Derbyshire Healthcare NHS Foundation Trust

PUBLIC BOARD MEETING
TUESDAY 5 SEPTEMBER 2023 TO COMMENCE AT 09:30
CONFERENCE ROOMS A&B, RESEARCH & DEVELOPMENT CENTRE, KINGSWAY, DERBY DE22 3LZ

	TIME	AGENDA	LED BY
1.	9:30	Chair's welcome, opening remarks and apologies, declarations of interest	Selina Ullah
PATIENT STORY			
2.	9.35	Patient Story "*the importance of a trauma informed approach to care"*	Carolyn Green
STANDING ITEMS			
3.	10.00	Minutes of Board of Directors meeting held on 4 July 2023	Selina Ullah
4.		Matters arising – Actions Matrix	Selina Ullah
5.		Questions from members of the public	Selina Ullah
6.	10:05	Chair's update	Selina Ullah
7.	10:15	Chief Executive's update	Mark Powell
STRATEGY, PERFORMANCE AND RISK			
8.	10:30	Integrated Performance report	A Odunlade/ R Leyland//C Green
11:00 B R E A K			
9.	11:10	Trust Strategy progress update	Vikki Ashton Taylor
10.	11:20	Kingsway Land Disposal	Ade Odunlade
11.	11:30	Emergency Preparedness, Resilience and Response Core Standards	Ade Odunlade
12.	11:40	Board Assurance Framework Issue 2 (version 2.2) for approval	Justine Fitzjohn
GOVERNANCE AND COMPLIANCE			
13.	11:50	Freedom to Speak Up Guardian Report	Tamera Howard
14.	12:00	Fit and Proper Person Declaration	Selina Ullah
BOARD COMMITTEE ASSURANCE			
15.	12:05	Board Committee Assurance Summaries	Committee Chairs
REPORTS FOR NOTING ON ASSURANCE FROM BOARD COMMITTEES			
16.	12:15	Quality and Safeguarding Committee - Mortality Report	Lynn Andrews
17.	12:20	People and Culture Committee - 2023/24 Flu Vaccination Campaign	Ralph Knibbs
18.	12:25	People and Culture Committee - request to receive Board delegated authority to approve Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) October submissions	Ralph Knibbs
CLOSING BUSINESS			
19.	12:35	Identification of issues arising for inclusion or updating in the BAF	Selina Ullah
20.		Meeting effectiveness	Selina Ullah
FOR INFORMATION			
Glossary of NHS Acronyms 2023/24 Forward Plan			

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

The next meeting will be held at 09.30 on 7 November 2023 in Conference Rooms A&B, Centre for Research and Development, Kingsway. Arrangements will be notified on the Trust website 7 days in advance of the meeting.

Users of the Trust's services and members of the public are welcome to observe meetings of the Board. Participation in meetings is at the Chair's discretion.

Our vision

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

Our values

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

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

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

(a) Directorships, including non-executive directorships held in private companies or PLCs (with the exception of those dormant companies).
(b) Ownership or part ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS.
(c) Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS.

(d) A position of authority in a charity or voluntary organisation in the field of health and social care.

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

Derbyshire Healthcare NHS Foundation Trust

MINUTES OF A MEETING OF THE BOARD OF DIRECTORS

Held in Conference Rooms A and B
Research and Development Centre, Kingsway, Derby DE22 3LZ

Tuesday 4 July 2023

MEETING HELD IN PUBLIC

Commenced: 09.30 Closed: 12:20

PRESENT	Selina Ullah	Trust Chair
	Tony Edwards	Deputy Trust Chair
	Ralph Knibbs	Senior Independent Director
	Lynn Andrews	Non-Executive Director
	Deborah Good	Non-Executive Director
	Ashiedu Joel	Non-Executive Director
	Geoff Lewins	Non-Executive Director
	Mark Powell	Chief Executive
	Ade Odunlade	Chief Operating Officer and Deputy Chief Executive
	Dr Arun Chidambaram	Medical Director
	Carolyn Green	Director of Nursing and Patient Experience
	Rachel Leyland	Interim Director of Finance
IN ATTENDANCE	Anna Shaw	Deputy Director of Communications and Engagement
	Rebecca Oakley	Deputy Director of People and Inclusion
For DHCFT2023/064	Nikki	Guest for Patient Story
For DHCFT2023/064	Joe Thompson	Assistant Director of Clinical Professional Practice
	Sue Turner	Board Secretary
APOLOGIES	Jaki Lowe	Director of People and Inclusion
	Vikki Ashton Taylor	Director of Strategy, Partnerships and Transformation
	Justine Fitzjohn	Trust Secretary
OBSERVERS	Andrew Beaumont	Public Governor, Erewash
	Christine Williamson	Public Governor, Derby City West
	Angela Kerry	Public Governor, Amber Valley
	Sandra Austin	Carers Forum
	Anna Bennett	Head of Nursing for Older People's Services

DHCFT 2023/063	**CHAIR'S WELCOME, OPENING REMARKS, APOLOGIES FOR ABSENCE AND DECLARATION OF INTERESTS** Trust Chair, Selina Ullah welcomed Board colleagues, Governors, members of staff and the public who were observing to the first meeting of the Board of Directors held in person since the start of the COVID pandemic in March 2020. Apologies were noted as listed. Deputy Director of People and Inclusion, Rebecca Oakley deputised for Director of People and Inclusion, Jaki Lowe. The Register of Directors' Interest for 2023/24 was noted with no declarations of interest raised with any of today's agenda items.

DHCFT 2023/064	**PATIENT STORY** Today's patient story was heard from Nikki who shared the meaning behind the mantra she lives her life by "Tolerate, educate. Here I am, see me. Say hello, learn, change the world". Part of Nikki's struggle with her mental health has been related to gender dysphoria. Around 20 years ago, Nikki was referred to a psychologist and through these sessions, she realised that the unconscious life she had been living was that of a woman. She began her transition at the age 65 and underwent gender affirming surgeries when she was 70 and 71. Nikki has used a variety of services including and Psychiatry, Psychology, The Older Adult Crisis Team and the Older Adult Community Mental Health Team. Despite the challenges Nikki experienced she praised the Trust staff she came into contact with throughout her treatment. She thought they were all excellent, committed people, who work in a service that is understaffed, under-supported and underfunded. The main theme of her story focussed on the NHS needing to be more connected to help the trans community to be referred for mental health treatment or gender reassignment. Nikki felt strongly that more deaths and suicides will occur within the trans community unless the NHS receives funding for gender reassignment. She also thought Trust can deliver a better service by providing education to staff so they can better support people who are trans, especially young people who are struggling to understand their sexuality and gender. The development of the mental health helpline has been invaluable for Nikki. Like lots of other people, her mental health is worse at night when she feels a sense of isolation. Although she thought the helpline was a good service, it sometimes took 20 to 30 minutes to have her call answered which impacted on her anxiety and mental stress. Director of Nursing and Patient Experience, Carolyn Green agreed there is a need to help the trans community and young people who are struggling with their gender. She was aware that the suicide rate and suicidal tendencies among transgender persons are considerably high compared to general population. Medical Director, Arun Chidambaram agreed with the importance of supporting the future trans generation in how they are viewed by society and give hope to young trans people. With the NHS being so underfunded Mark Powell was mindful that there could be organisations beyond the NHS that the Trust could work in partnership with. He and Selina thanked Nikki on behalf of the Board for sharing her story and for raising the importance of personalised care and for advocating on behalf of the trans community. They assured her that Trust staff participate in inclusion training but there is room for them to be educated to support people who have transitioned or who are in the process of transitioning. Being listened to is the starting point. **RESOLVED: The Board of Directors noted the importance of providing education and training to staff so they can better support people who are trans.**
DHCFT 2023/065	**MINUTES OF THE PREVIOUS BOARD OF DIRECTORS MEETING** The draft minutes of the previous meeting held on 9 May 2023 were accepted as a correct record of the meeting.
DHCFT 2023/066	**ACTION MATRIX** The Board reviewed and closed the completed actions. No actions remained outstanding.
DHCFT	**QUESTIONS FROM MEMBERS OF THE PUBLIC**

2023/067	No questions had been directly submitted for a response ahead of the meeting. Governors represent the population of Derbyshire and any questions raised with them by members of the public are taken to the Council of Governors.
DHCFT 2023/068	**CHAIR'S UPDATE** The Chair's update summarised Selina's activity since the previous Board meeting held on 9 May. Selina has continued to visit a number of services interacting with frontline staff, patients and carers. She and CEO, Mark Powell jointly visited the Amber Valley Child and Adolescent Mental Health Service (CAMHS) Community Mental Health Team (CMHT), Amber Valley Intellectual Disability Team, Amber Valley Older Adults CMHT, Derbyshire Recovery Partnership (Drug and Alcohol Support), Amber Valley Working Age Adult CMHT and the Mental Health Helpline. She and Mark were struck by the passion and desire to provide quality services for patients and service users despite the challenge of increased demand and capacity. She also visited Killamarsh CMHT last week. Selina was pleased to see that several of the Non-Executive Directors (NEDs) are also familiarising themselves with Trust services through quality visits. Positive feedback was seen during a well attended Staff Network Conference. The Trust has nine staff networks which are an invaluable means of engaging with colleagues and hearing about their experience of working for the Trust and ways that can improve their experience, promote inclusion of difference and use their lived experience to improve services. Another area of focus for Selina was the Mental Health Carers Forum that she attended on 5 June when she responded to having a Board Champion for Carers and their request for the voice of carers to be heard at a Board level. Selina was pleased to report that NED, Deborah Good now attends the Carers Forum meetings as the nominated Board Lead for Carers. Selina also spoke about the work of the Office of Modern Governance who are leading the independent development review which assesses the Trust against the Well Led Framework for leadership and governance. Selina gave thanks to all colleagues and Governors who took part in the review, their perspective is an important component of the review and in identifying areas where the Trust can improve. Positive feedback has so far been received from the review and Selina looks forward to the final report being received at the end of July. In terms of Trust business Selina attending the Audit and Risk Committee on 20 June to approve the Annual Report and Accounts on behalf of the Board. She gave thanks to the Finance team for the efficient and speedy preparation of the financial accounts for audit. She also thanked Trust Secretary, Justine Fitzjohn for co-ordinating the Annual Report and to all involved in contributing to its constituent parts. Finally, Selina was pleased to report that on 21 June an extraordinary Confidential Board meeting was held to discuss the East Midlands Perinatal Mental Health Provider Collaborative Final Business Case and approve the business case for submission to NHS England (NHSE). Also at this meeting, the Board had a helpful discussion on strategy and received a briefing on the Joint Forward Plan (JFP). A number of suggested amendments to the JFP have been sent to the Integrated Care Board for inclusion in the final version. **RESOLVED: The Board of Directors noted the content of the Chair's update.**
DHCFT 2023/069	**CHIEF EXECUTIVE'S REPORT**

Mark Powell's report covered current local issues and national policy developments. The report also reflects a wider view of the Trust's operating environment. Reference was made to the following points.

National Context
Mark drew attention to the significant milestone for the NHS and the Trust of formally stepping down the COVID-19 incident. This has brought a formal close to over three years of responding to the pandemic and the beginning of the recovery from it. Mark thanked everyone at DHcFT for their commitment and dedication throughout this difficult and challenging period.

NHSE has published its first Equality, Diversity and Inclusion (EDI) Improvement Plan that has been developed in consultation with staff, their networks, and a range of stakeholders. The Board was mindful of how the plan centres around high impact actions (HIAs) which outlines targeted interventions by protected characteristic, which align with the HIAs and their goals. The People and Culture Committee will monitor this work to ensure the Trust has one consistent plan that picks up the national requirement linked to the Trust's local requirements and the EDI Strategy.

Deputy Trust Chair, Tony Edwards highlighted that Board members will be attending their final Board Leadership for Inclusion Initiative (BLFII) session in July which is strengthening the Board's focus on inclusion and will ensure that inclusion is embedded in all aspects of the Trusts' business. Senior Independent Director, Ralph Knibbs who is also the Chair of the People and Culture Committee which oversees the Trust's inclusion work supported Tony's thoughts and endorsed the importance of ensuring that the staff networks are fully involved and engaged in this work. Non-Executive Director, Ashiedu Joel added further context to this work by indicating how the staff networks are involved within the EDI Steering Group to strengthen inclusion across the Trust.

Within the Trust
Mark thanked colleagues who supported the recent industrial action involving Junior Doctors in June, and whilst a number of patient appointments were rescheduled, colleagues worked together to ensure that patient safety was maintained throughout the industrial action.

Mark's report also celebrated a number of achievements. These included the Specialist Community Public Health Nursing team who support asylum seeking families in Derby who have been successfully shortlisted in the Health Equalities category of the NHS Parliamentary Awards. The national winners will be announced in a special awards ceremony at the House of Commons on 5 July, the 75th birthday of the NHS. The Trust has also successfully retained its two-star award Triangle of Care status from the Carers Trust.

Mark referred to his first CEO report to the Board when he undertook to provide an update at today's meeting on any emerging themes from his first three months in post. Mark has since spent considerable time visiting services, holding drop-in sessions and live engagement events. He was grateful for the warm welcome he received and for the discussions that have helped broaden his understanding of the key issues colleagues are responding to day to day. In the main Mark received positive feedback and witnessed a great deal of team cohesion and innovation based on existing strategies within the Trust. Mark saw the clear ambition across services and colleagues' devotion to making quality improvements and enhancing patient care. He saw first-hand their real worry about the number of people waiting to access our services and a genuine concern about the financial challenges and the outlook over the next three years. The need to have better visibility of senior leaders was another concern raised.

The key issue Mark learned concerned colleagues desire to receive clarity on the Trust's priorities, how the Trust is structured, its partnerships etc. As part of the ongoing Trust communications and engagement plan Mark and the Executive Leadership Team (ELT) intend to introduce a focus on the issues that have been raised. These discussions will

	be directed through established internal communication and engagement routes, with focused conversations on each area raised. This will allow wider feedback from colleagues, together with a collective approach to making any changes and a clear plan of action. Non-Executive Director, Lynn Andrews noted how Mark's report gave a good overview of how staff are feeling. During quality visits to services Lynn and the NEDs have also picked up similar issues and she asked how the Board can resolve the concerns staff have raised. Mark was conscious that staff are feeling the aftereffects of COVID and are questioning where accountability and responsibility lies now they are emerging from three years working under a command and control culture. Now that the Trust is moving towards a normal business environment the Board and the Trust's senior leaders need to ensure colleagues feel empowered and have the skills to work within a normal business environment and create more engagement by meeting face to face rather than online. The intention is to reset the Trust's day to day working model linked with hybrid working so that Derbyshire Healthcare will thrive as people settle into this new work pattern. **Regional Update** Mark met with East Midlands Alliance CEO's and Chairs on 9 June when the Alliance's strategic themes were discussed and future strategic priorities for the work of the Alliance. A paper that set out the recent work of the Alliance was appended to Mark's report and was noted by the Board. **RESOLVED: The Board of Directors discussed and scrutinised the report and sought assurance around any key issues raised.**
DHCFT 2023/070	**<u>INTEGRATED PERFORMANCE REPORT (IPR)</u>** The IPR provided an update on key finance, performance and workforce measures at the end of May 2023. The following points were discussed in detail: **Operations** Chief Operating Officer, Ade Odunlade gave an overview of performance and interworking that impacts on many areas of performance. The increase in out of area placements was discussed as there continues to be a high level of occupancy on the adult acute wards. Mental health is the area that suffers when society comes under pressure and this is being seen in the number of admissions under the Mental Health Act. Many people are being discharged who need extra support and an appropriate place to stay which takes considerable time to manage. Community Mental Health teams are aiming to manage people in the community so they receive help earlier to prevent them reaching a point of crisis and arrive at hospital out of hours or at weekends. It was noted that a bid is in preparation for a portion of the Integrated Care Board's adult social care discharge funding, which would be used to support discharge and free up beds through improving timely discharge. It is intended that future iterations of the IPR will include discharge priority metrics. Deborah Good was concerned about the substantial factors that are impacting services and wanted to get a sense of when Autism assessments will consistently achieve the commissioned level of 26 a month as 17 were carried out in May. Ade assured Deborah that the target has been achieved since the assessment model had changed and reported that 41 assessments were carried out just recently. It takes a considerable amount of time to complete an assessment and more people have been trained to carry them out which will improve the waiting time to be seen. Deborah was also concerned that Talking Therapies services were being overwhelmed. Ade assured her staff are working tirelessly to ensure people are supported. Improving population health is a key factor in managing this situation. The Trust works with social care and public health in this area and there is a lot of progress being made with voluntary sector involvement.

Tony Edwards was mindful that the IPR is brought to the Board before it is seen by the Finance and Performance Committee. As Chair of the Committee Tony looked forward to discussing the points Deborah raised at the July meeting of the Committee to understand the challenges being faced and progress being made in these areas.

Finance
Interim Executive Director of Finance, Rachel Leyland reported a breakeven Year to Date (YTD) position against a planned surplus of £0.5m, an adverse variance of £0.5m. The forecast position at month 2 is breakeven against the plan of breakeven. The forecast assumes that we deliver efficiencies in full and find mitigations to offset emerging cost pressures associated with pay inflation and agency expenditure.

Non-Executive Director, Geoff Lewins referred to agency costs which YTD totals £1.7m against a plan of £0.9m, which is an adverse variance to plan of £0.8m and is just below the planning guidance target of 3.7%. He saw that the highest area of agency usage continues to be for consultants and nurses and asked what action is being taken to improve these costs. Rachel responded that efficiencies at month 2 were behind plan. The weekly transformation group is working on month 3 and driving progress internally as well as within the System. Some of these agency costs are associated with supporting a patient with extremely complex needs although improvements have been seen in the use of Health Care Assistants (HCAs). ELT would be discussing action with regard to agency spend going forward.

Lynn was conscious that the next Board meeting in September will take place five months into the financial year and asked if the Board could be provided with a finance update in the interim. It was established that report scheduling ensures that each month's finance position is reported to the Finance and Performance Committee or the Board of Director meetings. The Committee would be meeting on 18 July when the finance position for month 3 would be reviewed along with operational performance, the efficiency programme and agency costs. It was agreed that the Board will be appraised of the current situation after month 3 is reviewed by the Committee.

ACTION: Month 3 finance position to be circulated to Board members outside of the Finance and Performance Committee

During discussion Mark urged the Board Committees to re-evaluate and articulate what they seek assurance on to enable the Executive Directors to provide the NEDs with the assurance they require.

People performance
Deputy Director of People and Inclusion, Rebecca Oakley reported on the continued positive progress being made with appraisal compliance. Turnover remains within the target range of 8-12% and is in line with national and regional comparators. Sickness absence was 5% in May 2023, which is the lowest level recorded for over two years. The overall position of posts filled at the end of May was 92%, with a vacancy rate of 8.95%. The recruitment team continue to work closely with divisions to develop targeted and bespoke campaigns. The overall level of compliance with the clinical and management supervision targets has remained low since the start of the pandemic, however improvements are being made.

Tony and Ashiedu were surprised that the results of the staff survey had not been received by the Board this month. Rebecca clarified that the response to the results of the staff survey is being reported to the July meeting of the People and Culture Committee.

Ralph asked to know more about plans to improve staff absence levels. Rebecca advised that she felt confident that measures put in place to ensure maximum support for sickness absence are having a positive impact and hoped that the June figures will

	see a decrease in levels. She expects that the appointment of a staff psychologist who will provide support to teams and individuals will have a positive effect on current levels. **Quality** Director of Nursing and Patient Experience, Carolyn Green reported that the proportion of patients whose care plans have been reviewed continues to be recorded as lower than expected and is currently on a downward trajectory in month 2. Compliance around Care Programme Approach (CPA) has been the subject of a commissioned 360 review by the Trust's internal auditor and is part of an action plan to improve compliance in fundamental care standards including CPA. Lynn Andrews as Chair of the Quality and Safeguarding Committee highlighted that since month 2 the Committee had seen a significant improvement being made with the recording of care plans with some returning to over 90% compliance level. Prone restraint has increased. The overall numbers of prone restraint are lower than the regional average per bed number but physical restraints have increased. This appears to be related to a high number of repeated incidents attributed to a small group of patients. The Trust's Positive and Safe Support Team continue to spend time in clinical areas to support and train clinical staff live during practice. Mark Powell referred to the increase in the use of restrictive practice and asked for an update on work identified to reduce the current level. Carolyn reported that a high level of disturbances in inpatient areas has resulted in an increase in the use of restrictive practice which is due to complex illnesses in a patient group. Support from additional staff has been required to maintain safety as well as police involvement when disturbances have occurred. Tony was mindful of the significant disruption caused by industrial action and wanted to understand what implications would arise from consultants taking strike action. Arun indicated that mitigations were in place to minimise the impact of consultants taking industrial action and assured Tony of the huge appetite amongst staff to ensure patient safety is not compromised. Carolyn referred back to today's patient story and outlined that although the Trust has a clear policy for transgender patients, these patients cannot be referred to specialist services because their individual gender choices cannot always be supported. Work will continue with commissioners until solutions are met when the new build facility is opened. Carolyn also drew attention to the spike in medicines incidents. A visit to areas using the Electronic Patient Medication Administration (ePMA) highlighted issues around digital literacy which has impacted on these types of incidents. Carolyn assured the Board that action identified to resolve these incidents and improve digital education is being reviewed by the Medicines Management Group and reported to the Quality and Safety Committee. Having held extensive discussion on the IPR the Board agreed that although positive assurance had been obtained from action being taken to progress challenging areas, limited assurance was received on current performance. Further scrutiny of performance will take place within the Finance and Performance Committee and People and Culture Committee. **RESOLVED: The Board of Directors:** **1) Received limited assurance from current performance across the areas presented.** **2) Formally agreed that this report incorporated the key elements of assurance to the Trust Board that would otherwise have come from Finance and Performance Committee and People and Culture Committee reporting.**
DHCFT	**RE-VALIDATION OF DOCTORS COMPLIANCE STATEMENT**

2023/071	Medical Director, Dr Arun Chidambaram provided the Board with an update on medical appraisal and revalidation activity within the Trust during the 2022/23 medical appraisal cycle. The purpose of medical revalidation and appraisal is to support and develop the Trust's medical workforce through reflection on clinical practice, whilst complying with GMC frameworks to protect patients. As of 31 March 2023, 112 doctors had a connection with DHCFT for appraisal. Of these, 93 doctors completed their appraisal within the required time and 19 doctors have not completed an appraisal during this time frame. Of these, 3 doctors have had a GMC deferral of revalidation agreed after recommendation by the Responsible Officer. It was noted that high quality training by an external provider is valued by attendees and several new appraisers have joined the existing cohort as a result of this training. The report highlighted some practice changes that will require departure from the previous culture regarding the move to a new appraisal and job planning platform. The Board understood that following a vigorous process, a suitable provider with a proven track record has been identified and work is underway to secure a contract with them. The Trust will in the meantime continue to use the current system until the new platform is in place. The Board noted that the People and Culture Committee had received positive feedback concerning appraisal checks and governance process behind the medical appraisal process. The Board was satisfied that the Trust has maintained high standards for the quality of its medical appraisals and agreed that the Chief Executive would sign the Statement of Compliance required by NHS England. Work will continue to reduce the number of doctors, whose appraisal timeframes are falling outside of the required standard and it is anticipated that the move to an electronic appraisal platform will be of great benefit. **RESOLVED: The Board of Directors:** **1) Noted that the Trust is compliant with the Medical Profession (Responsible Officers) Regulations 2010** **2) Agreed that Chief Executive, Mark Powell would sign the statement of compliance** **3) Noted the previous scrutiny of the medical appraisal process and governance undertaken by the People and Culture Committee.**
DHCFT 2023/072	**<u>POSITION STATEMENT - WELL LED</u>** This report provided the Board with an update on the governance processes the Trust has in place to meet the requirements of well-led under the CQC (Care Quality Commission) and NHS England joint well-led framework. It set out how the Trust is monitoring compliance against the eight key lines of enquiry (KLOEs) for well-led at service level and Trust wide level. The report evidenced that the Trust has strong governance processes in place which is also tested through internal and external auditing. Examples contained in the report gave a good level of assurance and provided positive assurance on progress and spotlighted key evidence of Board Leadership. Having noted that the objective is to maintain the 'Good' rating for well-led and to receive a positive report from the Office of Modern Governance, Lynn Andrews challenged whether the intention should be to demonstrate that certain areas have achieved "Outstanding" levels. The Board discussed the potential to aspire to an "Outstanding" rating and considered that some areas have not had the resource to achieve that ambition. Formal feedback from the Well Led Review will determine the potential to achieve an "Outstanding" rating, provide a better understanding of all service areas and identify areas that require further focus.

	Discussion developed around the need to celebrate the success of innovative work undertaken within the divisions and for the onus to be on divisional leaders to share their success stories with the Communications team so they can be promoted internally and externally. Overall the Board received significant assurance with regards the levels around the well-led domain and in activating a Well Led Learning Review to establish further improvement. **RESOLVED: The Board of Directors:** **1) Noted the update** **2) Received significant assurance with around the well-led domain and in activating a Well Led Learning Review to establish further improvement.**
DHCFT 2023/073	**<u>BOARD COMMITTEE ASSURANCE SUMMARIES</u>** The Board Assurance summaries from recent meetings of the Trust Board Committees were accepted as a clear representation of the priorities to be taken forward in forthcoming meetings. The following points were brought to the attention of the Board by Committee Chairs: • **Audit and Risk Committee:** Recent meetings have concentrated on the production of the 2022/23 Annual Report and Accounts. Positive reports were also received on Data Security and Protection, Counter Fraud and the Freedom to Speak Up process. A report from the Trust's Internal Auditor, highlighted issues around SystmOne implementation and the importance of digital education and process compliance. • **Finance and Performance Committee:** In addition to discussions held earlier within the IPR, the Making Room for Dignity Programme highlighted areas where there are financial challenges and ongoing work progressing VAT abatement. Overall the programme is making good progress. • **Quality and Safeguarding Committee:** Recent performance in transformation of care within the new Neurodevelopmental service is the best that has been achieved so far. The intention is to sustain this level of performance. Significant assurance was obtained from ligature risk management arrangements against CQC requirements and current compliance in managing ligature risks. The final version of the Quality Account for 2022/23 was signed off by the Committee under delegated authority of the Trust Board. Significant assurance was obtained from both safeguarding children and adults' activity in the Trust. • **Mental Health Act Committee:** Good assurance was received on the ongoing work to ensure improved training levels in Mental Capacity Act, Deprivation of Liberty Safeguards (DoLS) and Triangle of Care training. A focussed report was received on the use of restrictive practice and absconsion. Based on the data within the report the Committee was confident that staff are working within the Code of Practice. • **People and Culture Committee:** A deep dive into leadership development gave an overview of the range of programmes available as part of the leadership offer. The Aspiring to Be (A2B) programme is a key strength and has further potential for supporting aspiring talent. This is a good offer that will help retention and a clear strategy for leadership development aligned with the NHS Long Term Plan is to be developed. A review of the medical appraisal and revalidation activity during the 2022/23 medical appraisal cycle was undertaken in preparation for the formal re-validation of Doctors Compliance Statement being submitted to the Trust Board at today's meeting. • **Neurodevelopmental (ND) Services Committee in Common (CiC):** The CiC received feedback from the Executive to Executive Meeting that the Alliance work would continue, with changes being made quickly to allow easier ways of working for integrated teams and to respond to feedback received from staff. As part of the changes a new ND Steering Group will be established and it is proposed to stand down the CiC. The ND Steering Group will provide operational oversight of the Alliance work and the work would be reported through existing governance structures in both DHcFT and DCHS.

	The Board was requested to agree to stand down the CiC at this time and to receive assurance regarding the work through the existing governance structure through the relevant Board Committees. The Board was satisfied that it is within the Board Committees where much of the scrutiny and challenge takes place which is an important part of the Trust's governance requirements. **RESOLVED: The Board of Directors:** **1) Noted the Board Assurance Summaries.** **2) Agreed to stand down the CiC at this time and to receive assurance regarding the work through the existing governance structure through the relevant Board Committees.**
DHCFT 2023/074	**ASSURANCE FROM THE QUALITY AND SAFEGUARDING COMMITTEE** **Guardian of Safe Working (GOSW) Annual Report 2022/23** This report details the provisions made to ensure safe working for junior doctors and arrangements in place to identify, quantify and remedy any risks to the organisation. The report was received for information and noting by the Board having previously been scrutinised by the Quality and Safeguarding Committee. As Chair of the Quality and Safeguarding Committee, Lynn Andrews reported that the Committee had received significant assurance from the GOSW Annual Report. The current GOSW, Dr Kaanthan Jawahar was commended for discharging the duties of the role and continuing to improve processes to advocate for junior doctor colleagues. **RESOLVED: The Board of Directors received and noted the high level of scrutiny and assurance received by the Quality and Safeguarding Committee for the Guardian of Safe Working Annual Report 2022/23**
DHCFT 2023/075	**IDENTIFICATION OF ANY ISSUES ARISING FROM THE MEETING FOR INCLUSION OR UPDATING IN THE BOARD ASSURANCE FRAMEWORK (BAF)** No additional items were identified for inclusion in the BAF.
DHCFT 2023/076	**2022/23 BOARD FORWARD PLAN** The forward plan outlining the programme for 2023/24 was noted and would be reviewed further by all Board members for the financial year ahead.
DHCFT 2023/077	**MEETING EFFECTIVENESS** This first face to face meeting held by the Board since March 2020 enabled strong engagement and resulted in valuable dialogue across all matters discussed.
The next meeting to be held in public session will be held in person at 09:30 on 5 September 2023 in Conference Rooms A and B, Centre for Research and Development, Kingsway, Derby.	

				BOARD OF DIRECTORS (PUBLIC) ACTION MATRIX - SEPTEMBER 2023			
Date	**Minute Ref**	**Item**	**Lead**	**Action**	**Completion Date**	**Current Position**	
9.5.2023	DHCFT 2023/051	Trust Operational Plan Update 2023/24	Vikki Ashton Taylor	Consideration to be given to how the Board Committees will monitor delivery of the Trust's and the system's ambitions for activity and performance, workforce, and finances and how this is captured in reporting	~~4.7.2023~~ 5.9.2023	Trust Strategy progress update report to September Board identifies Board Committee delivery oversight aligned to BAF strategic objectives	Green
4.7.2023	DHCFT 2023/070	Integrated Performance Report	Rachel Leyland	Month 3 finance position to be circulated to Board members	5.9.2023	Circulated to Board on 24 July 2023.	Green

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

Trust Chair's report to the Board of Directors

Purpose of Report

This report is intended to provide the Board with the Trust Chair's reflections on my activity with and for the Trust since the previous Board meeting on 4 July 2023. The structure of this report reflects the role that I have as Trust Chair.

Our Trust and Staff

1. On 11 July I attended the re-signing of the Armed Services Covenant. The covenant is a pledge that we acknowledge and understand that those who serve or who have served in the armed forces, and their families, should be treated with fairness and respect in the communities, economy, and society they serve with their lives. The covenant focusses on helping members of the armed forces community have the same access to our services and a commitment to providing support to access services, as well removing any barriers to access that they may face.

   A special thanks to Gemma Saunders, Chair of the Armed Forces Network. Gemma has worked tirelessly to ensure the work of the Armed Forces Network is embedded in the Trust, that it has a profile both within the Trust and outside, and we have been successful in being recognised with a much coveted gold award for the Employer Recognition Scheme standard award.

2. On 25 July, I visited the Children's Services, along with Mark Powell and Lynn Andrews, Non-Executive Director (NED) and Chair of the Quality and Safeguarding Committee. We commenced our visit at Temple House, where we met colleagues from the Day Service which opened in October 2022; the Crisis and Urgent Care Team, which are both funded via new Mental Health Transformation monies; the Participation groups including the Children and Young People group and parents and experts by experience. We then travelled to Peartree Health Centre and met the Health Visiting Team, where we saw first-hand the challenging environment and social stressors experienced by the community the Health Visitors work with. This was followed by a visit to Rosehill Street to see where some of our services are provided and working in partnership with primary care and community care. We also visited St Pauls where we met the Complex Health Team, the Paediatric Therapy Team (Occupational Therapy and Physio), the Attention Deficit and Hyperactivity Disorder (ADHD) Nurse Team, the Children in Care and Adoption (CICA) Team, the Community Paediatric Team, the 0-19 Services, School Health Team who provided an overview of The Lancaster Model (TLM), the team making our services and the Trust "Baby friendly"; achieving the UNICEF accreditation. We also met the Specialist Health Visiting teams providing services to families with a child with Learning Disabilities and parents seeking asylum.

   It was a busy day and suffice to say we not only saw and heard about the challenges our colleagues and services face but also the innovative work being done by them. We heard about the many awards and accreditation our services have achieved. These service visits are invaluable in understanding the work of the Trust but also in triangulating the reports we receive at Board on quality,

safety, performance, finance, risk and staffing. Our thanks to all the team managers and colleagues who spoke to us and shared their experiences of working for the Trust. Their passion and commitment shone through and was both inspiring and uplifting to see. A special thanks to Scott Lunn, Divisional Manager, who organised the day for us, his leadership and passion for Children's Services was a joy to see.

3. On 8 August I met with our Freedom to Speak Up Guardian, Tamera Howard. The Freedom to Speak Up (FTSU) Guardian has the role of supporting staff to speak up when they feel unable to do so by other routes. This is a very important role and it is vital that the guardian has the support of senior leadership to do her job and remove any obstacles or barriers. Tam comes to report on her work to the Board on a regular basis, she also has a nominated Board lead to support her in Geoff Lewins, NED and she has access to the CEO and myself. Having an open culture is key to patient safety as we have recently seen from the Lucy Letby case.

4. On 21 August I attended an all staff update on our Making Room for Dignity programme. Aerial drone footage was shared showing the significant progress that has been made in the building works. As the building structures become more developed the reality of the scale of transformation becomes ever more evident. It is an exciting time for the Trust and our patients, and the Programme team are doing a phenomenal job in ensuring the work keeps to timescales and in budget whilst minimising the disruption that comes with such a large scale capital and refurbishment programme over multiple sites. In my last report I informed that we will be selecting the names for the units and the wards via a process of voting by colleagues. The final names are Derwent Unit (Chesterfield) including wards Sycamore, Oak and Willow, Carsington Unit (Kingsway) with wards Wren, Dove and Robin; the Psychiatric Intensive Care Unit (PICU) will be named Kingfisher House; the Older Adult (Blue Ward) at Walton Hospital will become Bluebell Ward and the new wards at the Radbourne Unit will be called Jasmine Ward and Orchid Ward.

5. Consultants play a key part in the assessment, treatment and care of our patients. Although there is a national shortage of consultants in almost every field of healthcare, it is very exciting when there is an opportunity to recruit to a vacancy and to have applicants. Ralph Knibbs, Chair of People and Culture Committee and Senior Independent Director chaired the panel interview for a Consultant in Older People's Psychiatry on 29 August.

6. Of late we have had a number of memorial events for colleagues who have sadly passed away. On 10 July we held two memorial events for four of our colleagues: Duncan McNivan, Marie White, Lauren Smyth and Gillian Lemmon. They were much loved and respected colleagues and will be greatly missed. On the 11 July we held a one minute silence for Jess Melbourne after a battle with cancer. Jess worked in CAMHS and many colleagues paid heartfelt tributes to Jess and the difference she had made to the lives of her patients and colleagues alike. Our condolences to the family, friends and colleagues of Duncan, Marie, Lauren, Gill and Jess.

7. I'm pleased to confirm that the Trust has been shortlisted in three award categories in the forthcoming APNA (Asian Professionals National Alliance) Awards. Congratulations to Amber Ghei, Communications Officer, who is a finalist in the Rising Star award category and Ade Odunlade, Chief Operating Officer, who has been shortlisted for the Mentoring and Coaching Champion award. The Trust is also a finalist in the Trust of the Year category, which will be

presented to an organisation that has demonstrated positive outcomes through promoting and driving forward the Equality, Diversity and Inclusion (EDI) agenda.

8. The Trust has been recognised for all the engagement work that is core to our work and Trust values. We have been shortlisted at the national Patient Experience Network Awards, which recognise best practice in patient experience across all areas of health and social care. We have been shortlisted in the staff engagement/improving staff experience category for our Icare (Increase Confidence, Attract, Retain, Educate) Development Framework which was developed to support the emotional, educational and wellbeing needs of newly employed health care support workers.

9. Finally, congratulations to our wellbeing teams across Joined Up Care Derbyshire who have also been selected as finalists in the most inclusive menopause friendly employer category at the Menopause Friendly Employer Awards.

Council of Governors

10. I met with Susan Ryan on 4 August in her capacity as Lead Governor. The purpose of the meetings between the Trust Chair and the Lead Governor are to ensure that we are open and transparent around the challenges and issues that the Trust is dealing with. They are also an important way of building a relationship and understanding of the workings of the Board and the Council of Governors.

11. On 8 August the Governance Committee met, chaired by David Charnock, Governor. The agenda covered plans for the Annual Members meeting in September, feedback from governors' engagement activities including recent quality visits, the governors annual effectiveness survey and governor training and development.

12. The next Council of Governors meeting will be on 7 November and the next Governance Committee takes place on 11 October 2023.

Board of Directors

13. The Board commissioned the Office of Modern Governance to undertake a review of our governance and leadership. The review has concluded and Justine Fitzjohn, Trust Secretary and I met with Moosa Patel and Sarah Boulton for the initial feedback on 11 July. We met again with Mark Powell on 23 August to receive the draft report. Overall, it is a positive report and I intend to share the findings of the report at the next Public Trust Board. I would like to thank everyone who took time to speak to Moosa and Sarah and of course we will share the findings with our stakeholders.

14. On 19 July the Board engaged in its fourth and final session of the Board Leadership for Inclusion Initiative (BLFII). This was held face to face and continues to be an important means for building Board understanding and confidence in becoming an anti-racist organisation. Board members are all having one to one coaching with the facilitators as a further tool for development. The aim of this programme is to strengthen the Board's focus on inclusion. The programme gives the Board the tools to mainstream inclusion in all aspects of the Trust's business. The Board is developing its action plan to embed inclusion, address inequalities and ensure the Trust is an anti-racist organisation.

15. On 26 July the Remuneration and Appointments Committee met to approve some Board changes.

16. I have also continued to meet with all NEDs individually on a quarterly basis. In the last quarter I have met with Ralph Knibbs and Deborah Good. We use these quarterly meetings to review progress against their objectives, any developmental needs and to discuss any issues of mutual interest.

System Collaboration and Working

17. On 8 July I met with Julie Houlder, Chair at Derbyshire Community Health Services NHS Foundation Trust (DCHS), as part of our regular catch ups. These meetings provide a useful opportunity to explore any issues that have arisen and also foster collaboration at a place/locality level.

18. On 10 July I met with Richard Wright, Interim Chair of the Joined Up Care Derbyshire (JUCD) Integrated Care Board (ICB). We explored some of the challenges we face as a system.

19. On 11 July Mark and I held a four way meeting with Julie Holder, DCHS Chair and Tracy Allen, DCHS CEO, to discuss areas of concern and synergy between our two organisations.

20. On 24 July I attended the JUCD Chairs meeting with Richard Wright, along with the Local Authority elected members, to discuss how the Integrated Care System can work better together and priority areas of work.

21. On 23 August Mark Powell and I met with Richard Wright and Chris Clayton, CEO of JUCD. This was an opportunity to update Richard and Chris on the work of the Trust, our developments, challenges, and priorities for 2023/24.

Regulators, NHS Providers and NHS Confederation and others

22. I attend fortnightly briefings from NHS England for the Midlands region, which has been essential to understand the challenges and expectations of provider Trusts, for example the industrial action being taken by junior doctors and consultants and the recent case of Lucy Letby.

23. I have also joined, when possible, the weekly calls established for Chairs of Mental Health Trusts hosted by the NHS Confederation Mental Health Network in collaboration with the Good Governance Institute, where support and guidance on the Board continues to be a theme.

24. As a Trustee of NHS Providers, I attend the NHS Providers Board meeting. The meeting held on 5 July in London focussed on the ongoing impact on waiting times, elective recovery, long term conditions, mental health, and the industrial action that is being taken by junior doctors and consultants.

25. I attended the NHS Confederation Chairs meeting which focussed on the recently announced Long Term Conditions policy and underpinning framework. The format was consultative with the aim to have input from providers in the final policy framework which is being developed by NHS England.

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

Assurances

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

Consultation

This report has not been to other groups or committees.

Governance or Legal Issues

None

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

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

Demonstrating inclusive leadership at Board level

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

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

Recommendations

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

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

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 5 September 2023

Chief Executive's Report

Purpose of Report

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

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

National Context

Trial of Lucy Letby

On 18 August I received a letter from NHS England following the verdict in the trial of Lucy Letby. In the letter, NHS England's leadership team confirms that it will cooperate fully with the independent inquiry announced by the Department of Health and Social Care into events at the Countess of Chester Hospital. It also sets out the immediate steps that are being taken to strengthen patient safety in order to prevent anything like this happening again.

I was personally shocked by the crimes that Lucy Letby committed, and my thoughts are with all the families affected. The full learning will come out of the independent inquiry but as a Trust we will be reviewing NHS England's immediate recommendations and report our compliance with these through our quality governance framework, to Trust Board.

Within the Trust

Industrial action

Thank you to colleagues who supported our services during the industrial action which involved many of the Trust's junior doctors and consultant colleagues during both July and August. Whilst a number of patient appointments were rescheduled, colleagues worked together to ensure patient safety was maintained throughout the industrial action. We continue to seek to ensure all appointments are rescheduled and take place as soon as possible.

Service pressure and patient flow

The last few weeks have seen our services under significant pressure. This follows a similar national picture for mental health services. The need for acute inpatient beds has been high, which has resulted in a greater than expected use of out of area beds over the summer period. Further detail on these pressures are

identified in the integrated performance report for Board colleagues to discuss and seek assurance on.

New services

Our Criminal Justice Liaison and Diversion team have now launched the Derbyshire element of the national Reconnect programme, which helps people leaving prison to find health and support services in the community upon their release. The Reconnect team will work with individuals from 12 weeks before their release and for up to six months after their release, 'signposting' them to appropriate services and helping them with booking appointments and filling out forms.

Thank you to all colleagues and partners who have been involved in developing these new services.

NHS 75 celebrations:

The NHS turned 75 on 5 July and the Trust was involved in a number of local, regional and national celebrations.

- Five colleagues (Stacey Rach, Dr Vinita Kapoor, Amany Rashwan, Susie Scales and Al Munnien) represented the Trust at a special service at Westminster Abbey on 5 July (and featured on East Midlands Today).

- Over 50 colleagues came together with teams from across Joined Up Care Derbyshire and the wider NHS to take part in NHS 75 Park Runs at various locations.

- Andy Wright, our Learning Disability/Autism In-Reach Lead received an invitation to a reception at 10 Downing Street, in recognition of him regularly going above and beyond what is expected of him in his role to support patients and colleagues.

- The Trust's Specialist Community Public Health Nursing team were shortlisted in the health equalities category at the NHS Parliamentary Awards for their work to reduce inequalities in health and social care by supporting asylum-seeking families in Derby.

- Our annual League of Friends Summer Fayre took place on 2 July, raising valuable funds that will support people in the Trust's services. An NHS 75 'big tea' took place at the fayre and Derbyshire Healthcare was first to share the Derbyshire-wide system NHS 75 baton at the event, before passing this on to colleagues at Derbyshire Community Health Services.

Making Room for Dignity – naming our new facilities:

On the day of the NHS's birthday, the Trust announced the names for our new inpatient mental health facilities, currently under construction. This followed a competition that was open to colleagues, services users, partners and carers. I am pleased to confirm the names for our new services as follows – thank you to everyone who took part:

- The new adult acute unit in Chesterfield will be called the Derwent Unit. Its wards will be called the Sycamore, Oak and Willow Wards.

- The new adult acute unit at Kingsway Hospital in Derby will be called the Carsington Unit. Its wards will be the Wren, Dove and Robin Wards.

- Sitting next to the Carsington Unit will be the new Psychiatric Intensive Care Unit or PICU, which will be called Kingfisher House.

- The Blue Ward at Walton Hospital will become Bluebell Ward when it opens for older adult patients with mental health needs.

- The new wards at the Radbourne Unit will be called Jasmine Ward and Orchid Ward, once the refurbishments are complete.

Achievements and celebrations:

In July, I was delighted to share that Derbyshire Healthcare had been awarded the Defence Employer Recognition Scheme gold award, which recognises our commitment as an employer to support our armed service colleagues and their families. The Trust was recognised for its willingness to recruit and support veterans, reservists, cadet force adult volunteers and military family members, which underlines the values we hold throughout our organisation.

We also re-signed the Armed Forces Covenant in front of members of the Armed Forces and the Derbyshire community. We last signed the covenant in 2019 and have made great strides since then to support the Armed Forces community. The signing of the covenant marks a renewed Trust commitment to ensuring that all members of the armed forces receive the support they need whether they are employees or patients.

In August, we received confirmation that the one-year review of our Veterans Aware accreditation had been completed successfully. The Trust continued to meet all eight of the standards and Derbyshire Healthcare as described as “an exceptional Veteran Aware Trust”. There was praise for the Armed Forces Network and its chair, Gemma Saunders, and I would like to thank them for all their efforts.

Well done to colleagues in our Memory Assessment Service as they have surpassed the national target rate of 67% in their dementia diagnosis rate. This has been a phenomenal achievement and is well ahead of the recovery action plan. The team worked very hard and embraced the use of quality improvement tools and techniques to look at how they can make small cyclical improvements in the way they deliver their service.

Two of our Consultants, Dr Rais Ahmed and Dr Chinwe Obinwa, have been recognised as Fellows by the Royal College of Psychiatrists for their contributions to psychiatry. Fellowships are awarded by the Royal College as a mark of distinction and recognition of contributions across psychiatry and are only available to those who have been members for 10 continuous years or more.

Leanne Walker, a former Child and Adolescent Mental Health Services (CAMHS) service user who is currently working as a Project Support Officer – Lived

Experience for Derbyshire's Living Well Programme, has been recognised nationally for her efforts to ensure that young people can participate in their own care and in service improvements. Leanne has been shortlisted at the 2023 National Service User Awards in the Lived Experience Leader Award. This is a very special award and to be recognised nationally is a huge achievement. The winners will be announced at an awards ceremony on 20 September.

The Trust has been shortlisted in three award categories in the forthcoming APNA (Asian Professionals National Alliance) Awards. Congratulations to Amber Ghei, Communications Officer who is a finalist in the Rising Star award category and Ade Odunlade, Chief Operating Officer, who has been shortlisted for the Mentoring and Coaching Champion award. The Trust is also a finalist in the Trust of the Year category, which will be presented to an organisation that has demonstrated positive outcomes through promoting and driving forward the ED&I agenda.

The Trust has also been shortlisted at the national Patient Experience Network Awards, which recognise best practice in patient experience across all areas of health and social care. We have been shortlisted in the staff engagement/improving staff experience category for our Icare (Increase Confidence, Attract, Retain, Educate) Development Framework which was developed to support the emotional, educational and wellbeing needs of newly employed health care support workers.

Congratulations to our wellbeing teams across Joined Up Care Derbyshire who have also been selected as finalists in the most inclusive menopause friendly employer category at the Menopause Friendly Employer Awards.

<u>Wider Developments</u>:

I was pleased to welcome Chris Hopson, Chief Strategy Officer for the NHS, to Kingsway Hospital in July as part of a wider visit to Derby. Chris was interested to hear about the different components of our Making Room for Dignity programme and the benefits these new services will have for people in our care. I also continue to showcase the development of our new facilities to local MPs.

We continue to receive compliments and thanks for our services, with 29 nominations being received in June and 34 in July for our DEED staff recognition scheme.

We have provided information on a wide range of different awareness days and weeks since the Board last met including Armed Forces Week, Pride month, International Non-binary Day, Breastfeeding Awareness Week and South Asian Heritage Month. The Trust promotes these days in order to raise awareness, provide information and signpost people to further support. The Trust has also attended Chesterfield and Belper Pride, with Derby Pride scheduled to take place in September.

Selina and I displayed the Windrush flag outside the Ashbourne Centre at Kingsway Hospital in June in recognition of Windrush Day, marking the 75th anniversary of the arrival of the passengers of the Empire Windrush to the UK. The day also celebrates the contribution and achievements of the Windrush generation and their descendants.

Internally:

In July we held a special event in our memorial garden, in memory of our colleagues Marie White, Duncan McNiven, Gillian Lemmon and Lauren Smyth. A plant and plaque have been placed in the garden for each colleague and people came together to share their memories. I encourage colleagues and partners to visit our memorial garden at Kingsway Hospital.

Colleagues also came together for a minute's silence in memory of Jess Melbourne, who was a Cognitive Behavioural Therapy (CBT) Trainee within our CAMHS IAPT service. Jess was a well-liked and respected member of our CAMHS team and is very much missed.

We re-established the Trust's Leadership Forum in June and the team have now come together twice to discuss key issues. The Leadership Forum will continue to take place each month, with an agenda shaped by colleagues.

I attended my first meeting of the Staff Forum in July, where we discussed a number of issues including a focused presentation from our Disability and Wellness Staff Forum. Thank you and congratulations to Katherine Hosseini, our Deputy Chief Pharmacist, whom the Forum approved as their new co-chair, alongside Leida Roome.

My drop-in Coffee and Conversations sessions continue to take place across our services, and I have visited more services since my last report, including the Radbourne Unit 136 suite, High Peak community mental health team (CMHT) and a full day spent with our Children's Services.

In my previous report I have highlighted some of the themes I identified when meeting with colleagues as part of my induction. Executive colleagues and I have started to respond to some of the key themes raised, providing clarity and further information which I hope has been useful. To date this has included an update on the principles that sit behind the national community mental health framework and how this is being implemented across Derbyshire. Executive colleagues are also visiting our community mental health teams (CMHTs) to discuss this further. We have also provided clarity around the ongoing operational restructure, in order to align the Trust's services to the emerging Derbyshire Places. A review of the current Trust Strategy is also underway, in order to simplify and clarify our Trust-wide priorities.

Our Annual Members Meeting (AMM) will take place virtually this year on Wednesday, 20 September from 4pm. Everyone is welcome to attend the AMM and hear about our work during 2022/23 and plans for 2023/24. More information about the AMM can be found on our Trust website.

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

Risks and Assurances

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

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

Consultation

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

Governance or Legal Issues

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

Public Sector Equality Duty and Equality Impact Risk Analysis

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

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

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

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

Recommendations

The Board of Directors is requested to:

1) Scrutinise the report
2) Seek further assurance around any key issues raised.

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

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

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 5 September 2023

Integrated Performance Report

Purpose of Report

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

Executive Summary

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

Operational Performance

This chapter has been developed to provide a greater level of assurance to the Board on actions being taken to address areas of underperformance. The chapter includes performance against the relevant NHS national long term plan priority areas. This month includes a section on the recently formed East Midlands Gambling Harm Service, and a section on bed occupancy and length of stay.

Most challenging areas:

- Waiting times for adult autistic spectrum disorder assessment
- Paediatric outpatients 18-week referral to treatment
- Inappropriate out of area placements
- NHS Talking Therapies waiting times

Most improved areas:

- Psychological services waiting times continuing to reduce month on month
- CAMHS waits continue to reduce

Key next steps:

- **Measuring our progress**: The DHcFT Productivity Group are developing a suite of metrics for Productivity – to enable us to monitor and evidence improvements in Productivity
- **High intensity users with personality disorder** – a programme planned to explore and review these using a collaborative system wide approach with a view to avoid non-appropriate conveyances to Emergency Departments and help direct patients to the right pathway of care.

- **Improving flow:** The establishment of a multi-agency admission and Discharge Hub to oversee the flow of patients in hospital helping to reduce longer length of stays.
- **MHRV: Reducing avoidable conveyance:** The system has also committed to a Mental Health Response Vehicle via NHSE procurement for 2024/25 in line with the LTP initiative. This service will include a Paramedic and Mental Health Nurse response. The service will be aimed at reducing the ambulance stack, ambulance dispatch and inappropriate mental health attendances to ED.
- **'Plan on a page' – for Reducing Health Inequalities:** We will be working with all service lines across the organisation to build a 'plan on a page' on how they will evolve and adapt our services to ensure we are actively working to reduce health inequalities using a strategic approach linking in with the Voluntary, Community, and Social Enterprise (VCSE) sector using population insights and census information to focus our efforts and understand disparities in order to effectively reduce them.
- **RCRP –** We are internally forming a working group to strategically work with the system to formulate our response to 'Right care Right place'

Finance

At the end of July the year to date position is a surplus of £1.0m against a planned surplus of £0.9m, a favourable variance of £0.1m. This is mainly driven by the improvement in the efficiency programme which continues to be on plan at the end of July. Agency expenditure is being partially offset by vacancies and interest income being ahead of plan. The forecast position at month 4 is breakeven against a plan of breakeven. The forecast assumes that we deliver efficiencies in full and find mitigations to offset the emerging cost pressures associated with pay award inflation, agency costs and pressures related to a complex patient who is being supported on one of our wards.

