



Derbyshire Healthcare
NHS Foundation Trust

Derbyshire Healthcare NHS Foundation Trust Meeting of the Board of Directors

To be held digitally via MS Teams
13 January 2021 09:30 - 13 January 2021 12:30

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**NOTICE OF A VIRTUAL PUBLIC BOARD MEETING – WEDNESDAY 13 JANUARY 2021
TO COMMENCE AT 9:30am**

Following national guidance on keeping people safe during COVID-19 this will be a virtual meeting conducted digitally via Microsoft Teams technology

	TIME	AGENDA	LED BY
1.	9:30	Chair's welcome, opening remarks and apologies, declarations of interest	Caroline Maley
2.		Patient Story	Carolyn Green
3.		Minutes of Board of Directors meeting held on 3 November 2020	Caroline Maley
4.		Matters arising – Actions Matrix	Caroline Maley
5.		Questions from Governors or members of the public	Caroline Maley
6.	10:00	Chair's Update	Caroline Maley
7.	10:10	Chief Executive's Update	Ifti Majid
STRATEGY AND OPERATIONAL PERFORMANCE AND QUALITY ASSURANCE			
8.	10:30	Integrated Performance and Activity Report	C Wright / J Lowe / C Green / M Powell
9.	10.45	COVID-19 update	Mark Powell
B R E A K			
10.	11:15	Health and Wellbeing briefing including Flu/COVID vaccine (verbal update)	Jaki Lowe
11.	11:35	Cultural Intelligence (verbal update)	Jaki Lowe
12.	11:55	Annual Emergency Planning Report (EPPR)	Mark Powell
13.	12:05	Learning from Deaths Mortality Report	John Sykes
GOVERNANCE			
14.	12:15	Board Committee Assurance Summaries: Quality and Safeguarding 10 November and 8 December, People and Culture 24 November, Finance and Performance 17 November, Mental Health Act 11 December 2020	Committee Chairs/ Justine Fitzjohn
CLOSING MATTERS			
15.	12:30	- Identification of any issues arising from the meeting for inclusion or updating in the Board Assurance Framework - Meeting effectiveness	Caroline Maley
FOR INFORMATION			
Summary Report from the Council of Governors meeting held 3 November 2020 Glossary of NHS Acronyms 2020/21 Forward Plan 2021/22 Draft Forward Plan			

Questions that are applicable to the agenda, and at the Chair's discretion, can be sent by email to the Board Secretary up to 48 hours prior to the meeting for a response provided by the Board at the meeting. Email: sue.turner17@nhs.net

The Trust Chair may, under the Foundation Trust's Constitution, request members of the public to withdraw for the Board to conduct its remaining business in confidence as special reasons apply or because of information which is likely to reveal the identities of an individual or commercial bodies.

The next meeting will be held at 9.30am on 2 March 2021. It is anticipated that this meeting will be held digitally via MS Teams

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

Participation in meetings is at the Chair's discretion

Our vision

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

Our values

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

Our Trust values are:

People first – We focus on our colleagues, in the knowledge that a well-supported, engaged and empowered workforce results in good patient care.

Respect – We respect and value the diversity of our patients, colleagues and partners and support a respectful and inclusive environment.

Honesty – We are open and transparent in all we do.

Do your best – We work closely with our partners to achieve the best possible outcomes for people.



DECLARATION OF INTERESTS REGISTER 2020/21		
NAME	INTEREST DISCLOSED	TYPE
Margaret Gildea Non-Executive Director	<ul style="list-style-type: none"> Director, Organisation Change Solutions Limited (mentoring client from First Steps (Eating Disorders) as part of Organisation Change Solutions) 	(a, b) (a)
Gareth Harry Director of Director of Business Improvement and Transformation	<ul style="list-style-type: none"> Chair, Marehay Cricket Club Member of the Labour Party Mother is a member of Amber Valley Borough Council 	(d) (e) (c, e)
Ashiedu Joel Non-Executive Director	<ul style="list-style-type: none"> Trustee at The Bridge (East Midlands) in Loughborough Director/Owner Ashioma Consults Ltd Director/Co-owner Peter Joel & Associates Ltd 	(a)
Geoff Lewins Non-Executive Director	<ul style="list-style-type: none"> Director, Arkwright Society Ltd 	(a)
Jaki Lowe Director of People and Inclusion	<ul style="list-style-type: none"> General Medical Council Associate 	(e)
Ifti Majid Chief Executive	<ul style="list-style-type: none"> Board Member NHS Confederation Mental Health Network Kate Majid (spouse) is Operations Director (North), Priory Group 	(e) (a, e)
Mark Powell Chief Operating Officer	<ul style="list-style-type: none"> Chair of Governors, Brookfield Primary School, Mickleover, Derby 	(e)
Dr Julia Tabreham Non-Executive Director	<ul style="list-style-type: none"> Director of Research and Ambassador Carers Federation 	(a)
Dr John Sykes Medical Director	<ul style="list-style-type: none"> Undertakes paid assessments of patients at the request of the local authorities under the Mental Health Act and Mental Capacity Act and acts likewise for solicitors representing patients 	(e)
Richard Wright Deputy Trust Chair and Non-Executive Director	<ul style="list-style-type: none"> Chair Sheffield UTC Multi Academy Trust Board Member, National Centre of Sport and Exercise Medicine Sheffield Member of the Advisory Panel, Sheffield Hallam Business School Chair, System Finance Oversight Group, Joined Up Care Derbyshire (JUCCD) 	(a) (a) (d)

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

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

**MINUTES OF A VIRTUAL
MEETING OF THE BOARD OF DIRECTORS
TUESDAY 3 NOVEMBER 2020**

VIRTUAL MEETING VIA MS TEAMS	
Commenced: 9.30am	Closed: 1pm

- | | | |
|--|--|--|
| PRESENT | Caroline Maley
Richard Wright
Margaret Gildea

Geoff Lewins
Dr Sheila Newport
Dr Julia Tabreham
Ashiedu Joel
Ifti Majid
Claire Wright
Mark Powell
Dr John Sykes
Carolyn Green
Gareth Harry
Jaki Lowe
Justine Fitzjohn | Trust Chair
Deputy Trust Chair and Non-Executive Director
Senior Independent Director and Non-Executive Director

Non-Executive Director
Non-Executive Director
Non-Executive Director
Non-Executive Director
Chief Executive
Deputy Chief Executive & Director of Finance
Chief Operating Officer
Medical Director
Director of Nursing & Patient Experience
Director of Business Improvement & Transformation
Director of People and Inclusion
Trust Secretary |
| IN ATTENDANCE | Anna Shaw
Sue Turner
Samantha Parr
Fiona Rushbrook
Kirsty
Clare Meredith | Deputy Director of Communications & Involvement
Board Secretary
Individual Placement and Support Manager
OT Lead and Professional Lead for Community Specialists
Equal Forum Member
Equality, Diversity and Inclusion Advisor |
| For DHCFT2020/084
For DHCFT2020/084
For DHCFT2020/089
For DHCFT2020/101 | | |
| OBSERVERS | <i>There were no public observers as technical issues prevented the meeting being live streamed</i> | |

DHCFT 2020/083	<p><u>CHAIR'S WELCOME, OPENING REMARKS, APOLOGIES FOR ABSENCE AND DECLARATION OF INTERESTS</u></p> <p>Due to the need for social distancing to help limit the spread of COVID-19, this was a virtual meeting, held via MS Teams.</p> <p>The Trust Chair, Caroline Maley, welcomed everyone to meeting including the Trust's Lead Governor, other Governors and members of staff and the public observing via live streaming. It was later discovered that a technical failure had prevented them access to the meeting via the live streamed link.</p> <p>No declarations of interest declared, other than those already recorded on the formal register of Directors' interests.</p>
DHCFT 2020/084	<p><u>PATIENT STORY</u></p>

	<p>Samantha Parr, Individual Placement and Support Manager joined the meeting to talk about the “Work Your Way” Individual Placement and Support (IPS) employment support service that helps people with severe mental health difficulties gain paid work.</p> <p>The service was launched in March 2020 and had to be paused for three months a week after the launch as the team were redeployed to essential roles in response to COVID-19. The service was resumed in June working alongside Community Mental Health Teams (CMHTs) and is helping provide individuals with sustainable work. Samantha reported on a number of success stories resulting in people now being settled in their ideal jobs.</p> <p>Non-Executive Director, Sheila Newport was mindful of the difference that being in paid employment makes to individuals and asked how much capacity there was for providing opportunities for people given the IPS collaboration with South Yorkshire Housing Association. Samantha described how she and her colleagues had built better opportunities and joined up careers with other partners over the county and signpost people to apply to employment or benefit services in their own area. This has been done without need for a waiting list and there is a readiness of prospects.</p> <p>Chief Executive, Ifti Majid reflected on the success stories and asked if any particular employers across the county are more willing to work in partnership with the Trust’s IPS service. Samantha advised that the IPS service is driven solely by what the client wants. So far clients have not been employed by one main employer and have been employed by different organisations. Employers are keen to work with the IPS service on behalf of the NHS and have responded extremely positively.</p> <p>Director of Business Improvement and Transformation, Gareth Harry shared his admiration for how the IPS team operates with professionals within the mental health community team and of the strong partnership they have with South Yorkshire Housing Association. He expects as investment monies start to come in through transformation this service will be able to expand further.</p> <p>The Board was aware of how unemployment has a detrimental impact on physical and mental health. Caroline Maley thanked Samantha on behalf of the Board for providing an insight into IPS and the lived examples of people who have used the service and looked forward to meeting service user Sarah outside of the meeting with Ifti to learn about her experience of IPS.</p> <p>RESOLVED: The Board of Directors noted the positive outcomes of people who have found sustainable work through the use of the IPS service.</p>
<p>DHCFT 2020/085</p>	<p><u>MINUTES OF THE BOARD OF DIRECTORS MEETING HELD ON 1 SEPTEMBER 2020</u></p> <p>The minutes of the previous meeting, held on 1 September 2020, were accepted as a correct record of the meeting.</p>
<p>DHCFT 2020/086</p>	<p><u>ACTIONS MATRIX</u></p> <p>The Board agreed to close all completed actions. Updates were provided by members of the Board and noted on the actions matrix. All completed actions were scrutinised to ensure that they were fully complete.</p> <p><u>MATTERS ARISING</u></p> <p>DHCFT2020/073 Appointment of the Trust’s Wellbeing Guardian The wellbeing of the Trust’s staff improves the outcomes for patients. Discussions have been held with Non-Executive Director, Sheila Newport about her taking on this role which is expected to be in place in time for the next Board meeting to be held in January.</p>
<p>DHCFT 2020/087</p>	<p><u>QUESTIONS FROM GOVERNORS OR MEMBERS OF THE PUBLIC</u></p>

A number of questions had been submitted for a response ahead of today's meeting. A question from a former Governor and service user had been raised at the Annual Members Meeting held on 1 September. This service user was informed that their question summarised below would be raised formally at the next Board meeting and has been responded to directly.

Since some of the mental health professionals have been servicing the 24 hour helpline and some staff have been unable to work as they have been shielding, unwell with COVID-19 or caring for their children, there will have been considerably fewer professionals available to treat existing patients. To what extent has this impacted negatively on the mental health and wellbeing of existing patients? How has the trust measured impact and wellness? How does the Trust know how well or unwell patients are when there have been few face to face appointments?

A response was made by Medical Director, John Sykes:

- We have concentrated on maintaining essential services whilst reducing infection risk for patients and staff
- Parallel to this we have maintained contact with the most vulnerable patients in the community mostly virtually but also face to face where necessary
- The admission rate has remained fairly constant but length of stay has significantly decreased. We are assessing the readmission rate and patient satisfaction feedback.
- We have seen an increase in patients who are acutely ill with psychotic illnesses but audit showed that this was not due to lack of contact with our services. 50% of this group were unknown to the Trust previously. This reflects a national picture and seems to be some effect of the pandemic that we do not currently fully understand.
- We are now picking up on routine contact with patients and whilst undoubtedly many have suffered as a consequence of the pandemic restrictions there is also evidence of remarkable resilience.
- Infection control measures and the consequences for estates mean that we cannot offer patients the choice of face to face appointments based solely on preference. This is available, however, when there are compelling medical, psychological or social reasons for a physical face to face consultation. Long term increase in psychiatric morbidity as a result of the pandemic is predicted and we are working with commissioners to secure the necessary increase in capacity to respond to this.

Two other questions had been received from one of the Trust's Governors:

How many COVID-19 waves is the NHS planning for?

Chief Executive, Ifti Majid responded that the Trust is planning for two waves of COVID-19 related activity throughout the winter period into spring and is anticipating that this will be complicated by winter pressures and respiratory illnesses during the winter period.

75% of suicides in Mental Hospitals are by hanging. Why are ligature points not removed either when the hospital is initially designed/built or as a consequence of quality visits?

A response was made by Director of Nursing and Patient Experience, Carolyn Green:

- Losing a member of the Trust's community in an inpatient setting by ligature is a very distressing event for everyone involved and the loss of life to the family is incredibly painful.
- All of the Trust's service facilities undergo extensive ligature assessments.
- New anti-ligature equipment is released every year and investment programmes to find new ways to reduce the risk continually look for new ways to reduce the risks and adopt new research practices and ideas. This work is never done.
- Unfortunately acute mental distress is increasing and more home treatment options

	<p>are offered. The people in our hospital settings are often actively suicidal and constantly looking for ways to end their life.</p> <ul style="list-style-type: none"> • The Trust is constantly investing in new ways to eradicate the risk and has removed a large number of ligature risk points. However, people are also discovering and using non-fixed ligatures. • The Trust continues to invest in this area and in psychological approaches to reach people who have lost hope and have great impulsivity. • The Trust strongly recommends both physical investment in its estate but also in psychological response to help people choose life. This is part of the suicide reduction strategy, trauma informed practice and use of significant staffing levels on the wards to invest in the therapeutic feeling as well as the fabric of our wards. <p>A question had also been received from a service user about their personal care which would not be appropriate to discuss in the meeting. This person is now in contact with the clinical service in response to their questions.</p>
<p>DHCFT 2020/088</p>	<p><u>CHAIR'S UPDATE</u></p> <p>Caroline Maley's report provided the Board with reflections on her activity in terms of her role as Trust Chair since the previous Board meeting held on 1 September and outlined virtual engagement with colleagues during the ongoing pandemic.</p> <p>At the last meeting the Trust was looking to restore services and reshape how services would be delivered. Since then with increasing COVID activity and the consequential impact on staff and service users within the county, Caroline underlined how proud she was of the organisation and thanked everyone for what they had achieved over the past months especially through the increased COVID-19 activity.</p> <p>Caroline drew attention the two Schwartz Rounds she participated in which focussed on the experience of staff who were redeployed in the first phase of the pandemic. She hopes that lessons learned about redeployment can be built on as the Trust moves forward into the second phase. Caroline mentioned that she is exploring the possibility of using thematic inputs from the Schwartz rounds into the work of the Non-Executive Directors (NEDs) and the Board but within the confines of confidentiality and licence restrictions that may exist with these rounds.</p> <p>Caroline thanked Governors for all their support over months. The Trust has said goodbye to a number of governors recently and it is hoped that the next phase of elections in early 2021 will fill the gaps that are now appearing in the Council.</p> <p>The last few months have also been very busy with system meetings, regional meetings and national meetings. Attention was drawn to the notes from the Joined up Care Derbyshire (JUCD) meeting held on 17 September which is also detailed in Ifti Majid's Chief Executive Update.</p> <p>RESOLVED: The Board of Directors noted the content of the Chair's update.</p>
<p>DHCFT 2020/089</p>	<p><u>CHIEF EXECUTIVE'S REPORT</u></p> <p>Ifti Majid's report provided the Board with feedback on changes within the national health and social care sector, and an update on developments occurring within the local Derbyshire health and social care community as influenced by the NHS response to the pandemic, and how to learn lessons from the response. The Board noted that the report reflects a wider view of the Trust's operating environment and risks that may affect the organisation. These will be taken forward to assess their operational and strategic impact, and recorded on operational risk registers, or the Board Assurance Framework (BAF), as appropriate. Information around the Midlands Strategic Transformation and Recovery Board (STAR) and JUCD was also included in the report as well as regional updates.</p> <p>Included in the report were the findings from the Care Quality Commission's (CQC)</p>

inspection of the Hartington Unit and Ifti expressed his thanks to everyone involved in the visit. It was clear that the CQC is mindful of the improvements made by the unit. The report also shows the good practice that is coming through that needs to be focussed on and celebrated. There are also areas that were challenged in the unit's response to COVID-19 that need to be concentrated on.

Ifti talked about the Equal Forum that was set up to support change through engagement with people who use the Trust's services as well as carers. Joining Ifti for this item was Kirsty, a member of the Equal Forum who had been invited to hear the Board discuss concerns raised by the Forum about their connection with the Trust.

Positive investment into the EQUAL network will provide a much needed resource to bring out Trust commitments and pledges to the life in positive and impactful ways to influence our organisation and our improvements.

The core areas of concern were around how people who use the Trust's services can be involved in pandemic planning and with how services are set back up and included and consulted with about the Long Term Plan. Concern was also raised about how senior posts were being advertised without the involvement of people using the Trust's services. There were also some worries about good practice involving people using services when the indication was that services had been paused and how Equal Forum members can be supported and debriefed when they have been involved in developing processes within the Trust.

The Board noted the examples of when the Equal Forum could have been more involved on behalf of service users and the movement towards inviting Forum members to be involved in the recovery period of COVID-19 and in system recovery work. It was acknowledged that the Trust is actively looking at how direct representation can be had from people with lived experience to improve reporting into the Equal Forum. This would be taken forward further with Kirsty who commented that it was good to know that the Board was committed to involving the Equal Forum in further developing the mental health framework and was thanked for being present for this discussion.

Ifti noted the dedication that Trust colleagues have displayed in the face of a significantly challenging working environment especially now that more staff are absent from work with COVID related complications due to significantly increasing transmission rates in Derby and Derbyshire. Ifti assured the Board that the measures that colleagues have put in place in the organisation will ensure that the Trust remains in control of the situation. The focus being made on strong infection prevention and control is paying dividends in equipping the Trust to be in the very best place to manage this deteriorating situation.

Non-Executive Director, Julia Tabreham was interested to hear the powerful voice emerging through the Equal Forum and was pleased that the Board has committed to better involve the Forum and the Council of Governors in holding the Board to account in their public scrutiny role and asked if there is anything more that the Board can do to enhance this relationship. Ifti explained that the structure for governors is laid down in statute in terms of their role relating to the governance of the Trust. The scrutiny for excellent practice within the Trust's services is held within the work of the CQC on behalf of the people who use its services and the public. Governors, NEDs and the Equal Forum are the voices of the people who use the Trust's services and its staff. The role of the Board and the Board Committees is to tie this together with NED colleagues triangulating feedback through their Board Committee membership.

Deputy Trust Chair, Richard Wright thought it was clear from Ifti's earlier comments that the second wave of the pandemic will be prolonged to the spring and asked if there were any responses carried out in the first wave that might be done differently in the second wave. Ifti replied that the lessons learned approach taken after the first wave has enabled us to see the benefit of actions that worked well so that a more finessed approach can be taken. This time round components of services will be specifically flexed in response to COVID-19 and will put us in a good place for managing this situation over time.

The Board discussed how colleagues are extremely tired, not just in the workplace but also with the uncertainty in the environment and with family worries. Never has looking after the wellbeing of staff been more important. The Trust's wellbeing offer was noted as being essential along with providing long term support to enable staff to connect with each other to help them face the longevity of what is expected over the winter.

Senior Independent Director, Margaret Gildea admired how the putting people first value was being prioritised and had seen that staff had responded with appreciation. She was worried that some staff might have felt that some messages have been put across in a commanding and tone because of the need to act at pace and asked that leadership at every level be sensitive to how comments can be misinterpreted because leaders themselves are feeling anxious and tired. The Board concurred and discussed the importance of supporting the hierarchy of the organisation and for communication mechanisms to give enough impetus to operating faster so decisions can be made at pace. The live engagement sessions that have taken place with divisions are helping with this and very positive responses have been received from colleagues in response to messages made to all staff.

STRATEGY REFRESH

The updated Trust Strategy was included in Ifti's report in appendix 3. The Board recalled previous discussions about the importance of the Trust's vision and values remaining live and current and very relevant to the way the organisation is being run. It was acknowledged that the strategic objectives remain relevant to the COVID-19 pandemic but the building blocks have been revised to reflect the lessons learned throughout the pandemic and include the Trust's people first value. The Board recognised that the new strategy is re-directing the culture it wants to create within the organisation and approved the refreshed strategy.

RESOLVED: The Board of Directors:

- 1) Scrutinised and discussed the report, noting the risks and supported the actions being taken**
- 2) Formally approved the refreshed strategy.**

**DHCFT
2020/090**

INTEGRATED PERFORMANCE AND ACTIVITY REPORT

This report updated the Board of Directors on the Trust's performance at the end of September 2020. The report focussed on key finance, performance and workforce measures and was written prior to the current advanced COVID-19 period. The Executive Leads for operations, finance, quality and workforce drew attention to the key themes.

Director of Finance and Deputy Chief Executive, Claire Wright reported on the Trust's financial outlook which is showing a good half year position in ensuring income matches expenditure. The Board was updated on the status of the national capital bids for the eradication of dormitories. Although these bids have been submitted they have not yet been approved and have not been included as costs in the forecast. It is anticipated that the approval timeframe will be extended to provide better value for trusts. In the meantime, key expenditure will continue for estate and ligature improvements. The Board was assured that the Finance and Performance Committee is continuing to monitor in detail the financial side of operating performance and restoration and recovery as well as dealing with demand and capacity in this current rapidly changing environment.

Director of People and Inclusion, Jaki Lowe updated the Board on workforce and was pleased to report that appraisals and training resumed in September following the period where training was paused owing to the pandemic. The backlog that resulted is being addressed in a secure way in line with infection prevention control (IPC) measures. Particular focus is being given to immediate life support (ILS) and IPC training in inpatient areas. The sickness absence rates for short and long term sickness have improved and are currently below the average absence rate for mental health trusts. There has now

been a slight rise in cases being reported which is in line with national test and trace results and the increase nationally in COVID-19 cases. This demonstrates robust approach being taken to keeping people safe and protected and working from home where possible.

Carolyn Green's briefing highlighted the increase in the number of incidents of moderate to catastrophic harm, this being significantly impacted by deaths of people within substance misuse services. The number of patients in Psychiatric Intensive Care Unit (PICU) out of area beds is reducing. Weekly meetings are being held with the Clinical Commissioning Group (CCG) in order to monitor bed use and explore alternative arrangements. Risks around waiting lists are making headway this will continue to be focused on to ensure people are seen as quickly as possible. Although referrals have reduced there has been a surge in demand for adult acute inpatient services with admissions through the crisis service or as a result of ongoing or recurrent psychosis accounting for over two thirds of all admissions. In September almost half of the admissions were people admitted under the Mental Health Act.

John Sykes added that acuity on inpatient units is very high with more than the usual incidence of psychosis and the amount of incidents of psychosis is higher than traditionally seen which will lead to inpatient units facilitating discharges. The internal test track and trace will have an effect on staffing issues as the second wave progresses.

Caroline Maley was concerned about the high numbers of young people and adults waiting Autism Spectrum Disorder (ASD) assessment. She felt that no one should have to wait so long to be seen and reminded the Board of previous discussions concerning lack of commissioning of an ASD assessment and treatment service. Carolyn Green concurred and advised that the EQUAL Forum had raised this in the past. The lack of ASD service has also been escalated as a quality concern to commissioners but this service is not being invested in by the CCG at this current time. It is expected that ASD services will be prioritised in the Long Term Plan for 2023-24 and is too long to wait for effective action.

Non-Executive Director, Geoff Lewins challenged why supervision appeared to be showing a downward trajectory and how this could improve. Carolyn Green assured Geoff that although supervision is showing a downward trend to just below 10%, teams are being supervised to get back on a balanced trajectory. Training and supervision is being prioritised and newly qualified professionals' supervision is taking place and preceptorships are being undertaken.

Richard Wright asked whether the Attend Anywhere appointment system is contributing to reducing waiting list times and whether this practice is as effective as face to face appointments. John Sykes explained that all individual consultations are risk assessed and the capability to hold face to face consultations is retained if a virtual assessment is not felt to be appropriate. Clinicians' training in the past has been associated with face to face assessments as opposed to virtual assessment. Clinicians are now learning from best practice research and incorporating this into virtual working. John was pleased to report that there have been no negative instances reported concerning virtual platforms. Gareth Harry echoed the work described by John Sykes as demand from service users shows that this is their preferred method of consultation and consultants have impressively embraced this new technology.

It was noted at this point that technical issues were preventing Governors, staff and members of the public from accessing the meeting via the live streamed link.

RESOLVED: The Board of Directors confirmed that limited assurance had been obtained from current performance across the areas presented.

<p>DHCFT 2020/091</p>	<p><u>FLU/COVID-19 VACCINATION PROGRAMME</u></p> <p>This report presented by Jaki Lowe provided an update on the progress and delivery of the Trust's comprehensive flu vaccination programme. The report also served to assure the Board of the Trust's engagement and contribution to national and regional plans to prepare</p>
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	<p>for a COVID-19 vaccination programme.</p> <p>The flu programme commenced on 13 October using the booking system developed for this year's campaign. A third of all colleges have already been vaccinated maximising on protecting themselves, family, friends, colleagues and patients. This was thought to be as a result of the successful approach taken this year that will be used to implement delivery of the COVID vaccine.</p> <p>Caroline Maley was pleased to see that good in-roads have been made with the vaccination programme. The Board discussed how well staff were engaging with the programme. Any hotspot areas showing reluctance to be vaccinated are being focussed on and increased communication is being made to staff including the use of a podcast encouraging staff to understand the importance of being vaccinated.</p> <p>The Board recognised that in preparing this year's flu programme the Trust remains compliant with the Healthcare Worker Influenza Vaccination Best Practise Management checklist and looked forward to hearing at the next meeting in January that the Trust has achieved the anticipated target.</p> <p>RESOLVED: The Board of Directors</p> <ol style="list-style-type: none"> 1) Reviewed the contents and approach being undertaken by the Trust 2) Received assurance that adequate protection has been considered 3) Reviewed progress against trajectory
<p>DHCFT 2020/092</p>	<p><u>ANNUAL REVALIDATION OF DOCTORS</u></p> <p>John Sykes informed the Board that he had explored the issue of inclusion with the Medical Staff Committee and Trust Medical Advisory Committee and a series of Microsoft Teams consultations was being planned and this would include the issue of continuing professional development.</p> <p>The Board noted that report detailing a package of engagement events will be taken to the Executive Leadership Team for recommendation and looked forward to being informed of the next stages.</p> <p><i>Chief Operating Officer, Mark Powell joined the meeting at this point.</i></p> <p>RESOLVED: The Board of Directors noted the verbal update on the Annual Revalidation of Doctors.</p>
<p>DHCFT 2020/093</p>	<p><u>LEARNING FROM DEATHS MORTALITY REPORT</u></p> <p>The 'National Guidance on Learning from Deaths' requires each Trust to collect and publish specified information on a quarterly basis. This report presented by John Sykes covers the period 1 June to 24 August 2020.</p> <p>It was noted that since the last report the mortality group has strengthened the process for screening new deaths. Sheila Newport as Non-Executive Lead for Mortality agreed that the report provided assurance on the thoroughness of the Trust's data and the process of learning from deaths. Sheila and John Sykes have held discussions on aligning the report with Serious Incident reporting to enable better understanding of the lessons learnt.</p> <p>John Sykes added that in order to support the NHS to further improve patient safety, the Trust is preparing for the introduction of a new Patient Safety Incident Response Framework (PSIRF). This new approach will enable us to assess behaviours, decisions and actions that assist learning and improvement.</p> <p>On behalf of the Board, Caroline Maley agreed for the report to be published on the Trust's website in line with national guidance welcomed this new approach which is thought to be the best standard for conducting mortality reviews and patient safety investigations.</p>

	<p>RESOLVED: The Board of Directors accepted this Mortality Report as assurance of the Trust's approach and agreed for the report to be published on the Trust's website as per national guidance.</p>
<p>DHCFT 2020/094</p>	<p><u>GUARDIAN OF SAFE WORKING REPORT</u></p> <p>This report from the Trust's Guardian of Safe Working (GOSW) provides data about the number of junior doctors in training in the Trust, full transition to the 2016 junior doctor contract and any issues arising therefrom. It was presented by John Sykes as Dr Saxena, the Trust's GOSW, had been required on clinical duties. Caroline Maley requested that Dr Saxena be invited to present her report at a future meeting if at all possible.</p> <p>The Board noted that the Quality and Safeguarding Committee accepted this report on 13 October 2020 and took this as assurance of the Trust's approach in discharging its statutory duties regarding safe working for medical trainees.</p> <p>Non-Executive Director, Ashiedu Joel asked how risks had been mitigated for junior doctors within the BME group if they have been affected by any potential complications which may have arisen through existing health condition during the COVID-19 pandemic. John Sykes assured Ashiedu that this has been monitored closely and that every doctor from this group has been offered a health risk assessment. The issues that tended to arise were associated with people who had an underlying condition which put them in a high risk category and these doctors were moved to areas that were COVID secure. This was dealt with on a case by case basis and all doctors were able to participate with their training and no one was disadvantaged through their health.</p> <p>RESOLVED: The Board of Directors:</p> <ol style="list-style-type: none"> 1) Noted the contents of the report as assurance of the Trust's approach in discharging its statutory duties regarding safe working for medical trainees. 2) Noted that on 13 October 2020 the Quality and Safeguarding Committee received significant assurance from the contents of the report.
<p>DHCFT 2020/095</p>	<p><u>QUALITY AND SAFEGUARDING COMMITTEE ASSURANCE</u></p> <p>The Board received three annual reports that had previously been scrutinised and accepted by the Quality and Safeguarding Committee:</p> <p>Safeguarding Children and Adults at Risk Annual Report</p> <p>The annual production of this report is a governance requirement of both the Trust and the Safeguarding Children and Adults Boards. The report was offered by the Executive Lead with significant assurance regarding the fulfilment of legal and statutory duties and governance requirements. The Board noted that the Trust has had a successful year and continues to fully discharge its duties in safeguarding children and adults.</p> <p>RESOLVED: The Board of Directors received and approved the Safeguarding Children and Adults Annual Report.</p> <p>Derby City Children in Care Annual Report</p> <p>This annual report provided an overview of the progress, challenges, opportunities and future plans to support and improve the health and wellbeing of looked after children in Derby City. The Board accepted the report and received significant assurance from the Trust's solid performance in producing the required outcomes for children in care and agreed that the key priorities associated with cultural awareness will be taken forward for 2020/21 as an additional aspect of this work.</p> <p>Richard Wright was conscious that so much depends on the way the Trust works with partners to protect children in care and asked if any problems were foreseen in maintaining the relationships that have been fostered. Carolyn Green assured Richard that the Trust had planned over the summer the surge being seen in referrals associated with domestic</p>

