Derbyshire Healthcare
NHS Foundation Trust

Derbyshire Healthcare NHS Foundation Trust
Meeting of the Public Board of Directors

To be held digitally via MS Teams and livestreamed to the public
6 September 2022 09:30 - 6 September 2022 12:30

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Derbyshire Healthcare NHS Foundation Trust

PUBLIC BOARD MEETING
TUESDAY 6 SEPTEMBER 2022 TO COMMENCE AT 09:30
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	Selina Ullah
2.	9:35	Patient Story	Carolyn Green
3.		Minutes of Board of Directors meeting held on 5 July 2022	Selina Ullah
4.		Matters arising – Actions Matrix	Selina Ullah
5.		Questions from members of the public	Selina Ullah
6.	10:00	Chair's update	Selina Ullah
7.	10:10	Chief Executive's update	Ifti Majid
STRATEGY, OPERATIONAL PERFORMANCE AND QUALITY ASSURANCE			
8.	10:25	Integrated Performance report	C Wright/R Leyland J Lowe/C Green/A Odunlade
9.	10:45	Emergency Preparedness, Resilience and Response (EPRR) Core Standards - Ratification of Emergency Incident Response Plan and Procedures	Ade Odunlade
11:00 B R E A K			
10.	11:10	Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) prior to submission end October 2022	Jaki Lowe
11.	11:15	2022/23 Flu Campaign	Jaki Lowe
12.	11:25	Workforce Plan for 2022/23	Jaki Lowe
13.	11:35	Position Statement – Improving Safety	John Sykes
14.	11:45	Draft Mental Health Bill	John Sykes
GOVERNANCE			
15.	12:00	Board Assurance Framework Issue 2, 2022/23	Kel Sims
16.	12:10	Freedom to Speak Up Guardian Report	Tam Howard
17.	12:20	Board Committee assurance summaries of meetings held during July 2022	Committee Chairs
CLOSING MATTERS			
18.	12:30	- Identification of any issues arising from the meeting for inclusion or updating in the Board Assurance Framework - Meeting effectiveness	Selina Ullah
FOR INFORMATION			
Glossary of NHS Acronyms 2022/23 Forward Plan			

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

The next meeting will be held at 09.30 on 1 November2022. 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 work compassionately and supportively with each other and those who use our services. We recognise a well-supported, engaged and empowered workforce is vital to good patient care.
Respect – we respect and value the diversity of our patients, colleagues and partners and for them to feel they belong within our respectful and inclusive environment.
Honesty – we are open and transparent in all we do.
Do your best – we recognise how hard colleagues work and together we want to work smarter, striving to support continuous improvement in all aspects of our work.

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DECLARATION OF INTERESTS REGISTER 2022/23		
NAME	**INTEREST DISCLOSED**	**TYPE**
Tony Edwards Non-Executive Director	• Independent Member of Governing Council, University of Derby	(a)
Deborah Good Non-Executive Director	• Trustee of Artcore - Derby	(e)
Carolyn Green Director of Nursing and Patient Experience	• Midlands and East Regional Director, National Mental Health Nurse Directors Forum	(e)
Ralph Knibbs Non-Executive Director	• Vice Chair, RFU Diversity & Inclusion Implementation Group, England Rugby Football Union	(e)
Geoff Lewins Non-Executive Director	• Director, Arkwright Society Ltd • Director, Cromford Mill Limited (wholly owned trading subsidiary of Arkwright Society)	(a) (a)
Jaki Lowe Director of People and Inclusion	• General Medical Council Associate	(e)
Ifti Majid Chief Executive	• Co-Chair of NHS Confederation BME leaders Network • Chair of the NHS Confederation Mental Health Network • Trustee of the NHS Confederation • Spouse is Managing Director (North) Priory Healthcare	(d) (d) (d) (e)
Ade Odunlade Chief Operating Officer	• Trusteeship African Council for Nursing & Midwifery • Research Lead on Observations for Ox e-Health • Chair, NHS Providers Chief Operating Officer Network	(d) (e) (e)
Dr John Sykes Medical Director	• Undertakes paid assessments of patients at the request of the local authorities under the Mental Health Act and Mental Capacity Act and acts likewise for solicitors representing patients	(e)
Selina Ullah Trust Chair	• Non-Executive Director, Solicitors Regulation Authority • Director/Trustee, Manchester Central Library Development Trust • Non-Executive Director, General Pharmaceutical Council • Non-Executive Director, Locala Community Partnerships CIC • Non-Executive Director, Accent Housing Group • Director, Muslim Women's Council • Trustee and Board member of NHS Providers representing Mental Health Providers	(a) (e) (e) (e) (e) (e) (e)

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

Derbyshire Healthcare NHS Foundation Trust

MINUTES OF A VIRTUAL MEETING OF THE BOARD OF DIRECTORS TUESDAY 5 JULY 2022

VIRTUAL MEETING VIA MS TEAMS

Commenced: 09.30 . Closed: 11:38

PRESENT	Selina Ullah	Trust Chair
	Geoff Lewins	Non-Executive Director
	Deborah Good	Non-Executive Director
	Ifti Majid	Chief Executive
	Claire Wright	Deputy Chief Executive and Director of Finance
	Ade Odunlade	Chief Operating Officer
	Dr John Sykes	Medical Director
	Carolyn Green	Director of Nursing and Patient Experience
	Vikki Ashton Taylor	Director of Strategy, Partnerships and Transformation
	Justine Fitzjohn	Trust Secretary
IN ATTENDANCE	Rebecca Oakley	Acting Deputy Director of People and Inclusion
	Anna Shaw	Deputy Director of Communications and Engagement
	Jas Khatkar	NExT Director
	Sue Turner	Board Secretary
	Lee Doyle	Deputy Director, Working Age Adult Community, Specialist Services, Children's Services, Psychology, Operational Performance
	Scott Lunn	Clinical Lead Children's Services
	Iona Giddings	Aspirant/Allied Health Professional
	Shanneil Steel	Student Nurse
APOLOGIES	Dr Sheila Newport	Non-Executive Director
	Ralph Knibbs	Non-Executive Director
	Ashiedu Joel	Non-Executive Director
	Jaki Lowe	Director of People and Inclusion
OBSERVERS*	Andrew Beaumont	Public Governor, Erewash
	Susan Ryan	Public Governor, Amber Valley
	David Charnock	Appointed Governor, University of Nottingham
	Denise Baxendale	Membership and Involvement Manager
	Ian Strange	Technical Analyst
	Lynn Andrews	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 2022/054	**CHAIR'S WELCOME, OPENING REMARKS, APOLOGIES FOR ABSENCE AND DECLARATION OF INTERESTS** Trust Chair, Selina Ullah opened the meeting and thanked all colleagues for their ongoing contribution to the continued delivery of quality services within the Trust while responding to the pandemic. Given the recent increase in the number of COVID cases the meeting was conducted via Microsoft Teams and livestreamed to the public. The Register of Directors' Interest was noted. No declarations of interest were raised with any of the agenda items. Apologies were noted as listed. Acting Deputy Director of People and Inclusion, Rebecca Oakley attended as the nominated deputy of Director of People and Inclusion, Jaki Lowe. Selina welcomed a number of new members, including Jas Khatkar who joined the Trust through the NExT Director scheme and Vikki Ashton Taylor, who joined the Board on 1 June 2022 as Director of Strategy, Partnerships and Transformation. Visitors to today's meeting included Scott Lunn, Clinical Lead Children's Services and Iona Giddings, Aspirant/Allied Health Professional who both shadowed Director of Nursing and Patient Experience, Carolyn Green and Student Nurse, Shanneil Steel who shadowed Ade Odunlande, Chief Operating Officer. Deputy Director, Working Age Adult Community, Specialist Services, Children's Services, Psychology, Operational Performance, Lee Doyle attended as part of his involvement in the Nye Bevan development programme. Due to unforeseen circumstances there would not be a patient story discussed at today's meeting.
DHCFT 2022/055	**MINUTES OF THE BOARD OF DIRECTORS MEETING HELD ON 10 MAY 2022** The minutes of the previous meeting held on 10 May 2022 were accepted as a correct record of the meeting.
DHCFT 2022/056	**ACTION MATRIX AND MATTERS ARISING** The Board was updated on action agreed at the previous meeting on 10 May relating to item DHCFT2022/044 Workforce Standards Formal Submission 2021/22. Assurance on the assessment of safer staffing within Workforce Standards would be received when the Workforce Plan is submitted to the Board at the September meeting.
DHCFT 2022/057	**QUESTIONS FROM MEMBERS OF THE PUBLIC** No questions had been submitted for a response ahead of today's meeting. Any questions raised with the Trust's Governors by members of the public will be taken to the Council of Governors meeting.
DHCFT 2022/058	**CHAIR'S UPDATE** Selina Ullah's report summarising her activity in her role as Trust Chair since the previous meeting held on 10 May was noted. The report covered Selina's recent visits to services and feedback received from patients and carers, staff engagement events and conversations held with the staff networks which has given Selina a good understanding of how staff are feeling and engaging with the Trust. Selina also attended the Trust's Medical Advisory Committee (TMAC) discussing clinical leadership and heard directly from clinicians about their work and the challenges they face day to day.

	On behalf of the Board Selina thanked Non-Executive Directors (NEDs) Richard Wright and Margaret Gildea for their unstinting service during their tenure. Richard and Margaret left the Trust at the end of June to take up new roles on the Joined Up Care Derbyshire (JUCD) Integrated Care Board (ICB). Selina also thanked the governors for their role in appointing new NEDs, including Ralph Knibbs who joined the Trust on 1 July. Selina referred to the meeting of the Audit and Risk Committee that she attended on 14 June to approve on behalf of the Board the 2021/22 Annual Report and Accounts. She thought it worthy to note the exceptional performance and co-operation given by the Trust's Finance team to the Trust's external auditor, Mazars, during the production of the Annual Accounts. Selina took the opportunity to give her thanks to Trust Secretary, Justine Fitzjohn and her team who contributed to the Annual Report. She also thanked Kyri Gregoriou, Interim Assistant Director of Clinical Professional Practice for leading the preparation of the Annual Quality Account which was approved by the Quality and Safeguarding Committee in May which is available on the Trust's website. **RESOLVED: The Board of Directors noted the content of the Chair's update.**
DHCFT 2022/059	**<u>UPDATE ON COVID-19 CASES</u>** Before Chief Executive, Ifti Majid presented his report Director of Nursing and Patient Experience, Carolyn Green provided an update on COVID-19 cases. Due to the increase in COVID-19 rates, the Trust has strengthened its infection prevention and control measures and has reintroduced the wearing of face masks within the workplace on a temporary basis to slow the spread of transmission and it is hoped that COVID-19 rates will stabilise quickly.
DHCFT 2022/060	**<u>CHIEF EXECUTIVE'S REPORT</u>** Ifti Majid's CEO 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. **Trust Strategy** Ifti opened his report by referring to the final version of the revised Trust Strategy that has been shared widely in the organisation . The final strategy retains the Trust's vision and values and outlines the 'Derbyshire Healthcare eight essentials' that will be a focus throughout the organisation during 2022/23. The strategy gives a clear direction of the priorities in both outward and internal facing areas and was duly signed off by the Board. **National context** Ifti discussed two national reports, the Messenger Review of leadership and management in the health and social care sector and the Equality and Human Rights Commission's inquiry into the experiences of lower-paid ethnic minority workers in health and social care. Both these reports are relevant because their recommendations cover diversity and inclusion, learning and collaborative leadership and the standard approach for appraisals for managers and racial inequalities experienced by lower-paid ethnic minority staff. Both these reports will be discussed further by the People and Culture Committee. **Regional context** Appendix 1 of Ifti's report contained an emergent partnership agreement for the Mental Health, Neurodiversity and Learning Disability Alliance across Derbyshire that sets the tone for how health organisations, local authority and voluntary sector, the police and crime commissioner are going to operate and agree to the creation of an Alliance. Carolyn Green was impressed with the draft partnership agreement and asked if the next iteration could illustrate how the joint management approach to be taken by the Alliance will impact different cultures and groups of people so the partnership can better support the people of Derby and Derbyshire. Ifti and Director of Strategy, Partnerships and

	Transformation, Vikki Ashton Taylor welcomed Carolyn's feedback and will work with the Alliance to build this response into the agreement, together with outcomes that will better illustrate to people what this agreement means. **Within the Trust** Ifti thanked colleagues for participating in the live engagement hours. Staff Q&A sessions are proving to be an effective engagement tool and serve as a temperature check on issues affecting colleagues. Concerns relating to the impact of the pandemic and worries about the cost of living were able to be openly discussed and will enable the Trust to consider different measures to support people during these financially challenging times. Ifti applauded colleagues' imaginative ways of celebrating the Jubilee with patients and formally congratulated Ward 33 on winning the Queen's Platinum Jubilee decoration competition. All of the entries were of an exceptionally high standard and Ifti was touched by the lengths colleagues went to, to ensure patients on inpatient wards were able to join in the Jubilee celebrations. Visits were made by Ifti to the Dementia Rapid Response Team and Intensive Treatment Team at their new base in Bakewell, the Enhanced Care Ward at the Radbourne Unit and the Paediatric Therapy Team at St Paul's House. During these visits Ifti observed examples of colleagues working with patients and their families in such a compassionate way and wanted to celebrate this with the Board. Non-Executive Director, Deborah Good thought Ifti's report gave a great insight into the work being carried out within the different services. She was concerned about the effect that the high cost of living is having on lower paid staff as she had heard that some staff have left the Trust so they can work closer to home due to rising fuel costs and she wondered what the Trust was doing to improve staff retention. Ifti assured Deborah that the Trust is committed to listening and responding to what colleagues are saying. Colleagues have said they feel they are subsidising the NHS when using their own vehicles to travel to treat patients. They are also concerned about increases in the price of food and utilities. Given the increase in the cost of petrol/diesel, improvements have been made to mileage rates and the Trust will continue to support colleagues and try to ensure they are not financially disadvantaged because of their working patterns or positions. Ifti understands that the increase in the cost of living affects colleagues' mental health and wellbeing and assured the Board that staff will be signposted to where they can get support. **RESOLVED: The Board of Directors:** **1) Scrutinised the report, noting the risks and actions being taken** **2) Sought assurance around key issues raised** **3) Signed off the Trust Strategy.**
DHCFT 2022/061	**<u>PERFORMANCE AND ACTIVITY REPORT</u>** The Board of Directors was updated on key finance, performance and workforce measures at the end of May. **Operations** Chief Operating Officer, Ade Odunlade reiterated his thanks to staff for maintaining a good performance across services. He thought their response to the challenges that arose due to the rise in service demand while responding to COVID-19 was admirable. As well as dealing with the data migration of PARIS to SystmOne staff managed to maintain service delivery while managing an increasing number of changes to the model of assessments. Ade was pleased to report that the waiting list for psychology has continued to reduce. Recruitment to a number of posts across adult services is progressing and a review of

the structure of psychological service will enable a better utilisation of skills to support people across Derbyshire. There has been a steady rise in waiting times for referral to treatment in community paediatrics. The longest wait time is now in excess of 56 weeks and this currently sits on the risk register as a high risk. The service is carrying two vacancies which have been redesigned to a more generic post and recruitment is progressing. Sickness and COVID-19 absences are still having an impact on clinics. Increased demand in Child and Adolescent Mental Health Services (CAMHS) have also been compounded by challenges with recruitment.

Finance
Deputy Chief Executive and Director of Finance, Claire Wright reported that at the end of May, the overall year to date position was a deficit of £1.1m compared to the plan deficit of £0.6m, which is an adverse variance to plan of £0.5m. The main drivers for the adverse variance to plan are related to undelivered cost improvement programmes and additional cost pressures which are partially offset by additional inflationary income not included in the current financial plan. The Finance and Performance Committee is seeking assurance on how to catch up on this key area.

In terms of agency costs May expenditure was less than April but it is not yet at a level that it should be. Further work is required and additional controls have been put in place to deliver savings in this area. The two highest areas of agency usage relate to Consultants mainly in CAMHS and Nursing staff. Following an internal review of the financial risks additional agency controls have been put in place.

The Trust's financial plan and the System financial plan were resubmitted to NHSEI on 20 June. Claire explained that both the System plan and the Trust plan have moved from a deficit position to a breakeven position, although there are risks to achieving this break even position. For capital this does include a 5% planning variance which will need to be mitigated in year to achieve the system capital plan and will be closely scrutinised by the Finance and Performance Committee and system equivalent.

People performance
Acting Deputy Director of People and Inclusion, Rebecca Oakley highlighted areas of people performance. Although there has been a reduction in COVID-19 absences, at the end of May there was an increase in absences related to stress and anxiety. Work is taking place with mangers to signpost staff to support networks and making sure health and wellbeing conversations are regularly taking place with colleagues.

There has been a continued focus on recruitment and the fast track completion of posts process resulted in 483 key posts being worked through. Active bank staff continue to support the substantive workforce. May saw a reduction of agency filled requests and there is now a conscious move to rapidly reduce reliance on agency staff in line with pre-COVID-19 levels. Mandatory training continues to be a key focus of ongoing recovery for the Trust.

Quality
Carolyn Green reported that families and carers are concerned about Psychiatric Intensive Care Unit (PICU) inappropriate out of area placements. Although these placements are classed as inappropriate according to the national definition, we are currently one of the few trusts in the country without a PICU and have no choice but to place these people out of area. Work will continue to ensure PICU placements are made as local as possible to try to reduce travel for families.

In terms of wider Trust activity the wards are extremely busy. There are ongoing work streams to support the continuing need to reduce restrictive practice, including the introduction of body worn cameras and monitoring of restrictive practice within forums. There is considerable work to do in terms of quality improvement to maintain the standards required for the people of Derbyshire while maintaining clinical standards when services are under pressure.

	Non-Executive Director, Geoff Lewins wished to know more about patients who have their accommodation recorded as 'unsettled'. Carolyn and Ade both responded that there are not enough providers operating in Derbyshire who can provide accommodation for people with mental health and learning disability needs and local authorities cannot provide the housing stock or support. In response to Selina challenging whether the Trust has the capacity to respond to the end of year financial deficit, Claire explained that one solution will be to reduce waste and increase innovation. However, some of the issues the Trust will be dealing with will need to be addressed by the whole System. The NHS is required to complete a financial governance audit by the end of this month. This will help give assurance on good financial stability processes and governance which will be addressed through the Finance and Performance Committee. The Trust has in the past had a strong financial position and the medium term financial plan needs to be completed in order to move towards a more financially stable position. Selina expressed her support for the wellbeing offers in place to support staff and asked Rebecca Oakley to ensure that colleagues are able access support services during their work time. Rebecca assured Selina that there are a wide range of local resources that can be accessed by staff across their working time and out of hours. Selina welcomed the point about being mindful of the financial impact of travelling to appointments and asked how the Trust can provide opportunities to reduce the financial burden of travel costs. Carolyn assured Selina that the Trust is taking a balanced view by offering the choice of face to face appointments or virtual appointments. As a Trust, we have made it clear that we do not want to pass on costs to people. Services are working in collective ways to help patients and offer vocational support in both inpatient and community settings and will continue to grow ideas and support individuals while we navigate the cost of living crisis. Selina asked Ade about the waiting time for psychology and referred to the 25% vacancy rate in the psychology service. Ade reported that recruitment to a number of vacant and part-time posts is progressing. However, around 24% of posts are currently vacant across all of psychological services and there is a recruitment strategy to reduce the 24% vacancy gap. He assured the Board that people are being supported while they are waiting for treatment and is hopeful that positive change will be possible in the next few months that will broaden this offer. Having discussed performance across the Trust's services, the Board concluded that although limited assurance was taken from current performance, service performance overall was considered to be good. **RESOLVED: The Board of Directors received limited assurance from current performance across the areas presented.**
DHCFT 2022/062	**<u>ANNUAL MEDICAL APPRAISAL SIGN OFF</u>** Medical Director, Dr John Sykes updated the Board on medical appraisal within the Trust and data from the 2021/22 medical appraisal cycle. The Trust continues to carry out high quality medical appraisals that have been adapted to be more supportive to doctors. Medical staff are well engaged with the appraisal process despite challenges due to the pandemic. The report assured the Board that the Trust is compliant with the regulations and supported the sign off of the compliance statement by the Trust Chair. **RESOLVED: The Board of Directors:** **1) Noted the contents of this report** **2) Confirmed that report gives assurance that the Trust is compliant with the Medical Profession (Responsible Officer Regulation) 2010 as amended in 2013**

	3) Agreed sign off arrangements and submission to NHS England.
DHCFT 2022/063	**LEARNING FROM DEATHS MORTALITY REPORT** The 'National Guidance on Learning from Deaths' requires each Trust to collect and publish specified information on a quarterly basis. This report covers the period 26 March to 30 May 2022. John assured the Board that the Mortality Review Group's review of cases have shown that no deaths were due to problems in care. Learning is taken from patient safety reviews and no deaths have been reported where the patient tested positive for COVID-19. There is very little variation between male and female deaths and no unexpected trends were identified according to ethnic origin or religion. Investment to grow the community forensic team and improvements made to the electronic patient record system (EPR) have resulted in better patient investigations and safety reviews. Geoff Lewins noted that the report mentioned both PARIS and SystmOne EPR systems and queried whether some records will continue to be held on PARIS after migration to SystmOne. John clarified that after the decommissioning of PARIS all records will be held on SystmOne going forward. Geoff also challenged how the Mortality Group managed to meet the required targets when five out of eight case-note review sessions were cancelled due to lack of medic availability. John assured Geoff that the Trust is meeting its targets and is favourably benchmarked compared to other organisations. Clinical and medical staff are required to attend these investigation sessions and John has discussed their attendance with the wider medical body to ensure medical and clinical representation does not weaken. Having discussed the report, 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. **RESOLVED: The Board of Directors accepted this Mortality Report as assurance of the Trust's approach and agreed for the report to published on the Trust's website as per national guidance.**
DHCFT 2022/064	**CORPORATE GOVERNANCE UPDATE** Trust Secretary, Justine Fitzjohn updated the Board on Well Led work and highlighted the publication of three key draft pieces of governance guidance for trusts recently issued by NHS England and NHS Improvement (NHSEI). **Position Statement Well Led** Board Well Led work is progressing to prepare for the Well Led element of the expected Care Quality Commission (CQC) inspection. A comprehensive Board leaders pack has been created which is supported by an evidence library. An Executive lead for each of the eight Well Led Key Lines of Enquiry (KLOE) will ensure that the leaders pack is regularly updated in preparation for the inspection, the timing of which is yet to be announced. The Board is holding a joint session with the Council of Governors on 5 July that will cover the Trust's plans for preparing for an inspection as supporting the Council of Governors is a key component of the Trust's leadership. **Governance guidance documents – consultation** NHSEI have recently issued an updated Code of Governance for NHS provider trusts, and a new Addendum to the guide to the duties of NHS Foundation Trust Governors and new guidance on good governance and collaboration under the NHS provider licence. These three draft documents give a good overview of the guidance in terms of System working and are in the consultation stage which closes on 8 July. All three will be taken through the relevant Board Committees and the Council of Governors as governors have expressed a positive appetite to work within the System.

	The Board was pleased to note that Justine Fitzjohn and the Trust Secretaries across the System are engaging to better understand the System architecture and how this updated guidance will impact the capacity of Non-Executive Directors who are also members of the ICB Board Committees and how best they can serve a sovereign trust and the Derbyshire System. **RESOLVED: The Board of Directors:** **1) Noted the update on Board Well Led** **2) Noted the overview of the three draft governance documents**
DHCFT 2022/065	**GUARDIAN OF SAFE WORKING REPORT** Th report from the Trust's Guardian of Safe Working (GOSW) provided data about the number of junior doctors in training in the Trust. The report details arrangements made to ensure safe working within the Junior Doctors contract and arrangements in place to identify, quantify and remedy any risks to the organisation. John Sykes took the Board through the report and highlighted how the on call rota can be relatively busy for the higher trainees, usually this is to do with Mental Health Act (MHA) related work during the evening. This led to one incident in this quarter where the out of hours work breached the rest requirements for the higher trainee and resulted in the Trust's first fine for a breach in rest periods for a higher trainee. Following on from this the Mental Health Act (MHA) Lead for the Trust has spoken to the Medical Students Committee and has agreed to discuss ways to prevent this from happening again and proposed that MHA assessments take place during the day rather than the evening to ensure this not an onerous commitment for Junior Doctors. In response to Selina asking how issues raised during the Junior Doctors Forum are resolved and reported, John explained that a lot of these issues concern inpatient work, particularly after hours and are resolved through good exchange of information and problem solving through the matrons interfacing with doctors and other clinicians. It was noted that this was the final report from Smita Saxena as she has now completed her tenure as the GOSW. Thanks were given to Smita for her commitment in ensuring that there are procedures in place to support Junior Doctors. **RESOLVED: The Board of Directors noted the contents of the report as assurance of the Trust's approach in discharging its statutory duties regarding safe working for medical trainees.**
DHCFT 2022/066	**COMMITTEE IN COMMON PROPOSAL** This item was deferred until a future meeting.
DHCFT 2022/067	**FIT AND PROPER PERSON TEST CHAIR'S DECLARATION** Selina Ullah presented her Chair's declaration that all Trust Board Directors meet the fitness test and do not meet any of the 'unfit' criteria as per the Fit and Person's Test regulations (Health and Social Care Act 2008 Regulation 2014). It is the Chair's responsibility to declare annually that processes are maintained for ensuring compliance with fit and proper person regulation (FPPR). The report confirmed that a robust process is in place to ensure that FPPR processes have been applied to all Board members and that this is recorded in Executive Directors' and Non-Executive Directors' personal files. Selina declared that she was satisfied that all Directors of the Trust, including Non-Executive, and Executive Directors (including voting and non-voting) are deemed to be fit and that none meet any of the 'unfit' criteria.

	Ifti commented that the Messenger review's spotlight on NHS leadership and management might mean changes will be made to FPPR arrangements next year, which was noted by the Board. **RESOLVED: The Board of Directors received full assurance from the Chair's declaration that that all Directors meet the fitness test and do not meet any of the 'unfit' criteria.**
DHCFT 2022/068	**BOARD COMMITTEE ASSURANCE SUMMARIES** The Board Committee Assurance Summaries demonstrated the work of the committees since their last update to the Board. The Assurance Summaries were accepted and noted by the Board as a clear representation of the priorities that were discussed and will be taken forward in forthcoming meetings. No questions were raised with the Assurance Summaries as it is within the Board Committees where much of the scrutiny and challenge takes place which is an important part of the Trust's governance requirements. **RESOLVED: The Board of Directors noted the Board Assurance Summaries.**
DHCFT 2022/069	**IDENTIFICATION OF ANY ISSUES ARISING FROM THE MEETING FOR INCLUSION OR UPDATING IN THE BOARD ASSURANCE FRAMEWORK (BAF)** Carolyn Green was mindful that the current increase in COVID-19 cases could potentially disrupt the Trust's recovery of access standards. This risk is being recorded in the Risk Register and BAF and will be taken forward by the Quality and Safeguarding Committee.
DHCFT 2022/070	**2022/23 BOARD FORWARD PLAN** The 2022/23 forward plan outlining the programme for the remainder of the year was noted and will be reviewed further by all Board members for the financial year ahead.
DHCFT 2022/071	**MEETING EFFECTIVENESS** The Board agreed that the meeting had been successfully conducted as a live streamed meeting. Lee Doyle and Scott Lunn both admired the Board's people first approach during today's discussions. The challenge put forward by Non-Executive Directors was positive to hear and the response from Executive Directors was a useful insight. Selina thought the papers were of a good standard, particularly the Quality Impact Assessments which is relevant to the documents the Board reads and is a real strength of this Trust.
The next meeting to be held in public session will be held at 9.30am on 6 September 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.	

				BOARD OF DIRECTORS (PUBLIC) ACTION MATRIX - SEPTEMBER 2022			
Date	**Minute Ref**	**Item**	**Lead**	**Action**	**Completion Date**	**Current Position**	
10.5.2022	DHCFT 2022/044	Workforce Standards Formal Submission 2022	Director of People and Inclusion	Assurance on the assessment of safer staffing within Workforce Standards be received by the Board	6.9.2022	Receiving the Workforce Plan at the September meeting will meet this requirement and close this gap.	Green

Key:

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

Derbyshire Healthcare NHS Foundation Trust
Report to the Public Board of Directors – 6 September 2022

Trust Chair's Report to the Board of Directors

Purpose of Report

This report is intended to provide the Board with the Trust Chair's reflections on activity with and for the Trust since the previous Board meeting on 5 July 2022. The structure of this report reflects the role that I have as Trust Chair.

Our Trust and Staff

1. As the situation with the pandemic continues to improve, I have been able to undertake more service visits. Visiting services and speaking to colleagues, patients and carers gives an invaluable insight and provides a way of triangulating the reports we receive in committees and at Board. I am excited that after a two year break, we are returning to our Quality Visits. The Quality Visits will give our teams the chance to present and show areas they are proud of. It gives that time for Executives and Non-Executive Directors (NEDs) to meet colleagues and hear their stories first-hand and learn about good practice and improvements and also for the Trust Board to take away and support the challenges. I would like to thank Carolyn Green and Kyri Gregoriou for organising and ensuring we can safely visit teams and services to maintain contact with staff and service users.

2. On 25 July I visited the Kedleston Unit, our Forensic service, the Allied Health Professionals team, the Catering department, Patient Experience team and our Estates department. I was able to speak to our colleagues who shared their experience of providing services, ideas for service improvement and ways to improve efficiency. I was able to do some further service visits on 22 August with Ifti. We visited the Corbar View and the Buxton and High Peak and North Dales team. We also visited the Dementia Rapid Response team and the In Reach Home Treatment Teams in Bakewell and the Adult and Older Adults teams based in the Old Vicarage in Bolsover. I was struck by their passion for what they do and their desire to provide excellent care.

3. On 26 July I attended the memorial service and tree planting for Prince Ncube, Patience Govera and Peter Sloan at Kingsway and on 23 August a memorial service was held for Mark Wright. Ifti and I met with their families and spoke to some of their colleagues. Colleagues paid their personal tributes and shared their memories of Prince, Patience, Peter and Mark. The services were recorded and shared with Trust colleagues. This was a sad occasion for all, however, family members expressed how pleased they were to see how the Trust was commemorating the memory of their loved ones.

4. In the meantime, I have been attending as many of the team live engagement events being hosted via MS Teams as I can. I attended the live engagement sessions held for the Admin and Clerical Service, Adult Inpatients, Older People's Services and Children's Services. These meetings are very useful to me in terms of understanding how our colleagues are feeling and hear first-hand about the challenges they are experiencing, as well as how engaged they are with the Trust.

5. I have also been meeting some of our senior leadership team. On 12 July I met with Samina Arfan, Head of Equalities, Diversity and Inclusion and Vikki Ashton Taylor, Director of Strategy, Partnerships and Transformation who have both joined the Trust recently. I also met with Becki Priest, Deputy Director of Practice and Transformation on 9 August.

6. On 28 July, I joined the virtual Schwartz Round, the theme of which was 'The Derbyshire Redemption'. It was very moving to hear about the impact of addiction, the recovery journey and the importance of organisation culture in supporting colleagues. It was very affirming to hear about the positive culture and compassion experienced by colleagues. Thank you for letting me join you.

7. A critical stakeholder for Trust management are our staff side representatives. I have met with Lee Fretwell, Lead Convener, RCN Union. I also met with Dr Kaanthan Jawahar, Deputy Chair of the LMC and Paul Hardy, Lead Convener Unison. I found these meetings very insightful and valuable.

8. I would like to thank all staff for their ongoing commitment and dedication shown to the Trust and our service users over two heatwaves, both of which came with a red and amber alert respectively. A red alert warning means there is a risk to life and infrastructure. Despite this our staff colleagues showed immense resilience and fortitude in the delivery of care and keeping our patients/service users safe.

Council of Governors

9. The Nominations and Remunerations Committee met on 22 July, following the interviews for the post of Non-Executive Director, Quality, to make its recommendation for appointment to the Council of Governors.

10. On 26 July an Extraordinary Meeting was held to ratify the appointment of Lynn Andrews as NED, Quality. Lynn comes with a wealth of experience and track record in quality, clinical improvement and system working. Lynn was previously Chief Nurse at Chesterfield Royal and is a Derbyshire resident. Lynn impressed the panel with her strong values, patient focus, experience of quality, safety and improvement and her wider system knowledge and relationships. She will be a great asset to the Board as we strengthen and embed quality improvement in the organisation. Lynn will be chairing the Quality Committee when Dr Sheila Newport retires.

11. On 2 August I met virtually with three of our Staff Governors as part of our quarterly catch ups, to understand how they are managing in their work, both as a Governor and a member of staff. We discussed some of the concerns and suggestions they had picked up from staff colleagues and we agreed a number of actions. I really value this contact and would like to thank them for the work that they do for the Council.

12. On 9 August I attended the Governors Governance Committee. This was chaired by Ruth Grice and Marie Hickman. We discussed a number of business items including how the governors will be involved in the CQC Well Led Inspection, what public engagement activities the governors have been involved in and formulating the 'holding to account' questions. We held a virtual joint Council of Governors/Board meeting on 5 July following the public Board in the morning. This meeting was extremely well attended by Governors, who have embraced the use of technology superbly well.

13. On 25 August I met with Susan Ryan and Julie Boardman in their capacity as Lead Governor and Deputy Lead Governor. The purpose of the meeting between the Trust Chair and the Lead Governors is to ensure that we are open and transparent around the challenges and issues that the Trust is dealing with. Regular meetings between the Lead Governors and Chair are an important way of building a relationship and understanding of the working of both governing bodies. I was able to share with them about the leadership changes taking place and early thoughts about the plans being considered.

14. The Annual Members Meeting will be held on 21 September. Having considered the uncertain environment we are operating in and the logistics of finding a suitable venue, it has been agreed that this will be held virtually again this year.

15. Council of Governors meetings are held in the afternoon of Public Board meetings, so after today, the next meeting will be 1 November. The next Governance Committee takes place in October.

Board of Directors

16. 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 the public and our staff to observe the Board meeting.

17. We have held several Remuneration and Appointment Committees over the summer to receive the updates on changes in the Executive Leadership Team and agree the plans in place to ensure continuity, leadership stability and delivery of Trust priorities.

18. We welcome Lynn Andrews, who joins the Board in a designate NED role from 5 September. Lynn will have a period of handover, taking over from Sheila when she retires later in the year.

19. A Board and senior leaders session on Quality Improvement took place on 13 August, which focused on the Trust's programme of building quality improvement capability. This is a key aspect of the Trust's Quality Improvement Strategy and an important enabler in our quality improvement and sustainability drive.

20. I continue to meet with my NED colleagues on a quarterly basis to review their objectives, development needs and discuss their perspectives on how the Board and Trust is delivering Trust priorities.

21. We have been busy onboarding our two newest NEDs, Ralph Knibbs, Chair of People and Culture Committee and Senior Independent Director and Tony Edwards, Chair of Finance and Performance Committee. Both have made an excellent start and are making a strong contribution to the Trust and their respective committees.

System Collaboration and Working

22. Joined Up Care Derbyshire (JUCD) met on 11 July online via MS Teams. The session was specifically held for NEDs and Chairs of Provider Collaboratives.

23. On 20 July we held a Board to Board meeting with University Hospitals Derby and Burton (UHDB). It was a very informative and valuable exercise and many areas of common interest, concerns and opportunities to work together in a more joined up way were identified. All agreed that it had been a great success and a joint plan of action on the identified priorities is being developed. I would like to thank Kathy Mclean, Chair of UHDB for being so supportive of closer working between our respective organisations and to Magnus Harrison, Interim CEO UHDB and Ifti Majid, our CEO, for leading and facilitating the discussions to such a positive conclusion.

24. On 1 July the Integrated Care Board (ICB) became a legal entity. The four Derbyshire Provider Chairs met with John MacDonald, Chair ICB/JUCD on 21 July to consider the changes in approach/focus that is required as the system begins to operationalise and embed.

25. I have continued to meet regularly with the chairs of the East Midlands Alliance of mental health trusts, which has been a very useful source of sharing best practice and peer advice.

Regulators, NHS Providers and NHS Confederation and others

26. I attended the NHS Providers Board meeting on 7 July in London. It was my first Board meeting and I also had my induction to NHS Providers. In the evening I attended the meeting to say farewell to the outgoing CEO, Chris Hopson, who has joined NHS England as Director of Strategy. I was able to meet some of the Chairs from the East Midlands Alliance in person for the first time since my appointment.

27. I have attended regular briefings from NHSE/I for the Midlands region, which has been essential to understand the impact of ongoing pandemic pressures on services, other system pressures e.g. ambulance waits, elective recovery, workforce issues, Out of Area placements of complex patients and waiting times in mental health and autism services.

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

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

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

Risks and Assurances

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

Consultation

This report has not been to other groups or committees.

Governance or Legal Issues

None

Public Sector Equality Duty and Equality Impact Risk Analysis

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

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

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

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

Demonstrating inclusive leadership at Board level

As a Board member I have ensured that I am visible in my support and leadership on all matters relating to diversity and inclusion. I attend meetings to join in the debates and conversation and to challenge where appropriate, and also to learn more about the challenges of staff from groups who are likely to be or seem to be

disadvantaged. I ensure that the NEDs are also engaged and involved in supporting inclusive leadership within the Trust.

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

Recommendations

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

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

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 6 September 2022

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. On 15 July the government published its Building the Right Support for People with a Learning Disability and Autistic People Action Plan. The plan brings together key elements from existing reports into one document, recommendations, and announcements from across government and public services, aimed at improving care and support for people with a learning disability and autistic people, to provide a clear view as to what must be delivered. Given our role in both delivering and leading these services across the system, this is of key importance for our Organisation.

   The Plan sets out five key principles that link together the key commitments in the plan:

   1. Keeping people safe
   2. Personalised care and support
   3. Working together towards improvement and integration of care and support
   4. Holding ourselves and others accountable
   5. Inclusive decision-making

   The key commitments detailed in the plan require implementation and change at a national, regional and system/single organisational level. Below are some of those commitments that seemed particularly relevant to our Trust and local system:

   - A review of inpatient advocacy and recommendations for next steps by Summer 2022;
   - Ensuring people with a learning disability and autistic people have received a Safe and Wellbeing Review if they were in mental health inpatient care as at 31 October 2021 – Summer 2022;
   - Continuing Independent Care (Education) and Treatment Reviews and work with the Oversight Panel to improve the circumstances of people who remain in long term segregation – all those within scope to be offered a review by end of 2022;

- Refreshing the Care (Education) and Treatment Review policy by Summer 2022;
- Implementing a programme of personalised workforce development for staff who support those who may be at risk of admission or are ready to be discharged – April 2023;
- Providing community learning disability teams and intensive support teams with the opportunity to commence advanced and consultant level practice training by April 2023 – April 2025;
- Consideration by the Department of Health and Social Care (DHSC) of a rapid review of funding flows which was published on 14 July 2022;
- Publishing guidance setting out minimum expectations for Dynamic Support Registers to identify children, young people, and adults most at risk of admission – Summer 2022;
- Supporting employers to embed the learning disability and autism core capability frameworks across relevant social care and health workforces by April 2023;
- Rolling out an accredited commissioning qualification and a training programme for two cohorts of senior leaders to increase their skills and knowledge to support local commissioners by April 2023; and
- Developing and trialling autism training in (a) adult inpatient mental health settings (March 2023) and (b) mental health community and inpatient settings for all age groups (September 2022 to April 2025);
- A full ICS footprint roll out of designated keyworkers for children and young people with a learning disability and autistic children and young people – March 2023.

Nationally the Building the Right Support Delivery Board will support implementation of the plan, with task and finish groups established in particular areas, and will hold commitment owners accountable for delivery. As an organisation with responsibility for commitments, we will be expected to use our own governance and reporting mechanisms and those within the Joined Up Care Derbyshire Delivery Board to drive progress. While the Delivery Board's primary focus is at a national level, it is recognised in the plan that regional and local level implementation is important to successful delivery. The government wants the action plan to be actively used by and to inform the health, social care, education, housing, and criminal justice workforce with the levers in their local areas to make positive change happen.

The plan's emphasis is on strengthening community support, but it is recognised that there may be times when admission to a mental health hospital would be appropriate and offer a therapeutic benefit - this fits well with our experience locally. The government therefore plans to retain some inpatient capacity to meet the needs of people with co-occurring, treatable, mental health conditions. Some capacity for forensic inpatient care will also be retained so that people with a learning disability or autistic people, who come into contact with the criminal justice system, have a safe and appropriate alternative to prison.

Board colleagues should also note from my previous briefings on the revisions to the Mental Health Act (MHA) that there will also be significant impact on people with a learning disability or autism through these reforms:

- Limiting the scope to detain people with a learning disability or autistic people under the MHA;
- Making it a statutory requirement for responsible clinicians to have regard to the findings and recommendations from Care (Education) and Treatment Reviews (C(E)TRs) and include them in the patient's care and treatment plan, unless there are good reasons not to;
- Introducing a new power of Supervised Discharge to enable the discharge of restricted patients into conditions in the community which amount to a deprivation of liberty; and
- Introducing new duties on commissioners to ensure that there are adequate community-based services in their local area to support people with learning disability and autistic people and to hold a dynamic support register which includes an 'at risk of admission' component.

Local compliance and planning with relation to the plan will be monitored through the Mental Health, Learning Disability and Autism Board. However, as a Trust, we will need to consider amendments to the integrated performance report to ensure we are monitoring progress against those items we have statutory accountability for.

2. On 29 July 2022, the Department of Health and Social Care (DHSC) published several pieces of guidance in the context of the Health and Care Act 2022 (the Act) and the establishment of statutory Integrated Care Systems (ICSs) covering:

- The guidance on integrated care strategies outlines statutory requirements for how Integrated Care Partnerships (ICPs) will operate, including involving a range of local stakeholders in the development of the strategy. It also sets out some non-statutory expectations but empowers ICPs to define the focus and content of their strategies locally.
- The Health and Wellbeing Board (HWB) guidance articulates how HWBs will be expected to work with ICPs, as well as confirming that HWBs will maintain their existing roles. I note that the guidance gives welcome flexibility for systems to decide how best to manage this interface based on local contexts and footprints.
- The guidance on ICPs working with adult social care providers sets out five high-level principles for their involvement in system working. It makes clear that adult social care providers are key partners in ICPs and should be involved in system planning discussions.
- The guidance on how Health Overview and Scrutiny Committees (HOSC) should work with ICSs sets out that HOSCs largely retain their previous powers with a remit to constructively scrutinise the effectiveness of health and care services, with integrated care boards (ICBs) and ICPs now falling within this scope.

East Midlands Region and Derbyshire Context

3. Derbyshire's Integrated Care Partnership (ICP) met in August with a focus on a number of key areas including:

- Agreement that the ICP will be formed in full from October 2022 and as such terms of reference were discussed and noted.

- Development of the mandated strategy for the ICP that focussed on the five Department of Health and Social Care expectations: being a core part of the integrated carer system, being rooted in the needs of local people, communities and place, overseeing population health strategies, supporting integration and subsidiarity, being inclusive in strategy development. We also agreed it should reflect the 'life course' approach used in Joined Up Care Derbyshire (JUCD) strategy.
- Agreed the interim strategy must be signed off by December 2022 with development and engagement work between September and November.
- Citizen engagement in the development of JUCD's Integrated Care Strategy and Joint Forward Plan, the inter-relationships between them from an engagement perspective, and a proposal for how this engagement might be progressed in line with the People and Communities Strategic Engagement Framework. It was discussed by the Public Partnership Committee at their meeting on 2 August 2022. We agreed three phases of development through to consultation between January and February 2023 with the plan published in March 2023.

4. The Provider Collaborative for Derbyshire continues to meet monthly with a current focus on agreeing priority action areas around supporting services such as People, Digital and Estates. Given the support for the partnership agreement by all Boards, the provider Collaborative is now meeting in full form:

    a. We have now agreed 5 priorities for people integration through the collaborative that are: Developing a collaborative recruitment and resourcing hub, a single JUCD induction programme, system wide alignment of mandatory training, HR/people management policy alignment, enablement of more effective movement of colleagues around the system.
    b. We reviewed the ten JUCD digital initiatives and agreed to map out the core priorities from this plan to be reviewed and escalated through the Provider Collaborative.
    c. We agreed the need to separate out management of system pressures, recovery from COVID-19 and business as usual from the need to continue with long term plan driven transformation and members of the provider collaborative have agreed to escalate a proposal to do this and to form a separate Transformation Board in the system to the JUCD System Executive in September.

5. On 11 July we held the first of a series of development sessions for all Non-Executive Directors (NEDs) across the Derbyshire system with the aim of ensuring all NEDs are equally sighted on system developments. This first session focussed on the establishment of NHS Derby and Derbyshire as the Integrated Care Body (ICB) its emerging interaction with the Integrated Care Partnership and the roles of the Provider Collaborative at Scale and at Place.

6. In August I attended the Q1 2022/23 Midlands Regional and National MH Deep Dive Meeting, chaired by the HSE Regional Director, with the National Director in attendance. The focus of the meeting was in relation to regional and system performance exceptions, showcasing work around advancing health inequalities and reviewing some of the innovations around workforce, new roles and progress across the Midlands.

7. The Mental Health, Learning Disability and Autism System Delivery Group (MHLD&A SDG) continues to meet monthly with a focus on strategy development, performance monitoring and management and transformation. Since the last Board of Directors meeting, focus has been on:

Strategy

- The ongoing development of the formal Mental Health, Learning Disability and Autism Alliance, with potential partners discussing the partnership agreement in their Boards or relevant Committees, as we did in the July Board. A reminder for Board is that this is a ground-breaking potential due to the wide scope of partners involved. We have now arranged a system-wide engagement event to discuss this further in September.
- Discussions around how reporting within the MHLD&A SDG links in with broader system transformation work and makes use of the new electronic project management software.

Performance

- In line with many systems nationally, we continue to be challenged with respect to core compliance with long term plan and constitutional targets. In order to help focus, we are holding a number of deep dives into areas of most concern and to date we have done that in terms of:
    - Access to community perinatal services
    - Community Mental Health Team (CMHT) community contacts
    - Children and Young People Eating Disorder performance
    - Transforming care cohort admission numbers.

Transformation

Some of the main areas of transformation or service development we have been discussing include:

- Children and Young People national key working initiative
- Special Educational Needs and Disability (SEND) neurodevelopmental assessment hub development
- The opportunity to bid as part of a national initiative for a mental health fast response vehicle for Derbyshire
- The developing outline case for Learning Disability Assessment and Treatment services

Within our Trust

8. As you will recall, we recently undertook a recruitment process to appoint a new Medical Director, following the news of the retirement of Dr John Sykes. John has been the Trust's Medical Director since it formed in 2001. Our sincere thanks to John for all his dedication and hard work in contributing to the Trust being the success it now is.

    I am delighted to confirm the appointment of Dr Arun Chidambaram as the Trust's new Medical Director. Arun will start in post on Monday, 3 October 2022 and will work closely with John before he retires from the role of Medical Director.

    Arun is a Consultant Forensic Psychiatrist and is currently the Deputy Chief Medical Officer and Medical Director at Lancashire and South Cumbria NHS

Foundation Trust. He has previously held roles as Deputy Medical Director and Operational Medical Director across a number of organisations, including being the Interim Medical Director at Mersey Care NHS Foundation Trust. I know Arun is looking forward to joining the Trust and I am confident he will be a really good fit for the organisation and our people first approach.

In what has become a tradition, there will be an opportunity for colleagues to meet with Arun before he starts in post in September, as Arun will be joining our August All Staff Q&A session which takes place between 12.30pm – 1.30pm on Wednesday, 28 September.

John will continue to be the Trust's Medical Director until Arun commences in post in October. Following this time, John will continue to work in the Trust, in his role as a Consultant Psychiatrist in North Derbyshire.

9. July has been a key month for leadership development. On 12 July Claire Wright spent the morning with our preceptees leading a discussion about being actively inclusive in practice and 'shaping all our futures'. In a very interactive session, she explored the essence of truly inclusive actions and leadership. The preceptees got their 'thinking caps' on to generate fantastic reflections about inclusion, including what being anti-racist really means for us as people in our practice and as leaders. The session explored examples of health inequalities and wider bias in action and discussed how we all own our part to play in understanding and addressing inequalities. Thank you to the preceptees for their insight and honest reflections in the very vibrant discussions and sharing of personal experiences. I know from feedback I have heard that Claire's session was very successful, thought-provoking and impactful.

   On 14 July Claire also led another leadership session discussing health inequalities and active inclusion with the postgraduate trainee doctors and consultants. A morning of two halves, where in the first part, Claire led a great session of shared examples of why active inclusion matters and reflecting how important it is to recognise and seek to improve health inequalities in our everyday roles and in our medical leadership. It was great to hear from some of our consultants about their own work in this area. In the second part of the morning, Claire supported Dr Vishnu Gopal, who led the Trust's first ever doctors rewards and recognition event. Dr Gopal devised the event to celebrate successes and to showcase good practice, taking the time to say thank you and recognise the efforts and achievements of both the trainees and the trainers. I know both parts of the session were very well received and were another great example of our Trust values in action.

10. In July and August we held two very important ceremonies in our Memorial Garden at Kingsway Hospital.

    In July it was a privilege to host a remembrance event for three colleagues who sadly passed away whilst in service of our Trust, Prince Ncube, Patience Govera and Peter Sloan. It was wonderful that members of Prince, Patience and Peter's families were able to join us to celebrate their lives and recognise their individual contribution to the lives of the people of Derbyshire.

In August we were joined by Mark Wright's wife and daughters at his memorial service as we celebrated his unique and 16 year long passion for helping young people with mental health difficulties in Derbyshire.

Mark, Prince, Patience and Peter will all be sadly missed and we are fortunate to have such a wonderful memorial garden maintained so immaculately and with such care by colleagues from our estates and grounds team. My thanks to everybody who attended these two important events and those who helped with the organising.

11. During August I had a routine meeting with Amanda Solloway, local Derby MP. As Board members are aware, Amanda has been a staunch supporter of our organisation over recent years and is passionate about improving the lives of local people who need mental health support. We discussed an upcoming awareness raising event run by the Head High Charity, as well as current challenges and opportunities, such as our Making Room For Dignity Programme.

12. In the last month we have seen a gradual reduction in the number of colleagues away from work due to a COVID-19 based absence. At the time of reporting, this stood at 23, the lowest for over a year (0.8% of all sickness absence). In addition, the number of positive patients on our wards have remined very low, generally oscillating between 0 and 2.

    This is good news and has supported us to continually review our use of PPE including face masks and, whilst remaining compliant with national guidelines, we have been able to support keeping colleagues more comfortable during some of the hot weather.

    We are now responding to national guidelines and policy and preparing for the autumn vaccination round for both COVID-19 boosters and flu. Vaccinations will be available for Derbyshire Healthcare colleagues at a number of sites county wide and at our award winning Hub at Kingsway.

13. Since the last Board Meeting, Selina and I have been fortunate to visit the following teams:

    - Kedleston Unit, Kingsway Hospital
    - Adult Physiotherapy Hub
    - Catering Department
    - High Peak Adult Community Mental Health Team
    - High Peak Older Adult Community Mental Health Team
    - North Dales Dementia Rapid Response Team and Intensive Home Support Team
    - Bolsover Community Mental Health Team

    During the visits, we were able to have conversations with many colleagues covering broad areas such as gaining a better understanding of the service, the challenges and, importantly, hearing about innovation and things colleagues were proud of. We also discussed worries about the cost of living, mileage reimbursement rates, the operational structure changes and proposed increased alignment with Place, the standard of some of our estate, both

wonderful new buildings such as Endcliffe Mount in Bakewell and more unsuitable property, such as that in Buxton.

14. We have continued to hold regular all colleagues Q&A sessions during July and August, again with very high levels of attendance with between 200 and 250 colleagues joining both calls.

    Key points raised by colleagues included:

    - Changes within the Executive Team and our robust continuity plans
    - The cost of living
    - Hybrid working approaches
    - Green plan and opportunities to ensure when developing new ways of working to emphasise our commitment to the green plan
    - Car parking and disruption on the Kingsway site

    In addition, we have held a number of all staff and Division specific open conversations with colleagues about our plans to link operational management more closely with the emerging Place Alliance structure in Derbyshire. These meetings, led by our Managing Directors, with Executive Directors present, are focused around the need to explain the current integrated care context, hear concerns and opportunities, and together consider any suggestions or builds on proposals. We have meetings scheduled through to November for all staff, service areas and professional groups.

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

Risks and Assurances

- Our strategic thinking includes 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.

The action plan for people with a learning disability or autism is a vital step in trying to close the inequality gap for this group of people, both in terms of access to services and, vitally, health outcomes, as we know people with a learning disability have significantly worse health and sadly die younger than people in the general population.

I think that the documentation linked to integrated care systems that reenforces the role of the Health and Wellbeing Board is really important as this is a key tenant of overseeing our drive to increase population health.

It should be noted that as we look to move to interim leadership arrangements and more permanent recruitment, maintaining and increasing diversity in our Executive Team remains a priority. This is something we have been able to do successfully in our interim arrangements.

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

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 6 September 2022

Performance Report

Purpose of Report

The purpose of this report is to provide the Board of Directors with an update of how the Trust was performing at the end of July 2022. The report focuses on key finance, performance and workforce measures.

Executive Summary

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

Operations

The transition to SystmOne in May 2022 has resulted in a large number of recording errors which have affected some of the performance measures. Where possible to do so, the position has been manually calculated through auditing each individual record, however in some cases the sheer volume of records concerned has meant it has not been possible, and so those charts contain no data for June and July. The SystmOne project team are still working to address these issues.

<u>Three-day follow-up of all discharged inpatients</u>
The national standard for follow-up has been exceeded throughout the 24-month period. The position in May to July 2022 has been manually calculated by auditing all of the reported breaches.

<u>Data quality maturity index</u>
The level of data quality has been significantly better than expected for the last 3 months. We would expect to consistently exceed the national target.

<u>Early intervention 14-day referral to treatment</u>
Patients with early onset psychosis are continuing to receive very timely access to the treatment they need.

<u>Early intervention 14-day referral to treatment – incomplete (people currently waiting to be seen)</u>

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

IAPT 18-week referral to treatment
This is an example of a very tightly controlled process, and we would expect to, and do continue to, consistently exceed the 95% standard.

IAPT 6-week referral to treatment
The national standard has consistently been exceeded throughout the reporting period.

IAPT patients completing treatment who move to recovery
This is an annual target and year to date we are exceeding target. For the past 24 months the national standard has been achieved.

Patients placed out of area in adult acute wards
There has been no data available re out of are placements since the transition to SystmOne in May 2022, however this is expected to be resolved by the end of August 2022. Trusts are required to submit a snapshot every month of the number of patients placed out of area at month end and the Trust's position was as follows: May: 5, June: 0, July: 3.

Patients placed out of area in psychiatric intensive care units (PICU)
The Trust does not currently have a PICU, so anyone requiring psychiatric intensive care has to be placed out of area. There has been no data available re out of area placements since the transition to SystmOne in May 2022, however this is expected to be resolved by the end of August 2022. Trusts are required to submit a snapshot every month of the number of patients placed out of area at month end and the Trust's position was as follows: May: 23, June: 25, July: 7.

Waiting list for care coordination
The average wait to be seen had been significantly low for 11 months but returned to common cause variation in April 2022. Data since May 2022 is not currently available owing to the SystmOne transition issues. These are expected to be resolved by the end of August 2022.

Waiting list for adult autistic spectrum disorder (ASD) assessment
The average wait is currently 71 weeks and the longest wait is almost 4 years. The situation is likely to continue to worsen until there is an increase to investment in the service, as demand for the service far outstrips commissioned capacity. There has also been a significant reduction in capacity to undertake assessments in the last 6 months owing to long term staff absence, meaning the contracted level of assessments has not been achieved.

Waiting list for psychology
Over the last 11 months, the number of people waiting has continued to gradually reduce. Investment has been made into the service and recruitment to a number of vacant and part-time posts across adult services continues to progress. We continue to review the waiting lists in line with trauma sensitive working in considering how we manage people on a waiting list and we are developing a new waiting well guide for those service users. We are reviewing the structure of psychological service to create a division to better utilise the skills we have in

supporting people across the Derbyshire landscape and making sure it is sustainable for the future.

Waiting list for Child and Adolescent Mental Health Services (CAMHS)
CAMHS continue to receive a higher number of referrals both via the routine and urgent care pathway. As a consequence, the CAMHS external waiting list is increasing by 10% per quarter. We have agreed to temporarily move all staff into locality teams where they will have a team manager, senior colleagues and a consultant to provide operational and clinical oversight of all patients waiting and open for the allocated geographical patch. This will provide assurance that all children requiring an urgent assessment will be prioritised in addition to those children accessing Children's Emergency Department. We will also prioritise cases open to the service with no allocated worker. This is a temporary measure (initially 3 months). Referrals will still be accepted during this period, and there will be processes to manage the waiting list in accordance with the waiting well policy.

Waiting list for community paediatrics
We continue to see a steady rise in waiting times for referral to treatment in community paediatrics. We are carrying two vacancies which have been advertised. We have appointed to one post on a substantive basis and will seek to re-advertise the second role. Sickness absences are still having an impact on clinics. To mitigate we have also brought in some additional capacity at Speciality Doctor level on a temporary basis and will continue to use locum cover where we can. The neuro-developmental pathway development is ongoing. The business case includes a fixed term Speciality Doctor to focus on the autistic spectrum disorder pathway. Securing these posts would have a significant impact on the waiting list. We await final Integrated Care Board (ICB) approval for the investment requested.

Outpatient appointments cancelled by the Trust
The level of cancellations has been within common cause variation for the last 24 months. There was a spike in May which may be data issues linked to the transition to SystmOne.

Outpatient appointment did not attends (DNA)
The level of defaulted appointments has remained within common cause variation for the last 24 months and in the current process the trust target of 15% or lower is likely to be consistently achieved.

Finance

At the end of July, the overall year to date position is a deficit of £1.3m compared to the plan deficit of £0.5m, an adverse variance to plan of £0.5m. The main driver for the adverse variance to plan is related to the undelivered CIP (Cost Improvement Programme) which is slightly offset by some additional income.

However, there are significant areas of risk in and outside of that plan driven by the planning assumptions that have been followed, such as the delivery of the required 3% efficiencies, Agency expenditure and the containment of COVID-19-19 costs.

Efficiencies

The full year plan includes an efficiency requirement of £6.0m phased equally across the financial year. At the end of May there remains an unidentified gap to plan of £3.0m. Work continues with senior leaders across the organisation to identify further efficiencies to close this gap, with a focus on recurrent delivery.

Agency
Agency expenditure year to date totals £2.4m against a plan of £0.9m, an adverse variance to plan of £1.5m. The two highest areas of agency usage relate to Consultants mainly in CAMHS and Nursing staff. NHSE have confirmed that tighter agency controls will be introduced from September.

COVID-19 costs
The financial plan assumes no expenditure for COVID-19 after the end of May as per the planning guidance. In June there was £0.2m of costs which was a significant reduction of previous months however, there was a slight increase in July up to £0.4m which reflects patient cases and staff absences.

Out of area placements
Expenditure for adult acute out of area placements totals £1.3m to date.

Capital expenditure
Following the resubmission of the capital plan expenditure has been in line with the plan for June and July. The forecast assumes full spend to plan by the end of the financial year.

Better Payment Practice Code (BPPC)
In July the 95% target was achieved across all invoices in terms of value and exceed the target in terms of volume of invoices paid.

People

Annual appraisals
Appraisal levels continue to be below our expectations. There is however a significant improvement over the last eight months. There is a planned appraisal focus for September which will include communication targeted at those who are non-compliant and an increased focus in the monthly divisional achievement reviews.

Annual turnover
Turnover remains high and above the Trust target range of 8-12%. There has been a small improvement from the previous month. From the latest national NHS staff annual turnover benchmarking data, the Trust was ranked 7th highest mental health trust for stability of the workforce.

Compulsory training
Mandatory training continues to be a key focus and an ongoing recovery position for the Trust. Overall, the 85% target level has been achieved for the last four months.

Staff absence
Sickness absence remains high and above the 5% target threshold. July saw a 6.09% increase in COVID-19 absences accounting for 20% of all absences. There was a small reduction in stress/anxiety related absences, but this

remains the highest reason for absence. A continued focus on ensuring we are managing and supporting colleagues with sickness absences has taken place over July.

Supervision
Levels of compliance with the clinical and management supervision standards have remained low since the start of the pandemic.

Proportion of posts filled
Staffing levels have remained around 91% in July and we have seen a small reduction in vacancy rate. Nationally, recruitment has been recognised as needing a significant review of current approaches and an overhauling recruitment programme has been launched.

Bank staff
Actions from the Temporary Strategy Workforce Group have started to impact total agency high cost usage, but this continues to be a local and system focus. Key areas of attention have been developed and presented to key committees, these have been developed to support the temporary workforce and further develop the service to ensure the organisation is supported by a contemporary temporary workforce offer that embodies the organisational values, clinical quality and value for money.

Quality

Compliments
The number of compliments continues to remain below the expected level. A project supporting the electronic patient survey will provide a further method of receiving compliments, complaints, and concerns. With an increase in accessibility, it is expected that a natural increase in patient feedback will occur over the next six months.

Complaints
The number of formal complaints is above the trust target; however a number of complaints were received in relation to reduced face to face contact and reduced access to services. As face-to-face contact continues to increase and as services stand back up, it is expected that the number of complaints will reduce.

Delayed transfers of care (DTOC)
Since the multi-agency discharge events (MADE) were held, numbers of delayed transfers of care have reduced and now sit below the mean line. Work continues within the rapid review processes and clinical meetings and a housing officer was recruited in May who will support the identification of placements for patients who do not need to be on a hospital ward. The trust has also recently started a “medically fit for discharge” meeting where any barriers to discharge are identified and discussed.

Care plan reviews
A programme of clinical quality audit is being implemented across the trust divisions which will help to identify those patients whose care plans require review.
Patients in employment

Around one third of patients have no employment status recorded at present and the decline in patients recorded as being in employment coincides with the data migration to SystmOne. The Individual Placement Support (IPS) Service continues to have success in supporting people into employment even during the pandemic and the service is currently expanding. The Trust has also employed two experts by experience to focus on the implementation and management of Health Education England training in relation to peer support working and apprentices.

Patients in settled accommodation
Around one third of patients have no accommodation status recorded and the decline in patients with a recorded settled accommodation status again coincides with the data migration to SystmOne. Therefore, this may also be a data issue. This will be investigated and reviewed during the next quarter.

Medication incidents
Although there is fluctuation with the number of medication incidents recorded, they are within the common cause variation in relation to the mean. The medicines management operational subgroup is currently revising the medications error procedure, considering Trust values. A report on incidents is also reviewed within the Monthly Clinical Operational Assurance Team (COAT) meeting for each division.

Incidents of moderate to catastrophic actual harm
The number of reported incidents of moderate to catastrophic harm increased from April with a spike between June and July. This increase appears to be related to repeated incidents involving a small number of patients. This is expected to reduce over the next quarter, but it will continue to be monitored by the Heads of Nursing team on a quarterly basis.

Duty of Candour (DOC)
The increase in Duty of Candour reported incidents as anticipated in the previous report is due to a change in how DOC incidents are reported. Training around accurately reporting DOC continues within clinical teams and a new Family Liaison Officer has now commenced in post and a review into the current process of quality assurance, auditing and reviewing of incidents is underway.

Prone restraint
Data analysis and review has shown that incidents involving prone restraint have increased between June and July related to repeated incidents involving a small number of patients. The overall numbers of prone restraint are lower than the regional average per bed numbers and it is expected that incidents related to prone restraint will reduce over the next quarter. This will continue to be monitored.

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

Seclusion
The use of seclusion has been above the mean common cause variation from October 2021. This is linked to a small number of patients who have been placed in seclusion on more than one occasion on an acute ward and then on the enhanced care ward. Further auditing and investigation will be carried out by the Head of Nursing for Acute and Assessment Services and will also include the links to Psychiatric Intensive Care Unit (PICU) use.

Falls on inpatient wards
After an abnormal spike of incidents in March, a review of falls was commissioned and identified that a high number of falls were related to the same small number of patients. From this review a bi-weekly falls review meeting, chaired by the Matron for older adult services has been established to identify any specific needs for those patients falling regularly. This appears to have had a positive impact with incidents related to falls reducing.

Care hours per patient day (CHPPD)
CHPPD is rolling data updated monthly, to show staffing levels in relation to patient numbers on an inpatient ward. In the latest published national data when benchmarked against other mental health trusts, we were very slightly below average.

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

Risks and Assurances

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

Consultation

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

Governance or Legal Issues

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

Public Sector Equality Duty and Equality Impact Risk Analysis

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

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

- This report reflects performance related to all of the Trust's service portfolio and therefore any decisions that are taken as a result of the information provided in this report is likely to affect members of those populations with protected characteristics in the REGARDS groups.
- Any specific action will need to be relevant to each service and considered accordingly, so for example, as parts of the report relate specifically to access to Trust services; we will need to ensure that any changes or agreed improvements take account of the evidence that shows variable access to services from different population groups.

Recommendations

The Board of Directors is requested to:

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

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

Report prepared by: **Pete Henson, Head of Performance (Operations)**

Rachel Leyland, Deputy Director of Finance

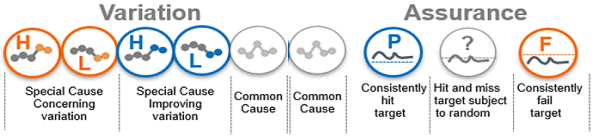
Rebecca Oakley, Head of Organisational Effectiveness

Joseph Thompson 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		P	93%	80%	80%	100%	90%
2	Data quality maturity index	H	P	99%	95%	97%	98%	98%
3	Early intervention 14 day referral to treatment - complete		P	67%	60%	68%	105%	86%
4	Early intervention 14 day referral to treatment - incomplete		?	79%	60%	56%	112%	84%
5	IAPT 18 week referral to treatment	H	P	100%	95%	100%	100%	100%
6	IAPT 6 week referral to treatment		P	83%	75%	83%	96%	89%
7	IAPT patients completing treatment who move to recovery		?	55%	50%	47%	62%	55%
8a	Average patients out of area per day - adult acute	H	?		0.0	-2	13	6
8b	Patients placed out of area - adult acute	H	?		0.0	0	21	11
9a	Average patients out of area per day - PICU	H				8	21	15
9b	Patients placed out of area - PICU	H				17	32	24
10a	Waiting list - care coordination - average wait to be seen	H				10	26	18
10b	Waiting list - care coordination - number waiting at month end	H				15	55	35
11a	Waiting list - ASD assessment - average wait to be seen	H		72		62	67	64
11b	Waiting list - ASD assessment - number waiting at month end	H		1,866		1268	1472	1370
11c	ASD assessments		?	13	26	4	30	17
12a	Waiting list - psychology - average wait to be seen	H		49		35	47	41
12b	Waiting list - psychology - number waiting at month end	H		600		720	915	818
13a	Waiting list - CAMHS - average wait to be seen	H		21		12	20	16
13b	Waiting list - CAMHS - number waiting at month end	H		538		345	506	425
14a	Waiting list - community paediatrics - average wait to be seen	H		24		10	16	13
14b	Waiting list - community paediatrics - number waiting at month end	H		1,423		719	1001	860
15	Outpatient appointments cancelled by the Trust		?	8%	5%	4%	11%	8%
16	Outpatient appointment "did not attends"		P	11%	15%	9%	14%	12%
17	Annual appraisals	H	F	76%	85%	71%	76%	73%
18	Annual turnover	H	P	13%	8-12%	11%	13%	12%
19	Compulsory training		?	86%	85%	83%	87%	85%
20	Staff absence		?	6%	5%	5%	8%	6%
21	Clinical supervision		F	71%	95%	69%	77%	73%
22	Management supervision	L	F	73%	95%	72%	78%	75%
23	Filled posts		F	90%	100%	87%	92%	89%
24	Bank staff use	L	?	5%	5%	5%	7%	6%
25	Compliments received		?	93	119	57	132	94
26	Formal complaints received		P	19	13	7	28	17
27	Delayed transfers of care		P	1%	3.5%	-0.6%	1.9%	0.6%
28	CPA reviews	L	F	87%	95%	88%	94%	91%
29	Patients in employment	L		6%		11%	14%	12%
30	Patients in settled accommodation	L		42%		54%	61%	57%

Key to symbols[1]:



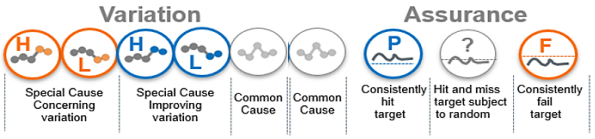
Blue dots indicate special cause variation, better than expected.

Orange dots indicate special cause variation, worse than expected.

[1]The rating symbols were designed by NHS Improvement

	Metric Name	Variance	Assurance	Latest Value	Target	Lower process limit	Upper process limit	Mean
31	Number of medication incidents			54		26	84	55
32	No. of incidents of moderate to catastrophic actual harm			94	48	22	81	51
33	No. of incidents requiring Duty of Candour			18	1	-1	10	5
34	No. of incidents involving prone restraint			19	12	-2	18	8
35	No. of incidents involving physical restraint			58	46	-2	93	46
36	No. of new episodes of patients held in seclusion			29	14	1	30	15
37	No. of falls on inpatient wards			37	30	17	46	32

Key to symbols[1]:

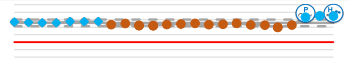
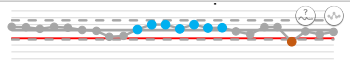
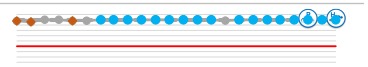
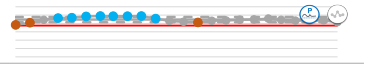
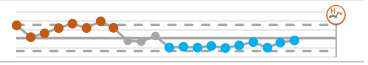
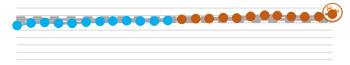
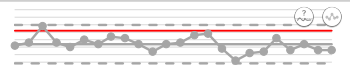
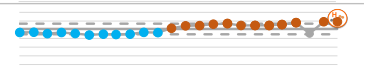
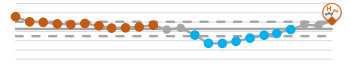
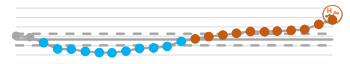


Blue dots indicate special cause variation, better than expected.

Orange dots indicate special cause variation, worse than expected.

