Derbyshire Healthcare
NHS Foundation Trust

PUBLIC BOARD MEETING
TUESDAY 7 NOVEMBER 2023 TO COMMENCE AT 09:30
CONFERENCE ROOMS A&B, RESEARCH & DEVELOPMENT CENTRE, KINGSWAY, DERBY, DE22 3LZ

	TIME	AGENDA	LED BY
1.	9:30	Chair's welcome, opening remarks and apologies, declarations of interest	Selina Ullah
PATIENT STORY			
2.	9.35	Patient Story "*My experience of using Physiotherapy and Occupational Therapy services as a person with Cerebral Palsy in Derbyshire*"	Dave Mason Kyri Gregoriou
STANDING ITEMS			
3.	10.00	Minutes of Board of Directors meeting held on 5 September 2023	Selina Ullah
4.		Matters arising – Actions Matrix	Selina Ullah
5.		Questions from members of the public	Selina Ullah
6.	10:05	Chair's update	Selina Ullah
7.	10:15	Chief Executive's update	Mark Powell
STRATEGY, PERFORMANCE AND RISK			
8.	10:35	Integrated Performance report	Exec Director Leads
11:05 B R E A K			
9.	11:15	Ward 35 inspection report	Dave Mason Arun Chidambaram Ade Odunlade
10.	11:25	Making Room for Dignity progress update	Andy Harrison
11.	11:35	Position Statement - CQC "Safe" domain	Arun Chidambaram
GOVERNANCE AND COMPLIANCE			
12.	11:45	Board Assurance Framework 2023/24 Issue 3.2	Justine Fitzjohn
13.	11:55	Well Led Review	Selina Ullah
BOARD COMMITTEE ASSURANCE			
14.	12:05	Board Committee Assurance Summaries	Committee Chairs
REPORTS FOR NOTING ON ASSURANCE FROM BOARD COMMITTEES			
15.	12:15	Quality and Safeguarding Committee: - Mortality Report - Guardian of Safe Working Report - Safeguarding Children and Adults Annual Report 2022/23 - Children in Care Annual Report 2022/23 - Infection Prevention and Control Annual Report 2022/23 and IPC BAF	Lynn Andrews
16.	12:25	People and Culture Committee: - Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) submission retrospective sign off - Workforce Plan 2023/24	Ralph Knibbs
CLOSING BUSINESS			
17.	12:35	Identification of issues arising for inclusion or updating in the BAF	Selina Ullah
18.		Meeting effectiveness	Selina Ullah
FOR INFORMATION			
Trust Sealings six month update Summary of Council of Governors meeting held 5 September 2023 Glossary of NHS Acronyms 2023/24 Forward Plan			

Questions applicable to the agenda, and at the Chair's discretion, can be sent by email to the Board Secretariat at dhcft.boardsecretariat@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 16 January 2024 in Conference Rooms A&B, Centre for Research and Development, Kingsway. Arrangements will be notified on the Trust website 7 days in advance of the meeting.

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

Our vision

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

Our values

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

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

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

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

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

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

Derbyshire Healthcare NHS Foundation Trust

MINUTES OF A MEETING OF THE BOARD OF DIRECTORS

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

Tuesday 5 September 2023

MEETING HELD IN PUBLIC

Commenced: 09.30 Closed: 12:30

PRESENT	Selina Ullah	Trust Chair
	Tony Edwards	Deputy Trust Chair
	Ralph Knibbs	Senior Independent Director
	Lynn Andrews	Non-Executive Director
	Deborah Good	Non-Executive Director
	Geoff Lewins	Non-Executive Director
	Mark Powell	Chief Executive
	Ade Odunlade	Chief Operating Officer and Deputy Chief Executive
	Dr Arun Chidambaram	Medical Director
	Carolyn Green	Director of Nursing and Patient Experience
	Rachel Leyland	Interim Director of Finance
	Vikki Ashton Taylor	Director of Strategy, Partnerships and Transformation
	Justine Fitzjohn	Trust Secretary
IN ATTENDANCE	Anna Shaw	Deputy Director of Communications and Engagement
For DHCFT2023/079	Jill	Guest for Patient Story
For DHCFT2023/079	Joe Thompson	Assistant Director of Clinical Professional Practice
For DHCFT2023/090	Tamera Howard	Freedom to Speak Up Guardian
	Sue Turner	Board Secretary
APOLOGIES	Jaki Lowe	Director of People and Inclusion
	Ashiedu Joel	Non-Executive Director
OBSERVERS	Janet Dean	360 Assurance, Internal Auditor
	Sandra Austin	Carers Forum

DHCFT 2023/078	CHAIR'S WELCOME, OPENING REMARKS, APOLOGIES FOR ABSENCE AND DECLARATION OF INTERESTS Trust Chair, Selina Ullah welcomed Board colleagues and observers to today's meeting. Selina opened the meeting by thanking Director of Nursing and Patient Experience for her significant contribution to the Trust over the last nine years and wished her well before she takes up her appointment as the Chief Nursing Officer for Black Country Healthcare NHS Foundation Trust, on a secondment basis. Selina also thanked Board Secretary, Sue Turner for her support to the Board over the last nine years as she was attending her 77th and final public board meeting before retiring from the Trust in November. Apologies were recorded as listed. The Register of Directors' Interest for 2023/24 was noted. No declarations of interest were declared with the exception of Carolyn Green who declared that there were no items on today's agenda that caused any conflict of

	interest associated with her forthcoming appointment with Black Country Healthcare NHS Foundation Trust.
DHCFT 2023/079	PATIENT STORY Today's patient story was heard from Jill who shared her thoughts on "the importance of a trauma informed approach to care". Jill was accompanied by her husband and supported by Assistant Director of Clinical Professional Practice, Joe Thompson. Jill has almost 30 years' experience of mental health services this included inpatient admissions and support received from the Trust's community services. The main theme of Jill's story focussed on the different styles of support offered by community and inpatient services and how conversations and interaction with clinicians can affect the impact on recovery. Jill experienced continued excellent practice from a number of Community Psychiatric Nurses (CPNs) and has seen an improvement in the way the Crisis Team operates. She received excellent support and continuity from her Community Psychiatrist and praised the introduction of the 24 hours mental health support phone line. She felt that communication between the various community services had led to improvements in continuity of care which reduced unhelpful and often traumatic re-questioning, re-evaluating and unsettling changes to diagnosis or medication. Jill had great respect for the staff but felt that communication, collaboration and recovery was not as effective following her admission as an inpatient. She felt that care on the ward was "being done to her" rather than "with her" and she felt frustrated at not being understood. Jill believed that adopting a Trauma Informed Care approach to care has grown within community services and is promoting the wellbeing of individuals within supportive working relationships, not only for service users but also for the staff who provide these services. She asked that this approach be rolled out across all areas of service to a more Trauma Informed Approach. Non-Executive Director, Lynn Andrews saw this as a good example of how inpatients and community teams can connect and work together. Carolyn added that services have been applying a trauma informed and compassionate care approach for some time and clinicians benefit from regular teaching sessions that increase their responsiveness in trauma and psychological awareness. A number of events have been held within the Trust to inform and motivate trauma informed developments. This approach commenced incrementally with community teams and this is why Jill felt that they were way ahead of inpatient services. The Trust will benefit from its development of trauma informed practice in the new hub of psychology within the new facility being built at Kingsway. Medical Director, Arun Chidambaram assured Jill that since last year training undertaken by multi-disciplinary teams on how they respond to inpatients has been underpinned by the trauma informed approach and will include a lived experience voice as part of this training. Chief Executive, Mark Powell valued Jill's opinion and articulated how he and the Board were sighted on the elements of trauma informed care and would capture Trauma Informed Care within the Trust strategy. Jill made the point that trauma informed care is not easily quantifiable. She hoped that in three years' time she can report favourably on inpatient services as much as community services. On behalf of the Board, Selina thanked Jill for sharing her story and hoped she could take some comfort from the commitment pledged by the Board to scaling up and embedding trauma informed practice work and across the Trust's services. The Board will regularly review how embedded trauma informed practice is working as this affects people's lives and is not quantifiable.

	RESOLVED: The Board of Directors noted the importance of ensuring that a trauma informed approach is embedded within Trust services.
DHCFT 2023/080	MINUTES OF THE PREVIOUS BOARD OF DIRECTORS MEETING The draft minutes of the previous meeting held on 4 July 2023 were accepted as a correct record of the meeting.
DHCFT 2023/081	ACTION MATRIX The Board reviewed and closed the completed actions. No actions remained outstanding.
DHCFT 2023/082	QUESTIONS FROM MEMBERS OF THE PUBLIC No questions had been directly submitted for a response ahead of the meeting. Governors represent the population of Derbyshire and any questions raised with them by members of the public are taken to the Council of Governors.
DHCFT 2023/083	CHAIR'S UPDATE Selina's wide range of visits and activities since the previous Board meeting held on 4 July demonstrated the complexity of the Trust's services and was evidenced by a day of visits she made to Children's services with Chief Executive, Mark Powell and Lynn Andrews who is also the Chair of the Quality and Safeguarding Committee and will be taking on the role of the Board Champion for Children's services. This visit provided an insight into the spectrum of Children's services and Selina was touched by the team's determination in dealing with the complexity of the issues that they manage on a daily basis. Having an open culture to speak up and raise concerns is key to patient safety as seen recently from the Letby case. Tamera Howard, the Trust's Freedom to Speak Up (FTSU) Guardian has the role of supporting staff to speak up when they feel unable to do so by other routes and Selina meets with her regularly. Tamera also has a nominated Non-Executive Director (NED) lead to support her in Geoff Lewins and she would join today's meeting to report on her work. Selina closed her update by referring to the Office of Modern Governance's (OMG) review of the Trust's governance and leadership. Overall, it is a positive report and Selina intends to share its findings at the next Public Trust Board meeting. Selina gave thanks to everyone who took time to speak to Moosa Patel and Sarah Boulton of OMG and gave special thanks to Trust Secretary, Justine Fitzjohn and her team for collating this work. RESOLVED: The Board of Directors noted the content of the Chair's update.
DHCFT 2023/084	CHIEF EXECUTIVE'S REPORT Mark Powell's report covered current local issues and national policy developments. The report also reflects a wider view of the Trust's operating environment. Reference was made to a number of points. National Context Mark outlined the Trust's commitment to complete all NHS England's (NHSE) recommendations arising from the recent Letby case that will reflect on the Trust's processes for speaking up and raising concerns. Medical Director, Arun Chidambaram will be leading the response to be made to NHSE's recommendations on behalf of the Trust. The Board would consider all the national recommendations to ensure every possible lesson is learnt from this conviction and will report on the Trust's compliance through our quality governance framework, to Trust Board.

	Within the Trust Mark referred to the recent and forthcoming industrial action and thanked all colleagues who have supported the planning and ongoing response. The Board continues to respect the right of colleagues to take part in lawful industrial action such as this and whilst a number of patient appointments were rescheduled, colleagues have worked together to ensure patient safety was maintained throughout. Trust services have come under significant pressure in the last few weeks. This follows a similar national picture for mental health services. The need for acute inpatient beds has been high, which has resulted in a greater than expected use of out of area beds over the summer period. Further detail on these pressures would be discussed during the review of the Integrated Performance report (IPR) under item DHCFT2023/085 below. Mark referred to the recent fire that broke out on Ward 34 at the Radbourne Unit. He wanted to record his admiration for the way staff responded to the incident and the care and attention they paid to their patients to ensure they remained safe and unharmed while continuing to receive the best possible care. Their quick response prevented what could have been a much more serious incident. Arun was invited to update the Board on the industrial action involving junior doctors and consultants that has been planned for September and October. This combined industrial action involving junior doctors and consultants is unprecedented and the level of support from colleagues has been phenomenal. Mark and Arun were keen to ensure that the response to industrial action is not treated as business as usual. It will clearly have an impact on services and a supporting piece of work is being undertaken to assess the extent it is having. Mark was confident that the Trust will be able to mitigate the action being taken. Arun is leading this work and will take a report on our response to the industrial action and the role of the incident management team, the impacts, risks and mitigations the Trust is working to the Quality and Safeguarding Committee on 12 September. On a lighter note, Mark congratulated colleagues who have been recognised through recent award nominations. Geoff Lewins referred to the recent discovery that Reinforced Autoclaved Aerated Concrete (RAAC) was present in education settings and asked what the Trust's approach would be if RAAC was found to exist in any of its buildings. Chief Operating Officer, Ade Odunlade reported that a survey had been carried out across the Trust's entire estate to assess the situation and he was confident that none of the buildings are affected. Non-Executive Director, Deborah Good referred to the number of visits Mark had made to services and was pleased that there would be an increased focus on informality during quality visits to services as this will give greater visibility of the Board. RESOLVED: The Board of Directors discussed and scrutinised the report and sought assurance around any key issues raised.
DHCFT 2023/085	<u>INTEGRATED PERFORMANCE REPORT</u> The IPR provided an update on key finance, performance and workforce measures at the end of July 2023. Operations Chief Operating Officer, Ade Odunlade gave an overview of performance. The most challenging areas included waiting times for adult autistic spectrum disorder assessment, Paediatric outpatients 18-week referral to treatment, inappropriate out of area placements and NHS Talking Therapies waiting times. The most improved areas

	were Psychological services waiting times which are continuing to reduce month on month and Child and Adolescent Mental Health Service (CAMHS) waits continue to reduce. The Board discussed the increased demand on services which saw a similar trend last summer and noted that work is taking place to understand why this is occurring at this time of year. There has also been a recent rise in out of area placements and a deep dive into plans to improve the trajectory will take place at the Finance and Performance Committee. Discussion also focussed on improving patient flow. It was noted that a multi-agency admission and discharge hub is being established to oversee the flow of patients in hospital helping to reduce longer length of stays. The Quality and Safeguarding Committee and Finance and Performance Committee are both monitoring demand for out of area placements, inpatient flow and what is preventing patients from being discharged into a place of care. Deborah Good was concerned that community mental health caseloads were double the national average which is also affecting flow. Ade responded that clinical decision making on discharge is challenging and this is being impacted by the surge in demand. The number of caseloads has reduced as some people have stepped down from specialist services into the domain of Living Well. The Heads of Nursing and the Safeguarding team are ensuring these people are being actively seen. The Trust is also working with Primary Care Networks (PCN) to ensure caseloads are sensibly balanced. Ade asked the Board to note that the NHS East Midlands Gambling Harms Service was launched on 20 June. The service is managed by the Trust in Derby and offers specialist treatment and support to people struggling with problem gambling across the East Midlands. The service is a clinical team that includes psychologists, therapists, mental health practitioners and psychiatrists. Within the team there are also experts by experience – people who have recovered from a gambling addiction themselves. The team offers help with specific problems experienced by individuals, and support and advice to family members and carers and works alongside other agencies and services that can help with problems such as mental health, debt management and housing. Finance Interim Executive Director of Finance, Rachel Leyland reported on the forecasting that has been undertaken to achieve financial balance by year end. Points discussed included agency costs and transformation to make recurrent efficiencies. Geoff Lewins saw that the report showed positive improvements in some areas but not with agency costs. Rachel reported that that forecast assumes the delivery of efficiencies in full development of mitigations to offset the emerging cost pressures associated with pay award inflation, agency costs related to a complex patient who is being supported on one of the wards. Additional recruitment work streams are a continued area of focus this includes action developing from an agency summit focussing on qualified nurses. Ade commented that there is a national shortage of specialist professionals that are needed to deliver services which is part of the national recruitment initiative. Ade anticipates slow movement on agency costs and was pleased to report that the Trust had recently been successful in recruiting to roles which indicates that the organisation is seen as an employer of choice. Mark emphasised that patient safety is of paramount importance. The Finance and Performance Committee is to review the revised plans on agency spend and any associated risks. The Committee is to also address flow as it is impacting the workforce. Tony Edwards as Chair of the Finance and Performance Committee highlighted that the Committee would also be focussing on the forecast for this year and 2024/25 and savings to be delivered through the Cost Improvement Programme (CIP) The

Committee will look at the success in finding savings and how this will feature in the plan for next year. A report on the medium term plan across the system for 2024/25 will be received by the Committee on 26 September.

Geoff also asked to know more about the Trust's liquidity. Rachel responded that cash is forecasted to be quite healthy. Money is being drawn down from the national funding for dormitory eradication and focussed discussions on cash will be held by the Finance and Performance Committee. Cash at the end of July was £40.2m the same as the previous month and is forecast to be at planned levels of £23.6m by the end of the financial year.

People performance

Recent progress was noted in recruitment and training compliance. Turnover remains in line with national and regional comparators and is within the target range of 8-12%.

There was a request from Tony Edwards to include an update on the staff survey within future IPR reports. Trust Secretary, Justine Fitzjohn reminded the Board that a comprehensive report on the results of the staff survey had been received by the Board in May. In the meantime the staff survey report received by the People and Culture Committee in July would be circulated to the Board and updates from the staff survey concerning operational detail will be included in the IPR to be received at the November meeting. Selina was mindful that last year's response rate to the staff survey had been slower than the previous year. Senior Independent Director, Ralph Knibbs and Chair of the People and Culture Committee assured Selina that a plan of action has been developed by looking at the lessons learned from last year to prepare for the 2024/25 survey.

Ralph was concerned that the IPR showed that the management of clinical supervision had plateaued and wanted to know if there was a reason why compliance had not improved. He was advised by Carolyn Green that the Divisional Assurance Reviews (DARs) were targeting inconsistencies in order to make improvements in the next two quarters.

ACTION: Updates from the staff survey concerning operational detail to be featured future IPR reports

Quality

Carolyn reiterated that services have undergone a difficult period during the which resulted in a number of out of area placements (OOAs). Despite this teams have fared well in maintaining quality and safeguarding standards while meeting 85% bed occupancy and have controlled reductions on seclusion and restraint. The strategic plan is to work with local authority partners ensure patients discharge is not delayed as much as they have been. The Heads of Nursing will ensure quality and safety standards are maintained and improve flow so that further OOA placements are not incurred.

Lynn Andrews as Chair of the Quality and Safeguarding Committee assured the Board that while monitoring quality of care the Committee has oversight of all of these issues and wanted to commend staff for maintaining such high standards in extremely difficult circumstances.

Geoff was pleased to see that training compliance continues to improve but was disappointed that care planning compliance had remained static. Carolyn responded that the entire Care Plan Approach (CPA) was undergoing targeted improvement work. Definite improvements have been seen recently but there has also been an increase in demand. Work will continue to ensure the correct standards are in place.

Deborah liked the inclusion of the hot spots table in the report. The areas that are recurring were of particular concern and she asked for assurance on the impact of any work that would improve these areas. Carolyn assured Deborah that hot spots are taken extremely seriously and are reviewed by the Executive Leadership Team (ELT) and are

	also targeted at DARs. She confirmed that Wards 34, 35 and 36 have received Executive Director visits and will receive targeted organisational development intervention. Having held extensive discussion on current performance the Board agreed that although positive assurance had been obtained from action being taken to progress challenging areas, limited assurance was received on current performance. Further scrutiny of performance will take place primarily within the Finance and Performance Committee and the People and Culture Committee as well as the Quality and Safeguarding Committee. RESOLVED: The Board of Directors: 1) Received limited assurance from current performance across the areas presented 2) Formally agreed that this report incorporated the key elements of assurance to the Trust Board that would otherwise have come from Finance and Performance Committee and People and Culture Committee reporting.
DHCFT 2023/086	<u>TRUST STRATEGY PROGRESS UPDATE</u> Director of Strategy, Partnerships and Transformation, Vikki Ashton Taylor updated the Board on progress in delivering the priority actions identified in the organisational strategy. Following feedback from staff and subsequent discussions by the Board, the strategy is in the process of being updated. The updated strategy will retain the previously agreed vision, values, building blocks and priority actions but will reflect the organisational reset, following Mark Powell's commencement in post as Chief Executive Officer in April. The Board noted the 2023/24 Q1 progress in delivering the priority actions as set out in the Trust's 2022 – 2025 organisational strategy and looked forward to dedicating time at Board Development in October to refreshing the strategy before presenting the new simplified version to the Board at the next meeting in November. RESOLVED: The Board of Directors noted the 2023/24 Q1 progress in delivering the priority actions as set out in the Trust's 2022 – 2025 organisational strategy.
DHCFT 2023/087	<u>KINGSWAY LAND DISPOSAL</u> The Board received a proposal for the exchange of Trust Land for connection into the drainage system currently operated by Tilia Homes. Ade Odunlade explained that this piece of land that the Trust owns has no identified benefit to the organisation. The proposal is to 'exchange' the piece of land the Trust presently owns for the access right to the drainage. There will be an additional cost to the Trust of connection to the drainage, but this cost (estimated at £36k) together with the valuation of the land (£170k) is significantly lower than the cost of having to creating an alternative drainage connection and other associated costs (estimated at £1.1m). In response to Lynn Andrews querying whether a covenant was necessary to protect the Trust's position with regard to needing access to the land in the future, Ade informed the Board that this was being looked at by the Trust's solicitors to ensure that access can be had to carry out repairs or maintenance to drainage. RESOLVED: The Board of Directors approved the proposed disposal of Trust Land in exchange for connection into the drainage system currently operated by Tilia Homes as detailed in the report.
DHCFT 2023/088	<u>EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE CORE STANDARDS</u>

	The Board considered the Emergency Preparedness, Resilience and Response (EPRR) portfolio and this year's self-assessment. The annual core standards have been prepared ahead of the submission to NHSE and Derbyshire ICB for the end of August. Following initial discussion with the Executive Leadership Team and direction to achieve substantial compliance, significant progress has been made within the EPRR portfolio to respond to this. The Board was requested to note there continues to be a delay in some elements, in part due to ongoing incidents and the required responses to industrial action. The EPRR and Sustainability team have continued to progress the EPRR portfolio and responded extremely well to the challenges the Trust has been faced with over the past year. The Board noted each of the domains the Trust is measured against and agreed to the proposed position being submitted. Thanks were extended to all colleagues who have been involved in this significant piece of work. RESOLVED: The Board of Directors: 1) Received the Core Standards self-assessment to be submitted to the ICB and NHS England 2) Received significant assurance of ongoing work to improve and further enhance the Trust's compliance with the EPRR core standards.
DHCFT 2023/089	<u>BOARD ASSURANCE FRAMEWORK ISSUE 2 (VERSION 2.2) FOR APPROVAL</u> Trust Secretary, Justine Fitzjohn presented the Board with the second issue of the BAF for 2023/24. The Board noted the positive actions to close key gaps in control and the measures in place ensure improvement is sustained. Mark referred to risks 2A and 2B under Strategic objective 2 – *To be a GREAT Place to Work* and asked that the People and Culture Committee scrutinises the actions and mitigations at the Committee's September meeting to ensure 2A and 2B objectives can be delivered. The key gap in control under risk 2A "*We have not engaged with our Bank staff to develop a strong sense of belonging, engagement and psychological contract with the Trust"* was referred to by Carolyn especially as bank staff had been demonstrating outside the building today because they are unhappy with pay and conditions. The Board thanked bank staff and noted that the BAF has been updated to show that band 5/6 bank pay has been approved for alignment to Agenda for Change. Lynn challenged the way the BAF is updated and thought it would be helpful if the BAF could be mapped with the timing of the Board Committees. Justine pointed out that there will never be a perfect alignment and assured Lynn that there was just one occasion when the BAF is out of step with the scheduling of the Board Committee meetings. ACTION: Triangulation of BAF and scheduling of Board Committee meetings to be assessed RESOLVED: The Board of Directors: 1) Reviewed and approved this second issue of the BAF for 2023/24 2) Received significant assurance 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 3) Agreed to continue to receive updates in line with the forward plan for the Trust Board.
DHCFT 2023/090	<u>FREEDOM TO SPEAK UP GUARDIAN REPORT</u>

	Freedom to Speak Up Guardian, Tam Howard joined the meeting and presented her Freedom To Speak Up (FTSU) half yearly report to ensure the Board is aware of FTSU cases within the Trust. The Board discussed key themes being raised and noted the positive increase in the number of colleagues speaking up and confirmed its commitment to encouraging open, honest communication and support for staff who speak up to raise their concerns. Discussion also centred around concerns in relation to a potential lack of inclusion and discrimination for BME colleagues in a few areas of the Trust including concerns from a student nurse. Tony referred to point 3.8 of the report concerning the ethnicity of workers which shows that in Q1 2023/24, 33.3% of colleagues speaking up identified as Black and Minority Ethnic (BME) but this reduced to 25% in Q2 and Q3. Tam responded that BME staff are speaking up but some view the ethnicity of the FTSUG as a barrier. Some staff have also found that their concerns did not get the outcome that they hoped for. Some colleagues have raised that they have been subjected to incidents of racism within the Trust and we are doing our best to address this as it is not acceptable and we are monitoring and reviewing each case. The Board considered that the number of concerns being raised should be seen as a positive indication that people feel confident to speak up. It is important when staff raise these concerns they feel their concerns are being taken seriously and are dealt with quickly and effectively so that people feel safe to continue to raise their concerns. Ralph relayed that conversations held within the People and Culture Committee about engagement have shown that FTSU processes are effective. The Committee had discussed the importance of making people feel confident to raise concerns and to trust that they will be treated with respect throughout the process. Selina drew a comparison with today's patient story as not everything can be quantified in metrics. It is important to improve listening and responding to colleagues who raise concerns and think more creatively and involve the end users in designing a lived experience voice in improving our process. Mark saw that a number of concerns were being resolved and compassion and kindness is being shown to people but there are some residual issues that are unacceptable. There are on occasion times when people will not feel their concern has been resolved despite best efforts and they will have implications on the individuals involved. The Freedom to Speak Up Reflection and Planning Tool creates a benchmark and assurance that works to promote and respond to how speaking up at work. This will be taken forward in Board Development in October. The points around our strategic position and EDI will also be part of this discussion at Board Development. RESOLVED: The Board of Directors: 1) Supported the current mechanisms and activities in place for raising awareness of the FTSU agenda. 2) Discussed the report and received significant assurance from 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) Pledged commitment to engage with the process and completion of the FTSU Reflection and Planning Tool and the FTSU strategy consultation at Board Development in October 2023.
DHCFT 2023/091	<u>FIT AND PROPER PERSON DECLARATION</u> Selina presented the Chair's declaration that all Trust Board Directors meet the fitness test and do not meet any of the 'unfit' criteria as per the Fit and Person's Test regulations (Health and Social Care Act 2008 Regulation 2014).

	The Board noted the forthcoming publication of the new Fit and Proper Persons Test (FPPT) Framework that the Trust will be required to follow by 31 March 2024. Members of the Board confirmed they were satisfied that due process has been followed in line with the Trust's Fit and Proper Persons Policy to ensure that all relevant post holders meet the fitness test and do not meet any of the 'unfit' criteria. Comprehensive files containing evidence to support the elements of the fitness test are retained and regularly reviewed to ensure contents are updated as required. RESOLVED: The Board of Directors: 1) Received full assurance from the Chair's declaration that that all Directors meet the fitness test and do not meet any of the 'unfit' criteria 2) Noted the publication of the new Fit and Proper Persons Test (FPPT) Framework that the Trust will be required to fully comply with by 31 March 2024.
DHCFT 2023/092	<u>BOARD COMMITTEE ASSURANCE SUMMARIES</u> The Board Assurance summaries from recent meetings of the Board Committees were accepted as a clear representation of the priorities to be taken forward in forthcoming meetings. No points of note were raised by the Chairs of the Audit and Risk or People and Culture Committee. The following points were brought to the attention of the Board: Quality and Safeguarding Committee: Chair, Lynn Andrews drew attention to the high demand for Autism assessments. A full risk assessment of the service the Trust is commissioned for will be received at the Committee's September meeting. A similar report will also be taken to the Finance and Performance Committee in September that will focus on performance and responsiveness. Finance and Performance Committee: Chair, Tony Edwards reported that the Committee is closely monitoring the Making Room for Dignity programme and received assurance on progress being made. 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. It was recognised that much of today's discussions had previously been covered by the Finance and Performance Committee. RESOLVED: The Board of Directors noted the Board Assurance Summaries.
DHCFT 2023/093	<u>ASSURANCE FROM THE QUALITY AND SAFEGUARDING COMMITTEE</u> Mortality Report: The Quality and Safeguarding Committee regularly receives and scrutinises the Mortality Report. The report presented by the Medical Director on 11 July provided significant assurance of the Trust's approach and the learning to be had from the process. Having noted that the Quality and Safeguarding Committee had no concerns with the report's findings, the Board accepted the Mortality Report as assurance of the Trust's approach and agreed for the report to be published on the Trust's website as per national guidance. RESOLVED: The Board of Directors received and noted the high level of scrutiny and assurance received by the Quality and Safeguarding Committee from the Mortality Report.
DHCFT 2023/094	<u>ASSURANCE FROM THE PEOPLE AND CULTURE COMMITTEE</u> 2023/24 Flu Vaccination Campaign: A paper setting out the flu campaign for 2023/24 and the work undertaken to deliver against the CQUIN target of 75 – 80% was considered by the People and Culture Committee on 25 July prior to the report being

	submitted to the Board. The Board was pleased to note plans to order sufficient vaccines and the provision of more accessible flu vaccinations to staff, patients and health and social care staff directly involved in the care of their patients. Significant assurance was obtained from the programme that will provide vital protection to staff and patients for this winter. Thanks were made to Pharmacy, the Health Protection Unit, Communications team and Derbyshire Community Health Services Foundation Trust (DCHS) colleagues Flu planning group who have been involved in the planning of this year's approach. Request to receive Board delegated authority to approve Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) October Submissions: NHS organisations must submit the WRES and WDES datasets to NHS England by 31 August 2023 and this year's submission has been made. The WRES and WDES dataset and corresponding action plan must then be agreed by the Board and published on the Trust's public-facing website by 31 October 2023. Committee Chair, Ralph Knibbs requested that delegated authority be granted to the People and Culture Committee on 19 September 2023 to review and approve the 2022/23 WRES and WDES action plans. The Board will then be presented with the WRES and WDES data submission and action plans at the next meeting on 7 November. Delegated authority was granted to the People and Culture Committee as due to the time tabling set by NHS England too small a window remains from the submission and subsequent analysis of data, consultation and co-creation of actions to approval by the Board. This is a frustration shared by Joined Up Care Derbyshire (JUCD) partners. The Board wished there was a better way to handle the Board sign off of the WRES/WDES data annually rather than delegating and then signing off retrospectively in November but understood this would involve a reschedule of Board meetings throughout the year. RESOLVED: The Board of Directors: 1) Received and noted the good levels of scrutiny and assurance received by the People and Culture Committee on the 2023/24 Flu Vaccination Campaign. 2) Granted delegated authority to the People and Culture Committee on 19 September 2023 to approve the 2022/23 WRES and WDES October submission.
DHCFT 2023/095	<u>IDENTIFICATION OF ANY ISSUES ARISING FROM THE MEETING FOR INCLUSION OR UPDATING IN THE BOARD ASSURANCE FRAMEWORK (BAF)</u> Risks associated with industrial action are to be included in the BAF. The BAF is to also be updated to include risks and mitigations in failure to meet acceptable standards of care planning and also safety monitoring with regard to the Letby case. The Quality and Safeguarding Committee will be monitoring inpatient standards and these will be updated in the next iteration of the BAF.
DHCFT 2023/096	<u>2022/23 BOARD FORWARD PLAN</u> The forward plan outlining the programme for 2023/24 was noted and would be reviewed further by all Board members for the financial year ahead.
DHCFT 2023/097	<u>MEETING EFFECTIVENESS</u> Today's patient story on "the importance of a trauma informed approach to care" had connected to conversations concerning service and flow. Continuing to meet face to face has had a positive effect on discussions. Justine Fitzjohn suggested that consideration be given to connecting matters covered in the Board Assurance

	Committee summaries to other areas of the agenda.

The next meeting to be held in public session will be held in person at 9:30am on 7 November 2023 in Conference Rooms A and B, Centre for Research and Development, Kingsway, Derby.

				BOARD OF DIRECTORS (PUBLIC) ACTION MATRIX - NOVEMBER 2023			
Date	**Minute Ref**	**Item**	**Lead**	**Action**	**Completion Date**	**Current Position**	
5.9.2023	DHCFT 2023/085	Integrated Performance Report	COO	Updates from the staff survey concerning operational detail to be featured future IPR reports	7.11.2023	Staff survey operational data now included in IPR	Green
5.9.2023	DHCFT 2023/089	BAF Update	Trust Secretary	Triangulation of BAF and scheduling of Board Committee meetings to be assessed	7.11.2023	Discussions have taken place outside of the Board meeting an exercise will be held to see if any refinements can be made to the scheduling going forward.	Amber

Key:

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

Trust Chair's report to the Board of Directors

Purpose of Report

This report is intended to provide the Board with the Trust Chair's reflections on my activity with and for the Trust since the previous Board meeting on 6 September 2023. The structure of this report reflects the role that I have as Trust Chair.

Our Trust and Staff

1. On 20 September I chaired the Annual Members Meeting and the theme this year was 'working with you'. There are a number of statutory requirements including the presentation of the annual report and accounts and a report on membership but we also take this opportunity to celebrate achievements and had a some really inspirational presentations on how patients and carers are pivotal in helping us improve and shape our services.

2. I attend the staff conference on 11 October, the theme for this year's conference was 'time to reset'. Mark has given a detailed overview in his report but I was pleased to see the energy in the room and the ambition our colleagues have for our Trust and in the delivery of quality services. Colleagues spoke of the ambition to develop greater personal accountability and strong teams that are both accountable and high performing.

3. In terms of changes to the Executive Director Team, Mark welcomes Dave Mason, as our Interim Director of Nursing and Patient Experience in his report and I would like to thank Kyri Gregorio for stepping into the role for the last six weeks, ensuring we continue to deliver for our patients. He has dealt with some challenging matters and demonstrated his leadership skills and abilities admirably. We sadly say goodbye to Ade Odunlade, Chief Operating Officer (COO) who has taken a role closer to home due to unexpected personal reasons. Ade has made a real impact during his time both within the Trust and in the wider system. He has been a champion of the Women's Network and was recognised nationally for his mentoring and coaching of emerging talent. The COO portfolio will be temporarily covered by two Acting Executive Directors of Operations. David Tucker and Lee Doyle will undertake these roles with specific portfolios, providing additional capacity to the Executive Team while a substantive recruitment process takes place. Welcome David and Lee.

   We also say goodbye to Jaki Lowe, Director of People and Inclusion, who leaves us at the end of this month. Jaki has built an able team, provided strong leadership during Covid and led on a range of people policies with the Board which resulted in our positive staff survey results. Rebecca Oakley, Deputy Director will be stepping up as Interim Director of People and Inclusion until a substantive appointment is made. I would like to thank Ade and Jaki on behalf of the Trust and wish them both the very best for the future.

4. On 26 October I met with the Chairs of our various staff networks following recent communication from the SoS for Health and Social Care which has created some concern across the NHS. I was able to reiterate the importance the Board places on equality, diversity and inclusion and living the values of the Trust in being recognised with a much coveted gold standard award.

Council of Governors

5. I met with Susan Ryan our Lead Governor on 26 October, the purpose of the meetings between the Trust Chair and the Lead Governor is to ensure that we are open and transparent around the challenges and issues that the Trust is dealing with. They are also an important way of building a relationship and understanding of the workings of the Board and the Council of Governors.

6. On 11 October the Governance Committee met, chaired by Marie Hickman, Staff Governor and Co-Chair. Geoff Lewins, Non-Executive Director, attended on my behalf. I was pleased to hear of the desire amongst governors to meet more face to face. In response I have organised two coffee mornings with Governors one in Chesterfield on 3 November and one in Derby on 6 November as an opportunity to hear from Governors outside formal meetings.

7. The next Council of Governors meeting will then be on 5 March 2024. The next Governance Committee takes place on 7 December. We will be meeting the Governors in January during one of our more informal Board/ Council of Governor sessions, which we have twice a year.

Board of Directors

8. I met the Board Committee Chairs met on 13 September and this was followed by Board Development where we received the Well Led Review (WLR) report, the summary WLR report is attached as a separate item on this meeting's agenda.

9. On 19 September I joined the People and Culture Committee, chaired by Ralph Knibbs, Non-Executive Director. Attending Board Committee meetings from time to time assists me in gaining further insight into some of the areas the Committees are seeking assurance on in terms of performance and outcomes and areas that are in development.

10. On 18 October Tony Edwards, Deputy Chair chaired the Confidential Board on my behalf. There was a further Extraordinary Confidential Board meeting on 27 October. The purpose of these two meeting was primarily to discuss commercially confidential updates around the Making Room for Dignity programme.

11. There have been a number of meetings of the Remuneration and Appointments Committee to transact some of the changes to the Executive team I mention earlier in my report.

12. I have also continued to meet with all Non-Executive Directors (NEDs) individually on a quarterly basis. This quarter I have met with Ralph Knibbs, Tony Edwards and Lynn Andrews. We use these quarterly meetings to review progress against their objectives, any developmental needs and to discuss any issues of mutual interest.

System Collaboration and Working

13. On 19 October, Tony Edwards attended in my place the system wide event to discuss the Integrated Care System plan for 2024 and the priorities.

14. I met Richard Wright, Interim Chair of the Integrated Care Board (ICB) on 23 October with the other Provider Chairs and Local Authority leads. We

explored some of the challenges we face as a system we also discussed the system wide event that was held the previous week and the next steps.

15. On 27 October I met with Julie Houlder, Chair at Derbyshire Community Health Services (DCHS) as part of our regular catch ups and also discuss the planned Board to Board session to be held on 6 November. These meetings provide a useful opportunity to explore any issues that have arisen and also foster collaboration at a place/locality level.

Regulators, NHS Providers and NHS Confederation and others

16. On 6 September I attended the NHS England event for Chairs and CEOs which was specifically in response to the Letby case. Mark has set out the Trust's response to the initial questions raised by NHS England in his report.

17. On 15 September I attended the APNA (Asian Professionals National Alliance) conference. The Trust was shortlisted for a number of awards. I am very proud to say we were successful in winning the Trust of the Year in the recognition of our equality, diversity and inclusion work.

18. I attend fortnightly briefings from NHS England for the Midlands region, which has been essential to understand the challenges and expectations of Provider Trusts.

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

20. As a Trustee of NHS Providers, I attend the NHS Providers Board meeting held on 1 November. The challenges faced by providers was discussed as well as the forthcoming NHS Providers annual conference.

21. On 27 October I was invited to take part in a podcast on leadership, resilience and trauma.

And finally……..

I would like to set out the Board's and my own appreciation and thanks to Sue Turner, our Board Secretary who retires on the 10 November. Sue has been with the Trust since 2014 and works tirelessly to support the Board and its Committees, she will be sorely missed by all.

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

Assurances

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

Consultation

This report has not been to other groups or committees.

Governance or Legal Issues

None

Public Sector Equality Duty and Equality Impact Risk Analysis

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

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

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

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

Demonstrating inclusive leadership at Board level

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

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

Recommendations

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

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

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

Chief Executive's Report

Purpose of Report

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

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

National Context

CQC State of Care report 2023

On 20 October the CQC published its State of Care 2022/23 report. This is the CQC's annual assessment of health and social care in England. The report acknowledges that NHS staff faced an unprecedented combination of pressures and rising demand last year, including tens of thousands more mental health appointments. The Trust continues to work with its system partners to focus on our recovery plans including reducing waiting times and out of area placements.

Right Care, Right Person (RCRP)

Right Care Right Person (RCRP) is a recent national agreement acknowledging Police are increasingly involved in responding to the public with a range of health or social circumstance needs including those having some form of mental health distress when they are not necessarily the most appropriate agency to respond.

Police involvement in these circumstances can result in those people with a mental health need and/or in a crisis experiencing greater distress and having poorer experiences of the mental health care pathway. While there will always be cases where the Police need to be involved in responding to someone in a mental health crisis, the Right Care Right Person approach will ensure the Police are only involved in mental health situations where necessary.

This means that from the provisional implementation date of April 2024, Police involvement will only occur where there is a real and immediate risk to life or serious harm, or where a crime or potential crime is involved.

In order to support this transition, a partnership reference group across Derbyshire has been established led by the Integrated Care Board (ICB), with a number of workstreams, to inform the development of a set of Standard Operating Procedures. The workstreams are progressing with specific risk and delivery assessments to fully understand current gaps, risks and possible mitigations. A costing and value for money exercise will be undertaken once the full implications of RCRP are understood across system partners. The overall implementation is likely to require further investment to support changes that a number of partners

will need to make, including Derbyshire Healthcare.

Reinforced Aerated Autoclaved Concrete (RAAC)

There has been a full inspection programme at over 70 properties the Trust either owns, leases or runs service out of to find out if RAAC is present. I am pleased to report that no RAAC is present at the properties where inspections have already taken place and / or the landlord's organisation has confirmed it is not present. We are awaiting the results for three leasehold properties which are undertaking specialist inspections.

Within the Trust

Flood response

I would like to recognise the tremendous efforts made by colleagues when Derby and Derbyshire experienced significant flood disruption in October. An Incident Management Team approach was quickly put in place to mitigate any potential risks to Trust services, and to ensure colleagues could safely travel to and from work. There were many colleagues who worked quickly to find solutions, providing transportation for team members and much-needed medication to service users across the county. Many colleagues volunteered for or extended their shifts at short notice to ensure patients were kept safe, with some needing to stay away from home overnight. This was another great example of Team Derbyshire Healthcare putting people first when it really mattered.

Industrial Action

Thank you to colleagues who supported our services during the industrial action which involved many of the Trust's junior doctors and consultant colleagues during September and October. This most recent action saw both groups of doctors away from work at the same time, which is a reminder of the exception nature of this industrial action. Whilst a number of patient appointments were rescheduled, colleagues worked together to ensure patient safety. We will ensure all appointments are rescheduled and take place as soon as possible.

Annual Members' Meeting (AMM)

The Trust's AMM took place on 20 September, on the theme of 'working with you'. We received a powerful presentation on the value of lived experience, welcoming speakers from our EQUAL Forum, Medical Education Unit and Carers' Forums who shared their experiences and expertise, including the value they bring to our team through teaching and training.

The theme of involvement continued in the update on our Making Room for Dignity programme where patients and carers have a key role in supporting the design of our new therapeutic areas. Key features that will be included in our new facilities were showcased at the AMM, including innovative sensory rooms.

Members of the Trust's Council of Governors shared further details about their important role and activities that have taken place over the last year to ensure our membership is reflective of the communities we serve. We also received an impressive update on the work of our occupational therapy teams and the different projects that are underway, making a huge difference to people's lives. There were some fantastic examples of gardening, cooking and crafting projects and the

value these bring to people's recovery.

Staff Conference

The Trust's annual Staff Conference took place in October and it was great to come together with colleagues from a wide variety of teams and locations to talk about our theme 'time to reset'.

It was a really positive day, where we welcomed our guest speaker, former England Rugby World Cup Winner, Maggie Alphonsi. Maggie spoke powerfully about how we could all create a winning mindset, overcome adversity and reset to achieve our goals, even when obstacles are put in our way.

Using Maggie's tips, we then worked together to determine what success looked like for us, what we needed to change and how we could create our own winning mindset. There was some positive and consistent feedback about how we needed to focus on 'getting the basics right', how we could encourage and empower each other, understanding what drives each other so we can work together as a team to achieve our goals.

We spoke about embracing learning and innovation, quality improvement approaches and the importance of celebrating our success. Colleagues also raised key themes including the need to allow ourselves time, a need to keep things simple, and the importance of having personal, professional and clinical accountability.

We also spoke about the updated Trust Strategy, which has been simplified in response to colleagues' previous feedback. Engagement will start next year to develop a new three-year Trust Strategy, building on many of the themes we discussed at the Staff Conference. Colleagues also expressed an appetite to review the Trust values alongside the Strategy.

Trust Board appointment

I am pleased to confirm the appointment of David (Dave) Mason as the Trust's Interim Director of Nursing and Patient Experience. Dave comes from Nottinghamshire Healthcare NHS Foundation Trust, where he has been the Associate Director of Nursing, Quality and Patient Experience for the last seven years. Dave will join the Trust on Monday 30 October and work closely with and lead our nursing, quality and patient experience teams. Selina covers more about other changes to Board membership in her Chair's report.

Speak up Month – October

October was Speak Up Month and we took the opportunity to talk about speaking up, outlining a commitment to listening to and act on feedback received, working together to break down any potential barriers. This is an important part of the national recommendations that followed the Lucy Letby case. I have included the Trust's response to the national recommendations at the end of my report.

Black History Month

Colleagues from our staff networks came together to celebrate Black History Month, which also took place during October. Our BME and Women's Staff Networks worked together to develop an exciting programme of events

throughout the month, supporting this year's theme of 'saluting our sisters'. Special cultural menus were also offered at the Kingsway Restaurant on Wednesdays during October.

New services

- The East Midlands Perinatal Mental Health Provider Collaborative launched on 1 October. This is a new partnership that is responsible for perinatal (mother and baby) mental health inpatient services in the region; taking over responsibility from NHS England. Derbyshire Healthcare is the lead provider, meaning that we now take an overall lead in co-ordinating the work of the collaborative, with partners working together in joint decision making. Although the collaborative will focus on the quality and effective delivery of inpatient perinatal services, it will also support the whole perinatal care pathway, which is why providers of community perinatal services are also partners. The collaborative will involve service users and their families to ensure actions and plans are driven by the patient voice, and to co-produce our strategies and planning.

- The Chesterfield Living Well service launched on 9 October. The new service has been provided in response to the national Community Mental Health Framework, which forms part of the NHS Long Term Plan and encompasses both a short-term and long-term (current Community Mental Health Teams) offer of care. The service will be accessed by a multi-agency service single point of access (SPOA) which will enable easy access via the GP.

  The multi-agency team consists of Peer Support Workers, Wellbeing Coaches, Social Care Practitioners, Occupational Therapists and Community Psychiatric Nurses, and is aimed at in assisting those who fall through the 'gaps' between primary and secondary care or people who need support with different aspects of their life that can affect their mental health, such as housing advice, loneliness support or physical healthcare needs.

  Living Well Derbyshire launched in the High Peak in August and has already received positive results in the local community. North East Derbyshire and Bolsover, Derbyshire Dales, Erewash, South Derbyshire, and Amber Valley launching in the coming months.

- Two new services have opened in Chesterfield over the last month. A new crisis house, which opened on 18 September, will provide 24/7 residential support for people referred by mental health professionals at the Trust, while the safe haven will offer out-of-hours support on a self-referral basis every day of the week between 4.30pm to 12am for anyone who is struggling with their mental health. The two schemes are part of a wider programme of partnership activity led by NHS Derby and Derbyshire Integrated Care Board (ICB) and Joined Up Care Derbyshire which aims to improve outcomes for people and reduce the need for people to attend hospital Emergency Departments when they are experiencing immediate mental health needs. Both services are led by charity, P3.

Achievements and celebrations

- Congratulations to our Trust Chair, Selina Ullah, who was recognised by the HSJ (Health Service Journal) in October as one of the most influential minority ethnic health leaders. Selina, who became one of the first Muslim female NHS Chairs in the country when she joined Derbyshire Healthcare in 2021, was recognised on the 'bubbling under' list for her work to support the development of a more diverse board and inclusive workforce.

- In September Susie Scales, Clinical Lead School Nurse across Derby City, was awarded the prestigious Queen's Nurse award for her work within children's services. Susie was recognised for demonstrating a high level of commitment to patient care and nursing practice within the community.

- The Trust received positive recognition at the APNA (Asian Professionals National Alliance) conference and awards in September. Derbyshire Healthcare won the 'Trust of the Year' award for promoting equality, diversity and inclusion and Chief Operating Officer Ade Odunlade was named the 'Mentoring and Coaching Champion' of the year. Our Communications Officer, Amber Ghei, received a certificate for her outstanding contribution in the 'Rising Star' category.

- Congratulations to members of our Armed Forces Network who recently attended a ceremony to receive the Defence Employer Recognition Scheme gold award, which recognises the Trust's ongoing commitment to our armed forces community. We received the award for our proactive approach to recruiting and supporting veterans, reservists, cadet force adult volunteers and military family members.

- Leanne Walker, Living Well Project Support Officer, received the Lived Experience Leader Award at the National Service User Awards on 20 September. Leanne was recognised for her work in driving mental health projects forward; using her lived experience to inspire others and make a difference at a service and national level.

- The Trust's ICARE framework received a special commendation from NHS England at the National Health Care Support Worker Conference in October. This is great recognition for the Trust, in addition to the impact the programme has already made over the past eight months. The framework was developed to support the emotional, educational and wellbeing needs of newly employed health care support workers.

- World Mental Health Day took place on 10 October, with the theme this year being 'Mental health is a universal human right'. One in four people will continue to experience a mental health problem of some kind each year in England. However, I am aware that many people continue to face stigma and discrimination, and do not feel included, or part of our communities. This suggests we have more to do to improve knowledge, raise awareness and drive actions that promote and protect everyone's mental health.

  Our CAMHS team held an event at Temple House on the day to raise awareness and reduce stigma of mental health conditions, providing lots of

information to support children, young people and their families

- The Trust recently held two successful open recruitment events in September and October. We look forward to seeing the positive impact of these new recruitment approaches.

- Amy Hudson, Finance Assistant raised over £3,400 in October by undertaking a 1150km charity bike ride that she completed in one week, to raise money for the charity Rethink Mental Illness.

- 5 October was World Teachers' Day. On the day we reflected on teaching being a core part of our work, through the Medical Education Unit, where we also have people with lived experience making an important impact in training our workforce of the future.

- We also shared messages, promoted and celebrated a number of awareness days including National AHPs (Allied Health Professions) Day, National Coming Out Day, World Menopause Day and various activities that were taking place in recognition of World Suicide Prevention Day – amongst many more.

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

Risks and Assurances

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

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

Consultation

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

Governance or Legal Issues

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

Public Sector Equality Duty and Equality Impact Risk Analysis

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

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

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

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

Recommendations

The Board of Directors is requested to:

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

Report presented by: Mark Powell
Chief Executive Officer

Report prepared by: Mark Powell
Chief Executive Officer

Appendix 1

NHS England (NHSE) wrote to providers on 18 August following the outcome of the trial of Lucy Letby. NHSE gave the commitment to doing everything possible to prevent anything like this happening again, and set out the decisive steps they are already taking towards strengthening patient safety monitoring. They referred to the roll-out of medical examiners and implementation of Patient Safety Incident Response Framework (PSIRF) and reminded us of the importance of NHS leaders listening to the concerns of patients, families and staff, and following whistleblowing procedures, alongside good governance.

As a Trust they have asked is to urgently ensure:

1. All staff have easy access to information on how to speak up.
2. Relevant departments, such as Human Resources, and Freedom to Speak Up Guardians are aware of the national Speaking Up Support Scheme and actively refer individuals to the scheme.
3. Approaches or mechanisms are put in place to support those members of staff who may have cultural barriers to speaking up or who are in lower paid roles and may be less confident to do so, and also those who work unsociable hours and may not always be aware of or have access to the policy or processes supporting speaking up. Methods for communicating with staff to build healthy and supporting cultures where everyone feels safe to speak up should also be put in place.
4. Boards seek assurance that staff can speak up with confidence and whistle-blowers are treated well.
5. Boards are regularly reporting, reviewing and acting upon available data.

Below is the Trust's response:

1. All staff have easy access to information on how to speak up.

Information on how to speak up is shared with colleagues on a regular basis. This is supported by wider messages about the Trust's commitment to having an open and honest culture, where speaking up is encouraged and seen positively. These messages have been applied to a wide range of issues, ranging from reporting incidents on Datix to speaking to our Freedom to Speak Up Guardian FTSUG). The Trust's Guardian has also promoted speaking up directly with teams, many of which have a local speaking up champion in place.

There is a dedicated page on the Trust's internet with a 'raise a concern' button on the home page. Staff can raise concerns confidentially and anonymously. The FTSUG attends the Trust's corporate induction and all new starters who attend the FTSU session are recorded as completing the National Guardian's Office (NGOs) Speak Up training module. The material covers how staff can speak up (internally and externally).

Feedback from the 2022 national staff survey gave the Trust an average score in raising concerns, with a slight drop from 2021 in the responses shared by staff. Whilst Freedom to Speak Up activity continues to rise; this suggests there is more we can do to encourage staff to speak up and feel assured that their voice counts.

October is national Speak Up month, which provided an opportunity to further strengthen these messages following the Letby recommendations. This theme of this year's national campaign is 'breaking barriers', which will be used to relaunch an internal campaign focused on speaking up.

This will include:

- Development of a new Trust video, talking about why it is important to speak up, ways that this can be achieved and how we can work together to remove any barriers
- Introduction of a new poster campaign promoting speaking up
- Weekly blogs throughout October on different aspects of speaking up - by our Freedom to Speak Up Guardian, Guardian of Safe Working, lead Executive and Non-Executive Directors
- Further promotion of our Speaking Up Champions
- A focused engagement hour on speaking up, using Slido for feedback and an open conversation about how we can remove any barriers that can stop colleagues from speaking up.
- There is a national 'wear green Wednesday' taking place throughout October Trust staff were encouraged to wear green for the day of the Staff Conference on 11 October, which provided clear visual support for speaking up
- Other national materials were shared in Trust communications, examples were the speaking up email footer, pledge template and word search
- This was supported by regular messages throughout the month in existing communication channels, including messages from the Chief Executive.

2. Relevant departments, such as Human Resources, and Freedom to Speak Up Guardians are aware of the national Speaking Up Support Scheme and actively refer individuals to the scheme.

Our FTSUG actively promotes this scheme and has supported staff members in applications. The FTSUG forwarded information on the scheme when it was first launched to appropriate contacts in People Services.

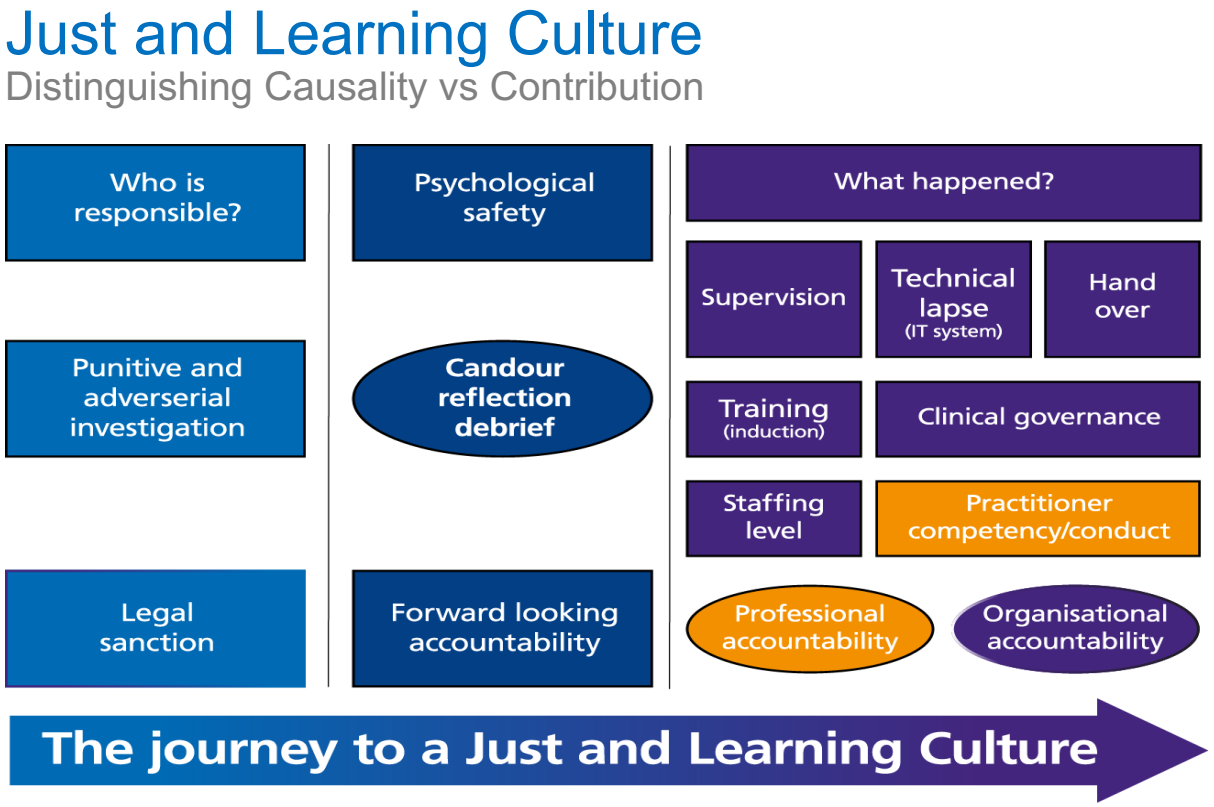
3. Approaches or mechanisms are put in place to support those members of staff who may have cultural barriers to speaking up or who are in lower paid roles and may be less confident to do so, and also those who work unsociable hours and may not always be aware of or have access to the policy or processes supporting speaking up. Methods for communicating with staff to build healthy and supporting cultures where everyone feels safe to speak up should also be put in place.

Our FTSUG attends the staff network meetings to actively promote speaking up and there is diversity within the FTSU champions cohort. The FTSUG works jointly with the Equality, Diversity and Inclusion (EDI)team to support 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. In the most recent Board report (September 2023) a theme was flagged around discrimination in relation to a potential lack of inclusion and discrimination for BME colleagues The FTSU report

also contains statistics on ethnicity of workers and areas raising concerns, allowing targeted promotion by the FTSUG, including visits and appointments out of hours on occasion.

4. Boards seek assurance that staff can speak up with confidence and whistle -blowers are treated well.

We provide a standard session on compassionate leadership for new starters during induction emphasising the need to act, when staff receive/ hear information. Within this session there is a focus on psychological safety. In this session, we also promote just and learning culture.



The FTSUG report categorises concerns in accordance with NGO guidance. The NGO requires all Public Interest Disclosure Act (PIDA) concerns to be recorded and submitted on returns. PIDA is the legal framework and protection around whistle-blowers. A key protection for all raising concerns outside of PIDA is that there should be no detriment to speaking up, this is also a data field for FTSU reporting.

5. Boards are regularly reporting, reviewing and acting upon available data

As an organisation, we review patient safety incident data and mortality data through the Quality and Safeguarding Committee. During this year 2023/24, we have focussed on disaggregating the patient safety data by relevant characteristics to understand any hidden risks.

Within the Mental Health Act Committee, we review data on restrictive practices. We have also focussed on whether patient groups with various vulnerabilities receive less favourable outcomes. We were an early adopter of Patient Safety Incident Framework (PSIRF) and have fully embedded this approach which promotes learning, moving away from blame. This is a departure from Root Cause Analysis

approach and will help foster learning.

We have set up Learning Lessons group to share key findings from patient safety investigations. As these forums are attended by representatives from all services, this is also an opportunity for cross learning.

We have a strong governance around mortality learning.

Learning from Deaths Procedure

An improved process has been implemented within the patient Electronic Record which aids staff in identifying deaths which meet the threshold for reporting. This process fulfils stage one in that all deaths are considered for Red Flags as identified under the national Learning from Deaths procedure. The Mortality team are conducting random weekly audits of deaths against the Red Flags to provide assurance that the new process is working as intended and changes will be made accordingly.

Analysis of Data

The Trust Mortality database is fed directly by the NHS Spine and updated approximately every eight 8 hours. The Data is in relation to any active patient or patient who has died within six months of discharge from services.

Future developments

We are planning to cross reference mortality data with some high risk variables (relevant to mental health services) within the data platform. This will be received by the Quality and Safeguarding Committee and the Trust has agreed some additional analysis that will help with learning.

FTSU

In relation to FTSU the Board and the Audit and Risk Committee (ARC) receives a report every six. The Board report gives key data on speak up cases within the Trust; an analysis of trends within the organisation and actions being taken to improve speaking up culture. This information is challenged at Board. The report also lists the actions taken to enhance visibility and promote FTSU to ensure that the FTSU culture is continuously improved. The ARC focuses on compliance with the FTSU policy. A triangulation report presented to People and Culture Committee contains FTSU data along other key feedback data.

A NED supports the FTSUG and speak up culture in the Trust. The Board also holds development sessions themed around the contents of the FTSU Reflection and Planning Tool which is to be completed by the Board by January 2024. The Trust's Speak Up Strategy will be approved by the Board in November 2023. In September 2023 all Board members committed to complete the NGO's 'Follow Up' module.

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 7 November 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 September 2023. The report focuses on key finance, performance and workforce measures.

Executive Summary

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

Operational Performance

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

Most challenging areas:

- Waiting times for adult autistic spectrum disorder assessment – demand continues to outstrip commissioned capacity; activity levels have increased significantly however we have now achieved the contractual target
- Paediatric outpatients 18-week referral to treatment
- Inappropriate out of area placements
- NHS Talking Therapies waiting times
- Mean Length of stay has increased from 52 days to 54 days (August 2023).

Most improved areas:

- Psychological services waiting times continuing to reduce month on month.
- CAMHS waits are continuing to reduce.
- Bed Occupancy: The proportion of adult acute mental health bed occupancy classed as clinically ready for discharge (%) has improved and stands at 3.78%, better than the peer average of 5.09%. A decrease in this proportion can be seen to release much-needed capacity in mental health provider settings.

Key next steps:

- Measuring our progress: The DHcFT Productivity Group are progressing with the development of a suite of metrics for productivity. A productivity dashboard prototype has now been produced as well as a 'Plan on page' to help drive improving the productivity of our clinical teams – help standardise (where we are able to do so clinically) and using insights give us a regional and trust wide view of our service line productivity.
- Development of the Waiting Times Dashboard by IM&T.
- Divisional Performance reviews to drive rigour and assurance to CQC framework and improve compliance in areas of challenge.
- High intensity users with personality disorder – a programme planned to explore and review this patient group using a collaborative system wide approach with a view to avoid non-appropriate conveyances to Emergency Departments and help direct patients to the right pathway of care.
- Improving flow: Discharge Priority Funding being utilised to support flow and discharge - system integrated flow function with clinical support. An Integrated flow model anchored within CMHT will be live by December 2023.
- 'Plan on a page' – for Reducing Health Inequalities. We are now working with all service lines across the organisation to build a 'plan on a page' on how they will evolve and adapt services to ensure we are actively working to reduce health inequalities using a strategic approach linking in with the VCSE sector, using population insights and census information to focus our efforts and understand disparities in order to effectively reduce them.
- RCRP – The Right Care Right Place implementation group is fully established, having provided key recommendations to the system Executives on implementation of the national programme in September 2023, the group are now working on a workstream basis to formulate a RCRP SOP with a view to roll out the programme across the System in Quarter 1 of 24/25.

Finance

At the end of September, the year to date position is a surplus of £1.1m against a planned surplus of £1.0m, a favourable variance of £0.1m. Agency expenditure is partially being offset by vacancies and interest income being ahead of plan. The forecast position is breakeven against a plan of breakeven. The forecast assumes that we deliver efficiencies in full and find mitigations to offset cost pressures associated with pay award inflation, agency costs, out of area expenditure, industrial action and pressures related to a complex patient who is being supported on one of our wards.

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

Efficiencies

The plan includes an efficiency requirement of £8.8m phased equally across the financial year. As at the end of September £4.1m was achieved against a YTD target of £4.4m. The forecast assumes that all efficiencies are delivered, currently £7.3m of the £8.8m has been identified.

Key next steps

- Develop and sign off plans for the full £8.8m efficiency requirement
- Development of recurrent plans to minimise impact into 2024/25 currently 84% are non-recurrent
- Deep dive planned in November 2023 to monitor and evaluate progress against the CIP plan.

Agency

Agency expenditure YTD totals £5.2m against a plan of £2.6m, an adverse variance to plan of £2.6m. This includes £1.5m of additional costs to support a complex patient on one of our wards. The two highest areas of agency usage continue to relate to Consultants and Nursing staff. The agency expenditure as a proportion of total pay for September is 6.1%. The plan for the year is set at 3.5% which just below the target set by NHSE in the planning guidance of 3.7%. Agency is forecast to be above plan by £3.4m, of which £2.2m relates to the complex patient that is being supported. The Trust's first Medical Bank is currently being established, having recently procured the 'Patchwork' system to help facilitate this.

Out of Area Placements

The plan for out of area expenditure has been reduced by £1.0m in 2023/24 as part of the £8.8m efficiency programme. As at the end of September there was an overspend of £0.7m against the revised plan and a forecast overspend of £1.0m for the end of the financial year. There were 15 out of area patients at the end of September, the forecast assumes a gradual reduction to 4 from M9 onwards.

Capital Expenditure

Capital expenditure at the end of September is slightly above plan, the forecast is to be on plan by the end of the financial year.

Better Payment Practice Code (BPPC)

In September the target of 95% was exceeded by value but was very slightly under at 94.9% on volume.

Cash and Liquidity

Cash at the end of September is at £37.9m and is forecast to be at planned levels of £23.6m by the end of the financial year.

People

Annual appraisals

Appraisal levels continue to be below expectations, however significant positive progress has been made month on month.

Annual turnover

Overall turnover is currently very slightly over 12% but has been significantly lower than normal for the last 10 months and remains in line with national and regional comparators.

Compulsory training

Overall, the 85% target level has been achieved for the last 18 months. Immediate Life Support (ILS) and Positive and Safe training compliance continue to remain in a stable position. Derbyshire Community Health

Services NHS Trust's workforce team have been undertaking a large piece of work to the Electronic Staff Record (ESR) to correct the alignment of resuscitation training to staff roles. This is impacting on the accuracy of reporting of resuscitation compliance but is due to be completed this month.

Staff absence

Sickness has been significantly lower than normal for the last 9 months but remains above the target of 5%.

Key next steps:

- ***Divisional wellbeing summits commenced in September and are providing a focus on both long-term and short-term absences in each division.***

Proportion of posts filled

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

Key next steps:

- ***A number of recruitment events have taken place and there is a large Trust-wide event planned for the end of October at Chesterfield Football Club***

Bank and agency staff

Bank staff use has remained above the 5% target for most of the last 24 months. This is mainly owing to a combination of vacancies and increased levels of occupancy and acuity on the adult acute wards. Agency use has been above target for the last 3 months.

Key next steps:

- ***Authorisation Panel – to establish process to authorise agency requests across DHcFT utilising a panel – weekly panel from 1 November***
- ***Business case to propose recruitment of additional Healthcare Assistant workforce to cover the clinical activity rather than reliance on temporary staffing***
- ***Across the system an agency reduction programme has been established***

Supervision

The overall level of compliance with the clinical and management supervision targets has remained low since the start of the pandemic, however improvements continue to be made. Currently 131 teams are 100% compliant with management supervision, 83 teams are 100% compliant with clinical supervision and 65 teams are now 100% compliant with both.

Key next steps:

- ***Improvement plan in place in Operational Services***
- ***An audit of supervision processes is currently in progress, which is being undertaken by 360 Assurance. The overall objective of the audit is to assess the actions the Trust is taking to improve supervision performance and accurate recording of supervision time for both clinical and non-clinical staff.***

Quality

Compliments
The number of compliments received remains within common cause variation.

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

Delayed transfers of care (DTOC)
7% of service users met the criteria as clinically ready for discharge in July. The most common reason for delay is the identification of appropriate housing or social care placements.

Key next steps:

- ***Twice weekly clinically ready for discharge meetings where any barriers to discharge are identified and discussed to support resolution.***
- ***The Older People's division are supporting the scoping of a Dementia Care Unit for Derbyshire which is due to open in 2024.***

Care plan reviews
The current percentage of patients who have had their care plan reviewed and have been on Care Plan Approach (CPA) for over 12 months is 51%.

Key next steps:

- ***A process for monitoring compliance and quality will be implemented in each division and monitored via the monthly Fundamentals of Care meeting***
- ***The Community Mental Health Teams have been set a target to achieve 60% compliance for patients who have had their care plan reviewed and have been on CPA for over 12 months by December 2023 and 85% compliance by April 2024.***

Patients in employment and in settled accommodation
Around one third of patients have no employment status or accommodation status recorded at present.

Key next steps:

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

Medication incidents
Between July and September 2023 there has been a 20% decrease in the number of medication incidents reported. Medication incidents are largely of low-level harm and therefore reflect accurate reporting and learning opportunities and reporting is actively encouraged.

Key next steps:

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

Incidents of moderate to catastrophic actual harm
This data demonstrates the number of DATIX incidents occurring recorded as moderate to catastrophic harm. There has been an increase of 20 incidents between July and September which has taken the number of incidents reported outside of common cause variation. Ongoing Monitoring by the Patient Safety Team and the Heads of Nursing/Practice.

Duty of Candour
Duty of Candour reported incidents remain within expected thresholds. The Trust Family Liaison Office has created information leaflets and standing operating procedures to support staff in completing duty of candour. Training around accurately reporting duty of candour continues within clinical teams.

Prone restraint
Prone restraint has increased from 9 to 12 incidents between July and September 2023. Over the next six months there are plans for Simulation Training including seclusion, self-harm and ligature simulation. A programme manager and clinical lead have been recruited and the project is currently in the scoping phase with plans for training the trainer sessions to start in October 2023.

Physical restraint
Physical restraints have reduced to around 80 incidents between July and September 2023 bringing incidents involving physical restraint back in line with common cause variation.

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

Seclusion
Seclusions between July and September 2023 have continued in line within common cause variation and under the mean average of 20 episodes of seclusion.

Falls on inpatient wards
A spike of falls was seen between July and September due to numerous falls reported for the same individual. This has now resolved and the number of falls reported is at its lowest since February 2023.

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

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

Risks and Assurances

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

Consultation

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

Governance or Legal Issues

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

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

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

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

Recommendations

The Board of Directors is requested to:

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

Report presented by:	Ade Odunlade Chief Operating Officer
Report prepared by:	Peter Henson Head of Performance
	Sabia Hussain Deputy Managing Director
	Joanne Wilson Interim Deputy Director of Finance
	Rebecca Oakley Deputy Director, People & Inclusion
	Joseph Thompson Assistant Director of Clinical Professional Practice

Integrated Performance Report Performance Key Insights

Bed pressure

- There is a persistently high level of bed occupancy on the adult acute wards – currently 101% - which is impacting on capacity for further admissions and resulting in an increasing number of out of area acute placements. This calendar year to date 67% of admissions have been under the Mental Health Act, which is significantly higher than previous years. We are also seeing a significant increase in the number of adult acute inpatients with a length of stay of 60 plus days. These factors would suggest an increasing level of acuity in the patient group being cared for. A bid for a portion of the Integrated Care Board's adult social care discharge funding was successful and from October 2023 is being used to support discharge and free up beds through improving timely discharge.
- Over the past few years, patients open to Derby City B and Derby City C Community Mental Health Teams have accounted for almost a third of all adult acute admissions. The postcode area from which the highest numbers of patients were admitted was Derby DE23. The newly established Derby Crisis House is based in DE23 so potentially could have a positive impact on reducing admissions from that area.
- In England, according to the latest data published by NHS England, over 12 months there were almost 231,000 inappropriate out of area placement bed days, of which 95% were with private providers, at an average cost of £648 per day. That equates to £142 million of money from the NHS budget. In the Trust, 79% of inappropriate placements were at Psychiatric Intensive Care Units, so once the Trust has its own PICU there should be a significant reduction. The trust's inappropriate adult acute placements were below average when compared to our peers. (Out of Area Placements in Mental Health Services, July 2023 - NHS Digital)

NHS Talking Therapies

- Demand for the service continues to be high and the number of referrals received this financial year has increased by 12% compared with the previous year. In addition, there has been a loss of capacity for provision of Cognitive Behavioural Therapy (CBT) and Step 2 treatment within our sub-contractor, which the Trust's budgets are not able to mitigate. This increased demand and reduction in treatment capacity is inevitably impacting on waiting times. Longer waiting lists also require more administration and clinical support for call backs and waiting well support which further takes away capacity. The Trust has a higher average number of contacts per treatmentthan our counterparts in Derbyshire. There is a push to increase discharge numbers, which has a downward pressure on contacts per treatment. This creates a tension between correct doses for presenting problems versus discharge numbers.

Adult Autistic Spectrum Disorder Assessment

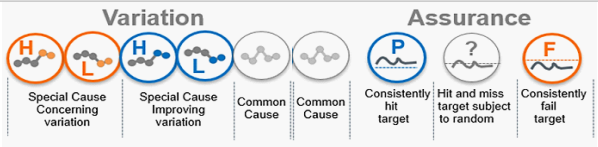
- The service continues to experience long waits to be seen for assessment. This is a national problem: the number of people waiting in England has increased to 143,000. (Autism Statistics, July 2022 to June 2023 - NHS Digital). In the Trust, the level of funded capacity has fallen far short of the demand for the service for many years, as a result of financial pressures on the system. This has inevitably resulted in increased waits. Actions have been taken to maximise capacity within the existing financial envelope, which are predicted to result in the annual target for assessments being exceeded for the first time this financial year.

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			30		20	32	26
1b	Waiting list - care coordination - number waiting at month end			104		53	98	75
2a	Waiting list - ASD assessment - average wait to be seen			79		70	75	72
2b	Waiting list - ASD assessment - number waiting at month end			1,850		1776	2027	1901
2c	ASD assessments			65	26	4	40	22
3a	Waiting list - psychology - average wait to be seen			23		1	73	37
3b	Waiting list - psychology - number waiting at month end			578		751	954	853
4a	Waiting list - CAMHS - average wait to be seen			16		16	25	20
4b	Waiting list - CAMHS - number waiting at month end			219		367	542	454
5a	Waiting list - community paediatrics - average wait to be seen			38		21	27	24
5b	Waiting list - community paediatrics - number waiting at month end			2,257		1653	2066	1860
6	Outpatient appointments cancelled by the Trust			8%	5%	4%	11%	7%
7	Outpatient appointment "did not attends"			13%	15%	10%	14%	12%
B1	3 day follow-up			86%	80%	78%	96%	87%
D1	Community Mental Health Access (2 plus contacts)			11,420	11,899	9101	9875	9488
E1	Children & Young People Mental Health Access (1 plus contact)			3,235		2893	3091	2992
E4	Community Mental Health Access (2 plus contacts)			100%	95%	55%	103%	79%
E5	Children & Young People Mental Health Access (1 plus contact)			100%	95%	24%	109%	66%
G3	Early intervention 14 day referral to treatment - complete			79%	60%	64%	108%	86%
G3	Early intervention 14 day referral to treatment - incomplete			92%	60%	59%	117%	88%
H0	IAPT 6 week referral to treatment			48%	75%	63%	77%	70%
H1	IAPT 18 week referral to treatment			98%	95%	99%	100%	100%
H2	IAPT 1st to 2nd Treatment over 90 Days			30%	10%	2%	21%	12%
H7	IAPT patients completing treatment who move to recovery			54%	50%	43%	61%	52%
I1	Individual Placement and Support Access			260	343	106	384	245
K2	Total inappropriate out of area bed days			2,235		1,216	1,941	1,578
K2	Average patients out of area per day - adult acute			14	0	0	10	4
K2	Patients placed out of area - adult acute			20	0	0	18	8
K2	Average patients out of area per day - PICU			21	0	7	20	13
K2	Patients placed out of area - PICU			31	0	13	31	22
L1	Perinatal Rolling 12 Months Access			8%	10%	4%	5%	4%
L2	Perinatal Access Year to Date			520	1,070	162	514	338
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

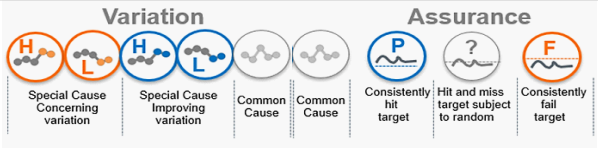
B. People

	Metric Name	Variation	Assurance	Latest Value	Target	Lower process limit	Upper process limit	Mean
1	Annual appraisals			82%	90%	75%	80%	77%
2	Annual turnover			13%	8-12%	12%	14%	13%
3	Compulsory training			89%	85%	86%	88%	87%
4	Staff absence			6%	5%	5%	8%	7%
5	Clinical supervision			77%	95%	72%	77%	75%
6	Management supervision			74%	95%	70%	76%	73%
7	Filled posts			93%	100%	89%	95%	92%
8	Bank staff use			7%	5%	5%	7%	6%

C. Quality

	Metric Name	Performance	Assurance	Latest Value	Target	Lower process limit	Upper process limit	Mean
1	Compliments received			103	119	72	150	111
2	Formal complaints received			13	13	4	32	18
3	Delayed transfers of care			7%	3.5%	3.0%	9.4%	6.2%
4	CPA reviews			57%	95%	67%	80%	73%
5	Patients in employment			12%		10%	14%	12%
6	Patients in settled accommodation			30%		37%	49%	43%
7	Number of medication incidents			87		45	107	76
8	No. of incidents of moderate to catastrophic actual harm			92	48	20	85	53
9	No. of incidents requiring Duty of Candour			0	1	0	6	2
10	No. of incidents involving prone restraint			12	12	0	23	11
11	No. of incidents involving physical restraint			78	46	31	107	69
12	No. of new episodes of patients held in seclusion			19	14	4	36	20
13	No. of falls on inpatient wards			25	30	19	53	36

Key to symbols[1]:



Blue dots indicate special cause variation, better than expected.

Orange dots indicate special cause variation, worse than expected.

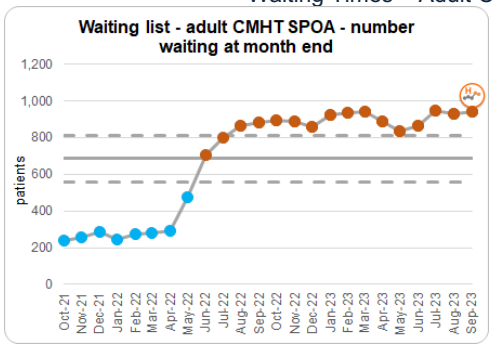
[1]The rating symbols were designed by NHS Improvement

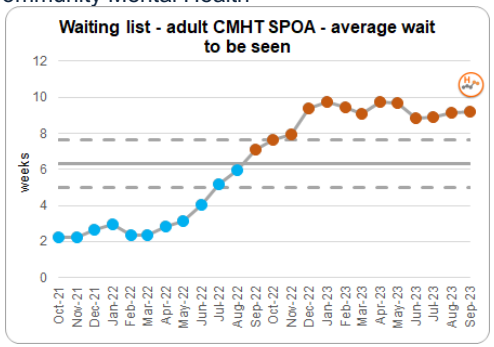
Derbyshire Healthcare
NHS Foundation Trust

Operations

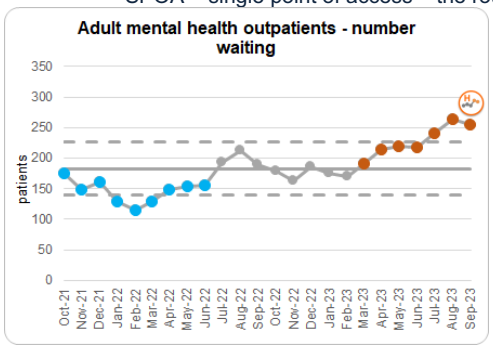
Operational Performance

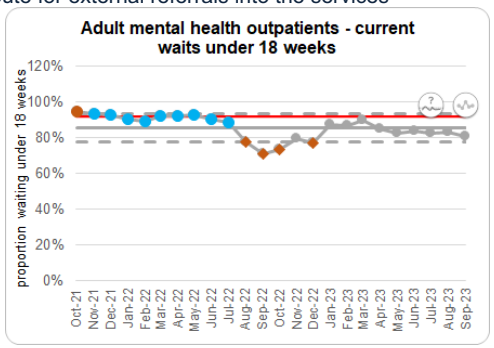
Waiting Times – Adult Community Mental Health





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





Summary

The number waiting is increasing over time. The average wait is fairly stable at around 9 weeks.
The outpatient waiting lists have been increasing significantly for the last 7 months and the proportion of people waiting over 18 weeks is increasing.

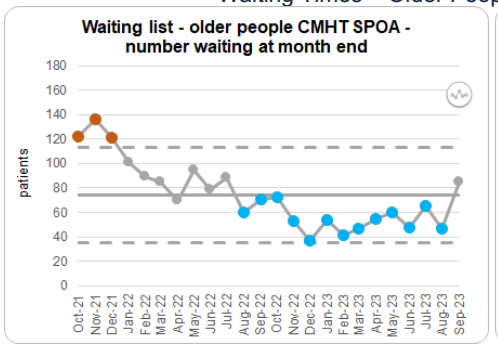
The working age adult community teams continue to receive more referrals in comparison with the older adult teams. Working age adult teams also hold a significant number of patients over the age of 65, accounting for 4% of the total caseload. This has previously been explored and it was found to be difficult to move over a lot of patients to older people's teams owing to concerns raised by older adult medics and also the need for continuity of care in some cases.

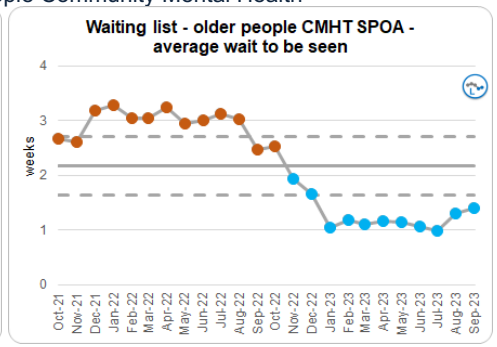
In the most recently published national benchmarking data, the Trust's median length of stay in community mental health services from referral to discharge was 108 days, which is higher than the national median of 70 days, but has reduced by 14% since last reported. The Trust's average community mental health caseload size as a proportion of total trust caseload was 43.1%. In comparison, the national median was 30.7%. Caseloads are high, and with high caseloads it is difficult for teams to have capacity to pick up new cases. (https://model.nhs.uk/).

