Derbyshire Healthcare NHS Foundation Trust

AGENDA

PUBLIC BOARD MEETING
TUESDAY, 5 NOVEMBER 2024 TO COMMENCE AT 9.30AM
CONFERENCE ROOMS A&B, RESEARCH & DEVELOPMENT CENTRE, KINGSWAY, DERBY, DE22 3LZ

	TIME	AGENDA	LED BY
1.	9:30	Chair's welcome, opening remarks, apologies and declarations of interest 1.1 Register of Interests 2024/25	Selina Ullah
PATIENT STORY			
2.	9.35	Patient Story, *"My personal journey from Derbyshire Recovery Partnership to recovery through nature"*	Tumi Banda
STANDING ITEMS			
3.	10.00	Minutes of the Board of Directors meeting held on 1 October 2024	Selina Ullah
4.		Matters arising – Action Matrix	
5.		Questions from members of the public	
6.	10.05	Chair's update – verbal	Selina Ullah
7.	10.20	Chief Executive's update	Mark Powell
OPERATIONAL PERFORMANCE			
8.	10.35	Focused Performance Report	Vikki Ashton Taylor/ Tumi Banda
BREAK – 11.05am			
STRATEGIC PLANNING AND CORPORATE GOVERNANCE			
9.	11.15	Approval of New Trust Strategy	Vikki Ashton Taylor
10.	11.30	Trust Sealings (six-monthly, for information)	Justine Fitzjohn
11.	11.35	Board Assurance Framework Update	Justine Fitzjohn
BOARD COMMITTEE ASSURANCE			
12.	11.45	Board Committee Assurance Summaries	Committee Chairs
REPORTS FOR NOTING ON ASSURANCE FROM BOARD COMMITTEES			
13.	12.15	<u>Quality and Safeguarding Committee</u> 13.1 Guardian of Safe Working Report 13.2 Learning from Deaths/Mortality 13.3 Annual Report – Children in Care/Looked After Children 13.4 Annual Report – Safeguarding Children and Adults at Risk 13.5 Annual Report - Special Educational Needs and Disabilities (SEND) 13.6 Annual Report - Infection Prevention and Control (IPC) Report and IPC Board Assurance Framework (BAF)	 Arun Chidambaram Arun Chidambaram Tumi Banda Tumi Banda Tumi Banda Tumi Banda
CLOSING BUSINESS			
14.	12.25	Consideration of any items affecting the BAF	Selina Ullah
15.		Meeting effectiveness	
FOR INFORMATION			
Forward Plan - 2024/25 Glossary of NHS Acronyms			

Questions applicable to the agenda, and at the Chair's discretion, can be sent by email to the Board Secretariat 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 on 14 January 2025 at 9.30am in Conference Rooms A and B, Centre for Research and Development, Kingsway. Arrangements will be notified on the Trust website seven 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.

DECLARATION OF INTERESTS REGISTER 2024/25		
NAME	**INTEREST DISCLOSED**	**TYPE**
Lynn Andrews Non-Executive Director	• Trustee for Ashgate Hospice, Chesterfield	(e)
Vikki Ashton Taylor Deputy Chief Executive and Chief Delivery Officer	• Magistrate, covering mainly Derbyshire and Nottinghamshire Courts	(e)
Tony Edwards Deputy Trust Chair	• Independent Member of Governing Council, University of Derby	(a)
Deborah Good Non-Executive Director	• Trustee of Artcore, Derby	(e)
Ashiedu Joel *(until 31-Jul-2024)* 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 • School of Business and Law Advisory Board Member, De Montfort University • Independent Chair, Derby and Derbyshire Drug and Alcohol Strategic Partnership • Justice of the Peace, Leicester, Leicestershire and Rutland Magistracy	(a) (a) (a) (a) (a) (a) (a) (a) (e) (e)
Ralph Knibbs Senior Independent Director	• Trustee of the charity called Star* Scheme	(d)
Geoff Lewins Non-Executive Director	• Director, Arkwright Society Ltd • Director, Cromford Mill Limited (wholly owned trading subsidiary of Arkwright Society)	(a) (a)
Mark Powell Chief Executive	• Treasurer, Derby Athletic Club	(d) (e)
James Sabin Director of Finance	• Spouse works at Sheffield Health & Social Care NHS Foundation Trust as Head of Capital and Therapeutic Environments	(e)
Selina Ullah Trust Chair	• Non-Executive Director, Solicitors Regulation Authority • Director/Trustee, Manchester Central Library Development Trust • Non-Executive Director, General Pharmaceutical Council • Non-Executive Director, Locala Community Partnerships CIC • Non-Executive Director, Accent Housing Group • Director, Muslim Women's Council • Trustee and Board member of NHS Providers representing Mental Health Providers	(a) (e) (e) (e) (e) (e) (e)
All other members of the Board of Directors have submitted a nil return, meaning they have no interests to declare.		

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

MINUTES OF A MEETING OF THE BOARD OF DIRECTORS

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

Tuesday, 1 October 2024

MEETING HELD IN PUBLIC

Commenced: 10.00am Closed: 1.12pm

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
	Vikki Ashton Taylor	Deputy Chief Executive and Chief Delivery Officer
	Tumi Banda	Director of Nursing, Allied Health Professions, Quality and Patient Experience
	Dr Arun Chidambaram	Medical Director
	Justine Fitzjohn	Director of Corporate Affairs and Trust Secretary
	Rebecca Oakley	Director of People, Organisational Development and Inclusion
	James Sabin	Director of Finance
IN ATTENDANCE	Anna Shaw	Associate Director of Communications and Engagement
DHCFT/2024/072	Alex Balcon	Mental Health Nurse (Guest for Patient Story)
DHCFT/2024/081	Tam Howard	Freedom to Speak Up Guardian
DHCFT/2024/072	Joe Thompson	Assistant Director of Clinical and Professional Practice
	Jo Bradbury	Corporate Governance Officer
OBSERVERS	Lynne Elliott	Registered Nurse
	Lesley Fitzpatrick	Advanced Clinical Practice (ACP) Lead
	Sian Morgan	Practice Facilitator

DHCFT/ 2024/071	**CHAIR'S WELCOME, OPENING REMARKS, APOLOGIES FOR ABSENCE AND DECLARATION OF INTERESTS** Deputy Trust Chair, Tony Edwards, opened the meeting on behalf of Trust Chair, Selina Ullah who was delayed. Tony welcomed colleagues and observers and made introductions as appropriate. Board members were reminded to introduce themselves when speaking. There were no declarations of interest on agenda items. The Board noted the current Declarations of Interests Register.
DHCFT/ 2024/072	**PATIENT STORY – "FROM PATIENT TO PRACTITIONER. THE IMPORTANCE OF REASONABLE ADJUSTMENTS"** Alex Balcon, Mental Health Nurse, introduced himself and gave an overview of his idyllic and carefree formative years. However, this changed when he lost his older sister to an aggressive form of cancer, which led to his diagnosis and treatment for depression. Alex

	explained that he was introduced to recreational drugs by a friend, which helped him feel better in the short term but he then fell into a period of self-destruction, resulting in him considering ending his life. Following time in and out of inpatient services in a mental health hospital, Alex was diagnosed with paranoid schizophrenia and prescribed clozapine. It was at this time that Alex was inspired by a particular clinician, someone that gave him hope and the aspiration to become a Mental Health Nurse. Alex explained he struggled through the Access course, whilst also dealing with the loss of his beloved mum, through cancer. On graduation, Alex started work as a Registered Mental Health Nurse on the inpatient wards. However, his requests for reasonable adjustments, which included reflection time, private space in the event of rare panic attacks and formal support from his mentor were not supported. Whilst Alex was considering alternative careers, where his mental health would not present a barrier, he received a call from Jill Smith, Tissington Ward Manager, Older Adult Services, where he had spent some time as a student Nurse. Jill had recognised Alex's potential and asked if he was interested in a role. She was also able to offer breaks, additional supervision, support and reflective time to support Alex. Alex expressed his respect for Jill as an inspirational leader and his appreciation for her commitment to the reasonable adjustments, which has made him feel a valued member of the team. He extended wholehearted thanks to Mark Powell, Chief Executive, Joe Thompson, Assistant Director of Clinical and Professional Practice, the Board and leaders like Jill. The Board noted that the reasonable adjustments have allowed Alex to practice in his dream role and how his experiences feed his passion and empathy to support others. Tony thanked Alex for his open, honest and incredible story and observed that reasonable adjustment should not be a barrier to working as a Mental Health Nurse. Arun agreed that employers should do more. Deborah Good, Non-Executive Director, thanked Jill for making 'that' telephone call and hoped this story and the importance of reasonable adjustments will filter across all Trust services. It was agreed that sharing the experiences with senior leaders and partners would be a powerful reminder of the benefits. Mark acknowledged it must have been nerve-racking today but Alex had 'brought to life' the value of lived experience that Alex draws on to support patients so well. Tony highlighted that leaders need to understand the benefits of providing reasonable adjustments and encourage staff to have the confidence to request them. Rebecca Oakley, Director of People, Organisational Development and Inclusion, added there is a view that reasonable adjustments just focuses on desks and chairs and she recognised that this leadership skill and value needs to be reflected in Trust policy. **RESOLVED: The Board of Directors was greatly inspired by Alex's story and keen to promote the importance of providing reasonable adjustments within the Trust.**
DHCFT/ 2024/073	**MINUTES OF THE PREVIOUS BOARD OF DIRECTORS' MEETING** The draft minutes of the previous meeting held on 2 July 2024 were accepted as a correct record of the meeting.
DHCFT/ 2024/074	**ACTION MATRIX AND MATTERS ARISING**

	The Board reviewed and closed the completed actions. There was one action due for completion in November 2024. There were no matters arising.
DHCFT/ 2024/075	**QUESTIONS FROM MEMBERS OF THE PUBLIC** No questions had been received.
DHCFT/ 2024/076	**CHAIR'S UPDATE** The report provided the Board with the Trust Chair's reflections on activity with and for the Trust since the previous Board meeting on 2 July 2024. The report was taken as read in the Chair's absence. Deborah asked about any learning opportunities from the transformational programs at the Birmingham Community Providers Collaborative. Mark advised the Trust has been in consultation with colleagues to follow up and understand their journey. **RESOLVED: The Board of Directors noted the content of the update.**
DHCFT/ 2024/077	**CHIEF EXECUTIVE'S UPDATE** Mark drew attention to the Lord Darzi Review, the findings of which will inform a new 10-year health plan and three 'big shifts' from: • hospital to community care • analogue to digital • treating sickness to preventing it. Taking a broader view, Mark acknowledged the NHS England (NHSE) guidance based on learning from the incident in Nottingham last year, with safety as the pivotal consideration. It was noted that the Trust has submitted the self-assessment of mental health services to the Integrated Care Board (ICB). This will feed into a local review, to ensure there are clear policies in place to meet the needs of people in Derbyshire with severe mental health illness. Mark shared that several gaps in Trust service provision have been identified and these will be discussed in further detail with the ICB and undergo scrutiny at the Quality and Safeguarding Committee, to understand the risks and next steps. He added that findings from the review will be summarised nationally. Mark reported that from Quarter 1 of 2024/25, the Trust has been placed into the National Oversight Framework (NOF) Segment 3, from the previous default Segment 2. The change is based on the ICB's assessment of the Trust's financial position and the concerns raised by the Care Quality Commission (CQC), following their recent inspection, along with some performance issues, for example, inappropriate out of area placements. It was noted that there would be more frequent review meetings, chaired jointly by the ICB and NHSE, which will increase scrutiny and also offer clarity and the support for the Trust to move back to Segment 2. The fantastic work across all services was praised and Mark drew attention to the recognition and awards detailed in his report. Finally, he formally welcomed Tumi Banda to the Trust and the Board, as Director of Nursing, Allied Health Professions (AHP), Quality and Patient Experience. Tony echoed the welcome to Tumi and extended thanks to Dave Mason, Interim Director of Nursing and Patient Experience during his time with the Trust and also Michelle Bateman, Chief Nurse, Derbyshire Community Health Services (DCHS) NHS Foundation Trust for her recent support.

	Lynn Andrews, Non-Executive Director, stated the importance of understanding the NOF exit criteria and offered her support. Mark appreciated the offer and added that the Trust is making progress on the elements identified. **RESOLVED: The Board of Directors scrutinised the report, noting the risks and actions being taken.** Selina joined the meeting and agreed to take over chairing the meeting after the break.
DHCFT/ 2024/078	**<u>INTEGRATED PERFORMANCE REPORT (IPR)</u>** The IPR provided an update on how the Trust was performing at the end of August 2024, focusing on key finance, performance, and workforce measures. Executive Directors drew attention to the following areas and responded to questions: **Operations** Vikki Ashton Taylor, Deputy Chief Executive and Chief Delivery Officer, highlighted that benchmarking against similar providers in the Midlands, evidences a number of areas where the Trust is delivering exceptionally well and is considered a regional exemplar. She reported improvements around flow, length of stay, bed occupancy and in particular, a significant reduction in Adult Acute inappropriate out of area placements, down to five from 20+ at the beginning of the year. It was noted that the new Psychiatric Intensive Care Unit (PICU) will support care closer to home and through continuous improvement methodology, there has been a 15% increase in home treatment. Vikki pointed out an error in the papers around Memory Assessment Service waiting times, *"waits from referral to assessment are currently around 35 weeks"*, which should be, *"24"* weeks. Lynn reflected on a recent visit to the Bolsover Community Mental Health Team; and the challenges of moving from a long to a short-term offer. In terms of Living Well, her question was the practicality of engaging with patients if they are reluctant to do so. Vikki responded that the majority of patients choose continued support and where they don't, this is followed up, if there is still no engagement, this is communicated back to their GP. It was noted that in addition, Mental Health Support Workers try to connect with that individual. Lynn probed further in relation to the longer-term impact and the Trust's confidence to deliver appropriate care for those individuals. Mark linked this to the Derbyshire review on intensive and assertive community health treatment and emphasised that Community Mental Health and Living Well are correlated. It was noted that progress around addressing the identified gaps in community provision is being monitored by the Quality and Safeguarding Committee. The Trust policies are clear that 'did not attends' (DNA) are not used as a reason for discharge from care for this vulnerable patient groups. Deborah commented on the exceptional success within Psychology and Psychological Therapy to reduce waiting lists and improve performance through Quality Improvement and she queried how this can be translated across the Trust. Vikki advised that a push to share best practice is endorsed at the Divisional Performance Review meetings. Mark agreed there has been significant improvement, however, he emphasised that the service has received significant funding, which needs to be acknowledged. **Quality**

Tumi stated one of his areas of focus is to improve Care Plan compliance and the Heads of Nursing are working on this. It was noted that through a multi-disciplinary team approach, medication errors remain low and all medications are now recorded on SystmOne. Other areas of improvement include a reduction in seclusions and decrease in falls by 46%.

Geoff Lewins, Non-Executive Director, reflected on the slow progress around Care Planning and asked what can be done to ensure improvement. Tony echoed this concern and stated that Care Planning is one of the top issues raised by Governors.

Tumi acknowledged the worry and confirmed a different approach is required in terms of accountability in that any registered Nurse should be able to do Care Planning.

Lynn added that Care Planning is a focal point within Quality and Safeguarding Committee meetings and there has been progress however she welcomed a fresh approach from Tumi.

Selina raised three questions:

- Is there a pattern of low-level harm, medication incidents?
- Are falls due to acuity and frailty or policy?
- Is enough focus given to "open to employment" numbers, which remain unchanged since August 2022?

Tumi responded:

- A task and finish group is working on reducing the number of medication incidents, and moving forward, future issues should be admin-related rather than clinical. He agreed to update at the next Board meeting
- Acuity and frailty cannot be discounted in relation to falls, however it is also important to consider other safety factors such as the correct footwear. In addition, the right interventions are vital, team stability is important to know their patients. Tumi added Care Planning is enhanced through Allied Healthcare Professionals (AHP) assessment
- This needs to be explored further with system partners. More can always be done to support people into employment, especially within the voluntary sector.