	<p>violence and community unrest. City Council services are under extreme pressure now that activity has increased since children returned to school.</p> <p>RESOLVED: The Board of Directors:</p> <ol style="list-style-type: none"> 1) Received significant assurance from the work within the Trust around looked after children and young people and the continued partnership working to ensure the best outcome is achieved for this vulnerable group of children and young people. 2) Accepted the annual report and agreed the key priorities set for 2020/21 <p>Infection Control Annual Report</p> <p>This report summarised the activity over the preceding twelve months of work related to infection control. The Board noted that all standards are above the national level and are fully compliant with the audit programme against national infection control guidance. Significant assurance was received on standards of cleanliness of clinical areas and food preparation areas. Significant assurance was also obtained from the approaches and knowledge acquired in accordance with emerging evidence and international / national and regional learning.</p> <p>Margaret Gildea as Chair of the Quality and Safeguarding Committee confirmed that these reports were intensely scrutinised by the Committee and took the opportunity to congratulate the Trust's Safeguarding Children's and Adults Teams in achieving their high standard of work.</p> <p>The Board also commended the work undertaken by the Infection Prevention and Control Team and Estates, Facilities and Catering services for the outstanding standards achieved.</p> <p>RESOLVED: The Board of Directors:</p> <ol style="list-style-type: none"> 1) Noted the reporting of key areas, such as surveillance of healthcare associated infections; alert organisms, outbreaks of infection, staff training 2) Received significant assurance that approaches and learning are evolving in accordance with emerging evidence and international / national and regional learning 3) Received significant assurance on standards of cleanliness of clinical areas and food preparation areas.
	<p><u>QUALITY REPORT / QUALITY ACCOUNT FOR 2019/20</u></p> <p>The Board received a progress update on the Quality Report / Quality Account for 2019/20 that is currently out for consultation following a revised timetable due to COVID-19.</p> <p>It was noted that the Quality Report has been distributed as required, including Governors, colleagues at Derby and Derbyshire Clinical Commissioning Group, Derby City Council, Derbyshire County Council, and NHS England. In order to meet the revised timetable to finalise quality accounts, delegated authority was granted to the Quality and Safeguarding Committee to approve the final version for publication on 15 December 2020.</p> <p>Geoff Lewins as Chair of the Audit and Risk Committee mentioned that normally the Quality Report would go to the Audit and Risk Committee for sign off and accepted that under the circumstances it is appropriate for the Board to grant delegated authority to the Quality and Safeguarding Committee.</p> <p>RESOLVED: The Board of Directors noted</p> <ol style="list-style-type: none"> 1) Noted the update on the Quality Report/Quality Account for 2019/20 following a revised timetable due to COVID-19 2) Granted delegated authority to the Quality and Safeguarding Committee to approve the final version of the Quality Report / Quality Account for 2019/20 before submission.
DHCFT	<u>MONTH 7-12 2020/21 FINANCIAL PLAN</u>

<p>2020/097</p>	<p>Claire Wright presented the Board with the financial plan for month 7-12 which is in line with the system financial plan. This plan was submitted on 5 October with an aggregate deficit or 'gap' of £43m. Individual organisational plans were submitted on 22 October in line with that system plan. In response to regulator feedback, the system finance lead also submitted a letter outlining the system's current work around some potential mitigations for the £43m gap, which at the time of writing total £25m.</p> <p>The Board noted that the system financial plan for month 7-12 generates an organisational deficit of £0.6m after a fair share of the system top up allocation and COVID allocation, along with funding from the growth allocation to cover Mental Health Investment Standard (MHIS) investments. There are some costs that are included in the plan which are unfunded which are the drivers for the deficit of £0.6m. This 0.6m deficit is included within the £43m gap.</p> <p>Claire clarified that NHS organisation systems had been expected to submit break-even plans. She assured the Board of the robust working between all system partners who have acknowledged that the £43m deficit is a 'system problem to solve' irrespective of where that gap manifests itself in individual organisation plans. She explained that there is potential to improve the £0.6m deficit within the £43m but this might not happen in this financial year. The Board would be kept updated as the position progresses from a system perspective through the Integrated Performance Report.</p> <p>Geoff Lewins asked Claire to clarify the capital position regarding funding of £4.1m and the potential risks if funding is not approved. Claire replied that approval of funding for capital improvements is still awaited before it can be forecast within any potential spend. She hoped that this programme of work can be approved and finalised as a priority and confirmed that this will be monitored by the Finance and Performance Committee.</p> <p>Claire gave her personal thanks to Deputy Finance Director, Rachel Leyland and the wider Finance team for pulling together the Trust's financial plan in a very short timeframe and her commendation was echoed by the Board.</p> <p><i>Medical Director, John Sykes left the meeting at this point</i></p> <p>RESOLVED: The Board of Directors noted the organisational financial plan for month 7-12 along with the progress on potential mitigations for the system gap and the approach to financial management for the second half of 2020/21.</p>
<p>DHCFT 2020/101</p>	<p><u>STRATEGIC IMPLICATIONS OF THE OUTCOMES OF THE 2019-20 WORKFORCE RACE EQUALITY STANDARD (WRES) AND WORKFORCE DISABILITY EQUALITY STANDARD (WDES)</u></p> <p>The WRES Report and Action Plan 2019/20 has been published on the Trust's website after being approved by the People and Culture Committee. This report presented by Claire Wright updated the Board on progress made with the 2019-20 Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES).</p> <p>The WRES has nine evidence-based indicators focusing on the experience of BME colleagues in the workplace and shows there is still work to be done to address the variations in recruitment, opportunities for progression and development and working conditions for people from a BME background. Action taken to improve this indicator will drive long term change through the future and is a commitment from the organisation to take this forward. In comparison with other organisations the Trust has much greater involvement and contact between senior leaders and the networks. This is a strong feature within the Trust and will make a difference in achieving WRES outcomes.</p> <p>The WDES implementation and data shows there is considerable work to be done to address the variations in experience, workforce representation, progression and development for staff with disabilities and long term conditions. Declaration is crucial for</p>

	<p>increasing declaration levels so that a truly involved and culturally led programme can provide an understanding of what impact these indicators have on the experience of people within the Trust and to ensure inclusion is embedded within all the Trust's processes as well as ensuring that talent within the organisation is developed to provide greater opportunities for people, especially in developing experts.</p> <p>The Board discussed the progress made so far and agreed there is still a lot to build on to enable resources to be aligned with the strategic change. It is clear that while colleagues support the approach being taken they want to see actions that result in change. In recognising the all-encompassing nature of the WRES and WDES action plans Geoff Lewins recommended using RAG rating and suggested that titles be sub-divided as this might drive completion. This was thought to be useful and will be featured in future action plans.</p> <p>Non-Executive Director, Ashiedu Joel echoed the thoughts of her Board colleagues and talked about the need to focus more on some of the issues that are more personal to individuals; that have a direct impact on how colleagues bring their whole selves to work. Ashiedu asked how the Trust can achieve the BME Inclusion target of 15% BME representation in each of the Agenda for Change (AfC) pay bands across the Trust by 2028 and challenged whether the right structures are in place to achieve this target. The Board was conscious that improvements can be made and that the solution is for everybody to support the WRES objectives and for colleagues to feel confident in having difficult conversations with leaders about how they want to be led.</p> <p>Margaret Gildea reflected on the processes behind the actions and on the "it is not okay" campaign. She thought the Board should do some more work on what "it is not okay" in relation to its role and of individual Board members.</p> <p>Mark Powell wondered whether the WRES actions might not be overt or challenging enough in the way Ashiedu described and that perhaps they should be made more overt when wider communications are made within the Trust so they are at the forefront of issues that need addressing and be much clearer about how to deliver these actions and what the expected impact might be. Ifi responded that responsibility sits with the Board for implementing the change and not the networks.</p> <p>Caroline Maley concluded that this discussion had illustrated that there is so much more that needs to be done and proposed that the Board should put aside some time within its Board Development programme so the implications of the WRES and WDES can be taken forward to support the future of the inclusion strategy and through the development of the new People Plan.</p> <p>ACTION: WRES and WDES support within the inclusion strategy and new People Plan to be featured in the Board Development programme</p> <p>RESOLVED: The Board of Directors:</p> <ol style="list-style-type: none"> 1) Considered and discussed the strategic implications of the WRES 2019/20 2) Supported a review of the Inclusion Strategy to create the leverage and improvements that the Trust is expecting 3) Agreed that as part of the strategy review the Board will develop the Trust's approach to inclusive leadership and embed Cultural Intelligence throughout the organisation 4) Considered and discussed the strategic implications of the WDES 2019/20 5) Agreed to strengthen the Trust's approach through the development of the new People Strategy.
<p>DHCFT 2020/102</p>	<p><u>BOARD ASSURANCE FRAMEWORK - ISSUE 3</u></p> <p>Trust Secretary, Justine Fitzjohn presented the third issue of the BAF for 2020/21.</p> <p>Due to the impact of COVID-19 earlier this year and in line with the national directive for a</p>

	<p>governance 'light' approach across organisations Issues 1 and 2 of the BAF for 2020/21 focused on the risks faced by the organisation in response to the pandemic. Issue 3 has now been developed in line with the broader revised objectives which support delivery of the Trust Strategy, and in line with the recovery and restoration phase for NHS services. Seven risks have been identified in relation achievement of the three strategic objectives of Great Care; Great Place to Work; and Best Use of Money.</p> <p>Usually a programme of deep dives for each BAF risk to the relevant Board Committees is undertaken throughout the year. Due to the impact of the COVID-19 pandemic on the Trust's usual governance arrangements, and the likelihood that the risks currently identified will span into 2021/22, it is proposed that only the risks rated as extreme be subject to deep dives this year.</p> <p>Geoff Lewins confirmed that the Audit and Risk Committee had discussed whether risk 1a <i>"There is a risk that the Trust will fail to provide standards for safety and effectiveness as required by our patients and our Board"</i> was correctly rated in light of potential pandemic risks. The Committee decided it was correctly rated as high and took assurance that the Quality and Safeguarding Committee will closely monitor the risk mitigations.</p> <p>Having reviewed the risk mitigations Board was satisfied with the key risks articulated in this version of the BAF and approved the third issue of the BAF for 2020/21.</p> <p>RESOLVED: The Board of Directors:</p> <ol style="list-style-type: none"> 1) Approved this third issue of the BAF for 2020/21 and gained assurance from process of the review, scrutiny and update of the BAF in seeking to identify and mitigate risks to achieving the Trust's strategic objectives 2) Agreed the timetable for deep dives for 2020/21 3) Agreed to continue to receive updates in line with the forward plan for the Board.
<p>DHCFT 2020/103</p>	<p><u>BOARD COMMITTEE ASSURANCE SUMMARIES</u></p> <p>The Board Committee Assurance Summaries were presented. The Board agreed that the summaries demonstrated the work of committees over the last two months and acknowledged that they clearly represented the different priorities that will be taken forward in forthcoming meetings.</p> <p>RESOLVED: The Board of Directors noted the Board Assurance Summary report</p>
<p>DHCFT 2020/104</p>	<p><u>IDENTIFICATION OF ANY ISSUES ARISING FROM THE MEETING FOR INCLUSION OR UPDATING IN THE BOARD ASSURANCE FRAMEWORK (BAF)</u></p> <p>Additional items as a result of discussions held today were considered for inclusion within the BAF as follows:</p> <ul style="list-style-type: none"> • The Executive Leadership Team will look at the WRES and the WDES action regarding cultural competence, protected characteristics and outcomes plans and agree how mitigations can be included in the next iteration of the BAF. • BAF Risk 1a will include risks associated with waiting times for ASD service and will articulate that the long term plan does not meet the needs of people with ASD.
<p>DHCFT 2020/105</p>	<p><u>2020/21 BOARD FORWARD PLAN</u></p> <p>The 2020/21 forward plan outlining the programme for bi-monthly meetings was noted and will be reviewed further by all Board members throughout the financial year. The forward plan for 2021/22 is currently in development.</p>
<p>DHCFT 2020/106</p>	<p><u>MEETING EFFECTIVENESS</u></p> <p>All Board members agreed that the meeting had been successfully conducted. Thorough</p>

	<p>discussions had taken place on inclusion which resulted in decisions being made to ensure inclusion and cultural intelligence is more highly prioritised within the Trust.</p> <p>Although it was disappointing that some technical issues had been experienced during the meeting Caroline extended her thanks to the technical team in the background for their support in enabling this meeting to take place.</p>
<p>DHCFT 2020/107</p>	<p><u>REGISTER OF TRUST SEALINGS</u></p> <p>The report detailing the authorised use of the Trust Seal since November 2019 was noted for information and provided full assurance that this has been undertaken in accordance with the Standing Financial Instructions and Standing Orders of the Board of Directors.</p> <p><u>SUMMARY REPORT FROM THE COUNCIL OF GOVERNORS MEETING HELD 1 SEPTEMBER 2020</u></p> <p>The summary from the September meeting of the Council of Governors was noted for information.</p>
<p>The next meeting to be held in public session will take place at 10.30am on Wednesday 13 January 2021. Owing to the current coronavirus pandemic this meeting will be held digitally and will be live streamed via MS Live Events.</p>	

BOARD OF DIRECTORS (PUBLIC) ACTION MATRIX - JANUARY 2021							
Date	Minute Ref	Item	Lead	Action	Completion Date	Current Position	
1.9.2020	DHCFT2020/075	Integrated Performance Report	Jaki Lowe	People and Culture Committee to seek assurance from action plans to improve safer staffing levels to meet the requirements of the Long Term Plan. The Committee is to also obtain assurance from staff turnover levels and how the Trust can attract more people to the organisation	2.3.2021	People and Culture Committee discussed action taking place to keep staff levels safe during the pandemic period and how staff resources are to be linked with the requirements of the Long Term Plan. A report on resourcing plan and how this is linked to the Long Term Plan will be received by the Committee in January prior to a wider report on staffing and what the future will look like being aken to the Board in March	Yellow
3.11.2020	DHCFT2020/101	Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES)	Justine Fitzjohn	WRES and WDES support within the inclusion strategy and new People Plan to be featured in the Board Development programme	2.3.2021	Implications of the WRES and WDES to support the future of the inclusion strategy and through the development of the new People Strategy is being included in the Board Development Programme (timeline TBC).	Green

Resolved		GREEN	1	50%
Action Ongoing/Update Required		AMBER	0	0%
Action Overdue		RED	0	0%
Agenda item for future meeting		YELLOW	1	50%
			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 3 November 2020. The structure of this report reflects the role that I have as Trust Chair.

May I take this opportunity to wish members of the Board, staff, Governors and all stakeholders a happy new year. May 2021 be a year of good health and restoration for all.

Our Trust and Staff

1. Given the on-going pandemic, I have agreed to discontinue my visits to teams across the Trust until such time as it is thought to be safe, both for staff and for myself, to visit. In conjunction with Director of Nursing and Patient Experience, Carolyn Green and Director of Business Improvement and Transformation, Gareth Harry, we are looking to introduce virtual team visits for all of the Non-Executive Directors (NEDs) and I look forward to reporting on the success of this in my next report.
2. In the meantime, I have been attending as many of the team live engagement events being hosted via MS Teams. These meetings are very useful to me in terms of understanding how staff are feeling and engaged with the Trust. I am pleased to note that a number of the NEDs are now also joining these calls.
3. On 29 October, I joined a presentation by guest speaker Jennifer Izekor about cultural intelligence. This was a part of the Black History Month which was a full programme of thought provoking and interesting events across the Trust. I am pleased that we are planning to work with Jennifer in 2021.
4. A Schwartz Round is a multidisciplinary opportunity for professionals to discuss the emotional and social issues that arise in patient care. These have been held virtually over the past few months. On 26 November, I attended a Round which was framed around the Redeployment: "Empty Roads and Empty Houses". It was very moving to hear about the impact of the pandemic and in particular the redeployment of staff to other areas of our Trust. On 17 December I attended another Round: "When a Child is Born". This discussion focussed on the experience of a staff member on maternity leave and how the pandemic has impacted upon her and her family through a very uncertain period. It opened the opportunity to a wider discussion on the feeling of loss and grief as we have been working through the pandemic and face the prospect of working in very different ways. Thank you for letting me join you.
5. On 2 December I joined the monthly meeting of the Occupational Therapy team based at the Hartington Unit. It was an ideal opportunity to hear from staff how the team had to adapt to work through the pandemic with the changes in the environment requiring thinking on their feet to deliver great patient care. I was pleased to hear a very positive story from a member of the team (employed by Derbyshire Community Health Services) who had been on rotation with the Trust for the past nine months. She was moving on but not

being replaced as the funding for the rotation has been removed. I would like to see rotation brought in across the Joined up Care Derbyshire system as a way of growing the opportunities and talent that we have at our disposal.

6. I would like to recognise the Winter Wellbeing Campaign that ran through the month of December. The resources and creativity shown was fantastic – my thanks to all members of staff who worked so hard behind the scenes to make this happen. This brought a strong focus for everyone on our own health and wellbeing.
7. Thank you to all staff for your on-going commitment and dedication shown to the Trust and our service users over an extraordinary time. We hope that the next year will see us conquer Covid with the vaccine available and the greater wisdom and understanding of the virus and how to manage it. We hope for a return to a more stable way of life.

Council of Governors

8. We held a virtual joint Council of Governors meeting on 3 November following the public Board in the morning. This meeting was extremely well attended by Governors, who have embraced the use of technology superbly well. We streamed this meeting for the public to watch.
9. The Governance Committee of the Council met on 10 December. It was good to have Kelly Sims back chairing the meeting following her redeployment to support the distribution of PPE for the Trust. This was a very well attended meeting, and I was pleased with the engagement and participation of all the Governors attending. I continue to be grateful to our Governors for their support for the Trust at this time.
10. Following the Board meeting on 13 January, the Council of Governors and Board will be meeting to undertake some joint development work, including discussion around the work of the Trust through the pandemic, and the future developments that we are considering as part of strategic planning. I look forward to a good meeting with both of these important governance groups together.

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

11. The next meeting of the Council of Governors will be on 2 March 2021, following the Public Board meeting on that day. The next Governance Committee takes place on 9 February.

Board of Directors

12. All meetings continue to be held as virtual meetings using MS Teams, enabling Board members to keep connected whilst working remotely. We have continued to live stream our public Board meetings to enable members of public and our staff to observe the Board meeting. Regrettably our live

streaming of the November meeting failed due to technical difficulties, but we continue to have a clear aim to meet the requirement for our meetings to be held in public.

13. On 1 December there was a Board Information Sharing session which looked at progress around dormitory eradication. Later in the meeting we were joined by Dr Chris Clayton, Executive Lead of Joined Up Care Derbyshire to share his thinking with the Board on the development of the Integrated Care System (ICS).
14. On 16 December the Remuneration and Appointments Committee met to receive an update on Board mandatory training and to consider the Board Development programme in the months ahead. NED mandatory training was also delivered around data security and protection.
15. Also on 16 December the Board met in a confidential session to further consider our estates strategy.
16. The Non-Executive Directors (NEDs) have met regularly with Ifti Majid and me to ensure we have been fully briefed on developments as needed. The NEDs have also met on 19 November as “Committee Chairs” to review progress across all the Board sub-committees and in particular the management and closure of cross committee actions. I have also continued to meet with all NEDs individually. Since the last Board meeting I have met with Julia Tabreham and Geoff Lewins. We use these quarterly meetings to review their progress against their objectives and to discuss any issues of mutual interest.

System Collaboration and Working

17. Joined Up Care Derbyshire (JUCD) met on 19 November using MS Teams. Attached as Appendix 1 are the key messages noted from this meeting. This meeting was preceded by a meeting of the Chairs of the NHS Provider Trusts.
18. At the beginning of December, the Joined Up Care Derbyshire application to become an ICS was approved. The formal announcement is included as Appendix 2 attached to this report. This is an important milestone in this journey.
19. On 14 December, the Boards of all the NHS Providers, the Clinical Commissioning Groups (CCGs), Local Authority partners and others came together in a joint JUCD development meeting. There were over 110 people on the call. Part of the meeting was also used to consider the implications of the paper published on 26 November by NHS England and NHS Improvement (NHSE/I): Integrated Care: Next steps to building strong and effective care systems across England.
20. A further development session was held on 17 December to continue debating the shape of the ICS and governance and structural implications of the Integrated Urgent Care Service (IUCS) application and the NHSE/I paper. This is important work and will be covered in the CEO report today. I am pleased at the level of engagement from our Trust, but note that this development comes at a time of extreme pressure in the NHS in the middle of a pandemic.
21. I have continued to meet regularly with the chairs of the East Midlands Alliance of mental health trusts, which has been a very useful source of sharing best practise and peer advice. The East Midlands Alliance also continues to

develop its collaboration. On 6 November the CEOs and Chairs met together to take stock of how the Alliance might operate in the years to come. This is a very positive collaboration and I look forward to seeing it grow and develop. More information is included in the CEO report.

22. I have also been joining the East Midlands Chairs Development network, which is sponsored by Prem Singh, Chair of Derbyshire Community Health Services NHS Foundation Trust and Councillor Sue Woolley, Chair of Lincolnshire Health and Wellbeing Board. This group met on 25 November and heard of some good practical examples of Anchor Institution activities from Barts Health and Suffolk and North East Essex ICS. It continues to be a useful forum to see what other ICS and areas are doing to improve services. It includes NHS and local authority colleagues.

Regulators, NHS Providers and NHS Confederation and others

23. On 3 December, I attended a Chairs and Chief Executives virtual network meeting hosted by NHS Providers. In addition to the usual strategic policy update from Chris Hopson, we heard from Dr Navina Evans who is CEO of Health Education England; from Professor Keith Willett on the Brexit position and then an update from Sir Simon Stevens, CEO of NHS England.
24. I attend fortnightly briefings from NHSE / I for the Midlands region, which has been essential to understand the progress of the management of the pandemic. It has been reassuring to see our performance on important matters such as flu vaccinations and lateral flow testing being strong amongst our peers. It is also a forum to hear about progress from Midlands STAR (Strategic Transformation and Recovery) Board. These matters will be picked up within the CEO report to the Board.
25. I have also joined the weekly calls established for Chairs of mental health trusts hosted by the NHS Confederation Mental Health Network in collaboration with the Good Governance Institute where support and guidance on the Board through the pandemic has been a theme. A number of the NEDs have also attended weekly calls for NEDs on a range of useful topics.

Strategic Considerations

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

Assurances

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

Consultation

This report has not been to other groups or committees.

Governance or Legal Issues

None

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

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

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

Demonstrating inclusive leadership at Board level

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

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

Recommendations

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

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

Joined Up Care Derbyshire Board - 19 November 2020

 The logo for 'Joined Up Care Derbyshire' is displayed in white text on a blue rectangular background.
Key Messages

At this the 2nd Board meeting in public since the start of the covid-19 pandemic, there was a strong focus on supporting staff in the system to weather the strain of the pandemic, and the role of the board as an anchor institution in the wider determinants of health. The term anchor institution refers to large, typically non-profit organisations like hospitals, local councils, and universities whose long-term sustainability is tied to the wellbeing of the populations they serve.

Improving Wellbeing through the Power of Physical Activity – Fit4Life

The board commenced with an inspiring presentation delivered by Andrea Kemp from Shift-Together a Community Interest Company focusing on initiatives which improve health and wellbeing, and Lynn Tory who participated in the Fit4Life programme.

Fit4Life started in 2019 at Chesterfield Royal Hospital, following the results of a staff survey, which highlighted that staff wanted to be more active and well. Shift-Together worked with staff at the hospital to look for sustainable ways of increasing physical activity and reducing sedentary behaviour, which along with 1:1 health coaching, includes identifying and encouraging local leaders who would support the continuation of the programme, working with whole departments, so colleagues could support one another, and looking for activities in and around the area. Over 60 participants took part with many reporting that they felt more positive and focused on work as a result. Lynn shared her remarkable success story, which showed the potential of the programme to have far reaching impacts on communities, not just individuals.

Learning from Covid-19

During July and August, a process of engagement took place with STPs/ICSs and the NHSE/I Midland's regional leadership to capture learning from the management of the COVID-19 incident. The outcomes of this work led to the publication of a report entitled NHSE/I Midlands Region Learning from COVID-19 and was intended to enable the adoption of proven good practice, inform the restoration and recovery process and assist the work of the Regional System Transformation and Recovery (STaR) Board.

57 recommendations were made within this report, some of which require a local response. The report is being socialised widely locally to get a wide perspective on the actions needed locally, and the results of this process will be brought back to a future board meeting for consideration.

System Operating Model

Dr Chris Clayton, Executive Lead for Joined Up Care Derbyshire opened up a discussion on a proposed system operating model, the next steps in the JUCD system architecture, and emphasised its importance in ensuring that the system can make the difference it wants to make. The model is designed to ensure the system is coherent and cohesive in what it does together, so it is done once, and done well. This included a discussion around how the board delivered on the concepts of 'strategic intent' and 'strategic partnership', acknowledging that the board was the most strategic group in the health and social care system. The model will be finalised in December and implemented early in the New Year.

Joined Up Care Derbyshire receives approval for next steps in development


 The logo for 'Joined Up Care Derbyshire' is displayed in white text on a blue rectangular background.

Joined Up Care Derbyshire, the partnership of health and care organisations in Derby and Derbyshire, has been confirmed as a new Integrated Care System in the latest wave of approval announcements by NHS England.

Integrated Care Systems (ICS) bring together the NHS, local councils and other partners to plan and provide local services across the area they serve. They enable health and care organisations to join forces and apply their collective strength to addressing their residents' biggest health challenges, many exacerbated by Covid-19. This means tackling health inequality, joining up care for those with multiple conditions, improving support for people with lifelong illness and supporting children to lead healthy lives.

It also includes workforce planning, quality improvement and the oversight of system performance including health outcomes, quality of care, operational and financial performance. The move to Integrated Care Systems represents the next step on the journey for what have previously been known as System Transformation Partnerships (STPs).

Last month, NHS England announced a proposal for ICSs to be given new statutory powers to take greater accountability for the performance and development of local health and care, including the commissioning of services, increased collaboration between service providers and adopting additional roles currently performed at a regional or national level.

Joined Up Care Derbyshire submitted its application to become an ICS in November, demonstrating that the local partnership had in place the required leadership, governance, partner relationships and performance oversight to be fully able to join up and transform health and care services in Derby and Derbyshire.

The approval from NHS England highlights the confidence in Joined Up Care Derbyshire to manage existing and future performance issues, in a system that has historically worked very closely together, not least to manage the impact of the Covid-19 pandemic, and confidence in the partnerships' plans to continue to develop and improve.

John MacDonald, Independent Chair of the Joined Up Care Derbyshire ICS, said:

“This is very exciting news for the patients and staff who live and work within the Derby and Derbyshire areas. It reflects not only that our regulators think we are up to the requirements of the future delivery of health and care in our system, but also the excellent track record our services have in caring for patients on a daily basis.

“It is easy to be lost in the acronyms and terminology of such an announcement, but we must remember that first and foremost this is about improving health and care services for the benefit of local people, and that is right at the heart of our progress.

“Joined Up Care Derbyshire will be responding to the recent NHSE proposals around the potential future statutory role of ICSs, but in any event, today’s announcement is testament to the way in which we already have a tremendous health and care partnership in Derby and Derbyshire.”

NHS England announced the approval of eleven new ICSs on Thursday, and an NHSE Chief Executive Sir Simon Stevens said:

““Now is the time to accelerate on integrated care so we have strong health and care systems serving every part of the country. The past year has demonstrated the importance of joined-up working. This will be just as critical as we work together to address the wider social and economic consequences of the Covid pandemic.”

“The new ICSs have won their status by demonstrating a “common vision” across their constituent partners and have shown robust operational and financial plans and proposals for collective leadership and accountability.”

More information on Joined Up Care Derbyshire is available at:

Web: www.joinedupcarederbyshire.org.uk
Twitter: @joinedupcare
Facebook: Joined Up Care Derbyshire
Instagram: @joinedupcarederbyshire

Chief Executive's Report to the Public Board of Directors

Purpose of Report

This report provides the Board of Directors with feedback on changes within the national health and social care sector, as well as providing an update on developments occurring within our local Derbyshire health and social care community. Given the COVID-19 pandemic, much of the content is influenced by the NHS response to the pandemic and how to learn lessons from the response. The report also updates the Board on feedback from external stakeholders, such as our commissioners, and feedback from our staff. The report should be used to support strategic discussion on the delivery of the Trust strategy. The Board should note that the report reflects a wider view of the Trust's operating environment and serves to horizon scan for risks that may affect the organisation. Risks identified are highlighted in the report and taken forward to assess their operational and strategic impact, and recorded on operational risk registers, or the Board Assurance Framework, as appropriate.

National Context

1. On 26 November 2020 NHS England and NHS Improvement (NHSE/I) published *Integrating Care: Next steps to building strong and effective integrated care systems across England*. It sets out NHSE/I's view of the strategic direction of system working, including a consultation on two new proposals to put Integrated Care Systems (ICSs) on a statutory footing in the NHS Bill, expected in late spring 2021. The paper was tabled and discussed at the NHSE/I board meeting on 26 November 2020. In summary there are eight key points that our Board should note, recognising we commenced discussion around this as a system when the Boards of statutory organisations came together for the first time on the 14 December 2020. Those eight key points are:
 - This paper sets out the view of NHSE/I on the strategic and operational direction of system working, underpinned by detailed policy and legislative proposals. The paper is positioned to open up a discussion about how ICSs could be embedded in legislation or guidance.
 - It proposes a national plan to accelerate ICS development in 2021/22. NHSE/I will increasingly devolve more functions and resources from the national and regional teams to ICSs ahead of potential legislative change to be implemented from April 2022.
 - NHSE/I are seeking views on two options for putting ICSs on a fuller statutory footing than its original proposals (September 2019), both of which require legislative change. The first option involves creating a mandatory board/joint committee at ICS level with an accountable officer. The second option, which NHSE/I prefer, is a corporate NHS body at ICS level that essentially repurposes the CCG and brings its statutory functions into the ICS. In this scenario, the ICS leader would be a fulltime accounting officer role.

- The paper importantly recognises the leadership role played by providers at both system and Place level. NHSE/I want to support at scale collaboration between acute, ambulance and mental health providers and Place-based partnerships across community services, primary care and local government (as well as other partners). This emphasis on providers and Place provides a pragmatic approach to the next stage of development of system working that we welcome.
- NHSE/I is now directing ICSs to firm up their governance and decision making arrangements in 2021/22 to reflect their growing roles and responsibilities, including establishing Place and provider collaborative leadership arrangements.
- This document confirms that NHSE/I will increasingly organise NHS finances at ICS level, giving ICS leaders responsibility for allocating a 'single pot' of NHS funding for their patch.
- It also reaffirms the shift to strategic commissioning at ICS level, with other commissioning activities moving to provider organisations/collaboratives and Place-based partnerships. Further changes to the commissioning landscape are expected in the legislative proposals.
- The 2021/22 NHS operational planning guidance will set out further detail on the implementation of all these changes next financial year. NHSE/I will also publish further supporting material for provider collaboratives in early 2021. We will continue engaging in this policy development process and the drafting of any legislative proposals.

It is the role of our Board, along with colleagues on other boards, to work together to consider the impact of this on those cohorts of people we currently provide services to, maintaining the focus on the delivery of high-quality effective care at all times. It will require Board members in development sessions to explore personal and organisational readiness to cede authority to the various system groups in development. This document sits well with the confirmation that Joined Up Care Derbyshire (JUCD) has now been approved as an Integrated Care System (ICS).

2. On 23 December CEOs and Chairs of NHS Trusts received a letter from Amanda Pritchard and Julian Kelly providing information on the operational priorities for winter and into 2021/22. The letter covers priorities for the rest of 2020/21, planning for 2021/22 and the 2021/22 financial framework. NHS England and NHS Improvement has confirmed that no planning returns are required in response to the letter, but the Board should note it does contain some actions.

In summary the letter covers:

Priorities for remainder of 2020/21

1. *Responding to ongoing COVID-19 demand*
Local organisations should continue to plan on the basis that we will remain in a level 4 incident for at least the rest of this financial year and NHS trusts should continue to safely mobilise all of their available surge capacity over the coming weeks.

Maintaining rigorous infection prevention and control procedures continues to be essential. This includes separation of blue/green patient pathways,

asymptomatic testing for all patient-facing NHS staff and implementing the ten key actions on infection prevention and control, which includes testing inpatients on day three of their admission.

All systems are now expected to provide timely and equitable access to post-COVID-19 assessment services, in line with the commissioning guidance.

2. *Implementing the COVID-19 vaccination programme*

Vaccinations should take place in line with Joint Committee on Vaccination and Immunisation (JCVI) guidance to ensure those with the highest mortality risk receive the vaccine first.

