Derbyshire Healthcare NHS Foundation Trust

**PUBLIC BOARD MEETING**
**TUESDAY 7 MARCH 2023 TO COMMENCE AT 09:30**
**This will be a virtual meeting conducted via MS Teams**

You can access the meeting via this link

| | TIME | AGENDA | LED BY |
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| **1.** | 9:30 | Chair's welcome, opening remarks and apologies, declarations of interest | Selina Ullah |
| **2.** | 9:35 | Patient Story | Joe Wileman |
| **3.** | 9:55 | Minutes of Board of Directors meeting held on 17 January 2023 | Selina Ullah |
| **4.** | | Matters arising – Actions Matrix | Selina Ullah |
| **5.** | | Questions from members of the public | Selina Ullah |
| **6.** | 10:00 | Chair's verbal update | Selina Ullah |
| **7.** | 10:10 | Interim Chief Executive's update and Integrated Care Strategy | Carolyn Green |
| **STRATEGY, OPERATIONAL PERFORMANCE AND QUALITY ASSURANCE** | | | |
| **8.** | 10:25 | Integrated Performance report | A Odunlade / R Leyland / J Lowe / Tumi Banda / |
| **9.** | 10:50 | Continuous Quality Improvement: A Stocktake | Vikki Ashton Taylor |
| **11:00 B R E A K** | | | |
| **10.** | 11:10 | Position Statement - focus on Effective CQC domain | Tumi Banda/ Arun Chidambaram/Jaki Lowe |
| **11.** | 11:25 | Learning from Deaths Mortality report | Arun Chidambaram |
| **12.** | 11:35 | Guardian of Safe Working Report | Arun Chidambaram |
| **GOVERNANCE** | | | |
| **13.** | 11:45 | Corporate Governance update | Justine Fitzjohn |
| **14.** | 11:55 | Board Assurance Framework Update | Justine Fitzjohn |
| **15.** | 12:05 | Freedom to Speak Up Guardian Report | Tamera Howard |
| **16.** | 12:15 | Fit and Proper Person Policy | Justine Fitzjohn |
| **17.** | 12:20 | Board Committee assurance summaries of meetings | Committee Chairs |
| **CLOSING MATTERS** | | | |
| **18.** | 12:30 | - Identification of any issues arising from the meeting for inclusion or updating in the Board Assurance Framework<br>- Meeting effectiveness | Selina Ullah |
| **FOR INFORMATION** | | | |
| Glossary of NHS Acronyms<br>2023/24 Forward Plan | | | |

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

**The next meeting will be held at 09.30 on 9 May 2023. 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 observe 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.

| DECLARATION OF INTERESTS REGISTER 2022/23 | | |
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| **NAME** | **INTEREST DISCLOSED** | **TYPE** |
| **Lynn Andrews**<br>Non-Executive Director | • Trustee for Ashgate Hospice in Chesterfield | (e) |
| **Vikki Ashton Taylor**<br>Director of Strategy, Partnerships and Transformation | • Magistrate covering mainly Derbyshire and Nottinghamshire Courts | (e) |
| **Tumi Banda**<br>Interim Director of Nursing and Patient Experience | • Jabali Men's Network | (d) |
| **Tony Edwards**<br>Non-Executive Director | • Independent Member of Governing Council, University of Derby | (a) |
| **Deborah Good**<br>Non-Executive Director | • Trustee of Artcore - Derby | (e) |
| **Carolyn Green**<br>Deputy Chief Executive and Chief Nurse | • Midlands and East Regional Director, National Mental Health Nurse Directors Forum | (e) |
| **Ashiedu Joel**<br>Non-Executive Director | • Director, Ashioma Consults Ltd<br>• Director, Peter Joel & Associates Ltd<br>• Director, The Bridge East Midlands<br>• Director, Together Leicester<br>• Lay Member, University of Sheffield Governing Council<br>• Fellow, Society for Leadership Fellows Windsor Castle | (a)<br>(a)<br>(a)<br>(a)<br>(a)<br>(a) |
| **Ralph Knibbs**<br>Non-Executive Director | • Vice Chair, RFU Diversity & Inclusion Implementation Group, England Rugby Football Union | (e) |
| **Geoff Lewins**<br>Non-Executive Director | • Director, Arkwright Society Ltd<br>• Director, Cromford Mill Limited (wholly owned trading subsidiary of Arkwright Society) | (a)<br>(a) |
| **Jaki Lowe**<br>Director of People and Inclusion | • General Medical Council Associate | (e) |
| **Ifti Majid**<br>Chief Executive | • Co-Chair of NHS Confederation BME leaders Network<br>• Chair of the NHS Confederation Mental Health Network<br>• Trustee of the NHS Confederation<br>• Spouse is Managing Director (North) Priory Healthcare | (d)<br>(d)<br>(d)<br>(e) |
| **Ade Odunlade**<br>Chief Operating Officer | • Trusteeship African Council for Nursing & Midwifery<br>• Research Lead on Observations for Ox e-Health<br>• Chair, NHS Providers Chief Operating Officer Network<br>• Governor of Eden Park High School, Beckenham, Kent<br>• Member of the Advisory Board of XRT Therapeutics (digital compony helping people to overcome phobia and anxiety) | (d)<br>(e)<br>(e)<br>(e)<br>(e) |
| **Becki Priest**<br>Interim Director of Quality and Allied Health Professionals | • Has a consultancy called IPS support assisting health and care organisations to implement employment support or to review their practice and currently has a contract with IPS Grow which is part of social finance | (b) |
| **Selina Ullah**<br>Trust Chair | • Non-Executive Director, Solicitors Regulation Authority<br>• Director/Trustee, Manchester Central Library Development Trust<br>• Non-Executive Director, General Pharmaceutical Council<br>• Non-Executive Director, Locala Community Partnerships CIC<br>• Non-Executive Director, Accent Housing Group<br>• Director, Muslim Women's Council<br>• Trustee and Board member of NHS Providers representing Mental Health Providers | (a)<br>(e)<br>(e)<br>(e)<br>(e)<br>(e)<br>(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 17 JANUARY 2023

**VIRTUAL MEETING VIA MS TEAMS WEBINAR**

Commenced: 09.30 Closed: 12:30

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| **PRESENT** | Selina Ullah | Trust Chair |
| | Ralph Knibbs | Senior Independent Director |
| | Tony Edwards | Non-Executive Director |
| | Lynn Andrews | Non-Executive Director |
| | Deborah Good | Non-Executive Director |
| | Ashiedu Joel | Non-Executive Director |
| | Geoff Lewins | Non-Executive Director |
| | Carolyn Green | Interim Chief Executive |
| | Ade Odunlade | Chief Operating Officer and Interim Deputy Chief Executive |
| | Dr Arun Chidambaram | Medical Director |
| | Rachel Leyland | Interim Director of Finance |
| | Tumi Banda | Interim Director of Nursing and Patient Experience |
| | Jaki Lowe | Director of People and Inclusion |
| | Becki Priest | Interim Director of Quality and Allied Health Professionals |
| | Justine Fitzjohn | Trust Secretary |
| **IN ATTENDANCE** | Anna Shaw | Deputy Director of Communications and Engagement |
| | Jas Khatkar | NExT Director |
| | Joe Wileman | Head of Programme Delivery |
| | Sue Turner | Board Secretary |
| **For DHCFT2023/00** | Thomas | Patient Story |
| | Kyri Gregoriou | Deputy Director of Nursing and Quality Governance |
| | Sabia Hussain | Deputy Managing Director, Delivery, Performance and Transition |
| | Heather Kazingizi | Head of Services - Children's Division, Northeast London NHS Foundation Trust |
| **APOLOGIES** | Vikki Ashton Taylor | Director of Strategy, Partnerships and Transformation |
| **OBSERVERS** | Pete Henson | Head of Performance |
| | Susan Ryan | Public Governor, Amber Valley |
| | Andrew Beaumont | Public Governor, Erewash |
| | Chris Mitchell | Public Governor, High Peak and Derbyshire Dales |
| | Cheryl Hall | |
| | Five Health Group Ltd | |

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

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| **DHCFT 2023/001** | **CHAIR'S WELCOME, OPENING REMARKS, APOLOGIES FOR ABSENCE AND DECLARATION OF INTERESTS**<br><br>Trust Chair, Selina Ullah welcomed everyone to today's meeting which was held via Microsoft Teams public webinar. A particular welcome was extended to Carolyn Green who was attending in her new capacity as Interim Chief Executive.<br><br>Two guests were welcomed, Sabia Hussain, Deputy Managing Director for Delivery, Performance and Transition who was attending as part of her induction and Heather Kazingizi, Head of Services - Children's Division, Northeast London NHS Foundation Trust who had been invited to shadow Carolyn Green.<br><br>Apologies were noted as listed. No declarations of interest were raised with any of the agenda items. The Register of Directors' Interest was noted. Non-Executive Director, Lynn Andrews' new appointment as a trustee for Ashgate Hospice in Chesterfield would be added to the register. |
| **DHCFT 2023/002** | **UPDATE ON INDUSTRIAL ACTION**<br><br>Carolyn Green gave a verbal update on the status of action being taken to ensure staff are allowed their legal right to safely participate in industrial action. The Incident Management Team is operating on a daily basis to ensure safe staffing levels are in place across derogated services while RCN (Royal College of Nursing) industrial action takes place on Wednesday 18 and Thursday 19 January 2023.<br><br>Carolyn thanked Executive colleagues and their direct reports for their safe management of derogations to ensure a satisfactory skill mix is in place to allow colleagues to take industrial action. Carolyn thanked the safe leadership of Interim Director of Nursing and Patient Experience, Tumi Banda for ensuring there is intense support available over the next 72 hours to make sure the Trust's services are managed safely both for inpatients and people in the community. |
| **DHCFT 2023/003** | **PATIENT STORY**<br><br>Deputy Director of Nursing and Quality Governance, Kyri Gregoriou who has been supporting patients to bring their stories to the Board relayed Thomas's experience of being a service user with a diagnosis of Autism Spectrum Disorder (ASD) on an inpatient ward. Thomas joined the meeting virtually just after his story had been relayed by Kyri and highlighted his priority issues.<br><br>Thomas has a diagnosis of emotionally unstable personality disorder and was diagnosed with ASD at the age of 25. He has a long history of mental health struggles and inpatient admissions. Thomas has a lot to be proud of, especially being the first person to train vocationally in a Secure Training Centre and undertook the first teleconference Community Treatment Review in Derbyshire. Thomas has no formal education and no GCSEs but became a professional chef with over seven years' experience. He is also a fully qualified emergency first aid responder and survived compartment syndrome in his dominant forearm.<br><br>Thomas talked about his time while he was an inpatient at the Radbourne Unit in 2022. At the time of his admissions staff were aware that he had ASD s and believes that during his time as an inpatient some of his experiences could have been better. When he was first admitted the care he received was very good but it dwindled off and his one to one time with staff was not as consistent when he started to recover. He believes he would have been helped if this one to one treatment had continued throughout his stay on the ward.<br><br>At the time of Thomas's admission there were a lot of restrictions in place due to the COVID pandemic and he was moved between rooms and dormitories quite often which |

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| | he found difficult due to his ASD diagnosis. He believes that if staff had more training and awareness around supporting patients with ASD they would consider the potential impact of moving patients around and how this could affect them. The recreational activities could be better especially in the evenings and weekends. Thomas also found that at the weekend a lot of temporary staff were on duty and they wouldn't spend much time speaking with inpatients as they were more focussed on having the opportunity to catch up with their colleagues.<br><br>Thomas articulated how his discharge home was very structured but the communication between the ward staff and his community team could have been co-ordinated better to ensure there were no issues with things like his medication.<br><br>Thomas was keen to talk about the good experiences he had as inpatient. He found most of the staff to be really caring and they went over and above to try help him and the other patients. As a person with ASD he found the structure and the routine on the ward helpful and he liked knowing when he would receive his medication and his meals. There were a lot of preceptee nurses on the ward and although they didn't have much experience, they were really helpful and tried really hard to be supportive.<br><br>Thomas liked that there were also checks of his physical health. He also liked and benefitted from the multidisciplinary team meetings when lots of different opinions were considered including his own. He felt the managers were very person centred and tried to be as supportive as possible and had a real passion for their work. Thomas also praised the work of the occupational therapists who worked well with the recreation team so that there were activities to occupy him and the other patients which stopped him from getting bored.<br><br>Thomas made some suggestions that he passionately believes would improve care and services in the future:<br><br>• When somebody is diagnosed with ASD, this should be an automatic trigger event for a Care and Treatment Review<br>• Having a sensory room in every unit would be beneficial for patients with ASD and also for general de-escalation and could prevent restrictive practise<br>• Having Oxehealth installed would be a benefit to the inpatient wards as it would reduce the need for shining a light on patients while they are asleep to check on them at night<br>• It would be extremely helpful to have a person trained in de-escalation supporting staff on the wards to prevent unnecessary restrictive practise<br>• Use of weighted blankets<br>• There should be a specific role for a staff member to work across both wards and community services to support an integrated discharge.<br><br>Carolyn Green found Thomas's story extremely helpful. She agreed with his recommendations and asked her Board colleagues to include them in the new facilities when they are built.<br><br>Interim Director of Nursing and Patient Experience, Tumi Banda committed to ensuring that all Thomas's recommendations are taken forward. He accepted that certain shifts lack staffing and he outlined the development of an improved multi-disciplinary team model that will staff our units differently, particularly at weekends and improve the activities patients can engage in. Tumi is also putting an emphasis on ensuring agency staff are working to the same level of care and have senior nurses and clinical leads available at weekends who can ensure that quality of care is continued.<br><br>The Board liked Thomas's suggestion that a specific role is developed to manage patients' transition to discharge. This role could sit within the Crisis and Home Treatment Team and be someone who is familiar with the issues that brought the person into hospital who will ensure that their care package is sustained through their discharge into the community setting. |

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| | Thomas's suggestion of using the assessment tool he has developed to assess people's needs if they are neurodiverse was also thought to be a valuable addition and would be used to ensure people's sensory needs are balanced.<br><br>Chief Operating Officer, Ade Odunlade agreed with Thomas that it is important that patients sleep well and are not interrupted by staff checks. Although not all patients would benefit from Oxehealth the guidance that has been developed for the NHS will help each trust to best manage Oxehealth. The use of weighted blankets as Thomas suggested will also be used in existing wards and the new facilities.<br><br>Selina was grateful to Thomas for taking the time to share his story and thanked him for his recommendations that will be used within the Trust's existing and new build facilities. She hoped he would accept the Board's offer to join the Trust's EQUAL Group and thanked him for the contribution he was making to the Trust. Selina also thanked everyone who worked behind the scenes to enable Thomas and other patients to share their experience with the Board.<br><br>**RESOLVED: The Board of Directors noted the recommendations contained in Thomas's story.** |
| **DHCFT 2023/004** | **MINUTES OF THE BOARD OF DIRECTORS MEETING HELD ON 1 NOVEMBER 2022**<br><br>The minutes of the previous meeting held on 1 November 2022 were accepted as a correct record of the meeting. |
| **DHCFT 2023/005** | **ACTION MATRIX**<br><br>The Board reviewed and closed the completed actions. No actions remained outstanding. |
| **DHCFT 2023/006** | **QUESTIONS FROM MEMBERS OF THE PUBLIC**<br><br>No questions had been submitted for a response ahead of the meeting.<br><br>Selina reminded the Board that Governors represent the public and any questions raised with them by members of the public are taken to the Council of Governors under their holding to account role. |
| **DHCFT 2023/007** | **CHAIR'S UPDATE**<br><br>Selina's report summarised her activity since the previous Board meeting. Three main themes emerged from her report of coming together, celebration and preparing for the future. The theme of coming together was evident from the staff conference held on 3 November. The Trust also held the Hearts award as a celebration of the work that colleagues are delivering. Thanks were extended to the Communications team who organised these wonderful events that enabled the celebration of the excellent care and innovative work of people nominated for each of the categories.<br><br>Board members were delighted to hear that Selina was a joint winner of the South Asian NHS Pioneer Award, recognising her as one of first Muslim women to Chair an NHS Trust.<br><br>Selina was pleased to confirm the appointment of the new CEO Mark Powell after a thorough recruitment process and consultation which was another example of colleagues coming together. Mark will commence as CEO on 3 April.<br><br>Selina paused to reflect on the sad loss of two colleagues. The Trust came together to observe a minute's silence for Duncan McNiven a nursing assistant in the older adult service who passed away at home and Marie White, a valued member of the Children's |

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| | Services Division. Board members offered their heartfelt condolences to their families, friends and colleagues.<br><br>The report also covered recent activity by the Council of Governors. Governors have been extremely active and Selina thanked them for their continued support.<br><br>Non-Executive Director, Lynn Andrews wanted to recognise the award achieved by Selina and previous CEO, Ifti Majid and thanked them for representing the Trust. She was aware of the many achievements to celebrate but wondered how the Trust's stakeholders viewed our organisation and wondered how this was assessed especially in terms of the 'Well Led' aspect of our work which is led by the CQC. Selina recognised that the Trust works in a collegiate way within the Integrated Care Board (ICB) and with our partners who are aware of our work. Carolyn Green outlined how our partners feel particularly integrated with the Trust and have spoken highly of their engagement within the organisation. Carolyn looked forward to continuing with these forums and will hand over this work to Mark Powell when he takes up his role as CEO in April so he can continue to showcase the Trust's innovative and high quality work.<br><br>Selina thanked all Trust staff for their continued commitment to patients and staff while having to deal with cost of living pressures and the effects of industrial action.<br><br>**RESOLVED: The Board of Directors noted the content of the Chair's update.** |
| **DHCFT 2023/008** | **<u>INTERIM CHIEF EXECUTIVE'S REPORT</u>**<br><br>Carolyn Green's Interim CEO report provided the Board with a detailed update on local and national developments within the national and local Derbyshire health and social care sector over the last two months. The following points were highlighted.<br><br>**Within our Trust**<br>The Trust's Making Room for Dignity programme team recently received confirmation of funding from NHS England, enabling the Psychiatric Intensive Care Unit (PICU) construction works to begin at Kingsway Hospital in line with the new adult acute unit there. Confirmation of the additional investment required to complete the whole programme consisting of<br><br>• Northern Derbyshire Older Adults: 12-bed relocation (Hartington Unit to Walton Hospital)<br>• Radbourne Unit Acute: 34-bed refurbishment (female)<br>• Acute Plus: 8-bed refurbishment - Audrey House (female) – Initially as a 10-bed decant ward.<br><br>Thanks were extended by the Board to all colleagues who have been involved in securing funding which will transform services through providing private ensuite bedrooms and for the exciting new hospital builds. This includes an Adult Acute Mental Health Unit and a Psychiatric Intensive Care Unit.<br><br>Carolyn was heartened by the feedback she received when carrying out service visits and gained a better understanding of the innovative work colleagues were proud of as well as the challenges they face. A visit to Children's services revealed that they felt that their voice was under-represented as the focus was mainly on Mental Health and Learning Disability services. For this reason Carolyn spotlighted the high performance of Children's services, particularly the outcomes of the Derby health visiting team's annual performance, which are amongst the best in the country. This phenomenal level of service means that babies, families and parents will thrive because of the diligence and performance of our Children's services.<br><br>**2023/24 Priorities and Operational Planning Guidance**<br>Delivering the priorities contained in the Operational Planning Guidance 2023/24 will be a difficult challenge over the next year. Key progress is also required to deliver the |

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| | ambitions in the NHS Long Term Plan. Carolyn was certain that Board members would work under the lead of Director of Strategy, Partnerships and Transformation, Vikki Ashton Taylor and given the financial situation that the NHS is experiencing, temper expectations about what is achievable. Non-Executive Director, Tony Edwards and Chair of the Finance and Performance Committee assured the Board that the Committee would embark on delivering operational planning objectives at its next meeting on 24 January.<br><br>**National Context**<br>Carolyn was pleased to report that NHS England have committed to fund 15 new clinics to provide specialist treatment for people with serious gambling problems and Derby has been identified to deliver the clinic for the East Midlands.<br><br>**East Midlands Region and Derbyshire Context**<br>The Trust has continued building partnerships through East Midlands Alliance. The Mental Health, Learning Disabilities and Autism Board continues to embed its approach, known as Recovery Action Planning, to ensure that all areas where we are not performing to the required level, have a clear plan with improvement milestones. Carolyn reflected on how today's brilliant patient story touched on the work we will take forward to improve our services to suit people with neurodiversity.<br><br>**RESOLVED: The Board of Directors scrutinised the report, noting the risks and actions being taken and accepted assurance around key issues raised.** |
| **DHCFT 2023/009** | **<u>INTEGRATED PERFORMANCE REPORT</u>**<br><br>The Board was updated on key finance, performance and workforce measures at the end of November 2022. Executive Directors drew attention to the following areas and responded to questions.<br><br>**Operations**<br>Chief Operating Officer, Ade Odunlade highlighted the improved presentation of operational performance in this edition. He outlined the ongoing increase in demand for services, alongside staffing pressures in some areas and a focused approach to managing waiting lists. Ade was satisfied with the Trust's recovery plan despite demand outstripping capacity we are commissioned for especially in ASD services which the Mental Health Learning Disability and Autism Board is working to rectify.<br><br>In response to a question from Non-Executive Director, Geoff Lewins asking about the gap in delivery between demand and commissioning level, Ade confirmed that previously we were able to deliver to our model. However, now we have changed the model of assessment and have increased capacity we are exceeding what we are contracted for but it is difficult to meet the demand for the service. Overall performance within the organisation and productivity is growing and there is a whole range of cultural work taking place that will enhance the efforts already being made.<br><br>Tony thought the improvements made to the report were much more focussed on the action being taken and questioned the revised approach being taken to improve waiting lists. He hoped waiting lists will benefit from the extra funding received and asked for assurance on the process of implementation and how this project was progressing. Ade responded that although the extra money received is a welcome addition it will not solve the problem. It has galvanised the system to work together to improve working models and he hopes that in the coming months an improvement will be seen.<br><br>Geoff asked how IAPT which is now called Talking Therapies was progressing. Ade reported that one of the changes has been the significant amount of transitional work that has taken place. A number of people decided it was time to progress their career in other areas and it has been slow progress building the staffing numbers back up. At the same time this is an area where we have seen higher utilisation especially during |

COVID and post COVID. Resources are being monitored and staff continue to be supported in their career progression.

Carolyn was pleased with the new reporting style and was grateful to Ade and his team for rising to the challenge of meeting constitutional targets while maintaining clear transparency.

Selina wished to know more about perinatal access and asked if there was scope to use funds in the communities. Carolyn reported that the operating framework contained in the NHS Long Term Plan will only release money to specific areas of targeted delivery. Additional finance cannot be drawn down if we are not delivering against specific performance objectives. There is a plan to achieve a better level of delivery through a recovery action plan that has been applied to the Perinatal service.

**Finance**

Interim Executive Director of Finance, Rachel Leyland reported that the forecast remains on plan to achieve a break-even position by the year end. There was a deficit of £0.37m at the end of November which is a favourable variance to plan of £0.67m. Rachel expects there to be some improvement to the forecast outturn at end of the financial year. This will be discussed in detail together with risks that remain with assumptions in the forecast by the Finance and Performance Committee this month. A positive note was the reduction in agency expenditure down to £400k.

Geoff Lewins was pleased to see some positive aspects and referred to the non-recurrent nature of efficiencies that will need to be focussed on in the cost improvement program not just for this year but for next year as well. Rachel agreed efficiencies have been delivered non-recurrently this year and this will lead to problems for the next financial year in delivering some of the improvements for the Trust's and the system position. One off benefits and recurrent efficiencies will be a focussed on in operational planning as well. The Finance and Performance Committee will receive an update at this month's meeting which will give a better understanding of the forecast.

**People performance**

Director of People and Inclusion, Jaki Lowe reported that People performance has improved over recent months and she outlined the priority work for improving training, retention and staff absence. Appraisal rates have improved and will continue to be a focus to ensure our systems accurately capture people focused data and we will see improved results in recording of data in due course.

The People and Culture Committee has discussed staff turnover and how to retain staff. The Trust has a recruitment and retention policy and a lot of work has taken place on hot spot areas and to establish why people are leaving. The Trust has one of the best vacancy rates compared with comparable organisations which is due to the combination of the recruitment team being more creative in recruitment campaigns and the inventive work undertaken on inclusion. Absence rates are still above target and this is due to taking early action supporting people back into work. The use of bank and agency staff continues to increase and People services are making sure they have the same support as substantive staff as they are an essential part of our workforce.

Tony asked when the results of the staff survey will be released and also wanted to know more about workforce planning. He also asked how bank and agency staff were engaged with to obtain their suggestions on how their experience could be improved. Jaki responded that the staff survey results were embargoed and would be reported to the Board in May. She was anticipating strong results overall and would include in the report detail of what has impacted the results. Workforce planning is being articulated through NHS England (NHSE) and Health Education England (HEE). Jaki expects to see a real focus on how to improve supply nationally and locally.

Lynn Andrews was pleased to see clinical supervision and mandatory training improving. She wanted to know what learning is being taken from consistent improvements and

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| | how can we further improve? Jaki assured Lynn that managers have been supported in managing supervision and in recording the information obtained from supervisions. As a result of this discussion Selina requested that rather than provide an answer the People and Culture Committee undertakes a deep dive in appraisals, managerial supervision and staff wellbeing. Ralph Knibbs as Chair of the People and Culture Committee accepted this action and reported that the Committee already has a programme of deep dives planned to seek assurance on these matters.<br><br>**Quality**<br>Interim Director of Nursing and Patient Experience, Tumi Banda reported that work is ongoing to improve care plan performance. Incidents of moderate or catastrophic harm are falling due to embedding training that the patient safety team are leading. Improvements with restrictive practice continue to be made due to the training that is improving the culture of restrictive practice.<br><br>In response to Non-Executive Directors, Deborah Good and Ashiedu Joel wanting to know more about the challenges being faced with the migration of care plan data to the new software, Tumi outlined how additional capacity has been provided to review care plans. Heads of Nursing are focussing on embedding professional clinical practice in this area and he anticipates that a positive update will be made to the Quality and Safeguarding Committee in February regarding care plan practice.<br><br>The Board formally acknowledged that key elements of the report are routinely reported to the Finance and Performance and People and Culture Committees. It was agreed that although limited assurance had been received from current performance positive assurance had been obtained from learning of action being taken forward.<br><br>**ACTION: People and Culture Committee to undertake deep dive into appraisals, managerial supervision and staff wellbeing.**<br><br>**RESOLVED: The Board of Directors:**<br>**1) Received limited assurance on current performance across the areas presented**<br>**2) Formally acknowledged 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**<br>**3) Preferred the revised format of the Operations section of the main body of the report.** |
| **DHCFT 2023/010** | **<u>ASSURING QUALITY CARE</u>**<br><br>In a recent Panorama documentary: undercover report findings of poor and abusive care in NHS mental health secure services, poor care, abuse - physical and verbal assault and negative cultures were reported on. This report is in response to a request from Claire Murdoch, National Director for Mental Health, that trusts investigate their own areas to identify, eradicate and prevent this kind of abuse from happening.<br><br>The Board noted that the report demonstrates current practice and further improvements to ensure full assurance that high quality care occurs across Derbyshire Healthcare. A range of different practices and action taken including the recommencement of the Quality Visits programme, mock CQC inspections and out of hours visits has ensured that quality care is in place across ward environments.<br><br>Lynn as Chair of the Quality and Safeguarding Committee confirmed that she had gained further assurance of the additional work that the Trust undertaken in addition to regular clinical practice. She and Ralph were pleased to see the focus is on safety and that Staff Side fully support the improvement and learning culture being embedded within clinical groups. Reflecting on today's patient story, Deborah emphasised how important is that bank staff are fully engaged in ensuring there is no disparity in quality of care at weekends. |

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| | Selina thanked Interim Director of Quality and Allied Health Professionals, Becki Priest for her report that assured the Board of the continuous improvement work to develop and maintain an open culture across the Trust's services which is key to the success of this piece of work.<br><br>**RESOLVED: The Board of Directors received significant assurance on the oversight and continuous improvement to develop and maintain an open culture.** |
| **DHCFT 2023/011** | **<u>ASSURANCE OF CQUIN PROGRESS</u>**<br><br>Tumi Banda updated the Board with assurance on progress against the CQUINs (Commissioning for Quality and Innovation) for 2022/23 and new CQUINs for 2023/24.<br><br>The Board noted the progress made towards the achievement of CQUINs and work taking place towards the Trust's aspiration to fully achieve them while delivering evidence-based person-centred care. Tumi highlighted that achieving the CQUIN for the required 90% target for staff flu vaccinations might not be realised. 52% of staff have received their flu vaccine as of December 2022 despite the regular communications sent to staff and clinics that have been set up in locations across the Trust to enable staff to access vaccinations more easily.<br><br>The Board discussed the importance of being sighted on the delivery of quality indicators and having an insight into CQUIN delivery in the public domain. It was agreed that the Quality and Safeguarding Committee will maintain close scrutiny of CQUIN performance at pathway level and how CQUIN delivery can be achieved. CQUIN delivery performance will in future also be included in the Integrated Performance Report.<br><br>**ACTION: CQUIN delivery performance to be included in IPR. Quality and Safeguarding Committee to monitor how CQUIN delivery can be achieved.**<br><br>**RESOLVED: The Board of Directors:**<br>**1) Noted the contents of the report**<br>**2) Reviewed progress against actions**<br>**3) Received assurance on the issues highlighted**<br>**4) Agreed that CQUIN delivery performance will be included in the Integrated Performance Report.** |
| **DHCFT 2023/012** | **<u>POSITION STATEMENT FOCUSSING ON CQC DOMAINS – RESPONSIVE</u>**<br><br>Ade provided the Board with a deep dive into the responsiveness of the Trust's services. The report showed that the majority of services are meeting existing and proposed standards. Overall services within the organisation are responsive but there are some where being responsive continues to be a significant challenge. Recovery action plans are in place and progress is reported in the Integrated Performance Report in line with the Trust's responsibility to deliver the requirements set out by the CQC.<br><br>Lynn asked whether the paper was supposed to tackle all the key lines of inquiry related to the responsive domain and challenged whether the programme for each domain needed to be looked at. Ade agreed there were a breadth of areas where responsiveness can be measured but this report was based primarily on performance. Specific areas will be further looked at across all of the domains later in the year.<br><br>Tony questioned whether areas that are over performing could have resources reapplied to areas that need improvement. Medical Director, Arun Chidambaram responded that although staff can move within the inpatient services it depends on their specialty and readiness of to move between services. A move has to be clinically appropriate and it is important to make sure that staff have adequate support and training when moved to a different area. |

| | |
|---|---|
| | The Board thanked Ade for his report and looked forward to developments as they as they progress in further reporting.<br><br>**RESOLVED: The Board of Directors noted the contents of this report.** |
| **DHCFT 2023/013** | **<u>LEARNING FROM DEATHS MORTALITY REPORT</u>**<br><br>In line with national guidance on learning from deaths, the Board received its regular quarterly report covering the period 1 August to 30 September 2022 which had also been reported to the Quality and Safeguarding Committee meeting in December 2022.<br><br>The Trust received 317 death notifications of patients who had been in contact with our services within the six months prior to their death. There is little variation between male and female deaths; 146 male deaths were reported compared to 171 females. No inpatient deaths were recorded. The report showed no significant gender divide or ethnicity.<br><br>Geoff was curious about the number of Mortality Review Group meetings that did not take place due to clinicians not being in attendance and wanted to know if this accounted for a loss of review activity. Arun assured Geoff that these reviews took place outside of the formal Mortality Group with adequate expertise present. He also gave his assurance that the learning is shared with clinicians through the Learning from Deaths procedure which is then embedded within our services. The review process is currently being relaunched to establish what works well for clinicians in order to increase clinical involvement.<br><br>As a result of discussing the diversity data presented in the report and whether there is any disparity with gender split compared with the population, it was noted that future reporting will show improved detail on race/gender that will give a better understanding of variations and inequalities.<br><br>**RESOLVED: The Board of Directors accepted the 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 2023/014** | **<u>GUARDIAN OF SAFE WORKING REPORT (GOSW)</u>**<br><br>The GOSW report provided data about the Trust's Junior Doctors and arrangements in place to identify and remedy any risks.<br><br>Arun outlined that the intention of the report was not to provide assurance of the Trust's approach in discharging its statutory duties regarding safe working for junior doctors but to request the Board's support of the improvement strategy that has been developed for exception reporting that resulted from breaching rest requirements and fines levied against the Trust. It is expected that improved reporting and increasing the number of junior doctor forums will provide a better understanding of any breaches.<br><br>The Board recognised the important role that junior doctors play and supported the strategy to increase the number of junior doctor forums and intelligence around the out of hours rota that will further assure the safety of services. Board members thought this was an extremely thorough report that set out clear proposals and conveyed thanks to Dr Kaanthan Jawahar in his new role as Guardian of Safe Working. Thanks were also extended to Dr Smita Saxena who recently stepped down as Guardian of Safe Working.<br><br>**RESOLVED: The Board of Directors:**<br>**1) Noted the contents of the report.**<br>**2) Understood that at this stage the GOSW is unable to give assurance of the Trust's approach in discharging its statutory duties regarding safe working for doctors employed on the 2016 junior doctor contract** |

| | |
|---|---|
| | **3) Supported the strategy and plan that has been developed, which is realistic to deliver and thus provide the assurances required in due course.** |
| **DHCFT 2023/015** | **INFECTION PREVENTION AND CONTROL**<br><br>The Board received the annual update on progress made against recent changes to the Infection Prevention Control (IPC) Guidelines and Board Assurance Framework (BAF) including the Trust's response to the COVID-19 pandemic and precautions in place.<br><br>Throughout this year there has been an increase in clinical/operational involvement in complying with the national IPC framework standards in response to the pandemic. The Board commended the IPC team for the tailored approach that resulted in low rates of infection across services and for the support given to both patients and staff to receive vaccinations for flu and COVID.<br><br>Thanks were extended to the Quality and Safeguarding Committee for applying such diligence in this area. The Board accepted the updated IPC BAF as evidence of compliance with National IPC framework standards.<br><br>**RESOLVED: The Board of Directors:**<br>**1) Noted progress since last annual update**<br>**2) Received significant assurance from the report**<br>**3) Accepted the up to date Board Assurance Framework as evidence of compliance with National IPC framework standards as recommended by the Quality and Safeguarding Committee** |
| **DHCFT 2023/016** | **BOARD COMMITTEE ASSURANCE SUMMARIES**<br><br>Summaries were shared from recent meetings of Trust Board Committees. Although the Board Assurance summaries were not discussed, the Board was satisfied that it is within the Board Committees where much of the scrutiny and challenge takes place which is an important part of the Trust's governance requirements. The Assurance Summaries were accepted as a clear representation of the priorities that were discussed and will be taken forward in forthcoming meetings.<br><br>**RESOLVED: The Board of Directors noted the Board Assurance Summaries.** |
| **DHCFT 2023/017** | **IDENTIFICATION OF ANY ISSUES ARISING FROM THE MEETING FOR INCLUSION OR UPDATING IN THE BOARD ASSURANCE FRAMEWORK (BAF)**<br><br>Areas that are not fully conforming with constitutional standards will be looked at to ensure they are fully captured in the BAF. |
| **DHCFT 2023/018** | **2022/23 BOARD FORWARD PLAN**<br><br>The 2022/23 forward plan outlining the programme for the remainder of the year was noted and would be reviewed further by all Board members for the financial year ahead. |
| **DHCFT 2023/019** | **MEETING EFFECTIVENESS**<br><br>The Board agreed that the meeting had been successfully conducted as a virtual meeting. |
| **DHCFT 2023/020** | **CHAIR'S CLOSING REMARKS**<br><br>The Chair reiterated her thanks to guest observers Sabia Hussain and Heather Kazingizi for attending today's meeting and sought their comments. Sabia thought the patient story was extremely powerful and liked how it framed the entire meeting. It was very evident to her that the Board is extremely focussed on patient outcomes and quality improvements. Heather Kazingizi was impressed by the warmth that Selina projected |

| | |
|---|---|
| | as Chair and with the way that the contribution of front line services was discussed at Board level and with the number of improvements and recommendations made from today's patient story. |
| The next meeting to be held in public session will be held at 09.30 on 5 March 2023. | |

| | | | | BOARD OF DIRECTORS (PUBLIC) ACTION MATRIX - MARCH 2023 | | | |
|---|---|---|---|---|---|---|---|
| **Date** | **Minute Ref** | **Item** | **Lead** | **Action** | **Completion Date** | **Current Position** | |
| 17.1.2023 | DHCFT 2023/009 | Integrated Performance Report | DPI | People and Culture Committee to undertake a deep dive into appraisals, managerial supervision and staff wellbeing. | 7.3.2023 | Factored into the People and Culture Committee's deep dive programme and will take place on 28 March 2023. | Green |
| 17.1.2023 | DHCFT 2023/011 | Assurance of CQUIN progress | DON | CQUIN delivery performance to be included in IPR. Quality and Safeguarding Committee to monitor how CQUIN delivery can be achieved. | 7.3.2023 | CQUIN delivery performance included in IPR. CQUIN delivery is reported to Quality & Safeguarding Committee and performance is included in the Quality Performance Dashboard. | Green |

**Key:**

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

**Derbyshire Healthcare NHS Foundation Trust**
Report to the Board of Directors – 7 March 2023

# Interim Chief Executive's Report

## 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. They are recorded on operational risk registers or the Board Assurance Framework as appropriate.

## Personal Reflections

This is the second and final CEO Board report I will write and present for Derbyshire Healthcare NHS Foundation Trust in my role as interim leader.

## Industrial Action

This period has seen a period of significant change in the landscape of the NHS and a period of industrial unrest. Derbyshire Healthcare did experience formal industrial action in January 2023. Our management team and Emergency Planning and Response teams continue to work in partnership with Staff-side partners and were able to deliver a safe outcome for people in our care and colleagues in Derbyshire. Colleagues worked together to deliver their commitments to safety, maintained safe care through derogations and enabled colleagues to express their view. Planned industrial action for nursing and allied health colleagues at the beginning of March has been paused subject to active pay negotiations. In addition, we are planning for wider proposed industrial action with junior doctors. I am very grateful for our Emergency Preparedness, Resilience and Response (EPRR) operational teams and Staff-side collaborations and their continued support.

## COVID

In the last month we have seen a gradual increase and turbulence in the number of colleagues away from work due to a COVID based absence. At the time of reporting, this was on an upward trajectory. Since the last Board meeting, we have had a couple of spikes of positive patients in our inpatient facilities. This continued pattern remains in line with what we expected to see.

Our vaccination hub continued to serve in delivering COVID boosters and flu vaccinations to colleagues and patients up until February 2023 and is now in a period of hibernation.

**Service Visits**

Since the last Board meeting I have been fortunate to visit the following teams:

- St Andrew's House – Learning Disability teams as part of their quality visit
- Colleagues who have kindly asked me to meet with them to share feedback of their experiences of working in the Trust
- Post induction events in multiple areas.

During the visits I was 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 activities colleagues were proud of.

**Engagement Events**

We have continued to hold regular Q&A sessions with all colleagues during January and February. These have continued to have high levels of attendance with between 150 and 200 colleagues joining these events and follow up correspondence and emails.

Key points we discussed included:

- Open sessions – all areas
- Discrimination
- How we hold our culture of intolerance of any form of discrimination in the Trust
- How we support and promote learning from colleagues who have had allegations of discrimination that were held or not upheld in line with our organisational values and just culture.

**Performance and Acting Upon Feedback**

Since the last report, I have undertaken a number of feedback sessions with new inductees to the organisation. This feedback has been used to look at quality and service improvements. Feedback included tailored induction for those new to the NHS and referring to colleagues, not using their name and job role, but their pay grade, referred to in the NHS as Banding.

I have had a number of colleagues meet me as Interim CEO and lead Director for Freedom to Speak Up.

- Issues include openness on sharing information
- Impacts of previous incidents at work on psychological wellbeing
- Impacts of being an employee and in receipt of services and the ability to choose to remain under the care of Derbyshire Healthcare services.

All casework is anonymised and is recorded and logged with the Freedom to Speak up Guardian.

**East Midlands Region and Derbyshire Context**

The Joined Up Care Derbyshire System Delivery Board for Mental Health, Learning Disability and Autism continued to meet as a partnership - we continue to work in a fully collaborative meeting.

Highlights include:

- Receiving feedback from the deaf community and hearing about progress of improvement work groups (see attached Appendix A). The Trust is a key provider of services and we have much to do to ensure we improve and listen to this feedback and deliver for this important group in our community.
- Receiving feedback on preventing re-offending rates and strategy
- Funding for additional support to those requiring high level support for Diabetes and psychological ill health. An important area to our Trust Chair.

The Mental Health, Learning Disability and Autism Delivery Board continues to embed its approach known as Recovery Action Planning to ensure that all areas, where we are not performing to the required level, have a clear plan with improvement milestones. We continue to focus on access to Children and Young People's Eating Disorder services and our Perinatal Community services and we note the memory assessment service in the Older People's service is highly productive, and is under resourced for the population and demand, when assessed regionally. The Board will review this factor as part of planning and performance improvement.

System meetings and collaborations continue at pace and a key outcome was the development of the Integrated Care Provider (ICP) draft strategy which is appended to the report at Appendix B. I would ask Board members to note the move from reaction to ill health into preventative and improvement work.

**The National context**

**Hewitt Review -** national review

The Hewitt Review: an independent review of integrated care systems. The former Health Secretary, Patricia Hewitt, is leading an independent review into how the oversight and governance of Integrated Care Systems (ICSs) can best enable them to succeed.

This is very much an opportunity for all of us with a stake in ICSs to shape our future. Following initial consultation with local NHS leaders, the next stage of the review is focusing on five workstreams:

- Prevention and population health management
- Integration and place
- Autonomy, accountability, and regulation
- Productivity and finance
- Digital and data.

Colleagues from patient and service user groups, local government, the voluntary community faith and social enterprise sector and the social care provider sector,

as well as the NHS, have all been invited to participate in the work streams, reflecting the partnerships that constitute ICSs.

Representatives at the Trust have been asked to join the Integration and Place workstream bringing a Derby and Derbyshire Place and community health provider perspective to the work.

An initial set of principles have emerged already from the engagement work that are providing a framework for the workstreams:

- Collaboration – seeing the centre, regions, systems and places as real partners working together with complementary and interdependent roles as opposed to a hierarchy
- A limited number of shared priorities
- Giving local leaders space and time to lead
- Providing the right support to ICS in a bespoke way geared to the whole system and the
- Partners within in it
- Balancing freedom with accountability; and
- Enabling timely, relevant, high quality and transparent data to support integration, improvement, innovation and accountability.

**National Audit Office**

The National Audit Office (NAO) have released a report on 9 February 2023 on NHS mental health services. The report highlights numerous issues faced by NHS mental health services, including workforce pressures and struggles to meet targets for young people's eating disorder services. This continues to be a factor both nationally and in Derbyshire.

Many people will experience mental health problems in their lives. Around one in six adults in England have a common mental health disorder, and around half of mental health problems start by the age of 14. The proportion of young people estimated to have a probable mental disorder rose between 2017 and 2022, following the COVID-19 pandemic: for example, among 17 to 19-year-olds, the proportion went up from 10% to 26%.

The report goes on to conclude:

- Since 2016, the NHS has taken some important first steps towards closing the historical and acknowledged gap between mental and physical health services. The Department of Health and Social Care (DHSC) and NHS England (NHSE) made a series of clear commitments and plans to expand and improve mental health services, but they have not defined what achieving full parity of esteem for mental health services would entail.

- Consequently, it is unclear how far the current commitments take the NHS towards its end goal, and what else is needed to achieve it. While funding and the workforce for mental health services havs increased and more people have been treated, many people still cannot access services or have lengthy waits for treatment. Staff shortages continue and data that would demonstrate the results of service developments are limited.

- DHSC and NHSE acknowledge that it will now take longer to achieve some of the existing commitments following the COVID-19 pandemic, amid signs of a large rise in mental health conditions, particularly among young people. Over the next few years, demand for mental health services will continue to significantly outstrip provision, putting pressures on patients, staff and people trying to access services.

- DHSC and NHSE have plans to pursue challenging new ambitions such as improving community mental health services, but they need to be in a position to apply the lessons learned from their efforts to date. They have further to go to ensure value for money in their expansion efforts and will need to demonstrate a firmer grip on the significant ongoing risks to their ambitions.

These national reflections do connect to feedback across the workforce on how it feels to work at the front line.

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

**Risks and Assurances**

- Our strategic thinking includes an assessment of the national issues that will impact on the organisation and its community that it serves.
- Feedback from staff, people who use our services and members of the public is being reported into the Board.

**Consultation**

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

**Governance or Legal Issues**

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

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

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

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

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

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

The national investment model in Mental Health and Learning Disability services at the end of the mental health investment period will mean that commissioned services will be able to meet between 26% and 30% of population demand. This is set and pre-covid / cost of living levels. – NHS Confederation and Centre for Mental Health - No wrong door December 2022.

**Recommendations**

The Board of Directors is requested to:

1) Scrutinise the report, noting the information and actions being taken
2) Comment and give feedback on the change of approach in the ICP strategy
3) Seek further assurance around any key issues raised.

**Report prepared and presented by:** **Carolyn Green**
**Interim Chief Executive**


# Mental Health, Learning Disabilities & Autism System Delivery Board


# Presentation on D/deaf people with mental health experiences in Derby/shire

# Who are we?

Hamza Shaikh - Deaf Advocacy

Sarah Tupling - Peer Coach for Derby Deaf Well-being service

# Sarah's story
# Radbourne Unit based at Derby Royal Hospital

- Local Mental Health hospital – Deaf service users.
- Sarah's personal experiences

# Sarah’s story The Barberry based in Birmingham

National Deaf service; Jasmine Suite is based in Birmingham and Solihull Mental Health NHS Foundation Trust

Referrals accepted with written agreement of GP, and local community mental health team or community learning disability team.

# Hamza’s story

- Community mental health team at Osborn House
- The Barberry Jasmine Suite
- SignHealth Deaf Charity CBT and counselling sessions
- Mental health assessment at Royal Derby Hospital

# Teresa’s story

- Teresa was diagnosed with Ushers’ syndrome in 2003 at age of 33.
- Surrendered driving licence and car
- Functional and emotion depression for 4 years but continued working with a supportive employer
- Uses Direct Payment to support
- No deaf specific services including counselling services to support on coping with dual sensory loss.
- Was isolated for several years

# Who are the people in Deaf and Hard of hearing community?

- Deaf People
- Hard of hearing people
- Deafblind people
- British Sign Language users
- Derby City and Derbyshire local residents

# Statistics

- Deaf people face multiple barriers to access healthcare and poorer outcomes compared to the hearing population (Sign Health, 2014)
- Deaf people have higher rates of mental health issues due to social exclusion and/or functional or organic damage to the brain (NHS England, 2020; Department of Health, 2005)
- Derby and Derbyshire home to biggest Deaf community in the UK outside of London (British Deaf Association, 2014; Office for National Statistics, 2022)

Derbyshire Mental Health Forum

# Statistics (Sign Health Charity, 2022)

**74% of Deaf people found it more difficult to access healthcare during the pandemic.**

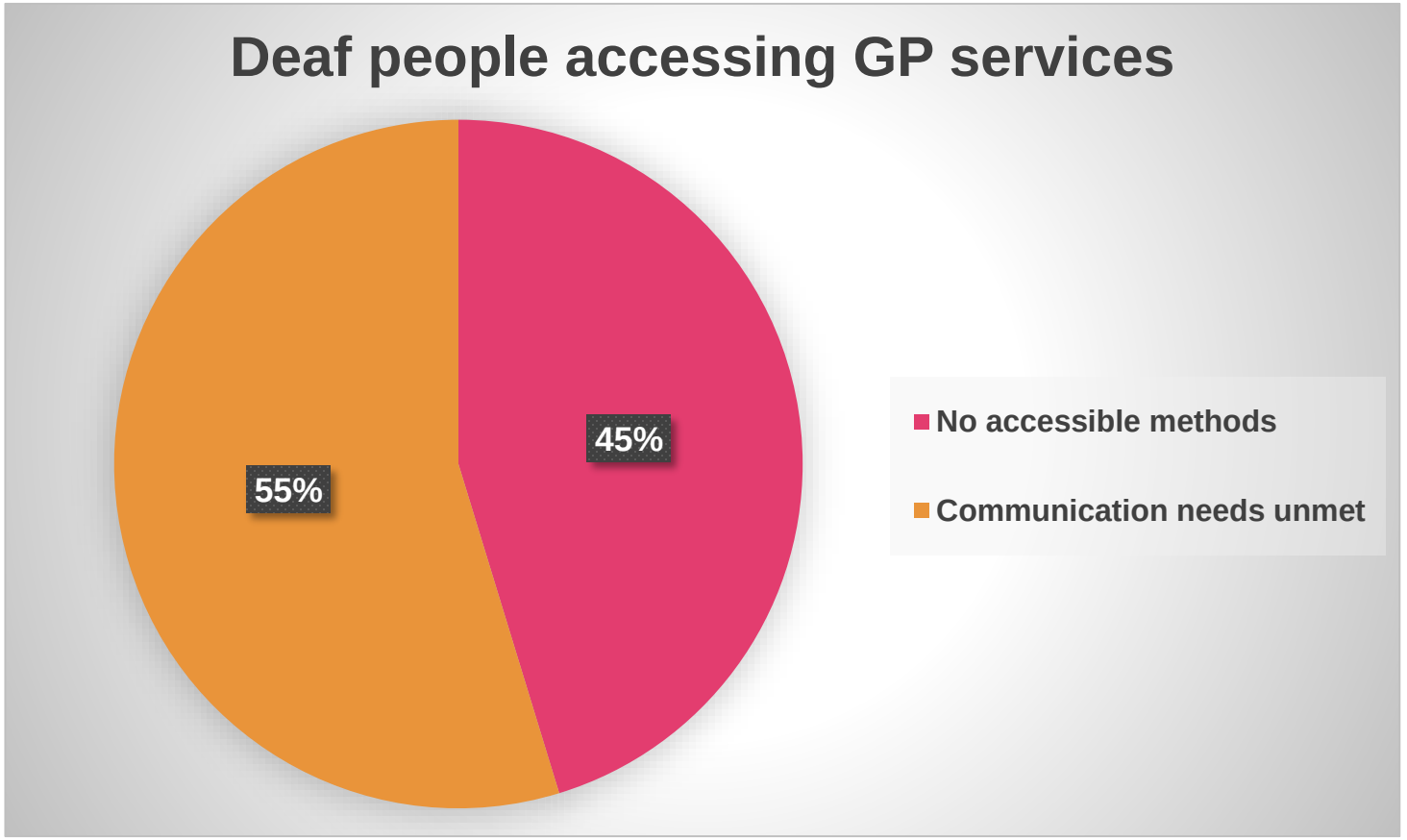
**78% said Government information shared during the pandemic was inaccessible.**

# Statistics (Sign Health Charity, 2022)

The following groups of people were at more risk from death – people with:

- Hearing impairment 4x higher
- Vision impairment 8.4 times higher
- Dual-sensory impairment 11.7 times higher

**When sign language users finally get to see their doctor, they are forced to communicate in ways that cause misunderstandings, confusion, misdiagnosis and poor treatment. 8 in 10 Deaf people want to use sign language, 3 in 10 are given the chance.'**



# Statistics (Census 2021, RNID 2021 and Sense 2022)

**There are Deaf BSL users, at least:**

- **443 in Derby**
- **250 in Derbyshire**

**14.2% meant 1 in 7 people have moderate to severe hearing loss who lives in Derby and Derbyshire.**

**In 2022 it is estimated that there are over 450,000 people in the UK who are deafblind. This is expected to increase to over 610,000 by 2035!**

# Number of communication support workers available (NRCPD, 2023)

**On the NRCPD register (Interpreters registration body to practice) in East Midlands alone, there are:**

- **110 Sign Language Interpreters, just 30 live in Derbyshire.**
- **16 Trainee interpreters**
- **2 trainee translators**
- **1 lip speaker**
- **1 Electronic notetaker**

**Please note: Notetakers & Lip speakers do not have to register with NRCPD.**

# What do the numbers mean?

- In East Midlands there is 15 Deaf people per interpreter
- In Derbyshire it is 23 Deaf people per interpreter

**This shows a severe shortage of interpreters and communication support workers. This could explain why 1-in-2 (50%) deaf people experience mental health.**

# What does the statistics meant for D/deaf people?

Deaf people are deprived from services and information.

Demand outstrips supply.

Need for early intervention to mental health/well-being services which will reduce mental health escalating.

Deaf people are not accessing information and services.

Communication Unlimited need more interpreters including trainee interpreters.

D/deaf staff needs regular interpreters/Communication Support Workers in order to break down barriers for other deaf people.

# Where We Are Now?

- Derby/Derbyshire Deaf People First Alliance discussed the need for improved mental health services in May 2022
- Deaf Mental Health Day in July 2022. Attended by representatives from deaf organisations and staff across the mental health system.
- Report available on request by emailing jodie@erewashcvs.org.uk
- Deaf Mental Health Focus group – meeting bi monthly
- Experts by Experience
- Core 20 Plus 5 recognised group
- Health Needs Assessment
- Strategic Action Plan

# What Do We Need Support With?

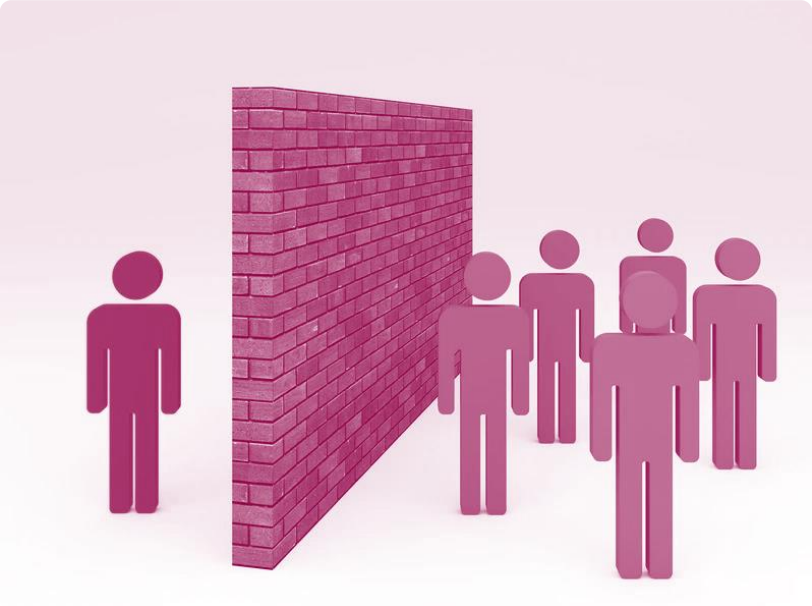
- Conversation about sign language interpreters – capacity and recognition of gaps in system e.g. funding
- Support to continue growing Expert by Experience voice of Deaf people
- Work on Derby and Derbyshire Emotional Health and Wellbeing Website
- Acknowledgment that additional work is happening with no investment
- Consideration of the need for general advocacy roles
- Help with promoting specialist advocacy role (Spot purchase in place)
- Local service for Deaf people in crisis
- Support to develop long term strategic plan to have a Deaf service

# Why is it important to work with us?

We have lived experiences of:

- Deafness
- Dual sensory loss
- Mental health
- Deaf culture
- BSL Language
- Break down barriers

Derby Deaf Well-being Service



We share our knowledge and skills with you all.

# Any questions?

Appendix B

Joined Up Care Derbyshire

# Draft

# Derby and Derbyshire

# Integrated Care Strategy

## For consideration by the ICP Board

## 08 February 2023

NHS

The Derbyshire VCSE sector Alliance

Derby City Council

DERBYSHIRE County Council

Joined Up Care Derbyshire

## Contents

## Foreword

Integrated care systems provide a positive opportunity for Derby and Derbyshire residents to receive joined up care and support to meet their health and care needs.

Derby City Council and Derbyshire County Council have responsibility for a range of social care and public health functions that support our residents to live well. Our two local authorities are working alongside NHS colleagues, Healthwatch, district and borough councils and the voluntary and community sector to deliver integrated care for our residents.

The Covid pandemic and cost of living pressures have negatively impacted the health of our population in so many ways. Our budgets and services are experiencing challenges and pressures on a regular basis. Our workforce is going the extra mile every day.

Integrated care is not a solution in itself; however it does allow us to develop new ways of working, utilise new technology, maximise the skills of our precious workforce to create new opportunities to collaborate and work together. It will not be easy but there is a shared local commitment to do all we can within the resources available to do our best for Derby and Derbyshire.

Our Integrated Care Strategy summarises the first steps on the journey and describes how we will further grow and develop our shared approaches. There is huge ambition and commitment across the City and County to get this right for our communities. Delivering against the proposals in this strategy has the potential to help us provide a more preventative approach to health, tackle inequality and improve outcomes for local residents.

As Joint Chairs and Vice Chair of the Derby and Derbyshire Integrated Care Partnership we hope that you find the information useful, engaging and that it provides a clear understanding of the journey we are on and what we want to achieve by doing more together for our local populations.

Cllr Carol Hart
Cabinet Member for Health and Communities – Derbyshire County Council
Chair of the Derbyshire Health and Wellbeing Board

Cllr Roy Webb
Cabinet Member for Adults, Health and Housing – Derby City Council
Chair of the Derby Health and Wellbeing Board

John MacDonald
Chair of Derbyshire Integrated Care Board

# 1. Introduction

## 1.1 Purpose of this document

This document has been produced for consideration at the Integrated Care Partnership (ICP) Board on 8 February 2023. It is a first draft of the Derby and Derbyshire Integrated Care Strategy and builds on the Framework Document considered by ICP Board members on 7 December 2022.

The purpose of the Joined Up Care Derbyshire (JUCD) Integrated Care Strategy is to set out how Local Authority, NHS, Healthwatch, and Voluntary Sector organisations will work together to improve the health of Derby and Derbyshire citizens, and further the transformative change needed to tackle system health and care challenges.

The final draft of the Strategy will be produced for consideration by the ICP Board in April 2023. The approved version will then be published in line with national guidance, with a copy provided to each partner local authority and the Integrated Care Board.

A summary of the Strategy will also be produced to accompany the final document. This will be designed to communicate the key elements in a shorter and more simplified manner with the use of infographics and easier to understand language. It will also convey the relationship between this Strategy and other key planning documents and priorities, so that staff and citizens can see how the Integrated Care Strategy and its strategic aims align with health and wellbeing and other key strategies.

The Strategy will not be static, the national guidance requires that *Integrated care partnerships must consider revising the integrated care strategy whenever they receive a joint strategic needs assessment*. Therefore further versions of the Strategy will be produced and published in line with this requirement. To this end the Strategy should be regarded as a starting point for assessing and improving the integration of care.

## 1.2 Impact of this Strategy

In developing this Strategy a question consistently posed by the team leading its production has been *'what will not happen if we do not have this Strategy, what are the gaps it is seeking to fill'?*

The aim is to develop a document that describes both a high-level strategic intent and the practical steps the Derby and Derbyshire System will take together to provide care that is more integrated, and which provides better outcomes for citizens, in response to population health and care needs.

In response to the question stated above, the Integrated Care Strategy will impact in the following ways:

- **Collaboration and collective working -** The collaborative work to develop the Strategy has helped to strengthen partnership working and engagement between local authorities, the NHS, the VCSE sector and Healthwatch, that will prove beneficial beyond the remit of the Integrated Care Strategy and should act as a springboard for better collective working moving forward. In short, the way in which we are developing this Strategy is just as important as the content.

- **A joined up approach to strategic enablers** - The Strategy captures for the first time the key, enabling actions that are critical to the development of high quality and sustainable integrated care, and identifies key areas of focus to test these actions.

- **Agreement on key areas of focus to test our strategic aims and ambitions for integrated care -** The process for developing the Strategy has resulted in system-wide agreement on three key areas of focus that will help deliver key population health and service delivery outcomes, they are:

  - **Start Well** - To improve outcomes and reduce inequalities in health, social, emotional, and physical development of children in the early years (0-5) via school readiness
  - **Stay Well** - To improve prevention and early intervention of the 3 main clinical causes of ill health and early death in the JUCD population - Circulatory disease, respiratory disease and cancer
  - **Age/ Die Well** - To enable older people to live healthy, independent lives at their normal place of residence for as long as possible. Integrated and strength based services will prioritise health and wellbeing, help people in a crisis to remain at home where possible, and maximize a return to independence following escalations

- **Engagement -** It is critical that the improvements expected as a result of this Strategy are meaningful and impactful to citizens. The strategic approach to engagement developed by JUCD, which includes key principles and frameworks will be key to success. It sets out how we will listen consistently to, and collectively act on, the experience and aspirations of local people and communities. The Integrated Care Strategy provides an ideal opportunity to test and further develop this approach.

### 1.3 National Guidance on the preparation of Integrated Care Strategies

The guidance currently available on the Gov.UK website is the same as referenced in the December 2022 Framework Document. Please refer to that document or the guidance itself (Guidance on the preparation of integrated care strategies) for further information.