The Board Assurance Framework (BAF) risk that the *Trust fails to deliver its revenue and capital financial plans*, is rated as Extreme for 2023/24 due to the inherent risks that are built into the financial plan.

<u>Efficiencies</u>
The plan includes an efficiency requirement of £8.8m phased equally across the financial year. As at the end of July £2.9m was achieved against a year to date target of £2.9m. The forecast assumes that all efficiencies are delivered, currently £7.4m of the £8.8m has been identified.

Key next steps
- **Develop and sign off plans for the full £8.8m efficiency requirement**
- **Development of recurrent plans to minimise impact into 2024/25 currently 83% are non-recurrent**

<u>Agency</u>
Agency expenditure YTD totals £3.4m against a plan of £1.8m, an adverse variance to plan of £1.6m. This includes £0.9m of additional costs to support a complex patient on one of our wards. The two highest areas of agency usage continue to relate to Consultants and Nursing staff. The agency expenditure as a proportion of total pay for July is 6.3%. The plan for the year is set at 3.5% which just below the target set by NHSE in the planning guidance of 3.7%.

Out of Area Placements
The plan for out of area expenditure has been reduced by £1.0m in 2023/24 as part of the £8.8m efficiency programme. As at the end of July there was an overspend of £257k against the revised plan and a forecast overspend of £685k for the end of the financial year. There were 12 out of area patients at the end of July, the forecast assumes from month 7 patient numbers reduce to the plan of 4.

Capital Expenditure
Capital expenditure at the end of July is slightly under plan, the forecast is to be on plan by the end of the financial year.

Better Payment Practice Code (BPPC)
In July the target of 95% was exceeded by both value and volume.

Cash and Liquidity
Cash at the end of July is at £40.2m the same as the previous month and is forecast to be at planned levels of £23.6m by the end of the financial year.

People

Annual appraisals
Appraisal levels continue to be below our expectations, however significant positive progress has been made for the last ten months.

Annual turnover
Turnover remains in line with national and regional comparators and is within the target range of 8-12%.

Compulsory training
Overall, the 85% target level has been achieved for the last 16 months. Immediate Life Support (ILS) and Positive and Safe training compliance continue to remain in a stable position.

Staff absence
Sickness has been significantly lower than normal for the last 7 months but remains above the target of 5%.

Key next steps:

- ***Divisional wellbeing summits are planned to take place from September***

Proportion of posts filled
The overall position at the end of July was 93%.

Key next steps:

- ***The Strategic Recruitment and Retention Lead has now commenced in post and is working closely with teams to develop bespoke campaigns and recruitment approaches***

Bank and agency staff
Agency fill has decreased again slightly this month. The highest usage is medical grades.

Key next steps:

- ***Consider an incentive to bring additional clinically experienced workforce into the Acute Inpatient Wards for Adults of Working Age.***
- ***Establishing protocol to cover the circumstances where the various levels of Agency workforce can be utilised, and level of authorisation required.***
- ***Across the system an agency reduction programme is being established***

Supervision

The overall level of compliance with the clinical and management supervision targets has remained low since the start of the pandemic, however improvements are being made. Currently 124 teams are 100% compliant with management supervision, 77 teams are 100% compliant with clinical supervision and 53 teams are 100% compliant with both.

Key next steps:

- ***Improvement plan in place in Operational Services, with weekly monitoring of progress***
- ***Escalation of those people who have not been supervised for 3 months***

Quality

Compliments

The number of compliments has increased above the mean and remains within common cause variation.

Complaints

The number of complaints received per month remains stable. No specific theme has been identified. Information around complaints is reviewed by the Heads of Nursing/Practice in a quarterly patient experience committee report which is sent to the Trust Quality and Safeguarding committee for assurance.

Delayed transfers of care (DTOC)

7% of service users met the criteria as clinically ready for discharge in July. The most common reason for delay is the identification of appropriate housing or social care placements. A recent review identified that in older adult inpatient services, 76% of patients do not return to the environment they were referred from.

Key next steps:

- ***Twice weekly discharge meetings to continue to identify and address any barriers to discharge***
- ***The Older People's division are currently supporting the scoping of a Dementia Care Unit for Derbyshire which is due to open in 2024.***

Care plan reviews

The current percentage of patients who have had their care plan reviewed and have been on CPA for over 12 months is 52%, an increase of 3% between and May and July 2023.

Key next steps:

- ***A process for monitoring compliance and quality will be implemented in each division and monitored via the monthly Fundamentals of Care meeting, (in Inpatients, the Clinical Reference Group) and the Divisional Clinical Operational Assurance Team (COAT) meetings.***

Patients in employment and in settled accommodation

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

Key next steps:

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

Medication incidents

Between May to July 2023 there has been a 30% decrease in the number of medication incidents reported following a spike that took the number of medication incidents outside of common cause variation.

Key next steps:

- ***Development of a medicine ward folder where the medicine management quick reference guides relating to key policies and procedures will be available This is currently being trialled in the North with a plan to roll out in the South impatient wards if it is ratified in April 2024.***
- ***DHCFT Pharmacy are feeding back to ward managers on a quarterly basis about shared learning from meetings with Chesterfield Royal Hospital pharmacy.***

Incidents of moderate to catastrophic actual harm

This data demonstrates the number of DATIX incidents occurring recorded as moderate to catastrophic harm. There has an 49% increase in incidents between May and July. Analysis suggests that this is due to both a number of new types of incidents reported in these months and a general increase in the number of incidents that are routinely reported with a specific rise in incidents recorded as “aggression/abuse”. This is consistent with anecdotal reports from staff that acuity on the inpatient wards is increasing.

Duty of Candour

Duty of Candour reported incidents remain within expected thresholds. The Trust Family Liaison Office has created information leaflets and standing operating procedures to support staff in completing duty of candour communications.

Prone restraint

Prone restraint has decreased by a total of 11 incidents between May and July 2023 and is now below both the Trust target of 12 incidents and the mean of 10.

Physical restraint
Physical restraints have remained at around 90 incidents between May and July 2023 with a spike up to around 120 in June.

This is being reviewed within the Reducing Restrictive Practice Group and the Trust Positive and Safe Support Team continue to offer extra training sessions to improve training availability for staff.

Seclusion
Seclusions between May and July 2023 have reduced by 40% and are now in line with the Trust target of 12.

Falls on inpatient wards
The bi-weekly falls meeting started in April 2022 appears to have had a positive impact with incidents related to falls plateauing at 32, below the mean of 35 May and July 2023. This is monitored via the Head of Nursing and Clinical Matron and learning from the bi-weekly falls meeting is reviewed in the monthly Divisional Clinical Operational Assurance Team (COAT) meeting.

Care hours per patient day (CHPPD)
In the latest published national data when benchmarked against other mental health trusts, our staffing levels were average overall.

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

Risks and Assurances

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

Consultation

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

Governance or Legal Issues

Information supplied in this paper is consistent with the Trust's responsibility to deliver all relevant 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. The proposed level is limited assurance.
2) Formally agree that this report incorporates the key elements of assurance to the Trust Board that would otherwise have come from Finance and Performance Committee and People and Culture Committee reporting.
3) Determine whether further assurance is required.

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

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

Sabia Hussain
Deputy Managing Director

Rachel Leyland
Director of Finance

Rebecca Oakley
Deputy Director, People & Inclusion

Joseph Thompson
Assistant Director of Clinical Professional Practice

Integrated Performance Report Performance Key Insights

Bed pressure

- There continues to be a **high level of occupancy** on the adult acute wards – **currently 104%** - which is impacting on capacity for admissions. This calendar year to date **72% of admissions have been under the Mental Health Act,** which is significantly higher than previous years. We are also seeing a significant increase in the number of adult acute inpatients with a length of stay of 60 plus days. These factors would **suggest an increasing level of acuity** in the patient group being cared for. A bid has been submitted for a portion of the Integrated Care Board's adult social care discharge funding, which would be used to support discharge and free up beds through improving timely discharge.
- There has been a spike in out of area beds despite acute bed usage at typical levels. Admissions are at average weekly levels; discharges are below average weekly levels since the school holidays commenced. This is the same trend as last July, but discharges were high ahead of school holidays last year. Long stayers are showing a trend increase linked to discharge slow down. Male occupancy is consistent; female had a spike in January and follows out of area bed trend suggesting female bed capacity may be the out of area demand need. North wards had low discharges in late June/ early July; south had normal levels of discharging, suggesting north is a bigger issue.
- 40% of bed occupancy relates to readmitters. Readmitters are skewed towards females. The median length of stay is 15 days for 30-day re-admissions, and 17 days for any readmission within a year. There is double the relative number of people with personality disorders for readmitters versus non-readmitters. There is no significant difference in ethnicity versus general inpatient population. Readmitters are more likely to flow from Liaison Psychiatry, and are twice as likely versus non readmitters to be clustered as non-psychotic chaotic and challenging disorders and ongoing or recurrent psychosis (high disability). It is less likely for the next service contact following discharge to be with CMHT, early intervention, or home treatment, and much more likely to be Liaison Psychiatry. This suggests that there may be a significant personality disorder readmission issue and an opportunity to deliver care in the community as an alternative to a short stay.

Paediatric Outpatients

- Prior to March 2021 the referrals received was a level of demand that the service could manage, however Since March 2021 the volume of **referrals received has risen by 42%** and **this higher level of demand has persisted to date.** In 2019, the British Association for Community Child Health reported on the **longstanding workforce shortages** in community child healthcare which were having an adverse impact on waiting times and service delivery, leading to unacceptable delays for patients across the country. At that time, the Royal College of Paediatrics and Child Health estimated that an additional 856 paediatric consultants were needed to meet demand in the UK. This workforce shortage has continued. The Trust itself currently has 2 vacancies and a number of consultants reaching retirement age. A review of pathways is ongoing. The Royal College of Paediatrics and Child Health's paediatric training is now moving to a new training pathway structure which will reduce the time to complete to seven years, instead of eight, and will consist of two levels instead of three.

Adult Autistic Spectrum Disorder Assessment

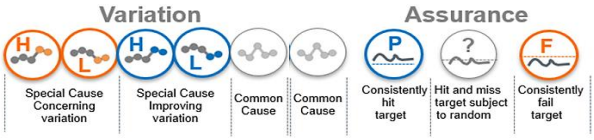
- The service continues to experience long waits to be seen for assessment. This is a national problem: the number of people waiting in England has **increased by 169%** since pre-COVID to 140,000 (**Autism assessment waiting times 2023**). In the Trust the level of funded capacity has fallen far short of the demand for the service for many years, as a result of financial pressures on the system. **This has inevitably resulted in increased waits**. Actions are being taken to **maximise capacity within the existing financial envelope**.

Assurance Summary

A. Operations

	Metric Name	Performance	Assurance	Latest Value	Target	Lower process limit	Upper process limit	Mean
1a	Waiting list - care coordination - average wait to be seen			27		19	31	25
1b	Waiting list - care coordination - number waiting at month end			127		50	89	69
2a	Waiting list - ASD assessment - average wait to be seen			77		68	73	71
2b	Waiting list - ASD assessment - number waiting at month end			2,225		1786	1983	1884
2c	ASD assessments			30	26	5	34	19
3a	Waiting list - psychology - average wait to be seen			34		46	56	51
3b	Waiting list - psychology - number waiting at month end			602		812	1033	923
4a	Waiting list - CAMHS - average wait to be seen			21		15	25	20
4b	Waiting list - CAMHS - number waiting at month end			284		374	568	471
5a	Waiting list - community paediatrics - average wait to be seen			37		19	25	22
5b	Waiting list - community paediatrics - number waiting at month end			2,081		1522	1939	1730
6	Outpatient appointments cancelled by the Trust			5%	5%	4%	11%	7%
7	Outpatient appointment "did not attends"			14%	15%	10%	14%	12%
B1	3 day follow-up			86%	80%	79%	96%	87%
D1	Community Mental Health Access (2 plus contacts)			11,324	11,899	9000	9823	9411
E1	Children & Young People Mental Health Access (1 plus contact)			2,975		2887	3064	2975
E4	Community Mental Health Access (2 plus contacts)			73%	95%	56%	93%	75%
E5	Children & Young People Mental Health Access (1 plus contact)			100%	95%	15%	110%	63%
G3	Early intervention 14 day referral to treatment - complete			90%	60%	64%	110%	87%
G3	Early intervention 14 day referral to treatment - incomplete			86%	60%	58%	117%	88%
H0	IAPT 6 week referral to treatment			54%	75%	66%	79%	73%
H1	IAPT 18 week referral to treatment			100%	95%	99%	100%	100%
H2	IAPT 1st to 2nd Treatment over 90 Days			32%	10%	2%	21%	11%
H7	IAPT patients completing treatment who move to recovery			48%	50%	43%	61%	52%
I1	Individual Placement and Support Access			220	343	104	384	244
K2	Total inappropriate out of area bed days			2,036		1,197	1,909	1,553
K2	Average patients out of area per day - adult acute			10	0	0	9	3
K2	Patients placed out of area - adult acute			17	0	0	15	6
K2	Average patients out of area per day - PICU			15	0	6	19	13
K2	Patients placed out of area - PICU			28	0	12	31	21
L1	Perinatal Rolling 12 Months Access			7%	10%	4%	5%	4%
L2	Perinatal Access Year to Date			441	1,070	156	506	331
N4	Data quality maturity index			98%	95%	98%	98%	98%

Key to symbols[1]:



Blue dots indicate special cause variation, better than expected.

Orange dots indicate special cause variation, worse than expected.

[1]The rating symbols were designed by NHS Improvement

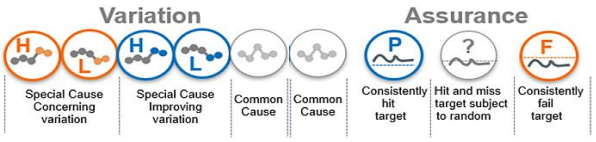
B. People

	Metric Name	Variation	Assurance	Latest Value	Target	Lower process limit	Upper process limit	Mean
1	Annual appraisals			84%	90%	74%	79%	77%
2	Annual turnover			12%	8-12%	12%	14%	13%
3	Compulsory training			89%	85%	85%	88%	87%
4	Staff absence			6%	5%	5%	8%	7%
5	Clinical supervision			78%	95%	72%	77%	75%
6	Management supervision			77%	95%	70%	76%	73%
7	Filled posts			93%	100%	88%	94%	91%
8	Bank staff use			6%	5%	5%	7%	6%

C. Quality

	Metric Name	Performance	Assurance	Latest Value	Target	Lower process limit	Upper process limit	Mean
1	Compliments received			120	119	72	142	107
2	Formal complaints received			22	13	6	30	18
3	Delayed transfers of care			8%	3.5%	2.4%	8.8%	5.6%
4	CPA reviews			52%	95%	70%	83%	76%
5	Patients in employment			12%		10%	14%	12%
6	Patients in settled accommodation			33%		40%	51%	45%
7	Number of medication incidents			96		39	105	72
8	No. of incidents of moderate to catastrophic actual harm			82	48	17	83	50
9	No. of incidents requiring Duty of Candour			0	1	0	6	2
10	No. of incidents involving prone restraint			7	12	0	22	10
11	No. of incidents involving physical restraint			89	46	25	105	65
12	No. of new episodes of patients held in seclusion			14	14	1	37	19
13	No. of falls on inpatient wards			32	30	22	50	36

Key to symbols[1]:



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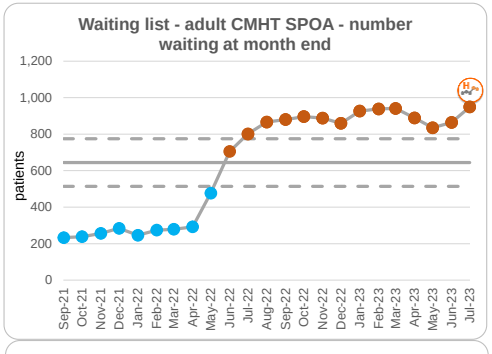
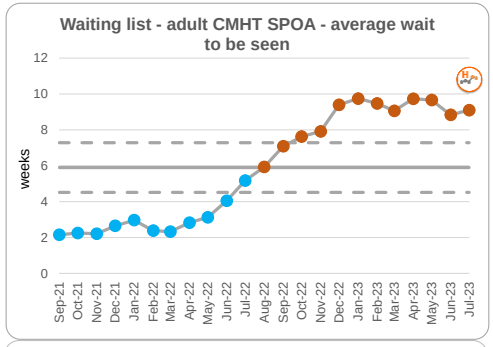
Derbyshire Healthcare
NHS Foundation Trust

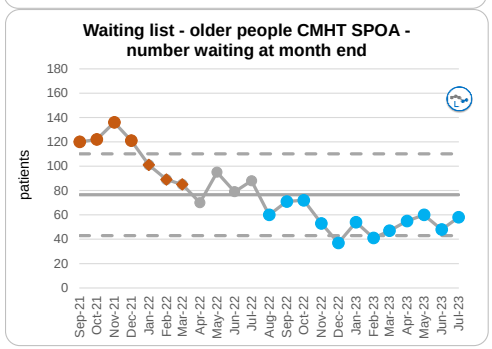
Operations

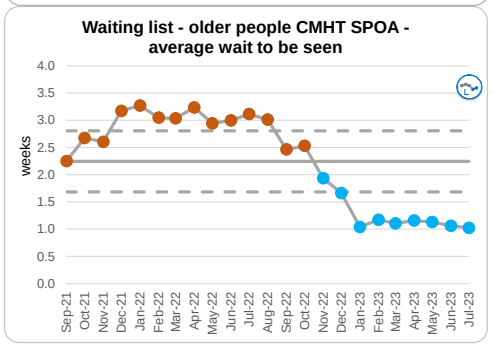
Operational Performance

Waiting Times – Community Mental Health









SPOA = single point of access – the route for external referrals into the services

Summary

The number waiting is increasing over time in adult SPOAs but reducing in older adult SPOAs. The average wait is fairly stable in adult at around 9 weeks, and is very low in older adult at around 1 week.

The working age adult community teams continue to get more cases in comparison to the older adult teams. Working age adult teams also hold a significant number of patients over the age of 65. This has previously been explored and it was found to be difficult to move over a lot of patients to older people's teams owing to concerns raised by older adult medics and also the need for continuity of care in some cases.

In the most recently published benchmarking data, the Trust's median length of stay in community mental health services from referral to discharge was 125 days, which is considerably higher than the national median of 60 days. The Trust's average community mental health caseload size as a proportion of total trust caseload was 45.8%. In comparisons, the national median was 28.1%. Our caseloads are high, and with high caseloads it is difficult for the teams to have capacity to pick up new cases. (https://model.nhs.uk/).

Cost of living is having an impact on the mental health of our communities, and as a result we are seeing more referrals because of anxiety and depression.

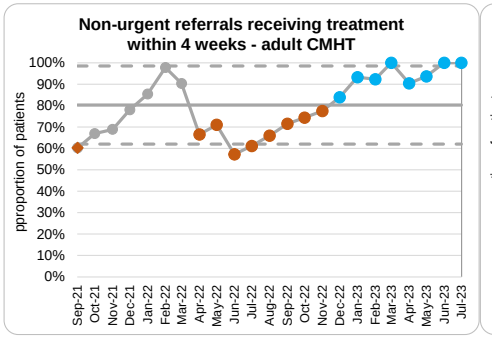
Some teams continue to experience significant staffing gaps, resulting in reduced capacity to pick up routine assessments, as they have to concentrate on the urgent and essential tasks, including hospital avoidance.

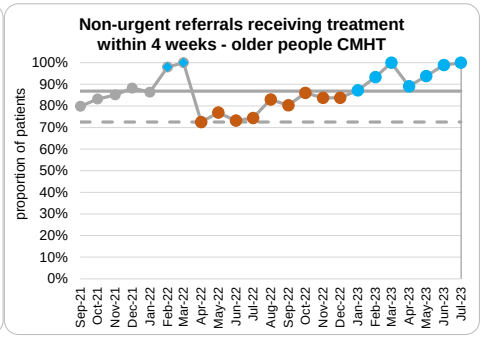
Actions

- Area Service Managers are currently working with the SPOA nurses regarding the number of assessments SPOA nurses should be completing (one suggestion is that a 1.0 wte SPOA nurse should complete 5 new assessments a week), at present, we are seeing some SPOA nurses completing 1-2 new assessments a week, which correlates to teams with higher waits.
- In comparison to the national median of 9.1%, the discharge rate from Trust community health services as a proportion of caseload was 7.7%. This means that we discharge fewer people and with the flow of referrals, our waiting list will continue to be high. The work in Living Well will mitigate this, as we will be working with the multiagency teams to proactively move on people in the community. Clinical leads are currently undertaking caseload reviews with staff. We are also exploring nationally where secondary services offer time limited interventions.
- Data recording and accuracy remains an ongoing issue, with some contacts not being counted and therefore people remaining on waiting lists when they should be removed. Information management have developed a weekly email to go to individual clinicians and managers to try and address and improve recording in SystmOne.

NHS England Proposed Access Standards

In 2022 NHSE proposed several access standards for mental health, including that adults and older adults accessing community-based services for non-urgent mental health care should start to receive help within four weeks of referral. The proposals are yet to be implemented. The charts below give an indication of how the Trust might be performing against the proposed standard, giving the proportion of patients receiving their second contact in the month who were seen within 4 weeks of referral.

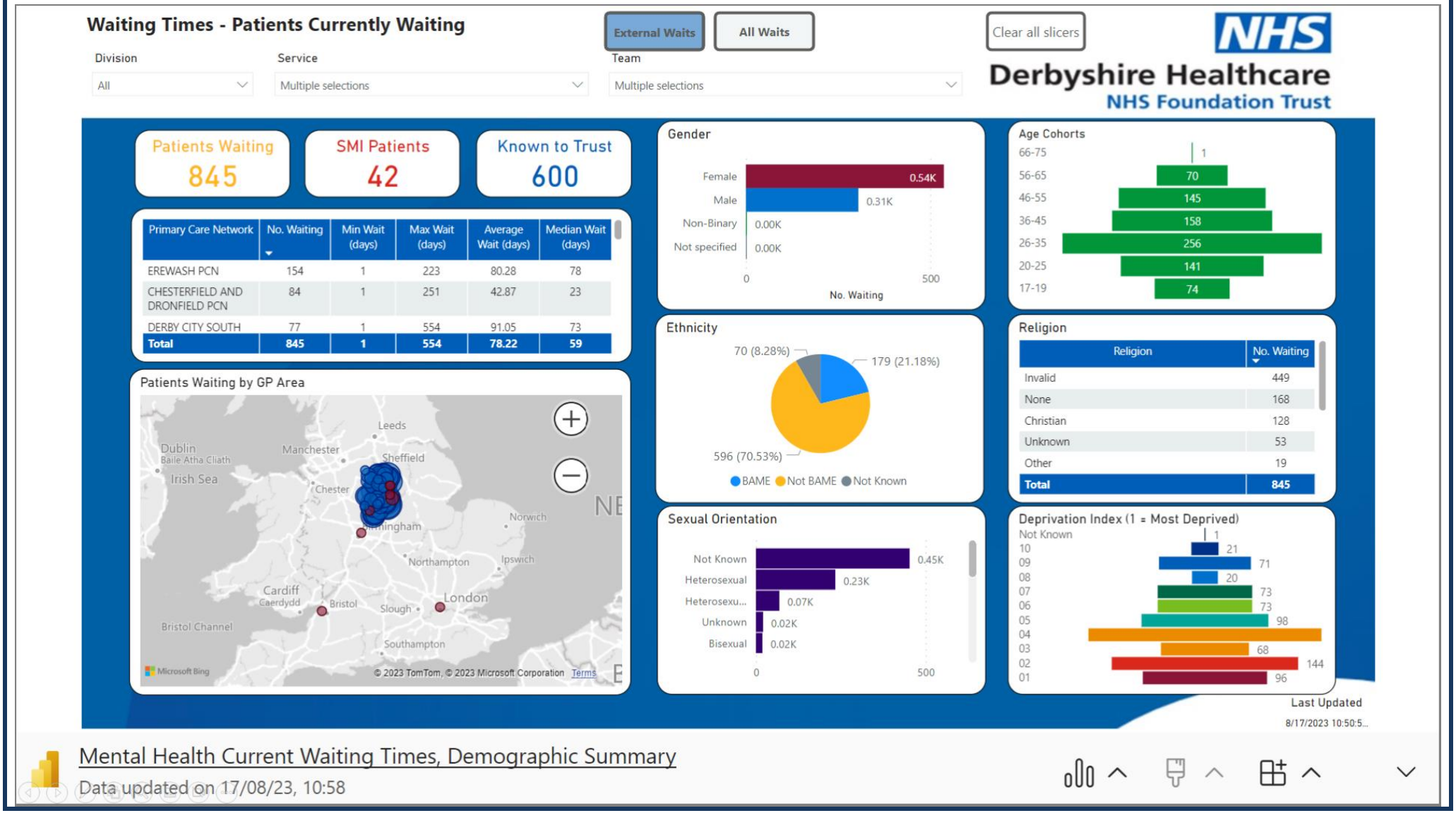




Operational Performance

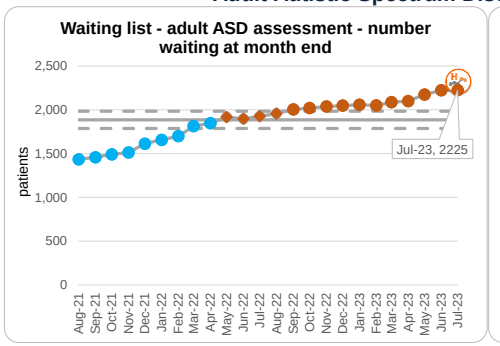
Waiting Times Dashboards

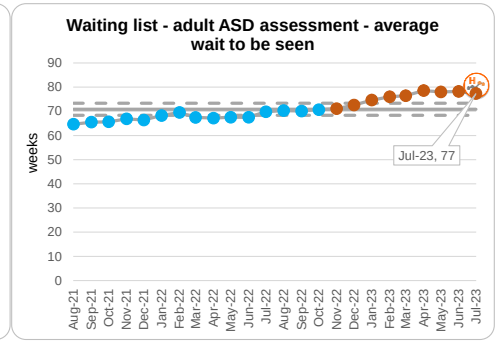
The Information Management & Technology Team are in the process of developing waiting times dashboards for the various services within the Trust. The dashboards can be filtered by multiple demographic factors, including gender, ethnicity, deprivation, sexual orientation, age and religion, and by Primary Care Network, Service and Team. The data updates daily overnight and is drillable down to patient level. This is an excellent piece of work that will support Operational Services with the monitoring of equity of access and reduction of waiting times. Below is an example screenshot:



Operational Performance

Adult Autistic Spectrum Disorder Assessment Service





Referrals

Year	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2016				18	15	20	23	28	31	26	27	18
2017	19	17	9	20	23	21	25	22	27	43	30	29
2018	29	34	32	41	47	40	62	41	45	54	48	22
2019	92	65	52	50	82	71	77	49	59	34	55	46
2020	83	32	28	45	20	46	17	27	14	48	77	74
2021	43	56	58	59	85	80	64	56	51	70	55	114
2022	62	62	141	74	100	97	50	70	88	65	70	52
2023	40	10	43	41	110	89	79					

Assessments

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2016				19	7	22	5	4	19	20	15	13
2017	35	37	47	22	22	18	30	16	24	34	30	12
2018	20	15	23	18	19	20	22	11	13	14	20	20
2019	33	24	25	24	19	18	15	11	26	30	34	15
2020	28	27	22	1	5	11	20	16	18	29	18	15
2021	20	17	22	22	17	12	14	14	24	24	15	6
2022	12	12	21	13	10	14	8	6	20	22	20	15
2023	22	28	24	22	18	31	30					

Summary

Demand for the service continues to outstrip capacity (commissioned to undertake 26 assessments per month but receiving around 80 referrals per month this financial year). At the end of July 2023 there were 2,225 adults waiting for adult ASD assessment, which is an increase of 126 since the last report. A revised approach to waiting list management is being mobilised and should start to have an impact from quarter 4 2023/24. Referrals peaked in April 2022 at 141. The number of completed assessments per month has increased and we are on track to achieve the full year contractual target of 312 by March 24.

Actions

- Clinical efficacies: processes and pathways are not fully standardised with lengthy time for completion of assessment. Review of clinical processes to increase screening success and increase the number of ASD assessments completed, pathways to be streamlined, and implementation of an all age pathway which is focusing actions and joint work with CYP services to minimise confusion and duplication of wait and process at transition .Currently a pilot is in place starting next month to action an increase in assessments.
- Improving skill mix and developing a flexible /responsive workforce: as the autism assessment team is a small team any unavailability impacts significantly on performance. A specialist bank has been designed to offer team cover and flexibility whilst building a multi professional skill mix. This is alongside rolling recruitment to all vacant posts is now having an impact and forms part of the pilot to increase assessments from next month
- Support of individuals on the diagnostic pathway is now in place and taking referrals with a focus to increase the numbers - whilst this won't reduce wait time for diagnosis, it will improve the experience and will alert people to options available to them. Pathway is disjointed and support has previously been limited between the various stages of the diagnostic pathway.
- Increased support to individuals pre and post diagnosis will improve their experience, understanding, and support any management of anxiety reducing the risk of sudden need to access services ,earlier awareness can be raised through signposting from the support services to the specialist teams
- Healios contract is now extended for 18-25 year olds: these individuals in transition are currently on the adult wait list, with several passed from children's services. Fast track to assessment for this group which will enable earlier support to be recommended and will allow for links between children and adult services and ongoing development of an all-age pathway
- Health Education England funding secured for a 12-month proof of concept around diagnostic tool, using screening tool as indicative diagnosis

Transforming Care Programme

Indicator	Target	Actual	Latest period
Number of adults in ICB commissioned inpatient care	35	30	Jun-23
Number of adults in secure inpatient care	19	18	Jun-23
Number of CYP in specialised/ secure inpatient care	6	4	Jun-23

Summary

The current targets are being achieved in all 3 areas. New, challenging trajectories have been agreed from July 2023 onwards. Significant performance improvements & transformation are required for JUCD to meet its end of year trajectory for the number of ASC&/LD people who are in receipt of inpatient care. Overreliance on inpatient care and a lack of credible community-based alternatives are the primary areas of concern. Currently, inpatient numbers remain above agreed national targets and out of line with projected performance levels. Improvements in position fluctuate and need to be sustainably managed.

Actions

Adults:

A Rapid Improvement Plan is currently in place, with 3 focused actions:

1. Reduce adult mental health inpatient admissions through improved admission avoidance processes, increased preventative offers, and intensive work with the Community Mental Health and Crisis Resolution and Home Treatment Teams,
2. Improved discharge planning and processes (including repatriation) for long-stay OOA Locked Rehab, Secure, and ATU patients;
3. Improved discharge planning and processes for local ATU inpatients and increased local step-down offers. Underpinning the RIP is a detailed Recovery Action Plan, with 9 themed areas of actions. Together, the actions aim to achieve our agreed forecast modelling and trajectory of a reduction of Adult mental health inpatient admissions from 5.54 a month to 4 a month.

Children:

- We now have an established permanent Strategic Escalation team to support MDTs to support CYP in crisis, this will be further developed in year to be community facing.
- Collaboration with LA partners in the development of an all age DSR.
- CAMHS urgent care team based TCP worker being recruited providing early support and intervention.
- CYP Case Managers being bought into the Mental Health trust from outside agency to improve links.
- Build on the successful CYP ICB escalation pathway.
- Improved care crisis services response to CYP with LD&A– ICB Investment into Complex Behaviour Service to increase community support for CYP with LD&A
- Roll out of 5 Community ND hubs across Derbyshire
- Recruitment to additional Specialty Dr across CAMHS ID and CBS
- DHCFT CYP Community ID and CAMHS ID teams under single management structure

Psychology & Psychological Therapies

Introduction
The Division of Psychology and Psychological Therapies was formed in April 2023 and significant work continues to create the new structure within the various data systems to enable reporting across all psychological services. The waiting list data below excludes adult ASD assessment waits and NHS Talking Therapies waits which are reported on separately in this report.

Workforce update
The systems team continue to progress on working on a solution to allow us to access our data. Presently this is not possible. An issue with ESR being incorrect has also further slowed progress, but this will be resolved this month. Sickness within the division is an average of 5% overall and NHS Talking Therapies (IAPT) has reduced to 7%. Morale remains positive, but individuals are feeling the pressure and challenges of the waiting list and the vacancies we currently do have. The vacancy rate is up slightly on last month at just over 6%. This is due to roles being offered to newly qualified psychologists, who will be on the HCPC register in October and therefore able to start work. This does mean that we will have a gap over the next couple of months.

The new structure continues to get positive feedback from members. Following debate and discussion, training standards for psychotherapists have been published internally. This is about keeping our standards of skill and therefore care high. CBT roles in particular have been highlighted at equivalence through KSA guidance, however, this does not replace having a core profession and therefore statutory regulation for regulated activity.

In relation to hybrid working, the majority of staff in the division prefer to work this way, meeting the needs of patients as well as supporting wellbeing and work-life balance for staff and includes telephone consultation, MS Teams and Attend Anywhere.

There has now been agreement for DHCFT to manage the delivery of psychological care in the north of the county for our LD colleagues. This process now needs to go through a management of change, agreement and signing of the SLA. We are inheriting an underfunded and desolate service, where all psychologists have left, but will work hard to recruit so service users in the North have support.

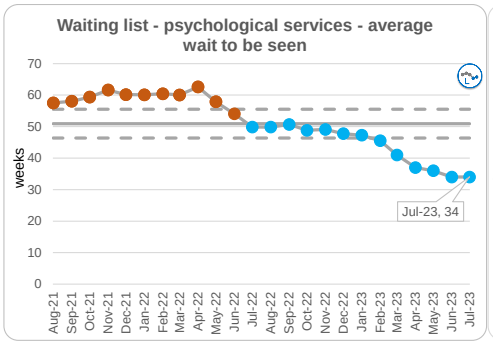
The system has approached us to develop our health services, asking if we could consider recruiting to a post in diabetes care. However, the challenge of short term funding is showing.

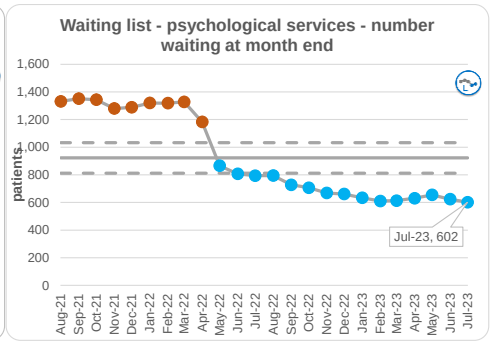
Friends & Family Test
Friends and Family Test, where reported, continues to show excellent feedback. In the last 12 months:

- Cognitive Behavioural Therapy received 49 responses and 100% were positive
- Amber Valley Adult Psychology received 11 responses and 73% were positive
- Amber Valley Older Adult Psychology received 1 response and it was positive
- Adult ASD Assessment Service received 1 response and it was positive
- Psychodynamic Psychotherapy received 2 responses which were both positive
- NHS Talking Therapies received 1,865 responses and 98% were positive.

Partnership, system and PLACE working
Teams continue to develop local working relationships with the specialist teams now inputting into the North of the county, where they have never previously been commissioned to do so. This has taken careful persuasion for staff to work out of less familiar areas.
There remain challenges with funding from the ICB, whereby we have been asked to recruit and then the money has been pulled. This is creating challenges for finance and people management.
The work with the University of Nottingham is ongoing. The new consultant psychologist post funded by the Universities of Nottingham & Lincoln has now settled in and we continue to provide the most placements for trainees within the region. When looking across the midlands region more widely, we are in a very strong position comparatively.

Waiting lists and referrals
Demand for psychological services continues to outstrip delivery causing pockets of longer waits. Overall waiting lists do however continue to reduce. At the end of July 2023, 602 people across Derbyshire were waiting to be seen by psychological services, with an average wait time of 34 weeks. Following a reduction in recent months, the number waiting and waiting times have stabilised. There is more work to be done here. We are exploring the use of new technology to manage the wait lists and re booking systems is supporting this. The longest reported wait has been in Amber Valley Adult Psychology Team. This was due to a staff member not being at work for an extended period of time. This person has now left the Trust and we are able to recruit into that role.





Trust wide staff wellbeing
We continue to receive requests from across the workforce for more psychological team support and reflective practice. Our new counselling psychologist started at the beginning of August and she has already received a team and individual referral, via special request prior to the service officially being open.

Supervision & appraisal
Clinical supervision is currently being reported as 89% for the division. Our aim is for 100% and this is raised at the monthly Leads meeting as well as within our Divisional COAT. Appraisal completion is also monitored and is at 88%.

Increasing trauma and psychological awareness
The Bite size psychological teaching sessions continue to have good attendance with a range of topics being delivered. Following the trauma informed launch conference on the 5th May, a series of follow up workshops, sessions and training have been delivered. The TIC oversight board is focussing on development and delivery Trust wide. This co-produced strategy, training and teaching is supported by two psychologists on brief secondments (6 moths part time) to lead this.

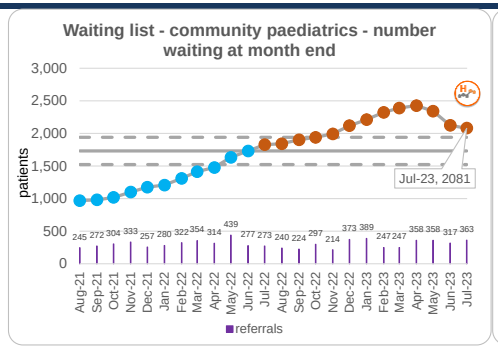
Benchmarking and productivity
Due to the lack of benchmarking national data in relation to psychological services (outside of specialised commissioned services), we are working with Nottinghamshire Healthcare NHS Foundation Trust, Leicestershire Partnership NHS Trust and Lincolnshire Partnership NHS Foundation Trust to pull together and better understand our regional standards. This remains ongoing and is challenge due to differing data recording.

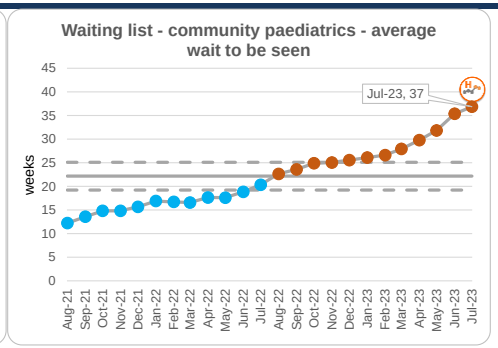
Conference 2023: "Thriving not surviving"
We are holding our first divisional conference in September to highlight good practice. We have Professor Paul Gilbert as our Key Note speaker to kick start a day of learning, CPD, connectivity and sharing good practice. This will improve morale, a sense of belonging and provide a safe opportunity for staff to present posters and presentations.

Operational Performance

Ongoing actions • Regional benchmarking • Reduce vacancies further • Build up offering for ND in the north of the county • Consider different type / ways / innovations for delivery of psychological care • To continue to deliver psychological awareness and trauma informed training • To continue to understand and build psychological safety within the division and wider trust • Lead on work around relational boundaries and safety • To complete the Division of Psychology and Psychological Therapies through finalising ESR and hierarchy as well as for data reporting • Continued work with systems team to improve accuracy of SystemOne reporting and data capture • Improve compliance with appraisals and supervision	

Operational Performance





Summary

At the end of July 2023 there were 2,081 children waiting. The average wait time was 37 weeks.

Internal factors:

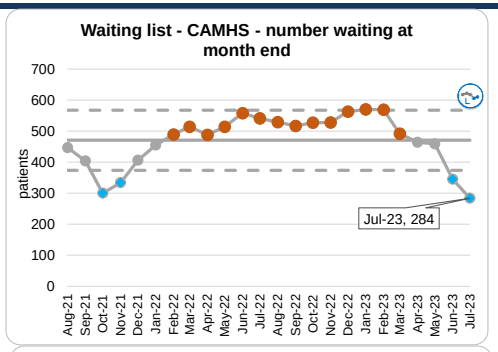
- Challenges to recruitment- 2 Consultant vacancies; retirement age for many of our Paediatricians; national shortage; increased cost per hour for external locums.
- Pathways are unclear and single point of referral does not effectively manage children being referred into the service.
- Difficulty in discharging children under NICE guidance and shared care agreements in relation to medication for ADHD – specialist nursing team caseloads continue to expand causing problems with flow from the Comm Paeds service.
- Lack of suitable clinical working space remains.

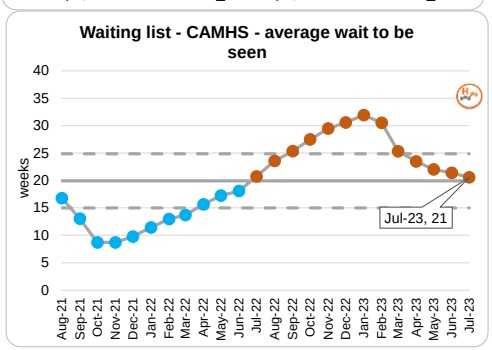
External factors contributing to increased demand on Community Paediatricians:

- Prior to March 2021 the referrals received was a level of demand that the service could manage, however Since March 2021 the volume of referrals received has risen and this higher level of demand has persisted to date.
- ASD/ADHD demand for specialist assessment increased 400% from 2018 to 2023 (22/23 4575 referrals per annum) with maximum South Derbyshire system capacity to assess 1900 per year)
- Developmental delay referrals to community paediatricians increased following the pandemic
- Appointment duration has increased due to the increased complexity of CYP presenting needs post the pandemic.
- Delay in mobilisation of the Community Hubs, and waiting times for other support services has also increased which have impacted on ability to signpost outside of our own service.

Mitigation:

- Neurodevelopmental (ND) business case 400k received January 2023 (75% less than proposed business case to address current demand) – Update, clinical posts have been appointed to including triage nurse to support pathways to the community hubs and interviews for the clinical psychologist are planned for next week. Review of current pathways is ongoing, including engagement with the transformation team to support changes and proposals.
- Engagement with the community hubs, internal and external partners is underway with a view of providing a number of options to make small and targeted changes to current pathways and referral points which has been highlighted as a priority.
- Clinic space remains under constant review – Oakwood Children's centre will hopefully be opened up over the next few weeks which will provide a hub for ND work and support joined up working with the hope this could become a 'one stop shop' for children and families in the city.
- Review of vacant consultant posts and workforce.
- Review of active signposting and resources for families to access for support, advice and information, updates to website planned.
- Ongoing Quality Improvement – C&YP ND transformation (phase 1) started May 2023



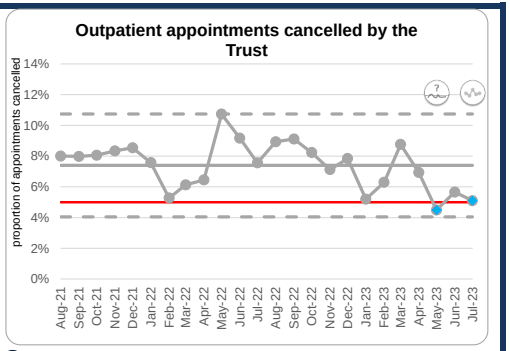


Summary

At the end of July 2023, 284 children were waiting to be seen, with an average wait time of 21 weeks. The Triage and Assessment Team is continuing to have a positive impact on waits.

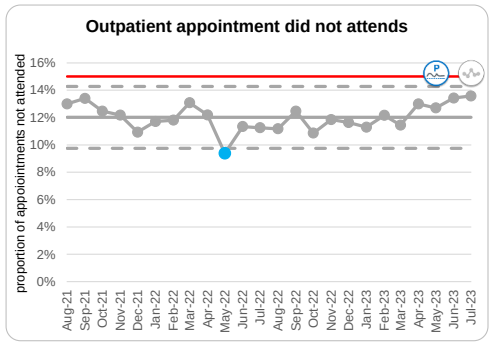
Actions

- By the end of June 2023, it was expected that 5 clinicians would be fully up and running with triaging, soon to be 6. However, although there have been further applicants joining the team, owing to sickness and still waiting on one individual's DBS check to clear, the team is currently at 70% establishment and therefore, still not working at optimum efficiency.
- Clearly though, the model is continuing to have a significant positive impact on waiting times and average waits, with the number of children awaiting an assessment, the lowest it has been (284) since this reporting period began in August 2021. If the current trajectory continues, the average wait target will be achieved by the time of the next report.



Summary

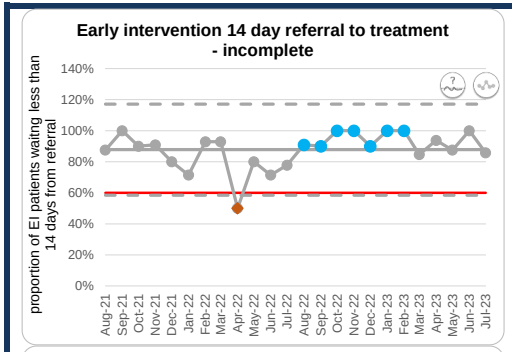
This indicator was introduced as a measure of patient inconvenience some years ago and when cancelling appointments, the administrators should identify whether or not the patient was aware of the appointment in order to enable differentiation between cancellation of virtual and actual appointments. Recording accuracy needed to improve and so further training in the use of SystmOne was arranged for those concerned. As a result, the level of reported cancellations is very close to the target threshold.

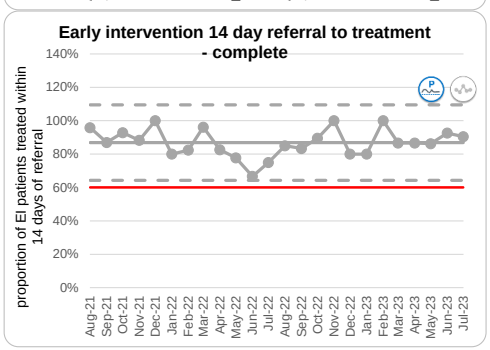


Summary

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

Operational Performance

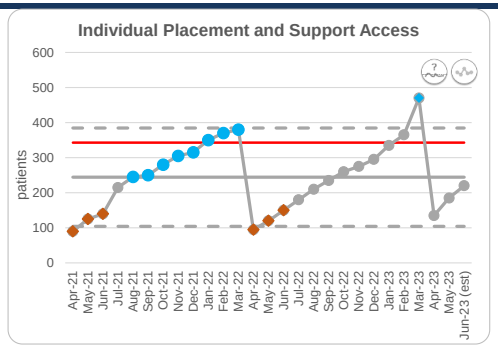




Summary

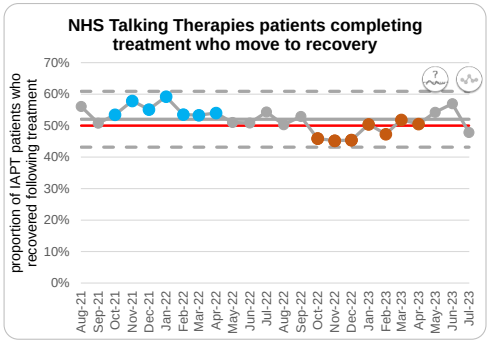
Patients with early onset psychosis are continuing to receive very timely access to the treatment they need. Occasionally delays result from difficulties contacting patients to arrange appointments, or patients not attending their planned appointments.

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



Summary

This is a year-end target for the number of new people accessing the individual placement and support services within the financial year. The target was achieved in 2021/22, achieved a month early in 2022/23 and is on target year to date this financial year.

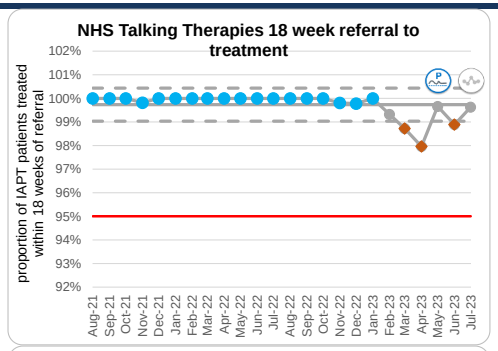


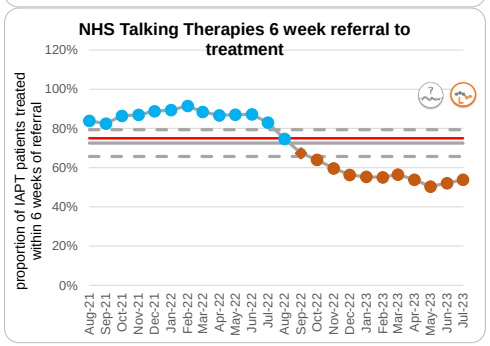
Summary

Recovery rates exceeded target for the first months of the year, giving a year to date figure in excess of 50%. There has been a reduction in performance in July, however this will be monitored going forwards.

Actions

- Work continues on informing clinicians of their own performance via service management.
- Service wide meetings discussing performance and updating clinicians on plans and progress continue.





Summary

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

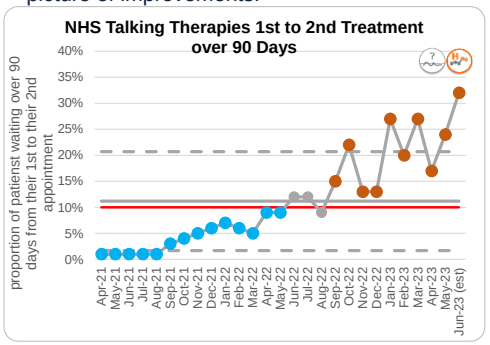
6 week waits have been below standard for 11 months. There are marginal improvements in achievement from May to July 2023.

Wait times from referral to assessment/treatment and 1st to 2nd treatment have been lengthening.

Referrals continue at, or above, pre pandemic levels with a 12.5% increase in May compared to April, this adds to pressures on wait times in the coming weeks and months. There is continued pressure on the PWP team who conduct most of the service assessments, as there are vacancies which we have struggled to recruit to. This has been further exacerbated by a reduction in PWPs and CBT qualified staff amongst our sub-contractor DRCS. PWPs are eligible for Hi Intensity training after 2 years post qualification. There is a risk that we will lose more PWPs to this training as TMHD does not have funding for trainees this financial year from HEE or the ICB. There are September and March cohorts which could be challenging.

Actions

- Recent PWP recruitment has been more successful with staff being recruited. The service continues to recruit and is hopeful of more successful appointments.
- To improve the referral to assessment/ treatment rates, assessments have started to flow to Xyla, funded from deferred income.
- Online bookable appointments have been rolled out to all PWPs appointments, there are some reductions in DNAs, but time will give a better picture of improvements.



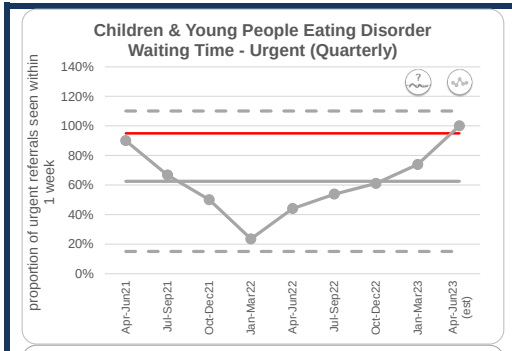
Summary

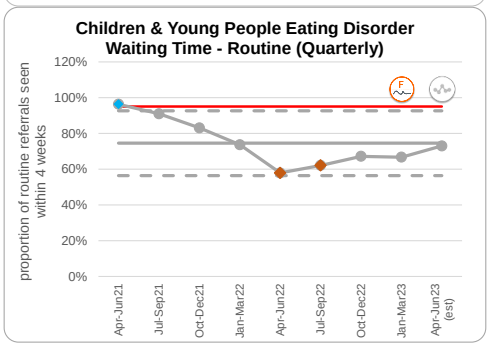
1st to 2nd treatment waits have been significantly high and above target for the last 7 months.

