the Intercollegiate Role Framework, RCN, RCGP, 2020). The team also contribute to health care plans for all looked after children including children with special educational needs and/or disabilities.

4.2 The team continue to improve their offer for Children in Care by including; the delivery of health promotion to children and young people, support for care leavers, development of a robust system to collate health histories for care leavers, improved identification of risk of child exploitation (including boys/young men) and provision for children who have special needs and/or disability.

4.3 The staffing levels for the health team at the end of the financial year (March 2020) were as follows:

Designation	Hours	WTE
Designated Doctor	4 hours (1 session)	
Designated Nurse (SDCCG)	37.5 hours	1 (From May 2017)
Named Nurse	30 hours	0.8
Specialist Nurse	14 hours	0.37
Specialist Nurse	22.5 hours	0.6
Specialist Nurse	32 hours	0.85
Specialist Nurse	26 hours	0.7

Section 5: Children in Care and Adoption Administrators

5.1 The Children in Care administrative team consists of an Administrator Coordinator (Band 4) and two Administrators (two at Band 3). During August 2020 to March 2021 one of the Children in Care Administrator roles was a vacancy due to the previous Administrator leaving the service. A successful candidate was appointed in March 2021.

5.2 The purpose of all three roles is to provide a comprehensive administrative support service to the Children in Care Health team, ensuring that all administration needs are fully met and that the administrative processes and procedures run smoothly. Responding and making decisions where necessary and follow up any actions from health professionals from local and external areas with confidentiality, discretion and diplomacy due to the sensitive information being shared regarding these vulnerable children.

5.3 During the COVID-19-19 pandemic the administration team have continued to work incredibly hard whilst still trying to make improvements to the way they work and ensure robust administration systems and processors are in place. The Admin Co-ordinator has worked hard to maintain an oversight of compliance and has highlighted any issues or challenges to both the Operational Lead and Clinical Lead. The Admin Co-ordinator, Named Nurse and Operational Lead have weekly compliance meetings to discuss any concerns (Consent issues, Initial health assessment compliance, Review health assessments, Local authority responses). We have improved the initial health assessment consent form allowing for verbal consent to be obtained by the social worker. This has helped to support the timeliness for consent ensuring compliance is met. The Admin Co-ordinator has created a new process whereby the Administrators are allocated work on a weekly basis, this allows the Co-Ordinator to have an improved overview on workload/compliance within the team, and report on this. The Team Administrators have dedicated time to ensure 'Groups and Relationships' within the patients electronic record are kept up to date.

Section 6: COVID-19 Pandemic

6.1 During the period of 2020/21 there was a pandemic which resulted in several lockdowns. The COVID-19-19 Pandemic resulted in changes to the way we delivered the statutory service, ensuring service users and practitioners were kept safe. At the start of the first lockdown in March 2020 the Designated Nurse LAC and the Designated Doctor LAC developed flowcharts for undertaking Initial Health Assessments and Review Health Assessments to ensure the service continued to be delivered to a high standard and to maintain compliance with statutory requirements.

6.2 During Quarter 2 the team started to undertake some face to face initial health assessments, in a COVID-19 secure health centre, using PPE as per Trust guidance, as part of the step-up plan. As shown in the table below throughout the remainder of 2020-21 the doctors continued to offer a variety of face to face and virtual appointments

	Quarter 1 Apr - Jun 2020	Quarter 2 Jul - Sep 2020	Quarter 3 Oct - Dec 2020	Quarter 4 Jan – Mar 2021
Total	60	78	50	46
Face to Face (including OOA)	0	24	20	35
Telephone (including OOA)	60	54	30	11

6.3 During Quarter 4 the team started to undertake some face to face review health assessments, in a COVID-19 secure health centre, using PPE as per Trust guidance, as part of the step-up plan. A benchmark was agreed between the Named Nurse, Operational Lead and Designated Nurse for LAC as a guide for the Children in Care Nurses to follow when looking at offering a face to face appointment. Restoration is underway and flexed to the needs of the child/young person, depending on individual choice and to capture those out of area when waiting lists are long or the out of area provider is able to complete the Review Health Assessment within a timely manner.

6.4 Foster carer sessions were on hold and resumed in April 2021. The Designated Nurse LAC and the Named Nurse CiC held a virtual session for foster carers in April 2021 on mindfulness. This session received positive feedback from the foster carers. It was felt that the session was supportive and was welcomed by the foster carers following on from the COVID-19-19 pandemic.

6.5 The health history booklet and process has been improved in partnership with the Provider, Local Authority, leaving care teams (recommended in Ofsted inspection). The Designated Nurse for Looked after Children secured funding in 2018/19 to purchase Health History folders which will follow the child/young person through their time whilst in care. Throughout 2019/20 the Designated Nurse Looked after Children has worked closely with publishers to develop the Health History folders and with the Named Nurse for Children in Care in planning to roll these out in 2020/21. Due to the COVID-19-19 Pandemic the roll out of the Health Passports was delayed until June 2021.

Section 7: Health Data and Performance for year 2020/21

7.1 Health data and Local Authority performance is a mandated submission to the Department for Education on a yearly basis and the table below summarises the performance over the last three years:

*please note all health data for 2020/21 is provisional until submitted to the Department for Education in July 2021

Health Data Indicator	2018/19	2019/20	2020/21
Annual health assessments	96.1%	93.5%	93.8%
Dental checks	91.4%	92.3%	29.2%
Immunisations up to date	92.8%	92.1%	93.1%
Development checks (two RHAs in the 12 months for under 5 years old)	91.9%	90.2%	96.6%

NB: the data is only mandatory for those children/young people in care for a period of 12 months or more

7.2 **Annual Health Assessments** – Derby's completion rate of annual health assessments has increased from 93.5% in 2019-20 to 93.8% in 2020-21, an increase of 0.3 percentage points. The 2020-21 percentage is the second highest percentage that has been achieved in Derby over the past seven years. The 2020-21 percentage is higher than the 2019-20 national, comparator authority average and the East Midlands average.

Dental Checks - Derby's completion rate of dental checks has decreased significantly during 2020-21. This is due to most dental practices being closed for routine check-ups during the COVID-19-19 pandemic. 29.2% of children in care had a routine dental check during 2020-21. This is a decrease from 92.3% in 2019-20. It is worth noting that children were able to access dental care for emergency care eg: pain, severe issues, broken teeth

etc throughout the COVID-19-19 pandemic. Routine dental care is now in a restoration phase and children are now able to access routine care.

Immunisations - Derby's completion rate of immunisations has increased from 92.1% in 2019-20 to 93.1% in 2020-21, an increase of 1.0 percentage points. Derby's 2020-21 performance remains higher than the 2019-20 national comparator and East Midlands averages for the seventh year running.

Development Checks - Derby's completion rate of development assessments has increased to its highest performance seen in Derby over the past seven years. 96.6% of children in care had up to date Health Development Checks in 2020-21. This is an increase from 90.2% seen in 2019-20. Derby is above the 2019-20 national and comparator authority average. The Children in Care Nurses worked exceptionally hard to capture some of the development assessments for children placed out of area at a distance during the COVID-19 Pandemic due to out of area providers struggling to undertake these within timescales.

7.3 Since the Children in Care team have access and the mechanism to update Liquid Logic (Local Authority IT system), the accuracy of heath data has significantly improved. The Named Nurse for Children in care and the Designated Nurse for Looked after Children meet on a quarterly basis to ensure all the correct information is recorded and any outstanding information is passed onto the Children in Care Nurses and admin to chase.

Section 8: Summary of achievements in year 2020/21

8.1 During the period of 2020/21 the Children in Care health team have continued to experience some changes and it has been acknowledged despite this the Specialist Nurses, Medical Advisors and Administration Team have shown innovation and marked improvements within their service delivery.

The following are an indication of the progress made and not an exhaustive list of achievements:

8.2 During quarter 3 and 4 the Administrative Coordinator and Named Nurse have worked internally with the provider to continue working with the Initial Health Assessment Pathway. These changes have resulted in more efficient working, improved compliance with initial health assessment statutory timescales and improved service delivery across administration and clinical areas.

8.3 Completion of the CCG ‘Markers of Good Practice’ assurance framework in quarter 4 (detailed in section 9, page 15).

8.4 The end of year Health Performance Data was positive as shown in section 7 considering the challenging year due to the pandemic.

8.5 The Named Nurse for Children in Care and the Service Lead for Children in Care Derbyshire have worked closely during 2020/21 to improve and standardise pathways and processes to work towards Joined up Care Derbyshire.

8.6 Action learning sets facilitated have continued within the service. Due to the pandemic these have been delivered virtually. Sessions have focussed on the strategy meetings process and completion of the health exchange form and the missing from known address process.

8.8 The Designated Nurse, Designated Doctor, Named Nurse and the Administrator Coordinator have continued to strengthen existing relationships and networks with key professionals, local partners and agencies locally and regionally, which has facilitated information sharing, health outcomes and the voice of the child (including those out of area).

8.9 Health access to Liquid Logic Child Social Care system has been established, which has been proven to improve information sharing between agencies (in the best interest of looked after children) and had a positive impact on the accuracy and validity of health data reportable to Department for Education. At the end of each quarter health information is uploaded onto Liquid Logic and any missing information is followed up by the Children in Care Team.

8.10 Reporting and assurance into the Derby and Derbyshire Clinical Commissioning Group (DDCCG) Quality and Performance Committee have been strengthened via quarterly reporting of performance and quality of the Children in Care service. This has allowed the Named Nurse for Children in Care the opportunity to access and interrogate health data more robustly internally within the Trust, using relevant and useful reporting systems. This in-depth provision of evidence has enabled a more robust way of working at both team and service level and influenced improvements.

8.11 Health performance although provisional until submitted in July 2020 continues to remain high despite the COVID-19 pandemic. Due to dental practices being closed and not offering routine appointments there was a huge impact on the dental data for 2020/21.

8.12 Review of the service specification took place and agreed between provider and commissioner.

Section 9: Markers of Good Practice (MOGP)

9.1 In February 2021 the Children in Care team submitted the Markers of Good Practice action plan for 2020/21 instead of the full self-assessment tool for Children in Care within Derby City, this was a joint agreement due to the COVID-19 pandemic. The Markers of Practice Action Plan, which is 'RAG' rated, provides the Children in Care Team with a productive opportunity to showcase their service to the Clinical Commissioning Group and Designated Professionals.

9.2 With the submission of evidence and 'RAG' rating, the action plan supports the Children in Care team to highlight progress, any gaps or improvements that are required to assure the commissioners our service is working towards a 'gold standard' delivery and that the needs of the Children in Care are being met and identified in line with the statutory guidance.

9.3 Following the MOGP action plan submission, representatives from the Clinical Commissioning Group and Designated Professionals completed the feedback in written format due to the COVID-19 pandemic. A discussion was held between the commissioners

from DDCCG. Each standard was discussed, and it was confirmed whether or not the 'RAG' rating provided by the Provider was in line with that of the commissioners' assessment.

9.4 Strengths and challenges were identified, agreed by both parties and an action plan developed for the provider to work through within the year 2021/22 to achieve compliance in the areas that were not yet rated as green. The Markers of Good Practice action plan will be fed back to the Safeguarding Children's Committee by the Head of Safeguarding Children's Service and at the Safeguarding Operational Leads meeting held by the organisation by the Named Nurse Children in Care. The action plan will continually be discussed at the Safeguarding Operational Leads Meeting and with the Designated Nurse for Looked after Children.

9.5 The Clinical Commissioning Group have been assured that the Children in Care service provision is overall at a good standard and the Health Provider is working in partnership in all areas that have been identified as requiring further progression or improvement.

Section 10: Provider and Partnership Working

10.1 The Children in Care Team acknowledge the need to 'work together' with the Local Children Commissioners, Local Authority and CCG to fulfil the statutory requirements for Looked after Children.

10.2 The Children in Care Team cover the following cohorts:

BORN IN, LIVES IN – Looked after Children born in Derby City and reside within the City.

BORN IN, LIVES OUT (placed near home) – Looked after Children that were born in Derby City but reside within approximately 20 miles away from Derby City in another Local Authority area.

BORN IN, LIVES OUT (at a distance) – Looked after Children that were born in Derby City but reside in another Local Authority area over 20 miles away from Derby City.

BORN OUT, LIVES IN – Looked after Children that were born in another area outside of Derby City but reside in Derby City.

10.3 The Children in Care Team attend and contribute to the multi-agency enhanced case management meetings which take place every six weeks. These are professional meetings held to discuss young people placed in residential children's homes. The purpose of these meetings is to share relevant and proportionate information, to identify any risks, look at what is working well, things professionals are concerned about and any relevant actions.

10.4 The Named Nurse and Head of Direct Services and Children's Residential Care have worked together to set up health meetings between the residential children's homes managers and the link nurses for each home to discuss health for young people residing at Local Authority Residential Children's Homes.

Section 11: Quality Assurance Processes

11.1 For quality assurance of the statutory Initial Health Assessments for Looked after Children, a monthly timeliness of Initial Health Assessment audit is completed by the DDCCG Designated Nurse LAC, with the intent of contemporaneous feedback to social care and the health team as to where in the process has had either a positive or negative impact on timeliness. Obtaining timely consent from parents by social care is being noted to be a key factor that does impact on subsequent timeliness for completion of the Initial Health Assessment as an appointment can only be undertaken when the consent for the statutory Initial Health Assessment is in place. Since November 2020 the Designated Nurse LAC has been undertaking a weekly report sent to the Local Authority and Children in Care to identify any issues with consent and any actions are highlighted.

11.2 In tandem with the monthly timeliness audit, the Designated Doctor LAC completes an annual audit of a random sample in Quarter 2/3 of 10 Looked after Children using the Initial Health Assessment quality checklist tool. Once key factors are identified within the audit that has had either a positive or negative impact, internal action plans are put into place for forward planning for the next financial year to ensure we able producing Initial Health Assessments of a good enough standard that reflects the needs of the individual Looked after Child.

Section 12: Analysis of Adoption and Medical Adviser Activity

This section has been compiled by Derby City medical adviser's Dr A Marudkar and Dr P Vundela, Children in Care and Adoption Team, Derby City.

This section of the report has been prepared based upon the information available from DHCFT data and data provided by the Local Authority regarding adoption related work

ADOPTION ACTIVITY

There have been some changes to the adoption activity during the Pandemic period from April 2020. These reflect the changes made nationally to the Adoption regulations by the Department of Health in liaison with Coram BAAF, to accommodate the unprecedented major changes in working patterns and the restricted capacity of the available medical workforce during the Pandemic, while still satisfying the requirements of Adoption regulations.

12.1 There are two medical advisers contributing to the Adoption work for Derby city. This includes attending the Adoption panels and preparing the reports for the children coming up for adoption panel. The Adult Health Reports are prepared separately by a GP specialist. One adoption panel per month is attended by either medical adviser in role of panel member, on an alternate monthly basis.

There have been some temporary changes to this practice as agreed by Adoption East Midlands (AEM) due to the limitations of physically attending the adoption panels as panel

members. The medical reports for the children to be matched are still provided in the usual manner and panel advice is still given, based upon the paperwork provided by AEM. There are stricter timescales to this new process due to the inherent issues of remote working and technology.

12.2 The Regionalised Adoption service (Adoption East Midlands) continues to work incorporating four neighbouring regions of Derby City, Derbyshire, Nottingham City and Nottinghamshire. The cases for matching the Derby City children continue to be heard at any of the panels within the region, attended by different medical advisers. An efficient and timely liaison between different medical advisers is needed to explore and clarify any issues in advance of panel, which may get affected by the capacity issues, requiring Medical advisers to be available all the time as queries may arise from any panel.

12.3 The following adoption activity data is provided by Adoption East Midlands (from 1 April 2020 to 31 March 2021)

- Number of Adoption panels having medical advice provided by Derby City Medical advisers - 11 (12 in 2019/20)
- Number of matching reports provided to AEM – 52 (27 in 2019/20)
- Number of Adult health reports completed by the GP Specialist – 93 (98 in 2019/20)

There has been a very significant increase in the numbers of matching reports provided for the year 2020/21 as compared to last year for Derby City, the number has almost doubled. This has made a significant impact on the medical adviser's capacity to provide these reports in a timely manner, further affected by unprecedented periods of absences during the pandemic and appointment of the new Medical Adviser during this period.

The number of adult health reports has further reduced slightly (by 5%), these figures have remained more or less stable over the last two years, indicating ongoing recruitment of adopters during the pandemic.

There were no prospective adopter consultations undertaken formally (by face to face or telephone) during this period, as the agreed regional process continued for prospective adopter consultations providing the preadoption advice in a targeted and formal way in writing. We continue to invite questions in writing from adopters via the social worker, which are responded to in writing, included on the report if possible, or separately if received later, also the report format is very comprehensive and includes any history and implications in detail. A telephonic consultation is only provided in selected cases to answer any specific queries which remain. This process commenced at the start of AEM in April 2019 and a significant reduction in this activity was already been noted in last year's annual report.

12.4 The training sessions by medical advisers for prospective adopters, foster carers and social workers were suspended during this period due to the pandemic pressures and restrictions, but they are being resumed with the training provided virtually. These training sessions are aimed to be delivered three times a year, incorporating training on common clinical issues in adoption scenario, i.e. Impact of maternal smoking, alcohol and drug misuse in pregnancy and Blood borne infection screening in vulnerable and high-risk children.

12.5 Both the medical advisers attend regular quarterly AEM meetings with other medical advisers and panel advisors (plus commissioners if appropriate). They also attend panel training days twice a year, although these were suspended during COVID-19 pandemic period.

12.6 The Named Doctor for Children in Care and the Named Nurse for Children in Care also deliver a training lecture on Children in Care and Adoption as part of the GP vocational training course in Derby.

Section 13: Voice of the Child

13.1 The voice of the child/young person is embedded in all aspects of the Children in Care service development and delivery. It is essential that children and young people are listened to and their views responded to in order to promote and respect the rights of children.

13.2 The voice of the child is obtained through a variety of mechanisms (dependent on their age, capacity, levels of understanding, analysis of non-verbal cues and body language):

- The child/young person is offered the opportunity where age appropriate to be seen alone
- At each appointment confidentiality is explained to the child or young person
- Identification in collaboration with the child/young person of their own strengths, wishes, feelings and their needs
- Use of the evaluation form after health assessments or any individual contact with a child or young person
- Clear documentation of the child's voice by using direct speech quotes or agreed summary of conversations.

13.3 As mentioned previously, due to the COVID-19 pandemic the Children in Care Nurses have worked hard to capture the voice of the child through virtual methods if the review health assessment has not been undertaken face to face.

Section 14: Strength and Difficulties Questionnaire (SDQ)

14.1 This questionnaire was introduced by the Department of Education's data collection for Looked after Children after 31 March 2008. This tool is an outcome measure that is used for tracking the emotional and behavioural difficulties of Looked after Children and Young People at a national level and its completion is a statutory requirement. The SDQ is a clinically validated behavioural screening questionnaire for use with 4 to 16-year olds.

14.2 Social Care has a statutory responsibility to send the questionnaire to carers and should be completed in time to support inform emotional health assessment element of the review health assessment and health care plan. The SDQ assists to inform the health professional's decisions about possible referrals to specialist mental health and psychological services. It is recognised as best practice to have sight of the completed SDQ at the point of the review health assessment, as this can aid evaluation of the child's emotional health and wellbeing.

14.3 The Local Authority, Designated Nurse and Named Nurse have continued to work together to strengthen the SDQ pathway in order to ensure a more robust process and increase the completion rate of the questionnaire. This process ensures that the SDQ score provided by the Local Authority was in line with the Review Health Assessment and supported the Specialist Nurse identifying any emotional or behavioural difficulties of the child/young person and assessing the impact of support provided (or if required). The SDQs are being completed in good time to enable this information to feed into other work, such as the health assessment.

14.4 All data shown below for 2020/21 is provisional until submitted to Department for Education in July;

Year	Percentage of completion rate	Average score (higher the score = higher need)
2016-2017	79%	16.3
2017-2018	93.6%	16.2
2018-2019	92.7%	14.8
2019-2020	92.5%	14.7
2020-2021	91.8%	15.0

Ref: Data made available from Derby City Local Authority Informatics Department

From the table above the overall completion rate for 2020/21 was 91.8% this is slightly lower than 2019/20, however The Department for Education requires a minimum completion rate of 75%. Derby achieved 91.8% which is well above the 75% target. The average score for 2020/21 was 15.0, although a slight increase from 2019/20, is a significant drop from 2017/18. This potentially indicates improved emotional health and wellbeing of children and young people in care.