**Legal requirements**
The legal requirements stated in the guidance are included below along with a statement on the compliance of the Draft Strategy against these requirements.

| Legal requirements stated in July 2022 Guidance | Current status for Draft Strategy |
|---|---|
| The integrated care strategy must set out how the **'assessed needs' from the joint strategic needs** assessments in relation to its area are to be met by the functions of integrated care boards for its area, NHSE, or partner local authorities. | Three key areas of focus emanating from 'assessed needs' have been selected as a focus for the Strategy and to test the strategic aims and ambitions for the development of integrated care, with implementation to be overseen by the ICP. The Joint Forward Plan will describe how other 'assessed needs' will be met. |

| | |
|---|---|
| In preparing the strategy, the ICP must, in particular, consider whether the needs could be more effectively met with an arrangement under **S75** of the NHS Act 2006. | The governance arrangements for the three key areas of focus will consider S75 arrangements. |
| The ICP **may include a statement on better integration of health or social care services with 'health-related' services in the strategy**. | It is proposed that the wording included in this Strategy document should meet the requirement stated. |
| The ICP must have regard to the **NHS mandate** in preparing the strategy. | The NHS Mandate is referenced in this draft Strategy, however at the time of writing the 2023/24 Mandate has not been published.<br><br>The three key areas of focus will incorporate relevant requirements of the Mandate and the Joint Forward Plan is likely to play a more substantive role in responding to the Mandate, given its broader remit and its focus on delivery. |
| The ICP **must involve in the preparation of the strategy: local Healthwatch organisations** whose areas coincide with or fall wholly or partly within the ICP's area; and people who live and work in the area. | Derby and Derbyshire Healthwatch organisations have been involved through the Communications and Engagement Group for the Strategy (please see **Section 6** for work to date), through their membership of the ICP Board and through separate conversations with the team leading the development of the Strategy.<br><br>Moving forward Healthwatch will play a key role in the finalisation and delivery of the Strategy, for example by:<br>• Ensuring authentic conversations with citizens help shape and drive work programmes for the key areas of focus and enabling plans<br>• Feeding into evaluation work, ensuring the many different 'voices' of citizens are listened to when assessing progress and the impact of changes made to services. |
| The **ICP must publish the strategy** and give a copy to each partner local authority and each ICB that is a partner to one of those local authorities. | The final version of the Strategy (April 2023) will be published in line with the guidance. |
| ICPs must consider **revising the integrated care strategy whenever they receive a joint strategic needs assessment** | This will be done when new JSNAs are received and when new health and wellbeing strategies are agreed. |

### 1.4 Aligning the Integrated Care Strategy

The Strategy will complement joint strategic needs assessments and the joint local health and wellbeing strategies. The health and wellbeing boards remain responsible for producing both of these documents, and these will continue to have a vital role at Place.

The ICP will need to ensure that the Strategy facilitates subsidiarity in decision making, ensuring that it only addresses priorities that are best managed at system-level, and not

replace or supersede the priorities that are best done locally through the joint local health and wellbeing strategies.

References are included in this document to illustrate how the development of the Strategy is being aligned with other system strategies and plans and where further work may be required. Please see **Appendix 1** for a visualisation of how health strategies link together.

Guidance has recently been released (NHS England » Guidance on developing the joint forward plan) to support integrated care boards (ICBs) and partner organisations develop their first 5-year joint forward plans (JFPs) with system partners. The guidance includes the following statement:

*..we encourage systems to **use the JFP to develop a shared delivery plan for the integrated care strategy** (developed by the ICP) and the joint local health and wellbeing strategy (developed by local authorities and their partner ICBs, which may be through HWBs) that is supported by the whole system, including local authorities and voluntary, community and social enterprise partners.*

Conversations are currently being held in the System to discuss the JUCD approach to production of the JFP and the relationship with the implementation of this Strategy.

### 1.5 Hallmarks for the Strategy

The hallmarks agreed through the Framework Document have been used to help guide the development of this Draft Strategy:

- There is an inclusive approach to developing the content
- The development of the Strategy and its recommended actions is based upon a strong culture of collaboration between JUCD organisations and alliances.
- We will develop a broad and deep engagement approach to inform the further development of the Strategy and relevant implementation plans
- This is a strategy for JUCD, not for regulators, and the process of developing it, should be as important as the content of the Strategy itself
- We will develop content that can be converted into statements which mean the public can easily understand how this Strategy will make a difference to them (*to be done following agreement of the Draft Strategy*).

### 1.6 Involvement and engagement in the development of this framework document

A range of senior colleagues from the NHS, local authorities, Healthwatch and the VCSE sector have been part of working groups to develop the brief, framework, and approach for the Draft Strategy, following the update on the development of an Integrated Care Strategy provided to the ICP Board in October 2022. This broad involvement has been very helpful in testing the proposed content and whether it is framed in a way that aligns with other system strategies and plans.

### 1.7 Format and content of the document

References are included in this document to national and system strategies/ plans that are relevant to the development of this Strategy – please see **Section 2**. Minimal content has

been included on these to keep the content of this document focused. The strategic aims for the Strategy are also included in this section**.**

The population health and care needs of Derby and Derbyshire are a fundamental driver for the Strategy. **Section 3** includes a summary of JUCD priority outcomes and indicators. These are based upon joint strategic needs assessments and health and wellbeing strategies and align with outcomes included in Local Authority plans. A section is also included on proposals relating to health protection arrangements.

A main thrust of the Strategy is the need to focus on strategic enablers that are critical to the development of high quality and sustainable integrated care in response to the stated population health and care needs. These enablers are summarised in **Section 4**.

There are three 'key areas of focus' proposed in **Section 5** spanning prevention, early intervention and service delivery. They are not framed as priorities, as they are not necessarily regarded as being more important than other topics. Instead they have been chosen by senior responsible owners from across the System as ideal areas to test our strategic aims and ambitions for integrated care, in response to population health and care needs. They are categorised under the headings of Start Well, Stay Well, and Age/ Die.

The plans for these key areas of focus will include ambitions that span multiple years and for many metrics we may not see attributable improvement until the medium to long term. Delivery plans will need to explain the connections between improvements to be achieved in the short-term (for example in responding to health and care annual operating plan requirements) and ones that will be achieved in the medium to long term, and to also show how they fit together. The Joint Forward Plan will be helpful in this regard.

Other key issues flagged by the ICP and ICB Boards that will be integral to the work arising from this Strategy include addressing health inequalities, the further development of population health management and maximising the NHS contribution to tackling wider determinants of health.

**Section 6** summarises the JUCD approach to engagement and the use of insights, and the outline plan for engagement on the Strategy and the key areas of focus.

**Section 7** outlines the need and intent to evaluate strategy implementation, including the impact of plan delivery for the three key areas of focus. The content is under development and will be updated for the final version in April 2023.

## 2. Strategic Context

### 2.1 National context

<u>The Health and Care Act 2022</u>
The Health and Care Act 2022 put new requirements on NHS and Local Authorities, including the requirements to produce an Integrated Care Strategy, set up an Integrated Care Partnership and establish an Integrated Care Board.

<u>NHS Mandate</u>

The ICP must have regard to the NHS Mandate, alongside guidance from the Secretary of State, when preparing the Integrated Care Strategy. The 2023-24 Mandate and accompanying objectives are awaited.

The NHS Mandate will help inform this Strategy; however it is by its nature NHS centric and some of its content is quite operational, and therefore the primary response to the Mandate will be through the Joint Forward Plan.

National focus on prevention and early intervention
There have been recent calls from national organisations for an increased focus on prevention and early intervention, which echo one of the strategic aims for this Strategy - *Prioritise prevention and early intervention to avoid ill health and improve outcomes.*

The paper published in January 2023 Joint vision for a high quality and sustainable health and care system | Local Government Association provides the views of the Local Government Association, the Association of Directors of Adult Social Services, and the NHS Confederation and endorses the approach outlined in this Strategy:

*"Our three national organisations agree that our vision for all partners in the health and care system must focus first and foremost on promoting the health, wellbeing and prosperity of our citizens. This vision is relevant to all of us, whether we need care, support or treatment now or in the future, provide unpaid care for family members, work in social care or health, or run businesses that contribute to health and wellbeing outcomes. It focuses on:*

- *maximising health and wellbeing and preventing or delaying people from developing health and social care needs*
- *redirecting resources so that when people need treatment, and short term support they are assisted to make as full a recovery as possible, restoring their health, wellbeing and independence*
- *maximising independence and wellbeing for people with ongoing heath and/or social care needs by working with them to put in place the care and support that works for them."*

**2.2 JUCD Strategic context**

Introduction
It is recognised that the current environment for health and care is very challenging on a number of fronts including the lived reality of workforce capacity and wellbeing challenges, Covid related backlogs, and financial constraints. And in the context of this Strategy we cannot expect these challenges to diminish in the near future.

There are other System plans that will better describe approaches for dealing with the issues of today and the need for near-term responses, and whilst it is not the intention to downplay or disregard these challenges in developing this Strategy, it is important for the System to also identify what can be done more effectively and efficiently by integrating resources and by working differently, through medium and long-term lens. Therefore through this Strategy we will seek to identify and exploit such opportunities.

It will be important to build on examples of where we do things really well in Derby and Derbyshire and to understand how actions, partnerships and behaviours that have led to successful outcomes, can accelerate our plans for integrated care, and to help build an

appreciative inquiry approach to the development of the Strategy and subsequent implementation plans. In the final version of the Strategy examples of good practice aligned to the key areas of focus and strategic enablers will be incorporated into the document.

The following sub-sections include references to local strategies and plans that need to be considered when developing integrated care. It is not a simple landscape, and at the current time there are multiple, relevant strategies or plans under development, in response to government, NHS and local requirements. A common goal for colleagues working across the System in this space should be to assess other, relevant planning exercises and collectively to try and develop a coherent logic for how the documents align with each other. **Appendix 1** provides an infographic that seeks to help in this regard, and this will be developed further in the final version of the Strategy.

ICS System Development Plan

The ICS System Development Plan is a recent document and includes four strategic priorities (using the NHS stated aims for ICSs). We have agreed that for the Integrated Care Strategy we should build out from the content included in that Plan and have strategic aims for the development of integrated care, that can sit alongside the stated strategic priorities for the ICS, these strategic aims are;

- **Prioritise prevention and early intervention to avoid ill health and improve outcomes**
- **Reduce inequalities in outcomes, experience, and access**
- **Develop care that is strengths based and personalised**
- **Improve connectivity and alignment across Derby and Derbyshire, to ensure people experience joined up care, and to create a sustainable health and care system**

Joint Forward Plan

Section 1 outlined the guidance for Joint Forward Plans, released by NHS England in December 2022, and the initial conversations in relation to the Integrated Care Strategy.

JUCD Operational Plan 2023-2024

Prevention, access and productivity are key themes/ requirements that are driving the 2023-24 operational plan, which responds to guidance released by NHS England. Whilst the Integrated Care Strategy will also focus on other themes (as reflected in the strategic aims), it will also be important that the SROs for the key areas of focus to examine contributions to improvements in access and productivity, as well as prevention.

Local Authority Plans 2022-2025

Please see **Section 3** for an outline of how outcomes, ‘must do’s’ and ‘headline initiatives’ from these plans align with the stated population health and care needs.

Adult social care and children’s strategies

Relevant stated priorities in local strategies covering adult social care and children' services need to align with the aims for the integrated care key areas of focus to support our ambitions for collaboration and integration.

Health and wellbeing strategies
Please see **Section 3** for reference to the Derby City and Derbyshire health and wellbeing plans and the alignment between these, the JSNAs, and current work to develop a Health Inequalities Strategy.

Anchor Institutions
The work of the Derby/ Derbyshire Anchor Partnership needs to be incorporated into the design and delivery plans for this Strategy.

The two local authorities, local NHS organisations and JUCD, Derby County Community Trust and the University of Derby are signatories to an Anchor Charter, and together with Rolls Royce, are members of Derbyshire's founding Anchor Partnership. Together they aim to use their collective influence to help address socio-economic and environmental determinants and enable and facilitate community wealth building, working together through the Derby and Derbyshire Health and Wellbeing Boards and the Integrated Care Board.

The Anchor Partnership has agreed to initially focus its combined influence and actions on the following two impact areas – workforce and access to work, and social value in procurement. Anchor workshops have commenced in recent months with relationships established through communications colleagues in each organisation.

It will be important to consider how best to align Anchor Partnership actions with the work emanating from this Strategy on key enabling functions and across the Start Well, Stay Well, and Age/ Die Well areas of focus.

## 3. Population Health and Care Needs

### 3.1 Introduction

Work has been undertaken by system colleagues to develop a set of JUCD priority population outcomes and key indicators (known as Turning the Curve) based upon the Derby and Derbyshire Joint Strategic Needs Assessments. These focus on increasing life expectancy, increasing healthy life expectancy, and reducing inequalities. The system outcome priorities/ indicators have been chosen because they are key drivers of the conditions that cause ill health, premature mortality, and inequalities in these, with the biggest causes of death in our population being cancer, respiratory and circulatory disease. This is reflected in emerging work to develop a JUCD health inequalities strategy which reflects the Core20Plus5 NHS England approach to reducing inequalities.

The Derbyshire and Derby Health and Wellbeing Strategies are to be updated during 2023. The content for this document and the needs outlined in this Section are therefore based upon the existing health and wellbeing strategies.

### 3.2 Life expectancy and healthy life expectancy

The health of a population can be described using healthy life expectancy and life expectancy statistics, and health inequalities can be starkly demonstrated by illustrating the difference in length of life, and how many of those years are spent in good health. Please see **Table 1** below for a summary of the differences in Derby and Derbyshire.

**Table 1**

| | Derby | Derbyshire |
|---|---|---|
| Life Expectancy at Birth [inequality gap*], in years | | |
| Female | 82.1 [10.1] | 83.0 [7.4] |
| Male | 78.6 [10.2] | 79.6 [8.3] |
| Healthy Life Expectancy At birth, 2017-19 [inequality gap, 2009-13*], in years | | |
| Female | 62.0 [19.2] | 61.3 [13.5] |
| Male | 59.9 [18.7] | 61.1 [13.7] |

**Life Expectancy at Birth statistical measures estimate the average number of years a new-born baby would survive if they experienced the age-specific mortality rates in this area throughout life. Healthy life expectancy describes reported years in good health. The gap describes the difference between the least and most deprived populations.*

The inequalities illustrated in **Table 1** are distributed differently across the area. Poorer outcomes are linked to areas of socio-economic deprivation and certain groups including, but not limited to, those from Black, Asian, and Minority Ethnic backgrounds, with serious mental illness, living with disabilities, LGBTQ+ people and those currently homeless.

The emerging work to develop a JUCD health inequalities strategy incorporates a review of the drivers of ill-health and mortality, the inequalities which exist between and within communities and sets out desired population outcomes, and priority indictors for affecting outcomes and inequalities – Please see **Section 3.3**.

### 3.3 Our desired population outcomes

The following statements have been developed locally to describe if the population were living in good health, it would be experienced as follows:

- **Start Well** - Women have a healthy pregnancy, children are born safe and well into a nurturing and secure relationship with care givers, with good nutrition, access to health care, social care, and education. Children thrive and develop positive and healthy relationships.

- **Stay well** - All citizens live a healthy life, can make healthy choices, and are protected from harm. They maintain quality of life and recover well from ill health or injury.

- **Age well and die well** - Citizens thrive and stay fit, safe, and secure into older age. They maintain independence and actively participate in society. They have a personalised, comfortable, and supported end of life.

### 3.4 System wide population indicators

The following 'Turning the Curve' indicators have been recommended as important 'markers' on the way to improving high-level outcomes. They address direct risk factors for the main causes of death, illness, and inequalities, including mental health:

1. **Reduce smoking prevalence**
2. **Increase the proportion of children and adults who are a healthy weight**
3. **Reduce harmful alcohol consumption**
4. **Improve participation in physical activity**
5. **Reduce the number of children living in low-income households**
6. **Improve air quality**
7. **Improve self-reported wellbeing**
8. **Increase access to suitable, affordable, and safe housing.**

JUCD has also identified additional indicators to reduce specific inequalities in the system drawing on local data and NHS recommendations*. See below for the "Plus 5" indicators (clinical areas of focus which require accelerated improvement).

- **Maternity:** ensuring continuity of care for 75% of people from Black, Asian and minority ethnic communities and from the most deprived groups**.**
- **Severe mental illness (SMI) and Learning Disabilities:** ensuring annual health checks for 60% of those living with SMI or learning disabilities**.**
- **Improving Vaccination uptake:** reducing inequalities in uptake of life course, COVID, flu and pneumonia vaccines
- **Early cancer diagnosis:** 75% of cases diagnosed at stage 1 or 2 by 2028.
- **Hypertension case-finding:** to allow for interventions to optimise blood pressure and minimise the risk of myocardial infarction and stroke

* https://www.england.nhs.uk/about/equality/equality-hub/core20plus5/

***Note**: Guidance on Core 20 Plus 5 for CYP has recently been issued nationally and will require consideration. Five clinical areas of focus are asthma, diabetes, epilepsy, oral health, and mental health with specific actions recommended.*

### 3.5 Derby City Council Plan

A number of the outcomes and 'must do's' under the four focus areas included within the Derby City Council Plan align to and support health and wellbeing plans, and the desired population outcomes and priority health indicators stated above. For example the following are referenced:

- Cleaner air and lower CO2
- Decent, sufficient, and affordable housing with an emphasis on the homes of vulnerable people
- Reducing inequalities and wealthier and healthier residents
- Health and wellbeing strategy with a focus on childhood obesity and public health statutory requirements
- Provide effective strategic leadership to drive stronger integration of health, housing, community, and social care agendas, safeguarding adults that need it
- Establish a citywide Prevention Strategy, focusing on building independence using individual and community assets

### 3.6 Derbyshire Council Plan

Within the Derbyshire plan one can see how the stated 'headline initiatives' align with health and wellbeing plans, and the desired population outcomes and priority health indicators, examples include:

- Working with partners to benefit the health and wellbeing of people in Derbyshire by better integrating health and social care and developing the Better Lives transformation programme
- Driving forward the ambitious improvements in Children's Services to positively strengthen outcomes for children and young people
- Work with people with learning disabilities, recovering from mental ill health and, or autism to develop Council services to ensure they are tailored to meet individuals needs and help people achieve their personal goals
- Work with partners to enable individuals and communities to lead healthier and happier lives, accessing support when and where they need it to encourage physical activity, help people stop smoking and manage their weight
- Help and empower more young people with disabilities to be independent in their transition to adulthood

In addition the council has published its "Best Life Derbyshire" Strategy in 2023 with a focus on people with lived experience being able to define the outcomes they want from social care.

### 3.7 Health protection

Integrated care partnerships are asked to consider health protection in their integrated care strategy, with system partners including UKHSA, local authorities and the NHS who, among other bodies, have health protection responsibilities to deliver improved outcomes for the population and communities served. Health protection includes:

- Infection and prevention control (IPC) arrangements within health and social care settings

- Tackling antimicrobial resistance
- Reducing vaccine-preventable diseases through immunisation
- Assurance of national screening programmes
- Prevention activities related to health protection hazards such as needle exchanges for blood-borne viruses (BBVs)
- Commissioning of services for response to health protection hazards (such as testing, vaccination and prophylaxis) and to tackle health protection priorities (such as tuberculosis or BBV services)
- Emergency preparedness, resilience and response (EPRR) across all hazards
- Other health threats determined as priorities

The Directors of Public Health (DsPH) have the duty, under the Health and Social Care Act (2012), to be assured that the local health protection system is working effectively and to ensure that the health of the population is protected. This is sought through the Derby and Derbyshire Health Protection Board, chaired by one of the DsPH and reporting to the Health and Wellbeing Boards; an arrangement that has been in place since 2013. The development of the integrated care system is an opportunity to ensure this is embedded within the local health and care system.

Work is underway to identify key areas of work that require system support, these include:

- Developing the infection prevention and control system
- Ensuring a successful and safe transfer of the responsibility to commission immunisation services
- Ensuring oversight of screening programmes is appropriately linked to the system
- Improved connection for existing strategies e.g. air quality
- Pathway improvements for individuals with complex health protection needs e.g. those with TB who have no recourse to public funds

The following strategic actions have been identified:

- Request a commitment from the ICP to sponsor a review of the governance and architecture for health protection in Derby and Derbyshire.
- Produce a health protection strategy for Derby and Derbyshire to clarify and drive the work of the Health Protection Board and establish agreed outcome measures.
- Review the three key areas of the focus for the Integrated Care Strategy and identify prioritised health protection actions. Secure commitment from the SROs to include these actions as an integral element of their work plans, and to work with Public Health colleagues on their resolution.
- Ensure health protection priorities are included within the appropriate workstreams, and that progress is reported to the Health Protection Board.

# 4. Strategic Enablers

## 4.1 Introduction

A key thrust of this Strategy is to focus on enabling actions that are critical to the development of high quality and sustainable integrated care and our response to population health and care needs. These have been grouped as follows:

- System architecture and governance
- System shared purpose, values, principles, and behaviours
- Enabling functions and approaches

## 4.2 System architecture and governance

Through this Strategy we will strive to ensure there is a 'parity of attention' on health inequalities, population health, and prevention within system reporting and governance arrangements, to ensure clarity and visibility on how we track our ambitions for our Start Well, Stay Well, Age/ Die Well key areas of focus, and wider improvement actions.

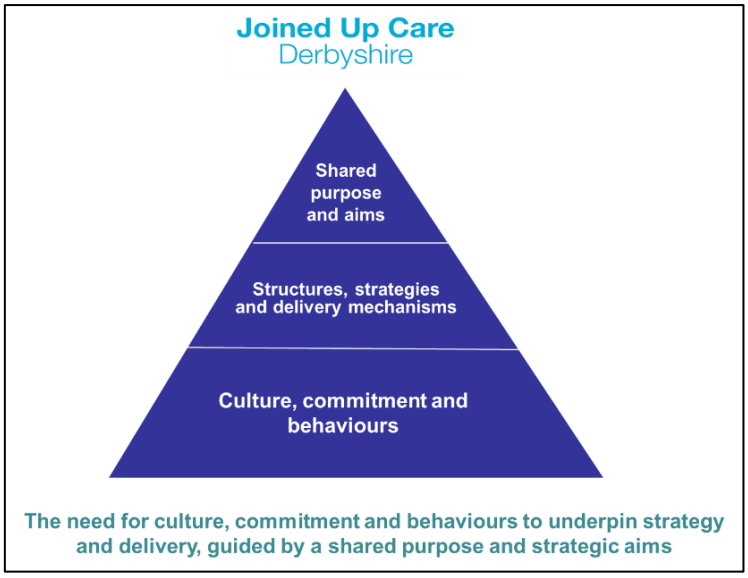
This objective needs to be set in the context of current work taking place to establish a renewed mandate to guide next steps for our collective "Integrated Care" approach, and JUCD governance architecture. A series of guiding questions to the Provider Collaboration at Scale and the Provider Collaboration at Place movements have been asked to help inform the renewed mandate.

Currently the two Place Partnerships and the Integrated Place Executive provide the primary governance arrangements for the Integrated Care Strategy on behalf of the ICP. In this context the role of the ICP in supporting and overseeing the delivery of this Strategy needs to be established, post approval of the final document.

Further consideration is also required in relation to how the Strategy's key areas of focus are governed. All three of the proposal documents described issues with current governance and delivery arrangements that will need to be addressed if benefits are to be maximised. There also needs to be feedback loop processes for how the agreed plans are continually informed by health and wellbeing plans and JSNAs, and vice versa.

## 4.3 System shared purpose, values, principles, and behaviours

Many of the key strategic enabling actions that are intended to support improvement through practical and transactional solutions, may not succeed, without significant underlying changes in behaviours to support a one-system approach, due to established processes and organisational sovereignty issues. A simple over-arching framework to ensuring a balanced approach is included below.




In the absence of a whole system, shared set of values and principles to underpin the development and delivery of the Integrated Care Strategy then consideration should be given to this, alongside organisational development support that may be required to facilitate the process, to ensure that the Strategy is built on sustainable cultural foundations.

Where success has been achieved in developing integrated care to date, it is important to reflect on the conditions that facilitated the success, both transactional and cultural. Work will take place to gather and review this intelligence to inform further engagement, with leaders, staff, and the public.

Work will now commence to scope how a set of shared values and principles to underpin the development and delivery of the Integrated Care Strategy could be developed.

**4.4 Enabling services and approaches**

Strategies and improvement plans for enabling functions and approaches should encompass all organisations/ alliances in the System (unless not deemed relevant) and support the achievement of our strategic aims for integrated care.

The content under this Section seeks to summarise current strategies and improvement plans and also flag key constraints that will need to be addressed. The following enabling functions and approaches are included:

- Workforce
- Digital and data
- VCSE sector
- Carers
- Strengths based approaches
- Population health management
- Commissioning
- Quality drivers
- Estate

Primary care is refenced in Section 4.5.

There is already alignment between some of the content in this section and the content in Section 5, where aims and constraints are stated for the key areas of focus selected to test and mobilise this Strategy. This reflects the fact that there is already considerable joint working taking place across the System. The leadership for each of the key areas of focus will be expected to work closely with enabler leads to further this alignment and to develop work programmes that will help to test enabling strategies and improvement plans in real world situations and gather learning to inform continuous improvement.

The content in the following sections (**4.4.1 to 4.4.9**) has been co-produced with JUCD leads for the functions and services covered.

### 4.4.1 Workforce

Our vision for the JUCD workforce is:
*"Anyone working in health and care within Derby and Derbyshire feels part of one workforce which is focused on enabling our population to have the best start in life, to stay well and age well and die well. Our workforce will feel valued, supported and encouraged to be the best they can be and to achieve the goals that matter to them wherever they work in the system."*

Key enablers to achieving the vision include:

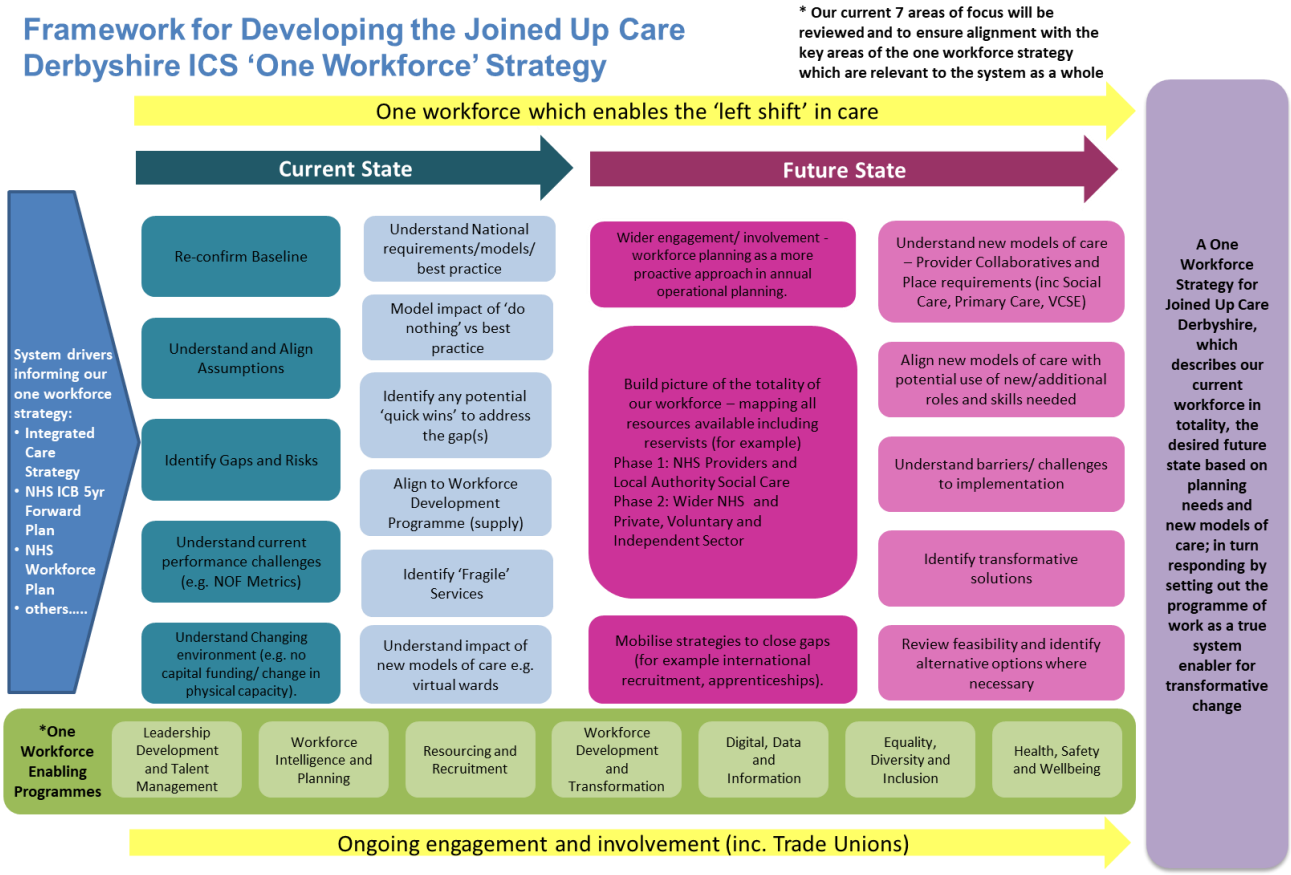
- A single point of access for new recruits, with a "no wrong door" approach to seeing people as a system asset, to be deployed wherever their skills fit best
- An integrated system rather than organisational approach to assessing workforce supply requirements
- Unified approach to leadership and talent development and OD
- An inclusive talent approach as the driver for recruitment and development
- Consistency of People Services offers, regardless of employing organisation - "One People Service across all places"
- Use of technology to enable ease of movement between organisations and reduce non value adding processes
- Clearer sense of common purpose and agreement on priorities for where we can work together, share resources
- Prioritisation of investment in training and development in prevention, personalisation and health inequalities

Some of the key challenges, and constraints to achieving the vision and our integrated care strategic aims include:

- Lack of dedicated workforce expertise to support integration
- Better understanding of the current workforce in the scope of this plan, what the requirement will be in light of the integrated care strategy and a joint approach between service leads and People Services to develop plans to bridge the gap using new approaches to skill mix, expanding/ introducing new roles and deploying staff closer to service users
- High percentage of social care staff who are in the PVI sector and therefore harder to influence in terms of workforce planning and development
- Fragmented and short-term nature of funding streams for workforce transformation and development
- Lack of trust in processes and governance between statutory sector partners and between statutory sector and VSCE

Current areas of focus therefore include delivering the conditions that will enable a JUCD 'one workforce', spanning health and local authority organisations; leadership development at a system level; the Joined Up Careers initiative; and the 'Quality Conversations' training programme which develops a strength based, personalised mindset for health and care staff.

The following infographic summarises our framework for developing the JUCD 'One Workforce' Strategy. We will need to align and embed this framework as part of the work programmes for the key areas of focus included in **Section 5**. Feedback on the Workforce vision, and the framework, through this Draft Strategy will help to further develop the approach.




### 4.4.2 Digital and data

The Digital and Data strategic aims and delivery priorities will support and enable the System to work towards the realisation of its strategic priorities and desired population outcomes through:

- **The ability to share citizen/patient information** to support care delivery across health and social care, including;
  - **Derbyshire Shared Care Record (DSCR).** The deployment of the DSCR will be expanded to include hospices, care homes, community pharmacies and other commissioned health and social care providers services. The DSCR provides clinicians and professionals with the most up to date patient/ citizens information to support the delivery of optimal care.

  - **Front Line Digitisation; Electronic Patient Record (ePR**). To enable collaborative working, deliver faster care, pathway redesign, reduced clinical risk and Population Health Management a new ePR will be deployed across our acute hospitals.
  - **Digitising in Social Care (DiSC)** – the implementation of digital social care record for care homes and domiciliary care providers, technology to support falls prevention and other technology evidence to enable citizens to be supported in the place they call home
- **A data architecture to enable population health management to be embedded** across the system to inform service planning and delivery. The ambition is to create a holistic view of citizens that incorporates wider determinants of health to improve physical and mental health outcomes.
- **Digitally enabled care delivery using tools and technology** to improve citizens knowledge and understanding to take greater control of their health and care
- **Digital and data innovation to support technology enabled care pathways** to augment care delivery, efficiency, and citizen/ patient/ staff experience
- **Digitisation of the wider health and social care economy** to improve care and opportunity for future interoperability and data sharing
- **Supporting and developing our citizens and workforce** in the use and adoption of digital services
- **Ensuring an inequity is not created** for those that are impacted. As we push our 'digital by default' vision we must ensure an inequity is not created for those that are impacted by the following barriers:
  - access issues
  - equipment, broadband connectivity, wifi, affordable data packages

This activity will be informed and prioritised through a systemic use of the nationally mandated and benchmarked 'Digital Maturity Assessment' and 'What Good Looks Like' tools.

### 4.4.3 VCSE sector

Nationally it is recognised that the VCSE sector is a vital cornerstone of a progressive health and care system and is critical in the delivery of integrated and personalised care and helping to reduce health inequalities. The National Development Programme – *Embedding the Voluntary Community and Social Enterprise (VCSE) Sector within Integrated Care Systems (ICS) 2022/2023,* which JUCD is part of, describes how;

*"ICSs should ensure their governance and decision-making arrangements support close working with the sector as a strategic partner in shaping, improving and delivering services, as well as developing and delivering plans to tackle the wider determinants of health. VCSE partnership should be embedded as an essential part of how the system operates at all levels. This will include involving the sector in governance structures and system workforce, population health management and service redesign work, leadership and organisational development plans."*

Locally, our ambition is for the VCSE sector to be considered as a key enabler for integrated care. It already makes a significant contribution to health and social care through complementary as well as mainstream provision, often supporting people who are under the radar of statutory services. This was particularly evident during the pandemic. VCSE organisations can also support, engage and articulate the needs of both communities of place, interest and condition.

The integrated care strategy provides an opportunity for a less transactional relationship with the VCSE sector where it can contribute at all points of the planning cycle; helping to define needs through soft intelligence, helping to design services so that they meet the needs of communities, as well as offering new and cost-effective approaches to service delivery.

Engaging this contribution will improve services for local people but there are challenges to making this happen that need to be addressed through the implementation of this Strategy and wider system actions. Some of these are listed below and a commitment to tackling these challenges is a key recommendation to the Integrated Care Partnership:

- Building understanding between sectors and changing culture and behaviours
- Supporting and developing the paid and volunteer workforce
- Involving such a large and diverse number of VCSE organisations in a defined ICS structure and communicating with them
- Finding investment, commissioning and support approaches that will make the most of what local VCSE organisations have to offer and develop longer term relationships
- Stimulating greater VCSE sector engagement and delivery in key system initiatives such as hospital discharge
- Enabling communities of place, condition and interest to shape services
- Building the capacity of VCSE organisations

How the VCSE sector will be embedded in the ICS and the processes and culture necessary to make this happen will be captured in a Memorandum of Understanding to be signed off and adopted by ICS partners.

**4.4.4 Carers**

The Derbyshire Carers Strategy has recently been refreshed (‘2022 Refresh’). The priorities within the Strategy are:

- Improving carer health and wellbeing
- Information and advice
- Carer employment and financial wellbeing
- Early identification and support
- Young carers
- Services and systems that work for carers
- Involving carers as experts
- Recognising and supporting carer in the wider community

System wide adoption of the priorities and pledges set out within the ‘Carers Strategy Refresh’ will ensure its greatest impact in effectively supporting unpaid family carers. Leads for the key areas of focus and relevant enablers (including workforce) for the Integrated Care Strategy will be expected to commit to the pledges within the Carers Strategy and to develop action/ delivery plans to help to realise the significant benefits to carers to improve their health and wellbeing and to support them effectively in their caring role.

**4.4.5 Strengths based approaches**

Strength based approaches already feature as a facilitative method for catalysing change and improvements in JUCD services. For example, Derby City Council has implemented a strengths based approach based around 8 principles, with the aim of achieving stability and reducing risk for children and young people, and to encourage the involvement of children and young people and their families in decision-making so that they are more in control of

the support they receive and thereby their everyday lives. And a strengths based approach is a key feature of the Team Up approach, and Derbyshire County Council's "Best Life Derbyshire" strategy for social care.

What is a strengths based approach?
Taking a strengths based approach simply means helping people find their own solutions and to create change through their own strengths and the assets available to them. It works at any level, individual, team or system.

Why is it required?
*"The dysfunctions of the traditional management system keep many organizations in perpetual fire-fighting mode, with little time or energy for innovation. This frenzy and chaos also undermines the building of values based management cultures."*

*(Peter Senge – The Fifth Discipline)*

Strengths based approaches build resilience, motivation and self-sufficiency. They have been proven to be significantly more effective than traditional deficit based approaches at creating lasting change and continuous quality improvement. This is especially so in complex adaptive systems such as health and care, or in getting the best out of a highly educated workforce.

At the current time when burnout is high amongst the workforce, approaches that build motivation and resilience are essential. Finding a way through this will require a relentless focus on our strengths, supporting people to find their own solutions and trusting them to make their own decisions.

How can it be applied?
There are many successful models and initiatives that use strengths based approaches. These include coaching, appreciative inquiry, human learning systems, quality conversations, local area coordination, Think Local, Act Personal, the 'What Matters to You' movement, personalisation, human learning systems and Team Up Derbyshire. However deficit based approaches still predominate in health and care.

Champions training for a selection of acute, LA, DCHCS, VCSE staff has been arranged from December 2022, with the aim of embedding strength- based approaches in practice, improving communication / understanding across the system and exploring system risk.

It is proposed that we create, implement, and embed strengths based approaches across Joined up Care Derbyshire working as an integral element of a system-level organisational development strategy.

### 4.4.6 Population health management

Population health management (PHM) uses data and information to understand what factors are driving the physical and mental health in the population and in communities. Better understanding through better use of data then helps to improve the health and wellbeing of people now and into the future. It seeks to reduce health inequalities and addresses the wider determinants of health through collaborative partnership working.

A Derbyshire-wide systematic approach to PHM is being developed and pilot activity to test the different approaches has been undertaken at a local level in four different parts of

Derbyshire. Learning from these pilots will inform next steps and the approach will be developed through the course of 2023, utilising system intelligence and insights, and the adoption of an analyse, plan, do, review approach to all interventions.

There are strong links between PHM and the Turning the Curve approaches. The next steps of the PHM work will focus on the Turning the Curve actions to improve the overall health of local populations.

Effective PHM requires data, data sharing agreements and digital enablers to facilitate effective outcomes. Significant development work is required across the system, including linking with digital, information governance and analyst colleagues.

### 4.4.7 Commissioning

Commissioning and funding allocations are key enablers for achieving our strategic aims and the objectives outlined by leaders for the key areas of focus included in this Strategy. This is likely to result in the System facing difficult decisions, given the current financial context and the expected need for increased resources to be targeted at prevention and early intervention activities.

There are currently extensive collaborative commissioning and joint funding arrangements, but we recognise the need to review and refresh these, seeking opportunities to 'consider whether the needs could be more effectively met with pooled budget arrangements under **S75** of the NHS Act 2006.

Colleagues leading the three key areas of focus will be asked to recommend changes in commissioning and funding arrangements that they have assessed are necessary to achieve the aims and objectives agreed for their areas. and more generally in this Strategy, including the need for an increased focus on prevention and early intervention.

It is indicated that there will be more flexibilities within national guidance for collaborative use of resources and we will review the opportunities that they will present to support delivery of the Strategy.

### 4.4.8 Quality drivers

Key areas of focus will include:

- Collaborative working between system partner patient experience and patient engagement teams to improve connectivity and alignment
- Bringing together system partners to align quality and equality impact assessments (QEIA) to develop care services that meet the needs of our population
- Bringing together health & social care partners to review and implement learning from LeDeR reviews
- Reducing health inequalities for people with learning difficulties by bringing together system partners to increase the use of annual health checks with their local GP service
- In collaboration with system partners, NHS England, and the Kings Fund, we are a pilot system in leading a project to look at experience of care across an ICS

### 4.4.9 Estate

NHS and local authority services in Derby and Derbyshire are provided in multiple settings and in multiple buildings. These services and buildings need to be fit for purpose in terms of

being safe and appropriate environments for everyone who uses them. This takes a great deal of forward planning to ensure we are providing the right kind of accommodation to meet the evolving requirements of health and care services. By having the right kind of environments we can help to tackle health inequalities, promote a sense of wellbeing from being in well-designed spaces, reduce the carbon footprint involved in constructing, running and maintaining buildings, and ensure we are meeting our targets on sustainability.

The  estate is a key enabler in delivery of the long-term plan; helping the System to transform by optimising the use of the estate, which can adapt to changing service models, and promote co-location and multiple occupancy of buildings  with patient, people, places and partnerships as key drivers.

The main priorities of the Estates Strategy are:

- Transform places and services - prioritise & maximise the use of the best quality estate, which is modern, agile and fit for purpose to support patient care
- A smaller better, greener public estate - Create an estate which is more efficient, effective and sustainable through optimisation
- Partnership approach - Work with our partners to strengthen collaboration and benefit from multi agency working

**4.5 Primary care**

Primary care is at the heart of communities (GPs, HVS, GPs, dentists, pharmacists, opticians, community nursing) and acts as a first point of contact for the people accessing the NHS/ gateway to the system.

Every day, more than a million people nationally benefit from the advice and support of primary care professionals, however; there are real signs of genuine and growing discontent with primary care – both from the public who use it and the professionals who work within it. Access to general practice is at an all-time low, despite record numbers of appointments and primary care teams are stretched beyond capacity, with staff morale at a record low. Primary care as we know it may become unsustainable in a relatively short period of time.

<u>A vision for integrating primary care</u>
The Fuller Stocktake (released May 2022) is a new vision for integrating primary care, improving the access, experience and outcomes for communities, which centres around three essential offers:

- Streamlining access to care and advice for people who get ill but only use health services infrequently: providing them with much more choice about how they access care and ensuring care is always available in their community when they need it
- Providing more proactive, personalised care with support from a multidisciplinary team of professionals to people with more complex needs, including, but not limited to, those with multiple long-term conditions
- Helping people to stay well for longer as part of a more ambitious and joined-up approach to prevention.

The key areas of focus and implementation plans for the Integrated Care Strategy will need to encompass the vision summarised above.

### 4.6 Difficult questions

A desired output for the final Strategy is to have a consensus on the 'difficult questions' that face the System if our strategic aims and service objectives are to be delivered. Some of these potential questions have already been floated in discussions regarding development of the Strategy and have included the following:

- How ambitious can we be on 'pooled funding'? What is the realistic scope of pooling resources from across constituent organisations?
- What do we collectively think joint commissioning could or should achieve?
- How can our financial planning support a shift to prevention?

Work is also underway to review JUCD examples of good integrated care practice to understand the difficult issues or decisions that have been overcome and to draw out key themes that may be helpful for our key areas of focus to learn from.

It is anticipated that supporting leaders and their teams to overcome generic and high impact challenges will need to be an active role for the governance arrangements described in **Section 4.2**, on the basis that the resolution for at least some of these issues will need to be elevated above local decision-making arrangements.

## 5. Key Areas of Focus

### 5.1 Introduction

There are three key areas of focus spanning prevention, early intervention and service delivery. Please see **Sections 5.2 to 5.4** for summary information on each.

They are not framed as priorities, as they are not necessarily regarded as being more important than other topics. Instead they have been chosen by senior responsible owners from across the System as ideal areas to test our strategic aims and ambitions for integrated care, in response to population health and care needs. They are:

- **Start Well** - To improve outcomes and reduce inequalities in health, social, emotional, and physical development of children in the early years (0-5) via school readiness
- **Stay Well** - To improve prevention and early intervention of the 3 main clinical causes of ill health and early death in the JUCD population - Circulatory disease, respiratory disease and cancer
- **Age/ Die Well** - To enable older people to live healthy, independent lives at their normal place of residence for as long as possible. Integrated and strength based services will prioritise health and wellbeing, help people in a crisis to remain at home where possible, and maximize a return to independence following escalations

After the Strategy is approved, the focus will immediately shift to delivery, and the work programmes that will be responsible for realising benefits. A set of common requirements

will be produced to guide the work, and this will support the Integrated Place Executive in managing delivery of the Strategy on behalf of the ICP Board. There is of course significant work already underway across the System within the scope of the three areas of focus and this will be built on as part of the process.

Additional programme resource will be required to drive, support and co-ordinate this work, alongside delivery of the development plans for the enabling functions and services.

### 5.2 Start Well area of focus

**Aim**

**To improve outcomes and reduce inequalities in health, social, emotional, and physical development of children in the early years (0-5) via school readiness.**

**Rationale for inclusion as a key area of focus**

It is important that children and young people can 'Start Well'. This aim links directly to the JUCD ambition to ensure *People have a healthy pregnancy, children are born safe and well into a nurturing and secure relationship with care givers, with good nutrition, access to health care, social care and education. Children thrive develop positive and healthy relationships.* The overall approach will be preventative.

The Children and Young People's Delivery Board will undertake a pathway approach, incorporating prevention and early intervention that ensures connectivity across the system, and supports the Board's vision to *provide a seamless health, education and social care pathway for children and young people in Derby and Derbyshire - one that enables all children and young people to be healthy and resilient and, if support is needed, enables them to plan their care with people who work together, allowing them to achieve the outcomes that are important to them.*

The work will include a focus on the 20% most deprived population. The emerging 'plus' groups for this priority are teenage parents, homeless families, looked after children, children born at a low birthweight (due to factors during pregnancy), and children with special educational needs.

Derby, Derbyshire Child Health Profiles and benchmarking nationally indicates the need for this priority, and we are engaged with Healthwatch to ensure support for this priority from children, young people and their families. And a recent community consultation undertaken by Derby Health Inequalities Partnership exploring perceptions of health and inequalities, highlighted a key theme of respondents wanting to 'break the cycle 'of poor health in their communities with a focus on children and young people's health.

This priority is supported nationally via the requirements in the NHS Long term plan, 'Core 20 PLUS 5 for CYP' to reduce health inequalities and SEND (special educational needs and disabilities) statutory requirements. It is also aligned locally to the ICS strategy (overarching, in development), Health and Wellbeing Boards priorities (City and County), 'Turning the Curve' Priorities, Children and Family Learners Board priorities (Derby), Childrens Partnerships Priorities (County), Safeguarding Partnership, Healthwatch and local insight.

**Key issues that will need to be addressed**

- Improving staff retention and development is critical to success
- Service commissioning and provision is currently fragmented, and this priority will provide the momentum for better connectivity across the system and more effective and efficient working
- Existing governance is fragmented by organisation. Giving the CYP Delivery board greater authority and responsibility would ensure decision making is reflective of whole system impact and focus on the long-term vision of both JUCD and the Delivery Board
- Importance of setting behaviours in young children and setting foundations for good health
- A seamless pathway approach to support and care with empowerment given to children, young people and their families from an early age will ensure efficiency is achieved, and the effectiveness of service delivery will be improved
- A review of the current workforce position (including the VCSE sector), the need to map future staffing, describe the shift required, and ensure plans are developed to achieve the shift needed
- Digital and data, particularly the sharing of data across the system will be critical to success, with access to timely and sub-system level data to inform planning. Information governance processes are key to enable effective information sharing across agencies
- Maximising the beneficial impact of communication and engagement

**Suggested measures for improvement**

- School readiness: the % of children achieving a good level of development at the end of reception.

This is published nationally and annually in the Public Health Child Health Profile data that is measured at the end of Reception year. It includes several dimensions and is impacted by a range of sub-indicators: those related to the family (maternal mental health, homelessness, family income and parental education), the child (low birth weight, health status and immunisation rates) and services (quality and availability of funded early education) among many others.

### 5.3 Stay Well area of focus

**Aim**

**To improve prevention and early intervention of the 3 main clinical causes of ill health and early death in the JUCD population - Circulatory disease, respiratory disease and cancer.**

**Rationale for inclusion as a key area of focus**

To prioritise prevention and collectively contribute to ill-health avoidance and improve outcomes for the local population.

The Population Health Management Steering Group has expressed a clear intention to reduce inequalities in outcomes, experience, and access. For example, identifying groups experiencing inequity of access to preventative services, and using this insight to inform subsequent targeted action to redress this.

Reducing morbidity from the three clinical conditions selected through a prevention approach will reduce and manage the demand on resources required for treatment of later stage disease, thus improving the sustainability of the health and care system.

There will be a focus on modifiable behaviours for both mortality and morbidity, across the range of diseases/ conditions, which contribute the most to mortality/ morbidity respectively.

Mortality:

1. Tobacco
2. High systolic blood pressure
3. Dietary risks

Morbidity:

1. High BMI
2. Tobacco
3. High fasting plasma glucose

Preventing ill health is beneficial for population wellbeing and reduces demand for NHS services and was identified in The Marmot Review as a key objective to reducing health inequalities and its associated social and economic costs. Preventative interventions such as cardiac rehabilitation have been shown to reduce non-elective admissions and early cancer diagnosis leads to increased survival and reduces financial impact, both on healthcare resources but also on an individual's ability to work and support their family.

Local insights identify prevention as a priority, for example:

- *"People welcome the move to focusing on the wider determinants of health but feel that priorities still reflect improvements in services, rather than wealth, education, and prevention."*

**Key issues that will need to be addressed**

- Existing governance and delivery arrangements are currently organisation centred which can inhibit system collaboration and added value of working across organisations to a single, shared aim. In addition, partners (such as the VCSE sector) and those beyond the local organisational system are key to a prevention approach
- Shift of funding, resources, and people towards a preventative focus, where health outcomes are influenced earlier in both clinical and non-clinical pathways
- Coordinated and joined up communications support for health promotion activities
- Strong productive partnerships across JUCD and broader partners, including education, the police and the criminal justice system, transport services, and local employers
- Workforce - the need for effective processes that enable staff to move between organisations and productively function in an organisation other than their employer
- Digital and IT - Flexible IT infrastructure, with shared access to drives, documents, records and data sets
- Simplify referral routes into services and enable effective self-referral to all services which the patient is motivated to engage with
- Population Health Management is a key enabler to this prevention priority
- Exploring the potential to co-locate services, regardless of the providing organisation

- Engagement with carers is key to understand the barriers they experience, for both their own health and wellbeing, along with those they care for

**Suggested measures for improvement**

Long term outcomes:

- Contribute to reducing the life expectancy gap between the most and least deprived people in Derby and Derbyshire, given that the three clinical conditions selected contribute the most to the local life expectancy gap.

Short-medium term outcomes:

- Identify and subsequently reduce identified inequalities in access to associated services, experience and outcomes from each service, for each condition.

Progress will be monitored against a set of metrics by demographic profile (a draft set has been produced). It is anticipated this will be agreed by System partners, including identifying those directly aligned to a specific partner (e.g. smoking cessation rates), along with those that some/ all partners can contribute to (e.g. referrals to smoking cessation services).

### 5.4 Age/ Die Well area of focus

**Aim**

**To enable older people to live healthy, independent lives at their normal place of residence for as long as possible. Integrated and strength based services will prioritise health and wellbeing, help people in a crisis to remain at home where possible, and maximize a return to independence following escalations.**

**Rationale for inclusion as a key area of focus**

A key ambition is a 'left shift' of care so that focus is increased on maintaining functioning and independence. Prevention and proactive identification of patients, combined with risk stratification, and effective care planning provides the best approach to supporting those patients and carers who have the most complex needs; this enables them to take an active part in decisions concerning their health and wellbeing and subsequently reducing the demand for health and social care services. When more critical episodes of care occur it is necessary to have responsive integrated community provision available so that acute admissions happen when it is the best option, not because it is the only option.

A fundamental principle of the proposed programme of work (and the leadership and delivery through place based working) to respond to this priority is a strength based approach in terms of the individual, the teams that are supporting and the communities they are part of.

The main vehicle for improving outcomes in this priority area is building integrated local planning, service responses and support in the community (including statutory services, VCSE, independent care providers, individuals and communities). Whilst the value of more integrated, locally delivered care will benefit many (if not all) groups it is particularly evident for those living with frailty and at the end of life.

The selection of this priority builds on engagement with the population over a number of years which has identified themes in terms of what is important to them, to keep them well, and their expectations from services. Derbyshire people have identified being able to stay in their own home for as long as it is safe to do as the most important thing to help them keep their independence and stay healthy as they get older (Healthwatch Report – 2019).

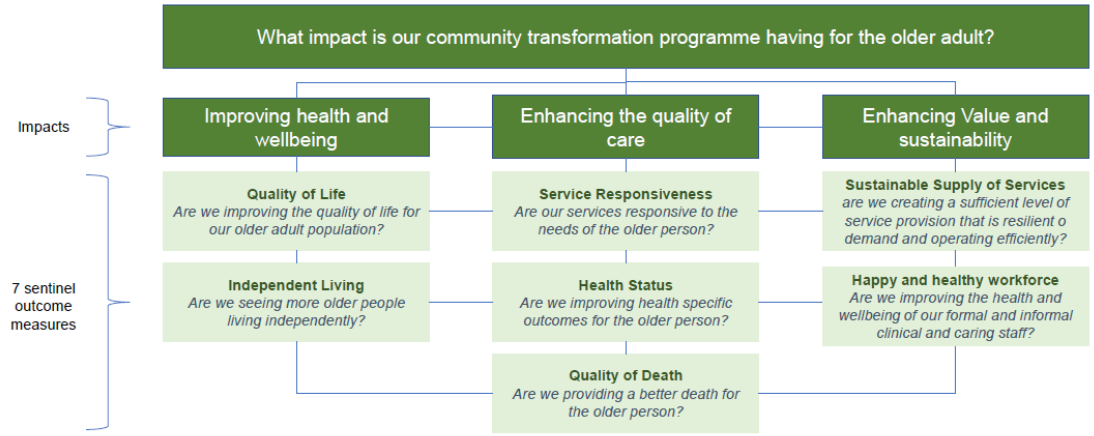
**Key issues that will need to be addressed**

- Support when navigating health and care – 'no wrong door' - Any point of access to the health and care system should be able to direct the user or carer to the right place
- Joined-up communication – tackle conflicting information, the need to repeat information and inconsistencies, helping staff understand the wider needs of the service user and carer, beyond the condition they are seeking help for
- Working together to reduce the potential tension regarding organisational sovereignty as demonstrated through individual policies, procedures, cultures etc. alongside the need for teams of people to work together with shared processes
- Trust – between groups of staff, and also service users' confidence in staff as advocates. Addressing the impact that existing cultures across organisations and teams have on the ability to make this shift will be an important factor to consider
- Governance mechanisms established through Place and a number of connected programmes of work needs greater ownership, visibility and system backing, if we are to affect the longer term necessary shift to improved population health and slow growth in demand. Our current governance structures don't always effectively support 'distributed responsibility' and working across teams
- The form and pace at which new financial models and mechanisms for collaborative commissioning can be developed and which may need differential allocation. Ensuring commissioning processes are aligned and reward the right things
- Further developments in workforce planning to better meet the needs of the population who are ageing or at the end of their lives
- The ability to access and update a single record to support the care of an individual, and to prevent individuals and their carers having to repeat information to many agencies and staff having to waste time updating multiple systems
- An embedded model for using Population Health Management data to plan and target provision
- The VCSE sector is vital in understanding and meeting the needs of this population
- Co-location of teams that are working together / serving the same cohort
- Ongoing and increasing commitment to ensuring subsidiarity and local determination of delivery

**Suggested measures for improvement**

It is proposed that 'measurement activities' for this priority are organised under 7 sentinel outcome measures – please see figure below.

There is also a National Integration Index planned to be rolled out in 2023 that will help us understand the level of integration and the impact / benefits experienced by citizens.




# 6. Engagement

## 6.1 JUCD approach to engagement

Gathering insight from our diverse population about their experiences of care, their views and suggestions for improvement of services, and their wider needs in order to ensure equality of access, and quality of life is a key component of an effective and high performing Integrated Care System (ICS). These insights, and the diverse thinking of people and communities will be essential to enabling JUCD to tackle health inequalities and the other challenges faced by our health and care system.

As a result, JUCD has developed a strategic approach to engagement, which includes key principles and frameworks that will underpin our ways of working. It sets out how we will listen consistently to, and collectively act on, the experience and aspirations of local people and communities within JUCD. This includes supporting people to sustain and improve their health and wellbeing, as well as involving people and communities in developing plans and priorities, and continually improving services.

Our Ambition is:

- To embed our work with people and communities at the heart of planning, priority setting and decision-making to drive system transformation work, ensuring the voices of patients, service users, communities and staff are sought out, listened to, and utilised resulting in better health and care outcomes for our population
- To recognise that relationship building is important to increase trust and improve involvement and needs to be considered on a planned, systematic, and continuous basis, with the required investment of time
- To ensure continuous engagement that reflects this new relationship with the public, capitalises on those emotional connections and brings people and communities into the discussion rather than talks to them about the decision

In order to ensure a systematic approach, our engagement with people and communities is supported by several frameworks. These frameworks are in different stages of development and co-production with system partners, including people and communities, and are outlined below:

**Governance Framework** -
This examines the structures that provide the interface between people and communities at all levels of the ICS, allowing insight to feed into the system, to influence decision making. This is also about making sure appropriate assurance frameworks are in place for ensuring we implement the principles outlined in our Engagement Strategy across the system. It includes our Patient and Public Partner Programme, our Guide to Patient and Public Involvement in the ICS, and the development of our Public Partnership Committee.


**Engagement Framework** – This includes the methods and tools available to all our system partners to support 'continuous conversations' with people and communities in transformational work to improve health and care services. This includes our Citizens' Panel, Online Engagement Platform, PPG network, Readers Panel, Public and Patient Insight Library and Derbyshire Dialogue. The model we use for our Patient and Public Insight Library, has been promoted by NHS England as good practice, and a template has been created to allow other systems to duplicate it.

**Co-production Framework** - This is our work to embed, support and champion co-production in the culture, behaviour, and relationships of the ICS, including senior leadership level. Drawing together good practice from around the system we plan to co-produce a co-production framework and are in the process of setting up a task group, which will include patient and public partners.

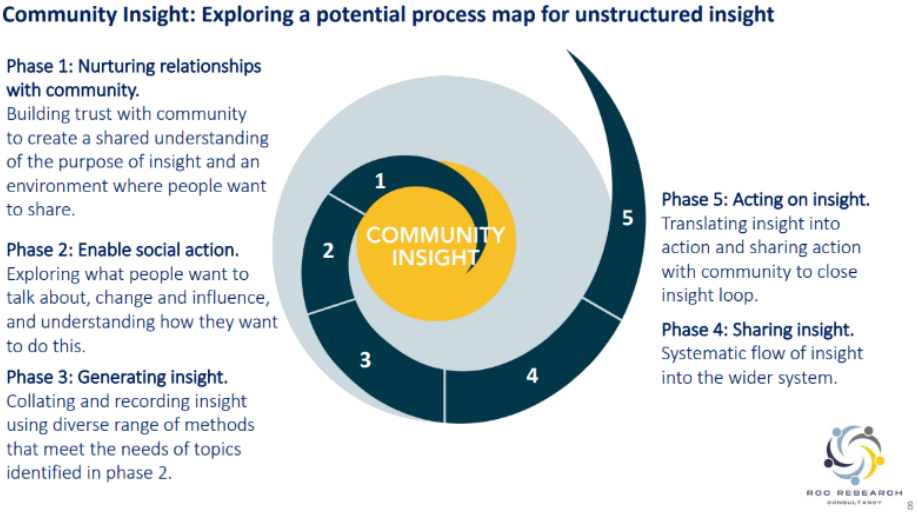
**Evaluation Framework** – This is being created to allow us to reflect on and examine our public involvement practice and the impact this has both on our work, but on our people and communities. The Evaluation Framework will outline how we will measure and appraise our range of methods, and how this will support ongoing continuous improvement.

**Insight Framework** - The Insight Framework is the most exciting development so far and looks at how we identify and make better use of insight that is already available in local communities to inform the work of the ICS.

Many communities already have established mechanisms of finding out what's important to people, with regards to their wants, needs and aspirations. We will be seeking to harness and examine that insight and present it in a way that will enable the ICS to listen to and take action, to truly put the voice of people and communities at the heart of decision making.

This approach is about authentic collaboration with communities without a pre-set agenda and will require that we are brave and believe that people know what they need to be well and happy. It will also require us to align our governance structures to support community led action.


A key part of the Insight Framework is our process map outline which outlines 5 phases, please **see figure below**. We plan to co-produce what good looks like in all 5 phases of our model, and then build on strengths-based approaches that are already out there in communities to support them to overcome the barriers that we know they currently encounter. This work will be centred around Place and support the ambition to be a social model that is outcome driven and strength based; focussing on the assets of individuals and communities and developed with them through local leadership.




### 6.2 Approach undertaken to support the development of the Integrated Care Strategy

An ‘Engagement Workstream for the ICS Strategy’ was created in July last year with representation from health, local authorities, Healthwatch and the VCSE Alliance. This workstream has overseen the development of an 'Insights Document' that has pulled together insight that has been gathered throughout the system over the past 12 months into one place and which highlights high-level themes under the following headings - Integration, Health Inequalities, Quality/Improvement, Strengths Based/ Personalised Care and Health Protection, and Understanding Public Behaviours, Choices, and Attitudes. This was made possible due to the existence of our Patient and Public Insight Library.

This Insight Document has been considered by SROs and teams as part of the evidence base for the selection of key areas of focus for this Strategy under the headings - Start Well, Stay Well and Age Well.

Subject to the agreement of this Draft Strategy the next steps are summarised as follows:

- Present and discuss the Draft Strategy and communicate the selection of the three key areas of focus with the wider public via the Derbyshire Dialogue Forum (15 February 2023), and with local organisations and forums through a series of presentations February – March.
- Co-produce I/ we statements to help communicate the ambitions of the Strategy and the key areas of focus.
- For the three key areas of focus – Hold an initial Derbyshire Dialogue on 15 February to outline the purpose and content of the strategy, and then initiate a process of continuous engagement including the following steps:

    - Hold online engagement events for each of the 3 areas allowing leads to present information in an accessible way and invite comments about what actions are needed to achieve the ambitions set out and capture these to inform plans.
    - Support these conversations through our Online Engagement Platform, with opportunities to continue to ask questions and make suggestions.
    - Create surveys for each area to gather feedback from a wider cohort of people targeted as required.
    - Facilitate and support conversations between programme leads and local community groups who express interest in the key areas of focus, helping to ensure we do not just rely solely on people having digital access, using existing groups and forums where possible, with support from the VCSE sector.
    - Ensure feedback/ insight from these conversations is listened to, considered, and actioned through the implementation plans for the three key areas of focus.

## 7. Evaluation

### 7.1 Introduction

Once the ICP has approved and published the Integrated Care Strategy a process for overseeing delivery progress will be required. This could include, if appropriate, identifying, and evaluating the impact that the Strategy has had on commissioning and delivery decisions from multiple perspectives, including providers, citizens, communities, and those engaged in the production of the strategy.

### 7.2 Measures

In **Section 3** population health and inequalities indicators are referenced. These measures will need to be considered as part of the evaluation process, alongside other measures specific to the key areas of focus, some of which are referenced in **Sections 4 and 5**.

It is noted that there is national work underway by the CQC and by the King's Fund to develop qualitative and quantitative integration measures, through an "Integration Index". JUCD is a pilot site for this work, and this should support evaluation efforts. We will draw on outputs from this work as they emerge and use these to engage local stakeholders.