Deborah suggested the Individual Placement and Support (IPS) Service is able to assist and Vikki advised the local authority also receives funding to support people into employment.

People

Rebecca reported a positive reduction in short and long-term sickness absence, along with improvements in training compliance, for which there will be a focus to improve the measure for bank and agency staff.

It was noted that there is to be increased focus around turnover within AHPs, along with actions to reduce agency usage.

Geoff commended the positive trends, including for appraisals. However, he asked if the targets around supervision were achievable due to the continued low compliance. Rebecca advised the Trust is following up the recommendations from the recent audit by 360 Assurance, which will result in improvements. Mark drew attention to the ongoing challenges within Corporate Services and the need for increased oversight. **Action, Rebecca Oakley**.

Finance

James Sabin, Director of Finance, confirmed that as at the end of August, the year-to-date position is on plan, however, achievement of the forecast remains an area of challenge. He reported improvements for inappropriate out of area placements and bank and agency usage and added that further reductions are required.

	It was noted that year to date efficiencies are behind plan by £0.4m and work continues in progressing sign-off of the project initiation documents (PIDs) and quality and equality impact assessments (QEIAs) to ensure the required savings. Mark emphasised these gaps need to be closed as effectively as possible and he reflected on a news bulletin that day, which confirmed the NHS has already overspent for the year. He reminded the Board that the Trust is on plan and needs to continue on this path. Discussion focussed on the achievement of efficiencies and the potential number of vacancies that might be removed, whilst considering the short and long-term impacts of this. Lynn asked about Children's Services data within the IPR and Vikki confirmed this will be incorporated and that much work has been undertaken by Pete Henson, Head of Performance, Delivery and Clustering, to develop the Balanced Score Card, for the Divisional Performance Reviews. Selina asked if the Committee Chairs were assured by the data in the report and the suggested level of significant assurance. The Trust used four levels of assurance but in practice only two were used. Mark suggested the methodology used to define levels be revisited. Justine Fitzjohn, Director of Corporate Affairs and Trust Secretary, pointed out the Board Committee Assurance summaries provide additional assurance. **RESOLVED: The Board of Directors:** **1. Noted current performance across the areas presented, giving split assurance, significant in terms of the robustness of the reporting structures but limited in terms of the areas of under-performance** **2. Formally agreed 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.**
DHCFT/ 2024/079	**<u>TRUST STRATEGY PROGRESS UPDATE</u>** The Board received an update on progress in delivering the priority actions identified in the Trust Strategy for delivery during quarter 1, 2024/25. Due to the clear and self-explanatory update, there were no questions. **RESOLVED: The Board of Directors noted the Q1, 2024/25 progress in delivering the priority actions as set out in the updated Trust 2022–2025 organisational strategy and the progress to develop a new Trust Strategy.**
DHCFT/ 2024/080	**<u>BOARD ASSURANCE FRAMEWORK (BAF) UPDATE</u>** The Board received issue 2.3 of the BAF for 2024/25, which had already been approved under Chief Executive and Chair emergency powers due to the re-scheduling of the Board meeting date. Justine advised there had been several updates, de-escalation of some risks and the addition of new strategic priorities. It was noted that Committee Chairs are to focus on the MRfD risks at their meeting this afternoon. Selina queried the narrative around Risk 4B, which she found to be ambiguous: ***"Risk 4B – There is a risk of reputational damage if the Trust is not viewed as a strong partner***

	Updates have been added to cite the improvements in waiting times for autism assessments, and the expansion of work undertaken by the Director of Nursing, AHPs and Patient Experience in relation to patient and carers forums". The risk lead will be asked to clarify the narrative on this particular risk. **RESOLVED: The Board of Directors:** **1. Noted this approved, second issue of the BAF for 2024/25 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. Agreed to continue to receive updates in line with the forward plan for the Trust Board.**
DHCFT/ 2024/081	**<u>FREEDOM TO SPEAK UP (FTSU)</u>** Tam Howard, Freedom to Speak Up Guardian, presented the half yearly report which gave the Board data on the number of Freedom to Speak Up (FTSU) cases within the Trust, along with an analysis of trends and actions being taken to improve speaking up culture. Tam highlighted completion of the Board's follow up training and the positive feedback received around the eLearning module which is currently at 80% compliance. The number of cases had increased compared to those reported in March and the emerging or ongoing themes include culture and inappropriate attitudes and behaviours. Tam was thanked for the succinct, thorough report and for her commitment in the role. Justine recognised the incredibly positive training compliance. Rebecca observed the increase in worker safety/wellbeing cases and had hoped the personal accountability charter might have impacted positively. Tam responded that some areas need greater support. She reflected on a number of student concerns which she had shared in summary with Mark. Tony commented that universities have a responsibility to students and the obligation should not rest entirely with the employer. Selina added that the student concerns have also been raised to the Governors and need to be addressed. Mark stated this is always a helpful report and he was pleased at the inclusion of lessons learned. He gave the assurance that significant concerns are escalated as appropriate through the Executive team. It was noted that the positive feedback from students is also captured. Ralph Knibbs, Senior Independent Director, asked if the Trust is moving in the right direction and if people feel more confident to speak up. Tam pointed out that speaking up is never easy, however, it is improving. She added there is a task group for students, although increased emphasis at corporate induction and across the Trust would be helpful. It was noted that the Trust is working with the University of Derby on a half day leadership programme and follow up session, which will focus on bullying and discrimination. As the Non-Executive Director aligned to FTSU, Geoff emphasised his confidence in the support Tam receives from the Executive Team. He reminded the Board that raising concerns through the FTSU Guardian and FTSU Champions is a positive pathway but ideally concerns would be raised through management. **RESOLVED: The Board of Directors:** **1. Supported the current mechanisms and activities in place for raising awareness of the FTSU agenda**

	2. Determined the report sufficiently assures the Board of the FTSU agenda at the Trust and that those proposals made by the FTSUG promote a culture of open and honest communication to support staff to speak up.
DHCFT/ 2024/082	**PLANNING UPDATE** The Board received a progress update on development of the 2024/25 operational plan. Vikki highlighted what has been agreed within the partnership system, the key deliverables and what has been incorporated into the IPR. **RESOLVED: The Board of Directors noted the progress report on the 2024/25 Planning Process.**
DHCFT/ 2024/083	**EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE (EPRR CORE STANDARDS** The Board received an update on the Emergency Preparedness, Resilience and Response (EPRR) core standards and development of the EPRR portfolio within the Trust and also an outline of the regional context for 2022/23 and Trust submission for 2023/24. Vikki reported on the significant progress to move the Trust from the 2023/24 non-compliance and following completion of a self-assessment, the current position is significantly compliant, as supported by the ICB. Confidence in the Trust's resilience and capability to respond in the event of an incident occurring was noted. However, Vikki cautioned there is a possibility the NHSE will report partial compliance. Tony was encouraged by the progress which reflects an immense transformation. **RESOLVED: The Board of Directors noted the progress to date, agreeing significant assurance on the ongoing work to further enhance the EPRR portfolio within the Trust.**
DHCFT/ 2024/084	**BOARD COMMITTEE ASSURANCE SUMMARIES** The Board Assurance summaries from recent meetings of the Trust Board Committees were accepted as a clear representation of the priorities that were discussed and will be taken forward in forthcoming meetings. The following points were brought to the attention of the Board by Committee Chairs: **Audit and Risk Committee:** Geoff Lewins, Committee Chair acknowledged the useful internal audit reports and noted that counter fraud is in a good position. Geoff highlighted a need for clarity and triangulation of the Making Room for Dignity (MRfD) programme BAF risks. **Finance and Performance Committee:** Tony Edwards, Committee Chair, drew attention to the written summary for July's meeting and gave a verbal update from the meeting held the previous day. He reflected on an extensive discussion around the MRfD challenges and advised that Arun given an update on shaping of the digital strategy. Additional key items were noted, including Finances/Operations, procurement restructuring and an update on the healthy position with collaborations and alliances. **People and Culture Committee:** There had been two meetings of the Committee and Ralph Knibbs, Committee Chair reflected on the main items covered, which included recruitment and transformational progress for the MRfD programme. Other key items discussed at the Committee were the flu/Covid vaccination campaign and progress around bank and agency spend. It was noted that recruitment is underway for the Head of Equality, Diversity and Inclusion (EDI) post and the improvement plans to encourage increased

	engagement with the Staff Survey. Ralph added that the annual Workforce Plan, Flu Campaign and WRES/WDES reports are to be presented today, following assurance at the September Committee meeting. James commented on the MRfD transformation work and the importance of the messaging to staff that this is not a "lift and shift" exercise. Ralph pointed out that the two-year programme was only launched in early September and that Andy Harrison, Senior Responsible Owner, Acute Care Capital Programme, would be able to update on colleague feedback and engagement. Discussion focussed on the need for more granularity and measures around the two-year programme, along with an emphasis on pace. It was agreed that this is a significant concern to be translated into short, medium and long-term risks. **Quality and Safeguarding Committee:** Lynn Andrews, Committee Chair, reflected on the meetings held in July. It was noted that the regular item, Fundamental Standards had been amended from significant to limited assurance and this is based on embeddedness, rather than implementation of actions. **RESOLVED: The Board of Directors noted the Board Assurance Summaries.** Mark made an observation that it had been some time since the Board received any escalations from Committees and he suggested these be considered, for example, the Care Planning Approach would benefit from Board scrutiny. Selina agreed this is a valid challenge, in particular, the concerns around MRfD have not been formalised. The Board discussed the risk thresholds, along with the judgement of the Chairs. It was suggested there should be more focus on outcomes prior to escalation. Ralph commented that escalations could impact negatively on the relations between Committee members so it was important to manage the process correctly and in line with Trust values.
DHCFT/ 2024/085	**<u>REPORTS FOR NOTING ON ASSURANCE</u>** **<u>ASSURANCE FROM THE AUDIT AND RISK COMMITTEE</u>** **Review of Standing Financial Instructions (SFIs):** Geoff confirmed the SFIs and the proposed changes have been reviewed and agreed by the Committee and presented to Trust Board for final ratification. **RESOLVED: The Board of Directors agreed the proposed changes.** **<u>ASSURANCE FROM THE FINANCE AND PERFORMANCE COMMITTEE</u>** **Revised Terms of Reference (ToR):** Tony explained that the ToR have recently been amended to provide more clarity on membership and quoracy. **RESOLVED: The Board of Directors approved the revised version of the Committee's ToR.** **<u>ASSURANCE FROM THE PEOPLE AND CULTURE COMMITTEE</u>** **Annual Workforce Plan – 2024/25:** Ralph shared an overview of the triangulation of the financial plan and data from people systems across the Alliance. Tony observed the breadth of the plan and the absence of performance measures to track progress. Ralph agreed that additional granularity, filtered by Division is required.

	RESOLVED: The Board of Directors noted and supported the progress of the overall workplan. **Flu and COVID Campaign Plan – Autumn/Winter 2024/25:** the report outlined the work to be undertaken to deliver the programme. Ralph confirmed that vaccination is the most effective method to increase staff resilience and the target is for 75% compliance. It was noted that the Trust Communications team is to support promotion of the plan. **RESOLVED: The Board of Directors noted that a full discussion has taken place in People and Culture Committee.** **Workforce Race Equality Standards (WRES) and Workforce Disability Equality Standard (WDES) 2023/24:** Ralph expressed his disappointment on behalf of the Committee at progress of the action plans and it was noted that Rebecca is to bring proposals for improvement to the Executive Leadership Team (ELT). **RESOLVED: The Board of Directors:** **1 Ratified the WRES and WDES reports and Action Plans, which were approved by the People and Culture Committee on 24 September 2024 and approved for publication on the Trust's public-facing website** **2 Noted the EDI Steering Group to have quarterly oversight on progress towards action areas with progress updates to the People and Culture Committee.** **ASSURANCE FROM THE QUALITY AND SAFEGUARDING COMMITTEE** **Safer Staffing Annual Review:** Lynn confirmed the assurance provided to the Committee on the work being undertaken to monitor and develop the skill mix of staff across Derbyshire Healthcare NHS Foundation Trust (DHcFT) to ensure safe services. **RESOLVED: The Board of Directors noted the contents of the report and its scrutiny and assurance received at the Quality and Safeguarding Committee.**
DHCFT/ 2024/086	**CONSIDERATION OF ITEMS AFFECTING THE BOARD ASSURANCE FRAMEWORK (BAF)** Following today's discussions, it was noted that the BAF is to be updated with the strategic risks and mitigations, associated with the Lord Darzi Review, the review of Community Mental Health services and the National Oversight Framework move to Sector 3.
DHCFT/ 2024/087	**MEETING EFFECTIVENESS** The Board unanimously agreed that today's patient story was exceptionally powerful and connected with the agenda items. Lynn particularly liked the challenges from the Executive Directors and Arun was able to identify correlation with sub-committees. Justine welcomed the strong working partnership displayed between Geoff and Tam and Ralph had been heartened by Tam's compassion towards the student nurses that have contacted her. He added that the WRES and WDES responsibilities of the Trust need to be robustly embraced. In her capacity as observer, Lesley had found it interesting to see how the Board members challenge each other.
The next meeting to be held in public session will be held in person on 5 November 2024 at 9.30am in Conference Rooms A and B, Centre for Research and Development, Kingsway, Derby.	

ACTION MATRIX - BOARD OF DIRECTORS - NOVEMBER 2024							
Date	**Minute Ref**	**Item**	**Lead**	**Action**	**Completion Date**	**Current Position**	
05-Mar-2024	DHCFT/ 2024/031	Position Statement - CQC Domains	Director of Nursing, Allied Health Professions, Quality and Patient Experience	To revise the CQC core standards reports and include forward trajectories for respective performance to meet CQC compliance.	12-Nov-2024	A new Fundamental Standards report will be submitted to the November Quality and Safeguarding Committee for support and this will complement current governance around CQC actions and compliance. The new report will then be presented to Board regularly and will cover the full range of fundamental standards for quality and safety rather than focusing on individual domains.	Yellow
01-Oct-2024	DHCFT/2024/078	Integrated Performance Report (IPR) People	Director of People, Organisational Development and Inclusion	Demonstrate improvements around Appraisal compliance within Corporate Services.	05-Nov-2024	Verbal update to be provided under Matters Arising.	Amber

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

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 5 November 2024

Chief Executive's Update

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, 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

Developing the 10-year Health Plan

On Monday 21 October the Department for Health and Social Care (DHSC) and NHS England (NHSE) launched Change the NHS; help build a health service fit for the future; a national conversation to develop the 10-year Health Plan.

The context for this is Lord Darzi's independent review of the NHS, which was intended to start an open and honest conversation about the state of our health and service and the reforms needed. The review revealed the scale of the challenge we face and set out that we must focus on providing more care in the community, so hospitals are able to treat the sickest patients, make better use of technology, and do more to prevent ill health.

Change the NHS is a national engagement exercise to develop the 10-Year Health Plan as a result of Lord Darzi's report. DHSC and NHSE want the public and staff to be at the centre of reimagining the NHS, as well as experts from across health and care. There is a national portal found at change.nhs.uk to share experiences and ideas.

Over the course of the coming months there will be further opportunities for staff to feed in views, including a series of face-to-face all-day staff engagement events in the new year across each of the seven regions.

Review of Community Mental Health

In my last report I covered how the Integrated Care Board (ICB) had commenced its local review to ensure there are clear policies in place to meet the needs of people in Derbyshire with severe mental health illness. This was following the publication of NHSE guidance on intensive and assertive community mental health treatment.

Each ICB was required to submit a response to NHSE by 30 September. The Trust has provided a detailed plan aligned to the national guidance to the ICB. Several service gaps have been identified as part of the submission to the ICB with further discussion being undertaken at the Mental Health and Learning Disability Board regarding the investment required to mitigate the gaps identified.