Actions

- Implementation of MaST to support with caseload reviews, flow and waiting lists. Managers and Clinical Leads will be using this to inform conversations in supervision with their teams instead of the Data Science Platform
- Away day with service managers and clinical leads for adults of working age and older adult CMHTs focusing on data, productivity and performance – the key message is around the leads and their teams owning their data, ensuring it is accurate and taking actions to address
- Information Management & Technology Team have supported to develop a weekly email to managers and individual clinicians to highlight where data is missing in SystmOne, which impacts data quality and activity count
- An activity expectation has been agreed and shared with the adult and older adult CMHT leads along with a guide on what counts as 'meaningful' activity
- The Transformation Team are leading a piece of work to define expectations around length of time it should take to complete welcome calls and initial conversations to help in understanding capacity versus demand

Waiting Times – Older People Community Mental Health





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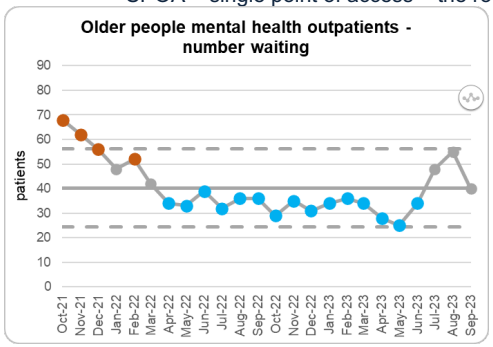
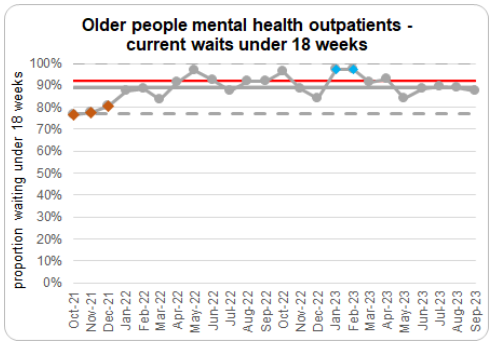




Summary

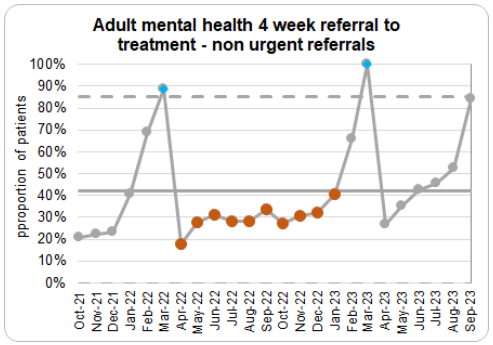
The number waiting is reducing in older adult SPOAs. The average wait is very low at around 1 week.
A small number of people are waiting for each outpatient service but waits are too long in Amber Valley.

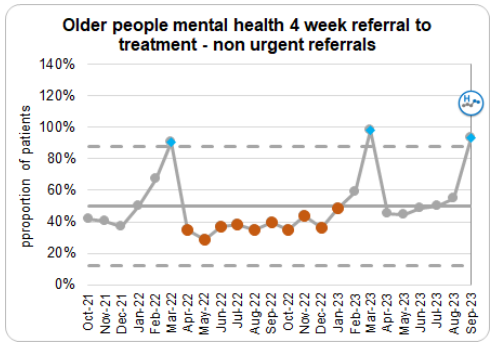
Actions

- An improvement plan is in place to address the number of unreconciled appointments. There is also now a non-medical prescriber in post within the team to increase the outpatient clinic capacity.

Operational Performance

Waiting Times – 4 Week Waits for Non-urgent Community Mental Health Referrals



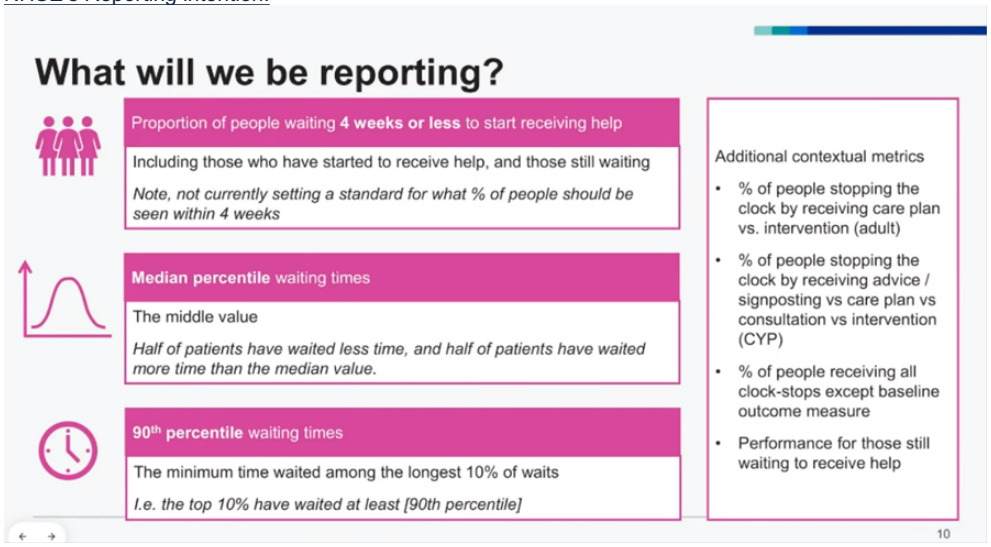


Summary

The data above is indicative only. The charts show waiting times in non-urgent CMHT teams based on referral to second contact. The measures do not include patients who are currently waiting for their second contact. Currently showing phase 1 compliance and does not take into account SNOMED or specific interventions. All data is for episodes referred within the selected year.

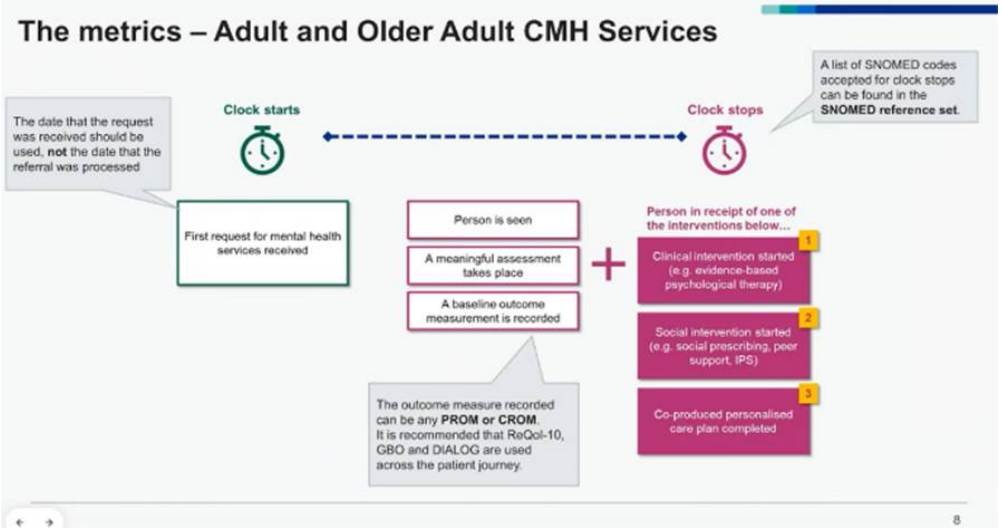
At a recent webinar, providers were advised that NHSE intend to start publishing waits data publicly from the end of the financial year, using the mental health services data set data that is submitted by all mental health providers to NHSE monthly. The published waits will be system level, not provider level. There will be no waiting times standards set, but they will likely be introduced further down the line.

NHSE's Reporting intention:

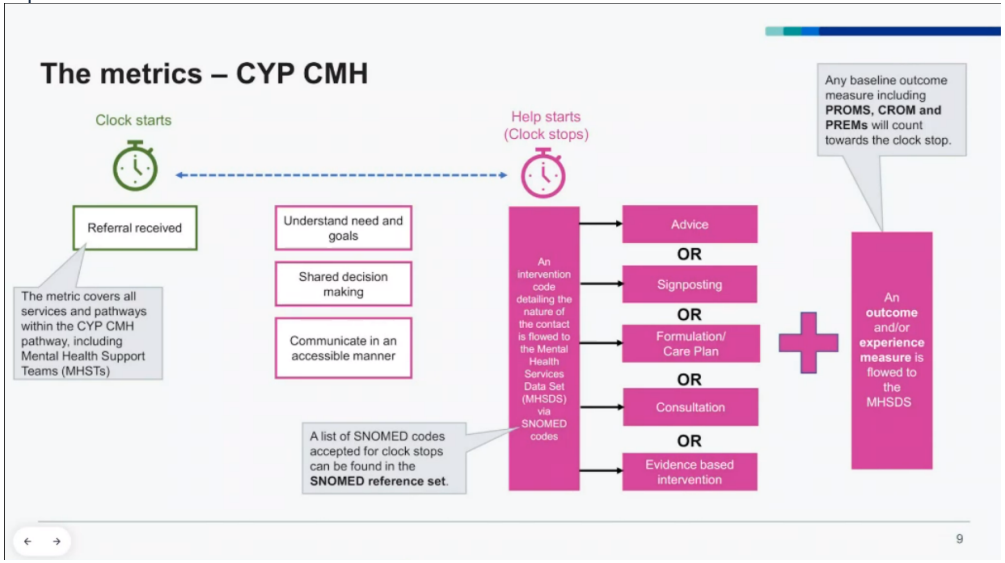


The official NHSE technical guidance is yet to be published. The concept of a pathway will bring in more complexity, which will need to be understood, for example who would take responsibility for a patient referral if it is split across several teams. When NHSE start to produce national data, the IM&T team will be able to review it and see how something similar might be derived locally to use for monitoring and reporting purposes internally.

For adult and older adult community mental health teams (CMHT), to stop the clock, a patient will have to be seen, to have a meaningful assessment plus a clinical intervention, a social intervention, or a completed, co-produced personalised care plan, and to have 3 completed baseline outcome measures. Providing advice or guidance no longer stops the clock in adult & older adult services:



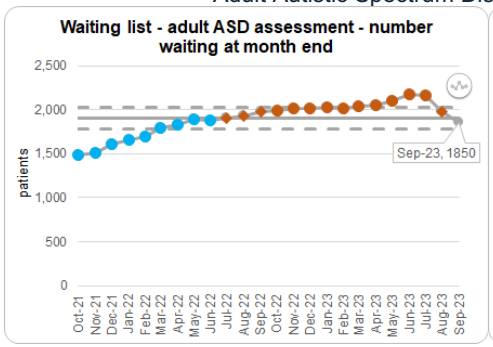
For children & young people, the clock stops following provision of advice, or signposting, or formulation/care plan, or consultation, or evidence based intervention, PLUS a completed outcome or experience measure:

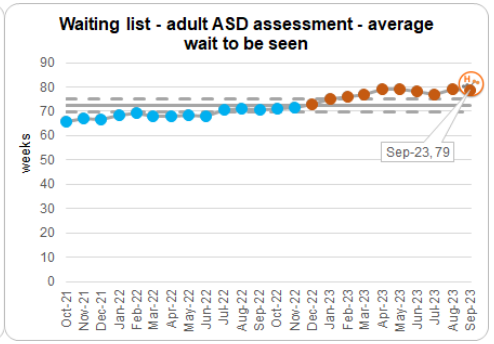


(slides © NHS England 2023)

Operational Performance

Adult Autistic Spectrum Disorder Assessment Service





Referrals

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

Assessments

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2016				19	7	22	5	4	19	20	15	13
2017	35	37	47	22	22	18	30	16	24	34	30	12
2018	20	15	23	18	19	20	22	11	13	14	20	20
2019	33	24	25	24	19	18	15	11	26	30	34	15
2020	28	27	22	1	5	11	20	16	18	29	18	15
2021	20	17	22	22	17	12	14	14	24	24	15	6
2022	12	12	21	13	10	14	8	6	20	22	20	15
2023	22	28	24	22	18	31	30	35	65			

Summary

Demand for the service continues to outstrip capacity (commissioned to undertake 26 assessments per month but receiving around 80 referrals per month this financial year). At the end of September 2023 there were 1850 adults waiting for assessment, which is a reduction of 375 since the last report. A revised approach to waiting list management is being mobilised and should start to have an impact from quarter 4 2023/24. Referrals peaked in April 2022 at 141. The number of completed assessments per month has increased and the year-to-date contractual target is now being exceeded by 28%.

Actions

- Clinical efficacies: Review of clinical processes to increase the number of ASD assessments completed has resulted in a marked increase in assessments completed in September.
- Support of individuals on the diagnostic pathway is now in place and taking referrals with a focus to increase the numbers of uptake which has been lower than anticipated (some of this due to slow or no responses from those contacted) - whilst this won't reduce wait time for diagnosis, it will improve the experience and will alert people to options available to them.
- Increased support to individuals pre and post diagnosis will improve their experience, understanding, and support any management of anxiety reducing the risk of sudden need to access services, earlier awareness can be raised through signposting from the support services to the specialist teams.
- Healios contract for 18-25 year olds continues.

Transforming Care Programme

Area	Measure	Month	Target	Actual
Inpatient services	Number of adults in ICB commissioned beds	Aug-23	25	26
	Number of adults in Secure inpatient care	Aug-23	18	19
	Number of CYP In Specialised/secure inpatient care	Aug-23	3	1
Reduction in health inequalities	Number of annual health checks	Aug-23	298	346
LeDeR Program	Achievement of LeDeR timescales	Jul-23	-	99%
	Achievement of LeDeR standards	Jul-23	-	78%

Summary

New, challenging trajectories have been agreed from July 2023 onwards. Significant performance improvements & transformation are required for JUCD to meet its end of year trajectory for the number of ASC&/LD people who are in receipt of inpatient care. Overreliance on inpatient care and a lack of credible community-based alternatives are the primary areas of concern. Currently, inpatient numbers remain above agreed national targets and out of line with projected performance levels. Improvements in position fluctuate and need to be sustainably managed. Adults in ICB commissioned beds: The end of August position was +1 over trajectory. This was due to an admission to Ashgreen ATU for a person who was at serious risk to self and had been violent to others. Admitted to Hillside August for a period of assessment and treatment. Adults in secure inpatient care: The end of August position was +1 over trajectory. This was due to an admission to an eating disorder bed in August for assessment and treatment.

Actions

Reducing Inflow: non-Clinical in-reach now fully mobilised. Revised action plans on LAEP, DSR and CTRs processes. RCA evidencing that when clinically challenged around function of behaviours versus treatable mental illness alternatives to hospital are being explored and admissions avoided. ND elements being fed into new design framework for flow for adult acute mental health – including practical packages element to eliminate MFFDs. Pilot of ASD case management for 6 months support for high intensity and High ED/acute frequency patients.

Improving Flow: implementing new cohorting approach for RAG-rating of discharge planning, attached to LoS expectations, DSR usage and systematic escalation processes. Recruited a lead to coordinate all the AMH, out of area locked rehabs/ATU and spec com beds and plan repatriation back to Derbyshire. Including setting up community services for these individuals including contracting linking in with ICB (started on 4th July 2023). Non-clinical in reach extending scope to include mobilisation of a high intensity/high frequency service user expediting discharge from AMH. Key working tendered to Affinity and strategic manager recruited – targeted resource for 0-25 yrs 'Go live' August 2023 referrals starting to be received.

Expediting complex discharges / Improving outflow: introduction of new cohorting approach with attached escalation and management. This will include ensuring 12 step discharge planning is commenced immediately, that barriers to discharges are identified at earliest stage and where possible processes run in parallel. New bi-weekly LDA/AMH discharge meetings underway, jointly chaired by Managing Directors covering acute mental health and neurodevelopmental with attendance from consultants, matrons, TCP leads and other operational colleagues. Note position below accounts for September 23 and October 23 under revised RAG approach. Future months' work is underway to apply new approach to validate current RAG position.

Annual health checks: Q1 performance 811 against a target of 850. Achievement of 305 AHC's during July & 346 during August. This performance is above trajectory requirement for the quarter so far. Flag added to SystmOne to identify to secondary care clinicians individual's AHC status so they can promote and undertake (if appropriate) within secondary care consultation. GP training – Strategic Health Facilitation Team (SHFT) deliver continual training to GPs, inc. bespoke action plans for surgeries below 75% compliance in 2022-23. Targeted work with Specialist schools to promote AHC to 14 yr +.

Psychology & Psychological Therapies

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

Workforce update
ESR is now all but resolved. The last few niggly issues are being dealt with presently. The next stage is to be able to access and use the data locally. Sickness within the division is at 6.4%, slightly higher than the previous month (5.07%).

Morale remains positive, but staff are impacted by all the changes in the system and Trust. The vacancy rate within the Division is at 5.7%, which is an amazing achievement considering where were a year ago. The new structure continues to get positive feedback from members, providing connection, belonging and a space to share ideas. Following debate and discussion, training standards for psychotherapists have been published internally and average caseloads are currently being reviewed and agreed by band.

In relation to hybrid working, the majority of staff in the division continue to work this way, meeting the needs of patients as well as supporting wellbeing and work-life balance for staff and includes telephone consultation, MS Teams and Attend Anywhere. Services continue to grow and stretch themselves, with new asks arriving often.

LD psychology in the North of the county has joined the DP&PT. 4 staff will TUPE over to us in November (the process is currently underway). We have started the recruitment process for staff to work in this part of the county and have successfully recruited 0.2 of FST so far. This will be one of the biggest challenges for the team given the lack of psychologists available to recruit and the diminishing services in that part of the county over the last 12 months.

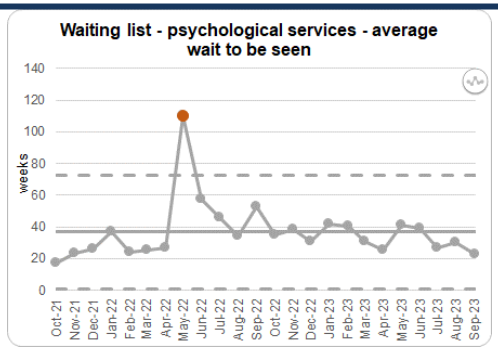
We now have 6 Multi-professional ACs in training and two qualified. These exciting new roles will help offer flexibility for people who use our services, and some stability and leadership to the workforce.

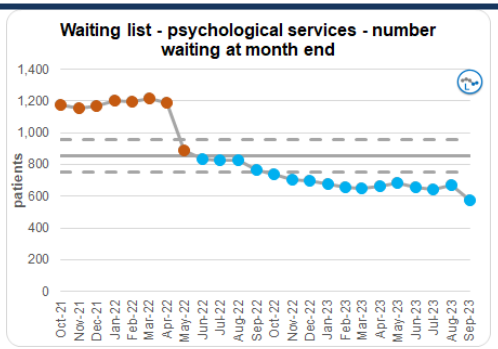
Friends & Family Test
Friends and Family Test, where reported, continues to show excellent feedback. In the last 12 months:

- Cognitive Behavioural Therapy received 40 responses and 100% were positive
- Amber Valley Adult Psychology received 13 responses and 85% were positive
- Adult ASD Assessment Service received 2 responses which were both positive
- Psychodynamic Psychotherapy received 2 responses which were both positive
- NHS Talking Therapies received 1,889 responses and 97% were positive.

Partnership, system and PLACE working
This continues to grow and develop in line with the living well. Staff are working across the landscape and linking in with GP services and VCSE sector.

Waiting lists and referrals
The headlines remain that demand continues to outstrip supply, despite different ways of working and increased productivity. Due to these changes in practice, validation of waiting lists and a focus on productivity all wait times are reducing and the trajectory remains positive. At the end of September 2023, 602 people across Derbyshire were waiting to be seen by psychological services, with an average wait time of 23 weeks. There has been focused QI work around OA, LD and some WAA teams to achieve this.





Trust wide staff wellbeing
The requirement for psychological support in the form of reflective practice, team debriefs and 1:1 intervention continues to grow. We cannot meet the need even with our staff wellbeing service now set up and offering drop-in sessions as well as 1:1 and team support (referred through HR or psychology). This need remains a pressure and this service is now at capacity.

Supervision & appraisal
Clinical supervision is currently being reported as 88.24% for the division. Whilst this remains high, our aim is for 100%. This is raised at the monthly Leads meeting as well as within our Divisional COAT. Appraisal completion is also monitored and is at 83.3% a drop of around 5% from last month. This will hopefully rise again next month once all September's appraisals are recorded.

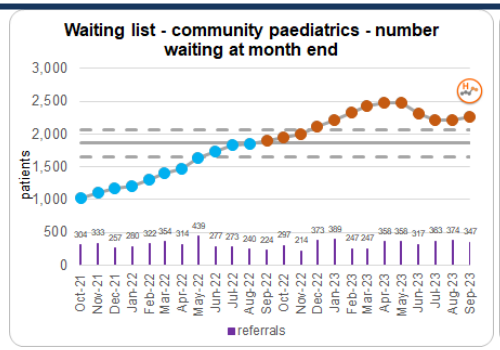
Increasing trauma and psychological awareness
The Bite size psychological teaching sessions continue to have good attendance with a range of topics being delivered. Requests are out for the planning for 24/25. The trauma informed Board has met for the 3rd time and is now beginning to form the strategy and recommendations for the Trust.

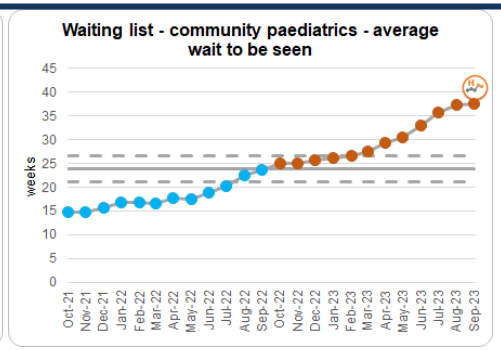
Benchmarking and productivity
We have started this process, although the challenge is different metrics in each area. As a start, we will be trying to pull together comparisons of waiting times and caseloads. Each trust has also used transformation monies in different ways, creating different type of service.

Conference 2023: "Thriving not surviving"
We held our first divisional conference in September to highlight good practice. As well as Professor Paul Gilbert as our keynote, we had 14 presentations from staff in the division and a range of interesting and thought-provoking posters. The day was well attended and feedback was overwhelmingly positive, especially in relation to building connection and relationships and sharing good practice. Everyone requested a yearly conference going forwards based on the energy and increased motivation this has brought.

Ongoing actions
- Expanding services
- Breaking down barriers between services and improving patient pathway
- Promoting importance of psychological safety
- Building and promoting trauma informed working (including strategy development and a model for inpatient acute care)
- Increasing productivity by review of data through individual teams. Setting standards for average caseloads as part of this work.
- Working with Asylum seekers

Operational Performance





Summary

At the end of September 2023 there were 2,257 children waiting. The average wait time was 38 weeks. Of note the current shortage and subsequent loss of ADHD medication will mean that children on specific medications will need to be reviewed as a matter of urgency as withdrawal has physical health implications. These children on current prescriptions will be prioritised and this will again impact and increase waiting times for children. We are trying to decipher the number of children across complex health services who are currently prescribed medication for ADHD as this is a significant number. In addition, this will put extra demands on secretaries, Dr's and nurse prescribers as we try to mitigate the impact of this on the children and families. This is under review currently.

Internal factors:

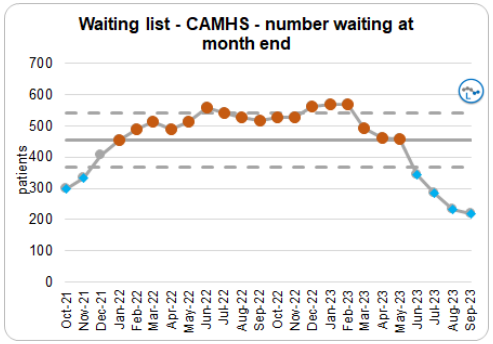
- Challenges to recruitment- 2 Consultant vacancies; retirement age for many of our Paediatricians; national shortage; increased cost per hour for external locums.
- Pathways are unclear and single point of referral does not effectively manage children being referred into the service.
- Difficulty in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

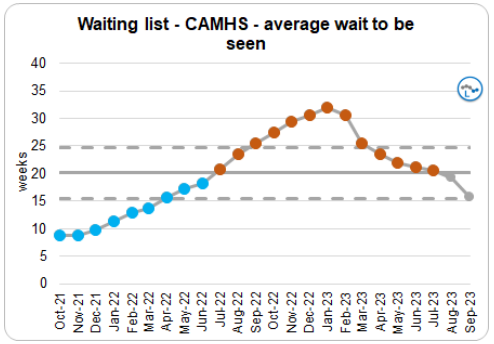
External factors contributing to increased demand on Community Paediatricians:

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

Mitigation:

- Appointed DASM post to lead on transformation work for the ND pathway. As part of this role there will be a review of pathways active signposting and resources for families to access for support, advice and information and updates to website planned. This will also include Ongoing Quality Improvement for the C&YP ND transformation.
- Recruitment update – newly appointed clinical psychologist starting in January 24, Waiting list co-ordinator and triage nurse in post. Review of remaining funds and appropriate recruitment continues.
- Engagement with the community hubs continues. We are working with the appointed triage nurse to work collaboratively to identify how service will work together to improve CYP and family experience.
- Clinic space remains under constant review – Oakwood Children's centre is now open and being used by the Community Paediatricians and ADHD nursing team, also some joint appointments are starting in this space with speech and language teams.
- Review of vacant consultant posts and workforce continues, including consideration for skill mixing some of these posts. Working with recruitment team to update job descriptions to make them more attractive to potential applicants. Currently advertised posts include Specialty Doctor, Consultant Paediatrician ND & generic work and also Named Doctor for safeguarding – consultant.



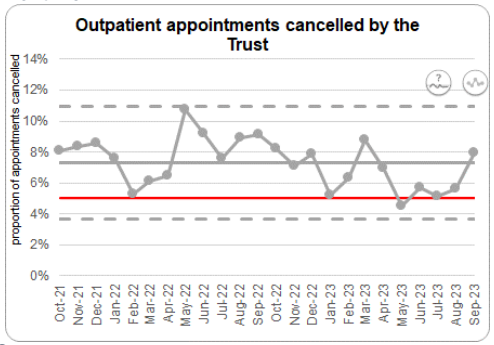


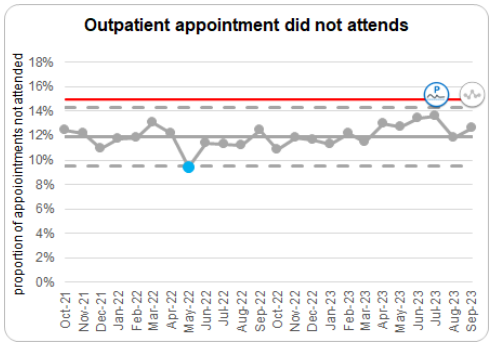
Summary

At the end of September 2023, 219 children were reportedly waiting to be seen, with an average wait time of 16 weeks. The Triage and Assessment Team is continuing to have a positive impact on waits.

Actions

- The triage assessors are now all in post.
- The model is continuing to have a significant positive impact on waiting times.
- A data quality issue has been identified following implementation of the new model, of telephone triage appointments mistakenly being treated as initial assessments, which is affecting reporting, Once addressed, it is expected to result in an increase to the reported waiting list but a further reduction in waiting times. The team has been working with IM&T to resolve and going forward a more accurate picture will be reflected. By November, the service will be booking people in for assessment who have been waiting 36-38 weeks. These longest waits are the shortest they have been for a significant period of time.

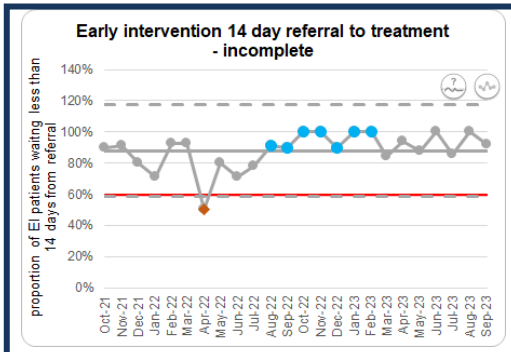


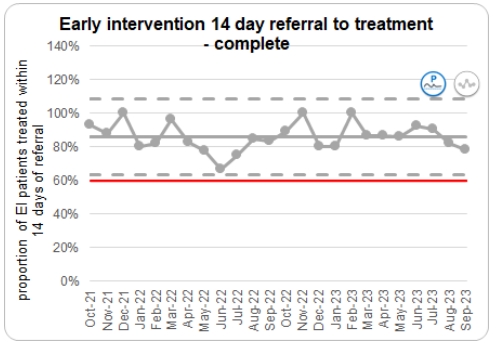


Summary

There was an increase in cancellations in September owing to strike action, with those appointments rearranged. The level of defaulted appointments (did not attends) has remained within common cause variation, averaging just under 12% and in the current process the trust target of 15% or lower is likely to be consistently achieved.

Operational Performance

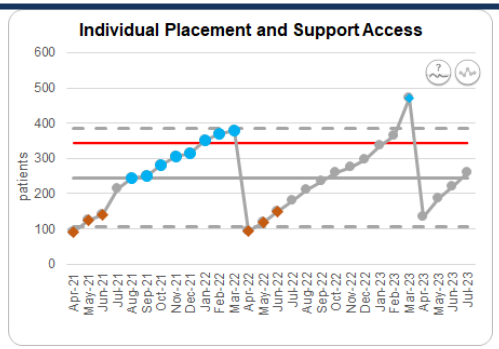




Summary

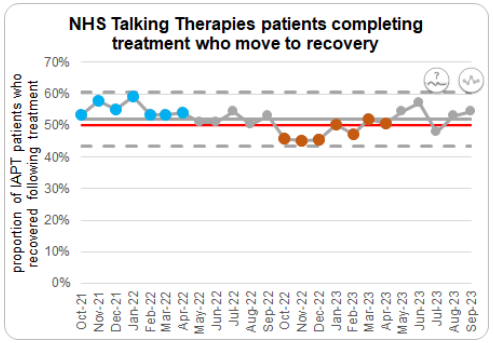
Patients with early onset psychosis are continuing to receive very timely access to the treatment they need. Occasionally delays result from difficulties contacting patients to arrange appointments, or patients not attending their planned appointments.

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



Summary

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

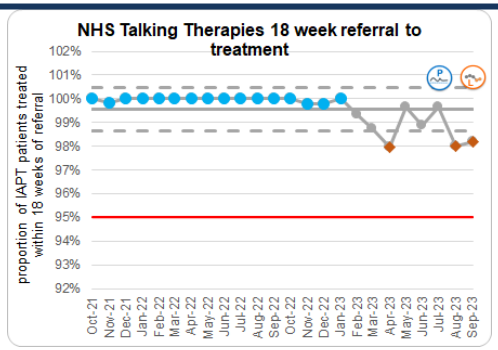


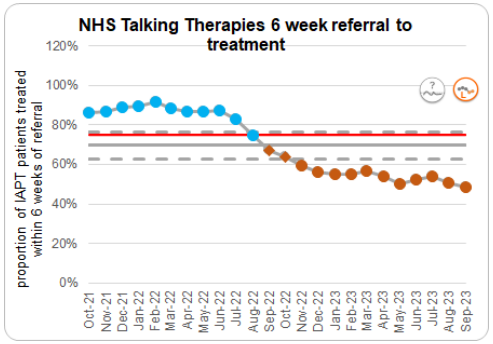
Summary

Recovery rates have exceeded 50% for 5 out of the 6 months for this financial year with September exceeding 54%. Year to date at M6 is 52.91%

Actions

- Work continues on informing clinicians of their own performance via service management.
- Service wide meetings discussing performance and updating clinicians on plans and progress continue.
- Further discussions clarifying acceptance criteria and plans for assessment workshops have started.



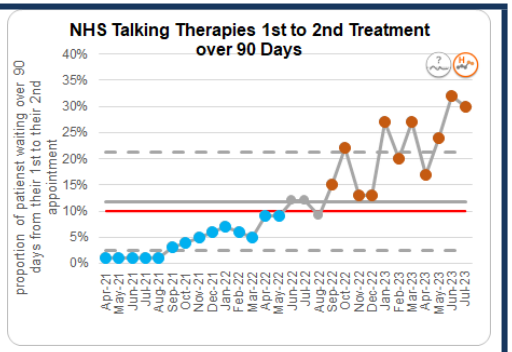


Summary

- The 95% standard for 18-week waits from referral to treatment continues to be consistently exceeded.
- The 6 week wait for referral to treatment continues to decline. This graph picks up a percentage of discharges who met the 6 week target.
- However there are improvements month on month for 6 week compliance for entering treatment, this should reflect an improvement when discharged following treatment but there will be a delay before this starts to improve.
- Referrals continue to maintain a pre pandemic levels and treatment wait lists are longer due to a loss of resource amongst our sub contracting organisation which our fixed budget cannot mitigate.

Actions

- Recent PWP recruitment has been more successful with staff being recruited. The service continues to recruit and now has only 1WTE vacant.
- To improve the referral to assessment/ treatment rates, assessments have started to flow to Xyla, funded from deferred income. This has had a 40% plus improvement on referral to



Summary

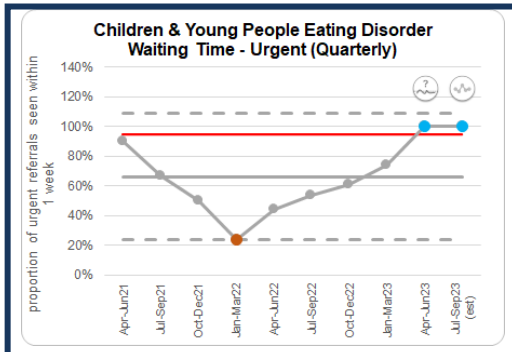
1st to 2nd treatment waits have been significantly high and above target for the last 7 months.

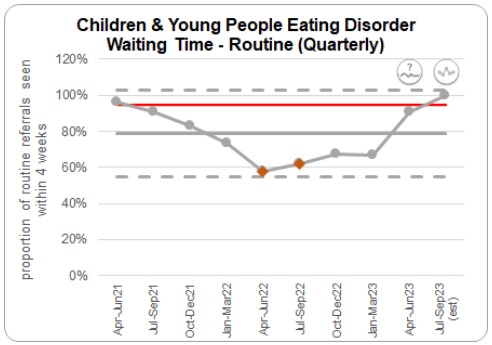
Actions

- Monthly service Manager discussion over longest waiters to reduce outliers. Standing agenda item. This has had a significant impact on the longest waiters.
- Supportive caseload management frameworks have been introduced to give better scrutiny of productivity in relation to average contacts. This has had 10% impact on average contacts per treatment.
- Further work is in progress with IESO with a work plan of promotion of the service, crib sheets for assessing clinicians and rolling attendance at service wide meetings.
- Maintain a focus on attendance and reduction of DNAs. Booked contacts in September were the highest year to date, however DNAs increased negating the gains. Consideration of the timings of appointment reminders continues.
- Review acceptance criteria to achieve more appropriate referrals.
- Bookable appointment slots are rolled out to all PWPs assessors, these also allow for cancellations being re-offered to patients should someone cancel their appointment. We are awaiting further functionality to inform referrers when their appointment is, this is in development by Mayden who manage IAPTuS.
- Working towards cross provider agreements to advertise wait times for all providers offering better patient choice reducing wait times. This has been agreed by commissioners and agreed that providers will provide this information for average waits.

		treatment	

Operational Performance

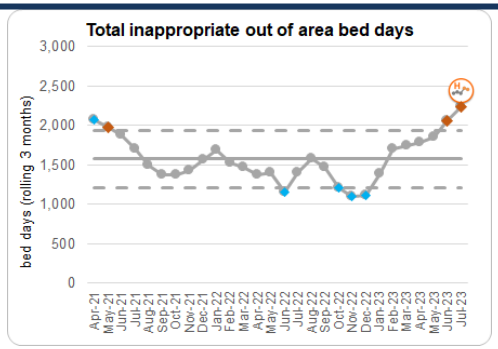




Summary

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

The Division also internally monitors the C&YP Eating Disorder Service waits from 1st to 2nd contact. In quarter 1 the average wait was 11 days, and in quarter 2 it was 4 days.



Summary

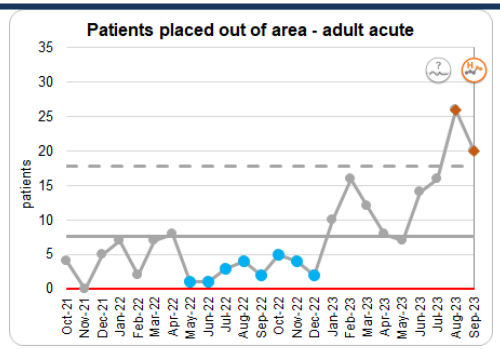
This is a national measure giving a combination of inappropriate out of area adult acute placements and inappropriate out of area psychiatric intensive care unit placements, calculated on a rolling 3 months' basis.

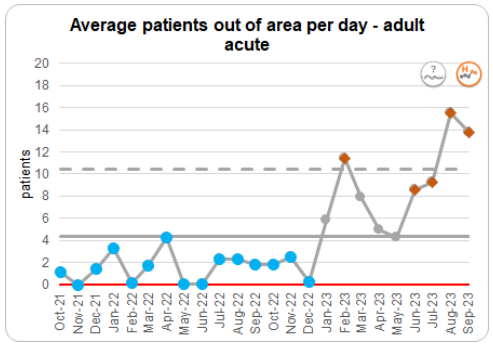
There is an ongoing demand for inpatient beds. This has been a consistent factor over many weeks. Generally, we are finding people are more acutely unwell and acuity is much higher than we would usually expect: two thirds of all patients admitted to hospital are detained under the Mental Health Act. As a result, people are taking longer to recover. The increase in acuity is also apparent when we look at the number of patients in PICU.

The crisis teams are working with higher than usual caseloads in an attempt to avoid admissions to hospital wherever possible and appropriate. the teams are effective at reducing admissions, managing to treat 94% of people in the community without requiring admission.

A few disruptions/ delays to service offers introduced to impact presentations and clinical pathways have been experienced:

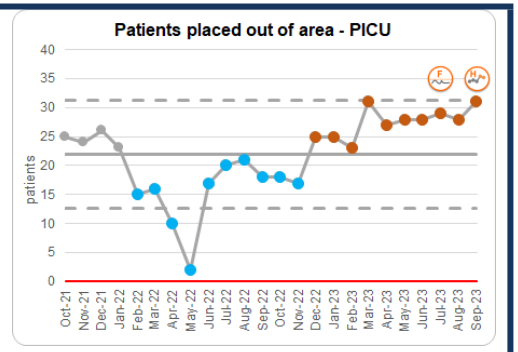
- Step Down – unfortunately the 5 step down beds did not open in March as initially hoped. The works to comply with health and safety requirements are now complete and the service opened in August 23.
- The 4 bedded Chesterfield Crisis House and safe haven was delayed until September 2023.
- Ripley and Swadlincote crisis café – delayed due to open in December 2023.
- Derby Crisis House – the temporary reduction in capacity due to works on one of the bedrooms has now been resolved and the 4 beds are full.

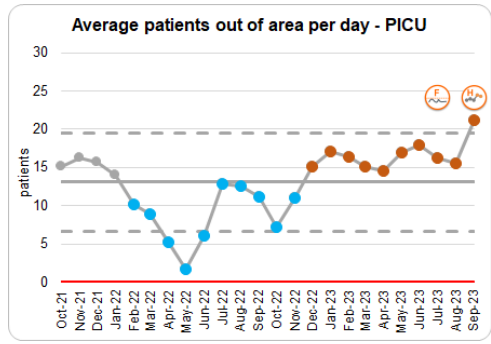




Actions

- Liaison with ICB regarding adjustments to the commissioning arrangements for High Peak patients.
- Transition of Care Navigator post to be appointed to support patients on step down pathway.
- The increase in demand for inpatient beds for LD&A patients continues. Changes to the pathway to improve assessment and decision making have been implemented. Twice weekly meeting to monitor current inpatients.
- Reviewing of the gatekeeping function to comply with the fidelity model.
- Purposeful admission workstream.
- Updated flow structure has been developed and will be implemented. This will provide a multi-agency response to the admission and discharge challenges experienced.
- Derbyshire Mental Health Response Vehicle is due to be implemented in April 2024.
- To enhance the impact from the community Emotional Regulation Pathway to support prevention of admission to hospital and/or facilitate early discharge.





Summary

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

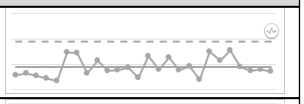
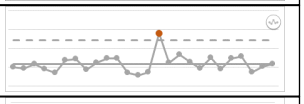
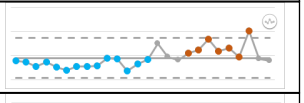
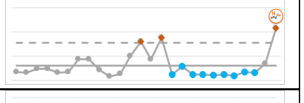
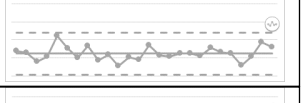
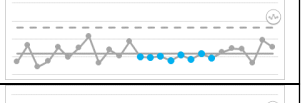
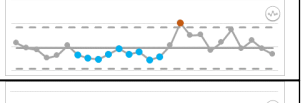
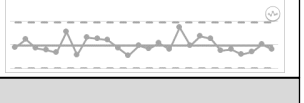
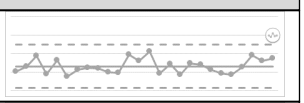
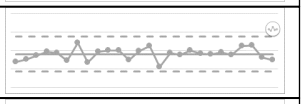
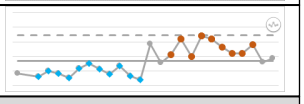
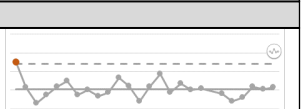
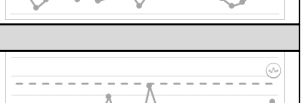
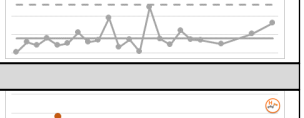
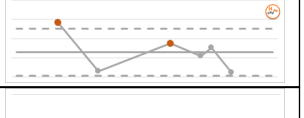
Actions

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

		• To enhance the inpatient offer regarding Trauma Informed Care.	

Operational Performance

Length of stay (days)

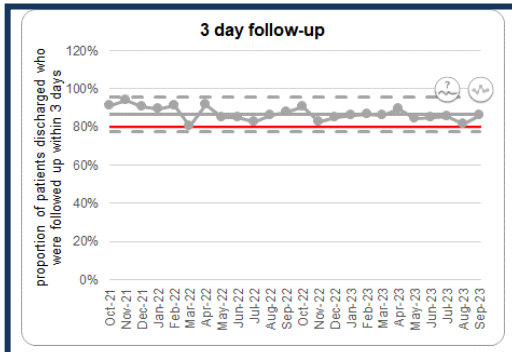
Clinical area	Beds	Bed occupancy Sep-23	Average duration of stay to date (days) of current inpatients	Average length of stay (days) Sep-23 discharged	Change versus previous month discharged	Change over time – average length of stay of discharged inpatients
Adult Acute						
Morton	20	98%	30	38	↘	
Pleasley	20	106%	59	61	↗	
Tansley	20	99%	47	40	↘	
Enhanced Care	10	38%	181	215	↗	
Ward 33	20	99%	57	79	↘	
Ward 34	20	96%	57	76	↘	
Ward 35	20	101%	42	35	↘	
Ward 36	20	107%	88	40	↘	
Older People						
Tissington	18	103%	74	86	↗	
Cubley Female	18	84%	67	75	↘	
Cubley Male	18	89%	70	93	↗	
Perinatal						
The Beeches	6	57%	3	58	↗	
Rehabilitation						
Cherry Tree Close	23	78%	330	806	n/a	
Low Secure						
Curzon Ward	8	100%	412	n/a	n/a	
Scarsdale Ward	10	83%	814	n/a	n/a	

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

In the latest Model Mental Health Trust data, the Trust's average length of stay of discharged patients of 53.9 days was in the lowest 25% of Trusts, well below the provider median of 73.7 days.

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

Operational Performance

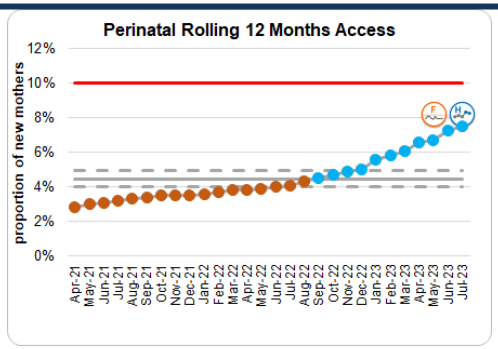


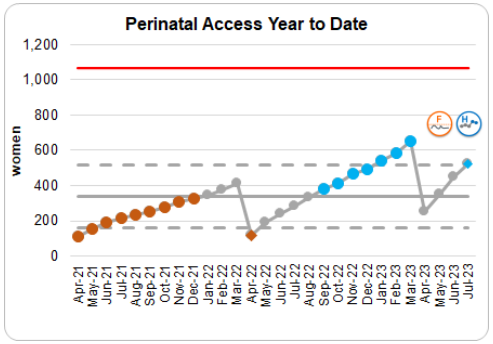
Summary

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

Actions

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





Summary

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

The number of live births in Derby & Derbyshire has been lower each subsequent year than when the target was set, which makes it more challenging to achieve as there are fewer mothers who potentially need perinatal mental health support (awaiting publication of 2021 data):

Live Births	Derby	Derbyshire	Total	Difference v 2016
2021	2898	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	

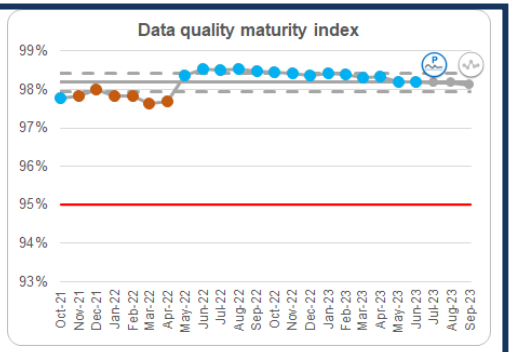
There is now an identified demand for the service following an increase in referrals which remain on an upward trajectory.

Capacity continues to be demonstrated within the system to offer over 90 assessments a month. Achieved target within service level data in June.

Monthly access since then has been impacted by DNA rates and staff sickness.

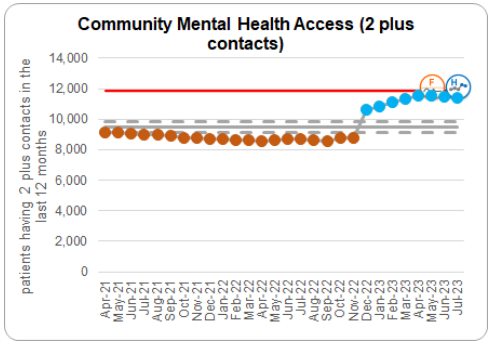
Actions

- Rapid review undertaken supported by Trust performance team and RWH to address residual reporting, data issues. Separation of North and South community data facilitated with individual cost codes.
- Caseload demand and capacity modelling in development. Team specific job plans in development to address unwarranted variation and improve patient flow within community teams.
- Community outreach worker funded from Start for Life programme and Specialist assessor role introduced in the South CMHT.
- Service has strategic direction to address health inequalities and potential barriers to access.
- Initial assessments by the maternal mental health service are lower than expected due to complexity of cases and hence longer time in treatment than anticipated. Psychology assessments are often completed for women already open to the service. Recording issue on SystmOne recently identified.
- Waiting well offer in place to support patients whilst on the waiting lists.



Summary

The level of data quality is consistently high. It is expected that the national target will continue to be exceeded.



Summary

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

This financial year the year-end target has been increased to 11,899 and services are on target to achieved it by year end.

Operational Performance

Patients not seen for over 12 months

Count of Appt booked	Appt booked?		
Service	No	Yes	Total
ADULT CARE COMMUNITY	127	84	211
COUNTY NORTH	9	22	31
BOLS & CC ADULT CMHT - OUTPATIENTS	8	11	19
CHESTERFIELD C ADULT CMHT - OUTPATIENTS		5	5
EI NTH	1		1
KILLMSH & NC ADULT CMHT - OUTPATIENTS		6	6
COUNTY SOUTH	36	16	52
AMBER VALLEY ADULT CMHT - OUTPATIENTS	33	2	35
EREWASH ADULT CMHT - OUTPATIENTS	1	2	3
SOUTH & DALES ADULT CMHT - COMMUNITY	2		2
SOUTH & DALES ADULT CMHT - OUTPATIENTS		11	11
SOUTH & DALES ADULT CMHT - SPOA		1	1
DERBY CITY	82	46	128
DERBY CITY ADULT CMHT B - OUTPATIENTS	5	17	22
DERBY CITY ADULT CMHT B - SPOA	1		1
DERBY CITY ADULT CMHT C - OUTPATIENTS	58	29	87
PHYS HEALTH MONITORING	18		18
OLDER PEOPLES CARE	38	8	46
OLDER PEOPLES COMITY CARE	38	8	46
AMBER VALLEY OA CMHT - OUTPATIENTS	25	2	27
CHESTERFIELD C OA CMHT - COMMUNITY	1		1
CHESTERFIELD C OA CMHT - OUTPATIENTS		3	3
DERBY CITY OA CMHT - OUTPATIENTS	1		1
MAS NORTH - MAS	1	2	3
MAS NORTH - PSYCHOLOGY	1		1
MAS SOUTH - MAS	6	1	7
MAS SOUTH - PSYCHOLOGY	3		3
Total	165	92	257

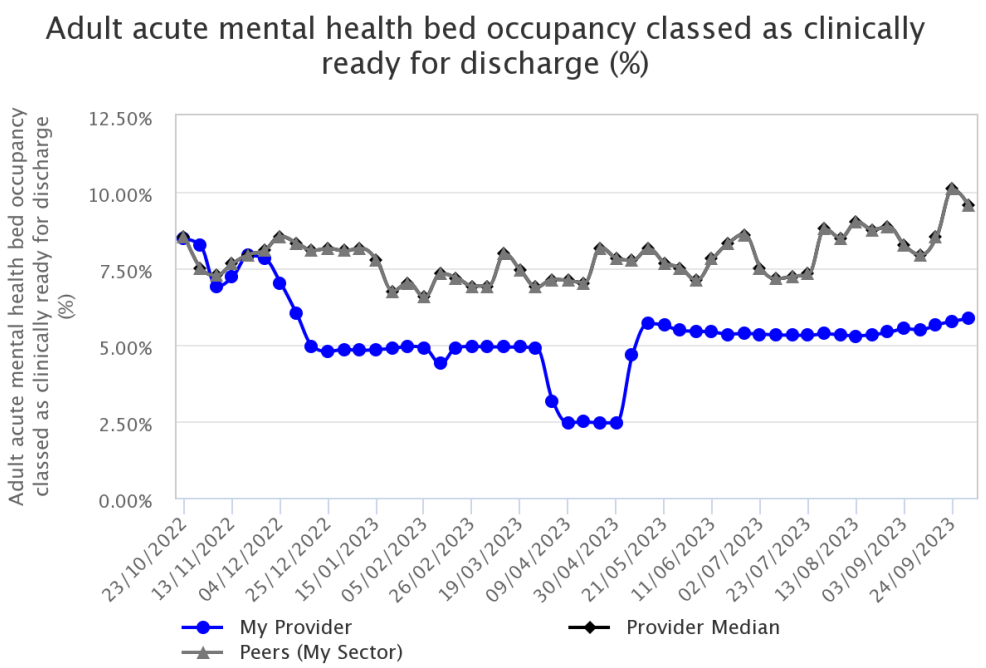
Summary

There are 257 patients on community mental health caseloads who have not been seen for over 12 months, according to their records. This is a 19% reduction since the last report. Some will be people who have been discharged but the discharge has not been recorded on the electronic patient record.

Actions

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

Clinically ready for discharge



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

Summary

This shows the proportion of adult acute mental health patients classed as clinically ready for discharge but continuing to reside in mental health hospitals against the total number of occupied beds. In the most recently published data, the Trust's clinically ready for discharge rate was 5.9%, which compares favourably with the overall provider median of 9.6% but continues to negatively impact on bed availability for people who need inpatient care.

Actions

- The pilot of the discharge tracking tool on Tansley with ward-led management of the tool proved unsuccessful owing to issues of capacity and competing priorities of the clinical team to drive this forward.
- In adult, a twice weekly clinically ready for discharge meeting is held with the discharge coordinators, and with attendance from social care. Actions are then taken away to escalate as required.
- In older adult, delays in discharge are predominately placement issues in specialist 24-hour care settings. The teams hold twice weekly rapid review meetings with social care in attendance. Actions are taken from this and escalated as necessary. Ward flow coordinators chase placements requests and funding processes. On average every successful placement has been preceded by 8 to 10 providers declining to offer placement. Other reasons for delay are funding related, social care delays and family related issues.

Appointments not reconciled

Service	Current	Previous	Change
COUNTY SOUTH ADULT	565	472	93
OLDER PEOPLES COMMUNITY CARE	457	391	66
COUNTY NORTH ADULT	286	332	-46
CAMHS	167	263	-96
PSYCHOLOGY ASM3	306	200	106
DERBY CITY ADULT	169	158	11
PERINATAL	143	157	-14
ACUTE INPATIENT NORTH	177	149	28
NOT KNOWN	177	131	46
ACUTE INPATIENT SOUTH	113	111	2
ADULT URGENT ASSESSMENT	66	88	-22
LEARNING DISABILITIES	70	78	-8
OLDER PEOPLES ACUTE CARE	38	70	-32
COMPLEX CARE	18	33	-15
SPECIALIST CARE MGT	24	28	-4
PSYCHOLOGY ASM2	11	18	-7
PSYCHOLOGY ASM1	21	15	6
SUBSTANCE MISUSE	24	13	11
SPECIALIST CARE	40	7	33
HEALTH PROTECTION UNIT	0	2	-2
OVERALL	2872	2716	156

Summary

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

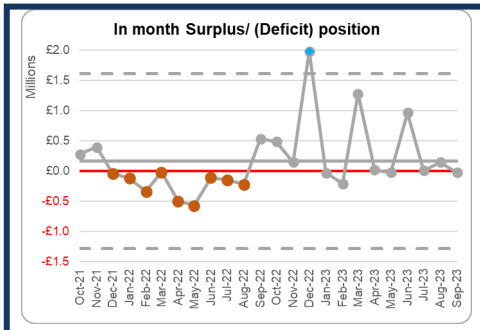
Actions

- Weekly reporting to the teams and clinicians concerned.
- IM&T are developing a weekly automated report to individual clinicians and managers which will highlight any data quality issues within their caseload on SystmOne, to enable ongoing monitoring and for corrective action to be taken. The pilot has been extended to several teams and is approaching completion.
- Away day with service managers and clinical leads for adult and older adult CMHTs focusing on data, productivity and performance – the key message is around the leads and their teams owning their data, ensuring it is accurate and taking actions to address

Derbyshire Healthcare
NHS Foundation Trust

Finance

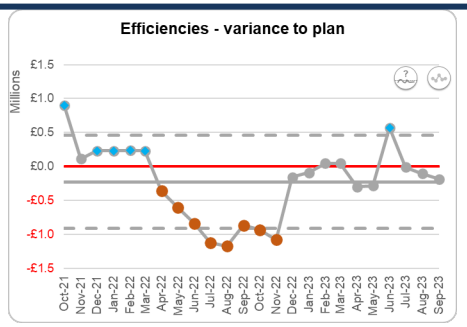
Financial Performance



Summary

At the end of September, the YTD position is a surplus of £1.1m against a planned surplus of £1.0m, a favourable variance of £0.1m. Agency expenditure is being partially offset by vacancies and interest income being ahead of plan. The forecast position is breakeven against a plan of breakeven. The forecast assumes that we deliver efficiencies in full and find mitigations to offset the emerging cost pressures associated with pay award inflation, agency costs, out of area expenditure, industrial action and pressures related to a complex patient that is being supported on one of our wards.

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

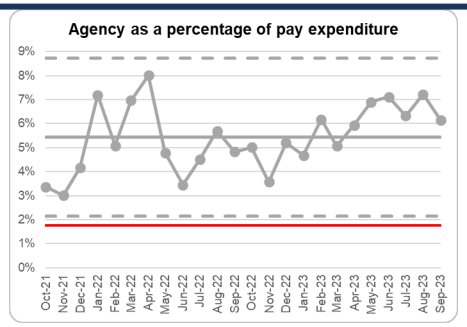


Summary

The plan includes an efficiency requirement of £8.8m phased equally across the financial year. As at the end of September £4.1m was delivered against a target of £4.4m. The forecast assumes that all efficiencies are delivered. Currently £7.3m of the £8.8m target has been found with further work on-going to identify plans for the balance. Further work is also required to ensure plans are delivered recurrently, as 84% of the £7.3m is currently identified as non-recurrent.

Delivery of the transformation initiatives contributing to the efficiency programme is being overseen by a weekly Transformation Programme Delivery Group.

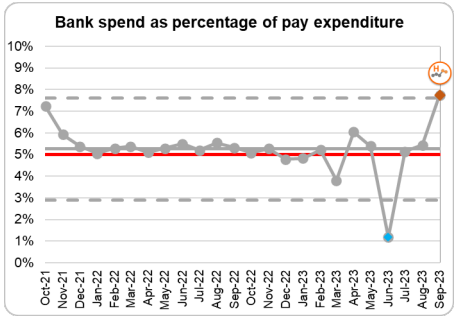
The group seeks assurance that initiatives are on track and identifies additional support and intervention where schemes are off trajectory. Initiatives which are off trajectory and/or forecast to be off trajectory are expected to provide a situation, background, assessment and recommendation report including suggested mitigations to take forward.



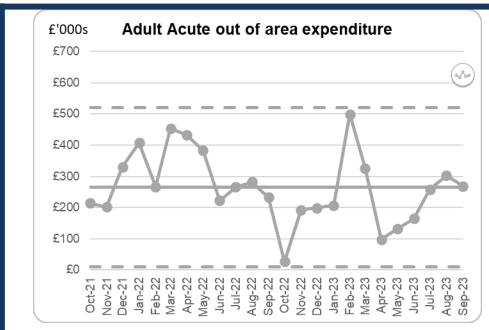
Summary

Agency expenditure YTD totals £5.2m against a plan of £2.6m, an adverse variance to plan of £2.6m. This includes £1.5m of additional costs to support a complex patient on one of our wards. The two highest areas of agency usage continue to relate to Consultants and Nursing staff. The agency expenditure as a proportion of total pay for September is 6.1%. The plan for the year is set at 3.5% which just below the target set by NHSE in the planning guidance of 3.7%.

Agency is forecast to be above plan by £3.4m, of which £2.2m relates to the complex patient that is being supported.



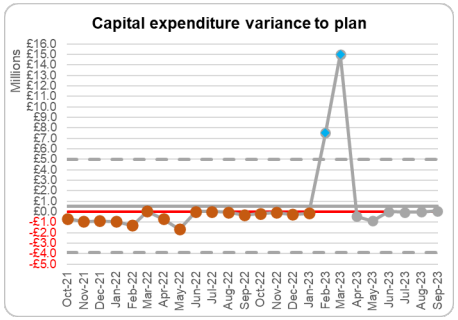
Bank expenditure YTD totals £4.1m against a plan of £3.9m, an adverse variance to plan of £0.2m. In July there was an accrual release for backdated pay which then was partially reversed in September due to ELT agreement to backdate B2-B3 increase to April 2022. The forecast is an adverse variance of £0.1m.



Summary

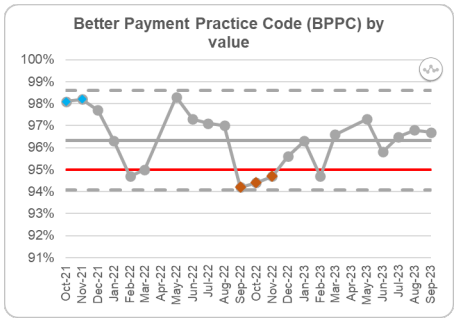
The plan for out of area expenditure has been reduced by £1.0m in 2023/24 as this is one of the transformation schemes identified as part of the £8.8m efficiency requirement. As at the end of September there was an overspend against the reduced plan of £0.7m with a forecast overspend of £1.0m. Out of area patient numbers were at 15 at the end of September, the forecast assumes a gradual reduction to 4 from M9 onwards.

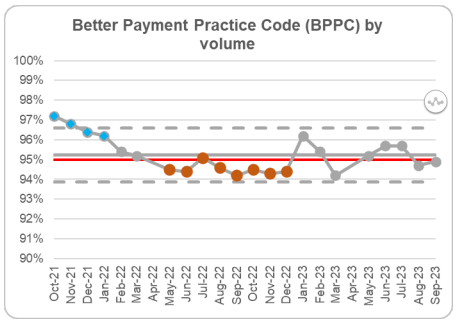
Financial Performance



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

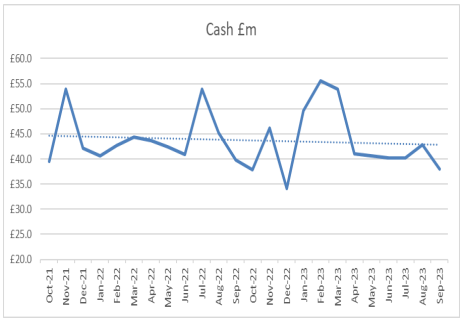
Capital expenditure was above plan in the last two months of 2022/23 due to the additional capital expenditure related to the dorms project (which came with additional funding that was not originally in the plan).



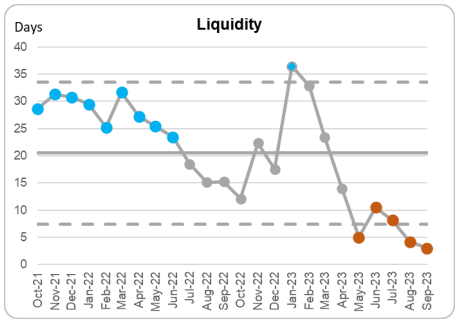


Summary
The Better Payment Practice Code (BPPC) sets a target for 95% of all invoices to be paid within 30 days. BPPC is measured across both invoice value and volume of invoices.

At the end of September, the value of invoices exceeded the target at 96.7% and by volume was slightly under the targe at 94.9%.



Summary
Cash increased in February and March due to the additional funding for the Dorms capital projects that was drawn down. Cash reduced in April and May due to payment of capital invoices. Cash at the end of September is at £37.9m and is forecast to be at planned levels of £23.6m by the end of the financial year. The in-year reduction is driven by the reduction in capital accruals from 2022/23 and the level of capital expenditure planned for 2023/24.

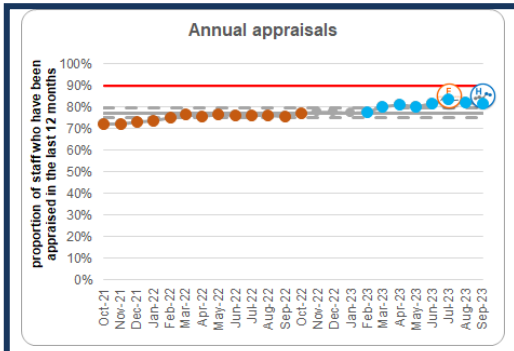


Summary
The chart above shows the liquidity levels over the last two years. Liquidity levels were high in 2021/22. In 2022/23 the liquidity reduced until the last quarter due to the timing of cash receipts related to the centrally funded capital schemes for the eradication of dorms. The Public Dividend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

Derbyshire Healthcare
NHS Foundation Trust

People

People Performance



Summary

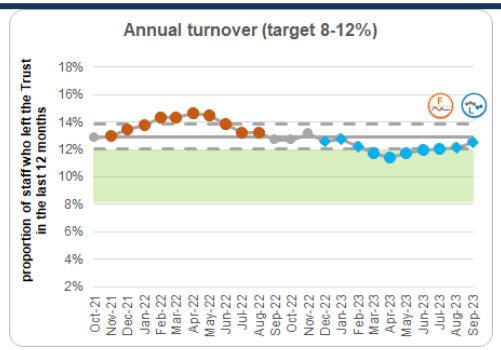
Appraisal levels continue to be below our expectations with Operational Services currently at 85% and Corporate Services at 69%, against a target of 90%. Overall, significant improvement has been seen month on month for the last 8 months.

Actions

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

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

Compliance also continues to be monitored by the People & Culture Committee and through TOOL.



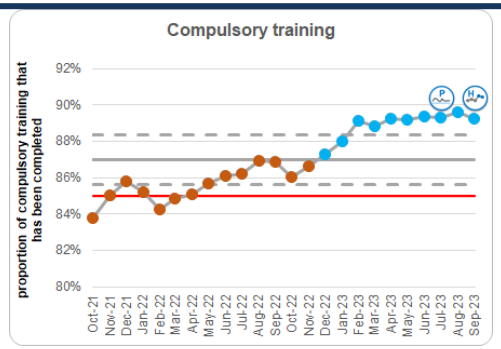
Summary

Overall turnover is currently very slightly over 12%, but has been significantly lower than normal for the last 10 months and remains in line with national and regional comparators.

Actions

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

- Continue to strengthen and grow wellbeing champions in every team in order to support health and wellbeing.
- Charitable funding has been secured to provide additional wellbeing support and team development.
- A health check programme has been commissioned and rollout commenced this September.
- Review of staff benefits to support engagement and retention with full benefits offer has commenced.
- The Coaching Network has now been relaunched and is focusing on career conversations via a coach in order to support personal development and growth opportunities, thereby enhancing staff retention.



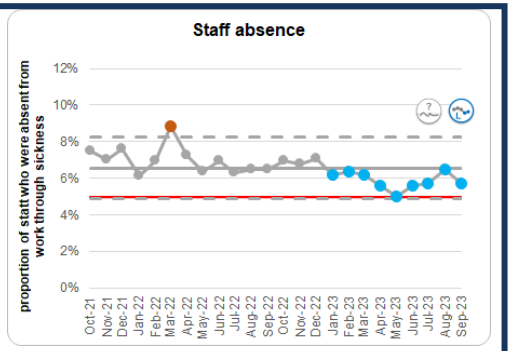
Summary

Overall, the 85% target level has been achieved for the last 18 months. Operational Services are currently 90% compliant and Corporate Services slightly lower at 84%.

Derbyshire Community Health Services NHS Trust's workforce team have been undertaking a large piece of work to the Electronic Staff Record (ESR) to correct the alignment of resuscitation training to staff roles. This is impacting on the accuracy of reporting of resuscitation compliance, but is due to be completed this month.

Actions

- A cleanse of ESR training data to support colleagues to access all virtual training as easily as possible is nearing completion.
- Compliance at divisional level is monitored at regular Divisional Achievement Reviews (DAR).



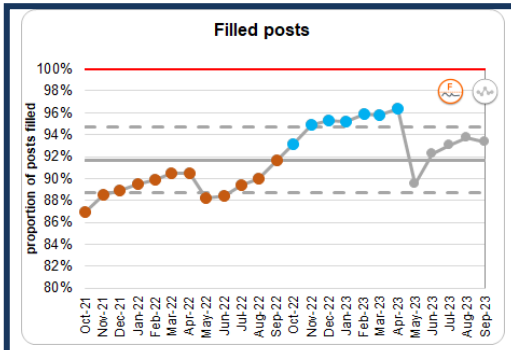
Summary

Sickness absence has been significantly lower than normal for the past 9 months. In Sep 23 the overall absence rate was 5.7% (Operational 6%, Corporate 4%). Stress, anxiety or depression is the main reason for absence, but has reduced by 6%. There has been an increase in cases of coronavirus recently. In the most recently published national data, the average absence rate for mental health trusts was 4.9% and nationally the main reason for absence continues to be stress, anxiety, or depression, accounting for over 26% of all absence. NHS Sickness Absence Rates, May 2023 - NHS Digital

Actions

- Divisional wellbeing summits commenced in September and are providing a focus on both long-term and short-term absences in each division. This is to ensure that robust wellbeing plans are in place and that all support is being provided to each absent employee.
- Occupational Health (OH) have attended team and management meetings to ensure managers are fully maximising the support available for colleagues who are unwell.
- Continuing to work with OH to ensure the management referral and outcome is utilised to its full potential for both individuals and managers.

People Performance

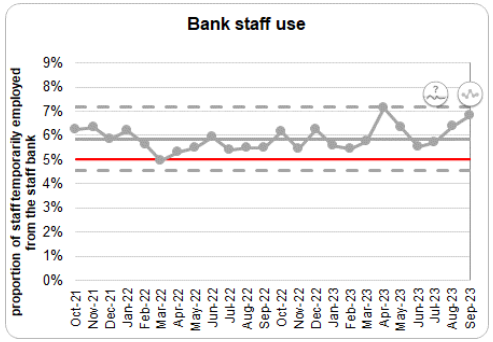


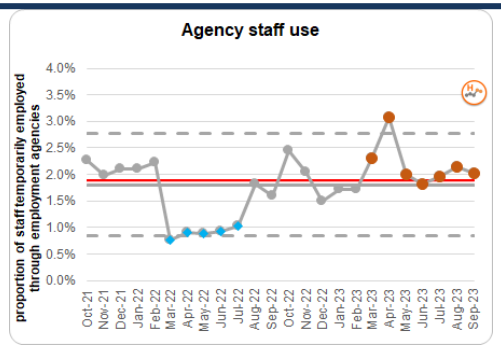
Summary

At the end of September, 93% of posts overall were filled.

Actions

- A number of recruitment events have taken place and there is a large Trust-wide event planned for the end of October at Chesterfield Football Club
- Strategic Recruitment and Retention Lead working closely with teams on bespoke campaigns and recruitment approaches.
- Actions, support and tracking have been agreed for divisional workforce plans to realise the workforce requirements for 2023/24.
- Ongoing sessions to support colleagues to explore new roles such as Associate Physicians and Advanced Clinical Practitioners (ACPs)





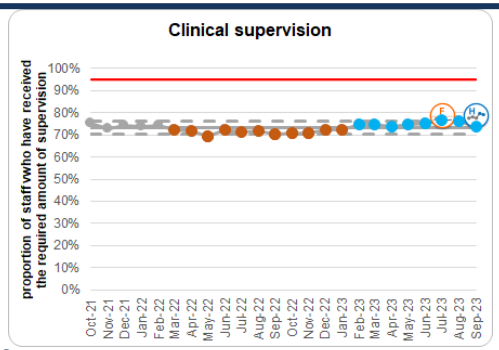
Summary

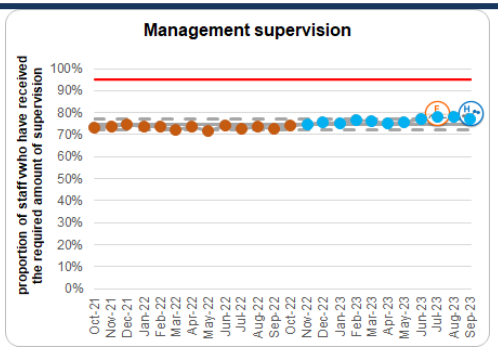
Bank staff use has remained above the 5% target for most of the last 24 months. This is mainly owing to a combination of vacancies and increased levels of occupancy and acuity on the adult acute wards. Agency use has been above target for the last 3 months.

Actions

Further actions to reduce agency use have been identified and are being implemented, as follows:

- Authorisation Panel - to establish process to authorise agency requests across DHcFT utilising a panel commenced weekly panel from 1st November.
- Develop exit strategy to eradicate all non-clinical agency use by 1st December 2023.
- To review the pay rates for bank staff
- Business case to propose recruitment of additional Healthcare Assistant workforce to cover the clinical activity rather than reliance on temporary staffing.
- The development of a medical bank.
- Establishing protocol to cover the circumstances where the various levels of Agency workforce (including Thornbury) relates to enhanced, safer and emergency staffing levels.
- To recruit additional Registered General Nurses
- Across the system an agency reduction programme has been established, led by the Deputy HR Director at Chesterfield Royal Hospital





Summary

As seen with compulsory training and appraisals, Operational Services continue to perform at a considerably higher level than Corporate Services for both types of supervision (management: 83% versus 63% and clinical: 79% versus 28%). Progress continues to be made. At a team level, 131 teams are 100% compliant with management supervision and 83 teams are 100% compliant with management supervision, with 65 teams now 100% compliant with both types of supervision.

Actions

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

- Data cleanse ongoing to ensure all completed supervisions are recorded correctly and to ensure that all staff are aligned to the correct budget code and line manager within ESR.
- Ongoing monitoring of compliance in service line and divisional operational meetings for both management and clinical
- Supervision report has been produced by IM&T to highlight in red anyone where no supervision has been undertaken in past 3 months. This is distributed weekly to senior operational management for action.
- Ongoing monitoring of supervision through regular monthly performance meetings with Area Service Managers and Operational leads - issues escalated to divisional operational meeting as needed

An audit of supervision processes is currently in progress, which is being undertaken by 360 Assurance. The overall objective of the audit is to assess the actions the Trust is taking to improve supervision performance and accurate recording of supervision time for both clinical and non-clinical staff.

This includes:

- Understanding the Trust's system for recording supervision
- Confirming what arrangements are in place to remind staff supervision should take place
- Confirming responsibilities of line managers/staff for initiating, documenting and recording supervision
- Assessing the arrangements the Trust has put in place to improve the percentage of staff receiving supervision.
- Undertaking a staff survey for all staff who would normally be expected to have supervision.

Hotspots and Triangulation September 2023

The hot spot and triangulation focus list for key workforce metrics identifies teams that are most in need of attention and support. The table lists the top 20 teams in need of attention and support. Teams with an x also featured in the Top 20 last quarter. Please note that to fall into the focus list a team must have at least 10 employees.

Sickness Absence September 2023		HC	%	
Catering Radbourne	Estates + Facilities	10	24.48%	*
Chesterfield C OA CMHT	Older Peoples Care	14	23.82%	*
Ward 35 RU 'IP'	Adult Care Acute	31	22.18%	*
0-19 Across Localities	Children's Services	41	14.97%	
0-19 Locality 2	Children's Services	37	14.59%	*
Pleasley Ward HU 'IP'	Adult Care Acute	33	14.31%	
Ward 33 RU 'IP'	Adult Care Acute	32	11.90%	*
CAMHS Admin	Children's Services	27	11.41%	
CAMHS EA Assist	Children's Services	10	11.36%	
Memory Assessment Service	Older Peoples Care	20	11.25%	
Tissington Ward 'IP'	Older Peoples Care	43	11.07%	
CRHT City	Adult Care Acute	23	10.88%	
CRHT HP+N Dales	Adult Care Acute	11	10.85%	*
Low Secure Kedleston Kway'IP'	F+R & Specialist Services	52	10.81%	
Mental Health Act	Corporate Central	11	10.50%	
LD Admin	Neuro Developmental	12	10.44%	
CRHT Chesterfield	Adult Care Acute	28	10.25%	
El Sth + City	Adult Care Community	22	10.23%	
Erewash OA CMHT	Older Peoples Care	18	10.18%	
H P + NDales OA CMHT	Older Peoples Care	22	10.02%	

Appraisal Compliance September 2023		HC	%	
Domestics MH Properties	Estates + Facilities	18	11.11%	
SUI	Nursing + Quality	10	22.22%	*
Management Adult Acute	Adult Care Acute	14	23.08%	*
MH Liaison Team Nth	Adult Care Acute	23	27.27%	*
Tansley Ward HU 'IP'	Adult Care Acute	32	27.59%	*
Domestic Kingsway	Estates + Facilities	63	27.87%	
Medical School	Med Education & CRD	10	33.33%	
Medic Adult Comm Sth	Adult Care Community	12	40.00%	*
Medic OA Inpatient 'IP'	Older Peoples Care	11	40.00%	
Domestic Psychiatric Unit	Estates + Facilities	16	43.75%	
County South Receptionists	Estates + Facilities	13	46.15%	*
Derby City C Adult CMHT	Adult Care Community	14	46.15%	
Eating Disorders Service	F+R & Specialist Services	13	46.15%	*
Nursing and Operations Management	Nursing + Quality	16	46.67%	*
Enhanced Care Ward RU 'IP'	Adult Care Acute	25	50.00%	*
Medic Adult Comm City	Adult Care Community	11	50.00%	*
CRHT HP+N Dales	Adult Care Acute	11	60.00%	*
Medic Adult Comm Nth	Adult Care Community	13	60.00%	
Catering Radbourne	Estates + Facilities	10	62.50%	
Sth Derbyshire Adult CMHT	Adult Care Community	16	62.50%	*

Compulsory Training Compliance September 2023		HC	%	
County South Training Grades	Med Education & CRD	17	54.73%	*
County South Receptionists	Estates + Facilities	13	60.00%	*
Domestics MH Properties	Estates + Facilities	18	62.22%	*
County North Training Grades	Med Education & CRD	19	66.46%	*
Paediatric Medics	Children's Services	20	69.04%	*
Catering MH	Estates + Facilities	16	70.70%	*
Maintenance	Estates + Facilities	29	73.21%	*
Medic OA Inpatient 'IP'	Older Peoples Care	11	74.39%	
Domestic Kingsway	Estates + Facilities	63	74.59%	*
Tansley Ward HU 'IP'	Adult Care Acute	32	75.69%	
DerbyshireSubstanceMisuse	F+R & Specialist Services	25	75.71%	*
Domestic Psychiatric Unit	Estates + Facilities	16	76.25%	*
UPC Management	Clinical Serv Manage	10	77.01%	*
CAMHS SC Eating Disorders	Children's Services	15	77.61%	*
Management Adult Acute	Adult Care Acute	14	78.05%	*
Medic Adult Comm Nth	Adult Care Community	13	78.38%	*
County Elderly Service Medical	Older Peoples Care	16	78.71%	*
Derby City C Adult CMHT	Adult Care Community	14	80.00%	
Morton Ward HU 'IP'	Adult Care Acute	36	80.23%	*
Sth Derbyshire Adult CMHT	Adult Care Community	16	81.10%	

Annual Turnover September 2023		HC	%	
County South Receptionists	Estates + Facilities	13	38.96%	
Childrens Physiotherapy	Children's Services	22	34.95%	
Trust Wide CLDT Physio	Neuro Developmental	10	31.30%	*
Transforming Care Programme	Neuro Developmental	18	30.00%	
Physiotherapy	F+R & Specialist Services	11	27.27%	*
SUI	Nursing + Quality	10	26.87%	*
UPC Management	Clinical Serv Manage	10	26.87%	
Ward 35 RU 'IP'	Adult Care Acute	31	26.84%	*
0-19 Locality 1 + 5	Children's Services	31	26.02%	*
IP'S Com Mental Health	Adult Care Community	24	25.86%	
CAMHS SC Eating Disorders	Children's Services	15	23.84%	*
Amber Valley OA CMHT	Older Peoples Care	17	23.53%	
Ward 34 RU 'IP'	Adult Care Acute	24	23.15%	
Operational Admin	Children's Services	13	22.93%	*
LD Admin	Neuro Developmental	12	22.36%	
The Hub RU 'IP'	Adult Care Acute	23	21.90%	
Living Well Prog City	Adult Care Community	19	21.43%	*
Enhanced Care Ward RU 'IP'	Adult Care Acute	25	21.24%	
Liaison + Diversion	F+R & Specialist Services	25	21.05%	
Killmsh + N C Adult CMHT	Adult Care Community	21	20.69%	*

Bank Usage September 2023		HC	%	
Ward 33 RU 'IP'	Adult Care Acute	32	69.86%	*
Ward 35 RU 'IP'	Adult Care Acute	31	56.28%	*
Enhanced Care Ward RU 'IP'	Adult Care Acute	25	44.96%	*
Ward 34 RU 'IP'	Adult Care Acute	24	39.39%	*
Ward 36 RU 'IP'	Adult Care Acute	29	37.19%	*
Morton Ward HU 'IP'	Adult Care Acute	36	27.35%	*
Cubley Female KWay 'IP'	Older Peoples Care	54	23.53%	*
Inpat Rehab CTC KWay 'IP'	F+R & Specialist Services	36	22.59%	*
Cubley Male KWay 'IP'	Older Peoples Care	49	22.42%	*
Perinatal Inpatient RU 'IP'	F+R & Specialist Services	31	18.47%	
CRHT South	Adult Care Acute	26	17.90%	*
Tansley Ward HU 'IP'	Adult Care Acute	32	17.84%	*
Tissington Ward 'IP'	Older Peoples Care	43	17.57%	*
Pleasley Ward HU 'IP'	Adult Care Acute	33	17.45%	*
CRHT HP+N Dales	Adult Care Acute	11	13.72%	
Low Secure Kedleston KWay 'IP'	F+R & Specialist Services	52	12.27%	*
CRHT Chesterfield	Adult Care Acute	28	11.56%	
Medical School	Med Education & CRD	10	8.22%	*
Domestic Kingsway	Estates + Facilities	63	7.97%	*
CRHT City	Adult Care Acute	23	7.95%	*

Agency Usage September 2023		HC	%	
OOA Bed Management Team	Adult Care Acute	10	27.64%	
Tansley Ward HU 'IP'	Adult Care Acute	32	23.53%	*
Medic Adult Comm Nth	Adult Care Community	13	20.83%	*
Pleasley Ward HU 'IP'	Adult Care Acute	33	18.54%	*
Ward 35 RU 'IP'	Adult Care Acute	31	15.16%	*
Morton Ward HU 'IP'	Adult Care Acute	36	13.92%	*
CAMHS SC Eating Disorders	Children's Services	15	10.23%	*
Medic Adult Comm City	Adult Care Community	11	7.22%	*
Ward 33 RU 'IP'	Adult Care Acute	32	7.20%	*
Enhanced Care Ward RU 'IP'	Adult Care Acute	25	7.12%	*
CRHT City	Adult Care Acute	23	6.49%	*
County Elderly Service Medical	Older Peoples Care	16	6.17%	*
Paediatric Medics	Children's Services	20	5.71%	*
Living Well Prog City	Adult Care Community	19	5.20%	*
High Peak Living Well	Adult Care Community	12	4.66%	
Ward 34 RU 'IP'	Adult Care Acute	24	4.39%	*
Catering MH	Estates + Facilities	16	4.17%	
MH Helpline + Support Srvs	Adult Care Acute	18	1.55%	*
Pharmacy	Med Education & CRD	49	1.44%	
Cubley Female KWay 'IP'	Older Peoples Care	54	1.00%	*

Staff Survey 2023

The 2023 National NHS staff survey offers a snapshot in time of how people experience their working lives, gathered at the same time each year. Its strength is in capturing a national picture alongside local detail, enabling a range of organisations to understand what it is like for staff across different parts of the NHS and work to make improvements. This year the survey was launched on the 25th September and is due to close on the 24th November.

We are currently (as at 20th October) at a 34% response rate for the organisation, which is above average when compared to other Mental Health Trust response rates.

Staff Engagement Plan

Prior to the launch of the survey, we have worked with the communications team to plan a way with colleagues as much as possible to support response rates. This includes weekly updates shared to staff covering the response rates and encouragement to complete – asking leaders to support colleagues to have protected time during working hours to complete the survey. We have utilised the NHS England Engagement tool kit including promotional posters and myth busting.

Staff Survey Week

13th-17th November we will be launching Staff Survey week to focus on engaging with any staff who are yet to complete the survey, sessions will be held at a number of sites and a communications campaign will be run over the week.