### 7.3 Evaluation and impact

It is proposed that evaluation can be considered at two levels:

Evaluation of the Strategy: including a high level consideration of progress against the strategic aims, and an assessment of how successfully other intentions included in the Strategy have progressed, including ambitions for organisational development at a system level and a focus on behaviours and culture to ensure that the Strategy is built on sustainable cultural foundations.

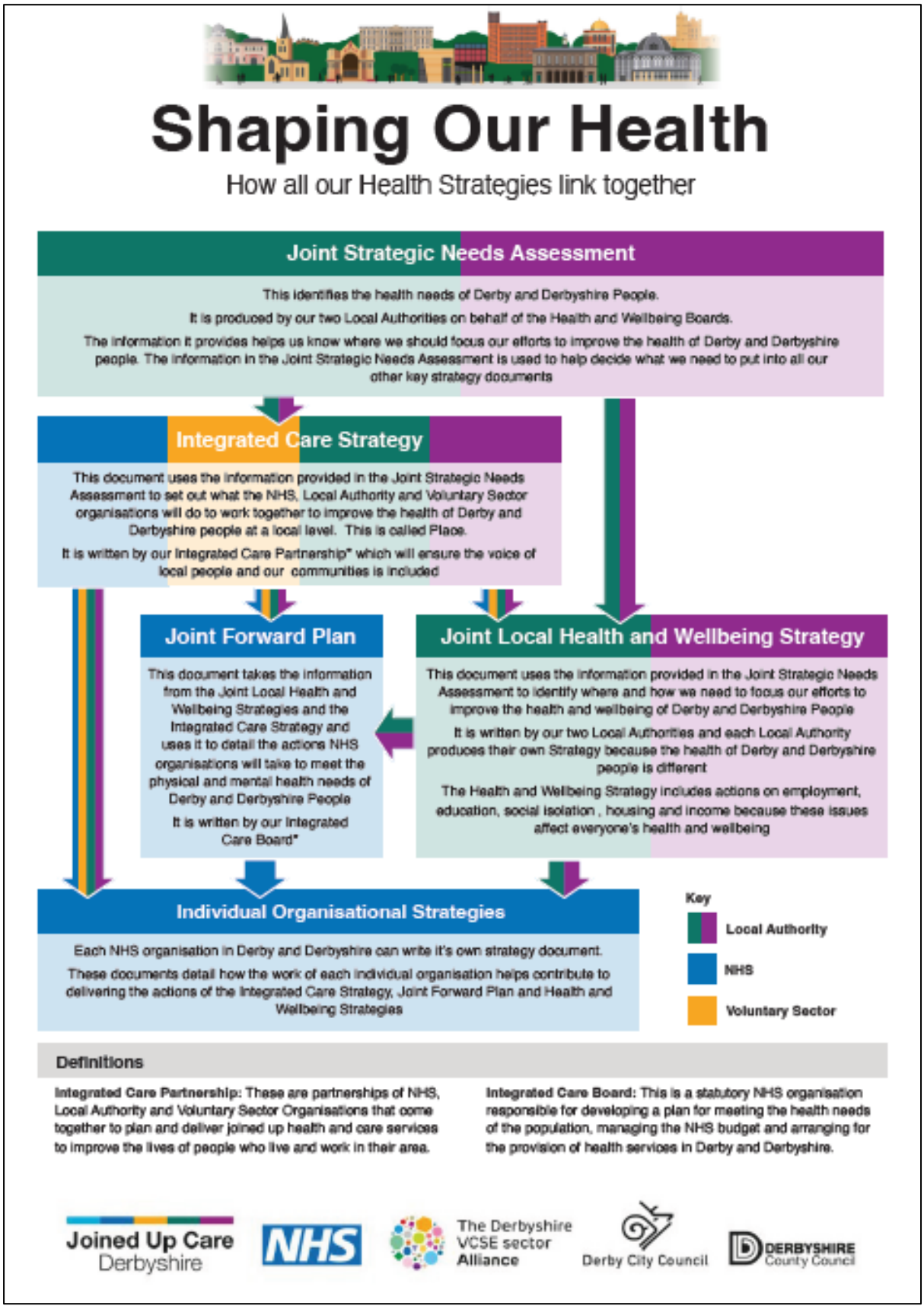
Evaluation of the key areas of focus and key enabling functions: SRO led work on evaluation methodology and measures, to track implementation against objectives.

### 7.4 Evaluation support

The ICP/ IPE will need to consider whether external input into evaluation would provide additional benefits to those gained via local evaluation routes for evaluation of the Strategy. Options are being explored through fact-finding contacts with The King's Fund, the Social Care Institute for Excellence, and the "Leading Integration Peer Support Programme" run jointly by the NHS Confederation, the Local Government Association and NHS Providers.

The SROs for the three key areas of focus will need to assess existing and potential options for external support. This should include the involvement of Healthwatch and align with the engagement approach and particularly the work on citizen Insights.

## Appendix 1 – How our health strategies and the Joint Forward Plan link together



**Derbyshire Healthcare NHS Foundation Trust**
Report to the Board of Directors – 7 March 2023

# Integrated Performance Report

## Purpose of Report

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

## Executive Summary

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

## Operational Performance

This chapter has been developed to provide a greater level of assurance to the Board on actions being taken to address areas of underperformance. The chapter now also includes performance against the relevant NHS national long term plan priority areas.
Most challenged areas:

- Waiting times for adult Autistic Spectrum Disorder assessment
- Child and Adolescent Mental Health Services.
- Paediatric outpatients
- Improving Access to Psychological Therapies (IAPT) 6-week referral to treatment.

Most improvements:

- Waits reducing month on month for the last 10 months.
- Target achieved for Community mental health access 2 plus contacts.
- IAPT patients completing treatment who move to recovery.

Key next steps:

1. Evolving the Performance report to incorporate the following metrics to help improve wait times, patient flow, timely discharge and patient outcomes:

    - **Re-admitters acute bed occupancy** – fill by inpatients who have already had one or more admission in last 6 months. DHCFT has c40 beds filled

by these re-admitters at any one time and this occupancy can be compared by weighted population with peers
- **Crisis presentation rates – on and off caseload**. DHCFT has >300 on-caseload crisis presentations monthly and c150 off-caseload beds. Again, can be compared by weighted pop with peers
- **CMHT case length on discharge (average)** – this is going up and up, well beyond 500 days and is much higher than peers

2. All metrics will be framed within a regional and national context going forward to ensure we are working as an organisation to aspire to achieve the best outcomes for our patients in a data driven way ensuring we are continually striving to improve our wait times, service provision and patient experience.

3. The Health Inequality Programme Board is currently being established so we will be regularly reporting on key actions and metrics associated with reducing health inequalities for our patients.

4. The Productivity Programme board is currently being established with a view to establish a Trust wide programme dedicated to improving how productive we are as an organisation the metrics for which will be reported on a regular basis to ensure we are continually striving to achieve the best productivity both efficiently and beneficially for our patients.

**Finance**

At the end of January, the overall year to date (YTD) position is a surplus of £1.6m compared to the plan deficit of £1.3m, a favourable variance to plan of £2.9m. The forecast is now a surplus of £2.8m against the plan of breakeven. Therefore along with the reduction in the identified financial risks within the Board Assurance Framework (BAF) the ***risk has been reduced from Extreme to Moderate.***

<u>Efficiencies</u>
The full year plan includes an efficiency requirement of £6.0m phased equally across the financial year***. All plans are on track to deliver in full by the end of the financial year.***

Whilst the full requirement for efficiencies has been identified the majority of the schemes are non-recurrent (68%) which is adversely impacting on 2023/24 financial plans.

<u>Agency</u>
Agency expenditure YTD totals £5.9m against a plan of £2.0m, an adverse variance to plan of £3.9m. The two highest areas of agency usage continue to be driven by Consultants mainly in CAMHS and Nursing staff.

- Key next steps: ***Proactive recruitment and review of skill mix, creating new roles and development opportunities to bring a different skill set to facilitate multidisciplinary team working and address the nursing shortage by 30 June 2023.***

Covid costs
The financial plan assumes no expenditure for Covid after the end of May as per the planning guidance for 2022/23. There has been a significant reduction in covid related expenditure since August and January levels remains low.

Out of Area Placements
Expenditure for adult acute out of area placements totals £2.4m to date. The forecast assumes ten placements a month for the remainder of the financial year.

- Key next steps: ***A review is underway of out of area patients using insightful business intelligence, as we have seen a significant rise in recent weeks to allow for a root cause analysis to further understand the cause and help form a targeted action plan.***

Capital Expenditure
Following the resubmission of the capital plan in June expenditure is slightly below plan at the end of January. In October NHSE/I requested that the forecast expenditure across the system was reduced to remove the 5% planning assumption that had been built into the plan therefore the forecast reflects this underspend of £0.3m.

Better Payment Practice Code (BPPC)
In January the target of 95% was achieved by value but the volume was slightly below the target at 94.3%.

Cash and Liquidity
Cash remains high at £50m at the end of January however this is expected to reduce in line with capital expenditure to £32m by the end of the financial year. The changes in the liquidity ratio in 2022/23 has been driven by the timing of cash receipts related to the centrally funded Making Room for Dignity capital scheme.

2023/24 financial plan
Currently financial plans for 2023/24 both for revenue and capital expenditure are being developed as a system in readiness for a draft submission on 23 February 2023 and final submission at the end of March 2023.

Due to the timing of submission it is requested that the Finance and Performance Committee have delegated authority to sign off the final plan on behalf of the Trust Board.

**CQUIN**

**CCG1 - Flu vaccinations for frontline healthcare workers**

The vaccination uptake for health care workers was at 52% by end of December 2022 this has increased to 59% in January. However, It is anticipated that the set target of 90% will not be reached by the end of the flu campaign 2022/23.

Key next steps*:* ***To increase uptake of flu vaccinations, the Health Protection Unit (HPU) have engaged with providers to disseminate the benefits of flu***

***vaccination to their team. Additional targeted communications are being used to increase uptake.***

**CCG9: Cirrhosis and fibrosis tests for alcohol dependent patients**

The set targets are being met in this CQUIN. There have been various initiatives implemented in the Q1 and Q2 which saw improvement in testing. The working group continues to monitor the initiatives and share learning.

**CCG10a: Routine outcome monitoring in Children and Young People (CYP) and perinatal mental health services**

The set targets for this CQUIN have not been met in Q1, Q2 or Q3. It is however unlikely that the target of 40% compliance will be reached by the end of the 2022/23 campaign

- **Key next steps**: There has been increased trained offer to Routine Outcome Monitoring (ROM), on Microsoft Teams. Divisional CQUIN lead attended managers meeting, encouraged discussion around their use within staff supervision. YouTube video created for staff re: The Revised Child Anxiety and Depression Scale (RCADS). Within the CYP Division, CQUIN meetings take place once per month along with discussion in operational meetings and team meetings. information is also shared with staff via email..

It should however be noted that when looked at individually, the Perinatal Community teams are achieving the 40% target.

**CCG10b: Routine outcome monitoring in community mental health services**

To date the paired outcome target for Community is being achieved, currently 48%. Is likely that the CMHT's will continue to surpass their target of 40% at the end of the 2022/23 campaign.

**CCG11: Use of anxiety disorder specific measures in IAPT**

There has been improvement in the CQUIN between Q1, Q2 and Q3. Changes have been made to coding by the Information Management and Technology (IM&T) team so that scores on the Health Anxiety short form measures (ADSM) now flow into the IAPT data set. If improvements continue the service may meet their compliance target of 65% by the end of the 2022/23 campaign.

- Key next steps: ***Work is ongoing to understand discrepancies between reported figures on NHS Futures and standard reports within IAPTuS. Data flows are now consistently appearing on NHS Futures, however data is 2 quarters behind.***

    - ***Clinician level data on ADSM completion rates are being used in management supervision monthly.***
    - ***ADSM compliance is monitored at the monthly management team meeting as a standing agenda item and at IAPT Board.***

- ***ADSMs are also discussed at patch meetings with clinicians in their geographical areas***

**CCG12: Biopsychosocial assessments by MH liaison services**

The liaison service has achieved the CQUIN target of 80% in Q2 as the data for December is not yet available, it is likely that the current figure will change, and the service will meet their 80% target for Q3. Of those service users who did not receive an assessment, the main reasons were the patient absconding for refusing an assessment after being referred (60%).

**PSS8: Outcome measurement in perinatal inpatient services**

From November 2022, outcome measures are being embedded into routine practice to ensure consistent monitoring of outcomes for patients and a monthly audit is in place to monitor progress against the CQUIN. The team have made changes to ensure the PROM is completed prior to leave if completing on discharge might become a challenge. This appears to have had a positive impact as the team have achieved their PROM target in Q3. they are also meeting the lower threshold for the CROM target and are confident they will meet this and achieve both targets by the end of the 2022/23 campaign.

**CQUIN 2023/24 - Update**

The CQUINs for 2023/24 will be reported to the Trust Quality and Safeguarding Committee and submitted to TOOL for assurance quarterly outlining how the trust is performing against the specific Threshold measures. An action plan will also be submitted identifying any barriers or areas that require improvement with a goal-based plan identifying both what being done and what is required to achieve the upper threshold. There will be a monthly meeting for CQUIN leads to report on their progress and request support or escalation.

**People**

<u>Annual appraisals</u>
Appraisal levels continue to be below our expectations.

- Key next steps: ***We are working closely with Divisions to ensure ESR records are fully up to date and reflective of actual compliance. Divisional People Leads are working proactively with their team to combat areas of low compliance.***

<u>Annual turnover</u>
Turnover remains high.

- Key next steps: ***The new exit interview process is now fully implemented. A triangulation of key people metric data and intelligence from key leads is now in place to ensure teams needing support takes place promptly to minimise staff leaving the teams.***

Compulsory training
Overall, the 85% target level has been achieved for the last 10 months.

Staff absence
January 2023 sickness was 6.2% which is the lowest we have recorded for over a year. The main reason for absence continues to be stress and anxiety and 2023 will see further investment in resources to support colleagues who are struggling at work and home.

Proportion of posts filled
Staffing levels continue to improve with January seeing another increase. A targeted recruitment campaign and face to face event took place for trainee healthcare support workers and Occupational Therapists (OTs). Work continues on implementing learning from the cultural intelligence recruitment programme.

Bank staff
January saw a small increase in agency spend, mainly due to the industrial action and an increase in the acuity of patients on a number of wards. Overall bank fill rates remained high.

- Key Next steps: ***Agency spend is high across the system and a system plan is being developed to aid reduction***.

Supervision
The overall level of compliance with the clinical and management supervision targets has remained low since the start of the pandemic. Improvements can be seen at a team level, with 103 teams now 100% compliant with management supervision and 70 teams now 100% compliant with management supervision.

**Quality**

Compliments
The number of Trust compliments dropped by 30 between December. A project to implement an automated electronic patient survey will provide a further method of receiving compliments and concerns. It is expected that an increase in compliments, and concerns will occur over the next 6 months.

Complaints
The number of formal complaints received has increased between November 2022 and January 2023 from 10 to 15 per month. This is above the Trust target of 12 per month. The complaints team are monitoring this, but no specific theme has been identified.

Delayed transfers of care (DTOC)
The number of DTOC has decreased by 2.5% to 0% between November 2022 and January 2023. DCHFT numbers are consistently low when compared with the national picture and continue to record results below the Trust threshold of 3.5%. From November 2022 the Trust Flow Team have introduced a weekly,

multi-agency discharge planning meeting that reviews and identifies any potential barriers for discharge and from this develops an action plan to prevent delay in discharges. The current indication is that these interventions are having a positive impact.

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.

- Key Next Steps: ***The Assistant Director of Clinical Professional Practice attended the Divisional operation meeting in February 2023 and the Head of Nursing is supporting services to develop team-based care plan compliance plans including identifying and protecting staff time for administration. This will be monitored through the divisional monthly Clinical Operational Assurance Team (COAT) and the monthly operational meeting. The older adult team has also identified an action plan to improve care plan compliance.***

Patients in employment and in settled accommodation

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

- Key Next steps: ***Business intelligence is being used to identify Data Quality Maturity Index information recorded on referral which from February 23 will be reviewed regularly by Ward and Service Managers in order to develop targeted actions and plans. This will be monitored via monthly service specific operational meetings with a view to improve on this.***

Medication incidents

Work continues to be underway to reduce numbers of medication incidents. Common variation continues to be within expected thresholds.

- Key next steps: ***The number of medication incidents is reviewed via the monthly medication management subgroup and is reported on within the quarterly thematic "Feedback Intelligence Group" (FIG) report by the Heads of Nursing and is included in the Serious Incidents bi-monthly report. Any actions identified are reviewed via the medicines management subgroup and the Serious Incidents bi-monthly report is taken to the Quality and Safeguarding Committee for assurance.***

Incidents of moderate to catastrophic actual harm

This data demonstrates the number of DATIX incidents occurring of moderate at catastrophic harm. There was an increase in incidents in November but from December these are on a downward trajectory.

- Key next steps: **The patient safety team and Head of Nursing team are reviewing this data to understand the variation.**

Duty of Candour
Duty of Candour reported incidents have been on a downward trajectory since April which coincides with the Patient Safety Team undertaking training with Service Managers and Heads of Nursing to support them in understanding and interpreting new national guidance.

Prone restraint
Prone restraint has increased since November 2022.

- Key next steps**: *A review of the data is underway as the Head of Nursing for Acute and Assessment services is completing an in-depth qualitative audit and thematic review of seclusion and restraint. This is due to be completed by the end of March 2023.***

Physical restraint
Physical restraints have increased between November2022 and January 2023.

- *Key next steps**: This is being reviewed and monitored within the Reducing Restrictive Practice Group and the Trust Positive and Safe Support Team are placing extra training sessions to improve training availability for staff.***

Seclusion
Seclusions have increased between November 2022 and January 2023 from 14 to 17.

- Key next steps: ***Where there have been increased incidents of seclusion, reviews have been completed and This is monitored through the monthly PSST DATIX meeting and the Reducing Restrictive Practice group. The increase in Seclusion is in line with the increase in physical and prone restraint over the same period***.

Falls on inpatient wards
Between November and December 2022 falls fell from 38 to 28 but they have increased to 37 in January 2023.

- Key next steps: ***A review of falls was undertaken, identifying the patients affected allowing for a bespoke personal patient by patient review and intervention to be implemented which fed into the bi-weekly falls review meeting, chaired by the Matron for Older Adult Services which continued to identify any specific needs for those patients falling regularly. The impact and actions from this meeting are reported to the Divisional Clinical Reference Group for assurance. 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. In the latest published national data when benchmarked against other mental health trusts, our staffing levels continue to be 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) Delegate authority to the Finance and Performance Committee to sign off the operational financial plan for the final submission at the end of March.
2) Confirm the level of assurance obtained on current performance across the areas presented. The proposed level is limited assurance.
3) 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.
4) Determine whether further assurance is required.

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

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

**Sabia Hussain**
**Deputy Managing Director**

**Rachel Leyland**
**Director of Finance**

**Rebecca Oakley**
**Acting Deputy Director, People & Inclusion**

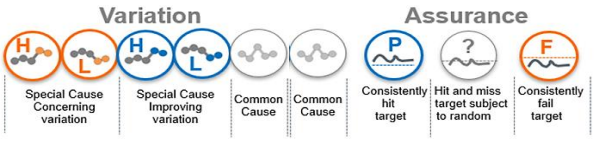
**Joseph Thompson**
**Assistant Director of Clinical Professional Practice**

## Assurance Summary

### A. Operations

| | Metric Name | Performance | Assurance | Latest Value | Target | Lower process limit | Upper process limit | Mean |
|---|---|---|---|---|---|---|---|---|
| 1a | Waiting list - care coordination - average wait to be seen | | | 45 | | 18 | 33 | 26 |
| 1b | Waiting list - care coordination - number waiting at month end | | | 113 | | 43 | 80 | 62 |
| 2a | Waiting list - ASD assessment - average wait to be seen | | | 75 | | 65 | 70 | 68 |
| 2b | Waiting list - ASD assessment - number waiting at month end | | | 2,038 | | 1495 | 1716 | 1606 |
| 2c | ASD assessments | | | 22 | 26 | 4 | 31 | 17 |
| 3a | Waiting list - psychology - average wait to be seen | | | 47 | | 38 | 51 | 44 |
| 3b | Waiting list - psychology - number waiting at month end | | | 460 | | 641 | 814 | 727 |
| 4a | Waiting list - CAMHS - average wait to be seen | | | 32 | | 14 | 23 | 18 |
| 4b | Waiting list - CAMHS - number waiting at month end | | | 575 | | 381 | 545 | 463 |
| 5a | Waiting list - community paediatrics - average wait to be seen | | | 29 | | 15 | 20 | 17 |
| 5b | Waiting list - community paediatrics - number waiting at month end | | | 1,877 | | 1023 | 1353 | 1188 |
| 6 | Outpatient appointments cancelled by the Trust | | | 5% | 5% | 4% | 11% | 8% |
| 7 | Outpatient appointment "did not attends" | | | 11% | 15% | 9% | 14% | 12% |
| B1 | 3 day follow-up | | | 86% | 80% | 78% | 98% | 88% |
| D1 | Community Mental Health Access (2 plus contacts) | | | 8,780 | 10,044.0 | 8710 | 8992 | 8851 |
| E1 | Children & Young People Mental Health Access (1 plus contact) | | | 2,960 | | 2821 | 2998 | 2910 |
| E4 | Children & Young People Eating Disorder Waiting Time - Routine | | | | 95% | | | 82% |
| E5 | Children & Young People Eating Disorder Waiting Time - Urgent | | | | 95% | | | 63% |
| G3 | Early intervention 14 day referral to treatment - complete | | | 80% | 60% | 64% | 107% | 86% |
| G3 | Early intervention 14 day referral to treatment - incomplete | | | 100% | 60% | 55% | 116% | 86% |
| H0 | IAPT 6 week referral to treatment | | | 55% | 75% | 76% | 90% | 83% |
| H1 | IAPT 18 week referral to treatment | | | 100% | 95% | 100% | 100% | 100% |
| H2 | IAPT 1st to 2nd Treatment over 90 Days | | | 22% | 10% | 2% | 10% | 6% |
| H7 | IAPT patients completing treatment who move to recovery | | | 50% | 50% | 45% | 61% | 53% |
| I1 | Individual Placement and Support Access | | | 260 | 343.0 | 107 | 323 | 215 |
| K2 | Total inappropriate out of area bed days | | | 1,215 | | 1312 | 1950 | 1631 |
| K2 | Average patients out of area per day - adult acute | | | 4 | 0 | -3 | 8 | 3 |
| K2 | Patients placed out of area - adult acute | | | 7 | 0 | -3 | 15 | 6 |
| K2 | Average patients out of area per day - PICU | | | 16 | | 6 | 19 | 13 |
| K2 | Patients placed out of area - PICU | | | 23 | | 12 | 30 | 21 |
| L1 | Perinatal Rolling 12 Months Access | | | 5% | 10% | 3% | 4% | 4% |
| L2 | Perinatal Access Year to Date | | | 360 | 1,070.0 | 126 | 386 | 256 |
| N4 | Data quality maturity index | | | 98% | 95% | 98% | 98% | 98% |

Key to symbols[1]:




Blue dots indicate special cause variation, better than expected.

Orange dots indicate special cause variation, worse than expected.

[1]The rating symbols were designed by NHS Improvement

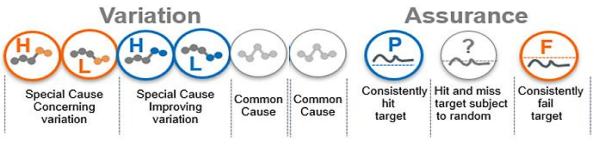
## B. People

| | Metric Name | Variation | Assurance | Latest Value | Target | Lower process limit | Upper process limit | Mean |
|---|---|---|---|---|---|---|---|---|
| 1 | Annual appraisals | H | F | 77% | 85% | 72% | 77% | 75% |
| 2 | Annual turnover | | P | 13% | 8-12% | 12% | 14% | 13% |
| 3 | Compulsory training | H | ? | 88% | 85% | 83% | 87% | 85% |
| 4 | Staff absence | | F | 6% | 5% | 5% | 8% | 7% |
| 5 | Clinical supervision | L | F | 72% | 95% | 69% | 76% | 72% |
| 6 | Management supervision | | F | 75% | 95% | 72% | 77% | 75% |
| 7 | Filled posts | H | F | 96% | 100% | 87% | 93% | 90% |
| 8 | Bank staff use | | ? | 5% | 5% | 5% | 7% | 6% |

## C. Quality

| | Metric Name | Performance | Assurance | Latest Value | Target | Lower process limit | Upper process limit | Mean |
|---|---|---|---|---|---|---|---|---|
| 1 | Compliments received | | ? | 98 | 119 | 63 | 136 | 100 |
| 2 | Formal complaints received | | P | 16 | 13 | 5 | 30 | 18 |
| 3 | Delayed transfers of care | | P | 0% | 3.5% | -0.5% | 2.2% | 0.9% |
| 4 | CPA reviews | L | F | 61% | 95% | 80% | 91% | 86% |
| 5 | Patients in employment | | | 12% | | 10% | 15% | 12% |
| 6 | Patients in settled accommodation | L | | 40% | | 46% | 57% | 52% |
| 7 | Number of medication incidents | | | 67 | | 30 | 94 | 62 |
| 8 | No. of incidents of moderate to catastrophic actual harm | | P | 53 | 48 | 14 | 78 | 46 |
| 9 | No. of incidents requiring Duty of Candour | | ? | 2 | 1 | -5 | 12 | 4 |
| 10 | No. of incidents involving prone restraint | H | ? | 21 | 12 | 0 | 18 | 9 |
| 11 | No. of incidents involving physical restraint | | ? | 87 | 46 | 17 | 88 | 53 |
| 12 | No. of new episodes of patients held in seclusion | | ? | 18 | 14 | 1 | 31 | 16 |
| 13 | No. of falls on inpatient wards | | ? | 35 | 30 | 19 | 48 | 33 |

Key to symbols[1]:

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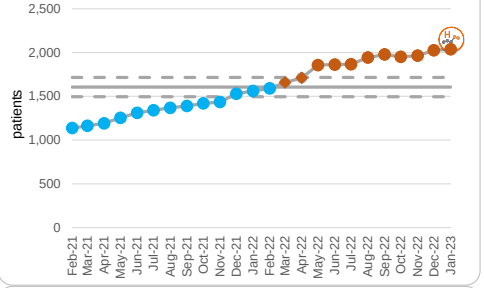
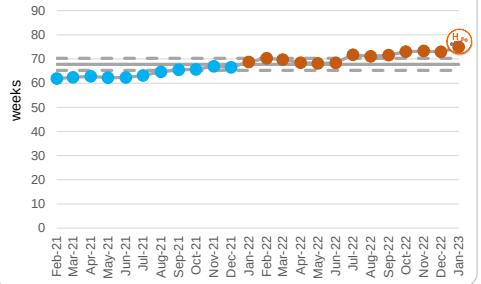
# Operational Performance Summary

## Most Challenged Areas

### Waiting list - adult ASD assessment - number waiting at month end




### Waiting list - adult ASD assessment - average wait to be seen



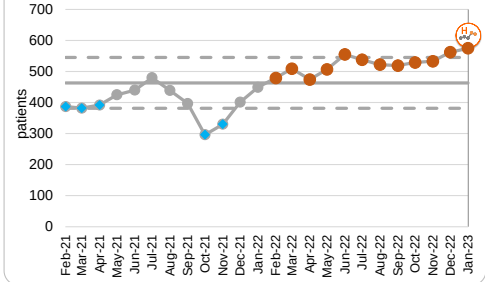

**Summary**

Demand for the service continues to outstrip capacity (commissioned to undertake 26 per month but currently receiving referrals 76 per month this financial year to date). At the end of January 2023 there were 2,038 adults waiting for adult ASD assessment, which is an increase of 74 since the last report. A revised approach to waiting list management is being mobilised and should start to have an impact from quarter 4.

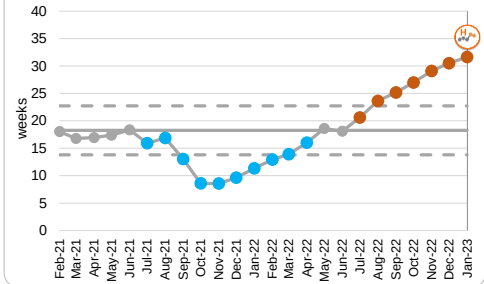
**Actions**

- Increase workforce capable of assessment: 20 newly trained staff (pending ADOS licensing), by Feb 2024.
- Introduce robust flagging system on EPR, accurate reporting data and consistency to operational processes, by Qtr2 2023.
- Review clinical processes to increase screening success and increase the number of ASD assessments completed, in order to meet target for assessments by Qtr1 2023.

### Waiting list - CAMHS - number waiting at month end




### Waiting list - CAMHS - average wait to be seen



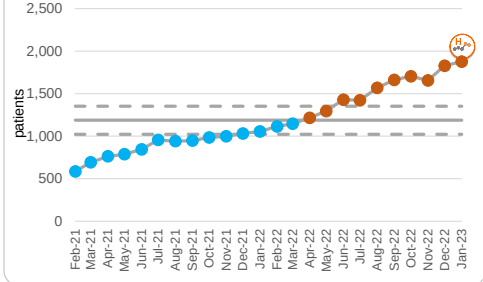

**Summary**

At the end of January 2023, 575 children were waiting to be seen with an average wait time of 32 weeks.

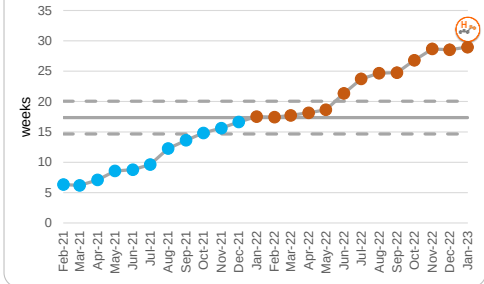
**Actions**

- Prioritise the waiting list and ensure available assessment slots for the priority cases – ongoing.
- Redesign the Assessment Team Model and reduce wait times, start to mobilise mid-January 2023
- Launch a Core CAMHS Team to alleviate saturation across core teams and increase flow and specialist support/ intervention for those that require it: start to mobilise mid-January 2023.

### Waiting list - community paediatrics - number waiting at month end




### Waiting list - community paediatrics - average wait to be seen



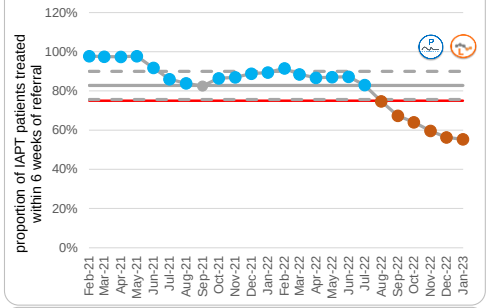

**Summary**

At the end of January 2023 there were 1,877 children waiting to be seen which is an increase of 221 since the last report. The average wait time was 29 weeks.

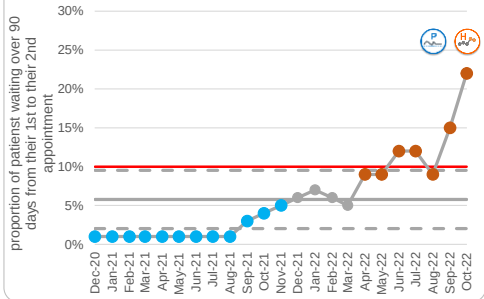
**Actions**

- Increased number of clinical slots enabling more children to be seen and a reduction in waits
- Neurodevelopmental business case has now been approved which will increase clinical time by appointment of Specialty Dr for ASD, also included in funds is a non-medical prescriber/ triage nurse, which will support earlier point on skill mix
- To ensure the wellbeing of people on the waiting list while they are waiting

### IAPT 6 week referral to treatment




### IAPT 1st to 2nd Treatment over 90 Days




**Summary**

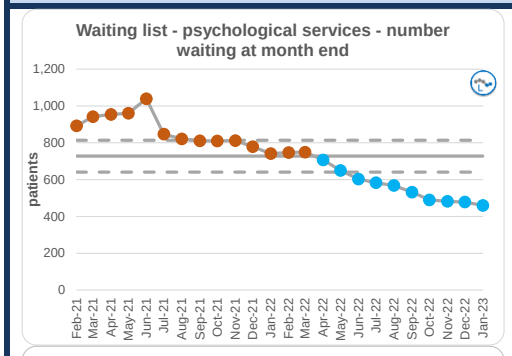
Wait times have been lengthening owing to returns to near pre-pandemic levels of referral, difficulty in recruiting to Psychological Wellbeing Practitioner qualified roles, some long-term sickness and increases in complexity and treatment contacts. Additionally attended appointments for assessments are lower than we would like and improving this should achieve some wait time gains.

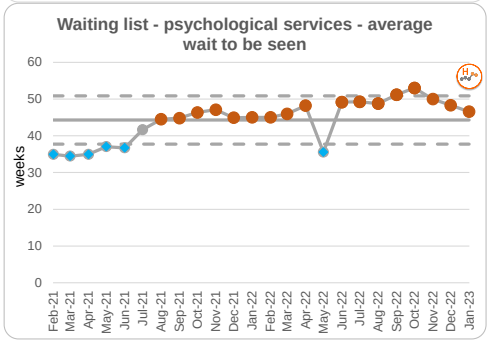
**Actions**

- Recruitment to the qualified PWP posts, complete the training of the 3 new PWP trainees, and revisit the use of agency staff as an interim measure.
- A booking clerk is in post to book short notice appointments into cancelled slots
- NHSE are funding bookable appointments which we will adopt via IAPTuS for assessment slots.

# Operational Performance Summary

## Most Improved Areas



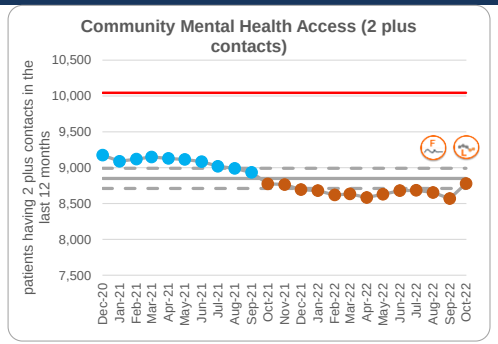




### Summary

At the end of January 2023, 460 people across Derbyshire were waiting to be seen by psychological services with an average wait time of 47 weeks. The number of people waiting has continued to gradually reduce and the reduction is statistically significant. The trend is continuing.

### Actions

- Recruitment drive
- Upskilling of current workforce to deliver moderate intensity psychological interventions (e.g., EMDR delivery; skills groups, trauma stabilisation groups); increase group work offers
- Creation of Division of Psychological Therapies to improve efficiency of delivery.




### Summary

The Trust was set a very challenging target to increase the number of adults and older adults receiving 2 or more contacts in a year from community mental health services to 10,044 by the end of March 2023, which was an increase of 14% on current performance.

A recovery action plan was put in place and analysis of internal data would indicate that the target level of activity is now being achieved:

| ReportingPeriod | Attended |
|---|---|
| Apr-22 | 11,939 |
| May-22 | 12,076 |
| Jun-22 | 12,894 |
| Jul-22 | 12,349 |
| Aug-22 | 12,114 |
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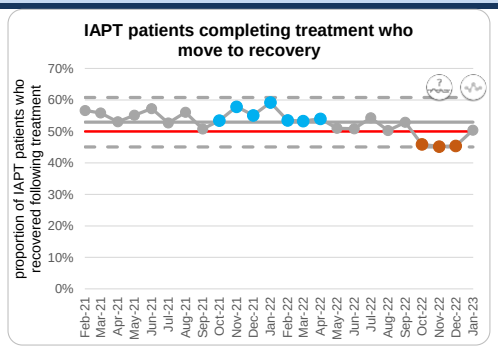
| Nov-22 | 10,975 |
| Dec-22 | 10,284 |
| Jan-23 | 10,364 |

As the national data is a few months in arrears and the target is a rolling twelve months' target, this achievement will take some time to be reflected in the national data.



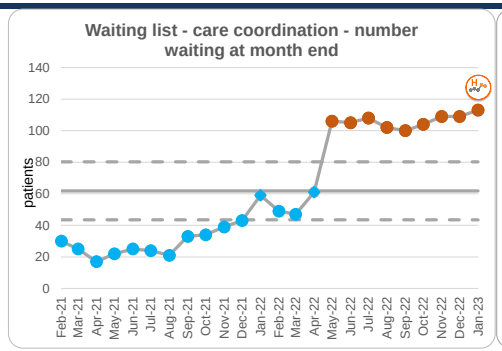

### Summary

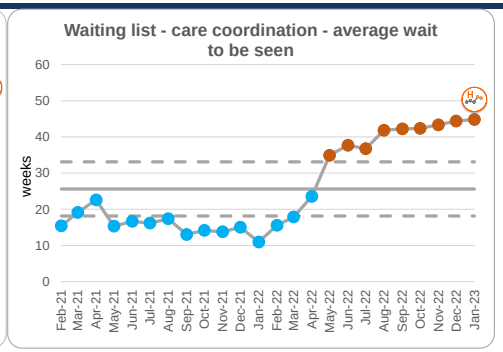
This is an annual target and year to date the target is being exceeded. The drop in performance from October to December 2022 is likely to have been an unintended consequence of implementing waiting list waiting well checks, which included taking measures. This has been amended and the positive effects of this action have now started to be reflected in the data.

Derbyshire Healthcare
NHS Foundation Trust

# Operations

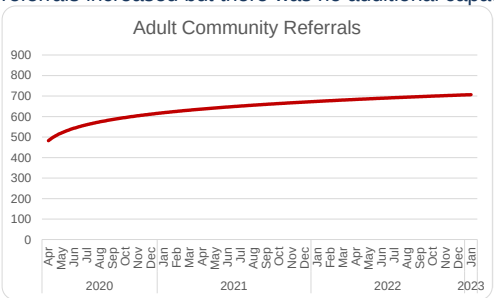
# Operational Performance

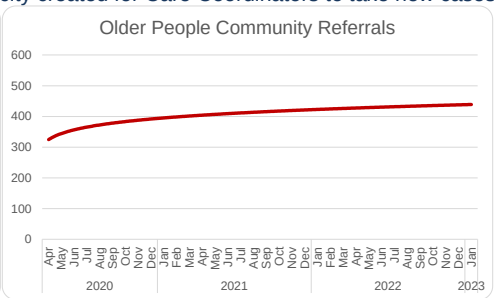



**Summary**

There are a number of key factors impacting on waits. As we came out of the pandemic, the number of referrals increased but there was no additional capacity created for Care Coordinators to take new cases:




Staff are experiencing fatigue (ongoing issue raised during and post pandemic). Some teams are in distress owing to staffing challenges:

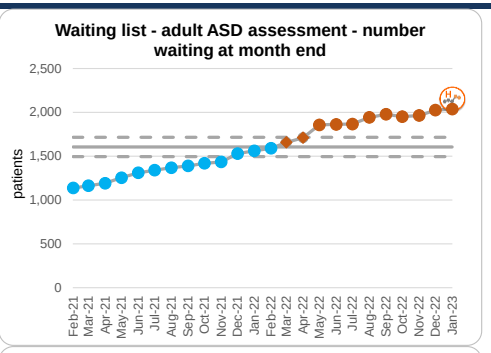
| Adult Community | Turnover | Sickness | Vacancies |
|---|---|---|---|
| Bols + C C Adult CMHT | 15% | 3% | 16% |
| Chesterfield C Adult CMHT | 12% | 5% | 6% |
| High Peak Adult CMHT | 43% | 28% | 19% |
| Killmsh + N C Adult CMHT | 27% | 5% | 22% |
| North Dales Adult CMHT | 0% | 0% | 11% |
| Amber Valley Adult CMHT | 4% | 1% | -9% |
| El Sth + City | 13% | 17% | -9% |
| Erewash Adult CMHT | 5% | 10% | 10% |
| South + Dales Adult CMHT | 21% | 0% | 5% |
| Derby City B Adult CMHT | 7% | 2% | 13% |
| Derby City C Adult CMHT | 0% | 12% | 3% |

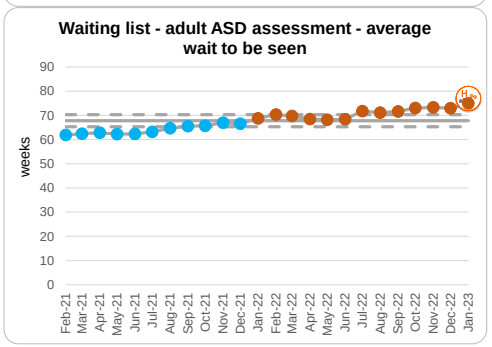
| Older People Community | Turnover | Sickness | Vacancies |
|---|---|---|---|
| Amber Valley OA CMHT | 17% | 6% | 14% |
| Bols + CC OA CMHT | 0% | 6% | 7% |
| Chesterfield C OA CMHT | 8% | 1% | 1% |
| Derby City OA CMHT | 4% | 3% | 15% |
| Erewash OA CMHT | 10% | 0% | 11% |
| H P + NDales OA CMHT | 0% | 19% | -7% |
| Killmsh + N C OA CMHT | 23% | 10% | 16% |
| OA Day Services | 23% | 8% | 19% |
| South + Dales OA CMHT | 20% | 9% | 3% |

Migration to SystmOne has also presented an ongoing challenge for staff, with some staff still struggling to use SystmOne, which is impacting on data quality.

**Actions**

- Roll out of Living Well to improve flow of patients and reduce waits, by 31/3/2024
- Review of the CPA policy to Care Principles & CPA to reduce admin time and release more time to care, by 30/6/2023
- Proactive recruitment and review of skill mix, creating new roles and development opportunities to bring a different skill set to facilitate multidisciplinary team working and address the nursing shortage by 30/6/2023



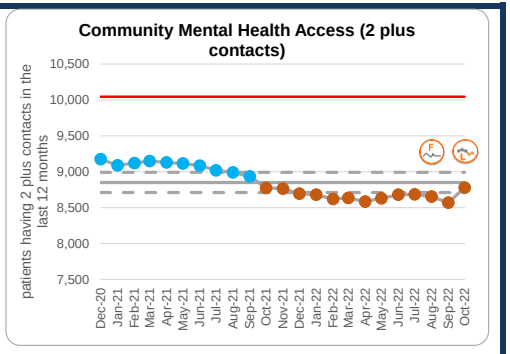




**Summary**

Demand for the service continues to outstrip capacity (commissioned to undertake 26 per month but currently receiving referrals 76 per month this financial year to date). At the end of January 2023 there were 2,038 adults waiting for adult ASD assessment, which is an increase of 74 since the last report. A revised approach to waiting list management is being mobilised and should start to have an impact from quarter 4.

**Actions**

- Increase workforce capable of assessment: 20 newly trained staff (pending ADOS licensing), by Feb 2024.
- Introduce robust flagging system on EPR, accurate reporting data and consistency to operational processes, by Qtr2 2023.
- Clinical efficacies: Review clinical processes to increase screening success and increase the number of ASD assessments completed, in order to meet target for assessments by Qtr1 2023.

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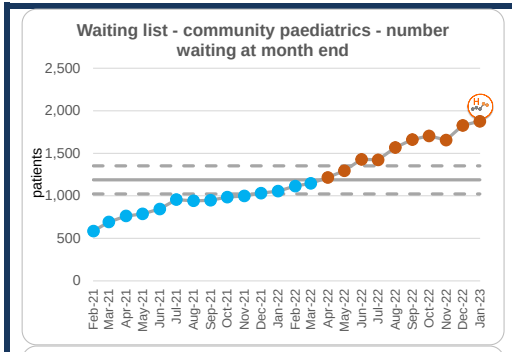
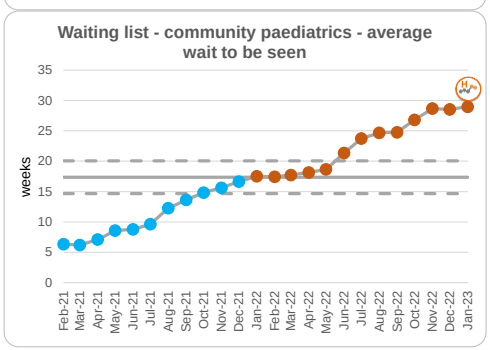


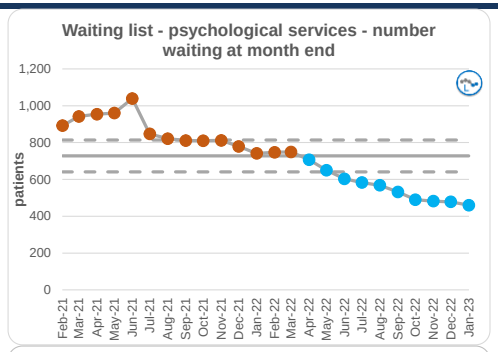



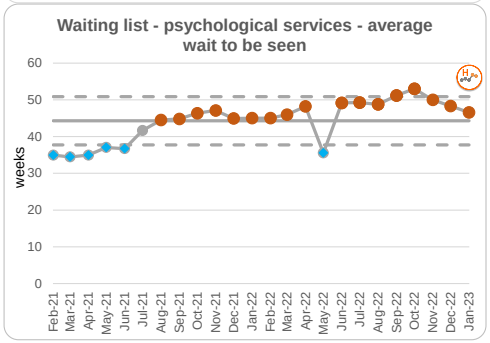

**Summary**

At the end of January 2023 there were 1,877 children waiting to be seen which is an increase of 221 since the last report. The average wait time was 29 weeks.

**Actions**

- Available slots were increased in November 2022 which made a slight impact on the waiting list, however with the loss of the regular Locum in December and ongoing vacancies the waiting list continues to rise. To mitigate we continue to search for appropriate Locum Doctors to cover Swadlincote and City
- Saturday and additional clinics have been proposed and some extra clinics by non-medical prescribers in the Attention Deficit Hyperactive Disorder (ADHD) team have helped manage the follow-up appointments. Suitable accommodation has been problematic
- Recruitment to the neurodevelopmental business case is underway.
- A review of the Single Point of Access and the multidisciplinary meeting (MDM) pathways is also a priority



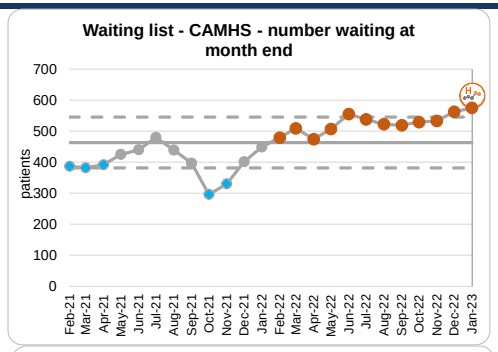



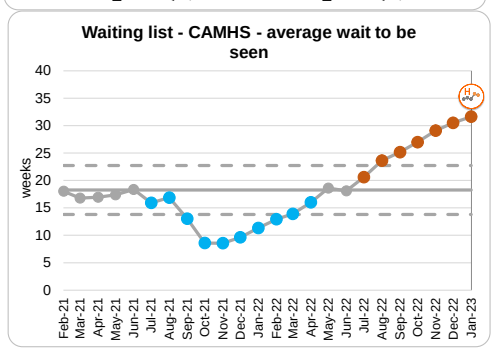

**Summary**

At the end of January 2023, 460 people across Derbyshire were waiting to be seen by psychological services with an average wait time of 47 weeks. The number of people waiting has continued to gradually reduce and the reduction is statistically significant. The trend is continuing.

**Actions**

- Recruitment drive in order to be 85% recruited & reduce the vacancy factor - immediate.
- Upskilling of current workforce to deliver moderate intensity psychological interventions, by 31/3/2024
- Creation of Division of Psychological Therapies to improve efficiency of delivery. Look to pool resources across the county to smooth out peaks and troughs and work with other teams; utilise population health data to understand needs in specific areas; make sure data is accurate, by 31/3/2023

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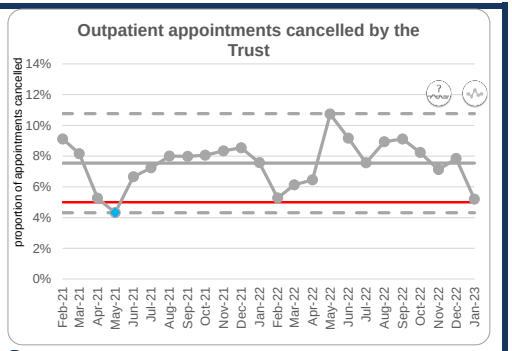
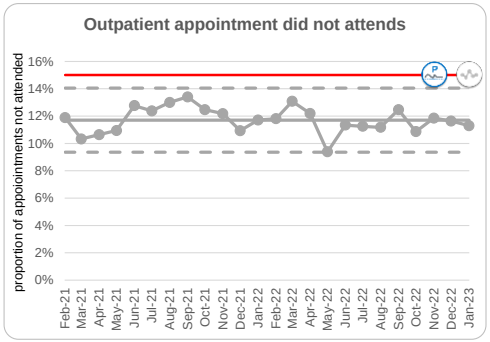



**Summary**

This indicator was introduced as a measure of patient inconvenience some years ago and when cancelling appointments, the administrators should identify whether or not the patient was aware of the appointment in order to enable differentiation between cancellation of virtual and actual appointments. Recording accuracy needs to improve and so further training in the use of SystmOne has been arranged for those concerned.

**Actions**

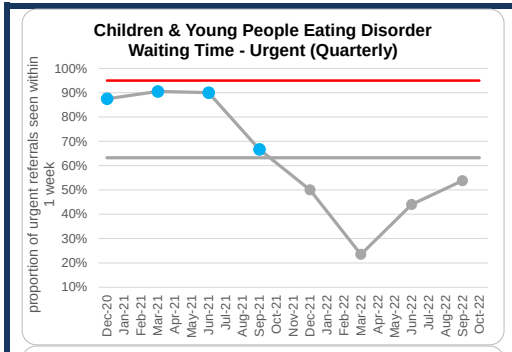
- Refresher training for admin staff
- Discussion in supervision with admin staff
- Professional Heads of Admin to distribute instructions regularly on how to cancel clinics correctly.

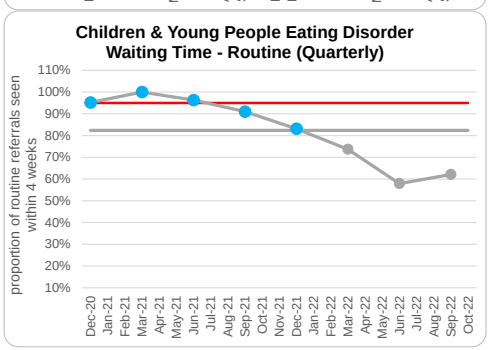



**Summary**

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

# Operational Performance



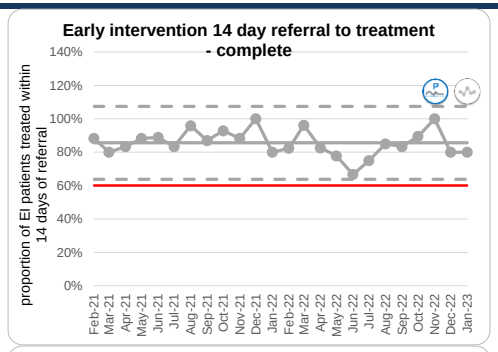



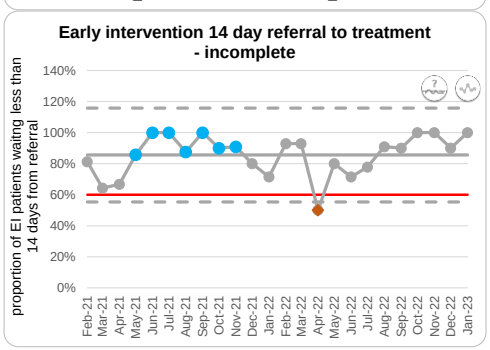

**Summary**

These standards focus on effective treatment at the earliest opportunity in order to improve outcomes, reduce rates of relapse and need for admission. The two waiting time standards are that children and young people (up to the age of 19), referred for assessment or treatment for an eating disorder, should receive NICE-approved treatment with a designated healthcare professional within one week for urgent cases, and four weeks for every other case (target 95%). A recovery action plan is in place which is being led by the Integrated Care System, as this service is delivered by two providers within the system who are experiencing similar issues. The key actions within the plan that are being taken, with an aim to achieving the objective by the end of March 2023, are summarised below.

**Actions**

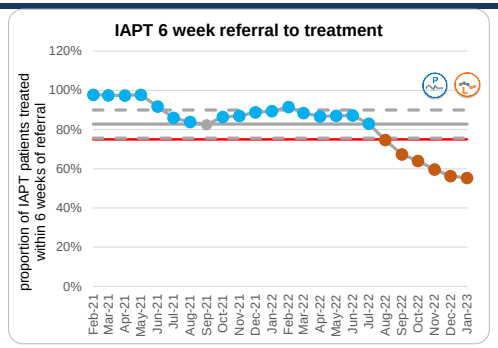
- Development and implementation of recruitment strategy
- Improved accuracy of recording
- Design and delivery of Derbyshire Avoidant Restrictive Food Intake Disorder pathway




**Summary**

Patients with early onset psychosis are continuing to receive very timely access to the treatment they need. Occasionally delays result from difficulties contacting patients to arrange appointments, or patients not attending their planned appointments. The service is generally very responsive and has exceeded the national 14-day referral to treatment standard of 60% or more people on the waiting list to have been waiting no more than 2 weeks to be seen in all but one month over the past 2 years.

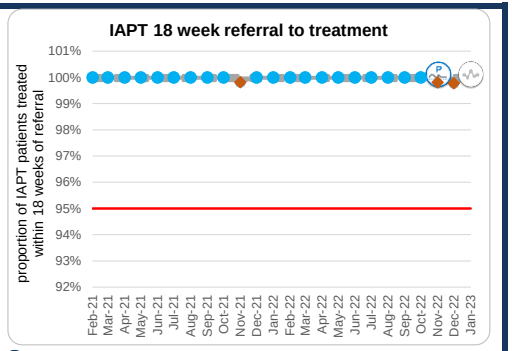



**Summary**

Wait times from referral to assessment/ treatment and 1st to 2nd treatment have been lengthening due to returns to near pre-pandemic levels of referral, difficulty in recruiting to Psychological Wellbeing Practitioner qualified roles, some long-term sickness and increases in complexity and treatment contacts. This has seen a decline in the achievement of the 6-week referral to treatment up to January 2023, although this decline has slowed in the last month. Additionally, attended appointments for assessments are lower than we would like and improving this should achieve some wait time gains. 27% did not attend and gave no notice Jan-Dec 2022, and 20% were cancelled by, or on behalf of, patients at step 2.

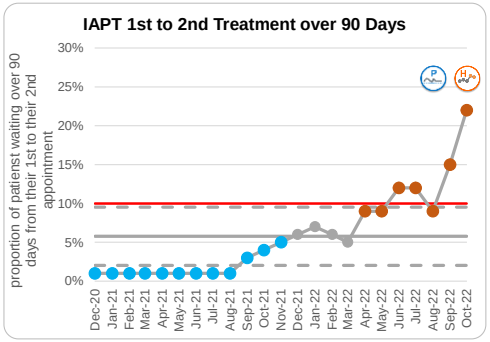
**Actions**

- Recruitment to the qualified PWP posts, complete the training of the 3 new PWP trainees, and revisit the use of agency staff as an interim measure.
- A booking clerk is in post to book short notice appointments into cancelled slots
- NHSE are funding bookable appointments which we will adopt via IAPTuS for assessment slots.




**Summary**

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



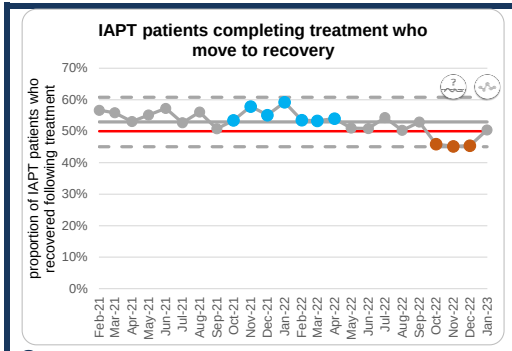

**Summary**

Waits have been significantly high for the last 7 months and above target for the last 2 months.

**Actions**

- Consolidate the waiting lists.
- Service Manager discussion over longest waiters monthly to reduce outliers.
- Review productivity and average contacts to increase treatments and reduce wait times.
- Review acceptance criteria to achieve more appropriate referrals.
- Introduction of supportive technology either at referral or to support treatment.
- Introduce bookable appointments increasing available treatment slots.

# Operational Performance

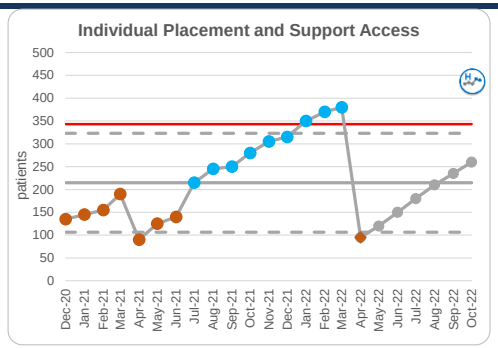



**Summary**

This is an annual target and year to date we are exceeding target. The dip in performance was likely to have been an unintended consequence of implementing waiting list waiting well checks, which included taking measures. This has been amended and the positive effects have now started to be reflected in the data.

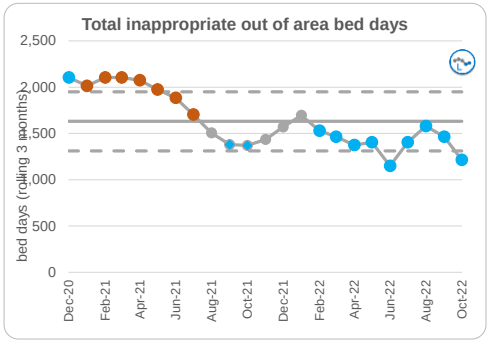
**Actions**

- Clarification and communication of referral criteria, for clinicians/ referrers and service users.
- Focus on productivity to reduce wait times and inform clinicians clearly of their own performance.
- Removal of outcome measures as part of waiting well appointments



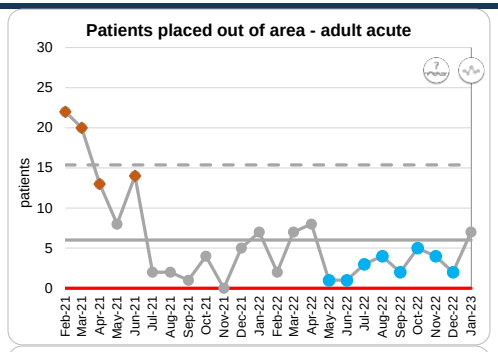

**Summary**

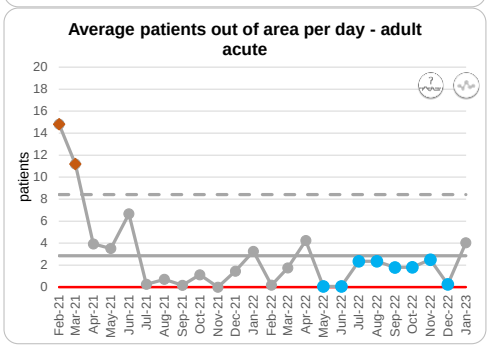
This is a year-end target for the number of new people accessing the individual placement and support services within the financial year. The target was achieved in 2021/22 and is currently on target to be achieved this financial year also.




**Summary**

This is a combination of inappropriate out of area adult acute placements and inappropriate out of area psychiatric intensive care unit placements, calculated on a rolling 3 moths' basis. The actions being taking to improve the position of each placement type are detailed in the next 2 columns.



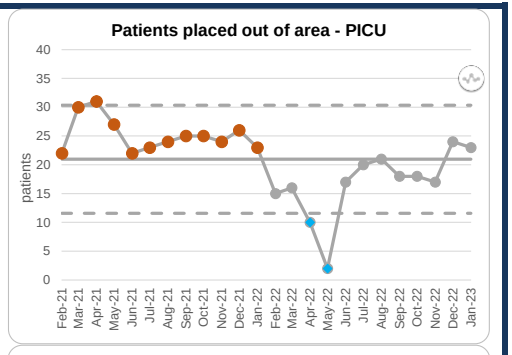



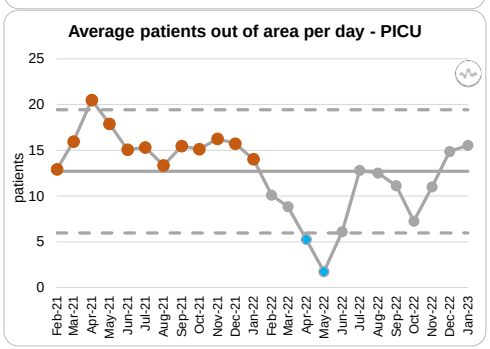

**Summary**

This continues to be impacted upon by persistently high levels of bed occupancy 100% plus, delayed transfers of care and above average length of stay. In recent months there has been an increase in delayed transfers of care with access to ongoing residential care often delayed. We are also experiencing increase acuity regarding patients admitted to hospital. The overall system remains under pressure with University Hospitals of Derby currently declaring a critical incident because of flow challenges and Chesterfield Royal Hospital likely to be in a similar situation very shortly.

**Actions**

- To establish an internal acute transformational delivery board to bring together improvement and transformation workstreams to enable further improvements in flow
- Reduction in people clinically ready for discharge to generate improved flow and admission capacity
- Reduction in length of stay to generate improved flow and admission capacity



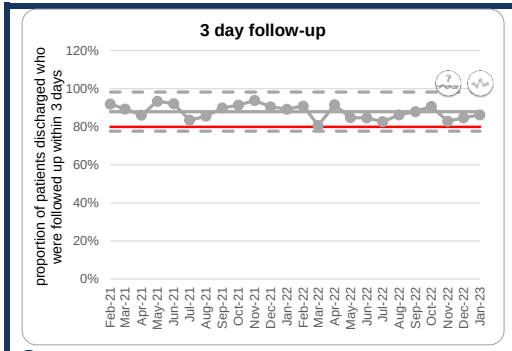

**Summary**

There is no local PICU provision, so anyone needing psychiatric intensive care must be placed out of area, however, work continues on the provision of a new build PICU in Derbyshire.