Progress around addressing the identified gaps in service provision at the Trust is being monitored by the Trust's Quality and Safeguarding Committee. The Board Assurance Framework has also been amended to take account of the risks identified.

Emergency Preparedness, Resilience and Response (EPRR) Core Standards

There is a strategic national framework for health EPRR for NHS-funded organisations in England. The Trust's compliance against the national EPRR core standards have been submitted to NHSE and the Derbyshire ICB for review and we have now received the outcome of the assurance assessment for the Trust.

Based on their feedback we have accepted two additional partial recommended ratings which will be rectified by April 2025. These relate to the ongoing work around learning lessons from incidents. Where recommendations have been made against individual core standards, this will be incorporated into the EPRR portfolio and workplan as appropriate. The ICB have identified 6 areas of good practice which they would like to share with the region; this includes Psycho-social response to a major incident, training programme critical services list and evacuation and shelter plan.

Given the additional two partial recommended ratings the Trust has achieved an overall compliance level of 90%. As a result of this, the ICB have confirmed a substantial compliance grading for 2024, and the planned confirm and challenge session is no longer required, which is a great achievement.

Regional and Local Context

National Oversight Framework (NOF)

We had our first review meeting under the NOF Segment 3 in September. These meetings are jointly chaired between the ICB and NHSE. It was a productive meeting, and the Trust was able to demonstrate its recent improvements in performance for out of area placements and progress in compliance with CQC actions. An important factor in this process will be to jointly agree the exit criteria to NOF 2 and improvement plan against the areas flagged around quality, operational and financial performance.

Improving Access to Psychological Therapies

Derbyshire Healthcare is one of several providers of talking therapy services across the county. NHS Derby and Derbyshire Integrated Care Board (ICB) have taken the decision to re-procure the service and are expecting to announce the successful provider(s) in 2025.

Having reviewed the tender documentation, the Trust has taken the difficult decision not to enter a bid to provide talking therapy services (IAPT) for 2025-2030. Unfortunately, the reduced financial envelope outlined in the new tender means it is no longer possible for the Trust to provide these services.

This has been an incredibly difficult decision to take as we have provided high-quality talking therapy services for the last 15 years and our feedback and outcomes have consistently been exceptional. This is a very difficult and uncertain time for colleagues who work in this service. We have arrangements in place to provide support for them, alongside a working group with the ICB to ensure that we continue to mitigate any service risks as the transition to new arrangements take place in 2025.

Our Trust and Staff

Our new Trust Strategy

I'm delighted that we will be presenting the Trust's new Strategy for approval at this Board meeting. Our new Strategy is the culmination of 10 months of engagement with a wide variety of stakeholders, including staff, service users, carers, and partner organisations.

Importantly, it sets out our vision, values and ambition for our patients, service users, carers, and colleagues, seeking to ensure that we work with our partners to provide contemporary services that remain value for money and provide excellent outcomes.

2024 Staff Conference

Over 150 colleagues, representing Trust services and professions, came together on 23 October for our annual Staff Conference. The theme for the event was 'The Time is Now' and captured progress made over the last 12 months, whilst also focusing on current local and national challenges to discuss the big changes we would like to see across our services in the coming years.

Mark Foster, former Olympic swimmer, was our guest speaker at the event and colleagues enjoyed hearing about Mark's experiences and his focus on attitude, accountability and being the best you can be – both individually and as part of a team. We discussed Mark's insights alongside the Trust's newly developed personal accountability charter, to explore how this could be embedded Trust-wide and at an individual and team level.

All the feedback received on the day was captured and will be collated to shape our future strategic delivery plan, aligned to the new Trust Strategy. Thank you to everyone who attended and supported the event, including sponsors Hill Dickinson, GMP Drivercare and the Kingsway Group.

Making Room for Dignity (MRfD)

The MRfD programme continues to progress. Bluebell ward is expected to open shorty, enabling the safe move of our older adult patients from the Hartington Unit to this newly refurbished ward. Audrey House is also now complete, with the team working on the final touches to make the facility warm and welcoming for servicer users, families and colleagues.

Work continues to progress on both Adult Acute Units. Owing to a small number of specification changes that are required, along with some supply issues there is now a short delay with both facilities expected to be opened in spring 2025. At this point, we will be able to move patients from both the Radbourne and Hartington Units.

Until such time, we have taken the decision to pause the work on the Radbourne Unit. Unfortunately, unforeseen technical issues with the ground works and foundations have led to some exceptional additional noisy works being required for extensive periods of time, over a material period of the construction phase. This made working and caring for patient very difficult. Despite people's best efforts and trials of various alternative interims solutions, it has been decided that the best course of action is to pause the works until we have moved patients across to the new unit. This is deemed the best course of action for current patients and staff. This will also help redirect resources to support the preparedness to open the Adult Acute units.

The Trust has recently been through a NHSE gateway review process as part of a national readiness check in relation to the two Adult Acute units. This led to a several recommendations which the Trust is taking forward. This includes some changes to governance and workstreams to facilitate this moving from the construction phase to a structure which supports preparing for mobilisation and move towards business as usual.

The financial impact of the above is being evaluated but the plan remains to reconvene and commence works on the Radbourne Unit in Spring of 2025 following transfer of the wards to the new environments.

Staff Engagement

On 2 October, we held an **online all-staff engagement hour**, where colleagues were able to put questions to me and other senior leaders. The event also included presentations on our Living Well programme, to transform community mental health services, and emergency preparedness and resilience. In addition, colleagues were reminded of the importance of completing the annual NHS Staff Survey, a vital way to tell us, anonymously, about ways that the Trust could improve.

I'm pleased to say that, at the time of writing, the survey response rate is very positive, though we have set ourselves an ambitious target as we want to receive a representative sample of colleagues' views.

On 8 October, we launched our new **Partners in Progress reciprocal mentoring scheme**, where pairs of colleagues from different cultural backgrounds, generations or professions learn from each other and trade experiences, knowledge, and skills. We believe this scheme will enable colleagues to build new connections and gain a greater awareness of the barriers and challenges that others face, resulting in improved staff morale and performance, and a greater focus on reducing inequalities.

On 18 October, I met with our recently recruited International Nurses and heard about their experiences of settling into a new country and new roles. They provided some valuable feedback on how they have been supported through the whole process and were very positive about this support both in terms of their roles and pastoral care. I have asked if they will provide their staff story at a future Trust Board meeting.

Engagement activity

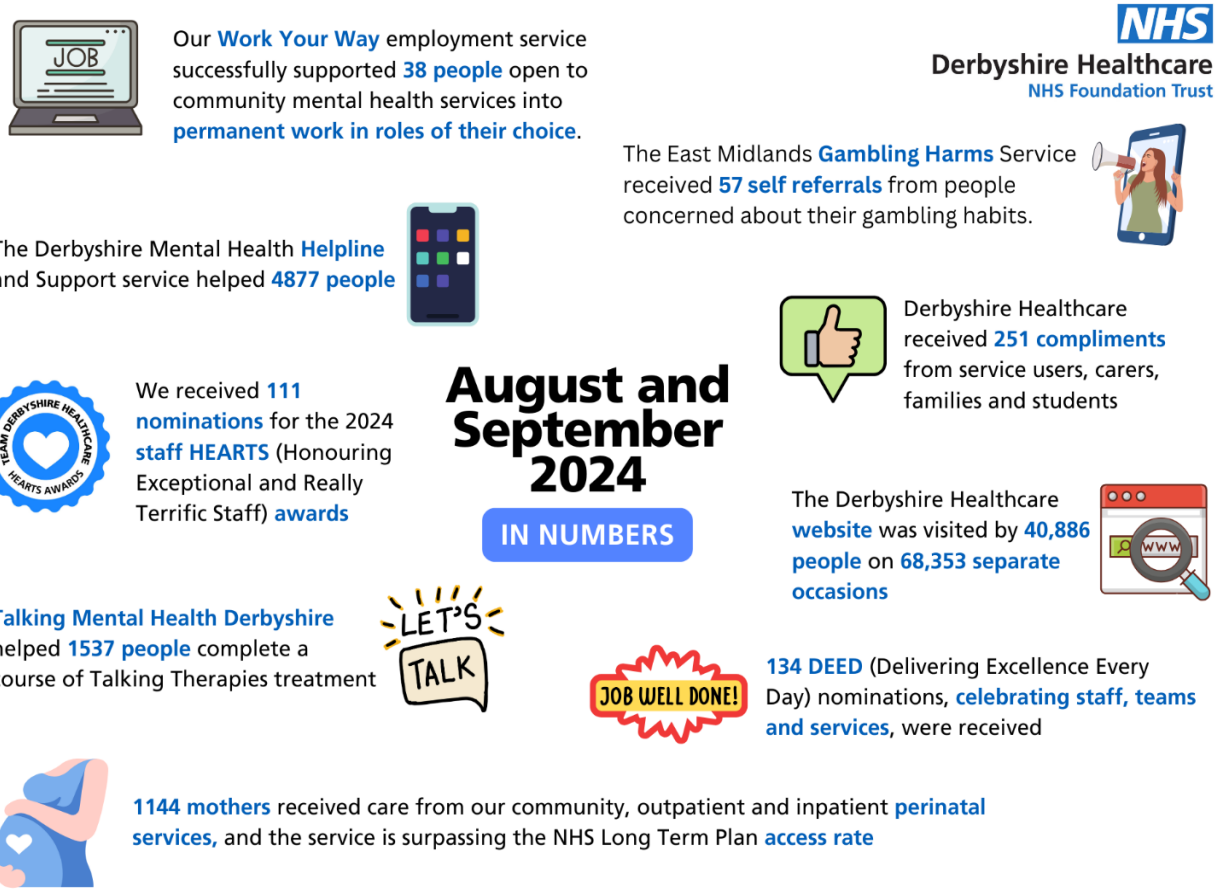
- I was pleased to accompany two local MPs on tours of our new-build mental health facilities during October. First, **Toby Perkins, MP for Chesterfield**, viewed the Derwent Unit on the Chesterfield Royal Hospital site; then **Baggy Shanker, MP for Derby South**, toured the Carsington Unit at our Kingsway site. Both Toby and Baggy were keen to learn how the new facilities, with their en-suite rooms and more therapeutic environments, will impact on the care we provide to local people with acute mental health needs. Both the Derwent Unit and the Carsington Unit will open in 2025.
- The Executive team met with the Senior Leadership team at the **University of Derby** recently to discuss how we can work together on a number of important issues including addressing health inequalities, training and development, recruitment and retention of health professionals, research and development, work experience opportunities and any other areas where we could potentially support each other on our shared priorities. This is an important partnership for the Trust and one that I will keep Board colleagues updated on as work progresses.
- Our **careers event** at Pride Park stadium in Derby on 12 October attracted more than 200 attendees, eager to learn about potential opportunities at the Trust. We have expanded our approach to recruitment more generally in the last 12 months and a recent social media campaign resulted in 50 applicants for Trainee Nursing Associate roles.
- Support for our **Deaf community** continues to be a key topic of conversation, and the Trust's Board of Directors was pleased to welcome representatives from our Deaf community to a health inequalities focused development session in September. Among the topics discussed were the barriers experienced by the Deaf community and the negative impact this could have on their access to, and experience of, our services. This was followed up with a similar discussion amongst the Trust's senior leaders at a subsequent Leadership Forum. We are also looking to arrange similar sessions with representatives from our Black Minority Ethnic (BME) communities, as we look to identify and address health inequalities.
- Our **Annual Members Meeting**, held on 26 September, was an extremely interactive and successful event. This year's meeting focused on 'the health of our children and young people', reflecting the fact that the Trust provides a number of children's and family health services in Derby and southern Derbyshire. There was a marketplace featuring different Trust teams and then, at the formal meeting, a deep dive into our children's services and the efforts being made to innovate and deliver services more effectively, to meet the rising demand. There was also a presentation by our CAMHS (Child and Adolescent Mental Health Service) Participation team, showing how we involve young people and parents with lived experience in this service.

- The event culminated with the announcement of the winners of a children and young people's writing competition; the winning entries can be found on the Trust website in the 'latest news' section, as can more information about the CAMHS Participation team. I would like to thank our Membership and Involvement Manager and our Governors for organising the AMM and the writing competition.

Recent achievements

- Our Trust has been named, along with Derbyshire Community Health Services (DCHS) NHS Foundation Trust, as the winner of a national **Step into Health Award** for the support we provide to members of the Armed Forces. The Trust and DCHS won in the 'Forces-Friendly Employer' category, which recognises NHS organisations that have excelled in creating a supportive environment for employees from the Armed Forces community. The success is in large part due to the efforts of our **Armed Forces Staff Network**, which is run jointly across Derbyshire Healthcare and DCHS and which works with senior managers at the two NHS Trusts to ensure that armed forces personnel are encouraged to apply for jobs and, if successful, are then supported as they make the transition to 'civvy street'.
  Both Trusts have worked hard to advocate for the rights of those from the Armed Forces community through focused engagement across a range of platforms, including both local and national events targeting veterans and those associated with the forces. Direct support has also been provided for service personnel who leave the military and need significant adjustments such as signposting to available mental health services. This has helped to create a sense of belonging for the community, ensuring people feel seen and understood during a challenging time in their lives.
- The **I-CARE (Increase confidence, attract, retain, educate) Programme team** has won a Healthcare People Management Association's (HPMA) Excellence in People Award for its work supporting the emotional, educational and wellbeing needs of newly employed healthcare support workers (HCSWs), and for providing innovative training opportunities. The team were particularly celebrated for combining both pastoral support and accessible training on key topics relevant to the role of HCSWs so that they can deliver safe and effective care in mental health services. The programme has generated very positive feedback, with 99% of participants either strongly agreeing or agreeing, that the I-CARE training framework has a positive impact on their confidence.
- Becky Walker and Alison Moores of our **CAMHS (Child and Adolescent Mental Health Service) Participation team** gave a presentation at a national Royal College of Psychiatrists' event on 14 October. Becky, who is Participation Team Manager, and Alison, who is the Lead Parent Peer Support Worker, were invited to speak at the Quality Network for Community CAMHS (QNCC Forum) about the excellent work being done to embed participation from experts by experience across the service.
- We will shortly hold our **annual staff awards** ceremony, known as HEARTS: Honouring Exceptional and Really Terrific Staff. This year, we have received a record number of nominations, 111 in total, reflecting the breadth of good practice across our services. I was part of the awards panel that had the very difficult task of shortlisting these nominations, to identify our finalists and winners. Reading the nominations made me proud to be a member of Team Derbyshire Healthcare.

Trust activity



Raising awareness

10 October was World Mental Health Day and colleagues in the Trust marked the occasion in several ways. Our Child and Adolescent Mental Health Service (CAMHS) held their annual open day at Temple House in Derby, showcasing the work they do and the work of other local organisations. This event was attended by local schools, families and health professionals and was a great success. In addition, several experts by experience shared their personal journeys on the day including Marc Riley, who is a Lived Experience Facilitator at the Trust; Marc's story of how NHS mental health services changed his life was published on the Derbyshire Times website. The Trust also supported in the promotion of Derby's Safe Haven – one of two safe havens in the county that is open from 4.30pm to 12.30am each night and offers a compassionate and non-judgmental space to people who feel unable to cope.

October was **Black History Month**. As part of this important month, the Trust celebrated its diverse workforce by sharing colleagues' stories and shining a spotlight on their lives. Several colleagues, including Joshua Ige, Chinwe Obinwa, Kuda Mumvuri and Sifo Dlamini were kind enough to talk about their backgrounds, their roles and what Black History Month means to them. Joshua, Chinwe, Kuda and Sifo persuasively explained how they bring to their roles a deep understanding of the needs of people from Derbyshire's minority and ethnic communities. The stories of Joshua, Chinwe, Kuda and Sifo can be read on the Trust website, in the 'latest news' section.

October is also **Speak Up Month,** and we are taking the opportunity to remind Trust colleagues of the importance of speaking up if they have concerns about the quality of patient care. We have made a commitment to take these concerns very seriously.

