



**Derbyshire Healthcare**  
NHS Foundation Trust

# Derbyshire Healthcare NHS Foundation Trust

## Meeting of the Board of Directors

To be held digitally via MS Teams

18 January 2022 09:30 - 18 January 2022 12:00

# INDEX

1. Agenda Public Board Agenda 18 JAN 2022.doc.....	3
1.1 Trust Vision and Values.pdf.....	4
1.2 2021-22 Declaration of Interests Register Updated 7.9.2021.docx.....	5
3. Draft Public Board Minutes 2 NOV 2021.docx.....	6
4. Board of Directors Public Actions Matrix Jan 2022.pdf.....	17
6. Trust Chair Update Jan 2022.docx.....	18
7. CEO Update January 2022.docx.....	28
7.1 Appendix 1 East Midlands Alliance draft Collaborative Agreement.pdf.....	37
8. Integrated Performance Report Jan 2022.docx.....	46
9. National Policy the Drug Strategy and what it means for DHCFT Jan 2022.do.....	88
9.1 New Drug strategy implications Dec 2021.pptx.....	91
10. Responsiveness Report Jan 2022.docx.....	103
11. Board Committee Assurance Summaries Nov and Dec 2021.docx.....	117
Summary of CoG meeting 2 November 2021.docx.....	128
Glossary of NHS Terms updated Jan 2022.docx.....	130
V6 2021-22 Board Forward Plan 18.1.2022.pdf.....	136

**PUBLIC BOARD MEETING**

**TUESDAY 18 JANUARY 2022 TO COMMENCE AT 9:30am**

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

	TIME	AGENDA	LED BY
1.	9:30	Chair's welcome, opening remarks and apologies, declarations of interest and Register of Directors' Interests	Selina Ullah
2.		Staff Story	Jaki Lowe
3.		Minutes of Board of Directors meeting held on 2 November 2021	Selina Ullah
4.		Matters arising – Actions Matrix	Selina Ullah
5.		Questions from members of the public	Selina Ullah
6.	10:00	Chair's Update	Selina Ullah
7.	10:10	Chief Executive's Update - Update on East Midlands Collaborative Agreement	Ifti Majid
<b>STRATEGY, OPERATIONAL PERFORMANCE AND QUALITY ASSURANCE</b>			
8.	10:25	Integrated Performance Report	C Wright/J Lowe/ C Green/A Odunlade
<b>10:45 B R E A K</b>			
9.	11:00	Drug Strategy	Carolyn Green and Dr Richard Martin
10.	11:20	Quality Position Statement - Responsiveness	Ade Odunlade
<b>GOVERNANCE</b>			
11.	11:35	Board Committee Assurance Summaries of meetings of Finance and Performance, Quality and Safeguarding, Mental Health Act and People and Culture Committees held during November and December 2021	Committee Chairs
<b>CLOSING MATTERS</b>			
12.	11:50	- Identification of any issues arising from the meeting for inclusion or updating in the Board Assurance Framework - Meeting effectiveness	Selina Ullah
<b>FOR INFORMATION</b>			
Summary of Council of Governors meeting Glossary of NHS Acronyms 2021/22 Forward Plan			

Questions that are applicable to the agenda, and at the Chair's discretion, can be sent by email to the Board Secretary up to 48 hours prior to the meeting for a response provided by the Board at the meeting. Email: [sue.turner17@nhs.net](mailto: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 1 March 2022. It is anticipated that this meeting will be held digitally via MS Teams**  
Users of the Trust's services and other members of the public are welcome to attend the meetings of the Board.

**Participation in meetings is at the Chair's discretion**

## Our vision

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

## Our values

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

Our Trust values are:

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

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

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

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



DECLARATION OF INTERESTS REGISTER 2021/22		
NAME	INTEREST DISCLOSED	TYPE
<b>Margaret Gildea</b> Senior Independent Director	<ul style="list-style-type: none"> <li>Director, Organisation Change Solutions Limited</li> <li>Coaching and organisation development with First Steps Eating Disorders</li> <li>Director, Melbourne Assembly Rooms</li> </ul>	(a) (e) (d)
<b>Carolyn Green</b> Director of Nursing and Patient Experience	<ul style="list-style-type: none"> <li>Midlands and East Regional Director, National Mental Health Nurse Directors Forum</li> </ul>	(e)
<b>Gareth Harry</b> Director of Director of Business Improvement and Transformation	<ul style="list-style-type: none"> <li>Chair, Marehay Cricket Club</li> <li>Member of the Labour Party</li> </ul>	(e) (e)
<b>Ashiedu Joel</b> Non-Executive Director	<ul style="list-style-type: none"> <li>Director, Ashioma Consults Ltd</li> <li>Director, Peter Joel &amp; Associates Ltd</li> <li>Director, Leicester Council of Faiths</li> <li>Director, The Bridge East Midlands</li> <li>Director, Together Leicester</li> <li>Lay Member, University of Sheffield Governing Council</li> </ul>	(a) (a) (a) (a) (a) (a)
<b>Geoff Lewins</b> Non-Executive Director	<ul style="list-style-type: none"> <li>Director, Arkwright Society Ltd</li> <li>Director, Cromford Mill Limited (wholly owned trading subsidiary of Arkwright Society)</li> </ul>	(a) (a)
<b>Jaki Lowe</b> Director of People and Inclusion	<ul style="list-style-type: none"> <li>General Medical Council Associate</li> </ul>	(e)
<b>Ifti Majid</b> Chief Executive	<ul style="list-style-type: none"> <li>Board Member of NHS Confederation Mental Health Network</li> <li>Co-Chair, NHS Confederation BME Leaders Network</li> <li>Spouse is Operations Director (North) at Priory Healthcare</li> </ul>	(d) (d) (e)
<b>Ade Odunlade</b> Chief Operating Officer	<ul style="list-style-type: none"> <li>Director- CMC Foundation Christian Charity</li> <li>Trusteeship African Council for Nursing &amp; Midwifery</li> <li>Research Lead on Observations for Ox e-Health</li> <li>Director – Jonathan Davids Limited (currently converting to Dormant Company)</li> </ul>	(a) (d) (e) (a)
<b>Dr Julia Tabreham</b> Non-Executive Director	<ul style="list-style-type: none"> <li>Research and Ambassador Carers Federation</li> <li>Daughter's partner, Amit Pore is Team Lead for the NHS Passport. Amit is employed by Netcompany, working in collaboration with NHS Digital and NHSX (NHS joint organisation for digital, data and technology)</li> <li>Daughter-in-Law, Dr Jacqueline Tsang is Consultant Obstetrician, Newham Hospital, London</li> </ul>	(d) (e) (e)
<b>Dr John Sykes</b> Medical Director	<ul style="list-style-type: none"> <li>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</li> </ul>	(e)
<b>Selina Ullah</b> Trust Chair	<ul style="list-style-type: none"> <li>Non-Executive Director - Solicitors Regulation Authority</li> <li>Director/Trustee, Manchester Central Library Development Trust (voluntary role)</li> <li>Non-Executive Director, General Pharmaceutical Council</li> <li>Non-Executive Director, Locala Community Partnerships CIC</li> <li>Non-Executive Director, Accent Housing Group</li> </ul>	(a) (a) (e) (e) (e)
<b>Richard Wright</b> Deputy Trust Chair and Non-Executive Director	<ul style="list-style-type: none"> <li>Non-Executive Director (Chair) of Sheffield UTC Multi Academy Educational Trust</li> </ul>	(a)

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

- (a) Directorships, including non-executive directorships held in private companies or PLCs (with the exception of those dormant companies).
- (b) Ownership or part ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS.
- (c) Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS.
- (d) A position of authority in a charity or voluntary organisation in the field of health and social care.
- (e) Any connection with a voluntary or other organisation contracting for National Health Services, or hold a position of authority in a 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 2 NOVEMBER 2021**

<b>VIRTUAL MEETING VIA MS TEAMS</b>	
Commenced: 09.30	Closed: 12.48

<b>PRESENT</b>	Selina Ullah Richard Wright Margaret Gildea Dr Sheila Newport Geoff Lewins Dr Julia Tabreham Ashiedu Joel Ifti Majid Claire Wright Ade Odunlade Carolyn Green Dr John Sykes Gareth Harry Jaki Lowe Justine Fitzjohn	Trust Chair Deputy Trust Chair and Non-Executive Director Senior Independent Director Non-Executive Director Non-Executive Director Non-Executive Director Non-Executive Director Chief Executive Deputy Chief Executive and Director of Finance Chief Operating Officer Director of Nursing and Patient Experience Medical Director Director of Business Improvement and Transformation Director of People and Inclusion Trust Secretary
<b>IN ATTENDANCE</b>	Anna Shaw Sue Turner Lyndsay Gray Roy Carr Kyri Gregoriou Amy Johnson	Deputy Director of Communications Board Secretary Clinical Lead 136 Services and Service Manager for JET Carer Assistant Director of Clinical Professional Practice Family Liaison and Investigation Facilitator
<b>DHCFT2021/094</b>	Roy Carr	Carer
<b>DHCFT2021/094</b>	Kyri Gregoriou	Assistant Director of Clinical Professional Practice
<b>DHCFT2021/094</b>	Amy Johnson	Family Liaison and Investigation Facilitator
<b>OBSERVERS*</b>	Lynda Langley Andrew Beaumont Julie Boardman David Charnock Denise Baxendale Ian Strange Pete Henson Leanne Walker Craig Kennady Jane Wall Nicola Spriggs Jan Nicholson Samantha Shaw Natalie Day Raj Purewal Kevin Parkinson Kim Harris	Public Governor, Chesterfield and Lead Governor Public Governor, Erewash Public Governor, High Peak and Derbyshire Dales Appointed Governor, University of Nottingham Membership and Involvement Manager Technical Analyst Head of Performance Chair, LGBT+ Network Covid19 Response Team Service Support Manager Deputy Performance Manager Paediatric Occupational Therapist Performance Office Performance Analyst Member of the public Member of the public Member of the public

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

**DHCFT  
2021/093**

**CHAIR'S WELCOME, OPENING REMARKS, APOLOGIES FOR ABSENCE AND  
DECLARATION OF INTERESTS**

Due to the need for social distancing to help limit the spread of COVID-19, this was a virtual meeting, held via MS Teams and livestreamed to the public. As the number of infections have increased in Derbyshire the Board of Directors will continue to meet virtually.

Trust Chair, Selina Ullah, welcomed everyone to her first meeting as Trust Chair since commencing in post on 14 September. Lyndsay Gray, Clinical Lead 136 Services and Service Manager for JET attended the meeting to shadow Director of Nursing and Patient Experience, Carolyn Green.

Selina was mindful that it had been a difficult 19 months for staff since the start of the pandemic and thanked them for their contribution to the continued delivery of quality services within the Trust.

The Register of Directors' of Interest was noted. No declarations were raised with any agenda items

**DHCFT  
2021/094**

**PATIENT STORY**

Roy Carr was welcomed and thanked for agreeing to share his experience of being a carer to his brother Adrian who sadly took his own life. Roy talked about the challenges he faced living over 100 miles away from his brother and how he found this an isolating experience. He explained that although Adrian did not have an enduring mental illness, he was observed to have many 'social stressors' and was vulnerable due to his unstable working life in the aerospace industry, his history of anxiety and depression and heavy reliance on alcohol.

Adrian's death was subject to a Serious Incident Review. Whilst this highlighted aspects of good practice and effective communication, it also acknowledged that there were clearly missed opportunities supporting Adrian within the primary and secondary mental health services. While he was under the Trust's care a psychiatrist had worked with Adrian to help him develop coping strategies for social stressors. From Roy's perspective he did not think the psychiatrist had listened to Adrian correctly and he stressed the need for accurate recording of consultations, especially when there is a difference of opinion. A number of appointments had to be cancelled and this brought into question Roy's trust in the service Adrian was under, especially as last minute cancellations, even if justified, can be seen as rejection. Roy also felt that service professionals should have a better understanding of the impact that social stresses have on people so they can help them deal with debt, housing and unemployment.

Chief Executive, Ifti Majid apologised to Roy on behalf of the Trust and opened discussions on the lessons to be learned from Roy's and Adrian's experience, particularly the importance of providing compassionate person centred care, connecting care between primary and secondary mental health services and wider social care and support to help patients with their health and wellbeing. Director of Nursing and Patient Experience, Carolyn Green committed to drive learning from Roy's experience through to the wider mental health system and to improve the Trust's alcohol support service. She committed to meet with Roy to update him on how the improvements that will be made to support services and proposed using Roy as a resource to help improve the organisation's services.

Selina thanked Roy for sharing his and his brother's experience and hoped he could take some comfort from talking to the Board and assured him that the Trust will respond to his feedback within the wider system. She appreciated that the chance to tell his lived experience was immensely important to Roy as there was a person behind this serious incident who lived, as well as one who died.

	<p><b>ACTION: Connecting care between primary and secondary mental health services and wider social care is to be taken forward within JUCD to ensure the same level of insight is obtained from Roy's and Adrian's experience.</b></p> <p><b>RESOLVED: The Board of Directors considered the importance of connecting care between primary and secondary mental health services and wider social care and support to help patients with their health and wellbeing.</b></p>
<b>DHCFT 2021/095</b>	<p><b><u>MINUTES OF THE BOARD OF DIRECTORS MEETING HELD ON 7 SEPTEMBER 2021</u></b></p> <p>The minutes of the previous meeting held on 7 September were accepted as a correct record of the meeting.</p>
<b>DHCFT 2021/096</b>	<p><b><u>ACTIONS MATRIX AND MATTERS ARISING</u></b></p> <p>Reference was made to the action regarding improvements to be made to the Learning from Deaths Mortality Report received at the July meeting. The Quality and Safeguarding Committee will maintain oversight of this action and address the underlying issues relating to the gaps in the data with the operational management team to resolve and will escalate any further issues to the Board.</p>
<b>DHCFT 2021/097</b>	<p><b><u>QUESTIONS FROM MEMBERS OF THE PUBLIC</u></b></p> <p>No questions had been submitted for a response ahead of today's meeting.</p>
<b>DHCFT 2021/098</b>	<p><b><u>CHAIR'S UPDATE</u></b></p> <p>Selina Ullah presented her first Chair's update to the Board since joining the Trust in September. As a new starter in the Trust she shared positive feedback about the Trust's revamped induction process and with her experience of meeting staff through the live online Engagement Sessions. She found it inspiring listening to staff sharing how they are delivering services, addressing waiting times, innovating, promoting wellbeing and some of the pressures they are facing and she expressed her pride in leading Team Healthcare. Selina also outlined her involvement in a number of activities to date including meeting with colleagues and governors.</p> <p>In regard to system collaboration and working, Selina attended the Joined Up Care Derbyshire (JUCD) Board on 16 September. Discussions focussed on the progress made by the various work streams and the complexities of becoming an operational Integrated Care Board (ICB) on 1 April 2022. Selina highlighted that the Board will need to discuss what this means to the Trust and the organisation's role within the wider system.</p> <p>Selina discussed the plan to recruit a new Non-Executive (NED) vacancy to replace Julia Tabraham when she steps down from her role at the end of December and she thanked Julia on behalf of the Board for her contribution to the Trust during her term as a NED.</p> <p><b>RESOLVED: The Board of Directors noted the content of the Chair's update.</b></p>
<b>DHCFT 2021/099</b>	<p><b><u>CHIEF EXECUTIVE'S REPORT</u></b></p> <p>Ifti Majid's report provided the Board with an update on local and national developments within the national and local Derbyshire health and social care sector over the last two months.</p> <p>Key points from the JUCD Board meeting held in public on 16 September were covered in Ifti's report. Attention was drawn during the meeting to the patient story which focused on autism, both diagnosis and post diagnostic support, as well as transition from children to adult services. This led to a conversation around current service plans and the new autism support service and the Trust's role as an Anchor Organisation in Derbyshire.</p>



### **Provider Collaboratives at Scale**

Ifti referred to the provider collaboratives and the work that was underway within JUCD, particularly the three suggested models of delivery for provider collaborative at scale that should be considered by the local Integrated Care System (ICS) to assess their suitability. It is proposed that the initial member organisations of the Provider Collaborative would be Chesterfield Royal Hospital NHS Foundation Trust, Derbyshire Community Health Services NHS Foundation Trust, Derbyshire Healthcare NHS Foundation Trust, DHU Health Care CIC, East Midlands Ambulance Service NHS Trust and University Hospitals of Derby and Burton NHS Foundation Trust. This proposal will support the emerging national requirement around a local mental health, learning disability and autism collaborative/alliance via the provider collaborative subgroup. The Board was requested to receive the briefing note on Provider Collaboration at Scale and formally agree its support for the direction of travel.

Deputy Trust Chair, Richard Wright thought that the Mental Health Learning Disability and Autism Delivery Board was an important collaborative. It had links with Roy's carer story and it makes a strong case for joined up provision. Richard hoped that this type of provider collaborate and delegation of authority will not complicate decision making. Ifti described how a Mental Health Alliance will be formally constituted within the provider collaborative as the model being adopted across the ICS. The Mental Health Learning Disability and Autism Delivery Board will link in with the different provider collaboratives. The Trust will work with the new chair and chief executive of the Integrated Care Board (ICB) to ensure the collaborative will consist of component members that are equal in authority to act. Further discussion about delegated authority will be held during Board Development to consider the effect that this will have on the Trust's governance when the ICB is set up in April 2022.

Board members agreed to the proposal identified in Provider Collaboration at Scale briefing with the exception of Director of Nursing and Patient Experience, Carolyn Green who asked for it to be formally noted that she disagreed with elements of the proposal.

### **Trust Green Plan**

The draft Trust Green Plan that supports the NHS aim to reduce carbon emissions to 'net zero' outlined in the 2020 NHS report 'Delivering a 'Net Zero' National Health Service' (2020) was contained in Appendix 2 of the report. The Green Plan focuses on nine areas workforce, travel, facilities and. The delivery of this plan will help raise the profile of sustainability by providing robust leadership and direction under Chief Operating Officer, Ade Odunlade as the Trust's net zero Board member.

The Board agreed the draft Green Plan and confirmed that monitoring of the associated Green Plan delivery programme will be taken through the Finance and Performance Committee.

### **Roadmap out of lockdown**

The Board discussed the priority areas for focus in quarter 3 of the Trust's Roadmap and the ongoing response to COVID-19 featured in Appendix 3 that has been developed to give colleagues a broad understanding of how the Trust will recover from the pandemic. A key component of the Roadmap is about keeping safe. Staff are continuing to be urged to follow infection and control measures, maintain social distancing, wear face coverings and regularly wash their hands. Staff are to continue to undertake lateral flow tests and are being encouraged to receive their COVID-19 and flu vaccinations. The final section in the Roadmap focussed on getting the basis right so that quality can continue to improve which links to today's patient and carer story about focussing on service users receiving a good experience.

### **RESOLVED: The Board of Directors:**

- 1) Scrutinised the report, noting the risks and actions being taken.**
- 2) Agreed to the direction of travel identified in the proposal from the Provider Collaboration at Scale Sub-Committee (Appendix 1) with the exception of the Director of Nursing and Patient Experience**
- 3) Supported and signed off the Green Plan (Appendix 2).**

**PERFORMANCE AND ACTIVITY REPORT**

This report updated the Board of Directors on the key finance, performance and workforce measures at the end at the end of September 2021.

**Operations**

Chief Operating Officer, Ade Odunlade reported that the Trust has maintained its performance measures and key targets. He highlighted that to date the Trust has consistently exceeded the national standard for patients being followed up within three days following discharge from mental health inpatient wards to ensure their wellbeing during the period when they are at their most vulnerable. Improving Access to Psychological Therapies (IAPT) is another area that performs well.

Over the last few months services have performed well in making sure patients are receiving care within Derbyshire with no patients being treated out of area. Waiting lists are currently in the best situation they have been in three years. A concerted effort has been made to significantly reduce waiting list times and this process will continue. Richard Wright challenged how these levels in waiting list times can be maintained. Ade assured Richard that continuous oversight and management will focus on performance does not slip.

The Health Protection Unit is focussing on providing both flu and COVID-19 vaccinations. It was significant to note that 93% of Trust colleagues have received their first vaccination and 90% have received both vaccinations. Booster vaccinations have also commenced in the Trust. There are no cases of COVID positive patients on inpatient wards, and this is due to the high vaccination rates within the Trust, as well as colleagues' excellent IPC standards.

**Finance**

Deputy Chief Executive and Director of Finance, Claire Wright reported that the Trust had broken even on revenue for the first half the year. The financial plan for month 7-12 was discussed later during the meeting.

With regards to self-funded capital, the Trust is forecast to be above plan by £0.6m by the end of the financial year. The above-plan forecast expenditure is related to the self-funded elements of the dormitory eradication programme and Psychiatric Intensive Care Unit (PICU), acute-plus plans and is therefore part of system discussions on capital prioritisation for use of system Capital Department Expenditure Limit (CDEL). The Trust has received additional capital funding for the initial stages of the dormitory eradication programme. Further funding has been agreed for the dormitory eradication programme with allocations totalling £80m over the next three years subject to full business case approvals.

**People performance**

Director of People and Inclusion, Jaki Lowe reported that the appraisal process is being reinstated across all services. They were replaced in the interim by structured wellbeing and risk assessment conversations which will continue within the appraisal discussion. Jaki also talked about the difference between corporate and operational services in terms of appraisals with corporate services focussing on the support they have given to the Trust during the pandemic.

A targeted approach is being taken to staff absence. General Managers and Area Service Managers have been tasked with compiling sickness action plans. This will be reported through the Trust Oversight Operational Leadership meeting (TOOL). Jaki was pleased to report that staff turnover has returned within target during the last month. The Trust currently has one the highest stability indexes in comparative trusts which indicates that the organisation has a stable workforce.

**Quality**

Carolyn Green was pleased to report that in general the quality of the Trust's services remains in a stable position. The number of reported incidents involving restraint and seclusion have reduced. Performance could be better on autism assessments although referrals are continuing. It is hoped that a significant change to investment in the service

	<p>expected next year that will help with autism assessments. Although performance is under the 28 week waiting standard there are a number of children waiting in Paediatrics and Children’s services. Waiting list for Community Paediatrics continues to be significantly shorter than the average 28 week waiting time. Although there is strength in these services there will be a continued focus to bring Paediatrics and Child and Adult Mental Health Services (CAMHS) together.</p> <p>Non-Executive Director, Sheila Newport referred to the investment that is expected next year in Autism services and asked how this investment will improve performance. Ifti responded that nationally there are 45,000 people waiting more than 13 weeks for autism assessments and care. The Trust has already added over £1m of investment this year to help people with autism and consideration will be given to how new monies will be invested in new models of care that will improve assessments and support in the community.</p> <p>The Board discussed how the Board Committees are to focus on areas for improvement. The Committees will also focus on metrics linked to Roy’s story concerning debt, housing and employment and provide a greater level of assurance on performance. The Board Assurance Framework (BAF) will also be looked at to include strategic risks concerned with operating needs and other areas where the Trust has responsibility within JUCD.</p> <p>Carolyn Green challenged performance around transformation of care and how the Trust can continue to meet the needs of the population as she was concerned that there are a number of under 18s CAMHS Tier 4 patients and patients with autism occupying acute mental health beds. Ade Odunlade explained that in order to rectify these challenges the Derbyshire system has to work together to improve integration, review services and expand the environment to manage the complexity of patients that are under the Trust’s care. Work is taking place to mobilise and fully utilise the workforce and ensure that flow within services is integral to make sure that discharges are worked on and managed with other system partners. This is a collective responsibility that needs to be resolved by using system leadership to raise this issue at a system level.</p> <p>Carolyn confirmed that the Quality and Safeguarding Committee will discuss the risks associated with the deterioration in accessing Tier 4 beds and the increase in the number of patients with a Learning Disability and Autism when the Committee reviews the BAF on 9 November.</p> <p>Selina concluded discussion by advising that the Board will discuss the complexity around sovereignty within the JUCD system at Board Development to establish its system leadership role in order to be clear on the Trust’s wider accountability.</p> <p>The Board also received and noted the update on Derbyshire TCP performance contained in Appendix 3 of the performance report.</p> <p><b>RESOLVED: The Board of Directors:</b></p> <ol style="list-style-type: none"> <li>1) Received limited assurance from current performance across the areas presented</li> <li>2) Received and noted the update on Derbyshire TCP performance.</li> </ol>
<p><b>DHCFT 2021/101</b></p>	<p><b><u>NHSI FINANCIAL ANNUAL PLAN MONTHS 7-12 2021/22</u></b></p> <p>The Board was asked to review and approve the current draft plan for month 7-12 (H2) of 2021/22 and to agree the method for the Trust Board’s final sign off.</p> <p>It was agreed that an internal sub-group of the Board’s choosing consisting of either the Trust Chair or Deputy Chair, CEO, Director of Finance and chairs of the Finance and Performance Committee and the Audit and Risk Committee will meet to review and approve the final version of the H2 plan in more detail before submission.</p> <p><b>Post meeting note:</b> The H2 Plan was agreed for submission during a meeting of the internal sub-group of the Board on 10 November. The sub-group consisted of:</p>

	<p>Selina Ullah, Trust Chair  Richard Wright, Chair, Finance and Performance Committee  Geoff Lewins, Chair, Audit and Risk Committee  Claire Wright in her capacity as both CEO and Finance Director  Rachel Leyland, Deputy Director of Finance.</p> <p><b>RESOLVED: The Board of Directors:</b></p> <ol style="list-style-type: none"> <li>1) <b>Noted the assumptions contained in the current draft financial plan for October 2021 to March 2022</b></li> <li>2) <b>Agreed that a sub-group of the Trust Board’s choosing, approves the final version of the H2 plan before submission.</b></li> </ol>
<p><b>DHCFT  2021/102</b></p>	<p><b><u>STRATEGIC IMPLICATIONS OF THE OUTCOMES OF THE 2020/21 WORKFORCE RACE EQUALITY STANDARD (WRES) AND WORKFORCE DISABILITY EQUALITY STANDARD (WDES) SUBMISSIONS</u></b></p> <p>The WRES Report and Action Plan 2020/21 has been published on the Trust’s website after being approved by the People and Culture Committee. This report presented by Jaki Lowe updated the Board on progress made with the 2020/21 Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES).</p> <p>Jaki updated the Board on progress with the work undertaken on WRES which is key to developing the Trust’s culture and improve experiences of BME colleagues and the WDES in terms of understanding the experiences of staff living with disabilities or long-term conditions. This year, the Trust is looking for a fundamental shift in the approach to inclusion through embedding a distributed leadership approach through which the collective impact will be improved through leadership modelling and high engagement with those with lived experience.</p> <p>Elements are also being focussed on in the WDES. The WDES is unique in that it depends on people declaring if they have a disability or long term condition. Jaki was pleased to report that targeted actions are in place to improve the level of reporting.</p> <p>Claire Wright asked if the People and Culture Committee had discussed WRES indicator 5 concerning racism experienced by staff from patients or members of the public. Claire was assured that the Committee has scrutinised allegations of racism and hate crimes and is reinforcing the expectation that it is not acceptable for any Trust colleagues to experience racism or hate crimes. The Quality and Safeguarding Committee also reviews all incidents of violence and harassment of staff.</p> <p>Non-Executive Director, Ashiedu Joel challenged indicator 6 and 7 concerning the impact of language and behaviour and asked what training education or awareness raising was being carried out within the Trust to ensure it fits into inclusive leadership. Jaki responded that the cultural intelligence programme will be rolled out through the organisation and the benefits will start to be seen in around twelve months’ time. In the meantime oversight meetings take place on all cases reported to ensure appropriate action is taken. Day one of the Trust’s induction programme focusses on behaviour and relationships and covers how people are expected to be mindful of the Trust’s people first values. There is also a module in place that takes a workshop approach that brings people together in a team to talk about language and use of banter.</p> <p>Ifti applauded the strategic approach being taken to awareness conversations and interventions and was pleased that the People and Culture Committee will take forward the impact of the WRES and WDES actions and review the experience of BME people and the disabled community within the Trust.</p> <p>The Board was mindful that elements of Roy’s story was concerned with people’s experience of care and how health professionals communicate with other partners in Derbyshire and will ensure a partner approach to equality is aligned. The strategic implications of the WRES</p>

	<p>and the WDES and experience of colleagues directly links to the effect of care given to patients.</p> <p>The Board discussed the importance of supporting individuals to succeed and challenge any areas of discriminatory challenges. It was agreed that this zero tolerance approach will be made visible across the organisation and the system. The Board's ambitions for an inclusive decision-making culture will be articulated and built into the Trust's processes and driven through the People and Culture Committee.</p> <p><b>RESOLVED: The Board of Directors considered and discussed the strategic implications of the WRES submission 2020/21.</b></p>
<p><b>DHCFT 2021/103</b></p>	<p><b><u>QUALITY POSITION STATEMENT – EFFECTIVE</u></b></p> <p>Carolyn Green presented the Board with a focused report on 'Effectiveness' as part of the wider expanded quality reporting relating to CQC (Care Quality Commission) domains and NHS Improvement requirements.</p> <p>The Board acknowledged that this was a positive and detailed report that looked at how the Trust can best improve effectiveness and outcomes for people who use its services but there are areas that require development. Significant assurance was received from the remarkable achievements that are a testament to Trust staff that will be celebrated and promoted. The Trust's achievements in research and development were also thought to be an area to be showcased. Elements of today's carers story revealed there is work to do to improve family liaison and in reducing suicide in people using drugs and alcohol that will be taken through to the next phase. There are also risks associated with forensic services that need improving. The Trust is making good inroads with suicide prevention work and is carrying out significant work to move forward with sexual safety.</p> <p>The Board discussed the importance of sharing the good work that goes on within the Trust and agreed that this will be celebrated and promoted by the Communications team.</p> <p><b>RESOLVED: The Board of Directors received significant assurance on the areas presented.</b></p>
<p><b>DHCFT 2021/104</b></p>	<p><b><u>GUARDIAN OF SAFE WORKING REPORT</u></b></p> <p>This regular report from the DHCFT Guardian of Safe Working (GOSW) provides data about the number of junior doctors in training in the Trust, full transition to the 2016 Junior Doctor Contract. The report details arrangements made to ensure safe working within the new contract to identify, quantify and remedy any risks to the organisation.</p> <p>The Board considered the report to be strong evidence of the good work that the GOSW is carrying out with junior doctors. Significant assurance was received from the approach that continues to be taken to ensure safe working for medical trainees.</p> <p><b>RESOLVED: The Board of Directors received significant assurance of the Trust's approach in discharging its statutory duties regarding safe working for medical trainees.</b></p>
<p><b>DHCFT 2021/105</b></p>	<p><b><u>LEARNING FROM DEATHS MORTALITY REPORT</u></b></p> <p>This report presented by Medical Director, John Sykes covered the period 30 April to 22 July 2021 and updated the Board on how the Trust continues to review and learn from any deaths of people who have been in contact with our services.</p> <p>The report was considered in the context of identifying people who are using the Trust's services. John confirmed that deaths are reported and reviewed through the Trust's incident reporting system (Datix) which is also contained in the Serious Incident report received by the Quality and Safeguarding Committee. The mortality report covered 28 case reviews</p>

	<p>where a selection of deaths had been looked at to establish if anything was missing in patients' experience of care. From 30 April to 22 July 2021 there have been zero deaths reported where the patient tested positive for COVID-19.</p> <p>The Board was assured that the Trust is following recommendations outlined in the National Guidance on Learning from Deaths and agreed for the report to be published on the Trust's website.</p> <p><b>RESOLVED: The Board of Directors 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.</b></p>
<p><b>DHCFT 2021/106</b></p>	<p><b><u>BOARD ASSURANCE FRAMEWORK UPDATE - ISSUE 3 2021/22</u></b></p> <p>Trust Secretary, Justine Fitzjohn presented the Board with the third issue of the Board Assurance Framework (BAF) for 2021/22.</p> <p>In the last issue approved by the Board in July there were nine operational risks rated as high or extreme on the corporate risk register that were aligned to the related BAF risks. Each of these has been reviewed by the risk owner and the Director Lead. This resulted in there now being five operational risks from the corporate risk register that are aligned to the BAF.</p> <p>Justine assured the Board that consideration of wider system risks and how they impact the Trust and collaboration work within the system discussed earlier in today's meeting will be captured in the next iteration of the BAF.</p> <p>The Board acknowledged that the BAF is thoroughly scrutinised by the Board Committees for the risks they are responsible for and approved this third issue of the BAF for 2021/22.</p> <p><b>RESOLVED: The Board of Directors:</b></p> <ol style="list-style-type: none"> <li>1) <b>Approved this third issue of the BAF for 2021/22</b></li> <li>2) <b>Received significant assurance from the process of the review, scrutiny and update of the BAF in seeking to identify and mitigate risks to achieving the Trust's strategic objectives</b></li> <li>3) <b>Agreed to continue to receive updates in line with the forward plan for the Trust Board.</b></li> </ol>
<p><b>DHCFT 2021/107</b></p>	<p><b><u>APPROVE STANDING FINANCIAL INSTRUCTIONS</u></b></p> <p>The Standing Financial Instructions (SFIs) have been reviewed and updated and were presented to the Board to be ratified. Claire Wright highlighted that the SFIs have not been updated since 2019 due to the emergency response where temporary SFIs have been in place and outlined the material changes and general updates. These included:</p> <ul style="list-style-type: none"> <li>• Change the name of NHS Improvement to NHS England and Improvement</li> <li>• The term 'manpower' replaced by workforce</li> <li>• The term 'People Services' replaced with 'People and Inclusion'</li> <li>• 'his/her/herself' replaced with 'their/them/themselves'</li> <li>• Section 8 Tendering and Contracting has been updated to reflect EU changes to the 'EU Directives Governing Public Procurement' to the 'Public Contract Regulations 2015'.</li> </ul> <p>It was noted that the SFIs have gone through robust consultation and scrutiny by the Executive Leadership Team and the Audit and Risk Committee. Having reviewed the revisions itemised in the report the SFIs were ratified by the Board.</p> <p><b>RESOLVED: The Board of Directors ratified the SFIs</b></p>
<p><b>DHCFT 2021/108</b></p>	<p><b><u>QUALITY AND SAFEGUARDING COMMITTEE RECEIPT OF ANNUAL REPORTS 2020/21</u></b></p>

	<p>The Board received three annual reports that had previously been scrutinised and accepted by the Quality and Safeguarding Committee:</p> <p><b>Safeguarding Children and Adults at Risk</b> The annual production of this report is a governance requirement of both the Trust and the Safeguarding Children and Adults Boards. The report evidenced a successful year and provided significant assurance regarding the fulfilment of legal and statutory safeguarding duties.</p> <p><b>Derby City Looked After Children Provision</b> This annual report provided an overview of the progress, challenges, opportunities and plans to support and improve the health and wellbeing of looked after children in Derby City and provided significant assurance of the work within the Trust around looked after children and young people and the continued partnership working to ensure the best outcome is achieved for this vulnerable group of children and young people.</p> <p><b>Infection Prevention and Control</b> This report summarised the activity over the preceding twelve months and demonstrated the consistent high level of performance against infection control standards and related management activities work. Significant assurance was received on standards of cleanliness of clinical areas and food preparation areas and with approaches and learning are evolving in accordance with emerging evidence and international / national and regional learning. The Board commended the work undertaken by the Infection Prevention and Control Team and Estates, Facilities and Catering services for the outstanding standards achieved</p> <p>The Board received the annual reports and thanked colleagues for their important work throughout the pandemic in these areas.</p> <p><b>RESOLVED: The Board of Directors received significant assurance from the annual reports that had previously been scrutinised and accepted by the Quality and Safeguarding Committee.</b></p>
<p><b>DHCFT 2021/109</b></p>	<p><b><u>BOARD COMMITTEE ASSURANCE SUMMARIES</u></b></p> <p>The Board Committee Assurance Summaries demonstrated the work of the committees since their last update to the Board and were accepted as a clear representation of the priorities that were discussed and will be taken forward in forthcoming meetings. Discussions held within the committees were summarised by the Committee Chairs as follows:</p> <p><b>Finance and Performance Committee:</b> The dormitory eradication and Psychiatric Intensive Care Unit (PICU) projects continue to progress well. Solutions are now in place for handheld devices and e-prescribing within OnEPR. The delivery of continuous improvement projects (CIP) continue to improve the financial position.</p> <p><b>Mental Health Act Committee:</b> The September meeting provided positive assurance that safeguards of the Mental Health Act have been appropriately applied. Significant assurance was received on the use of restrictive practice across the Trust and from the use of Section 136 Suites and engagement with the police on use of the mental health triage service.</p> <p><b>People and Culture Committee:</b> The People and Inclusion Dashboard continues to develop and be increasingly valuable. Focussed discussions took place on sickness data and length of time to recruit staff. Discussions on the results of the pulse check staff survey highlighted increasing levels of sickness absence in the medical workforce.</p> <p><b>Audit and Risk Committee:</b> Good levels of assurance were received that operational risks were being appropriately captured in the BAF. The review of the 202/21 Annual Report and Accounts production established that this had been a very effective process. The importance</p>

	<p>of Freedom to Speak Up processes provided significant assurance with the Trust's arrangements. The high level of compliance with Data Security and Protection measures provided positive assurance that information is handled correctly and protected from unauthorised access, loss, damage and destruction.</p> <p><b>Quality and Safeguarding Committee:</b> The Health Protection Unit is making good progress on delivering flu vaccinations and COVID-19 booster vaccinations to staff and inpatients. The Safeguarding Children and Adults reports provided significant assurance that both units are in a stable position providing a full service. Forensic service risks, positive waiting times and improvements in physical healthcare reporting were also discussed and monitored over the two meetings held in September and October. Cross collaboration with the People and Culture Committee on issues such as safer staffing and capacity issues with the medical workforce is working well.</p> <p>The Board recognised that it is within the Board Committees where much of the scrutiny and challenge takes place and that which is such an important part of the Trust's governance requirements.</p> <p><b>RESOLVED: The Board of Directors noted the Board Assurance Summaries</b></p>
<p><b>DHCFT 2021/110</b></p>	<p><b><u>IDENTIFICATION OF ANY ISSUES ARISING FROM THE MEETING FOR INCLUSION OR UPDATING IN THE BOARD ASSURANCE FRAMEWORK (BAF)</u></b></p> <p>Consideration of wider system risks and how this impacts the Trust as a sovereign trust and collaboration work within the system will be captured in the next iteration of the BAF.</p>
<p><b>DHCFT 2021/111</b></p>	<p><b><u>2021/22 BOARD FORWARD PLAN</u></b></p> <p>The 2021/22 forward plan outlining the programme for the remainder of the year was noted and will be reviewed further by all Board members throughout the financial year.</p>
<p><b>DHCFT 2021/112</b></p>	<p><b><u>REPORTS RECEIVED FOR INFORMATION</u></b></p> <p><b>Register of Trust Sealings</b> The report detailing the authorised use of the Trust Seal 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><b>Summary report from the Council of Governors</b> The summary from the meetings of the Council of Governors was noted for information.</p>
<p><b>DHCFT 2021/113</b></p>	<p><b><u>MEETING EFFECTIVENESS</u></b></p> <p>Board members agreed that the meeting had been successfully conducted as a live streamed meeting held in the public domain with the correct items placed on a comprehensive agenda. Today's patient and carer story had been particularly impactful and will be taken forward within JUCD to ensure the same level of insight is obtained from Roy's and Adrian's experience. There will also be opportunities to improve the themes arising from their experience through the mental health framework.</p>
<p>The next meeting to be held in public session will be held at 9.30am on 17 January 2022. Owing to the current rate of infection during the 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 2022						
Date	Minute Ref	Item	Lead	Action	Completion Date	Current Position
6.9.2021	DHCFT 2021/088	Freedom to Speak Up Guardian Report	DPI	People and Culture Committee to explore the Impact that the investigation process has on staff wellbeing, length of time that investigations take and staff satisfaction with the process	18.1.2022	On 23 November 2021 the People and Culture Committee received significant assurance that Employee Relations casework is being dealt with in a timely manner and that future plans will mitigate any current procedural or policy issues. Assurance was also received that the additional risks associated with case work, employee mental health and working through a pandemic situation have been reviewed and appropriate mitigating action taken as far as possible. Employees are being treated in a fair and consistent way in accordance with legislative requirements and ACAS best practice. Future plans are to shift the culture to build effective relationships and team working and preventative work which resolves issues informally and sustainably.
2.11.2021	DHCFT 2021/094	A carers story	DON	Connecting care between primary and secondary mental health services and wider social care is to be taken forward within JUCD to ensure the same level of insight is obtained from the carer and his brother's experience	18.1.2022	An appointment was scheduled to meet the carer but is subject to a small delay due to pandemic planning. This experience was discussed at the EQUAL Service Users and Carers Group. Reducing waiting times and implementing the Community Mental Health Framework (CMHF) is key to full delivery.

Key:	Resolved	GREEN	1	50%
	Action Ongoing/Update Required	AMBER	1	50%
	Action Overdue	RED	0	0%
	Agenda item for future meeting	YELLOW	0	0%
			2	100%

## **Trust Chair's report to the Board of Directors**

### **Purpose of Report**

This report is intended to provide the Board with the Trust Chair's reflections on my activity with and for the Trust since the previous Board meeting on 2 November 2021. The structure of this report reflects the role that I have as Trust Chair.

I would like to take this opportunity to wish members of the Board, staff, Governors, and all stakeholders a happy new year. May 2022 be a year of stabilisation, good health and restoration for us, our service users and respective services and organisation.