November 13th - 17th Staff Survey Week					
	Monday 13th November	***Tuesday 14th November***	***Wednesday 15th November***	***Thursday 16th November***	***Friday 17th November***
AM	Kingsway Drop-in session	The Radbourne Unit drop-in session/Ward visits	Hartington Unit drop-in session and ward visits: Pleasley Ward Morton Ward Tansley Ward	Bayheath House Visit/Drop-in session Walton Hospital Visit	Albany House, Ashbourne Centre, Bramble House, Tissington Unit visit and drop in
PM	Cherry Tree/Cubley court/Kedleston Unit/IT/Finance Visits	St Andrews drop-in session/team visits	Virtual Drop-in	Walton Hospital Visit	Virtual Drop-in

Visibility of Leaders

Leaders across the organisation are working in collaboration with the OD Lead to understand the needs of each service, specifically if any additional support is needed for individuals to complete the survey.

Prior to the survey launching, leaders engaged with staff in all teams to understand if paper copies were required. This enabled us to offer more inclusive ways for the survey to be complete.

Onsite visits have been offered to all teams, the OD Lead and the Divisional People Lead for each area are currently organising visits to sites to hold drop-in sessions within the staff survey week or at a different time/date to suit the service needs.

The Staff Survey will close on the 24th November, and we will start to receive first look results end of December/early January 2024.

Learning from 2022

The implementation of actions from the 2022 staff survey is ongoing both at Trust and Divisional Level.
Key actions taken over the last quarter include:

New Appraisal documentation	• New appraisal documents launched to support career moves across system to talent management/succession plan more effectively and support staff in their careers. • New training package rolled out to support appraiser and appraisee to ensure a meaningful appraisal • Launching November - objective setting virtual bite sized sessions to support clear, meaningful objectives to be set at individual and team level
Career Conversation	• The opportunity to have a more in-depth career conversation is now included as part of the appraisal conversation • Talent management and succession planning pilot has commenced at senior level
Health & Wellbeing	• New in-house staff psychologist to support employee wellbeing commenced in post in July • We have strengthened our offer from resolve to enable more team support following incidents • We have increased our in-house reflective practice offer through increasing capacity of our clinical psychologists to enable more teams to have a regular opportunity for reflection and support together
Flexible Working	• Hybrid working clarity and principles developed • Flexible working review commenced

People Performance

Directorates have their own detailed, focused plan that is tailored with the leaders and the DPLs to reflect the results and the ongoing feedback from staff.

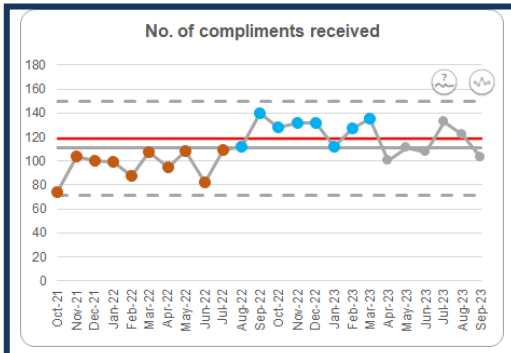
This includes workstreams for:

- Creating a supportive and open culture
- Employee Engagement
- Health and Wellbeing
- Consistent People-Centred Leadership
- Appraisals with Clear objectives
- Team working
- Team development
- Succession planning
- Staff development

Derbyshire Healthcare
NHS Foundation Trust

Quality

Quality Performance



Summary

Between July and September, the number of compliments has fallen from 130 to 110. This is consistent with common cause variation

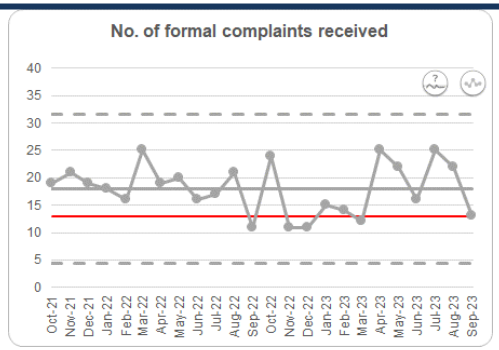
It is not possible to identify a specific reason for the fluctuation in compliments recorded as compliments are mostly received verbally and staff do not always accurately record them and there is no consistent process of recording them across the Trust, however, actions are being taken to ensure that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

Actions

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

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

  So far over 60 teams have signed up to this platform. The electronic patient survey platform gives teams the opportunity to create a QR code which allows service users to feedback directly to the team. service receivers are also given the opportunity to feedback verbally and via paper forms if this is preferred.

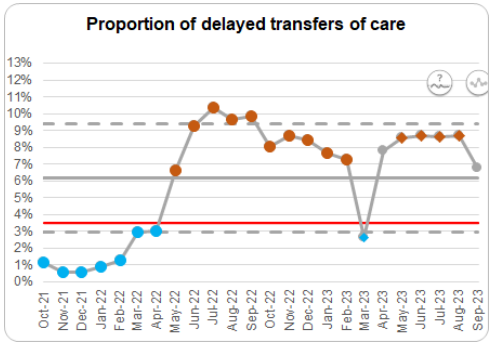


Summary

The number of formal complaints received by the Trust has fallen from 25 to 14 between July and September. This is in line with the trust target of 12 complaints and below the mean, in line with common cause variation when viewed across past two years.

Actions

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



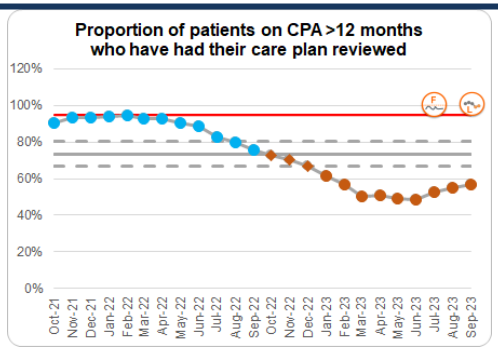
Summary

Between July and September, the number of service users meeting the criteria as Clinically ready for discharge (CRD) (formally called delayed transfer of care (DTOC) has decreased from 9% to 7%.

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

Actions

- The Trust has a Twice weekly CRD meeting where any barriers to discharge are identified and discussed to support resolution.



Summary

The current percentage of patients who have had their care plan reviewed and have been on CPA for over 12 months is 51%, a fall of 1% between and July and September 2023.

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

Actions

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

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

.

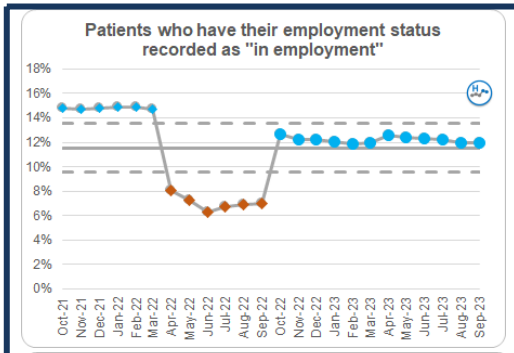
- Each team has been asked to review the current report and cleanse the data to ensure that non-eligible patients are excluded.

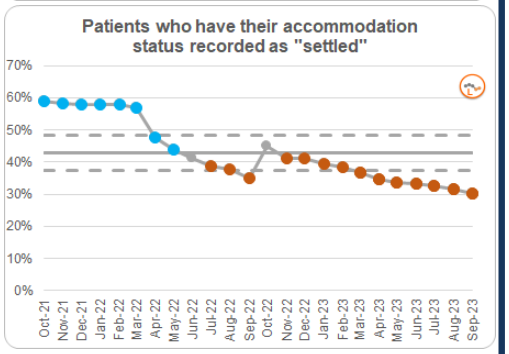
- A process for monitoring compliance and quality will be implemented in each division and monitored via the monthly Fundamentals of Care meeting, (in Inpatients, the Clinical Reference Group) and the Divisional Clinical Operational Assurance Team (COAT) meetings.

- The Community Mental Health Team have a target to achieve 60% compliance for patients who have had their care plan reviewed and have been on CPA for over 12 months by December 2023 and 85% compliance by April 2024.

	• The OA division are currently supporting the scoping of a Dementia Care Unit for Derbyshire which is due to open in 2024.	

Quality Performance



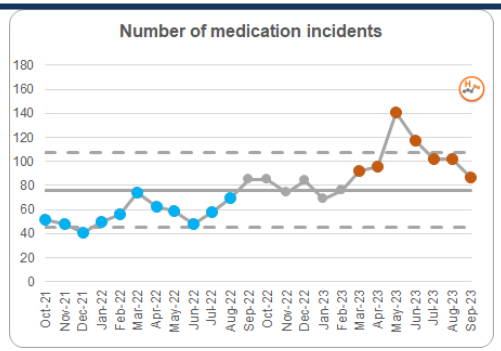


Summary

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 July and September 2023. The number of patients who have their accommodation status recorded as settled fallen by 3% over this same period.

Actions

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



Summary

Between July and September 2023 there has been a 20% decrease in the number of medication incidents. Medication incidents are largely of low-level harm and therefore reflect accurate reporting and learning opportunities and reporting is actively encouraged.

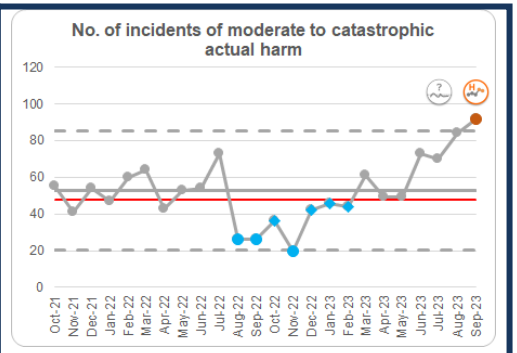
The number of medication incidents reported is now coming back in line with common cause variation when compared with data from the past two years.

Actions

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

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

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



Summary

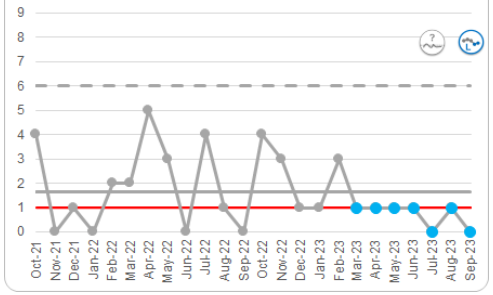
This data demonstrates the number of DATIX incidents occurring recorded as moderate to catastrophic harm. There has been an increase of 20 incidents between July and September which has taken the number of incidents reported outside of common cause variation.

Analysis suggests that this is due to an increase in the number of incidents routinely reported by staff following support from the Patient Safety team and a rise in incidents recorded as “self harm”. The increase in self harm incidents is attributed to a high number of repeated incidents involving to a small group of patients. This is consistent with anecdotal reports from staff that acuity on the inpatient wards is increasing.

This will be monitored by the Patient Safety team and the Heads of Nursing/Practice.

Quality Performance

No. of incidents requiring Duty of Candour



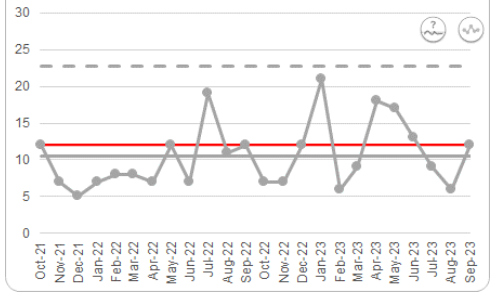
Summary

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

Actions

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

No. of incidents involving prone restraint



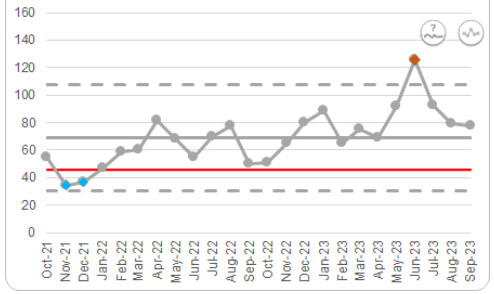
Summary

Prone restraint has increased from 9 to 12 incidents July and September 2023 in line with the Trust target of 12 incidents.

Actions

- Over the next six months there are plans for Simulation Training including seclusion, self-harm and ligature simulation. A programme manager and clinical lead have been recruited and the project is currently in the scoping phase with plans for training the trainer sessions to start in October 2023.
- The PSST have developed training around alternative injection sites which should reduce the need for prone restraint. Training dates are due to be sent out to staff in December 2023.

No. of incidents involving physical restraint



Summary

Physical restraints have reduced to around 80 incidents between July and September 2023 bringing incidents involving physical restraint back in line with common cause variation when compared with the previous two years.

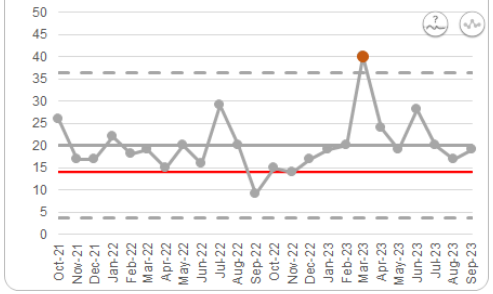
This is reviewed within the Reducing Restrictive Practice Group and the Trust Positive and Safe Support Team continue to offer extra training sessions to improve training availability for staff.

The previous increase in physical restraint appears to have been related to the increased acuity of patients in inpatient settings and a high number of repeated incidents attributed to a small group of patients who are awaiting specialist placements and require the bespoke support. The reduction is consistent with some of these patients being discharged.

Actions

- The Trust Positive and Safe Support Team are placing extra training sessions to improve training availability for staff. Compliance with positive and safe training is currently at 70% for teamwork and 46% for breakaway training. The drop in compliance in breakaway training was due to a new staff group being added to the mandatory cohort who are all currently non-compliant until they have received the training. This is however on an upward trend. Furthermore, the PSST continue to spend time in clinical areas to support and train clinical staff, live during practice.

No. of new episodes of patients held in seclusion



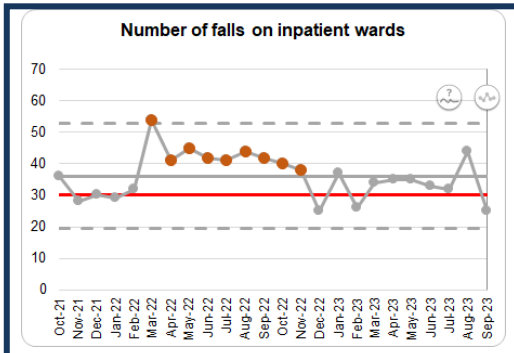
Summary

Seclusions between July and September 2023 have continued in line within common cause variation and under the mean average of 20 episodes of seclusion.

Actions

- Episodes of seclusion will continue to be monitored via the reducing restrictive practise group.
- A review focused on peer support including debrief started in May 2023 and is expected to have an impact on further reducing the number of seclusion incidents when it is completed at the end of 2023.
- This review will be presented and monitored through the Reducing Restrictive Practise Group

Quality Performance



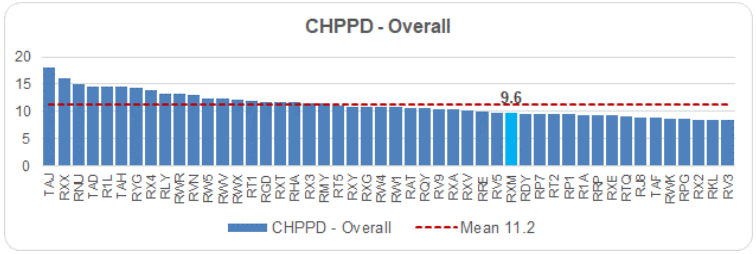
Summary

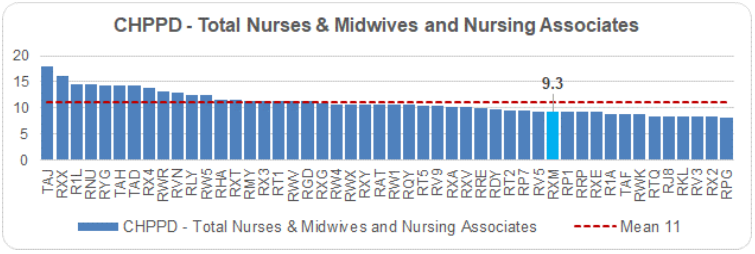
- The Biweekly falls meeting started in April 2022 appears to have had a positive impact with incidents related to falls plateauing, below the Mean of 35. A spike of falls was seen between July and September due to numerous falls reported for the same individual this has now resolved and the number of falls reported is at its lowest since February 2023. The number of falls reported is monitored via the Head of Nursing and Clinical Matron and learning from the Biweekly falls meeting is reviewed in the monthly Divisional COAT meeting.

Care Hours per Patient Day (CHPPD)

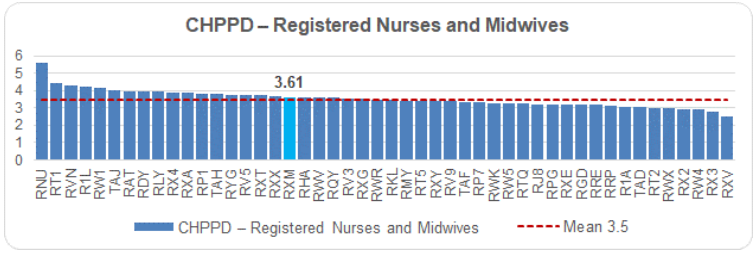
CHPPD is rolling data updated monthly, to show staffing levels in relation to patient numbers on an inpatient ward. Every month, the hours worked during day shifts and night shifts by registered nurses and midwives and by healthcare assistants are added together. Each day, the number of patients occupying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

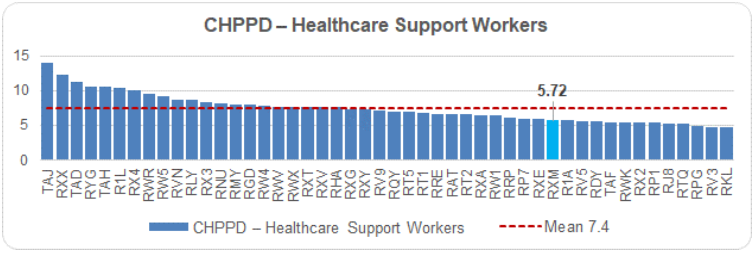
The charts below indicate that the Trust's CHPPD overall achieved 9.6 hours, which was below average when benchmarked against other mental health trusts in the country. For total nurses and nursing associates the Trust achieved 9.3 hours against the national average of 11 hours:





For registered nurses the Trust achieved 3.6 hours against the national average of 3.5 hours. For healthcare support workers the Trust achieved 5.7 hours against the national average of 7.4 hours:





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

Friends and Family Test

NHS England have resumed publication of the friends and family test data. The latest position for mental health Trusts was as follows:

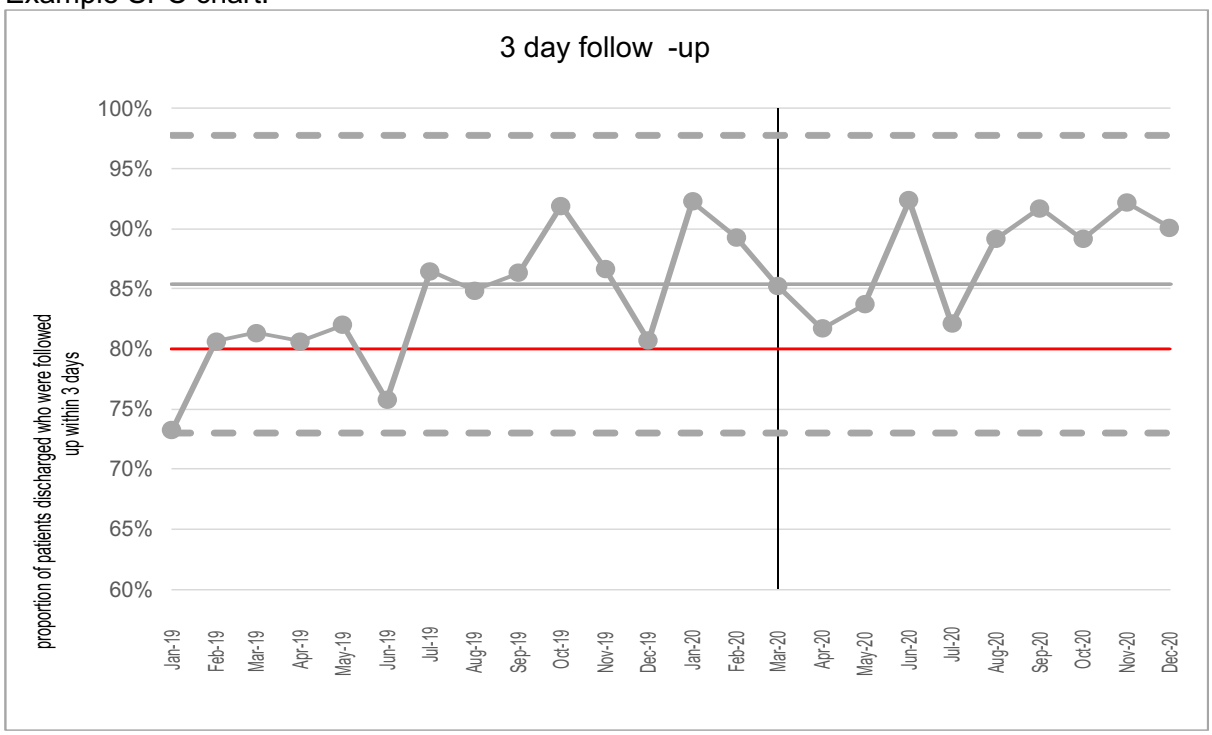
Trust Name	Total Responses	Total Eligible	Percentage Positive	Percentage Negative
England (including Independent Sector Providers)	**21,990**	**838,617**	**87%**	**6%**
England (excluding Independent Sector Providers)	**21,147**	**826,902**	**87%**	**6%**
Selection (excluding suppressed data)	**21,990**	**838,617**	**87%**	**6%**
HERTFORDSHIRE COMMUNITY NHS TRUST	29	907	100%	0%
DUDLEY INTEGRATED HEALTH AND CARE NHS TRUST	29	1,834	100%	0%
FRESHNEY PELHAM CARE LIMITED	5	10	100%	0%
THE HUNTERCOMBE GROUP	6	215	100%	0%
CITY HEALTH CARE PARTNERSHIP CIC	196	3,060	98%	2%
BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST	94	1,340	98%	1%
ST MATTHEWS HEALTHCARE	43	502	98%	2%
SOUTH TYNESIDE AND SUNDERLAND NHS FOUNDATION TRUST	115	1,782	97%	1%
NAVIGO HEALTH AND SOCIAL CARE CIC	161	3,341	96%	1%
BLACK COUNTRY HEALTHCARE NHS FOUNDATION TRUST	211	17,629	96%	3%
GATESHEAD HEALTH NHS FOUNDATION TRUST	23	165	96%	0%
BIRMINGHAM WOMEN'S AND CHILDREN'S NHS FOUNDATION TRUST	63	28	95%	3%
ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST	54	15,150	94%	4%
NORTHAMPTONSHIRE HEALTHCARE NHS FOUNDATION TRUST	36	8,270	94%	6%
CYGNET HEALTH CARE LIMITED	86	2,106	94%	5%
DEVON PARTNERSHIP NHS TRUST	274	3,365	94%	1%
DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST	222	17,098	94%	2%
SUTTON MENTAL HEALTH FOUNDATION	117	289	94%	2%
HUMBER TEACHING NHS FOUNDATION TRUST	208	4,990	93%	2%
SHEFFIELD HEALTH & SOCIAL CARE NHS FOUNDATION TRUST	66	6,797	92%	2%
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	24	352	92%	8%
MIDLANDS PARTNERSHIP NHS FOUNDATION TRUST	274	23,591	92%	3%
WEST LONDON NHS TRUST	133	8,915	91%	3%
TEES, ESK AND WEAR VALLEYS NHS FOUNDATION TRUST	1,905	140,689	91%	2%
BRADFORD DISTRICT CARE NHS FOUNDATION TRUST	94	9,646	90%	6%
SOUTH WEST YORKSHIRE PARTNERSHIP NHS FOUNDATION TRUST	434	13,175	90%	5%
BARNET, ENFIELD AND HARINGEY MENTAL HEALTH NHS TRUST	746	9,095	90%	3%
LEEDS COMMUNITY HEALTHCARE NHS TRUST	50	1,125	90%	8%
SOUTHERN HEALTH NHS FOUNDATION TRUST	875	15,504	90%	6%
SURREY AND BORDERS PARTNERSHIP NHS FOUNDATION TRUST	272	9,190	90%	4%
MERSEY CARE NHS FOUNDATION TRUST	594	20,722	89%	4%
DORSET HEALTHCARE UNIVERSITY NHS FOUNDATION TRUST	344	6,648	89%	6%
CHESHIRE AND WIRRAL PARTNERSHIP NHS FOUNDATION TRUST	643	12,565	89%	7%
BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST	688	28,926	89%	6%
ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST	207	19,470	89%	5%
SOLENT NHS TRUST	215	1,940	89%	6%
LINCOLNSHIRE PARTNERSHIP NHS FOUNDATION TRUST	729	4,923	89%	2%
NORTH STAFFORDSHIRE COMBINED HEALTHCARE NHS TRUST	315	14,880	89%	5%
CAMBRIDGESHIRE AND PETERBOROUGH NHS FOUNDATION TRUST	214	2,554	88%	5%
PENNINE CARE NHS FOUNDATION TRUST	948	11,716	88%	3%
CENTRAL AND NORTH WEST LONDON NHS FOUNDATION TRUST	356	24,357	88%	4%
SOUTH WEST LONDON AND ST GEORGE'S MENTAL HEALTH NHS TRUST	536	20,382	88%	7%
CUMBRIA, NORTHUMBERLAND, TYNE AND WEAR NHS FOUNDATION TRUST	545	34,894	88%	5%
LANCASHIRE & SOUTH CUMBRIA NHS FOUNDATION TRUST	1,391	41,861	88%	8%
ISLE OF WIGHT NHS TRUST	47	2,487	87%	4%
LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST	177	7,317	86%	7%
KENT AND MEDWAY NHS AND SOCIAL CARE PARTNERSHIP TRUST	675	14,217	86%	4%
NORTHUMBRIA HEALTHCARE NHS FOUNDATION TRUST	64	829	86%	5%
CAMDEN AND ISLINGTON NHS FOUNDATION TRUST	234	1,693	85%	6%
TAVISTOCK AND PORTMAN NHS FOUNDATION TRUST	55	3,058	85%	2%
SOUTH LONDON AND MAUDSLEY NHS FOUNDATION TRUST	410	38,395	85%	4%
AVON AND WILTSHIRE MENTAL HEALTH PARTNERSHIP NHS TRUST	553	6,031	85%	4%
SUSSEX PARTNERSHIP NHS FOUNDATION TRUST	123	14,282	85%	4%
GREATER MANCHESTER MENTAL HEALTH NHS FOUNDATION TRUST	633	25,100	84%	11%
SOMERSET NHS FOUNDATION TRUST	12	7,841	83%	17%
LIVEWELL SOUTHWEST	229	2,192	82%	5%
BIRMINGHAM AND SOLIHULL MENTAL HEALTH NHS FOUNDATION TRUST	401	18,420	82%	10%
GLOUCESTERSHIRE HEALTH AND CARE NHS FOUNDATION TRUST	157	1,391	82%	7%
NORTH EAST LONDON NHS FOUNDATION TRUST	635	6,780	81%	8%
HERTFORDSHIRE PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST	708	11,853	81%	9%
NORFOLK AND SUFFOLK NHS FOUNDATION TRUST	280	27,457	78%	16%
EAST LONDON NHS FOUNDATION TRUST	551	34,131	78%	11%
OXLEAS NHS FOUNDATION TRUST	822	17,689	78%	8%
NOTTINGHAMSHIRE HEALTHCARE NHS FOUNDATION TRUST	98	13,833	73%	17%
LEICESTERSHIRE PARTNERSHIP NHS TRUST	479	11,762	68%	23%
CORNWALL PARTNERSHIP NHS FOUNDATION TRUST	71	4,778	48%	32%

Data source: https://www.england.nhs.uk/publication/friends-and-family-test-data-july-2023/

Appendix 1

Statistical Process Control Chart (SPC) Guidance

Example SPC chart:



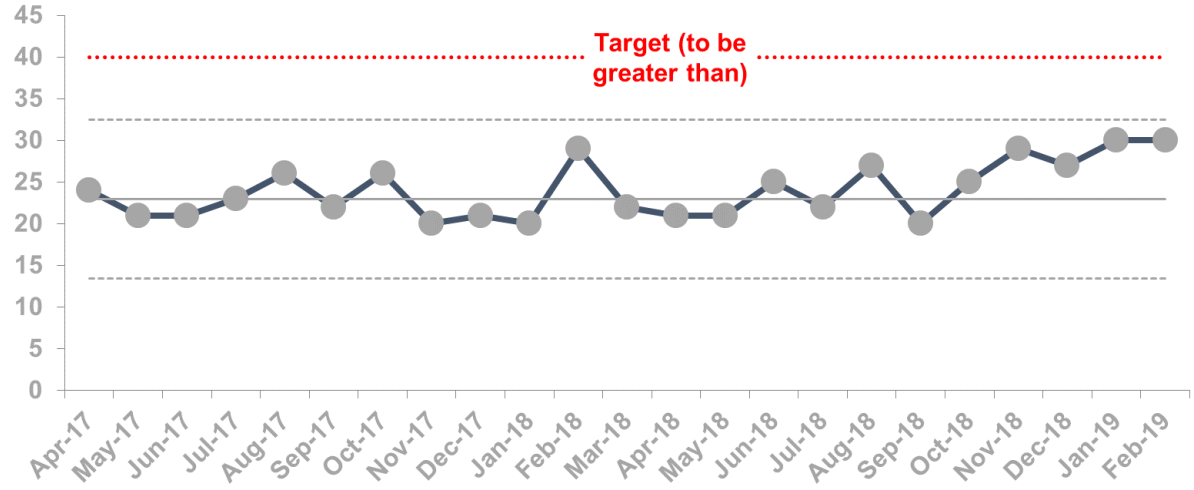
- The red line is the target.
- The grey dots are the actual performance each month. They are coloured grey as performance each month is normal in this example.
- The solid grey line is the average (mean) of all the grey dots.
- The grey dotted lines are called process limits, or control limits.

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

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

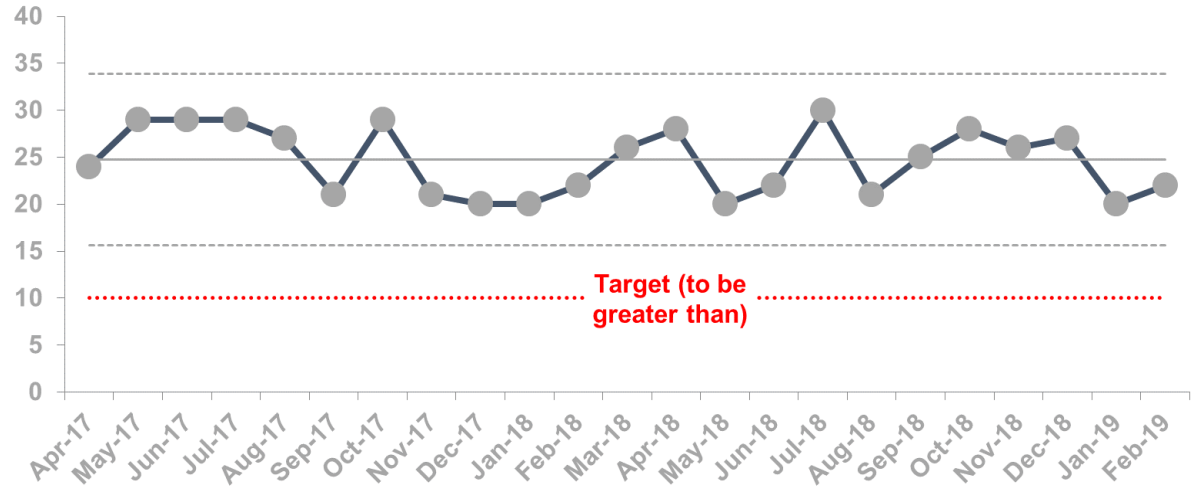
Things to look out for:

1. A process that is not working



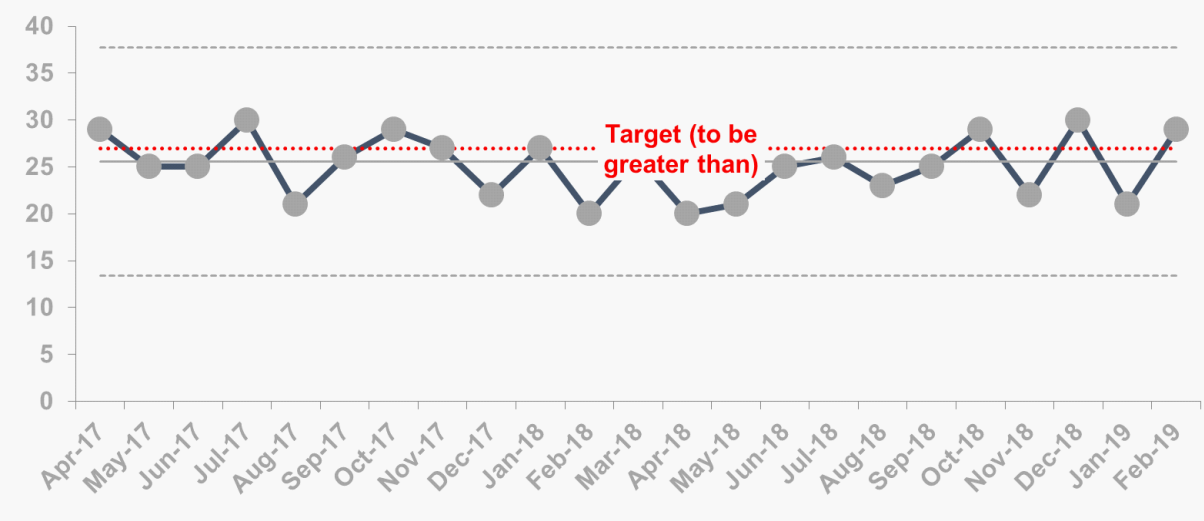
In this example the target is higher than the upper dotted grey line. This means that the target will never be achieved. To achieve the target, we need to change how we do things.

2. A capable process



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

3. An unreliable system

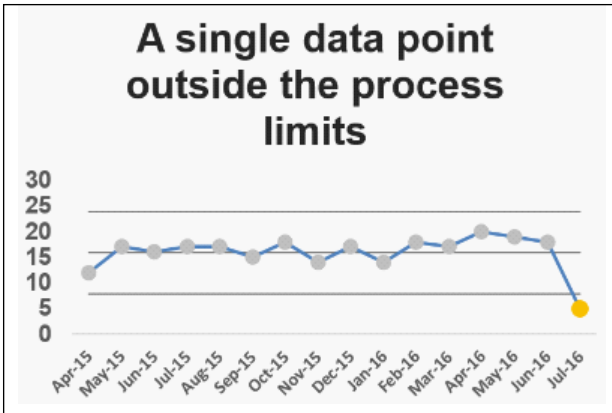
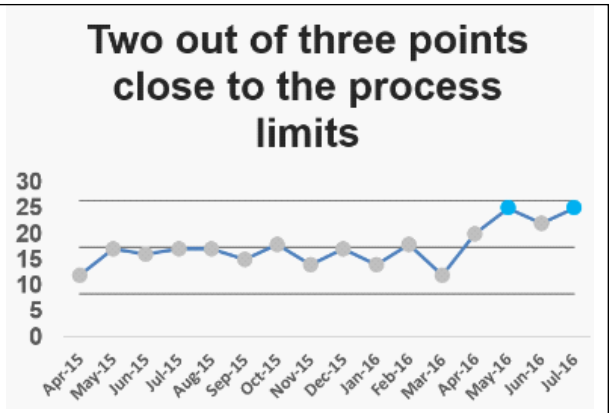


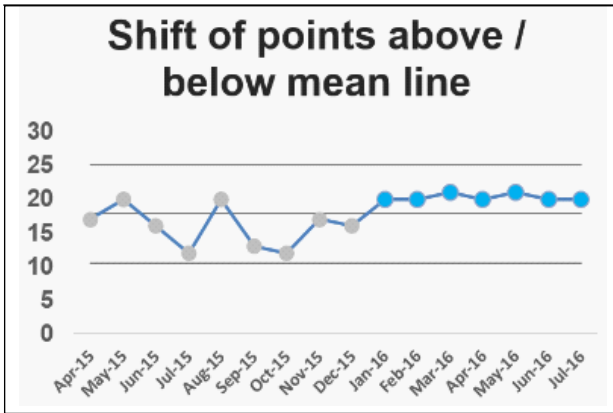
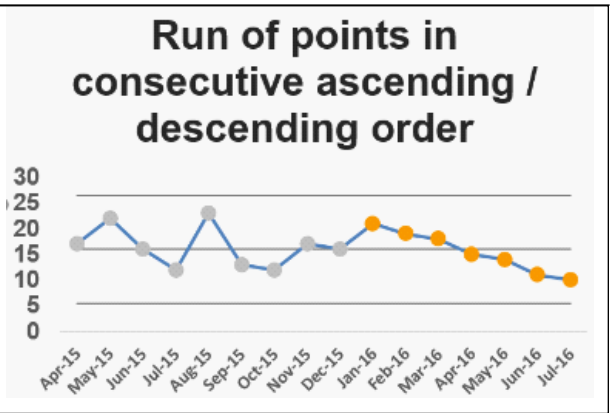
In this example the target line sits between the 2 grey dotted lines. As it is normal for the grey dots to fall anywhere between the 2 dotted grey lines, this means that it is entirely random as to whether or not the target will be achieved. So, this system is unreliable and needs to be redesigned if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

4. Unusual patterns in the data

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

There are four scenarios where this can happen:

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

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

Frequently seen in the NHS:

"Spuddling" - To make a lot of fuss about trivial things, as if they were important.

Spuddling leads to tampering and tampering nearly always increases variation.

Sometimes the first and most important thing we need to react to is the degree of variation in a process.

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

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

CQC Inspection Assurance Update

Purpose of Report

To provide an update on actions taken in relation to the CQC's unannounced focussed inspection of Ward 35, Radbourne Unit, and to determine a level of assurance in respect of progress of improvement works to date.

Executive Summary

The report highlights a recent inspection carried out by the CQC on ward 35 at the Radbourne unit, during which concerns were highlighted in relation to several areas of patient experience and quality including the ward environment, the use of restrictive practice, informing people of their rights, care planning and risk assessment.

The Trust has taken immediate action in response to these concerns and providing appropriate levels of assurance to the CQC in relation to the specific concerns identified during their inspection.

In addition to this immediate response, the Trust has also taken action to review its current governance and assurance frameworks, in order to ensure robust processes are in place to identify and address patient experience and quality concerns.

In addition, the findings of the ward 35 inspection have been addresses throughout all inpatient wards, to ensure that learning is shared and that assurance in relation to patient safety is established.

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

The paper focuses on the reduction of risk across all clinical areas of the Trust through the review and improvement of governance processes linked to CQC actions and service improvements. The report highlights recently completed actions, along with ongoing work to further improve patient experience and patient safety and the structures around them to ensure a high level of assurance, continuity and sustainability.

Consultation

- Director of Nursing and Patient Experience
- Deputy Director of Nursing
- Chief Operating Officer
- Medical Director

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 & 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:

- Individuals with Mental Health issues have a higher mortality rate, compliance with essential monitoring is a clinical necessity to impact upon this outcome.

Recommendations

The Board of Directors is requested to:

1) Review the report in line with the recent CQC inspection
2) To determine a level of assurance from the report

Report prepared and presented by:

Ade Odulande
Chief Operating Officer

Arun Chidambaram
Medical Director

Dave Mason
Interim Director of Nursing and Patient Experience

Kyri Gregoriou
Deputy Director of Nursing and Quality Governance

CQC Inspection Assurance Update

On 20 to the 21 of September 2023, the CQC completed an unannounced focused inspection on ward 35 at the Radbourne Unit.

The visit was in response to a previous Mental Health Act Visit to ward 35 on the 5 September, where concerns relating to the quality of care being provided were highlighted.

As a result of this focused inspection, 11 “must do’” actions and 13 “should do’” actions were identified by the CQC, who requested that the Trust respond and provide assurance that the ward had been made safe, that people received the right care and treatment, and that appropriate measures were taken to provide assurance.

The areas of focus within the Ward 35 inspection, related to areas such as the ward environment, the use of restrictive practice, informing people of their rights, care planning and risk assessment.

Since the inspection, the Trust has completed 5 of the 11 “Must do” actions and 11 of the 13 “should do’” actions.

Where actions have been identified as not complete, all actions to ensure patient safety have been completed, however, actions have not been signed off as completed due to the need for further evidence of embeddedness and sustainable assurance.

For some actions, further developmental work quality improvement is required to ensure that new processes are meeting the required improvements and that staff are fully aware of the change in practice. Such improvements include revisions to the handover process and also debriefs.

The Trust is currently revising the initial quality improvement plan in light of the publication of the CQC’s final report and is reviewing completed actions to ensure ongoing sustained improvements and to ensure that the quality and sustainability of evidence is of a high standard.

Following the CQC inspection and immediate feedback, immediate improvements were made. Furthermore, an immediate review of all inpatient wards was also carried out in line with the findings, to ensure care was on all wards, met the expected standards, in line with patient safety and the Key Lines of Enquiry. A learning lessons approach has been taken to ensure a high level of patient care is imbedded across all wards within the Trust, with clear triangulation processes linking together patient safety, patient experience and risk. To reduce the risk of near misses, the Trust has also taken the same approach within community team settings, where assurance processes linked to the recent inspection are being implemented.

As a result of the findings, a review of all processes linked to CQC and Quality are underway to ensure completion of actions with robust continuity and oversight. The

Trust recognises that there remain some improvements to be made, however, is assured through current governance and assurance structures that services are safe for patients. Key actions have been taken in order to be assured and for oversight at all levels. Core governance structures have been reviewed, to ensure learning, improvement and sustainability are clearly monitored at all levels within the Trust with a route to board and back to front line staff. Responsibility and accountability of roles has also been reviewed and is being communicated to people to ensure clear understanding and robust leadership.

Existing CQC actions from both formal, MHA and internal mock inspections have all been reviewed within current governance structures. Within these groups, oversight, challenge and support are continuous with clear outcomes and action being allocated.

Moreover, service line improvement plans are under development with clear routes into the Divisional Assurance Reviews. Clear timeframes of completion and escalation to Trust Operational Oversight Leadership Group and Executive Leadership Team Group are also part of the improvements to ensure appropriate pace, with clinical quality teams supporting to ensure sustainable plans are in place and where appropriate quality improvement tools are being utilised.

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

Making Room for Dignity Programme progress update

Purpose of Report

This report is to update the Board of Directors and provide assurance with progress on the Making Room for Dignity (MRfD) Programme.

Executive Summary

The MRfD Programme has three aims, to:

- eradicate dormitory wards for adult inpatient mental health provision;
- eradicate mixed age group wards for adult inpatient mental health provision; and
- eradicate the use of inappropriate Out of Area Psychiatric Intensive Care Unit (PICU) beds

through delivery of six interdependent projects, phased over the next two years.

Refurbishment of the Bluebell Ward at Walton Hospital, Chesterfield, commences this month, to provide a purpose designed 12-bed facility for older adults. Stepnell Construction will complete the refurbishment in July 2024 and the unit will go-live in August 2024, completing the eradication of mixed-age group wards.

70% of the dormitory eradication is delivered through the two new build adult acute units: the Derwent Unit in Chesterfield and the Carsington Unit in Derby. IHP have made significant progress with both buildings, with an expectation that both units will be watertight before the end of the month, protecting the internal fit out of the units from the winter weather. Both units are due to go-live in November 2024.

The refurbishment of Ward 32 at the Radbourne Unit commences this month, to provide a 17-bed ward for female service users with single ensuite rooms. Kier will complete this complex refurbishment in February 2025, with the service going live March 2025. This means that 89% of dormitories will be eradicated by end of next financial year, with the final 17-bed ward at the Radbourne Unit completing in March 2026 and going live April 2026.

Eradicating the use of inappropriate out of area specialist beds is delivered through the refurbishment of Audrey House as an 8-bed Enhanced Care Unit and the building of Kingfisher House, a 14-bed Psychiatric Intensive Care Unit, both on the Kingsway site in Derby. The Audrey House refurbishment will be completed by our construction partners Arden FES within the next 8-weeks with the specialist service going live November 2024. IHP are building Kingfisher House adjacent to the Carsington Unit, with a build completion date of November 2024 and go-live March 2025.

A ‘branded’ recruitment programme has been developed for the additional clinical staff required for the new and refurbished units. There are 27 wte additional posts that need to be recruited in this financial year and, in addition to these, the recruitment team have been actively recruiting to existing vacancies. The majority of the MRfD additional clinical posts, 204 wte (whole time equivalent), will be recruited

next financial year in advance of the units opening.

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

- Construction contracts for the AAUs and PICU were signed in April 2023.
- Construction contract for Bluebell Ward signed October 2023.
- Construction contract for Ward 32 signed November 2023.
- The capital construction costs are fully funded, with a number of cost pressures resulting from hyperinflation in construction market material costs, and cashflow, being managed by the MRfD Programme Delivery Team.
- The Programme Delivery Team continue to pursue VAT abatement for the three new build construction projects.

Consultation

- There is a ‘Making Room for Dignity Programme Board’ on which a Non-Executive Director sits, alongside other Trust and stakeholder colleagues, which receives regular updates, considers key programme issues and receives updates from the associated workstreams in the programme.
- Engagement in the programme activities are well developed and embedded into the Programme with our EQUAL patient and carer representation group advising on building design and equipment.
- The project team meet with local, regional and national NHSEI colleagues on a regular basis and will continue to do so for the life of the Programme.

Governance or Legal Issues

Completion of the MRfD Programme projects is fundamental to eradiation of dormitories and eradication of inappropriate out of area specialist placements, both of which are regulatory requirements by the CQC and NHS England policy.

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:

Ensuring that Equality, Diversity and Inclusion (EDI) benefits are well thought-out and securely delivered in this wide-ranging programme of work will maximise the overall benefits to patient experience and outcomes and will be included throughout the programme.

EDI stakeholder engagement / inclusion in the programme activities are well developed and embedded into the Programme with our EQUAL patient and carer representation group and a dedicated People Division Lead for the Organisational Development and Change Management elements of the Programme.

Inclusion factors to take into account include, but are not limited to, those relating to:

- gender-related benefits or dis-benefits, including those for people with trans and non-binary gender identities
- physical and other disabilities; benefits or dis-benefits in accessibility, outcomes and/or experiences
- autism-friendly environments
- supporting religious or belief activities within inpatient facilities
- challenging hetero-normative assumptions in design and service delivery
- maximising the opportunity for new and flexible working considerations in transformational planning and service delivery.

Actions to Mitigate/Minimise Identified Risks

- Involvement of service users and EDI representation has helped ensure the Programme Delivery Team consider inclusion risks and consider how best to take action to mitigate them.
- Each project within the Programme has a detailed EQIA completed which has been reviewed and accepted by the JUCD EQIA panel with regular reviews for each scheduled in.

Recommendations

The Board of Directors is requested to note the progress to date and assurance on delivery of the MRfD Programme.

Report presented and prepared by:	Andy Harrison Senior Responsible Owner Acute Care Capital Programme

Making Room for Dignity

NHS
Derbyshire Healthcare
NHS Foundation Trust

Making Room for Dignity

Programme Update November 2023

DHCFT @derbyshcft
www.derbyshirehealthcareft.nhs.uk

Making a positive difference

Making Room for Dignity Programme

Background

The MRfD Programme has three aims, to:

- ❑ **eradicate dormitory wards for adult inpatient mental health provision**
- ❑ **eradicate mixed age group wards for adult inpatient mental health provision**
- ❑ **eradicate the use of inappropriate Out of Area PICU beds.**

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Making Room for Dignity Programme

Eradicate dormitory wards:

- Derwent Unit in Chesterfield
- Carsington Unit in Derby
- Both AAUs: 54-bed single ensuite rooms
- Significant progress by IHP since last update
- Both units will complete autumn 2024
- Units will go-live in November 2024

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Making Room for Dignity Programme

Eradicate dormitory wards:

Making Room for Dignity

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Making Room for Dignity Programme

Eradicate dormitory wards:

Making Room for Dignity

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Eradicate dormitory wards:

- **Refurbishment of Ward 32, Radbourne Unit**
- **Kier construction partner**
- **Commences November 2023**
- **Completes February 2025 / go-live March 2025**
- **89% of dormitories eradicated at this point**
- **Final 17-bed ward: completes March 2026 and goes live April 2026.**

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Eradicate mixed age group wards:

- ❑ Refurbishment of Bluebell Ward
- ❑ Purpose designed facility for older adults
- ❑ Stepnell Construction refurb partner
- ❑ Commences November 2023
- ❑ Refurbishment completes July 2024
- ❑ Unit goes live in August 2024

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Eradicate use of Out of Area PICU beds:

- ❑ Refurbishment of Audrey House
- ❑ Purpose designed enhanced care unit
- ❑ Arden FES construction partner
- ❑ Refurbishment completes December 2023
- ❑ Unit will go-live in November 2024

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Eradicate use of Out of Area PICU beds:

- ❑ Kingfisher House
- ❑ Purpose designed 14-bed PICU
- ❑ IHP construction partner
- ❑ Build completes November 2024
- ❑ Unit will go-live in March 2025

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- Older Adults – Bluebell Ward
- Derwent Adult Acute Unit (Chesterfield)
- Carsington Adult Acute Unit (Kingsway)
- Radbourne Unit: Ward 32
- Radbourne Unit: Ward 35
- Audrey House – Enhanced Care Unit
- Kingfisher House - Psychiatric Intensive Care Unit

Go-Live	Dorms Eradication
Aug 2024	29% (100% OAs)
Nov 2024	40%
Nov 2024	78%
Mar 2025	89%
Apr 2026	100%
	Specialist Services
Nov 2024	36% (F)
Mar 2025	100% (M)

Making Room for Dignity

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Making Room for Dignity Programme

Role	Number
Student Nurse (employed)	6 qualified in March 23 18 currently employed 8 to qualify in March 24 1 Return to practice
University Student Nurses	22 recruited in 2022 31 offered jobs 2023 (5 still in discussion)
Registered Mental Health Nurse	8 recently recruited for Pleasley Ward 3 starting Jan – March 23 5 starting in September
Nurse Apprentice	1
Trainee Nurse Associates	7 current 1 qualified March 23 5 due to qualify Sept 23 9 starting 2023
Registered General Nurse	1 at the Hartington Unit
Healthcare Support Worker Apprentice	1

Making Room for Dignity

Making a positive difference

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

Position Statement - CQC “Safe” domain

Purpose of Report

To review our approach to improving safety against the national NHS Patient Safety strategy published in July 2019 and offer an update again CQC domains on safety.

Executive Summary

The Medical Director offers his reflections on the essential requirements to achieve the highest safety standards and the Trust Board’s role in this.

These reflections are then linked to the foundations of the National Patient Safety Strategy which is based on two foundations:

- Patient safety culture
- Patient safety systems

The strategic aims of Insight, Involvement and Improvement are linked to a number of commitments for the Trust and local systems which are reviewed.

Finally, there is a stocktake giving an overview of current safety issues in our Trust against the safety domain as assessed by CQC.

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.	

Assurances

Timing constraints unfortunately resulted in the paper coming to the Trust Board without a review at the Quality and Safeguarding Committee.

Consultation

This paper has been discussed at the Executive Leadership Team and with safety leads within the Trust.

Governance or Legal Issues

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

Public Sector Equality Duty and Equality Impact Risk Analysis

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

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

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

Recommendations

The Board of Directors is requested to:

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

Report presented by: Dr Arun Chidambaram
Medical Director

Report prepared by: Dr Arun Chidambaram
Medical Director

Position Statement - CQC “Safe” domain

The purpose of this document is to provide a position statement with regards to patient safety with a focus on CQC “ Safe” domain.

The document outlines:

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

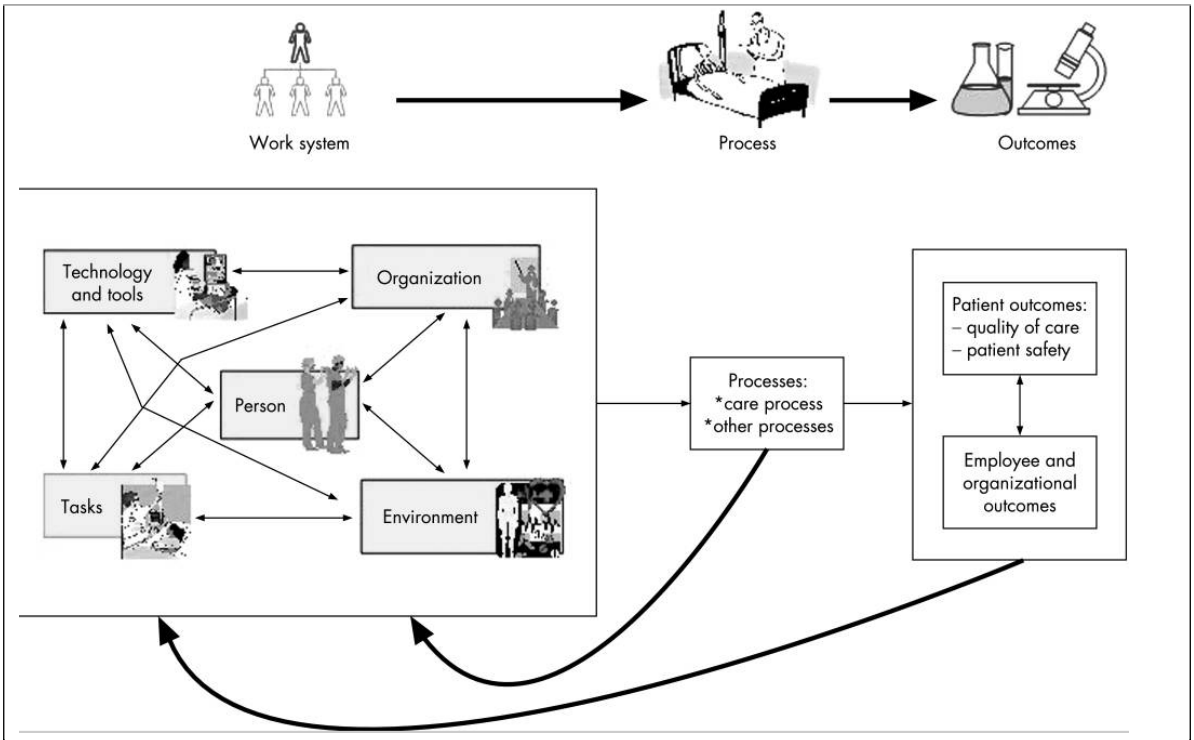
Introduction

Patient safety has evolved significantly over the past two decades. The significant shift away from Root Cause Analysis is a good example of that positive shift. Safety 2.0 focusses on forward learning rather than retrospective learning that arises from things that have gone wrong already.

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

- A clear sense of “mission” (*Foundation: Patient Safety Culture)*
  For every member of staff to understand what Great Care – A Great Place to Work – Best Use of Money means for their role and to have this reflected in their appraisal including an individual and team commitment to Quality Improvement. We will build on this mission by developing an overarching clinical strategy.

- An integrated approach (*Foundation: Patient Safety System)*
  For each part of the service to understand that their decisions and actions influence other parts of the service (including those outside the Trust) and vice versa. This is an essential part of the new patient safety strategy that relies on systems thinking and refers to SEIPS model. (Systems Engineering Initiative for Patient Safety). Whenever there is an opportunity to design/redesign a new process/ structure, we make sure that safety is embedded within the design. Our new build is a good example of how we have been implementing this.



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

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

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

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

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

- A compassionate Just Culture (*Foundation: Patient Safety Culture)*

  Our Trust was an early adopter and a pilot site for the new Patient Safety Incident Framework. We have now commissioned human factors training and will be delivering training for staff that is commensurate to their role. Implementing a just and learning culture approach will be an essential and vital follow-up to the implementation of Patient Safety Incident Review Framework. Any outputs from the PSIRF would benefit from Just culture approach.

Just and Learning Culture framework

Distinguishing Causality vs Contribution

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

  We have set up learning lessons groups and this has helped to embed standardised way of responding to patient safety themes. There is more work to be done in assuring that practice changes arising from patient safety learning is fully embedded.
- Outcomes *(Strategic Aim: Improvement)*
  These need to be SMART and related to the dynamics described above.

The foundations of the National Patient Safety Strategy

The Trust's approach to patient safety will build on the National Patient Strategy published in July 2019. The national strategy is based on two foundations: a patient safety culture and patient safety systems and there is a clear link between these and what the Trust's Medical Director considers are essential areas for development of safety standards in the Trust.

Foundation 1: Patient safety culture

Fear of blame is a significant barrier in achieving patient safety, so psychological safety is key to unearth the learning, where there is a good and transparent discussion about what went wrong and how it can be improved. Most often these discussions focus on " who is wrong" which perpetuates fear.

Though there are national initiatives and guidance (just culture guide by NHSE), there is a need to create local frameworks. The just culture framework described in the previous section is for our own organisation. This is shared with new starters during their induction on a session about compassionate leadership.

Foundation 2: Patient safety system

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

- Workforce

Our Trust is focussing on recruitment and retention – we have appointed Alex Dougall as recruitment lead for our Trust. There are a number of staff well-being initiatives. Our “People First” value is something our staff are proud of and is embedded.

- Regulation

A shared understanding of safety across all regulatory organisations (i.e. the Health and Care Professions Council, Nursing & Midwifery Council, General Medical Council, Medicines and Healthcare Products Regulatory Agency and Care Quality Commission) will be crucial to maintain an effective safety system and safety culture. Earlier this month, we launched a “just culture” pilot with GMC.

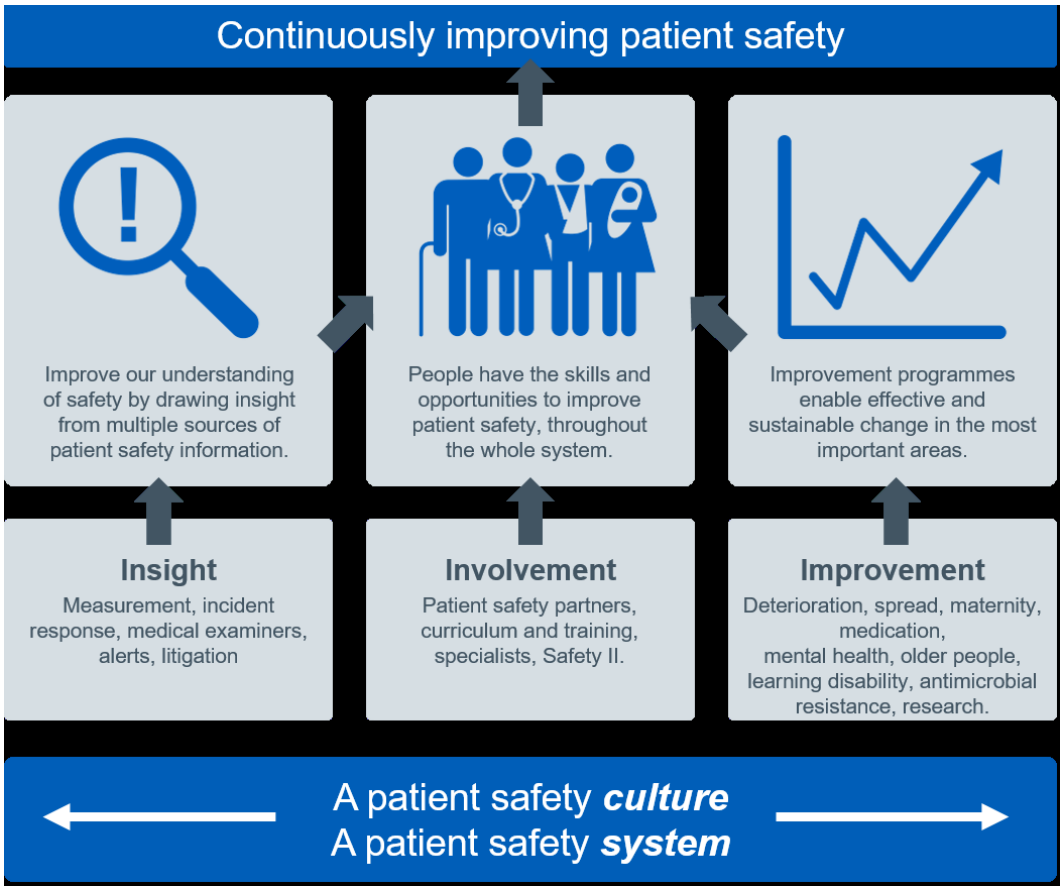
- Digital technology and information sharing
  Data protection and security, electronic patient records, electronic prescribing and patient access to records are key to effective communication. We have reached an agreement to share key components of our patient information with our ICB to promote information sharing. Electronic prescribing is now live and further work is ongoing in terms of optimising its use.

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

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

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

Summary of the NHS Patient Safety Strategy



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

3.1 Insight

The NHS will:

- Adopt and promote key safety measurement principles and use culture metrics to better understand how safe care is:
    - We are setting up a new group to triangulate safety incidents and ER activity to ensure that actions required are implemented without delays. This will be under the leadership of our Deputy Director of Nursing and Quality Governance.
- Use new digital technologies to support learning from what does and does not go well, by replacing the National Reporting and Learning System with a new safety learning system:
    - The Learn from Patient Safety Events (LFPSE) service is a new national NHS service for the recording and analysis of patient safety events that occur in healthcare which will replace both the National Reporting and Learning (NRLS) and Strategic Executive Information System (STEIS) reporting systems. The service introduces a range of innovations to support the NHS to improve learning from the over 2.5 million patient safety events recorded each year, to help make care safer. LFPSE is currently being introduced across

the NHS as organisations switch to recording patient safety events onto the new LFPSE service, rather than the National Reporting and Learning System (NRLS) and Strategic Executive Information System (StEIS) it is replacing. Due to technical difficulties of how DATIX and the new system work together many NHS organisations have been unable to implement the change in accordance with the rollout deadline of October 2023. Organisations have been working in unison with DATIX to resolve the issues and revised software is expected mid-October 2023 which will then be tested by the Risk Management team to ensure the system is safe to go live internally. This means that for a period of approx. 6 weeks the Trust like many others may be in a position of breaching reporting requirements of the NHS Contract should the NRLS system fail however it has been confirmed that no provider will face sanctions as a result. Should the NRLS fail then the trust board will be made aware, and the Risk Management team will conduct manual uploads in relation to Major and Catastrophic Incidents to LPSE online , however all other gradings will be batch uploaded once the software issues have been resolved.

- Introduce the Patient Safety Incident Response Framework to improve the response to and investigation of incidents - This is now embedded in terms of the framework for investigations. Further work is currently underway in terms of other aspects – human factors training.

- Implement a new Medical Examiner system to scrutinise deaths – The roll out for Mental Health Trusts is delayed.

- Improve the response to new and emerging risks, supported by the new National Patient Safety Alerts Committee – We have a Trust process to cascade the alerts to the relevant services.
- Share insight from litigation to prevent harm. – This information will be shared with Quality and Safeguarding Committee in a meaningful way to supplement learning.

3.2 Involvement

The NHS will:

- Establish principles and expectations for the involvement of patients, families, carers and other lay people in providing safer care- Carers are involved in drafting Terms of Reference for patient safety investigation and they are consulted throughout the process of investigations. Family liaison role has made a qualitative and quantitative difference to family involvement. However, funding constraints has meant that we could not continue of provide the same capacity for family liaison.
- Create the first system-wide and consistent patient safety syllabus, training and education framework for the NHS – Training programme for our Trust is finalised and there are some operational challenges in rolling out this extensive training to the required staff. We will undertake a targeted approach as capacity will be an ongoing challenge.

- Establish patient safety specialists to lead safety improvement across the system – our Trust patient safety lead also delivers the function of patient safety specialist. There is a need to have this specialism across the system alongside the need for a system wide peer group to share learning across the system.
- Ensure people are equipped to learn from what goes well as well as to respond appropriately to things going wrong. – Within the Trust we share learning from what went well and celebrate good practice in terms of maintaining patient safety, but there is still an ongoing culture within NHS to focus on the adverse events.
- Ensure the whole healthcare system is involved in the safety agenda. - The Health Safety Investigation Bureau has been relaunched and hopefully it will plug some of the gaps in the system space.

3.3 Improvement

The NHS will:

- Deliver the National Patient Safety Improvement Programme, building on the existing focus on preventing avoidable deterioration and adopting and spreading safety interventions – we continue to engage in the regional programmes delivered on a MH provider footprint. Key programmes are sexual safety and suicide prevention.
- Deliver the Maternity and Neonatal Safety Improvement Programme to support reduction in stillbirth, neonatal and maternal death and neonatal asphyxial brain injury by 50% by 2025.
- Develop the Medicines Safety Improvement Programme to increase the safety of those areas of medication use currently considered highest risk.
- Deliver a Mental Health Safety Improvement Programme to tackle priority areas, including restrictive practice and sexual safety.
- Work with partners across the NHS to support safety improvement in priority areas such as the safety of older people, the safety of those with learning disabilities and the continuing threat of antimicrobial resistance.
- Work to ensure research and innovation support safety improvement.

Outcomes

The Mental Health Safety Improvement Programme (MHSIP) was launched on 10 May 2021. This aims to reduce national variation in the following areas by 2024. Key ambitions are:

- Reduction in suicide and deliberate self-harm in inpatient settings (MH and acute hospitals) and in the healthcare workforce. (We have commissioned an external review of inpatient deaths that have occurred in the last quarter. We will be appointing a Trust suicide prevention lead – the new role will have both operational and strategic aspects)

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

- Improve the sexual safety of patients and staff on inpatient mental health units. (There has been a recent focus on training relevant to promoting sexual safety that includes aspects of safeguarding)

Context for patient safety in DHCFT

Safety Stocktake

The focus around the CQC's Safety KLOEs will continue and cover many of the areas already mentioned above. The additional commitment required by the national strategy related to safety issues that affect older people (e.g. falls prevention, pressure sore prevention, use of frailty index) and people with learning disabilities (e.g. STOMP/STAMP, Care and Treatment Reviews) will need an enhanced focus on reporting but are already the subject of significant quality improvement work.

The CQC Key Lines of Enquiry are as follows and are subject to regular reporting to Board Committees:

KLOE 1 – Safeguarding Adults and Children
Our Trust staff compliance with training requirements is monitored by Board Committees. Generally the feedback from patient safety investigations is that our practice standards are good.

KLOE 2 – Managing Staffing Risks

KLOE 3
(a) Electronic Patient Record
System One is fully implemented, however the optimisation continues. Leadership capacity is an ongoing issue.
(b) Data Security
Our compliance in training is exemplary. We are also involved in horizon scanning and implement proactive measures in terms of cyber-security risk.
(c) Care Planning
This is an area where our teams need ongoing support
(d) Transition from Child and adolescent mental health services CAMHS

KLOE 4
(a) Medicines Management
(b) Physical Healthcare

KLOE 5
(a) Infection Control
(b) Safety Planning and Risk Assessment
(c) Restrictive Interventions

KLOE 6

(a) Learning from Deaths
We continue to explore ways of improving learning from deaths.

(b) Emergency Preparedness, Resilience and Response (EPRR)
We have dealt with response to Industrial Actions through our EPRR framework.

The following were highlighted in Joined Up Care Derbyshire, before the Covid pandemic, as commissioning gaps that were impacting upon the Trust's patient safety:

- CAMHS – this is identified as a fragile service within our ICB and appropriate system interventions are being explored in partnership with our Trust leads.

- Adult eating disorder service – this service has been managing significant complexity over the last year and its resilience is currently being stretched. We have requested support from Provider Collaborative as the expertise lies beyond the boundaries of ICB.

- There is no pathway for Adult ADHD and Adult Autism Spectrum Disorder. Currently a working group is exploring options to set this up in Derbyshire ICB, supported by our Director of Strategy, clinical leads, ICB lead and Medical Director.

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors - 7 November 2023

Board Assurance Framework (BAF)
Issue 3, 2023/24 – Version 3.3

Purpose of Report

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

Executive Summary

Executive Director Leads, Deputy Directors, Operational Leads and Trust Senior Managers have reviewed the risks and provided comprehensive updates. Issue 3 (version 3.1) was reviewed by the Executive Leadership Team (ELT) on 4 October 2023 and version 3.2 was approved at Audit and Risk Committee on12 October.

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***

Four new key gaps in control and associated actions were added by the previous Director of Nursing:

- *Clinical improvement in the current use and transformation of Care Programme Approach (CPA), to support safe community practice*
- *Clinical improvement in the current practice standards for new mental health in-patient standards released by NHS England*
- *Review of the new Major Conditions Strategy and Suicide Prevention Strategy for England: To consider a reset of the Trust Strategy*
- *Review of Patient Carer Race Equality Framework and develop implementation plan*

The Quality and Safeguarding Committee requested a further review of these by the Interim Director of Nursing, to add to the actions to close the gaps in control – The updates have been shared with the Audit and Risk Committee and are included in version 3.3 for Board.

Risk 1B – ***There is a risk that the Trust does not deliver key regulatory and strategic requirements related to dormitory eradication and PICU and that the Trust estate more generally is not maintained sufficiently well to comply with regulatory and legislative requirements***

One of the actions has an improved RAG rating, from Red to Amber, as contractors are due to commence work on site for the Older Adult service relocation in November 2023.

Risk 2A – ***There is a risk that we are unable to create the right culture with high levels of staff morale***

One of the actions to close key gaps in control has a worsened RAG rating, from Amber to Red, as there has been no movement in planned leadership development over the last quarter and there were delays in delivering the face-to-face leadership forum.

Another action has been changed from Green to Amber. This related to engagement of bank staff and whilst work has commenced on training competencies there has been no movement over the last quarter and overall the planned improvements are behind the target timeframe.

Risk 2B – ***There is a risk that we do not have a diverse workforce with the right number of people with the right skills to support and deliver safe high-quality care***

One action has an improved RAG rating, going from Amber to Green as the workforce summit was held in August and the Trust workforce plan has been developed and presented to the People and Culture Committee.

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

The following key gap in controls has been closed:

- *Plan required for the development of the Mental Health Learning Disability and Autism Delivery Board (MHLDA DB) to become a provider alliance.*

MHLDA Provider Alliance formally established partnership agreement and a Joined Up Care Derbyshire (JUCD) Neurodiversity and Learning Disability Alliance Festival was formally launched in September 2022.

An additional key gap in controls has been identified and was added following ELT review:

- *Internal ICB capacity changes to achieve revised expenditure requirements in 20023/24 and 2024/25 may impact on capacity and capability to deliver key deliverables such as system planning, and programmes of transformation*

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***

Two of the actions to close key gaps in controls have an improved RAG rating, both going from Red to Amber because:

Data reviews show significant improvement the flow of patients through IST to support admission avoidance and early discharge

An overall quality plan for improvement for LD&A inpatients including out of area in place has been developed following review by ICB quality team.

Operational Risks – There are four Trust-wide operational risks rated as high/extreme linked to the Trust strategic objectives. One of the operational risks previously linked to Risk 1A, relating to anti-ligature clothing and mattresses, has been removed from the BAF report as the Risk Handler has re-assessed the rating as moderate.

BAF Reporting Cycle/Format – All changes/updates to this issue of the BAF, compared with Issue 2 2022/23, are indicated by blue text. All text that has been stricken through will be removed from the next issue.