The NHS needs to be prepared and ready to mobilise additional vaccination sites as quickly as possible in the event that further vaccines are approved by the independent regulator.

COVID-19 vaccination is the highest priority task for primary care networks, including offering the vaccination to all care home residents and workers.

All NHS trusts should be ready to vaccinate their local health and social care workforce very early in the new year, as soon as authorisation and delivery of further vaccine is received.

3. *Maximising capacity in all settings to treat non-COVID-19 patients*

Systems should continue to maximise their capacity in all settings. This includes making full use of the £150m funding for general practice capacity expansion. NHS trusts should continue to treat as many elective patients as possible, prioritising those who have been waiting the longest, while maintaining cancer and urgent treatments.

NHS trusts have already been notified of the need for a Q4 activity plan for their local independent sector site by Christmas and this should be coordinated at system level.

Clinical quality and safety should continue to be safeguarded and all NHS trust boards are required to consider the Ockenden review of maternity services and the 12 urgent clinical priorities at their next public meeting, along with an assessment of their maternity services against the review's immediate and essential actions.

4. *Responding to other emergency demand and managing winter pressures*

In addition to the previously announced £80m in new funding to support winter workforce pressures, systems are asked to take the following steps to support the management of urgent care:

- Ensure those who do not meet the 'reasons to reside' criteria are discharged promptly. All systems are asked to improve performance on timely and safe discharge, as set out in a separate letter, as well as taking further steps that will improve the position on 14+ and 21+ day length of stay.
- Complete the flu vaccination programme, including vaccinating staff against flu.

- Continue to develop NHS 111 as the first point of triage for urgent care services in each locality, with the ability to book patients into the full range of local urgent care services.
- Maximise community pathways of care for ambulance services referral, as a safe alternative to conveyance to emergency departments.

5. *Supporting the health and wellbeing of our workforce*

Systems should continue to deliver the actions in their local People Plans and remind all staff that wellbeing hubs will mobilise in the new year in each system.

In addition to the above, all clinical commissioning groups and NHS trusts should have a senior responsible officer (SRO) to lead the EU/UK transition work and issues should be escalated to the regional incident centre established for COVID-19, EU transition and winter.

Planning for 2021/22

Systems should continue to:

1. Recover non-COVID-19 services: an aspiration has been set that all systems should aim for top quartile performance in productivity on high volume clinical pathways: ophthalmology, cardiac services and MSK/orthopaedics. Systems and trusts are asked to appoint a board level executive lead for elective recovery to start preparing system based recovery plans that focus on addressing treatment backlogs and long waits.
2. Strengthen delivery of local People Plans, and make ongoing improvements on: equality, diversity and inclusion of the workforce; growing the workforce; designing new ways of working and delivering care; and ensuring staff are safe and can access support for their health and wellbeing.
3. Address the health inequalities that COVID-19 has exposed. Systems will be expected to make and audit progress against the eight urgent actions set out on 31 July.
4. Accelerate the planned expansion in mental health services through delivery of the Mental Health Investment Standard together with the additional funding provided in the Spending Review for tackling the surge in mental health cases.
5. Prioritise investment in primary and community care, to deal with the backlog and likely increase in care required for people with ongoing health conditions, as well as support prevention through vaccinations and immunisations.

The 2021/22 financial framework

The financial framework for 2021/22 will have the following key features:

1. Revenue funding will be distributed at system level, continuing the

approach introduced this year and consistent with the NHS Long Term Plan financial settlement. There will be additional funding to offset some of the efficiency and financial improvements that systems were unable to make in 2020/21.

2. Systems will need to calculate baseline contract values to align with these financial envelopes so there is a clear view of baseline financial flows. These should be based on 2019/20 outturn contract values adjusted for non-recurrent items.
3. Systems and organisations should start to develop plans for how COVID-19 costs can be reduced and eliminated once we start to exit the pandemic.
4. System capital envelopes will also be allocated based on a similar national quantum and using a similar distributional methodology to that introduced for 2020/21 capital planning.

The financial numbers will be provided early in the new year in conjunction with fuller planning guidance once NHS England and NHS Improvement has resolved any further funding to reflect the ongoing costs of managing COVID-19. Further detail of non-recurrent funding announced in the recent Spending Review for elective and mental health recovery will also be provided at that point.

For our Board there is a developing understanding that the recently announced £500m investment in mental health services mentioned above is to be used to bring forward the Long Term Plan ambitions from 2022/23 to 2021/22. In addition, we need to be considering those services we need to 'recover' to pre-COVID levels of activity and performance and the oversight we, in conjunction with the Mental Health, Learning Disability and Autism Delivery Board, need to have over both the mental health minimum investment standard, and the programme of enhancing mental wellbeing support to NHS staff locally.

Local Context

3. On 14 December all boards from Derbyshire NHS Provider organisations, the Derby and Derbyshire Clinical Commissioning Groups (CCGs), and the two local authorities came together for the first time in a joint development session. The aim of the development session was very much predicated on developing a response to the document discussed above in section 2 of my report. Members heard a briefing on the paper and then had the opportunity to get involved in two workshops around understanding if we believed the ICS proposals provided the right foundation for the NHS over the next ten years, and comment on which formal statutory method should be adopted i.e. partnership or the recommended option 2 of a statutory organisation. The importance of local systems being able to develop governance relevant and effective for them, rather than it being a requirement. We also had the opportunity to discuss the best ways to achieve a population health focus. It was particularly pleasing to hear Deputy Chief Executive and Director of Finance, Claire Wright leading a presentation about the advantages seen in the new ways of working in the Mental Health, Learning Disability and Autism Delivery Board.
4. The Midlands Strategic Transformation and Recovery Board that I am a member of, continues to meet monthly. We continue to review the work of each of the

workstreams in light of every increasing pressure from the second wave of COVID-19. The Working Groups are focused on developing outputs that are critical to both our COVID response and to delivering our regional ambitions. Some of the key points discussed included:

- Health inequalities including a priority focus on mitigating the risks to exacerbating health inequalities posed by the second wave and ensuring addressing health inequalities is driving the outputs of all the Working Groups.
- Clinical pathways where there is unwarranted variation in outcomes when comparing the Midlands to the rest of England and agreeing priority areas to focus on.
- Actions to support the restoration and recovery of services.
- Actions to support staff wellbeing and mental health.
- ICS development and frameworks for 2021/22 that will support “Place” becoming the priority focus for planning building on the national; guidelines agreed earlier.

As a reminder for Board there are for working groups as follows:

- Clinical Services and Commissioning Strategies
- Strategies and Approaches to addressing health inequalities and prevention (I also sit on this group)
- Timely and safe restoration and recovery of services
- How we lead, organise and run NHS Midlands

5. On 17 December Joined Up Care Derbyshire (JUCD) Board members held a development session to continue discussions on new ways of system-first working.

The meeting received a verbal update on COVID-19 across the system and the rising incidents seen in South Derbyshire, Bolsover, Amber Valley and parts of the City. We heard about the roll out of lateral flow testing and the roll out by system provider colleagues of the flu/COVID vaccination programme (both hospital and Primary Care Network (PCN) staged roll out), as well as dealing with the backlog of patients via the planned care board and preparing for the EU exit. This led to a conversation recognising how high pressures were in the system.

We also noted that the Ockenden Review of Maternity Services would be brought to the January JUCD Board for a system collective view. Our Board should note that as a Trust we have submitted our initial gap analysis and indicative action plan as required.

The draft Terms of Reference (ToR) for the JUCD Board Assurance Groups were presented to the meeting for discussion including:

- Integrated Care Partnership (ICP) Board, which includes the Place group, provider collaboratives group and the clinical and professional reference group
- Risk and Governance Assurance Committee
- System Anchor Institution Committee.

There was broad support for each of the group frameworks, but more work needed to understand delegated authority and in particular relating to the ICP

Board about if it should be a formal sub-committee or a subset of JUCD Board. There was also general agreement that the estates group should sit with the system finance assurance group and that the People and Culture Board needed some review to separate out assurance role from delivery role.

We also reviewed a proposal to allocate some internal audit time to undertake some ICS facing work. The proposal was to use this allocated time to work on developing the right ICS governance model, looking at: what are the powers reserved to statutory boards, what are the powers already delegated to CEOs/AO, and how we might go about thinking through how we see responsibilities/powers in the ICS space. Broad support for the approach was given, noting the meeting was not a formally constituted meeting, so formal approval could not be given.

Within our Trust

6. Flu vaccinations were a major focus in the organisation since our last Board meeting. There were significant worries that exposure to flu and COVID would leave colleagues, and therefore our services, very vulnerable. It was a great effort this year and by 15 December we had significantly surpassed last year's much longer programme with 81% of frontline colleagues having received their vaccination. My thanks to all colleagues who received their vaccination and there is no doubt this will have an impact on the resilience of our services. By 21 December our figure had increased to 84% making us the second highest performing mental health or community trust in the Midlands.
7. Board members will be aware of the importance of two key developments in the ongoing fight against the COVID-19 virus. The introduction of rapid testing for all frontline facing colleagues via lateral flow test kits and the commencement of COVID vaccinations at the two hospital hubs in Derbyshire. In the Trust, by 22 December, we had received 1,647 lateral flow tests, of which 1,545 were distributed to colleagues and registered for use, equating to 94% registration. This benchmarks well with like organisations in terms of usage. As of 22 December, our positivity rate was 0.53%, which is in line with Midlands' averages.

I am delighted colleagues in our organisation are starting to receive COVID vaccinations at the hospital hubs in Derbyshire. We are adopting the national risk stratification approach, starting with those colleagues who are extremely clinically vulnerable, then moving to those with a clinical vulnerability.

8. As I have stated previously in public, I continue to be so very impressed with the way colleagues in our organisation have responded to this dreadful pandemic. Setting aside the way the pandemic has affected their personal lives through the Christmas and New Year period, colleagues have continued to be focused on supporting each other and those vulnerable they either directly or in-directly are for.

Whilst we saw a drop in colleagues away from work up to early December, as the number of community transmissions have raised very significantly, along with the new virus strain, we have now seen an upward turn in those colleagues who are away from work due to COVID-19 related reasons either self-isolating pending test results, or in a few cases having tested positive. At the time of writing the report we had 81 colleagues away from the workplace.

The number of patients in our inpatient facilities remains low (1 at the time of writing the report down from a high of 11). We have seen an increase in the number of outbreaks we have been managing in both in-patient and community teams, however we have sought and received assurance that our infection prevention and control compliance remains very robust.

I think it important at this point to acknowledge those colleagues who worked through the Christmas and New Year period, and in particular those frontline colleagues and incident management team colleagues who worked over Christmas Day, Boxing Day and New Year's Day to keep our services safe – our grateful thanks.

9. Board members will be aware that despite the pandemic response we successfully migrated the electronic patient record system for our CAMHS and Learning Disability services over to SystmOne on 1 December. This signifies the first phase of our plan to roll all services over onto the SystmOne platform over the course of the next year. The Board will want to join me in expressing my thanks to all colleagues in those services and the implementation project team for all their hard work and dedication that was needed to ensure this transition was managed in a safe and effective way. The document attached in Appendix A demonstrates how the number of issues raised from 'go live' has significantly reduced, evidencing a well-managed transition.
10. We must recognise the impact the ongoing pandemic is having on the resilience and wellbeing of all colleagues in the Trust, something I shared in my feedback from live engagement events last month. During December we have run a 'Winter Wellbeing Campaign' in which on every day in December we reminded colleagues of different ways they can access help and support, speak up about challenges, have a moment of amusement, stay healthy, be mindful and also give us an opportunity to say thank you. It was during this campaign we provided colleagues with a wellbeing 'goodie bag' and a handwritten thank you note from me. My thanks to all colleagues who were involved in making this campaign such a success.
11. I would like to thank colleagues again this year for their participation in the annual staff survey and at such a pressurised time as well. This year 60.1% of colleagues took part in the survey which is simply fantastic given the competing priorities colleagues had. As a reminder our total last year was 60%. Early feedback is starting to come through, but it is unlikely we can formally declare the results in full until the next Board meeting.
12. Over the last two months we have held several 'Live' Divisional Engagement Events chaired by myself, with the aim of offering colleagues the chance to tell us as a senior leadership team how they are finding working in the Trust at present, along with an opportunity to ask questions, make suggestions and share innovations. I have been pleased to welcome Non-Executive Directors to these sessions as well. Engagement sessions have been held with:
 - Older Adult Community Services
 - Adult Acute Services
 - Adult Community Services
 - Forensic and Rehabilitation Services
 - Corporate Services
 - Admin and Clerical Staff

These events have been very well attended, helped using a virtual format on Microsoft Teams. Whilst the topics discussed have varied to some degree depending on the group, there have been common themes some of which include:

- COVID vaccinations, safety, priority lists and the alterations around allergies
- Lateral flow tests, mainly focussing on process around reporting
- Annual leave and the need to enable and encourage colleagues to take a restorative break
- Activity levels increasing across all service areas and the challenge in wave 2 of attempting to keep routine interventions going as well as critical services
- Leadership support
- The importance of completion and review of health risk assessments and our BME colleague risk assessments
- Great opportunity for us to say thank you to colleagues directly.

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

Strategic Considerations

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

Assurances

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

Consultation

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

Governance or Legal Issues

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

Public Sector Equality Duty & 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. There are some great examples of good practice in this document. The co-development of the timetable of events for Black History Month and the launch of It's Not OK both demonstrate a drive to reduce bias and discrimination through emersion in stories and narrative to support increased understanding of the experience of discrimination as well as causes.

During these two months colleagues from our BME Steering Group have asked us to recommence regular, weekly, meetings with them as we are going through wave 2 – this is something that was readily agreed to and these meetings have recommenced. In addition, we have increased representation in our incident management team with colleagues representing our BME and disability and wellness groups/communities.

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

Recommendations

The Board of Directors is requested to:

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

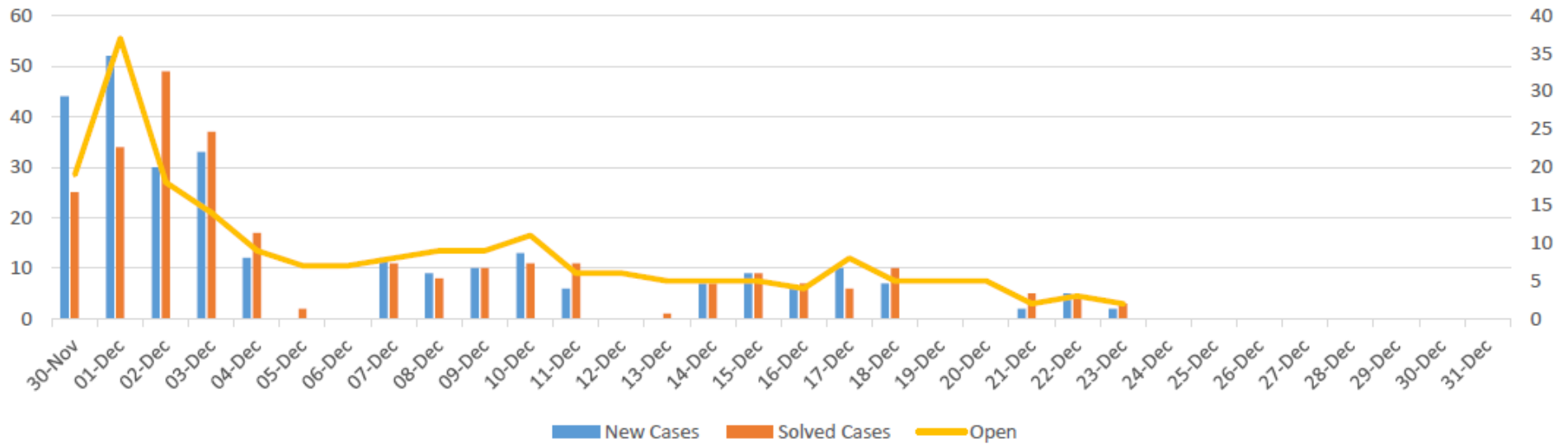
Report presented by: Ifti Majid
Chief Executive

Report prepared by: Ifti Majid
Chief Executive

Issue Overview

2 new issues reported: 0 critical, 2 major and 0 minor.

03 issues have been resolved during the day and 02 issues remain outstanding.



* Please note 'New Cases' and 'Solved Cases' are measured on the primary (left) axis, whereas the 'Open Cases' are measured on the secondary (right) axis.

CAMHS specific:

- New cases: 2
- Solved cases: 2
- Open: 1

LD specific:

- New cases: 0
- Solved cases: 1
- Open: 1



Performance Report

Purpose of Report

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

Executive Summary

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

Finance

Revenue: For month 7 and beyond the retrospective top up income process has ceased and the monthly and year to date financial performance is measured against our share of the fixed income allocation for the remainder of the year.

There is a favourable variance after the first eight months of the year. This means that we are now reporting a cumulative surplus of £1.2m year to date. This is largely due to pay costs being lower than expected due to slippage on recruitment.

To reflect the changing expectations for costs between now and the end of the year we have updated our forecast for the year end. We currently expect to end the year with a surplus of £0.8m. We had originally planned to end the year with a deficit of £0.6m. The changes are due to: deferred income release, changes in recruitment expectations and revenue costs related to the capital plan changes related to dormitories and impairments.

Our forecast position forms part of the Joined Up Care Derbyshire (JUCD) wider system financial position. The overall system plan had expected to end the year with a deficit of £43m. This has now improved in light of the first two months of the second half of the year. At month 8, organisations within the system are now forecasting improved positions. This has been made possible due to mitigations and revised cost expectations. The aggregate impact of these changes mean that we are very close to living within the total Derbyshire budget overall. However this is not without risk, for example as regards current unknowns such as year-end carry forward annual leave cost.

Our Trust's COVID-19-specific costs for November totalled £741k (against the COVID-19 allocation of £700k per month). The majority of these costs are staff-related including bank and agency. With regard to agency costs specifically the

Board should note that we expect to exceed our agency ceiling this year by about £0.5m (18%).

Out of area costs also continue to be required as a result of COVID-19 because not all Trust beds are available for use due to the need to maintain a COVID-19 secure inpatient environment. This is the case even if 'vacant' bed numbers exceed the number of out of area placements. We spent about £170k on out of area placements in November.

Capital: For 'business as usual' capital we are behind plan by £1.3m. However this is offset by the unfunded COVID-19 capital expenditure for laptops of £1.2m, we continue to await confirmation of COVID-19 capital funding.

The capital programme is impacted significantly by expectations and timing of plans for the eradication of dormitories and the plans to build a local Psychiatric Intensive Care Unit. This was the subject of recent Board discussion and the capital plan will be further updated to reflect those discussions and the outcome of dormitory bidding process when known.

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

Operations

Seven day follow-up/ three day follow-up

To date we have consistently achieved the national standards for follow-up of patients discharged from inpatient wards.

Data quality maturity index

Despite being lower than normal for the last two months, the level of data quality remains well above the national target. Data quality is being impacted upon by the increasing waiting lists. Most referrals are received from GPs, who are not mandated to provide any Mental Health Services Data Set (MHSDS) data and so the vast majority of the MHSDS data will not be known until the patient completes a patient registration form when they attend for their first appointment.

Early intervention in psychosis

The service continues to perform consistently well against the national 14 day referral to treatment standard and regarding patients currently waiting to be seen who have been waiting less than 14 days.

Talking Mental Health Derbyshire (IAPT)

The service continues to exceed the national standard for 18 week referral to treatment. The pandemic impacted on performance against the 6 week referral to treatment standard, however with all staff having returned to their substantive posts in September 2020, the standard could be achieved and further improvement has been seen, returning to normal in November 2020.

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

CAMHS continue to utilise telephone and Attend Anywhere for clinical contacts where possible. This is having a positive impact on the size of the waiting list. The average wait to be seen continues to be much longer than normal.

Waiting list for community paediatrics

Back in 2016 there were over 1300 children on the waiting list - many who had been waiting over 12 months and 60% who had been waiting over 18 weeks. Demand outstripped capacity and the service was experiencing persistent difficulties with recruitment and retention. Following significant and sustained effort by the team, as it stands there are now just 220 children on the waiting list of whom 98% have been waiting less than 18 weeks to be seen, against the national standard of 92%. Going forward we anticipate a large increase in the number of referrals which is likely to impact on performance.

Waiting list for Autistic Spectrum Disorder (ASD) assessment

Although the referral rate for 2020/21 is currently 33% lower than last financial year this is still a significant volume, with the assessment hiatus in March-July having also impacted on overall waiting times. The current ASD waiting list has increased to 1,072 with the longest wait being almost 3 years. Remote assessments are preferred at present in order to maximise numbers and limit the impact on face-to-face contact and estate requirements. The service will explore other options going forward.

Waiting list for psychology

The average wait to be seen has reduced for the first time in seven months but remains much higher than normal. The volume of patient contacts has increased and is predominantly conducted through telephone or video.

Patients placed out of area – adult acute

Factors arising out of COVID-19, have resulted in a reduction in bed availability of 25 beds. We are using fewer out of area beds than we have closed beds, which is a significant achievement. Currently there are 12 patients placed in Mill Lodge and work is underway to improve the continuity of care for patients placed at Mill Lodge which is hoped will achieve “appropriate out of area” status.

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

The PICU usage continues to be monitored closely with Clinical Commissioning Groups (CCG) and NHS England/NHS Improvement (NHSE/I). Current usage is 13 patients. There was a significant increase in female usage but this has recently subsided and currently there are 9 males and 4 females. CCG are leading recommissioning of PICU beds and this could result in using beds that achieve “appropriate out of area” status.

Review of the impact of the COVID-19 pandemic

This section provides the Board with a comprehensive review of operational factors which we might have expected to have been impacted upon by the pandemic, including Mental Health Act (MHA) activity; admissions; A&E Liaison activity; Liaison and Diversion activity (criminal justice); community and outpatient

activity and referral levels; older adult urgent care activity; Crisis Assessment and Home Treatment activity; new mental health presentations of people not previously known to DHCFT; Registered deaths in Derby and Derbyshire – all causes; ethnicity recording; waiting lists; patients not seen for over 12 months and timely correspondence with General Practice (outpatient letter processing speed).

People

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

Annual appraisals

The position has been deteriorating in many areas over the course of the pandemic. A revised, shortened process is being rolled out across the Trust to facilitate a well-being conversation which will incorporate key questions and can be reported through appraisal completion on ESR by the line manager.

Annual turnover

The rate of turnover has been normal for the last 11 months and remains within the Trust target of 8-12%. A high retention rate such as ours can result in a healthier culture, a happier workforce and higher productivity.

Compulsory training

A Training Cell continues to meet weekly to support the Divisions with regards to improving the training position and focusing on key priority areas. The Cell continues to monitor progress against training recovery plans and sustainability. The expected outcome is to ensure compliance targets are reached by the end of March 2021.

Staff absence

Staff absence has been higher than the Trust target of 5% for all but one of the last 24 months and statistically it is very unlikely that the target will be achieved. Absence has increased over the last 3 months but remains within normal variation. Around 3% of the current absence is COVID-19-related.

Supervision

The levels of compliance with the clinical and managerial supervision targets have remained lower than normal since the start of the pandemic and for the last few months have been gradually worsening.

Vacancies

The proportion of posts filled was statistically higher than normal for the first time. This may be an indicator of the positive team culture within the Trust and links in with the low level of staff turnover.

Bank staff use

Bank staff use has been rising and was statistically higher than normal this month which is likely to be a result of the increased level of staff absence.

Quality

Incidents

Incidents of moderate to catastrophic harm appear to have reduced in November after reaching a peak in October.

Seclusion and restraint

The use of seclusion was within normal variation, although with an increasing trend in physical restraint and prone restraint. There are ongoing work streams to support the continuing need to reduce restrictive practice.

Patients in settled accommodation and patients in employment

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

Care plan reviews

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

Complaints, concerns and compliments

The number of compliments decreased in line with the emergence of COVID-19 and the significant changes to many of our clinical services. The number of complaints increased between June and November with a particular theme around both concerns and complaints of access to services.

Duty of Candour

In this report there is one instance of Duty of Candour. This relates to a complaint that was raised regarding diagnostic overshadowing and physical health care response to a patient whilst an inpatient.

Number of falls on inpatient wards

The number of reported falls has decreased since September however still demonstrates an increased trend.

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

Assurances

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

Consultation

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

Governance or Legal Issues

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

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

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

Recommendations

The Board of Directors is requested to:

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

Report presented by: Mark Powell
Chief Operating Officer



























Report prepared by: Peter Henson
Head of Performance

Claire Wright
Director of Finance/Deputy CEO

Celestine Stafford
Assistant Director People and Culture Transformation




Vicki Baxendale
Interim Assistant Director, Nursing, Quality & Governance

Assurance Summary

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

¹The rating symbols were designed by NHS Improvement

Key:

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

Detailed Narrative

1. Operations

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

Patients are followed up in the days following discharge from mental health inpatient wards to provide support and ensure their wellbeing during the period when they are at their most vulnerable. To date we have consistently achieved the national standards for follow-up. Confidence limits will be calculated for the new standard once there are enough data points: SPC charts require a minimum of 10 data points in order to create a valid chart, although there is increased reliability when using 20 or more data points¹.

B. Data quality maturity index

Despite being lower than normal for the last 2 months, the level of data quality remains well above the national target. Data quality is being impacted upon by the second wave of the pandemic owing to increasing waiting lists as a result of needing to concentrate resources on our critical services. Waiting lists impact on data quality because as soon as a referral is accepted the patient's data has to be included in the mental health minimum data set (MHSDS). Most referrals are received from GPs, who are not mandated to provide any MHSDS data. Therefore the vast majority of the MHSDS data will not be known until the patient completes a patient registration form when they attend for their first appointment. This has been a common issue across the country for many years and the most recently published national data² provides assurance that our data quality is high when compared with other mental health trusts (Appendix 3).

C. Early intervention

The service continues to perform consistently well against the national 14 day referral to treatment standard and regarding patients currently waiting to be seen who have been waiting less than 14 days. Within normal variation we would expect both standards to be achieved 100% of the time.

D. Talking Mental Health Derbyshire (IAPT)

The service continues to exceed the national standard for 18 week referral to treatment. The pandemic impacted on performance against the 6 week referral to treatment standard, however with all staff having returned to their substantive posts in September 2020, the standard could be achieved and further improvement has been seen, returning to normal in November 2020.

E. Waiting list for Child and Adolescent Mental Health Services (CAMHS)

CAMHS continue to utilise telephone and Attend Anywhere as vehicles to support clinical contacts; face to face appointments are offered only when clinically indicated. This is having a positive impact on the size of the waiting list and for the last 6 months the waiting list has remained within normal levels. The average wait to be seen continues to be much longer than normal.

F. Waiting list for community paediatrics

Back in 2016 there were over 1300 children on the waiting list - many who had been waiting over 12 months and 60% who had been waiting over 18 weeks. Demand outstripped capacity and the service was experiencing persistent difficulties with recruitment and retention.

The service have worked long and hard to improve the patient experience and are to be congratulated for the monumental achievement in reducing waiting times and numbers waiting to

¹ <https://www.england.nhs.uk/improvement-hub/wp-content/uploads/sites/44/2017/11/An-Overview-of-Statistical-Process-Control-SPC.pdf>

² <https://digital.nhs.uk/binaries/content/assets/website-assets/data-and-information/data-tools-and-services/data-services/data-quality/dgmi-december-2020/20-09-dgmi-monthly-publication---sept-20-v3-publish.xlsx>

the lowest they have been to date. As it stands there are just 220 children on the waiting list of whom 98% have been waiting less than 18 weeks to be seen, against the national standard of 92%.

As reported last time, there has been a reduction in referrals received in recent months owing to a temporary cross-service closure of the neurodevelopmental assessment pathway. Community paediatrics have agreed to be the service which opens for the starting point (the assessments of children under 6 years old) and so when the full pathway opens we anticipate a large increase in the number of referrals which is likely to impact on performance.

G. Waiting list for Autistic Spectrum Disorder (ASD) assessment

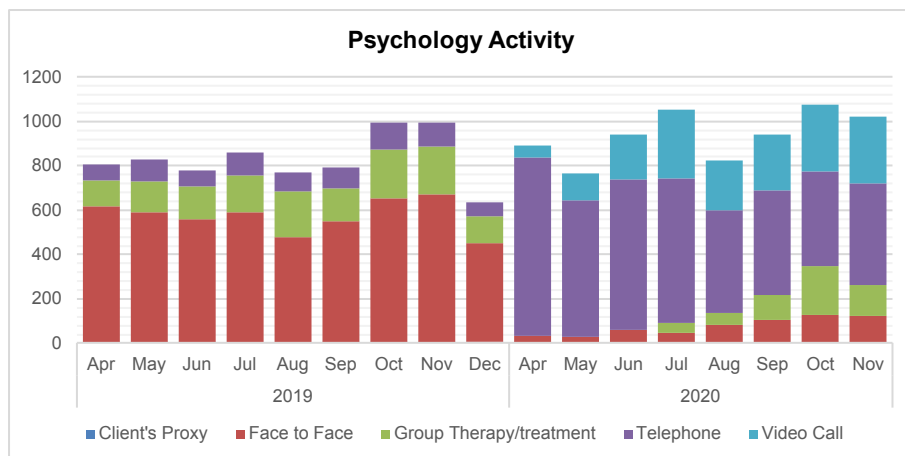
To enable staff to be redeployed as part of the COVID-19 incident response, in mid-March ASD assessments were suspended. The service remained open to referrals which were processed remotely by the team administrator. From July the partial team undertook a successful, limited pilot on the feasibility of using Attend Anywhere, coupled with a new DHCFT assessment tool, for ASD assessments. Following the return of the redeployed ASD staff into their substantive roles in September the team has been undertaking ASD assessments, either remotely or through home visits if required.

Although the referral rate for 2020/21 is currently 33% lower than last financial year this is still a significant volume, with the assessment hiatus in March-July having also impacted on overall waiting times. The current ASD waiting list has increased to 1,072 with the longest wait being almost 3 years.

A recent pilot of face-to-face assessments for those clinically or logistically unable to undertake an online assessment has been piloted successfully within an adapted environment. This is seen as viable but requires additional staff time and additional space and cleaning so currently has limited availability. The length of face-to-face time required for ASD assessments (4 hours) has meant remote assessments are preferred at present in order to maximise numbers and limit the impact on face-to-face contact and estate requirements. There is an ongoing risk that this may lead to a two tier assessment waiting list, with more rapid access for those who can access remote technology, however the ASD assessment service will explore other options going forward.

H. Waiting list for psychology

The average wait to be seen has reduced for the first time in 7 months but remains much higher than normal. The volume of patient contacts has increased and is predominantly conducted through telephone or video.



I. Patients placed out of area – adult acute

It must be noted that we have recently experienced a COVID-19 outbreak on Ward 36. This has resulted in the ward being closed to further admissions. At the time of writing this means that there are 12 beds closed on ward 36. We have rearranged Morton ward and Tansley ward at the Hartington Unit to provide the admission capacity required and in doing so we have changed these wards to single sex wards: Morton is now a female ward and Tansley is a male ward. However in doing this further beds are closed. For example:

- Morton has a total of 4 beds closed
- Pleasley has a total of 3 beds closed
- Tansley has a total of 3 beds closed
- Ward 33 has a total of 3 beds closed
- Ward 36 has a total of 12 beds closed.

In total there are 25 acute beds closed and therefore maintaining out of area bed usage at the level we have is a significant achievement because we are using fewer out of area beds than we have closed beds.

Currently there are 12 patients placed in Mill Lodge and work underway to improve the continuity of care for patients placed at Mill Lodge which is hoped will achieve “appropriate out of area” status.