### **Our Trust and Staff**

1. We are now entering the third year of the pandemic. Last year we began the journey to restore services and begin to get back to some semblance of normality with a planned roadmap. We managed to get to our third quarter of our roadmap only to be hit by the third wave of the pandemic and the Omicron variant. On 24 December we received a letter from NHS England (NHSE) outlining how the Trust should respond to the surge in cases and the impact on services arising from infections rates and staff absences given the high transmissibility of the Omicron variant.
2. As part of the Trust's roadmap, I had planned with the Director of Nursing and Patient Experience, Carolyn Green to restore quality visits in person in January. The quality visits are an important part of quality assurance for the Board and provide a good opportunity to hear from staff and patients of the reality on the ground. Although these visits have been taking place virtually it is not ideal. Given the current situation with Omicron, it is my intention to reinstate the face to face visits at the earliest point when it is safe to do so.
3. 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 Non-Executive Directors (NEDs) are also joining these calls.
4. On 10 November and 8 December I attended our Disability and Wellness Network and our BME Staff Network. I was pleased to meet colleagues and hear of the progress that is being made and how we can work together to improve colleague experience. I look forward to attending the other Networks in due time.
5. Our Annual Staff Conference was held virtually on 24 November. The theme of the conference was 'Getting back on track'. The guest speaker was Amar Latif an inspirational leader, television personality and entrepreneur who is visually impaired. Over 120 staff colleagues attended and were inspired, motivated, and energised by Amar and by his account of his life and the challenges he

has faced. The staff workshops identified, a number of priorities for the Trust to concentrate its efforts on and which, both Chief Executive, Ifti Majid and I are committed to progressing.

6. On 29 November I had arranged to visit Tissington House, Kedleston Unit and The Beeches Mother and Baby Unit. Unfortunately due to sudden and unexpected inclement weather the visits had to be cancelled on the day.
7. I would like to recognise the Winter Wellbeing Campaign that ran through the month of December. The resources including motivational speakers and fitness gurus such as Mr Motivator was both very creative and was varied enough such that there was something for everyone to do – my thanks to all members of staff who worked so hard behind the scenes to make this happen. This campaign brought a strong focus for everyone on our own health and wellbeing.
8. Thank you to all staff for your ongoing commitment and dedication shown to the Trust and our service users over an extraordinary time and another wave of the pandemic. We hope that the coming year will see us stabilise and begin the journey to a greater sense of normality.

### **Council of Governors**

9. We held a virtual joint Council of Governors meeting on 2 November following the public Board in the morning. This meeting was extremely well attended by Governors. Governors were complimentary about the Board meeting they had observed earlier and the holding to account aspect of performance they observed. Richard Wright, Deputy Chair and Chair of the Finance and Performance Committee presented to Governors on Child and Adolescent Mental Health Service (CAMHS) waiting times and the work being carried out to ensure performance is maintained despite the ongoing demand and challenges. NED, Sheila Newport gave a comprehensive account of her activities as a NED and the portfolio of responsibilities she has.
10. The Governance Committee of the Council met on 8 December, chaired by Julie Lowe. I continue to be grateful to our Governors for their support for the Trust at this time.
11. Following the Board meeting on 18 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 this current Omicron wave of the pandemic and the future development of the system and the implementation of the Integrated Care Board (ICB) and Integrated Care Partnership (ICP).
12. 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. We met on 16 November to discuss my objectives with Margaret Gildea, Senior Independent Director. 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 have valued Lynda's insights and wisdom which have been invaluable to me in my role as Trust Chair. I am pleased that Lynda has once again taken an active role in our

recruitment of NEDs with final interviews taking place on 17 January 2022. Lynda has continued to work with other lead governors in the system over this period and has reported that our Governors are exemplars for their engagement activity outside the Trust, helping to benchmark our processes for continued engagement with governors.

13. The next meeting of the Council of Governors will be on 1 March 2022, following the Public Board meeting on that day. The next Governance Committee takes place on 8 February.

### **Board of Directors**

14. 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 livestream our public Board meetings to enable members of public and our staff to observe the Board meeting. We are intending to not only livestream our Board meeting in January but also make it available to view by the wider public. This will continue to support our aim to make our meetings open and accessible to all.
15. On 29 November the Board met in a confidential session to further consider Learning Disability (LD) and Autism harmonisation.
16. On 15 December the Remuneration and Appointments Committee met to receive an update on senior management changes, Integrated Care Board appointments, Board mandatory training and to consider the Board Development programme in the months ahead.
17. A Board Development session was also held on 15 December to review the Trust strategy and the building blocks. The Board identified a number of areas for consideration and requested the executives to undertake some further work for additional discussion.
18. The NEDs have met regularly with Ifti and I to ensure we have been fully briefed on developments as needed. The NEDs have also met on 30 November as “Committee Chairs” to review progress across all the Board sub-committees and in particular the management and closure of cross committee actions. NED mandatory training was also provided on information governance and data protection. This was our first face to face meeting which was very welcome and allowed me to meet all the NEDS in person for the first time. The meeting was conducted in line with Covid safety guidance.
19. I have also continued to meet with all NEDs individually. Since the last Board meeting, I have met with Julia Tabreham, who finished her term as a NED with the Trust on 20 December. I have conducted Julia’s exit interview and quarterly review with NED, Geoff Lewins. We use these quarterly meetings to review NEDs’ progress against their objectives and to discuss any issues of mutual interest.
20. We have advertised and shortlisted applicants for the NED vacancy arising from Julia leaving and will have interviewed the shortlisted candidates on 17 January with ratification of the decision at the Council of Governors meeting on 18 January.

## **System Collaboration and Working**

21. Joined Up Care Derbyshire (JUCD) met on 5 November as a workshop using MS Teams. 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 to gather the thoughts and ideas regarding the creation of the new ICB and ICP.
22. The timescales for the go live date for the ICB has now changed to 1 July 2022 from 1 April due to the considerable pressures faced by NHS organisations.
23. I have assisted John McDonald, Chair Designate of Derbyshire ICB with the recruitment of the ICB independent NED recruitment in preparation for the new ICB. Four of the five NED roles have been potentially filled subject to NHSE ratification. I am pleased at the level of NED and Executive Director 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.
24. I am meeting 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 15 November the Board had a presentation from the East Midlands Alliance Perinatal Mental Health Collaborative.
25. On 16 November I attended the East Midlands Mental Health symposium along a number of our NEDs.

## **Regulators, NHS Providers and NHS Confederation and others**

26. I attended the annual NHS providers conference held on 15 and 16 November. It was an opportunity to hear from NHS leaders about not only the challenges but also policy and good practice.
27. On 3 December I attended a Chairs and Chief Executives virtual network meeting with Amanda Pritchard, CEO of NHS England hosted by NHS Providers and chaired by Chris Hopson, CEO of NHS Providers.
28. I attend fortnightly briefings from NHS England and NHS Improvement (NHSE/I) for the Midlands region which has been essential to understand the progress of the management of 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 Ifti's CEO report to the Board.
29. I attend 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.

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

<b>Assurances</b>
<ul style="list-style-type: none"> <li>• The Board can take assurance that the Trust level of engagement and Influence is high in the health and social care economy.</li> <li>• Feedback from staff and other stakeholders is being reported into the Board.</li> </ul>

<b>Consultation</b>
This report has not been to other groups or committees.

<b>Governance or Legal Issues</b>
None

<b>Public Sector Equality Duty &amp; Equality Impact Risk Analysis</b>
<p>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.</p> <p>Below is a summary of the equality-related impacts of the report:</p> <p>This report reflects a wide range of activities across the Trust, and consideration relating to ensuring inclusion is embedded in operational work of the Trust. The specific services visited provide support to those with protected characteristics by the nature of their work. I am developing my own awareness and understanding of the inclusion challenges faced by many of our staff.</p> <p>With respect to working with governors, I will continue to support the approach taken by the Trust to work actively to encourage a wide range of nominees to Trust governor elections and strive that the Council of Governors is representative of the communities they serve. The Trust also provides support to any current or prospective governors to enable them to carry out their role to address any specific needs they may have. This includes providing transport for those who may not be able to access public transport due to physical needs, accommodating communication requirements and providing support workers at meetings.</p>

### **Demonstrating inclusive leadership at Board level**

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

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

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

### **Recommendations**

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

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

**Joined Up Care Derbyshire Board - 19 November 2020****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**

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](http://www.joinedupcarederbyshire.org.uk)

Twitter: [@joinedupcare](https://twitter.com/joinedupcare)

Facebook: [Joined Up Care Derbyshire](https://www.facebook.com/joinedupcarederbyshire)

Instagram: [@joinedupcarederbyshire](https://www.instagram.com/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. 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. As has become traditional, on Christmas Eve NHS England & Improvement (NHSEI) published the planning guidance for 2022/23. As a Board, we note the context that this planning guidance is set within: At the end of January, we will mark two years since paramedics from Yorkshire Ambulance Service and hospital teams in Hull and Newcastle started to treat this country's first patients with COVID-19, and earlier this month we marked the anniversary of the first COVID-19 vaccine dose – and the milestone of 100 million doses – delivered in the biggest and fastest vaccination programme in NHS history.

As Board colleagues will note from later in my report, we now find ourselves again operating within a level 4 National Incident in response to the emergence of the Omicron variant, with community transmission rates locally at alarming levels, and these levels now showing themselves in the number of colleagues we have away from work and the number of positive patients in our inpatient facilities.

The document also notes the significant progress that has been made in preparing for the proposed establishment of statutory Integrated Care Systems (ICS). It clarifies that to allow sufficient time for the remaining parliamentary stages, a new target date of 1 July 2022 has been agreed for statutory arrangements to take effect and ICBs to be legally and operationally established. Finally, Amanda Pritchard, Chief Executive NHS England (NHSE) notes that our ability to fully realise the objectives set out in this document is linked to the ongoing level of healthcare demand from COVID-19. Given the immediate priorities and anticipated pressures, the planning timetable will be extended to the end of April 2022, and this will be kept under review.

The NHS's financial arrangements for 2022/23 will continue to support a system-based approach to planning and delivery and will align to the new ICS boundaries agreed during 2021/22. Ten key priority areas are identified for 2022/23:

- Invest in our workforce – with more people (for example, the additional roles in primary care, expansion of mental health and community services, and tackling substantive gaps in acute care) and new ways of working, and by strengthening the compassionate and inclusive culture needed to deliver outstanding care.
- Respond to COVID-19 ever more effectively – delivering the NHS COVID-19 vaccination programme and meeting the needs of patients with COVID-19.
- Deliver significantly more elective care to tackle the elective backlog, reduce long waits and improve performance against cancer waiting times standards.
- Improve the responsiveness of urgent and emergency care (UEC) and build community care capacity – keeping patients safe and offering the right care, at the right time, in the right setting. This needs to be supported by creating the equivalent of 5,000 additional beds, in particular through expansion of virtual ward models, and includes eliminating 12-hour waits in emergency departments (EDs) and minimising ambulance handover delays.
- Improve timely access to primary care – maximising the impact of the investment in primary medical care and primary care networks (PCNs) to expand capacity, increase the number of appointments available and drive integrated working at neighbourhood and place level.
- Improve mental health services and services for people with a learning disability and/or autistic people – maintaining continued growth in mental health investment to transform and expand community health services and improve access.
- Continue to develop our approach to population health management, prevent ill-health and address health inequalities – using data and analytics to redesign care pathways and measure outcomes with a focus on improving access and health equity for underserved communities.
- Exploit the potential of digital technologies to transform the delivery of care and patient outcomes – achieving a core level of digitisation in every service across systems.
- Make the most effective use of our resources – moving back to and beyond pre-pandemic levels of productivity when the context allows this.
- Establish Integrated Care Boards (ICBs) and collaborative system working – working together with local authorities and other partners across their ICS to develop a five-year strategic plan for their system and places.

With respect to expectations around mental health, learning disability and autism services, the guidance is clear that:

- Continue to expand and improve their mental health crisis care provision for all ages.
- Ensure admissions are intervention-focused, therapeutic and supported by a multi-disciplinary team, utilising the expansion of mental health provider collaboratives across the whole mental health pathway, where systems plan such developments.

- Continue the expansion and transformation of mental health services, as set out in the NHS Mental Health Implementation Plan 2019/20 – 2023/24, to improve the quality of mental healthcare across all ages.
- Continue to grow and expand specialist care and treatment for infants, children and young people, by increasing the support provided through specialist perinatal teams for infants and their parents up to 24 months, and through continuing to expand access to children and young people’s mental health services.
- Systems to maintain a focus on improving equalities across all programmes, noting the actions and resources identified in the Advancing Mental Health Equalities Strategy.
- Delivery of the Mental Health Investment Standard (MHIS) remains a mandatory minimum requirement, ensuring appropriate investment of baseline funding and SDF to deliver the mental health NHS Long Term Plan objectives by 2023/24.
- Increase the rate of annual health checks for people aged 14 and over on a GP learning disability register towards the 75% ambition in 2023/24.
- Continue to improve the accuracy of GP learning disability registers so that the identification and coding of patients is complete, and particularly for under-represented groups, such as children and young people and people from ethnic minority groups.
- Maintain a strong commitment to reducing reliance on inpatient care for both adults and children with a learning disability and/or who are autistic, consistent with the ambition set out in the NHS Long Term Plan, and to develop community services to support admission avoidance and timely discharge.
- Build on the investment made in 2021/22 to develop a range of care and diagnostic services for autistic people delivered by multi-disciplinary teams.
- Implement the actions coming out of Learning Disability Mortality Reviews (LeDeRs), including following deaths of people who are autistic, to tackle the inequalities experienced by people with a learning disability; these have been exacerbated by the pandemic.

The Board should note that some £75m national service development funding (SDF) will be available to support the learning disability and autism requirements of the plan, along with the minimum investment standard funding and the SDF, to support long term plan implementation

The planning process (and Board should note that the contents of the plan are in line with expectations and current planning) will be led through the Mental Health, Learning Disability and Autism System Delivery Board with strong connections to the Children’s Board.

2. At the end of November, the Department of Health and Social Care announced an independent review into the health impact of potential bias in medical devices.

There are growing concerns that the way medical devices and technologies are designed and used could mean a patient’s diagnosis and treatment is affected by their gender or ethnic background, exacerbating existing inequalities in healthcare.

The coronavirus pandemic has exposed health disparities across the country, as the virus had a greater impact on those whose underlying health was poorer, and death rates have been higher among people from ethnic minority communities.

While current UK regulations set out clear expectations, they do not currently include provisions to ensure that medical devices are equally effective, regardless of demographic factors, such as ethnicity.

The independent review will look at devices such as oximeters – used to measure oxygen levels – to identify potential discrepancies in how they work for different ethnic groups. As part of this, the review will consider whether existing regulations mean there is a systemic bias inherent in medical devices.

Existing research on this has highlighted the need for this issue to be further examined, as these devices are critical for monitoring and deciding if treatment is needed for diseases such as COVID-19, where every minute counts and accurate data is vital.

Details of who will be leading the review will be set out in due course.

The review will examine medical devices currently on the market to identify areas of concerns in these products, and aims to:

- Take forward work on identifying where systematic bias and risk exist with existing approved devices
- Make recommendations on how these issues should be tackled in the creation of a medical device from design to use, including potentially via regulation, and
- Be future-focused and consider the enhanced risk of bias in the emerging range of algorithmic based data/artificial intelligence tools.

It is hoped initial findings can be completed and presented by the end of January 2022. This is something that we will be keeping close to, through the national work I am involved in with the NHS Confederation, and I will be able to keep the Board updated on progress and outcomes of this vital review.

### **Local Context**

3. At the November Joined Up Care Derbyshire (JUCD) ICS Board meeting, John MacDonald confirmed that the Board would be stood down from the end of December 2021 to enable the establishment of the shadow ICB and Integrated Care Partnerships (ICPs) from January 2022. John noted, and I think our Board would agree, we have much to be proud of with JUCD ICS, with this change being a notable step in our journey to become a statutory ICS. John noted and thanked all organisations for their commitment to the development of the ICS to date, something that as a Board we have played a significant part in, not just at Executive level, but with significant Non-Executive Director (NED) commitment as well.

Whilst John recognised the Integrated Care Board (ICB) and Integrated Care Partnership (ICP) membership will be different to the previous JUCD ICS Board

membership, he noted his commitment to ensuring that ICB Board development is not undertaken in isolation and will be planning for broader participation in the development sessions currently being planned for 2022. From various planning conversations, these conversations will include areas such as Place Partnerships and Provider Collaboration at Scale, Digital, Population Health Management and Turning the Curve to Address Inequalities.

4. Board colleagues will recall we mentioned a draft East Midlands Provider Collaborative agreement back at our October Board Development session and the actual document was then circulated in early November for Board colleagues' comments. This version (9) makes a few key changes detailed below from the version our Board commented on in June 2021:

- Referring to, rather than incorporating, the detail of the pathway specific Provider Collaborative Agreements
- Removing the appointment of an independent Chair
- Including the appointment of a provider Chair as the Alliance Board Chair
- Incorporating annual governance reviews involving provider Chairs

For completeness, I have attached the draft document as appendix 1, should Board colleagues have any further comments they wish to make.

### **Within our Trust**

5. On 24 November, Board members will be pleased to note we held our third annual staff conference, this time the event was a virtual Microsoft Teams based event. The focus of this years' event was 'Getting Back on Track', a nod to the improving COVID position at that time and our desire to start to think about those things we need to focus on in the coming year. We were joined by Amar Latif, who was a hugely inspirational guest speaker, talking about his experiences since becoming blind as a teenager and how he has built resilience to overcome any obstacles that come his way.

There were lots of key messages shared by Amar about the importance and value of approaching challenges with the right mindset – building our resilience to achieve positive results. I know this resonated with colleagues at the staff conference and we were all blown away by Amar's positivity, creative way of tackling obstacles, and sheer lack of fear.

We also spoke about the importance of an asset-based approach rather than a deficit-based approach – and how Amar has used his blindness as a strength – saying it was his blindness that kept him seeing the world.

We also spent time in focus groups, giving thought to what are the key areas we should be focussing on as a Trust, and it seemed to me that four areas emerged very strongly:

- Meeting up and connecting with colleagues
- How we continue to improve our recruitment approach
- How we look at short term sickness and absences
- How we use the space we have a bit differently as many teams continue to work in new and flexible ways.



The event was very well attended and my thanks to all colleagues who were involved in the detailed planning and logistics for the event and to those who attended



6. During December I met with colleagues who joined the Trust in June, by way of giving them a space to share with me how it felt in the first six months of being in our Trust. Thanks to all colleagues who attended, and so openly shared their experiences, of which a small summary is below:

- Joining during COVID can be tough, especially not getting a chance to meet those who you will closely work with face to face – takes a little longer to settle in
- Felt welcomed and unanimously described the Trust as friendly
- Compared to previous experiences, can feel our people first drive
- Day 1 induction was a triumph – to meet so many senior people and hear their views at the very start was really good
- Time to do training felt a little cramped in the first few weeks.

This feedback was very valuable, and I will continue meeting with all new starter cohorts six months into their employment with us.

7. 16 December was a record-breaking day. We held our December all staff engagement session, with no agenda, just billed as a question and answer session with me and executives. We had over 330 colleagues on the call and we had free flowing conversations about vaccine mandating, increasing COVID levels again, Christmas precautions, activity in services and how busy it felt, annual leave, methods for connecting with each other, morale and many other areas. Colleagues requested more of these events.

8. A highlight of my December each year is the judging of the Christmas decorations competition. This year we adopted a hybrid approach by judging decorations virtually, then myself and Jaki Lowe (Director of People and Inclusion) going out to visit the winners (with strict compliance to IPC (Infection Prevention and Control) guidelines). The standard of entry was very high and it was a difficult decision but we eventually agreed the winners were:

- Best overall inpatient display - Tansley Ward
- Best overall non inpatient display - Library Services
- Best overall working from home display - Melanie Dawson
- Best patient participation - Cubley Court
- Best diversity and inclusion – Estates
- Most inventive IPC friendly festive decorations - The Beeches
- Overall winner – Jackie's Pantry



9. On behalf of the whole Board, I wanted to pay tribute to the tremendous dedication of all colleagues in our organisation who have managed another year of the pandemic and have continued to keep vulnerable people who need to use our services safe, through superb infection, prevention and control mechanisms and practice. In addition, colleagues have almost universally managed increasing demand for our services, as well as increasingly complex presentations. On behalf of the Board – Thank you!

In addition, the Christmas and New Year period has been particularly challenging, due to the emergence of the Omicron variant. Community transmission rates in Derbyshire are at their highest ever with parts of the County topping 2,000 per 100,000 population. This has led (understandably and unavoidably) to us needing to manage some of the highest rates of positive inpatients since the pandemic began and more than 190 colleagues absent from work, due to COVID related reasons. With this backdrop, added thanks to those colleagues who worked over the Christmas and New Year period and those who volunteered to give up time off to support wards and teams.

As a Trust we have worked hard to ensure all our services are kept running, even though we have had to seek out colleagues prepared to move into different services in order to keep some of those most effected by sickness running. As a Board, I am sure you would join me in expressing sincere thanks to all colleagues who have been so flexible during this latest phase of the pandemic.

10. Over the last two months we have continued to hold several 'Live' Divisional Engagement Events, chaired by either the Divisional General Manager or Executive lead, with the aim of offering colleagues the chance to tell us as a senior leadership team how they are finding working in the Trust at present, along with an opportunity to ask questions, make suggestions and share

innovations. I have been pleased to welcome Non-Executive Directors to these sessions as well. Engagement sessions have been held with:

- Children's Services
- Corporate Services

In addition, we have held a number of sessions, focussing on vaccinations and the impending legislation change around mandatory vaccines for frontline NHS colleagues.

I have been lucky to be able to get on the road and meet with colleagues from our Breakout Team, the Hartington Unit, Tissington House and Cherry Tree Close and, since the New Year, I have met with colleagues from our High Peak Adult Community Mental Health Team (CMHT) and Older Adult CMHT, as well as spending time with a consultant colleague at St Andrews House and our North Memory Assessment Team.

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

### Strategic Considerations

1) We will deliver <b>great care</b> by delivering compassionate, person-centred innovative and safe care	X
2) We will ensure that the Trust is a <b>great place to work</b> by attracting colleagues to work with us who we develop, retain and support by excellent management and leadership	X
3) We will make the <b>best use of our money</b> 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.

Visibility of myself and other Board members is a key plank of our engagement strategy, which in turn is essential in terms of supporting opportunities for sharing concerns around the 9 protected characteristics. I think the report shows that, despite the pandemic during December and early January, there was significant contact and engagement with colleagues.

One of the things I take away from the plan for 2022/23 is the continued and overt focus on health inequalities, both in terms of the macro strategic level, the advent of the ICS legislation and how that supports the health of local communities, but also at a more operational level, for example the use of specific health promotion tools for mental health services.

Areas of risk from this report include vaccine roll out and the need to monitor differential uptake within the protected characteristics, both at a community level and within our colleagues in Trust.

## **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**

## **East Midlands Alliance for Mental Health and Learning Disabilities**

### **Draft governance arrangements for comment**

**October 2021**

#### **Summary**

The East Midlands Alliance for Mental Health and Learning Disabilities was formed in summer 2019 based on a Memorandum of Understanding agreed by the providers boards. As the Alliance has developed, the Chairs and CEOs have agreed to establish an Executive Board and to refresh the governance arrangements.

The draft agreement is circulated to Provider Boards for comment ahead of a final version for approval.

#### **Changes from the June 2021 version**

The key changes from the Collaborative Agreement circulated for comment in June 2021 are:

- Referring to, rather than incorporating, the detail of the pathway specific Provider Collaborative Agreements
- Removing the appointment of an independent Chair
- Including the appointment of a provider Chair as the Alliance Board Chair
- Incorporating annual governance reviews involving provider Chairs

#### **Review process**

This draft was shared with the CEO group at the Alliance Board on 8 October. It has also been shared with provider Chairs. An update on the process and headlines was provided at the Board development sessions on 13 and 14 October.

**Provider Boards are asked to review and comment on this draft with a view to bringing a final version for approval to the next round of Board meetings.**

The feedback will be reviewed at the joint Chair and CEO meeting in December.

# **East Midlands Alliance for Mental Health and Learning Disabilities**

## **Collaborative agreement**

**Version 9**

**15 October 2021**

**DRAFT – Not approved**

## **1. Background**

1.1 The East Midlands Alliance for Mental Health and Learning Disabilities was formed in summer 2019 bringing together the six largest providers of mental health and learning disability services in the East Midlands. The establishment of the Alliance was based on a Memorandum of Understanding agreed by the providers boards.

1.2 The Alliance has made strong progress in areas of joint work including the establishment of four Provider Collaboratives to take on the organisation and commissioning of specialised veterans, forensic, child and adolescent mental health and adult eating disorder services from NHS England.

1.3 As the work programme has expanded and the formal responsibility for specialised services moves across from NHS England to the Alliance, the provider Boards have agreed to establish an Alliance Executive Board based on a new Collaborative Agreement.

## **2. The Alliance partners**

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

## **3. Aims and objectives of the East Midlands Alliance**

3.1 The Alliance was established in 2019 based on a Memorandum of Understanding approved by the six provider members. The aims in setting up the Alliance were to:

- establish a more formal collective arrangement to strengthen joint working and support delivery of the NHS Long Term Plan,
- to share learning across the East Midlands,
- undertake the strategic oversight of the Provider Collaboratives
- to develop a stronger collective East Midlands voice for mental health and learning disabilities.

3.2 The establishment of the regional alliance is consistent with the national mental health leadership view that each NHS Trust will be part of a local system provider alliance and a wider regional provider alliance.

3.3 The agreed initial objectives in setting up the Alliance included:

- Working together to improve the quality and effectiveness of Mental Health and Learning Disabilities services in the East Midlands
- Working more collectively to deliver the NHS Long Term Plan across the East Midlands region
- Establishing a more effective voice for mental health and learning disabilities via an Alliance
- Sharing best practice and effective solutions to common issues
- Thinking and acting more strategically across the East Midlands
- Being consistent with the national policy direction
- Establishing a vehicle through which to take strategic decisions relating to the East Midlands Provider Collaboratives

#### **4. Governance**

4.1 The Alliance Board does not seek to establish a new organisation or legal entity. The Alliance Board is established by the Providers, each of which remains a sovereign organisation, to provide a governance framework for the further development of collaborative working between the Providers.

4.2 The Alliance Board will function through engagement and discussion between its members so that each of the Providers makes a decision in respect of each matter considered by the Alliance Board. The decisions of the Alliance Board will, therefore, be the decisions of the individual Providers, the mechanism for which shall be authority delegated by the individual Providers to their representatives (normally their CEO) on the Alliance Board. The Providers will ensure that the Alliance Board members understand the status of the Alliance Board and the limits of the authority delegated to them.

4.3 The Alliance is made up of willing partners and as such, any of the six member organisations can withdraw from the Alliance. This should be done in writing from the CEO and Chair of the organisation to the other Alliance members. Withdrawal from the East Midlands Provider Collaboratives will be managed in line with the withdrawal procedures, including notice periods and surviving terms, set out in the respective Partnership Agreements.



## **5. Executive Board**

- 5.1 The Alliance will be overseen by an Executive Board which will be made up of the Chief Executives of the six provider partners. The Board will meet every two months.
- 5.2 The Alliance Board will oversee the development and implementation of an annual work programme, respond to opportunities and shared challenges through collaborative work, allocate specific tasks to the professional groups and act as the Part B Board for the East Midlands Provider Collaboratives.
- 5.3 The Alliance Board will receive updates from each of the East Midlands Provider Collaboratives including key risks, issues and strategic decisions. The Alliance Board will act in line with the respective Provider Collaborative agreements which have been approved by the Boards of the Alliance members.
- 5.4 The Board will be chaired by one of the provider Chairs for a one year term before rotating to another provider Chair.
- 5.5 Conflicts of interest will be declared at the start of each Alliance Board meeting. Conflicts of interest relating to the pathway specific East Midlands Provider Collaboratives will be managed in line with the relevant approved Partnership Agreement.
- 5.6 The Alliance Board will agree an annual work programme informed by the Boards of the member organisations.
- 5.7 The Alliance will hold regular joint Board development sessions to share progress and review issues of common interest to member Boards.
- 5.8 A common Board paper will be circulated following each Alliance Board to keep provider Boards updated and to set out any decisions for the member Boards.
- 5.9 The Alliance Board will undertake an annual review of the effectiveness of the governance arrangements and the impact of the Alliance. This review will be carried out with the Chairs of the member organisations.

## **Annex one - Terms of reference for the Alliance Board**

### **To be completed**

Purpose

Status and authority

Accountability

Responsibilities

Membership, attendance and responsibilities

Quorum

Chairing arrangements

Decision making

Conduct of business

Conflicts of interest

Review

**Annex two – links to the Provider Collaborative agreements**

Signed by

for and on behalf of

.....

**Derbyshire Healthcare NHS Foundation Trust**

Signed by

for and on behalf of

.....

**Leicestershire Partnership NHS Trust**

Signed by

for and on behalf of

.....

**Lincolnshire Partnership NHS Foundation Trust**

Signed by

for and on behalf of

.....

**Northamptonshire Healthcare NHS Foundation Trust**

Signed by

for and on behalf of

.....

**Nottinghamshire Healthcare NHS Foundation Trust**

Signed by

.....

for and on behalf of

**St Andrew's Healthcare**

## **Performance Report**

### **Purpose of Report**

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

### **Executive Summary**

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

#### **Operations**

##### Three-day follow-up of all discharged inpatients

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

##### Data quality maturity index

Increasing waiting lists resulting from the pandemic continue to have a negative impact on data quality, however we would expect to consistently exceed the national target.

##### Early intervention 14-day referral to treatment

We would expect to consistently exceed the national standard for referral to treatment, meaning our patients with early onset psychosis are continuing to receive very timely access to the treatment they need.

##### Early intervention 14-day referral to treatment – incomplete

The service continues to perform consistently well against the national 14-day referral to treatment standard of 60% or more people on the waiting list to be have been waiting no more than 2 weeks to be seen.

##### IAPT 18-week referral to treatment

This is an example of a very tightly controlled process and we would expect to consistently exceed the 95% standard.

##### IAPT 6-week referral to treatment

We should expect to consistently exceed the national standard.

##### IAPT patients completing treatment who move to recovery

This is an annual target and year to date we are exceeding target. For the past 16 months the national standard has been achieved.

#### Patients placed out of area – adult acute

Significant work has been undertaken since April 2021 in order to try and reduce inappropriate out of area placements to a minimum in line with the objective of the Five Year Forward View for Mental Health (The Mental Health Taskforce, 2016) which was to eliminate inappropriate out of area placements for acute mental health care for adults by 2020/21 (including Psychiatric Intensive Care Unit (PICU) placements).

#### Patients placed out of area per day– Psychiatric Intensive Care Units

There is no PICU provision in Derbyshire so anyone needing psychiatric intensive care needs to be placed out of area. Work continues to progress towards obtaining agreement to build a Trust PICU.

#### Waiting list for care coordination – average wait

The average wait to be seen has continued to remain significantly low over the last seven months.

#### Waiting list for care coordination – number waiting

The number of people waiting to be allocated a care coordinator has been significantly low for the last 14 months.

#### Waiting list for adult autistic spectrum disorder (ASD) assessment

To meet demand, there would need to be between 54 and 67 assessments completed per month (the 65th to 85th percentile). Currently the service is funded to complete 26 assessments per month and has been averaging 20 until recently owing to sickness and vacancies.

#### Adult autistic spectrum disorder assessments per month

The commissioned target for assessments has been achieved for the last two months.

#### Waiting list for psychology

We continue see the impact of the pandemic on waits. Many patients are still waiting owing to the pandemic and a desire to be seen face to face as opposed to by video call. The average waiting time has risen slightly in the last two months. Referrals remain steady. Recruitment to a number of vacant and part time posts across adult services is in progress. However, we have nearly a 30% vacancy rate across all of psychological services, with the biggest gaps being in the community mental health teams.

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

The waiting list initiative in September and October 2021 has resulted in a significant reduction in waiting times and the number of children waiting to be seen.

#### Waiting list for community paediatrics

The complete closure of this pathway earlier this year and the subsequent reopening has resulted in a surge of referrals, including both new and repeat referrals. In March and April 2021 this was in excess of 400 and the pathway continues to receive a high volume of referrals each month. The number of children waiting currently stands at 689, some of whom are awaiting neuro-developmental assessment.

### Outpatient appointments cancelled by the Trust

The proportion of cancelled appointments was significantly higher than expected from March 2020 owing to the pandemic but for the last 16 months has been significantly lower than expected, however in the current process the 5% target is unlikely to be achieved. This financial year the most common reason recorded for cancellation has been "appointment brought forward". This is when a patient needs to be seen more urgently and so is offered an earlier appointment. The second most common reason was cancellation owing to consultant sickness.

### Outpatient appointment "did not attends"

The level of defaulted appointments has remained within common cause variation for the last 19 months and in the current process the trust target of 15% or lower is likely to be consistently achieved.

## **Other Operational Matters of Note**

### Health Protection Unit

The Health Protection Unit (HPU) is busy continuing to offer both Covid and Flu vaccinations to staff, inpatients and some community patients. There is a project underway to support those patients with severe mental illness and those most vulnerable who often experience health inequalities. We continue to work as Joined Up Care Derbyshire (JUCCD), meeting weekly with Derbyshire Community Health Services NHS Foundation Trust (DCHS). The HPU remains a supportive arm for all staff to contact and receive information and guidelines.

### Vaccination status

95% of patient facing staff have now received their first vaccination and 93% have received both vaccinations. Booster vaccinations are continuing and so far, 70% of patient facing staff have received their booster.

## **Finance**

### Revenue

<b>YTD Performance November 2021</b>	<b>Plan £m</b>	<b>Actual £m</b>	<b>Variance £m</b>
Operating income	118.090	117.517	(0.573)
Operating expenses	(114.792)	(114.009)	0.963
<b>Operating Surplus/(Deficit)</b>	<b>3.118</b>	<b>3.508</b>	<b>0.390</b>
Non-operating expenses	(2.555)	(2.933)	(0.378)
<b>Surplus/(Deficit)</b>	<b>0.563</b>	<b>0.575</b>	<b>0.012</b>

<b>Forecast outturn Performance</b>	<b>Plan £m</b>	<b>Actual £m</b>	<b>Variance £m</b>
Operating income	178.488	178.845	0.357
Operating expenses	(174.569)	(174.614)	(0.045)
<b>Operating Surplus/(Deficit)</b>	<b>3.919</b>	<b>4.234</b>	<b>0.312</b>
Non-operating expenses	(3.819)	(4.115)	(0.296)
<b>Surplus/(Deficit)</b>	<b>0.100</b>	<b>0.116</b>	<b>0.016</b>



Following submission of the H2 at the end of November, the ledger has been updated to reflect the revised H2 and therefore full year plan. All of the adjustments to the pay, non-pay and income budgets have been transacted in budgets held centrally so there has been no impact to the Divisional budgets.

In month 7 and 8 there was a planned surplus totalling £563k and actual year to date (YTD) position was a surplus of £575k. The forecast outturn is slightly above plan by £16k.

Clinical income has been forecast based on the new Clinical Commissioning Group (CCG)/NHSE allocations contained in the H2 plan which have been adjusted for the pay award, including the backpay related to H1. Other adjustments for increased service developments have also been forecast in line with the revised CCG allocations for both income and expenditure. As the income allocations were based on recruitment assumptions at a point in time, no slippage against the revised allocation has been reported in the current position.

Pay is forecast to be underspent by £1.0m which was all generated in H1 due to slippage on investments and general vacancies.

Non-pay is forecast to be above plan by £1.4m, of which £744k related to overspend in H1 plus further additional spend in H2.

#### Efficiencies

The full year plan includes an efficiency require of £2.3m mainly phased in the second half of the financial year. The forecast at month 8 assumes that this will be over delivered by £0.2m.

#### Agency

At the end of month 8 agency expenditure is above the ceiling by £1.12m which equates to 55%. The two highest areas of agency spend relates to medical staff and ancillary staff (mainly domestics). The forecast assumes that agency costs will reduce slightly over the remaining months of the financial year but is still generating forecast spend of £4.7m which is above the ceiling by £1.6m (54%). The forecast does include a contingency of £60k for any unforeseen agency usage.

#### Out of Area Placements

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

#### Covid costs

The Trust has an allocation of £0.7m a month for months 1-8 for Covid-related expenditure. The year-to-date expenditure is currently below that allocation by £0.5m.

#### Capital

With regards to self-funded capital, the Trust is slightly above plan at the end of month 8 by £0.9m and it is now forecast to be above plan by £0.3m by the end of the financial year. The above-plan forecast expenditure is related to the self-funded elements of the dormitory eradication programme, PICU and acute-plus

plans and is therefore part of system discussions on capital prioritisation for use of system capital departmental expenditure limit (CDEL).

The Trust has received additional Public Dividend Capital (PDC) funding for the initial stages of the dormitory eradication programme, this is the year two element of the original Memorandum of Understanding (MOU). Further funding has been agreed for the dormitory eradication programme with allocations totalling £80m over the next three years.

#### Cash

Cash is at £41m at the end of November. For the remaining months of the financial year cash remains steady around £39m each month.

#### **People**

##### Annual appraisals

The appraisal process is now recommencing for full appraisals across all services. In the interim they were replaced by a structured wellbeing conversation and health risk assessment reviews were to be kept up to date.

##### Annual turnover

The rate of turnover has been higher than the Trust target range of 8-12% for the last three months. Retention is an issue where other mental health trusts across the Midlands are offering incentives to attract and retain staff. We are looking at all options to address this and building upon our excellent reputation as a good local employer.

##### Compulsory training

A recovery plan continues to improve training compliance. Operational Services are currently above target at 87% compliant.

##### Staff absence

Sickness absence rates have increased gradually over the last 3 months with the greatest increase in short term absence. This is largely due to coughs, colds and flu like symptoms and COVID-19 absence, including vaccination recovery.

##### Supervision

The levels of compliance with the clinical and management supervision targets have remained low since the start of the pandemic, with higher levels seen in Operational Services than in Corporate Services..

##### Proportion of posts filled

Prior to the start of this financial year there were a number of factors that artificially lowered the vacancy rate; however, this has now been adjusted for at the start of the financial year. There has been a steady improvement in our recruit to post rate with the number of vacancies going to advert now reducing month on month.

##### Bank staff

Following a period of seven months of unusually high bank staff use, in recent times the position has returned to common cause variation.

## Quality

### Compliments

The number of compliments decreased in line with the emergence of COVID-19 and the significant changes to many of our clinical services. As a result of reduced face to face contact, there has been a drop in the number of compliments received. Work is underway to improve feedback from service users via an electronic survey received by text or email.

### Complaints

The number of complaints increased with a particular theme around both concerns and complaints of access to services.

### Delayed transfers of care

The number of delayed transfers of care (DTC) has increased in line with targeted work with teams around identifying and documenting DTCs.

### Care plan reviews

The proportion of patients whose care plans have been reviewed continues to be lower than usual. However, as can be seen there is a positive trajectory and improvements in the percentage of reviewed care plans.

### Patients in employment

Around a third of patients have no employment status recorded. For those with a recorded status, almost 47% are unemployed. The Individual Placement Support (IPS) service continues to have success in supporting people into employment even during the current pandemic and the service is currently expanding.

### Patients in settled accommodation

Around a third of patients have no accommodation status recorded. For those with a recorded status, just under 2% are recorded as being homeless.

### Medication incidents

The medicines management operational subgroup are currently revising the medication error procedure, taking into account Trust values and the Acute Inpatient Matrons are in the process of updating the relevant policies which will reduce the number of insignificant incidents.

### Incidents of moderate to catastrophic actual harm

The number of reported incidents of moderate to catastrophic harm have remained within common cause variation throughout the reporting period.

### Duty of Candour

There have been four instances of Duty of Candour in the last three months. This comes in line with reports being finished and signed off by the executive serious incident group resulting in pockets of data increase.

### 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 forums. Data analysis and review has shown that even where restraint and seclusion has increased, the use of prone restraint has continued to reduce.

### Physical restraint

The number of reported incidents involving restraint have remained within common cause variation throughout the reporting period. It is important to highlight that a common impacting factor to restrictive practice is increased use of bank, vacancies, increased sickness, staffing challenges and concerns relating to closed culture.

### Seclusion

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

### Falls on inpatient wards

The new Matron and Head of Nursing for the older adult areas have been working on reducing falls across the inpatient areas. It is important to acknowledge that falls have also been occurring on Pleasley Ward, a mixed older adult and working age adult ward which provides challenge in training and implementing change.

### Care Hours per Patient Day

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

## **Strategic Considerations**

1)	We will deliver <b>great care</b> by delivering compassionate, person-centred innovative and safe care	X
2)	We will ensure that the Trust is a <b>great place to work</b> by attracting colleagues to work with us who we develop, retain and support by excellent management and leadership	X
3)	We will make the <b>best use of our money</b> 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.