Section 15: Special Educational Needs / Disability

15.1 All children in care who have a Special Educational Need or Disability (SEND) have a flag on their electronic records. All children in care who have an Educational, Health and Care Plan (EHCP) have a patient status alert on their electronic records.

15.2 Universal services also have the patient status alert for EHCP and the flag for SEND. For all children with an EHCP, the Trust has been informed via internal systems (in collaboration with Local Authority) and received a copy of the plan on the child's electronic records. Early identification of any learning concerns can be captured pre-school during Review Health Assessments for example; developmental delay, behavioural issues and school readiness. The graduated response is delivered where low-level intervention can be put in place with support before deciding to refer onto specialist services. The graduated response helps providers, specialist and mainstream provision to work together on achieving the best outcomes for children and young people. If the pre-school child does have a confirmed

diagnosis, we have a team of specialist health visitors who will support the child and their family as appropriate.

15.3 If a child or young person is born in Derby City and placed in Derby City or is born out of Derby City and placed in Derby City the responsibility of the EHCP lies with Derby City Local Authority. For children and young people who are born in Derby City and placed outside of Derby City the responsibility of the EHCP lies with the Local Authority where the child or young person is placed (see extract from the Code of practice below).

15.4 'A significant proportion of looked after children live with foster carers or in a children's home and attend schools in a different local authority area to the local authority that looks after them. Local Authorities who place looked after children in another authority need to be aware of that authority's Local Offer if the children have SEND. Where an assessment for an EHC plan has been triggered, the authority that carries out the assessment is determined by Section 24 of the Children and Families Act 2014. This means that the assessment must be carried out by the authority where the child lives (i.e. is ordinarily resident), which may not be the same as the authority that looks after the child. If a disagreement arises, the authority that looks after the child, will act as the 'corporate parent' in any disagreement resolution.' (Special educational needs and disability code of practice: 0 to 25 years (2015).

15.5 The Designated Nurse for Looked after Children continues to work closely with Derby City Local Authority and other Local Authorities to get a copy of all final Education, Health and Care Plans to be attached to the electronic records of all children in care. This has improved over the past few years so that the children in care team have a copy of the final EHCP attached to the electronic records.

15.6 The Children in Care Nurses complete Review Health Assessments (RHA) on all children and young people who are placed in care (by the health team depending on where the child is living). The Review Health Assessment follows on from the Initial Health Assessment for all children under 5yrs they have their RHA every 6 months and for those over 5yrs every year. The nurse carries out a holistic assessment recognising any health needs, a health care plan is developed and referrals on to appropriate specialist services. The plan is to get appropriate services involved early, supporting the child or young person to prevent the issue moving up to EHCP. This is known as the graduated response. The graduated response is monitored whilst the child or young person is in care through the Children in Care review meetings. This is a child focused meeting where the following topics are discussed;

- Care Plan
- Contact
- Placement
- Health
- Education

This is a multi-agency meeting where services in place are identified and achieved outcomes are discussed.

Section 16: Priorities for Year 2021/22

16.1 **DHcFT Provider key priorities for 2021/22:**

- To deliver health promotion within the Local Authority Residential Children's Homes focusing on Healthy Eating initially
- To continue to represent health at the Enhanced Case management Meetings and Health Meetings with the Local Authority Children's Residential Homes
- Continue with foster carer sessions
- To roll out and implement the use of the new health passports
- To continue to work closely with the County Children in Care Team working towards the Joined-up Care Derbyshire Approach
- To build relationships with the leaving care team to improve support around transition
- To continue to deliver quarterly action learning sets for all Children in Care Nurses in collaboration with the Designated Nurse for Looked after Children
- To build relationships with the Youth Offending Team
- To develop a training resource for foster carers and residential children care workers to use when supporting children and young people with sexual health.
- ICE system (Integrated Clinical Environment) – to allow access to the electronic pathology system to enable doctors to request Blood Born Virus tests and results electronically
- To submit the Markers of Good Practice Assurance Tool

16.2 These key priorities are an overview of some of the on-going work and strong commitment to improving the health and welfare of children in care. The vision continues to be that we ensure all children in care reach their natural potential through the interventions of competent, skilled, compassionate professionals and their drive to make a difference to this vulnerable group of children and young people.

Section 17: References

Keep on Caring: Supporting Young People from Care to Independence, June 2016, Department for Education

Promoting the health and well-being of looked-after children, March 2015, Department of Health and Department of Education

Looked after children: Knowledge, skills and competencies of health care staff, Intercollegiate Role Framework, December 2020, Royal College of Paediatrics and Child Health

Stats: looked after children, Department for Education, 2017

https://www.gov.uk/government/collections/statistics-looked-after-children

The Corporate Parenting Strategy 2019-2021, Derby City Council

Legislation

- Children Act 1989
- Children and Social Work Act 2017
- Adoption and Children Act (2002, 2010, 2013)
- Children and Young People's Act (2008)
- Children and Families Act (2014)
- The Children and Social Work Act (2017)

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 2 November 2021

Infection Prevention and Control Annual Report 2020/21

Purpose of Report

This paper summarises the activity over the preceding 12 months of work related to infection control.

Executive Summary

- We continue to provide a consistent high level of performance against infection control standards and related management activities.
- Our number of reported cases of key alert organisms is very low.
- During the pandemic we have seen a limited number of outbreaks, compared to other mental health organisations we believe this is a result of a combination of measures taken at the start of and during the pandemic.
- Benchmarked against other organisations we have seen very little service disruption and have taken proactive steps to ensure Infection Prevention and Control (IPC) measures and containment have been balanced with the wider risks of disrupted service and inaccessibility to beds.
- Inspection of clinical areas has been maintained and essential works have been maintained using IPC and COVID-19 secure measures to ensure safety.
- COVID-19 incidents have been well managed, and the Trust has robust measures in place to assure the incidents are managed and contained with minimal disruption to services.
- The Trust has taken decisive actions when required to ensure patient safety is preserved, including the rapid stand up of Audrey House to provide a 'fire break' when cases were rising across both Acute In-Patient units and jeopardising safe access to beds.
- The Teams have worked with NHS England (NHSE) and Public Health England (PHE) to ensure that learning and challenge and scrutiny can be provide and assured against. This has resulted in a positive approach to learning lessons and communication.
- The Director of Infection Prevention Control has continued to support and maintain an enhanced cleaning programme. The hotel service staff have been exemplary in this undertaking.
- We have maintained our five star rating for kitchen cleanliness awarded by the local authority.
- The Trust is contributing to local learning and has developed new systems and processes to ensure IPC standards and COVID secure guidelines are adhered to for the safety of all of our service users and colleagues.
- The Board can be assured that our compliance with standards has had oversight from our regulators during the inspection visit in 2019, and subsequent visits since the onset of COVID-19. We have received positive feedback on our approach and culture to staff support and our oversight of outbreaks by NHS England.

- The resilience of staff remains our key priority and as such we are working toward our highest ever compliance figure for Flu.
- The potential impact of further resurgence of the pandemic outbreak is a key risk and safety of service receivers and colleagues remains our highest priority.
- Additional investment in infection prevention control approaches and equipment remains a priority for 2020/21.

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

Risks and Assurances

- We have reviewed the current audit programme against National infection control guidance and it is contemporaneous and compliant.
- There are evidently robust cleanliness measures in place.
- There continues to be robust oversight of infection control incidents or outbreaks.
- All infection control policies are in date and have been reviewed to ensure they are compliant with current COVID guidance.

Consultation

- This paper provides the annual update since September 2020 to present.
- Discussed and scrutinised by the Quality and Safeguarding Committee on 12 October 2021. Significant assurance was confirmed and the report was approved for submission to the Trust's Board of Directors on 2 November.

Governance or Legal Issues

- This paper provides update on regulatory aspects – identifying compliance with standards which may form part of a CQC inspection or enquiry. These would include patient safety, leadership, responsiveness and effectiveness. Standards are set in the Healthcare Associated Infections Code of Practice for Infection Prevention and Control 2015.
- There are both governance and contractual element to the emergency preparedness planning and work.

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. The report is not felt to have a negative impact on any persons with protected characteristics. The learning and evidence base regarding the disproportionate impact upon some communities related to COVID-19 is emerging. DHCFT have incorporated learning where possible and remain open to improving approaches to improve outcomes for those who access our services and colleagues who provide them.
2. There has been significant learning and understanding garnered from the UIPC work and vaccination programmes. Local evidence has highlighted that people who experience health inequalities require additional and focussed support either directly from healthcare providers or amongst the resources within key groups in the local community. DHCFT are part of the vaccine inequalities group and working with other agencies and community support services to reduce these barriers.
3. Key stakeholder groups have been formed to contribute towards and review emerging evidence.
4. The Infection Prevention and Control team are grateful for the support of colleagues across the trust to identify ways our approach can be improved and embrace any learning which contributes to better outcomes and learning.

Recommendations

The Board of Directors is requested to:

1) Note the reporting of key areas, such as surveillance of healthcare associated infections – alert organisms, outbreaks of infection, staff training.
2) Receive significant assurance that approaches and learning are evolving in accordance with emerging evidence and international / national and regional learning
3) Receive significant assurance on standards of cleanliness of clinical areas and food preparation areas.

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

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

Infection Prevention and Control Annual Report – 2020/21

Report prepared by Richard Morrow Assistant Director of Public and Physical Health (lead for Infection Prevention and Control), on behalf of Carolyn Green – Director of Nursing and Patient Experience and Director for Infection Prevention and Control.

1.0 Introduction

1.1 2020/21 has been a challenging year across health care providers due to the ongoing impact of COVID-19. This report summarises the approaches to Infection Prevention Control at Derbyshire Healthcare NHS Foundation Trust (DHCFT).

1.2 Preventing the spread of infection remains a key focus in healthcare, with a statutory requirement to fulfil mandated standards for all healthcare providers. The Health and Social Care Act 2008 enabled a code of practice to be established with standards which are overseen by the Care Quality Commission (CQC).

1.3 The Code of Practice: Prevention and Control of Healthcare Associated Infections (2015) provides the framework for the standards we are required to achieve, and this report will detail the actions and on-going work which underpins the achievement of this. The regulation of this activity falls as part of the inspection programme undertaken by the CQC. Infection Prevention and Control considerations are part of the ongoing framework of improvements undertaken by the organisation. The table outlines the key elements of the guidance and the work undertaken by the Trust;

Health and Social Care Act 2012 Standards	
Systems in place 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 that their environment and other users may pose to them.	• PHCIC Executive Committee has remained during COVID-19 pandemic as an essential meeting. • Review and update of local policies and inclusion of revised and updated national guidance. • Regular incident reviews through SI and DATIX flags. • Tissue viability and infection control support network (internal champions, and link to regional and national networks). • Annual training updates and policy and procedure updates. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.
Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.	• PLACE annual reviews, regular walk arounds - cleanliness / estates checks. • Implementation for new national Cleaning standards and cleanliness ratings to be displayed for each ward. • Supportive and responsive estates and facilities teams.
Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.	• Updated guidance reviewed when circulated and policies adjusted. Focus on CPE for 2019 alongside increased vigilance against hospital acquired infections. • Annual audit plan and oversight of antibiotic stewardship.
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.	• Updated and accessible policies are available through updated trust intranet and internet site. • Infection control link nurses and support nurse to discuss / assess and liaise with colleagues to provide advice and support for techniques, interventions and unusual or unclear presentations. • Support to develop management plans to compliment care planning around the holistic needs of service receivers.
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.	• VTE assessments are carried out as an assessment baseline when people come into our in-patient services. • Prophylactic prescribing is in place to ensure that risks are mitigated where possible. • EPR enables alerts to be flagged for conditions where transmission or susceptibility is identified on a medium- or long-term basis. • Liaise with CCG, Public Health England and NHSE/I to ensure national or regional concerns are responded to appropriately.
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.	• DHCFT has updated and reviewed policies and procedures. • Al colleagues have access to PPE and hand cleaning products. • Blended model of e-learning and face to face training. • Post incident analysis and shared learning following infection control incidents. • Signage displayed in high traffic and vulnerable areas.
Provide or secure adequate isolation facilities.	• Individual rooms available with bathroom facilities when required. • Cohort Nursing facilities available as required.
Secure adequate access to laboratory support as appropriate.	• PHE and regional IPCSAG support available. • National network and support system linked in to NHSI / E available,
Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.	• Individual management plans using physical health management tool guidance are in place. • Monitoring of updates to infection control guidance and to IPC BAF. • Identifying new products and approaches to limit the spread of infection.
Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection.	• DHCFT have an established relationship with Occupational Health provision locally using an evolved health • Swift access to assessment and advice is available. • Feedback to managers and colleagues is provided to ensure swift resolution to concerns and adjustments can be made,

1.4 Preventing the spread of infection is an integral aspect of both patient safety and patient experience, providing assurance and a visible marker of standards and the quality of care service users should expect to receive. DHCFT is proud of the high standards we continue to achieve and the comparatively low rates of infection we see.

1.5 As learning and guidance has been developed during the COVID-19 pandemic we are beginning to see changes to monitoring frameworks and greater attention paid to communicable infections, In addition the this work there remains a significant focus upon the management of disease where increasing anti-biotic resistance is flagged as a containment and treatment risk.

1.6 National guidance COVID-19: guidance for maintaining services within health and social care settings – Infection prevention and Control recommendations was released in January 2020. This guidance has been through multiple iterations and there is a specific it is anticipated that a revised version which covers respiratory illnesses is due for release imminently.

1.7 A specific version of the COVID 18 IPC guidelines was released earlier this year following Consultation with national mental health and learning disability leads. This guidance clarifies the interpretation of pathways and suggested mitigations for the challenges encountered within Mental health and Learning disability settings, where isolation and limited movement are compromised and can contribute to restrictive practice. Key mitigations recommended are;

1. **increasing cleaning** – DHCFT have had enhanced the domestic services team, cleaning rounds and extent and coverage of Antichlor usage.
2. **use of personal protective equipment** – DHCFT have ensured that adequate stocks of PPE and support for staff to use it correctly have been in place since the start of the pandemic. In addition, we also have posters, and regular communications to promote ongoing use.
3. **hand hygiene** - Access to hand washing and hand sanitisation products is a priority and this is regularly promoted. The trust uses lightboxes to enable teams to check their hand hygiene technique is effective.
4. **physical distancing** – Limiting footfall and non-essential movement around team bases and clinical areas has been a clear focus. There is clear signage and markers to enable people to check they socially distanced in accordance with current IPC and COVID secure guidelines.

1.8 In addition to these measures the trust moved clinical staff into uniforms and scrubs at the start of the Pandemic. It is believed that this conscious switch into uniform has helped clinical staff differentiate between work and home / personal life and raised the professional standards associated with IPC. The trust and communications team have proactively encouraged people to take time off if they are unwell particularly as atypical of non-symptomatic spread is key feature of SARS transmission.

1.9 The trust has seen comparatively low transmission rates compared to other organisations. It is felt to be the compound effect of these measures alongside a clear and structured Incident Management Team approach to communication that has enabled this.

2.0 National context

2.1 The term HCAI covers a wide range of infections. The most well-known include those caused by methicillin-resistant *Staphylococcus aureus* (MRSA), methicillin-sensitive *Staphylococcus aureus* (MSSA), *Clostroides difficile* (C. diff) and *Escherichia coli (E. coli)*. HCAIs cover any infection contracted:

• as a direct result of treatment in, or contact with, a health or social care setting

• as a direct result of healthcare delivery in the community

• as a result of an infection originally acquired outside a healthcare setting (for example, in the community) and brought into a healthcare setting by patients, staff or visitors and transmitted to others within that setting (for example, norovirus).

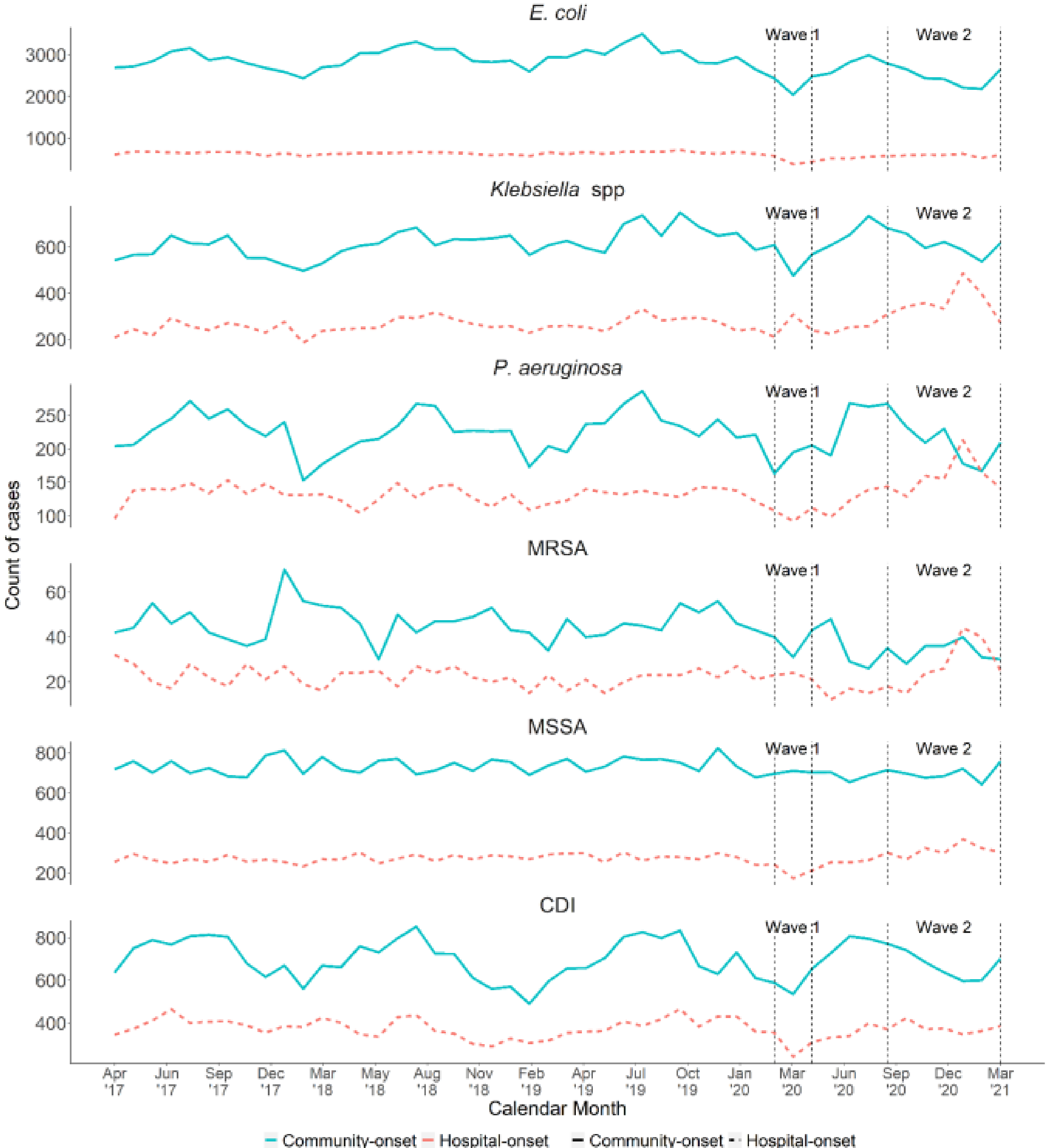
HCAIs pose a serious risk to patients, clients, staff and visitors to health and social care premises. They can incur significant costs for the NHS and others and cause significant morbidity and mortality for those infected.

2.2 Over recent years, through sustained progress against challenging expectations, the rates of healthcare associated infection reported nationally have continued to fall, however between April 2020 and March 2021 there was a slight rise hospital onset methicillin-resistant Staphylococcus aureus (MRSA). In contrast the rates for methicillin-sensitive *Staphylococcus aureus* (MSSA) and *Escherichia coli (E. coli)* have reduced for the first time (source - Annual epidemiological commentary: Gram-negative bacteraemia, MRSA bacteraemia, MSSA bacteraemia and C. difficile infections; gov.uk) DHCFT have very low incidences of these infections and this remains the case with no statistically relevant shift in infection rates.

Cleanliness in healthcare facilities remains a high priority, with the well-established links between poor environmental standards and rates of infection. The emphasis on the speciality and related work is now much more proactive, rather than reacting to events after the fact. This has seen a considerable focus now on ‘zero tolerance’ of healthcare associated infections, with healthcare associated infection now being largely preventable. There is ongoing focus by NHS England on pandemic influenza preparedness and the expected IPC guidelines due out late October 2021 will be focussed on respiratory illness assessment, monitoring and pandemic preparedness.