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

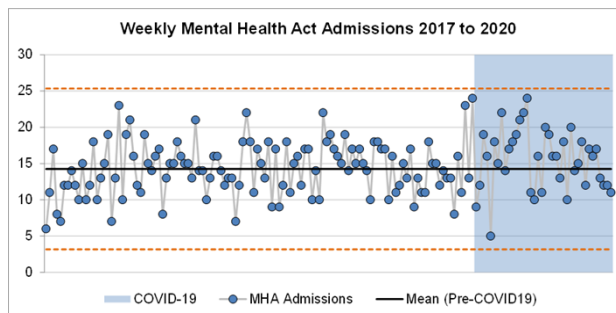
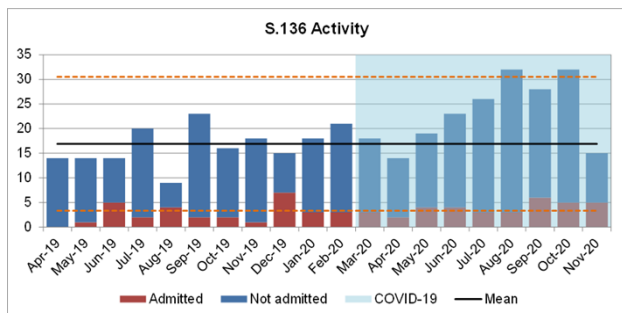
The PICU usage continues to be monitored closely with CCG and NHSE/I. Current usage is 13 patients. There was a significant increase in female usage but this has recently subsided and currently there are 9 males and 4 females. CCG are leading recommissioning of PICU beds and this could result in using beds that achieve “appropriate out of area” status.

2. Review of the Impact of the COVID-19 Pandemic

This section provides the Board with a comprehensive review of operational factors which we might have expected to have been impacted upon by the pandemic.

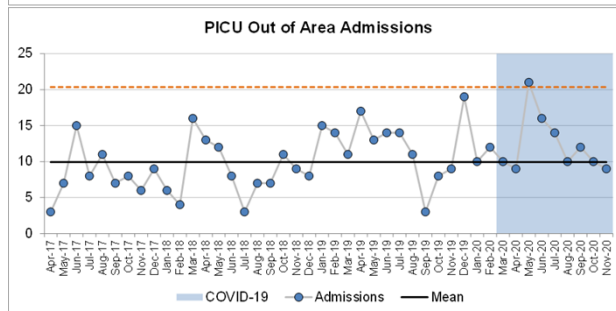
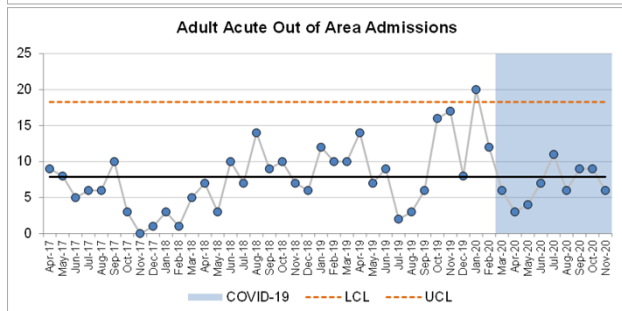
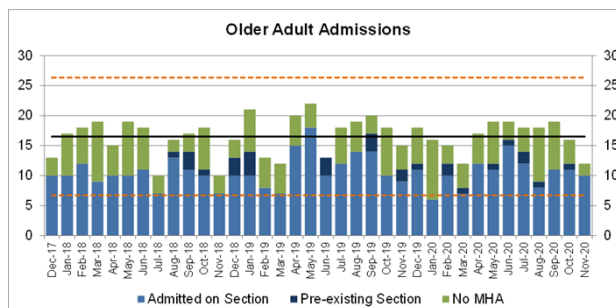
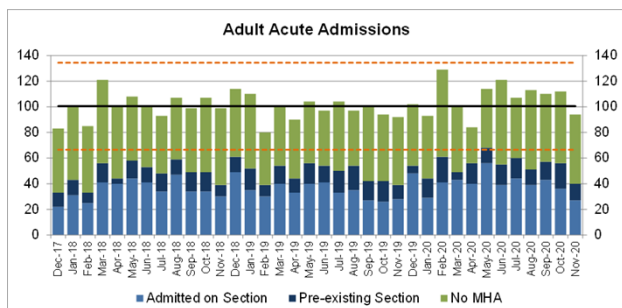
A. Mental Health Act (MHA) activity

The volume of Section 136 activity has been above average since the start of the pandemic and significantly higher than normal in August and October. The average weekly number of MHA admissions has increased by around 2 per week. These factors would suggest that people are becoming more acutely unwell before coming into contact with services, which may be an indicator of the reduced levels of support from health and social care organisations as a result of the pandemic.



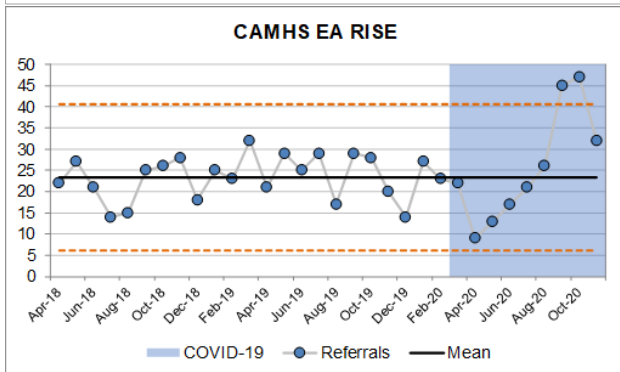
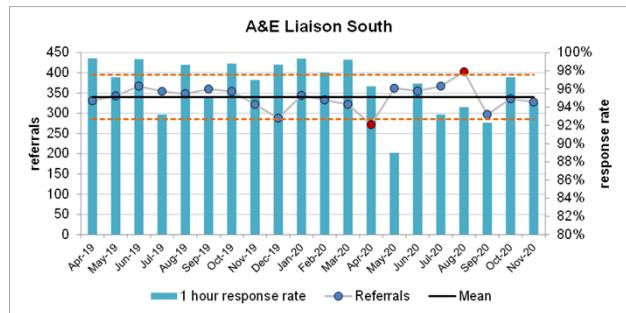
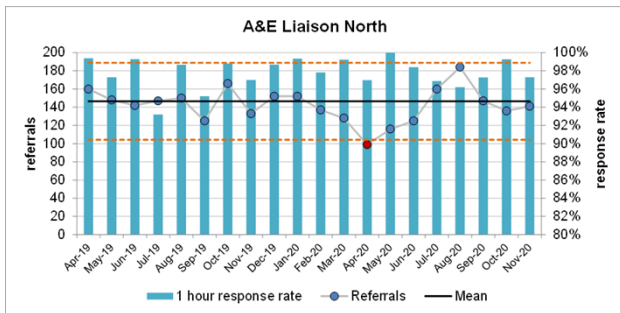
B. Admissions

Adult and older adult admissions have both been above average most months. Adult acute out of area admissions have been below average two thirds of the time during the pandemic, with PICU admissions remaining at normal levels following an unusual spike in May 2020.



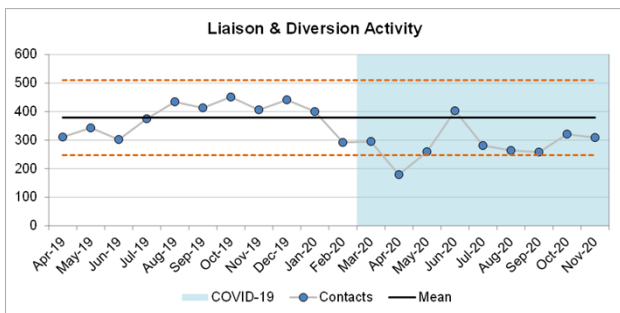
C. A&E Liaison activity

Activity of both adult teams dropped significantly in April 2020 but since then has generally been normal, apart from a spike in August 2020 in A&E Liaison South. The CAMHS team saw presentations fall below average from the start of the pandemic but were then significantly higher than normal in September and October 2020 before returning to normal this month.



D. Liaison and Diversion activity (criminal justice)

Activity was unusually low in April 2020 but since then has returned to normal variation, with activity in 8 out of the last 9 months being lower than average.



E. Children's services activity

Children's services are generally performing at the same levels as last year, the exception being school nursing.

Service	ACTIVITY COMPARISON 2020 V 2019									
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Overall
Community Paediatrics	107%	75%	116%	96%	117%	115%	90%	98%	85%	100%
Community Therapy (Occupational Therapy)	45%	64%	64%	60%	96%	61%	65%	65%	94%	64%
Community Therapy (Physiotherapy)	113%	103%	125%	101%	93%	100%	88%	119%	123%	105%
Derby & South Derbyshire ID SPoE				0%						0%
Derbyshire Special Schools & The Lighthouse	81%	122%	114%	126%		92%	45%	55%	150%	83%
Health Visiting	109%	94%	112%	102%	96%	115%	105%	118%	93%	106%
School Nursing Service	43%	32%	33%	73%	81%	38%	41%	44%	58%	44%
Senior Disability Health Visitors	146%	103%	171%	160%	138%	144%	74%	77%	238%	122%
Specialist Nursing (ADHD)	103%	98%	141%	101%	86%	100%	76%	77%	70%	95%
Specialist Nursing (Continence)	56%	65%	85%	73%	74%	46%	59%	91%	105%	69%
Specialist Nursing (Health Visitors)	0%	0%				0%				0%
Specialist Nursing (Learning Disabilities)	107%	49%	61%	163%	167%	151%	102%	72%	50%	94%

F. Mental health outpatient activity

Activity levels have been increasing following a dip in April 2020 and year to date ranges from 83-100% of levels seen the previous financial year. There is some variation across services, with Derby City B outpatients standing at 40% of last year's activity level to date.

Service	ACTIVITY COMPARISON 2020 V 2019									
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec (to date)	Overall
ADULT CARE COMMUNITY	56%	68%	89%	78%	88%	98%	94%	101%	41%	83%
COUNTY NORTH	97%	100%	119%	95%	119%	109%	105%	109%	31%	104%
BOLS & CC ADULT CMHT - OUTPATIENTS	119%	93%	146%	110%	103%	114%	85%	117%	62%	108%
CHESTERFIELD C ADULT CMHT - OUTPATIENTS	109%	105%	91%	77%	96%	87%	86%	109%	13%	92%
EI NTH	85%	109%	115%	79%	66%	159%	98%	97%	25%	101%
HP & N DALES ADULT CMHT - OUTPATIENTS	46%	76%	89%	83%	168%	97%	104%	74%	15%	82%
KILLMSH & NC ADULT CMHT - OUTPATIENTS	110%	135%	182%	131%	201%	143%	294%	170%	52%	162%
COUNTY SOUTH	31%	50%	68%	82%	93%	93%	89%	105%	55%	74%
AMBER VALLEY ADULT CMHT - OUTPATIENTS	27%	47%	58%	61%	88%	90%	99%	73%	77%	64%
EI STH & CITY	35%	33%	81%	71%	66%	150%	79%	75%	0%	68%
EREWASH ADULT CMHT - OUTPATIENTS	39%	71%	89%	78%	114%	87%	88%	166%	112%	86%
SOUTH & DALES ADULT CMHT - OUTPATIENTS	26%	43%	53%	162%	96%	92%	84%	101%	27%	72%
DERBY CITY	32%	44%	72%	50%	52%	88%	81%	83%	50%	62%
DERBY CITY ADULT CMHT B - OUTPATIENTS	15%	29%	36%	23%	39%	64%	58%	71%	28%	40%
DERBY CITY ADULT CMHT C - OUTPATIENTS	50%	58%	143%	86%	65%	120%	107%	90%	73%	89%
EATING DISORDERS SERVICE	680%	488%	418%	277%	267%	292%	208%	140%	0%	289%
FORENSIC & MH REHAB	467%	93%	271%	255%	540%	188%	138%	136%	0%	194%
COMPLEX CARE	467%	93%	271%	255%	540%	188%	138%	136%	0%	194%
OLDER PEOPLES CARE	51%	59%	80%	54%	83%	119%	115%	138%	47%	85%
OLDER PEOPLES COMMUNITY CARE	51%	59%	80%	54%	83%	119%	115%	138%	47%	85%
SPECIALIST CARE SERVICES	113%	81%	121%	96%	105%	70%	113%	130%	65%	100%
LEARNING DISABILITIES	93%	63%	104%	74%	60%	38%	147%	126%	0%	78%
PERINATAL	146%	116%	147%	135%	262%	155%	86%	133%	69%	135%

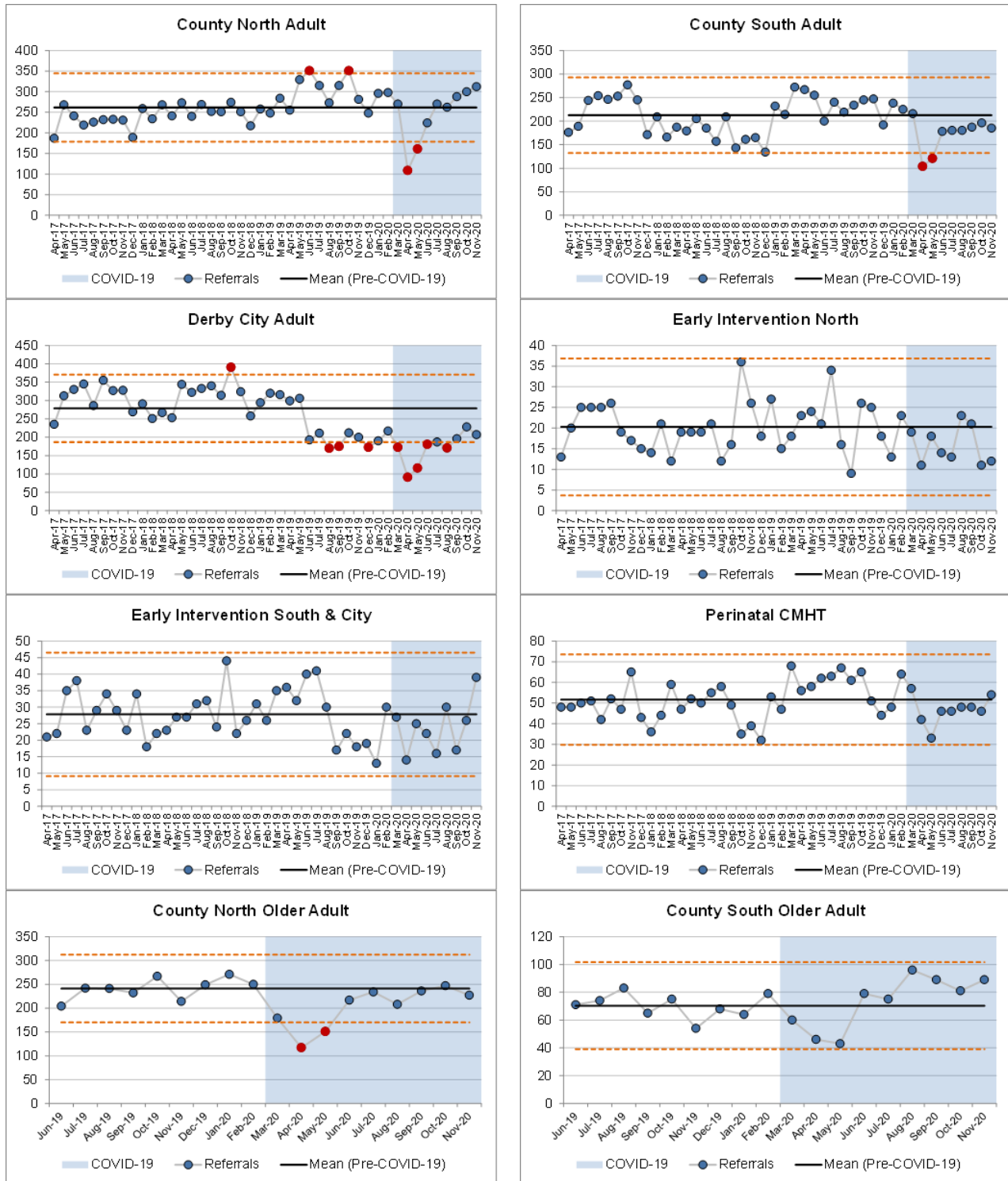
G. Mental health community activity

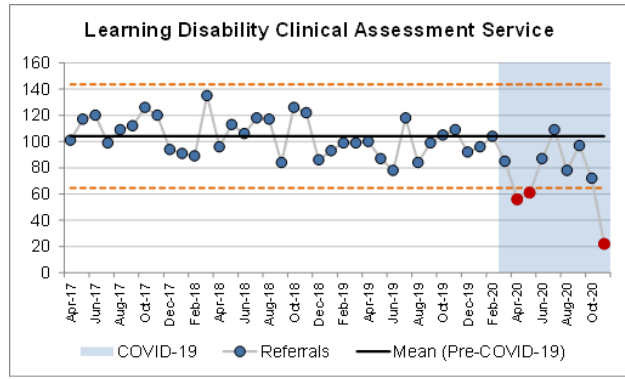
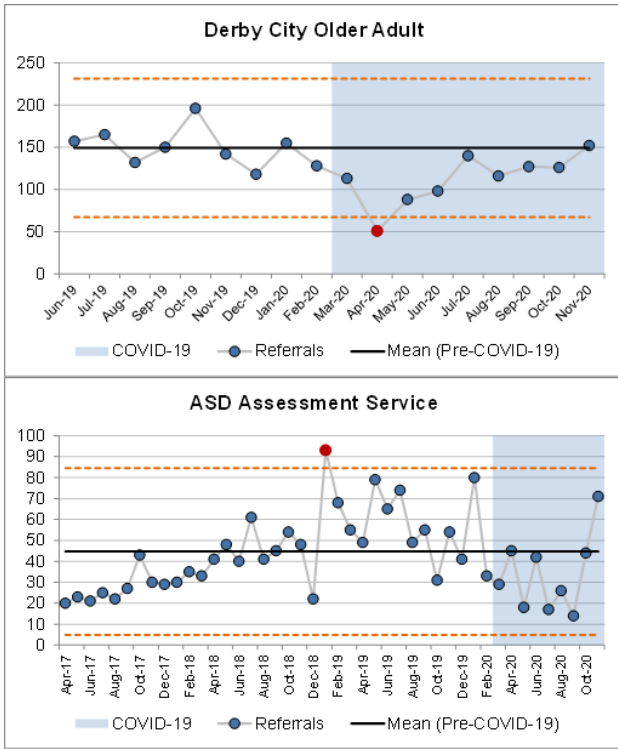
Overall there has been more activity this financial year than last, with a shift from face-to-face to telephone as the main vehicle for making contact. As with outpatients, Derby City B community activity is low at 75%.

Service	ACTIVITY COMPARISON 2020 V 2019									
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Overall
Adult Community	127%	112%	130%	112%	102%	106%	92%	94%	88%	107%
Amber Valley	122%	113%	113%	104%	125%	125%	109%	98%	121%	112%
Bolsover & Clay Cross	138%	113%	149%	152%	124%	158%	111%	99%	98%	126%
Chesterfield Central	104%	95%	98%	79%	78%	93%	86%	79%	78%	88%
Early Intervention	144%	100%	123%	100%	87%	97%	86%	81%	66%	98%
Eating Disorders Service	153%	125%	144%	106%	110%	90%	85%	93%	78%	110%
Erewash	159%	147%	154%	116%	116%	94%	102%	109%	103%	121%
High Peak & North Dales	140%	100%	126%	124%	99%	83%	80%	78%	64%	99%
Killamarsh & North Chesterfield	143%	150%	181%	148%	131%	127%	105%	120%	90%	135%
South & Dales	186%	163%	183%	181%	154%	132%	94%	96%	118%	142%
Derby City Team B	66%	69%	94%	72%	66%	74%	72%	88%	82%	75%
Derby City Team C	146%	112%	119%	120%	102%	122%	81%	103%	100%	111%
Older Adult Community	125%	112%	119%	104%	100%	119%	99%	98%	96%	108%
Amber Valley	119%	128%	123%	102%	92%	106%	95%	94%	75%	105%
Bolsover & Clay Cross	114%	117%	103%	118%	111%	108%	100%	84%	93%	104%
Chesterfield Central	195%	142%	137%	98%	103%	120%	91%	87%	117%	115%
Day Hospital	0%	30%	17%	0%	80%	#DIV/0!	122%	16%	#DIV/0!	40%
Derby City	113%	97%	116%	118%	97%	139%	107%	102%	101%	110%
Erewash	129%	134%	169%	122%	114%	143%	90%	97%	79%	120%
High Peak & North Dales	181%	122%	159%	131%	136%	131%	106%	96%	92%	126%
Inreach & Home Treatment	56%	58%	65%	52%	73%	93%	107%	86%	66%	72%
Killamarsh & North Chesterfield	109%	72%	87%	80%	80%	94%	78%	100%	161%	90%
South & Dales	199%	170%	130%	114%	109%	124%	100%	122%	113%	129%
Grand Total	126%	112%	126%	109%	101%	111%	94%	96%	91%	107%

H. Mental health community referrals

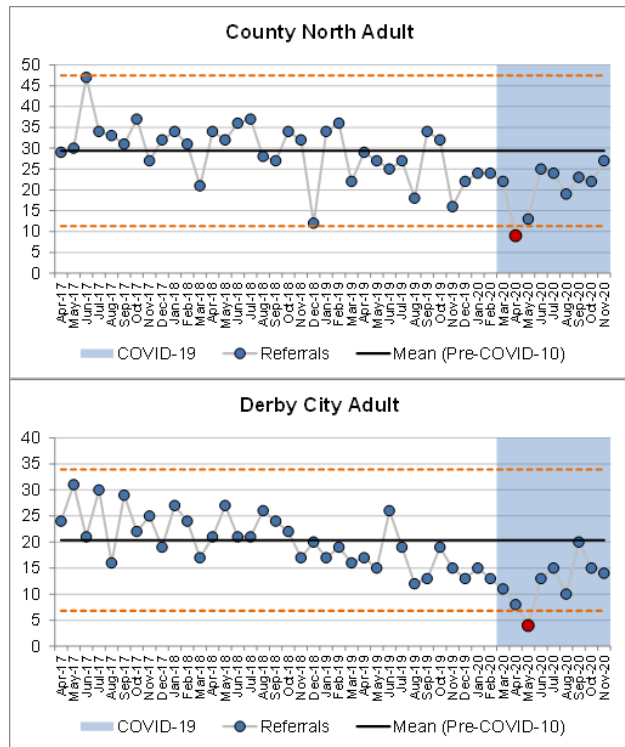
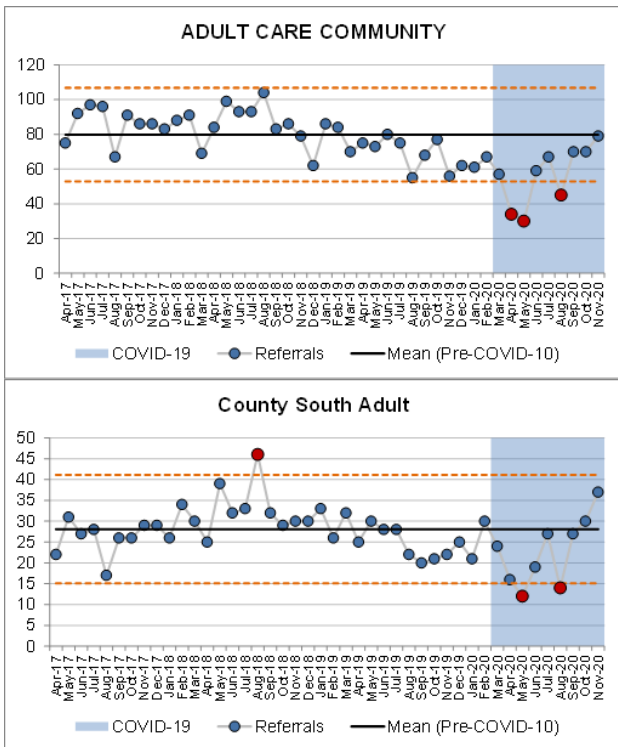
Referrals received by Derby City Adult and County South Adult have been significantly low throughout the pandemic. In County North Adult the volume of referrals received has returned to normal following a significant drop in April and May 2020. For Early Intervention Services, Perinatal Community and Learning Disability Services, referrals have remained within normal variation throughout. In older adults, Derby City and County North referrals have been lower than average most of the time; however County South referrals have been above average for the last 6 months. ASD assessment referrals have been lower than average most of the time.

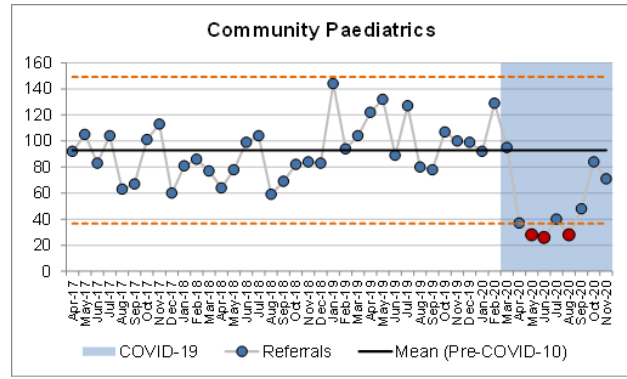
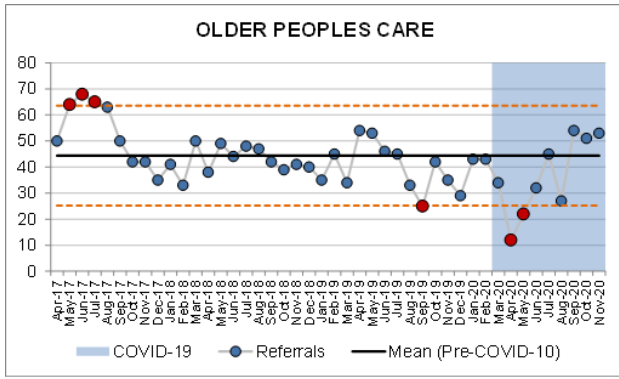




I. Outpatient new referrals

Adult outpatient referrals overall have been below average since July 2019, falling significantly in April, May and August 2020. There is some variation across the County, with County South returning to normal in recent months. Older adult outpatient referrals have returned to normal following a dip in April and May 2020. Paediatric referrals have been lower than normal for the last 8 months.





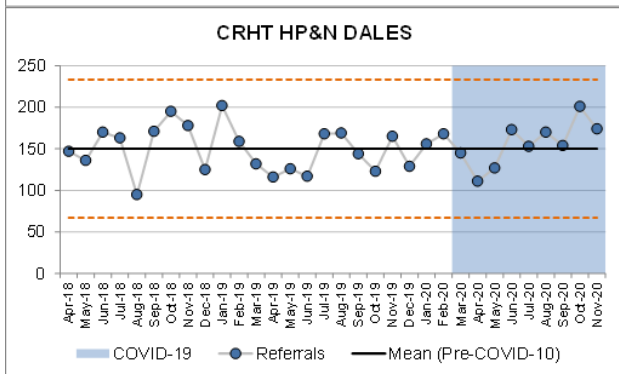
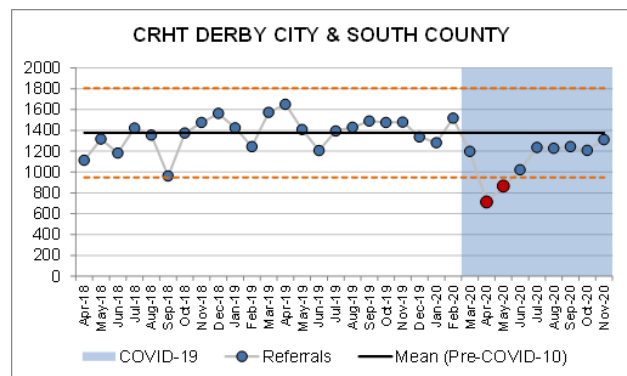
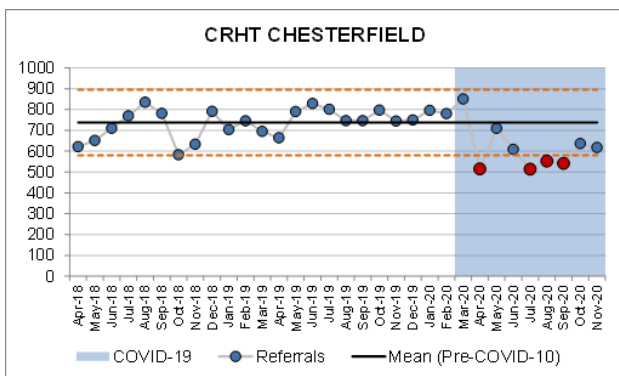
J. Older adult urgent care activity

Dementia rapid response activity levels dropped significantly at the start of the pandemic but have been increasing in recent months. There is some variation across the 3 services ranging from 62-85%.

Team	ACTIVITY COMPARISON 2020 V 2019									
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec ytd	Overall
DISCHARGE LIAISON TEAM OA	44%	16%	10%	53%	54%	81%	96%	81%	20%	52%
DRRT CHESTERFLD & NED & B	50%	58%	46%	62%	68%	78%	89%	65%	47%	62%
DRRT HP & N DALES	57%	66%	104%	129%	62%	77%	101%	114%	87%	85%
DRRT STH	73%	41%	54%	94%	73%	92%	104%	85%	100%	77%
ECT DEPARTMENT - ACUTE		4%	0%	0%	0%	18%	12%	18%		9%

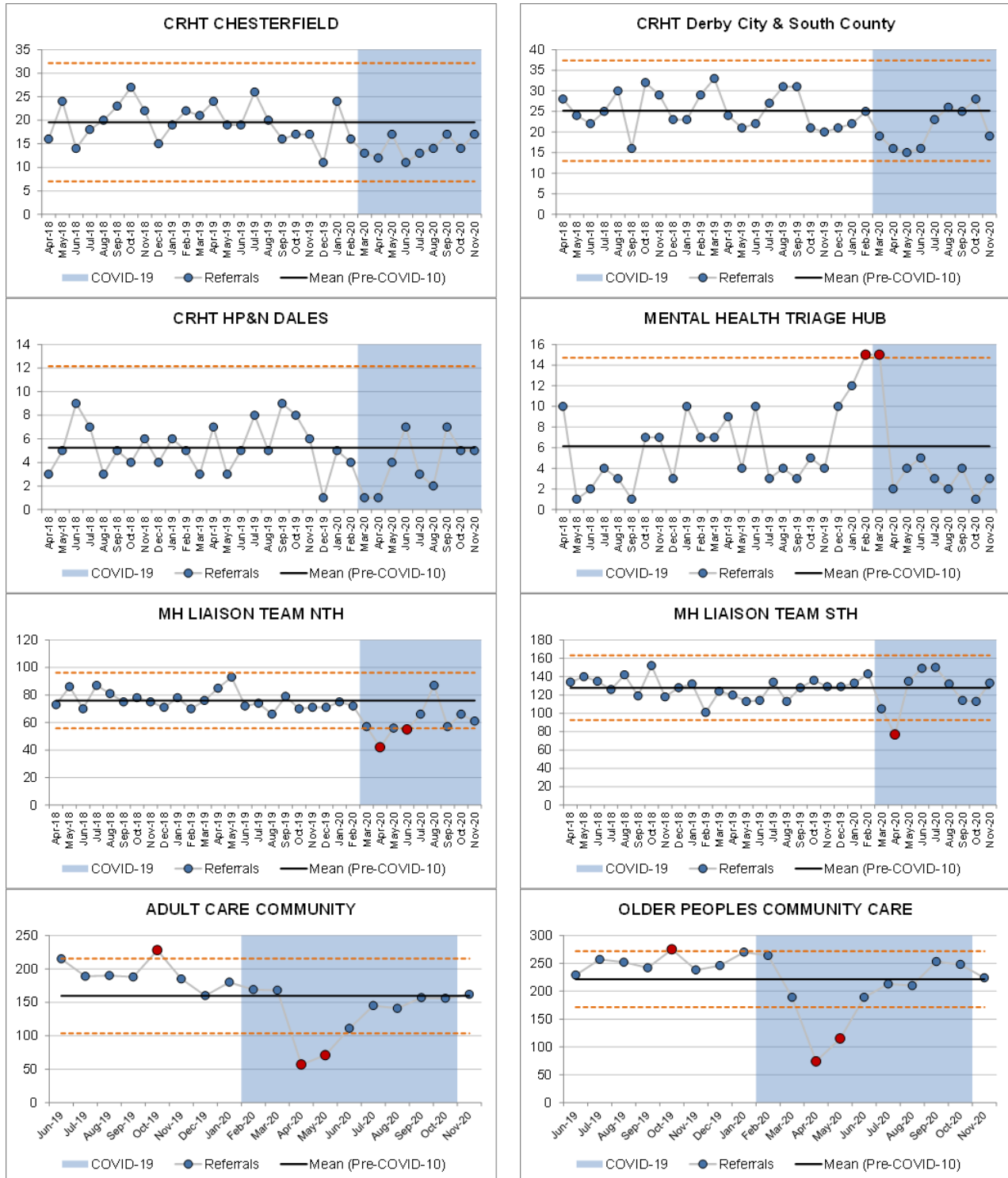
K. Crisis Assessment and Home Treatment activity

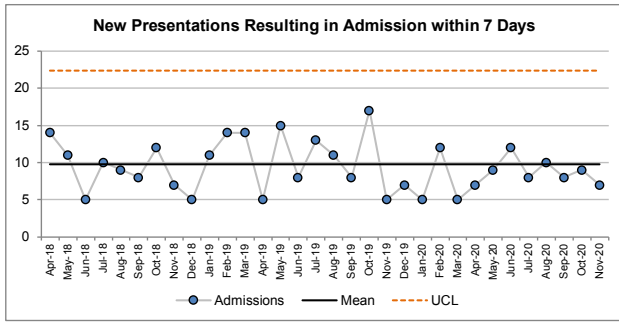
Activity levels have been significantly low in Chesterfield and Derby City & South County since the start of the pandemic, however activity in High Peak has remained at normal levels and if it is above average in December this would indicate a significant increase since June 2020.