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

Risks and Assurances

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

Consultation

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

Formal Reviews:

- Executive Leadership Team, Issue 3.1: 04.10.23
- Audit and Risk Committee, Issue 3.2: 12.10.23

Governance or Legal Issues

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

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

Recommendations

The Board of Directors is requested to:

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

Report presented by: Justine Fitzjohn
Trust Secretary

Report prepared by: Kel Sims
Risk and Assurance Manager

Board Assurance Framework 2023/24 – Issue 3.3 Board October 2023

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

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

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

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

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

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

Root causes:

a) Workforce supply and lack of capacity to deliver effective care across hotspot areas, increasing risks in the clinical and medical workforce
b) Risk of substantial increase in clinical demand in some services
c) Changing demographics of population and substantial impacts of inequality within the deprived wards of the city and county
d) Intermittent lack of compliance with Care Quality Commission (CQC) standards specifically the safety domain
e) Lack of embedded outcome measures at service level
f) Known links between Serious Mental Illness (SMI) and other co-morbidities, and increased risk factors in population including inequality/ intersectionality, with escalating risks in alcohol consumption
g) Lack of compliance with physical healthcare monitoring in primary and secondary care, has improved but not at the required level for reductions in mortality
h) Restoration and recovery of access standards in autism and memory assessment services, due to demand
i) Lack of appropriate environment to support high quality care, i.e. single gender dormitories and PICU leading to out of area (OOA) bed use for PICU
~~j) Lack of capacity to meet population demand for community forensic team~~
k) Local NHS Trusts will offer Recruitment and Retention Premium to Consultant Psychiatrists in specialist services and other clinical staff due to competitive practices that destabilises Trust clinical services and leads to a deterioration in waiting time and potentially in safety
l) Due to the move in Electronic Patient Record (EPR) system and the transitional working arrangements there is potential that data quality could adversely affect clinical standards ~~patient safety~~
m) Violent crime in the community, sexual safety incidents and youth violent crime all increasing in Derby and Derbyshire
n) Health inequalities across the Derbyshire footprint. Initial insights show gaps in access to service, case load and worsening patient outcomes for our patients
o) Sustained pressure in the crisis and acute care pathway with bed occupancy over 85% and increased waiting time for patients to access bedded care from the community
p) Cost of living crisis with ~~and possible commencement of~~ post pandemic surge in June 2023. Sustained increases in referrals since January 2023, (20% addition)
q) Gaps in Advocacy for Children who are under 18. Exploration with local authority to ensure fair access to advocacy
r) Learning from other organisations in their ability to maintain adequate mortality, serious incidents and learning reviews to respond to improve practice and to also comply with the coroner's formal requirements

Board Assurance Framework 2023/24 – Issue 3.3 Board October 2023

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

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

Key Controls

Preventative – Quality governance structures, teams and processes to identify quality related issues; mandatory training; Duty of Candour processes; clinical audits and research; health and safety audits; risk assessments; physical health care screening and monitoring; monitoring and effective responses to infection and control guidance, EQUAL unannounced visits to services and anonymised bright ideas service improvement ideas. Feedback intelligence from independent advocacy, Director visits in and out of hours and Quality Visits

Detective – Quality dashboard reporting; quality visit programme/virtual clinical service contact visits; incident, complaints and risk investigation; Fire Safety Regulations (FSR) compliance checks; mortality review process; physical health care monitoring clinics pilots; safety check log; Head of Nursing and Matron compliance visits, reviewed model of announced and unannounced visits to service throughout the 24-hour period

Directive – Trust Strategy and commitments; Quality Improvement Strategy; Physical Health Care Strategy; Safeguarding Strategy; Suicide Reduction Strategy; clinical strategies; policies and procedures available via Trust intranet; Central Alerting System (CAS) alerts; Risk Management Strategy; clinical sub committees of the Quality and Safeguarding Committee

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

Key gaps in control	Key actions to close gaps in control	Impact on risk to be measured by	Expected completion date (Action review date)	Summary of progress on action	Action on track

Inability to complete physical health checks for patients whose consultations remain undertaken virtually	Improvement plan to be developed and implemented to ensure required physical health care checks are completed [ACTION OWNER: MD]	Compliance with physical healthcare checks, reported in the Quality Dashboard A 360 audit has been commissioned to review whether these improvements are embedded	~~(30.09.23)~~ (31.12.23)	Revised metrics now form part of the quality dashboard and are reported regularly to the Quality and Safeguarding Committee Implementation of coaching and self-report pilot model of care ~~in~~ underway to improve compliance and patient empowerment via the Health Protection Unit Targeted actions now in place across all service lines to improve on physical health checks ~~to improve practice with an increased focus on adult inpatient services~~ 360 Assurance audit completed, and actions implemented Quality improvement targeted work in September 2023 to improve clinical standards	AMBER
Implementation of revised priority actions for 'Good Care' which support the Trust strategy	Redesign improvement plans to align to revised building blocks which support the Trust Strategy [ACTION OWNER: DON]	Compliance with suite of metrics and reporting schedule detailed in quality dashboard	~~30.09.23~~ (31.12.23)	New strategy actions published and being reviewed in Quality Visit programme and in Divisional Achievement Reviews Progress ~~is being~~ made in recovering the five	AMBER

				essential standards. Intermittent non-compliance is a re-occurring theme exacerbated by clinical activity. Sustained improvement work continues Focused improvement work in Neurodevelopmental Services is required in September 2023 in care planning and in patient safety planning	
Insufficient investment in autism assessment and treatment services to meet demand. No commissioned treatment services Waiting time increased over COVID-19 period, exacerbated by underlying demand – ASD diagnostic waiting lists remain high	Investment required by ICS to meet assessment and treatment demands [ACTION OWNERS: COO/DSPT]	Agreed funding allocation has occurred, recruitment to posts is active	(31.12.23)	~~Mental Health Learning Disability and Autism Delivery Board (MHLDA DB) agreed additional investment in a new neuro diversity diagnostic pathway. Investment included in 2022/23 system operational plan.~~ ~~Associated recovery action plan in place (RAP) - Progress is being made at commissioned level but un-met need remains a sustained pressure over 18 weeks~~ Funding for additional investment in autism diagnostic services is no-longer available. Revised Recovery Action Plan (RAP) developed with ICB	AMBER

				in September 2023 to undertake fuller case for investment in autism offer in Quarter 2 new Specialist Well-being Navigator (SWN) service to support people with 'waiting well' has been mobilised Escalations and discussions with the MHLD AB to ensure the system is able to respond to the need of the population using current resources	
Six service areas assessed as 'Requires Improvement' by CQC in relation to safety	Develop and implement an improvement plan to enable all six service areas to reach 'Good' for safety in relation to the CQC standards [ACTION OWNER: DON]	CQC inspection and assessment	~~(30.09.23)~~ (31.12.23)	Significant improvement in all services 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~~ are identifying ~~identified~~ areas of action ~~for each team~~ Three CQC actions remain open due to intermittent compliance	AMBER
			~~(30.09.23)~~		AMBER

Gap in operating standards for acute and community mental health services	Enhanced monitoring of acute and community mental health services by the Nursing and Quality Directorate [ACTION OWNER: DON] Implement Royal College of Psychiatrists (RCP) Standards across Acute Services [ACTION OWNERS: MD/DON/COO] Implement Community Mental Health Framework [ACTION OWNER: DSPT]	Improvement in operating standards compliance. To be confirmed by external CQC inspection and assessment of at least 'Good' Accreditation for Inpatient Mental Health Services (AIMS) to be completed by end of Quarter 3 2023/24 Implemented Acute Inpatient Mental Health Service Accreditation (RCP Standards) reported in Divisional Achievement Reviews and Quality Account Implemented Mental Health Community Framework to Quality and Safeguarding Committee	(31.12.23) (31.03.24) 31.03.24	Increased performance management scrutiny and unannounced site visits ~~have been~~ undertaken with compliance checks Mock inspections completed in acute services, there is support for the ~~services on the~~ areas requiring improvement Work being carried out to become accreditation ready ahead of the implementation of the shift consultation to ensure compliance with European Working Time Directive (required as part of an accreditation application) Policy and Standard Operating Procedure (SOP) for Derbyshire Living Well and Derby Wellbeing Services ~~to support with practice, delivery and governance~~ is published ~~in draft~~ Internal Trust programme Board in place to strengthen contribution and involvement in system-wide programme and delivery	

				Mobilisation underway in High Peak and Derby City. Next phase is Chesterfield and North-East Derbyshire Quarter 3 2023/24 Revised approach which entails a phased roll-out of the service model agreed and being implemented across sites Additional clinical and quality scrutiny and management support in place to support the transformation plan	
Implementation of clinical governance improvements with respect to: - Outcome measures - Clinical service reviews including reduction in excess waiting times - Getting it Right First Time (GIRFT) reviews	Develop and implement an improvement plan [ACTION OWNERS: MD/DON/COO/DSPT]	Compliance with suite of metrics and reporting schedule	~~(30.09.23)~~ (31.12.23)	NICE guideline mapping established, governance work continues ~~Agreed~~ Programme of work in place from Performance Summit continues to progress RAP Plans in place and regularly reviewed ~~focussing across four key workstreams to make improvements: Engagement; quality improvement and approach to management; review of metrics and data optimisation. All workstreams are progressing, wait times management underpinned~~	AMBER

				~~by recovery action plans have been developed and are being monitored via TOOL and the MHLDA DB~~	
Implementation of new quality priorities for: - Sexual safety - Implementing CQUINS and Clinical outcome measures - Recovering services – equally well - New Trust strategy and priorities - Dormitory eradication programme	Develop and implement an improvement plan to enable all quality priorities to be implemented [ACTION OWNER: DON]	Compliance with suite of metrics and reporting schedule	~~(30.09.23)~~ (31.12.23)	Reducing violence – Body worn camera investment in place Sexual safety – Improvement work (dashboard, preceptorship training and protocols) commenced. Sexual safety on professional standards video launched with new training Sexual safety checklist for services in design ~~Monitoring and learning from sexual safety work continues – New course on professional standards/ boundaries and sexual safety commissioned~~ Dormitory eradication programme in construction Trauma informed practice conference and work programme commenced in May 2023. Trauma lead in post for six months to develop training and strategy	GREEN

				Plan for existing dormitory stock and a plan to maintain and improve dignity for active bed stock assessed and presented to the ICB	
There is a risk that patients in our care in Derbyshire or commissioned services may receive poor care due to experiencing abuse or professional misconduct. Learning from other independent and national exposures of abuse	Revisit all assurances and scrutinise practice, gathering intelligence and implement an improvement plan to enable all services to provide the highest standard of care which would be expected [ACTION OWNERS: DON/MD]	Engagement and mobilisation of the organisation to discuss learning from recent exposes Discuss and activate colleagues to revisit what compassionate care means and actively encourage, inspire, reward – Supervision, reflective practice and asking for help Mobilise and re-emphasise expectations of standards of care and Freedom to Speak Up Revisit system and process of governance and using intelligence to take oversight of services Inspire conversations re the risks of harm and closed cultures. Reset the culture and the tone of the requirement for professional scrutiny and all employee requirements to prevent harm and report poor care/ abuse Strengthen out of hours, weekends and night announced and unannounced visits. To promote access to multiple managers, relationships, so	~~(30.09.23)~~ (31.12.23)	~~There is a~~ wide range of ~~opportunities~~ options for colleagues to have conversations about care delivery and raise concerns available, including Trust-wide and divisional engagements, Freedom to Speak Up, Schwartz Rounds Improvements in engagement of temporary staff ~~have been~~ identified Increased~~ing~~ visibility of senior staff through Quality Visits, mock CQC inspections and out of hours visits Robust oversight of patient safety incidents, concerns, complaints, and compliments with scrutiny from independent partners, e.g. Healthwatch and experts by experience being core members of Patient and Carer Experience Committee	AMBER

		colleagues feel empowered to report any concerns ~~Review LD physical health care access, provision access to acute liaison nurses and inspire acute and community colleagues in this area of safety for our community~~ Professional leads are in place to ensure that registered professional staff practice in line with their professional codes Review reports and allegations in multi-disciplinary manner and include safeguarding and security specialist with effective recording and monitoring		External partnership working including Healthwatch, Advocacy services and statutory services within safeguarding and secure services. The Trust provides assurance and participates in external reviews alongside the ICB and Adult Safeguarding Board	
Clinical improvement in the current use and transformation of Care Programme Approach (CPA), to support safe community practice	Implement an improvement plan to enable all services to provide the highest standard of care [ACTION OWNERS: DON/MD]	Review of changes to national policy to replace CPA Safe and effective practice is in place	(31.12.23)	Ongoing oversight of CPA continues with focus on care planning and risk assessment Review of new/alternative models underway with plans to replace CPA in the future Fundamentals of Care group oversight of key core aspects of CPA CPA training continues at present, until alternative identified	AMBER
Clinical improvement in the current practice standards for new mental health in-patient standards released by NHS England	Scrutinise new practice standards and develop a new improvement plan to enable all services to provide the highest standard of care	Review new standards and new reporting requirements with the clinical improvement team	(31.12.23)	Review of new standards underway	AMBER

	[ACTION OWNERS: DON/MD]			Request for Trust to become pilot site for new standards framework, once formally available	
Review of the new Major Conditions Strategy and Suicide Prevention Strategy for England: To consider a reset of the Trust Strategy	Scrutinise new policy direction and develop new plans Routinely review incidents for learning in suicide prevention including cluster analysis and benchmarking [ACTIONS OWNERS: DON/MD]	Adjust strategy and policy to meet requirements Undertake a cluster analysis of in-patient and acute care pathway deaths	(31.12.23)	Review of new strategy for Major Conditions and Suicide Prevention Patient Safety Incident Response Framework (PSIRF) priorities for 2024/25 focusing on prevention and oversight, linked to new strategies Trust clinical strategy to be reviewed and implemented and to include relevant national strategies	AMBER
Review of Patient Carer Race Equality Framework and develop implementation plan	Revisit new policy direction and develop new plans [ACTION OWNER: MD]	Review framework and develop implementation plan	(31.12.23)	Patient Experience Strategy event completed Patient Experience Strategy to be renewed, with the voice of patient and carers at the forefront, ensuring race and equality clearly referenced	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
3009	Learning Disabilities Services	Demand for Autism Spectrum Disorder (ASD) assessment Service far outstrips	20.06.23: There has been no increase in budget but the team now at a full complement of staff after a long period of shortages due recruitment problems and sickness. The team are making changes to pilot alternative assessment processes which should be faster but are admin-heavy. Additional funding has been provided on a one-year basis to employ	01.01.16	04.01.24	HIGH

		contracted activity	someone who can complete some research to evaluate the changes that are going to be implemented 04.10.23: Outstanding risks - waiting time is still significantly above NICE targets and will continue to be so and there continue to be high and increasing referral rates. Currently at limit with regards to full staffing. Risks mainly related to continued complaints about waiting times			
22790	Corporate Services – Pharmacy	Prescribing Valproate to women of child-bearing potential: Failure to comply with regulations	24.05.23: ePMA now deployed to all services in the Trust which will help with our understanding of valproate use and can be incorporated into planning. Reporting will need to be constructed as part of the optimisation of ePMA 22.09.23: Approaches to using SystmOne data are now being explored by the Medicines Safety Officer, in order to generate a true level of assurance. We still await clear guidance from MHRA	28.02.22	18.12.23	HIGH

Strategic Objective 1 – To Provide GREAT Care in all Services

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

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

Root causes:

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

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

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

Key Controls

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

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

Key gaps in control	Key actions to close gaps in control	Impact on risk to be measured by	Expected completion date (Action review date)	Progress against action	Action on track
	Deliver two new adult acute 54-bed units with ~~a~~ single room en-suite with additional staffing and new model of care VAT abatement appeal – Combined capital funding shortfall risk of £14.2m ~~£11.6m~~ ~~£10.7m~~ if appeal unsuccessful [ACTION OWNER: COO]	Delivery of approved business cases	~~(30.09.23)~~ (31.12.23)	Two new build adult acute unit FBCs nationally approved September 2022, funded by £80m national PDC and £18.6m CDEL. ICS supported and approved revenue funding Delay in national approval and redesign of foundations. ~~Phased completion April 2024 – March 2025~~ Planned to go live November 2024 HMRC appeal on VAT abatement claim in process. The risk is monitored through Making Room for Dignity, reporting to each F&P Committee meeting	AMBER
	Older Adult service relocation to refurbished ward with single room en-suite and gender segregation, with additional staffing and new model of care, by September 2024 to eradicate dormitories in Northern Derbyshire and avoid this 12-bed service being isolated in otherwise vacated wards, increasing service user safety issues National PDC capital funding approval [ACTIONS OWNER: COO]	Delivery of approved business case	~~(30.09.23)~~ (31.12.23)	Older Adult service relocation FBC and revenue funding approved by ICS National PDC capital funding approved by NHSE ~~December 2022~~ ~~Significant cost pressure from initial submission, scheme temporarily paused to achieve affordability~~	~~RED~~ ~~GREEN~~ AMBER

Lack of adherence to emerging national guidance and policy requiring the elimination of mixed sex wards and dormitory style inpatient facilities				Scheme re-tendered due to affordability, contractor appointed, start on site November 2023, planned go-live August 2024	
	Audrey House refurbishment as decant ward to enable Radbourne Unit dormitory eradication refurbishment. Dormitories cannot be fully eradicated without use of this decant ward National PDC capital funding approval [ACTIONS OWNER: COO]	Delivery of approved business case	~~(30.09.23)~~ (31.12.23)	National PDC capital funding approved by NHSE ~~December 2022.~~ Refurbishment scheduled January – October 2023 No longer required for decant, completion as enhanced care unit November 2023, go-live November 2024 ~~Live as decant ward November 2023 – October 2024. Further refurb scheduled November 2024. Live as Acute-Plus February 2025~~	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 National PDC capital funding approval [ACTIONS OWNER: COO]	Delivery of approved business case	~~(30.09.23)~~ (31.12.23)	FBC and revenue funding approved by ICS. National PDC capital funding approved by NHSE December 2022. ~~Following Audrey House refurb for decant,~~ Radbourne Ward 32 refurb scheduled November 2023 – January 2025 and live March 2025. Refurb Ward 35 scheduled January 2025 – March 2026, live April 2026 Significant cost pressure being actioned, contracts split, Ward 32 continuing as	RED

				planned whilst cost pressure resolved for Ward 35	
Lack of an accessible Derbyshire wide Psychiatric Intensive Care Unit (PICU)	Delivery of local PICU arrangements (new build and associated projects taking into account gender considerations) £3.5m national capital agreed November 2022. Derbyshire CDEL flexibility agreed for Trust to fund £10.9m remaining capital from cash reserves 2022/23 and 2023/24. VAT abatement risk National PDC capital funding approval [ACTIONS OWNER: COO]	Agreed programme of work with capital funding to support it	~~(30.09.23)~~ (31.12.23)	FBC approved by ICS in June 2022 for 14-bed male PICU and 8-bed Acute-Plus female facility PICU fully funded by national and Trust capital November 2022. HMRC appeal on VAT abatement claim in process – Capital funding shortfall risk if appeal unsuccessful. Practical completion expected November 2024, live March 2025. Acute-Plus national PDC capital funding approved by NHSE December 2022	AMBER

				~~Refurbishment following decant ward is scheduled November 2024. Live as Acute-Plus February 2025~~	

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

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

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

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

Root causes:

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

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

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

Key Controls

Preventative – Trust utilises NHS provided solutions as widely as possible, i.e., Office 365, NHS Mail to ensure compliance with mandated requirements. Use of the secure Health and Social Care Network (HSCN) specified by NHS Digital. Staff training on data security and protection. Regular all staff communications regarding safe ways of working and phishing emails. Contract with NHS Arden and Greater East Midlands Commissioning Support Unit provides information governance and security services, includes review of risks and addressing of vulnerabilities. Subscription with NHS Digital Care Certification Programme highlights cyber vulnerabilities and monitors Trust's compliance against them

Detective – Cyber essentials framework: NHS Digital encourage all organisations to comply. Advanced Threat Protection (ATP) monitors every server and device to highlight threats and software vulnerabilities

Directive – Compliance with NHS Digital requirements. Monthly rigor review meeting with NHS Arden and Greater East Midlands Commissioning Support Unit. Security and Protection Policies and Procedures. Business continuity plan and procedure

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

Key gaps in control	Key actions to close gaps in control	Impact on risk to be measured by	Expected completion date (Action review date)	Progress against action	Action on track
Business continuity plans reflect changes to service delivery such as increased phone and video contacts	All services to review business continuity plans to ensure they take account of the increased use of phone and video contacts for care provision and also use of video conferencing for operational delivery [ACTION OWNER: COO]	Reporting to the Divisional Achievement Reviews (DARs)	~~(30.09.23)~~ (31.12.23)	~~Due to ongoing industrial action, there has been a delay in progression. The timeline has been reviewed with completion by August 2023. EPRR Steering Group meeting July to receive update on service's business impact analysis, incorporating the increased use of technology~~ EPRR Steering Group to monitor and update TOOL in October/ November 2023 Reviews of Business Continuity Plans took place as part of submission of Core Standards in August 2023, following discussion at TOOL. Areas with outstanding work required to complete by end September 2023 with support from EPRR teams	AMBER

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

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

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

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

Root causes:

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

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

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

Key Controls

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

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

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

				~~compliance is at 90% against a target of 85%. Infection Prevention and Control Level 2 compliance is at 87% against a target of 85%~~ Level 1 and level 2 three-yearly IPC training are above compliance target Head of Nursing and Matron walkabouts are ~~in place and~~ conducted routinely	

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

Strategic Objective 2 – To be a GREAT place to work

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

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

Root causes:

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

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

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

Key Controls

Preventative – Freedom to Speak Up Guardian (FTSUG) self-assessment and six monthly reports; annual review of people development plan commissioned through People and Inclusion directorate; provision of information through induction processes for new staff; staff engagement sessions; Equality, Diversity and Inclusion (EDI) Delivery Group meeting; supported networks for diverse staff groups and allies; Health and Well-being Network; workforce planning design meeting; Culture and Leadership Delivery Group Detective – Quarterly Pulse Checks, FTSUG log and escalations; staff network engagement; WRES, WDES, wellbeing champion network, executive led engagement sessions; non-executive, executive and deputy visits to teams Directive – Joined Up Care Derbyshire (JUCD) People Strategy, National People Plan; People building blocks and priorities; Strategic people priorities, Communications Strategy, ICS People 5x7 plan					
Assurances on controls (internal)			**Positive assurances on controls (external)**		
National staff survey and reporting into board, ELT and divisions Quarterly pulse check and action planning process Staff survey analysis and reporting Exit interview analysis and reporting			Benchmarking in mental health and at system level Outstanding results from 2021 staff survey, identifying significant improvements across all themes		
Key gaps in control	**Key actions to close gaps in control**	**Impact on risk to be measured by**	**Expected completion date (Action review date)**	**Progress against action**	**Action on track**
Lack of planned leadership development growth and stretch programmes and opportunities including coaching and mentoring	Strategy developed to align to organisational leadership needs Review of system level leadership offer and impact Review and development of Trust leadership offer and impact Re-establish leadership forum Development of coaching access at local, system and national [ACTIONS OWNER: DPI]	Percentage of leaders with development plan as part of objectives Percentage of leaders attending local, system or national leadership programmes	~~(30.09.23)~~ (31.12.23) Complete	Deputy Director of People is part of system leadership workstream to review current offer and develop 12-month plan on leadership offer – Draft proposal ~~developed,~~ to be finalised New leadership programme (aimed at band 8B staff) completed Leadership forum revised and first forum took place December 2022 with monthly forums now planned throughout 2023. ~~– January, February and March delayed due to industrial action.~~ First face to face forum ~~will now take~~	~~AMBER~~ RED

				took place ~~April~~ June 2023 Third cohort of Aspiring-2-Be leadership course launched Second leadership conference planned for October 2023 on Just and Restorative Culture for Leaders	
Fully embedded person-centred culture of leadership and management	Review of policies and processes to support a person-centred approach to leadership and management Introduce just and restorative culture approach Review of leadership development offer Re-establish line manager development sessions Scrutiny of people data at divisional level [ACTIONS OWNER: DPI]	Reduced number of formal staff relations issues/cases reported in monthly people assurance report to ELT Staff survey results Reporting to TOOL	~~(30.09.23)~~ (31.12.23)	~~Just and restorative culture conference taken place~~ Review of cases and case management reported to ELT in October 2022, reports ~~now~~ feeding in bi-monthly with reasons for delays identified Deep dive on employment review cases and processes took place at PCC in February 2023 ~~Civility and~~ Respect policy published ~~approved, submitted for ratification in April 2023 – Ready for launch~~ System funding secured for Just and Restorative Culture training programme and materials ~~to commence summer 2023~~	AMBER

No operating framework through which to maximise the impact of staff networks	Collaboratively develop and Implement Staff Network Framework to provide consistency across the networks with clear framework, clarity of roles and objectives to increase engagement with under-represented staff Support to Bi-monthly network Chairs meetings through DPI, Head of EDI and EDI Manager [ACTIONS OWNER: DPI]	Engagement and buy-in by network Chairs Sign up to the framework by network Chairs and Executive Directors Annual updates by network Chairs of engagement undertaken to be included in annual reports	~~(30.09.23)~~ (31.12.23)	New executive model implemented in December 2022. Draft framework ~~now~~ developed and engagement with key stakeholders commenced New EDI steering group established; ~~and~~ meetings commenced Network chair meetings operating and attended by DPI and Head of EDI Staff network conference held May 2023	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 key services via People Services in DCHS and UHDB	Review of current People and Inclusion structure to align to needs and priorities of Trust, identify gaps and develop plan to mitigate Review of gaps in services delivered by People Services or UHDB and develop accountability framework Formalise existing governance meetings to ensure clear processes in place for People and Inclusion Services contract and UHDB key service contracts Review of current communications and engagement and people priorities across the Trust and system [ACTIONS OWNER: DPI]	A People and Inclusion structure that can support the Trust to deliver against the people priorities Accountability dashboard presented to ELT quarterly Terms of reference in place and regular meetings A People and Inclusion structure that can support system-wide priorities People and Inclusion staff survey results	~~(30.09.23)~~ (31.12.23)	Contract review meetings established for Occupational Health and Payroll Services (UHDB) New governance structure to be developed to manage the Joint Venture – ~~Early~~ Discussions commenced Monthly payroll contract meetings in place - Improvement Manager appointed by UHDB for six months to support contract, data and system standardisation	RED
Lack of maturity of EDI framework	Produce and implement EDI framework with clear legislative, and mandated NHS national regional and local deliverables required for the EDI function and structure to deliver	Agree framework and capacity requirements to deliver Regular wider engagement with EDI Delivery Group, and divisional	~~(30.09.23)~~ (31.12.23)	~~Draft framework presented to ELT~~ Trust Reducing Health Inequalities Board now	AMBER

	[ACTION OWNER: DPI]	leads taking place Final presentation to PCC Roll out of framework Delivery against the People Performance Dashboard		established, meeting with Trust -wide and system stakeholders to direct our response to reducing health inequalities Draft framework outlines measures	
We have not engaged with our Bank staff to develop a strong sense of belonging, engagement and psychological contract with the Trust	Regular monthly engagement sessions Staff survey participation Clinical supervision and appraisal participation Alignment to Agenda for Change for pay and conditions [ACTIONS OWNER: DPI]	Staff survey participation response rates Staff survey engagement scores Attendance at engagement sessions	Complete ~~(30.09.23)~~ (31.12.23) ~~(30.09.23)~~ (31.12.23)	Engagement sessions ~~booked~~ held October~~, November and December~~ 2022~~, and~~ to January 2023 Partaking in first national bank staff survey Aligned all bank staff bands 2, 3, 4 and 7 to Agenda for Change pay scales Band 5/6 bank pay approved for alignment to Agenda for Change Review of bands 2 and 3 roles on bank versus substantive roles and agreement on transition into band 3 with training Review of training competences for bank and agency commenced	~~GREEN~~ AMBER
Lack of visible and differential staff benefits and responsive support for staff that reflects current working conditions, e.g., cost of living crisis	Review of gaps in benefits to realign to staff needs Review of current reward and recognition framework	Staff survey engagement score Staff turnover Pulse check scores	~~(30.09.23)~~ (31.12.23)	Delivering Excellence Every Day awards (DEEDs) revised and re-launched ~~Staff awards took place November 2022~~	RED

	Develop range of staff benefits that align to Trust values and 'people first' approach Develop the salary sacrifice offer to support colleagues with cost of living crisis [ACTIONS OWNER: DPI]			System-wide discussions commenced regarding a ~~with regards a system-wide~~ benefits package Mileage rates adjusted to reflect cost of living crisis National pay award approved and implemented ~~to be awarded in June pay for all Agenda for Change staff~~ Review of lease cars with view to offer a more attractive rate as a retention tool has commenced Learning shared from UHDB survey on what matters most to colleagues when at work Flexible working engagement programme planned to launch ~~July~~	
Inconsistency in application of an in inclusive approach impact on developing and sustaining a sense of belonging	Embed an inclusive approach, promoting equality and ensuring diversity at all levels through learning and development, Schwartz Rounds, personal development reviews, mid-year reviews, rewards and awards, objective settings [ACTIONS OWNER: DPI]	Year on year change WRES/WDES, staff surveys and lived experience of staff through staff networks Data drawn from all engagement activities so we are able to identify impacts on staff experience and any inequalities that need to be closed	~~(30.09.23)~~ (31.12.23)	Work commenced - Divisional level EDI staff survey data shared with divisions. ~~and~~ Divisional People Leads are leading discussions on actions on improvements and achievements	AMBER

Systematic planning and attendance of training	Training to be embedded in e-roster and designed to support safe staffing by minimising face to face sessions needed Progress the breaks and shift pattern change process [ACTIONS OWNER: DPI]	Full compliance with safer staffing levels in line with NHSI Workforce Safeguards Training compliance in line with CQC requirements Staff survey health and wellbeing scores Comprehensive system and trust level health and wellbeing offer Compliance with NHSI workforce safeguards requirements Staff are able to take breaks and access the right health and wellbeing support E-roster team appropriately resourced and supported	~~(30.09.23)~~ (31.12.23)	New reporting processes in place ~~that feeds into~~ for TOOL, PCC and Board – Now embedded with triangulation on staffing/agency/bank to be included at PCC Shift and break consultation being planned, to commence ~~early~~ 2023 Training lead meeting regularly with all service managers to review staff training plans Meetings scheduled with neighbouring mental health Trusts to compare training offers and delivery modes	AMBER

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

Record ID	Service Line	Title	Risk: Summary of Progress	Date Risk Created	Date of Next Review	Residual Risk Rating
22961	Operational Services – management Team	Industrial action	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 24.10.23: Industrial action with the British Medical Association has been paused for a period of time, reducing the overall risk from extreme to high, but we continue to feel the effects of the action	28.11.22	01.12.23	HIGH

Strategic Objective 2 – To be a GREAT place to work

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

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

Root causes:

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

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

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

Key Controls

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

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

Key gaps in control	Key actions to close gaps in control	Impact on risk to be measured by	Expected completion date (Action review date)	Progress against action	Action on track
An integrated workforce plan and planning process that feeds into pipeline plans and ensures we have the right people in the right place with the right skills	Develop a Trust Workforce Plan linking demand and capacity, workforce redesign to ensure a fully funded workforce Develop vacancy rate data and breakdown variances in vacancy data Establish a workforce transformation group to develop workforce development plans and ownership at divisional level [ACTIONS OWNER: DPI]	Vacancy rates Time taken to fill vacant posts Transformational posts, e.g. apprenticeships all identified Reduction in agency costs	~~(30.09.23)~~ (31.12.23)	~~High level Workforce Plan developed and presented to Board~~ Workforce transformation group commenced ~~December~~ 2022 - Divisional workforce plans being developed to support 2023/24 workforce plan System workforce conference took place February 2023 with key speakers from DHCFT	~~RED~~ AMBER

				~~Workforce summit planned for early July to bring together key Clinical and operational leads to review divisional workforce plans and associated actions~~ Workforce summit held August 2023 to review new roles and implementation. Divisional workforce plans and associated actions were reviewed 2023/24 Trust workforce plan developed and presented at PCC	
We do not have an effective and embedded succession talent management processes	Develop a Talent Management Strategy Pilot career conversations for senior leaders and roll out career conversations for all colleagues Work as a system to develop system-wide approach to talent management and align where best for the Trusts [ACTIONS OWNER: DPI]	Career conversations taking place Internal appointments/promotions Turnover rate Key staff survey measures	~~(30.09.23)~~ (31.12.23)	Talent Strategy finalised Pilot launched for senior leaders in January 2023 – Phase one meetings with each executive taking place Deputy DPI is system lead on talent management System appraisal developed to support system movements and talent management Trust talent pilot with senior leaders running up to September, following which data will be ~~calibrated and~~ presented ~~back~~ to ELT	AMBER
Lack of capacity, experience and plans for recruiting overseas	Develop International Recruitment (IR) plan and programme Appoint IR team to lead programme	Number of IR appointments Retention rate of IR	~~(30.09.23)~~ (31.12.23)	IR pastoral support officer appointed Funding secured for four IRs	RED

	Engage with national IR support Access national IR funding Support Trust teams to prepare for IR arrivals [ACTIONS OWNER: DPI]			Regular meetings established with midlands IR lead System AHP IR bid successful Clinical Educator of IR appointed Recruitment and Retention Lead appointed~~, commencing August~~ – Trust-only post	
Onboarding and Retention process and planning needs to be embedded	Understand the key retention issues for posts/teams/professions with the highest turnover Ensure 'stay conversations' form part of regular 1:1s Develop NHS retention framework for nursing [ACTIONS OWNER: DPI]	Improvements to turnover Staff survey engagement scores	~~(30.09.23)~~ (31.12.23)	'Stay' survey piloted with Allied Health Professionals and 1-2 year starters New starter survey completed with all started in six months and learning shared at Trust and divisional level Nursing retention framework self-assessment completed System retention lead appointed to support Trust level and system work Recruitment and Retention Lead appointed ~~to lead on retention~~ - Trust-wide	AMBER
Medical staffing team and role not sufficiently developed Workforce plan for medical staff not in place	Review existing medical staffing team and workforce support and identify gaps Develop new model to support and maximise the medical workforce Develop medical agency model to ensure efficient usage Develop a medical staff workforce plan	Engagement of medical workforce Reduction in agency spend	Complete ~~(30.09.23)~~ (31.12.23)	Terms of reference agreed by MD and COO for review of existing medical staffing team and creation of a medical workforce plan. Resources identified and funding agreed for the review by ELT First medical staffing workshop completed March 2023	AMBER

	[ACTIONS OWNER: DPI]			Further discussions held as part of the agency summit – Agreed action to support agency reduction	
Lack of culturally competent recruitment processes	Completion and implementation of recommendations of the Above Difference recruitment and retention system pilot Wider engagement with recruiting managers, staff networks, clinical leads and operational leads Quartile monitoring of utilisation of Above Difference recruitment and retention tools Continuous improvement approach to implementing learning [ACTIONS OWNER: DPI]	WRES and WDES data shows year on year improvement, staff survey and lived experience of staff Increase the proportion of applications from ethnic minority groups, increase likelihood of shortlisting and reduce disparity in all areas	~~(30.09.23)~~ (31.12.23)	Recruitment leads across the system all trained through Above Difference programme Pilot nearing completion with six workstreams completing key learning to be shared at future system human resources meeting to agree actions and programme management to move forward at pace Examples of innovation already being trialled such as one page job description being piloted by two teams	RED
Effectiveness of recruitment policy, practice and processes	Review and develop existing recruitment Key Performance Indicators (KPIs) to ensure fit for purpose Where appropriate move away from TRAC to advertise jobs and use fast track processes, e.g. Indeed/MSforms Develop cohort recruitment for key posts Improve the multidisciplinary working (HR, communications and recruiting managers) to enable better planned and executed campaigns [ACTIONS OWNER: DPI]	Time to recruit Number of applicants applying and successfully shortlisted Campaign impact and reach Financial savings through cohort recruitment	~~(30.09.23)~~ (31.12.23)	KPI review commenced Indeed piloted for hard to fill posts in acute Cohort recruitment successfully piloted for Health Care Assistants and Human Resources apprenticeships System recruitment post approved with funding to pilot a cohort recruitment approach including writing inclusive adverts and job descriptions Trust Strategic Recruitment and Retention Lead appointed	AMBER

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

Strategic Objective 3 – To Make BEST use of Our Resources

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

Impact: Trust becomes financially unsustainable

Root causes:

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

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

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

Key Controls

Preventative – Integrated Care System (ICS) signed off and fully support the dormitory eradication programme. Devoted and adequate team for Programme delivery. High quality business cases. Regular meetings with NHSE on programme progress. Meaningful stakeholder engagement (internal and external). Robust cash flow forecasting and delivery. Multi-disciplinary development of financial plans for new programmes of work. System sign-off and appropriate governance arrangements for new programmes of work: Budget training, segregation of duties, management of commissioning risk through system engagement and leadership, mandatory counter fraud training and annual counter fraud work programme: Enhanced cash management

and forecasting aligned to large capital and transformational programmes Detective – Risk logs and programme-reporting (capital/transformation) informs ongoing financial risk assessment: Audits (internal, external and in-house); scrutiny of financial delivery, bank reconciliations; continuous improvement including cost improvement planning (CIP) and efficiency / QI delivery; contract performance, local counter fraud scrutiny Directive – Business plans and templates set out clear financial plans and assumptions: Standing financial instructions; Treasury management procedures, budget control, delegated limits, recruitment approval processes; business case approval process; invest to save/Quality Improvement methodology and protocol and Plan Do Study Act. Risk and gain share agreements, Local Operating Procedure for Acute Capital Programme

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

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

- VAT abatement appeal unsuccessful - Guaranteed Maximum Price exceeds national funding envelope (due to hyperinflation and other factors)				National PDC capital funding approved by NHSE for two new builds and three refurbishment schemes, plus PICU year 1 Hyperinflation still affecting sub-contractor costs with significant cost pressures on Radbourne Unit Refurb and Older Adults ward refurb requiring ongoing action HMRC appeal on VAT abatement claim at ADR stage ~~in process~~ – Combined capital funding shortfall risk ~~of £12.4 10.7 14.2m~~ if appeal unsuccessful	
System capital programme funding shortfall for self-funded Trust capital programme: System Capital Departmental Expenditure Limit (CDEL) inadequacy for system capital requirements	System capital draft planning assumes the final year of the self-funded element of the PICU build through system CDEL / Trust cash reserves VAT abatement appeal in progress Access any new national funding streams in year to maximise system capital plan in order to redirect CDEL capital for other schemes [ACTIONS OWNER: DOF]	Ongoing reporting will ascertain how and when the shortfall can be bridged by additional capital sources	31.03.24	System capital plan has been submitted as part of planning process and will be limited to high priority schemes and includes two new builds and year 2 of PICU from system CDEL.	AMBER
Additional revenue ~~not~~ related to new builds, refurbishments and PICU not fully funded by System	Close partnership working with ICB and System partners. National funding for PDC revenue costs included in allocations for 2023/24 plan Early recruitment to staffing built into revenue plan of the Trust and funded by the system (both income and expenditure in the plan) [ACTIONS OWNER: DOF]	Monitoring and reporting of income allocations and expenditure in year	31.03.24	Funding for PDC revenue from NHSE included in financial plan submission. Guidance change has put £2.5m at risk, which is currently being discussed with regional NHSE on any potential solutions Funding for early recruitment costs from ICB allocations included in the financial plan submission	AMBER

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

				Financial sustainability plan developed All new investments to follow governance processes with business cases to ELT. All emerging costs that are deemed 'out of our control' such as industrial action, pay award funding shortfall, excess inflation and PDC funding withdrawal are all being reported separately across the system and reported to regulators as risks to delivery of the breakeven plan Announcement of £200m additional funding for the NHS for winter resilience, more details are awaited on impact to systems	

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

Record ID	Service Line	Title	Risk: Summary of Progress	Date Risk Created	Date of Next Review	Residual Risk Rating
23067	Corporate - Finance	The Trust fails to deliver its revenue and capital plans	Financial detriment resulting from: - Large capital development programme - Commissioning decisions, including tender processes or wider system first decisions - Non-delivery of transformational and efficiency schemes - Loss of income and required service developments - Costs to deliver services exceed income Efficiency and transformation programme monitoring and escalation process in place. Cost pressures are currently being managed in the overall position	21.06.23	22.12.23	EXTREME

Strategic Objective 4 - To be a GREAT Partner

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

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

Root causes:

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

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

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

Key Controls

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

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

Key gaps in control	Key actions to close gaps in control	Impact on risk to be measured by	Expected completion date (Action review date)	Progress against action	Action on track
~~Plan required for the development of the MHLDA DB to become a provider alliance~~	~~Plan to be developed in partnership with all other organisations in the alliance [ACTION OWNER: DSPT]~~	~~Establish the Derby and Derbyshire MHLDA provider alliance~~	~~(30.09.23)~~	~~All Boards in the Derbyshire system agreed their support for the direction of travel for a single provider collaborative across the system, sitting below that it is explicit that there will be a MHLDA Provider Alliance~~ ~~MHLDA Provider Alliance formally established partnership agreement~~ ~~The JUCD Neurodiversity and LD Alliance Festival was formally launched in September 2022~~	~~GREEN BLUE~~

Increased decision-making at a system and/or provider alliance level may create conflicting accountabilities with the Trust-level governance structures which could result in an increased governance burden	Keep Trust structures under continuous review against the wider governance landscape, including the provider collaboratives and alliance arrangements – This in turn may lead to a formal change of DHCFT governance arrangements [ACTION OWNERS: CEO/Trust Secretary]	Board level confidence in new and emerging governance structures and ability to gain assurance on DHCFT risks and issues via system level governance regime	(31.12.23)	Ongoing review of Trust governance to ensure operational performance delivery of MHLDA constitutional standards that DHCFT is a lead or main provider of the performance. Trust CEO is a member of ICB Derbyshire Provider Collaborative Leadership Board have an agreed work programme as approved by ICB	AMBER
Internal ICB capacity changes to achieve revised expenditure requirements in 20023/24 and 2024/25 may impact on capacity and capability to deliver key deliverables such as system planning, and programmes of transformation	Keep changes to staffing levels and work programmes under regular review. This may lead to system wide agreement on priorities [ACTION OWNER: DSPT]	Impact monitored through system wide MHLDA Delivery Board	(31.12.23)	Escalation of risk and impact to ICB Review DHCFT staffing to identify succession planning opportunities and/or cover arrangements	RED

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

Strategic Objective 4 – To be a GREAT partner

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

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

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

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

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 3	Accepted	Tolerated	Not Accepted

Key Controls

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

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

Key gaps in control	Key actions to close gaps in control	Impact on risk to be measured by	Expected completion date (Action review date)	Progress against action	Action on track
System partners report that some of its core constitutional targets were not being met and was failing to make progress, at pace and scale	New internal performance improvement group and clarity to Trust Board on which DHCFT constitutional standards are not being met and whether the DHCFT contribution is the lead or material and how performance will improve Recovery action plans for areas where constitutional standards are not being met [ACTIONS OWNERS: COO/DSPT]	Improvement in performance in constitutional standards Recovery action plans in place in all required areas	(31.03.24)	Integrated performance report ~~has been to~~ allows insight on key areas of improvement, ~~for targeted~~ with actions and narrative around next steps. CQUIN, and Real World Health insights have been added to track on a monthly basis to ensure we improve performance and patient outcomes ~~Once developed,~~ Prototype dashboard to measure compliance with constitutional standards has been presented to the Productivity Board and will be monthly going forward until ready to go to TOOL ~~to be reviewed monthly at TOOL / Productivity Board. This will support measuring performance for subsequent RAP plans to be developed for areas requiring improvement~~	RED
System partners report that DHCFT is inward looking and does not fully support PLACE developments	Managing Directors to design a communication and improvement plan, with 360 feedback that PLACE partners feel DHCFT support, data is provided and their support named Managing Director is accessible [ACTION OWNER: COO]	PLACE / PCN and GP Directors provide direct feedback to Managing Directors on their relationship, knowledge and impact of the additional leadership support. This includes examples of collaboration and the impact of this support	~~(30.09.23)~~ (31.12.23)	Managing Directors (MDs) actively engaging with Primary Care Networks (PCNs) MDs are now members of Derby City PLACE Board and PLACE County Partnership Board	GREEN

		Confirmation of frequency of contact, joint action / achievement log of issues raised and achieved Managing Directors reports to TOOL with summary of impact to ELT		Executive Directors are members of Integrated Place Executive. Senior management representation named for all PLACE Alliance groups. City and County partnership board are currently developing purpose which MDs are actively involved in. MDs are also linking in with local GP forums within the City and County CEO meeting with GP network monthly Appointment of a Lead GP – Mental Health specifically for Derby City Place to support relations, pathways and opportunities between the Trust and primary care	
Social care partners have reported that the lack of progress on autism diagnostic reductions is difficult and would like to see increased pace of improvements	Improvement plan for joint autism service [ACTION OWNER: COO]	Feedback from social care on awareness of the Autism Strategy and autism waiting times reduce across the interagency investment plan	(31.12.23)	Autism investment no-longer available from ICB, revised discussions in place from September 2023 ~~plan agreed within MHLDA spend in 2023~~ Autism waiting times have now been achieved for the 26 contracted assessments per month, and sustained for year to date ~~and we are on target to achieve for Quarter 1 2023. Work continues to improve capacity to sustain compliance~~	AMBER

GP networks and partners report they do not feel connected to the MHLDA DB and are not aware of strategic decisions that are made	Communication and engagement plan with GP networks [ACTION OWNER: DSPT]	Feedback form GP networks on connectivity to the MHLDA DB and DHCFT named leads, information supplied GP networks reflect that they are briefed and actively engaged	~~(30.09.23)~~ (31.12.23)	MD membership in PLACE Alliance Boards agreed in January ~~Monthly~~ GP and DHCFT engagement events were established to receive feedback and answer any strategic or system questions on DHCFT and the MHLDA DB Collaborative working with PCNs to appoint to mental health practitioners as part of the additional roles reimbursement scheme (ARRS) roles Organisational representation on system wide primary and community care delivery Board	GREEN
Police partners report they do not always feel supported by mental health services and are under pressure to respond to mental health crisis	Police Education, support, communication and improvement plan with MH Delivery Board and Trust Directors [ACTION OWNER: DSPT]	Inter-agency meeting and review of a joint way forward in 2023 including • Police Training • Suicide prevention work • Joint co-produced outcomes Agreed outcomes are monitored and reported through the MHLDA DB with liaison with DHCFT Police Liaison group	~~(30.09.23)~~ (31.12.23)	Police now a formal member of the MHLDA DB and attending and contributing New national guidance in draft and collaborative approaches including staffing of 136 suites included in programme level investment Street triage pilot established between Police and Trust Mental Health Response Vehicle (MHRV) to be implemented from April 2024, to reduce pressure on Police to respond to mental ill health calls	AMBER

				Crisis cafes planned for opening in near future Trust chairing the Right Care Right Place (RCRP) implementation group across the Derbyshire system with Police stakeholders and system colleagues	
Patient and carers groups report that they would like to see more progress in service user and carer involvement and moving from engagement to decision making	Peer support strategy and objectives for EQUAL and the Mental Health Engagement Group [ACTION OWNERS: DON/MD]	Peer support strategy Co-production in Patient and Carer Race Equality Framework (PCREF) requirements	~~(30.09.23)~~ (31.12.23)	EQUAL group established to support service user and carer engagement. EQUAL has created several sub committees and informs future service improvements across the East Midlands Perinatal Mental Health Provider Collaborative	AMBER

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

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

Multiple System Strategic Risk

There is a risk to safe, effective clinical care across Derbyshire impacting upon patients, due to not achieving national standards and variation of clinical practice and service commissioning in the Learning Disability (LD) Transforming Care Partnership and in ICS in-patient LD bedded care

Impact: May lead to avoidable harm and delays in accessing appropriate services, affecting patients, their family members and staff

Root causes:

a) The community Intensive Support Team and Learning Disability models have non-standardised operating models and require more capacity
b) Currently the delivery and commissioning partnership in Derbyshire have not met national standards or local ambitions for more robust community-based offers, working across the geography and in an integrated way with partners including social care and the voluntary sector
c) The collective vision for Learning Disability services across Derbyshire and the formal outcome to achieve repatriation to Derbyshire has not been effective with some people remaining in outsourced areas of England for extended and significant periods of time
d) Inpatient bedded facilities do not meet safer staffing levels due to substantial vacancies
e) Derbyshire bedded facilities do not meet current standards, e.g., en-suite accommodation, safety and environmental standards and the seclusion room does not meet the required standards as outlined in the Mental Health Act Code of Practice. (The CQC did note the lack of appropriate provisions in the seclusion room available in 2016 but this was not noted as a requirement notice)
f) The current LD bedded care facilities do not meet the national specifications for the Royal College of Psychiatrists Learning Disability recommended standards and are not in line with future clinical model for the LD&A pathway for Derbyshire
g) Gaps in controls – Derbyshire bedded care facilities for LD services had not had a full CQC inspection since 2016 as a core service. There may have been a drift in scrutiny connected to inspection
h) Health inequalities across our Derbyshire footprint – Initial insights show gaps in access to service, case load and worsening patient outcomes

BAF Ref: 23-24 MS1	Director Lead: Ade Odunlade (COO)	Responsible Committee: Quality and Safeguarding Committee within DHCFT Quality and Performance Committee within the Derbyshire ICS Mental health, LD and Autism Board in terms of system operational delivery

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

Key Controls

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

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

Key gaps in control	Key actions to close gaps in control	Impact on risk to be measured by	Expected completion date (Action review date)	Summary of progress on action	Action on track
The community Intensive Support Team and Learning Disability models require improved models of support	Review all models of support offered by the Intensive Support Team (IST) [ACTION OWNERS: COO/DON/MD]	Outcome of review – Improved models of support	~~(30.09.23)~~ (31.12.23)	Review outcome: Services brought together across the North and South under a single manager and now have single clinical pathways. Work still to do to ensure final stages of parity Data reviews show significant improvement the flow of patients through IST to support admission avoidance and early discharge,	~~RED~~ AMBER

				particularly from adult mental health wards ~~Establishment of a DHCFT Productivity Programme Board and an operational delivery review are underway. Clinical delivery audit is also underway supported by NHSE/I to further understand wicked issues~~ ~~Patient flow review via MADE events underway as Learning Disability beds are occupied by patients who are clinically fit for discharge~~	
Improvements are required in rapidly returning patients who access Learning Disabilities and Autism (LD&A) services to local care to enable them to live their lives in the least restrictive manner as close to home as possible	Continue to work on developed delivery improvement plan, owned by system partners, to improve position. This includes new cohort stratification approach that has been developed – key action to implement and fully embed approach to ensure focussed system action on existing inpatients who are place inappropriately and out of area [ACTION OWNER: COO]	Improvement plans developed and implemented resulting in a stabilised service and positive outcomes for patients working across partner systems Enhancing and reviewing Listening and Engagement Active Partnerships (LEAP) procedures Improvement plans in admission avoidance, crisis alternatives to admission and market stimulation and development, including improvement in the use of Dynamic Support Registers as a means of admission avoidance Make significant impacts on the number of stranded patients who have delayed discharges in units	~~(30.09.23)~~ (31.12.23)	Full cross-system delivery plan ~~developed and being actively driven and monitored by revised~~ continues to be monitored through Neurodevelopmental Delivery group Board – Includes action plan in response to inflow, flow and outflow as discussed with NHSE and ICB leaders Enhanced community support workstream focussing on improvements for delivery of LEAPs and optimal use of Dynamic Support Register	RED

		across the country resulting in the NHSE escalations		Market engagement workshops held with partners to drive improvements in provider options. Further work required by local authority and ICB to ensure impact – Trust supporting New co-hosting approach for discharge planning, attached to length of stay metrics and 12 point discharge plan to be introduced from September 2023 ~~Benefits realisation sessions took place in September 2022 – Attended by all system partners. Nine themed benefits for the neurodevelopmental programme identified – Submitted to align future reporting~~ ~~Review of ways of working for Intensive Support Team undertaken to address variation in service offer~~ ~~Full integrated operational pathway mapping workshops with all system partners completed with and action plan to meet~~	

				~~fidelity of optimal pathway~~ ~~Coproduction workshops completed with service users, families and carers to shape delivery plan~~ ~~Improved oversight is in place but significant improvement in performance and outcome is required in returning complex individuals with learning difficulties/autism and risks. Derbyshire ICS remain an outlier~~	
Current substantial staff vacancies are negatively impacting on safer staffing levels in a non-DHCFT Derbyshire bedded care facility	Compliance with NHS Improvement (NHSI) Workforce Safeguards requirements [ACTIONS OWNERS: COO/DON]	Full compliance with safer staffing levels in line with the NHSI Workforce Safeguards	~~(30.09.23)~~ (31.12.23)	Reviews of safer staffing and stabilisation in non-DHCFT Derbyshire bedded LD facility - ~~Part~~ Some stabilisation achieved, further work under new structures required Workforce issues including recruitment and retention, staff wellbeing and mitigations against use of agency staff considered. Ongoing commitment to working in an alliance with DCHS to support a resolution for future bedded care for LD&A services across Derbyshire	AMBER
Clinical care standards in a non-DHCFT Derbyshire bedded care facility including care plans, levels	Develop an improvement plan for all Derbyshire in-patient LD&A services [ACTION OWNERS: COO/DON]	Full compliance with required care standards	~~(30.09.23)~~ (31.12.23)	External review of Long-Term Segregation and review to end restrictive	~~RED~~ AMBER

of incidents, restrictive practices including the use of long-term segregation are not compliant with clinical care standards		External review of Long-Term Segregation and review to end restrictive practices		practices complete Overall quality plan for improvement for LD&A inpatients including out of area in place following review by ICB quality team - Reporting to JUCD Clinical Quality Reference Group in September 2023. This includes trying to reduce the level of out of area care Ward recruitment and management responsibility has returned to DCHS, they are considering their model on the unit. DHCFT General Manager supporting ~~The Trust is working with JUCD on a strategic outline case for the future of bedded care for LD&A in Derbyshire~~ ~~Some improvements in clinical standards~~ Work on future model for inpatient care continues, Further capacity to support developments to be identified across partners Care plan work continues	

				~~Strategic Outline Case for the future of bedded care for LD&A in Derbyshire cleared at System Delivery Board to take into Outline Business Case – Work ongoing~~	
Lack of adherence to national guidance and policy on in-patient care in a non-DHCFT Derbyshire bedded care facility	Deliver a single room en-suite delivery plan and programme of work [ACTION OWNER: COO/DON]	Delivery of approved business cases for development of single en-suite facilities, seclusion suite at specification standards and other improving the therapeutic and healing environment requirements Implementation of programme of work	~~(30.09.23)~~ (31.12.23)	~~Initial review and development of business plan to be undertaken by other provider~~ Work to provide facilities that meet national standards to be completed ~~– Expected completion date to be confirmed~~ Joint proposal paper providing an overview of the work to date across the system being co-developed with recommended next steps for executive discussion in October 2023	AMBER

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

Risk Rating

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

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

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

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

Action Owners

CEO	Chief Executive Officer
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 Public Board of Directors – 7 November 2023

Well Led Review Update

Purpose of Report

To provide the summary report from the External Development Review of Leadership and Governance using the Well led framework, noting that an action plan has been developed for on-going monitoring by the Audit and Risk Committee.

Executive Summary

The Board has received regular updates on the Trust's well led work in terms preparing for the Board Well Led element of a CQC inspection but also on the external development review against the well led framework. The well led review (WLR) was carried out by the Office of Modern Governance (OMG) and the final report which includes the recommendations has been issued. The agreed recommendations have been built into an action plan that will be reported to and monitored by the Audit and Risk Committee.

Attached is the summary report, the findings from the report will be shared internally as well as with the Trust's Regulators.

As a reminder, the WLR 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 high level summary of the assessment of the Trust's governance arrangements against the well-led review framework in the report is a positive one. During the course of the review the Office of Modern Governance indicate they observed many elements of good or leading-edge leadership and governance practice. This is balanced by the highlighting of areas where a sharpening or subtle refocusing of the Trust approach will accelerate the journey of improvement the Trust is on. These areas have been reflected in the recommendations.

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

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

Assurances

The WLR report is a positive evaluation of the Trust's Leadership and Governance against the Joint NHSE/CQC Well Led Framework and provides the Board with assurance of compliance.

Consultation

Updates on the well led work has been reported at Public Board and this Committee.

Governance or Legal Issues

- 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.
- One of the actions from the 2020 CQC Well Led report was for the Trust to progress its plans for an external Well Led Development Review based on NHSE expectations that all providers to carry out an externally facilitated review every three to five years. Our last review was carried out in 2017. The Board can confirm the review has now been carried out and also explain why it had been delayed.

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:

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.

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.

Well Led - KLOE 3

W3.8 - Are equality and diversity promoted within and beyond the organisation? Do all staff, including those with particular protected characteristics under the Equality Act, feel they are treated equitably?

Well Led - KLOE 7

W7.1 Are people's views and experiences gathered and acted on to shape and improve the services and culture? Does this include people in a range of equality groups?

W7.2 Are people who use services, those close to them and their representatives actively engaged and involved in decision-making to shape services and culture? Does this include people in a range of equality groups?

W7.3 Are staff actively engaged so that their views are reflected in the planning and delivery of services and in shaping the culture? Does this include those with a protected equality characteristic?

Recommendations

The Board of Directors is requested to note the contents of the summary report, accept the proposed recommendations and note that the delivery of the recommendations will be via the action plan, as progressed through the Audit and Risk Committee.

Report presented by: Selina Ullah
Trust Chair

Report prepared by: Justine Fitzjohn
Trust Secretary

Office of Modern **Governance**

Derbyshire Healthcare NHS Foundation Trust

Well Led **Review**

Final Report

6 October **2023**

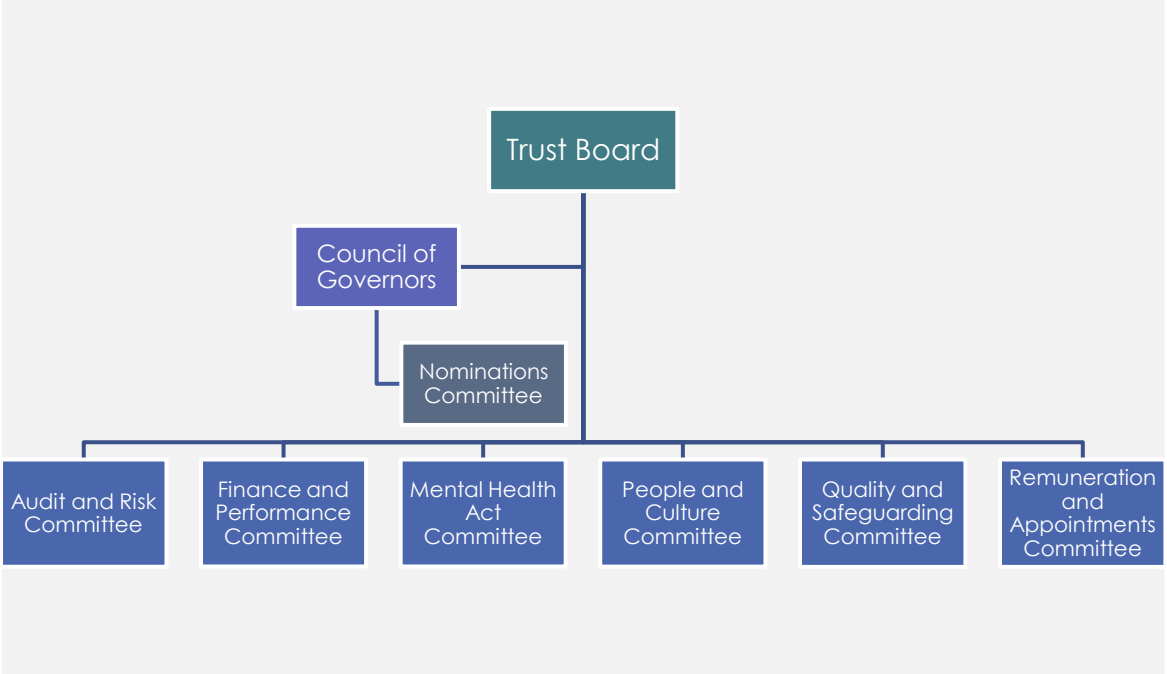
Contents

1. Background and Context

1.1 Derbyshire Healthcare NHS Foundation Trust (referred to hereafter as the Trust or DHC) was established in February 2011 as an NHS Foundation Trust and is a provider of NHS mental health, learning disabilities and substance misuse (drug and alcohol) services in Derby city and Derbyshire county. DHC also provides a wide range of children's services.

1.2 The Trust employs more than 2,800 staff providing services from a number of community bases across the whole of Derbyshire. Across the County and the City, the Trust serves a combined population of approximately one million people across a geographical footprint that covers circa 1,000 square miles. The rural, semi-rural and urban landscape gives rise to a mixture of affluent and seriously deprived areas, which is in sharp contrast to the City of Derby which is home to a diverse population where over 300 languages are spoken.

1.3 The Trust has an embedded Committee structure which broadly aligns with its strategic priorities. The structure is shown below.



1.4 DHC structured around eight clinical divisions; and which are shown below:

Adult Mental Health Services for Adults of a Working Age	Children's Care Services	Community Mental Health Services for Adults of a Working Age	Forensic and Mental Health Rehabilitation Services
Mental Health Services for Older People	Neurodevelopmental Services	Psychology and Psychological Therapies Division	Specialist Care Services

1.5 The Trust vision is *"to make a positive difference in people's lives by improving health and wellbeing"*.

1.6 The last full Care Quality Commission inspection of the Trust took place between the 26 to 28 November 2019 with the report published on the 6 March 2020 when the Trust as a whole was rated as "good". This represented an improvement from its previous Care Quality Commission inspection in 2016. The detailed inspection ratings are shown below:

Domain	Rating	Domain	Rating
Safe	Requires improvement	Responsive	Good
Effective	Good	Well led	Good
Caring	Good		

1.7 A great deal has however happened since that inspection and which are important contextual elements for this developmental well-led review.

1.8 It is particularly worth noting that the Board has undergone significant natural change since that Care Quality Commission inspection in November 2019. Of the fifteen individuals (as set out in Section 2) that currently comprise the Board or who are attendees to the Board only three were in their current role at the time that inspection was undertaken, representing a significant renewal of the Board. Two thirds of the Board have only been in post since 2021 (five Non-Executive Director appointments and five Executive Director appointments). It is to the credit of the Trust that it has acted swiftly to provide interim arrangements to cover the Executive posts and recruited quickly to the Non-Executive posts.[1]

1.9 Significantly at the time we conducted our review, the Trust, like all parts of the NHS, had a sizeable change agenda to deliver. Alongside the priorities every NHS trusts faces around delivering safe and high-quality services, the Trust is operating within financially challenged times, undergoing a major programme of investment in its facilities and care environments alongside difficulties in recruiting and retaining staff, and working with system partners as part of the Derby and Derbyshire Integrated Care System (ICS).

1.10 Furthermore, these pressures need to be seen against the backdrop of a global pandemic, the likes of which has never been seen before. DHC has had to adapt to that, across all of its functions, with staff who are exhausted and facing personal challenges through over two years of the pandemic, and a subsequent costs of living crisis for many. As a consequence of the pandemic, DHC service users and carers are experiencing changes never seen before and are likely to see a deterioration in their physical and mental health condition, develop new health needs, experience wider inequalities and may struggle to access services provided by the Trust.

1.11 At the time of our review, the Board is incrementally migrating towards face-to-face meetings, after a prolonged period of virtual meetings. The meetings we observed as part of this review were, all bar one, undertaken virtually. Virtual meetings have understandably stifled the natural flow of conversation - and deprived those who attend meetings as members or attendees of visual cues that are a key feature of all meetings.

1.12 It has also meant that because meetings are taking place virtually, meeting members and attendees have been deprived of the side conversations with each other, informal conversations with Trust staff perhaps ahead of or after meetings that are so crucial for absorbing informal intelligence and which is not possible to replicate in the virtual meeting format.

1.13 Our observation of all the meetings and the conclusions we have drawn therefore need to be read within that context.

1.14 We next set out in Section 2 our review methodology and then in Section 3 we have set out our detailed observations against each of the eight well-led framework KLOEs.

1.15 Finally, Section 4 sets out our principal recommendations, though Board members will wish to note that as they read our detailed findings, other smaller improvements are suggested which could form part of an overall Trust action plan that seeks to take the review findings forward.

1 Of these changes, three Non-Executive Directors and the Chair left having served two terms of office. The vacancies in the Executive Director cohort were down to retirements and promotions.

2. Methodology

2.1 Our extensive review methodology for DHC comprised the following key stages:

Background documentation

2.2 We reviewed a range of background documentation which we requested of the Trust and which included past Board and Committee papers, terms of reference, work programmes, standing financial instructions, constitution, key policies, relevant risk and strategy documents.

Meeting observations

2.3 We observed meetings of the Board and a Council of Governors (CoG) meeting as shown below:

Board of Directors Public Meeting, 9 May 2023	Board Development Session, 17 May 2023	CoG, 9 May 2023.

2.4 We also observed the following Committees of the Board:

Audit and Risk Committee, 25 May 2023	People and Culture Committee, 14 June 2023
Finance and Performance Committee, 23 May 2023	Quality and Safeguarding Committee, 11 May 2023
Mental Health Act Committee, 9 June 2023	

2.5 We observed a couple of meetings across the Divisional structure of the Trust:

Trust Oversight Operational Leadership Group, 1 June 2023	Mental Health Services for Older People Clinical and Operational Assurance Team, 5 July 2023

Board member interviews

2.6 We undertook confidential non-attributable interviews with the following Board Members or attendees to the Board:

Name	Designation	Date
Dr Arun Chidambaram	Medical Director	12 May 2023
Ade Odunlade	Chief Operating Officer	16 May 2023
Tony Edwards	Deputy Chair and Non-Executive Director	17 May 2023
Geoff Lewins	Non-Executive Director	18 May 2023
Ralph Knibbs	Senior Independent Director and Non-Executive Director	18 May 2023
Carolyn Green	Director of Nursing and Patient Experience	18 May 2023
Ashiedu Joel	Non-Executive Director	23 May 2023
Lynn Andrews	Non-Executive Director	6 June 2023
Deborah Good	Non-Executive Director	7 June 2023
Rachel Leyland	Interim Executive Director of Finance	7 June 2023
Justine Fitzjohn	Trust Secretary	12 June 2023
Mark Powell	Chief Executive	13 June 2023
Selina Ullah	Chair	13 June 2023
Vikki Ashton-Taylor	Director of Strategy, Partnerships and Transformation	14 June 2023
Rebecca Oakley	Deputy Director of People and Inclusion (deputising for the Director of People and Inclusion)	29 June 2023

Divisional leadership interviews

2.7 We undertook two meetings with a cross section of seventeen individuals that comprise the leadership teams across the different divisions in the Trust.

Stakeholder interviews

2.8 We undertook confidential and non-attributable interviews with a nineteen stakeholders which were identified by us in conjunction with the Trust. These were drawn from neighbouring NHS organisations, local government, the voluntary sector, the Derby and Derbyshire ICS, as well as internal and external stakeholders, the Care Quality Commission, and NHS England.

Senior leaders

2.9 We undertook a focused session with twelve senior leaders across the Trust.

Focus groups

2.10 We undertook a series of focus groups to gain a further granular understanding of the Trust. These are listed below:

Group	Number who took part	Date
CoG Focus Group 1	7	6 June 2023
CoG Focus Group 2	11	8 June 2023
Staff - Focus Group 1	14	8 June 2023
Staff - Focus Group 2	12	12 June 2023
Service User and Carer Focus Group 1	7	9 June 2023
Service User and Carer Focus Group 2	5	12 June 2023

2.11 In addition to the staff focus groups, we also drew upon the NHS Staff Survey 2022 results for the Trust which were presented to the Board at its May 2023 meeting.

3. Key Findings and Commentary by KLOE

1. We have undertaken a review of governance arrangements at DHC against NHS England's Well-Led Governance Framework, which was last updated in June 2017. We want to thank the Trust for commissioning ourselves to undertake this review and we thank the Board, senior leadership, and particularly the Chair, Chief Executive and the Trust Secretary and her team for their support throughout our review, as well as service users and carers, members of the CoG, staff and stakeholder organisations for taking the time to participate in our review.

2. The last full Care Quality Commission inspection report for the Trust was published in March 2020 when the Trust as a whole was rated as "good". A great deal has however happened since then and which are important contextual elements for this developmental well-led review. It is particularly worth noting that Board composition has undergone significant natural change and renewal since that Care Quality Commission inspection. It is to the credit of the Trust that it has acted swiftly to provide interim arrangements and give confidence that it has built resilience and a consistency of purpose and values into the Board at a time of change.

3. It is also important to acknowledge that at the time we conducted our review, the Trust, like all parts of the NHS, had a sizeable change agenda to deliver. Alongside the priorities every NHS organisation faces around delivering safe and high-quality services, the Trust is operating within financially challenged times, undergoing a major programme of investment in its facilities and care environments alongside difficulties in recruiting and retaining staff, and working with system partners as part of the emerging Derby and Derbyshire ICS. Furthermore, these pressures and challenges need to be seen against the backdrop of a global pandemic, the likes of which has never been seen before, and its ongoing impact on staff and on the communities DHC serves.

4. At the time of our review, the Board is incrementally migrating towards face-to-face meetings, after a prolonged period of virtual meetings. All but one of the meetings we observed as part of this review were undertaken virtually. Virtual meetings have understandably stifled the natural flow of conversation - and deprived those who attend meetings as members or attendees of visual cues that are a key feature of all meetings, and our review findings need to be seen within this context.

5. Our high-level summary of DHC against the well-led review framework is a positive one and we have during the course of our review observed many elements of good or leading-edge leadership and governance practice. There are areas where a sharpening or subtle refocusing of the Trust approach will accelerate the journey of improvement the Trust is on.

6. Perhaps the biggest challenge, which the Trust is fully sighted to or already progressing, is the recognition that the newness of the Board creates a unique set of challenges. These will lessen over time as the Board becomes more experienced but creates short to medium term risks. This inevitably bleeds out into a need to clarify roles and responsibilities between Executive Directors and the Divisional leadership teams and a need to address the development of leadership teams at the Divisional level, and creating a much clearer accountability framework; and recasting the Trust Strategy 2022-2025 to reflect greater system working and the challenges the Trust now faces.

7. Alongside these challenges, perhaps the other significant issue is the need to better understand and then address stakeholder perceptions of the Trust. The Trust has a strong record and reputation for stakeholder engagement but a sizeable minority of external stakeholders highlighted inconsistencies in messages coming from the Trust and the reality of delivery.

8. We have throughout our review discerned a collective sense of renewal at all levels and across all our meetings and interactions with DHC. This has created a great deal of positive energy and momentum within DHC. There are several reasons for this, such as the appointment of a new Chief Executive in April 2023 and the listening exercise he has embarked upon which will support a refocusing of the Trust ambitions for the years ahead, the huge opportunities created by the significant investment in facilities, the emergence from the pandemic, and the appointment of new Non-Executive Directors and Executive Directors. We feel this sense of renewal and refresh, can act as a powerful springboard to drive DHC forward and provide the required focus to ensure our review findings are progressed in a timely manner.

9. We have below provided assessment of DHC against the eight well-led framework KLOE.

KLOE 1: Leadership, Capacity and Capability

10. DHC has the leadership capacity and capability to deliver high-quality, sustainable care to the citizens of Derby and Derbyshire which is tempered to the extent that the majority of Executive and Non-Executive Board leaders are relatively newly appointed in post. While this change at the top brings many positives in terms of energy, impetus and fresh thinking it will inevitably bring a change to priorities and the way things are done, which in the short term creates some vulnerabilities for the Board, as it grows and matures over time through experience.

11. There are also pressures on the capacity of Divisional and Clinical leaders at times, who do not always feel they have dedicated time, resources or support to undertake their leadership role alongside a demanding clinical workload within the context of operational pressures and workforce shortages.

12. Board members comprise a range of complementary skills, backgrounds and experiences and the Board is diverse from a gender, ethnicity and thought perspective. We observed a cohesive Board, with trust, respect and candour at its heart. The unitary working of the Board could be further developed and enhanced through a structured development programme.

13. Observation of meetings, interactions with leaders and staff provided evidence of a strong commitment to values in how Board leaders act, speak and conduct themselves. The values of 'compassion,' 'caring,' 'person-centred,' 'supportive' and 'collaborative' were most frequently used to describe the leadership culture within the Trust and we certainly observed this in practice. The Board places a strong emphasis on staff well-being and culture. In particular the 'People First' value resonated strongly with leaders at all levels within the Trust. 'People First' however needs to be revisited to ensure it means the same thing to everyone and to clarify the balance and link between staff and service users.

14. Board leaders are recruited and appraised using values as a key element of the recruitment and selection process. For newly appointed Board leaders, while they certainly bring relevant and complementary skills, knowledge and fresh perspectives to the challenges of the Trust, what they lack is: specific knowledge and experience; corporate memory; knowledge of the Trust and its services; and of the NHS and how it operates.

15. Board and senior leaders we spoke to identified financial and workforce pressures as providing the main challenges to quality and sustainability and in relation to workforce could clearly identify the actions being taken to address them. Actions taken to address the cost improvement challenge were not as advanced nor as well worked through.

16. Staff we spoke to as part of the review largely perceived the Trust to be well led and governed. In particular, the Chair and Chief Executive demonstrate a sound values base and have the confidence to challenge and provide strong and effective leadership, whilst remaining respectful and compassionate.

17. The newly appointed Chief Executive in particular was cited for his visibility as well as his open and listening approach as he met and visited staff right across the Trust. A number of Executive Directors are similarly perceived to be approachable and listening. The Chair is also visible, known and seen to be listening in all parts of the Trust and wider Derby and Derbyshire healthcare system, though the Non-Executive Directors much less so. Quality visits and walkabouts have not yet resumed in a consistent and systematic way.

18. The Chair and Chief Executive are highly regarded as engaged and active leaders within the wider Derby and Derbyshire ICS but for executive team members and other senior leaders this is variable, with little evidence they are embedded within the wider activities of the system.

19. The Board has identified clear priorities to develop a consistent approach to inclusive, compassionate and people centred leadership and to provide active leadership within the Derby and Derbyshire ICS. Several leadership development initiatives are offered to support delivery of this ambition, but there is not a holistic and clear strategy linking these together with a clear vision on what needs to be achieved.

KLOE 2: Vision and Strategy

20. There is a clear vision and credible strategy to deliver high-quality sustainable care to the people of Derby and Derbyshire and there are robust plans to deliver it. This would be considerably enhanced through the articulation and integration of a Clinical Strategy to really drive delivery of the key strategic priorities. The reality of the delivery plans needs to be further tested and sense checked within the context of increasing demand and tightening of finances.

21. There is a clear vision in place 'To make a positive difference in people's lives by improving health and wellbeing' which is underpinned by four values of 'People First, Respect, Honesty and Do Your Best.' Quality and sustainability are very much at the heart of the four strategic priorities of 'Great Care, Great Place to Work, Great Partner and Best Use of Resources.'

22. The Trust Strategy is clear and structured in setting out its ambition, aims and expected outcomes. It describes the key activities or 'Building Blocks' which will enable achievement of each of the four strategic objectives. The aim of each set of Building Block strategic activities is to bring about an improvement in the basics, to embed continuous improvement approaches and to effect larger scale transformation. Critically, there remains further work to be done in the sense that there is a strong need for a clearly articulated Clinical Strategy to really integrate and drive forward the Trust Strategy, building on the already published Clinical Ambition.

23. An annual delivery plan for each year of the life of the Trust Strategy identifies the essential areas to focus on for that year together with detailed plans on how that will be delivered. The Operational Plan identifies priorities for 2023/24 aligned to the Trust Strategy alongside key transformation programmes. It also outlines Performance Improvement Deliverables to enable progress to be monitored and reviewed.

24. For 2023/24, the reality of delivering this plan in full, given the wider environment of greater financial challenge within the context of increased demand for Trust services has been recognised and acknowledged. There is a Board ambition to ensure care remains high quality and sustainable by taking a quality improvement approach to strategic execution in order to improve the efficiency and effectiveness of service delivery and ways of working. And to work more closely with partners in seeking new ways of doing things.

25. However, given the scale of the pressures, the achievement of this ambition remains at risk, and there may be a need for the Board to further test this and reset the level of ambition.

26. The vision, values and Trust Strategy have been developed using a structured planning process in collaboration with staff, service users and other stakeholders. In refreshing this Strategy in 2022, staff and the CoG were further engaged using on-line surveys, a staff conference and other communication routes.

27. The vision, values and strategic objectives feature as part of the recruitment and appraisal process and is a core element of corporate induction. In our focus groups and discussions with leaders and staff throughout the Trust there was a good level of understanding in broad terms of the Trust strategic direction and also of the DHC values and what that in turn means for how they undertake their respective roles.

28. Because of the newness of the Board there is not always a consistent level of understanding of the Trust Strategy. That same inconsistency of understanding is also true for system partners who were not always able to clearly describe their understanding of DHC's Strategy.

29. The Trust Strategy is set within the context of the wider health and social care system across Derby and Derbyshire. Through its collaboration with partners in the Derby and Derbyshire ICS, DHC has made a commitment to deliver integration of care as part of Joined Up Care Derbyshire (JUCD). This also sets the DHC Strategy within the system ambition to address health inequalities.

30. Progress against delivery of the DHC Strategy is monitored and reviewed through the DAR and through quarterly progress reports on delivery to the Board, and annually through a Roadmap. Additionally, the Board Assurance Framework (BAF) outlines risks to the delivery of the Trust Strategy and is presented to the Board and its Committees on a regular basis.

KLOE 3: Culture

31. There is a recognisable and distinctive DHC culture which is characterised by openness, respect and support and is exemplified in the Trust value of 'People First.' Those who work in the Trust, at all levels recognise the culture and are proud of it and it is equally recognised by system partners and other stakeholders. It is a culture which should support the delivery of high-quality sustainable care.

32. In 'People First' there is the recognition that a well-supported, engaged and empowered workforce is vital to good care. And the ambition is that staff will work compassionately and supportively with each other and with service users and carers. They recognise the Board focus on the safety and wellbeing of staff.

33. We spoke to a number of staff and leaders individually and in focus groups. In the majority of cases, they feel supported, respected and valued. They are proud to work for DHC and feel positive about its leadership and direction.

34. The Board has established a People and Culture Committee to provide oversight of all workforce and staff culture issues, which monitors and reviews delivery of support and improvements in this area including appraisals, turnover, training, sickness absence, recruitment, retention, clinical supervision, Freedom to Speak Up (FTSU) and bank/agency staff usage. The Board Integrated Performance Report (IPR) has a dedicated workforce section.

35. There is an active Staff Forum which meets every other month with the Executive Leadership Team (ELT) which has led on improvements in working practices across the Trust which is focussed on making the Trust a 'Great Place to Work.'

36. What we heard and observed in focus groups was that in the main, staff have cooperative and supportive relationships within their teams and work collaboratively, sharing responsibility and dealing with differences in a respectful way.

37. There are a number of service user and carer groups. The CoG has a particular focus on service users. Also, the EQUAL forum brings together carers and people with lived experiences who represent the interests of a wider group of voices.

38. The vision and values are used in a variety of ways to calibrate standards of behaviour and performance. For example, through selection and recruitment processes, through induction, appraisals, and supervision.

39. The Team Derbyshire Healthcare promise aims to bring the values to life by making Trust commitments to health, wellbeing and value of staff and asking for commitments around behaviour and action in return.

40. The Trust value of 'honesty' represents the Board and Trust aspiration to be open and transparent in all it does.

41. We heard in the focus groups that Board leaders role model a culture of openness and listening, and we heard that in the main, staff feel listened to and heard. They receive responses and feedback. We heard many times that the Chair and Chief Executive exemplify this culture of openness and listening.

42. For a minority of staff, though leaders are listening they do not feel their voice is being heard or acknowledged.

43. There are well embedded FTSU arrangements in place and a FTSU Policy with regular updates on activity and cases coming the People and Culture Committee. And employment policies are embedded with 'Just Culture' principles.

44. The Board itself is diverse in terms of gender, ethnicity and thought. That is however not reflected in the levels below where there is much less ethnic diversity. There are active Staff Networks in place covering each of the protected characteristics whose aim is to advocate and engage on behalf of their members.

45. A minority of staff do not feel they are treated equitably and they are more likely to come from a particular protected characteristic; this being one of the development areas highlighted in the NHS Staff Survey 2022 results.

KLOE 4: Roles and Governance

46. There is a strong and embedded governance framework in place that facilitates Board oversight of good quality service provision and the execution of the Trust Strategy. It compares well with other mental health foundation trusts. Governance and management arrangements at all levels generally work well together but further clarity is required around Divisional accountability and oversight arrangements and around the multiplicity of meetings post-pandemic whose remit and escalation route is unclear. This has blurred the line of sight from Divisions through to the Committees and then upwards to the Board.

47. There are effective and well embedded structures, processes and systems of accountability to facilitate the delivery of the Trust Strategy and good quality sustainable services. The DHC governance structure provides an effective flow of decision making, assurance and escalation of issues.

48. The Board oversees the delivery of the Trust Strategy and the provision of good quality services and is supported by a governance infrastructure comprising the Board Committees of Audit and Risk, Finance and Performance, Mental Health Act, People and Culture, Quality and Safeguarding, and Remuneration and Appointments. Their focus on areas where performance is challenged needs to be stronger and Committee reporting to the Board would benefit from being more clearly focused around assurance.

49. Consideration should be given to establishing a Digital and Information Committee, given the scale of the digital transformation agenda.

50. Arrangements are in place to regularly review and improve all elements of the governance structures. Board and Committee performance is evaluated annually. All Board Directors receive an annual appraisal based on achievement of their objectives which are aligned with the Trust's strategic plans and objectives. All appraisal processes observed represented best practice, and included 360^0 feedback for the Chair and the Non-Executive Directors.

51. The CoG holds the Non-Executive Directors to account individually and collectively for Board performance, and evaluates its performance on an ongoing basis, regularly feeding back through the Chair.

52. The ELT provides a conduit between the governance and management systems and sets the tone by promoting a culture of empowerment, inclusivity and devolution of responsibility with accountability.

53. Governance and management levels generally function effectively and interact with each other appropriately though further work is required to reduce the multiplicity of meetings in Divisions and ensure there is clarity of purpose in the primary Divisional oversight and governance meetings.

54. The primary oversight meetings of the Divisions - the Divisional Achievement Reviews (DAR) and Trust Oversight Operational Leadership (TOOL), and within the Divisions through the Clinical and Operational Assurance Team (COAT) have several positive elements but their purpose needs revisiting, in order to offer assurance and escalation routes into the ELT, and Board and Committee governance, and Executive Directors need to better hold Divisional leadership to account for delivery.

55. Divisional oversight and governance meetings revealed duplication of discussions, lack of clarity around reporting of issues, strong in terms of information exchange and co-ordination, less clear in terms of decision making.

56. It is not always clear where Divisional outcomes are reported back in through the Board governance processes.

57. This lack of clarity is further impacted by what has been described by many we spoke to as an 'explosion' of meetings post-pandemic. Clinical and Divisional staff attend and/or report in to a range of operational meetings in addition to DAR, TOOL and COAT, and it is not clear to them on what their remit is, what value they have and if there is any escalation route.

58. There is an experienced, committed and highly functioning corporate governance team providing excellent support to the Board in all aspects of its role. At times, this team leads on governance matters rather than simply supports and there is a need for newer Board leaders to develop more fully their own commitment and delivery of governance.

59. Staff at all levels individually seem clear about their roles and they understand what they are accountable for, and to whom.

60. It is clear that the Board maintains a clear strategic focus and appropriate independence and distance in its oversight of operational delivery. The boundaries between Non-Executive Director and Executive Director roles are clear and well understood, and Non-Executive Directors are conscious to remain strategic, but need to be consistently more challenging.

61. DHC is an integral and committed member of JUCD and has a strong record of accomplishment of providing a range of clinical and community services with NHS and voluntary sector organisations across the local health and social care system. These arrangements with partners are, in the main, managed effectively though there is a renewed commitment by DHC to ensure the Trust delivers with its partner, Derbyshire Community Health NHS Foundation Trust, high-quality person-centred care in relation to the jointly provided Learning Disabilities and Autism service.

62. Observation of the Mental Health Act Committee which monitors and obtains assurance that the safeguards of the Mental Health Act and Mental Capacity Act are upheld provided strong evidence of good discussion and debate on the specifics of compliance requirements and robust levels of scrutiny and challenge.

KLOE 5: Risks and Performance

63. Board, operational and clinical assurance systems are comprehensive enabling performance issues to be escalated appropriately.

64. The Trust measures its performance using a range of online reports and dashboards that are linked to the electronic patient records and are updated daily overnight, providing an almost live view. These 'dashboards' give comprehensive oversight of key performance and workforce measures, which drill down from a strategic, to a divisional and then down to a team level. The aim is to ensure that all staff and all meetings utilise a common set of data sources - 'a single version of the truth.'

65. Operational and quality performance management in the Divisions has been reviewed in the last two years and is now overseen by TOOL. This team has established an Executive Governance and Delivery operational infrastructure. Each of the clinical Divisions holds a monthly COAT meeting, which monitors and manages Divisional level performance. Further, oversight of the Divisions is through a DAR meeting every six to eight weeks with some members of ELT.

66. TOOL's approach is one of positive challenge and confirmation, encouraging empowerment and autonomy of decision making within the clinical Divisions, but as already noted, its role needs revisiting. This performance management system facilitates escalation of issues through the clear structure. As noted above further work is needed to clarify what is being escalated for governance purposes, and what is being escalated for management purposes and where and how these escalations are reported.

67. A comprehensive IPR is presented at each Board meeting which covers detailed information on operational performance, quality of care delivery, workforce and culture metrics and finances. Each Board Committee receives its own section of the dashboard at each meeting for detailed discussion, scrutiny and challenge so that it is able to provide assurance to the Trust Board.

68. Observation of Boards and Committees suggests the performance dashboards are not being employed fully and consistently. For example, in Board meetings and at the Finance and Performance Committee in particular, scrutiny and challenge of dashboards could be much stronger. For the Committees we observed, Quality and Safeguarding did not have a quality dashboard on the agenda, and the timing of Finance and Performance and People and Culture was such that they were presented with dashboards that had already been received and scrutinised at a Board meeting. This suggests that the sequencing of Committees needs to be looked at to ensure the Board fully benefits from scrutiny and challenge applied at the Committee level.

69. In regard to the future, DHC has taken a system perspective to form a Reducing Health Inequalities Delivery Board to bring together Trust teams and services to collectively identify, address and reduce the health inequalities being experienced locally through performance management of whole pathways of care in Derby and Derbyshire.

70. The Audit and Risk Committee oversees the planning, delivery and implementation of improvement actions of an annual Internal Audit Plan to monitor quality, operational and financial processes. and systems to identify where action should be taken, and there are further relevant close links on the internal audit programme via the Quality and Safeguarding Committee.

71. There is an active Clinical Audit as well as a Research and Development team and a planned annual Clinical Audit Programme in addition to internal clinical reviews and deep dives into specific service areas.

72. There are well embedded and well understood systems and processes in place for identifying, recording and managing risks in all areas of the Trust. The overall Trust approach to risk management is sound, as is the construction of the BAF and Corporate Risk Register and Board and organisational focus on risks is good. There is strong alignment between Board members on what the top strategic risks are, and also between recorded risks and what staff say is on their worry list.

73. There is positive discussion of the BAF across the Committees and at the Board and good evidence that shows that the BAF has become more embedded with strong discussions on strategic risks management, underpinned by clear scrutiny and challenge. The Board needs to revisit its risks appetite which feels to us to need review within the context of the strategic aims and objectives of DHC.

74. There are well developed systems and processes for taking potential risks into account when planning services, including in the areas of Business Continuity and Emergency Planning, Winter Pressures, Emergency Preparedness, Resilience and Response and the ability to stand up an Incident Management Team to support rapid decision-making should the need arise.

75. The Quality and Safeguarding Committee oversees a process to assess the impact on quality and patient safety of each of the individual schemes in the Trust wide Cost Improvement Programme with evidence that these schemes can be rejected if there is the risk of compromising care.

KLOE 6: Information

76. Quality and sustainable performance both receive sufficient coverage in meetings at all levels and this has been enhanced by significant investment in analytics, a clinical data centre and Real World Health together with the use of NHS Benchmarking to improve the use of information and performance.

77. All staff have access to information via Connect Intelligence - a reporting tool that collates multiple sources of data into one place. The Trust measures its performance using a range of online dashboards and reports that are linked to the electronic patient records and updated daily overnight.

78. This 'single version of truth' includes both quality and sustainability measures and is discussed, challenged and interrogated at all levels - at team level, COAT, TOOL, DAR, Committee and Board as described above.

79. A comprehensive IPR is presented at each Board meeting which covers detailed information on operational performance, quality of care delivery, workforce and culture metrics and finances. Each target, goal, metric is shown on a run chart using Statistical Control Measures to highlight progress. Each chart is accompanied by a narrative summary and actions being taken to address delivery. These service performance measures are clear.

80. The Trust should now look to build on this by adopting a pyramid reporting approach - with information being filtered as it moves across the governance architecture of the Trust so that by the time it comes to the Board, it is very much a high-level exception-based overview, informed by the discussions and deliberations that have taken place at the Committee level and the levels below that.

81. Information is used not only to provide assurance but also to measure for improvement. For example, there are clear plans outlined in the Quality Improvement Strategy and good evidence of learning from the themes and changes made to Trust services as a result of feedback on incidents and complaints. The Trust has set up a Productivity Board to better understand how productivity could be improved by using information to identify opportunities to deploy resources to better effect.

82. Performance and quality information system technology includes data quality validation checks. This is sense checked by operation and quality teams.

83. Presentation of information in dashboards at Board and Committees includes narrative alongside KPIs in which executive judgement is used to triangulate and connect information.

84. A Digital Strategy is driving transformation in the use of IT to monitor and improve the quality of care. The migration to a new electronic patient record - SystmOne, enables the Trust to more effectively integrate across the whole system and pathways of care. Other successes include the increase in the use of video consultations and hybrid working arrangements across the Trust.

85. The digital agenda needs to gather pace and have greater ambition, if DHC is to capitalise on and unlock the benefits of this agenda.

86. Information Governance arrangements remain fully compliant with evidence of learning from the small number of occasions when there have been data security breaches.

KLOE 7: External Partners Engaged

87. DHC has a strong record and reputation for stakeholder engagement both internally and outside the Trust. It uses a variety of means to gather service user, carer, staff and partner views and experience to shape and improve services and culture. The Trust engages via a range of structures, groups and networks. Crucially, the open and transparent engagement culture means that services benefit from hearing and responding to a variety of voices.

88. There is an open and constructive relationship with the CoG and significant engagement, in addition to the governance and accountability role at the Trust of the CoG. For example, Governors participate in quality visits where they are encouraged to engage with staff, understand and learn about services delivered and provide feedback on their experiences. Governors also play a vital role for the Trust in engaging with local voluntary organisations, service users and carer groups, local consultative forums, their members and the public and bringing their views, issues and feedback back into the Trust. An Engagement Log enables a formal record of this varied activity to be recorded from which themes and issues can be identified.

89. Service users and carers are able to use their lived experience and knowledge to work with the Trust through the EQUAL group to focus on service improvements.

90. There is active engagement with staff in many ways. There is a Staff Forum and Staff Support Networks representing those with protected characteristics.

91. The work around the Workforce Race Equality Standard and Workforce Disability Equality Standard is informed by this work and network suggestions feature in the action plans. The annual NHS Staff Survey, pulse surveys and the monthly executive led all staff briefing are also an opportunity to embrace staff views and questions.

92. As noted in the previous section, DHC is an integral and committed member of JUCD and demonstrates this in a variety of ways. The Chief Executive chairs and is Accountable Officer for the Mental Health System Delivery Board and the Director of Strategy, Partnerships and Transformation is the Senior Responsible Officer for the Mental Health Programme. The Chief Executive is leading the work across the system to establish Integrated Care Partnerships across the City and County. The Trust Chief Executive is the Chief Executive Provider Collaborative representative on the Derby and Derbyshire Integrated Care Board.

93. DHC is an active partner with other mental health providers through the East Midlands Alliance.

94. DHC has a strong history of working well with partners across the health and social care economy and provides several clinical services in partnership with other providers across the NHS and voluntary sector. The belief is that this collaborative approach will bring benefits to service users and carers through wider learning, sharing information and expertise to help provide the best possible care.

95. As noted earlier, the Trust is, in the main, viewed by its stakeholders, both internal and external, as an open, honest, inclusive and listening Trust. This is mirrored by the Board. It should be acknowledged that in spite of the above, a sizeable minority of external stakeholders highlighted inconsistencies in messages coming from the Trust and the reality of delivery. The phrase used in these instances was that the Trust 'talks the talk but does not always walk the walk.' The example consistently quoted to illustrate this was the decision by the Trust to unilaterally change terms and conditions of service of community staff without any prior communication with or reference back to system partners.

KLOE 8: Learning, Improvement and Innovation

96. There is evidence of continuous learning, improvement and innovation in DHC. The Trust has a 'Building Block' strategic commitment to enhance and embed learning and innovation and to underpin this a refreshed Quality Improvement Strategy is in place, accompanied by an implementation plan.