Statistically overall case numbers are falling however it should be borne in mind that during the pandemic the activity in Hospitals was atypical and attendances fluctuated significantly during the phases of the pandemic. Further research to understand the impact of staff and public behaviours, PPE usage, comorbid infection, increased length of stay for post COVID recovery etc and the association with infection rates is currently being explored. The following table provides the statistical fluctuations over recent years;

Monthly Counts of Gram- negative and S.Aureus bacteraemis, and C.diifficle infections in England, April 2017 to March 2021 (source Annual epidemiological commentary: Gram-negative bacteraemia, MRSA bacteraemia, MSSA bacteraemia and C. difficile infections– Gov.uk)



Recent focus on the impact of healthcare associated infection has now shifted somewhat from MRSA bacteraemia and *Clostroides difficile* to looking now at other emergent resistant organisms such as *Escherichia coli,* and the significant impact the communicable conditions such as Norovirus have on delivering health care.

3.0 Structures within Derbyshire Healthcare NHS Foundation Trust

3.1 The Chief Executive holds the responsibility for overall standards; however, the Trust is required to designate a Director lead for Infection Prevention and Control (DIPC), this is undertaken by the Director of Nursing and Patient Experience.

3.2 The Assistant Director of Public and Physical Health is responsible for the day to day delivery of the plan of work and ensuring this meets the required standards. This role is both strategic and involved in delivery of training, clinical advice and planning.

3.3 Since September 2013, an Infection Control Support Nurse (currently 0.6 wte, increased hours from last year) has been in post to assist the Assistant Director of Public and Physical Health in the delivery of clinical support, advice, training and audit of standards.

3.4 The Trust has recruited a dedicated Health Protection Unit team to ensure that the vaccination programmes: track and trace follow up, infection incidence monitoring and advise and additional Infection Prevention and Control support alongside this team is made up of 1 band 7 w.t.e clinical lead, 3.6 w.t.e band 5 colleagues.

3.5 The Head of Estates and Facilities oversees the maintenance, cleanliness and support services which are vital aspect of meeting high standards.

3.6 The programme of work has been previously devised and delivered by the Physical Health and Infection Control Committee (PHCIC), which formed a key component of the Governance structure. This committee has been reporting via the Divisional Clinical Operational Assurance Teams (COAT) as required.

3.7 The Physical Health and Infection Control Committee (PHCIC) group link to the divisional Clinical Operational Assurance Team (COAT) meetings and will feed into the meeting structures being established as part of the re-establishment of the Trust's governance framework.

3.8 In addition to this the meeting has support and oversight from an executive committee formed to support the delivery of the wide-reaching agenda of the Physical health Care and Infection Control Committee (PHCIC). This meets bi-monthly as an adjunct to the main clinical PHCIC meeting.

3.9 An annual report detailing the work of the Infection Control Team and the PHCIC is submitted to the Quality and Safeguarding Committee as part of the trusts oversight and governance approach.

4.0 Key achievements of 2020/21

4.1 Continued investment in the capital programme has seen sustained improvement in the care environment in several locations, through a dedicated capital expenditure allocation for Infection Control in 2020/21.

- Replacement furniture and flooring within the inpatient units as part of a rolling programme of upgrade and improvement, furniture upgraded to ensure cleanliness requirements could be met as part of pandemic response.

- Furniture and equipment have been provided for newly established physical health monitoring clinics in Community.
- Flooring and fittings upgrades have taken place in the PFI sites on Kingsway site to facilitate mover to Tissington house from Ward1.
- Physical health monitoring equipment from Oxehealth has been installed and is in use; currently exploring business case to extend the coverage within existing estate at Kingsway and prospective new builds.
- Radbourne and Hartington Unit have had furniture replaced and the bed replacement programme across both units is nearing completion.
- Audrey House has had some work undertaken to improve the facility in case of need to open at short notice as 'fire-break' or overspill capacity.
- Implementation of SEPSIS policy and coalition with regional SEPSIS best practice implementation group.

4.2 Continued delivery of training programmes for clinical and support staff who are identified as requiring the training. Training sessions are largely delivered as either 'face to face via Micro Soft teams' taught session, via the 'block' training methodology; there is an e-learning option for staff to access. This year we have included some additional information which specifically talks through Water born Pathogen and the methods employed by the trust to manage these risks, namely temperature control and chemical dosing. This is being actively promoted as the trust attempts to ensure that training is delivered in a manner which maintains the capacity for people to socially distance and reduce any transmission spread related to COVID-19 secure guidelines.

4.3 Since September 2020 we have had several COVID-19 Outbreaks, (see table below). We had no seasonal Flu Outbreaks or Nora Virus outbreak last year; tests for these were carried out in several settings. The clinical presentation of COVID-19 is varied, and the list of likely symptoms has changed as new variants have emerged giving rise to clinical overshadowing for various illnesses.

Clinical Team	Date	Patients affected	Staff affected	Comments
Cherry Tree Close	22/09/2021	0	2 0 in response to the Outbreak a significant number of staff were tested.	Initial outbreak identified between night workers.
Kedleston unit	02/10/2021	1 – likely Hospital Acquired Infection following time spent at acute	1 – linked to household contact of staff member at Cherry tree Close.	Extensive testing and liaison between DHCFT and UHDB – case numbers very high locally.
Radbourne unit catering department	20/10/2021	1 - confirmed 2nd staff member suspected, later confirmed as other illness.	0	Staff members isolating and all staff supported to access a COVID test. Contingency plan to deliver food from Kingsway enacted.
Ward 1 London Road Community Hospital	26/10/2021	2 – supported transfer to RDH	3 – (all attended RDH)	Staff and patient transmission identified as likely separate routes. Significant testing initiated and bank staff identified who had worked

Clinical Team	Date	Patients affected	Staff affected	Comments
				across other areas. Staff bank bubble plan enacted.
County South CRHT	02/11/2021	2 staff confirmed	1 patient confirmed.	Potential contact between staff members and community patient who later tested COVID positive. Staff isolation and enhanced testing enacted.
Radbourne Unit Enhanced care ward	08/11/2021	3 staff	1 patient	Staff bubbles reviewee and recognition that staff house sharing and travelling to work together was a potential challenge.
Radbourne unit Ward 36 /Medical staffing meeting	11/12/2021	17 staff	4 patients	Significant impact on medical staffing following two meetings where there were some identified breaches in social distancing and PPE compliance. High acuity and patient movement (transfers from acute hospital). Ward closed.
DRRT and Cubley Court	30/12/2021	13 staff	4 patients	Initial outbreak detected amongst Older Adult DRRT and then subsequent staff and patient cases in Cubley Court. Office moves and Christmas team meeting (PPE compliance, social distancing) linked to outbreak.
Morton ward – Hartington unit	22/01/2021	2 staff	4 patents	Admission ward with high activity, likely transmission route linked to transfers from local Acute hospital of patients with high acuity and unable to adhere to COVID guidelines.
Ward 36 - Radbourne Unit	17/02/2021	3 patents	0 staff	Transfers from RDH (very high COVID activity and acuity).
Radbourne Unit	22/02/2021	7 patients	6 staff	Increasing case numbers and significant challenges to isolate affected individuals. Significant risks as multiple cases meant that admission capacity was limited, creating associated risks for community patients needing admission.
Hartington Unit	22/02/2021	6 patients	0 staff	Increasing cases across admission wards – Unit Outbreak called at the same time as Radbourne Unit due to impact on clinical services and to reduce management burden of multiple outbreaks and enable clinicians to focus upon necessary interventions.
Audrey House – opened to provide fire break.	26/02/2021			Audrey House enabled cohorting of female patients with COVID to enable the management of isolation and support requirements.
Cubley Court – Kingsway site	25/08/2021	1 staff member	1 patient	Likely HCAI as patient had not been anywhere away from ward. PPE and IPC compliance revisited and refreshed.

Clinical Team	Date	Patients affected	Staff affected	Comments
Morton Ward – Hartington Unit	27/08/2021	3 staff members	0 patients	Possible outbreak identified from Health Protection Unit review; PPE breach identified in ward office.

4.4 Useful interventions

- Review of PPE and IPC compliance
- Deploy lightbox
- Review cleaning schedules and roster cover / access to deep cleans
- Close wo admissions until extent of impact has been established
- Liaise with PHE and CCG regarding ward closure status and seek advice
- Share any learning with Communications team for immediate dissemination
- Ensure staff well-being plan is enacted.

4.5 Learning from incidents

- PPE compliance, particularly in meetings is crucial
- Limiting spread through cleaning of equipment in between use and consciously cleaning after use
- Maintain social distance and awareness that high risk areas are ward offices etc.
- COVID is opportunistic and indiscriminate
- Encouraging people to be honest helps us to reduce risk of spread
- Paying attention to the needs of staff groups who are tired and working hard, helps them to maintain focus
- Reducing occupancy reduces risk of IPC breaches and enables social distancing
- Staff were encouraged to have flu vaccination across the unit if they have not already had it
- The affected patients were nursed in isolation
- All patients who were safe to receive care at home were encouraged to take leave.
- Signage was displayed alerting visitors, relatives and carers
- Everyone visiting, staying and working on the ward was continually advised about hand washing and reducing traffic on and off the ward
- NHSE and CCG were kept informed as per winter pressures and contractual guidance
- A post incident review was conducted, and many positive lessons learnt regarding good communication and prevention of cross contamination
- The estates team were responsive and enhanced cleaning off handrails etc. was pivotal in managing cross contamination risks.

4.4 In keeping with the Flu campaign for 2020/21 we used the HOPE acronym;

- **H**and washing (not just hand gel) and PPE are key. Wash them well, wash them often!
- **O**bserve basic infection control standards, bare below the elbow, be aware of what you touch and minimise unnecessary contact.
- **P**lease remember - Jewellery, watches and nail varnish can harbour infection and reduce the effectiveness of good hand washing.
- **E**veryone can help! The more we can all do to limit spread the better, literally share hope, not Flu.

The Trust achieved an 84% Health Care Worker uptake figure for Flu vaccinations.

4.5 Surveillance of healthcare associated infections (HCAI alert organisms) have seen no cases of MRSA bacteraemia acquired within the trust between April 2019 – March 2020 – this has been the case for seven consecutive years.

4.6 COVID-19 vaccinations commenced in December 2020 regionally. The Trust opened its Hospital Hub in February 2021. The hub was commissioned because of its convenient location for staff and service users living in the local area and to provide an accessible and flexible opportunity for vaccinations for both patients and staff.

The hub was commissioned to provide the AstraZeneca vaccine and we contributed to the (Learning Disability/Serious Mental Illness (LD/SMI) community uptake figure of 89%/79%. These figures compare favourably with other areas; however, they represent the disparity and links to deprivation and other health inequalities which disproportionally affect these groups.

DHCFT front line health care workers reaching 92% first dose and 89% fully vaccinated (marginally above the regional figure of 91%.

The hub is entering into phase 3 and 'evergreen' offer now and has been signed off for use of the Pfizer vaccine. The vaccination programme for Flu is also underway and for the first time we can offer concomitant vaccination as per the guidance in the green book chapter 14a. The Quality Assurance framework document for the Hospital hub has been refreshed and is in appendix 1. Our primary focus is in addressing the inequalities gap and improving uptake of our at-risk cohorts as identified by the Joint Committee on Vaccination Immunisation (JCVI) at risk groups.

4.7 Cleaning scores, measured against the national standards of cleanliness, have continued to meet the nationally defined 'excellent' standard in clinical areas across the year (see detailed performance in the section 'Assurance').

4.8 Cleaning schedules remain consistent with national guidance and are held at ward level for access by staff and patients / visitors.

4.9 Patient Led Assessment of the Care Environment (PLACE) inspections did not take place last year as the service user involvement was deemed to place people attending the visits and the areas at unnecessary additional transmission risk. The 2021 inspection programme is described as PLACE – lite and will have reduced attendance within areas in accordance with current IPC and COVID secure guidelines.

4.10 Continued development of the skills and leadership of the Infection Control Link Nurses programme brings a strong focus of clinical leadership and a conduit for information between the specialist team and clinical level. The infection control audit has been reviewed as the safety of sharps was highlighted last year by the infection control link nurses. The audit is derived from a national safety standards audit and is undertaken annually by all in-patient areas.

In addition to this we introduced a weekly audit cycle to ensure that areas are maintaining COVID secure assessments and IPC signage / PPE/ hand washing standards, audits are uploaded centrally for assurance and accessibility and this year's schedule although delayed due to COVID-19 has seen assurances regarding hand hygiene and COVID assessments reviewed and submitted to CQC as part of their IPC health check framework.

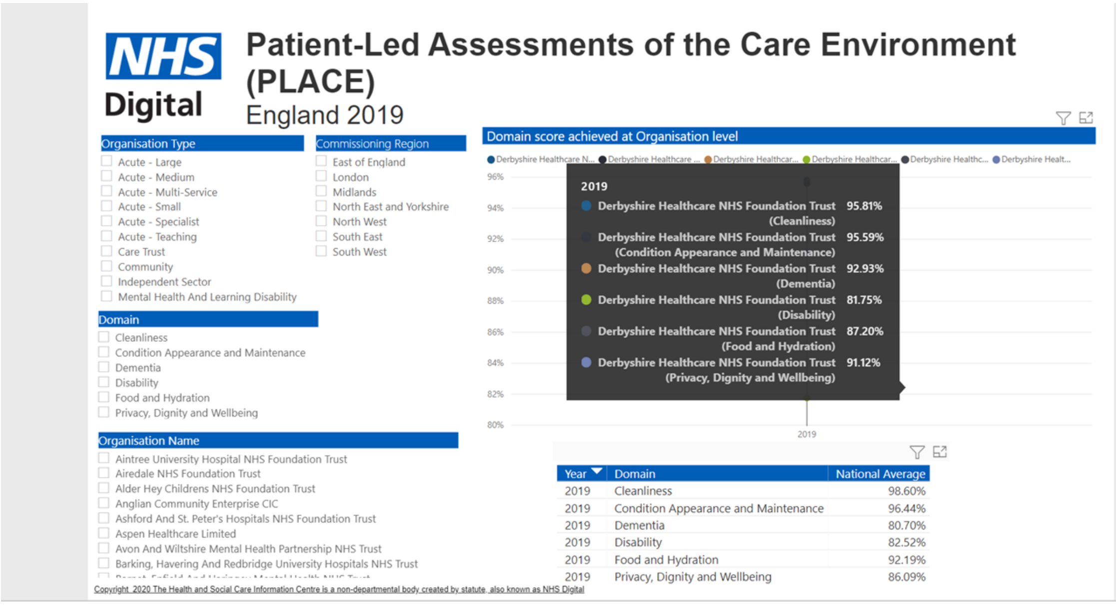
4.11 The CQC have feedback through their IPC health check report in 2020 and also through mental health act visits that they are satisfied with the approaches being taken by the trust. This is in addition to the inspection report which saw the Trusts rating improve to Good in February 2020.

4.12 This year we have identified new infection control link nurses and are developing an enhanced programme to improve the skill set and impact the link workers have within their respective clinical teams.

5.0 Assurances

5.1 The Facilities team continue to deliver high standards of cleanliness. This means we remain in the 'excellent' range which is supported by the findings in the last PLACE inspections. The highest standards and greatest cleaning services input are delivered in inpatient wards and patient facilities. This year the approach is PLACE-Lite and these assessments are being undertaken currently.

The Hotel Services and Estates teams continue to undertake visits to the Community Mental Health unit's premises to ensure all environmental standards and being met and to check that all planned maintenance is in accordance with the proposed works schedule. A number of improvements have been made following these visits and new flooring, replacement of carpets and furniture have improved the environment and reduced potential infection control risks. The estates and facilities team are currently working through the implementation of the new nationals Standards in cleanliness. See section 7.



Year	Domain	National Average
2019	Cleanliness	98.60%
2019	Condition Appearance and Maintenance	96.44%
2019	Dementia	80.70%
2019	Disability	82.52%
2019	Food and Hydration	92.19%
2019	Privacy, Dignity and Wellbeing	86.09%

The comment from the Estates and Facilities Manager sums up the reason that the score is reduced;

"Food and Organisation Food section, this is not the food that patients eat (Ward Food section). This section is about things such as, having a cooked breakfast every day, if we serve hot desserts at every main meal and do patients receive snacks three times a day. Things like having a cooked breakfast every day, hot desserts at each main meal we do not do, or three snacks, this is at the choice of the patients, clinical staff and dieticians and is a considered choice to promote a healthy diet. we hope that following the National Catering Standards release, PLACE will alter these questions, we have given feedback in regards to this previously. We also loose marks for not having an a la carte menu - a 24 hour menu that never changes and the patients can pick from 16 or so choices for each course. For patients that are in hospital for several days or more this very quickly becomes repetitive. We operate a four week menu which gives a much larger variety but impacts upon our scores. I do raise this annually as well and it was pleasing to hear that the Dietetic association have also been raising this."

5.2 The Heads of Nursing rounds have continued to provide assurance of key standards in the inpatient wards, where on a twice yearly basis, representatives from Infection Control, and Hotel Services join the Heads of Nursing to inspect the clinical areas from an environmental quality perspective. They provide a proactive and engaged oversight within their respective environments, anticipating maintenance and quality issues at an early stage (and ensuring action is taken) and also the opportunity to seek informal feedback from patients on the wards as to the comfort and cleanliness of the wards. Following on from last year's report this has seen a significant increase in the oversight of IPC and cleanliness in these areas.

5.3 Healthcare associated infection (HCAI) surveillance demonstrates our performance, as reported to the Commissioning organisation. We continue to show consistent performance here, with clinical focus on anticipation of possible infection risks and a swift, appropriate response, for example to suspected diarrhoeal illness. This has

seen a significant emphasis on prevention of cross infection, and rising confidence in staff to deal with potential infection risks as they arise.

2020/21 has seen a significant rise in reporting COVID-19 related concerns. DATIX now has a category for COVID-19 related matters as our reporting framework has evolved

5.4 During 2020/21, there have been 14 ward closure as a result of COVID-19, this has caused significant disruption to service delivery. However the decisive action of clinicians, rapid access to testing and excellent symptomatic assessment has meant that Outbreaks have not seen significant spread. The Radbourne and Hartington Unit Outbreaks in February 2021 lead to the temporary reopening of Audrey Hose. This enabled COVID positive patients to be cohort nursed and enabled critical flow to be maintained in order to reduce the risks to service users who needed access to beds in the community. This 'fire break' brought an end to rapidly rising cases across both units.

All infection control issues are reviewed and there have been no outbreaks of MRSA bacteraemia and Clostroides difficile. As in previous years learning from Physical Health Care and Infection Control Committee (PHCIC) learning points are also distributed via the Infection Control link nurses and via clinical training.

The catheter passport was introduced last year and has been evaluated to have been a success. The infection control support nurse has been working with colleagues to increase awareness / confidence and skills related to catheter care.

5.5 Clinical audit specifically to infection control is focussed on two key areas during the year:

- Infection control general standards (hand hygiene, PPE use, donning and doffing, signage, sharps, decontamination equipment). Thematic review of the general infection control audit saw areas of work needed in regards to the storage of equipment. There has been a focus upon maintaining clutter free environments within clinic spaces.
- Last year an audit of toy cleaning highlighted some challenges for the clinical team in evidencing after each play contact that toys had been cleaned. This has been amended in the current protocol to show that toys are being cleaned in accordance with the policy and this is recorded weekly.
- Hand hygiene audits are being undertaken across the organisation and the light box and dye are utilised to good effect.

5.6 Clinical compulsory training continues to take place for those staff who are required to attend, as identified as part of the training framework, and administrated via the training passport system. Compliance is monitored via the Physical Health Care and Infection Control Committee at a strategic level, and attendance is managed by each of the Divisions. Frequency of attendance is currently agreed as every three years, and these are largely taught sessions via the 'block training' method.

5.7 An influenza vaccination campaign was delivered for staff and patients who met the criteria. The final staff uptake figures significantly increased to 84% in 2020/21 (was 71.9% in previous year).