[1]The rating symbols were designed by NHS Improvement

Operational Services Performance Summary

Indicator	Target	Position Jun 2022	National benchmark	Divisional Breakdown[1] AA	AC	Ch	F&R	OP	Psy	SC	Run Chart
● 3-day follow-up	80%	93%	75%	92%			100%	100%		100%	
● Data quality maturity index	95%	97%	81%	91%	97%	85%	92%	98%	98%	98%	
● Early intervention 2-week referral to treatment	60%	72%	69%		72%						
● Early intervention current waits under 2 weeks	60%	73%	28%		73%						
● IAPT 18-week referral to treatment	95%	100%	98.5%							100%	
● IAPT 6-week referral to treatment	75%	83%	89%							83%	
● IAPT recovery rate	50%	55%	50%							55%	
● Adult acute out of area placements – daily average	0	No data	7	No data							
● PICU out of area placements – daily average	0	No data	3	No data							
● Adult ASD assessment average wait (weeks)	n/a	72	n/a							72	
● Adult ASD assessments	26	13	n/a							13	
● Psychology average wait to be seen (weeks)	n/a	49	n/a							49	
● CAMHS average wait to be seen (weeks)	4[2]	21	n/a			21					
● Paediatrics average wait to be seen (weeks)	18	24	12			24					
● Outpatient appointment Trust cancellations	5%	8%	n/a		7%	7%		12%		13%	
● Outpatient appointments not attended (DNAs)	15%	11%	n/a		18%	8%		1%		0%	

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

Performance Summary

3-day follow up
The national standard for follow-up exceeded the national average by 17% and has been achieved by all Divisions. This process is tightly monitored by Samantha Shaw, the Trust's Performance Analyst, who routinely chases up the relevant teams prior to any potential breaches to ensure patients get timely support post discharge. As reported last time, investigation into reported breaches has highlighted issues with recording on SystmOne rather than actual breaches. This should improve as people get used to using the new system and the change to how things need to be recorded.

Early intervention
The services continue to perform consistently highly in terms of patients accessing services in a timely manner.

Improving access to psychological therapies (IAPT)
The quality of care provided by IAPT is evident as both national access standards and the national recovery standard have consistently been exceeded.

Data quality maturity index
Overall as a Trust, we continue to perform consistently highly against this standard.

Adult acute inappropriate out of area placements
There is currently no data available owing to the transition to SystmOne. This is expected to be resolved by the end of August.

Psychiatric Intensive Care Unit (PICU) inappropriate out of area placements
Although these placements are classed as inappropriate according to the national definition, we are currently one of the few Trusts in the country without a PICU and so have no choice. However, work is in progress towards a new build PICU provision in Derbyshire.

Waiting list for adult autistic spectrum disorder (ASD) assessment
The average wait is currently 71 weeks and the longest wait is almost 4 years. The situation is likely to continue to worsen until there is an increase to investment in the service, as demand for the service far outstrips commissioned capacity. There has also been a significant reduction in capacity to undertake assessments in the last 6 months owing to long term staff absence, meaning the contracted level of assessments has not been achieved.

Waiting list for psychology
Over the last 11 months, the number of people waiting has continued to gradually reduce. Investment has been made into the service and recruitment to a number of vacant and part-time posts across adult services continues to progress. We continue to review the waiting lists in line with trauma sensitive working in considering how we manage people on a waiting list and we are developing a new waiting well guide for those service users.

Waiting list for Child and Adolescent Mental Health Services
CAMHS continue to receive a higher number of referrals both via the routine and urgent care pathway. As a consequence, the CAMHS external waiting list is increasing by 10% per quarter. We have agreed to temporarily move all staff into locality teams where they will have a team manager, senior colleagues and a consultant to provide operational and clinical oversight of all patients waiting and open for the allocated geographical patch. This will provide assurance that all

children requiring an urgent assessment will be prioritised in addition to those children accessing Children's Emergency Department. We will also prioritise cases open to the service with no allocated worker. This is a temporary measure (initially 3 months). Referrals will still be accepted during this period, and there will be processes to manage the waiting list in accordance with the waiting well policy.

Waiting list for community paediatrics
We continue to see a steady rise in waiting times for referral to treatment in community paediatrics. We are carrying two vacancies which have been advertised. We have appointed to one post on a substantive basis and will seek to re-advertise the second role. Sickness absences are still having an impact on clinics. To mitigate we have also brought in some additional capacity at Speciality Doctor level on a temporary basis and will continue to use locum cover where we can. The neuro-developmental pathway development is ongoing. The business case includes a fixed term Speciality Doctor to focus on the autistic spectrum disorder pathway. Securing these posts would have a significant impact on the waiting list. We await final Integrated Care Board approval for the investment requested.

Outpatient appointments cancelled by the Trust
The level of cancellations has been within common cause variation for the last 24 months. There was a spike in May which may be data issues linked to the transition to SystmOne.

Outpatient appointment did not attends
The level of defaulted appointments has remained within common cause variation for the last 24 months and in the current process the trust target of 15% or lower is likely to be consistently achieved.

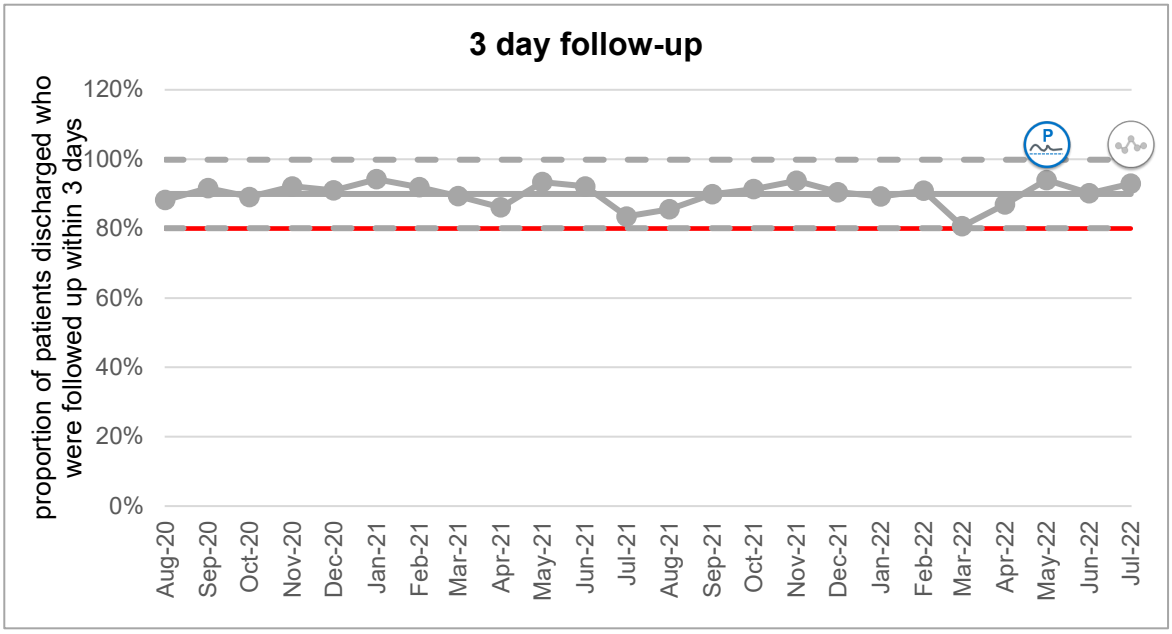
Benchmarking Sources

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

Detailed Narrative

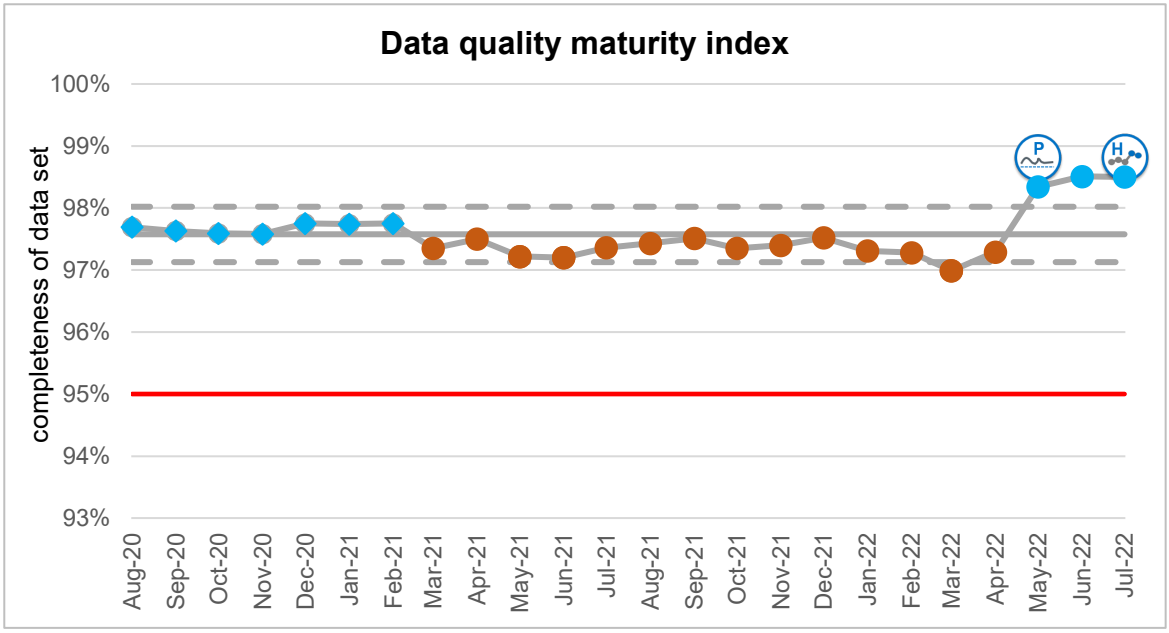
Operations

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



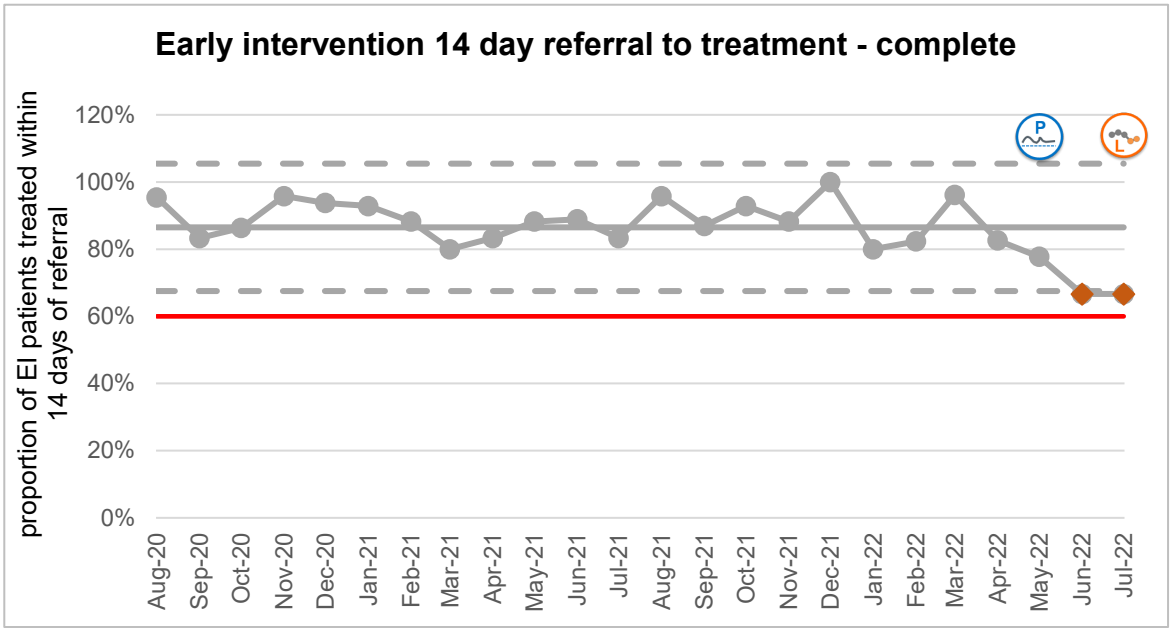
Patients are followed up in the days following discharge from mental health inpatient wards to provide support and ensure their wellbeing during the period when they are potentially at their most vulnerable. The national standard for follow-up has been exceeded throughout the 24-month period. The position in May to July 2022 has been manually calculated by auditing all of the reported breaches.

2. Data quality maturity index



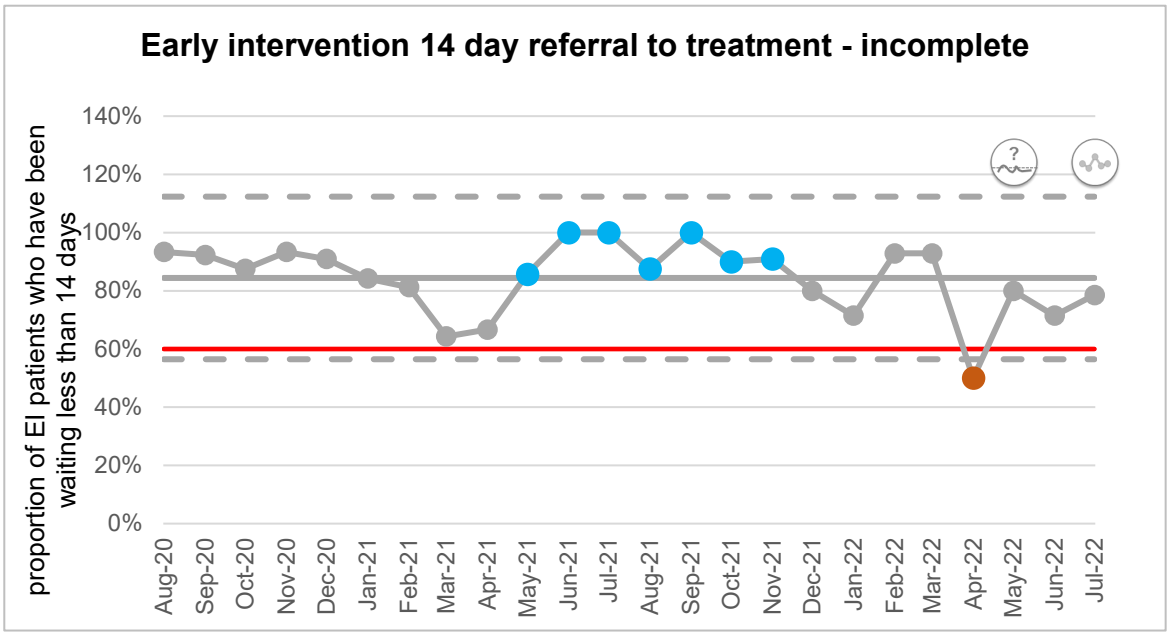
The level of data quality has been significantly better than expected for the last 3 months. We would expect to consistently exceed the national target.

3. Early intervention 14-day referral to treatment



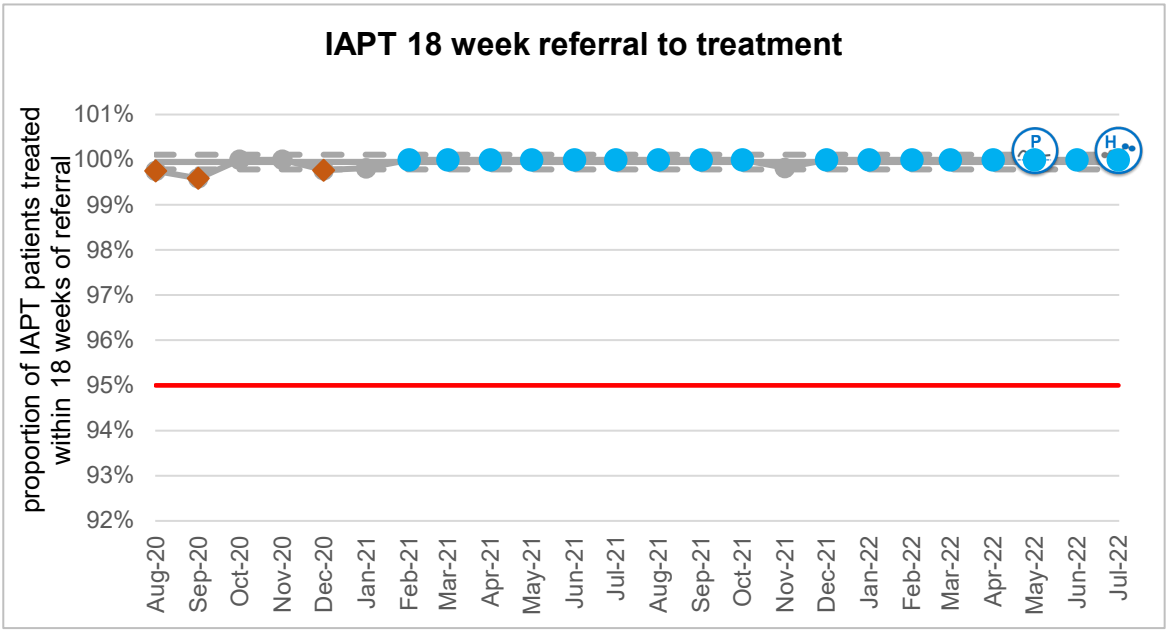
Patients with early onset psychosis are continuing to receive very timely access to the treatment they need.

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



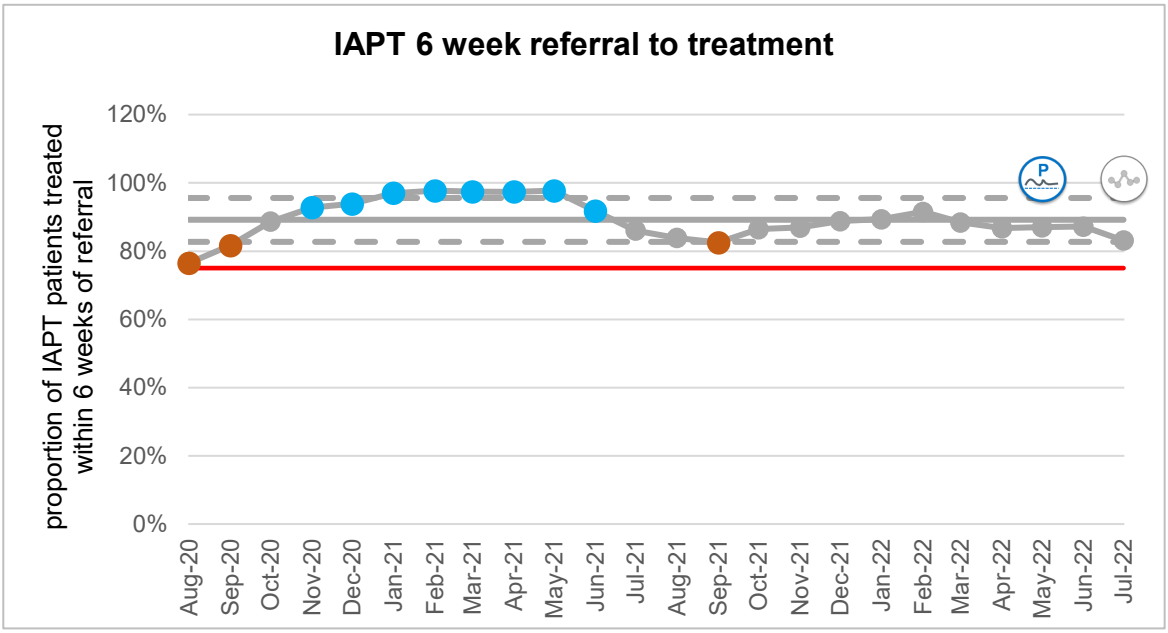
The service has exceeded the national 14-day referral to treatment standard of 60% or more people on the waiting list to have been waiting no more than 2 weeks to be seen in all but one month. Reasons people were waiting longer than 2 weeks included difficulty making contact owing to wrong numbers being provided by GPs, people not answering the phone, people not being at home when cold-called and people not attending their agreed appointments.

5. IAPT 18-week referral to treatment



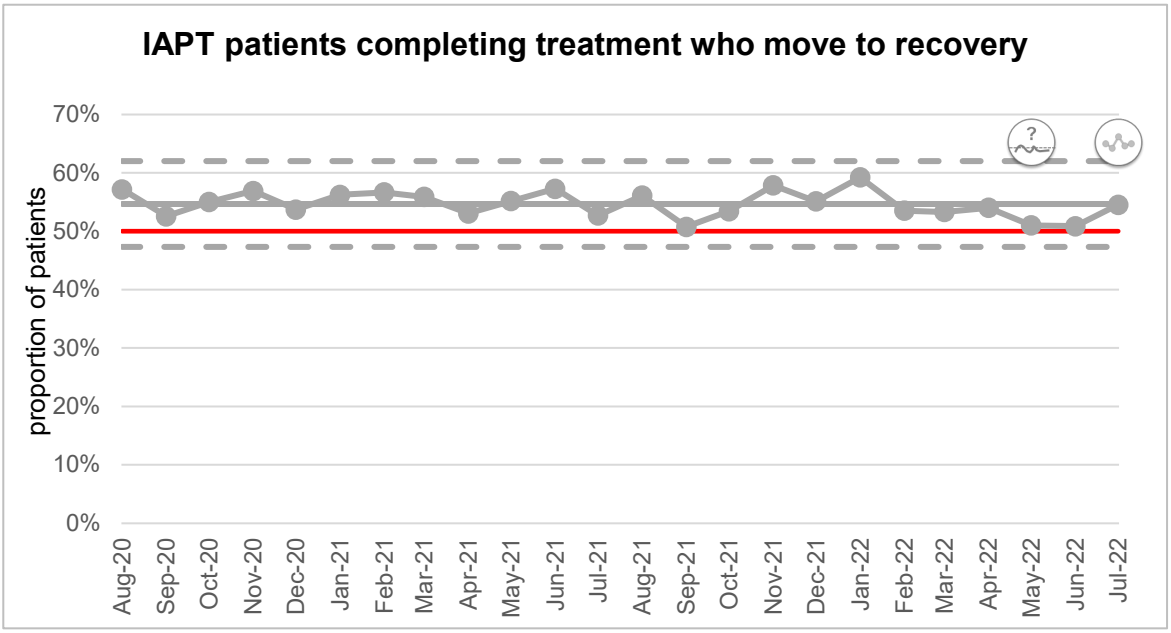
This is an example of a very tightly controlled process, and we would expect to consistently exceed the 95% standard.

6. IAPT 6-week referral to treatment



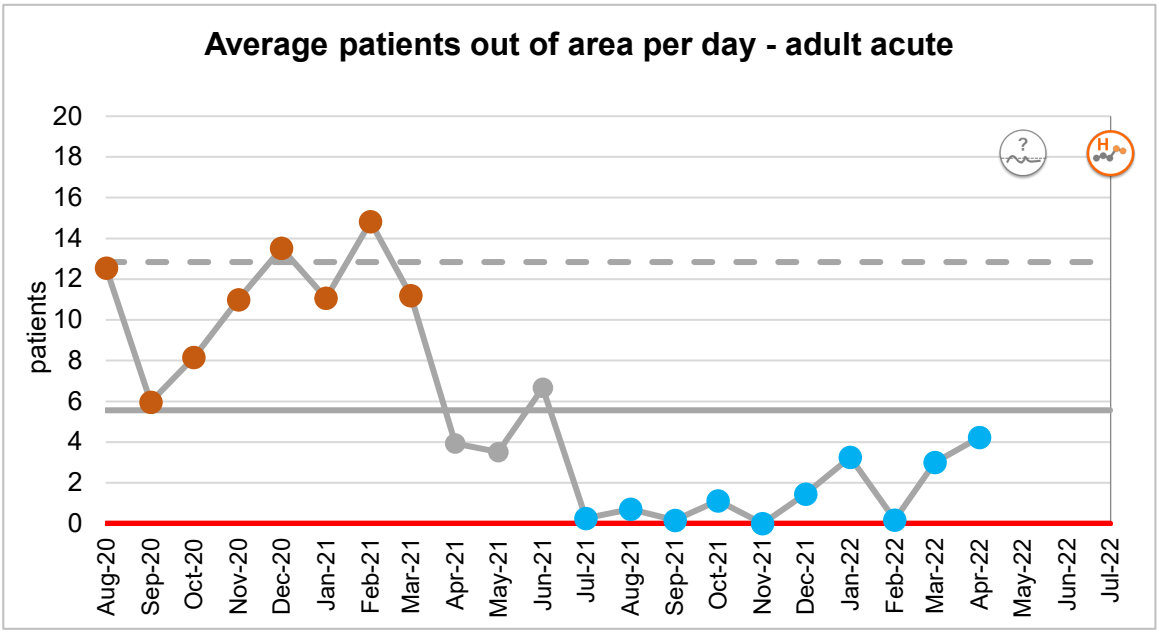
The national standard has consistently been exceeded throughout the reporting period.

7. IAPT patients completing treatment who move to recovery



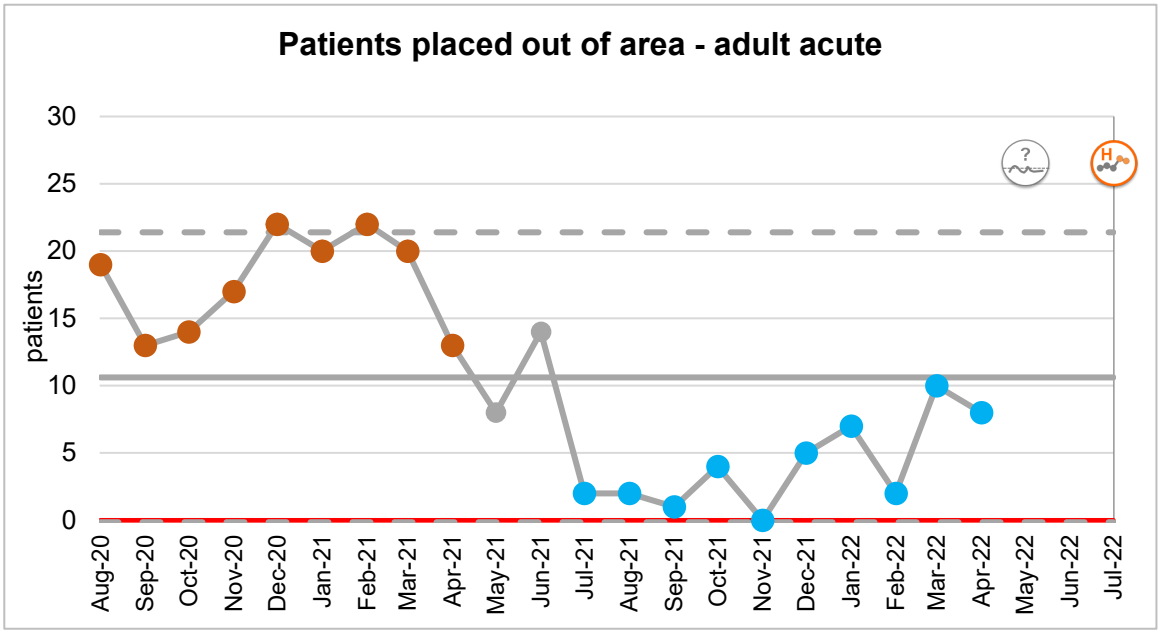
This is an annual target and year to date we are exceeding target. For the past 24 months the national standard has been achieved, with common cause variation seen throughout the data period.

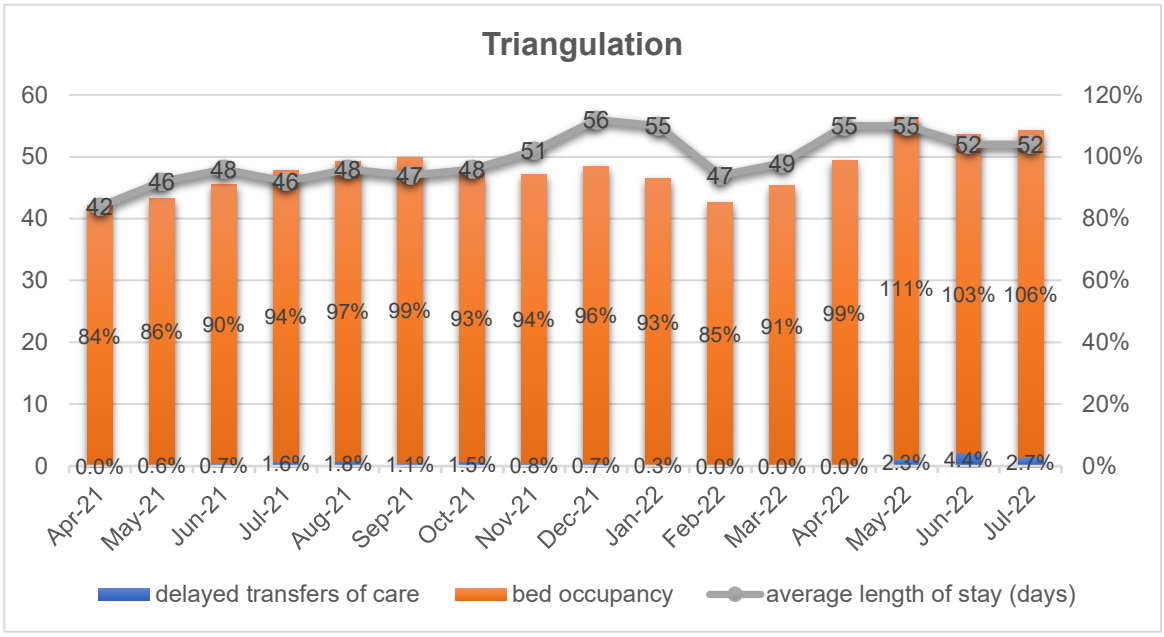
8a. Average number of patients placed out of area per day – adult acute



The significant reduction in in appropriate out of area placements was difficult to maintain during the most recent spike in the COVID-19-19 pandemic. Given our significant dormitory bed base and the requirement to ensure social distancing and effective and safe cohorting arrangements, it resulted in a temporary increase in inappropriate out of area bed use in March and April. A number of actions were put in place which have proven to be effective. There has been no data available since the transition to SystmOne in May 22, however this is expected to be resolved by the end of August 22. Trusts are required to submit a snapshot every month of the number of patients placed out of area at month end. The Trust's position for inappropriate out of area acute placements at month end was as follows: May 5, June 0, July 3.

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

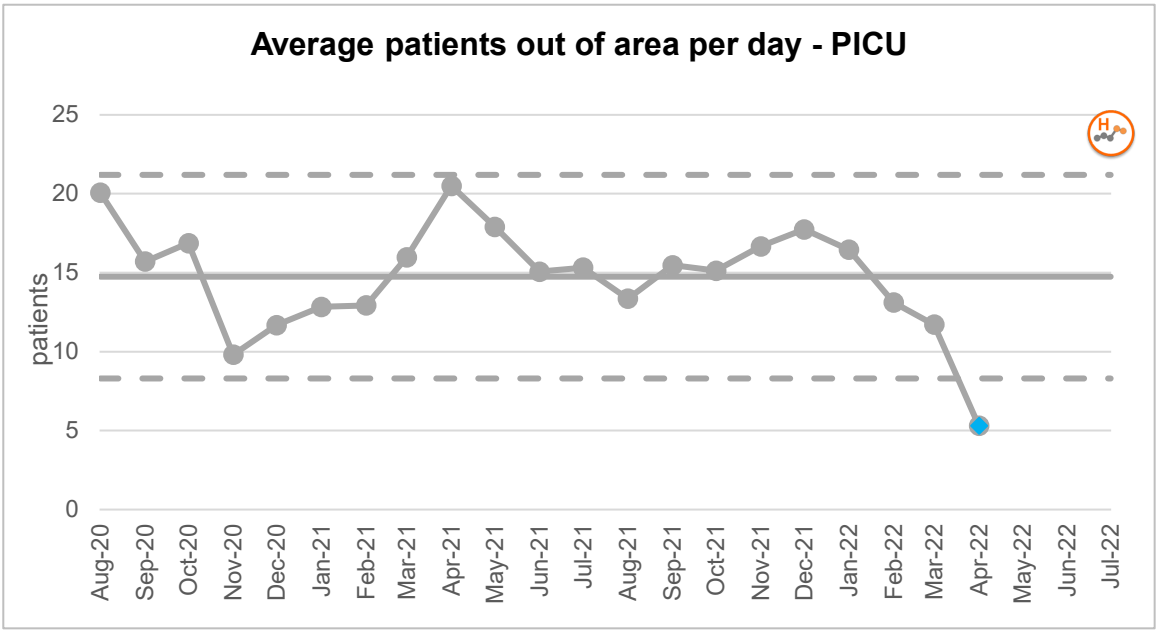




The level of inappropriate out of area acute placements is being impacted upon by high levels of bed occupancy, delayed transfers of care and above average length of stay. In recent months occupancy has exceeded 100%. This is where patients have returned home for a period of trial home leave and their beds have been occupied by new admissions. From queuing theory, to enable flow of patients through the system bed occupancy should not exceed 85% (the Erlang equation)[1].

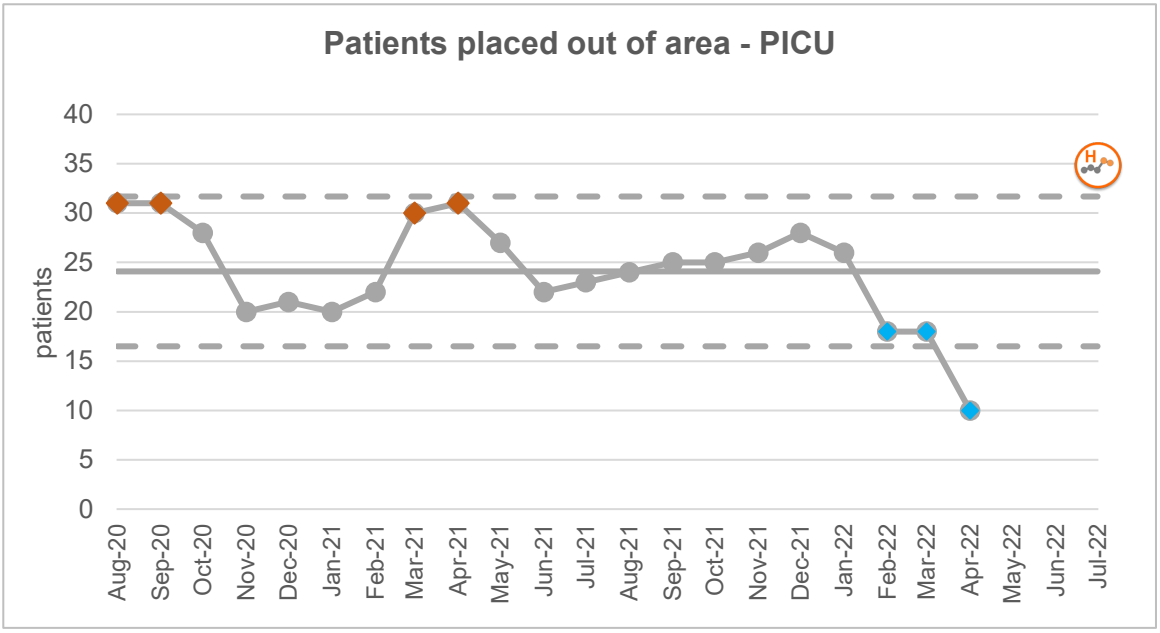
[1] Jones R (2013) Optimum bed occupancy in psychiatric hospitals. Psychiatry On-line http://www.priory.com/psychiatry/psychiatric_beds.htm

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

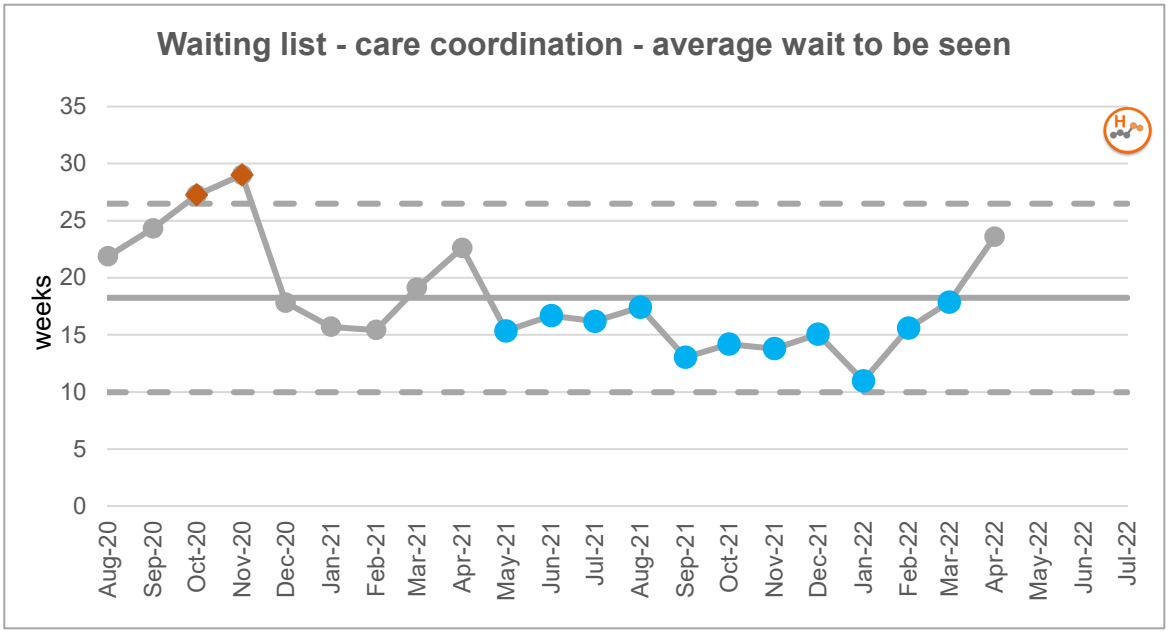


There is no local PICU provision, so anyone needing psychiatric intensive care needs to be placed out of area, however, work is in progress towards a new build PICU provision in Derbyshire. NHS Improvement continuity of care principles have been established with two PICU providers: Northamptonshire Healthcare NHS Foundation Trust and Elysium, as agreed in partnership with Derbyshire Urgent Care Steering Board. Trusts are required to submit a snapshot every month of the number of patients placed out of area at month end. There has been no data available since the transition to SystmOne in May, however this is expected to be resolved by the end of August. The Trust's position for inappropriate out of area PICU placements at month end was as follows: May 23, June 25, July 7.

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

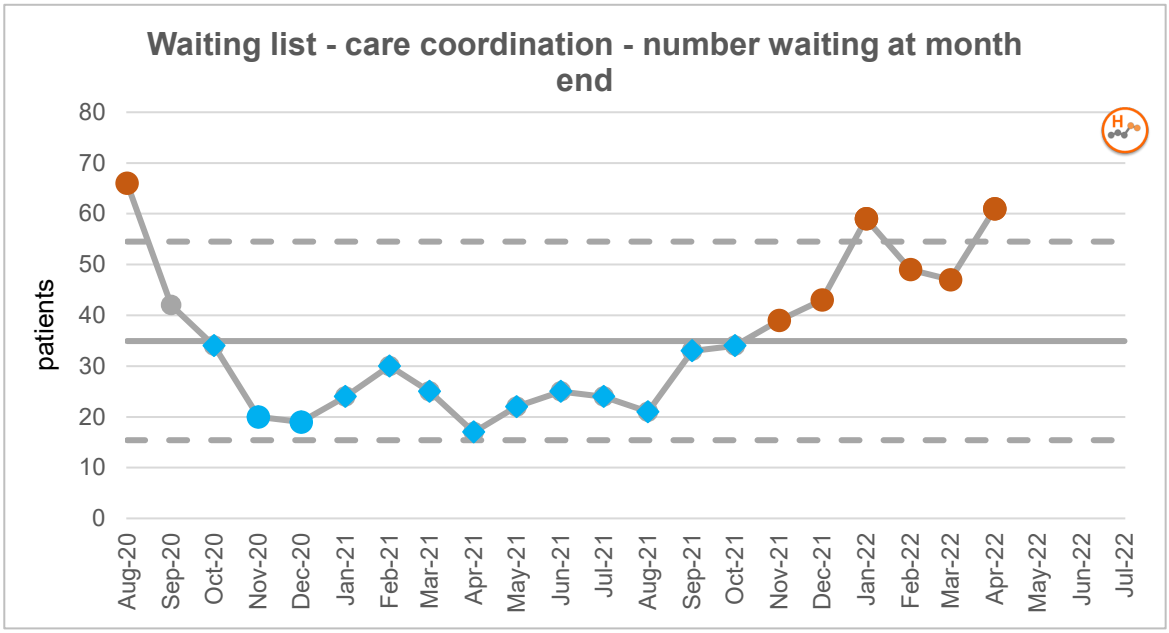


10a. Waiting list for care coordination – average wait



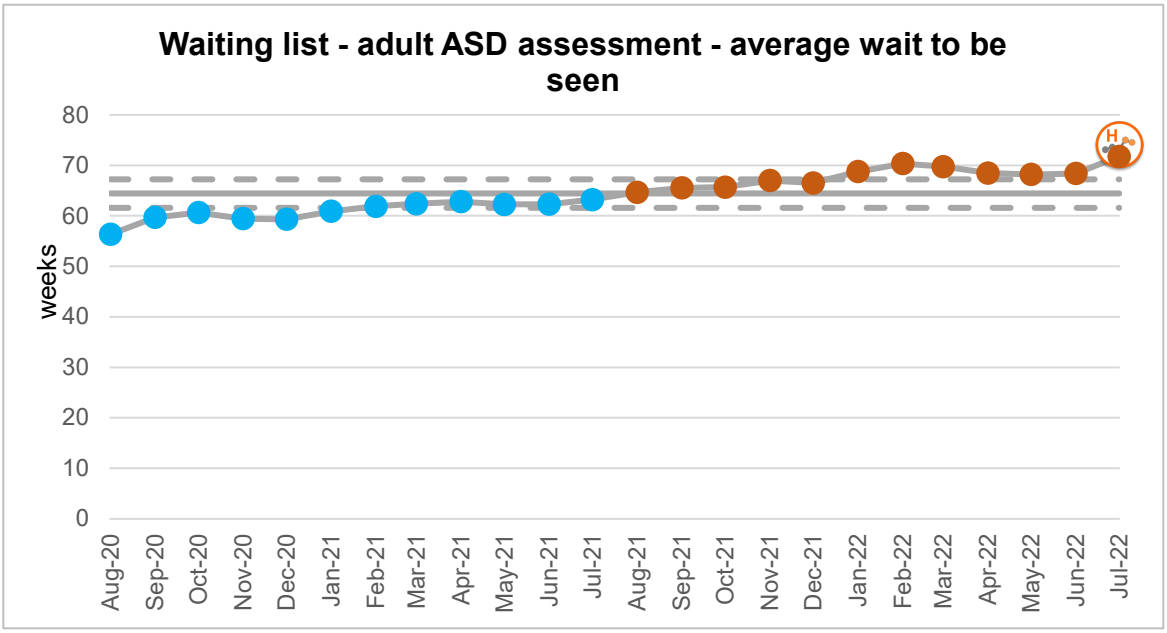
The average wait to be seen had been significantly low for 11 months but returned to common cause variation in April. Data since May 2022 is not currently available owing to the SystmOne transition issues. These are expected to be resolved by the end of August 2022.

10b. Waiting list for care coordination – number waiting



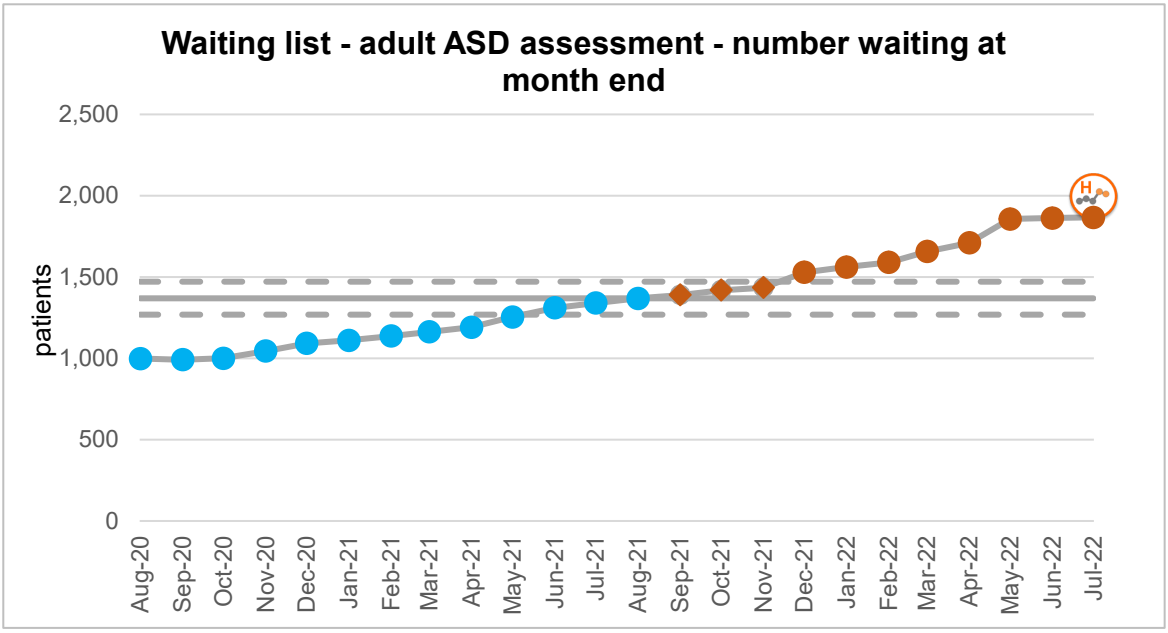
Data since May 2022 is not currently available owing to the SystmOne transition issues. These are expected to be resolved by the end of August 2022.

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



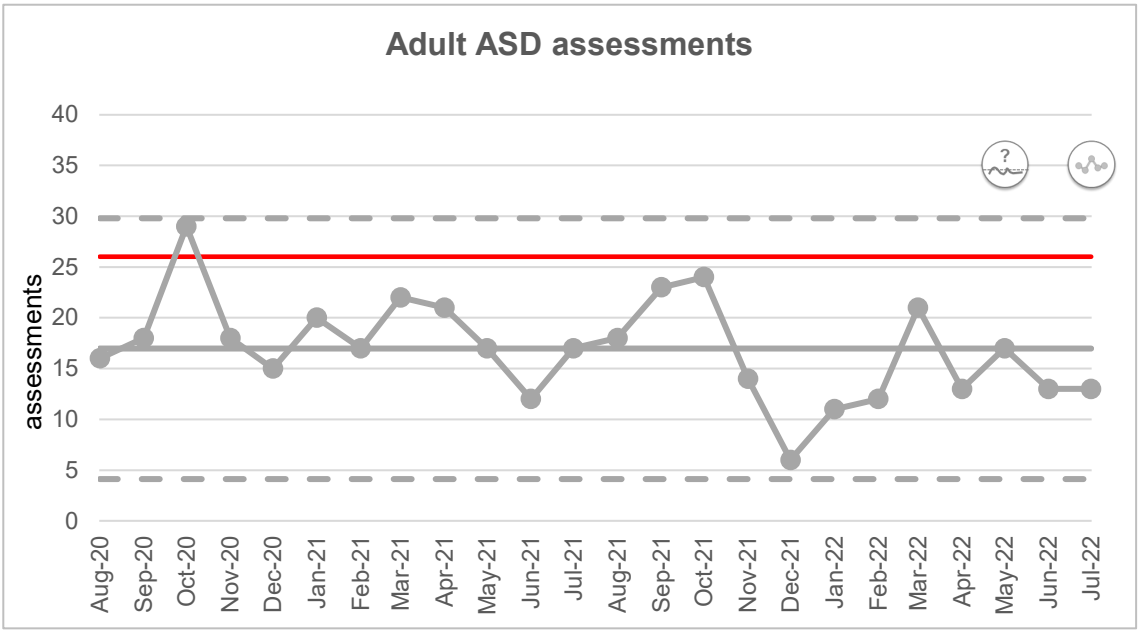
The average wait is currently 71 weeks and the longest wait is almost 4 years. The situation is likely to continue to worsen until there is an increase to investment in the service, as demand for the service far outstrips commissioned capacity: referrals have increased from 66 per month to 86 per month this financial year to date, but the team is only commissioned to undertake 26 assessments per month.

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



At the end of July 2022 there were 1,874 people waiting for adult ASD assessment, which is an increase of 87% over the 2-year period.

11c. Adult autistic spectrum disorder assessments per month



There has been a significant reduction in capacity to undertake assessments in the last six months owing to long term staff absence, meaning the contracted level of assessments has not been achieved. The team has also had notice from a very experienced assessor that they will be retiring. This now means that only 1.4 wte in the team is completing assessments.

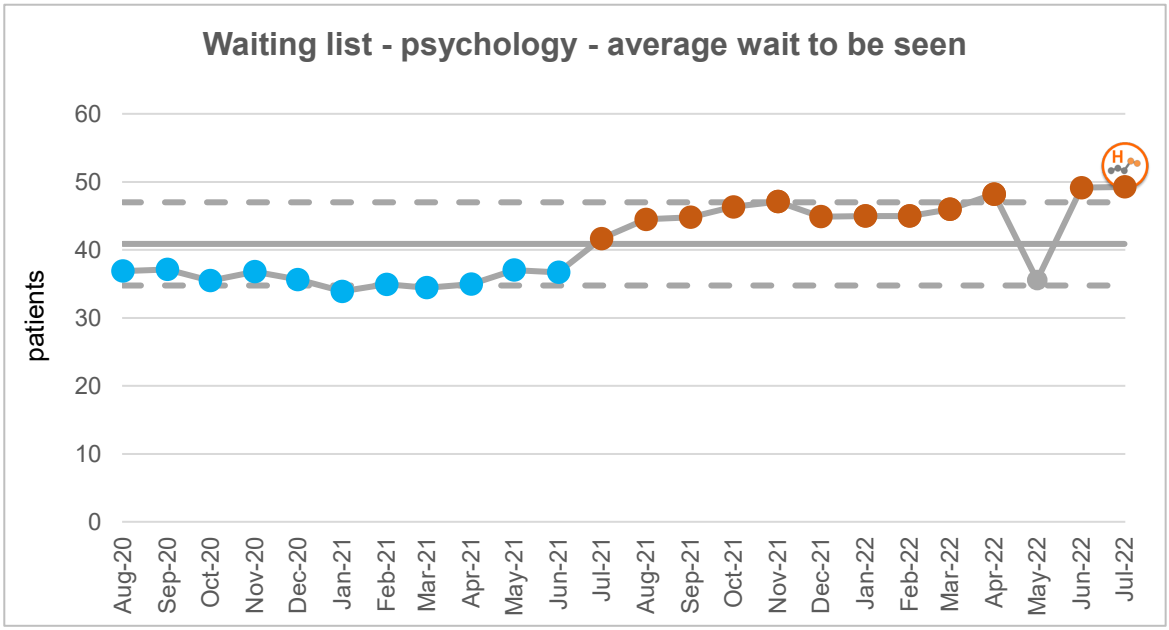
Listening to feedback from the assessment team, the monotonous assessment-only routine is not fulfilling for clinicians and patients and therefore an urgent review of the vacancies and a restructure has meant that we have put the Specialist Autism Team and the diagnostic team together to recruit posts that complete both assessment and intervention/support. These posts are due to close for shortlisting mid-August and have already attracted a number of suitable applicants.

The Trust has also asked the psychological therapists to consider assessment being core to all functions rather than just a few and are looking at rolling out a training programme that will increase the number of assessments across all teams. We will talk to General Manager colleagues to ensure that volunteers for training come forward, and that they will be supported to release them for training.

Whilst there is a significant financial and staffing time cost to this, the benefits are as follows:

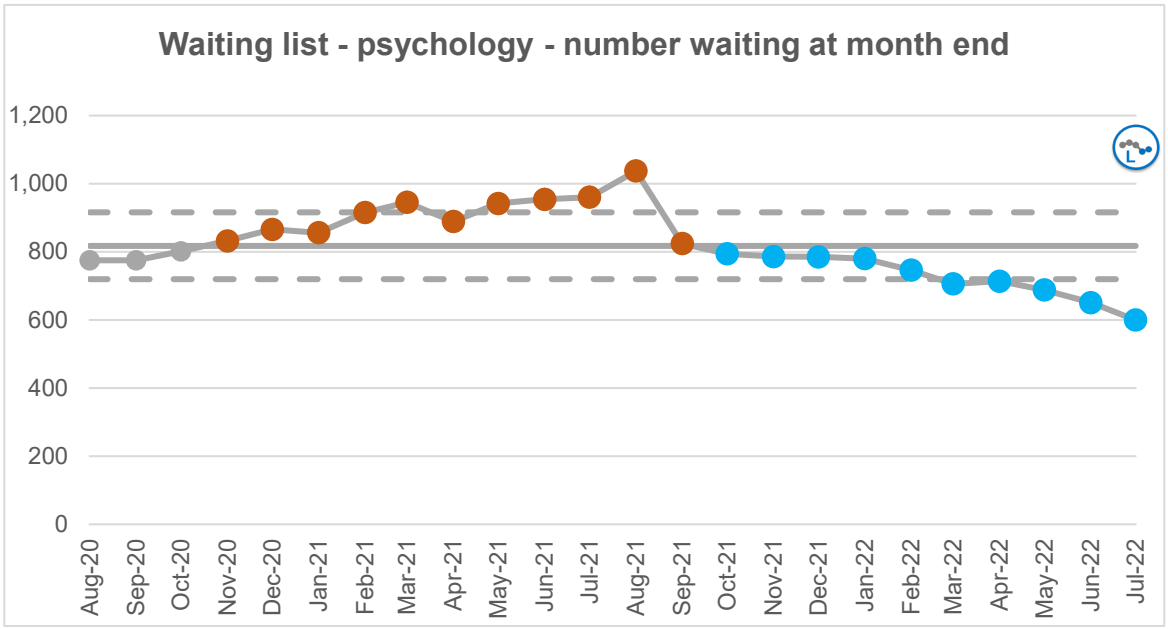
- Patients would not then end up on the adult ASD assessment waiting list
- Patients would get diagnoses and support in the same place they were receiving their other mental health support
- The numbers of adult ASD diagnostic assessments delivered through the trust would increase, meeting the 26 contractual requirement
- We would start to meet more of the need of the population right across the landscape, more in line with place
- The osmosis of upskilling around ASD knowledge within non-neurodevelopmental services will increase awareness and should support the early identification of patients and reduce hospital admissions across this cohort.

12a. Waiting list for psychology – average wait



Last month the average wait to be seen reduced to 36 weeks, but this has risen this month to 46 weeks. Many patients are still waiting owing to the pandemic and a personal preference to be seen face to face as opposed to by video call. There is a further impact due to vacant posts as we continue to struggle to recruit qualified staff.

12b. Waiting list for psychology – number waiting



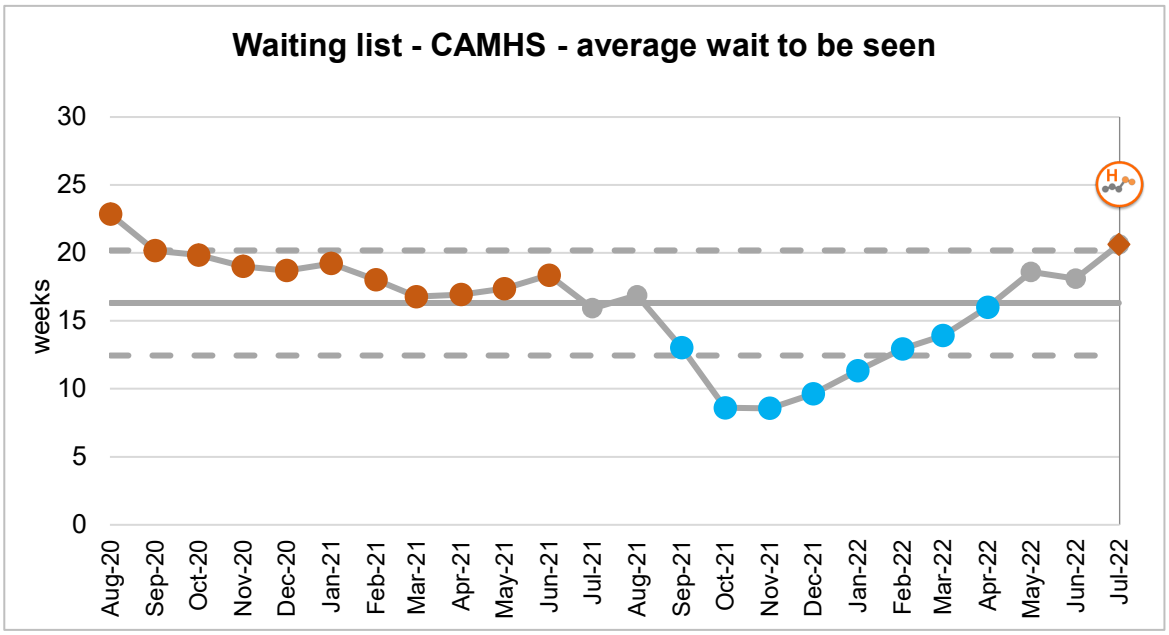
Over the last 11 months, the number of people waiting has continued to gradually reduce and the reduction is statistically significant. Although this is the correct trajectory, we must note that investment has been made into the service and recruitment to a number of vacant and part-time posts across adult services continues to progress. One of the pockets of challenge where the waiting times are above the average are the city teams. We now have two new starters to the City Community Mental Health teams (CMHTs) in the next month. We are utilising monies to recruit to short term Assistant Psychologist posts to support those qualified staff delivering treatment and care. There remains a national shortage of qualified psychologists, with all Trusts struggling to recruit. We remain in line with our regional colleagues with this figure.

After some delay in getting the new psychological therapies recruitment website up and running this went live at the beginning of July. We have had some interest, but although this has yet to translate into applications for roles, we are hopeful. We continue to look at other models of delivery such as digital and remote working and have created more flexible roles. We are also looking at other models of treatment such as group work, to see if this can support greater access to psychological care. We are also building some psychological training resources to support our nursing, occupational therapy and medical colleagues with working more psychologically.

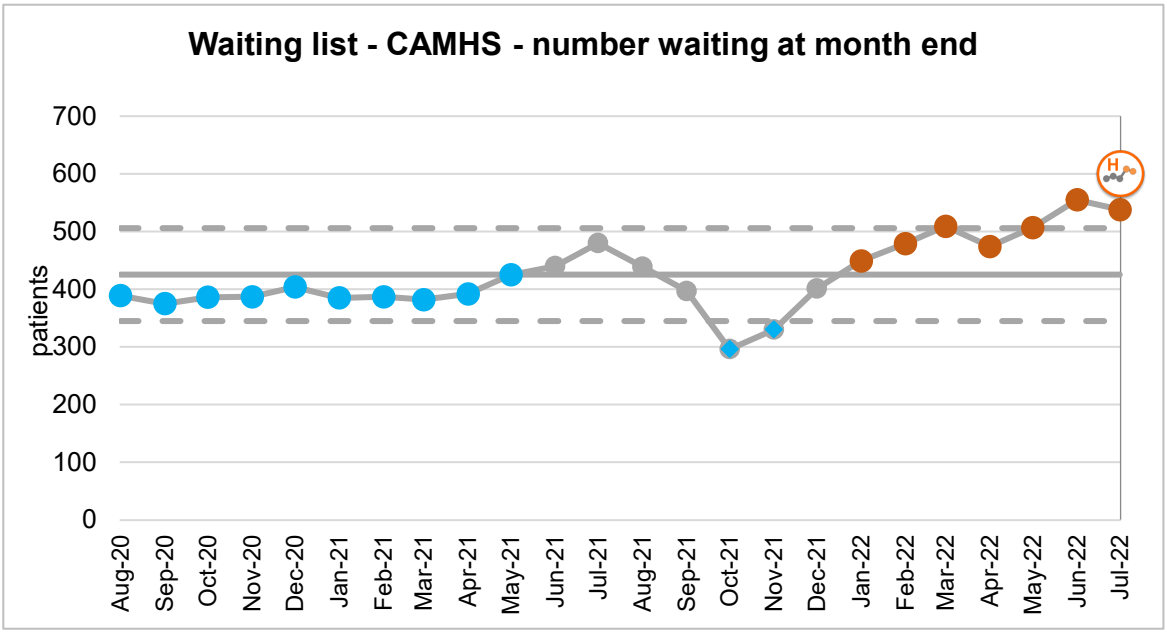
We continue to review the waiting lists in line with trauma sensitive working in considering how we manage people on a waiting list and we are developing a new waiting well guide for those service users. Barriers of movement between services remain high priority to remove. This work continues to develop as the Living Well transformation takes place.

We are reviewing the structure of psychological service to create a division to try and better utilise the skills we have in supporting people across the Derbyshire landscape and making sure it is sustainable for the future. Discussions are now taking place in different forums about how best to deliver this structural change.

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



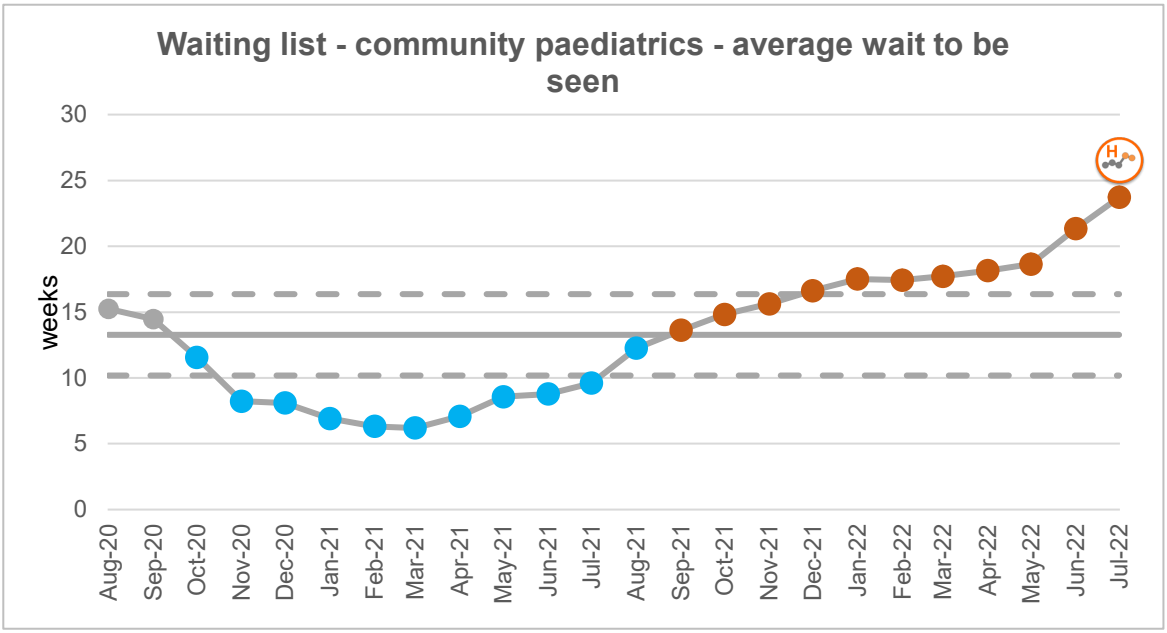
13b. Waiting list for Child and Adolescent Mental Health Services – number waiting



CAMHS continue to receive a higher number of referrals both via the routine and urgent care pathway. Workforce challenges, increased complexity of presentations and reduced community services for additional support have resulted in the CAMHS external waiting list increasing by 10% per quarter. Teams are operating with limited clinical oversight or access to a consultant, and we have a higher number of children in service than ever before. Following an urgent review of the CAMHS model which took place on 19 August by Dominic Pitter, Area Service Manager, Scott Lunn, Divisional Clinical Lead and Chloe Martin, Deputy Area Service Manager, the decision was made – locally – to focus on urgent/priority assessments, and all internal unallocated cases, and to ensure that all staff fall within an established team with clear clinical and operational support. We have agreed to temporarily move all staff into locality teams where they will have a team manager, senior colleagues and a consultant to provide the operational and clinical oversight of all patients waiting and open for the allocated geographical patch. This will provide assurance that all children requiring an urgent assessment will be prioritised in addition to those children accessing Children's Emergency Department. We will also prioritise cases open to the service with no allocated worker.

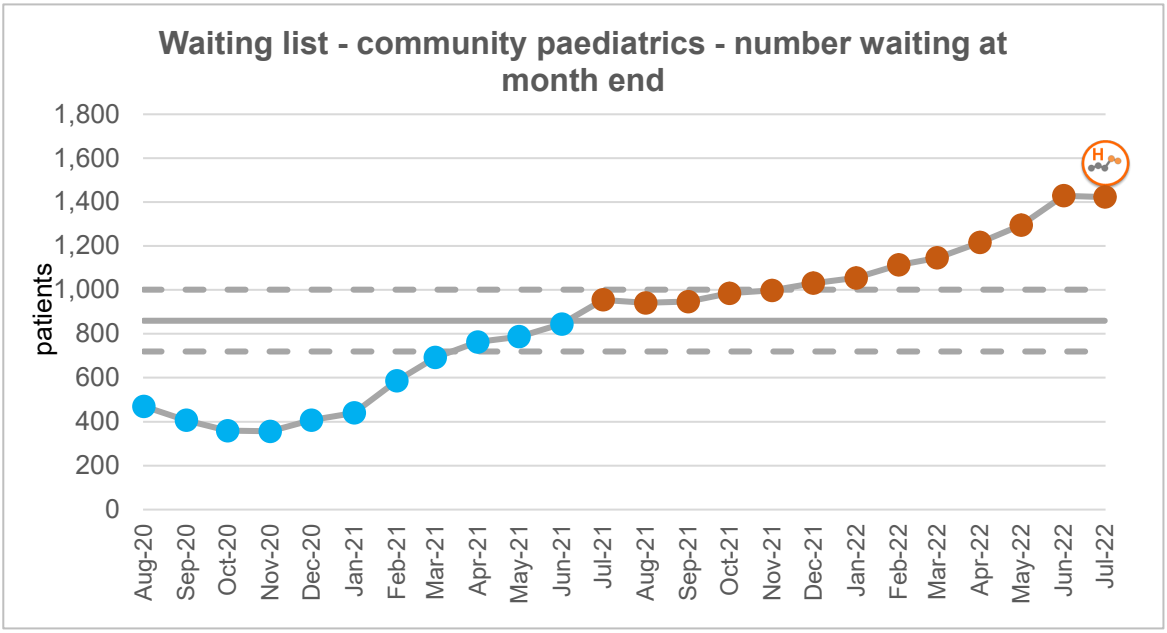
This is a temporary measure (initially three months). Referrals will still be accepted during this period, and there will be processes to manage the waiting list in accordance with the waiting well policy.

14a. Waiting list for community paediatrics – average wait



We continue to see a steady rise in waiting times for referral to treatment in community paediatrics. The longest wait time is now in excess of 56 weeks and currently sits on the risk register as a high risk. We are carrying two vacancies which have been advertised and redesigned to a more generic post. We have appointed to 1 post on a substantive basis and will seek to re-advertise the second role. Sickness absences are still having an impact on clinics and overall wellbeing and health issues are and will continue to impact on the availability of new appointment and follow up clinic slots. To mitigate we have also brought in some additional capacity at Speciality Doctor level on a temporary basis and will continue to use locum cover where we can. We recognise that flow is an issue for the service and are working to review the Core offer and what we could do differently to help manage the increasing waiting list.

14b. Waiting list for community paediatrics – number waiting

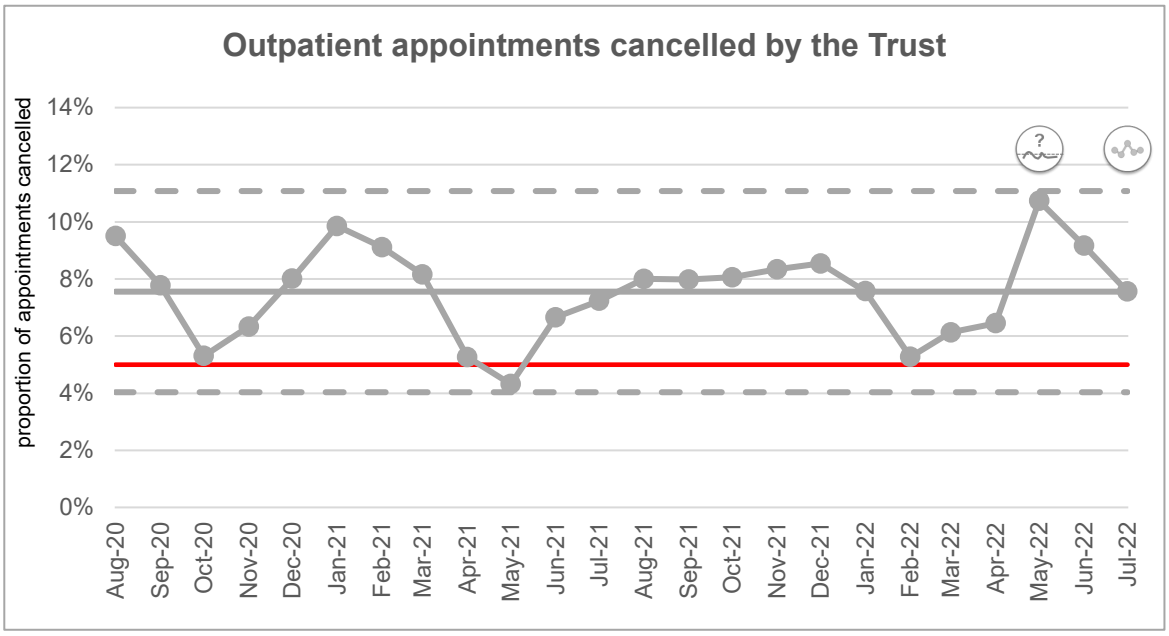


The neuro-developmental pathway development is ongoing, and we have recently advertised the Speciality Doctor post into a full-time substantive post. The business case also includes a second fixed term Speciality Doctor to focus on the autistic spectrum disorder pathway. Securing these

posts will have a significant impact on the waiting list. This is a really positive development for the service line. We await final Integrated Care Board approval for the investment requested.

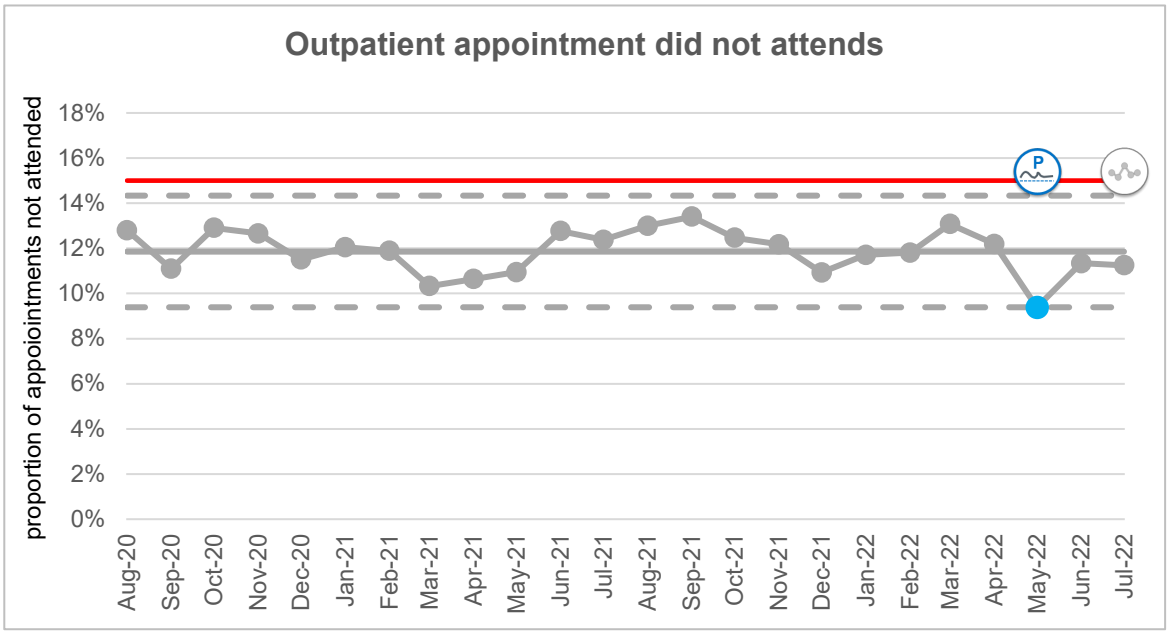
We have plans to further review the whole medical structure: what is working well, where the gaps are and where we need more support. Review of the referral pathways and website is ongoing. We hope to improve the experience for children, families, carers, and professionals who access our services.