In memoriam

In recent weeks, the Trust has paid tribute to four colleagues who have sadly passed away: **Deborah Hall, Samantha Hourd, Deborah Matthews and Joanne Roberts**. Team members of these four colleagues have shared their memories and, where the families agree, a one minute's silence has taken place. Debbie, Sam, Debs and Jo will also be remembered in our memorial garden at Kingsway in Derby. Colleagues affected by loss or grief have been supported through a range of staff wellbeing services.

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 scrutinise the report and seek further assurance around any key issues raised.

Report presented and prepared by:	**Mark Powell** **Chief Executive Officer**

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 5 November 2024

Focused Performance Report

Purpose of Report

In the absence of the full Integrated Performance Report (IPR) that was presented to the meeting on 1 October 2024, the purpose of this report is to provide the Board of Directors with a focused review of performance around improving flow in adult acute services: a summary update on the current financial position and a summary of improvements in safety.

Executive Summary

Patient Flow

Between June and September, the Trust made significant progress with better managing patient flow through implementation of a comprehensive recovery action plan (RAP). The RAP implementation is overseen by the Trust's Acute Transformation Board and the system-wide Mental Health, Learning Disability and Autism Delivery Board. Improvements are as follows:

Overall

- Reduced inappropriate out of area placements: month end September 2024 - five adult acute and nine (eight male and one female) Psychiatric Intensive Care Unit (PICU) patients in inappropriate out of area beds
- The newly-built PICU (14 male beds) and Enhanced Care Unit (eight female beds) due to open Spring 2025 will ensure for the first time that those patients requiring PICU treatment can be cared for within Derby and Derbyshire.

Inflow

- 15% increase in home treatments compared with last financial year, as a result of the purposeful admissions work undertaken
- Introduction of the CAMHS 3.5 service
- 6% reduction in mental health liaison presentations (867 per month 2024/25 compared to 919 per month 2023/24) as a result of the Living Well (community mental health team transformation) roll-out. Resulting in freed up capacity within secondary care mental health community teams to be able to provide support to more acutely unwell patients in the community.

Flow

- Bed occupancy currently 95%, having reduced from circa 107%
- Length of stay of discharged adult acute inpatients: median 30 days, year to date (28 in Aug 2024) and mean average length of stay for August is 41 days. The national benchmark data stands at 54 days.

Discharge

- 28-day readmissions: 4% (Aug 2024)
- Delays to discharge of clinically ready for discharge patients (regularly around 10% which is 10-15 patients) remains a key risk to flow and length of stay – mitigations being developed by the System Strategic Discharge group.

Further benefits are anticipated from a number of the additional actions set out in the RAP, for example the culture of care and model of care approach to patient care has only just launched but will have a positive therapeutic impact on patients. In addition, the purposeful admission is expected to have more impact as we go forward, and the Community Mental Health Team (CMHT) use of the management and supervision tool (MAST) as a predictive tool should highlight a cohort of patients that are likely to be admitted into hospital and enable earlier intervention to prevent the need for an inpatient bed.

Despite the significant efforts to improve patient flow, the month of October has seen an increase in demand for inpatient beds which has impacted both bed occupancy levels and patients being cared for in an out of area bed. Additional actions to address these pressures have included the implementation of regular mini multi-agency discharge events (MADE) with system partners to support the discharge of patients who are clinically ready for discharge (now daily), daily senior reviews of all in patients across the units and CMHT review of escalated patients.

Looking forward, we are partnering with Nottinghamshire and Leicestershire Trusts to share learning and best practice and visiting Lincolnshire to see their Mental Health Walk-in Centre in action.

2024/25 Financial Position

At the end of September, the year to date (YTD) position is a deficit of £4.1m, which is slightly better than plan by £0.1m. Pay and income are below plan mainly due to slippage on investments and non-pay expenditure is above plan reflecting pressures in out of area expenditure.

The forecast assumes full delivery of the £6.4m deficit plan and all organisations within the Derbyshire System are still forecasting to achieve plan but with emerging risks predominantly in the acute providers. The key assumptions in the forecast are listed in the report.

Mitigations to offset some of these risks relate to vacancies, some as a direct result of the recruitment pause but also in relation to slippage on recruitment to developments.

Improvements in Safety

The Trust has a comprehensive action plan to embed the safety improvements. There is a robust governance framework in place, including clinical and operational oversight ensuring progress on all actions.

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 operational performance and regulatory compliance. The use of run charts provides the Board with performance assurance as it enables the differentiation between common cause and special cause variation.

Consultation

The content of this report has been considered in various other forums.

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 Trust's acute care service portfolio which provides services to individual based on holistic, person-centred assessment and so any decision 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

Recommendations

The Board of Directors is requested to confirm the level of assurance obtained on current performance across the areas presented. The recommended level is limited assurance.

Report presented by: **Vikki Ashton Taylor**
Deputy Chief Executive and Chief Delivery Officer

Tumi Banda
Director of Nursing, Allied Health Professionals, Quality and Patient Experience

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

David Tucker
Managing Director

Libby Runcie
Deputy Director of Nursing

Focused Performance Report

Part 1 - Improving Flow in Adult Acute Services

Governance

The Urgent Care Mental Health Transformational Delivery Board provides a platform to monitor the progress of the overall flow recovery action plan (RAP), and is led by David Tucker, Managing Director and Becki Priest, Deputy Director and Chief Allied Health Professional. The action plan identifies a range of clinical and operational developments and provides engagement and oversight with the various workstreams, identifying blocks to progress and establishing mitigations as required.

Measures of Success

The following are metrics that have been identified to illustrate impact of this work:

- Out of area placements – reduction in the number of inappropriate acute out of area placements. To maintain position of less than four
- Length of stay – reduction in the average length of stay for adult acute inpatient care. To maintain a position of less than 32 days
- Occupancy levels – reduction in the occupancy levels for adult acute inpatient care. To maintain a position less than 95% bed occupancy
- Admissions – reduction in the number of patients admitted each month from an average of 80 per month to 70 per month
- Emergency Department 12-hour breaches – reduction in 12-hour breaches to zero
- Crisis house beds – increase usage in crisis house beds to achieve 80% occupancy
- Clinically ready for discharge – reduction in the number of inpatients identified as clinically ready for discharge to under 4% of total inpatients.

Update

The Delivery Board was relaunched in July 2024. Some workstreams are newly established whilst others have been progressing for some time. Leads for the newer and more complex workstreams have been asked to develop workstream objectives and project proposals for purposes of clarity.

Some workstreams are transactional and expected to be short lived (for example, development of standard operating procedures (SOP)) whereas others are more transformational (for example, Purposeful Admission and Gate Keeping) and will have longer lifespan.

Monthly Update

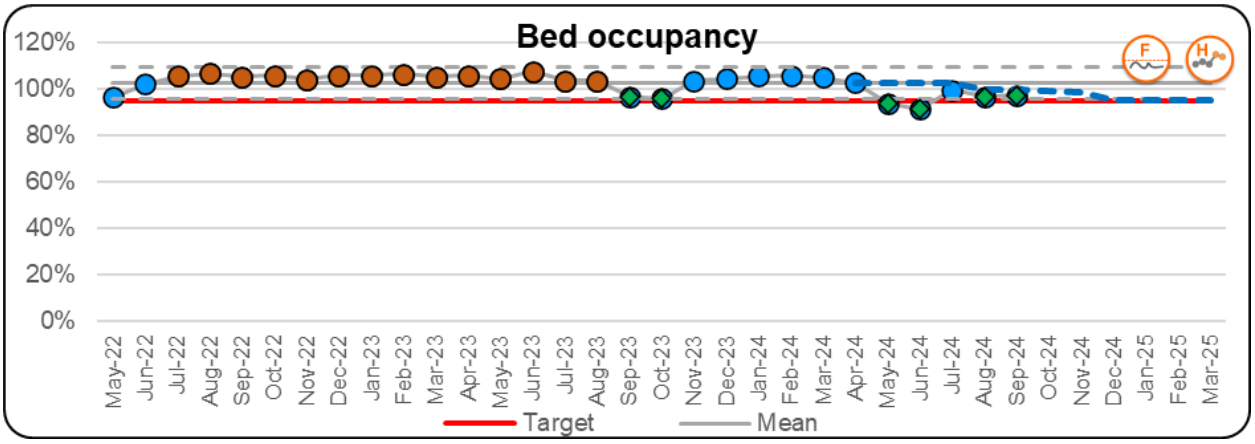
As the Delivery Board develops it is expected that it will be possible to provide an update from each workstream to the Delivery Board each month.

Metrics

As mentioned above a range of metrics have been identified to help illustrate impact and success. Below is a summary of the latest position in relation to these metrics.

1. Bed occupancy

The chart gives the proportion of Trust adult acute inpatient beds that were occupied each month. In September, the position was 97%, which was a slight reduction from the previous month. The solid red line indicates the target of 95%. The national benchmark data is 90.2%. The trajectory is indicated by the blue dotted line.

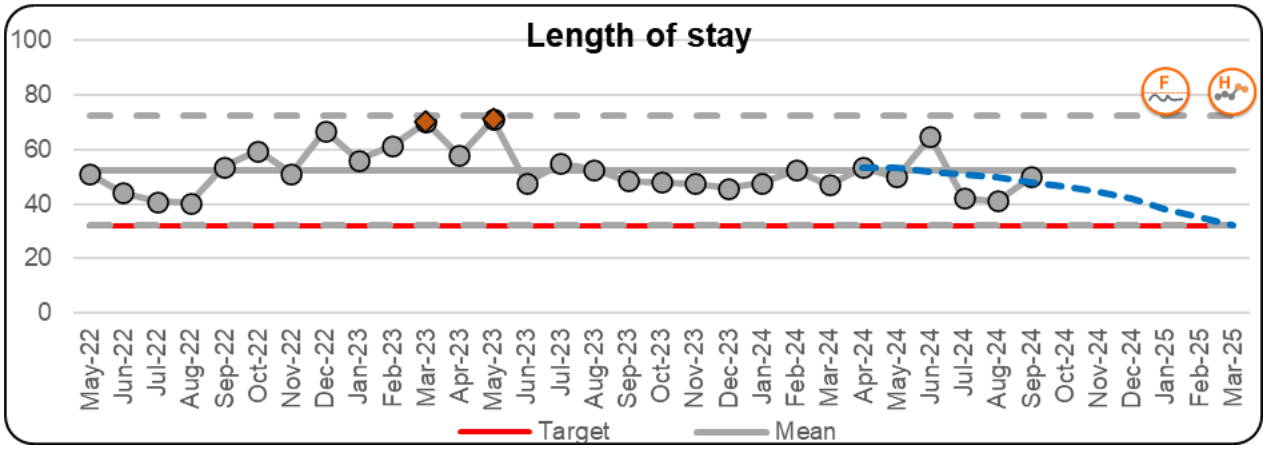


Update

- Gatekeeping process is being implemented which ensures a multi-disciplinary review prior to admission
- The process will slow down the decision to admit but will increase likelihood of avoiding admission wherever possible
- Review of leave bed protocol has resulted in reduction in admissions into leave beds, hence helping to reduce bed occupancy levels
- The position has improved this month and continues to remain ahead of trajectory.

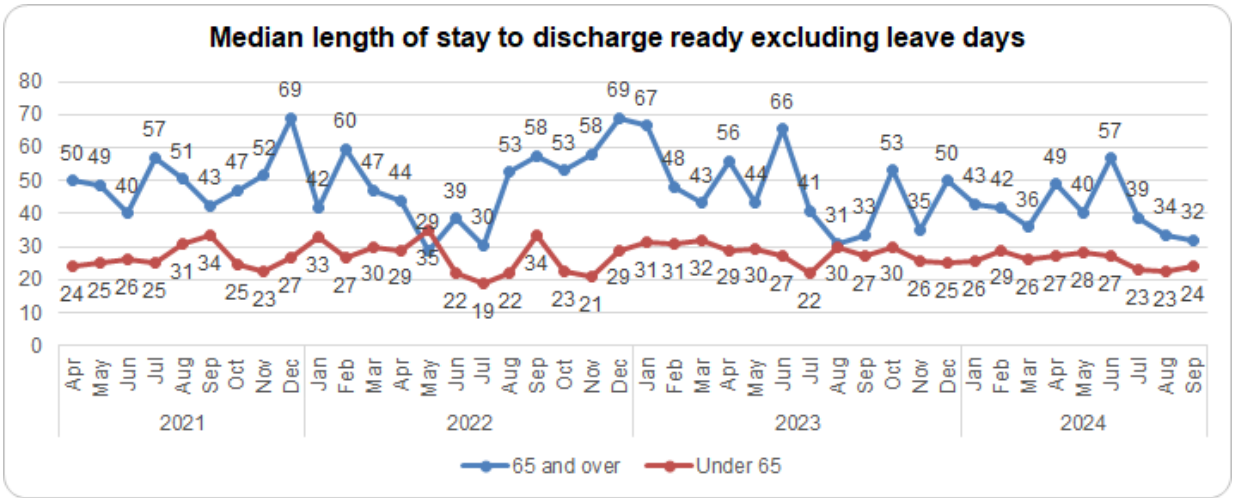
2. Length of Stay

Adult acute inpatient length of stay (mean average length of stay of patients discharged in month from Trust adult acute beds, excluding Pleasley Ward patients aged over 65 years) which for August is 41 days. The solid red line indicates the target which is 32 days. The national benchmark data (solid grey line) currently stands at 54.4 days. The trajectory is indicated by blue dotted line.



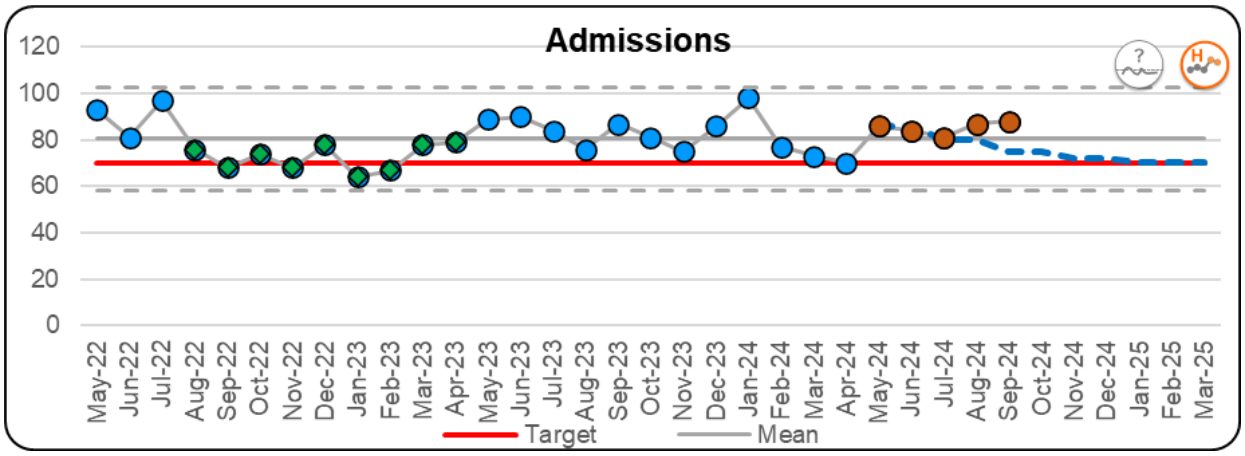
Update

- Given that the data is collected at point of discharge, this data is distorted when patients with a longer length of stay are discharged, as was the case in September
- The position significantly improved in July and August
- When calculating inpatient length of stay in the same way as likely was used when the 32-day national target was set (median length of stay excluding leave days, of acute inpatients discharged aged under 18-64 years – NHS Benchmarking Club), the Trust's adult acute length of stay is below the national target and has been achieved every month since October 2022. See below:



3. Admissions

The chart shows the number of admissions to Trust adult acute inpatient beds during the month, which for September was 88. The solid red line indicates the target, which reflects the aim to reduce admissions by an average of 10 per month by financial year end. The blue dotted line indicates the trajectory.