Actions

- Monthly service Manager discussion over longest waiters to reduce outliers. Standing agenda item. This has had a significant impact on the longest waiters.
- Supportive caseload management frameworks have been introduced to give better scrutiny of productivity in relation to average contacts.
- Further work is in progress with IESO with a work plan of promotion of the service, crib sheets for assessing clinicians and rolling attendance at service wide meetings.
- Maintain a focus on attendance and reduction of DNAs
- Review acceptance criteria to achieve more appropriate referrals.
- Bookable appointment slots are rolled out to all PWPs assessors, these also allow for cancellations being re-offered to patients should someone cancel their appointment.
- Working towards cross provider agreements to advertise wait times for all providers offering better patient choice reducing wait times.

Operational Performance

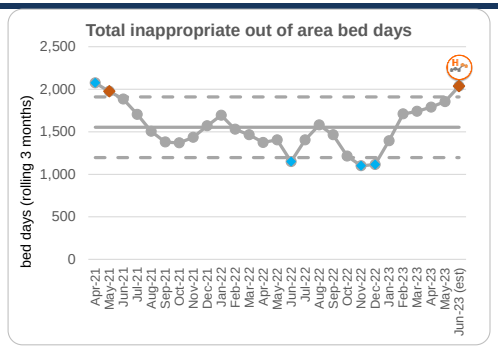




Summary

The two waiting time standards are that children and young people (up to the age of 19), referred for assessment or treatment for an eating disorder, should receive NICE-approved treatment with a designated healthcare professional within one week for urgent cases, and four weeks for every other case (target 95%). The Trust's Child & Adolescent Eating Disorder Service is generally achieving around 100% for both standards, but unfortunately although the NHS England national standard states that *"CLOCK STARTS on the date the referral is received by the Community Eating Disorder Service for Children & Young People (CEDS-CYP) or generic CAMHS where the reason for referral is for a suspected eating disorder"*, the national measure is not based on service, it is purely based on anyone under 19 with a referral reason of eating disorder, and so referrals made to adult services are being included and are negatively impacting on the reported position.

The Division is now also internally monitoring the C&YP Eating Disorder Service waits from 1st to 2nd contact. In quarter 1 the average wait was 11 days, and the median wait was 7 days.



Summary

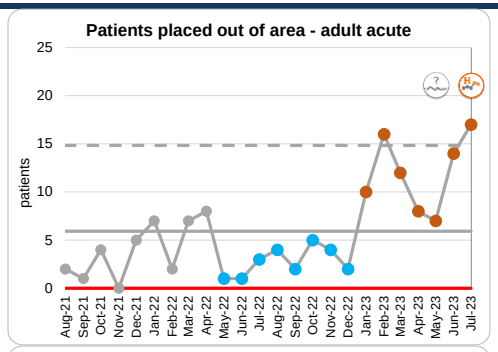
This is a national measure giving a combination of inappropriate out of area adult acute placements and inappropriate out of area psychiatric intensive care unit placements, calculated on a rolling 3 months' basis.

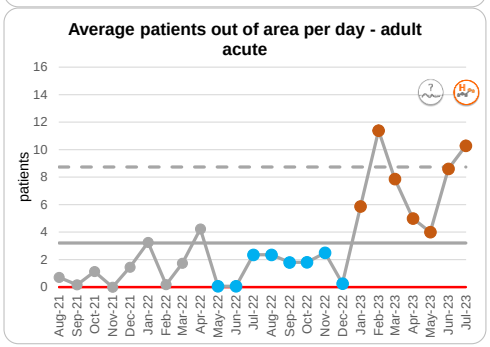
There is an ongoing demand for inpatient beds. This has been a consistent factor over many weeks now and we are not seeing any significant change in that. Some of this is expected as a result of seasonal variation but the demand has been continuous for longer than anticipated. Generally, we are finding people are more acutely unwell and acuity is much higher than we would usually expect. As a result, people are taking longer to recover. The increase in acuity is also apparent when we look at the number of patients in PICU.

The crisis teams are working with caseloads higher than usual in attempt to avoid admissions to hospital wherever possible.

There have also been a few disruptions/delays to service offers that we were hoping would impact presentations and clinical pathways:

- Step Down – unfortunately the 5 step down beds did not open in March as initially hoped. Works to comply with health and Safety requirements are underway and hoping that these will be available to open from 14th August 2023.
- Chesterfield safe haven & Crisis House – Unfortunately the 4 bedded Chesterfield Crisis House and safe haven have been delayed until September 2023.
- Ripley and Swadlincote crisis café – delayed due to open in December 2023.
- Derby Crisis House – temporary reduction in capacity due to works on one of the bedrooms.





Actions

- Changes have been made to the authorisation protocol for out of area beds. This is now escalated to Managing Director and Director on Call.
- Gatekeeping and Purposeful Admission protocols being developed and to be implemented when agreed.
- Community based medication initiation being developed and implemented when available.
- Street triage pilot has resumed providing more suitable pathway to assessment and decision making in the community.
- Step down beds – now Aug 23
- Chesterfield safe haven and crisis house – now Sep 23
- Ripley & Swadlincote crisis café – now Dec 23

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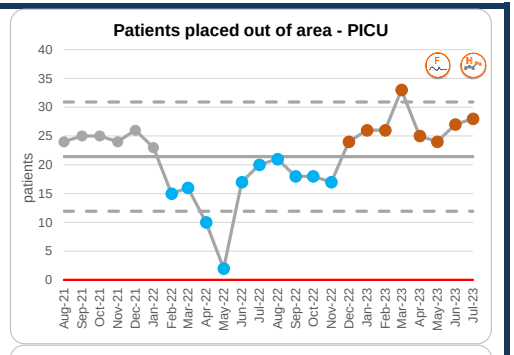
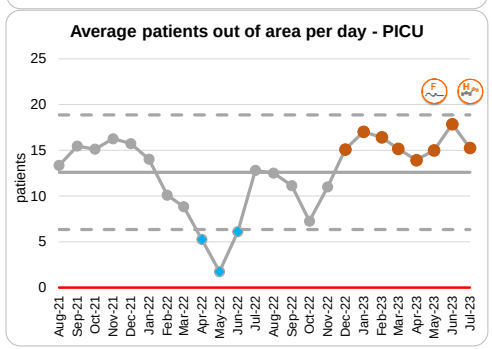




Summary

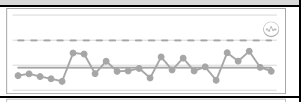
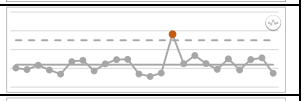
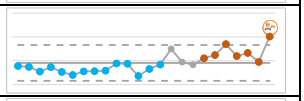
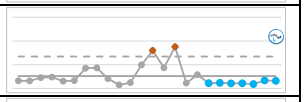
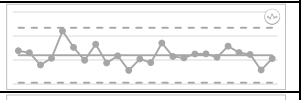
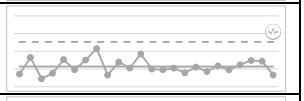
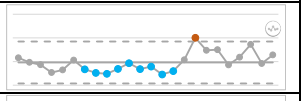
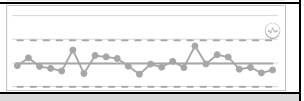
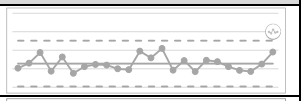
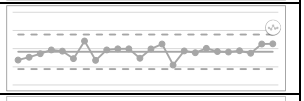
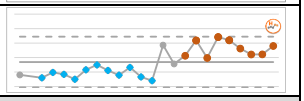
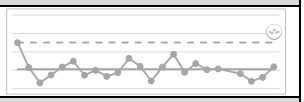
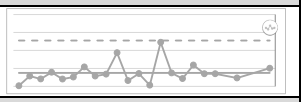
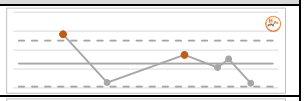
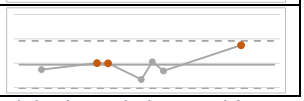
There is no local PICU provision, so anyone needing psychiatric intensive care must be placed out of area, however, work continues on the provision of a new build PICU in Derbyshire. As a result of actions there has been some reduction in PICU placements and at the time of writing there are a total of 15 patients placed in PICU beds.

Actions

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

Operational Performance

Length of stay (days)

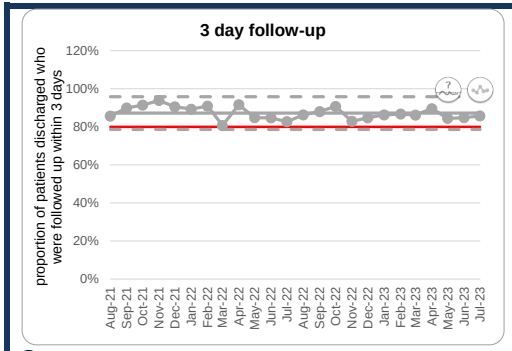
Clinical area	Beds	Bed occupancy July-23	Average duration of stay to date (days) of current inpatients	Average length of stay (days) July-23 discharged	Change versus previous month discharged	Change over time – average length of stay of discharged inpatients
Adult Acute						
Morton	20	103%	31	38	↘	
Pleasley	20	100%	49	37	↘	
Tansley	20	100%	51	101	↗	
Enhanced Care	10	100%	92	32	↘	
Ward 33	20	103%	71	53	↗	
Ward 34	20	108%	43	33	↘	
Ward 35	20	106%	35	64	↗	
Ward 36	20	113%	57	35	↗	
Older People						
Tissington	18	101%	56	95	↗	
Cubley Female	18	79%	74	113	→	
Cubley Male	18	97%	77	140	↗	
Perinatal						
The Beeches	6	98%	30	59	↗	
Rehabilitation						
Cherry Tree Close	23	86%	359	506	n/a	
Low Secure						
Curzon Ward	8	99%	347	n/a	n/a	
Scarsdale Ward	12	72%	836	n/a	n/a	

Explanatory note: where occupancy is over 100% this means that patients are on periods of trial home leave and their beds are being used for new admissions while they are at home. Leave beds used are predominantly safe planned leave, so leave would normally be extended, where safe to do so, to prevent 2 patients being in one bed. Patients are encouraged to not spend too much time in their room, so even if a patient was to return we would have the day to look at where we can shift beds around. It is a constant daily challenge for the Bed Management Team, who do a sterling job.

The average lengths of stay of patients discharged in July from Tansley, Cubley Female and Cubley Male were unusually high owing to discharges of several patients from each ward with very long lengths of stay, which will have a positive impact on length of stay going forward.

Research based on Erlang's queuing theory suggests that with the size of our bed base there should be a maximum occupancy of 85% in order to have readily available beds to enable management of acutely ill patients to occur in a safe and appropriate setting, and in order to protect both patients and staff from untoward incidents arising from busyness. https://www.priory.com/psychiatry/psychiatric_beds.htm

Operational Performance

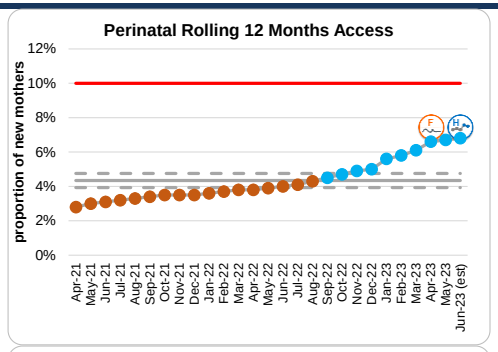


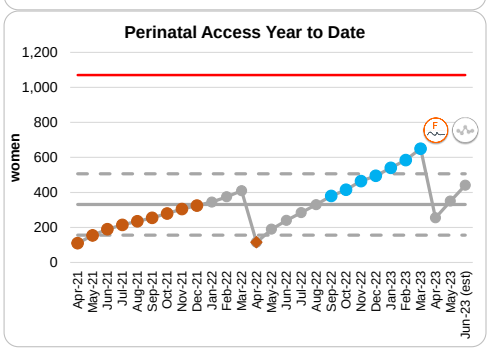
Summary

Patients are followed up in the days following discharge from mental health inpatient wards to provide support and ensure their wellbeing during the period when they are potentially at their most vulnerable. The national standard for follow-up has been exceeded throughout the 24-month period.

Actions

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





Summary

This is a measure of the number of women accessing services in the 12-month period as a percentage of Office for National Statistics (ONS) 2016 births (target 10%). There has been a significant increase in access when compared with last financial year.

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

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

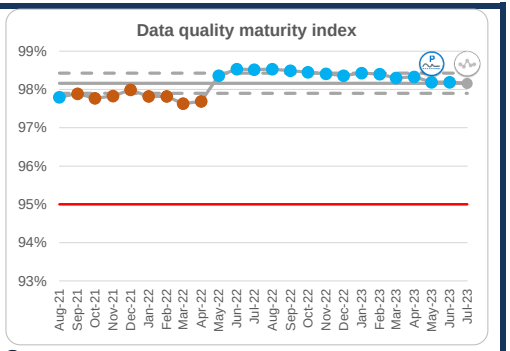
The official data from NHS England is published several months in arrears, so the June 23 position has been estimated using internal data.

Capacity continues to be demonstrated within the system to offer 90 assessments a month. Over 91 assessments were recorded locally within June. The rolling 12-month access remains on an upward trajectory.

July's figures are likely to be under target due to a large percentage of DNA's and reduction in staffing due to annual leave, sickness and industrial action.

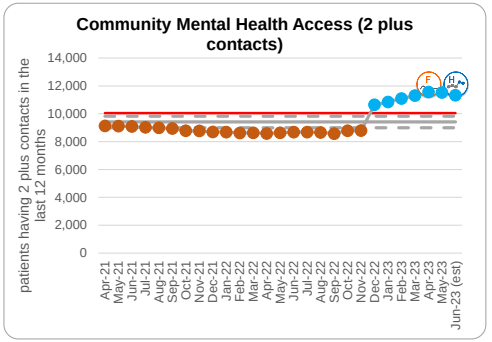
Actions

- The Data Warehouse team have been able to identify areas of recording on SystmOne that are impacting nationally reported data and an action plan has been commenced to address this within teams.
- Referrals into the service have increased since April/May. The introduction of self-referrals, satellite clinics, joint antenatal clinics and community outreach working aim to further maximise future assessment opportunities.
- Early data from the DNA pilot has highlighted areas for improvement in terms of service processes and communications.
- The service is utilising Trust productivity and health inequality forums to underpin patient flow processes and ensure parity of access.
- Further recruitment into Psychology posts are needed to increase capacity across the service.



Summary

The level of data quality has been significantly better than expected for 14 of the last 15 months. It is expected that the national target will be consistently exceeded.



Summary

The Trust was set a challenging target to increase the number of adults and older adults receiving 2 or more contacts in a year from community mental health services to 10,044 by the end of March 2023, which was an increase of 14% on current performance. A recovery action plan was put in place and successfully implemented, resulting in activity exceeding the target for each of the last 4 months of the financial year.

This financial year the year-end target has been increased to 11,899. and is on target to be achieved by year end.

Operational Performance

Patients not seen for over 12 months

Count of Appt booked	Appt booked?		
Team	No	Yes	Total
ADULT CARE COMMUNITY	**132**	**120**	**252**
COUNTY NORTH	**25**	**26**	**51**
BOLS & CC ADULT CMHT - OUTPATIENTS	11	20	31
CHESTERFIELD C ADULT CMHT - COMMUNITY	1		1
CHESTERFIELD C ADULT CMHT - OUTPATIENTS	1	3	4
EI NTH	1		1
HP & N DALES ADULT CMHT - COMMUNITY	1		1
HP & N DALES ADULT CMHT - OUTPATIENTS	10		10
KILLMSH & NC ADULT CMHT - OUTPATIENTS		3	3
COUNTY SOUTH	**34**	**26**	**60**
AMBER VALLEY ADULT CMHT - OUTPATIENTS	26	14	40
EREWASH ADULT CMHT - COMMUNITY	3		3
EREWASH ADULT CMHT - OUTPATIENTS		2	2
EREWASH ADULT CMHT - SPOA	1		1
SOUTH & DALES ADULT CMHT - COMMUNITY	2		2
SOUTH & DALES ADULT CMHT - OUTPATIENTS	1	9	10
SOUTH & DALES ADULT CMHT - SPOA	1	1	2
DERBY CITY	**73**	**68**	**141**
DERBY CITY ADULT CMHT B - OUTPATIENTS	14	27	41
DERBY CITY ADULT CMHT C - COMMUNITY	1		1
DERBY CITY ADULT CMHT C - OUTPATIENTS	51	40	91
PHYS HEALTH MONITORING	7	1	8
OLDER PEOPLES CARE	**53**	**11**	**64**
OLDER PEOPLES COMITY CARE	**53**	**11**	**64**
AMBER VALLEY OA CMHT - OUTPATIENTS	22	1	23
BOLS & CC OA CMHT - SPOA	1		1
CHESTERFIELD C OA CMHT - OUTPATIENTS	3		3
DERBY CITY OA CMHT - OUTPATIENTS	4	1	5
KILLMSH & NC OA CMHT - OUTPATIENTS		1	1
MAS NORTH - MAS	8	7	15
MAS NORTH - MAS 24		1	1
MAS NORTH - PSYCHOLOGY	1		1
MAS SOUTH - MAS	9		9
MAS SOUTH - PSYCHOLOGY	5		5
Total	**185**	**131**	**316**

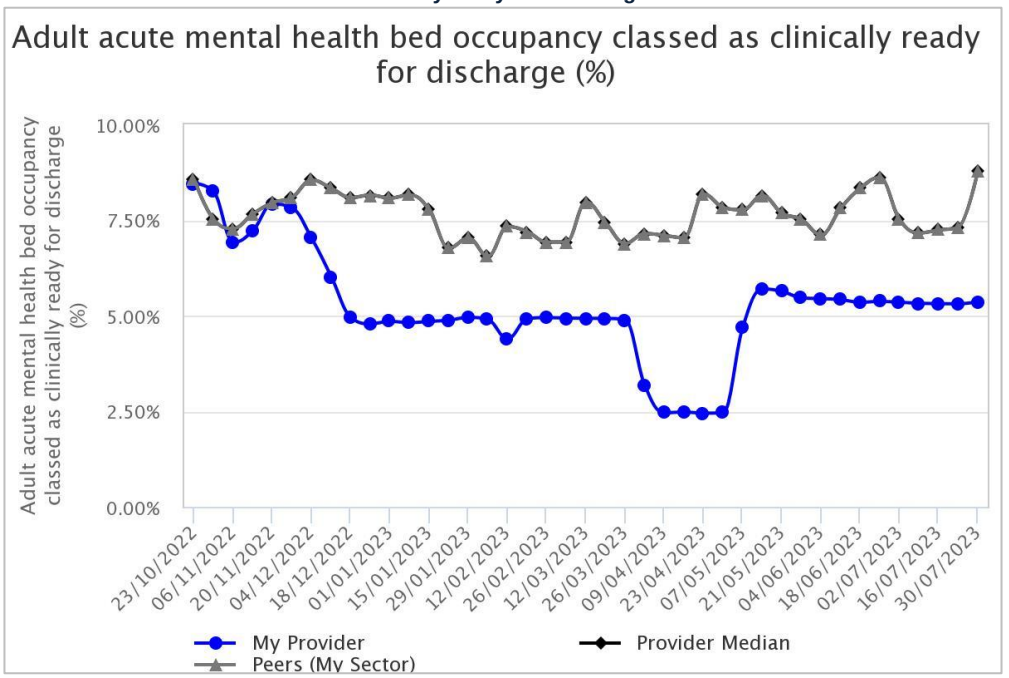
Summary

There are 316 patients on community mental health caseloads who have not been seen for over 12 months, according to their records. Some will be people who have been discharged but the discharge has not been recorded on the electronic patient record.

Actions

- Currently the performance team report weekly to the teams concerned, in order to ensure that records are corrected, and that people are given appointments who need them. However, this is a safety net approach, and it is important that teams take ownership of their own caseloads.
- Services to review the cases concerned and correct any errors on the patient records.
- Services to arrange appointments where required.
- Action is being taken to embed a culture of caseload ownership, review and management within all services of the organisation.

Clinically ready for discharge



Adult acute mental health bed occupancy classed as clinically ready for discharge (%) - Model Mental Health

Summary

This shows the proportion of adult acute mental health patients classed as clinically ready for discharge but continuing to reside in mental health hospitals against the total number of occupied beds. In the most recently published data, the Trust's clinically ready for discharge rate was 5.4%, which compares favourably with the overall provider median of 8.8% but continues to negatively impact on bed availability for people who need inpatient care.

Actions

The pilot of the Discharge Tracking Tool went live as planned on the 3 July 2023 on Tansley Ward. It is a live working document displayed on the TV screen, enabling ward staff to view the current status of the discharge planning position for each patient. There are currently dedicated staff taking responsibility for keeping the document up to date throughout the pilot stage, with some changes and updates to the document contents being under review. The use and benefits of the document is being reviewed fortnightly with the intention that once we have it in a position to be proving it is beneficial it will be taken to the daily rapid reviews to inform the management of red to green, estimated discharge date and provide a task management approach.

Appointments not reconciled

Service	Current	Previous	Change
COUNTY SOUTH ADULT	472	590	-118
OLDER PEOPLES COMMUNITY CARE	391	512	-121
COUNTY NORTH ADULT	332	342	-10
CAMHS	263	251	12
PSYCHOLOGY ASM3	200	217	-17
DERBY CITY ADULT	158	246	-88
PERINATAL	157	180	-23
ACUTE INPATIENT NORTH	149	126	23
NOT KNOWN	131	77	54
ACUTE INPATIENT SOUTH	111	70	41
ADULT URGENT ASSESSMENT	88	108	-20
LEARNING DISABILITIES	78	97	-19
OLDER PEOPLES ACUTE CARE	70	83	-13
COMPLEX CARE	33	37	-4
SPECIALIST CARE MGT	28	41	-13
PSYCHOLOGY ASM2	18	29	-11
PSYCHOLOGY ASM1	15	51	-36
SUBSTANCE MISUSE	13	0	13
SPECIALIST CARE	7	11	-4
HEALTH PROTECTION UNIT	2	0	2
OVERALL	2716	3068	-352

Summary

There are a number of appointments where the attendance outcome of the appointment has not been recorded, i.e. whether the patient attended or not. This will be impacting on reported waits, activity levels and reported did not attend rates. This is linked to the move to SystmOne and people getting used to how to record activity. There has been significant improvement over the last 12 months, and a further 12% improvement since the last report.

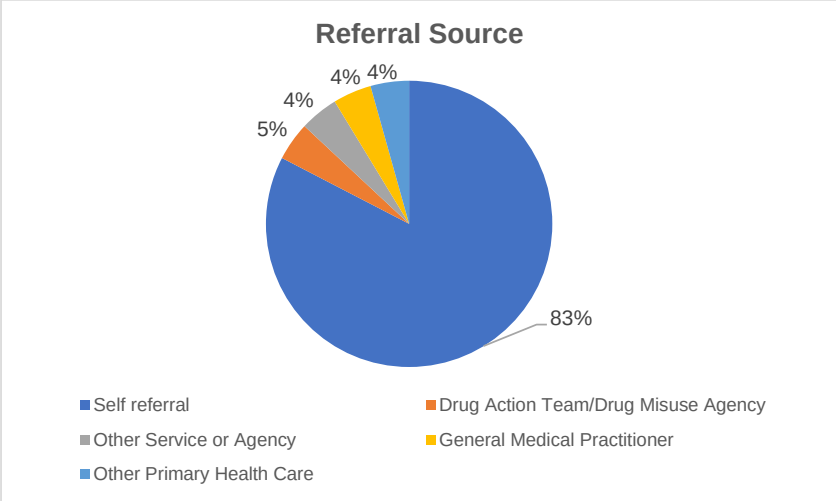
Actions

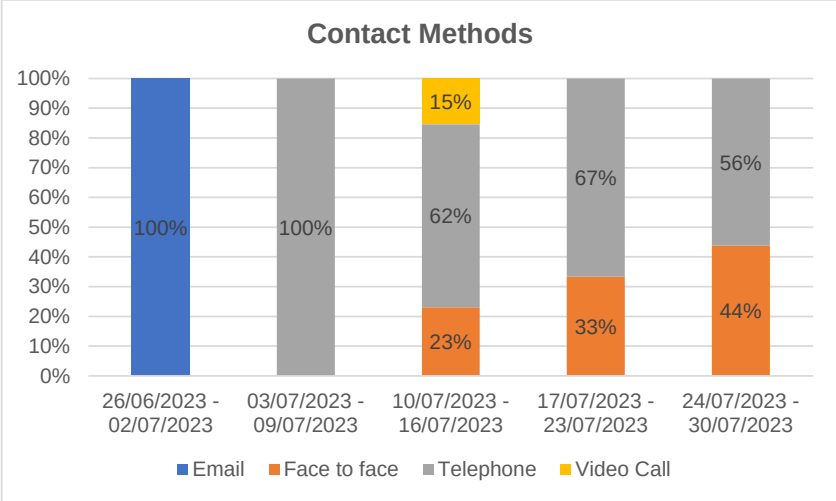
- Weekly reporting to the teams and clinicians concerned
- Monthly reporting to Divisional General Managers
- Monitoring at Divisional Achievement Reviews
- IM&T are developing a weekly automated report to individual clinicians and managers which will highlight any data quality issues within their caseload on SystmOne, to enable ongoing monitoring and for corrective action to be taken. This is currently being tested with a community team.

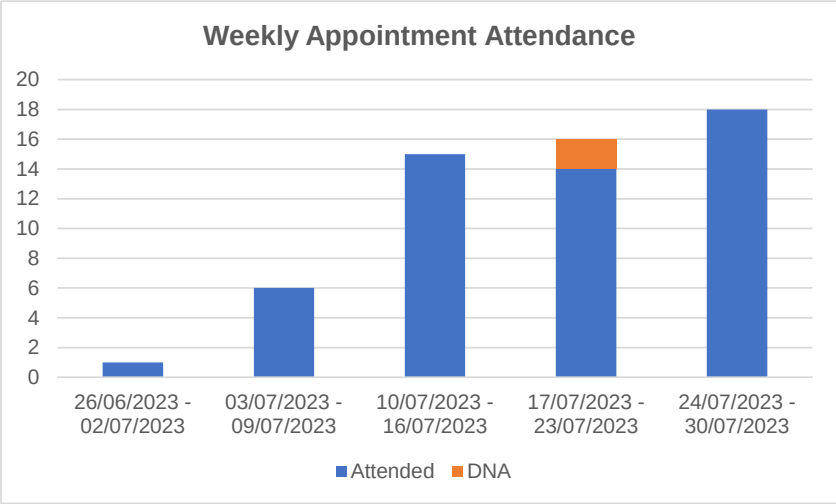
Operational Performance

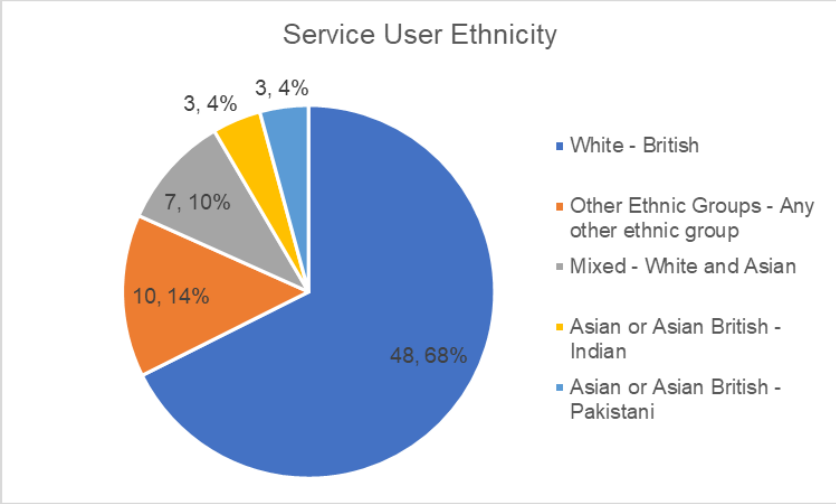
East Midlands Gambling Harms Service

The NHS East Midlands Gambling Harms Service was launched on 20 June 2023. The Service offers specialist treatment and support to people struggling with problem gambling across Derbyshire, Leicestershire, Lincolnshire, Northamptonshire, Nottinghamshire and Rutland. The Service is managed by Derbyshire Healthcare NHS Foundation Trust, and receives support from some of the Trust's partner organisations, working with other healthcare providers in the region through the East Midlands Alliance for Mental Health, Learning Disabilities and Autism. The Service is one of a number of NHS gambling services now in operation across the country, funded by NHS England as part of the NHS Long Term Plan. The Service is a clinical team made up of psychologists, therapists, mental health practitioners and psychiatrists. Within the team there are also experts by experience – people who have recovered from a gambling addiction themselves. The team is based in Derby but offers support to people across the East Midlands. Most of this support is provided through virtual treatment programmes, but face-to-face support may be an option where it is considered more appropriate. The team offers additional help with specific problems experienced by individuals, and support and advice to family members and carers. The team works alongside many other agencies and services that can help with problems such as mental health, debt management and housing.





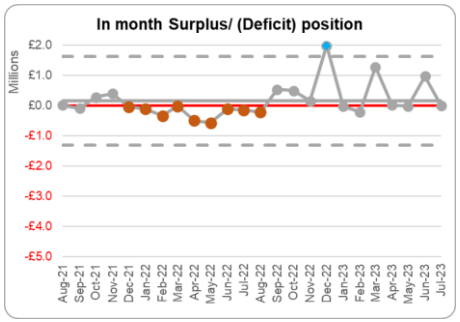




Derbyshire Healthcare
NHS Foundation Trust

Finance

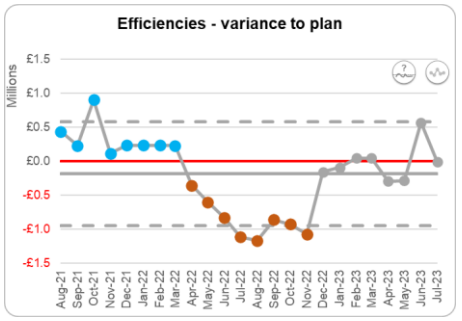
Financial Performance



Summary

At the end of July the YTD position is a surplus of £1.0m against a planned surplus of £0.9m, a favourable variance of £0.1m. This is mainly driven by the improvement in the efficiency programme which continues to be on plan at the end of July. Agency expenditure is being partially offset by vacancies and interest income being ahead of plan. The forecast position at month 4 is breakeven against a plan of breakeven. The forecast assumes that we deliver efficiencies in full and find mitigations to offset the emerging cost pressures associated with pay award inflation, agency costs and pressures related to a complex patient that is being supported on one of our wards.

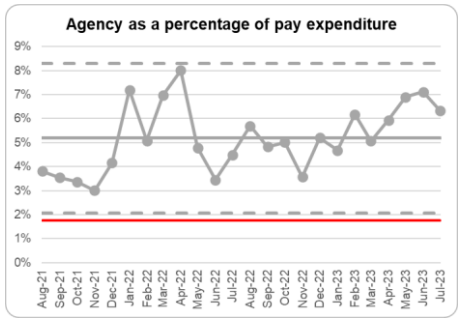
The Board Assurance Framework (BAF) risk *that the Trust fails to deliver its revenue and capital financial plans for 2023/24,* is rated as EXTREME due to the financial risks that are inherent in the 2023/24 financial plan.



Summary

The plan includes an efficiency requirement of £8.8m phased equally across the financial year. As at month 4 £2.9m was delivered against a target of £2.9m. The forecast assumes that all efficiencies are delivered. Currently £7.4m of the £8.8m target has been found with further work on-going to identify plans for the balance. Further work is also required to ensure plans are delivered recurrently, as 83% of the £7.4m is currently identified as non-recurrent.

Delivery of the transformation initiatives contributing to the efficiency programme is being overseen by a weekly Transformation Programme Delivery Group.
The group seeks assurance that initiatives are on track and identifies additional support and intervention where schemes are off trajectory. Initiatives which are off trajectory and/or forecast to be off trajectory are expected to provide a situation, background, assessment and recommendation report including suggested mitigations to take forward.

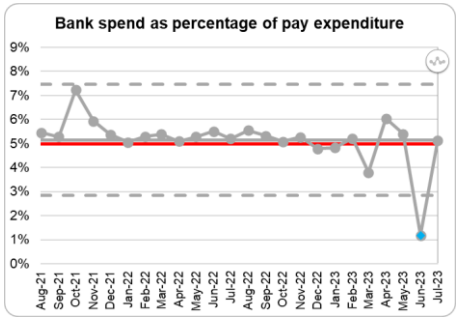


Summary

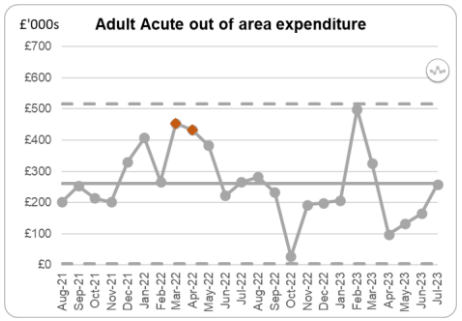
Agency expenditure YTD totals £3.4m against a plan of £1.8m, an adverse variance to plan of £1.6m. This includes £0.9m of additional costs to support a complex patient on one of our wards. The two highest areas of agency usage continue to relate to Consultants and Nursing staff.

The agency expenditure as a proportion of total pay for July is 6.3%. The plan for the year is set at 3.5% which just below the target set by NHSE in the planning guidance of 3.7%.

Agency is forecast to be above plan by £2.6m, of which £1.5m relates to the complex patient that is being supported.



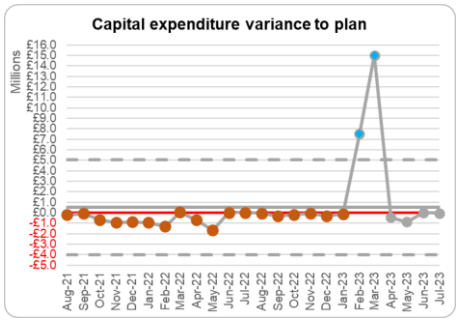
Bank expenditure YTD totals £2.3m against a plan of £2.6m, a favourable variance to plan of £0.3m, this includes releasing an accrual in month 3 for assumed back pay. The forecast is a favourable variance of £0.6m.



Summary

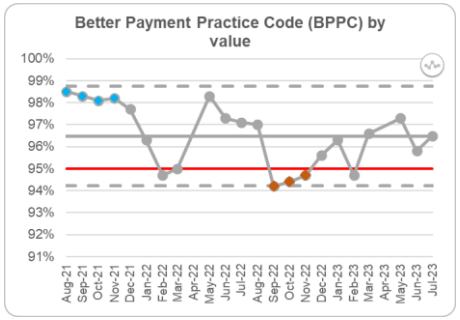
The plan for out of area expenditure has been reduced by £1.0m in 2023/24 as this is one of the transformation schemes identified as part of the £8.8m efficiency requirement. As at the end of July there was an overspend against the reduced plan of £257k with a forecast overspend of £685k. Out of area patient numbers were at 12 at the end of July, the forecast assumes from month 7 patient numbers reduce to plan of 4.

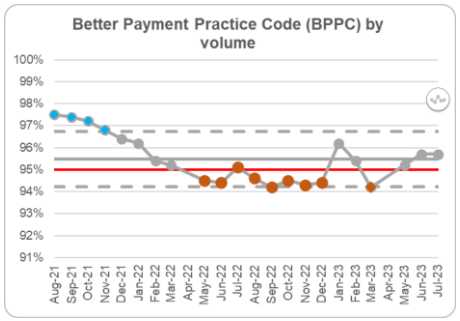
Financial Performance



Summary
Capital expenditure at the end of July is slightly under plan, the forecast is to be on plan by the end of the financial year.

Capital expenditure was above plan in the last two months of 2022/23 due to the additional capital expenditure related to the dorms project (which came with additional funding that was not originally in the plan).

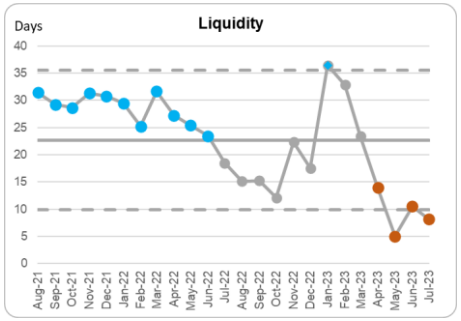




Summary
The Better Payment Practice Code (BPPC) sets a target for 95% of all invoices to be paid within 30 days. BPPC is measured across both invoice value and volume of invoices.

At the end of July, the value of invoices exceeded the target at 96.5% and by volume at 95.7%.

Summary
Cash increased in February and March due to the additional funding for the Dorms capital projects that was drawn down. Cash reduced in April and May due to payment of capital invoices. Cash at the end of July is at £40.2m the same as the previous month and is forecast to be at planned levels of £23.6m by the end of the financial year. The in-year reduction is driven by the reduction in capital accruals from 2022/23 and the level of capital expenditure planned for 2023/24.



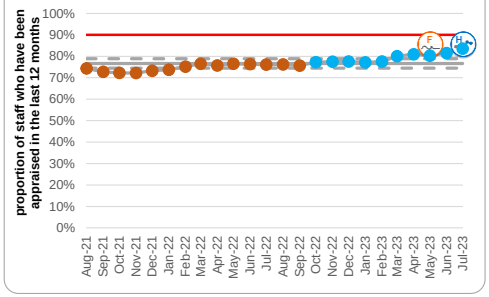
Summary
The chart above shows the liquidity levels over the last two years. Liquidity levels were high in 2021/22. In 2022/23 the liquidity reduced until the last quarter due to the timing of cash receipts related to the centrally funded capital schemes for the eradication of dorms. The Public Dividend Capital (PDC) drawdown requests caught up in January which drove the increased level in January. The PDC drawdown for 2023/24 came into effect in month 3.

Derbyshire Healthcare
NHS Foundation Trust

People

People Performance

Annual appraisals



Summary

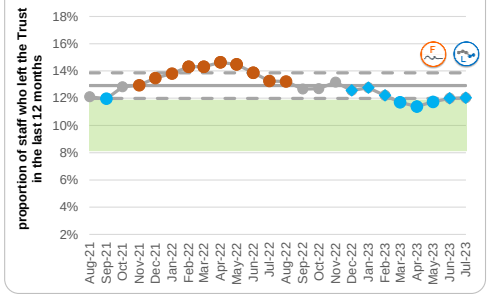
Appraisal levels continue to be below our expectations with Operational Services currently at 85% and Corporate Services at 79%. Overall, significant improvement has been made month on month for the last 10 months.

In Operational Services a recovery action plan has been put in place, with progress continuing to be monitored weekly by senior management.

Key actions include:

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

Annual turnover (target 8-12%)



Summary

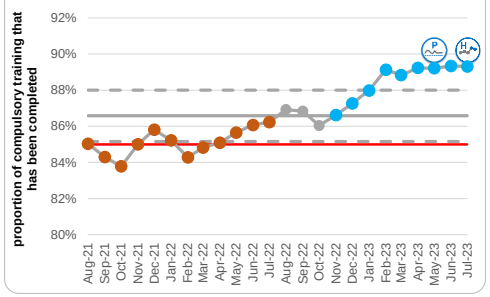
Turnover remains at 12%, within the target range of 8-12% and in line with national and regional comparators.

Actions

Actions taken from the staff survey results 2022/23 to support retention and improve turnover include:

- Strengthen and grow wellbeing champions in every team to support health and wellbeing and Charitable funding secured to provide small budget for team wellbeing initiatives.
- Health check programme commissioned with rollout commencing September.
- Review of staff benefits to support engagement and retention with full benefits offer launch planned for Autumn.
- Relaunch of Coaching Network with focus on career conversation via a coach to support development discussions and growth opportunities.

Compulsory training



Summary

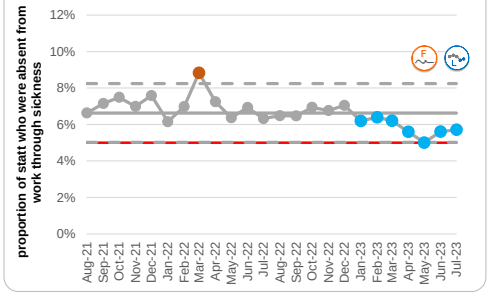
Overall, the 85% target level has been achieved for the last 16 months. Operational Services are currently 91% compliant and Corporate Services slightly lower at 83%.

Immediate Life Support (ILS) and Positive and Safe training compliance continue to remain in a stable position.

Actions

- A six week cleanse of ESR training data has commenced to support colleagues to access all virtual training as easily as possible.
- Non-compliance at divisional level is being fed into Divisional Achievement Reviews (DAR).

Staff absence



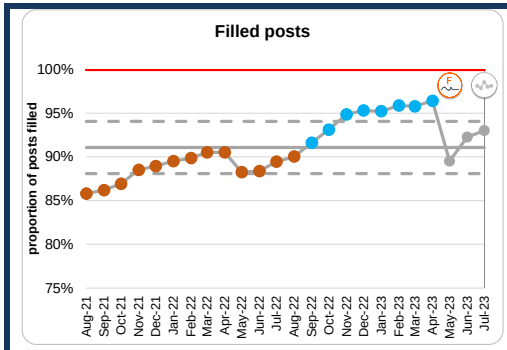
Summary

Sickness absence has been significantly lower than normal for the past 7 months. In July 23 the overall absence rate was 5.7% (Operational 6%, Corporate 4%). In the most recently published national data, the average absence rate for mental health trusts was 5.3% and nationally the main reason for absence continues to be stress and anxiety, accounting for over 24% of all absence. NHS Sickness Absence Rates, March 2023 - NHS Digital

Actions

- Divisional wellbeing summits are planned to take place from September to provide a focus on both short term and long term absences in each division and to ensure there is a robust wellbeing plan in place and all support is being provided to each absence.
- Occupational Health (OH) are currently attending management and team meetings to ensure managers are fully maximising the support available for colleagues and working with OH to ensure the management referral and outcome is utilised to its full potential for both individuals and managers.

People Performance

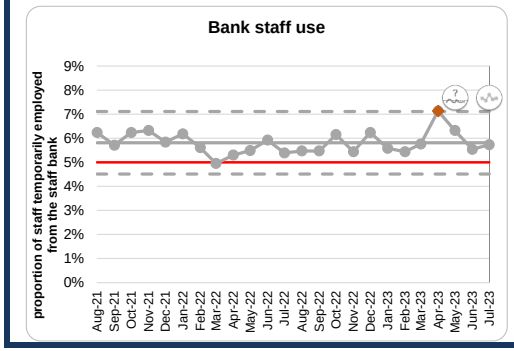


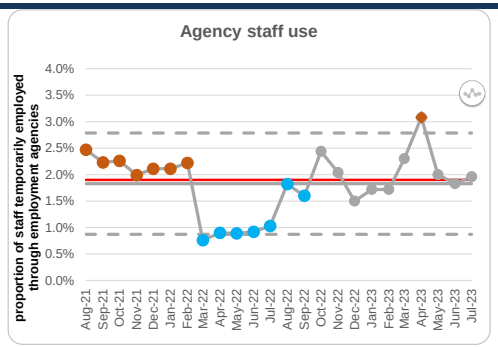
Summary

The overall position as at the end of July was 93%.

Actions

- A number of Recruitment events across our sites are planned to take place in the Autumn with a large Trust wide event planned for the end of October at the Chesterfield Football Club
- The Strategic Recruitment and Retention Lead has now commenced in post and is working closely with teams to develop bespoke campaigns and recruitment approaches.
- A Workforce Summit was held in July to review all Divisional Workforce Plans and ensure actions, support and tracking are agreed for divisions to realise the workforce requirements for 2023/24.
- A New Roles Summit was held in August and ongoing sessions are planned to support colleagues to explore new roles such as Associate Physicians and Advanced Clinical Practitioners (ACPs)





Summary

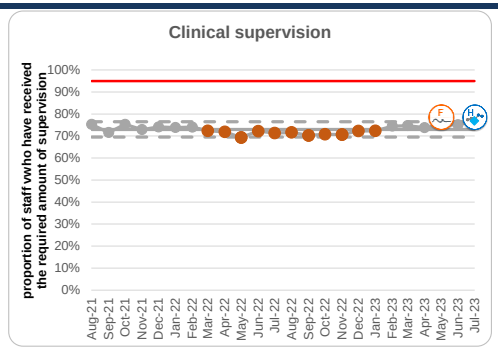
Agency fill has decreased slightly this month. Highest usage in medical grades (in excess of 300 shifts). Thornbury usage continues to be minimal with 21 bookings in June. Only 1 unregistered grade usage for Thornbury.

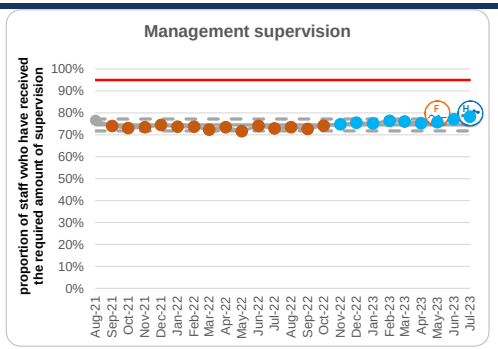
Actions

A further Agency Summit was held in July to review progress against actions and consider further steps to ensure we minimise agency usage. Further actions identified and now being implemented include:

- The need to review the clinical offer within adult acute wards to deliver a therapeutic and clinically safe offer managing clinical risk and reducing likelihood of burnout within staff team.
- Consider an incentive to bring additional clinically experienced workforce into the Acute Inpatient Wards for Adults of Working Age.
- Establishing protocol to cover the circumstances where the various levels of Agency workforce can be utilised, and level of authorisation required.

Across the system an agency reduction programme is being established, led by the Deputy HR Director at Chesterfield Royal Hospital.





Summary

As seen with compulsory training and appraisals, Operational Services continue to perform at a considerably higher level than Corporate Services for both types of supervision (management: 82% versus 63% and clinical: 80% versus 33%). The overall level of compliance with the clinical and management supervision targets became low as a result of the pandemic, but steady progress is being made to improve compliance. At a team level, 124 teams are 100% compliant with management supervision and 77 teams are 100% compliant with management supervision, with 53 teams now 100% compliant with both types of supervision.

Actions

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

- Data cleanse to take place to ensure all completed supervisions are recorded correctly and to ensure that all staff are aligned to the correct budget code and line manager within ESR – in progress.
- Operational managers to ensure supervision tree structures are in place for each team, with identified clinical supervisors for all staff in a clinical facing role
- Ongoing monitoring of compliance in service line and divisional operational meetings for both management and clinical
- Review of criteria for clinical supervision for Operational Managers at Area Service Manager and above, and consider professional supervision as an alternative in line with the supervision policy – complete
- All Adult Acute Care Service Managers have completed supervision trees to highlight managerial and clinical supervisors. Supervision trees also highlight any use of groups/group supervision (primarily for clinical supervision).
- Supervision report has been produced by IM&T to highlight in red anyone where no supervision has been undertaken in past 3 months. This is now distributed weekly to senior operational management for action.
- Children's Services Head of Nursing is offering group clinical supervision to Special Schools and LD community teams
- Staffing pressures in the smaller teams within Children's Services mean that the operational manager is regularly pulled into clinical care. Plan to review the leadership of these teams with change management proposals progressing.
- Ongoing monitoring of supervision through regular monthly performance meetings with Area Service Managers and Operational leads - issues escalated to divisional operational meeting as needed

People Performance

Hotspots and Triangulation July 2023

The hot spot and triangulation focus list for key Workforce metrics identify Wards/Teams that are most in need of attention and support. The table lists the top 20 teams in need of attention and support by Workforce KPI. Teams with a x also featured in the Top 20 last quarter. Please note that to fall into the focus list a Ward/Team must have at least 10 employees.