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

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

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

## **Recommendations**

The Board of Directors is requested to:

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

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

**Report prepared by: Peter Henson  
Head of Performance**  
**Rachel Leyland  
Deputy Director of Finance**  
**Celestine Stafford  
Assistant Director People & Culture Transformation**  
**Kyri Gregoriou  
Assistant Director of Clinical Professional Practice**

## Assurance Summary

Metric Name	Variation	Assurance	Latest Value	Target	Lower process limit	Upper Process limit	Mean
1	3 day follow-up		93%	80%	77%	100%	89%
2	Data quality maturity index		97%	95%	97%	98%	98%
3	Early intervention 14 day referral to treatment - complete		88%	60%	68%	108%	88%
4	Early intervention 14 day referral to treatment - incomplete		79%	60%	62%	113%	87%
5	IAPT 18 week referral to treatment		100%	95%	100%	100%	100%
6	IAPT 6 week referral to treatment		87%	75%	80%	97%	88%
7	IAPT patients completing treatment who move to recovery		58%	50%	45%	63%	54%
8a	Average patients out of area per day - adult acute		0		0	15	8
8b	Patients placed out of area - adult acute		0		3	25	14
9a	Average patients out of area per day - PICU		17		9	21	15
9b	Patients placed out of area - PICU		26		19	33	26
10a	Waiting list - care coordination - average wait to be seen		12		13	31	22
10b	Waiting list - care coordination - number waiting at month end		38		19	59	39
11a	Waiting list - ASD assessment - average wait to be seen		68		53	60	57
11b	Waiting list - ASD assessment - number waiting at month end		1,406		1051	1183	1117
11c	ASD assessments		27	26	4	33	19
12a	Waiting list - psychology - average wait to be seen		49		32	40	36
12b	Waiting list - psychology - number waiting at month end		762		732	930	831
13a	Waiting list - CAMHS - average wait to be seen		10		16	22	19
13b	Waiting list - CAMHS - number waiting at month end		333		354	483	418
14a	Waiting list - community paediatrics - average wait to be seen		15		9	15	12
14b	Waiting list - community paediatrics - number waiting at month end		990		567	848	708
15	Outpatient appointments cancelled by the Trust		8%	5%	4%	18%	11%
16	Outpatient appointment "did not attends"		12%	15%	9%	15%	12%
17	Annual appraisals		72%	85%	72%	78%	75%
18	Annual turnover		13%	8-12%	10%	12%	11%
19	Compulsory training		85%	85%	82%	88%	85%
20	Staff absence		7%	5%	5%	8%	6%
21	Clinical supervision		73%	95%	71%	79%	75%
22	Management supervision		74%	95%	74%	80%	77%
23	Filled posts		89%	100%	87%	92%	90%
24	Bank staff use		6%	5%	5%	7%	6%
25	Compliments received		93	119	59	146	102
26	Formal complaints received		21	13	4	25	14
27	Delayed transfers of care		0%	3.5%	-0.6%	1.7%	0.6%
28	CPA reviews		93%	95%	89%	95%	92%
29	Patients in employment		10%		10%	11%	11%
30	Patients in settled accommodation		47%		56%	61%	58%

Key to symbols <sup>1</sup> :	Variation	Assurance
Special Cause Concerning variation	Special Cause Improving variation	Consistently hit target
Common Cause	Common Cause	Hit and miss target subject to random
Consistently fail target		

Blue dots indicate special cause variation, better than expected.

Orange dots indicate special cause variation, worse than expected.

<sup>1</sup>The rating symbols were designed by NHS Improvement

Metric Name		Variance	Assurance	Latest Value	Target	Lower process limit	Upper process limit	Mean
31	Number of medication incidents			44		22	81	51
32	No. of incidents of moderate to catastrophic actual harm			58	48	16	80	48
33	No. of incidents requiring Duty of Candour			0	1	-2	4	1
34	No. of incidents involving prone restraint			7	12	-2	22	10
35	No. of incidents involving physical restraint			33	46	-1	89	44
36	No. of new episodes of patients held in seclusion			16	14	-1	32	16
37	No. of falls on inpatient wards			25	30	8	47	28

Key to symbols <sup>1</sup> :	<b>Variation</b> Special Cause Concerning variation Special Cause Improving variation Common Cause Common Cause				<b>Assurance</b> Consistently hit target Hit and miss target subject to random Consistently fail target			Blue dots indicate special cause variation, better than expected.
							Orange dots indicate special cause variation, worse than expected.	
<sup>1</sup> The rating symbols were designed by NHS Improvement								

## Operational Services Performance Summary

Indicator	Target	Position Nov 2021	National benchmark	Divisional Breakdown <sup>1</sup>						Run Chart
				AA	AC	Ch	F&R	OP	Psy	
● 3-day follow-up	80%	93%	76%	94%			100%	86%	100%	
● Data quality maturity index	95%	97%	81%	94%	97%	86%	96%	98%	98%	97%
● Early intervention 2-week referral to treatment	60%	88%	68%		88%					
● Early intervention current waits under 2 weeks	60%	85%	67%		85%					
● IAPT 18-week referral to treatment	95%	99.8%	99%						99.8%	
● IAPT 6-week referral to treatment	75%	87%	92%						87%	
● IAPT recovery rate	50%	58%	50%						58%	
● Adult acute out of area placements – daily average	0	0	11	0						
● PICU out of area placements – daily average	0	17	4	17						
● Care coordination average wait to be seen (weeks)	n/a	12	n/a	No data						
● Adult ASD assessment average wait (weeks)	n/a	68	n/a						68	
● Adult ASD assessments	26	27	n/a						27	
● Psychology average wait to be seen (weeks)	n/a	49	n/a						49	
● CAMHS average wait to be seen (weeks)	4 <sup>2</sup>	10	n/a		10					
● Paediatrics average wait to be seen (weeks)	18	15	14		15					
● Outpatient appointment Trust cancellations	5%	8%	n/a	10%	6%	3%	11%	18%		
● Outpatient appointments not attended (DNAs)	15%	12%	n/a	17%	4%	4%	3%	12%		

<sup>1</sup> Key: AA Adult Acute Care, AC Adult Community Care, Ch Children's Services, F&R Forensic & Mental Health Rehabilitation, Psy Psychology and SC Specialist Care Services

<sup>2</sup> Proposed access standard ([NHSE](#))



## **Performance Summary**

### Three-day follow up

The national standard for follow-up has again been consistently achieved by all Divisions and continues to exceed the national average. This process is tightly monitored by the Trust's Performance Analyst, who routinely chases up the relevant teams prior to any potential breaches.

### Early intervention and talking therapy (IAPT)

The services perform consistently highly in terms of patients accessing services in a timely manner. The effectiveness of IAPT is seen in the recovery rate which is higher than the national standard and the national average.

### Data quality maturity index

Overall, we continue to perform consistently highly against this standard. The two Divisions who are being reported as below target are Adult Acute and Children's Services (CAMHS). A number of inaccuracies with the CAMHS reported position have been identified linked to SystemOne. This is yet to be resolved.

### Adult acute inappropriate out of area placements

Significant progress has been made on reducing inappropriate out of area adult acute placements and in November there were none at all.

### PICU inappropriate out of area placements

Although these are classed as inappropriate according to the national definition, we are one of the few Trusts in the country without a PICU and so have no choice. The bid for a PICU new build in Derbyshire continues to progress.

### Adult ASD assessment

To meet demand, there would need to be between 54 and 67 assessments completed per month (65th to 85th percentile). Currently the service is funded to complete 26 assessments per month. The commissioned target for assessments has been achieved for the last 2 months.

### Waiting times for psychology

We continue see the impact of the pandemic on waits. Many patients are still waiting owing to the pandemic and a desire to be seen face to face as opposed to by video call. The average waiting time has risen slightly in the last 2 months. Referrals remain steady. Recruitment to a number of vacant and part time posts across adult services is in progress. However, we have nearly a 30% vacancy rate across all of psychological services, with the biggest gaps being in the community mental health teams.

## Waiting times for Child and Adolescent Mental Health Services (CAMHS)

The waiting list initiative in September and October 2021 has resulted in a significant reduction in waiting times, however they remain higher than the national aspiration of four weeks.

## Waiting times for community paediatric outpatients

Waiting times to be seen remained well within the national standard of 18 weeks and were very slightly higher than the national average.

## Outpatient appointments cancelled by the Trust

The proportion of cancelled appointments has been higher than target in all Divisions except Forensic & Mental Health Rehabilitation. The most common reason recorded for cancellation was “appointment brought forward”. This is when a patient needs to be seen more urgently and so is offered an earlier appointment. The second most common reason was cancellation owing to consultant sickness.

## Outpatient appointment “did not attend”

The level of defaulted appointments was below target in all division except adult community.

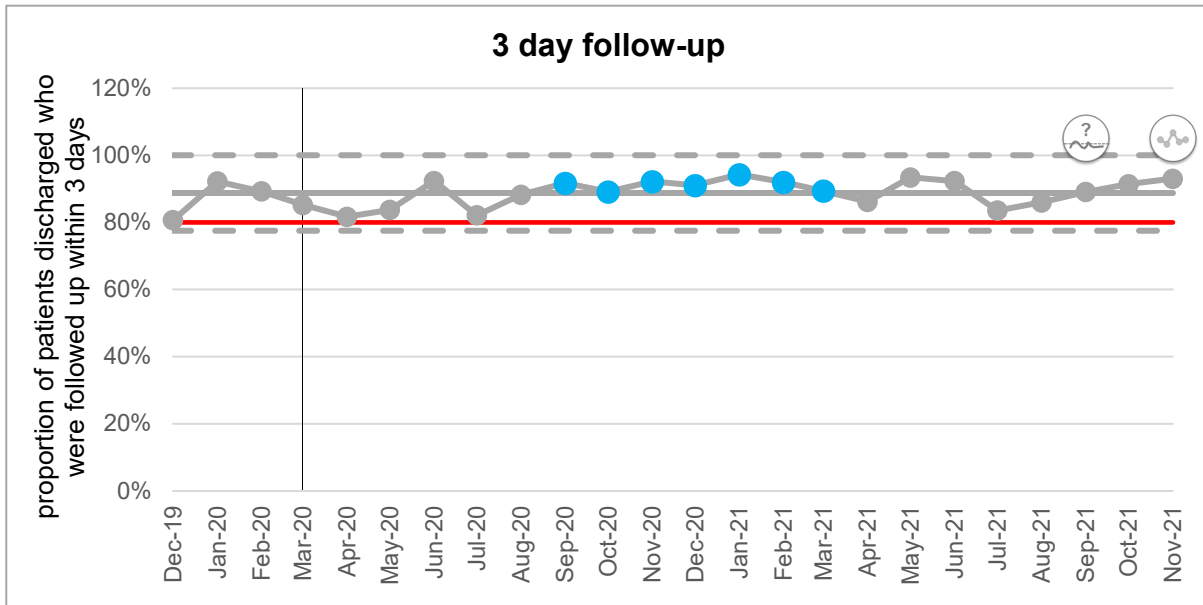
## **Benchmarking Sources**

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

**Detailed Narrative**

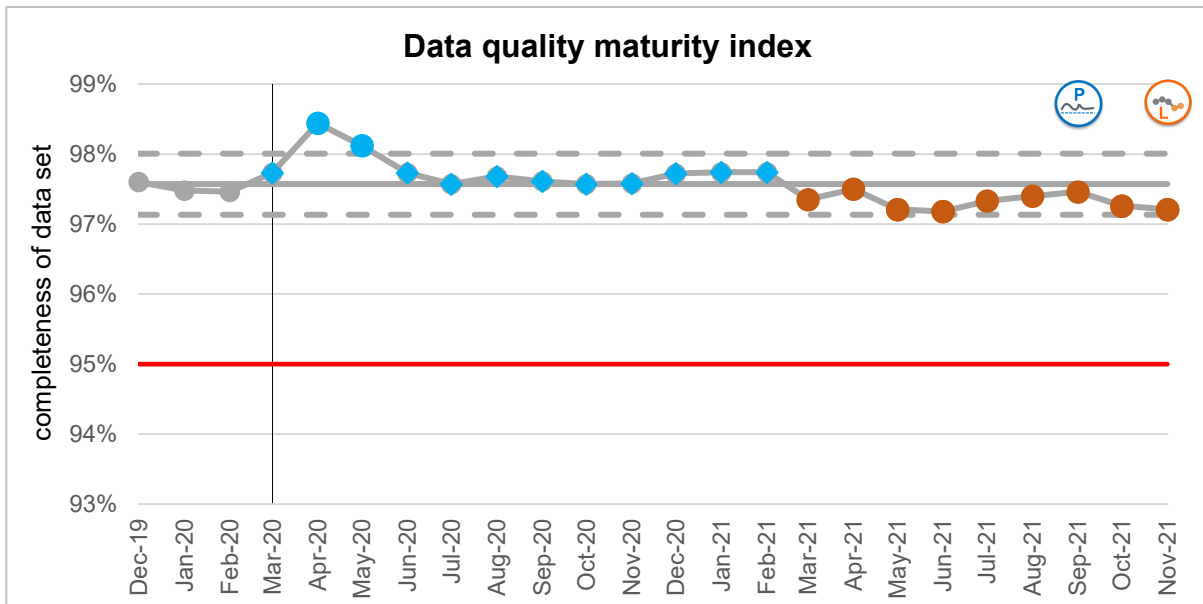
**Operations**

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



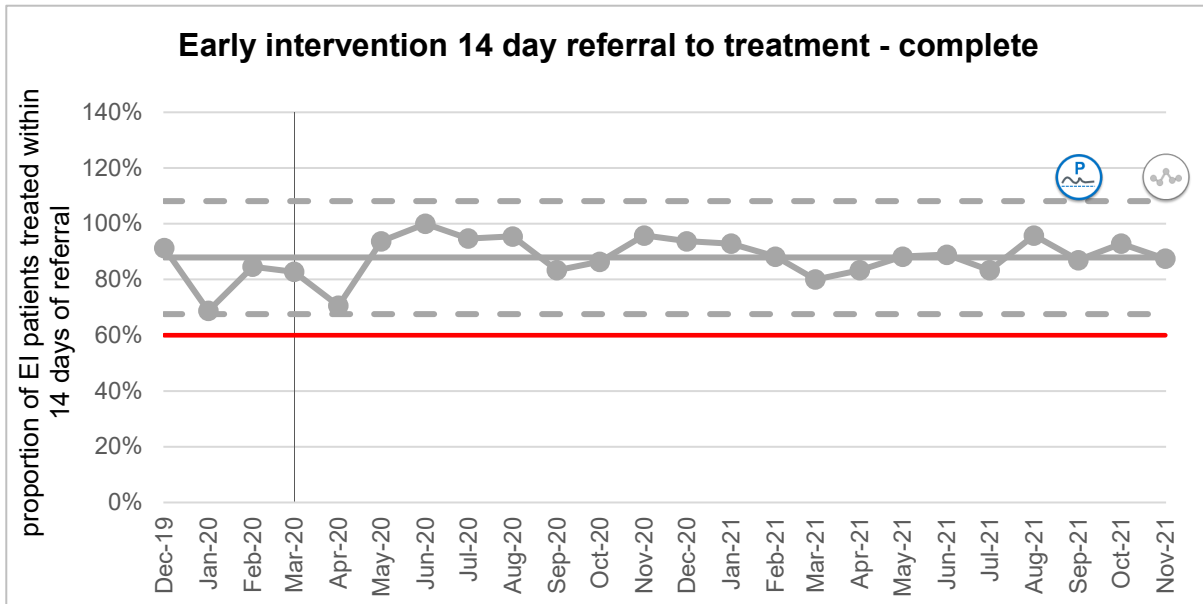
Patients are followed up in the days following discharge from mental health inpatient wards to provide support and ensure their wellbeing during the period when they are at their most vulnerable. To date we have consistently exceeded the national standard for follow-up which came into effect from 1 April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

2. Data quality maturity index



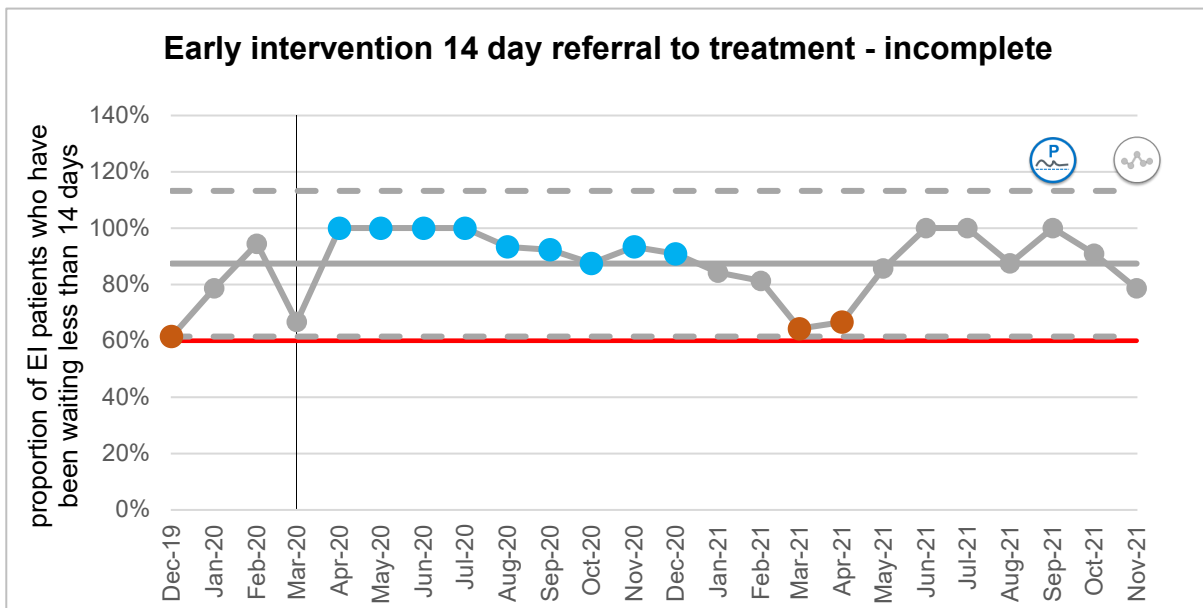
Increasing waiting lists resulting from the pandemic continue to have a negative impact on data quality, however we would expect to consistently exceed the national target. Our level of data quality is high when benchmarked with other Trusts (see appendix 2).

3. Early intervention 14-day referral to treatment



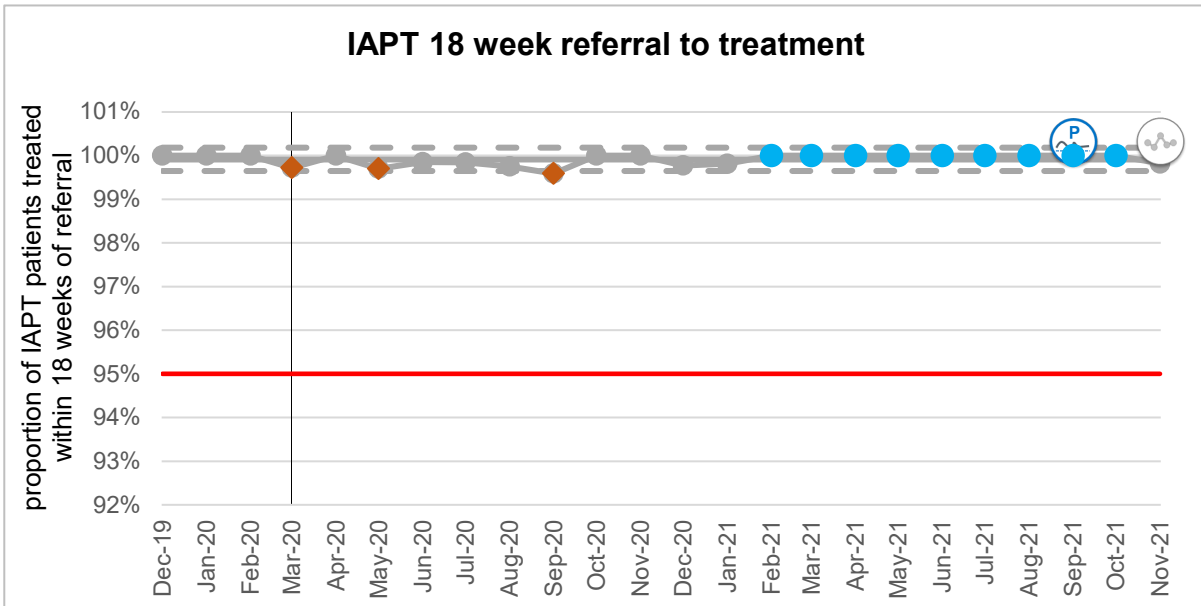
We have continued to see common cause variation throughout the 24-month period. We would expect to consistently exceed the national standard for referral to treatment, meaning our patients with early onset psychosis are continuing to receive very timely access to the treatment they need.

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



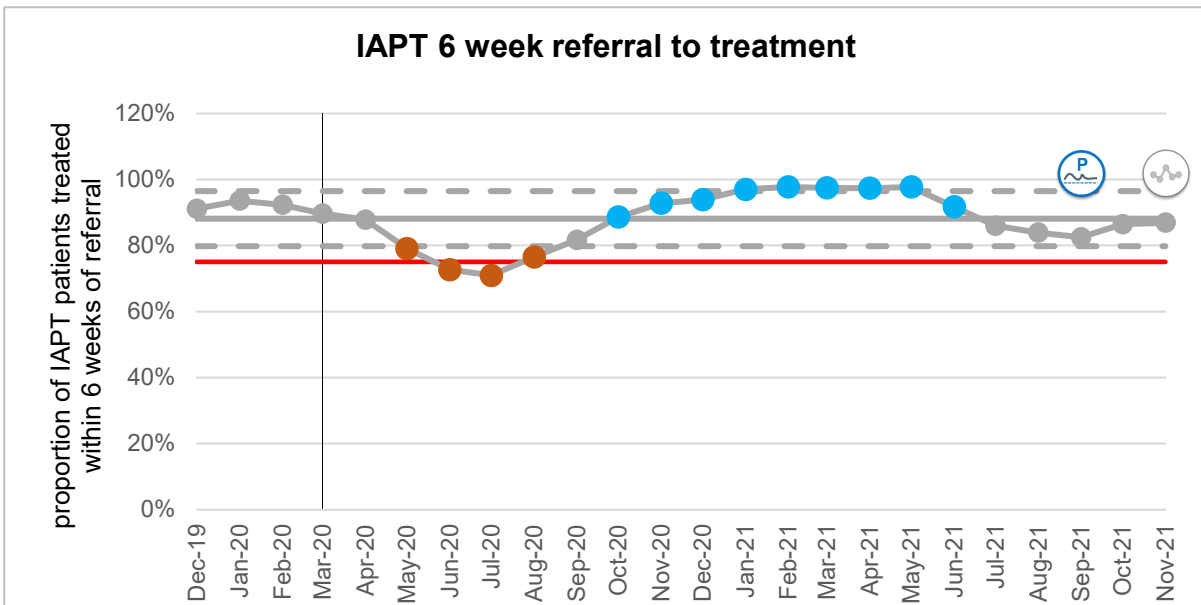
The service continues to perform consistently well against the national 14-day referral to treatment standard of 60% or more people on the waiting list to be have been waiting no more than 2 weeks to be seen. The target has been achieved throughout the 24-month period, and for the last seven months we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

5. IAPT 18-week referral to treatment



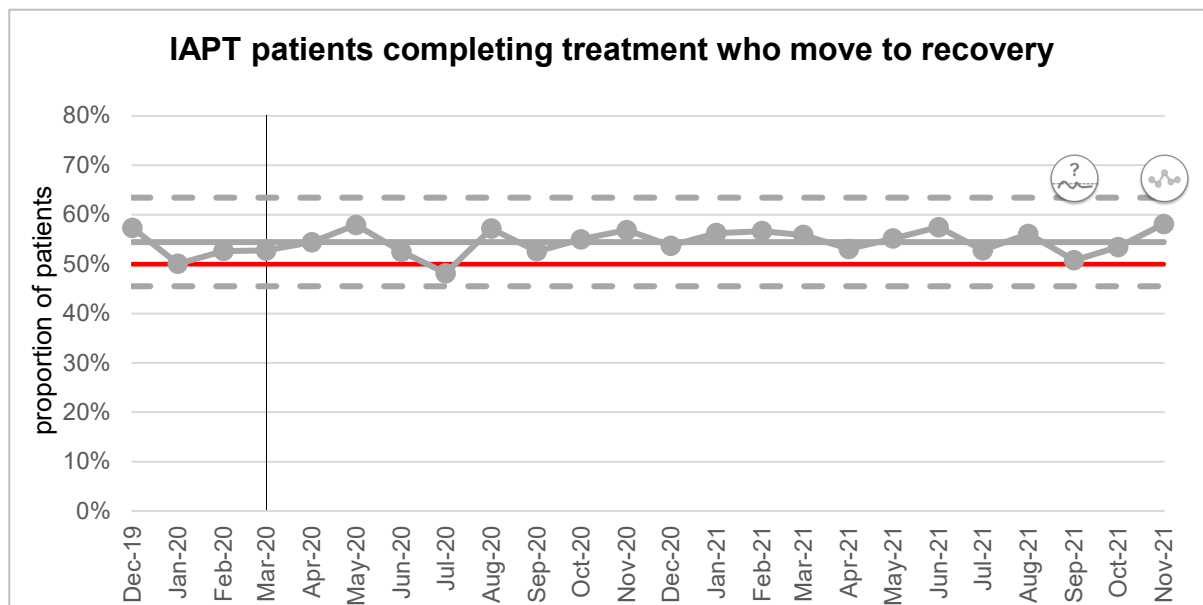
This is an example of a very tightly controlled process and we would expect to consistently exceed the 95% standard. The national target has been exceeded throughout the 24-month reporting period.

6. IAPT 6-week referral to treatment



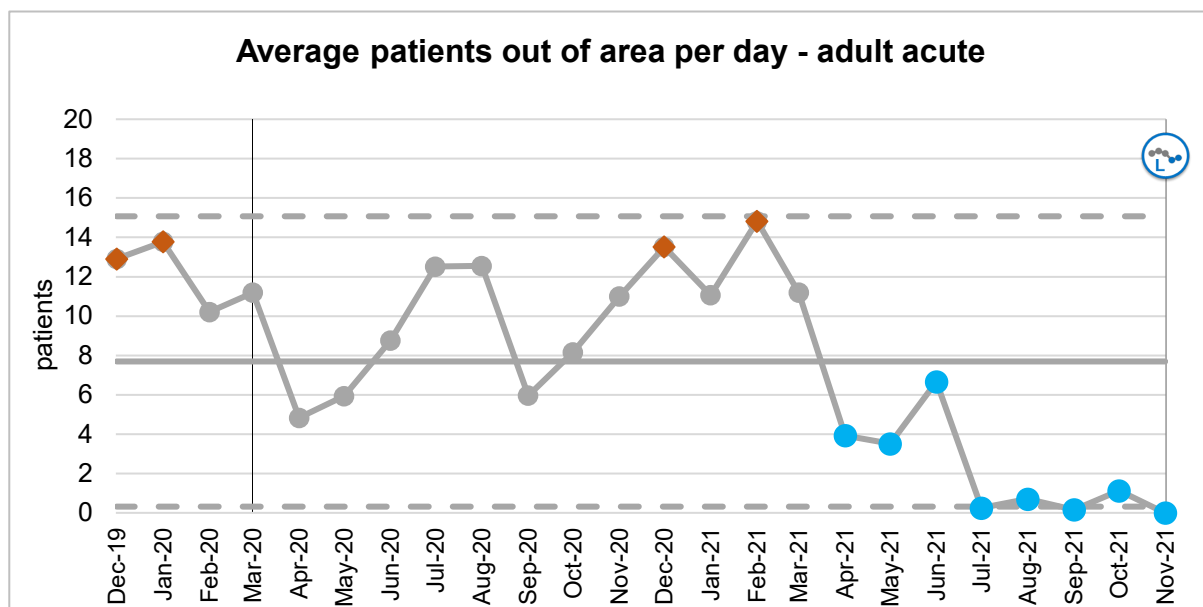
Following a period of seven months of special cause concerning variation as a result of staff being redeployed to support other services as the pandemic progressed, the staff returned to IAPT in November 2020 and for nine months performance was significantly better than expected before returning to common cause variation. We should expect to consistently exceed the national standard.

7. IAPT patients completing treatment who move to recovery



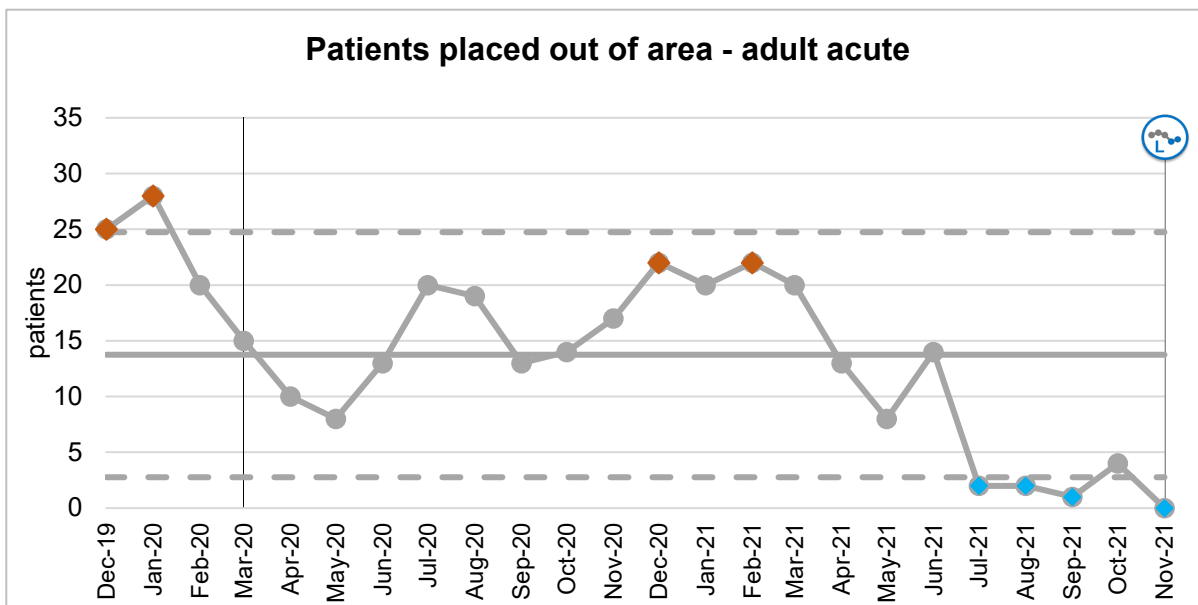
This is an annual target and year to date we are exceeding target. For the past 16 months the national standard has been achieved, with common cause variation seen throughout the data period.

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

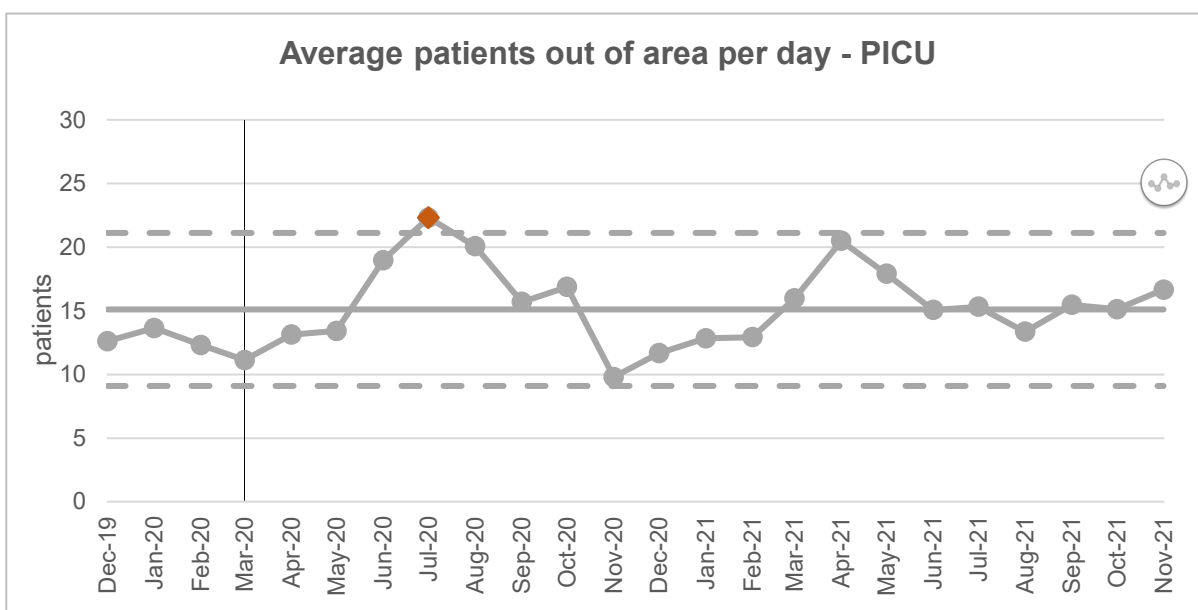


In order to facilitate social distancing and cohorting, we continue to operate with ten fewer Trust adult acute beds than were in use before the pandemic. We are continuing to commission 11 beds at Mill Lodge, Kegworth in order to make up the shortfall. These beds are classed as appropriate placements as they are based within Derbyshire and we have achieved continuity of care standards. Significant work has been undertaken since April 2021 in order to try and reduce inappropriate out of area placements to a minimum in line with the objective of the *Five Year Forward View for Mental Health* (The Mental Health Taskforce, 2016) which was to eliminate inappropriate out of area placements for acute mental health care for adults by 2020/21 (including PICU placements).

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

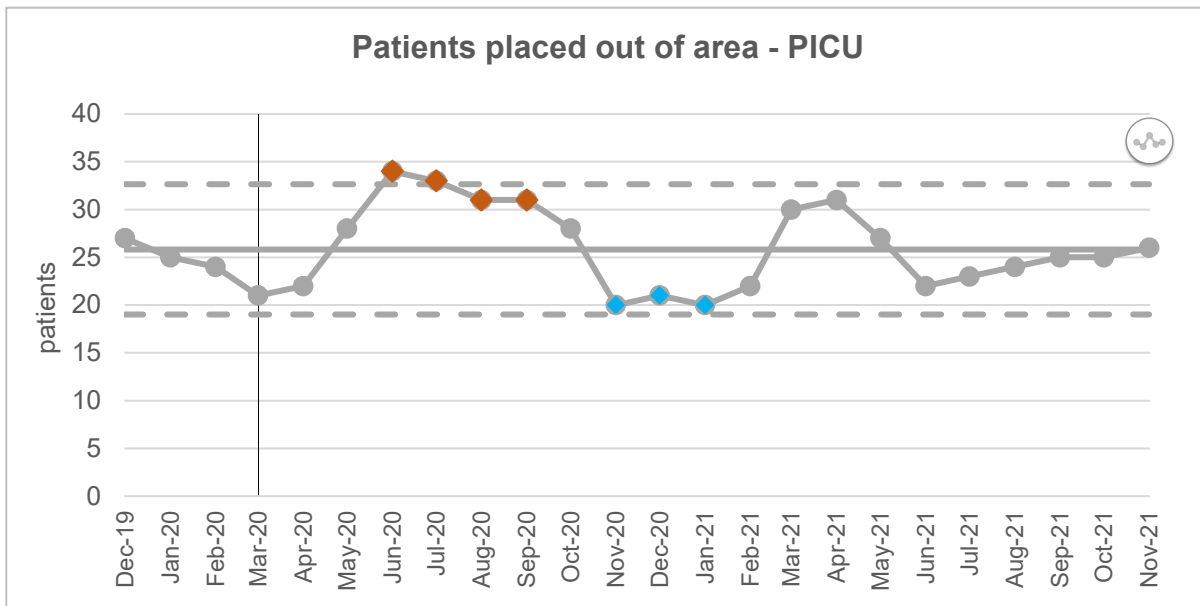


9a. Average number of patients placed out of area per day– Psychiatric Intensive Care Units

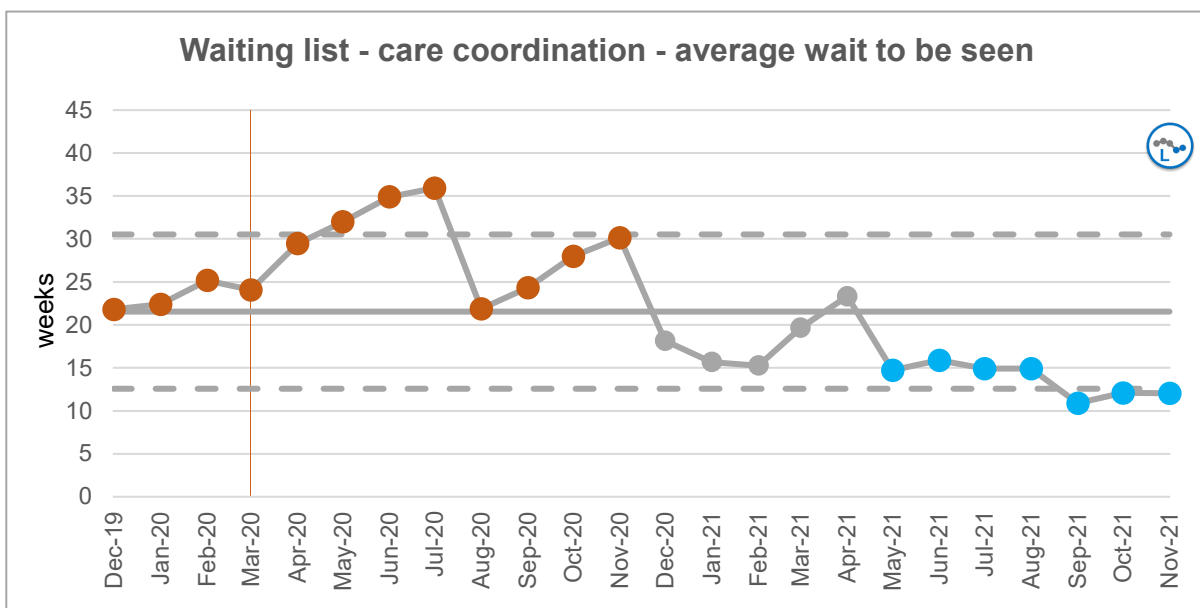


There is no PICU provision in Derbyshire so anyone needing psychiatric intensive care needs to be placed out of area. Work continues to progress towards obtaining agreement to build a Trust PICU. In the meantime, PICU usage has remained within common cause variation for the last 16 months.

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



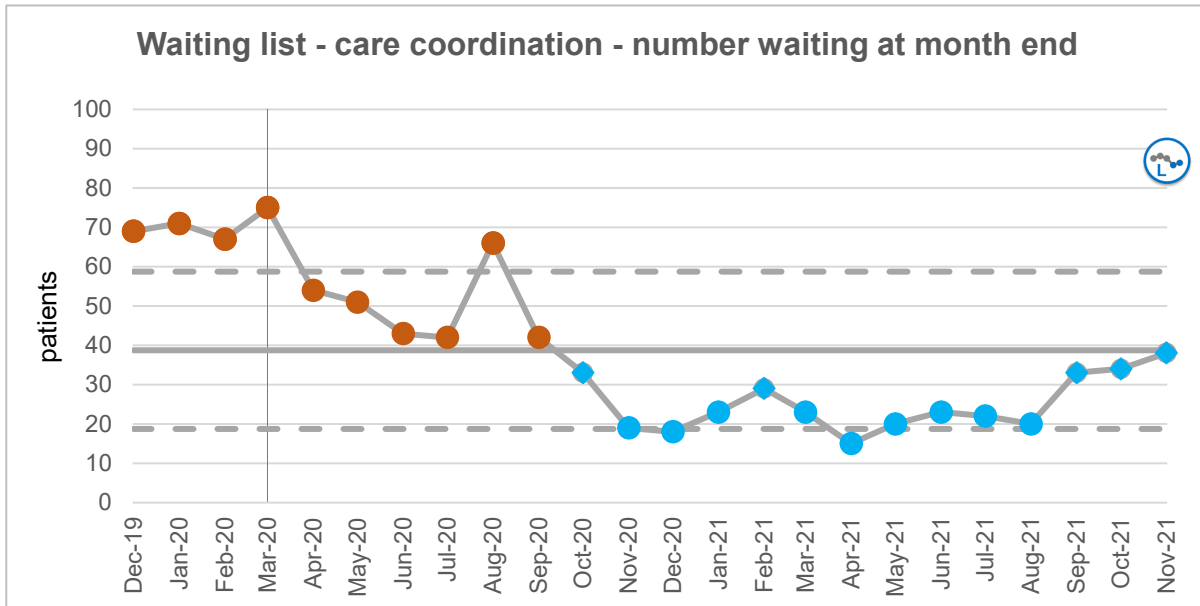
10a. Waiting list for care coordination – average wait



The average wait to be seen has continued to remain significantly low over the last seven months.