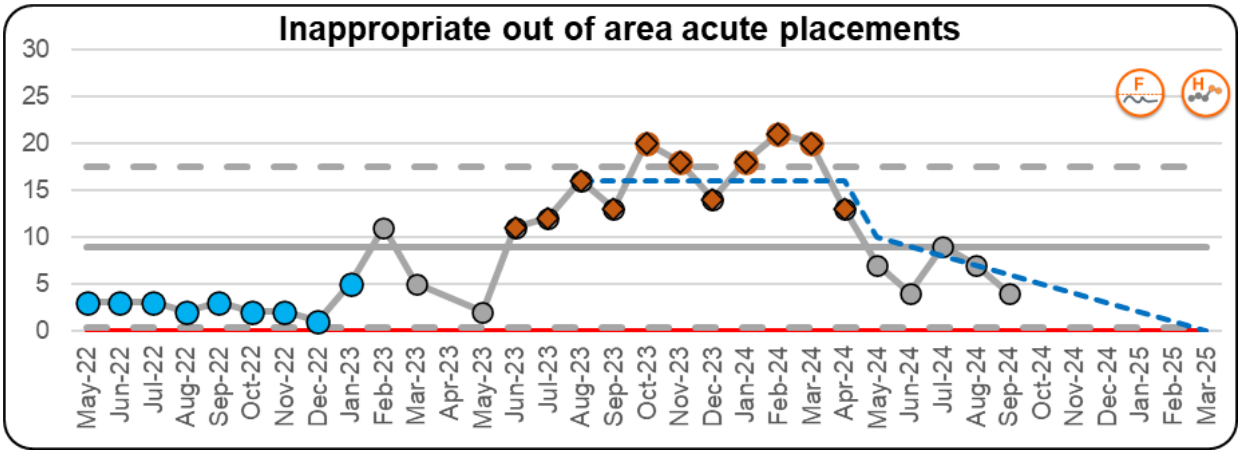
Update

- The introduction of the gatekeeping process was contributing to the reduction in number of admissions into inpatient beds over the past few months. However, this improvement has not been sustained for the last two months, which were above trajectory

- The number of admissions in a single month is not necessarily problematic or indicative of ongoing concern. However, were this to be combined with an extended length of stay, it is likely that it would cause capacity issues. Therefore, owing to this being two months only and combined with low median length of stay, this is not causing any significant concern at this point.

4. Inappropriate Adult Acute Out of Area Placements

The chart shows the number of patients in inappropriate adult acute out of area mental health beds at month end, which for September was seven. The solid red line indicates the target which is zero use of inappropriate out of area acute beds. The blue dotted line indicates the trajectory.

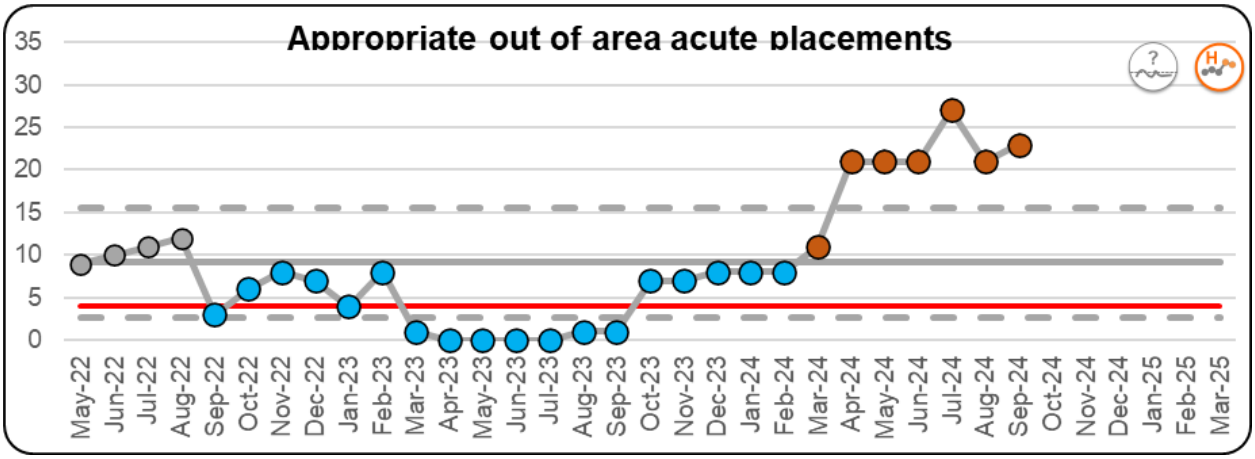


Update

- Progress continues to be made in line with trajectory and at the end of September there were just four patients placed out of area
- The overall improvement since February 2024 is encouraging.

5. Appropriate Acute Out of Area Placements

The chart shows the number of patients in appropriate adult acute out of area mental health beds at month end, which for September was 23. This will include patients placed in units where continuity of care principles are being met (Sherwood, Mill Lodge), individual patient choice, or where the patient is a staff member. The solid red line indicates the target of four per month.

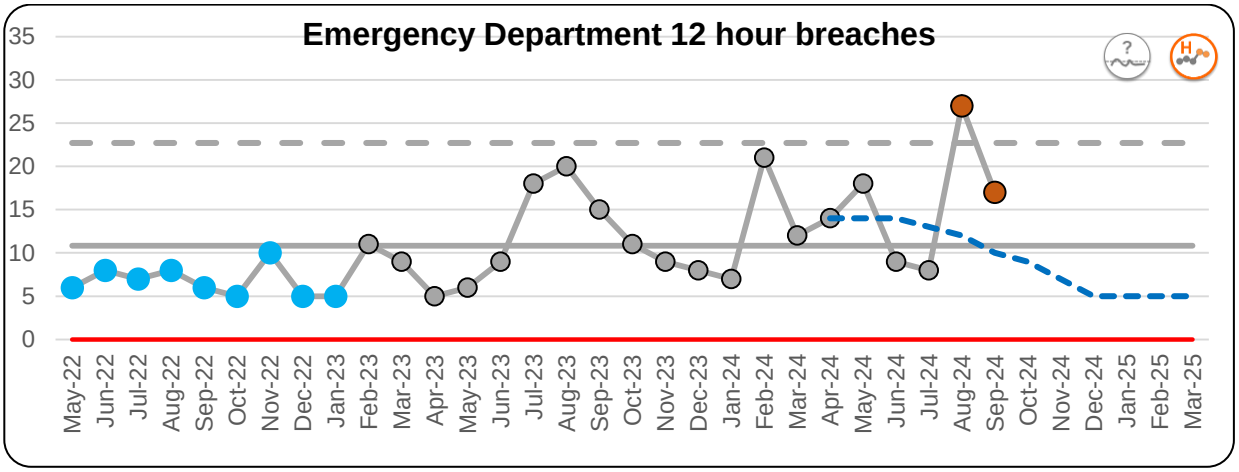


Update

- There are block contracts in place for 12 beds at Sherwood and 6 Beds at Mill Lodge, where continuity of care principles are met
- Additional spot purchase beds at Sherwood and Mill Lodge have been available resulting in additional “appropriate” placements
- Staff members are placed in non-trust and non-block contract beds
- This performance is in part related to the Making Room for Dignity programme which has resulted in a number of closed Trust beds, reducing capacity for admissions.

6. 12-hour Emergency Department Breaches

The chart shows the number of 12-hour breaches in Emergency Departments (ED) during the month, which for September was 17. The solid red line indicates the target of zero ED breaches every month. The dotted blue line indicates the trajectory.

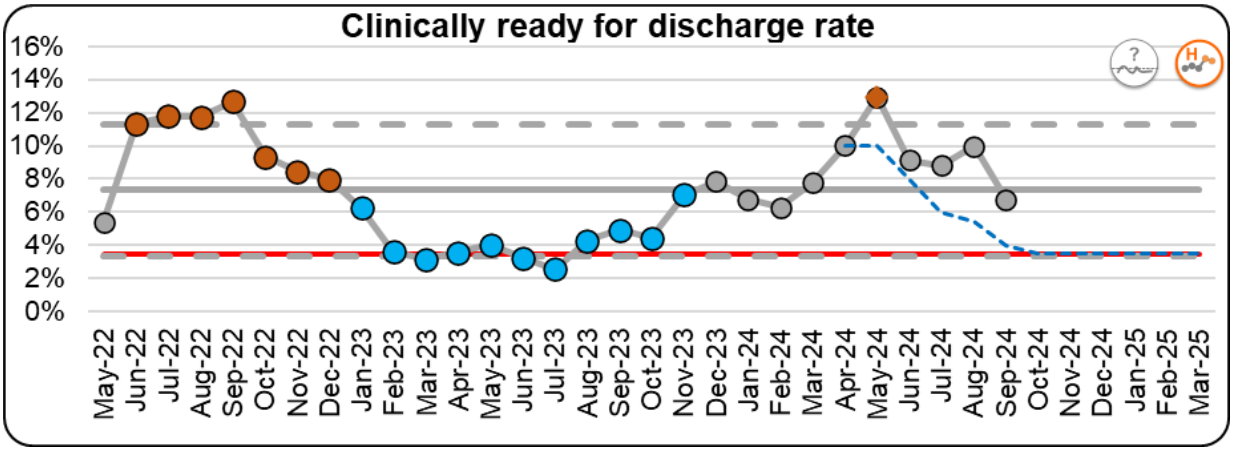


Update

- The national clock start time measurement has been adjusted to the point of arrival in ED, where previously it was from point of referral to the mental health liaison team. As predicted, this will increase the number of 12-hour breaches. Often the patient will be in ED for many hours before a Mental Health Act assessment is carried out. As a result, it is not uncommon that the patient has been in ED for more than 12 hours before a decision is made that the patient needs to be admitted to a mental health bed
- The gatekeeping process also takes time by facilitating a multi-disciplinary review of the patient’s care and how current crisis can be managed. A comprehensive gatekeeping process can prevent the patient being admitted to hospital. Unfortunately, attempting to make a decision to admit too quickly will increase the likelihood of admission
- Liaison with the acute hospitals and the Integrated Care Board (ICB) has taken place to explain the potential impact of the new gatekeeping process and we are working together to help manage this
- To commission an in-depth review in order to gain greater insight and explore whether further actions might be taken within the Trust and/or with partners to reduce the number of 12-hour breaches.

7. Clinically Ready for Discharge (CRFD)

The chart shows the proportion of patients in adult acute beds who were clinically ready for discharge, which for September was 6.8%. The solid red line indicates the target of 3.5%. The blue line indicates the trajectory. The current benchmarking data with peers was 7.1% (Model Mental Health clinically ready for discharge July 2024).

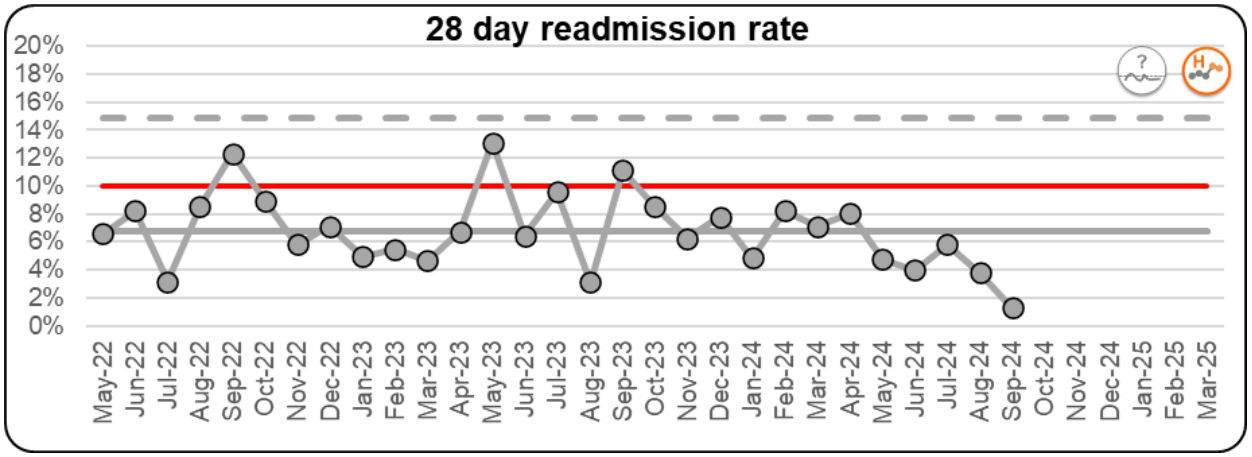


Update

- The proportion of patients that are CEFD remains higher than trajectory
- Escalation process established including weekly multi agency forum
- The Strategic Integrated Flow Lead now attends Pathways Operation Group (POG), System-Wide Discharge Planning Implementation Group (DPIG) and Strategic Discharge Group (SDG). Work underway to ensure mental health position is standing item on agendas
- Analysis of patients CRFD indicates main themes are housing, placement providers (lack of beds or declining patients due to risk), funding decisions (awaiting panel decisions and often panel declining placement offers despite numerous other options having been explored) and patient and family choice
- To commission a deep dive to gain greater insight and explore whether further actions can be taken within the Trust and/or with partners to reduce number patients clinically ready for discharge.

8. Readmissions

The chart shows the proportion of patients readmitted to a trust bed within 28 days of discharge, which for September was 1.3%. The target is to achieve under 10% which is indicated by the solid red line. There is currently no benchmarking data available.

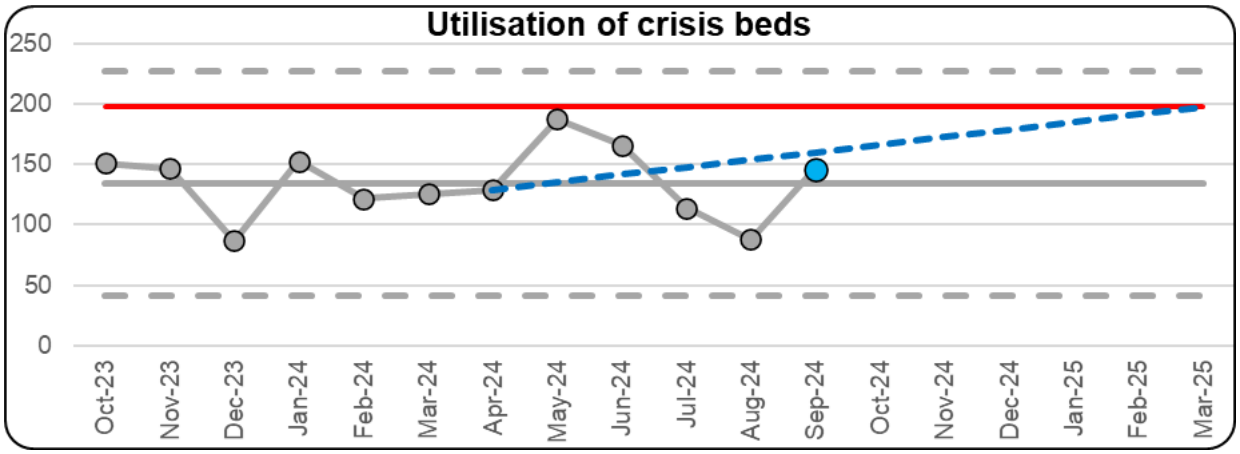


Update

- Generally, the readmission rates have been very low and this is something we are very keen to maintain. Monitoring this metric provides a quality measure indicating the potential impact of work being carried out.

9. Crisis House Bed Use

The chart shows the number of occupied bed days during the month. The solid red line indicates the target which reflects 80% occupancy. The blue dotted line indicates the trajectory.



Update

- The increased usage of the crisis house in May has not been sustained
- The position is underperforming when compared to the trajectory, however in September there has been a statistically significant increase
- To commission an in-depth review to gain greater insight and explore whether further actions can be taken within the Trust and/or with partners to increase utilisation of Crisis House beds.