Sickness Absence June 2023		HC	%	
Catering Radbourne	Estates + Facilities	10	20.75%	x
CRHT HP+N Dales	Adult Care Acute	11	17.47%	x
Nursing and Operations Management	Nursing + Quality	14	16.53%	x
Morton Ward HU 'IP'	Adult Care Acute	35	15.87%	
High Peak Adult CMHT	Adult Care Community	11	14.64%	x
Patient Records	Ops Support	10	14.63%	
Cubley Female KWay 'IP'	Older Peoples Care	54	12.53%	x
Trust Wide CLDT Physio	Neuro Developmental	10	12.30%	
Ward 35 RU 'IP'	Adult Care Acute	26	12.18%	
Ward 33 RU 'IP'	Adult Care Acute	32	12.09%	
CAMHS SC Recovery	Children's Services	21	11.28%	x
Domestic Psychiatric Unit	Estates + Facilities	16	11.12%	
0-19 Locality 2	Children's Services	36	10.95%	x
DRRT Chesterfld + NED + B	Older Peoples Care	22	10.87%	
Domestics MH Properties	Estates + Facilities	19	10.61%	
0-19 Locality 1 + 5	Children's Services	28	10.50%	x
IAPT	Psychology	82	10.46%	
Bols + CC OA CMHT	Adult Care Community	12	10.42%	
Killmsh + N C OA CMHT	Older Peoples Care	10	10.31%	
Chesterfield C OA CMHT	Older Peoples Care	13	9.96%	

Appraisal Compliance June 2023		HC	%	
County South Receptionists	Estates + Facilities	13	15.38%	
SUI	Nursing + Quality	10	22.22%	x
DerbyshireSubstanceMisuse	F+R & Specialist Services	26	25.00%	x
MH Liaison Team Nth	Adult Care Acute	22	28.57%	x
Nursing and Operations Management	Nursing + Quality	14	30.77%	
Medic Adult Comm City	Adult Care Community	14	33.33%	x
Tansley Ward HU 'IP'	Adult Care Acute	34	36.67%	
Enhanced Care Ward RU 'IP'	Adult Care Acute	28	38.46%	
Management Adult Acute	Adult Care Acute	14	38.46%	x
Physiotherapy	F+R & Specialist Services	12	41.67%	
Medic OA Inpatient	Older Peoples Care	10	44.44%	
Medic Adult Comm Sth	Adult Care Community	14	50.00%	
Sth Derbyshire Adult CMHT	Adult Care Community	15	53.33%	x
CAMHS SC Eating Disorders	Children's Services	11	54.55%	
MH Helpline + Support Srvs	Adult Care Acute	18	58.82%	x
Eating Disorders Service	F+R & Specialist Services	22	59.09%	
Ward 35 RU 'IP'	Adult Care Acute	26	60.00%	
CRHT HP+N Dales	Adult Care Acute	11	60.00%	
LD Admin	Neuro Developmental	10	60.00%	x
Specialist Autism Team	Neuro Developmental	11	60.00%	x

Compulsory Training Compliance June 2023		HC	%	
Domestics MH Properties	Estates + Facilities	19	52.78%	x
County South Training Grades	Med Education & CRD	21	56.38%	x
County South Receptionists	Estates + Facilities	13	61.54%	x
County North Training Grades	Med Education & CRD	15	66.10%	x
Maintenance	Estates + Facilities	29	71.43%	x
Domestic Kingsway	Estates + Facilities	61	71.69%	x
Paediatric Medics	Children's Services	20	72.16%	x
UPC Management	Clinical Serv Management	10	72.62%	
DerbyshireSubstanceMisuse	F+R & Specialist Services	26	73.46%	x
Medic Adult Comm Nth	Adult Care Community	13	74.58%	x
County Elderly Service Medical	Older Peoples Care	16	75.17%	x
Nursing and Operations Management	Nursing + Quality	14	77.19%	x
Management Adult Acute	Adult Care Acute	14	77.24%	x
Medic OA Inpatient	Older Peoples Care	10	77.65%	
Catering MH	Estates + Facilities	16	78.98%	x
Domestic Psychiatric Unit	Estates + Facilities	16	80.00%	x
Specialist Autism Team	Neuro Developmental	11	80.00%	
CAMHS SC Recovery	Children's Services	21	81.34%	
CAMHS SC Eating Disorders	Children's Services	11	81.48%	
Morton Ward HU 'IP'	Adult Care Acute	35	81.58%	

Annual Turnover June 2023		HC	%	
High Peak Adult CMHT	Adult Care Community	11	34.29%	x
CAMHS SC Eating Disorders	Children's Services	11	34.04%	x
Catering Radbourne	Estates + Facilities	10	32.14%	x
The Hub RU	Adult Care Acute	23	31.70%	x
IPS Com Mental Health	Adult Care Community	20	29.70%	
Ward 35 RU 'IP'	Adult Care Acute	26	28.97%	
Phys Health Monitoring	Adult Care Community	13	27.91%	x
Physiotherapy	F+R & Specialist Services	12	26.87%	x
PSGY LD	Psychology	10	26.47%	x
County Elderly Service Medical	Older Peoples Care	16	26.23%	x
SUI	Nursing + Quality	10	25.71%	
MH Helpline + Support Srvs	Adult Care Acute	18	25.40%	x
Operational Admin	Children's Services	13	22.50%	
South + Dales OA CMHT	Older Peoples Care	15	22.50%	
Killmsh + N C Adult CMHT	Adult Care Community	20	21.92%	x
Living Well Prog City	Adult Care Community	11	21.82%	
Trust Wide CLDT Physio	Neuro Developmental	10	21.62%	
Information Technology Department	Ops Support	39	20.24%	
Trust Board	Corporate Central	16	19.83%	x
0-19 Locality 1 + 5	Children's Services	28	19.57%	

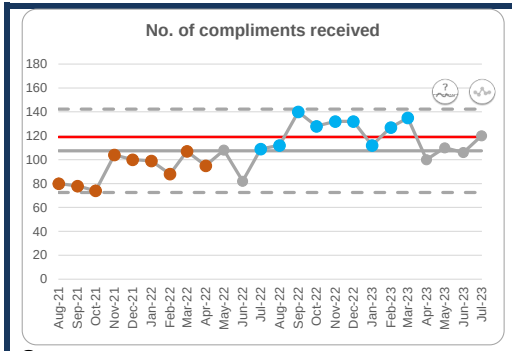
Bank Usage June 2023		HC	%	
Ward 33 RU 'IP'	Adult Care Acute	32	48.05%	x
Enhanced Care Ward RU 'IP'	Adult Care Acute	28	47.35%	x
Ward 35 RU 'IP'	Adult Care Acute	26	44.90%	x
Ward 34 RU 'IP'	Adult Care Acute	25	35.07%	
Ward 36 RU 'IP'	Adult Care Acute	31	27.14%	x
Morton Ward HU 'IP'	Adult Care Acute	35	23.24%	x
Cubley Male KWay 'IP'	Older Peoples Care	48	22.24%	x
Cubley Female KWay 'IP'	Older Peoples Care	54	21.05%	x
Tissington Ward 'IP'	Older Peoples Care	43	19.92%	x
Pleasley Ward HU 'IP'	Adult Care Acute	29	19.85%	x
Tansley Ward HU 'IP'	Adult Care Acute	34	19.84%	x
CRHT South	Adult Care Acute	25	15.53%	
County South Receptionists	Estates + Facilities	13	11.31%	x
Domestic Kingsway	Estates + Facilities	61	10.95%	x
Low Secure Kedleston KWay 'IP'	F+R & Specialist Services	49	10.51%	x
Inpat Rehab CTC KWay 'IP'	F+R & Specialist Services	35	10.48%	x
MH Liaison Team Sth	Adult Care Acute	28	10.16%	
Medical School	Med Education & CRD	11	10.14%	
CRHT City	Adult Care Acute	23	8.24%	
MH Helpline + Support Srvs	Adult Care Acute	18	8.07%	

Agency Usage June 2023		HC	%	
Medic Adult Comm Nth	Adult Care Community	13	19.14%	
Tansley Ward HU 'IP'	Adult Care Acute	34	16.12%	x
Pleasley Ward HU 'IP'	Adult Care Acute	29	15.81%	x
Ward 35 RU 'IP'	Adult Care Acute	26	14.83%	x
Medic Adult Comm City	Adult Care Community	14	13.47%	
Enhanced Care Ward RU 'IP'	Adult Care Acute	28	12.50%	x
Morton Ward HU 'IP'	Adult Care Acute	35	10.81%	x
CAMHS SC Eating Disorders	Children's Services	11	10.23%	
MH Helpline + Support Srvs	Adult Care Acute	18	8.26%	
Living Well Prog City	Adult Care Community	11	6.71%	
County Elderly Service Medical	Older Peoples Care	16	6.17%	
CRHT Chesterfield	Adult Care Acute	27	5.65%	
Paediatric Medics	Children's Services	20	5.55%	
CRHT City	Adult Care Acute	23	5.01%	
Ward 36 RU 'IP'	Adult Care Acute	31	4.84%	x
Ward 33 RU 'IP'	Adult Care Acute	32	4.42%	x
County South Training Grades	Med Education & CRD	21	2.86%	
Ward 34 RU 'IP'	Adult Care Acute	25	2.45%	
IAPT	Psychology	82	1.44%	x
Cubley Female KWay 'IP'	Older Peoples Care	54	1.29%	

Derbyshire Healthcare
NHS Foundation Trust

Quality

Quality Performance



Summary
Between May and July 2023 the number of compliments has increased overall from 110 to 120 and is now above the mean of 110.

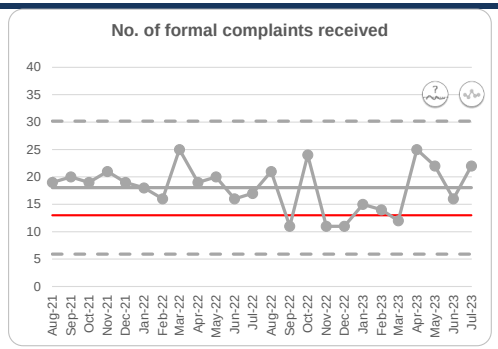
It is not currently possible to identify a specific reason for the fluctuation in compliments recorded as compliments are mostly received verbally and staff do not always accurately record them and there is no consistent process of recording them across the Trust, however, actions are being taken to ensure that all compliments received by services are recorded.

Actions

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

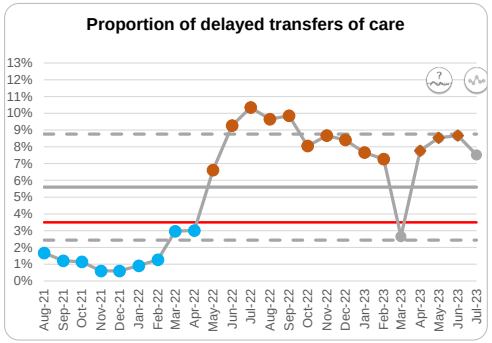
- An option for teams to use an electronic patient survey went live in July 2023 and provides another method for Trust services to obtain feedback including compliments and concerns.

  With an increase in accessibility, it is expected that an increase in compliments, and concerns will occur over the next 6 months. The electronic patient survey platform also gives teams the opportunity to create a QR code which allows service users to feedback directly to the team. service receivers are also given the opportunity to feedback verbally and via paper forms if this is preferred.



Summary
The number of formal complaints received by the Trust has stayed the same at 22 between May and July 2023. This is above the trust target of 12 complaints but is close to the mean and in line with common cause variation when viewed across past two years.

Actions
The complaints team are monitoring this, but no specific theme has been identified. Information around complaints is reviewed by the Heads of Nursing/Practice in a quarterly patient experience committee report which is sent to the Trust Quality and Safeguarding committee for assurance.

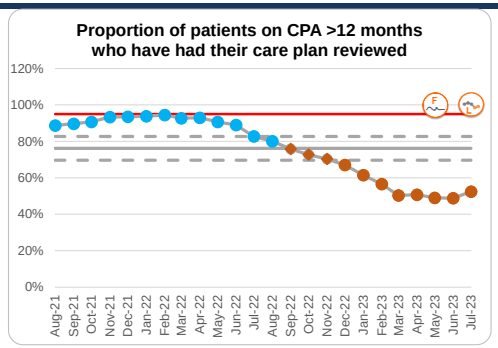


Summary
Between May and July 2023, the number of service users meeting the criteria as Clinically ready for discharge (CRD) (formally called delayed transfer of care (DTOC) has decreased from 8% to 7%.

The most common reason for patients meeting the criteria for CRD is the identification of appropriate housing or social care placements. A recent review identified that in older adult inpatient services, 76% of patients do not return to the environment they were referred from.

Actions

- The Trust has a Twice weekly CRD meeting where any barriers to discharge are identified and discussed to support resolution.
- The OA division are currently supporting the scoping of a Dementia Care Unit for Derbyshire which is due to open in 2024.



Summary
The current percentage of patients who have had their care plan reviewed and have been on CPA for over 12 months is 52%, an increase of 3% between and May and July 2023.

However, care plan compliance in the CMHT has increased to 77%. A 7% increase from May 2023

Staff vacancies, sickness, industrial action and patient acuity have all contributed to the current percentage of patients who have had their care plan reviewed and have been on CPA for over 12 months.

Actions
Compliance around CPA has been the subject of a commissioned 360 review by an external company and is part of an action plan to improve compliance in fundamental care standards including CPA.

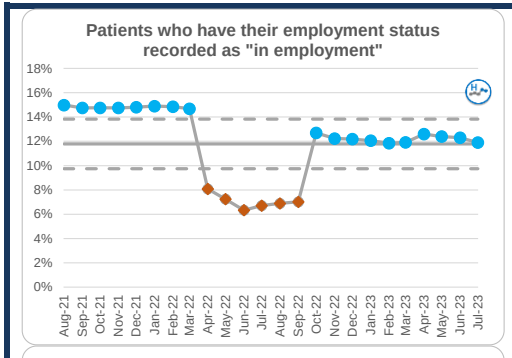
The Trust services have identified action plans to improve care plan, risk screen and CPA compliance as below:

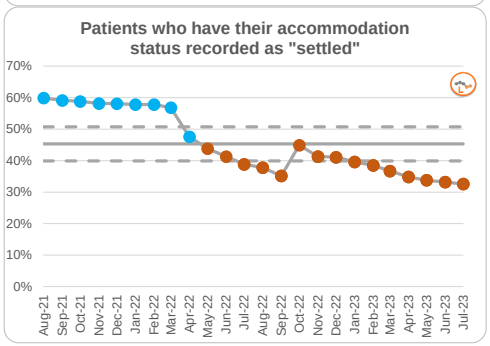
.

- Each team has been asked to review the current report and cleanse the data to ensure that non-eligible patients are not included.

- A process for monitoring compliance and quality will be implemented in each division and monitored via the monthly Fundamentals of Care meeting, (in Inpatients, the Clinical Reference Group) and the Divisional Clinical Operational Assurance Team (COAT) meetings.

Quality Performance



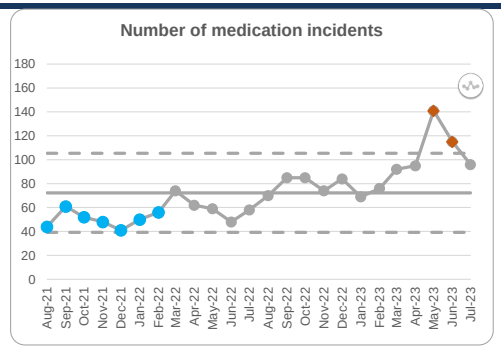


Summary

Around one third of patients have no employment status or accommodation status recorded at present and the decline in patients recorded as being in employment coincides with the data migration to SystmOne. There has been no change in the number of patients recorded as in employment between May and June 2023. The number of patients who have their accommodation status recorded as settled has also remain the same between may and June 2023

Actions

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



Summary

Between May to July 2023 there has been a 30% decrease in the number of medication incidents reported following a spike that took the number of medication incidents outside of common cause variation. The Pharmacy department reported that the spike correlated to a planned approach to raise awareness and improve Trust reporting around medication incidents in response to concerns around underreporting over previous years. When considered the incidents are largely of low-level harm and therefore reflect better reporting and learning opportunities and should be actively encouraged.

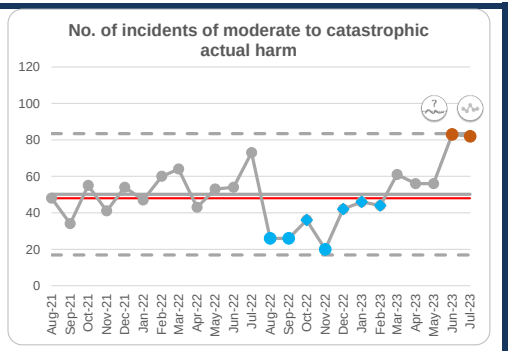
The decrease in medication incidents is likely related resolution of the factors that were contributing to the spike such as the bank holidays (due to more prevalence of agency and bank staff on these occasions), a Junior Doctors strike and the launch of the Electronic Patient Medication Administration (ePMA) which has impacted on type of incidents and reporting numbers.

Actions

To support services, the Pharmacy team have identified some learning points including:

- Development of a medicine ward folder where the medicine management quick reference guides relating to key policies and procedures will be available This is currently being trialled in the North with a plan to roll out in the South impatient wards if it is ratified in April 2024.
- DHCFT Pharmacy are feeding back to ward managers on a quarterly basis about shared learning from meetings with Chesterfield Royal Hospital pharmacy.

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



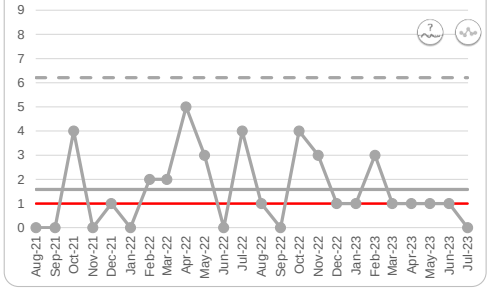
Summary

This data demonstrates the number of DATIX incidents occurring recorded as moderate to catastrophic harm. There has an 49% increase in incidents between May and July. Analysis suggests that this is due to both a number of new types of incidents reported in these months and a general increase in the number of incidents that are routinely reported with a specific rise in incidents recorded as “aggression/abuse”. This is consistent with anecdotal reports from staff that acuity on the inpatient wards is increasing.

This will be continue to be monitored by the patient safety team.

Quality Performance

No. of incidents requiring Duty of Candour



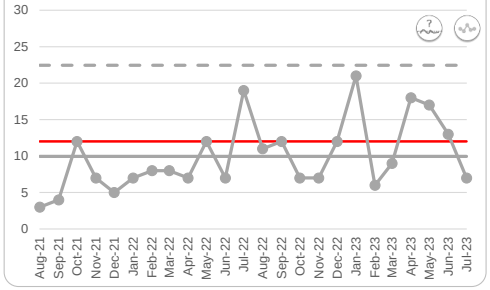
Summary

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

Actions

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

No. of incidents involving prone restraint



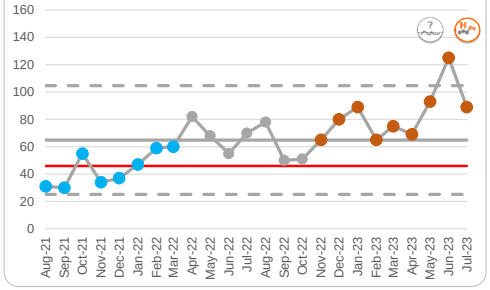
Summary

Prone restraint has decreased by a total of 11 incidents between May and July 2023 and is now below both the Trust target of 12 incidents and the mean of 10.

Actions

- Over the next six months there are plans for Simulation Training including seclusion, self-harm and ligature simulation. A programme manager and clinical lead have been recruited and the project is currently in the scoping phase with plans for training the trainer sessions to start in October 2023.
- The PSST are also in the process of planning training around alternative injection sites which should reduce the need for prone restraint and this should be ready for implementation by October 2023.

No. of incidents involving physical restraint



Summary

Physical restraints have remained at around 90 incidents between May and July 2023 with a spike up to around 120 in June.

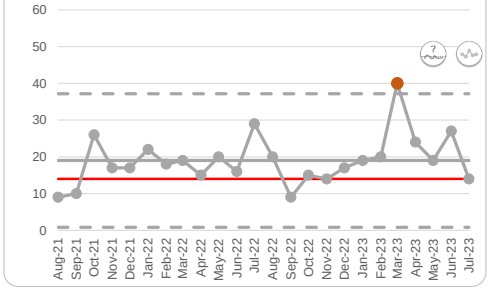
This is being reviewed within the Reducing Restrictive Practice Group and the Trust Positive and Safe Support Team continue to offer extra training sessions to improve training availability for staff.

The average increase in physical restraint and the spike in June appear to be related to the increased acuity of patients in inpatient settings and a high number of repeated incidents attributed to a small group of patients who are awaiting specialist placements and require the bespoke support.

Actions

- The Trust Positive and Safe Support Team are placing extra training sessions to improve training availability for staff. Compliance with positive and safe training is currently at 73% for teamwork and 40% for breakaway training. the drop in compliance in breakaway training is due to a new staff group being added to the mandatory cohort who are all currently non-compliant until they have received the training. Furthermore, the PSST continue to spend time in clinical areas to support and train clinical staff, live during practice.

No. of new episodes of patients held in seclusion



Summary

Seclusions between May and July 2023 have reduced by 40% and are now in line with the Trust target of 12.

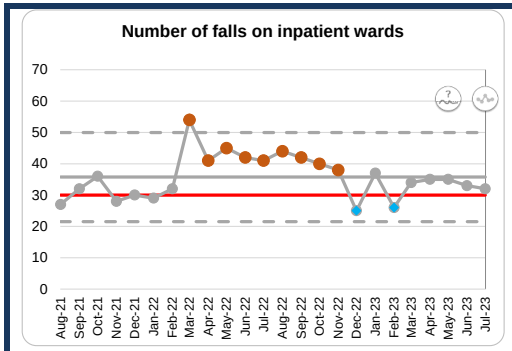
Actions

Episodes of seclusion will continue to be monitored via the reducing restrictive practise group.

A review focused on peer support including debrief started in May 2023 and is expected to have an impact on further reducing the number of seclusion incidents when it is completed at the end of 2023

This review will be presented and monitored through the Reducing Restrictive Practise Group

Quality Performance



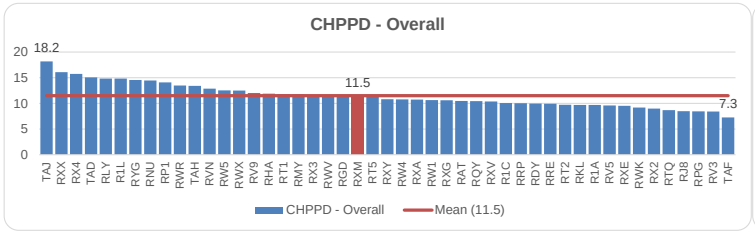
Summary

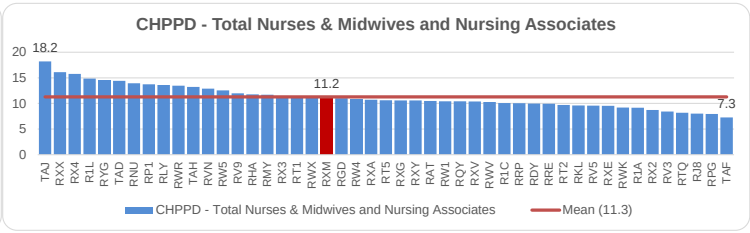
- The Biweekly falls meeting started in April 2022 appears to have had a positive impact with incidents related to falls plateauing at 32, below the Mean of 35 May and July 2023. This is monitored via the Head of Nursing and Clinical Matron and learning from the Biweekly falls meeting is reviewed in the monthly Divisional COAT meeting.

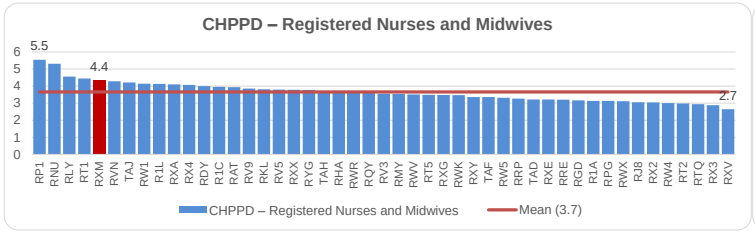
Care Hours per Patient Day (CHPPD)

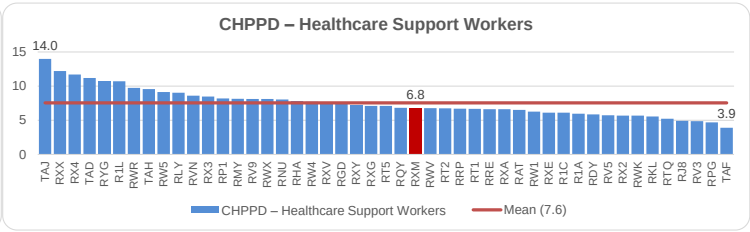
CHPPD is rolling data updated monthly, to show staffing levels in relation to patient numbers on an inpatient ward. Every month, the hours worked during day shifts and night shifts by registered nurses and midwives and by healthcare assistants are added together. Each day, the number of patients occupying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

The charts below show how we compared in the latest published national data when benchmarked against other mental health trusts. The Trust was exactly average overall, very slightly below average for total nurses & nursing associates, above average for registered nurses, and below average for healthcare support workers:







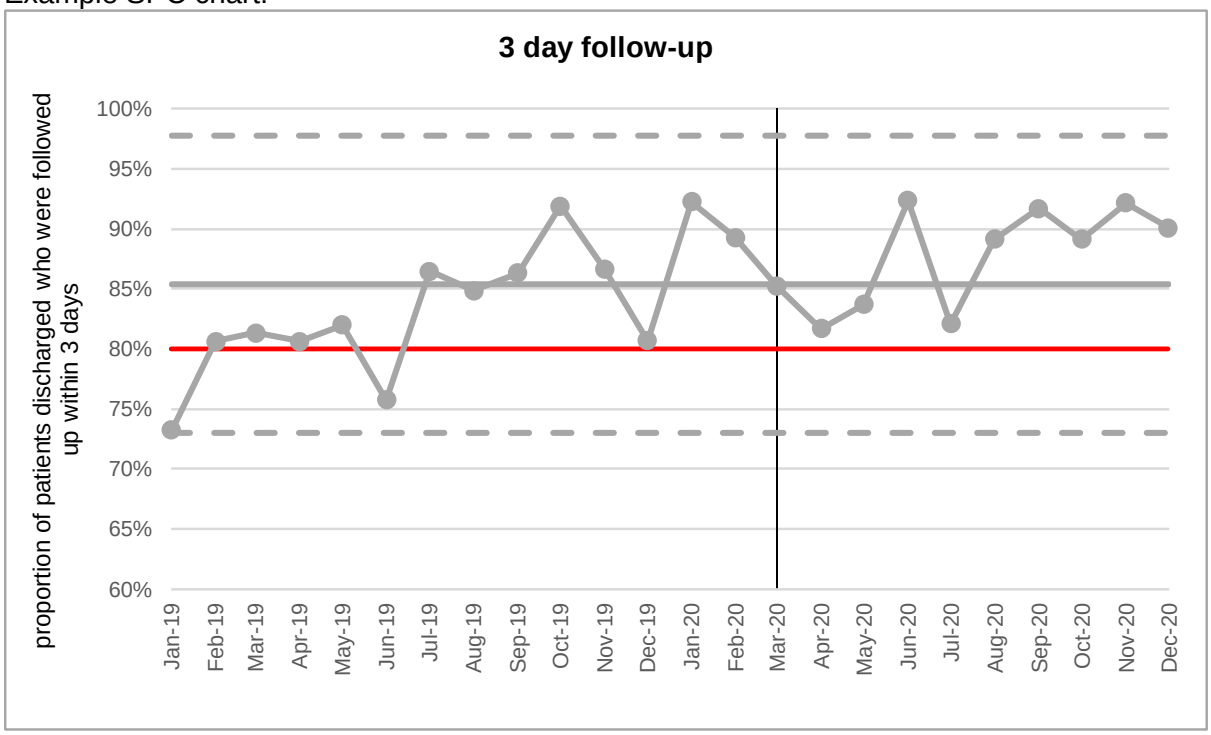


https://www.england.nhs.uk/publication/care-hours-per-patient-day-chppd-data/

Appendix 1

Statistical Process Control Chart (SPC) Guidance

Example SPC chart:



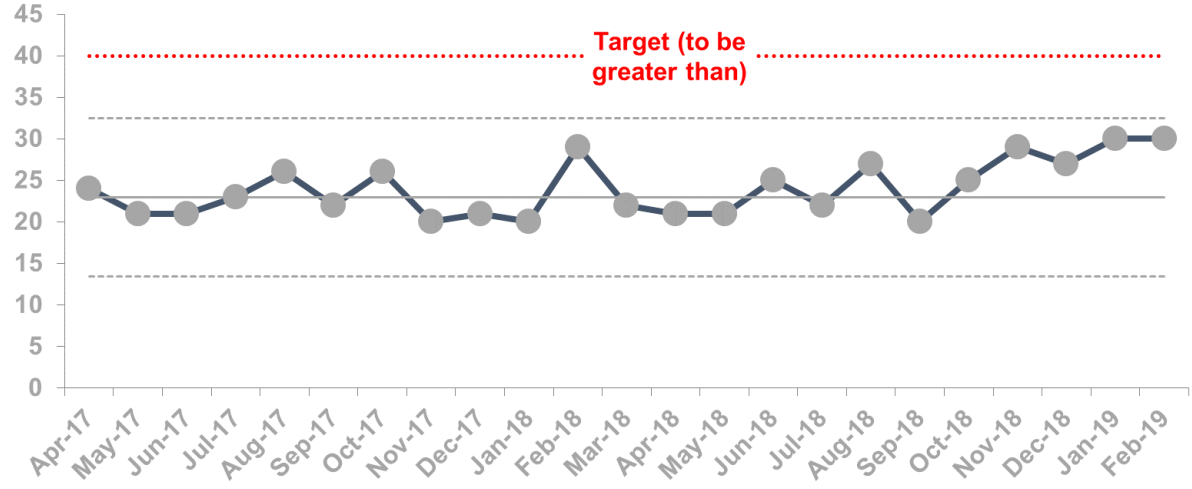
- The red line is the target.
- The grey dots are the actual performance each month. They are coloured grey as performance each month is normal in this example.
- The solid grey line is the average (mean) of all the grey dots.
- The grey dotted lines are called process limits, or control limits.

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

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

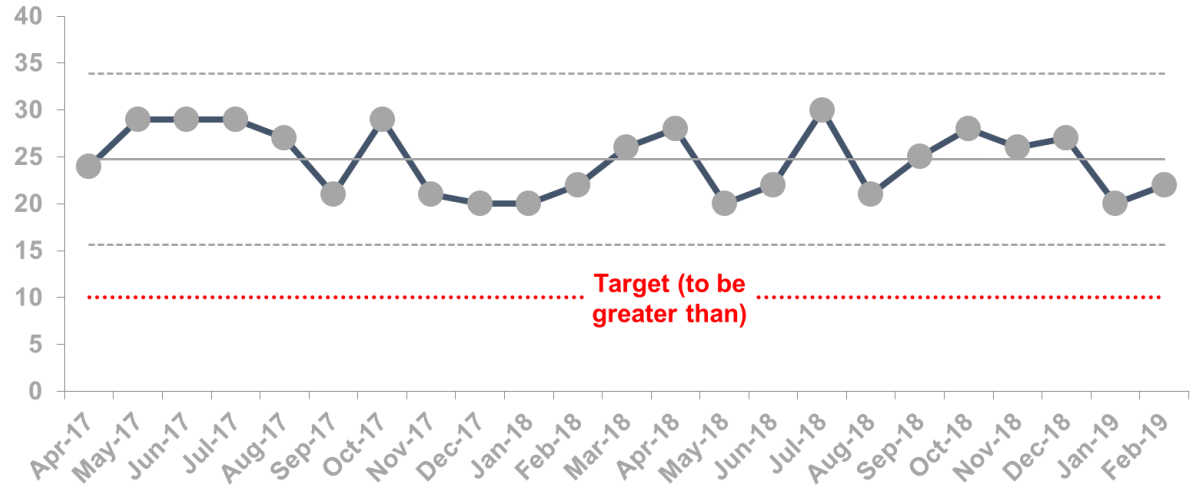
Things to look out for:

1. A process that is not working



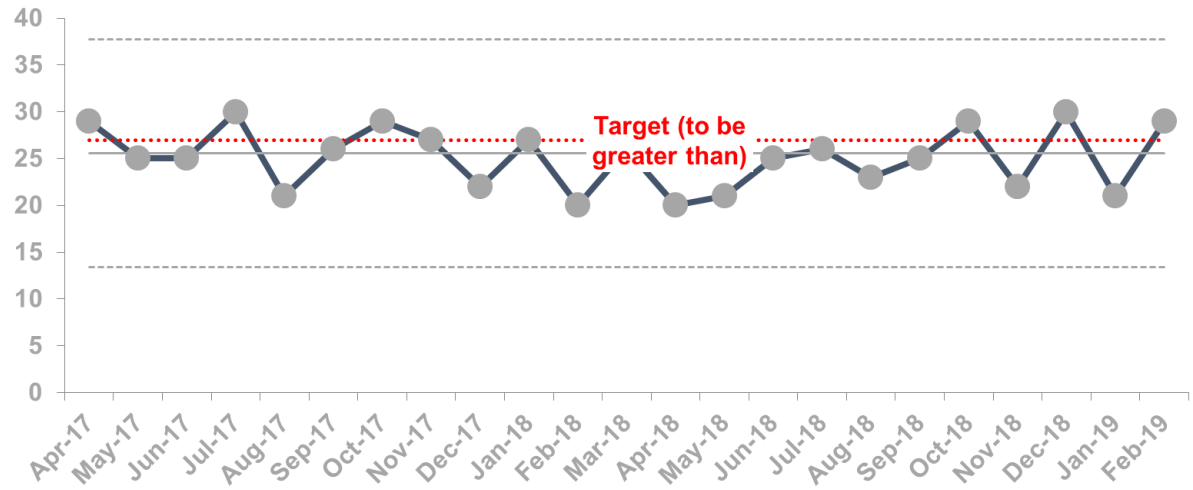
In this example the target is higher than the upper dotted grey line. This means that the target will never be achieved. To achieve the target, we need to change how we do things.

2. A capable process



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

3. An unreliable system

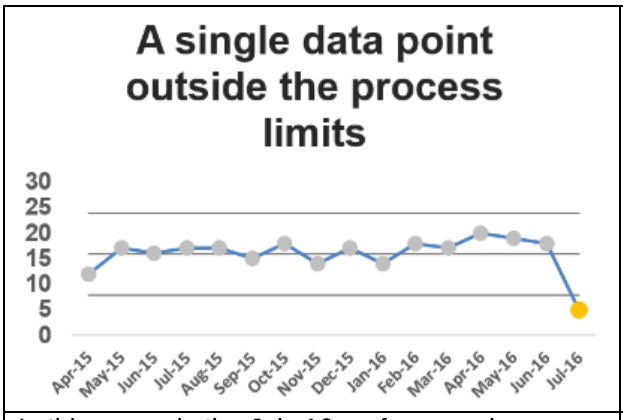
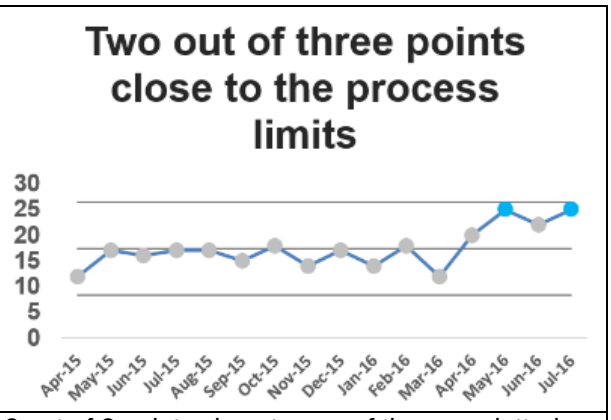


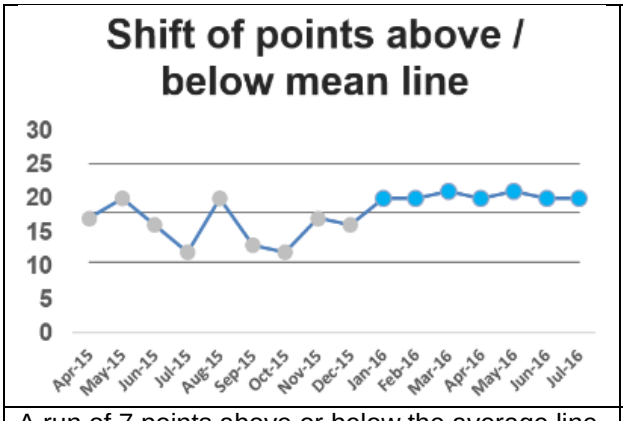
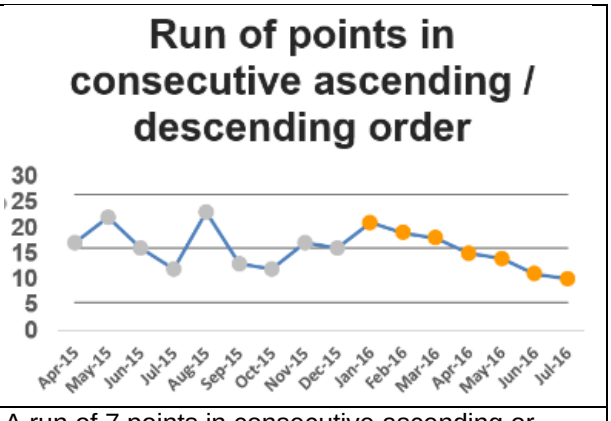
In this example the target line sits between the 2 grey dotted lines. As it is normal for the grey dots to fall anywhere between the 2 dotted grey lines, this means that it is entirely random as to whether or not the target will be achieved. So, this system is unreliable and needs to be redesigned if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

4. Unusual patterns in the data

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

There are four scenarios where this can happen:

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

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

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

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

Trust Strategy 2022 – 2025: 2023/24 Quarter 1 Progress Report

Purpose of Report

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

Executive Summary

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

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

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

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

These building blocks set out the focused group of priorities under each strategic objective, called the Derbyshire Healthcare Eight Essentials, and in order to deliver these, a number of priority actions were identified. The attached summary (appendix A) sets out the Derbyshire Healthcare Eight Essentials delivery position, and details progress against each of the contributing priority actions included in the strategy as at the end of quarter one (Q1) 2023/24.

Of the 24 priority actions, six had an expected completion date by end of Q1 2023/24 with five reporting as now completed. This includes delivery of the dementia diagnoses rate and the perinatal community mental health access standard of 10% which has resulted in more people being diagnosed with dementia and therefore being able to access more timely care and treatment, and more timely support for women requiring support with their mental health either during pregnancy or in the first year following the birth of a child.

There is one undelivered priority action which was due for completion by end Q1 2023/24: Deliver a less than 32 days average length of stay on our acute MH wards through maintaining occupancy levels at less than 85%.The revised delivery date is Q1 2024/25. Specific actions underway achieve this target date are the commencement of an Emotional Regulation Pathway with Ward 33 as a pilot area.

This will help to realign the inpatient offer to more effectively meet the needs of this patient group. In addition, the establishment of a multi-agency admission and discharge hub to oversee the flow of patients in hospital helping to reduce longer length of stays, and the introduction of Purposeful Admission to provide clear objectives regarding purpose of the admission enabling inpatient wards to improve indication of readiness for discharge.

In terms of the three undelivered priority actions from Q4 2022/23:

- **The development of a workforce plan at organisational level:** This was achieved in Q1 2023/24. Divisional workforce plans have been developed to support delivery of in year operational plans. A Workforce Summit and New Roles Summit have been held for staff to share challenges, and agree actions needed including any ongoing workforce developments to consider. An annual process is now embedded to support organisational continual learning.
- **Improving processes and support for people experiencing matters that could cause stress reactions:** this will be achieved in Q2 2023/24 with the appointment of a Trust staff clinical psychologist to support staff experiencing high levels of stress and trauma.
- **Implementation of the East Midlands (EM) Perinatal Provider Collaborative:** the Trust is currently operating as a lead provider in shadow form. Since the last report, the Board has approved the final business case and the NHS England Assurance Panel to approve the go live on 1 October due to take place 6 September.

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

Following feedback form staff and subsequent discussions by the Trust Board, the strategy is in the process of being updated. The updated strategy will retain the previously agreed vision, values, building blocks and priority actions but will reflect the organisational reset, post the commencement in post of the new Chief Executive Officer. This will be presented to the Board in Q3 2023/24.

The Board is asked to note the 2023/24 Q1 progress in delivering the priority actions as set out in the Trust's 2022 – 2025 organisational strategy.

Strategic Considerations	
1) We will deliver **great care** by delivering compassionate, person-centred innovative and safe care.	x
2) We will ensure that the Trust is a **great place to work** by creating a compassionate, skilled and empowered leadership, creating a vibrant culture where colleagues feel they belong, thrive and are valued.	x
3) The Trust is a **great partner** and actively embraces collaboration as our way of working.	x

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

Risks and Assurances

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

Consultation

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

Governance or Legal Issues

None identified

Public Sector Equality Duty and Equality Impact Risk Analysis

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

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

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

Recommendations

The Board of Directors is requested to note the 2023/24 Q1 progress in delivering the priority actions as set out in the Trust's 2022 – 2025 organisational strategy.

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

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

Derbyshire Healthcare
NHS Foundation Trust

DHCFT Trust Strategy

Progress Update Q1 2023/24

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

PALE GREEN: 2022/23 PREVIOUSLY REPORTED DELIVERY

Improve recruitment and retention

Annual Priority 22/23	Improve recruitment and retention				
Priority action	**UPDATE**	**Action owner**	**Expected completion date**	**Committee Oversight**	**Outcomes**
Develop a workforce plan that delivers the operational plan, workforce and service transformations and creates a sustainable approach to volume and hard-to-recruit posts	Delivered Q1 2023/24 Workforce plan developed at organisational level, divisional workforce plans developed and shared across divisions. Workforce summit and new roles summit held to share challenges, actions needed and ongoing workforce developments to consider. Annual process now embedded for continual learning	Director of People and Inclusion	Q3 2022/23 Now revised to Q1 2023/24	People and Culture Committee BAF: Strategic objective 2 – 23-24 2A and 2B	Increased efficiency in recruitment processes for high-volume recruitment through cohorted processes Reduced vacancy rate as reducing reliance on posts where there are supply issues
Review recruitment processes and training to build in inclusive recruitment and selection practice	Delivered Q4 2022/23 Review completed as part of system wide inclusive recruitment pilot and post and funding identified for inclusive recruitment lead to further develop best practice for DHCFT	Director of People and Inclusion	Q4 2022/23	People and Culture Committee BAF: Strategic objective 2 – 23-24 2A and 2B	Increased diversity in all applications and shortlists Reduced race disparity in Bands 7 and above Increased confidence from networks WRES and WDES data improves
Develop a consistent approach across the Trust to people-centred leadership embedding feedback, effective supervision, career progression, development and support	Delivered Q1 2023/24 Review completed as part of system wide inclusive recruitment pilot and post and funding identified for inclusive recruitment lead to further develop best practice for DHCFT	Director of People and Inclusion	Q1 2023/24	People and Culture Committee BAF: Strategic objective 2 – 23-24 2A and 2B	We maximise development of DHCFT people and careers and make the most of people's unique talents Reduce turnover of key professions and individuals Increased progression of BME staff into managerial positions

Maximise colleague wellbeing and attendance

Annual Priority 22/23					
Priority action	**UPDATE**	**Action owner**	**Expected completion date**	**Committee Oversight**	**Outcomes**
Improve the health and wellbeing and risk assessment processes so that they are being used dynamically and systematically across the Trust and meet the unique needs of all our people	Delivered Q4 2022/23 Health and Wellbeing conversations in place and rolled out, culture work underway, EDI steering group established, quality summit established, Professional Nursing Advocates in work place (restorative supervision), supervision policy reviewed. Review of all risk assessments with OH completed and alignment to health and wellbeing conversations.	Chief Operating Officer, Director of People and Inclusion, and Director of Nursing and Patient Experience	Q4 2022/23	People and Culture Committee BAF: Strategic objective 2 – 23-24 2A and 2B	Reduction in stress-related absence Culturally sensitive and appropriate conversations and support is in place Maintain staff survey results on health and wellbeing We are supporting people to be safe and well
Improve processes and support for people who are experiencing matters that could cause stress reactions inside and outside of work	Completion date post Q1 2023/24 New OH contract being reviewed with view to move closer to supporting stress absences. Appointment of DHCFT staff clinical psychologist now made to support staff experiencing high levels of stress and trauma	Director of People and Inclusion and Chief Operating Officer	Q4 2022/23 Now revised to Q2 2023/24	People and Culture Committee BAF: Strategic objective 2 – 23-24 2A and 2B	Reduction in stress-related absence Reduced average length of stress-related absence Improved staff survey on staffing levels Reduction in agency and bank expenditure

Achieving our Long Term Plan performance requirements

Annual Priority 22/23					
Priority action	**UPDATE**	**Action owner**	**Expected completion date**	**Committee Oversight**	**Outcomes**
Deliver a <32 days average length of stay on our acute MH wards through maintaining occupancy levels at <85%. Adult Crisis and Home Treatment Services provided in line with fidelity model	Off track with risks to delivery Q1 2023/24 The average length of for our acute MH wards stay as at July 2023 is 51 days. Recovery actions underway include the Emotional Regulation Pathway ward 33 pilot, establishment of a multi agency admission and Discharge Hub, and the introduction of Purposeful Admission to provide clear objectives regarding purpose of the admission.	Chief Operating Officer	Q1 23/24 Revised completion date is Q1 2024/25	Finance and Performance Committee BAF: Strategic objective 1 – 23-24 1A	Zero inappropriate out of area acute placements Improved care planning and smoother discharge arrangements Improved continuity of care Admissions avoided
Deliver perinatal community mental health access standard of 10% of prevalence	Delivered Q1 2023/24 Current performance: 10% (June 2023) Recovery Action plan implementation continues to be monitored	Director of Strategy, Partnerships and Transformation	Q1 23/24	Finance and Performance Committee BAF: Strategic objective 1 – 23-24 1A	Improved access to mothers and partners to specialist perinatal mental health services
Recover dementia diagnosis rates to national target of 67%	Delivered Q1 2023/24 Current performance: 67.7% (July 2023)	Director of Strategy, Partnerships and Transformation	Q1 23/24	Finance and Performance Committee BAF: Strategic objective 1 – 23-24 1	Shorter waiting times Backlog clearance COVID 'missed referrals' found and services accessed

Continue to develop our formal partnerships

Annual Priority 22/23					
Priority action	**UPDATE**	**Action owner**	**Expected completion date**	**Committee Oversight**	**Outcomes**
With colleagues from the statutory and voluntary sector, establish a formal Mental Health and Learning Disabilities Alliance in Derbyshire with a formal partnership agreement in place	Delivered Q3 2022/23 Mental Health and Learning Disabilities Alliance established. Partnership Agreement in place.	Director of Strategy, Partnerships and Transformation	Q3 22/23	System Oversight: NHS Executive BAF: Strategic objective 4 – 23-24 4A and 4B	Collaborative infrastructure established to support future cross-system work in co-production with experts by experience (EbE)
Successfully implement the provider collaborative for Perinatal inpatient services across the East Midlands with DCHFT as the lead provider	Off track but will deliver Q3 2023/24 Operating as lead provider in shadow form. Formal go live delayed from April 2023 until October 2023 due to national decision to align all go live dates.	Director of Strategy, Partnerships and Transformation	Q3 2023/24 Revised from Q4 2022/23	Finance and Performance Committee BAF: Strategic objective 4 – 23-24 4A and 4B	Collaborative infrastructure in place to enable provider-led collaboration over improvements in Perinatal inpatient services and joining up inpatient and community pathways
Work in partnership with DCHS to progress the harmonisation of Learning Disabilities and Autism services across the city and county	Completion date post Q1 2023/24 Work continues to ensure parity of services across north and south, joint clinical governance and joint financial management. Further work is required to join up corporate processes however a project has recently launched to bring together a single EPR expected to complete in July 2024. The Committee in Common has closed, and a new steering group reporting to both boards established.	Chief Operating Officer		Finance and Performance Committee BAF: Strategic objective 4 – 23-24 4A and 4B	Single clinical and leadership responsibility for all services across Derbyshire. Improved quality of inpatient and community services

The five quality areas

Annual Priority 22/23					
Priority action	**UPDATE**	**Action owner**	**Expected completion date**	**Committee Oversight**	**Outcomes**
Each division will have its own specific quality requirement standards. The Clinical Director, Head of Nursing/Practice and lead AHP/ Psychologist/Therapist will lead the achievement of these core clinical practice standards	Completion date post Q1 2023/24 Quality dashboard established across the Trust QI training established and projects underway, data triangulated with service users and EBE. DARs review core standards and progress being made in targeted improvement areas. Both recovering core standards and improvements	Director of Nursing and Patient Experience	Annual with quarterly achievement requirements	Quality and Safeguarding Committee BAF: Strategic objective 1 – 23-24 1A	Recovering our clinical practice standards, ensures we provide safer care to our people An example would be in Substance Misuse: Assessment Plan of care Safety assessment Outcome measure Implementing the drug strategy
Focusing on the safety domain of practice and preparing for new changes in mental health legislation –Liberty Protection Safeguards and a new emergent Mental Health Act	Completion date post Q1 2023/24 Paused until further national progression	Medical Director	Annual with quarterly achievement requirements	Quality and Safeguarding Committee BAF: Strategic objective 1 – 23-24 1A	Improvements in the safety domain of our CQC registration Advance preparation for legislative changes for DHCFT and to support the ICS

Embed and develop our electronic patient care record

One team
One approach
One Derbyshire

Annual Priority 22/23					
Priority action	**UPDATE**	**Action owner**	**Expected completion date**	**Committee Oversight**	**Outcomes**
Finalise the Phase 3 and 4 implementation of the move to SystmOne electronic patient record (EPR) system	Delivered Q3 2022/23 SystmOne fully implemented	Director of Strategy, Partnerships and Transformation	Q2 2022/23	Finance and Performance Committee BAF: Strategic objective 1 – 23-24 1C	All secondary care services across the Trust on SystmOne
Deliver electronic prescribing and the electronic transfer of prescriptions element of the OnEPR programme	Delivered Q2 2023/24 EPMA is now live within: Adult and Neurodevelopment services (ANS) CAMHS, and Community Mental Health teams (CMHT), Inpatient services and Crisis services	Director of Strategy, Partnerships and Transformation	Q2 2023/24	Finance and Performance Committee BAF: Strategic objective 1 – 23-24 1C	All services and prescribers are able to write and transfer prescriptions electronically. Improved accuracy of prescribing and adherence to formulary.
Optimise the use of SystmOne across the Trust, realising the benefits identified in the original business case	Completion date post Q1 2023/24 Ongoing training programme in place. Standard Operating Procedures agreed for service areas. Oversight of benefits realisation monitored through the Clinical Digital Board	Director of Strategy, Partnerships and Transformation	Q2 2023/24	Finance and Performance Committee BAF: Strategic objective 1 – 23-24 1C	Quicker access for staff to the records they need Improved communication with other system partners, either directly through records or via the Derbyshire shared care record.

Spending smarter, reducing waste and saving money

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

Making Room for Dignity Programme

Annual Priority 22/23					
Priority action	**UPDATE**	**Action owner**	**Expected completion date**	**Committee Oversight**	**Outcomes**
Seek national approval of both Adult Acute Unit full business cases	Delivered Q3 2022/23 Adult Acute Unit full business cases approved nationally and construction commenced	Senior Responsible Officer (SRO) Acute Care Capital Programme	Q3 2022/23	Finance and Performance Committee BAF: Strategic objective 1 – 23-24 1B and 1D	Commence construction of Adult Acute Units at Kingsway Hospital and Chesterfield Royal Hospital
Seek JUCD approval of full business cases for Older Adult Service relocation, Radbourne refurbishment, PICU and Acute-Plus unit	Delivered Q3 2022/23 JUCD approved all four full business cases subject to identification of capital	Senior Responsible Officer (SRO) Acute Care Capital Programme	Q3 2022/23	Finance and Performance Committee BAF: Strategic objective 1 – 23-24 1B and 1D	Enable construction to commence immediately capital funds secured
Prioritisation of local business cases within remaining local capital funding available currently	Delivered Q4 2022/23 £25 million local approved to complete funding for AAUs and PICU	Senior Responsible Officer (SRO) Acute Care Capital Programme		Finance and Performance Committee BAF: Strategic objective 1 – 23-24 1B and 1D	Schedule construction and recruitment to prioritised schemes with capital available
Seek additional national capital funding sources to complete programme	Delivered Q4 2022/23 Additional £31 million national capital and construction of all builds scheduled	Senior Responsible Officer (SRO) Acute Care Capital Programme	Q1 2023/24	Finance and Performance Committee BAF: Strategic objective 1 – 23-24 1B and 1D	Schedule construction and recruitment of remaining schemes when capital available
Schedule recruitment to additional staff required for each scheme within programme	Delivered 20023/24 Revenue scheduled for recruitment, training and familiarisation of additional staff in advance of service go-live (the majority is scheduled to be drawn down April 2024 and beyond)	Senior Responsible Officer (SRO) Acute Care Capital Programme	Q1 2023/24	Finance and Performance Committee BAF: Strategic objective 1 – 23-24 1B and 1D	Additional staff recruited, trained and familiarised with buildings by service commencement dates.

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 5 September 2023

Kingsway Land Disposal

Purpose of Report

To present to the Board for approval the proposed exchange of Trust Land for connection into the drainage system currently operated by Tilia Homes.

Executive Summary

- The Trust owns a piece of land for which it has no identified benefit
- That piece of land has been included in Tilia's plans for their residential development and Tilia are therefore seeking ownership of it
- At the same time, the Trust is seeking to connect to the drainage which is on Tilia's land
- The proposal therefore is to 'exchange' the piece of land the Trust presently owns for the access right to the drainage. There will be an additional cost to the Trust of connection to the drainage, but this cost (estimated at £36k) together with the valuation of the land (£170k) is significantly lower than the cost of having to creating an alternative drainage connection and other associated costs (estimated at £1.1 million).

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 creating a compassionate, skilled and empowered leadership, creating a vibrant culture where colleagues feel they belong, thrive and are valued.	
3) The Trust is a **great partner** and actively embraces collaboration as our way of working.	X
4) We will make the **best use of resources** by making financially wise decisions and avoiding wasting resources to ensure financial recovery and long term sustainability.	X

Risks and Assurances

Without connection to the drainage system, the Trust would have to either regularly evacuate the existing drainage collection tanks (not technically or financially sustainable) or incur substantial costs in connecting to the nearest drainage system that is not operated by Tilia.

Consultation

- The authors have consulted with external solicitors and a quantity surveyor during the course of negotiations with Tilia
- The Executive Leadership Team, supported the proposal at its meeting on 15 August 2023.

Governance or Legal Issues

- The Trust's Standing Financial Instructions (SFIs) require the disposal to be authorised by the Board
- There is no requirement to first offer the land to NHS England as it is not used to deliver a Commissioner Requested Service.

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 paper raises no equality-related matters.

Recommendation

The Board of Directors is requested to approve the proposed disposal of Trust Land in exchange for connection into the drainage system currently operated by Tilia Homes as detailed in the report.

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

Report prepared by: **Andrew Coburn**
Assistant Director of Legal, Governance and Mental Health Legislation

Andy Donoghue
Associate Director of Estates and Facilities

Kingsway Land Disposal

Proposal

A chronological background is provided below however, in brief, it is proposed that the Trust transfer ownership of a piece of land (see Fig. 1) in exchange for the forgoing of the costs of connecting to the drainage system. The land has been valued at £170k but it is acknowledged that it has little commercial value other than to Tilia Homes who have included it into their site plans, and is of no use to the Trust. The value of connecting into the drainage (including off-site works) is £1.1 million. Please note that the Trust will still pay £36k for Tilia Homes to carry out the works of the connection. The payment is cost effective.

In line with the Trust's Standing Financial Instructions (SFIs) see below, authority is sought for the exchange and thus, dispose of the land.

Fig. 1

Background

1. Tilia Homes notified the Trust in October 2022 that they had included some Trust land within their designs for housing amounting to some 660m² of land adjacent the Kedleston Unit (configured as 2 long sections of land immediately adjacent the existing Trust boundary line – see Fig 1). At this point Tilia offered

to provide a new connection (from Trust land onto the 'green wedge/park' to be created adjacent the Kedleston Unit) by way of compensation. This was subsequently dismissed by the Trust (after consultation with clinical colleagues) as not being suitable given the service users located in the Kedleston Unit.