97. A Trust Transformation Team has been formed and is active in progressing a range of improvement ideas and a pipeline of transformation projects. At this stage, the programme of work for quality improvement is currently under developed though there is clear ambition to expand it and to link it much more explicitly to other strategies, for example education and training.

98. Continuous progress can be seen in a number of areas activity and in many cases, are part of business as usual. The Trust focus has been on embedding learning following the 2019 Care Quality Commission inspection and during the pandemic, with the aim of developing and maintaining sustained quality improvements across a range of areas. For example, learning from Serious Incidents and how these are fed back into changes to Trust practices for improvement are reported into Quality and Safeguarding Committee and other governance routes as evidence of learning. This includes mortality events and learning from deaths.

99. Trust research and development efforts were paused during the pandemic as staff were redeployed to pandemic related activities. This has now resumed and targeted at national public health priorities related to pandemic learnings.

100. DHC employs standardised improvement tools and methods, rolling out a quality improvement methodology for staff in areas targeted for change and a number of staff have been trained in quality improvement methodology. LifeQI systems and Quality Improvement health platform forms part of this and while there are an increasing number of staff trained, the number remains relatively small and it would be helpful to roll this out more comprehensively around the Trust.

101. There is an appetite for innovation and a need for it, given the scale of challenges in different areas of Trust activity. Staff do sometimes take the opportunity to take time out to review clinical practices and implement innovations, supported by data and quality improvement methodology. There is ambition to go much further and this forms part of the Quality Improvement implementation plan.

102. There is evidence of communication within and across the Trust of numerous improvements and innovations that have been introduced, raising awareness and celebrating achievement. That said, some staff we spoke to feel the Trust needed to promote improvements and innovations better, internally and externally, and adopt a more commercial approach around innovations developed by the Trust.

4. Concluding Remarks and Recommendations

Concluding remarks

4.1 The boards of all NHS providers have a sizeable and challenging strategic and operational agenda to address over the next few years.

4.2 Alongside a range of Trust specific issues, there are external challenges around addressing the regulatory landscape, operating in a post pandemic world, and greater system working.

4.3 For the Trust to successfully address this agenda will require continued effective development of the Board as a collective and sustained Board leadership, using the recommendations we have made as the primary focus for that.

4.4 Whilst our review has identified some development areas, we also observed a sense of renewal and refresh at DHC signalled by the arrival in particular of the new Chief Executive and observed and heard so many positive examples of good leadership and governance to demonstrate across the eight well-led framework KLOEs that there is a very exciting agenda ahead for the Board and the organisation more widely.

4.5 In that sense this review and its findings can act as a launch pad for moving DHC to the next stage of its journey.

4.6 We also strongly believe that the Trust Board has all the constituent elements to be effective and is serious about board leadership, board processes and continued effective governance, and alongside which, we have observed considerable commitment to this review by the Trust.

4.7 In that sense, this review presents a unique opportunity to further renew and reinvigorate the governance arrangements within the Trust and our recommendations in this concluding section of our report seeks to do that.

4.8 Addressing the areas for development that we have identified as part of this review in a systematic manner, building on progress to date and drawing on learning from other sectors will, we have no doubt, noticeably accelerate Board leadership and governance arrangements at the Trust.

Recommendations

4.9 In order to take the issues, we have identified in our report forward, we have made a number of recommendations which are set out below.

4.10 We suggest that the Board considers the findings outlined within this report and develop a response in relation to the matters raised. This response should clearly outline how the Board proposes to implement our various recommendations and describe how the Board will monitor progress going forward.

4.11 We have given each recommendation a priority and a suggested timescale for implementation, but recognise that the Board will wish to review these carefully to ensure that the subsequent implementation plan is owned and deliverable.

	Actions to be implemented within 6 months of this review	Actions to be implemented within 12 months of this review
KLOE 1: Leadership, Capacity and Capability	**R1.** Devise and implement a planned and structured two-year Board Development Programme. At its core this should include activities to support the collective and unitary acumen of the Board including soft skills development and a grounding in effective boardroom behaviours. In addition, there should be separate elements to support the collective and individual development of Executive Directors and the individual development of Non-Executive Directors **R2.** Devise a Leadership Strategy based on the vision of inclusive, compassionate and people centred skills. This should be clear on priorities, actions and outcomes and should enable connection with the various leadership initiatives underway **R3.** Fully expand the existing Talent and Succession Plan to support the identification and development of talented and emerging leaders at all levels in the Trust. An integral part of this should be a Board Succession Plan to ensure arrangements are in place to support the sustainability of a balanced board with the requisite skills and experience to achieve the long-term strategy	
KLOE 2: Vision and Strategy	**R4.** The Board to sense check and challenge the current Trust Strategy to establish stretching and realistic outcomes given: - The scale of the ambitious programme of commitments in the two years remaining of the current Trust Strategy - Significant changes in the external environment including the need to address the system deficit **R5.** Follow through and complete work currently underway to tap in to the clinical expertise of the workforce to integrate the Clinical Strategy, aligning it to the overarching Trust Strategy **R6.** Review the priority actions identified to monitor progress of the Trust Strategy with a view to identifying corresponding high level KPIs that are connected directly to the two clinical priorities and the four strategic priorities	
KLOE 3: Culture	**R7.** Board discussion on 'People First' to clarify what it means in practise and establish common understanding and agreement	**R14.** Board to explicitly define the desired culture in DHC and identify a sub-set of overarching workforce indicators to enable the Board to understand when the culture is changing
KLOE 4: Roles and Governance	**R8a.** Develop more manageable and forward-looking Board agendas by creating a stronger linkage to the BAF and through the introduction of consent agendas	**R15.** Review the role and purpose and reporting lines for all meetings below the Committee level to ensure they have a clear role and remit, and disestablish those that do not serve a clear assurance purpose

	Actions to be implemented within 6 months of this review	Actions to be implemented within 12months of this review
KLOE 4: Roles and Governance	**R9.** Agree a prescriptive Trust-wide approach for Board and Committee papers, accompanied by the development of a clear 'glide path' for their production, and create space for greater ELT focus and ownership of Board and Committee papers **R10.** Review the sequencing of Committee meetings in relation to Board meetings to ensure that the Board fully benefits from the work of the Committees **R11.** Consider a revised reporting template for Committee reporting to the Board and consider placing these report more prominently on the Board agenda	**R16.** Consider establishing a Digital and Information Committee, given the scale of the digital transformation agenda DHC has to progress. An early action for the Committee needs to be oversight of a programme of work designed to inject greater pace and ambition in relation to implementation of the Digital Strategy **R17.** Undertake a review of the Trust Constitution. This review should take account of the addendum to the Statutory Guide for Governors and specifically how the legal duties of the CoG support system working and collaboration and the principles regarding collaboration and system working in the June 2021 ICS Design Framework
KLOE 5: Risks and Performance	**R12.** Clarify the role and purpose of the primary Divisional oversight and governance meetings at the Trust, most notably, DAR, COAT and TOOL and ensure across a greater element of holding to account	**R18.** Revise BAF reporting to the Board by adopting a more streamlined 'pyramid report' approach that better reflects the scrutiny and challenge applied at the Committee level **R19.** Undertake a review of the number of open Trust wide risks and Corporate Services risks **R20.** Review the Trust risk appetite annually and within the context of evolving strategic and operational issues
KLOE 6: Information	**R8b.** In conjunction with **R8a**, consider any further actions to refresh and refine the Trust approach to reporting at Board, Committee and at the Divisional level	**R21.** Explore how Quality Improvement and processes could be improved and better aligned to the delivery of key strategic objectives
KLOE 7: External Partners Engaged	**R13.** Explore as part of a structured development programme stakeholder perceptions of the Trust and how comments and feedback in our review can be built upon positively	**R22.** In collaboration with the CoG, commission a programme of development for the CoG, which includes how the CoG can provide enhanced scrutiny and challenge and use this review as a platform for looking at the CoG induction programme and how engagement with the membership can be enhanced **R23.** Consider how various engagement activities undertaken by the Trust to engage further with service users and carers get themed to drive change strategically
KLOE 8: Learning, Improvement and Innovation		**R24.** Explore how areas of innovative practice at DHC could be better promoted, internally and externally

Board Committee Assurance Summary Reports to Trust Board – 7 November 2023

The following summaries cover the meetings that have been held since the last public Board meeting held on 5 September and are received for information.

- Quality and Safeguarding Committee 12 September and 10 October
- Mental Health Act Committee 15 September
- Finance and Performance Committee 26 September
- People and Culture Committee 21 September
- Audit and Risk Committee 12 October

Quality and Safeguarding Committee - key items discussed 12 September 2023

Summary of BAF Risks with Quality and Safeguarding Committee oversight

Consideration was given to Issue 2 2023/24, Version 2.3 of the Board Assurance Framework (BAF) risks allocated to the Committee to give context to discussions during the meeting to ensure assurances received are focused on mitigating key risks to achieving the Trust's strategic objectives.

Actions to close key gaps in control under 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"* were noted. Further updates to Risk 1A included the closure of two other gaps:

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

With regards to Risk 1D *"There is a risk that the organisation is in breach of essential standards for privacy and dignity in its acute bedded care facility as it has not fully completed its dormitory eradication programme. This may result in regulatory action if mitigation to improve safety does not occur"* two actions were downgraded, from amber to red. Both were due to significant cost pressures regarding affordability relating to Older Adult service relocation and Radbourne Unit dormitory eradication. One of the actions relating to Audrey House refurbishment has improved the rating from red to amber, as work progresses but the original timeframe will not be met.

Risk Escalation and Assurance report

This report outlined the process of the risk register reviews and summarised the current status of extreme/high level Trust-wide operational risks. The report also provided an update on compliance rates for the tiered risk management training programme.

The Medical Director provided assurance that the closure and review of risks undergoes a rigorous exercise within Trust Operational Oversight Leadership (TOOL), Divisional Assurance Reviews (DARs) and Clinical Operational Assurance Team meetings (COATs).

Significant assurance was received regarding the risk management and reporting strategy based on the assurance received by the Audit and Risk Committee on the process behind risk management within the Trust. Significant assurance was also obtained from the delivery of risk management training.

Industrial Action Mitigation Plans

The Committee considered and noted the Trust's response to date to the numerous industrial action events. The report provided an overview of the period of industrial action the Trust has been involved in and outlined the role of the Incident Management Team (IMT) in managing the risks and mitigations and the impact on the Trust's ability to deliver services safely. The report

showed that no abnormal variation had been seen as a result of the industrial action that took place during May and June.

The tremendous effort amongst staff to work together and the impact that industrial action is having on people working on the front line was not underestimated by the Committee. Discussion focussed on the need to ensure that the long term effect of industrial action does not become a feature of normal activity. The Emergency Preparedness, Resilience and Response (EPRR) Sustainability team is actively looking at areas of risk and the possible long term impact of staff carrying the burden of this pressure.

Recommendations arising from the Letby case

A verbal briefing was received by the Medical Director on the independent inquiry announced by the Department of Health and Social Care into the events committed by Lucy Letby at the Countess of Chester Hospital NHS Foundation Trust.

The Trust has commenced its preparations to respond to the national recommendations made by NHSE with regard to strengthening patient safety monitoring and speaking up/raising concerns. Accountability of senior leadership and the Board will be the main area of focus.

The Committee was pleased to hear that medical staff feel confident to approach the Safeguarding team if they suspect any dangerous activity. Discussions have been held with staff about how patterns in incidents can be linked within rosters and reported through Datix. A point of note was that a number of junior doctors are raising issues directly with the Guardian of Safe Working (GOSW) rather than the Freedom to Speak Up Guardian (FTSUG). Despite the FTSUG meeting with junior doctors they feel more confident talking to the GOSW. The Guardian of Safe Working and Freedom to Speak Up Guardian regularly link up.

The Committee noted the verbal update and was assured that every possible lesson will be learnt from Letby's conviction.

Quality Performance Dashboard

The report provided a positive view of the key clinical performance indicators within the dashboard given the impact of recent industrial action and staffing issues.

Reference was made to the reduction in complaints and concerns between May and August, although the number of compliments has fallen by 18%. It is anticipated that further detail regarding compliments will feature in the dashboard on a quarterly basis.

The report showed that the current percentage of patients who have had their care plan reviewed and have been on Care Plan Approach (CPA) for over 12 months is 55%, an increase of 5% between and May and August 2023. Work is taking place with the Heads of Nursing (HON) to improve the way the divisions are using CPA. A working group meets monthly to review the Trust approach to CPA that will ensure clinicians are confident in the CPA application and it is anticipated greater compliance will be seen in CPA by December.

The Committee took significant assurance from the progress made to reach clinical performance targets. Limited assurance was obtained with the progress being made with CPA compliance.

Outstanding CQC Actions Update

An update report on the headway being made to complete outstanding CQC actions was offered with limited assurance.

No further actions achieved completion this month with regard to CQC comprehensive inspections or Mental Health Act reports. The biggest area where action is required is with improving care planning. Work to scrutinise and ensure continuous improvement is being led and focussed on by clinical leads.

The Committee concurred that productivity could be achieved through good practice. The report provided limited assurance on progress towards completion of actions. It was noted that targeted improvement work to reach the required level is progressing with scrutiny at Divisional Assurance Reviews.

Neurodevelopmental Services Update

The Committee considered the progress being made with Neurodevelopmental (ND) Services.

Autism assessments are maintaining the commissioned target of 26 a month but this is not meeting demand. The current referral rate is 35 per month. A number of ND admissions over the last few months have been for autism. Work is taking place to improve routes to admission from the Community Mental Health Teams (CMHTs).

Escalation for non-compliance for Learning Disability (LD) Annual Health Checks full recovery action plan is being developed with Primary Care Network (PCN) and the ICB to meet national target for 2023/24. Although accountability for delivering health checks sits with the PCN the Committee will continue to have oversight of health check compliance.

A review of the Friends and Family Test is being led by ND to increase feedback into services and ensure that the Trust is able to hear the voices of hard-to-reach communities and for people who have challenges in using IT.

The Committee acknowledged the amount of work and effort that has shown a major improvement in the ND service and received significant assurance from this update report.

Clinical Research Annual Report 2022/23

A review of the Research and Development Annual Report and plans for 2023/24 showed a healthy spread across services.

The National Institute of Health Research (NIHR) regional Clinical Research Network enables DHCFT as a research site to host national high quality multi-site grant funded research for patient benefit. There has been good involvement in research covering a wide cross section of clinical services at DHCFT, participant research experience surveys provide participant feedback for improvement and a range of collaborations have been undertaken to enhance service delivery.

The success of the embedded Research and Evaluation model has led to a wide range of research, evaluation and improvement activities undertaken within clinical services having impact at local service and wider Trust level. The increasing demand from other clinical services has led to the development of a business case for the future of a sustainable Trust-wide delivery model.

As a service Research and Development is closely aligned with Quality Improvement and work has commenced within the embedded research function to determine assessment of impact.

The Library and Knowledge Service Strategy 2023-2026 provides the vision for how the service develop over the next three years. It is based on the key drivers of the Trust Strategy, the Research and Development strategic plan and the Health Education England framework for NHS library and knowledge services and was approved by the Committee.

The Committee recognised the correlation of research relating to clinical activity and the alignment with Quality Improvement and welcomed the growth in reporting for 2023/24. Significant assurance was received from the activity and plans reported. The Committee also received significant assurance that there is a generally sound system of control designed to meet the system's objectives. However, some weakness in the design or inconsistent application of controls put the achievement of particular objectives at risk.

Dual Diagnosis Improvement Plan

The Committee received an overview of clinical risks and improvements needed in line with co-existing substance misuse and quality improvement. The report included a gap analysis into the wider Mental Health and Substance Misuse services to review if the Trust is compliant with NICE guidance (CG120).

The report evidenced that across the UK alcohol and drug misuse is common among patients who die by suicide. However, only a minority of patients who died by suicide between 2008 and 2018 were in contact with specialist alcohol and drug misuse services. It is recommended that in order to reduce alcohol and drug misuse local drug and alcohol services should be available that

work jointly with mental health services for patients with mental illness and alcohol and drug misuse. Other clinical measures that could reduce suicide risk in this group are alcohol and drug misuse assessment skills in frontline staff and specialist alcohol and drug misuse clinicians within mental health services.

The Committee accepted that this exploration of clinical standards and insight into exploration of the NICE guideline and improvement work is offered without an assessment of assurance as this is emerging Quality Improvement work. This work will be reviewed in the Divisional Achievement Reviews with a review of impact in six months. .

Assuring Quality Of Care

The Committee received an update on progress made in assuring Quality of Care in response to Clare Murdoch's letter on inpatient care since the last report was received at the June meeting. The report identifies gaps and actions to further reinforce assurance to support the request from Claire Murdoch..

Discussion focussed on the challenges concerned with high bed occupancy rates and maintaining clinical standards. A review of all clinical standards is being carried out and additional staff have been assigned to the ward. The Medical Director is leading this QI work to ensure standards increase and bed occupancy reduces starting with the Radbourne Unit followed by the Hartington Unit.

The Committee accepted significant assurance from the oversight and continuous improvement to develop and maintain an open culture. Significant assurance was obtained from the action set out in the report.

Review of Quality Priorities and CQUINS

The report provided an update on quarter 1 as set out within the 2023/24 Quality Account.

A specific point of assurance was required on the Making Room for Dignity programme in order to be assured that all the quality priorities have been considered within the new build facilities. It was noted that all the national and regional checks have been considered and no new guidance has been released since the original set of checks was carried out. The committee requested at the December meeting to provide assurance that work is on track and summarise the need for any additional checks.

Despite the gap in control seen in Perinatal services under CQUIN15b and CQUIN15c significant assurance was received from the report. It is expected that the outcome measures in Perinatal will be completed by the end of Q4.

Safeguarding Children Assurance Report

An assessment of Safeguarding Children activity in the Trust against statutory and legislative requirements provided the Committee with significant assurance.

The report highlighted the continued high activity which the Safeguarding team is fully engaged in to support the services and showed areas where risks and pressures impact on Safeguarding Children.

The Committee was concerned that the paediatric allocated session for a Named Doctor still remains vacant with the role being covered by a Safeguarding Children Doctor who is a psychiatrist. A paediatrician is required for this post as well as a psychiatrist and it was understood that recruitment for these hours is ongoing. It was noted that a number of people have expressed an interest in particular roles within Safeguarding Children services and the team is seen as strong and that people are keen to join.

Safeguarding Adults Assurance Report

An update on Adult Safeguarding performance and activity and review of statutory requirements provided full assurance that statutory duties are being met.

The report showed a similar position to Safeguarding Children. Clinical activity continues to be

high with increasing complexity of safeguarding referrals and clinical cases. There is good communication between operational managers and the Safeguarding Adults team which ensures timely and proportionate responses to incidents. Mental health homicides are an area of continued focus.

Sexual safety standards continue to be a pressure. Work is ongoing around the quality priority of improving sexual safety and further national guidance been released by NHSE in September will be incorporated into future plans.

Clarification was sought on the new Derby and Derbyshire person in a position of trust (PIPOT). The policy is currently being reviewed with the Employee Relations team to reflect the changes. The policy will also be adapted in collaboration with the Police to ensure our protocols comply with this guidance. The outcomes and findings of the Letby criminal investigation will also be incorporated into the policy.

Safeguarding Children and Adults at Risk Annual Report

The annual production of this report is a governance requirement of both the Trust and the Safeguarding Children Partnership and Adult Safeguarding Boards. The report confirmed that the Trust has a strong and robust safeguarding infrastructure.

The Committee received significant assurance from the work of the Trust in discharging its formal statutory duties to vulnerable children and approved the report for submission to the Board on 7 November.

Derby City Children in Care Annual Report 2022/23

This report contained an overview of the progress, challenges, opportunities and future plans to support and improve the health and wellbeing of looked after children in Derby City. The report provided significant assurance on the provision, performance, and outcomes for children in the service. Health performance has been maintained and exceeded the levels set to ensure outcomes for our children.

Having scrutinised the report the Committee was satisfied that the Trust has discharged its formal statutory duties to vulnerable children and approved the report for submission to the Trust Board on 7 November.

Allegations Against Staff Carers and Volunteer Policy

The Allegations Against Staff Carers and Volunteer policy was ratified the policy on the understanding that it will return for further review after it has undergone a significant check in legislation in PIPOT and the Letby findings and will return to the December meeting for review.

Board Assurance Framework – key risks identified: Quality improvements in safety practice will be updated in the BAF.

Escalations to Board or other committee: The People and Culture Committee to be asked to receive a training evaluation report specifically for Safeguarding training.

Next Meeting: 10 October 2023

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

Quality and Safeguarding Committee - key items discussed 10 October 2023
Board Assurance Framework (BAF) The latest version of the BAF risks allocated to the Committee were scrutinised. The Chair asked for additional narrative to be added to the newest actions to close key gaps in control under Risk 1A. Clarification was also sought on whether the Patient Carer Race Equality Framework also covered disability. The Committee expressed concern about the overdue reviews and the level of escalation needed.
CQC Actions Progress was given on CQC actions and preparedness for future inspections. The Committee focused on the findings of the recent CQC inspection of Ward 35 which had been carried out following concerns raised at a previous Mental Health Act visit. There is a full report on this within the Public Board papers for 7 November. The Trust continues to carry out mock inspections. Although many of the issues were rapidly rectified after the inspection, the Committee was still concerned about progress on the CQC actions and general compliance against standards and therefore agreed limited assurance. Actions from any future Mental Health Act visits would be built into the CQC action report presented to the Committee.
Infection Control update The update included the Infection Control Board Assurance Framework and the Committee agreed significant assurance around the Trust's compliance with National IPC standards but limited assurance around the policy updates.
Serious Incidents Bi-Monthly Report The six-monthly report showed areas identified for improvement and successes to date within the Patient Safety Team workflow and incident process. The Committee noted that Level 1 Essentials for Patient Safety was now mandatory in light of the Letby case. Overall the report was accepted with significant assurance.
Learning from Deaths/Mortality Report The National Guidance on Learning from Deaths requires each Trust to collect and publish specified information on a quarterly basis. The report covers the period 1 June to 31 August 2023. The Committee agreed significant assurance and would confirm this when the reports is presented to the Board in November.
Quality Improvement Strategy 2021 - 2024 - Annual Update The 2021-2025 Quality Improvement Strategy aims at building Quality Improvement (QI) capability and infrastructure in the organisation. 12 out of the 14 actions have been completed and 2 remain in progress for completion in March 2024.
Report from Guardian of Safe Working The quarterly report provided data about the number of Junior Doctors in training in the Trust, full transition to the 2016 Junior Doctor contract and any issues arising. It included arrangements made to ensure safe working within the new contract and arrangements in place to identify, quantify and remedy any risks to the organisation. Significant assurance was agreed around the duties and requirements as set out in the 2016 Junior Doctor terms and conditions of service are being met.
Patient Experience Quarterly Report This update focused on Compliments and Complaints to provide the committee with assurance regarding the themes and changes made to Trust services as a result of feedback on incidents and complaints made to the Patient and Carer Experience Committee. Friends and Family

Survey returns remain low in some areas; however, improved feedback formats are due for roll out which will provide a variety of feedback options for service users including an electronic patient survey which has been co-produced with service user involvement. The Committee will welcome sight of the progress and response rates by December as processes become more embedded. Overall the report was accepted with significant assurance.
Quality Impact Analysis update The Committee received an update on QI capability building and impact analysis. Almost 500 colleagues are now trained at a level of QI training and the Trust is predicting to complete around 700 training sessions by the end of March 2024. The report gave an outline of the initiatives and the value towards the Cost Improvement Programme together with an update on the outcomes of the impact analysis.
Board Assurance Framework – key risks identified: Revisions to the new gaps in control were asked for. Escalations to Board: None Next Meeting: 14 November 20023

Committee Chair: Lynn Andrews	Executive Lead: Director of Nursing and Patient Experience

Mental Health Act Committee - key items discussed 15 September 2023

Escalations from the Mental Health Act Operational Group and Terms Of Reference

Escalations from the meeting of the MHA Operational Group held on 21 August were as follows:

The exploration of implementing a blanket restriction of locked doors on inpatient areas was noted. It is proposed that doors will remain locked to manage risks, including episodes of absconding. It was understood that locked doors are in operation across other trusts and as such the Trust is not an outlier. Although locked doors are a restrictive practice it was thought to be the best action to take to manage risks. These circumstances have been discussed with patients and are explained at each shift change.

A considerable number of revisions were made to improve the MHA Operational Group's Terms of Reference (ToR). The Committee ratified the ToR on the understanding that they will be further revised to confirm improved membership and quoracy to ensure that the MHA Operational Group is compliant with MHA regulatory practices. The revised ToR will be presented for review by the Committee at the next meeting in December.

Mental Health Act Managers Report

The MHA Quarterly Report covering MHA Office activity from 1 April to 30 June was considered. The report was previously discussed at the MHA Operational Group. Points of note included improvements in the reading of s.132 inpatient ward rights to patients on admission.

Community Treatment Order (CTO) activity has seen a total of three lapses during this period. Renewals should be completed within one month. Lapses have involved a transition from one Responsible Clinician to another. Work is taking place to develop a CTO rights improvement plan and to ensure better communication regarding patients who are subject to CTO.

The Committee was assured that the three yearly Associate Hospital Managers (AHMs) reviews have concluded to ensure all AHMs have the requisite skills, knowledge and experience to continue in the role. The Trust will shortly be recruiting a number of AHMs given recent departures.

Specific matters relating to CQC reports on MHA monitoring visits for the Kedleston Unit and Cubley Court were noted. The MHA office has spent a considerable amount of time listening to teams following MHA visits. Action is being taken to liaise with service managers with a focus on compliance with MHA requirements.

Significant assurance was obtained from the MHA Manager's report.

Training Report

An update on Mental Capacity Act (MCA) training within the Safeguarding Adults Level 3 class.

Progress was noted overall despite not hitting 90% compliance target. The MCA 2005 training is undertaken as part of Safeguarding Adults Level 3 (including Levels 1 and 2) plus DoLs, MCA and Wrap/PREVENT. This is a full day class attended by staff requiring mandatory compliance of all disciplines and is delivered to staff Band 4 and above. The whole day class also includes sessions on Cuckooing and Domestic Abuse Act 2021.

Concern was raised that Care Programme Approach (CPA) training was not meeting compliance. Detailed work is being developed on fundamental standards to resolve gaps in compliance. Work is taking place to improve compliance and develop a wider scope of CPA. It is anticipated that when CPA legality is changed the Trust will already be compliant and this will be evident in the training compliance figures for the next meeting in December.

Restrictive Practice Quality Report

The Committee was updated on progress made regarding implementation of the Positive and Safe strategy in specific aspects that connect with the Mental Health Act Committee, oversight of the Code of Practice or concerns highlighted within Mental Health Act reports.

Although the report is received twice-yearly by the Quality and Safeguarding Committee, which takes primacy on the practice issues, matters are highlighted to the Mental Health Act Committee to give assurance that the Trust is discharging its responsibilities under the Code of Practice, in line with the Reducing Restrictive Practise Policy.

The report identified areas that require further improvement. Physical restraint showed a slight increase. Prone restraint and seclusion have reduced. These aspects were seen as a positive indication. Absconsion rates reported over the last six months show an increasing trend which is likely to be related to how locked doors are being managed. It is expected that this will be improved once the policy on locked doors is revised.

Having discussed the report the Committee agreed that significant assurance could be taken from overall performance progress but limited assurance due to the ongoing issue regarding the functionality of the Brigid App. The Committee will be updated on the resolution of these issues at the next meeting in December by way of a joint statement from patients and IT to clarify the position.

Use of Section 136 Suites 135/136 linked to “A Safer Place to Be” (CQC 2014)

The Committee considered the use of Section 136 suites/Section 135/136 linked to “A Safer Place to Be” (CQC 2014). This collaborates with multi-professionals and relates to the Joint Policy for Derbyshire on the Operation of Section 136 of the Mental Health Act 1983 Policy and Procedures.

Discussion focussed on the CQC work plan for Section 136 for the year 2023 which is largely centred around embedding and sustaining progress an improvement, made in terms of the CQC action plan 2020. This has included firming up data collection/local audit and using the information to drive improvement and standards. It is anticipated that all actions will be on track for completion when the Committee next meets in December.

Discussion also took place on the governance process for completing Section 136 CQC actions, it was clarified that the Quality and Safeguarding Committee receives a progress update on the completion of actions from the nursing teams. The MHA Operational Group is responsible for monitoring and logging CQC actions that arise and will ensure this Committee has full oversight of the actions being logged. These actions are also taken through Trust Operational Oversight Leadership (TOOL).

It was agreed that the Quality and Safeguarding Committee is to have full oversight of the governance process for CQC Section 136 actions in order to be assured that the process is being embedded and progress is being made. A progress report will be taken through the December Quality and Safeguarding Committee.

The Committee received limited assurance from the work already completed but noted the ongoing work for the CQC Section 136 action plan.

Section 136 Steering Group and use of Section 136 Suites

Key points of note included the rapid increase of 136 detentions since October 2022 Trust-wide, which were mainly due to changes within Police custody. Increased activity has been as a result of a rise in alcohol related difficulties, as well as an increase in activity of patients requiring a seclusion pathway due to aggression. The potential for poverty related to the cost of living crisis, breakdowns in relationships and the increase of homelessness has also contributed to increased distress and self-harm. The re-launch of the street triage pilot scheme showed a reduction and the benefit of street triage. The 135/136 Rights leaflet which is now in easy read format and accessible in the Section 136 suites is proving invaluable.

The Committee concluded that although the work already completed especially in terms of street triage and the Mental Health helpline has shown positive signs, there is a need to compare the Trust’s data with the data from the police and local authority to understand if there is an underlying problem or if increase in demand is due to a growth in the number of very unwell people in Derby and Derbyshire. Current data is revealing an increase in admission and industrial action has caused reduced capacity in the community which is having a significant impact on all entry points of our services.

The Committee supported the efforts of the steering group and saw evidence that compliance is being monitored with regard to the data, themes and trends, alongside audit requirements for CQC purpose and for best standards.

Verbal update from Associate Hospital Manager (AHM)

AHMs have completed their appraisals and have renewed their contracts for the next three years. A number of positive aspects were covered by the appraisal process and no negative comments arose.

The majority of hearings have been uncontested and all AHMs have taken part. It was noted that the quality of medical reports were thought to be good which enables effective decision making.

The suggestion of AHMs meeting face to face was discussed and would be arranged through their development training.

Action Plan – 360 Assurance Audit

The Trust's internal auditors 360 Assurance recently conducted a governance audit and the follow up of CQC actions following MHA visits, specifically regarding the MHA actions. In terms of the Clinical Audit the MHA Operational Group is monitoring the audits.

The Committee noted that all actions to be completed by end of September 2023 are now complete. These actions agreed would enable evidence to be provided to 360 Assurance that their audit recommendations are being completed.

Limited assurance was taken from the actions pertaining to the report.

Policy Review

Three policies were reviewed and ratified:

MHA Overarching Policy
Joint Policy for Derbyshire on the Operation of the Section 135 of the Mental Health Act 1983 Policy and Procedures
Mental Health Act 1983 – S 117 Policy

Board Assurance Framework – key risks identified: None

Escalations to Board or other committee: Concern that CPA training is not on target is to be escalated to the Board.

Next Meeting: 15 December 2023

Committee Chair: Ashiedu Joel	Executive Lead: Dr Arun Chidambaram, Medical Director

Finance and Performance Committee - key items discussed 26 September 2023
Assurance on Estate Strategy – Making Room For Dignity Update The Committee received updates on significant decisions and events, including the key risks and the next steps of the programme. Construction inflation indices amounted to £5.2 million unmitigated cost pressures. This has been flagged with NHSE and the potential risk to completing dormitory eradication in Derbyshire. There had been positive recruitment for Health Care Assistants with no more vacancies for this staff group. The next focus would be on the registered nurse vacancies. An update was given on the VAT abatement issue, including the date of the alternative dispute resolution hearing. An update was also given on contracts for the programme as well as the impact on the delays and the costs of out of area placements as a result of any delays. The Finance and Performance Committee received limited assurance on the progress of the programme to date and the risks associated with it.
Operational Performance The report covered the performance as at the end of July. Waiting lists continue to be a challenge in particular the Adult Autistic Spectrum Disorder assessment list, assurance was given that people were supported whilst waiting. The Trust was delivering more assessments than contracted for and there were opportunities to do the assessment slightly different, making the process more efficient. Discussion took place on the out of area placements which were a cost pressure as well as impacting on patient experience. There were plans in place to reduce the numbers. Other areas covered were utilisation of step down beds and bed occupancy levels. The Committee requested a deep dive paper on bed use to come to a future meeting. The Committee noted the concerns about Wi-Fi connectivity and the impact on devices that collect patient information. The Gambling Harm Service was now being led by the Trust across the East Midlands. The latest update on neurodevelopmental services was discussed including the background on annual health checks conducted GPs for learning disabilities and autism patients. Limited assurance was given on the performance report.
National Cost Collection Pre-Submission Sign Off The Committee signed off the National Cost Collection (NCC) submission for 2022/23. This is a requirement under the NHS Provider Licence. Work has been ongoing with the supplier of the new costing system which is going well. Some local benchmarking data will be provided.
Perinatal Mental Health Provider Collaborative The East Midlands Perinatal Mental Health Provider Collaborative was expected to go-live on the 1 October 2023 with the Trust as Lead Provider. The approval process was explained and informal feedback had been very positive. There would be some conditions attached in relation to the financial model and risk gain share and public health.
Impact Annual Report The annual IMPACT report for 2022-23 was presented to the meeting
Emergency Preparedness, Resilience and Response The paper had already been presented to the Trust Board and therefore the Committee took this paper as being read
Financial Governance and Plan Delivery, Including CIP The month five financial position was presented noting a better than planned situation to date, with breakeven forecasted. The financial risks are flagged with NHSE regularly on a regional basis.

There would be funding pressures due to the withdrawal of non-depreciation related income from NHSE around the public dividend capital (PDC) and also around Industrial Action, Pay Award pressures and excess inflation. There had been an announcement for additional monies for winter resilience. Medium Term forecast work had started to identify the underlying deficit being carried from 2023/24 into 2024/25.

The Agency Summit and action plan was presented and the Committee still had concerns about the high levels of agency spend. The performance against the Public Sector payment policy was also presented and was positive for the Trust.

Limited assurance was given on the agency paper.

Continuous Quality Improvement Update

The Committee noted an under delivery of £1.6 million against the planned savings of £8.1 million. However a number of schemes, not referenced in the paper, would be over delivering, and therefore offset the position. The risk levels were noted in terms of the number of schemes that are non-recurrent versus recurrent. A number of sessions have taken place to try and identity additional schemes and how those either could be turned from non-recurrent to recurrent or even as new schemes.

There is a strong focus on productivity particularly in Community Mental Health. Generally by increasing productivity, the demand for agency staff will be reduced and will lead to a better service for the local population because of greater throughput of patients. The Committee was assured of processes to complete 2023-24 transformation programme.

Board Assurance Framework (BAF) 2023/24 overview

The BAF risks for this Committee have been reviewed and updated and the overarching finance risk had been added to the Corporate Risk Register and this reflects the financial risk on the BAF.

Discussion took place on whether a deep dive on the finance risk is required at this Committee but the Committee was assured that the risks reported in the finance report and the enhanced reporting going forward will provide enough detailed evidence for oversight of this risk.

Escalations to Board or other Committees: The Committee agreed an escalation to the Chair and Chief Executive to ensure that sufficient focus is being given to addressing the medium-term underlying deficit of the Trust.

Items added to the Board Assurance Framework: None
Next scheduled meeting: 21 November 2023

Executive Lead: Rachel Leyland, Interim Director of Finance

Audit and Risk Committee - key items discussed 12 October 2023
Board Assurance Framework (BAF) The Committee approved Issue 3 of the BAF for 2023/24 and were assured on the process of the review, scrutiny, and update of the BAF that seeks to identify and mitigate risks to achieving the Trust's strategic objectives. Clarity would be sought on whether it will be necessarily to bring the finance risk deep dive to the January meeting.
Risk Management Strategy 2023 -2025 The Committee agreed significant assurance regarding the risk management progress made against the 2023-2025 Risk Management Strategy. Work would continue to try and improve performance on Risk Management reviews.
Review of the 2022/23 Annual Report And Accounts Production Annually the Committee reviews the process for the Annual Report and Accounts Production, to identify any learning that would be helpful for the next year. All agreed that it had gone well again with everyone working effectively together to ensure statutory requirements were met.
Freedom to Speak Up (FTSU) update The six-monthly report on the implementation of the Trust's Freedom to Speak Up (FTSU) policy framework evidenced the positive reaction to FTSU. Significant assurance was obtained from the adequacy of the Trust's arrangements by which Trust staff may, in confidence, speak up about possible improprieties in matters of financial reporting and control and related matters or any other matters of concern. The Board had a recent development session on FTSU where it agreed its approach to the toolkit which needs to be submitted by the end of January 2024, a number of queries around the toolkit action plan were raised. The Committee was pleased to see all the positive promotion during October, which is FTSU month, including a video that would be launched at the Staff Conference.
Data Security and Protection report This report included an update on the completion of the 2022/23 Data Security and Protection (DS&P) Toolkit and current progress towards meeting the new requirements of the 2023/24 DS&P Toolkit. The Trust had a very successful 2022/23 DS&P year with standards met for the toolkit submission, including achievement of the minimum 95% training compliance target. The Committee noted the substantial assurance and high confidence from our internal auditors in this work. The report also gave an update on the Trust's cyber security arrangements and how information risk is managed.
Conflict of Interest and Declarations of Interest Monitoring Arrangements The Trust's returns for Decision Making Staff had been positive in comparison to previous years and provided significant assurance that the Declaration of Interest Policy is implemented in respect of Decision Making Staff and is generating appropriate responses from those who hold that position. The Committee noted that the return rate for gifts was low and could be an indicator of the cost of living pressures. There had been one declaration of sponsorship which had been assessed as having no impact on any Trust operations or financial expenditure. The auditors at the meeting felt that the Trust's returns were low in comparison with other their other NHS clients and stressed the importance of promoting the requirements of the policy.
Intellectual Property Policy and Procedures The revised policy was agreed.

Well Led Action Plan The Committee received the first draft of the action plan, which was created out of the External Development Review of Leadership and Governance using the Well Led Framework, for ongoing monitoring by the Committee. It was agreed to receive the action plan quarterly.
Internal Audit Progress The Committee received an update against progress with the internal; audit plan. The stage one work against the Head of Internal Audit Opinion had been completed and terms of reference had been agreed for two further reviews. The rates of implementation of outstanding actions stood at 100%. The usual Board Development Session on the BAF will be facilitated by 360 Assurance in February.
Counter Fraud update Progress was given on the completion of work from the Trust's Counter Fraud, Bribery and Corruption Plan. This included detail on the proactive work and how this relates to the Trust's past and projected future Counter Fraud Functional Standard Return (CFFSR) scores, as well as giving summary information about allegations and investigations. Significant assurance was received that alerts and fraud warning intelligence have been appropriately communicated to the Trust. International Counter Fraud week falls in November this year and this would be promoted within the Trust. The Fraud Policy, which is normally reviewed on a three-year cycle, was updated with some minor changes. Mandate Fraud continues to be a significant risk across all NHS organisations.
External Audit Progress The Trust's External Auditors, Mazars would be starting their planning work in January for completion by the end of February with an interim audit booked for March 2024. Assurance was given that they have resource in place to ensure reporting timelines are met. Emerging areas for the financial statement audit were listed, including IFRS16.
Board Assurance Framework – key risks identified: None in addition. Escalations to Board: None Next Meeting: 25 January 2024

Committee Chair: Geoff Lewins	Executive Lead: Justine Fitzjohn, Trust Secretary

People and Culture Committee - key items discussed 19 September 2023

People and Culture Committee BAF Risk Summary

The Committee reviewed the two high rated Board Assurance Framework (BAF) risks it is responsible for in the context of discussions and the current work programmes to establish whether their overall rating should remain high.

Risk 2A *"There is a risk that we are unable to create the right culture with high levels of staff morale."*

Risk 2B *"There is a risk that we do not have a diverse workforce with the right number of people with the right skills to support and deliver safe high-quality care."*

Discussion took place on key gaps in control associated with workforce planning. It was agreed this risk rating could be reduced from red to amber as measures in place show an improvement .

The EDI position will be updated in the next iteration of the BAF.

People and Inclusion Assurance Dashboard

A review of current performance provided limited assurance.

July's training compliance level remained above target. There are improvements in the level of competency with Moving and Handling training and overall better management of training trajectory.

Turnover remains on target. The vacancy rate of 7.07% represents improvements across key areas. Some great appointments have been made to posts that have been difficult to recruit to. Improvements are to be made to the way the turnover, staff vacancies and recruitment chart is presented in the dashboard.

Having reviewed and discussed the dashboard it was agreed that the executive summary is to include additional commentary in to enable the Committee to agree the level of assurance it can obtain from each performance measure.

Workforce Plan 2023/24

The Workforce Plan 2023/24 and was received prior to being presented to the Board in November.

The Committee supported the progress being made with the workplan and accepted that reshaping/development of services will need to be embedded in each stage of cultural transformational change. The plan is evolving and will need to be looked at again when the Trust Strategy is refreshed.

Discussion took place on the contribution that new roles are making to teams. It was agreed that a detailed report on the impact that these roles are having on the workforce is to be scheduled at a future meeting.

The Committee received limited assurance that the Trust has a workforce plan to support the growth, tracking and workforce challenges for the next 12 months. Took limited assurance that the workforce plan will ensure delivery against all workforce requirements for the next 12 months.

2022/23 Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES)

The Workforce Race Equality Standard (WRES) / Workforce Disability Equality Standard (WDES) submission was received and approved prior to retrospective sign off by the Board in November.

People and Culture Committee - key items discussed 19 September 2023	
The Committee welcomed the new WRES and WDES approach and liked its clarity and ambition. Rather than being stand-alone data exercises, the WRES and WDES now forms part of the broader equality, diversity, and inclusion landscape. Where appropriate, the actions arising from both reports are aligned with existing and new workstreams in People and Inclusion and with the six High Impact Actions in the NHSE EDI Improvement Plan.	
Bank Staff The Bank Staff report paid particular focus on performance and engagement, the work to align band 5 and 6 pay with substantive workers and the move to the Agenda for Change pay scale and the movement of band 2 to band 3 with relevant training. Having reviewed and discussed bank staff and agency usage the Committee was pleased to note the progress that has been made and acknowledged the need for ongoing work to identify and make further improvements. Due the meeting not being quorate for this final item agreement on the level of assurance to be taken from the usage of temporary workforce at Trust level could not be considered.	
Escalations to Board or other committees: Board Assurance Framework – key risks identified: BAF risks and mitigations associated with workforce planning are to be re-rated to amber from red. The EDI position will be updated in the next iteration of the BAF. Next Meeting: 28 November 2023	
Committee Chair: Ralph Knibbs	Executive Lead: Jaki Lowe, Director of People and Inclusion

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 7 November 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 June to 31 August 2023.

Executive Summary

- All deaths directly relating to Covid-19 are reviewed through the Learning from Deaths procedure unless they meet an additional Incident Red Flag in which case they are reviewed under the Incident Reporting and Investigation Policy and Procedure. From 1 June to 31 August 2023 there has been no deaths reported where the patient tested positive for Covid-19.
- The Trust received 490 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; 249 male deaths were reported compared to 241 females.
- No Inpatient deaths were recorded.
- The Mortality Review Group have temporarily changed the objective of the Case Record Review Thursday meetings with medics. The Patient Safety Team Investigation Facilitators are utilising the meetings for advice and medical support for their ongoing investigations.
- The Trust has reported five Learning Disability deaths in the reporting timeframe and two patients with a diagnosis of Autism Spectrum Disorder (ASD).
- Medical Examiner officers have been established at all Acute Trusts in England and their role will be extended to include deaths occurring in the community, including at NHS Mental Health and Community Trusts. The implementation of this process had been expected by April 2023 however due to the complexities involved in data sharing this has been paused Nationally for community-based services. The Patient Safety team will continue to work with Medical Examiners to ensure the Trust maintains momentum in this area.
- Good practice identified through case note reviews is fed back to clinicians involved as part of our appreciative learning.

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

Assurances

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

Consultation

The Quality and Safeguarding Committee received assurance from 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

Governance or Legal Issues

- There are no legal issues arising from this report.
- 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 June to 31 August 2023. There is very little variation between male and female deaths; 249 male deaths were reported compared to 241 females.

- No unexpected trends were identified according to ethnic origin or religion.

Recommendations

The Board of Directors is requested to accept this Mortality Report on assurance from the Quality and Safeguarding Committee 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
Safer Care Coordinator

Learning from Deaths - Mortality Report

1. Background

In line with the CQC's recommendations in its review of how the NHS investigates patient deaths, the National Quality Board published a framework for NHS Trusts - 'National Guidance on Learning from Deaths[1]'. The purpose of the framework is to introduce a more standardised approach to the way NHS Trusts report, investigate and learn from patient deaths, which should lead to better quality investigations and improved embedded learning.

To date the Trust has met all the required guidelines. The report presents the data for 1 June to 31 August 2023.

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

- Discussions with the Regional Medical Examiners have taken place to discuss the implementation of the Medical Examiner process within our Trust. A standard operating procedure will be developed between Chesterfield Royal Hospital and University Hospital of Derby and Burton. The implementation of this process had been expected by April 2023 however due to the complexities involved in data sharing this has been paused Nationally for community-based services. The Patient Safety team will continue to work with Medical Examiners to ensure the Trust maintains momentum in this area.

- Cause of death information is currently being sought through the Coroner offices in Chesterfield and Derby but only a very small number of cause of deaths have been made available. It is hoped that this will improve once Medical Examiners commence the process of reviewing the Trusts non-coronial deaths.

- The mortality team have now received a new schedule outlining the medics who will be attending Case Record Review sessions in 2023 for both North and South consultants. Meeting invites for 2023 have now been set up and sent to all consultants involved.

- Regular audits continue to be undertaken to ensure compliance with policy and procedure and any necessary amendments made. This has included auditing complaint data against names of deceased patients to ensure this meets the requirements specified in the National guidance. The last audit was completed on 1 October 2023.

3. Data Summary of all Deaths

Note that inpatients and learning disability (LD) data is based upon whether the patient has an open inpatient or LD referral at time of death. The table below outlines information for 1 June to 31 August 2023.

	June	July	August
Total Deaths Per Month	158	182	150
LD Referral Deaths	4	1	0
Inpatient Deaths	0	0	0

Correct as of 28/09/2023

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

249 patients were male, 241 were female, of these 367 were white British, 91 were any other ethnic group and 32 had no known ethnicity assigned. The youngest age was 0 years, the eldest age was 101.

From 1 June to 31 August 2023, the Trust received 490 death notifications of patients who have been in contact with our services.

4. Review of Deaths

Total number of Deaths from 1 June to 31 August 2023 reported on Datix	56 “Unexpected deaths” 0 Covid-19 deaths 10 “Suspected deaths” 1 “Expected - end of life pathway”. NB some expected deaths have been rejected so these incidents are not included in the above figure. 0 Inpatients deaths
Incidents assigned for a review	53 incidents assigned to the operational incident group. 13 incidents assigned to the executive incident group. 0 did not meet the requirement. 1 incident is to be confirmed

Only deaths which meet Trust Red Flags are reported through the Trust incident reporting system (Datix) and are reviewed through the Untoward Incident Reporting and Investigation Process. These Red Flags apply to any patient open to services within the last six months prior to their death:

- Homicide – perpetrator or victim
- Domestic homicide - perpetrator or victim
- Suicide/self-inflicted death, or suspected suicide
- Death following overdose
- Death whilst an inpatient
- Death of an inpatient who died within 30 days of discharge from a DHCFT hospital
- Death following an inpatient transfer to acute hospital
- Death of patient on a Section of the Mental Health Act or Deprivation of Liberty Safeguards (DoLs) authorisation
- Death of patient following absconsion from an inpatient unit
- Death following a physical restraint
- Death of a patient with a learning disability
- Death of a patient where there has been a complaint by family / carer / the Ombudsman, or where staff have raised a significant concern about the quality-of-care provision
- Death of a child (this will also be subject to scrutiny by the Child Death Overview Panel)

- Death of a patient open to safeguarding procedures at the time of death, which could be related to the death
- Death of a patient with historical safeguarding concerns, which could be related to the death
- Death where a previous Coroners Regulation 28 has been issued
- Death of a staff member whilst on duty
- Death of a child under the age of 18 of a current or previous service user who has died in suspicious circumstances
- Where an external organisation has highlighted concerns following the death of a patient whether they were open to the Trust at time of death or not.
- *Death of a patient with Autism*
- *Death of a patients who had a diagnosis of psychosis within the last episode of care*

The last two red flags have been added this year to ensure that the Trust meets the Learning from Deaths guidance and recent changes to the LEDER reporting requiement of patients who have a diagnosis of autism.

5. Learning from Deaths Procedure

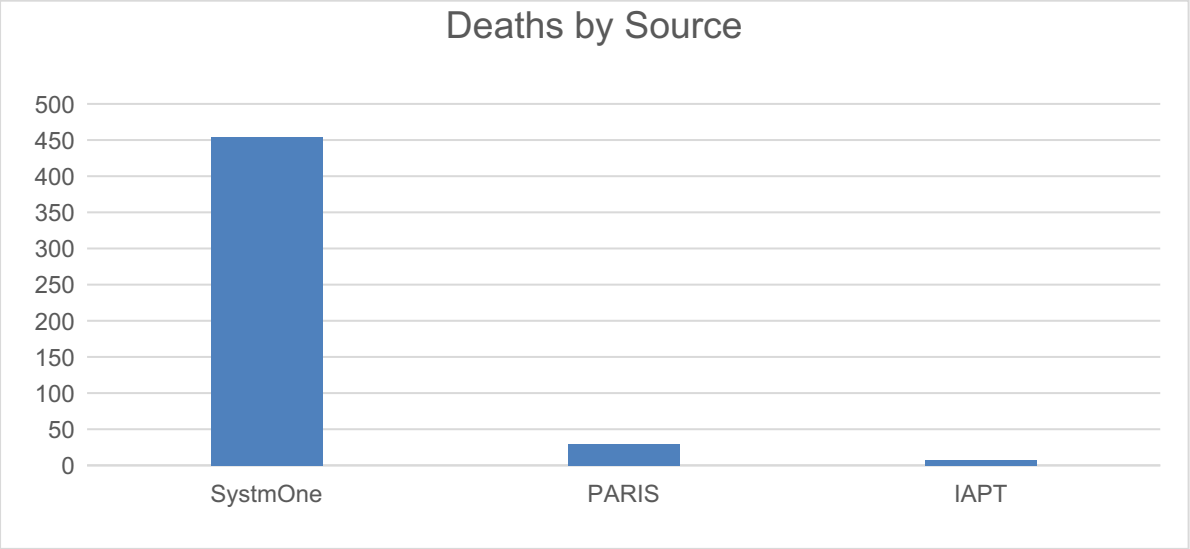
The Trust has now completed the move of its mortality process which has been implemented within the patient Electronic Record, this aids staff in identifying deaths which meet the threshold for DATIX reporting. This process fulfils stage one of the Learning from Deaths in that all deaths are considered for Red Flags as identified under the national Learning from Deaths procedure. This is a significant improvement in process and will release some capacity within the service to re-deploy into other priorities such as actions and high-profile incident management. The plan will also allow for more joined up working with Corporate and Legal services ensuring better sharing of information and identification of priorities for both services.

The Mortality team are conducting random weekly audits of deaths against the Red Flags to provide assurance that the new process is working as intended and changes will be made accordingly.

From the 1 June to 31 August 2023 there has been no deaths reported where the patient tested positive for Covid-19.

6. Analysis of Data

6.1 Analysis of deaths per notification system 1 June to 31 August 2023

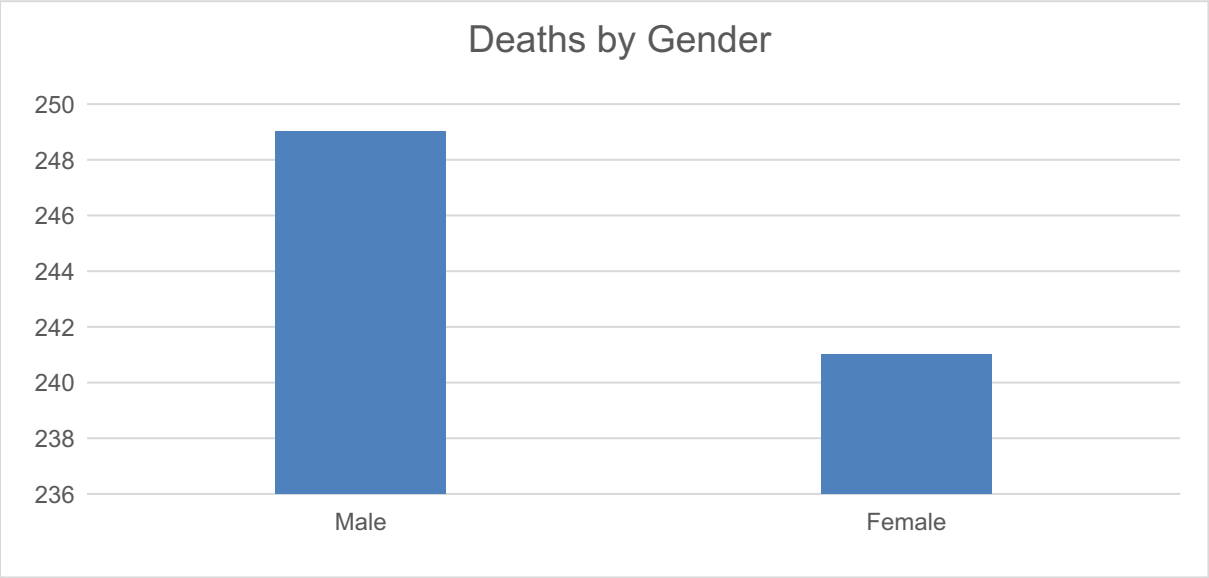


System	Number of Deaths
IAPT	7
PARIS	29
SystmOne	454
Grand Total	490

The data above shows the total number of deaths reported by each notification system. The majority of death notifications were predominately pulled from SystmOne which is not unexpected given the Trust's move the One EPR.

6.2 Deaths by Gender

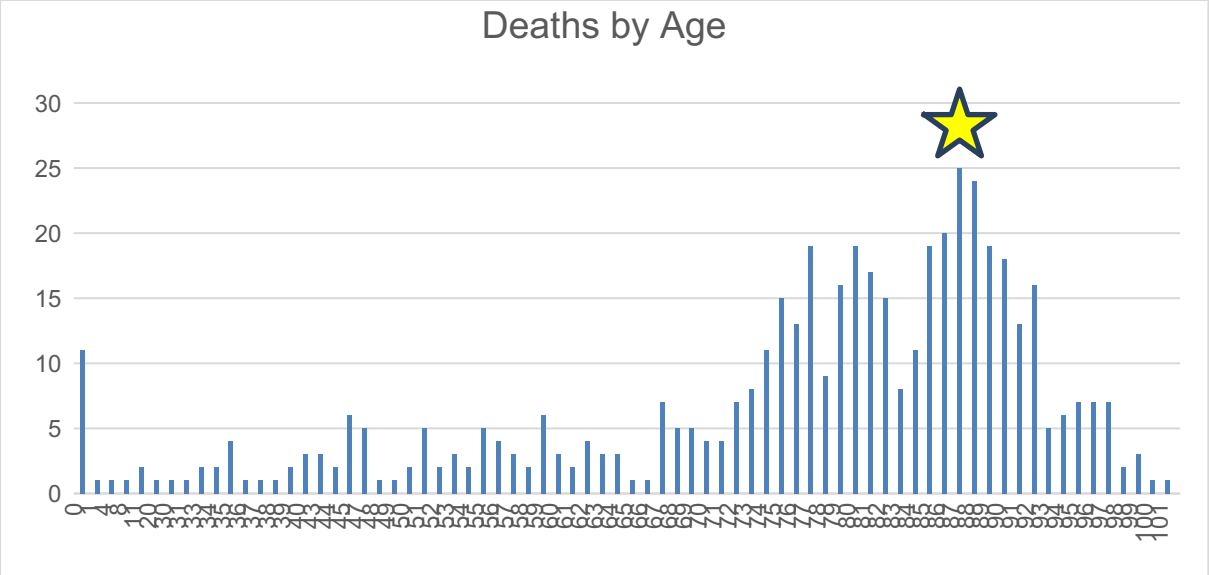
The data below shows the total number of deaths by gender for 1 June to 31 August 2023. There is very little variation between male and female deaths; 249 male deaths were reported compared to 241 females.



Gender	Number of Deaths
Male	249
Female	241
Grand Total	490

6.3 Death by Age Group

The youngest age was classed as zero, and the oldest age was 101 years. Most deaths occurred within the 85-90 age groups (indicated by the star).



6.4 Learning Disability Deaths (LD)

	June	July	August
LD Deaths	4	1	0

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 June to 31 August 2023, the Trust has recorded five Learning Disability deaths. The Trust now receives a quarterly update from LeDeR which highlights national good practice and identified learning; this is shared in the Mortality monthly meeting.

The Trust also is required from 1 January 2022 to report deaths of patients who have a diagnosis of Autism Spectrum Disorder (ASD) for this reporting period the Trust has reported two deaths.

6.5 Death by Ethnicity

White British is the highest recorded ethnicity group with 367 recorded deaths, 22 deaths had no recorded ethnicity assigned, and 10 people did not state their ethnicity. The chart below outlines all ethnicity groups.

Ethnicity	Number of Deaths
White - British	367
Other Ethnic Groups - Any other ethnic group	73
Not Known	22
Not stated	10
White - Any other White background	5
White - Irish	5
Black or Black British - Any other Black background	2
Mixed - Any other mixed background	2
Asian or Asian British - Indian	2
Asian or Asian British - Any other Asian background	1
Mixed - White and Black African	1
Grand Total	490

6.6 Death by Religion

Christianity is the highest recorded religion group with 219 recorded deaths, 187 deaths were (blank) with no recorded religion assigned. The table below outlines all religious groups.

Religion	Number of Deaths
Christian	219
(blank)	187
Church of England, follower of	26
Church of England	22
Unknown	5
Religion NOS	4
Not Religious	4
Methodist	4
Christian religion	3
Roman Catholic	2
Catholic: non Roman Catholic	2
Catholic religion	1
Patient Religion Unknown	1
Atheist	1
Nonconformist	1
Protestant	1
None	1
Atheist movement	1
Sikh	1
Jehovah's Witness	1
Hindu	1
Pagan	1
Muslim	1
Grand Total	490

6.7 Death by Sexual Orientation

Heterosexual or straight is the highest recorded sexual orientation group with 274 recorded deaths. 187 had no recorded information available. The chart below outlines all sexual orientation groups.

Sexual Orientation	Number of Deaths
Heterosexual	274
(blank)	185
Sexual orientation not given - patient refused	18
Heterosexual or Straight	5
Sexual orientation unknown	2
Unknown	2
Bisexual	2
Homosexuality NOS	1
Not appropriate to ask	1
Grand Total	490

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 90 recorded deaths.

Disability	Number of Deaths
(Blank)	323
Gross Motor Disability	90
Intellectual Functioning Disability	37
Emotional Behaviour Disability	16
Hearing Disability	9
Physical Disability	6
Walking Disability	2
Registered Disabled	1
Sight	1
Mobility and Gross Motor	1
Other	1
Learning Disability	1
Behaviour And Emotional	1
Learning Disability (Dementia)	1
Grand Total	490

There was a total of 167 deaths with a disability assigned and the remainder 323 were blank (had no assigned disability).

7. Medical Examiners

Medical Examiner officers have been established at all Acute Trusts in England. The role of these offices is now being extended to also cover deaths occurring in the community, including at NHS Mental Health and Community Trusts. Medical Examiners are to provide independent scrutiny of deaths not taken at the outset for

coroner investigation. They will carry out a proportionate review of medical records and give families and next of kin an opportunity to ask questions and raise concerns. This process will inform learning to improve care for future patients, or, in a smaller number of cases, may be referred to others for further review. Their involvement will also provide reassurance to the bereaved.

Overall Medical Examiners will seek to answer the following three questions:

- What caused the death of the deceased?
- Does the coroner need to be notified of the death?
- Was the care before death appropriate?

Discussions with the Regional Medical Examiners have taken place to discuss the implementation of the Medical Examiner process within our Trust. A standard operating procedure will be developed between Chesterfield Royal Hospital and University Hospital of Derby and Burton. The implementation of this process had been expected by April 2023 however due to the complexities involved in data sharing this has been paused Nationally for community-based services. The Patient Safety team will continue to work with Medical Examiners to ensure the Trust maintains momentum in this area.

8. Recommendations and Learning

Changes will be implemented within the DATIX system to support early identification of themes and learning from incidents which are not taken to further Patient Safety learning review, this information will be fed into Learning the Lessons Subgroups alongside themes and recommendations from Learning Reviews to support the development of Quality Improvement programmes. Current themes are detailed below:

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 are 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 November 2023

Guardian of Safe Working Quarterly Report (October 2023)

Purpose of Report

This quarterly 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) Aside from one, all other exception reports have been for overtime working in core hours, resulting in time back in lieu (TOIL). The other exception report was for breaching the minimum rest requirements on a non-resident on call shift (results in payment to the doctor and a fine levied against the Trust.
2) Response times for exception reports remain slow (> 7 days) as per the electronic exception reporting system. Much of this is felt to be because of delays in the doctor meeting with the relevant supervisor, but also difficulties in accessing/using the exception reporting system. The GOSW aims to provide a visible comment as soon as practicable for all exception reports that are submitted, and will complete exception reports on behalf of doctors and supervisors with written confirmation.
3) The number of vacant shifts that needed filling has seen a significant increase (and therefore a significant increase in expenditure). Though unable to confirm in time for this committee, it is suspected that this is due to industrial action.
4) A separate cost code is set up to hold fines levied. A second confirmation is still required from Medical Education before any expenditure can go out, however the GOSW is seeking to be set up as an approver to remove this step.
5) The Trust has introduced ‘middle tiers’ for both the North and South psychiatry rotas. These are not yet live as they are awaiting executive sign off from a financial perspective (several SAS doctor colleagues have volunteered to join these rotas as there are insufficient WTEs from the ST4+ doctors to staff these tiers). The risk remains for this to cause a rise in exception reports from ST4+ doctors breaching their non-resident on call minimum rest requirements. This will be monitored going forwards.

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 (annual report) to this Committee with the Joint Local Negotiating Committee, the Trust Medical Training Committee, the Junior Doctor Forum and its constituent junior doctors. Following presentation to the Quality and Safeguarding Committee on 10 October, this report will be shared with the Junior Doctor Forum and its constituent junior doctors.

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 contents of this report.
2) Support the GOSW in becoming an approver for expenditure from the GOSW cost code.
3) Receive assurance from the Quality and Safeguarding Committee that the duties and requirements as set out in the 2016 Junior Doctor terms and conditions of service are being met.

Report presented by: Dr Kaanthan Jawahar
Guardian of Safe Working

Report prepared by: Dr Kaanthan Jawahar
Guardian of Safe Working

GUARDIAN OF SAFE WORKING QUARTERLY REPORT
(October 2023)

1. Trainee data

Extended information supplied from 6 April to 26 September 2023

Numbers in post for doctors in training

Numbers of doctors in post WTE	North	South
FY1	3	5
FY2	2	5
GP ST	3.5 (headcount 4)	7
CT	10.4 (headcount 11)	11.8 (headcount 12)
HSTs	3.5 (headcount 4)	6.2 (headcount 7)
Paediatrics ST	0	1.8 (headcount 2)

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

Covering the period 5 April to 26 September 2023

Total number of exception reports = 13 (all working hours related)

Location	No of exceptions raised	No of exceptions closed	No of exceptions outstanding
North	11	11	0
South	2	2	0
Total	13	13	0

Grade	No of exceptions raised	No of exceptions closed	No of exceptions outstanding
CT1-3	4	4	0
ST4-7	2	2	0
GP	0	0	0
Foundation	7	7	0
Total	13	13	0

Action taken

Location	Payment	TOIL	Not agreed	No action required
North	0	11	0	0
South	1	1	0	0
Total	1	12	0	0

Response time

Grade	48 hours	7 days	Longer than 7 days	Open
CT1-3	0	0	4	0
Foundation	0	1	6	0
ST4-7	0	0	2	0
GP	0	1	12	0

- One exception report arose on the south non-resident on call rota (ST4+ doctors) that resulted in payment to the doctor and fines levied against the Trust. This was for breaching the minimum rest requirements.
- The remainder of the exception reports were for 'overtime' – core hours running over. Time back in lieu (TOIL) was taken for these.
- Response times routinely exceed 7 days – much of this arises from difficulties in having a prompt meeting with the relevant supervisor, as well as ease of use of the exception reporting electronic system. The GOSW has stepped in on occasions to complete the exception reports after receiving email confirmation from the doctor and supervisor. The GOSW also looks to provide viewable comments as soon as practicable for each exception report.

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 £895.75 through cost code G62762. All fines levied are the result of breaching rest requirements on non-resident on call rotas. All were south.
- Thus far, fines have been spent on junior doctor social meals (one for the north and one for the south). Medical Education have put in place a process whereby a doctor can be reimbursed relatively quickly from this cost code. Equity in access and no reimbursement for alcohol are parameters that need to be followed.

5. Locum/Bank Shifts covered (6April to 26 September 2023)

	North	Cost	South	Cost
Locum/bank shifts covered	37	£20881.37	37	£21276.80
Agency locum shifts covered	0	0	0	0

- The number of shifts needing to be covered has seen a significant increase (e.g. 37 require covering for the north in the period set out above, whereas 19 needed covering in the whole of the financial year ending April 2023).
- The granular detail of this could not be obtained in time for authoring this report, however ongoing industrial action is the likely reason.

6. Agency Locum
Nil

7. Vacancies (6 April to 26 September 2023)

	North	South
CT1-CT3	0.2	0.2
ST4-7	2	1.5
GP Trainees	0	0.2
Foundation	1	0

8. Qualitative information

- Induction sessions for rotational junior doctors are now well established – these appear as a standard part of the induction put together by Medical Education colleagues.
- JDF meetings take place every two months. There were two further meetings at a great frequency after the junior doctor industrial action commenced.
- A new constitution for the JDF was agreed at the last JDF meeting.
- Personalised work schedules are being considered by the JDF and Medical Education (recently discussed at the Trust Medical Training Committee).
- Fatigue and Facilities monies have largely been spent/allocated. The primary use was refurbishment of junior doctor common room areas, but also more recently uniform scrubs. The remaining balance (£235.90) has been ring-fenced for further purchases of uniform scrubs.
- A separate cost code is set up to hold fines levied. A second confirmation is still required from Medical Education before any expenditure can go out, however the GOSW is seeking to be set up as an approver to remove this step.
- Previously this committee was informed that the South psychiatry rota will have a registrar tier from August 2023. This is yet to go live, however the doctors on this rota are now covering both general and older adults. This poses a risk to further breaches of non-resident on call rest requirements, especially considering that the registrar on call will be seeing both general and older adult patients (there will remain separate general and older adult consultant rotas). The breaches may also lead to a secondary educational impact, where immediate TOIL leads to a loss of educational opportunities. At

present such instances have not materialised through the exception reporting system, however the GOSW is monitoring the situation and liaising with junior doctor colleagues to ensure all feel supported to submit exception reports.

- The Trust is looking to implement the same type of middle tier in the north of the trust – they have volunteer SAS doctors for both north and south to fill the vacant slots (the trust does not receive sufficient WTE ST4+ doctors to fully staff both proposed rotas). This requires financial sign off at an executive level before it can go live.

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 November 2023

Safeguarding Children and Adults Annual Report 2022/23

Purpose of Report

The Annual Report is a governance requirement of both the Trust and the Safeguarding Children Partnership and Adult Safeguarding Boards. It provides assurance that the Trust is meeting its legal and statutory performance and governance requirements.

Executive Summary

- The Trust has had a successful year and continues to fully discharge its statutory safeguarding duties.
- The Trust's officers have discharged the duties as set in legislation and requirements outlined by the Health Regulator, the Care Quality Commission (CQC). The Annual Report includes how the Trust has been independently scrutinised and assessed.
- The report describes the challenges and achievements faced in the year and overall this has been a successful year.
- The report monitors trends in activity and analyses the themes from this activity and use the referral information and helpline activity to adapt training, plan clinical audits or develop policy and procedure from learning reviews, which have been maintained in this year.
- Safeguarding Unit including Multi Agency Safeguarding Hub (MASH) health activity over the year 2022/23 and its activity, impact and feedback from partners that has continued to be positive.
- The report provides quantitative, qualitative, and narrative evidence of the scope and extent of work undertaken within the year and how the Safeguarding Unit assures itself that it is meeting its duties by development of its staff who work with children, young people, adults, and their families. This report is offered with significant assurance on the work of the unit.
- Audit activity is included in the report. Feedback of audit has been included in the Report to provide evidence on the internal and external governance process and how the Unit provides quality improvement of practice, which has continued
- The report describes the new initiatives/objectives/priorities 2023/2024 which have been developed with partners and based upon themes and learning. Sexual safety continues to be a priority area with significant scrutiny and focus on practice.
- The Quality and Safeguarding Committee received significant assurance from the report on the Trust's systems, governance, learning and improvement of standards of practice. The report demonstrates a robust system of scrutiny and a commitment to sound practice.

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

Risks and Assurances

- The team seeks to actively mitigate and manage risk. Where necessary risks are escalated to the Quality and Safeguarding Committee as part of the reporting process from the Safeguarding Children and Safeguarding Adults Operational Groups.
- The Committee obtained significant assurance that the Safeguarding Unit, including MASH Health, Section 11 Audit, the Local Authority and Markers of Good Practice and the Safeguarding Accountability and Assurance Framework (SAAF). This framework builds on its predecessor by strengthening the NHS commitment to promoting the safety, protection and welfare of children, young people and adults.
- This national framework has been developed in partnership with other arm's length and professional bodies. It has been updated to reflect changes in policy and legislation since its last iteration and seeks to clarify the roles and responsibilities in relation to system working. In addition, it provides the flexibility needed at local level to support the professional practice of individuals and the partnerships needed to promote healthy behaviours to keep individuals and communities safe from harm.
- SAAF is meeting its legal and statutory duties and obligations.

Consultation

- The team has consulted internally and with partners throughout the year as appropriate to specific areas of activity, for example, policy development, public protection developments, refining processes within the MASH.
- The report is written after consultation between the Assistant Directors for both Safeguarding Adults and Children.
- The report was scrutinised by the Quality and Safeguarding Committee on 12 September.

Governance or Legal Issues

The Trust meets statutory obligations and legal duties with regard to:Mental Health Act [1983]; Mental Capacity Act [2005]; The Care Act [2014]; Children and Families Act [2014]; Human Rights Act [1998] Domestic Violence, Crime and Victims Act [2004] and our internal systems, structures and processes are joined up and effective.

Statutory guidance issued under Section 29 of the Counter-Terrorism and Security Act 2015
Section 26 of the Counter-Terrorism and Security Act 2015 (the Act) places a duty on certain bodies ("specified authorities" listed in Schedule 6 to the Act), in the exercise of their functions, to have "due regard to the need to prevent people from being drawn into terrorism". This guidance is issued under section 29 of the Act. The Act states that the authorities subject to the provisions must have regard to this guidance when carrying out the duty.

Health Specified Authorities
80 - The Health specified Authorities in Schedule 6 to the Act are as follows:

NHS Foundation Trusts

- NHS England has incorporated 'Prevent' into its safeguarding arrangements, so that Prevent awareness and other relevant training is delivered to all staff who provide services to NHS patients. These arrangements have been effective and should continue.
- The Chief Nursing Officer in NHS England has responsibility for all safeguarding and a Safeguarding Lead, working to the Director of Nursing, is responsible for the overview and management of embedding the Prevent programme into safeguarding procedures across the NHS. This is replicated in our Trust.

Section 325 to 327B of the Criminal Justice Act 2003(CJA) established multi-agency public protection arrangements (MAPPA) in each of the 42 criminal justice areas of England and Wales. These arrangements are designed to protect the public, including victims of crime, from serious harm by sexual or violent and other dangerous offenders. MAPPA are the statutory arrangements for managing sexual and violent offenders. MAPPA is not a statutory body but is a mechanism through which agencies can better discharge their statutory responsibilities and protect the public in a co-ordinated manner.

The Trust meets the required standards for our regulators and our professional regulatory bodies Codes of Practicei.e. Safe, Caring, Effective, Responsive, Well-led and Safeguarding are one of the gold threads that runs throughout. We apply national guidelines and evidence based best practice e.g. NICE, DoH, National Statistics.

The Trust contributes as an equal partner in multi-Agency forumse.g. MAPPA; MARAC; Channel; Child and Adult Safeguarding Boards and subgroups and takes part in peer assessment, benchmarking and self-assessment and assurance.

The Trust invests in staff across multiple agencies and servicesto ensure high levels of competence and confidence and achieve consistently good practice that is constantly updated and refreshed within a culture of learning from both successful and adverse situations.

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 re-assignment, 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 field of safeguarding adults at risk of abuse is underpinned by the following six key principles:

- Empowerment - of the individual to make decisions.
- Protection - support and representation for those in need.
- Prevention - of abuse / neglect as well as helping the person to reduce the risks of harm and abuse that are unacceptable to them.
- Proportionality - responses should be least restrictive to the person's rights.
- Partnerships - working collaboratively to prevent, identify and respond to harm.
- Accountability - and transparency in delivering safeguarding.
  Safeguarding is intended to support those most vulnerable to being at risk of abuse, many of whom have protected characteristics relating to age, gender, disability, religion, and sexual orientation. The intention of safeguarding governance and due diligence is to recognise the vulnerability to abuse of people engaging with Trust services and apply the principles to all aspects of safeguarding practice.

The Trust cannot mitigate all the population health outcomes for children and adults in our community. However, it can influence the wider system and put in place preventative or detective measures to reduce preventable harms.

The Trust cannot stop abuse, but it can assess, engage, offer early detection, and intervene to reduce the impact of abuse and monitor the harms associated with being at risk of harm.

Recommendations

The Board of Directors is requested to receive the report which is offered by the Quality and Safeguarding Committee with significant assurance regarding the fulfilment of legal and statutory duties.

Report presented by:	Lynn Andrews Chair, Quality and Safeguarding Committee
Report prepared by:	Members of the Safeguarding Team, including MASH Health, Safeguarding Trainers and the Operational Team members

NHS
Derbyshire Healthcare
NHS Foundation Trust

Safeguarding Children and Adults at Risk Annual Report 2022/23

INTRODUCTION

The safeguarding of all Derbyshire Health Care Foundation NHS Trust patients, adults, children and their families remains the highest of priorities. Safeguarding and 'Think Family' is integrated throughout everything we do. The purpose of this report is to provide a review and analysis of the year's safeguarding activity and our objectives for the coming year.

We would like to give thanks to all the staff within the Trust for all their commitment to safeguarding our staff and people who use our services and will to do our upmost to continue '*keeping up the great work'* so we can continue to move forward together.

This report sets out the work of DHCFT in relation to safeguarding and the necessary frameworks in place to continue to learn, develop and refine the service. The Trust continues to work in partnership with statutory and voluntary partners across Derbyshire and bordering localities to discharge its responsibilities in relation to safeguarding children and adults at risk.

We have had another busy 12 months characterised by high levels of activity, increased complexity of calls for advice, strategy discussions and referrals. As a Trust we strive to develop and grow together and learn and develop in all areas of Safeguarding.

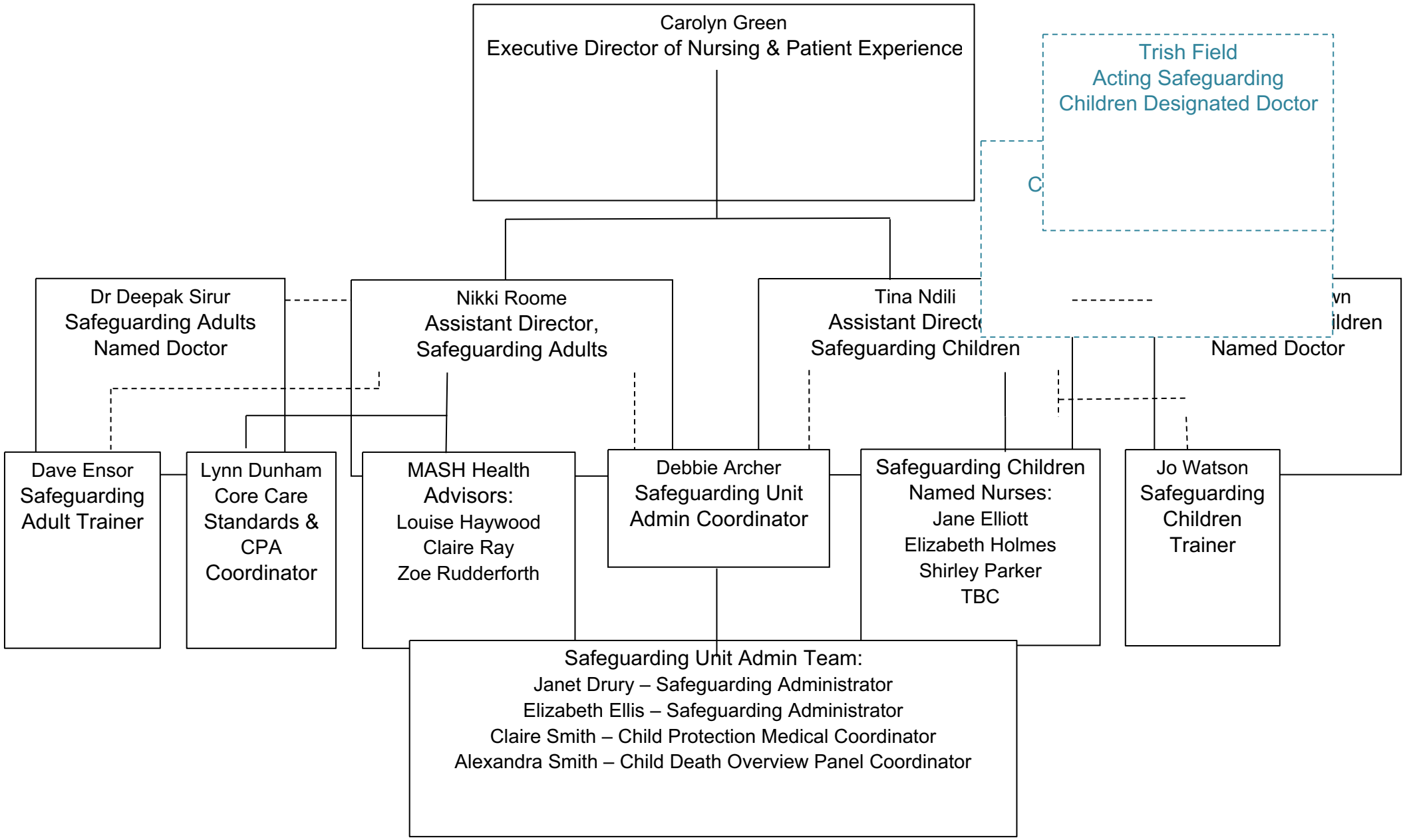
SAFEGUARDING UNIT REPORTING STRUCTURE

DHCFT is committed to partnership working to discharge its statutory duties with Derby City and Derbyshire Safeguarding Children Partnership and Adult Safeguarding Boards. There is Trust representation and attendance at all subgroups and multi-agency meetings. Effective safeguarding relies on strong partnerships within the Trust and with other agencies and the Safeguarding Boards in a culture of open, transparent, consistent, and respectful cooperation.

Safeguarding Children and Adults Operational Groups report on a quarterly basis to the Quality and Safeguarding Committee which reports directly to the Trust Board. -

The Safeguarding Unit prepare a monthly Safeguarding Information Report that is issued to all Clinical Operational Assurance Team (COAT) meetings for the Trust which includes Specialist, Children's, Neighbourhood, Forensic and Campus Divisions. The report ensures that all new guidance, legislation, policy and relevant information is circulated to ensure staff are aware and updated as necessary.
Both Safeguarding Operational Groups can escalate matters that require executive or committee consideration / inclusion in the Trust Risk Register but, equally, can escalate good news stories, lessons learned to share across the Organisation.

SAFEGUARDING UNIT STRUCTURE



SAFEGUARDING CHILDREN'S PERFORMANCE DASHBOARD – 2022/23

Item	Metric	Quarter 1, 2022-2023	Quarter 2, 2022-2023	Quarter 3, 2022-2023	Quarter 4, 2022-2023
1	Number of advice calls received and reported	271	201	222	118
2	Number of supervision/group sessions	99	135	166	122
3	Number of Information Exchange Form Research completed / strategy discussions or meetings attended	174	157	128	133
4	Number of child Protection medicals – Suspected NAI & Neglect	51	52	52	57
5	Number of children discussed at CHANNEL	0	1	0	2
6	Number of MARAC cases with children discussed at MARAC	145	95	171	186
7	Number of referrals to CSC	17	19	14	8
8	CIC Caseload - Born In Lives In	243	244	246	230
	CIC Caseload - Born In Lives Out	392	388	372	368
	CIC Caseload - Born Out Lives In	5	5	10	10
	CIC Caseload - Unknown	1	4	23	41
	Team Unknown	2	2	2	2
	Total CIC Caseload	643	643	653	651
9	Number of Child Deaths	16	13	14	13
10	Number of children referred for risk of FGM	1	0	2	3
11	Number of children on a child in need plan	239	250	216	197
12	Distinct count of children affected by DV during the Quarter	729	276	327	303
13	Number of children on a child protection plan	431	408	396	383
14	Number of children admitted to an adult inpatient bed	1	1	0	1
15	Number of young carers	11	10	9	11

Key for acronyms within Dashboard:

NAI	Non-Accidental Injury
MARAC	Multi Agency Risk Assessment Committee
CSC	Children's Social Care
CIC	Children in Care
DV	Domestic Violence

Analysis of the main features within the safeguarding children dashboard:

- Supervision figures show compliance remains stable, the Safeguarding Team deliver flexible supervision and a cascade model is place. This has worked extremely well ensuring staff received their safeguarding supervision in a timely manner.
- S47s and strategy meetings remains high which contributes to the pressure on the resources of the Safeguarding Children Team, the complexity of issues and number of adult mental health issues adds significant pressure.

- MARAC cases and children impacted by Domestic Abuse continue to be at a consistently high level.
- Referrals to Children's Social Care have reduced, this is due to the work around referrals and thresholds which is ongoing within training, supervision and advice which has had a positive impact.