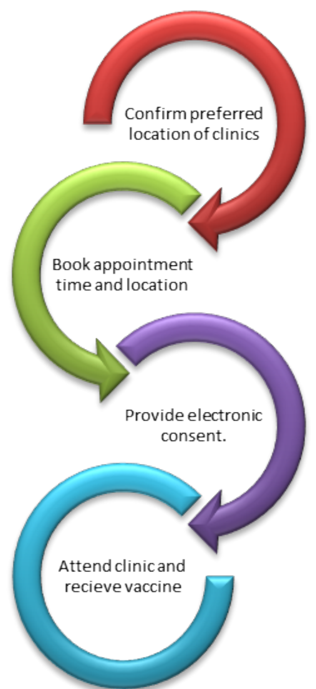
As in previous years we adopted a peer vaccinator model for the majority of vaccinations provided. For the 2021/22 campaign we are taking a significantly different approach and setting up more IPC and COVID secure compliant focus. Whilst the Peer support model remains present, the approach is to give attending colleagues assurance that they will be vaccinated in a COVID secure environment using touch lite, paper lite (virtual registration, socially distanced queuing and PPE for attendees and vaccinators).

The target set by the organisation is 90% this year, it is anticipated that we will meet this target.

The following outlines the approach being developed for this year's Flu approach:

The experience gained during the national level 4 incident in regards to antigen and antibody testing clinics and the 2020/21 Flu campaign and COVID vaccination programme has seen rapid learning to realise
IPC compliant and efficient clinic models which:

- Live booking system launched for Flu, COVID booster (separately or together).
- Pre-book appointments to allow clinics to match demand.
- Virtual registration and consent process to manage IPC concerns / streamline process.
- Allocated vaccine awaiting colleagues on attendance.
- Support vaccinators to manage capacity and demand and rapid administration of vaccines.
- The trust will utilise its social media platforms (Facebook, Twitter, LinkedIn) and communications team to ensure colleagues are aware of how and when to book into clinics.



- The communication strategy for 2021/22 is intentionally simple; the focus is on ease of access, safe attendance and administration – the visual campaign is simply the arm of a health care worker ready to receive their vaccine.
- The trust has developed a Memorandum of Understanding (MOU) for greater system working with partners at DCHS enabling both organisations to support the vaccination of its respective staff from shared access clinic sites.

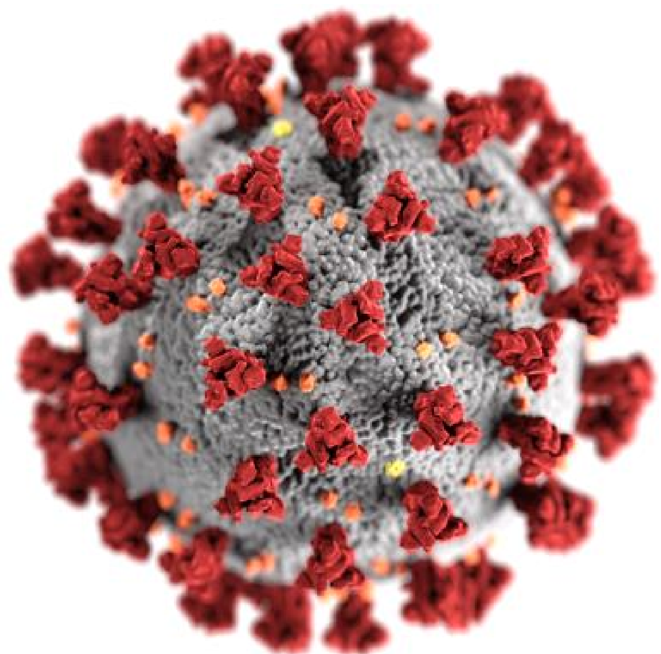
5.8 Hotel services continue to provide assurance on key service delivery areas, such as food hygiene, pest control, laundry and linen supplies, and the duty of care audits required under the NHS Waste Management regulations. A full review of the laundry contract has taken place as a joint venture, with a single provider in place. The kitchens at Kingsway and Radbourne sites have had had environmental health inspections and were once again awarded 5 star ratings by Derby City Council. This is a very public method of demonstrating quality, as it is used across all food preparation establishments. We continue to gain additional assurance by using an independent Environmental Health officer to undertake inspections and guidance, as well as the local authority inspections. Pest control contractors call outs have reduced this year and the estates and facilitated department have arranged for replacement bins and refuse collection vessels to reduce pest control incidents.

Planned inspections of kitchen areas taking place as a preventative measure measures this year and the estates team have been very proactive in dealing with the small number of incidents reported in order to ensure that issues are addressed quickly and effectively to maintain confidence from the people who access and work with our services.

5.9 Estates continue to provide a monitoring system and maintenance programme to maintain safe water quality. Focussed work in ensuring proactive flushing records are maintained have been a recent focus of the Estates planned, proactive management. A water safety group is established with focussed prevention of Legionella and also other issues with potable water such as Pseudomonas.

5.10 Risks relating to infection control are recorded on the DATIX risk register against each Ward/Team in line with the Risk Assessment Policy and Procedures. This identifies a number of ‘required’ risk assessments that wards/teams must complete and review at least annually.

6.0 Coronavirus Pandemic



6.1 During early 2020 the emergence of the Novello-Coronavirus Wuhan strain was recognised and by March 2020 the NHS had entered level 4 pandemic with significant changes to service delivery and the implementation of significant measures to reduce the spread of the virus and protect NHS emergency services to enable them to cope with the international outbreak.

The Trust has taken significant steps and provided assurances to the CQC that we were managing the impact of the outbreak in the best way possible for patients and colleagues at DHCFT. This work has been overseen by the Incident management Team which was implemented in Late February 2020 and stood down to be replaced by the COVID Oversight Meeting in September 2021.

6.2 The Trust has taken a significant number of actions since the outbreak and the rapidly emerging and changing picture and guidance has contributed to the update and oversight of the Board Assurance Framework (BAF) document in Appendix 2.

6.3 As the Pandemic moves into an Endemic phase we are currently undertaking some reflective practice events and capturing learning from the Pandemic to inform governance approaches moving forwards.

7.0 Next steps and priorities

7.1 The organisation continues to place prevention of infection, along with prevention of harm, as a central feature of clinical service delivery. A focus on continuing to equip the workforce is pivotal to this. The delivery of a compulsory training requirement means that staff are equipped to deliver care in a way that prevents the spread of infection, and provides them with the clinical leadership to seek advice where required. Audit and ownership of the results by clinical teams through the infection control leads is a key part to improve safety and encourage curiosity in emerging areas such as antimicrobial resistance.

7.2 Continued focus on strong, visible clinical leadership will continue to see practice at the highest standards, with staff empowered to seek advice and support where needed. Strong leadership also brings consistency of standards.

7.3 Continued commitment in capital expenditure on the Estate will ensure that environmental risk is kept to a minimum (for example on-going replacement schedule for furnishings), upgrade of ward and community facilities reduces the risk of poor environment and enhances patient experience. Work is underway and requires continued commitment to support safe practice. Monitoring of external contracted services ensures the highest standards are achieved on our behalf. This is an important aspect of quality assurance.

7.4 On-going support for the delivery of high standards of hotel services, and specialist infection control advice when needed.

7.5 Commitment to working with other providers, to ensure we play our part as a health economy in reducing the burden of healthcare associated infections, such as CPE, Norovirus, Clostrioides *difficile* and MRSA. In addition, we are engaged with other providers in learning from COVID-19.

7.6 There is ongoing support for the developmental work undertaken to meet Nutritional standards by the Nutrition Steering Group. There remains a strong focus on improving diabetes care and management, particularly pre-diabetes assessment / intervention and adjustments have been made to menus to promote healthier food choices.

7.7 A continued commitment to the provision of high standards of cleanliness in our premises with the ability to have highly trained and flexible staff helps us meet clinical need. The trust has seen significant increases in the number of contracted staff working in our hotel services to deliver the enhanced cleaning requirements of COVID-19 secure services and IPC guidelines.

7.9 Increasing the number of IPC link workers to support the additional work and physical health monitoring requiring during the pandemic and endemic related to COVID-19.

7.10 Increasing the access and availability of physical health monitoring equipment for clinical staff in community settings to improve both assessment and intervention for service receivers of the organisation. This will be coupled to robust cleaning schedules for the equipment to assure against IPC standards.

7.11 The new ‘National Standards of Healthcare Cleanliness were published by NHS England and NHS Improvement in April 2021 – they are a suite of documents comprising

- National Standards of Healthcare Cleanliness 2021
- National Standards of Healthcare Cleanliness 2021 Appendices
- National Standards of Healthcare Cleanliness 2021 Health and Safety
- National Standards of Healthcare Cleanliness 2021 Pest Control
- National Standards of Healthcare Cleanliness 2021 Healthcare Cleaning Manual

These standards apply to all healthcare environments and replace the National specifications for cleanliness in the NHS 2007 (and amendments) published by the National Patient Safety Agency.

Acute and Mental Health Trusts have 12 months to reach full implementation of the new standards.

Currently cleaning across the Trust is in line with the 2007 specifications – the guidance issued suggests that where this is the case, costs for achieving the new standards should be no more than existing levels – however, this cannot be fully verified until the implementation work is substantially completed.

The new standards reflect modern methods of cleaning, infection prevention and control and important considerations for cleaning services during a pandemic.

The standards have been designed to

- Focus on a collaborative approach (with differing groups involved in the cleaning process)
  - Replace cleaning audit scores with star ratings for patient facing areas
  - Increased flexibility – all healthcare settings and additional risk ratings for functional areas
  - Introduce efficacy audits – now include the whole cleaning process
  - Introduce a Commitment to Cleanliness charter
  - Support benchmarking and performance management

7.11.1 Implementation Stages

Each organisation can decide how their cleaning resources are best organised for their local environment and services but meeting the aspects of the new standard noted below is mandatory.

7.11.2 Functional risk review

6 new Functional Risk categories (FR1 to FR6) – allocation of a risk category to each functional area or group of rooms. Each FR category has a pre-determined audit frequency from weekly through to annually.

Dementia wards have been classified as 'FR2' (audit frequency monthly with target score of 95%) and mental health wards as 'FR3' (audit frequency of bi-monthly with target score of 90%)

Once the FR categories are identified, produce cleaning specifications – these detail 'elements' (a set list of 50 broad clinical and non-clinical 'items' that require cleaning in a healthcare environment), the performance parameters required and the frequency of clean for each FR category.

7.11.3 Responsibilities document

Once the cleaning specification is defined, a responsibility matrix needs to be completed for each of the noted elements to confirm who has responsibility for cleaning after patient use and for scheduled daily or periodic cleaning.

7.11.4 Audit frequency gap analysis

Each site will need a gap analysis to determine if cleaning frequencies (and responsibilities) need to change and to confirm what further actions might be required to meet the cleaning specifications.

7.11.5 Audit regime and efficacy check

Audit scores for cleaning (for each FR category) will now include a percentage score (for internal verification purposes) and a star rating (for external verification purposes). Internal percentage scores will be split by responsible staff groups (cleaning, nursing etc..).

To meet safe standards, the efficacy of the cleaning process is as important as the technical outcomes of cleaning – efficacy audits need to be set up to provide assurance and

7.11.6 Commitment to Cleanliness Charter

The Commitment to Cleanliness Charter sets out our commitment to achieve a consistently high standard of cleanliness in all healthcare premises – it will need to be displayed in areas where it will be seen. National templates are available for use.

The Charter should be displayed once the initial start ratings are determined (as below)

7.11.7 Star ratings

The star ratings for an area (such as a ward) are calculated form the percentage audit scores of the component rooms and spaces (which are likely to include a mix of FR categories) – the star ratings are based on the overall outcome, referenced back to pre-determined bandings for each FR category to give a blended result.

The first set of star ratings (for cleaning staff only) are to be produced at the end of the first 6-month implementation period.

7.11.8 Implementation timescales

Functional risk review Q1 - 2021/22

Responsibilities document Q1 - 2021/22

Audit frequency gap analysis Q2 - 2021/22

Audit regime efficacy checks Q3 - 2021/22

Cleaning Charter Q2 - 2021/22

Star ratings Q2 - 2021/22

7.11.9 The Trust is on track to deliver within the timescales allocated.

8.0 Potential risks in delivery

8.1 Operational support for the infection control support nurse role is pivotal in the ability to deliver the programme of work and level of clinical support and responsiveness needed to meet clinical demand. There is considerable pull on staff resources regionally and locally particularly to deliver the vaccination programmes.

8.2 The uptake of the influenza vaccination by staff should be considered as a key protective and public health responsibility of the organisation and requires continued support to improve uptake.

8.3 Continued operational support to achieve compliance with compulsory training.

8.4 Any impact on ability to deliver cleaning services to the current high standard in the inpatient areas and clinical bases would have an impact on existing infection control standards. There have been some indications that the National team identify the link between infection and cleaning is weakening in relation to lower risk pathways.

8.5 The organisation needs to ensure that we maintain monitoring of externally provided contracts, such as laundry, cleaning (North County units), pest control and maintenance to ensure that that standards are not allowed to slip in extremely challenging operating environments.

7.6 The organisation needs to remain focussed that Hotel Services remain equipped to be able to continue to maintain the high standards of cleanliness we currently achieve.

Richard Morrow
Assistant Director of Public and Physical Health Care
11 October 2021

Appendix 1

Quality Assurance Framework – Hospital Hub.

Official Publication approvals reference: C1141 COVID-19 vaccination programme

Quality Assurance Framework: COVID-19 vaccination sites

Version 1, 4 March 2021

Introduction

The purpose of this framework is to provide organizations delivering COVID-19 vaccine services with a quality assurance tool aligned to the operating frameworks and standard operating procedures underpinning the delivery models for these settings: Hospital Hubs, Local Vaccination Services (LVS) and Vaccination Centers (VC).

The tool can be used to ensure services have ongoing robust assurance in place, to demonstrate compliance with the legal frameworks for COVID-19 vaccine delivery and to ensure the standards expected for a healthcare setting are met. It will also help identify any areas of risk and show the corrective actions taken in response. The tool can be used as a self-assessment or by those responsible for reviewing the quality of healthcare in the locality. The tool can provide assurance to trust and PCN boards that organizational compliance has been systematically reviewed.

This framework is not mandated. If organizations don't use it, they should ensure they have equivalent mechanisms to evidence assurance. It is recommended that the assurance framework is used to establish the monitoring needed for day-to-day oversight as new services are developed, then completed within 8 weeks of opening (or as soon as possible if the service has been operational for longer than 8 weeks). The tool should also inform future service development including up-scaling of existing services.

The framework is aligned to the Care Quality Commission framework for ease of use alongside other quality assurance processes.

Legislative mechanisms

The 2012 Human Medicines Regulations set out a comprehensive regime for the authorisation of medicinal products for human use; for the manufacture, import, distribution, sale and supply of those products; for their labelling and advertising; and for pharmacovigilance.

They also provide for enforcement powers for the authorisation and supervision or administration of medicinal products for human use.

All medicines are classified according to three legal categories which are: Prescription only Medicines, Pharmacy Medicines and General Sales List Medicines.

All vaccines are classed as prescription only medicines which means that they can only be supplied on the authority of a prescriber (doctor or other independent prescriber).

The regulations do not permit nurses, or other registered healthcare professionals (HCPs), who are not qualified prescribers to administer or supply prescription only medicines (POMs) unless one of four types of instruction is in place:

1. Signed prescription
2. Patient Specific Direction (PSD)
3. Patient Group Direction (PGD)
4. National Protocol (for influenza or COVID-19 vaccines only)

The vaccination service must operate under one of the above types of instruction.

Service summary

Site name	Region	Vaccination service type (Model)	Type(s) of instruction in place for vaccine administration.
Kingsway hospital hub	JUCD	Hospital Hub	AZ PGD (due for withdrawal as of 01/09/21) Pfizer PGD received 21/09/21 - HH approval pending.
Service summary *Provide a narrative describing the service including location, the vaccines being administered, and for VCs, the number of PODs in operation: The Kingsway Hospital hub is a combined staff and patient access hub for staff and partners of DHCFT and LD and SMI service users. The hub is approved for the administration of AZ. The hub has provided a roving model for hospital inpatients for SMI and LD clients at Hartington, Kingsway, Radbourne and Local private providers.*			

Author: Richard Morrow
Role Assistant Director of Public and Physical health Care
Date of completion:30/03/2021 (updated 21/09/2021)

Assurance framework

Key Line of Enquiry	Suggested evidence	Gaps in assurance	Mitigating actions
Safe Clients using the vaccination service are protected from abuse and avoidable harm.			
There is evidence of learning from incidents and a transparent reporting culture: • Serious Incidents and adverse events are escalated in accordance with the National SOP for the Management of COVID-19 vaccination clinical incidents and enquiries • Adverse vaccine events are reported via the MHRA (Medicines and Healthcare product Regulatory Agency) Yellow Card system; https://coronavirus-yellowcard.mhra.gov.uk/	• Policy/SOP • Daily safety briefing • Thematic Incident data • Yellow card submission data Process for referring to the Clinical Advice and Response		DATIX process in place. Recording process of adverse events and instances within vaccination booking and post administration monitoring in place. 17/9/2021 – have we reviewed incidents related to the vaccination hub?

Key Line of Enquiry	Suggested evidence	Gaps in assurance	Mitigating actions
The deployment, governance, handling, and preparation of vaccines are in accordance with the Specialist Pharmacy Service Technical Standard Operating Procedures (SOPs) for COVID- 19 Vaccines	Approved SOPS pre vaccine in operation. To include procedure for roving vaccinators in PCNs (primary care networks).		Pfizer approval SOP pending and revised PGD pending RVOC confirmation. (21/09/2021)
Cold chain monitoring is in place and breaches identified in a timely manner	• Audit • SOP • Temperature		
Delivery of the vaccine is checked, accepted, and recorded by a registered healthcare professional and cold chain maintained.	SOP		
There is a process in place to oversee and manage safe access and queuing – with scope to adapt in anticipation of each new cohort	• SOP • Patient flow/patient • Pathway		

Key Line of Enquiry	Suggested evidence	Gaps in assurance	Mitigating actions
National guidance and resources for COVID-19: infection prevention and control (IPC) is adhered to and overseen.	• Policy • Nominated IPC lead • IPC audit/site assurance visit • Hand hygiene audit		
There is an approved process to manage clinical waste from the point of usage to disposal/collection to ensure the health and safety of staff, volunteers and clients.	• SOP • Audit • Clinical waste contract		
Staff and volunteers are tested using Lateral Flow point of care testing. The plan is overseen and meets the Lateral Flow national protocol of twice-weekly testing.	T&T compliance data.		Daily report sent to site lead.
There is evidence that the environment is assessed as safe; in line with COVID secure guidance by HSE (Health & Safety Executive) There is good ventilation throughout the service	Environmental checklist and assurance certificate by H&S/Estates Lead.		

Key Line of Enquiry	Suggested evidence	Gaps in assurance	Mitigating actions
Provision for the management of adverse reactions is in line with guidance with the Green Book Ch14a, recommendations for medicines and equipment by the Resuscitation Council UK, are risk assessed and monitored.	• Policy • Resus medicines and equipment audit • Risk assessment		Recovery room and equipment provided.
Attendees are safeguarded against abuse and neglect. Staff comply with provider safeguarding policies (adults and children). Safeguarding concerns attributed to the vaccination service are reported and monitored	• Polices (adults and children). • Safeguarding audits.		
There is a process to review staff rosters to ensure staffing and the supervision of delegated practice is in accordance with the legal framework in place	Staffing data: • Turnover • Vacancies • Sickness • Bank fill rates		Roster in development / place but currently in transition between rostering models / flu and COVID booster concomitant delivery. Dedicated staff recruited to hub and additional support being provided by bank.

Key Line of Enquiry	Suggested evidence	Gaps in assurance	Mitigating actions
Clinical records are maintained according to policy. Personal identifiable data (PID) is managed in accordance with provider approved information governance process	• Policy in place • Documentation audit (for example an information governance audit)		
Risks are managed, reviewed and kept up to date	Risk register		
All staff including volunteers have undergone appropriate recruitment checks prior to appointment.	Employment checks		
Procedures are in place to handle multiple vaccines safely including staff awareness and training, IT, storage, and separation in 'time and space'	• SOP • Medicines management • audit • Daily Safety Huddles		
There is a process in place to ensure equipment is used and tested as per manufactures guidance and fit for purpose	Equipment audit		

Key Line of Enquiry	Suggested evidence	Gaps in assurance	Mitigating actions
Effective: The vaccination service successfully achieves intended outcomes. Service provision is evidence based.			
Available capacity is in line with the site target max throughput per day. Alternatively, operational ramp up plans are in place to resolve the use of capacity.	• Vaccine utilisation data • Capacity data • DNA (Did Not Attend) data		Anticipated run rate of 24 COVID booster vaccinations per hour.
The consenting processes is in line with the legal framework as detailed in the Green Book, overseen in practice by a suitably skilled practitioner. The support provided is in line with the Mental Capacity Act and Equality Acts to including the provision of reasonable adjustments and documentation of best interest decisions.	• SOP • Workforce allocation • MCA (Mental Capacity Act) audit		
There is enough oversight and monitoring to prevent vaccine wastage.	• Vaccine utilisation data • Reserve lists in place to prevent wastage of vaccine		

Key Line of Enquiry	Suggested evidence	Gaps in assurance	Mitigating actions
Public health messaging following vaccination is available, up to date and regularly reviewed in line with national PHE (Public Health England) policy and guidance (PHE 'What to Expect' Leaflet).	Information inventory		
Workforce models are agile and flexible to enable increase in throughput as supplies increase	Plan for scale up including consideration of non-registered and registered workforce.		