2. The Trust instructed land surveyors in November 2022 to provide a formal valuation of the land to assist further negotiations (having confirmed to Tilia the Trust had a duty to seek best value for any disposal). At this point the land was valued at £170k.

3. The Trust appointed solicitors in December 2022 to confirm exact land ownership arrangements.

4. Throughout this time, the Trust (and its contractor IHP) had been in discussion with Tilia regarding new surface water and foul water connections into the main road sewer on Cherry Tree Close (to facilitate drainage from the recently re-located Trust waste compound). It was understood that Tilia were amenable to this solution and would agree arrangements with the Trust.

5. The sewers in the road are currently not 'adopted' and technically remain under Tilia control.

6. Tilia contacted the Trust in March 2023 confirming they would now be seeking 'costs' from the Trust to connect to the drainage system.

7. The Trust held meetings with its contractor in April 2023 to establish if a viable alternative drainage design might be possible (to connect the waste compound drains to either existing Trust drainage systems or other local authority 'adopted' sewers). No alternative economical technical solution was identified (without adopting complex and risky 'pumped' solutions or undertaking works deemed 'not affordable' within the existing capital envelope for the Dormitory scheme).

8. The Trust held meetings with Homes England in April/May 2023 to establish Tilia's exact interest in the land/road/sewers. Homes England confirmed that whilst they retained ultimate freehold title to the land, Tilia were holding it under licence until the new housing development was completed and therefore, the Trust would need to agree any financial matters/transactions directly with Tilia.

9. In June 2023 Tilia confirmed their costs for connecting to their existing sewers (as originally discussed) which were £36k and provided a figure of £1.1m for the 'costs avoided' by the Trust not having to connect to the nearest known local authority 'adopted' sewer and proposed the Trust transfer the land to Tilia in lieu of incurring these costs. The Trust has discussed these costs with a Quantity Surveyor and they were deemed to be within reasonable levels.

Extract from Standing Financial Instructions (SFIs)

The Governance to execute such a transaction is covered by Section 14 of the SFIs:

14.1.3 *Budget holders must notify the Director of Finance where they propose that assets are to be sold, scrapped, or otherwise disposed of. Each disposal must be validated by reference to authorisation documents and invoices (where appropriate) and accounted for appropriately. (see disposals and condemnations section)*

Budget holders must seek approval from the Trust Board to declare any land or buildings as surplus to NHS requirements and available for disposal and income.

Budget holders and service managers must notify the Financial Controller if assets are being transferred between buildings or otherwise relocated, to allow for the asset register to be updated.

If any assets remain in empty buildings, it is the exiting service manager that is responsible for those assets until the building has been handed over to a new service or to Estates.

No assets that have been identified to hold Commissioner Requested Services in accordance with the NHS England Licence Agreement are allowed to be sold without prior consultation and agreement with NHS England in line with current guidance and approval from the Board. The Trust asset register includes a list of all assets which have been identified as being locations of Commissioner Requested Services

Recommendation:

The Board of Directors is requested to approve the proposed disposal of Trust Land in exchange for connection into the drainage system currently operated by Tilia Homes.

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 5 September 2023

Emergency Preparedness, Resilience and Response (EPRR) Core Standards Self-Assessment

Purpose of Report

This report provides an overview of the EPRR portfolio and this year's self-assessment.

Executive Summary

The annual core standards have been prepared ahead of the submission to NHSE and Derbyshire ICB for the end of August. Following initial discussion with the Executive Leadership Team and direction to achieve substantial compliance, significant progress has been made within the EPRR portfolio to respond to this. However, to note there continues to be a delay in some elements, in part due to ongoing incidents and the required responses to industrial action.

There have been several new guidance documents within EPRR that are being reviewed and incorporated into current planning and development. The core standards have received a further review at a national level which has changed some of the evidence requirements. The Confirm and Challenge session is scheduled for October 2023. This year's deep dive focus is training and exercising considering the updated guidance document.

As a Trust we are measured against the following domains:

- Governance [100% fully compliant]
- Duty to risk assess [100% fully compliant]
- Duty to maintain plans [64% fully compliant]
- Command and control [100% fully compliant]
- Training and Exercising [100% fully compliant]
- Response [100% fully compliant]
- Warning & Informing [100% fully compliant]
- Cooperation [100% fully compliant]
- Business Continuity [90% fully compliant]
- HazMat/Chemical, Biological, Radiological and Nuclear (CBRN) [90% fully compliant]

This year's deep dive focuses on Training and Exercising [100% fully compliant].

This report provides an update to the Board against each of the domains and asks for the Board's support to the proposed position to be submitted.

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

Risks and Assurances

- The Trust continues to prepare and respond to incidents as required
- The workplan is ongoing to support further development and monitoring through the EPRR steering group.

Consultation

This report was considered by ELT on 29 August 2023.

Governance or Legal Issues

- Compliance with the Civil Contingencies Act 2004
- Compliance with the NHS England Emergency Preparedness, Resilience and Response Framework 2022 (incorporating the Core Standards).

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:

- Any potential equality and diversity implications will be assessed and managed as plans are reviewed, developed and implemented. Initial response to an incident will always consider preservation of life as a priority above all other issues. Following the initial lifesaving phase all REGARDS issues will be considered in detail.

Recommendations

The Board of Directors is requested to:

1) Receive the Core Standards self-assessment to be submitted to the ICB & NHS England
2) Confirm and challenge as appropriate
3) Be assured of ongoing work to improve and further enhance the Trust's compliance with the EPRR core standards.

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

Report prepared by: **Celia Robbins**
EPRR and Sustainability Lead

Emergency Preparedness, Resilience and Response (EPRR)

Core Standards Update

Introduction

Over the last 12 months the Trust has continued to progress the EPRR portfolio including the Core Standards requirements. Our Core Standards self-assessment position has significantly improved, and it is anticipated that the Trust will be substantially compliant, subject to the confirm and challenge session in October. This is against a notable backdrop of a series of incidents in the trust and a required respond to Industrial Action. There has been a further review of the standards and the process of the confirm and challenge has added an additional level of scrutiny to the evidence provided. This report provides an update on each domain, current challenges, and next steps.

Governance

The Trust is submitting as **fully compliant** with this domain, Finance and Performance Committee receive update reports and we report annually to the Trust Board. Our Chief Operating Officer continues to hold the Accountable Emergency Officer role for the Trust. The workplan provides the overview of activities and identifies deadlines for completion of work.

Duty to Risk Assess

The Trust is submitting as **fully compliant** with this domain, and continues to comply with these standards, we hold a Trust wide risk assessment incorporating the Derbyshire Community Risk Register. It has also been updated to incorporate the newly revised National Risk Register release end of July 2023. These risks are monitored and reviewed in line with the Trust's risk management policy.

Duty to Maintain Plans

This is the domain with **the greatest number of partial compliant standards at 4 out of 11 standards.** This is due to several changes in national guidance and additional requirements for individual trusts. Several plans have been updated and are available on Focus; where plans are outstanding task and finish groups have been implemented to support in the delivery of the document.

The following plans are currently partially compliant:

- New and emerging pandemics – working with IPC colleagues to consider UKHSA guidance and NHSE IPC Framework.
- Countermeasures – discrepancy around roles and expectations of pharmacists and EPRR response roles. System discussions ongoing to support in the development of a plan.
- Mass casualty – the Trust has offered psycho-social support following an incident; however, the wider response needs further development.

- Evacuation and shelter – we have our fire evacuation plans; however, we have a requirement for a whole hospital site evacuation. An MDT task and finish group has been implemented to develop site specific plans.

Command and Control

The Trust is submitting as **fully compliant** for this domain and continues to provide an operational 24/7 response structure through a First On Call Manager South and North and a Second On Call Manager. This is being reviewed to ensure sustainability of the roster and colleagues maintaining their competencies.

Training and Exercising

The Trust is submitting as **fully compliant** for this domain. The EPRR Team continue to provide training for staff as outlined in the NHS EPRR Framework, the number of training sessions has been disrupted by the ongoing response to industrial action. However, many colleagues have received the required training. The training pathway is due its annual review and will incorporate feedback from evaluations and training feedback. Further work is required to widen the scope for all staff training to increase the current knowledge and understanding of EPRR and requirements within the Trust. A training needs analysis has been developed to ensure all training provided is as required and expected.

Although submitting as fully compliant, Trust Board are asked to note ahead of the challenge session; that there has not run an exercise in the typical sense due to the number of events that have occurred and the Incident Management Team (IMT) response that has been implemented to respond to the incident. This overrides the requirement for a tabletop exercise, which is why compliance is expected to be met. System exercises have taken place and the Trust have participated in these events including Exercise Artic Willow and Exercise Poppins.

Response

The Trust is submitting as **fully compliant** for this domain. The Incident Coordination Centre plan has been reviewed and identifies key information required for establishing a physical IMT response.

During the last year we have also responded to several incidents; each event has provided us with an opportunity to review plans and identify lessons for further embedding within the EPRR portfolio this includes.

- Operation London Bridge September 2022
- Loss of network to Kingsway Site December 2022
- RCN Industrial Action December 2022
- Unison Industrial Action January 2023 (external)
- Level 3 Cold Weather (snow) January 2023
- Door Security failure March 2023
- BMA Industrial Action Junior Doctors March 2023 (ongoing)
- Multi-agency response to snow March 2023
- 999 Failure June 2023

- Planned power outages for Kingsway site as part of the Making Room for Dignity Programme
- BMA Industrial Action Consultants July 2023 (ongoing)
- Extreme operational / bed flow pressure August 2023

Warning and Informing

The Trust is submitting as **fully compliant** for this domain. The EPRR Incident Communications Plan has received its annual review and remains current. Additional Executive colleagues have now undergone media training.

Cooperation

The Trust is submitting as **fully compliant** with this standard; we are represented at the Local Resilience Forum in both planning and response meetings. We participate in the Local Health Resilience Partnership meeting with Executive Leader representation. The Health Emergency Planning Operations Group (HEPOG) group has been re-established with the introduction of the ICB and their restructured EPRR team. This has brought opportunity to further develop system planning. The Trust is also represented at Local Resilience Forum Meetings at the various subgroups.

Business Continuity

Of the ten requirements for this domain, the Trust is submitting nine as fully compliant and one as partially compliant. Colleagues have enacted business continuity arrangements over recent months due to the ongoing responses to industrial action, however, there has been a delay in completing relevant paperwork. With the additional support and direction this picture has significantly improved. Further training sessions are planned for the next stage in the process for developing the business continuity management system within the Trust. NHSE have released new guidance to support in the development of Trust's business continuity management system, this will require the review of the current Business continuity (BC) Policy to align the document as required. The EPRR team continue to support managers as they develop their plans and action cards for BC incidents. There is one partial standard within this domain in relation to testing and exercising services documents, this work is planned for Q3 ahead of the 360 Audit process.

Chemical Biological Radiological Nuclear (CBRN)/Hazardous Material

Considering the ongoing responses to incident and other areas within the portfolio of a higher level of risk, **this domain is recommended to Trust Board as less priority for action**. This type of event remains a low risk for the Trust but there is a requirement for a response capability. Elements of this have been captured within the Counter Terrorism Plan and work is ongoing to further develop the Trust's response considering the changes to the national core standards for this domain. The outstanding standard for this section is Exercising, this will be address in October as part of the system exercise.

Deep Dive – Training and Exercising

The focus on training and exercising considered the training needs analysis of the Trust, data available to evidence colleagues who have undergone training, training

materials, reviewing of content and audit processes for updating training as required. It also incorporates evaluation of delivery and ensures future sessions are amended based on feedback. All elements of this deep dive are available and part of our training and exercising package.

Conclusion

The Core Standards have been reviewed and updated this year with numerous changes. The overall level of compliance will be given once our submission has been reviewed. Across the core standards we have achieved the following:

- Fully compliant – 52
- Partially compliant – 6

The Trust Board can be assured of the following:

1. There is an action plan in place to support meeting the outstanding actions by April 2024. This will be monitored through the EPRR Steering group.
2. The EPRR Work plan will further enhance the Trust's compliance to the Core Standards

On this basis Trust Board is asked to support the proposed submission position as substantially compliant, noting the areas that may be raised as part of the challenge sessions, and provide any feedback or guidance ahead of the October session on this.

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors - 5 September 2023

Board Assurance Framework (BAF)
Issue 2, 2023/24 – Version 2.3

Purpose of Report

To meet the requirement for Boards to produce an Assurance Framework. This report details the second issue of the BAF for 2023/24.

Executive Summary

Director Leads, Deputy Directors, Operational Leads and Trust Senior Managers have reviewed the risks and provided comprehensive updates. Issue 2 was reviewed by the Executive Leadership Team (ELT) on 4 July and approved by the Audit and Risk Committee (ARC) on 20 July.

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 following actions to close key gaps in control have been signed off by the Chief Operating Officer as the measures to close the gaps have all been completed and improvement is sustained. Corresponding updates were also received from the Director of Nursing:

> *Embedded learning from CQC regulatory actions, particularly in relation to clinical standards and improvement of training governance.*
>
> *The Trust has not embedded a robust system of operational management and educational governance and has not learnt lessons from the 2016 and 2020 inspections.*

The blue rating and updates regarding completion of both were approved by ARC so both actions have been stricken through and will be removed from the next issue of the BAF.

Risk 1B – *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:* Two of the actions have been down-graded, from Amber to Red, both due to significant cost-pressures and concerns regarding affordability, they relate to Older Adult service relocation and Radbourne Unit dormitory eradication.

One of the actions, relating to Audrey House refurbishment, has an improved rating, from Red to Amber, as work progresses but the original timeframe will not be met.

Risk 4A – *Whilst there are significant benefits from the creation of the Integrated Care System (ICS) as an NHS body, there is a risk that the effects of the change may impact negatively on the cohesiveness of the Derbyshire health and care system:* The following key gap in controls has been closed:

Maintenance of relationships with ICB colleagues during period of change and potential instability

The action has been completed. The ICB is in place and relationships have been established, this is now 'business as usual' and the action has been closed by the Director of Strategy, Partnerships and Transformation.

The blue rating and updates regarding completion were approved by ARC so the action has been stricken through and will be removed from the next issue of the BAF.

Risk 4B – *There is a risk of reputational damage if the Trust is not viewed as a strong partner:* Two actions have improved RAG ratings, both now Green, as they are both in progress and on target:

System partners report that DHCFT is inward looking and does not fully support PLACE developments – from Red to Green

GP networks and partners report they do not feel connected to the MHLDA DB and are not aware of strategic decisions that are made – from Amber to Green

Operational Risks: There are five Trust-wide operational risks rated as high/extreme linked to the Trust strategic objectives. Since the BAF was reviewed by Board in the last quarter, two operational risks have been removed from the report and two new ones have been added:

Risk 22804: Risks identified due to pharmacy staffing issues – reduced rating from High to Moderate:

Recruitment remains challenging with 30-40% vacancy rates due to expansion of roles across all sectors and imbalanced e demand/supply. ePMA now implemented across the trust which will allow pharmacists to work with a little more flexibility and reduces some anxieties/pressures for them and their managers.

This allows us to step down our level of risk, while acknowledging our vacancies and the need to continue efforts to recruit. Likelihood of pressure remains the same (we still have significant vacancies) but the consequence has reduced due to ePMA and more assured Pharmacy Technician staffing.

Risk 23009: Failure to follow Standard Operating Procedures (SOPs) causes inaccuracies in reported information - risk to patient safety – reduced rating from High to Very Low:

Reporting issues identified SOP and process maps are updated to reflect service changes. Staff have been provided with refresher training.

Risk 22961 Relating to potential consequences of industrial action – the rating was increased, from High to Extreme in the last quarter as more strike action was taken.

New Risks

ID	Title	Current Rating	Linked To
23040	Anti-ligature clothing and mattresses can be torn	High Risk	Risk 1A
23067	The Trust fails to deliver its revenue and capital plans	Extreme Risk	Risk 3A

BAF Reporting Cycle/Format: All changes/updates to this issue of the BAF, compared with Issue 1 2022/23, are indicated by blue text. All text that has been stricken through will be removed from the next issue.

Director Lead updates will next be taken in the fortnight after the Board meeting on 5 September. Board Committee updates from meetings held in September will also be taken for inclusion in the first version of Issue 3, to be reviewed by ELT at the start of the next quarter, in October.

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

Risks and Assurances

This paper details the current Board Assurance risks and provides assurance on the process of the review, scrutiny and update of the BAF in seeking to identify and mitigate risks to achieving the Trust's strategic objectives.

Consultation

- Executive Directors
- Interim Chief Executive Officer
- Trust Secretary
- Deputy Directors
- Operational Leads
- Managing Directors
- General Managers
- Service Line Managers
- Operational Risk Handlers

Formal Reviews:

- Executive Leadership Team, Issue 2.1: 4 July 2023
- Audit and Risk Committee, Issue 2.2: 20 July 2023.

Governance or Legal Issues

Governance or legal implications relating to individual risks are referred to in the BAF itself, where relevant.

Public Sector Equality Duty and Equality Impact Risk Analysis

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

Specific elements within each BAF risk and associated actions are addressed by the relevant lead Executive Director in taking forward.

Recommendations

The Board of Directors is requested to:

1) **Review and Approve** this second issue of the BAF for 2023/24 and the assurance the paper provides of the process of the review, scrutiny and update of the BAF in seeking to identify and mitigate risks to achieving the Trust's strategic objectives
2) Continue to receive updates in line with the forward plan for the Trust Board.

Report presented by: **Justine Fitzjohn**
Trust Secretary

Report prepared by: **Kel Sims**
Risk and Assurance Manager

Board Assurance Framework 2023/24 – Issue 2 Board 5 September 2023

PART ONE – RISKS TO DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST'S STRATEGIC OBJECTIVES

Ref	Principal Risk	Director Lead	Rating (Likelihood x Impact)	Responsible Committee
Strategic Objective 1 - To Provide GREAT Care in all Our Services				
23-24 1A	There is a risk that the Trust will fail to provide standards for safety and effectiveness as required by our patients and our Board	Director of Nursing (DON) / Medical Director (MD)	**HIGH (4x4)**	Quality and Safeguarding Committee
23-24 1B	There is a risk that the Trust does not deliver key regulatory and strategic requirements related to dormitory eradication and Psychiatric Intensive Care Unit (PICU) and that the Trust estate more generally is not maintained sufficiently well to comply with regulatory and legislative requirements	Chief Operating Officer (COO)	**HIGH (3X5)**	Finance and Performance Committee
23-24 1C	There is a risk that the Trusts increasing dependence on digital technology for the delivery of care and operations increases the Trusts exposure to the impact of a major outage	Chief Operating Officer (COO)	**MODERATE (3x4)**	Finance and Performance Committee
23-24 1D	There is a risk that the organisation is in breach of essential standards for privacy and dignity in its acute bedded care facility as it has not fully completed its dormitory eradication programme. This may result in regulatory action if mitigation to improve safety does not occur	Director of Nursing (DON) / Chief Operating Officer (COO)	**MODERATE (3x4)**	Quality and Safeguarding Committee
Strategic objective 2 – To be a GREAT Place to Work				
23-24 2A	There is a risk that we are unable to create the right culture with high levels of staff morale	Director of People and Inclusion (DPI)	**HIGH (4x4)**	People and Culture Committee
23-24 2B	There is a risk that we do not have a diverse workforce with the right number of people with the right skills to support and deliver safe high-quality care	Director of People and Inclusion (DPI)	**HIGH (4x4)**	People and Culture Committee
Strategic Objective 3 – To Make BEST Use of Our Resources				
23-24 3A	There is a risk that the Trust fails to deliver its revenue and capital financial plans	Director of Finance (DOF)	**EXTREME (4X5)**	Finance and Performance Committee

Board Assurance Framework 2023/24 – Issue 2 Board 5 September 2023

Strategic Objective 4 – To be a GREAT Partner				
23-24 4A	Whilst there are significant benefits from the creation of the Integrated Care System (ICS) as an NHS body, there is a risk that the effects of the change may impact negatively on the cohesiveness of the Derbyshire health and care system	Director of Strategy, Partnerships and Transformation (DSPT)	**MODERATE (3x3)**	Trust Board
23-24 4B	There is a risk of reputational damage if the Trust is not viewed as a strong partner	Director of Strategy, Partnerships and Transformation (DSPT)	**HIGH (4x4)**	Trust Board

Board Assurance Framework 2023/24 – Issue 2 Board 5 September 2023

Strategic Objective 1 – To Provide GREAT Care in all Our Services

There is a risk that the Trust will fail to provide standards for safety and effectiveness as required by our patients and our Board

Impact: May lead to avoidable harm including increased morbidity and mortality; delays in recovery; and longer episodes of treatment; affecting patients, their family members, staff or the public

Root causes:

a) Workforce supply and lack of capacity to deliver effective care across hotspot areas, increasing risks in the clinical and medical workforce
b) Risk of substantial increase in clinical demand in some services
c) Changing demographics of population and substantial impacts of inequality within the deprived wards of the city and county
d) Intermittent lack of compliance with Care Quality Commission (CQC) standards specifically the safety domain
e) Lack of embedded outcome measures at service level
f) Known links between Serious Mental Illness (SMI) and other co-morbidities, and increased risk factors in population including inequality/ intersectionality, with escalating risks in alcohol consumption
g) Lack of compliance with physical healthcare monitoring in primary and secondary care, has improved but not at the required level for reductions in mortality
h) Restoration and recovery of access standards in autism and memory assessment services, due to demand
i) Lack of appropriate environment to support high quality care, i.e. single gender dormitories and PICU leading to out of area (OOA) bed use for PICU
j) Lack of capacity to meet population demand for community forensic team
k) Local NHS Trusts will offer Recruitment and Retention Premium to Consultant Psychiatrists in specialist services and other clinical staff due to competitive practices that destabilises Trust clinical services and leads to a deterioration in waiting time and potentially in safety
l) Due to the move in Electronic Patient Record (EPR) system and the transitional working arrangements there is potential that data quality could adversely affect patient safety
m) Violent crime in the community, sexual safety incidents and youth violent crime all increasing in Derby and Derbyshire
n) Health inequalities across the Derbyshire footprint. Initial insights show gaps in access to service, case load and worsening patient outcomes for our patients
o) Sustained pressure in the crisis and acute care pathway with bed occupancy over 85% and increased waiting time for patients to access bedded care from the community
p) Cost of living crisis and possible commencement of post pandemic surge in June 2023. Sustained increases in referrals since January 2023, (20% addition)

BAF Ref: 23-24 1A	**Director Lead**: Carolyn Green (DON) / Dr Arun Chidambaram (MD)	**Responsible Committee**: Quality and Safeguarding Committee

Key Controls

Inherent Risk Rating			**Current Risk Rating**				**Target Risk Rating**			**Risk Appetite**		
High	Likelihood 4	Impact 4	High	Likelihood 4	Impact 4	Direction ⬌	Moderate	Likelihood 3	Impact 4	Accepted	Tolerated	Not Accepted

Preventative – Quality governance structures, teams and processes to identify quality related issues; mandatory training; Duty of Candour processes; clinical audits and research; health and safety audits; risk assessments; physical health care screening and monitoring; monitoring and effective responses to infection and control guidance, EQUAL unannounced visits to services and anonymised bright ideas service improvement ideas. Feedback intelligence from independent advocacy, Director visits in and out of hours and Quality Visits
Detective – Quality dashboard reporting; quality visit programme/virtual clinical service contact visits; incident, complaints and risk investigation; Fire Safety Regulations (FSR) compliance checks; mortality review process; physical health care monitoring clinics pilots; safety check log; Head of Nursing and Matron compliance visits, reviewed model of announced and unannounced visits to service throughout the 24-hour period
Directive – Trust Strategy and commitments; Quality Improvement Strategy; Physical Health Care Strategy; Safeguarding Strategy; Suicide Reduction Strategy; clinical strategies; policies and procedures available via Trust intranet; Central Alerting System (CAS) alerts; Risk Management Strategy; clinical sub committees of the Quality and Safeguarding Committee

Assurances on controls (internal)	Positive assurances on controls (external)
Quality and Trust dashboards Scrutiny of Quality Account (pre-submission) by committees Programme of physical healthcare and other clinical audits and associated plans Infection Control Board Assurance Framework reported to NHS England Positive and Safe self-assessment reported to the East Midlands Head of Nursing/Practice and Matron compliance visits Quality visit programme and out of hours visits	National enquiry into suicide and homicide NHS Litigation Authority (NHSLA) scorecard demonstrating low levels of claims Safety Thermometer identifies positive position against national benchmark Mental Health Benchmarking data identifies higher than average qualified to unqualified staffing ratio on inpatient wards CQC comprehensive review 2020 Trust is rated Good; two core services rated outstanding, two rated as require improvement Identified Trust fully compliant with National Quality Board (NQB) Learning from Deaths guidance Transitional Monitoring Meetings with CQC (bi-monthly), no conditions Patient Safety Incident Response Framework (PSIRF) implementation

Key gaps in control	Key actions to close gaps in control	Impact on risk to be measured by	Expected completion date (Action review date)	Summary of progress on action	Action on track
~~Embedded learning from CQC regulatory actions, particularly in relation to clinical standards and improvement of training governance~~	~~Review operational governance of training compliance [ACTION OWNER: DPI]~~ ~~Develop and implement improvement plan to ensure sustained compliance with mandatory training [ACTION OWNERS: DPI/COO]~~	~~Embedded compliance with mandatory training and compliance rates. Reported to People and Culture Committee (PCC)~~ ~~Lack of recurrence of common themes regarding training compliance. Reported to PCC~~	~~30.06.23~~	~~Improved governance reporting to Board, PCC, ELT reintroduced through performance reviews on key metrics is sustained and will remain in heightened monitoring for six months i.e.~~	~~GREEN BLUE~~

		~~and to be led by the operational leadership teams~~		~~Positive and Safe and Immediate Life Support (ILS) training compliance~~ ~~Work continues to review~~ ~~Reviewed~~ ~~the best way to deliver training, that~~ ~~reducing~~ ~~es the impact on the delivery of clinical services, which may includes~~ ~~virtual opportunities~~ ~~Divisional reviews focused on improvement standards in the essential standards~~ ~~Focused work on gender specific wards and clinical safety for those who self-harm and clinical skills diversification in safer staffing~~ ~~Additional scrutiny on reducing restrictive practices. Locked doors, seclusion and appropriate use of restraint~~ ~~All service lines continue to work to improve compliance with action plans. Mandatory training currently 92% compliant~~ ~~Training compliance continues to remain high – Action complete~~	

~~The Trust has not embedded a robust system of operational management and educational governance and has not learnt lessons from the 2016 and 2020 inspections~~	~~Review operational governance of training compliance [ACTION OWNERS: DPI/COO]~~	~~The Trust continues to have significant instability in training compliance and oversight of safety training~~ ~~The Trust management team need to move to a proactive oversight, projections of high-risk areas of safety training and advance management of risk~~ ~~Publication of ILS / PSTS training as core risk areas in the Trust Board reporting until stability is achieved~~ ~~Sign-off of the outstanding CQC actions~~	~~30.06.23~~	~~Repeat variations in operational delivery and practice in educational governance. Focus remains in Acute Care and Older Adult Inpatients Services~~ ~~PCC receive a compliance report on all CQC outstanding actions, and a plan is presented against any actions that are not compliant. A trajectory is prepared to establish when the training will achieve the required compliance standard and signed off by PCC~~ ~~06.03.23: ILS training was 89%. Positive and Safe is at 78% and monitoring is in place~~ ~~Bi-monthly Training and Workforce Group now in place, chaired by the DPI~~ ~~CQC actions signed off~~	~~GREEN BLUE~~
Inability to complete physical health checks for patients whose consultations remain undertaken virtually	Improvement plan to be developed and implemented to ensure required physical health care checks are completed [ACTION OWNER: MD]	Compliance with physical healthcare checks, reported in the Quality Dashboard A 360 audit has been commissioned to review whether these improvements are embedded	~~(30.06.23)~~ (30.09.23)	Revised metrics now form part of the quality dashboard and are reported regularly to the Quality and Safeguarding Committee Implementation of coaching and self-report pilot model of care in	AMBER

				underway to improve compliance and patient empowerment via the Health Protection Unit Targeted actions are now in place across all service lines to improve on physical health checks to improve practice with an increased focus on adult inpatient services 360 Assurance audit completed, and actions being implemented	
Implementation of revised priority actions for 'Good Care' which support the Trust strategy	Redesign improvement plans to align to revised building blocks which support the Trust Strategy [ACTION OWNER: DON]	Compliance with suite of metrics and reporting schedule detailed in quality dashboard	~~(30.06.23)~~ 30.09.23	New strategy actions published and being reviewed in Quality Visit programme and in Divisional Achievement Reviews Progress is being made in recovering the five essential standards. Intermittent non-compliance is a re-occurring theme exacerbated by clinical activity. Sustained improvement work continues	AMBER
Insufficient investment in autism assessment and treatment services to meet demand. No commissioned treatment services Waiting time increased over COVID-19 period, exacerbated	Investment required by ICS to meet assessment and treatment demands [ACTION OWNERS: COO/DSPT]	Agreed funding allocation has occurred, recruitment to posts is active	~~30.06.23~~ (31.12.23)	Mental Health Learning Disability and Autism Delivery Board (MHLDA DB) agreed additional investment in a new neuro diversity diagnostic pathway. Investment	AMBER

by underlying demand – ASD diagnostic waiting lists remain high				included in 2022/23 system operational plan~~.~~ ~~Additional in year funding to trial a new approach to assessment services for autism has been provided by the ICB – Progress is being monitored, and mobilisation has started but there continues to be insufficient long-term funding~~ ~~There continues to be insufficient long-term funding; it is hoped the new approach will demonstrate a case for future investment~~ Associated recovery action plan in place (RAP) - Progress is being made at commissioned level but un-met need remains a sustained pressure over 18 weeks ~~ASD contracted assessments per year have been achieved. Work continues to improve capacity to sustain compliance~~	
Six service areas assessed as 'Requires Improvement' by CQC in relation to safety	Develop and implement an improvement plan to enable all six service areas to reach 'Good' for safety in relation to the CQC standards [ACTION OWNER: DON]	CQC inspection and assessment	~~(30.06.23)~~ (30.09.23)	Significant improvement in all services~~. Plan to meet training compliance is not fully compliant~~	AMBER

				There has been a programme of mock CQC inspections in hotspot areas namely inpatient areas and now moving to community services. A thematic report will be presented to TOOL. The inspections have been received very positively by staff and are leading to identified areas of action for each team ~~Six~~ Three CQC actions remain open due to intermittent compliance~~, training compliance targets to be met~~	
Gap in operating standards for acute and community mental health services	Enhanced monitoring of acute and community mental health services by the Nursing and Quality Directorate [ACTION OWNER: DON] Implement Royal College of Psychiatrists (RCP) Standards across Acute Services [ACTION OWNERS: MD/DON/COO] Implement Community Mental Health Framework [ACTION OWNER: DSPT]	Improvement in operating standards compliance. To be confirmed by external CQC inspection and assessment of at least 'Good' Accreditation for Inpatient Mental Health Services (AIMS) to be completed by end of Quarter 3 2023/24 Implemented Acute Inpatient Mental Health Service Accreditation (RCP Standards) reported in Divisional Achievement Reviews and Quality Account	~~(30.06.23)~~ (30.09.23) (31.03.24) 31.03.24	Increased performance management scrutiny and unannounced site visits have been undertaken with compliance checks Mock inspections completed in acute services, there is support for the services on the areas requiring improvement Work being carried out to become accreditation ready ahead of the implementation of the shift consultation to ensure compliance with European Working Time Directive (required as part	AMBER

		Implemented Mental Health Community Framework to Quality and Safeguarding Committee		of an accreditation application) ~~Recruitment now underway. Given lack of medic availability (due to increased clinical demand) for PSII and mortality reviews, specific areas of need will be targeted in initial pilot~~ ~~Design of new fully integrated model completed~~ ~~Accreditation for Inpatient Mental Health Services (AIMS) to be completed by end of Quarter 3 2023/24~~ Policy and Standard Operating Procedure (SOP) for Derbyshire Living Well and Derby Wellbeing Services to support with practice, delivery and governance is published ~~in draft~~ Internal Trust programme Board in place to strengthen contribution and involvement in system-wide programme and delivery. ~~Implementation~~ Mobilisation underway in High Peak and Derby City. Next phase is	

				Chesterfield and North-East Derbyshire early 2023/24 Additional quality scrutiny and management support in place to support the transformation plan	
Implementation of clinical governance improvements with respect to: - Outcome measures - Clinical service reviews including reduction in excess waiting times - Getting it Right First Time (GIRFT) reviews	Develop and implement an improvement plan ~~to enable all governance improvement plans to be implemented~~ [ACTION OWNERS: MD/DON/COO/DSPT]	Compliance with suite of metrics and reporting schedule	~~(30.06.23)~~ (30.09.23)	NICE guideline mapping established, and governance work continues Agreed programme of work in place from Performance Summit focussing across four key workstreams to make improvements: Engagement; quality improvement and approach to management; review of metrics and data optimisation. All workstreams are progressing, wait times management underpinned by recovery action plans have been developed and are being monitored via TOOL and the MHLDA DB	AMBER
Implementation of new quality priorities for: - Sexual safety - Implementing CQUINS and Clinical outcome measures - Recovering services – equally well	Develop and implement an improvement plan to enable all quality priorities to be implemented [ACTION OWNER: DON]	Compliance with suite of metrics and reporting schedule	~~(30.06.23)~~ (30.09.23)	Reducing violence – Body worn camera investment in place Sexual safety – Improvement work (dashboard, preceptorship training and protocols) all commenced. Sexual	GREEN

- New Trust strategy and priorities - Dormitory eradication programme				safety on professional standards video launched Sexual safety checklist for services in design Monitoring and learning from sexual safety work continues – New course on professional standards/ boundaries and sexual safety commissioned Dormitory eradication programme in construction Trauma informed practice conference and work programme commenced in May 2023 Plan for existing dormitory stock and a plan to maintain and improve dignity for active bed stock assessed and presented to the ICB ~~in design~~	
There is a risk that patients in our care in Derbyshire or commissioned services may receive poor care due to experiencing abuse or professional misconduct. Learning from other independent and national exposures of abuse	Revisit all assurances and scrutinise practice, gathering intelligence and implement an improvement plan to enable all services to provide the highest standard of care which would be expected [ACTION OWNERS: DON/MD]	Engagement and mobilisation of the organisation to discuss learning from recent exposes Discuss and activate colleagues to revisit what compassionate care means and actively encourage, inspire, reward – Supervision, reflective practice and asking for help	~~(30.06.23)~~ (30.09.23)	There is a wide range of opportunities for colleagues to have conversations about care delivery and raise concerns, including Trust-wide and divisional engagements, Freedom to Speak Up processes, Schwartz Rounds	AMBER

		Mobilise and re-emphasise expectations of standards of care and Freedom to Speak Up Revisit system and process of governance and using intelligence to take oversight of services Inspire conversations re the risks of harm and closed cultures. Reset the culture and the tone of the requirement for professional scrutiny and all employee requirements to prevent harm and report poor care/ abuse Strengthen out of hours, weekends and night announced and unannounced visits. To promote access to multiple managers, relationships, so colleagues feel empowered to report any concerns Review LD physical health care access, provision access to acute liaison nurses and inspire acute and community colleagues in this area of safety for our community Professional leads are in place to ensure that registered professional staff practice in line with their professional codes Review reports and allegations in multi-disciplinary manner and include safeguarding and security specialist with effective recording and monitoring		Improvements in engagement of temporary staff have been identified Increasing visibility of senior staff through Quality Visits, mock CQC inspections and out of hours visits Robust oversight of patient safety incidents, concerns, complaints, and compliments with scrutiny from independent partners, e.g. Healthwatch and experts by experience being core members of Patient and Carer Experience Committee External partnership working including Healthwatch, Advocacy services and statutory services within safeguarding and secure services. The Trust provides assurance and participates in external reviews alongside the ICB and Adult Safeguarding Board	

Related operational high/extreme risks on the Corporate Risk Register:

Record ID	Service Line	Title	Risk: Summary of Progress	Date Risk Created	Date of Next Review	Residual Risk Rating
3009	Learning Disabilities Services	Demand for Autism Spectrum Disorder (ASD) assessment Service far outstrips contracted activity	20.06.23: There has been no increase in budget but the team now at a full complement of staff after a long period of shortages due recruitment problems and sickness. The team are making changes to pilot alternative assessment processes which should be faster but are admin-heavy. Additional funding has been provided on a one-year basis to employ someone who can complete some research to evaluate the changes that are going to be implemented	01.01.16	20.09.23	HIGH
22790	Corporate Services – Pharmacy	Prescribing Valproate to women of child-bearing potential: Failure to comply with regulations	24.05.23: ePMA now deployed to all services in the Trust which will help with our understanding of valproate use and can be incorporated into planning. Reporting will need to be constructed as part of the optimisation of ePMA. We still await updated national guidance from MHRA	28.02.22	01.09.23	HIGH
23040	Adult Care - Acute	Anti-ligature clothing and mattresses can be torn	Liaison with Patient Safety Team and Manufacturer and Director of Nursing - This is a known risk, none of the items can be purchased fully anti-ligature, staff to briefed on the residual risks by Heads of Nursing Updates requested from Risk Handler, Line Manager copied into requests	09.05.23	09.07.23	HIGH

Board Assurance Framework 2023/24 – Issue 2 Board 5 September 2023

Strategic Objective 1 – To Provide GREAT Care in all Services

There is a risk that the Trust does not deliver key regulatory and strategic requirements related to dormitory eradication and PICU and that the Trust estate more generally is not maintained sufficiently well to comply with regulatory and legislative requirements

Impact:
Low quality care environment specifically related to dormitory wards
Crowded staff environment
Patient safety and dignity risks associated with dormitory in-patient bedded care
Non-compliance with statutory care environments
Non-compliance with statutory health and safety requirements

Root causes:

a. Long term under investment in NHS capital projects and estate
b. Limited opportunity for Trust large scale capital investment
c. Increasing expectations in care and working environments as national capital strategy and surrounding legislative and regulatory requirements evolve
d. National capital funding restrictions for business-as-usual capital programme for Trusts and Integrated Care Systems

BAF Ref: 23-24 1B	**Director Lead**: Ade Odunlade (COO)	**Responsible Committee**: Finance and Performance Committee

Key Controls

Inherent Risk Rating			**Current Risk Rating**				**Target Risk Rating**			**Risk Appetite**		
High	Likelihood 4	Impact 4	High	Likelihood 3	Impact 5	Direction ⬌	Moderate	Likelihood 3	Impact 4	Accepted	Tolerated	Not Accepted

Preventative – Routine environmental assessments for statutory health and safety requirements; environmental risk assessments reported through DATIX; Infection, Prevention Control (IPC) risk assessments
Detective – Reporting progress against Premises Assurance Model (PAM) to the Executive Leadership Team (ELT); Dormitory Eradication Board reports into Trust Board
Directive – Capital Action Team (CAT) role in scrutiny of capital projects; IPC policy and procedure

Assurances on controls (internal)	Positive assurances on controls (external)
IPC risk assessments Health and Safety Audits Premises Assurance Model System (PAMS) reporting providing updates on key priority areas Estates Strategy	Mental Health Capital Expenditure bidding process External authorised reports for statutory health and safety requirements 2020/21 Estates and Facilities Management internal audit (limited assurance)

Key gaps in control	Key actions to close gaps in control	Impact on risk to be measured by	Expected completion date (Action review date)	Progress against action	Action on track
Lack of adherence to emerging national guidance and policy requiring the elimination of mixed sex wards and dormitory style inpatient facilities	Deliver two new adult acute 54-bed units with ~~a~~ single room en-suite with additional staffing and new model of care VAT abatement appeal – Combined capital funding shortfall risk of £10.7m if appeal unsuccessful [ACTION OWNER: COO]	Delivery of approved business cases	~~(30.06.23)~~ (30.09.23)	Two new build adult acute unit FBCs nationally approved September 2022, funded by £80m national PDC and £18.6m CDEL. ICS supported and approved revenue funding Delay in national approval and redesign of foundations. Phased completion April 2024 – March 2025 HMRC appeal on VAT abatement claim in process	AMBER
	Older Adult service relocation to refurbished ward with single room en-suite and gender segregation, with additional staffing and new model of care, by September 2024 to eradicate dormitories in Northern Derbyshire and avoid this 12-bed service being isolated in otherwise vacated wards, increasing service user safety issues National PDC capital funding approval [ACTIONS OWNER: COO]	Delivery of approved business case	~~(30.06.23)~~ (30.09.23)	Older Adult service relocation FBC and revenue funding approved by ICS National PDC capital funding approved by NHSE December 2022 ~~Refurbishment scheduled June – December 2025. New unit live May 2024~~ Significant cost pressure from initial submission, scheme temporarily paused to achieve affordability	~~AMBER~~ RED
	Audrey House refurbishment as decant ward to enable Radbourne Unit dormitory eradication refurbishment. Dormitories cannot be fully eradicated without use of this decant ward	Delivery of approved business case	~~(30.06.23)~~ (30.09.23)	National PDC capital funding approved by NHSE December 2022. Refurbishment scheduled January – October 2023.	~~RED~~ AMBER

	National PDC capital funding approval [ACTIONS OWNER: COO]			Live as decant ward November 2023 – October 2024. Further refurb scheduled November 2024. Live as Acute-Plus ~~January~~ February 2025	
	Radbourne Unit dormitory eradication refurbishment to provide two 17-bed wards with single room en-suite, with additional staffing and new model of care, to complete dormitory eradication in Southern Derbyshire. Service users continue to receive care in non-compliant wards until this refurbishment is completed National PDC capital funding approval [ACTIONS OWNER: COO]	Delivery of approved business case	~~(30.06.23)~~ (30.09.23)	FBC and revenue funding approved by ICS. National PDC capital funding approved by NHSE December 2022. Following Audrey House refurb for decant, Radbourne Ward 32 refurb scheduled November 2023 – January 2025 and live March 2025. Refurb Ward 35 ~~34~~ scheduled January 2025 – March 2026, live April 2026 Significant cost pressure being actioned, contracts split, Ward 32 continuing as planned whilst cost pressure resolved for Ward 35	~~AMBER~~ RED
Lack of an accessible Derbyshire wide Psychiatric Intensive Care Unit (PICU)	Delivery of local PICU arrangements (new build and associated projects taking into account gender considerations) £3.5m national capital agreed November 2022. Derbyshire CDEL flexibility agreed for Trust to fund £10.9m remaining capital from cash reserves 2022/23 and 2023/24. VAT abatement risk £1.7m National PDC capital funding approval [ACTIONS OWNER: COO]	Agreed programme of work with capital funding to support it	~~(30.06.23)~~ (30.09.23)	FBCs approved by ICS in June 2022 for 14-bed male PICU and 8-bed Acute-Plus female facility PICU fully funded by national and Trust capital November 2022. HMRC appeal on VAT abatement claim in process – Capital funding shortfall risk of £1.7m for PICU if appeal unsuccessful. Practical completion expected November 2024, live March 2025. Acute-Plus national PDC capital funding	AMBER

				approved by NHSE December 2022. Refurbishment following decant ward is scheduled November 2024. Live as Acute-Plus February 2025	

Related operational high/extreme risks on the Corporate Risk Register: None

Strategic Objective 1 – To Provide GREAT Care in all Our Services

There is a risk that the Trust's increasing dependence on digital technology for the delivery of care and operations increases the Trust's exposure to the impact of a major outage

Impact: This could lead to the disruption in the provision of services with risk to patient safety

Root causes:

a. Increasing reliance on a single electronic patient record
b. Increasing use of video software for the direct provision of care and operational purposes
c. Increased staff home working
d. Increasing electronic collaboration across health and social care partners
e. Increasing global instability and risk from state supported cyber attacks
f. Increase in locally developed system solutions to support DHCFT and partner operations and performance, i.e., COVID and flu vaccination, health risk assessments

BAF Ref: 23-24 1C	**Director Lead**: Ade Odunlade (COO)	**Responsible Committee**: Finance and Performance Committee

Key Controls

Inherent Risk Rating			**Current Risk Rating**				**Target Risk Rating**			**Risk Appetite**		
Moderate	Likelihood 3	Impact 4	Moderate	Likelihood 3	Impact 4	Direction ⟺	Moderate	Likelihood 2	Impact 4	Accepted	Tolerated	Not Accepted

Preventative – Trust utilises NHS provided solutions as widely as possible, i.e., Office 365, NHS Mail to ensure compliance with mandated requirements. Use of the secure Health and Social Care Network (HSCN) specified by NHS Digital. Staff training on data security and protection. Regular all staff communications regarding safe ways of working and phishing emails. Contract with NHS Arden and Greater East Midlands Commissioning Support Unit provides information governance and security services, includes review of risks and addressing of vulnerabilities. Subscription with NHS Digital Care Certification Programme highlights cyber vulnerabilities and monitors Trust's compliance against them
Detective – Cyber essentials framework: NHS Digital encourage all organisations to comply. Advanced Threat Protection (ATP) monitors every server and device to highlight threats and software vulnerabilities
Directive – Compliance with NHS Digital requirements. Monthly rigor review meeting with NHS Arden and Greater East Midlands Commissioning Support Unit. Security and Protection Policies and Procedures. Business continuity plan and procedure

Assurances on controls (internal)	Positive assurances on controls (external)
IM&T Strategy delivery update to F&P – Annual Embedded programme of software and hardware upgrades Live testing of business continuity plans	Templar Cyber Organisational Readiness Report (CORS) Annual external cyber review by Dynac (vulnerability scan) Data Security and Protection annual review by Internal Audit, weighted toward cyber security Compliance with Data Security and Protection Toolkit, including high levels of training compliance

Key gaps in control	Key actions to close gaps in control	Impact on risk to be measured by	Expected completion date (Action review date)	Progress against action	Action on track
Business continuity plans reflect changes to service delivery such as increased phone and video contacts	All services to review business continuity plans to ensure they take account of the increased use of phone and video contacts for care provision and also use of video conferencing for operational delivery [ACTION OWNER: COO]	Reporting to the Divisional Achievement Reviews (DARs)	~~(30.06.23)~~ (30.09.23)	Due to ongoing industrial action, there has been a delay in progression. The timeline has been reviewed with completion by August 2023 ~~Emergency Planning and Business Continuity Manager is reviewing each business continuity plan to ensure that they are appropriate and consistent. April 2023~~ EPRR Steering Group meeting July to receive update on service's business impact analysis, incorporating the increased use of technology	AMBER

Related operational high/extreme risks on the Corporate Risk Register: None

Strategic Objective 1 - To Provide GREAT Care in all Our Services

There is a risk that the organisation is in breach of essential standards for privacy and dignity in its acute bedded care facility as it has not fully completed its dormitory eradication programme. This may result in regulatory action if mitigation to improve safety does not occur

Impact: May adversely impact on regulatory requirements to provide safe and quality care. Patients' dignity and privacy may be impacted. Enforcement regulatory notices may issued against the Trust that may impact on Trust reputation and restrictions to capitol could be applied.

Root causes:

a) There was commitment across mental health services to eradicate dormitories by 2022 – Although the Trust has active plans for Making Room for Dignity with a fully funded programme, with the building and infrastructure commencing, the Trust has not delivered in the set timeframes
b) Infrastructure does not comply with current standards
c) Outdated approach of delivering mental health care in dormitories does not comply with current guidance
d) Dormitories compromise patient privacy and dignity due to the dormitory layout
e) Dormitories do not comply with Infection, Prevention and Control (IPC) guidance
f) Dormitories could compromise Health and Safety regulations and increase risks, e.g. fire safety
g) Dormitories are not therapeutic spaces to provide mental health care in

BAF Ref: 23-24 1D	**Director Lead**: Carolyn Green (DON) / Ade Odunlade (COO)	**Responsible Committee**: Quality and Safeguarding Committee

Key Controls

Inherent risk rating			Current risk rating				Target risk rating			Risk appetite		
Moderate	Likelihood 3	Impact 4	Moderate	Likelihood 3	Impact 4	Direction ⇔	Moderate	Moderate 3	High 4	Accepted	Tolerated	Not Accepted

Preventative – Screening of each admission considering safety, care and infection control needs supported by the infection control team, health and safety audits; risk assessments; physical health care screening and monitoring; Maintaining environments and cleaning, Director and senior leader visits, Quality Visits. Quality governance structures, teams and processes to identify quality related issues. EQUAL unannounced visits to services and anonymised bright ideas service improvement ideas. Mock inspections
Detective – Quality dashboard reporting; Quality Visit programme/virtual clinical service contact visits; incident, complaints, and risk investigation; Fire Safety Regulations (FSR) compliance checks; mortality review process; physical health care monitoring clinics pilots; safety check log; Head of Nursing and Matron compliance visits, reviewed model of announced and unannounced visits to service throughout the 24 hour period, cleaning schedules and maintenance logs. Compliance to Delivering Same Sex Accommodation requirements
Directive – Trust Strategy and commitments; Quality Improvement Strategy; Physical Health Care Strategy; Safeguarding Strategy; Suicide Reduction Strategy; clinical strategies; policies and procedures available via Trust intranet; Central Alerting System (CAS) alerts; Risk Management Strategy; clinical sub committees of the Quality and Safeguarding Committee, Making room for dignity programme

Board Assurance Framework 2023/24 – Issue 2 Board 5 September 2023

Assurances on controls (internal)	Positive assurances on controls (external)
Quality and Trust dashboards Bed Management processes Scrutiny of Quality Account (pre-submission) by committees Programme of physical healthcare and other clinical audits and associated plans Infection Control Board Assurance Framework reported to NHS England Positive and Safe self-assessment reported to the East Midlands Head of Nursing/Practice and Matron compliance visits Cleaning and maintenance schedules Infection Prevention and Control training Level 1 and 2 Trust targets of 85% compliance	Delivery of Same Sex Accommodation Guidance Safety Thermometer identifies positive position against national benchmark Mental Health Benchmarking data identifies higher than average qualified to unqualified staffing ratio on inpatient wards CQC comprehensive review 2020 Trust is rated Good; two core services rated outstanding, two rated as require improvement Internal audits: Risk management; data security and protection Estates and Facilities Management internal audit (limited assurance) Transitional Monitoring Meetings with CQC (bimonthly), no conditions Patient Safety Incident Response Framework (PSIRF) implementation Safe staffing guidance Monitoring of IPC standards compliance and reporting ICS IPC Team

Key gaps in control	Key actions to close gaps in control	Impact on risk to be measured by	Expected completion date (Action review date)	Progress against action	Action on track
Inpatients care is delivered in wards with dormitories, that compromise on patient dignity, privacy and effective IPC practice	Implement bed management process that ensure that admissions are screened to comply to gender, safety and IPC requirements Ensure that the environments are routinely check by clinicians, estates, and domestic staff Infection Prevention and Control monitoring, and training compliance Effective monitoring of the clinical environments by clinical, estates and domestic staff [ACTIONS OWNERS: DON/COO]	Monitor and report breaches of same sex admission breaches Monitoring of maintenance and cleaning schedules Head of Nursing and Matron environmental walk abouts Infection and Prevention and Control reports and monitoring of infections Individual screening of admissions to appropriate ward environments to ensure gender needs, safety needs and IPC needs are met Provision of other rooms for privacy and confidentiality	31.03.25	Fully funded programme of work in place 'Making Room for Dignity' Construction has started on the new builds in Chesterfield and Derby. The designs have been co-produced with construction experts, clinicians, carers, patients and people with lived experience The new or refurbished environments will require more staff and the recruitment of the staff is now under way with planning phase already started March 2023: Infection Prevention and Control Level 1 compliance is at 90% against a	AMBER

				target of 85%. Infection Prevention and Control Level 2 compliance is at 87% against a target of 85% Head of Nursing and Matron walkabouts are in place and conducted routinely	

Related operational high/extreme risks on the Corporate Risk Register: None

Strategic Objective 2 – To be a GREAT place to work

There is a risk that we are unable to create the right culture with high levels of staff morale

Impact: This could impact on the wellbeing and motivation of our people as well as the quality and effectiveness of the services we provide. This could also impact on our ability to recruit as well as maintain staff, with a potential negative impact on the broader reputation of Derbyshire Healthcare.