L. New mental health presentations of people not previously known to DHCFT

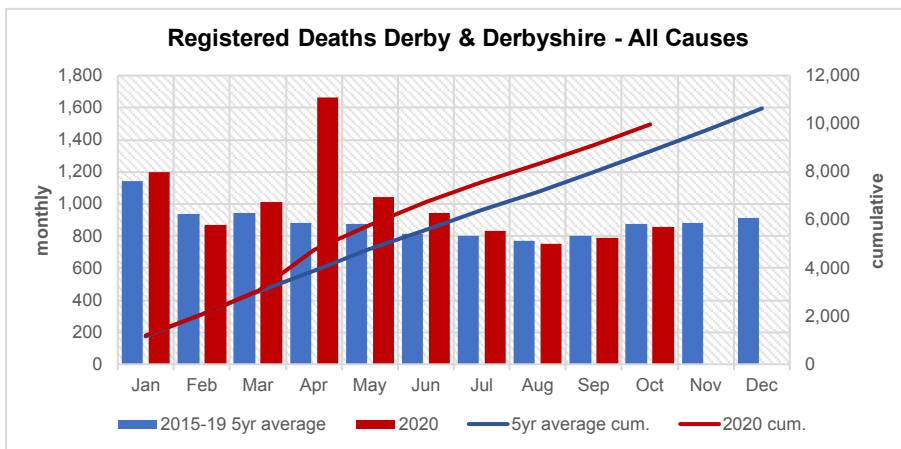
Generally the number of people presenting with mental health problems who were not previously known to the Trust has been normal. Exceptions are Chesterfield Crisis Team, the Mental Health Triage Hub and Adult Community, all whom have seen significantly lower numbers of new presentations than normal. New presentations resulting in admissions have remained at normal levels.





M. Registered deaths in Derby & Derbyshire – all causes

This year a much greater number of people sadly died in April than in previous years. At that point the cumulative registered deaths were 18% higher than the previous 5 year average. The difference has been gradually reducing each month since June. Year to date to October there have been 11% more cumulative registered deaths than the previous year. This is similar to the position for England as a whole.



N. Recording of patient ethnicities

The level of recorded ethnicities remains high at 91% but has been very gradually reducing over time. 55% of the missing ethnicities relate to patients who have not been seen by the Trust yet.

Service	Not known	Grand Total	% Not Known
MAS SOUTH - MAS	531	1298	41%
ASD ASSESSMENT SERVICE	331	1019	32%
LIAISON & DIVERSION	38	193	20%
DERBY CITY OA CMHT - COMMUNITY	62	466	13%
AMBER VALLEY OA CMHT - COMMUNITY	39	369	11%
PERINATAL CMHT	26	273	10%
MAS NORTH - MAS	50	563	9%
SOUTH & DALES ADULT CMHT - COMMUNITY	30	341	9%
DERBY CITY ADULT CMHT B - COMMUNITY	35	416	8%
CHESTERFIELD C ADULT CMHT - COMMUNITY	39	592	7%
DERBY CITY ADULT CMHT C - COMMUNITY	33	500	7%
EREWASH ADULT CMHT - COMMUNITY	24	328	7%
AMBER VALLEY ADULT CMHT - COMMUNITY	20	346	6%
AMBER VALLEY ADULT CMHT - OUTPATIENTS	21	772	3%

O. Waiting lists

Community waiting lists for most teams are generally quite small and in most cases the majority of patients have been waiting less than 20 weeks. The ASD Assessment Service has a large waiting list and long waits. CAMHS also have a number of children waiting longer than we would want. These factors pre-date COVID-19.

Waits for mental health outpatients worsened significantly but have subsequently recovered to normal levels for the past 3 months.

Waits for paediatric outpatients have improved massively since August 2020 and the national standard of 92% of patients currently waiting less than 18 weeks is now being achieved.

Waiting times for care coordination and the number of patients waiting for care coordination have both reduced significantly.

Waiting times for ASD assessment and the number of patients waiting for ASD assessment have both increased significantly over time. This growth pre-dates COVID-19.

Waiting times for psychology have been significantly higher than normal during the pandemic, however the number of people waiting has remained at normal levels.

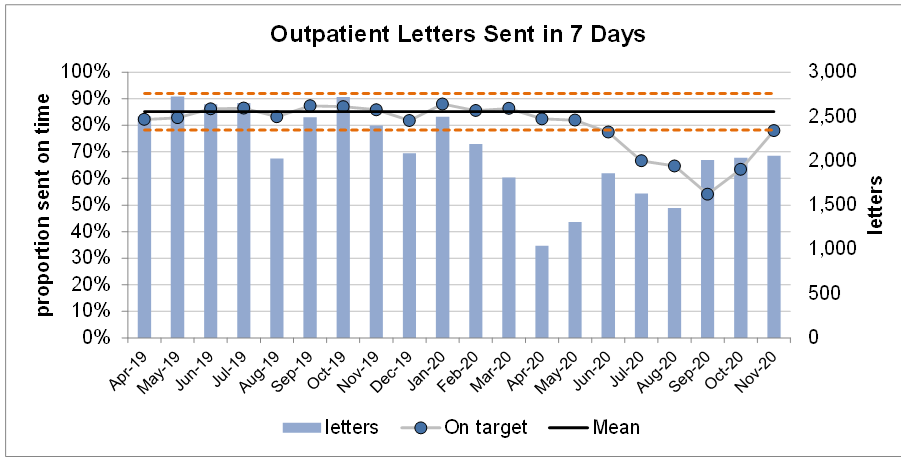
Waiting times for CAMHS have been significantly high since August 2019. The number of children waiting has been below average for the last 5 months.

P. Patients not seen for over 12 months

There are 851 patients open to mental health services who have not been seen by anyone for over 12 months, of whom 143 are patients awaiting ASD assessment. The pandemic started 273 days ago therefore this issue pre-dated COVID-19, although it is likely to have been exacerbated by it.

Q. Timely correspondence with General Practice

Letter processing speed dipped significantly lower than normal from July 2020 despite the volume of letters reducing. There has been some improvement over the last 2 months.



3. People

In order to release capacity to manage the COVID-19 pandemic, all NHS organisations were instructed by Amanda Pritchard, Chief Operating Officer, NHS England and NHS Improvement³, to suspend appraisals and revalidation and to reduce the volume of mandatory training as appropriate. This resulted in a backlog of training and appraisals.

A. Annual appraisals

The position has been deteriorating in many areas over the course of the pandemic. A revised, shortened process is being rolled out across the Trust to facilitate a well-being conversation which will incorporate key questions and can be reported through appraisal completion on ESR by the line manager.

	Target	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Movement
Appraisal Completion	90%	81%	78%	77%	78%	74%	73%	69%	69%	
Corporate Services	90%	81%	76%	72%	71%	61%	59%	47%	45%	
Business Improvement + Transformation	90%	80%	45%	18%	10%	40%	40%	50%	50%	
Corporate Central	90%	55%	50%	42%	38%	38%	33%	37%	34%	
Estates + Facilities	90%	92%	90%	93%	91%	69%	58%	27%	29%	
Finance Services	90%	95%	90%	67%	86%	95%	90%	95%	95%	
Med Education & CRD	90%	50%	48%	47%	47%	43%	37%	32%	29%	
Nursing + Quality	90%	67%	63%	52%	43%	41%	41%	45%	49%	
Ops Support	90%	89%	85%	79%	76%	68%	88%	86%	78%	
People Services	90%	33%	33%	50%	50%	33%	20%	29%	38%	
Operational Services	90%	81%	78%	78%	80%	77%	76%	74%	74%	
Adult Care Acute	90%	84%	81%	79%	79%	76%	77%	75%	76%	
Adult Care Community	90%	79%	76%	78%	78%	77%	77%	68%	66%	
Children's Services	90%	74%	71%	71%	73%	69%	67%	70%	67%	
Clinical Serv Management	90%	54%	50%	50%	50%	45%	46%	38%	38%	
Forensic + MH Rehab	90%	90%	92%	93%	90%	92%	89%	84%	88%	
Older Peoples Care	90%	89%	88%	90%	93%	89%	86%	87%	87%	
Performance Delivery Clustering	90%	100%	100%	100%	100%	100%	100%	100%	100%	
Psychology	90%	65%	59%	56%	61%	58%	53%	50%	48%	
Specialist Care Services	90%	80%	73%	77%	78%	74%	74%	73%	77%	

B. Annual turnover

The rate of turnover has been normal for the last 11 months and remains within the Trust target of 8-12%. A high retention rate such as ours can result in a healthier culture, a happier workforce and higher productivity.

C. Compulsory training

A Training Cell continues to meet weekly to support the Divisions with regards to improving the training position and focusing on key priority areas. The Cell continues to monitor progress against training recovery plans and sustainability. The expected outcome is to ensure compliance targets are reached by the end of March 2021.

The training team have been given additional administration resources who are proactively contacting people in an attempt to fill available training places. The Trust have provided a Marquee at Kingsway in order to provide a COVID-19 safe environment for the delivery of face to face training including Positive and Safe training and Adult & Paediatric Basic Life Support. External Immediate Life Support training delivery has been commissioned and training is planned until the end of March 2021.

All statutory mandatory training remains accessible online and Divisions are encouraging their teams to complete.

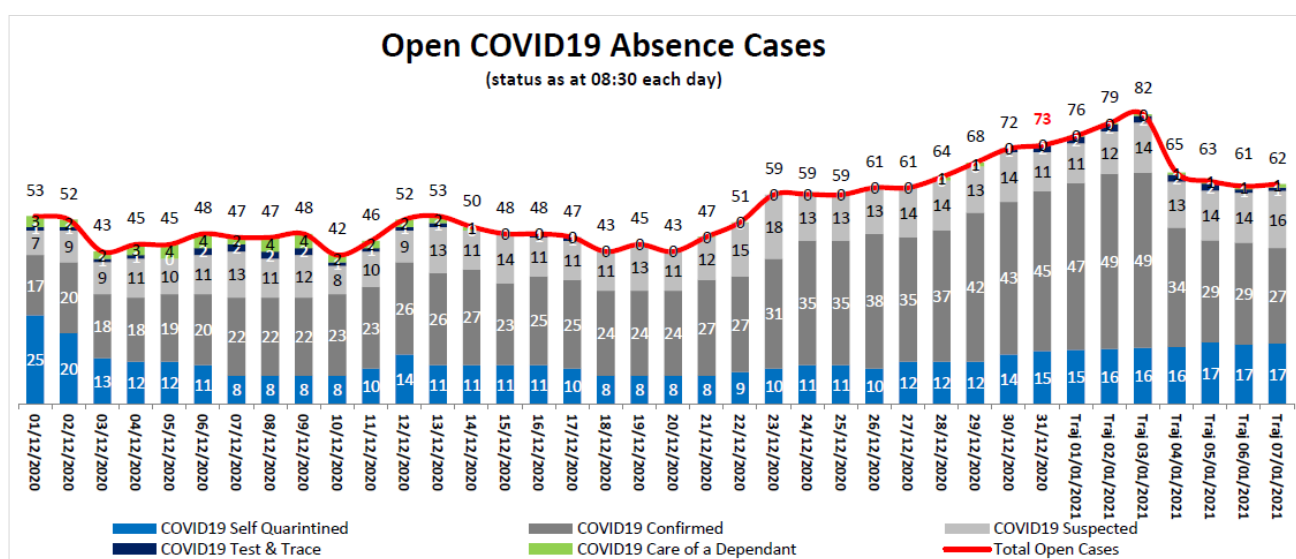
³ <https://www.england.nhs.uk/coronavirus/publication/reducing-burden-and-releasing-capacity-at-nhs-providers-and-commissioners-to-manage-the-covid-19-pandemic/>

D. Staff absence

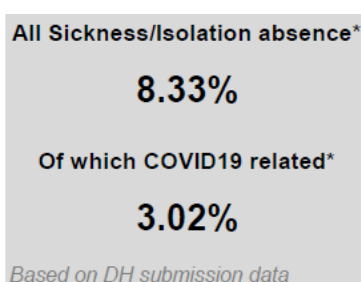
Staff absence has been higher than the Trust target of 5% for all but one of the last 24 months and statistically it is very unlikely that the target will be achieved. Absence has increased over the last 3 months but remains within normal variation. As would be expected, rates of sickness absence are higher in operational services than in corporate:

	Target	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Movement
Sickness Absence	5%	6%	6%	5%	5%	4%	5%	6%	7%	
Corporate Services	5%	4%	4%	3%	3%	4%	4%	4%	4%	
Business Improvement + Transformation	5%	0%	0%	0%	1%	0%	0%	6%	0%	
Corporate Central	5%	1%	1%	1%	4%	1%	1%	1%	0%	
Estates + Facilities	5%	7%	7%	6%	6%	8%	8%	7%	7%	
Finance Services	5%	0%	0%	0%	0%	0%	1%	1%	0%	
Med Education & CRD	5%	4%	4%	4%	2%	4%	4%	3%	2%	
Nursing + Quality	5%	2%	2%	2%	1%	1%	2%	2%	7%	
Ops Support	5%	2%	2%	2%	1%	2%	2%	2%	3%	
People Services	5%	0%	0%	4%	0%	1%	0%	0%	0%	
Operational Services	5%	6%	6%	6%	5%	4%	5%	6%	8%	
Adult Care Acute	5%	9%	9%	7%	5%	6%	8%	9%	11%	
Adult Care Community	5%	6%	6%	8%	7%	5%	7%	7%	9%	
Children's Services	5%	4%	4%	4%	4%	3%	3%	4%	3%	
Clinical Serv Management	5%	6%	6%	8%	7%	7%	1%	0%	0%	
Forensic + MH Rehab	5%	4%	4%	4%	3%	4%	7%	8%	9%	
Older Peoples Care	5%	7%	7%	5%	4%	3%	4%	5%	7%	
Performance Delivery Clustering	5%	0%	0%	0%	2%	5%	4%	0%	0%	
Psychology	5%	3%	3%	3%	5%	4%	3%	4%	6%	
Specialist Care Services	5%	4%	4%	4%	5%	3%	5%	5%	8%	

COVID-19 absence, having fallen for a number of months, has been rising steadily since mid-December and is forecast to remain high. Once the schools re-open we would expect to see an increase in care of dependent absence as a result of the planned mass testing in schools.



At the time of writing COVID-19 absence accounts for around 3% of overall absence:



E. Supervision

The levels of compliance with the clinical and managerial supervision targets have remained lower than normal since the start of the pandemic and for the last few months have been gradually worsening.

Division	Service Line	Staff	Managerial Supervision	Clinical Supervision
Corporate Services	Business Improvement +	10	100%	N/A
	Corporate Central	45	60%	100%
	Estates + Facilities	183	42%	N/A
	Finance Services	21	86%	N/A
	Med Education & CRD	57	40%	50%
	Nursing + Quality	47	83%	48%
	Ops Support	94	83%	43%
	People Services	9	44%	40%
	Total	466	59%	46%
Operational Services	Adult Care Acute	479	73%	57%
	Adult Care Community	346	68%	79%
	Children's Services	480	82%	77%
	Clinical Serv Management	13	69%	25%
	Forensic + MH Rehab	133	54%	61%
	Older Peoples Care	406	88%	79%
	Performance Delivery Clustering	4	100%	N/A
	Psychology	103	72%	86%
	Specialist Care Services	289	84%	75%
	Total	2253	77%	72%

F. Vacancies

The proportion of posts filled was statistically higher than normal for the first time. This may be an indicator of the positive team culture within the Trust and links in with the low level of staff turnover.

G. Bank staff use

Bank staff use has been rising and was statistically higher than normal this month which is likely to be a result of the increased level of staff absence.

4. Quality

A. Incidents

Incidents of moderate to catastrophic harm appear to have reduced in November after reaching a peak in October. This appears to be within normal variation and is a similar number of moderate to catastrophic harm incidents in November 2019.

B. Seclusion and restraint

The use of seclusion was within normal variation, although with an increasing trend in physical restraint and prone restraint. There are ongoing work streams to support the continuing need to reduce restrictive practice; including the introduction of body worn cameras, monitoring of restrictive practice within the “reducing restrictive practice forum” and monthly thematic reviews carried out by the Head of Nursing.

C. Patients in settled accommodation and patients in employment

There are some slight variances in this data, but the very small range on the vertical axis of the graph means that the significance of visible change needs to be approached with some caution. Accommodation and employment will clearly be affected by the current pandemic and its financial consequences, so this data will continue to be monitored closely. However there is a slight increasing trend in patients in employment and the Individual Placement Support service continues to have success in supporting people into employment even during the current pandemic.

D. Care plan reviews

The proportion of patients whose care plan has been reviewed continues to be lower than usual. Teams have been prioritising essential tasks, with reduced routine contact, and also trying to engage with people who use our services in different ways, e.g. in virtual ways using Attend Anywhere. We will monitor this over the coming months as teams restore services in line with national expectations, whilst continuing to be impacted by the COVID-19 situation and the ongoing need to prioritise essential tasks.

E. Complaints, concerns and compliments

The number of compliments decreased in line with the emergence of COVID-19 and the significant changes to many of our clinical services. The number of complaints increased between June and November with a particular theme around both concerns and complaints of access to services. Derbyshire Healthcare NHS Foundation Trust continues to work with Health Watch, including receiving regular feedback through governance structures and service user and carer surveys.

F. Duty of Candour

In this report there is one instance of Duty of Candour. This relates to a complaint that was raised regarding diagnostic overshadowing and physical health care response to a patient whilst an inpatient.

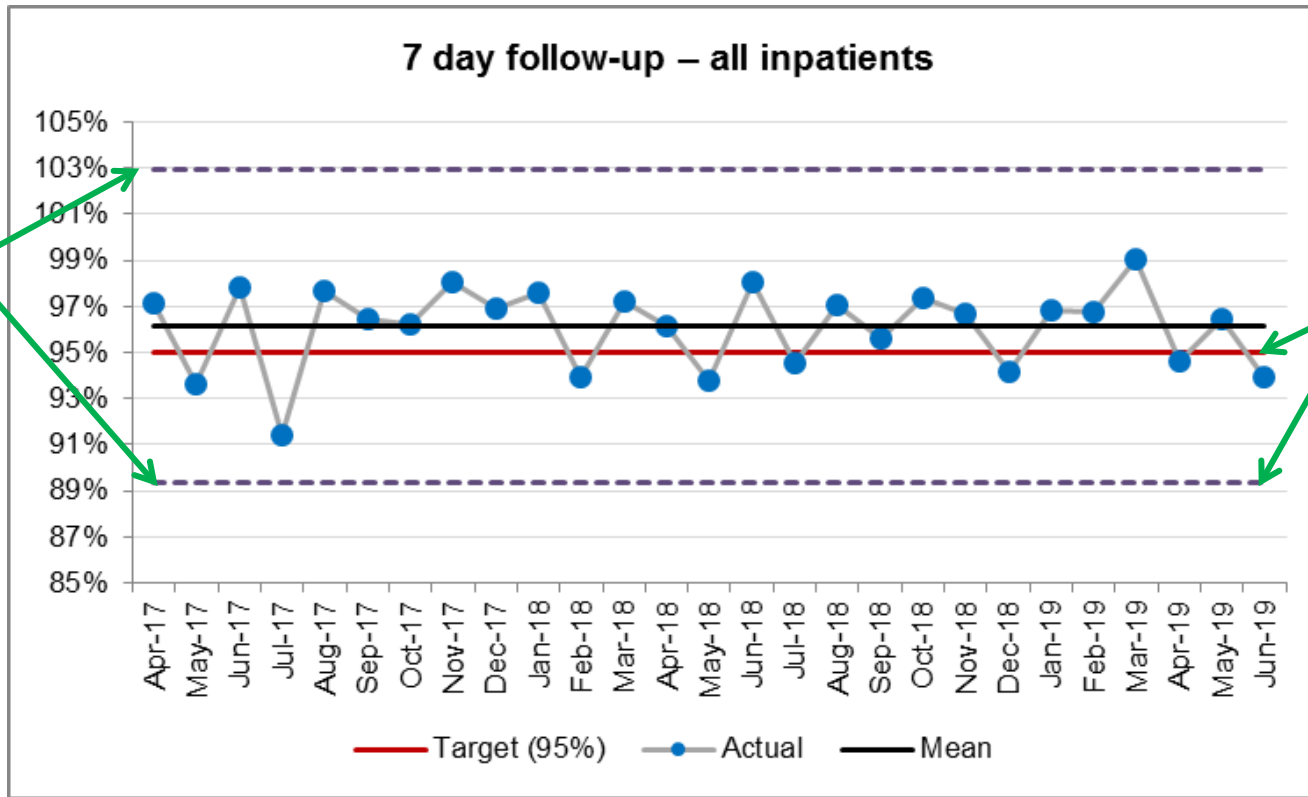
G. Number of falls on inpatient wards

The number of reported falls has decreased since September however still demonstrates an increased trend. This is likely to be as a consequence of enhanced reporting of falls from staff after promotion of good practice in this area and that nationally we are likely to see an increase in falls generally. This is as a result of people being de-conditioned from exercising less and not going out during the COVID-19 pandemic and resulting restrictions on movement.

Appendix 1

How to Interpret a Statistical Process Control Chart (SPC)

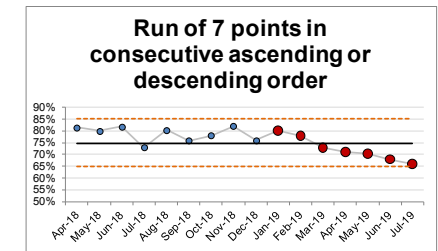
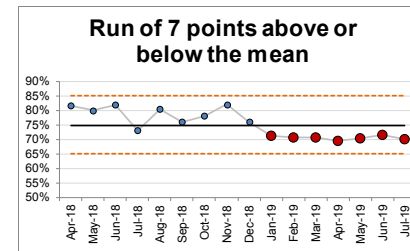
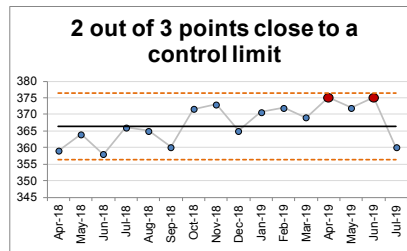
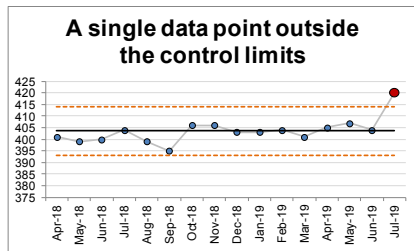
The dotted lines are the “control limits”. Any performance between these 2 lines is normal for the current system. This is known as “normal variation”



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

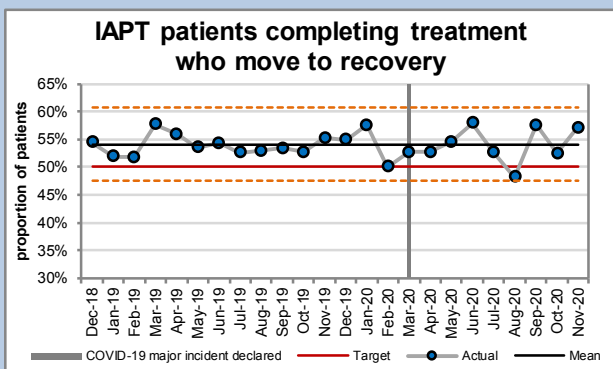
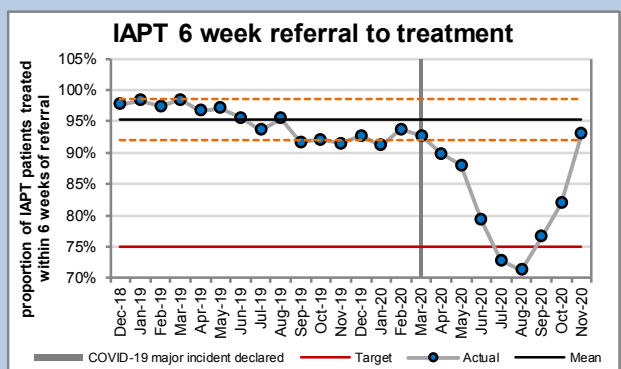
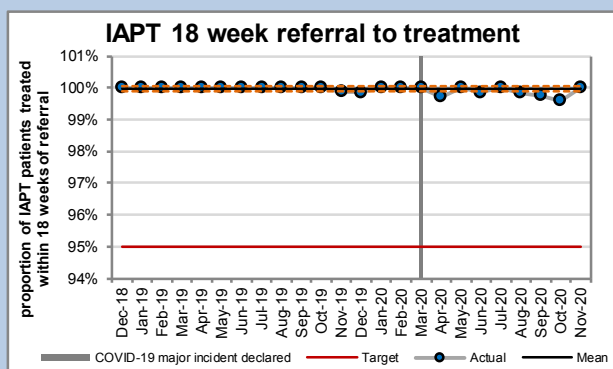
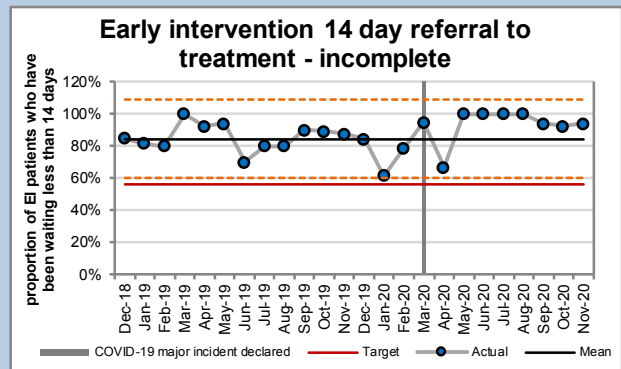
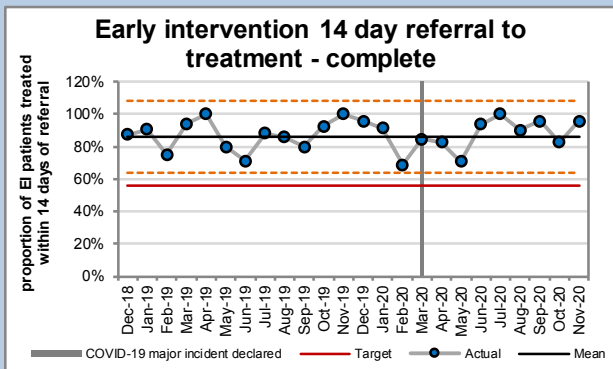
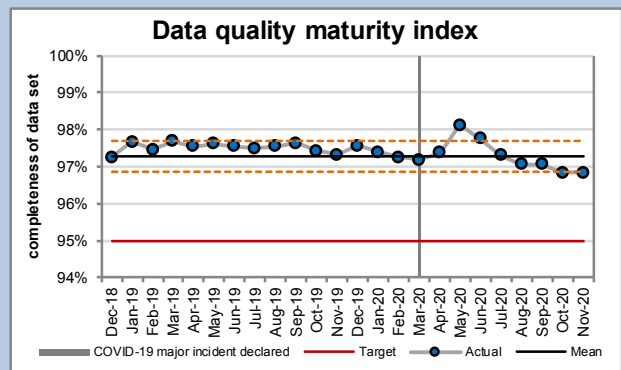
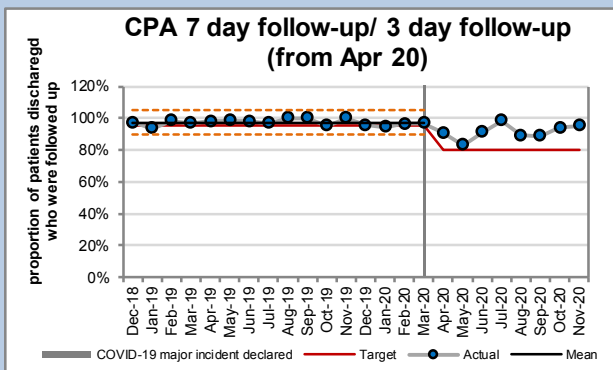
In this case the target line is above the lower control limit which indicates that the system is ineffective.