SAFEGUARDING ADULTS' PERFORMANCE DASHBOARD – 2022/23

	METRIC		QTR1	QTR2	QTR3	QTR4
1	Number of adult safeguarding referrals made where allegation is within their own service		121	87	99	101
2	Number of PiPoT referrals made by the Trust		N/A	4	3	2
3	Full attendance at MAPPA 3 meetings (monthly)		100%	100%	100%	100%
4	MASH Health strategy discussions for children		88	113	108	120
5	MASH Health strategy discussions for adults		26	37	29	22
6	Number of domestic violence medium cases discussed at triage		259	245	233	258
7	Number of urgent DoLs authorised.		10	7	6	7
8	Number of Standard DoLs applied for to the LA.		10	7	2	6
9	Number of people with an authorised DoLS granted by Supervisory body.		0	2	5	1
10	Number of referrals to coroner for people who have passed away and have an authorised DoLS granted by Supervisory body		0	0	0	0
11	Sexual Safety in Trust Inpatient Service. Incidents of alleged inappropriate sexual behaviour, sexual assault and sexual abuse to a patient by another patient or other party.	Other Party to Patient	N/A	N/A	6	2
		Patient to Other Party	N/A	N/A	2	3
		Patient to Patient	N/A	N/A	4	2
		Patient to Staff	N/A	N/A	20	1
		Staff to Patient	N/A	N/A	3	1
		Staff to Staff	N/A	N/A	0	0

Analysis

The performance dashboard continues to provide data that offers a level of assurance to the Trust regarding safeguarding activity, trends, and areas of challenge.

Where we see themes emerging we have endeavoured to provide more learning for staff. We identified themes around domestic violence which has focussed bespoke learning from Domestic Homicide reviews for in-patient staff.

The Adult Safeguarding Trainer remains in post and the safeguarding training compliance has improved and the evaluations continue to be positive. This is felt to be due to the delivery of safeguarding training on MS teams.

The operational meeting provides a safe space to discuss complex cases and safeguarding themes that may need to be raised with the Safeguarding Adults Board or require further focus in our training.

The safeguarding teams continue to ensure clinical standards in ensuring consent to refer to a safeguarding referral is recorded on the referral proforma. Scrutiny and focus by the Health Advisors in the MASH is helping to improve compliance and outcomes in this area.

MASH Health Advisors continue to consistently meet the required Key Performance Indicators as part of this Trust contracted activity.

The quality priority and improvement work around professional boundaries and sexual safety is ongoing and visible throughout DHCFT. We have responded to all sexual safety incidents in a timely manner offering support and assurance to our service users, staff and our multi-agency partners.

The performance and evidence provided in this Annual Report demonstrates that we have continued to meet our statutory and Public Protection duties and also reflects the key strategic priorities of the Derby and Derbyshire Safeguarding Adult Boards, Prevention: Making Safeguarding Personal and Quality Assurance.

DHCFT SAFEGUARDING CHILDREN TRAINING POSITION

This provides an update to the safeguarding children training provision, compliance and action plan in the Trust as at May 2023 and covers the period of April 2022 to April 2023

Training Name	Target Group	Compliant	Non-Compliant	Compliant %	Change from last year
C Safeguarding Children Level 1 Annual	539	493	46	91%	Up 12%
C Safeguarding Children Level 1 once only	1914	1858	56	97%	Same
R Safeguarding - Children Level 2 3 yearly	518	432	86	88%	Down 5%
R Safeguarding - Children Level 2 once only	1447	1388	59	96%	Same
R Safeguarding - Children Level 3 3 yearly	1162	1006	156	87%	Up 9%
R Safeguarding - Children Level 3 Annual	306	257	49	84%	Up 4%
R Safeguarding - Children Level 4 Annual	7	7	0	100%	Same

During the last training year, there has been no cancelled training by The Incident Management Team in response to the Covid 19 pandemic and no significant disruptions to impact on training delivery planning. The expected standard is over 85%.

All level 1 and 2 training during this last year has been via E-learning. Level 2 sessions are also being delivered by MST.

Within this training period there have been sixty level 3 sessions offered, which is twelve sessions more than last year. As a result, 1031 staff have received their level 3 training, which is 311 more staff than last year. There were 1163 spaces made available, meaning 132 more staff could have attended a session. This data has improved from last year, where over 300 spaces were not utilised. All sessions were via Microsoft Teams (MST).

Training data is closely monitored, and staff and managers are liaised with regarding accessing sessions and addressing barriers to access. Bespoke sessions to address this are also in place for some staff groups.

There are 137 staff within DHCFT that are non-compliant for level 3 and have not booked on a session. This data is 79 staff for level 2 learning across the Trust. These staff members are being re contacted and targeted by training administration team as the priority area.

DHCFT SAFEGUARDING ADULTS – TRAINING POSITION

This report provides an update to the 383 Safeguarding Adults Level 3 (inc. Level 1&2 plus DOLS, MCA & Wrap/PREVENT) training in DHCFT as of 30 April 2023 and covers the period of 1 April 2022 to 31 March 2023

Training Name	Target Group	Compliant	Non-Compliant	Compliant %	Change from last year
383|LOCAL|C Safeguarding - Adults Level 1 (Non Clinical) (3 Yearly)|	576	518	58	90%	Up 10%
383|LOCAL|C Safeguarding - Adults Level 1+2 (All Clinical) (3 yearly)|	1875	1729	146	92%	Up 5%
383|LOCAL|R Safeguarding - Adults Level 3 (3 Yearly)|	117	108	9	92%	Down 1%

30 April 2023

Competency	Does Not Meet Requirement	Meets Requirement	Target Group	%
383|LOCAL|C Safeguarding - Adults Level 1 (Non Clinical) (3 Yearly)|	58	518	576	89.93%
383|LOCAL|C Safeguarding - Adults Level 1+2 (All Clinical) (3 yearly)|	146	1729	1875	92.21%
383|LOCAL|R Safeguarding - Adults Level 3 (3 Yearly)|	9	108	117	92.31%

30 April 2022

Row Labels	Does Not Meet Requirement	Meets Requirement	Target Group	%
383|LOCAL|C Safeguarding - Adults Level 1 (Non Clinical) (3 Yearly)|	133	539	672	80.21%
383|LOCAL|C Safeguarding - Adults Level 1+2 (All Clinical) (3 yearly)|	257	1676	1933	86.70%
383|LOCAL|R Safeguarding - Adults Level 3 (3 Yearly)|	9	120	129	93.02%

All level 1 and 2 training during this last year has been via E-learning. All Level 3 sessions are full day classes and are delivered via MS Teams. These classes also include Mental Capacity Act (MCA; Deprivation of Liberty Safeguards (DoLs); PREVENT Level 3.

In the period 1 April 2022 – 31 March 2023 there were 62 Level 3 classes delivered, compared to 42 between 1 April 2021 – 31 March 2022. As a result, 824 staff have received their level 3 training, which is 106 up on the previous year. Each class has availability for 22 attendees, giving a potential target of 1364 spaces. However 540 spaces were not utilised. There has only been one class cancelled during this period- at last minute due to the trainer's close family bereavement.

However, this should not detract from the extremely positive direction in which Safeguarding Adults Level 3 (Inc. Levels 1 & 2), MCA, DoLs, Prevent and WRAP is on course to achieve targets. This is especially pertinent due to increase in compliancy requirements with additional staff recently having need to access the Level 3.

The Safeguarding leads take a highly proactive stance and recognise the preventative nature of a competent workforce. The Trainer and leads are also offering 'bespoke' classes for specific Safeguarding Adults requirements to teams/units in the Trust, as requested by managers. This approach has been welcomed by the Teams and has resulted in significant improvements.

SAFEGUARDING CHILDREN ADVICE THEMES

Top 5 Advice Themes:

	2021/22	2022/23
1	Parenting Skills/Capacity/Basic Care	Parenting Skills/Capacity/Basic Care
2	Domestic Violence	Neglect
3	Neglect	DHCFT procedures
4	Child's Mental Health	Physical Injury/Abuse
5	Emotional Abuse	Community Resources

We continue to analyse the calls for advice into the Safeguarding unit:

- In comparison to the last annual report period Domestic Abuse is not in the top 5 themes. This is quite surprising considering the figures we monitor and the children impacted on with regards Domestic Abuse, one reason for this is that the team believe our staff are becoming more confident and competent in dealing with Domestic Abuse in their practice. This is partly due to training and also the lessons cascaded from the multi-agency Domestic Abuse audit that have been completed.
- Neglect is still present which has always been a significant issue in our organisation. This is partially around our staff's consideration re thresholds and poverty faced by the our specific patient group within the area and the very real feedback and experience from our staffs concern with regards the presentation and living conditions of families. We have also seen this issue and a crossover with parenting skill/capacity and basic care.
- Due to the nature of a large proportion of the Trust patient group we also have a large number of staff concerns around the capacity to parent if there is impact as a consequence of their mental health, substance misuse and or learning disability.
- Community resources remain a concern for staff as resources are being reduced or stopped, that are often associated with prevention and this has a significant impact on families who need services to prevent family breakdown.
- Our colleagues making calls around procedures is welcomed and actively encouraged as our message to staff is always to refer to procedures and do not assume you know them. Staff checking out procedures against thresholds appropriately, is a positive sign of the service.

CHILDREN AUDITS

Trust Internal Audits

Three safeguarding children audits have been completed during the period of this report, see below:

- Patients with complex needs are allocated a Care Coordinator; Cases discussed at MDMs/ Clinical Case discussion include analysis and action; and are documented within EPR.
- Do referrals to Adult Social Care consider the impact of this on children within the family (Think Family)?
- Quality of Safeguarding Children Supervision
- The Quality of Safeguarding Children's Referrals made into Derbyshire Starting Point by DCHS Services.

The Trust took part in a safeguarding Children Partnership Audit:

Multi agency audit – CRE 2022

Children at Risk of Exploitation (CRE) This procedure focuses on safeguarding and protecting children at risk of exploitation (CRE) and outlines the actions to be taken. Children and young people who are sexually or criminally exploited or at risk of exploitation are victims of child abuse.

Cohort: Child aged between 13 and 16
Subject: How effective is the multi-agency partnership at identifying and responding to children at risk of or experiencing exploitation?
Timescale: The audit considered the experiences of the child/young person over the last 6 months
Supporting documents:
CRE procedures, CRE Risk Assessment, Derby and Derbyshire CRE Strategy.

Multi-Agency Audit into Domestic abuse - 22

Cohort: The agreed scope was child in need, 3 cases with a child aged 2 and under and 3 aged 3-5 with case selection ensuring that there are older siblings in at least 3 cases.
Subject: to determine how well the partnership identifies and responds to children and families experiencing domestic abuse. This was in response to a number case reviews where domestic abuse was a feature of the child's lived experience and several recent changes both nationally and locally to improve the response to domestic abuse including the Domestic Abuse Bill and the introduction of new perpetrator programmes locally.
Timescale: covering 6 months prior to the point of audit.

Audit Outcome

Conclusions, analysis and recommendations are cascaded within the Trust to share the findings and learning and action is taken on challenges presented.

ADULT AUDITS

Multi agency audits are undertake 3 monthly by City and County Adult Safeguarding Boards. DHCFT contribute to these. The learning from the audits is reflected in level 3 training and disseminated throughout DHCFT via information sharing documents, by the Learning on one page document (LOOP).
Themes for the last year have been:

- Learning Disability and sexual abuse.
- Homelessness
- Safeguarding adult referrals and Direct payments
- Self-neglect
- Domestic Abuse in over 65-year-olds
- Safeguarding where a crime has been committed in Over 65-year-olds.
- Financial abuse and transitional safeguarding

SECTION 11 AUDIT

Section 11 of the Children Act 2004 places duties on a range of organisations, agencies and individuals to ensure their functions, and any services that they contract out to others, are discharged having regard to the need to safeguard and promote the welfare of children. The CCG and the safeguarding children partnership undertake an audit yearly to each organisation.

NHS Derby and Derbyshire integrated Care Board (DDICB) and Derby and Derbyshire Safeguarding Children Partnership (DDSCP) completed the Section 11 self-assessment and a virtual safeguarding children quality meeting on the 10th of November 2022.

NHS Derby and Derbyshire integrated Care Board (DDICB) were pleased to report that they were fully assured with the evidence provided in the Section 11 self-assessment and the further information / assurance received from the Safeguarding Children Team during the safeguarding children quality meeting.

The table below shows FULL compliance. The standards are:

1. Accountability Structure
2. A culture of listening to children, young people, carers and to staff
3. Information Sharing
4. Safe Recruitment and Dealing with Allegations Against People Working With Children
5. Effective appropriate supervision and support for staff, including training

Section 11 compliance rating (2021/22)	
Standard 1	Full Compliance
Standard 2	Full compliance
Standard 3	Full compliance
Standard 4	Full Compliance

Standard 5	Full compliance

LOOKED AFTER CHILDREN MARKERS OF GOOD PRACTICE (MOGP)

In February 2023 the Children in Care Team submitted the Markers of Good Practice assurance tool to the Integrated Care Board for Derby City and Derbyshire (DDICB). The Markers of Good Practice assurance tool, which is 'RAG' rated, provides the Children in Care Team with a productive opportunity to showcase their service to the Integrated Care Board and Designated Professionals.

With the submission of evidence and 'RAG' rating, the assurance tool supports the Children in Care team to highlight progress, any gaps or improvements that are required to assure the Integrated Care Board our service is working towards a 'gold standard' delivery and that the needs of the Children in Care are being met and identified in line with the statutory guidance.

Following the MOGP action plan submission, representatives from the Integrated Care Board and Designated Professionals completed the feedback in written format with a decision as to whether a meeting face to face with the provider is required. A discussion was held between the commissioners from DDICB. Each standard was discussed, and it was confirmed whether the 'RAG' rating provided by the Provider was in line with that of the commissioners' assessment.

Strengths and challenges were identified, agreed by both parties and an action plan will be developed by the provider to work through within the year 2023-2024 to achieve compliance in the areas that were not yet rated as green. The Markers of Good Practice action plan will be fed back to the Safeguarding Children's Committee by the Director of Nursing and Patient Experience, and at the Safeguarding Operational Leads meeting and the Childrens Clinical Refence Group held by the Organisation by the Named Nurse Children in Care.

Derby and Derbyshire Integrated Care Board (DDICB) fed back that the evidence clearly demonstrates the Organisation and Team's commitment to meeting the needs of Children in Care at every stage of their journey in the care of the Local Authority and beyond. DDICB have been significantly assured about the quality of the service provision and appreciate the providers honesty whereby further progress is required.

SAFEGUARDING ADULTS' ASSURANCE FRAMEWORK (SAAF)

The SAAF was reported on in last year's report. The next SAAF is due September 2024.

CARERS

I can confirm that Derbyshire Healthcare NHSFT retain their Triangle of Care Star. This is a comprehensive submission, backed by clear evidence, describing the activities and progress that has been made to retain the two-star rating despite pausing through the pandemic.

Comments: There is a clear thread of carer involvement, participation and co-production through the Triangle of Care standards that is embedded in activities across the Trust. The

implementation of the Participant Carers and Experts by Experience Reward and Recognition Policy, clearly show that the expertise and experience of carers is valued appropriately, and I would like to use this as an example for other Trusts and, indeed, our own work at Carers Trust when involving carers.

Not all Trusts have made training for staff mandatory and again this shows the importance of including carers within the Trust.

It was particularly useful to hear how the carers voice is embedded at all levels of the Trust and how this meets the Carer Experience Thermometer from board level, through to quality accounts and the importance of the Carer Engagement meetings.

What might be perceived as small actions, such as the grab bags and regular newsletters show that system wide carer inclusion feels embedded at all levels of service.

Support: Carers Survey. Carers Trust are looking at measuring impact and surveying carers and including the system questions from the Carers Engagement Thermometer. Once finalised there would, therefore, be an option for Trusts to use a standardised questionnaire. The Carers Trust National Steering Group are looking at this at their June 2023 meeting and we aim to have a template available by the Summer.

There is a new section on discharge within the Triangle of Care Handbook, 3rd edition which will be available online by mid-June.
We hope that a new web area for Triangle of Care and the re-launch of Regional Hubs will support more shared learning and resources.

Exploration of hosting a Regional Hub for the Midlands is being considered.

SEXUAL SAFETY

Work continues to strengthen our understanding around sexual safety for people who use or service and people who work within our service. Involvement in the East Midlands Community of practice continues with sharing of policies and work around sexual safety.

Reporting from both units have improved. Staff have completed a sexual safety questionnaire which evidences they know how to recognise and respond to sexual safety incidents.

There have been a DHCFT video produced to alert staff to recognise issues around behaviours and boundaries. This is widely shared throughout the Trust.

There has been a video for patients produced and circulated throughout DHCFT and Inpatient Units for patients to increase understanding about their sexual safety.

Sexual safety has been embedded in to the Icare programme. Following the success of the Icare programme for new starters and recognising increasing requests to book longer serving Support Workers onto the programme, we have developed two training days which are aimed specifically

at existing Healthcare Support Workers within the Trust. The training will build on existing knowledge and understanding with more in-depth material and will also aim to address closed cultures and attitudinal issues.

The first training will cover the below topics and is aimed at Support Workers from all services:

- Mental Illness
- Communication and Empathy
- Professional Boundaries
- Therapeutic Engagements
- Effective Documentation

A further day will be offered to Acute Inpatient Support Workers with additional content around psychological interventions, sexual safety and patient centred care. The expectation would be for Acute Inpatient Support Workers to attend both days, in any order. Dates for the second session will become available later in the year.

Sexual safety has been included in the new Supervision Policy to include the importance of discussing sexual safety and helping staff understand that people are better protected when they are empowered to speak out about unwanted sexual behaviour and can speak openly about their sexual safety concerns.

The non-recent abuse guidance has been reviewed by the Safeguarding Unit and the Derby and Derbyshire Safeguarding Children's Partnership. Our newly reviewed non-recent abuse support leaflet for service users has also been reviewed and reprinted and is included in the guidance.

PUBLIC PROTECTION

MARAC - Multi Agency Risk Assessment Conference

The Multi Agency Risk Assessment Conference (MARAC) is a multi-agency approach to managing cases of domestic abuse where the victim has been identified as being at high risk of serious harm or homicide.

MARAC meetings bring together representatives from both statutory and voluntary agencies with the aim of sharing information and developing a safety plan for victims and their families with a view to reducing the risks and the likelihood of repeat victimisation. The victim does not attend the meetings but is represented by an Independent Domestic Violence Advisor (IDVA) who speaks on their behalf.

MARAC meetings are held every week, alternating between the south of the county and the north. This allows cases from both areas of the county to be discussed fortnightly.

From 5 April 2022 to 21 March 2023 South Derbyshire MARAC discussed 748 cases.

Themes discussed at MARAC include:

- Physical assault/ abuse
- Emotional abuse
- Sexual assault/ abuse
- Coercive control
- Abuse of the victim via the children
- Malicious allegations to services about the victim
- Stalking
- Harassment
- Breaches of bail conditions/ Non-Molestation Order/ Restraining Order (RO) by the perpetrator
- Victim not engaging with criminal justice processes regarding the domestic abuse
- Psychological abuse
- Strangulation
- Victim Isolated from friends/ family
- Victims prevented from attending health services
- Threats to kill the victim/ children/ victim's family / friends
- Victim Pregnant; miscarriage before or after incident
- Use of weapons or items to harm the victim
- Use of drugs (victim/ alleged perpetrator)
- Use of alcohol (victim/ alleged perpetrator)
- Honour based violence

Challenges:

- Recording after MARAC remains a significant resource issue
- MARAC Clinician Research can be lengthy
- The COVID-19 Pandemic impacted on the MARAC process, this used to be face to face at Derbyshire Constabulary HQ in Ripley. The meetings developed via Teams and has been extremely successful enabling increased attendance.

Overall, the MARAC process is an excellent example of multi-agency working which DHCFT is fully committed to.

MAPPA (Multi-agency Public Protection Arrangements):

The purpose of MAPPA is to "Protect the public, including previous victims of crime, from serious harm by sexual and violent offenders." (MAPPA Guidance (2012) Version 4.0, Section 1). These arrangements are statutory. It does this by ensuring that all relevant agencies work together effectively to:

- Identify all MAPPA offenders
- Complete comprehensive multi-agency risk assessments
- Devise, implement and review robust multi-agency risk management plans
- Focus the available resources in a way which best protects the public from serious harm.

DHCFT continues to maintain 100% attendance at MAPPA 3 meetings and case reviews. DHCFT attends out of area MAPPA 3 meetings where the offender is known to Derbyshire.

PREVENT:

The 2011 Prevent strategy has three specific strategic objectives:
Respond to the ideological challenge of terrorism and the threat we face from those who promote it prevent people from being drawn into terrorism and ensure that they are given appropriate advice and support work with sectors and institutions where there are risks of radicalisation that we need to address.

DHCFT is fully committed to attendance at the Channel meetings. The Assistant Director of both Safeguarding Adults and Children and the Named Safeguarding Doctor attend the Channel meetings. We continue to maintain 100% attendance at these meetings.

Our level 3 safeguarding adults training supports this process by focus on understanding the risk of radicalisation to ensure staff understand the risk and build the capabilities to deal with it, communicate and promote the importance of the duty; and ensure staff implement the duty effectively.

A pathway for referral into CAMHS and working age adult community teams has been developed by the DHCFT Prevent Lead to ensure the need for clear information to identify those at risk of radicalisation and a commitment for the prevent team to outline the mental health presentation so a conversation can be held around balancing the risk of radicalisation and the clinical need. This was well received by the prevent Board in April 2023.

Serious Organised Crime and Exploitation Meeting (SocEx):

SocEX is a tactical meeting which has replaced the Mult-Agency CRE Tasking and Local Organised Crime Partnership Boards. Following am inspection it was recommended that Derbyshire Constabulary engages with its safeguarding partners and reviews its assessment and information sharing processes to ensure vulnerable children are identified at the earliest stage and referred without delay to the most appropriate level of support.

The Multi-Agency SocEx structures will allow operational, tactical and strategic oversight of exploitation and serious organised crime disruption across the County of Derbyshire.

This will be underpinned by information and intelligence sharing which will have, or has the potential to have, an impact on the communities of Derbyshire, across each Local Authority and Operational Policing Division.

At each level of governance, the same key information using the Victim, Offender, Location, Themes (VOLT) will be utilised. This will make it easier to consistently share this information and intelligence among partners and across borders with our other law enforcement services.

This partnership response will also aid the identification, disruption, and enforcement against serious organised crime networks in Derbyshire by increasing awareness, information sharing and utilising multi-agency disruption activity with our partners and other law enforcement agencies. This structure will allow us to understand key risk areas and report into the Safer Communities, Safer Derby, Health and Wellbeing, Local Criminal Justice and Adult Safeguarding Boards, alongside the Children's Safeguarding Partnership.

Both Assistant Directors of Safeguarding Adults and Children attend the tactical partnership meeting to provide a multiagency response to identified areas of emerging threat and risk in relation to the exploitation of children, vulnerable adults and the emergence of serious and organised crime.

MASH HEALTH ADVISORS 2022/23

A Multi-Agency Safeguarding Hub (MASH) is a team which brings together agencies (and their information) in order to identify risks to children and adults in Derby at the earliest possible point and respond with the most effective interventions.

MASH Health

MASH Agencies have returned to the office since COVID-19 and we continue to use a hybrid model of face to face meetings with external agencies utilising Microsoft teams. Probation have also joined the MASH. A longitudinal data analysis (2017-2022) highlighted an activity increase of 75% for MASH Health Advisors over 5 years with an overall 300% increase in adult referrals and 32% increase for children's referrals. MASH Health also continue to liaise with Starting Point Health advisors to develop practice, share experiences and continue to ensure effective and appropriate information sharing. MASH Health continue to take advice calls for the trust and complete 'face-face' checks with other MASH agencies. These are on the increase due to increased presence in the MASH.

Adults

Data highlights a 15% decrease in adult information exchange forms from the previous year. However, as the Trust has now moved to Systm1 and a shared patient record, MASH Health have access to significantly more information leading to more time spent on adult referrals. In addition, Adult strategy meetings have increased by 109% and liaison with other professionals continues to increase. The highest number of referrals is in relation to neglect and self-neglect with physical and financial abuse following closely behind. This follows previous years findings.

MASH Health are now completing delegated safeguarding enquiries for the Trust for incidents on the inpatient wards, it is too early to determine how this will develop.

Children

Children strategy meetings remain very similar to previous years with physical abuse remaining the highest, followed by sexual abuse and high risk domestic abuse. There was also an increase in Children at Risk of Exploitation CRE strategy meetings. MASH Health continue to contribute to PCOT (Protecting Children Online Team) triage meetings which are booked daily but on

average 4.5 referrals are discussed a month.

Historically there have been clear declines in referrals during school holidays however in August 2022 activity remained at a steady level as seen in term times. It could be hypothesised that this is because schools improved connecting with children outside of school during lockdowns.

Domestic Abuse

There has been a 20% decrease in medium risk domestic abuse cases discussed. This is likely due to the new Police process that the Domestic Abuse Review Team (DART) review all domestic abuse notifications leading to some being downgraded to standard risk. There has been a noticeable increase in medium risk domestic abuse that social care have requested a strategy meeting on due to the nature of the concerns. These are progressed to a S47 strategy meeting either before or following Triage.

Testimonies

Hannah Rafferty, Deputy Head Of Service, People Service Directorate, Reception Service:
Our MASH Health Advisors are critical in ensuring that information sharing between health, social care and police takes place in a timely way. The information shared by the MASH health advisors informs the multi-agency discussion about threshold in strategy meeting and enables safety plans to be informed, vulnerabilities more easily identified and as a result leads to the formation of well-informed safety plans. The three health advisors based in MASH, ensure that research is completed without delay and always ensure that there are available for strategy meetings and share their knowledge and expertise with colleagues supporting the Think Family Approach.

Jade Wilkinson, Acting Senior Practitioner, Multi Agency Safeguarding Hub, (MASH):

- *Adults MASH colleagues have a good working relationship with MASH Health Advisors which enables positive outcomes for the customers we work with.*
- *Health advisors are prompt and robust with proving relevant information needed for safeguarding adults enquiries. Both in the office and via email/telephone etc.*
- *Health advisors make a positive contribution to strategy meetings held and assisting with ongoing safety plans.*
- *Health advisors are supportive with new starters / students etc that join Adults MASH.*

LEARNING FROM REVIEWS

Child Safeguarding Practice Reviews (CSPR):

The Derbyshire Healthcare NHS Foundation Trust Safeguarding Children Team have contributed to 11 Child Safeguarding Practice Reviews within the time frame of the annual report. Two of the reviews were including two cases each as the themes and learning were similar.

Activity includes providing reports based on agreed terms of reference regarding children and adults in the family home and their contact with Trust Services. There is also a requirement to attend panel meetings, practitioner learning events, sign off panels to agree final reports and meetings about publication and publicity arrangements.

The Trust attends all Partnership action planning meetings also to ensure actions are completed and evidence is provided to assure against recommendations for each review. This gives assurance across the Partnership that actions are complete or give a progress position and enable agency challenge as necessary. Learning briefs are developed by the Partnership to disseminate the learning throughout the Organisations.

The Trust cascades learning via various routes including professional meeting and Organisation reports. Due to the sensitive and distressing nature of Child Safeguarding Practice Reviews the Safeguarding Team provide support to staff and management. Support for the Safeguarding Team is available as required via Trust wellbeing support services and supervision.

Domestic Homicide Reviews (DHRs) and Safeguarding Adult Reviews [SARs]

The Trust is actively involved in Domestic Homicide Reviews and Safeguarding Adult Reviews. Work continues to complete outstanding actions from previously published reports. These actions are overseen by the relevant Adult Safeguarding Board and Community Safety Partnership. We are currently working on 3 SARs and 5 DHRs.

Learning briefs are developed by the Adult Safeguarding Board to disseminate the learning to partner organisations. The Trust cascades learning via various routes including professional meeting and organisation reports. The recommendations and learning are incorporated into our level 3 safeguarding training.

Focussed learning has been undertaken within the trust around specific themes identified form SAR/DHR recommendations. This year there have been focussed sessions within the Trust around the theme of domestic abuse.

OBJECTIVES 2023/24

Led by the operational group and assurance on progress provided to the Quality Committee.

Objective / Initiative	
1.	To continue to develop and integrate the Children's and Adults Safeguarding Team within the Trust.
2.	To ensure that succession planning, develop expertise within the workforce and consider talent management and support development by secondments into the safeguarding unit.
3.	To continue to support staff around complex and to provide safeguarding leadership to the organisation.
4.	To support CQC standards / improvements and initiatives and ensure it remains a golden thread throughout the organisation.
5.	To work in partnership with agencies with regards to multi agency audits and disseminated the learning and to continue to undertake internal safeguarding audits and disseminate the learning
6.	To continue to ensure that Think family remains the focus in everything we do.
7.	To continue to undertake a joint City / County Section 11 and SAAF. To ensure actions are identified and completed.
8.	To make further developments in assuring Sexual Safety within the Trust's services and publish the Sexual Safety policy for patients and staff, in line with this being a Trust Quality Priority.
9.	To work alongside staff around quality of referrals, threshold and escalation
10.	To commission annual level4 safeguarding training
11.	To ensure full participation in multi-agency child safeguarding practice reviews, learning reviews and Domestic Homicide reviews and SARs. Ensuring that all recommendations are completed and learning disseminated throughout DHCFT.
12.	To work alongside both and Children's safeguarding partnership and the Adult safeguarding board around their agreed priorities for 2023/24
13.	To ensure safeguarding representation on relevant internal and external meetings. Carry out any related activity/actions.
14.	To continue to work alongside the NED safeguarding lead, the executive safeguarding lead for the trust and the quality and safeguarding committee. To ensure quality, assurance and governance

GLOSSARY OF ACRONYMS

CCG: Clinical Commissioning Group
CIC: Children In Care
CQC: Care Quality Commission
COAT: Clinical Operational Assurance Team
CPA: Care Programme Approach
CSE: Child Sexual Exploitation
CSC: Children's Social Care
CSPR: Child Safeguarding Practice Review
DDSCP: Derby City and Derbyshire County Safeguarding Children Partnership

DDCCG: Derby and Derbyshire Clinical Commissioning Group
DHCFT: Derbyshire Health Care Foundation Trust
DHRS: Domestic Homicide Reviews
DV: Domestic Violence
DOLS: Deprivation Of Liberty Safeguards
ESR: Electronic Staff Records
IEF: Information Exchange Form
KPI: Key Performance Indicators
MDMs: Multi-Disciplinary Meeting
MAPPA: Multi-Agency Public Protection Arrangement
MARAC: Multi-Agency Risk Assessment Conference
MASH: Multi-Agency Safeguarding Hub
MCA: Mental Capacity Act
MHA: Mental Health Act
MOGP: Markers Of Good Practice
MSP: Making Safeguarding Personal
MST: Microsoft Team
NAI: Non-Accidental Injury
PDL: Professional Development Lead
PCOT: Protecting Children Online Team
POLIT: Police Online Investigation Team
RAG: Red Amber Green (rating)
SAAF: Safeguarding Accountability and Assurance Framework
SAPDB: Safeguarding Adults Performance Dashboard
SARS: Safeguarding Adults Reviews
TOC: Triangle Of Care
SUDI: Sudden Unexplained Death in Infancy
WRAP: Workshop to Raise Awareness of Prevent

REPORT PREPARED BY (and contributions from):

Tina Ndili - Assistant Director Safeguarding Children
Nikki Roome - Assistant Director Safeguarding Adults
Debbie Archer - Safeguarding Unit Administrative Coordinator
Elizabeth Holmes – Safeguarding Children Named Nurse
Zoe Rudderforth - MASH Health Advisor
Louise Haywood - MASH Health Advisor
Claire Ray – MASH Health Advisor
Jo Watson - Safeguarding Children Trainer
Dave Ensor – Safeguarding Children Trainer
Dr Deepak Sirur – Named Doctor for Safeguarding Adults
Dr Wendy Brown – Named Doctor for Safeguarding Children
Kelly Thompson – Named Nurse for Children in Care
Carolyn Green – Director of Nursing and Patient Experience/Board Safeguarding lead.

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

Children in Care Annual Report 2022/23

Purpose of Report

The purpose of this report is to provide Derbyshire Healthcare NHS Foundation Trust (DHCFT) an overview of the progress, challenges, opportunities, and future priorities to support and improve the health and wellbeing of Children in Care in Derby City. This report is to provide assurance to the Board on how this service is discharging its legal duties and clinical standard requirements.

Executive Summary

- The report includes all cohorts of Children in Care that Derby City Local Authority are responsible for, no matter where they live.
- The report provides significant assurance on the provision, performance, and outcomes for children in the service. Health performance has been maintained and exceeded the levels set to ensure outcomes for our children.
- The report was provided to the Quality and Safeguarding Committee to scrutinise and ensure the Trust has discharged our formal statutory duties to our vulnerable children.
- It is known that Children in Care are at elevated risk of worse health outcomes. Children in Care health screening services are in place to reduce and mitigate this risk. The health outcomes for our community in Derby are above our regional comparator and demonstrate above average performance and good outcomes.
- It is recognised that the Children in Care health team have core competencies, specialist skills, knowledge, and attitudes to act as advocates, undertake health assessments and identify and manage health needs.
- Last year, there were major changes nationally in the way medical reports are provided for the ADM (Agency Decision Maker) following a court ruling (called Somerset ruling). This had affected the medical adviser's workload in an unprecedented way since January 2022 requiring a large number of additional medical reports to be done within strict deadlines, which was achieved with making adjustments in the workforce resources. This workload has now settled with making planned changes in the report format.

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

Risks and Assurances

- The organisation will assure measures are put into place in accordance with the service specification
- Maintain working relationships with other partner agencies/services
- The statutory timescales will be monitored, and evidence is provided and scrutinised, in order, to achieve outcomes
- Training compliance will be scrutinized to ensure competency of staff to the right level.

Consultation

- This report has been developed by the Named Nurse for Children in Care with information that is held by both provider and local authority
- Various members of the wider Children in Care team have contributed to the report
- A child friendly Annual Report will be developed in a leaflet form.
- The report provided the Quality and Safeguarding Committee on 10 September 2023 with significant assurance of the work within DHCFT around Children in Care and young people and the continued partnership working to ensure the best outcome is achieved for this vulnerable group of children and young people.

Governance or Legal Issues

- The Trust meets statutory obligations and legal duties regarding: Mental Health Act [1983]; Mental Capacity Act [2005]; The Care Act [2014]; Children and Families Act [2014]; Human Rights Act [1998] Domestic Violence, Crime and Victims Act [2004] and our internal systems, structures and processes are joined up and effective.

- The Trust meets the required standards for our Regulators and our Professional Regulatory bodies Codes of Practice i.e., Safe, Caring, Effective, Responsive, Well-led and Safeguarding are one of the gold threads that runs throughout. We apply national guidelines and evidence based best practice e.g., NICE, DoH, National Statistics.
- The Trust contributes as an equal partner in multi-Agency forums e.g., MAPPA; MARAC; Channel; Child and Adult Safeguarding Boards and subgroups and takes part in peer assessment, benchmarking and self-assessment and assurance.
- The Trust invests in staff across multiple agencies and services to ensure high levels of competence and confidence and achieve consistently good practice that is constantly updated and refreshed within a culture of learning from both successful and adverse situations.

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:

- Empowerment - of the individual to make decisions.
- Protection - support and representation for those in need.
- Prevention - of abuse / neglect as well as helping the person to reduce the risks of harm and abuse that are unacceptable to them.
- Proportionality - responses should be least restrictive to the person's rights.
- Partnerships - working collaboratively to prevent, identify and respond to harm.
- Accountability - and transparency in delivering safeguarding.

Recommendations

The Board of Directors is requested to:

1) Note that the Quality and Safeguarding Committee received significant assurance of the work within DHCFT around Children in Care and young people and the continued partnership working to ensure the best outcome is achieved for this vulnerable group of children and young people
2) Note that the Quality and Safeguarding Committee accepted the annual report and agreed on the key priorities set for 2023/24.

Report presented by: **Lynn Andrews**
Chair, Quality and Safeguarding Committee

Report prepared by: **Kelly Thompson**
Named Nurse Children in Care

Derbyshire Healthcare
NHS Foundation Trust

ANNUAL REPORT FOR DERBY CITY LOOKED AFTER CHILDREN PROVISION

Year 2022-23

Contributors:

Kelly Thompson (Named Nurse for Children in Care – DHcFT)

Dr A Marudkar (Medical Advisor for Children in Care – DHcFT)

Dr I Mehwish (Medical Advisor for Children in Care – DHcFT)

Natalie Legge (Admin Coordinator – DHcFT)

Section 1: Introduction and context

The purpose of this report is to provide Derbyshire Healthcare NHS Foundation Trust (DHcFT) an overview of the progress, challenges, opportunities, and future plans to support and improve the health and wellbeing of looked after children in Derby City. This includes all cohorts of looked after children that Derby City Local Authority are responsible for, no matter where they live (see section 4 for explanation of the differing cohorts).

1.1. The report will outline how Commissioners, Designated Professionals, Local Authority and Health Providers have worked together in partnership to meet the health needs of children in care in Derby City; in line with the statutory guidance 'Promoting the health and wellbeing of looked after children' (DH, 2015).

It will summarise key improvements, service performance; along with setting out the objectives and priorities for the next financial year (2023/24) for Children in Care in Derby City.

1.2. This report has been compiled in partnership with the Named Nurse for Children in Care, the Medical Advisors and Specialist Children in Care Nurses and Admin.

1.3. Within all national and local policies and guidance the service is known as Looked after Children, however within Derbyshire Healthcare NHS Foundation Trust the service is known as Children in Care.

Context

1.4. **Definition of a looked after child/ child in care**

A child that is being looked after by the Local Authority; they might be living with:

- Foster parents
- At home with their parents under the supervision of Children's Social Care
- In Local Authority or private residential children's homes
- Other residential settings such as schools or secure units.

They might have been placed in care voluntarily by parents struggling to cope, or Children's Social Care may have intervened because a child was at significant risk of harm.

Health and wellbeing of looked after children

1.5. It is well recognised that children's early experiences have a significant impact on their development and future life chances. As a result of their experiences and blended effects of

poverty, poor parenting, chaotic lifestyles, abuse and neglect, looked after children often are at greater risk and have poorer health than their peers (DfE, DH, 2015).

Ref: Promoting the health and wellbeing of looked-after children, March 2015, Department for Education and Department of Health

1.6. The Royal College of Paediatrics and Child Health (2020) states that looked after children and young people have greater mental health problems, along with developmental and physical health concerns such as speech and language problems, bedwetting, coordination difficulties and sight problems. Furthermore, the Department for Education and Department of Health (2015) argue that almost half of children in care have a diagnosable mental health disorder and two thirds have special educational needs. When there are delays in identifying or meeting the emotional and mental health needs this can have a detrimental effect on all aspects of their lives leading to unhappy unhealthy lives as adults.

Ref: Promoting the health and wellbeing of looked-after children, March 2015, Department for Education and Department of Health

Ref: Looked after children: Knowledge, skills and competencies of health care staff, Intercollegiate Role Framework, December 2020, Royal College of Paediatrics and Child Health

Section 2: Statutory Framework, Legislation and Guidance

The statutory guidance focused around Looked after Children is in abundance; the key documents and legislation are outlined as follows:

2.1 **Children Act (1989)**

Under this Act a child is defined as being 'looked after' by the local authority if the child or young person is in their care for a continuous period of more than 24 hours by the authority.

There are four main groups:

- **Section 20** children who are accommodated under a voluntary agreement with their parents
- **Section 31 and 38** children who are subject to an interim care order or care order
- **Section 44 and 46** children are subject to emergency orders
- **Section 21** children who are compulsory accommodated including children remanded to the care of the local authority or subject to criminal justice supervision with a residence requirement.

2.2 **Adoption and Children Act (2002)**

This Act modernised the law regarding adoptive parenting in the UK and international adoption. It also enabled more people to be considered by the adoption agency as prospective adoptive parents. This Act also places the needs of the child being adopted above all else.

2.3 **Children and Young People's Act (2008)**

The purpose of the Act is to extend the statutory framework for children in care in England and Wales and to ensure that such young people receive high quality care and services which are focused on and tailored to their needs

2.4 **Children and Families Act (2014)**

This Act strengthens the timeliness of processes in place to ensure children are adopted sooner. Due regard is given to the greater protection of vulnerable children including those with additional needs

2.5 **Promoting the health and wellbeing of looked after children (March 2015)**

This guidance was issued by the Department of health and Education. It is published for Local Authorities, Clinical Commissioning Groups now Integrated Care Boards - ICB, Service Providers and NHS England.

2.6 **Looked after children: Knowledge, skills and competences of health care staff intercollegiate role framework (December 2020)**

This document sets out specific knowledge skills and competencies for professionals working in dedicated roles for looked after children

2.7 **The Children and Social Work Act (2017)**

Improves decision making and support for looked after and previously looked after children in England and Wales

- Improve joint work at local level to safeguard children and enabling enhanced learning to improve practice in child protection
- Enabling the establishment of new regulatory regime for the social work profession
- Improve the provision of relationship and sex education in schools

Section 3: Looked after Children data and profile

National and local data

3.1 The number of looked after children has increased steadily over the past eight years. There were 82,170 Looked after Children on 31 March 2022, an increase of 1.6%, compared to 31 March 2021. (Department for Education DfE, Department of Health DH, 2021).

3.2 **Number of children looked after in England from 31 March 2015 to 2022**

2015	**69,540**
2016	**70,440**
2017	**72,670**
2018	**75,420**
2019	**78,150**
2020	**80,080**
2021	**80,850**
2022	**82,170**

Ref: Data made available from Derby City Local Authority Informatics Department

3.3 Number of children looked after in Derby from 31 March 2016 to 31 March 2022

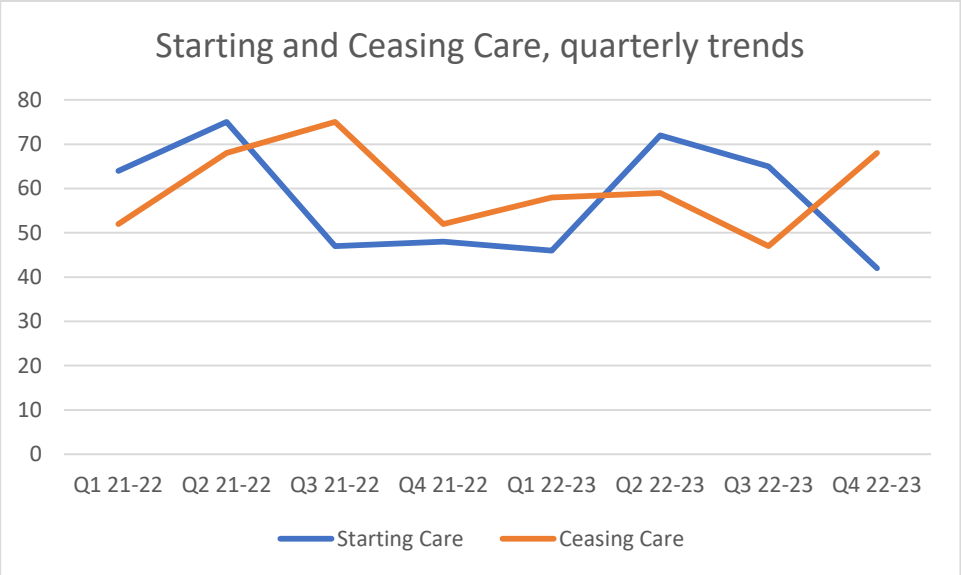
2016	**452**	**4% decrease from 2015**
2017	448	0.8% decrease from 2016
2018	491	8% increase from 2017
2019	562	12% increase from 2018
2020	588	4.6% increase from 2019
2021	642	9.4% increase from 2020
2022	627	2.3% decrease from 2021
2023	620	1.1% decrease from 2022

Ref: Data made available from Derby City Local Authority Informatics Department

The number of Children in Care has decreased by 28 cases during Q4 to 620. This is a decrease of seven cases compared to twelve months ago (31 March 2022) when we had 627 cases. This equates to a decrease of 1.1%.

3.4 Children in Care - starting and ceasing care - quarterly trends

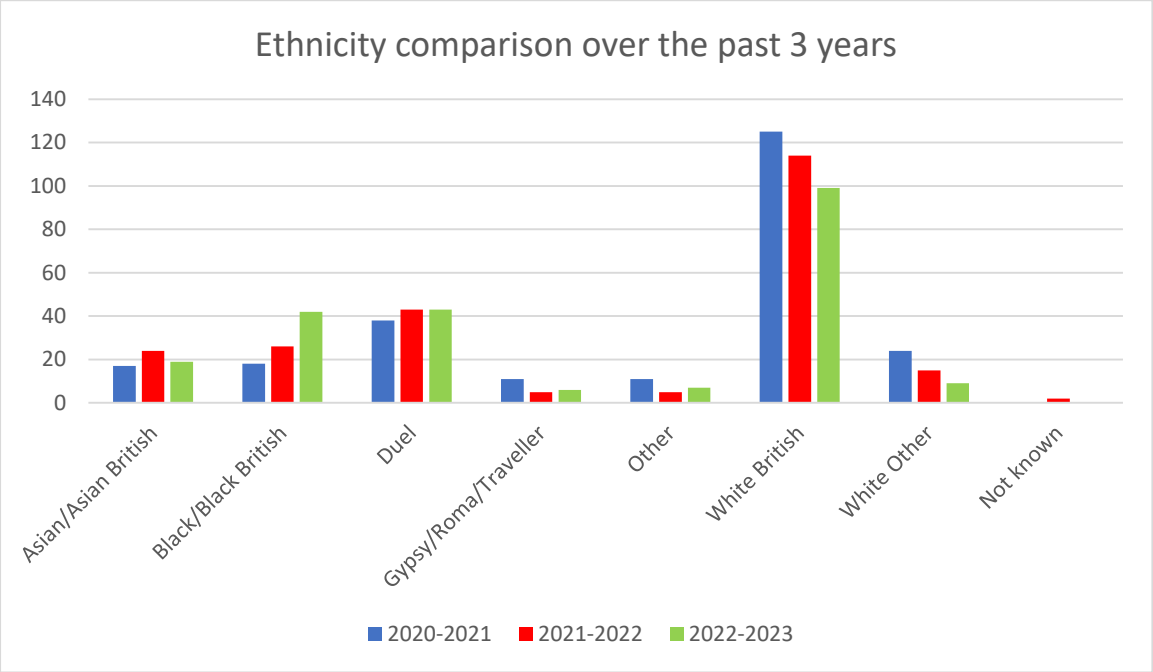
During Q2 and Q3 there was a higher level of children entering care compared to leaving care. There was a significant reduction in the number of entrants into care during Q4 2022-23. There was a total of 42 entrants into care compared to 65 seen in the previous quarter. (35% decrease)**.** On average there are around 57 new entrants per quarter, so this quarter is much lower than the current quarterly average**.** During Q4 there were more exits from care than entrants with a net reduction of 26 cases.



Ref: Data made available from Derby City Local Authority Informatics Department

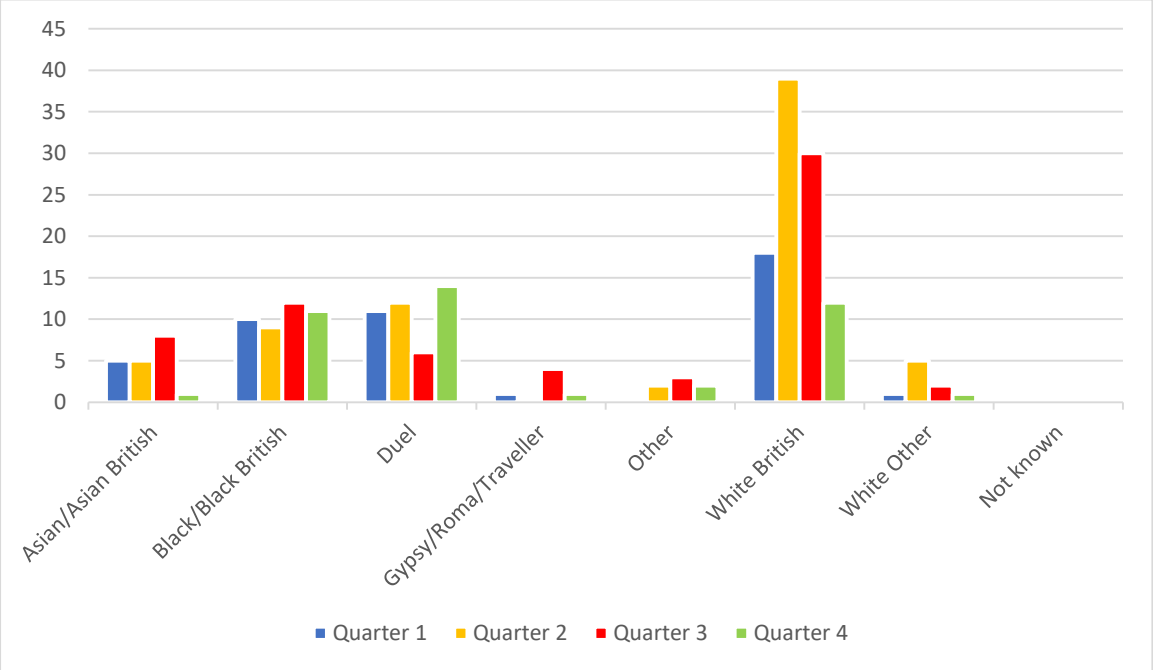
Profile of looked after children in Derby City

3.5 Ethnicity comparisons over the last three years:



Ref: Data made available from Derby City Local Authority Informatics Department

Ethnicity comparisons over the last year per quarter:



Ref: Data made available from Derby City Local Authority Informatics Department

The Children in Care team acknowledge, adapt, and respond to the many changes in demographics of children in care, and understand that different ethnicities are changing. The Children in Care team are dedicated to ensuring that the care offered is culturally adapted to each ethnicity demographic and offer a culturally competent service.

The placement team try to match ethnicity/culture where they can, however this is not always possible due to the balancing of availability and timings. Culture and identity are always discussed at Looked after Children reviews and plans are put in place to ensure the child's needs are being met and fulfilled. The Review Health Assessment pre-checklist has a section to prompt the nurses to confirm the ethnicity and to consider if care offered is culturally adapted and offers a culturally competent service.

Unaccompanied Asylum-Seeking Children (UASC) leaflets (gender specific and general health) are available in different languages for our children in care.

Derby City Local Authority are linked to the East Midlands Migration group and the team manager attends the meetings. Any relevant information is distributed to the Designated Nurse for Looked after Children and shared with the Children in Care Team.

The Local Authority have employed a specific UASC team, in order, to support the continuity and cultural compatibility.

As shown in the above data, there is an increase of children in care from the Black/Black British and Dual Heritage ethnic groups; this reflects the diverse demographics within Derby City and the new emerging communities. The number of White British children coming into care has continued to decrease within the last 3 financial years, and dual nationality children have steadily increased.

In the last financial year April 2022 – March 2023 White British children have been the dominating ethnicity to come into care in Derby. Black/Black British, Asian/Asian/British and the Gypsy/Roma/Traveller communities have also seen a steady increase of children coming into care also.

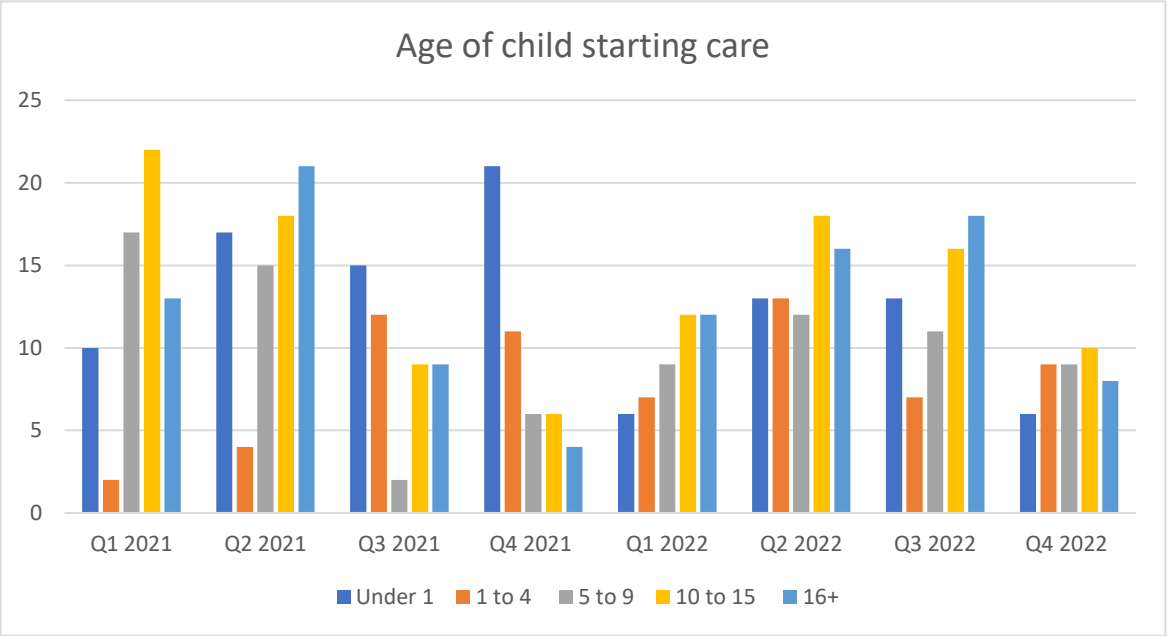
3.6 Gender of looked after children in March 2023

Gender	
Male	55%
Female	45%

Ref: Data made available from Derby City Local Authority Informatics Department

There were 343 males and 274 females in care on 31 March 2023. This equates to a split of 55% male versus 45% female. There were 69 more boys than girls in care on 31 March 2023.

3.7 **Age comparisons over the last two years:**

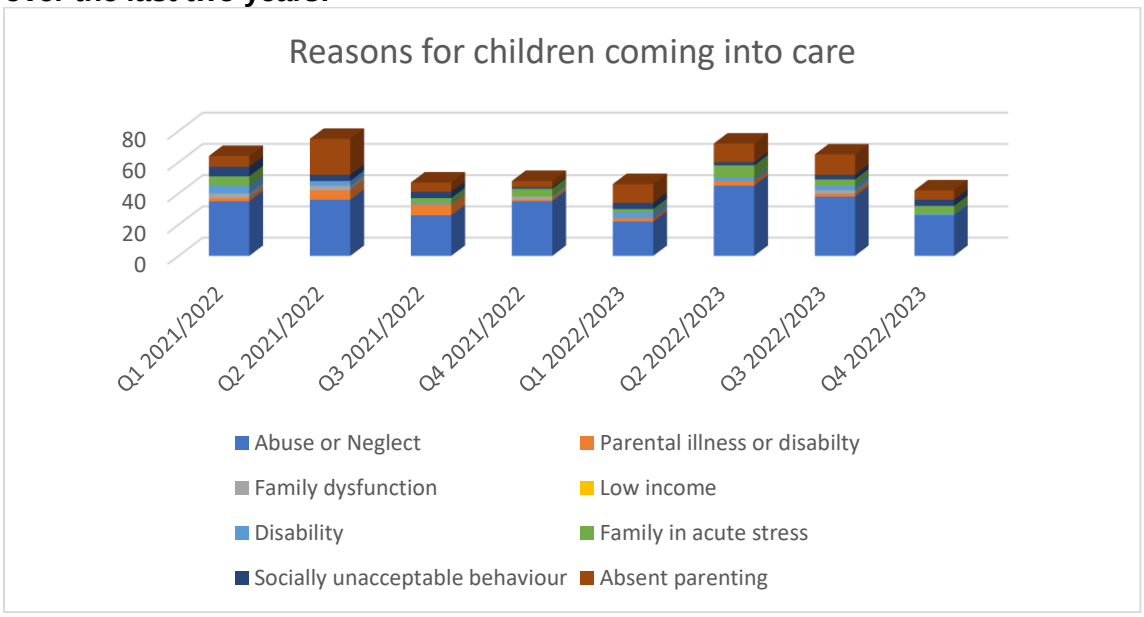


Ref: Data made available from Derby City Local Authority Informatics Department

There has been a slight increase in the number of children aged 1 to 4 years old, rising from 94 children on 31 December 2022 to 96 on 31 March 2023. This age group equates to 15.5% of the overall cohort. The percentage of children aged 5 to 9 has continued to decrease during Q4, dropping from18.7% in the previous quarter to 18.1% on 31 March 2023. There were 112 children in care in this age group on 31 March 2023 compared to 124 seen 12 months ago.

The 10-15 age group have the largest percentage of children with 40.2% in this age bracket (249 children). The number of young people aged 16 or over has reduced from 146 to 134 since Q3. This equates to 21.6% of the overall cohort. Of the 134 young people in care aged 16 or over on 31 March 2023, 35 were UASC.

3.8 **Reasons for children coming into care and ceasing care – comparison per quarter over the last two years:**

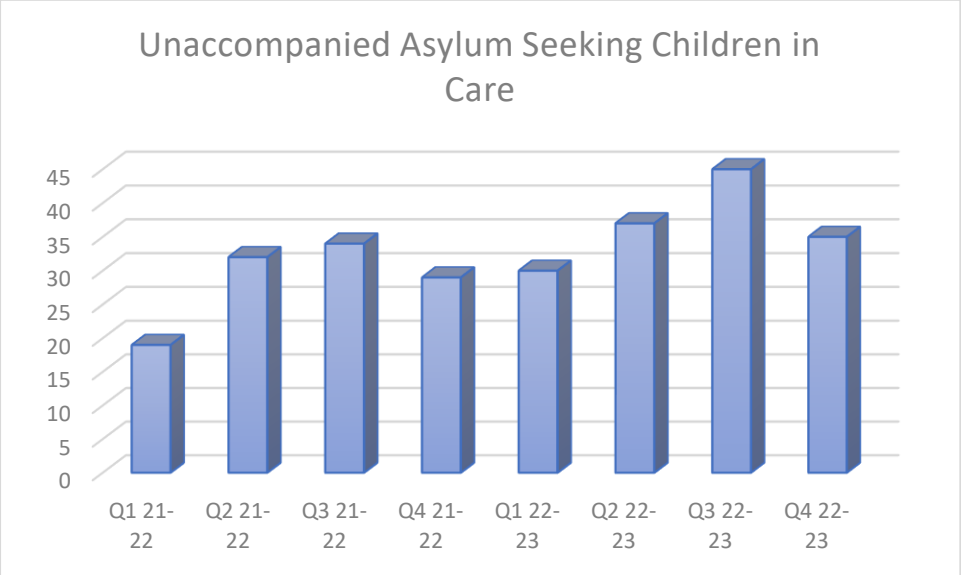


Ref: Data made available from Derby City Local Authority Informatics Department

Abuse and neglect remain the most dominant reason for children/young people coming into care, with the percentages remaining relatively stable in reason categories reflected in the above data. In the first half of the year 2021/2022 and 2022/2023 there was an increase in children coming into care due to absent parenting however these percentages have started to decrease towards the end of 2022/2023. Families in acute stress figures have steadily risen from 2021/2022 to 2022/2023.

3.9 Unaccompanied Asylum Seeker Children 2021/23

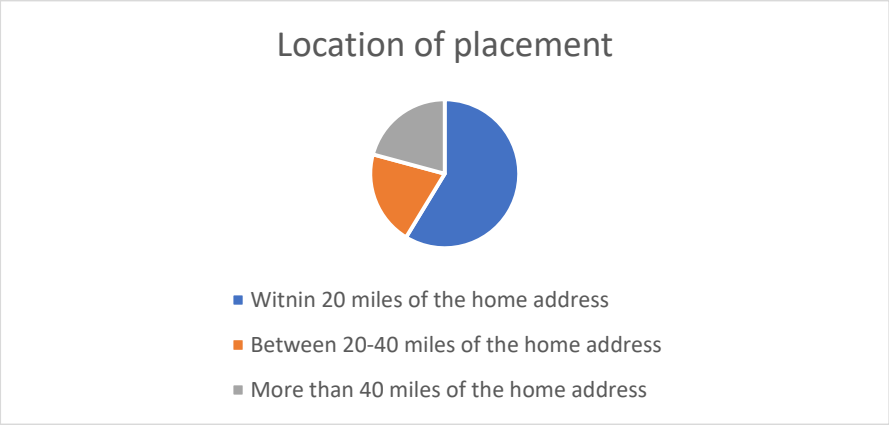
There were 35 UASC in care on 31 March 2023. This equates to 5.6% of the overall cohort. There were 29 UASC in care 12 months ago, 31 March 2022 (4.6% of the overall cohort).



Ref: Data made available from Derby City Local Authority Informatics Department

3.9 Location of Placement

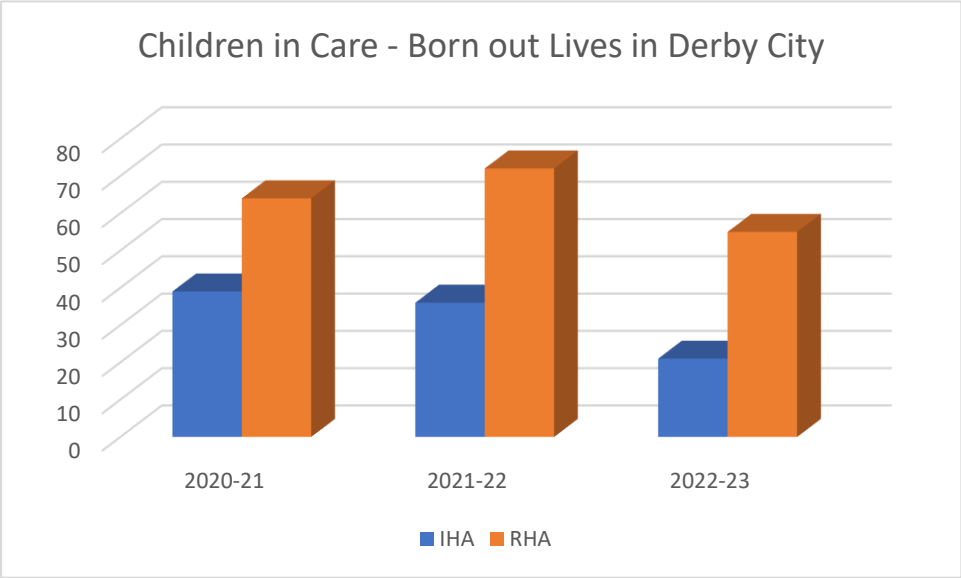
This is now the highest percentage seen for some time. The Children in Care Team undertake Initial and Review Health Assessments for children born in Derby City living within a 20-mile radius of their home address. A total of 237 placements were located within the Derby City boundary on 31 March 2023. This equates to 38.2% of all placements. This is an increase of 0.9% compared to the previous quarter



Ref: Data made available from Derby City Local Authority Informatics Department

- 58.7% of all placements are within 20 miles of the home address (364 out of 620)
- 20.5% of all placements are between 20 and 40 miles of the home address (127 out of 620)
- 20.8% of all placements are more than 40 miles of the home address (129 out of 620)

3.10 **Children in Care – Born out Lives in Derby City**



Ref: Data made available from Derby City Local Authority Informatics Department

BORN OUT, LIVES IN – Looked after Children that were born in another area outside of Derby City (or taken into care by an external Local Authority) but reside in Derby City. Children in Care placed in Derby City from other Local Authorities are supported by the 0-19 Service. Derby City Children in Care Team will undertake Health assessments on behalf of other Local Authorities upon request. In 2022-23 there was a decrease in requests for both Initial Health Assessments and Review Health Assessments to be completed by the Children in Care Team.

Section 4: DHcFT service provision for Looked after Children

4.1 The DHcFT Children in Care health team have core competencies, specialist skills, knowledge, and attitudes to act as advocates, undertake health assessments, identify, and manage health needs and provide support/training to Foster Carers and Children's homes (in line with the Intercollegiate Role Framework, RCN, RCGP, 2020). The team also contribute to health care plans for all looked after children including children with special educational needs and/or disabilities.

4.2 The team continue to improve their offer for Children in Care by including the delivery of health promotion to children and young people, support for care leavers, development of a robust system to collate health histories for care leavers, improved identification of risk of child exploitation (including boys/young men) and provision for children who have special needs and/or disability.

4.3 The staffing levels for the health team at the end of the financial year (March 2022) were as follows:

Designation	Hours	WTE
Designated Doctor	Vacancy	0.1
Designated Nurse (DDCCG, now DDICB)	37.5 hours	1
Named Nurse	30 hours	0.8
Specialist Nurse	30 hours	0.8
Specialist Nurse	26 hours	0.7
Specialist Nurse	22.5 hours	0.6
Specialist Nurse	22.5 hours	0.6
Band 4 Admin Coordinator	30 hours	0.8
Band 3 Administrator	30 hours	0.8
Band 3 Administrator	26 hours	0.7

4.4 BORN IN, LIVES IN – Looked after Children born in Derby City (or taken into care by Derby City Local Authority) and reside within the City.

BORN IN, LIVES OUT (placed near home) – Looked after Children that were born in Derby City (or taken into care by Derby City Local Authority) but reside within approximately 20 miles away from Derby City in another Local Authority area.

BORN IN, LIVES OUT (at a distance) – Looked after Children that were born in Derby City (or taken into care by Derby City Local Authority) but reside in another Local Authority area over 20 miles away from Derby City.

BORN OUT, LIVES IN – Looked after Children that were born in another area outside of Derby City (or taken into care by an external Local Authority) but reside in Derby City. Children in Care placed in Derby City from other Local Authorities are supported by the 0-19 Service. Derby City Children in Care Team will undertake Health assessments on behalf of other Local Authorities upon request.

Section 5: Children in Care and Adoption Administrators

5.1 The Children in Care administrative team consists of an Administrator Coordinator (Band 4) and two Administrators (two at Band 3). During Quarter 2,3 and 4 in 2022-2023 the Children in Care team had an Administrator on long term sickness leaving the team with just two staff members and ad hoc cover.

5.2 The purpose of all three roles is to provide a comprehensive administrative support service to the Children in Care Health Team, ensuring that all administration needs are fully met and that the administrative processes and procedures run smoothly. Responding and making decisions where necessary and following up any actions from health professionals from local and external areas with confidentiality, discretion, and diplomacy due to the sensitive information being shared regarding these vulnerable children.

5.3 The Covid pandemic has been progressively stepped down during the last financial year 2022 – 2023. The team have continued to follow improvements to the way that they work and ensure robust administration systems and processors are in place following the COVID pandemic. The Admin Co-ordinator has worked hard to maintain an oversight of compliance and has highlighted any issues or challenges to both the Operational Lead and Named Nurse/Clinical

Lead. The Admin Co-ordinator has introduced weekly compliance reports to ensure that any concerns are recognised early and will then communicate and discuss any concerns (Consent issues, Initial health assessment compliance, Review health assessments, Local authority responses) with the Operational Lead and Named Nurse as and when is needed. We have improved the Initial Health Assessment consent form to ensure that correct consent is obtained by the social worker in a timely manner to ensure compliance. The Admin Co-ordinator has updated the consent process and the Blood Born Infection testing process to ensure that information is gathered in a timely manner. The Admin Coordinator and Team Administrators continue to dedicate time to ensure 'Groups and Relationships' within the electronic patient record are kept up to date. The Admin Co-Ordinator has worked with the local authority to deliver training and information around the children in care process and consent to ensure all staff involved in delivering service are working to best practices and fully understand the processes and impact on the service.

Section 6: Health Data and Performance for Year 2022/23

6.1 Health data and Local Authority performance is a mandated submission to the Department for Education on a yearly basis and the table below summarises the performance over the last four years:

** Please note all health data for 2022/23 is provisional until submitted to the Department for Education in July 2023 **

Health Data Indicator	2019/20	2020/21	2021/22	2022/23
Annual health assessments	93.5%	93.8%	92.6%	92.9%
Dental checks	92.3%	29.2%	77%	90.6
Immunisations up to date	92.3%	93.1%	94.1%	95.3%
Development checks (two RHAs in the 12 months for under 5 years old)	90.2%	96.6%	86.9%	98.6%

NB: the data is only mandatory for those children/young people in care for a period of 12 months or more

6.2 **Annual Health Assessments** – The performance for Health Assessments has increased during Q4 rising from 87.8% to 92.9%. The local target was 90%. Derby achieved 92.6% in 2021-22 so we're above last year's position. The comparator authority average for 2021-22 was 94% so Derby is slightly under this

Dental Checks - The performance for Dental checks increased significantly during Q4 rising from 47.5% to 90.6% This is above than the 2021-22 comparator authority average of 82% and above our final figure of 77% seen in 2021-22.

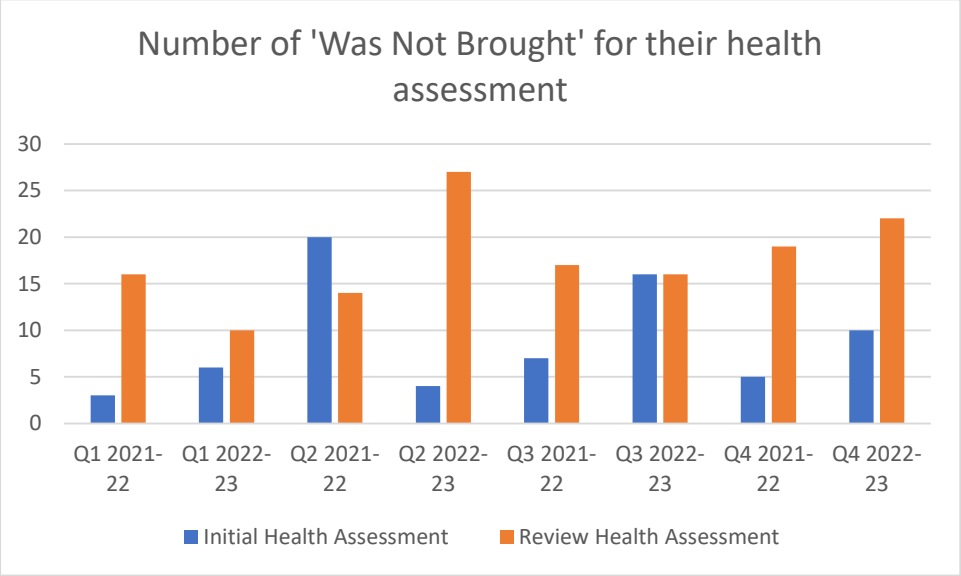
Immunisations - The performance for up-to-date Immunisations has increased during Q4 rising from 91.0% to 95.3%. The local target was 92%. The comparator authority average for 2021-22 was 93% so Derby is above this.

Development Checks - The performance for Health Development Checks improved during Q4 rising from 86.4% to 98.6%. The local target was 87%. This is Derby's highest ever

performance. Just one child under 5 did not receive their second health development check out of a total of 70 children. Derby City Children in Care Team pulled in some additional under 5s for those living out of area – in the best interests for the child/ren as they were progressing through the adoption pathway. This will indeed impact on these children being placed with their forever family sooner because of this work.

6.3 Since the Children in Care team have access and the mechanism to update Liquid Logic (Local Authority IT system), the accuracy of heath data has significantly improved. The Named Nurse for Children in care and the Designated Nurse for Looked after Children meet on a quarterly basis to ensure all the correct information is recorded and any outstanding information is passed onto the Children in Care Nurses and admin to chase.

6.4 Shown in the table below are the number of children in care who were not brought to their health assessments during 2021-22 and 2022-23.



Ref: Data made available from Derby City Local Authority Informatics Department

Some of the reasons for 'was not brought' to appointment are shown below:

- Young person refused to attend
- Foster carer not aware of the appointment – it is the responsibility of the social worker to inform the foster carer of the Initial Health Assessment appointment date and time
- Foster carer forgot to cancel
- Child placed with parent
- Foster carer did not receive the appointment letter
- Foster carer mislaid the appointment letter

Any 'was not brought' or cancellation of the health assessment appointment, for whatever reason, can have a huge impact on our compliance. The Children in Care Team have a 'was not brought' pathway to follow if a child is not brought to their appointment.

Section 7: Analysis of Adoption and Medical Adviser Activity

This section is compiled by Derby City medical advisers
Dr A Marudkar and Dr P Vundela ,
Children in Care and Adoption Team, Derby City

This section of the report has been prepared based upon the information available from DHCFT data and data provided by the Local Authority regarding adoption related work.

ADOPTION ACTIVITY

There have been some changes to the adoption activity during the Pandemic period from April 2020, some being more permanent and have continued this year. These continue to reflect the changes made nationally to the Adoption regulations by the Department of Health in liaison with Coram BAAF, satisfying the requirements of Adoption regulations.

Last year, there were major changes nationally in the way medical reports are provided for the ADM (Agency decision Maker) following a court ruling (called Somerset ruling). This had affected the medical adviser's workload in an unprecedented way since January 2022 requiring a large number of additional medical reports to be done within strict deadlines, which was achieved with making adjustments in the workforce resources. This workload has now settled with making planned changes in the report format.

7.1 There are two medical advisers contributing to the Adoption work for Derby city. This includes preparing the reports for the children coming up for adoption at the ADM and matching stage. The Adult Health Reports are prepared separately by a GP specialist. One adoption panel per month is attended by either medical adviser in role of panel member, on an alternate monthly basis.

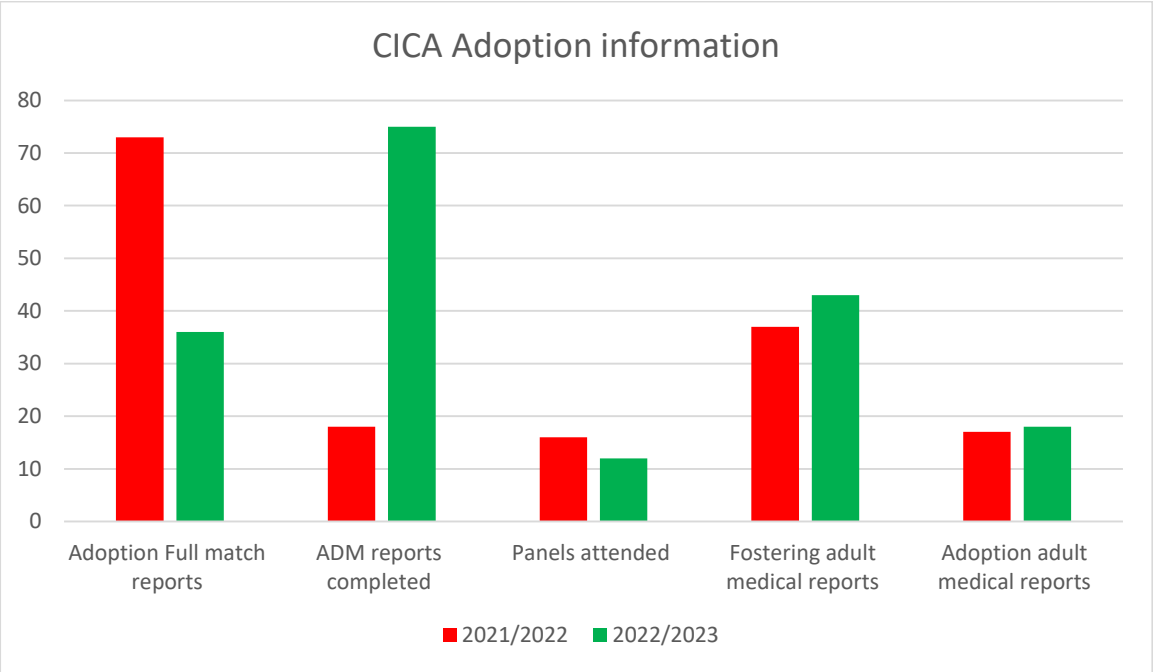
Medical adviser's attendance at Adoption panels is currently optional, with Derby medical advisers not attending at present due to their workload, but this is to be encouraged. The medical reports for the children to be matched are still provided in the usual manner and panel advice is still given, based upon the paperwork provided by Adoption East Midlands The panel are still happening remotely and medical adviser is available for advice if needed, but currently not actually attending.

7.2 The Regionalised Adoption service (Adoption East Midlands) continues to work incorporating four neighbouring regions of Derby City, Derbyshire, Nottingham City and Nottinghamshire. The cases for matching the Derby City children continue to be heard at any of the panels within the region, attended by different medical advisers. An efficient and timely liaison between different medical advisers is needed to explore and clarify any issues in advance of panel, which may get affected by the capacity issues, requiring Medical Advisers to be available all the time as queries may arise from any panel.

7.3 The following adoption activity data is provided by Adoption East Midlands (From 1st April 2022 to 31st March 2023)

- Total number of adoption children's medical reports (Matching reports) – 36 (73 in 2021-22)

- Total number of ADM Reports – 75 (18 in 2021-22, this was new additional work following Somerset ruling since January 2022)
- Total number of adult medical reports – 61, which includes reports for fostering and adoptive parents, (54 in 2021-22)
- Total number of panels attended (advice provided by Derby City medical advisers) – 12 (16 in 2021-22)
- Number of Prospective adopter consultations undertaken - 5 (2 in 2021-22, none in 2020-21)



This reflects some unusually low number of children coming to panel for matching last year although this may be due to the clearing of COVID backlog of matching children in previous two years. A significant number of reports were made at the ADM stage, rolling them on and updating them at the matching stage.

The number of adult health reports has further reduced slightly, these figures have remained stable over the last 2 years, indicating ongoing recruitment of adopters during the Pandemic.

There were 5 prospective adopter consultations undertaken formally (by telephone, none face to face) during this period, as the previously agreed regional process continued for prospective adopter consultations providing the preadoption advice in a targeted and formal way in writing. We continue to invite questions in writing from adopters via the social worker, which are responded to in writing, included on the report if possible, or separately if received later, also the report format is very comprehensive and includes any history and implications in detail. A telephonic consultation is only provided in selected cases, if requested, to answer any specific queries which remain or if the child has a very significant or complex medical condition

7.4 The training sessions by medical advisers for prospective adopters, foster carers and social workers were re commenced last year, with the training provided virtually 3 times during this period as agreed, incorporating training on common clinical issues in an adoption scenario, i.e., impact of maternal smoking, alcohol and drug misuse in pregnancy and Blood Borne

Infection screening in vulnerable and high-risk children. It is hoped that this activity will continue.

7.5 Both the Medical Advisers attend regular quarterly AEM meetings with other Medical Advisers and panel advisors (plus commissioners if appropriate). They also attend panel training days twice a year.

7.6 The Named Doctor for Children in Care and the Named Nurse for Children in Care also deliver a training lecture on Children in Care and Adoption as part of the GP vocational training course in Derby.

Section 8: Sleep Practitioner Training

8.1 During 2022-23 the Children in Care Team were successful in securing funding for a Specialist Nurse for Children in Care to attend Sleep Practitioner training delivered by The Sleep Charity. The training provided evidence-based intervention for children aged 12 months upwards. The Specialist Nurse for Children in Care learnt about the significance sleep has on a body and brain and networked with other course attendees from a variety of backgrounds. This opportunity was in response to a request made by one of the Specialist Nurses for Children in Care to commit to supporting staff to continue the personal/professional development by the Trust. Children in Care often have issues with sleep whether this be related to trauma, undiagnosed medical conditions or from simply a disruption to routine when moved to a placement. The training helped the Specialist Nurse for Children in Care understand how professionals can better support our carers and young people to establish better sleep hygiene practices or just remind them of how to get back to what works best and then move forward.

The Specialist Nurse for Children in Care was able to share their learning with colleagues and with carers and a sleep pathway was established to ensure the correct referrals were made in a timely fashion. The Specialist Nurse for Children in Care has been able to continue to develop their learning through additional training by The Sleep Charity and will continue to share their learning with others.

Section 9: Derby and Derbyshire Development Day

9.1 The Named Nurses for Children in Care for Derby City and Derbyshire and the Designated Nurses for Children in Care for Derby and Derbyshire Integrated Care Board held a development day for Derby City and Derbyshire Children in Care Teams.

9.2 A Specialist Nurse for Children in Care from the Derby City Team delivered a session on Intellectual disabilities. The aims of the session were for the participants to understand the definitions of ‘What is a Learning disability’ and the definition of a Learning Difficulty. As part of the group activities set, role play was used on a case study to show and to demonstrate the difficulties a young person with an Intellectual Disability may face when attending a clinic appointment for a Review Health Assessment.

In groups, the participants were asked to identify what difficulties a young person with an Intellectual Disability may display before the clinic appointment and during the clinic appointment.

Following on from this, the participants in their groups discussed, what they, as practitioners could introduce into their clinical practice to help to put in to place the reasonable adjustments for the young person attending the clinic. A list of reasonable adjustments was created in which practitioners could introduce into their teams.

The communication needs of a young person with an Intellectual Disability was discussed as a group highlighting amongst others the delay in processing verbal language a young person may face.

A discussion was held with the groups around the challenges of communication with a young person if they have communication difficulties or may be non- verbal.

It was acknowledged the Children in Care Teams introduce themselves to young people when they attend clinic, however the Specialist Nurse for Children in Care wanted to take this further to address how the nurse would introduce themselves to a young person who has limited language but uses Makaton as a form of communication.

As a group we learnt how to use the finger spelling alphabet. The Children in Care Teams learnt how to sign in Makaton: 'What my name is'. To ask the young person, 'What is your name'? They learnt how to ask in Makaton, 'How are you'?

We made a pledge as a group to introduce these basic Makaton signs at future clinic appointments to increase our skills in communication with young people who have communication difficulties.

Section 10: Links to the Residential Children's Homes

A Specialist Nurse for the children in Care Team started in post in 2022, the nurse was keen to support colleagues with the drop-in sessions for the Local Authority Residential Children's Homes. The Children in Care Team decided to discuss with one of the home managers to look at re-starting the existing drop-in and offer sessions to the other Residential Children's homes as well. Being the new link nurse for one home and the associate link for another home the Specialist Nurse was pleased to have this opportunity to utilise their skills.

Over the last year, from discussion with the home managers about which topics they would like to be covered, sessions have been offered on; sleep, healthy eating, dental health, relationships, sexual health and contraception, puberty, alcohol awareness, and emotional health/refuelling. It was arranged for a worker from the Breakout service to join the link nurse for the session on alcohol awareness for their expertise and additional resources. This session was well received by one young person who had not joined one of the sessions previously. They were able to engage and openly discuss some of their personal experiences which was extremely positive. There are plans to continue the joint session on alcohol awareness at another Residential Children's Home.