**Actions**

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

# Operational Performance

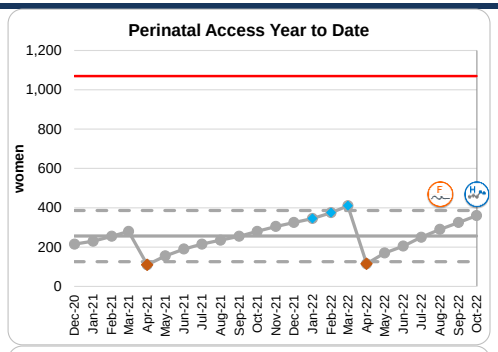


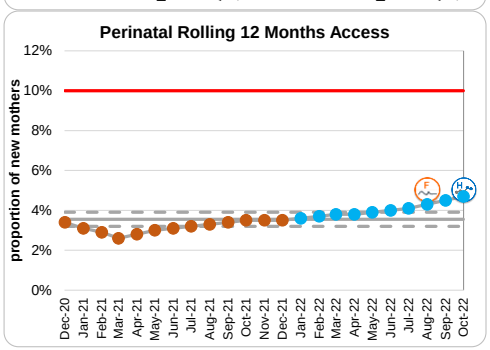

**Summary**

Patients are followed up in the days following discharge from mental health inpatient wards to provide support and ensure their wellbeing during the period when they are potentially at their most vulnerable. The national standard for follow-up has been exceeded throughout the 24-month period. Some ongoing recording issues have been experienced following the move to SystmOne, however these have now largely been addressed as people have become used to how to record on the new system.

**Actions**

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




**Summary**

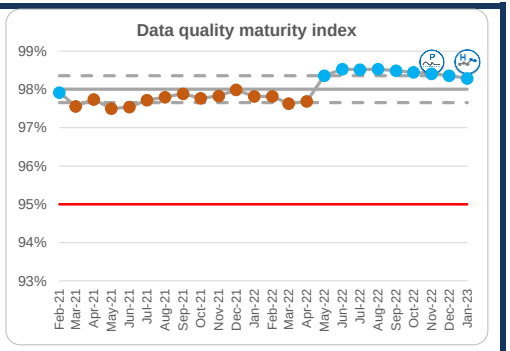
This is the number of women accessing services in the 12-month period as a percentage of Office for National Statistics (ONS) 2016 births (target 10%).

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

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

**Actions**

- Data quality checks to verify recording of assessments working with Information Management Team, to aid monitoring of performance against target
- Increase capacity in teams to enable further assessments to be undertaken. Utilise focused assessments, joint antenatal clinics, workforce/recruitment planning. To result in reduced waits and increased access to the service
- Increase referrals: increase in assessments from maternal mental health service
- Target areas of low referrals, bespoke training to GP's and Health Visitors; increase communications regarding the advice line.
- Development of birth trauma and tokophobia pathways.
- Record assessments from the specialist midwives.
- Improved awareness of referral pathways
- The Trust Quality Improvement team have been engaged to monitor progress against trajectories and revise the step changes that were expected in quarter 4 of 2022/23
- Bespoke offer of support from the Perinatal Clinical Network
- Monthly operational meetings to discuss progress amongst Perinatal Teams, and to consider further actions, local targets set and monitored within teams/roles
- Quarterly updates shared by Managing Director to Delivery board, Targeted delivery from 31st March 2023



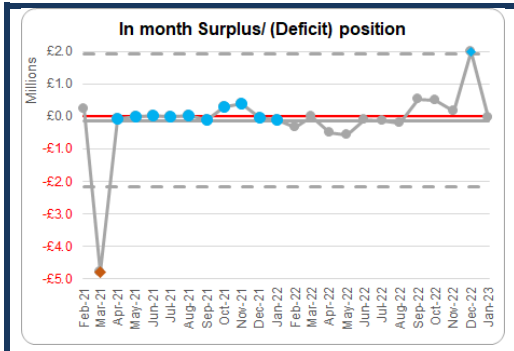

**Summary**

The level of data quality has been significantly better than expected for the last 9 months. It is expected that the national target will be consistently exceed.

Derbyshire Healthcare
NHS Foundation Trust

# Finance

# Financial Performance

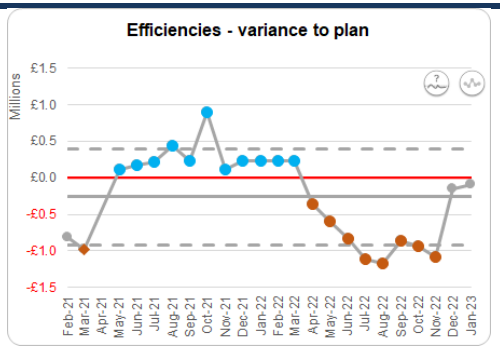



**Summary**

At the end of January, the overall year to date (YTD) position is a surplus of £1.6m compared to the plan deficit of £1.3m, a favourable variance to plan of £2.9m. At month 9 the forecast changed from a breakeven position to a surplus of £2.8m against the plan of breakeven. The forecast at month 10 remains on track to deliver the forecast surplus of £2.8m. The surplus position has been driven by additional non recurrent income and one off pay and non-pay benefits.

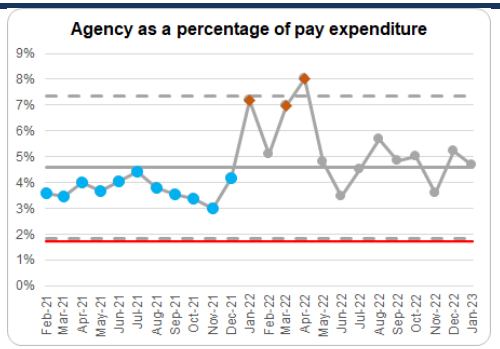
There are still some risks to delivering the £2.8m surplus that continue to be monitored however most of these risks are now reducing.

Therefore, due to the change in the 2022/23 revenue forecast position from breakeven to a £2.8m surplus, along with the reduction in some of the identified financial risks within the Board Assurance Framework (BAF) both from a revenue and capital point of view, the BAF risk *that the Trust fails to deliver its revenue and capital financial plans* has been reduced from Extreme to Moderate.




**Summary**

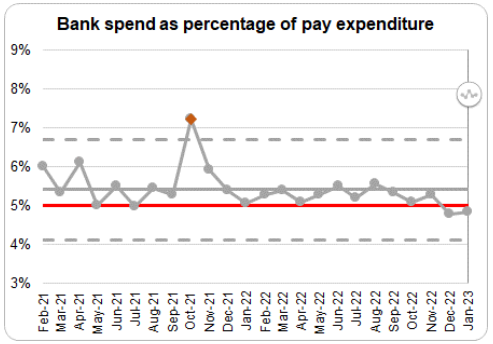
The full year plan includes an efficiency requirement of £6.0m phased equally across the financial year. As at the end of January, the full £6.0m has been transacted in the ledger and all schemes are on track to deliver in full. However, a considerable proportion of the efficiencies are non-recurrent in nature 68% which drives the underlying position and will have an adverse impact on 2023/24 financial plans.



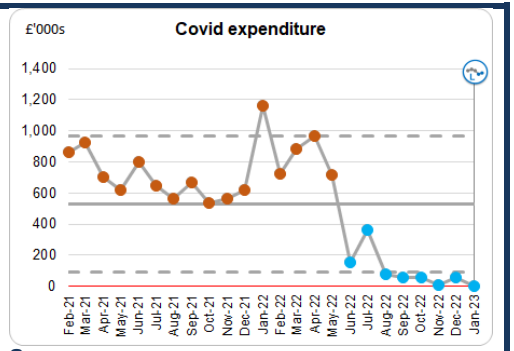

**Summary**

Agency expenditure year to date (YTD) totals £5.9m against a plan of £2.0m, an adverse variance to plan of £3.9m. The two highest areas of agency usage relate to Consultants mainly in CAMHS and Nursing staff on the wards. Agency expenditure for January was £0.6m, a small reduction from the previous month and is in line with the average over the last two years but remains significantly above the target.

The planning guidance for 2023/24 states that agency expenditure should not exceed 3.7% of the total pay expenditure, whereas January's expenditure equates to 4.7% of the total pay expenditure.




Bank staff expenditure YTD totals £6.2m against a plan of £5.7m with average spend of £0.6 per month, except for October 2021 where that increased to £0.8m. For the last two months bank expenditure as a percentage of total pay expenditure has been below the target of 5%. The main areas of bank spend continue to relate to Nursing on the wards along with Domestics.

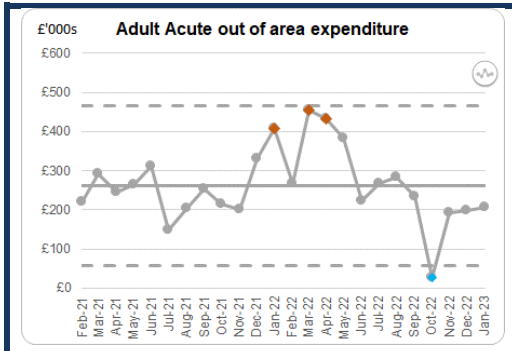



**Summary**

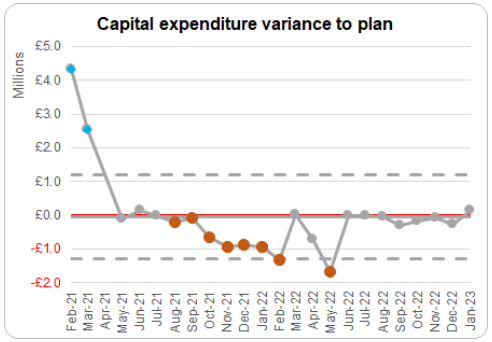
The Trust has an income allocation of £0.3m a month for the financial year for Covid-related expenditure. The financial plan assumes no expenditure after the end of May as per the planning guidance.

The above chart shows that expenditure has been reducing throughout this financial year with expenditure since August significantly lower than in previous months.

# Financial Performance

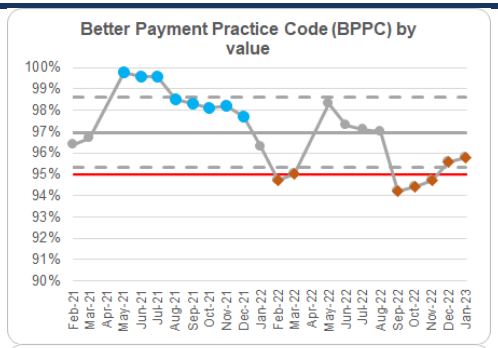


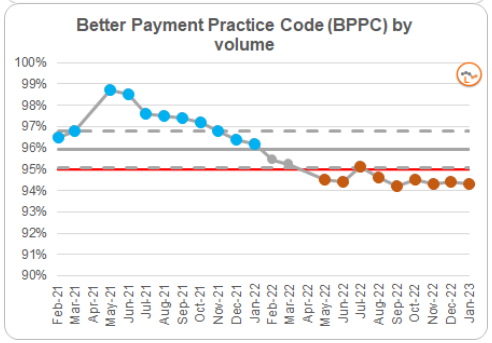

**Summary**
Expenditure for adult acute out of area placements including block purchased beds and cost per case beds has reduced compared to previous levels. YTD £2.4m has been spent on out of area adult acute placements. The forecast assumes that there will be ten out of area placements in February and March.




**Summary**
Capital expenditure was reporting behind plan in April and May, however that was against the April plan submission. The capital plan was resubmitted in June 2022 which changed the capital system allocation to reflect the requirement of the self-funded elements of the Making Room for Dignity project.

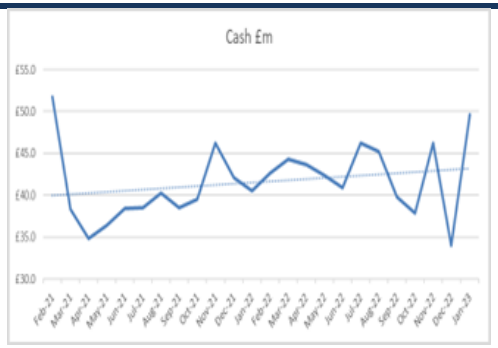
Capital expenditure is slightly behind plan year to date but is forecast to achieve the 5% planning reduction by the end of the financial year.



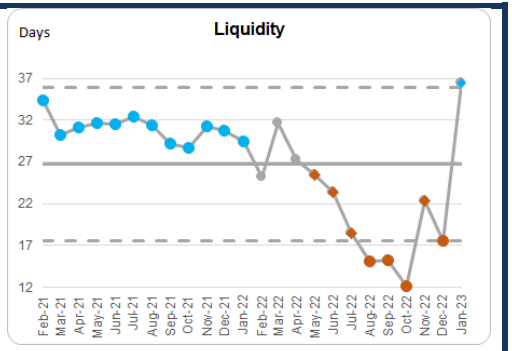

**Summary**
The Better Payment Practice Code sets a target for 95% of all invoices to be paid within 30 days. BPPC is measured across both invoice value and volume of invoices.

At the end of January, the value of invoices achieved the target at 95.8%, however the volume of 94.3% was both slightly below target.




**Summary**
The chart above shows the levels of cash over the last two years. It is important to remember that in 2020/21 CCGs paid the block contract amounts in advance, so 2 months were received in April 2020 and then no payment in March 2021 which brought the cash back down to the same level in March 2020.

At the end of January cash is currently at £49.7m and is forecast to be £31.7m at the end of the financial year. The forecast reduction in cash reflects the use of cash reserves for the self-funded elements of the capital plan.




**Summary**
The chart above shows the liquidity levels over the last two years. Liquidity levels were high in 2020/21 and reduce during 2021/22, which is due to two main factors, not making a surplus and the level of capital expenditure being above depreciation levels.

The reason for the downturn in 2022/23 is due to the timing of cash receipts related to the centrally funded capital schemes for the eradication of dorms. The PDC drawdown requests have caught up which has driven the increased level in January.

**Planning 2023/24**

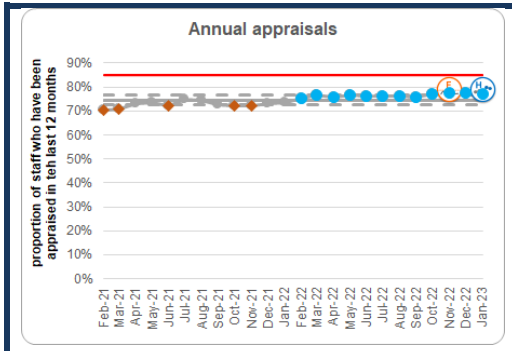
Currently financial plans for 2023/24 both for revenue and capital expenditure are being developed as a Derbyshire system in readiness for a draft submission on 23 February 2023 and final submission on 30 March 2023.

Due to the timing of the submission, it is being requested that the Finance and Performance Committee have delegated authority to sign off the final plan submission on behalf of the Trust Board.

Derbyshire Healthcare
NHS Foundation Trust

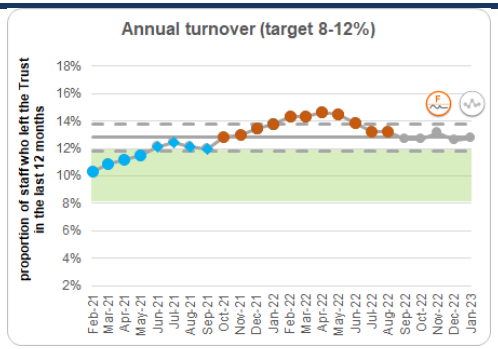
# People

# People Performance



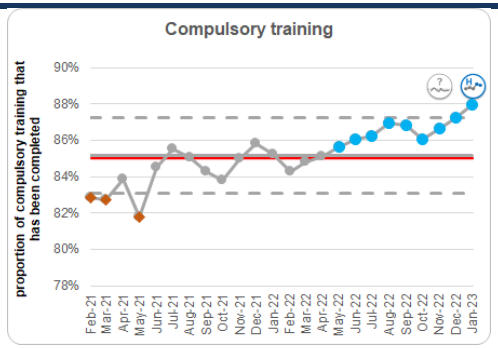

**Summary**
Appraisal levels continue to be below our expectations with Operational Services currently at 80% and Corporate Services at 62%.

**Actions**
- Work has continued with increased support on using the Electronic Staff Record (ESR) to record an appraisal and the Divisional People Lead for each division is working with leaders to look at reasons for low compliance.
- The RCN industrial action in January will have resulted in some appraisals being cancelled and a delay in the recording of some.
- Compliance also continues to be monitored at Divisional Achievement Reviews and via the Trust Operational Oversight Leadership Team (TOOL).




**Summary**
Turnover remains high and above the Trust target range of 8-12%.

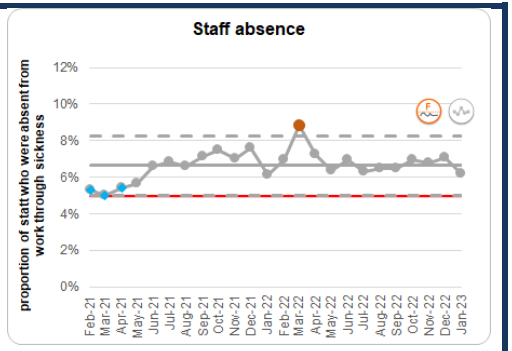
**Actions**
- The new exit interview process is now fully implemented and in January compliance was 59.7%. This is a significant improvement from previous months where compliance was below 10% on the old process.
- A triangulation of key people metric data and intelligence from key leads is now in place to ensure teams needing support takes place promptly to minimise staff leaving the teams.
- STAY surveys are being run with these teams and also teams requesting the survey to support the team to develop bespoke retention initiatives.




**Summary**
Overall, the 85% target level has been achieved for the last 10 months. Operational Services are currently 89% compliant and Corporate Services slightly lower at 83%.

Immediate Life Support (ILS) and Positive and Safe training compliance continue to remain in a stable position. ILS is currently 86% complaint and positive and safe at 73%.

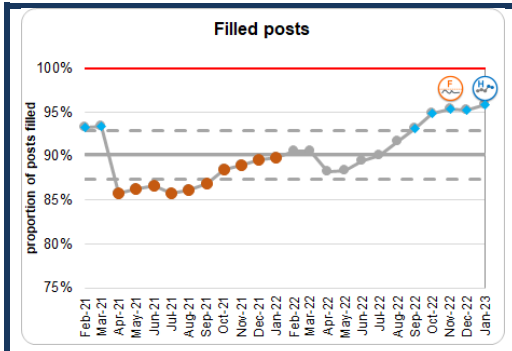
**Actions**
A training summit is planned for March to focus on the long-term training plan – including mode and model of delivery for the current elements that are face to face delivery.




**Summary**
January 2023 sickness was 6.2% which is the lowest we have recorded for over a year. Despite the RCN industrial action over 2 days in January, recorded absence improved during the week of the action with more colleagues returning to work who had previously been off sick.

**Actions**
The main reason for absence continues to be stress and anxiety and 2023 will see further investment in resources to support colleagues who are struggling at work and home. This includes a staff support clinical psychologist and additional health and wellbeing resources.

# People Performance

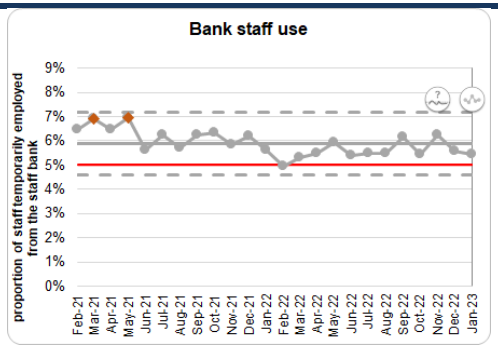



**Summary**

Staffing levels continue to improve with January seeing another increase and overall position of 91.07% and another reduction in vacancy rate which is now at 4.07%.

**Actions**

- A targeted recruitment campaign and face to face event took place for trainee healthcare support workers and OTs. Both were very successful and again used innovation ways to target the audience, outside of the routine TRAC recruitment system.
- Work continues on implementing learning from the cultural intelligence recruitment programme and the first one-page job description will go live next month.

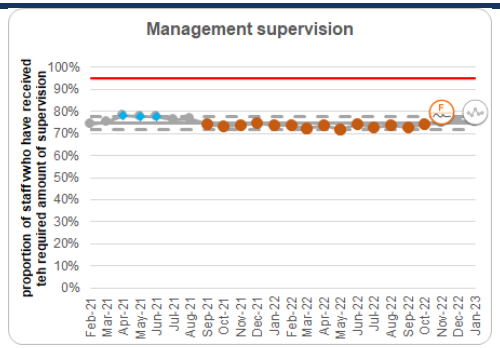


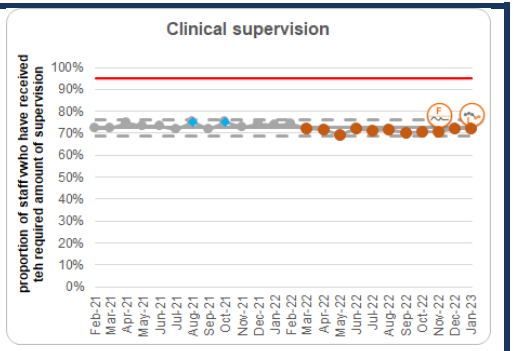

**Summary**

January saw a small increase in agency spend, mainly due to the industrial action and an increase in the acuity of patients on a number of wards. Overall bank fill rates remained high with a small increase since December from 61% to 63%. In total 5,809 shifts were requested in January and an overall fill rate of 77.3% was achieved – this is the highest since January 2022.

**Actions**

Agency spend is high across the system and a system plan is being developed to aid reduction.




**Summary**

As seen with compulsory training and appraisals, Operational Services continue to perform at a considerably higher level than Corporate Services for both types of supervision (management: 76% versus 61% and clinical: 74% versus 20%).

The overall level of compliance with the clinical and management supervision targets has remained low since the start of the pandemic, however improvements can be seen at a team level, with 103 teams now 100% compliant with management supervision and 70 teams now 100% compliant with management supervision.

The staffing challenges that are impacting on waiting lists will also be impacting on capacity to undertake supervision:

| Adult Community | Turnover | Sickness | Vacancies |
|---|---|---|---|
| Bols + C C Adult CMHT | 15% | 3% | 16% |
| Chesterfield C Adult CMHT | 12% | 5% | 6% |
| High Peak Adult CMHT | 43% | 28% | 19% |
| Killmsh + N C Adult CMHT | 27% | 5% | 22% |
| North Dales Adult CMHT | 0% | 0% | 11% |
| Amber Valley Adult CMHT | 4% | 1% | -9% |
| El Sth + City | 13% | 17% | -9% |
| Erewash Adult CMHT | 5% | 10% | 10% |
| South + Dales Adult CMHT | 21% | 0% | 5% |
| Derby City B Adult CMHT | 7% | 2% | 13% |
| Derby City C Adult CMHT | 0% | 12% | 3% |

| Older People Community | Turnover | Sickness | Vacancies |
|---|---|---|---|
| Amber Valley OA CMHT | 17% | 6% | 14% |
| Bols + CC OA CMHT | 0% | 6% | 7% |
| Chesterfield C OA CMHT | 8% | 1% | 1% |
| Derby City OA CMHT | 4% | 3% | 15% |
| Erewash OA CMHT | 10% | 0% | 11% |
| H P + NDales OA CMHT | 0% | 19% | -7% |
| Killmsh + N C OA CMHT | 23% | 10% | 16% |
| OA Day Services | 23% | 8% | 19% |
| South + Dales OA CMHT | 20% | 9% | 3% |

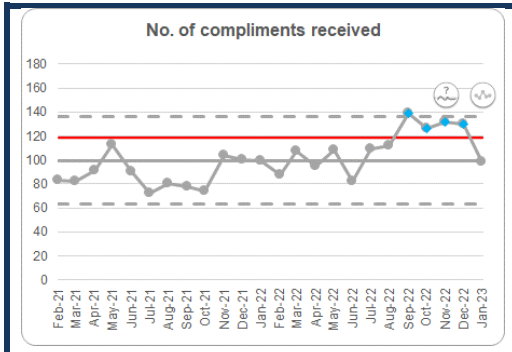
**Actions**

- In operational services, the position is monitored regularly at Operational Management Meetings, Clinical & Operational Oversight Team meetings, and at divisional achievement reviews.
- An in-depth report into supervision rates has been commissioned by the Executive Leadership Team

Derbyshire Healthcare
NHS Foundation Trust

# Quality

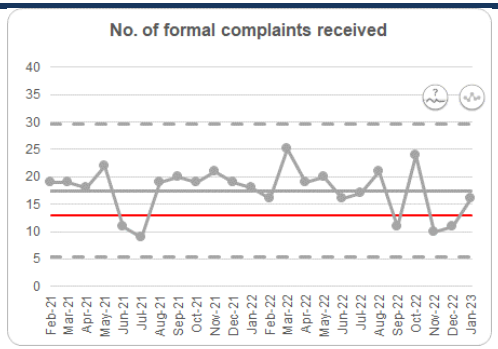
# Quality Performance




**Summary**
The number of trust compliments dropped by 30 between December and January following an increasing trend between September and December.

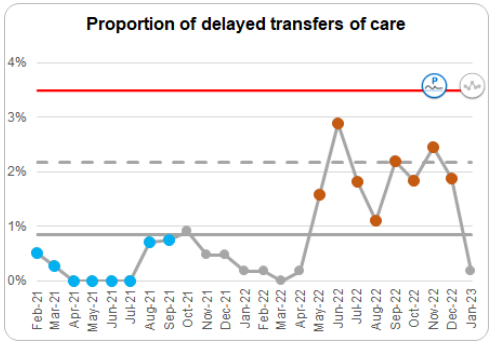
It is not possible to identify a specific reason for the fluctuation in compliments recorded as compliments are mostly received verbally and staff do not always accurately record them and there is no consistent process of recording them across the trust.

**Actions**
- The Heads of Nursing (HoN) have been asked to provide assurance that compliments are being accurately recorded and that a clear process is identified. This has been raised within the divisional Clinical reference groups to encourage staff to record compliments and for teams to consider the method of compliment recording. This is monitored through the quarterly Patient Experience Committee report.
- A project to implement an automated electronic patient survey will provide a further method of receiving compliments and concerns. With an increase in accessibility, it is expected that an increase in compliments, and concerns will occur over the next 6 months as the electronic patient survey is expected to go live across the Substance Misuse, Older Adult, Working Age Adult and Childrens divisions in April 2023 and then in the Neurodevelopmental Division by May 2023.



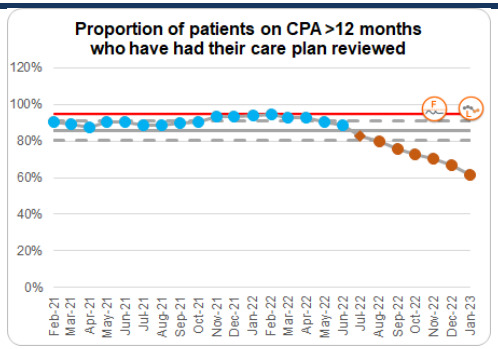

**Summary**
The number of formal complaints received has increased between November 2022 and January 2023 from 10 to 15 per month. This is above the Trust target of 12 per month.

**Actions**
The complaints team are monitoring this, but no specific theme has been identified.




**Summary**
Although the number of DTOC has decreased by 2.5% to 0% current DTOC between November 2022 and January 2023, DCHFT numbers are consistently low when compared with the national picture and continue to record results below the Trust target of 3.5%.

**Actions**
- The Trust has a twice weekly “clinically ready for discharge” meeting where patients identified as DTOC are reviewed and any barriers to discharge are identified and discussed.
- From November 2022 the Trust Flow Team have introduced a weekly, multi-agency discharge planning meeting that reviews and identifies any potential barriers for discharge and from this develops an action plan to prevent delay in discharges. The current indication is that these interventions are having a positive impact.

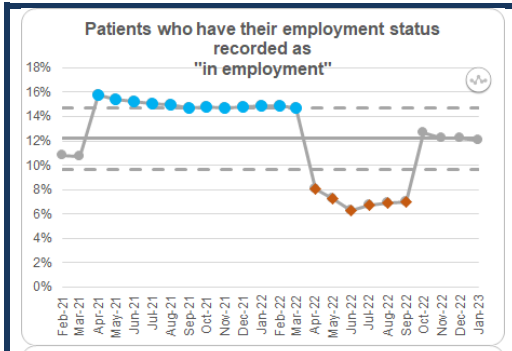


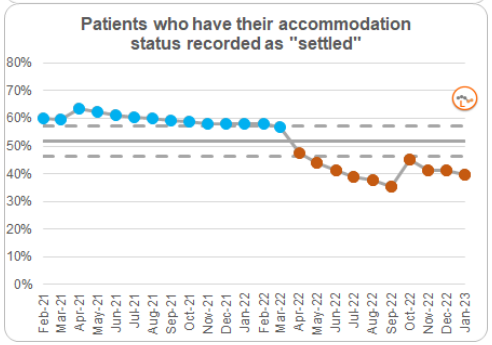

**Summary**
The proportion of patients whose care plans have been reviewed continues to be recorded as lower than expected and is currently on a downward trajectory. In the Working Age Adult Community Mental Health teams, data has been affected by the migration from PARIS to SystmOne as some of the service users who had care plans in place on Paris have not yet had them migrated to the new EPR. Community Mental Health Teams were given a goal of ensuring all Service Users who require a care plan, have one on by the 31 December 2022. Due to staff vacancies, sickness and patient acuity this was not achieved. The current percentage of patients who have had their care plan reviewed and have been on CPA for over 12 months is 61%, a reduction of 10% between December and January.

**Actions**
The Assistant Director of Clinical Professional Practice attended the Divisional operation meeting in February 2023 and the Head of Nursing (HoN) is supporting services to develop team-based care plan compliance plans including identifying and protecting staff time for administration. This will be monitored through the divisional monthly COAT and the Monthly operational meeting.

The older adult team has also identified an action plan to improve care plan compliance including:
- Services to complete 3 case note audits per month and feedback to HoN who will interpret and produce a quarterly summary which will be shared with the GM and ASM.
- Training will be identified for those staff who require support with care plan quality.
- The clinical leads complete 5 mini audits per week for each team and send these to HoN to address any issues or themes quickly.
- HoN will ensure the improvement plan is updated weekly with the audit results and electronic reporting, including any themes emerging or barriers and will report this via the monthly divisional COAT meeting for monitoring and assurance.

# Quality Performance



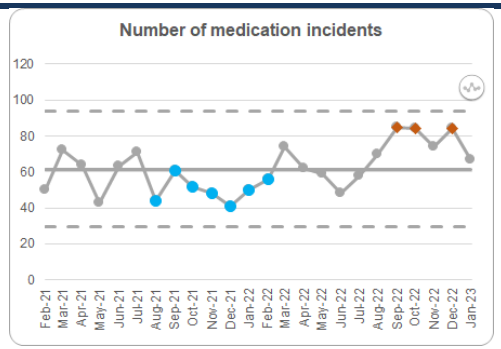




**Summary**

Around one third of patients have no employment status or accommodation status recorded at present and the decline in patients recorded as being in employment coincides with the data migration to SystmOne. There has been no change in the number of patients recorded as in employment between November and January.

**Actions**

- A report has been developed which informs teams if there are gaps in the current Data Quality Maturity Index information recorded on referral and from February 2023, Ward and Service Managers will be asked to review this report weekly and action any gaps identified. This will be monitored via monthly service specific operational meetings.
- Issues around inputting data have been identified and an improvement plan was implemented in the Older Adult Division in October including regular audit




**Summary**

Work continues to be underway to reduce numbers of medication incidents. Common variation continues to be within expected thresholds.

**Actions**

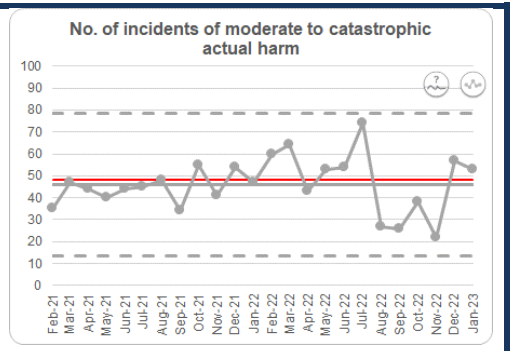
The number of medication incidents is reviewed via the monthly medication management subgroup and is reported on within the quarterly thematic “Feedback Intelligence Group” (FIG) report by the Heads of Nursing and is included in the Serious Incidents Bi-monthly report. Any actions identified are reviewed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

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. This is monitored through both the feedback intelligence group report and the Medicines Management Operational Subgroup (MMOS) and the majority of these incidents are categorised as minor or insignificant.

The pharmacy team identified some learning points which they introduced in December 2022 and January 2023:

- Development of an agency ward folder where the medicine management e-learning is printed out as PDFs for reference. This is currently being trialled in the North with a plan to roll out in the South impatient wards if it is ratified in April.
- DHCFT Pharmacy are feeding back to ward managers on a quarterly basis about shared learning from meetings with Chesterfield Royal Hospital pharmacy.
- From January 2023 nursing staff have an open medicine Q&A with Medicine Safety Officer when required.
- The Pharmacy provide routine medicine updates to all staff via a medicine newsletter from January 2023

In October 2022 the Children's Division started electronic prescribing and medicines administration (EPMA) a solution which digitises the process of prescribing and recording medication administered to patients within the Division. This will be rolled out across the trust and should also help reduce the number of medication incidents over the next six months. It is too early to see the impact of EPMA on medication incidents, but this will be monitored and reported upon in subsequent reports. A report on incidents is also reviewed within the Monthly COAT meeting for each division.



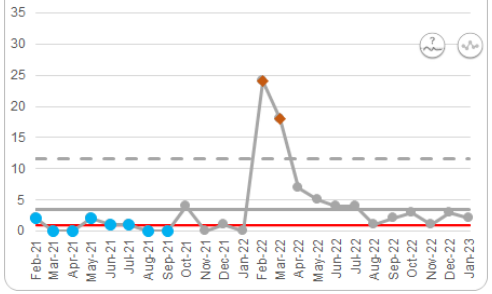

**Summary**

This data demonstrates the number of DATIX incidents occurring of moderate at catastrophic harm. There was an increase in incidents in November but from December these are on a downward trajectory. The patient safety team and Head of Nursing team are reviewing this data for any patterns.

From April 2023, this data will be split into physical harm and psychological harm-based incidents.

# Quality Performance

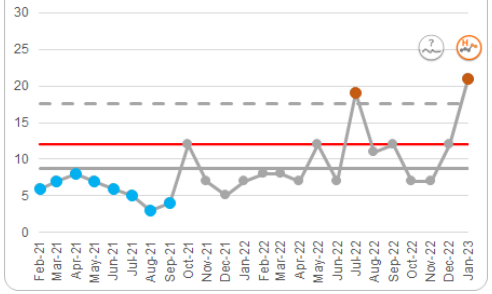
### No. of incidents requiring Duty of Candour




**Summary**
Duty of Candour reported incidents have been on a downward trajectory since April which coincides with the Patient Safety Team undertaking 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.

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

### No. of incidents involving prone restraint



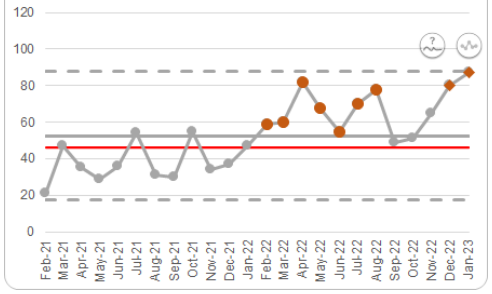

**Summary**
Prone restraint has increased since November 2022. From December 2022 the Trust Positive and Safe Support Team (PSST) implemented a change in the way staff are taught to support service users into seclusion, including:

- Seclusion Simulation Training
- Self-harm and Ligature Simulation Training
- Restraint Training Updates
- Alternate Injection site training
- Safety Pods

This means that prone restraint in these circumstances will no longer be necessary in all situations and there is evidence via DATIX that safety pods are being used to exit seclusion in a seated position. It should be noted that the overall numbers of prone restraint are lower than the regional average per bed number and with the interventions outlined above it is expected incidents of prone restraint will reduce over the next quarter.

**Actions**
A review of the data is underway as the Head of Nursing for Acute and Assessment services is completing an in-depth qualitative audit and thematic review of seclusion and restraint and with the PSST. This is due to be completed by the end of March 2023. Following a review of data, the increase of prone restraint is linked to a small number of service users being restrained on multiple occasions.

### No. of incidents involving physical restraint

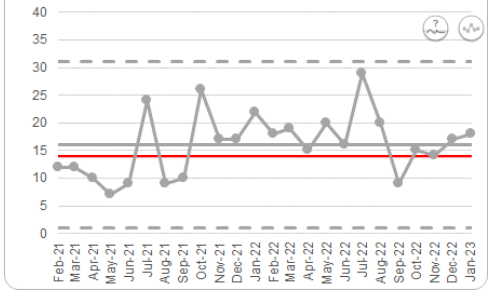



**Summary**
Physical restraints have increased between November 2022 and January 2023. This is being reviewed and monitored within the Reducing Restrictive Practice Group. These increases appear to be related to the increased acuity of patients in inpatient settings and a high number of repeated incidents attributed to a small group of patients.

**Actions**

- The Trust Positive and Safe Support Team are placing extra training sessions to improve training availability for staff. Compliance with positive and safe training is increasing and is currently at 71% for teamwork and 81% for breakaway training.
- Furthermore, the PSST are spending more time in clinical areas to support and train clinical staff, live during practice.

### No. of new episodes of patients held in seclusion

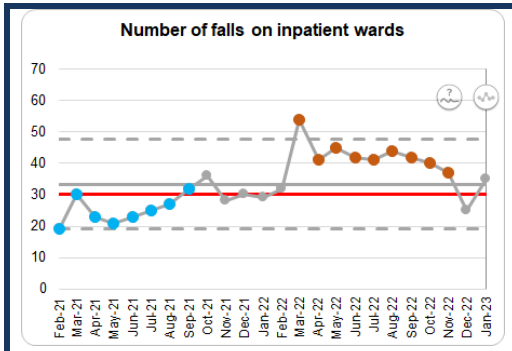



**Summary**
Seclusions have increased between November 2022 and January 2023 from 14 to 17. The increase in Seclusion is in line with the increase in physical and prone restraint over the same period.

**Actions**

- Where there have been increased incidents of seclusion, reviews have been completed and This is monitored through the monthly PSST DATIX meeting and the Reducing Restrictive Practice group.
- The Head of Nursing for Adult Acute and Assessment Services is also leading a task and finish group doing a qualitative audit and thematic review of seclusion and restraint supported by the PSST and inpatient clinical leads. Actions for this review will be presented and monitored through the Reducing Restrictive Practice Group.

# Quality Performance




**Summary**

Between November and December 2022 falls fell from 38 to 28 but they have increased to 37 in January 2023. A review of falls identified that a high number of falls were related to the same small number of patients.

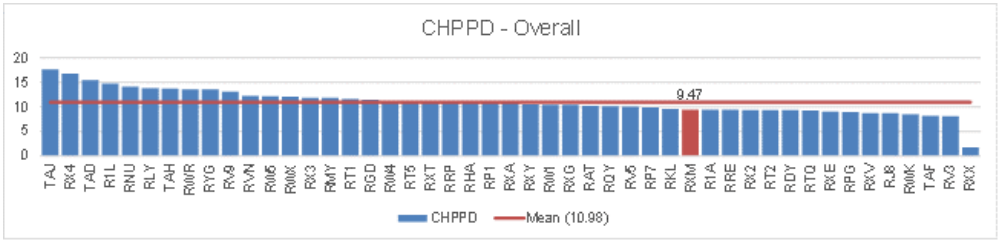
**Actions**

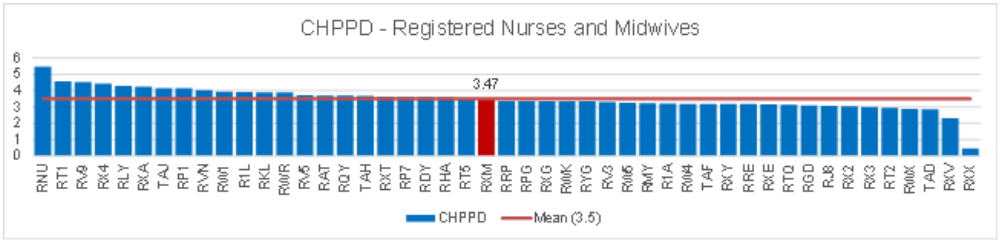
The bi-weekly falls review meeting, chaired by the Matron for Older Adult Services, continues to identify any specific needs for those patients falling regularly. The impact and actions from this meeting are reported to the Divisional Clinical Reference Group for assurance. This will continue to be monitored over the next quarter.

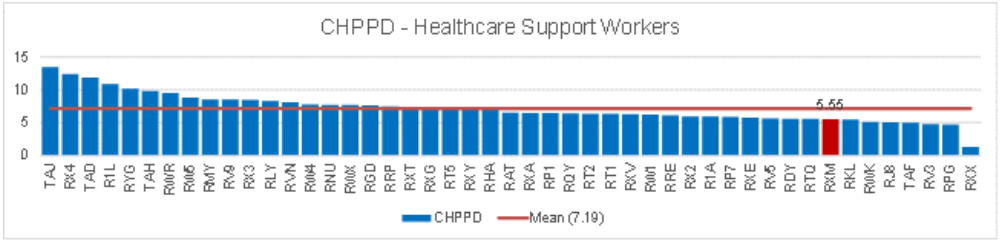
**Care Hours per Patient Day (CHPPD)**

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.

The charts below show how we compared in the latest published national data when benchmarked against other mental health trusts. We were below average overall:



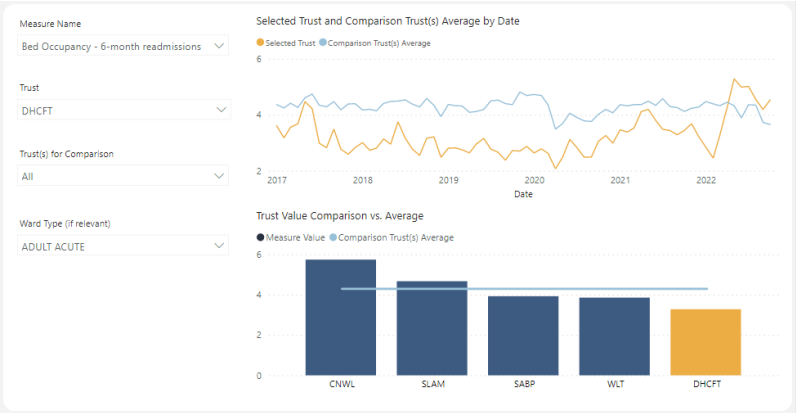




https://www.england.nhs.uk/publication/care-hours-per-patient-day-chppd-data/

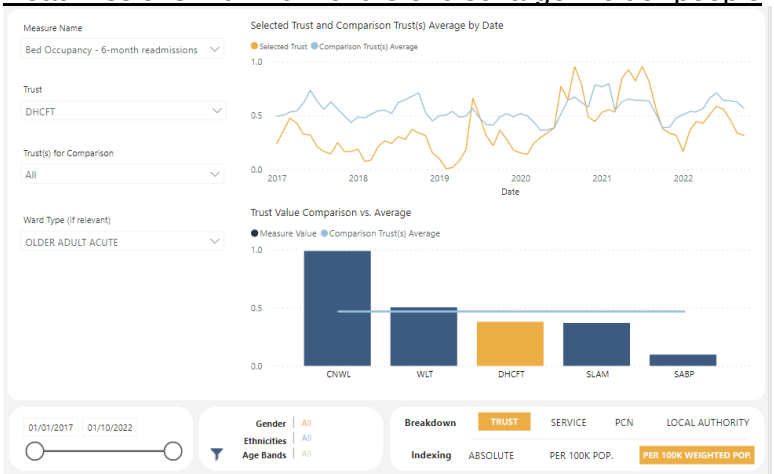
**Performance Insights: Readmissions within 6 months of Discharge**
**Real World Health Benchmarking Data**

Readmissions within 6 months of discharge – adult acute



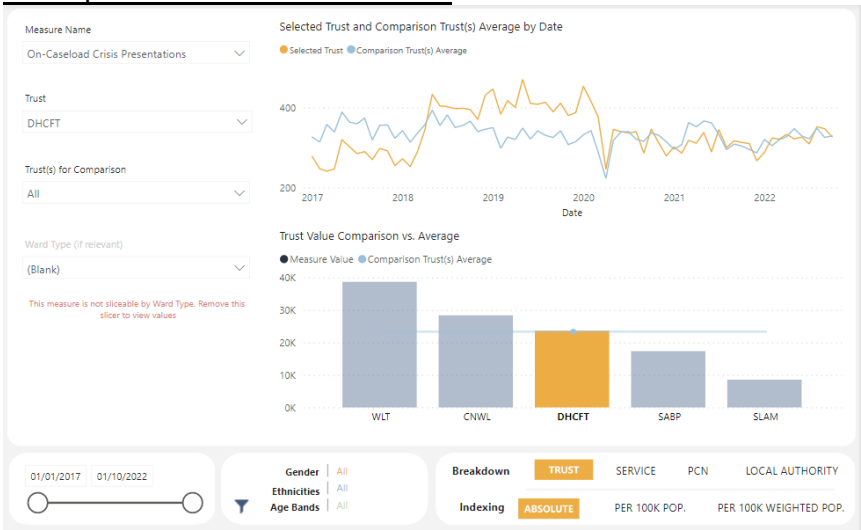

***The Trust has had an average of 3.3 readmissions within 6 months per 100k weighted population of people previously admitted to adult acute inpatient beds. This is well below average and the lowest rate in comparison with the other trusts in the sample.***

Readmissions within 6 months of discharge – older people




***The Trust has had an average of 0.4 readmissions within 6 months per 100k weighted population of people previously admitted to older adult inpatient beds. This is below average in comparison with the other trusts in the sample.***

Crisis presentations – on caseload



**Please note the data for Quarter 3 is due for submission in February 2023 so some data may change when final numbers are confirmed.**

## CQUIN 2022/23

| 2022/23 summary table CCG CQUINs | | | | | | | |
|---|---|---|---|---|---|---|---|
| **CQUIN** | **Topic** | **Lower Threshold** | **Upper Threshold** | **Q1** | **Q2** | **Q3** | **Q4** |
| CCG1 | Staff flu vaccinations | 70% | 90% | n/a | n/a | 52% | |
| CCG9 | Cirrhosis and fibrosis tests for alcohol dependent patients | 20% | 30% | 33% | 84.6% | 66.7% | |
| CCG10a | Routine outcome monitoring in Children and Young People (CYP) mental health services and perinatal mental health services | 10% | 40% | 18% | 7% | *6% (data only available up to end of November as not yet available on NHS futures) | |
| CCG10b | Routine outcome monitoring in community mental health services | 10% | 40% | 49% | 48% | 52% (data only available up to end of November) | |
| CCG11 | Use of anxiety disorder specific measures in Improving Access to Psychological Therapies (IAPT). (This CQUIN applies to the Talking Mental Health Contract) | 55% | 65% | 57% | 61% | 62% | |
| CCG12 | Biopsychosocial assessments by mental health liaison services | 60% | 80% | 67% | 80% | 74% (December data to be added) | |
| **PSS8** | Outcome measurement in perinatal inpatient services | 75% Clinician Reported Outcome Measures (CROM) | 95% CROM | 88% | 56% | 65% | |
| | | 35% Patient Reported Outcome Measures (PROM) | 55% PROM | 25% | 33% | 55% | |

*** Although the overall number on NHS futures is 6%, the individual number for perinatal services is 40% and the individual number for CYP is 4%. this would indicate that the average should be 22% which would be below the lower threshold.**

## Progress Update

### CCG1 - Flu vaccinations for frontline healthcare workers

The vaccination uptake for health care workers was at 52% by end of December 2022 this has increased to 59% in January. 52% is a reduction from the same period last year. DHCFT is in the mid-range and there is reduced uptake in the region and the country. There has been increased vaccination fatigue, hesitance and it may be that staff are concerned about other issues such as cost of living. To increase uptake of flu vaccinations, the Health Protection Unit (HPU) have engaged with Trust managers / Matrons / ASM to disseminate the benefits of flu vaccination to their team. they have also worked closely with Comms to get a positive message out and have worked closely with Derbyshire Community Health Services (DCHS)to enable each other's staff to access flu vaccine easily.

The HPU have roved around the County taking the flu vaccine to all DHCFT bases which didn't have a flu vaccine offering from DCHS. They also produced banners which are dropped off at locations several days before the clinic and have a weekly vaccination cell meeting with HPU, Pharmacy and Assistant Director of Public and Physical Health to discuss governance, mobilisation and targets.

However, It is anticipated that the set target of 90% will not be reached by the end of the flu campaign 2022/23. These difficulties are not isolated to Derbyshire as vaccine fatigue is a regional trend and there has been a national reduction in flu vaccine uptake.

**CCG9: Cirrhosis and fibrosis tests for alcohol dependent patients**

The set targets are being met in this CQUIN. There have been various initiatives implemented in the Q1 and Q2 which saw improvement in testing. The working group continues to monitor the initiatives and share learning.

Some of the challenges to compliance have been that the Digital Team have been unable to set up a report from the Electronic Patient Record (EPR) as the required field has not yet been mapped into the data warehouse. This is currently under review. No specific operational date has been given but this will be chased in February 2023

Staffing challenges within Radbourne Unit and Hartington unit are hampering improvement in compliance.

**CCG10a: Routine outcome monitoring in Children and Young People (CYP) and perinatal mental health services**

The set targets for this CQUIN have not been met in Q1, Q2 or Q3. Various initiatives have been put in place to ensure that there are improvements in this CQUIN. There has been increased trained offer to Routine Outcome Monitoring (ROM), on Microsoft Teams. Divisional CQUIN lead attended managers meeting, encouraged discussion around their use within staff supervision. YouTube video created for staff re: The Revised Child Anxiety and Depression Scale (RCADS).

Within the CYP Division, CQUIN meetings take place once per month along with discussion in operational meetings and team meetings. information is also shared with staff via email. It is however unlikely that the target of 40% compliance will be reached by the end of the 2022/23 campaign.

It should however be noted that when looked at individually, the Perinatal Community teams are achieving the 40% target.

**CCG10b: Routine outcome monitoring in community mental health services**

To date the paired outcome target for Community is being achieved, currently 48%. NHSE/I have suggested that outcome measures Goal based Outcomes (GBO), Dialog and Recovering Quality of Life (ReQol) will become part of NHS minimum data set and as a result to forward plan, the Division has commenced monthly meetings to further review of the implementation of PROMs.

ReQol is already embedded in the CMHT's and dialog is currently being completed by Early Intervention teams. Service Mangers and Clinical leads continue to encourage completion of paired outcomes in supervisions.

Is likely that the CMHT's will continue to surpass their target of 40% at the end of the 2022/23 campaign.

**CCG11: Use of anxiety disorder specific measures in IAPT**

There has been improvement in the CQUIN between Q1, Q2 and Q3. Changes have been made to coding by the Information Management and Technology (IM&T) team so that scores on the Health Anxiety short form measures (ADSM) now flow into the IAPT data set.

- The team are however putting in interventions to improve compliance which appear to have had a positive impact including:
- Work is ongoing to understand discrepancies between reported figures on NHS Futures and standard reports within IAPTuS. Data flows are now consistently appearing on NHS Futures, however data is 2 quarters behind.

- Clinician level data on ADSM completion rates are being used in management supervision monthly.
- ADSM compliance is monitored at the monthly management team meeting as a standing agenda item and at IAPT Board.
- ADSMs are also discussed at patch meetings with clinicians in their geographical areas

If improvements continue the service may meet their compliance target of 65% by the end of the 2022/23 campaign.

**CCG12: Biopsychosocial assessments by MH liaison services**

The liaison service has achieved the CQUIN target of 80% in Q2 as the data for December is not yet available, it is likely that the current figure will change, and the service will meet their 80% target for Q3.

Of those service users who did not receive an assessment, the main reasons were the patient absconding for refusing an assessment after being referred (60%).

For patients who refused an assessment, there was evidence in the EPR of staff attending ED to encourage participation and evidence of staff liaising with ED staff to explore reasons of self-harm, understand level of risk and what support/services patients currently have access to. This will continue to be explored.

It is likely that the service will meet their compliance target at the end of the 2022/23 campaign.

**PSS8: Outcome measurement in perinatal inpatient services**

From November 2022, outcome measures are being embedded into routine practice to ensure consistent monitoring of outcomes for patients and a monthly audit is in place to monitor progress against the CQUIN. The Health of the Nation Outcome Scales (HoNOS) is used as a Clinician-reported Outcome Measure (CROM) and Clinical Outcomes in Routine Evaluation (Core-10) as a PROM. The goal is for completion of HoNOS and Core-10 on admission and discharge to ensure a pair of each of the outcome measures.

The team have made changes to ensure the PROM is completed prior to leave if completing on discharge might become a challenge. This appears to have had a positive impact as the team have achieved there PROM target in Q3. they are also meeting the lower threshold for the CROM target and are confident they will meet this and achieve both targets by the end of the 2022/23 campaign.

**CQUIN 2023/24**

As identified in the previous report, The CQUINs for 2023/24 will be reported to the Trust Quality and Safeguarding Committee and submitted to TOOL for assurance quarterly outlining how the trust is performing against the specific Threshold measures. An action plan will also be submitted identifying any barriers or areas that require improvement with a goal-based plan identifying both what being done and what is required to achieve the upper threshold. There will be a monthly meeting for CQUIN leads to report on their progress and request support or escalation.

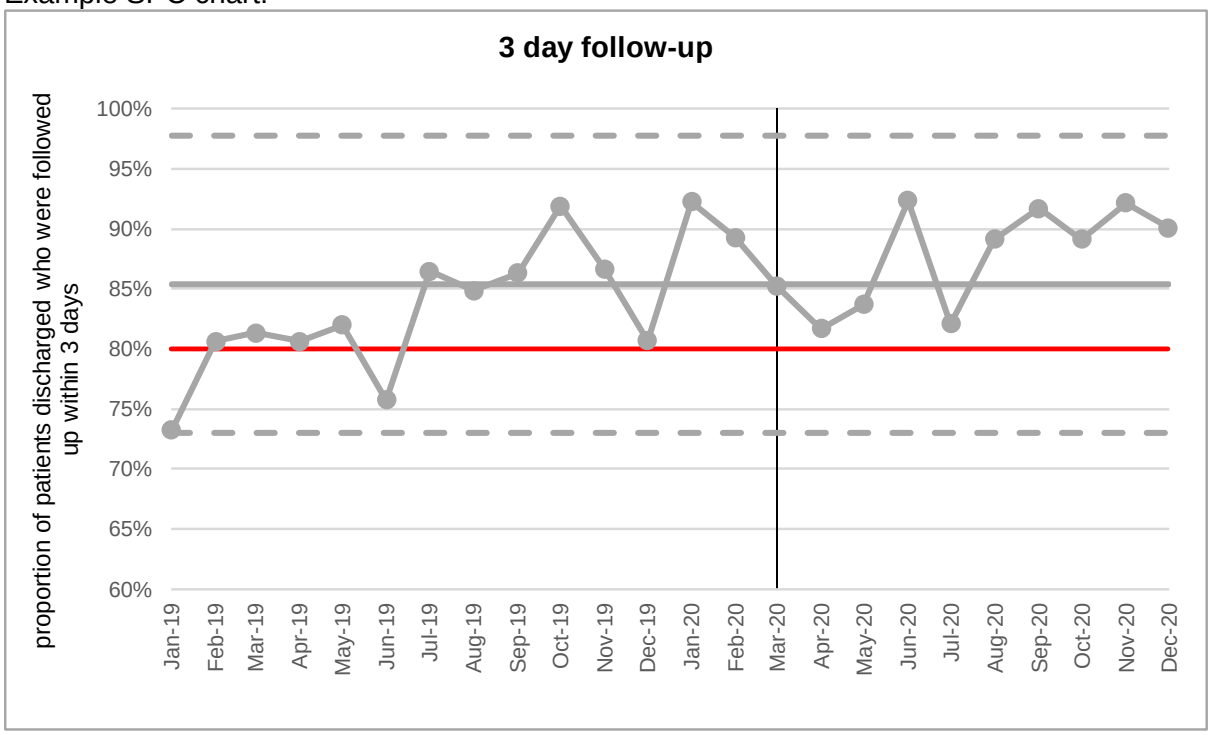
| 2023/24 summary table CCG CQUINs | | | |
|---|---|---|---|
| **CQUIN** | **Topic** | **Lower Threshold** | **Upper Threshold** |
| **CQUIN01** | **Staff flu vaccination** | 75% | 80% |
| **CQUIN15a** | **Routine outcome monitoring in community mental health services** | Paired overall<br>Min: 20% | Paired overall<br>Max: 50% |
| | | Paired PROMs<br>Min: 2% | Paired PROMs<br>Max:<br>10% |

| CQUIN | Topic | Lower Threshold | Upper Threshold |
|---|---|---|---|
| **CQUIN15b** | **Routine outcome monitoring in CYP and community perinatal mental health services** | 20% | 50% |
| **CQUIN15c** | **Routine outcome monitoring in inpatient perinatal mental health services** | 75% CROM; | 95% CROM; |
| | | 35% PROM | 55% PROM |
| **CQUIN17** | **Reducing the need for restrictive practice in adult/older adult settings** | 75% | 90% |

**Appendix 1**

# Statistical Process Control Chart (SPC) Guidance

Example SPC chart:



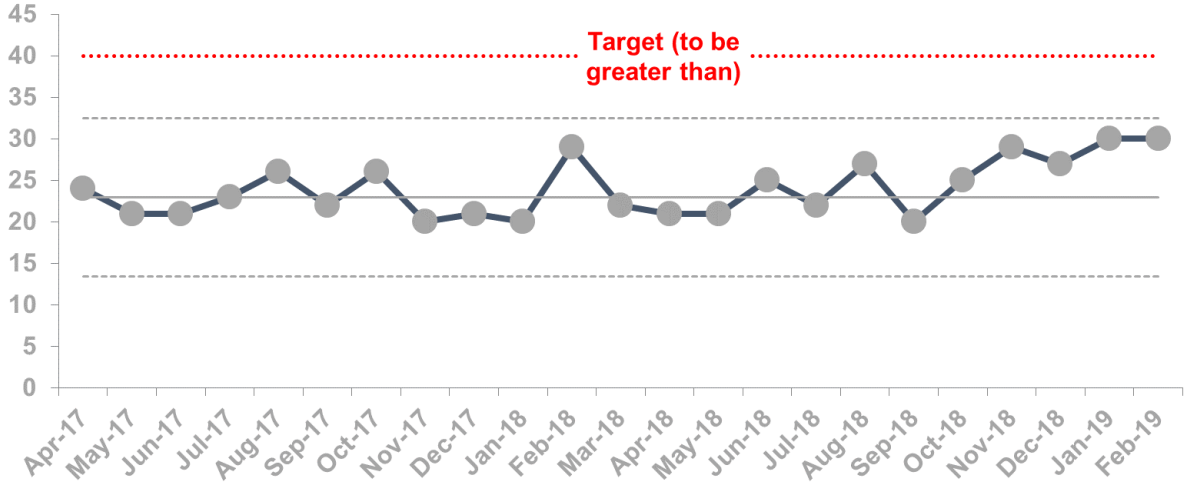

- The red line is the target.
- The grey dots are the actual performance each month. They are coloured grey as performance each month is normal in this example.
- The solid grey line is the average (mean) of all the grey dots.
- The grey dotted lines are called process limits, or control limits.

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

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

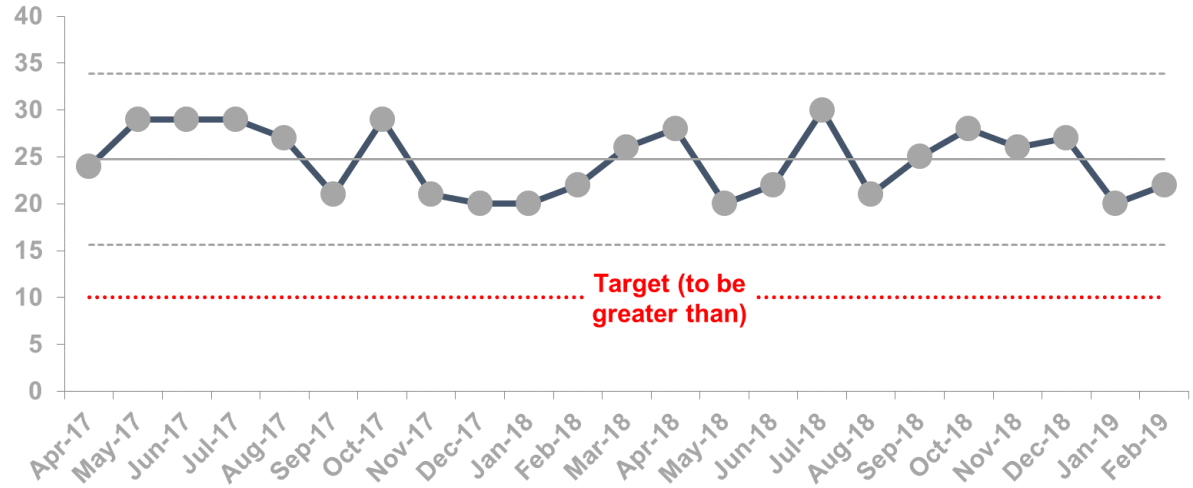
**Things to look out for:**

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



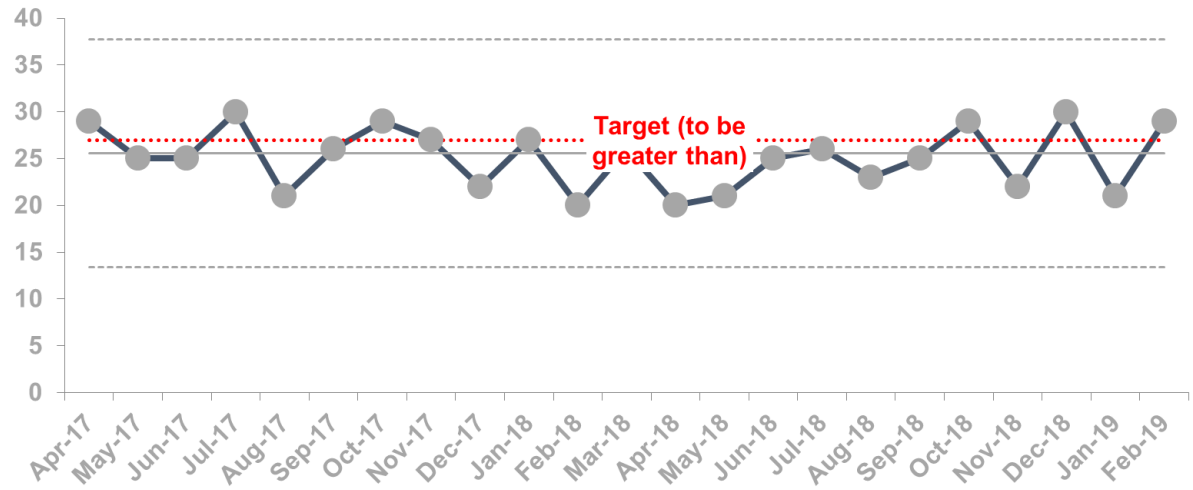
In this example the target is higher than the upper dotted grey line. This means that the target will never be achieved. To achieve the target, we need to change how we do things.