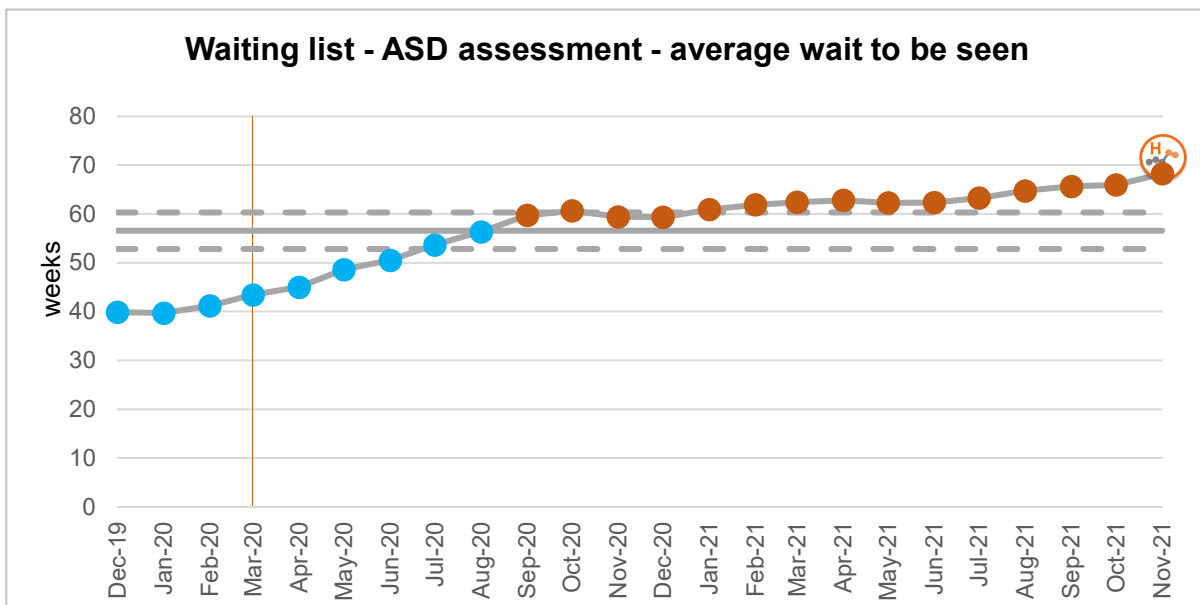


10b. Waiting list for care coordination – number waiting



The number of people waiting to be allocated a care coordinator has been significantly low for the last 14 months.

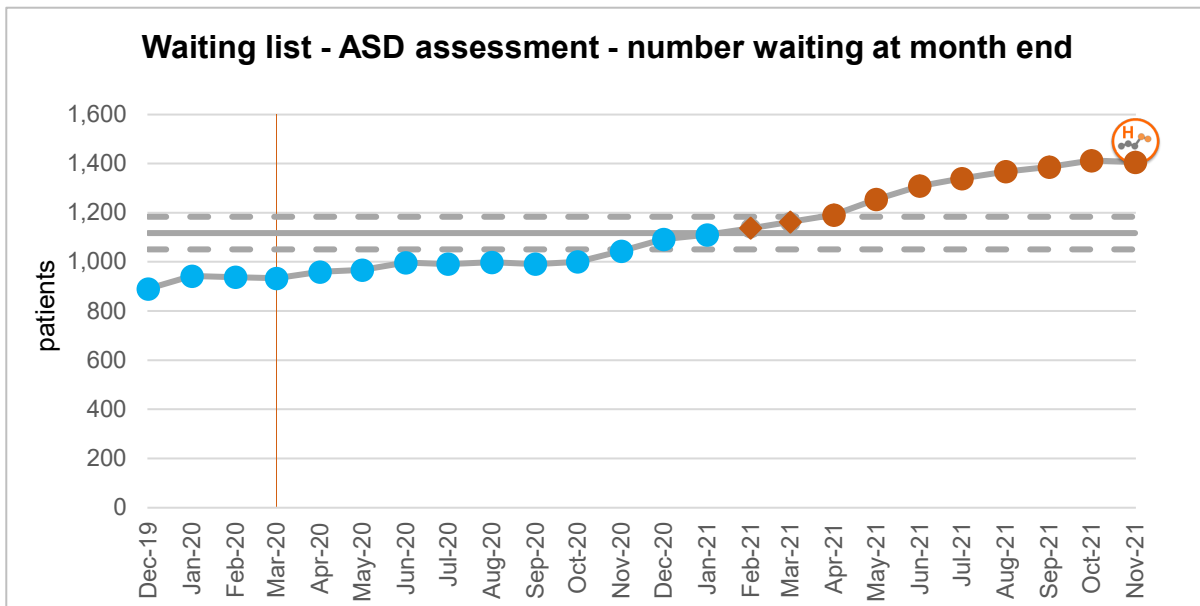
11a. Waiting list for adult autistic spectrum disorder (ASD) assessment – average wait



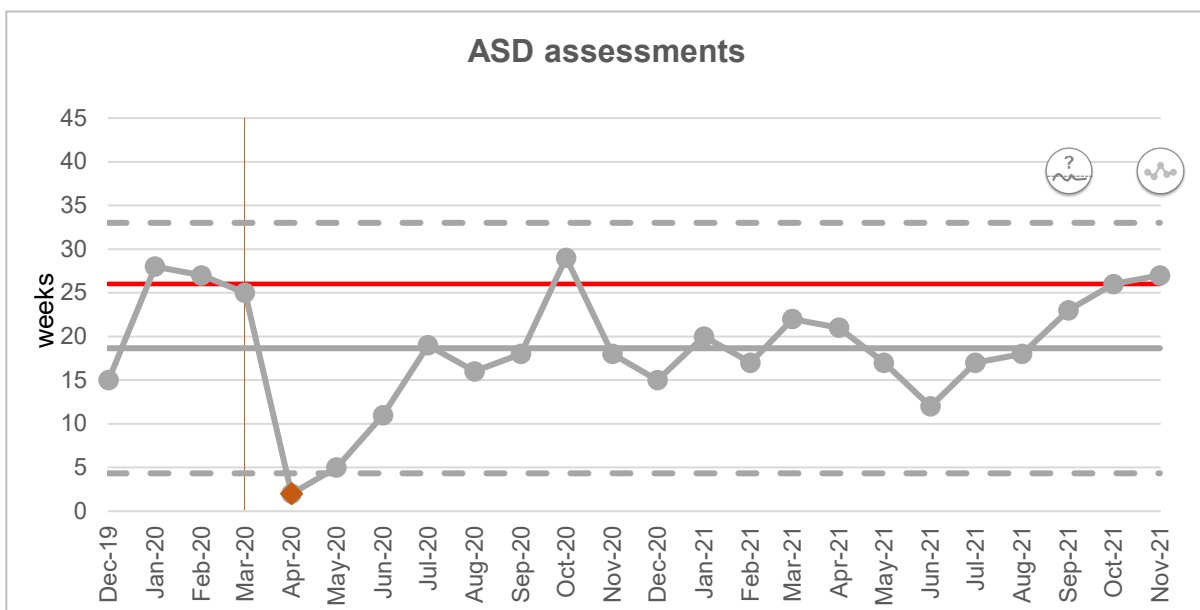
This still remains high. To meet demand, there would need to be between 54 and 67 assessments completed per month (the 65th to 85th percentile). Currently the service is funded to complete 26 assessments per month and has been averaging 20 until recently owing to sickness and vacancies. The current adult autism spectrum disorder ASD waiting list is now 1401 people, with the longest wait now almost 3½ years. The situation is likely to continue to worsen until there is a change to investment in the service.

Further, next month there will be a drop in assessments completed owing to the absence of two of the team as a result of unforeseen life events.

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



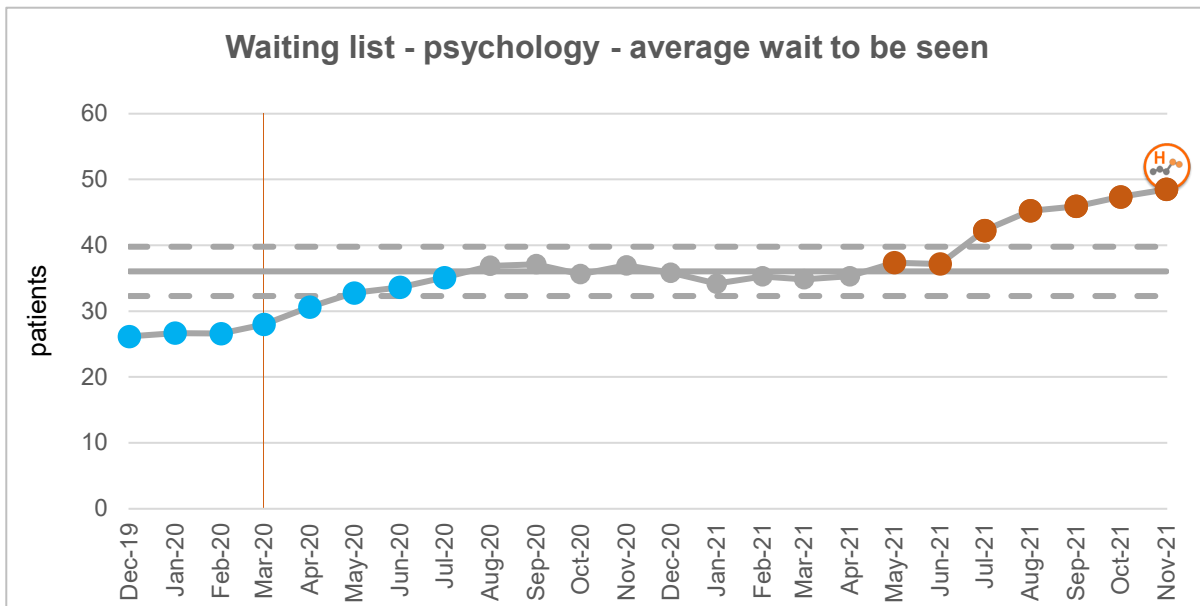
11c. Adult autistic spectrum disorder assessments per month



The commissioned target for assessments has been achieved for the last 2 months. We are continuing with our COVID-19 recovery plans. We have identified locations, timings and protocols for safe COVID-19 face to face appointments. All team members are continuing to alternate between offering some face-to-face appointments and some online appointments.

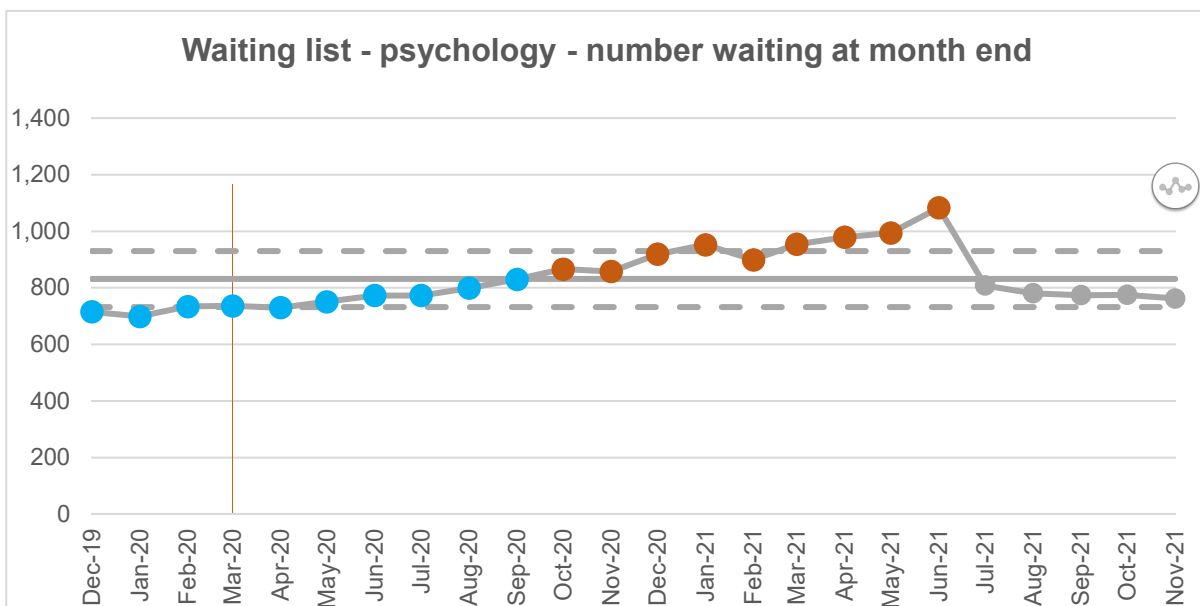
Further, we have now employed an assistant psychologist who starts in January 21, to try and support the assessing team. We are also discussing the availability of an external provider being contracted to complete a number of assessments to support trying to reduce the waiting list and provide more timely assessments.

12a. Waiting list for psychology – average wait



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

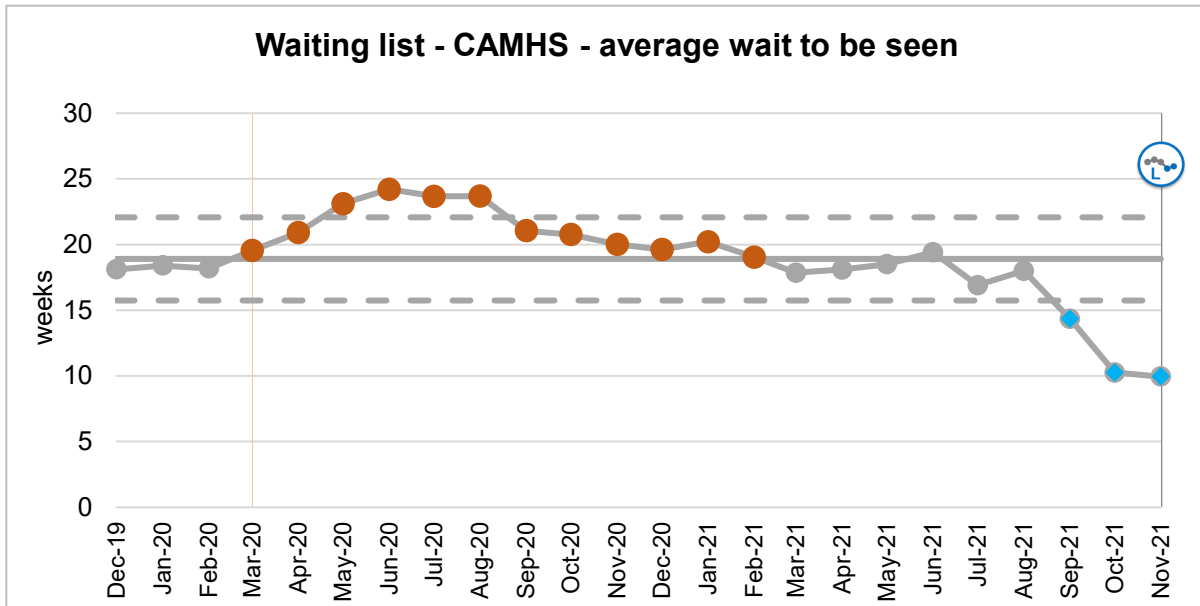
12b. Waiting list for psychology – number waiting



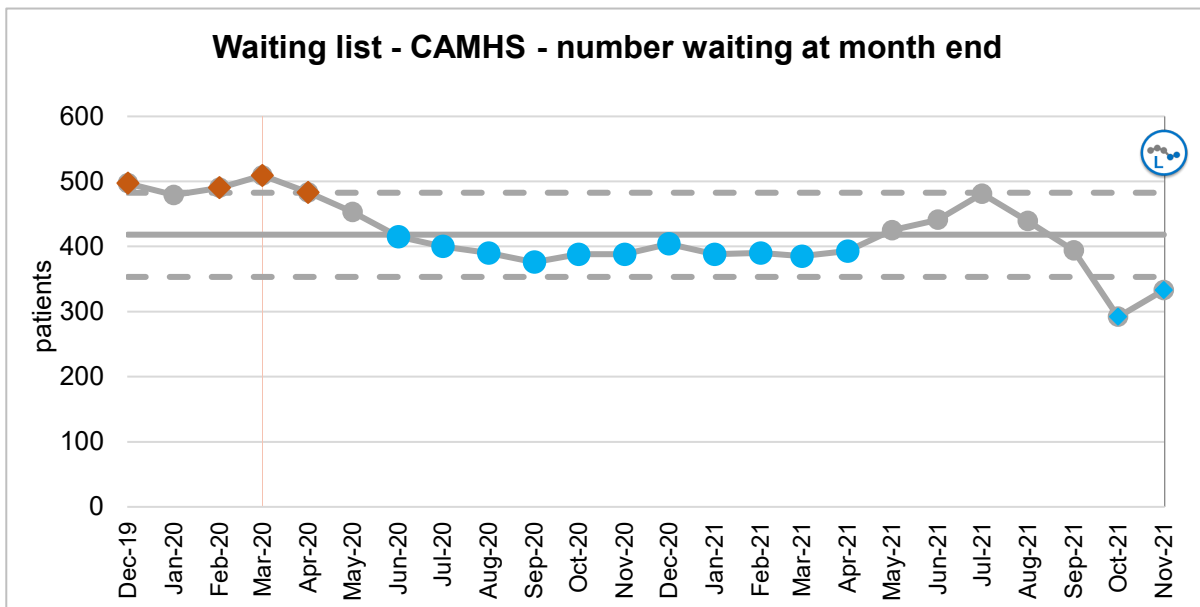
The number of people waiting has been below average for the last 5 months. Recruitment to a number of vacant and part time posts across adult services is in progress. However, we have nearly a 30% vacancy rate across all of psychological services, with the biggest gaps being in the community mental health teams (CMHTs).

We have continued to review the waiting lists in line with trauma sensitive working in considering how we manage people on a waiting list and barriers of movement between services. The need for increased access to psychological services is being considered with a mapping exercise across all of the CMHTs being completed.

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

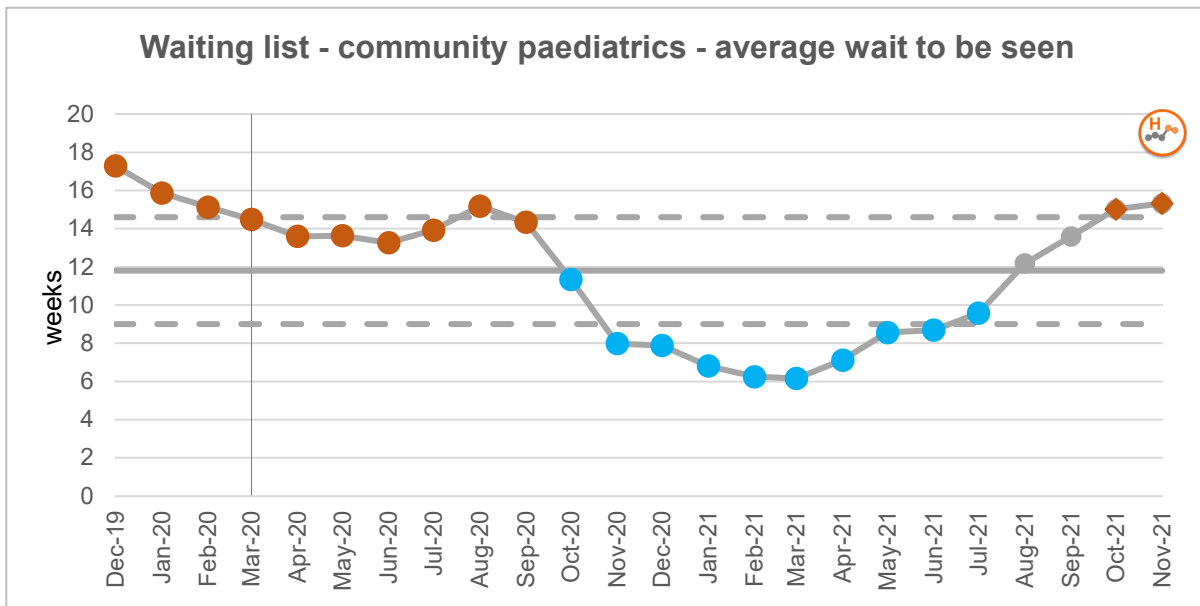


13b. Waiting list for Child and Adolescent Mental Health Services – number waiting

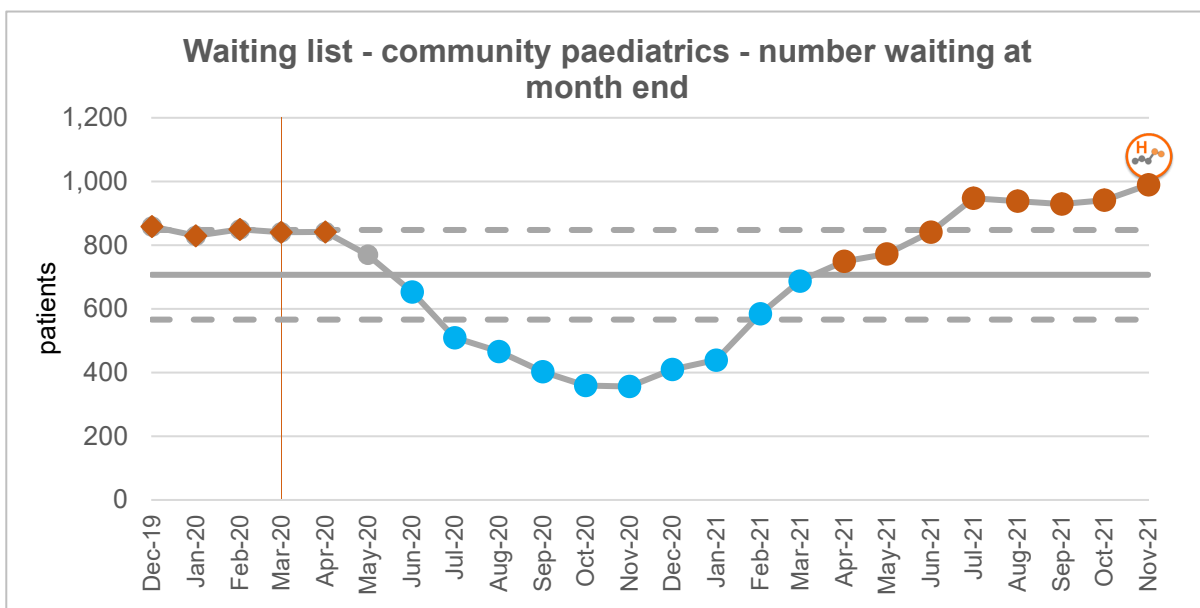


The waiting list initiative in September and October 2021 has resulted in a significant reduction in waiting times and the number of children waiting.

14a. Waiting list for community paediatrics – average wait

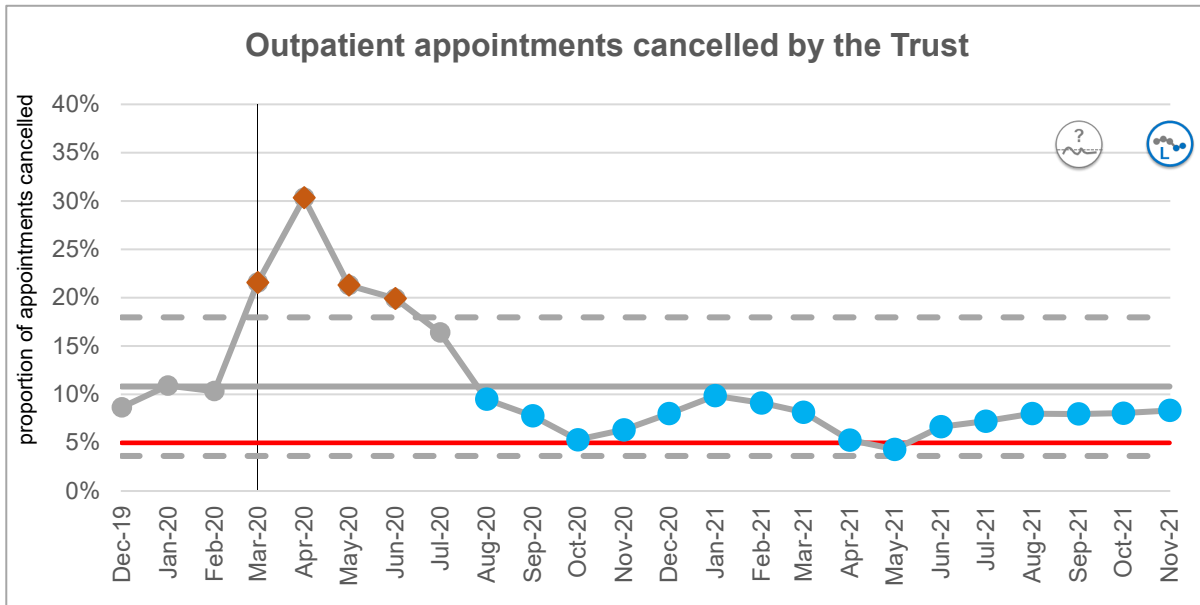


14b. Waiting list for community paediatrics – number waiting



The complete closure of this pathway earlier this year and the subsequent reopening has resulted in a surge of referrals, including both new and repeat referrals. In March and April 2021 this was in excess of 400 and the pathway continues to receive a high volume of referrals each month. The number of children waiting currently stands at 689, some of whom are awaiting neuro-developmental assessment of which there is ongoing development and a new Speciality Doctor has been appointed for 12 months. There has been a steady increase in waiting times since the Summer which is regularly updated on the risk register; we also have sickness and a vacancy. To mitigate we have a locum in post currently until March 2022 for three days per week and following a number of failed attempts to recruit a substantive community paediatrician we have redesigned the job description in the hope it will be more appealing. We are awaiting approval from the Royal College before this is readvertised. The centralised approach has allowed for flexibility across the city and county when areas have received high numbers of referrals which has helped manage the flow. In addition, the substantive appointment of the Waiting List Coordinator helps us to understand and manage the waiting times better.

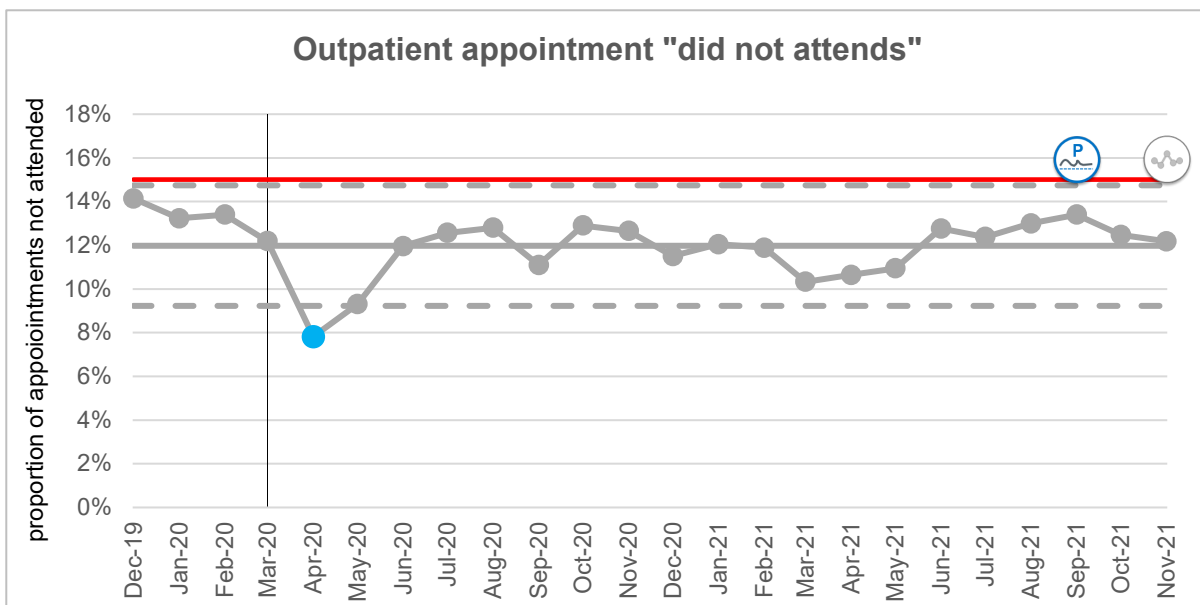
15. Outpatient appointments cancelled by the Trust



The proportion of cancelled appointments was significantly higher than expected from March 2020 owing to the pandemic but for the last 16 months has been significantly lower than expected, however in the current process the 5% target is unlikely to be achieved. This financial year the most common reason recorded for cancellation has been “appointment brought forward”. This is when a patient needs to be seen more urgently and so is offered an earlier appointment. The second most common reason was cancellation owing to consultant sickness.

The Trust operates a virtual clinic system with the aim of limiting the number of cancellations. The patient is unaware of the appointment until the appointment letter is sent out three weeks before the appointment date. The three weeks’ notice was introduced to reduce inconvenience to patients through cancellations and to bring us into line with the national standard for appointment notice (*Elective Care Model Access Policy*. NHS Improvement, 2019).

16. Outpatient appointment “did not attends”



The level of defaulted appointments has remained within common cause variation for the last 19 months and in the current process the trust target of 15% or lower is likely to be consistently achieved.

## **Other Operational Matters of Note**

### **A. Health Protection Unit (HPU)**

The HPU are busy continuing to offer both Covid and Flu vaccinations to staff, inpatients and some community patients.

There is a project underway to support those patients with severe mental illness and those most vulnerable who often experience health inequalities. Working with Public Health England, the HPU will aim to support people in the community with SMI to be fully informed of Covid and the vaccination programme and, where consenting, will vaccinate those patients as well as utilising the time to make any other physical health checks. The work will be conducted under a service evaluation, with the outcomes distributed for wider learning.

We continue to work as Joined Up care Derbyshire, meeting weekly with Derbyshire Community Health Services NHS Foundation Trust to work through the Derbyshire-wide vaccination programme, highlighting areas of good practice and learning lessons for future vaccination clinics.

As the Covid guidelines are changing the HPU remains a supportive arm for all staff to contact and receive information and guidelines.

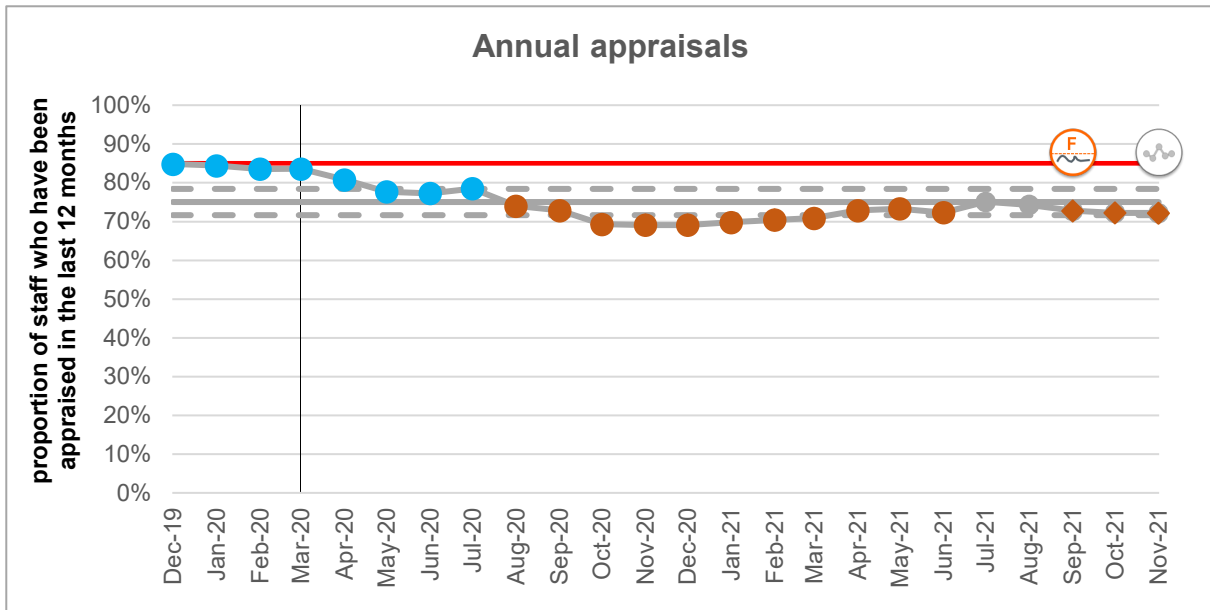
The HPU are also encompassing more infection prevention and control work across the trust with a view to continuing this in the new year.

### **B. Vaccination status**

95% of patient facing staff have now received their first vaccination and 93% have received both vaccinations. Booster vaccinations are continuing and so far, 70% of patient facing staff have received their booster.

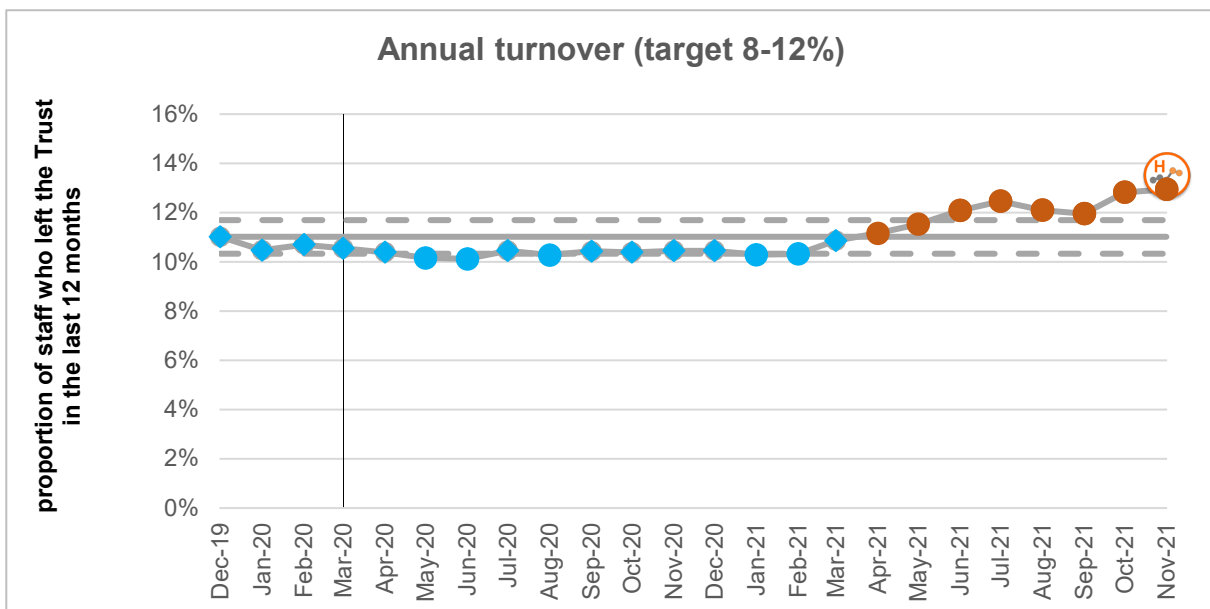
## People

### 17. Annual appraisals



The level of compliance has been significantly lower than expected for quite some time. Operational Services currently sit at 77% and Corporate Services at 50%. The appraisal process is now recommencing for full appraisals across all services. In the interim they were replaced by a structured wellbeing conversation and health risk assessment reviews were to be kept up to date. Further communications relating to recording of appraisals will be sent out during December.

### 18. Annual turnover

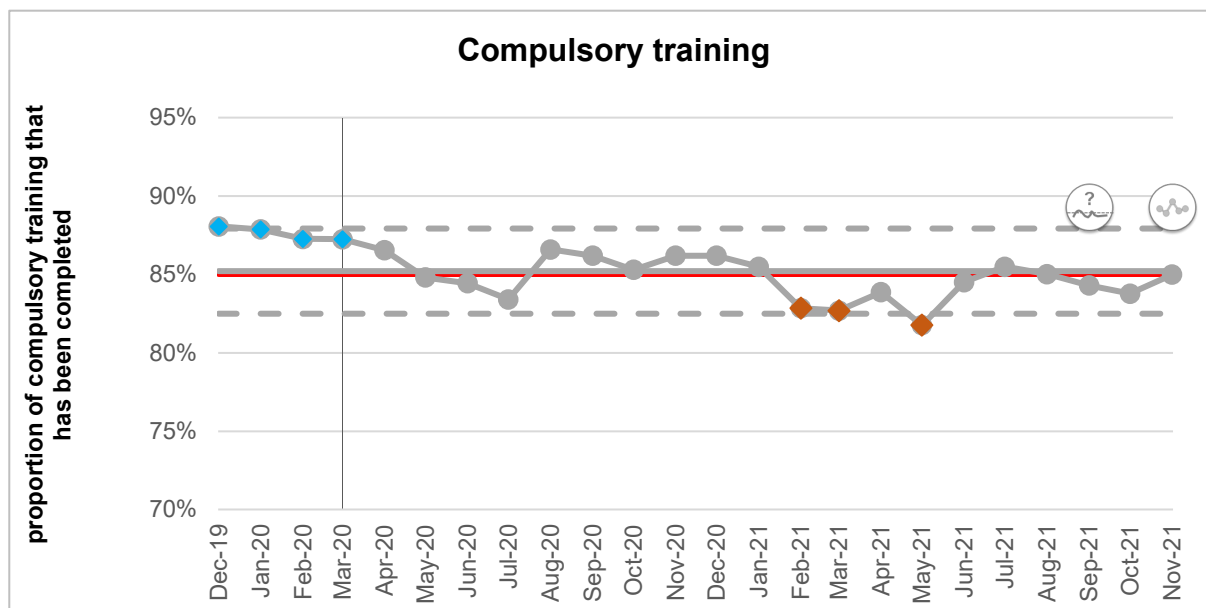


The rate of turnover has been higher than the Trust target range of 8-12% for the last three months. Retention is an issue where other mental health trusts across the Midlands are offering incentives to attract and retain staff. We are looking at all options to address this and building upon our excellent reputation as a good local employer.



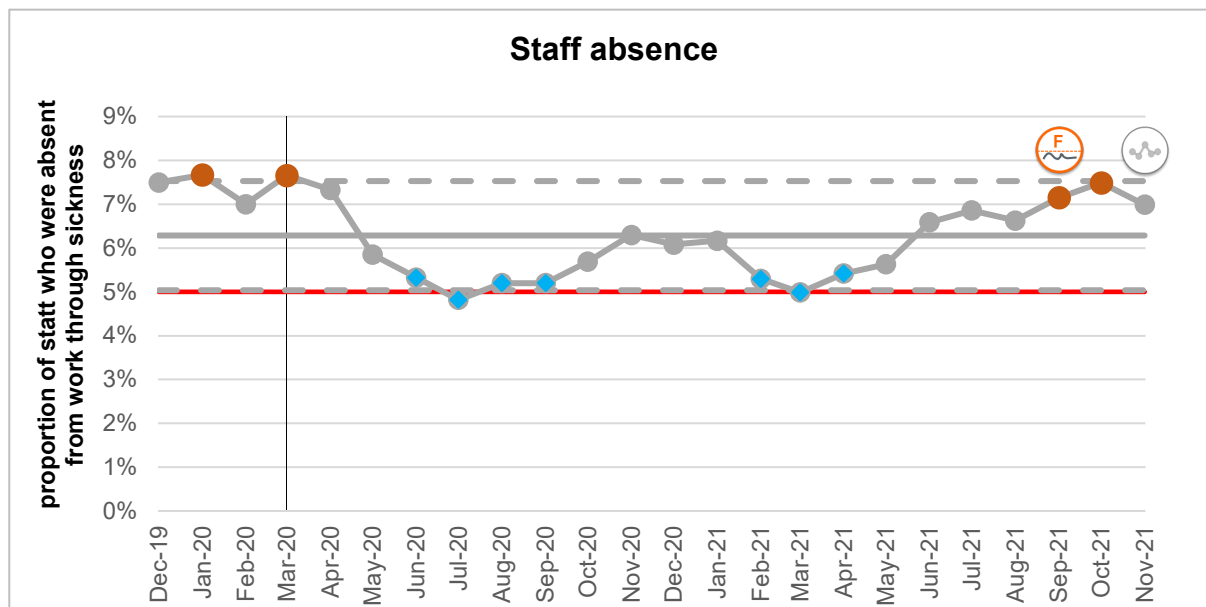
In the latest national NHS staff turnover benchmarking data (August 2021) the Trust was ranked 8<sup>th</sup> highest mental health trust for stability of the workforce (<https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics/august-2021>).

### 19. Compulsory training



A recovery plan continues to improve training compliance. The full training requirement – compulsory training and role specific training – is now around 70,770 attendances by our total workforce on 81 courses, with just over 15,760 individual attendances to be completed. Operational Services are currently above target at 87% compliant with compulsory training, with Corporate Services slightly lower at 77%.