15. Outpatient appointments cancelled by the Trust



The level of cancellations has been within common cause variation for the last 24 months. There was a spike in May 22 which may be data issues linked to the transition to SystmOne.

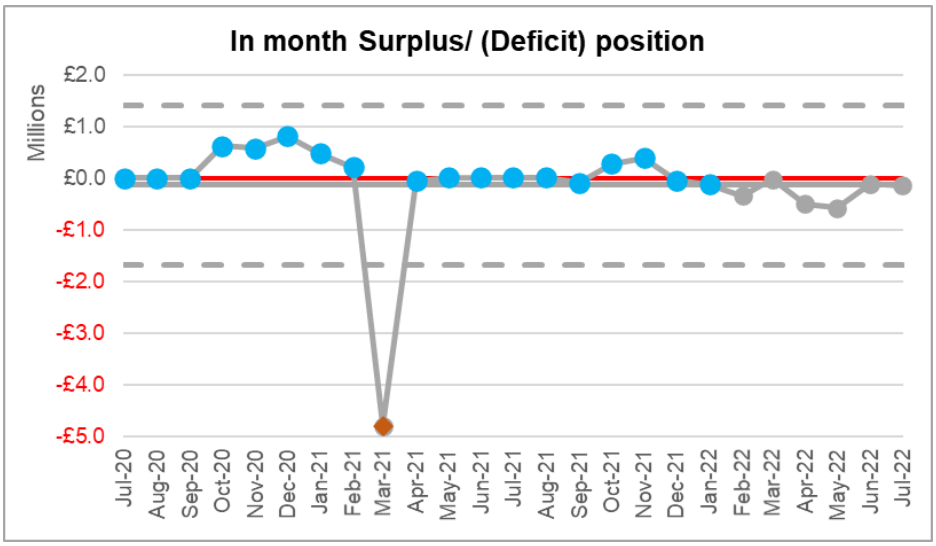
16. Outpatient appointment did not attends



The level of defaulted appointments has remained within common cause variation for the last 24 months and in the current process the trust target of 15% or lower is likely to be consistently achieved.

Finance

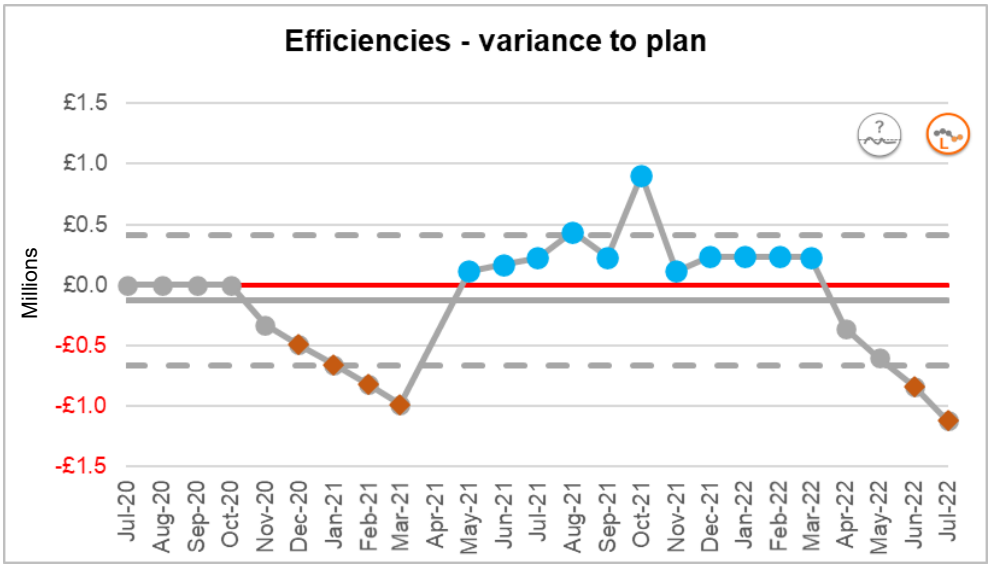
Overall Financial Position



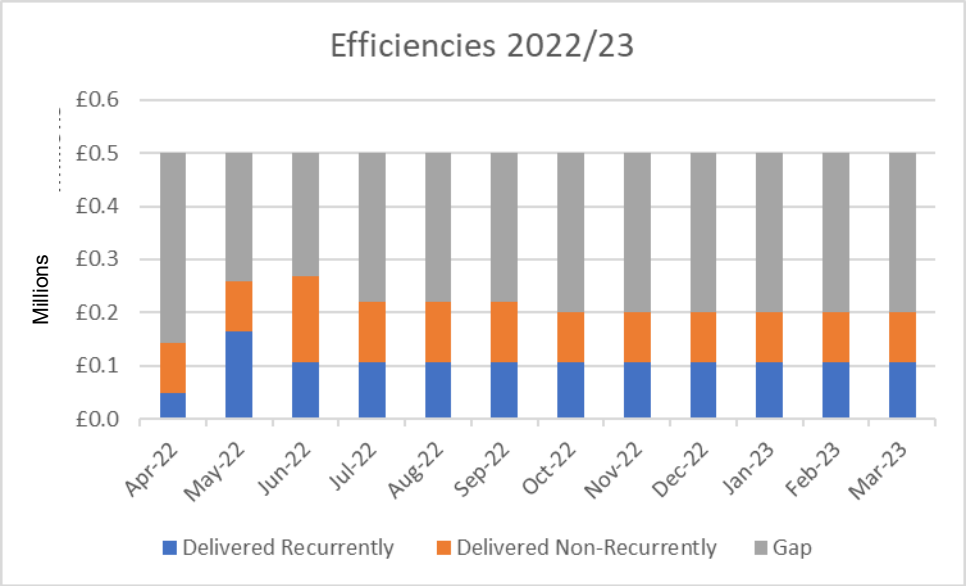
At the end of July, the overall year to date position is a deficit of £1.3m compared to the plan deficit of £0.5m, an adverse variance to plan of £0.5m. The main driver for the adverse variance to plan is related to the undelivered CIP which is slightly offset by some additional income.

However, there are significant areas of risk in and outside of that plan driven by the planning assumptions that have been followed, such as the delivery of the required 3% efficiencies, Agency expenditure and the containment of COVID-19 costs.

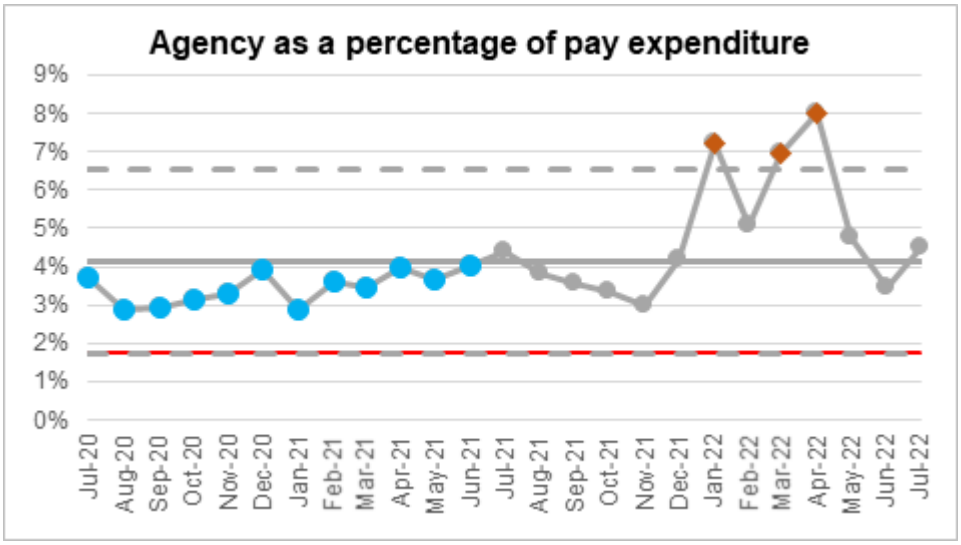
Efficiencies



The full year plan includes an efficiency requirement of £6.0m phased equally across the financial year. At the end of July there is a gap to delivery of £1.1m, with a full year gap of £3.0m. A further £0.5m of schemes are currently progressing through the Quality and Equality Impact Assessment process. Work continues with senior leaders across the organisation to identify further efficiencies to close this gap, with a focus on recurrent delivery.



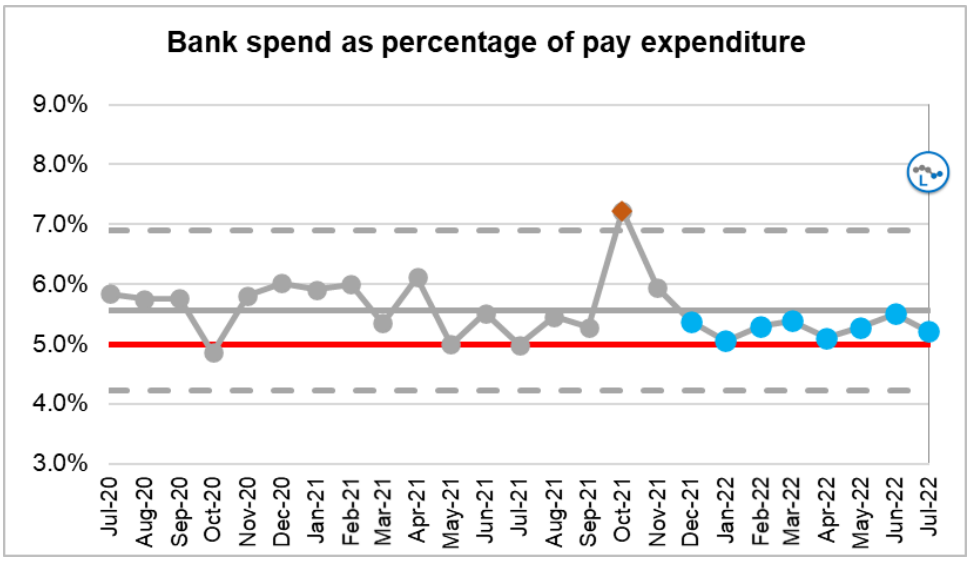
Temporary Staffing



Agency expenditure year to date (YTD) totals £2.4m against a plan of £0.9m, an adverse variance to plan of £1.5m. The two highest areas of agency usage relate to consultants - mainly in CAMHS -and nursing staff. Agency expenditure did reduce significantly in June to £0.4m but has slightly increased in July to £0.5m.

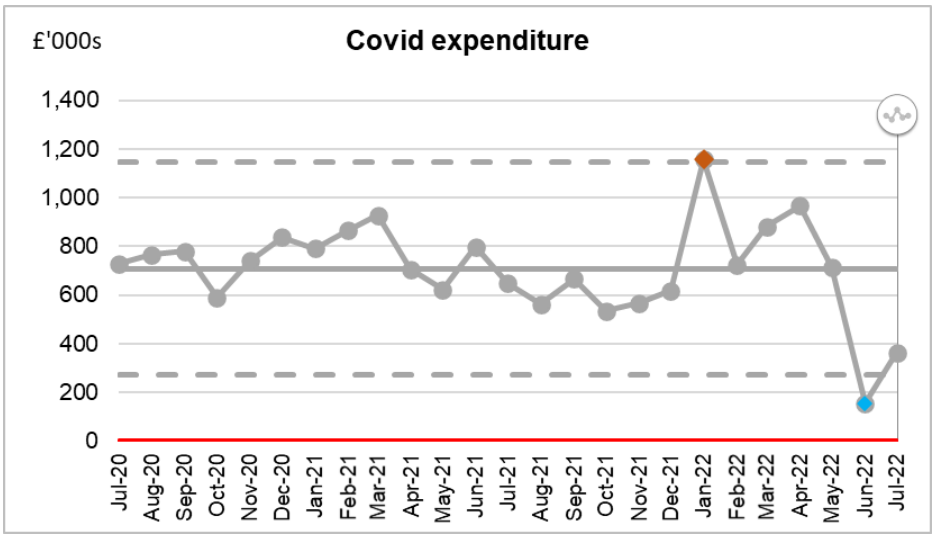
NHSE have confirmed that tighter agency controls will be introduced from September covering the following:

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



Bank staff expenditure YTD totals £2.4m against a plan of £2.4m with average spend of £0.6 per month with the exception of October where that increased to £0.8m. The areas of bank spend relate to Qualified Nursing and support workers on the wards along with Domestics.

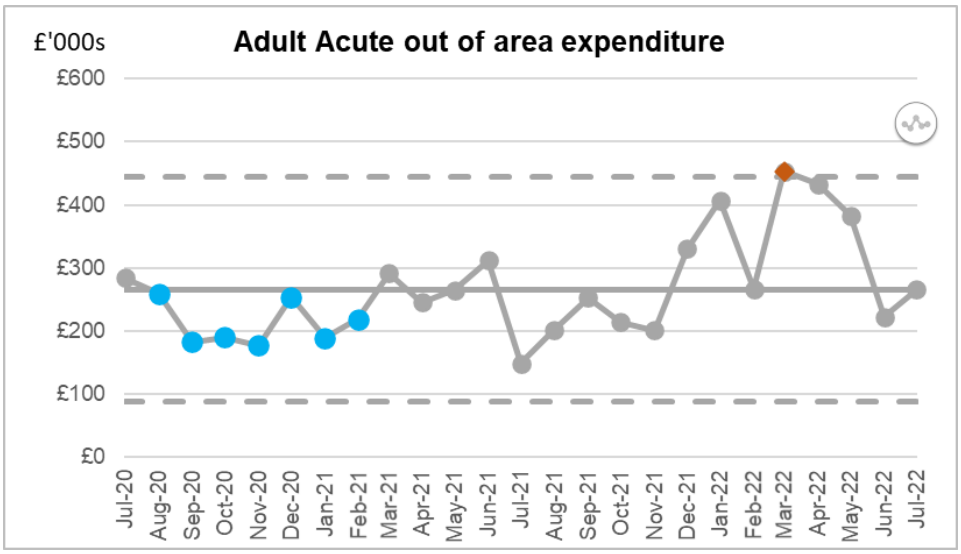
COVID-19 costs



The Trust has an income allocation of £0.3m a month for the financial year for COVID-19-related expenditure. The financial plan assumes no expenditure after the end of May as per the planning guidance.

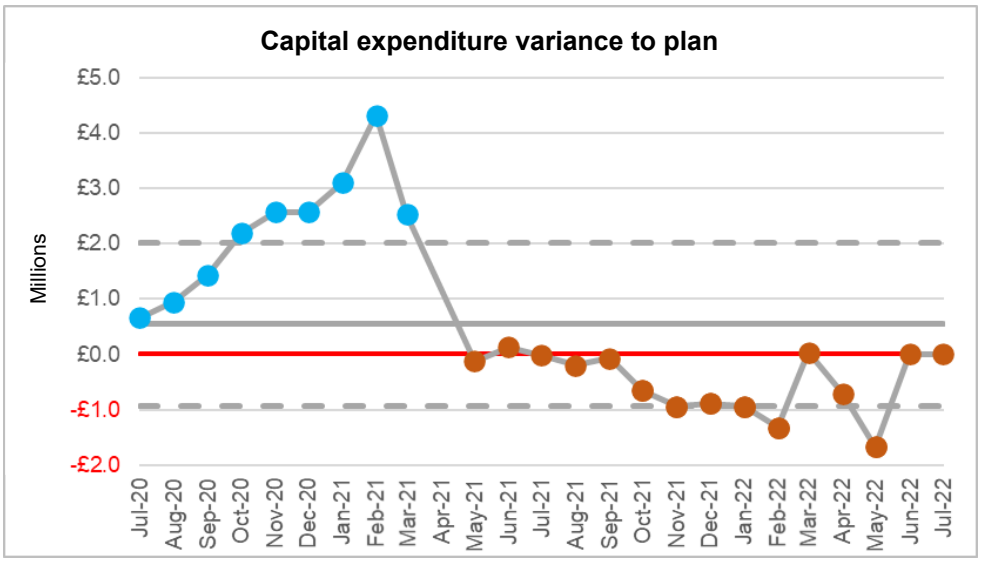
June's expenditure significantly reduced down to £0.2m but has slightly increased in July to £0.4m which reflects patient cases on the wards and staff absences.

Out of Area Placements



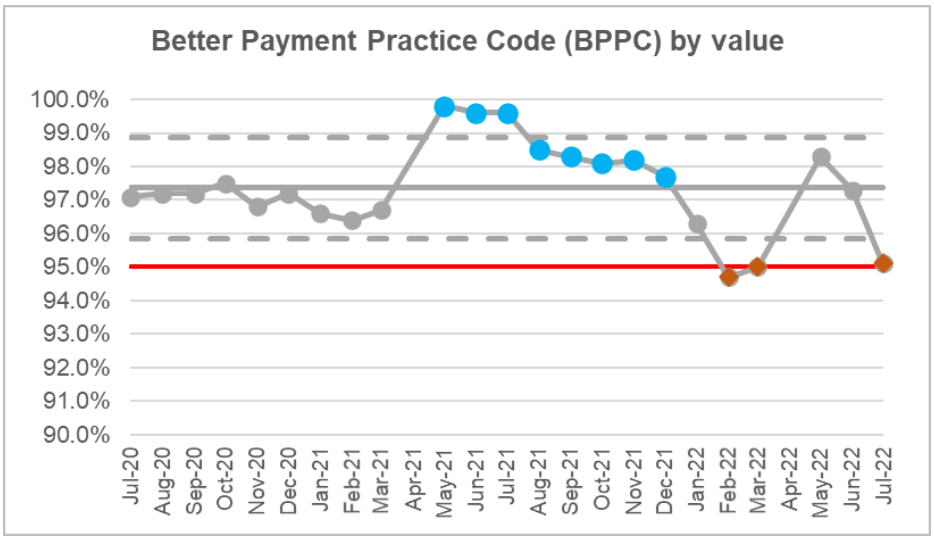
Expenditure for adult acute out of area placements including block purchased beds and cost per case beds has started to reduce compared to more recent levels. YTD £1.3m has been spend on placements.

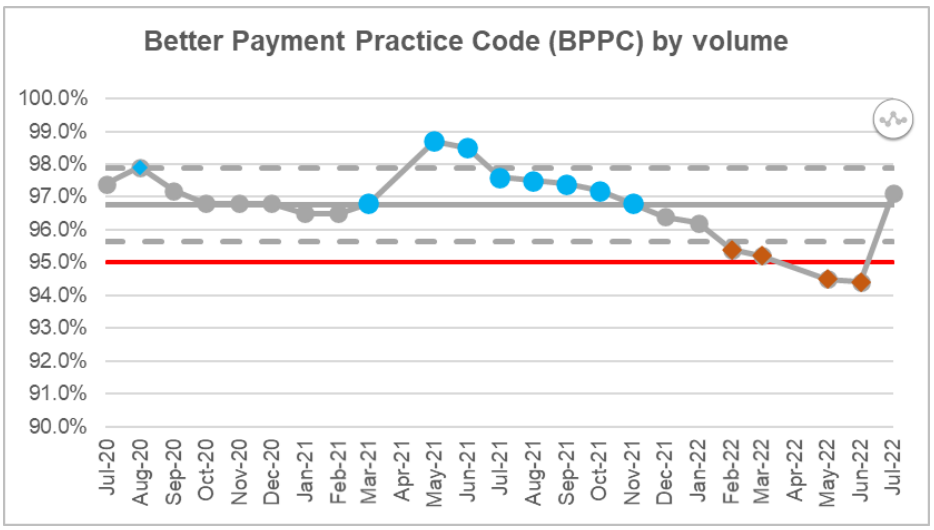
Capital Expenditure



Capital expenditure was showing behind plan in April and May, however that was against the April plan submission. The capital plan was resubmitted in June which changed the capital system allocation to reflect the requirement of the self-funded elements of the Making Room for Dignity project. Capital expenditure is now on plan YTD and forecast to achieve full planned spend by the end of the financial year.

Better Payment Practice Code (BPPC)



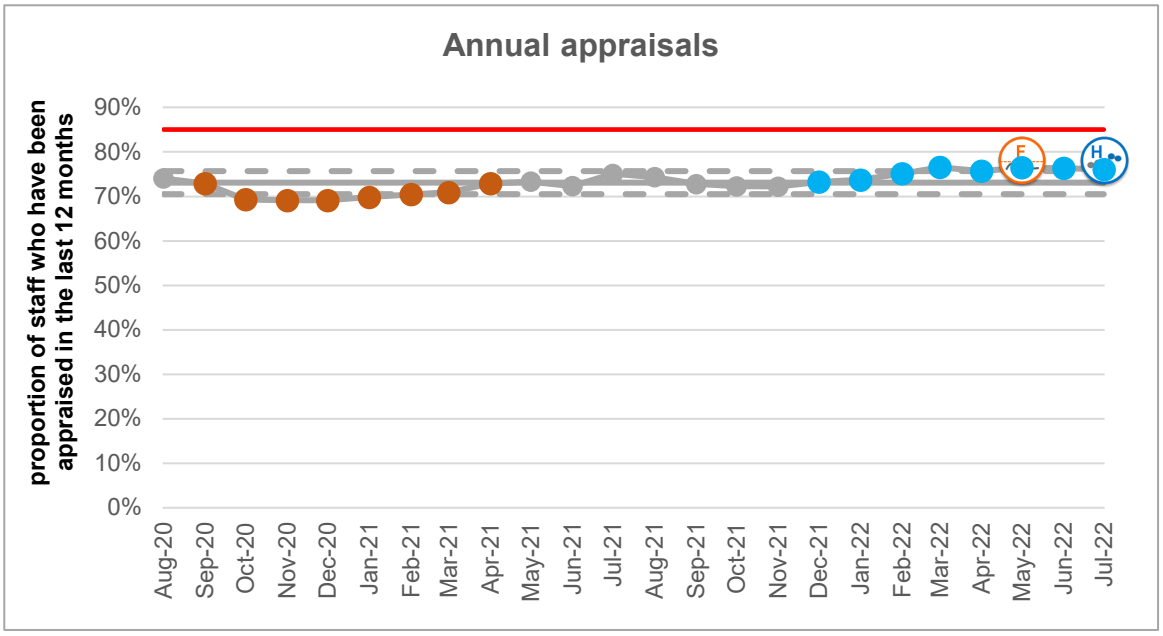


The Better Payment Practice Code sets a target for 95% of all invoices to be paid within 30 days. BPPC is measured across both invoice value and volume of invoices.

At the end of July, non-NHS invoices achieved the target for volume at 95.2% and exceed the target by value at 97.5%. However, NHS invoices were both at 94.7% for volume and value.

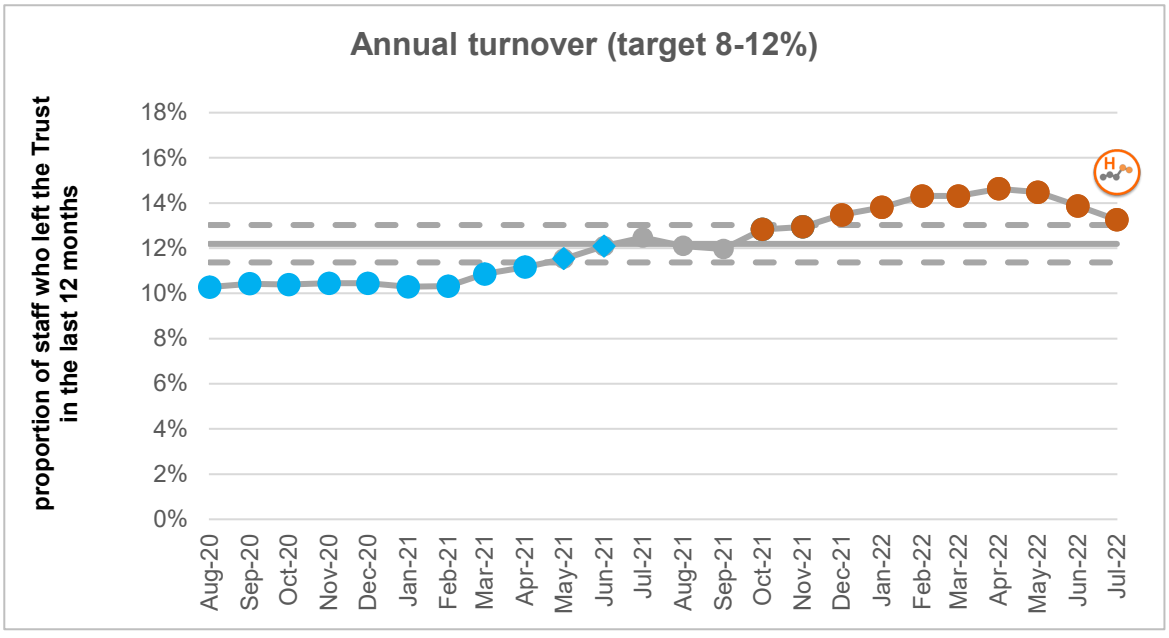
People

17. Annual appraisals

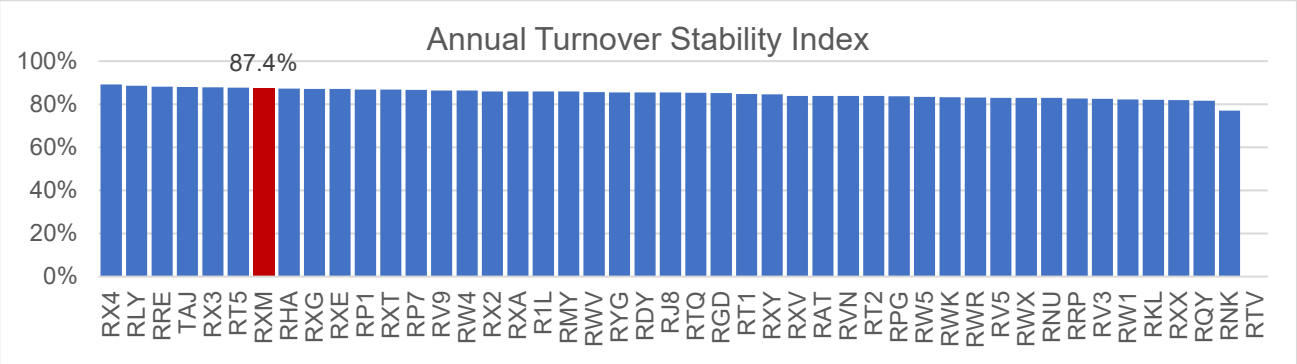


Appraisal levels continue to be below our expectations with Operational Services currently at 83% and Corporate Services at 48%. Colleagues have been taking more leave during this period which in part will have impacted. There is however a significant improvement over the last eight months. There is a planned appraisal focus for September which will include communication targeted at those who are non-compliant and an increased focus in the monthly divisional achievement reviews.

18. Annual turnover

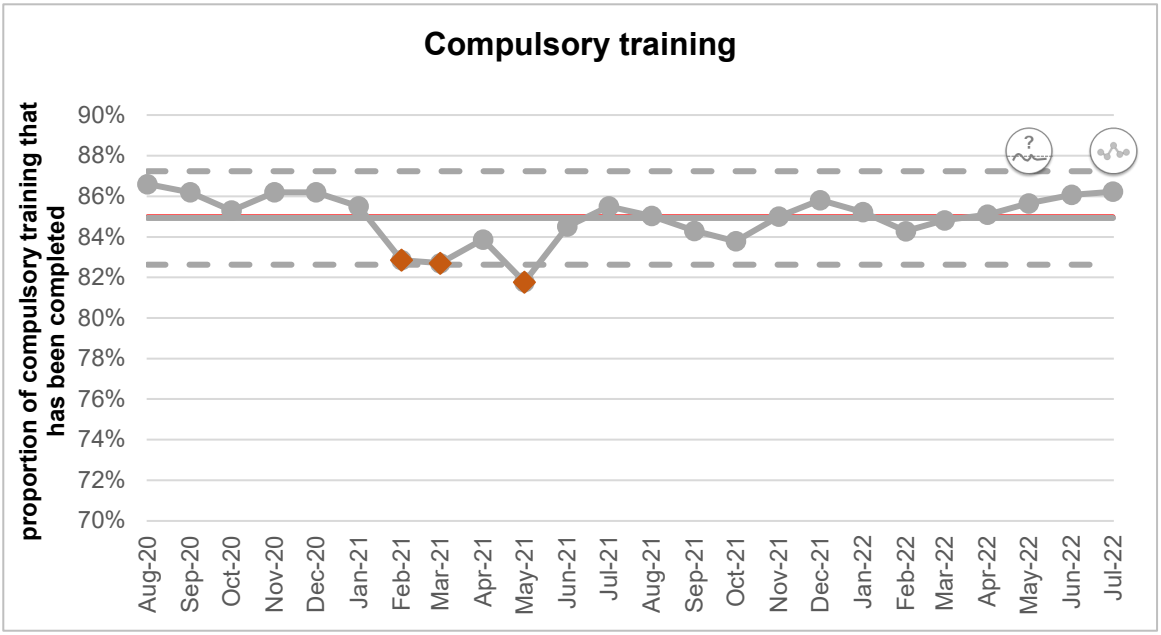


Turnover remains high and above the Trust target range of 8-12%. There has been a small improvement from the previous month with a 0.6% reduction. From the latest national NHS staff annual turnover benchmarking data, the Trust was ranked 7th highest mental health trust for stability of the workforce and we have a number of schemes targeting specific issues such as high levels of turnover in those with under two years' service.



(https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics/april-2022)

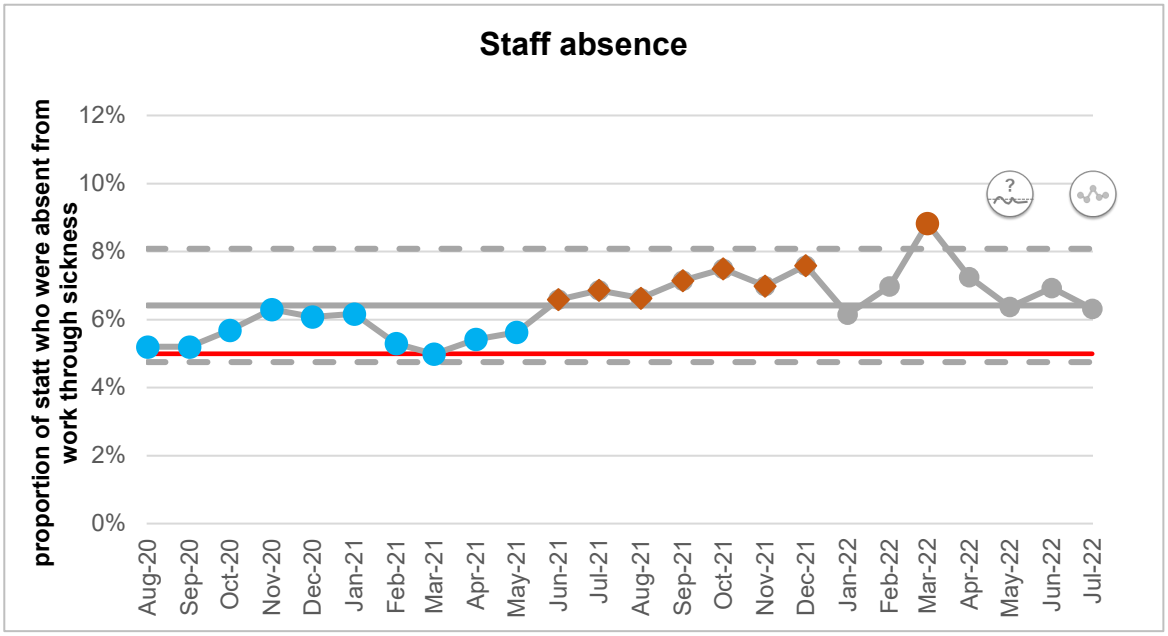
19. Compulsory training



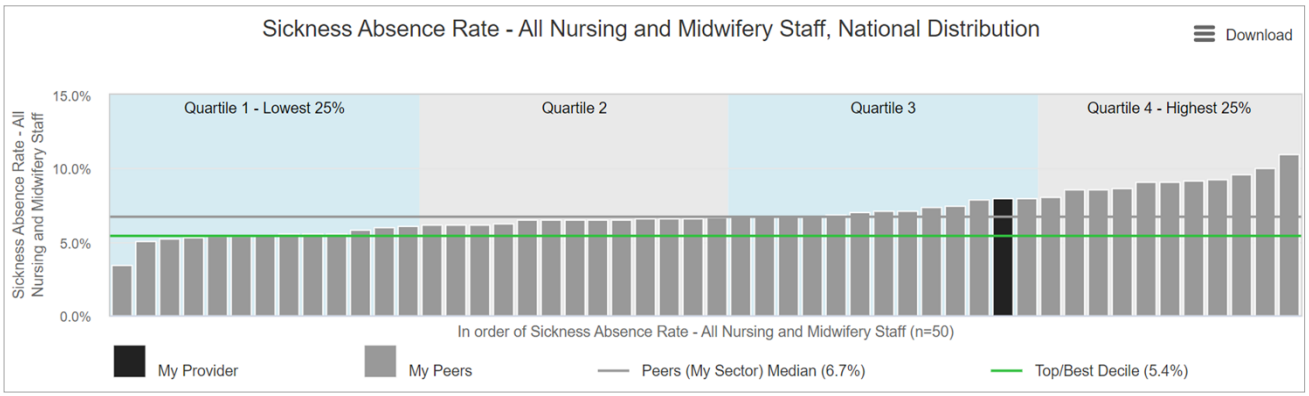
Mandatory training continues to be a key focus and an ongoing recovery position for the Trust. Overall, the 85% target level has been achieved for the last four months. Operational Services are currently 89% compliant and Corporate Services slightly lower at 75%.

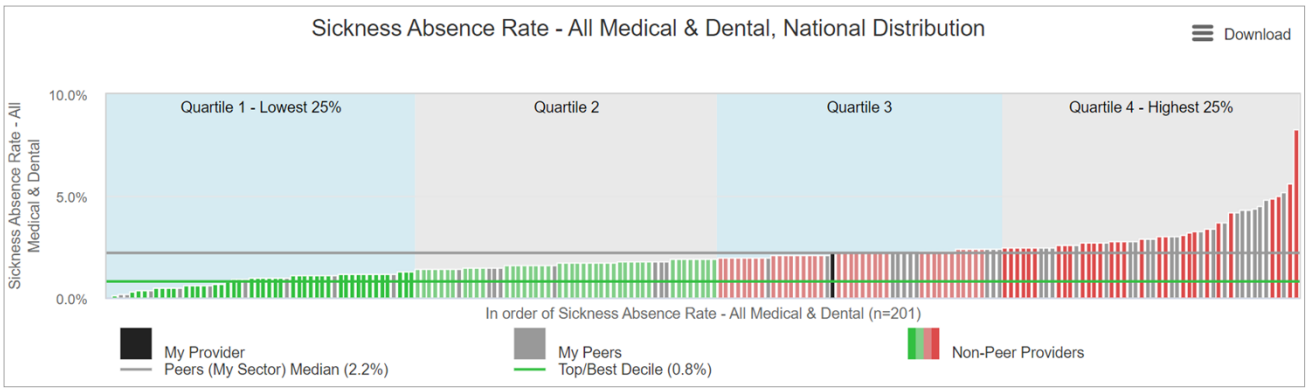
The training team have focused on Immediate Life Support and Positive and Safe training to improve compliance against these two key training programmes. Non-compliant colleagues have been contacted and booked onto a training programme. Block training approaches have been developed and applied in acute areas. We are now focusing on reviewing the current training passport to ensure all training is appropriate and relevant to individual roles. A review date has been set for the end of September at which point we will assess other actions that may need to be addressed.

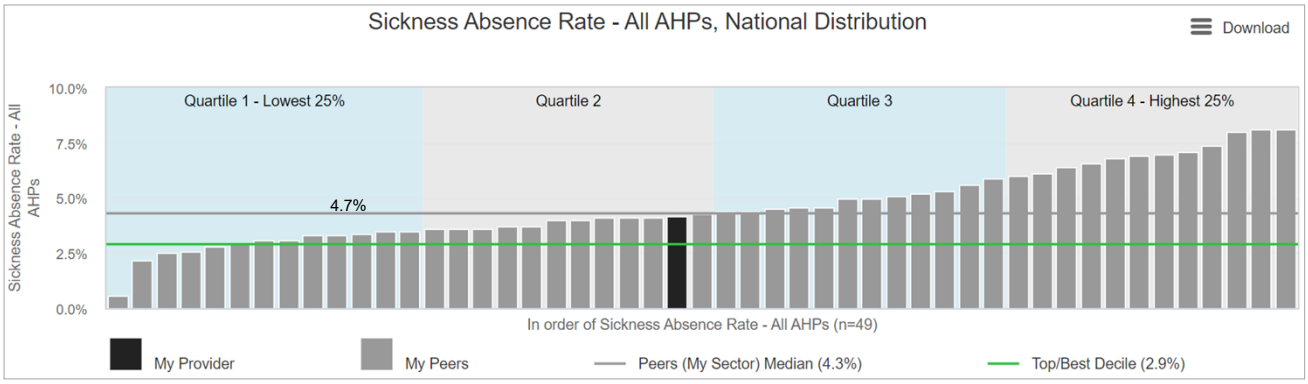
20. Staff absence



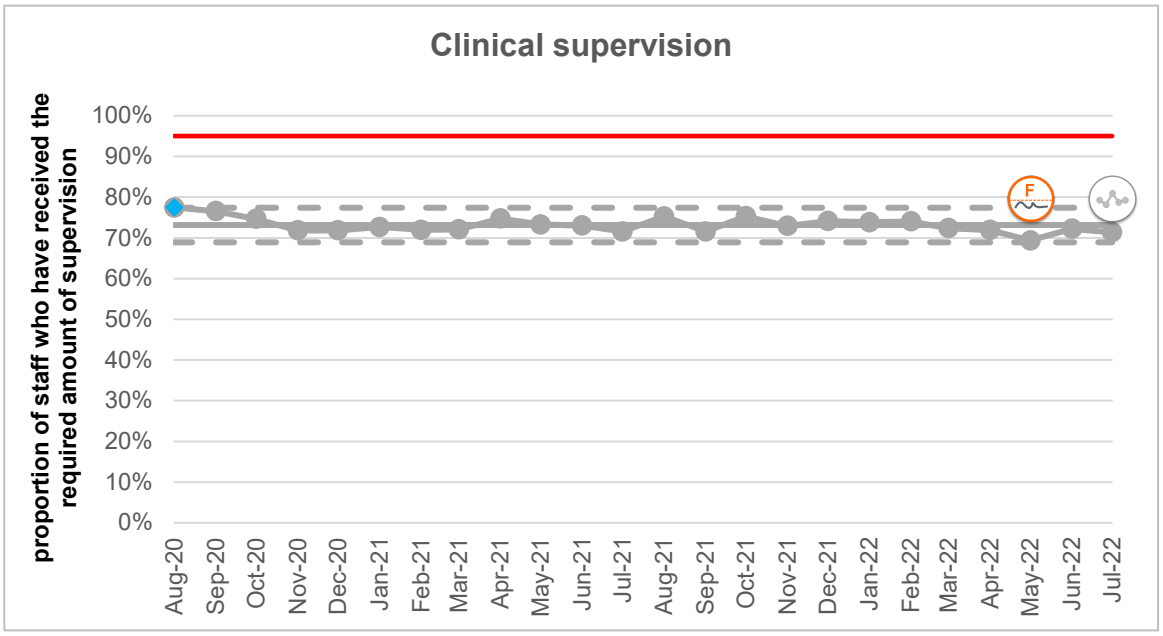
Sickness absence remains high and above the 5% target threshold. July saw a 6.09% increase in COVID-19 absences accounting for 20% of all absences. There was a small reduction in stress/anxiety related absences, but this remains the highest reason for absence. A continued focus on ensuring we are managing and supporting colleagues with sickness absences has taken place over July. The benchmarking data below compare the sickness absence levels of the Trust by different staff groups, with the absence levels of other organisations. The Trust is denoted by the black columns. (Data source: https://model.nhs.uk/).







21. Clinical supervision

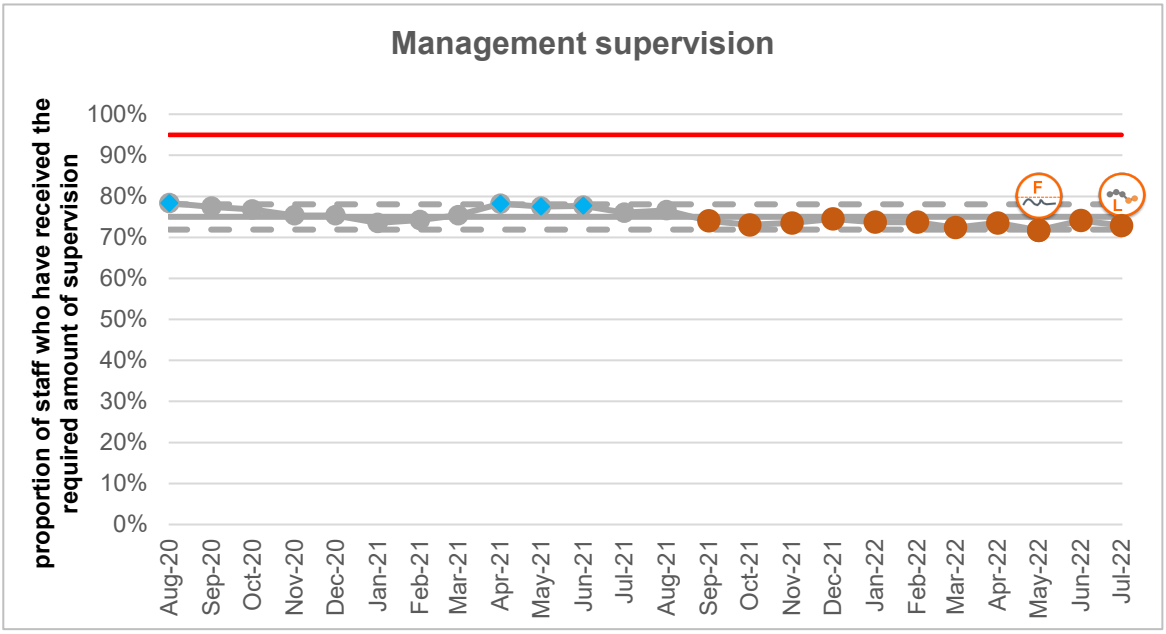


The required amounts of supervision per 12 months - in line with the Trust's Supervision Policy - are as follows:

- Management supervision – a minimum of 5 hours per 12 months, adjusted for part-time staff
- Clinical supervision – a minimum of 6 hours per 12 months, adjusted for part-time staff

Compliance is the percentage of staff who have completed the amount of supervision required over the 12-month period. Data is adjusted to allow for staff who are not at work and the appropriate levels of supervision required are also flexed if returning to work following a period of absence. Staff who are unable to be supervised based on their assignment status or owing to long term sickness are excluded.

22. Management supervision

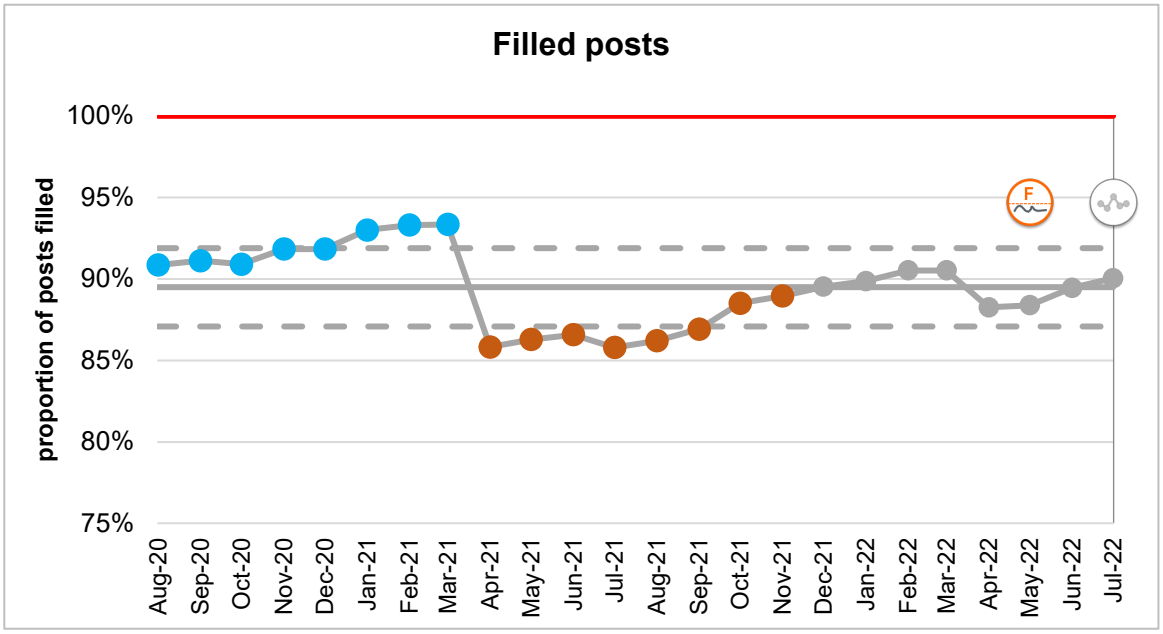


The levels of compliance with the clinical and management supervision targets have remained low since the start of the pandemic. As seen with compulsory training and appraisals, Operational Services continue to perform at a considerably higher level than Corporate Services for both types of supervision (management: 76% versus 60% and clinical: 71% versus 17%).

Compliance with the 12-month supervision targets by Division:

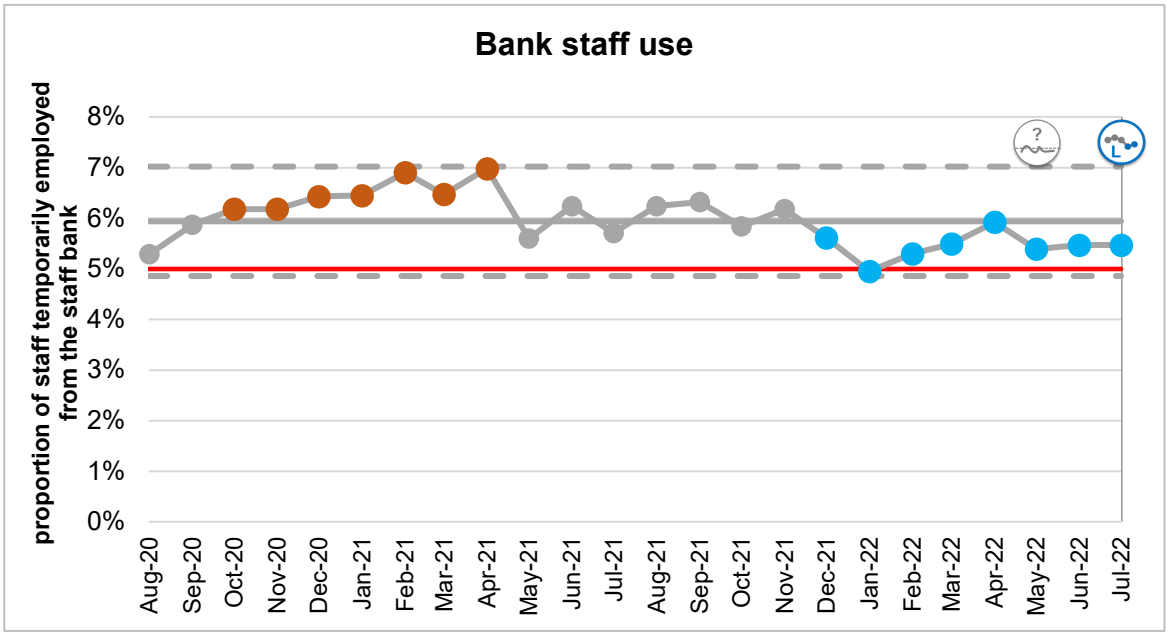
Division	Service Line	Staff	Management	Clinical
Corporate Services	Business Improvement + Transformation	9	100%	N/A
	Corporate Central	51	75%	0%
	Estates + Facilities	172	67%	N/A
	Finance Services	22	91%	N/A
	Med Education & CRD	114	30%	23%
	Nursing + Quality	56	52%	24%
	Ops Support	58	95%	0%
	People + Inclusion	42	33%	5%
	Total	524	60%	17%
Operational Services	Adult Care Acute	470	70%	64%
	Adult Care Community	353	69%	78%
	Children's Services	463	83%	74%
	Clinical Serv Management	15	67%	0%
	Forensic + MH Rehab	134	77%	83%
	Neuro Developmental	111	77%	66%
	Older Peoples Care	402	87%	88%
	Performance Delivery Clustering	4	100%	N/A
	Psychology	112	63%	79%
	Specialist Care Services	214	70%	72%
	Total	2278	76%	75%
Total		2802	73%	71%

23. Proportion of posts filled



Staffing levels have remained around 91% in July and we have seen a small reduction in vacancy rate. Nationally, recruitment has been recognised as needing a significant review of current approaches and an overhauling recruitment programme has been launched which will deliver six packages of work and will start with collecting evidence which leads to better recruitment outcomes that are inclusive and equitable and also define the key performance indicators which will form the basis of how we measure longer term impact. This will also include building national core competencies for recruitment teams in order to locally deliver on the overhauling recruitment actions.

24. Bank staff

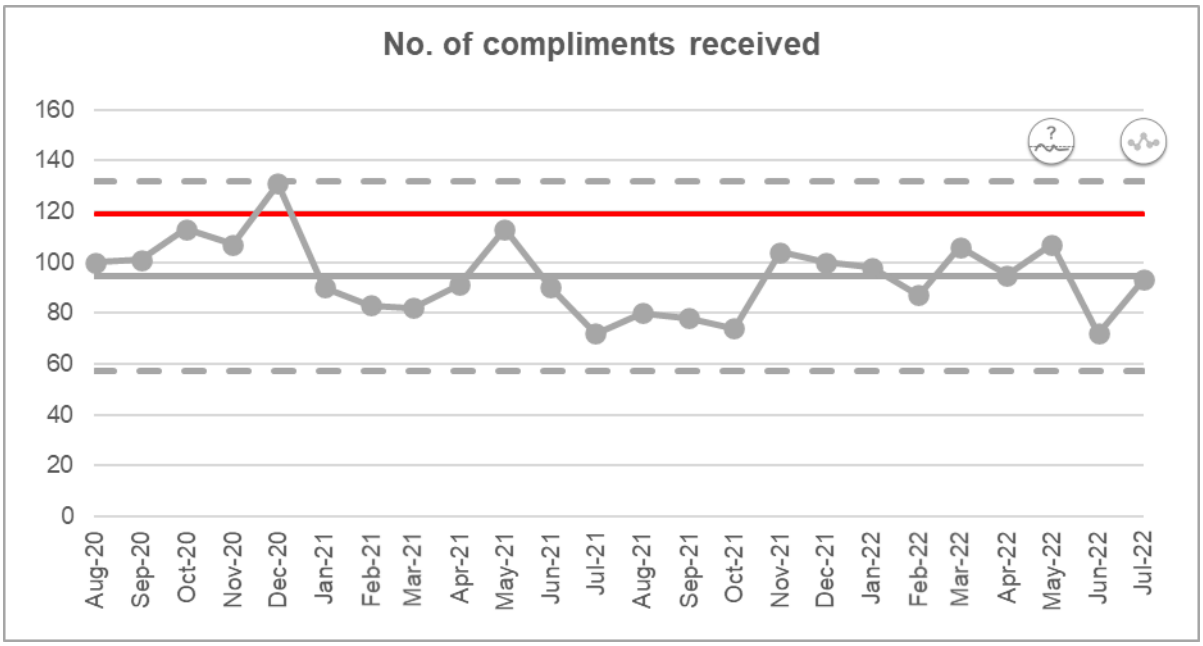


Actions from the Temporary Strategy Workforce group have started to impact total agency high cost usage, but this continues to be a local and system focus. Key areas of attention have been developed and presented to key committees, these have been developed to support the temporary workforce and further develop the service to ensure the organisation is supported by a contemporary temporary workforce offer that embodies the organisational

values, clinical quality and value for money. Bank worker engagement has also been a priority with a successful listening event, input into the national workstream that is designing the bank worker survey and engaging with NHS England to ensure the national focus on temporary workforce is understood and benefits are realised at a local level.

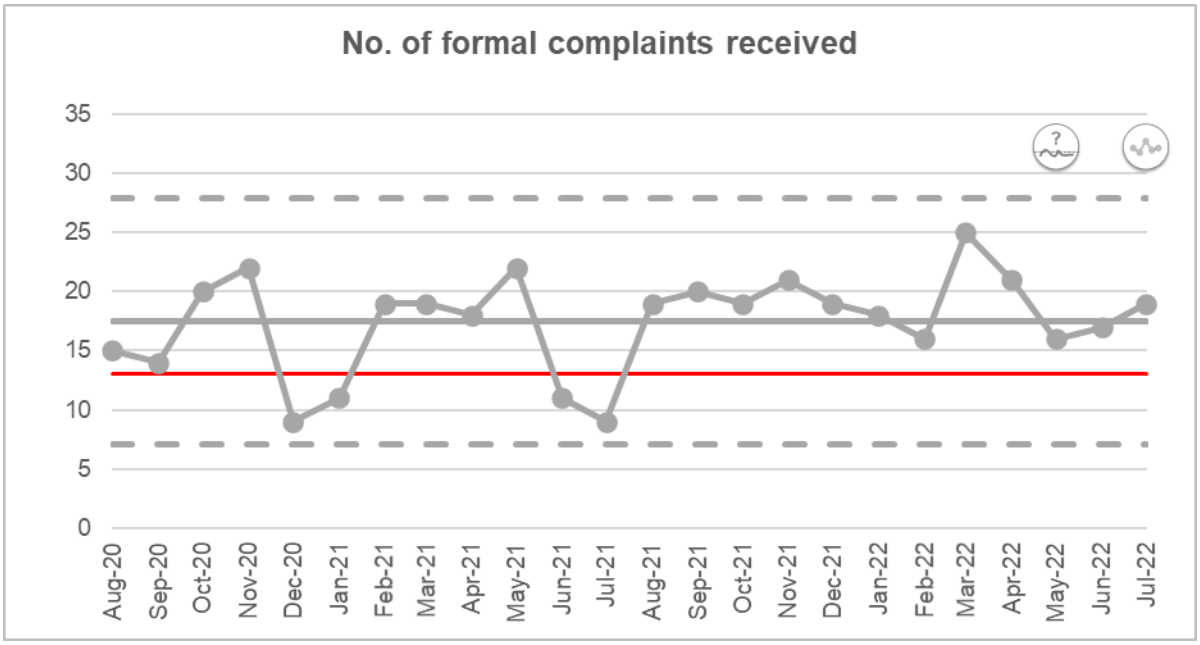
Quality

25. Compliments



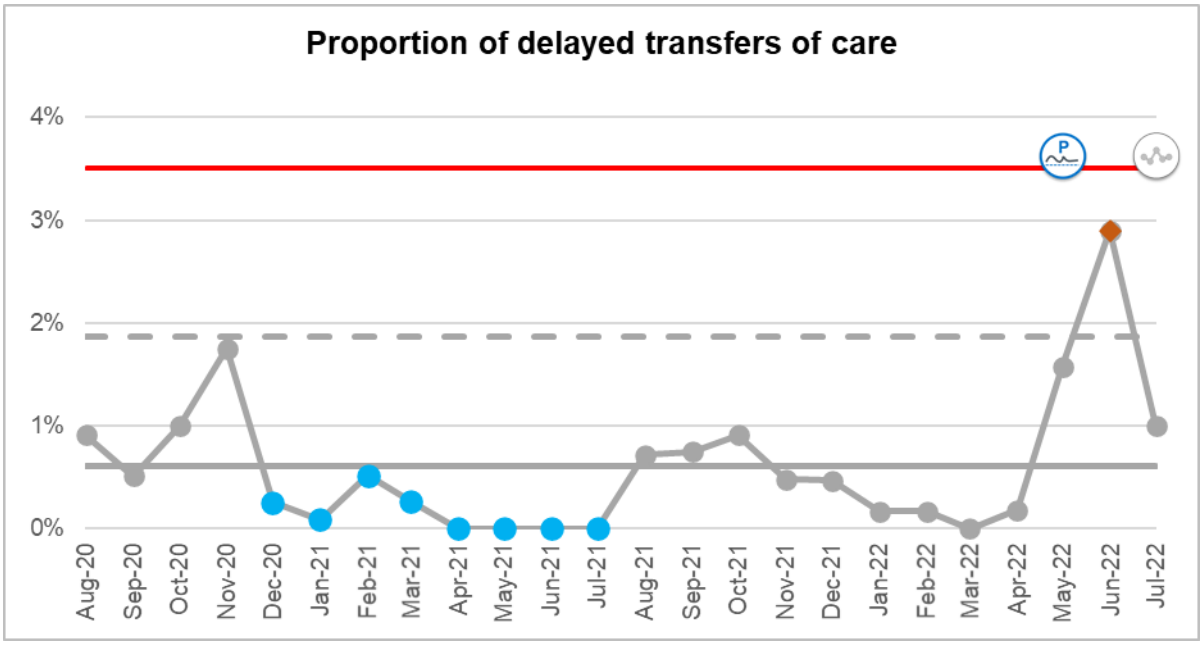
The number of compliments continues to remain below the expected level. This is due to compliments mostly being received verbally and then staff not accurately recording them. The Heads of Nursing have been asked provide assurance that compliments are accurately recorded and a project supporting the electronic patient survey will provide a further method of receiving compliments, complaints, and concerns. With an increase in accessibility, it is expected that a natural increase in compliments, complaints and concerns will occur over the next six months.

26. Complaints



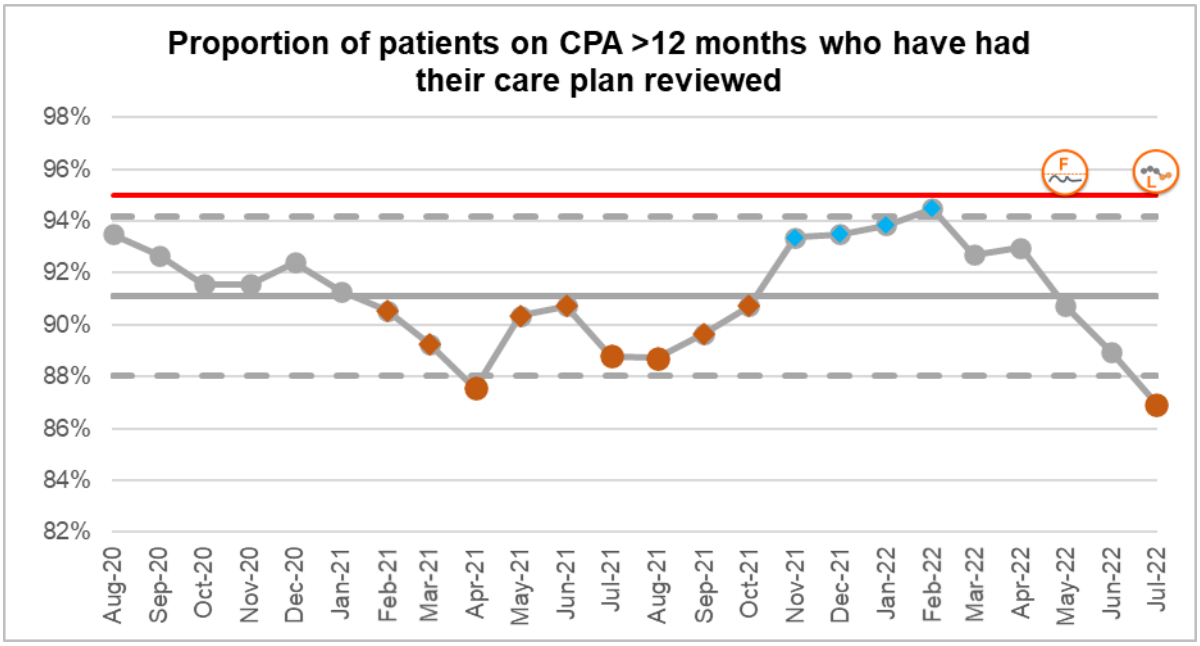
The number of formal complaints received continues to be within common cause variation in relation to the mean. The number of formal complaints is above the trust target; however a number of complaints were received in relation to reduced face to face contact and reduced access to services. As face-to-face contact continues to increase and as services stand back up, it is expected that the number of complaints will reduce. The implementation of the electronic patient survey should also give patients another way of feeding back without having to make a formal complaint.

27. Delayed transfers of care (DTOC)



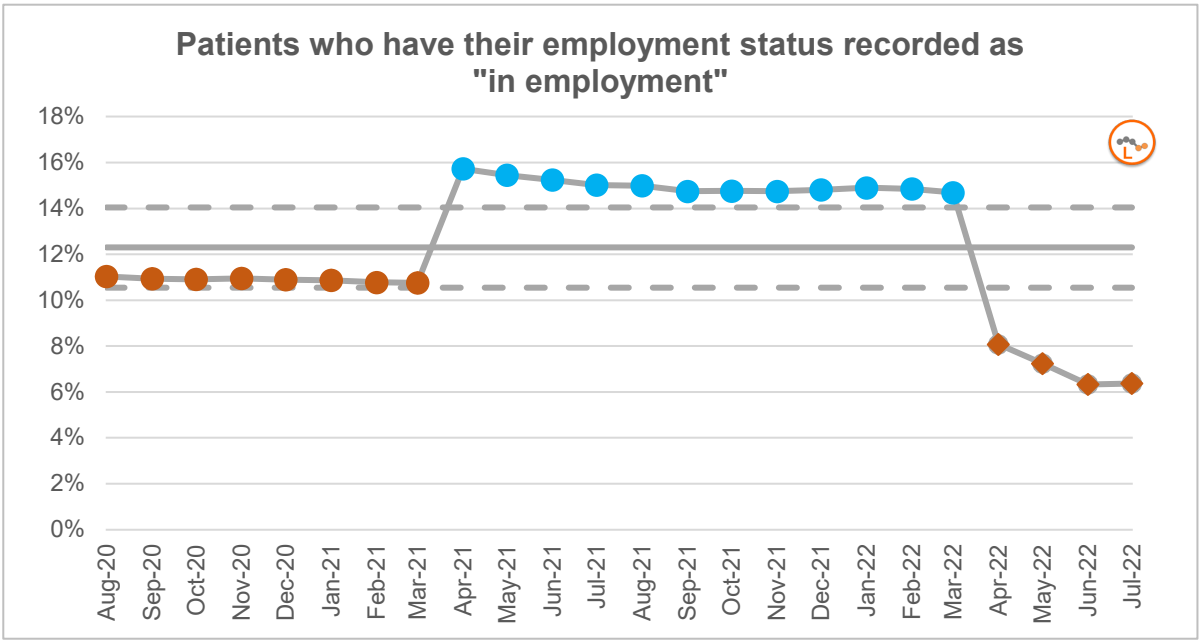
Since the multi-agency discharge events (MADE) were held, numbers of delayed transfers of care have reduced and now sit below the mean line. Work continues within the rapid review processes and clinical meetings and a housing officer was recruited in May so they will support the identification of placements for patients who do not need to be on a hospital ward. The trust has also recently started a “medically fit for discharge” meeting where any barriers to discharge are identified and discussed. The way DTOC is reported has also recently changed so this could account for the sudden increase recorded. It is expected that this will reduce over the next quarter.

28. Care plan reviews



The proportion of patients whose care plans have been reviewed continues to be recorded as lower than expected and is currently on a downward trajectory. This is likely due to care plans that have not yet been migrated over to SystmOne and data quality issues with how this information is being captured. A programme of clinical quality audit is being implemented across the trust divisions, led by the Heads of Nursing, which will help to identify those patients whose care plans require review. This will be monitored over the next six months, and we expect the trajectory to improve.

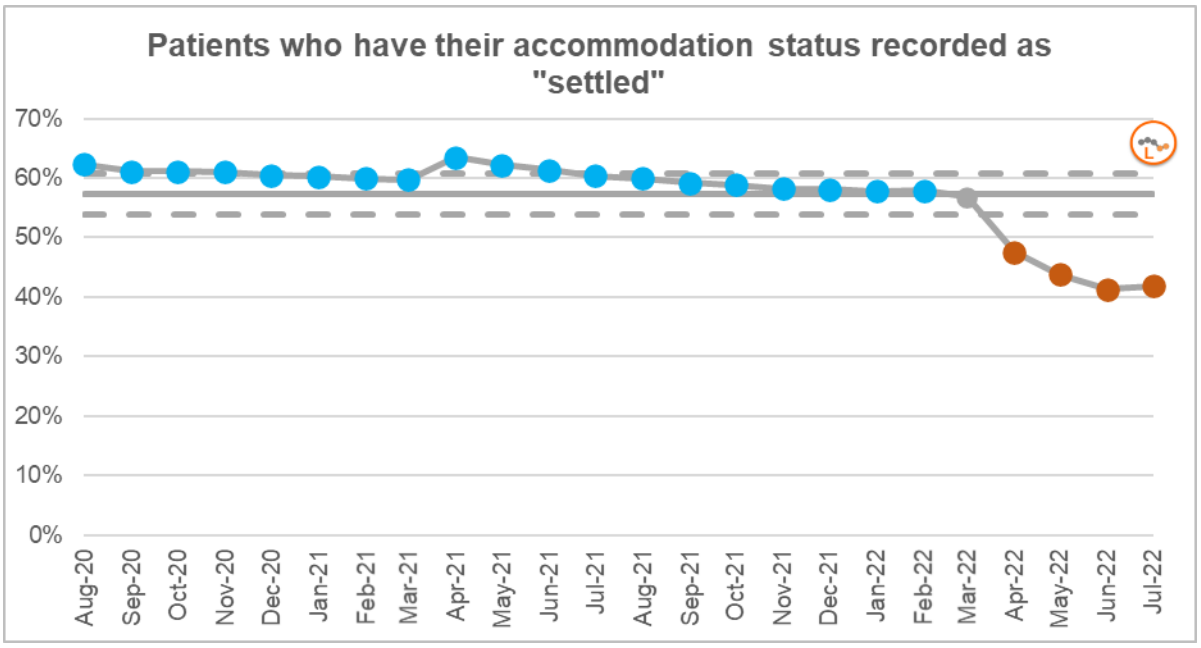
29. Patients in employment



Around one third of patients have no employment status recorded at present and the decline in patients recorded as being in employment coincides with the data migration to SystmOne. Therefore, this may be a data quality issue. This will be investigated and reviewed during the next quarter. The Individual Placement Support (IPS) Service continues to have success in supporting people into employment even during the pandemic and the service is currently expanding. They currently have 11 employment support workers, and this is planned to expand to 18 by March 2023 and to 23 by March 2024. The IPS Service has employed two peer support workers to support

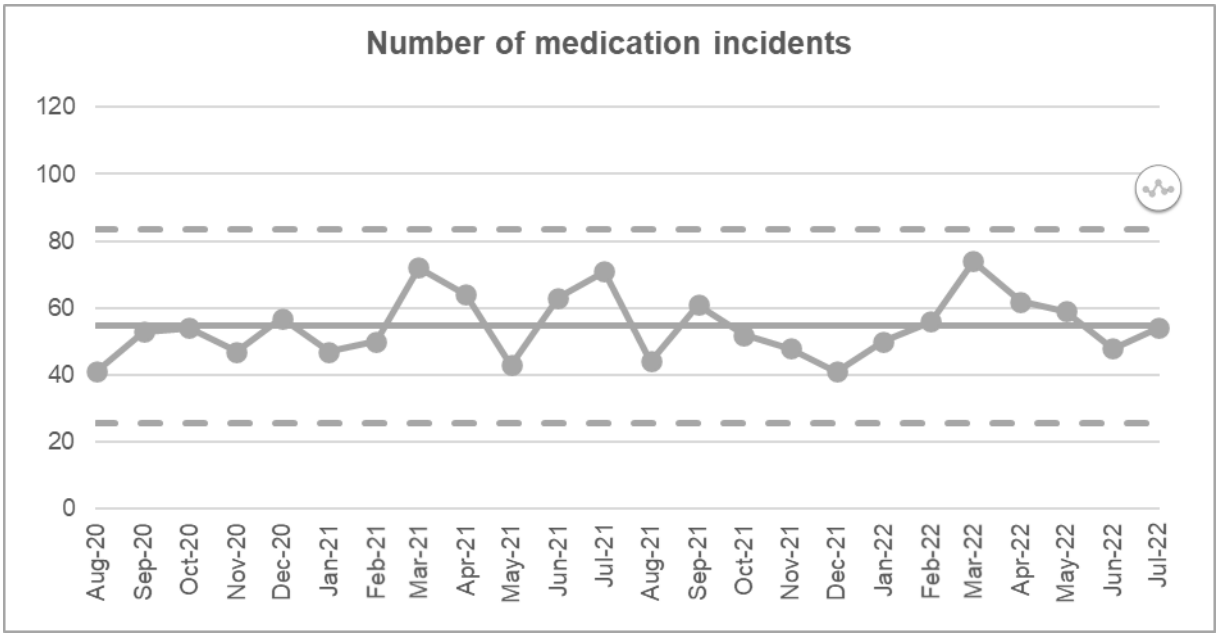
service users back into work and to help them manage worries and anxieties and two team leaders have now been appointed. The Trust has also employed two experts by experience to focus on the implementation and management of Health Education England training in relation to peer support working and apprentices.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

30. Patients in settled accommodation



Around one third of patients have no accommodation status recorded and the decline in patients with a recorded settled accommodation status again coincides with the data migration to SystmOne. Therefore, this may also be a data issue and this will be investigated and reviewed during the next quarter.