Our young people are of various ages between 11 and 17 so the link Nurses must ensure that the sessions are tailored to fit with the needs of the children and young people. The Specialist Nurses have used various styles at the drop-in sessions; sometimes they have used a display board to talk about, used worksheets/quizzes, had group discussion using some prompts with visual information on cards and used flipchart paper for the young people to present their ideas from discussion. Some of the young people choose not to engage, some engage with parts of the sessions, some fully engage, and some prefer to 'listen round the corner' rather than joining in directly, which the nurses still feel is of great benefit as they have stated they do not wish to join in the group activity but can still 'listen in' and gain knowledge and information.

In some sessions the young people have 'gone off topic' as they were not keen on talking about the subject for that day, so the nurses have tried to steer conversations towards a health

topic that was related to what the young person wanted to talk about to continue to aim for health promotion.

Two of the homes are more engaging and receptive to the drop-in sessions and relationships are strong between the staff and the CIC link nurses. Home staff are encouraged to take part in the session if they are able, which can help to encourage the young people to engage. Where possible the link nurses also try to offer resources/handouts and leaflets (if appropriate) to leave with the staff about the topic that has been covered. This can be helpful to staff for their own awareness but also to support them in discussing further with the young people after the sessions or for those young people who might have been away from the home at the time or had declined to engage. As the link nurses have been visiting the homes more frequently, relationships with the young people are growing and it is lovely to see young people participating. The link nurses also welcome feedback from the young people about what topics being delivered.

The timing of the drop-in sessions has been adjusted to enable young people to return from school and the link nurses are also flexible with the times for the dates that fall during the school holidays. It has been appropriate intermittently to offer one of the care homes a more 'generic' drop-in so young people can access the Children in Care nurse in a more 'informal' way to enable them to raise any health issues they have with the nurse rather than it being a planned topic session. This has been positive in building up relationships with young people and for them to get to know the link nurses.

As well as information for the drop-in sessions, care home staff have also requested at times information/resources specifically for individual young people, for example: on hygiene and sexuality and 1:1 work has been offered to those individual young people at a later date.

Section 11 Summary of achievements in year 2022/23

11.1 During the period of 2022/23 the Children in Care health team have continued to experience some changes and it has been acknowledged despite this the Specialist Nurses, Medical Advisors and Administration Team have shown innovation and marked improvements within their service delivery.

The following are an indication of the progress made and not an exhaustive list of achievements:

11.2 Improved compliance with initial health assessment statutory timescales and improved service delivery across administration and clinical areas.

11.3 Completion of the CCG now ICB 'Markers of Good Practice' assurance framework. (Detailed in section 13, page 25/26).

11.4 The end of year Health Performance Data was positive as shown in section 6 considering vacancies within the team and two new starters.

11.5 The Designated Nurse for Children in Care was successful in securing some funding to develop animation videos to explain what a health assessment is. There are two animation videos available on You-Tube for younger and older children. The links for the animation videos have been shared and have been added to our appointment letters.

11.6 The Designated Nurse, Designated Doctor, Named Nurse, and the Administrator Coordinator have continued to strengthen existing relationships and networks with key professionals, local partners, and agencies locally and regionally, which has facilitated information sharing, health outcomes and the voice of the child (including those out of area).

11.7 Health access to Liquid Logic Child Social Care system continues to improve information sharing between agencies (in the best interest of looked after children) and has a positive impact on the accuracy and validity of health data reportable to Department for Education. At the end of each quarter health information is uploaded onto Liquid Logic and any missing information is followed up by the Children in Care Team.

11.8 Reporting and assurance into the DDICB Quality and Performance Committee have been strengthened via quarterly reporting of performance and quality of the Children in Care service. This has allowed the Named Nurse for Children in Care the opportunity to access and interrogate health data more robustly internally within the Trust, using relevant and useful reporting systems. This in-depth provision of evidence has enabled a more robust way of working at both team and service level and influenced improvements.

11.9 The Specialist Nurses for Children in Care are link nurses to the Local Authority Residential Children's Homes. There are two Specialist Nurses who link with each Local Authority Residential Children's Home. Over 2022-23 the link nurses have offered health drop-in sessions to each home on a variety of health topics chosen by each home depending on the health needs of the children and young people residing there. These have either been delivered by the Specialist Nurses for Children in Care or jointly with another health service, such as the drugs and alcohol service or the sexual health service. Topics have also included sleep and healthy/unhealthy relationships.

11.10 Foster carer sessions have been delivered face to face over 2022-23. Some of the topics covered have included, puberty, emotional resilience, development, preschool development, eating disorders, dental care, and sleep. The foster carers choose the topics for the year, and these have been delivered by the Designated Nurse CiC, Named Nurse CiC, Specialist Nurses for CiC and the doctors within the CiC team.

11.11 The Named Nurse from Derby City and Derbyshire held a successful development day for both Children in care teams which was funded by Derby and Derbyshire Integrated Care Board. There were a variety of presentations on the day covering, equality, diversion and inclusion, vitamin D, a session from the Tuberculosis Nurse, Oral Hygiene, and Learning Disability with a networking session at the end.

11.12 The children in Care Team have provided opportunities for students to shadow the team throughout 2022-23.

11.13 The Children in Care Team have been nominated for Trust DEED awards both individually and as a team.

11.14 Access and training has been provided for all doctors on the Integrated Clinical Environment pathology system. This has improved internal systems and timeliness of Blood Born Infection screening and results.

11.15 Health meetings have continued between the children in care Nurses and the Residential Children's Homes Managers.

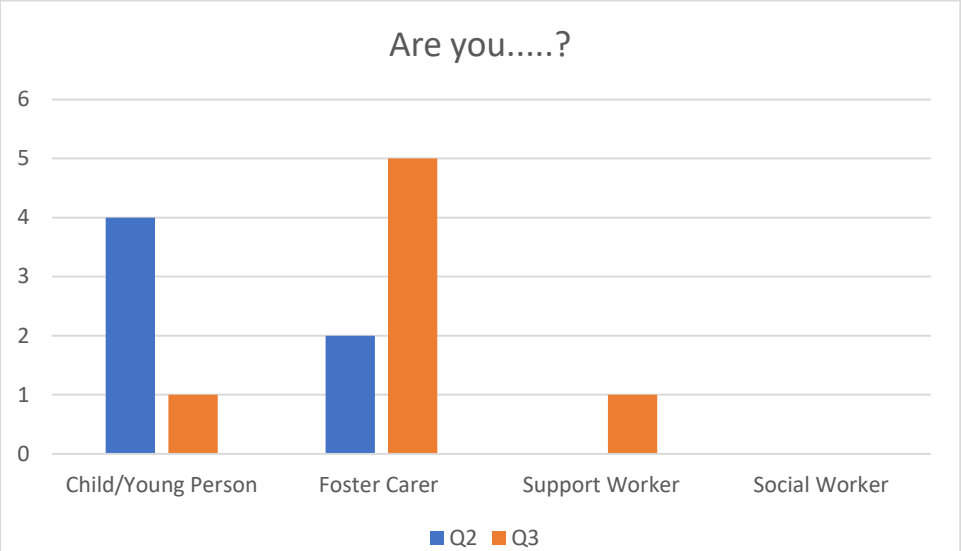
11.16 Enhanced Case Management meetings have continued. These are a multidisciplinary meeting focusing on certain topics appropriate to the young person using an outcomes-based tool.

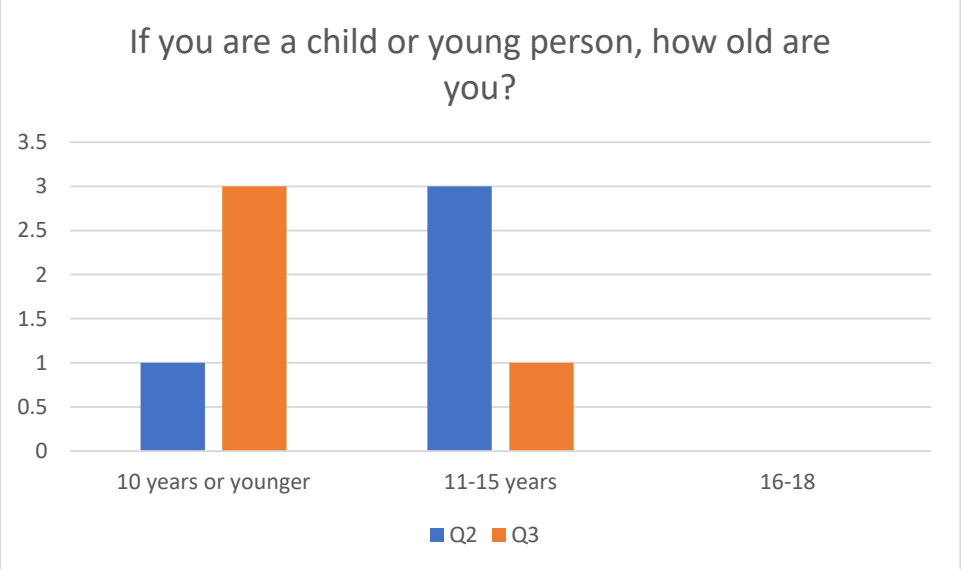
11.17 One of our Specialist Nurses for Children in Care had the opportunity to attend a funded Sleep Practitioner Course (see section 8). This was delivered through the Sleep Charity and the Children in Care Nurse expressed a particular interest in this area. The Children in Care Nurse will be able to train and cascade knowledge and resources down to the rest of the team.

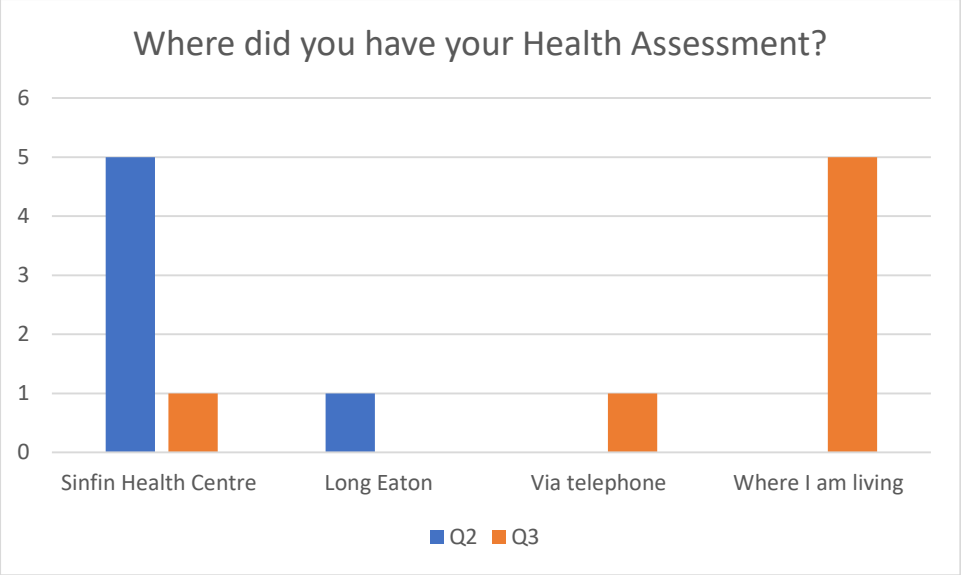
Section 12: The Survey Monkey Feedback

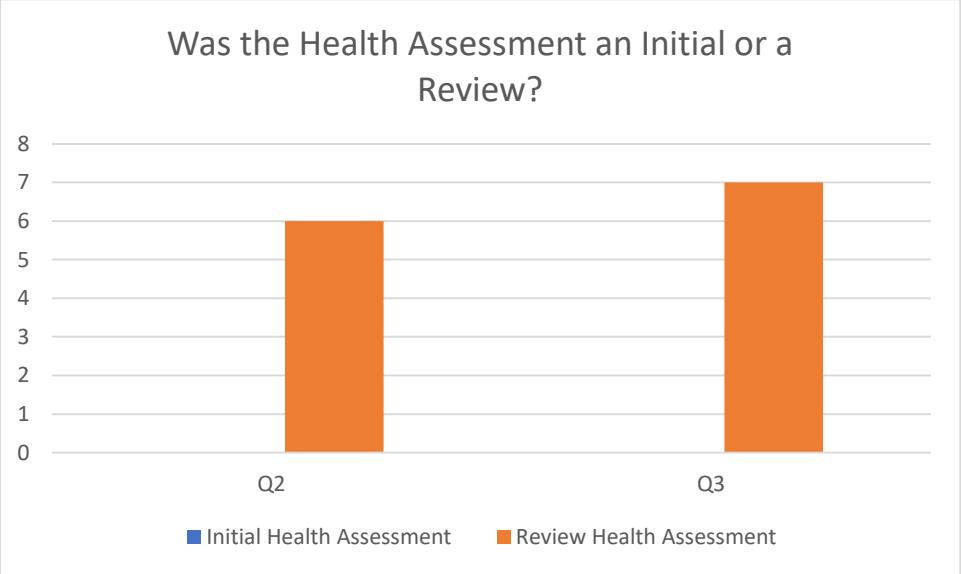
12.1 The Designated Nurse Children in Care supported the Named Nurse Children in Care to develop a survey monkey questionnaire to capture feedback from children, young people, and carers on their experience of having an Initial Health Assessment and Review Health Assessment

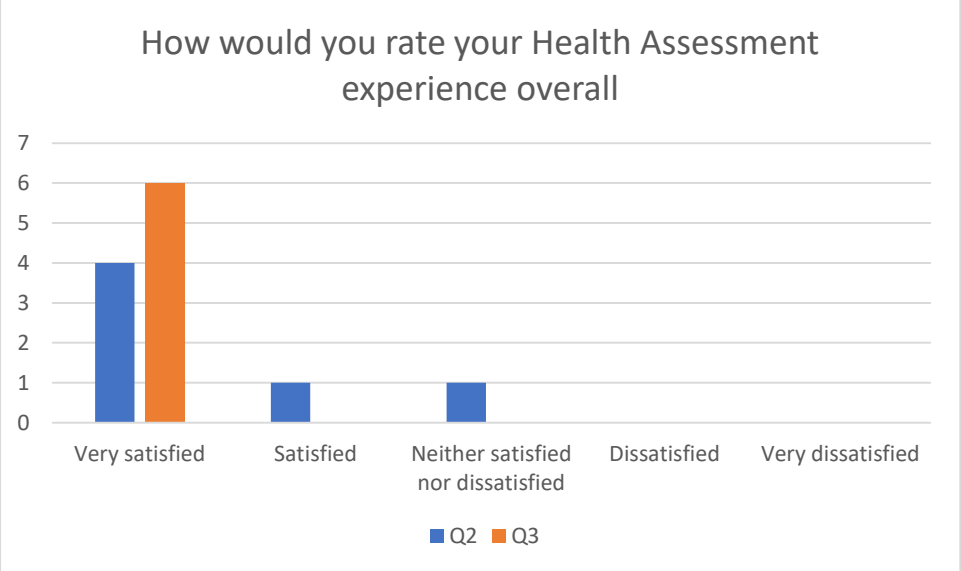
12.2 The results from the survey monkey questionnaires for quarter two and three are as follows:

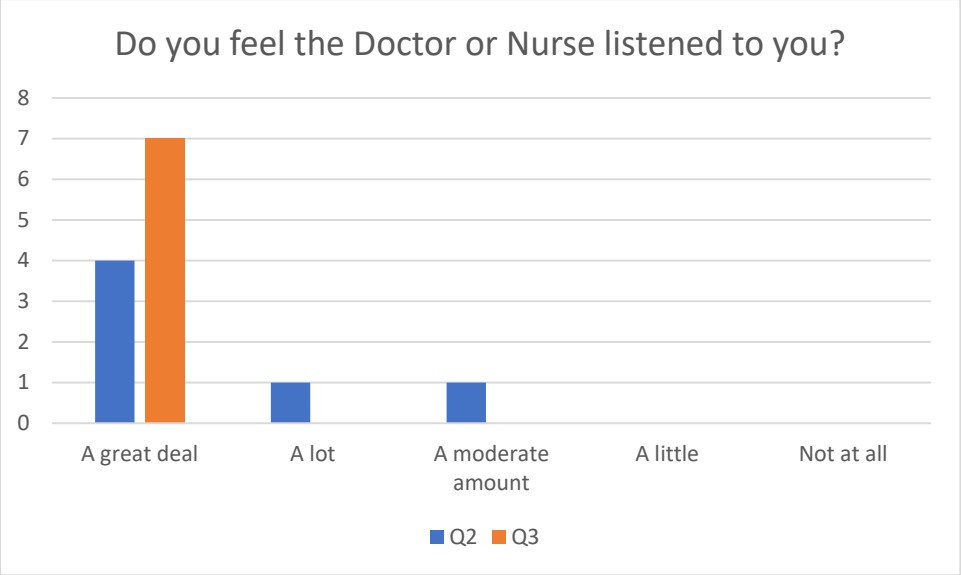


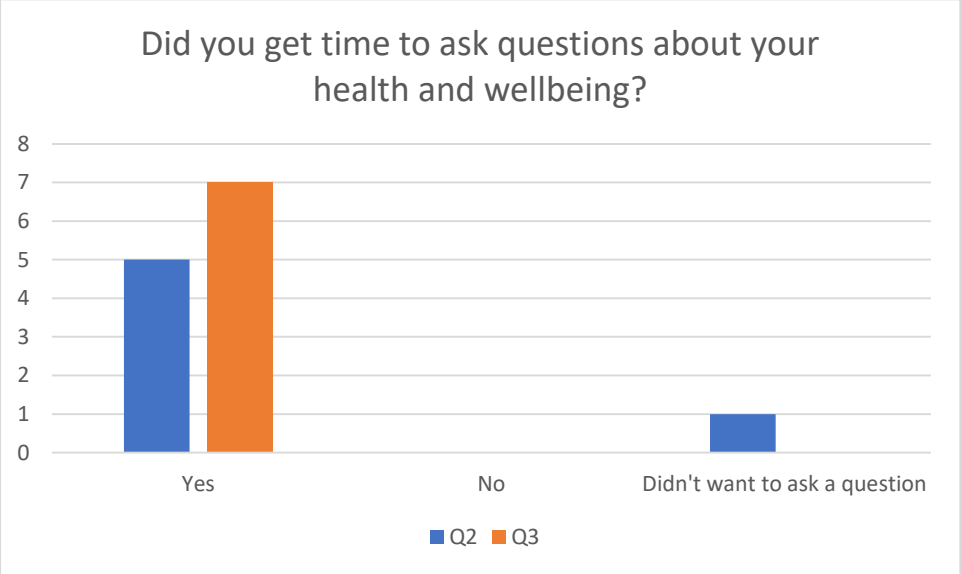


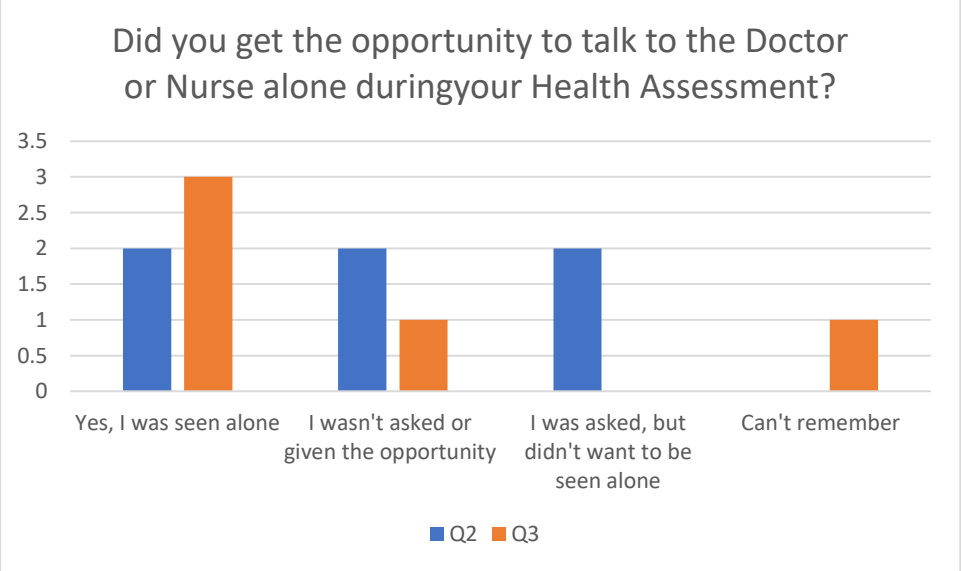

Where did you have your Health Assessment?
6
5
4
3
2
1
0
Sinfin Health Centre
Long Eaton
Via telephone
Where I am living
Q2
Q3

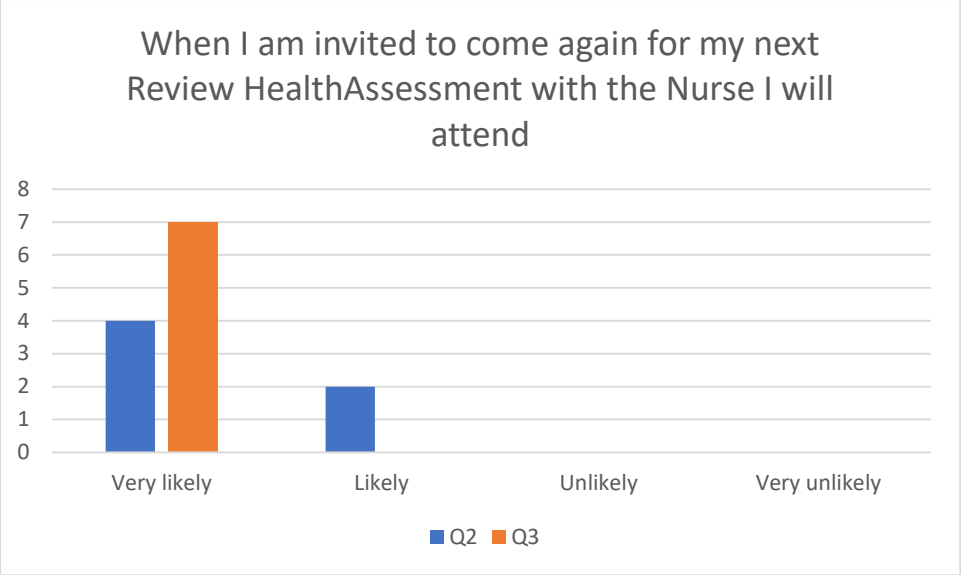

Was the Health Assessment an Initial or a Review?
8
7
6
5
4
3
2
1
0
Q2
Q3
Initial Health Assessment
Review Health Assessment


How would you rate your Health Assessment experience overall
7
6
5
4
3
2
1
0
Very satisfied
Satisfied
Neither satisfied nor dissatisfied
Dissatisfied
Very dissatisfied
Q2
Q3


Do you feel the Doctor or Nurse listened to you?
8
7
6
5
4
3
2
1
0
A great deal
A lot
A moderate amount
A little
Not at all
Q2
Q3


Did you get time to ask questions about your health and wellbeing?
8
7
6
5
4
3
2
1
0
Yes
No
Didn't want to ask a question
Q2
Q3


Did you get the opportunity to talk to the Doctor or Nurse alone duringyour Health Assessment?
3.5
3
2.5
2
1.5
1
0.5
0
Yes, I was seen alone
I wasn't asked or given the opportunity
I was asked, but didn't want to be seen alone
Can't remember
Q2
Q3



12.3 Some of the comments provided are shown below:

- Totally 'top-notch'
- Was great with the child. Lovely nature
- Excellent
- Very friendly, put the child at ease
- 'I am very satisfied because the nurse was extremely kind and understanding'

Section 13: Markers of Good Practice (MOGP)

13.1 In February 2023 the Children in Care team submitted the Markers of Good Practice assurance tool to the Integrated Care Board for Derby City and Derbyshire (DDICB). The Markers of Good Practice assurance tool, which is 'RAG' rated, provides the Children in Care Team with a productive opportunity to showcase their service to the Integrated Care Board and Designated Professionals.

13.2 With the submission of evidence and 'RAG' rating, the assurance tool supports the Children in Care team to highlight progress, any gaps or improvements that are required to assure the Integrated Care Board our service is working towards a 'gold standard' delivery and that the needs of the Children in Care are being met and identified in line with the statutory guidance.

13.3 Following the MOGP action plan submission, representatives from the Integrated Care Board and Designated Professionals completed the feedback in written format with a decision as to whether a meeting face to face with the provider is required. A discussion was held between the commissioners from DDICB. Each standard was discussed, and it was confirmed whether the 'RAG' rating provided by the Provider was in line with that of the commissioners' assessment.

13.4 Strengths and challenges were identified, agreed by both parties and an action plan will be developed by the provider to work through within the year 2023-2024 to achieve compliance in the areas that were not yet rated as green. The Markers of Good Practice action plan will be fed back to the Safeguarding Children's Committee by the Director of Nursing and Patient Experience, and at the Safeguarding Operational Leads meeting and the Childrens Clinical Refence Group held by the organisation by the Named Nurse Children in Care.

13.5 Derby and Derbyshire Integrated Care Board (DDICB) fed back that the evidence clearly demonstrates the organisation and team's commitment to meeting the needs of Children in Care at every stage of their journey in the care of the Local Authority and beyond. DDICB have been significantly assured about the quality of the service provision and appreciate the providers honesty whereby further progress is required.

Section 14: Priorities for Year 2023/24

14.1 **DHcFT Provider key priorities for 2023/24:**

- To continue to deliver health promotion within the Local Authority Residential Children's Homes
- To continue to represent health at the Enhanced Case management Meetings and Health Meetings with the Local Authority Children's Residential Homes
- To continue to deliver health sessions to foster carers sessions
- To continue to provide health passports and health history summaries
- To ensure the Service Action Plan is updated
- To continue to work closely with the County Children in Care Team working towards the Joined-up Care Derbyshire Approach
- To build relationships with the leaving care team to improve support around transition
- To ensure children and young people are aware of the animation videos to explain what a health assessment is
- To submit the Markers of Good Practice Assurance Tool
- To fill the Designated Doctor vacancy
- Continue to provide opportunities for students

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

Infection Prevention Control (IPC) BAF update (new version issued 19 September 2023)

Purpose of Report
To outline DHCFT's compliance with the Infection Prevention Control Board Assurance framework as part of our regulatory compliance in accordance with the Health and Social Care Act.

Executive Summary
The Trust can demonstrate compliance and full assurance within most areas within the BAF: • The new version attached with compliance dashboards was released in September 2023. • The Trust is an integral part of ICB monitoring framework (IPCSAG) • The Trust is compliant with schedule 4 monitoring requirements • The Trust partakes in Antimicrobial Resistance (AMR) committee work and monitors performance against locally agreed measures • Mitigation and remedial action is in place for areas of partial assurance • The Trust has low incidence rates • The Trust has maintained high performance against national cleaning standards and PLACE assessment standards.

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

- Full assurance against majority of areas.
- New and emerging virus policy is in final stages of sign off (mitigation SOP in place until complete).

Consultation

- Estates and Facilities working group
- Physical Healthcare and Infection Prevention Control (PHCIC) membership
- Health Protection Unit
- Quality and Safeguarding Committee

Governance or Legal Issues

Complaint with regulatory practice standards.

Public Sector Equality Duty and Equality Impact Risk Analysis

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

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

- EDIA data to ensure equity of response is routinely monitored as IPC risks are higher within certain communities and recognising health inequality is a significant factor in reducing risk to service user groups with increased health vulnerabilities.

Recommendations

The Board of Directors is requested to:

1) Receive assurance from the Quality and Safeguarding Committee that the Trust is compliant with National IPC standards.
2) Consider that the Quality and Safeguarding Committee recommends that the Board accept the up to date BAF as evidence of compliance with National IPC framework standards and expectations.

Report presented by: **Arun Chidambaram**
Medical Director

Report prepared by: **Richard Morrow**
Deputy Director of Infection Prevention and Control, Public and Physical Healthcare

Infection Prevention and Control board assurance framework v0.1						
	Key Lines of Enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	**Comments**	**Compliance rating**
1. Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks their environment and other users may pose to them						
Organisational or board systems and process should be in place to ensure that:						
1.1	There is a governance structure, which as a minimum should include an IPC committee or equivalent, including a Director of Infection Prevention and Control (DIPC) and an IPC lead, ensuring roles and responsibilities are clearly defined with clear lines of accountability to the IPC team.	The Trust has a bi-monthly Physical Health care and Infection Control Committee meeting cahired by trust Medical Director and co-chaired by AD Public and Physical Health Care (Deputy DIPC). This committee reports to the Qualty and Safe Gaurding Committee chaired by the DIPC.	None.	The System IPC SAG and regional NHSE IPC meetigs are attended by Deputy DIPC and updates, findings and regional assurance requitemnts are feedback via PHCIC.	N/A	3. Compliant
1.2	There is monitoring and reporting of infections with appropriate governance structures to mitigate the risk of infection transmission.	Infections are reported through DATIX system.	None.	The System IPC SAG and regional NHSE IPC meetigs are attended by Deputy DIPC and updates, findings and regional		3. Compliant
1.3	That there is a culture that promotes incident reporting, including near misses, while focusing on improving systemic failures and encouraging safe working practices, that is, that any workplace risk(s) are mitigated maximally for everyone.	Inciednts are reported through the DATIX ssytem and IPC incidents are flagged to IPC link Nurse for support. Clinical records and lisiaon with Nursing and medical team is provided on review.	None.	Incidents reported vis Pathology lab or other sources are checked by IPC team to ensure they are logged onto DATIX.	N/A	3. Compliant
1.4	They implement, monitor, and report adherence to the NIPCM.	Clinical records and lisiaon with Nursing and medical team is provided on review. Incidents are shaed and overseen by colleagues in IPCSAG / UKHSA / NHSE as required by reporting standards.	None	IPCSAG provide feedback around Trust complianace and reporting standards.	N/A	3. Compliant
1.5	They undertake surveillance (mandatory infectious agents as a minimum) to ensure identification, monitoring, and reporting of incidents/outbreaks with an associated action plan agreed at or with oversight at board level.	Surveillance is routinely moniored and AMR prescribng and infection rates are monitoed at trsust and system level.	None	IPCSAG provide feedback around Trust complianace and reporting standards. AMR monitoring group and Schedule 4 reports also ensure comlaince and oversight is maintained.	N/A	3. Compliant
1.6	Systems and resources are available to implement and monitor compliance with infection prevention and control as outlined in the responsibilities section of the NIPCM.	Audit framework in place with over view by PHCIC. / IPCSAG.	None	IPCSAG provide feedback around Trust complianace and reporting standards. AMR monitoring group and Schedule 4 reports also ensure comlaince and oversight is maintained.	N/A	3. Compliant
1.7	All staff receive the required training commensurate with their duties to minimise the risks of infection transmission.	All staff udertake level 1 training and clincial staff undertake level 2 training. New frameowrk being impemented for 2023/24.	None	New fraework introduv=cing level 3 IPC for leads is being developed ahead of impementation in 2024.	N/A	3. Compliant
1.8	There is support in clinical areas to undertake a local dynamic risk assessment based on the hierarchy of controls to prevent/reduce or control infection transmission and provide mitigations. (primary care, community care and outpatient settings, acute inpatient areas, and primary and community care dental settings)	HPU and AD Public and Physical Hath care are avilable to support teams to undertake locl ris assessemnts. Infection control link nurses also provode local support.	None	Infection lik worker forum is being developed further.	N/A	3. Compliant
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections						
System and process are in place to ensure that:						

	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
2.1	There is evidence of compliance with National cleanliness standards including monitoring and mitigations (**excludes some settings e.g. ambulance, primary care/dental unless part of the NHS standard contract** these setting will have locally agreed processes in place).	National Cleaning Standards are dispayed as per guidnace for all ward areas.	None	N/A	N/A	3. Compliant
2.2	There is an annual programme of Patient-Led Assessments of the Care Environment (PLACE) visits and completion of action plans monitored by the board.	Progarmme was undertaken in 2022/23 and schedued for delivery 2023/24.	None	N/A	Site visits were undertaken in 2022 - good standard met.	0. Not applicable
2.3	There are clear guidelines to identify roles and responsibilities for maintaining a clean environment (including patient care equipment) in line with the national cleanliness standards.	Equipment cleaning policy identifies roles and rep[sonbilites for cleanliness and audits assure agianst comlaince with standards.	Recent audits have highlighted gaps in frequency of checks.	Enhanced ovesight of checks adherence	N/A	2. Partially compliant
2.4	There is monitoring and reporting of water and ventilation safety, this must include a water and ventilation safety group and plan. **2.4.1** Ventilation systems are appropriate and evidence of regular ventilation assessments in compliance with the regulations set out in HTM:03-01. **2.4.2** Water safety plans are in place for addressing all actions highlighted from water safety risk assessments in compliance with the regulations set out in HTM:04-01.	Monitored by eastates and facilities team, assurance checks are reported to Heath and safty group or esclated to Deputy Director for IPC.	None	N/A	N/A	3. Compliant
2.5	There is evidence of a programme of planned preventative maintenance for buildings and care environments and IPC involvement in the development new builds or refurbishments to ensure the estate is fit for purpose in compliance with the recommendations set out in HBN:00-09	IPC lead is included in new buld deveopemnt programme and assurance checks for key stages of building developemnt requested / reviewed as required.	None	N/A	N/A	3. Compliant
2.6	The storage, supply and provision of linen and laundry are appropriate for the level and type of care delivered and compliant with the recommendations set out in HTM:01-04 and the NIPCM.	Laundry contract is managed by external provider and reviewed by Housekeeping services with input from IPC lead.	None	N/A	N/A	3. Compliant
2.7	The classification, segregation, storage etc of healthcare waste is consistent with HTM:07:01 which contains the regulatory waste management guidance for all health and care settings (NHS and non-NHS) in England and Wales including waste classification, segregation, storage, packaging, transport, treatment, and disposal.	Safe dispaosal of helathccare waste is managed in accordance with current regulations.	None	N/A	N/A	3. Compliant
2.8	There is evidence of compliance and monitoring of decontamination processes for reusable devices/surgical instruments as set out in HTM:01-01, HTM:01-05, and HTM:01-06.	N/A to DHCFT setting	N/A	N/A	N/A	0. Not applicable

	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
2.9	Food hygiene training is commensurate with the duties of staff **as per food hygiene regulations**. If food is brought into the care setting by a patient/service user, family/carer or staff this must be stored in line with food hygiene regulations.	Processses are in place for the labelling and storage of fod stuffs brought in for service users and checked by staff. Food hygiene training (level 2 and 3) is available and attendnace / copliance monitored.m	Incidents of incorrectly labelled / stored food items have been reported within last 12 months.	Review of incidents and remedial checks	N/A	2. Partially compliant

	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
3. Ensure appropriate antimicrobial stewardship to optimise service user outcomes and to reduce the risk of adverse events and antimicrobial resistance						
Systems and process are in place to ensure that:						
3.1	If antimicrobial prescribing is indicated, arrangements for antimicrobial stewardship (AMS) are maintained and where appropriate a formal lead for AMS is nominated.	Trust atttend regional AMS group, report to Schedule 4 oversight group for AMS prescribing and attend IPCSAG. Medicine management committee and PHCIC Committee also review with oversight report bi-annually (within PH upadte paper) sent to QSCG.	None	N/A	N/A	3. Compliant
3.2	The board receives a formal report on antimicrobial stewardship activities annually which includes the organisation's progress with achieving the UK AMR National Action Plan goals.	Included withn Medicianes managemnt and PHCIC annula reprots.	None	N/A	N/A	3. Compliant
3.3	There is an executive on the board with responsibility for antimicrobial stewardship (AMS), as set out in the UK AMR National Action Plan.	Medical Director is identifed lead for AMR prescribing.	None	N/A	N/A	3. Compliant
3.4	NICE Guideline NG15 'Antimicrobial Stewardship: systems and processes for effective antimicrobial medicine use' or Treat Antibiotics Responsibly, Guidance, Education, Tools (TARGET) are implemented and adherence to the use of antimicrobials is managed and monitored: • To optimise patient outcomes. • To minimise inappropriate prescribing. • To ensure the principles of Start Smart, Then Focus are followed.	Trust is a low volume prescriber, however tracking straems are ustilised in accordance with locally - system level) agreed priorities.	None	N/A	N/A	3. Compliant
3.5	Contractual reporting requirements are adhered to, progress with incentive and performance improvement schemes relating to AMR are reported to the board where relevant, and boards continue to maintain oversight of key performance indicators for prescribing, including: • Total antimicrobial prescribing. • Broad-spectrum prescribing. • Intravenous route prescribing. • Treatment course length.	Schedule 4 compliance is monitored via system level CQRG.	None	N/A	N/A	3. Compliant
3.6	Resources are in place to support and measure adherence to good practice and quality improvement in AMS. This must include all care areas and staff (permanent, flexible, agency, and external contractors)	DHCFT work with local prtners and report agianst locally agreed high priority areas. C.Diff for 2023/24 for example.	None	None	v.low incidents within trust belo	3. Compliant
4. Provide suitable accurate information on infections to patients/service users, visitors/carers and any person concerned with providing further support, care or treatment nursing/medical in a timely fashion						
Systems and processes are in place to ensure that:						
4.1	Information is developed with local service-user representative organisations, which should recognise and reflect local population demographics, diversity, inclusion, and health and care needs.	IPCSAG and AMR group coordinate locally agreed aannula action plans and areas of high incidence / prevalnce. DHCFT monitor ia ccordance with these local tragets.	None	N/A	N/A	3. Compliant

	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
4.2	Information is appropriate to the target audience, remains accurate and up to date, is provided in a timely manner and is easily accessible in a range of formats (eg digital and paper) and platforms, taking account of the communication needs of the patient/service user/care giver/visitor/advocate.	Information leaflets related to treatment or condiotn are provided and avialble in a range of formats.	None	N/A	N/A	3. Compliant
4.3	The provision of information includes and supports general principles on the prevention and control of infection and antimicrobial resistance, setting out expectations and key aspects of the registered provider's policies on IPC and AMR.	Local signage, community meetings etc will discuss locally implemented IPC measures. Face masks/ hand hygiene etc are available for service users as required.	None	N/A	N/A	3. Compliant
4.4	Roles and responsibilities of specific individuals, carers, visitors, and advocates when attending with or visiting patients/service users in care settings, are clearly outlined to support good standards of IPC and AMR and include: • Hand hygiene, respiratory hygiene, PPE (mask use if applicable) • Supporting patients/service users' awareness and involvement in the safe provision of care in relation to IPC (eg cleanliness) • Explanations of infections such as incident/outbreak management and action taken to prevent recurrence. • Provide published materials from national/local public health campaigns (eg AMR awareness/vaccination programmes/seasonal and respiratory infections) should be utilised to inform and improve the knowledge of patients/service users, care givers, visitors and advocates to minimise the risk of transmission of infections.	Cleaning standards are dispalyed. PPE / IPC support measures available and checked, signange in place, cmmunity meetings to discuss local meaitres or advice prvided. Community rates motored and esclation plans in place if transmission riks is ncreased / detected.	None	Community metings and procative contct in the event of any infection being identifed.	N/A	3. Compliant
4.5	Relevant information, including infectious status, invasive device passports/care plans, is provided across organisation boundaries to support safe and appropriate management of patients/service users.	Signage and emergency signage available at all sites. Service user care plans impleemnted as required in the vevent of suspected / idenifed infection being deteeced.	None	N/A	N/A	3. Compliant
5. Ensure early identification of individuals who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to others.						
Systems and processes are in place to ensure that patient placement decisions are in line with the NIPCM:						
5.1	All patients/individuals are promptly assessed for infection and/or colonisation risk on arrival/transfer at the care area. Those who have, or are at risk of developing, an infection receive timely and appropriate treatment to reduce the risk of infection transmission.	screening processes are in place on admission into care settings for inpatents.	None	N/A	N/A	3. Compliant

	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
5.2	Patients' infectious status should be continuously reviewed throughout their **stay/period of care**. This assessment should influence placement decisions in accordance with clinical/care need(s). If required, the patient is placed /isolated or cohorted accordingly whilst awaiting test results and documented in the patient's notes.	NEWS2 and symptomatic monitoring is undertaken by clincial team providing care to the patient.	None	N/A	**N/A**	3. Compliant
5.3	The infection status of the patient is communicated prior to transfer to the receiving organisation, department, or transferring services ensuring correct management/placement.	Pwertinent clincial information is handed over on transfer foprm or to the oragnisation.	None	SBARD sysem is in use in between DHCF	N/A	3. Compliant
5.4	Signage is displayed prior to and on entry to all health and care settings instructing patients with respiratory symptoms to inform receiving reception staff, immediately on their arrival.	Signange appropriate to care setting is displayed.	none	signange checks against current IPC guid	care setting is mental helath fioc	3. Compliant
5.5	Two or more infection cases (or a single case of serious infection) linked by time, place, and person triggers an incident/outbreak investigation and this must be reported via governance reporting structures.	Infectious incidents are monitoed and tracjed by HPU with oversight and montoring processes stepped up accordingly.	None	N/A	Pre-emptve monitoring prior to	3. Compliant
6.5	**Systems are in place to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection**					
Systems and processes are in place to ensure:						
6.1	Induction and mandatory training on IPC includes the key criteria (SICPs/TBPs) for preventing and controlling infection within the context of the care setting.	IPC training, link nuyrses and policies are all focussed on improving undertanding of SICP and when to escalte to TBP based upon local dynamic risk assessment	None	reuglar communications to support unde	N/A	3. Compliant
6.2	The workforce is competent in IPC commensurate with roles and responsibilities.	IC training is montored via performance reports across all divisions.	None	N/A	N/A	3. Compliant
6.3	Monitoring compliance and update IPC training programs as required.	As above	None	N/A	N/A	3. Compliant
6.4	All identified staff are trained in the selection and use of personal protective equipment / respiratory protective equipment (PPE/RPE) appropriate for their place of work including how to safely put on and remove (donning and doffing) PPE and RPE.	As above	None	N/A	N/A	3. Compliant
6.5	That all identified staff are fit-tested as per Health and Safety Executive requirements and that a record is kept.	Staff who undertake AGP procedures are routinely fit tested as per H and S requirements.	None	N/A	Cahnges to national guidmace reflected in step down of all inpatent staff ruiring FFP3 mask fitting. Agreed at QSCG in May 2023.	3. Compliant
6.6	If clinical staff undertake procedures that require additional clinical skills, for example, medical device insertion, there is evidence staff are trained to an agreed standard and the staff member has completed a competency assessment which is recorded in their records before being allowed to undertake the procedures independently.	Any addirtonal training requirements are idnetifed and supported by training and develpemnt team.	None	N/A	N/A	3. Compliant
7. Provide or secure adequate isolation precautions and facilities						

	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
Systems and processes are in place in line with the NIPCM to ensure that:						
7.1	Patients that are known or suspected to be infectious as per criterion 5 are individually clinically risk assessed for infectious status when entering a care facility. The result of individual clinical assessments should determine patient placement decisions and the required IPC precautions. Clinical care should not be delayed based on infectious status.	Screening and support processes are in pace with advice available form HPU regarding tretament / cohorting / managemnt of indivisudals and groups as required.	None.	Post incident reviews in pace to enbale l	N/A	3. Compliant
7.2	Isolation facilities are prioritised, depending on the known or suspected infectious agent and all decisions made are clearly documented in the patient's notes. Patients can be cohorted together if: • Single rooms are in short supply and if there are two or more patients with the same confirmed infection. • There are situations of service pressure, for example, winter, and patients may have different or multiple infections. In these situations, a preparedness plan must be in place ensuring that organisation/board level assurance on IPC systems and processes are in place to mitigate risk.	Apprpriate cohorting arrangents are available across al areas wit flexibility to supporrt either infectious patients or those wh need enahnced protection (e.g. NMABS elkgible). Proportionate to riks presented.	None	N/A	N/A	3. Compliant
7.3	Transmission based precautions (TBPs) in conjunction with SICPs are applied and monitored and there is clear signage where isolation is in progress, outlining the precautions required.	TBP meaures are available to step up as required in all settings.	None	N/A	N/A	3. Compliant
7.4	Infectious patients should only be transferred if clinically necessary. The receiving area (ward, hospital, care home etc.) must be made aware of the required precautions.	DHCFT are comlaint with this guidance as per national and locally agreed protocols.	None	N/A	N/A	3. Compliant
8. Provide secure and adequate access to laboratory/diagnostic support as appropriate						
Systems and processes to ensure that pathogen-specific guidance and testing in line with UKHSA are in place:						
8.1	Patient/service user testing for infectious agents is undertaken by competent and trained individuals and meet the standards required within a nationally recognised accreditation system.	DHCT are comlaint with this guiance.	None	N/A	N/A	3. Compliant
8.2	Early identification and reporting of the infectious agent using the relevant test is required with reporting structures in place to escalate the result if necessary.	DATIX and cross referece with pathology labs for patents involved with DHCFT in place. Local IPC netwrok supports review of aptients who have moved between poviders to identify lead provider for reviews as required.	None	N/A	N/A	3. Compliant
8.3	Protocols/service contracts for testing and reporting laboratory/pathology results, including turnaround times, should be in place. These should be agreed and monitored with relevant service users as part of contract monitoring and laboratory accreditation systems.	Path lab services provided bylocal acute provider, specialst mntiroing for claozapine bloods provided under sperate contract.	None	N/A	N/A	3. Compliant

	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
8.4	Patient/service user testing on admission, transfer, and discharge should be in line with national guidance, local protocols and results should be communicated to the relevant organisation.	DHCFT is comalinat with current testing protocosls. E.g. Covid LFD tes on discae to care hoe proviers within 48 hours prior to discharge.	None	N/A	N/A	3. Compliant
8.5	Patients/service users who develops symptom of infection are tested / retested at the point symptoms arise and in line with national guidance and local protocols.	DHCFT is comalinat with current testing protocosls.	None	N/A	N/A	3. Compliant
8.6	There should be protocols agreed between laboratory services and the service user organisations for laboratory support during outbreak investigation and management of known/ emerging/novel and high-risk pathogens.	DHCFT is comalinat with current testing protocosls and has arrangements in pace through IPCSAG and EPRR to step up testing when required / directed.	None	N/A	N/A	3. Compliant
8.7	There should be protocols agreed between laboratory services and service user organisations for the transportation of specimens including routine/ novel/ emerging/high risk pathogens. This protocol should be regularly tested to ensure compliance.	DHCFT is comalinat with current testing protocosls.	None	N/A	N/A	3. Compliant
9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections						
9.1	Systems and processes are in place to ensure that guidance for the management of specific infectious agents is followed (as per UKHSA and the NIPCM) (UKHSA and NHSE A to Z pathogens list to be added once published). Policies and procedures are in place for the identification of and management of outbreaks/incidence of infection. This includes monitoring, recording, escalation and reporting of an outbreak/incident by the registered provider.	DHCFT has policies in pace fr coammon and known infections. EPRR processes are in place for new and emerging	New and emeeging virus policy is under review and needs completion and sign off.	polcy pending publication. Respiratory V	N/A	2. Partially compliant
10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection						
Systems and processes are in place to ensure that any workplace risk(s) are mitigated maximally for everyone. This includes access to an occupational health or an equivalent service to ensure:						
10.1	Staff who may be at high risk of complications from infection (including pregnancy) have an individual risk assessment.	Processes are in palce with local managent teams and supported by OH services in accordnace with current national protocols.	None	N/A	N/A	3. Compliant
10.2	Staff who have had an occupational exposure are referred promptly to the relevant agency, for example, GP, occupational health, or accident and emergency, and understand immediate actions, for example, first aid, following an occupational exposure including process for reporting.	Processes are in palce with local managent teams and supported by OH services in accordnace with current national protocols.	None	N/A	N/A	3. Compliant

	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
10.3	Staff have had the required health checks, immunisations and clearance undertaken by a competent advisor (including those undertaking exposure prone procedures (EPPs).	Processes are in palce with local managent teams and supported by OH services in accordnace with current national protocols.	None	N/A	N/A	3. Compliant

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

Workforce Race Equality Standard (WRES) 2022/23 submission and, Workforce Disability Equality Standard (WDES) 2022/23

Purpose of Report

The Workforce Race and Disability Equality Standards (WRES and WDES) provide narrative to the WRES and WDES data sets submitted to NHS England by 31 August 2023. The data and narrative are accompanied by action plans which were approved by the People and Culture Committee prior to retrospective sign off by the Board in November.

Executive Summary

The WRES and WDES are nationally mandated data collection frameworks to enable NHS Commissioners and providers to measure race and disability equality in organisations. The indicators in each report are set out in turn with an explanation and show trends over time where possible.

The reports are to be published on the Trust's public website and so the data and explanations are presented in a straightforward manner to enable ease of understanding for the public and all colleagues in the Trust.

Rather than being stand-alone data exercises, the WRES and WDES are intended to form part of the broader equality, diversity, and inclusion landscape. Where appropriate, the actions arising from both reports are aligned with existing and new workstreams in People and Inclusion and with the 6 High Impact Actions in the NHSE EDI Improvement Plan. Individual actions are brought together into four areas:

1. Bullying, Harassment, Abuse and Discrimination
2. Inclusive Recruitment
3. Progression and Promotion
4. Culture of Inclusion and Belonging

It is proposed that the EDI Steering Group will have quarterly oversight of progress made towards these action areas in addition to specifics in the 6 High Impact Actions. This will enable an ongoing dialogue with staff networks and representatives on a regular basis throughout the year.

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

Assurances

- The WRES and WDES datasets have been submitted to NHS England in time for the deadline of 31 August 2023
- The EDI Steering Group will have quarterly oversight on progress on the above action areas.

Consultation

The action plan incorporates actions consulted on with the BME and DAWN staff networks for the report in 2021/22. The report has been written in consultation with the Deputy Director of People and Inclusion.

The action plan and submissions were approved by the People and Culture Committee on 19 September under delegated authority of the Trust Board.

Governance or Legal Issues

Section 149 of the Equality Act sets out the Public Sector Equality Duty (PSED), which offers protection in relation to employment, as well as access to goods and services. The PSED strengthens the duty on employers to eliminate discrimination and advance equality of opportunity for staff with protected characteristics and foster good relations between people.

Public Sector Equality Duty & Equality Impact Risk Analysis

In complying with the WRES and WDES data collection and action plans, reports must identify the equality related impacts on the nine protected characteristics of age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage and civil partnership and pregnancy and maternity. The REGARDS group of people includes people with Economic disadvantage in addition to others covered by protected characteristics.

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

- The WRES and WDES seek to measure some aspects of race and disability equality at the Trust. They provide useful numerical data which illuminate where the Trust has made progress and where further work is needed. The aggregated data model (BME and White, Disabled and non-Disabled) can risk overlooking disparities within groups (for example different types of disability) and particular risks to groups based on intersectional identity, for example, additional discrimination experienced by ethnic minority women or those who identify as White from a Roma, Gypsy or Traveller identity.
- Some of the disadvantages of the WRES and WDES are outlined in the reports and these can partially be overcome if supplemented with additional qualitative data which offer a richer picture of the lived experience of colleagues.

Recommendations

The Board of Directors is requested to:

1) Ratify the WRES Report and Action Plan which had been previously approved by the People and Culture Committee on 19 September 2023 as published on the Trust's public-facing website.
2) Note that the EDI Steering Group is to provide quarterly oversight on progress towards action areas to the People and Culture Committee.

Report presented by: **Rebecca Oakley**
Deputy Director, People and Inclusion

Report prepared by: **Tom Harrison**
Head of EDI

NHS
Derbyshire Healthcare
NHS Foundation Trust

Workforce Race Equality Standard (WRES)

Annual Report 2022/23

October 2023

DHCFT @derbyshcft
www.derbyshirehealthcareft.nhs.uk

Making a positive difference

Contents

Introduction

The Workforce Race Equality Standard (WRES) is a data collection framework which measures elements of race equality in NHS organisations. Implementing the WRES is a requirement for NHS Commissioners and NHS healthcare providers including independent organisations through the NHS contract.

The WRES is designed around nine indicators, or measures, which compare Black and Minority Ethnic (BME) colleagues and their White counterparts. We acknowledge and respect that not everyone is comfortable with the term "BME" and prefer other terms instead. However, in following national guidance, this report uses consistent terminology. We also acknowledge that comparing two groups has the disadvantage of masking disparities within each group.

Five indicators of the WRES are populated with workforce data from our Electronic Staff Record (ESR) and show comparative data for BME and White staff. This includes the distribution of staff in each pay band, access to training, likelihood of being appointed following shortlisting, likelihood of entering a formal disciplinary process, and representation in very senior leadership. The remaining four indicators are populated with comparative data from the national Staff Survey and includes: experiences of bullying, harassment, and abuse; discrimination, and perceptions of fairness in career progression. Numerical data[1] gleaned from the WRES provides a degree of insight into race equality at the Trust but is best used in conjunction with additional information (such as Freedom to Speak Up, employee relations and recruitment) and the qualitative data from the lived experiences of our colleagues themselves.

Each indicator is set out separately in this report with narrative content and main trends written in italics.

As a public service, our Trust is bound by the Public Sector Equality Duty and, as such, we are committed to:

- Eliminating unlawful discrimination, harassment, and victimisation.
- Advancing equality of opportunity between people.
- Fostering good relations between people.

In progressing towards these goals, the WRES data is accompanied by an action plan approved by the Trust Board of Directors.

[1] As a relatively small Trust, our numerical data expressed as percentages or ratios can be more prone to fluctuation. For example, where only a small number of staff are counted (fewer than 10), a small number of additional recruits, or leavers, can have a bigger impact on percentage scores than in larger groups of staff. In the report, we have highlighted where this might be the case and shown data trends over time to give the most accurate picture.

Context

The Trust serves the population of Derby City and Derbyshire County, both of which have different profiles in race and ethnicity. In the 2011 census, Derby City was 24.7% BME and 75.3% White, while Derbyshire County was 4.2% BME and 95.8% White[2]. In the NHS nationally, 22.4% of staff are from a BME background[3].

A snapshot of data taken on 31 March 2023 shows the total number of staff employed by Derbyshire Healthcare was 3073. Of these, 567 identified as BME and 2442 identified as White. There was no data recorded for 64 members of staff. The proportion of BME staff over time is as follows:

	2018	2019	2020	2021	2022	2023
Total % of BME staff employed within the Trust as of 31 March	12.6	12.9	13.8	15.5	16.7	18.5

From 2018 to 2023, the number of BME staff has increased from 314 to 567. This is a percentage increase of 44.6% compared to the total workforce increase of 18.8%.

Indicator 1

Indicator 1 is a measure of staff distribution across pay bands (Under Band 1 to Very Senior Manager (VSM)). Data are collected in three main occupational groups: non-clinical, clinical (non-medical), and clinical (medical and dental). The figures as of 31 March 2022 and 2023 are shown in the following table. The headcount figure (in black) is the total headcount. The percentage figure (in blue) is the proportion of BME or White staff *within* each pay band for that year. Percentage figures have been rounded up or down to whole numbers.

Non-Clinical

	2022			2023		
Pay Band	BME # (%)	White # (%)	Unknown # (%)	BME # (%)	White # (%)	Unknown # (%)
Under Band 1	0 (0%)	1 (100%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Band 1	0 (0%)	0 (0%)	1 (100%)	0 (0%)	0 (0%)	1 (100%)
Band 2	50 (28%)	120 (68%)	7 (4%)	50 (26%)	135 (70%)	7 (4%)
Band 3	18 (9%)	179 (90%)	2 (1%)	20 (10%)	174 (89%)	1 (1%)
Band 4	13 (9%)	127 (89%)	2 (1%)	18 (11%)	144 (88%)	1 (1%)
Band 5	11 (13%)	72 (85%)	2 (2%)	9 (11%)	71 (87%)	2 (2%)

[2] Derbyshire Observatory – Population Ethnicity

[3] NHS England » NHS Workforce Race Equality Standard (WRES)2022 data analysis report for NHS trusts

Band 6	3 (6%)	47 (89%)	3 (6%)	5 (9%)	51 (89%)	1 (2%)
Band 7	1 (4%)	21 (91%)	1 (4%)	5 (15%)	27 (79%)	2 (6%)
Band 8a	0 (0%)	20 (100%)	0 (0%)	0 (0%)	21 (100%)	0 (0%)
Band 8b	1 (10%)	9 (90%)	0 (0%)	0 (0%)	12 (100%)	0 (0%)
Band 8c	1 (7%)	13 (93%)	0 (0%)	1 (9%)	10 (91%)	0 (0%)
Band 8d	1 (13%)	7 (87%)	0 (0%)	0 (0%)	4 (100%)	0 (0%)
Band 9	0 (0%)	0 (0%)	0 (0%)	0 (0%)	5 (100%)	0 (0%)
VSM	2 (25%)	6 (75%)	0 (0%)	1 (20%)	4 (75%)	0 (0%)

In 2023, the overall percentage of BME staff in non-clinical roles is slightly lower than the figure across the whole Trust. 64.2% of the total number of BME staff are concentrated in Bands 2 and 3 compared to 46.9% of the total number of White staff. 1.8% of the total number of BME staff are in roles at Band 8a and above compared to 8.5% of White staff. In terms of the total number of staff at 8a and above (58 excluding unknowns), 3.5% are BME and 96.5% White[4].

Clinical (non-medical)

	2022			2023		
Pay Band	BME # (%)	White # (%)	Unknown # (%)	BME # (%)	White # (%)	Unknown # (%)
Under Band 1	3 (38%)	5 (63%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Band 1	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Band 2	1 (13%)	6 (75%)	1 (13%)	1 (25%)	3 (75%)	0 (0%)
Band 3	92 (25%)	260 (72%)	11 (3%)	112 (29%)	259 (29%)	12 (3%)
Band 4	12 (11%)	97 (87%)	2 (2%)	16 (12%)	114 (87%)	1 (1%)
Band 5	66 (21%)	234 (75%)	11 (4%)	84 (25%)	245 (72%)	11 (3%)
Band 6	79 (11%)	643 (87%)	13 (2%)	92 (12%)	649 (86%)	11 (1%)
Band 7	31 (10%)	279 (89%)	5 (2%)	36 (10%)	315 (88%)	7 (2%)
Band 8a	11 (13%)	73 (85%)	2 (2%)	13 (14%)	78 (85%)	1 (1%)
Band 8b	3 (7%)	36 (88%)	2 (5%)	4 (8%)	45 (92%)	0 (0%)
Band 8c	2 (11%)	16 (98%)	0 (0%)	2 (12%)	15 (88%)	0 (0%)
Band 8d	1 (50%)	1 (50%)	0 (0%)	0 (0%)	5 (100%)	0 (0%)
Band 9	0 (0%)	0 (0%)	0 (0%)	1 (100%)	0 (0%)	0 (0%)
VSM	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)

The overall percentage of BME staff in clinical (non-medical) roles is slightly higher than the figure across the whole Trust. Further analysis of groups of staff can bring some of the disparities into sharper focus. For example, the majority of registered nurses (amongst others) are employed at Bands 5, 6 and 7 and, to an extent, the band increase represents career progression. Looking at the total number of staff in each

[4] Unknowns have been excluded for this narrative paragraph.

BME and White group for these bands, the percentage differences highlight the uneven distribution.

Clinical (Non-medical) staff at Bands 5-7

	BME total: 212	White total: 1209
Band 5	(84) 39.6%	(245) 20.3%
Band 6	(92) 43.4%	(649) 53.7%
Band 7	(36) 17.0%	(315) 26.1%

For Bands 8a and above (total headcount excluding unknowns is 163), BME staff comprise 12.2% and White staff 87.7%.

Clinical (medical and dental)

	2022			2023		
	BME # (%)	White # (%)	Unknown # (%)	BME # (%)	White # (%)	Unknown # (%)
Consultants	45 (58%)	31 (40%)	2 (3%)	50 (62%)	29 (36%)	2 (3%)
of which senior medical manager	0 (0%)	1 (100%)	0 (0%)	1 (100%)	0 (0%)	0 (0%)
Non-consultant career grade	17 (53%)	14 (44%)	1 (3%)	22 (58%)	15 (40%)	1 (3%)
Trainee grades	17 (57%)	10 (33%)	3 (10%)	24 (62%)	12 (30%)	3 (7%)
Other	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)

In Clinical (Medical and dental) roles, the disparity is not represented by total numbers in the same way for other groups. For this staff group, disparities can include clinical awards, academic posts, and fitness to practice referrals. This is analysed further in the Medical WRES (MWRES) which will be published in February 2024.

Indicator 2

Relative likelihood of staff being appointed from shortlisting across all posts calculated for the 12 months prior to 31 March in the reporting year. If a candidate is shortlisted, it means they have met the criteria to be interviewed for the post they are applying for.

Indicator 2 is expressed as a “disparity ratio” where complete parity, or equality, is represented by the figure 1. A figure of 2 would be that a shortlisted candidate is twice as likely to be appointed. In Indicator 2, a figure above 1 shows the extent to which a White candidate is more likely to be appointed. The table below shows this trend over time.

	2018	2019	2020	2021	2022	2023
Indicator 2	1.57	2.86	2.02	1.60	1.78	1.75

Indicator 2 shows a continuing disparity over time. Given the overall large numbers of shortlisted and appointed candidates, there is a possibility that the overall figure masks wider disparities in particular areas.

Indicator 3

Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation. A figure above 1 would indicate BME staff are more likely to enter the formal disciplinary process.

	2018	2019	2020	2021	2022	2023
Indicator 3	3.03	2.45	1.43	10.52	0.0	2.70
No. of cases	Unavailable	BME 5 White 13	BME 2 White 11	BME 2 White 1	BME 0 White 4	BME 8 White 5

This indicator shows the likelihood of entering formal discipline compared to the proportion of BME and White staff in the whole organisation. On the face of it, the disparity ratio in 2021 shows the greatest disparity but this score is unrepresentative of the small number of total discipline cases overall. The potentially more concerning figure is in 2023. The overall pattern remains that BME staff are proportionately more likely to enter formal discipline than are White staff. The numerical data here is of some value but needs supplementing with qualitative data to understand the full picture.

Indicator 4

Relative likelihood of staff accessing non-mandatory training and CPD. A figure above 1 would indicate BME staff are less likely to access non-mandatory training and CPD.

	2018	2019	2020	2021	2022	2023
Indicator 4	1.53	0.97	1.13	1.52	0.73	1.31

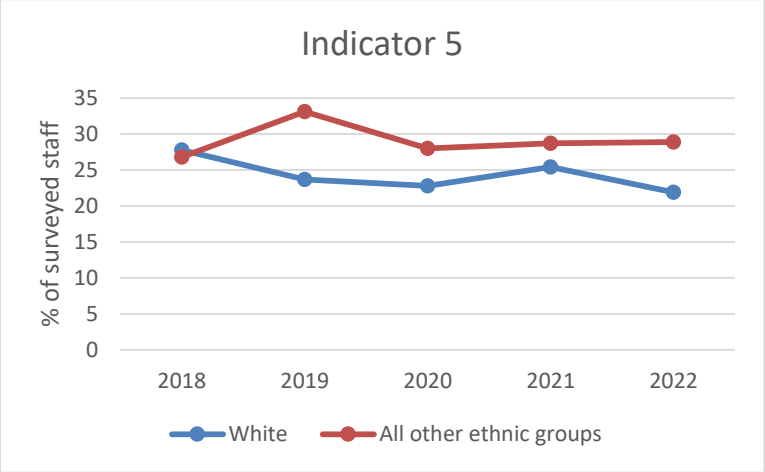
This disparity ratio applies to all staff so is more likely to be an accurate representation and the trend over time is of greater parity than some other indicators. When read against indicator 7 (perceptions of fairness in career progression and promotion) we can see that that a wide disparity remains. It may be that there is more equitable access to professional development learning but this is not translating into progression.

Indicators 5-8

Data for the following Indicators are taken from the staff survey[5] and do not include figures for 2023 as those results will be published in 2024. A benchmarking report compares Derbyshire Healthcare to other Mental Health and Learning Disability Trusts (51 organisations are in the benchmarking group).

Indicator 5

Percentage of staff experiencing harassment, bullying or abuse from patients, relatives, or members of the public in the last 12 months.



In 2022, the percentage for BME staff was 28.9% and has risen slightly over time indicating this is a persistent issue in the Trust. The 2022 figure for White staff is 21.9% which is a steady improvement.

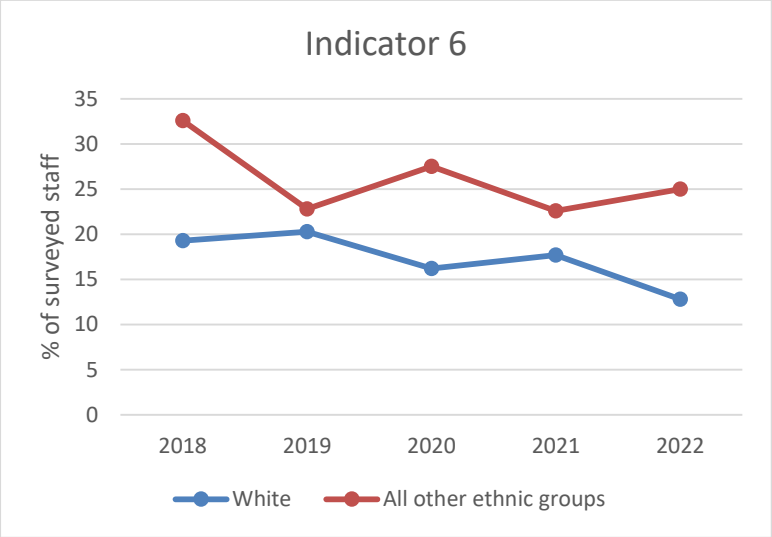
Out of the respondents to the staff survey (48% of the total number of staff), 50 BME staff and 266 White staff reported being harassed, bullied, or abused by patients, relatives or members of the public.

For both groups of staff, the % figures are slightly lower than the average in the benchmarking groups.

[5] The full data set is available here: NHS Staff Survey Benchmark report 2022 (nhsstaffsurveys.com)

Indicator 6

Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months.

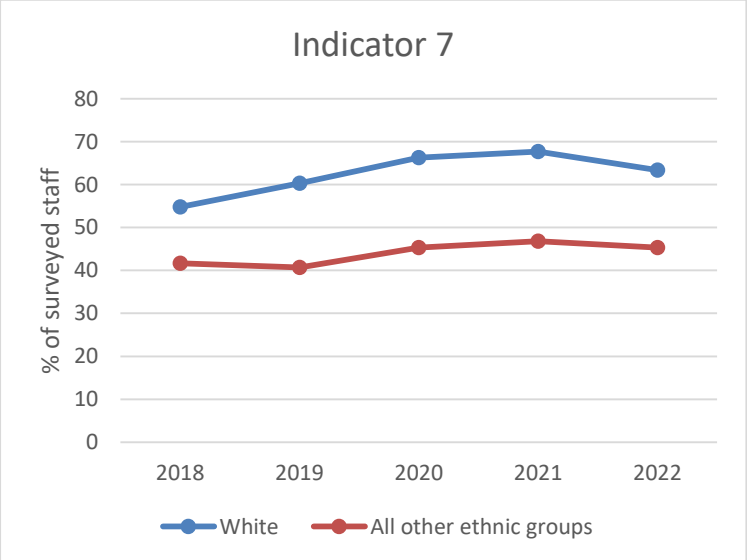


In 2022, the percentage for BME staff was 25% compared to 12.8% for White staff. Incidents of harassment, bullying and abuse from other staff has steadily reduced for both groups over time and a persistent disparity has remained.

Out of the respondents to the staff survey (48% of the total number of staff), 43 BME staff and 163 White staff reported being harassed, bullied, or abused by their colleagues.

Indicator 7

Percentage believing that the Trust provides equal opportunities for career progression or promotion.



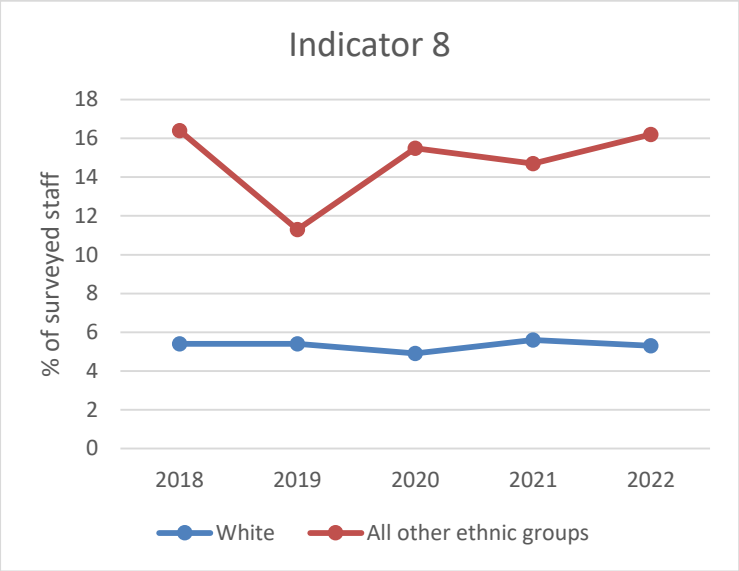
In 2022, the percentage for BME staff was 45.3% compared to 63.4% for White staff. Figures for both groups have steadily improved over time, but a wide and persistent disparity remains.

Out of the respondents to the staff survey, 77 BME staff and 761 White staff believed the Trust provides equal opportunities for career progression and promotion.

Over time, the picture at the Trust is largely consistent with other trusts in the benchmarking group. Compared to that group, our figure is marginally higher for White staff at the trust and lower for BME staff.

Indicator 8

Percentage of staff who have personally experienced discrimination at work from their manager/team leader or other colleagues in the last 12 months.



In 2022, the percentage for BME staff was 16.2% compared to 5.3% for White staff. Apart from the outlier figure for BME staff in 2019, the data has remained consistent for both groups over time and a persistent disparity remains.

Out of the respondents to the staff survey (48% of the total number of staff), 28 BME staff and 64 White staff experienced discrimination from their manager, team leader or other colleagues.

The data mirrors the national trend against the benchmarking groups with an increased percentage figure for BME at the Trust compared to the whole group.

Indicator 9

Percentage difference between the organisation's Board voting membership and the overall workforce. This Indicator shows the representation of BME staff by comparing two figures: the percentage of BME staff in the organisation, the percentage of BME voting membership at the Board, and then working out the difference. The figure below is the difference between the two figures. For example, in 2023, the percentage figure for BME staff across the whole workforce is 18.5% and the percentage for BME voting Board members is: 33.3%. The difference is therefore 14.8%. This is similar to the previous year when the difference was 16.7%.

Conclusions

The WRES provides NHS trusts with a series of quantitative measures which demonstrate race disparity. WRES data has been collected since 2018 from which we can assess trends over time. We can also draw some conclusions about what is and is not working to improve race equality at the Trust.

Positive progress has been made year-on-year to maximise opportunities at the Trust for minority communities and this has resulted in a more representative total staff

group. Over the past two years we have also increased ethnically diverse leadership at Board level. This gives the Trust a firm basis in making progress towards equality. However, as demonstrated above, there are persistent issues with bullying, harassment and discrimination from colleagues, managers, and members of the public.

We also know that the figures show BME staff in many occupational groups are overly represented in lower pay bands and there is a continuing disparity in many mid-level to senior leadership posts.

Analysing numerical WRES data tells us the “what”, and we are committed to further investigation into the “why”. To maximise the effectiveness of the WRES, the indicator measures and accompanying actions will be an integral part of wider culture transformation at the Trust.

Action Plan

The Action Plan in the 2022 WRES Report was written in consultation with a broad group of colleagues including members of our BME staff network. Some of the actions have been completed and others are in progress. The actions relating to culture change are necessarily multi-year actions and remain in the action plan.

Quarterly oversight of the WRES actions sits with the Equality, Diversity & Inclusion (EDI) Steering Group which is chaired by the Non-Executive Director for EDI. The group brings together colleagues in key corporate roles, with staff networks and staff representatives. In June 2023, NHS England published its EDI Improvement Plan[6] with six high impact actions, some of which are aligned to the WRES objectives below.

The Trust is also undertaking a wide-ranging and comprehensive review into its organisational culture of which WRES will be an integral part.

[6] NHS equality, diversity, and inclusion improvement plan (england.nhs.uk)

Action Area	Activities	Who The EDI Steering Committee will be sighted on all actions and review progress at quarterly meetings.	When	Status
Bullying, Harassment, Abuse and Discrimination	Audit of employee relations cases and training for investigations and complaint handling.	Chief Executive Officer with delegated responsibility to be confirmed. Employee Relations Manager	2023/4	To be commenced.
	Redesign EDI Essentials Training to clearly state what behaviour consists of, how to prevent it, and manage it when it occurs.	EDI Team	March 2024	To be commenced.
	Candidates put forward for the Active Bystander Train-the-Trainer programme.	EDI Team and others (in progress).	October 2023	To be commenced.
	Deliver facilitated sessions on "Understanding and Talking About Race".	EDI Team	October 2023	To be commenced.
Inclusive Recruitment	Broader project including implementing culturally intelligent approaches.	Strategic Recruitment Lead	Ongoing and to continue in 2024.	Ongoing.
	Redesign and roll-out of recruitment and selection training.			
Progression and Promotion	Review of Recruitment Inclusion Guardians	Head of EDI Strategic Recruitment Lead	March 2024	To be commenced.
	Develop specific actions related to JUCD career aspirations and barriers questionnaire for BME colleagues.	Deputy Director of People & Inclusion	March 2024	Ongoing.
Culture of Inclusion and Belonging	Wide-ranging review of Trust organisational culture (including anti-racism approaches) to be co-designed with stakeholders across the Trust and tender process for external partner.	Chief Executive Officer with external partner and delegated authority to be confirmed.	2024	To undergo tendering process.

Derbyshire Healthcare
NHS Foundation Trust

Workforce Disability Equality Standard (WDES)

Annual Report 2022/23

October 2023

Contents

Introduction

The Workforce Disability Equality Standard (WDES) is a data collection framework which measures elements of disability equality in NHS organisations. Implementing the WDES is a requirement for NHS Commissioners and NHS healthcare providers including independent organisations through the NHS contract.

The WDES is designed around ten indicators, or measures, which compare disabled colleagues and their non-disabled counterparts. We acknowledge and respect that some people with disabilities refer to themselves as Disabled denoting this part of their identity. However, in following national guidance, this report uses consistent terminology and refers to "disabled staff". We also acknowledge that comparing two groups has the disadvantage of masking disparities within each group.

Four indicators of the WDES are populated with workforce data from our Electronic Staff Record (ESR) and show comparative data for disabled and non-disabled staff. This includes the distribution of staff in each pay band, likelihood of being appointed following shortlisting, likelihood of entering a formal capability process, and representation in very senior leadership. A further five indicators are populated with comparative data from the national Staff Survey and includes: experiences of bullying, harassment, and abuse; discrimination, feeling pressure to come into work while unwell, and perceptions of fairness in career progression. The remaining metric refers to whether the voices of disabled staff are heard within the organisation.

Numerical data[1] gleaned from the WDES provides a degree of insight into race equality at the Trust but is best used in conjunction with additional information (such as Freedom to Speak Up, employee relations and recruitment) and the qualitative data from the lived experiences of our colleagues themselves. The data on ESR relating to our disabled staff is incomplete although this has increased following a concerted effort to improve. This is explored below in more detail.

Each indicator is set out separately in this report with narrative content and main trends written in italics.

As a public service, our Trust is bound by the Public Sector Equality Duty and, as such, we are committed to:

- Eliminating unlawful discrimination, harassment, and victimisation.
- Advancing equality of opportunity between people.
- Fostering good relations between people.

[1] As a relatively small Trust, our numerical data expressed as percentages or ratios can be more prone to fluctuation. For example, where only a small number of staff are counted (fewer than 10), a small number of additional recruits, or leavers, can have a bigger impact on percentage scores than in larger groups of staff. In the report, we have highlighted where this might be the case and shown data trends over time to give the most accurate picture.

In progressing towards these goals, the WDES data is accompanied by an action plan approved by the Trust Board of Directors.

Context

The Trust serves the population of Derby City and Derbyshire County, both of which have different profiles in terms of disability. In the 2011 census, data shows the percentage of people indicating that their day-to-day activities were limited by a long-standing illness. In Derby City, the figure was 18.5% and in Derbyshire County, the figure was 20.4%. This definition is unlikely to cover various conditions which might be defined as a disability. Similarly, the NHS Staff Survey asks whether staff have a disability or long-term condition, and this is recorded differently on ESR as solely a disability. This slightly hinders getting accurate data, however, the WDES does indicate clear trends and disparities between disabled and non-disabled staff.

Figures from the Department for Work and Pensions in 2021/22 indicate that 24% of the total population have a disability[2].

A snapshot of data taken on 31 March 2023 shows the total number of staff employed by Derbyshire Healthcare was 3072. Of these, 273 identified as disabled, 2270 identified as non-disabled. There was no data recorded for 529 members of staff. The recorded proportion of disabled staff over time is as follows:

	2018	2019	2020	2021	2022	2023
Total % of disabled staff employed within the Trust as of 31 March	Unavailable	4.5% (115)	4.4% (117)	5.3% (149)	6.7% (194)	8.9% (273)

Indicator 1

Indicator 1 is a measure of staff distribution across pay bands (Under Band 1 to Very Senior Manager (VSM)). Data are collected in three main occupational groups: non-clinical, clinical (non-medical), and clinical (medical and dental). The figures as of 31 March 2022 and 2023 are shown in the following table. The headcount figure (in black) is the total headcount. The percentage figure (in blue) is the proportion of disabled or non-disabled staff *within* each pay band for that year. Percentage figures have been rounded up or down to whole numbers.

[2] UK disability statistics: Prevalence and life experiences - House of Commons Library (parliament.uk)

Non-Clinical

	2022			2023		
Pay Band	Disabled # (%)	Non-disabled # (%)	Unknown # (%)	Disabled # (%)	Non-disabled # (%)	Unknown # (%)
Cluster 1 Bands <1 to 4	34 (7%)	377 (73%)	109 (21%)	45 (8%)	402 (73%)	104 (19%)
Cluster 2 Bands 5 to 7	11 (7%)	125 (78%)	25 (16%)	19 (11%)	132 (76%)	22 (13%)
Cluster 3 Bands 8a to 8b	2 (7%)	17 (57%)	11 (37%)	6 (18%)	19 (58%)	8 (24%)
Cluster 4 Bands 8c to 9 and VSM[3]	3 (10%)	23 (73%)	5 (17%)	1 (4%)	21 (84%)	3 (12%)

Clinical

	2022			2023		
Pay Band	Disabled # (%)	Non-disabled # (%)	Unknown # (%)	Disabled # (%)	Non-disabled # (%)	Unknown # (%)
Cluster 1 Bands <1 to 4	30 (6%)	377 (69%)	123 (25%)	41 (8%)	372 (72%)	105 (20%)
Cluster 2 Bands 5 to 7	102 (8%)	1005 (74%)	254 (19%)	140 (10%)	1091 (75%)	219 (15%)
Cluster 3 Bands 8a to 8b	8 (6%)	101 (80%)	18 (14%)	13 (9%)	112 (79%)	16 (11%)
Cluster 4 Bands 8c to 9 and VSM	1 (5%)	15 (75%)	4 (20%)	1 (4%)	20 (87%)	2 (9%)
Cluster 5 Medical and Dental Staff-Consultants	3 (4%)	47 (60%)	28 (36%)	5 (6%)	52 (64%)	24 (30%)
Cluster 6 Medical and Dental Non-consultant career grade	0 (0%)	19 (60%)	13 (41%)	1 (3%)	22 (58%)	15 (39%)
Cluster 7 Medical & Dental Trainees	0 (0%)	17 (57%)	13 (43%)	1 (3%)	27 (69%)	11 (28%)

[3] Very Senior Manager

The number of unknowns has reduced within every cluster and the overall percentage of recorded disabled staff has steadily increased. This gives us more confidence in the data derived from ESR.

Indicator 2

Relative likelihood of staff being appointed from shortlisting across all posts calculated for the 12 months prior to March 31 in the reporting year. If a candidate is shortlisted, it means they have met the criteria to be interviewed for the post they are applying for.

Indicator 2 is expressed as a "disparity ratio" where complete parity, or equality, is represented by the figure 1. A figure of 2 would be that a candidate is twice as likely to be appointed. In Indicator 2, a figure above 1 shows the extent to which a non-disabled candidate is more likely to be appointed. The table below shows this trend over time.

	2018	2019	2020	2021	2022	2023
Indicator 2	2.88	1.40	1.05	1.05	1.04	1.17

The clear trend over time shows that there is a reduced disparity in shortlisting. However, caution should be exercised given the large numbers of shortlisted and appointed candidates. There is a possibility that the overall figure masks some disparities in particular areas. Further data analysis is required to look at shortlisting in relation to different types of disability.

Indicator 3

Relative likelihood of staff entering the formal capability process, as measured by entry into a formal capability process. This is calculated for the 12 months prior to 31 March in the reporting year. From 2022 this is calculated over a 2-year period and the figure divided by two, hence the appearance of halves in the headcount figure. A figure above 1 would indicate disabled staff are more likely to enter the formal capability process.

	2018	2019	2020	2021	2022	2023
Indicator 3	Unavailable	0.0	0.0	0.0	0.0	0.0
Average Headcount	Unavailable					
Disabled		0	0	0	0	0.5
Non-disabled		0	0	0	0.5	1.5

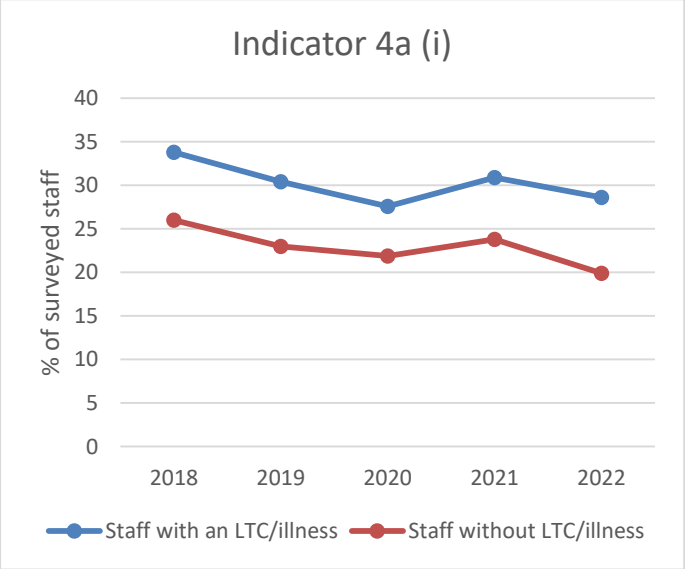
Given the very low number of formal capability cases overall, this Indicator offers limited insight into the comparative experiences of disabled and non-disabled staff when there are performance concerns.