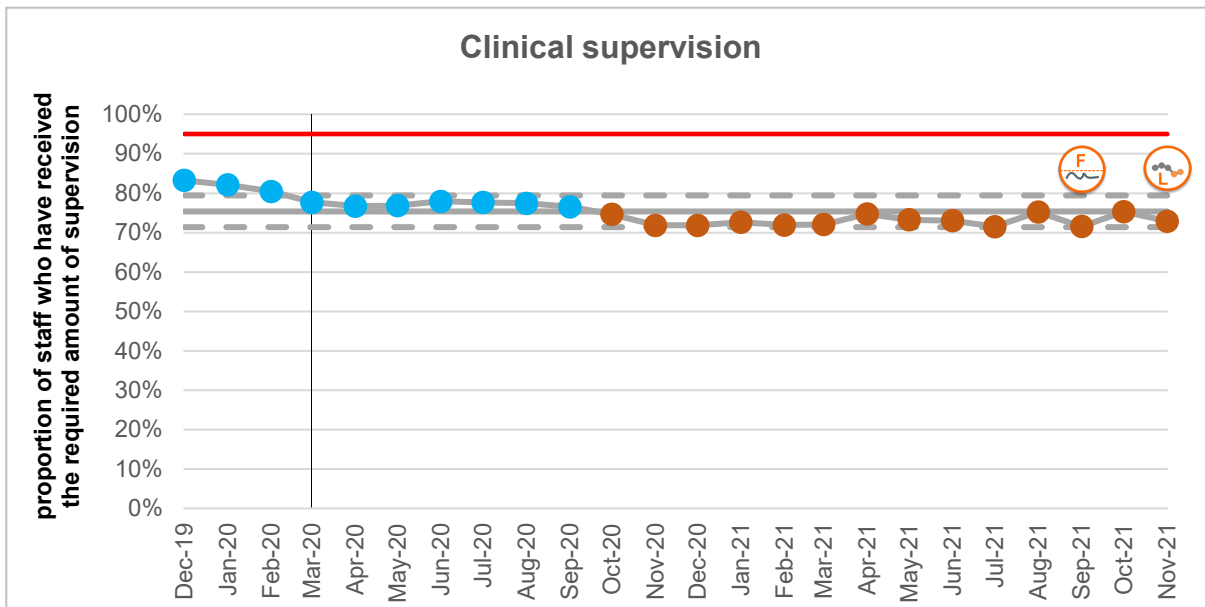
### 20. Staff absence



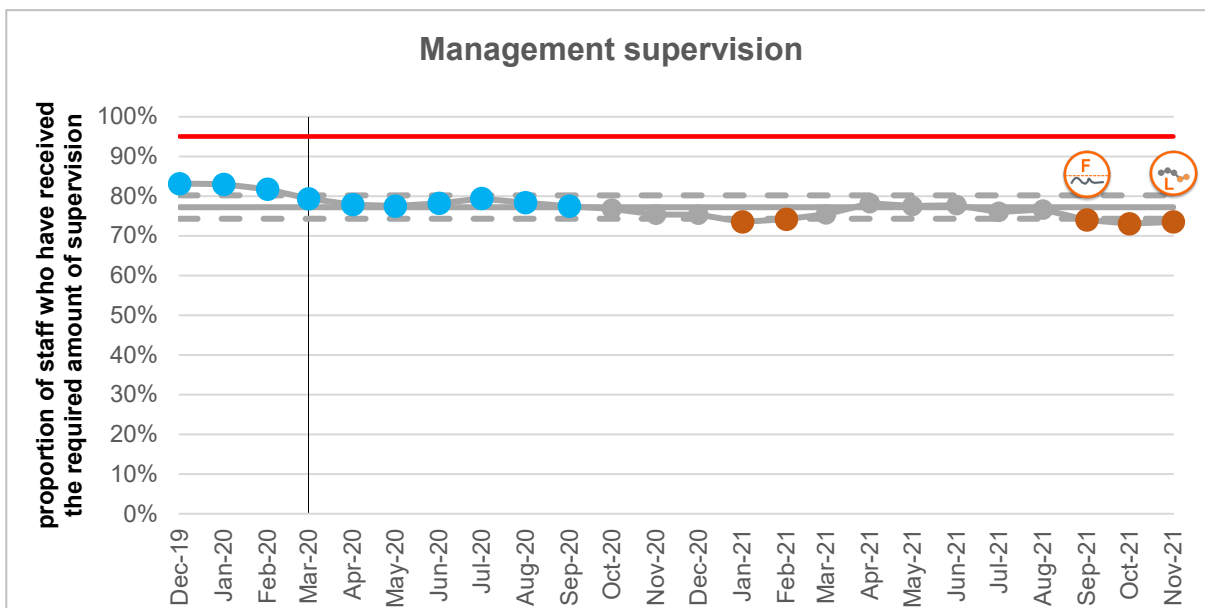
Corporate Services are below the target threshold at 4.7%, with Operational Services currently sitting at 8.4%. Regular heat maps are being produce enabling General Managers and Area Service Managers to compile sickness action plans to address on a Divisional basis, reporting through the Trust Operational Oversight Leadership meeting (TOOL). Sickness absence rates have increased gradually over the last three months with the greatest increase in short term absence which for October was 0.7% increase on the previous month. This is largely due to coughs, colds and flu like

symptoms and COVID-19 absence. COVID-19 absence includes vaccination and recovery absences, and this is in line with previous trends when the first and second vaccinations were administered. This is likely to be the trend during the current vaccination period.

21. Clinical supervision

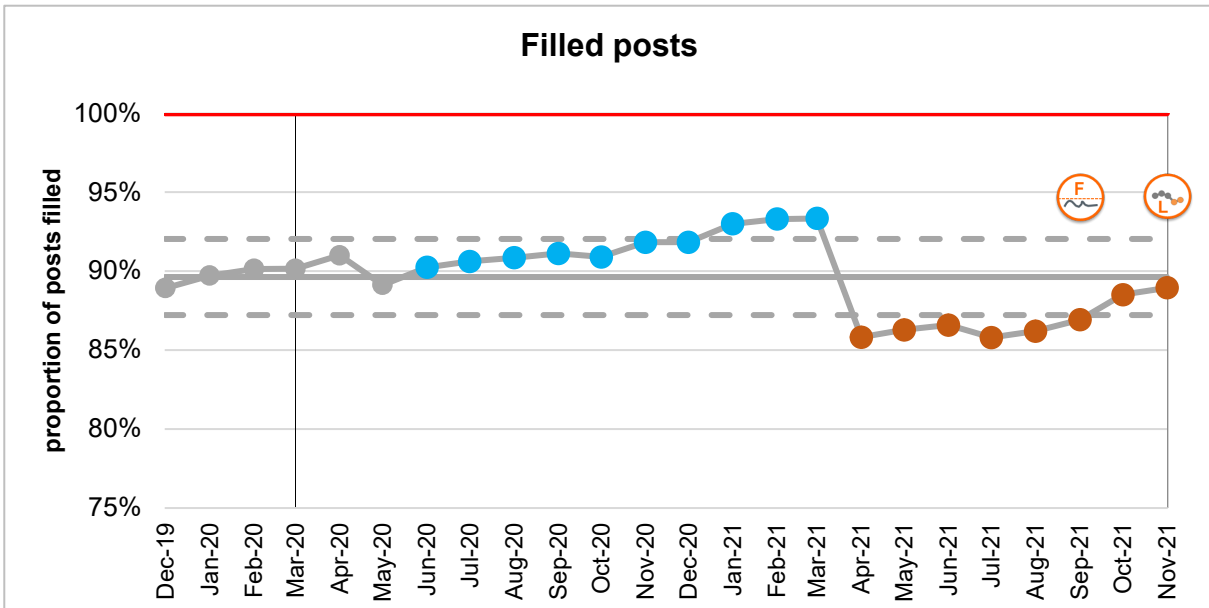


22. Management supervision



The levels of compliance with the clinical and management supervision targets have remained low since the start of the pandemic. As seen with compulsory training and appraisals, Operational Services are performing at a considerably higher level than Corporate Services for both types of supervision (management: 75% versus 58% and clinical: 74% versus 37%).

23. Proportion of posts filled

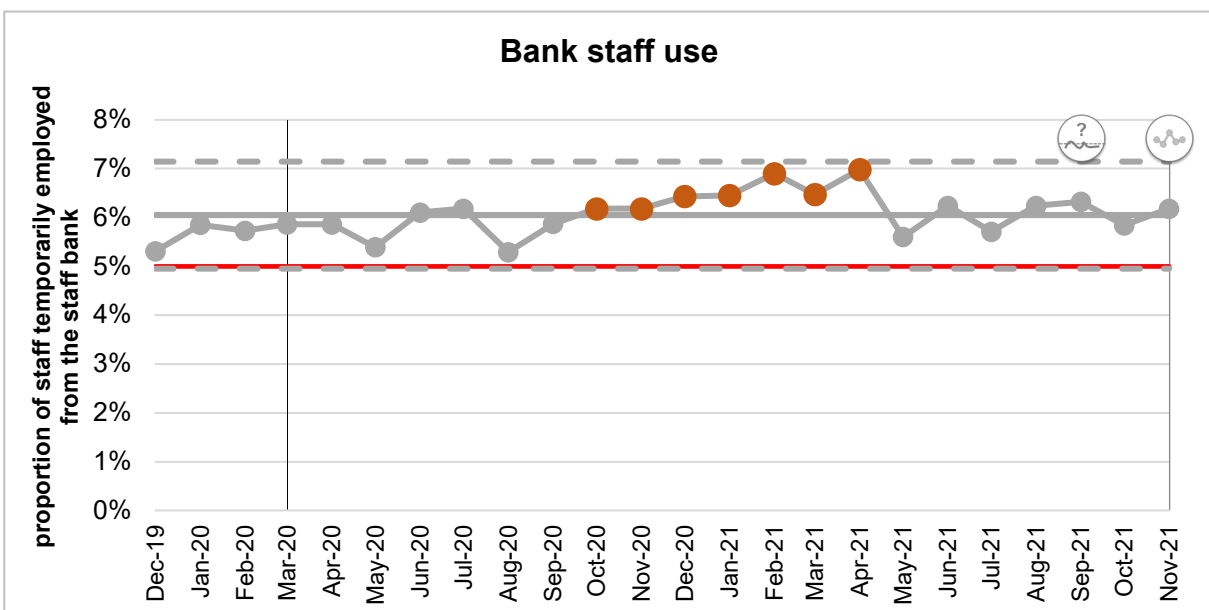


Prior to the start of this financial year there were a number of factors that had in effect artificially lowered the vacancy rate prior to April 2021, however this has now been adjusted for at the start of this financial year, which is where we can see a significant drop in filled posts. The increased number of vacancies in 2021/22 budgets are as detailed below:

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

There has been a steady improvement in our recruit to post rate with the number of vacancies going to advert now reducing month on month.

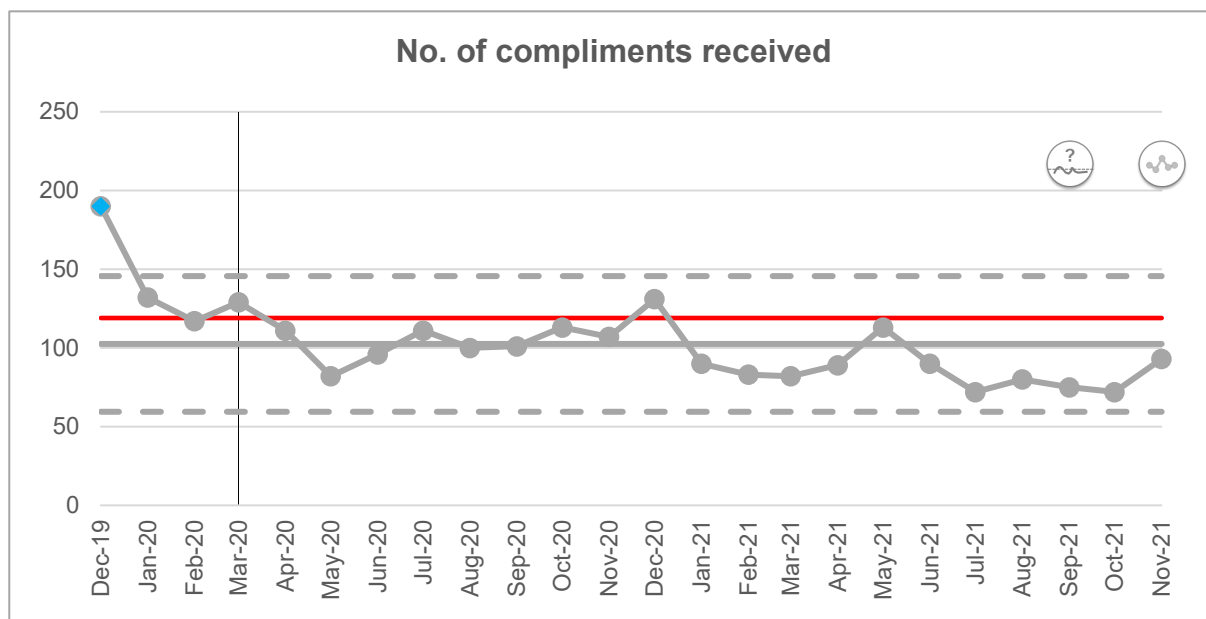
24. Bank staff



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

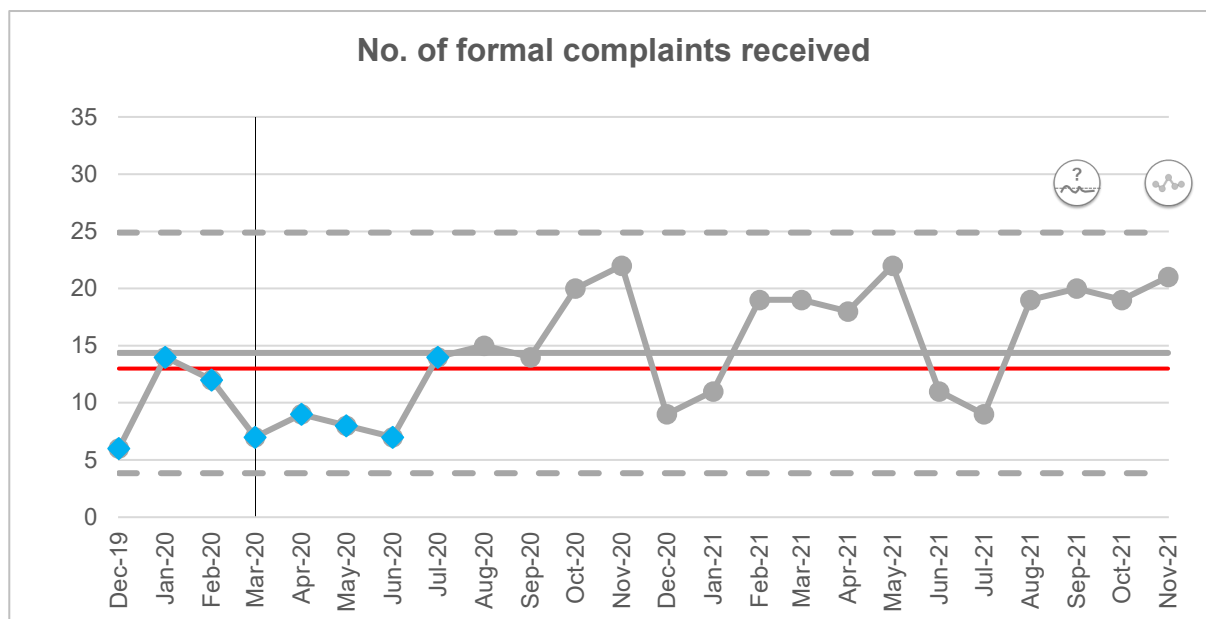
## Quality

### 25. Compliments



The number of compliments decreased in line with the emergence of COVID-19 and the significant changes to many of our clinical services. A large number of compliments are received by staff during face-to-face contact and then entered by staff. As a result of reduced face to face contact, there has been a drop in the number of compliments received. This is below the expected target. Work is underway to improve feedback from service users via an electronic survey received by text or email. A pilot within the Crisis resolution and home treatment (CRHT) is coming to an end with positive feedback from the team and service users. Plans are in place to attend Clinical Operational Assurance Team (COAT) meetings across divisions to discuss wider roll out and implementation in January 2022. The pilot has shown a three month feedback total of 47 for the electronic survey, compared to the previous 12 month feedback total of 69 for the paper version of the survey.

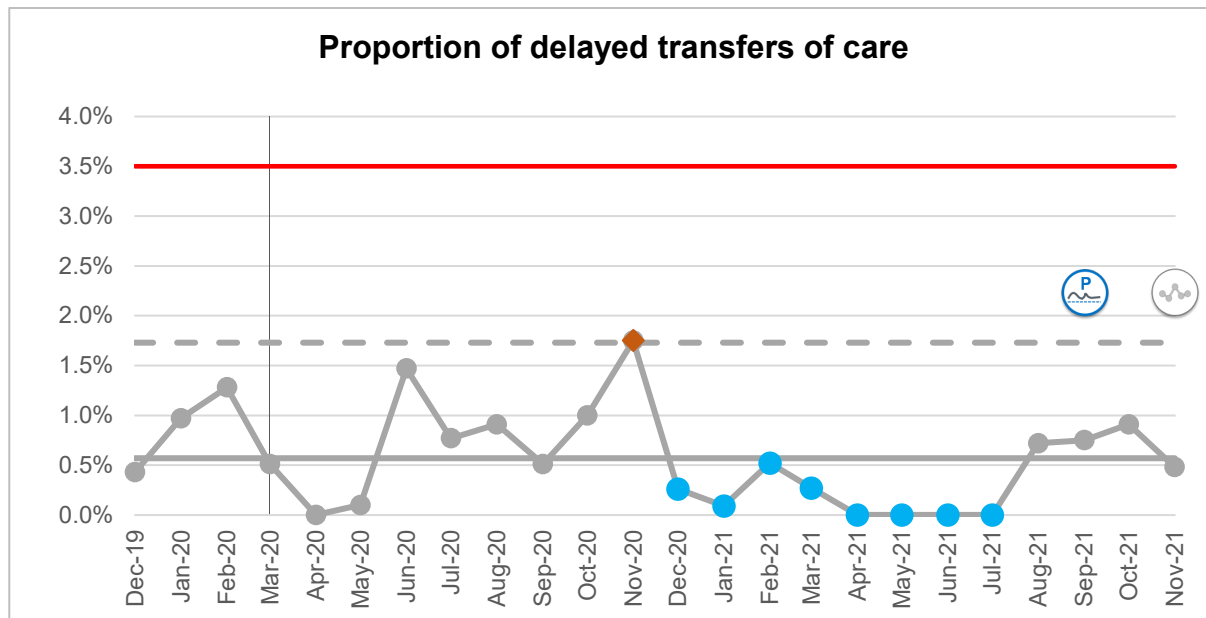
### 26. Complaints



The number of complaints increased with a particular theme around both concerns and complaints of access to services. Derbyshire Healthcare NHS Foundation Trust continues to work with Health Watch, including receiving regular feedback through governance structures and service user and

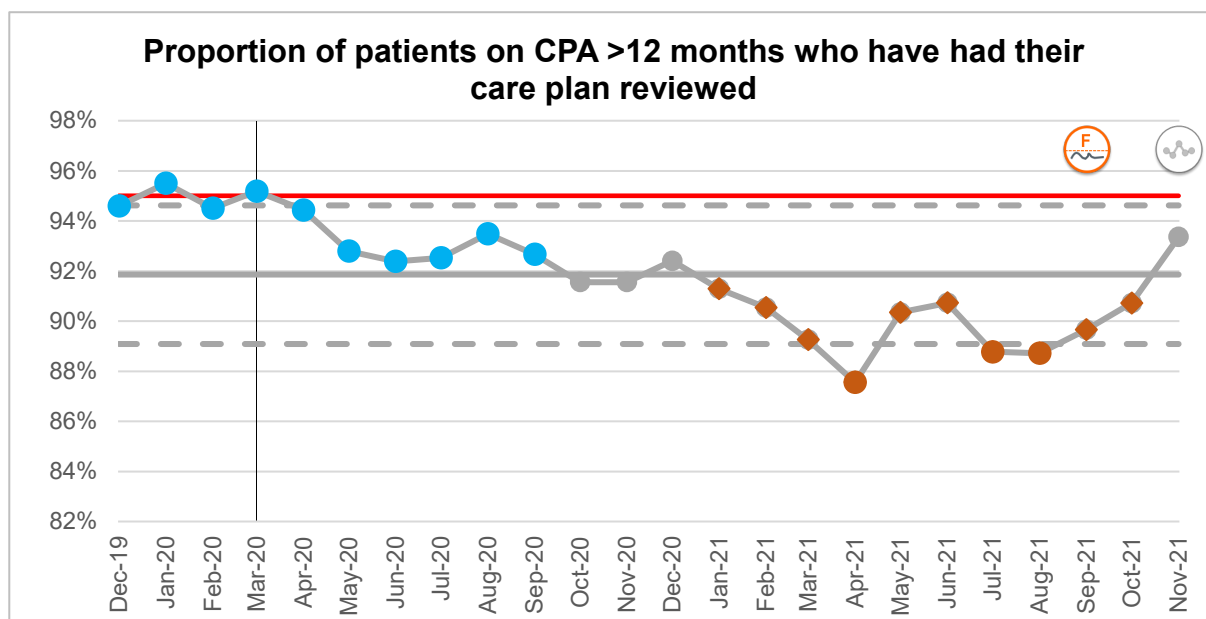
carer surveys. The recent results from the Mental Health Community Survey have presented similar themes, with service users and carers feeling they have struggled with the reduction in face-to-face contact with services during the COVID-19 Pandemic. Furthermore, some complaints have been in relation to discharge processes and communication and so a discharge working group with experts and carers has been created and led by the Head of nursing for community services. This aims to improve processes to reduce complaints.

27. Delayed transfers of care



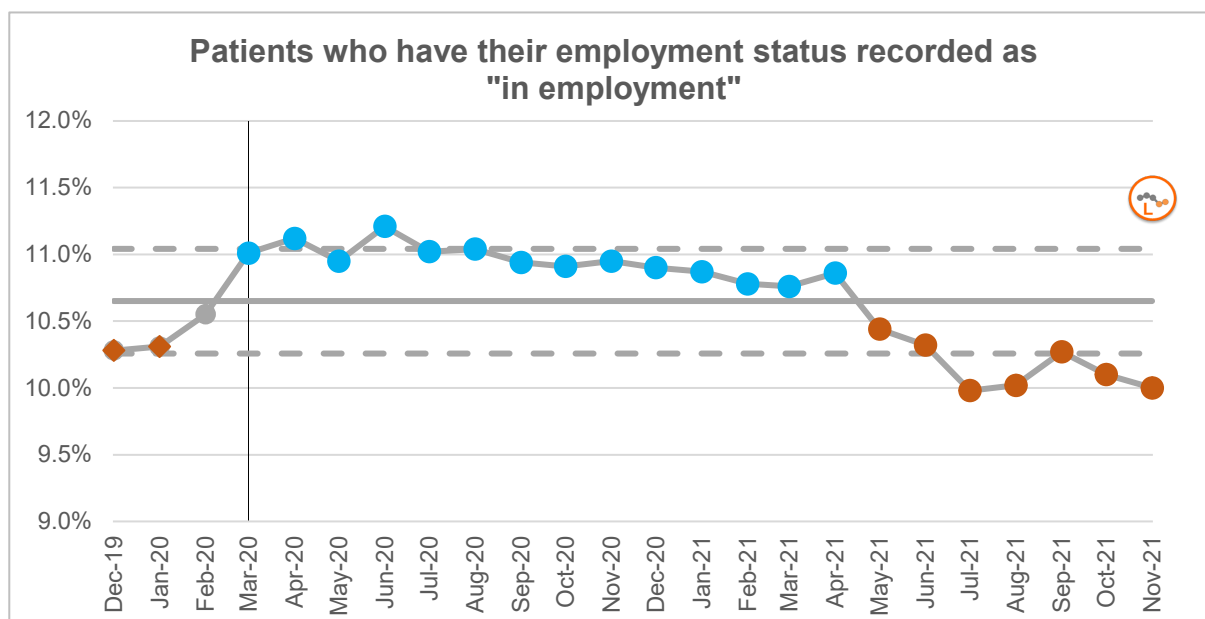
The number of DTOCs has increased in line with targeted work with teams around identifying and documenting DTOCs. Furthermore, the recent multi-agency discharge event (MADE) and Perfect Day event have resulted in an increase DTOC number. Although above the mean number, the data presents a number below the higher level.

28. Care plan reviews



The proportion of patients whose care plans have been reviewed continues to be lower than usual. However, as can be seen there is a positive trajectory and improvements in the percentage of reviewed care plans. Work continues to improve this month by month and this is expected to continue.

## 29. Patients in employment

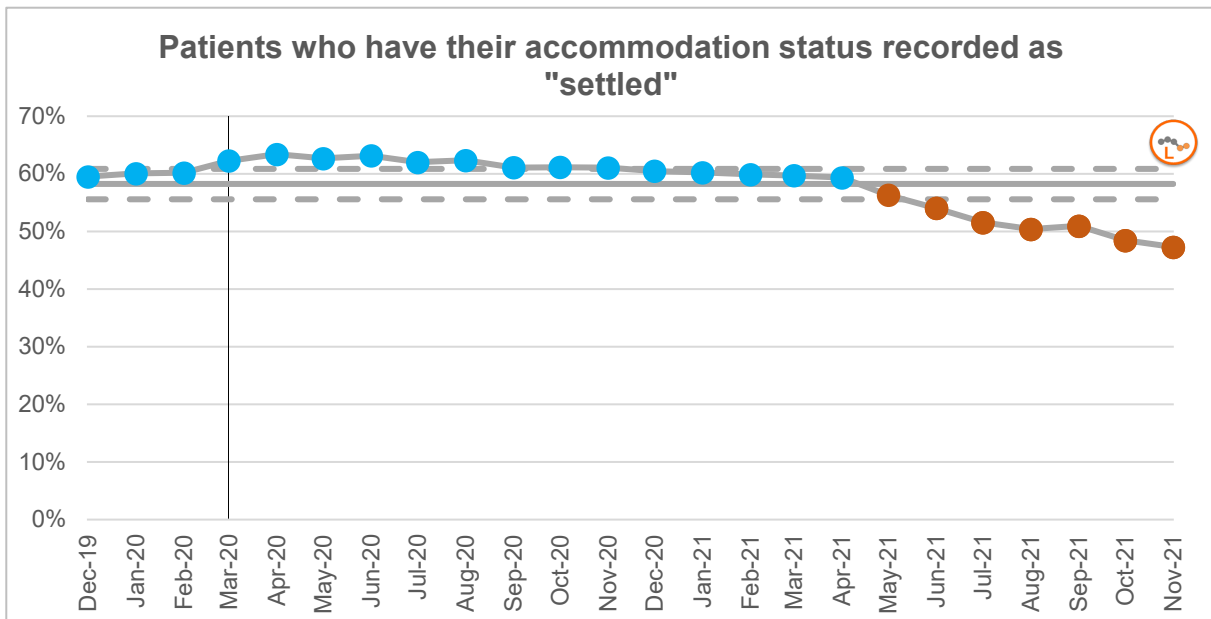


Around a third of patients have no employment status recorded. For those with a recorded status, the breakdown is as follows:

Recorded status	n	%
Unemployed	4847	46.9%
Employed	2264	21.9%
Long-Term Sick Or Disabled	1511	14.6%
Students Not Wk Or Seeking Wk	1075	10.4%
Retired	309	3.0%
Homemaker Not Wk Or Seeking Wk	134	1.3%
No Benefits Not Wk Or Seeking	109	1.1%
Unpaid Voluntary Work	71	0.7%
Self-employed	2	0.02%
Recently unemployed	1	0.01%
Unpaid work	1	0.01%
Made redundant	1	0.01%
Does voluntary work	1	0.01%
On sick leave from work	1	0.01%

The Individual Placement Support (IPS) Service continues to have success in supporting people into employment even during the current pandemic and the service is currently expanding. The Trust has recently employed two experts by experience to focus on the implementation and management of Health Education England training in relation to peer support working and apprentices. As a result, those in employment or education is expected to improve in time. This aims to support people into employment, apprentice or education.

30. Patients in settled accommodation

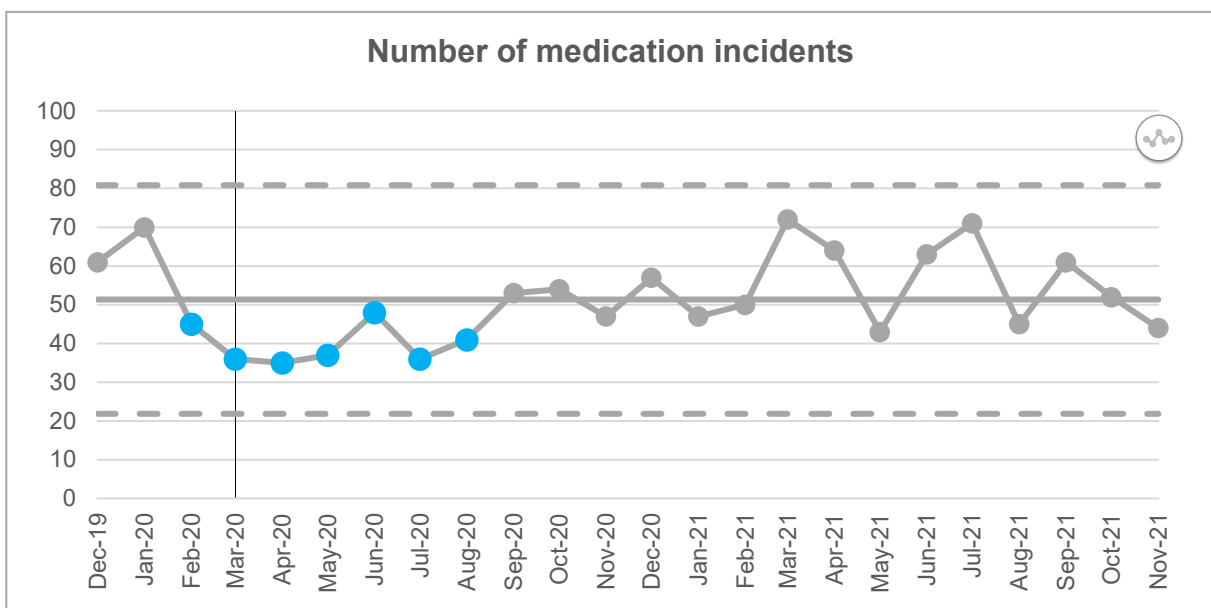


Around a third of patients have no accommodation status recorded. For those with a recorded status, the breakdown is as follows:

Recorded status	n	%
Mainstream Housing	8895	90.7%
Mobile Accommodation	10	0.1%
Accomm Criminal Justice Sup	12	0.1%
Accomm Mh Care/support	342	3.5%
Accomm Other Care Support	209	2.1%
Acute/long Stay Hospital/resid	129	1.3%
Sheltered Housing	38	0.4%
Homeless	168	1.7%

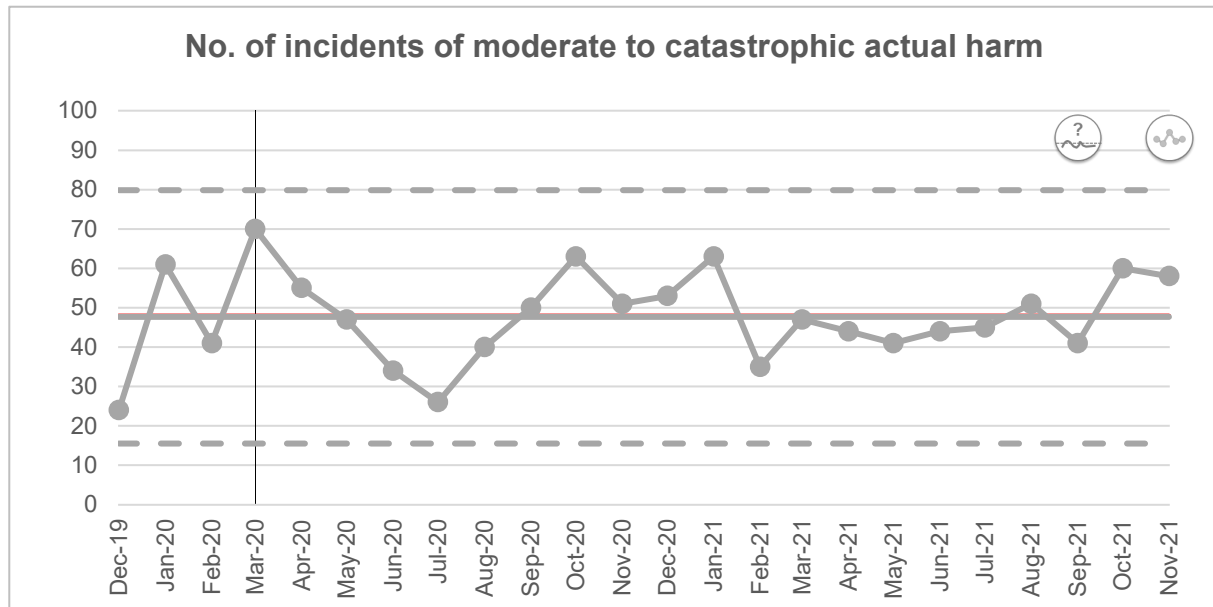
It is important to acknowledge that only a small percentage of patients have their accommodation recorded on the electronic patient record and so this data represents only a small proportion of patients.

31. Medication incidents



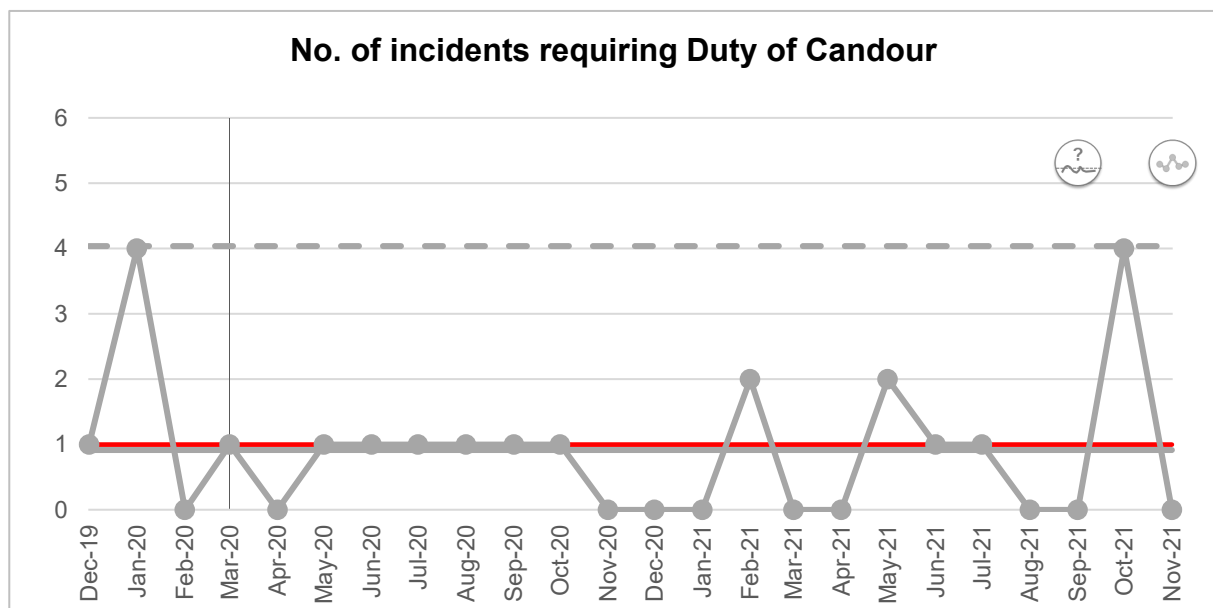
When looking into medication incidents, they take a variety of forms, from missed doses, wrong medication administration, missed fridge temperature recording, prescription error and non-location of medication. As a result, there are several factors that impact such as how busy the ward is, number of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

### 32. Incidents of moderate to catastrophic actual harm



The number of reported incidents of moderate to catastrophic harm have remained within common cause variation throughout the reporting period. However, there has been a recent increase bringing the total above the mean line. This will continue to be monitored by the Heads of Nursing team on a quarterly basis and fed into the relevant COAT meetings.

### 33. Duty of Candour

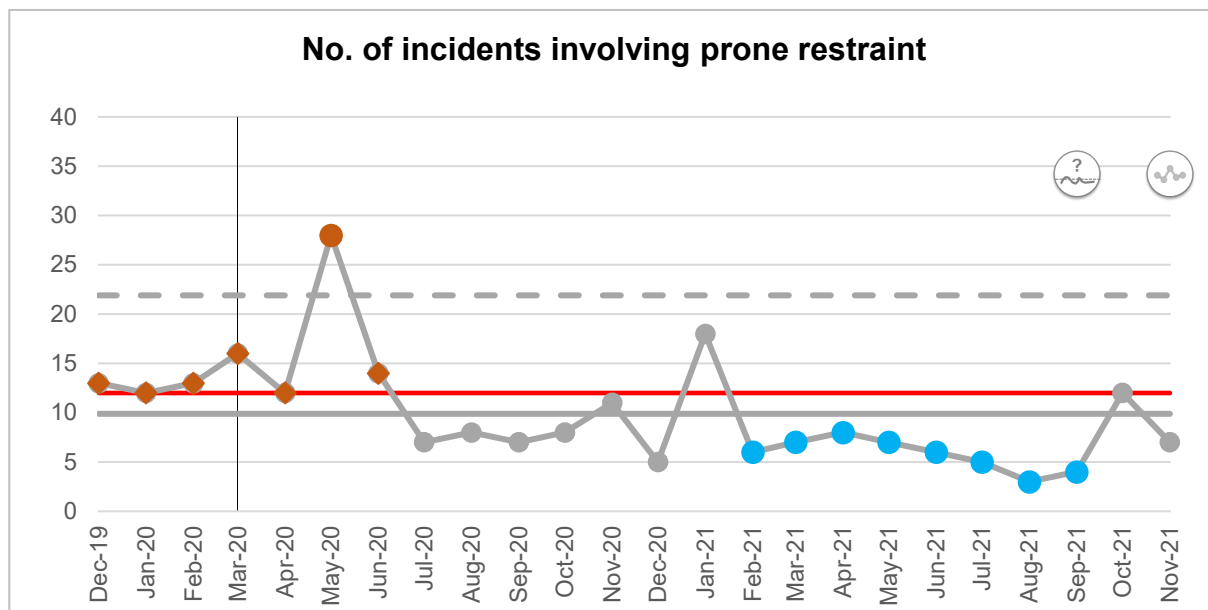


There have been four instances of Duty of Candour in the last three months. This comes in line with reports being finished and signed off by the executive serious incident group resulting in



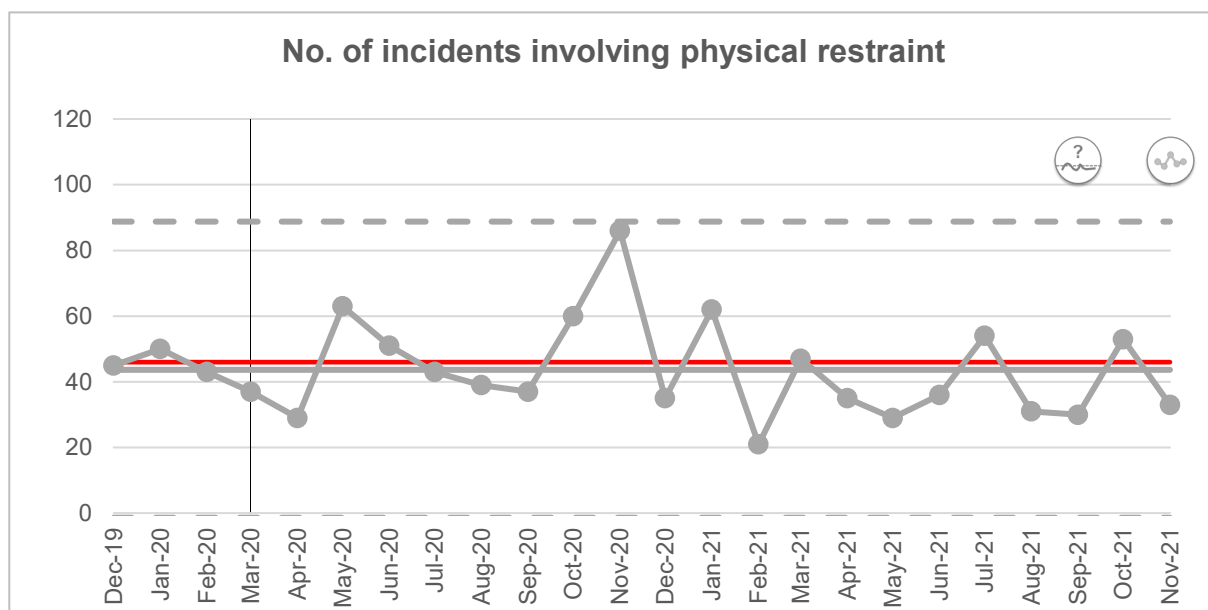
pockets of data increase. This pattern is expected as groups of reports are signed off and Duty of Candour raised.

### 34. Prone restraint



There are ongoing work streams to support the continuing need to reduce restrictive practice, including the introduction of body worn cameras, monitoring of restrictive practice within forums. Data analysis and review has shown that even where restraint and seclusion has increased, the use of prone restraint has continued to reduce. A spike in prone restraint in October has been linked to an increase in seclusion within the same month. A review of the data shows no patterns as incidents are spread across wards, however, largely within the Radbourne unit. A small spike in incidents on ward 35 has resulting in the need for further review and monitoring.