Root causes:

a) The changes being made to national terms and conditions and pensions in the current economic climate, create additional pressures for people
b) The staffing and work challenges lead to unhealthy working practices and hours of work
c) The levels and pace of change and transformation are unprecedented
d) The growth of, increasing complexity and sometimes unconnected national and regional ask in the People and Inclusion directorate
e) The level of change and turnover in the Board and senior leadership
f) The cost-of-living crisis is not matched by compensatory solutions in national terms and conditions
g) The capacity of leaders to focus on supporting, engaging and developing people
h) Lack of consistency and expectations of people leaders
i) Lack of strategic development pathway for leaders
~~j) Historic under training and development leaders~~
~~k) No clear development pathway for leaders~~
~~l) Lack of clarity on the leadership role at different levels~~
j. The volatile work environments where staff can be exposed to harm and trauma
k. The delivery of wellbeing, leadership, occupational health and engagement is led at arms-length with delivery through joint arrangements with DCHS and UHDB
l. Legacy team issues exist in areas across the Trust
m. The need to develop cultural competence and confidence that is needed to value and create a sense of belonging for people of all backgrounds, ethnicities and with lived experience
n. The long-term lack of investment in Organisational Development and Equality Diversity and Inclusion (EDI) teams, practices and solutions
o. Historical dual approach to bank staff which leads to differential treatment
p. The potential erosion of benefits and differentiation enjoyed by Trust staff, for example car parking
q. Limited representation of staff within networks and no clear and consistent operating framework

BAF Ref: 23-24 2A	**Director Lead**: Jaki Lowe (DPI)	**Responsible Committee**: People and Culture Committee

Key Controls

Inherent risk rating			Current risk rating				Target risk rating			Risk appetite		
High	Likelihood 4	Impact 4	High	Likelihood 4	Impact 4	Direction ⟺	Moderate	Likelihood 3	Impact 3	Accepted	Tolerated	Not Accepted

Preventative – Freedom to Speak Up Guardian (FTSUG) self-assessment and six monthly reports; annual review of people development plan commissioned through People and Inclusion directorate; provision of information through induction processes for new staff; staff engagement sessions; Equality, Diversity and Inclusion (EDI) Delivery Group meeting; supported networks for diverse staff groups and allies; Health and Well-being Network; workforce planning design meeting; Culture and Leadership Delivery Group
Detective – Quarterly Pulse Checks, FTSUG log and escalations; staff network engagement; WRES, WDES, wellbeing champion network, executive led engagement sessions; non-executive, executive and deputy visits to teams
Directive – Joined Up Care Derbyshire (JUCD) People Strategy, National People Plan; People building blocks and priorities; Strategic people priorities, Communications Strategy, ICS People 5x7 plan

Assurances on controls (internal)	Positive assurances on controls (external)
National staff survey and reporting into board, ELT and divisions Quarterly pulse check and action planning process Staff survey analysis and reporting Exit interview analysis and reporting	Benchmarking in mental health and at system level Outstanding results from 2021 staff survey, identifying significant improvements across all themes

Key gaps in control	Key actions to close gaps in control	Impact on risk to be measured by	Expected completion date (Action review date)	Progress against action	Action on track
Lack of planned leadership development growth and stretch programmes and opportunities including coaching and mentoring	Strategy developed to align to organisational leadership needs Review of system level leadership offer and impact Review and development of Trust leadership offer and impact Re-establish leadership forum Development of coaching access at local, system and national [ACTIONS OWNER: DPI]	Percentage of leaders with development plan as part of objectives Percentage of leaders attending local, system or national leadership programmes	~~(30.06.23)~~ (30.09.23) ~~31.05.23~~ Complete	Deputy Director of People is part of system leadership workstream to review current offer and develop 12-month plan on leadership offer – Draft proposal developed, to be finalised New leadership programme (aimed at band 8B staff) completed Leadership forum revised and first forum took place December 2022 with monthly forums now planned throughout 2023 – January, February and March delayed due to industrial action. First face to face forum will now take place ~~April~~ June 2023	AMBER

				Third cohort of Aspiring-2-Be leadership course launched Second leadership conference planned for October on Just and Restorative Culture for Leaders	
Fully embedded person-centred culture of leadership and management	Review of policies and processes to support a person-centred approach to leadership and management Introduce just and restorative culture approach Review of leadership development offer Re-establish line manager development sessions Scrutiny of people data at divisional level [ACTIONS OWNER: DPI]	Reduced number of formal staff relations issues/cases reported in monthly people assurance report to ELT Staff survey results Reporting to TOOL	~~(30.06.23)~~ (30.09.23)	Just and restorative culture conference taken place Review of cases and case management reported to ELT in October 2022, reports now feeding in bi-monthly with reasons for delays identified ~~continues every six months~~ Deep dive on employment review cases and processes took place at PCC in February 2023 Civility and Respect policy approved, submitted for ratification in April 2023 – Ready for launch System funding secured for Just and Restorative Culture training programme and materials to commence summer 2023	AMBER
No operating framework through which to maximise the impact of staff networks	Collaboratively develop and Implement Staff Network Framework to provide consistency across the networks with clear framework, clarity of roles and objectives to increase engagement with under-represented staff	Engagement and buy-in by network Chairs Sign up to the framework by network Chairs and Executive Directors	~~(30.06.23)~~ (30.09.23)	~~Discussions with network Chairs to progress~~ New executive model implemented in December 2022. Draft framework now developed and engagement	AMBER

	Support to Bi-monthly network Chairs meetings through DPI, Head of EDI and EDI Manager [ACTIONS OWNER: DPI]	Annual updates by network Chairs of engagement undertaken to be included in annual reports		with key stakeholders commenced New EDI steering group established, and meetings commenced Network chair meetings operating and attended by DPI and Head of EDI Staff network conference held May 2023	
The current capacity and structure of the People and Inclusion directorate is not able to meet the Trust, system, regional and national demands alongside challenges from outsourcing key services via People Services in DCHS and UHDB	Review of current People and Inclusion structure to align to needs and priorities of Trust, identify gaps and develop plan to mitigate Review of gaps in services delivered by People Services or UHDB and develop accountability framework Formalise existing governance meetings to ensure clear processes in place for People and Inclusion Services contract and UHDB key service contracts Review of current communications and engagement and people priorities across the Trust and system [ACTIONS OWNER: DPI]	A People and Inclusion structure that can support the Trust to deliver against the people priorities Accountability dashboard presented to ELT quarterly Terms of reference in place and regular meetings A People and Inclusion structure that can support system-wide priorities People and Inclusion staff survey results	~~(30.06.23)~~ (30.09.23)	Contract review meetings established for Occupational Health and Payroll Services (UHDB) New governance structure to be developed to manage the Joint Venture – Early discussions commenced Monthly payroll contract meetings in place - Improvement Manager appointed by UHDB for six months to support contract, data and system standardisation	RED
Lack of maturity of EDI framework	Produce and implement EDI framework with clear legislative, and mandated NHS national regional and local deliverables required for the EDI function and structure to deliver [ACTION OWNER: DPI]	Agree framework and capacity requirements to deliver Regular wider engagement with EDI Delivery Group, and divisional leads taking place Final presentation to PCC	~~(30.06.23)~~ (30.09.23)	Draft framework presented to ELT	AMBER

		Roll out of framework Delivery against the People Performance Dashboard			
We have not engaged with our Bank staff to develop a strong sense of belonging, engagement and psychological contract with the Trust	Regular monthly engagement sessions Staff survey participation Clinical supervision and appraisal participation Alignment to Agenda for Change for pay and conditions [ACTIONS OWNER: DPI]	Staff survey participation response rates Staff survey engagement scores Attendance at engagement sessions	Complete ~~(30.06.23)~~ (30.09.23) ~~(30.06.23)~~ (30.09.23)	Engagement sessions ~~booked virtually for~~ held October, November and December 2022, and ~~face to face session for~~ January 2023 Partaking in first national bank staff survey Aligned all bank staff bands 2, 3, 4 and 7 to Agenda for Change pay scales ~~Started discussions with Staffside to review Bands 5 and 6 current spot rate with view to align to Agenda for Change~~ Band 5/6 bank pay approved for alignment to Agenda for Change Review of bands 2 and 3 roles on bank versus substantive roles and agreement on transition into band 3 with training Review of training competences for bank and agency commenced	GREEN
Lack of visible and differential staff benefits and responsive support for staff that reflects current working conditions, e.g., cost of living crisis	Review of gaps in benefits to realign to staff needs Review of current reward and recognition framework	Staff survey engagement score Staff turnover Pulse check scores	~~(30.06.23)~~ (30.09.23)	Delivering Excellence Every Day awards (DEEDs) ~~have been~~ revised and re-launched	RED

	Develop range of staff benefits that align to Trust values and 'people first' approach Develop the salary sacrifice offer to support colleagues with cost of living crisis [ACTIONS OWNER: DPI]			Staff awards took place November 2022 System-wide discussions commenced with regards a system-wide benefits package Mileage rates adjusted to reflect cost of living crisis National pay award approved and to be awarded in June pay for all Agenda for Change staff Review of lease cars with view to offer a more attractive rate as a retention tool has commenced Learning shared from UHDB survey on what matters most to colleagues when at work Flexible working engagement programme planned to launch July	
Inconsistency in application of an in inclusive approach impact on developing and sustaining a sense of belonging	Embed an inclusive approach, promoting equality and ensuring diversity at all levels through learning and development, Schwartz Rounds, personal development reviews, mid-year reviews, rewards and awards, objective settings [ACTIONS OWNER: DPI]	Year on year change WRES/WDES, staff surveys and lived experience of staff through staff networks Data drawn from all engagement activities so we are able to identify impacts on staff experience and any inequalities that need to be closed	~~(30.06.23)~~ (30.09.23)	Work commenced - Divisional level EDI staff survey data shared with divisions and Divisional People Leads are leading discussions on actions on improvements and achievements	AMBER

Systematic planning and attendance of training	Training to be embedded in e-roster and designed to support safe staffing by minimising face to face sessions needed Progress the breaks and shift pattern change process [ACTIONS OWNER: DPI]	Full compliance with safer staffing levels in line with NHSI Workforce Safeguards Training compliance in line with CQC requirements Staff survey health and wellbeing scores Comprehensive system and trust level health and wellbeing offer Compliance with NHSI workforce safeguards requirements Staff are able to take breaks and access the right health and wellbeing support E-roster team appropriately resourced and supported	~~(30.06.23)~~ (30.09.23)	New reporting processes in place that feeds into TOOL, PCC and Board – Now embedded with triangulation on staffing/agency/bank to be included at PCC Shift and break consultation being planned, to commence early 2023 Training lead meeting regularly with all service managers to review staff training plans Meetings scheduled with neighbouring mental health Trusts to compare training offers and delivery modes	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
22961	Operational Services – management Team	Industrial action	Uncertainty around numbers of staff who would participate in industrial action, December 2022 onwards Weekly Strategy meeting with Managing Directors, Head of Organisational Effectiveness, Assistant Director for Clinical Professional Practice and EPRR Lead. Involvement of Staffside in planning group	28.11.22	31.10.23	EXTREME

Strategic Objective 2 – To be a GREAT place to work

There is a risk that we do not have a diverse workforce with the right number of people with the right skills to support and deliver safe high-quality care

Impact: May lead to reduced staffing levels and skill gaps which impact on safe staffing levels and addressing health inequalities in patient facing services and the ability of our supporting and corporate teams to support front line services

Root causes:

a. There are occupational shortages nationally which mean that the supply of staff is limited
b. There is fierce competition for professions between NHS providers for a limited number of people
c. People want to work more flexibly and a different approach to employment in 'generation z'
d. There is no embedded workforce planning across the NHS informing the supply chain
e. There is no connection between people and finance systems impacting on the ability to do real time effective planning
f. The long-term pandemic response and recovery and resultant pressures for staff has impacted on the attractiveness of careers in the NHS
g. The delivery of people services is led at arms-length through the joint venture with DCHS, with limited direct ability to manage ebbs and flows of demand
h. The transformation plans require the largest scaling of services and therefore workforce growth
i. Workforce models are not in place across the organisation
j. Lack of certainty of the final workforce needs Making Room for Dignity
k. A large proportion of the workforce is within 10 years of possible retirement
l. The demand and usage of bank staff has doubled in the last two years
m. Pressures on workforce development and Continued Professional Development (CPD) funding may risk ability to develop skills and expertise we need
n. Funding pressures not aligned with workforce demand
o. Inherent bias in processes, policy and approach which have led to disparity in the workforce
p. Historic challenges in attracting, retaining and progressing people from diverse backgrounds, with lived experiences and with disabilities into the NHS

BAF Ref: 23-24 2B	**Director Lead**: Jaki Lowe (DPI)	**Responsible Committee**: People and Culture Committee

Key Controls

Inherent risk rating			**Current risk rating**				**Target risk rating**			**Risk appetite**		
High	Likelihood 4	Impact 4	High	Likelihood 4	Impact 4	Direction ⟺	Moderate	Likelihood 3	Impact 4	Accepted	Tolerated	Not Accepted

Preventative – Alliance, system and national Human Resources forums for sharing best practice and risk mitigation, website, workforce plan
Detective – People Performance Report in Tool, ELT and PCC; Bank Improvement Group; Combined Delivery Group with multi-disciplinary team (MDT) input; Medical Staffing Group, Sustainability Meeting; FTSU culture; exit interview process stay interview process
Directive – People building blocks; strategic priorities; 5x7 System People Priorities; JUCD Careers Team; JUCD and People and Inclusion meeting; recruitment policy and procedure; TRAC recruitment system; safe staffing plans

Assurances on controls (internal)	Positive assurances on controls (external)
People Performance Report in Tool, ELT and PCC People Dashboard in PCC PCC forward plan and deep dive plan Workforce plan Embedded recruitment and retention scheme	Healthcare Support Workers (HCSW) submissions System operational planning process Safe staffing report

Key gaps in control	Key actions to close gaps in control	Impact on risk to be measured by	Expected completion date (Action review date)	Progress against action	Action on track
An integrated workforce plan and planning process that feeds into pipeline plans and ensures we have the right people in the right place with the right skills	Develop a Trust Workforce Plan linking demand and capacity, workforce redesign to ensure a fully funded workforce Develop vacancy rate data and breakdown variances in vacancy data Establish a workforce transformation group to develop workforce development plans and ownership at divisional level [ACTIONS OWNER: DPI]	Vacancy rates Time taken to fill vacant posts Transformational posts, e.g. apprenticeships all identified Reduction in agency costs	~~(30.06.23)~~ (30.09.23)	High level Workforce Plan developed and presented to Board Workforce transformation group commenced December 2022 Divisional workforce plans being developed to support 2023/24 workforce plan System workforce conference took place February 2023 with key speakers from DHCFT Workforce summit planned for early July to bring together key clinical and operational leads to review divisional workforce plans and associated actions	RED

We do not have an effective and embedded succession talent management processes	Develop a Talent Management Strategy Pilot career conversations for senior leaders and roll out career conversations for all colleagues Work as a system to develop system-wide approach to talent management and align where best for the Trusts [ACTIONS OWNER: DPI]	Career conversations taking place Internal appointments/promotions Turnover rate Key staff survey measures	~~(30.06.23)~~ (30.09.23)	Talent Strategy finalised Pilot launched for senior leaders in January 2023 – Phase one meetings with each executive taking place Deputy DPI system lead on talent management System appraisal developed to support system movements and talent management Trust talent pilot with senior leaders running up to September, following which data will be calibrated and presented back to ELT	AMBER
Lack of capacity, experience and plans for recruiting overseas	Develop International Recruitment (IR) plan and programme Appoint IR team to lead programme Engage with national IR support Access national IR funding Support Trust teams to prepare for IR arrivals [ACTIONS OWNER: DPI]	Number of IR appointments Retention rate of IR	~~(30.06.23)~~ (30.09.23)	IR pastoral support officer appointed ~~and commenced in post~~ Funding secured for four IRs Regular meetings established with national midlands IR lead System AHP IR bid successful Clinical Educator of IR appointed ~~in process of being recruited to~~ Recruitment and Retention Lead appointed, commencing August – Trust-only post	RED
Onboarding and Retention process and planning needs to be embedded	Understand the key retention issues for posts/teams/professions with the highest turnover	Improvements to turnover Staff survey engagement scores	~~(30.06.23)~~ (30.09.23)	'Stay' survey piloted with Allied Health Professionals and 1-2 year starters	AMBER

	Ensure 'stay conversations' form part of regular 1:1s Develop NHS retention framework for nursing [ACTIONS OWNER: DPI]			New starter survey completed with all started in six months and learning shared at Trust and divisional level Nursing retention framework self-assessment completed System retention lead appointed to support Trust level and system work Recruitment and Retention Lead appointed to lead on retention Trust-wide	
Medical staffing team and role not sufficiently developed Workforce plan for medical staff not in place	Review existing medical staffing team and workforce support and identify gaps Develop new model to support and maximise the medical workforce Develop medical agency model to ensure efficient usage Develop a medical staff workforce plan [ACTIONS OWNER: DPI]	Engagement of medical workforce Reduction in agency spend	Complete ~~(30.06.23)~~ (30.09.23)	Terms of reference agreed by MD and COO for review of existing medical staffing team and creation of a medical workforce plan Resources identified and funding agreed for the review by ELT First medical staffing workshop completed March 2023 Further discussions held as part of the agency summit – Agreed action to support agency reduction	AMBER

Lack of culturally competent recruitment processes	Completion and implementation of recommendations of the Above Difference recruitment and retention system pilot Wider engagement with recruiting managers, staff networks, clinical leads and operational leads Quartile monitoring of utilisation of Above Difference recruitment and retention tools Continuous improvement approach to implementing learning [ACTIONS OWNER: DPI]	WRES and WDES data shows year on year improvement, staff survey and lived experience of staff Increase the proportion of applications from ethnic minority groups, increase likelihood of shortlisting and reduce disparity in all areas	~~(30.06.23)~~ (30.09.23)	Recruitment leads across the system all trained through Above Difference programme Pilot nearing completion with six workstreams completing key learning to be shared at future system human resources meeting to agree actions and programme management to move forward at pace Examples of innovation already being trialled such as one page job description being piloted by two teams	RED
Effectiveness of recruitment policy, practice and processes	Review and develop existing recruitment Key Performance Indicators (KPIs) to ensure fit for purpose Where appropriate move away from TRAC to advertise jobs and use fast track processes, e.g. Indeed/MSforms Develop cohort recruitment for key posts Improve the multidisciplinary working (HR, communications and recruiting managers) to enable better planned and executed campaigns [ACTIONS OWNER: DPI]	Time to recruit Number of applicants applying and successfully shortlisted Campaign impact and reach Financial savings through cohort recruitment	~~(30.06.23)~~ (30.09.23)	KPI review commenced Indeed piloted for hard to fill posts in acute Cohort recruitment successfully piloted for Health Care Assistants and Human Resources apprenticeships System recruitment post approved with funding to pilot a cohort recruitment approach including writing inclusive adverts and job descriptions Trust Strategic Recruitment and Retention Lead appointed	AMBER

Related operational high/extreme risks on the Corporate Risk Register: None

Strategic Objective 3 – To Make BEST use of Our Resources

There is a risk that the Trust fails to deliver its revenue and capital financial plans

Impact: Trust becomes financially unsustainable

Root causes:

a) Financial detriment (revenue, cash and/or capital) resulting from large capital development programme, in particular dormitory eradication and associated capital schemes
~~b)~~ Organisational financial detriment created by commissioning decisions or wider 'system-first' decisions including enactment of risk-sharing agreement in partnership arrangements or changes in NHS financial arrangements. System financial position resulting in required additional financial savings to support the System position from Mental Health funds
c) Non-delivery of expected financial benefits from transformational activities
d) Non-delivery of required levels of efficiency improvement
e) Lack of sufficient cash and working capital
f) Loss due to material fraud or criminal activity
g) Unexpected income loss or non-receipt of expected transformation income (e.g. long-term plan (LTP) and Mental Health Investment Standard (MHIS) without removal of associated costs
h) Costs to deliver services exceed the Trust financial resources available
i) Lack of cultural shift/behaviours to return to financial cost control regime
j) Inability to reduce temporary staffing expenditure

BAF Ref: 23-24 3A	**Director Lead**: Rachel Leyland (DOF - Interim)	**Responsible Committee**: Finance and Performance Committee

Key Controls

Inherent Risk Rating			Current Risk Rating				Target Risk Rating			Risk Appetite		
Moderate	Likelihood 2	Impact 5	Extreme	Likelihood 4	Impact 5	Direction ↑	Moderate	Likelihood 2	Impact 5	Accepted	Tolerated	Not Accepted

Preventative – Integrated Care System (ICS) signed off and fully support the dormitory eradication programme. Devoted and adequate team for Programme delivery. High quality business cases. Regular meetings with NHSE 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 efficiency / QI delivery; contract performance, local counter fraud scrutiny

Directive – Business plans and templates set out clear financial plans and assumptions: Standing financial instructions; Treasury management procedures, budget control, delegated limits, recruitment approval processes; business case approval process; invest to save/Quality Improvement methodology and protocol and Plan Do Study Act. Risk and gain share agreements, Local Operating Procedure for Acute Capital Programme

Assurances on controls (internal)	Positive assurances on controls (external)
Dormitory eradication and PICU Programme monitoring and reporting. Urgent decision-making taking place and relevant meetings in place Appropriate monitoring and reporting of financial delivery – Trust overall and programme-specific including 'Use of Resources' reporting updates Assurance levels gained at Finance and Performance Committee Delivery of Counter fraud and audit work programme with completed and embedded actions for all recommendations Independent assurance via internal auditors including HFMA checklist, external auditors and counter fraud specialist that the figures reported are valid and systems and processes for financial governance are adequate Local Operating Procedure in operation for Acute Capital Programme Board and F&P oversight of Acute Capital Programme delivery	NHSE feedback throughout progress of dormitory eradication Programme and business cases in programme Systems Finance and Estates Committee/System Project Management Office/system DOF meetings etc. Internal Audits – Financial integrity and key financial systems audits External Audits – Strong record of high-quality statutory reporting with unqualified opinion National Fraud Initiative – No areas of concern Local Counter fraud work – Referrals show good counter fraud awareness and reporting in Trust and no material losses have been incurred. Use of risk-based activity in new counter fraud standards Information Toolkit rating – Evidencing strong cyber risk management (ref fraud/criminal financial risk) Programme Director, Senior Responsible Officer completed NHS Better Business Case Training

Key gaps in control	Key actions to close gaps in control	Impact on risk to be measured by	Expected completion date (Action review date)	Progress against action	Action on track
Trust cash and capital risks related to national funded acute capital programme: - Inflation cost risk - Risk-share - Cashflow timings and variability - VAT abatement appeal unsuccessful	Risk share arrangements with PSCP Programme approach and engagement with all stakeholders. Close involvement with NHSE VAT abatement appeal in progress [ACTIONS OWNER: DOF]	Cash and capital reporting and forecasting evidence of plan delivery and/or indicates areas of required management action	31.03.24	Regular oversight of capital and cash position. Reporting to Trust Programme meetings and Committees on risks and mitigations Hyper-inflation cost risk remains is very high due to world events and economy	AMBER

- Guaranteed Maximum Price exceeds national funding envelope (due to hyperinflation and other factors)				National PDC capital funding approved by NHSE for two new builds and three refurbishment schemes, plus PICU year 1 Hyperinflation still affecting sub-contractor costs with significant cost pressures on Radbourne Unit Refurb and Older Adults ward refurb requiring ongoing action HMRC appeal on VAT abatement claim in process – Combined capital funding shortfall risk of £12.4~~10.7m~~ if appeal unsuccessful	
System capital programme funding shortfall for self-funded Trust capital programme: System Capital Departmental Expenditure Limit (CDEL) inadequacy for system capital requirements	System capital draft planning assumes the final year of the self-funded element of the PICU build through system CDEL / Trust cash reserves VAT abatement appeal in progress Access any new national funding streams in year to maximise system capital plan in order to redirect CDEL capital for other schemes [ACTIONS OWNER: DOF]	Ongoing reporting will ascertain how and when the shortfall can be bridged by additional capital sources	31.03.24	System capital plan has been submitted as part of planning process ~~being finalised but~~ and will be limited to high priority schemes and includes two new builds and year 2 of PICU from system CDEL	AMBER
Additional revenue ~~not~~ related to new builds, refurbishments and PICU not fully funded by System	Close partnership working with ICB and System partners. National funding for PDC revenue costs included in allocations for 2023/24 plan Early recruitment to staffing built into revenue plan of the Trust and funded by the system (both income and expenditure in the plan) [ACTIONS OWNER: DOF]	Monitoring and reporting of income allocations and expenditure in year	31.03.24	~~ICB and DCHS partners contributing to OBC/FBC development~~ Funding for PDC revenue from NHSE included in financial plan submission. Funding for early recruitment costs from ICB allocations included in the financial plan submission MHLDA DB agreed to oversee revenue delivery contained within programme spend	AMBER

Insufficient substantive staffing into vacancies and temporary staffing costs for bank and agency staff do not reduce	Additional management action and oversight [ACTION OWNER: DOF]	Enhanced bank and agency costs reported as part of wider financial and workforce reporting	31.03.24	Reports to ELT and F&P outlining current areas of pressure and required actions to be taken as part of the financial planning decision making process ~~Quality Improvement (QI) process started and agency summit to be convened~~ Agency summit has taken place with agreed actions for medical and non-medical agency workstreams. Funding contribution agreed with Eating Disorder Provider Collaborative for exceptional agency costs	RED
Non-delivery of required recurrent cost reduction and improved efficiency and Quality Improvement	Compilation and delivery of planned Trust efficiencies and quality improvements to deliver 2023/24 plan including recurrent long term cost reductions to return to breakeven Planning for 2023/24 assumes 3% recurrent delivery and 1% non-recurrent delivery ~~(this is subject to further review and planning decisions)~~ [ACTIONS OWNER: DOF]	Efficiency and QI reporting to Execs and F&P	31.03.24	Limited schemes identified at time of draft plan submissions. Schemes now identified to deliver £8.7m in full. Work is on-going to finalise PIDs and EQIAs. Some schemes are delivering at month 2 ~~Area of urgent work as reported to ELT in order to identify full £8.7m requirement. Area of urgent work following discussions with F&P committee on reducing the current planned deficit position and F&P has closed the gap and schemes have been identified for the full £6m~~	RED
Financial cost pressures created both internally and by system first decisions leading to the requirement for mitigations to close both the internal gap and the system financial gap	Additional 'stretch' management action required to reduce other cost and mitigate impact to achieve overall financial position [ACTION OWNER: DOF]	Achievement is incorporated into most likely case forecast reported to ELT, F&P, and system reporting Business cases to go through ELT before any financial commitments are made, ensuring good governance process are followed	31.03.24	The financial position for Derbyshire is a risk to the statutory duties for DHCFT to manage its financial position Financial plan for 2023/24 ~~is being~~ finalised. Plan assumes a level of inflationary cost uplift in line with national guidance	RED

				Financial sustainability plan developed All new investments to follow governance processes with business cases to ELT	

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
23067	Corporate - Finance	The Trust fails to deliver its revenue and capital plans	Financial detriment resulting from: - Large capital development programme - Commissioning decisions, including tender processes or wider system first decisions - Non-delivery of transformational and efficiency schemes - Loss of income and required service developments - Costs to deliver services exceed income System agreements in place to support revenue and capital funding for new builds and capital funding secured from DHSC Oversight and monitoring through ELT, F&P Committee and Trust Board Internal and external audits, Counter Fraud programme Efficiency and transformation programme monitoring and escalation process in place Cost controls and governance processes in place	21.06.23	01.09.23	EXTREME

Strategic Objective 4 - To be a GREAT Partner

Principal risk: Whilst there are significant benefits from the creation of the Integrated Care System (ICS) as an NHS body, there is a risk that the effects of the change may impact negatively on the cohesiveness of the Derbyshire health and care system

Impact: Financial position of the Derbyshire Health and Care system worsens; working relationships across the system deteriorates; loss of confidence from regulators in the Derbyshire system

Root causes:

a) New senior management relationships across organisations, with potential new appointments in system leadership roles with the creation of the new ICS as an NHS body and the creation of provider collaboratives
b) Creation of mental health, learning disability and autism provider collaborative may destabilise some of the established relationships in place across Derbyshire
c) Creation of system level governance structures may impact on provider Foundation Trust governance arrangements and decision-making processes
d) ICB staff impacted by change, may lead to increased staff turnover in teams supporting the delivery of the Mental Health Long-Term Plan and subsequent loss of organisational memory
e) The Trust taking on additional lead-provider responsibilities at an ICS or regional level could impact on the quality, performance and financial risks faced by the organisation

BAF Ref: 23-24 4A	**Director Lead**: Vikki Ashton Taylor (DSPT)	**Responsible Committee**: Trust Board

Key Controls

Inherent Risk Rating			**Current Risk Rating**				**Target Risk Rating**			**Risk Appetite**		
High	Likelihood 4	Impact 4	Moderate	Likelihood 3	Impact 3	Direction ↓	Moderate	Likelihood 3	Impact 4	Accepted	Tolerated	Not Accepted

Preventative – Governance structures in place at a system and Delivery Board level. Ongoing close communication with NHSE/I, mental health and learning disability teams at a regional and national level. Assumed NHSE/I-led appointment process to new ICS Board positions
Detective – Early meetings to be put in place with all new appointees at an executive level. Continuing engagement in all Joined up Care Derbyshire governance from DHCFT representatives. Due diligence processes undertaken prior to accepting any lead provider responsibilities
Directive – Mental Health, Learning Disability and Autism System Delivery Board to engage widely across membership on the development of any provider collaborative with agreed plans and processes. Gateway process run by NHSE prior to agreement to establish the Trust as lead-provider in any regional collaborative

Board Assurance Framework 2023/24 – Issue 2 Board 5 September 2023

Assurances on controls (internal)	Positive assurances on controls (external)
Regular reporting of position to Board by CEO Regular ELT updates and discussions NED Board members on JUCD committees and Board Board agreement required prior to undertaking of lead-provider responsibilities	Monthly Mental Health and Learning Disability assurance meetings with NHSE/I teams with DHCFT represented by DSPT Appointments/ assurance of new ICS Board (ICB) through NHSE/I processes Gateway process run by NHSE prior to agreement to establish a Trust as lead-provider in regional collaboratives

Key gaps in control	Key actions to close gaps in control	Impact on risk to be measured by	Expected completion date (Action review date)	Progress against action	Action on track
~~Maintenance of relationships with ICB colleagues during period of change and potential instability~~	~~Weekly meetings of wider MHLD system transformation team. Support and guidance provided from DHCFT~~ ~~Early meetings at DHCFT Board level with all new appointees into the ICB [ACTIONS OWNER: DSPT]~~	~~Staff turnover from wider transformational team, including ICB staff~~ ~~Positive working relationships formed with all new appointees in the Derbyshire system~~	~~(30.06.23)~~	~~Weekly meetings continuing~~ ~~ICB now formed and fully recruited to and great effort is being made on maintaining strong working relationships. However, there remains a potential risk around evolving ICB culture and required reductions in staffing numbers~~ ~~ICB governance and emerging provider collaborative governance in place~~	~~GREEN~~ BLUE
Plan required for the development of the MHLDA DB to become a provider alliance	Plan to be developed in partnership with all other organisations in the alliance [ACTION OWNER: DSPT~~CEO~~]	~~Development and agreement of Mental Health, Learning Disability and Autism (MHLDA) Provider Alliance before December 2021~~ Establish the Derby and Derbyshire MHLDA provider alliance	~~(30.06.23)~~ (30.09.23)	All Boards in the Derbyshire system ~~have~~ agreed their support for the direction of travel for a single provider collaborative across the system, sitting below that it is explicit that there will be a MHLDA Provider Alliance	GREEN

				MHLDA Provider Alliance formally established partnership agreement The JUCD Neurodiversity and LD Alliance Festival was formally launched in September 2022	
Increased decision-making at a system and/or provider alliance level may create conflicting accountabilities with the Trust-level governance structures which could result in an increased governance burden	Keep Trust structures under continuous review against the wider governance landscape, including the provider collaboratives and alliance arrangements – This in turn may lead to a formal change of DHCFT governance arrangements [ACTION OWNERS: CEO/Trust Secretary]	Board level confidence in new and emerging governance structures and ability to gain assurance on DHCFT risks and issues via system level governance regime	(31.12.23)	Ongoing review of Trust governance to ensure operational performance delivery of MHLDA constitutional standards that DHCFT is a lead or main provider of the performance. DHCFT CEO is a member of ICB Derbyshire Provider Collaborative Leadership Board have an agreed work programme as approved by ICB	AMBER

Related operational high/extreme risks on the Corporate Risk Register: None

Strategic Objective 4 - To be a GREAT partner

There is a risk of reputational damage if the Trust is not viewed as a strong partner

Impact:
May lead to poor experience and care for people accessing services within Place and communities

Root causes:

a) Organisation historically too internally focused - Provider responsibilities impacting on executives' capacity
b) Not actively engaging enough as part of a broader multi-agency partnership at Place and community level
c) Increasing national expectations in provider collaboration and multi-disciplinary delivery model at Place level

BAF Ref: 23-24 4B	**Director Lead**: Vikki Ashton Taylor (DSPT)	**Responsible Committee**: Trust Board

Key Controls

Inherent risk rating			**Current risk rating**				**Target risk rating**			**Risk appetite**		
High	Likelihood 4	Impact 4	High	Likelihood 4	Impact 4	Direction ⟺	Moderate	Likelihood 3	Impact 3	Accepted	Tolerated	Not Accepted

Preventative – Active membership in each Local Place Alliance; Active participation in Place Executive; Regular meetings with NHSE on programme progress; Meaningful stakeholder engagement (internal and external); Multi-disciplinary and cross organisational development and implementation of services
Detective – Quality Improvement (QI) delivery; Contract performance; Continuing engagement in all Joined up Care Derbyshire governance from DHCFT representatives
Directive – Integrated Care Strategy; Joint Forward Plan (JFP); Trust Strategy

Assurances on controls (internal)	**Positive assurances on controls (external)**
Appointment to Managing Director roles Regular TOOL and ELT updates and discussions NED Board members on JUCD committees CEO on ICB	Monthly Mental Health and Learning Disability assurance meetings with NHSE Monthly reporting by County and City Places to JUCD Place Executive Patient surveys conducted by Healthwatch

Key gaps in control	Key actions to close gaps in control	Impact on risk to be measured by	Expected completion date (Action review date)	Progress against action	Action on track
System partners report that some of its core constitutional targets were not being met and was failing to make progress, at pace and scale	New internal performance improvement group and clarity to Trust Board on which DHCFT constitutional standards are not being met and whether the DHCFT contribution is the lead or material and how performance will improve Recovery action plans for areas where constitutional standards are not being met [ACTIONS OWNERS: COO/DSPT]	Improvement in performance in constitutional standards Recovery action plans in place in all required areas	(31.03.24)	The integrated Performance report has been to allow insight on key areas of improvement, for targeted actions and narrative around next steps. CQUIN, and Real World Health insights have been added to track on a monthly basis to ensure we improve performance and patient outcomes ~~Recovery action plans underpinned by quality improvement (QI) methodology, developed for constitutional standards where DHCFT are non-compliant – Positive outcomes are already apparent, e.g., CMHT 2+ contacts~~ ~~Transforming care (LD & A patients) remains off trajectory and has a full recovery plan~~ Once developed, dashboard to measure compliance with constitutional standards to be reviewed monthly at TOOL / Productivity Board. This will support measuring performance for subsequent RAP plans to be developed for areas requiring improvement	RED

System partners report that DHCFT is inward looking and does not fully support PLACE developments	Managing Directors to design a communication and improvement plan, with 360 feedback that PLACE partners feel DHCFT support, data is provided and their support named Managing Director is accessible [ACTION OWNER: COO]	PLACE / PCN and GP Directors provide direct feedback to Managing Directors on their relationship, knowledge and impact of the additional leadership support. This includes examples of collaboration and the impact of this support Confirmation of frequency of contact, joint action / achievement log of issues raised and achieved Managing Directors reports to TOOL with summary of impact to ELT	~~(30.06.23)~~ (30.09.23)	Managing Directors (MDs) actively engaging with Primary Care Networks (PCNs) MDs are now members of Derby City PLACE Board and PLACE County Partnership Board ~~equivalent County Board~~ Executive Directors are members of Integrated Place Executive. Senior management representation named for all PLACE Alliance groups. City and County partnership board are currently developing purpose which MDs are actively involved in. MDs are also linking in with local GP forums within the City and County CEO meeting with GP network monthly – Positive feedback on attitude and responsiveness	~~RED~~ GREEN
Social care partners have reported that the lack of progress on autism diagnostic reductions is difficult and would like to see increased pace of improvements	Improvement plan for joint autism service [ACTION OWNER: COO]	Feedback from social care on awareness of the Autism Strategy and autism waiting times reduce across the interagency investment plan	(31.12.23)	Autism investment plan agreed within MHLDA spend in 2023. Autism waiting times have now been achieved for the 26 contracted assessments per month and we are on target to achieve for Quarter 1 2023. Work continues to improve capacity to sustain compliance	AMBER
GP networks and partners report they do not feel connected to the MHLDA DB and are not aware of strategic decisions that are made	Communication and engagement plan with GP networks [ACTION OWNER: DSPT]	Feedback form GP networks on connectivity to the MHLDA DB and DHCFT named leads, information supplied	~~(30.06.23)~~ (30.09.23)	MD membership in PLACE Alliance Boards agreed in January Monthly GP and DHCFT engagement events	~~AMBER~~ GREEN

		GP networks reflect that they are briefed and actively engaged		established to receive feedback and answer any strategic or system questions on DHCFT and the MHLDA DB Collaborative working with PCNs to appoint to mental health practitioners as part of the additional roles reimbursement scheme (ARRS) roles	
Police partners report they do not always feel supported by mental health services and are under pressure to respond to mental health crisis	Police Education, support, communication and improvement plan with MH Delivery Board and Trust Directors [ACTION OWNERS: DSPT/CEO]	Inter-agency meeting and review of a joint way forward in 2023 including • Police Training • Suicide prevention work • Joint co-produced outcomes Agreed outcomes are monitored and reported through the MHLDA DB with liaison with DHCFT Police Liaison group	(30.06.23) (30.09.23)	Police now a formal member of the MHLDA DB and attending and contributing New national guidance in draft and collaborative approaches including staffing of 136 suites included in programme level investment Street triage pilot established between Police and Trust	AMBER
Patient and carers groups report that they would like to see more progress in service user and carer involvement and moving from engagement to decision making	Peer support strategy and objectives for EQUAL and the Mental Health Engagement Group [ACTION OWNERS: DON/MD/CEO]	Peer support strategy Co-production in Patient and Carer Race Equality Framework (PCREF) requirements	(30.06.23) (30.09.23)	EQUAL group established to support service user and carer engagement. EQUAL has created several sub committees and informs future service improvements across the East Midlands Perinatal Mental Health Provider Collaborative	AMBER

Related operational high/extreme risks on the Corporate Risk Register: None

PART TWO – SYSTEM BASED RISK IMPACTING ON AND MITIGATED BY MULTIPLE SYSTEM ORGANISATIONS

Multiple System Strategic Risk		
There is a risk to safe, effective clinical care across Derbyshire impacting upon patients, due to not achieving national standards and variation of clinical practice and service commissioning in the Learning Disability (LD) Transforming Care Partnership and in ICS in-patient LD bedded care **Impact:** May lead to avoidable harm and delays in accessing appropriate services, affecting patients, their family members and staff **Root causes:** a) The community Intensive Support Team and Learning Disability models have non-standardised operating models and require more capacity b) Currently the delivery and commissioning partnership in Derbyshire have not met national standards or local ambitions for more robust community-based offers, working across the geography and in an integrated way with partners including social care and the voluntary sector c) The collective vision for Learning Disability services across Derbyshire and the formal outcome to achieve repatriation to Derbyshire has not been effective with some people remaining in outsourced areas of England for extended and significant periods of time d) Inpatient bedded facilities do not meet safer staffing levels due to substantial vacancies e) Derbyshire bedded facilities do not meet current standards, e.g., en-suite accommodation, safety and environmental standards and the seclusion room does not meet the required standards as outlined in the Mental Health Act Code of Practice. (The CQC did note the lack of appropriate provisions in the seclusion room available in 2016 but this was not noted as a requirement notice) f) The current LD bedded care facilities do not meet the national specifications for the Royal College of Psychiatrists Learning Disability recommended standards and are not in line with future clinical model for the LD&A pathway for Derbyshire g) Gaps in controls – Derbyshire bedded care facilities for LD services had not had a full CQC inspection since 2016 as a core service. There may have been a drift in scrutiny connected to inspection h) Health inequalities across our Derbyshire footprint – Initial insights show gaps in access to service, case load and worsening patient outcomes		
BAF Ref: 23-24 MS1	**Director Lead**: Ade Odunlade (COO)	**Responsible Committee**: Quality and Safeguarding Committee within DHCFT Quality and Performance Committee within the Derbyshire ICS Mental health, LD and Autism Board in terms of system operational delivery

Board Assurance Framework 2023/24 – Issue 2 Board 5 September 2023

Key Controls												
Inherent Risk Rating			**Current Risk Rating**				**Target Risk Rating**			**Risk Appetite**		
High	Likelihood 4	Impact 4	High	Likelihood 4	Impact 4	Direction ⬌	Moderate	Likelihood 3	Impact 3	Accepted	Tolerated	Not Accepted

Preventative – Health and safety audits; risk assessments; investment in estates development; workforce plan covering recruitment and retention. Mental Health Act Code of Practice
Detective – CQC inspection reports; quality visit programme/virtual clinical service contact visits; incident, complaints and risk investigations; safety check log; Head of Nursing and Matron compliance visits
Directive – Trust Strategy and commitments; Quality Improvement Strategy; Physical Health Care Strategy; Safeguarding Strategy; policies and procedures available via Trust intranet

Assurances on controls (internal)	Positive assurances on controls (external)
Regional and national escalation process internal preparation	Advisory support provided by DHCFT to the system on bedded care standards for Learning Disability in-patient services Involvement of Local Government Association to deliver a peer review Involvement of external consultants – Two reports

Key gaps in control	Key actions to close gaps in control	Impact on risk to be measured by	Expected completion date (Action review date)	Summary of progress on action	Action on track
The community Intensive Support Team and Learning Disability models require improved models of support	Review all models of support offered by the Intensive Support Team [ACTION OWNERS: COO/DON/MD]	Outcome of review – Improved models of support	~~(30.06.23)~~ (30.09.23)	Review outcome: Services brought together across the North and South under a single service manager. Establishment of a DHCFT Productivity Programme Board and an operational delivery review are underway. Clinical delivery audit is also underway supported by NHSE/I to further understand wicked issues	RED

				Patient flow review via MADE events underway as Learning Disability beds are occupied by patients who are clinically fit for discharge	
Improvements are required in rapidly returning patients who access Learning Disabilities and Autism (LD&A) services to local care to enable them to live their lives in the least restrictive manner as close to home as possible	Continue to work on developed delivery improvement plan, owned by system partners, to improve position. This includes new cohort stratification approach that has been developed – key action to implement and fully embed approach to ensure focussed system action on existing inpatients who are place inappropriately and out of area [ACTION OWNER: COO]	Improvement plans developed and implemented resulting in a stabilised service and positive outcomes for patients working across partner systems Enhancing and reviewing Listening and Engagement Active Partnerships (LEAP) procedures Improvement plans in admission avoidance, crisis alternatives to admission and market stimulation and development, including improvement in the use of Dynamic Support Registers as a means of admission avoidance Make significant impacts on the number of stranded patients who have delayed discharges in units across the country resulting in the NHSE escalations	~~(30.06.23)~~ (30.09.23)	Full cross-system delivery plan developed and being actively driven and monitored by revised Neurodevelopmental Delivery Board Benefits realisation sessions took place in September 2022 – Attended by all system partners. Nine themed benefits for the neurodevelopmental programme identified – Submitted to align future reporting Review of ways of working for Intensive Support Team undertaken to address variation in service offer Full integrated operational pathway mapping workshops with all system partners completed with ~~and~~ action plan to meet fidelity of optimal pathway Coproduction workshops completed with service users, families and carers to shape delivery plan	RED

				Improved oversight is in place but significant improvement in performance and outcome is required in returning complex individuals with learning difficulties/autism and risks. Derbyshire ICS remain an outlier	
Current substantial staff vacancies are negatively impacting on safer staffing levels in a non-DHCFT Derbyshire bedded care facility	Compliance with NHS Improvement (NHSI) Workforce Safeguards requirements [ACTIONS OWNERS: COO/DON]	Full compliance with safer staffing levels in line with the NHSI Workforce Safeguards	~~(30.06.23)~~ (30.09.23)	Reviews of safer staffing and stabilisation in non-DHCFT Derbyshire bedded LD facility - Part stabilisation achieved Workforce issues including recruitment and retention, staff wellbeing and mitigations against use of agency staff considered. Ongoing commitment to working in an alliance with DCHS to support a resolution for future bedded care for LD&A services across Derbyshire	AMBER
Clinical care standards in a non-DHCFT Derbyshire bedded care facility including care plans, levels of incidents, restrictive practices including the use of long-term segregation are not compliant with clinical care standards	Develop an improvement plan for all Derbyshire in-patient LD&A services [ACTION OWNERS: COO/DON]	Full compliance with required care standards External review of Long-Term Segregation and review to end restrictive practices	~~(30.06.23)~~ (30.09.23)	External review of Long-Term Segregation and review to end restrictive practices complete Ward recruitment and management responsibility has returned to DCHS, they are considering their model on the unit. DHCFT General Manager supporting	RED

				The Trust is working with JUCD on a strategic outline case for the future of bedded care for LD&A in Derbyshire Some improvements in clinical standards Care plan work continues Strategic Outline Case for the future of bedded care for LD&A in Derbyshire cleared at System Delivery Board to take into Outline Business Case – Work ongoing	
Lack of adherence to national guidance and policy on in-patient care in a non-DHCFT Derbyshire bedded care facility	Deliver a single room en-suite delivery plan and programme of work [ACTION OWNER: COO/DON]	Delivery of approved business cases for development of single en-suite facilities, seclusion suite at specification standards and other improving the therapeutic and healing environment requirements Implementation of programme of work	~~(30.06.23)~~ (30.09.23)	Initial review and development of business plan to be undertaken by other provider Work to provide facilities that meet national standards to be completed – Expected completion date to be confirmed	AMBER

Related operational high/extreme risks on the Corporate Risk Register: None

Board Assurance Framework 2023/24 – Issue 2 Board 5 September 2023

Risk Rating
The full Risk Matrix, including descriptors, is shown in the Trust's Risk Management Strategy

RISK ASSESSMENT MATRIX					
The Risk Score is a multiplication of Consequence Rating X Likelihood Rating					
The Risk Grade is the colour determined from the Risk Assessment Matrix					
	CONSEQUENCE				
LIKELIHOOD	INSIGNIFICANT 1	MINOR 2	MODERATE 3	MAJOR 4	CATASTROPHIC 5
RARE 1	1	2	3	4	5
UNLIKEY 2	2	4	6	8	10
POSSIBLE 3	3	6	9	12	15
LIKELY 4	4	8	12	16	20
ALMOST CERTAIN 5	5	10	15	20	25

Risk Grade/Incident Potential
Extreme Risk
High Risk
Moderate Risk
Low Risk
Very Low Risk

Actions on Track for Delivery Against Gaps in Controls and Assurances	Colour Rating
Action completed	Blue
Action on track to completion within proposed timeframe	Green
Action implemented in part with potential risks to meeting proposed timeframe	Amber
Action not completed to original or formally agreed revised timeframe. Revised plan of action required	Red

Action Owners

CEO	Chief Executive Officer
DOF	Director of Finance – Currently Interim
MD	Medical Director
DSPT	Director of Strategy, Partnerships and Transformation
COO	Chief Operating Officer
DON	Director of Nursing and Patient Experience – Currently Interim
DPI	Director of People and Inclusion

Definitions

Preventative	A control that limits the possibility of an undesirable outcome
Detective	A control that identifies errors after the event
Directive	A control designed to cause or encourage a desirable event to occur
Corrective	A control to limit the scope for loss and reduce the extent of undesirable outcomes

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 5 September 2023

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

Purpose of Report

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

Executive Summary

This FTSU report to Board sets out the number of cases and FTSU themes raised in the last six months from January to June 2023 at Derbyshire Healthcare NHS Foundation Trust (DHCFT).

Total case numbers (72 cases) seen in this report to Board for the period are a slight decrease on the 76 cases reported in the March 2023 FTSU report to Board for the period July to December 2022.

Emerging, or ongoing, themes include:

- **Culture/Worker Safety and Wellbeing:** colleagues have spoken up about the quality of leadership on a ward and the impact on their wellbeing.

- **Discrimination:** some concerns in relation to a potential lack of inclusion and discrimination for BME colleagues in a few areas of the Trust including concerns from a student nurse.

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

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

Strategic Considerations	
1) We will deliver **great care** by delivering compassionate, person-centred innovative and safe care.	x
2) We will ensure that the Trust is a **great place to work** by creating a compassionate, skilled and empowered leadership, creating a vibrant culture where colleagues feel they belong, thrive and are valued.	x

3) The Trust is a **great partner** and actively embraces collaboration as our way of working.	x
4) We will make the **best use of resources** by making financially wise decisions and avoiding wasting resources to ensure financial recovery and long-term sustainability.	

Risks and Assurances

Reporting on speaking up is presented to the Trust Board and the Audit and Risk Committee (ARC) every six months to provide assurance on progress made. The People and Culture Committee (PCC) also receive FTSU information as part of the wider staff feedback dashboard.

The Board will be completing the Freedom to Speak Up Reflection and Planning Tool in October 2023. The Reflection and Planning Tool creates a benchmark and assurance that works to promote and respond to how speaking up at work is progressing. The Audit and Risk Committee continues to monitor the progress of the FTSU action plan.

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

Consultation

Executive Leadership Team.

Governance or Legal Issues

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

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 joint working of the EDI team and FTSUG supports future ways of working to support BME staff to raise concerns.
- Any FTSU concerns logged around discrimination from BME staff with protected characteristics provide assurance that these issues are supported

by employee relations/HR processes; and that any wider issues are being considered by senior Trust leadership.

- This report highlights some areas of good practice including having FTSU Champions from a diverse range of backgrounds, as well as increased numbers of BME colleagues speaking up. This level of engagement is felt to be partly responsible for colleagues from BME communities contacting the Guardian.

Recommendations

The Board of Directors is requested to:

1. Support the current mechanisms and activities in place for raising awareness of the FTSU agenda.
2. Discuss the report and determine whether it sufficiently assures the Board of the FTSU agenda at the Trust and that those proposals made by the FTSUG promote a culture of open and honest communication to support staff to speak up.
3. Engage with the process and completion of the FTSU Reflection and Planning Tool and the FTSU strategy consultation.

Report presented by: **Tamera Howard**
Freedom to Speak Up Guardian

Report prepared by: **Tamera Howard**
Freedom to Speak Up Guardian

Derbyshire Healthcare NHS Foundation Trust
Public Trust Board – 5th September 2023
Freedom to Speak Up Report

1. Introduction

1.1 The Freedom to Speak Up Guardian (FTSUG) is part of a culture of speaking up and acts to enable patient safety concerns to be identified and addressed at an early stage. Freedom to Speak Up (FTSU) has three components: improving and protecting patient safety, improving and supporting worker experience and visibly promoting learning cultures that embrace continual development. The Care Quality Commission (CQC) assesses a Trust's speaking up culture under the Well-Led domain of its inspections.

1.2 The FTSU report covers the period from January to June 2023: Quarters 4 2022/23 and Quarter 1 2023/24. Reporting to Board is on a six-monthly basis.

2. Aim

2.1 This report aims to provide the Board with:

- Information on the number of cases being dealt with by the FTSUG and themes identified from January to June 2023.
- Information on what the Trust has learnt and what improvements have been made as a result of workers speaking up.
- Actions taken to improve FTSU culture in the Trust, including progress in the promotion of the FTSUG role and addressing barriers to speaking up.
- Updates from the National Guardians Office (NGO).
- Key recommendations to Board.

3. Summary of Freedom to Speak Up Concerns

3.1 Concerns are categorised in accordance with NGO guidance. The NGO requires concerns relating to Patient Safety, Bullying and Harassment, Worker Safety and Wellbeing, Public Interest Disclosure Act (PIDA) concerns, anonymous concerns and those suffering detriment or demeaning treatment, as a result of speaking up, to be recorded on a quarterly basis.