### 2. A capable process




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

### 3. An unreliable system




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

## 4. Unusual patterns in the data

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

There are four scenarios where this can happen:

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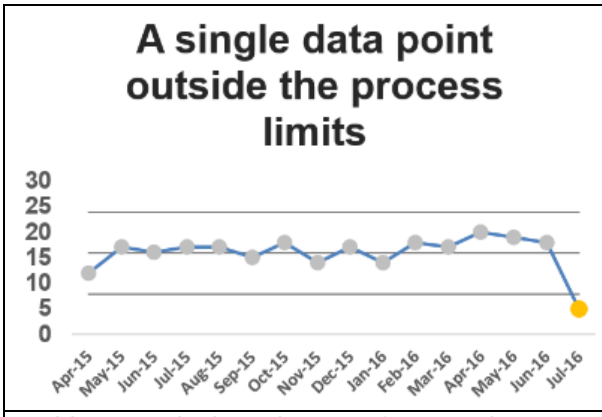
<td> 
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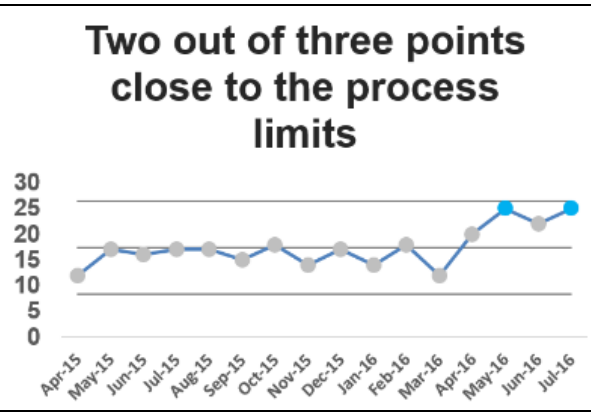
<td> 
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<tr>
<td>In this example the July 16 perfomance is significantly lower than expected and falls beneath the lower grey dotted line.</td>
<td>2 out of 3 points close to one of the grey dotted lines is statistically significant, in this case they are blue, indicating better than expected performance.</td>
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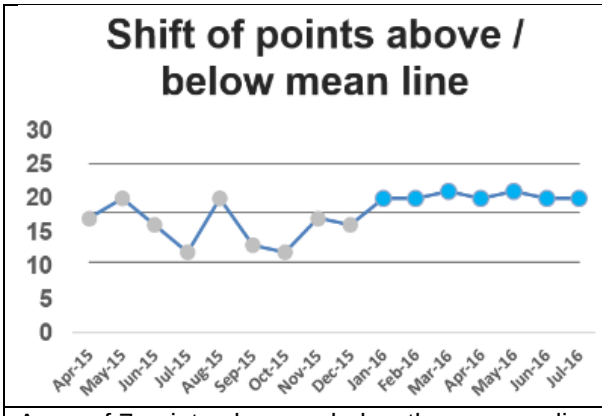
<td> 
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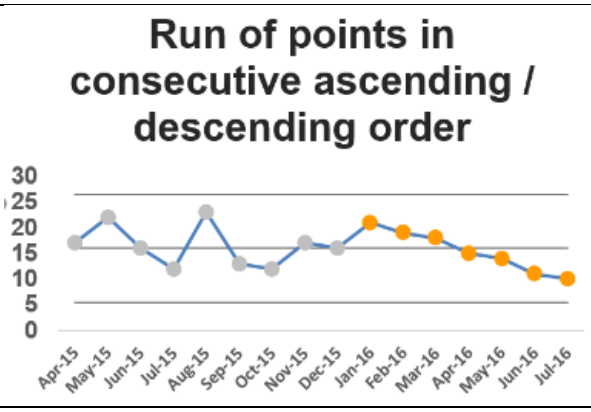
<td> 
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<td>A run of 7 points above or below the average line is significant. In this example it might indicate that an improvement was made to the process in Jan 16 that has proven to be effective.</td>
<td>A run of 7 points in consecutive ascending or descending order is significant. In this example things are getting worse over time.</td>
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(Adapted from guidance kindly provided by Karen Hayllar, NHS England & NHS Improvement)

**Derbyshire Healthcare NHS Foundation Trust**
Report to the Board of Directors – 7 March 2023

# Quality Improvement (QI) – A Stocktake

## Purpose of Report

Update on progress in implementing the QI Strategy 2021-2024 with particular reference to the QI capability building programme and its impact.

## Executive Summary

At the launch of the QI strategy at the end of 2021, there were around a dozen staff identified as having recognised improvement methodology training in the trust. As of February 2023, there are no fewer than 373. These are colleagues trained across one of a number of levels of either AQuA or Quality, service improvement and redesign (QSIR), from basic through to advanced.

As part of the development of the AQuA QI training programme, Trust executives and many senior leader colleagues have reflected on our QI culture with a view to reinforcing commitment to improvement as we continue to build our QI capability.

For the next phase of training in 2023, focus is on areas where there are skills deficits or where there is improvement work happening or scheduled which will benefit from targeted training.

An ongoing survey of colleagues who have undergone QI training in the previous two to three months shows 76% have used their training on an improvement idea in the three months since training, 94% intend to use their training on an improvement idea in the next three months, and 71% report a positive experience in relation to support from colleagues.

The Trust's QI platform for working on ideas (LifeQI) is seeing increased use from QI trained colleagues with 59 of 373 staff accessing the system and 31 of those 59 attached to improvement initiatives. We expect these numbers to continue increasing and will continue to support uptake and use.

As part of the evaluation of QI we are also looking at impact through the experience and outcomes for patients. Ahead of this report and on the same agenda, a patient story relating to a QI initiative of green social prescribing was presented. This quality improvement initiative was progressed through a QI methodology by QI trained colleagues using trust QI infrastructure.

We are continuing to develop QI infrastructure which supports the generation and progression of ideas. The Trust intranet space has areas for advice and guidance, templates and tools and a host of things relating to QI.

Progressing delivery of the QI strategy has strengthened our QI capability and has increased opportunities for staff to put QI skills to use in delivering the trust strategic objectives of providing great care, being a great place to work, making the best use of resources and being a great system partner. They help live the values of the organisation; that we achieve things aligned to our aims through our people and that make a positive difference to the people of Derbyshire.

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

**Risks and Assurances**

Aligns with and seeks to deliver against the trust's strategic aims.

**Consultation**

- High level aims have been outlined in the QI strategy and more detailed plans have been discussed at ELT and TOOL
- Estimated capacity demands, time commitments and associated plans have been discussed with relevant operational managers and deputy directors
- Financial figures in the report have been verified and/or provided by Finance.

**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:

- None.

**Recommendations**

The Board of Directors is requested to:

1) Note the content of the report and the progress of activities to date in delivery of the 2021-2024 Quality Improvement Strategy

2) Support existing and newly identified activities relating to delivery of remaining objectives within the current QI strategy and the development of the next iteration from 2024.

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

**Report prepared by:** **Joe Wileman**
**Head of Programme Delivery**

**Quality Improvement (QI) Strategy Intent**

The latest QI strategy agreed in November 2021 (2021-2024) set out the ambition to create the right conditions for staff and teams to feel empowered to develop and improve the services they provide. Integral to this were core principles focusing on:

- developing a culture where ideas can come from anyone in any role
- having systems in place that facilitate and support idea development
- training in QI methodology and ongoing support and coaching
- communicating, sharing QI stories and growing a QI network
- nurturing a shared commitment to a model of continuous improvement at all levels

Delivery of the QI strategy strengthens our QI capability and increase the opportunities to put those skills to use in delivering the trust strategic objectives of providing great care, being a great place to work, making the best use of resources and being a great system partner.

**Implementation**

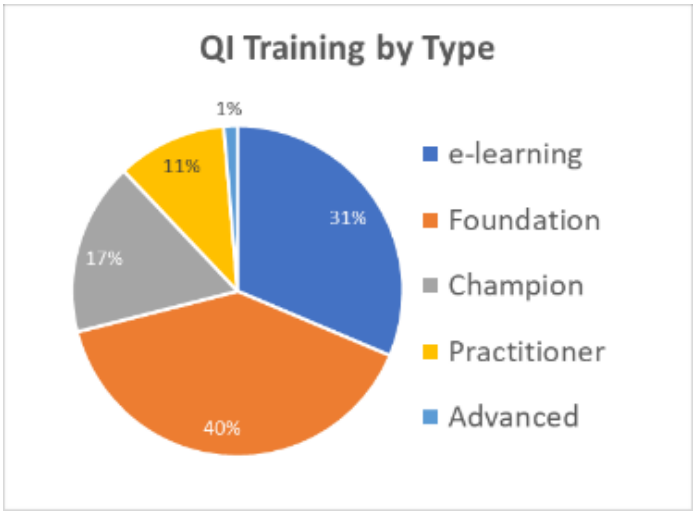
A corresponding QI strategy implementation plan identified 14 actions of which 11 have been completed relating to building QI capability through training / procuring training capacity, building intranet space and functionality, quality awards, programme management office, building on learning, re-engineering transformation function, creating improvement opportunities and joint working with JUCD partners on QI initiatives. The remaining 3 actions are part completed and on track relating to development of a QI platform (LifeQI running and growing in use and content), building QI into roles and determining extend of mandatory or role specific training, and evaluating the effectiveness of the QI strategy and implementation. The following sections are evidence of progress.

<u>Training programme</u>

At the launch of the QI strategy there were around a dozen staff identified as having recognised improvement methodology training. Over the last 15 months and as of February 2023, there are no fewer than 373. These are colleagues trained across one of a number of levels of either AQuA (Advanced Quality Alliance) or QSIR (Quality Service Improvement and Redesign).

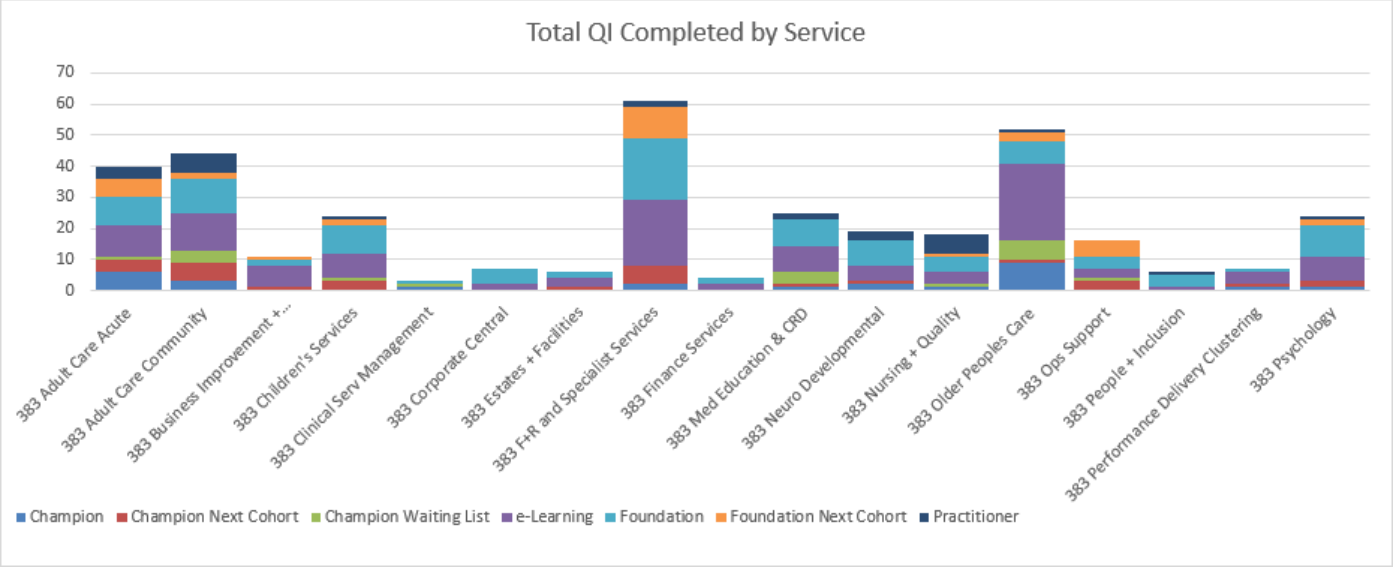
Total staff trained in a QI methodology since QI strategy launch = 373

| Training Methodology | E-learning | Foundation (1 day) | Champion (2 day) | Practitioner (5 day) | Adv / Assoc (assmt) |
|---|---|---|---|---|---|
| AQuA | 117 | 148 | 63 | 27 | 3 |
| QSIR | - | 0 | - | 13 | 2 |



The training plan for 2023-2024 is currently in development and awaiting funding commitment. It will be designed to target areas where there are skills deficits or where there is particular improvement work happening or scheduled which will benefit from targeted training. In addition, it will consider levels of training by role and identify which roles for which it may be recommended or mandated. Currently the e-learning offer is available to all staff with access to ESR but this may be complemented in the year ahead with a taught session.

The following graph shows numbers of staff trained by service area.




** Note this bar chart shows total numbers so smaller teams will have fewer staff to train*

Executive board / senior leader development

As part of the development of the AQuA training programme, trust executive and senior leader colleagues have reflected on our QI culture with a view to reinforcing commitment to improvement as we continue to build our QI capability. In doing this it has explored processes for QI that will be further developed that will work within team Derbyshire Healthcare principles to make it part of our fabric, integral to everyday business, built from the ground up with permission and empowerment.

Putting the QI training to use – post training survey

A recently commenced and ongoing survey is in place engaging with colleagues who have undergone QI training in the previous two to three months, to seek the extent to which they have applied the learning or intend to in the coming months. Findings from the surveys to date show:

76% have used their training on an improvement work in the 3 months since training
94% intend to use their training on an improvement idea in the next 3 months
71% report a positive experience in relation to support from their colleagues, team and organisation with most other responses neutral.

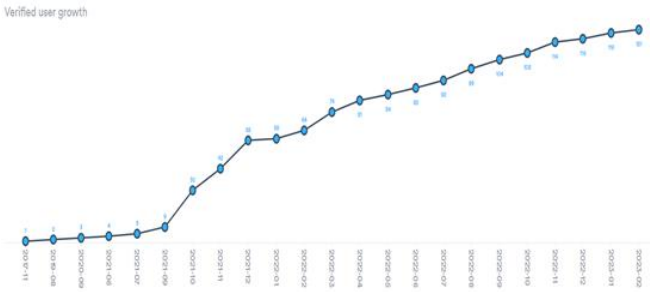
These are encouraging early results in line with expectation, and we will continue to monitor and report progress.

LifeQI

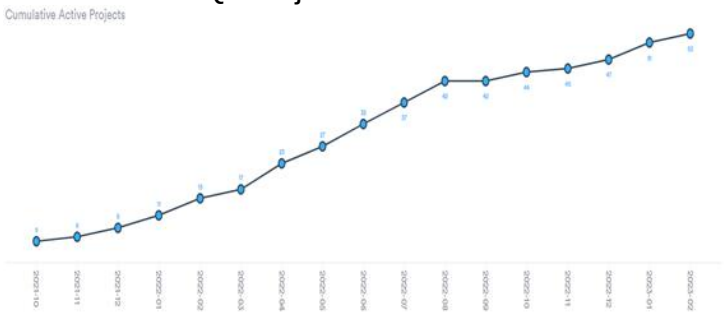
LifeQI is the trust platform for working on and sharing trust improvement ideas and represents a key component of the QI infrastructure. It follows that the more people trained means more QI initiatives, which in turn means greater use of the LifeQI platform.

- There are 121 registered trust users of the LifeQI system
- There are 53 live initiatives on the LifeQI system
- Within these initiatives there are 71 listed benefits aligned to trust strategic objectives
- Of the 373 staff now QI trained, 59 access the LifeQI platform
- Of the 59 QI trained staff accessing the platform, 31 are attached to improvement initiatives

Growth in LifeQI Users




Growth in LifeQI Projects

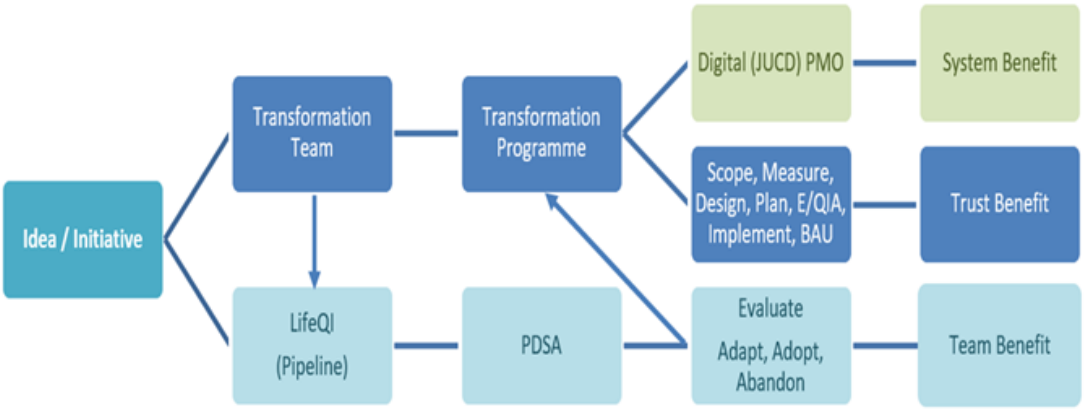



It should be noted that use of LifeQI is an indication only as we know many improvement initiatives of low complexity and risk are 'got on with' at a local level requiring little support, and it is not the intention of any associated QI infrastructure to be unduly burdensome or inhibit idea progression. To be better sighted on some of this to inform and share learning from improvement work, we will further refine processes to ensure a simple no/light touch pathway for these ideas.

ePMO

Another platform for initiatives is the ePMO (electronic Programme Management Office). This has similarities to LifeQI in that it is a repository for improvement work but goes further to incorporate governance tools and processes, recognising that most of the content is transformational, has system interdependencies and typically has financial value benefit. It is the space where trust and system level transformation and cost improvement programmes are managed and reported on. In the 2022-2023 transformation programme, there are 31 initiatives aligned to 8 programmes of which 23 contribute £6,015,662 to the trust cost improvement plan.

The ePMO in itself is not a product of the QI strategy but represents a pre-existing stage of the quality improvement continuum where initiatives that have significant financial value, resource demands, complexity or risk 'graduate' to the transformation programme and ePMO for greater governance controls.




This is shown in the diagram above which plots the path initiatives might typically take and the relationship between stages. Pipeline or local initiatives which are tested and developed may have scale or spread opportunities and graduate to the transformation programme. In turn these may

graduate to the Derbyshire system space where there are significant system benefits or interdependencies.

Intranet space – submitting ideas – stories and learning – QI directory

QI infrastructure supports the generation, development and progression of ideas. The trust intranet space has areas for advice and guidance, templates and tools and a host of things relating to QI.


A recent addition has been the introduction of a 'niggles page' (named by the people whose idea it was) which is a place for colleagues to post things they are struggling with and haven't managed to resolve. In the first month to the end of January 2023 we had 10 submitted niggles of which 9 are being resolved by colleagues who are now QI trained or being supported by their QI trained peers. We have scheduled evaluation to better understand where niggles are coming from and why they are not resolved at an earlier stage.

**Impact**

In considering the impact of the QI strategy we are looking at the 'so what'; to what extent is the QI capability building and development of associated infrastructure having a positive effect.

In addition to the 53 initiatives on LifeQI and 31 projects in the ePMO aligned to a range of ideas to improve patient care, the way in which we work and the use of resources, there are schemes underway and in development supported by QI methodology through trained staff that will have quality and efficiency impact in 2023-2024.

| **Quality driven** | **Use of resources / efficiency driven** |
|---|---|
| Community MH framework and LW system programme | e-job planning |
| Adult mental health urgent care system programme | Video consultation optimisation |
| Neurodevelopmental system programme | Video consultation on MS Teams/AirMid |
| Dementia and Delirium system programme | Voice recognition |
| CRHT caseload management | Delivering to constitutional standards |
| Diversifying skill mix | Use of patient app |
| Medication collection | Focus on productivity and unwarranted variation |
| Rehab project | Books, journals, subscriptions optimised process |
| MAS model | Postage cost reduction |
| Care homes model | Paid breaks and e-rostering |
| Day hospital | Use of agency staff |
| Perinatal | Estates utilisation through room booking app |
| Clean Air Project | |
| Lift Share | |
| No caller ID | |
| Waiting time visibility | |

Bringing this to life, the patient story you heard at the beginning of Trust Board about a patient in our rehabilitation service and the wild gardening initiative was rooted in QI and delivered and supported by QI trained staff using the tools and platforms discussed in this report. That QI initiative, along with the others progressed this year and the ones in planning and scoping for 2023-2024 live the values of the organisation; that we achieve things aligned to our aims through our people that make a positive difference to the people of Derbyshire.

QI Aspects of the patient story

Green social prescribing is the practice of supporting people to engage in nature-based activities to support their health and wellbeing. It can include activities such as walking, cycling, community gardening and food-growing projects, as well as practical conservation tasks such as tree planting. Green prescribing for example would include prescribing appropriate physical activity to people living with long-term conditions to help manage their conditions better and improve their mental well-being.

GreenSPring is a particular green social prescribing initiative and is one of seven government funded 'Test and Learn' pilot areas tasked with investigating 'preventing and tackling mental ill health through green social prescribing', and it has enabled system partners to come together to explore this aim. Derbyshire Healthcare along with system partners has been involved in 3 test projects and the one you heard about today in the patient story was the Wild Gardening Group at Cherry Tree Close (the others were Active Confidence, and Personal Health Budget scheme to financially support people to access green health activities)

The project focused on improving the health and care system to improve access to green space and sustainable provision of 'green health' activities for residents of Derbyshire. There is a wealth of peer-reviewed data demonstrating the benefits of nature-based wellbeing activity for mental health (both maintenance and recovery), achieving improved mental health outcomes, reduced health inequalities, reduced demand on the health and social care system and reduced isolation and loneliness.

Evaluation / Identified Benefits

All three projects including the wild gardening group progressed following a QI methodology supported by recent QI training and input from the improvement and transformation team. There are a number of observed qualitative and quantitative benefits from the pilot project:

- Positive feedback from participants who report improved mental wellbeing (note patient story)
- Co-produced care and treatment plans
- Meaningful activity during inpatient stay
- Collaborative working and relationship building
- New interests, skills and new opportunities
- Improved purpose and self-esteem
- Discharge plan opportunities and links to community groups providing support closer to home

In addition, working relationships with system partners has been established or further developed. Amongst these partners are Natural England, Derbyshire Wildlife Trust, Grow Outdoors CIC, Derbyshire Community Health Services, Derbyshire Public Health, Active Derbyshire, and many other local community partners who have joined as part of a Green Provider network collaborative.

As part of the QI framework and exploring potential scale and spread and adaptation, we have looked to learn and share with other projects seeking similar aims. With varying success, we developed buddying schemes together with Rethink and then CVS in Amber Valley to identify peer volunteers and service users open to our community teams and who had an interest in green health activities; we know anecdotally that when support to attend a group is withdrawn, a person may not sustain their own attendance and buddying may encourage continued participation. Despite several adaptations, switching organisations, and different forms of advertising we have yet to implement a sustainable solution and recognise that a (national) lack of peer volunteers may be a limiting factor at this time. With time and capacity when available, and through further improvement cycles we will continue to identify innovative ways of tapping into and increasing this capacity.

The cost of the pilot project was £4,400 which was funded through the GreenSPring pilot scheme. There is no recurrent funding available currently to run further supported cycles as Green Spring is a time-limited government initiative which ceases to exist beyond March 2023.

In the funded period however, it has evidenced the potential benefits of sustainable investment into community resources to truly embed a new way of working collaboratively with our community partners.

The team will continue to explore opportunities for:

- Commitment and investment to develop a programme of collaborative working between green providers and our forensic and rehab units (Kedleston Unit are also very interested in running a similar project).

- System working in the provider collaboratives which would make available community resources for the people of Derbyshire to access, both from our inpatient units and in the community. The Community Mental Health Framework emphasises the need for people to be involved and stay well in their local communities however, many smaller community providers are vulnerable to funding shortfalls and joined up system working is key to a cohesive community offer.

Beyond this pilot we want to ensure that people have access to this support for years to come. We are working to define the system change needed to embed green social prescribing in the pathway and in communities to realise the potential of green social prescribing in the long-term.

**Next steps for QI strategy**

There were 14 identified actions associated with delivering the QI Strategy. 11 of these are complete and the remaining ones are on schedule, these are:

- Increase users and activity on LifeQI to next phase of 200 licenses and 100+ initiatives.
- Greater lived experience and patient involvement in QI initiatives. There is much evidence of this but there is work to do to better understand the amount and type of activity to assure ourselves of significant and effective engagement.
- Build QI into appropriate job descriptions and roles and align training requirements.

In addition to the original QI strategy delivery actions there are:

- Continue to build QI capability and roll out targeted plan for 2023-2024.
- Align planning processes (including RAP and CIP), QI/transformation and Performance for improved reporting and management of interdependent aims.
- Continue Board development in shaping and furthering QI culture.
- Develop QI engagement and communication within the trust exploring new channels and interactions.
- Continue the work which has started at system level to develop the Derbyshire improvement education offer. This will align with the NHSE QSIR programme and increase capacity of QSIR Associates working with the QSIR College.
- Evaluate the effectiveness of the current QI strategy to inform the next iteration due 2024.

**Report by Joe Wileman**
**Head of Programme Delivery**

**Derbyshire Healthcare NHS Foundation Trust**
Report to the Board of Directors – 7 March 2023

# Quality Position Statement - Effectiveness

## Purpose of Report

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

## Executive Summary

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

This paper is an updated review from 2021, as well as a quality position statement on effectiveness and this paper is an analysis from a helicopter view of effectiveness of our services through a clinical lens, as well as considering the Effectiveness domain:

> *Effective. - By effective, CQC Health regulator we mean that people's care, treatment and support achieve good outcomes, promotes a good quality of life and is based on the best available evidence.*

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

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

The report also uses known clinical evidence of effectiveness, as outlined as issues and learning published in 2022 by The National Confidential Inquiry and into Suicide and Safety in Mental Health.

It provides an update on the improvement work around reducing restrictive practice and improving sexual safety.

| 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. | |
| 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**

This report is offered with assurances around contained data and metrics of national benchmarking.

**Consultation**

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

**Governance or Legal Issues**

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

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

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

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

- This is a Trust wide helicopter view of effectiveness and impact through a clinical lens. The over-arching findings are a positive view of quality and effectiveness.

- There is a continued risk to people in our care in sexual safety, which as an organisation we have prioritised as a quality priority to mitigate. There is an adverse impact for women who use our services. We have improvement plans to mitigate these risks.
- There is a continued risk to people in our care in reducing in-patient and community suicide. Men are over-represented in this group.
- There is a continued risk that individuals, who are treated out of their area have worse clinical outcomes than those people in our care who are treated locally or with continuity of care principles in a close-proximity service. The Trust has mitigated this significantly and there is clear evidence of significant improvement.
- The quality position report is an assurance overview of the evidence and service provision rather than an executive action and mitigation report.

**Recommendations**

The Board of Directors is requested to:

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

**Report presented by:** **Tumi Banda**
**Interim Director of Nursing and Patient Experience**

**Report prepared by:** **Vicki Baxendale**
**Deputy Director of Regulated Practice & Special Projects**

# Quality Position Statement - Effectiveness

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

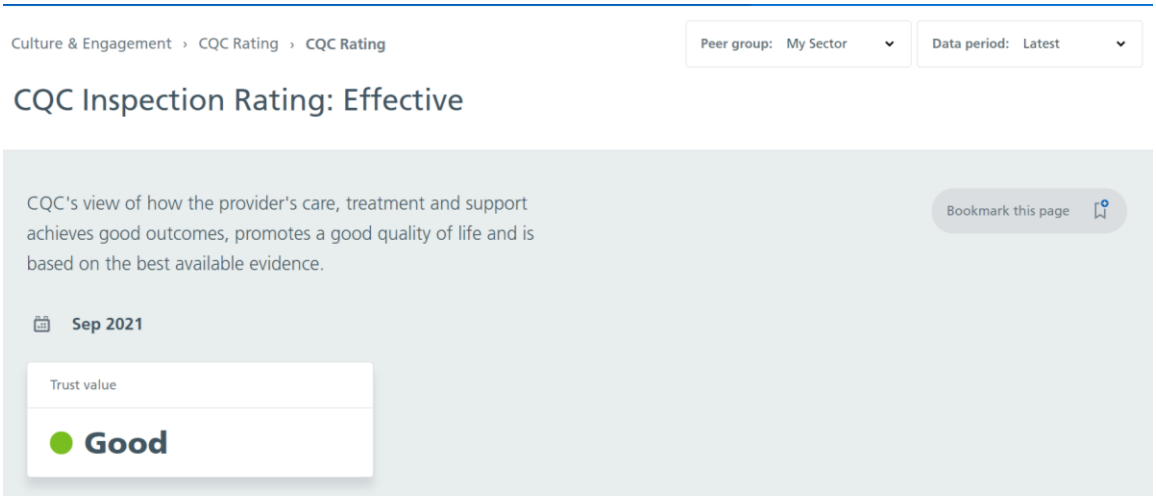
This paper is a review and a quality position statement on effectiveness and this paper is an analysis from a helicopter view of effectivenss of our services through a clinical lens.

It is by its nature a highlight report, this is an update on the report presented 2021.

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

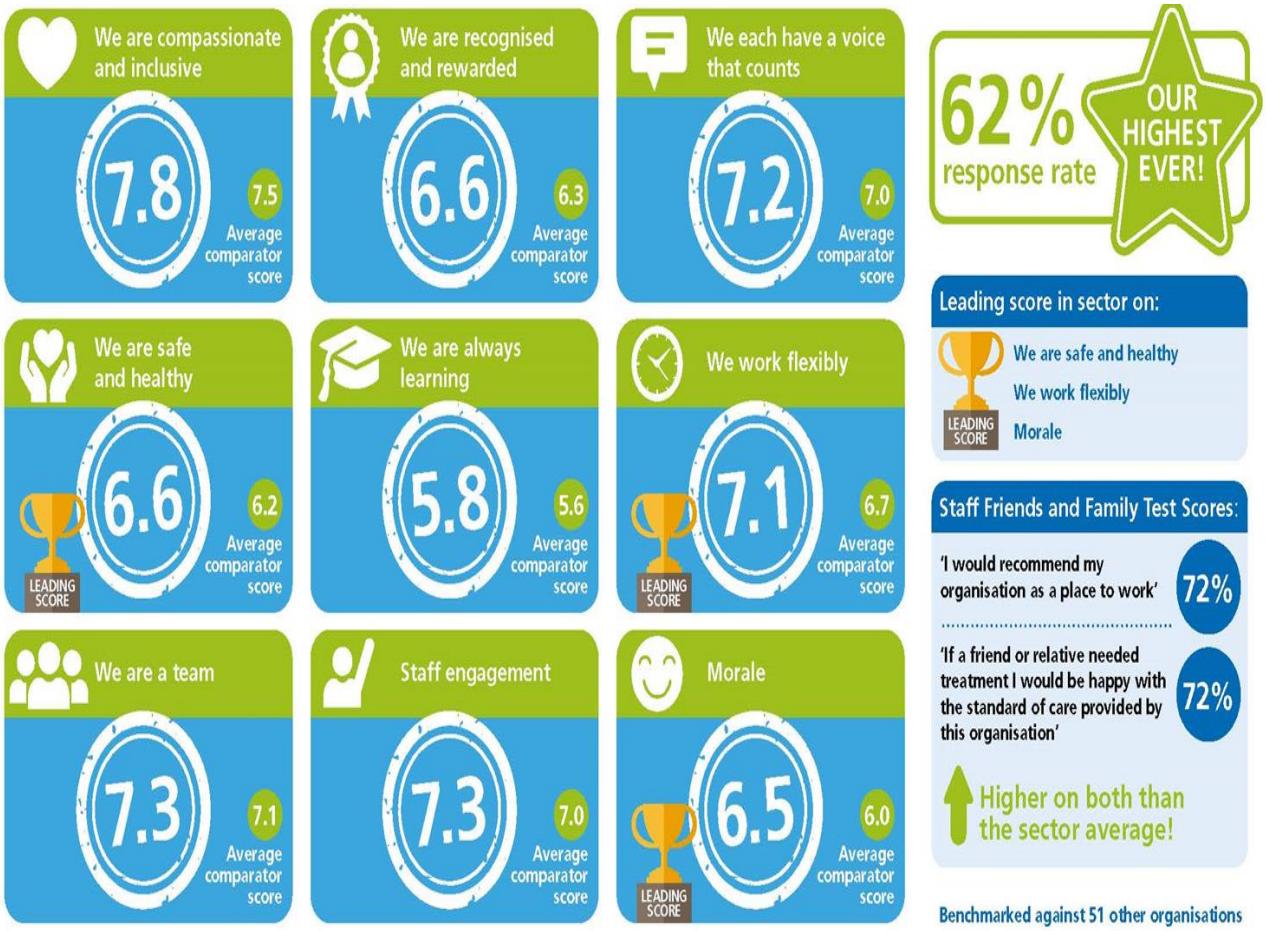
The report also uses known clinical evidence of effectiveness as outlined as issues and learning published in 2021 by The National Confidential Inquiry and into Suicide and Safety in Mental Health.

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




The Trust strategy has been clear for several years, it is to improve the lived experience for staff who work in our services and by doing so have improved outcomes for patient care. There is a wealth of evidence in leadership literature that supports the premise of staff that feel well looked after by their organisation will perform better.

The table below demonstrates the trust performance in the Staff Survey that was conducted end of 2021. (2022 results are not available yet in time for this report)




This indicates that our colleagues within the Trust are feeling well supported and would not only recommend the Trust as a place to work but would also be happy for friends and relatives to be cared for by the Trust.

The results are consistently high when compared to the average scores across similar organisations, it is also notable that it was the highest ever response rate for the Trust; consistently high results and an increased response indicate a motivated workforce.

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

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

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

However, what we can be clear about is that the People First policy is having positive impacts upon staff motivation.

This is further supported by a signficantly low vacancy rate of 4.77%, our regional neighbours range between 11.2% and 17.3%.

The staff survey is made up of staff feedback measures of perceived levels of quality of care. This is a good indicator, however, must be viewed with activity data.

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

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

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


**DHCFT contribution to reducing suicide**

The Trust contributes to suicide prevention working closely with Public Health and through the Trust's leads.

**Effectiveness of planning and response - Follow Up Post Discharge**

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

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

**NHS Mental Health Benchmarking**

| MH - DHCFT | Mean | Median |
|---|---|---|
| 90% | 83% | 85% |

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

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

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

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

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

**Effectiveness in child and adolescent mental health services (CAMHS)**

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

**Key findings in brief**

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

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

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

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

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

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

Below data is from National Benchmarking Network November 2022

Benchmarking Network

**Community**

| | CAM115 | Mean | Median | National trend |
|---|---|---|---|---|
| Total CYPMHS: referrals received per 100,000 population (0-18) | 2,245 | 4,869 | 4,457 | |
| Total CYPMHS: referrals accepted per 100,000 population (0-18) | 2,239 | 3,759 | 3,559 | |
| Total CYPMHS: referral acceptance rate | 100% | 77% | 76% | |
| Total CYPMHS: referrals signposted per 100,000 population (0-18) | ... | 721 | 546 | Data not available |
| Total CYPMHS: referrals declined per 100,000 population (0-18) | ... | 578 | 413 | Data not available |
| Total CYPMHS: proportion of referrals that were re-referrals | 10% | 13% | 11% | |
| Total CYPMHS: proportion of referrals received marked urgent / emergency | 27% | 13% | 11% | |

**Effectiveness in Children's services**

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

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

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

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

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

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

February 2023

Children In Care Health Assessment compliance

| | |
|---|---|
| Children Under 5 | 85.9% |
| Children 5 and over | 78.5 |

This report summarises letter requests for the LLRL13 SEND Return

| Letter Requests/Number of Plans | Apr-22 | May-22 | Jun-22 | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | Jan-23 | Feb-23 | Mar-23 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Letter1 | 30 | 49 | 53 | 46 | 20 | 35 | 42 | 50 | 41 | 39 | 42 | |
| Letter2 | 91 | 92 | 74 | 96 | 90 | 71 | 97 | 70 | 126 | 132 | 76 | |
| EHCP Draft | 34 | 18 | 27 | 38 | 28 | 29 | 17 | 30 | 32 | 35 | 24 | |
| EHCP | 63 | 42 | 28 | 45 | 41 | 51 | 63 | 54 | 41 | 29 | 38 | |

| Response Times (by Month of Response) for Children Open in Reporting Year | Apr-22 | May-22 | Jun-22 | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | Jan-23 | Feb-23 | Mar-23 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| No. Letter 2 Responses with Preceding Letter 2 | 87 | 94 | 89 | 85 | 81 | 61 | 115 | 84 | 98 | 103 | 122 | |
| No. Letter 2 Responses within 42 Days | 87 | 94 | 89 | 85 | 81 | 61 | 115 | 84 | 98 | 103 | 122 | |
| Letter 2 % | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | |
| No. Letter 2s where Response Date Deadline Falls in Month (42 days after Letter 2 Request) | 59 | 112 | 94 | 76 | 81 | 83 | 87 | 94 | 69 | 130 | 118 | |
| No. Letter 2s Due where Response Recorded and Within 42 Days | 59 | 112 | 94 | 76 | 81 | 83 | 87 | 94 | 69 | 130 | 118 | |
| % Letter 2s Due where Response Recorded and Within 42 Days | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | |

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

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

Why this is important?

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

**Children's service – 0-19**

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

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

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

**Effectiveness in Substance misuse services**

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

1. The services have been stretched, but we have been able to secure Significant PHE Covid funding for 21/22. This has been allocated to both the city and county substance misuse services to maintain effectiveness.
2. County (DRP) – Funding will be allocated to a team of 10 staff in the county focussed on targeted criminal justice interventions, in line with changes in our community.
3. City (Derby Drug and Alcohol Service) have been allocated investment to improve accessibility to Alcohol Services including developing a new website and a promotional strategy within Derby City. Additionally, we will also be funding a Buvidal (Buprenorphine depot injection) pilot for a small number of patients, with known improvement in effectiveness.
4. Stability in service with the formal confirmation of City Contract extension until 2023 and County contract extension until 2024.

**Aiming for no out-of-area admissions**

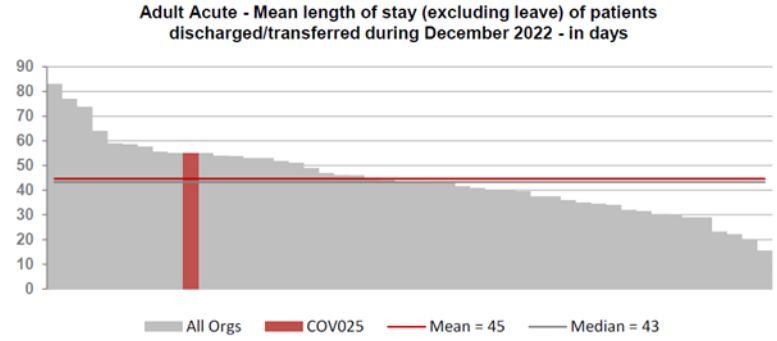
Very ill patients should be accommodated in a local inpatient unit. Being admitted locally means that patients stay close to home and the support of their friends and family and are less likely to feel isolated or to experience delayed recovery. Local admission should also result in simpler discharge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

Although DHCFT does have some people admitted out of the local area this is a low number against the national average. Data from NHS Digital for December 2021-November 2022 indicates we had 3 placements per day out of area for the year with a national range of 0-63 placements per day.

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

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

National benchmarking indicates in December 2022 that our average length of stay in Adult Acute has increased since before the Covid19 pandemic.




| | 2019/20 | December | Change |
|---|---|---|---|
| National average | 34.7 | 44.6 | 29% |
| COV025 | 33.5 | 55.0 | 64% |

**24-hour crisis resolution/home treatment teams**

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

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

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

**Achieved and maintained in Derbyshire Healthcare in 2022** – supplemented by the 24 hour Crisis line

**Family involvement in 'learning lessons'**

Working more closely with families could improve suicide prevention. Services should consult with families from first contact, throughout the care pathway and when preparing plans for hospital discharge and crisis plans. Staff should also make it easier for families to

pass on concerns about suicide risk and be prepared to share their own concerns. This could help to ensure there is a better understanding of the patient's history and what is important to them in terms of their recovery and may support better compliance with treatment. There should be a multi-disciplinary review following all suicide deaths, involving input from and sharing information with families.

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

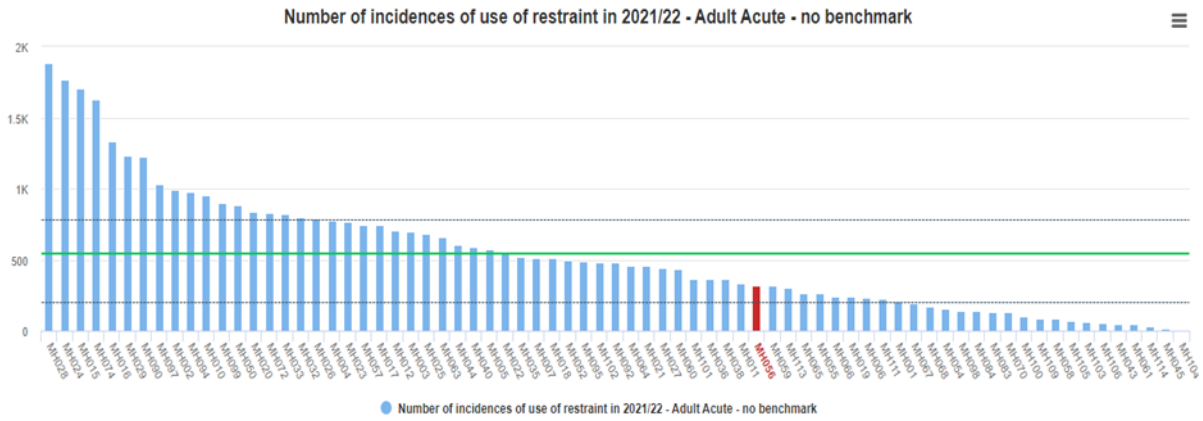
In the event of a service user dying whilst under our care we have a robust incident review process that offers the involvement of families to aid learning. The Family Liaison Team initiates contact with the family to offer either family support and to ascertain if the family would like to engage in the review or feedback on the outcome, dependent on family wishes.

**Achieved and maintained in Derbyshire Healthcare in 2022**- we work towards our Triangle of care standards in 2022/23 and we maintain our Family liaison services and family involvement in learning. We have a number of engagement processes for families both on an individual basis and a strategic basis, families and carers are offered support and signposting as per Triangle of Care Standards, there are family groups held in both inpatient units, family therapy is offered within inpatient services to support greater communication and understanding within families. The Trust also has the Carer Engagement Group, Equal and carer representation on the Patient and Carer Experience Committee.

**Safer wards**

Following NCISH recommendations, suicide using non-collapsible ligature points became an NHS 'never event' (a serious incident that is preventable) in 2009. This means that health services are required to monitor their incidence and are provided with advice to reduce the risk. Since then suicide by mental health in-patients continues to fall; there were 74 suicides by in-patients in the UK (excluding Northern Ireland) in 2018. Between 2008 and 2018, around a third of in-patient suicides took place on the ward. Many of these deaths were by hanging/strangulation from low-lying ligature points. In our study of clinicians' views of good quality practice in mental healthcare, clinicians emphasised practices that improved safety in a ward environment such as observations conducted by trained staff.

To further support safer wards we have adopted a trauma informed approach to care, we view the use of restraint as a last resort. We have robust oversight of any restrictive practice ranging from blanket restrictions to seclusion. National Benchmarking data indicates our incidents of restraint are low in comparison to other trusts.




Over the past 12 months the Use of Force Act (2018) statutory guidance came into effect in March 2022; a gap analysis was undertaken and the related restrictive practice policies have been updated to reflect the new guidelines.

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

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

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

As of 31st December 2022 our turnover rate is 12.57%, our regional neighbours range from 8.7% to 15.24%

**Clinical effectiveness of Learning Disability services**

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

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

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

The CQC looked at:

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

4. How digital technology has supported or prevented services from being able to provide people with the care and support they need.

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

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

**Achieved and maintained in Derbyshire Healthcare in 2022**- Derbyshire Healthcare services did not have any trust specific actions

**Effectiveness in Older People's care**

| **Data December 2022** | **DHCFT** | **National average** |
|---|---|---|
| Older adult admissions per 100,000 resident population | 11.4 | 10.8 |
| Older adult mean length of stay (excluding leave) | 50.99 | 78.45 |
| Number of Readmissions within 30 days for 2021/22 | 8 | 10.9 |
| Older adult readmissions | 3% | 5% |

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

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

**Sexual safety inpatient wards- what do we know?**

Foley and Cummings (2018)

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

All of this evidence and understanding will and has been used to informed our future clinical models and will be developed further to inform our metrics for the future to measure how we use the evidence and measure the impact.
Our sexual safety policy is being updated to ensure that we

- Support staff in responding to sexual safety incidents and to ensure that sexual safety is promoted across the DHCFT footprint.

- Raise awareness to the issues related to sexual safety, sexuality and sexual health and promote sexual wellbeing and ensure those who lack mental capacity are protected
- Raise awareness of the professional boundaries between staff and patients are and ensure supported to recognise and take appropriate action when there has been or where there is the potential to breach such boundaries.
- Promote discussions in teams about achieving sexual safety and that all concerns relating to sexual incidents are listened to and actioned timely and appropriately
- Ensure that where an incident sexual abuse has occurred, immediate steps are taken to safeguard the individual including relevant referrals to the Local Authority, police and a Datix is completed
- To provide a safe environment for every person using and working in our services.
- To ensure all persons, i.e., staff, patients and visitors who may be subject of a sexual incident are supported.

A video has been developed and circulated across the trust discussing the need to maintain therapeutic boundaries and what to do if staff feel they are becoming blurred.
Using a trauma informed approach, we acknowledge peoples experience of trauma and how this may continue to affect them.

**Effectiveness in 2021/22/23**

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

**Develop gender sensitive services and indicators in 2022/23 +**

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

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

**How and Why – the future?**

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

**Overall summary**

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

There has not been a deterioration in our current practices.

We do have more areas to continue to improve.

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

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

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

1. Specialist alcohol and drug services are available, with a protocol for the joint working with mental health services (including shared care pathways, referral and staff training).
2. There is a specific management protocol or written policy on the agreed

3. Protocols for managing self-harm patients who are under mental health care should highlight the short-term risk of suicide, especially where there is coexisting alcohol and drug misuse.

4. There is specific training in place for staff on substance misuse assessment.

5. There are specialist substance misuse clinicians within mental health services. This is an area of further exploration and development in acute mental health service pathways.

**Notable Highlight 2022**

In 2022 it was confirmed by NHS England that DHCFT would be the Lead provider for the East Midlands Perinatal Inpatient Collaborative. This is supported by the Long Term Plan of care closer to home and more locally commissioned services. The Collaborative mean that all Mental Health providers in the East Midlands will be working together in partnership to provide and improve inpatient Perinatal Mental Health care. There is a strong Expert by Experience group embedded at all levels of the collaborative ensuring that clinically led decisions around service models are the most appropriate for our service users.

It is exciting and positive to see the Trusts services flourishing over 2021/22.

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

**Derbyshire Healthcare NHS Foundation Trust**
Report to the Board of Directors – 7 March 2023

## Learning from Deaths - Mortality Report

**Purpose of Report**

The 'National Guidance on Learning from Deaths' requires each Trust to collect and publish specified information on a quarterly basis. This report covers the period 1 October to 31 December 2022.

**Executive Summary**

- All deaths directly relating to Covid-19 are reviewed through the Learning from Deaths procedure unless they meet an additional Incident red flag in which case they are reviewed under the Incident Reporting and Investigation Policy and Procedure. From 1 October to 31 December 2022 there has been zero deaths reported where the patient tested positive for Covid-19.
- The Trust received 643 death notifications of patients who had been in contact with our service within the 6 months prior to their death. There is little variation between male and female deaths; 309 male deaths were reported compared to 334 females.
- No Inpatient deaths were recorded.
- The Mortality Review Group reviewed 12 deaths through a Stage 2 Royal College of Psychiatrists Care Review Tool. These reviews were undertaken by a multi-disciplinary team, of the 12 deaths reviewed none were due to problems in care. There has been a total of 24 meetings scheduled for the period, 12 of these were attended, 12 sessions were not able to proceed due issues affecting attendance.
- The Trust has reported 5 Learning Disability deaths in the reporting timeframe and no patients with a diagnosis of Autism Spectrum Disorder (ASD).
- Discussions with the Regional Medical Examiners have taken place to discuss the successful implementation of the Medical Examiner process within our Trust. It was hoped this process would commence on 1 February 2023 however technical delays within the Acute service have resulted in a delay till 1 March 2023.
- Good practice identified through case record reviews is fed back to clinicians involved as part of our appreciative learning.
- The Patient Safety Team are currently reviewing themes and recommendations from investigations to support better dissemination of learning.

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

**Assurances**

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

**Consultation**

- The Quality and Safeguarding Committee received significant assurance from the report on 14 February 2023.

**Governance or Legal Issues**

There are no legal issues arising from this report.

The Care Quality Commission Regulations - this report provides assurance as follows:

- Outcome 4 (Regulation 9) Care and welfare of people who use services
- Outcome 14 (Regulation 23) Supporting staff
- Outcome 16 (Regulation 10) Assessing and monitoring the quality of service provision
- Duty of Candour (Regulation 20).

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

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

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

- 1 October to 31 December 2022. There is very little variation between male and female deaths; 309 male deaths were reported compared to 334 females.
- No unexpected trends were identified according to ethnic origin or religion.

**Recommendations**

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

**Report presented by:** **Arun Chidambaram**
**Medical Director**

**Report prepared by:** **Rachel Williams**
**Lead Professional for Patient Safety and Experience**

**Louise Hamilton & Aneesa Akhtar-Alam**
**Mortality Technicians**

## Learning from Deaths - Mortality Report

### 1. Background

In line with the CQC's recommendations in its review of how the NHS investigates patient deaths, the National Quality Board published a framework for NHS Trusts - 'National Guidance on Learning from Deaths[1]'. The purpose of the framework is to introduce a more standardised approach to the way NHS Trusts report, investigate and learn from patient deaths, which should lead to better quality investigations and improved embedded learning. To date the Trust has met all the required guidelines. This report presents the data for 1 October to 31 December 2022.

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

- Meetings with the Chesterfield Royal Hospital and University Hospital of Derby and Burton Regional Medical Examiners have taken place to discuss the implementation of the Medical Examiner process within our Trust. The standard operating procedure is under review for agreement. It was hoped a go live date of 1 February would be achievable however due to delays in the development of systems for accessing patient records for the Acute this has been extended to 1 March 2023. Medical Examiners will then be able to commence reviewing the Trusts non-coronial deaths.

- Cause of death information is currently being sought through the Coroner offices in Chesterfield and Derby but only a very small number of cause of deaths have been made available. Whilst access to this information is expected to improve through engagement of the Medical Examiners on non-coronial deaths cause of death will remain an issue for those deaths reported through DATIX.

- During 1 October to 31 December 2022 12 Case Record Review sessions have been undertaken in relation to deaths which meet the incident criteria. Unfortunately, 12 sessions did not take place due to lack of medic availability.

- The mortality team have now received a new schedule outlining the medics who will be attending Case Record Review sessions in 2023 for both North and South consultants. Meeting invites for 2023 have now been set up and sent to all consultants involved.

- Regular audits continue to be undertaken to ensure compliance with policy and procedure and any necessary amendments made. This has included auditing complaint data against names of deceased patients to ensure this meets the requirements specified in the National guidance. The last audit was completed in December 2022.

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

**Data Summary of all Deaths**

Note that inpatients and learning disability (LD) data is based upon whether the patient has an open inpatient or LD referral at time of death. The table below outlines information for 1 August to 31 December 2022.

| | October | November | December |
|---|---|---|---|
| Total Deaths Per Month | 228 | 176 | 239 |
| LD Referral Deaths | 3 | 1 | 1 |
| Inpatient Deaths | 0 | 0 | 0 |

*Correct as of 16 January 2023*

309 patients were male, 334 were female, of these 477 were white British, 103 were any other ethnic group and 27 had no known ethnicity assigned. The youngest age was 0 years, the eldest age was 104. From 1 October to 31 December 2022, the Trust received 643 death notifications of patients who have been in contact with our services.

## 4. Review of Deaths

Only deaths which meet Trust Red Flags are reported through the Trust incident reporting system (Datix) and are reviewed through the Untoward Incident Reporting and Investigation Process. These Red Flags apply to any patient open to services within the last six months prior to their death.

- COVID – 19 suspected or confirmed death of an open patient (6 month rule not applicable)
- Homicide – perpetrator or victim. (This criterion only relates to patients open to services within the last 6 months)
- Domestic homicide - perpetrator or victim (This criterion relates to patients open to services within the last 6 months)
- Suicide/self-inflicted death, or suspected suicide
- Death following overdose
- Death whilst an inpatient
- Death of an inpatients who died within 30 days of discharge from a DHCFT hospital
- Death following an inpatient transfer to acute hospital
- Death of patient on a Section of the Mental Health Act or DoLs authorisation
- Death of patient following absconsion from an inpatient unit
- Death following a physical restraint
- Death of a patient with a learning disability
- Death of a patient where there has been a complaint by family/ carer/ombudsman, or staff have raised a significant concern about the quality of care provision
- Death of a child (and will likely be subject to scrutiny by the Child Death Overview Panel)
- Death of a patient open to safeguarding procedures at the time of death, which could be related to the death
- Death of a patient with historical safeguarding concerns, which could be related to the death
- Death where a previous Coroners - Regulation 28 has been issued

- Death of a staff member whilst on duty
- Death of a child under the age of 18 of a current or previous patient who has died in suspicious circumstances
- Where an external organisation has highlighted concerns following the death of a patient whether they were open to the Trust at time of death or not
- Psychosis within the last episode of care
- Autism

| | |
|---|---|
| Total number of Deaths from 1 October to 31 December 2022 reported on Datix | 64 "Unexpected deaths"<br>0 Covid-19 deaths<br>4 "Suspected deaths"<br>8 "Expected - end of life pathway"<br>NB some expected deaths have been rejected so these incidents are not included in the above figure<br>0 Inpatients deaths |
| Incidents assigned for a review | 58 incidents assigned to the operational incident group<br>0 did not meet the requirement<br>0 incident is to be confirmed |

## 5. Learning from Deaths Procedure

The mortality team review all applicable non DATIX reported deaths against the Trust red flags and those outlined in the Royal College of Psychiatrists Care Review Tool. All non DATIX deaths including community deaths are reviewed to ascertain if they meet the Trust red flags. Those patient deaths which meet these 'red flag' criteria are DATIX reported and subject to the Trust internal incident review process.

At the stage of determining if a death meets the criteria for reporting as an incident, teams are required to review all deaths against the Trust Incident 'Red Flags'. Previously under mortality the Trust was reviewing community deaths against locally defined flags in addition to what is required but had over committed its resources in this area and a redesign of the process was undertaken as learning was limited from these reviews.

The form based on section one of the Royal College of Psychiatrists Care Review Tool for mortality reviews has now been prepared for utilisation within the EPR. The go live date for this was expected 1 February 2023 however has been delayed till 1 March 2023 to allow for greater communication with Operational colleagues. It is important to note that clinical teams already assess each death when determining if a DATIX incident is required. This will release capacity within the Patient Safety team and allow for greater return on the Case Record Review process.

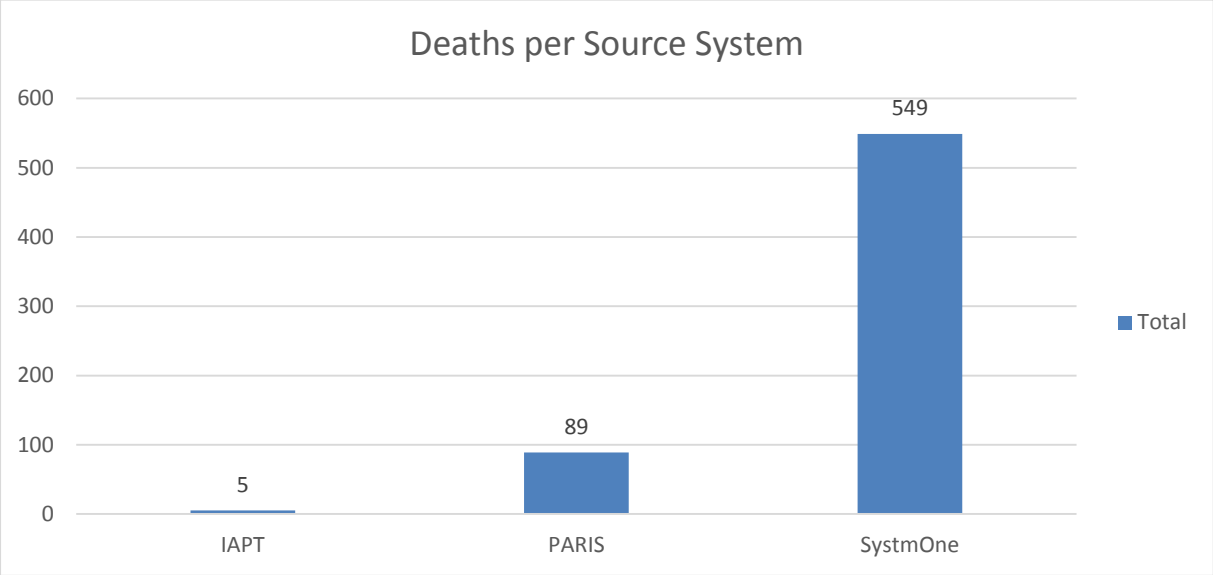
For the period 1 October to 31 December 2022, the Mortality Review Group reviewed 12 deaths through a Stage 2 Case Record Review. These reviews were undertaken by a multi-disciplinary team, and it was established that of the 12 deaths reviewed, none were due to problems in care.

From the 1 October  to 31 December 2022 there has been no deaths reported where the patient tested positive for Covid-19.

Head of Clinical Quality from NHS Derby and Derbyshire Integrated Care Board / Joined Up Care Derbyshire was invited by the Lead Professional for Patient Safety/Experience to undertake an independent review of the Trust Incident Process to ascertain if any improvements could be made. No actions were required and there was satisfaction that the Trust had robust systems in place for monitoring incidents.

## 6. Analysis of Data

### 6.1 Analysis of deaths per notification system since 1 October  to 31 December 2022

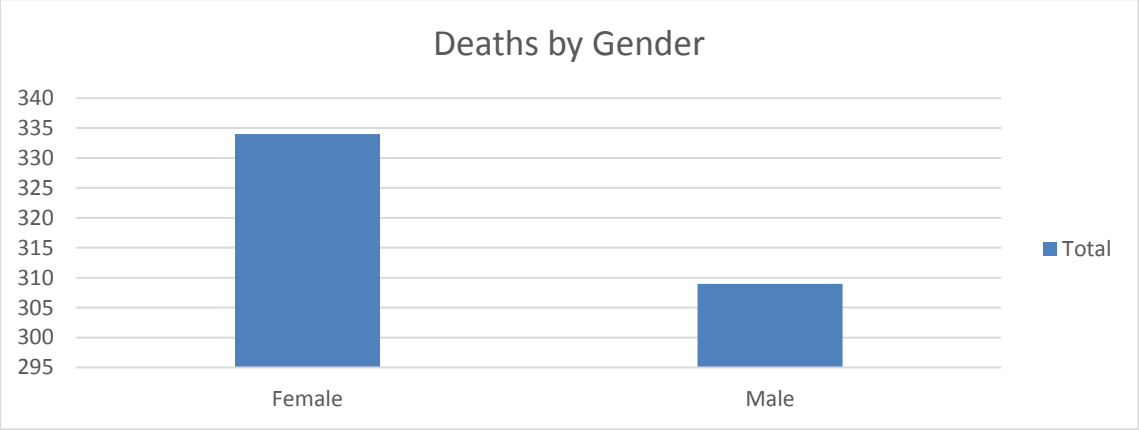



| System | Number of Deaths |
|---|---|
| IAPT | 5 |
| PARIS | 89 |
| SystmOne | 549 |
| **Grand Total** | **643** |

The data above shows the total number of deaths reported by each notification system. The majority of death notifications were pulled from SystmOne. This clinical record system is aligned to our largest population of patients and a population at greatest risk of death due to the proportion of older people in our care.  The Trust has now moved to one EPR and future reports will no longer provide this information.