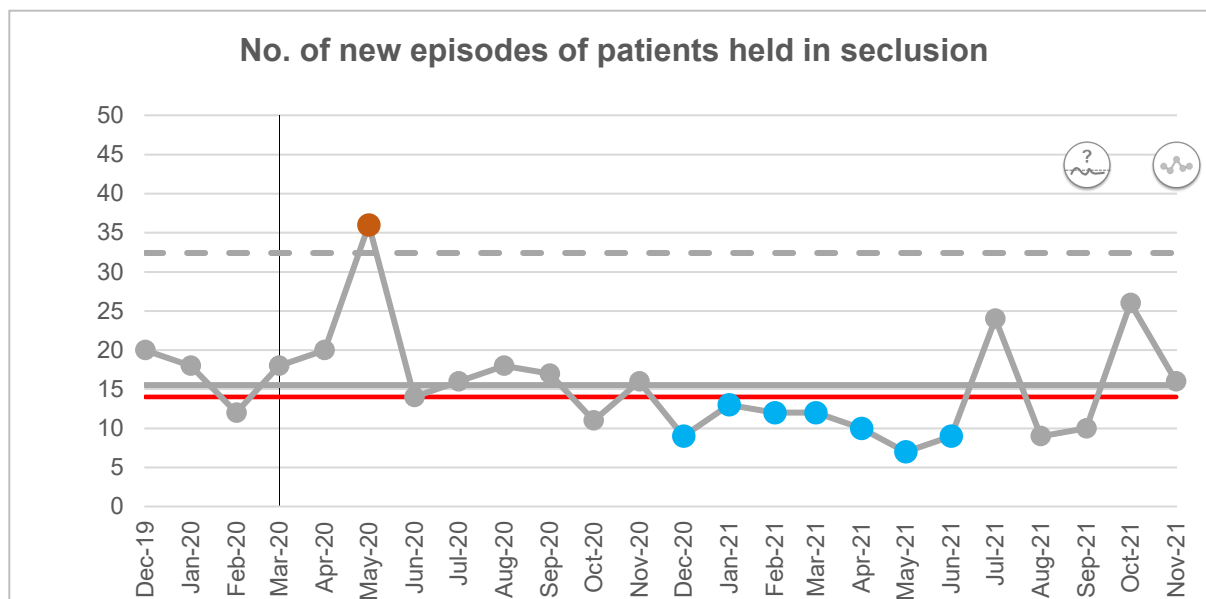
### 35. Physical restraint



The number of reported incidents involving restraint have remained within common cause variation throughout the reporting period. The changes in numbers are linked to the data above relating to prone restraint and below relating to seclusion. It is important to highlight that a common impacting factor to restrictive practice is increased use of bank staff, vacancies, increased sickness, staffing challenges and concerns relating to closed culture. A working group has been created to put

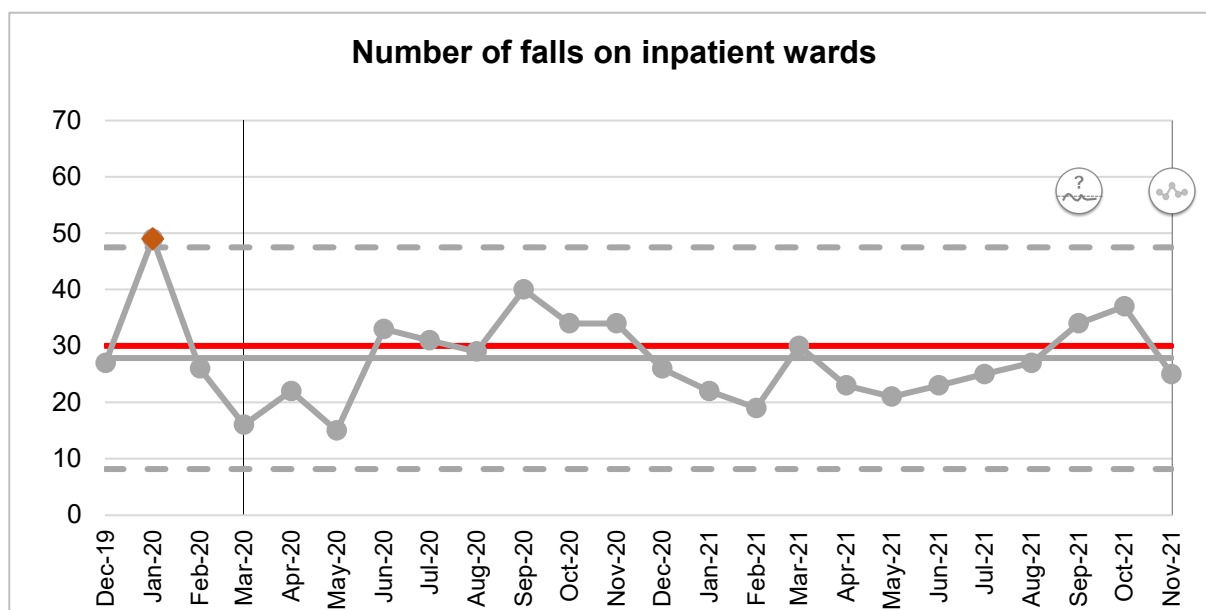
together a working procedure for assessing closed cultures and what needs to be done where closed cultures are identified. This work aims to improve patient feedback along with reducing restrictive practice both in inpatient services and community services.

### 36. Seclusion



The use of seclusion was within common cause variation, however, has increased in July and October. In further investigating this trend, there appears to be a link to a small number of patients who have been placed in seclusion on more than one occasion. This data will be monitored for patterns and further support needs for individual areas. Further auditing and investigation will be carried out by the new head of nursing for Acute and Assessment service when they commence in January. Although some spikes have been seen within the data in the last 6 months, the ongoing number of seclusion incidents generally remains low and below the mean number.

### 37. Falls on inpatient wards



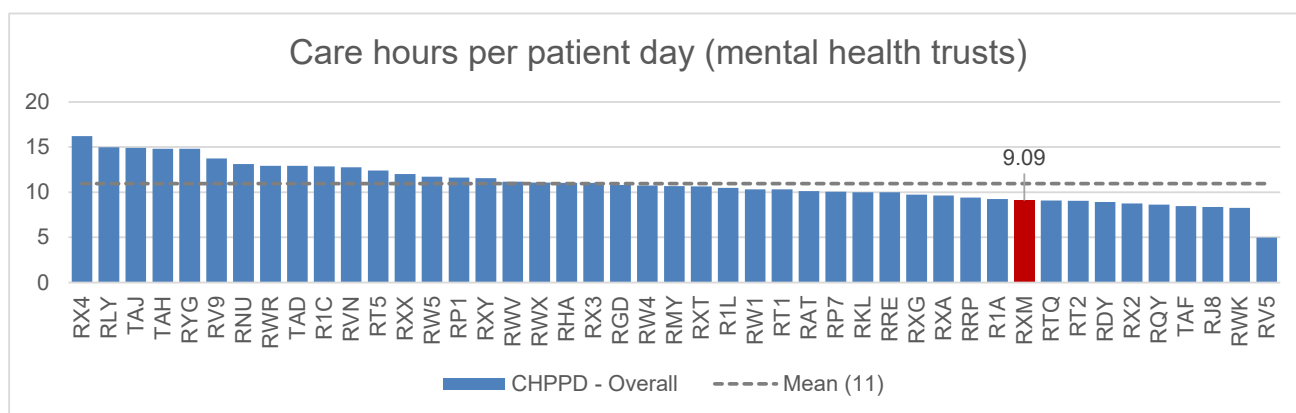
After an increase above the mean line in September and October, the number of falls in November has fallen, similar to previous months. The new Matron and Head of Nursing for the older adult areas have been working on reducing falls across the inpatient areas. It is important to acknowledge that falls have also been occurring on Pleasley Ward, a mixed age older adult and working age adult ward which provides challenge in training and implementing change. Plans are in

place for the older adult cohort to move to a new setting in 2022 which will allow for more focused work to occur.

### Care Hours Per Patient Day (CHPPD)

CHPPD is rolling data updated monthly, to show staffing levels in relation to patient numbers on an inpatient ward. Every month, the hours worked during day shifts and night shifts by registered nurses and midwives and by healthcare assistants are added together. Each day, the number of patients occupying beds at midnight is recorded. These figures are added up for the whole month and divided by the number of days in the month to calculate a daily average. Then the figure for total hours worked is divided by the daily average number of patients to produce the rate of care hours per patient day. Work is underway to implement processes relating to staffing levels and how they are recorded in line with CHPPD and patient acuity. This will be in the form of the MHOST reporting system and SafeCare module within E-Roster.

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

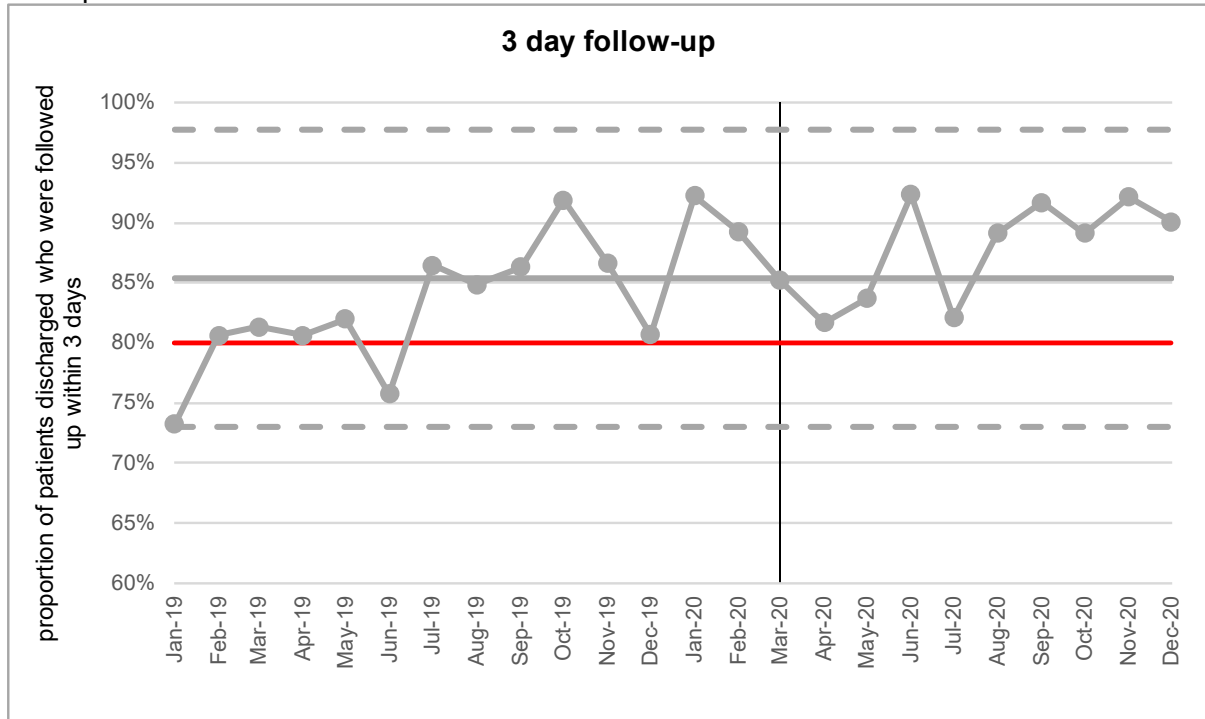


Data source: [NHS England » Care hours per patient day \(CHPPD\) data](#)

## Appendix 1

### Statistical Process Control Chart (SPC) Guidance

Example SPC chart:



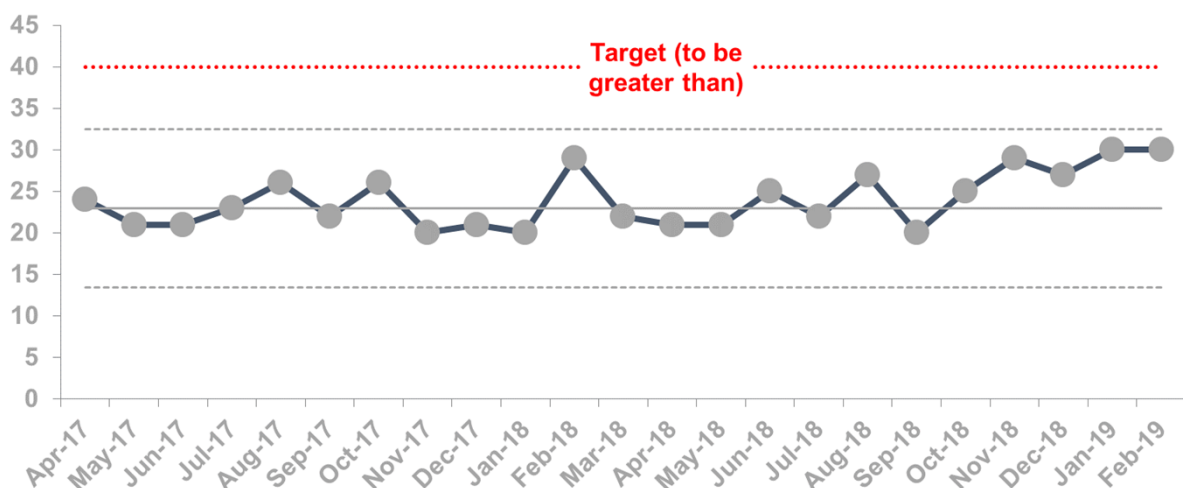
- The red line is the target.
- The grey dots are the actual performance each month. They are coloured grey as performance each month is normal in this example.
- The solid grey line is the average (mean) of all the grey dots.
- The grey dotted lines are called process limits, or control limits.

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

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

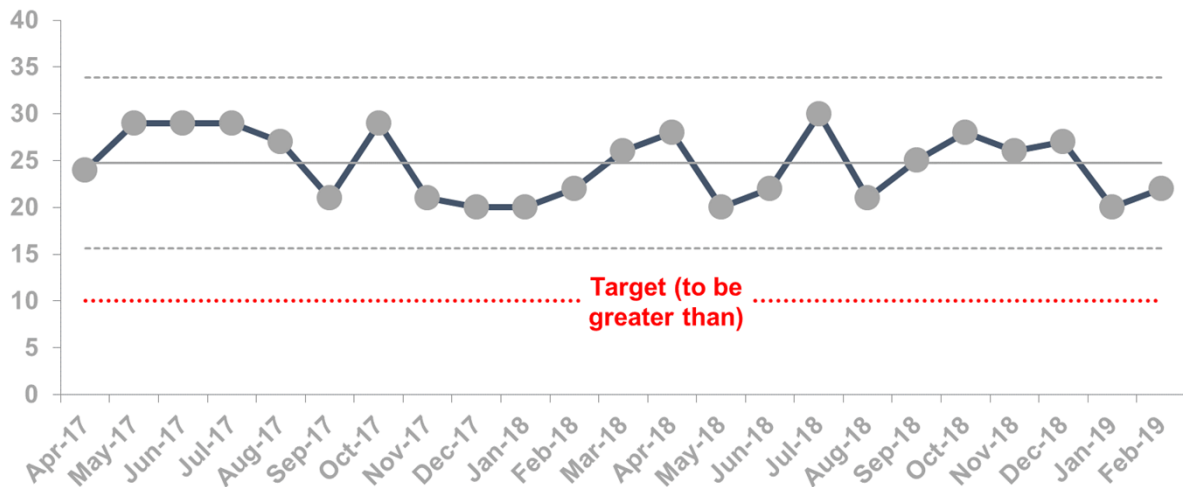
#### Things to look out for:

##### 1. A process that is not working



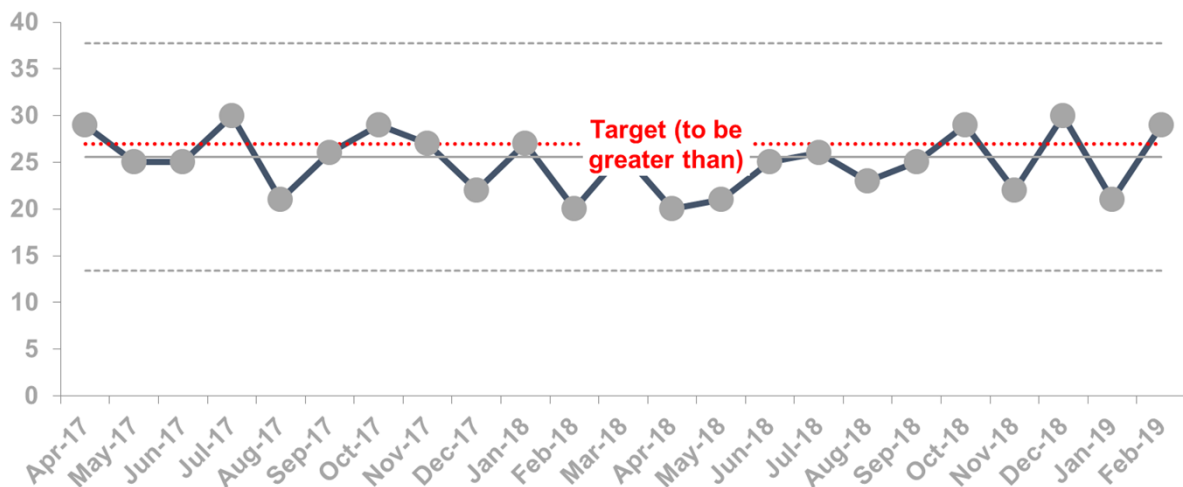
In this example the target is higher than the upper dotted grey line. This means that the target will never be achieved. To achieve the target, we need to change how we do things.

## 2. A capable process



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

## 3. An unreliable system

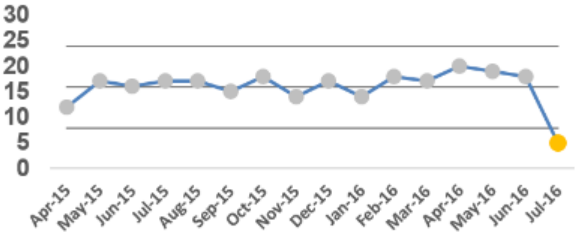
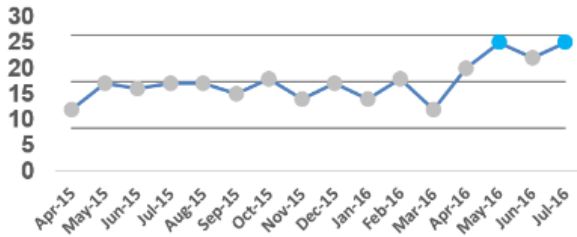
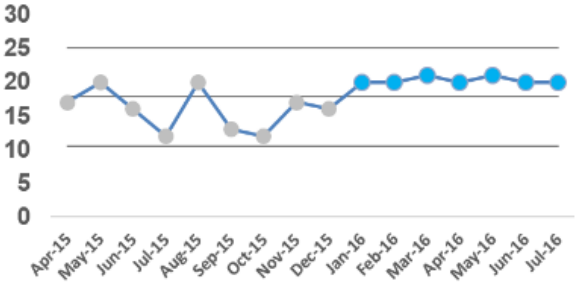
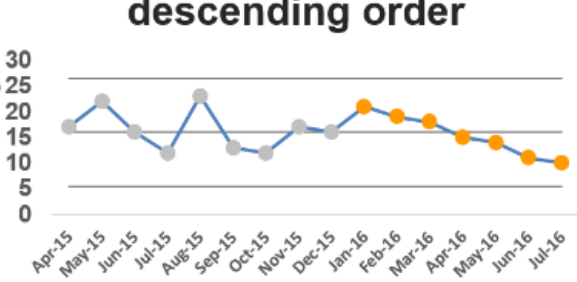


In this example the target line sits between the 2 grey dotted lines. As it is normal for the grey dots to fall anywhere between the 2 dotted grey lines, this means that it is entirely random as to whether or not the target will be achieved. So, this system is unreliable and needs to be redesigned if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

**4. Unusual patterns in the data**

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

There are four scenarios where this can happen:

<p style="text-align: center;"><b>A single data point outside the process limits</b></p>  <p>The chart shows a line graph with a central average line at 17.5 and two grey dotted lines representing process limits at 10 and 25. The data points fluctuate around the average line from April 2015 to June 2016. In July 2016, the data point drops significantly below the lower process limit to approximately 5, and is highlighted in orange.</p>	<p style="text-align: center;"><b>Two out of three points close to the process limits</b></p>  <p>The chart shows a line graph with a central average line at 17.5 and two grey dotted lines representing process limits at 10 and 25. The data points fluctuate around the average line. In May 2016, the data point is very close to the upper process limit (around 24) and is highlighted in blue. In June 2016, the data point is also very close to the upper process limit (around 24) and is highlighted in blue.</p>
<p>In this example the July 16 performance is significantly lower than expected and falls beneath the lower grey dotted line.</p>	<p>2 out of 3 points close to one of the grey dotted lines is statistically significant, in this case they are blue, indicating better than expected performance.</p>
<p style="text-align: center;"><b>Shift of points above / below mean line</b></p>  <p>The chart shows a line graph with a central average line at 17.5 and two grey dotted lines representing process limits at 10 and 25. The data points fluctuate around the average line. Starting in January 2016, the data points consistently rise above the average line, indicating a shift in the process.</p>	<p style="text-align: center;"><b>Run of points in consecutive ascending / descending order</b></p>  <p>The chart shows a line graph with a central average line at 17.5 and two grey dotted lines representing process limits at 10 and 25. The data points fluctuate around the average line. From January 2016 onwards, the data points show a clear downward trend, indicating a run of points in consecutive descending order.</p>
<p>A run of 7 points above or below the average line is significant. In this example it might indicate that an improvement was made to the process in Jan 16 that has proven to be effective.</p>	<p>A run of 7 points in consecutive ascending or descending order is significant. In this example things are getting worse over time.</p>

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

## Appendix 2 – Data Quality Maturity Index Benchmarking Data

Mental Health Trust	Aug -21	July -21	Jun -21	May -21	Apr -21
National Average	80.5	81.7	82.5	82.7	81.9
BIRMINGHAM AND SOLIHULL MENTAL HEALTH NHS FOUNDATION TRUST	98.6	93.9	94.3	95.0	93.4
GREATER MANCHESTER MENTAL HEALTH NHS FOUNDATION TRUST	98.4	56.7	56.8	56.7	57.4
TEES, ESK AND WEAR VALLEYS NHS FOUNDATION TRUST	98.0	98.9	99.2	98.1	99.5
NORTH STAFFORDSHIRE COMBINED HEALTHCARE NHS TRUST	97.8	81.5	82.0	83.4	84.7
CAMBRIDGESHIRE AND PETERBOROUGH NHS FOUNDATION TRUST	97.5	90.5	90.8	88.3	90.2
BARNET, ENFIELD AND HARINGEY MENTAL HEALTH NHS TRUST	97.2	93.2	93.3	93.1	93.3
CAMDEN AND ISLINGTON NHS FOUNDATION TRUST	97.1	93.8	94.0	94.1	93.9
TAVISTOCK AND PORTMAN NHS FOUNDATION TRUST	96.8	0.0	61.4	61.6	61.3
ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST	96.5	-	-	-	-
NOTTINGHAMSHIRE HEALTHCARE NHS FOUNDATION TRUST	96.3	90.2	91.8	91.9	91.9
DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST	96.1	96.9	95.5	95.7	95.0
KENT AND MEDWAY NHS AND SOCIAL CARE PARTNERSHIP TRUST	95.9	82.0	82.0	82.5	79.5
NORFOLK AND SUFFOLK NHS FOUNDATION TRUST	95.4	86.5	86.5	86.6	87.3
LINCOLNSHIRE PARTNERSHIP NHS FOUNDATION TRUST	95.3	89.3	89.2	89.5	72.2
SOUTH WEST LONDON AND ST GEORGE'S MENTAL HEALTH NHS TRUST	95.3	65.9	65.9	66.0	66.2
SOUTH LONDON AND MAUDSLEY NHS FOUNDATION TRUST	95.0	32.0	32.0	27.5	27.5
HERTFORDSHIRE PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST	94.8	99.5	99.5	99.5	99.4
WEST LONDON NHS TRUST	94.8	84.2	83.8	85.5	84.3
SOUTH WEST YORKSHIRE PARTNERSHIP NHS FOUNDATION TRUST	94.0	93.4	93.4	93.4	93.3
WORCESTERSHIRE HEALTH AND CARE NHS TRUST	94.0	90.0	90.3	90.5	90.8
ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST	93.9	88.4	88.5	90.1	90.1
CUMBRIA, NORTHUMBERLAND, TYNE AND WEAR NHS FOUNDATION TRUST	93.8	95.4	5.6	5.6	4.8
EAST LONDON NHS FOUNDATION TRUST	93.7	92.4	92.5	92.5	92.6
BRADFORD DISTRICT CARE NHS FOUNDATION TRUST	93.3	89.0	89.9	89.8	89.8
AVON AND WILTSHIRE MENTAL HEALTH PARTNERSHIP NHS TRUST	93.1	83.4	83.3	80.0	80.2
MIDLANDS PARTNERSHIP NHS FOUNDATION TRUST	93.1	84.7	84.3	84.2	84.2
SURREY AND BORDERS PARTNERSHIP NHS FOUNDATION TRUST	92.7	93.7	93.7	93.7	91.9
SUSSEX PARTNERSHIP NHS FOUNDATION TRUST	92.7	91.3	91.2	91.4	91.7
PENNINE CARE NHS FOUNDATION TRUST	92.5	73.6	74.1	74.1	74.0
CENTRAL AND NORTH WEST LONDON NHS FOUNDATION TRUST	92.3	82.9	84.1	72.8	72.9
LEICESTERSHIRE PARTNERSHIP NHS TRUST	92.3	85.0	85.1	85.2	85.9
NORTHAMPTONSHIRE HEALTHCARE NHS FOUNDATION TRUST	91.8	94.4	94.3	94.2	94.1
OXLEAS NHS FOUNDATION TRUST	91.7	91.4	91.7	90.5	90.4
LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST	91.4	99.8	99.2	99.2	99.1
SOLENT NHS TRUST	91.4	95.4	95.4	95.3	94.7
LANCASHIRE & SOUTH CUMBRIA NHS FOUNDATION TRUST	91.0	26.4	25.2	26.4	24.6
CORNWALL PARTNERSHIP NHS FOUNDATION TRUST	90.6	95.9	96.1	96.1	95.9
GLOUCESTERSHIRE HEALTH AND CARE NHS FOUNDATION TRUST	89.4	94.5	94.9	95.2	94.8
DEVON PARTNERSHIP NHS TRUST	89.1	97.2	97.2	96.8	97.3
SHEFFIELD HEALTH & SOCIAL CARE NHS FOUNDATION TRUST	88.7	80.8	80.8	81.2	80.8
SOUTHERN HEALTH NHS FOUNDATION TRUST	88.4	99.7	99.7	99.7	99.7
CHESHIRE AND WIRRAL PARTNERSHIP NHS FOUNDATION TRUST	88.1	62.8	61.0	61.2	62.5
DORSET HEALTHCARE UNIVERSITY NHS FOUNDATION TRUST	87.8	91.2	91.1	91.0	91.4
BLACK COUNTRY PARTNERSHIP NHS FOUNDATION TRUST	87.1	36.3	36.0	0.0	27.6
NORTH EAST LONDON NHS FOUNDATION TRUST	86.4	94.7	94.7	94.9	93.5
COVENTRY AND WARWICKSHIRE PARTNERSHIP NHS TRUST	86.0	90.7	90.8	90.9	91.1
OXFORD HEALTH NHS FOUNDATION TRUST	82.4	91.2	91.8	92.5	91.5
MERSEY CARE NHS FOUNDATION TRUST	50.1	49.8	42.6	49.8	49.9
BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST	49.9	86.7	91.9	84.7	94.8
HUMBER TEACHING NHS FOUNDATION TRUST	36.6	92.3	92.4	92.7	93.0
NORTH WEST BOROUGHES HEALTHCARE NHS FOUNDATION TRUST	0.0	0.0	0.0	0.0	0.0

Data source: [Data quality - NHS Digital](#)

## **National Policy changes and influence on Derbyshire Healthcare strategy and the Trust and wider services**

### **Purpose of Report**

The purpose of this report is to provide the Board of Directors with a joint briefing on the new National Drug Strategy, why and what this could mean for our collective strategies.

### **Executive Summary**

The government published in December 2021 a ten year plan for real change, with an ambition to reduce overall use towards a historic thirty year low. Commitments are made across government to break drug supply chains while simultaneously reducing the demand for drugs by getting people suffering from addiction into treatment, and deterring recreational drug use.

This government presents a case that will help us to level up by stopping the cycle of crime driven by addiction, keeping violence out of neighbourhoods across the country and saving lives through reducing the number of drug related deaths and homicides. The plan is supported by record investment of nearly £900m of dedicated funding over the Spending Review period, taking the total investment over three years to £3bn.

The ten year plan is also the formal, substantive response to the Independent Reviews of Drugs led by Dame Carol Black and accepts all of her key recommendations.

The plan sets out three core priorities:

1. Break drug supply chains
2. Deliver a world-class treatment and recovery system
3. Achieve a shift in the demand for recreational drugs

The government presents that will be achieved by:

- Continuing to roll-up exploitative and violent county lines and strengthen our response across the drug supply chain, making the UK a significantly harder place for organised crime groups to operate
- Investing a further £780m to rebuild drug treatment and recovery services, including for young people and offenders, with new commissioning standards to drive transparency and consistency
- Strengthening the evidence for how best to deter use of recreational drugs, ensuring adults change their behaviour or face tough consequences, and with universal and targeted activity to prevent young people starting to take drugs



- Local partners working together on our long-term ambitions will be key to the strategy's success, and we will develop a new set of local and national outcomes frameworks to measure progress against our key strategic aims through which government and public services can be held to account at both national and local levels.

Derbyshire is now highly unusual in retaining drug services in the NHS and provides a city and county consortium arrangement.

A presentation on the strategy is summarised and a joint presentation from our Assistant Director of Public Health, Richard Martin and Carolyn Green, Director of Nursing and Patient Experience to brief the Board on what the strategy states and exploration of approaches to be considered.

### Strategic Considerations

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

### Governance or Legal Issues

Information supplied in this paper is consistent with the Trust's responsibility as the lead provider of this county wide service.

### Public Sector Equality Duty and Equality Impact Risk Analysis

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

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

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.

Dictionaries define stigma as an indelible mark or a stain, and the term is generally applied to an attribute or status that makes a person unacceptable in other people's eyes.

Stigma is different from disapproval of particular behaviours because it is not necessarily linked to the actions of an individual, but rather to what is assumed about 'someone like that'. It also goes beyond stereotyping, as the stereotypical perception of who or what the person is becomes their defining feature, obscuring other aspects of their individuality and becoming fixed and hard to change. Such stigma then often leads to prejudice and active discrimination.

The stigmatisation of people with drug problems has serious consequences for government policy.

- Key policies seeking greater reintegration and recovery, moving people from benefits into work, and a focus on public health will not succeed while stigmatising attitudes are pervasive.
- If people with drug problems are seen as 'junkie scum' and 'once a junkie always a junkie', people will be reluctant to acknowledge their problems and seek treatment, employers will not want to give them jobs, landlords will be reluctant to give them tenancies and communities will resist the establishment of treatment centres. As a result, drug problems will remain entrenched rather than overcome and the wider factors that enable a person to step back in their lives are substantially hindered.
- Some would argue that, since drugs such as cannabis and heroin are illegal, this stigma is necessary to demonstrate society's disapproval of drug use. However, while society needs to set norms for behaviour and people need to take responsibility for their action, stigmatisation of people who have developed drug problems goes beyond that. Such stigma sees all people with drug problems as conforming to a stereotype (evil, thieving, dirty, dangerous etc.) and applies the label for life, and in so doing impedes the recovery that society wishes to promote.

As a leading provider of this service, we have a duty to challenge the stigma and discrimination both within our community and champion the voice and attention required of these services in the wider ICS.

## **Recommendations**

The Board of Directors is requested to:

- 1) Receive a briefing on the Drug strategy, consider your own personal commitment to these services, and how we enable them to flourish in Derbyshire.
- 2) Consider our own Trust and ICS contribution to the reduction of drug related deaths and reducing the risk of accidental, intentional death and death through inability to access health services.
- 3) To consider the population needs of Derby and Derbyshire in terms of Drugs strategy and improvement work.

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

**Report prepared by: Richard Martin, Assistant Director of Public Health and Carolyn Green**



# From harm to hope

*New 10-year drugs plan – PH implications*

Richard Martin

Assistant Director Public Health

# Contents

- *General overview of the strategy (first 3 years)*
- *High level focus – deliver world class treatment and recovery*
- *High level focus – achieve generational shift in demand for drugs*

*What does this mean for Public Health – detailed implications*

- *Treatment – finance and accountability*
- *New developments & better integration of services*
- *Recovery, criminal justice and prisons*
- *Shift in demand – early intervention and prevention*
- *Partnerships and accountability*
- *National and local outcomes frameworks*

# General Overview

- 10 year plan - £3bn over next 3 years
- Multi-government departmental
  - *Home Office; Ministry of Justice; Department of Health and Social care*
  - *Department for Levelling up, Housing and Communities*
  - *Department for Work and Pensions; Department for Education*
  - *Department for Culture , Media and Sport*
- 3 key strands
  - *Break drug supply chains (crime)*
  - ***Deliver a world class treatment and recovery system (death and harm) \****
  - ***Achieve a generational shift in demand for drugs (drug use)\****
- By 2024/25
  - Prevented 1,000 deaths
  - 20% increase in treatment places (33% increase for rough sleepers)
  - Prevented 750,000 crimes
  - Treatment place for every addicted offender
  - 50% increase in YP treated by specialist substance misuse services

# General Overview

- Overarching accountability is Combating Drugs Minister
- New national outcomes framework developed - April 2022
- Local delivery partners held to account through a local outcomes framework and local senior accountable owners – April 2022
- Each local area to have a strong senior multi-organisational partnership and interconnectivity with the ICS
- A new commissioning quality standard to be developed that supports transparency and accountability between partners

# World-class treatment & recovery

- Additional £780m over 3 years (on top of drug funding already in PHRFG)
- Rebuild local authority commissioned substance misuse services – quality, capacity and outcomes
- Strategically rebuild and develop a professional substance misuse workforce
- Ensure physical and mental health needs (and where relevant enforcement needs) are addressed via better integration of services
- Improve access to accommodation alongside treatment - for those sleeping rough and those needing support to maintain secure safe housing
- Improve employment opportunities
- Increase referrals into treatment as part of the criminal justice system and part of community sentences that engage offenders
- Improve engagement of people before they leave prison and better continuity of care in the community

# Generational shift in demand for drugs

- Fund cross-governmental research to establish an evidence base that drives real world change in attitudes to the acceptability of illegal drug use
- Take decisive action to target people in possession of illegal drugs and apply tougher, more meaningful consequences
- Deliver school-based prevention and early intervention through mandatory relationships, sex and health education with clear expectations that all pupils will learn about the dangers of drugs and alcohol
- Support young people and families most at risk of substance misuse through a range of interventions that provide early targeted support – including the Supporting Families Programme



# What does this mean for Public Health & the Resilience programme?

*detailed implications*

# Treatment & recovery

## Ensuring prisoners remain engaged in treatment after release

- Using the new ring-fenced PH drugs grant to prioritise continuity of treatment provided in prison into the community, seamlessly
- Develop more specialist drug treatment staff to work with local prisoners as they leave prison to help them re-enter the community and start treatment
- Use of digital technology so that prisoners can meet virtually with community-based treatment providers before release
- Integrate Health and Justice Partnership Co-ordinators into the ICS ensuring prisons and probations are involved in local commissioning discussions

# Generational shift in demand for drugs

## School-based prevention and early intervention

- Enhancement of approaches to building the resilience of young people giving them a good start in life – the Health Child Programme (universal and proportionate universalism) – *0-19 Public Health Nursing*
- Long-term monitoring of the efficacy of statutory relationships, sex and health educations curriculum in schools – the drugs education part
- Review current in-school programmes aimed at supporting children with vulnerabilities – managing emotions, coping with challenges and exercising behavioural control
- Multi-disciplinary approaches to provide wrap around support for those most at risk of involvements in serious violence and county lines

## Supporting young people and families most at risk of substance misuse

- Transformation of ‘Start for Life’ services creating local family hubs that provide access to support and ensure babies have the best start in life – *0-19 PH Nursing involvement*

# Partnerships and accountability

## Multi-agency leadership and defining local priorities

- Focused, ring-fenced investment to deliver additional support across treatment and recovery services
- Improved partnership working and multi-agency senior leadership – a strategic partnership of relevant organisations and key individuals with a nominated chair as the [strategy's] responsible owner
- Partnership can cover one or more local authorities, has proactive oversight of the implementation of all three strategic priorities and provides a single point to central government
- Multi-agency leadership of combating drug use could operate through existing Health and Wellbeing Board or Integrated Care Partnership structures
- Local partnership will conduct a joint needs assessment through the review of local drug data and use this to agree a local drug strategy and action plan
- Structures and processes to be operational in 2022/23 alongside the new quality standard for commissioning substance misuse treatment

# Partnerships and accountability

## National and local outcomes and frameworks (*treatment strand*)

- A new national outcomes framework is being developed to measure progress across the implementation of the strategy (long-term view and intermediate outcomes)
- Noticeable scrutiny on measures around: *deaths from drug misuse, volume of hospital admissions related to drug misuse, numbers in treatment and a new quality and outcome treatment measure for 2022*
- A new aligned local outcome framework will also be developed. Local performance will be compared with similar areas
- Potential for future funding to be dependent on showing progress on these outcomes
- New national commissioning quality standards will support local areas to align services with the outcomes required
- Local areas will need to produce their own annual report analysing local performance and identifying appropriate next steps

# What does this mean for Derbyshire Healthcare and Public Health?

- Co-align our approach to Trauma sensitive services
- Working together and further embed our strong relationships
- Substantial investment and focus on Substance misuse services
- A training needs analysis and investment into training in drug and Alcohol across JUCD
- A detailed investment plan
- Targeted support to reduce self harm and suicide of individuals often stigmatised by mainstream services

More than anything – it brings hope....

## Responsiveness Update

### Purpose of Report

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

### Executive Summary

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

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

The Trust continues to be responsive across many of the services it provides, achieving the majority of existing standards and proposed standards. However, there remain a number of services where being responsive continues to be a significant challenge. Pan service restoration post pandemic will address some of these access issues.

### Strategic Considerations

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

### Assurances

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

## **Consultation**

- This paper has not been considered by any other Committee.

## **Governance or Legal Issues**

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

## **Public Sector Equality Duty and Equality Impact Risk Analysis**

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

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

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

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

## **Recommendations**

The Board of Directors is requested to note the contents of this report.

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

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

**Lee Doyle**  
**Deputy Director of Operational Services**



## 1. Introduction

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

### Existing access standards

The standards are outlined in the Handbook to the NHS Constitution for England<sup>1</sup>. The applicable standards are as follows:

- The right to start consultant-led treatment within a maximum of 18 weeks from referral for non-urgent conditions.
- A maximum seven-day wait for follow-up after discharge from psychiatric in-patient care for people under adult mental illness specialties on Care Programme Approach (this reduced to a maximum 3 day wait from April 2020).
- 75% of people referred to the improving access to psychology therapies (IAPT) programme should begin treatment within six weeks of referral and 95% of people referred to the IAPT programme should begin treatment within 18 weeks of referral.
- More than 56% of people experiencing a first episode of psychosis will start treatment within a NICE-recommended package of care with a specialist early intervention in psychosis service within two weeks of referral (this increased to 60% in 2020<sup>2</sup>)

In addition, the NHS committed that by 2020/21, 95% of children and young people referred for assessment or treatment for an eating disorder should receive NICE-approved treatment with a designated healthcare professional within one week for urgent cases and within four weeks for every other case<sup>3</sup>.

### Proposed access standards

Following a clinically led review of mental health access standards in 2019 and subsequent pilot by mental health providers in collaboration with acute NHS trusts, in July 2021 NHS England<sup>4</sup> proposed a number of additional new standards as follows:

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

---

<sup>1</sup> <https://www.gov.uk/government/publications/supplements-to-the-nhs-constitution-for-england/the-handbook-to-the-nhs-constitution-for-england>

<sup>2</sup> <https://www.england.nhs.uk/wp-content/uploads/2016/07/fyfv-mh.pdf>

<sup>3</sup> <https://www.england.nhs.uk/wp-content/uploads/2015/07/cyp-eating-disorders-access-waiting-time-standard-comm-guid.pdf>

<sup>4</sup> <https://www.england.nhs.uk/2021/07/nhs-england-proposes-new-mental-health-access-standards/>

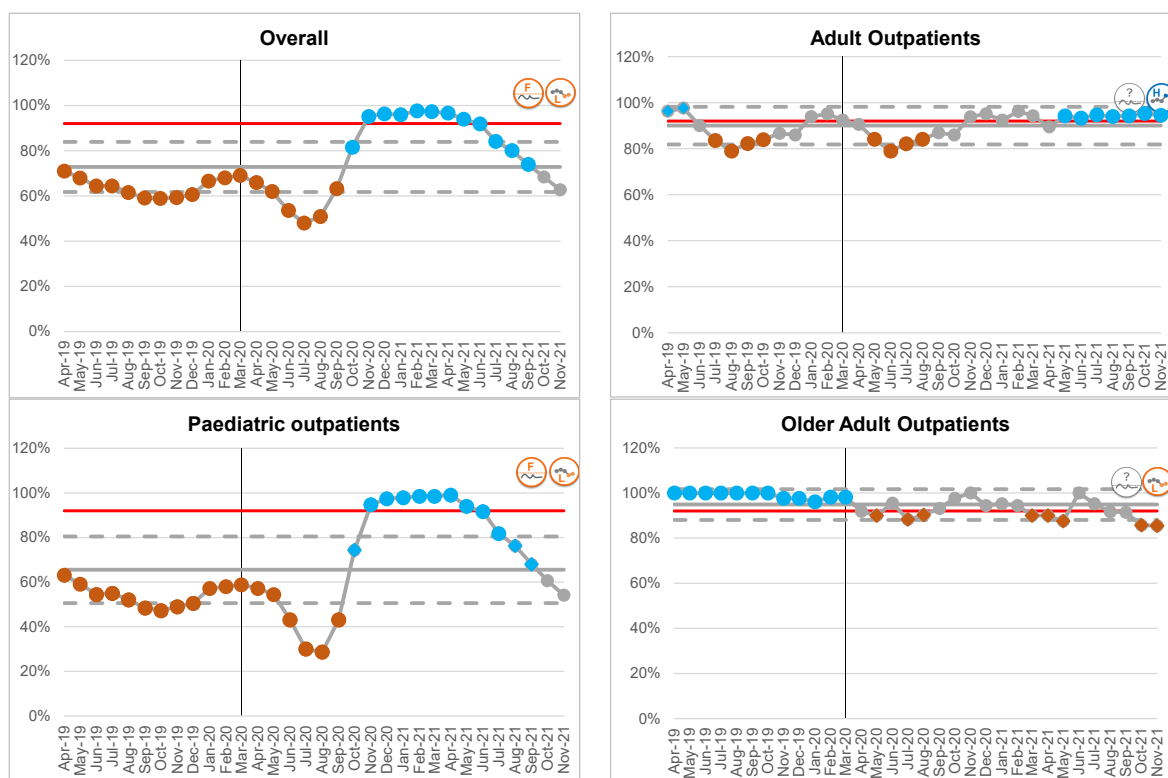
NHS England consulted on the proposed standards between July and September 2021. To date the outcome of the consultation is yet to be published.