Conclusion

The Urgent Care Mental Health Transformational Delivery Board is at an early stage since the relaunch. This provides a platform to monitor the progress of the workstreams, identify blocks and mitigations. Progress is being made and this is beginning to impact on the performance data as indicated within this report. There are a number of metrics that are ahead of trajectory. However, there is some early indicators that other metrics are struggling. As a result, some initial actions are proposed.

Further benefits are anticipated from a number of the additional actions set out in the RAP, for example the culture of care and model of care approach to patient care has only just launched but will have a positive therapeutic impact on patients. In addition, the purposeful admission is expected to have more impact as we go forward, and the Community Mental Health Team (CMHT) use of MAST as a predictive tool should highlight a cohort of patients that are likely to be admitted into hospital and enable earlier intervention to prevent the need for an inpatient bed.

Current Performance

Despite the significant efforts to improve patient flow, the month of October has seen an increase in demand for inpatient beds which has impacted both bed occupancy levels and patients being cared for in an out of area bed. Additional actions to address these pressures have included the implementation of regular mini MADE events with system partners to support the discharge of patients who are clinically ready for discharge (now daily), daily senior reviews of all in patients across the units and CMHT review of escalated patients. Looking forward, we are partnering with Nottinghamshire and Leicestershire Trusts to share learning and best practice and visiting Lincolnshire to see their Mental Health Walk-in Centre in action.

Part 2 - 2024/25 Financial Position

At the end of September, the year to date (YTD) position is a deficit of £4.1m which is slightly better than plan by £0.1m. Pay and income are below plan mainly due to slippage on investments and non-pay expenditure is above plan reflecting pressures in out of area expenditure.

The forecast assumes full delivery of the £6.4m deficit plan and all organisations within the Derbyshire System are still forecasting to achieve plan but with emerging risks predominantly in the acute providers.

Key assumptions in the forecast:

- CIP is delivered in full, with 25% of the balance being assumed as cost out of the forecast and the other 75% will be delivered from vacant posts and therefore costs not in the forecast
- Acute out of area – forecasted placements are significantly higher than the plan which is generating £1.5m adverse variance (£1.3m last month)
- In-patient areas – Adult Acute wards are off plan by £2.3m with other wards underspending by £0.2m, net adverse variance of £2.1m
- Making Room for Dignity programme slippage has additional costs included against it in the forecast, consuming a significant proportion of the current YTD slippage
- Costs related to supporting the patient with complex needs ended at the beginning of September.

Mitigations to offset some of these risks relate to vacancies, some as a direct result of the recruitment pause but also in relation to slippage on recruitment to developments.

Part 3 - Improvements in Safety

Trust has a comprehensive action plan to embed the improvements safety. There is a robust governance framework in place, including clinical and operational oversight ensuring progress on all actions. Assurance reports are presented to the Quality and Safeguarding Committee.

Our Trust has signed up for two national programmes that support quality improvement (QI) in mental health inpatient settings. The Culture of Care programme is supported by Royal College of Psychiatrists and the Mental Health Act Quality Improvement programme is supported by Viriginia Mason Institute. Though the programmes are linked to specific wards, there is a plan to share any learning from the QI programmes with all of the inpatient services.

The inpatient areas have made progress in several quality and safety domains and quantitative data has been shared with CQC to evidence this. The progress made is summarised below:

Seclusion

- The number of new episodes of seclusions between May-August 2024 have decreased by 21%
- This will continue to be monitored through the patient safety meetings and the Reducing Restrictive Practise Group.

Number of Incidents Involving Physical Restraint

- Physical restraints have decreased by 56%, this decrease is attributable to a reduction on self-harm incidents and staff intervention required to prevent individuals harming themselves.

Number of Self-harm/Ligatures

- Ligature incidents have reduced by 19%
- Several workstreams continue to work towards improving care and reducing incidents and self-harm including a e-learning module and talk sessions.

Number of incidents of moderate to catastrophic harm

- These have decreased and there is a debrief in place for both staff and patients and this is audited from both a compliance and quality perspective.

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 5 November 2024

Trust Strategy - 2024-2028

Purpose of Report

To present the new Trust Strategy 2024–2028 for approval.

Executive Summary

Engagement on the development of a new Trust Strategy has taken place throughout 2024, with feedback received from a large number of people representing a variety of internal and external audiences. These comments have directly shaped the content and format of the new Trust Strategy.

The Trust Strategy includes an updated Trust vision, values and strategic priorities. It also includes a new Personal Accountability Charter, focused on how we can strengthen colleagues' personal accountability to demonstrate the behaviours our values expect.

A detailed Delivery Plan will support the new Trust Strategy and outline the ways in which our strategic priorities will be achieved. Progress will be reported to the Trust's Board of Directors on a quarterly basis.

The Trust Strategy also reflects the new brand identity being introduced across Trust materials. The new brand will be rolled out as part of the wider plans to launch and embed the new Trust Strategy.

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 new Trust Strategy has been developed through an engagement approach with internal and external audiences. Many opportunities have been given for people to input and comment on the Strategy and a large number of people have been involved throughout the year
- This engagement has directly shaped the content and format of the new Trust Strategy, including the development of a new Personal Accountability Charter
- Language and accessibility have been central to conversations about the new Strategy, with the overall readership age of the Trust values (as the most public facing aspect of the Strategy) being reduced.

Consultation

Extensive engagement has taken place, starting in February 2024 which has directly shaped the new Trust Strategy. This has included:

- Ongoing engagement with Trust staff, with virtual and face to face sessions taking place on different aspects of the Trust Strategy throughout the year
- Regular conversations have taken place with the Trust's Council of Governors, staff networks, carers and the EQUAL Forum, with changes being made to reflect the feedback received
- During September and October 2024 a draft version of the Trust Strategy was shared with partners and external stakeholders to gain wider feedback, including two drop-in engagement sessions to discuss the new Trust Strategy.

Governance or Legal Issues

The Board Assurance Framework (BAF) will be updated in line with the new strategic priorities.

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

- The Trust's approach to equality, diversity and inclusion is outlined in the Trust Strategy
- Consideration has been given to health literacy and readership age, particularly with the new public facing Trust values, where the value titles have a reading age of 14 and the descriptions a reading age of 15.
- Imagery included reflects a variety of protected characteristics.

Recommendations

The Board of Directors is requested to Approve the new Trust Strategy.

Report presented by: **Vikki Ashton Taylor**
Deputy Chief Executive and Chief Delivery Officer

Report prepared by: **Anna Shaw**
Associate Director of Communications and Engagement

Derbyshire Healthcare
NHS Foundation Trust

Trust Strategy

2024–2028

WE MAKE A POSITIVE DIFFERENCE IN EVERYTHING WE DO

Chief Executive's introduction

NHS
Derbyshire Healthcare
NHS Foundation Trust

Welcome to Derbyshire Healthcare's Trust Strategy for 2024–2028. This Strategy outlines our new, bold vision for the future, and the ways we will work in order to achieve our ambitions. We are committed to making positive changes that, in turn, have a positive impact on the people we support.

It is important that the Trust Strategy tackles current challenges, whilst also being flexible in adapting to a changing social and political environment over the coming years.

We have many examples of excellent practice, innovations and making improvements to the ways we work. This Strategy aims to build on and extend our previous successes.

We are moving forward and addressing the challenges that remain following the COVID-19 pandemic, where we have seen a significant increase in demand for all our services. We have also experienced changes in people's expectations of our services and how they want to access and fulfil their healthcare needs, together with changes to the ways people work and their expectations of the Trust as a good partner, and prospective or long-term employer.

This Strategy seizes an opportunity to transform our services and the way we work. Our ambition is to make ongoing improvements to the care we provide, in a way that improves and enhances people's access, outcomes and experiences of our services, making continuous quality improvements. We will make better use of data and digital technologies to achieve our strategic priorities.

Our ambition is to support people in the community as much as possible, working with local partners to provide joined up care that supports people to live at home, remain in work and access the support they need to live healthy lives.

Alongside this approach we are seeing an increasing number of people who present with a range of complex health needs and conditions. It is important that we provide local access to services that support this group of people, and that we provide care through modern, evidenced based approaches, and in environments that promote privacy and dignity that aid recovery.

We face a number of complex challenges and start this Trust Strategy in a deficit financial position. We will need to take bold and difficult decisions with our partners to ensure that we continue to provide good quality of care to people who access our services, whilst also having a sustainable financial future.

Our greatest resource are our colleagues. We need to work with our colleagues to build an inclusive culture that enables teams to improve and innovate to meet the demands of a challenging healthcare environment. Our approach to achieving the strategic priorities outlined in this Strategy can be seen in the Trust's new vision and values, which have been co-created with our colleagues, governors, carers and people with lived experience of our services.

Our colleagues have asked for clearer accountability, so we have co-produced a new Personal Accountability Charter that sets out how we expect our values to be expressed through our day-to-day interactions, creating a new, more visible, culture of accountability

A significant part of the Strategy is our ongoing commitment to equality, diversity and inclusion. This runs through our vision, values, strategic priorities and personal accountability charter.

I'm excited about the Strategy and the opportunity it affords us to make a real and positive difference to the lives of people in Derby and Derbyshire.

Mark Powell
Chief Executive

Strategy on a page

NHS
Derbyshire Healthcare
NHS Foundation Trust

Our vision

We make a positive difference in everything we do

Our strategic priorities

Our values

Caring
We provide safe care and support people to achieve their goals

Inclusive
We respect and include everyone in all we do

Patient focused
Our care and clinical decisions will be respectful of and responsive to the needs and values of our service users, patients, children, families and carers.

Partnerships
We will work together with our system partners, explore new opportunities to support our communities and work with local people to shape our services and priorities.

WE MAKE A POSITIVE DIFFERENCE IN EVERYTHING WE DO

Ambitious
We offer high quality services, and we commit to ongoing improvement

Belonging
We come together to create a culture that is welcoming, open and trusting

People
We will attract, involve and retain staff creating a positive culture and sense of belonging

Collaborative
We work together to achieve the best outcomes for our people and communities.

Productive
We will improve our productivity and design and deliver services that are financially sustainable.

About us

Derbyshire Healthcare is a provider of NHS mental health, learning disabilities and substance misuse services in Derby city and Derbyshire county. We also provide a wide range of children's health services in Derby and southern Derbyshire, and we run the East Midlands Gambling Harms Service.

Derbyshire is a county that covers 1000 square miles with a population of about one million people. The rural, semi-rural and urban landscape gives rise to a mixture of affluent and seriously deprived areas. The city of Derby is a vibrant place where over 300 languages are spoken.

There are a number of health inequalities experienced by communities in Derby City and the county of Derbyshire that impact upon people's physical and mental health and wellbeing.

**Derbyshire Healthcare NHS Foundation Trust is working in partnership with Derbyshire Community Health Services NHS Foundation Trust through an Alliance model, to provide an integrated Adult Neurodevelopmental Service.*

Our services

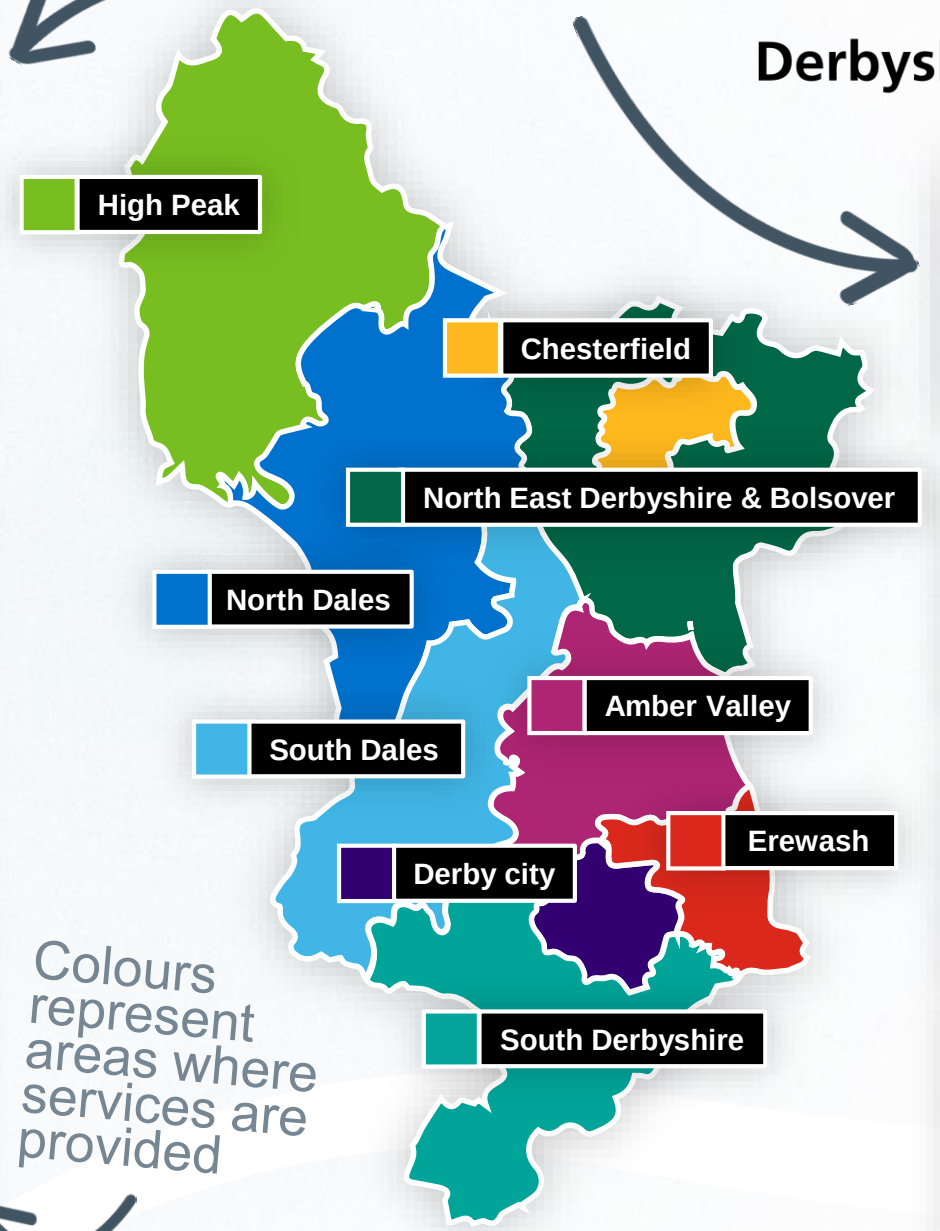
NHS
Derbyshire Healthcare
NHS Foundation Trust

Mental health services
Community mental health services are offered across the county. Our inpatient mental health services for adults, older adults, rehabilitation and forensic services are county-wide but located in Derby and Chesterfield.

Children's public health services
Such as health visiting and school nursing

Substance misuse services
Drug and alcohol recovery services

Gambling harms service (also across all the East Midlands)



Colours represent areas where services are provided

Children's complex health services
Supporting children with neurodevelopmental, behavioural and physical and movement needs

Adult learning disability/ neurodevelopmental services*

Child and adolescent mental health services (CAMHS) and children's eating disorders services

Eating disorders services for adults

Context

Derbyshire Healthcare
NHS Foundation Trust

The context within which this Trust Strategy has been developed is important, as our actions and priorities must meet the needs of the day, whilst also being flexible to accommodate new priorities as the environment continues to evolve.

Our Strategy is being developed in the initial months of a new Government. The Darzi Review, which identifies current problems across the NHS has recently been published, ahead of a new Health Plan which is expected next year. Nationally there are three required shifts:

- From hospital to community settings
- From analogue to digital services
- From treatment to preventative approaches.

Whilst this Strategy outlines our approach to these three priorities, it is important that we continue to respond to any new legislation or developments that take place across the NHS and the services we provide. An annual Delivery Plan will sit alongside this Trust Strategy to ensure progress against all strategic priorities is met.