## 6.2 Deaths by Gender

The data below shows the total number of deaths by gender for 1 October to 31 December 2022

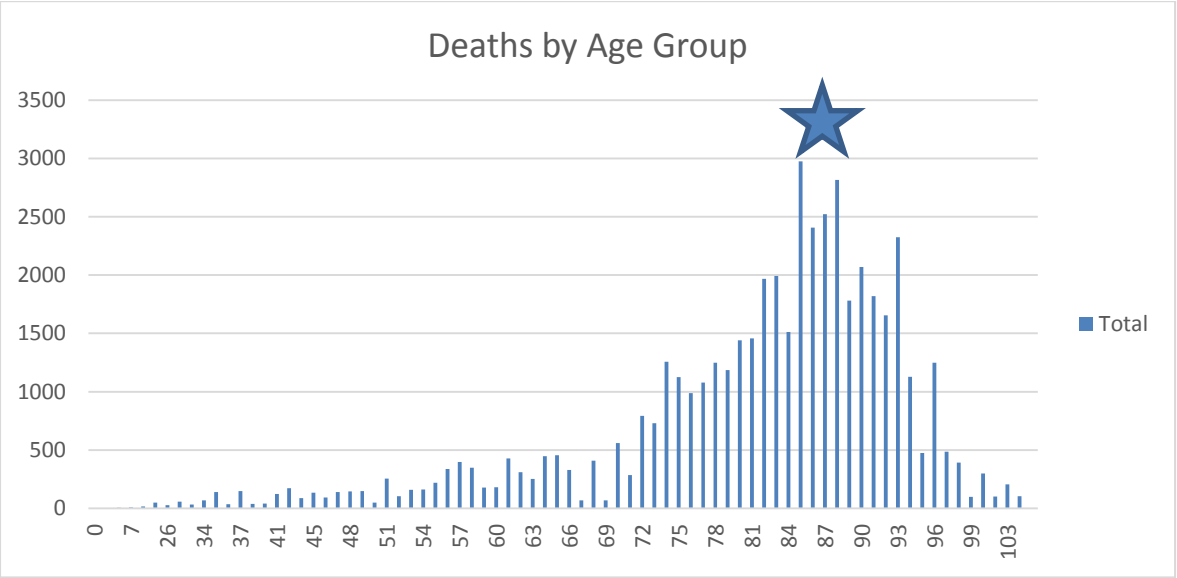



| Gender | Number of Deaths |
|---|---|
| Female | 334 |
| Male | 309 |
| **Grand Total** | **643** |

There is very little variation between male and female deaths; 309 male deaths were reported compared to 334 females.

## 6.3 Death by Age Group

The youngest age was classed as zero, and the oldest age was 104 years. Most deaths occurred within the 85-88 age groups (indicated by the star).



## 6.4 Learning Disability Deaths (LD)

| | August | September | December |
|---|---|---|---|
| LD Deaths | 3 | 1 | 1 |

The Trust reviews all deaths relating to patients diagnosed with a Learning Disability. The Trust also currently sends all Learning Disability deaths that have been reported through the Datix system to the Learning Disabilities Mortality Review (LeDeR) programme.

During 1 October to 31 December 2022, the Trust has recorded five Learning Disability deaths. The Trust now receives a quarterly update from LeDeR which highlights national good practice and identified learning; this is shared in the Mortality monthly meeting.

The Trust also is required from 1 January 2022 to report deaths of patients who have a diagnosis of Autism Spectrum Disorder (ASD) for this reporting period the Trust has reported no deaths.

## 6.5 Death by Ethnicity

White British is the highest recorded ethnicity group with 477 recorded deaths, 27 deaths had no recorded ethnicity assigned, and 12 people did not state their ethnicity. The chart below outlines all ethnicity groups.

| Ethnicity | Count of Ethnicity |
|---|---|
| Black or Black British - Caribbean | 1 |
| Black or Black British - African | 1 |
| Asian or Asian British - Indian | 1 |
| Asian or Asian British - Any other Asian background | 1 |
| Black or Black British - Any other Black background | 2 |
| White - Irish | 3 |
| Asian or Asian British - Pakistani | 5 |
| White - Any other White background | 10 |
| Not stated | 12 |
| Not Known | 27 |
| Other Ethnic Groups - Any other ethnic group | 103 |
| White - British | 477 |
| **Grand Total** | **643** |

## 6.6 Death by Religion

Christianity is the highest recorded religion group with 308 recorded deaths, 248 deaths were (blank) with no recorded religion assigned. The table below outlines all religious groups.

| Religion | Count of Religion |
|---|---|
| Sikh | 1 |
| Anglican | 1 |
| Pentecostalist | 1 |
| Catholic religion | 1 |
| Catholic: Not Roman Catholic | 2 |
| Atheist | 2 |
| Not Given Patient Refused | 2 |
| Christian religion | 2 |
| Patient Religion Unknown | 2 |
| Religion NOS | 2 |
| Jehovah's Witness | 3 |
| Agnostic | 3 |
| Muslim | 4 |
| Not Religious | 6 |
| Methodist | 7 |
| Roman Catholic | 8 |
| Church of England, follower of | 41 |
| Unknown | 248 |
| Christian | 308 |
| **Grand Total** | **643** |

## 6.7 Death by Sexual Orientation

Heterosexual or straight is the highest recorded sexual orientation group with 331 recorded deaths. 293 had no recorded information available. The chart below outlines all sexual orientation groups.

| Sexual Orientation | Count of Sexual Orientation |
|---|---|
| Male homosexual | 1 |
| Not Appropriate To Ask | 1 |
| Bisexual | 1 |
| Female homosexual | 1 |
| Homosexuality NOS | 1 |
| Sexual orientation not given - patient refused | 14 |
| Unknown | 293 |
| Heterosexual Or Straight | 331 |
| **Grand Total** | **643** |

## 6.8 Death by Disability

The table below details the top five categories by disability. Gross motor disability was the highest recorded disability group with 103 recorded deaths.

| Disability | Count of Disability |
|---|---|
| Walking disability | 2 |
| Physical disability | 2 |
| Learning Disability | 2 |
| Emotional behaviour disability | 13 |
| Hearing disability | 17 |
| Intellectual functioning disability | 34 |
| Gross motor disability | 103 |
| **Grand Total** | **173** |

There was a total of 186 deaths with a disability assigned and the remainder 457 were blank (had no assigned disability).

## 7. Medical Examiners

Medical Examiner officers have been established at all Acute Trusts in England. The role of these officers is now being extended to also cover deaths occurring in the community, including at NHS Mental Health and Community Trusts. Medical Examiners are to provide independent scrutiny of deaths not taken at the outset for Coroner investigation. They will carry out a proportionate review of medical records and give families and next of kin an opportunity to ask questions and raise concerns. This process will inform learning to improve care for future patients, or, in a smaller number of cases, may be referred to others for further review. Their involvement will also provide reassurance to the bereaved.

Overall Medical Examiners will seek to answer the following three questions:

- What caused the death of the deceased?
- Does the coroner need to be notified of the death?
- Was the care before death appropriate?

Discussions with the Regional Medical Examiners have taken place to discuss the implementation of the Medical Examiner process within our Trust. A standard operating procedure is currently under review for agreement and plans were in place for a go live date of 1 February 2023. Due to difficulties for the Acute in accessing multiple system types and records the implementation date has been moved back to 1 March 2023. By 1 March 2023 the Acute will have been able to finalise a system which supports Medical Examiner direct EPR access and reviews into the Trust non-coronial deaths will commence.

## 8. Recommendations and Learning

The Trust senior Mortality review group is currently undergoing a revision and will become more focussed on the process of embedding learning from all incidents and supporting operational teams around the review process for non-red flag deaths. The Patient Safety Team is currently mapping out how this group will work with others under development.

| Improvement issue | Actions required update |
|---|---|
| Transfer of the deteriorating patient | Internal investigations have highlighted themes regarding the transfer and return of patients between inpatient services for the Trust and Acute providers such as Chesterfield Royal Hospital. This includes handover of information, and the way patients are conveyed. A quality improvement project is underway between Derby Hospital and DCHFT |
| Self-harm of patients whilst on leave from inpatient services | Investigations have highlighted issues in relation to adult inpatient leave arrangements including section 17 leave arrangements. A further thematic review has been completed on conclusion of current inpatient suspected suicide incidents active at present. An action plan has been developed. The Patient safety Team is leading on the coordination of the review of the current processes and quality improvement actions |
| MDT process improvements within CMHTs | Investigations have highlighted themes in relation to MDT processes within CMHTs and works are currently underway to review the EPR and recording documentation and MDT process to ensure this is fit for purpose and being adhered to. |
| Falls prevention | Pockets of increased falls have been noted and currently there are pilots underway within Older Adult in patient service for the use of bed and chair sensors. A Trust Falls Group meets regularly to discuss improvements and themes |
| Family liaison and engagement | The package of support available to families involved in an internal investigation/ review has been identified as an area for improvement. This includes consistency of support, timeframes and establishing a pathway for escalation. Work is underway to develop an agreed package which will be offered and how this will be supported by the Trust. |
| Multi-agency engagement following incidents | It is known that patients are often known to multiple services both internally and externally. Works have been commissioned to consider agreements needed to enhance multi-agency working with partner agencies when an incident investigation has been commissioned to improve shared learning and enhance family liaison and support. |
| Relapse prevention and MDT resource management within Amber Valley Adult Community Mental Health Services | As a result of an internal investigation and concerns raised by staff a piece of work is being commissioned to consider themes in relation to the resource and function of the MDT process within the Amber Valley CMHT. |
| Integrated care services | Investigations have highlighted the need for improvements in the care pathway of patients open to more than one service. A conference will be held which will include representation from all service lines, Clinical Directors, Medical Director and Deputy Director of Nursing and Quality as well as incident investigation leads to review themes and devise a plan of action to enhance internal integrated care. This conference will also include external integrated care with providers such as Social Care. |
| Inappropriate admission to inpatient adult ward | Investigations into high profile incidents of inappropriate admissions to Adult Mental Health inpatient services brought to attention an on-going issue in this area. Review of lower grade incidents and discussions with the service line have confirmed a long-standing theme in this area. A review of inappropriate admissions is currently underway |

**Derbyshire Healthcare NHS Foundation Trust**
Report to the Board of Directors – 7 March 2023

# Guardian of Safe Working Quarterly Report

## Purpose of Report

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

## Executive Summary

The Board is requested to note:

1) The Junior Doctor Forum (JDF) meetings have recommenced on a bi-monthly basis since they ceased in the summer of 2022.
2) Three exceptions reports were submitted in the south arising from breaching non-resident on call requirements. These have resulted in time off in lieu (TOIL) and payment to the doctor, as well as fines levied against the trust. Two further exception reports were for resident doctors needing to stay late on their day jobs. TOIL was agreed. One further exception report was for a resident doctor on the 12 hour on call shift being unable to take a meaningful break. This was felt to be an exceptionally busy shift rather than a recurring pattern. TOIL was agreed.
3) The previous report to the Board and Quality and Safeguarding Committee showed there were retrospective payments due to some doctors through exceptions reports (breaching non-resident on call rest requirements). Delays were noted in processing these owing to a lack of a GOSW cost code and a reporting line through Medical Education. There is now a cost code, these payments have been processed, including fines levied against the Trust and the reporting line has been removed.
4) The current fines amount totals £1261.87. Junior doctor representatives, via the JDF, are currently considering how to spend this.
5) The GOSW now delivers induction sessions on their role as well as on exception reporting to new doctors rotating into the Trust. The GOSW is also attending Deputy Director of Medical Education (DME) 'drop in sessions' to observe and advise where junior doctors have queries that fall under the GOSW's remit.
6) Personalised work schedules and exception reporting training for supervisors remains on the improvement agenda for the GOSW.
7) The previous report highlighted the consultation process on creating a new registrar tier on the south psychiatry rotas out of hours. The consultation has concluded and been discussed at the December Joint Local Negotiating Committee, and the January JDF. At the point of submitting this report, a referendum style vote is being put to the affected registrars. The outcome will be fed back to the Trust via the relevant clinical director.

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

**Assurances**

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

**Consultation**

- The GOSW has shared the previous report with the Joint Local Negotiating Committee, the JDF and its constituent junior doctors. This open sharing will continue. This report has not been shared owing to a short lead in time, however the contents that form this report has been discussed at the JDF.
- This report provided the Quality and Safeguarding Committee with significant assurance on 14 February 2023 that the Trust is discharging its statutory duties in employing junior doctors on the 2016 contract.

**Governance or Legal Issues**

None

**Public Sector Equality Duty & Equality Impact Risk Analysis**

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

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

- None

**Recommendations**

The Board of Directors is requested to:

1) Note the contents of this report.
2) Whilst the previous report outlined that the GOSW could not give assurances to the Trust that it was discharging its statutory duties in employing junior doctors on the 2016 contract, this is no longer the case.

**Report presented by:** **Dr Arun Chidambaram**
**Medical Director**

**Report prepared by:** **Dr Kaanthan Jawahar**
**Guardian of Safe Working**

**GUARDIAN OF SAFE WORKING QUARTERLY REPORT**
**(February 2023)**

## 1. Trainee data

Extended information supplied from 26 November 2022 to 6 February 2023

### Numbers in post for doctors in training

| Numbers of doctors in post WTE | North | South |
|---|---|---|
| FY1 | 3 | 5 |
| FY2 | 2 | 4 |
| GP ST | 3.6 (headcount 4) | 6.4 (headcount 7) |
| CT | 10.6 (headcount 11) | 11.8 (headcount 12) |
| HSTs | 3 | 7.2 (headcount 8) |
| Paediatrics ST | | 0.8 ST3, 0.4 ST4 & 0.6 ST5 (headcount 3) |

**Key**
CT = Core trainee years 1-3
FY1/FY2 = Foundation year trainee (years 1 and 2)
HST = Specialty trainee (ST) years 4-7
GP ST = General practice specialty trainee
Paediatrics ST = Paediatrics specialty trainee (year 4+)

## 2. Exception Reports (working hours)

Covering the period 26 November 2022 to 6 February 2023

| Location | No of exceptions carried over from last report | No of exceptions raised | No of exceptions closed | No of exceptions outstanding |
|---|---|---|---|---|
| North | 0 | 1 | 0 | 1 |
| South | 0 | 5 | 5 | 0 |
| Total | 0 | 6 | 5 | 1 |

| Grade | No of exceptions carried over from last report | No of exceptions raised | No of exceptions closed | No of exceptions outstanding |
|---|---|---|---|---|
| CT1-3 | 0 | 3 | 2 | 1 |
| ST4-7 | 0 | 3 | 3 | 0 |
| GP | 0 | 0 | 0 | 0 |
| Foundation | 0 | 0 | 0 | 0 |
| Total | 0 | 6 | 5 | 1 |

### Action taken

| Location | Payment | TOIL | Not agreed | No action required |
|---|---|---|---|---|
| North | 0 | 2 | 1 | 0 |
| South | 3 | 3 | 0 | 0 |
| Total | 3 | 5 | 1 | 0 |

### Response time

| Grade | 48 hours | 7 days | | Longer than 7 days | Open |
|---|---|---|---|---|---|
| CT1-3 | 0 | 0 | | 2 | 1 |
| Foundation | 0 | 0 | | 0 | 0 |
| ST4-7 | 0 | 0 | | 3 | 0 |

Three exception reports in the South were submitted for breaching non-resident on call rest requirements (one doctors). These resulted in TOIL, payment and fines levied against the Trust (see section 4).

One exception report was for a resident doctor failure get a meaningful break during their 12 hour shift. Discussion with the doctor outlined that this was an unusual occurrence (had it been a repeating pattern a fine may have been levied against the trust, and the type of shift would have needed a formal review). TOIL was agreed with the doctor.

Two exception reports were submitted by resident doctors (one north and one south) for extra time worked on their relevant day jobs. TOIL has been agreed for both, however one is still outstanding as the doctor is struggling to discuss the exception report with their supervisor.

All exception reports took beyond the 7 day target. Feedback on why this was included the doctor being very busy, their supervisors being busy, the Christmas break and difficulties in accessing the exception reporting system. It must also be noted that the GOSW has made it clear to the doctors in the Trust that they are exercising their discretion to allow exception reports to be submitted when possible, and this sentiment also extends to the supervisor meeting.

## 3. Work schedule reviews

No formal work schedule reviews during this period.

## 4. Fines

The current total of fines available for the JDF to spend is £1261.87 through cost code G62762.

Fines accrued since the last GOSW report total £297.45.

All fines are the result of breaching rest requirements on non-resident on call rotas. All were south.

## 5. Locum/Bank Shifts covered

| | North | Cost | South | Cost |
|---|---|---|---|---|
| Locum/bank shifts covered | 24 | £11647.67 | 838 | £22422.87 |
| Agency locum shifts covered | 0 | | 0 | |

## 6. Agency Locum

Nil

## 7. Vacancies

| | North<br>Dec 22 – Feb 23 | South<br>Dec 22 – Feb 23 |
|---|---|---|
| CT1-CT3 | 0.4 | 0.2 |
| ST4-7 | 3 | 0 |
| GP Trainees | 0.4 | 0.6 |
| Foundation | 0 | 0 |

Locum/bank shifts covered in section 5 are largely the results of these rota gaps. In particular the south NROC rota has gaps owing to a doctor going on parental leave.

ST4-7 doctor 'vacancy' numbers must be interpreted within the context of them being supernumerary.

## 8. Qualitative information

Junior Doctor Forum meetings have resumed as of January 2023. They will be bi-monthly, with dates agreed for the remainder of 2023. The GOSW is also seeking to align its constitution with the BMA model – this will ensure contractual obligations are covered, but also bedding in its distinct role with respect to other committees junior doctors interact with. A draft constitution was tabled at the last meeting, however time and more pressing agenda items means this has been deferred to the March meeting. Should the committee wish to see the agenda and minutes of the January meeting these can be supplied.

Since the previous meeting, a separate cost code has been set up to hold GOSW fines and the reporting lines through Medical Education have been removed. This brings the GOSW role and the JDF into line with contractual expectations.

The previous report to this Committee highlighted the GOSW's plan to restore assurance in their role and remit. This included rolling inductions sessions for rotating doctors, attendance at Deputy DME drop in sessions and restoring bi-monthly Junior Doctor Forum meetings. All of these targets have been met. The outstanding items from the original plan are to embed personalised work schedules and to deliver further training/guidance to supervisors on exception reporting.

The proposed registrar tier south psychiatry rota out of hours has undergone the relevant consultation. At the time of preparing this report a referendum-style vote is plan involving the affected registrars. As outlined to the Committee in the previous report, moving to this new rota, which would combine older and general adult workloads, brings with it the risk of further breaches of non-resident on call requirements, and therefore both tiredness as a risk for doctors involved, and financial penalties for the Trust.

## 9. Compliance of rotas

Current work schedules are compliant with the 2016 junior doctor contract.

## 10. Other concerns raised with the Guardian of Safe Working (GoSW)

None that are not already covered in section 8.

**Derbyshire Healthcare NHS Foundation Trust**
Report to the Board of Directors – 7 March 2023

# Corporate Governance Update

## Purpose of Report

To give an update on Board Well Led and an update on the review against the new Code of Governance for NHS Provider Trusts which will come into effect from 1 April 2023.

## Executive Summary

Board Well Led

Work is on-going to assess the leadership of the Board against the Well Led Framework both in terms preparing for the Board Well Led element of a CQC inspection but also commissioning an external development review. The Board will recall that the external review had previously been paused pending a CQC inspection. However as we have no imminent date a CQC inspection it has been decided to commission the review in line with the NHSE guidance and best practise.

The external Well Led review will help to:

- deepen the Board's own understanding of its leadership and governance through objective and constructive review and challenge;
- identify key development actions in relation to the Well Led framework (that may supplement the action areas already highlighted by the CQC and in turn help provide evidence for any future CQC inspection); and
- enable some skills transfer and knowledge sharing from the external provider who will have experience of undertaking similar reviews elsewhere

The next steps will build on work already done, including the Board leaders pack which is supported by an evidence library. There is an Executive lead for each of the eight Well Led Key Lines of Enquiry (KLOE) and the whole Board is preparing for a development day on 15 March to re-assess compliance against the KLOEs.

The Council of Governors has also established a Well Led working group to help governors prepare for the assessments. The preparation will complement the wider preparation of the CQC core services inspection, which also includes a well led domain.

Code of Governance

The updated Code of Governance for NHS Provider Trusts will come into effect from 1 April 2023. This replaces the 2014 NHS Foundation Trust Code of Governance and sets out an overarching framework for the corporate governance of trusts, supporting delivery of effective corporate governance, understanding of statutory requirements where compliance is mandatory and provisions with which trusts must comply, or explain how the principles have been met in other ways.

'Comply or explain' gives trusts the flexibility to adopt alternative practices and explain how this continues to meet the principles of good governance.

An initial review has been undertaken by the Trust Secretary and in general, the provisions of the code do not greatly differ from the 2014 version since the statutory roles, responsibilities and liabilities of the Board of Directors have not changed. However, there are some underlying themes which are included for the first time.

- Requirement of the Board to assess the Trust's contribution to the objectives of the Integrated Care Partnership (ICP) and ICB as part of its assessment of its performance with system partners highlighted as key stakeholders
- Inclusion of the Board's role in assessing and monitoring the culture of the organisation and taking corrective action as required and investing in, rewarding and promoting the wellbeing of its workforce
- New focus on equality, diversity and inclusion among Board members and training for those undertaking director-level recruitment. The Board should have a plan in place for the Board and senior management of the organisation to reflect the diversity of the local community and/or workforce
- Greater involvement for NHS England (NHSE) in recruitment and appointment processes for the Board and use of the NHSE remuneration structure for Chair and Non-Executive Director remuneration

The Trust's Corporate Governance Framework will be assessed against the new code and adjustments made to any core documents such as Terms of Reference and the Scheme of Delegation. The Trust makes a statement of compliance against the code in its annual report and consideration will need to be given to the reporting of compliance against the code in 2023/24.

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

**Assurances**

Thorough preparation of the Leaders' Pack will provide the Board with assurance of the Trust's key messages and position ready for the CQC inspection. The external development work will review the Trust's governance processes to ensure appropriate compliance, reporting back to the Board and its Committees and the Council of Governors as necessary.

**Consultation**

The governance documents have previously been circulated to Board members.

**Governance or Legal Issues**

The CQC inspection framework for all registrants includes an assessment of current performance of Well Led, which is explicitly linked to the well-led framework. Failure to demonstrate that we are Well Led and have robust governance processes in place may lead to enforcement and regulatory actions.

The Trust must comply with its licence and the statutory framework referred to in these governance documents. The Code of Governance sets out the provisions that Trusts should comply with or explain how alternative arrangements comply.

**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:

Well Led KLOEs 3 and 7 include prompts relating to Equality, Diversity and Inclusion. The Leaders' Pack narrative will address those questions with relevant evidence to support them. Governance of the Trust includes broad consideration of equality and diversity issues for example as a key part of Board Committee business, and as an important element of governor training and development to ensure that decision making encompasses equality impact considerations. Each Board Committee has a specific objective around equality.

**Recommendations**

The Board of Directors is requested to:

1. Note the update on Board Well Led including the commissioning of an external development review
2. Note the update on the Code of Governance

| | |
|---|---|
| **Report prepared and presented by:** | **Justine Fitzjohn**<br>**Trust Secretary** |

**Derbyshire Healthcare NHS Foundation Trust**
Report to the Board of Directors - 7 March 2023

**Board Assurance Framework (BAF)**
**Issue 4, 2022/23**

**Purpose of Report**

To meet the requirement for Boards to produce an Assurance Framework. This report details the fourth and final issue of the BAF for 2022/23.

**Executive Summary**

Each Director Lead has reviewed the risks allocated to them and provided comprehensive updates. All changes/updates to this issue of the BAF, compared with Issue 3 2022/23, are indicated by blue text. All text that has been stricken through will be removed from the next issue.

Three risks have reduced ratings and one (MS1) has an increased rating. One risk has moved from strategic objective 3 (to make best use of our resources) to objective 4 (to be a great partner) and a new risk has also been added to strategic objective 4. All were approved by the Audit and Risk Committee on 02.02.23:

**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*"** – Four of the actions to close gaps in control have improved ragging, all from red to amber. The likelihood rating has reduced from 4 to 3, which reduces the overall risk rating from extreme to high.

**Risk 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"*** – Three of the actions to close the gaps in assurance were completed in the last quarter so the internal assurances on controls have been updated to reflect this. Consideration was given to the inclusion of this risk in the BAF going forward as the actions to close the gaps in control are almost fully complete. Inclusion in the BAF is required and is a result of the Templar Cyber Organisational Readiness Report (CORS report) 2020-21. Central to this was to ensure the 'golden thread' for information risk was firmly established from CEO to Trust Board and with support from Office of the Senior Information Risk Owner (SIRO) (and Data, Security and Protection team). Benchmarking was undertaken by the Risk and Assurance Manager to review how the risk was captured in other trusts' BAF reports, to ensure that all aspects of the information risk were identified, and as a result the title of the risk has been updated.

**Risk 3A "*There is a risk that the Trust fails to deliver its revenue and capital financial plans"*** – The root causes section has been updated and two of the actions to close gaps in control have improved ragging, from red to amber. The Interim Director of Finance has updated the overall risk rating, which has been

approved by the Finance and Performance Committee and the Audit and Risk Committee. The likelihood of the risk occurring has been reassessed as a level 2 (from a level 4), which reduces the overall risk rating from extreme to moderate.

**Risk 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"*** – ELT and the Audit and Risk Committee approved this being moved from strategic objective 3 to objective 4 (to be a great partner) as it relates to the ICS. This is now presented as **Risk 4A**. The risk rating has also been reduced from high to moderate, the Director Lead summarised the rationale for the reduced rating:

> *"The review of our performance reporting and interface with the ICB is now a normal way of working rather than specifically because of the organisational change – We are moving towards business as usual."*

**Risk 4B "*There is a risk of reputational damage if the Trust is not viewed as a strong partner*"** – This is a new risk added under strategic objective 4; it will be included in the 2023/24 BAF and returned to ELT in Issue 1 to review progress on the identified actions to close gaps in control.

**Risk MS1 "*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*"**– The risk rating has been increased, from moderate to high as two of the actions to close key gaps in control have down-graded ragging, from green to red and none of the actions are 'in progress'. The CEO reviewed the risk and actions to close the gaps in control and provided the following rationale for the increased rating, which was approved by the Audit and Risk Committee:

> *"All LD beds are still closed to admissions and there are still some quality issues – There is no fit-for-purpose seclusion room, there are a number of patients with no discharge plan and this is on national escalation. The risk remains high until beds re-open."*

**Operational Risks**

There are six Trust-wide operational risks rated as high linked to the Trust strategic objectives. Since the last BAF issue two operational risks have been removed:

**22815 *Risk to Patient Safety Team service delivery*** – The CEO advised in 2022 that this should be closed. Further review by the Interim Director of Nursing confirmed that there are no outstanding risks identified by the Risk Handler. Any issues relating to staffing levels in the team should be captured on the issues log.

**22954 *Availability of defibrillators*** – As the defibrillators are being replaced across the Trust and completion of the task is imminent, the rating has been reduced from high to moderate so this no-longer links to the BAF.

**Deep Dives**

Previously it was reported that deep dives were planned for January 2023 at the Audit and Risk Committee for Finance and Performance extreme risks. However, both risks have reduced ratings and so the deep dives were removed from the agenda.

**BAF 2023/24**
Approval has already been received (by the Audit and Risk Committee) to include risks 1D and those under strategic objective 4 in the 2023/24 BAF.

The Board is required to review all other risks included in this report and decide which should be carried forward into the 2023/24 BAF. Following Board decision the Risk and Assurance Manager will refresh the BAF report in readiness for the Director reviews to prepare Issue 1 2023/24.

In February a BAF Board development session was facilitated by 360 Assurance (internal auditors). At that session the following improvements to the BAF report were agreed:

- The word 'ongoing' should be removed from the report, in its place there should be either a review date (in brackets) or a completion date for all actions
- Progress updates should be more succinct so as to present the current position and shorten the report. To note, all issues and versions of the BAF report are archived so historical updates are not lost
- The 'corrective' section in the 'key controls' should be removed from each risk as it's not usual practice to include it anymore due to the corrective measures being captured in the actions to close gaps in key controls.

The Risk and Assurance Manager will update Issue 1 2023/24 to reflect the points above and work with Director Leads to ensure review/completion dates are established for all actions.

| **Strategic Considerations** | |
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| 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, Operational Leads and General Managers

**Formal Reviews:**

- Executive Leadership Team, Issue 4.1: 3 January 2023
- Audit and Risk Committee, Issue 4.2: 2 February 2023

**Governance or Legal Issues**

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

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

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

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

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

**Recommendations**

The Board of Directors is requested to:

1) **Approve** this fourth 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) **Review** all risks within the report to consider which should be carried forward to the 2023/24 BAF
3) **Agree** the implementation of the improvements identified at the BAF Board development session
4) Continue to receive updates in line with the forward plan for the Trust Board.

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

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

# Board Assurance Framework 2022-23 – Issue 4.3 - 7 March 2023

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

| Ref | Principal Risk | Director Lead | Rating (Likelihood x Impact) | Responsible Committee |
|---|---|---|---|---|
| **Strategic Objective 1 - To Provide GREAT Care in all Our Services** | | | | |
| 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 | 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) | ~~**EXTREME (4x5)**~~ **HIGH (3X5)** | 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 2C | There is a risk that we are unable to create the right culture with high levels of staff morale | Director of People and Inclusion (DPI) | **HIGH (4x4)** | People and Culture Committee |
| 22-23 2D | There is a risk that we do not have a diverse workforce with the right number of people with the right skills to support and deliver safe high-quality care | Director of People and Inclusion (DPI) | **HIGH (4x4)** | People and Culture Committee |
| **Strategic Objective 3 – To Make BEST Use of Our Resources** | | | | |
| 22-23 3A | There is a risk that the Trust fails to deliver its revenue and capital financial plans | Director of Finance (DOF) | ~~**EXTREME (4x5)**~~ **MODERATE (2X5)** | 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)**~~ ~~**MODERATE (3x3)**~~ | ~~Trust Board~~ |
| **Strategic Objective 4 – To be a GREAT Partner** | | | | |
| 22-23 4A | Whilst there are significant benefits from the creation of the Integrated Care System (ICS) as an NHS body, there is a risk that the effects of the change 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)**~~ **MODERATE (3x3)** | Trust Board |
| 22-23 4B | There is a risk of reputational damage if the Trust is not viewed as a strong partner | Director of Strategy, Partnerships and Transformation (DSPT) | ~~**HIGH (4x4)**~~ | Trust Board |

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

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

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

**Root causes:**

a) Workforce supply and lack of capacity to deliver effective care across hotspot areas, increasing risks in the medical workforce
b) Risk of substantial increase in clinical demand in some services and COVID-19 and cost of living 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 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
j) 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
k) Lack of capacity to meet population demand for community forensic team
l) 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
m) Violent crime in the community, sexual safety incidents and youth violent crime all increasing in Derby and Derbyshire

| **BAF Ref**: 22-23 1A | **Director Lead**: Tumi Banda (DON – Interim) / Dr Arun Chidambaram (MD) | **Responsible Committee**: Quality and Safeguarding Committee |
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### Key Controls

| **Inherent Risk Rating** | | | **Current Risk Rating** | | | | **Target Risk Rating** | | | **Risk Appetite** | | |
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| 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. EQUAL unannounced visits to services and anonymised bright ideas service improvement ideas. Feedback intelligence from independent advocacy, Director visits and Quality Visits
**Detective** – Quality dashboard reporting; quality visit programme/virtual clinical service contact visits; incident, complaints and risk investigation; Fire Safety Regulations (FSR) compliance checks; mortality review process; physical health care monitoring clinics pilots; safety check log; Head of Nursing and Matron compliance visits, reviewed model of announced and unannounced visits to service throughout the 24 hour period
**Directive** – Trust Strategy and commitments; Quality Improvement Strategy; Physical Health Care Strategy; Safeguarding Strategy; Suicide Reduction Strategy; clinical strategies; policies and procedures available via Trust intranet; Central Alerting System (CAS) alerts; Risk Management Strategy; clinical sub committees of the Quality and Safeguarding Committee
**Corrective** – Board committee structures and processes ensuring escalation of quality issues; six monthly safer staffing and 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) |
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| Quality and Trust dashboards<br>Scrutiny of Quality Account (pre-submission) by committees<br>Programme of physical healthcare and other clinical audits and associated plans<br>Infection Control Board Assurance Framework reported to NHS England<br>Positive and Safe self-assessment reported to the East Midlands<br>Head of Nursing/Practice and Matron compliance visits | National enquiry into suicide and homicide<br>NHS Litigation Authority (NHSLA) scorecard demonstrating low levels of claims<br>Safety Thermometer identifies positive position against national benchmark<br>Mental Health Benchmarking data identifies higher than average qualified to unqualified staffing ratio on inpatient wards<br>CQC comprehensive review 2020 Trust is rated Good; two core services rated outstanding, two rated as require improvement<br>Identified Trust fully compliant with National Quality Board (NQB) Learning from Deaths guidance<br>2020/21 Internal audits: Risk management; data security and protection<br>2020/21 Estates and Facilities Management internal audit (limited assurance)<br>Transitional Monitoring Meetings with CQC (bi-monthly), no conditions<br>Patient Safety Incident Response Framework (PSIRF) implementation and progress – Two years prior to national roll out in 2022 |

| 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 |
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| Embedded learning from CQC regulatory actions, particularly in relation to improvement of training governance | Review operational governance of training compliance<br>[ACTION OWNER: DPI] | Embedded compliance with mandatory training and compliance rates. Reported to | ~~31.12.22~~<br>30.06.23 | Improved governance reporting to Board, PCC, ELT reintroduced through | ~~AMBER~~<br>GREEN |

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| | Develop and implement improvement plan to ensure sustained compliance with mandatory training<br>[ACTION OWNERS: DPI/COO] | People and Culture Committee (PCC)<br><br>Lack of recurrence of common themes regarding training compliance. Reported to PCC and to be led by the operational leadership teams | | performance reviews on key metrics, i.e. Positive and Safe and Immediate Life Support (ILS) training compliance continues being reported to Board<br><br>~~The backlog from the pandemic and stop and start training has significantly impacted on compliance~~<br><br>~~01.08.22: Manual handling training is now above the minimum required standard~~<br><br>~~26.09.22: Improvements have been made across all training compliance but not above the 75% minimum level at all times. Particular focus on ILS and positive and safe continues at every PCC~~<br><br>Training for all inpatient colleagues is now being scheduled via the rostering system to ensure attendance is planned and staff are able to be released<br><br>Work continues to review the best way to deliver face to face training that reduces the impact on the delivery of clinical | |

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| | | | | services, makes it easier for colleagues to attend and ensures we maintain the high level of clinical knowledge and expertise to develop excellence in our services<br><br>06.12.22: Adult CMHT mandatory training now over 75%<br><br>Regular reporting in place for targeted action<br><br>Developing a plan in the long term re: introducing a holiday for people to do their training and digitalising the training<br><br>03.01.23: Adult CMHT mandatory training now over 91% | |
| 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<br>[ACTION OWNERS: DPI/COO] | The Trust continues to have significant instability in training compliance and oversight of safety training<br><br>The Trust management team need to move to a proactive oversight, projections of high-risk areas of safety training and advance management of risk<br><br>Publication of ILS/ PSTS training as core risk areas in the Trust Board reporting until stability is achieved | ~~31.03.23~~<br>30.06.23 | Repeat variations in operational delivery and practice in educational governance remain in acute care and older adult in-patient services. Grip and performance improvement of service level operational leaders still requires further improvement – A pervasive culture of minimising poor performance continues<br><br>PCC receive a compliance report on all | AMBER |

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| | | Sign off of the outstanding CQC actions (five overdue actions) | | CQC outstanding actions and a plan is presented against any actions that are not compliant. A trajectory is prepared to establish when the training will achieve the required compliance standard and signed off by PCC<br><br>06.12.22: Training stats are overall at 80%. Focus on acute areas which stands at 74% overall. Weekly reports are provided by the training team<br><br>03.01.23: ILS training compliance 81%. Monitoring processes in place for targeted action | |
| 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<br><br>A 360 audit has been commissioned to review whether these improvements are embedded | ~~(31.12.22)~~ (31.03.23) | Revised metrics included in Quality Dashboard reported to Quality and Safeguarding Committee. Maintenance to be monitored though dashboard data<br><br>Remain under monitoring – Consistent approach 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 | AMBER |

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| | | | | 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<br><br>Additional audit and scrutiny of physical healthcare checks are now back in place to continually improve practice. Sustained improvement is not fully embedded. A pervasive culture of minimising poor performance continues (inpatient acute) – Practice improvement most required at the Hartington Unit | |
| 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<br>[ACTION OWNER: DON] | Compliance with suite of metrics and reporting schedule detailed in quality dashboard | ~~(31.12.22)~~<br>(31.03.23) | Very positive staff survey (2022) in learning, morale which all positive indicators for clinical stability and safer services<br><br>New strategy actions published and will be reviewed in quality visit programme and in Divisional Achievement Reviews | AMBER |
| Insufficient investment in autism assessment and treatment services to meet demand. No commissioned treatment services | Investment required by CCG to meet assessment and treatment demands<br>[ACTION OWNERS: COO/DSPT] | Agreed funding allocation has occurred, recruitment to posts is active | ~~(31.12.22)~~<br>30.06.23 | Mental Health and Learning Disability and Autism Board (MHLD AB) agreed investment in | AMBER |

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| Waiting time increased over COVID-19 period, exacerbated by underlying demand | | | | principle into autism services<br><br>ASD diagnostic waiting lists remain high~~. To support improving the position, the merger to create a single Autism diagnostic and intervention offer took place in July. This includes shared resources and an overarching operational manager 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~~<br><br>MHLD AB agreed additional investment in a ~~review and design of~~ a new neuro diversity diagnostic pathway. Investment included in 2022/23 system operational plan. This will require a three-year investment and first year | |

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| | | | | funded as a pressure to the programme spend<br><br>~~The proposed revised pathway will be reviewed at the System MHLD&A Delivery Board in October 2022~~<br><br>~~ICB will only part fund plan within existing programme spend. Awaiting confirmation of the impact of this on the improvement plan and trajectory~~<br>Additional in year funding to trial a new approach to assessment services for autism has been provided by the ICB, and mobilisation has started. This has included the design and commissioning of VCSE hosted posts to support pre and post diagnostically across the pathway, the creation of a specialist bank of staff to run clinic days for assessment and identification of training. This will also expand scope to cover currently unavailable ADHD services<br><br>There continues to be insufficient long-term funding; it is hoped the | |

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| | | | | new approach will demonstrate a case for future investment | |
| 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<br><br>DON continues arm's length monitoring of monthly NHS benchmarking which continue to not follow the national trend<br><br>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~~<br>30.06.23 | Safety standards remain in place for urgent referrals. Limited evidence of COVID related surge in demand. Robust oversight in place<br><br>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<br><br>Capacity against 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)<br><br>DARs fully operational. Referrals and wait lists discussed and changes post-covid included<br><br>The Serious Incident Team have returned to standard operating levels and backlog cleared<br><br>Psychological surge is not occurring in all service lines. Tracking and | GREEN |

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| | | | | detailed monitoring of impact, still being actively monitored (changes in complexity, increasing psychosis, Eating Disorders and CAMHS referrals, but across all services are not elevated<br><br>Violent crime in the community, sexual safety incidents and youth violent crime all increasing in Derby and Derbyshire<br><br>~~Covid vaccination booster programme commenced.~~ Health Hub continues to support staff and promote within public health<br><br>03.01.23: Recent review of critical functions to support disruptions. Covid and Flu campaign continues, recent sickness (non-covid) has increased – Short-term relating to viral illnesses. Operational plans in place to support recovery. Internal monitoring including citation at the MHLD&A Board | |
| 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<br>[ACTION OWNER: DON] | CQC inspection and assessment | ~~31.12.22~~<br>~~31.01.23~~<br>31.03.23 | Significant improvement in all services. Plan to meet training compliance is not fully compliant | AMBER |

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| | | | | Residual CQC actions still require further attention to embed and sustain improvements – There are currently five open actions for the acute and community service. The significant theme training compliance<br><br>There has been a programme of mock CQC inspections in hotspot areas namely inpatient areas and now moving to community services. A thematic report will be presented to TOOL. The inspections have been received very positively by staff and are leading to identified areas of action for each team<br><br>Progress has been made on the open actions with two closed in December 2022. There is closer monitoring in Quality and Safeguarding Committee | |
| Gap in operating standards for acute and community mental ealth services | Enhanced monitoring of acute and community mental health services by the Nursing and Quality Directorate [ACTION OWNER: DON]<br><br>Implement Royal College of Psychiatrists (RCP) Standards across Acute Services [ACTION OWNERS: MD/DON/COO] | Improvement in operating standards compliance. To be confirmed by external CQC inspection and assessment of at least 'Good'<br><br>Implemented Acute Inpatient Mental Health Service Accreditation (RCP Standards) reported in Divisional | ~~(31.12.22)~~ ~~31.01.23~~ 31.01.23<br><br>(31.03.24) | Increased performance management scrutiny and unannounced site visits have been undertaken with compliance checks<br><br>Mock inspections have been completed in acute services and there is support for the services | AMBER |

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| | | Achievement Reviews and Quality Account | | on the areas requiring improvement | |
| | Implement 2019 Community Mental Health Framework<br>[ACTION OWNER: DSPT] | Implemented Mental Health Community Framework to Quality and Safeguarding Committee | ~~(31.10.22)~~<br>(31.03.23) | 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<br><br>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<br><br>Active recruitment now underway and named specific pilot areas in roll-out<br><br>Design of new fully integrated model completed~~.~~ ~~Implementation delayed by Voluntary, Community and Social Enterprise~~ | |

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| | | | | ~~(VCSE) procurement processes, now resolved~~<br><br>~~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~~<br><br>~~The go-live sites have taken place in High Peak and Derby City – Further project support being explored to further support the improvement plan~~<br><br>Royal College of Psychiatrists (RCP) Acute AIMS standards being reviewed for acute units, each area being scored ahead of accreditation. Clinical Leads have been trained as peer reviewers for AIMS, undertaking reviews for other acute units seeking accreditation and supporting our own accreditation. Standards have altered. And now include workforce access to breaks. This is a separate piece of work and project which is also underway | |

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| | | | | ~~The High Peak team retrospective planning phase continues. Ongoing work around team configuration in the county to wards/boundaries continues impacting on timescales~~<br><br>~~The Derby City MDT are taking on new introductions in one patch (DE24) and will expand coverage over the months~~<br><br>~~Chesterfield and Derbyshire Dales remain in a planning phase in preparation for the integration with the CMHT North East Derbyshire & Bolsover are yet to commence their planning phase. We are currently working with partners to agree boundaries and alignment of teams to the new ICB architecture~~<br><br>The process of drafting an Operational Policy for Derbyshire Living Well and Derby Wellbeing Services to support with practice, delivery and governance has begun<br><br>03.01.23: Challenges remain in High Peak around workforce, recent | |

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| | | | | Service Manager change to support. Working with the ICB with regards to social care integration.<br><br>Full implementation within Derby City on the 06.02.23, working with the ICB on this plan including system communications<br><br>Internal DHCFT work - Plans remain to support Community Mental Health Framework delivery; monitoring through the Trust Programme Board. Next phase is Chesterfield and North East Derbyshire | |
| Implementation of clinical governance improvements with respect to:<br><br>- Outcome measures<br>- Clinical service reviews including reduction in excess waiting times<br>- Getting it Right First Time (GIRFT) reviews<br>- Patient Safety Incident Response Framework (PSIRF) implementation<br>- Commissioning for Quality and Innovation (CQUIN) Framework<br>- National Institute for Health and Care Excellence (NICE) guidelines | Develop and implement an improvement plan to enable all governance improvement plans to be implemented [ACTION OWNERS: MD/DON/COO/DSPT] | Compliance with suite of metrics and reporting schedule | ~~(31.12.22)~~<br>(31.03.23) | Trust's COVID recovery roadmap outlines timescales for standing up of core clinical governance developments, commenced June 2021<br><br>PSIRF implementation continues – New processes in place. Staff training on PSIRF has occurred and staff capacity in place<br><br>CQUIN progress included in DARs<br><br>NICE guideline mapping recommenced September 2021 | AMBER |

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| | | | | Getting it Right First Time (GIRFT) reviews for Acute and Crisis were held in July 2021, action plan received<br><br>Rehabilitation pathway, April 2022 – Revised as commencing in October 2022 due to unexpected absence<br><br>Reduction in waiting times included in DARs. Work continues until the gap is significantly reduced. Progress in Older Adults pathways continues in MAS waiting times, benchmarking against regions shows sustained improvement<br><br>Performance summit held; the outcome will be an improved matrix to measure outcomes against clinical governance improvements. Waiting times management reviewed, how to manage waiting times differently – Paper was presented at Quality and safeguarding Committee<br><br>Agreed programme of work in place from Performance Summit | |

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| | | | | focussing across four key workstreams to make improvements: Engagement; quality improvement and approach to management; review of metrics and data optimisation. All workstreams are progressing, in particular wait times management recovery action plans have been developed and are being monitored via TOOL | |
| Implementation of new quality priorities for:<br><br>- Sexual safety<br>- Implementing CQUINS and Clinical outcome measures<br>- Recovering services – equally well<br>- New Trust strategy and priorities<br>- Dormitory eradication programme | Develop and implement an improvement plan to enable all quality priorities to be implemented<br>[ACTION OWNER: DON] | Compliance with suite of metrics and reporting schedule | ~~(31.12.22)~~<br>(31.03.23) | Reducing violence – Body worn camera investment in place<br><br>Sexual safety – Improvement work (dashboard, preceptorship training and protocols) all commenced. Sexual safety on professional standards video launched, feedback being collected<br><br>London Road Ward 1 Older Adult service dormitory beds ~~have~~ closed. Dormitory eradication programme in construction<br><br>Plan for existing dormitory stock and a plan to maintain and improve dignity for active bed stock in design | GREEN |

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| There is a risk that patients in our care in Derbyshire or commissioned services may receive poor care due to experiencing abuse or professional misconduct. Learning from other independent and national exposures of abuse | Revisit all assurances and scrutinise practice, gathering intelligence and implement an improvement plan to enable all services to provide the highest standard of care which would be expected<br>[ACTION OWNERS: DON/MD] | Engagement and mobilisation of the organisation to discuss learning from recent exposes<br><br>Discuss and activate colleagues to revisit what compassionate care means and actively encourage, inspire, reward – Supervision, reflective practice and asking for help<br><br>Mobilise and re-emphasise expectations of standards of care and Freedom to Speak Up<br><br>Revisit system and process of governance and using intelligence to take oversight of services<br><br>Inspire conversations re the risks of harm and closed cultures. Reset the culture and the tone of the requirement for professional scrutiny and all employee requirements to prevent harm and report poor care/ abuse<br><br>Strengthen out of hours, weekends and night announced and unannounced visits. To promote access to multiple managers, relationships, so colleagues feel empowered to report any concerns<br><br>Review Learning Disability physical health care access, provision access to acute liaison nurses and inspire acute and | ~~(31.12.22)~~<br>(31.03.23) | Programme of engagement and planning has commenced<br><br>Night and evening weekend visits commenced by a wider team of leaders<br><br>Review of LD patients in providers and care offers in two acute Trusts - Completed<br><br>~~Delivery plan and progress will be reported to the Quality and Safeguarding Committee in November and December 2022~~<br>There is a wide range of opportunities for colleagues to have conversations about care delivery and raise concerns, including reflective discussions, Trust-wide and divisional engagements, Freedom To Speak Up processes, Schwartz Rounds<br><br>During this process an improvement to engagement of temporary staff has been identified and a solution is being explored with temporary staffing and Clinical and Quality directorate colleagues | AMBER |

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| | | community colleagues in this area of safety for our community | | Increasing visibility of senior staff through the mechanism Quality Visits, mock CQC inspections and out of hours visits<br><br>Robust oversight of patient safety incidents, concerns, complaints, and compliments with scrutiny from independent partners, e.g. Healthwatch and experts by experience being core members of Patient and Carer Experience Committee<br><br>The Trust welcomes external partnership working including Healthwatch, Advocacy services and statutory services within the safeguarding arena and secure services<br><br>The Trust has processes to support people with a learning disability or autistic people who are admitted to our acute and secure services<br><br>The Trust welcomes the opportunity to provide assurance and participate in external reviews alongside the ICB and Adult Safeguarding Board | |

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

| Record ID | Service Line | Title | Risk: Summary of Progress | Date Risk Created | Date of Next Review | Residual Risk Rating |
|---|---|---|---|---|---|---|
| 3009 | Learning Disabilities Services | Demand for Autism Spectrum Disorder (ASD) assessment Service far outstrips contracted activity | 04.04.22: The team is still not commissioned to provide the number of assessments which are required for the region. Working with CCG to develop a long-term plan. Complaints and concerns have been raised<br><br>07.11.22: Diagnostic team and SAT team merged to provide additional resilience. Further training secured for other professionals to be able to assess people routinely. Specialist pool/bank being set up to offer opportunity for clinics to be had outside the main team | 01.01.16 | 12.05.23 | HIGH |
| 21586 | Community Care Services (Older People) | Wait times breaching CCG contract | 23.06.22: A new MDM model is established with a blended approach to clinical activity. 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<br><br>Wait times are still high, with 24-25 week waits. The team are still working through the transformation process, making efficiencies where possible. Under review with General Manager | 12.12.18 | 01.03.23 | 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.<br><br>Replacement of the Pharmacy IT system is a possible solution but appears disproportionate in terms of team capacity and financial pressures<br><br>Patch has now been tested on four computers and is being deployed to all remaining users in the department | 16.05.22 | 03.03.23 | HIGH |

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|---|---|---|---|---|---|---|
| 22790 | Corporate Services – Pharmacy | Prescribing Valproate to women of child-bearing potential: Failure to comply with regulations | 24.06.22: Support for safe use of Valproate in compliance with MHRA in development<br><br>26.09.22: Current risk rating reviewed. Risk remains due to lack of IT system that will reconcile prescribing with patient identifying information (sex and age). Plan is currently for full roll-out of Epma in 2023. To review in 6-months as reassess risk in the light of Epma progress and any national work around valproate as an identified priority for patient/medicines safety | 28.02.22 | 27.03.23 | **HIGH** |

# Board Assurance Framework 2022-23 – Issue 4.3 - 7 March 2023

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

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

**Impact:**
Low quality care environment specifically related to dormitory wards
Crowded staff environment 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 | ~~Extreme~~ High | Likelihood ~~4~~ 3 | Impact 5 | Direction ↓ | Moderate | Likelihood 3 | Impact 4 | Accepted | Tolerated | Not Accepted |

**Preventative** – Routine environmental assessments for statutory health and safety requirements; environmental risk assessments reported through DATIX; ~~COVID secure workplace~~ Infection, Prevention Control (IPC) risk assessments
**Detective** – Reporting progress against Premises Assurance Model (PAM) to the Executive Leadership Team (ELT); Dormitory Eradication Board reports into Trust Board
**Directive** – Capital Action Team (CAT) role in scrutiny of capital projects; ~~COVID secure workplace~~ IPC 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~~ IPC risk assessments<br>- Health and Safety Audits<br>- Premises Assurance Model System (PAMS) reporting providing updates on key priority areas<br>- Estates Strategy | - Mental Health Capital Expenditure bidding process<br>- External authorised reports for statutory health and safety requirements<br>- 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~~ | ~~(31.12.22)~~ | ~~Revised Estates Strategy is now complete and was approved by TOOL on 07.04.22~~ | ~~GREEN BLUE~~ |
| Lack of adherence to emerging national guidance and policy requiring the elimination of mixed sex wards and dormitory style inpatient facilities | Deliver two new adult acute 54-bed units with ~~a~~ single room en-suite with additional staffing and new model of care<br><br>VAT abatement appeal – Combined capital funding shortfall risk of £10.7m if appeal unsuccessful<br>[ACTION OWNER: COO] | Delivery of approved business cases | Hard deadline for national funding of March 2024 | Two new build adult acute unit FBCs nationally approved September 2022, funded by £80m national PDC and £18.6m CDEL. ICS supported and approved revenue funding Delay in national approval and redesign of foundations ~~impact on practical completion – Now June 2024~~ – Phased completion from April 2024 through to March 2025<br><br>HMRC appeal on VAT abatement claim in process | AMBER |
| | Older Adult service relocation to refurbished ward with single room en-suite and gender segregation, with additional staffing and new model of care, by ~~March~~ September 2024 to eradicate dormitories in Northern Derbyshire and avoid this 12-bed service being isolated in otherwise vacated wards, increasing service user safety issues | Delivery of approved business case | ~~(31.01.23)~~ (30.06.23) | Older Adult service relocation FBC and revenue funding approved by ICS<br><br>~~Awaiting outcome NHSE national additional PDC bid to Treasury~~ | ~~RED~~ AMBER |

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| | National PDC capital funding approval [ACTION OWNER: COO] | | | National PDC capital funding approved by NHSE December 2022<br><br>Refurbishment scheduled June – December 2025; New unit live 01.04.24 | |
| | Audrey House refurbishment as decant ward to enable Radbourne Unit dormitory eradication refurbishment. Dormitories cannot be fully eradicated without use of this decant ward<br><br>National PDC capital funding approval [ACTION OWNER: COO] | Delivery of approved business case | ~~(31.01.23)~~ (30.06.23) | ~~Awaiting outcome NHSE national additional PDC bid to Treasury~~<br>National PDC capital funding approved by NHSE December 2022. Refurbishment scheduled January - August 2023. Live as decant ward September 2023 – September 2024. Further refurb scheduled October - November 2024. Live as Acute-Plus 01.02.25 | ~~RED~~ AMBER |
| | Radbourne Unit dormitory eradication refurbishment to provide two 17-bed wards with single room en-suite, with additional staffing and new model of care, to complete dormitory eradication in Southern Derbyshire. Service users continue to receive care in non-compliant wards until this refurbishment is completed<br><br>National PDC capital funding approval [ACTION OWNER: COO] | Delivery of approved business case | ~~(31.01.23)~~ (30.06.23) | FBC and revenue funding approved by ICS<br><br>~~Awaiting outcome NHSE national additional PDC bid to Treasury~~<br>National PDC capital funding approved by NHSE December 2022. Following Audrey House refurb for decant, Radbourne Ward 32 refurb scheduled September 2023 – March 2025 and live May 2025. Refurb Ward 34 scheduled March 2025 – March 2026 live April 2026 | ~~RED~~ AMBER |
| Lack of an accessible Derbyshire wide Psychiatric Intensive Care Unit (PICU) | Delivery of local PICU arrangements (new build and associated projects | Agreed programme of work with capital funding to support it | ~~(31.01.23)~~ (30.06.23) | FBCs approved by ICS in June 2022 for 14-bed male PICU and 8-bed Acute-Plus | ~~RED~~ AMBER |

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| | taking into account gender considerations)<br><br>£3.5m national capital agreed November 2022. Derbyshire CDEL flexibility agreed for Trust to fund £10.9m remaining capital from cash reserves 2022/23 and 2023/24. VAT abatement risk £1.7m<br><br>National PDC capital funding approval [ACTION OWNER: COO] | | ~~PICU delivery subject to national capital availability~~ | female facility, subject to additional capital availability. ~~Additional national capital being sought for PICU foundations initially~~<br><br>~~Practical completion expected June 2024. Acute-Plus still dependant on additional national funding approval~~<br><br>PICU fully funded by national and Trust capital November 2022. HMRC appeal on VAT abatement claim in process – Capital funding shortfall risk of £1.7m for PICU if appeal unsuccessful. Practical completion expected June - November 2024, live April 2025<br><br>Acute-Plus national PDC capital funding approved by NHSE December 2022. Refurbishment following decant ward is scheduled October - November 2024. Live as Acute-Plus 01.02.25 | |
| ~~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~~<br><br>~~Premises Assurance Model (PAM) assessment to be completed [ACTION OWNER: COO]~~ | ~~Completion of agreed recommendations and management actions~~<br><br>~~Reporting to Finance and Performance Committee twice yearly and any exceptions in between~~ | | ~~Agreed recommendations and management actions completed September 2021~~<br><br>~~Reporting to Finance and Performance Committee started May 2021 and now embedded~~ | ~~BLUE~~ |

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|---|---|---|---|---|---|
| | ~~Review of current estates and facilities governance structures [ACTION OWNER: COO]~~ | ~~Governance structure in place~~ | | ~~Internal governance structure in place and meeting monthly~~<br><br>~~Management audit undertaken by internal auditors Quarter 4 2020/21. All actions complete~~<br><br>~~Governance reporting includes audit recommendation response and delivery - Complete~~ | |

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

# Board Assurance Framework 2022-23 – Issue 4.3 - 7 March 2023

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

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

# Board Assurance Framework 2022-23 – Issue 4.3 - 7 March 2023

| Assurances on controls (internal) | Positive assurances on controls (external) |
|---|---|
| IM&T Strategy delivery update to F&P – ~~September 2021~~ Annual<br>Embedded programme of software and hardware upgrades<br>Live testing of business continuity plans | - Templar Cyber Organisational Readiness Report (CORS)<br>- Annual external cyber review by Dynac (vulnerability scan)<br>- Data Security and Protection annual review by Internal Audit, weighted toward cyber security<br>- 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<br>[ACTION OWNER: COO] | Reporting to the Divisional Achievement Reviews (DARs) | ~~31.01.23~~<br>31.03.23 | Programme of updating underway. Emergency Planning and Business Continuity Manager is reviewing each business continuity plan to ensure that they are appropriate and consistent<br><br>Desk based exercise undertaken and reported to the Data Security and Protection (DSP) committee. Actions identified being progressed<br><br>The priority has been 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. Full review of business continuity | AMBER |

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| | | | | management system is ongoing ~~being undertaken~~ | |
| ~~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~~ | | ~~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~~<br><br>~~This work will be continuously ongoing. As weaknesses are identified in software patches and/or upgrades are undertaken – Action complete, BAU~~ | ~~BLUE~~ |
| ~~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~~ | | ~~Desk based exercise undertaken and reported to the DSP committee. Actions complete~~ | ~~BLUE~~ |
| ~~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~~ | | ~~CORS recommendations and actions complete and improvements embedded~~ | ~~BLUE~~ |

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

# Board Assurance Framework 2022-23 – Issue 4.3 - 7 March 2023

## Strategic Objective 2 - To be a GREAT place to work

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

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

**Root causes:**

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

| **BAF Ref**: 22-23 2C | **Director Lead**: Jaki Lowe (DPI) | **Responsible Committee**: People and Culture Committee |
|---|---|---|

## Key Controls

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

# Board Assurance Framework 2022-23 – Issue 4.3 - 7 March 2023

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

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

| Key gaps in control | Key actions to close gaps in control | Impact on risk to be measured by | Expected completion date (Action review date) | Progress against action | Action on track |
|---|---|---|---|---|---|
| Lack of planned leadership development growth and stretch programmes and opportunities including coaching and mentoring | Review of system level leadership offer and impact<br><br>Review and development of Trust leadership offer and impact<br><br>Re-establish leadership forum<br><br>Development of coaching access at local, system and national<br>[ACTIONS OWNER: DPI] | Percentage of leaders with development plan as part of objectives<br><br>Percentage of leaders attending local, system or national leadership programmes | ~~01.02.23~~<br>31.03.23 | Deputy Director of People is part of system leadership workstream to review current offer and develop 12 month plan on leadership offer<br><br>New leadership programme (aimed at band 8B staff) launched and commences October 2022<br><br>Leadership forum revised and first forum took place December 2022 with monthly forums now planned throughout 2023 ~~and launch planned December 2022~~ | AMBER |

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|---|---|---|---|---|---|
| Fully embedded person-centred culture of leadership and management | Review of policies and processes to support a person-centred approach to leadership and management<br><br>Introduce just and restorative culture approach<br><br>Review of leadership development offer<br><br>Re-establish line manager development sessions<br><br>Scrutiny of people data at divisional level<br>[ACTIONS OWNER: DPI] | Reduced number of formal staff relations issues/cases reported in monthly people assurance report to ELT<br><br>Staff survey results<br><br>Reporting to TOOL | 31.03.23 | Just and restorative culture conference taken place<br><br>Review of cases and case management to be reported into ELT in October 2022 | AMBER |
| No operating framework through which to maximise the impact of staff networks | Collaboratively develop and Implement Staff Network Framework to provide consistency across the networks with clear framework, clarity of roles and objectives to increase engagement with under-represented staff<br><br>Support to Bi-monthly network Chairs meetings through DPI, Head of EDI and EDI Manager<br>[ACTIONS OWNER: DPI] | Engagement and buy-in by network Chairs<br><br>Sign up to the framework by network Chairs and Executive Directors<br><br>Annual updates by network Chairs of engagement undertaken to be included in annual reports | ~~30.11.22~~<br><br>~~31.12.22~~<br><br>(31.03.23) | ~~Discussions taken place on the need for a framework early summer – Now complete~~<br><br>~~Work paused during summer due to long term sickness of Head of EDI~~<br><br>Discussions with network Chairs to progress ~~timetabled for 20.10.22~~<br><br>New executive model implemented in December 2022. Draft framework now developed and engagement with key stakeholders commenced | AMBER |
| The current capacity and structure of the People and Inclusion directorate is not able to meet the Trust, system, regional and national demands alongside challenges from outsourcing | Review of current People and Inclusion structure to align to needs and priorities of Trust, identify gaps and develop plan to mitigate<br><br>Review of gaps in services delivered by People Services or UHDB and develop accountability framework | A People and Inclusion structure that can support the Trust to deliver against the people priorities<br><br>Accountability dashboard presented to ELT quarterly | ~~31.12.22~~<br>31.03.23 | Contract review meetings established for Occupational Health and Payroll Services (UHDB)<br><br>New governance structure to be developed to manage the Joint Venture – Early | RED |