Key Line of Enquiry	Suggested evidence	Gaps in assurance	Mitigating actions
Staff overseeing and delivering vaccines are appropriately trained and competent and up to date with current vaccines.	Policy. Education audit including training and competency sign off compliance. Competency Audit.		PGD for Pfizer being revised in accordance with JCVI updates and green book amendments related concomitant delivery with Flu.
Caring: Clients are treated equitably with care, compassion dignity and respect.			
Service user experience is captured and informs service and quality improvement	Service user feedback. Service user engagement.		Follow up feedback received through informal means (Facebook, involved professionals) Service user feedback provided to vaccine inequalities group and also national LD team. QR codes and system to enable people to provide feedback.

Key Line of Enquiry	Suggested evidence	Gaps in assurance	Mitigating actions
Complaints and compliments are responded to in accordance with policy. Themes inform ongoing quality improvement.	Policy. Complaints records. Complaints audit.		Issues attended to and logged in feedback section of booking form. Summary of feedback provided from Phase 2 campaign to trust and regional colleagues.
Patient advocate or support roles (for example from St John Ambulance in Vaccination Centres) are in place to support attendees and to support with navigation and throughput.	Workforce model. Role specification.		Colleagues are in place to guide / support / direct and ++ opportunities to identify additional support needs. LD days are focused on adjustments to make experience and access as straight forwards as possible.
Responsive: The vaccination service is organised to meet the needs of the designated population.			
Information for attendees is regularly reviewed and updated according to information standards.	Policy. Information inventory.		Updated PGD received and circulated 21/09/21.
The services are responsive to meet the needs of diverse and seldom heard populations. • Privacy and dignity • Translation • Accessibility • Navigation and access	Policy in place. Demographic data. Service user feedback. Equality Impact assessments Disability access provisions		

Key Line of Enquiry	Suggested evidence	Gaps in assurance	Mitigating actions
Well Led There is evidence of effective leadership and robust governance processes in place to oversee activity within the vaccination service.			
There is a clinical lead responsible for the delivery of all aspects of vaccination service	Service specification		
Clinical governance and supervision processes are in place and signed off by the Vaccination Site Clinical Lead	Approved SOP		Revised PG received 21/09. Supervision and support processes in place.
There is Pharmacist oversight into the vaccination process.	Named person available for day-to-day vaccine queries		
Statutory and Mandatory Training records demonstrate compliance with local policy	Training data		
There are policies and procedures in place to oversee the experience and wellbeing of staff	Policy. Staff survey results.		

Key Line of Enquiry	Suggested evidence	Gaps in assurance	Mitigating actions
There are policies and procedures in place to oversee the experience and wellbeing of staff staff including the safe provision of adequate staff rest areas	Roster review (break allocation). COVID-19: Secure assessment of Staff break areas.		
There is an agreed process to facilitate ongoing quality improvement.	QI plan. Lessons learned. Quality boards Daily huddles		Daily huddles and responsive site lead model in place. QI life platform utilisation (KH).
Staff Indemnity has been considered through honorary contracts or service level agreements where not directly employed (including volunteers where vaccinating)	Lead employer agreement for staff.		Check the changes in regard to phase 3 delivery against regional sign off.

Key Line of Enquiry	Suggested evidence	Gaps in assurance	Mitigating actions
There are business continuity plans applicable to the site in the event of a major incident. • IT down time • Fire • Cold/hot weather • Security • Traffic management arrangements • Power failure (These are examples only not exhaustive)	BCPs. Local Health Resilience Forums Cold chain management policy Including out of hours.		

Summary

Final comments:	Good governance evident / building on learning from previous experience. IPC compliance will need refresh as clinics have been closed throughout August and early September. Explore formal feedback mechanism through system. Review of incident data and feedback data ongoing. Ongoing work to resolve Roster needs and staffing requirement.
Overall summary of assurance Select as applicable	The evidence provides: **Substantial assurance**: The service demonstrates robust processes for ongoing assurance across all domains and evidence is consistent with good practice. **Full assurance**: The service demonstrates robust processes for ongoing assurance across all domains. Further evidence is required to demonstrate good practice **Limited assurance:** The service is developing robust processes for ongoing assurance across all domains. **Concerns highlighted:** Improvements required and a repeat assurance review in [insert due date]

Action plan template

Issue	Mitigating Action	Lead	By when	Status	Comments
IPC compliance will need refresh once clinics re-open.	Cleaning and visual checks indicate good level of compliance. Robust cleaning rota and wipe down procedures and evident form walk around. Hand hygiene audit as well.	JC / CM	1/10/2021	Green	Refresh of IPC audit required when hub re-opens. Adequate supplies of PPE and cleaning products in situ, cleaning rosters and in between contact cleaning protocols in place. Social distancing, queue management and flow arrangements agreed.
Explore formal feedback mechanism through system.	Contributions to regional learning through vaccine inequalities work, feedback into hub team.	RM	23/9/2021	Green	Provide report from regional VIG once sheared (expected 23/09. Develop informal feedback mechanisms for capturing feedback. Utilise QI life platform (KH)
Review of incident data and feedback data.	Cross reference DATIX and booking system data and review for themes.	CM / FB	1/10/2021	Green	DATIX incidents have been reviewed, resolution and mitigations in place.
Ongoing work to resolve Roster needs and staffing requirement.	Staff booking moving to bank booking system, some issues to resolve.	CM / FB	1/10	Amber	Staff rosters being developed for new clinics.

References and links to further information

Anaphylaxis guidance for vaccination settings: https://www.resus.org.uk/about-us/news-and-events/rcuk-publishes-anaphylaxis-guidance-vaccination-settings

Asymptomatic staff testing for COVID-19:

Coronavirus » Asymptomatic staff testing for COVID-19 (england.nhs.uk)

Care Quality Commission: Monitoring questions for hospital-led COVID-19 vaccination services: https://www.cqc.org.uk/guidance-providers/how-we-inspect-regulate/monitoring-questions-hospital-led-covid-19-vaccination#accordion-4

COVID-19 vaccinator competency assessment:

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment data/file/943646/Core competency assessment tool v3.pdf

Green Book, Chapter 14a - COVID-19 - SARS-CoV-2. 12 February 2021: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment data/file/955548/Greenbook chapter 14a v6.pdf

Health and Safety Executive: Making your workplace COVID-secure during the coronavirus pandemic (hse.gov.uk)

2012 Human Medicines Regulations: https://www.legislation.gov.uk/uksi/2012/1916/contents/made

Legal mechanisms for administration of the COVID-19 Vaccine(s): C0923-legal-mechanisms-for-adminstration-of-the-covid-19-vaccines-v2-10-december-2020.pdf (england.nhs.uk)

National guidance and resources for COVID-19: infection prevention and control (IPC): https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control

Public Health England information leaflet 'What to expect after vaccination': https://www.gov.uk/government/publications/covid-19-vaccination-what-to-expect-after-vaccination

Public Health England Coronavirus (COVID-19) Resource Centre: https://coronavirusresources.phe.gov.uk/

Specialist Pharmacy Service Technical Standard Operating Procedures (SOPs): https://www.sps.nhs.uk/home/publications/standard-operating-procedures/

Standard operating procedure Management of COVID-19 vaccination clinical incidents and enquiries: https://www.england.nhs.uk/coronavirus/publication/standard-operating-procedure-management-of-covid-19-vaccination-clinical-incidents-and-enquiries/

Appendix 2

Board Assurance framework IPC

Infection Prevention and Control Board Assurance Framework

1. Systems are in place 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 posed by their environment and other service users

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
Systems and processes are in place to ensure: Local risk assessments are based on the measures as prioritised in the hierarchy of controls. The risk assessment needs to be documented and communicated to staff;	Physical health indicators and IPC indicators are crossed along the admission pathway. This is reconciled on admission and gaps identified to tests / assess / action. This is recorded in the EPR in PARIS in a newly designed section and alerted to community services. This has been checked and audited by the EPR/ clinical safety officer	No evidence of systemic gaps. To maintain standards, a number of mitigating actions are in place to sustain this practice	Monitoring compliance reports and cross-referencing vulnerable patient lists (formally national shielded lists – until September 2021), physical health checks and cohort agreements is reviewed regularly. Monitoring lists and additional data reports with security from IMT and senior clinicians is in place.

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
The documented risk assessment includes: a review of the effectiveness of the ventilation in the area; operational capacity; prevalence of infection/variants of concern in the local area.	• Ventilation has been reviewed and some remedial works identified to replace fire dampers. • Operational capacity is under constant review for adherence to National safer staffing standards. • PHE and regional SVOC provide oversight of variants of concerns and regional infection rates.	Fire damper work underway.	• Fire dampers being replaced in accordance with recent review.
Triaging and SARS-CoV-2 testing is undertaken for all patients either at point of admission or as soon as possible/practical following admission across all the pathways;	Clear clerking and screening protocols and routine use of PCR lab tests to augment clinical assessment., SOP's in place.		Evidence that people have been isolated due to clinical presentation rather than solely PCR tests.
• when an unacceptable risk of transmission remains following the risk assessment, consideration to the 6 | IPC board assurance framework extended use of Respiratory Protective Equipment RPE for patient care in specific situations should be given;	RPE assessments are in place. RPE fit tester available and range of equipment proportionate to procedures undertaken by trust clinicians in situ.	None	RPE fit tester and updates to current FFP3 stocks in place.

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
• there are pathways in place which support minimal or avoid patient bed/ward transfers for duration of admission unless clinically imperative	The Trust identified admission pathways on cohorting arrangements and these have been updated UN reviewed by the ethics cell all the way through the covert outbreak with updates made when national policy documents have changed.	The pathway has been monitored throughout the covid outbreak I've been found to work well in older adult functional and organic settings the capacity to maintain isolation for longer periods of time where required has been maintained.	If admission capacity has been stretched and this has posed risk or potential detriment to patients requiring hospital admission a mitigation plan has been discussed, agreed and implemented with support from Public Health England and NHSE/I.
• that on occasions when it is necessary to cohort COVID or non-COVID patients, reliable application of IPC measures are implemented and that any vacated areas are cleaned as per guidance.	Cleaning arrangements are in place as per the admission eso PS for adult and older adult wards. the standards are checked against national guidelines using a walk around IPC compliance monitor.	No gaps identified	cleaning standards are overseen by domestic services manager Ward matron and IPC leads.

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
Resources are in place to enable compliance and monitoring of IPC practice including: • staff adherence to hand hygiene? • staff social distancing across the workplace • staff adherence to wearing fluid resistant surgical facemasks (FRSM) in: a) clinical b) non-clinical setting	there is an IPC checklist in place which covers all of the aspects of IPC hand hygiene compliance signage and donning doffing and safe disposal of PPE. In the event of an outbreak these documents are reviewed under walk round conducted by the IPC lead or nominated representative. These are in addition two regular visits to the Ward to monitor good practise and share learning from visits and feedback from other providers.	Occasional breaches in ppe have been identified these have been followed up by supportive conversations feedback to line managers on a review of standards to ensure lessons have been learned. In the case of repetitive breaches, a small number of staff members have been issued compliance notices which are stored in the HR file.	Regular feedback provided towards and lessons learned identified from feedback during any outbreaks or lessons learned from other providers have been cascaded through team meetings Trust communications. The acute units have their own publications Radbourne roundup and Hartington matters where key messages are also communicated.
• monitoring of staff compliance with wearing appropriate PPE, within the clinical setting • consider implementing the role of PPE guardians/safety champions to embed and encourage best practice	PPE compliance monitoring is in place utilising the IPC walk around tool this is overseen by Ward matrons word manager unit manager IPC Leeds IPC link nurse and colleagues visiting the units.	Gaps in insurance are discussed at the time that the any breaches are identified in order to ensure live learning and fed back to teams and area service managers as part of thematic review.	Compliance checks are part of day to day operations and carried out weekly.

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
• that twice weekly lateral flow antigen testing for NHS patient facing staff has been implemented and that organisational systems are in place to monitor results and staff test and trace;	The trust has ensured that all staff working in frontline forward facing patient roles have access to lateral flows testing kits on replenishment when stocks run low. The trust has a lfd monitoring system so that stuff can upload results and provide assurance two colleagues and partner organisations were required that they are compliant with that LFD testing.	There is a reminder system which recognises when staff haven't submitted an LFD test result for more than seven days and promise people to complete a test. The system is monitored by service managers and the lateral flow test lead.	compliance is monitored and trends and themes related to compliance issues. This has been more chsallenging since the switch to national system. LFT +ve results reported through HPU and deliciated reporting process. Offered to work with DHSC to improve flow of info.
• additional targeted testing of all NHS staff, if your location/site has a high nosocomial rate, as recommended by your local and regional Infection Prevention and Control/Public Health team;	PHE and DHU have supported access to targeted testing when required in the event of outbreak.	This capacity has been required on a small number of occasions due to the uptake of PCR testing in September 2020	This is monitored through incident management meetings and I'll break meetings supported by colleagues from PHE and NHSE.
• training in IPC standard infection control and transmission-based precautions are provided to all staff	IPC level one training is available to all staff and IPC level 2 training to all impatient stuff. Compliance with IPC level one and level 2 training is reviewed at all outbreaks. Compliance with IPC level one and level 2 training is reviewed as part of ongoing clinician key training compliance.	The trust has replaced his maintained high standards of compliance throughout the outbreak.	any areas where performance has been identified as low have had remedial action plans agreed and these have been monitored to completion. An outbreak monitoring tool was developed in February 2021 to ensure that training compliance is monitored and recorded as part of outbreak meetings.
• IPC measures in relation to COVID-19 should be included in all staff Induction and mandatory training	All staff receive IPC training as part of induction regular mantra training updates	as above	as above

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
• all staff (clinical and non-clinical) are trained in: o putting on and removing PPE; o what PPE they should wear for each setting and context;	all staff in clinical areas received instructional training on donning and doffing techniques on the safe removal and disposal of PPE. This was delivered by a mixture of face to face and instructional videos shared via social media (trust Facebook page).	Safe donning and doffing of PPE was also monitored through walk round IPC compliance cheques. Any issues regarding donning and doffing were addressed with staff members at the time.	Staff have supported one another to improve doffing and donning technique and share good practise with colleagues.
• all staff (clinical and non-clinical) have access to the PPE that protects them for the appropriate setting and context as per national guidance;	PPE stocks are monitored and replenished through dedicated PPE inbox and distribution.	As above	

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
• there are visual reminders displayed communicating the importance of wearing face masks, compliance with hand hygiene and maintaining physical distance both in and out of the workplace	The trust has refreshed its poster displays in accordance with PHE and NHSE guidelines issued throughout the pandemic. The estate sale meeting has coordinated a consistency cheque and ensured that a regular review of signage using the most up to date approved signs is in place, to ensure covid secure and IPC guidelines are maintained.	IPC walk round checks make sure signage is correctly displayed	any incorrect or missing signage is supplied when required.
• national IPC national guidance is regularly checked for updates and any changes are effectively communicated to staff in a timely way	the incident management team monitors the PHE and NHSE Sites on national communications for updates and information to compare against current policy and update accordingly. The incident management team monitor the trust incident management communication inbox for any updates provided Incident management team members attend national webinars and updates UN disseminate any information required.	Trust IPC lead attends regional IPCSAG meetings and the DiPC attends national meetings to ensure trust standards are in line with current guidelines and to ensure that any pending guideline changes accommodated within plans.	Trust communications team ensure that all staff unnotified when national guidance is updated and changed. The SOP's are updated for adult and older adult inpatient care and the perinatal unit when changes are made.
• changes to national guidance are brought to the attention of boards and any risks and mitigating actions are highlighted	The imt and incident management director alongside the director of infection prevention control and sure any changes to national IPC standards are communicated to board.	Updates have been provided throughout the pandemic.	

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
• risks are reflected in risk registers and the board assurance framework where appropriate	Risk registers have been updated and I wanted as part of outbreaks or where specific risks have been identified as part of the incident response. These risks are also reviewed through the health and safety committee.	communication has been maintained between health and safety lead and IPC lead with oversight and executive level responsibility undertaken by the organisational director for health and safety and director of infection prevention control.	Risk registers are reviewed and updated and accordance with changing evidence or escalating or decreasing risk .
• robust IPC risk assessment processes and practices are in place for non COVID-19 infections and pathogens	the trust continues to monitor for non covered related infection such as MRSA, E-Coli, flu and norovirus to name a few. At the start of the pandemic one of the key issues ways to increase surface cleaning by increasing the number of hours available from domestic services staff (increase staff numbers and working hours). the trust also ensured that Acticlor was used for all surface point cleaning.	The trust has very low incidences of non covered infections. This is comparable with other mental health providers as national reports indicate a lower than average incidence flu, norovirus another common transmissible disease over the last 12 months.	We continue to benchmark against other similar organisations auntie DHCFT continue staff low incidences.

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
• That Trust Chief Executive, the Medical Director or the Chief Nurse approves and personally signs off, all daily data submissions via the daily nosocomial sitrep.	The trust is had a system in place to ensure sign off of all submitted data by the Medical Director Chief Nurse, Chief Executive Officer within the time scales identified by the national incident team. The Trust has initiated several key reporting lines such as swap testing and outcomes to ensure up to date accurate information is submitted to inform the national team and incident response.	Support team have been in place to ensure this information is gathered in a timely manner unsubmitted when required.	
• This Board Assurance Framework is reviewed, and evidence of assessments are made available and discussed at Trust board	The IPC BAF is reviewed and has been previously submitted to Trust Board for assurance an update of key actions taken to manage infection prevention control risks within the organisation.	An action plan for any identified gaps have been addressed through COVID oversight meeting (replaced IMT in September 2021, PHCIC and Divisional Governance structures.	Oversight being monitored as transition between phases occurs.
• the Trust Board has oversight of ongoing outbreaks and action plans	The Trust Board is cited on outbreak management action plans via the daily escalation to the executive leadership team and monitored through oversight of submission through the national reporting system.	The Director Of Infection Prevention Control is a core member of the COVID oversight meeting.	The system has worked well the team have addressed any concerns quickly and efficiently.

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
• there are check and challenge opportunities by the executive/senior leadership teams in both clinical and non-clinical areas	The COVID oversight meeting is made up of senior clinicians an executive leads and issues and incidents are discussed and debated with a culture of healthy challenge unrespectful curiosity in order to ensure safe and considered outcomes alright identified for colleagues and service users within the trust.	The trust has contributed to system wide partnership working with numerous examples of progressive and helpful collegic working with colleagues from other organisations as part of the Joined Up care Derbyshire approach.	Derbyshire's covid vaccination delivery programme, ppe mutual aid, antibody testing, antigen testing response are all indicators of robust local working.

Infection Prevention and Control Board Assurance Framework

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 procedures are in place to ensure: • designated teams with appropriate training are assigned to care for and treat patients in COVID-19 isolation or cohort areas.	Cohorting and isolation plans have identified staff groups to work directly with covid positive patients in order to ensure that stuff are not exposing other patients on the wards to unnecessary risk. Delineated areas and isolation procedures to ensure that patients can be treated separately from one another. The trust has enacted cohorting plans to ensure covert positive patients can be safely treated together, when physically well enough. The trust has enacted cohorting plans to ensure clinically shielded or highly clinically vulnerable patients can be cohort nursed to avoid exposure risk from nearly admitted all patients with noted covid exposure risk.	Hey cohorting and isolation plans are reviewed routinely modified in light of knew national guidelines were appropriate and updated on a regular basis.	All clinical teams have a lock of current covid isolation guidelines these are reviewed and overseen by the COVID oversight meeting.