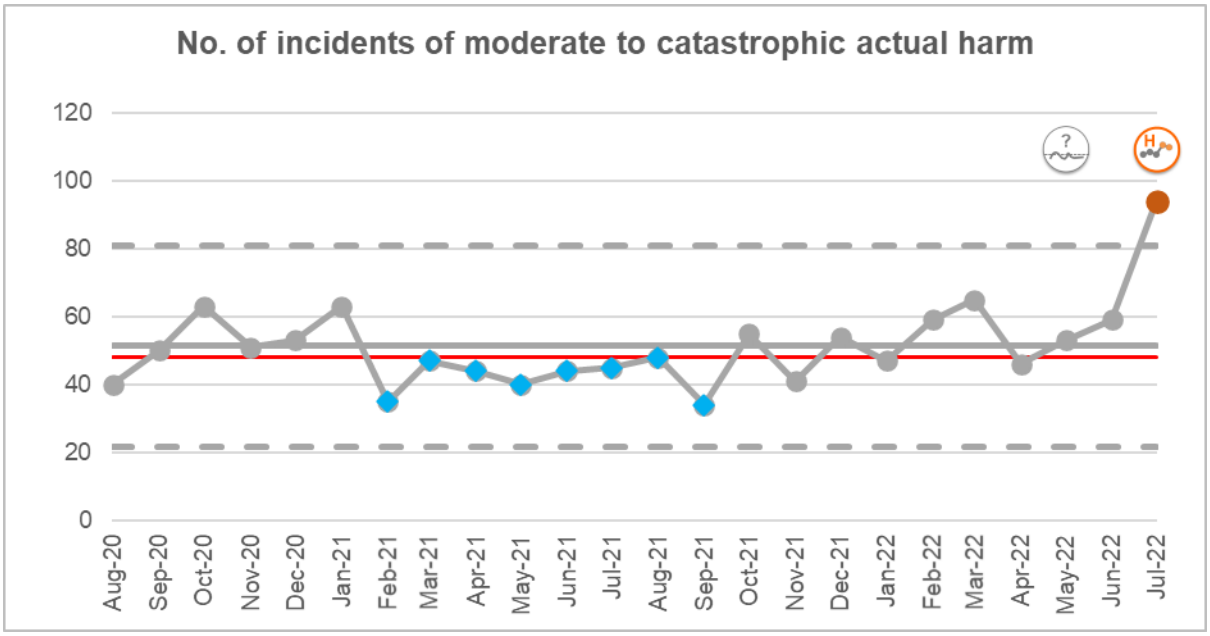
31. Medication incidents



Although there is fluctuation with the number of medication incidents recorded, they are within the common cause variation in relation to the mean. When looking into medication incidents, they take a variety of forms, from missed doses, wrong medication administration, missed fridge temperature

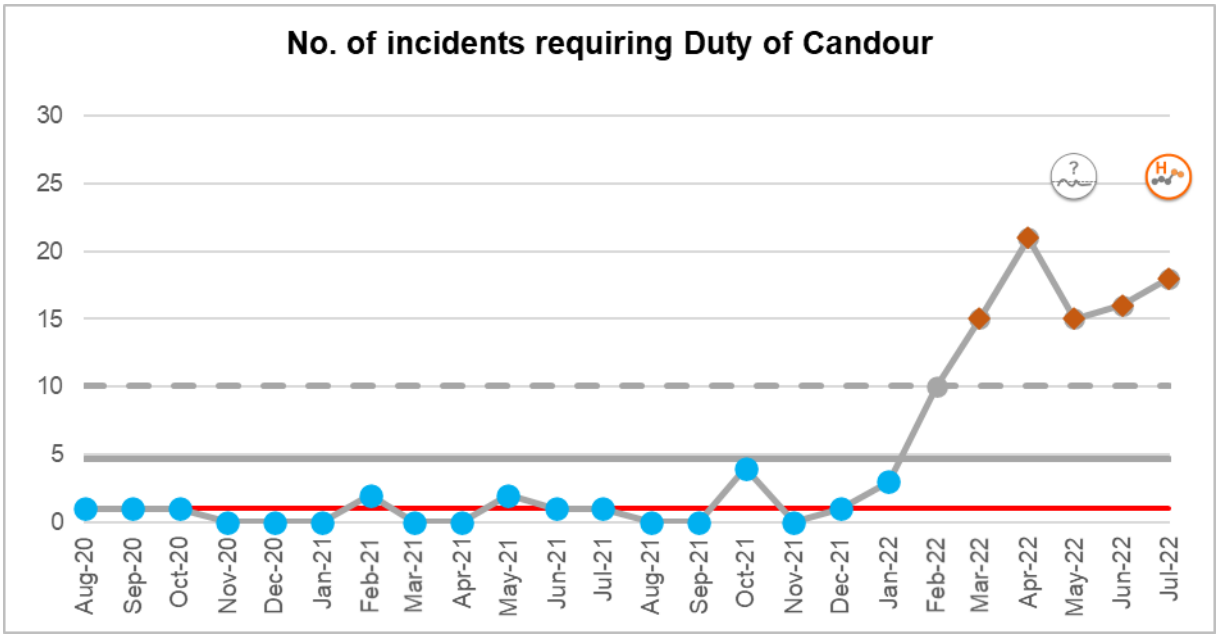
recording, prescription error and documenting errors. The medicines management operational subgroup is currently revising the medications error procedure, considering Trust values, and the Acute Inpatient Matrons and Head of Nursing are in the process of updating the relevant policies which will reduce the number of insignificant incidents. A report on incidents is also reviewed within the Monthly COAT meeting for each division.

32. Incidents of moderate to catastrophic actual harm



The number of reported incidents of moderate to catastrophic harm increased from April with a spike between June and July. This increase appears to be related to repeated incidents involving a small number of patients. This is expected to reduce over the next quarter, but it will continue to be monitored by the Heads of Nursing team on a quarterly basis and fed into the relevant COAT meetings.

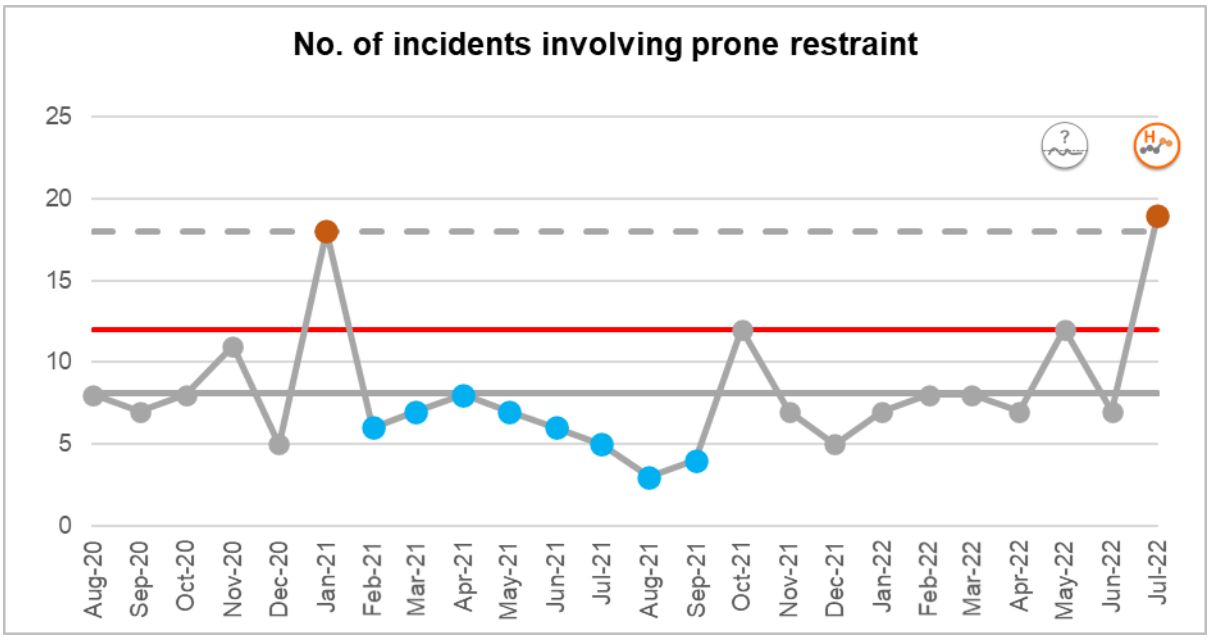
33. Duty of Candour



The increase in Duty of Candour reported incidents as anticipated in the previous report is due to a change in how DOC incidents are reported on the DATIX reporting system and a greater awareness

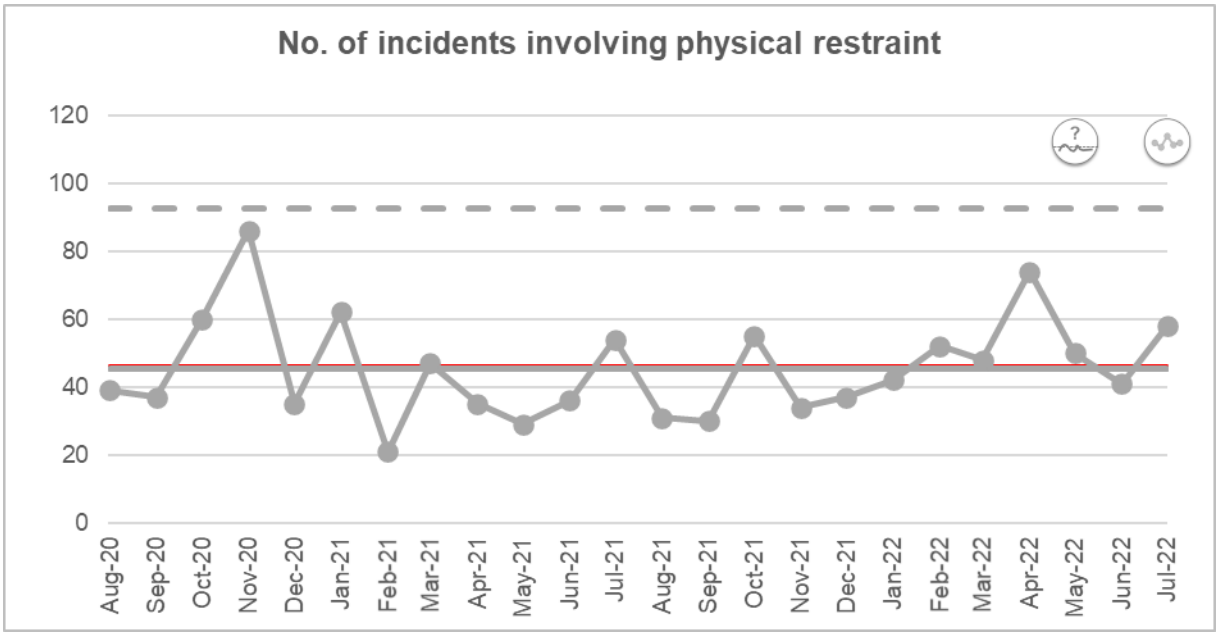
around reporting in clinical teams. This commenced in February 2022. From May 2022, the Patient Safety Team have undertaken training with Service Managers and Heads of Nursing to support them in understanding and interpreting new national guidance related to DOC which has allowed for a more accurate and consistent approach to DOC and better adherence to policy. Training around accurately reporting DOC continues within clinical teams and a new Family Liaison Officer has now commenced in post and a review into the current process of quality assurance, auditing and reviewing of incidents is underway. Due to these developments, it is expected that over the next quarter the number of incidents reported requiring DOC will stabilise and a more accurate mean will be established.

34. Prone restraint



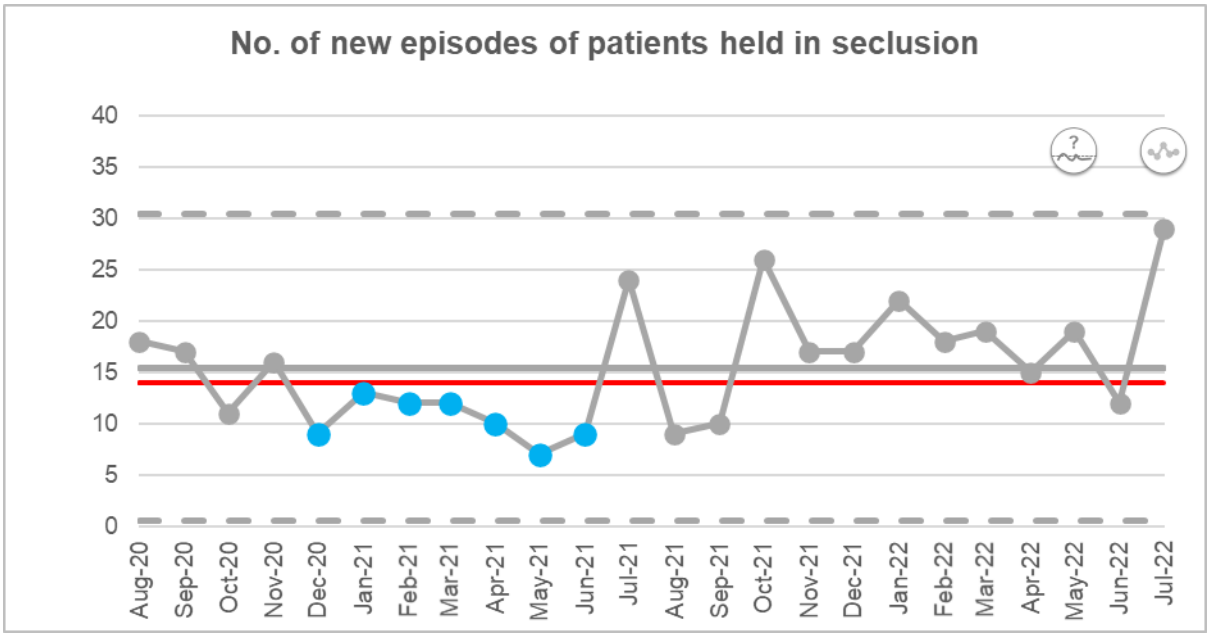
There are ongoing workstreams to support the continuing need to reduce restrictive practice, including the work around introducing body worn cameras. The monitoring of restrictive practice is done within specific forums and data analysis and review has shown that incidents involving prone restraint have increased between June and July related to repeated incidents involving a small number of patients. The overall numbers of prone restraint are lower than the regional average per bed numbers and it is expected of incidents related to prone restraint will reduce over the next quarter. This will continue to be monitored.

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.

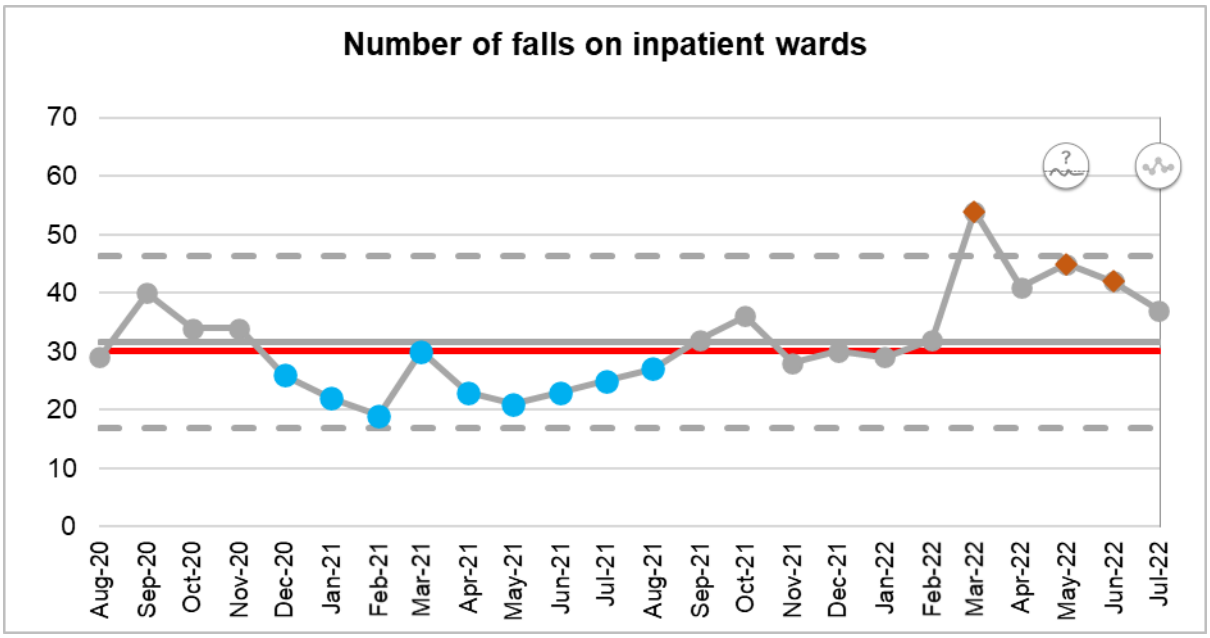
36. Seclusion



The use of seclusion has been above the mean common cause variation from October 2021. On further investigation of this trend, there is a link to a small number of patients who have been placed in seclusion on more than one occasion on an acute ward and then the enhanced care ward. This data will be monitored for patterns and further support needs for individual areas. Further auditing

and investigation will be carried out by the Head of Nursing for Acute and Assessment Services and will also include the links to Psychiatric Intensive Care Unit use.

37. Falls on inpatient wards

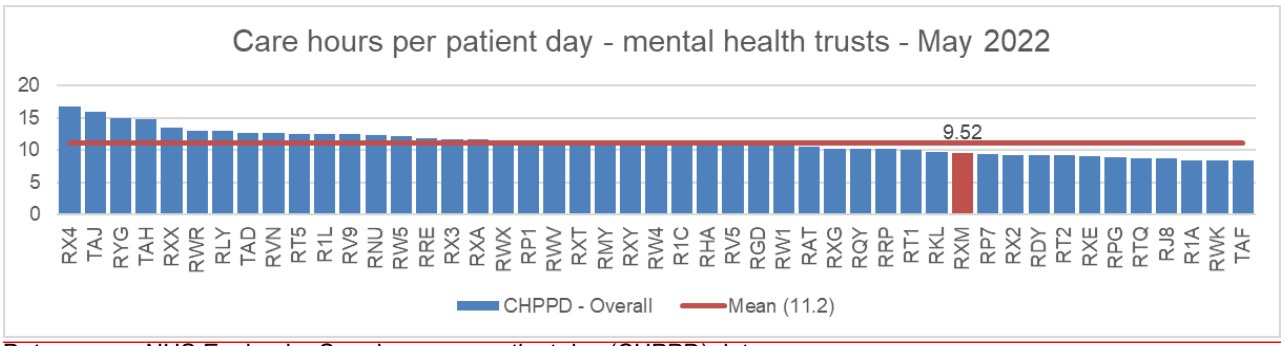


After an abnormal spike of incident in March 2022, A review of falls was commissioned and identified that a high number of falls were related to the same small number of patients. From this review a bi-weekly falls review meeting, chaired by the Matron for older adult services, has been established to identify any specific needs for those patients falling regularly. This appears to have had a positive impact with incidents related to falls reducing and continuing a downward trajectory between April and July. This will continue to be monitored over the next quarter.

Care Hours Per Patient Day (CHPPD)

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

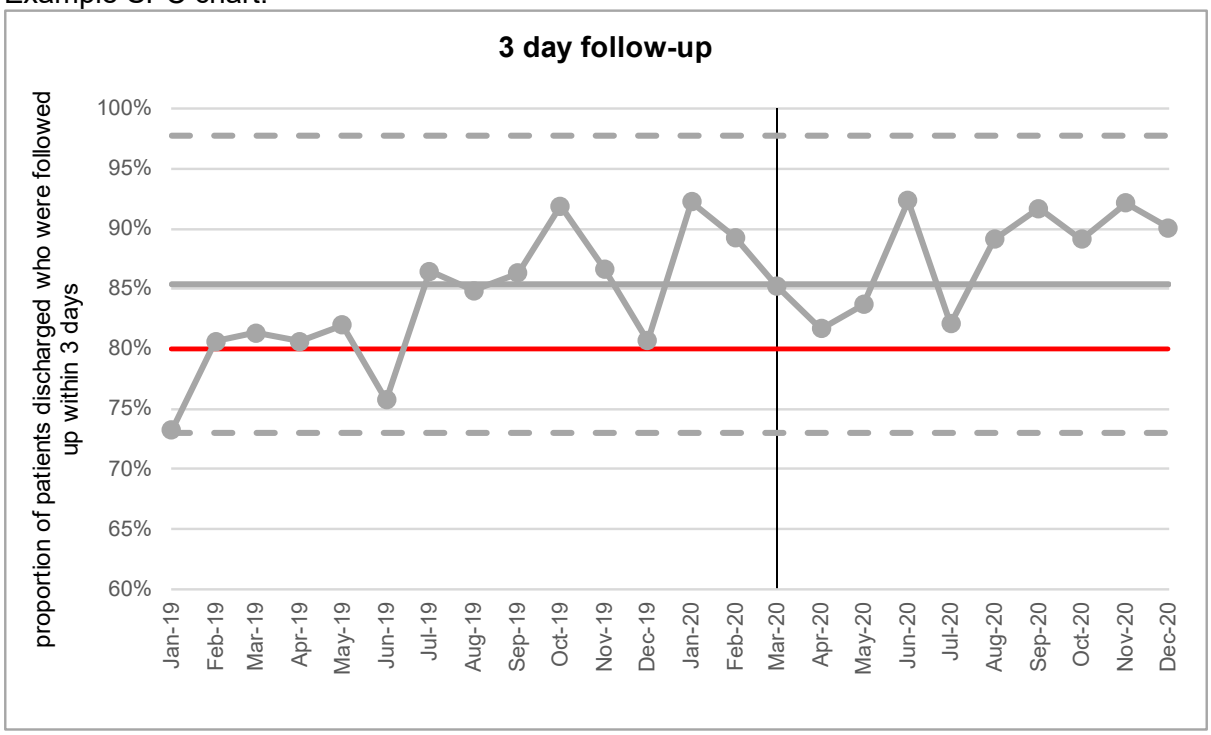
The chart below shows how we compared in the latest published national data when benchmarked against other mental health trusts. We were very slightly below average:



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

Statistical Process Control Chart (SPC) Guidance

Example SPC chart:



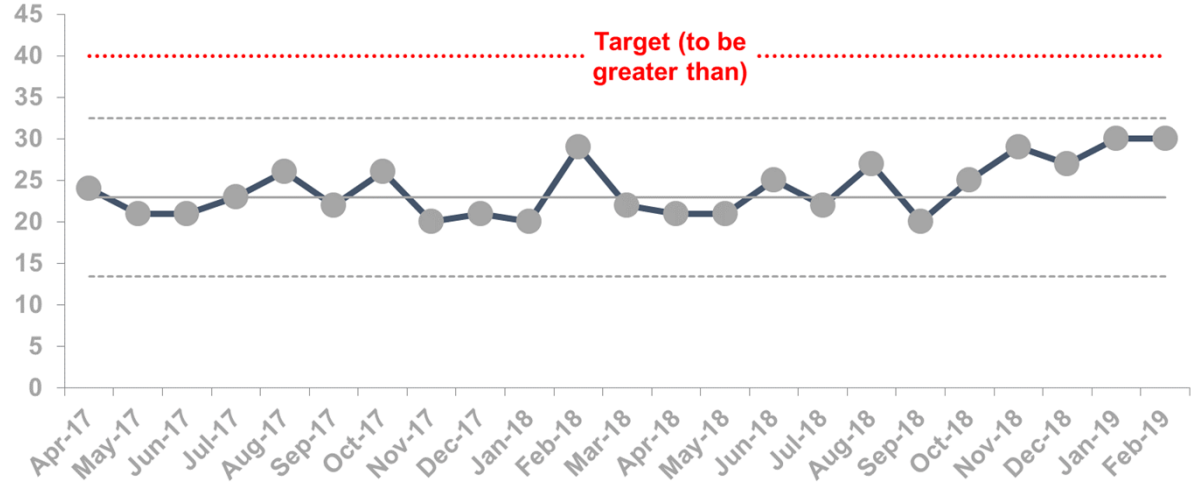
- The red line is the target.
- The grey dots are the actual performance each month. They are coloured grey as performance each month is normal in this example.
- The solid grey line is the average (mean) of all the grey dots.
- The grey dotted lines are called process limits, or control limits.

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.

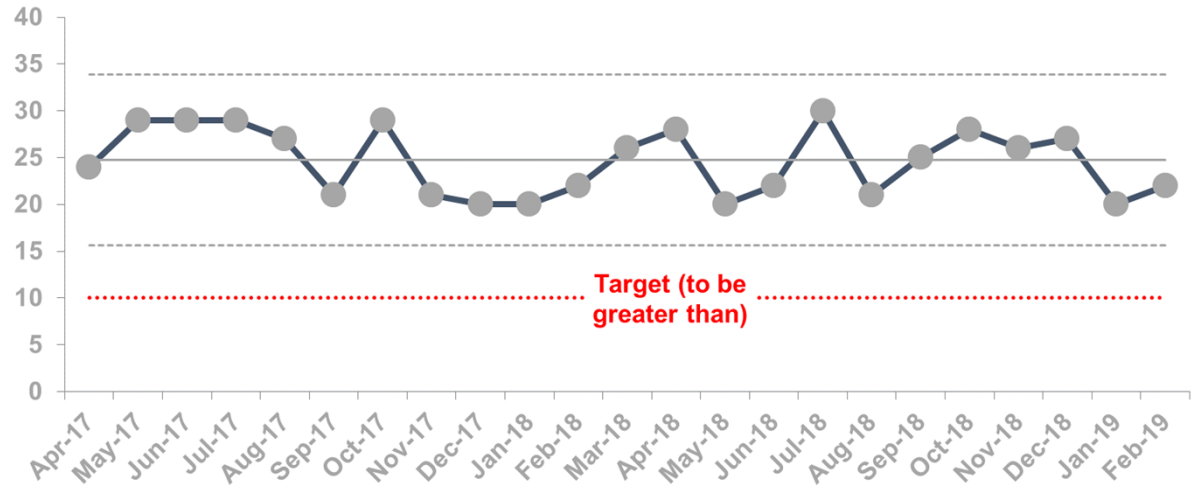
Things to look out for:

1. A process that is not working



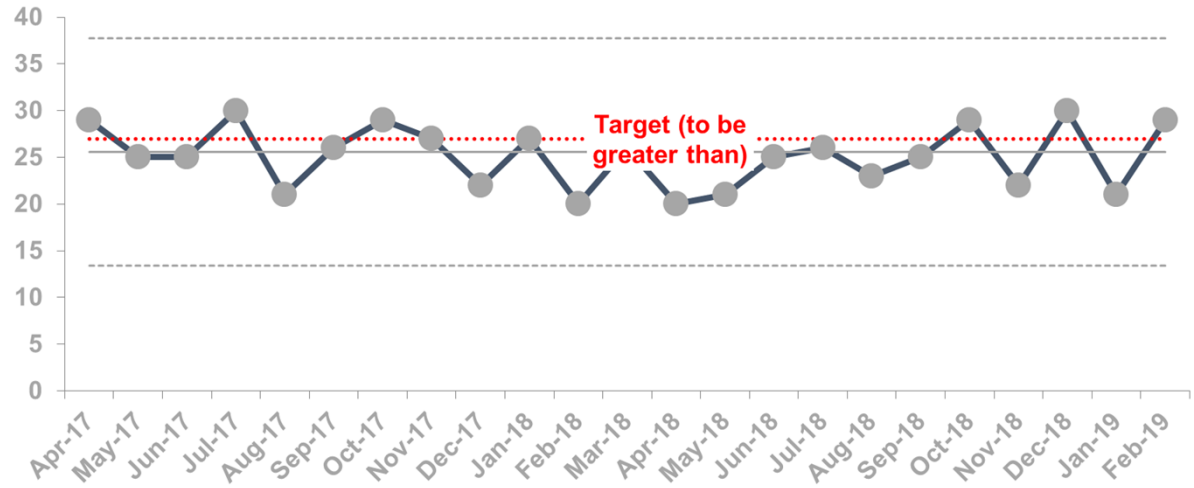
In this example the target is higher than the upper dotted grey line. This means that the target will never be achieved. To achieve the target, we need to change how we do things.

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

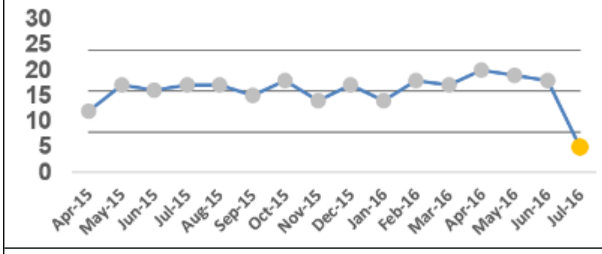
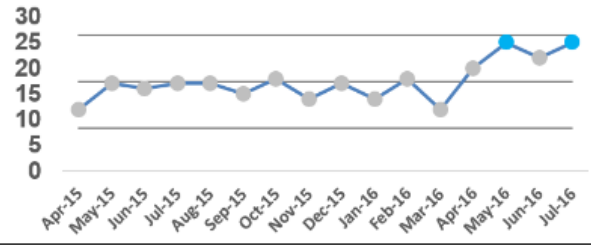


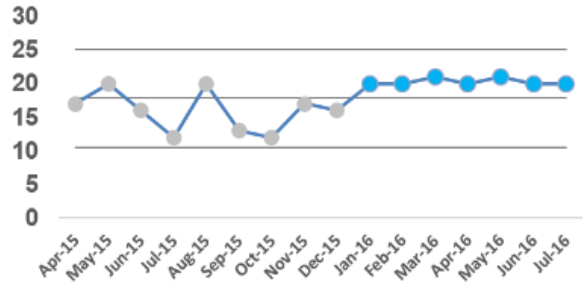
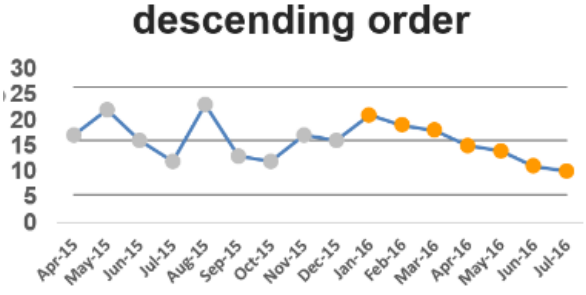
In this example the target line sits between the two grey dotted lines. As it is normal for the grey dots to fall anywhere between the two dotted grey lines, this means that it is entirely random as to whether or not the target will be achieved. So, this system is unreliable and needs to be redesigned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

4. Unusual patterns in the data

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

There are four scenarios where this can happen:

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

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

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

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 6 September 2022

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

Purpose of Report

This report provides an overview of the Trust's EPRR portfolio and the outcome of the 21/22 Core Standards Self-Assessment.

Executive Summary

The Trust has continued to provide a level of incident response to the COVID-19 over the last year, but work has continued to ensure the EPRR portfolio progresses. This report provides the annual update against the core standard domains, the self-assessment is enclosed with this report. The Core Standards have been reviewed by the national team and several changes have been made, there is reference to these changes in the spreadsheet. This has resulted in areas we were anticipating moving to full compliance now at partial due to the changes in narrative and expectation for the standard.

The Core Standards have been reviewed and updated this year with numerous changes. The overall level of compliance will be given once our submission has been reviewed, the documentation shared with this report shows across the 68 standards we have achieved the following:

- Fully compliant – 25
- Partially compliant – 27
- Not compliant – 2 *(detail included below)*
- Not applicable – 14

The Board can be assured there are plans in place for the outstanding actions.

Several new guidance documents have been issued during 2022, work to align our current plans is ongoing but it is not yet completed. This year the Deep Dive has focused on Shelter and Evacuation planning. We are not compliant with the Shelter and Evacuation deep dive section; work is scheduled for September – December to rectify this issue.

As a Trust we are measured against the following domains:

- Governance
- Duty to Risk Assessment
- Duty to Maintain plans
- Command and Control
- Training and Exercising
- Response
- Warning and Informing
- Cooperation

- Business Continuity
- Chemical, Biological, Radiological and Nuclear (CBRN)
- Deep Dive – Shelter and Evacuation

The report provides an update to the Board against the above domains.

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

Risks and Assurances

There is an ongoing workplan to support the outstanding actions, this is monitored through the EPRR Steering Group

Consultation

- Finance and Performance Committee receive 6 monthly updates on the EPRR Portfolio
- The Self-Assessment spreadsheet has not been received in any other forum.

Governance or Legal Issues

- Compliance with the Civil Contingencies Act 2004
- Health and Social Care Act 2022
- Compliance with the NHS England Emergency Preparedness, Resilience and Response Framework (2022)

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

- The EPRR Core Standards is an external document providing an overarching view of the Trust's preparedness for all types of emergencies. There are a number of component internal policies that deliver the compliance to the core standards; these documents will require a more in-depth equality impact assessment to evaluate the impact of the Trust's response to a variety of scenarios.
- Any potential equality and diversity implications will be assessed and managed as policies are reviewed, developed and implemented. Consideration will also be given to any exercising or training sessions scheduled to incorporate the cross cutting needs of the population we serve who may be affected by an EPRR related incident. Initial response to an incident will always consider preservation of life as a priority above all other issues. Following the initial lifesaving phase all REGARDS issues will be considered in detail.

Recommendations

The Board of Directors is requested to:

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

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

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

Emergency Preparedness, Resilience and Response (EPRR)

Annual Report 2022

Introduction

The Trust is continuing to respond to COVID-19 and although at a reduced level, the action plan to begin work to improve the Non-Compliance rating from 20/21 has progressed. The Core standards have received a national review therefore several of the standards have changed. This has resulted in areas previously expected to be fully compliant are now only at partial due to the change in narrative and expectation of the standard. It has been identified that the level of work required to facilitate the EPRR portfolio within the Trust was insufficient, so an Emergency Planning & Business Continuity Officer has been appointed to provide additional resource to the team who is a great asset.

The two areas currently non-compliant are: standard 14 (plan in place for the Mass Countermeasures distribution) and standard 25 (a new standard for mandatory staff awareness and training). Detail on these are provided in their appropriate sections below.

Governance

The Trust is partial fully compliant with this domain, Finance and Performance Committee receive update reports and reported annually to the Trust Board. Our Chief Operating Officer continues to hold the Accountable Emergency Officer role for the Trust. The workplan provides the overview of activities and identifies deadlines for completion of work. The area of partial compliance relates to the resource given to the work of the EPRR portfolio within the Trust. We are awaiting to hear from NHS England to see if there is a tool we can use to assess the resource required. The addition of our Officer role has significantly increased the level of capacity within the Trust.

Duty to Risk Assess

Within the EPRR portfolio there are two specific Trust wide risks, a generic risk encapsulating the National and Derbyshire Community risk register (this is the requirement for the standard). These risks are monitored and reviewed in line with the Trust's risk management policy. The Trust is fully compliant with this standard.

Duty to Maintain Plans

There are several the standards that are fully compliant within this domain. A significant piece of work has been undertaken to fully rewrite the incident response plan for this Trust. In doing so, we have captured several standards within one document. We have developed a new Severe Weather Plan encapsulating all weather related incidents, we have also incorporated dust/air pollution as identified within the standards. In addition, we have incorporated some lessons from the recent heatwave and reviewed the plan accordantly.

There is a system wide piece of work in the development of the psycho-social support for children and young people (C&YP) following a major incident. A paper was taken to the C&YP Mental Health Board for an agreement to complete this piece of work with partners. This work is yet to be completed but is progressing.

The evacuation and shelter and lockdown standards remain at partial compliance. As part of the workplan for September to December we have an externally facilitated exercise, then task and finish workshops to complete this standard. Further narrative is in the deep dive section.

We have one standard where we are not compliant, based on having a plan in place for the Mass Countermeasures distribution (standard 14). New guidance has been developed early 2022 which is being reviewed and the necessary actions for the Trust need to be developed into a plan. There is already basis for drawing content together for this, so it is expected this can be done with support from colleagues to reach compliance within a reasonable timeframe however will not be compliant before initial submission.

Command and Control

The Trust continues to provide an operational 24/7 response structure through a 1st On Call Manager South and North and a 2nd On Call Manager. There is further work to be done in relation to training for on call staff, this is reflected in the next section.

Training and Exercising

A number of virtual training sessions have been conducted however it was felt that this is not the best method of incident response training and future events need to be face to face. The EPRR Team have developed an extensive training and exercising programme which will come into force from September 2022. As part of the NHSE EPRR Framework review there is now a requirement for all EPRR training to be aligned to the national occupational standards for Civil Contingencies. This requires a piece of work to review the current training and ensuring the content meets the standards. Managers are also expected to maintain a Continuing Professional Development (CPD) portfolio for EPRR which we will support.

A training pathway has been designed to ensure all aspects of incident response are covered and will ensure staff are fully trained as required. Standard 25 is a new standard with a requirement for EPRR training to be part of induction and mandatory training therefore as present is not compliant. Work has already started with the training team to consider how we can address this issue, including its introduction in the induction process and an e-learning piece to be supported by a robust communications plan, and will be completed by December 2022.

Response

The Incident Coordination Centre needs to be reviewed, elements of this required the updated EPRR Incident Response Plan to be finalised; this would ensure the content/location and requirements would align with the plan. This piece of work is something that can be rectified quickly and will be incorporated into the managers training.

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

- System wide – Critical Incident July 2022
- Critical Incident Standby – Energy Centre, Kingsway Site July 2022
- Level 4 Heatwave – Extreme heat July 2022
- Loss of Wi-Fi to inpatient site – July 2022
- Storm Eunice – February 2022
- Inpatient Unit Boiler failure

We continue to respond to COVID-19 at a reduced level but over the last year have seen a number of spikes which has seen an increased response through our incident management team.

Warning and Informing

Working in collaboration with the Communications team we have developed an EPRR Communications Plan, this outlines how we will communicate with staff, patients and service users, partners/stakeholders and the media during an incident. This has helped to meet numerous standards within this domain, however to note further work will be needed is in relation to media spokespersons from the Executive Leadership Team; once the new board roles are confirmed.

Cooperation

We are fully compliant with this standard; we are represented at the Local Resilience Forum in both planning and response meetings. We participate in the Local Health Resilience Partnership meeting with Executive Leader representation. The mutual aid arrangements which was an outstanding action last year has been captured within the new EPRR Incident Response Plan.

Business Continuity

Due to the ongoing response incidents, including COVID-19, and the lack of resource within the EPRR team the priority for action was the EPRR Incident Response Plan. This has resulted in a delay in the progression of the business continuity domain. Now additional resource is available within the EPRR team there is a workplan in place to rectify this area.

Work has been undertaken during the year to support teams as we have responded to business continuity related events. We have supported teams when estate work has been completed to consider the provision of services to patients during the outage. We continue to work closely with teams to support them in the progression of their

business impact analysis documents and the service specific business continuity plans.

Chemical Biological Radiological Nuclear (CBRN)/Hazardous Material

As with the Business Continuity domain above this area of work has paused, this is also due to the risk picture for this type of event. It has been reviewed as a low risk for the Trust, but we are still required to maintain a response to this type of event. This work will be completed by April 2023.

Deep Dive – Evacuation and Shelter

Ahead of the core standards being released, the EPRR team were aware that the evacuation and shelter plan and lockdown plan needed to be reviewed. To support in this, we wanted to facilitate a training and exercising session around counter terrorism with the support of Derbyshire Constabulary. This would support with development of the plan and understanding of roles and responsibilities. This session is booked for 29 September 2022 with task and finish groups scheduled ready to complete the work required. All the areas within the deep dive will be rectified and plans ratified by December 2022.

Conclusion

The Core Standards have been reviewed and updated this year with numerous changes. The overall level of compliance will be given once our submission has been reviewed. Across the 68 standards we have achieved the following

- Fully compliant – 25
- Partially compliant – 27
- Not compliant – 2
- Not applicable – 14

The Trust Board of Directors can be assured of the following:

1. There is an action plan in place to support meeting the outstanding actions by April 2023. This will be monitored through the EPRR Steering group.
2. The EPRR Work plan will further enhance the Trust's compliance to the Core Standards

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 6 September 2022

Emergency Preparedness Resilience and Response (EPRR) Incident Response Plan

Purpose of Report

To provide an update on the Trust's EPRR Incident Response Plan.

Executive Summary

The EPRR Incident Response Plan is a completely new response document for the Trust. It replaces the previous Emergency Incident Response Plan and Procedures. As outlined in the Core Standards 2020/21 there were several aspects missing within the response plan that have now been incorporated.

The plan has been split into sections to make it easier to read and follow. Additional action cards have been developed including Chaplaincy, EPRR lead, bleep holder and Estates on call. The incident management team has become more dynamic in how it is structured with essential roles having specific action cards, but additional colleagues may be requested to support depending upon the incident. At the point of writing, work is ongoing around the development of a Consultant on Call action card. This is undergoing discussion and not yet delivered but anticipated to be incorporated at a later date.

As we continue in our response to COVID-19 it was essential to ensure learning from the pandemic has been identified and considered within the development of this new plan. This includes virtual incident management approaches, situational reporting and the use of Microsoft Teams. As a result of the changes to the NHS England EPRR Framework (2022), relevant information has been included within the Trust plan.

Within the legacy of the old plan the content did not include reference to JESIP, the Joint Emergency Services Interoperability Principles. This is a collaborative approach with all agencies involved with EPRR to ensure commonality in terminology, incident management and command roles and responsibilities. It provides tools that can be used for decision making, situational updates and tactical/strategic briefing memoirs. All these aspects have been written into the new iteration of the plan and will be further enhanced during the upcoming training sessions for managers.

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

Risks and Assurances

EPRR Generic Risk is monitored through the EPRR Steering Group – this encapsulates all types of risks. This attached plan is generic to cover all eventualities.

Consultation

- EPRR Steering Group
- Finance and Performance Committee
- Health Emergency Planning Operational Group (System Health partners)
- On call managers

Governance or Legal Issues

- Compliance with the Civil Contingencies Act 2004
- Health and Social Care Act 2022
- Compliance with the NHS England Emergency Preparedness, Resilience and Response Framework (2022)

Public Sector Equality Duty and Equality Impact Risk Analysis

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

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

- The EPRR Core Standards is an external document providing an overarching view of the Trust's preparedness for all types of emergencies. There are several component internal policies that deliver the compliance to

the core standards; these documents will require a more in-depth equality impact assessment to evaluate the impact of the Trust's response to a variety of scenarios.

- Any potential equality and diversity implications will be assessed and managed as policies are reviewed, developed and implemented. Consideration will also be given to any exercising or training sessions scheduled to incorporate the cross-cutting needs of the population we serve who may be affected by an EPRR related incident. Initial response to an incident will always consider preservation of life as a priority above all other issues. Following the initial lifesaving phase all REGARDS issues will be considered in detail.

Recommendations

The Board of Directors is requested to:

1) Receive the new EPRR Incident Response Plan for approval
2) Confirm and challenge as appropriate
3) To agree to minor amendments being approved by Trust Operational Oversight Leadership (TOOL) with major changes coming back to Trust Board
4) Be assured of ongoing work to improve and further enhance the Trust's EPRR Portfolio.

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

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

Derbyshire Healthcare
NHS Foundation Trust

EPRR Incident Response Plan

In the event of an EPRR Incident turn immediately to Response Section 2

Service area	Issue date	Issue no.	Review date	
Trust wide		1		
Ratified by	**Ratification date**	**Responsibility for review:**		
Board		Emergency Planning		

Document published on the Trust Intranet under: Emergency Planning

Did you print this document?

Please be advised that the Trust discourages retention of hard copies of policies and can only guarantee that the Policy on the Trust Intranet site is the most up-to date version

IMMEDIATE ACTIONS

If you have received notification that an incident has been declared

and you have not read this plan

DO NOT READ IT NOW

Find your relevant action card in Section 3

AND FOLLOW THE INSTRUCTIONS

Derbyshire Healthcare NHS Foundation Trust

EPRR Incident Response Plan

Version number: 1.0

First published:

Updated: N/A

Prepared by: Emergency Planning & Business Continuity Manager

FOI: No – please speak with EP&BC Manager first

The Plan is a live document and is kept under regular review. Revisions and updates will be circulated to all named holders. Further information on most recent changes may be obtained by checking the Trust

Document change history

Version	Date	Comments
1.0		New plan developed from legacy documents within the Trust.

Should you require access to the audit record of this document, please email dhcft.eprr@nhs.net

Auditing, Updating and Amending of this Plan

i. The distribution of this plan and any revisions is controlled through a register of plan holders. Registered holders of this plan are listed in this section. The register lists job titles and place of work.
ii. If a registered plan holder changes position, contact details or leaves their organisation they should notify the Emergency Planning Team.
iii. The Emergency Planning Team will be responsible for issuing new and amended documents in accordance with the register of plan holders.
iv. Information relating to the revision will be held in the page footer, eg date of issue, date of review, version number and page.
v. Plan holders are required to replace copies of superseded documents with the revised versions. All superseded versions should be destroyed.
vi. The Major Incident plan will be audited on an annual basis by the Emergency Planning Team using the tool created on page 7 of this Plan and in accordance with the Audit and Assessment Tool produced by the Department of Health.
vii. A formal review of the plan will be undertaken every three years and a report of any amendments and updates, including any training and exercises, will be reported to the Trust Board.

Derbyshire Healthcare NHS Foundation Trust

Amendment Request Form

Plan Date		Version
Page(s) to be amended/added		
Page Number	Section	Amendment/Addition Request
Name	Job title/Department	Date
Contact details		

Actioned	
Date	

Please return to : **dhcft.eprr@nhs.net**

Derbyshire Healthcare NHS Foundation Trust

EPRR Incident Response Plan

Register of Holders

Plan No.	Name/Location
	Incident Coordination Centre – Kingsway House
	Chief Executive Office
	Radbourne Unit
	Hartington Unit
	Kingsway Bleep
	EPRR Office
	On call Managers
	On call SharePoint site

Contents

1.0 Introduction

Derbyshire Healthcare NHS Foundation Trust is required to respond to incidents in a timely and appropriate way. This Emergency Preparedness, Resilience & Response (EPRR) Incident Response Plan has been designed to offer a framework to those involved in an incident response; it gives due consideration to all phases of an incident whilst referencing the core legislation, NHSE Frameworks and guidance documentation for EPRR.

1.1 Scope

This plan provides the framework for incident management within the Trust. As such, this document outlines the response mechanisms, communication channels, roles and responsibilities and reporting arrangements for any EPRR incident response.

Due to the nature of the services provided within the Trust, this plan does not include the management of operational pressures please refer to the Service Closure Policy for further details.

This plan falls under the scope of the overall Trust EPRR Policy.

1.2 Who is the Plan for?

This plan describes what actions need to be taken and by whom, in the event of an EPRR related incident. This has potential to have an immediate impact on all or part of the Trust.

All staff need to be aware of the existence and familiar with the content of the EPRR IP, identifying their role within the plan and how their individual contributions impact upon a successful implementation process.

The EPRR lead is responsible for working with senior managers to identify staff likely to be involved in an EPRR incident response and to ensure they have the appropriate training, equipment and knowledge to be able to respond safely and effectively to an emergency or major incident. Executives and senior managers must also ensure they are sufficiently familiar with the contents and requirements of this plan, and that they are ready and able to deliver an immediate response in accordance with the provisions of the plan.

1.3 Incident Definitions

The NHS England Emergency Preparedness Framework 2022 defines significant incidents and emergencies as they may apply to NHS funded organisations and the varying scale of these incidents.

Under Section 1 of the CCA 2004 an “emergency” means:

a) *“an event or situation which threatens serious damage to human welfare in a place in the United Kingdom;*
b) *an event or situation which threatens serious damage to the environment of a place in the United Kingdom;*

c) *war, or terrorism, which threatens serious damage to the security of the United Kingdom".*

For the NHS, incidents are classed as either:

- Business Continuity Incident
- Critical Incident
- Major Incident

Each will impact upon service delivery within the NHS, may undermine public confidence and require contingency plans to be implemented. NHS organisations should be confident of the severity of any incident that may warrant a major incident declaration, particularly where this may be due to internal capacity pressures, if a critical incident has not been raised previously through the appropriate local escalation procedure.

Incident classification	**Definition** *(NHS England EPRR Framework 2022, Section 6.4)*
Business Continuity Incident	an event or occurrence that disrupts, or might disrupt, an organisation's normal service delivery, to below acceptable predefined levels. This would require special arrangements to be put in place until services can return to an acceptable level. Examples include surge in demand requiring temporary re-deployment of resources within the organisation, breakdown of utilities, significant equipment failure or hospital acquired infections. There may also be impacts from wider issues such as supply chain disruption or provider failure.
Critical Incident	any localised incident where the level of disruption results in an organisation temporarily or permanently losing its ability to deliver critical services; or where patients and staff may be at risk of harm. It could also be down to the environment potentially being unsafe, requiring special measures and support from other agencies, to restore normal operating functions. A Critical Incident is principally an internal escalation response to increased system pressures/disruption to services.
Major Incident	The Cabinet Office, and the Joint Emergency Services Interoperability Principles (JESIP), define a Major Incident as an event or situation with a range of serious consequences that require special arrangements to be implemented by one or more emergency responder NHS Emergency Preparedness Resilience and Response Framework agency. In the NHS this will cover any

	occurrence that presents serious threat to the health of the community or causes such numbers or types of casualties, as to require special arrangements to be implemented.

1.4 Levels of incidents

The NHS England Emergency Preparedness Framework 2022 (Section 7) describes an incident in terms of 4 levels, which will be used by all NHS organisations.

Level 1	An incident that can be responded to and managed by an NHS-funded organisation within its respective business as usual capabilities and business continuity plans
Level 2	An incident that requires the response of a number of NHS-funded organisations within an ICS and NHS coordination by the ICB in liaison with the relevant NHS England region
Level 3	An incident that requires a number of NHS-funded organisations within an NHS England region to respond. NHS England to coordinate the NHS response in collaboration with the ICB. Support **may** be provided by the NHS England Incident Management Team (National).
Level 4	An incident that requires NHS England national command and control to lead the NHS response. NHS England Incident Management Team (National) to coordinate the NHS response at the strategic level. NHS England (Region) to coordinate the NHS response, in collaboration with the ICB, at the tactical level.

Figure 1: NHS incident response levels

1.5 Community Risk Registers

Community risk registers are published and regularly reviewed and updated by the relevant Local Resilience Forum (LRF) in line with the Civil Contingencies Act 2004 (CCA). They highlight potential hazards in the counties and how local services would respond in the event of an emergency. Representatives of the NHS organisations in Derbyshire contribute to the community risk registers through involvement with the various task groups of the LRFs.

The registers are intended to assure residents of the measures and plans which have been put in place to respond to the potential hazards. They have been prepared in accordance with statutory national guidance on emergency preparedness.

The areas of potential risk are listed under the following headings:

- Industrial accidents/environmental pollution
- Transport accidents
- Severe weather
- Structural
- Human health
- Animal health
- Public protest
- Industrial/technical failure

The registers cover non-malicious events (i.e. hazards) rather than threats (i.e. terrorism). This does not mean that threats have not been considered, but that given the sensitivity of the information, specific details are not published.

The community risk registers for Derbyshire can be found at : Community risk register | Derbyshire Local Resilience Forum (derbyshireprepared.org.uk)

1.6 Derbyshire Healthcare NHS Foundation Trust Risk Register

Derbyshire Healthcare NHS Foundation Trust has an internal organisational risk register, where risks are scored and monitored. The Trust has a specific EPRR Risk assessment which is monitoring through the internal governance process – this is supplemented by the Derbyshire Community Risk Register.

1.7 Command and Control

The management of an EPRR incident response and recovery is undertaken at one or more of three ascending levels: operational (bronze), tactical (silver) and strategic (gold). This is base on the concepts of command, control and coordination which are defined as follows:

- **Command** is the exercise of authority that is associated with a role or rank within an organisation, to give direction to achieve defined objectives.
- **Control** is the application of authority, combined with the capability to manage resources, to achieve defined objectives.
- **Coordination** is the integration of multi-agency efforts and available capabilities which may be interdependent, to achieve defined objectives. The coordination function will be exercised through control arrangements and required that command of individual organisations personnel and assets is appropriately exercised in the pursuit of the defined objectives.

The levels are defined by their differing functions rather than specific rank, grade or status.

1.7.1 Operational command

Operational command is the level at which the immediate 'hands on' work is managed. Operational commanders will concentrate their effort and resources on the specific tasks within their geographical or functional area of responsibility. Operational commanders will be identified in the organisational response plans.

Individual organisations retain command authority over their own resources and personnel, but each organisation must liaise and coordinate with all other organisations involved, ensuring a coherent and integrated effort. This may require the temporary transfer of personnel or assets under the control of another organisation.

These arrangements will usually be able to deal with most events or situations but if greater planning, co-ordination, or resources are required, an additional tier of management may be necessary. The operational commander will consider whether a tactical level is required and advise accordingly.

1.7.1.1 DHCFT Operational Role / Bronze

This operational role would be undertaken by the Bleep Holder on our inpatient units or a Service Manager within our community bases.

1.7.2 Tactical command

The purpose of the tactical level is to ensure that the actions taken by the operational level are coordinated, coherent and integrated to achieve maximum effectiveness, efficiency and desired outcomes.

Where formal co-ordination is required at tactical level, then an LRF tactical coordinating group (TCG) may be convened with multi-agency partners within the area of operations. The NHS tactical commander at the TCG will be identified by the Integrated Care Board (ICB). They will ensure that all NHS-funded organisations are coordinated through local health tactical coordination groups. In addition, the NHS ambulance service(s) will be present on the TCG in their role as an emergency service.

The NHS tactical commander will:

- determine priorities for allocating available resources
- plan and coordinate how and when tasks will be undertaken
- obtain additional resources if required
- assess significant risks to inform tasking of operational commanders
- ensure the health and safety of the public, patients and NHS personnel.

The NHS tactical commander must ensure that the operational commanders have the means, direction and coordination to deliver successful outcomes.

Where it becomes clear that resources, expertise or coordination are required beyond the capacity of the tactical level, it may be necessary to invoke the strategic level of management to take overall command and set the strategic direction.

1.7.2.1 DHCFT Tactical Role / Silver

This tactical role would be undertaken by the Area Service Manager during hours and the 1st On Call Manager out of hours. For further information about the Derbyshire LRF response, please see the On Call Sharepoint or speak to the EPRR team.

1.7.3 Strategic command

The purpose of the strategic level is to consider the incident in its wider context; determine longer-term and wider impacts and risks with strategic implications; define and communicate the overarching strategy and objectives for the response; establish the framework, policy and parameters for operational and tactical; and monitor the context, risks, impacts and progress towards defined objectives.

Where an event or situation has a particularly significant impact, substantial resource implications or lasts for an extended duration, it may be necessary to convene a multi-agency coordinating group at the strategic level, bringing together the strategic commanders from relevant organisations. This group is known as the strategic

coordinating group (SCG). This group is usually convened by the chair of the LRF following a request from one of the LRF members.

The SCG does not have the collective authority to issue commands to individual responder agencies; each will retain its own command authority and defined responsibilities and will exercise control of its own operations in the normal way.

The local NHS strategic commander at the SCG will be identified and agreed between NHS England and the ICB.

The Secretary of State (SofS) and/or NHS England may require some organisations to act in a particular way in an emergency, (under section 253 of the NHS Act 2006). The organisations that are subject to such orders include:

- NHS England, ICB, NHS trusts and NHS foundation trusts, and
- other organisations that provide services commissioned by the SofS, NHS England, ICB or a local authority under particular sections of the 2006 Act

In addition, the providers of NHS ambulance service(s) will be present in their role as an emergency service.

The purpose of the SCG is to take overall responsibility for the multi-agency management of the incident and to establish the policy and strategic framework within which operational and tactical command and coordinating groups will work.

The SCG will:

- determine and promulgate a clear strategic aim and objectives, and review them regularly
- establish a policy framework for the overall management of the event or situation
- prioritise the requirements of the tactical level and allocate personnel and resources accordingly
- formulate and implement media handling and public communication plans
- direct planning and operations beyond the immediate response to facilitate the recovery process.

For incidents across multiple SCG areas, NHS England regional and national teams, as appropriate, will undertake command, control and coordination of the NHS and will be responsible for appropriate representation to regional and central coordination structures and groups. The decision on the impact of the incident on the NHS from across more than one SCG area will be taken by the relevant NHS England (Regional) Director(s) and the NHS England National Director for EPRR.

1.7.3.1 DHCFT Strategic Role / Gold

This strategic role would be undertaken by the Accountable Emergency Officer, who for the Trust is the Chief Operating Officer during hours and the 2nd On Call Manager

out of hours. For further information about the Derbyshire LRF response, please see the On Call Sharepoint or speak to the EPRR team.

1.8 Accountability – Roles and Responsibilities

The NHS Act 2006 places a duty on relevant service providers to appoint an individual to be responsible for discharging the duties under section 252A(9), outlined below. This individual is known as the Accountable Emergency Officer. NHS England expect all NHS-funded organisations to have an AEO with regard to EPRR. Chief Executives may designate the responsibility for EPRR as a core part of their organisation's governance and its operational delivery programmes. Chief Executives will be able to delegate this responsibility to a named director.

1.8.1 Accountable Emergency Officer (AEO)

The AEO will be a board-level director (or equivalent in organisations without a board) responsible for EPRR. They will have executive authority and responsibility for ensuring that the organisation complies with legal and policy requirements. They will provide assurance to the board that strategies, systems, training, policies and procedures are in place to ensure their organisation responds appropriately in the event of an incident.

AEO's will be aware of their legal duties to ensure preparedness to respond to an incident within their health community to maintain the public's protection and maximise the NHS response.

Specifically, the AEO will be responsible for ensuring that their organisation:

- itself and any sub-contractors are compliant with the EPRR requirements as set out in the CCA 2004, the 2005 Regulations, the NHS Act 2006, the Health and Care Act 2022 and the NHS Standard Contract, including this Framework and the Core Standards
- is properly prepared and resourced to deal with an incident
- itself and any sub-contractors it commissions have robust business continuity planning arrangements in place that align to ISO 22301 or subsequent guidance that may supersede this
- has a robust surge capacity plan that provides an integrated organisational response and has been tested with other providers and partner organisations in the local area served
- complies with any requirements of NHS England, in respect of monitoring compliance
- provides NHS England with such information as it may require for the purpose of discharging its EPRR functions
- is appropriately represented by director-level engagement with and effective contribution to any governance meetings, sub-groups or working groups of the LHRP and/or LRF, as appropriate

The AEO is supported in the discharge of these responsibilities by the Emergency Planning Team. The EPRR lead is responsible for developing an annual EPRR work plan which is overseen by the AEO. The work plan takes account of the LHRP work plans and any actions identified from exercises and the annual EPRR core standards assurance process.

The AEO is also supported by a non-executive director to endorse assurance to the Board that the organisation is meeting its obligations with respect to EPRR and relevant statutory duties under the CCA 2004 and the NHS Act 2006 (as amended). This includes assurance that the organisation has allocated sufficient experienced and qualified resource to meet these requirements.

1.8.2 NHS Provider Organisations

To meet their obligations under the Civil Contingencies Act 2004, NHS Act 2006 and the NHS Standard Contract providers of NHS-funded services are required to:

- support ICBs within their ICS and NHS England in discharging their EPRR functions and duties, locally and regionally
- have robust and effective structures in place to adequately plan, prepare and exercise the tactical and operational response arrangements, both internally and with their local healthcare partners
- ensure business continuity plans mitigate the impact of any emergency, so far as is reasonably practicable
- ensure robust 24/7 communication 'cascade and escalation' policies and procedures are in place, to inform the ICB, NHS England, healthcare and multiagency partners, as appropriate, of any incident impacting on service delivery
- ensure that recovery planning is an integral part of its EPRR function
- provide assurance that any sub-contractors are delivering their contractual obligations with respect to EPRR
- ensure organisational planning and preparedness is based on current risk registers
- provide appropriate director-level representation at LHRP(s) and appropriate tactical and/or operational representation at local ICS planning groups in support of EPRR requirements.

1.8.3 Derbyshire Healthcare NHS Foundation Trust EPRR Steering Group

The Trust has an internal EPRR steering group, which meets to discuss issues related to emergency planning. The group is chaired by the EPRR Lead. Minutes of the meeting are shared and circulated to all members. Reports are submitted as required through the Trust's committee structure.

1.9 Links to other plans

There are a number of plans/guidance documents are available to support an incident response; this list is not exhaustive.

Internal (available on FOCUS)

- Bomb threat
- Lockdown
- Severe Weather
- Pandemic Influenza Policy
- Business Continuity Management System
- EPRR Policy

External

- LRF Multi-agency plans – speak to EPRR team for further information
- Civil Contingencies Act 2004 - Civil Contingencies Act 2004 (legislation.gov.uk)
- NHS England Emergency Preparedness, Resilience and Response Framework 2022 - eprr-framework.pdf (england.nhs.uk)
- NHS England Incident Response Plan (National) 2017 - NHS-england-incident-response-plan-v3-0.pdf
- Concept of operations for the management of mass casualties - concept-operations-management-mass-casualties.pdf (england.nhs.uk)

1.10 Information sharing

Under the CCA 2004 and 2005 Regulations responders have a duty to share information with partner organisations. This is a crucial element of civil protection work; it underpins all forms of co-operation. NHS-funded organisations should formally consider the information required to plan for and respond to an emergency. They should determine what information can be made available in the context of the CCA 2004.

Within Derbyshire there is an information sharing agreement which the Trust has signed; there are also several information sharing policies the Trust holds which should be considered prior to the releasing of data. Any information shared needs to go through a formal process of approval prior to release, this should be with a member of the Trust Board/Caldicott Guardian.

1.11 Logging and Record Keeping

NHS-funded organisations must have appropriately trained and competent Loggists to support recording of decisions made in the management of an incident. Loggists are an integral part of any incident management team. All those tasked with logging must do so to best practice standards and understand the importance of logs in the decision-making process, evaluation and identifying lessons, and as evidence for any subsequent inquiries.

Following an incident, internal investigations, external scrutiny and/or legal challenges may be made. These may include coroners' inquests, public inquiries, criminal investigations and civil action.

When planning for and responding to an incident, all decisions made or actions taken must be recorded and stored in a way that can be retrieved later to provide evidence. It may be necessary to provide all documentation; therefore, robust and auditable systems for documentation and decision-making must be maintained. Best practice for the retention of documents is shown in the table below.

Category	Examples	Minimum retention period	Final action
Incidents (declared)	Decision logbooks, on call log book, incident related documents including plans and organisational structure Paper and electronic records	30yrs	Review, archive or destroy under confidential conditions
Exercise	Paper and electronic records	10yrs	Review, archive or destroy under confidential conditions
EPRR	Incident response plans, guidance, standard operating procedures, core standards for assurance Electronic records	30yrs	Review, archive or destroy under confidential conditions

2.0 Plan Activation

The response to an incident may be triggered in a number of ways. Internally this could be triggers by an incident such as a fire or security incident. If an incident is occurring external to the Trust notification may come from a partner agency such as East Midlands Ambulance Service, ICB or Derbyshire County Council. This may be received by telephone through Switchboard; in some instances, such alerts may also come directly from NHS England at a regional or national level.

Severe Weather incidents would see alerts and warning come from the Met Office or Environment Agency. See the Severe Weather Plan for further information. In all cases partner agencies have Trust contact details for an in hours and out of hours response.

This plan will be activated upon receipt of information which indicates an incident has occurred affecting the Trust's ability to operate in a business-as-usual approach. The definition of the incident Business Continuity, Critical or Major will be determined by the nature of the event. In order to gather sufficient information to inform a decision whether to activate the plan, it is recommended that the Initial Response Aide Memoire to be completed along with an SBAR (Situation, Background, Assessment, Recommendation). Both documents are included in the appendix.

2.1 DHCFT Incident Coordination Centre (ICC)

The Trust's primary Incident Coordination Centre (ICC) is located on the Kingsway Site.

- Meeting Room 10, Kingsway House, Kingsway Hospital

An alternative location would include

- Chief Executive's Office, Ashbourne Centre, Kingsway Hospital
- Radbourne Unit
- Hartington Unit

In the event of an EPRR related incident, the ICC would be established in the most appropriate location. The primary ICC hosts equipment and materials that could be required/utilised during an incident. When activated the room will become part of the incident response and all other meetings will be cancelled and relocated by the meeting organiser.

The establishment of the ICC is captured within the 'How to set up the ICC guide'. This is available on the On-call SharePoint. The Incident Director may decide that additional resources are required and will have the necessary authority/responsibility to obtain them.

2.2 Virtual Response / Face to Face Response

Depending upon the nature of the incident will determine the required response, if the incident can be managed virtually this should be considered. The primary method should be for a face-to-face method for an EPRR Incident Response.

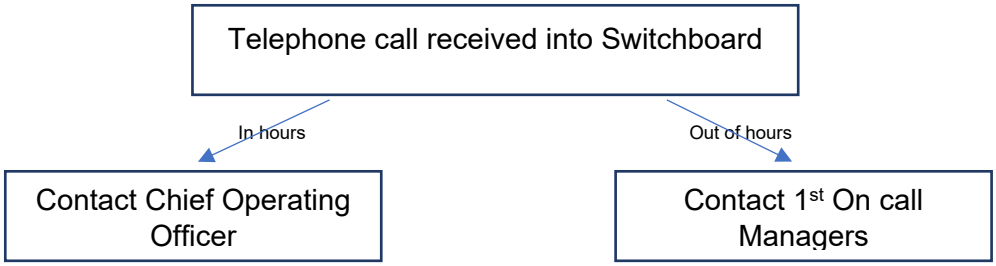
If the incident has occurred within a Trust inpatient site, the relevant 1st on call manager should attend the site. The opposite 1st on call manager should join the 2nd on call manager in the Incident Coordination Centre. In hours, the Area Service Manager should remain on site and the Chief Operating Officer (or deputy) should proceed to Kingsway House.

2.3 MS Teams Support

A template MS Teams Team is on standby to support the response to an EPRR incident. Within it are all of the documents in the appendices, template documents and copies of key Trust plans / policies. It hosts contact details and provides a central forum for the incident to be coordinated through. Colleagues involved in the incident would be given access at the time. A standard operating procedure has been written and prepared to support this function. It is available on the On Call SharePoint.

2.4 DHCFT Incident Notification Procedures

Please see the next page for the flow chart.



Record details on Incident Aide Memoir

Verify details are necessary

Access the Trust's response	
• Are there any road closures? • Are there any public health risks? • Are any of the Trusts staff affected? • Are any healthcare facilities affected? • Is there a risk to patient safety? • Is it affecting an in hours or out of hours service? • Is it an internal or external EPRR incident? • What further information do you require?	• Are there any business continuity issues? • Do partner agencies require assistance/support? • Are the media involved? • Do you need to attend site? • Does the Incident Coordination Centre require establishment? • Do you need to declare it as an EPRR incident? • Have you informed relevant parties?

No Action Required	EPRR Incident Declaration	Major Incident
Inform 2nd On Call for information Complete the Incident Aide Memoir and send to dhcft.eprr@nhs.net for their records. If you are unsure on further actions, review the EPRR Incident response plan or contact the initial caller for further details. Make a log on the On-Call SharePoint.	**Contact 2nd On Call and agree next steps** Check if any Trust facilities, staff, patients are affected by the incident. Proceed to site of the incident. North/South 1st on Call to support as required. Start a log if not already activated. Start using the pre-populated MS Teams group in response to incident	**Contact 2nd On Call and agree next steps** Activate the Major Incident Response to manage the ongoing incident. 2nd on Call to make their way to the Incident Coordination Centre (ICC) at Kingsway House. 1st On Call Managers to attend site, primary to incident location, support to the ICC. Start using the pre-populated MS Teams group in response

2.5 Incident Management Team (IMT)

This group comprises of strategic level representatives likely to be integral to the strategic response to the incident. Others may be added at the discretion of the Incident Director. In normal office hours the position of Incident Director would normally be held by the Chief Operating Officer. Out of Hours this position would be assumed by the 2nd On Call Manager until such time at which it may be changed.

The Gold Command provides strategic leadership.

- It should try to avoid tactical or operational level decision making where possible by delegating where appropriate to Silver Command.
- It is the most senior decision making within the Trust for matters concerning response to an incident.
- It should include decision makers of appropriate seniority and scope. This may include some or all of the Executive Leadership Team (ELT). ELT should not duplicate matters discussed during IMT Meetings
- Depending on the nature of the incident IMT may include the following staff (this list is not exhaustive):
    - Chief Operating Officer
    - Executive Medical Director.
    - Executive Director of Nursing
    - Deputy Director Operations
    - Head of Estates & Facilities.
    - General Manager IMT & Records
    - Deputy Director of Communications & Engagement
    - Executive Director of Workforce and Organisational Development.
    - Clinical Lead(s) as appropriate.
    - EPRR lead.
    - Loggist

In a lengthy incident deputies should be identified for all IMT roles.

Also, in a Cyber or Data Security Incident it is a legal requirement for the Data Protection Officer to be informed and involved in all Cyber/Data Security/information incidents.

Depending on the scale and duration of an incident Gold Command will require a degree of administrative support. For example, a response to a pandemic would require significant administrative support to ensure that agendas, papers and correspondence is organised and stored appropriately. Administrative support differs to the role of incident loggist.

Action cards can be found in the appendix for the following Gold Command roles:

- Incident Director
- Tactical Commander
- Incident Loggist(s)
- Administrative Support
- Head of Communications
- Medical Lead
- Bleepholder
- EPRR Support
- Switchboard

A full term of reference and draft Gold Command agenda are stored in the appendix.

2.6 Incident Management Team – Specialist Cells

Depending on the nature of the incident IMT should consider the establishment of specialist subject cells to support it in meeting its agreed objectives. This may include the management and interpretation of incoming guidance. Specialist cells allow the Trust to work proactively to respond to challenges in specific areas. Examples of Specialist Cells are as follows:

- Infection Prevention & Control
- Patient Flow
- Workforce
- Ethics
- Pharmacy & Medicines
- Tactical & Operational Recovery Working Group

Cells should present their updates as and when required by IMT. A template for Specialist Cell updates is contained in the appendix.

2.7 Situational Reporting

During a EPRR Incident it will be necessary for the Incident Director to gather information from individual Divisional/Services on their response to the incident. This reporting will be initiated by Incident Director and cascaded to Tactical Commander/General Managers/Service Manager who will liaise with Operational/Bronze leads within their Division/Service to gather the necessary information.

The situation report template for Division/Service is included in the appendix.

Should situation reporting be required the Incident Director will need to ensure the following:

- A clear timetable for submission that allows a reasonable timescale for sitreps to be compiled and collected.

- Clear instructions as to where Tactical Commander/ASM/Service should send completed sitreps e.g. dhcft.EPRR@nhs.net or a new generic email address to deal with specific incident related matters.
- Awareness of demands for information from external organisations such as ICB, Local Authorities and NHS England and ensure the timetable for collecting information internally fits in with local and regional reporting arrangements.
- All completed sitreps are saved in a specific incident folder on EPRR shared drive/MS Teams that may be accessed only by appropriate staff. Each sitrep should be stored individually and dated as follows YYYYMMDD e.g. 20220801

2.8 Situational Reporting – External partner requests

The declaration of an EPRR related incident is likely to result in information requests from partners such as the ICB and NHSE Midlands Region. The national NHSE sitrep template should be completed for an incident and is available on the On call SharePoint site.