Indicators 4a to 9b

Data for the following Indicators are taken from the staff survey[4] and do not include figures for 2023 as those results will be published in 2024. The data from the staff survey refers to staff who indicate they have a "long-term condition or illness" rather than a disability. This is due to the staff survey and ESR collecting information in a different way. Long-term condition is referred to as LTC below. A benchmarking report compares Derbyshire Healthcare to other Mental Health and Learning Disability Trusts (51 organisations are in the benchmarking group).

Indicator 4a (i)

Percentage of staff experiencing harassment, bullying or abuse from patients, service users or members of the public in the last 12 months.



In 2022, the percentage of staff with an LTC was 28.6% compared to 19.9% of staff without an LTC. The figure for both groups has fallen steadily and show a downward trend.

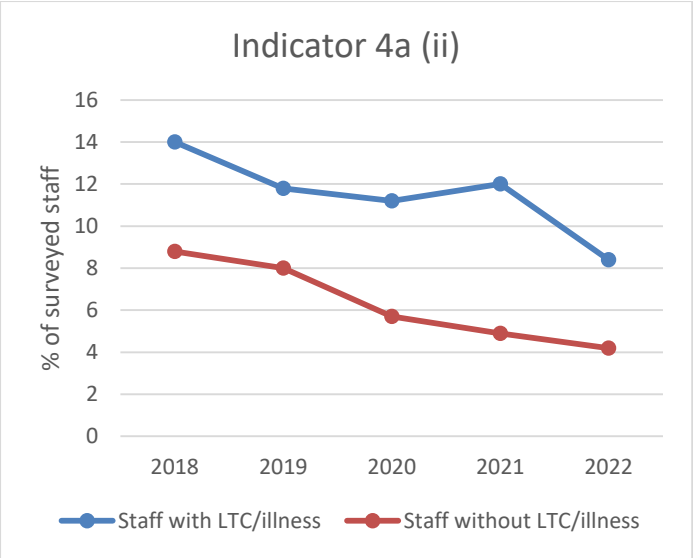
Out of the respondents to the staff survey (48% of the total) 126 staff with an LTC reported positively to this question and 187 staff without an LTC.

The Trust figures are lower than those in the benchmarking group.

[4] The full data set is available here: NHS Staff Survey Benchmark report 2022 (nhsstaffsurveys.com)

Indicator 4a (ii)

Percentage of staff experiencing harassment, bullying or abuse from their managers in the last 12 months.



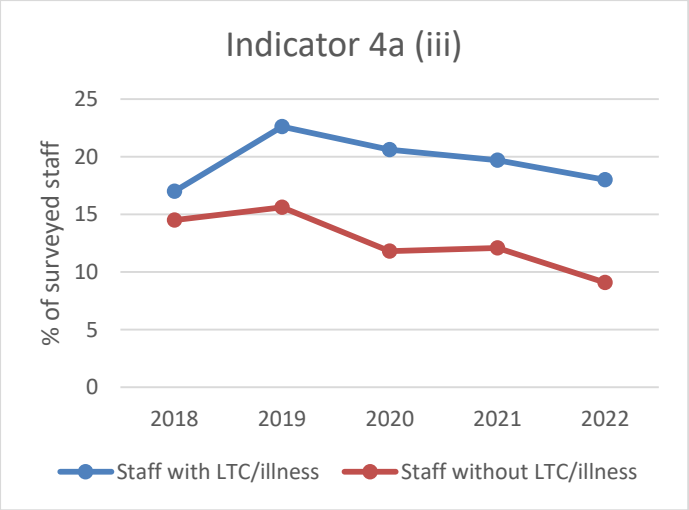
In 2022, the percentage of staff with an LTC was 8.4% compared to 4.2% of staff without an LTC. The figure for both groups has fallen steadily and show a downward trend.

Out of the respondents to the staff survey (48% of the total) 36 staff with an LTC reported positively to this question and 39 staff without an LTC.

The Trust figures are lower than those in the benchmarking group.

Indicator 4a (iii)

Percentage of staff experiencing harassment, bullying or abuse from other colleagues in the last 12 months.



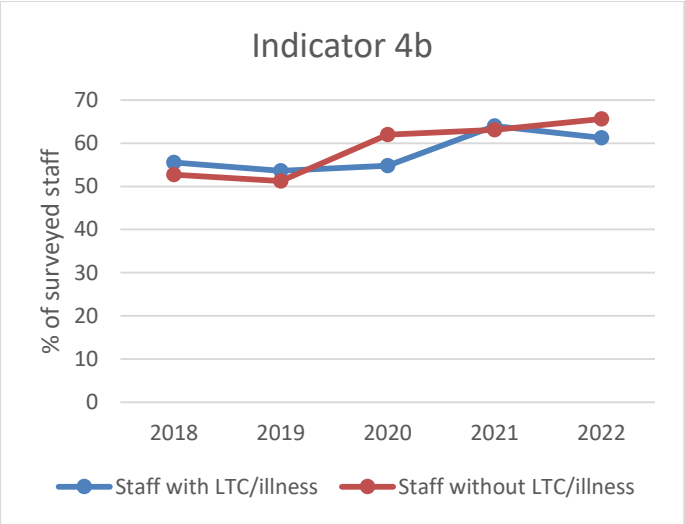
In 2022, the percentage of staff with an LTC was 18% compared to 9.1% of staff without an LTC. The figure for staff with an LTC has slightly increased over time which contrast with a downward trend for staff without an LTC.

Out of the respondents to the staff survey (48% of the total) 79 staff with an LTC reported positively to this question and 84 staff without an LTC.

The Trust figures are lower than those in the benchmarking group.

Indicator 4b

Percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it.



In 2022, the percentage of staff with an LTC was 61.2% compared to 65.6% of staff without an LTC. The figure for both groups has risen steadily and show an upward trend.

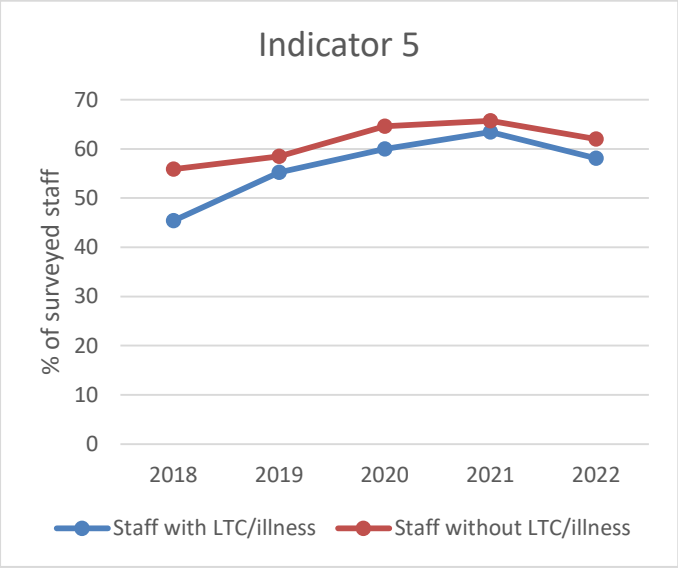
Out of the respondents to the staff survey (48% of the total) 93 staff with an LTC reported positively to this question and 148 staff without an LTC.

The Trust figures are similar to those in the benchmarking group.

In Indicators 4a (i-iii), show that 241 respondents with an LTC reported being bullied, harassed, or abused but out of these, only 152 responded to question 4b so the data in 4b should be read with caution.

Indicator 5

Percentage of staff who believe that their organisation provides equal opportunities for career progression or promotion.

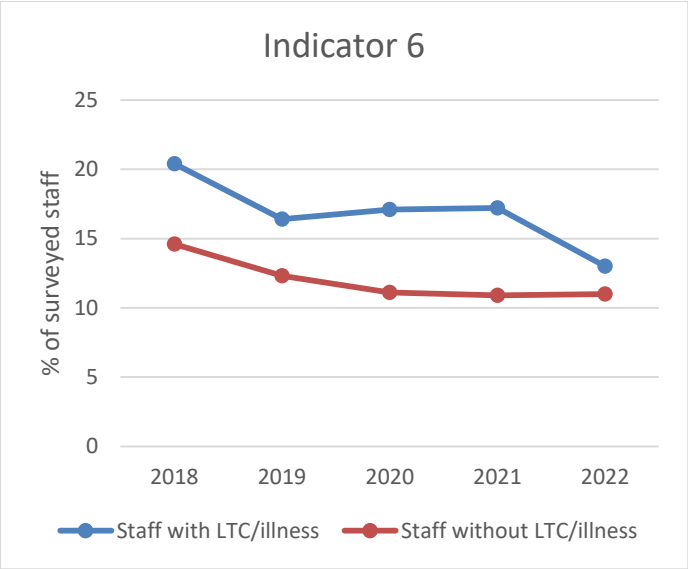


In 2022, the percentage of staff with an LTC was 58.1% compared to 62.0% of staff without an LTC. The figure for both groups has risen steadily and show an upward trend.

The Trust figures are similar to those in the benchmarking group.

Indicator 6

Percentage of staff saying they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.

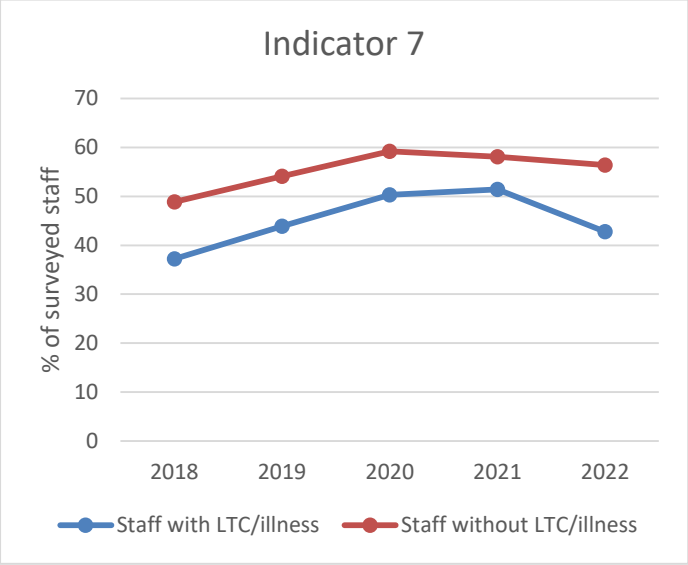


In 2022, the percentage of staff with an LTC was 13.0% compared to 11:0% of staff without an LTC. The figure for both groups have reduced steadily and are reaching parity in a downward trend.

Compared to the benchmarking group, our Trust figures are significantly lower for staff with an LTC and slightly lower for staff without an LTC.

Indicator 7

Percentage of staff saying they are satisfied with the extent to which the organisation values their work.



In 2022, the percentage of staff with an LTC was 42.8% compared to 56.4% of staff without an LTC. The figure for both groups had risen steadily in an upward trend. However, this has reduced significantly for staff with an LTC. Future data will show whether this is an outlier or a more concerning downward trend. The recent downward trend is not shown in the benchmarking group.

The Trust figures are similar overall to those in the benchmarking group.

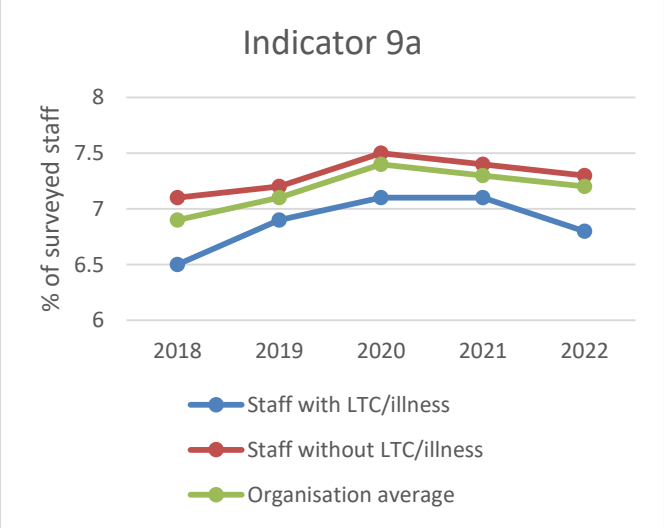
Indicator 8

Percentage of staff with a long-lasting health condition or illness saying their employer has made reasonable adjustments to enable them to carry out their work.

Figures in the staff survey are that 86.1% of staff with an LTC or illness felt that had reasonable adjustments had been made. This compared to a benchmarked figure of 78.8%.

Indicator 9a

Staff engagement score for disabled staff, compared to non-disabled staff.



Indicator 9b

Has your trust taken action to facilitate the voices of disabled staff in your organisation to be heard (Yes/No)

Yes. We have an active staff network DAWN (Disability and Well-being Network) who are supported with resources from the Trust who provide support for their members and are members of the EDI Steering Group.

Indicator 10

Percentage difference between the organisation's Board voting membership and the overall workforce.

This Indicator shows the representation of disabled staff by comparing two figures: the percentage of disabled staff in the organisation, and the percentage of voting membership at the Board, and then working out the difference. In 2023, the percentage difference between the organisation's Board voting membership and its

organisation's overall workforce is 9.29 % (18.18% of Board voting membership declared a disability compared to 8.89% of overall workforce).

Conclusions

The WDES provides NHS trusts with a series of quantitative measures which demonstrate race disparity. WDES data has been collected since 2019 from which we can assess trends over time. We can also draw some conclusions about what is and isn't working to improve disability equality at the Trust.

In common with trusts across NHS England, there is a continuing issue with unrecorded data on the Electronic Staff Record. However, the Trust has made real progress on this in recent years, reducing the number of unknowns across each cluster group. The DAWN staff network has been instrumental in this achievement. While ESR records "disability", the staff survey records staff who have a long-term conditions or illness so there are some difficulties in directly comparing the two groups. However, we can see clearly where the disparities lie in the Trust. On most measures of bullying, harassment and discrimination, staff with a long-term condition or illness are significantly more likely to have negative work experiences than their counterparts. On a positive note, many of the indicators are showing improvements over time although there are some instances of widening disparity.

Analysing numerical WDES data tells us the "what", and we are committed to further investigation into the "why". To maximise the effectiveness of the WDES, the indicator measures and accompanying actions will be an integral part of wider culture transformation at the Trust.

Action Plan

The Action Plan in the 2022 WDES Report was written in consultation with a broad group of colleagues including members of our DAWN staff network. Some of the actions have been completed and others are in progress. The actions relating to culture change are necessarily multi-year actions.

Quarterly oversight of the WDES actions sits with the Equality, Diversity & Inclusion (EDI) Steering Group which is chaired by the Non-Executive Director for EDI. The group brings together colleagues in key corporate roles, with staff networks and representatives. In June 2023, NHS England published its EDI Improvement Plan[5] with six high impact actions, some of which are aligned to the WDES objectives below. The Trust is also undertaking a wide-ranging and comprehensive review into its organisational culture of which WDES will be an integral part.

[5] NHS equality, diversity, and inclusion improvement plan (england.nhs.uk)

Action Area	Activities	Who The EDI Steering Committee will be sighted on all actions and review progress at quarterly meetings.	When	Status
Bullying, Harassment, Abuse and Discrimination	Audit of employee relations cases and training for investigations and complaint handling.	Chief Executive Officer with delegated responsibility to be confirmed. Employee Relations Manager	2023/4	To be commenced.
	Redesign EDI Essentials Training to clearly state what behaviour consists of, how to prevent it, and manage it when it occurs.	EDI Team	March 2024	To be commenced.
	Candidates put forward for the Active Bystander Train-the-Trainer programme.	EDI Team and others (in progress).	October 2023	To be commenced.
Inclusive Recruitment	Broader project including implementing culturally intelligent approaches.	Strategic Recruitment Lead	Ongoing and to continue in 2024.	Ongoing.
	Redesign and roll-out of recruitment and selection training with emphasis on reasonable adjustments.			
Progression and Promotion	Review of Recruitment Inclusion Guardians	Head of EDI Strategic Recruitment Lead	March 2024	To be commenced.
	New policy on Disability Leave and Reasonable Adjustments. Centralised reasonable adjustments budget and process.	Head of EDI	March 2024	In progress
Culture of Inclusion and Belonging	Wide-ranging review of Trust organisational culture to be co-designed with stakeholders across the Trust and tender process for external partner.	Chief Executive Officer with external partner and delegated authority to be confirmed.	2024	To undergo tendering process.

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

Trust Workforce Plan 2023/24

Purpose of Report

The purpose of this report is to provide assurance that the Trust is:

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

The workforce plan is required to enable the delivery of the Making Room for Dignity project and Living Well programme and is a crucial part of the self-assessment process for Workforce Standards.

Executive Summary

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

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

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

Crucial to this investment and the new roles and reshaping/development of services is the cultural transformational change which needs to be embedded in each stage of these developments. Further development of an inclusive culture which creates a sense of belonging for all our people within DHCFT will be our

planned cultural intelligence programme, our work on leadership, culture and behaviours which together will mean that the people in Derbyshire healthcare are delivering high quality care in a way that embraces and celebrates the whole workforce.

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

Risks and Assurances

The developments and actions summarised in the paper evidence how the Trust is aligning the strategic ambitions and plans in line with organisational, regional and national workforce plans.

Consultation

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

This report was received by the People and Culture Committee on 19 September.

Governance or Legal Issues

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

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

Public Sector Equality Duty and Equality Impact Risk Analysis

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

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

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

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

Recommendations

The Board of Directors is requested to:

1) Note this workforce plan and its contents and support the strategic actions outlined above
2) Note that the People and Culture Committee supported the progress of the workplan
3) Note that the People and Culture Committee received limited assurance that the Trust has a workforce plan to support the growth, tracking and workforce challenges for the next 12 months
4) Note that the People and Culture Committee Took limited assurance that the workforce plan will ensure delivery against all workforce requirements for the next 12 months.

Report presented by: **Rebecca Oakley**
Acting Director of People and Inclusion

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

Workforce Plan 2023/24

1.0 Strategic Oversight

This document has been produced to provide the Board, the Trust's Executive Leadership Team, other staff members and our partners with a clear description of the Derbyshire Healthcare NHS Foundation Trust Workforce Plan for 2023/24. The document is intended to provide an update to workforce planning activity within the Trust as part of the annual operational planning round.

The strategic workforce plan reflects the Trusts expected whole time equivalent (wte) by the end of 31st March 2024. The plan takes in account the opening staff in post position as of 31st March 2023 and is then adjusted for expected in year developments (filling of existing vacancies, service developments, cost improvement programmes and workforce transformation). Planned total workforce growth over and above turnover for 2023/24 is 232.13wte.

	Contracted Staff in Post (WTE)		
Staff Group	Outturn Year End 2022/23	Plan Year End 2023/24	Variation
Registered nursing, midwifery and health visiting staff	995.58	1,136.94	141.36
Registered scientific, therapeutic and technical staff	373.88	398.28	24.40
Support to clinical staff	456.56	485.98	29.42
Infrastructure support	685.54	715.21	29.67
Medical and dental	181.12	188.40	7.28
	2,692.68	**2,924.81**	**232.13**

Work also continues to review future service developments for 2023/24 which indicates the Trust will require an additional 60.29 WTE for the new Making Room for Dignity project and an additional 45.10 WTE for the Living Well project.

Existing turnover and vacancies remain a challenge with an overall vacancy rate of 6.59% currently in the Trust and annual turnover of 11.70%, however 110.57wte of planned growth to Staff in Post for 2023/24 has already been achieved between 1 April and 30 September 2023, leaving a gap of 121.56wte still to be recruited over and above turnover to achieve the planned growth target by the end of the financial year.

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

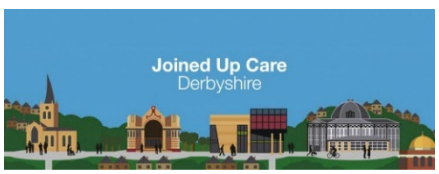
Improved Retention – Filling Vacancies – Reduction in Bank and Agency usage

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

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

2.0 Strategic Forces Impacting on Services and Workforce Planning

Several strategic factors will impact upon the Trust's services and will have workforce implications that will need to be considered. However, some of the workforce implications of these strategic factors are in development and may be subject to change.



Integrated Care Systems (ICSs)

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

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

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

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

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

The NHS Long Term Workforce Plan

The publication of the NHS Long Term Workforce Plan in June 2023 is one of the most seminal moments in the 75-year NHS history. This is the first time the government has asked the NHS to come up with a comprehensive workforce plan; a once-in-a-generation opportunity to put staffing on a sustainable footing and improve patient care. The Plan is ambitious, and it is bold, while being rooted in the reality experienced by patients and staff now, and it is rigorously aligned to the improvements in care that we aspire to make for patients. Even more crucially, it doesn't just herald the start of the biggest recruitment drive in health service history, but also of an ongoing programme of strategic workforce planning – something which is unique amongst other health care systems with national scale.

The strategic direction for the long term, fall into three clear priority areas:

• **Train:** significantly increasing education and training to record levels, as well as increasing apprenticeships and alternative routes into professional roles, to deliver more doctors and dentists, more nurses and midwives, and more of other professional groups, including new roles designed to better meet the changing needs of patients and support the ongoing transformation of care.

TRAIN; We will train over 450,000 healthcare professionals over the next five years. This means that by 2028:

- Medical training places will grow by 33% to 10k a year
- Nurse training places will grow by 34% to 40k a year
- AHP training places will grow by 13% to 17k a year
- Training places for new roles such as nursing associates, advanced care
- practitioners, anaesthesia associates, peer support workers and others will grow by more than 30% to c16k a year
- Pharmacy training places will grow by 29% to 4,300 a year
- Grown the number of support to clinical workers by more than 110,000
- The number of GP training places will grow by 25% to 5k a year

NHS recruitment processes will be reformed to support this growth and ensure NHS organisations support their local job market.

• **Retain:** ensuring that we keep more of the staff we have within the health service by better supporting people throughout their careers, boosting the flexibilities we offer our staff to work in ways that suit them and work for patients, and continuing to improve the culture and leadership across NHS organisations.

RETAIN; Retention improvements can contribute to retaining up to 130,000 more staff in the NHS. To make this a reality, the NHS will need to continue to improve culture, inclusion and ways of working and make the NHS People Promise a reality for everyone. This includes better opportunities for career development, improved flexible working options, alongside government reforms to the pension scheme.

• **Reform:** improving productivity by working and training in different ways, building broader teams with flexible skills, changing education and training to deliver more staff in roles and services where they are needed most, and ensuring staff have the right skills to take advantage of new technology that frees up clinicians' time to care, increases flexibility in deployment and provides the care patients need more effectively and efficiently.

REFORM;

- We will take full advantage of digital and technological innovations, such as Artificial Intelligence (AI), speech recognition, robotic process automation (RPA) and remote monitoring, to provide a more efficient service for staff and patients.
- To ensure patients benefit from a broader range of skilled professionals, we will increase the proportion of new roles from 1% of the workforce in 2022 to 5% by 2036/37.
- We will expand clinical apprenticeships from 7% of training places today to 22% by 2030.
- We will work with universities to improve student experience, reducing leaver rates from courses, and using new technology to prepare people for work in a modern NHS

3.0 Service / Workforce Transformation

In order to better understand the current and future workforce demand and challenge throughout the Trust, the Trust has held two Workforce Summits for our Leaders, one focusing on the NHS Long Term Workforce Plan and one focusing on New Roles.

Reflections from the Workforce Summit

1. New Roles • skill mix - how, where and with what support and funding • training re: new roles / new skills / leadership • planned workshop to bring clarity re: what the new roles are, how they are supported, what they can do what they can't, funding implications etc. • Nursing Associate – how can we tailor to MH competency • Governance framework and assurances • Skill mix e.g. new build - what are required tasks to be delivered and build roles/model	**2. Integrated Team Working** • promote integrated team working around patients • balance to recognise and respect professional identity whilst being more integrated/accepting of new roles/ • broader understanding of skills needed to do different tasks traditionally under the remit of one profession • share good practice • dedicated integrated team development days • clinical leadership important • everyone's business - less siloed working • role specific - chief AHP / medical trainees as pipeline for consultants / preserving professional identify

3. Recruitment
• flexibility of roles, even within role i.e. not just new roles
• innovative recruitment approaches:
  ○ branding videos describing role, team, area of work etc.
  ○ limit number of times same JD is put out - take a different approach or new role if unsuccessful x 2
  ○ revisit one-stop shop recruitment initiatives
  ○ alternative recruitment approaches (not NHS jobs)
  ○ slicker processes from application to arrival
• recognise younger generation have different expectations - need to flex to respond to this
• more clinically led recruitment
• breadth of opportunity - how can do placements differently
• onboarding important for retention
	4. Staff Experience
	• robust induction priority – need for innovation
	• leadership modelled throughout the organisation
	• apply flexile working transparently, with innovation, default to 'yes' with some clear expectations, sharing good practice
	• flexibility can be modelled from above - giving managers flexibility also to innovate
	• wellbeing and resilience comes in all shapes and sizes - flexibility / hybrid working / team development / development opportunities
	• processes and procedures need to be slicker e.g. long term sickness - HWB look at policies and processes

Reflections from the New Roles Summit

Non-Medical Prescribers • Explore opportunities for physiotherapists and other AHPs • Ensure there is a clear contractual arrangement • Consider opportunity for NMP roles in Living Well workforce plan • Matching where there are willing Consultants works well • Skill match to service need **Advanced Clinical Practitioners** • Role is very new in mental health • Area specific needs for each role • Personal scope of practice • Dedicated lead needed as per NMP model • Is/will become a regulated role • Royal Derby provides great training • Trusts overview of all these roles • Link ACPs with qualified NMPs as next stage of development **Multi Professional Approved Clinician** • Only 121 in the country with commitment for 1000 if LT WFP • AC database holds details – Louise has access as lead • Can have a nurse prescriber who is also an AC	• Culture – expectation, flexibility, • Skills sets – build around the needs of the patient • Need the right people to discuss we are the converted • Influence at senior level and develop a strategic approach • Need time for planning and reflection (manage chaos) • How develop this as a system working in collaboration – particularly for training and supervision • There should be a mix of these roles within each team • How can we allocate time for training • How do we meet the supervision requirements • Understanding the skill mix we need and have – what is the gap • Clearly defined job descriptions • Retention and career development opportunities • Triumverate model, team discussion • Business case development, cost vs benefit, options appraisal • Where is the value –budgets • Understanding gaps and alternative roles

The Trust continues to work towards introducing and increasing the number of new roles within services.

Staffing requirements for the Making Room for Dignity Programme (MRfD)

Whilst significant investment in new, modern, and therapeutic mental health inpatient environments will facilitate and enable improvements in service provision, and enhancement of patient experience, increased safety, and patient outcomes, it is our healthcare teams who provide care that will continue to deliver on our Trust's vision: 'To make a positive difference in people's lives by improving health and wellbeing.' In total, 237.67 whole time equivalent staff are being recruited, with additional staff for existing services recruited 3 months before go-live, and new specialist service staff recruited 5 months before go-live. A 'branded' recruitment programme has been developed, in addition to employment and training of student nurses and nursing associates. The table below highlights the expected operational dates, the target dates for staff recruitment, and the total additional workforce needed to ensure the successful launch of these MRfD programme.

Unit Name	Hospital	Bed Capacity	Operational Date	Staff in Post Target	Additional Staff Needed (wte)
Bluebell Ward	Walton Hospital	12-beds	1st August 2024	1st May 2024 (3 months early)	33.58
Derwent Adult Acute Unit	Chesterfield Royal Hospital	54-beds	1st November 2024	1st August 2024 (3 months early)	33.49
Carsington Adult Acute Unit	Kingsway Hospital	54-beds	1st November 2024	1st August 2024 (3 months early)	27.53
Audrey House Enhanced Care Unit	Kingsway Hospital	8-beds	1st November 2024	1st June 2024 (5 months early)	55.86
Kingfisher House PICU	Kingsway Hospital	14-beds	1st March 2025	1st October 2024 (5 months early)	70.88
Radbourne Unit Ward 32	Royal Derby Hospital	17-beds	1st March 2025	1st December 2024 (3 months early)	14.82
Radbourne Unit Ward 35	Royal Derby Hospital	17-beds	1st April 2026	1st January 2026 (3 months early)	1.51

This staffing will be crucial to ensure that each unit operates effectively and with 'safer staffing' levels to provide the necessary care and support to service users.

The early recruitment of staff for these units is a positive step, as it allows for adequate time for training, orientation, and the establishment of effective teams and ensures that the units can open on schedule with limited disruption to servicer user recovery.

Living Well Programme

In February 2020, NHS England published a new Community Mental Health Framework (CMHF), which is a 3 year NHS programme aiming to improve care for people with Severe Mental Illness (SMI). In Derbyshire this new way to offer holistic health and wellbeing support is called 'Living Well Derbyshire'.

Derbyshire Healthcare NHS Foundation Trust, voluntary sector organisations, local authorities, the CCG and those with a lived experience of mental health illness, and their carers, have been working collaboratively to create

transformative new service models for the communities in High Peak and Derby City, which will then be implemented in the remaining localities across the county.

We are currently on year 3 of this programme and moving forward with the recruitment that is needed to complete the programme. In total since 2020 we have recruited to around 166 WTE to support the development of the framework and over the next year plan to recruit to a further 81.1 WTE as a programme, 45.1 WTE specifically for DHCFT.

This staffing will be crucial to ensure that the programme and its community teams operate effectively with safe staffing to ensure a high quality of care to service users.
The recruitment of staff is to be complete by the end of the financial year. To ensure success we have developed a recruitment strategy alongside the recruitment lead to utilise alternative methods.

Role	Additional WTE	HOST
Wellbeing coach	14	Rethink/VCSE
Team Lead	3	DHCFT
CPN	8	DHCFT
Band 6 resource	2.5	DHCFT
CMHT Pharmacist	2.5	DHCFT
Substance Misuse Liaison Worker/ OT?	3	DHCFT
ED Assistant OT	2	DHCFT
ED Peer worker	3	VCSE
Psychiatrist	0.8	DHCFT
Administrator	3	DHCFT
Medical secretary	1	DHCFT
psychologist	1	DHCFT
OT	6	DHCFT
Peer Support	1	Rethink/VCSE
OT Apprentice	5	DHCFT
Employment Specialist	2	DHCFT
Senior Psychologist	1	DHCFT
Psychology assistant	3.5	DHCFT
clinical psychologist	0.8	DHCFT
Community support worker	6	Local Authority
Senior Practitioner	1.5	Local Authority
Dietitian	1	Local Authority
Peer Worker	5	VCSE
Physical Health Worker	3	VCSE
VCSE Manager/ workforce lead	1.5	Rethink/VCSE
Total	**81.1**	

Recruitment update

To support and provide assurance for the recruitment for the ongoing programmes there is an ongoing strategy to ensure success of recruitment into all posts.

A newly appointed Strategic Recruitment Lead has commenced in post for the Trust who will review and further develop the recruitment timeline/strategy for the programmes, which will include a detailed plan for each category of roles and how we will adapt our approach dependant on each role, as and when funding becomes available, in line with the wider programme timescales.

The focus over the next year will be on utilising alternative means of recruiting through social media, websites, promotional advertising and branching out into the community to attract a more diverse range of applicants as part of an inclusive recruitment approach, whilst promoting what the programmes and the organisation have to offer.

This includes the following initiatives:

- Recruitment campaigns for the fast-track Registered Nurse (Band 5) to Lead Nurse (Band 6) programme as part of the unique career development offer that is available by working for the Trust. The development of these posts will enable the Trust to be competitive in a challenging job market.
- Expressions of Interest offered at all recruitment events and websites to collect data from applicants who have expressed an interest in working for the Trust. All applicants will be sent relevant information about a range of jobs available and signposted to current opportunities. All qualified staff will be signposted directly to line managers for fast tracked interviews, should they meet the requirements and there are vacancies in the areas applicants are interested in.

- For specialist and hard to fill roles such as medical Consultants/Staff Grade Doctors applicant packs are being developed along with video adverts from medics currently working in the Trust and the use of paid job board advertisements to support those specific campaigns. Campaigns will be developed, and bespoke strategies will vary depending on the roles recruited to.
- A review of our recruitment approaches for estates and facilities roles will be carried out with the aim of targeting wider promotions within our communities such as the use of job centres.
- Careers events will continue to be held to promote the vacancies currently available at the trust and collecting data for an applicant pool.
- A focus on international recruitment and working with international agencies to recruit Mental Health Nurses and Occupational Therapists into the Trust.
- Recruitment to a Practice Facilitator who will support new international rivals to help them prepare for the Objective Structured Clinical Examination (OSCE).
- Continued engagement with current staff to aid in retention and wellbeing.
- Creation of recruitment packs and, video adverts and paid recruitment campaigns.
- Further engagement with the Universities of Derby, Nottingham and Leicester
- Promotion of the wellbeing offer at all staff engagement events
- Paid collaboration with Indeed Jobs website to ensure our roles are priority
- The Recruitment for the trust and all programmes is a top priority to ensure safe staffing and high quality service user experience and engagement.

Internally to review our current practices we are also looking into:

- Review good practice job descriptions and adverts to ensure they are reflective of the role and attract applicants
- Utilising the iCIMS platform to collect staff stories videos to display our values and qualities as an organisation

Divisional Workforce Plan updates

	New Roles	Supply	Assurance
Older People's Mental Health	• Development of Living Well role	• Clinical apprenticeship pipeline, plan to develop current workforce, recruitment events and review of skill mix, proactive engagement with higher trainees for medical workforce	Making Room for Dignity project group to support recruitment and training.
Acute Assessment Adults of Working Age	• Internal and external apprenticeships for Assistant Practitioners, Registered Nurses, Occupational Therapy and Approved Clinician / Responsible Clinician roles. • Pilot of Approved Clinician / Responsible Clinician roles in Acute and Crisis Resolution Home Treatment Team settings. • Longer term Approved Clinician / Responsible Clinician strategy needed to embed within services going forward.	• Focussed recruitment events for current and Making Room for Dignity projects across Registered Nurses & Allied Health Professional roles. • Skill mix and transformation review to look at Occupational Therapy staffing in/out of numbers. • Making Room for Dignity roadshows and external and internal events, advertising and promotion, comms and international recruitment. • Option to free up staff to train whilst in current non-Psychiatric Intensive Care Unit role for establishment of new ward team (inc. Acute+ and Psychiatric Intensive Care Unit)	Dedicated Making Room for Dignity recruitment role to drive forward.
Community Mental Health Adults of Working Age	• Care Navigators (Living Well)	• Nurse and Occupational Therapist apprenticeships under consideration	Discussions through Clinical & Operational Assurance Team and divisional operational meetings

	New Roles	Supply	Assurance
	• Mental Health Wellbeing Practitioners in recruitment to pilot • Physical Health in Mental Health workers in recruitment for Community Mental Health transformation • Nurse Associate in recruitment process as a new role to increase skill mix. • Approved Clinician / Responsible Clinician in discussion. Job description been developed. Identifying team & funding.	• Non-Medical Prescribers in recruitment with plan to develop from Band 6 to 7 • Mental Health Practitioners currently open to Registered Mental Health Nurses, Occupational Therapists, Learning Disability nurses and Social Workers to increase registered workforce, as difficult to recruit to Registered Mental Health Nurses.	
Neurodevelopment	• Experienced clinical psychology post on ward as per Inpatient Advanced Clinical Practitioners guidance and Quality Network for Learning Disability Services standards and AP time on ward to support assessment and interventions	• Band 6 Allied Health Professional (Speech and Language Therapist/Occupational Therapist/physio) skill-mix taking more band 5s to grow our own – need to consider apprenticeships & international recruitment. • More senior clinical posts to retain highly skilled clinical staff - 2 x Trainee Advanced Clinical Practitioners HoP recruited to for 12 months	
Children's	• Nurse & Allied Health Professional apprenticeship training - limited funds available to support these posts. Particularly in a small service area where there is not the scope within budget to be more flexible regarding roles. • Child and adolescent mental health services Psychiatry – skill mix review alongside medic case load review completed 2022. Increase in appt to Non-Medical Prescribers, Advanced Clinical Practitioners, Specialty Doctors and Approved Clinician / Responsible Clinician roles as a result.	• Health Visitor/School Nurse – workforce development lead • Additional practice educator roles • Skill mix review with 6wte posts to alternative bands and professions. • Call to action local advertising campaign. • Retention package • Children and Young People/Child and adolescent mental health services skill mix review with increased use of engagement workers, band 4 & 5 nursing/Allied Health Professional posts. • Increased the number of Occupational Therapy student placements and technical posts at Band 4 • Increased the number of Physio student placements and technical posts at Band 4	Executive Leadership Team, Clinical & Operational Assurance Team and Trust Operational Oversight Leadership Team
Forensic and Rehabilitation	• Eating Disorders Team still in recruitment through usual channels & considering alternative roles	• Forensic Community Team, Liaison & Diversion - on going recruitment and band 5 to 6 nurse development process in place. Consider skill mix and alternative professions. • New Gambling Service – challenge recruiting Cognitive behavioural	

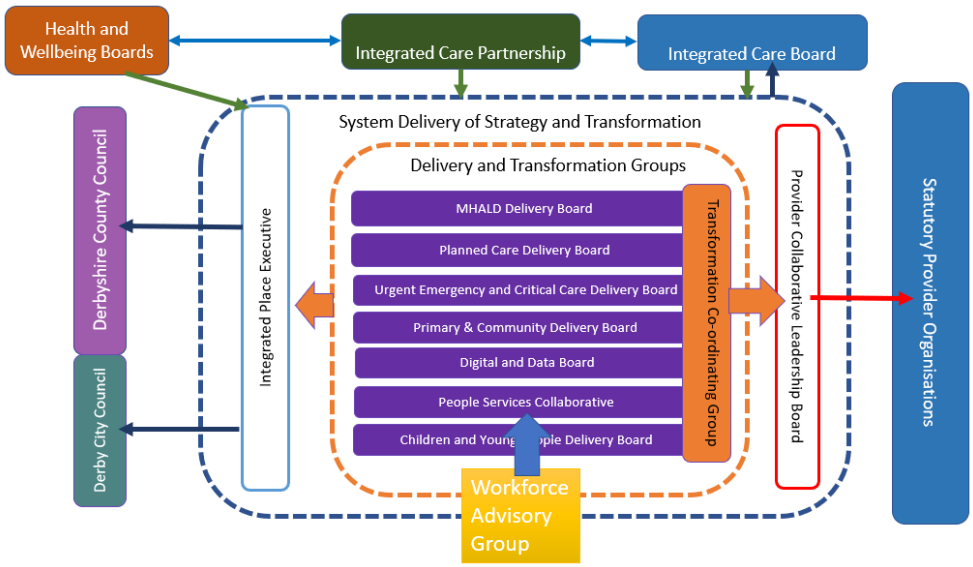
	New Roles	Supply	Assurance
		therapists. Increased banding on 1 Cognitive behavioural therapist post, leaves 1.8 that still requires recruitment. • Dietetics and Physio - looking at activity, difficult to recruit to mental health dietetics and physio. Commenced growing own in Physio work underway to do the same in Dietetics	
Pharmacy		• Pharmacy Support Workers - route into Pharmacy Technician training (PTPT). Established competency-based Band 2 to Band 3 pathway with good completion rate. • Specialist Mental Health Pharmacists - fund post-graduate Mental Health pharmacy qualifications for pharmacists & support independent prescribing qualifications. Established Band 6 to Band 7 competence-based pathway to support less experienced pharmacists to be able to practice as specialist mental health pharmacists. • Trainees – supporting pre-reg and undergraduate trainees and development of an Integrated Care System CoP • Retention – adopted hybrid working including working from home days. • Pharmacy Technicians - resumed a training/ apprentice pathway for Pre-registration Trainee Pharmacy Technicians	
Allied Health Professionals	• Explore opportunity for a dedicated Chief Allied Health Professional role. • Creation of Task and finish group for Advanced Clinical Practitioners in discussion at Allied Health Professional council. • Embedded speech and language therapy representation in adults of Working age.	• Plan for Allied Health Professional apprenticeships but challenge regarding backfill costs. • International recruitment ongoing but at small scale • Improve retention - Face to face stay conversations for new recruits at 9 and 14 months. Supporting the operationalisation of exit interview for all staff leaving roles to identify any common themes	
Division of Psychology and Psychological Therapies	• New structure with completed skill mix now finalised and in place • CBT therapists as part of CMHTs • Use of a range of psychological therapy training across the landscape and profession	• Divisional vacancies around 7% (lower than nationally and regionally) • New 0.4 consultant psychologist funded by Universities of Nottingham & Lincoln (Doctorate in Clinical Psychology). • Increased number of trainees employed by the	Recruitment issues highlighted through COAT and CRG All trainee MPACs on trajectory to complete and register as an approved clinician Manager's Monthly Update provided monthly for review for each service

	New Roles	Supply	Assurance
	• Assistant Psychologists delivering group work into the living well • Multi Professional Approved Clinicians: 6 current trainees 4 will likely be approved by the spring and the other two end of 24 beginning of 25 (nurses and Psychologists). One more MAPC training post agreed to come on line in the spring. • Employing counselling psychologists in areas where their skills are beneficial	trust: 16 across 3 year groups – aim to recruit straight from training • Hosting more trainees from other areas including the Maudsley • Themes re leavers relate to NHS working, not the Trust / division • Issues with recruiting staff through subcontractors in talking mental health	

	Increase in clinical contracted staff in post April to September 2023	Vacancy rate September 2023
Older People's Mental Health	9.22	5.51%
Adult Care Acute	14.59	8.72%
Adult Care Acute - Adult Urgent Assessment Only	3.89	
Community MH Adults of Working Age	25.4	2.83%
Neurodevelopment	8.19	3.75%
Children's	3.7	6.73%
Forensic and Rehabilitation/Specialist Services	10.03	7.61%
Pharmacy	6.04	0.00%

Workforce planning and workforce transformation governance

The Derby & Derbyshire Integrated Care System (ICS) Architecture/Governance for workforce planning is described below.



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

- Standardising pay rates /agreements for employment.
- Training offer – standardising courses / gaining economies of scale on delivery.
- Workforce needs – looking at roles and responsibilities.

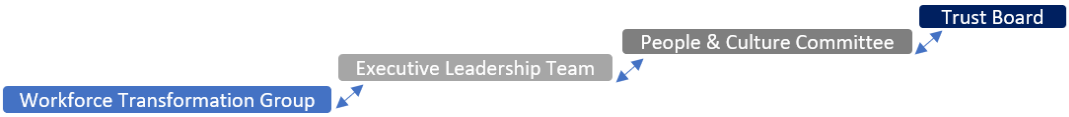
- Focus on retention – looking at cross organisational career paths and support options, need to look at culture of working and embedding psychological safety within workplace.
- Using cross organisational working / placements to support breaking down of organisational ego and increasing understanding of pressures and demands.
- Making the best use of a joint workforce

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

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

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

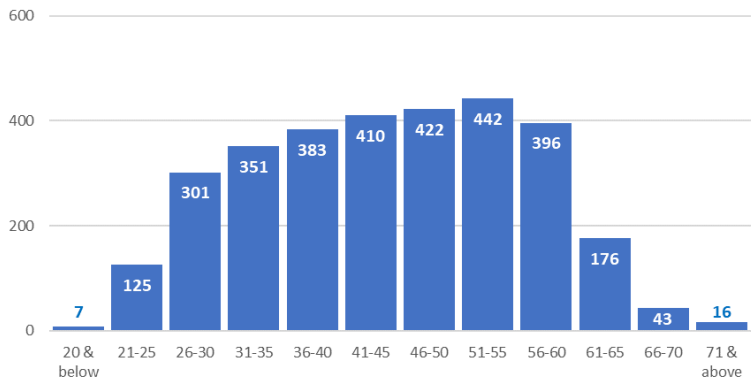
The Trusts Architecture/Governance for workforce planning is described below.

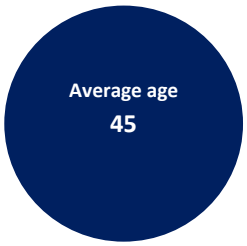


The Workforce Transformation Group membership has representatives from all service areas and clinical staff groups.

4.0 Trust Workforce Profile

DHCFT Workforce Age Profile

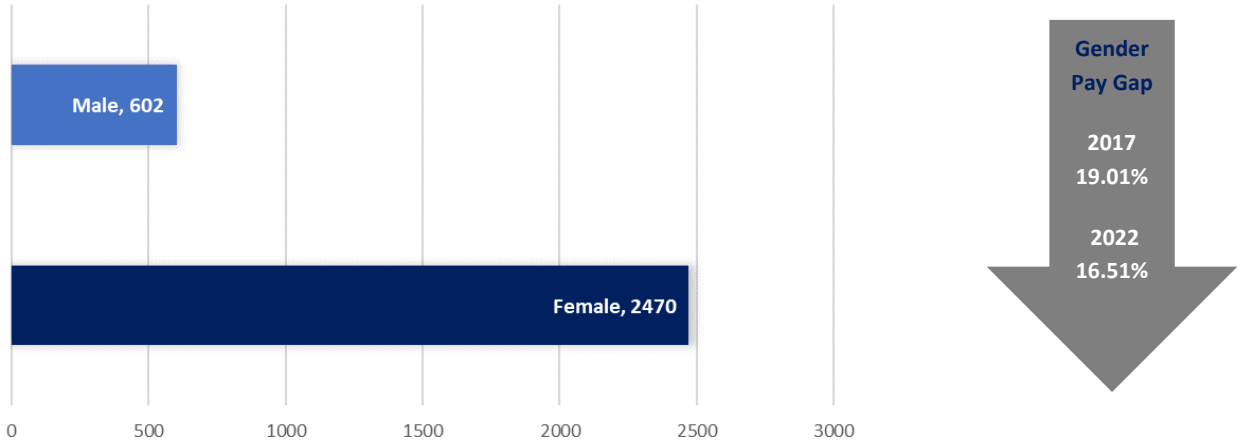




The average age within the Trust is 45 years of age and this has remained the same for many years. The data shows that 34.93% of the workforce are aged 51 or above, with only 4.30% of the workforce below the age of 25. The opportunity for retirement at age 55 with special class status for many staff, poses additional risk to workforce supply against demand in clinical roles. Analysis of the nursing workforce highlights that 32.01% of staff are aged 51 and over, with 29.75% of medical staff falling within this age range. Allied Health Professional workforce highlights 21.56% of staff are aged 51 and over, Additional Professional Scientific and Therapeutic staff (this includes psychologists and social workers) 30.62% and 32.58% Additional Clinical Services (clinical support staff) are aged 51 and over.

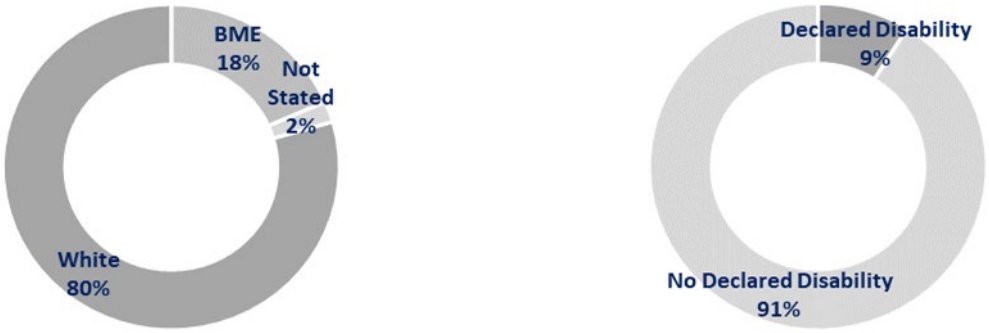
The average retirement age over the past 12 months was 60 years and 10 months. The average retirement age for Nursing staff was 58, for medical staff 61, Allied Health Professionals 64, Additional Professional Scientific and Therapeutic staff 65 and for Clinical Support Staff it was 63. Retention of specialist skills and knowledge within these key staff groups will be a priority moving forwards as well as attracting, developing, and retaining the workforce of the future. Workforce development strategies including role redesign, development of new roles and apprenticeships will be key for workforce supply to meet demand now and in the future.

DHCFT Workforce Gender Profile



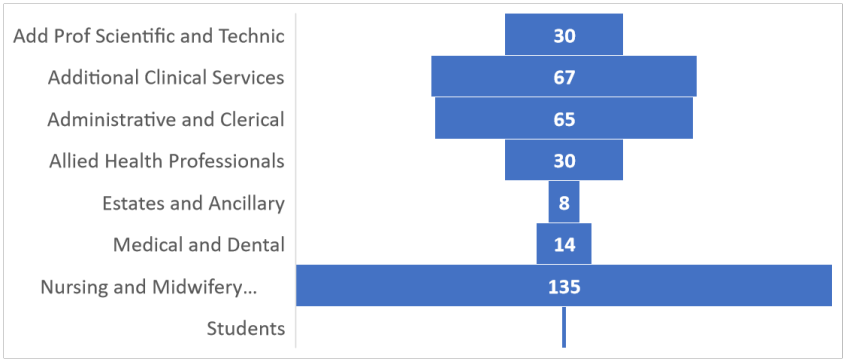
We currently employ 3072 people (contracted staff in post) of which 20% are male and 80% female. This is a similar position to the NHS as a whole, currently 23% male and 77% female. The latest Gender Pay Gap (GPG) submission for the Trust reported a GPG of 16.51% based on the average hourly rate, down from 19.01% in 2017 when the GPG reporting was launched nationally. Work continues within the Trust to reduce the gap further through our Equality, Diversity and Inclusion (EDI) team, staff, managers, union and professional body representatives and partners.

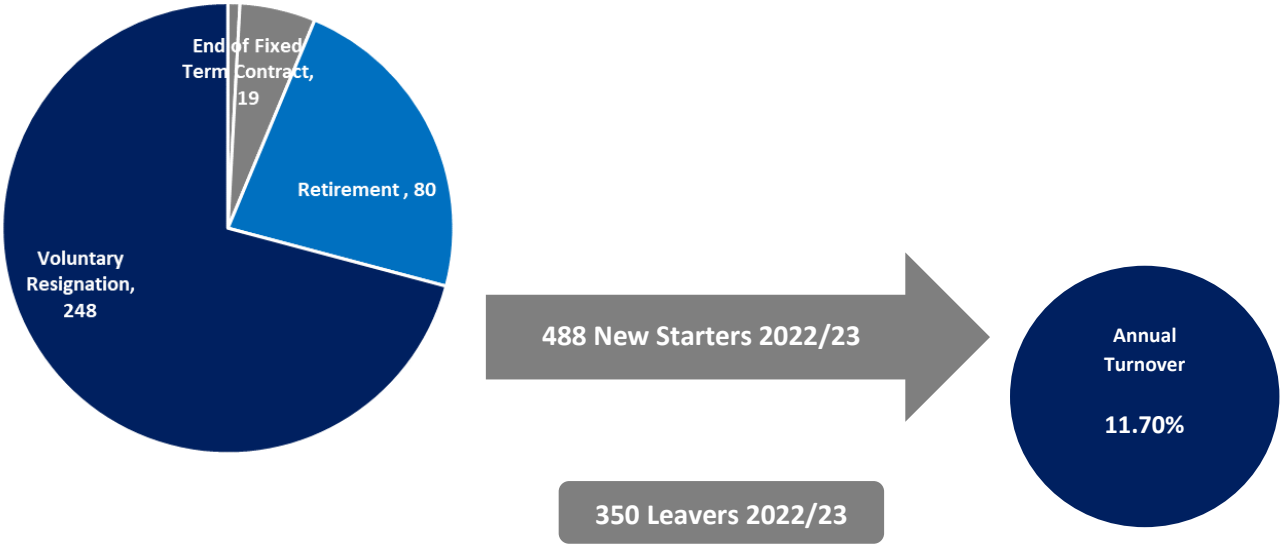
DHCFT Workforce Ethnicity and Disability Profile



Our current workforce ethnicity is made up of 80% white, 18% BME and 2% recorded as not stated. Comparted to 2017, we have seen a 6% increase in our BME workforce from 12% to 18%. Our current workforce declaring a disability is 9%. Compared to 2017 we have seen a 4% increase in staff declaring a disability from 5% to 9%. Improved data quality through the recruitment process and employees updating their personal information on the Electronic Staff Record (ESR), along with the initiatives like the introduction of the Inclusion Guardian in the Recruitment process have all played a key role.

DHCFT Workforce Leavers Profile





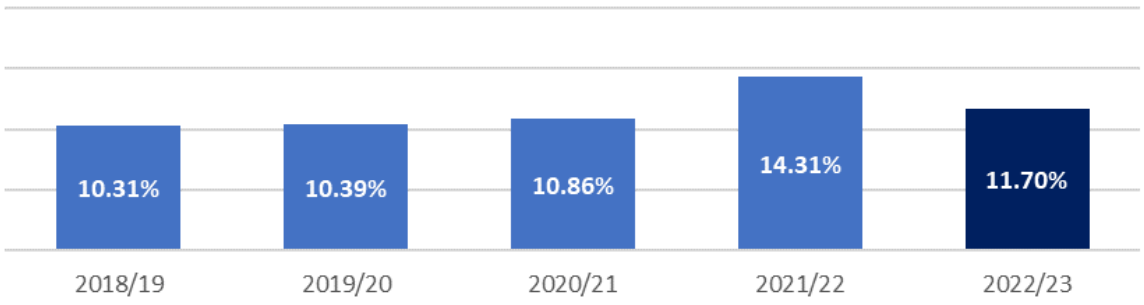
During 2022/23 we welcomed 488 new starters into the Trust through external recruitment and we saw 350 staff leave the Trust, of which 23% retired. Analysis of leaver data shows that 18% of staff leave within their first year of employment with the Trust, 15% between 1 and 2 years, 11% between 2 to 3 years, 7% between 3 to 4 years and 49% with more than 4 years' service.

Reviewing 'Voluntary Resignation' reason for leaving, 'Other/Not known' represented 17% of all leavers, followed by 16% for 'Work Life Balance', 14% for 'Promotion', 9% for 'Relocation' and 7% 'To undertake further education or training'.

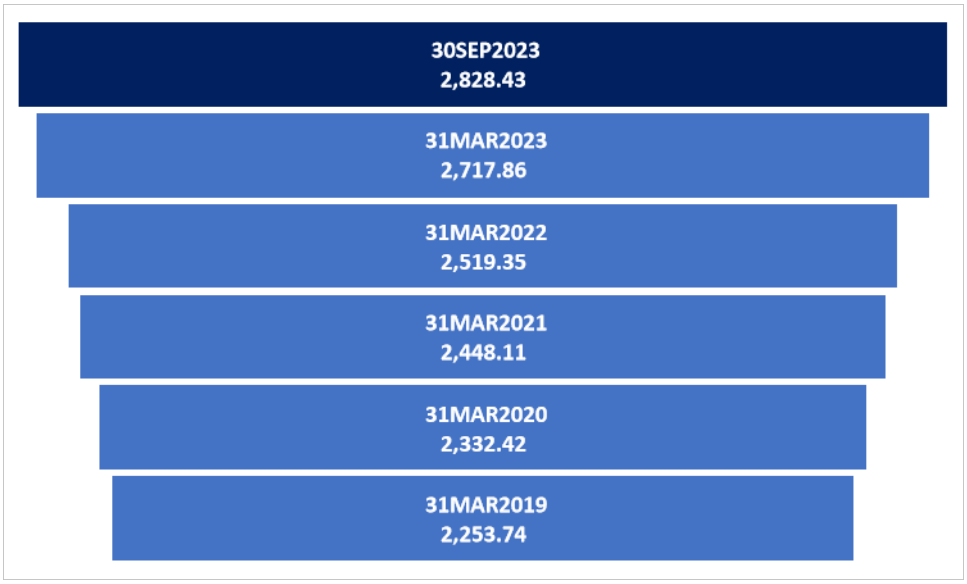
Annual turnover within the Trust is running at 11.70%, which is 2.61% lower than in the previous year. The highest level of turnover is within the Allied Health Professionals staff group running at 14.23%, followed by Additional Clinical Services (Clinical Support Staff) at 13.50% and Nursing & Midwifery Registered 12.38%.

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

DHCFT Workforce Supply (Turnover and Growth)



Annual turnover rates for the Trust remain below the National MH & LD average of 13.84% and below the East Midlands MH & LD average of 12.23% for 2022/23. Historical turnover rates have run at around 10% and following a period of delayed natural turnover and in particular retirements during the pandemic, turnover rates are now returning to pre pandemic levels. By continuing to improve our retention rates we hope to help our workforce supply by reducing the number of staff we need to recruit to maintain existing staffing levels.



WTE Variation 31MAR2023 v 30SEP2023
110.57

WTE Variation 31MAR2019 v 31MAR2023
464.12

Contracted staff in post increased by 464.12 whole time equivalents (wte) during the period March 2019 to March 2023, representing workforce growth of 20.59% over and above turnover. The Trust continues to see an increase in contracted staff in post over and above turnover at 110.57wte (4.07% growth) for the period 1 April to 30 September 2023 which means we have delivered 48% of the planned workforce growth of 232.13wte for this financial year. The increase in 2023/24 contracted staff in post so far, includes 67.78 wte clinical posts and 19.91 wte clinical support posts. Trust vacancy rates continue to decrease, from 10.46% in April 2023 to 6.59% in September 2023.

Further work continues over and above traditional recruitment to maximise all workforce supply routes to cover turnover and close the gap on vacancies by the end of the financial year. This work includes 3 Nurses and 3 Specialty Doctors from oversees recruitment, 2 nurses on a return to practice programme, 5 Health Visitor preceptees, 2 School Nurse preceptees, 31 Apprenticeships (covering Trainee Nurse Associates, Mental Health Top Up programme and Allied Health Professionals) and a further 11 support role apprenticeships. There are also a further 125 preceptees, 95 in Nursing and 25 in the Allied Health Profession, on track for completion by the end of the financial year.

5.0 Challenges and Risks

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

- National shortage of key occupations
- Future commissions of key posts insufficient for current and expected demand
- Meeting the financial challenge

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

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

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

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

he main risk that we carry is around workforce supply which is echoed across the ICS. The existing demand on supply pipelines has increased, staff turnover remains high, in particular an increase in the number of retirements, and an aging workforce. Post Covid the Trust experienced higher levels of turnover and sickness absence than pre Covid, however we are now seeing a downward trend in both metrics.

There are also risks associated with the workforce for the Making Room for Dignity and Living Well transformation programmes due to the scale of additional workforce needed, these include:

- Unable to grow the workforce if existing vacancies are not filled before the recruitment of additional staff
- Safe staffing numbers resourced by the ICB through the business cases is not achieved
- Understaffing due to difficulty recruiting qualified staff in specialty areas
- Loss of experienced staff during transition to new hospital
- Lack of experienced staff / mentors to support the high number of newly qualified staff
- Insufficiently skilled/trained workforce due to a lack of staff training pre-opening

These risks are managed through the programme governance structures with agreed mitigating actions and identified risk owners.

6.0 Strategic Actions

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

Looking after our people

The staff at Derbyshire Healthcare are able to access a wide range of health and wellbeing opportunities to support the maintenance and improvement of wellbeing and also support when additional support is required. Opportunities include all aspects of health and wellbeing such as physical and lifestyle, emotional and psychological, financial, social, occupational and intellectual and team wellbeing.

During 2022 Derbyshire Healthcare, along with partnership organisations across Joined up Care Derbyshire, participated in the Britain's Healthiest Workplace (BHW) Survey which provided much needed data about the health of our colleagues. As anticipated, awareness of the wellbeing offer was challenged, with only 26% of employees being aware of all of the interventions available to them. However, 90% of employees who accessed those interventions reported improved health and wellbeing. To improve awareness, we have introduced a new mailing list to provide regular wellbeing updates. We have also begun work in collaboration with People's Services to identify teams who scored poorly in the NHS staff survey in response to the question 'My organisation takes positive action on health and wellbeing'. Teams will be provided with wellbeing information and encouraged to identify a wellbeing champion in their area.

In 2023 the first 'Your wellbeing survey' was launched, to build on the work started with the BHW survey to further understand the health needs of our workforce and we are awaiting the results.

This year will focus on raising awareness of the JUCD 'Your wellbeing timetable' a one stop shop that hosts a multitude of wellbeing opportunities, delivered by all the organisations within the ICB. Since January 2023, 652 sessions have been attended by Derbyshire Healthcare colleagues.

With stress continuing to be the primary reason for absence, alongside existing wellbeing support we have scheduled a number of sessions including a stress workshop, stress HIIT sessions and healthy working. To ensure that our sessions are as inclusive as possible we have recently introduced a booking form which gathers important role and demographic data so we may look to target groups who do not access those wellbeing opportunities.

The Resolve service continues to provide a vital service to colleagues, having received over 207 referrals between April 2022 and March 2023, with 100% of staff rating the service they received as good or excellent. The Resolve service also deliver team sessions when there may have been distressing or untoward events with twenty-seven sessions being delivered throughout the year.

Belonging in the NHS

Belonging in the NHS is one of the four pillars of the NHS People Plan. Together with our commitment to create a compassionate and inclusive culture in the NHS People Promise, the Trust is committed to making this a felt reality for everyone in our organisation. Equality, Diversity & Inclusion (EDI) sits at the heart of this approach for the benefit of our patients, local community, colleagues, and the people who we hope will join us for their future career.

Our Staff Survey results, and Workforce Race and Disability Equality Standard (WRES and WDES) reports show areas of positive progress in developing a workforce which is more representative of our local community, and this includes diversity in the most senior leadership level at the Trust. However, like other NHS Trusts, there have been persistent challenges in bullying, harassment and discrimination, and in equitable opportunities for career

progression. Tackling inequality and creating an environment in which all our people can thrive is essential to creating a great place to work and to receive care.

As a public sector organisation, we are committed to the objectives in the Public Sector Equality Duty to:

- Eliminate discrimination, harassment and victimisation
- Advance equality of opportunity
- Foster good relations between people

In 2023/24, the Trust is embarking on a wide-ranging review of organisational culture which will highlight areas where unfairness occurs and why and develop targeted actions to address them, as well as areas of good practice to build on. In addition, the Trust will be working towards the 6 High Impact Actions in the NHS England EDI Improvement Plan. The actions in the WRES and WDES reports this year have been brought together into four main areas to improve our culture and benefit everyone who works with us:

- Creating and sustaining a culture of inclusion and belonging
- Addressing bullying, harassment, abuse, and discrimination
- Inclusive recruitment
- Career progression and promotion

This work takes place within the legal framework of the Equality Act 2010 and national NHS guidance and, importantly, with our colleagues' voices and experiences at the heart of the process.

New ways of working

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

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

Growing for the future

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

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

7.0 Recommendations

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

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

Trust Seal report

Purpose of Report

This report provides the Trust Board with a six month update of the authorised use of the Trust Seal since the last report to the Board on 9 May 2023.

Executive Summary

The Trust's Standing Financial Instructions (point 8.18) state that every contract which exceeds £500,000 shall be executed under the Common seal of the Trust and be signed by the Trust Secretary and an Executive Director (voting or non-voting) duly authorised by the Chief Executive and not from the originating department.

These transactions will apply where the Board has previously approved the business through the Capital Expenditure Plan or the Estates Strategy. In accordance with the Standing Orders of the Board (section 12 point 6) a report of all sealing shall be made to the Trust Board twice a year. The report will contain details of the seal number, the description of the document and date of sealing. The register will be retained by the Trust Secretary.

A report on use of the seal was last made to the Board on 9 May 2023. Since the last report, the Trust Seal was used as follows (where the contract value for these transactions exceeded £500,000 or where the nature of the transaction required a seal, ordinarily property transactions such as deeds or leases):

- DHCFT98 (25 April 2023) Contract financial allocation 2022/23. Derbyshire liaison and diversion pathway MHTR
  (1) NHS England
  (2) Derbyshire Healthcare NHS FT
- DHCFT99 (28 April 2023) Lease of Oakwood Children's Centre, Springwood Drive, Oakwood, Derby, DE21 2RQ
  (1) Derby City Council
  (2) Derbyshire Healthcare NHS FT
- DHCFT100 (13 May 2023) Contract for provision of public health services – Derby Integrated Drug and Alcohol Treatment and Recovery system
- DHCFT101 (27 July 2023) Contract variation – CV01-P3
  (1) Derbyshire Healthcare NHS FT
  (2) P3
- DHCFT102 (16 October 2023) Contract for the provision of Adult Integrated Drug and Alcohol Treatment and Recovery services
  (1) Derbyshire County Council
  (2) Derbyshire Healthcare NHS FT
- DHCFT103 (27 October 2023) P22 FA Template A_0181 Major Work Project – Stage 4 Contract Design and Refurbishment of Adult Acute Facilities Inpatients (Ward 32) Radbourne Unit, Derby, between:
  (1) Kier Infrastructure and
  (2) Derbyshire Healthcare NHS FT

- DHCFT104 (31 October 2023) Contract variation – CV02 - DCHS Psychological Therapies Service Specification – North County
  (1) Derbyshire Healthcare NHS FT
  (2) Derbyshire Community Health Services NHS FT

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

Assurances

Use of the Trust Seal has been undertaken in accordance with the Standing Financial Instructions and Standing Orders of the Board of Directors.

Consultation

N/A

Governance or Legal Issues

The affixing of the seal is consistent with the Board's responsibilities outlined within the Standing Financial Instructions and Standing Orders of the Board of Directors.

Public Sector Equality Duty and Equality Impact Risk Analysis

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

There is no direct impact on those with protected characteristics arising from this report.

Recommendations

The Board of Directors is requested to note the authorised use of the Trust Seal since the last report to the Board on 9 May 2023 and receive full assurance that this has been undertaken in accordance with the Standing Financial Instructions and Standing Orders of the Board of Directors.

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

Report prepared by: **Sue Turner**
Board Secretary

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

Report from the Council of Governors meeting

The Council of Governors has met once since the last report, on 5 September 2023, and the meeting was conducted as a hybrid meeting.

Chief Executive's update
On behalf of the Chief Executive who was unable to attend the meeting, the Director of Strategy, Partnerships and Transformation gave an update on current issues affecting the Trust. Areas covered included:

- The Trust's financial position
- The management of the consultant and junior doctors industrial action
- Trust accolades
- The Lucy Letby case and NHS England's immediate recommendations
- The Trust has undertaken considerable work to improve its response and support to people in communities with dementia and diagnosis of dementia and has surpassed the national target for this.

Presentation of the Annual Report and Accounts 2022/23 and report from the external auditors
The Interim Director of Finance presented the Annual Report and Accounts 2022/23 and confirmed that they will also be presented, consistent with financial reporting, at the Annual Members Meeting on 20 September 2023.

The representative from the Trust's external auditors, Mazars provided a summary of the positive annual report letter and outlined their responsibilities as follows:

- Give an opinion on the Trust's financial statements
- Assess the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources (the value for money conclusion).

The representative from Mazars confirmed that the audit was completed by the deadline and that they had not identified any significant weaknesses which would require further work or wider reporting.

Extension of External Audit Contract
The Council of Governors approved the recommendation from the Trust's Audit and Risk Committee to extend the contract with Mazars for a further two years.

Non-Executive Directors Report
One of the Non-Executive Directors (NEDs) presented their overview reports on their role and activities at the Trust and within the Joined Up Care Derbyshire system.

Escalation Items to the Council Of Governors from the Governance Committee
Governors received a response to a holding to account question to the NEDs around the Trust's wellbeing support for keeping our staff well. Assurance was given that staff are accessing the wellbeing support available to them.

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

Annual Members Meeting update
The Membership and Involvement Manager gave an overview of the plans for the Annual Members Meeting which is taking place on 20 September. This included an outline of the programme.

Governance Committee Report
The Committee Chair presented a report of the meetings held on 8 June and 8 August 2023.

Governor Membership Engagement Action Plan update
Governors reviewed the Action Plan and noted the progress made.

RECOMMENDATION
The Trust Board is asked to note the summary report from the Council of Governors meeting held on 5 September 2023.

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Term / Abbreviation	**Terms in Full**
A	
A&E	Accident & Emergency
ACCT	Assessment, Care in Custody & Teamwork
ACE	Adverse Childhood Experiences
ADHD	Attention Deficit Hyperactivity Disorder
AfC	Agenda for Change
AHP	Allied Health Professional
AIMS	Royal College of Psychiatrists Accreditation for Inpatient Mental Health Services Standards
ALB	Arms-length body such as NHS Improvement (NHSI) and NHS England (NHSE)
AMM	Annual Members' Meeting
AMHP	Approved Mental Health Professional
ANP	Advanced Nurse Practitioner
AO	Accountable Officer
ASD	Autism Spectrum Disorder
ASM	Area Service Manager
B	
BAF	Board Assurance Framework
BLS	Basic Life Support (ILS Immediate Life Support)
BMA	British Medical Association
BME	Black,& Minority Ethnic group
BoD	Board of Directors
C	
CAMHS	Child and Adolescent Mental Health Services
CASSH	Care and Support Specialised Housing
CBT	Cognitive Behavioural Therapy
CCG	Clinical Commissioning Group (defunct from 1 July 2022)
CCT	Community Care Team
CDMI	Clinical Digital Maturity Index
CE	Chief Executive
CEO	Chief Executive Officer
CGA	Comprehensive Geriatric Assessment
CHPPD	Care Hours Per Patient Day
CIP	Cost Improvement Programme
CMDG	Contract Management Delivery Group
CMHF	Community Mental Health Framework
CMHT	Community Mental Health Team
CNST	Clinical Negligence Scheme for Trusts
COAT	Clinical Operational Assurance Team
COF	Commissioning Outcomes Framework
CoG	Council of Governors
COO	Chief Operating Officer
CPA	Care Programme Approach
CPD	Continuing Professional Development
CPN	Community Psychiatric Nurse
CPR	Child Protection Register

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Term / Abbreviation	**Terms in Full**
CQC	Care Quality Commission
CQI	Clinical Quality Indicator
CQUIN	Commissioning for Quality and Innovation
CRG	Clinical Reference Group
CRH	Chesterfield Royal Hospital
CRHT	Crisis resolution and home treatment
CRS	(NHS) Care Records Service
CRS	Commissioner Requested Services
CSF	Commissioner Sustainability Fund
CTO	Community Treatment Order
CTR	Care and Treatment Review
D	
DAR	Divisional Assurance Review
DAT	Drug Action Team
Datix	Trust's electronic incident reporting system of an event that causes a loss, injury or a near miss to a patient, staff or others
DBS	Disclosure and Barring Service
DBT	Dialectical Behavioural Therapy
DfE	Department for Education
DCHS	Derbyshire Community Health Services NHS Foundation Trust
DDCCG	Derby and Derbyshire Clinical Commissioning Group
DHCFT	Derbyshire Healthcare NHS Foundation Trust
DIT	Dynamic Interpersonal Therapy
DNA	Did Not Attend
DoH	Department of Health
DoLS	Deprivation of Liberty Safeguards
DRRT	Dementia Rapid Response Team
DSPT	Director of Strategy, Partnerships and Transformation
DOF	Director of Finance
DON	Director of Nursing
DPI	Director of People and Inclusion
DPS	Date Protection and Security
DNA	Did not attend
DPA	Data Protection Act
DRRT	Dementia Rapid Response Team
DTOC	Delayed Transfer of Care
DVA	Derbyshire Voluntary Action (formerly North Derbyshire Voluntary Action)
DWP	Department for Work and Pensions
E	
ECT	Enhanced Care Team
ECW	Enhanced Care Ward
ED	Emergency Department
EDS2	Equality Delivery System 2
EHIC	European Health Insurance Card
EHR	Electronic Health Record
EI	Early Intervention
EIA	Equality Impact Assessment
EIP	Early Intervention In Psychosis

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Term / Abbreviation	**Terms in Full**
ELT	Executive Leadership Team
EMDR	Eye Movement Desensitising and Reprocessing Therapy
EMR	Electronic Medical Record
EPMA	Electronic Prescribing and Medicine Administration
EPR	Electronic Patient Record
ERIC	Estates Return Information Collection
ESR	Electronic Staff Record
EUPD	Emotionally Unstable Personality Disorder
EWTD	European Working Time Directive
F	
FBC	Full Business Case
FFT	Friends and Family Test
FOI	Freedom of Information
FSR	Full Service Record
FT	Foundation Trust
FTE	Full-time Equivalent
FTN	Foundation Trust Network
FTSU	Freedom to Speak Up
FTSUG	Freedom to Speak Up Guardian
F&P	Finance and Performance
5YFV	Five Year Forward View
G	
GDPR	General Data Protection Regulation
GGI	Good Governance Institute
GIRFT	Getting it Right First Time
GMC	General Medical Council
GP	General Practitioner
GPFV	General Practice Forward View
H	
HCA	Healthcare Assistant
H1	First half of a fiscal year (April through September)
H2	Second half of a fiscal year (October through the following March)
HEE	Health Education England
HES	Hospital Episode Statistics
HoNOS	Health of the Nation Outcome Scores
HSCIC	Health and Social Care Information Centre
HSE	Health and Safety Executive
HWB	Health and Wellbeing Board
I	
IAPT	Improving Access to Psychological Therapies
Icare	Increase Confidence, Attract, Retain, Educate
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

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Term / Abbreviation	**Terms in Full**
ILS	Immediate Life Support (BLS – Basic Life Support)
IMT	Incident Management Team
IM&T	Information Management and Technology
IRHTT	In-reach Home Treatment Team
IPP	Imprisonment for Public Protection
IPR	Integrated Performance Report
IPT	Interpersonal Psychotherapy
J	
JNCC	Joint Negotiating Consultative Committee
JTAI	Joint Targeted Area Inspections
JUCB	Joined Up Care Board
JUCD	Joined Up Care Derbyshire
K	
KLOE	Key Lines of Enquiry (CQC)
KPI	Key Performance Indicator
KSF	Knowledge and Skills Framework
L	
LA	Local Authority
LCFS	Local Counter Fraud Specialist
LD	Learning Disabilities
LD/A	Learning Disability and Autism
LHP	Local Health Plan
LHWB	Local Health and Wellbeing Board
LOS	Length of Stay
LPS	Liberty Protection Safeguards
LTP	Long Term Plan
M	
MADE	Multi-agency Discharge Event
MARS	Mutually Agreed Resignation Scheme
MAU	Medical Assessment Unit
MAS	Memory Assessment Service
MAPPA	Multi-agency Public Protection Arrangements
MARAC	Multi-agency Risk Assessment Conference (meeting where information is shared on the highest risk domestic abuse cases between representatives of local police, probation, health, child protection, housing practitioners, Independent Domestic Violence Advisors (IDVAs) and other specialists from the statutory and voluntary sectors.
MASH	Multi-Agency Safeguarding Hub
MCA	Mental Capacity Act
MD	Medical Director
MDA	Medical Device Alert
MDM	Multi-Disciplinary Meeting
MDT	Multi-Disciplinary Team
MFF	Market Forces Factor
MHA	Mental Health Act
MHAC	Mental Health Act Committee
MHIN	Mental Health Intelligence Network

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Term / Abbreviation	**Terms in Full**
MHIS	Mental Health Investment Standard
MHLT	Mental Health Liaison Team
MHRT	Mental Health Review Tribunal
MSC	Medical Staff Committee
MSK	Musculoskeletal (conditions)
MSU	Medium secure unit
N	
NCRS	National Cancer Registration Service
NED	Non-Executive Director
NICE	National Institute for Health and Care Excellence
NHS	National Health Service
NHSE	National Health Service England
NHSI	National Health Service Improvement
NHSEI	NHS England and NHS Improvement
NIHR	National Institute for Health Research
O	
OBC	Outline Business Case
ODG	Operational Delivery Group
OOA	Outside of Area
OPMO	Older People's Mental Health Services
OP	Outpatient
OSC	Overview and Scrutiny Committee
OT	Occupational therapy
P	
PAB	Programme Assurance Board
PAG	Programme Advisory Group
PALS	Patient Advice and Liaison Service
PAM	Payment Activity Matrix
PARC	Psychosis and the reduction of cannabis (and other drugs)
PARIS	This is an electronic patient record system
PbR	Payment by Results
PCC	Police & Crime Commissioner
PCC	People and Culture Committee
PCN	Primary Care Networks
PDSA	Plan, Do, Study, Act
PHE	Public Health England
PICU	Psychiatric Intensive Care Unit
PID	Project Initiation Document
PiPoT	People in Positions of Trust
PLIC	Patient Level Information Costs
PMLD	Profound and Multiple Disability
PPE	Personal Protection Equipment
PPI	Patient and Public Involvement
PPT	Partnership and Pathway Team
PREM	Patient Reported Experience Measure
PROMS	Patient Reported Outcome Measure
PSF	Provider Sustainability Fund
PSIRF	Patient Safety Incident Review Framework

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Term / Abbreviation	**Terms in Full**
Q	
QAG	Quality Assurance Group
Q&SC	Quality and Safeguarding Committee
QIA	Quality Impact Assessment
QIPP	Quality, Innovation, Productivity Programme
R	
RAID	Rapid Assessment, Interface and Discharge
RCGP	Royal College of General Practitioners
RCI	Reference Cost Index
REGARDS	Race, Economic disadvantage, Gender, Age, Religion or belief, Disability and Sexual orientation
RTT	Referral to Treatment
S	
SAAF	Safeguarding Adults Assurance Framework
SBARD	Situation, Background, Assessment, Recommendation and Decision (SBARD) tool
SBS	Shared Business Services
SEND	Special Educational Needs and Disabilities
SFI	Standing Financial Instructions
SI	Serious Incidents
SID	Senior Independent Director
SIRI	Serious Incident Requiring Investigation
SLA	Service Level Agreement
SLR	Service Line Reporting
SMI	Severe Mental Illness
SOC	Strategic Options Case
SOF	Single Operating Framework
SPOA	Single Point of Access
SPOE	Single Point of Entry
SPOR	Single Point of Referral
STEIS	Strategic Executive Information System
STF	Sustainability and Transformation Fund
STP	Sustainability and Transformation Partnership
SUI	Serious (Untoward) Incident
SystmOne	Electronic patient record system
T	
TARN	Trauma Audit and Research Network
TCP	Transforming Care Partnerships
TCS	Transforming Community Services
TDA	Trust Development Authority
TMT	Trust Management Team
TUPE	Transfer of Undertakings (Protection of Employment) Regulations 1981
TMAC	Trust Medical Advisory Committee (now Medical Senate)
TOOL	Trust Operational Oversight Leadership
U	
UDBH	University Hospitals of Derby and Burton
UEC	Urgent and emergency care

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Term / Abbreviation	**Terms in Full**
V	
VARM)	Vulnerable Adult Risk Management
VO	Vertical Observatory
W	
WDES	Workforce Disability Equality Standard
WRES	Workforce Race Equality Standard
WTE	Whole Time Equivalent
Y	
YTD	Year to Date

(updated May 2023)

Exec Lead	Meeting date	9 May 23	4 Jul 23	5 Sep 23	7 Nov 23	18 Jan 24	5 Mar 24
	Paper deadline	2 May	26 Jun	29 Aug	30 Oct	8 Jan	26 Feb
Trust Sec	Declaration of Interests	X	X	X	X	X	X
DON	Patient/Staff Story	X	X	X	X	X	X
CHAIR	Minutes/Matters arising/Action Matrix	X	X	X	X	X	X
CHAIR	Board review of effectiveness of meeting	X	X	X	X	X	X
CHAIR	Board Forward Plan (for information)	X	X	X	X	X	X
CHAIR	Summary of Council of Governors meeting (for information)	X	X		X	X	X
CHAIR	Chair's Update	X	X	X	X	X	X
CEO	Chief Executive's Update	X	X	X	X	X	X
STRATEGIC PLANNING AND CORPORATE GOVERNANCE							
DSPT	Trust Strategy progress update	X		X		X	
DPI	Staff Survey Results (following assurance at People and Culture Committee)	X					
DPI	Annual Gender Pay Gap Report for approval (following assurance at People and Culture Committee)	X					
DPI	Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) request for Board delegated authority for People and Culture Committee meeting on 19 September to approve the October submissions			X			
DPI	Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) Strategic implications/retrospective sign off after PCC on 19 September				X		
DPI	Workforce Plan for 2023/24				X		
DPI	Annual Approval of Modern Slavery Statement following assurance at People and Culture Committee (to be published on Trust website on approval)	X					
DPI	2023/24 Flu Campaign			X			
Trust Sec	Corporate Governance Report (to be published on Trust website on approval)	X					
Trust Sec	NHS Improvement Year-End Self-Certification (within Corp Gov Report)	X					
Trust Sec	Year-end governance reporting from Board Committees and approval of ToRs (within Corp Gov report)	X					
Trust Sec	Trust Sealings (six monthly - for information - also within May Corp Gov report)	X			X		
Trust Sec	Annual Review of Register of Interests	X					
Trust Sec	Board Assurance Framework Update	X		X	X		X
Trust Sec	Freedom to Speak Up Guardian Report (six monthly)			X			X
Trust Sec	Board Effectiveness Report				X		
Trust Sec	SIRO Data Security and Protection update					X	
Trust Chair	Fit and Proper Person Declaration			X			
DPSPT/DoF	Operational/ Financial Plan	X					
Committee Chairs	Board Committee Assurance Summaries	X	X	X	X	X	X

Exec Lead	Meeting date	9 May 23	4 Jul 23	5 Sep 23	7 Nov 23	18 Jan 24	5 Mar 24
OPERATIONAL PERFORMANCE							
DON/DOF/ DPI/COO	Integrated performance and activity report to include Finance, People performance and Quality	X	X	X	X	X	X
DSPT	ICB Joint Forward Plan (included in CEO Update)		X				
COO	Emergency Preparedness, Resilience and Response (EPRR) Core Standards			X			
COO/Prog Director	Making Room for Dignity progress	X			X		
DON/COO/ DPI	Workforce Standards Formal Submission/Safer Staffing (prior to publishing on website) following assurance at PCC	X					
QUALITY GOVERNANCE							
EXEC	Position Statement - focus on CQC domains (Well Led CQC & NHSI) as per schedule	Caring DON	Well Led Trust Sec		Safe MD	Responsive COO	Effective DON MD & DPI
MD	Learning from Deaths Mortality report on assurance from Quality and Safeguarding Committee	AR		X	X	X	X
MD	Guardian of Safe Working Report on assurance from Quality and Safeguarding Committee		AR		X	X	X
DON	Receipt of Annual Reports on assurance from Quality and Safeguarding Committee: - Annual Looked After Children - Safeguarding Children and Adults at Risk				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	Update on Mental Health Bill					X	
DON	Assuring Quality Care					X	
DON	Outcome of Patient Stories - every two years - due March 2024						X
POLICY REVIEW							
DOF/ Trust Sec	Standing Finance Instructions Policy and Procedures Review (May 2023)	X					