3.2 **Table 1** shows that the FTSUG logged 37 cases in Q4 2022/23 and 35 cases in Q1 2023/24. In Quarter 2 2023/24, 16 cases have been logged. The average number of cases per quarter for a Mental Health Trust is 29.3 From July 2022 to June 2023 (12 months), DHCFT's average cases per quarter were 37. The average number for all small NHS Trusts in 2022/23 is 17.3 per quarter (Source: NGO Annual Report 2022/23).

3.3 **Patient safety and quality:** During Q4 2022/23 and Q1 of 2023/24, patient safety and quality concerns represented 6.9% of cases. From June to December 2022, they represented 5.2% of cases. Patient safety and quality

concerns are directed to the Director of Nursing and Patient Experience. According to the NGO Annual Report 2022/23, Patient safety concerns represented 19.3% of all concerns nationally.

Table 1: FTSU Data Q4 2022/23 and Q4 2023/2024

Types of Concerns	Q4 2022/23	Q1 2023/24
With an element of **Bullying and Harassment (NGO/PIDA)**	**6**	**6**
With an element of **Patient Safety and Quality (NGO/PIDA)**	**3**	**2**
With an element of **Worker Safety and wellbeing (NGO)**	**10**	**15**
Potential Fraud or Criminal Offence (PIDA)	**1**	**0**
Attitude & Behaviours	10	14
Compassionate Leadership	9	14
Culture	8	7
Health and Safety	0	1
Policy, Process and Procedure	19	11
Total Cases reported to FTSUG*	**37**	**35**
Public Interest Disclosure Act (PIDA) concerns	**10**	**8**
Reportable to NGO: Bullying and Harassment / Patient Safety / Worker Safety	19	19
Anonymous / Other	3	2
Person indicates suffering a detriment as a result of speaking up	0	0
Number of cases that have received feedback	34	33

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

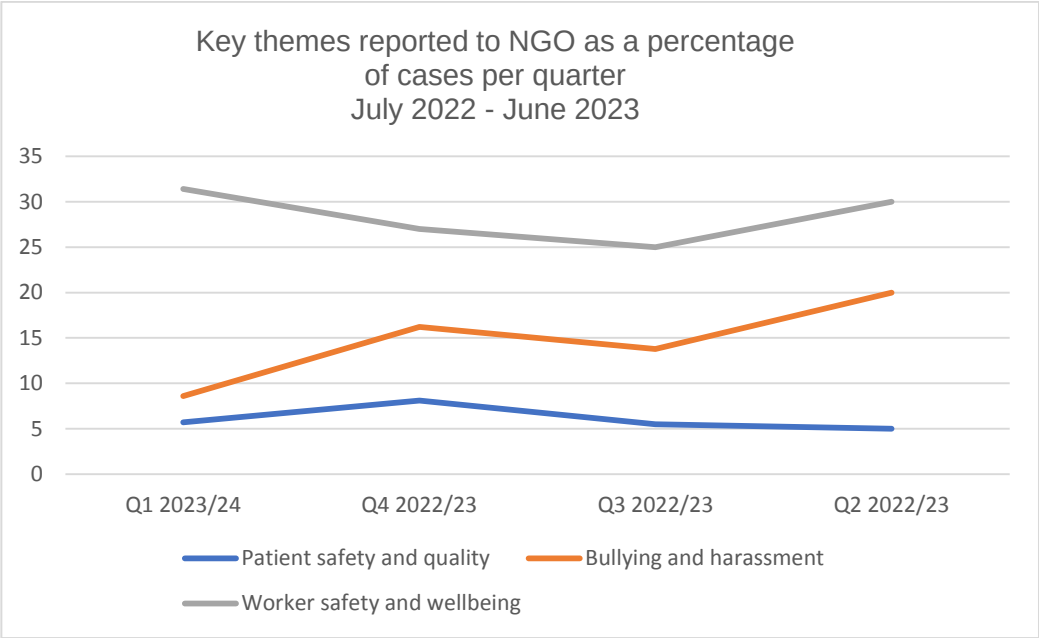
3.4 **Bullying and Harassment concerns** represented 16.7% of cases raised to the FTSUG from January to June 2023. This is a slight decrease on the 17.1% of cases raised from July to December 2022. Bullying and harassment levels for the 12 months from July 2022 to June 2023 are 16.9% which is lower than the 22% raised nationally to FTSUGs during 2022/23. (Source: NGO Annual Report 2022/23)

The FTSUG promotes the Trust's Dignity at Work policy, Trust wellbeing offers, staff-side support and Employee Relations where staff require support around bullying and harassment matters. A new policy, Civility, Respect and Resolution is being introduced and training is provided to managers on this policy.

3.5 **Worker safety and wellbeing theme:** The percentage for was 34.7% of all cases for Q1 2022/23 and Q4 2023/24. This is slight decrease on the 38.1% of all cases seen in Q2 and Q3 of 2022/23. Nationally in 2022/23 the average for worker safety and wellbeing was 27.4%. (Source: NGO Annual Report 2022/23). Information on all theme categories is found in the NGO Recording Cases and Reporting Data Guidance 2022.

Figure 1 shows Bullying and Harassment, Patient Safety and Worker Safety and Wellbeing cases as percentage of number of cases per quarter as reported to the NGO over the January to June 2023 period.

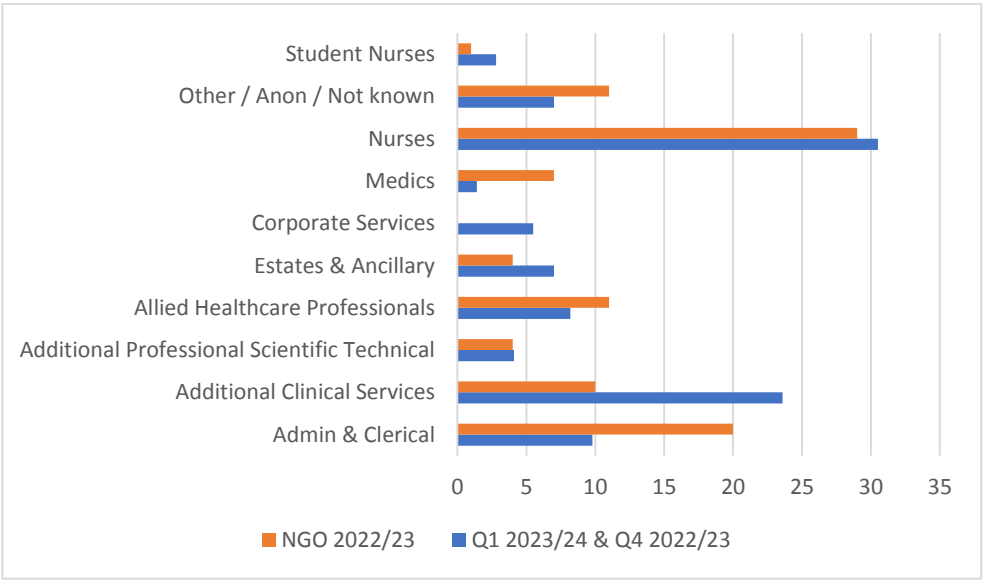
Figure 1



3.6 **Professional groups**: In Q4 2022/23 and Q1 2023/24, 30.5% of staff approaching the FTSUG were nurses. This is lower than the in Q2 and Q3 2022/23, where 38.1% of staff approaching the FTSUG were nurses, but is similar to the average nationally reported by the NGO at 29%. (Source: NGO Annual Report 2022/23). See Figure 2.

In Q1 2023/24, there were higher numbers of nursing and healthcare assistants speaking up in the Trust. This is a positive as the NHS Staff Survey 2022 showed that nursing/healthcare assistants and medics confidence in speaking up is deteriorating, particularly for raising unsafe clinical practice concerns and feeling that they will be addressed (Source: NGO Annual Report 2022/23).

Figure 2: Professional groups speaking up in Q1 2023/24 and Q4 2022/23 as a percentage of total cases per quarter in comparison to NGO 2022/23 data.



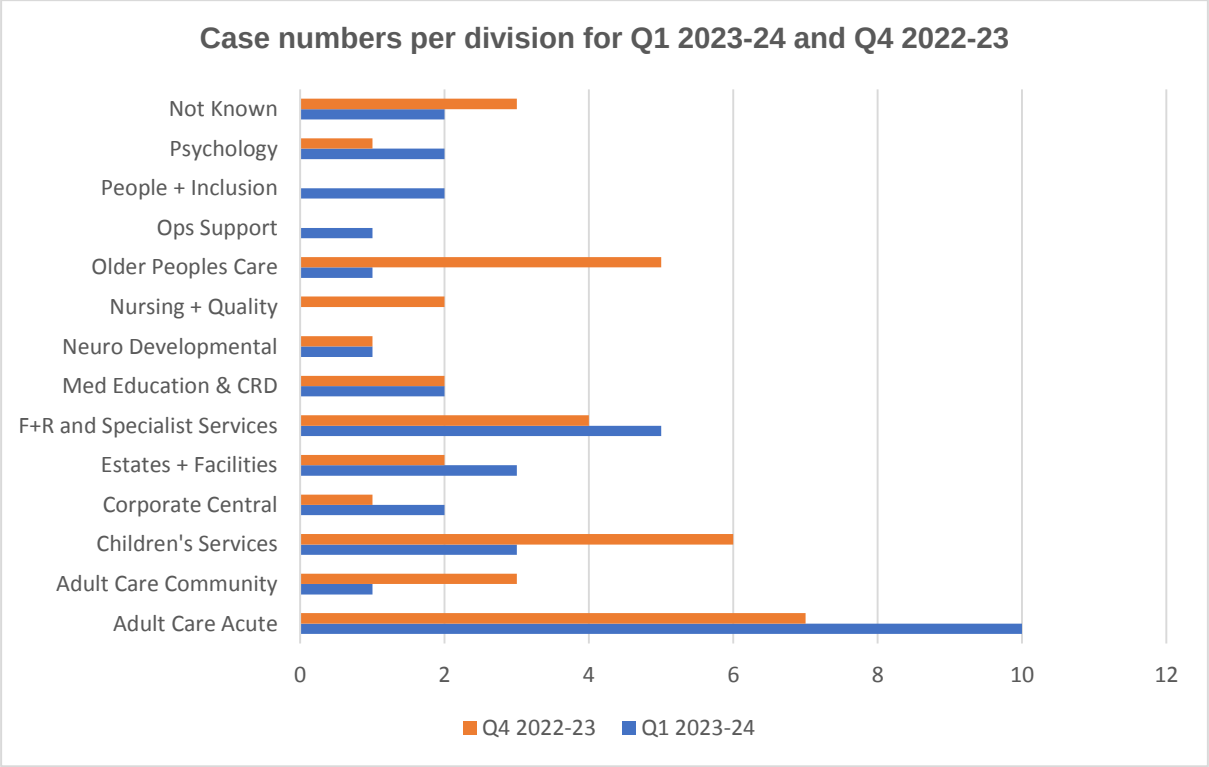
3.7 **Experiencing detriment or demeaning treatment:** In Q4 2022/23 and Q1 2024, 0% of workers reported that they had experienced a detriment or demeaning treatment as a result of speaking up. NGO average for detriment in 2022/23 was 3.9% (Source: NGO Annual Report 2022/23)

3.8 **Ethnicity of workers:** In Q4 2022/23 and Q1 2023/24, 33.3% of colleagues speaking up identified as Black and Minority Ethnic (BME). In Q2 and Q3 of 2022/23, 25% of staff speaking up identified as BME. According to DHCFT's WRES Annual Report and Action Plan 2021/22, 16.7% of the workforce are from BME.

3.9 **Anonymous, Confidential or Open concerns:** Anonymous concerns decreased to 6.9% of concerns for Q4 2022/23 and Q1 2023/24. From June to December 2022, they were 9.2% of cases. Anonymous concerns reported nationally in 2022/23 were 9.3% (Source: NGO Annual Report 2022/23)

3.10 **Concerns raised by Division:** Figure 3 shows the number of cases from divisions across the Trust. Adult Care Acute was raised in Q1 2023/24 due to a number of staff from one team speaking up.

Figure 3



4. Emerging or ongoing themes with learning/action points

4.1 Attitudes and behaviours / Culture / Worker safety and wellbeing

A number of staff in acute adult care have spoken up about the quality of leadership and its possible impact on quality of care and their safety and wellbeing.

Learning/Action:

- Senior leaders aware and responsive. A supportive plan has been put in place to address concerns. Compassionate response and support for leader also in place. Closed culture survey carried out across services. Resolve will also be involved in supporting ward.

4.2 Lack of compassionate leadership

Some concerns in relation to a perceived lack of compassionate leadership/management approach for some individuals. Each issue, where consent given, progressed individually, and through support of employee relations/staff-side or through senior leaders such as the Area Service Manager (ASM) or General Manager (GM).

Learning/Action:

- Ongoing training on Civility, Respect and Resolution policy for managers. Policy to be launched in near future
- Kinder culture - A Kind Life is being considered for Trust culture and improvement in the near future.

4.3 Discrimination

Some concerns in relation to perceived discrimination in some areas of the Trust including concerns from a student nurse.

Learning/Action:

- Senior leaders are aware of areas of concern
- Student task and finish group around inclusion issues and an action plan in place
- Unleashed offering some workshops on understanding how to create an inclusive place to work and to best support people of different identities
- New supportive EDI lead in place in relation to FTSU themes.

5. Improving Speaking Up Culture

5.1 **Improving visibility and networking:** The FTSUG presents at monthly Trust Inductions, to Junior Doctors, preceptees and students. The FTSUG attends team meetings / Away Days on request. The FTSUG is now holding regular

face-to-face drop-ins in some acute settings including The Radbourne Unit and Kedleston Unit. In May 2023, the FTSUG engaged with University of Derby and delivered FTSU training to 300 nursing students which included some students on placement within the Trust.

5.2 **Board Culture:** A well-received Board development session was delivered by the FTSUG in November 2022. The Board development session was themed around the contents of the FTSU Reflection and Planning Tool which is to be completed by the Board by January 2024. A further session on completion of the Tool is planned for October 2023.

5.3 **Supporting communities who face barriers to speaking up:** The FTSUG regularly engages with the Equality, Diversity and Inclusion (EDI) Team to address inclusion issues and share themes for diverse groups.

5.4 **Triangulation of data and FTSU:** the FTSUG is meeting regularly with senior leaders including the Deputy Director of Nursing and the Deputy Director of People and Inclusion to discuss triangulation of data. The FTSUG produces a report for the People and Culture Committee to support triangulation of data.

5.5 **Network of FTSU Champions:** The FTSUG holds monthly catch-up meetings with Speaking Up Champions to share good practice, support any speaking up matters and to share NGO information**.** Champions referred in 26% of concerns during Q4 2022/23 and Q1 of 2023/24. DHCFT currently has 22 FTSU Champions who come from a range of divisions across the Trust with 30% of FTSU Champions identifying as BME.

5.6 **Non-Executive Directors:** the FTSUG is supported by a Non-Executive Director (NED) lead for Speaking Up, Geoff Lewins. The FTSUG holds monthly meetings with the NED to share FTSUG practice and areas for support and development.

6. Learning, improvement, and development in relation to Speaking Up Culture within the Trust.

6.1 **Evaluation feedback on Speaking Up:** An evaluation form for individuals who have spoken up is sent out following contact with the FTSUG using an online link. 94% of those responding from January to July 2023 said ‘yes’ they would speak up again. 72% of those invited to respond gave did not complete the evaluation. These specific questions are required by the NGO.

6.2 **DCHFT Freedom to Speak Up Strategy:** The FTSUG has produced a Speak Up Strategy in consultation with the Chief Executive and Deputy Director of People and Inclusion. This will be shared with PCC and staff networks for further comment and development in September 2023. In the FTSU Reflection and Planning Tool for Boards, the board is asked to evidence that it has a comprehensive and up-to-date strategy to improve its FTSU culture.

6.3 **Derbyshire Integrated Care System** (ICS): the FTSUG meets monthly with other ICS FTSUGs to discuss system arrangements around FTSU. The group has completed a return to the ICS on FTSU arrangements across the system.

6.4 **Staff Survey 2022: Raising Concerns**
Figure 5 shows that we are performing above, or at the same level, as our peers in terms of raising concerns and are and the national average in relation to raising concerns in the staff survey 2022.

Figure 5 Raising Concerns for DHCFT in relation to staff survey 2022 (from model.nhs.uk)

Raising concerns	Data period	Provider value	Peer average	National value
I would feel secure raising concerns about unsafe clinical practice.	2022	76.7%	76.7%	72.8%
I am confident that my organisation would address my concern.	2022	61.5%	61.7%	57.8%
I am confident that my organisation would address my concern. staff response to Staff Survey.	2022	56.8%	55.5%	49.9%
I feel safe to speak up about anything that concerns me in this organisation	2022	70.8%	67.3%	62.5%

7 National Guardian's Office and related National Changes

7.1 **FTSU Policy**: The new FTSU policy based on the NHSE template was ratified by the Audit and Risk Committee on 27 April 2023. The FTSU policy is now live on Focus (staff intranet).

7.2 **FTSU Reflection and Planning Tool:** The Board must complete the NHSE FTSU Reflection and Planning Tool by January 2024. The FTSUG and Trust Secretary will work with the Board to plan and complete the Reflection and Planning Tool in October 2023. The Reflection and Planning Tool will be shared at the March 2024 Board meeting.

7.3 In June 2023, the National Guardian's Office (NGO) released Fear and Futility: What does the NHS Staff Survey tell us about speaking up. The NGO notes in the report that 'the Freedom to Speak Up sub-score declined from 6.5 in 2021 to 6.4 in the 2022 NHS Staff Survey. The fall equates to a 1.5% change in responses to the speaking up questions. Given the numbers who answered these questions (over 600,000 workers) this equates to a decrease in over 9,000 workers' confidence to speak up.

There were declines on all measures relating to speaking up, both relating to raising concerns about clinical safety and speaking up more generally.

While the results have improved since the 2015 Freedom to Speak Up Review and resulting actions, this continues the fall in NHS workers' confidence to speak up since the pandemic. Of particular concern is the marked fall in how

safe people feel to raise a clinical concern. A question about whether people feel that if they spoke up, their concerns would be addressed has also shown a deterioration. This creates a worrying picture of potentially increasing disillusionment and a feeling that speaking up is futile. Speaking up can only bring improvements if leaders and managers listen up and follow up.'

8. Conclusion

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

8.2 The Board will continue to use the positive culture around speaking up to drive recommendations from the report forward and to deliver meaningful and visible responses to Trust wide concerns.

9. Recommendations

The Trust Board is asked to:

1. Support the current mechanisms and activities in place for raising awareness of the FTSU agenda.
2. Discuss the report and determine whether it sufficiently assures the Board of the FTSU agenda at the Trust and that those proposals made by the FTSUG promote a culture of open and honest communication to support staff to speak up.
3. Engage with the process and completion of the FTSU Reflection and Planning Tool and the FTSU strategy consultation.

Tamera Howard
Freedom to Speak up Guardian
Derbyshire Healthcare NHS Foundation Trust

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors - 5 September 2023

Fit and Proper Persons Test Chair's Declaration

Purpose of Report

To present the Chair's declaration that all Trust Board Directors meet the fitness test and do not meet any of the 'unfit' criteria as per the Fit and Person's Test regulations (Health and Social Care Act 2008 Regulation 2014).

Executive Summary

Under the Fit and Person's Test regulations (Health and Social Care Act 2008 Regulation 2014) all provider organisations must ensure that Director level appointments meet the 'Fit and Proper Persons Test' and the regulations place a duty on NHS providers not to appoint a person or allow a person to continue to be an Executive Director or equivalent or Non-Executive Director under given circumstances. The regulations have been integrated into the CQC registration requirements and fall within the remit of their regulatory inspection approach.

It is the responsibility of the Chair to discharge the requirement placed on the Trust to ensure that all Board Directors meet the fitness test and do not meet any of the 'unfit' criteria. The Chair is required to present an annual declaration to this effect which is set out in Appendix 1.

The Trust has processes in place to ensure that the appropriate checks are made on appointment of Board Director level posts and that relevant checks and supporting information relating to existing post holders have been provided and there are proactive processes set in place to ensure the ongoing review and monitoring of the filing system for all Board Directors. Unfortunately, due to an administrative error, there is a DBS check outstanding for one member of the Board, this is in process and that individual has completed their self-declaration against the requirements.

Checks have been carried out for all new Board Directors who have joined the Trust since the last annual declaration. Comprehensive files containing evidence to support the elements of the fitness test are retained and regularly reviewed to ensure contents are updated as required. The Chair's annual declaration covers 2022/23 and up to present to include the recent appointments and appraisals. Each Board Director has completed an annual self-declaration under the Fit and Proper Persons Policy and each new Board Director has completed one on commencement with the Trust.

The CQC commented as part of their report following the comprehensive inspection in January 2020 that we had satisfactory procedures in place relating to applying the Fit and Proper Persons Test for Trust Directors.

On 2 August 2023 NHS England published a new Fit and Proper Persons Test (FPPT) Framework which encompasses five out of the seven recommendations from the Kark Review from 2019. The legislation has not changed but this new framework aims to support NHS organisations' compliance with the 2014 regulations and makes some changes to the checks and balances that are intended to ensure directors satisfy the regulatory requirements. Guidance for chairs and for staff on implementation has also been issued and NHS England expect elements of the framework to be used from 30 September 2023 with full implementation by 31 March 2024. A summary of the new requirements is included as Appendix 2.

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 creating a compassionate, skilled and empowered leadership, creating a vibrant culture where colleagues feel they belong, thrive and are valued.	X
3)	The Trust is a **great partner** and actively embraces collaboration as our way of working.	
4)	We will make the **best use of resources** by making financially wise decisions and avoiding wasting resources to ensure financial recovery and long term sustainability.	

Assurances

- The Board can receive assurance that due process has been followed in line with the Trust's Fit and Proper Persons Policy to ensure that all relevant post holders meet the fitness test and do not meet any of the 'unfit' criteria
- That comprehensive files have been established and maintained for each relevant post, evidencing compliance and that proactive processes have been set in place to monitor the filing system.

Consultation

This report has not been considered by other groups/committees. However, confirmation of Fit and Proper Person Test compliance for Non-Executive roles is reviewed by the governor Nomination and Remuneration Committee, and confirmation of compliance with Fit and Proper Persons Test requirements have been overseen by the Remuneration and Appointments Committee for Executive Director appointments made in year.

Governance or Legal Issues

- It is a requirement of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 that NHS bodies undertake a 'fit and proper person test'
- The regulations have been integrated into the CQC's registration requirements and falls within the remit of their regulatory inspection approach.

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.

Recommendation

The Board of Directors is requested to:

1) Receive full assurance from the Chair's declaration that that all Directors meet the fitness test and do not meet any of the 'unfit' criteria
2) Note the publication of the new Fit and Proper Persons Test (FPPT) Framework that the Trust will be required to fully comply with by 31 March 2024.

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

Report prepared by: **Justine Fitzjohn**
Trust Secretary

Appendix 1

Fit and Proper Persons Test Chair's Declaration

DECLARATION:

I hereby declare that appropriate checks have been undertaken in reaching my judgment that I am satisfied that all Directors of the Trust, including Non-Executive Directors, and Executive Directors (including voting, non-voting and Acting) are deemed to be fit and that none meet any of the 'unfit' criteria. Specified information about Board Directors is available to regulators on request.

Signed

Selina Ullah – Trust Chair – August 2023

Appendix 2

Summary of the Key points from the NHS England Fit and Proper Test Framework[1] for Board Members

Source - NHS Providers Next Day Briefing – 3 August 2023

- **The framework is positioned in the wider context of good governance, leadership and board development and applies to all board members of specified NHS organisations, including interim appointments and non-voting members.** Integrated care board (ICB), CQC and NHSE board members are now within its scope, in addition to NHS provider trust and foundation trust (FT) board members**.**

- **The majority of the requirements echo those that already existed in previous FPPT guidance.** Core elements that continue to be assessed are: good character; possessing the qualifications, competence, skills and experience required; and financial soundness. These are in addition to standard employment checks such as CV checks, proof of identity and right to work.

- The statutory requirements of the FPPT are set out in Regulation 5 of the Health and Social Care Act 2008 (Regulations 2014). This is a non-statutory framework, based on the recommendations of the Kark Review.

- The framework introduces a new **standardised board member reference**. These should be created whenever a board member leaves an NHS organisation, regardless of whether they are moving immediately to another NHS role and should be sought by employing NHS organisations when making a job offer. The reference is based on the NHS standard reference template but includes additional questions relevant to the FPPT.

- **The Electronic Staff Record (ESR) will be used to store information related to FPPT** checks and references. This will provide a standard way to record and report compliance internally. Retrospective population of data is not proposed.

- **From 30 September, the board member reference template should be used** for all new board appointments, and new references completed and retained locally for any board member leaving after this date.

- The full framework should be fully implemented by **31 March 2024**.

- A full FPPT against the core elements of the framework should be undertaken whenever new appointments are made, if a board member moves to a new board role in their current organisation, and annually thereafter.

- Annual self-attestations by board members to confirm adherence to the regulations will continue

- For joint appointments, checks will be undertaken by the host/employing organisation and confirmed to the other contracting organisations. For board

[1] https://www.england.nhs.uk/publication/nhs-england-fit-and-proper-person-test-framework-for-board-members/

roles filled by two individuals (job shares) both individuals will need to be assessed.

- **The chair of the board is accountable for taking all reasonable steps to ensure the FPPT is effectively implemented** in their organisation. NHSE regional directors are responsible for ensuring chairs of provider trusts/FTs and ICBs meet the requirements.

- Dispute resolution arrangements differ depending on whether the individual was appointed by NHSE. Processes to resolve disputes about data and information and about the outcome of FPPT assessments are detailed.

- the framework is published alongside eight appendices which include templates, checklists and a privacy notice.

- The additional guidance for chairs provides a summary of the requirements, focused on the actions chairs will need to take.

- Further guidance summarises processes for conducting the testing, entering the information into the Electronic Staff Record (ESR) and signing off the FPPT.

- Appendix 8 accompanying the framework announces an evaluation of its effectiveness 18 months following this launch, and advises that future consideration will be given to implementing a public facing register and including other 'significant roles' within scope.

A directory of board level learning and development opportunities[2] was published at the same time as the FPPT framework.

[2] https://www.england.nhs.uk/long-read/directory-of-board-level-learning-and-development-opportunities/

Board Committee Assurance Summary Reports to Trust Board – 5 September 2023

The following summaries cover the meetings that have been held since the last public Board meeting held on 4 July and are received for information.

- Quality and Safeguarding Committee 11 July
- Finance and Performance Committee 18 July
- Audit and Risk Committee 20 July
- People and Culture Committee 25 July

Quality and Safeguarding Committee - key items discussed 11 July 2023
Summary of Board Assurance Framework (BAF) Risks Issue 1, 2023/24 – Version 1.3 of the Board Assurance Framework (BAF) risks allocated to the Committee was considered to give context and focus to discussions during the meeting to ensure assurances received are focused on mitigating key risks to achieving the Trust's strategic objectives. Actions to close key gaps in control within high rated 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* had been signed off by the Chief Operating Officer as the measures to close the gaps have all been completed and improvement is sustained. These updates would be incorporated within the next iteration of the BAF (Issue 2, version 2.2) being submitted to the Audit and Risk Committee for review on 20 July prior to the BAF being submitted to the Trust Board for approval on 5 September.
Outstanding CQC actions An update report evidenced the headway being made to complete outstanding CQC actions. Targeted and sustained improvements in care planning are expected to be seen when the report is received at the next meeting in September. Mental Health Act visits and learning from mock inspections continue to be embedded. Clarification was sought on the condition of curtains and lockers which are not always in a good state of repair. The CQC can still report these as issues despite teams providing evidence of how and when the damage was caused by patients being violent or using curtains for ligatures and the Estates team being notified to repair the damage. Estates walkarounds are thought to be the most effective model to reduce this risk. Limited assurance was received from completion of improvement actions with significant assurance taken from the continued focus to repair practice gaps.
Joint Forward Plan The Committee was asked to note that formal publication the Joint Forward Plan (JFP) will take place in July 2023 by the Integrated Care Board (ICB). Aspects of the JFP discussed by the Board around investment funding and delivery of services have been fed back to the ICB for inclusion in the JFP and will be worked on by the ICB over the next 12 months. In terms of governance routes the delivery of this strategy will be led through the system wide delivery boards who are the key partners in delivering the transformation plan. Reporting through the Trust will be fed through the Quality and Safeguarding Committee and the Finance and Performance Committee on a six monthly basis. The next update will evidence how actions relating to quality and safety are being delivered in the next report due at the February 2024 meeting.

Community Mental Health Framework

A comprehensive progress update on the mobilisation of the Community Mental Health Framework (CMHF) and progress against the Trust's local plan.

The programme has been co-running for 2.5 years and the wave 1 roll out was made in the most challenging areas in Derbyshire High Peak and Derby City. Teams have found it difficult to deliver a fully integrated service working with limited resource in partnership with voluntary sector organisations. The programme is being taken forward in a phased approach and Medical leadership has been increased for this transformation to take staff through this process.

In terms of future reporting this will continue on a six monthly basis in order to receive assurance that quality standards are safe in the service being delivered.

Neurodevelopmental service update

A verbal update from Chief Operating Officer on progress being made with the new Neurodevelopmental service highlighted the confines of the Autism assessment service the Trust is commissioned for. The service is only commissioned to carry out 26 assessments a month. There are a considerable number of people waiting for assessment and the service does not have the resource to increase capacity. The model of assessment has been adapted to make it a shorter process using a variety of clinicians' skills and abilities. Despite these changes it will not be possible to complete all the assessments on the waiting list.

Having been made aware of the constraints around the service, the Committee was advised that people with Autism or learning disabilities (LD) are also admitted to the acute pathway and of the challenges being felt by local authorities operating in partnership with the service. It was agreed that the BAF would be looked at to include risks relating to these three categories of patients admitted to acute wards.

The Committee concluded that the Autism service is working within the confines of the contract it is commissioned for but the high demand cannot be met by working to NICE Guidelines. A comprehensive report will be taken to the next meeting in September that will provide a full risk assessment of the service the Trust is commissioned for, an overview of the waiting list and details of how the waiting well process is operating. A similar report will also be taken to the Finance and Performance Committee in September that will focus on performance and responsiveness.

Quality Visit update

This report set out the Quality Visit process for Season 11, progress to date and plans over 2022/23, including plans for Season 12.

Quality Visits are used to give teams the opportunity to showcase areas of good practice in line with the Quality Improvement strategy and to drive the quality priorities and strategy and areas of challenge, and also enable teams to reflect on the feedback from people who use their services. The content and learning from the visits are used for assurance and development of the Quality Report and Quality Account.

Limited assurance was obtained from the Quality Visit process report due to the organisational issues and cancellations incurred as a result of industrial action. Although it is not currently possible to set out the future strategy for Quality Visits changes would be made to next season in line with feedback received from Executive Directors and NEDs and the teams they have visited.

Annual Inquest and Claims Activity (received for noting)

Inquest activity: Overall, there has been a 66% increase in statement requests over the past five years. It is anticipated that there will be a continued increase in statements requested due to the courts needing to clear a backlog of cases.

The Committee noted the number of inquests and associated activity during 2022/23 and the continued increase in demand and was concerned that it will be difficult to keep up with the pace required as the time between statement requests and the deadline for requests will be relatively short i.e. 13 weeks. The necessary learning to be embedded cannot always be shown within a 13 week period and mitigations need to be in place to reduce this potential. The Committee understood the pressure this will add to people's workload as well as the emotional impact this will have on staff and how it will increase the possibility for Prevention of Future Death Reports (PDFs).

Full assurance was received from the preparatory work by the Assistant Director of Legal Governance and Mental Health Legislation and support given to Trust staff in preparation for Inquests which has contributed to the receipt of 'no PFDs' during the year. The increased potential for the Trust to receive a PDF report and the mitigations in place to reduce this potential.

Claims Activity: The low number of claims, and even more limited number of successful claims, suggests the Trust, overall is operating safely.

In terms of debt recovery, it was noted that the Legal department has been working alongside the Finance team to improve the recovery of outstanding debt, particularly salary overpayments and lease car debts.

Quality Improvement Project

This report demonstrated the use of Quality Improvement (QI) methodology to improve the standardisation, timeliness and efficiency of the Occupational Therapy admission process in a mental health inpatient service.

The report was noted as a clear and replicable account of how the older adult inpatient occupational therapy team in Cubley and Tissington wards increased the timeliness of their initial assessments completed within seven days of admission by approximately 30%. This everyday QI work is expanding and this specific project demonstrated a direct impact on falls reduction.

Programme updates from Divisional Assurance Reviews

The report demonstrated how performance is monitored and how escalations are taken to the Trust Operational Oversight Leadership Team (TOOL) and escalated to the Executive Leadership Team (ELT) to ensure full oversight of quality, operational and financial performance issues.

Significant assurance was obtained from the process followed through Divisional Assurance Reviews and from the information provided on scrutiny and the role of the executive and impact on overall clinical performance.

Patient Experience quarterly update

Significant assurance was received regarding the themes and changes made to Trust services as a result of feedback on incidents and complaints made to the Patient and Carer Experience Committee. The report provided an overview of the analysis of the complaints and incidents data for Quarter 4 of the financial year 2022/23. The report evidenced the ongoing work to ensure learning is implemented from incidents and complaints and received significant assurance on performance.

Serious Incidents report

This report provided significant assurance from the information relating to all Patient Safety process for incidents occurring from the from 1 April to 31 May 2023.

Significant assurance was obtained from that there is a robust process in place for managing incidents. A key highlight was the successful establishment of a senior Learning the Lessons oversight group that will monitor quality improvement plans and support the Trust's mortality review process. This will also ensure significant progress in clearing the backlog in overdue actions.

Learning From Deaths / Mortality Report

The 'National Guidance on Learning from Deaths' requires each Trust to collect and publish specified information on a quarterly basis. This report covers the period 1 April to 31 May 2023.

The Committee noted the effectiveness of the data and the process for carrying out reviews and the further improvements that will be made in establishing cause of death, age ethnicity and different characteristics.

This Mortality Report was accepted as assurance of the Trust's approach and agreed for the report to be considered by the Trust Board of Directors on 5 September and then published on the Trust's website as per national guidance.

Skill Mix and Safer Staffing

Significant assurance was received from the required skill mix and provide assurance on the work being undertaken to monitor and develop the skill mix of staff across Derbyshire Healthcare to ensure safe services.

The Trust's compliance with standards and the good rigour applied to safety and the Trust's national reputation for operating best practice was noted. The key risk concerns having substantial levels of junior preceptorship staff in place. The Trust has invested heavily in the preceptorship team. The use of junior preceptorship staff is carefully mapped and taken into account. Additional support in the preceptorship team is deployed. In addition during skill mix reviews staffing levels, the ward size and occupancy levels are taken into account.

Chief Pharmacist's six month update

The Committee was appraised of progress in implementing the Medicines Optimisation Strategy and the Pharmacy Strategy. The report highlighted medicines and pharmacy-related issues on the Risk Register. Medicines expenditure trends were summarised as well as the interaction with the ICS and ICB with respect to Medicines Optimisation and Pharmacy.

The good progress made in implementing the Medicines Optimisation Strategy 2021-24 was noted. A key step has been the recent implementation of Electronic Prescribing and Medicines Administration (EPMA) which will facilitate improvement in many areas of medicines assurance.

There has been increased expenditure of key items. This is particularly driven by the growth in the use of long-acting injections for psychosis and in melatonin and Attention Deficit Hyperactivity Disorder (ADHD) medication by Children's division. Savings are expected from the use of generic long-acting injection in place of the previous branded product. There is a good understanding with the team of the medicines causing significant cost pressures.

The Committee acknowledged the ongoing work by the Executive Team to relieve the pressure felt within the Pharmacy team. Concern remains with the difficulty in recruiting pharmacists which is a national issue and is reflected in the Risk Register.

Significant assurance was received from the strong oversight of the use of medicines within the organisation and any risks. The report also provided significant assurance that the Pharmacy department is fit for purpose with robust plans for our workforce sustainability.

There was also full assurance that required strategies are in place and being implemented, with a plan to review and update these in a timely manner.

Policy Review

The Care of the Acutely Disturbed Pregnant Patient Policy and Procedures has been revised after review by the Positive and Safe Team alongside input from The Beeches and DHCFT Pharmacy and was ratified by the Committee.

Board Assurance Framework – key risks identified: BAF to be updated to reflect constraints with ND service and with risks associated with patients being admitted to acute care wards who have ND, LD or ASD

Escalations to Board or other committee: The Finance and Performance Committee is to address ND performance and responsiveness.

Next Meeting: 12 September 2023

Committee Chair: Lynn Andrews	**Executive Lead: Carolyn Green, Director of Nursing and Patient Experience**

Finance and Performance Committee - key items discussed 18 July 2023

Making Room for Dignity (MRfD) assurance on Estate Strategy

A formal request for Alternative Dispute Resolution has been made in relation to the VAT abatement issue. HMRC has appointed a mediator and a meeting will be convened over the coming months.

Progress is being made with the lease issue at Chesterfield Royal Hospital site.

The second Victorian well that was discovered at the Kingsway site has now been capped.

There are several cost pressures that need to be managed and the project team are confident that these can be mitigated through the risk share arrangements.

With regards the works required at Walton Hospital, it has been agreed to re-tender the construction phase.

The committee received assurance on the progress of the programme and the risks associated with it.

Financial Governance and Plan delivery including CIP

The Committee received the Month 3 position reported against the breakeven plan. Month 3 is better than plan by £0.2m with the forecast outturn of breakeven. There are several key risks in delivery of the plan, such as delivery of efficiency programme in full, reducing agency costs and managing emerging cost pressures.

Agency remains above plan at the end of quarter 1 by £1.3m however a proportion of this relates to the support of a complex patient. A second agency summit is planned to take place in order to update on current actions and identify further opportunities to reduce agency usage.

As at month 3 reporting efficiencies were on plan year to date. However there remains a gap to be closed of £1.9m, and the forecast assumes that gap will be closed, this is discussed in more detail in the Continuous Improvement report.

The report continues to be developed with new information added into the report this month such as new cash metrics that have been introduced by NHSE in the monthly reporting template. The report will continue to be updated with a focus on the range within the forecast position with best/worst case and more information on cash forecasts.

The Committee gained limited assurance on delivery of the financial plan due to the level of risks that are being managed that were highlighted at the time of the plan submission.

Continuous Improvement update

At month 3 there were 23 initiatives with a planned delivery of £7.4m, a shortfall of £1.4m. However, work is progressing with the efficiency programme group meeting weekly and the most recent update from that group is that the shortfall has reduced to £0.6m.

Main action from that group is to move non-recurrent savings to recurrent.

Need to understand the risk on waiting lists and quality which will be covered by the QEIA process.

A detailed report on the current position of the schemes was circulated after the meeting and will be included in the update report going forward.

Quality Improvement training continues, and focus is on priority transformation areas. There is also a push for completion of e-learning in the areas of transformation work.

Operational Performance

The report covers the performance as at the end of May, which was presented to the last Trust Board meeting.

The most challenge area is waiting lists and a more detailed report is being developed and will come to the next meeting.

Waiting times for adult autism continues to be a challenging area along with adult out of area placements which have increased but are forecast to reduce back down in the second half of the financial year.

Most improved areas were psychological services waiting list reduction which continues to reduce month on month and the target being achieved for the 2 plus contacts within community mental health. CAMHS waits are also starting to reduce.

The clinical co-ordination centre has been fully established looking at flow, productivity and benchmarking information. Modules on population insights are being finalised and the productivity programme board is now fully established.

A more detailed overview of the work and ambitions of the productivity board will be presented by colleagues at the next committee meeting.

Neurodevelopmental services update

ND adult mental health admissions remain in escalation with NHSE but on the agreed trajectory for quarter 1 and currently on trajectory in quarter 2.

A recovery action plan is being developed for LD Annual health checks with the expectation that Primary Care and ICB will meet national targets for 2023/24.

Business environments

<u>EM Perinatal MH Provider Collaborative</u>
The Trust Board has previously approved the business case and that has been submitted to regional NHSE.

There are on-going discussions on the financial flows and whether that will be a hybrid approach or if it will need to follow the national approach.

A reporting template was provided to the Committee which seeks to capture the reporting requirements going forward. It was agreed that this reporting mechanism of the Provider Collaborative needs to be separate from the operational reporting of the organisation.

The Committee were assured on progress to date.

<u>Other system discussions</u>
The Exec to exec meetings are continuing between ourselves and DCHS.

Proposals are being discussion in relation to Psychology services.

Board Assurance Framework 2023/24 overview

The three BAF risks for this Committee have been reviewed and updated.

Also to note an overarching finance risk has been added to the Corporate risk register and this reflects the financial risk on the BAF.

Discussion took place on whether a deep dive on the finance risk is required at this Committee but the Committee was assured that the risks reported in the finance report and the enhanced reporting going forward will provide enough detailed evidence for oversight of this risk.

Escalations to Board or other Committees: None
Board Assurance Framework: – Noting further to update.
Next scheduled meeting: 26 September 2023

Executive Lead: Rachel Leyland, Interim Director of Finance

Audit and Risk Committee - key items discussed 20 July 2023

Board Assurance Framework (BAF)

Issue 2 (version 2.2) of the BAF for 2023/24 was presented for review. The actions to close key gaps in controls and actions with improved RAG ratings were noted, along with a new high rated risk added 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 concerning anti-ligature clothing and mattress that can be torn".* A new extreme rated risk has also been included within the finance risk 3a "*There is a risk that the Trust fails to deliver its revenue and capital financial plans".*

The amber rating of the key gap in control with regard to the Autism Assessment service was discussed as service capacity is not meeting demand. Although the amber rating reflects the improved input in the service the Quality and Safeguarding Committee would be asked to look at risk and mitigations in relation to the Autism service demand to establish whether this gap in control should be rated red rather than amber.

Having conducted a thorough review of the BAF the Committee was satisfied that well targeted work is being undertaken to address gaps in control and approved the BAF for submission to the Trust Board on 5 September, subject to queries relating to the Autism Assessment service that will be taken forward by the Quality and Safeguarding Committee.

Operational Risk Management Report

The effectiveness of the Trust's risk management processes and Datix record keeping mapped against the Internal Auditor's risk management recommendations and actions provided significant assurance.

Significant assurance was also received from the priority given to risk reviews carried out within risk oversight groups such as Trust Operational Oversight Leadership (TOOL), Divisional Assurance Reviews (DARs), and Clinical Operational Assurance Team (COATs).

Standing Financial Instructions (SFI) Waiver Update

The Waiver Register for the financial year 2022/23 showed that the majority of claims were for tenders rather than quotations. The Committee compared this expenditure to that of the previous year and saw that expenditure continues to be mostly related to the various ongoing estate projects.

The Committee acknowledged that report demonstrated very genuine reasons why waivers have been put in place and accepted the report with significant assurance.

Data Security and Protection 2022/23 Annual Report

A position statement on the recent completion of 2022/23 Data Security and Protection (DS&P) toolkit also included the work of the DS&P Committee, DS&P risk and incident management and Information Commissioner's Office (ICO) concerns. The report also evidenced a number of achievements in maintaining high standards of recording keeping which is a direct resulted from the training that the Data Protection team provide within the Trust.

The Committee acknowledged the excellent 2022/23 DS&P toolkit submission and audit report and continued focus on maintaining high standards and the continued progress and focus on Cyber Security.

Data Quality Update - Operational Indicators Data Validation

A report on activities undertaken over the last six months to ensure the Trust maintains good data quality provided assurance of the grip the Information Management Technology and Records (IMT&R) department has on data quality to ensure that the data held and used to oversee the operation of the Trust is a true and accurate reflection of the operational performance. This includes ensuring that the correct people are given access to the Trust's Information and that staff regularly agree to the Trust's Terms and Conditions of use.

A number of achievements were highlighted in the report that will continue to be addressed. The Committee noted that as processes become more and more complex it is imperative that the amount of manual processing is kept to a minimum to reduce the potential for errors. The significance of operational teams ensuring that electronic records are complete, accurate and up to date was also acknowledged.

Sickness Management update on outstanding actions

An update of the work on sickness absence management following the 360 Assurance internal audit which took place in October 202 evidenced the positive progress made in view of the actions that were agreed.

The report demonstrated how the Trust is now utilising the full potential of support for managers and individuals who are absent from work.

Given the improvements made full assurance was obtained from the work taken against the 360 Assurance audit actions, the outcome of which has been demonstrated in the reduced absence sickness rate.

Salary Overpayments

This report set out the position with overpayments and actions implemented in relation to the management and prevention of overpayments.

The new termination system is now reducing the number of overpayments due to late terminations. Several overpayments have been avoided using the new system, however there is still more work to be done to ensure the system is fully embedded by employees and managers as there are still cases where employees have not used the new system and/or have submitted retrospectively.

Having noted the progress made, limited assurance was received at this stage that the new systems being implemented have had a positive impact. The Committee requested that a further report on salary overpayments be received at the January 2024 meeting.

Internal Audit Progress

Internal Auditor, 360 Assurance gave an account of internal audit progress work carried out during the period 18 May to 13 July 2023.

Since the previous meeting 360 Assurance have published the 2023/24 Data Security and Protection Toolkit report providing substantial assurance. The Terms of Reference for the 2023/24 Head of Internal Audit Work Programme have been issued.

Counter Fraud Progress Report

The completion of work from the Trust's Counter Fraud, Bribery and Corruption Plan provided significant assurance that sufficient controls and management mechanisms are in place within the Trust to mitigate fraud, bribery and corruption risks. It is clear that the 360 Assurance Counter Fraud Specialists have effectively challenged Trust officers to ensure that identified risks and system weaknesses are adequately mitigated in line with recommendations made by 360 Assurance and/or NHS Counter Fraud Authority.

Counter Fraud Annual Report including NHS Counter Fraud Authority Functional Return

This annual report summarised 360 Assurance's counter fraud provision for the Trust during 2022/23 and confirmed that the Trust met its requirement to submit its 2023 Counter Fraud Functional Standard Return (CFFSR) statement of compliance by 31 May 2023.

External Audit progress

The initial term of Mazars' contract with the Trust with Mazars ends at the point at which they will be issuing their Auditor's Annual Report to the Council of Governors in September. Mazars confirmed their commitment to continue as the Trust's external auditor.

Clinical Audit 2022/23 Annual Report and 2023/24 Clinical Audit Plan

The Committee was taken through the overall 2022/23 Clinical Audit programme, its fitness for purpose and its delivery and was provided with an initial view of the Clinical Audit Programme for 2023/24 covering clinically prioritised areas including physical health, Mental Health Act, Core Care Standards, NICE guidance, safeguarding and prescribing practice.

The Committee saw that Clinical Audit is making a difference and leading to improved practice and received overall assurance on the systems and processes used to deliver the 2022/23 Clinical Audit programme. However, there have been ongoing delays in project completion but there have been positive achievements in action plan completion. It was accepted that 2023/24 is a year of transition as Quality Improvement (QI) methods are implemented and embedded for practice change. While systems and processes for Clinical Audit have been adapted to facilitate the transition, this is likely to take longer to embed and is dependent on the rate of adoption of QI across the organisation. Although there are some gaps in managing the backlog in project completion and maintaining the pace to implement the QI culture change the report provided limited assurance due to the work that is still required. It is anticipated that further assurance will be obtained once the new QI cultures have been embedded.

Board Assurance Framework – key risks identified: The Quality and Safeguarding Committee is to look at risk and mitigations in relation to the Autism service demand to establish whether this gap in control should be rated red rather than amber.

Escalations to Board: None
Next Meeting: 12 October 2023

Committee Chair: Geoff Lewins	**Executive Lead: Justine Fitzjohn, Trust Secretary**

People and Culture Committee - key items discussed 25 July 2023

Summary of BAF Risks

The Committee considered the Board Assurance Framework (BAF) risks it has oversight of in the context of subsequent discussions and the current work programmes.

Risk 2A: There is a risk that we are unable to create the right culture with high levels of staff morale

Risk 2B: There is a risk that we do not have a diverse workforce with the right number of people with the right skills to support and deliver safe high-quality care

Recent updates and risk ratings made to the BAF with regard to workforce and themes concerning recruitment and retention and engagement were discussed and noted.

People and Inclusion Assurance Dashboard

The data presented in the dashboard had improved significantly and gave a better understanding of how processes are managed. Despite this, limited assurance was obtained from current people performance.

Improvements in absence management is making a positive difference. Particular areas are being targeted to drive improvements. The improvement seen in training compliance is hoped to be a sustainable step change.

2023/24 Flu Campaign

A report setting out the flu campaign for 2023/24 and the work undertaken to deliver against the CQUIN target of 75 – 80% was considered prior to the report being submitted to the Trust Board in September.

The paper covered plans to order sufficient vaccines and provision of more accessible flu vaccinations being made to staff at high volume meetings and events. The Trust will be holding engagement sessions to explore concerns or questions that may help resolve or understand issues in more detail regarding the impact of mandatory vaccination as there is regional and national concern about the legacy impact of mandatory vaccination work and whether this will reduce uptake.

EDI Quarter 1 Report

The Head of Equality, Diversity and Inclusion (EDI) took the Committee through current EDI activity and the proposed future reporting framework. The report set out the intention to align EDI more simply to the six High Impact Actions (HIA) in the NHS EDI Improvement Plan. Future activity will be designed to progress the HIAs further and meeting the strategic objective of "Great Place to Work". It is proposed that equal emphasis is given to culture and behaviour as to systems and processes in an approach which empowers and engages the whole workforce.

Significant assurance was received from proposed EDI reporting framework. The Committee was pleased that a simplified and more easily understandable approach was being taken to EDI across the Trust. The report was seen as a starting point that will engage the workforce so that every person feels a part of the EDI process.

2022 Staff Survey Actions

This report updated the Committee on the 2022 staff survey actions taken since the survey data and reports were received at the start of 2023. The report also covered the plans being developed to ensure a successful 2023 survey launch and significant improvement on last year's disappointing 48% response rate.

Full assurance was obtained from actions taken to date at Trust and divisional level based on 2022 staff survey data and that actions taken will be used to develop a 'you said, we did' for the 2023 survey communications campaign to support increasing response rates. Full assurance was received from proposed plans for early engagement and ongoing communications campaign for the 2023 staff survey.

People Priorities

The Committee received a strategic overview of the People Priorities for 2023/24 that will support the Trust to work towards the objective of making Derbyshire Healthcare a Great Place to Work.

Discussion focussed on the national people strategic drivers that are contributing to the People Priorities and how they align both to Trust and national objectives and collaboration with other organisations within the Integrated Care Board (ICB). The priorities will be used as a basis to develop the detail of the People Strategy which will be presented at a future People and Culture Committee meeting.

Escalations to Board or other committees: The Quality and Safeguarding Committee will be advised that a deep dive into disciplinary investigations will be undertaken by the People and Culture Committee at the next meeting on 19 September.

Board Assurance Framework – key risks identified: None
Next Meeting: 19 September 2023

Committee Chair: Ralph Knibbs	**Executive Lead: Jaki Lowe, Director of People and Inclusion**

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 5 September 2023

Learning from Deaths - Mortality Report

Purpose of Report

The 'National Guidance on Learning from Deaths' requires each Trust to collect and publish specified information on a quarterly basis. This report covers the period 1 April to 31 May 2023.

Executive Summary

- All deaths directly relating to Covid-19 are reviewed through the Learning from Deaths procedure unless they meet an additional Incident Red Flag in which case they are reviewed under the Incident Reporting and Investigation Policy and Procedure. From 1 April to 31 May 2023 there has been zero deaths reported where the patient tested positive for Covid-19.
- The Trust received 343 death notifications of patients who had been in contact with our service within the 6 months prior to their death. There is little variation between male and female deaths; 167 male deaths were reported compared to 175 females.
- No Inpatient deaths were recorded.
- Due to the number of active Case Record Reviews the function of the weekly Mortality Review Group supported by medical staff has been temporarily adapted to allow Investigation Facilitators to take specific active complex cases for medical opinion or input to offer a timelier resolution. This is a temporary arrangement to assist in reducing backlog and the function of the group will return to weekly review of non-complex deaths.
- The Trust has reported five Learning Disability deaths in the reporting timeframe and no patients with a diagnosis of Autism Spectrum Disorder (ASD).
- Medical Examiner officers have been established at all Acute Trusts in England and their role will be extended to include deaths occurring in the community, including at NHS Mental Health and Community Trusts. The implementation of this process had been expected by April 2023 however due to the complexities involved in data sharing this has been paused Nationally for community-based services. The Patient Safety team will continue to work with Medical Examiners to ensure the Trust maintains momentum in this area.
- Good practice identified through case note reviews is fed back to clinicians involved as part of our appreciative learning.