The requests for information should ensure sign off within the organisation by relevant members of the Trust Board as appropriate.

2.9 Guidance Log

Any long running incident is likely to attract input from external partners and central Government. This may result in the issue of guidance covering all aspects of incident response. The Trust may need to evidence its response to such guidance if a public inquiry is held. It will be necessary to keep a log of guidance received and how it is dealt with to ensure that adherence to guidance can be demonstrated.

2.10 Mutual Aid

Depending upon the nature of the incident it may be necessary to consider mutual aid from partner agencies this should be request through the System Escalation call initially or through the Derbyshire Local Resilience Forum who may be able to assist.

In the event, that capacity has been exceeded or the nature of the incident requires specific capability to deliver, the military may be required to augment responses; this is known as Military Aid to the Civil Authorities (MACA). This is not a guaranteed resource and may incur a charge.

Further information is available from Requests for Military Aid to the Civil Authorities (MACA) from the NHS in England or the EPRR team.

3.0 Action Cards

Action Card 1 EPRR Incident Response Incident Director	
Role: The role of the Incident Director is to • Provide strategic leadership to the Trust, looking at the 'Big Picture' • Direct, plan and coordinate the recovery phase of the incident • Establish and maintain liaison with external partners • Manage any potential harm to the Trust's reputation • Manage communications with staff, patients, public and media This role would be filled by the Chief Operating Officer (or deputy) during hours, 2nd On Call Out of Hours.	
Incident Status – Standby	
Receive briefing from Tactical (Silver) Commander as to the scale and nature of the incident	
Consider whether a physical or virtual response is required for the incident	
Inform the Chief Executive Officer of the incident status	
Begin preparation of the NHSE Sitrep report for submission to ICB and NHSE Regional Team	
Incident Status: Incident Declared	
Liaise with the Trust Chief Executive and provide a situation briefing	
Consider which incident level the Trust is declaring • Business Continuity • Critical • Major	
Proceed to the Incident Coordinating Centre and assist with setting up the room if not already established	
Establish communication with North and South First on call Managers. • Provide advice and guidance on the overall strategy • Agree the nature and frequency of updates between Gold and Silver command. • Gold should stay separate from Silver meetings	
Make contact with your loggist (if available) and agree how the log will be completed and how you will communicate with each other. If no loggist is available maintain your own log	
Liaise with other agencies for managing information requests and mutual aid support where required – confirm with Silver what has already been shared before calling: • ICB (ask for the 1st On Call 01246 277271) • NHS E&I Midlands on call (07623 515942) For coordination of MACA requests please see guidance on the SharePoint site/MS Teams	
Complete first Sitrep report / SBAR for submission	
Review Gold Command Terms of Reference and prepare meeting agenda utilising template.	
Establish strategic aims and objectives with other members of the health community.	
Establish an incident recovery strategy:	

• Contact appropriate people to form the recovery team • Action a recovery plan which meets the requirements of the incident	
In conjunction with the Silver Commanders and the EPRR Lead undertake a regular review of the composition of the Hospital Incident Command Team. Consider staff welfare and the potential need for staff relief and shift change over. The timing, outcome of the review and actions taken should be fully recorded.	
INCIDENT STATUS: 'Incident Stand down'	
Confirm 'Stand Down' arrangements with the Silver Commanders and Finalise external communications	
Continue with Recovery phase of the incident	
Participate in a hot debrief which will be led by Silver	
Ensure all personal logs, handwritten notes and paperwork are handed into the EPRR Team	

RECOVERY GUIDANCE FOR GOLD COMMAND

- Start the Recovery plan at the onset of the incident
- Keep an ongoing list of items to be addressed following the stand down of the incident
- The Recovery plan should consider the following:

Operations	Have any patient appointments been cancelled? Is there necessary resource to re-book appointments? Have any services been suspended? Have any services been outsourced elsewhere? This may have a financial implication Has the Trust incurred any breaches that require reporting or explanation?
Economic	Is anything owed to external parties as a result of the incident? Will the incident incur additional staffing costs? Is there likely to be any insurance claims?
Infrastructure	Has there been any damage to buildings, equipment, or ICT assets? How long will any repairs take?
Environmental	Has the incident produced a large amount of waste? Is there any contaminated waste?
Humanitarian	Is there a plan to offer staff post-incident support, e.g. wellbeing, psychosocial support? Is there a plan to thank staff for their involvement? Is there a plan to help displaced patients? e.g. not from the region
External Interest	Are media statements prepared? Is there a plan if the Trust is asked to accommodate VIP visits? Consider an appropriate place for a memorial, e.g. if people want to leave flowers

Action Card 2 EPRR Incident Response Tactical Commander	
Role: The role of the Tactical (Silver) Commander is to manage the overall response to an incident and coordinate the incident team. In order to achieve this, you will • Develop a tactical action plan to meet the incident aim and objectives • Ensure that critical front-line services are protected and ensure continued delivery of critical services • Maintain contact with external partners where required at a Silver/Tactical level • Be supported by an EPRR Lead who has specialised knowledge on local and multi-agency plans • Establish communication routes and reporting frequency with all relevant command rooms and hubs This role would be filled by the Service Manager (or deputy) during hours, 1st On Call Out of Hours.	
Incident Status – Standby	
Out of hours: liaise with opposite 1st on call manager to clarify who will be the lead.	
Receive briefing from the Bleep Holder as to the scale and nature of the incident	
Complete the IIMARCH briefing template	
Consider whether a physical or virtual response is required for the incident	
Brief the Incident Director of the current situation	
Incident Status: Incident Declared	
Ensure comms is disseminated immediately (pop up or email) to declare the incident (with Lead Comms Officer)	
Activate the ICC – in hours Emergency Planning will support with this	
Activate any specialist plans – in hours Emergency Planning will support with this	
Ensure that the core Hospital Incident Command Team posts have been filled. **Additional personnel with relevant expertise can join the command team however this should be restricted to a minimum number of essential personnel**	
Introduce yourself to the Loggist and start the log. (Maintain your own log until the Loggist arrives)	
Ensure the ICC has made contact with operational hubs to ensure a point of contact and visibility within the ICC of everyone involved	
Establish strategy for reducing workload: - Create capacity in conjunction with divisional bronze leads (e.g. one-over policy, expedite discharges, transfer of patients etc) - Evacuation/redistribution of patients (e.g. ward or floor closure) - Reduce incoming activity (e.g. suspend less critical activities, elective activity, ambulance diverts)	
Agree the **IIMARCH** Briefing model (see information pack) distribute to hubs	

Establish frequency for meetings and frequency of updates required from/to Bronze, and from/to Gold	
Agree an **internal and external comms strategy** with the Lead Comms Officer and Gold	
The next series of actions are no particular order and may need to be repeated throughout the course of the incident.	
Develop and review **action plan** to meet aim and objectives of the incident as agreed with the Hospital Incident Command Team	
Undertake a regular review of the composition of the Hospital Incident Command Team. Consider **staff welfare** and the potential need for staff relief and shift change over.	
Liaise with Silver / Tactical equivalent in external organisations as required	
Approve any additional spending in conjunction with Gold where necessary. Ensure Finance are informed in working hours.	
Escalate to Gold if mutual aid is required	
INCIDENT STATUS: 'Incident Stand down'	
Agree 'Stand Down' arrangements with HICT, cascade information to all staff and partner agencies (with Lead Comms Officer)	
Contact Switchboard and ask for the stand down message to be activated	
Facilitate the hot debrief (this should happen on the same day as closure of the incident	
Ensure all personal logs, handwritten notes and paperwork are handed into the EPRR Team	

Action Card 3 EPRR Incident Response Loggist	
Role: The role of the Loggist (as outlined in the Civil Contingencies Act 2004) is to keep an accurate record of decisions made. The Log can be used later in the case of public enquiry and relied upon in court. The Loggist is not the minute taker at a meeting they are only to record the assigned officer's decisions.	
Incident Status – Standby	
Proceed to the incident room and assist with the set up if not already completed	
Contact the Incident Commander and check additional admin support has been requested.	
Incident Status: Incident Declared	
In Gold liaise with the Incident Coordinator to find out who you are logging for and have a pre-brief with them before you begin. For Silver liaise with whoever requested you to be loggist. The pre-brief with the chair will help you identify what you are meant to log and the sign off process at the end	
Note details of the venue, date, time and if possible complete a table plan of who is present	
• Your entries must be clear, intelligible and accurate • Write in permanent black pen • Your record must be contemporaneous (written at the time) • Ensure you note dates, times (use 24hr clock) places and people concerned • Only note down facts, do not assume anything, give your own comment or opinion • Entries in the record must be in chronological order	
NO ELBOWS • **No E**rasures • **No L**eaves must be torn out of the Log Book • **No B**lank spaces – rule them through • **No O**verwriting • **No W**riting above or below lined area • Unused space at end of a page must be ruled through with a diagonal line, initialled by you, dated and timed • Record all questions and answers in direct speech • Unused spaces must be ruled out with a single line • Mistakes must be ruled through with a single line and initialled • Any mistake you make which you notice at the time of writing must be ruled through by you with a single line, initialled and the correct word added after the mistake.	
INCIDENT STATUS: 'Incident Stand down'	
Log the decision to stand down the incident response	
Go through the log with the decision maker and debrief – sign off the log at the end of the shift and ensure the integrity of the record	
Attend the hot debrief	

Action Card 4 EPRR Incident Response EPRR Lead	
Role: • To provide command support and advice to the Incident Management Team in line with this action card and knowledge of associated incident response plans. • Liaise with external agencies through the Local Resilience Forum, Resilience Direct and Tactical Coordination Group (TCG) where required. • Compile the IIMARCH assessment template with Silver/Gold • Collate all paperwork from the incident following declaration of stand down. • Prepare debrief and follow up in conjunction with the EPRR team This role would be filled by the EPRR Team during working hours.	
Incident Status – Standby	
Receive briefing from the Bleep Holder/Incident Commander as to the scale and nature of the incident	
Complete the IIMARCH briefing template	
Consider whether a physical or virtual response is required for the incident	
Incident Status: Incident Declared	
Proceed to the relevant ICC and assist with setting up the room for management of the incident	
Compile the IIMARCH incident briefing with the Silver and/or Gold Commander.	
Advise Commanders on any internal or external policies or plans which need to be enacted. Contribute to the decision management process and ensure the widest range of options are identified before decisions are made. Advise on the likely consequences that may result from any actions proposed. Provide impartial advice to the Incident Management Team when requested	
Identify Loggist available to attend the ICC. Brief and support them.	
Ensure frequency of updates to and from hubs and Gold command has been established	
Ensure an internal and external comms strategy has been established	
Where required, ensure DHCFT representation is organised to attend / dial into TCG/SCG as requested locally. Assist or undertake this function as required.	
Ensure you have logged on to Resilience Direct for sharing of information from partner agencies.	
Assist Silver Commander in managing staff welfare within the ICC	
INCIDENT STATUS: 'Incident Stand down'	
Following stand down, collate all documentation in relation to the incident for cataloguing and retention	
Prompt commander to conduct a hot debrief	

Action Card 5 EPRR Incident Response Communications Representative	
Role: • To offer expert advice and guidance to the incident commanders on the Communications Strategy for the incident • Prepare and distribute the Trust communications for patients, staff and partners • Management of Media and external communication requests • Link with partner agency communications teams for a consistent message and approach	
Incident Status – Standby	
Obtain a full update of the situation from the Strategic Commander or Tactical Commander within the Incident Coordination Centre (ICC). Decide on the need to attend at this stage or not	
Incident Status: Incident Declared	
Consider whether it is necessary to attend the Incident Coordination Centre	
Receive a briefing from the Incident Commander and consider any further initial actions required from a communications perspective	
Commence a log for the incident	
Make contact with comms leads from partner agencies	
Facilitate any media requests and maintain a log	
Identify a spokesperson in the early stages of the incident, establish a timetable with spokespeople	
Prepare all staff emails informing them of the incident and maintain updates throughout	
Keep a log of all decisions made, times, and rationale.	
INCIDENT STATUS: 'Incident Stand down'	
Prepare all staff email to inform them of the change in incident status. Liaise with partners to provide an update	
Consider recovery actions required to support the return to business as usual	
Ensure all paperwork relating to the incident is collated and made available to the EPRR team	
Participate in a hot debrief with the Incident Commander	

Action Card 6 EPRR Incident Response Bleep Holder	
Role: To coordinate the Operational Hub in response to the incident. Acting as a conduit for information and sharing situational awareness.	
Incident Status – Standby	
Consider whether an incident requires escalation and a more coordinated approach.	
Prepare a briefing for staff and begin collating information to share with the Senior Medic & Tactical Commander	
Incident Status: Incident Declared	
• Ensure you have a full briefing on the incident from Silver Commander and are able to brief staff within your teams/wards. • Follow the Joint Decision Model	
Consult Business Continuity Plans and ensure all staff are able to access them.	
Confirm your contact details with Silver Command and with your own staff – (email and telephone.)	
Consider identifying a deputy Bronze Commander and consider sending them home to come on shift later if required to continue response 24/7.	
Clarify when you must provide situation reports (sitreps) to Silver or Gold Command and ensure that you assign ample time to gather information. Ensure all staff are aware of sitrep requirements	
Ensure that formal handovers take place between Bronze Commanders and that Silver Command always has details of your and your deputy's telephone and email.	
Keep a log of all decisions made, times, and rationale.	
INCIDENT STATUS: 'Incident Stand down'	
Consider recovery actions required to support the return to business as usual	
Ensure all paperwork relating to the incident is collated and made available to the EPRR team	
Participate in a hot debrief with the Senior Medic and Tactical Commander	
Facilitate a hot debrief with senior nurses on the unit	

Action Card 7 EPRR Incident Response Switchboard	
Role: To take the initial alert in relation to the incident and support with further calls as required.	
Incident Status – Standby	
On receipt of the call, make a note of the following information M – Major incident declared? Y/N E – Exact Location T – type of incident H – Any known hazards? A – Access / Egress issues? N – Number of casualties? E – Emergency Services on scene/other agencies?	
Provide all of this information immediately to the Chief Operating Officer during hours and 1st On call Manager out of hours.	
Undertaken actions as required by the Chief Operating Officer or EPRR Team to support incident response	
Incident Status: Incident Declared	
Complete actions as above – note that standby may not be declared.	
Maintain a communications log recording all telephone calls associated with the incident	
Any further calls providing updates on the incident must be shared with the COO or On Call Managers	
If calls are received by the media or members of the public they must be directed to	
INCIDENT STATUS: 'Incident Stand down'	
Attend the hot debrief	

Action Card 8 EPRR Incident Response Chaplaincy	
Role: To attend the site of the incident and offer pastoral support to staff, patients and visitors to the site.	
Incident Status – Standby	
Not usually contacted for incident standby	
Incident Status: Incident Declared	
Make yourself known to the Bleep Holder on site	
Consider whether additional faith representatives are required to support the incident	
Offer support to those on site as required	
For a protracted incident consider establishing a rota with Faith Colleagues to provide an ongoing support role.	
Make sure to maintain a log of decisions or actions taken to support with the incident	
Escalation any issues to the Bleep holder as necessary	
INCIDENT STATUS: 'Incident Stand down'	
Attend the hot debrief with the Bleep holder	
Continue to provide support if required	

Action Card 9 EPRR Incident Response Estates Manager On Call	
Role: • To offer expert advice and guidance to the incident commanders • To coordinate the estates resources in response to the incident	
Incident Status – Standby	
Assess the situation and the impact upon the infrastructure, utility provision and complete a METHANE report.	
Escalate the incident should you deem the requirement for a coordinated response	
Incident Status: Incident Declared	
Attend site and make yourself known to the Service Manager / 1st On Call Manager	
Keep a log of all decisions made, times, and rationale.	
Active the on-call Estate technician, plumber, and electrician as appropriate	
Continue to assess the incident location and consider the need for any additional resources require to support the response	
Act a conduit for estates, utilities, maintenance staff and porters	
Access the readiness of buildings, access to buildings, structure and fabric of buildings any emergency supplies required	
Provide handover to Associate Director of Estates and Facilities or Deputy during office hours	
INCIDENT STATUS: 'Incident Stand down'	
Participate in a hot debrief with the Incident Commander	
Consider recovery actions required to support the return to business as usual	
Ensure all paperwork relating to the incident is collated and made available to the EPRR team	

4.0 Plan Review

The Major Incident Plan will be formally reviewed on an annual basis by the EPRR team and following any incident and/or lessons learned, or changes to legislation and guidance. The amended plan will be presented to the EPRR Steering Group for approval. The Board (or another committee with delegated responsibility for EPRR) will be asked to sign off the plan. Any changes to the plan shall be recorded in the auditing tool by the EPRR team and reflected in the version control of this document.

4.1 Training

The EPRR team will devise and monitor attendance at an ongoing programme of training for staff appropriate to their level of responsibility within the organisation, including members of the on-call rotas. Staff will be expected to complete all modules within the time frame of 12 months. In addition, opportunities will be afforded to staff to participate in relevant training with other organisations.

All new staff will receive basic EPRR awareness training at their induction, covering the organisation's statutory responsibilities and their role in a major incident, linked to identified threats and hazards. All new staff will be told where to find various incident plans.

4.2 Exercises

The EPRR Incident Response Plan will be regularly tested during multi-agency exercises arranged by the LRFs, other local NHS and non-NHS organisations, and through internal table-top exercises. The communications links will be tested on a six-monthly basis. The Trust will undertake/be part of a live exercise every three years.

4.3 Circulation

Copies of the plan will be distributed electronically to those individuals identified in the Register of Holders on page 7 of this plan. A copy of the plan will also be placed on the intranet, physical copies of the plan will be distributed in secure locations, listed on page 7 of this plan.

Version control and distribution is the responsibility of the EPRR Lead who holds the master copy.

4.4 Reporting of Incidents

If any relevant action has been taken by the organisation in relation to an incident, this should be reported through the usual incident reporting procedure. The senior manager on call should ensure that any significant issues reported out of hours are logged on the next working day using the online reporting tool and alert the EPRR team.

4.5 Debrief Procedures

Once the incident has been formally stood down, a debrief should be arranged to discuss any outstanding issues and review incident procedures.

The debrief will seek to identify:

- What was supposed to happen?
- What actually happened?
- Why were there differences?
- What did we learn?
- Are there any improvements to be made to procedures?

The EPRR team will consider if the debrief needs to:

- Take place internally/externally/multi agency?
- Will it take place remotely/in person?
- Will both hot and cold debriefs be needed?

The EPRR team will then collate responses to produce a post incident report and identify lessons learned from the incident. This learning shall then be shared and used to update plans.

It is vital that this post-incident debrief process is recognised as a positive learning process.

Appendix A – Incident aide memoire

What has happened? **Location & Postcode?** **Building Name?**	
Any Casualties? **Number and type?** **Patient(s) & NHS Number(s)?** **Staff?** **Public?**	
Any hazards present? **Live cables?** **Rising floods?** **Risk of infection?**	
Are emergency services required? **Have emergency services been called or on scene?** **Who is the emergency services contact?**	
Do I need to inform others? **Inform Silver/Gold colleagues?** **On call staff?** **Do I need to inform partners?**	
Check resources in on call folder **Have Business Continuity Plans been activated?** **Is this a Business Continuity, Critical or Major Incident?**	
What is required? **Needs?** **Expectations?** **Resources?** **Advice?** **Authority to make decisions?**	

Next Steps **Agree timetable for future calls** **Agree who will join the calls** **If escalating this incident fill out SBAR form.**	
Start a log. **Include all actions/decisions and rationale**	

Appendix B SBAR Template

Situation	Describe situation that has occurred	
Background	Explain background/history of incident and impact on services / patient safety	
Assessment	Confirm your understanding of issues involved	
Recommendation	Explain needs, expectations and what you would like to happen Ask receiver to repeat information to ensure understanding	

Appendix C – Divisional / Service Area Daily Sitrep Template

Divisional / Service Area Details	
Division/Service:	Date:
Name & Role:	Time:
Telephone:	
Email:	
Instructions: • Form to be completed daily by General Managers / Service Managers • Completed forms to be sent to dhcft.EPRR@nhs.net by 1030am • Please complete all fields. If there is nothing to report, or the information request is not applicable, please insert NIL or N/A.	
SITREP	
Operational Issues	
Are you experiencing any serious operational difficulties (e.g. service closure)? Y/N (If yes, please provide details)	
Do you have any issues you wish to escalate?	
Patient Related Issues. Please detail: • Inpatient constraints (i.e. closed beds) • Patients to come in who cannot be accepted immediately and why • Surge in demand • Community pressures	•

Staffing Issues. Please detail • Teams with high absence rates impacting on service delivery • Individual staffing concerns	•
Partner Agency/Locality Issues. Please detail: • All MFFD • Interface issues	•
Support Services Issues (i.e. domestic, IT, estates etc)	

Appendix D Incident Management Team Draft Terms of Reference

Draft Aims for Incident Management Team

- To provide a strategic command and control for the trust across all areas of business in relation to the incident.
- To minimise disruption to trust services caused by the incident.
- To ensure a continued safe and caring environment for patients and staff.
- To ensure coordination of response with external agencies.

Draft Objectives for Incident Management Team

- To consider the impact on service delivery and ensure close liaison with Silver Commanders (Care Group Directors/Associate Nurse Directors).
- To ensure communications with staff, patients, partners and public are accurate, timely and consistent.
- To ensure situation reporting is conducted in a timely manner in line with timetables set by NHS England.
- To ensure appropriate representation of the Trust at any external decision-making bodies.
- Ensure records/logs are kept of Incident Management Team decisions/actions.
- To consider the financial impacts on the Trust of the EPRR incident and, where necessary, make appropriate arrangements to maintain the financial integrity of the Trust.

Chair: Chief Operating Officer / 2nd On Call Manager

Deputy: Managing Directors

Membership

This group comprises of strategic level representatives from teams likely to be integral to the response to the incident. Others may be added at the discretion of the Accountable Emergency Officer (Chief Operating Officer) or deputy. The Incident Management Team provides strategic leadership, and its business should not be duplicated by ELT. It does not provide tactical or operational level decision making. It may comprise of the following:

- Chief Operating Officer
- Executive Medical Director.
- Executive Director of Nursing
- Managing Directors
- Head of Estates & Facilities.
- General Manager IMT & Records
- Deputy Director of Communications & Engagement
- Executive Director of Workforce and Organisational Development.

- Clinical Lead(s) as appropriate.
- EPRR lead.
- Loggist

In Attendance:

- General Managers / Service Managers
- Human Resources Representative
- If required to attend by invitation:
- Information Management Clinical Systems Representative
- Finance Representative
- Chief Pharmacist
- Infection, Prevention and Control Lead
- Staff Side representation

In a lengthy incident deputies should be identified for all Incident Management Team roles.

Also, in a Cyber or Data Security Incident it is a legal requirement for the Data Protection Officer to be informed and involved in all Cyber/Data Security/information incidents.

Specialist subject Cells may be established to provide reports and updates to Gold Command to inform decision making. These may comprise of other members of staff within the Trust who are subject matter experts. Cells may cover subjects such as Recovery, Workforce and Infection Prevention & Control.

Reporting Arrangements

Reporting arrangements to external agencies can be found in Section 2. Scale and frequency of internal reporting to and from Tactical and Operational hubs is at the discretion of the Trust Incident Management Team.

Appendix E – Incident Management Team Draft Agenda

Date:

Time:

Location:

Chair:

Attendees:

No.	Item	Decision/Action
1	Appointment of Chair • Welcome and Introductions • Review of attendance	
2	Purpose of Meeting and Aims and Objectives • Coordinate a strategic response and maintain strategic focus Perseveration of life mitigate impact Prevent further harm Return to normal asap These might be general aims e.g. to ensure patient safety, delivery of critical services and prompt and accurate communication and specific ones e.g. supporting safe evacuation of a particular ward. Keep it	

	strategic for Gold Command leave tactical and operational matters to Silver and Bronze.	
3	Urgent Actions for Attention • Assistance required – E.g. from teams under pressure. • Identification of areas at risk – vulnerable infrastructure, people, teams. • Actions from previous Gold Command Meetings.	
4	Situational Update all Divisions and Services • Headlines from Silver Commands. • Silver Command Situation Reports.	
5	Bring in information from partner agencies/dial ins E.g. if flooding: • Met Office • Environment Agency • Local Authority In other scenarios information may come from NHSE, ICB, UKHSA or Local Authorities.	
6	Response Strategy Consider	

	• Direct and wider impacts – for patients, staff, health, infrastructure – e.g. buildings, essential services. • The operational response – response impact on capability and capacity. • Significant risks, emerging issues • Assumptions and critical uncertainties • Requirement for activation of assistance (mutual aid) • Forward look – set up support cells for Gold e.g. Workforce, IPC, Recovery.	
7	Communication Strategy Patients, Staff, Partners. Agree lines to take with stakeholders and agree with communications teams at any external agencies involved, e.g. emergency services, local authority, ICBs, NHSE, UKHSA etc	
8	Review of Actions Development of Situation Report. Ensure you agree a written sitrep when you have received all the information and circulate this as widely as is appropriate post meeting.	
9	Review of Gold Command Membership – Consider who needs to be at future meetings.	
10	Date and time of next meeting	
11	Agree Log with Loggist	

Ref	Domain	Standard name	Standard Detail	Mental Health Providers	Supporting Information - including examples of evidence
Domain 1 - Governance					
1	**Governance**	**Senior Leadership**	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director within their individual organisation, and have the appropriate authority, resources and budget to direct the EPRR portfolio.	Y	Evidence • Name and role of appointed individual • AEO responsibilities included in role/job description
2	**Governance**	**EPRR Policy Statement**	The organisation has an overarching EPRR policy or statement of intent. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes.	Y	The policy should: • Have a review schedule and version control • Use unambiguous terminology • Identify those responsible for ensuring policies and arrangements are updated, distributed and regularly tested and exercised • Include references to other sources of information and supporting documentation. Evidence Up to date EPRR policy or statement of intent that includes: • Resourcing commitment • Access to funds • Commitment to Emergency Planning, Business Continuity, Training, Exercising etc.
3	**Governance**	**EPRR board reports**	The Chief Executive Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board, no less than annually. The organisation publicly states its readiness and preparedness activities in annual reports within the organisation's own regulatory reporting requirements	Y	These reports should be taken to a public board, and as a minimum, include an overview on: • training and exercises undertaken by the organisation • summary of any business continuity, critical incidents and major incidents experienced by the organisation • lessons identified and learning undertaken from incidents and exercises • the organisation's compliance position in relation to the latest NHS England EPRR assurance process. Evidence • Public Board meeting minutes • Evidence of presenting the results of the annual EPRR assurance process to the Public Board • For those organisations that do not have a public board, a public statement of readiness and preparedness activitites.
4	**Governance**	**EPRR work programme**	The organisation has an annual EPRR work programme, informed by: • current guidance and good practice • lessons identified from incidents and exercises • identified risks • outcomes of any assurance and audit processes The work programme should be regularly reported upon and shared with partners where appropriate.	Y	Evidence • Reporting process explicitly described within the EPRR policy statement • Annual work plan
5	**Governance**	**EPRR Resource**	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource to ensure it can fully discharge its EPRR duties.	Y	Evidence • EPRR Policy identifies resources required to fulfil EPRR function; policy has been signed off by the organisation's Board • Assessment of role / resources • Role description of EPRR Staff/ staff who undertake the EPRR responsibilities • Organisation structure chart • Internal Governance process chart including EPRR group

Ref	Domain	Standard name	Standard Detail	Mental Health Providers	Supporting Information - including examples of evidence
6	Governance	Continuous improvement	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the review and embed into EPRR arrangements.	Y	Evidence • Process explicitly described within the EPRR policy statement • Reporting those lessons to the Board/ governing body and where the improvements to plans were made • participation within a regional process for sharing lessons with partner organisations
Domain 2 - Duty to risk assess					
7	Duty to risk assess	Risk assessment	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider all relevant risk registers including community and national risk registers.	Y	• Evidence that EPRR risks are regularly considered and recorded • Evidence that EPRR risks are represented and recorded on the organisations corporate risk register • Risk assessments to consider community risk registers and as a core component, include reasonable worst-case scenarios and extreme events for adverse weather
8	Duty to risk assess	Risk Management	The organisation has a robust method of reporting, recording, monitoring, communicating, and escalating EPRR risks internally and externally	Y	Evidence • EPRR risks are considered in the organisation's risk management policy • Reference to EPRR risk management in the organisation's EPRR policy document
Domain 3 - Duty to maintain Plans					
9	Duty to maintain plans	Collaborative planning	Plans and arrangements have been developed in collaboration with relevant stakeholders to ensure the whole patient pathway is considered.	Y	Partner organisations collaborated with as part of the planning process are in planning arrangements Evidence • Consultation process in place for plans and arrangements • Changes to arrangements as a result of consultation are recorded
10	Duty to maintain plans	Incident Response	In line with current guidance and legislation, the organisation has effective arrangements in place to define and respond to Critical and Major incidents as defined within the EPRR Framework.	Y	Arrangements should be: • current (reviewed in the last 12 months) • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
11	Duty to maintain plans	Adverse Weather	In line with current guidance and legislation, the organisation has effective arrangements in place for adverse weather events.	Y	Arrangements should be: • current • in line with current national UK Health Security Agency (UKHSA) & NHS guidance and Met Office or Environment Agency alerts • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required • reflective of climate change risk assessments • cognisant of extreme events e.g. drought, storms (including dust storms), wildfire.

Ref	Domain	Standard name	Standard Detail	Mental Health Providers	Supporting Information - including examples of evidence
12	**Duty to maintain plans**	**Infectious disease**	In line with current guidance and legislation, the organisation has arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including High Consequence Infectious Diseases.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Acute providers should ensure their arrangements reflect the guidance issued by DHSC in relation to FFP3 Resilience in Acute setting incorporating the FFP3 resilience principles.
13	**Duty to maintain plans**	**New and emerging pandemics**	In line with current guidance and legislation and reflecting recent lessons identified, the organisation has arrangements in place to respond to a new and emerging pandemic	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
14	**Duty to maintain plans**	**Countermeasures**	In line with current guidance and legislation, the organisation has arrangements in place to support an incident requiring countermeasures or a mass countermeasure deployment	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Mass Countermeasure arrangements should include arrangements for administration, reception and distribution of mass prophylaxis and mass vaccination. There may be a requirement for Specialist providers, Community Service Providers, Mental Health and Primary Care services to develop or support Mass Countermeasure distribution arrangements. Organisations should have plans to support patients in their care during activation of mass countermeasure arrangements. Commissioners may be required to commission new services to support mass countermeasure distribution locally, this will be dependant on the incident.
15	**Duty to maintain plans**	**Mass Casualty**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to incidents with mass casualties.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Receiving organisations should also include a safe identification system for unidentified patients in an emergency/mass casualty incident where necessary.

Ref	Domain	Standard name	Standard Detail	Mental Health Providers	Supporting Information - including examples of evidence
16	**Duty to maintain plans**	**Evacuation and shelter**	In line with current guidance and legislation, the organisation has arrangements in place to evacuate and shelter patients, staff and visitors.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
17	**Duty to maintain plans**	**Lockdown**	In line with current guidance, regulation and legislation, the organisation has arrangements in place to control access and egress for patients, staff and visitors to and from the organisation's premises and key assets in an incident.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
18	**Duty to maintain plans**	**Protected individuals**	In line with current guidance and legislation, the organisation has arrangements in place to respond and manage 'protected individuals' including Very Important Persons (VIPs),high profile patients and visitors to the site.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
19	**Duty to maintain plans**	**Excess fatalities**	The organisation has contributed to, and understands, its role in the multiagency arrangements for excess deaths and mass fatalities, including mortuary arrangements. This includes arrangements for rising tide and sudden onset events.	Y	Arrangements should be: • current • in line with current national guidance in line with DVI processes • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required

Ref	Domain	Standard name	Standard Detail	Mental Health Providers	Supporting Information - including examples of evidence
Domain 4 - Command and control					
20	**Command and control**	**On-call mechanism**	The organisation has resilient and dedicated mechanisms and structures to enable 24/7 receipt and action of incident notifications, internal or external. This should provide the facility to respond to or escalate notifications to an executive level.	Y	• Process explicitly described within the EPRR policy statement • On call Standards and expectations are set out • Add on call processes/handbook available to staff on call • Include 24 hour arrangements for alerting managers and other key staff. • CSUs where they are delivering OOHs business critical services for providers and commissioners
21	**Command and control**	**Trained on-call staff**	Trained and up to date staff are available 24/7 to manage escalations, make decisions and identify key actions	Y	• Process explicitly described within the EPRR policy or statement of intent The identified individual: • Should be trained according to the NHS England EPRR competencies (National Minimum Occupational Standards) • Has a specific process to adopt during the decision making • Is aware who should be consulted and informed during decision making • Should ensure appropriate records are maintained throughout. • Trained in accordance with the TNA identified frequency.
Domain 5 - Training and exercising					
22	**Training and exercising**	**EPRR Training**	The organisation carries out training in line with a training needs analysis to ensure staff are current in their response role.	Y	Evidence • Process explicitly described within the EPRR policy or statement of intent • Evidence of a training needs analysis • Training records for all staff on call and those performing a role within the ICC • Training materials • Evidence of personal training and exercising portfolios for key staff
23	**Training and exercising**	**EPRR exercising and testing programme**	In accordance with the minimum requirements, in line with current guidance, the organisation has an exercising and testing programme to safely* test incident response arrangements, (*no undue risk to exercise players or participants, or those patients in your care)	Y	Organisations should meet the following exercising and testing requirements: • a six-monthly communications test • annual table top exercise • live exercise at least once every three years • command post exercise every three years. The exercising programme must: • identify exercises relevant to local risks • meet the needs of the organisation type and stakeholders • ensure warning and informing arrangements are effective. Lessons identified must be captured, recorded and acted upon as part of continuous improvement. Evidence • Exercising Schedule which includes as a minimum one Business Continuity exercise • Post exercise reports and embedding learning
24	**Training and exercising**	**Responder training**	The organisation has the ability to maintain training records and exercise attendance of all staff with key roles for response in accordance with the Minimum Occupational Standards. Individual responders and key decision makers should be supported to maintain a continuous personal development portfolio including involvement in exercising and incident response as well as any training undertaken to fulfil their role	Y	Evidence • Training records • Evidence of personal training and exercising portfolios for key staff

Ref	Domain	Standard name	Standard Detail	Mental Health Providers	Supporting Information - including examples of evidence
25	**Training and exercising**	**Staff Awareness & Training**	There are mechanisms in place to ensure staff are aware of their role in an incident and where to find plans relevant to their area of work or department.	Y	As part of mandatory training Exercise and Training attendance records reported to Board
Domain 6 - Response					
26	**Response**	**Incident Co-ordination Centre (ICC)**	The organisation has in place suitable and sufficient arrangements to effectively coordinate the response to an incident in line with national guidance. ICC arrangements need to be flexible and scalable to cope with a range of incidents and hours of operation required. An ICC must have dedicated business continuity arrangements in place and must be resilient to loss of utilities, including telecommunications, and to external hazards. ICC equipment should be tested in line with national guidance or after a major infrastructure change to ensure functionality and in a state of organisational readiness. Arrangements should be supported with access to documentation for its activation and operation.	Y	• Documented processes for identifying the location and establishing an ICC • Maps and diagrams • A testing schedule • A training schedule • Pre identified roles and responsibilities, with action cards • Demonstration ICC location is resilient to loss of utilities, including telecommunications, and external hazards • Arrangements might include virtual arrangements in addition to physical facilities but must be resilient with alternative contingency solutions.
27	**Response**	**Access to planning arrangements**	Version controlled current response documents are available to relevant staff at all times. Staff should be aware of where they are stored and should be easily accessible.	Y	Planning arrangements are easily accessible - both electronically and local copies
28	**Response**	**Management of business continuity incidents**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).	Y	• Business Continuity Response plans • Arrangements in place that mitigate escalation to business continuity incident • Escalation processes
29	**Response**	**Decision Logging**	To ensure decisions are recorded during business continuity, critical and major incidents, the organisation must ensure: 1. Key response staff are aware of the need for creating their own personal records and decision logs to the required standards and storing them in accordance with the organisations' records management policy. 2. has 24 hour access to a trained loggist(s) to ensure support to the decision maker	Y	• Documented processes for accessing and utilising loggists • Training records
30	**Response**	**Situation Reports**	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to incidents including bespoke or incident dependent formats.	Y	• Documented processes for completing, quality assuring, signing off and submitting SitReps • Evidence of testing and exercising • The organisation has access to the standard SitRep Template
31	**Response**	**Access to 'Clinical Guidelines for Major Incidents and Mass Casualty events'**	Key clinical staff (especially emergency department) have access to the 'Clinical Guidelines for Major Incidents and Mass Casualty events' handbook.		Guidance is available to appropriate staff either electronically or hard copies

Ref	Domain	Standard name	Standard Detail	Mental Health Providers	Supporting Information - including examples of evidence
32	**Response**	**Access to 'CBRN incident: Clinical Management and health protection'**	Clinical staff have access to the 'CBRN incident: Clinical Management and health protection' guidance. (Formerly published by PHE)		Guidance is available to appropriate staff either electronically or hard copies
Domain 7 - Warning and informing					
33	**Warning and informing**	**Warning and informing**	The organisation aligns communications planning and activity with the organisation's EPRR planning and activity.	Y	• Awareness within communications team of the organisation's EPRR plan, and how to report potential incidents. • Measures are in place to ensure incidents are appropriately described and declared in line with the NHS EPRR Framework. • Out of hours communication system (24/7, year-round) is in place to allow access to trained comms support for senior leaders during an incident. This should include on call arrangements. • Having a process for being able to log incoming requests, track responses to these requests and to ensure that information related to incidents is stored effectively. This will allow organisations to provide evidence should it be required for an inquiry.
34	**Warning and informing**	**Incident Communication Plan**	The organisation has a plan in place for communicating during an incident which can be enacted.	Y	• An incident communications plan has been developed and is available to on call communications staff • The incident communications plan has been tested both in and out of hours • Action cards have been developed for communications roles • A requirement for briefing NHS England regional communications team has been established • The plan has been tested, both in and out of hours as part of an exercise. • Clarity on sign off for communications is included in the plan, noting the need to ensure communications are signed off by incident leads, as well as NHSE (if appropriate).
35	**Warning and informing**	**Communication with partners and stakeholders**	The organisation has arrangements in place to communicate with patients, staff, partner organisations, stakeholders, and the public before, during and after a major incident, critical incident or business continuity incident.	Y	• Established means of communicating with staff, at both short notice and for the duration of the incident, including out of hours communications • A developed list of contacts in partner organisations who are key to service delivery (local Council, LRF partners, neighbouring NHS organisations etc) and a means of warning and informing these organisations about an incident as well as sharing communications information with partner organisations to create consistent messages at a local, regional and national level. • A developed list of key local stakeholders (such as local elected officials, unions etc) and an established a process by which to brief local stakeholders during an incident • Appropriate channels for communicating with members of the public that can be used 24/7 if required • Identified sites within the organisation for displaying of important public information (such as main points of access) • Have in place a means of communicating with patients who have appointments booked or are receiving treatment. • Have in place a plan to communicate with inpatients and their families or care givers. • The organisation publicly states its readiness and preparedness activities in annual reports within the organisations own regulatory reporting requirements
36	**Warning and informing**	**Media strategy**	The organisation has arrangements in place to enable rapid and structured communication via the media and social media	Y	• Having an agreed media strategy and a plan for how this will be enacted during an incident. This will allow for timely distribution of information to warn and inform the media • Develop a pool of media spokespeople able to represent the organisation to the media at all times. • Social Media policy and monitoring in place to identify and track information on social media relating to incidents. • Setting up protocols for using social media to warn and inform • Specifying advice to senior staff to effectively use social media accounts whilst the organisation is in incident response
Domain 8 - Cooperation					

Ref	Domain	Standard name	Standard Detail	Mental Health Providers	Supporting Information - including examples of evidence
37	**Cooperation**	**LHRP Engagement**	The Accountable Emergency Officer, or a director level representative with delegated authority (to authorise plans and commit resources on behalf of their organisation) attends Local Health Resilience Partnership (LHRP) meetings.	Y	• Minutes of meetings • Individual members of the LHRP must be authorised by their employing organisation to act in accordance with their organisational governance arrangements and their statutory status and responsibilities.
38	**Cooperation**	**LRF / BRF Engagement**	The organisation participates in, contributes to or is adequately represented at Local Resilience Forum (LRF) or Borough Resilience Forum (BRF), demonstrating engagement and co-operation with partner responders.	Y	• Minutes of meetings • A governance agreement is in place if the organisation is represented and feeds back across the system
39	**Cooperation**	**Mutual aid arrangements**	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies. In line with current NHS guidance, these arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.	Y	• Detailed documentation on the process for requesting, receiving and managing mutual aid requests • Templates and other required documentation is available in ICC or as appendices to IRP • Signed mutual aid agreements where appropriate
40	**Cooperation**	**Arrangements for multi area response**	The organisation has arrangements in place to prepare for and respond to incidents which affect two or more Local Health Resilience Partnership (LHRP) areas or Local Resilience Forum (LRF) areas.		• Detailed documentation on the process for coordinating the response to incidents affecting two or more LHRPs • Where an organisation sits across boundaries the reporting route should be clearly identified and known to all
41	**Cooperation**	**Health tripartite working**	Arrangements are in place defining how NHS England, the Department of Health and Social Care and UK Health Security Agency (UKHSA) will communicate and work together, including how information relating to national emergencies will be cascaded.		• Detailed documentation on the process for managing the national health aspects of an emergency
42	**Cooperation**	**LHRP Secretariat**	The organisation has arrangements in place to ensure that the Local Health Resilience Partnership (LHRP) meets at least once every 6 months.		• LHRP terms of reference • Meeting minutes • Meeting agendas
43	**Cooperation**	**Information sharing**	The organisation has an agreed protocol(s) for sharing appropriate information pertinent to the response with stakeholders and partners, during incidents.	Y	• Documented and signed information sharing protocol • Evidence relevant guidance has been considered, e.g. Freedom of Information Act 2000, General Data Protection Regulation 2016, Caldicott Principles, Safeguarding requirements and the Civil Contingencies Act 2004

Ref	Domain	Standard name	Standard Detail	Mental Health Providers	Supporting Information - including examples of evidence
Domain 9 - Business Continuity					
44	**Business Continuity**	**BC policy statement**	The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the commitment to a Business Continuity Management System (BCMS) that aligns to the ISO standard 22301.	Y	The organisation has in place a policy which includes intentions and direction as formally expressed by its top management. The BC Policy should: • Provide the strategic direction from which the business continuity programme is delivered. • Define the way in which the organisation will approach business continuity. • Show evidence of being supported, approved and owned by top management. • Be reflective of the organisation in terms of size, complexity and type of organisation. • Document any standards or guidelines that are used as a benchmark for the BC programme. • Consider short term and long term impacts on the organisation including climate change adaption planning
45	**Business Continuity**	**Business Continuity Management Systems (BCMS) scope and objectives**	The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented. A definition of the scope of the programme ensures a clear understanding of which areas of the organisation are in and out of scope of the BC programme.	Y	BCMS should detail: • Scope e.g. key products and services within the scope and exclusions from the scope • Objectives of the system • The requirement to undertake BC e.g. Statutory, Regulatory and contractual duties • Specific roles within the BCMS including responsibilities, competencies and authorities. • The risk management processes for the organisation i.e. how risk will be assessed and documented (e.g. Risk Register), the acceptable level of risk and risk review and monitoring process • Resource requirements • Communications strategy with all staff to ensure they are aware of their roles • alignment to the organisations strategy, objectives, operating environment and approach to risk. • the outsourced activities and suppliers of products and suppliers. • how the understanding of BC will be increased in the organisation
46	**Business Continuity**	**Business Impact Analysis/Assessment (BIA)**	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(es).	Y	The organisation has identified prioritised activities by undertaking a strategic Business Impact Analysis/Assessments. Business Impact Analysis/Assessment is the key first stage in the development of a BCMS and is therefore critical to a business continuity programme. Documented process on how BIA will be conducted, including: • the method to be used • the frequency of review • how the information will be used to inform planning • how RA is used to support. The organisation should undertake a review of its critical function using a Business Impact Analysis/assessment. Without a Business Impact Analysis organisations are not able to assess/assure compliance without it. The following points should be considered when undertaking a BIA: • Determining impacts over time should demonstrate to top management how quickly the organisation needs to respond to a disruption. • A consistent approach to performing the BIA should be used throughout the organisation. • BIA method used should be robust enough to ensure the information is collected consistently and impartially.

Ref	Domain	Standard name	Standard Detail	Mental Health Providers	Supporting Information - including examples of evidence
47	Business Continuity	Business Continuity Plans (BCP)	The organisation has business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure	Y	Documented evidence that as a minimum the BCP checklist is covered by the various plans of the organisation. Ensure BCPS are Developed using the ISO 22301 and the NHS Toolkit. BC Planning is undertaken by an adequately trained person and contain the following: • Purpose and Scope • Objectives and assumptions • Escalation & Response Structure which is specific to your organisation. • Plan activation criteria, procedures and authorisation. • Response teams roles and responsibilities. • Individual responsibilities and authorities of team members. • Prompts for immediate action and any specific decisions the team may need to make. • Communication requirements and procedures with relevant interested parties. • Internal and external interdependencies. • Summary Information of the organisations prioritised activities. • Decision support checklists • Details of meeting locations • Appendix/Appendices
48	Business Continuity	Testing and Exercising	The organisation has in place a procedure whereby testing and exercising of Business Continuity plans is undertaken on a yearly basis as a minimum, following organisational change or as a result of learning from other business continuity incidents.	Y	Confirm the type of exercise the organisation has undertaken to meet this sub standard: • Discussion based exercise • Scenario Exercises • Simulation Exercises • Live exercise • Test • Undertake a debrief Evidence Post exercise/ testing reports and action plans
49	Business Continuity	Data Protection and Security Toolkit	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	Y	Evidence • Statement of compliance • Action plan to obtain compliance if not achieved
50	Business Continuity	BCMS monitoring and evaluation	The organisation's BCMS is monitored, measured and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.	Y	• Business continuity policy • BCMS • performance reporting • Board papers
51	Business Continuity	BC audit	The organisation has a process for internal audit, and outcomes are included in the report to the board. The organisation has conducted audits at planned intervals to confirm they are conforming with its own business continuity programme.	Y	• process documented in EPRR policy/Business continuity policy or BCMS aligned to the audit programme for the organisation • Board papers • Audit reports • Remedial action plan that is agreed by top management. • An independent business continuity management audit report. • Internal audits should be undertaken as agreed by the organisation's audit planning schedule on a rolling cycle. • External audits should be undertaken in alignment with the organisations audit programme

Ref	Domain	Standard name	Standard Detail	Mental Health Providers	Supporting Information - including examples of evidence
52	**Business Continuity**	**BCMS continuous improvement process**	There is a process in place to assess the effectiveness of the BCMS and take corrective action to ensure continual improvement to the BCMS.	Y	• process documented in the EPRR policy/Business continuity policy or BCMS • Board papers showing evidence of improvement • Action plans following exercising, training and incidents • Improvement plans following internal or external auditing •Changes to suppliers or contracts following assessment of suitability Continuous Improvement can be identified via the following routes: • Lessons learned through exercising. • Changes to the organisations structure, products and services, infrastructure, processes or activities. • Changes to the environment in which the organisation operates. • A review or audit. • Changes or updates to the business continuity management lifecycle, such as the BIA or continuity solutions. • Self assessment • Quality assurance • Performance appraisal • Supplier performance • Management review • Debriefs • After action reviews • Lessons learned through exercising or live incidents
53	**Business Continuity**	**Assurance of commissioned providers / suppliers BCPs**	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements align and are interoperable with their own.	Y	• EPRR policy/Business continuity policy or BCMS outlines the process to be used and how suppliers will be identified for assurance • Provider/supplier assurance framework • Provider/supplier business continuity arrangements This may be supported by the organisations procurement or commercial teams (where trained in BC) at tender phase and at set intervals for critical and/or high value suppliers
54	**Business Continuity**	**Computer Aided Dispatch**	Manual distribution processes for Emergency Operations Centre / Computer Aided Dispatch systems are in place and have been fully tested annually, with learning identified, recorded and acted upon		• Exercising Schedule • Evidence of post exercise reports and embedding learning
Domain 10 - CBRN					
55	**CBRN**	**Telephony advice for CBRN exposure**	Key clinical staff have access to telephone advice for managing patients involved in CBRN incidents.	Y	Staff are aware of the number / process to gain access to advice through appropriate planning arrangements
56	**CBRN**	**HAZMAT / CBRN planning arrangement**	There are documented organisation specific HAZMAT/ CBRN response arrangements.	Y	Evidence of: • command and control structures • procedures for activating staff and equipment • pre-determined decontamination locations and access to facilities • management and decontamination processes for contaminated patients and fatalities in line with the latest guidance • interoperability with other relevant agencies • plan to maintain a cordon / access control • arrangements for staff contamination • plans for the management of hazardous waste • stand-down procedures, including debriefing and the process of recovery and returning to (new) normal processes • contact details of key personnel and relevant partner agencies

Ref	Domain	Standard name	Standard Detail	Mental Health Providers	Supporting Information - including examples of evidence
57	**CBRN**	**HAZMAT / CBRN risk assessments**	HAZMAT/ CBRN decontamination risk assessments are in place appropriate to the organisation. This includes: • Documented systems of work • List of required competencies • Arrangements for the management of hazardous waste.	Y	• Impact assessment of CBRN decontamination on other key facilities
58	**CBRN**	**Decontamination capability availability 24 /7**	The organisation has adequate and appropriate decontamination capability to manage self presenting patients (minimum four patients per hour), 24 hours a day, 7 days a week.		Rotas of appropriately trained staff availability 24 /7
59	**CBRN**	**Equipment and supplies**	The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients. • Acute providers - see Equipment checklist: https://www.england.nhs.uk/ourwork/eprr/hm/ • Community, Mental Health and Specialist service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf • Initial Operating Response (IOR) DVD and other material: http://www.jesip.org.uk/what-will-jesip-do/training/	Y	Completed equipment inventories; including completion date
60	**CBRN**	**PRPS availability**	The organisation has the expected number of PRPS (sealed and in date) available for immediate deployment. There is a plan and finance in place to revalidate (extend) or replace suits that are reaching their expiration date.		Completed equipment inventories; including completion date
61	**CBRN**	**Equipment checks**	There are routine checks carried out on the decontamination equipment including: • PRPS Suits • Decontamination structures • Disrobe and rerobe structures • Shower tray pump • RAM GENE (radiation monitor) • Other decontamination equipment. There is a named individual responsible for completing these checks		Record of equipment checks, including date completed and by whom.

Ref	Domain	Standard name	Standard Detail	Mental Health Providers	Supporting Information - including examples of evidence
62	**CBRN**	**Equipment Preventative Programme of Maintenance**	There is a preventative programme of maintenance (PPM) in place for the maintenance, repair, calibration and replacement of out of date decontamination equipment for: • PRPS Suits • Decontamination structures • Disrobe and rerobe structures • Shower tray pump • RAM GENE (radiation monitor) • Other equipment		Completed PPM, including date completed, and by whom
63	**CBRN**	**PPE disposal arrangements**	There are effective disposal arrangements in place for PPE no longer required, as indicated by manufacturer / supplier guidance.		Organisational policy
64	**CBRN**	**HAZMAT / CBRN training lead**	The current HAZMAT/ CBRN Decontamination training lead is appropriately trained to deliver HAZMAT/ CBRN training		Maintenance of CPD records
65	**CBRN**	**Training programme**	Internal training is based upon current good practice and uses material that has been supplied as appropriate. Training programmes should include training for PPE and decontamination.	Y	Evidence training utilises advice within: • Primary Care HAZMAT/ CBRN guidance • Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what-will-jesip-do/training/ • A range of staff roles are trained in decontamination techniques • Lead identified for training • Established system for refresher training
66	**CBRN**	**HAZMAT / CBRN trained trainers**	The organisation has a sufficient number of trained decontamination trainers to fully support its staff HAZMAT/ CBRN training programme.		Maintenance of CPD records
67	**CBRN**	**Staff training - decontamination**	Staff who are most likely to come into contact with a patient requiring decontamination understand the requirement to isolate the patient to stop the spread of the contaminant.	Y	Evidence training utilises advice within: • Primary Care HAZMAT/ CBRN guidance • Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what-will-jesip-do/training/ • Community, Mental Health and Specialist service providers - see Response Box in 'Preparation for Incidents Involving Hazardous Materials - Guidance for Primary and Community Care Facilities' (NHS London, 2011). Found at: http://www.londonccn.nhs.uk/_store/documents/hazardous-material-incident-guidance-for-primary-and-community-care.pdf • A range of staff roles are trained in decontamination technique
68	**CBRN**	**FFP3 access**	Organisations must ensure staff who may come into contact with confirmed infectious respiratory viruses have access to, and are trained to use, FFP3 mask protection (or equivalent) 24/7.	Y	

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 6 September 2022

WRES and WDES 2021-22 submission update

Purpose of Report

To update the Trust Board on progress with the work on the 2021-22 Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) submissions.

To request Board delegated authority for the People and Culture Committee (PCC) meeting to approve the Action Plan Submissions for 31 October deadlines respectively at the meeting of the Committee on 20 September 2022.

Executive Summary

The WRES is a set of evidence-based indicators that compare the workplace experience of Black and Minority Ethnic (BME) staff and white staff. The WDES compares the workplace experience of staff living with disabilities or long-term conditions and non-disabled staff.

NHS organisations must submit the WRES and WDES datasets to NHS England by 31 August 2022 and this year's submission has been made. The WRES and WDES dataset and corresponding action plan must then by published on the Trust's public-facing website by 31 October 2022. Finally, the completed reports must then be shared with commissioners as part of the quality schedule.

The datasets have been shared with a range of stakeholders.The national schedule for submitting data and developing plans has always been a challenge impacting on the quality of full discussions with different networks and groups. It has been a source of frustration for all those engaged in this planning process.

Last year we extended the engagement beyond the networks and the Executive Leadership Team (ELT) to include management teams to encourage ownership and involvement across the organisation. Our WRES expert, Rubina Reza has been increasingly working with and supporting divisions on their plans to address race inequality.

This year we will be implementing a new approach that builds on the process in previous year, gives an opportunity for us to build in conversations and plans on intersectionality, create a more comprehensive engagement approach which has the following elements:

- Actions that are shaped by and connect with delivery of the Joined Up Date Derbyshire (JUCD) Equality Diversity and Inclusion (EDI) Strategy that have been developed in engagement with networks and stakeholders from previous years plans
- Priorities and actions to address this year's data, developed with networks, divisions and with trust wide engagement

The JUCD EDI strategy was developed with extensive engagement across the system and provides our approach to delivery of the Midlands Race Equality and Inclusion Strategy, WRES, WDES and Model Employer targets.

The first part of the plan will be submitted to the People and Culture Committee in September, these plans are already committed and have had full engagement locally and where appropriate at system level. They are generally commitments that span more than one year and are rolled into this year.

The wider plan will be developed in the context of this year's data. We will identify the top three metrics to be addressed in year, along with the actions that will be progressed to achieve those.

The numbers of people attending the networks is lower than we would want, although there is a group of people for both the BME and Disability and Long Term Conditions network who are highly committed, engaged and active. This year we will discuss with the networks an approach to open up much wider involvement through trust wider engagement events.

A review of plans with networks and stakeholders will take place quarterly thereafter and these will be reported into the People and Culture Committee and be revised on the website accordingly.

At the November Trust Board we will present the WRES and WDES data submission, explore what that is telling us, share the priorities that have been identified and the full year plan.

It is important to note that the network sponsor is a vital part of supporting networks to maximise their impact and the value they feel. We made some changes this year which have been very well received. Our CEO has been the sponsor for the BME Network and with his imminent departure we will revisit the allocation of sponsors. This will be done in conjunction with a review of the network framework all aimed at maximising the engagement, impact and experience of the networks.

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

Assurances

- Delivery against the action plans for the WRES and WDES is monitored by the Executive Leadership team.

- The new Trust Operational Oversight Meeting with senior leaders has regular agenda items on EDI.
- A live set of data has been established this year so we can track progress in year and we will extend that further this year.

Consultation

We have commenced the process of engagement with discussions with the Executive Leadership team, Network Chairs and this will progress further as outlined in the paper in September and October.

Governance or Legal Issues

- Reporting the WRES and WDES is a mandatory requirement of the NHS Standard Contract. The Trust is required to submit the WRES and WDES datasets to NHS England by 31 August 2022. This has been completed.

  The WRES and WDES dataset and action plan must be published on the Trust's external website by 30 October 2022.

- Undertaking the WRES and WDES demonstrates the Trust's commitment to the Equality Act 2010 and the Public Sector Equality Duty.

Public Sector Equality Duty and Equality Impact Risk Analysis

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

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

The WRES and WDES provide an overview of the workplace experiences for our Black and Minority Ethnic (BME) staff and our staff with disabilities and/or long-term conditions. Though only covering two of the protected characteristics, the WRES and WDES also gives us an idea of our overall workplace culture for all staff, including rates of bullying, harassment and abuse.

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

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

It is widely acknowledged that focus in any area such as race or disability, creates wider positive equality impacts for other protected characteristics.

Recommendations

The Board of Directors is requested to give delegated authority to People and Culture Committee on 20 September 2022 to approve the 2021-22 WRES and WDES Part 1 Plan.

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

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 6 September 2022

2022/23 Flu Vaccination Campaign

Purpose of Report

To assure the Board of Directors on the proposed plans for the 2022/23 flu vaccination campaign building from performance and experience in 2021/22 and previous years. The report is to provide an overview of the organisation's approach to the Flu Campaign 2022/23.

The paper outlines the necessary steps to achieving the vaccination of frontline healthcare workers for Derbyshire Healthcare NHS Foundation Trust (DHCFT) to reach minimum expectations of 100% offered and 90% Vaccinated.

Executive Summary

The 2022/23 campaign is set to run between October 2022 and February 2023 with an aspiration to vaccinate 90% of the NHS workforce across all sectors. The CQUIN target for 2022 is between 70% and 90% recognising the expanded target group and reduced performance nationally in 2021.

The reporting system developed in 2021 will also allow internal oversight of how many vaccines have been undertaken, how many are booked and who has attended to optimise performance and address any gaps.

Frequently Asked Questions (FAQs) are already being developed based upon initial questions and feedback from colleagues and we will evolve this as the programme develops. Colleagues are interested in the relationship between the Flu and COVID-19, the association with future COVID-19 vaccination programme. The mandated vaccine (VCOD) which was intended to come into effect in early 2022 will likely have polarised opinion towards vaccination and we need to be sensitive to the impact / effect this has on uptake and vary our approach accordingly.

Performance will be monitored through TOOL, divisional oversight and engagement with support from the Flu leadership team. Engagement events and targeted adjustments will be accommodated in response to feedback.

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

Risks and Assurances

- Compliance with COVID-19 IPC guidance and staff safety are core to model
- Ambition is to vaccinate all staff (we have vaccine capacity to do this)
- Systematic approach building upon learning from previous COVID vaccination work and last year's Flu campaign
- Cold store issues and medicines management integral to model to avoid waste and efficiency
- Reporting framework will be monitored through DHCFT vaccination cell meeting.

Consultation

- Feedback from staff has been sought to support the development of the 2022/23 campaign
- Colleagues from Pharmacy, the Health Protection Unit, Communications team and DCHS have been involved in the planning of this year's approach
- Review of previous season's performance and opportunities for improvement.

Governance or Legal Issues

- CQUIN alignment.
- Adherence to the Medicines Act legislation.
- Green Book Immunisation guidance
- COVID-19 Infection prevention Control guidance
- Trust strategy.
- National Immunisation Monitoring Service requirements (NIMS).

Public Sector Equality Duty and Equality Impact Risk Analysis

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

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

The respective needs of all staff have been considered and the ability to access clinics which are Infection Prevention and Control (IPC) compliant, able to offer time and one to one support for those with significant health concerns vulnerabilities if required (longer appointment etc) have been factored in.

There is a risk to the Trust due to insufficient sustainable workforce capacity or less than optimal productivity resulting in an adverse impact on service quality, staff wellbeing and recovery plans. The team have reviewed feedback from previous campaigns to identify lessons learned and opportunities for improvement.

Recommendations

The Board of Directors is requested to:

1) Review the contents and approach and receive significant assurance about the programme being undertaken by the Trust
2) Consider that this plan provides adequate protection the 'winter readiness' approach fits with DHCFT values and strategy
3) Recognise that that costings for the campaign are unable to be determined at this time but include cost of bank staff, administration support, requirement for pharmacy support and transport / logistics
4) Acknowledge the NHS England and Improvement (NHSEI) reporting requirements (100% offered, 85% vaccinated healthcare workers)
5) Recognise the potential impact that concomitant administration may have on the programme.
6) Receive significant assurance on the planning of this year's flu programme.

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

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

Flu Campaign 2022/23 DHCFT

Introduction

The 2022/23 campaign is set to be run between October 2022 and February 2023 with an aspiration to vaccinate 90% of the NHS workforce across all sectors. DHCFT achieved 62.1% vaccination for influenza according to the published figures. This is based on a frontline HCW staff group of 2113. Whilst this figure is significantly lower than previous years it was achieved in the context of the pandemic and against a backdrop of 97.5% total staff COVID vaccination. The denominator has changed for 2022/23 as the JCVI criteria for HCW was redefined as part of the preparation to mandate COVID vaccinations earlier in 2022. Whilst the mandate did not come into effect the newly defined cohort remains in place for 2022/23 season.

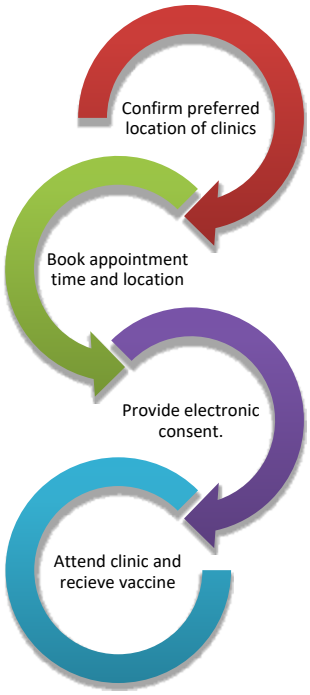
The reporting period will begin in Q3 and run into Q4. Considering the National Pandemic response to COVID-19 and significantly increased health concerns about respiratory disorders and illness it is assumed that everyone who works for the trust (all staff groups) will have access to a vaccine. We have ordered 3000 QIVr vaccines for DHCFT staff. This vaccine gives ability to vaccinate colleagues with egg allergies/ intolerance and is available to 18+ adults with no upper age limit.

CCG1: Staff flu vaccinations	
Applicability: Acute, Community, Mental Health, Ambulance	Staff flu vaccinations are critical in reducing the spread of flu during winter months; therefore protecting those in clinical risk groups and reducing the risk of contracting both flu and COVID-19 at the same time and the associated worse outcomes, and reducing staff absence and the risk for the overall safe running of NHS services.
CQUIN goal: 70% to 90%	Section 1.7 of NICE guideline NG103 makes recommendations for increasing the uptake of vaccination amongst healthcare staff. From 2021, the green book has made clear that this should include non-clinical staff who have contact with patients.
Supporting ref: NICE NG103[1]	

The Vaccines are expected to be delivered during the last week in September. This is expected to be 300 dosages from the manufacturer. The remaining 2,700 doses will be delivered two weeks later on the 21st of October.

The CQUIN target is between 70 and 90% recognising the expanded target group and reduced performance nationally in 2021.

We plan to have vaccinated 90% of the team at DHCFT by 20/11/2022



The method

The experience gained during the Pandemic has seen rapid learning to realise IPC compliant and efficient clinic models which:

- Identify likely numbers per location using ESR data.
- Pre-book appointments to allow clinics to match demand. In development for launch early September (dates and locations identified with the Health Protection Unit (HPU)

- Virtual registration and consent process to manage IPC concerns / streamline process.
- Allocated vaccine awaiting staff on attendance. Clinics starting as vaccines arrive.
- Support vaccinators to manage capacity and demand and rapid administration of vaccines.

The clinics will utilise a locally evolved system of booking, administration, logistics oversight and internal reporting which are adapted to suit a flu and COVID clinic approach. This gives opportunity to deliver high turnover clinics with minimal contact points and we can provide concomitant administration if that is requested. **DHCFT work closely with Derbyshire Community Health Services NHS Foundation Trust (DCHS) to develop a collegiate delivery programme for staff across both organisations.**

All clinics will have access to full PPE for administrators and vaccinators and those attending the clinics will have access to face masks. Enhanced cleaning and products to wipe down and maintain cleanliness will be available, alongside enhanced cleaning of the areas prior to and following the clinics.

Feedback from last year's campaign and lessons learnt

- Continue working closely with DCHS under a Memorandum of Understanding (MOU). We believe this remains worthwhile despite different vaccines being used by the respective organisations.
- Approximately 200 of members of staff from each organisation were vaccinated by the other organisation.
- Feedback from peer vaccinators – computer system issues (familiarity), paper preference, a lot of training to do, problems accessing BLS. Lessons learnt - work with peers earlier, begin August, the training may be more manageable, offer each peer a contact name and number to assist with IT queries, organise a team Basic Life Support (BLS) for peers.
- October to December DHCFT to rove to different DHCFT bases twice weekly to vaccinate whole teams.
- Purchased pull up banners with wipeable section for date and location of clinic.
- Posters to have wipeable section for date and location of clinic.
- Liaise with estates to assist with vaccine distribution adding more flexibility to deliveries
- Utilise a 'Flu page' on Focus with ongoing calendar of vaccination dates and Q&As such as age and egg free info etc.
- When arranging individual clinics at various bases, this will be promoted by individual emails to relevant teams, walk around the base on the day, pull-up banner by the entrance on the day.
- Engage sub-misuse staff in August and September to facilitate patient vaccinations.
- Prize drawer may not have been worthwhile due to the timing. DCHS use planned in charitable offering to Unicef connected to a target, food bank support or contribution to inequalities work / groups could be an option – this option could be explored
- Feedback from colleagues remains consistent that focus on CQUIN target is toxic for the campaign and should be avoided.

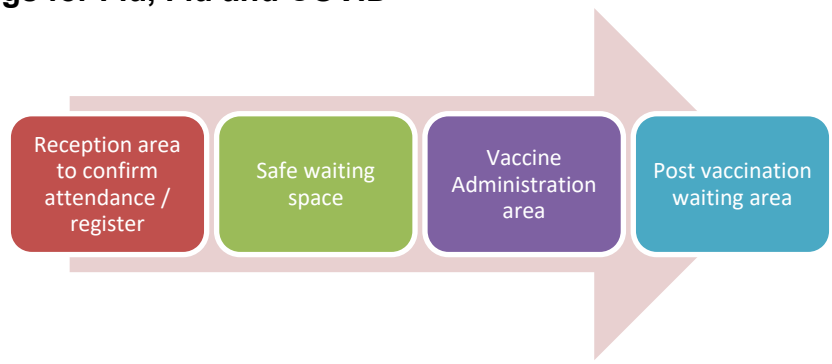
We have already begun to develop a FAQ (frequently asked questions) based upon initial questions and feedback from colleagues and we will evolve this as the programme develops. Colleagues are interested in the relationship between the Flu and COVID-19, the association with future COVID-19 vaccination programme. The vaccine mandate which was intended to come into effect in early 2022 will likely have polarised opinion towards vaccination and we need to be sensitive to the impact / effect this has on uptake and vary our approach accordingly.

Communications

The Trust will utilise its social media platforms (Facebook, Twitter, LinkedIn) and communications team to ensure staff are aware of how and when to book into clinics. We have already initiated Comms alerts to all staff to the plan to enable access as widely and easily as possible and have been responding to comments from staff raised through social media or direct feedback. We are anticipating higher demand based upon staff's comments about associated risk if there is a rise in COVID cases during the winter period. The Australian case rates have been publicised in national news reports

The communication strategy for 2022/23 is intentionally simple; the focus is on ease of access, safe attendance, and administration. The offer to opt in or out is consciously avoided and we are asserting the expectation that people will want and access a vaccine. Safety and support to colleagues will be the key central messages.

Clinic settings for Flu, Flu and COVID



Currently we have a number of sites across Derbyshire which are familiar to teams, the reduction in COVID restrictions has enabled more site-based delivery options. This is being explored jointly with DCHS so a uniform offer can be developed for both organisations.

- The clinic settings provide a clean room in line with IPC clinical guidance for the administration of vaccines and account for privacy and dignity requirements.
- As the clinics will be operating a high throughput model there needs to be sufficient room for people to wait in a comfortable manner.
- The clinics will have adequate cold storage capacity for the flu vaccines and fridges will be temperature checked and monitored in accordance with the medicines code.
- The booking system DHCFT have developed and shared alongside DCHS is available to other system partners.

Staff resource

The approach utilises some peer vaccinators (released from usual duties) and some bank nursing staff who are being recruited for the sole purposes of providing clinic support. The vaccinators will be released for attendance at the bookable clinics and matched to the capacity requirements of the clinic. This is to enable the clinics to be accessible, efficient, IPC compliant and minimise disruption to service delivery.

The option for staff to attend in an ad hoc fashion is also available. Inpatient staff will have on site vaccinators able to facilitate vaccines as well.

The written instruction is being reviewed ahead of the vaccination programme and new and existing vaccinators will be inducted to assure competency and awareness of the systems and processes to allow safe and effective administration. A revised training package has been devised using a blended learning model of e-learning (bespoke package (Appendix 2), MSM TEAMS group calls for questions and clarification of expectations and small group sessions for those who need additional information or support.

IT system support and external reporting

DHCFT's Information management and reporting team have been instrumental to delivering the proposed model and enabling an efficient, user friendly and most importantly a minimum touch point system from an IPC perspective. We are confident we can meet the reporting requirements in a timely, transparent and clear manner.

The Trust COVID and Flu vaccination group are meeting weekly currently and have a reporting format in place to support organisations to demonstrate progress and escalate any local challenges. DHCFT have worked closely with DCHS and are sharing learning to ensure that we learn from and contribute to system wide learning. The challenges around written instructions and the legal aspects of the medicines code have been well discussed and we have a model which allows us to operate safely and with good governance within the scope of the medicines code and legislation.

Regarding gaps and challenges in coming weeks for consideration.

- The Board Champion will be the Director of People and Inclusion and the operational delivery will be led by Richard Morrow
- We are required to and will consider in our planning any incentives - the rising cost of living and winter fuel bills further impacts and we do not know the extent to which the vaccine mandate work has disincentivised people from future vaccination and this year more than ever we might need to consider
- Celebrating success – we will build into our communications plan a qualitative approach to motivate people across the trust to take part
- Quality improvement (QI) approach – this is being applied to all stages and the Flu / COVID-19 programmes have been developed utilising QI methodology over the last three seasons
- The post-mandate effect is unknown, we will seek feedback from colleagues to quantify and understand this further.