## 2. Trust performance against the existing and proposed access standards

### Existing standards

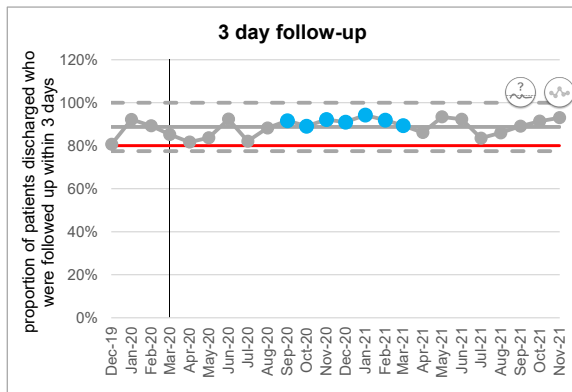
#### Consultant-led treatment

The national access standard is that 92% or more of the patients currently on the waiting list for a consultant-led outpatient service must have been waiting less than 18 weeks. In recent months the Trust has dropped below the national standard. This is linked to the significant increase in referrals to paediatric outpatients for neurodevelopmental assessment, which has been evident since January 2021. Older adult mental health outpatients have also fallen below standard on a few occasions. This is likely to be linked to the pandemic which was declared in March 2020, and the associated reduction in face-to-face contacts necessitated by infection control measures, as pre-pandemic this service was high performing, consistently exceeding standard.



#### Follow-up after discharge from psychiatric inpatient care

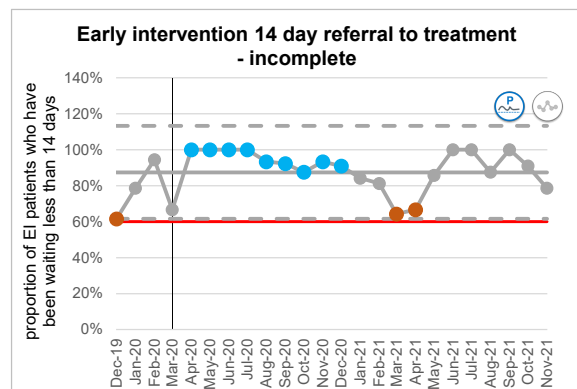
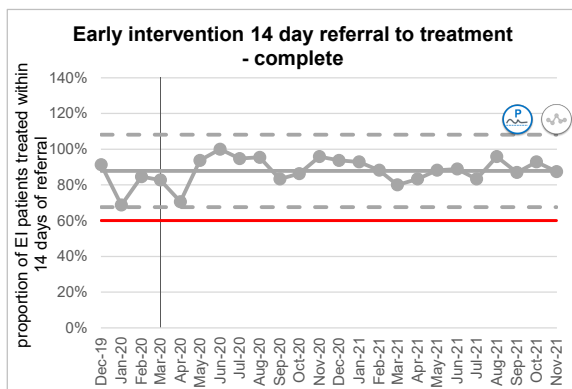
To date we have consistently exceeded the national standard for follow-up which came into effect from 1 April 2020.



**Early intervention in psychosis**

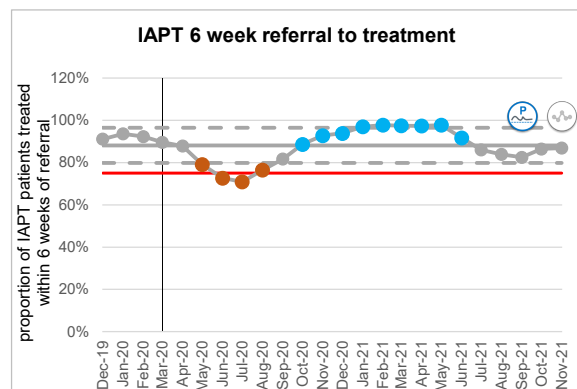
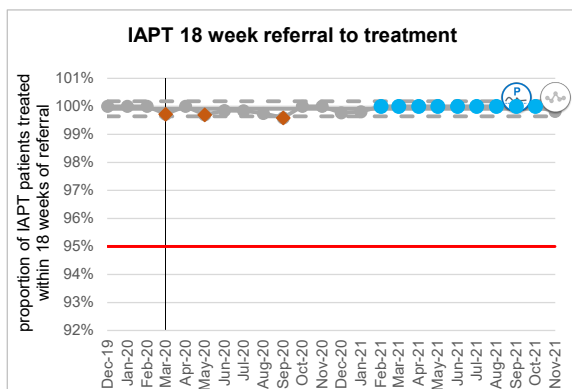
For completed treatments there has been common cause variation throughout the 24-month period and would expect to consistently exceed the national standard for referral to treatment, meaning patients with early onset psychosis are continuing to receive very timely access to the treatment they need.

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



**IAPT referral to treatment**

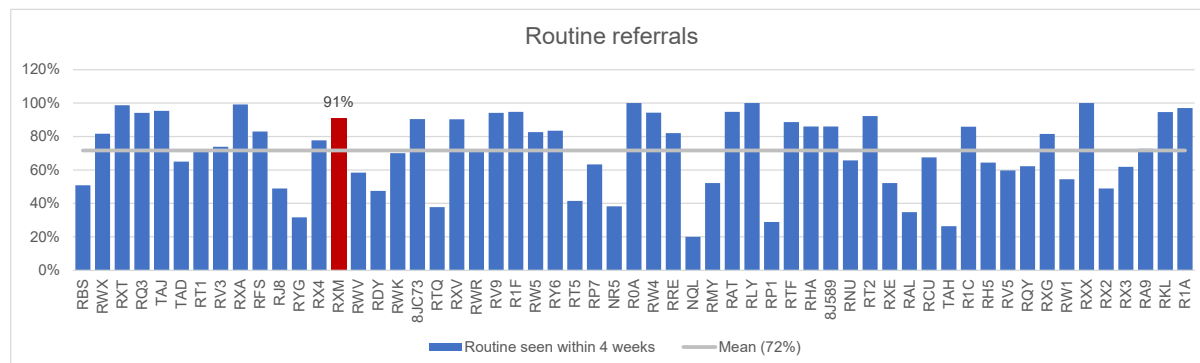
The national standard for 18-week referral to treatment (standard = 95%) has been exceeded throughout the reporting period. 6-week referral to treatment (standard = 75%) was impacted upon at the start of the pandemic owing to IAPT clinicians being redeployed to support other services for several months but has subsequently been consistently above standard.



IAPT is revising its waiting well policy to increase resource for treatment. In addition, trauma wait lists are being consolidated, patients contacted to determine whether they still need a service and a business case explored for temporary increase of staff via agency, and additional hours for existing staff.

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

In the latest published national data (quarter 2 – 2021/22) 91% of routine referrals were seen within four weeks of referral, which is below the national standard of 95% but is considerably higher than the national average of 72%.



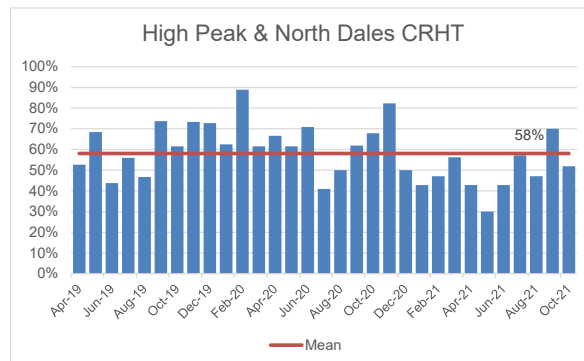
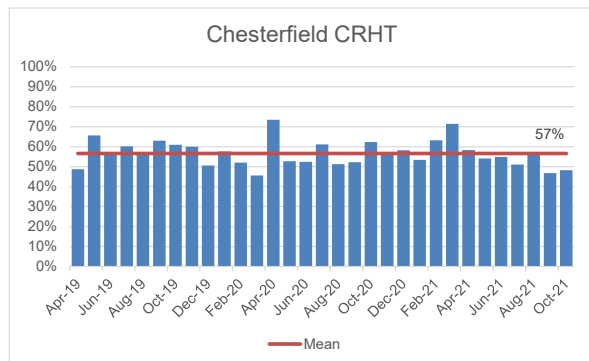
Data source: [Statistics » Children and Young People with an Eating Disorder Waiting Times \(england.nhs.uk\)](https://statistics.nhs.uk/articles-and-news/children-and-young-people-with-an-eating-disorder-waiting-times)

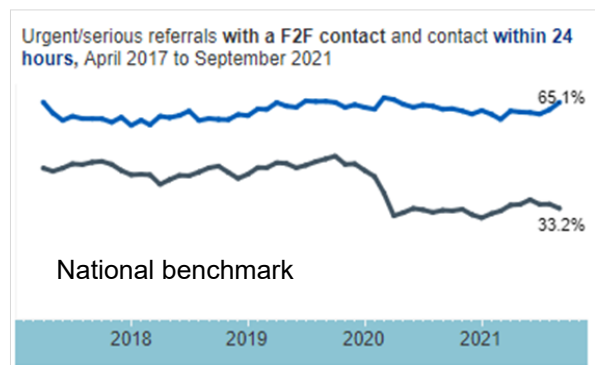
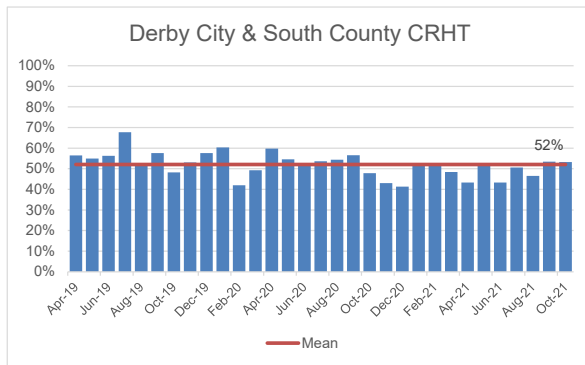
We have secured some short term funding via winter funds to add some temporary resource and also some funding via the Children and Young People (CYP) Crisis funding to increase the team capacity by 1.0 WTE (whole time equivalent).

### **Proposed access standards**

#### Urgent referral to a community based mental health crisis service

From the data there are around 94 referrals recorded as urgent per month in the south of the county and 59 per month in the north of the county. On average between 52% and 58% of these referrals were seen within 24 hours of referral to our crisis services, of whom 65% were seen face to face. Nationally around 65% were seen within 24 hours, of whom 33% were seen face to face.





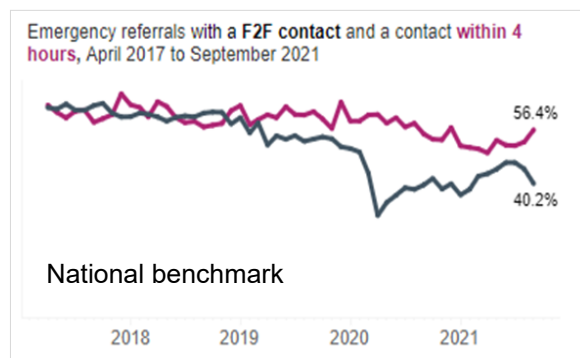
National benchmark data source: <https://future.nhs.uk/AdultMH/view?objectId=27382736>

Caveat: as we have only recently started formally collecting this data against the proposed standard and there are multiple options to select on Paris, the patient record system, in terms of referral priority, there is likely to be a level of inaccuracy within the historical data. Work is underway to data cleanse and improve recording accuracy going forward and the teams are receiving weekly reports to aid with this data quality improvement process.

### Very urgent referral to a community based mental health crisis service

As it stands there are around six referrals per month recorded as emergency or four hour priority in the south of the county and 19 recorded per month in the north of the county. 9% of these were seen within four hours of referral to our crisis services. Nationally around 56% were seen within four hours, of whom 40% were seen face to face.

As the Trust have only recently started formally collecting this data against the proposed standard, validation work continues, the teams are receiving weekly reports to support this data quality improvement process.



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

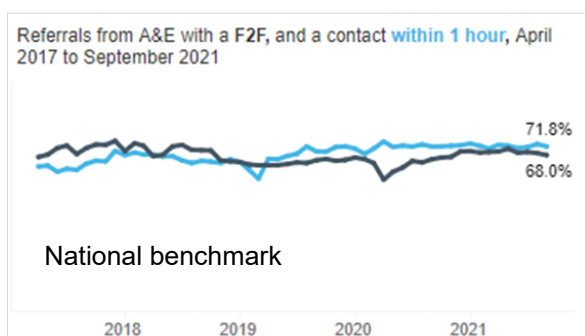
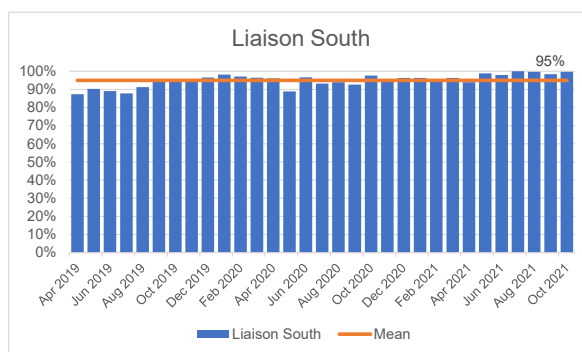
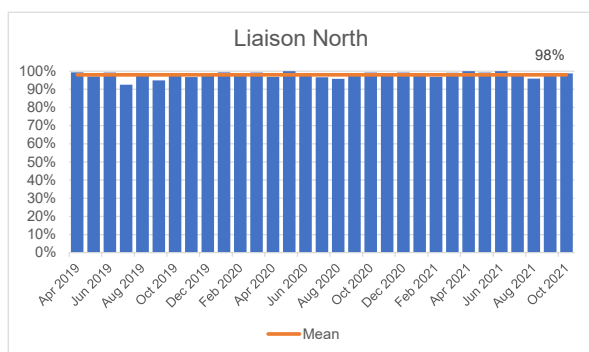
With the difference in referral numbers against north and south, there is an opportunity to understand this further in terms of referral profiles and classification of referrals to ensure a consistent approach. The acute services division with support from the board may seek to commission a piece of work to aid understanding around this.

### Patients referred from Accident and Emergency

On average 95% of adult referrals from A&E are seen within one hour of referral by Liaison South and 98% by Liaison North. This is much higher than the national benchmark of around 72%.

This is a fantastic response, especially when compared with the national average. There is an opportunity for the Trust to celebrate this achievement and how this is shared with the system with acute hospital system partners.

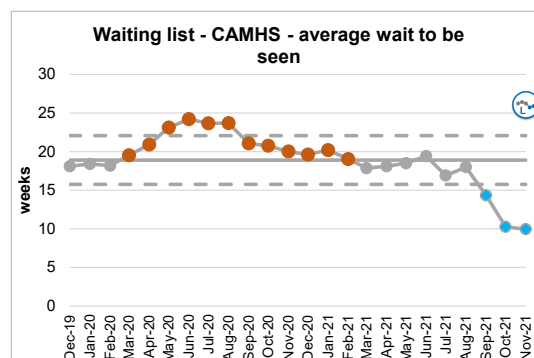
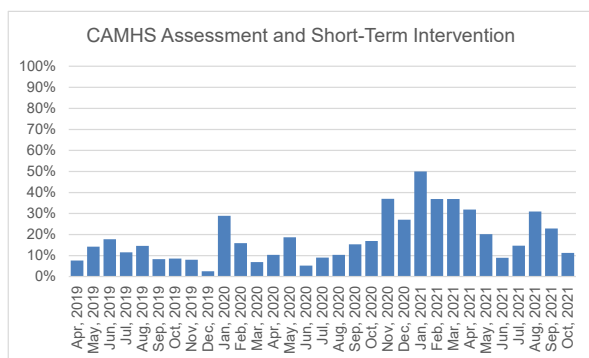
Currently there is no data collected relating to the Trust's CAMHS RISE Liaison Team regarding the proposed one hour standard.



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

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

Only around 18% of referrals have been seen within the proposed standard of four weeks. As reported to Board, significant work has been undertaken in recent months to reduce waits, with the average wait to be seen now standing at ten weeks.



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

The charts below provide performance against the proposed four week standard across the Trust's adult and older adult community mental health teams. Overall, around 52% of referrals are seen within four weeks of referral, 32% in adult services and 70% in older adult services. The data shows that there is quite a wide variation across teams.

A multiagency discharge event (MADE) was held in the community recently as part of improving flow.

## Adults

Part of the work of the divisional Clinical Reference Group is focusing on referral pathways, to ensure consistency across teams and improve pathways between primary and secondary care services.

A working group has been set up to develop discharge principles to enable flow through service, creating capacity and reducing wait times. The group includes clinical and operational colleagues, as well as carers and people with lived experience.

The Waiting Well policy is being reviewed by the Head of Nursing with input from people with lived experience to improve responsiveness and manage risks for those on the waiting lists.

The Community Mental Health framework transformation and the roll out of the Living Well model, will help to improve both access and responsiveness, with a 'no wrong door' approach and collaboration with primary care, social care and voluntary, community and social enterprise (VCSE) organisations in meeting individual's needs at the time when they need it.

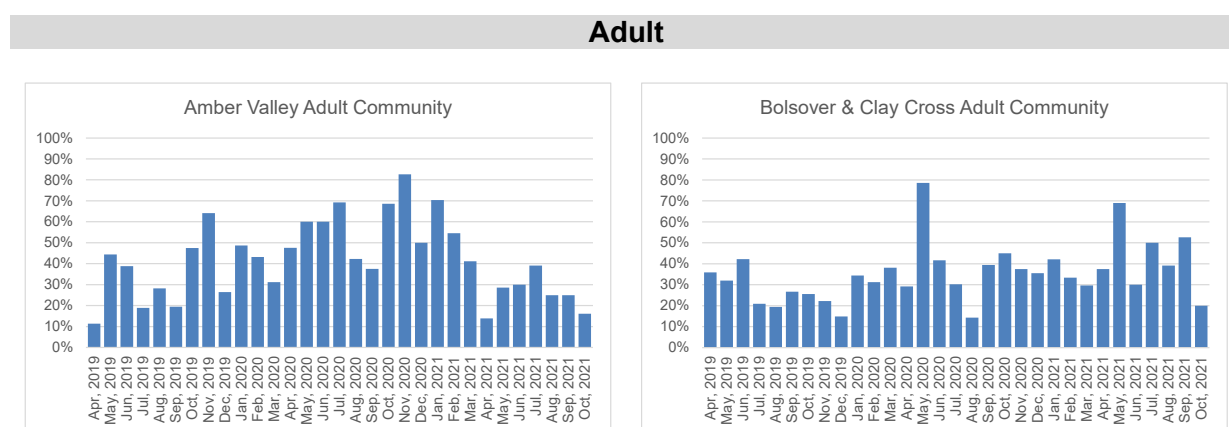
## Older adults

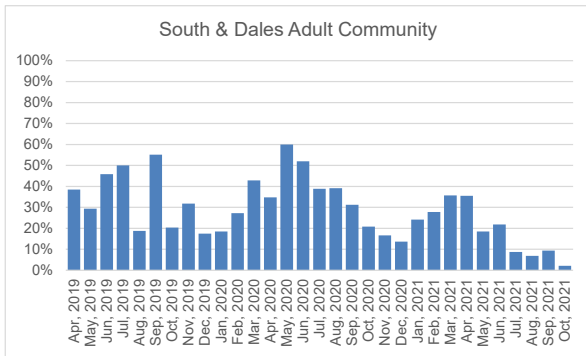
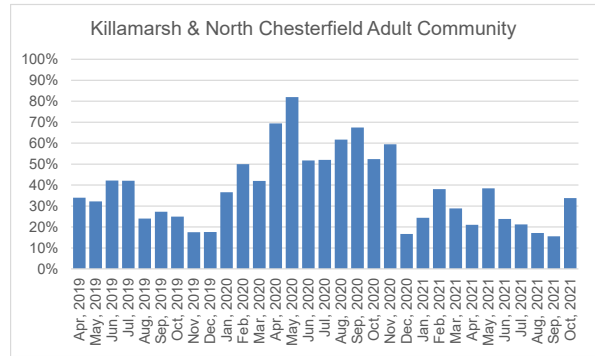
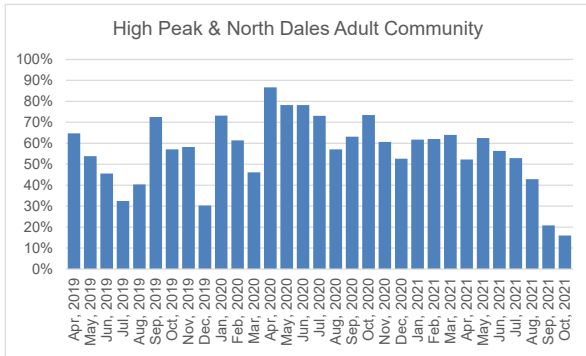
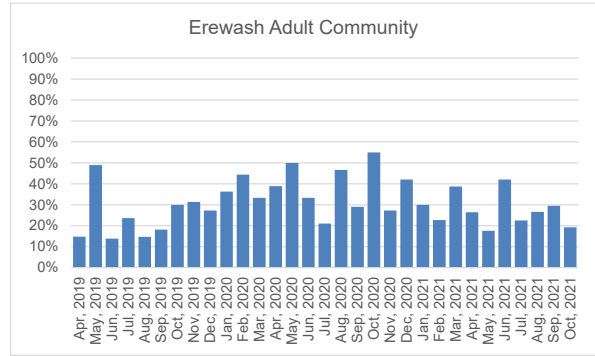
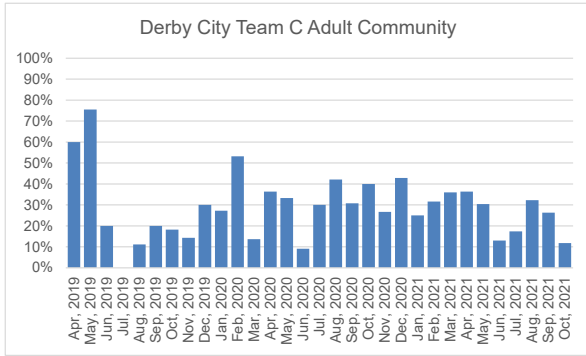
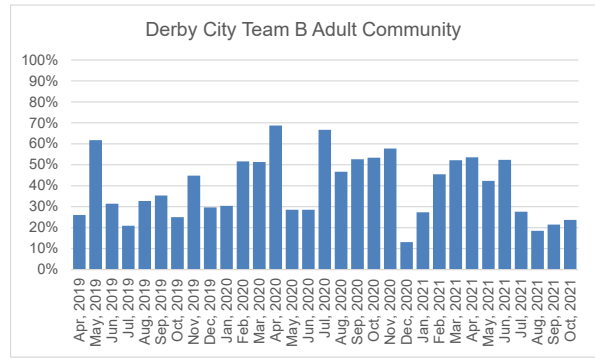
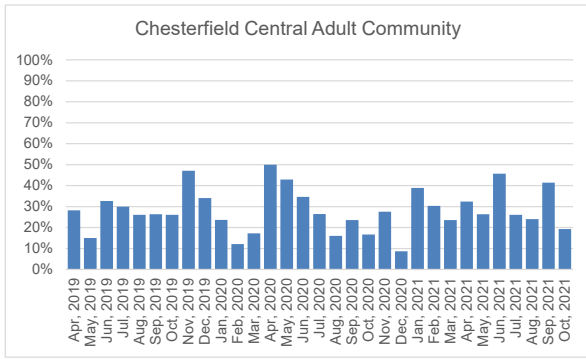
Wait times in Community Mental Health Teams (CMHTs) have reduced as redirected resources where necessary to reduce wait times. There remain some excessive waits in Bolsover and North Dales due to staff absence but non COVID absences has reduced so those wait times should also start to come down.

MAS – Additional resource in place until the end of the financial year, which is helping with some reduction in waits, the intention is to continue this into the next financial year based on the impact delayed diagnosis is having in other parts of the pathway.

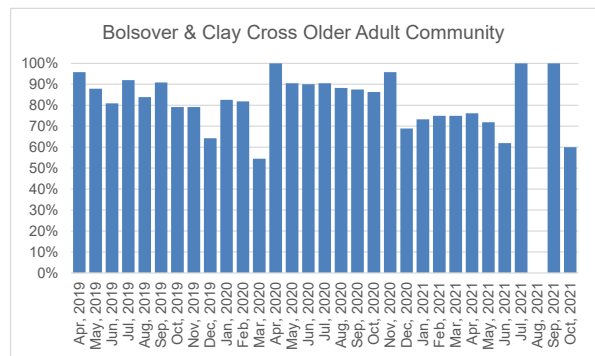
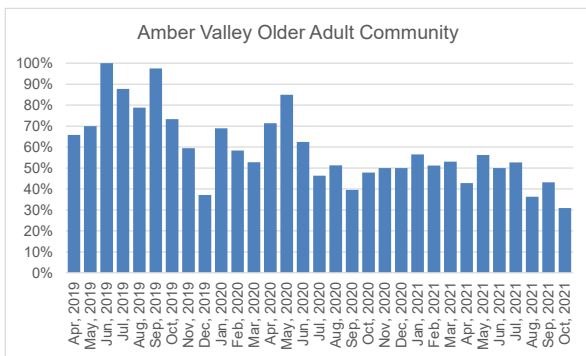
Day Services – waits will be impacted by stepdown again to support the Covid operational response, but they were reducing.

Pathways and flow- Clinical Leads carrying out work to improve flow and improving communication between services.

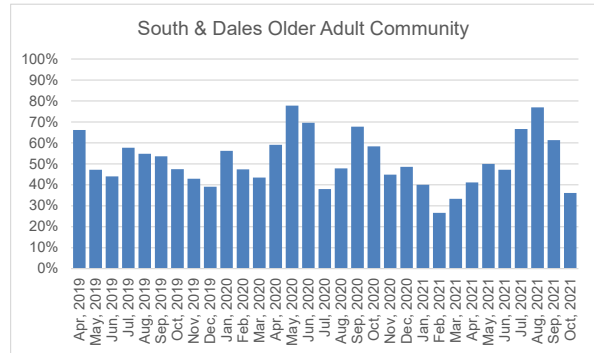
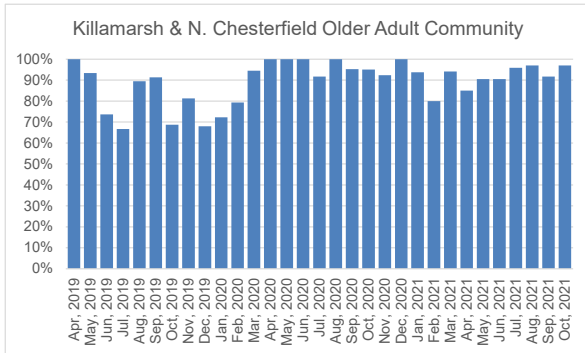
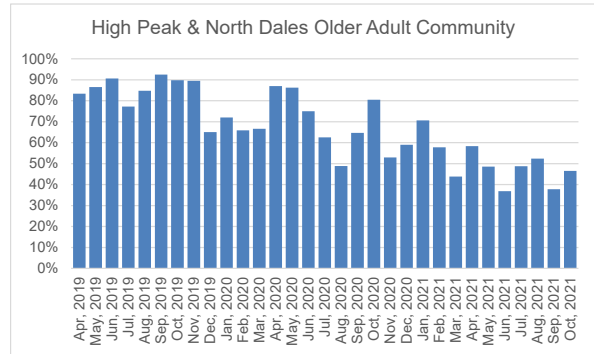
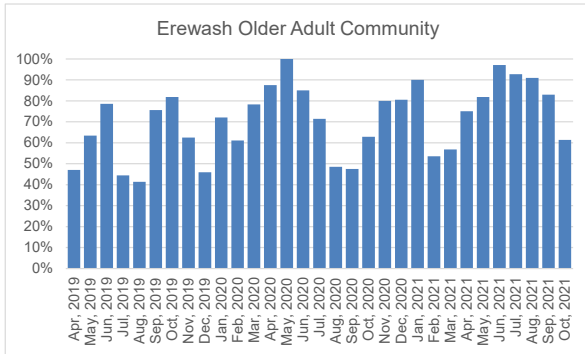
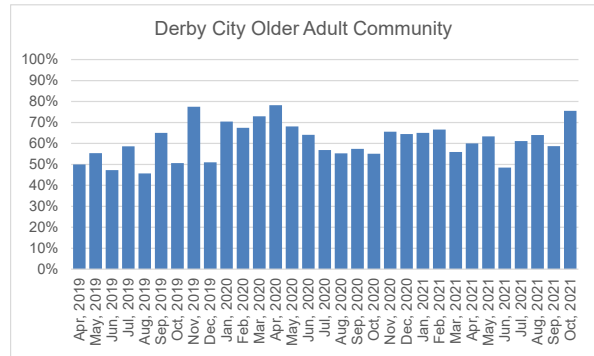
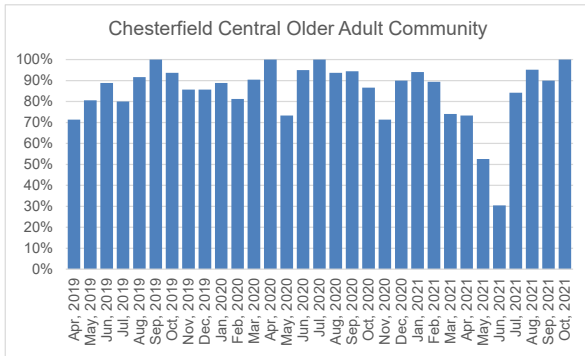




## Older Adult





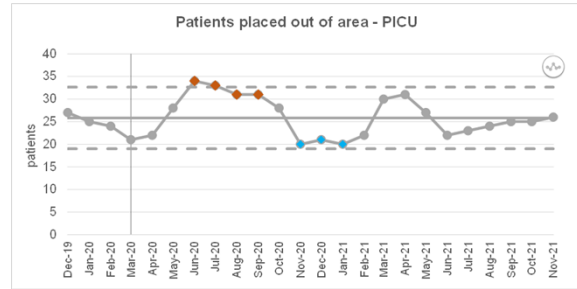
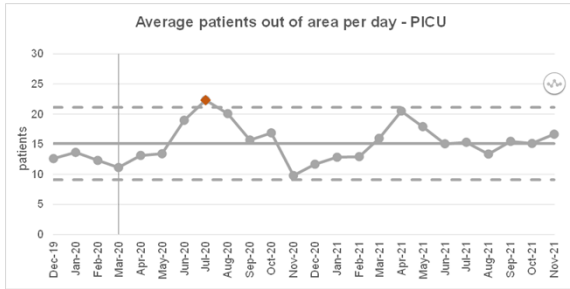
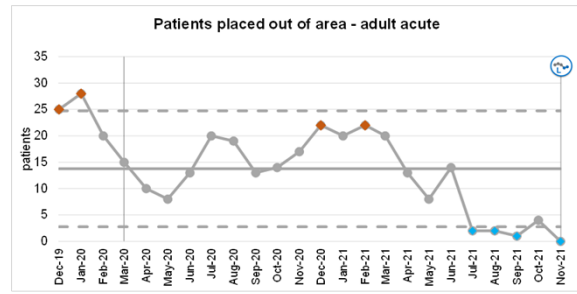
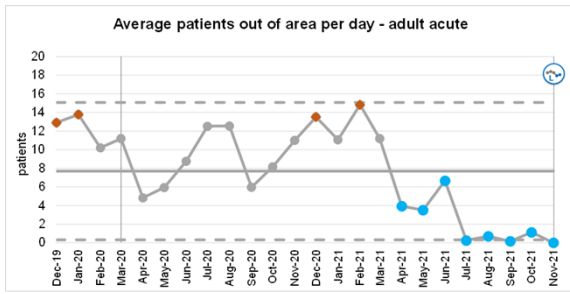


### 3. Other Considerations

#### Inappropriate out of area placements

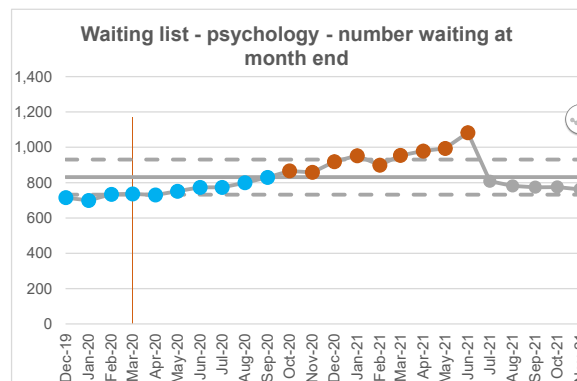
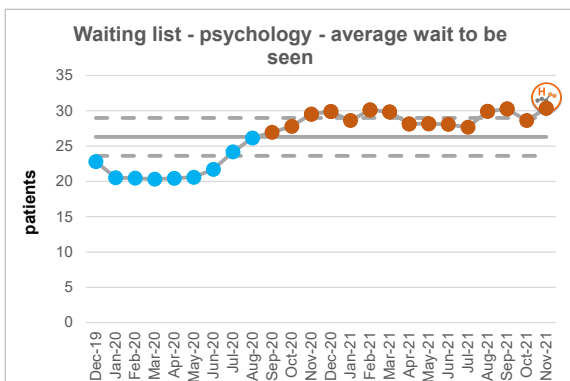
Significant work has been undertaken since April 2021 in order to reduce inappropriate out of area acute placements to a minimum in line with the objective of the Five Year Forward View for Mental Health (The Mental Health Taskforce, 2016) which was to eliminate inappropriate out of area placements for acute mental health care for adults by 2020/21 (including Psychiatric Intensive Care Unit (PICU) placements). A multi-agency discharge event (MADE) was held, resulting in system development and the use of data to improve flow. This eliminated the need for out of area acute placements, however there are currently a small number of placements owing to a reduction in Trust bed numbers as a result of supporting wider system needs, coupled with the pandemic necessitating a reduced bed base for infection prevention and control reasons.

There is currently no PICU provision in Derbyshire so anyone needing psychiatric intensive care needs to be placed out of area. However, work is in progress towards a new build PICU provision.



Waiting times for psychology

Although there is no national or local access standard there continues to be a significant challenge with respect to the waiting times for psychological support.



We continue see the impact of the pandemic on waits, with the average waits being significantly higher than expected for the last seven months. Many patients are still waiting owing to the pandemic and a desire to be seen face to face as opposed to by video call.

The number of people waiting has been below average for the last five months. Recruitment to a number of vacant and part time posts across adult services is in progress. However, we have nearly a 30% vacancy rate across all of psychological services, with the biggest gaps being in the community mental health teams (CMHTs).

We have continued to review the waiting lists in line with trauma sensitive working in considering how we manage people on a waiting list and barriers of movement between services. The need for increased access to psychological services is being considered with a mapping exercise across all of the CMHTs being completed.

The challenges highlighted here remain relevant. In response to this we are: -

- Focussing on recruitment – gaining support from people’s services for this. We are currently advertising. Within this work offering flexible and combined roles to make them attractive.

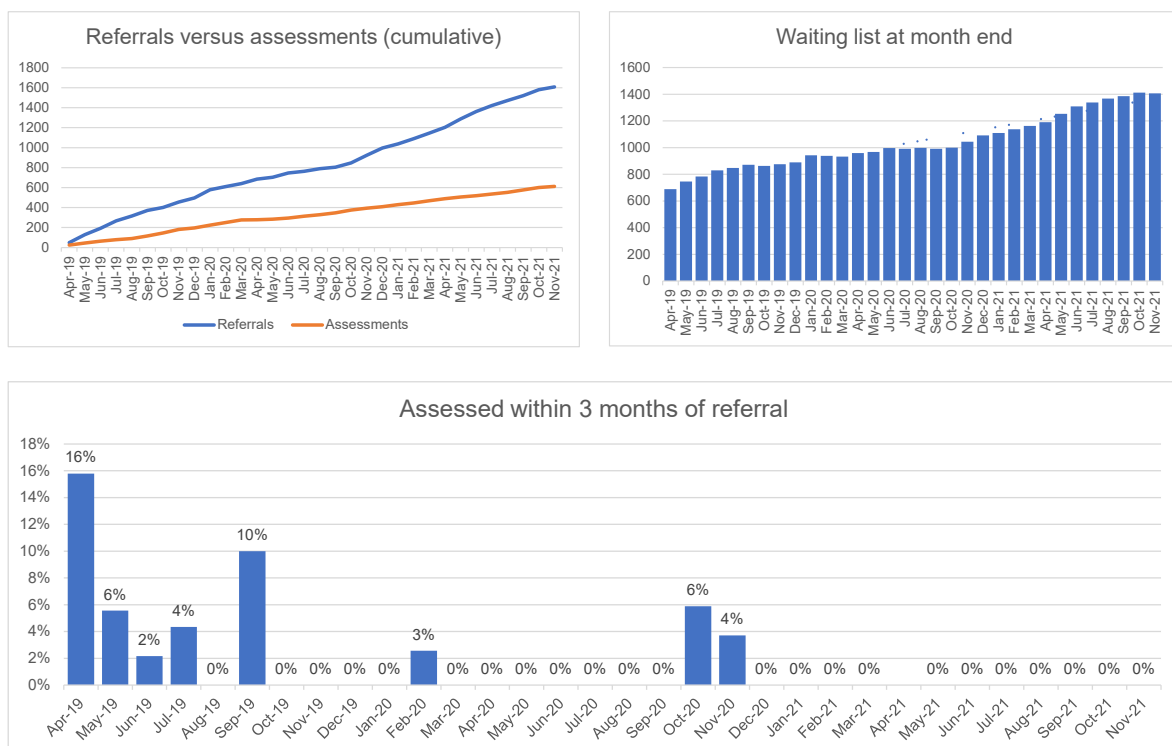
- The service is piloting recruiting a remote Cognitive Behavioural Therapist worker in the Community Mental Health Teams to see if this improves recruitment and delivery of treatment
- Highlighting the profile of psychology in Derbyshire through links with national and regional groups
- The service is employing assistant psychologists in short term contracts where we cannot recruit qualified staff
- The service is covering internal referrals and urgent matters through discussion within and across the teams
- The service leads are taking action to increase psychological skill within teams through training and awareness.

### Adult Autistic Spectrum Disorder (ASD) Assessment Service

There is no national access standard for adult ASD assessment and the Trust does not monitor access times, however the NICE Quality Standard [QS51] on autism (2014) sets a standard of three months from referral to diagnosis.

Demand for this service far outstrips commissioned capacity. To meet demand, 57-74 assessments would need to be completed per month. However, the Trust is contracted to deliver just 26 assessments per month and is achieving around 19. As a result, the waiting list has more than doubled over the sample period, with the longest wait being around 3.5 years.

There is now the opportunity for the Derbyshire system to review the current contractual arrangements and change these to support the referral demand.



In the immediate term the service has appointed an assistant psychologist to try and do some of the lower level of work, freeing up the experienced staff to deliver higher level assessment and treatment. The role starts in post on mid-January. There is also a short term offer to move an Occupational Therapist from elsewhere in Learning Disability and Autism who can contribute to this team. The assessment process has been reviewed, to reduce assessment time taken to the minimum.

#### **4. Conclusion**

The Trust continues to be responsive across many of the services it provides, achieving the majority of existing standards and proposed standards. However, there remain a number of services where being responsive continues to be a significant challenge. Pan service restoration post pandemic will address some of these access issues.

## Board Committee Assurance Summary Reports to Trust Board – 18 January 2022

The following summaries cover the meetings that have been held since the last public Board meeting held on 2 November 2021:

- Quality and Safeguarding Committee 9 November and 14 December
- Finance and Performance Committee 16 November
- People and Culture Committee 23 November
- Mental Health Act Committee 11 December

### Finance and Performance Committee - key items discussed 16 November 2021

#### Assurance on Estates strategy – dormitory eradication and Psychiatric Intensive Care Unit (PICU)

The national approval letters received for two Outline Business Cases (OBCs) - £80m national funding were reviewed and discussed and the risk profile updated.

Live discussions were held on completing enabling works before construction to de-risk the programme on speed required up to £12m funding for costs expected between April and August 2022 before Full Business Case (FBC) approval.

A mini business case is being developed for national committee to approve early draw down to result in the new Memorandum of Understanding (MOU).

The Radbourne Unit refurbishment and PICU/acute plus OBCs are progressing through nine of ten gateways – Joined Up Care Derbyshire (JUCD) Board being final stage of system approval.

Overview and scrutiny discussions are progressing positively. VAT abatement discussions were held.