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



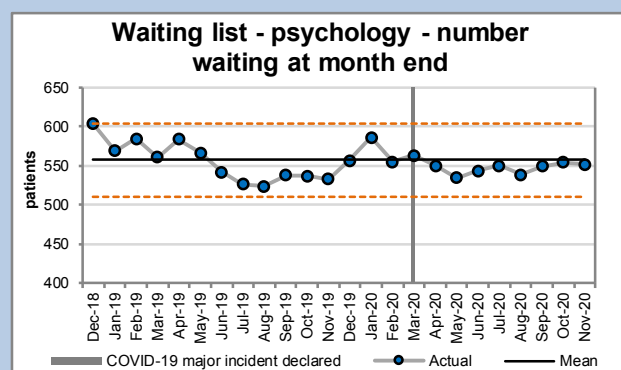
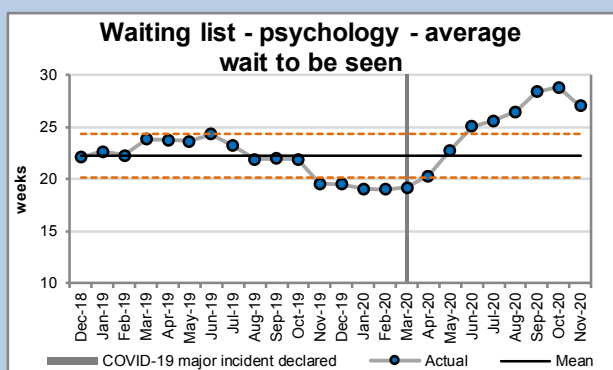
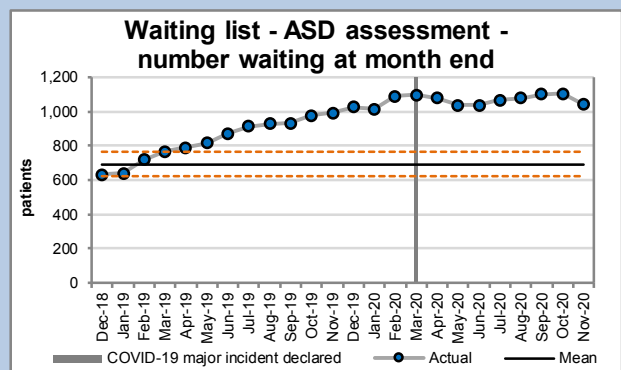
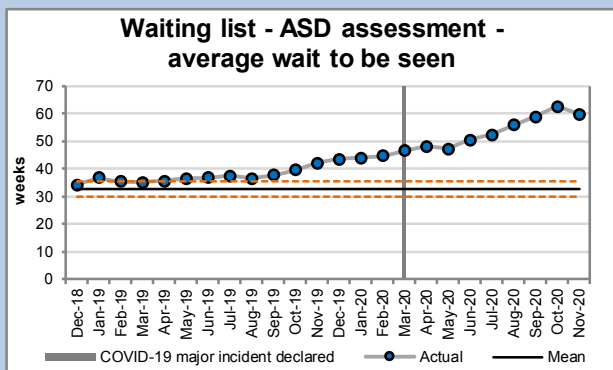
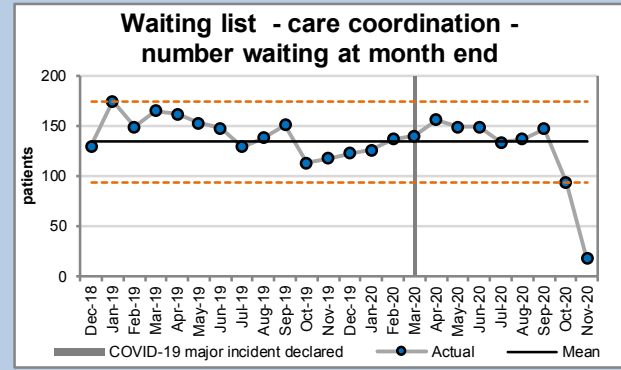
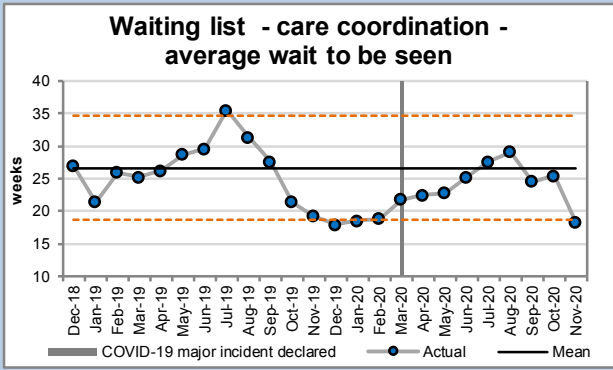
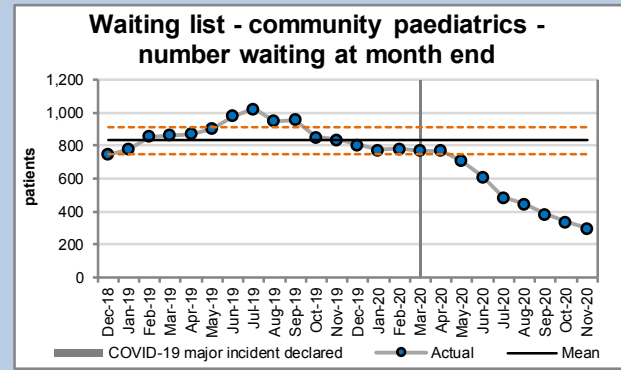
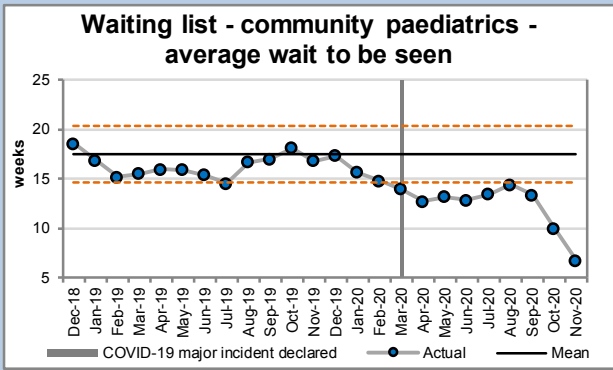
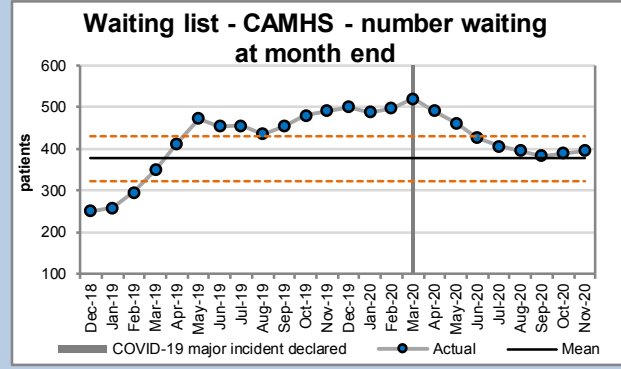
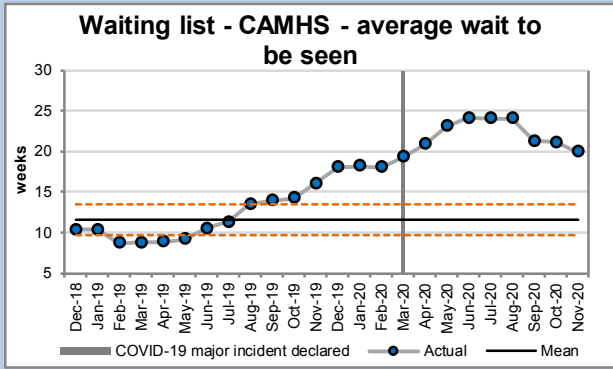
Appendix 2 – Charts⁴

Operational indicators

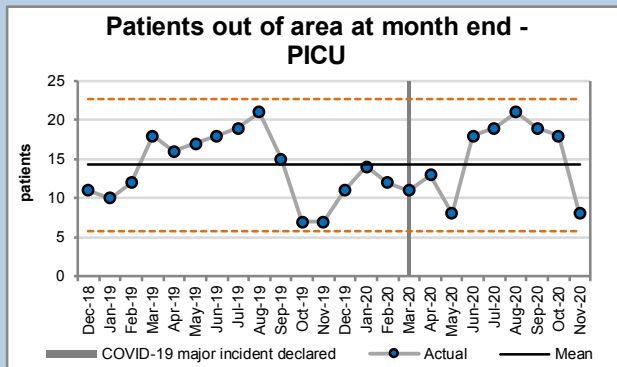
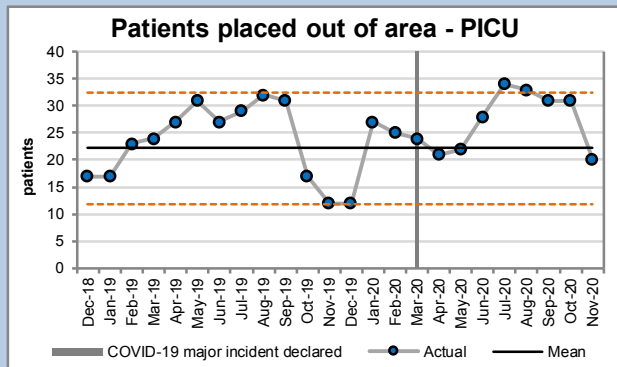
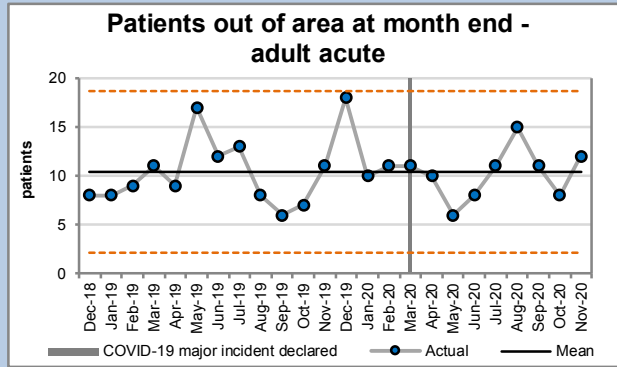
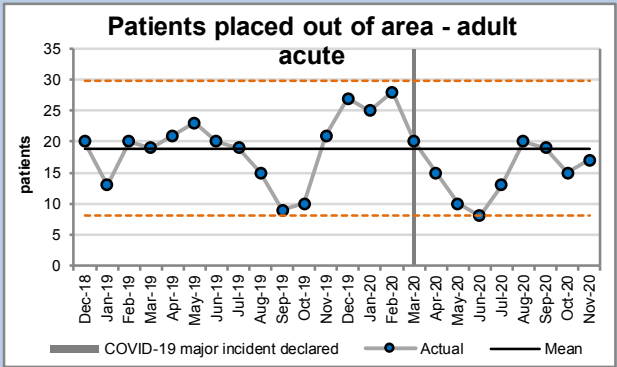


⁴ The control limits have been fixed at pre-COVID-19 levels to enable tracking of performance against the norm during the pandemic.

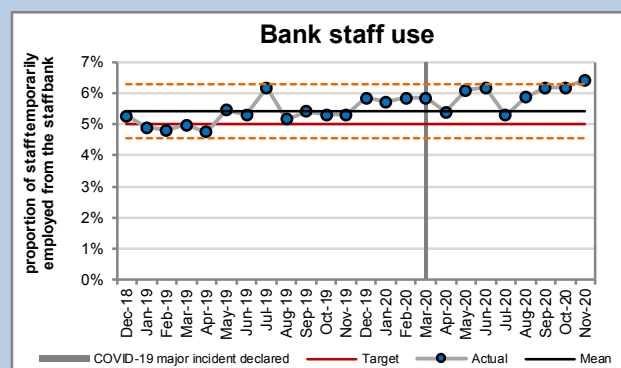
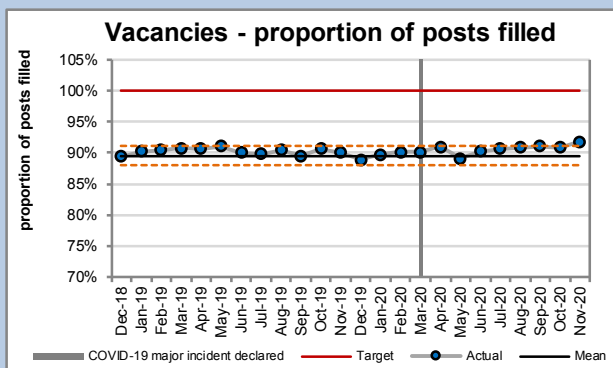
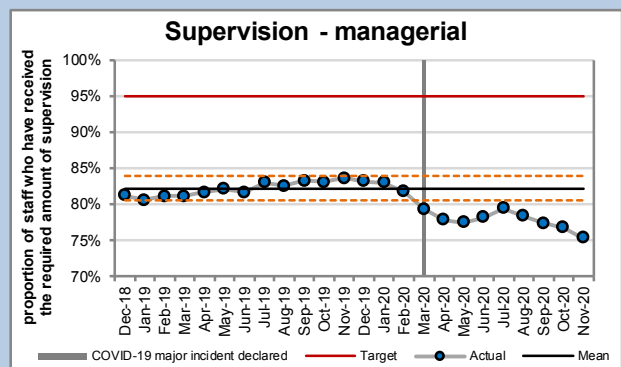
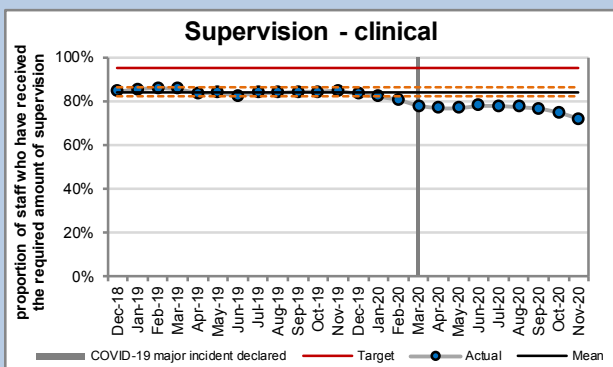
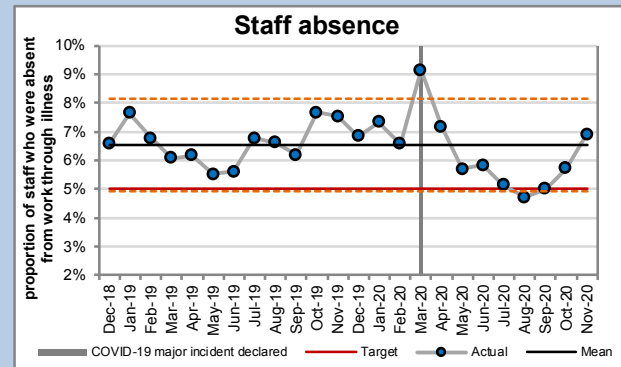
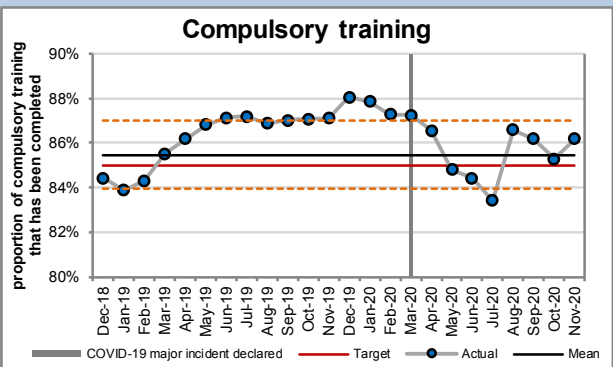
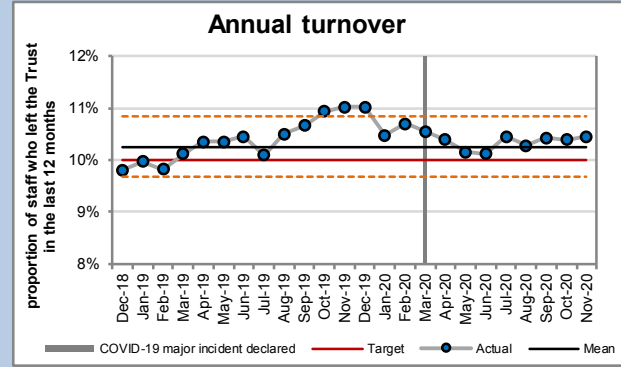
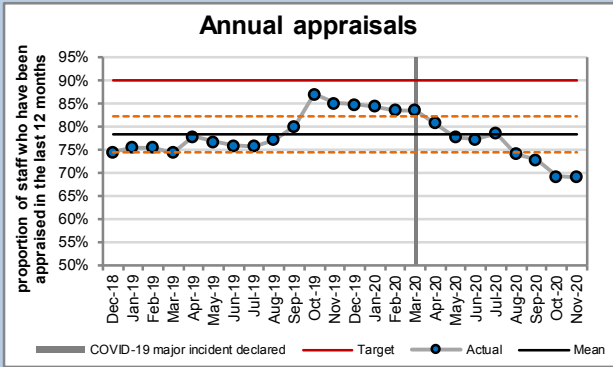
Operational indicators



Operational indicators



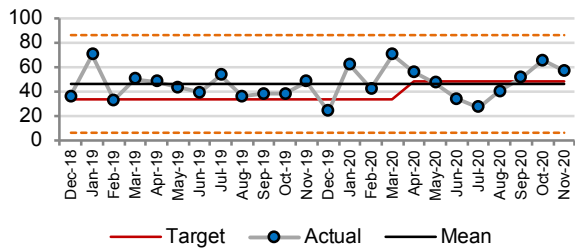
People indicators



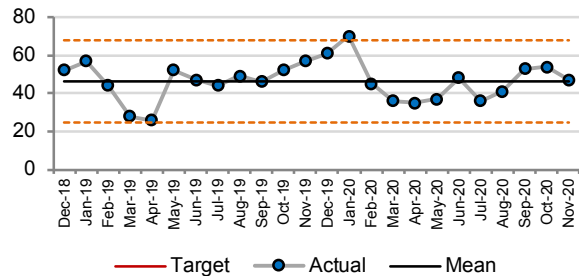
Quality Indicators

Safe

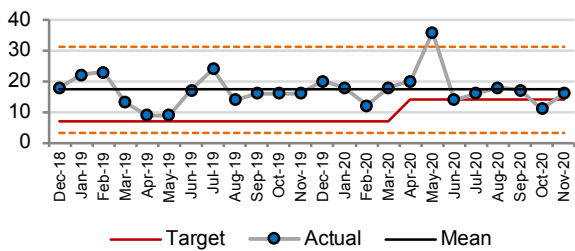
No of incidents of moderate to catastrophic actual harm



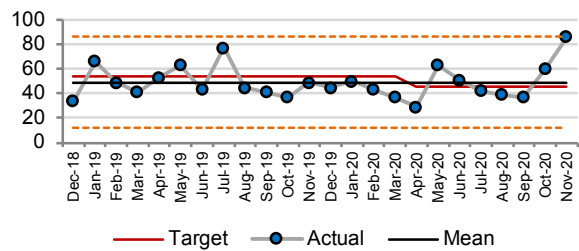
Number of medication incidents



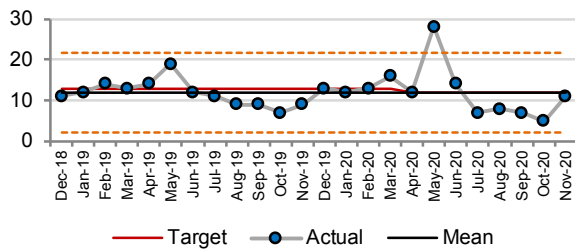
No of new episodes of patients held in seclusion



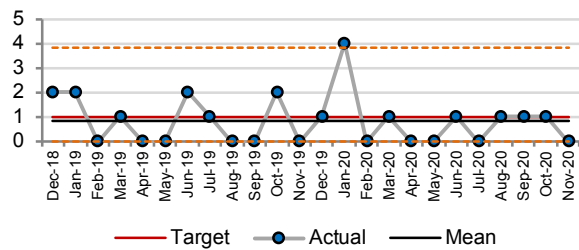
No of incidents involving physical restraint



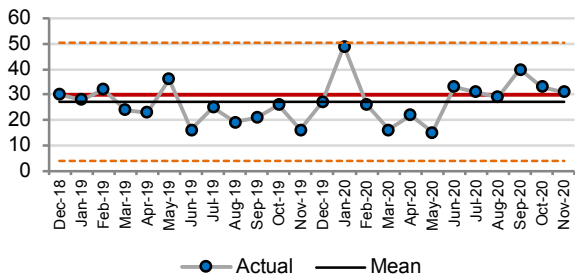
No of incidents involving prone restraint



No of incidents requiring Duty of Candour



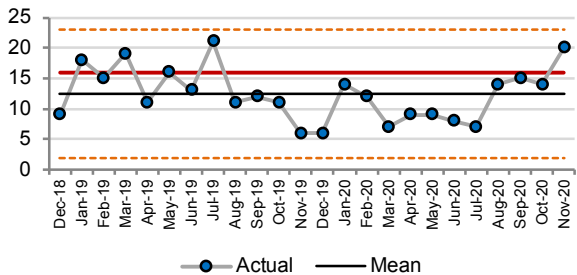
No of falls on in-patient wards



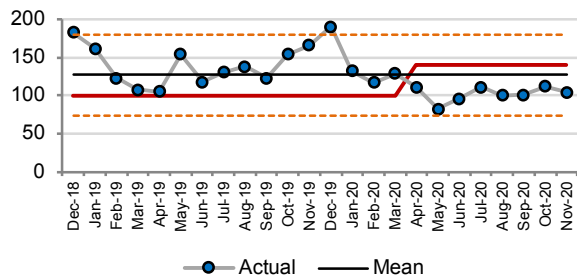
Quality Indicators

Caring

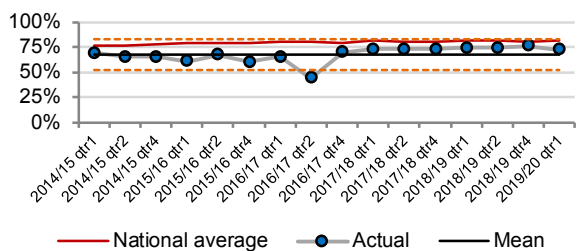
No of formal complaints received



No of compliments received

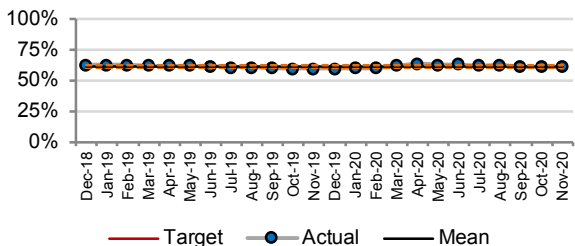


Staff Friends and Family Test - Recommending Care

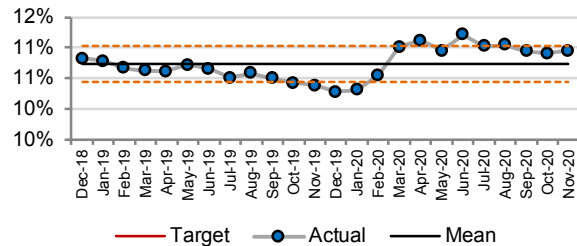


Effective

Patients Open to Trust In Settled Accommodation (M)

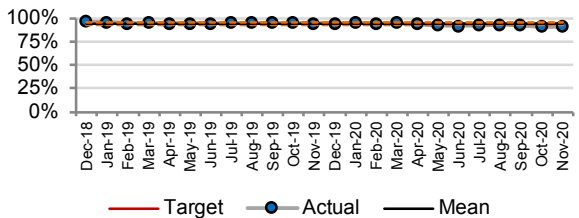


Patients Open to Trust In Employment (M)

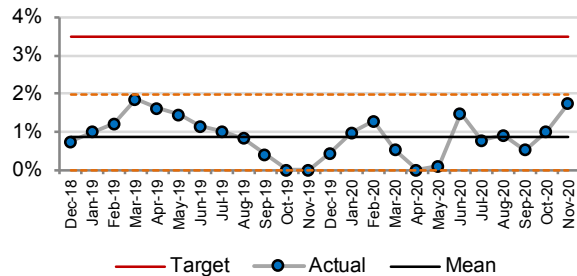


Responsive

% of patients who have had their care plan reviewed and have been on CPA > 12months



Delayed Transfers of Care (%)



Appendix 3 – Data Quality Maturity Index (DQMI) Benchmarking

PROVIDER NAME	September-2020	August-2020	July-2020	June-2020
National Average	80.1	83.0	82.3	81.6
BIRMINGHAM AND SOLIHULL MENTAL HEALTH NHS FOUNDATION TRUST	98.4	98.5	98.5	98.4
NORTH STAFFORDSHIRE COMBINED HEALTHCARE NHS TRUST	98.0	98.1	81.0	79.7
TEES, ESK AND WEAR VALLEYS NHS FOUNDATION TRUST	97.9	98.0	97.9	98.2
HERTFORDSHIRE PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST	97.3	94.7	97.2	97.3
LINCOLNSHIRE PARTNERSHIP NHS FOUNDATION TRUST	97.2	97.5	97.8	97.4
CAMDEN AND ISLINGTON NHS FOUNDATION TRUST	97.1	95.0	97.5	97.5
SOUTH LONDON AND MAUDSLEY NHS FOUNDATION TRUST	96.7	95.0	95.2	95.1
CAMBRIDGESHIRE AND PETERBOROUGH NHS FOUNDATION TRUST	96.6	97.1	97.5	97.1
DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST	96.4	96.7	96.7	96.6
ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST	95.8	95.9	96.6	96.3
NORTHUMBRIA HEALTHCARE NHS FOUNDATION TRUST	95.4	97.3	97.3	97.3
KENT AND MEDWAY NHS AND SOCIAL CARE PARTNERSHIP TRUST	95.3	95.5	95.1	95.2
BARNET, ENFIELD AND HARINGEY MENTAL HEALTH NHS TRUST	95.2	95.4	96.2	95.7
NOTTINGHAMSHIRE HEALTHCARE NHS FOUNDATION TRUST	95.1	95.3	96.2	96.0
GREATER MANCHESTER MENTAL HEALTH NHS FOUNDATION TRUST	95.0	96.5	94.6	94.2
SURREY AND SUSSEX HEALTHCARE NHS TRUST	94.6	99.3	99.3	94.5
SOMERSET PARTNERSHIP NHS FOUNDATION TRUST	94.3	97.3	97.3	97.2
MIDLANDS PARTNERSHIP NHS FOUNDATION TRUST	94.2	94.5	94.6	94.4
WORCESTERSHIRE HEALTH AND CARE NHS TRUST	94.2	94.6	95.1	95.3
HUMBER TEACHING NHS FOUNDATION TRUST	94.1	94.1	94.6	93.5
NORFOLK AND SUFFOLK NHS FOUNDATION TRUST	94.0	95.2	95.1	94.9
SOUTH WEST YORKSHIRE PARTNERSHIP NHS FOUNDATION TRUST	93.9	94.2	94.3	94.2
CENTRAL AND NORTH WEST LONDON NHS FOUNDATION TRUST	93.7	94.1	94.4	93.1
BUCKINGHAMSHIRE HEALTHCARE NHS TRUST	93.3	94.4	94.9	94.4
ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST	93.1	93.8	94.1	93.8
EAST LONDON NHS FOUNDATION TRUST	93.0	93.2	92.6	93.2
WEST LONDON NHS TRUST	93.0	93.9	93.8	93.4
CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST	92.8	94.4	94.4	93.3
BRADFORD DISTRICT CARE NHS FOUNDATION TRUST	92.7	93.0	90.8	90.3
CUMBRIA, NORTHUMBERLAND, TYNE AND WEAR NHS FOUNDATION TRUST	92.7	93.6	93.9	93.9
SOUTH WEST LONDON AND ST GEORGE'S MENTAL HEALTH NHS TRUST	92.1	92.5	91.9	92.2
SURREY AND BORDERS PARTNERSHIP NHS FOUNDATION TRUST	92.1	93.8	96.5	96.5
AVON AND WILTSHIRE MENTAL HEALTH PARTNERSHIP NHS TRUST	91.9	92.8	92.3	92.7
COUNTY DURHAM AND DARLINGTON NHS FOUNDATION TRUST	91.9	96.3	96.1	98.0
SOLENT NHS TRUST	91.6	92.3	92.6	92.3
OXLEAS NHS FOUNDATION TRUST	91.3	92.1	91.5	91.9
LEICESTERSHIRE PARTNERSHIP NHS TRUST	91.0	92.4	92.6	90.2
PENNINE CARE NHS FOUNDATION TRUST	90.7	92.1	92.1	92.1
SUSSEX PARTNERSHIP NHS FOUNDATION TRUST	90.6	91.0	91.3	91.4
BLACK COUNTRY PARTNERSHIP NHS FOUNDATION TRUST	90.5	91.7	91.7	93.2
NORTHAMPTONSHIRE HEALTHCARE NHS FOUNDATION TRUST	90.2	91.3	91.8	91.7
ISLE OF WIGHT NHS TRUST	90.1	90.9	92.5	92.4
TAMESIDE AND GLOSSOP INTEGRATED CARE NHS FOUNDATION TRUST	89.0	92.3	93.2	92.0
WALSALL HEALTHCARE NHS TRUST	89.0	95.3	95.4	95.7
CORNWALL PARTNERSHIP NHS FOUNDATION TRUST	88.7	89.7	90.1	89.8
NORTH CUMBRIA INTEGRATED CARE NHS FOUNDATION TRUST	88.1	90.5	90.7	90.6
DORSET HEALTHCARE UNIVERSITY NHS FOUNDATION TRUST	87.7	89.8	88.7	88.6
SHEFFIELD HEALTH & SOCIAL CARE NHS FOUNDATION TRUST	87.7	89.8	89.7	89.5
LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST	87.6	88.1	87.6	81.9
DEVON PARTNERSHIP NHS TRUST	87.0	89.1	87.2	87.8
GUY'S AND ST THOMAS' NHS FOUNDATION TRUST	86.8	94.9	94.9	95.1
SOUTHERN HEALTH NHS FOUNDATION TRUST	86.3	92.0	92.1	92.0
CHESHIRE AND WIRRAL PARTNERSHIP NHS FOUNDATION TRUST	86.0	86.1	91.3	90.2
DUDLEY AND WALSALL MENTAL HEALTH PARTNERSHIP NHS TRUST	85.5	90.5	90.2	90.8
OXFORD HEALTH NHS FOUNDATION TRUST	81.9	94.4	93.8	93.5
COVENTRY AND WARWICKSHIRE PARTNERSHIP NHS TRUST	80.5	82.2	83.1	83.2
NORTH EAST LONDON NHS FOUNDATION TRUST	64.7	68.5	69.4	69.4
BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST	57.0	91.5	90.9	91.1
LANCASHIRE & SOUTH CUMBRIA NHS FOUNDATION TRUST	51.4	93.1	92.1	92.5
MERSEY CARE NHS FOUNDATION TRUST	46.7	56.8	56.8	57.0
NORTH WEST BOROUGHES HEALTHCARE NHS FOUNDATION TRUST	44.1	54.7	54.9	89.0
GLOUCESTERSHIRE HEALTH AND CARE NHS FOUNDATION TRUST	36.7	42.0	42.1	42.3

Appendix 4 - Data Quality Kite Mark

Background

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

Approach



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

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

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

KPI Data Quality Reviews

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

Board COVID-19 Briefing

Purpose of Report

To provide an overview of the Trust's response to the ongoing COVID19 Pandemic.

Executive Summary

This briefing provides an update on the response to the COVID-19 Pandemic outlining the Incident Management Team (IMT) structure and cell function. It also captures an element of the EU Exit planning. It aims to supplement the daily communications and podcasts that colleagues have received.

The Incident Management Team is supported by a number of cells as shown below

- Workforce and Estates
- Infection, Prevention and Control
- Staff check and trace
- Flow and discharge
- Safer staffing
- EU Exit
- COVID Vaccine
- Training
- Ethics and Clinical Governance
- Partnership working

The report provides additional narrative on the core areas of current work / actions within each cell.

Strategic Considerations

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

Assurances

This report provides assurance that the Trust Incident Management Team is maintaining a coordinated response to the outbreak of the COVID-19 and additional pressures including EU Exit, Winter preparedness and the COVID Vaccination Programme

Consultation

This paper has not been received at any other meeting.

Governance or Legal Issues

- Coronavirus Bill
- Changes to Mental Health Act and Care Act
- NHSE Emergency Preparedness Resilience and Response Framework

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

As part of the ongoing response to COVID19 the Incident Management Team are considering equality impacts through the various work streams. Examples of this include

- Making communications available through email and podcasts. The podcasts are transcribed to ensure we consider our deaf community.
- Easy read documents have been made available and shared with our learning disabilities service for wider cascade.
- We have been considering our older adult population during discussions around the potential for relocating patients as part of the wider system request and the impacts this would have on our patients and staff.
- We have commenced the open access helpline which is available for our current cohort of patients and residents of Derby & Derbyshire.
- We have widened the scope of the IMT; we sought expressions of interest for a BAME role and Disability & Wellness role. This has been well received and volunteers have provided additional depth to the response.

Recommendations

The Board of Directors is requested to:

- 1) Receive the report
- 2) Be assured of a coordinated response to the incident
- 3) Confirm and challenge as appropriate.

Report presented by: Mark Powell
Chief Operating Officer

Report prepared by: Celia Robbins
Emergency Planning and Business Continuity Manager

COVID-19 Pandemic Trust Board Briefing

Introduction

We are continuing to provide an incident response to COVID-19; we have begun to consider in further detail the implications of EU Exit planning, winter within the NHS and the roll out of the COVID-19 Vaccination programme. The incident response function is provided seven days a week, 8am – 8pm. Daily Incident Management Team (IMT) meetings take place at 10am and 4pm.