In Summary

The campaign is progressing in a timely manner with actions and progress outlined. The Board of Directors is requested to:

1) Review the contents and approach and receive assurance about the programme being undertaken by the Trust
2) Consider that this plan provides adequate protection the ‘winter readiness’ approach fits with DHCFT values and strategy
3) Recognise that that costings for the campaign are unable to be determined at this time but include cost of bank staff, administration support, requirement for pharmacy support and transport / logistics
4) Acknowledge the NHSEI reporting requirements (100% offered, 85% vaccinated HCWs)
5) Recognise the potential impact that concomitant administration may have on the programme
6) Note that the MOU required to enable DHCS and DHCFT to work in partnership and vaccinate each other’s staff is in planning but not yet confirmed between respective organisations.

Thank you for taking the time to read this. We look forward to your feedback.

Richard Morrow
Assistant Director of Public and Physical Health Care
14 July 2022

Edited by:
Kyri Gregoriou
Deputy Director of Nursing and Quality Governance
31 August 2022

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 6 September 2022

Workforce Plan

Purpose of Report

The purpose of this report is to provide assurance to the Board that we are:

1. Embedding workforce planning across the organisation and in the Alliance
2. Developing triangulated plans bridging the financial plan, with data from our people systems
3. Bringing together the plans for all of the transformation activity inside the Trust and in the Alliance
4. Developing our plans for the professions to support workforce transformation and to enable us to maximise supply working with HEE and the regional people team

The workforce plan is required to enable the delivery of the Making Room for Dignity Project and Living Well and is a crucial part of the self-assessment process for Workforce Standards which was discussed at Board in May this year.

Executive Summary

Workforce planning is a risk and a gap nationally, regionally and in the Derbyshire System. There is a long term skills gap and planning is impacted significantly by the absence of aligned people and finance system that enable strategic and tactical resource planning to take place.

We have now closed the gap in the HR team and appointed a workforce transformation lead, which has enabled a collaborative approach to developing this year's plan and will mean that the process can be developed and delivered through the year. We have also appointed a Mental Health Alliance workforce planning lead. This is a step change from the capability, capacity and approach in previous years and is the start of a journey of embedding a dynamic and effective workforce planning process.

Our workforce plan has been developed with input from all services and supports the delivery of our overall organisational operational plan. The Workforce Plan establishes how we will provide the right workforce, in the right place, delivering the right care for the population of Derbyshire. It also outlines how we will deliver the objectives of the NHS Long Term Plan (LTP), and the People Plan, to ensure that we can achieve the ambitious improvements we want to see for our patients. The plan establishes how we will overcome the challenges we face in terms of our workforce, including staff shortages against a backdrop of a growing demand for our services. The workforce plan supports innovative system-wide workforce transformation projects that is changing the way our services are delivered for the patients of Derbyshire. This work aims to radically transform healthcare services, making best use of our assets, our workforce, breaking down silos between services and reducing fragmentation in service delivery. For our workforce it

means working in different ways, role transformation and improvements in quality of care and outcomes.

Within the LTP the Mental Health Implementation Plan provides a new framework setting out our commitment to deliver the most ambitious transformation of community mental health services and the wider mental healthcare workforce we have seen in the last 30 years.

Crucial to this investment and the new roles and reshaping/development of services is the cultural transformational change which needs to be embedded in each stage of these developments. Further development of an inclusive culture which creates a sense of belonging for all our people within DHCFT (the Trust) will be our planned cultural intelligence programme, our work on leadership, culture and behaviours which together will mean that the people in Derbyshire healthcare are delivering high quality care in a way that embraces and celebrates the whole workforce.

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

Risks and Assurances

- The developments and actions summarised in the paper evidence how the Trust is aligning the strategic ambitions and plans in line with organisational, regional and national workforce plans.
- The Board is invited to acknowledge significant assurance in the comprehensive development of this plan and limited assurance on its impact because this is the start of the plan and there will be significant multidisciplinary team work to deliver on this plan as well as influence national and regional supply.

Consultation

Consultation has commenced with wider operational services, clinicians, Divisional People Leads, our system colleagues through Joined Up Care Derbyshire (JUCD) and other key stakeholders.

Governance or Legal Issues

Delivery of the workforce plans will ensure that the Trust is compliant with:

- Monitoring and governance of the commitments as defined in the NHS LTP i.e. investments in both registered and non-registered parts of our workforce
- Monitoring and governance of the apprenticeship levy
- Safe Staffing Standards
- Financial Directives
- Working Time Directives 1998
- Equality Act 2010
- Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
- NHS Improvement's Agency Directives 2015
- National benchmarking
- NHSI weekly reporting for agency
- Monthly internal report from people resourcing for recruitment, bank and
- Agency usage targets
- Public expectations

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:

Our vision is to be an exemplar of good equalities practice. We are committed to advancing equality of opportunity and working productively with key stakeholders across the protected characteristics. We plan to attract, recruit and retain a wide range of staff from all sections of society to work in a positive, inclusive and nurturing environment. We also want to deliver, with dignity and respect, inclusive and accessible services that meet our patients' individual needs. We want to be the employer of choice for people living in the region, attracting local talent to work with us and for us, by recruiting a diverse, innovative, flexible and creative workforce.

The Trust has a legal requirement under the Equality Act (2010) to analyse and include equality considerations into day to day Trust business, including the design of policies, the delivery of services and employment. The law requires that we specifically respond to the three aims of the general equality duty. It is about identifying barriers and removing them before they create a problem, increasing the opportunities for positive outcomes for all groups, and using and making opportunities to bring different communities and groups together in positive ways. This is reflected throughout the workforce plan and its delivery.

Recommendations

The Board of Directors is requested to:

1) Note and support the progress of the workplan outlined above
2) Provide any further direction/comment on the delivery of the plan.

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

Report prepared by: **Liam Carrier**
Workforce Transformation, Lead People and Inclusion

Derbyshire Healthcare
NHS Foundation Trust

Workforce Plan

2022/23

July 2022

DHCFT @derbyshcft
www.derbyshirehealthcareft.nhs.uk

Making a positive difference

Contents

1.0 Strategic Oversight

This document has been produced to provide the Board, the Trust's Executive Leadership Team, other staff members and our partners with a clear description of the Derbyshire Healthcare NHS Foundation Trust Workforce Plan for 2022-23. The document is intended to provide an update to workforce planning activity within the Trust as part of the annual operational planning round.

The strategic workforce plan reflects the Trusts expected whole time equivalent (WTE) as at 31st March 2023. The plan takes in account the opening staff in post as at 31st March 2022 and is then adjusted for expected in year developments.

	Contracted Staff in Post (WTE)		
Staff Group	Outturn Year End 2021/22	Plan Year End 2022/23	Variation
Registered nursing, midwifery and health visiting staff	954.65	994.61	39.96
Registered scientific, therapeutic and technical staff	335.32	324.85	-10.47
Support to clinical staff	730.38	745.33	14.95
Infrastructure support	356.09	358.74	2.65
Medical and dental	175.67	179.25	3.58
	2,552.11	**2,602.78**	**50.67**

Work also continues to review future service developments for 2023/24 which indicates the Trust will require an additional 60.29 WTE for the new Making Room for Dignity project and an additional 47.40 WTE for the Living Well project.

Existing turnover and vacancies remain a challenge with an overall vacancy rate of 9.95% currently in the Trust.

The Trust continues to work towards its three key workforce priorities:

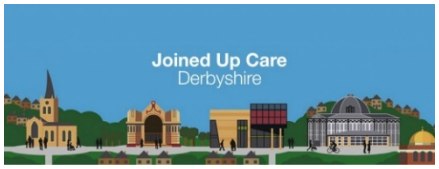
Improve Retention – Increase in Contracted Staff in Post – Reduction in Bank and Agency usage

Trust wide workforce planning and development capability is improving, and workforce development initiatives are responsive to key workforce needs.

The Workforce Plan presented in this report should be viewed as a point in time; workforce planning, transformation and development is a year-round activity and as such the plan is likely to change as learning progresses, more granular detail is uncovered and in response to the rapidly changing commissioning, political and policy landscape.

2.0 Strategic Forces Impacting on Services and Workforce Planning

Several strategic factors will impact upon the Trust's services and will have workforce implications that will need to be considered. However, some of the workforce implications of these strategic factors are in development and are not yet fully known.



Integrated Care Systems (ICSs)

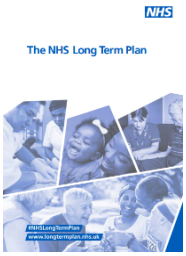
The Health and Care Act 2022 received Royal Assent from July 1st Integrated Care Boards (ICBs) are to replace Clinical Commissioning Groups and the role of Integrated Care Partnerships (ICPs) as the committee where health, social care, the voluntary sector, and other partners come together will be established in law as an Integrated Care System (ICS). Our ICS will continue to be known as Joined Up Care Derbyshire (JUCD); JUCD is the Derby and Derbyshire health and social care partnership for adults and children.

Having an ICS which is now established in law, with a new organisation that reflects the collaborative approach required, is very helpful to what we are aiming to achieve. Integrated Care Boards (ICBs) are responsible for developing a plan in collaboration with NHS trusts/foundation trusts and other system partners for meeting the health needs of the population, managing the NHS budget, and arranging for the provision of health services in the defined area.

In Derby and Derbyshire, our health and care system has worked in partnership for many years; the duties the Bill places on the local NHS and local authorities are welcomed and fit well with the direction we have been taking to improve the health of the local population.

When the NHS was set up in the 1940s its aim was to treat symptoms. It has come a long way since then, supporting people to live healthier lives. This change is continuing along that journey and aims to make social care and health even more aligned. Our health is affected by many things – ethnicity, class, housing, unemployment, financial stress, domestic abuse, poverty, and lifestyle choices. We need to look at through a partnership between the NHS, local authorities, and the voluntary sector

The workforce agenda is seen as critical to the success of the ICS; workforce makes up approximately 75% of all NHS spending, meaning workforce planning and workforce transformation are at the very heart of system-wide planning.



The NHS Long Term Plan

Published in January 2019, the LTP, outlined a 10-year practical programme of phased improvements to NHS services and outcomes, including a number of specific commitments to invest the agreed NHS five-year revenue settlement.

The national context has seen further emphasis on mental health provision, health inequalities, preventing hospital admissions, breaking down traditional organisational barriers, with care being centred on the individual. This will see the development of new care models and different types of organisations emerging.

In terms of the wider workforce implications of the LTP, the next two years will require imaginative approaches to workforce solutions and the development of new and different roles rather than traditional approaches to provide greater workforce mobility and flexibility. In addition, there is a requirement to adopt a more collaborative approach across local health systems to allow providers to deploy staff in different ways, where staff have a more flexible range of transferable skills to work across different care settings.

People Plan

Our workforce plan sets out how we intend to take the ambitions of NHS LTP and the NHS People Plan and work together to turn them into local action to improve services and the health and wellbeing of the communities we serve. This year the NHS People Plan will be replaced with a new Workforce Plan and the supply and demand of workforce will be at the core of this. We will build on work already commenced and align our processes to that of the emerging national operating model for workforce.

Whilst the majority of our Mental Health workforce is employed in the NHS there remains a significant workforce in our Local Authority, Private, Voluntary, and independent sectors (PVI), we are mindful of including all partners where feasible in the approach we take to supporting our system workforce.

The NHS People Plan, June 2020; provides guidelines for employers and systems, outlining behaviours and actions that staff can expect from leaders and colleagues to improve the experience of working in the NHS for everyone. Our JUCD people plan outlines key priority areas of:

- Looking after our people – with quality health and wellbeing support for everyone
- Belonging in the NHS – with a particular focus on tackling the discrimination that some staff face
- New ways of working – making effective use of the full range of our people's skills and experience
- Growing for the future – how we recruit and keep our people, and welcome back colleagues who want to return

3.0 Service / Workforce Transformation

In order to better understand the demand for workforce skills throughout the Trust, information has been obtained from Divisional Business Plans; the highlights of which are described below:

Service Level Highlights

Service and workforce transformations

Acute Mental Health Services for Adults of Working Age

The following processes are in place to support recruitment and retention within Working Age Adults Acute; automatic job offers are going to local nursing graduates that specifically provide jobs within acute wards, this is open to Registered Mental Health Nurse graduates from both Derby, Nottingham and Sheffield nursing courses. The feeding of longer-term recruitment is supported by ongoing investment in both the secondment of Healthcare Assistants to undertake the Nursing Associate training as well as the nursing apprentices. Following well established preceptorship process we now have a Band 5-to-Band 6 progression programme for all nurses. This allows Band 5 nurses to move through to the next level within Acute without the need to move away from acute services as the Band 6 roles are accommodated within their own wards.

Children's Services

In Children's Services we have a number of specialist services and considerable workforce challenges. We actively consider new investment and recruitment to vacancies, using skill mix principles and new roles where we can. Our current priorities include continued development of Mental Health nurses via undergraduate programmes, development of Children Adolescence Mental Health Consultants and the support for Child Branch undergraduate nursing. By having a pipeline of Registered Nurses coming through we can begin to address the significant deficit of Registered Health Visitors and School nurses via the Postgraduate Public Health programmes. New roles under development in Children's services include Advanced Clinical Practitioners, Non- medical prescribers and engagement workers. We have commenced a collaboration with DCHS for our health visitor and school nurses to create an enhanced offer at system level that has the potential to increase attraction and investment in this workforce.

Perinatal Community

The service continues to recruit in line with increased funding. In 22/23 this will increase the Psychology Resource considerably to support increased assessment capacity and treatment. We are looking to further develop our new starters. In addition, the service is developing peer support worker roles for recruitment in this financial year.

The Maternal Mental Health Service has recruited and launched in May 2022, a soft launch initially and wider communication and marketing around the

Older Peoples Services

In older people's services there is a requirement to ensure service users have access under the community mental health team framework to the Living Well teams, whilst also aligning services to the physical health pathways as outlined in the Long-Term Plan.

The division also needs to ensure the implementation of the fidelity model for crisis services and the ongoing provision of inpatient services including the inception of a dedicated older peoples functional admission ward to service the North of the county.

On a background of considerable challenges in recruiting suitably qualified nurses and occupational therapists this year's plan need to focus on the continued development of the clinical leadership structure to support recruitment and retention and the development of a programme to develop our own workforce to meet present and future needs including the creation of a substantial band 4 clinical workforce.

Forensic and Rehabilitation Services

Forensic and Rehabilitation have a number of transformation projects and redesign which include transformation of rehabilitation services to include a community rehabilitation offer to our patients and to have an enhanced pathway that includes both inpatient and community, this will include Nursing, physical health practitioners, peer support, occupational therapist, Approved Clinician/Responsible Clinician other discipline as well as the traditional nursing, medical, occupational therapists and psychologists. The model will incorporate third sector working and a strong emphasis on coproduction and peer support. The growth of the Community Forensic Mental Health service to ensure safe, recovery focussed care will focus on its core disciplines but utilising new roles to ensure that patients are supported across the spectrum including quality of life, physical health, education and employment to reduce recidivism and reduce inequality. The low secure unit will focus on physical health, education and vocational employment as well as its statutory core functions – the use of wellbeing workers or enhancing the skill set of staff in place is a goal for the coming year. Use of new ways of working and skill mix will continue to be explored. The need for Peer support is vital. Liaison and Diversion services with an all vulnerabilities specification will continue to grow, introduction of peer support and wider voluntary services engagement to ensure that the needs of clients in custody and court are enhanced and improving diversion is a key tenet for the service. Reduction in out of area

service will allow it to build gradually.

placements for rehabilitation and the continued excellent work of the Placement team to reduce need to review peer support and enablement workers to enhance the service.

Improving Access to Psychological Therapies

Talking Mental Health Derbyshire is a partnership of 5 Providers under Derbyshire Healthcare NHS Foundation Trust. The Trust workforce plan is to maintain its stepped care workforce within the current budget, whilst offering opportunities for career advancement via step 2 and step 3 backfill Health Education East Midlands funded training. The aim is to prepare the workforce for returning to tariff based payments in 2022/2023 for the final year of the current Improved Access to Psychological Therapy (IAPT) contract.

We will also support our partners to offer similar opportunities for training and career advancement in collaboration over training, supervision and student support. This should improve our ability to retain staff in service where there are clear avenues for advancement.

Substance Misuse

Substance Misuse Services are made up of two contracts, Derby Drug and Alcohol Service and Derbyshire Recovery Partnership. Both services have been allocated significant additional funding from OHID (Office for Health Improvement and Disparities). Derby City recruitment will concentrate on creation of an Assertive Outreach Alcohol Team with additional staffing. Derbyshire recruitment will increase key workers with continued funding for a Criminal Justice Team.

Perinatal Inpatient

Perinatal Inpatient has received additional funding to increase the workforce to maintain accreditation and improve the balance of staff. Recruitment this financial year has focussed on building up our qualified band 5 workforce due to staff turnover and challenges with recruiting replacement staff. We are adding additional social worker resource, developing peer support worker roles and band 5 to band 6 development roles to offer career advancement and retain staff. We continue to have experienced Nursery Nurse staff and have committed to employing preceptees.

Eating Disorders

The service has been allocated significant additional funding to provide a comprehensive eating disorders service for people with a primary eating disorder in Derby City and the High Peak 2021/2022. This has increased the staff number significantly from 12 to over 20 in the first year. The service is now more accessible to clients in Derby City and high peak. In 2022-2023 it is anticipated that the service will increase to a similar extent at the improved access is rolled out to other areas of Derbyshire. The service plans are intrinsically linked to the development of the Living Well Project. Nationally there are expansions in eating disorders services.

Dietetics

This is a small but essential team who work with the inpatient units and offer nutritional care training to staff too. There has been little opportunity to expand the workforce historically, but we have approached the Living Well Project to see if there is the possibility of offering dietetics as the teams are established. In addition, the service is advising around appropriate workforce expansion in line with the new developments in inpatient services and dormitory eradication. They are considering developing a specialist forensic and rehabilitation dietitian post in line with the review of rehabilitation services to address physical health inequalities within this service user group. Further developments include a 'Food Service Dietitian' to be based within the Catering Department as per the recommendation of the 'Report of the Independent Review of NHS Hospital Food'

Physiotherapy

As with Dietetics, Physio has had limited opportunity to expand. Expansion of services opportunities are also via the expansion of inpatient and dormitory eradication developments. The Professional Lead for Physiotherapy is exploring opportunities for funded trainee positions with onward substantive posts and advocating for Physio expansions within expanding services.

Estates and Facilities

Our Estates and Facilities Department actively grow their workforce through the use of apprenticeships. This allows employees to gain an National Vocational Qualification (NVQ) level 3 qualification in a number of building trades such as plumbing, electrical, joinery, painting and decorating and gardening. On completion of the NVQ employees are supported to undertake higher education courses, should they wish, which could enable them to gain the qualifications required to pursue a career in management in the department as and when vacancies become available.

Health Protection Unit

The Health Protection Unit was established in response to the covid 19 pandemic, offering vaccinations, advice, track and trace and outreach vaccinations for harder to reach groups. There is an ongoing responsibility to continue with this work, and to help with the seasonal flu campaigns.

The team has expanded and now includes infection control and tobacco harm reduction staff members. Due to the flu vaccination programme running from September to approximately January there is an opportunity for staff to support other programmes. A business case is being developed to support physical health checks for people on the General Practitioners Serious Mental Illness register supplementing the offer from the community mental health teams. This would potentially give the Health Protection Unit recurrent funding with the potential to expand offering signposting for wider health checks for cancer screening also.

Making Room for Dignity

Our acute inpatient services have commenced an ambitious and innovative programme to improve our acute mental health inpatient facilities over the next two years. This will involve the eradication of dormitory provision and the creation of single sex ensuite facilities, in modern state of the art therapeutic environments across the county, along with the development of new local specialist services and facilities. The plans are to build a new 54 bedded facility for males on the Kingsway Hospital Site, a 54 bedded facility for males, females and non-binary on the Chesterfield Royal Hospital site and the relocation of 12 beds for older adults to the Walton Hospital Site. Future plans also include the refurbishment of facilities at the Radbourne Unit, build a 14 bedded psychiatric intensive care unit on the Kingsway Hospital site and the refurbishment of an existing unit to create an acute plus facility. Whilst the plans currently require the full establishment of existing funded whole time equivalent staffing, there have been challenges to recruit to clinical roles in inpatient services. Future plans will require a significant increase in staffing for the new facilities. It is recognised that we cannot rely solely on being able to recruit to clinical vacancies i.e. mental health nurses, medics and therapists therefore other options are being considered. This includes growing our workforce to meet current and future needs through the use of apprenticeships and recruiting trainee nurse associates who would be supported to study the mental health nursing degree qualification. We are looking to recruit internationally and support the medical workforce through the trainee Advance Clinical Practitioner role and increase the number of qualified posts in this area. Sports Therapy roles have also been included in the plans to further support the therapy function along with Peer Support Workers which will allow opportunities for internal career progression.

Medical Staffing

We employ approximately 141 Medically qualified employees in a variety of roles. We know as a Trust that we can and do make a difference, and we therefore have to decide and be clear about what kind of difference we want to make. Our core purpose as an NHS Foundation Trust remains and we will continue to work on providing a comprehensive service available to all and work particularly hard to level up for those with protected characteristic. The health and wellbeing of all our people is key both existing and future, focussing on how we look after them as they recover to ensure we continue to be a great place to work in order to meet their health and wellbeing needs.

Consultant recruitment is a pinch point at present and is more precarious because, the cap on individual locum rates keeps rising and the Trust does not offer the incentives offered by some neighbouring Trusts. Current hotspots are consultant vacancies in the north and in our Children and Adolescent Mental Health Service (CAMHS) services where we are using agency locums. We will focus on workforce redesign to reduce reliance on posts we cannot fill and where there are extreme supply issues and incentivise where there is no other option in the short term. An example of the innovations is that we will be introducing digital consultants taking the learning from pilot sites where this has made a big impact. Therefore, we are focusing on enhanced engagement with the medical workforce, retention proposals and an agreed graded approach to any investments. As service viability, especially inpatient, are dependent on adequate (safe) medical staffing. A fortnightly medical workforce meeting focusses on maintaining this and ensuring adequate cover and planning is in place both for senior staff and trainees.

Robust workforce planning that recognises multidisciplinary and professional working is essential to enable our medical services are provided with efficiency and of a high quality. We intend to replicate our successful integration work with our partners moving with pace within Derbyshire. This provides the Trust and partners with the opportunity to move forward with a single shared plan that has not been available in such a way before. Our patients continue to tell us that our services are of high quality, but we know that at times our services could be improved. A key area of work will be to further integrate our care delivery with other services both within and outside our own organisation. We will achieve this by building on the strength of our clinical leaders, forging even closer collaborations between our Medical Directorate and with our partners. A priority will be to reduce current locum spend and identify opportunities that reduce and remove the variation in how services are delivered to bring greater efficiency and improved patient experience. We will also focus all our efforts on delivering the greatest level of high-quality care to patients at the earliest opportunity and ensure respect, dignity, kindness, and compassion remain at the core of how our patients and our people are treated.

In addition to this we will also use the rich source of information on staff experience derived from the annual staff survey and Pulse surveys to inform our direction of travel. It is important and compliant with Trust values that staff feel happy and confident in their roles, are able to work in areas where they can add the most value and are able to do the role they were trained to do. The aim is to establish the Trusts reputation as 'the place' to work. It is important to state that retaining, developing, and motivating people is where we need to place the greatest emphasis and investment once we have stabilised the current staff shortages. It is here the majority effort will be placed. Creating a great place for medical staff to work is what will attract potential employees. This will be in conjunction with senior medical leaders, operational managers, the Medical Education Department, Medical Staffing Manager, professional body representatives and People and Inclusion.

Community Mental Health Team (CMHT)

Living Well - NHS England has set out a plan of investment to deliver the Community Mental Health Framework in Derbyshire. This year (21/22) Derbyshire has been allocated £15m investment which has been split between Derbyshire healthcare NHSFT (DHCFT), Local Authority and Third Sector. With similar investment for 2022/23. From the modelling to date this has equated to 92 roles across Derbyshire, with 74.5 of these roles sitting with DHCFT. The investment has set to be rolled out by locality with the first wave focusing in on High Peak as the prototype, followed by City, Chesterfield, Dales and later in 2022 early 2023 North East Derbyshire then with the final localities Amber Valley and Erewash coming on board from April 2023. Each area will be reviewed and reconfigured to following the local authority or Primary Care Network (PCN) footprint. In addition to the £15m funding there has been further funding identified for new roles to sit within Primary Care Networks (PCNs), of which DHCFT will be the hosting employer. This equates to 315 new roles across the 15 PCNs in Derbyshire. The breakdown of these roles is being worked through with each individual PCN, but they range between a Band 5 – 7 and will be multidisciplinary. It is also anticipated that similar funding will also follow again for further PCN roles in 2022/23 and 2023/24. The Living Well forms part of Joined up Care Derbyshire, therefore the Community Mental Health Teams are made up of Multi Agency colleagues employed by DHCFT, the voluntary sector and Social Care which all formal integral parts to the Living well model being fully adopted, and meeting is outcomes. As the model embeds ongoing skill mix reviews will be required as the shift in 'Peoples' needs change and demands shift to different steps. This starting to move to a new style of matrix management which has not previously been adopted. Early Intervention in Psychosis (EIP) Service in Derbyshire to include provision for people with an At-Risk Mental State (ARMS). In line with the NHS Long Term Plan provision for people with an ARMS should be delivered by 2023/24. The estimated cost for this service development is £638,909.

Psychosis and psychotic disorders can be extremely debilitating. If untreated or poorly treated psychosis can become a long-term condition with high levels of relapse, inpatient admissions, comorbid health conditions and increased risk of suicide. The time from onset of psychosis to the provision of evidence-based interventions has been shown to have a significant influence on long-term outcomes. It is therefore essential that people with psychosis and at high risk of developing psychosis are identified early and offered clinical interventions to improve recovery outcomes and lower the overall cost of care.

Neurodevelopmental Services

There is a strong focus on improving care for people with learning disabilities and autism. Commitments include increasing access to support for children and young people with an autism diagnosis, developing new models of care to provide care closer to home and investing in intensive, crisis and forensic community support. The aim is that, by 2023/24, inpatient provision for people with learning difficulties or autism will have reduced to less than half of the 2015 level.

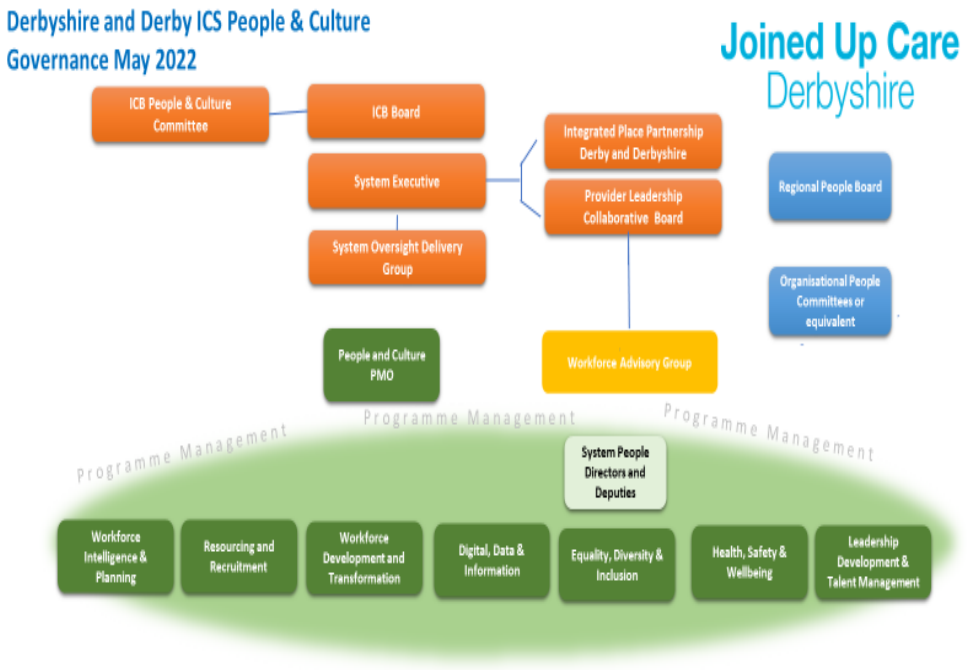
Early Intervention in Psychosis

The Early Intervention in Psychosis (EIP) Service in Derbyshire currently provides evidence-based interventions for 14–65-year-olds during the first three years following the onset of a First Episode of Psychosis (FEP). However, the onset of psychosis is typically preceded by a range of non-specific behavioural and psychological symptoms, functional deterioration, and attenuated psychotic symptoms or psychotic symptoms that are brief and self-limiting. The current proposal is to expand the EIP Service to provide clinical interventions for people with an At-Risk Mental State (ARMS). The aim of this treatment pathway would be to identify people at high risk of developing psychosis at an early stage and provide evidence-based interventions aimed at delaying or preventing transition to a m. This pathway would also provide a stepped care approach for people with emerging psychotic symptoms and co-existing mental health problems, including recovery

interventions and support to maintain social and family relationships. It is envisaged that treating ARMS cases will extend the positive outcomes previously found within EIP services, including reduced relapse rates, risk of suicide, number of hospital admissions, crisis contacts, in addition to improving employment and educational outcomes, social functioning and quality of life, in what has been shown to be a more cost-effective manner when compared to standard care

Workforce planning and workforce transformation governance

The System Level for Governance for workforce planning is described below.



In Joined Up Care Derbyshire a Mental Health Alliance has been established where a partnership agreement has been co-developed with all Partners. Early priorities identified by the Alliance include a focus on workforce development including the opportunities within the following areas:

- Standardising pay rates /agreements for employment.
- Training offer – standardising courses / gaining economies of scale on delivery.
- Workforce needs – looking at roles and responsibilities.
- Focus on retention – looking at cross organisational career paths and support options, need to look at culture of working and embedding psychological safety within workplace.
- Using cross organisational working / placements to support breaking down of organisational ego and increasing understanding of pressures and demands.
- Making the best use of a joint workforce

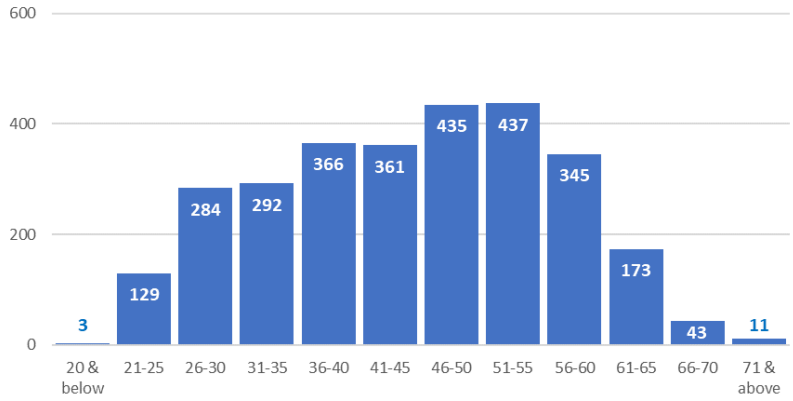
Alliance partners agreed that what would be beneficial is the development of a joint workforce strategy which includes:

- Joint recruitment activities
- Joint training needs analysis and plans
- Joint Career development opportunities

As such it is expected that the Alliance workplan delivery will support all organisations in reducing workforce risks, improving recruitment and retention.

4.0 Trust Workforce Profile

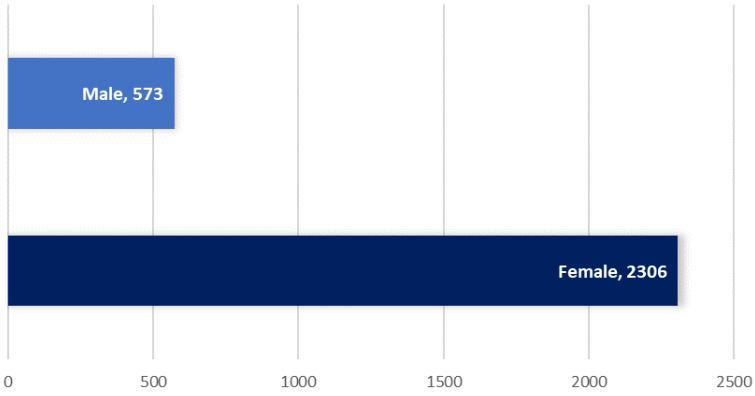
DHCFT Workforce Age Profile



The average age within the Trust is 45 years of age and this has remained the same for many years. The data shows that 35.05% of the workforce are aged 51 or above, with only 4.58% of the workforce below the age of 25. The opportunity for retirement at age 55 with special class status for many staff, poses additional risk to workforce supply against demand in clinical roles. Analysis of the nursing workforce highlights that 30.80% of staff are aged 51 and over, with 28.57% of medical staff falling within this age range. The Allied Health Professional workforce highlights 22.66% of staff are aged 51 and over, for Additional Professional Scientific and Therapeutic staff (this includes psychologists and social workers) 30.54% of staff fall within this age range and 35.62% of clinical support staff are aged 51 and over.

The average retirement age over the past 12 months was 60 years and 7 months. The average retirement age for Nursing staff was 60, for medical staff 60 years and 9 months, for Allied Health Professionals 60 years and 3 months, for Additional Professional Scientific and Therapeutic staff 61 years and 10 months and for Clinical Support staff it was 62 years and 4 months. Retention of specialist skills and knowledge within these key staff groups will be a priority moving forwards as well as attracting, developing, and retaining the workforce of the future. Workforce development strategies including role redesign, development of new roles and apprenticeships will be key for workforce supply to meet demand now and in the future.

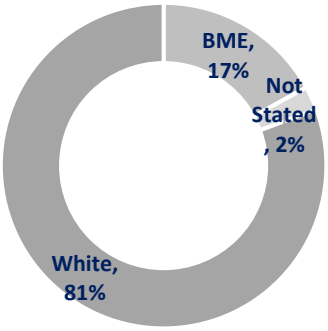
DHCFT Workforce Gender Profile

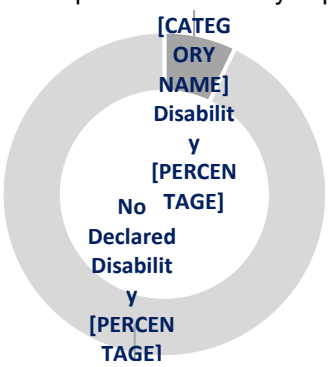


We currently employ 2879 people (contracted staff in post) of which 20% are male and 80% female. This is a similar position to the NHS as a whole, currently 23% male and 77% female. The latest Gender Pay Gap (GPG) submission

for the Trust reported a GPG of 15.41% based on the average hourly rate, down from 19.01% in 2017 when the GPG reporting was launched nationally. Work continues within the Trust to reduce the gap further through our Equality, Diversity and Inclusion (EDI) team, staff, managers, union and professional body representatives and partners.

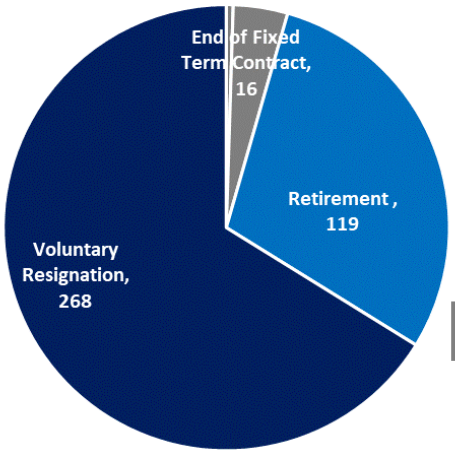
DHCFT Workforce Ethnicity and Disability Profile

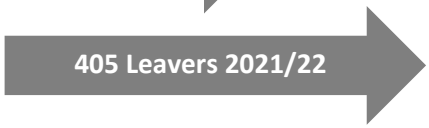




Our current workforce ethnicity is made up of 81% white, 17% BME and 2% recorded as not stated. Comparted to 2017, we have seen a 5% increase in our BME workforce from 12% to 17%. Our current workforce declaring a disability is 7%. Compared to 2017 we have seen a 2% increase in staff declaring a disability from 5% to 7%. Improved data quality through the recruitment process and employees updating their personal information on the Electronic Staff Record (ESR), along with the initiatives like the introduction of the Inclusion Guardian in the Recruitment process have all played a key role.

DHCFT Workforce Leavers Profile





During 2021/22 we welcomed 430 new starters into the Trust through external recruitment and we saw 405 staff leave the Trust, of which 29.38% retired. Analysis of leaver data shows that 19% of staff leave within their first year of employment with DHCFT, 16% between 1 and 2 years, 12% between 2 to 3 years, 7% between 3 to 4 years and 46% with more than 4 years' service.

Voluntary Resignation 'Work Life Balance' represented 13% of leaving reasons, followed by 12% for 'Promotion', 11% for 'Relocation' and 7% 'To undertake further education or training'.

Annual turnover within the Trust is running at 14.31%. The highest level of turnover is within the Allied Health Professionals staff group running at 19.22%, followed by Admin & Clerical at 15.29%, Additional Clinical Services at 15.07% and Nursing & Midwifery Registered 14.34%.

The Trust's approach to hybrid and flexible working and initiatives like the new the 'Stay' discussions will hopefully help to reduce those leaving the Trust and improve retention.

5.0 Challenges and Risks

As a Trust and as a system we recognise that there are a number of challenges which impact on the workforce, specifically:

- National shortage of key occupations
- Future commissions of key posts insufficient for current and expected demand

We may not be able to retain, develop and attract enough staff to protect their wellbeing to deliver high quality care, potentially leading to:

- Risk to the delivery of high-quality clinical care including increase waiting times
- Exceeding of budgets allocated for temporary staff
- Loss of income

In addition, the following areas impact on workforce recruitment and retention:

- Development opportunities for the existing workforce are limited
- Retention of staff in some key areas is difficult
- Sufficient funding to deliver alternative workforce solutions is constrained
- Maintaining a reputation as a great place to work
- Ensuring continued investment and support in apprenticeship programmes

The main risk that we carry is around workforce supply which is echoed across the ICS. The existing demand on supply pipelines has increased due to the impact of Covid, increased staff turnover, in particular an increase in the number of retirements, and an aging workforce. Post Covid the Trust has also experienced higher levels of sickness absence than pre Covid.

6.0 Strategic Actions

Specific strategic actions that are in place or are considered to be required in order to support the delivery of the Trust's aims and workforce challenges, needs and aspirations are outlined below and grouped under the headings within the People Plan.

Looking after our people

The wellbeing of our staff continues to be at the heart of our culture demonstrated by the 2021 NHS Staff Survey Results which described 74.9% of staff reporting that Derbyshire Healthcare takes positive action on health and wellbeing.

Additional wellbeing support introduced at the onset of the pandemic has continued throughout the year, this included bookable coaching calls with a member of the staff wellbeing team, access to peer support groups, wobble rooms and spaces, traumatic incident support, access to a 24/7 counselling helpline and numerous bespoke training sessions offered to staff. Monthly wellbeing activity programmes direct staff to live events and resources. Integral to nurturing and embedding a culture of wellbeing and a vital part of our COVID recovery our staff wellbeing champions network, which to date includes approximately 35 champions, continues to grow.

Emotional and psychological support continues to be offered by the Resolve service on an individual basis and with a referral rate of 9% this year. We have also been able to continue with the system wide offer for staff to access the Thrive app which provides a programme of wellbeing activity and Cognitive Behavioural Therapy (CBT) approaches. Thrive have also enhanced the wellbeing activity calendar via access to various webinars and recently supported the winter wellbeing programme by delivering bespoke sessions.

The Wellbeing team were able to launch and promote access to physical activity platforms, Fit4theFight and Be Military Fit. The recruitment of six Health Improvement Advisors (HIAs) across Joined up Care Derbyshire JUCD has increased the opportunity for access to shared physical activity sessions, amongst other wellbeing initiatives and will be promoted widely in the near future.
The reproductive and hormone health project has now concluded and has provided a valuable insight into the health needs of the workforce population. The project has helped to raise awareness and provided an extensive range of resources for staff. The established peer support group continues to be delivered on a monthly basis.

There is a current need and focus for staff around their financial wellbeing and we have had sessions provided by Marches Energy Charity to offer money saving advice and we continue with our financial wellbeing peer support group. The team has launched a financial wellbeing package which includes our offer from Salary Finance offering financial education and low-cost loans.

We also continue to receive requests for bespoke team support. This can be for teams who have experienced a difficult incident, for teams who are feeling exhausted and for those teams where morale is low. We have been responding to requests for team support either by coaching team leads or providing team sessions which are delivered by the Wellbeing team or if appropriate by the team at Resolve counselling service.

Belonging in the NHS

The Public Sector Organisations including DHCFT have legal and ethical obligations to reduce health inequalities and advance equality, with due regard to the elimination of discrimination, the promotion of equality of opportunity and the fostering of good relations between those who have a protected characteristic and those who do not share it, in accordance with the public sector Equality Duty of the Equality Act 2010

It is well documented that “the life expectancy of people with severe mental health problems can be up to 20 years less than the general population. In addition, the events of 2020 have shone a light on the inequality that persists in our society. The COVID-19 pandemic, which has disproportionately impacted specific groups, including Black, Asian and minority ethnic (BAME) communities, older people, and the LGBT+ community, learning disabilities also highlighted the inequalities in mental health care.

Tackling inequalities is important and challenging. It requires leaders at all levels, organisations and individuals to understand their own biases, beliefs and behaviours. It requires us to acknowledge the reality of inequality in the systems we operate and endeavour to tackle inequalities by understanding people’s experience and implementing change.

Underpinning the delivery of High-Level Workforce Plan 2022/23 is our commitment to partnership working and embedding equality, diversity and inclusion in all that we do and an opportunity to align with the national NHS People Plan sets a strong vision for a more inclusive NHS where diversity is celebrated, and staff are supported to thrive. This national vision underpins our EDI mission to be ‘positively inclusive’.

In addition, this plan also supports the Advancing Mental Equalities Strategy domain 3: “A diverse and representative workforce at all levels of the system, which is equipped with the skills and capabilities it needs to advance mental health equalities, is fundamental to achieving long-term change”.

This High-Level Workforce Plan 2022/23 builds on the work already being taken forward through our Trust Workforce Equality Objectives and aligns with our aspirations around Workforce Race Equality Standard (WRES), the Workforce Disability Equality Standard (WDES), the Gender Pay and Race Disparity Gaps. Ensuring that EDI benefits are well thought out and securely delivered in this wide-ranging programme of work will maximise the overall benefits to our staff and ultimately patient access, experience and outcomes in mental health services and will be included throughout the delivery of this programme.

This will contribute to overall Trust priority EDI outcomes:

- Address disparities highlighted in the Workforce Race Equality Standard (WRES) 2020/21 analysis and in line with the Midlands Workforce Race Equality and Inclusion (WREI) Strategy, the National WRES Strategy

aspirations/Long Term Plan and NHS People Plan. This includes improving BAME workforce diversity composition and representation to 20% in all AfC bands to reflect the local community we serve.

- Address disparities highlighted in the Workforce Disability Equality Standard (WDES) 2020/21 in line with national good practice, including increasing the declaration rate of staff with disabilities or long-term conditions.
- Address disability declaration rates in the trust with the aim to increase declaration rates
- Address high rates of bullying and harassment against staff with protected characteristics as highlighted on the NHS Staff Survey 2019 and 2020
- Develop more diversity in talent plans.

New ways of working

New ways of working enable Trusts to make the most of the skills within teams, with a key focus on upskilling staff and expanding capabilities. The principle behind this is that this creates a more flexible workforce, boosts morale, supports career progression and attracts new staff to the organisation.

Peer support workers (PSW) in DHCFT and other organisations. These support our Living Well teams. We have funding from HEE to train PSW and we coordinate this across the system. There is also supervision training and team preparation for teams and supervisors to ensure that PSW are given the support required.
PSW apprenticeships we are currently exploring apprenticeships for PSW but also for other roles
ACP (Advanced Clinical Practitioners) in mental health are being trained to support out workforce in different ways.
MST- the use of technology has enabled staff to work more effectively. Look towards additional digital technologies for the future
Princes Trust - DHCFT are scoping out using Princes Trust to obtain some short-term placement to provide an opportunity for experience work. This may help to recruit some staff into roles
Retain and attract more Volunteers who play a vital support role in the Trust

Growing for the future

The Trust's ageing workforce continues to be a risk in terms of retaining specialist skills and knowledge, however this is in line with the regional trend. Succession planning and talent management approaches, along with attraction strategies to increase representation of staff across all age groups will be key to addressing this.

Apprenticeships Level 2 and Level 3 for clinical support staff
Clinical apprenticeships Trainee Nurse Apprenticeships / Nurse degree / AHP registered roles / Top Up's
Linking in with colleges for future recruitment
HCSW Development Lead post providing support and development for getting staff ready for academic study where appropriate, offering opportunities for development
ACP trainees to augment out medical workforce
Non-clinical apprenticeships for Administration and for other Support Staff
Local and System wide recruitment campaigns

7.0 Recommendations

The Board is asked to note this workforce plan and its contents and support the strategic actions outlined above.

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 6 September 2022

Trust Strategy – Great Care
Building Block: Improving Safety

Purpose of Report
To review our approach to improving safety.

Executive Summary
The Medical Director offers his reflections on the essential requirements to achieve the highest safety standards and the Trust Board's role in this. These reflections are then linked to the fundamentals of the National Patient Safety Strategy which is based on two foundations: • Patient safety culture • Patient safety systems The strategic aims of Insight, Involvement and Improvement are then, in turn, linked to a number of commitments for the Trust and local systems which are reviewed. Finally, there is a stocktake giving an overview of current safety issues in our Trust.

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

Assurances

This report does not address safety issues directly related to COVID-19 pandemic issues that have been reported elsewhere.

This report is an overview. Assurance on the various themes and component parts are the subject of detailed reports to Board Committees.

Outstanding issues include:

- Confirmation of a Suicide Prevention Lead for the Trust and the relationship of that Lead to System Working.
- Clinical pressure on key services particularly CAMHS and Adult Eating Disorder Services.
- E-prescribing is not available in the Trust.

Consultation

This paper has been discussed with safety leads within the Trust.

Governance or Legal Issues

Of all the quality domains, safety is perhaps the imperative. It was assessed as requiring improvement by the CQC in March 2020 following their inspection in November 2019. All other domains were rated as good.

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:

Our patients are amongst the most vulnerable and disadvantaged in society. Inappropriate care approaches or lack of resources can exacerbate their difficulties and potentially make their condition worse.

Recommendations

The Board of Directors is requested to:

1) Confirm our commitment to improved safety for our staff and patients
2) Consider any additions that may be required to the Board Assurance Framework

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

Trust Strategy – great care

Building Block: Improving Safety

The purpose of this document is to update you on our approach to improving safety following the Board Report in July 2021. The national NHS Patient Safety Strategy was published in July 2019. This calls for the NHS to become the safest health care system in the world and it follows that Derbyshire Healthcare NHS Foundation Trust needs to become one of the safest health providers.

The document outlines:

1. The Medical Director's assessment of the essential requirements to achieve the highest safety standards;
2. The foundations of the National Patient Safety Strategy;
3. The commitment required for delivering the strategic aims of the National Patient Safety Strategy; and
4. The context for patient safety in DHCFT

1. The Medical Director's assessment of the essential requirements to achieve the highest safety standards (the link to the relevant element of the National Patient Safety Strategy is shown in italics).

- **A clear sense of "mission"** (*Foundation: Patient Safety Culture)*
  For every member of staff to understand what Great Care – A Great Place to Work – Best Use of Money means for their role and to have this reflected in their appraisal including an individual and team commitment to Quality Improvement.

- **An integrated approach** (*Foundation: Patient Safety System)*
  For each part of the service to understand that their decisions and actions have an effect on other parts of the service (including those outside the Trust) and vice versa. To anticipate these effects developing integrated service delivery to enhance safety and avoiding establishing unnecessary boundaries that may increase risk.

  To appreciate the **interplay between Performance – the Quality of Care Triad (patient experience/effectiveness/safety) – and Financial Management** and to manage with an overview anticipating that all elements are in play at once.

- **Adequate resources for the job** *(Strategic Aim: Involvement)*
  To ensure the deployment of an integrated workforce with an emphasis on team working to enhance effectiveness and compensate for shortages that may arise in different professional groups/teams from time to time.

  To ensure the provision of clean, safe, therapeutic environments and suitable equipment.

To work within Joined Up Care Derbyshire to close gaps in resources without compromising safety in existing services, securing investment when possible.

- **Avoidance of harm** *(Strategic Aim: Insight)*
  To minimise exposure to treatments or interventions that may unintentionally harm patients, physically or psychologically, and to deliver potentially high risk treatments as safely as possible.

  To accept it is sometimes wiser to mitigate high risk clinical situations in the community than to attempt to contain risks in hospital if they are likely to escalate there without any predictable satisfactory resolution.

- A **compassionate Just Culture** (*Foundation: Patient Safety Culture)*
  Care must be person centred and offer informed choice encouraging personal responsibility, recovery and resilience where possible and safe refuge and wrap around care when needed. Similarly, staff must see the same approach applied to their management and support in order to develop a philosophy recognised by the entire organisation and its patients and their carers.

  Expectations need to be realistic and discussed in an open and respectful way.

- A **learning culture** *(Strategic Aim: Improvement)*
  Learning from significant incidents, mortality reviews (and the quality improvement initiatives which results from them), needs to concentrate on human factors, systems and processes anticipating what similar or related scenarios may arise in the future.

  Education and training should follow a needs based approach determined by the professions and ideally the multi-professional teams themselves.

- **Outcomes** *(Strategic Aim: Improvement)*
  These need to be SMART and related to the dynamics described above.

These themes should therefore be reflected in the agendas for Public Board Meetings and other Board Committees.

2. The foundations of the National Patient Safety Strategy (2019)

The national strategy is based on two foundations: a **patient safety culture** and **patient safety systems** and there is a clear link between these and what the Trusts Medical Director considers are essential areas for development of safety standards in the Trust.

Foundation 1: Patient safety culture

The national strategy is clear that culture change cannot be mandated by strategy, but its role in determining safety is essential. A consistent message from NHS staff is that fear and blame are too prevalent, particularly in relation to involvement in patient safety incidents. We trust clinicians to support us when we are at our most vulnerable and rely on them to uphold high standards of professional behaviour and competence. Furthermore, there are mechanisms to hold them accountable if they are deliberately malicious or negligent and to ensure they are competent, which have the confidence of patients and the general public.

Staff should feel psychologically safe. Each individual should know that they will be treated fairly if things go wrong or they speak up with their concerns.

Serious Incident (SI) investigations can produce a culture of fear and blame and lead to risk averse practices which can paradoxically increase the chances of patient harm.

The NHS Patient Safety Strategy embraces the new Patient Safety Incident Response Framework (PSIRF) and A Just Culture Guide.

The national strategy outlines the following areas to support a patient safety culture:

- use existing culture metrics such as those in the NHS Staff Survey to understand your safety culture and focus on staff perceptions of the fairness and effectiveness of incident management

- focus on the development and maintenance of a Just Culture by adopting the NHS Just Culture Guide or equivalent

- embed the principles of a safety culture within and across local system organisations and align those efforts with work to ensure organisations adhere to the CQC well-led framework[1] and its Key Lines of Enquiries.

Features of a patient safety culture include:

- **Diversity**
  There should be a climate of inclusivity, trust and respect where people feel able to thrive as themselves. We are not all the same and this should be part of our strength.

- **Compelling vision and leadership**
  There needs to be a vision of what we want to achieve before leadership can create psychological safety. High performing teams are led by people who are kind and civil promoting a culture of honesty, authenticity and safe conflict.

[1] https://improvement.nhs.uk/documents/1259/Well-led_guidance_June_2017.pdf

- **Openness and transparency**
  Staff and patients need to be able to speak out to advocate for themselves and others without fear or favour. The focus needs to be on what needs to change rather than punitive action.

- **Continuous quality improvement**
  There should be an emphasis on learning from national clinical audits but also "bottom up" learning. Routinely collected data needs to be processed into information which enables everyone to be alert to the opportunities of learning and continuous improvement

Foundation 2: Patient safety system

A National Medical Examiner system has been established to enhance learning from scrutiny of death certification. This system is centred around acute hospitals with consideration of how it will work for mental health and community trusts now being rolled out. The Medical Director has campaigned for the causes of death of all patients to be released by NHS Digital to our Trust in order that we can address public health issues on a socio-geographical basis and the issue will now be raised with our local Medical Examiner. Whilst this remains unresolved Mortality Reviews are concentrating on "appreciative learning" and fidelity with Physical Healthcare guidance.

All Trusts have their own responsibility for improving safety. The National Patient Safety Team will focus on the following key areas, and it is imperative that the Trust also has a coherent effective approach to them:

- **Workforce**
  The link between workforce capacity and capability and patient safety has many factors, but workforce challenges clearly create pressures on the system. We must also recognise the importance of staff well-being on patient safety.

- **Regulation**
  A shared understanding of safety across all regulatory organisations (i.e. the Health and Care Professions Council, Nursing & Midwifery Council, General Medical Council, Medicines and Healthcare Products Regulatory Agency and Care Quality Commission) is crucial to maintain an effective safety system and safety culture. The NHS supports a single patient safety syllabus and is working with regulatory bodies to encourage uptake of this.

- **Digital technology and information sharing**
  Data protection and security, electronic patient records, electronic prescribing and patient access to records are key to effective communication.

Strategic Aims of the National Patient Safety Strategy and DHCFT commitments to delivery

Building on these two foundations, the National Strategy outlines three strategic aims to support the development of both patient safety culture and patient safety systems:

- improving understanding of safety by drawing intelligence from multiple sources of patient safety information (**Insight**)
- equipping patients, staff and partners with the skills and opportunities to improve patient safety throughout the whole system (**Involvement**)
- designing and supporting programmes that deliver effective and sustainable change in the most important areas (**Improvement**).

Summary of the NHS Patient Safety Strategy

The actions the NHS will take under each of these aims is shown below:

Insight

The NHS has:

- adopted and promoted key safety measurement principles including culture metrics to better understand how safe care is.
- uses digital technologies to support learning from what does and does not go well and has replaced the National Reporting and Learning System with a new safety learning system.
- introduced the Patient Safety Incident Response Framework to improve the response to and investigation of incidents.
- implemented a new Medical Examiner system to scrutinise deaths.
- improved the response to new and emerging risks, supported by the new National Patient Safety Alerts Committee.
- shares insight from litigation to prevent harm via NHS Resolution.

Involvement

The NHS has:

- established principles and expectations for the involvement of patients, families, carers and other lay people in providing safer care.
- created the first system-wide and consistent patient safety syllabus, training and education framework for the NHS.
- promoted the establishment of patient safety specialists to lead safety improvement across the system.
- Created healthcare systems to address the safety agenda.

Improvement

The NHS will:

- deliver the National Patient Safety Improvement Programme, building on the existing focus on preventing avoidable deterioration and adopting and spreading safety interventions.
- deliver the Maternity and Neonatal Safety Improvement Programme to support reduction in stillbirth, neonatal and maternal death and neonatal asphyxial brain injury by 50% by 2025.

- develop the Medicines Safety Improvement Programme to increase the safety of those areas of medication use considered high risk.

- deliver a Mental Health Safety Improvement Programme to tackle priority areas, including restrictive practice and sexual safety.

- work with partners across the NHS to support safety improvement in priority areas such as the safety of older people, the safety of those with learning disabilities and the continuing threat of antimicrobial resistance.

- work to ensure research and innovation supports safety improvement.

3. The national strategy details a number of commitments required by local systems/providers. Those relevant to DHCFT are extracted and listed below:

Topic	Objective	What and by when will it be delivered	Timescales	MD comment
Safety Culture	Support the development of a safety culture in the NHS	Local systems to set out in their LTP implementation plans how they will work to embed the principles of a safety culture. These should include monitoring and response to NHS staff survey results and any other safety culture assessments, adoption of the NHS Improvement A Just Culture Guide or equivalent, and adherence to the well-led framework	Not specified	Trust compliant
Safety System	No specific actions for local Trusts			
Insight	Deliver replacement for the NRLS and StEIS [with the Patient Safety Incident Management System (PSIMS)]	Local systems, including current non-reporters, to connect to the new system by end Q4 2020/21 Continuous increase in effective incident reporting (note this is not the same as total incident reporting as the replacement for NRLS should improve quality without necessarily increasing quantity)	End of Q4 2020/21	Completed

Topic	Objective	What and by when will it be delivered	Timescales	MD comment
	Implement the new Patient Safety Incident Response Framework (PSIRF)	Supported by regional teams, local systems are required to set out in their LTP implementation plans how they will implement the new PSIRF. Full implementation is anticipated by July 2021, informed by early adopter experience, of which this Trusts is an early adopter. Initially plans should: - identify PSIRF leads in local systems by Q4 2019/20 - anticipate development of organisational-level strategic plans for patient safety investigation and review by the end of Q2 2020/21 - ensure that leaders and staff are appropriately trained in responding to patient safety incidents, including investigation, according to their roles,[2] with delivery of that training and development from end Q2 2020/21 onwards - eliminate inappropriate performance measures from all dashboards/performance frameworks by Q2 2020/21 - as part of the organisation's quality governance arrangements, monitor on an annual basis the balance of resources for investigation versus improvement and whether actions completed in response to patient safety incidents measurably and sustainably reduce risk	End of Q4 2019/20 End of Q2 2020/21 End of Q2 2020/21 By Q2 2020/21 Annually	Trust compliant with above Delayed investigations and completion of action plans monitored
	Implement the National Patient Safety Alerts	100% compliance declared for all Patient Safety Alerts from Q2 2019/20 Compliance fell during pandemic. Now part of Exec SI group	By Q2 2019/20	Established as part of Exec SI group; Trust compliant
Involvement	Patient involvement in patient safety	Local systems and regions aim to include two patient safety partners on their safety-related clinical governance committees (or equivalents) by April 2022, who will have received required training by April 2022	By April 2022 To be trained by April 2022	Joined Up Care Derbyshire have the posts out to advert
	Deliver a patient safety curriculum and syllabus that supports patient safety training and education for the whole NHS	Support all staff to receive training in the foundations of patient safety by April 2023	By April 2023	Curriculum has been agreed and basic level training rolled out

[2] Note this training relates to currently available training in the specific skills required to effectively respond to patient safety incidents, particularly investigation skills. Wider work under the 'Involvement' section to develop and deliver a national patient safety curriculum and training will also incorporate relevant aspects of incident response, including investigation, but local systems should not delay work to ensure their existing staff are skilled to perform the roles they are asked to while the wider curriculum work takes

Topic	Objective	What and by when will it be delivered	Timescales	MD comment
	Develop a network of patient safety specialists	Identify to the national patient safety team at least one patient safety specialist per organisation by end Q4 2019/20 Release patient safety specialists for identified training by Q4 2021/22	End of Q4 2019/20	Completed Outstanding
Improvement	Deliver NPSIP priorities	NEWS2 adoption by all acute and ambulance trusts by Q4 2019/20	By Q4 2019/20	NEWS 2 implemented
	Deliver the Medication Safety Improvement Programme (MSIP)	The programme will reduce avoidable, medication-related harm in the NHS, focusing on high risk drugs, situations and vulnerable patients. Details to be confirmed	Not specified	MD has executive responsibility reporting to QSC. E-prescribing is the outstanding issue
	Deliver the Mental Health Safety Improvement Programme (MHSIP)	MHSIP engagement programme – local systems should develop safety improvement plans post their engagement meeting (unless agreed not needed) National programme to deliver 33% reduction in restrictive practice in pilot wards by Q4 2019/20 All mental health inpatient providers nominate a ward to participate in the improving sexual safety collaborative. Data collection to be confirmed	Not specified By Q4 2019/20 Not specified	Restrictive practice reported to MHAC and QSC. Part of regional programme of QI
	Address safety issues that affect older people	Continue to facilitate the Falls Collaborative Programme and improve falls prevention in hospital through the 2019/20 national CQUIN scheme Spread uptake of the electronic frailty index and routine frailty identification and assessment Link data on medications and falls Continue the Stop the Pressure Programme Spread Enhanced Health in Care Homes	Ongoing Not specified Not specified Not specified	Falls reduction and pressure sore prevention are reported to QSC
	Address safety issues that affect people with learning disabilities	Accelerate LeDeR and align with the medical examiner system Expand STOMP and STAMP Further spread use of care and treatment reviews All NHS-commissioned care to meet the learning disability improvement standards by 2023/24	Not specified Not specified Not specified By 2023/24	LeDeR feedback reported regularly to Trust Board as part of SI / Mortality Reports
	Deliver the UK National Action Plan for AKI	Improve the management of lower UTI in older people in all care settings by Q4 2019/20	By Q4 2019/20	Compliant

Outcomes

There will be an initial emphasis on specific work identified by the Patient Safety Collaborative (PSC) programmes. This will be aligned to the 7 NHS regional teams. If a provider appears to be challenged a Patient Safety Support Team will be assigned.

Current PSC programmes are as follows:

- Sepsis
- NEWS2
- Medication Safety
- Falls Prevention
- Pressure Ulcer Prevention
- Nutrition

All these aspects are covered by the Trust's approach to Physical Healthcare and progress reported to the Quality and Safeguarding Committee.

The Mental Health Safety Improvement Programme (MHSIP) was launched on 10 May 2021.

This aims to reduce national variation in the following areas by 2024.

Key ambitions are:

- Reduction in suicide and deliberate self-harm in inpatient settings (MH and acute hospitals) and in the healthcare workforce. (Executive Leadership Team (ELT) receives reports on inpatient suicides and has agreed and reviewed the overarching Suicide Prevention Strategy. The NHS Resolution suicide prevention action plan is subsumed into the overall suicide prevention action plan.) The Trust does not currently have a Suicide Prevention Lead and a System resourced solution is being sought. The Trust's suicide prevention training programme has been suspended pending a review and relaunch. The appointment of a (Joint) Trust lead post is being explored.

- A thematic analysis of inpatient deaths has been completed and is being consulted upon as part of a QI approach to improving patient safety.

- Reduce the incidence of restrictive practice in inpatient mental health and learning disability services. (This is part of a regional quality improvement approach with regular monitoring and reports to the Quality and Safeguarding Committee and Mental Health Act Committee.)

- Improve the sexual safety of patients and staff on inpatient mental health units.
  (We are active in this area and the estates strategy is relevant.)

4. Context for patient safety in DHCFT

Safety Stocktake

We all need to see safety as a priority and develop clinical models that are person centred and involve patients whenever possible in designing their own safe care and treatment plans. Compassionate trauma informed practice is key to this and has an

increasing evidence base. We need to use the same principles in our own self-regulation and management approaches so that this becomes the identity of the Trust and can be seen in its "personality". To this end we are developing our approach to:

- Vision and leadership
- A Just Culture
- Openness, transparency and listening
- Diversity and equality

The challenges will be related to "pace and scale" and how much of our training resource is aligned to these outcomes and whether staff survey results are an adequate measure of progress.

The Trust has reviewed our approach to Quality Improvement, particularly the potential benefits of integrating expertise in information management, research/development and clinical audit. The Director of Medical Education has redesigned medical input into QI projects.

As regards the emphasis on "avoidable harm" the following are relevant:

- Development of a strategy to develop trauma informed care. An Emotional Regulation Pathway has been developed and the work of the Joint Engagement Team is being reviewed.

- A related issue is reducing the use of restraint and restrictive practice, including rapid tranquillisation and a QI approach is being employed. When used restraint, seclusion and rapid tranquillisation need high fidelity to safety procedures including physical health monitoring.

- Sexual safety including estates provision.

- Response to physical healthcare emergencies, particularly the rapidly deteriorating patient. Psychiatric hospitals are never likely to match acute medical wards in this regard and there are related issues to address re suitability for admission, liaison models, palliative care approaches and training. ILS training includes simulating response to medical emergencies but only occurs once a year. A regular "lifeboat drill" model is likely to be more effective but would require significant investment.

- Infection Control. The trust has a strong track record and performed well during the COVID-19 pandemic.

- Medicines management and associated physical health care monitoring, particularly around the use of antipsychotics. A community infrastructure has been established and regular reporting shows a positive trajectory. Clinical audit has shown that strong leadership at team level is essential to achieve satisfactory performance and this is now the focus for quality improvement, which shows an improving picture.

The focus around the CQC's Safety key lines of enquiry (KLOEs) will continue and cover many of the areas already mentioned above. The additional commitment required by the national strategy related to safety issues that affect older people (eg falls prevention, pressure sore prevention, use of frailty index) and people with learning disabilities (eg STOMP/STAMP (Stopping over medication of people with a learning disability, autism or both-Supporting Treatment and Appropriate Medication in Paediatrics) Care and Treatment Reviews are the subject of significant quality improvement work.

The CQC Key Lines of Enquiry (KLOEs) are as follows and are subject to regular reporting to Board Committees:

KLOE 1 – Safeguarding Adults and Children

KLOE 2 – Managing Staffing Risks

KLOE 3

(a) Electronic Patient Record
(b) Data Security
(c) Care Planning
(d) Transition from CAMHS

KLOE 4

(a) Medicines Management
(b) Physical Healthcare

KLOE 5

(a) Infection Control
(b) Safety Planning and Risk Assessment
(c) Restrictive Interventions

KLOE 6

(a) Learning from Deaths
(b) Emergency Preparedness, Resilience and Response (EPRR)
The Trust has recent experience in this area(!) and our approach is being reviewed following new national guidance.

The following have been highlighted in Joined Up Care Derbyshire as gaps impacting upon the Trust's patient safety:

- Children's services - Paediatric 18 week waiting time – this has been resolved.
- Special Education Needs and Disabilities (SEND) services - resolved.

- Child and adolescent mental health services (CAMHS) Tier 4 inpatient provision. Investment in Crisis and Home Treatment has been agreed and service re-design implemented but there are still significant problems.
- Significant waiting lists for secondary care psychotherapy. A lead post has been established and there is significant improvement.
- An adult eating disorder service which is too small for the population it serves. Investment has been secured but there is still a significant gap.
- CAMHS eating disorder service had investment but demand has increased and is outstripping available resources and there are recruitment / retention problems with senior clinical posts.
- A learning disability service and autism assessment service that does not have the capacity to meet demand and is not compliant with the recommended timescale for 12-week assessments. The Mental Health, LD and Autism Delivery Board has agreed a programme of investment.
- No locally accessible PICU (Psychiatric Intensive Care Unit) service in Derbyshire }
- Inpatient dormitory stock not fit for purpose } Agreed Estates Strategy.
- Increasing pressure on adult community mental health teams. Integrated care schemes delivered in Derby City and the High Peak with roll out planned for other areas.

The Trust has a positive track record in the following areas showing our capacity for service re-design and innovation:

- Dementia Rapid Response Team and impact on reducing pressure on inpatient services
- Memory Assessment Service
- Substance Misuse Integrated Pathway
- CAMHS Phase 1 CYP IAPT (Improving Access to Psychological Therapies)
- Family liaison.
- EPR SystmOne roll out.

The Trust's approach to systems working, integrated care and securing investment as part of the NHS's Long-Term Plan is therefore a crucial safety issue. Investment in Community Forensic and related rehabilitation will become a safety priority over the next two years as the number of low secure beds is reduced nationally and patients are repatriated from locked door rehabilitation placements. Investment has been secured for development of our Forensic Services.

The Trust's currently identified strategic priorities for safety 2022/2023

The Trust Strategy 2022-2025 details "building blocks" for the next 3 years. These include "maintaining and improving safety in regulatory standards". Delivery will be through achievement in 8 essential areas for 2022/2023.

One of these areas include 5 quality clinical improvements for each clinical service in the following domains:

- Assessment
- Risk assessment and safety planning
- Care planning
- Outcome measurement
- Service specific improvement

} These are a priority in preparation for new legislation, ie amendments to the Mental Health Act and the introduction of Liberty Protection Safeguards

These clinical improvements are subject to regular performance reviews in our service lines.

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 6 September 2022

Draft Mental Health Act Bill

Purpose of Report

To brief the Board following the publication of the draft Mental Health Act Bill.

Executive Summary

It is anticipated that the Bill will be introduced into Parliament in 2023. The number of patients detained under the Mental Health Act has doubled since it was last amended in 1983. The new amendments are intended to help reverse that trend. This will require a focus on service development, patient flow management and practice (particularly risk assessment and management).

The brief concentrates on the new statutory requirements which will require investment in infrastructure especially the Mental Health Act Office and clinical time including administrative support.

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

Risks and Assurances

The amendments to the Mental Health Act and the introduction of Liberty Protection Safeguards are a standing item on the Mental Health Act Committee agenda.

Consultation

The Trust responded to the national consultation following the initial Mental Health Act review. Our leads are working with their colleagues in the Local Authorities on the implications of the expected amendments to the Mental Health Act and the introduction of the Liberty Protection Safeguards.

Governance or Legal Issues

Fidelity to the legal changes is an absolute governance requirement.

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:

- People with Learning Disabilities and Autism will no longer be able to be detained under Section 3 for treatment solely because of their disability.
- The Trust is part of a national research project, which aims to help understand the dynamics, which lead to a disproportionate number of people from ethnic minorities being detained under the Mental Health Act.

Recommendations

The Board of Directors is requested to:

1) Note the content of this brief.
2) Consider when further assurances will be required from the Mental Health Act Committee regarding the preparation required for these changes.

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

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

On 27 June 2022 the draft Mental Health Act Bill, together with explanatory notes and a Memorandum to the delegated powers and regulatory reform committee were published.

The Bill does not repeal the MHA 1983 but rather amends it. This paper will concentrate on the headline initial amendments and potential impact. The Bill itself makes changes arranged into 14 headings; a full list can be found at the end of this paper.

Timeline for implementation

It is important to highlight that the Bill will go before the pre-legislative Parliamentary Select Committee for scrutiny and so further amends could occur. It is currently scheduled that the Select Committee's report will be due by 16 December 2022 with a view to introducing the Bill into Parliament in 2023. The timeframe for full implementation has been muted at 2030 – 2031 but legal commentators suggest the Select Committee may attempt to hasten this given the need for reform in this area of law.

Key amendments

The Bill amends the definition of mental disorder so that individuals with learning disabilities and autism can no longer be detained under s.3 MHA solely because of this. It introduces obligations on ICBs to commission services and maintain an 'at risk register' and for this register to be considered in commissioning decisions. The register would be a consent-based register.

The criteria for detaining individuals under the civil sections is tightened and the definition of 'appropriate medical treatment' now addresses the concept of therapeutic benefit with a requirement that the treatment has a reasonably prospect of alleviating or preventing the worsening of the disorder.

Section 3 detentions will be shortened to 3 months from their current 6 months in the first instance with a further renewal at 6 months and then 1 year thereafter.

A requirement for a statutory care and treatment plan for all patients detained.

The current 3-month treatment period before a SOAD (Second Opinion Appointed Doctor) is required is to be reduced to 2 months. SOADs are also required at any time when a capable objecting patient who is objecting to their medication. The approach to treatment under Part 4 is brought closer inline to the Mental Capacity Act. The concept of advance choice documents however is not taken forward.

It is no longer possible to treat a capaciously or competently refusing patient under s. 62 MHA (the emergency treatment provisions).