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
• designated cleaning teams with appropriate training in required techniques and use of PPE, are assigned to COVID-19 isolation or cohort areas	The trust has identified deep clean teams across all of its inpatient services in addition to regular trained domestic services teams who provide enhanced hours and enhance cleaning across the inpatient areas. Additional cleaning services were sourced at the start of the outbreak and the trust is recruited additional staff through agency and bank contracts in order to assure robust cleaning rotors can be maintained.	Teams receive training in ppe and infection prevention control and or practise is overseen by the domestic services management team. The domestic services team the national framework for cleaning scores and these are reviewed at all outbreaks.	Cleaning scores across the organisation have been consistently high throughout the pandemic never below 95%. The trust has a contract with dchs he provides the cleaning services within the Hartington unit and in order to maintain clarity regarding cleaning standards the trust have negotiated with DCHS management team to ensure consistent approach has been taken where service provision is from the it's from another provider.

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
• decontamination and terminal decontamination of isolation rooms or cohort areas is carried out in line with PHE and other [national guidance]()	Terminal cleans are carried out in accordance with IPC guidelines and this is checked during the outbreak meetings. Decontamination cleans have been carried output as a precautionary measure when an unknown source of an outbreak have been identified to ensure environmental concerns can be ruled out.	In order to ensure adequate provision of terminal cleans an additional team was recruited to provide support into the Hartington unit to ensure that staff weren't being deployed from the Kingsway site base in order to ensure responsiveness.	feedback is provided to station facilities colleagues during world outbreak meetings and I'm team meetings.

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
• Assurance processes are in place for monitoring and sign off terminal cleans as part of outbreak management	Deep Clinton terminal cleans signed off by what managers or unit matrons where available.	What teams feedback on cleaning standards during our break meetings which are attended by States and facilities representatives in order to make sure any quality or standards issues can be picked up straight away.	Any issues concerns picked up through meetings to discuss IPC compliance and operate meetings.

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
• increased frequency at least twice daily of cleaning in areas that have higher environmental contamination rates as set out in the PHE and other national guidance	At the start of the pandemic additional cleaning staff enhancement cleaning rosters and extended use of actichlor were commissioned by the incident management team. A proposal was taken to trust board and funding was agreed for the organisation to enhance its cleaning services.	Impatient areas on areas of high level environmental contamination have more than twice daily cleaning routines in place.	Additional staff sort gaps in roster filled through agency where shortages are identified.

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
cleaning is carried out with neutral detergent, a chlorine-based disinfectant, in the form of a solution at a minimum strength of 1,000ppm available chlorine as per national guidance. If an alternative disinfectant is used, the local infection prevention and control team (IPCT) should be consulted on this to ensure that this is effective against enveloped viruses	As above on the 1st interventions carried out by cleaning by domestic services was to initiate the use of Actichlor alongside enhanced cleaning regimes.	Increase stocks actichlor were ordered and supply monitor through pharmacy.	This has been a trust standard throughout the pandemic.

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
• manufacturers' guidance and recommended product 'contact time' must be followed for all cleaning/disinfectant solutions/products as per national guidance	All staff within the domestic services team are trained with the use of active claw a chlorinated disinfectant products in order to ensure safe and appropriate use.	New inductees and agency staff partner with existing staff to ensure standards are maintained.	Department managers monitor cleaning standards within the domestic services team.

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
• 'frequently touched' surfaces e.g. door/toilet handles, patient call bells, over bed tables and bed rails should be decontaminated more than twice daily and when known to be contaminated with secretions, excretions or body fluids.	Enhanced cleaning was requested at the start of the pandemic with a conscious decision to work from the front door to bedroom door including star rails door handles window cells on any likely touchpoints identified through IPC what grounds.	Cleaning standards are reviewed against national standards document and fed back to wall team to ensure compliance.	Cleaning standards are not herons to cleaning schedules I checked weekly and cleaning schools reported in two outbreak meetings.

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
• electronic equipment e.g. mobile phones, desk phones, tablets, desktops & keyboards should be cleaned a minimum of twice daily	Wipe downs of all frequent touch items and supporting policy documents have been initiated to ensure safe use and adherence two above minimum standard cleaning regimes	IPC walk rounds monitor 4 observation UN compliance with these standards.	Any issues or concerns a fed back to local matron on IPC leads further exploration and contribute to lessons learned at world level stop

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
• rooms/areas where PPE is removed must be decontaminated, ideally timed to coincide with periods immediately after PPE removal by groups of staff (at least twice daily)	donning and doffing areas alright identified on all wards I'm stuff changing facilities have PPE stations and bins which are cleaned regularly throughout the day and above the minimum twice daily standard.	These are monitored through the IPC cheques and feedback provided to ward teams.	Donning and Doffing areas are monitored through IPC checks.

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
• reusable non-invasive care equipment is decontaminated: i. between each use ii. after blood and/or body fluid contamination iii. at regular predefined intervals as part of an equipment cleaning protocol iv. before inspection, servicing or repair equipment;	Cleaning protocols are in place in accordance with the Trusts cleaning and decontamination policies.	No gaps.	

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
• linen from possible and confirmed COVID-19 patients is managed in line with PHE and other national guidance and the appropriate precautions are taken	All contaminated linen is washed in alginate bags as per national IPC guidelines and in agreement with local laundry service providers.	The domestic services management team ensure this is clearly understood buy all domestic services staff unsupported by clinical staff who strip and baggage the contaminated linen.	Ward matrons, what managers, and domestic supervisor's regular check Regular this is happening.

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
• single use items are used where possible and according to single use policy	The trust has an adequate supply of single use items and they are disposed of in accordance with national IPC guidelines and waste disposal guidelines.	The trust has an adequate supply UN delivery toward areas of the correct disposal bags and has ensured that colleagues working on the wards know which items are disposed of in which bags.	IPC checklists are completed to ensure that the correct disposal of waste is monitored .

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
• reusable equipment is appropriately decontaminated in line with local and PHE and other national guidance and that actions in place to mitigate any identified risk;	any reusable equipment is cleaned using appropriate cleaning materials please be contaminated in accordance with national guidance.	Equipment cleaning cheques are in place within clinic environments to ensure concordance with national guidelines.	Completion of checklists is monitored as part of IPC compliance cheques.

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
• cleaning standards and frequencies are monitored in non- clinical areas with actions in place to resolve issues in maintaining a clean environment	Covert secure guidelines have been issued to ensure that teams are aware of the importance and frequency of cleaning work surfaces telephones computers keyboards etc and the adequate stocks of cleaning products are available to complete this. The trust has increase the number of cleaning hours in non clinical areas to support covert secure guidelines adherence and cleaning standards in these areas are also monitored.	Infrequent use of non clinical areas has generated some confusion in regards to frequency and adherence to cleaning standards any issues or incidents are identified and addressed.	domestic supervisors regularly meet to ensure any feedback related to non clinical areas is reviewed and addressed to ensure covert secure compliance.

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
• where possible ventilation is maximised by opening windows where possible to assist the dilution of air.	The air exchange rates were reviewed at the start of the pandemic and found to be within tolerance of the original specification of the building. Advice has been provided to promote a fresh air policy I'm to ensure ventilation is optimised within all clinical and non clinical areas.	Impatient psychiatric units have restrictions on window opening as a safety precaution this can inhibit the flow of air. When temperatures have been very high colleagues have been advised on the appropriate use of bladed fans and the necessary cleaning regime to ensure their safe use in extreme circumstances.	A review of the air damping on ventilation has been undertaken and some fire dampers require replacement – order placed and installation schedule identified.

3. Ensure appropriate antimicrobial use to optimize 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 processes are in place to ensure: • Arrangements around antimicrobial stewardship are maintained.	Maintenance audit showed oversight of antimicrobial stewardship.	Lone use of antimicrobials within the Trust.	Low evidence of infections maintained.
Mandatory reporting requirements are adhered to and Boards continue to maintain oversight.	As above, all mandatory reporting is maintained and monitored through IMT during pandemic incident meetings and existing governance structures.	Patient Safety Team monitors the data trends and flag any anomalies.	Patient Safety Team continue to monitor reporting data.

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: • implementation of national guidance on visiting patients in a care setting	National guidance, communication, signage and application are in place. Adapted to DHCFT for pts in distress. Trust website	Visitor in guidance under regular review and any updates or changes made to visiting guidelines are to ensure minimal restriction and compliance with IPC guidelines.	Communication of any changes to IPC guidelines are evident through SOPchanges for acute and older adult and perinatal inpatient areas.

• Areas in which suspected or confirmed COVID-19 patients are possibly being treated in areas clearly marked with appropriate signage and have restricted access.	National guidance, communication, signage and application are in place. Regular audits an walk around checks.	Appropriate use of signage checked as part of IPC walk around.	Any missing signage is identified and replaced.

• there is clearly displayed, written information available to prompt patients' visitors and staff to comply with hands, face and space advice	The Communications team have provided links and access to guidance (easy read ones and multi-lingual versions).Trust website	Reviewed by Comms team to ensure up to date versions are in use.	Requests for updates / improvements / clarification channels led daily by Comms.

Infection status is communicated to the receiving organization or department when a possible or confirmed COVID-19 patient needs to be moved.	All staff are aware of the need to provide clear information to receiving teams. Alerts flag in all documents to ensure key risks are not missed. Compliance with dxc information to homes and care homes	This is reaffirmed through IPC outbreak meetings. Review of incidents have highlighted no identified cases of failure to communicate COVID-19 status on discharge or transfer through omission.	Communication flag / logo reviewed (EPR). Patient Safety Team liaise with colleagues in other sectors if gaps in communication are identified.

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 to other people

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
Systems and processes are in place to ensure: • screening and triaging of all patients as per IPC and NICE Guidance within all health and other care facilities must be undertaken to enable early recognition of COVID-19 cases.	The clinical teams are concordant with all current NH S England guidance on pre screening testing and repeat testing of individuals admitted with unknown covert status.	No gaps identified	a daily report is issued and reviewed by the IPC team identifying current swab status of all in-patients.
• Front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19 symptons to minimize the risk of cross-infection as per national guidance	Processes identified appropriate to local Estates to acknowledge areas to screen and support isolated patients whilst diagnostic clarity is gained.	No gaps identified.	Enhanced cleaning is in place where high patient / staff traffic is unavoidable.
• staff are aware of agreed template for triage questions to ask	Stuff use the national indicators to identify any potential or likely covered infection and all patients are admitted into isolation until covert negative status has been assured.	No gaps	
• triage undertaken by clinical staff who are trained and competent in the clinical case definition and patient is allocated appropriate pathway as soon as possible	Screening tools and escalation protocols in place. SOP to direct colleagues.	No gaps.	

• face coverings are used by all outpatients and visitors	Visitor SOP includes active promotion of face coverings. PPE available at all units / clinical areas.	No gaps.	
• Individuals who are clinically extremely vulnerable from COVID-19 receive protective IPC measures depending on their medical condition and treatment whilst receiving healthcare e.g. priority for single room isolation;	In-Patient SOP identifies active promotion of individual risk assessment and measures. Review of national clinical incidents to identify any emerging risks associated with MH units.	No gaps.	
• provide clear advice to patients on use of face masks to encourage use of surgical facemasks by all inpatients (particularly when moving around the ward) if this can be tolerated and does not compromise their clinical care	As above	No gaps	
• monitoring of Inpatients compliance with wearing face masks particularly when moving around the ward (if clinically ok to do so)	As above	No gaps	Balance of UIPC and patient engagement needs to be maintained. IPC measures for staff are significant mitigation alongside increasing vaccination rates.
• Patients, visitors and staff are able to maintain 2 metre social & physical distancing in all patient care areas; ideally segregation should be with separate spaces, but there is potential to use screens, e.g. to protect reception staff.	In place where appropriate.	No gaps	

• for patients with new-onset symptoms, isolation, testing and instigation of contact tracing is achieved until proven negative	Access to national team and support provided. Local HPU will also undertake contact tracing role.	No gaps.	National changes to COVID secure and increased free movement have made this harder to monitor.
• there is evidence of compliance with routine patient testing protocols in line with Key actions: infection prevention and control and testing document;	All pts tested on admission who consent. The Trust has capacity to test all patients on admission and isolate / cohort until results are obtained.	Some pts refuse testing	Patient refusals can be challenging. SOP in place and routine support from PHE. Cohorting SOP reviewed regularly as case profiles change / emerge. Vaccination status is informing risk assessments.
• Patients that test negative but display or go on to develop symptons of COVID-19 are segregated and promptly re-tested.	COVID daily reporting with tracker SOP in place. Cohorting for highly vulnerable separate harm confirmed / suspected cases.	No gaps.	Step down undertaken in accordance with clinical risk assessment and national guidance for NHS hospitals.
• Patients that attend for routine appointments who display symptons of COVID-19 are managed appropriately.	This is in place. EWS monitoring for all patients. (Early warning system) As per PHE Guidance. SOP in place. Cohorting for clinically vulnerable / suspected cases	No gaps	Trust use medium / high risk pathway for inpatients and pre attendance symptom checker for non-urgent.

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: • separation of patient pathways and staff flow to minimise contact between pathways. For example, this could include provision of separate entrances/exits (if available) or use of one-way entrance/exit systems, clear signage, and restricted access to communal areas	SOP's and rota management arrangements in place. Adherence to safer staffing levels.	No gaps.	Rosters and bubble / peripatetic staffing arrangements in place to manage unnecessary movement.

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
• all staff (clinical and non- clinical) have appropriate training, in line with latest PHE and other national guidance to ensure their personal safety and working environment is safe	n.b Limited use of volunteers / contractors at this time. IPC training, Moving and Handling with IPC input re PPE and hand washing, etc in place. Guidance and supporting information such as posters, videos, etc, are all updated regularly.	Limited training capacity due to social distancing / availability of key equipment. Work station arrangements in situ. Signage posters from PHE website on display.	. Risk assessment in situ. Alternative methods of delivery varied (training).

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
• staff providing patient care and working within the clinical environment are trained in the selection and use of PPE appropriate for the clinical situation and on how to safely don and doff it.	PPE guidelines are reviewed / communicated. Direct and additional training is provided to all areas with increased vigilance and support for in-patients. Don and doff guidelines / videos – direct tracking delivered routinely.	COVID oversight meeting in place.	Regular walk arounds – review by PPE link worker.

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
Systems and processes are in place to ensure: • A record of staff training is maintained.	Training records are maintained by training department.	Risk assessments in place to prioritise training for key staff.	Additional training provided for aspiring nurses and redeployed practitioners

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
• adherence to PHE national guidance on the use of PPE is regularly audited with actions in place to mitigate any identified risk	Audits of usage undertaken on a daily basis.	Closely monitored to ensure availability. Regional escalation / mutual aid utilized.	Trust committed to standing down service rather than expect staff to work without correct PPE.

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
hygiene facilities (IPC measures) and messaging are available for all patients/individuals, staff and visitors to minimise COVID-19 transmission such as: ○ hand hygiene facilities including instructional posters ○ good respiratory hygiene measures ○ staff maintain physical distancing of 2 metres wherever possible in the workplace unless wearing PPE as part of direct care ○ staff maintain social distancing (2m+) when travelling to work (including avoiding car sharing) and remind staff to follow public health guidance outside of the	Lots of evidence of communications through Trust web page, weekly communications, trust roadmap and social media. SOP's in place and signage evident on walkarounds.	No gaps.	

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
• Staff regularly undertake hand hygiene and observe standard infection control precautions.	Monitored routinely. IPC link / leads attend wards to demonstrate / observe practice.	Hand hygiene and ICP measures are all communicated to all core staff.	Regularly refreshed through Comms.

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
• 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 as per national guidance	Pape towels provided in all areas.	No gaps.	

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
• guidance on hand hygiene, including drying should be clearly displayed in all public toilet areas as well as staff areas	Significant signage evident.	No gaps	

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
• Staff understand the requirements for uniform laundering where this is not provided for on site.	Guidance issued in line with PHE/ IPC guidelines.	No gaps	Regularly refreshed through Comms.

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
• all staff understand the symptoms of COVID-19 and take appropriate action (even if experiencing mild symptoms) in line with PHE and other national guidance if they or a member of their household display any of the symptoms	Trust training / communication about changes in diagnostic assessment, isolation periods, treatment interventions are all provided by Comms.	EPR system in place to assure that testing and results are available for central scrutiny.	Switch to SystmOne EPR has highlighted challenges in reporting, currently being resolved.

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
a rapid and continued response through ongoing surveillance of rates of infection transmission within the local population and for hospital/organisation onset cases (staff and patients/individuals)	Local, regional and national data regularly scrutinised and actions taken accordingly.	No gaps.	

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
• positive cases identified after admission who fit the criteria for investigation should trigger a case investigation. Two or more positive cases linked in time and place trigger an outbreak investigation and are reported.	SOP and review system in place for pre-outbreak montiring (local intelligence from HPU) and formal review in accordance with HCAI definition.	No gaps.	

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
robust policies and procedures are in place for the identification of and management of outbreaks of infection. This includes the documented recording of outbreak meetings.	SOP's and policies in situ.	No gaps.	

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: • restricted access between pathways if possible, (depending on size of the facility, prevalence/incidence rate low/high) by other patients/individuals, visitors or staff	All areas are compliant with bed spacing, management of access / egress to isolation areas. IPC / PPE and cleaning regimes. Yes, pts not always stood down. Onward communication in place. Delayed transfer review and care home / residential training and support to transition in place	No gaps	Regular walk throughs and review of guidance. Close liaison with Urology / Path labs. Cohort plans adjusted to attend to local need / demand. .

areas/wards are clearly signposted, using physical barriers as appropriate to patients/individuals and staff understand the different risk areas	As described in doc.	No gaps	

• Patients with suspected or confirmed COVID-19 are isolated in appropriate facilities or designated areas where appropriate.	SOP in existence (used for all inpatient areas). Overseen by IMT.	No gaps.	Reviewed against case priorities and emerging guidance.

• areas used to cohort patients with suspected or confirmed COVID-19 are compliant with the environmental requirements set out in the current PHE national guidance	All areas are compliant with bed spacing, management of access / egress to isolation areas. IPC / PPE and cleaning regimes.	No gaps.	Highly vulnerable clients are cohorted in 'clean' areas to protect vulnerability.

Patients with resistant / alert organisms are managed according to local IPC guidance, including ensuring appropriate patient placement.	Advice and support provided from PHE or local IPC / CCG team.	No gaps.	IPC link / lead will be reviewed with all specific cases

8. Secure adequate access to laboratory support as appropriate

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
Systems and processes are in place to ensure: • Testing is undertaken by competent and trained individuals	'Teach one, test one' model undertaken by lead clinicians. As per existing guidelines.	No gaps.	Medical and Junior nursing assurance in place. Escalations made re staffing testing results Evidence of wider ranging diagnostic reviews.
• Patient and staff COVID-19 testing is undertaken promptly and in line with PHE and other national guidance.	Trust has access to swabs, Path labs, conveyance and links to local testing system calls.	No gaps	Regular liaison to identify blocks in system and local / regional solutions.
• regular monitoring and reporting of the testing turnaround times with focus on the time taken from the patient to time result is available	Reports provided by SVOC	No gaps.	Escalation route of required.
• Screening for other potential infections takes place.	Routine screening for MRSA, C.diff in situ. Flu and Nora Virus where indicated by symptoms.	No gaps.	
all emergency patients are tested for COVID-19 on iission.	Testing protocols and SOP's in place. Monitored for uptake and effectiveness.	No gaps.	

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
those inpatients who go on to develop symptoms of /ID-19 after admission are retested at the point ptoms arise.	As above	No gaps.	
those emergency admissions who test negative on iission are retested on day 3 of admission, and again veen 5-7 days post admission.	As above	No gaps.	
that sites with high nosocomial rates should consider testing COVID negative patients daily.	As above	No gaps.	Enacted during outbreaks.
that those being discharged to a care home are being tested for COVID-19 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	SOP and oversight framework in place.	No gaps.	

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
- that those being discharged to a care facility within their 14 day isolation period should be discharged to a designated care setting, where they should complete their remaining isolation.	SOP and oversight framework in place.	No gaps.	
- that all Elective patients are tested 3 days prior to admission and are asked to self-isolate from the day of their test until the day of admission.	SOP in place, rarely occurs.	No gaps.	Medium pathway typically applied in MH settings.

9. Have and adhere to policies designed for 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: • Staff are supported in adhering to all IPC policies, including those for other alert organisms. • accessible to staff who require it.	IPC leads will highlight appropriate policy / guidance for all staff. Updating of policy guidance has been maintained.	No gaps.	Virtual reviews of policies have been undertaken to avoid delay / omission of updated guidance.

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
• any changes to the PHE national guidance on PPE are quickly identified and effectively communicated to staff	IMT review policy changes and communicate latest PHE guidance / information regularly. Daily podcasts and briefings. The full range is available for review.	No gaps	Staff questions are answered through communication forums.