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| key services via People Services in DCHS and UHDB | Formalise existing governance meetings to ensure clear processes in place for People and Inclusion Services contract and UHDB key service contracts<br><br>Review of current communications and engagement and people priorities across the Trust and system<br>[ACTIONS OWNER: DPI] | Terms of reference in place and regular meetings<br><br>A People and Inclusion structure that can support system-wide priorities<br><br>People and Inclusion staff survey results | | discussions commenced ~~meetings established for People and Inclusion Services~~<br><br>Monthly payroll contract meetings in place | |
| Lack of maturity of EDI framework | Produce and implement EDI framework with clear legislative, and mandated NHS national regional and local deliverables required for the EDI function and structure to deliver<br>[ACTIONS OWNER: DPI] | Agree framework and capacity requirements to deliver<br><br>Regular wider engagement with EDI Delivery Group, and divisional leads taking place<br><br>Final presentation to PCC<br><br>Roll out of framework<br><br>Delivery against the People Performance Dashboard | ~~30.11.22~~<br>~~31.01.23~~<br>31.03.23<br>~~31.12.22~~<br><br>~~31.03.23~~<br><br>~~31.03.23~~<br><br>~~31.03.23~~ | Draft framework is being presented to ELT by 31.01.23 ~~in November 2022~~ | AMBER |
| We have not engaged with our Bank staff to develop a strong sense of belonging, engagement and psychological contract with the Trust | Regular monthly engagement sessions<br><br>Staff survey participation<br><br>Clinical supervision and appraisal participation<br><br>Alignment to Agenda for Change for pay and conditions<br>[ACTIONS OWNER: DPI] | Staff survey participation response rates<br><br>Staff survey engagement scores<br><br>Attendance at engagement sessions | ~~31.01.23~~<br>28.02.23<br><br>~~31.01.23~~<br><br>~~31.12.22~~ | Engagement sessions commenced, sessions booked virtually for October, November and December 2022, and face to face session for January 2023<br><br>Partaking in first national bank staff survey<br><br>Aligned all bank staff bands 2, 3, 4 and 7 to Agenda for Change pay scales<br><br>Started discussions with Staffside to review Bands 5 and 6 current spot rate with | GREEN |

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| | | | | view to align to Agenda for Change | |
| Lack of visible and differential staff benefits and responsive support for staff that reflects current working conditions, e.g. cost of living crisis | Review of gaps in benefits to realign to staff needs<br><br>Review of current reward and recognition framework<br><br>Develop range of staff benefits that align to Trust values and 'people first' approach<br><br>Develop the salary sacrifice offer to support colleagues with cost of living crisis<br>[ACTIONS OWNER: DPI] | Staff survey engagement score<br><br>Staff turnover<br><br>Pulse check scores | ~~31.01.23~~<br>28.02.23 | Delivering Excellence Every Day awards (DEEDs) have been revised and relaunched<br><br>Staff awards took place November 2022 ~~taking place~~<br><br>System-wide discussions commenced with regards a system wide benefits package<br><br>Mileage rates adjusted to reflect cost of living crisis | RED |
| Inconsistency in application of an in inclusive approach impact on developing and sustaining a sense of belonging | Embed an inclusive approach, promoting equality and ensuring diversity at all levels through learning and development, Schwartz Rounds, personal development reviews, mid-year reviews, rewards and awards, objective settings<br>[ACTIONS OWNER: DPI] | Year on year change WRES/WDES, staff surveys and lived experience of staff through staff networks<br><br>Data drawn from all engagement activities so we are able to identify impacts on staff experience and any inequalities that need to be closed | (31.03.23) | This work will need to commence in the last quarter of 2022/23 | AMBER |
| Systematic planning and attendance of training | Training to be embedded in e-roster and designed to support safe staffing by minimising face to face sessions needed<br><br>Progress the breaks and shift pattern change process<br>[ACTIONS OWNER: DPI] | Full compliance with safer staffing levels in line with NHSI Workforce Safeguards<br><br>Training compliance in line with CQC requirements<br><br>Staff survey health and wellbeing scores<br><br>Comprehensive system and trust level health and wellbeing offer<br><br>Compliance with NHSI workforce safeguards requirements | ~~31.12.22~~<br>31.03.23 | New reporting processes in place that feeds into TOOL, PCC and Board – Now embedded with triangulation on staffing/agency/bank to be included at PCC<br><br>Work being done on a planned training day<br><br>Shift and break consultation being planned, to commence early 2023 | AMBER |

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| | | Staff are able to take breaks and access the right health and wellbeing support<br><br>E-roster team appropriately resourced and supported | | | |

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

| Record ID | Service Line | Title | Risk: Summary of Progress | Date Risk Created | Date of Next Review | Residual Risk Rating |
|---|---|---|---|---|---|---|
| 22961 | Operational Services – management Team | Industrial action | Uncertainty around numbers of staff who would participate in industrial action. Derbyshire was not included in the December days of action but was included in January days.<br><br>Weekly Strategy meeting with Managing Directors, Head of Organisational Effectiveness, Assistant Director for Clinical Professional Practice and EPRR Lead. Involvement of Staffside in planning group | 28.11.22 | 28.04.23 | EXTREME |

## Strategic Objective 2 – To be a GREAT place to work

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

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

**Root causes:**

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

| **BAF Ref**: 22-23 2D | **Director Lead**: Jaki Lowe (DPI) | **Responsible Committee**: People and Culture Committee |
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### Key Controls

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

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

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

| Key gaps in control | Key actions to close gaps in control | Impact on risk to be measured by | Expected completion date (Action review date) | Progress against action | Action on track |
|---|---|---|---|---|---|
| An integrated workforce plan and planning process that feeds into pipeline plans and ensures we have the right people in the right place with the right skills | Develop a Trust Workforce Plan linking demand and capacity, workforce redesign to ensure a fully funded workforce<br><br>Develop vacancy rate data and breakdown variances in vacancy data<br><br>Establish a workforce transformation group to develop workforce development plans and ownership at divisional level<br>[ACTIONS OWNER: DPI] | Vacancy rates<br><br>Time taken to fill vacant posts<br><br>Transformational posts, e.g. apprenticeships all identified<br><br>Reduction in agency costs | ~~31.01.23~~<br>31.03.23 | High level Workforce Plan developed and presented to Board<br><br>Workforce transformation group commenced December 2022 ~~commencing November 2022~~ | RED |

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| We do not have an effective and embedded succession talent management processes | Develop a Talent Management Strategy<br><br>Pilot career conversations for senior leaders and roll out career conversations for all colleagues<br><br>Work as a system to develop system-wide approach to talent management and align where best for the Trusts<br>[ACTIONS OWNER: DPI] | Career conversations taking place<br><br>Internal appointments/promotions<br><br>Turnover rate<br><br>Key staff survey measures | 31.03.23 | Talent Strategy in draft<br><br>Pilot ready to launch for senior leaders in January 2023<br><br>Deputy DPI system lead on talent management | AMBER |
| Lack of capacity, experience and plans for recruiting overseas | Develop International Recruitment (IR) plan and programme<br><br>Appoint IR team to lead programme<br><br>Engage with national IR support<br><br>Access national IR funding<br><br>Support Trust teams to prepare for IR arrivals<br>[ACTIONS OWNER: DPI] | Number of IR appointments<br><br>Retention rate of IR | ~~31.01.23~~<br>31.03.23 | IR pastoral support officer appointed and commenced in post<br><br>Funding secured for four IRs<br><br>Regular meetings established with national midlands IR lead<br><br>System AHP IR bid successful | RED |
| ~~The recruitment and retention scheme has not been fully embedded~~ | ~~Develop and launch a Recruitment and Retention Payment (RRP) scheme that provides clear guidance and a thorough process for appointing any RRP to a post(s)~~<br>~~[ACTIONS OWNER: DPI]~~ | ~~RRP applied to high risk posts and successfully attracts applicants and leads to appointment~~ | ~~31.12.22~~ | ~~RRP approach approved by ELT – Complete~~ | ~~AMBER~~<br>~~BLUE~~ |
| Onboarding and Retention process and planning needs to be embedded | Understand the key retention issues for posts/teams/professions with the highest turnover<br><br>Ensure ‘stay conversations’ form part of regular 1:1s<br><br>Develop NHS retention framework for nursing<br>[ACTIONS OWNER: DPI] | Improvements to turnover<br><br>Staff survey engagement scores | ~~31.01.23~~<br>31.03.23 | ‘Stay’ survey piloted with Allied Health Professionals and 1-2 year starters<br><br>New starter survey completed with all started in six months and learning shared at Trust and divisional level<br><br>Nursing retention framework self-assessment completed | AMBER |

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| | | | | System retention lead appointed to support Trust level and system work | |
| Medical staffing team and role not sufficiently developed<br><br>Workforce plan for medical staff not in place | Review existing medical staffing team and workforce support and identify gaps<br><br>Develop new model to support and maximise the medical workforce<br><br>Develop medical agency model to ensure efficient usage<br>Develop a medical staff workforce plan | Engagement of medical workforce<br><br>Reduction in agency spend | ~~31.01.23~~<br>31.03.23 | Terms of reference agreed by MD and COO for review of existing medical staffing team and creation of a medical workforce plan<br><br>Resources identified and funding needs to be agreed for the review by ELT | RED |
| Lack of culturally competent recruitment processes | Completion and implementation of recommendations of the Above Difference recruitment and retention system pilot<br><br>Wider engagement with recruiting managers, staff networks, clinical leads and operational leads<br><br>Quartile monitoring of utilisation of Above Difference recruitment and retention tools<br><br>Continuous improvement approach to implementing learning<br>[ACTIONS OWNER: DPI] | WRES and WDES data shows year on year improvement, staff survey and lived experience of staff<br><br>Increase the proportion of applications from ethnic minority groups, increase likelihood of shortlisting and reduce disparity in all areas | 31.03.23 | Recruitment leads across the system all trained through Above Difference programme<br><br>Pilot nearing completion with six workstreams completing key learning to be shared at future system human resources meeting to agree actions and programme management to move forward at pace<br><br>Examples of innovation already being trialled such as one page job description being piloted by two teams | RED |

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| Effectiveness of recruitment policy, practice and processes | Review and develop existing recruitment Key Performance Indicators (KPIs) to ensure fit for purpose<br><br>Where appropriate move away from TRAC to advertise jobs and use fast track processes, e.g. Indeed/MSforms<br><br>Develop cohort recruitment for key posts<br><br>Improve the multidisciplinary working (HR, communications and recruiting managers) to enable better planned and executed campaigns<br>[ACTIONS OWNER: DPI] | Time to recruit<br><br>Number of applicants applying and successfully shortlisted<br><br>Campaign impact and reach<br><br>Financial savings through cohort recruitment | ~~31.01.23~~<br>31.03.23 | KPI review commenced<br><br>Indeed piloted for hard to fill posts in acute<br><br>Cohort recruitment successfully piloted for Health Care Assistants and Human Resources apprenticeships | AMBER |

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

| Record ID | Service Line | Title | Risk: Summary of Progress | Date Risk Created | Date of Next Review | Residual Risk Rating |
|---|---|---|---|---|---|---|
| 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. Plan was presented to ELT and TOOL.<br><br>05.12.22: Staffing remains pressured. Additional pharmacist leaving the Trust to take up a new opportunity. No applicants for most pharmacist roles. Mitigations in place, with hope for growth in medium-long term | 18.03.22 | 20.03.23 | HIGH |

## Strategic Objective 3 – To Make BEST use of Our Resources

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

**Impact:** Trust becomes financially unsustainable

**Root causes:**

a) Financial detriment (revenue, cash and/or capital) resulting from large capital development programme, in particular dormitory eradication and associated capital schemes
~~b) 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~~
b) Organisational financial detriment created by commissioning decisions or wider 'system-first' decisions including enactment of risk-sharing agreement in partnership arrangements or changes in NHS financial arrangements. ~~during and beyond the pandemic~~ System financial position resulting in required additional financial savings to support the System position from Mental Health funds. Additional and stretch targets in Quarters 3 and 4
d) Non-delivery of required levels of efficiency improvement
e) Lack of sufficient cash and working capital
f) Loss due to material fraud or criminal activity
g) Unexpected income loss or non-receipt of expected transformation income (e.g. long-term plan (LTP) and Mental Health Investment Standard (MHIS) without removal of associated costs
h) Costs to deliver services exceed the Trust financial resources available
i) Lack of cultural shift/behaviours to return to financial cost control regime
j) Inability to reduce temporary staffing expenditure
k) Ongoing or re-emergence of COVID-related costs with insufficient covid funding
~~l) System financial position resulting in required additional financial savings to support the system position from mental~~

| | |
|---|---|
| c) Non-delivery of expected financial benefits from transformational activities | ~~health funds. Additional and stretch targets in Quarters 3 and~~ 4 |

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|---|---|---|
| **BAF Ref**: 22-23 3A | **Director Lead**: Rachel Leyland (DOF - Interim) | **Responsible Committee**: Finance and Performance Committee |

**Key Controls**

| **Inherent Risk Rating** | | | **Current Risk Rating** | | | | **Target Risk Rating** | | | **Risk Appetite** | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| High | Likelihood 3 | Impact 5 | ~~Extreme~~ Moderate | Likelihood 4~~-2~~ | 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<br>- Appropriate monitoring and reporting of financial delivery – Trust overall and programme-specific including 'Use of Resources' reporting updates<br>- Assurance levels gained at Finance and Performance Committee<br>- Delivery of Counter fraud and audit work programme with completed and embedded actions for all recommendations<br>- 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<br>- Local Operating Procedure in operation for Acute Capital Programme<br>- Board and F&P oversight of Acute Capital Programme delivery<br>- 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<br>- Systems Finance and Estates Committee/System Project Management Office/system DoF meetings etc.<br>- Internal Audits – Financial integrity and key financial systems audits<br>- External Audits – Strong record of high-quality statutory reporting with unqualified opinion<br>- National Fraud Initiative – No areas of concern<br>- 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)<br>-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:<br><br>- Inflation cost risk | Risk share arrangements with PSCP<br><br>Optimism bias and contingency discussions with NHSE/I on cash and capital | Cash and capital reporting and forecasting evidence 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 | ~~RED~~ AMBER |

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| - Risk-share<br>- Cashflow timings and variability<br>- Guaranteed Maximum Price exceeds national funding envelope (due to hyperinflation and other factors) | | | | Hyper-inflation cost risk remains is very high due to world events and economy<br>The affordability risk has escalated the wider programme risk to extreme<br><br>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~~ ~~for three refurbishment schemes~~<br><br>National PDC capital funding approved by NHSE December 2022 for three refurbishment schemes. HMRC appeal on VAT abatement claim in process – Combined capital funding shortfall risk of £10.7m if appeal unsuccessful | |
| System capital programme funding shortfall for self-funded Trust capital programme:<br><br>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. 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 | March 2024 and beyond (review quarterly) | System capital plan submitted under constrained CDEL envelope<br><br>Longer term planning commenced HMRC ~~view awaited~~ appeal commenced<br><br>PICU: £3.5m national capital agreed November 2022 and a further £6m agreed in January 2023. Derbyshire CDEL flexibility agreed for Trust to fund £10.9m remaining capital from cash reserves 2022/23 and 2023/24.<br><br>VAT abatement risk £1.7m | ~~RED~~ AMBER |

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| | | | | ~~NHSE/I PICU capital information awaited guidance issued and urgent discussions with national and regional teams to seek additional national PDC to address the funding shortfall – ongoing~~<br><br>~~This risk has crystalised, there is now a confirmed funding shortfall for the self-funded schemes within the overall programme~~ | |
| Trust cash risk related to PICU new build | System capital planning had included PICU self-funded elements which have had to augment the new build national schemes, but CDEL was constrained for the system. CDEL limits and are set against the hyperinflated costs for the programme as a whole, in order to ascertain the funding shortfall<br>National funding confirmed for part of the build and CDEL increase (without cash) confirmed for the remaining build so requires use of Trust cash reserves | Cash reporting and forecasting evidence of plan delivery and/or indicates areas of required management action | 31.03.24 | Regular oversight of cash position. Reporting to ELT, F&P and Trust Board<br><br>PICU Trust-funded requirement now reduced from £10.9m to £4.9m with additional PDC funding confirmed reduces cash reserves to £20m in 2023/24; requires some restriction of capital programme to replenish cash reserves | RED |
| Additional revenue not approved by System for Older Adults Service Relocation OBC and all non-national schemes | Close partnership working with CCG and System partners to agree OBCs and FBCs as System documents | System approvals of both OBCs and FBCs subject to capital funding sources | ~~31.12.22~~<br>31.03.23 | CCG and DCHS partners contributing to OBC/FBC development<br><br>MHLD&A Board agreed to oversee revenue delivery contained within programme spend.<br>However, note that all non-national FBCs are now require capital funding resolution before they can proceed – Outcome of NHSE bid to Treasury for additional capital received ~~awaited~~ | 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 | ~~31.12.22~~<br>31.03.23 | ~~National submitted in May and national approval expected August 2022~~ | AMBER |

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| | | | | Treasury approval may also be required given the value of the schemes which now include hyperinflation costs<br><br>Notification of outcome FBCs approved by NHSE, subject to conditions. HMRC appeal process commenced ~~ruling awaited~~ | |
| 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<br><br>Quality Improvement process meetings set up<br><br>Temporary staffing costs are being managed within the overall financial position | 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 has closed the gap and schemes have been identified for the full £6m | ~~RED~~ AMBER |
| 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. Updated IPC guidance received. Covid costs scrutiny enhanced. Costs have substantially reduced ~~been reducing but still remain~~ | ~~RED~~ AMBER |
| ~~Financial cost pressure created by system-first decisions – Sharing of system planning gap~~ | ~~Additional 'stretch' management action required to reduce other costs to mitigate impact to achieve overall financial position~~ | ~~Achievement is incorporated into most likely forecast as reported to ELT and F&P (and system reporting)~~ | ~~March 2023 (Quarterly)~~ | ~~Governance process in train for system partners to consider and enact changes to financial plans and forecasts as of September 2022~~ | ~~RED~~ |
| ~~Financial cost pressure created by unfunded pay award~~ | ~~Additional 'stretch' management action required to reduce other costs to mitigate impact to achieve overall financial position~~ | ~~Achievement is incorporated into most likely forecast as reported to ELT and F&P (and system reporting)~~ | ~~March 2023 (Quarterly)~~ | ~~Pay award enacted September. Updates to forecasts will reflect actual increasing costs.~~ | ~~RED~~ |

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| | | | | ~~Additional funding for relevant services will be explored with Local Authority~~ | |
| Financial cost pressures created by system first decisions and requirement for mitigation of system financial gap | Additional 'stretch' management action required to reduce other cost and mitigate impact to achieve overall financial position | Achievement is incorporated into most likely case forecast reported to ELT, F&P and system reporting | 31.03.23 | Guidance received in relation to governance process to enact changes to partner and system financial forecast<br><br>Funding secured from the local authorities for AFC cost pressures. One off benefit received from VAT abatement and slippage on recruitment to new investments is planned to deliver the required additional stretch surplus of £1.4m. The financial position for Derbyshire is a risk to the statutory duties for DHCFT to manage its financial position. Additional surplus required of £1.4m is being achieved through additional funding for revenue costs related to dormitories scheme along with additional stretch requirement | AMBER |

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

**Strategic Objective ~~3~~ 4 - ~~To Make BEST use of Our Resources~~ To be a GREAT Partner**

**Principal risk: Whilst there are significant benefits from the creation of the Integrated Care System (ICS) as an NHS body, there is a risk that the effects of the change 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**: 22-23 ~~3C~~ 4A | **Director Lead**: Vikki Ashton Taylor (DSPT) | **Responsible Committee**: Trust Board |
|---|---|---|

**Key Controls**

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

**Preventative** – Governance structures in place at a system and Delivery Board level. Ongoing close communication with NHSE/I, mental health and learning disability teams at a regional and national level. Assumed NHSE/I-led appointment process to new ICS Board positions
**Detective** – Early meetings to be put in place with all new appointees at an executive level. Continuing engagement in all Joined up Care Derbyshire governance from DHCFT representatives. Due diligence processes undertaken prior to accepting any lead provider responsibilities
**Directive** – Mental Health, Learning Disability and Autism System Delivery Board to engage widely across membership on the development of any provider collaborative with agreed plans and processes. Gateway process run by NHSE prior to agreement to establish the Trust as lead-provider in any regional collaborative
**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<br>- Regular ELT updates and discussions<br>- NED Board members on JUCD committees and Board<br>- 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<br>- Appointments/ assurance of new ICS Board (ICB) through NHSE/I processes<br>- 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<br><br>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<br><br>Positive working relationships formed with all new appointees in the Derbyshire system | ~~(31.12.22)~~ (31.03.23) | Weekly meetings continuing<br><br>ICB now formed and fully recruited to and great effort is being made on maintaining strong working relationships. However, there remains a potential risk around evolving ICB culture and impact on partnership working<br><br>Emerging ICB and broader system governance | GREEN |
| Plan required for the development of the MHLD&A Board to become a provider alliance | Plan to be developed in partnership with all other organisations in the alliance [ACTION OWNER: CEO] | Development and agreement of Mental Health, Learning Disability and Autism (MHLD&A) Provider Alliance before December 2021 | ~~(31.10.22)~~ (31.03.23) | 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~~<br><br>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 | GREEN |

| | | | | | |
|---|---|---|---|---|---|
| | | | | Board July 2022 and reviewed in November 2022 with new partners expressing an interest<br><br>The JUCD Neurodiversity and LD Alliance Festival ~~will be~~ was formally launched in September 2022<br><br>New TOR have been agreed and system partners connectivity and partnership continues in the MHLD&A Board | |
| Increased decision-making at a system and/or provider alliance level may create conflicting accountabilities with the Trust-level governance structures which could result in an increased governance burden | Keep Trust structures under continuous review against the wider governance landscape, including the provider collaboratives and alliance arrangements – This in turn may lead to a formal change of DHCFT governance arrangements [ACTION OWNER: CEO/Trust Secretary] | Board level confidence in new and emerging governance structures and ability to gain assurance on DHCFT risks and issues via system level governance regime | ~~(31.12.22)~~ (31.03.23) | Activity continues to help colleagues understand the ICS. The CEO continues to update the Board and Council of Governors<br><br>The ongoing updates are contributing to our commitment to review DHCFT governance arrangements<br><br>ICB draft constitution approved in the inaugural ICB Board meeting in July 2022. Review of Trust ~~governance pending subject to evolving ICB~~ to ensure operational performance delivery of MHLD&A constitutional standards that DHCFT is a lead or main provider of the performance.<br><br>Clear lines of accountability, operational delivery and | AMBER |

| | | | | | |
|---|---|---|---|---|---|
| | | | | performance outcome have been limited in the 2022 model and require additional refinement to ensure Trust performance is effective<br><br>DHCFT CEO now a member of ICB | |

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

| **Strategic Objective 4 - To be a GREAT partner** |
|---|
| **There is a risk of reputational damage if the Trust is not viewed as a strong partner**<br><br>**Impact:**<br>May lead to poor experience and care for people accessing services within Place and communities<br><br>**Root causes:** |

a) Organisation historically too internally focused
b) Not actively engaging enough as part of a broader multi-agency partnership at Place and Community level
c) Increasing national expectations in provider collaboration and multi-disciplinary delivery model at Place level

| **BAF Ref**: 22-23 4B | **Director Lead**: Vikki Ashton Taylor (DSPT) | **Responsible Committee**: Trust Board |
|---|---|---|

**Key Controls**

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

**Preventative** – Active membership in each Local Place Alliance; Active participation in Place Executive; Regular meetings with NHSE on programme progress; Meaningful stakeholder engagement (internal and external); Multi-disciplinary and cross organisational development and implementation of services
**Detective** – Quality Improvement (QI) delivery; Contract performance; Continuing engagement in all Joined up Care Derbyshire governance from DHCFT representatives
**Directive** – Integrated Care Strategy; Joint Forward Plan (JFP); Trust Strategy
**Corrective** – Risk mitigation activity and oversight at ICS system/other partnership level; Proactive reporting and forecasting of system wide transformation programme progress enabling remedial activity to take effect; General corrective management action

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

| **Key gaps in control** | **Key actions to close gaps in control** | **Impact on risk to be measured by** | **Expected completion date (Action review date)** | **Progress against action** | **Action on track** |
|---|---|---|---|---|---|

| | | | | | |
|---|---|---|---|---|---|
| System partners report that the ICB was not meeting some of its core constitutional targets and was failing to make progress, at pace and scale | New internal performance improvement group and clarity to Trust Board on which DHCFT constitutional standards are not being met and whether the DHCFT contribution is the lead or material and how performance will improve<br>[ACTION OWNERS: COO/DSPT] | Improvement in performance in constitutional standards | (31.03.24) | January 2023: Some performance targets have not been met for 12 months | RED |
| System partners at ICB report that DHCFT is inward looking and does not fully support PLACE developments | Managing Directors to design a communication and improvement plan, with 360 feedback that PLACE partners feel DHCFT support, data is provided and their support named Managing Director is accessible<br>[ACTION OWNER: COO] | PLACE / PCN and GP Directors provide direct feedback to Managing Directors on their relationship, knowledge and impact of the additional leadership support. This includes examples of collaboration and the impact of this support<br><br>Confirmation of frequency of contact, joint action / achievement log of issues raised and achieved<br><br>Managing Directors reports to TOOL with summary of impact to ELT | (30.06.23) | | RED |
| Social care partners have reported that the lack of progress on autism diagnostic reductions is difficult and would like to see increased pace of improvements | Improvement plan for joint autism service<br>[ACTION OWNER: COO] | Feedback from social care on feedback on awareness of the Autism Strategy and autism waiting times reduce across the interagency investment plan | (30.12.23) | November 2022: Lack of progress is reported particularly in North Derbyshire | AMBER |
| GP networks and partners report they do not feel connected to the MHLD&A Board and are not aware of strategic decisions that are made | Communication and engagement plan with GP networks<br>[ACTION OWNERS: DSPT] | Feedback form GP networks on connectivity to MHLD&A Board and DHCFT named leads, information supplied<br><br>GP networks reflect that they are briefed and actively engaged | (30.06.23) | Meeting scheduled in January 2023 to explore and agree collective solutions<br><br>Monthly sessions for GP networks - Engagement event to meet with the DHCFT CEO to receive feedback and answer any strategic or system | AMBER |

| | | | | | |
|---|---|---|---|---|---|
| | | | | questions on DHCFT and the MHLD&A Board | |
| Police partners report they do not always feel supported by mental health services and are under pressure to respond to mental health crisis | Police Education, support, communication and improvement plan with MH Delivery Board and Trust Directors<br>[ACTION OWNERS: DSPT/CEO] | Inter-agency meeting and review of a joint way forward in 2023 including<br>• Police Training<br>• Suicide prevention work<br>• Joint co-produced outcomes<br><br>Agreed outcomes are monitored and reported through MHLD&A Board with liaison with DHCFT Police Liaison group | (31.03.23) | Meeting scheduled in January 2023 to explore and agree collective solutions with Mick Burrows and colleagues | AMBER |
| Patient and carers groups report that they would like to see more progress in service user and carer involvement and moving from engagement to decision making | Peer support strategy and objectives for EQUAL and the Mental Health Engagement Group<br>[ACTION OWNERS: DON/MD/CEO] | Peer support strategy<br>Co-production in Patient and Carer Race Equality Framework (PCREF) requirements | (30.06.23) | | AMBER |

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

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

### Multiple System Strategic Risk

**There is a risk to safe, effective clinical care across Derbyshire impacting upon patients, due to not achieving national standards and variation of clinical practice and service commissioning in the Learning Disability (LD) Transforming Care Partnership and in ICS in-patient LD bedded care**

**Impact:** May lead to avoidable harm and delays in accessing appropriate services, affecting patients, their family members and staff

**Root causes:**

a) The community Intensive Support Team and Learning Disability models have non-standardised operating models and require more capacity
b) Currently the delivery and commissioning partnership in Derbyshire have not met national standards or local ambitions for more robust community-based offers, working across the geography and in an integrated way with partners including social care and the voluntary sector
c) The collective vision for Learning Disability services across Derbyshire and the formal outcome to achieve repatriation to Derbyshire has not been effective with some people remaining in outsourced areas of England for extended and significant periods of time
d) Inpatient bedded facilities do not meet safer staffing levels due to substantial vacancies
e) Derbyshire bedded facilities do not meet current standards, e.g., en-suite accommodation, safety and environmental standards and the seclusion room does not meet the required standards as outlined in the Mental Health Act Code of Practice. (The CQC did note the lack of appropriate provisions in the seclusion room available in 2016 but this was not noted as a requirement notice)
f) The current LD bedded care facilities do not meet the national specifications for the Royal College of Psychiatrists Learning Disability recommended standards and are not in line with future clinical model for the LD&A pathway for Derbyshire
g) Gaps in controls – Derbyshire bedded care facilities for LD services had not had a full CQC inspection since 2016 as a core service. There may have been a drift in scrutiny connected to inspection

| **BAF Ref**: 22-23 MS1 | **Director Lead**: Ade Odunlade (COO) | **Responsible Committee**:<br>Quality and Safeguarding Committee within DHCFT<br>Quality and Performance Committee within the Derbyshire ICS<br>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 | ~~Moderate~~ High | Likelihood ~~3~~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<br>Involvement of Local Government Association to deliver a peer review<br>Involvement of external consultants – Two reports |

| Key gaps in control | Key actions to close gaps in control | Impact on risk to be measured by | Expected completion date (Action review date) | Summary of progress on action | Action on track |
|---|---|---|---|---|---|
| The community Intensive Support Team and Learning Disability models require improved models of support | Review all models of support offered by the Intensive Support Team [ACTION OWNERS: COO/DON/MD] | Outcome of review – Improved models of support | ~~(31.12.22)~~ (31.03.23) | 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<br><br>Medical recruitment and retention is experiencing | ~~GREEN~~ RED |

| | | | | | |
|---|---|---|---|---|---|
| | | | | stagflation – Fewer locums available, reduced applications for substantive appointments. Competitors offering inflated salaries~~. Full report to ELT due 07.06.22~~<br><br>All LD beds still closed to admissions and still some quality issues – Seclusion room not fit for purpose, number of patients have no discharge plan and are on national escalation. Risk MS1 remains high until beds re-open | |
| Improvements are required in rapidly returning patients who access Learning Disabilities and Autism (LD&A) services to local care to enable them to live their lives in the least restrictive manner as close to home as possible | Continue to work on developed delivery improvement plan, owned by system partners, to improve position. This includes new cohort stratification approach that has been developed – key action to implement and fully embed approach to ensure focussed system action on existing inpatients who are place inappropriately and out of area [ACTION OWNER: COO] | Improvement plans developed and implemented resulting in a stabilised service and positive outcomes for patients working across partner systems<br><br>Enhancing and reviewing Listening and Engagement Active Partnerships (LEAP) procedures<br><br>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<br><br>Make significant impacts on the number of stranded patients who have delayed discharges in units across the country resulting in the NHSE escalations | ~~(31.12.22)~~<br>(31.03.23) | Full cross-system delivery plan developed and being actively driven and monitored by revised Neurodevelopmental Delivery Board. Benefits realisation sessions being arranged<br><br>Review of ways of working for Intensive Support Team as a productively drive to commence<br><br>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 | RED |

| | | | | | |
|---|---|---|---|---|---|
| | | | | delivery manager. This is complemented by a single system delivery plan bringing together actions against all recent review outcomes / recommendations<br><br>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<br>[ACTIONS OWNERS: COO/DON] | Full compliance with safer staffing levels in line with the NHSI Workforce Safeguards | ~~(31.01.23)~~<br>(31.03.23) | Reviews of safer staffing and stabilisation in non-DHCFT Derbyshire bedded LD facility<br><br>Part stabilisation achieved<br><br>Improvements in recruitment but safer staffing data shows we are still vulnerable | 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<br>[ACTION OWNERS: COO/DON) | Full compliance with required care standards<br><br>External review of Long-Term Segregation and review to end restrictive practices | ~~(31.01.23)~~<br>(31.03.23) | External review of Long-Term Segregation and review to end restrictive practices - Complete<br><br>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 | ~~GREEN~~<br>RED |

| | | | | | |
|---|---|---|---|---|---|
| | | | | This ASM is progressing an action plan to stabilise LD&A inpatient offer, which provides space and time for the longer-term approach to be worked through without delaying required response to challenges with this provision. Actions include:<br>• Recruitment and stabilisation of workforce<br>• Developing a multiagency plan for treatment and discharge of three patients<br>• Responding to the recent CQC and Mental Health Act records review<br>• Undertaking actions to address continuing safeguarding concerns<br>• Support to enable restraint reduction<br>• Address staff training requirements<br><br>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'<br>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<br>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<br><br>Some improvements in clinical standards<br><br>Care plan work continues<br><br>Some outstanding section 42 enquiry work to be completed<br><br>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<br><br>Coproduction workshops events to engage service users, families and carers have commenced | |

| | | | | | |
|---|---|---|---|---|---|
| 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<br><br>Implementation of programme of work | ~~(31.01.23)~~ (31.03.23) | Initial review and development of business plan to be undertaken, progress to reviewed<br><br>Work to provide facilities that meet national standards to be completed – Expected completion date to be confirmed<br><br>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**

# Board Assurance Framework 2022-23 – Issue 4.3 - 7 March 2023

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

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

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

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

**Action Owners**

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

**Definitions**

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

**Derbyshire Healthcare NHS Foundation Trust**
Report to the Board of Directors – 7 March 2023

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

## Purpose of Report

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

## Executive Summary

This FTSU report to Board sets out the number of cases and FTSU themes raised in the last six months from July to December 2022 at Derbyshire Healthcare NHS Foundation Trust (DHCFT).

Total case numbers (76 cases) seen in this report to Board for the period July to December 2022 are an increase on the 64 cases reported in the September 2022 FTSU report to Board for the period January to June 2022.

Emerging, or ongoing, themes include:

- **Culture:** Staff from an Adult Community Care team spoke up about matters relating to the roll out of the Living Well programme including issues around quality and development of the programme, perceived adverse impact on staff wellbeing and patients and lack of visible management.
- **Worker safety and wellbeing**
  Staff in Lived Experience roles, and some staff with lived experiences, spoke up about their wellbeing including a perceived lack of support and processes related to lived experiences.

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

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

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

**Risks and Assurances**

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

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

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

**Consultation**

- Executive Leadership Team.

**Governance or Legal Issues**

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

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

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

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

- The joint working of the EDI team and FTSUG supports future ways of working to support BME staff to raise concerns.
- Any FTSU concerns logged around discrimination from BME staff with protected characteristics provide assurance that these issues are supported by employee relations/HR processes; and that any wider issues are being considered by senior Trust leadership.

This report highlights some areas of good practice including the use of FTSU Champions from a BME background and attendance of the FTSU Guardian at the BME staff network meeting. This level of engagement is felt to be partly responsible for colleagues from BME communities contacting the Guardian.

**Recommendations**

The Board of Directors is requested to:

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

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

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

# Derbyshire Healthcare NHS Foundation Trust
# 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 July to December 2023: Quarters 2 and 3 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 July to December 2023
- Information on what the Trust has learnt and what improvements have been made as a result of workers speaking up
- Actions taken to improve FTSU culture in the Trust, including progress in the promotion of the FTSUG role and addressing barriers to speaking up
- Updates from the National Guardians Office (NGO)
- Key recommendations to Board.

## 3. Summary of 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 36 cases in Q3 2022/23 and 40 cases in Q2 2022/23. In Quarter 4 2022/23, 20 cases were logged in January 2023. 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 from January to December 2023 is 34.75 cases. The FTSUG believes the raised case numbers indicate that staff feel confident to speak up.

3.3 **Patient safety and quality:** During Q2 and Q3 of 2022/23, patient safety and quality concerns were limited to 5.2% of cases. From January to June 2022 they represented 1.5% of cases. Patient safety and quality concerns are directed to the Director of Nursing and Patient Experience. According to the National Guardian's Office Annual Report 2021/22, Patient safety concerns represented 19.1% of all concerns nationally.

**Table 1: FTSU Data Q4 2021/22 and Q1 2022/23**

| Types of Concerns | Q2 2022/23 | Q3 2022/23 |
|---|---|---|
| With an element of **Bullying and Harassment (NGO/PIDA)** | **8** | **5** |
| With an element of **Patient Safety and Quality (NGO/PIDA)** | **2** | **2** |
| With an element of **Worker Safety and wellbeing (NGO)** | **12** | **17** |
| **Potential Fraud or Criminal Offence (PIDA)** | **0** | **0** |
| Attitude and Behaviours | 12 | 11 |
| Compassionate Leadership | 14 | 5 |
| Culture | 15 | 6 |
| Health and Safety | 3 | 1 |
| Policy, Process and Procedure | 24 | 11 |
| **Total Cases reported to FTSUG*** | **40** | **36** |
| **Public Interest Disclosure Act (PIDA) concerns** | **10** | **7** |
| Reportable to NGO: Bullying and Harassment / Patient Safety / Worker Safety | 22 | 24 |
| Anonymous / Other | 5 | 2 |
| Person indicates suffering a detriment as a result of speaking up | 1 | 1 |
| Number of cases that have received feedback | | |

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

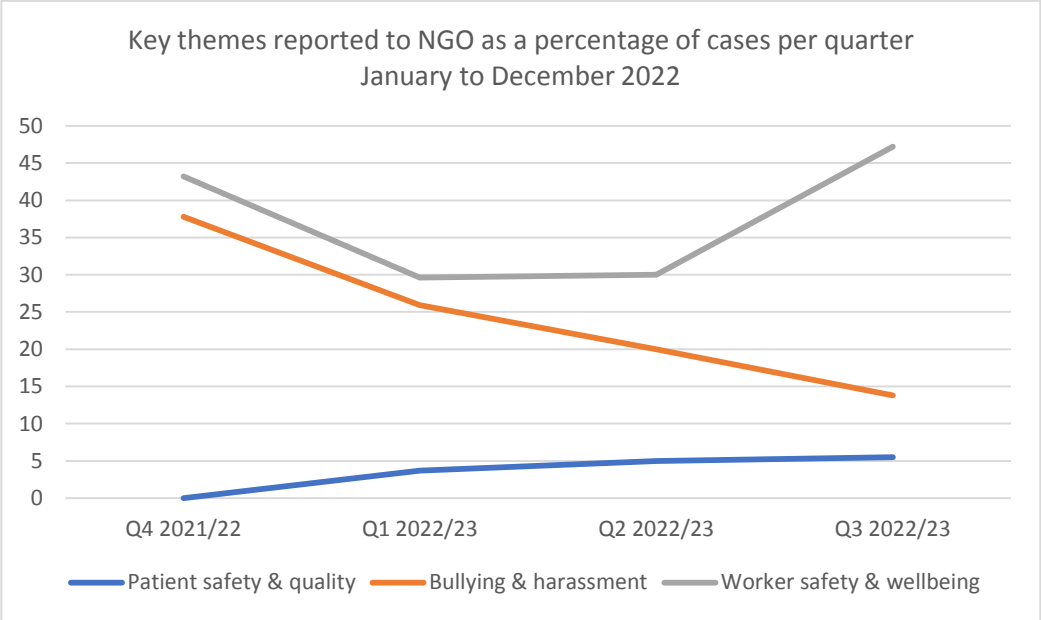
3.4 **Bullying and Harassment concerns** represented 17.1% of cases raised to the FTSUG from July to December 2022. This is a decrease on the 32.8% of cases raised from January to June 2022. Bullying and harassment levels for the 12 months from January to December 2022 are 24.3% which is lower than the 32.1% raised nationally to FTSUGs during 2021/22. (Source: NGO Annual Report 2021/22).

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

**Figure 1** shows Bullying and Harassment cases as a percentage of key themes along with Patient Safety and Worker Safety and Wellbeing as reported to the NGO over the January to December 2022 period.

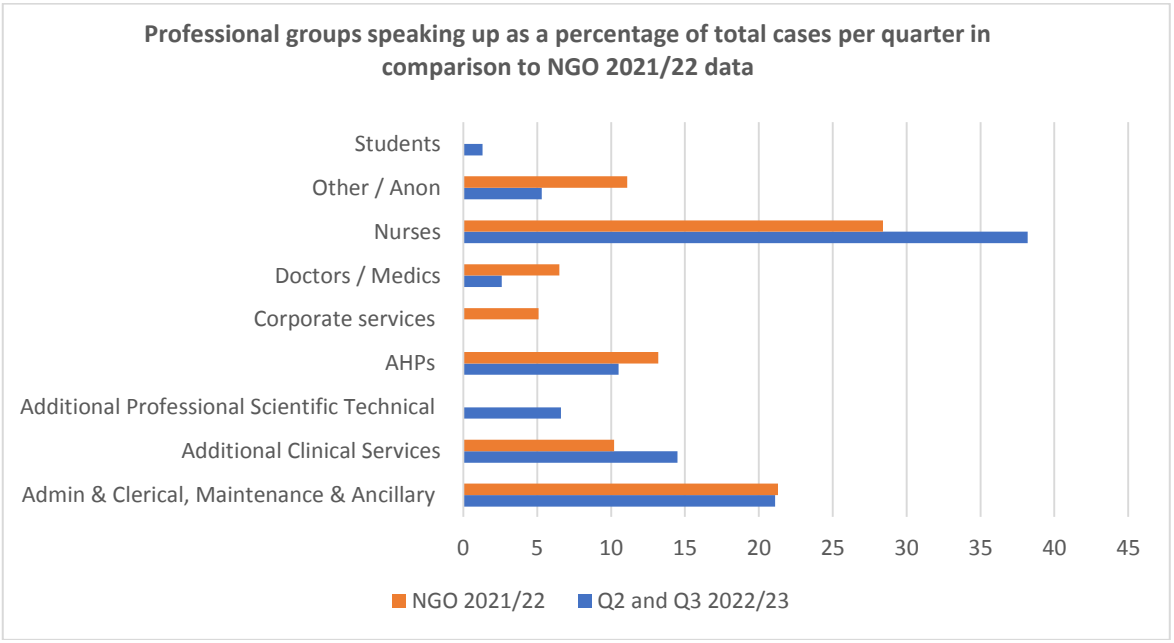
3.5 **Worker safety and wellbeing theme:** The percentage for Q2 and Q3 of 2022/23 was 38.1% of all cases. This is similar to the 37.5% of all cases seen in Q1 2022/23 and Q4 2021/22. Nationally in 2021/22 the average for worker safety and wellbeing was 13.7%. (Source: NGO Annual Report 2021/22). Information on all theme categories is found in the NGO Recording Cases and Reporting Data Guidance 2022.

**Figure 1**




3.6 **Professional groups**: In Q2 and Q3 2022/23, 38.1% of staff approaching the FTSUG were nurses. The average for the NGO nationally is 28.5%. (Source: NGO Annual Report 2021/22). See Figure 2.

**Figure 2**



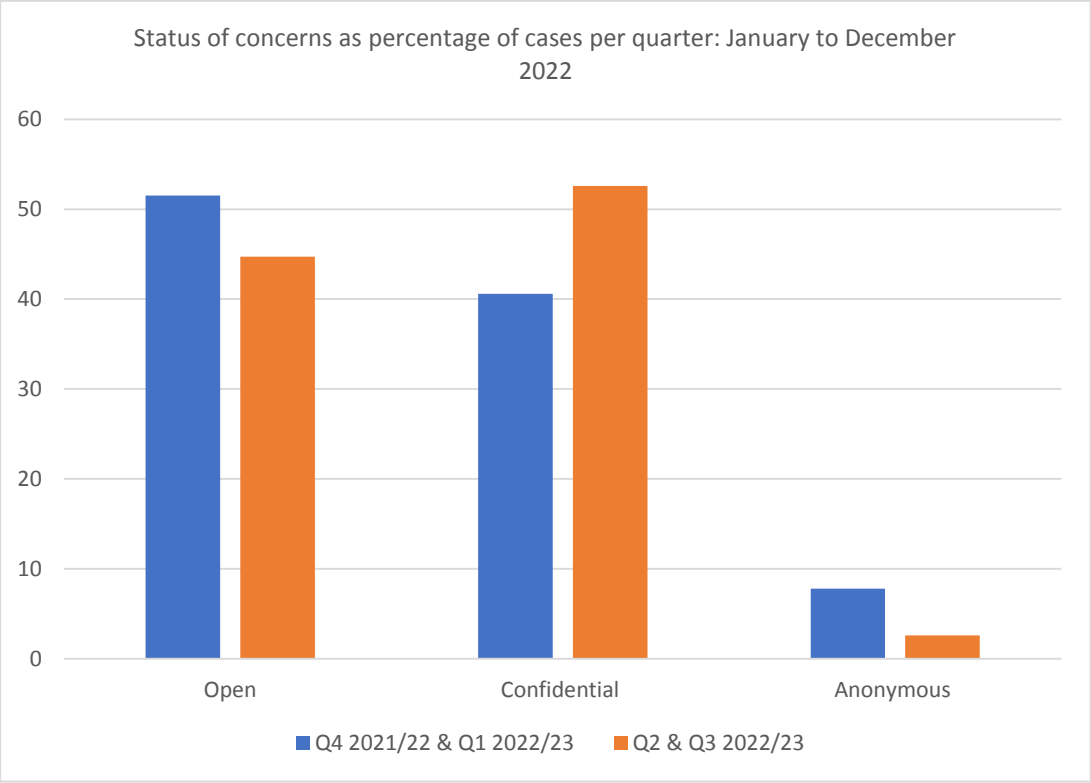
3.7 **Experiencing detriment or demeaning treatment:** In Q2 and Q3 2022/23, 2.6% (2 workers) felt that they had experienced a detriment or demeaning treatment as a result of speaking up. Both cases of detriment were investigated. NGO average for detriment in 2021/22 was 4.3%

3.8 **Ethnicity of workers:** In Q2 and Q3 of 2022/23, 25% of those speaking up identified as Black, Asian and Minority Ethnic. In Q1 2022/23 and Q4 2021/22, 18.75% of workers identified as BME. According to DHCFT's WRES Annual Report and Action Plan 2021/22, 16.7% of the workforce were from BME communities.

3.9 **Anonymous, Confidential or Open concerns:** Anonymous concerns increased slightly at 9.2% of concerns for Q2 and Q3 of 2022/23. From January to June 2022, they were 7.8% of cases. Anonymous concerns reported nationally in 2021/22 were 10.4%

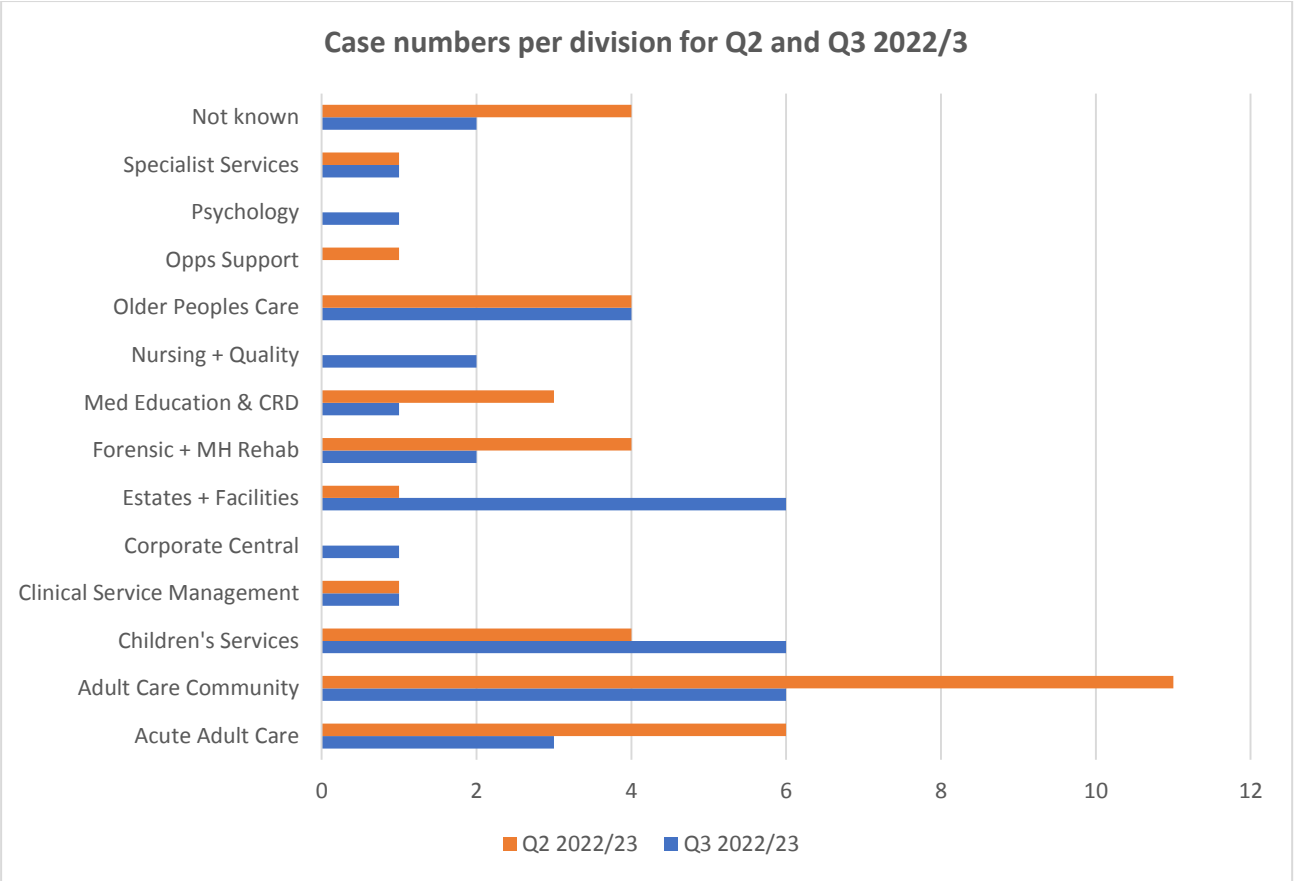
Confidential concerns, where workers wish to keep their identity private, but where they are known to the FTSUG, have increased in Q2 and Q3 of 2022/23 in relation to the preceding quarters. See Figure 3.

**Figure 3**




3.10 **Concerns raised by Division:** Figure 4 shows the number of cases from divisions across the Trust. Adult Care Community was raised in Q2 2022/23 due to a number of staff from one team speaking up.

**Figure 4**




3.11 **Seniority of those speaking up:** From July to December 2022, workers raised 75% of the FTSU cases (74.9% nationally, NGO 2021/22), 18.4% of concerns came from managers (15.2% NGO) with no cases raised by senior leaders (2.9% NGO).

## 4. Emerging or ongoing themes with learning/action points

4.1 **Worker safety and wellbeing / Policy, process and procedure**
A few staff within Lived Experience roles, and some with lived experience, spoke up about their wellbeing. For these staff, it was not always a positive experience in relation to their wellbeing particularly where a relapse point had been reached.

Some staff were left feeling that support and processes were not as they should be, for example, receiving appropriate supervision in a Lived Experience role or where they were accessing Trust services. One worker also talked about a lack of an effective policy around supporting staff with lived experience.

**Learning/action:**

A suggested action was to bring those within lived experience roles, and with lived experience, together much like in a staff network.

The development of a policy and process for supporting those who are in lived experience roles is also now in development with ongoing conversations continuing around action and support needed for lived experience roles.

4.2 **Culture/worker safety and wellbeing**

Staff from an Adult Community Mental Health team spoke up about a number of issues including:

- Roll out of Living Well programme and concerns about quality and development process of programme including adverse impact on staff wellbeing and patients.
- An extended period before Living Well roll out without consistent management in place.
- Issues raised were not being responded to in manner those in the team speaking up hoped for.

**Learning/action:** Issues escalated to leaders within the service. Organisational Development team were already involved in the support of the team and further engagement events were planned. Steps were taken to put a more visible leadership presence in place.

As a result of the team speaking up, it was decided to temporarily pause the Living Well programme for this Community Mental Health Team.

The Living Well programme is to recruit a programme manager and has established a programme board to ensure increased management and visibility of decision making in the programme.

## 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 blogs for Focus during Speaking Up Month in October 2022. The FTSUG continues to present at monthly Trust inductions, as well as to Junior Doctors, preceptees and students. The FTSUG presents at team meetings on request. The FTSUG is now holding regular face-to-face drop-ins in some acute settings. The FTSUG has engaged with University of Derby and delivered FTSU training to 300 nursing students which includes some students who have placements within the Trust.

5.2 **Board Culture:** A well-received Board development session was delivered by the FTSUG in November 2022. The Board of Directors met the National Guardian, Dr Jayne Chidgey-Clark, who presented some key FTSU statistics and answered questions. Board Directors engaged with their responsibility for creating a safe culture and an environment in which workers can highlight problems and make suggestions for improvement. FTSU Board Development sessions are part of a commitment to well led leadership. The Board Development Session was themed around the contents of the FTSU Reflection and Planning Tool which is to be completed by the Board by January 2024.

5.3 **Supporting communities who face barriers to speaking up:** The FTSUG engages with the Equality, Diversity and Inclusion (EDI) Team to address inclusion issues for diverse groups. The FTSUG has recently attended several staff network meetings. 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, including inclusion issues, 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. Triangulation of data has been identified as a gap in the FTSUGs gap analysis and further work will be carried out to link FTSU data with other relevant data. The FTSUG produces a report for the People and Culture Committee to also support triangulation of data.

5.5 **Network of FTSU Champions:** The FTSUG holds regular catch-up meetings with Speaking Up Champions to share good practice, support any speaking up matters and to share NGO information**.** Champions referred in 28% of concerns during Q2 and Q3 of 2022/23. DHCFT currently has 22 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. 95% of those responding from July to December 2022 said ‘yes’ they would speak up again. 60% of those invited to respond gave did not complete the evaluation. These specific questions are required by the NGO.

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

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

## 7 National Guardian’s Office and related national changes

7.1 **FTSU Policy**: An extension to the current policy has been requested in order to continue to develop the new FTSU policy. The intention is to report this to the Audit and Risk committee in October 2023. The new FTSU policy based on the NHSE template should be in place by January 2024.

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

7.3 **Using gap analysis to improve speaking up arrangements:** Following feedback, the National Guardians Office, collated together recommendations from the nine case review reports. The FTSUG has completed a gap analysis and used this to support the Board Development session in November 2022.

## 8. Conclusion

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

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

## 9. Recommendations

The Trust Board is asked to:

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

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

**Derbyshire Healthcare NHS Foundation Trust**
Report to the Board of Directors – 7 March 2023

## Fit and Proper Persons Policy and Procedures renewal

**Purpose of Report**

For the Board to ratify the renewal of the Trust's Fit and Proper Persons Policy and Procedures.

**Executive Summary**

The Trust's Fit and Proper Persons Policy and Procedures document is due for renewal. The Trust Secretary has reviewed the document and confirms that it is still compliant with the guidance and regulations and no significant changes have been made.

The Board will continue to receive the annual declaration from the Chair on compliance of the Policy.

In terms of progress on implementation of the recommendations made by Tom Kark QC following his review of the fit and proper person test In 2019, this work was paused during covid. The work was restarted in May 2022 and is currently being led by the Kark Implementation Steering Group. The outputs from the implementation work underway will include a Fit and Proper Person Test framework and guidance documents for use by individual organisations in applying the framework, and for other stakeholders to understand the process. Further updates will be issued to the Board when available.

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

**Assurances**

The policy and its indexes reflect latest guidance issued by NHS Providers and also to reflect guidance from CQC.

**Consultation**

The policy was previously approved by the Trust Board in March 2020.

**Governance or Legal Issues**

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 requires all trusts to ensure that all executive and non-executive director posts (or anyone performing similar or equivalent functions) are filled by people that meet the requirements of the Fit and Proper Persons Requirement (FPRR). The definition of directors includes those in permanent, interim or associate roles, irrespective of their voting rights at board meetings. These regulations were introduced in November 2014 and the fundamental standards came into force in April 2015.

It is a requirement of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 that NHS bodies undertake a 'fit and proper person test'.

The regulations have been integrated into the CQC's registration requirements, and falls within the remit of their regulatory inspection approach.

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

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

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

The Policy is applied to all Non-Executive and Executive Directors.

**Recommendations**

The Board of Directors is requested to note the update and approve the policy.

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

Derbyshire Healthcare
NHS Foundation Trust

# Fit and Proper Persons Policy and Procedure

| See also: | Located in the following policy folder on the Trust Intranet |
|---|---|
| Disciplinary Procedure for Medical Staff Policy and Procedures | People and Inclusion |
| Disciplinary Policy & Procedure | People and Inclusion |
| Disclosure and Barring Service (DBS) Policy and Procedures | People and Inclusion |
| Recruitment and Selection Policy and Procedures | People and Inclusion |
| Freedom to Speak Up Policy and Procedures | Corporate and Risk |

| Service area | Issue date | Issue no. | Review date | |
|---|---|---|---|---|
| Trust wide | March 202~~0~~3 | ~~2~~3 | March 202~~3~~6 | |
| **Ratified by** | **Ratification date** | **Committee/Group responsible for review:** | | |
| Board of Directors | March 202~~0~~3 | Trust Secretary | | |

Document published on the Trust Intranet under: Corporate and Risk Policies

**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

**ACCESSIBLE INFORMATION STANDARD**

The Accessible Information Standard directs and defines a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of service users.

Ensure you have considered an agreed process for: sending out correspondence in alternative formats and appointments for patients / service users with communication needs, where this is applicable.

Making a positive difference

# Checklist for Fit and Proper Persons Policy

| **Summary (Plain English)** Summarise the main points of the policy below in a style that is clear and easy to understand. Ensure the whole policy is written in plain English, using simple language where possible and avoiding convoluted sentences and obscure words. The resulting policy should be easy to read, understand and use, |
|---|
| The purpose of the Fit and Proper Persons Policy is to hold Trust Board members to account in relation to their conduct and performance and also to instill confidence in the public that the individuals leading the Trust are suitable to hold their position, in line with the requirements of the Fit and Proper Persons Regulations introduced in November 2014. |

| | | |
|---|---|---|
| **Name / Title of policy/procedure** | Fit and Proper Persons Policy | |
| **Aim of Policy** | To ensure all Executive and Non-Executive Director posts (or anyone performing equivalent/similar functions) are filled by people that meet the requirements of the Fit and Proper Persons Regulations. | |
| **Sponsor (Director lead)** | Trust Secretary | |
| **Author(s)** | Trust Secretary<br>Director of Nursing & Patient Experience | |
| **Name of policy being replaced** | Fit and Proper Persons Policy and Procedure | **Version No of previous policy: 2** |

| | |
|---|---|
| **Reason for document production:** | Renewal of required policy |
| **Commissioning individual or group:** | Trust Board |

| **Individuals or groups who have been consulted:** | **Date:** | **Response** |
|---|---|---|
| Executive Leadership Team | ~~24/2/2020~~31/01/2023 | Agreed |

**Version control (for minor amendments)**

| Date | Author | Comment |
|---|---|---|
| 20.1.2023 | Trust Secretary | Three yearly review, no significant updates. Old internet links removed, job titles revised. |

# Fit and Proper Persons Policy

## Table of Contents

# Fit and Proper Persons Policy

## 1. Introduction

### 1.1 Purpose

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 introduced a 'fit and proper persons test' for all NHS bodies. This policy outlines how the Trust will meet the requirements placed on the NHS which came into force on 1 October 2014 for all NHS bodies and for all providers on 1 April 2015.

Under the regulations, all provider organisations must ensure that Director level appointments meet the Fit and Proper Persons Test and the regulations place a duty on NHS providers not to appoint a person or allow a person to continue to be an Executive Director or equivalent or Non-Executive Director under given circumstances.

The regulations have been integrated into the Care Quality Commission's (CQC's) registration requirements, and falls within the remit of their regulatory inspection approach.

### 1.2 Scope

This policy applies to all Board appointments, i.e. Executive and Non-Executive Directors and those senior managers which are formally recognised as part of the Trust's Executive Leadership Team (ELT). This includes permanent, interim and associate positions. It also includes those individuals who are acting up in Board level positions.

## 2. Requirements

The introduction of the Fit and Proper Persons Requirements (FPPR) requires the Trust Chair to:

- Confirm to the CQC that the fitness of all new Directors has been assessed in line with the regulations; and
- Declare to the CQC in writing that they are satisfied that they are fit and proper individuals for that role both on appointment and an ongoing basis and do not meet any of the 'unfit' criteria.

The Trust will make every reasonable effort to assure itself about existing post holders and new applicants and to make specified information about board Directors available to the CQC on request.

Individuals who fall into the categories above must satisfy the Trust Chair they:

- Are of good character

- Hold the required qualifications and have the competence, skills and experience required for the relevant office for which they're employed
- Are able, by reason of their physical and mental health, after any required reasonable adjustments if required, capable of properly performing their work
- Can supply relevant information as required by schedule 3 of the act, i.e. documentation to support the FPPR
- Not have been responsible for or privy to, contributed to, or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on regulated activity (or providing a service elsewhere which if provided in England would be a regulated activity).

In accordance with schedule 4 part 1 of the act a person is deemed "unfit" if:

- The person is an undischarged bankrupt or a person whose estate has had sequestration awarded in respect of it and who has not been discharged
- The person is the subject of a bankruptcy restrictions order or an interim bankruptcy restrictions order or an order to like effect made in Scotland or Northern Ireland
- The person is a person to whom a moratorium period under a debt relief order applies under Part VIIA (debt relief orders) of the Insolvency Act 1986
- The person has made a composition or arrangement with, or granted a trust deed for, creditors and not been discharged in respect of it
- The person is included in the children's barred list or the adults' barred list maintained under section 2 of the Safeguarding Vulnerable Groups Act 2006, or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland
- The person is prohibited from holding the relevant office or position, or in the case of an individual from carrying on the regulated activity, by or under any enactment

## 2.1 Good character

In accordance with part 2 of the Act a person will fail the good character test if they:

- Have been convicted in the United Kingdom of any offence or been convicted elsewhere of any offence which, if committed in any part of the United Kingdom would constitute an offence
- Have been erased, removed, struck off a register of professionals maintained by a regulator of health care of social work professionals.

Whilst there is no statutory guidance on what constitutes 'good character', the CQC names the following features that are 'normally associated' with good character that trusts should take into account when assessing an individual under FPPR, in addition to matters specified in part 2 of schedule 4:

- Honesty
- Trustworthiness

- Integrity
- Openness
- Ability to comply with the law
- A person in whom the public can have confidence prior employment history, including reasons for leaving
- If the individual has been subject to any investigations or proceedings by a professional or regulatory body
- Any breaches of the Nolan principles of public life
- Any breaches of the duties imposed on directors under the Companies Act
- The extent to which the director has been open and honest with the trust
- Any other information which may be relevant, such as disciplinary action taken by an employer.