Informal patients will now have access to IMCAs(Independent Mental Capacity Advocates).

The concept of Nearest Relative is to be removed and replaced by the Nominated Person. The Nominated Person being chosen by the patient themselves rather than allocated according to statutory provisions. The Bill removes the right of a Nominated Person to object and stop a section 3

application; the Nominated Person can object when consulted but this can be overridden by the AMHP (Approved Mental Health Professional).

For forensic patients, there is now a 28-day time limit for transfer from prison to hospital.

There will be a Supervised Community Discharge which 'fixes' the gap created by Case Law [2018] to allow conditions in the community to amount to a deprivation of liberty in order for the protection of others provided it is no less beneficial for the patient than remaining in hospital.

The frequency with which a patient can appeal to a tribunal is increased and the Tribunal has a power to recommend that aftercare services are put in place.

Associate Hospital Managers remain unamended however given the decreased length of detentions it is anticipated, as the current requirement for review of renewals remains as per the '83 Act, the use of AHMs will increase.

Potential impact

The suggested amends will place the patient and their wishes more at the centre of their treatment and care pathway.

The exclusion of those with a learning disability and autism from longer term, section 3, detentions is broadly considered by commentators to be the correct direction of travel. Patients will, in the future, fall under the LPS for care and treatment (the LPS being authorised by an AMCP). The draft Code of Practice envisages any formal challenges (in the event that informal reconciliation is not possible) to LPS being pursued through the Court of Protection.

The combined impact of shorter detentions and the potential, therefore, for increased renewals, increased requirements to refer to a SOAD, increased access rights to the tribunal and, potentially, increased numbers of ASMs hearings are likely to have a significant impact on the MHA office's resources given the extra administrative time needed to process those safeguards of the MHA. There will be an increased need for more clinical and administrative time as professionals attend to the additional safeguards.

Content of the Bill

Content of the Bill, 14 headers:

- Autism and learning disability
- Grounds for detention and Community Treatment Orders
- Appropriate medical treatment
- The responsible clinician
- Treatment
- Community Treatment Orders
- Nominated persons
- Detention periods
- Periods for applications and references
- Patients concerned in criminal proceedings under sentence

- Help and information for patients
- After-care
- Miscellaneous
- General

Link to the draft Mental Health Act Bill

Draft Mental Health Bill 2022 - GOV.UK (www.gov.uk)

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors 6 September 2022

Board Assurance Framework (BAF)
Issue 2, 2022/23

Purpose of Report

To meet the requirement for Boards to produce an Assurance Framework. This report details the third issue of the BAF for 2022/23.

Executive Summary

Each Director Lead has thoroughly reviewed the risks allocated to them and provided comprehensive updates. These were all included in the submissions to ELT on 4 July 2022 and the Audit and Risk on12 July.

Risk 1C has been closed following updates from the Operational Leads (action leads) and in consultation with the Director Lead and the Chief operating Officer.

Risk 3B has been closed following review by the Finance and Performance Committee.

Risk 3A – The status of the actions to close the gaps in control have worsened, two have reduced ragging ratings (one from green to amber and one from amber to red). This is due to the escalation of the dormitories/Psychiatric Intensive Care Unit (PICU) risk.

The new Trust strategic objective, 'To be a GREAT Partner' has been added to the BAF report. All Directors Leads were asked to identify any risks associated with the delivery of this objective but currently none have been noted.

The system-based risk (2022-23 MS1) remains and is presented separately from the risks to the Trust strategic objectives.

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

Operational Risks

There are six Trust-wide operational risks rated as high linked to the Trust strategic objectives. Three of these are recently logged risks, two linked to Risk 1A and one to Risk 2A.

The risk relating to the Patient Safety Team and capacity to review serious incidents (ID 22815) has been fully addressed and the Director Lead has reported that this can now be closed, so it will be removed from the next issue of the BAF report.

A new pharmacy software system risk (ID 22838) has been linked to Risk 1A. Consideration was given to linking it to Risk 1D (as an IT systems risk) but ultimately the risk relates to pharmacy service provision and so patient safety.

A new pharmacy staffing risk has been linked to Risk 2A (ID 22804). Consideration was given to linking this to Risk 1A (as a risk to service delivery) but it stresses recruitment and training issues so has been linked to the strategic objective 'To be a Great Place to Work'.

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

Risks and Assurances

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

Consultation

- Chief Executive
- Executive Directors
- Non-Executive Directors
- Trust Secretary
- Operational Risk Handlers
- Deputy Directors of Operations and Operational Leads

Formal Reviews:

- Executive Leadership Team, Issue 2.1: 4 July 2022
- Audit and Risk Committee, Issue 2.2: 12 July 2022

Governance or Legal Issues

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

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

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

Recommendations

The Board of Directors is requested to:

1) **Approve** this first issue of the BAF for 2022/23 and the assurance the paper provides of the process of the review, scrutiny and update of the BAF in seeking to identify and mitigate risks to achieving the Trust's strategic objectives
2) Continue to receive updates in line with the Board's forward plan.

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

On behalf of: Justine Fitzjohn, Trust Secretary

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

Board Assurance Framework 2022/23 – Issue 2.3 Board 06 September 2022

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

Ref	Principal Risk	Director Lead	Rating (Likelihood x Impact)	Responsible Committee
Strategic Objective 1 - To provide GREAT care in all services				
22-23 1a	There is a risk that the Trust will fail to provide standards for safety and effectiveness as required by our patients and our Board	Executive Director of Nursing (DON)/Medical Director (MD)	**HIGH (4x4)**	Quality and Safeguarding Committee
22-23 1b	There is a risk that the Trust does not deliver key regulatory and strategic requirements related to dormitory eradication and Psychiatric Intensive Care Unit (PICU) and that the Trust estate more generally is not maintained sufficiently well to comply with regulatory and legislative requirements	Chief Operating Officer (COO)	~~**HIGH (4x4)**~~ **EXTREME (4x5)**	Finance and Performance Committee
~~22-23 1c~~	~~There is a risk that the Trust fails to maintain continuity of access to information to support effective patient care~~	~~Director of Strategy, Partnerships and Transformation (DSPT)~~	~~**MODERATE (3x4)**~~	~~Finance and Performance Committee~~
22-23 1d	There is a risk that the Trusts increasing dependence on digital technology for the delivery of care and operations increases the Trusts exposure to the impact of a major outage, i.e. cyber-attack, equipment failure	Chief Operating Officer (COO)	**MODERATE (3x4)**	Finance and Performance Committee
Strategic Objective 2 - To be a GREAT place to work				
22-23 2a	There is a risk that we do not sustain a healthy vibrant culture and conditions to make Derbyshire Healthcare Foundation Trust (DHCFT) a place where people want to work, thrive and to grow their careers	Director of People and Inclusion (DPI)	**HIGH (3x5)**	People and Culture Committee
22-23 2b	There is a risk of continued inequalities affecting health and well-being of staff	Director of People and Inclusion (DPI)	**HIGH (4x4)**	Trust Board
Strategic Objective 3 - To make BEST use of ~~our money~~ Resources				
22-23 3a	There is a risk that the Trust fails to deliver its revenue and capital financial plans	Executive Director of Finance (DOF)	**EXTREME (4x5)**	Finance and Performance Committee
~~22-23 3b~~	~~There is a risk that learning from the response to the COVID-19 outbreak, and transformation plans developed prior, does not lead to sustainable embedded transformation~~	~~Director of Strategy, Partnerships and Transformation (DSPT)~~	~~**HIGH (4x4)**~~	~~Finance and Performance Committee~~
22-23 3c	Whilst there are significant benefits from the creation of the Integrated Care System (ICS) as an NHS body, there is a risk that the effects of the change on senior managers from across the system may impact negatively on the cohesiveness of the Derbyshire health and care system	Director of Strategy, Partnerships and Transformation (DSPT)	**HIGH (4x4)**	Trust Board
Strategic Objective 4 – To be a GREAT Partner				

Strategic Objective 1 - To provide GREAT care in all services

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

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

Root causes:

a) Workforce supply and lack of capacity to deliver effective care across hotspot areas, increasing risks in the medical workforce
b) Risk of substantial increase in clinical demand in some services and COVID-19 related mental health surge
c) Changing demographics of population and substantial impacts of inequality within the deprived wards of the city and county
d) Intermittent lack of compliance with Care Quality Commission (CQC) standards specifically the safety domain
e) Lack of embedded outcome measures at service level
f) Known links between Serious Mental Illness (SMI) and other co-morbidities, and increased risk factors in population including inequality/ intersectionality, with escalating risks in alcohol consumption
g) Lack of compliance with physical healthcare monitoring in primary and secondary care, has improved but not at the required level for reductions in mortality
h) Restoration and recovery of access standards in autism and memory assessment services, due to COVID-19 pandemic
i) New and emerging risks related to waves of COVID-19, excess deaths associated with winter, risks to people with SMI in heatwaves due to increased mortality, impact of substantial economic downturn
j) Increased safeguarding and domestic violence related investigations as a result of harm to our patients and their families related to the impact of lockdown and as we exit the active pandemic period
k) Lack of appropriate environment to support high quality care, i.e. single gender dormitories and PICU leading to out of area (OOA) bed use for PICU
l) Lack of capacity to meet population demand for community forensic team
m) Deterioration in national enquiry into homicide – November 2021, above median
n) Local NHS Trusts will offer Recruitment and Retention Premium to Consultant Psychiatrists in specialist services and other clinical staff due to competitive practices that destabilises Trust clinical services and leads to a deterioration in waiting time and potentially in safety

BAF Ref: 22-23 1a	**Director Lead**: Carolyn Green (DON) / Dr John Sykes (MD)	**Responsible Committee**: Quality and Safeguarding Committee

Key Controls

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

Preventative – Quality governance structures, teams and processes to identify quality related issues; mandatory training; Duty of Candour processes;

clinical audits and research; health and safety audits; risk assessments; physical health care screening and monitoring; investment in COVID-secure environments and cleaning
Detective – Quality dashboard reporting; quality visit programme/virtual clinical service contact visits; incident, complaints and risk investigation; Fire Safety Regulations (FSR) compliance checks; mortality review process; physical health care monitoring clinics pilots; safety check log; Head of Nursing and Matron compliance visits
Directive – Trust Strategy and commitments; Quality Improvement Strategy; Physical Health Care Strategy; Safeguarding Strategy; Suicide Reduction Strategy; clinical strategies; policies and procedures available via Trust intranet; Central Alerting System (CAS) alerts; clinical sub committees of the Quality and Safeguarding Committee
Corrective – Board committee structures and processes ensuring escalation of quality issues; six monthly skill mix review; CQC action plans; learning from incidents, complaints and risks; actions following clinical and compliance audits; workforce issues escalation procedures; reporting to commissioners on compliance with quality standards; learning from other Trust experiences and national learning

Assurances on controls (internal)	Positive assurances on controls (external)
Quality and Trust dashboards Scrutiny of Quality Account (pre-submission) by committees Programme of physical healthcare and other clinical audits and associated plans COVID Board Assurance Framework reported to NHS England Positive and Safe self-assessment reported to the East Midlands Head of Nursing and Matron compliance visits	National enquiry into suicide and homicide NHS Litigation Authority (NHSLA) scorecard demonstrating low levels of claims Safety Thermometer identifies positive position against national benchmark Mental Health Benchmarking data identifies higher than average qualified to unqualified staffing ratio on inpatient wards CQC comprehensive review 2020 Trust is rated Good; two core services rated outstanding, two rated as require improvement Identified Trust fully compliant with National Quality Board (NQB) Learning from Deaths guidance 2020/21 Internal audits: Risk management; data security and protection 2020/21 Estates and Facilities Management internal audit (limited assurance) Transitional Monitoring Meetings with CQC (bi-monthly), no conditions

Key gaps in control	Key actions to close gaps in control	Impact on risk to be measured by	Expected completion date (Action review date)	Summary of progress on action	Action on track
Embedded learning from CQC regulatory actions, particularly in relation to improvement of training governance	Review operational governance of training compliance [ACTION OWNER: DPI] Develop and implement improvement plan to ensure sustained compliance with mandatory training [ACTION OWNERS: DPI/COO]	Embedded compliance with mandatory training and compliance rates. Reported to People and Culture Committee (PCC) Lack of recurrence of common themes regarding training	~~31.08.22~~ 30.09.22	~~New reporting mechanism commenced May 2021 with Positive and Safe and Immediate Life Support (ILS) training compliance reporting to Board~~	AMBER

		compliance. Reported to PCC and to be led by the operational leadership teams		~~ILS / Basic Life Support (BLS) / Safeguarding Adults / Children / Positive and Safe: All available. Next training recovery areas defined and being implemented in line with the Trust roadmap~~ Improved governance reporting to Board, PCC, ELT reintroduced through performance reviews on key metrics, i.e. Positive and Safe and Immediate Life Support (ILS) training compliance continues being reported to Board The backlog from the pandemic and stop and start training has significantly impacted on compliance. ILS and BLS compliance continue to improve although covid absence and vacancies are having an effect preventing release of staff ~~Implications of pandemic and stop and start training significantly impacting on steady flow of compliance. ILS and BLS back in recovery to improve compliance. Plan in place~~ ~~There are gaps in Mental~~	

				~~Capacity Act training, compliance is 83% at April 2022 – To be monitored for three months~~ ~~As at 03.05.22 manual handling training compliance was 69%~~ 01.08.22: Manual handling training has now above the minimum required standard	
The Trust has not embedded a robust system of operational management and educational governance and has not learnt lessons from the 2016 and 2020 inspections	Review operational governance of training compliance [ACTION OWNER: DPI & COO]	The Trust continues to have significant instability in training compliance and oversight of safety training The Trust management team need to move to a proactive oversight, projections of high-risk areas of safety training and advance management of risk Publication of ILS/ PSTS training as core risk areas in the Trust Board reporting until stability is achieved Sign off of the outstanding CQC actions (5 overdue actions)	~~30.06.22~~ 31.03.23		AMBER
Inability to complete physical health checks for patients whose consultations remain undertaken virtually	Improvement plan to be developed and implemented to ensure required physical health care checks are completed [ACTION OWNER: MD]	Compliance with physical healthcare checks, reported in the Quality Dashboard A 360 audit has been commissioned to review whether these improvements are embedded	~~30.06.22~~ (30.09.22)	Revised metrics included in Quality Dashboard reported to Quality and Safeguarding Committee. Maintenance to be monitored though dashboard data Remain under monitoring – Consistent approach	AMBER

				formulated for physical assessments to be completed face to face prioritised by need. Full progression of improvements has been impeded by the January COVID wave Successful bid to region to implement a coaching and self-report pilot model of health care to improve compliance and patient empowerment – Implementation through the Health protection unit Additional audit and scrutiny of physical healthcare checks are now back in place to continually improve practice. This follows unfavourable spot check audits, this remains an area of performance improvement	
Implementation of revised priority actions for 'Good Care' which support the Trust strategy	Redesign improvement plans to align to revised building blocks which support the Trust Strategy [ACTION OWNER: DON]	Compliance with suite of metrics and reporting schedule detailed in quality dashboard	~~31.05.22~~ 30.09.22	~~Indicators are within agreed tolerance including revised requirements as outlined in the COVID recovery roadmap~~ Very positive staff survey (2022) in learning, morale which all positive indicators for clinical stability and safer services	AMBER

				~~Health protection unit in place and active~~ ~~Quality dashboard embedded~~ New strategy actions in design and will be updated in June 2022 – Five quality actions and preparedness for changes to mental health legislation	
Insufficient investment in autism assessment and treatment services to meet demand. No commissioned treatment services Waiting time has increased over COVID-19 period, exacerbated by underlying demand	Investment required by CCG to meet assessment and treatment demands [ACTION OWNERS: COO/DSPT]	Agreed funding allocation has occurred, recruitment to posts is active	~~30.06.22~~ (30.09.22)	Mental Health and Learning Disability and Autism Board (MHLD AB) agreed investment in principle into autism services Expansion of teams in place ~~Recruitment to Derbyshire Community Health Services (DCHS) - North Autism Intensive Support Team (IST) and South Autism IST service has commenced~~ ~~Recruitment has begun for the Specialist Autism Team (SAT), with success in the South service~~ ASD diagnostic waiting lists remain high, with a combination of referral rate is outstripping	AMBER

				commissioned capacity, and issues with the delivery of commissioned capacity level due to sickness and retirement of staff significantly impacting the ASD diagnostic service. To support improving the position, the merger of this team with the Specialist Autism Team into a single Autism diagnostic and intervention offer has taken place week beginning 05.07.22. This includes shared resources and an overarching operational manager has been put in post to address the staffing issues and develop a recovery and improvement plan. Additional agencies are being explored to consider sub-contracting to release some immediate stress off the team and improve practice and assessment rate. Alternative providers for assessments are being considered at pace to lessen the impact on patient experience ~~Reduction in autism assessment waiting list still required. Increased~~	

				~~investment and revised service specification scheduled April 2022 in line with new National Autism Strategy is awaited~~ ~~Likely that waiting time will increase due to current staff absence. System exploration for waiting list initiative potential from private sector organisations.~~ MHLD AB agreed a review and design of a new neuro diversity diagnostic pathway. Investment included in 2022/23 system operational plan. There was a requirement for us to submit a second version of the plan on 20.06.22	
Monitoring of changes and patterns in population need in relation in the potential deterioration and other negative impacts due COVID-19	Continued monitoring and focus by the operations team and Divisional Achievement Reviews (DARs) [ACTION OWNERS: COO/MD/DON]	Monitoring of waiting list targets and implementation of mitigating actions. Reporting through DARs DON continues arm's length monitoring of monthly NHS benchmarking which continue to not follow the national trend Backlog in serious incident investigations has a recovery plan but is under significant stress and requires additional investment to mitigate this risk	31.12.22	Safety standards remain in place for urgent referrals. Limited evidence of COVID related surge in demand. Robust oversight in place Community mental health team (working age) not having increase in referrals. Acuity and activity in existing patients is significant. Monitoring and team support in place Capacity against	GREEN

				projected demand for non-inpatient contact and the inpatient demand is being reviewed. The Trust is feeding this work into the Strategic Operational Resilience Group (SORG) DARs fully operational ~~up and running again.~~ Referrals and wait lists discussed and changes post-covid included. ~~Ongoing, continue to monitor changes in patterns and population requirements for the next year~~ ~~Additional staffing and investment to the serious incident team has been given~~ 01.08.22: The SI team have returned to standard operating levels and backlog cleared ~~and may require additional investment to stabilise further, management and executive action by TOOL~~	
Six service areas assessed as 'Requires Improvement' by CQC in relation to safety	Develop and implement an improvement plan to enable all six service areas to reach 'Good' for safety in relation to the CQC standards [ACTION OWNER: DON]	CQC inspection and assessment	~~30.06.22~~ 30.09.22	Significant improvement in all services. Plan to meet training compliance is not fully compliant ~~by 31.05.21 was achieved~~ Residual CQC actions still require further attention to embed and sustain improvements – There	AMBER

				are currently 5 open actions for the acute and community service. The significant theme ~~focus~~ is training compliance	
Gap in operating standards for acute and community mental health services	Enhanced monitoring of acute and community mental health services by the Nursing and Quality Directorate [ACTION OWNER: DON]	Improvement in operating standards compliance. To be confirmed by external CQC inspection and assessment of at least 'Good'	~~30.06.22~~ (30.09.22)	Increased performance management scrutiny and unannounced site visits have been undertaken with compliance checks	AMBER
	Implement Royal College of Psychiatrists (RCP) Standards across Acute Services [ACTION OWNERS: MD/DON/COO]	Implemented Acute Inpatient Mental Health Service Accreditation (RCP Standards) reported in Divisional Achievement Reviews and Quality Account	(31.03.24)	Standards compliance work continues. Gaps in Accreditation for Inpatient Mental Health Services (AIMS) due to accommodation requirements. Finance and submission for accreditation will occur by September 2022 – Confirming accreditation date with AIMS Medic availability for PSII and mortality reviews has deteriorated due to pressure of clinical demand. Deputy MD is leading engagement of consultant workforce via clinical directors. MD issuing guidance on streamlining outpatient caseload to increase availability for governance work ~~New estates plan will meet standards when complete.~~	
	Implement 2019 Community Mental Health Framework [ACTION OWNER: DSPT]	Implemented Mental Health Community Framework to Quality and Safeguarding Committee	~~(30.06.22)~~ (30.09.22)		

				~~Plan for investment agreed with NHSE April 2021. Reported to Quality and Safeguarding Committee May 2021~~ Active recruitment now underway and named specific pilot areas in roll-out Design of new fully integrated model completed. Implementation delayed by Voluntary, Community and Social Enterprise (VCSE) procurement processes, now resolved Sites for year-two roll-out agreed as Derbyshire Dales, Chesterfield and North East Derbyshire/Bolsover. Go-live expected in High Peak and Derby City ~~The go-live of the model will be reviewed end of April~~ The go-live sites have taken place in High Peak and Derby City	
Implementation of clinical governance improvements with respect to: - Outcome measures - Clinical service reviews including reduction in excess waiting times	Develop and implement an improvement plan to enable all governance improvement plans to be implemented [ACTION OWNERS: MD/DON/COO/DSPT]	Compliance with suite of metrics and reporting schedule	~~(30.06.22)~~ (30.09.22)	Trust's COVID recovery roadmap outlines timescales for standing up of core clinical governance developments, commenced June 2021	AMBER

- Getting it Right First Time (GIRFT) reviews - Patient Safety Incident Response Framework (PSIRF) implementation - Commissioning for Quality and Innovation (CQUIN) Framework - National Institute for Health and Care Excellence (NICE) guidelines				PSIRF implementation continues – New processes in place ~~and approval of revised incident policy.~~ Staff training on PSIRF has occurred and staff capacity in place ~~to recommence~~ CQUIN progress to be included in DARs from 2022 NICE guideline mapping recommenced September 2021 Getting it Right First Time (GIRFT) reviews for Acute and Crisis were held in July 2021, action plan received. Rehabilitation pathway – April 2022 ~~Response received by Quality and Safeguarding Committee and significant progress and assurance on approach noted~~ Reduction in waiting times included in DARs. Work continues until the gap is significantly reduced. Progress in Older Adults pathways	
Implementation of new quality priorities for:	Develop and implement an improvement plan to enable all quality priorities to be implemented	Compliance with suite of metrics and reporting schedule	~~(31.05.22)~~ (30.09.22)	Reducing violence - Body worn camera investment in place ~~has commenced~~	GREEN

- Sexual safety - Implementing CQUINS and Clinical outcome measures - Recovering services – equally well - New Trust strategy and priorities - Dormitory eradication programme	[ACTION OWNER: DON]			Sexual safety – Improvement work (dashboard, preceptorship training and protocols) all commenced 01.08.22: New advisory training video being recorded in August 2022 Review of progress of dormitory eradication programme. London Road Ward 1 Older Adult service dormitory beds have closed. ~~Service relocated to Tissington~~. Update on dormitory eradication programme and clinical standards to be provided to the committee ~~at quarterly intervals~~	

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

Record ID	Service Line	Title	Risk: Summary of Progress	Date Risk Created	Date of Next Review	Residual Risk Rating

3009	Learning Disabilities Services	Demand for Autism Spectrum Disorder (ASD) assessment Service far outstrips contracted activity	04.04.22: The team is still not commissioned to provide the number of assessments which are required for the region. Demand continues to outstrip capacity. Working with CCG to develop a long-term plan. Complaints and concerns have been raised 23.06.22: As agreed with managers and commissioners the team is currently piloting use of a different assessment process with individuals identified from screening processes as being highly likely to meet the criteria for diagnosis. This is being done to see if it is possible to reduce the assessment and report writing time for some individuals and therefore increase the numbers of people that can be seen	01.01.16	28.10.22	**HIGH**
21586	Community Care Services (Older People)	Wait times breaching CCG contract	09.05.22: It is currently a 14 week wait for initial assessment in the North and a 24 week wait in the South. MAS is now fully recruited to, medics included. It is projected that we will start to see a reduction in wait times from July, alongside an increase in the diagnostic rates. Transformation works remain underway 23.06.22: A new MDM model is established with a blended approach to clinical activity. The lifting of covid restrictions means an increase in room availability for appointments. The Service Manager & Dementia Nurse Specialist is working on a plan for a 'MAS Flow Coordinator' to support with efficiencies and flow through the service	12.12.18	23.09.22	**HIGH**
21739	Operational Services	Emergency Preparedness, Resilience and Response (EPRR) Risks within Derbyshire	10.11.21: Risks locally still remain the same as there are external factors as well as internal ones. Any changes in national and regional risk registers and guidance will result in early review of this risk 28.03.22 The risk remains, we are actively responding to COVID-19 pandemic	23.07.19	27.09.22	**HIGH**
22838	Corporate Services - Pharmacy	Forced uninstall of pharmacy computer system: IE11 - EMIS	23.06.22: IE11 no longer supported by Microsoft, not yet removed from PCs by IM&T but expected to do so. Software patch not yet provided by EMIS, who we continue to chase. Replacement of the Pharmacy IT system is a possible solution but appears disproportionate in terms of team capacity and financial pressures. It would also be a protracted process and would not address the shorter-term risk of disruption to service provision 18.07.22: Patch received from EMIS and is now with ArdenGEM for testing	16.05.22	12.09.22	**HIGH**
22815	Corporate Services –	Risk to patient safety and service delivery	07.06.22: Inability to allocate over 30 overdue incidents for investigations due to lack of appropriately trained staff and operational	07.06.22	30.09.22	**HIGH**

	Nursing and Patient Experience	due to allocation of overdue incidents requiring investigation and Patient Safety staffing/resources	capacity. Overdue investigations. An increase in complaints from families has been seen who are waiting to receive the outcome of investigations 02.08.22: DON reported to TOOL that risk has been mitigated and can be closed. Risk Handler to review and close			

Strategic Objective 1 – To provide GREAT care in all services

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

Impact:
Low quality care environment specifically related to dormitory wards
Crowded staff environment and non-compliance with COVID-secure workplace environments
Non-compliance with statutory care environments
Non-compliance with statutory health and safety requirements

Root causes:

a. Long term under investment in NHS capital projects and estate
b. Limited opportunity for Trust large scale capital investment
c. Increasing expectations in care and working environments as national capital strategy and surrounding legislative and regulatory requirements evolve
d. National capital funding restrictions for business as usual capital programme for Trusts and Integrated Care Systems
e. Gaps in relation to the revised Premises Assurance Model (PAM)

BAF Ref: 22-23 1b	**Director Lead**: Ade Odunlade (COO)	**Responsible Committee**: Finance and Performance Committee

Key Controls

Inherent Risk Rating			Current Risk Rating				Target Risk Rating			Risk Appetite		
High	Likelihood 4	Impact 4	~~High~~ Extreme	Likelihood 4	Impact 4~~-5~~	Direction ⟷	Moderate	Likelihood 3	Impact 4	Accepted	Tolerated	Not Accepted

Preventative – Routine environmental assessments for statutory health and safety requirements; environmental risk assessments reported through DATIX; COVID secure workplace risk assessments
Detective – Reporting progress against Premises Assurance Model (PAM) to the Executive Leadership Team (ELT); Dormitory Eradication Board reports into Trust Board
Directive – Capital Action Team (CAT) role in scrutiny of capital projects; COVID secure workplace policy and procedure
Corrective – Short term investment agreed to support key risk areas including provision of equipment to ensure COVID secure workplace environments

Assurances on controls (internal)	Positive assurances on controls (external)
- COVID secure workplace assessments - Health and Safety Audits - Premises Assurance Management System (PAMS) reporting providing updates on key priority areas - Estates Strategy ~~(under revision for 2022/23)~~	- Mental Health Capital Expenditure bidding process - External authorised reports for statutory health and safety requirements - 2020/21 Estates and Facilities Management internal audit (limited assurance)

Key gaps in control	Key actions to close gaps in control	Impact on risk to be measured by	Expected completion date (Action review date)	Progress against action	Action on track
Estates Strategy delivery recommendations will need to be updated for ongoing COVID secure requirements	Review of Estates Strategy delivery recommendations to ensure compliance with ongoing COVID secure guidance [ACTION OWNER: COO]	Revised COVID compliant delivery recommendations	~~(31.05.22)~~ (31.12.22)	~~The strategy is currently being reviewed/revised to reflect changes in line with progress on the Dormitory Eradication Programme~~ Revised Estates Strategy is now complete and was approved by TOOL on 07.04.22	~~AMBER~~ Changed to GREEN
Lack of adherence to emerging national guidance and policy requiring the elimination of mixed sex wards and dormitory style inpatient facilities	Deliver a single room en-suite delivery plan and programme of work [ACTION OWNER: COO]	Delivery of approved business cases and surrounding associated schemes for dormitory eradication	~~(31.08.22)~~ Hard deadline for national funding of March 2024	Allocation of £80m confirmed FBCs approved by JUCD for two new build 54-bed acute units and in National approval process. Refurbishment of two existing acute wards. FBC approved by ICS subject to additional capital. ~~Seeking approval of further~~ FBC for Older Adult service relocation ~~which will complete eradication of dormitories. FBCs will be submitted for approval in May 2022~~approved by ICS subject to additional capital	AMBER
Lack of an accessible Derbyshire wide Psychiatric Intensive Care Unit (PICU)	Delivery of local PICU arrangements (new build and associated projects taking into account gender considerations) [ACTION OWNER: COO]	Agreed programme of work with capital funding to support it	~~(31.08.22)~~ (30.09.22) PICU delivery subject to national capital availability	FBCs approved by ICS in June 2022 for 14-bed male PICU and 8-bed Acute-Plus female facility, subject to additional capital availability ~~FBCs will be submitted for approval in May 2022~~	~~AMBER~~ Changed to RED

			~~date aligned to dorms new build and interim CCG contract dates~~		
Internal Audit recommendations highlighted the need for evidence of assurance on estate maintenance and wider governance for estate compliance with statutory legislation	Deliver Internal Audit report recommendations in full Premises Assurance Model (PAM) assessment to be completed [ACTION OWNER: COO] Review of current estates and facilities governance structures [ACTION OWNER: COO]	Completion of agreed recommendations and management actions Reporting to Finance and Performance Committee twice yearly and any exceptions in between Governance structure in place	~~31.08.22~~ (30.09.22)	FBCs approved for two new build 54-bed acute units and refurbishment of two existing acute wards. ~~Seeking approval of further~~ FBC for Older Adult service relocation approved subject to additional capital availability ~~which~~ will complete eradication of dormitories. FBCs approved for 14-bed male PICU and 8-bed Acute-Plus female facility. ~~FBCs will be submitted for approval in May 2022~~in June 2022 subject to additional capital funding Internal governance structure in place and meeting monthly Management audit undertaken by internal auditors Quarter 4 2020/21 – Report and actions all agreed Governance reporting will include audit recommendation response and delivery	~~AMBER Changed to GREEN~~ AMBER

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

Strategic Objective 1 – To provide GREAT care in all services

There is a risk that the Trust fails to maintain continuity of access to information to support effective patient care

Impact: Inability of staff to access patient records from the right place at the right time

Root causes:

a. Transfer to new electronic patient record provider
b. Inefficient access to clinical information in current system
c. Interoperability of systems with partner organisations
d. Current significant number of forms and processes resulting in issues regarding the consistency of recording of information

BAF Ref: 22-23 1c	**Director Lead**: Vikki Taylor (DSPT)	**Responsible Committee**: Finance and Performance Committee

Key Controls

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

Preventative – Local Implementation Groups (LIG) and overarching Clinical Design Authority (CDA) ensuring all forms and processes have been rigorously tested and signed off by representatives of the clinical services
Detective – Non-Executive Director (NED) Board member on OnEPR (one electronic patient record) Programme Delivery Board (PDB) providing project expertise and direct link to Board
Directive – OnEPR PDB governance oversight with respect to delivery of the new EPR with secured expert and experienced third-party provider; fully resourced project management team within the third-party provider and DHCFT; reporting on progress to Finance and Performance Committee (F&P) and fortnightly updates to ELT; rapid escalation of issues to ELT
Corrective – Phased approach to delivery (four phases over 18-month project delivery plan); 'Go/No Go' rationale agreed and measures for decision making, ahead of each delivery phase. Weekly 'Go/No Go' meeting in 10-week run up to 'Go Live' date for each phase of implementation

Assurances on controls (internal)	**Positive assurances on controls (external)**
- Weekly project update report and wider project progress report highlighting current position against delivery plan	

Key gaps in control	Key actions to close gaps in control	Impact on risk to be measured by	Expected completion date (Action review date)	Progress against action	Action on track
Capacity within the IM&T Team to support programme delivery to the level required by the project plan	Identify and agree priorities and release of staff [ACTION OWNER: COO]	Compliance with the agreed resource plan for the project	31.05.22	ELT agreed to amalgamate phase 3 and 4 with a go live date of 24.01.22. ELT decided to postpone the planned go live of 24.01.22 due to omicron. New plan in place for delivery on 09.05.22. project currently on plan for delivery on that date Final phase implemented on schedule 09.05.22. Propose closure of the risk	GREEN
Maintenance of staff well-being (in particular IM&T and Channel 3 staff) during final implementation of each delivery phase	Build in plans and expectations of working arrangements for IM&T and Channel 3 staff from phase 2 implementation onward [ACTION OWNER: DSPT]	Feedback from staff	31.05.22	Staff wellbeing considered on deciding to delay phase two and was an active influence on the judgement made to amalgamate phase 3 and 4 Adequate staffing resource and capacity built into programme plans for the remaining months Final phase implemented on schedule 09.05.22. Propose closure of the risk	GREEN
Adherence to the project delivery plan due to unforeseen circumstances	Close monitoring of the project risk register and issues log/regular updates with potential to adjust phasing of 'go live' decisions for each phase [ACTION OWNER: COO]	Adherence to the project delivery plan, which includes a range of clear measurable criteria against key milestones	31.05.22	ELT agreed to amalgamate phase 3 and 4 with a go live date of 24.01.22. ELT decided to postpone the planned go live of 24.01.22 due to omicron. New plan in place for delivery on 09.05.22. project currently on	AMBER

				~~plan for delivery on that date~~ ~~Final phase implemented on schedule 09.05.22. Propose closure of the risk~~	

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

Strategic Objective 1 – To provide GREAT care in all services

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

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

Root causes:

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

BAF Ref: 22-23 1d	**Director Lead**: Ade Odunlade (COO)	**Responsible Committee**: Finance and Performance Committee

Key Controls

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

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

Assurances on controls (internal)	Positive assurances on controls (external)
IM&T Strategy delivery update to F&P – September 2021	- Templar Cyber Organisational Readiness Report (CORS) - Annual external cyber review by Dynac (vulnerability scan) - Data Security and Protection annual review by Internal Audit, weighted toward cyber security - Compliance with Data Security and Protection Toolkit, including high levels of training compliance

Key gaps in control	Key actions to close gaps in control	Impact on risk to be measured by	Expected completion date (Action review date)	Progress against action	Action on track
Business continuity plans reflect changes to service delivery such as increased phone and video contacts	All services to review business continuity plans to ensure they take account of the increased use of phone and video contacts for care provision and also use of video conferencing for operational delivery [ACTION OWNER: COO]	Reporting to the Divisional Achievement Reviews (DARs)	30.09.22	Programme of updating underway. Emergency Planning and Business Continuity Manager is reviewing each business continuity plan to ensure that they are appropriate and consistent Desk based exercise undertaken and reported to the Data Security and Protection (DSP) committee. Actions identified being progressed Emergency Planning co-ordinating wider review	AMBER
Embedded programme of software and hardware upgrades	Prioritise work alongside organisational requirements and developments [ACTION OWNER: COO]	Information Technology Strategy (IT Strategy) 6-month update to Finance and Performance Committee	~~(31.05.22)~~ 30.09.22	Continual review of hardware and software undertaken in conjunction with NHS Arden and Greater East Midlands Commissioning Support Unit monthly as part of our 'Rigor' programme. Actions agreed to ensure that we continue to comply with the NHS mandate to operate on supported software and platforms Work ongoing – Examples of the progress being made would be EMIS Web and Dictate.IT which have both	GREEN

				been upgraded in the last month	
Live testing of business continuity plans	Desktop incident response exercise on IT failure to be completed [ACTION OWNER: COO]	Exercise evaluation report to Finance and Performance Committee	~~31.05.22~~ 30.09.22	~~Plan to do a desk-based review of business continuity plans by 30.04.22, co-ordinated by IM&T and Records and the Emergency Planning and Business Continuity Manager~~ Desk based exercise undertaken and reported to the DSP committee. Actions identified being progressed	GREEN
Some gaps identified in Cyber Operational Readiness Support (CORS) review undertaken by Templar	Consideration of recommendations for asset owners and policies – Trust to develop own actions in response [ACTION OWNER: COO]	Response to CORS recommendations report to Data Security and Protection Committee	~~31.05.22~~ 30.09.22	CORS recommendations and actions complete or underway and on target	GREEN

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

Strategic Objective 2 - To be a GREAT place to work

There is a risk that we do not sustain a healthy vibrant culture and conditions to make DHCFT a place where people want to work, thrive and to grow their careers

Impact: Risk to the delivery of high-quality clinical care
Inability to deliver transformational change
Exceeding of budgets allocated for temporary staff
Loss of income

Root causes:

a. National shortage of key occupations and registered professions
b. Future commissions of key posts insufficient for current and expected demand
c. Sufficient funding to deliver alternative workforce solutions
d. Retention of staff in some key areas
e. Overdependence on registered professions
f. Impact of COVID-19 pandemic
g. Increase in mental health demand and associated funding
h. Increase in use of technology
i. Consistent person-centred culture not fully embedded

BAF Ref: 22-23 2a	**Director Lead**: Jaki Lowe (DPI)	**Responsible Committee**: People and Culture Committee

Key Controls

Inherent risk rating			Current risk rating				Target risk rating			Risk appetite		
Extreme	Likelihood 4	Impact 5	High	Likelihood 4	Impact 5	Direction ↓	Moderate	Likelihood 2	Impact 5	Accepted	Tolerated	Not Accepted

Preventative – Workforce plan covering wide range of recruitment channels including targeted campaigns, 'Work For Us' internet page, leadership development, new role and skill mix changes, leadership development programme, increased well-being support, system workforce hub
Detective – Performance report identifying specific hotspots and interventions to increase recruitment and retention, Freedom to Speak Up Guardian role, Peoples Services Leadership Team meeting to oversee delivery of the People Agenda. Health risk assessments. Health and wellbeing conversations and well-being action plans. Black, Asian, and Minority Ethnic (BME) risk assessments
Directive – Wellbeing Strategy, infrastructure and programmes to support staff health and wellbeing. Workforce plan to grow and develop the workforce. Assurance reports on delivery of People Strategy to People and Culture Committee. Leadership support sessions. Staff engagement forums
Corrective – Leadership and Management Strategy and development programmes to build inclusive and engaging leadership and management. Leadership Programme – Core Leaders. Occupational health contract monitoring meeting

Assurances on controls (internal)	Positive assurances on controls (external)
Workforce Performance Report to Executive Leadership Team monthly Bimonthly People Dashboard to People and Culture Committee, includes recruitment tracker and deep dives ELT rolling programme of deep dives of strategic building blocks	Outstanding results from 2020 staff survey, identifying significant improvements across all themes Safe staffing reports and Care Hours Per Patient Day (CHPPD) reporting (planned versus actual staff)

Employee relations assurance report to ELT Deep dive review of the risk to Audit and Risk Committee (January 2021)	Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES) and gender pay gap reporting 2020/21 Internal Audit: WRES and WDES data quality (significant assurance) Reduction in employee relations cases ~~No employment tribunal cases~~ Reduce employment tribunal cases to zero

Key gaps in control	Key actions to close gaps in control	Impact on risk to be measured by	Expected completion date (Action review date)	Progress against action	Action on track
Time taken to recruit to new and vacant posts Lack of a recruitment plan showing the vacancies and recruitment position Lack of correlation between finance, HR and operational systems and information Insufficient clarity on hotspot areas and what needs to be done to address these areas	Recruitment plans in place for workforce requirements related to capital projects and mental health investment plans (relating to PICU plans and dormitory eradication) Establish a Multi-Disciplinary Team Recruitment Task and Finish group to establish a clear position on vacancies, starting January and completing by end of March 2021 [ACTONS OWNER: DPI]	Vacancy rates, time to recruit data within performance report to Board. People dashboard to PCC and monthly people assurance report to ELT Diversity in appointments. Target of 20% of workforce as BME	~~31.07.22~~ (30.09.22)	Recruitment processes working well. Plans in place for all new posts are being dynamically managed – Operational and 'business as usual' (BAU) ~~A new group scrutiny meeting with People & Inclusion Services is being launched, with a clear set of actions to address on the recruitment part of the process, to review vacancies and establishment controls. Recruitment key performance indicators now in place~~ A recruitment scrutiny meeting has been established, with a clear set of actions to address on the recruitment part of the process, to review vacancies and establishment controls. Recruitment KPIs are now being achieved. Recruitment summits have taken place with each division and actions developed to close the gap on	AMBER

				vacancies Apprenticeship profiling plan has been captured and will go to ELT The BME staffing rate continues to improve and is now at ~~16.5%~~ 16.99%	
Embedded flexible workforce arrangements in place	Implementing the learning from flexible working arrangement in response to the COVID-19 pandemic, i.e. home working Review of policies/processes and contracts of employment to embed flexible working Consultation taking place on hybrid working model Kingsway/Albany Temporary Home working consultation as a result of COVID-19 [ACTONS OWNER: DPI]	Sickness absence rate reported in performance dashboards as outlined above Staff survey responses Pulse and people pulse check responses Percentage of people working on flexible contracts with respect to hours and location (reporting metric to be developed)	(31.12.22) 30.09.22	DHCFT Promise for flexible working in place. Working from home and flexible working policies both updated. Guidance and advice for managers has been produced and focus groups on flexible working have been undertaken Pulse checks commenced and ~~will~~ continue to take place quarterly ~~– Operational and BAU~~ Delay in review due to COVID-19 surge. Survey now taken place and results currently being analysed and Kingsway/Albany group Hybrid model moving forward is still in transition Piloting the Stay process looking at flexible working options ~~Flexible working group in operation (NHSE/I initiative), led by Nursing & Quality on a six-month programme~~	GREEN

				~~Launch of hybrid principles from 01.04.22~~	
Fully embedded person-centred culture of leadership and management	Review of policies and processes to support a person-centred approach to leadership and management Review of leadership development offer Re-establish line manager development sessions Scrutiny of people data at divisional level [ACTONS OWNER: DPI]	Reduced number of formal staff relations issues/cases. Reported in monthly people assurance report to ELT Reporting to TOOL	Ongoing	'People First - Supporting colleagues fairly through workplace situations' in place and disciplinary and incident polices reviewed in line with approved proposal with 'Above Difference' to review cultural intelligence ~~- Started with Board session on 15.09.21~~ Line manager development sessions are now up and running External review of workforce policies completed Cases now being escalated effectively to ensure timely and appropriate management	GREEN
Development of a funded Workforce Plan that delivers on new role development	Develop and implement ~~2021/22~~ 2022/23 of the Workforce Delivery Plan (WDP) [ACTON OWNER: DPI]	Vacancy rate of registered posts reported in performance dashboards as outlined above and recruitment report to IMT No of new roles in place, metric to be developed. Apprenticeship student nurse uptake reported to Workforce Delivery Plan Group	Ongoing	Delivery of plan being monitored though Workforce Planning Delivery Group, through to ELT and PCC. Initial WDP reported to Board May 2021 Medical Workforce Project Group review of all vacancies, recruitment and agency spend fortnightly The Workforce Plan is included in the overarching People & Inclusion Services budget planning	AMBER

People and Inclusion Directorate shaped to deliver against future needs of the organisation	Review of Peoples Services model and plans Identify resources required to shape culture locally Develop performance framework to support delivery of revised model [ACTONS OWNER: DPI]	Service line agreements KPIs	Ongoing	New schedule of service agreed New service level agreements and key performance indicators being finalised with some proposed changes on engagement A new commissioning process in place A review of the joint venture from perspectives of service user and employees in people services are part of the system plan. Oversight meetings have commenced Meetings between CEO and Human Resources leads in DCHS and DHCFT in place	AMBER
Consolidate health and wellbeing provision and infrastructure, ensuring learning from COVID-19 pandemic is incorporated	Align well-being offer to local Sustainability and Transformation Plan (STP) and national offers Updating well-being offer, in particular mental health interventions Roll out of health and wellbeing plans for all staff Consider a reflective practice offer Review management of change policy to incorporate health and well-being discussions Similar review of appraisal policy and processes [ACTONS OWNER: DPI]	Maintain sickness absence rates to below 5% or below Reduction in sickness absence as a result of anxiety and stress Percentage uptake of health and wellbeing plans Published policies	~~(30.06.22)~~ (30.09.22)	Local, regional and national offer published via Trust intranet Increase uptake of health risk assessments Wellbeing offer has been reviewed. Health & Wellbeing Framework has been rolled out Review RESOLVE contract to increase capacity for referrals ~~Consider a reflective practice offer~~ ~~Absence rates have not decreased as anticipated –~~	AMBER

				~~Monitoring continues~~ Absence rates have not decreased as anticipated as COVID-19 and stress/burnout has been a key factor. Levels similar to pre-pandemic. Monitoring continues	
Training compliance in key areas below target set by the Trust Long-term solution required for the training venues for mandatory training and induction	Recovery being implemented Mandatory training to be rostered Estates team to consider options for central room booking and for training [ACTION OWNERS: DPI/COO]	Percentage of compliance with mandatory training reported to ELT~~-~~and bimonthly to Board as part of performance report Forward planning for training compliance	~~(30.06.22)~~ (30.09.22)	Recovery plan implemented, particularly in relation to ILS and Positive and Safe training. Forward plans to include rostering of training to be developed Significant impact of COVID-19 on release of staff – Extra resource given to support the Training and Development Team in admin is now permanent ~~to improve attendance at training remains in place until March 2022~~ Three additional trainers have been recruited. This will continue until March 2023 Target is 85% and we are below this A new training venue is required for Positive & Safe and Manual Handling training, this is being sourced, Manual handling currently at Midland House but this is due to close. Positive and Safe still at Kingsway ~~Target is 85% and we are above this. A new training~~	AMBER

				~~venue is required for Positive & Safe and Manual Handling training, this is being sourced~~	
Evidence of safer staffing levels of suitably qualified staff	Compliance with NHS Improvement (NHSI) Workforce Safeguards requirements [ACTION OWNER: ~~DPI~~ COO]	Full compliance with safer staffing levels in line with the NHSI Workforce Safeguards	~~31.05.22~~ 30.09.22	New reporting process started to incorporate ward level reporting. Board approval has been given to recruit two registered and two non-registered staff per ward, which wards are now actioning. HCA recruitment almost complete, registered staff is delayed due to national shortages Monitoring of actions to ensure E-Roster has the correct safer staffing template for each ward continues	GREEN

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

Record ID	Service Line	Title	Risk: Summary of Progress	Date Risk Created	Date of Next Review	Residual Risk Rating
22804	Corporate Services - Pharmacy	Pharmacy Staffing	There is a short-term deficit in our numbers of pharmacists and pharmacy technicians. Turnover has been increased by the growth of new posts within Primary Care Networks. We are not contributing to the training of pharmacy technicians within Derbyshire so recruitment is taking capacity from the acute Trusts who do provide training 23.06.22: Plan was presented to ELT and TOOL. The pharmacy team are currently delivering a reduced service because of staffing pressures. There remains a risk of further staff losses and financial difficulties. Current situation will be revisited in the Chief Pharmacists' Annual Report for the July 2022 meeting of the Quality and Safeguarding Committee and a review of pharmacy staffing and commitments will be provided to TOOL in March/April 2023	18.03.22	31.03.23	HIGH

Strategic Objective 2 - To be a GREAT place to work

There is a risk of continued inequalities affecting health and well-being of staff

Impact:
Risk to the delivery of high-quality clinical care
Inability to attract, recruit and retain a motivated and diverse workforce
Risk to the health and wellbeing of our staff
Risk to patients and communities having access to the right services
Escalation in formal cases impacting on individuals and teams
Reduced confidence by our communities in our Trust

Root causes:

a. Commissioning of services does not meet the need of diverse communities
b. Change management and transformation programmes lead to deterioration in experience
c. Processes and policies have inbuilt bias
d. Processes for advocacy and raising issues not clear or dealt with well
e. Gaps in cultural competence of leaders and managers

BAF Ref: 22-23 2b	**Director Lead**: Jaki Lowe (DPI)	**Responsible Committee**: Trust Board

Key Controls

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

Preventative – Freedom to Speak Up Guardian (FTSUG) self-assessment and six monthly reports; annual review of people development plan commissioned through People and Inclusion Directorate; provision of information through induction processes for new staff; staff engagement sessions; Equality, Diversity and Inclusion (EDI) Delivery Group meeting; supported networks for diverse staff groups and allies; Health and Well-being Network; workforce planning design meeting; Culture and Leadership Delivery Group; Training and Education Delivery Group
Detective – EDI updates to ELT, monthly performance report to Board; recruitment reporting to TOOL; Reverse Commissioning Project Group; Reverse Commissioning Steering Group; Equality Forum; attendance management monitoring; take up of Reasonable Adjustment Passports; updating of Electronic Staff Record (ESR) regarding disability and long-term conditions
Directive – People Strategy; Inclusion Strategy; Joined Up Care Derbyshire (JUCD) People Strategy
Corrective – Leadership and management development strategy ensuring inclusion is at the heart of all development; exit interview feedback

Assurances on controls (internal)		Positive assurances on controls (external)			
Executive Leadership Team rolling programme of deep dives on strategic building blocks		2020 staff survey results Gender pay gap annual assessment and report Assessment and report annually for Equality Delivery System (EDS2) WRES and WDES annual report 2020/21 Internal Audit WRES/Disability Worker Exclusion Scheme (DWES) data quality (significant assurance)			
Key gaps in control	**Key actions to close gaps in control**	**Impact on risk to be measured by**	**Expected completion date (Action review date)**	**Progress against action**	**Action on track**
Develop an Equality, Diversity and Inclusion Strategy (EDI Strategy) Insufficient resources in place to deliver the plans	Refresh and expanding the strategy Roll out review of cultural intelligence Launch events for the Equality, Diversity and Inclusion Strategy Development of directorate equality dashboards Recruitment process for the head of EDI and Race Equality Lead [ACTIONS OWNER: DPI]	Improved position regarding staff motivation in staff survey and pulse checks Freedom to Speak Up Index to People and Culture Committee and Board Inclusion Recruitment report Positive Friends and Family Test Percentage of exit interviews completed Metrics within the employee relations report	~~(30.06.22)~~ (30.09.22)	Strategy has been developed, engagement and embeddedness ~~to be~~ reviewed. EDI delivery group will oversee delivery of the strategy Strategic approach taken to Trust Board November 2021 Delivery group now stood up to full operating expectations and will oversee delivery of the strategy	AMBER
Refresh and expand engagement plans. Include lessons learnt from response to COVID pandemic	Establish approach for refreshing and expanding the engagement plan and a group to oversee the refresh Refresh 12-month engagement plan Develop a cultural sensitivity approach to health and wellbeing discussions [ACTIONS OWNER: DPI]	Improved staff survey results Positive Friends and Family Test Positive pulse check	~~(31.05.22)~~ (30.09.22)	Engagement plan for next 12 months to be developed in line with Trust roadmap Learning from COVID-19 has been completed and cultural sensitivity to health and wellbeing discussions were undertaken – Progress reporting into TOOL	GREEN

Gaps in the cultural competence of leaders and managers resulting in staff reporting being disadvantaged due to their protected characteristics	Roll out of cultural competence training to equip leaders and managers to be able to lead and support staff and provide the best experience for service users Participation in the national pilot on disciplinary processes Training on acceptable behaviours in teams where there are issues [ACTIONS OWNER: DPI]	Live WRES monitoring at corporate and directorate level BME case numbers Setting of targets at divisional level Development of divisional WRES Action plans	~~30.06.22~~ 30.09.22	Health risk assessment has been revisited and is now a dynamic process. Roll out of master classes for cultural intelligence start September 2021. Cultural workshops undertaken in areas of need (on disparity ratio of BME staff at Band 7 and above)	AMBER
Unequal experience of people with protected characteristics through recruitment process	Review of assurance framework that inclusion and recruitment guardians will use Increase the number and availability of Recruitment Inclusion Guardians (RIGs) Establish an escalation process where a RIG is not in place System Recruitment Pilot to change the recruitment process Review of all data from the Freedom to Speak Up Guardian, disciplinary cases and grievances to identify areas to address [ACTIONS OWNER: DPI]	Improved BME recruitment process outcomes Improved disparity ratios Review the role of the RIG from a panel member to an assurance process	31.12.22	Increased the number of inclusion guardians to 50+ System wide pilot on reviewing recruitment process was paused during the latest part of the pandemic. It will relaunch in June Senior appointments disparity at the most senior level have improved	AMBER

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

Strategic Objective 3 - To make BEST use of ~~our money~~ Resources

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

Impact: Trust becomes financially unsustainable

Root causes:

a) Financial detriment (revenue, cash and/or capital) resulting from large capital development programme, in particular dormitory eradication and associated capital schemes
b) Non approval of business case for national funding
c) Insufficient capital envelope for JUCD system that inhibits Trust capital spend requirements for required self-funded projects
d) Organisational financial detriment created by commissioning decisions or wider 'system-first' decisions including enactment of risk-sharing agreement in partnership arrangements or changes in NHS financial arrangements during and beyond the pandemic
e) Non-delivery of expected financial benefits from transformational activities
f) Non-delivery of required levels of efficiency improvement
g) Lack of sufficient cash and working capital
h) Loss due to material fraud or criminal activity
i) Unexpected income loss or non-receipt of expected transformation income (e.g. long-term plan (LTP) and Mental Health Investment Standard (MHIS) without removal of associated costs
j) Costs to deliver services exceed the Trust financial resources available
k) Lack of cultural shift/behaviours to return to financial cost control regime
l) Inability to reduce temporary staffing expenditure
m) Ongoing or re-emergence of COVID-related costs with insufficient covid funding

BAF Ref: 22_23 3a	**Director Lead**: Claire Wright (DOF)	**Responsible Committee**: Finance and Performance Committee

Key Controls

Inherent Risk Rating			Current Risk Rating				Target Risk Rating			Risk Appetite		
High	Likelihood 3	Impact 5	Extreme	Likelihood 4	Impact 5	Direction ↑	Moderate	Likelihood 2	Impact 5	Accepted	Tolerated	Not Accepted

Preventative – Integrated Care System (ICS) sign off and support for dormitory eradication work. Devoted and adequate team for Programme delivery. High quality business cases. Regular meetings with NHSIE on programme progress. Meaningful stakeholder engagement (internal and external). Robust cash flow forecasting and delivery. Multi-disciplinary development of financial plans for new programmes of work. System sign-off and appropriate governance arrangements for new programmes of work: Budget training, segregation of duties, management of commissioning risk through system engagement and leadership, mandatory counter fraud training and annual counter fraud work programme: Enhanced cash management and forecasting aligned to large capital and transformational programmes
Detective – Risk logs and programme-reporting (capital/transformation) informs ongoing financial risk assessment: Audits (internal, external and in-house); scrutiny of financial delivery, bank reconciliations; continuous improvement including cost improvement planning (CIP) and efficiency / QI delivery; contract performance, local counter fraud scrutiny
Directive – Business plans and templates set out clear financial plans and assumptions: Standing financial instructions; budget control, delegated limits, recruitment approval processes; business case approval process; invest to save/Quality Improvement methodology and protocol and Plan Do Study Act.

Risk and gain share agreements, Local Operating Procedure for Acute Capital Programme
Corrective – Risk mitigation activity and oversight at ICS system/other partnership level. Proactive reporting and forecasting of capital and wider transformation programme progress enabling remedial activity to take effect. General corrective management action; Use of contingency reserve (if available); Disaster recovery plan implementation; Performance reviews and associated support / in-reach

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

Key gaps in control	Key actions to close gaps in control	Impact on risk to be measured by	Expected completion date (Action review date)	Progress against action	Action on track
Trust cash and capital risks related to national funded acute capital programme: - Inflation cost risk - Risk-share - Cashflow timings and variability - Guaranteed Maximum	Risk share arrangements with PSCP Optimism bias and contingency discussions with NHSE/I on cash and capital	Cash and capital reporting and forecasting evidences of plan delivery and/or indicates areas of required management action	March 2024 and beyond (review quarterly)	Regular oversight of capital and cash position. Reporting to Trust Programme meetings and Committees on risks and mitigations Hyper-inflation cost risk remains is ~~currently~~ very high due to world events and economy The affordability risk has escalated	RED

Price exceeds national funding envelope (due to hyperinflation and other factors)				the wider programme risk to extreme This risk has crystalised: Confirmed hyperinflation significantly increased the price at FBC stage which resulted in need to reallocate Trust capital to augment the new build schemes. We are seeking additional national funding	
System capital programme funding shortfall for self-funded Trust capital programme: System Capital Departmental Expenditure Limit (CDEL) inadequacy for system capital requirements	System capital planning had included dorms/PICU self-funded elements which have had to augment the new build national schemes. But CDEL was constrained for the system ~~Discussions with NHSE/I – Attempt to access non CDEL funding for PICU. VAT abatement discussions with HMRC~~CDEL limits and are set against the hyperinflated costs for the programme as a whole, in order to ascertain the funding shortfall	Ongoing reporting will ascertain how and when the shortfall can be bridged by additional capital sources ~~Capital reporting remains on track and within plan~~	March 2024 and beyond (review quarterly)	System capital plan ~~being~~ submitted ~~finalised~~ under constrained CDEL envelope Longer term planning commenced HMRC view awaited. NHSE/I PICU capital information awaited Urgent discussions with national and regional teams to seek additional national PDC to address the funding shortfall This risk has crystalised, there is now a confirmed funding shortfall for the self-funded schemes within the overall programme	~~AMBER~~ Changed to RED
Additional revenue not approved by System for Older Adults Service Relocation OBC	Close partnership working with CCG and System partners to agree OBC as System document	System approvals in ~~April~~ June 2022	~~May 2022~~ 30.09.22	CCG and DCHS partners contributing to OBC/FBC development MHLDA Delivery Board agreed to oversee revenue delivery contained within programme spend. However, note that all non-national FBCs are now require capital funding resolution before they can proceed	AMBER

FBCs do not achieve national approval	Programme approach and engagement with all stakeholders. Close involvement with NHSE/I	Approval in system and by national investment committee	~~May 2022 submission~~ 30.09.22	National FBCs ~~to go through governance train May concluding in national~~ submitted~~ssions~~ in May and national approval expected August 2022 Treasury approval may also be required given the value of the schemes which now include hyperinflation costs Notification of outcome expected end of summer	~~GREEN~~ Changed to AMBER
Insufficient substantive staffing into vacancies and temporary staffing costs for bank and agency staff do not reduce	Additional management action and oversight	Enhanced bank and agency costs reported as part of wider financial and workforce reporting	March 2023 (Quarterly)	Reports to ELT and F&P outlining current areas of pressure and required actions in March and April will be ongoing	RED
Non-delivery of required recurrent cost reduction and improved efficiency and Quality Improvement	Compilation and delivery of planned Trust efficiencies and quality improvements to deliver 2022/23 plan including recurrent long term cost reductions to return to breakeven	Efficiency and QI reporting to Execs and F&P	March 2023 (Quarterly)	Partial delivery plan at time of draft and final plan submissions. Area of urgent work as reported to ELT and F&P ~~(17 March). Full plan required for final Plan submission (28 April)~~	RED
Covid costs continue and exceed funding available	Return to pre-pandemic operating models and release of additional costs	Covid cost reporting as part of wider financial reporting	March 2023 (Quarterly)	Pandemic uptick in first quarter of 2022/23. ~~Awaiting u~~Updated IPC guidance received. Covid costs scrutiny enhanced	RED

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

Strategic Objective 3 - To make BEST use of our money Resources

There is a risk that learning from the response to the COVID-19 outbreak, and transformation plans developed prior, does not lead to sustainable embedded transformation

Impact: Improvements in the quality of care, working lives and service efficiencies are lost

Root causes:

a) Impact of the COVID-19 pandemic and adherence to directives including COVID secure environments
b) Increased use of clinical consultations and interventions using virtual technology in response to COVID-19
c) Increased use of videoconferencing for clinical and corporate meetings in response to COVID-19
d) Closer relationships between community teams and inpatient services developed as a result of working within COVID-19 guidance
e) Less miles travelled miles on trust business due to greater use of virtual technology and videoconferencing
f) Flexible working arrangements for colleagues increased in response to COVID-19
g) Understanding of factors which have led to the reduction in sickness and absence of colleagues
h) Historical reliance on staff based in trust estate
i) Limited team autonomy to make local improvements at pace
j) Improvements to acute pathway length of stay during the pandemic are lost

BAF Ref: 22-23 3b	**Director Lead**: Vikki Taylor (DSPT)	**Responsible Committee**: Finance and Performance Committee

Key Controls

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

Preventative – Adherence to national and local guidance in relation to responding to the COVID-19 pandemic; Trust review group exploring how office and working spaces can reformed going forward
Detective – Transformation Team; EQUAL Forum; regular reporting to Finance and Performance Committee on pipeline to include future transformation; home working and COVID secure policies and procedures
Directive – Estates Strategy includes rationalisation of corporate estate. Home working promise agreed and circulated to all staff; Quality Improvement (QI) Strategy; clinical strategies
Corrective - Fortnightly System Restoration Cell focused on joint plans; restoration plans in line with Phase 3 national planning; evidence of local improvements at team level, i.e., risk stratification of caseloads, discharge processes. 'QI Life' software and use of will capture and report benefits. Ongoing covid guidance from the Trust Executive Team

Assurances on controls (internal)	**Positive assurances on controls (external)**
Reporting and deep dives to F&P Feedback from EQUAL Forum	- Patient surveys for patients with learning disabilities and Serious Mental Illness (SMI) conducted by Healthwatch

Key gaps in control	Key actions to close gaps in control	Impact on risk to be measured by	Expected completion date (Action review date)	Progress against action	Action on track
Implementation of the Estates Strategy in relation to community and corporate estate	Conduct estates optimisation work for community and corporate services [ACTION OWNER: COO]	Freeing up corporate estate to be utilised for clinical space	30.06.22	Work ongoing in line with Trust Roadmap. The Estates Strategy is currently being reviewed/revised to reflect changes in line with progress on the Dormitory Eradication Programme	GREEN
Embedding of current ways of working in a post COVID environment	Maintain directives on virtual meetings and non-patient facing activities to support new ways of working [ACTION OWNER: DSPT]	Less miles travelled on trust business compared to a pre COVID baselines More hours working from home compared to a pre COVID baselines	(30.06.22)	The organisation is continuing to operate under COVID-secure guidelines. Further work being undertaken at team, divisional and organisational level during phase 1 of the roadmap (Quarter 1) to look at medium-term operational models Ahead of phase 2 of the roadmap a shift in approach to face-to-face operational meetings based on risk assessments rather than Trust-wide directives will take place. The ambition to retain use of Teams for non-developmental meetings at a team and individual level remains Phase 3 of the roadmap implemented from 01.10.21. New ways of working embedded into divisional plans as agreed at TOOL. Potential for ongoing COVID-19	AMBER

				~~restrictions in late quarter 3 and quarter 4. The Trust roadmap is under fortnightly review by ELT~~ ~~Roadmap progress delayed by Omicrom wave. Revised roadmap issued 07.02.22~~ ~~A number of restrictions were lifted during 2022/23 Quarter 1 and 2. Strong organisational focus on encouraging and retaining blended/flexible working arrangements~~ ~~OnEPR roll out for Working Age Adult services took place 09.05.22~~ ~~Making room for dignity FBcs approved by Trust Board 07.06.22~~	
~~Learning from COVID-19 pandemic outbreak~~ ~~Pulse checks/staff survey – check~~	~~Review learning from colleagues [ACTION OWNER: COO]~~	~~Positive staff feedback on learning from COVID-19~~	~~31.05.22~~	~~Live staff engagement sessions continued throughout pandemic. Learning the Lessons surveys/focus groups undertaken, reported to Board~~ ~~Pulse checks completed in 2021. Staff survey 2022 results shared~~ ~~Linked to action above – Covid-19 specific learning to be shared further~~	~~GREEN~~
~~Implemented clinical strategies and Quality Improvement (QI) strategies and sign off all actions~~	~~Refresh Quality Improvement strategy and implementation plan~~ ~~Build in prioritised actions from clinical improvement strategies into divisional~~	~~Increase in no of people trained and supported to undertake Quarter 1 actions at a local team level~~ ~~Delivery against the divisional~~	~~(30.06.22)~~	~~Planning sessions with divisions/teams postponed due to focus on pandemic response. The Transformation Team are regularly meeting~~	~~AMBER~~

	~~business plans~~ ~~[ACTIONS OWNER: DSPT]~~	~~business plans~~		~~with divisional colleagues around 2021/22 and 2022/23 plans~~ ~~QI Strategy was agreed by the Quality & Safeguarding Committee in November 2021. Transformation Team working has recommenced following redeployment~~ ~~QI Implementation Plan agreed by Quality and Safeguarding Committee and Finance and Performance Committee in December 2021. Staff now starting training in QI methodologies~~ ~~Training now completed for 100 staff. Ambition is to train 1000 staff during 2022/23~~	
~~Improvements to acute pathway length of stay during pandemic are reversed~~	~~Fortnightly out of area monitoring meetings continuing, led by Medical Director~~ ~~Crisis team expansion and crisis alternatives to admissions in place and continuing to be developed.~~ ~~Social worker input on wards being sustained~~ ~~Transformational change postponed by pandemic restarted~~ ~~[ACTIONS OWNER: DSPT]~~	~~Bed occupancy being managed at less than 85%~~	~~(30.06.22)~~	~~The COO has instigated a new approach to the management of acute flow focusing on delivery of 85% bed occupancy rather than length of stay. New mechanisms are being implemented for patient reviews and discharge coordination~~ ~~Out of area acute placements are at very low levels since June 2021. Fortnightly monitoring meetings stood down~~ ~~Acute length of stay was included in MADE in October 2021 plans in development~~	~~AMBER~~

				~~based on results of the event, focussing on how we maintain 85% bed occupancy. Recommendations are feeding into a QI approach at a ward level~~ ~~Omicrom Wave response and national expectations on medically fit for discharge patients resulted in refreshed approach to flow and ongoing work to embed new processes learnt through the MADE events. Initial positive impact on occupancy and out of area placements, which continues to improve further. To be reviewed quarterly~~	

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

Strategic Objective 3 - To make BEST use of ~~our money~~ Resources

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

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

Root causes:

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

BAF Ref: 20_21 3c	**Director Lead**: Vikki Taylor (DSPT)	**Responsible Committee**: Trust Board

Key Controls

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

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

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

Key gaps in control	Key actions to close gaps in control	Impact on risk to be measured by	Expected completion date (Action review date)	Progress against action	Action on track
Maintenance of relationships with CCG/ICB colleagues during period of change and potential instability	Weekly meetings of wider MHLD system transformation team. Support and guidance provided from DHCFT Early meetings at DHCFT Board level with all new appointees into the ICB [ACTION OWNER: DSPT]	Staff turnover from wider transformational team, including CCG staff Positive working relationships formed with all new appointees in the Derbyshire system	~~(31.05.22)~~ (31.12.22)	Weekly meetings continuing A permanent ICB Chair was appointed in July 2021. The CEO advert was published on 01.09.21. Integrated Care Board CEO appointed in October 2021, incumbent CCG CEO successful ~~Other executive posts being recruited to from December 2021~~ ~~Recruitment process ongoing within ICS Board~~ Other executive posts now fully recruited. Three of the five full time Executive Director posts appointed from the CCG, remaining two posts externally appointed. Chief People Officer a shared post between UHDB and ICB Non-Executive member recruitment process for the	AMBER

				ICB now completed There remains a potential risk around evolving ICB culture and impact on partnership working	
Plan required for the development of the Mental Health, Learning Disability and Autism System Delivery Board (MHLD SDB) to become a provider ~~collaborative~~ alliance	Plan to be developed in partnership with all other organisations in the ~~collaborative~~ alliance [ACTION OWNER: CEO]	Development and agreement of Mental Health, Learning Disability and Autism (MHLD&A) Provider ~~collaborative~~ Alliance before December 2021	~~(31.05.22)~~ (31.10.22)	All Boards in the Derbyshire system have agreed their support for the direction of travel for a single provider collaborative across the system and sitting below that it is explicit that there will be a MHLD&A Provider Alliance. Work is starting imminently on what that form would look like ~~Three cross system development sessions held (and three more planned) on the creation of an Alliance. Expect agreement to be in place amongst partners before end of May 2022~~ All Foundation Trusts and both Local Authorities, the Voluntary Community and Social Enterprise (VCSE), Police and Police and Crime commissioner, independent mental health providers in Derbyshire have now agreed a formal partnership agreement - Presented to Board July 2022 The Alliance will be formally launched in September 2022 at high profile event	GREEN

Increased decision-making at a system and/or provider ~~collaborative~~ alliance level may impact on Trust-level governance structures becoming obsolete without regular review and change	Review of trust governance arrangements to be conducted in response to creation of ICS as an NHS Body with Non-Executive and Executive Director representation on the Board and the creation of a provider collaborative for Mental Health, Learning Disability and Autism [ACTION OWNER: CEO/Trust Secretary]	Board level confidence in new and emerging governance structures and ability to gain assurance on DHCFT risks and issues via system level governance regime	~~(30.06.22)~~ (31.12.22)	NHSE/I published ICS guidance documents and resources on 19.08.21 to support systems' transition into statutory Integrated Care Boards (ICBs) by 01.04.22. This document summarises these resources and provides detailed commentary on the ICB functions and governance guidance, model constitution and ICS people guidance A new series has been launched to help colleagues understand the new ICS. The CEO updated the Council of Governors on the MHLD SDB. The series of engagement events with key system leaders continues during Quarter 2 and 3 Monthly updates to Board as part of CEO reports continue Board/COG development session July 2022 focussed on changes to ICS and discussion about Governors' role July 2022 session for all system NEDs to consider new working arrangements DHCFT CEO has been formally appointed as partner member on ICD Board	AMBER

				ICB draft constitution agreed with a go live July 2022 this will trigger relevant review of Trust governance	

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

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

Multiple System Strategic Risk

There is a risk to safe, effective clinical care across Derbyshire impacting upon patients, due to not achieving national standards and variation of clinical practice and service commissioning in the Learning Disability (LD) Transforming Care Partnership and in ICS in-patient LD bedded care

Impact: May lead to avoidable harm and delays in accessing appropriate services, affecting patients, their family members and staff

Root causes:

a) The community Intensive Support Team and Learning Disability models have non-standardised operating models and require more capacity
b) Currently the delivery and commissioning partnership in Derbyshire have not met national standards or local ambitions for more robust community-based offers, working across the geography and in an integrated way with partners including social care and the voluntary sector
c) The collective vision for Learning Disability services across Derbyshire and the formal outcome to achieve repatriation to Derbyshire has not been effective with some people remaining in outsourced areas of England for extended and significant periods of time
d) Inpatient bedded facilities do not meet safer staffing levels due to substantial vacancies
e) Derbyshire bedded facilities do not meet current standards, e.g., en-suite accommodation, safety and environmental standards and the seclusion room does not meet the required standards as outlined in the Mental Health Act Code of Practice. (The CQC did note the lack of appropriate provisions in the seclusion room available in 2016 but this was not noted as a requirement notice)
f) The current LD bedded care facilities do not meet the national specifications for the Royal College of Psychiatrists Learning Disability recommended standards and are not in line with future clinical model for the LD&A pathway for Derbyshire
g) Gaps in controls – Derbyshire bedded care facilities for LD services had not had a full CQC inspection since 2016 as a core service. There may have been a drift in scrutiny connected to inspection

BAF Ref: 22-23 MS1	**Director Lead**: Ade Odunlade (COO)	**Responsible Committee**: Quality and Safeguarding Committee within DHCFT Quality and Performance Committee within the Derbyshire ICS Mental health, LD and Autism Board in terms of system operational delivery

Key Controls

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

Preventative – Health and safety audits; risk assessments; investment in estates development; workforce plan covering recruitment and retention. Mental Health Act Code of Practice

Detective – CQC inspection reports; quality visit programme/virtual clinical service contact visits; incident, complaints and risk investigations; safety check log; Head of Nursing and Matron compliance visits

Directive – Trust Strategy and commitments; Quality Improvement Strategy; Physical Health Care Strategy; Safeguarding Strategy; policies and procedures available via Trust intranet **Corrective** – Board committee structures and processes ensuring escalation of safety and quality issues; NICE Quality standards, Royal College of Psychiatrist standards for LD, CQC action plans; learning from incidents, complaints and risks; actions following clinical and compliance audits; workforce issues escalation procedures; reporting to commissioners on compliance with safety and quality standards					
Assurances on controls (internal)		**Positive assurances on controls (external)**			
Regional and national escalation process internal preparation		Advisory support provided by DHCFT to the system on bedded care standards for Learning Disability in-patient services Involvement of Local Government Association to deliver a peer review Involvement of external consultants – Two reports			
Key gaps in control	**Key actions to close gaps in control**	**Impact on risk to be measured by**	**Expected completion date (Action review date)**	**Summary of progress on action**	**Action on track**
The community Intensive Support Team and Learning Disability models require ~~review~~ improved models of support	Review all models of support offered by the Intensive Support Team [ACTION OWNERS: COO/DON/MD]	Outcome of review – Improved models of support	~~31.05.22~~ (30.09.22)	~~COO to submit review report to Quality and Safeguarding Committee~~ Initial review taken place to bring together services in North and South under a single Area Service Manager and a deputy. Further work planned for both an operational delivery review (using activity follows and patient contact time reviews to support reducing unwarranted variation and increases productivity) and clinical delivery audit supported by NHSE national nurse lead Medical recruitment and retention is experiencing stagflation – Fewer locums available, reduced	GREEN

				applications for substantive appointments. Competitors offering inflated salaries. Full report to ELT due 07.06.22	
Improvements are required in rapidly returning patients who access Learning Disabilities and Autism (LD&A) services to local care to enable them to live their lives in the least restrictive manner as close to home as possible	Continue to work on developed delivery improvement plan, owned by system partners, to improve position. This includes new cohort stratification approach that has been developed – key action to implement and fully embed approach to ensure focussed system action on existing inpatients who are place inappropriately and out of area ~~Develop an improvement plan for all Derbyshire in-patient LD&A services, to include the model, delivery, regulation and standards~~ [ACTION OWNER: COO]	Improvement plans developed and implemented resulting in a stabilised service and positive outcomes for patients working across partner systems Enhancing and reviewing Listening and Engagement Active Partnerships (LEAP) procedures Improvement plans in admission avoidance, crisis alternatives to admission and market stimulation and development, including improvement in the use of Dynamic Support Registers as a means of admission avoidance Make significant impacts on the number of stranded patients who have delayed discharges in units across the country resulting in the NHSE escalations	~~(31.05.22)~~ (30.09.22)	Full cross-system delivery plan developed and being actively driven and monitored by revised Neurodevelopmental Delivery Board. Benefits realisation sessions being arranged Review of ways of working for Intensive Support Team as a productively drive to commence ~~Initial review of progress to follow the review of models of support currently offered~~ ~~Monthly reviews of progress, development and implementation to be undertaken~~ Full integrated operational pathway mapping workshops with all system partners completed and action plan to meet fidelity of optimal pathway being driven by General Manager and new system delivery manager. This is complemented by a single system delivery plan bringing together actions	RED

				against all recent review outcomes/recommendations Improved oversight is in place but significant improvement in performance and outcome is required in returning complex individuals with learning difficulties/autism and risks. Derbyshire ICS remain an outlier	
Current substantial staff vacancies are negatively impacting on safer staffing levels in a non-DHCFT Derbyshire bedded care facility	Compliance with NHS Improvement (NHSI) Workforce Safeguards requirements ~~Staff temporarily redeployed from DHCFT to DCHS to ensure immediate safety and develop service stabilisation~~ [ACTIONS OWNERS: COO/DON/~~DPI~~]	Full compliance with safer staffing levels in line with the NHSI Workforce Safeguards	~~(31.05.22)~~ (30.09.22)	Reviews of safer staffing and stabilisation in non-DHCFT Derbyshire bedded LD facility ~~Reviews of DHCFT safer staffing, due to destabilisation of DHCFT services on releasing staff to an alternative facility~~ Part stabilisation achieved. Full stability will not occur until September 2022 - Appointed staff commencement dates	AMBER
Clinical care standards in a non-DHCFT Derbyshire bedded care facility including care plans, levels of incidents, restrictive practices including the use of long-term segregation are not compliant with clinical care standards	Develop an improvement plan for all Derbyshire in-patient LD&A services [ACTION OWNERS: COO/DON)	Full compliance with required care standards External review of Long-Term Segregation and review to end restrictive practices	~~(31.05.22)~~ (30.09.22)	As part of LD&A alliance working with DCHS, a new clinical operational model has been mobilised, with a specific ASM for inpatient and short breaks in place This ASM is progressing an action plan to stabilise LD&A inpatient offer, which provides space and time for the longer term	RED

				approach to be worked through without delaying required response to challenges with this provision. Actions include: • Recruitment and stabilisation of workforce • Developing a multiagency plan for treatment and discharge of the 3 patients • Responding to the recent CQC and Mental Health Act records review • Undertaking actions to address continuing safeguarding concerns • Support to enable restraint reduction • Address staff training requirements Alongside this, the Trust is working with JUCD on a strategic outline case for the future of bedded care for LD&A in Derbyshire. This is based on the principles of a clinical model where: 1. Where possible, most of the care and support is provided to people with a learning disability and / or autistic people is in	

				the community and close to home. This should be a holistic and responsive offer, built on community assets and the belief and understanding of what it means to have 'ordinary lives' 2. When specialist bedded care is absolutely needed, it is purposeful and delivered within a high quality, fit for purpose facility, that is responsive and flexible enough to meet a variety of needs, with an optimised length of stay, with commitment for continuation of appropriate support from community services throughout admission and beyond inpatient discharge 3. This specialist bedded care requires a range of options and facility types, including assessment and treatment, step down, crisis beds and – for a small number of people – specialist hospital placement options which are	

				within Derbyshire Some improvements in clinical standards Care plan work continues Some outstanding section 42 enquiry work to be completed Strategic Outline Case for the future of bedded care for LD&A in Derbyshire cleared at System Delivery Board to take into Outline Business Case	
Lack of adherence to national guidance and policy on in-patient care in a non-DHCFT Derbyshire bedded care facility	Deliver a single room en-suite delivery plan and programme of work [ACTION OWNER: COO/DON]	Delivery of approved business cases for development of single en-suite facilities, seclusion suite at specification standards and other improving the therapeutic and healing environment requirements Implementation of programme of work	~~(31.05.22)~~ (30.09.22)	Initial review and development of business plan to be undertaken, progress to reviewed Work to provide facilities that meet national standards to be completed – Expected completion date to be confirmed Single rooms, en-suite, seclusion room as outlined in MHA Code of practice	AMBER

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

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

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

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

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

Action Owners

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

Definitions

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

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 6 September 2022

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

Purpose of Report

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

Executive Summary

This FTSU report to Board sets out the number of cases and FTSU themes raised in the last six months from January to June 2022 at Derbyshire Healthcare NHS Foundation Trust (DHCFT).