Ensuring safety is at the core of our response, for patients, staff and volunteers. Clinical input is provided by a number of experts to ensure we are continuing to provide great care throughout. Changes to clinical services/practice are reviewed by the Ethics and Governance Cell.

The use of cells has continued to ensure we cover all aspects required within the response and this report is structured on those current in situ.

Workforce and Estates Cell

Staff Health and Wellbeing

- Winter Wellness Campaign – throughout the month of December
- Staffing absence for 6 January 2021: All absence 8.66% of which is COVID related 3.02%
- Christmas related activities that are COVID safe.

Estates

- Kingsway House and Albany House office moves
- Providing lockers to inpatient areas
- Deep cleans continue and additional cleans completed in relation to outbreak management on wards / clinical areas.

Infection Prevention Control Cell

- Management oversight of small outbreaks within clinical areas
- Continually reviewing national guidance in relation to changes in practice and advising on course of action within the Trust
- Ongoing promotion of personal protective equipment and best practice IPC guidance
- Review COVID positive patients and ensuring their and staff safety.

Staff Check and Trace Cell

- Monitoring of COVID related staff absence and interdependencies with other colleagues
- Mapping staff contacts and requirement for colleagues to undertake a COVID test
- Escalating emerging themes for review and action as required.

Flow and Discharge Cell

- Confirming discharge processes for inpatient services where appropriate
- There are currently 33 beds closed for COVID related issues (social distancing and infection, prevention and control measures)
- Delays in discharge escalations
- Reviewing of Legal Guidance for services supporting people of all ages during the coronavirus pandemic: mental health, learning disabilities and autism specialised commissioning
- Your COVID recovery guidance – working with system partners.

Safer Staffing

- Redeployment management
- Staffing concerns and mitigations
- Attended by operational services and corporate representation
- Meets daily

EU Exit Cell

- New cell under the IMT structure to oversee the requirements needed for our EU Exit planning arrangements
- Review of current guidance
- Daily reporting to NHS England and NHS Improvement (NHSE&I) began 23 December 2020

COVID Vaccine Cell

- New cell under the IMT structure
- Development of the Standard Operating Procedure
- Development of frequently asked questions (FAQs)
- Reviewing of national guidance and process

Training Cell

- Care Quality Commission (CQC) Statutory compliance
- Optimising fill rates for training
- Mitigations for loss of trainers

Clinical Governance and Ethics Cell

- This cell considered changes to service delivery and the wider implications
- Papers are received and reviewed by the Director of Nursing and Medical Director
- Service redeployment plans have recently been received within this cell.

Participation with the system and multi-agency partners

- Multi-agency strategic and tactical co-ordinating groups
- System Escalation Call and System Operational Resilience Group
- Mental Health work stream calls

- National NHS EPRR (Emergency Preparedness, Resilience and Response) response webinar
- National and Regional Medical Directors
- National and Regional Nurse Directors
- Safeguarding Boards recommenced and is restoring its function and this is elevating pressure on the safeguarding functions
- System flu group
- System COVID Vaccine group

Requests for information

- National situation report (sitrep) completed daily – beds occupied, vacant, COVID related patients, closed bed due to COVID. Management of confirmed patients, incorporating hospital acquired infections, staff absence and operational issues.

Emergency Preparedness Resilience and Response (EPRR) Annual Report

Purpose of Report

This report provides two core elements in relation to the EPRR portfolio for the Trust:

- 1) The outcome of the EPRR Core Standards Self-Assessment – full compliance
- 2) The EPRR Annual report 2020

Executive Summary

This report showcases the core standards required within the EPRR Framework as outlined by NHS England and NHS Improvement (NHSE&I) It highlights the areas of work that have been completed and identifies aspects which have been impacted by the ongoing response to the COVID-19 Pandemic. Work is still ongoing to ensure our plans remain current and that we are aligned with national guidance and legislation.

Within the report, the narrative discusses the progression throughout the year and elements which will require additional input; this was used as the evidence for our annual self-assessment which took place in October 2020. Our submission was received by the Clinical Commissioning Group (CCG) and we have maintained a full level of compliance within the EPRR agenda.

Strategic Considerations

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

Assurances

- This report provides assurance that the Trust is progressing to full compliance with the outstanding actions to be monitored through the EPRR Steering Group.
- The EPRR agenda is current and updating processes as required.

Consultation

- Executive Leadership Team 22 September 2020
- Finance and Performance Committee 30 September 2020

Governance or Legal Issues

- Compliance with the Civil Contingencies Act 2004
- Compliance with the NHS England Emergency Preparedness, Resilience and Response Framework 2015 (incorporating the Core Standards)

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

The EPRR Core Standards is an external document providing an overarching view of the Trust's preparedness for all types of emergencies. There are a number of component internal policies that deliver the compliance to the core standards; these documents will require a more in depth equality impact assessment to evaluate the impact of the Trust's response to a variety of scenarios.

Any potential equality and diversity implications will be assessed and managed as policies are reviewed, developed and implemented. Consideration will also be given to any exercising or training sessions scheduled to incorporate the cross cutting needs of the population we serve who may be affected by an EPRR related incident. 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) To receive the report and note the level of full compliance
- 2) Confirm and challenge as appropriate.

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

Report prepared by: **Celia Robbins**
Emergency Planning & Business Continuity Manager

Emergency Preparedness, Resilience and Response Annual Report 2020

Introduction

As part of the Emergency Preparedness, Resilience and Response (EPRR) framework within the NHS there is an annual self-assessment against the Core Standards. Due to the current pandemic and the statutory requirement for a formal assurance completed a reduced template which had been produced by the CCG. This was completed and highlighted that the Trust continues to maintain a full level of compliance against the core standards. The report outlines these standards and provides an update on this year's progress.

Governance

A number of policies have been extended due to the current climate; a full review will be undertaken and capture key learning from the incident. Further work is ongoing to review the Governance structure within the Trust based on the lessons identified process. The EPRR steering group met in October, however due to the changes in the response to COVID19 it has not been possible to convene an additional meeting. The EPRR Policy and Business Continuity Policy were ratified and agreed by the Trust Management Team in January 2020. A work programme is being developed to review areas that have been paused during the response to COVID and identified timeframes for moving forward.

Duty to Risk Assessment

A generic EPRR risk assessment is in situ; the work plan will need to be repopulated due to the disruption of the pandemic. This risk has been increased due to the ongoing nature of the current pandemic and the implications it has for us as a Trust.

Duty to maintain plans

A number of plans have been utilised during the incident and the lessons that have been captured through the learning lessons cell will be incorporated into their review. A small number of plans have had their governance review extended to be captured in early 2021 this includes the Emergency Incident Response Plan and the Heat Wave Policy and Procedure. This area has been scored at a 9 on the self-assessment due to further work required within the Business Continuity Plans.

Command and Control

We continue to maintain the First and Second on call rota, this has been added to with the provision of the Incident Management Team.

Training and Exercising

This will need to be rescheduled as part of the EPRR work plan when the pandemic is over; a large group of colleagues did receive their EPRR training in February 2020. Training will incorporate any actions identified through the learning lessons cell as part of the incident management team. These changes will also be reflected within our plans and policies as required.

Response

The Trust's response to the incident has grown and developed as we have progressed through the pandemic. The use of cells has worked well to task out actions for key areas of work. During the process we have undertaken the interim cell review to identify lessons for moving forward. Please refer to the COVID-19 Trust Board update for further narrative.

Warning and informing

Our communications colleagues have been involved with the wider communication groups, we have utilised a variety of mediums to communicate with staff during this time. The use of Facebook staff page, podcasts and daily briefings have been well received.

Cooperation

The Trust has responded to the various multi-agency response groups during the incident, including Strategic Coordination Group, System Escalation Cell, Recovery sub groups, Testing Cells, Health Sub-group.

Business Continuity

During this process last year we identified Business Continuity as an area that needed further work to bring us in line with the international standard, as required by the NHS EPRR Framework. Work has been ongoing to complete these actions; we now hold a new Business Continuity Management Policy and had begun to roll out the new template for individual service business continuity plans. This element is still in motion and on the template has been scored at a 9 due to ongoing work around this.

Learning from Deaths - Mortality Report

Purpose of Report

The 'National Guidance on Learning from Deaths' requires each Trust to collect and publish specified information on a quarterly basis. This report covers the period 1 August to 19 October 2020.

Executive Summary

During the COVID-19 pandemic, the learning from deaths process continued to be undertaken but slight changes to the process were initially made to allow for colleagues to undertake other duties. Activity has now resumed back to normal with weekly case note reviews and the daily reviewing and grading of all new deaths taking place.

All deaths directly relating to COVID-19 are reviewed through the Learning from deaths procedure unless they also meet a datix red flag, in which case they will be reviewed under the Untoward Incident Report Reporting Policy and Procedure.

- From 1 August to 19 October 2020 there has been 0 deaths reported where the patient tested positive for COVID-19.
- From 1 August to 19 October 2020, the Trust received 368 death notifications of patients who had been in contact with our service in the last six months. This is a decrease for the same period the previous year which was 385.
- Two Inpatient deaths were recorded. One patient died whilst on home leave from an adult inpatient ward and one patient died following transfer to A&E from an adult inpatient ward.
- The Mortality Review Group reviewed 29 deaths through a Stage 2 Case Note Review. These reviews were undertaken by a multi-disciplinary team and it was established that of the 29 deaths reviewed, 26 were not due to problems in care. One death was referred to Serious Incident Group for further review and a further two deaths were pending further information.
- The Trust has reported four Learning Disability deaths from 1 August to 19 October 2020
- There is very little variation between male and female deaths; 194 male deaths were reported compared to 174 female.
- Good practice identified through case note reviews is fed back to clinicians involved as part of our appreciative learning.
- The monthly mortality review group will be recommencing in November 2020, this group was put on hold during the COVID pandemic.

Strategic Considerations

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

Assurances

This report provides assurance that the Trust is following recommendations outlined in the National Guidance on Learning from Deaths.

Governance or Legal Issues

There are no legal issues arising from this Board 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 & 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.

- From the 1 August to 19 October 2020 there is very little variation between male and female deaths; 194 male deaths were reported compared to 174 female.
- No unexpected trends were identified according to ethnic origin or religion.

Recommendations

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

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

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 of the required guidelines.

The report presents the data for 1 August to 19 October 2020

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

- The Trust is still waiting to ascertain if Cause of death (COD) will be available through NHS digital. Currently COD is been ascertained through the coroner officers in Chesterfield and Derby but only a very small number of COD have been made available.
- Medic rotas are in place, we are awaiting a new rota for the north and south which is currently in process. We undertook six Case Note Review sessions , but unfortunately 13 sessions did not take place due to lack of medic availability
- Regular audits continue to be undertaken to ensure compliance with policy and procedure and any necessary amendments made. This has included auditing complaint data against names of deceased patients to ensure this meets the requirements specified in the National guidance.
- The Trust has also made a decision to return to grading all new deaths identified through the NHS Spine daily and conducting Case note review meetings twice weekly. All deaths directly relating to COVID-19 will be reviewed initially through the Learning from Deaths procedure unless they also meet a datix red flag (see page 5 of this report for definitions of these), in which case they will be reviewed under the Untoward Incident Reporting Policy and Procedure. The mortality reviewer will also produce a weekly COVID-19 death report to be shared with the incident management team. This report will include but is not limited to patient demographics, patient conditions, diagnosis and vulnerabilities, allowing the team to draw comparisons to identify themes and trends.
- The monthly Mortality review group meetings will resume in November 2020. These were put on hold during the COVID pandemic.

¹National Guidance on Learning from Deaths. National Quality Board. March 2017

3. Data Summary of all Deaths

Note that inpatients and learning disability (LD) data is based upon whether the patient has an open inpatient or LD referral at time of death.

	Aug	Sept	Oct (up to 19 October 2020)
Total Deaths Per Month	156	126	86
LD Referral Deaths	2	1	1

The table above shows information for 1 August to 19 October 2020. Correct as of 19th August 2020

From 1 August to 19 October 2020, the Trust received 368 death notifications of patients who have been in contact with our services.

4. Review of Deaths

Total number of Deaths from 1 August to 14 October 2020. reported on Datix	50 (of which 39 are reported as “Unexpected deaths”; 6 as “Suspected deaths”; 5 as “Expected - end of life pathway”)
Number reviewed through the Serious Incident Group	45 (5 pending for a review).
Number investigated by the Serious Incident Group	0 (16 did not require an investigation; 9 underway and 25 pending for a review)
Number of Serious Incidents closed by the Serious Incident Group?	16 (29 currently opened to SI group and 5 pending for a review, as of 14/10/2020)

Since 1 August to 19 October 2020 the Trust has recorded two Inpatient deaths at the Hartington Unit. One patient died whilst on home leave from an inpatient ward (Tansley) and one patient died following transfer to A&E from Pleasley Ward. These deaths have been reviewed under the *Untoward Incident Reporting and Investigation Policy and Procedure*.

Only deaths which meet the criteria below are reported through the Trust incident reporting system (Datix) and these are also reviewed using the process of the *Untoward Incident Reporting and Investigation Policy and Procedure*; any patient open to services within the last six months who has died, and meets the following:

- Homicide – perpetrator or victim
- Domestic homicide - perpetrator or victim
- Suicide/self-inflicted death, or suspected suicide
- Death following overdose
- Death whilst an inpatient
- Death of an inpatient who died within 30 days of discharge from a DHCFT hospital
- Death following an inpatient transfer to acute hospital

- Death of patient on a Section of the Mental Health Act or Deprivation of Liberty Safeguards (DoLs) authorisation
- Death of patient following absconson from an inpatient unit
- Death following a physical restraint
- Death of a patient with a learning disability
- Death of a patient where there has been a complaint by family / carer / the Ombudsman, or where staff have raised a significant concern about the quality of care provision
- Death of a child (this will also be subject to scrutiny by the Child Death Overview Panel)
- Death of a patient open to safeguarding procedures at the time of death, which could be related to the death
- Death of a patient with historical safeguarding concerns, which could be related to the death
- Death where a previous Coroners Regulation 28 has been issued
- Death of a staff member whilst on duty
- Death of a child under the age of 18 of a current or previous service user who has died in suspicious circumstances
- Where an external organisation has highlighted concerns following the death of a patient whether they were open to the Trust at time of death or not.

5. Learning from Deaths Procedure

From 1 August to 19 October 2020, The Mortality Review Group reviewed 29 deaths through a Stage 2 Case Note Review. These reviews were undertaken by a multi-disciplinary team and it was established that of the 29 deaths reviewed, 26 were not due to problems in care. Two deaths are pending further information and one death was referred to Serious Incident Group for further review under the Untoward Incident and Reporting Policy and Procedure.

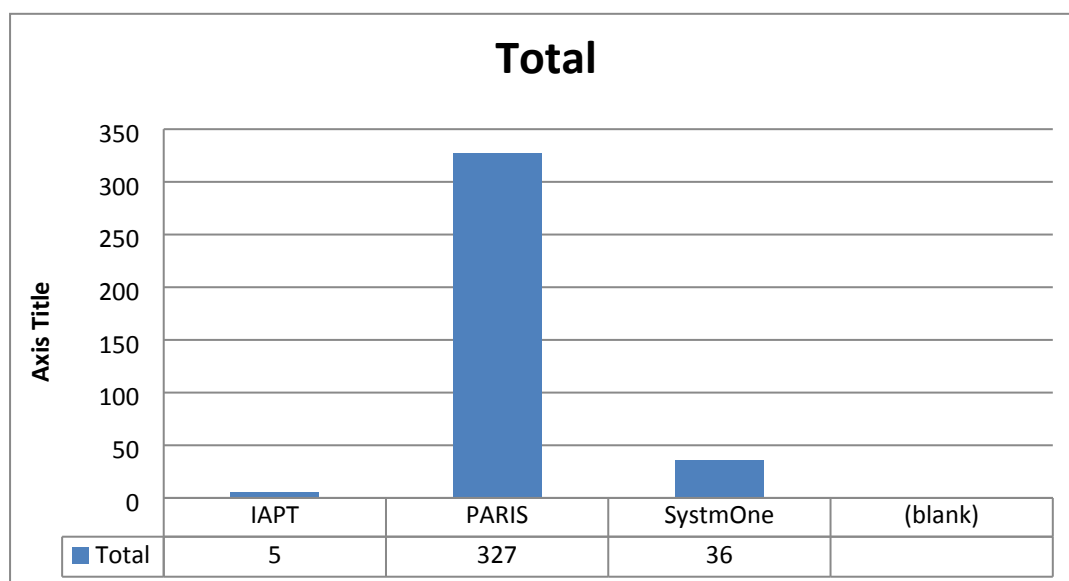
The Mortality Group review the deaths of patients who fall under the following 'red flags' as from 24 June 2020 these are as follows:

- Patient taking an anti-psychotic medication
- Death of a patient with a learning disability
- Patients with chronic pain
- Patients only open to outpatient services
- Patients with COVID19 (this is a temporary flag)

From 1 August to 19 October 2020 there has been no deaths reported where the patient tested positive for COVID-19.

6. Analysis of Data

6.1 Analysis of deaths per notification system since 1 August to 19 October 2020



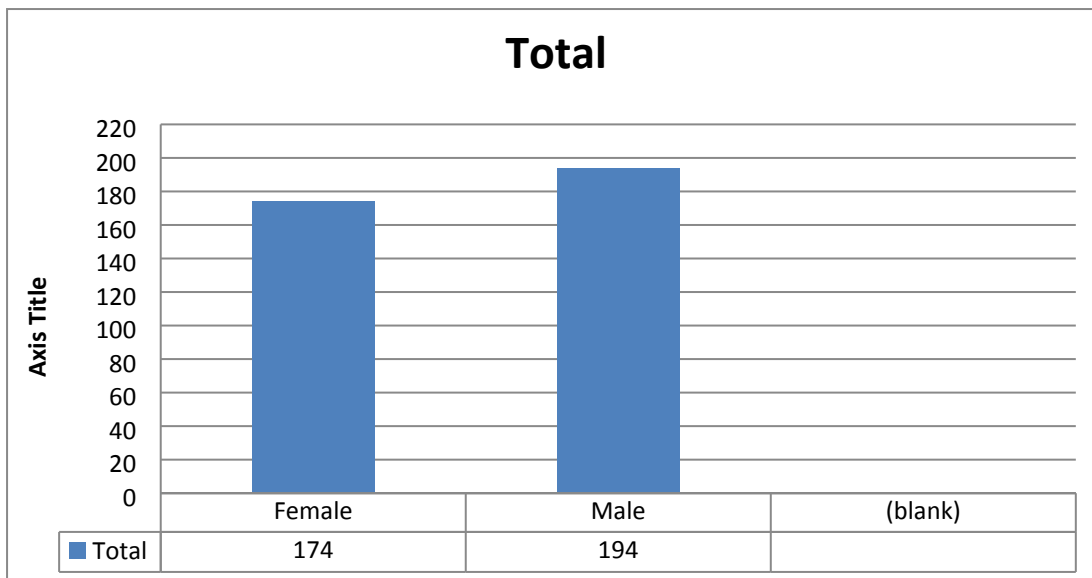
Row Labels	Count of Source System
IAPT	5
PARIS	327
SystemOne	36
Grand Total	368

The data above shows the total number of deaths reported by each notification system. The majority of death notifications were predominately pulled from PARIS. This clinical record system is aligned to our largest population of patients and a population at greatest risk of death due to the proportion of older people in our care.

6.2 Deaths by Gender since 1 August to 19 October 2020

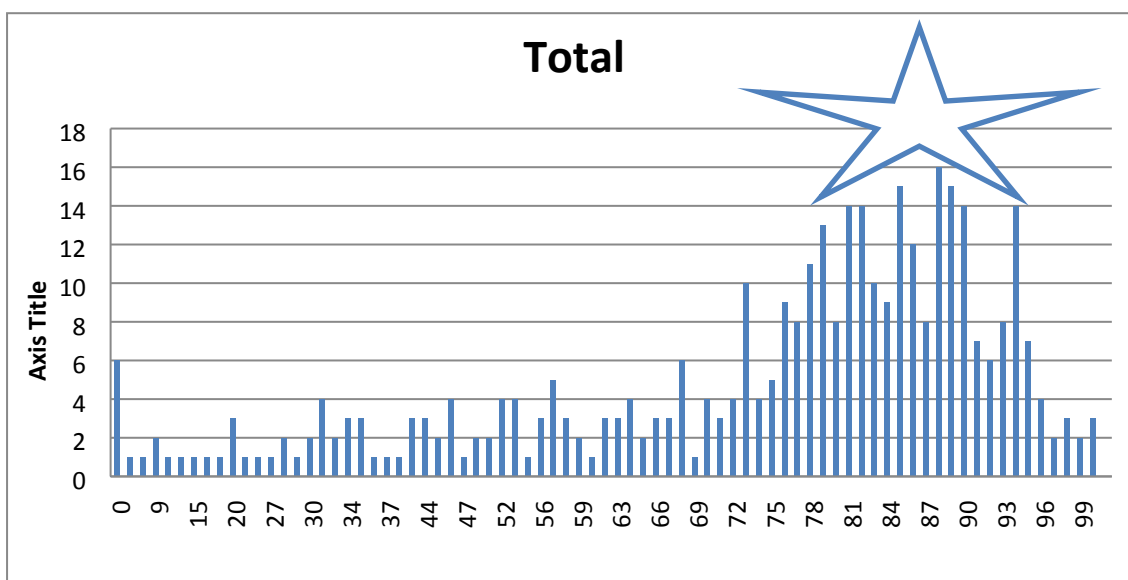
The data below shows the total number of deaths by gender 1 August to 19 October 2020. There is very little variation between male and female deaths; 194 male deaths were reported compared to 174 female.

Row Labels	Count of Gender
Female	174
Male	194
Grand Total	368



6.3 Death by Age Group since 1 August to 19 October 2020

The youngest age was classed as 0, and the oldest age was 100 years. Most deaths occur within the 80-95 age groups (indicated by the star).



6.4 Learning Disability Deaths since 1 August to 19 October 2020

	Aug 2020	Sept 2020	Oct 2020
LD Deaths	2	1	1

The Trust reviews all deaths relating to patients diagnosed with a Learning Disability. The Trust also currently sends all Learning Disability deaths that have been reported through the Datix system to the Learning Disabilities Mortality Review (LeDeR) programme. Due to challenges in reporting out from the LeDeR programme, we are unable to ascertain how many of our Trust's deaths have been reviewed through the LeDeR process. The Trust continues to share relevant information with LeDeR when requested which is used to inform their reviews.

Since 1 August to 19 October 2020, the Trust has recorded four Learning Disability deaths. The Trust now receives a quarterly update from LeDeR which highlights

national good practice and identified learning; this is shared in the Mortality monthly meeting.

6.5 Death by Ethnicity since 1 August to 19 October 2020

White British is the highest recorded ethnicity group with 294 recorded deaths, 51 deaths had no recorded ethnicity assigned, and 5 people did not state their ethnicity. The chart below outlines all ethnicity groups.

Row Labels	Count of Ethnicity
Caribbean	1
Asian or Asian British - Pakistani	1
Pakistani	1
African	1
White - Irish	2
White - Any other White background	3
Indian	4
Not stated	5
Other Ethnic Groups - Any other ethnic group	5
Not Known	51
White - British	294
Grand Total	368

6.6 Death by religion since 1 August to 19 October 2020

Christianity is the highest recorded religion group with 56 recorded deaths, 172 deaths had no recorded religion assigned and 11 people refused to state their religion. The chart below outlines all religion groups.

Row Labels	Count of Religion
Islam	1
Christian religion	1
Church of England, follower of	1
Pentecostalist	1
None	1
Agnostic	2
Catholic: Not Roman Catholic	2
Muslim	2
Atheist movement	2
Sikh	4
Roman Catholic	5
Methodist	7
Not Given Patient Refused	11
Unknown	26
Not Religious	27
Church Of England	47
Christian	56
Blank	172
Grand Total	368

6.7 Death by sexual orientation since 1 August to 19 October 2020

Heterosexual or straight is the highest recorded sexual orientation group with 106 recorded deaths. 231 have no recorded information available. The chart below outlines all sexual orientation groups.

Row Labels	Count of Sexual Orientation
Homosexual	1
Bisexual	1
Sexual orientation unknown	1
Bi-sexual	1
Not stated (declined)	2
Unknown	2
Not appropriate to ask	3
Heterosexual or straight	126
Blank	231
Grand Total	137

6.8 Death by disability since 1 August to 19 October 2020

Behavioural and emotional problems were the highest recorded disability group with 16 recorded deaths.

Top 5 Deaths by disability	Count of Disability
Sight	4
Physical disability	5
Learning Disability	8
Other	8
Learning Disability (Dementia)	10
Behaviour and Emotional	16
Grand Total	62

7. Recommendations and Learning

Below are examples of the recommendations that have been undertaken following the review of deaths. These recommendations are monitored by the Patient Safety Team and are allocated to a specific team, and individuals to be completed. This is not an exhaustive list.

- To further explore the role of families/carers in developing risk assessments, risk management plans and care plans
- Develop, clarify and/or ratify policies in relation to:
 - Section 17 leave
 - The involvement of police on wards (e.g. liaison, individual roles and responsibilities
 - when to escalate and involve the police on the ward, and, how this should be managed, minimised and situations de-escalated)
- The role of the responsible clinician in patient transfers between Trusts/provider services.
- To ensure that key times are accurately recorded in the clinical record if records are made retrospectively
- When staff open and complete a risk assessment it should be authorised in order for it to be clear who the author was.
- To raise with the Suicide Awareness Group the fact that there are a number of locations close to the hospital grounds and acute psychiatric units; where it is possible to make multiple purchases of paracetamol. For the group to consider undertaking a piece of work with shops in order to raise awareness of some of the issues that may be pertinent to patients who use our services.
- When staff open and complete a risk assessment it should be authorised in order for it to be clear who the author was.

8. Moving forward and aligning mortality reviews with the planned Patient Safety Incident Review Framework (PSIRF)

Work is currently underway to align the information set out in the National Guidance, Learning from deaths with the new planned Patient Safety Incident Response Framework to ensure that the national guidance in both documents is been adhered to, ensuring there is no duplication and an effective management of resources.

Board Committee Assurance Summary Reports to Trust Board – 13 January 2021

The following summaries cover the meetings that have been held since the last public Board meeting held on 3 November 2020.

Quality and Safeguarding Committee - key items discussed 10 November 2020
<p>Board Assurance Framework (BAF) and Risk Register Escalation Report</p> <p>The Committee reviewed its allocation of BAF risks and was mindful of emerging risks associated with the commissioning gap in Autism Spectrum Disorder (ASD) Service. The Committee noted the risk register report, which included compliance rates for the tiered risk management training programme currently in place. The number of risk assessments would be reduced through a service line based suite of risk assessments, this would reduce duplication and enable a renewed focus on the mitigations to manage the risks.</p>
<p>COVID-19 Summary Update</p> <p>This briefing on COVID-19 activity related to specific quality, clinical and safety aspects of care provision. Discussion covered the effects of dealing with the pandemic knowing that staff are tired and the importance of staff utilising a range of wellbeing support being made accessible to them.</p>
<p>Patient Safety Incident Response Framework (PSIRF)</p> <p>PSIRF is a new framework for investigating incidents that all trusts will have to adopt in 2022. Discussions concluded that the Trust is fully prepared to follow the PSIRF pilot process to review and investigate incidents for the period 1 December 2020 to 30 November 2021.</p>
<p>Quality Performance Dashboard</p> <p>The dashboard summarised highlights and challenges through the use of high level quality indicators, identified in line with the quality elements of the Trust Strategy and the Trust's quality priorities. Key findings included an overall reduction in patients held in seclusion prior to transfer to Psychiatric Intensive Care Unit (PICU).</p> <p>A reduction was seen in clinic letters sent to GPs within seven days. The Committee recognised the solutions that OnEPR will bring and agreed the drop in performance will be referred to the Finance and Performance Committee to establish whether mitigating action is in place to ensure performance and safe care. The Committee recognised the pressure being felt by services while responding to the national incident Level 4 and received significant assurance from performance in general with limited assurance from the gaps in control regarding care plans and GP letters.</p>
<p>Interim model of quality / clinical contact visits</p> <p>The new model for triangulation of virtual quality visits complying with the national direction of governance to reduce bureaucracy while ensuring a safe environment was discussed and supported by the Committee. An explanation was made of the types of visits which informed the Non-Executive Directors (NEDs) of their proposed role in the new model that will be in place by the end of the year.</p>
<p>Delivery of physical healthcare checks to patients</p> <p>The Committee was briefed on the approach being taken to deliver physical healthcare checks and provide interventions where necessary. The increased levels of COVID-19 and the need to adopt virtual appointments have prevented the anticipated rate of progress in implementing physical healthcare assessment checks. Assessments are being undertaken in a virtual form and an explanation was made on how health assessments are completed. An update report on the implementation of physical healthcare is to be made to the December meeting.</p>

<p>Learning from Deaths Mortality Report</p> <p>During the COVID-19 pandemic, the learning from deaths process continued to be undertaken but slight changes to the process were initially made to allow colleagues to undertake other duties. Normal activity has now resumed with weekly case note reviews and the daily reviewing and grading of all new deaths taking place. During the period 1 August to 19 October 2020 there were zero deaths reported due to COVID-19.</p>	
<p>Serious Incident (SI) Annual Report</p> <p>The report summarised SIs during 1 October 2019 to 30 September 2020. The Committee was advised on the restructure of SI reporting. Discussion concluded that the new framework will enable improved interpretation of results and additional systemic learning.</p>	
<p>Assurance/lack of assurance obtained</p> <ul style="list-style-type: none"> • Significant assurance with the Trust’s operating mechanisms in dealing with COVID-19 • Significant assurance that the Trust is fully prepared to follow the PSIRF pilot process to review serious untoward incidents • Significant assurance from the Trust’s approach to the review and learning from deaths • Quality Performance Dashboard provided significant assurance from performance in general with limited assurance due to gaps in control regarding issue of GP letters • Significant assurance obtained from the new virtual model for quality visits • Significant assurance from the SI annual report 	
<p>Key risks identified</p> <p>Risks associated with non-compliance with physical healthcare standards were considered necessary for inclusion in the BAF. The BAF will also be updated in line with the need to enhance Learning Disabilities (LD) Intensive Support Team (IST) services to improve care and treatment for individuals with ASD and support the commissioning gap.</p>	
<p>Decisions made</p> <ul style="list-style-type: none"> • The PSIRF pilot process to review and investigate incidents for the period 1 December 2020 to 30 November 2021 was supported • The Learning from Deaths and Mortality report was approved for consideration by the Trust Board on 13 January 2021 • The new structure of SI reporting was agreed. 	
<p>Escalations to Board or other committee</p> <ul style="list-style-type: none"> • Drop in performance in issue of GP letters will be referred to the Finance and Performance Committee to establish whether mitigating action is in place to ensure improved performance. • Restrictions due to COVID and clinical standards in physical healthcare against the Trust’s agreed physical healthcare standards and the future impact on funding and performance in line with the new community framework to be escalated the Finance and Performance Committee • NED Escalation to People and Culture Committee for analysis of concerns that staff have raised about feeling confident when expressing concerns • NED Escalation to People and Culture Committee on staff being tired and monitoring the effects of dealing with COVID-19 pandemic. 	
<p>Next Meeting – 8 December 2020</p>	
<p>Committee Chair: Margaret Gildea</p>	<p>Executive Lead: Carolyn Green, Director of Nursing and Patient Experience</p>

Quality and Safeguarding Committee - key items discussed 8 December 2020

Response to escalations made to the People and Culture Committee

The Committee was satisfied with the responses received from escalations taken to the People and Culture Committee on 24 November. Assurance was received that training compliance and recruitment targets/levels are under constant scrutiny. As a result of listening to people's experience of being redeployed while dealing with COVID-19 pandemic, support is being offered to help staff to adapt to their redeployed role and maintain connection with their substantive team. Action is also taking place to improve dialogue between managers and staff when discussing concerns.