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
• all clinical waste and linen/laundry related to confirmed or suspected COVID-19 cases is handled, stored and managed in accordance with current national guidance	As per guidance and in correct location, collection bags and disposal units.	No gaps.	Review of facilities has been undertaken several times during COVID outbreak.

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
PPE stock is appropriately stored and accessible to staff who require it	Control store and local stock cupboards in place and daily monitoring.	Good controls in place. These have included local procurement and supply rather than relying on national supply chain.	National shortages are tracked / escalated through local / regional / internal framework Reduced stocks are highlighted and replenished.

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: • Staff in 'at risk' groups are identified and managed appropriately including ensuring their physical well-being is supported. • Staff • Staff absence and well-being are monitored and staff who are self-isolating are supported and able to access testing. • Staff that test positive have adequate information and support to aid their recovery and return to work.	IMT have clear processes to protect shielded and vulnerable staff. Clear management structure, well-being checker, daily health support. Daily reports to IMT to review support. Keep in touch calls to staff by line manager and People services. This has been positively received. Clear protocol developments through regional staff testing cell, led by DHCFT clinicians. Selection of feedback on staff support is available.	Updated as new guidance / evidence is available.	Trust has clear risk assessment protocols and 'People first' strategies are in place to reduce personal risks. Review of approaches based upon staff feedback / comments. Staff feedback / concerns reported / responded by Managers / IMT / Trust Comms.

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
• that risk assessment(s) is (are) undertaken and documented for any staff members in an at risk or shielding groups, including Black, Asian and Minority Ethnic and pregnant staff	Health based risk assessment process well embedded.	No gaps.	

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
• staff required to wear FFP reusable respirators undergo training that is compliant with PHE national guidance and a record of this training is maintained and held centrally	Fit testing Programme is in situ. Variety of products available for staff to use.	Risk assessments in place for staff who cannot be fit tested.	Staff supported to deploy skills into other areas where fit testing compliance cannot be met. RPE fit tester recruited

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
• staff who carry out fit test training are trained and competent to do so	Register of fit tested staff linked to ILS training logs or specific responsibilities such as Children's Physio, where AGP procedures are undertaken.	Improving list of RPE checked staff.	Fit tester applies flexible approach.

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
all staff required to wear an FFP respirator have been fit tested for the model being used and this should be repeated each time a different model is used	As above	Improving trajectory.	Dedicated person with oversight of requirements.

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
• a record of the fit test and result is given to and kept by the trainee and centrally within the organisation	As above	No gaps.	

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
• for those who fail a fit test, there is a record given to and held by trainee and centrally within the organisation of repeated testing on alternative respirators and hoods	As above	No gaps.	

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
• for 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	As above	No gaps.	

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
• 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	As above	No gaps.	

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
following consideration of reasonable adjustments e.g. respiratory hoods, personal re-usable FFP3, staff who are unable to pass a fit test for an FFP respirator are redeployed using the nationally agreed algorithm and a record kept in staff members personal record and Occupational health service record	As above	No gaps.	

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
• 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	As above	No gaps.	

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
• consistency in staff allocation should be maintained, reducing movement of staff and the crossover of care pathways between planned/elective care pathways and urgent/emergency care pathways as per national guidance	As above	No gaps	

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
• all staff should adhere to national guidance on social distancing (2 metres) if not wearing a facemask and in non-clinical areas	Clear protocols in place.	No gaps.	Regular reminders and support given through Communications and walkarounds.

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
• health and care settings are COVID- 19 secure workplaces as far as practical, that is, that any workplace risk(s) are mitigated maximally for everyone	COVID secure guidelines embedded. Policy and signage in situ.	No gaps.	

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
• staff are aware of the need to wear facemask when moving through COVID-19 secure areas.	As above	No gaps.	

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
• staff absence and well-being are monitored and staff who are self- isolating are supported and able to access testing	HPU team support colleagues to understand latest wellbeing and national guidelines to minimise risk and promote wellbeing.	No gaps.	HPU team is a significant addition to the Trust's resources.

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
• staff who test positive have adequate information and support to aid their recovery and return to work	As above	No gaps.	

Board Committee Assurance Summary Reports to Trust Board – 2 November 2021

The following summaries cover the meetings that have been held since the last public Board meeting held on 2 September:

- Mental Health Act Committee 17 September
- Quality and Safeguarding Committee 14 September and 12 October
- Finance and Performance Committee 28 September
- People and Culture Committee 21 September
- Audit and Risk Committee 7 October

Mental Health Act Committee - key items discussed 17 September 2021
Response to escalation made to Finance and Performance Committee on how the inadequate wi-fi situation at the Radbourne Unit, The Beeches and Hartington Unit can be resolved Confirmation was received that the upgrade work to the Wi-Fi at the acute units had started.
Mental Health Act (MHA) Report The report had also been extensively covered by the MHA Operational Group on 16 August. Significant assurance was received from the MHA Manager's report that the safeguards of the MHA have been appropriately applied within the Trust.
Liberty Protection Safeguards A progress report on the Trust's preparations for Liberty Protection Safeguards (LPS) provided assurance that preparation for the introduction of LPS within the Trust is on track.
S136 Suites and use of Section 135/136 There has been an increase in S136 detentions with small amounts resulting in hospital admission and this is in line with the national picture. There is a high degree of variability month to month, summer months tend to see higher figures. There was a pattern that showed greater use in the early hours of the morning. Work is continuing to engage with the Police to encourage them to use the mental health triage service before the use of the S136 suites.
Training Compliance The report provided significant assurance on Mental Capacity Act and Deprivation of Liberty Safeguards training compliance levels as at 5 August 2021.
Restrictive Practice six month update The data provided an opportunity to continuously review quality of care and identify any learning needs. The report evidenced that over the past 24 months there have been improving the levels of restrictive practice being used. Significant assurance was overall and on the approach being taken but limited assurance was received on observations performance.
Escalations to Board or other Committee(s) None

Key risks identified None	
Consideration of any items affecting the BAF No items were considered necessary for updating within the BAF.	
Next Meeting – 10 December 2021	
Committee Chair: Dr Sheila Newport, Non-Executive Director	**Executive Lead: Dr John Sykes Medical Director**

Finance and Performance Committee - key items discussed 28 September 2021
Estates Strategy – Dormitory eradication and Psychiatric Intensive Care Unit (PICU) National Approval Committee held 28 September attended by Trust Programme SRO. Committee approved both dormitory Outline Business Cases (OBCs) with usual conditions for cases of this materiality. The national team will draft a Memorandum of Understanding (MOU) to provide funding (out of the £80m) for the enabling works in advance of FBC approval. Principal Supply Chain Partner appointed for refurbishment work. OBCs are in development for PICU, acute plus and balance of dormitory eradication through refurbishment. CDEL commitment discussions continue with JUCD and Regional Finance leads. Overview and scrutiny discussions and consultation discussions progressing well Specialist VAT advice is expected to be received in next few weeks Limited assurance.
OnEPR Programme update Phase 3 (working age inpatient) and phase 4 (working age community) will be combined into one delivery phase to optimise risks and benefits. Options were discussed with agreement by Executives for option 3 with the go live of 24 January 2022. Discussions with Channel 3 and risks, benefits and dependencies described and supported. It was noted that the additional costs are incorporated into financial forecast. The new plan is currently on track. Update on inpatient physical observations software solution App with a near-future implementation date was well received. Limited assurance.
Operational Performance Report covered key areas of performance to end of July and included three day follow up post-discharge, data quality maturity, waiting times across a number of services, placements. Multi-Agency Discharge Event (MADE) commenced 4 October – system flow review, action planning and exploration of any ‘hidden’ wait potential (linked to pandemic factors including referral numbers and potential for diverted attendance to different services). Child and Adolescent Mental Health Service (CAMHS) waiting list oversight – stocktake at the end of October on progress made and to determine waiting list management approaches in future. Adult out of area placements significant improvement. A 72 hour ‘limit’ on placements has been put in place as part of the quality initiative. Autism Spectrum Disorder (ASD) assessments discussion took place on current referral and wait picture. Limited assurance
Business environments – partnerships, planning and system transformation update Regional Provider collaboratives – Progress and key discussions from IMPACT (secure), Children and Young People Tier 4 collaborative. Local system working – including Multi Agency Discharge event to optimise flow through mental health urgent pathway Ongoing co-production for transformation of community mental health services, community perinatal, children and young people crisis and home treatment Dementia and delirium in particular the recovery of the memory assessment services performance.

Learning Disability (LD) and Autism services - progress with intensive support service and with improving the Derbyshire System performance for Transforming Care Programme (TCP) (which is in Regional/National escalation). Different collaborative approach is in development urgently with regard to the system delivery approach and associated leadership.

DHCFT as lead provider for Regional perinatal inpatient services – additional capacity secured to lead the process to establish regional partnership and appropriate governance path and determination of financial implications, timeframe to be confirmed

Recruitment challenges in the NHS. People and Culture conversations and data analysis. Rapid recruitment initiatives being led by COO.

Financial governance and plan delivery including CIP (Cost Improvement Programme)

Joined Up Care System position noted. Year to date H1 and forecast full year positions noted.

Current understanding of H2 planning discussed. Capital and cash planning and risks noted.

Current planning for cost improvement noted (subject to H2 and financial envelope confirmation).

Organisational and system accountability and discussions on underlying positions and exit run rates.

Agency spend still significantly above ceiling. Run rate analysis of core business, Covid and vaccination costs compared to estimated income (in absence of confirmed arrangements for H2).

Urgent need for transformation to progress the delivery of increased efficiencies that are expected to be required locally and nationally for H2 and beyond.

Better Payments Practice Code performance noted. Current off-payroll position noted.

Limited assurance obtained on plan delivery. Significant assurance obtained on appropriate financial governance

Continuous improvement including Quality Improvement (CI/QI) approach

Quality Improvement strategy refresh being developed including utilisation of new software and resources.

Approach to data capture on continuous improvement across strategic priorities

Alignment of CIP with CI/QI – tiered delivery approach and cross-team working.

Single system to show quality, staffing and productivity benefits

Material training requirements and buy-in to bring cultural change to everyday activities and decision making on quality improvement and processes

Level of QI assurance to be confirmed at Quality and Safeguarding Committee as part of Quality Improvement Strategy

Board Assurance Framework risks

No changes required and Committee discussions were appropriate to the BAF risks allocated to them

Escalations to Board or other committees

None

Next Meeting – 16 November 2021

Committee Chair: Richard Wright	**Executive Lead: Claire Wright, Director of Finance and Deputy Chief Executive**

Audit and Risk Committee - key items discussed 7 October 2021
Review of the Board Assurance Framework (BAF) The third issue of the BAF for 2021/22 showed there are now five operational risks from the corporate risk register that are aligned to the BAF. One new operational risk has been added to the corporate risk register and rated as extreme; this has been aligned to Risk 1a "*There is a risk that the Trust will fail to provide standards for safety and effectiveness as required by our patients and our Board.".* The Director of People and Inclusion (DPI) is Lead on BAF Risk 2b "*There is a risk of continued inequalities affecting health and wellbeing of both staff and local communities"* - the DPI suggests that any key gaps in control with regard to community members should be incorporated into 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"* with the Director of Nursing as Lead, under the umbrella of providing 'standards for safety and effectiveness as required by our patients'. The next iteration of the BAF going to the Board will summarise this change. The Committee approved the third issue of the BAF 2021/22 for submission to the Board on 2 November.
Summary of progress against the Risk Management Strategy 2019-2022 The report set out progress against the main objectives set within the strategy and highlighted the risk management process being carried out through division risk register through the newly developed Trust Operational Organisation Leadership (TOOL) meetings. Significant assurance was obtained from the progress made against the 2019-2022 Risk Management Strategy.
Review of 2020/21 Annual Report and Accounts Production A review of the production of the 2020/21 Annual Report and Accounts concluded that the process went well, with leads for each section working effectively together in order to ensure statutory requirements were met. Some areas of learning have been identified and will be taken forwards for the development of the report for 2021/22.
Freedom to Speak Up Update Report The six-monthly report on the implementation of the Trust's Freedom to Speak Up (FTSU) policy framework evidenced the positive reaction to FTSU, especially at staff induction. Significant assurance was obtained from the adequacy of the Trust's arrangements by which Trust staff may, in confidence, speak up about possible improprieties in matters of financial reporting and control and related matters or any other matters of concern.
Management of salary overpayments An update on the actions implemented in relation to the management and prevention of overpayments highlighted how overpayments have been due to late termination of leavers. New guidance being offered to managers will improve the level of control. Limited assurance was taken on the development and implementation of the reference guide in the anticipation that it will take another month before we can evidence any impact of the outlined actions on the overpayments.
Update on 2021/22 objectives for the Audit and Risk Committee The Committee confirmed it was satisfied with the progress made against its 2021/22 objectives.
Standard Financial Instructions (SFI) Revisions to SFIs were reviewed and agreed for submission to the Board for approval on 2 November 2021.

External Audit

The Trust's External Auditors, Mazars provided assurance that they have resource in place to ensure reporting timelines are met.

Declarations of Interest Update

This update was made to the Committee on the Trust's interest return for Decision Making Staff considering the lower than expected return reported in April 2021 due to the impact the COVID-19 response had had on returns.

The update report showed that declarations have returned to normal levels and provided significant assurance that the Declaration of Interest Policy is implemented in respect of Decision Making Staff and is generating appropriate responses from those who hold that position.

Data Security and Protection Report Q1 – Q2 (April – September 2021)

This report included a performance update on the Trust's progress towards meeting the requirements of the 2021-22 Data Security and Protection (DS&P) Toolkit. Including work of the DS&P Committee, incident breach monitoring and concerns.

The high level of compliance with the DS&P Toolkit provided significant assurance that information is handled correctly and protected from unauthorised access, loss, damage and destruction. Significant assurance was also obtained from the committed response of the DS&P Committee to data and cyber security.

Internal Audit

Since the last meeting in July the Trust's Internal Auditor, 360 Assurance have issued their Data Quality Framework report with significant assurance and published their Mandatory Training report with significant assurance.

Counter Fraud progress update

Since the last meeting on 1 July the Trust has submitted information to NHSCFA as part of a national exercise looking at purchase order (PO) versus non-PO spend and Covid-related public procurement notices (PPNs). The Counter Fraud Anti-Crime Specialist has launched a project to respond to the new requirements around the assessment and management of fraud risks. Significant assurance was received that alerts and fraud warning intelligence have been appropriately communicated to the Trust.

Counter Fraud and Bribery Policy and Procedures

The revised policy was seen to include more helpful detail to ensure individuals are supported and was ratified by the Committee.

Escalations to Board or other committees

No items were considered necessary for escalation.

Key risks identified

None

Next Meeting – 27 January 2022

Committee Chair: Geoff Lewins	**Executive Lead: Justine Fitzjohn, Trust Secretary**

Quality and Safeguarding Committee Assurance summary of meetings held 14 September and 12 October 2021

Quality and Safeguarding Committee - key items discussed 14 September 2021
Summary of BAF Risks BAF risks were considered within the Committee's current work programmes. Updates were discussed and agreed for 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"*. These included the community forensic risk and increased waiting times for memory assessment that will be incorporated in the next iteration of the BAF.
Progress on COVID-19 vaccinations Good progress is being made to ensure people within the Trust's care are vaccinated. The Trust has made significant headway above regional levels of compliance and above population levels and currently stands at 93% for colleagues. Significant assurance was received on the Trust's contribution to the Joined Up Care Derbyshire county vaccination programme.
Joined Up Care Derbyshire (JUCD) Learning Disabilities Provider Collaboration Reviews The report covered provider responsibilities across the collaboratives and showed that some areas within Learning Disabilities (LD) and Autism Spectrum Disorder (ASD) non-Trust pathways require further improvement. The Committee noted and was significantly assured by the completion of this review on the specific Trust's services.
Learning from Deaths Mortality Report Significant assurance was obtained from information relating to Serious Incidents (SIs) occurring from 30 April to 22 July. It was agreed that the report could be submitted to the Board on 2 November once the 'all deaths' figures have been corrected. In order to meet the Board's expectation that the report will show different ethnicities within Derbyshire communities and people's sexual orientation this data will have to be manually uploaded from wider non Trusts systems and data completeness checks will need to be implemented. For this specific report in cases of mortality, this may not be possible. The Committee was mindful of not wanting to create extra work for the team when it is clear that there is an underlying reason why full reporting is not possible within different reporting systems.
Physical Healthcare Annual Report The substantial progress made in physical health checks was seen as a significant turnaround. Despite the progress made in physical healthcare checks limited assurance was obtained from the report.
CQC recommended actions against the CCTV Policy The Committee was satisfied that solid data protection and a CCTV policy and procedures are in place and received significant assurance from the report.
NICE Guidelines NICE guidance management has been stood back up and is line with the position held with the COVID-19 pandemic. There is still more work to be completed and a progress run rate of NICE guidelines completion. Activity will increase within the COVID-19 recovery plan.
Patient Experience Quarterly Report The Patient Experience Quarterly Report provided an overview of the analysis of the complaints and incidents data for Quarter 1 of the financial year 2021/22 as well as themes and changes

made to Trust services as a result of feedback on incidents and complaints made to the Patient and Carer Experience Committee.

Although some areas are improving the report shows a worsening community survey picture in a t number of areas of patient experience. It was understood that due to the pandemic community services have been caring for patients virtually and this is a theme of feedback. Improvements are being prioritised in these areas and be evidenced in the next report to show how concerns are being turned around. Limited assurance was taken from the report due to these concerns that will be scrutinised further in the next quarterly report.

Safeguarding Children Assurance Report

A report of Safeguarding Children activity in the Trust updated the Committee with statutory and legislative requirements, together with progress made against the Trust's Safeguarding Strategy.

The Safeguarding Children Unit is in a stable position providing a full service with no gaps. During COVID-19 the Safeguarding Leads have ensured robust business continuity plans have been in place. The team is to be congratulated as assurance obtained from the report has remained consistent. Improvements noted in training compliance provided assurance with the recovery of the training programme.

Significant assurance was gained around Safeguarding Children activity, systems and controls within the Trust.

Safeguarding Adults Assurance Report

This report provided an update on Adult Safeguarding clinical practice standards. This included performance in implementing the Trust's Safeguarding Strategy and the safeguarding specific quality priorities for 2021 in improving sexual safety.

Overall the Safeguarding Adults Unit is in a more stable position. Solid improvements were noted in work taking place in the community particularly with the Community Forensic team providing supervision to colleagues working with service users with a forensic history across the Trust's services.

Significant assurance was received from the report.

Safeguarding Children and Adults at Risk Annual Report

The annual production of this report is a governance requirement of both the Trust and the Safeguarding Children and Adults Boards. It provided significant assurance that the Trust is meeting its legal and statutory performance and governance requirements in a consistent and reliable manner. The report confirmed that the Trust has had a successful year and continues to fully discharge its statutory safeguarding duties. The Committee approved the report for submission to the Board on 2 November.

Looked After Children Annual Report

This 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 Committee received significant assurance from the work of the Trust in discharging its formal statutory duties to vulnerable children. Approval was given for the report to be submitted to the Board on 2 November.

NICE Guidelines Policy and Procedure

The policy was reviewed and ratified by the Committee.

Escalations to Board or other committees

None

Key risks identified

The following consideration of items affecting the BAF were listed as follows:

• Gaps in control with implementing/recovery of NICE Guidelines • Gaps in control concerning community mental health services survey, quality of patient experience which may be related to virtual care offers and the lived experience of the pandemic • BAF risks relating to physical healthcare will remain rated as medium • Gaps in control relating to learning from deaths/mortality reporting equality data • Risks relating to assessment of LD and ASD risks are to capture the Trust's contribution as a provider to mitigate risks to patient safety and flow to the system risk and trajectory for improvement. • The red rated community forensic risk will be updated in the next iteration of the BAF, subject to an investment decision and commencement of the service • Waiting times breach for memory assessment is one of the Mental Health, Learning Disability and Autism Delivery Board risks that will also be updated in the BAF.
Next Meeting – 12 October 2021

Committee Chair: Margaret Gildea	**Executive Lead: Carolyn Green, Director of Nursing and Patient Experience**

Quality and Safeguarding Committee - key items discussed 12 October 2021
Summary of BAF Risks BAF risks were considered within the Committee's current work programmes. Risks relating to insufficient investment in autism assessment and treatment services and lack of reduction in autism waiting lists were discussed. Due to the high number of people with autism in the locality it was agreed that the rating of this risk should remain rated as amber.
COVID-19 and Health Protection Unit (HPU) update The Trust remains COVID-19 free with staff cases remaining low. Over the next two to three months the focus for HPU is on delivering flu vaccinations and COVID-19 booster vaccinations to staff and inpatients with full commencement of flu from early October and Pfizer Booster vaccine from 18 October 2021. The HPU will begin to formulate plans for post winter 2022 readiness and priorities for the forthcoming year. Significant assurance was received from
Commissioning of Community Forensic Services Significant assurance was obtained from progress made with the third phase of investment to further expand the existing Community Forensic Service. The Business Case was signed off by the Mental Health, Learning Disability and Autism System Delivery Board on 7 October and the recruitment programme has commenced.
Infection Prevention and Control (IPC) Annual Report 2020/21 Significant assurance was received from standards of cleanliness of clinical areas and food preparation areas. Significant assurance was also obtained from approaches and learning that are evolving in accordance with emerging evidence and international / national and regional learning. The IPC team was congratulated on their consistent high level of performance against infection control standards and related management activities. The report was approved for submission to the Board of Directors.
Chief Pharmacist's Quarterly Report This was considered to be a solid report that evidenced the significant grip that the Chief Pharmacist has on the delivery of COVID-19 vaccines, influenza vaccines and a staff vitamin D offer as well as the governance and assurance of medicines-specific aspects and the procurement and supply of pharmaceuticals. The report was accepted with significant assurance.