Total case numbers seen in this report to Board (64 cases) for the six-month period, January to June 2022, have remained similar to those reported in the March 2022 FTSU report to Board for July to December 2021 (62 cases).

Emerging, or ongoing, themes include:

- **Bullying and harassment including discrimination:** several BME staff spoke up about a number of perceived issues including struggling to access development and promotion opportunities that white colleagues were gaining access to; being performance managed without a policy/process in place; the effective use of the Recruitment Inclusion Guardian (RIG) process.
- **Compassionate leadership issues:** the FTSUG logged a number of cases from a team around perceived bullying and harassment including a lack of compassionate leadership and reduced staffing levels. The team had seen a high turnover of staff over a period of 18 months.

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

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

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

Risks and Assurances

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

The Board will be carrying out a refresh of a previous self-review of FTSU based on the updated NHSI toolkit issued in July 2019. Although this review has been delayed to a date in 2022, the Audit and Risk Committee continues to monitor the progress of the FTSU action plan. The toolkit provides a benchmark and assurance that works to promote and respond to how speaking up at work is progressing.

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

Consultation

- Executive Leadership Team.

Governance or Legal Issues

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

Public Sector Equality Duty and Equality Impact Risk Analysis

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

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

- The joint working of the EDI team and FTSUG supports future ways of working to support BME staff to raise concerns.
- Any FTSU concerns logged around discrimination from BME staff with protected characteristics provide assurance that these issues are supported by employee relations/HR processes; and that any wider issues are being considered by senior Trust leadership.

This report highlights some areas of good practice including the use of FTSU Champions from a BME background and attendance of the FTSU Guardian at the network leaders meeting and a wider national Guardian's training programme to improve FTSUGs engagement with BME staff. This level of engagement is felt to be partly responsible for colleagues from BME communities contacting the Guardian.

Recommendations

The Board of Directors is requested to:

1) Support the current mechanisms and activities in place for raising awareness of the FTSU agenda
2) Discuss the report and determine whether it sufficiently assures the Board of the FTSU agenda at the Trust and that proposals made by the FTSUG promote a culture of open and honest communication to support staff to speak up
3) Begin completing the revised Board Self-Review Tool as required by the National Guardian's Office
4) Support the development of the FTSU strategy and the refresh of the FTSU policy as required by the National Guardian's Office.

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

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

Freedom to Speak Up Report

1. Introduction

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

1.2 The FTSU report covers the period from January to June 2022: Quarter 4 of 2021/22 and Quarter 1 of 2022/23. Reporting to Board is on a six-monthly basis.

2. Aim

2.1 This report aims to provide the Board with:

- Information on the number of cases being dealt with by the FTSUG and themes identified from January to June 2022.
- Information on what the Trust has learnt and what improvements have been made as a result of workers speaking up.
- Actions taken to improve FTSU culture in the Trust, including progress in the promotion of the FTSUG role and addressing barriers to speaking up.
- Updates from the National Guardians Office (NGO).
- Key recommendations to Board.

3. Summary of concerns raised

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

3.2 **Table 1** shows that the FTSUG logged 27 cases in Q1 2022/23 and 37 cases in Q4 2021/22. In Q2 2022/23, 20 cases were logged by late August 2022. The average number of cases per quarter for a mental health trust of up to 5000 staff is 21.7 per quarter. DHCFT's average cases per quarter for a 12 month period from July 2021 to June 2022 is 31.5 cases. The FTSUG believes the raised case numbers indicate that staff feel confident to speak up.

3.3 **Patient safety and quality:** During Q1 2022/23 and Q4 of 2021/22, patient safety and quality concerns were limited to 1.5% of cases. Patient safety concerns are directed to the Director of Nursing and Patient Experience. According to the National Guardian's Office, Patient safety concerns represented 19.1% of all concerns nationally during 2021/22.

Table 1: FTSU Data Q4 2021/22 and Q1 2022/2023

Types of Concerns	Q4 2021/22	Q1 2022/23
With an element of **bullying and harassment (NGO/PIDA)**	**14**	**7**
With an element of **patient safety and quality (NGO/PIDA)**	**0**	**1**
With an element of **worker safety and wellbeing (NGO)**	**16**	**8**
Potential fraud or criminal offence (PIDA)	**0**	**0**
Attitude and Behaviours including lack of compassionate leadership	32	15
Culture	19	4
Policy, process and procedure	18	12
Health and safety	2	1
Patient experience	2	1
Total cases reported to FTSUG*	**37**	**27**
Public Interest Disclosure Act (PIDA) concerns	**14**	**8**
Reportable to NGO: bullying and harassment/patient safety/worker safety	30	16
Anonymous/other	3	2
Person indicates suffering a detriment as a result of speaking up	1	0
Number of cases that have received feedback	34	25

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

3.4 **Bullying and Harassment concerns** represented 32.8% of cases raised to the FTSUG from January to June 2022. This is an increase on the 27.4% of cases raised from January to June 2021. Bullying and harassment levels are similar to 32.1% raised nationally to FTSUGs during 2021/22. (Source: Speaking Up Data - National Guardian's Office). The FTSUG continues to promote the Trust's Dignity at Work policy, the Bullying and Harassment booklet, Trust wellbeing offers, staff-side support and Employee Relations where staff require support around bullying and harassment concerns.

Figure 2 shows the number of bullying and harassment cases recorded for DHCFT in the period April 2021 to March 2022 in comparison to other Midlands based Mental Health Trusts. This data is drawn from The Model Health System which is a data-driven improvement tool that supports health and care systems to improve patient outcomes and population health. For comparison, the national median during this period is 15 and the peer median (local Mental Health Trusts) is 15. Data for Q1 2022/23 is not yet available.

Figure 3 shows Model Health System data for the Trust in relation to patient safety and quality and bullying and harrassment from 2017/18 through to 2021/22. The comparison is against a peer median of Mental Health Trusts in the Midlands. (2019/2020 showed an increase in reporting for bullying and harrassment concerns logged because of a number of teams speaking up.)

3.5 **Worker safety and wellbeing theme:** The percentage for Q1 2022/23 and Q4 2021/22 was 37.5% of all cases. This is a decrease on the 45.2% of all cases seen in Q2 and Q3 2021/22. Nationally in 2021/22 the average for worker safety was 13.7% (Source: Speaking Up Data - National Guardian's Office). Worker safety was a category introduced in 2021/22 by the NGO.

Figure 1 shows themes reported to the NGO as a percentage of total cases per quarter through July 2021 to June 2022.

Figure 1

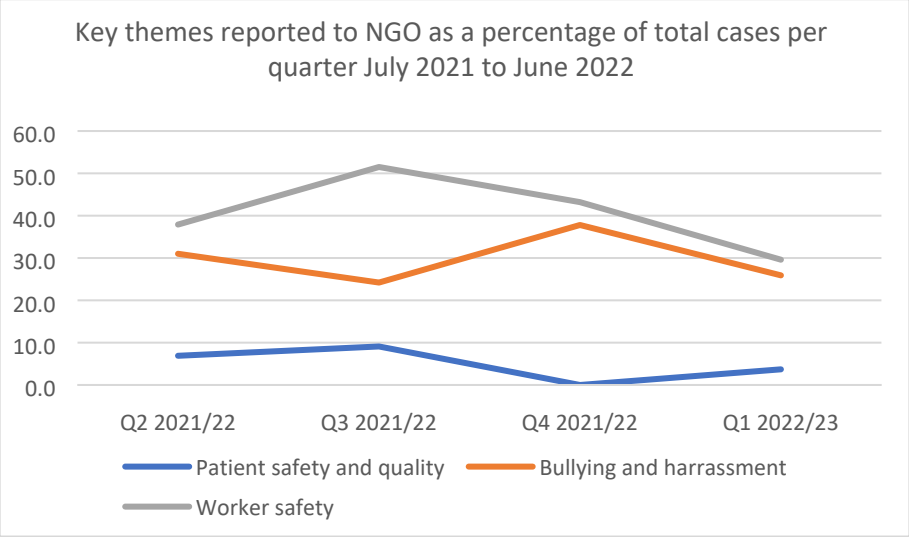


Figure 2

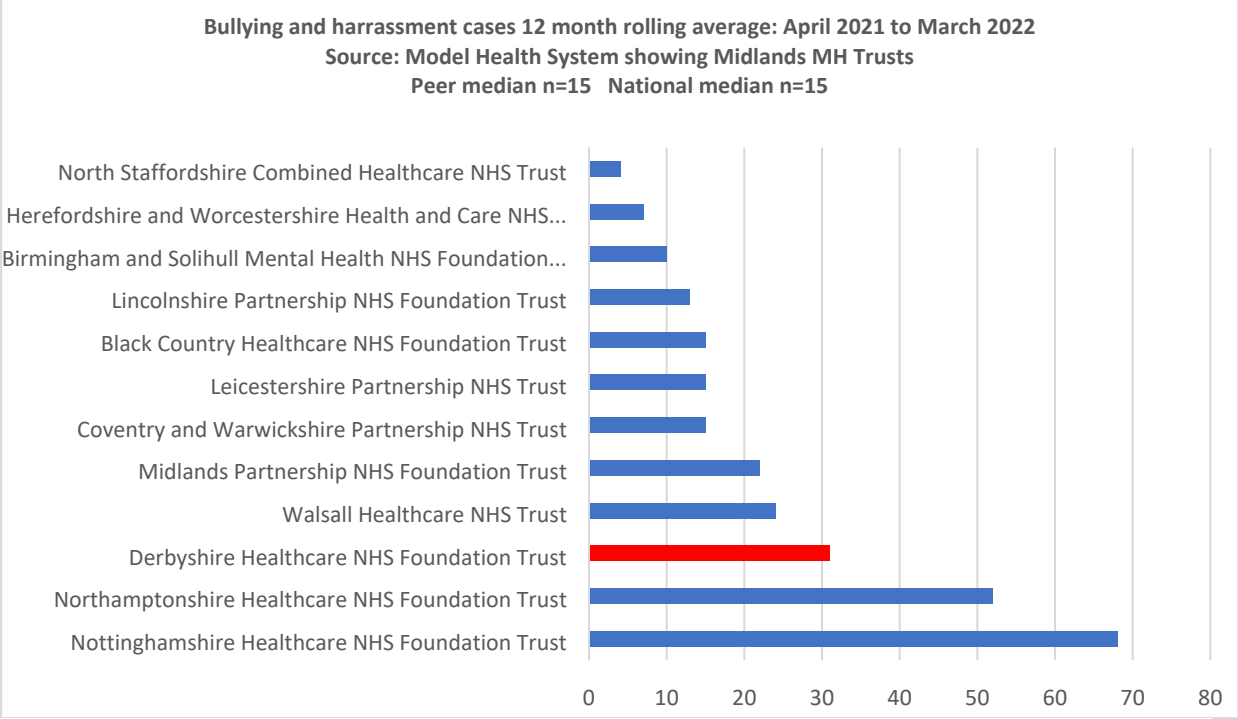
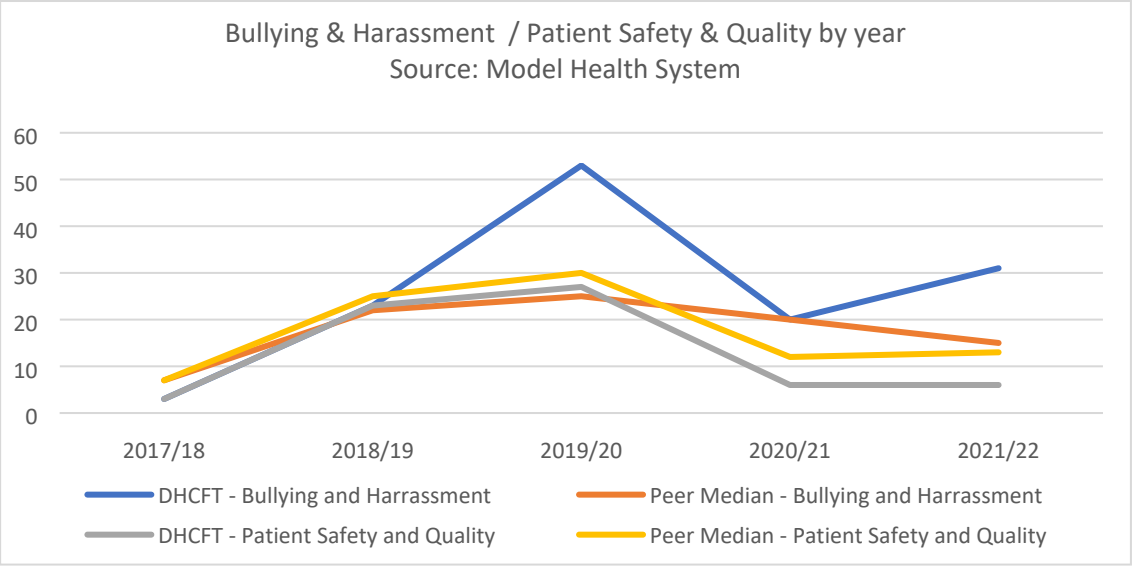


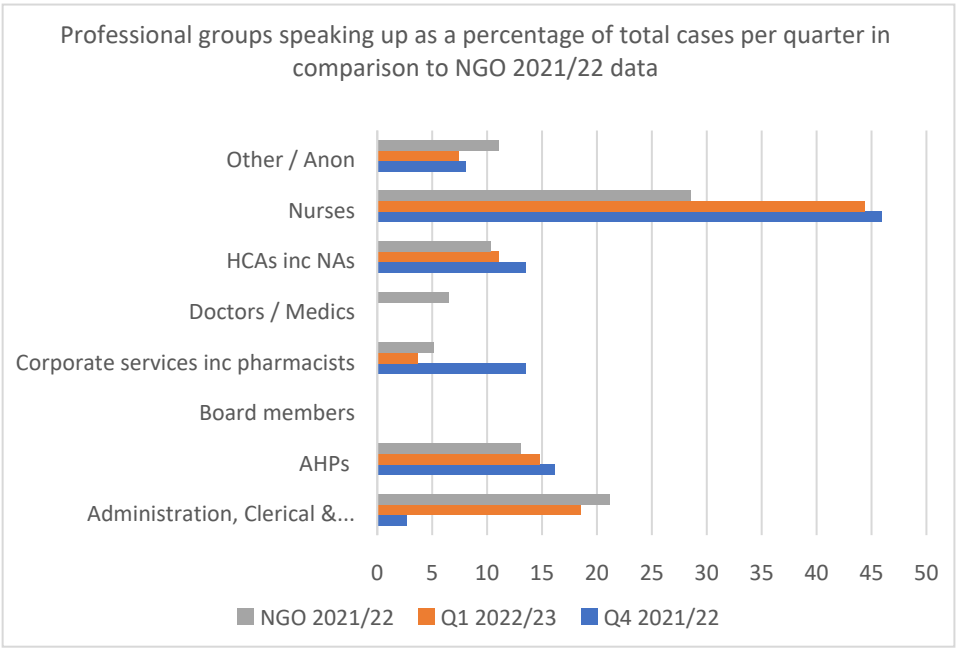
Figure 3



3.6 **Professional groups** speaking up in Q1 2022/23 and Q4 2021/22 are compared in **Figure 4** to those recorded nationally by the NGO in 2021/22. (Source: Speaking Up Data - National Guardian's Office).

In both quarters there was a significant increase in the numbers of nursing staff approaching the FTSUG. The average for the NGO nationally is 31%.

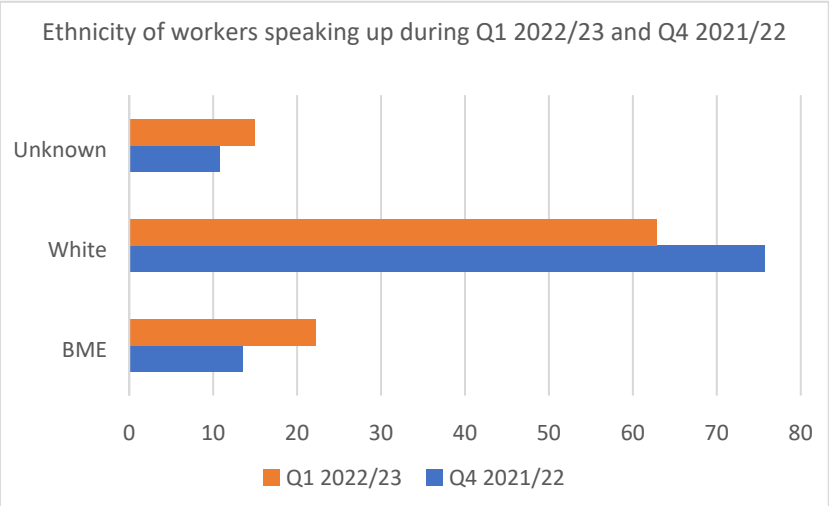
Figure 4



3.7 **Experiencing detriment or demeaning treatment:** In Q4 (2021/22), 2.7% (one worker) felt that they had experienced a detriment or demeaning treatment as a result of speaking up. In Q1 of 2022/23, no worker reported detriment.

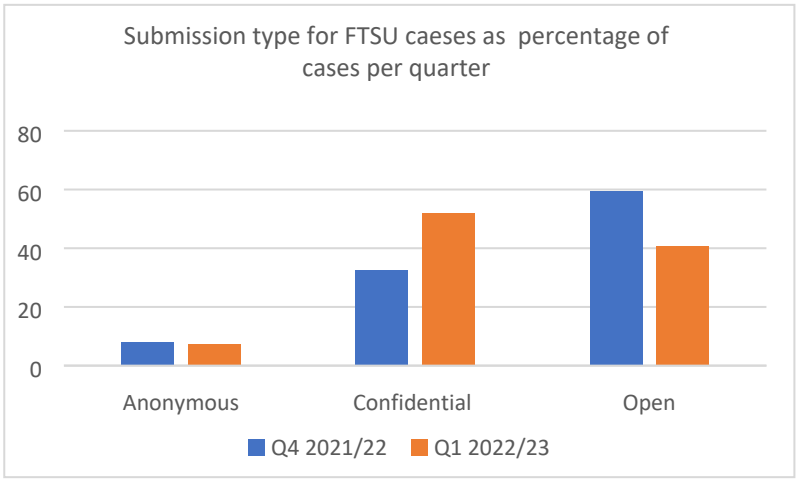
3.8 **Ethnicity of workers:** In Q4 2021/22, 13.5% of those speaking up identified as a BME worker; and in Q1 2022/23 22.2% of workers speaking up were BME. According to DHCFT's draft Workforce Race Equality Standard (WRES) Annual Report and Action Plan 2022/23, 16.7% of the workforce in the Trust in 2021/22 were BME. **Figure 5** shows BME, white and unknown as percentage of cases speaking up per quarter.

Figure 5



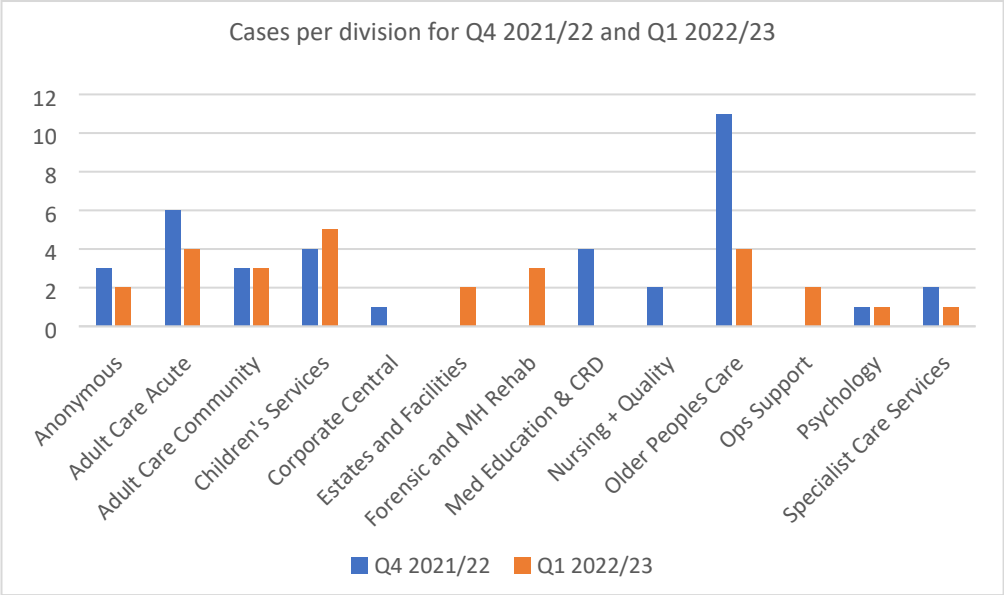
Anonymous, confidential or open concerns: Anonymous concerns decreased from 8.1% in Q4 2021/22 to 7.4% in Q1 2022/23. DHCFT anonymous cases are 7.8% for the six months: January to June 2022. In the preceding report to Board (July to December 2021) they were at 16.1%. Anonymous concerns reported nationally in 2021/22 were higher at 10.4% (Source: Speaking Up Data - National Guardian's Office). Confidential concerns, where workers wish to keep their identity private, but where they are known to the FTSUG, have increased in Q1 2022/23 in relation to Q4 2021/22. **Figure 6** shows the number of concerns per quarter as anonymous, confidential or open.

Figure 6



3.9 **Concerns raised by Division: Figure 7** shows the number of cases from divisions across the Trust. Older People's Care was raised in Q4 2021/22 due to a number of staff from one team speaking up. Adult Care Acute and Children's Services have greater numbers of staff and tend to see higher numbers of staff speaking up.

Figure 7



3.11 Seniority of those speaking up: In DHFT from January to June 2022, workers raised 76.6% of the FTSU cases (74.9% nationally, NGO 2021/22), 15.6% of concerns came from managers (15.2% NGO) with no cases raised by senior leaders (2.9% NGO). Source: Speaking Up Data - National Guardian's Office.

4. Emerging or ongoing themes with learning/action points

4.1 **Policy, process and procedure/staff wellbeing:** FTSUG had concerns in Q4 2021/22 around shift patterns and the proposed changes that were being considered prior to the pandemic in relation to the introduction of breaks. It was felt by those speaking up that breaks were needed to improve staff wellbeing.

Learning/action: concerns raised have been shared locally with relevant leaders for consideration and staff are being supported with these concerns. The project around shift changes was put on hold during the pandemic and may be considered again in the future.

4.2 **Compassionate leadership – lack of:** Several staff have raised concerns about behaviours of leaders in relation to employee relations processes and other issues which have impacted on their wellbeing. They have noted a lack of compassionate leadership in these interactions.

Learning/action: There is an understanding and awareness from senior leaders that NHS staff have experienced significant pressure from the pandemic; and that this has had an impact on staff wellbeing and behaviours. There has been a series of health and wellbeing training programmes running for managers/leaders. Staff speaking up are signposted to relevant sources of support including wellbeing support.

4.3 **Bullying and harassment:** FTSUG logged a number of cases from a team around perceived bullying and harassment including possible discrimination and a lack of compassionate leadership and reduced staffing levels. The team had a high turnover of staff over a period of 18 months.

Learning/action: senior leaders within these areas are aware of these concerns. Staff have entered into an HR process under the Trust's dignity at work policy. The Organisational Development lead is aware of these issues and is also supporting. A different manager has been brought into lead the team and feedback from staff is positive.

4.4 **Bullying and harassment including discrimination:** A few staff from a BME background spoke up about a number of issues including feeling they were struggling to access development and promotion opportunities that white colleagues were gaining access to; feeling they were being performance managed without a policy/process in place; the effective use of the Recruitment Inclusion Guardian (RIG) process.
Learning/action: BME staff supported by a range of options including staff-side/unions or have raised these issues directly with leaders. Inclusion themes have also been shared with the Equality, Diversity and Inclusion (EDI) team for further consideration. Ongoing programme of cultural intelligence running with senior leaders within Trust to support development around inclusion.

5. Improving Speaking Up Culture

5.1 **Improving visibility and networking:** the FTSUG has continued to promote the speaking up role on social media as well as writing a blog for Focus (staff intranet). The FTSUG continues to present at Trust inductions. The FTSUG has also presented tailored FTSU training sessions to the Junior Doctor network and to preceptees within the Trust as well as at team meetings and on request.

5.2 **Staff Survey 2021 support:** The FTSUG carried out an analysis of teams in relation to the five questions in the 2021 survey related to speaking up. These questions indicated whether staff felt knowledgeable, secure and encouraged to speak up and whether their concern would be addressed. Teams are being approached for awareness raising sessions around speaking up where there are poorer outcomes on these questions from the 2021 survey.

5.3 **Board culture:** A Board development session on Speaking Up is planned for late 2022. All Board Directors have a responsibility for creating a safe culture and an environment in which workers can highlight problems and make suggestions for improvement and FTSU is a fundamental part of this. Trusts are advised to carry out FTSU Board Development sessions as part of a commitment to well led leadership.

5.3 **Addressing barriers to speaking up:** Part of addressing barriers to speaking up and improving speaking up culture is linked to learning and development around speaking up. 200 staff in the Trust have carried out the speaking up training on ESR due mainly to staff who have attended the FTSU induction being logged as having completed the speak up eLearning package. The FTSUG hopes to encourage more staff to complete the speak up eLearning training.

5.4 **Supporting communities who face barriers to speaking up:** The FTSUG engages with the EDI Team to address inclusion issues for all diverse groups. The FTSUG also seeks guidance and support from the EDI Delivery group. The FTSUG has recently met with the network leads group. The FTSUG completed a programme, led by the NGO, for supporting BME staff to speak up. On a local level, the FTSUG has also recently presented to the EDI team at Derby and Derbyshire CCG on the role of the FTSUG.

The FTSUG also plans, in conjunction with the Organisational Development Lead, to develop a guide to support managers and leaders in addressing any barriers to speaking up and facilitating a healthy speaking up culture.

5.4 **Triangulation of data and FTSU:** the FTSUG considers regular reports from the Risk and Assurance Manager in order to triangulate data and to consider any barriers to speaking up identified from these reports. Future meetings have now been put in place with the Risk and Assurance Manager, the Lead for Patient Safety and Patient Experience and the Complaints Manager to further triangulate data and to improve FTSU culture and speaking up.

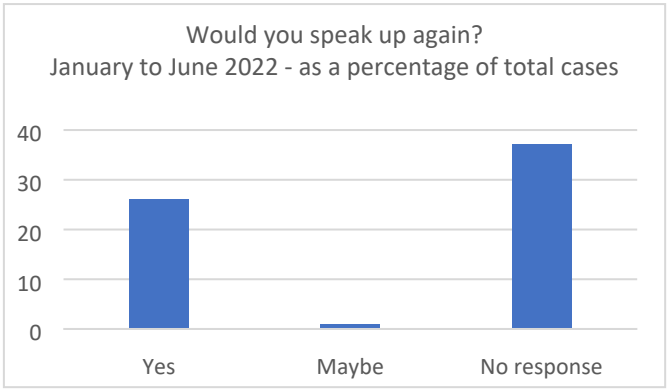
5.5 **Network of FTSU Champions:** The FTSUG holds regular catch-up meetings with Speaking Up Champions to share good practice, support any concerns or issues and to share NGO information**.** Champions referred in 22% of concerns during Q4 2021/22 and 18% during Q4 2021/22. DHCFT currently has 20 FTSU Champions who come from a range of divisions across the Trust. 30% of FTSU Champions are BME staff.

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

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

6.1 **Evaluation feedback on Speaking Up:** An evaluation form for individuals who have spoken up is sent out following contact with the FTSUG using an online link. **Figure 8** shows that 41% of those responding from January to June 2022 said ‘yes’ they would speak up again. 58% gave ‘no response’ as they did not complete the evaluation. These specific questions are required by the NGO.

Figure 8



6.2 **DCHFT Freedom to Speak Up Strategy:** The FTSUG has produced a Freedom to Speak Up Strategy for the Trust which is currently being shared with a range of networks and groups across the Trust for further comment. In the Self-Review Tool for Boards, the board is asked to evidence that it has a comprehensive and up-to-date strategy to improve its FTSU culture. The strategy has been shared with the NED for Speaking Up.

7 National Guardian's Office and related national changes

7.1 **FTSU Policy, Guidance and Reflection and Planning Tool**: In late June 2022, NHS England published its new and updated national Freedom to Speak Up policy and new and updated Freedom to Speak Up guidance and Freedom to Speak Up reflection and planning tool. These will help the Trust to deliver the People Promise for workers, by ensuring they have a voice that counts, and by developing a speaking up culture in which leaders and managers value the voice of their staff as a vital driver of learning and improvement.

NHSE is asking all trust boards to be able to evidence by the end of January 2024:

- An update to their local Freedom to Speak Up policy to reflect the new national policy template
- Results of their organisation's assessment of its Freedom to Speak Up arrangements against the revised guidance; and
- Assurance that it is on track implementing its latest Freedom to Speak Up improvement plan.

Dr Jayne Chidgey-Clark, the National Guardian, said: *"The publication of the updated universal Freedom to Speak Up Policy for the sector is an opportunity for organisations to refresh their Freedom to Speak Up arrangements. The new guidance we have developed in collaboration with NHS England will help leaders throughout the sector turn that policy into a healthy and supportive Speak Up, Listen Up, Follow Up culture."*

The FTSUG is in the process of updating the FTSU Policy for review. The updated guidance and review tool has been shared with Executive directors and the non-Executive director for FTSU.

7.3 **Speak up reviews:** There have been no recent speak up reviews (formally known as case reviews). There is an ongoing review into NHS Ambulance Trusts to understand the speaking up culture and to identify learning and make recommendations for improvement. This review is in response to consistent findings that, despite their inspection ratings, the speaking up culture in NHS Ambulance Trusts tended to be more challenged compared to other trust types.

7.4 **Using gap analysis to improve speaking up arrangements:** Following feedback, the National Guardians Office, collated together recommendations from the nine case review reports which have been published and grouped them thematically. The FTSUG has completed a gap analysis and will use this to support the Board to inform the reflection and planning tool.

7.5 NHSE/I have re-launched the **Speaking Up Scheme** (formally the Whistleblowing Scheme). This scheme was promoted to staff on Focus. The FTSUG also made contact with FTSUG Champions, as well as staff who have spoken up, to promote the scheme. The scheme only takes ten applicants a year. The FTSUG has supported two people to apply to the scheme.

8. Conclusion

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

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

9. Recommendations

The Trust Board is asked to:

1) Support the current mechanisms and activities in place for raising awareness of the FTSU agenda
2) Discuss the report and determine whether it sufficiently assures the Board of the FTSU agenda at the Trust and that proposals made by the FTSUG promote a culture of open and honest communication to support staff to speak up
3) Begin completing the revised Board Self-Review Tool as required by the National Guardian's Office
4) Support the development of the FTSU strategy and the refresh of the FTSU policy as required by the National Guardian's Office.

Tamera Howard
Freedom to Speak up Guardian
Derbyshire Healthcare Foundation Trust

Derbyshire Healthcare NHS Foundation Trust

Board Committee Assurance Summary Reports to Trust Board – 6 September 2022

The following summaries cover the meetings that have been held since the last public Board meeting held on 5 July 2022 and are received for information:

- Audit and Risk Committee 7 July
- Quality and Safeguarding Committee 12 July
- Finance and Performance Committee 19 July
- People and Culture Committee 26 July

Audit and Risk Committee – key items discussed 7 July 2022
Risk Management Audit – Actions Status Report A summary of progress against the actions identified in the Risk Management Audit 2021/22 undertaken by 360 Assurance (internal auditor) of current risks on the Datix risk register showed that substantial progress is being made to increase the standard of risk management reporting. Training in best practice will ensure greater qualitative responses from the risk handlers.
Board Assurance Framework (BAF) Issue 2, 2022/23 Issue 2 (version 2.2) of the BAF for 2022/23 reflected the scrutiny of each lead executive and work allocated to the relevant Board Committees. The Committee approved the BAF for submission to the Board for approval on 6 September, subject to the uplift of risk 1b *"There is a risk that the Trust does not deliver key regulatory and strategic requirements related to dormitory eradication and Psychiatric Intensive Care Unit (PICU) and that the Trust estate more generally is not maintained sufficiently well to comply with regulatory and legislative requirements"* risk rating to extreme circumstances outside of control that have resulted in the potential for non-delivery of a PICU and partial dormitory eradication. The Finance and Performance Committee will consider and uplift of risk 1b risk rating to extreme.
Data Quality update A progress update on activities undertaken over the last six months provided significant assurance on the substantial work that has been undertaken to ensure good quality data is maintained. As processes become more complex it is imperative that the amount of manual processing is kept to a minimum and that the operational teams ensure that electronic records are complete, accurate and up to date.
Salary overpayments An update on the position with overpayments, actions implemented in relation to the management and prevention of overpayments and plans to mitigate the number of overpayments. Limited assurance was obtained due to late terminations being the main reason for overpayments. A new internal system went live in July that will allow a better way to monitor terminations and minimise the risk of overpayments caused by late terminations. It is anticipated that the next update will show an improvement. The Committee was mindful that people have considerable cost of living challenges and of the distress that can be caused to individuals though the reclamation of salary overpayments and was pleased to note the compassionate approach being taken and that practical support is being given to staff.

Audit and Risk Committee – key items discussed 7 July 2022	
Internal Audit Contract Renewal Members of the Committee confirmed their satisfaction with the Internal Audit and Counter Fraud services provided by 360 Assurance and extended the contract for the next three years with potential to extend to five.	
Waiver Register A review of the Waiver Register that articulates why a service is only available from one source provided significant assurance on the process followed to approve and record waivers. Assurance was also obtained from the challenge that takes place behind the selection of suppliers.	
Claims Handling Policy and Procedure The slightly amended Claims Handling Policy and Procedure was ratified by the Committee.	
Commercial Insurance options appraisal A review of insurance risks the Trust has covered and uninsured gaps were considered and resulted in the recommendation that the Trust procures specific property insurance to cover, as a minimum, the new build hospitals and further explores the viability of procuring Cyber insurance.	
Internal Audit Progress The 360 Assurance's review of the Data Security and Protection Toolkit (DSPT) provided substantial assurance that the Trust has adequate arrangements in place for data security and protection. A small number of arrangements that need strengthening to ensure full, embedded and ongoing compliance with the requirements of the DSPT were identified.	
Counter Fraud Annual Report 2021/22 and progress update The annual report summarised counter fraud provision for the Trust during 2021/22. Significant work has taken place within the Trust to ensure awareness of Counter Fraud and the steps that will be taken in response to allegations. This work will continue to be rolled out during 2022/23.	
External Audit progress Effectiveness of Mazars' external audit report summarised the results of the annual satisfaction survey performed with Mazar's NHS external audit clients. A positive response was received from the Trust. Mazars fared well as results were consistently positive with the majority of responses being 'good' or 'excellent' in relation to their services. The Audit Completion Report follow up letter confirmed the conclusion of matters that were marked as outstanding within the Audit Completion Report.	
Clinical Audit update Assurance on the overall 2021/22 Clinical Audit programme, its fitness for purpose and its delivery; and to also provide an initial view of the Clinical Audit Programme for 2022/23. Significant assurance was obtained on the process of Clinical Audit with limited assurance on progress – (progress of Clinical Audit is reviewed by the Quality and Safeguarding Committee). The Committee was pleased that Quality Improvement methodology is being developed further through the QI training programme.	
Escalations to Board or other committees: None	
Next Meeting: 13 October 2022	
Committee Chair: Geoff Lewins	**Executive Lead: Justine Fitzjohn, Trust Secretary**

Quality and Safeguarding Committee - key items discussed 12 July 2022
Summary of Board Assurance Framework (BAF) Risks The Committee reviewed BAF risk 1a *"There is a risk that the Trust will fail to provide standards for safety and effectiveness as required by our patients and our Board"* it has oversight of in the context of discussions and the current work programmes. The new pharmacy software system risk has been linked to Risk 1a. The Committee also considered that the system risk for which the Committee is responsible for that has an effect on and is mitigated by multiple organisations has also impacted bed pressures and quality of care. *'There is a risk to safe, effective clinical care across Derbyshire impacting upon patients, due to not achieving national standards and variation of clinical practice and service commissioning in the Learning Disability (LD) Transforming Care Partnership and in ICS inpatient LD bedded care".*
Neurodevelopmental services update The report provided strong assurance on progression of full harmonisation of Learning Disabilities and Autism (LD&A) services in Derbyshire, working across DCHFT and Derbyshire Community Health Services (DCHS). Due to the high number of patients in acute inpatient beds and length of stay, DHCFT is leading an escalation with System partners to assess whether people are receiving the correct treatment within the correct service area.
CQC Action Plan delivery update The Committee was concerned that actions are not being closed with enough pace. The People and Culture Committee and Executive Leadership Team (ELT) are due to address compliance with mandatory training as this represents the majority of remaining outstanding CQC actions. If compliance levels are not resolved this will be escalated to the Board.
Skill Mix Review The report provided significant assurance on the required skill mix the and work being undertaken to monitor and develop the skill mix across the Trust to ensure safe services. The report also gave an overview of the skill mix and standards and evidenced the Trust's conservative view of staffing levels which is above the national registered nurse to patient ratio on benchmarking. This level of staffing has been maintained due to the larger than national recommended ward sizes of our acute services, increased turnover, environment and increases in acuity. The Trust sits above national benchmarking figures linked to staffing levels and shows a lower percentage of vacancies and turnover of staff compared to national and regional benchmarks.
NICE Guidelines The Committee was updated with the progress of the NICE Steering Group in promoting the consideration and application of National Institute for Health and Care Excellence (NICE) Guidelines and Quality Standards. The report evidenced where NICE guidance has steered improvement in clinical practice and provided significant assurance around the integration of NICE into usual practice.
Serious Incidents bi-monthly update The information relating to all Patient Safety process incidents occurring from 1 April to 31 May 2022 showed that Serious Incidents (SI) are being managed in line with the Trust Incident Reporting and Investigation Policy and Procedure and the national Serious Incident Framework. The Trust is also discharging its statutory Duty of Candour. Significant assurance was received from the detail contained in the report.

Quality and Safeguarding Committee - key items discussed 12 July 2022
Thematic learning from inpatient deaths This report set out the process of the analysis into the death of patients under the care of DHCFT inpatient settings. A total of 36 incidents were reviewed between January 2019 and May 2022. Incidents were themed to those related to physical health and those that were identified as suspected suicide. A central issue is the transition between acute hospital wards and Trust wards as regards physical health and the transition between inpatient and leave/discharge from mental health wards. Absonsion and risks associated with drugs and alcohol abuse are the main cause. The report was clinically factual and provided significant assurance of the number of lives that have been saved through staff intervention and safety measures. A number of deaths were caused by ongoing physical health conditions. The Committee was also assured by the high level of clinical engagement from the Medical Director and the Patient Safety team and the use of the Patient Safety Incident Response Framework (PSIRF) to lead quality improvement work. This includes working with the acute trust on safety and learning from these specific cases. The Trust's team will continue to improve practice and learning.
Chief Pharmacist's report The Committee was appraised of progress and concerns in medicines optimisation and pharmacy services. The report was accepted with significant assurance that the Trust has oversight and understanding of risks linked to medicines or pharmacy and that plans are in place to deliver improvement The Committee acknowledged the challenging recruitment and retention environment for pharmacy, in common with other healthcare staff groups because investment cannot be made in this area in the current financial envelope. Some investments have been made but not the full request of the extended workforce plan.
Patient Experience Quarterly Report The report showed an improving picture and provided significant assurance regarding the themes and changes made to Trust services as a result of feedback on incidents and complaints during Quarter 4 2021/22 made to the Patient and Carer Experience Committee.
Quality Visit Plan The Committee reviewed the quality visit process and its relaunch after a two-year gap, the new procedure for this season and the process to be followed with regards to feedback from quality visits. This adjusted approach includes the introduction of a collaborative way of evaluating and identifying improvements in clinical and non-clinical areas through listening to teams. It will also provide a platform for the Board supported by the quality visit team to orientate themselves around the working environment and meet the teams. Significant assurance was obtained from the approach being taken to the proposed new model of quality visit process.
Community Mental Health update The Committee received a quarterly update on the statutory objectives of the Community Mental Health Framework (CMHF) and delivery against local plan. The Trust is in the early stages of the Long Term Plan (LTP). Overall this work falls within the domain of the Mental Health, Learning Disability and Autism, Children and Young People System Delivery Board but was brought to the Committee to show the headway Community Mental Health Teams (CMHTs) are making with this change. Teams are implementing the plans and meeting their milestones and are being supported to ensure that integration is fully co-produced.

Quality and Safeguarding Committee - key items discussed 12 July 2022	
Compliance against national CAS Alert – Natasha's Law The Committee was updated with actions taken to address the Central Alerting System (CAS) alert recommendations related to changes to food standards and allergy monitoring framework following the inception of Natasha's law into legislation in October 2021. 'Natasha's Law' arose following the death of teenager Natasha Ednan-Laperouse who tragically lost her life following an allergic reaction to a prepacked food item lacking the relevant allergen labelling. This led to a call for further guidance and signage for allergy risks to address and support those living with food hypersensitivity. The CAS alert will continue to as a standing agenda item until full assurance is obtained that the measures in place to assure the fundamental aspects of the legislative changes have been met.	
Board Assurance Framework – key risks identified BAF risk 1a will be reviewed in respect of the number of inpatient deaths	
Escalations to Board or other committees If outstanding CQC actions relating to mandatory training compliance are not completed in preparation for visits from the CQC in 2022 this will be escalated to the Board	
Next Meeting – 13 September 2022	
Committee Chair: Dr Sheila Newport	**Executive Lead: Carolyn Green, Deputy Chief Executive**

Finance and Performance (F&P) Committee - key items discussed 19 July 2022
Making Room for Dignity (MRfD) Full suite of all six FBCs now supported by system. Awaiting funding solution for four previously self-funded projects with £36m funding gap excluding PICU timing and VAT risk and labour cost risk. Progress updated for the two new builds national schemes through NHSE approval routes including treasury. Timing changes may require additional draw down of additional capital and cash. Key risks plus communication and engagement. Updated programme resources and contract values and the financial governance noted. Limited assurance. **General Estates strategy update** Governance overview and KPI review. Key issues discussed and themes emerging from the Estates summit meetings and Reset, Recovery and Sustainability meeting. The strategy will be refreshed accordingly. Progress with Green plan noted and key issues flagged from certain buildings. New national cleaning standards implemented successfully.
OnEPR assurance update Verbal update provided post implementation go live on May 9. Project and data migration exit report is in progress and will come to next meeting. Post implementation issues linked to reporting being worked through. Looking to update governance arrangements into business as usual and the wider digital agenda.
Operational Performance Update on divisional breakdown on operational performance against targets to end of May 2022 Some reporting issues noted post go-live. In data migration process. Statutory requirements are largely being met. Waiting list new principles and operating models being worked through with delivery board and partners in Joined Up Care Derbyshire. Establishment of a hub for flexibility. Out of areas progress. Areas of NHSEI escalation oversight approach. Limited assurance.

Finance and Performance (F&P) Committee - key items discussed 19 July 2022	
Transforming Care Partnership (TCP) proposal and update and LDA transition Progress on operating model and setting up committee in common with DCHS. Improvements in local inpatient environment progressing well. Other aspects covered including TCP cohorts' progress against trajectory, staff transfers, LDA finance subgroup, data visibility.	
Business Environments update Progress with Perinatal Lead provider programme of work. Timeline options and approaches with associated governance. Due diligence is completed for finance and activity with final findings in line with interim views reported to board. Due diligence is in progress for quality. Lead clinician role is appointed. Risks outlined. Feedback from regulators on draft business case very positive.	
Financial plan update Month 3 position reported against the June submission breakeven plan. For month 3 adverse variance to plan of £0.7m mainly driven by the unmet CIP at that date. Financial risks of bank and agency and temporary staffing costs fill rates, new nursing approval processes, recruitment pipelines/onboarding/digital options etc, unmet CIP, covid costs and the ongoing contract for Mill Lodge to September and trajectory of bed usage and exit plan, out of area costs and the capital plan. Need to revisit the totality of longer-term commitments overseen by the delivery board programme of investments System planning and plan resubmission changes noted for revenue and capital plans.	
Continuous Improvement update Progress of Quality Improvement capability training and introductory work progressing well. New system programme management electronic system ePMO. Limited progress with recurrent CIP identification for 22/23 which needs urgent action to address.	
Board Assurance Framework 2022/23 overview Ratings for the F&P risks have been updated following discussions. F&P now has three risks, two of which are extreme (extreme deep dives – would go to Audit and Risk but TBC – given the detailed scrutiny at every F&P Committee) and one moderate (moderate normally does not require deep dive)	
Emergency Preparedness Resilience and Response (EPRR) update In line with Policy matrix – emergency Incident Response plan and procedures. Progress against action plan areas scrutinised since February discussions following changes in standards. Good progress in RAG rated risks. Leadership capacity and skills to respond successfully to multiple events. Learning from events and relevant review of policies and business continuity plans.	
Escalations to Board or other committees: None	
Next scheduled meeting – 27 September 2022	
Committee Chair: Tony Edwards	**Executive Lead: Claire Wright, Director of Finance**

People and Culture Committee - key items discussed 26 July 2022
Summary of BAF Risks The Committee reviewed the BAF risk 2a it has oversight of in the context of discussions and the current work programmes. *"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."* The new pharmacy staffing risk has been linked to risk 2a. As the risk concerns recruitment and training issues it has been linked to the strategic objective 'Great Place To Work'.
People and Inclusion Assurance Dashboard The dashboard shows the position of the organisation in recovery from the response to the COVID-19 pandemic. An improving picture was noted around performance.
Workforce Plan This comprehensive Workforce Plan is an integral part of safer staffing. Significant assurance was received from the approach being taken with limited assurance obtained in terms of delivery due to the Workforce Plan being in the early stage of its implementation. It was acknowledged that crucial to investment is the cultural transformational change that will need to be embedded in each stage of development of the Workforce Plan. The planned cultural intelligence programme and culture diagnostic process will deliver this cultural change across all teams of the organisation.
Training Compliance Delivery Compliance continues to demonstrate an overall positive position. Immediate life Support (ILS) has seen an increase and is currently at 64%. Compliance with Positive and Safe training is not achieving required levels due to a combination of unexpected staff leave within the Positive and Safe training team and low numbers of attendance on the course due to it being difficult to release staff from the wards. Focussed time is being invested into increasing compliance. If an improvement is not seen by the end of September the modules will be looked at to see how they can be delivered differently. Limited assurance was received overall due to the lack of compliance against Positive and Safe Training and ILS Level 3. Areas of deficit in the compliance of safety and mandatory training is to be reported to the next meeting on 26 September at which point a wider review of the training will be initiated if the Committee is not satisfied with the progress being made.
2022/23 Flu Vaccination Campaign The Committee received significant assurance from the proposed plans for the 2022/23 flu vaccination campaign building from performance and experience in 2021/22 and previous years. Safety and support to colleagues will continue to be the key central message.
System People Plan and development and priorities for Derbyshire Healthcare A presentation provided an oversight of the System people infrastructure and people priorities and the implications for the Committee since the new 'System People and Culture Committee' was put into place in June 2022. The Committee agreed that its first priority is to develop a people strategy that reflects the Trust's needs and provides a level of independence in terms of the Trust's workforce plan whilst articulating the organisation's people first and inclusion agenda with policies developed so they are compatible with what is happening in the System.

People and Culture Committee - key items discussed 26 July 2022	
Escalation from Quality and Safeguarding Committee The outgoing Medical Director was asked to provide his insight on how medical leadership can support and develop staff who have become used to working under controlled leadership during the pandemic. The Trust is recovering from the pandemic in reasonable order. Demand is high. The incoming Medical Director will be required to consider how to take forward System working and transformational change and the medical leadership that will be required.	
Escalations to Board or other committees None	
Board Assurance Framework – key risks identified None	
Next Meeting –20 September 2022	
Committee Chair: Ralph Knibbs	**Executive Lead: Jaki Lowe, Director of People and Inclusion**

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS

NHS Term / Abbreviation	Terms in Full
A	
A&E	Accident & Emergency
ACCT	Assessment, Care in Custody & Teamwork
ACE	Adverse Childhood Experiences
ADHD	Attention Deficit Hyperactivity Disorder
AfC	Agenda for Change
AHP	Allied Health Professional
AIMS	Royal College of Psychiatrists Accreditation for Inpatient Mental Health Services Standards
ALB	Arms-length body such as NHS Improvement (NHSI) and NHS England (NHSE)
AMM	Annual Members' Meeting
AMHP	Approved Mental Health Professional
ANP	Advanced Nurse Practitioner
AO	Accountable Officer
ASD	Autism Spectrum Disorder
ASM	Area Service Manager
B	
BAF	Board Assurance Framework
BLS	Basic Life Support (ILS Immediate Life Support)
BMA	British Medical Association
BME	Black,& Minority Ethnic group
BoD	Board of Directors
C	
CAMHS	Child and Adolescent Mental Health Services
CASSH	Care and Support Specialised Housing
CBT	Cognitive Behavioural Therapy
CCG	Clinical Commissioning Group (defunct from 1 July 2022)
CCT	Community Care Team
CDMI	Clinical Digital Maturity Index
CE	Chief Executive
CEO	Chief Executive Officer
CGA	Comprehensive Geriatric Assessment
CHPPD	Care Hours Per Patient Day
CIP	Cost Improvement Programme
CMDG	Contract Management Delivery Group
CMHF	Community Mental Health Framework
CMHT	Community Mental Health Team
CNST	Clinical Negligence Scheme for Trusts
COAT	Clinical Operational Assurance Team
COF	Commissioning Outcomes Framework
CoG	Council of Governors
COO	Chief Operating Officer
CPA	Care Programme Approach
CPD	Continuing Professional Development
CPN	Community Psychiatric Nurse
CPR	Child Protection Register

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Term / Abbreviation	**Terms in Full**
CQC	Care Quality Commission
CQI	Clinical Quality Indicator
CQUIN	Commissioning for Quality and Innovation
CRG	Clinical Reference Group
CRH	Chesterfield Royal Hospital
CRHT	Crisis resolution and home treatment
CRS	(NHS) Care Records Service
CRS	Commissioner Requested Services
CSF	Commissioner Sustainability Fund
CTO	Community Treatment Order
CTR	Care and Treatment Review
D	
DAT	Drug Action Team
Datix	Trust's electronic incident reporting system of an event that causes a loss, injury or a near miss to a patient, staff or others
DBS	Disclosure and Barring Service
DBT	Dialectical Behavioural Therapy
DfE	Department for Education
DCHS	Derbyshire Community Health Services NHS Foundation Trust
DDCCG	Derby and Derbyshire Clinical Commissioning Group
DHCFT	Derbyshire Healthcare NHS Foundation Trust
DIT	Dynamic Interpersonal Therapy
DNA	Did Not Attend
DoH	Department of Health
DoLS	Deprivation of Liberty Safeguards
DSPT	Director of Strategy, Partnerships and Transformation
DOF	Director of Finance
DON	Director of Nursing
DPI	Director of People and Inclusion
DPS	Date Protection and Security
DNA	Did not attend
DPA	Data Protection Act
DRRT	Dementia Rapid Response Team
DTOC	Delayed Transfer of Care
DVA	Derbyshire Voluntary Action (formerly North Derbyshire Voluntary Action)
DWP	Department for Work and Pensions
E	
ECT	Enhanced Care Team
ECW	Enhanced Care Ward
ED	Emergency Department
EDS2	Equality Delivery System 2
EHIC	European Health Insurance Card
EHR	Electronic Health Record
EI	Early Intervention
EIA	Equality Impact Assessment
EIP	Early Intervention In Psychosis
ELT	Executive Leadership Team
EMDR	Eye Movement Desensitising & Reprocessing Therapy

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Term / Abbreviation	**Terms in Full**
EMR	Electronic Medical Record
EPR	Electronic Patient Record
ERIC	Estates Return Information Collection
ESR	Electronic Staff Record
EUPD	Emotionally Unstable Personality Disorder
EWTD	European Working Time Directive
F	
FBC	Full Business Case
FFT	Friends and Family Test
FOI	Freedom of Information
FSR	Full Service Record
FT	Foundation Trust
FTE	Full-time Equivalent
FTN	Foundation Trust Network
FTSU	Freedom to Speak Up
FTSUG	Freedom to Speak Up Guardian
F&P	Finance and Performance
5YFV	Five Year Forward View
G	
GDPR	General Data Protection Regulation
GGI	Good Governance Institute
GIRFT	Getting it Right First Time
GMC	General Medical Council
GP	General Practitioner
GPFV	General Practice Forward View
H	
HCA	Healthcare Assistant
H1	First half of a fiscal year (April through September)
H2	Second half of a fiscal year (October through the following March)
HEE	Health Education England
HES	Hospital Episode Statistics
HoNOS	Health of the Nation Outcome Scores
HSCIC	Health and Social Care Information Centre
HSE	Health and Safety Executive
HWB	Health and Wellbeing Board
I	
IAPT	Improving Access to Psychological Therapies
ICB	Integrated Care Board
ICM	Insertable Cardiac Monitor
ICS	Integrated Care System
ICT	Information and Communication Technology
ICU	Intensive Care Unit
IDVAs	Independent Domestic Violence Advisors
IG	Information Governance
ILS	Immediate Life Support (BLS – Basic Life Support)
IMT	Incident Management Team
IM&T	Information Management and Technology
OOA	Outside of Area

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Term / Abbreviation	**Terms in Full**
IPP	Imprisonment for Public Protection
IPR	Integrated Performance Report
IPT	Interpersonal Psychotherapy
J	
JNCC	Joint Negotiating Consultative Committee
JTAI	Joint Targeted Area Inspections
JUCB	Joined Up Care Board
JUCD	Joined Up Care Derbyshire
K	
KLOE	Key Lines of Enquiry (CQC)
KPI	Key Performance Indicator
KSF	Knowledge and Skills Framework
L	
LA	Local Authority
LCFS	Local Counter Fraud Specialist
LD	Learning Disabilities
LD/A	Learning Disability and Autism
LHP	Local Health Plan
LHWB	Local Health and Wellbeing Board
LOS	Length of Stay
LPS	Liberty Protection Safeguards
LTP	Long Term Plan
M	
MADE	Multi-agency Discharge Event
MARS	Mutually Agreed Resignation Scheme
MAU	Medical Assessment Unit
MAS	Memory Assessment Service
MAPPA	Multi-agency Public Protection Arrangements
MARAC	Multi-agency Risk Assessment Conference (meeting where information is shared on the highest risk domestic abuse cases between representatives of local police, probation, health, child protection, housing practitioners, Independent Domestic Violence Advisors (IDVAs) and other specialists from the statutory and voluntary sectors.
MASH	Multi-Agency Safeguarding Hub
MCA	Mental Capacity Act
MD	Medical Director
MDA	Medical Device Alert
MDM	Multi-Disciplinary Meeting
MDT	Multi-Disciplinary Team
MFF	Market Forces Factor
MHA	Mental Health Act
MHAC	Mental Health Act Committee
MHIN	Mental Health Intelligence Network
MHIS	Mental Health Investment Standard
MHLT	Mental Health Liaison Team
MHRT	Mental Health Review Tribunal
MSC	Medical Staff Committee

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Term / Abbreviation	**Terms in Full**
MSK	Musculoskeletal (conditions)
MSU	Medium secure unit
N	
NCRS	National Cancer Registration Service
NED	Non-Executive Director
NICE	National Institute for Health and Care Excellence
NHS	National Health Service
NHSE	National Health Service England
NHSI	National Health Service Improvement
NHSEI	NHS England and NHS Improvement
NIHR	National Institute for Health Research
O	
OBC	Outline Business Case
ODG	Operational Delivery Group
OPMO	Older People's Mental Health Services
OP	Outpatient
OSC	Overview and Scrutiny Committee
OT	Occupational therapy
P	
PAB	Programme Assurance Board
PAG	Programme Advisory Group
PALS	Patient Advice and Liaison Service
PAM	Payment Activity Matrix
PARC	Psychosis and the reduction of cannabis (and other drugs)
PARIS	This is an electronic patient record system
PbR	Payment by Results
PCC	Police & Crime Commissioner
PCC	People and Culture Committee
PCN	Primary Care Networks
PDSA	Plan, Do, Study, Act
PHE	Public Health England
PICU	Psychiatric Intensive Care Unit
PID	Project Initiation Document
PiPoT	People in Positions of Trust
PLIC	Patient Level Information Costs
PMLD	Profound and Multiple Disability
PPE	Personal Protection Equipment
PPI	Patient and Public Involvement
PPT	Partnership and Pathway Team
PREM	Patient Reported Experience Measure
PROMS	Patient Reported Outcome Measure
PSF	Provider Sustainability Fund
PSIRF	Patient Safety Incident Review Framework
Q	
QAG	Quality Assurance Group
Q&SC	Quality and Safeguarding Committee
QIA	Quality Impact Assessment
QIPP	Quality, Innovation, Productivity Programme

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Term / Abbreviation	**Terms in Full**
R	
RAID	Rapid Assessment, Interface and Discharge
RCGP	Royal College of General Practitioners
RCI	Reference Cost Index
REGARDS	Race, Economic disadvantage, Gender, Age, Religion or belief, Disability and Sexual orientation
RTT	Referral to Treatment
S	
SAAF	Safeguarding Adults Assurance Framework
SBARD	Situation, Background, Assessment, Recommendation and Decision (SBARD) tool
SBS	Shared Business Services
SEND	Special Educational Needs and Disabilities
SFI	Standing Financial Instructions
SI	Serious Incidents
SID	Senior Independent Director
SIRI	Serious Incident Requiring Investigation
SLA	Service Level Agreement
SLR	Service Line Reporting
SMI	Severe Mental Illness
SOC	Strategic Options Case
SOF	Single Operating Framework
SPOA	Single Point of Access
SPOE	Single Point of Entry
SPOR	Single Point of Referral
STEIS	Strategic Executive Information System
STF	Sustainability and Transformation Fund
STP	Sustainability and Transformation Partnership
SUI	Serious (Untoward) Incident
SystmOne	Electronic patient record system
T	
TARN	Trauma Audit and Research Network
TCP	Transforming Care Partnerships
TCS	Transforming Community Services
TDA	Trust Development Authority
TMT	Trust Management Team
TUPE	Transfer of Undertakings (Protection of Employment) Regulations 1981
TMAC	Trust Medical Advisory Committee
TOOL	Trust Operational Oversight Leadership (replaced IMT)
U	
UDBH	University Hospitals of Derby and Burton
UEC	Urgent and emergency care
V	
VARM)	Vulnerable Adult Risk Management
VO	Vertical Observatory
W	

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Term / Abbreviation	**Terms in Full**
WDES	Workforce Disability Equality Standard
WRES	Workforce Race Equality Standard
WTE	Whole Time Equivalent
Y	
YTD	Year to Date

(updated 14 June 2022)

2022-23 Board Annual Forward Plan

Exec Lead	Meeting date	10 May 22	5 Jul 22	6 Sep 22	1 Nov 22	17 Jan 23	7 Mar 23
	Paper deadline	**25 Apr**	**27 Jun**	**29 Aug**	**24 Oct**	**9 Jan**	**27 Feb**
Trust Sec	Declaration of Interests	X	X	X	X	X	X
DON	Patient/Staff Story	X	X	X	X	X	X
CHAIR	Minutes/Matters arising/Action Matrix	X	X	X	X	X	X
CHAIR	Board review of effectiveness of meeting	X	X	X	X	X	X
CHAIR	Board Forward Plan (for information)	X	X	X	X	X	X
CHAIR	Summary of Council of Governors meeting (for information)	X	X		X	X	X
CHAIR	Chair's Update	X	X	X	X	X	X
CEO	Chief Executive's Update - Green Plan sign off (November each year)	X	X	X	X Green Plan	X	X
STRATEGIC PLANNING AND CORPORATE GOVERNANCE							
COO/DOF	NHSI Financial Annual Plan Month 7-12 2022/23				X		
DPI	Staff Survey Results	X					
DPI	Annual Gender Pay Gap Report for approval						X
DPI	Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) request for Board delegated authority for People and Culture Committee meeting on 20 September to approve the October submissions			X			
DPI	Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) Strategic implications/retrospective sign off after PCC on 20 September				X		
DPI	Workforce Plan for 2022/23			X			
DPI	2022/23 Flu Campaign			X			
Trust Sec	NHS Improvement Year-End Self-Certification	X					
Trust Sec	Year-end governance reporting from Board Committees and approval of ToRs	X					
Trust Sec	Corporate Governance Report	X					
Trust Sec	Review SOs, SFIs, SoD plus review/ratify SFI Policy (as Policy Review section below)						Amendment SFI
Trust Sec	Trust Sealings (six monthly - for information)	X			X		
Trust Sec	Annual Review of Register of Interests	X					
Trust Sec	Board Assurance Framework Update	X		X	X		X
Trust Sec	Freedom to Speak Up Guardian Report (six monthly)			X			X
Trust Chair	Fit and Proper Person Declaration		X				
Trust Sec	Annual Approval of Modern Slavery Statement	X					
Committee Chairs	Board Committee Assurance Summaries	X	X	X	X	X	X
OPERATIONAL PERFORMANCE							
DON/DOF/ DPI/COO	Integrated performance and activity report to include Finance, People, performance and Quality Dashboard	X	X	X	X	X	X
DPI	Equality Diversity and Inclusion (EDI) update				X		
COO	Emergency Preparedness, Resilience and Response (EPRR) Core Standards			X			

Exec Lead	Meeting date	10 May 22	5 Jul 22	6 Sep 22	1 Nov 22	17 Jan 23	7 Mar 23
DON/COO/ DPI	Workforce Standards Formal Submission/Safer Staffing (prior to publishing on website)	X					
QUALITY GOVERNANCE							
EXEC	Position Statement - focus on CQC domains (Well Led CQC & NHSI) as per schedule	Caring DON	Well Led Trust Sec	Safe MD	Responsive COO	Effective DON & DPI	Use of Resources (DOF)
MD	Learning from Deaths Mortality report (quarterly publication) (Jul/Nov/Jan/Mar)	AR	X		X	X	X
MD	Guardian of Safe Working Report		X		X	AR	X
DON	Infection Prevention and Control Annual Report and BAF				AR		
MD	Re-validation of Doctors Compliance Statement		X				
MD	Draft Mental Health Bill			X			
DON	Receipt of Annual Reports: - Annual Looked After Children - Safeguarding Children and Adults at Risk				AR AR		
DON	Outcome of Patient Stories - every two years - next due March 2024						
POLICY REVIEW							
COO	Emergency Incident Response Plan and Procedures prior to expiry 01/10/2022			X			
Trust Sec	Engagement between the Board of Directors and the CoG prior to expiry 30.11.2022				X		
DOF/ Trust Sec	Standing Finance Instructions Policy and Procedures Review						X
Trust Sec	Fit and Proper Person Policy prior to expiry 31/03/2023						X