### 2.2 Serious mismanagement or misconduct

In consideration of any instances of misconduct or mismanagement, consideration will be given to relevant guidance issued by the CQC, as set out below. Providers will have to reach their own decision as to whether any facts that are alleged reach the threshold of being "serious misconduct or mismanagement".

- "Misconduct" means conduct that breaches a legal or contractual obligation imposed on the director. It could mean acting in breach of an employment contract, breaching relevant regulatory requirements (such as mandatory health and safety rules), breaching the criminal law or engaging in activities that are morally reprehensible or likely to undermine public trust and confidence.

- "Mismanagement" means being involved in the management of an organisation or part of an organisation in such a way that the quality of decision making and actions of the managers falls below any reasonable standard of competent management. For example, failing to interpret data appropriately, failing to learn from incidents or complaints, and failing

## 3. Trust Procedure

### 3.1 Pre-Employment

The CQC expects senior leaders to set a tone and culture of the organisation that leads to staff adopting a caring and compassionate attitude. Therefore, it is important that in making appointments boards take into account the values of the organisation and the extent to which candidates provide good fit with those values. Values-based interviews, or values-based questions in other interviews, will be used.

All new appointments to the applicable posts will have the following recruitment checks in accordance with NHS Employment Check Standards issued by NHS employers, including:

- Proof of identity and right to work in the UK
- Proof of qualifications
- Professional registration and qualification check
- Full employment history and at least two detailed reference checks, one of which must be the most recent employer. Specifically this includes validating a minimum of three years continuous employment
- Occupational health assessment
- Disclosure and Barring Scheme (DBS) check (where appropriate to the role)
- Search of registers e.g. disqualified directors, bankruptcy and insolvency
- Google, news and social media searches

The standards that the Trust will follow at the recruitment stage, the assurance process to follow and evidence required is outlined in Appendix 2.

### 3.2 Declaration

Appointees will be asked to complete a declaration to include:

- Confirmation of their reasonable health after reasonable adjustments are made of properly performing tasks related to their role (subject to the relevant provisions of the Equality Act 2010)
- Any criminal and/or regulatory investigations
- Any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying out regulated activity
- Any undischarged bankruptcy, disqualification, debt relief orders etc
- Any inclusion on the Children's or Adults barred lists
- Any prohibition from holding relevant position or office under any law

### 3.3 External Recruitment Consultancy

Where the Trust engages recruitment consultants to asset with appointments, it may ask the consultants to carry to out some or all of the process, but the Trust will gain all necessary documentation to evidence that the checks have been carried out.

### 3.4 Ongoing Assurance

On an annual basis all relevant office holders will be asked to complete the fit and proper persons declaration (See Appendix 1).

The Trust will review the checks carried out on appointment, every three years or annually as appropriate (See Appendix 3).

With regard to the requirement for the Trust to be satisfied as to the post-holders, competence, skills and knowledge necessary for the post in which they are employed the following will be relied upon:

- Documented 360 Appraisals
- Provision of adequate training opportunities to include both individual and collective development.

### 3.5 Process to be followed on an issue or concern being raised

3.5.1 As set out above, some criteria are pass/fail, i.e. the Trust cannot appoint or have in place an individual in a relevant position if they do not satisfy the specific test. Other, particularly the tests of good character and any association with serious misconduct or responsibility for failure in a previous role, require the Trust to make a reasonable assessment as to fitness.

3.5.2 If, either at the time of appointment or later, it becomes apparent that circumstances exist or have arisen whereby a person may not be considered to meet all the requirements of a fit and proper person, the Trust Secretary shall inform the Chair (or if the person is the Chair, the Senior Independent Director (SID). The Trust must take appropriate action to investigation and rectify the matter.

3.5.3 The Chair (SID) shall, acting reasonably and having regard to guidance issued by the CQC or Monitor, determine whether the person meets the said requirements.

The Chair leads on addressing these concerns on a case by case basis and will need to consider whether an investigation is necessary or appropriate given the allegation. The Chair may choose to consult with the SID and the Director of People and Inclusion to determine the appropriate process to follow and action to take.

The Chair will consider the guidance as issued by NHS Providers, Fit and Proper Persons Regulations in the NHS, namely the Fit and Proper Persons Investigation Ten Step Guide, which covers:

| | |
|---|---|
| Step 1 | Receiving concerns in relation to a director |
| Step 2 | Deciding whether an investigation is necessary |
| Step 3 | Choosing who should carry out the investigation |
| Step 4 | Deciding the remit of the investigation |
| Step 5 | Deciding who to engage in the investigation |
| Step 6 | Agreeing any interim action |
| Step 7 | Gathering evidence |
| Step 8 | Managing competing factors in the investigation |
| Step 9 | Making a final decision |
| Step 10 | Managing the effects of the outcome |

3.5.4 Should the Chair consider the individual to be suitable, despite existence of information relevant to issues identified in Schedule 4, Part 2, the Chair's reasons should be recorded for future reference and made available.

3.5.5 If the Chair (SID) determines that the person does not or no longer meets the said requirements, that person may not be appointed, or appropriate disciplinary action be followed in line their tenure of office shall be terminated and that person shall cease to act as a Director.

3.5.6 The Chair should keep the Council of Governors informed throughout any investigation into a Non-Executive Director. However, the tension between confidentiality and transparency may lead to the Chair involving only the Lead Governor.

3.5.7 If action is taken against an Executive Director as an outcome of the hearing because of the failure to comply with Fit and Proper Persons Policy then the right to appeal will apply in accordance with existing Trust Policy & Procedures. In relation to Non-Executive Directors any appeal will be overseen by the Council of Governors. The criteria for removing Non-Executive Directors/Chair are set out in the Trust's Constitution.

### 3.6 Implementation

It is the ultimate responsibility of the Trust Chair to discharge the requirement placed on the Trust, to ensure that all Directors meet the fitness test and do not meet any of the 'unfit criteria'. The Trust Secretary is responsible for ensuring consistent application of the policy during the appointment process and for ensuring that all appropriate documentation is complete, retained and available. The Trust Secretary will support the Trust Chair in preparing the annual declaration for the Trust Board. The Trust Secretary may delegate responsibility for maintaining the records of completed Fit and Proper Persons declarations, initially to the PA to the Chief Executive.

The Council of Governors' Nominations & Remuneration Committee will receive a report to confirm the outcome of the Fit and Proper Person Checks regarding new Non-Executive Director appointments. The Trust Board's Remuneration & Appointments Committee will receive a report to confirm the outcome of the Fit and Proper Person Checks regarding Executive Director/Board appointments.

## 4. Associated Documents and References

Care Quality Commission, (2018). Regulation 5: Fit and proper persons: directors, Guidance for providers and CQC inspectors.
Fit and proper persons: directors - Care Quality Commission (cqc.org.uk)

Care Quality Commission, Regulation 5: Fit and proper persons: directors.
Fit and proper persons: directors - Care Quality Commission (cqc.org.uk)

NHS Employment Standards.
https://www.nhsemployers.org/topics-0/employment-standards-and-regulation

NHS Improvement (2017), Guidance on senior appointments in NHS trusts.
Guidance-on-senior-appointments-in-NHS-trusts.pdf (england.nhs.uk)

NHS Providers (2018), Fit and Proper Persons Regulations in the NHS: What do providers need to know?
Fit and proper persons regulations in the NHS: What do providers need to know? (nhsproviders.org)

## 5. Dissemination and Implementation

This policy will be made available on the intranet.

Awareness of this policy will be raised in the Statement of Main Terms and Conditions of Employment and local induction for relevant posts and a summary will be published on the People Services section on the intranet.

## 6. Consultation and Approval

The Joint Consultative Committee (JCC) reviewed the first version of the policy and the Executive Leadership Team (ELT) agreed the policy, which was ratified by the Trust Board. The 2020 and 2023 renewal of the policy required very minor amendments and was therefore did not require further consultation.

## 7. Equality and Diversity

The Trust is committed to ensuring that, as far as is reasonably practicable, the way we treat staff reflects their individual needs and does not discriminate against individuals or groups on any grounds.

## 8. Monitoring Compliance with this Policy

| Standard/ Process | Monitoring & Audit | | |
|---|---|---|---|
| | By | Committee | Frequency |
| Instances of non-compliance with policy | Trust Secretary | Remuneration & Appointments Committee and the Governors Nominations & Remuneration Committee | Annually |
| Pre-employment checks | Trust Secretary (Non-Executive Director appointments) and Director of People and Inclusion | Remuneration & Appointments | Upon completion of process |

| | | | |
|---|---|---|---|
| | (Executive Director Appointments) | Committee and the Governors Nominations & Remuneration Committee | |
| Annual Review | Trust Secretary | Trust Board | Annually |

# Appendix 1 - Pre-employment and annual declaration for Executive Directors, Non-Executive Directors and Director Equivalent Posts

## Fit and Proper Persons Declaration

1 It is a condition of employment that those holding Director and Director equivalent posts provide confirmation in writing, on appointment and thereafter on demand, of their fitness to hold such posts. Your post has been designated as being such a post. Fitness to hold such a post is determined in a number of ways, including (but not exclusively) by the Trust's provider licence, the Health and Social Care Act 2008 (Regulated Activities) Regulations 2008 ("the Regulated Activities Regulations") and the Trust's Constitution.

2 By signing the declaration below, you are confirming that you do not fall within the definition of an "unfit person" or any other criteria set out below, and that you are not aware of any pending proceedings or matters which may call such a declaration into question.

## Provider Licence

3 Condition of Derbyshire Health NHS Foundation Trust's Provider Licence ("The Licence") provides that the Licensee shall not appoint as a Director any person who is an unfit person, except with the approval in writing of NHS Improvement.

4 The Licence condition requires the Licensee to ensure that its contracts of service with its Directors contain a provision permitting summary termination in the event of a Director being or becoming an unfit person. The Licence also requires the Licensee to enforce that provision promptly upon discovering any Director to be an unfit person, except with the approval in writing of NHS Improvement.

5 An "unfit person" is defined within the Licence as:

(a) An individual:

(i) who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged; or

(ii) who has made a composition or arrangement with, or granted a trust deed for, his creditors and has not been discharged in respect of it; or

(iii) who within the preceding five years has been convicted in the British Islands of any offence and a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was

imposed on him; or

(iv) who is subject to an unexpired disqualification order made under the Company Directors' Disqualification Act 1986; or

(b) a body corporate, or a body corporate with a parent body corporate:

(i) where one or more of the Directors of the body corporate or of its parent body corporate is an unfit person under the provisions of sub-paragraph (a) of this paragraph, or

(ii) in relation to which a voluntary arrangement is proposed under section 1 of the Insolvency Act 1986, or

(iii) which has a receiver (including an administrative receiver within the meaning of section 29(2) of the 1986 Act appointed for the whole or any material part of its assets or undertaking; or

(iv) which has an administrator appointed to manage its affairs, business and property in accordance with Schedule B1 to the 1986 Act; or

(v) which passes any resolution for winding up; or

(vi) Which becomes subject to an order of a Court for winding up.

**Regulated Activities Regulations**

6 Regulation 5 of the Regulated Activities Regulations states that the Trust must not appoint or have in place an individual as a Director, or performing the functions of or equivalent or similar to the functions of, such a Director, if they do not satisfy all the requirements set out in paragraph 3 of that Regulation.

7 The requirements of paragraph 3 of Regulation 5 of the Regulated Activities Regulations are that:

(a) The individual is of good character.

(b) The individual has the qualifications, competence, skills and experience which are necessary for the relevant office or position or the work for which they are employed.

(c) The individual is able by reason of their health, after reasonable adjustments are made, of properly performing tasks which are intrinsic to the office or position for which they are appointed or to the work for which they are employed.

(d) The individual has not been responsible for, privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity.

(e) That none of the grounds of unfitness specified in Part 1 of Schedule 4 apply to the individual.

8 The grounds of unfitness specified in Paragraph 1 of Schedule 4 to the Registered Activities Regulations are:

(a) The person is an undischarged bankrupt or a person whose estate has had sequestration awarded in respect of it and who has not been discharged.

(b) The person is the subject of a bankruptcy restrictions order or an interim bankruptcy restrictions order or an order to like effect made in Scotland or Northern Ireland.

(c) The person is a person to whom a moratorium period under a debt relief order applies under Part VIIA (debt relief orders) of the Insolvency Act 1986.

(d) The person has made a composition or arrangement with, or granted a Trust deed for creditors and not been discharged in respect of it.

(e) The person is included in the children's barred list or the adults' barred list maintained under section 2 of the Safeguarding Vulnerable Groups Act 2006, or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland.

(f) The person is prohibited from holding the relevant office or position, or in the case of an individual carrying on the regulated activity, by or under any enactment.

## Trust's Constitution

9 The Trust's constitution places a number of restrictions on an individual's ability to become or continue as a Director. A person may not become or continue as a Director of the Trust if:

(a) They have been adjudged bankrupt or their estate has been sequestrated and in either case they have not been discharged.

(b) They have made a composition or arrangement with, or granted a

Trust deed for their creditors and have not been discharged in respect of it.

(c) They have within the preceding five years been convicted in the British Islands of any offence and a sentence of imprisonment (whether suspended or not) for a period of three months or more (without the option of a fine) was imposed on them.

(d) In the case of a Non-Executive Director they no longer satisfy the relevant requirements for appointment

(e) They are a person whose tenure of office as a Chair or as a Member or Director of a Health Service body has been terminated on the grounds that his/her appointment is not in the interests of public service, for non-attendance at meetings, or for non-disclosure of a pecuniary/non-pecuniary interest.

(f) They have within the preceding two years been dismissed, otherwise than by reason of redundancy, by the coming to an end of fixed term contract or through ill health, from any paid employment with a health service body;

information revealed by a Criminal Records Bureau check is such that it would be inappropriate for him to become or continue as a Director on the grounds that this would adversely affect public confidence in the Trust or otherwise bring the Trust into disrepute;

(g) They have had their name removed, by a direction under section 46 of the 1977 Act from any list prepared under Part II of that Act, and has not subsequently had their name included in such a list.

(h) They have been placed on the registers of Schedule 1 offenders pursuant to the Sexual Offences Act 2003 (as amended) and/or the Children and Young Person's Acts 1933 to 1969 (as amended) and his or her conviction is not spent under the Rehabilitation of Offenders Act 1974;.

(i) They fail to abide by the Constitution.

(j) They are under 16 years of age.

I acknowledge the extracts from the provider licence, Regulated Activities Regulations and the Trust's constitution above. I confirm that I do not fit within the definition of an "unfit person" as listed above and that there are no other grounds under which I would be ineligible to continue in post. I undertake to notify the Trust immediately if I no longer satisfy the criteria to be a "fit and proper person" or other grounds which I would be ineligible to continue in post come to my attention.

Name: _____ Signed: _____

Position: _____ Date: _____

## Appendix 2 - Table of requirements for complying with the regulations at the recruitment stage

Below are standards that the Trust will follow at the recruitment stage, the assurance process to follow and evidence required.

| Standard | | Assurance Process | Evidence |
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| 1. | The Trust should make every effort to ensure that all available information is sought to confirm that the individual is of good character as defined in Schedule 4, Part 2 of the regulations. The fit and proper persons 'test' must be applied before an individual is appointed to a position. | Recruitment checks in accordance with NHS Employment Check Standards issued by NHS Employers, including:<br>• Proof of identity and right to work in the UK<br>• Proof of qualifications<br>• Professional registration and qualification check<br>• Full employment history and at least two detailed reference checks, one of which must be the most recent employer. Specifically this includes validating a minimum of three years continuous employment<br>• Occupational health assessment<br>• Disclosure and Barring Scheme (DBS) check (where appropriate to the role)<br>• Search of registers e.g. disqualified directors, bankruptcy and insolvency<br>• Google, news and social media searches | • References<br>• Outcome of other pre-employment checks<br>• DBS check certificate where appropriate<br>• Register and internet search results<br>• List of referees and sources of assurance for Freedom of Information Act (FOIA) purposes |
| 2. | Where the Trust deems the individual suitable despite not meeting the characteristics outlined in Schedule 4, | • Report and debate at the nominations committee(s) | • Record that due process was followed for FOIA purposes |

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| | Part 2 of these regulations, the reasons should be recorded and information about the decision should be made available to those that need to be aware. | • Report and recommendation at the council of governors (for NEDs) or the board of directors (for executive directors) for foundation trusts, reports to the board for NHS trusts<br>• Decisions and reasons for decisions recorded in minutes<br>• External advice sought as necessary | |
| 3. | Where specific qualifications are deemed by the Trust as necessary for a role, the Trust must make this clear and should only employ those individuals that meet the required specification, including any requirements to be registered with a professional regulator. | • Requirements included within the job description for all relevant posts<br>• Proof of qualifications checked as part of the pre-employment checks | • Person specification<br>• Recruitment policy and procedure |
| 4. | The Trust should have appropriate processes for assessing and checking that the individual holds the required qualifications and has the competence, skills and experience required, to undertake the role; these should be followed in all cases and relevant records kept.<br><br>N.B. While this provision most obviously applies to executive director appointments in terms of qualifications, skills and experience will be relevant to | • Recruitment checks including a candidate's qualifications and employment references<br>• Recruitment processes including qualitative assessment and values-based questions<br>• Decisions and reasons for decisions recorded in minutes | • Recruitment policy and procedure<br>• Values-based questions<br>• Minutes of council of governors<br>• Minutes of board of directors |

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| | NED appointments. | | |
| 5. | In addition to 4. above, the Trust may consider that an individual can be appointed to a role based on their qualifications, skills and experience with the expectation that they will develop specific competence to undertake the role within a specified timeframe. | • Discussions and recommendations by the nominations committee(s)<br>• Discussion and decision at board of directors or council of governors meeting<br>• Reports, discussion and recommendations recorded in minutes of meetings<br>• Follow-up as part of continuing review and appraisal | • Minutes of committee, board and or council meetings.<br>• NED appraisal framework<br>• NED competence framework<br>• Notes of executive director appraisals |
| 6. | When appointing relevant individuals the Trust has processes for considering a person's physical and mental health in line with the requirements of the role, all subject to equalities and employment legislation and to due process. | • Self-declaration of past health issues subject to clearance by occupational health as part of the pre-employment process<br>• Offer of appointment should be subject to this health screening<br>• If a health issue is raised, should consider if it falls within definition of disability and if it does, consider whether reasonable adjustments in compliance with the Equality Act 2010 can be made. | • Occupational health clearance |
| 7. | Wherever possible, reasonable adjustments are made in order that an individual can carry out the role. | • Self-declaration of adjustments required<br>• Check steps taken are in line with requirements to make reasonable adjustments for employees under the Equality Act 2010<br>• NHS Employment Check Standards<br>• Board/council of governors decision. | • Minutes of board meeting/council of governors meeting |

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| 8. | The Trust has processes in place to assure itself that the individual has not been at any time responsible for, privy to, contributed to, or facilitated, any serious misconduct or mismanagement in the carrying on of a regulated activity; this includes investigating any allegation of such potential behaviour and making independent enquiries. Where the individual is professionally qualified, it may include fitness to practise proceedings and professional disciplinary cases. | • Same checks set out in 1, ie. past employment history in accordance with NHS Employers pre-employment check standards including a self-declaration of fitness in which candidates provide an explanation of past conduct/character issues where appropriate<br>• Clear consequences of false, inaccurate or incomplete information included in recruitment packs | • NED Recruitment Information pack<br>• Reference request for executive directors and NEDs |
| 9. | The Trust must not appoint any individual who has been responsible for, privy to, contributed to, or facilitated, any serious misconduct or mismanagement (whether lawful or not) in the carrying on of a regulated activity; this includes investigating any allegation of such potential behaviour. Where the individual is professionally qualified, it may include fitness to practise proceedings and professional disciplinary cases.<br><br>N.B. CQC accepts that trusts will use reasonable endeavours in this instance. The existence of a compromise | • Clear consequences of false, inaccurate or incomplete information included in recruitment packs<br>• Core HR policies for appointments and remuneration<br>• Checks set out in 1 above<br>• Included in reference requests<br>• Check publicly available information including serious case reviews | • Executive and non-executive Recruitment Information packs<br>• Core HR policies<br>• Reference request for executive directors and NEDs |

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| | agreement does not indemnify the new employer and trusts will need to ensure that their Core HR policies address their approach to compromise agreements. | | |
| 10. | A person who will be acting in a role that falls within the definition of a "regulated activity" as defined by the Safeguarding Vulnerable Groups Act 2006 must be subject to an enhanced DBS check.<br><br>N.B. CQC recognises that it may not always be possible for trusts to access a DBS check as an individual may not be eligible. | • Where an executive director or NED meets the eligibility criteria, trusts should apply for an enhanced DBS check<br>• If the director's role falls within the definition of a "regulated activity", the DBS check will establish whether the person is on the children's and/or adults' safeguarding barred list and whether they are prohibited from holding the office in question under other laws such as the Companies Act or Charities Act. | • DBS policy<br>• Enhanced DBS checks for eligible post-holders |
| 11. | As part of the recruitment/appointment process, trusts should establish whether the Individual is eligible for the relevant DBS check. | • Eligibility for DBS checks will be assessed for each vacancy arising<br>• OR<br>• All postholders will undergo an enhanced DBS check | • DBS policy |

## Appendix 3 – Complying with the regulations on an ongoing basis

Below are standards that the Trust will follow throughout the course of an individual's employment, the assurance process to be followed and the evidence to be produced.

| Standard | | Assurance Process | Evidence |
|---|---|---|---|
| 1. | The Trust should regularly review the fitness of directors to ensure that they remain fit for the role they are in; the trust should determine how often fitness should be reviewed based on the assessed risk to business delivery and/or the service users posed by the individual and/or role. | • Assessment of continued fitness to be undertaken each year as part of the appraisal process<br>• Checks of insolvency and bankruptcy register and register of disqualified directors to be undertaken each year as part of the appraisal process<br>• Board/Council of Governors to review, checks and agree the outcome<br>• Regular DBS checks<br>• Regular checks of relevant<br>• professional regulator's register<br>• Ensure there is an ongoing<br>• obligation in employment contracts to declare any criminal and/or regulatory investigations as soon as reasonably practicable | • Continued assessment as part of appraisal process<br>• Register checks if necessary<br>• Board/council minutes record that process has been followed |
| 2. | If the Trust discovers information that suggests an individual is not of good character after they have been appointed to a role, the trust must<br>take appropriate and timely action to investigate and rectify the matter. | • Core HR policies provide for such investigations<br>• Revised contracts allow for termination in the event of non-compliance with regulations and<br>• other requirements<br>• Contracts (for executive directors , and director-level equivalents) and agreements (for NEDs) | • Core HR polices<br>• Contracts of employment (for executive directors and director-level equivalents)<br>• Service agreements or equivalent (for NEDs) |

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| | The Trust has arrangements in place to respond to concerns about a person's fitness in relation to Regulation 5(3) and (4) after they are appointed to a role whether identified by the trust itself or others – and these are adhered to. | incorporate<br>• maintenance of fitness as a contractual requirement | |
| 3. | The Trust investigates, in a timely manner, any concerns about a person's fitness or ability to carry out their duties, and where concerns are substantiated, proportionate, timely action is taken; the trust must demonstrate due diligence in all actions. | • Core HR policies include the necessary provisions<br>• Action taken and recorded as required | • Core HR policies |
| 4. | Where a person's fitness to carry out their role is being investigated, appropriate interim measures may be required to minimise any risk to service users. | • Core HR policies | • Managerial action taken to backfill posts as necessary |
| 5. | The Trust informs others as appropriate about concerns/findings relating to a person's fitness; for example, professional regulators, CQC and other relevant bodies, and supports any related enquiries/ investigations carried out by others. | • Core HR policies | • Referrals made to other agencies if necessary |

## EQUALITY IMPACT ASSESSMENT TEMPLATE: FRONT SHEET.

| Question | Response |
|---|---|
| Name of 'policy' being assessed | Fit and Proper Persons Policy and Procedure |
| Summary of aims and objectives of the 'policy' | The purpose of the Fit and Proper Persons Policy is to hold Trust Board members to account in relation to their conduct and performance and also to instill confidence in the public that the individuals leading the Trust are suitable to hold their position, in line with the requirements of the Fit and Proper Persons Regulations introduced in November 2014 |
| Is this a new or existing 'policy'? | Existing |
| Please state which organisation is the EIA being completed for?<br><br>• Derbyshire Healthcare NHS FT<br>• Joint Derbyshire Healthcare NHS FT and Derbyshire Community Health Services<br>• Other (please give details) | Derbyshire Healthcare NHS FT |
| Division/Team/Service | Trust Secretariat |
| Date Stage 1 completed: Screening for Relevance: | 20.01.2023 |
| Is a Stage 2: EIA required to be completed after Stage 1?<br><br>Please provide justification | No |
| Date Stage 2 EIA completed: | |
| Name/s, job title/s and contact/s details of person/s completing this assessment | Justine Fitzjohn, Trust Secretary |
| Name, job title and contact details of responsible lead Director /Associate Director/Head of Service | Justine Fitzjohn, Trust Secretary |

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|---|---|
| Has this EIA been logged in your Division/Service/Team EIA Tracker? | Yes |

## EQUALITY IMPACT ASSESSMENT TEMPLATE: STAGE 1 SCREENING FOR RELEVANCE

(Please use plain English http://www.plainenglish.co.uk/, avoiding jargon and acronyms. EIA's are viewed by a wide range of people including decision-makers and the wider public)

| Question | Response |
|---|---|
| 1a: Summary of aims and objectives of the 'policy' | The purpose of the Fit and Proper Persons Policy is to hold Trust Board members to account in relation to their conduct and performance and also to instill confidence in the public that the individuals leading the Trust are suitable to hold their position, in line with the requirements of the Fit and Proper Persons Regulations introduced in November 2014 |
| 1b: Please state who this 'policy' will affect?<br>• Patients or Service Users<br>• Carers or families<br>• Commissioned Services<br>• Communities, in placed based settings<br>• Staff -<br>• Partners<br>• Stakeholder organisations<br>• Others (give details) | This policy applies to all Board appointments, i.e. Executive and Non-Executive Directors and those senior managers which are formally recognised as part of the Trust's Executive Leadership Team (ELT). This includes permanent, interim and associate positions. It also includes those individuals who are acting up in Board level positions. |
| 1c: Will the 'policy' impact equality and or inequalities?<br>• Access to or participation in a service<br>• Levels of representation in our workforce<br>• Reducing quality of life (i.e., health, poverty education, standard of living) | No |

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| 1d: If there are 'no' impact on equality and or inequalities, please provide an explanation? | All applicants and postholders will be covered by the Trust policies that cover EDI |
| 1e: If there are impacts on equality and or inequalities complete stage 2 EIA<br><br>If you plan to complete the assessment at a later stage, please state the timescale for this. | |

Derbyshire Healthcare NHS Foundation Trust

**Board Committee Assurance Summary Reports to Trust Board – 7 March 2023**

The following summaries cover the meetings that have been held since the last public Board meeting held on 17 January and are received for information. This also includes a summary of the Neurodevelopmental Services Committee in Common meetings held September to January.

- Finance and Performance Committee 24 January
- Audit and Risk Committee 2 February
- Quality and Safeguarding Committee 14 February
- People and Culture Committee 17 February
- Neurodevelopmental (ND) Services Committee in Common (CiC) 23 January

| **Finance and Performance Committee - key items discussed 24 January 2023** |
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| **Making Room for Dignity (MRfD) assurance on Estate Strategy**<br>The Committee received the following updates:<br>• Confirmation of national funding and CDEL flexibility for PICU for 2022/23 and 2023/24. Further national funding of £6m has been made available therefore reducing the requirement of using Trust cash reserves.<br>• Successful outcome of bid to Treasury for the three remaining schemes.<br>• Affordability issues with the energy feed at CRH site. Confirmation of national funding for the energy supply at CRH site has been received.<br>• The first stage of the VAT abatement appeal has been unsuccessful and next steps are being discussed with the VAT advisers.<br>• On-going land ownership issues still to be resolved<br>• Additional 12 weeks delay to PICU build due to the redesign work<br>The Committee supported the urgent prioritisation of next stages of the programme of work and was assured on progress and milestones being hit to date. |
| **General Estate Strategy update**<br>The Committee received an update on the following:<br>• The NHS Premises Assurance Model (PAM) submission with improved results on the previous year, performance and compliance levels have improved with work still required in some areas which are deemed low risk.<br>• Regular governance meetings are ongoing and there are currently no items or risks requiring escalation.<br>• The pilot studies for the agile working initiative are progressing. Completed full desk count across the organisation.<br>• National cleaning standards are in operation and current scores indicate that the Trust is consistently performing beyond the national target for both in-patient and community settings.<br>• There are no high-risk items within the backlog maintenance position, with the majority of significant risk items being addressed through previous capital programmes. |

**Operational Performance**

The Committee received the same report as presented to the last Trust Board and were provided with the following updates:

- ASD – linking with Public Health to understand the increase in referrals. This issue is to be raised at the Mental Health, Learning Disabilities and Autism Delivery Board.
- Care Co-ordination – Data issues due to system changes and case load challenges being highlighted from recent work undertaken.
- Psychology waiting list – pilot of a digital platform is ready to go live.
- A performance dashboard is being developed where performance metrics will be available on a daily basis

The Committee had positive feedback on the improvements made to the report and going forward would like to see the changes between reporting periods summarised in the exec summary.

**Transforming Care Partnership (TCP) proposal and update and Learning Disability and Autism (LDA) transition**

Derbyshire residents out of area has seen an improvement with admission reducing down to seven which reflects the hard work that had taken place, but this continues to be worked on.

Autism diagnostic waiting list remains high, with recover action plan in place.

Pathway improvement work – intensive support team providing a wraparound service

Committee In Common is still in development - agreements have been made on a single IT system and to re-align clinical operational policies. Programme leads have been identified to help support this work. More transparency required on reporting the actual financial impact on each organisation to the next Committee.

**Business Environments update**

The committee received any update on the progress of the East Midlands Provider Collaborative for Perinatal services and the decision that has been taken regionally and nationally to delay the go live date until October 2023, and the Committee noted the current position and the new timelines.

An update was shared with the Committee in relation to the East Midlands Gambling support service, where the Trust has received confirmation to proceed with mobilisation.

**2023/24 Planning update**

The Committee was presented with a summary of the planning guidance for 2023/24 along with next steps. Requirement for 5-year Joint Forward Plan (JFP), Organisational operational plan requiring various template submissions for finances, workforce, and activity.

Local planning for MH, LD and Autism, meeting Mental Health Investment Standard (MHIS) and Long Term Plan (LTP) requirements. The guidance includes a requirement to deliver 34 constitutional standards and 62 transformational objectives.

Next steps: system will oversee the JFP and will need to link into the MHLDA Delivery Board. Organisational operational plans being developed, and the Committee will receive progress reports including details of interim submissions in February.

**The Committee agreed to receive delegated authority from the Trust Board to approve the final operational plan submission at the meeting in March with the Chair and CEO in attendance.**

**Financial plan update**

The Committee received the Month 9 position reported against the breakeven plan. Month 9 is a favourable variance to plan. The forecast has now moved from a breakeven position to a surplus of £2.8m. This improvement is driven by additional income for pay award, VAT rebate, slippage on investments, additional benefit from Dormitory revenue funding and a further stretch requirement. This £2.8m surplus is part of the reduced system deficit of £19m.

Financial risks are starting to reduce particularly related to the delivery of efficiencies and managing cost pressures however the risk of increasing temporary staffing costs particularly agency continues.

Due to the reduction of the revenue risks and now forecasting a surplus position along with the capital risks reducing due to additional central funding for Walton, Radbourne and Audrey House along with an increase in centrally funded capital for PICU reducing the impact on the Trust's cash reserves, it is recommended that the overall BAF risk *3A "There is a risk that the Trust fails to deliver its revenue and capital financial plans"* is reduced from Extreme to Moderate.

The Committee agreed the recommendation to reduce the BAF risk to Moderate.

**Continuous Improvement update**

The Committee received a progress report on the Quality Improvement (QI) capability training programme.

A number of identified pipeline initiatives for potential savings are being incorporated into services plans to ensure they align with the joint forward plan.

Training on QI continues with the next area of focus on areas of skills deficits and areas of particular improvement work. There is also a focus on the measurement impact of the training rather than just the numbers trained, with a particular focus on progress and outcomes for patients.

**Board Assurance Framework 2022/23 overview**

There are three risks that the Committee are responsible for. This item was taken with the Finance update.

The main change relates to the improvement in risk 3A, and the Committee approved the recommendation to reduce the risk from Extreme to Moderate.

**Escalations to Board or other Committees:** None
**Board Assurance Framework**: – key risks identified: None
**Next scheduled meeting:** 21 March 2023

| **Committee Chair: Tony Edwards** | **Executive Lead: Rachel Leyland, Interim Director of Finance** |
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**Audit and Risk Committee - key items discussed 2 February 2023**

**Board Assurance Framework**

Issue 4 (version 4.2) of the BAF for 2022/23 reflecting the scrutiny of each lead executive and work allocated to the relevant Board Committee was reviewed and approved for submission to the Board on 7 March. Reduced risk ratings on risks 1B, 3A and 4A were approved as well as the increased risk rating on risk MS1.

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"* has been reduced from extreme to high.

Risk 3A *"There is a risk that the Trust fails to deliver its revenue and capital financial plans".* The considerable positive movement to improve gaps in control around risk 3A reduced the rating from extreme to moderate.

Risk 4A *"Whilst there are significant benefits from the creation of the Integrated Care System (ICS) as an NHS body, there is a risk that the effects of the change on senior managers from across the system may impact negatively on the cohesiveness of the Derbyshire health and care system"* has been reduced from high to moderate.

Multiple System Strategy Risk MS1 *"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"*.

**Operational Risk Management**

This report provided an update on the effectiveness of the risk management processes and Datix record keeping in reference to the 360 Assurance internal audit recommendations. The report also showed the current status of all Trust risk registers mapped against the 360 Assurance Risk Management Audit Report and actions within it.

Limited assurance was obtained from the report due to the need to see the trajectory of improvement on overdue risks which is to be made clear in subsequent reports.

**Annual Report Planning - Year End Timetable Planning**

The year-end timetable and key dates associated with the approval of the annual report and accounts provided assurance that year-end planning is under control. It was noted that the Finance and Performance Committee has delegated authority from the Board to sign off the Operational Plan 2023/24 for submission to NHSE.

**Approve Accounting Standards/Policies for 2022/23 Annual Accounts**

The Trust's accounting policies for 2022/23 Annual Accounts were reviewed and agreed following the publication of the Department of Health's Group Accounting Manual (GAM).

**External Audit**

The External Auditor, Mazars confirmed that the scope of the audit and timetable is consistent with the previous year and will be completed in June in line with reporting deadlines.

Mazars referenced the implementation of IFRS 16 relating to lease accounting which is applicable from 1 April and was satisfied with the Trust's preparatory work already undertaken in line with the new requirements.

Value for Money (VfM) will be much the same process as last year. Mazars have not identified any VfM risks at this stage of the audit and will maintain a close watch over financial sustainability and how arrangements interact with the regional system.

**Internal Audit**

The Internal Auditor (360 Assurance) outlined that work is underway in Liberty Protections Safeguards project and their review of Mental Health Act. Since the previous meeting work has commenced covering Divisional Governance, Financial Systems and the Data Quality review of Fundamental Care Standards documentation.

**Sickness Management Final Report:** The 360 Assurance audit concluded a level of limited assurance level to the controls examined and samples tested. These controls are being looked at further within the Trust to ensure that actions are developed to address the within the report.

**Head of Internal Audit Stage Two final memo:** The memo set out the findings from stage 2 of the Head of Internal Audit Opinion work programme. No formal recommendations were made. An extremely positive response was articulated with regard to the Trust's BAF process.

**Counter Fraud**

The key messages and progress made in relation to completion of work from the Trust's Counter Fraud, Bribery and Corruption Plan since the last meeting in October were noted.

The Committee received significant assurance that sufficient controls and management mechanisms are in place within the Trust to mitigate fraud, bribery and corruption risks.

**Sickness Absence Management Update**

An update of the work on sickness absence management following the 360 Assurance internal audit which took place in October 2022 provided limited assurance on the work to date and outcomes.

The Committee was mindful that this is a long term programme of work. The People and Culture Committee has full oversight of this work and is monitoring the effects of long Covid on sickness absence figures.

The Committee acknowledged the considerable improvement work that is taking place and took limited assurance from the progress being made to complete the outstanding audit actions.

**Salary Overpayments Update**

The position with overpayments, actions implemented in relation to the management and prevention of overpayments showed that the new improved 'notice system' has avoided a number of overpayments although there is still more work to be done with late terminations.

The Committee was satisfied to discontinue reporting on overpayments. However, due to the limited assurance taken from the report it was decided that a further update would be made at the July meeting.

**Conflicts of Interest and Declarations of Interest Update**

An update on the Trust's compliance with the guidance on conflicts of interest in the NHS provided significant assurance that the process for declaration of secondary employment and private practice is embedded in Trust processes which is evident from improved return rates.

**Commercial Insurance Options Assessment Follow Up**

This report gave an overview of insured risks the Trust has covered. Having thoroughly reviewed insurance options, the Committee recommended that appropriate property insurance is procured upon completion of the hospital new builds and requested that the Data Protection and Security Committee (DS&P) continues to keep the possible procurement of cyber insurance under review.

**Waiver Report**

The Waiver Register for quarters 1, 2 and 3 for the financial year 2022/23 provided significant assurance that tendering and contracting processes are conducted in accordance with the Trust's Standing Financial Instructions and any waivers and non-competitive quotations utilised from 1 April 2018 have been logged and are presented for review by the Audit and Risk Committee.

**Data Quality Update**

The Committee was updated on activities which ensure the Trust maintains good data quality and the ongoing work across the Information Management Technology and Records team (IMT&R) to increase the accuracy of Trust reporting.

Data quality/validation continues to be a challenge within SystmOne. The Committee gave its support to ensuring that operational teams make sure that electronic records are complete, accurate and up to date. The achievements undertaken by IMT&R provided the Committee with significant assurance on all points covered in the report.

**Escalations to Board or other Committees:** None
**Board Assurance Framework –** key risks identified: None
**Next scheduled meeting:** 27 April 2023

| **Committee Chair: Geoff Lewins** | **Executive Lead: Justine Fitzjohn, Trust Secretary** |
|---|---|

| Quality and Safeguarding Committee - key items discussed 14 February 2023 |
| --- |
| **Summary of Board Assurance Framework (BAF) Risks**<br><br>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. |
| **Outstanding CQC actions**<br><br>An update on the status of outstanding CQC actions provided significant assurance from the preparedness for CQC inspections and the sustained progress being made towards completion of outstanding CQC actions. Since the previous report one further action has been signed off and significant progress is being made with the remaining actions. |
| **Quality Performance Dashboard**<br><br>This bi-monthly update on progress regarding key clinical performance indicators highlighted issues that have arisen from the migration from Paris to SystmOne which is having a negative impact on the production of care plans. A number of solutions have been discussed with the software provider to ensure data compatibility. The Committee requested that a deep dive into care plans is received at the next meeting in March to demonstrate where the gaps are and the action being taken to achieve target.<br><br>Significant assurance was received from overall clinical performance with limited assurance from the quality of data and care plans. |
| **Assurance of CQUIN progress**<br><br>An update report on CQUIN progress set out areas that need prioritising. The Committee was confident that by Q4 good progress will have been made with all CQUINS with the exception of CCG1 - flu vaccinations for frontline healthcare workers. It is anticipated that the set target of 90% will not be reached by the end of the flu campaign 2022/23. Uptake was 52% at the end of December 2022 which is significantly below the target of 90%. These difficulties are not isolated to Derbyshire as there has been a national reduction in flu vaccine uptake. |
| **Divisional Achievement Reviews (DARs)**<br><br>Slides setting out the performance of the individual DARs provided assurance that there are good processes in place. Paediatrics external waits are increasing and the CAMHS external wait list is rising again. A decrease is being seen in the Children's services workforce across the whole region and with school nurses. |
| **Neurodevelopmental Services Update**<br><br>A response to the CQC's 'Who I am Matters' report provided an update on the points raised by the CQC.<br><br>The programme of work set out in the report was seen as open and transparent evidence of how the Trust has designed and improved this service using feedback received via the use of service users and families. The benefits and realisation of this work is already being seen by service users across the whole of the county with Derbyshire Community Health Services DCHS and the Trust aligned.<br><br>An update on progress made as a result of the Learning Disabilities Mortality Review (LeDeR) improvement programme for people with learning disabilities and Autism was reviewed. The report showed the changes that have been, and will be made, as a result of LeDeR and how this will support a reduction in health inequalities for this community. |

**Serious Incidents Bi-Monthly Report**

Significant assurance was obtained relating to all Patient Safety process incidents occurring from 1 October to 31 December 2022

Improvement work streams in relation to high level themes following incidents are becoming more structured. Momentum is being seen overall, especially with regard to Life QI (Quality Improvement platform) to support and chart the implementation of Patient Safety Incident Response Framework (PSIRF) and changes to Duty of Candour (DOC).

**Learning from Deaths/Mortality Report**

This mortality report covered the period 1 October to 31 December 2022. The report included the positive use of the Royal College of Psychiatrists Care Review Tool. These reviews were undertaken by a multi-disciplinary team, of the 12 deaths reviewed none were due to issues with care. Also highlighted were the positive discussions that had been held with the Regional Medical Examiners to discuss the successful implementation of the Medical Examiner process within the Trust.

Significant assurance was received from the overall positive message contained in the report. The Committee agreed for the report to be considered by the Trust Board of Directors.

**Positive and Safe Annual Report**

Significant assurance was received from the progress made regarding the implementation of the Positive and Safe strategy in reducing restrictive practices, reducing violence and keeping all of our people safe. The report also gave a summary of work completed to date and plans moving forward.

Discussion focussed how high bed occupancy can increase the use of restrictive practice. It is a small group of patients that need this type of intervention and the use of restrictive practice is actually low compared to our bed base.

**Assuring Quality Care**

The report provided significant assurance regarding oversight of care and the wide variety of opportunities for colleagues to gain support and raise any concerns regarding care delivery. Significant assurance was also taken from the continued work regarding developing an open culture across the Trust . The Committee agreed that a final report will be submitted to the Committee in September to confirm that all actions have been completed.

**Guardian of Safe Working report**

The Guardian of Safe Working (GOSW) report covered arrangements made to ensure safe working of junior doctors and plans in place to identify, quantify and remedy any risks to the organisation.

This comprehensive report provided the Committee with significant assurance. Whilst the previous report outlined that the GOSW could not give assurances that the Trust was discharging its statutory duties in employing junior doctors on the 2016 contract as a result of doctors breaching non-resident on call rest requirements, this is no longer the case.

**Getting it right first time (GIRFT)**

The Committee was briefed on progress made since the GIRFT report on Rehabilitation services was reported to the Committee in June 2022. The report summarised the gradual progress against the GIRFT recommendations.

The report was accepted with limited assurance as more measurable attainments against the GIRFT criteria are expected in the next report due in the summer.

**Chief Pharmacist's Report**

This quarterly report raised issues around medicines management and Pharmacy workforce.

It is clear that the Pharmacy workforce is extremely strained at a time when demand has increased. The Committee discussed and noted the challenges being faced by the Pharmacy team and understood the need to invest in this area over time. It was agreed that as progress is difficult to assess on a quarterly basis, reports would in future be received every six months and the Quality Performance Dashboard is to include a section covering Pharmacy performance.

**Community Mental Health Framework Bi-Annual Report**

The Committee was updated on the statutory objectives of the Community Mental Health Framework (CMHF) and delivery against local plan. The report was supplemented by the CMHF Programme Highlight Report produced for the MH, LDA & CYP (Mental Health, Learning Disabilities and Autism and Children and Young People) Delivery Board.

The Committee noted the transitional governance arrangements that will develop as we move to an emerging model of an integrated service for Derbyshire. The Trust is the in the process of developing a Standard Operating Procedures (SOP) document that will support teams with their delivery and a Memorandum of Understanding (MOU) that articulates and manages the expectations of each organisation.

**Patient Experience Strategy**

Due to the delays incurred during the COVID-19 pandemic, it was agreed that the current Patient Experience Strategy would be extended by 12 months. This would give the opportunity to complete the work that is currently ongoing and develop a comprehensive co-produced patient experience strategy for next year.

**Board Assurance Framework – key risks identified:** None
**Escalations to Board or other committees:** None
**Next Meeting – 14 March 2023**

| | |
|---|---|
| **Committee Chair: Lynn Andrews** | **Executive Lead: Tumi Banda, Interim Director of Nursing and Patient Experience** |

| People and Culture Committee - key items discussed 17 February 2023 |
| --- |
| **Summary of BAF Risks**<br><br>The Committee reviewed 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."* |
| **People and Inclusion Assurance Dashboard**<br><br>The dashboard continues to show an improved position. The People and Inclusion team are using the data provided in the dashboard to drive forward improvements.<br><br>The data was noted with discussion centred around the processes developed for clinical supervision to ensure optimum efficiency of supervision. |
| **Update on Industrial Action**<br><br>A verbal update on the partnership working between the Trust's management team and RCN members in preparation for planned industrial action highlighted how the Trust's management team had respected the right of colleagues to participate in industrial action and fully appreciated the reasons for industrial action and showed their support and compassion to staff on the picket line.<br><br>The Committee thanked Staff-side and RCN colleagues for maintaining a position of integrity and compassion and commitment to their roles in very challenging times while putting patient care at the forefront of partnership working. Thanks were also extended to Acting Deputy Director of People and Inclusion, Rebecca Oakley and Emergency Planning and Business Continuity Manager, Celia Robbins for stepping up to a position of leadership which ensured derogations were made quickly to ensure the continued delivery of care across services. |
| **System People Services**<br><br>This report provided information on the 'One Workforce' strategic approach in relation to Joined Up Care Derbyshire (JUCD) that will feed our services. The importance of having people within our organisation with lived experience was recognised by the Committee. As this work develops it will increase quality and efficiency across the system and our organisation. |
| **Deep Dive Employee Relations Case Management**<br><br>This deep dive set out the current status of employee relations case management which is in the main managed by the People Services Employee Relations team.<br><br>The report included an anonymised update on the numbers of live formal employee relations cases in progress and showed the improvements seen in the average time it is taking to resolve employee relations cases.<br><br>The Committee received significant assurance that the People Services Employee Relations Team has a detailed understanding of the current employee relations casework. Significant assurance was also obtained from the plans and actions in place to improve the position around the number of formal cases at the Trust, and also to ensure the timeframes to work through are processed and improved. |

**Triangulation on team cultures deep dive with an associated staff story**

This paper set out processes used in triangulation to focus on teams that may be struggling and in need of support. Detail of the work undertaken and the support provided to the team that was flagged through the triangulation process was fed back to the Committee directly from the team leader.

The Committee heard first-hand how the team had benefitted from a one to one coaching programme led by an external facilitator. Throughout the process, people's individual behaviours were focused on. The team absorbed the process and now have a better understanding of each other and an appreciation of their relationships within the team and would advocate this model to other teams in need of support.

Full assurance was taken from the approaches to the team culture work. The Committee also took full assurance that people metric data is being triangulated and used to support teams.

**New EDI framework**

The Committee reviewed and endorsed the Equality and Inclusion Framework, Operating Model and the EDI Function for DHCFT.

The EDI framework has a strategic focus on equity to tackle health inequalities. It is essential to the future viability of the NHS and its partners in the JUCD. There is a significant opportunity to the Trust to further develop leadership that excels at inclusivity, tackling the systemic inequalities that exist in our workforce, patients and system. This is a specific opportunity for the Trust to build on the good work it has already carried out at system level by embedding inclusion and taking more collaborative approach to resolve complex issues by building management capacity on inequality.

**Escalations to Board or other committees**: The lack of full Executive Director attendance and the need for fully briefed representatives to deputise for them in their absence is to be brought to the attention of the Executive Leadership Team.

**Board Assurance Framework – key risks identified:** None
**Next Meeting:** 28 March 2023

| **Committee Chair: Ralph Knibbs** | **Executive Lead: Jaki Lowe, Director of People and Inclusion** |
|---|---|

**Neurodevelopmental (ND) Services Committee in Common (CiC)**

The Trust (DHCFT) has established a Neurodevelopmental Services Committee in Common (CiC) that meets at the same time as Derbyshire Community Health Services NHS Foundation Trust's (DCHS) Neurodevelopmental Services Committee in Common (CiC).

The first meeting was held on 20 September 2022 and the CiC has met four further times, on 27 October, 28 November and 23 January 2023.

- 20 September

A presentation set out the strategic context including where services were provided by which Trust and information on budgets and workforce. A service plan sets out the ambition and clinical model, the work already underway and future developments, and next steps and is a key document for each CiC to track progress.

The Plan has four key areas:

1. ADHD and ASD Diagnostic

2. Step Up/Down Model

3. Inpatient Service

4. Intensive Support Team (IST).

There was debate on the interface with the Mental Health Learning Disability and Autism System Delivery Board which includes local authority and voluntary sector partners.

An issue was identified: the assumption that regular recruitment into the DHCFT employment would arrive at a "tipping point" where the majority of staff are employed in that trust will need to be revisited. The number of staff in scope indicate this would be too far in the future. Alternatives would need to be explored.

The CiC discussed the draft Memorandum of Understanding which will detail how the two Trusts will work together to provide services. Performance metrics were reviewed. It was noted that the clinical teams are integrating well and there are benefits to the collaborative working however the operational issues need to be addressed and the Executives from both organisations will work together to remove any barriers.

- 27 October 2022

The ND Services Priority Action Plan was discussed as well as the timeframes. Supporting information was received regarding the current inpatient provision, occupied bed days and length of stay and the drivers for change. The CiC agreed their priorities would reflect the action plan and key milestones and it would be a standing agenda item at the meeting.

Performance metrics were reviewed, including:

- Patients out of area in locked rehab and Assessment and Treatment units (ATU) due to no local provision available at the time of admission
- Demand continues to outstrip capacity within the Autism Diagnostic pathway
- At present there is no locally delivered adult service offer for ADHD in Derbyshire and service users access Sheffield Adult Autism and Neurodevelopmental Service (SAANS) received 188 Derbyshire ADHD referrals in 2021
- Good performance on health inequalities.

The CiC reviewed the issues that were impacting on the workforce working collaboratively including access to IT, operational structures, and variances in resources. The clinical teams are integrating well and there are benefits to the collaborative working however the operational issues need to be addressed and the Executives from both organisations will work together to remove any barriers.

- 28 November 2022

Collaborative working operational issues were reviewed. It was agreed that the Executives from both Trusts would meet in December 2022 to continue to discuss the detail on alliance

working. A joint paper would then be presented to the January CiC meetings to provide an update on the discussions and a proposed model. The ND Services Priority Action Plan and timeframes was presented and the CiC focussed on the exceptions and key updates since the last meeting. Assurance was accepted around the inpatient data, noting the good performance on health inequalities.

- 23 January 2023

Discussion took place on the agreement to move to an alliance/collaboration model where DCHS and the Trust will take responsibility for different elements of the service and report as an alliance into the Committees in Common. There will be a joint approach to project/programme management and work to resolve operational issues will continue at pace. It was agreed it would be important to maintain regular updates and communications with staff, including regular email updates and further engagement events to ensure all staff are kept up to date and engaged in the change process. The CiC received the Workforce Report which provided an overview of the key workforce areas of focus within the alliance, including operationalisation of joint leadership, hosting of posts and vacancies and issues with banding.

**Next Meeting:** 27 February 2023

| | |
|---|---|
| **Committee Chair: Deborah Good** | **Executive Lead: Ade Odunlade**<br>**Chief Operating Officer** |

| GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS | |
|---|---|
| **NHS Term / Abbreviation** | **Terms in Full** |
| **A** | |
| A&E | Accident & Emergency |
| ACCT | Assessment, Care in Custody & Teamwork |
| ACE | Adverse Childhood Experiences |
| ADHD | Attention Deficit Hyperactivity Disorder |
| AfC | Agenda for Change |
| AHP | Allied Health Professional |
| AIMS | Royal College of Psychiatrists Accreditation for Inpatient Mental Health Services Standards |
| ALB | Arms-length body such as NHS Improvement (NHSI) and NHS England (NHSE) |
| AMM | Annual Members' Meeting |
| AMHP | Approved Mental Health Professional |
| ANP | Advanced Nurse Practitioner |
| AO | Accountable Officer |
| ASD | Autism Spectrum Disorder |
| ASM | Area Service Manager |
| **B** | |
| BAF | Board Assurance Framework |
| BLS | Basic Life Support (ILS Immediate Life Support) |
| BMA | British Medical Association |
| BME | Black,& Minority Ethnic group |
| BoD | Board of Directors |
| **C** | |
| CAMHS | Child and Adolescent Mental Health Services |
| CASSH | Care and Support Specialised Housing |
| CBT | Cognitive Behavioural Therapy |
| CCG | Clinical Commissioning Group (defunct from 1 July 2022) |
| CCT | Community Care Team |
| CDMI | Clinical Digital Maturity Index |
| CE | Chief Executive |
| CEO | Chief Executive Officer |
| CGA | Comprehensive Geriatric Assessment |
| CHPPD | Care Hours Per Patient Day |
| CIP | Cost Improvement Programme |
| CMDG | Contract Management Delivery Group |
| CMHF | Community Mental Health Framework |
| CMHT | Community Mental Health Team |
| CNST | Clinical Negligence Scheme for Trusts |
| COAT | Clinical Operational Assurance Team |
| COF | Commissioning Outcomes Framework |
| CoG | Council of Governors |
| COO | Chief Operating Officer |
| CPA | Care Programme Approach |
| CPD | Continuing Professional Development |
| CPN | Community Psychiatric Nurse |
| CPR | Child Protection Register |

| GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS | |
|---|---|
| **NHS Term / Abbreviation** | **Terms in Full** |
| CQC | Care Quality Commission |
| CQI | Clinical Quality Indicator |
| CQUIN | Commissioning for Quality and Innovation |
| CRG | Clinical Reference Group |
| CRH | Chesterfield Royal Hospital |
| CRHT | Crisis resolution and home treatment |
| CRS | (NHS) Care Records Service |
| CRS | Commissioner Requested Services |
| CSF | Commissioner Sustainability Fund |
| CTO | Community Treatment Order |
| CTR | Care and Treatment Review |
| **D** | |
| DAR | Divisional Assurance Review |
| DAT | Drug Action Team |
| Datix | Trust's electronic incident reporting system of an event that causes a loss, injury or a near miss to a patient, staff or others |
| DBS | Disclosure and Barring Service |
| DBT | Dialectical Behavioural Therapy |
| DfE | Department for Education |
| DCHS | Derbyshire Community Health Services NHS Foundation Trust |
| DDCCG | Derby and Derbyshire Clinical Commissioning Group |
| DHCFT | Derbyshire Healthcare NHS Foundation Trust |
| DIT | Dynamic Interpersonal Therapy |
| DNA | Did Not Attend |
| DoH | Department of Health |
| DoLS | Deprivation of Liberty Safeguards |
| 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 |

| GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS | |
|---|---|
| **NHS Term / Abbreviation** | **Terms in Full** |
| EMDR | Eye Movement Desensitising & Reprocessing Therapy |
| EMR | Electronic Medical Record |
| EPR | Electronic Patient Record |
| ERIC | Estates Return Information Collection |
| ESR | Electronic Staff Record |
| EUPD | Emotionally Unstable Personality Disorder |
| EWTD | European Working Time Directive |
| **F** | |
| 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 |

| GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS | |
|---|---|
| **NHS Term / Abbreviation** | **Terms in Full** |
| OOA | Outside of Area |
| IPP | Imprisonment for Public Protection |
| IPR | Integrated Performance Report |
| IPT | Interpersonal Psychotherapy |
| **J** | |
| JNCC | Joint Negotiating Consultative Committee |
| JTAI | Joint Targeted Area Inspections |
| JUCB | Joined Up Care Board |
| JUCD | Joined Up Care Derbyshire |
| **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 |

| GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS | |
|---|---|
| **NHS Term / Abbreviation** | **Terms in Full** |
| MSC | Medical Staff Committee |
| MSK | Musculoskeletal (conditions) |
| MSU | Medium secure unit |
| **N** | |
| NCRS | National Cancer Registration Service |
| NED | Non-Executive Director |
| NICE | National Institute for Health and Care Excellence |
| NHS | National Health Service |
| NHSE | National Health Service England |
| NHSI | National Health Service Improvement |
| NHSEI | NHS England and NHS Improvement |
| NIHR | National Institute for Health Research |
| **O** | |
| OBC | Outline Business Case |
| ODG | Operational Delivery Group |
| 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 |

| GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS | |
|---|---|
| **NHS Term / Abbreviation** | **Terms in Full** |
| QIPP | Quality, Innovation, Productivity Programme |
| **R** | |
| RAID | Rapid Assessment, Interface and Discharge |
| RCGP | Royal College of General Practitioners |
| RCI | Reference Cost Index |
| REGARDS | Race, Economic disadvantage, Gender, Age, Religion or belief, Disability and Sexual orientation |
| RTT | Referral to Treatment |
| **S** | |
| SAAF | Safeguarding Adults Assurance Framework |
| SBARD | Situation, Background, Assessment, Recommendation and Decision (SBARD) tool |
| SBS | Shared Business Services |
| SEND | Special Educational Needs and Disabilities |
| SFI | Standing Financial Instructions |
| SI | Serious Incidents |
| SID | Senior Independent Director |
| SIRI | Serious Incident Requiring Investigation |
| SLA | Service Level Agreement |
| SLR | Service Line Reporting |
| SMI | Severe Mental Illness |
| SOC | Strategic Options Case |
| SOF | Single Operating Framework |
| SPOA | Single Point of Access |
| SPOE | Single Point of Entry |
| SPOR | Single Point of Referral |
| STEIS | Strategic Executive Information System |
| STF | Sustainability and Transformation Fund |
| STP | Sustainability and Transformation Partnership |
| SUI | Serious (Untoward) Incident |
| SystmOne | Electronic patient record system |
| **T** | |
| TARN | Trauma Audit and Research Network |
| TCP | Transforming Care Partnerships |
| TCS | Transforming Community Services |
| TDA | Trust Development Authority |
| TMT | Trust Management Team |
| TUPE | Transfer of Undertakings (Protection of Employment) Regulations 1981 |
| TMAC | Trust Medical Advisory Committee |
| 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 |

| GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS | |
|---|---|
| **NHS Term / Abbreviation** | **Terms in Full** |
| **W** | |
| 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 | 3 May 23 | 4 Jul 23 | 5 Sep 23 | 7 Nov 23 | 18 Jan 24 | 5 Mar 24 |
|---|---|---|---|---|---|---|---|
| | **Paper deadline** | **24 Apr** | **26 Jun** | **29 Aug** | **30 Oct** | **8 Jan** | **26 Feb** |
| Trust Sec | Declaration of Interests | X | X | X | X | X | X |
| DON | Patient/Staff Story | X | X | X | X | X | X |
| CHAIR | Minutes/Matters arising/Action Matrix | X | X | X | X | X | X |
| CHAIR | Board review of effectiveness of meeting | X | X | X | X | X | X |
| CHAIR | Board Forward Plan (for information) | X | X | X | X | X | X |
| CHAIR | Summary of Council of Governors meeting (for information) | X | X | | X | X | X |
| CHAIR | Chair's Update | X | X | X | X | X | X |
| CEO | Chief Executive's Update | X | X | X | X | X | X |
| **STRATEGIC PLANNING AND CORPORATE GOVERNANCE** | | | | | | | |
| 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 19 September to approve the October submissions | | | X | | | |
| DPI | Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) Strategic implications/retrospective sign off after PCC on 20 September | | | | X | | |
| DPI | Workforce Plan for 2023/24 | | | X | | | |
| DPI | 2023/24 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 | X | | | | | |
| Trust Sec | Trust Sealings (six monthly - for information) | X | | | X | | |
| Trust Sec | Annual Review of Register of Interests | X | | | | | |
| Trust Sec | Board Assurance Framework Update | X | | X | X | | X |
| Trust Sec | Freedom to Speak Up Guardian Report (six monthly) | | | X | | | X |
| Trust 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 |
| DSPT | ICB Joint Forward Plan and DHCFT Operational Plan | X | | | | | |
| DPI | Equality Diversity and Inclusion (EDI) update | | | | X | | |
| COO | Emergency Preparedness, Resilience and Response (EPRR) Core Standards | | | X | | | |
| DON/COO/ DPI | Workforce Standards Formal Submission/Safer Staffing (prior to publishing on website) | X | | | | | |

**2022-23 Board Annual Forward Plan**

| Exec Lead | Meeting date | 3 May 23 | 4 Jul 23 | 5 Sep 23 | 7 Nov 23 | 18 Jan 24 | 5 Mar 24 |
|---|---|---|---|---|---|---|---|
| **QUALITY GOVERNANCE** | | | | | | | |
| EXEC | Position Statement - focus on CQC domains (Well Led CQC & NHSI) as per schedule | Caring<br>DON | Well Led<br>Trust Sec | Safe<br>MD | Responsive<br>COO | Effective<br>DON MD & DPI | |
| MD | Learning from Deaths Mortality report (quarterly publication) (Jul/Nov/Jan/Mar) | AR | X | X | X | X | X |
| MD | Guardian of Safe Working Report | | AR | | X | X | X |
| DSPT | Continuous Quality Improvement: A Stocktake | | | | | | X |
| DON | Infection Prevention and Control Annual Report and BAF | | | | | AR | |
| MD | Re-validation of Doctors Compliance Statement | | X | | | | |
| MD | Draft Mental Health Bill | | | X | | | |
| DON | Assuring Quality Care | | | | | X | |
| DON | Receipt of Annual Reports:<br>- Annual Looked After Children<br>- Safeguarding Children and Adults at Risk | | | | X | | |
| DON | Outcome of Patient Stories - every two years - due March 2024 | | | | | | X |
| **POLICY REVIEW** | | | | | | | |
| DOF/<br>Trust Sec | Standing Finance Instructions Policy and Procedures Review (May 2023) | X | | | | | |