Patient Experience Strategy six month update The patient experience strategy work plan has continued to make progress, however, during the COVID-19 pandemic there has been some delay. The Patient and Carer Experience Committee has largely continued to function and meeting virtually, apart from the early parts of the pandemic in 2020. Work within the Trust has been underway to expand the engagement of carers and service users through the new hospital project and community mental health framework and integrated care system. Limited assurance was obtained from the progress being made with Patient Experience Strategy work plan as the improvements are in recovery post pandemic.	
Quality Impact Assessment Procedure Due to the COVID pandemic response, Cost Improvement Programmes were stood down by NHSEI from March 2020 to date. The second half of the 2021/22 year will include efficiency and productivity requirements of local systems and organisations. Should any new Cost Improvement Projects or schemes come forward to support the delivery of this financial requirement, the process outlined in the procedure will be reinstated. This paper proposed no changes from the procedure in place from before the pandemic and provided the Committee with significant assurance that a robust process and procedure is in place to ensure quality of services is not adversely impacted by the implementation of any cost improvement projects or schemes.	
Escalations to Board or other committees None	
Key risks identified None	
Next Meeting – 9 November 2021	
Committee Chair: Margaret Gildea	**Executive Lead: Carolyn Green, Director of Nursing and Patient Experience**

People and Culture Committee - key items discussed 21 September 2021
Summary of BAF Risks The Committee noted the BAF risks it is responsible for and challenged why Risk 2a "*There is a risk that we do not sustain a healthy vibrant culture and conditions to make Derbyshire Healthcare Foundation Trust (DHCFT) a place where people want to work, thrive and to grow their careers*" had been reduced from extreme to high bearing in mind high levels of turnover and level of unfilled vacancies.
People and Inclusion Performance Dashboard Limited assurance was received from the performance dashboard indicators. Staff sickness and the time taken to recruit resources were the main cause for concern. It is expected that new performance data indicators and new service level agreements will show improvements in these areas. Concerns raised with safer staffing data is to be escalated to the Quality and Safeguarding Committee.
Trust response to Paterson Enquiry - action plan An updated RAG rated report provided significant assurance of actions developed by the Trust's Medical Director in response to the Independent Inquiry. The Committee acknowledged that the Quality and Safeguarding Committee will receive assurance about operational issues and People and Culture Committee will receive assurance around the revision of the disciplinary policy for medical staff.
Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) 2020/21 and action plans sign off The WRES and WDES were received for review and approval, prior to submission to NHS England. The WRES shows improvement in the recruitment and representation of BME staff at senior levels but requires further work to address the variations in workplace experience with regards to harassment, bullying and the rates of disciplinary action against people from a BME background. Improvements were seen in WDES data across almost all indicators. Significant assurance was received from the WRES and WDES plans/actions.
Planning for 2021 NHS Staff Survey Following the outstanding results of last year's survey, significant assurance was received from the preparation that has taken place to launch the NHS Staff Survey 2021.
Analysis of Pulse Check/Staff Survey results from the medical workforce This report detailing the results of the 2020 National NHS Staff Survey, specifically relating to the medical workforce was produced following an escalation received from the Quality and Safeguarding Committee, where data was highlighting increasing levels of absence and stress amongst the medical workforce. Limited assurance was taken from the report as there are areas that require further focus within a number of key themes and questions. A further update was requested for the next meeting in November.
Developing Nurses through apprenticeships and supporting the Princes Trust The report highlighted the recent success with recruiting to a cohort of nursing apprentices and the work that the Trust is carrying out with the Princes Trust.

Significant assurance was obtained from the plans to support a cohort of the Princes Trust and from the different ways of working to ensure workforce pipelines are expanded.

Media Handling Policy and Social Media Policy

Updated versions of these two polices were reviewed and ratified by the Committee.

Escalations to Board or other committees

Anomalies around data relating to safer staffing escalated to the Quality and Safeguarding Committee.

Key risks identified

None

Next Meeting – 23 November 2021

Committee Chair: Julia Tabreham	**Executive Lead: Jaki Lowe, Director of People and Inclusion**

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 2 November 2021

Register of Trust Sealings

Purpose of Report
This report provides the Trust Board with a six month update of the authorised use of the Trust Seal since the last report to the Board on 4 May 2021.

Executive Summary

In July 2019 Section 8.18 of the Standing Financial Instructions and Standing Orders of the Board of Directors was amended and the contract value for when the Trust seal is required was increased from £100,000 to £500,000. Therefore, every contract which exceeds £500,000 shall be executed under the Common seal of the Trust and be signed by the Trust Secretary and an Executive Director (voting or non-voting) duly authorised by the Chief Executive and not from the originating department (as set out in the Board's Standing Financial Instructions point 8.18).

These transactions will apply where the Board has previously approved the business through the Capital Expenditure Plan or the Estates and Agile Working Strategy. In accordance with the Standing Orders of the Board (section 12 point 6) a report of all sealing shall be made to the Trust Board twice a year. The report will contain details of the seal number, the description of the document and date of sealing. The register will be retained by the Trust Secretary.

A report on use of the seal was last made to the Board on 4 May. Since the last report, the Trust Seal was affixed five times as follows (the contract value for these transactions was valued at over £500,000):

- DHCFT74: Erection of single storey plant building with compound at the Radbourne Unit, Royal Derby Hospital site
- DHCFT75: Agreement for lease with landlord's consent on lower ground floor, Town Hall, Ripley
- DHCFT76: Lease first floor, Town Hall Ripley
- DHCFT77: Ground floor lease, Deepdale
- DHCFT78: P22 Framework Agreement schedule 4, Sir Robert McAlpine.

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

Assurances

Use of the Trust Seal has been undertaken in accordance with the Standing Financial Instructions and Standing Orders of the Board of Directors.

Consultation

N/A

Governance or Legal Issues

The affixing of the seal is consistent with the Board's responsibilities outlined within the Standing Financial Instructions and Standing Orders of the Board of Directors.

Public Sector Equality Duty and Equality Impact Risk Analysis

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

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

Recommendations

The Board of Directors is requested to note the authorised use of the Trust Seal since May 2021 and receive full assurance that this has been undertaken in accordance with the Standing Financial Instructions and Standing Orders of the Board of Directors.

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

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

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 2 November 2021

Report from the Council of Governors meetings

The Council of Governors has met four times since the last report. Following national guidance on keeping people safe during COVID-19 and the need for social distance, the meetings were conducted digitally via Microsoft Teams.

Extraordinary Council of Governors held on 6 July 2021

This meeting was convened to approve the appointment of the new Trust Chair.

Confidential Council of Governors held on 6 July 2021

This meeting was convened to discuss a commercial and confidential matter regarding external auditor arrangements.

Council of Governors held on 7 September 2021

Chief Executive Update

The Chief Executive provided the meeting with an update which included:

- The current situation regarding the COVID-19 pandemic
- The Trust's roadmap out of lockdown
- Integrated Care Systems and collaborative working

Presentation of The Annual Report and Accounts 2020/21 and report from the External Auditors

Claire Wright, Deputy Chief Executive and Director of Finance presented a summary on the financial performance of the Trust during 2020/21. Mazars, the Trust's External Auditors, delivered a presentation on the Trust's Annual Audit Letter, summarising the key findings of the audit.

Lead Governor Role and Deputy Lead Governor Role

Caroline Maley reiterated the importance of the Lead Governor role and requested that the Council of Governors encourages eligible governors to submit a nomination for the Lead Governor role; and also for the Deputy Lead Governor role. A recommendation by the Governance Committee to reduce the eligibility criteria for the Lead Governor role from twelve to six months was was approved by the Council on 7 September.

Non-Executive Director Deep Dive Report

Geoff Lewins, as Chair of the Audit and Risk Committee, presented the Deep Dive to governors which included the annual report of the Audit and Risk Committee; and activities he has undertaken.

Escalation of items to the Council of Governors

One item of escalation was received from the Governance Committee meeting held on 10 August:

Governors seek assurance on the current status on psychiatrist recruitment and retention to the Trust's psychiatric services; and in particular an update on vacancies and whether these have been filled by permanent staff, locums or remain vacant.

The response was tabled at the meeting.

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 Non-Executive Directors (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.

Mental Health, Autism and Learning Disabilities System Delivery Board

Ifti Majid delivered a presentation on the Mental Health, Autism and Learning Disabilities System Delivery Board.

Governance Committee Report

The Chair of the Governance Committee presented a report of the meetings held on 15 June and 10 August. At the meetings the Committee reviewed the Terms of Reference and agreed that with one amend they were fit for purpose. The Committee also reviewed the Governor Membership Engagement Action Plan.

The Council of Governors approved the Committee's Terms of Reference as recommended by the Committee.

Any Other Business

Governors were encouraged to complete the Governor Annual Effectiveness survey; and to attend the Annual Members Meeting on 9 September 2021.

Confidential Council of Governors held on 7 September 2021
This meeting was convened to approve the minutes from the confidential Council of Governors held on 6 July.

Recommendation

The Board of Directors is asked to note the summary report from the Council of Governors.

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

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Term / Abbreviation	**Terms in Full**
CPR	Child Protection Register
CQC	Care Quality Commission
CQI	Clinical Quality Indicator
CQUIN	Commissioning for Quality and Innovation
CRB	Criminal Records Bureau
CRG	Clinical Reference Group
CRS	(NHS) Care Records Service
CRS	Commissioner Requested Services
CSF	Commissioner Sustainability Fund
CTO	Community Treatment Order
CTR	Care and Treatment Review
D	
DAT	Drug Action Team
DBS	Disclosure and Barring Service
DBT	Dialectical Behavioural Therapy
DfE	Department for Education
DDCCG	Derby and Derbyshire Clinical Commissioning Group
DCHS	Derbyshire Community Health Services NHS Foundation Trust
DHCFT	Derbyshire Healthcare NHS Foundation Trust
DIT	Dynamic Interpersonal Therapy
DNA	Did Not Attend
DH	Department of Health
DoLS	Deprivation of Liberty Safeguards
DNA	Did not attend
DPA	Data Protection Act
DRRT	Dementia Rapid Response Team
DTOC	Delayed Transfer of Care
DVA	Derbyshire Voluntary Action (formerly North Derbyshire Voluntary Action)
DWP	Department for Work and Pensions
E	
ECT	Enhanced Care Team
ECW	Enhanced Care Ward
ED	Emergency Department
E&D	Equality and Diversity
EDI	Equality, Diversity and Inclusion
EDS2	Equality Delivery System 2
EHIC	European Health Insurance Card
EHR	Electronic Health Record
EI	Early Intervention
EIA	Equality Impact Assessment
EIP	Early Intervention In Psychosis
ELT	Executive Leadership Team
EMDR	Eye Movement Desensitising & Reprocessing Therapy
EMR	Electronic Medical Record
EPR	Electronic Patient Record
ERIC	Estates Return Information Collection
ESR	Electronic Staff Record
EUPD	Emotionally Unstable Personality Disorder
EWTD	European Working Time Directive
F	

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS

NHS Term / Abbreviation	**Terms in Full**
FBC	Full Business Case
FFT	Friends and Family Test
FIMS	Financial Information Management System
FOI	Freedom of Information
FMP	Financial Management Programme
FOIA	Freedom of Information Act
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/FYFV	Five Year Forward View
G	
GDPR	General Data Protection Regulation
GGI	Good Governance Institute
GMC	General Medical Council
GP	General Practitioner
GPFV	General Practice Forward View
GPS	Government Procurement Services
H	
HA	Health Authority
HCA	Healthcare Assistant
HEE	Health Education England
HES	Hospital Episode Statistics
HoNOS	Health of the Nation Outcome Scales
HSCIC	Health and Social Care Information Centre
HSE	Health and Safety Executive
HWB	Health and Wellbeing Board
HWE	Healthwatch England
I	
IAPT	Improving Access to Psychological Therapies
ICM	Insertable Cardiac Monitor
ICS	Integrated Care System (formerly ACS)
ICT	Information and Communication Technology
ICU	Intensive Care Unit
IDVAs	Independent Domestic Violence Advisors
IG	Information Governance
ILS	Immediate Life Support (BLS – Basic Life Support)
IM&T	Information Management and Technology
IMCA	Independent Mental Capacity Advocate
OOA	Outside of Area
IPP	Imprisonment for Public Protection
IPR	Integrated Performance Report
IPT	Interpersonal Psychotherapy
J	
JNCC	Joint Negotiating Consultative Committee
JTAI	Joint Targeted Area Inspections
JUCB	Joined Up Care Board
JUCD	Joined Up Care Derbyshire

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Term / Abbreviation	**Terms in Full**
K	
KPI	Key Performance Indicator
KSF	(NHS) Knowledge and Skills Framework
L	
LA	Local Authority
LAC	Looked After Children
LCFS	Local Counter Fraud Specialist
LD	Learning Disabilities
LHP	Local Health Plan
LHWB	Local Health and Wellbeing Board
LOS	Length of Stay
LPS	Liberty Protection Safeguards
LTC	Long Term Conditions
LTP	(NHS) Long Term Plan
M	
MARS	Mutually Agreed Resignation Scheme
MAU	Medical Assessment Unit
MAS	Memory Assessment Service
MAPPA	Multi-agency Public Protection Arrangements
MARAC	Multi-agency Risk Assessment Conference (meeting where information is shared on the highest risk domestic abuse cases between representatives of local police, probation, health, child protection, housing practitioners, Independent Domestic Violence Advisors (IDVAs) and other specialists from the statutory and voluntary sectors.
MASH	Multi-Agency Safeguarding Hub
MCA	Mental Capacity Act
MDA	Medical Device Alert
MDM	Multi-Disciplinary Meeting
MDT	Multi-Disciplinary Team
MFF	Market Forces Factor
MHA	Mental Health Act
MHIN	Mental Health Intelligence Network
MHIS	Mental Health Investment Standard
MHRT	Mental Health Review Tribunal
MSC	Medical Staff Committee
MSK	Musculoskeletal (conditions)
N	
NAO	National Audit Office
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 Improvement
NHSPS	National Health Service Pension Scheme
NHST	National Health Service Trust
NIHR	National Institute for Health Research
NSFR	National Service Framework
O	

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Term / Abbreviation	**Terms in Full**
OBC	Outline Business Case
ODG	Operational Delivery Group
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
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
PPI	Patient and Public Involvement
PPT	Partnership and Pathway Team
PREM	Patient Reported Experience Measure
PROMS	Patient Reported Outcome Measure
PSF	Provider Sustainability Fund
PSIRF	Patient Safety Incident Review Framework
Q	
QAG	Quality Assurance Group
QC	Quality Committee
QIA	Quality Impact Assessment
QIPP	Quality, Innovation, Productivity Programme
R	
RAID	Rapid Assessment, Interface and Discharge
RCGP	Royal College of General Practitioners
R&D	Research and Development
RCI	Reference Cost Index
REGARDS	Race, Economic disadvantage, Gender, Age, Religion or belief, Disability and Sexual orientation
RTT	Referral to Treatment
S	
SAAF	Safeguarding Adults Assurance Framework
SBARD	Situation, Background, Assessment, Recommendation and Decision (SBARD) tool
SBS	Shared Business Services
SEND	Special Educational Needs and Disabilities
SI	Serious Incidents
SID	Senior Independent Director
SIRI	Serious Incident Requiring Investigation
SLA	Service Level Agreement

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Term / Abbreviation	**Terms in Full**
SLR	Service Line Reporting
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 (formerly plan)
SUI	Serious Untoward Incident
T	
TARN	Trauma Audit and Research Network
TCP	Transforming Care Partnerships
TCS	Transforming Community Services
TDA	Trust Development Authority
TMT	Trust Management Team
TUPE	Transfer of Undertakings (Protection of Employment) Regulations 1981
TMAC	Trust Medical Advisory Committee
U	
UDBH	University Hospitals of Derby and Burton NHS Foundation Trust
V	
VCS	Voluntary and Community Sector
VFM	Value for Money
VO	Vertical Observatory
W	
WDES	Workforce Disability Equality Standard
WRAP	Wellness Recovery Action Plan
WRES	Workforce Race Equality Standard
WTE	Whole Time Equivalent
Y	
YTD	Year to Date

Exec Lead	Item	4 May 21	6 Jul 21	7 Sep 21	2 Nov 21	18 Jan 22	1 Mar 22
	Paper deadline	**27 Apr**	**29 Jun**	**31 Aug**	**21 Oct**	**7 Jan**	**17 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 - Green Plan sign off (November each year)	X	X	X	X Green Plan	X	X
STRATEGIC PLANNING AND CORPORATE GOVERNANCE							
COO/DOF	NHSI Financial Annual Plan Month 7-12 2021/22				X		
DPI	Staff Survey Results	X					Headlines
DPI	Annual Gender Pay Gap Report for approval						X
DPI	Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) request for Board delegated authority for People and Culture Committee meeting on 21 September to approve the October submissions			X			X
DPI	Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) Strategic implications/retrospective sign off after PCC in Nov and update report in Mar 2022				X		X
DPI	2021/22 Flu Campaign	Summary result of 2020/21 campaign		X			
DPI	People Plan Annual Report						A
Trust Sec	NHS Improvement Year-End Self-Certification	X					
Trust Sec	Year-end governance reporting from Board Committees and approval of ToRs	X					
Trust Sec	Corporate Governance Framework						X
Trust Sec	Review SOs, SFIs, SoD plus review/ratify SFI Policy (as Policy Review section below)						
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	X		X
Trust Sec	Fit and Proper Person Declaration		X				
Trust Sec	Annual Approval of Modern Slavery Statement	X					
Committee Chairs	Board Committee Assurance Summaries (following every meeting	X	X	X	X	X	X
COO	Annual Emergency Planning Report (EPPR)					X	
DBI&T	Learning Disabilities Clinical Strategy - timeline TBC						
DBI&T	Mental Health, Learning Disability and Autism Annual summary - timeline TBC						
DBI&T/CEO	Trust Strategy/RoadMap Review (incorporated within CEO Report)	X			X		

2020-21 Board Annual Forward Plan

Exec Lead	Item	4 May 21	6 Jul 21	7 Sep 21	2 Nov 21	18 Jan 22	1 Mar 22
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		
DON/COO/DPI	Workforce Standards Formal Submission/Safer Staffing (prior to going on website)	X					
QUALITY GOVERNANCE							
	Quality Position Statement Report - focus on CQC domains (Well Led CQC & NHSI) as per schedule - Caring led by DON due April 2022		Safety MD	Well Led Trust Sec (interim report)	Effective DON & DPI	Use of Resources DOF	Responsive COO
MD	Learning from Deaths Mortality report (quarterly publication) (Jul/Nov/Jan/Mar)		X		X		
MD	Guardian of Safe Working Report	X		X	X		X
MD	NHSE Return on Medical Appraisals sign off - delayed for 2020/21						
DON	Control of Infection Annual Report				X		
MD	Re-validation of Doctors Compliance Statement			X			
DON	Receipt of Annual Reports: - Annual Looked After Children - Safeguarding Children and Adults at Risk				X X		
DON	Outcome of Patient Stories - every two years					X	
POLICY REVIEW							
DOF/ Trust Sec	Standing Finance Instructions Policy and Procedures Review SOs, SFIs, SoD plus review/ratify SFI Policy (next SFI review July 2022)				X Ratify revisions		
Trust Sec	Engagement between the Board of Directors and CoG (Nov 2022)						
Trust Sec	Fit and Proper Person Policy						X