Over recent years we have worked in line with the requirements of the NHS Long Term Plan (2019) and the subsequent NHS Mental Health Implementation Plan, which outlines a commitment to mental health services at a local level.

There continue to be many local and national priorities to be delivered by the Trust, with an ongoing commitment to improving services for children and people with mental health needs. Locally there continues to be commitment to the Mental Health Investment Standard (which sets guaranteed levels of spending on mental health services) although we are facing increasing pressure to make financial savings that will mean the Trust may become unable to deliver full improvements as anticipated.

The Derbyshire Strategic Plan for Mental Health, Learning Disability and Autism 2024-2027/8 outlines a focus on culture of care, what good looks like and care closer to home.

This Strategy outlines our organisational response to the national and local context set out above.

Within Derbyshire the Trust is developing a series of new facilities, which will start to open to patients during Winter/Spring 2024/25.

Bluebell Ward, a dedicated inpatient environment to support older adults with functional mental health needs, opens on the Walton Hospital site in Chesterfield in Winter 2024. This meets our clinical ambition to provide separate bespoke environments for adults and older adults, in line with best practice.

Derbyshire is one of a very small number of areas in the UK that continues to provide inpatient mental health services from outdated dormitory style wards. The county also currently has no local Psychiatric Intensive Care Unit (PICU) which means local people currently travel outside of Derbyshire to access this increased level of support.

Our new facilities in Derby and Chesterfield will offer en-suite accommodation across modern ward environments, together with a PICU co-located with the new acute mental health unit in Derby. This will significantly improve the privacy and dignity people experience when they are supported in our ward environments and provide a full range of mental health care close to home.

Whilst there are many positive things that we can build on, we know that demand for all our services is growing, and we are seeing people with increasingly complex needs. This means we need to increasingly transform and re-shape our services to ensure that those in most need are able to access our services. This is going to require some fundamental change to how we provide services, who to and where from. Continuing to do the same as we always have done, won't enable us to meet these challenges, so we will need to be bold and brave.

It is important that we embrace new technology, new ways of working and test innovative models of care to help us meet the increase in demand we have seen over recent years.

We also need to recognise that we can't do everything on our own and in isolation. Working with key partners and collaborating with others will help us achieve the ambitions set out in this strategy, so we must invest time in building relationships so that we can best meet the needs of our service users, patients and their loved ones.

Derbyshire Healthcare
NHS Foundation Trust

Vision and values

Derbyshire Healthcare
NHS Foundation Trust

Our vision

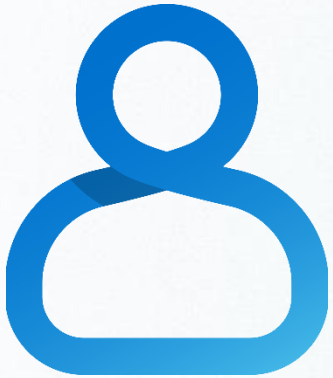
"We make a positive difference in everything we do."

Our values

Derbyshire Healthcare
NHS Foundation Trust

Caring

We provide safe care and support people to achieve their goals.



Inclusive

We respect everyone in all we do.

Ambitious

We offer high quality services, and we commit to ongoing improvement.

Belonging

We come together to create a culture that is welcoming, open and trusting.

Collaborative

We work together to achieve the best outcomes for our people and communities.

NHS
Derbyshire Healthcare
NHS Foundation Trust

Strategic priorities

Strategic priorities – the four Ps

Derbyshire Healthcare
NHS Foundation Trust

Our strategic priorities outline the high-level initiatives we will focus on in order to deliver the Trust vision. They will be a foundation for our decision making and resource allocation and form the basis of how we will measure performance and successful delivery of the Trust Strategy.

The priorities are all of equal focus and importance. Each will remain in place for the three years this Trust Strategy covers (Winter 2024 – Spring 2028) and will have a set of key deliverables which set under each priority. These will be reviewed on an annual basis to monitor progress, completion and to identify any new deliverables that reflect the changing environment in which we work.

A number of key plans and documents will support delivery of the strategic priorities, as outlined on the subsequent pages. Where these documents are not in place, they will be developed during the life of this Trust Strategy.

Our strategic priorities will be known as our four Ps:

Patient focused

Our care and clinical decisions will be respectful of and responsive to the needs and values of our service users, patients, children, families and carers.

People

We will attract, involve and retain staff creating a positive culture and sense of belonging.

Productive

We will improve our productivity and design and deliver services that are financially sustainable.

Partnerships

We will work together with our system partners, explore new opportunities to support our communities and work with local people to shape our services and priorities.

Patient focused

Derbyshire Healthcare
NHS Foundation Trust

Our care and clinical decisions will be respectful of and responsive to the needs and values of our service users, patients, children, families and carers.

Strategic intent:

Our services will deliver safe and high-quality care.

What success will look like:

- Improved patient experience and satisfaction
- Co-producing the way we provide care with people who use our services
- Improved timely access to our services
- Continuous improvement underpins our way of working
- A safety and learning culture
- Retain and improve our Care Quality Commission (CQC) rating
- We get the basics right and this results in improved outcomes
- Staff are confident in managing risks using evidence-based interactions
- Multi-disciplinary team working is embedded throughout our services.

This priority is supported by the following enabling plans:

- Clinical Plan
- Digital Plan
- Patient and Carer Experience Strategy
- Quality Strategy
- Continuous Improvement Plan
- Research and Development Plan.

People

Derbyshire Healthcare
NHS Foundation Trust

We will attract, involve and retain staff creating a positive culture and sense of belonging.

Strategic intent:

Derbyshire Healthcare is a great place to work.

What success will look like:

- Attracting a high skilled and diverse range of applicants to our roles
- Retaining our diverse talent through growth and development
- Staff survey results that are top scoring amongst our peers
- Competitive staff benefits and wellbeing offer
- Staff are delivering at the top of their professional standards
- Opportunities for professional and career development We are recognised as a truly diverse and inclusive Trust
- Being the employer of choice.

This priority is supported by the following enabling plans:

- People Plan
- Communications Plan
- Digital Plan
- Research and Development Plan
- Continuous Improvement Plan.

Productive

Derbyshire Healthcare
NHS Foundation Trust

We will improve our productivity and design and deliver services that are financially sustainable.

Strategic intent:

Our services will be productive, demonstrate best value for our population and be cost effective.

What success will look like:

- To increase productivity through continuous improvement approaches
- Understanding of our cost base
- Delivery of the agreed financial plan
- Reduction in overhead costs
- Increased proportion of money spent on community and care closer to home
- Our services access and use accurate and timely data to make improvements
- Our services make use of digital technologies
- Reduced NHS Carbon Footprint
- More efficient and effective use of our buildings
- Establish a business unit for income generation.

This priority is supported by the following enabling plans:

- Financial Sustainability Plan
- People Plan
- Sustainability Plan (incorporating the Green Plan)
- Estates Plan
- Digital Plan
- Continuous Improvement Plan
- Research and Development Plan.

Partnerships

Derbyshire Healthcare
NHS Foundation Trust

We will work together with our system partners, explore new opportunities to support our communities and work with local people to shape our services and priorities.

Strategic intent:

Our organisation will identify new ways of working, through new collaborative approaches.

What success will look like:

- Develop community mental health services aligned to our communities and Place
- Becoming a Teaching Trust
- Seamless pathways through integrated services
- Better understanding of our communities' needs and health inequalities
- We work with our local communities to improve our services and support healthy lifestyles
- Co-production and co-development with Experts by Experience, carers and service users
- We deliver as an anchor organisation
- We are a strong partner in Joined Up Care Derbyshire and the East Midlands Alliance.

This priority is supported by the following enabling plans:

- Research and Development Plan
- Clinical Plan
- Community and Stakeholder Engagement Plan
- Communications Plan
- Digital Plan.

NHS
Derbyshire Healthcare
NHS Foundation Trust

Additional information

Our partnership approach

Derbyshire Healthcare
NHS Foundation Trust

Derbyshire Healthcare is a partner of the Derbyshire Integrated Care System, locally called Joined up Care Derbyshire (JUCD). System working in this way brings organisations together to work with a joined-up approach.

The purpose of JUCD is to collectively:

- Improve health and wellbeing
- Improve care and quality of services
- Improve financial efficiency and sustainability.

In addition to this system-wide approach, the Trust is working in partnership with Derbyshire Community Health Services NHS Foundation Trust (DCHS) through an Alliance model, to align services across the City and County for people with a learning disability and/or neurodevelopmental needs.

We are working in collaboration with other regional providers through the East Midlands Alliance for Mental Health, Learning Disabilities and Autism, to ensure a regional approach to specialist services. The Alliance aims to improve quality and productivity, enable safe care, develop our workforce, improve population health and reduce inequalities.

Services are delivered through five provider collaboratives – Adult Eating Disorder, Child and Adolescent Mental Health Services (CAMHS), Forensic, Perinatal and Veterans – which operate across the East Midlands and are each led by one of the Alliance partners.

Derbyshire Healthcare is the lead provider for the Perinatal Provider Collaborative. The Trust is also the lead provider for the East Midlands-wide Gambling Harms Service.

The Trust is committed to delivering services at a local level (at Place), working closely with local statutory partners and the voluntary and community social enterprise (VCSE) sector. We have recently progressed this approach through the delivery of Living Well/Derby Wellbeing, which has a strong multi-agency approach in line with the requirements of the national Community Mental Health Framework. The Trust's services for children and young people, are also increasingly delivered at Place.

The Strategy emphasises that we aspire to be a great partner and that we are committed to building on the partnerships and collaborations we have in place, taking forward further opportunities to join up or integrate care in our communities. This will involve working with partners from all sectors to enable us to play our part in seeking to reduce health inequalities for the population we provide care to across Derby and Derbyshire.

Equality, diversity and inclusion

Derbyshire Healthcare
NHS Foundation Trust

A strong commitment to equality, diversity and inclusion (EDI) runs throughout this Trust Strategy. This applies equally to people who use our services to our colleagues, and relationships with our communities and partners.

The principles of equality, diversity and inclusion are relevant to all our strategic priorities, and this is a golden thread that runs throughout the Trust Strategy. One of the Trust values focuses on being inclusive in our approach and the way we work with others. This is supported by specific priorities outlining our inclusion approach within the strategic priorities on People, as outlined on page 12.

Priorities include:

- Having EDI objectives in place for the Trust Chair, Chief Executive and all Board members
- Implementation of the Patient and Carer Race Equality Framework (PCREF) to reduce racial inequalities
- Evidencing a speaking up culture with parity in protected characteristics
- Providing psychological support for victims of bullying, harassment, violence and discrimination
- Implementation of the commitments outlined in the Sexual Safety in Healthcare Charter
- Having reciprocal mentoring in place, with a focus on where it will have the most impact
- Utilising staff survey data on progression and career development to develop an understanding of where colleagues feel there are barriers and develop actions accordingly
- Developing a Trust-wide anti-racism approach, informed by existing best practice but co-created with colleagues to build engagement and motivation, and to model inclusion.
- Further supporting our staff networks and launching a Staff Networks Framework, with full complement of executive sponsors.

A culture of accountability

Derbyshire Healthcare
NHS Foundation Trust

The Trust Strategy has been developed through an engagement approach, which has involved Trust colleagues, partners, Trust governors and representatives of our patients, service users and carers. A draft version of the Trust Strategy was also shared with external stakeholders for feedback.

Whilst engaging with people about the development of the Trust Strategy, a recurring point of discussion focused on how we will ensure people adhere to the Trust values, and how we can strengthen colleagues' personal accountability to demonstrate the behaviours of values expect.

To achieve this, we have developed a new Personal Accountability Charter, that will sit alongside the new Trust Strategy.

This will be embedded into the Trust's People policies and outline a social contract between the Trust and its colleagues. Further developments also include a leadership accountability framework. A wider Organisational Development (OD) approach will be undertaken to embed the new charter into the Trust's culture.

The ongoing development of the Personal Accountability Charter will sit outside the strategic priorities included in the Trust Strategy. However, it is an important way in which the Trust values will be upheld across the Trust, and a key component of the Trust's wider cultural change.

Personal Accountability Charter

NHS
Derbyshire Healthcare
NHS Foundation Trust

Caring
We provide safe care and support people to achieve their goals

Inclusive
We respect everyone in all we do

Ambitious
We offer high quality services, and we commit to ongoing improvement

Belonging
We come together to create a culture that is welcoming, open and trusting

Collaborative
We work together to achieve the best outcomes for our people and communities.

Caring behaviours • We are kind • We are person-centred • We keep people safe	**How I can show caring behaviours** • I show kindness to others and think about their needs • I don't walk by if something is wrong or needs to be done • I meet professional standards
Inclusive behaviours • We are fair • We embrace and celebrate difference • We are professional	**How I can show inclusive behaviours** • I think about the impact of my actions on other people • I respect people and my surroundings and speak up when things don't feel right • I actively challenge discrimination
Ambitious behaviours • We learn • We are high performing • We are innovative	**How I can show ambitious behaviours** • I get the basics right, to underpin improvements • I listen, learn and improve • I deliver continuous improvements
Belonging behaviours • We are honest • We are accountable • We communicate	**How I can show belonging behaviours** • I look after my own health and wellbeing • I recognise the value and contributions of all colleagues • I take responsibility for what I do
Collaborative behaviours • We work well with others • We engage • We are good partners.	**How I can show collaborative behaviours** • I work with others to achieve shared outcomes • I break down barriers to achieving the best outcomes • I empower people to be partners in their care.

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 5 November 2024

Trust Sealings

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 7 May 2024.

Executive Summary

The Trust's Standing Financial Instructions (point 8.16) were revised in September 2024 to allow a more practical process for the signing of contracts, as the size of the organisation's contract values have grown. The authorised signatory limits reflect the delegated expenditure limits in section 3.2.2i.

Prior to the most recent change, all contracts over £500,000 were required to be sealed and these are the ones listed below. Going forward only deeds and contracts relating to the disposal, acquisition or leasing of land or property need to be executed under the Common Seal of the Trust.

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 7 May 2024. 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):

- DHCFT/121 (8 May 2024) Derbyshire Alcohol Advice Service (DAAS) County Substance Misuse between (1) DHCFT, and (2) Derbyshire Alcohol Advice Service (provision of adult integrated drug and alcohol treatment and recovery service)
- DHCFT/122 (24 May 2024) East Midlands Collaborative Perinatal Contract MH Lead Provider Model Subcontract for the provision of specialised mental health services (NHS standard contract) 2023/24 between (1) Derbyshire Healthcare NHS Foundation Trust, and (2) Nottinghamshire Healthcare NHS Foundation Trust
- DHCFT/123 (7 June 2024) Contract Variation: Provision of adult integrated drug and alcohol treatment and recovery service
- DHCFT/124 (14 June 2024) Contract variation – County Substance Misuse – additional payment for one off spend on staffing resources – funding from Derbyshire County Council Provider: Phoenix Ref. CV02, Commissioner: Derbyshire Healthcare NHS Foundation Trust
- DHCFT/125 (30 September 2024) NHSE East Midlands to Derbyshire Healthcare NHS Foundation Trust as Lead Provider for Perinatal services contract Ref: Derbyshire/LP Perinatal 2024/25.

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 7 May 2024 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**
Director of Corporate Affairs and Trust Secretary

Report prepared by: **Jo Bradbury**
Corporate Governance Officer

Emma Warrilow
Personal Assistant

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors - 5 November 2024

Board Assurance Framework (BAF)
Issue 3, 2024/25 – Version 3.3

Purpose of Report

To meet the requirement for Boards to produce an Assurance Framework. This report details the second issue of the BAF for 2024/25.

Executive Summary

Director Leads, Deputy Directors, Directors of Operations, Operational Leads and Trust Senior Managers have reviewed the risks to the Trust's strategic objectives for 2024/25 and provided comprehensive updates for the second issue of the BAF. The Executive Leadership Team (ELT) reviewed version 3.1 on 8 October 2024 and the Audit and Risk Committee (ARC) approved the updates (version 3.2) on 10 October 2024.