Response to escalations made to the Finance and Performance Committee

Assurance was received that monitoring GP letters is predicted to be 10% higher for November and is expected to continue to improve. Letters are sent to all outpatients and urgent letters are sent to GPs within seven days. The figures are increasing and the implementation of OnEPR will result in further improvements.

The Finance and Performance Committee also discussed how physical healthcare checks are falling within the Trust particularly in community settings because of the Covid-19 pandemic and the virtual nature of the service. The Committee was advised that the Finance and Performance Committee is fully aware of the financial risks associated with not meeting the target for physical healthcare checks. A report detailing the improvement plan for capturing physical healthcare data against the agreed physical healthcare standards, especially in acute inpatients, assured the Committee that the process will be more manageable.

Board Assurance Framework (BAF)

The BAF was considered to be a satisfactory representation of risks allocated to the Committee. Risks associated with not meeting physical healthcare targets would be included in the next iteration of the BAF.

COVID-19 Summary Update

Discussion centred on COVID levels amongst medical staff and concluded that staff are very aware of the systems and controls that are required and the safety measures that are in place.

CQC Actions Update

The steady headway being made was noted despite services being understandably behind timescales due to the pressures of working through the pandemic and staff being absent because of COVID. Discussion focussed on the need to ensure staff are adequately trained as this is an important factor for patient safety. The Committee was satisfied that staff are compliant with the approach being taken to reach the minimum level of compliance in mandatory training.

Person centred care and care planning delivery

It was noted that overall safety planning is robust. There are particular improvements to be made with safety practice that will improve with the implementation of OnEPR. There has been some slippage with the implementation of care planning within 24 hours of admission. This is expected to improve as it is being driven forward by senior nurses as part of compliance checks and the successful implementation of clinical standards.

Skill mix review (safer staffing)

Discussion covering the work being undertaken to monitor and develop the skill mix of staff to ensure safe services alongside the current COVID-19 pandemic concluded that the Trust is compliant with safer staffing levels despite services remaining fragile.

Physical Healthcare

Restrictions due to COVID and clinical standards in physical healthcare against the Trust's agreed physical healthcare standards and performance in line with the new community framework had been escalated to the Finance and Performance Committee for action. This report assured the Committee

<p>of work priorities being concentrated on inpatient, early intervention and community services to make the process easier manage. Progress will be regularly captured in performance reporting to the Board. The Committee was assured that the Finance and Performance Committee is aware of the financial risks associated with not meeting the target for physical healthcare checks.</p>
<p>Child and Adolescent Mental Health Services (CAMHS) waiting times during the COVID19 response</p> <p>Although the service remains under significant stress substantial headway is being made with CAMHS waiting times in emotional wellbeing commissioned services.</p>
<p>Quality Account approval</p> <p>Having received delegated authority from the Board, the final version of the Quality Report / Quality Account for 2019/20 was approved for submission.</p>
<p>Recap on PSIRF implementation</p> <p>The Trust is in the early stages of implementing Patient Safety Incident Response Framework (PSIRF) which will replace the Serious Incident Framework (SIF) as a more proactive and risk-based approach.</p>
<p>Safeguarding Adults Assurance Report</p> <p>The Safeguarding Adults report outlined how the Trust's safeguarding leads are discharging their legal duties on behalf of the Trust. The Committee was satisfied that statutory requirements continue to be met and that safe and appropriate restoration plans are in place for the Safeguarding Unit.</p>
<p>Safeguarding Children Assurance Report</p> <p>The Committee was made aware of the potential increase in demand around Safeguarding Children in the current climate of COVID-19 working processes. The Safeguarding Children team is fully engaged in all areas associated with providing statutory and legislative requirements on behalf of the Trust.</p>
<p>Assurance/lack of assurance obtained</p> <ul style="list-style-type: none"> • Significant assurance from the co-ordinated response to the COVID-19 incident and with ethical decision making and safety issues • Limited assurance on the full completion of CQC actions during the pandemic period • Limited assurance was obtained from care planning due to the partial progress in the required standard being continuously sustained • Significant assurance received that reviews of skill mixing are undertaken to re-evaluate associated risks and mitigate them • Limited assurance with the implementation of physical healthcare assessments due to the ongoing work in progress • Significant assurance with Safeguarding Adults activity. Statutory requirements continue to be met • Full assurance gained around Safeguarding Children activity, systems and controls within the Trust.
<p>Key risks identified</p> <p>No additional items were considered necessary for updating in the BAF. The Committee was mindful of the predicted surge in demand for mental health services and the effect this will have on investment for winter planning and associated risks within the BAF.</p>
<p>Decisions made</p> <ul style="list-style-type: none"> • Approval of the Quality Account for 2019/20 • Progress in physical healthcare assessments will be captured in performance reporting to the Board

Escalations to Board or other Committee	
No items were considered necessary for escalating to the Board or other Board Committees.	
Next Meeting – 8 February 2021	
Committee Chair: Margaret Gildea	Executive Lead: Carolyn Green, Director of Nursing and Patient Experience
People and Culture - key items discussed 24 November 2020	
<i>Attendance at this meeting was restricted to the Committee's Executive Lead, and Non-Executive Directors to enable other Executive Directors to attend essential operational meetings in response to the second wave of the pandemic.</i>	
Board Assurance Framework (BAF)	
The BAF was considered to be a robust representation of risks 2a and 2b assigned to the Committee.	
Escalation from Trust Board	
The Committee discussed the action taking place to keep staff levels safe during the pandemic period and how staff resources are to be linked with the requirements of the Long Term Plan. A report providing assurance on safer staffing and resourcing aligned with the People Plan will be taken to the next meeting of the Committee in January. A wider report on staffing and what the future will look like will then be taken to the Board in March.	
Escalation from Quality and Safeguarding Committee	
Two issues had been escalated, one about management addressing and resolving concerns and the other on safer staffing. Both issues were addressed to the satisfaction of the Committee. Discussion focussed on how the redeployment of staff is managed and how learning from people's experience of being deployed is being taken forward to provide support to staff and their managers. Action is also taking place to help improve dialogue between managers and staff when discussing concerns.	
Workforce Performance	
The new Workforce Performance Dashboard was received in its first iteration. The Dashboard will be developed further to contain additional key workforce data.	
Discussion concentrated on action taking place to keep staff levels safe during the pandemic and to ensure the Trust has the right workforce for when the Long Term Plan is in place.	
Update on the Flu Campaign	
The Committee noted the Flu Cell Plan Monitoring Framework Tool and discussed staff engagement in the programme.	
Assurance/lack of assurance obtained	
<ul style="list-style-type: none"> • Significant assurance was taken from the approach being taken with this year's flu vaccination programme • The Committee was significantly assured that the Trust remains compliant with the Healthcare Worker Influenza Vaccination Best Practise Management checklist. 	
Key risks identified	
As identified in BAF risks 2a and 2b.	
Decisions made	
The Committee supported the proposed structure of the Workforce Performance Dashboard.	

Escalations to Board or other Committee	
No matters were considered necessary for escalating to the Board or other Committees.	
Next Meeting – 26 January 2021	
Committee Chair: Julia Tabreham	Executive Lead: Jaki Lowe, Director of People and Inclusion

Finance and Performance Committee - key items discussed 17 November 2020	
Board Assurance Framework	
Content within the draft BAF risks was reviewed. Discussion covered the timing of deep dives and the utilisation of other sources of assurance such as the programme boards for OnEPR and Estates.	
Financial Governance	
The Committee discussed the updated month 7-12 revenue plan in light of the month 7 updated forecasts. The capital plan update is awaited as this is impacted on by the dormitory bids outcome. Cash levels and cash flow planning will be an important focus area once the dormitory bids outcome known. Significant assurance maintained on financial governance, limited assurance that the Trust will receive sufficient funds.	
CIP and Continuous Improvement	
Wave two of the pandemic affecting the planned approach to forward transformation planning. The Committee discussed transformation delivered during the pandemic including the amount of use of Attend Anywhere system. Focus is to be maintained on length of stay and on wider transformational planning.	
IMPACT partnership update	
Sub-contractual arrangements and risk and gain share discussions continue. Additional single item meeting is being planned to discuss further.	
Move to System One and EPR assurance	
Very good progress made to ensure the programme remains on track for delivery of first phase to go live at the end of November. Programme-specific efficiency and quality improvement is to be articulated in the next update to the Committee.	
Assurance on Estate Strategy	
The Committee discussed the status of business cases and ongoing discussions with NHSIE regulators. Additional Board session is to be arranged in order to revisit the position. Programme is now solely focussed on new-build options, not interim solutions.	
Operational Performance	
Discussion covered the impact of pandemic-related staffing absence on delivery of services and performance metrics such as waiting times. An update was also provided on the 24 hour mental health helpline, a further update on which will be received at year-end.	
The Committee also discussed two referral points escalated from the Quality and Safeguarding Committee. The first was the downturn in performance regarding GP letters that had since improved and will further be assisted by the OnEPR implementation. The second related to physical healthcare checks. An update report on the improvement action plan will be taken to the December meeting of the Quality and Safeguarding Committee.	
Escalations to Board or other Committee	
None	

Assurance/lack of assurance obtained	
<ul style="list-style-type: none"> • Significant assurance maintained on financial governance • Limited assurance that the Trust will receive sufficient funding for capital and revenue requirements • Limited obtained on current operational performance across the areas presented 	
Key risks identified	
As identified in BAF risks 2a and 2b	
Next Meeting: 19 January 2021	
Committee Chair: Richard Wright	Executive Lead: Claire Wright, Deputy Chief Executive / Director of Finance

Mental Health Act (MHA) Committee - key items discussed 11 December 2020	
MHA Tribunals	
Discussions regarding accessing MHA Tribunals at the previous meeting had established that there had been some technical problems in gaining access to the facility. Technical difficulties are now being resolved by the Trust's IT Department to allow successful participation by all parties in tribunal hearings.	
Reducing Restrictive Practice	
Restrictive practices are reviewed on a regular basis. There were no breaches or exceptions to report. The Committee was satisfied with the ongoing work to support the continuing need to reduce restrictive practice and was pleased that the Executive Leadership Team had approved the procurement of body worn cameras for inpatient areas and 136 Suites.	
Mental Health Act Manager's Report	
The report contained an analysis and assessment based on the period from 1 July 2019 to 30 September 2020 and was considered section by section. The report had also been extensively covered by the MHA Operational Group on 9 November.	
Attention was drawn to amendments being made to the Mental Health (Hospital, Guardianship and Treatment (England) Regulations 2020 that will allow for electronic sending and receiving of statutory forms relating to the management of patients under the Mental Health Act 1983. The proposed amendments have been brought forward due to the current Covid-19 pandemic to minimise face to face contact. Discussion focussed on the development of practical guidance to assist in applying the changes that will be updated and written in to guidance and Trust policies. Assurance was received that a working group being set up locally will take this work forward.	
Use of Section 135/136 in Derbyshire	
The complexity of the work being undertaken by the Section 135/136 Group was discussed. There has been a significant decrease in the number of detentions. It was thought that the promotion of the mental health helpline has helped patients avoid S136 assessments by using this support service.	
Training Compliance	
Due to COVID-19, all non-essential training has been paused so that services concentrate on the immediate task of supporting vital areas of service. Satisfactory training rates in essential training have been achieved during the pandemic. Compliance rates for training continue to be closely monitored.	
Update from Associate Hospital Managers (AHM)	
AHM representatives reported that although there had been some technical issues regarding virtual	

access of mental health tribunals hearings the use of MS Teams was working satisfactorily to enable all AHMs to work collaboratively.	
Assurance/lack of assurance obtained	
<ul style="list-style-type: none"> • Mental Health Act Manager's report provided significant assurance that the safeguards of the Mental Health Act are appropriately applied across the Trust. • Limited assurance was obtained from training compliance due to suspension of training during COVID-19. 	
Key risks identified	
Although the Committee is not responsible for any risks contained in the BAF the Committee considered that risks associated with the tight timeline for implementing changes to the regulations could be could be a risk that will affect the Board Assurance Framework (BAF).	
Decisions made	
Levels of seclusion and restrictive practices will be reported through the data contained in the MHA Manager's quarterly reports	
Escalations to Board or other Committee	
None	
Next Meeting – 12 March 2021	
Committee Chair: Sheila Newport	Executive Lead: John Sykes, Medical Director

Report from the Council of Governors meeting held on 3 November 2020

The Council of Governors met on 3 November 2020. Following national guidance on keeping people safe during COVID-19 and the need for social distance, this was a virtual meeting conducted digitally.

Chief Executive Update

Ifti Majid provided the meeting with an update on the current situation regarding the COVID-19 pandemic which included:

- Infection is rising in the UK and across the globe
- The number of people admitted into hospital is not at the levels experienced at the end of March and during April; however admissions are increasing
- The R number across the Midlands is above 1; 217 per 100,000 population
- The number of positive COVID-19 patients in Derbyshire beds has doubled in a week (from 76 to 42)
- The number of staff with a COVID-19 related absence has doubled since last week equating to 2½% of the workforce which compares favourably to other trusts
- The Trust is in the process of responding to the current crisis e.g.
 - Identifying essential services
 - Looking at staff capacity
 - Ensuring that colleagues who are deemed 'extremely clinically vulnerable' are working from home
 - Ensuring that risk factors (i.e. ethnicity) are identified
 - Developing wellbeing offers to support colleagues.

Governors Annual Effectiveness Survey

This survey is carried out yearly in line with best practice. A paper detailing the results of the survey was presented to the Governance Committee on 8 October. A total of 24 governors responded to the survey – this equated to 92.30 % (the current complement of governors at the time of the survey was 26).

A number of proposed actions in order to continue to enhance the effectiveness of the Council of Governors were listed in the paper. Actions include a task and finish group which has been established to review the responses; identify any areas for future governor training and development; discuss any issues raised; and to review the questions for next year.

Report form Governors' Nominations and Remuneration Committee held on 21 October 2020

The report outlined revisions to the Trust Chair/ Non-Executive Director (NED) appraisal process in light of the NHS Improvement (NHSI) guidance.

Non-Executive Director Deep Dive Report

Sheila Newport, clinical NED and Chair of the Mental Health Act Committee provided her deep dive report which included an overview of her role within the Trust.

Summary Integrated Performance Report

The Integrated Performance Report (IPR) was presented to the Council of Governors to provide an overview of the performance of the Trust. The NEDs reported on how the report had been used to hold Executive Directors to account in their respective Board Committees for areas with regards to workforce, finance, operational delivery and quality performance.

Escalation of items to the Council of Governors

Two items of escalation were received from the Governance Committee held on 8 October 2020:

Question 1:

How are NEDs assured that the Trust:

- a. Monitors:
 - i. the number of service users who return for treatment,
 - ii. the frequency of returning; and
- b. Then puts in place actions to provide permanent resolutions for service users?

Question 2:

How are NEDs assured that staff feedback from exit interviews is addressed properly and that there are effective processes in place to ensure that it is used to address any issues raised and to make improvements in working environments and service provision?

We request that an example of how this has been undertaken practically is included in the response which will help provide assurance that the processes are effective.

The responses were tabled at the meeting.

Governance Committee Report

Julie Lowe, Deputy Chair of the Governance Committee presented a report of the meeting held on 8 October. The meeting was attended by 80% of the Council of Governors. Three task and finish groups are in the process of being established focusing on the results of this year's Governors Effectiveness Survey; next year's Annual Members' Meeting and governor engagement.

**GLOSSARY OF NHS AND
DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS**

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

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS

NHS Term / Abbreviation	Terms in Full
CQI	Clinical Quality Indicator
CQUIN	Commissioning for Quality and Innovation
CRB	Criminal Records Bureau
CRG	Clinical Reference Group
CRHT	Crisis Resolution and Home Treatment Teams
CRS	(NHS) Care Records Service
CRS	Commissioner Requested Services
CSF	Commissioner Sustainability Fund
CTO	Community Treatment Order
CTR	Care and Treatment Review
D	
DAT	Drug Action Team
DBS	Disclosure and Barring Service
DBT	Dialectical Behavioural Therapy
DfE	Department for Education
DCHS	Derbyshire Community Health Services NHS Foundation Trust
DHCFT	Derbyshire Healthcare NHS Foundation Trust
DIT	Dynamic Interpersonal Therapy
DNA	Did Not Attend
DH	Department of Health
DoLS	Deprivation of Liberty Safeguards
DNA	Did not attend
DPA	Data Protection Act
DRRT	Dementia Rapid Response Team
DTOC	Delayed Transfer of Care
DVA	Derbyshire Voluntary Action (formerly North Derbyshire Voluntary Action)
DWP	Department for Work and Pensions
E	
ECT	Enhanced Care Team
ECW	Enhanced Care Ward
ED	Emergency Department
EDI	Equality, Diversity and Inclusion
EDS2	Equality Delivery System 2
EHIC	European Health Insurance Card
EHC	Education, Health and Care (plans)
EHR	Electronic Health Record
EI	Early Intervention
EIA	Equality Impact Assessment
EIP	Early Intervention In Psychosis
ELT	Executive Leadership Team
EMDR	Eye Movement Desensitising & Reprocessing Therapy
EMR	Electronic Medical Record
EPRR	Emergency Preparedness, Resilience and Response
EPR	Electronic Patient Record
ERIC	Estates Return Information Collection
EQAL	Forum where we can seek patient engagement
ESR	Electronic Staff Record
EUPD	Emotionally Unstable Personality Disorder
EWTD	European Working Time Directive
F	

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS

NHS Term / Abbreviation	Terms in Full
FBC	Full Business Case
FFT	Friends and Family Test
FOI	Freedom of Information
FRRT	Functional Rapid Response Team
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
GMC	General Medical Council
GP	General Practitioner
GPFV	General Practice Forward View
H	
HCA	Healthcare Assistant
HEE	Health Education England
HES	Hospital Episode Statistics
HoNOS	Health of the Nation Outcome Scores
HSCIC	Health and Social Care Information Centre
HSE	Health and Safety Executive
HWB	Health and Wellbeing Board
I	
IAPT	Improving Access to Psychological Therapies
ICM	Insertable Cardiac Monitor
ICS	Integrated Care System (formerly ACS)
ICT	Information and Communication Technology
ICU	Intensive Care Unit
IDVAs	Independent Domestic Violence Advisors
IG	Information Governance
ILS	Immediate Life Support (BLS – Basic Life Support)
IM&T	Information Management and Technology
IMT	Incident Management Team
OOA	Outside of Area
IPC	Integrated Personal Commissioning
IPP	Imprisonment for Public Protection
IPR	Individual Performance Review
IPT	Interpersonal Psychotherapy
J	
JNCC	Joint Negotiating Consultative Committee
JTAI	Joint Targeted Area Inspections
JUCB	Joined Up Care Board
JUCD	Joined Up Care Derbyshire
K	
KPI	Key Performance Indicator
KSF	Knowledge and Skills Framework

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS

NHS Term / Abbreviation	Terms in Full
L	
LA	Local Authority
LCFS	Local Counter Fraud Specialist
LD	Learning Disabilities
LHP	Local Health Plan
LHWB	Local Health and Wellbeing Board
LOS	Length of Stay
M	
MARS	Mutually Agreed Resignation Scheme
MAS	Memory Assessment Service
MAU	Medical Assessment Unit
MAS	Memory Assessment Service
MAPPA	Multi-agency Public Protection Arrangements
MARAC	Multi-agency Risk Assessment Conference (meeting where information is shared on the highest risk domestic abuse cases between representatives of local police, probation, health, child protection, housing practitioners, Independent Domestic Violence Advisors (IDVAs) and other specialists from the statutory and voluntary sectors.
MASH	Multi-Agency Safeguarding Hub
MCA	Mental Capacity Act
MDA	Medical Device Alert
MDM	Multi-Disciplinary Meeting
MDT	Multi-Disciplinary Team
MFF	Market Forces Factor
MHA	Mental Health Act
MHAC	Mental Health Act Committee
MHIN	Mental Health Intelligence Network
MHIS	Mental Health Investment Standard
MHRT	Mental Health Review Tribunal
MSC	Medical Staff Committee
MSK	Musculoskeletal (conditions)
N	
NCRS	National Cancer Registration Service
NED	Non-Executive Director
NICE	National Institute for Health and Care Excellence
NGO	National Guardians Office
NHS	National Health Service
NHSE	National Health Service England
NHSI	National Health Service Improvement
NIHR	National Institute for Health Research
O	
OBC	Outline Business Case
ODG	Operational Delivery Group
OPMH	Older People Mental Health
OP	Out Patient
OSC	Overview and Scrutiny Committee
OT	Occupational therapy
P	
PAB	Programme Assurance Board
PAG	Programme Advisory Group

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS

NHS Term / Abbreviation	Terms in Full
PALS	Patient Advice and Liaison Service
PAM	Payment Activity Matrix
PARC	Psychosis and the reduction of cannabis (and other drugs)
PARIS	This is an electronic patient record system
PbR	Payment by Results
PCC	Police & Crime Commissioner
PCN	Primary Care Networks
PCC	People and Culture Committee
PDSA	Plan, Do, Study, Act
PEEP	Personal Emergency Evacuation Plan
PHE	Public Health England
PICU	Psychiatric Intensive Care Unit
PID	Project Initiation Document
PiPoT	People in Positions of Trust
PLACE	Patient Led Assessments of Care
PLIC	Patient Level Information Costs
PMLD	Profound and Multiple Disability
PPE	Personal Protective Equipment
PPI	Patient and Public Involvement
PPT	Partnership and Pathway Team
PREM	Patient Reported Experience Measure
PROMS	Patient Reported Outcome Measure
PSF	Provider Sustainability Fund
PSIRF	Patient Safety Incident Review Framework
Q	
QAG	Quality Assurance Group
QC	Quality Committee
QIA	Quality Impact Assessment
QIPP	Quality, Innovation, Productivity Programme
QSC	Quality and Safeguarding Committee
R	
RAID	Rapid Assessment, Interface and Discharge
RCGP	Royal College of General Practitioners
RCI	Reference Cost Index
REGARDS	Race, Economic disadvantage, Gender, Age, Religion or belief, Disability and Sexual orientation
RIDDOR	Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013
RTT	Referral to Treatment
S	
SAAF	Safeguarding Adults Assurance Framework
SBARD	Situation, Background, Assessment, Recommendation and Decision (SBARD) tool
SBS	Shared Business Services
SEND	Special Educational Needs and Disabilities
SI	Serious Incident(s)
SID	Senior Independent Director
SIRI	Serious Incident Requiring Investigation
SLA	Service Level Agreement
SLR	Service Line Reporting
SMI	Serious Mental Illness

**GLOSSARY OF NHS AND
DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS**

NHS Term / Abbreviation	Terms in Full
SOAD	Second Opinion Appointed Doctor
SOC	Strategic Options Case
SOF	Single Operating Framework
SPL	Shielded Patient List
SPOA	Single Point of Access
SPOE	Single Point of Entry
SPOR	Single Point of Referral
STEIS	Strategic Executive Information System
STF	Sustainability and Transformation Fund
STP	Sustainability and Transformation Partnership
SUI	Serious (Untoward) Incident
T	
TARN	Trauma Audit and Research Network
TCP	Transforming Care Partnerships
TCS	Transforming Community Services
TDA	Trust Development Authority
TMT	Trust Management Team
TUPE	Transfer of Undertakings (Protection of Employment) Regulations 1981
TMAC	Trust Medical Advisory Committee
U	
UDBH	University Hospitals of Derby and Burton
V	
VO	Vertical Observatory
W	
WDES	Workforce Disability Equality Standard
WRES	Workforce Race Equality Standard
WSoA	Written Statement of Action
WTE	Whole Time Equivalent
Y	
YTD	Year to Date

2020-21 Board Annual Forward Plan

Exec Lead	Item	5 May 20	7 Jul 20	1 Sep 20	3 Nov 20	13 Jan 21	2 Mar 21
	Paper deadline	27 Apr	29 Jun	24 Aug	28 Oct	4 Jan	22 Feb
Trust Sec	Declaration of Interests	X	X	X	X	X	X
CG	Patient Story	X	X	X	X	X	X
CM	Minutes/Matters arising/Action Matrix	X	X	X	X	X	X
CM	Board review of effectiveness of meeting	X	X	X	X	X	X
CM	Board Forward Plan (for information)	X	X	X	X	X	X
CM	Summary of Council of Governors meeting (for information)	X		X	X	X	X
CM	Chair's Update	X	X	X	X	X	X
IM	Chief Executive's Update	X	X	X	X	X	X
STRATEGIC PLANNING AND CORPORATE GOVERNANCE							
MP/CW	NHSI Financial Annual Plan Month 7-12 2020/21				X		
JL	Staff Survey Results		X				X
JL	Equality Delivery System2 (EDS2) update						X
JL	Annual Gender Pay Gap Report for approval						X
JL	Workforce Race Equality Standard (WRES) prior to submission 31.10.20			X			
JL	Workforce Disability Equality Standard (WDES) prior to submission 31.10.20			X			
JL	2020/21 Flu Campaign (summary of 2020/21 to go to May 2021 meeting))			X	20/21 update		
JL	People Plan						X
Trust Sec	NHS Improvement Year-End Self-Certification	X					
Trust Sec	Year-End Governance Reporting from Board Committees and approval of ToRs	X					
Trust Sec	Corporate Governance Framework						X
Trust Sec	Review SOs, SFIs, SoD plus review/ratify SFI Policy (as Policy Review section below)		X				
Trust Sec	Trust Sealings (six monthly - for information - deferred to November due to Covid-19)	X			X		
Trust Sec	Annual Review of Register of Interests	X					
Trust Sec	Board Assurance Framework Update	X	X		X		X
Trust Sec	Freedom to Speak Up Guardian Report (six monthly)			X			X
Trust Sec	Fit and Proper Person Declaration		X				
Trust Sec	Annual Approval of Modern Slavery Statement		X				
Committee Chairs	Board Committee Assurance Summaries (following every meeting)	X	X	X	X	X	X
MP	Annual Emergency Planning Report (EPPR)					X	
GH	Business Plan Monitoring close down of 2019/20 (May) Proposal for 2020/21 (Jul) 2020/21	X	X				
GH	Learning Disabilities Clinical Strategy	X					
Gh	Mental Health, Learning Disability and Autism annual summary						X
GH	Trust Strategy Review	X			X		

2020-21 Board Annual Forward Plan

Exec Lead	Item	5 May 20	7 Jul 20	1 Sep 20	3 Nov 20	13 Jan 21	2 Mar 21
OPERATIONAL PERFORMANCE							
CG/CW/CS/MP	Integrated performance and activity report to include Finance, Workforce, performance and Quality Dashboard	X	X	X	X	X	X
CG/MP/CS	Workforce Standards Formal Submission/Safer Staffing (prior to going on website)						X
QUALITY GOVERNANCE							
Execs	Quality Position Statement Report - focus on CQC domains (Well Led CQC & NHSI (Trust Sec) as per schedule	Safety JS	Responsive MP	Well Led JF	Effective CG & JL	Use of Resources CW	Caring CG
JS	Learning from Deaths Mortality report (quarterly publication of information on death) (Jul/Nov/Jan/Mar)		X		X		
JS	Guardian of Safe Working Report	X	A		X		X
JS	NHSE Return on Medical Appraisals sign off - delayed for 2020/21						
CG	Control of Infection Report			A			
JS	Re-validation of Doctors		Update re delay		Verbal update		
CG	Receipt of Annual Reports: - Annual Looked After Children - Safeguarding Children and Adults at Risk				X		
CG	Outcome of Patient Stories - every two years					due 2022	
POLICY REVIEW							
CW	Standing Finance Instructions Policy and Procedures		X				
JF	Engagement between the Board of Directors and CoG (Nov 2022)						
JF	Fit and Proper Person Policy						X

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



Draft 2021-22 Board Annual Forward Plan

Exec Lead	Item	4 May 21	6 Jul 21	7 Sep 21	2 Nov 21	18 Jan 22	1 Mar 22
	Paper deadline	27 Apr	29 Jun	31 Aug	26 Oct	11 Jan	22 Feb
Trust Sec	Declaration of Interests	X	X	X	X	X	X
CG	Patient Story	X	X	X	X	X	X
CM	Minutes/Matters arising/Action Matrix	X	X	X	X	X	X
CM	Board review of effectiveness of meeting	X	X	X	X	X	X
CM	Board Forward Plan (for information)	X	X	X	X	X	X
CM	Summary of Council of Governors meeting (for information)	X	X	X	X	X	X
CM	Chair's Update	X	X	X	X	X	X
IM	Chief Executive's Update	X	X	X	X	X	X
STRATEGIC PLANNING AND CORPORATE GOVERNANCE							
MP/CW	NHSI Financial Annual Plan Month 7-12 2021/22				X		
JL	Staff Survey Results	X					Headlines
JL	Equality Delivery System2 (EDS2) update						X
JL	Annual Gender Pay Gap Report for approval						X
JL	Workforce Race Equality Standard (WRES) prior to submission end Oct 2021			X			
JL	Workforce Disability Equality Standard (WDES) prior to submission end Oct 2021			X			
JL	2021/22 Flu Campaign (summary of 2021/22 to go to May 2022 meeting)			X			
JL	People Plan Annual Report						A
Trust Sec	NHS Improvement Year-End Self-Certification	X					
Trust Sec	Year-end governance reporting from Board Committees and approval of ToRs	X					
Trust Sec	Corporate Governance Framework						X
Trust Sec	Review SOs, SFIs, SoD plus review/ratify SFI Policy (as Policy Review section below)		X				
Trust Sec	Trust Sealings (six monthly - for information)	X			X		
Trust Sec	Annual Review of Register of Interests	X					
Trust Sec	Board Assurance Framework Update	X	X		X		X
Trust Sec	Freedom to Speak Up Guardian Report (six monthly)			X			X
Trust Sec	Fit and Proper Person Declaration		X				
Trust Sec	Annual Approval of Modern Slavery Statement	X					
Committee Chairs	Board Committee Assurance Summaries (following every meeting)	X	X	X	X	X	X
MP	Annual Emergency Planning Report (EPPR)					X	
GH	Business Plan Monitoring close down of 2020/21 (May) Proposal for 2021/22 (Jul)	X	X				
GH	Learning Disabilities Clinical Strategy	X					
GH	Mental Health, Learning Disability and Autism Annual summary						X
GH	Trust Strategy Review	X			X		

Draft 2021-22 Board Annual Forward Plan

Exec Lead	Item	4 May 21	6 Jul 21	7 Sep 21	2 Nov 21	18 Jan 22	1 Mar 22
OPERATIONAL PERFORMANCE							
CG/CW/CS/MP	Integrated performance and activity report to include Finance, People, performance and Quality Dashboard	X	X	X	X	X	X
CG/MP/CS	Workforce Standards Formal Submission/Safer Staffing (prior to going on website)						X
QUALITY GOVERNANCE							
Execs	Quality Position Statement Report - focus on CQC domains (Well Led CQC & NHSI (Trust Sec) as per schedule	Safety JS	Responsive MP	Well Led JF	Effective CG & JL	Use of Resources CW	Caring CG
JS	Learning from Deaths Mortality report (quarterly publication) (Jul/Nov/Jan/Mar)		X		X		
JS	Guardian of Safe Working Report	A			X		X
JS	NHSE Return on Medical Appraisals sign off - delayed for 2020/21						
CG	Control of Infection Report			A			
JS	Re-validation of Doctors			X			
CG	Receipt of Annual Reports: - Annual Looked After Children - Safeguarding Children and Adults at Risk				X		
CG	Outcome of Patient Stories - every two years					X	
POLICY REVIEW							
CW	Standing Finance Instructions Policy and Procedures		X				
JF	Engagement between the Board of Directors and CoG (Nov 2022)						
JF	Fit and Proper Person Policy						X