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

Assurances

This report provides assurance that the Trust is following recommendations outlined in the National Guidance on Learning from Deaths.

Consultation

The Quality and Safeguarding Committee reviewed the report on 11 July 2023 and agreed for it to be considered by the Trust Board of Directors.

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.

- For the period 1 April to 31 May 2023 there was little variation between male and female deaths; 167 male deaths were reported compared to 175 females.
- No unexpected trends were identified according to ethnic origin or religion.

Recommendations

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

Report presented by:	**Lynn Andrews** **Chair, Quality and Safeguarding Committee** **Arun Chidambaram** **Medical Director**
Report prepared by:	**Lead Professional for Patient Safety and Experience and Mortality Reviewers**

Learning from Deaths - Mortality Report

1. Background

In line with the CQC's recommendations in its review of how the NHS investigates patient deaths, the National Quality Board published a framework for NHS Trusts - 'National Guidance on Learning from Deaths[1]'. The purpose of the framework is to introduce a more standardised approach to the way NHS Trusts report, investigate and learn from patient deaths, which should lead to better quality investigations and improved embedded learning.

To date the Trust has met all the required guidelines. The report presents the data for 1 April to 31 May 2023.

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

- Discussions with the Regional Medical Examiners have taken place to discuss the implementation of the Medical Examiner process within our Trust. A standard operating procedure will be developed between Chesterfield Royal Hospital and University Hospital of Derby and Burton. The implementation of this process had been expected by April 2023 however due to the complexities involved in data sharing this has been paused Nationally for community-based services. The Patient Safety team will continue to work with Medical Examiners to ensure the Trust maintains momentum in this area.

- Cause of death information is currently being sought through the Coroner offices in Chesterfield and Derby but only a very small number of cause of deaths have been made available. It is hoped that this will improve once Medical Examiners commence the process of reviewing the Trusts non-coronial deaths.

- The mortality team have now received a new schedule outlining the medics who will be attending Case Record Review sessions in 2023 for both North and South consultants. Meeting invites for 2023 have now been set up and sent to all consultants involved.

- 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 26 June 2023.

[1] National Guidance on Learning from Deaths. National Quality Board. March 2017

Data Summary of all Deaths

Note that inpatients and learning disability (LD) data is based upon whether the patient has an open inpatient or LD referral at time of death. The table below outlines information for 1 April to 31 May 2023.

	April	May
Total Deaths Per Month	163	180
LD Referral Deaths	3	2
Inpatient Deaths	1	0

Correct as of 22 June 2023

167 patients were male, 175 were female, of these 268 were white British, 46 were any other ethnic group and 17 had no known ethnicity assigned. The youngest age was 0 years, the eldest age was 102.

From 1 April to 31 May 2023, the Trust received 343 death notifications of patients who have been in contact with our services.

4. Review of Deaths

Total number of Deaths from 1 April to 31May 2023 reported on Datix	41 “Unexpected deaths” 0 Covid-19 deaths 9 “Suspected deaths” 4 “Expected - end of life pathway” NB some expected deaths have been rejected so these incidents are not included in the above figure 0 Inpatients deaths
Incidents assigned for a review	53 incidents assigned to the operational incident group 0 did not meet the requirement 1 incident is to be confirmed

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

- Homicide – perpetrator or victim
- Domestic homicide - perpetrator or victim
- Suicide/self-inflicted death, or suspected suicide
- Death following overdose
- Death whilst an inpatient
- Death of an inpatient who died within 30 days of discharge from a DHCFT hospital
- Death following an inpatient transfer to acute hospital
- Death of patient on a Section of the Mental Health Act or Deprivation of Liberty Safeguards (DoLs) authorisation
- Death of patient following absconsion from an inpatient unit

- Death following a physical restraint
- Death of a patient with a learning disability
- Death of a patient where there has been a complaint by family / carer / the Ombudsman, or where staff have raised a significant concern about the quality-of-care provision
- Death of a child (this will also be subject to scrutiny by the Child Death Overview Panel)
- Death of a patient open to safeguarding procedures at the time of death, which could be related to the death
- Death of a patient with historical safeguarding concerns, which could be related to the death
- Death where a previous Coroners Regulation 28 has been issued
- Death of a staff member whilst on duty
- Death of a child under the age of 18 of a current or previous service user who has died in suspicious circumstances
- Where an external organisation has highlighted concerns following the death of a patient whether they were open to the Trust at time of death or not.
- *Death of a patient with Autism*
- *Death of a patients who had a diagnosis of psychosis within the last episode of care*

The last two red flags have been added this year to ensure that the Trust meets the Learning from Deaths guidance and recent changes to the LEDER reporting requirement of patients with a learning disability who have a diagnosis of autism.

5. Learning from Deaths Procedure

The Trust has now completed a move in terms of its mortality process, a process has been implemented within the patient Electronic Record which aids staff in identifying deaths which meet the threshold for DATIX reporting. This process fulfils stage one of the Learning from Deaths in that all deaths are considered for Red Flags as identified under the national Learning from Deaths procedure. This is a significant improvement in process and will release some capacity within the service to re-deploy into other priorities such as actions and high-profile incident management. The plan will also allow for more joined up working with Corporate and Legal services ensuring better sharing of information and identification of priorities for both services.

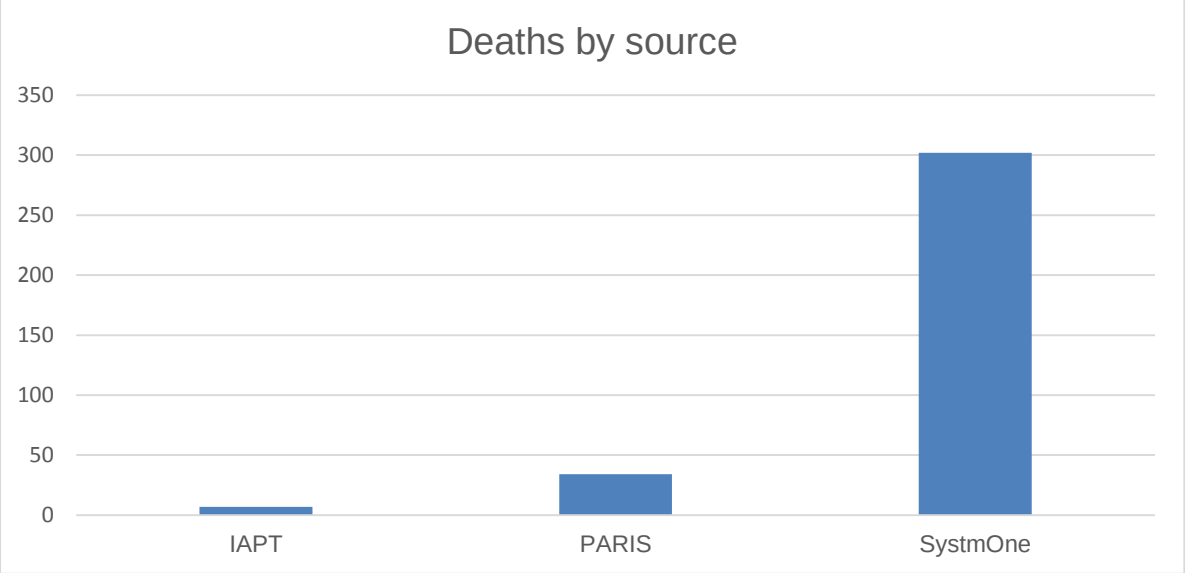
The Mortality team are conducting random weekly audits of deaths against the Red Flags to provide assurance that the new process is working as intended and changes will be made accordingly.

From the 1 April 2023 to 31 May 2023 there has been no deaths reported where the patient tested positive for Covid-19.

Analysis of Data

The Trust Mortality database is fed directly by the NHS Spine, therefore one point of data only. This data is updated approximately every 8 hours. The Data is in relation to any active patient or patient who has died within 6 months of discharge from services. The Trust continues in efforts to obtain cause of death information for non-coronial deaths, however any death which meets a Trust Red Flag for deaths will be reported to the DATIX system and considered under the incident process, this would include actively seeking cause of death from Coroners. This is problematic and can take considerable time to obtain. Once established the Medical Examiners process will help to establish cause of death for non-coronial deaths.

6.1 Analysis of deaths per notification system since 1 April 2023 – 31 May 2023

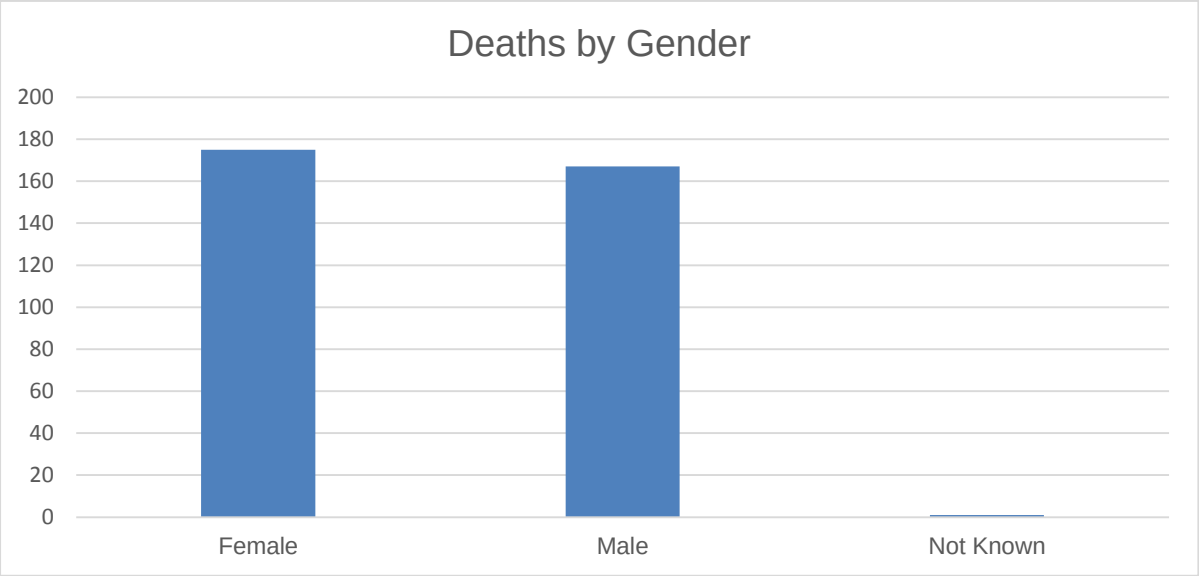


System	Number of Deaths
IAPT	7
PARIS	34
SystmOne	302
Grand Total	**343**

The data above shows the total number of deaths reported by each notification system. The majority of death notifications were predominately pulled from SystmOne. This clinical record system is aligned to our largest population of patients and a population at greatest risk of death due to the proportion of older people in our care.

6.2 Deaths by Gender

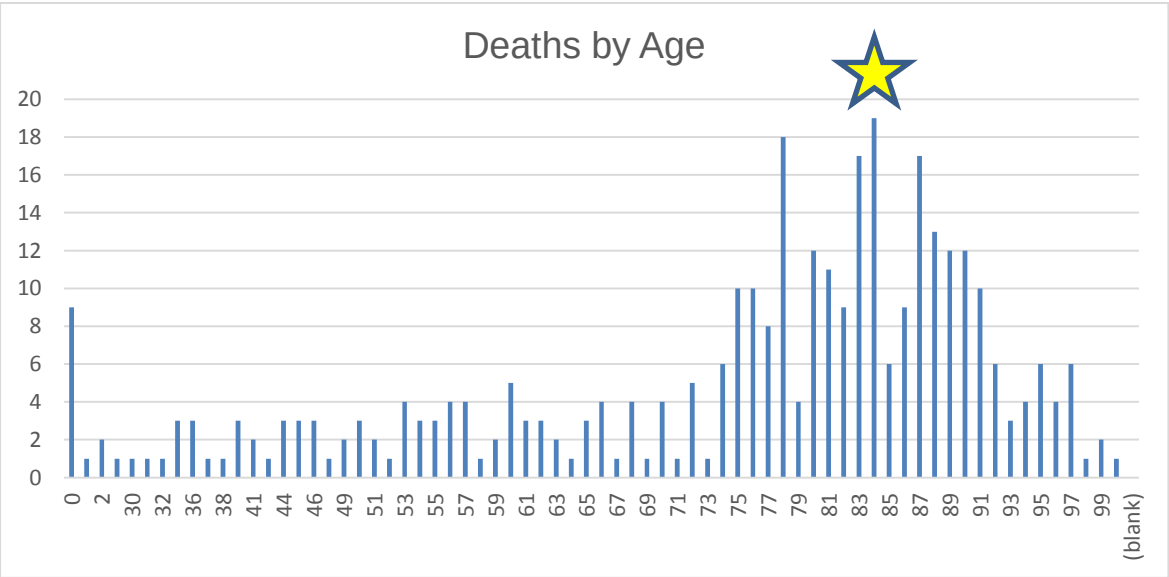
The data below shows the total number of deaths by gender for 1 April 2023 – 31 May 2023. There is very little variation between male and female deaths; 167 male deaths were reported compared to 175 females.



Gender	Number of Deaths
Female	175
Male	167
Not Known	1
Grand Total	**343**

6.3 Death by Age Group

The youngest age was classed as zero, and the oldest age was 104 years. Most deaths occurred within the 85-88 age groups (indicated by the star).



6.4 Learning Disability Deaths (LD)

	April	May
LD Deaths	3	2

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.

During 1 April 2023 to 31 May 2023, the Trust has recorded five Learning Disability deaths. The Trust now receives a quarterly update from LeDeR which highlights national good practice and identified learning; this is shared in the Mortality monthly meeting.

The Trust also is required from 1 January 2022 to report deaths of patients who have a diagnosis of Autism Spectrum Disorder (ASD) for this reporting period the Trust has reported 1 death.

6.5 Death by Ethnicity

White British is the highest recorded ethnicity group with 268 recorded deaths, 13 deaths had no recorded ethnicity assigned, and 4 people did not state their ethnicity. The chart below outlines all ethnicity groups.

Ethnicity	Count of Ethnicity
Asian or Asian British - Bangladeshi	1
Asian or Asian British - Indian	1
Asian or Asian British - Pakistani	3
Black or Black British - African	2
Black or Black or Black British - Caribbean Black British - Any other Black background	2
Mixed – Any other mixed background	1
Mixed – White and Black Caribbean	1
Not Known	13
Not stated	4
Other Ethnic Groups - Any other ethnic group	46
White - British	268
White - Irish	1
Grand Total	**343**

6.6 Death by Religion

Christianity is the highest recorded religion group with 152 recorded deaths, 125 deaths were (blank) with no recorded religion assigned. The table below outlines all religious groups.

Religion	Number of Deaths
Agnostic	1
Atheist	1
Atheist movement	2
Catholic religion	1
Catholic: Not Roman Catholic	1
Christian	149
Christian religion	3
Church of England	14
Church of England, follower of	17
Methodist	3
Muslim	5
None	4
Not Religious	2
Pagan	1
Patient Religion Unknown	1
Religion NOS	2
Roman Catholic	4
Unknown	6
Blank	125
Grand Total	**343**

6.7 Death by Sexual Orientation

Heterosexual or straight is the highest recorded sexual orientation group with 204 recorded deaths. 126 had no recorded information available. The chart below outlines all sexual orientation groups.

Sexual Orientation	Number of Deaths
Bisexual	1
Heterosexual	194
Heterosexual or Straight	10
Sexual orientation not given - patient refused	7
Unknown	1
Blank	125
Grand Total	**343**

6.8 Death by Disability

The table below details the top five categories by disability. Gross motor disability was the highest recorded disability group with 60 recorded deaths.

Disability	Number of Deaths
Behaviour and Emotional	2
Behaviour and Emotions: Learning Disability (Dementia); Self-care and Continence	1
Emotional behaviour disability	9
Gross motor disability	60
Hearing disability	6
Intellectual functioning disability	28
Learning Disability	1
Other	1
Blank	262
Grand Total	**343**

There was a total of 81 deaths with a disability assigned and the remainder 262 were blank (had no assigned disability).

7. Medical Examiners

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

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

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

Discussions with the Regional Medical Examiners have taken place to discuss the implementation of the Medical Examiner process within our Trust. A standard operating procedure will be developed between Chesterfield Royal Hospital and University Hospital of Derby and Burton. The implementation of this process had been expected by April 2023 however due to the complexities involved in data sharing this has been paused Nationally for community-based services. The Patient Safety team will continue to work with Medical Examiners to ensure the Trust maintains momentum in this area.

8. Recommendations and Learning

Action
Review the pathway of communication and documentation (including risk assessments and care plan) between crisis team and ward areas when a patient is due to be on s17 leave/discharged
Review the pathway of communication and documentation (including risk assessments and care plan) between CMHT and ward areas when a patient is due to be on s17 leave/discharged
Suicide prevention training to be restarted
To develop training on Emotionally Unstable Personality Disorder
Quality improvement project –ligature risks on inpatient units
To continue to raise the profile of referring patient who are high risk at discharge or complex on to the complex risk panel
Share the inpatient death report with all ward staff
To commence the bed sensor project – Cubley ward
Audit DNA/CPR /respect forms
Focus group to develop admission /transfer between the Trust and Acute when a patient is physically deteriorating
Quality improvement project older adult - Improving physical healthcare observations and care plans
ACP to continue to support transition between Acute and Mental health inpatient services alongside medical colleagues at the unit
Establish a physical health reporting working group to establish the new system one reporting frameworks to improve reports for assurance
Health Protection Unit to support wound care management and infection prevention and control investigation and follow up
Introduction of RESTORE2 into ILS training framework including review of current ILS provision
Notification of increased NEWS score via system one to senior colleagues to be reviewed
Review the discharge, transfer transitions, and leave policy
Review the Acute Inpatient Mental Health Services for Adults of Working Age Policy and Procedures
Following NHS training on MHOST in October, plan is to be rolled out incrementally across inpatient areas

To develop a ‘learning the lessons’ from incidents forum
To continue commissioned working group to review handheld clinical devices and compliance with observations including physical health observations
To review the possibility of an expert by experience for patient safety
Roll out of patient safety partners

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 5 September 2023

Assurance from People and Culture Committee
2023/24 Flu Vaccination Campaign

Purpose of Report

To outline the Flu campaign for 2023/24 and the work undertaken to deliver against the Commissioning for Quality and Innovation (CQUIN) target of 75 – 80%.

Executive Summary

- The Health Protection Unit (HPU) will lead on the work with support form peer vaccinators in key sites
- The Trust has purchased sufficient vaccinations based upon lessons learned for the 2022/23 campaign to ensure adequate supply and minimise waste
- The NHS England (NHSE) foundry portal will be the principal reporting platform at Integrated Care Board (ICB) level, to allow comparison data against other organisations and COVID-19 programme
- ImmForm data submission is being reviewed by the national team
- Blended working and reduced footfall on key sites are an area of focus for the planning of this campaign
- The underpinning message of the campaign is on informed choice, to support discussion of facts and evidence and to respect personal choice
- The Joint Committee on Vaccination and Immunisation (JCVI) detail has now been finalised and the work to ensure people have access to vaccines is progressing informed by the updated guidance.

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

Risks and Assurances

- 75% target is ambitious in the context of declining vaccination rates across the NHS
- We will work closely with system partners to deliver a flexible and quality service building on the work we have undertaken over the last few years.

Consultation

- Joined Up Care Derbyshire (JUCD) Flu planning group
- Weekly Vaccine Planning meeting (DHCFT)
- Derbyshire Community Health Services Foundation Trust (DCHS) colleagues Flu planning group
- People and Culture Committee: discussion held, and clarity requested on definition of frontline healthcare workers and who this does and doesn't include. This has been confirmed as:
    - Health and social care staff directly involved in the care of their patients or clients
    - Others involved directly in delivering health and social care such that they and vulnerable patients/clients are at increased risk of exposure to influenza (further information is provided in guidance from UK health departments).

Governance or Legal Issues

- CQUIN reporting requirement
- NIMS / NIVS (national vaccination recording database compliance)
- NHSE hospital hub site approval process
- JCVI green book compliance and adherence to annual updates regarding eligible cohorts and advisories.

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:

- Vaccination programmes have highlighted that uptake is significantly influenced by historic health inequalities and accessibility issues across a range of demographic groups and those with protected characteristics. This is noted amongst staff groups as well as those who access our services. The principle of 'proportionate universalism underpins the work of the team at trust level and across the JUCD system. Our data allows us insights into uptake amongst represented groups.

Recommendations

The Board of Directors is requested to receive the 2023/24 Flu Vaccination Campaign and note a full discussion has taken place in People and Culture Committee.

Report presented by: **Ralph Knibbs**
Senior Independent Director and Chair of People and Culture Committee

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

Flu Campaign 2023/24

The 2023/24 campaign is set to be run between October 2023 and February 2024 with an aspiration to vaccinate 75% of the NHS workforce across all sectors. DHCFT achieved 62.1% vaccination for influenza according to the published figures.

The reporting period will begin in Q3 and run into Q4. Considering the National Pandemic response to COVID-19 and ongoing significantly increased health concerns about respiratory disorders and illness, everyone who works for the trust (all staff groups) will be offered access to a vaccine. We have ordered 2500 vaccines for DHCFT staff and patients, this is to reduce the wastage we saw last year and anticipating that our colleagues will access vaccinations off-site, as around a third of DHCFT staff did during the last campaign. The trust can provide vaccine to colleagues with egg allergies / intolerance with no upper age limit. The vaccines are expected to be delivered during the last week in September.

CQUIN01: Flu vaccinations for frontline healthcare workers

Description	Achieving 80% uptake of flu vaccinations by frontline staff with patient contact.	
Numerator	Of the denominator, those who receive their flu vaccination.	
Denominator	Total number of frontline healthcare workers (HCWs), including non-clinical staff who have contact with patients, between 1 September 2023 and 28 February 2024.	
Exclusions	• Staff working in an office with no patient contact • Social care workers • Staff not in contact with patients for the whole of the flu vaccination period (eg maternity leave, long term sickness.	
Data reporting and performance	Monthly provider submission (between September and March) to UKHSA via ImmForm. Data will be made publicly available approximately six weeks after each quarter. Performance basis: Whole Period. Quarterly reporting not suitable due to cumulative nature of measure. See the section on Calculating Payment (above) for details about the basis for performance and payment.	
Scope	Services: Acute, specialised acute, community, mental health, specialised mental health, ambulance	Period: Quarters three and four only
Payment basis	Minimum: 75% Maximum: 80%	Calculation: Whole period %
Lead contact	england.vaccinecentresgroupsupport@nhs.net	

The above table is taken from the CQUIN-scheme-for-2023-24-indicator-specifications-version-1.1.pdf (england.nhs.uk)

Data collection for 2023/24 as in the previous year is captured within two systems. The first is populated by ImmForm data submitted by the trust in accordance with the Frontline health worker definition from the JCVI Influenza: the green book, chapter 19 - GOV.UK (www.gov.uk). This definition is open to interpretation and ambiguous in the JCVI document and the last definition provided was in 2021 in the Coronavirus » Operational Guidance: Vaccination of Frontline Health & Social Care Workers (england.nhs.uk) . To this end the trust has offered all

employees a vaccination for Flu since 2018. We have elected to only submit data for those we have vaccinated as Foundry data identifies those who have had the vaccination elsewhere through the NIMS system which the Trust is not able to replicate due to GDPR restrictions. The trust, as in previous years, notes that there is inconsistency between the CQUIN definition and the JCVI guidance regarding social care staff and will submit data as outlined in the detail of the letter circulated to trusts in 2021. The JCVI states.

Immunisation should be provided to healthcare and social care workers in direct contact with patients/clients to protect them and to reduce the transmission of influenza within health and social care premises, to contribute to the protection of individuals who may have a suboptimal response to their own immunisations, and to avoid disruption to services that provide their care. This would include:

- *Health and Social care staff directly involved in the care of their patients or clients.*
- *Others involved directly in delivering health and social care such that they and vulnerable patients/clients are at increased risk of exposure to influenza (further information is provided in guidance from UK health departments).*

The clarification guidance (Operational Guidance; Vaccination of Frontline Health and Social Care Workers. 2021) details the following as being eligible.

- *Staff working on the vaccination programme.*
- *Staff who have frequent face-to-face contact with patients and who are directly involved in patient care in either secondary or primary care, mental health, urgent and emergency care, and community settings.*
- *Those working in independent, voluntary, and non-standard healthcare settings such as hospices, and community-based mental health or addiction services.*
- *Laboratory, pathology, and mortuary staff*
- *Those working for a sub-contracted provider of facilities services such as portering or cleaning.*
- *Temporary, locum or 'bank' staff, including those working in the COVID-19 vaccination programme, students, trainees, and volunteers who are working with patients.*
- *Frontline social care workers directly working with vulnerable people who need care and support irrespective of where they work (for example in hospital, people's own homes, day centres, or supported housing); or who they are employed by (for example local government, NHS, independent sector or third sector).*

The second report is taken form the NHSE FOUNDRY system this includes all ESR staff and reconciles with the National Immunisation Service database (NIMS) and the Electronic Staff record (ESR) which reports all staff working for DHCFT. This report also provides uptake data by demographic and profession. Comparable data is also available for COVID vaccination taken from the same data sources, allowing exploration of the impact of work to support both campaigns and any differences identified in uptake.

The ICB has agreed that the FOUNDRY data will be the benchmark data for providers in Derbyshire as it is felt to the most consistent, does not leave reporting or results open to individual organisations interpretation and is inclusive of the benefit that all colleagues provide to ensuring services are delivered throughout the Winter period. DHCFT since 2018 and has included an offer for all staff irrespective of their role or profession to have a vaccine supported by the trust campaign. It should be noted though that approximately a third of colleagues access a Flu vaccine form their GP or local pharmacy and these would not be included in our ImmForm submission.

N.B. It is important to note that subsequent National reports will vary as UKHSA predominantly use ImmForm data and NHSE utilise the FOUNDRY data. This has been escalated to National level for resolution but there is no agreement currently to reconcile or stand down one system or the other.

The CQUIN target is between 75% and 80% recognising the expanded target group and reduced performance nationally in 2022/23.

There is regional and national concern about the legacy impact of the Mandatory vaccination work and whether this will reduce uptake. We will be holding engagement sessions to explore with colleagues any concerns or questions that may help resolve or understand these issues in more detail.

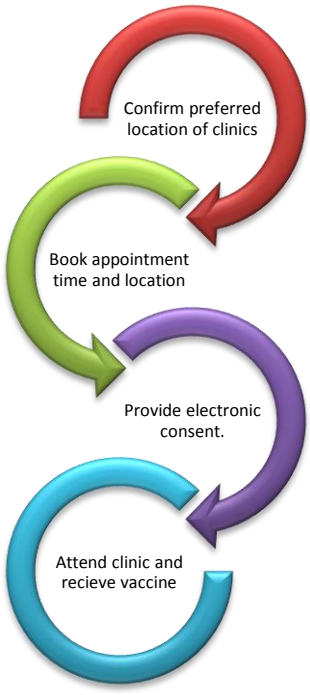
The vaccination work throughout the pandemic has been benefitted by taking a 'question asked – question answered' approach and then checking back to make sure that any further questions have been addressed. The focus of this year's campaign is to help people to **'make an informed choice'.**

We expect that most vaccines will be administered before mid-December 2023.

The method

The experience gained during the Pandemic has seen rapid learning to realise Infection Prevention and Control (IPC) compliant and efficient clinic models which:

- Identify likely numbers per location using ESR data and liaison with local managers.
- Pre-book appointments to allow clinics to match demand. In development for launch early September (dates and locations identified with HPU)
- Virtual registration and consent process to manage IPC concerns / streamline process.
- Allocated vaccine awaiting staff on attendance. Clinics starting as vaccines arrive.



The clinics continue to utilise a locally evolved system of booking, administration, logistics oversight and internal reporting which are adapted to suit both flu and COVID clinic approaches and allow concomitant administration.

DHCFT continue to work closely with DCHS to develop a collegiate delivery programme for staff across both organisations.

Feedback from last year's campaign and lessons learnt has been previously shared – the below are some of the pertinent issues:

Planning and engagement

- Wastage has been high as roughly 1/3 of all vaccines administered have been from Community services such as local pharmacy, GP etc. We have reduced the order quantity for 2023/24.
- Early planning / engagement meetings with operational leads to plan and publicise the programme have commenced to ensure that opportunities such as team meetings / away days are utilised.
- School holiday periods see very low uptake and bases are much quieter. Blended working models have been a challenge when attending team bases as numbers at site are notably lower than anticipated.

Communication

- Communications team are core to delivery – however there seem to be less engagement with trust wide comm's than before.
- Focussed communications for staff which reinforce patient safety and informed choice message is important.
- Personal testimonies remain a valuable engagement and promotion tool from Senior leadership team and trusted colleagues.
- Uptake of focus group / bespoke sessions was low during 2022/23 campaign – informal feedback would suggest that vaccination has been a lower priority against other life / work challenges.
- Reinforce that vaccination for colleagues is free.
- System approach to Comm's and materials is being explored.
- Focus on facts as well as the importance of the programme in terms of protecting patients. Wording of campaigns is important.

National / system level reflections

- Promote Flu and COVID-19 separately to avoid confusion, however being able to offer coadministration is helpful.
- There has been a negative impact of mandatory vaccination programme and language and wording which connect to that campaign are detrimental to uptake.
- Enable bulk uploads on NIVS (significant admin burden during this season's campaign).
- Positive meetings at system level provide opportunity to share good practice and enable collaboration between system partners is notable within the JUCD approach.
- Publishing staff uptake rates not a helpful tool – can be off-putting as seen as corporate target as opposed to protecting people.
- Review ethics of incentives for vaccination, system recommendation is to avoid this approach.

- Increased measles cases vaccination has identified that a cohort effect, where the children of families concerned about MMR vaccine, who are now parents themselves and appear to be concerned about vaccine safety for measles and other diseases, are voicing concern about vaccination efficacy.

Data / Reporting

- Reconciliation of national systems data is tricky as ESR data figure has been hard to replicate. Uptake Data can be viewed by demographic characteristics, which is helpful to better understand uptake and inequality.
- National dataset does not allow for individual or team vaccination rates to be explored.
- Resolve the requirement for the Vaccination as a condition of deployment (VCOD) reporting and the PHE HCW ImmForm submissions.
- Review uptake data with staff absence data (does vaccination equate to lower sickness or reduced risk of serious illness / transmission) to inform communications (the two do not appear to correlate locally).

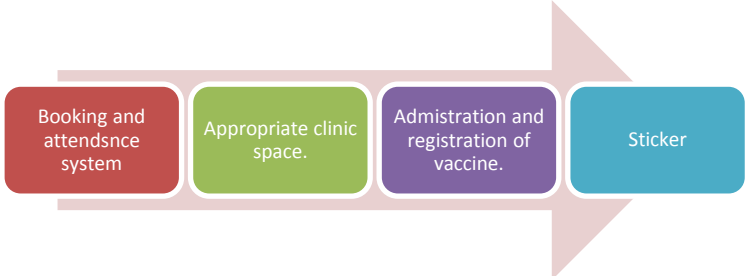
We have already begun to develop a FAQ (frequently asked question) based upon initial questions and feedback from colleagues and we will evolve this as the programme develops. Colleagues are interested in the relationship between the Flu and COVID-19, the association with future COVID-19 vaccination programme. The vaccine mandate which was intended to come into effect in early 2022 has polarised opinion towards vaccination and we need to be sensitive to the impact / effect this has on uptake and vary our approach and communications accordingly. The focus on informed choice, to support discussion of facts and evidence and to respect personal choice.

Communications

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

The **communication strategy** for 2023/24 is intentionally simple; the **focus is on informed choice**, to support discussion of **facts and evidence** and to **respect personal choice**. The offer to opt in or out is consciously avoided and we are asserting the expectation that people will want and access a **vaccine as a key patient safety initiative**.

Clinic settings for Flu, Flu and COVID



Currently we have several sites across Derbyshire including some of our team bases with clinic space.

- The clinic settings provide a clean room in line with IPC clinical guidance for the administration of vaccines and account for privacy and dignity requirements.
- The clinics will have adequate cold storage capacity for the flu vaccines and fridges will be temperature checked and monitored in accordance with the medicines code.
- The booking system DHCFT have developed and shared alongside DCHS will be utilised for efficiency and familiarity.

Staff resource

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

The option for staff to attend in an ad hoc fashion is also available. Inpatient staff will have on site vaccinators able to facilitate vaccines as well.

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

IT system support and external reporting

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

The trust COVID and Flu vaccination group are meeting weekly currently and have a reporting format in place to support organisations to demonstrate progress and escalate any local challenges.

DHCFT have worked closely with DCHS and are sharing learning to ensure that we learn from and contribute to system wide learning. The challenges around written instructions and the legal aspects of the medicines code have been well discussed and we have a model which allows us to operate safely and with good governance within the scope of the medicines code and legislation through a Memorandum of Understanding.

Regarding gaps and challenges in coming weeks for consideration.

- Board Champion – Jaki Lowe/Rebecca Oakley
- Incentive scheme – Local recommendation to avoid – stickers are still a useful and well received recognition of attending for vaccination

- Celebrating success – Oversight of uptake will be through the NHSE platform of Foundry as this provides demographic detail around uptake (no personally identifiable data) and correlates with COVID19 vaccination programme data. ImmForm data is less reliable as it does not identify colleagues who have been vaccinated elsewhere.
- Quality Improvement (QI) approach – this is being applied to all stages and the Flu / COVID-19 programmes have been developed utilising QI methodology over the last four seasons
- The post-mandate effect and growing disquiet on social media about the COVID-19 programme are expected to impact upon uptake rates
- Clear and simple message – supporting informed choice.

Richard Morrow
Assistant Director of Public and Physical Health Care
August 2023

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 5 September 2023

WRES and WDES 2022/23 submission update

Purpose of Report

To update the Trust Board on progress with the work on the 2022/23 Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) submissions.

To request Board delegated authority for the People and Culture Committee (PCC) meeting to approve the Action Plan Submissions for 31 October deadlines respectively at the meeting of the Committee on 19 September 2023.

Executive Summary

The WRES is a set of evidence-based indicators that compare the workplace experience of Black and Minority Ethnic (BME) staff and White staff. The WDES compares the workplace experience of Disabled and non-disabled staff.

NHS organisations must submit the WRES and WDES datasets to NHS England by 31 August 2023 and this year's submission has been made. The WRES and WDES dataset and corresponding action plan must then be agreed by the Board and published on the Trust's public-facing website by 31 October 2023. Finally, the completed reports must then be shared with commissioners as part of the quality schedule. As in 2022, delegated authority is requested due to the time tabling set by NHS England. From the submission and subsequent analysis of data to approval by the Board, too small a window remains in which to consult and co-create actions. This is a frustration shared by Joined Up Care Derbyshire (JUCD) partners.

The proposed actions will be developed with representatives from the BME and Disability and Wellbeing Network (DAWN) staff networks and explicitly link to the Trust's values and strategic objective of "Great Place to Work".

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

Assurances

- Delivery against the action plans for the WRES and WDES is monitored by the Executive Leadership Team and EDI Steering Group
- The new Trust Operational Oversight Meeting with senior leaders has regular agenda items on EDI
- A live set of data has been established so we can track progress throughout the year.

Consultation

We have commenced the process of engagement with Network Chairs and this will progress further as outlined in the paper in September to be published in October.

Governance or Legal Issues

- Reporting the WRES and WDES is a mandatory requirement of the NHS Standard Contract. The Trust is required to submit the WRES and WDES datasets to NHS England by 31 August 2023. This has been completed.

  The WRES and WDES dataset and action plan must be published on the Trust's external website by 31 October 2023.

- Undertaking the WRES and WDES demonstrates the Trust's commitment to the Equality Act 2010 and the Public Sector Equality Duty.

Aligning with national EDI (Equality, Diversity and Inclusion) programmes of work

The WRES and WDES are key measures in the Trust's data monitoring for workforce equality. Each Standard is comprised of data from the Staff Survey and ESR (Electronic Staff Record). The veracity of each Standard rests, to some extent, on the data quality and completion rates in ESR and the staff survey.

The WRES and WDES, alongside other metrics will also drive improvements and reduce race and disability disparity patients and their care, as it encourages the development of a more diverse, empowered, and valued workforce, and a better understanding of race and disability equality across the Trust's workforce and that of the NHS nationally.

The action plans for WRES and WDES will place a high priority on meeting two of the 6 High Impact Actions set out in the NHS England EDI (Equality, Diversity & Inclusion) Improvement Plan 2023:

High Impact Action 2: Embed fair and inclusive recruitment processes and talent management strategies that target under-representation and lack of diversity.

High Impact Action 6: Create an environment that eliminates the conditions in which bullying, discrimination, harassment and violence at work occur.

The data sets will also contribute to evidence for the self-assessment Equality Delivery System 2022 which references bullying, harassment and discrimination.

Recommendations

The Board of Directors is requested to give delegated authority to People and Culture Committee on 19 September 2023 to approve the 2022/23 WRES and WDES action plans.

Report presented by: **Ralph Knibbs**
Chair, People and Culture Committee

Report prepared by: **Rebecca Oakley,**
Deputy Director of People and Inclusion

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Term / Abbreviation	**Terms in Full**
A	
A&E	Accident & Emergency
ACCT	Assessment, Care in Custody & Teamwork
ACE	Adverse Childhood Experiences
ADHD	Attention Deficit Hyperactivity Disorder
AfC	Agenda for Change
AHP	Allied Health Professional
AIMS	Royal College of Psychiatrists Accreditation for Inpatient Mental Health Services Standards
ALB	Arms-length body such as NHS Improvement (NHSI) and NHS England (NHSE)
AMM	Annual Members' Meeting
AMHP	Approved Mental Health Professional
ANP	Advanced Nurse Practitioner
AO	Accountable Officer
ASD	Autism Spectrum Disorder
ASM	Area Service Manager
B	
BAF	Board Assurance Framework
BLS	Basic Life Support (ILS Immediate Life Support)
BMA	British Medical Association
BME	Black,& Minority Ethnic group
BoD	Board of Directors
C	
CAMHS	Child and Adolescent Mental Health Services
CASSH	Care and Support Specialised Housing
CBT	Cognitive Behavioural Therapy
CCG	Clinical Commissioning Group (defunct from 1 July 2022)
CCT	Community Care Team
CDMI	Clinical Digital Maturity Index
CE	Chief Executive
CEO	Chief Executive Officer
CGA	Comprehensive Geriatric Assessment
CHPPD	Care Hours Per Patient Day
CIP	Cost Improvement Programme
CMDG	Contract Management Delivery Group
CMHF	Community Mental Health Framework
CMHT	Community Mental Health Team
CNST	Clinical Negligence Scheme for Trusts
COAT	Clinical Operational Assurance Team
COF	Commissioning Outcomes Framework
CoG	Council of Governors
COO	Chief Operating Officer
CPA	Care Programme Approach
CPD	Continuing Professional Development
CPN	Community Psychiatric Nurse
CPR	Child Protection Register

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Term / Abbreviation	**Terms in Full**
CQC	Care Quality Commission
CQI	Clinical Quality Indicator
CQUIN	Commissioning for Quality and Innovation
CRG	Clinical Reference Group
CRH	Chesterfield Royal Hospital
CRHT	Crisis resolution and home treatment
CRS	(NHS) Care Records Service
CRS	Commissioner Requested Services
CSF	Commissioner Sustainability Fund
CTO	Community Treatment Order
CTR	Care and Treatment Review
D	
DAR	Divisional Assurance Review
DAT	Drug Action Team
Datix	Trust's electronic incident reporting system of an event that causes a loss, injury or a near miss to a patient, staff or others
DBS	Disclosure and Barring Service
DBT	Dialectical Behavioural Therapy
DfE	Department for Education
DCHS	Derbyshire Community Health Services NHS Foundation Trust
DDCCG	Derby and Derbyshire Clinical Commissioning Group
DHCFT	Derbyshire Healthcare NHS Foundation Trust
DIT	Dynamic Interpersonal Therapy
DNA	Did Not Attend
DoH	Department of Health
DoLS	Deprivation of Liberty Safeguards
DRRT	Dementia Rapid Response Team
DSPT	Director of Strategy, Partnerships and Transformation
DOF	Director of Finance
DON	Director of Nursing
DPI	Director of People and Inclusion
DPS	Date Protection and Security
DNA	Did not attend
DPA	Data Protection Act
DRRT	Dementia Rapid Response Team
DTOC	Delayed Transfer of Care
DVA	Derbyshire Voluntary Action (formerly North Derbyshire Voluntary Action)
DWP	Department for Work and Pensions
E	
ECT	Enhanced Care Team
ECW	Enhanced Care Ward
ED	Emergency Department
EDS2	Equality Delivery System 2
EHIC	European Health Insurance Card
EHR	Electronic Health Record
EI	Early Intervention
EIA	Equality Impact Assessment
EIP	Early Intervention In Psychosis

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Term / Abbreviation	**Terms in Full**
ELT	Executive Leadership Team
EMDR	Eye Movement Desensitising and Reprocessing Therapy
EMR	Electronic Medical Record
EPMA	Electronic Prescribing and Medicine Administration
EPR	Electronic Patient Record
ERIC	Estates Return Information Collection
ESR	Electronic Staff Record
EUPD	Emotionally Unstable Personality Disorder
EWTD	European Working Time Directive
F	
FBC	Full Business Case
FFT	Friends and Family Test
FOI	Freedom of Information
FSR	Full Service Record
FT	Foundation Trust
FTE	Full-time Equivalent
FTN	Foundation Trust Network
FTSU	Freedom to Speak Up
FTSUG	Freedom to Speak Up Guardian
F&P	Finance and Performance
5YFV	Five Year Forward View
G	
GDPR	General Data Protection Regulation
GGI	Good Governance Institute
GIRFT	Getting it Right First Time
GMC	General Medical Council
GP	General Practitioner
GPFV	General Practice Forward View
H	
HCA	Healthcare Assistant
H1	First half of a fiscal year (April through September)
H2	Second half of a fiscal year (October through the following March)
HEE	Health Education England
HES	Hospital Episode Statistics
HoNOS	Health of the Nation Outcome Scores
HSCIC	Health and Social Care Information Centre
HSE	Health and Safety Executive
HWB	Health and Wellbeing Board
I	
IAPT	Improving Access to Psychological Therapies
ICB	Integrated Care Board
ICM	Insertable Cardiac Monitor
ICS	Integrated Care System
ICT	Information and Communication Technology
ICU	Intensive Care Unit
IDVAs	Independent Domestic Violence Advisors
IG	Information Governance
ILS	Immediate Life Support (BLS – Basic Life Support)

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Term / Abbreviation	**Terms in Full**
IMT	Incident Management Team
IM&T	Information Management and Technology
IRHTT	In-reach Home Treatment Team
IPP	Imprisonment for Public Protection
IPR	Integrated Performance Report
IPT	Interpersonal Psychotherapy
J	
JNCC	Joint Negotiating Consultative Committee
JTAI	Joint Targeted Area Inspections
JUCB	Joined Up Care Board
JUCD	Joined Up Care Derbyshire
K	
KLOE	Key Lines of Enquiry (CQC)
KPI	Key Performance Indicator
KSF	Knowledge and Skills Framework
L	
LA	Local Authority
LCFS	Local Counter Fraud Specialist
LD	Learning Disabilities
LD/A	Learning Disability and Autism
LHP	Local Health Plan
LHWB	Local Health and Wellbeing Board
LOS	Length of Stay
LPS	Liberty Protection Safeguards
LTP	Long Term Plan
M	
MADE	Multi-agency Discharge Event
MARS	Mutually Agreed Resignation Scheme
MAU	Medical Assessment Unit
MAS	Memory Assessment Service
MAPPA	Multi-agency Public Protection Arrangements
MARAC	Multi-agency Risk Assessment Conference (meeting where information is shared on the highest risk domestic abuse cases between representatives of local police, probation, health, child protection, housing practitioners, Independent Domestic Violence Advisors (IDVAs) and other specialists from the statutory and voluntary sectors.
MASH	Multi-Agency Safeguarding Hub
MCA	Mental Capacity Act
MD	Medical Director
MDA	Medical Device Alert
MDM	Multi-Disciplinary Meeting
MDT	Multi-Disciplinary Team
MFF	Market Forces Factor
MHA	Mental Health Act
MHAC	Mental Health Act Committee
MHIN	Mental Health Intelligence Network
MHIS	Mental Health Investment Standard

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Term / Abbreviation	**Terms in Full**
MHLT	Mental Health Liaison Team
MHRT	Mental Health Review Tribunal
MSC	Medical Staff Committee
MSK	Musculoskeletal (conditions)
MSU	Medium secure unit
N	
NCRS	National Cancer Registration Service
NED	Non-Executive Director
NICE	National Institute for Health and Care Excellence
NHS	National Health Service
NHSE	National Health Service England
NHSI	National Health Service Improvement
NHSEI	NHS England and NHS Improvement
NIHR	National Institute for Health Research
O	
OBC	Outline Business Case
ODG	Operational Delivery Group
OOA	Outside of Area
OPMO	Older People's Mental Health Services
OP	Outpatient
OSC	Overview and Scrutiny Committee
OT	Occupational therapy
P	
PAB	Programme Assurance Board
PAG	Programme Advisory Group
PALS	Patient Advice and Liaison Service
PAM	Payment Activity Matrix
PARC	Psychosis and the reduction of cannabis (and other drugs)
PARIS	This is an electronic patient record system
PbR	Payment by Results
PCC	Police & Crime Commissioner
PCC	People and Culture Committee
PCN	Primary Care Networks
PDSA	Plan, Do, Study, Act
PHE	Public Health England
PICU	Psychiatric Intensive Care Unit
PID	Project Initiation Document
PiPoT	People in Positions of Trust
PLIC	Patient Level Information Costs
PMLD	Profound and Multiple Disability
PPE	Personal Protection Equipment
PPI	Patient and Public Involvement
PPT	Partnership and Pathway Team
PREM	Patient Reported Experience Measure
PROMS	Patient Reported Outcome Measure
PSF	Provider Sustainability Fund
PSIRF	Patient Safety Incident Review Framework
Q	

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Term / Abbreviation	**Terms in Full**
QAG	Quality Assurance Group
Q&SC	Quality and Safeguarding Committee
QIA	Quality Impact Assessment
QIPP	Quality, Innovation, Productivity Programme
R	
RAID	Rapid Assessment, Interface and Discharge
RCGP	Royal College of General Practitioners
RCI	Reference Cost Index
REGARDS	Race, Economic disadvantage, Gender, Age, Religion or belief, Disability and Sexual orientation
RTT	Referral to Treatment
S	
SAAF	Safeguarding Adults Assurance Framework
SBARD	Situation, Background, Assessment, Recommendation and Decision (SBARD) tool
SBS	Shared Business Services
SEND	Special Educational Needs and Disabilities
SFI	Standing Financial Instructions
SI	Serious Incidents
SID	Senior Independent Director
SIRI	Serious Incident Requiring Investigation
SLA	Service Level Agreement
SLR	Service Line Reporting
SMI	Severe Mental Illness
SOC	Strategic Options Case
SOF	Single Operating Framework
SPOA	Single Point of Access
SPOE	Single Point of Entry
SPOR	Single Point of Referral
STEIS	Strategic Executive Information System
STF	Sustainability and Transformation Fund
STP	Sustainability and Transformation Partnership
SUI	Serious (Untoward) Incident
SystmOne	Electronic patient record system
T	
TARN	Trauma Audit and Research Network
TCP	Transforming Care Partnerships
TCS	Transforming Community Services
TDA	Trust Development Authority
TMT	Trust Management Team
TUPE	Transfer of Undertakings (Protection of Employment) Regulations 1981
TMAC	Trust Medical Advisory Committee (now Medical Senate)
TOOL	Trust Operational Oversight Leadership
U	
UDBH	University Hospitals of Derby and Burton
UEC	Urgent and emergency care
V	

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Term / Abbreviation	**Terms in Full**
VARM)	Vulnerable Adult Risk Management
VO	Vertical Observatory
W	
WDES	Workforce Disability Equality Standard
WRES	Workforce Race Equality Standard
WTE	Whole Time Equivalent
Y	
YTD	Year to Date

(updated May 2023)

2023/24 Board Annual Forward Plan

Exec Lead	Meeting date	9 May 23	4 Jul 23	5 Sep 23	7 Nov 23	18 Jan 24	5 Mar 24
	Paper deadline	**2 May**	**26 Jun**	**29 Aug**	**30 Oct**	**8 Jan**	**26 Feb**
Trust Sec	Declaration of Interests	X	X	X	X	X	X
DON	Patient/Staff Story	X	X	X	X	X	X
CHAIR	Minutes/Matters arising/Action Matrix	X	X	X	X	X	X
CHAIR	Board review of effectiveness of meeting	X	X	X	X	X	X
CHAIR	Board Forward Plan (for information)	X	X	X	X	X	X
CHAIR	Summary of Council of Governors meeting (for information)	X	X		X	X	X
CHAIR	Chair's Update	X	X	X	X	X	X
CEO	Chief Executive's Update	X	X	X	X	X	X
STRATEGIC PLANNING AND CORPORATE GOVERNANCE							
DSPT	Trust Strategy progress update	X		X		X	
DPI	Staff Survey Results (following assurance at PCC)	X					
DPI	Annual Gender Pay Gap Report for approval (following assurance at PCC)	X					
DPI	Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) request for Board delegated authority for People and Culture Committee meeting on 19 September to approve the October submissions			X			
DPI	Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) Strategic implications/retrospective sign off after PCC on 19 September				X		
DPI	Workforce Plan for 2023/24				X		
DPI	Annual Approval of Modern Slavery Statement (following assurance at PCC)	X					
DPI	2023/24 Flu Campaign			X			
Trust Sec	Corporate Governance Report	X					
Trust Sec	NHS Improvement Year-End Self-Certification (within Corp Gov Report)	X					
Trust Sec	Year-end governance reporting from Board Committees and approval of ToRs (within Corp Gov report)	X					
Trust Sec	Trust Sealings (six monthly - for information) within Corp Gov report	X					
Trust Sec	Annual Review of Register of Interests	X					
Trust Sec	Board Assurance Framework Update	X		X	X		X
Trust Sec	Freedom to Speak Up Guardian Report (six monthly)			X			X
Trust Sec	Board Effectiveness Report				X		
Trust Sec	SIRO Data Security and Protection update			X			
Trust Chair	Fit and Proper Person Declaration			X			
DPSPT/DoF	Operational/ Financial Plan	X					
Committee Chairs	Board Committee Assurance Summaries	X	X	X	X	X	X
OPERATIONAL PERFORMANCE							
DON/DOF/ DPI/COO	Integrated performance and activity report to include Finance, People performance and Quality	X	X	X	X	X	X
DSPT	ICB Joint Forward Plan (included in CEO Update)		X				
DPI	Equality Diversity and Inclusion (EDI) update				X		
COO	Emergency Preparedness, Resilience and Response (EPRR) Core Standards			X			
COO/Prog Director	Making Room for Dignity progress	X			X		
DON/COO/ DPI	Workforce Standards Formal Submission/Safer Staffing (prior to publishing on website) following assurance at PCC	X					

2023/24 Board Annual Forward Plan

Exec Lead	Meeting date	9 May 23	4 Jul 23	5 Sep 23	7 Nov 23	18 Jan 24	5 Mar 24
QUALITY GOVERNANCE							
EXEC	Position Statement - focus on CQC domains (Well Led CQC & NHSI) as per schedule	Caring DON	Well Led Trust Sec		Safe MD	Responsive COO	Effective DON MD & DPI
MD	Learning from Deaths Mortality report (quarterly publication) (Sep/Nov/Jan/Mar)	AR		X	X	X	X
MD	Guardian of Safe Working Report		AR		X	X	X
DSPT	Continuous Quality Improvement: A Stocktake						X
DON	Infection Prevention and Control Annual Report and BAF					AR	
MD	Re-validation of Doctors Compliance Statement		X				
MD	Mental Health Bill			X			
DON	Assuring Quality Care					X	
DON	Receipt of Annual Reports: - Annual Looked After Children - Safeguarding Children and Adults at Risk				X		
DON	Outcome of Patient Stories - every two years - due March 2024						X
POLICY REVIEW							
DOF/ Trust Sec	Standing Finance Instructions Policy and Procedures Review (May 2023)	X					