Limited Assurance was received. The Local Operating Procedure (LOP) was supported and delegated limits noted. The Audit and Risk Committee is to review LOP ahead of their next meeting and process to be confirmed

#### Assurance on Estates strategy – half yearly update

All audit actions completed. KPIs are progressing well. National cleaning standards are on programme. The Green Plan was approved by the Board and is being operationalised. The property changes summary was noted.

Success was recognised. The Committee gained good confidence in services.

#### OnEPR Programme update

Phase 3 (working age inpatient) and phase 4 (working age community) will be combined into one.

Risks were discussed; the main current risk being around the data migration workstream meeting the 24 January deadline. The risk of delay is being ascertained imminently.

The App for ward-based observations has been rolled out with successful testing and resolution of issues. Now in a strong position ready for roll out.

Registration of smart cards was discussed as an example indicator of how people are feeling / prioritisation of choices being made by colleagues.

Limited assurance received.

## **Operational Performance**

The report showed that KPIs were met in the main. Some areas are still affected by Covid, in particular waiting times including Child and Adolescent Mental Health Service (CAMHS).

Autism Spectrum Disorder (ASD) has been commissioned for less than needed. This is a system issue to resolve and manage.

Psychology – increased capacity. Trust Operational Oversight Leadership (TOOL) group holding discussions on psychological therapies going forward.

Multi-agency discharge events (MADE) events are successful. Examples of data and main patient flow issues and variation in services were discussed. MADE summary will come back to a future meeting for overview.

Out of area placements remain very low for adult acute - currently zero. Improving Access to Psychological Therapies (IAPT) drop in access performance is being discussed.

Limited assurance.

## **Transforming Care Partnerships (TCP) proposal and transition and wider Learning Disability and Autism (LDA) discussion**

Current issues were discussed with all options being explored.

TCP situation is very complex. TCP performance rate of admissions continues to rise ahead of trajectory. New process being put in place by end of Q4 will aim for trajectory achievement.

Discharges with wraparound support intense work have taken place in the last two weeks.

National and regional escalations on TCP performance were reviewed. DHCFT is providing a lot of intensive support to system partners at local ATU.

Distinction of risk areas needed between TCP and the wider LDA services support is being provided. As further information is known the discussions and assurance oversight will take place at the most relevant Committee or Board; as relevant to Quality and Safeguarding Committee and Finance and Performance Committee (F&P) and the overarching discussions at Trust Board.

## **Update on Mental Health helpline**

The high levels of usage were seen as positive but does create resourcing pressures. There is increasing use at night. Age demographics are being considered. Levels of 'unknown' demographic data capture is being worked on to increase capture.

Mental Health Urgent Care workstream is discussed monthly and is well received. The helpline is having a positive impact on 111/EMAS/Emergency Departments. A return to prior levels of street triage is expected to help further as will more crisis alternatives.

There will be system project management consideration of value/benefits impacts across system activities.

Now that the helpline is business as usual it will not be separately report in future, but evaluation report will come to the Committee. The contract review point is March 2022 with relevant information to be flagged to Committee from the review.

## **JUCD LD Provider collaboration performance – committee risk ownership discussion**

Discussion took place in TCP/LDA discussion earlier.

## **Business environments – partnerships, planning and system transformation update**

Regional Provider collaboratives – DHCFT as East Midlands Perinatal Lead Provider progress to date discussed. Governance and assurance requirements are progressing. Development work is taking place with colleagues on clinical engagement and experts by experience discussions on the collaborative outcomes that might be sought.

The Forensic financial risk is significant - this year it is based on two things: initial NHS England (NHSE) allocation NHSE/Lead Provider seeking solutions. The other is occupancy related and out of area placements.

Occupancy financial risk held by provider where activity changes and out of area action plan sits. Consideration is being made of any implications for other lead provider arrangements and the resourcing/capacity implications of the perinatal work.

### **Financial governance and plan delivery including CIP (Cost Improvement Programme) and H2 planning**

- Joined Up Care system position noted
- H1 and month 7 position noted
- H2 planning noted as signed off in detail by previous Board subset meeting
- Capital and cash planning and risks noted
- Current planning for cost improvement noted
- Agency spend still significantly above ceiling
- Better Payments Practice Code performance noted
- Current off-payroll position noted

Limited assurance received on plan delivery. Significant assurance obtained on appropriate financial governance.

### **Continuous improvement including Quality Improvement approach**

Quality Improvement strategy signed off by Quality and Safeguarding Committee (QSC) on 9 November. Back to QSC implementation plan in future meeting. Regular reporting on implementation and impact will be reported to F&P.

Capacity pressures, the impact on wide ownership to ensure buy-in and possible need to filter some focus areas if capacity is a limiting factor.

### **Board Assurance Framework risks**

No changes required and Committee discussions were appropriate to the BAF risks allocated to F&P.

Discussion included challenge on level of OnEPR risk level (sitting at moderate). Learning from Covid pandemic element is being built into day to day work and incorporated in ongoing QI / transformation work. F&P is to receive another deep dive for BAF risk 3b *“There is a risk that learning from the response to the COVID-19 outbreak, and transformation plans developed prior, does not lead to sustainable embedded transformation”* given the ongoing pandemic and translation to day to day work.

### **Cyber risk BAF risk 1d – ‘semi-deep dive’**

*“There is a risk that the Trusts increasing dependence on digital technology for the delivery of care and operations increases the Trusts exposure to the impact of a major outage, i.e. cyber-attack, equipment failure.”*

Moderate risk level confirmed – component elements within the BAF were reviewed in a walk-through provided by COO.

### **Emergency Preparedness Resilience and Response (EPRR) annual report 2021 and Core Standards self-assessment outcome**

- Policies being update in response to changes to core standards this year
- Action plan in place to address areas of non-compliance in areas of change
- EPRR Steering group will complete actions at pace and update
- F&P is to receive a further update at next meeting in January.

### **Health and Safety – half year report**

The report covers Fire, Health and Safety and Security Management for April to September 2021. Fire warden turnaround is progressing well, final 24 people to be trained. Audits have included additional 26 questions around Covid secure and is performing well with assurance on compliance with evidence. A few Covid related incidents have occurred on security/access etc. Well-accepted changes have taken place in working practice

Good views that have few Covid positive environments indicate we can expect compliance visits for inpatient visits from Derbyshire Fire & Rescue Service (DFRS) and Fire Officer.

DCHFT is leading with Derbyshire Interagency group on improving accessibility and inclusion, new build/refurb opportunities will embrace this – e.g. pictorial information etc. Challenge is expected from F&P over the next 12 months to evidence the national promotion of successes

Significant assurance received.

### **Board Assurance Framework – key risks identified**

No changes required. Discussions were appropriate to the BAF risks allocated to F&P.

### **Escalations to Board or other committees**

Relevant Learning Disability and Autism risk discussions will routinely take place within the Quality and Safeguarding and Finance and performance Committees.

### **Next Meeting – 25 January 2022**

**Committee Chair: Richard Wright**

**Executive Lead: Claire Wright, Director of Finance and Deputy Chief Executive**

### **Quality and Safeguarding Committee - key items discussed 9 November 2021**

#### **Summary of BAF Risks**

BAF risks were considered within the Committee's current work programme. Updates were discussed and agreed for Risk 1a "*There is a risk that the Trust will fail to provide standards for safety and effectiveness as required by our patients and our Board*". Discussion covered delays in accessing Tier 4 beds and will be articulated in the next iteration of the BAF.

#### **Escalation from People and Culture Committee**

PCC requested that anomalies around safer staffing data and reporting that flows through to the e-roster system be looked at to establish if it is accurate.

QSC reviewed the automated report and the safe staffing standards model and confirmed that it has no residual concerns around data integrity. PCC was advised of these findings on 23 November and informed that learning has been taken from this reporting incident to ensure that internal operational reporting is refined to reflect the Trust safer staffing levels.

#### **Risk Register escalation assurance**

Significant assurance was received from the report. There are currently eight high/extreme operational risks open on the Trust-wide risk register, compared with nine reported in July 2021. Good headway is being made in all areas of risk management training. The report is to be regularly reviewed as a core part of operational business by the Trust Operational Oversight Leadership (TOOL) group.



## Quality Performance Dashboard

A review of the performance dashboard capturing September data showed a stable position with no indicators showing a deterioration. The backlog of Serious Incident (SI) action is being cleared and is under control. Duty of candour events remain stable. Complaints actions remain above the expected target. Psychiatric Intensive Care Unit (PICU) uptake is on a lower trajectory. Physical healthcare plans show an improving situation. No sexual safety incidents took place between July and September. All incidents of self-harm are being closely monitored for patterns and learning.

## Vaccination Inequalities

An update on work to address vaccine inequalities undertaken by the Trust in partnership with joined Up Care Derbyshire (JUCD) provided significant assurance from the work to address the needs of the local population that focussed on the unmet needs of underrepresented groups.

The Assistant Director of Public and Physical Healthcare and the Kingsway Hospital hub were commended for enabling reasonable adjustments for those people with hidden needs to attend for their vaccine.

## Ligature risk reduction

A gap analysis, with recommended actions from the Care Quality Commission (CQC) against the Trust's Ligature Risk Reduction Policy revealed the substantial headway made in anti-ligature design within the Trust. Completion of this review provided significant assurance on procedures and period of implementation as part of ongoing business as usual risk assessment.

## Skill mix and safer staffing review

This report provided a formal opinion on the required skill mix and assurance on the work to monitor and develop the skill mix of staff across the Trust to ensure safe services.

Significant assurance was obtained on safer staffing standards within the Trust. The report showed good indicators in terms of staff turnover, morale, the standards required on safer staffing skill mix and progress.

QSC discussed how the report showed a reduction in the staff vacancy rate. Although the Trust fares well in terms of the national picture and there is further work to be done to ensure and maintain robust programmes of recruitment, the QSC Executive lead was of the opinion that the narrative around recruitment and staffing within BAF risk *"There is a risk that the Trust will fail to provide standards for safety and effectiveness as required by our patients and our Board"* is not specific enough and it should be redefined so that it describes what the risks are around specific recruitment hotspots rather than a Trust wide value or risk. The COO and Director of People and Inclusion will follow up the definitions/narrative of the BAF risk 1a after discussions have been held at the PCC on vacancy and recruitment risks to ensure they are taken through the next iteration of the BAF.

## Escalations to Board or other committees

PCC is to review whether the 12% vacancy rate is determining the high rating of BAF risk 1a or whether there are more complex issues to be considered in terms of vacancies and define the rating level of this risk and whether it can be reduced and include specific recovery actions and /or reduce recruitment risks in named areas rather than Trust wide.

PCC is to look at workforce projects that will improve continuous quality and address how the QI training approach can be implemented to support the QI improvement plan.

## Board Assurance Framework – key risks identified

The narrative around recruitment and staffing within BAF risk 1a is to be redefined to describe what the risks are around specific recruitment hotspots rather than a Trust wide value. This has been escalated to PCC to review.

## Next Meeting – 14 December 2021

**Committee Chair: Margaret Gildea**

**Executive Lead: Carolyn Green, Director of Nursing and Patient Experience**

## **Quality and Safeguarding Committee - key items discussed 14 December 2021**

### **Summary of BAF Risks**

BAF risks were considered within the Committee's current work programmes. Key gaps in control around investment in autism assessment and treatment services and implementation of the Quality Improvement (QI) strategy were noted with assurance obtained that action to close these gaps are in progress.

### **Response to escalations taken to People and Culture Committee on 23 November 2021**

The People and Culture Committee (PCC) was asked to review the 12% vacancy rate and define whether the narrative within BAF risk 1a *"There is a risk that the Trust will fail to provide standards for safety and effectiveness as required by our patients and our Board"* can be more granular to include specific recovery actions and/or recruitment risks in named areas rather than reflecting a Trust wide view.

PCC reported that in terms of operational oversight of recruitment processes and safe staffing management, this is led by the Director of People and Inclusion and COO. The Trust does not operate within a 12% vacancy void. Staffing levels are adequately supplemented with bank and agency staff. Safe staffing reviews have provided assurance that there are enough staff to safely operate services.

QSC was satisfied that staffing levels are safe but felt there are areas with high turnover and a vacancy rate in excess of 12% that are over reliant on bank and agency staff. It was agreed that the COO will ensure that the targeted plan and mitigating action being taken to address areas with a high vacancy rate that are over reliant on bank and agency staff will be articulated within the next iteration of BAF risk 1a.

PCC was also requested to look at workforce projects that will improve quality and consider how Quality Improvement training can be made available to all staff. PCC confirmed that the Quality Improvement programme has been signed off and is now in place. QI improvement work is also monitored by the Finance and Performance Committee.

### **Development of the Clinical Operational Assurance**

This report updated the Committee on the recommencement of divisional full oversight through the Clinical Operational Assurance Teams (COATs).

The Trust has been in a period of transition from full Covid pandemic incident management to a planned and phased return to distributed clinical operational leadership. As part of the Trust roadmap the recommencement of COATs have resumed. Oversight of COATs is through the divisional performance achievement reviews at the Trust Operational Oversight Leadership (TOOL) group chaired by the COO.

### **Briefing on the new Community Mental Health Framework (CMHF)**

An advisory paper from Joined Up Care Derbyshire (JUCCD) on the new model for Derbyshire's Community Mental Health Teams was received and noted. Discussion focused on the engagement of primary and secondary care support. Quarterly CMHF updates are to be received. The next update is to set out the CMHF long term plan, statutory objectives and trajectory to meet delivery targets.

### **Care Planning/Person Centred Care**

The Committee considered the progress made regarding person centred care and care planning delivery across the Trust.

Audits continue to be carried out within divisions and services to monitor completed and the quality of care plans and safety plans.

Limited assurance on progress towards improved care planning processes due to performance issues experienced in the transition to SystemOne.

### **Serious Incidents update**

The report provided the Committee with information relating to all patient safety process incidents occurring from 1 August to 30 November 2021.

Significant assurance was received on the headway being made with SI process and progress made since transitioning to the new model.

### **Patient Experience quarterly report**

Themes and changes made to Trust services as a result of feedback on incidents and complaints made to the Patient and Carer Experience Committee were scrutinised.

QSC was satisfied there are no gaps in control. Significant assurance was obtained from the good level of learning, planned improvements and progress made particularly in view of the disruption to services over the last year due to the pandemic.

### **Safeguarding Children**

A report of Safeguarding Children activity in the Trust provided significant assurance around safeguarding activity, systems and controls within the Trust. The solid performance in training and increased knowledge and confidence in safeguarding duties and responses was noted.

The Trust is fully compliant with arrangements for Multi-agency Public Protection Arrangements (MAPPA) and Multi-agency Risk Assessment Conference (MARAC) processes.

### **Safeguarding Adults**

This report updated the Committee on Adult Safeguarding performance, including, training, Mental Capacity Act performance, Person in Position of Trust (PiPoT) and Multi-agency Safeguarding Hub (MASH) performance. The report provided significant assurance that statutory duties are being met. It also included an update on the quality priority of improving sexual safety and homicide review progress.

The Trust continues to fulfil public protection duties with attendance at MAPPA, Multi-agency Risk Assessment Conference (MARAC) and Channel. Although this quarter saw small reduction in Adult MASH activity there has been a 21% increase in activity since last year and this is expected to continue.

Although training compliance has seen a slight reduction as a result of capacity demands during the pandemic, training has since been delivered more consistently and the next quarter will see an improvement in training performance.

### **SEND inspection update and action plan**

QSC was updated on recent progress related to the Special Educational Needs and Disabilities (SEND) action plan, connected to the Derby City Council Written Statement of Action.

The SEND inspection showed improved areas and positive outcomes. Derby City Council were re-inspected in September 2021 and were judged to have made significant progress against the areas of concern.

It was agreed that as a result of these improvements and positive outcomes this report can now be received on an annual basis.

<b>Escalations to Board or other committees</b>	
None	
<b>Board Assurance Framework – key risks identified</b>	
BAF is to capture a gap in control in clinical performance of care and safety plans due to transition across EPR.	
<b>Next Meeting – 8 February 2022</b>	
<b>Committee Chair: Margaret Gildea</b>	<b>Executive Lead: Carolyn Green, Director of Nursing and Patient Experience</b>

<b>People and Culture Committee - key items discussed 23 November 2021</b>
<p><b>Summary of BAF Risks</b></p> <p>The Committee considered the BAF Risk 2a it is responsible for “<i>There is a risk that we do not sustain a healthy vibrant culture and conditions to make Derbyshire Healthcare Foundation Trust (DHCFT) a place where people want to work, thrive and to grow their careers</i>” in the context of subsequent committee discussions and work programme.</p>
<p><b>People and Inclusion performance dashboard</b></p> <p>The dashboard is much clearer in targeting the assurance required by the Committee and now includes further detail around race disparity ratio.</p> <p>Discussion concentrating on safer staffing and supervision provided assurance that inpatient wards are safely staffed. A benchmarking exercise showed that the number of staff the Trust provides for inpatient units is significantly higher than other trusts.</p> <p>The Committee was assured to hear that staff wellbeing and support was being prioritised and that clinical supervision is being driven through the Trust Oversight Operational Leadership meeting (TOOL) to further improve uptake.</p>
<p><b>Review into the Medical Workforce</b></p> <p>Following a review of an analysis of the results of Medical Workforce 2020 Staff Survey Results, the Quality and Safeguarding Committee (QSC) was concerned that some issues may lead to quality concerns.</p> <p>As a result of these concerns, an in-depth review into the medical workforce was undertaken by PCC. It was confirmed that safety and quality outcomes will be taken through the Medical Leadership Programme to support the medical workforce. The triumvirate of the Medical Director, chair of PCC and chair of QSC will monitor this work.</p>
<p><b>Action from Trust Board</b></p> <p>At the September Trust Board meeting a report from the Freedom to Speak Up Guardian (FTSUG) identified that further work should be undertaken to investigate the impact the investigation process has on employee wellbeing, length of time that investigations take and staff satisfaction with the process. The Board requested the PCC explores the impact that the investigation process has on staff wellbeing, length of time that investigations take and staff satisfaction with the process.</p> <p>As a result of the Board’s request an in-depth report exploring the investigation process established that the Trust has taken a major step forward as there has been a significant reduction in the number of formal cases and tribunals.</p> <p>The Committee received significant assurance that employee relations casework is being dealt with in a timely way bearing in mind Covid restrictions placed on services, employees with protected characteristics that require support during the process are being supported and future</p>

plans will mitigate any current procedural or policy issues. It was noted that future plans will be to shift the culture to build effective relationships and team working and preventative work to resolve issues informally and sustainably.

### **Safer staffing data**

QSC was requested to establish what the anomalies were around safer staffing data and reporting that flows through to the e-roster system and establish whether it is accurate.

PCC was satisfied that QSC had reviewed the automated report referred to, safe staffing, the standards and model and had no residual concerns around data integrity. Learning has been taken from this reporting incident through to the operational team to ensure that internal operational reporting reports are refined and aligned to reflect the Trust's safer staffing levels.

### **Escalations from QSC**

PCC discussed two escalations from QSC. The following response was agreed to be reported to QSC at the next meeting scheduled to take place on 14 December:

**Safer Staffing BAF Risk 1a narrative:** QSC requested that PCC reviews whether the 12% vacancy rate is determining the high rating of BAF risk 1a *"There is a risk that the Trust will fail to provide standards for safety and effectiveness as required by our patients and our Board"* and consider how the BAF narrative can be redefined so that it describes the risks around specific recruitment hotspots rather than reflecting a Trust wide value.

PCC took this to mean that QSC was unsure if enough was being done to improve recruitment. Safe staffing reviews have provided assurance that there are enough staff to safely operate services. Staffing levels are adequately supplemented with bank and agency staff. (Discussion held on safer staffing and supervision while reviewing the People and Inclusion dashboard itemised above also provided assurance that inpatient wards are safely staffed.)

**Quality Improvement (QI) training:** PCC was requested to look at workforce projects that will improve quality and address how the Quality Improvement (QI) training approach can be implemented to support the QI improvement plan.

The QI training programme is now in place. QI improvement work is also monitored by the Finance and Performance Committee.

### **Inclusive decision making leadership and support following Covid**

In recognising that many Derbyshire Healthcare leaders have been working and leading in different ways over the past 18 months a leadership debrief and development programme was commissioned supporting all Incident Management Team (IMT) members and team leaders through a debrief and reflection process.

This was considered to be a very worthwhile process that provided significant assurance that the Trust has recognised the commitment from leaders over the Covid pandemic and the impact it has had on colleagues' wellbeing.

### **Health and wellbeing update**

PCC was briefed on staff health and wellbeing developments and plans to support staff in their ongoing recovery from the impact of the pandemic.

The report provided significant assurance that the health and wellbeing offer is continually developing and expanding in line with changes in staff needs, feedback and the changing environment we are working in.

### **Escalations to Board or other committees**

No items were considered necessary for escalation. A number of escalations from QSC were closed off.

<b>Board Assurance Framework – key risks identified</b>	
None	
<b>Next Meeting – 1 February 2022</b>	
<b>Committee Chair: Julia Tabreham</b>	<b>Executive Lead: Jaki Lowe, Director of People and Inclusion</b>

<b>Mental Health Act Committee - key items discussed 11 December 2021</b>
<p><b>Mental Health Act (MHA) Report</b></p> <p>The report had been extensively covered by the MHA Operational Group on 8 November. The data contained in the report was comprehensively reviewed and provided the MHAC with significant assurance that the safeguards of the MHA have been appropriately applied within the Trust.</p>
<p><b>Liberty Protection Safeguards</b></p> <p>Although the code of practice is yet to be issued a progress report on the Trust's preparations for Liberty Protection Safeguards (LPS) provided assurance that preparation for the introduction of LPS within the Trust is on track.</p>
<p><b>Update on Mental Health Legislation</b></p> <p>The government has launched a consultation on the Mental Health Units (Use of Force) Act which aims to prevent the inappropriate use of force and ensure transparency and accountability about the use of force in mental health units. Requirements were due to commence in May 2022 but have been delayed due to Covid.</p>
<p><b>Verbal update on S17 Leave Standard Operating Procedures</b></p> <p>Changes to Standard Operating Procedures (SOP) were made following an audit of S17 leave. Quality improvement work is being developed as a result of the audit that highlighted that the process for S17 leave needs to be improved to help patients achieve their requirements.</p> <p>It was agreed that the Finance and Performance Committee will be requested to look at how SystemOne (electronic patient record system) can improve the process of S17 leave requirements.</p>
<p><b>S136 Suites and use of Section 135/136</b></p> <p>Prior to the COVID-19 pandemic there was a steady upward trajectory in Section 136 detentions within Derbyshire. Previously the trend was more apparent in the south of the county however, the north of the county is now seeing a similar shift. The increase in detentions is a national picture and is thought to be due to the Police dealing with an overall increase in mental health incidents.</p> <p>Increased capacity has been provided to help the Police provide an appropriate response. A street triage service that will reduce the number of S136 is being developed to see this through.</p>
<p><b>Complaints from patients detained under the MHA</b></p> <p>An analysis of complaints made by patients detained under the MHA showed that overall the number of complaints received by the Trust is tiny compared to the overall activity and more compliments are received than complaints. The number of complaints received by detained patients is correspondingly small. Care Planning is the predominant theme in complaints for detained patients.</p> <p>Evidence of the good work taking place to improve the experience of people detained under the MHA provided significant assurance. Difficulties in accessing services from certain communities and issues regarding inequalities will be included in the next six monthly report.</p>

**Training Compliance**

The report showed a static level of compliance in Mental Capacity Act and Deprivation of Liberty Safeguards training. Clarity around the number of people allowed to attend face to face training and any other restrictions is being communicated across the Trust.

**Restrictive Practice six month update**

The report evidenced improving levels of restrictive practice over the past 24 months. Incidents of seclusion and restraint are low. Spikes in data are being worked on to understand whether this is attributable to any culture change, acuity, or individual patient behaviour. The report identified areas for improvement and action provided significant assurance on action being taken.

**Update from Associate Hospital Managers**

Associate Hospital Managers are undertaking a number of renewal hearings. Hearings are operating well and no complaints have been received regarding them being conducted virtually. Reports have been positively received and the quality of reporting has improved considerably.

**Escalations to Board or other Committee(s)**

Finance and Performance Committee to address how SystemOne can improve the issue of S17 leave requirements.

**Key risks identified**

None

**Consideration of any items affecting the BAF**

No items were considered necessary for updating within the BAF.

**Next Meeting – 11 March 2022**

**Committee Chair: Dr Sheila Newport,  
Non-Executive Director**

**Executive Lead: Dr John Sykes  
Medical Director**

## **Report from the Council of Governors meeting**

The Council of Governors has met once since the last report on 2 November 2021. Following national guidance on keeping people safe during COVID-19 and the need for social distance, the meetings were conducted digitally via Microsoft Teams.

### Lead Governor role

- Governors were reminded that the Lead Governor is a statutory role and the Trust is required to inform the regulators of who the Lead Governor is
- Eligible governors are encouraged to consider expressing an interest in the Lead Governor role.

### Chief Executive Update

The Chief Executive provided governors with an update on the current situation regarding the COVID-19 pandemic; and an update on the Trust's roadmap.

### Council of Governors Annual Effectiveness Survey

- The outcome of the Council of Governors annual effectiveness survey 2021 was noted
- Governors agreed that the survey should be repeated in September 2022
- Governors noted the proposed additional actions developed in response to the survey feedback to further enhance the effectiveness of the Council of Governors.

### Report from the Nominations and Remuneration Committee and Council of Governors Approvals

- Governors approved the two-stage proposal for the recruitment to the three Non-Executive Directors vacancies
- It was noted that the Trust's Fit and proper Persons Test Policy has been complied in relation to the recruitment of the Trust Chair
- Governors approved the Expenses Policy
- Governors discussed the vacancies on the Committee and agreed that these will be promoted in Governor Connect. Eligible governors who wish to express an interest in joining the Committee are encouraged to contact Denise Baxendale, Membership and Involvement Manager.

### Non-Executive Director Deep Dive Report

Sheila Newport, clinical Non-Executive Director and Chair of the Mental Health Act Committee presented the Deep Dive to governors. Sheila gave an overview of her role within the Trust.



### Escalation of items to the Council of Governors

One item of escalation was received from the Governance Committee meeting held on 12 October 2021:

*In September 2021 it was reported in Derbyshire Live that the wait lists for children and young people services including Children and Adolescent Mental Health Services (CAMHS) were four months and that the Trust was planning a waiting list blitz in September. How are the Non-Executive Directors assured that the Trust is reducing the wait lists and are they assured that the waiting list initiatives, like the blitz in September, will improve waiting times and what is the average wait time now for our services in particular regarding young people services and CAMHS?*

The response was tabled at the meeting.

### Verbal Summary Integrated Performance Report

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

### Governance Committee Report

The Chair of the Governance Committee presented a report of the meeting held on 12 October 2021.

### Feedback from the Annual Members Meeting

Governors:

- Received and noted the feedback
- Agreed to form a task and finish group to plan next year's Annual Members Meeting which is scheduled for 21 September 2022.

### Any Other Business

Membership and Involvement Manager gave an update on the vacancies for the forthcoming elections – the process of which will begin in the New Year.

<b>GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS</b>	
<b>NHS Term / Abbreviation</b>	<b>Terms in Full</b>
<b>A</b>	
A&E	Accident & Emergency
ACCT	Assessment, Care in Custody & Teamwork
ACE	Adverse Childhood Experiences
ACP	Accountable Care Partnership
ACS	Accountable Care System (now known as ICS)
ADHD	Attention Deficit Hyperactivity Disorder
AfC	Agenda for Change
AHP	Allied Health Professional
AIMS	Royal College of Psychiatrists Accreditation for Inpatient Mental Health Services Standards
ALB	Arms-length body such as NHS Improvement (NHSI) and NHS England (NHSE)
AMM	Annual Members' Meeting
AMHP	Approved Mental Health Professional
ANP	Advanced Nurse Practitioner
AO	Accountable Officer
ASD	Autism Spectrum Disorder
ASM	Area Service Manager
<b>B</b>	
BAF	Board Assurance Framework
BLS	Basic Life Support (ILS Immediate Life Support)
BMA	British Medical Association
BAME	Black, Asian & Minority Ethnic group
BoD	Board of Directors
<b>C</b>	
CAMHS	Child and Adolescent Mental Health Services
CASSH	Care and 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
CMHF	Community Mental Health Framework
CMHT	Community Mental Health Team
CNST	Clinical Negligence Scheme for Trusts
COAT	Clinical Operational Assurance Team
COF	Commissioning Outcomes Framework
CoG	Council of Governors
COO	Chief Operating Officer
CPA	Care Programme Approach
CPD	Continuing Professional Development
CPN	Community Psychiatric Nurse

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

<b>NHS Term / Abbreviation</b>	<b>Terms in Full</b>
CPR	Child Protection Register
CQC	Care Quality Commission
CQI	Clinical Quality Indicator
CQUIN	Commissioning for Quality and Innovation
CRB	Criminal Records Bureau
CRG	Clinical Reference Group
CRHT	Crisis resolution and home treatment
CRS	(NHS) Care Records Service
CRS	Commissioner Requested Services
CSF	Commissioner Sustainability Fund
CTO	Community Treatment Order
CTR	Care and Treatment Review
<b>D</b>	
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
DDCCG	Derby and Derbyshire Clinical Commissioning Group
DHCFT	Derbyshire Healthcare NHS Foundation Trust
DIT	Dynamic Interpersonal Therapy
DNA	Did Not Attend
DH	Department of Health
DoLS	Deprivation of Liberty Safeguards
DBIT	Director of Business Improvement and Transformation
DOF	Director of Finance
DON	Director of Nursing
DPI	Director of People and Inclusion
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
<b>E</b>	
ECT	Enhanced Care Team
ECW	Enhanced Care Ward
ED	Emergency Department
EDS2	Equality Delivery System 2
EHIC	European Health Insurance Card
EHR	Electronic Health Record
EI	Early Intervention
EIA	Equality Impact Assessment
EIP	Early Intervention In Psychosis
ELT	Executive Leadership Team
EMDR	Eye Movement Desensitising & Reprocessing Therapy
EMR	Electronic Medical Record
EPR	Electronic Patient Record

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

<b>NHS Term / Abbreviation</b>	<b>Terms in Full</b>
ERIC	Estates Return Information Collection
ESR	Electronic Staff Record
EUPD	Emotionally Unstable Personality Disorder
EWTD	European Working Time Directive
<b>F</b>	
FBC	Full Business Case
FFT	Friends and Family Test
FOI	Freedom of Information
FSR	Full Service Record
FT	Foundation Trust
FTE	Full-time Equivalent
FTN	Foundation Trust Network
FTSU	Freedom to Speak Up
FTSUG	Freedom to Speak Up Guardian
F&P	Finance and Performance
5YFV	Five Year Forward View
<b>G</b>	
GDPR	General Data Protection Regulation
GGI	Good Governance Institute
GIRFT	Getting it Right First Time
GMC	General Medical Council
GP	General Practitioner
GPFV	General Practice Forward View
<b>H</b>	
HCA	Healthcare Assistant
H1	First half of a fiscal year (April through September)
H2	Second half of a fiscal year (October through the following March)
HEE	Health Education England
HES	Hospital Episode Statistics
HoNOS	Health of the Nation Outcome Scores
HSCIC	Health and Social Care Information Centre
HSE	Health and Safety Executive
HWB	Health and Wellbeing Board
<b>I</b>	
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)
IMT	Incident Management Team
IM&T	Information Management and Technology
OOA	Outside of Area
IPP	Imprisonment for Public Protection
IPR	Integrated Performance Report
IPT	Interpersonal Psychotherapy

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

<b>NHS Term / Abbreviation</b>	<b>Terms in Full</b>
<b>J</b>	
JNCC	Joint Negotiating Consultative Committee
JTAI	Joint Targeted Area Inspections
JUCB	Joined Up Care Board
JUCD	Joined Up Care Derbyshire
<b>K</b>	
KPI	Key Performance Indicator
KSF	Knowledge and Skills Framework
<b>L</b>	
LA	Local Authority
LCFS	Local Counter Fraud Specialist
LD	Learning Disabilities
LD/A	Learning Disability and Autism
LHP	Local Health Plan
LHWB	Local Health and Wellbeing Board
LOS	Length of Stay
LPS	Liberty Protection Safeguards
<b>M</b>	
MADE	Multi-agency Discharge Event
MARS	Mutually Agreed Resignation Scheme
MAU	Medical Assessment Unit
MAS	Memory Assessment Service
MAPPA	Multi-agency Public Protection Arrangements
MARAC	Multi-agency Risk Assessment Conference (meeting where information is shared on the highest risk domestic abuse cases between representatives of local police, probation, health, child protection, housing practitioners, Independent Domestic Violence Advisors (IDVAs) and other specialists from the statutory and voluntary sectors.
MASH	Multi-Agency Safeguarding Hub
MCA	Mental Capacity Act
MD	Medical Director
MDA	Medical Device Alert
MDM	Multi-Disciplinary Meeting
MDT	Multi-Disciplinary Team
MFF	Market Forces Factor
MHA	Mental Health Act
MHIN	Mental Health Intelligence Network
MHIS	Mental Health Investment Standard
MHRT	Mental Health Review Tribunal
MSC	Medical Staff Committee
MSK	Musculoskeletal (conditions)
MSU	Medium secure unit
<b>N</b>	
NCRS	National Cancer Registration Service
NED	Non-Executive Director
NICE	National Institute for Health and Care Excellence
NHS	National Health Service

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

<b>NHS Term / Abbreviation</b>	<b>Terms in Full</b>
NHSE	National Health Service England
NHSI	National Health Service Improvement
NHSEI	NHS England and NHS Improvement
NIHR	National Institute for Health Research
<b>O</b>	
OBC	Outline Business Case
ODG	Operational Delivery Group
OP	Out Patient
OSC	Overview and Scrutiny Committee
OT	Occupational therapy
<b>P</b>	
PAB	Programme Assurance Board
PAG	Programme Advisory Group
PALS	Patient Advice and Liaison Service
PAM	Payment Activity Matrix
PARC	Psychosis and the reduction of cannabis (and other drugs)
PARIS	This is an electronic patient record system
PbR	Payment by Results
PCC	Police & Crime Commissioner
PCN	Primary Care Networks
PDSA	Plan, Do, Study, Act
PHE	Public Health England
PICU	Psychiatric Intensive Care Unit
PID	Project Initiation Document
PiPoT	People in Positions of Trust
PLIC	Patient Level Information Costs
PMLD	Profound and Multiple Disability
PPE	Personal Protection Equipment
PPI	Patient and Public Involvement
PPT	Partnership and Pathway Team
PREM	Patient Reported Experience Measure
PROMS	Patient Reported Outcome Measure
PSF	Provider Sustainability Fund
PSIRF	Patient Safety Incident Review Framework
<b>Q</b>	
QAG	Quality Assurance Group
QC	Quality Committee
QIA	Quality Impact Assessment
QIPP	Quality, Innovation, Productivity Programme
<b>R</b>	
RAID	Rapid Assessment, Interface and Discharge
RCGP	Royal College of General Practitioners
RCI	Reference Cost Index
REGARDS	Race, Economic disadvantage, Gender, Age, Religion or belief, Disability and Sexual orientation
RTT	Referral to Treatment
<b>S</b>	
SAAF	Safeguarding Adults Assurance Framework

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

<b>NHS Term / Abbreviation</b>	<b>Terms in Full</b>
SBARD	Situation, Background, Assessment, Recommendation and Decision (SBARD) tool
SBS	Shared Business Services
SEND	Special Educational Needs and Disabilities
SI	Serious Incidents
SID	Senior Independent Director
SIRI	Serious Incident Requiring Investigation
SLA	Service Level Agreement
SLR	Service Line Reporting
SMI	Severe Mental Illness
SOC	Strategic Options Case
SOF	Single Operating Framework
SPOA	Single Point of Access
SPOE	Single Point of Entry
SPOR	Single Point of Referral
STEIS	Strategic Executive Information System
STF	Sustainability and Transformation Fund
STP	Sustainability and Transformation Partnership
SUI	Serious (Untoward) Incident
SystemOne	Electronic patient record system
<b>T</b>	
TARN	Trauma Audit and Research Network
TCP	Transforming Care Partnerships
TCS	Transforming Community Services
TDA	Trust Development Authority
TMT	Trust Management Team
TUPE	Transfer of Undertakings (Protection of Employment) Regulations 1981
TMAC	Trust Medical Advisory Committee
TOOL	Trust Operational Oversight Leadership (replaced IMT)
<b>U</b>	
UDBH	University Hospitals of Derby and Burton
UEC	Urgent and emergency care
<b>V</b>	
VO	Vertical Observatory
<b>W</b>	
WDES	Workforce Disability Equality Standard
WRES	Workforce Race Equality Standard
WTE	Whole Time Equivalent
<b>Y</b>	
YTD	Year to Date

(updated 11 January 2022)

2020-21 Board Annual Forward Plan

Exec Lead	Item	4 May 21	6 Jul 21	7 Sep 21	2 Nov 21	18 Jan 22	1 Mar 22
		Paper deadline					
		27 Apr	29 Jun	31 Aug	21 Oct	7 Jan	17 Feb
Trust Sec	Declaration of Interests	X	X	X	X	X	X
DON	Patient/Staff Story	X	X	X	X	X	X
CHAIR	Minutes/Matters arising/Action Matrix	X	X	X	X	X	X
CHAIR	Board review of effectiveness of meeting	X	X	X	X	X	X
CHAIR	Board Forward Plan (for information)	X	X	X	X	X	X
CHAIR	Summary of Council of Governors meeting (for information)	X	X		X	X	X
CHAIR	Chair's Update	X	X	X	X	X	X
CEO	Chief Executive's Update - Green Plan sign off (November each year)	X	X	X	X Green Plan	X	X
<b>STRATEGIC PLANNING AND CORPORATE GOVERNANCE</b>							
COO/DOF	NHSI Financial Annual Plan Month 7-12 2021/22				X		
DPI	Staff Survey Results	X					Headlines
DPI	Annual Gender Pay Gap Report for approval						X
DPI	Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) request for Board delegated authority for People and Culture Committee meeting on 21 September to approve the October submissions			X			X
DPI	Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) Strategic implications/retrospective sign off after PCC in Nov and update report in Mar 2022				X		X
DPI	2021/22 Flu Campaign			X			
DPI	People Plan Annual Report						A
Trust Sec	NHS Improvement Year-End Self-Certification	X					
Trust Sec	Year-end governance reporting from Board Committees and approval of ToRs	X					
Trust Sec	Corporate Governance Framework						X
Trust Sec	Goverance update						X
Trust Sec	Review SOs, SFIs, SoD plus review/ratify SFI Policy (as Policy Review section below)						
Trust Sec	Trust Sealings (six monthly - for information)	X			X		
Trust Sec	Annual Review of Register of Interests	X					
Trust Sec	Board Assurance Framework Update	X	X		X		X
Trust Sec	Freedom to Speak Up Guardian Report (six monthly)	X		X	X		X
Trust Sec	Fit and Proper Person Declaration		X				
Trust Sec	Annual Approval of Modern Slavery Statement	X					
Committee Chairs	Board Committee Assurance Summaries (following every meeting)	X	X	X	X	X	X
COO	Annual Emergency Planning Report (EPPR) - deferred - to be received 10 May 2022					X	
DBIT	Learning Disabilities Clinical Strategy - timeline TBC						
DBIT	Mental Health, Learning Disability and Autism Annual summary - timeline TBC						
CEO/DBIT	East Midlands Collaborative Agreement update (appended to CEO report)					X	
DBIT/CEO	Trust Strategy/RoadMap Review (incorporated within CEO Report)	X			X		



2020-21 Board Annual Forward Plan

Exec Lead	Item	4 May 21	6 Jul 21	7 Sep 21	2 Nov 21	18 Jan 22	1 Mar 22
<b>OPERATIONAL PERFORMANCE</b>							
DON/DOF/ DPI/COO	Integrated performance and activity report to include Finance, People, performance and Quality Dashboard	X	X	X	X	X	X
DPI	Equality Diversity and Inclusion (EDI) update				X		
DON/COO/ DPI	Workforce Standards Formal Submission/Safer Staffing (prior to going on website)	X					
<b>QUALITY GOVERNANCE</b>							
EXEC	Quality Position Statement Report - focus on CQC domains (Well Led CQC & NHSI) as per schedule - Caring led by DON due April 2022		Safety MD	Well Led Trust Sec (interim report)	Effective DON & DPI	Responsive COO	Use of Resources DOF
MD	Learning from Deaths Mortality report (quarterly publication) (Jul/Nov/Jan/Mar)		X		X		X
MD	Guardian of Safe Working Report	X		X	X		X
MD	NHSE Return on Medical Appraisals sign off - delayed for 2020/21						
DON	Control of Infection Annual Report				X		
DON	Infection Prevention and Control BAF						X
MD	Re-validation of Doctors Compliance Statement			X			
DON	Receipt of Annual Reports: - Annual Looked After Children - Safeguarding Children and Adults at Risk				X X		
DON	Outcome of Patient Stories - every two years						X
<b>POLICY REVIEW</b>							
DOF/ Trust Sec	Standing Finance Instructions Policy and Procedures Review SOs, SFIs, SoD plus review/ratify SFI Policy (next SFI review July 2022)				X Ratify revisions		
Trust Sec	Engagement between the Board of Directors and CoG (Nov 2022)						
Trust Sec	Fit and Proper Person Policy						X