Due to altered scheduling of the Board (from September to October), updates being received from ELT after ARC, and further requests for content from ARC updates have been made since version 3.2 was approved. The updates relate to:

- The expected Lord Darzi report
- Review of Community Mental Health – Nottinghamshire Healthcare recommendations
- National Oversight Framework – Level 3
- Making Room for Dignity (MRfD).

The main updates to the risks are as follows:

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

The internal assurances on controls have been updated to reflect the outcome of the CQC inspection in April 2024.

The Culture of Care national programme and the new quality improvement programme are cited in the updates against actions for clinical quality improvement in inpatient areas.

A root cause has been added: National Oversight Framework (NOF) Level 3 quality issues, and the external assurances section has been updated.

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

The imminent opening of Bluebell Ward is noted. Once this has been completed (in October) the RAG rating will be changed to blue and it will be removed from the next version of the BAF.

Risk 1C - 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

The EPRR Core Standards Recovery Action Plan is on track and substantial compliance is expected to show in the regional assessment due in October.

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

The outcome of the NHSE review of the Trust's IPC approach (August 2024) has been noted.

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

One action relating to a person-centred culture of leadership and management has a change in RAG rating, going from amber to red, as the Civility, Respect and Resolution Policy that was due to in October 2024 will now be launched in January 2025.

An additional key gap in controls has been identified and actions recorded against it. This relates to the MRfD programme and the possible impact on recruitment and retention.

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

Two actions to close gaps in key controls have a change in RAG rating, going from amber to red:

- Onboarding and retention process and planning needs to be embedded – Additional posts are required in the preceptorship team
- Lack of culturally competent recruitment processes – Inclusive recruitment for chairs has commenced but is yet to be completed.

An additional external control has been added: Regular NOF Level 3 meetings with NHSE and ICB (in relation to Making Room for Dignity (MRfD) recruitment).

A key gap in control has been updated (onboarding and retention process and planning needs to be embedded) to include the possible retention issues linked to the MRfD programme.

Risk 3A – There is a risk that the Trust fails to deliver its revenue and capital financial plans caused by factors including non-delivery of Cost Improvement Programme (CIP) targets and increased cost pressures not mitigated resulting in a threat to our financial sustainability and delivery of our statutory financial duties

The Director of Finance has thoroughly reviewed the risk, has added to the possible impact of the risk, provided more detail in the key gaps in controls and identified more actions to close those gaps.

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

Two key gaps in control had been previously identified but the second one has been removed as the ICB has now fully recruited to vacant posts. This will be removed from the next issue of the BAF.

The impact measures of the remaining key gap in control have been split, to separate the corporate governance systems from the risk reporting to the wider integrated care system. The latter is established and this measure has been met by the Risk and Assurance Manager.

Risk 4B – There is a risk of reputational damage if the Trust is not viewed as a strong partner

The risk and progress against actions remain stable, the status is little changed in the last quarter.

An external assurance has been added: Regular NOF Level 3 meetings with NHSE and ICB.

One key gap in control has been removed: 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. This has been incorporated into the gap in controls regarding constitutional targets possibly not being met. The associated requirement and updates have been moved to this section as a specific action to show evidence of improved performance.

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

Progress with the Trust working alongside DCHS is noted – An integrated service provision for neurodevelopmental services across both organisations for the system has been established.

Operational Risks

One high level operational risk has been added to Risk 1A – 'Risk to public due to management of Section 37/41'.

A recent audit highlighted that clinical documentation is not of the standard to effectively support and manage this group of patients and that poses risks to members of the public. An action has been logged to discuss next steps and how patients on S37/41s could be managed under the Forensic CMHT.

BAF Reporting Cycle/Format

All changes/updates to this issue of the BAF, compared with Issue 2 2024/25, are indicated by tracked changes (blue text). All text that has been stricken through will be removed from the next issue (Issue 4 2024/25).

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
- Deputy Directors
- Directors of Operations
- Operational Leads
- Managing Directors
- General Managers
- Operational Risk Handlers

Formal Reviews

- Executive Leadership Team, Issue 3.1: 8 October 2024
- Audit and Risk Committee, Issue 3.2: 10 October 2024

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 second issue of the BAF for 2024/25 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**
Director of Corporate Affairs and Trust Secretary

Report prepared by: **Kel Sims**
Risk and Assurance Manager

Board Assurance Framework 2024/25 – Issue 3.3 Board November 2024

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

Ref	Risk	Director Lead	Risk Rating	Responsible Committee
Strategic Objective 1 - To Provide GREAT Care in all Our Services				
24-25 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, AHPs and Patient Experience (DON) / Medical Director (MD)	**HIGH**	Quality and Safeguarding Committee
24-25 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 Delivery Officer (CDO)	**HIGH**	Finance and Performance Committee
24-25 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 Delivery Officer (CDO)	**MODERATE**	Finance and Performance Committee
24-25 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, AHPs and Patient Experience (DON) / Chief Delivery Officer (CDO)	**MODERATE**	Quality and Safeguarding Committee
Strategic objective 2 – To be a GREAT Place to Work				
24-25 2A	There is a risk that we are unable to create the right culture with high levels of staff morale	Director of People, Organisational Development and Inclusion (DPOI)	**HIGH**	People and Culture Committee
24-25 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, Organisational Development and Inclusion (DPOI)	**HIGH**	People and Culture Committee
Strategic Objective 3 – To Make BEST Use of Our Resources				
24-25 3A	There is a risk that the Trust fails to deliver its revenue and capital financial plans caused by factors including non-delivery of Cost Improvement Programme (CIP) targets and increased cost pressures not mitigated resulting in a threat to our financial sustainability and delivery of our statutory financial duties	Executive Director of Finance (DOF)	**EXTREME**	Finance and Performance Committee

Strategic Objective 4 – To be a GREAT Partner				
24-25 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	Chief Delivery Officer (CDO)	**MODERATE**	Trust Board
24-25 4B	There is a risk of reputational damage if the Trust is not viewed as a strong partner	Chief Delivery Officer (CDO)	**MODERATE**	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) Intermittent lack of compliance with Care Quality Commission (CQC) standards, specifically the safety domain
~~c)~~d) National Oversight Framework (NOF) Level 3 quality issues
~~d)~~e) Lack of embedded outcome measures at service level
~~e)~~f) Lack of compliance with physical healthcare monitoring in primary and secondary care, not at the required level for reductions in mortality
~~f)~~g) Restoration and recovery of access standards in autism and memory assessment services
~~g)~~h) 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
~~h)~~i) 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
~~i)~~j) Due to the move in Electronic Patient Record (EPR) system there is potential that data quality could adversely affect clinical standards
~~j)~~k) Health inequalities across Derbyshire. Initial insights show gaps in access to service, case load and worsening patient outcomes for our patients
~~k)~~l) 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
~~l)~~m) Gaps in Advocacy for Children who are under 18
~~m)~~n) Capacity to learn 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

BAF Ref: 24-25 1A	**Director Lead**: Dave Mason (Interim DON) / Dr Arun Chidambaram (MD)	**Responsible Committee**: Quality and Safeguarding Committee

Key Controls

Initial Risk Rating			**Current Risk Rating**			**Target Risk Rating**			**Risk Appetite**		
High	Likelihood 4	Impact 4	High	Likelihood 4	Impact 4	Moderate	Likelihood 3	Impact 4	Accepted	Tolerated	Not Accepted

Preventative – Quality governance structures, teams and processes to identify quality related issues; mandatory training; Duty of Candour processes; clinical audits and research; health and safety audits; risk assessments; physical health care screening and monitoring; 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 Board visits

Detective – Quality dashboard reporting; Board visits virtual clinical service contact visits; incident, complaints and risk investigation; clinical audit; 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	Assurances on controls – External
Trust quality and performance dashboards Scrutiny of Quality Account 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 Head of Nursing and Matron compliance visits Board visits and out of hours visits CQC action plan in place ~~in relation to the high level feedback~~ (April 2024) in response to high level inspection feedback, Section 31 requirements and review of Trust data by CQC ~~received from April 2024 inspection~~	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 Trust fully compliant with National Quality Board Learning from Deaths guidance Relationship Meetings with CQC taking place Patient Safety Incident Response Framework (PSIRF) implementation CQC inspection (April 2024) – Report pending Regular NOF Level 3 meetings with NHS England (NHSE) and Integrated Care Board (ICB) ICB local review to ensure there are clear policies in place to meet the needs of people in Derbyshire with severe mental health illness NHSE guidance on intensive and assertive community mental health treatment Lord Darzi report and anticipated 10 year plan for the NHS

Key gaps in control	Actions to close gaps in control	Impact on risk to be measured by	Expected completion or (review)	Summary of progress	Action rating
Implementation of revised priority actions for 'Good Care' which support the Trust strategy and in response to CQC inspections and recommendations	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 Internal reporting against self-assessment CQC inspection and assessment as a measurement tool	31.03.25	Quality Surveillance Dashboard revised (programme of ward visits which are assessed against the CQC's single assessment framework) A CQC/Fundamental Standards Trust Oversight Group has been established, which scrutinises progress of	AMBER

				actions arising from regulatory inspections and Mental Health Act visits and provides sign-off of completed actions CQC Executive Oversight Group in place – Weekly scrutiny of actions and updates reviewed Divisional Performance Reviews (DPRs) now embedded and the Trust Leadership Team (TLT) group has been reviewed	
Insufficient investment in autism assessment and treatment services to meet demand. No commissioned treatment services	Investment required by ICS to meet assessment and treatment demands [ACTION OWNER: CDO]	Agreed funding allocation has occurred, recruitment to posts is active	~~(30.09.24)~~ (31.12.24)	Commissioned target of 26 assessments per month now being sustainably exceeded. Discussions underway with ICB commissioners and executives on next steps to bolster ASD investment through contractual changes. Positive engagement session with GPs on their role in future pathways including need to include ADHD	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/CDO]	Improvement in operating standards compliance to be overseen by the Trust's CQC oversight group. To be confirmed by internal assessments against the new self-assessment framework and ultimately via external CQC inspection and assessment	31.03.25	Increased performance management scrutiny and unannounced site visits undertaken with compliance checks Mock CQC inspections continue	AMBER

	Implement Community Mental Health Framework [ACTION OWNER: CDO]	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	31.03.25	Policy and Standard Operating Procedure (SOP) for Derbyshire Living Well and Derby Wellbeing Services is published. Internal Trust programme Board in place to strengthen contribution and involvement in system-wide programme and delivery Mobilisation underway in High Peak, Derby City, Chesterfield and North-East Derbyshire System Programme Team now established following vacancies. Final stage of mobilisation now completed in ~~Quarter 4, 2023/24~~ in Amber Valley, Erewash, South Derbyshire and Derbyshire Dales	
Implementation of clinical governance improvements with respect to: - Outcome measures - Clinical service reviews including reduction in excess waiting times	Develop and implement an improvement plan [ACTION OWNERS: MD/DON/CDO]	Compliance with suite of metrics and reporting schedule	~~(30.09.24)~~ (31.12.24)	The re-launched Divisional Performance Reviews commenced in April. The DON is working on the development of a new clinical quality dashboard – A prototype has been developed and a paper ~~will be~~was submitted to ELT in ~~July~~ August re second phase deployment	AMBER

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	31.03.25	The Trust has developed a sexual safety plan and has signed up to the sexual safety charter 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 and was ~~ill be~~ submitted to QSG Committee in July Dormitory eradication programme in construction Trauma informed practice conference and work programme commenced in May 2023. Trauma lead appointed and ~~to~~ developed ~~-~~training and strategy Plan for existing dormitory stock and to maintain and improve dignity for active bed stock assessed and presented to the ICB	GREEN
Learning from other independent and national exposures of abuse presents the challenge that we need to have in place to identify poor or concerning behaviour	Revisit all assurances and scrutinise practice, gathering intelligence and implement an improvement plan to enable all services to provide the	Communication and effectively responding to learning from recent exposes	~~(30.09.24)~~ (31.12.24)	Options for staff to have conversations about care delivery and raise concerns available include Trust-wide and	AMBER

	highest standard of care which would be expected [ACTION OWNERS: DON/MD]	Mobilise and emphasise expectations of standards of care and Freedom to Speak Up ensuring that staff are aware of how to raise concerns Facilitate conversations on 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 colleagues feel empowered to report any concerns Professional leads are in place to ensure that registered professional staff are aware of the requirements to practice in line with their professional codes To work in accordance with the multi-agency policy relating to PIPOT		divisional engagements, Freedom to Speak Up, Schwartz Rounds Improvements in engagement of temporary staff identified Increased visibility of senior staff through Board 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 External partnership working including Healthwatch and advocacy services within safeguarding and secure services. The Trust provides assurance and participates in external reviews alongside the ICB and Adult Safeguarding Board Trust-wide Learning, Culture and Safety Group established ~~launched~~, providing oversight of	

				teams/services with repeating patterns for improvements to be made	
Clinical improvement in the current use and transformation of Care Programme Approach (CPA), to support safe community practice	Identify the Trust's preferred alternative model to replace CPA Establish transition plan which includes communications and training strategy and clear timeline for go live of the new system and detailing when use of CPA will cease Implement an improvement plan to enable all services to provide the highest standard of care [ACTIONS OWNERS: DON/MD]	Review of changes to national policy to replace CPA Safe and effective practice is in place	31.03.25	Ongoing oversight of CPA continues with focus on care planning and risk assessment Planning discussion has taken place in relation to the transition from CPA to the preferred alternative model, Dialogue Plus 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, which establishes the Trust's baseline position against the standards, identifies the gaps in compliance and details specific actions needed to achieve the standard, to enable all services to provide the highest standard of care [ACTION OWNERS: DON/MD]	Review new standards and new reporting requirements with the clinical improvement team	~~(30.09.24)~~ (31.12.24)	Commencement of the implementation of the national inpatient standards from January 2024. National lead has presented to the executive team and operational leads and the~~THE~~ Trust has joined the Culture of Care national programme. Pilot areas identified and programme commenced with good engagement The Trust has commenced a national quality improvement programme around good practice in Mental Health Act. These two programmes will be shared across all the inpatient units	AMBER

Review of the new Major Conditions Strategy and Suicide Prevention Strategy for England: To consider a reset of the Trust clinical 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	~~(30.09.24)~~ (31.12.24)	Review of new strategy for Major Conditions and Suicide Prevention PSIRF priorities for 2024/25 focusing on prevention and oversight, linked to new strategies Trust clinical strategy in development and in line with the timeline for completion of the Trust Strategy (to include relevant national strategies) Suicide prevention lead appointed in September 2024 Risk assessment, formulation, safety planning and suicide prevention training module developed. Will be rolled out to staff in November 2024	AMBER
Review of Patient Carer Race and Equality Framework (PCREF) and develop implementation plan	Revisit new policy direction and develop new plans [ACTION OWNER: MD]	Review framework and develop implementation plan	~~(30.09.24)~~ (31.12.24)	~~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~~ New Patient and Carer Strategy has gone through QSG and will be launched in line with the wider Trust Strategy	AMBER

				EDI lead will be responsible for workforce elements of PCREF - Recruitment process underway Central oversight and resource to be identified	

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

ID	Service Line	Title	Risk: Summary of Progress	Date Risk Created	Date of Next Review	Residual Risk Rating
3009	Learning Disabilities Services	Demand for Autism Spectrum Disorder (ASD) assessment service far outstrips contracted activity	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 06.08.24: Team has been working hard to streamline admin processes as much as possible to ensure accurate data reports. By the end of August everyone with a wait over two years will have been booked for an assessment or discharged. It is therefore expected that the waiting times will show as below 2 years at the end of September	01.01.16	~~23.07.24~~ 06.11.24	HIGH
22790	Corporate Services – Pharmacy	Prescribing Valproate: Failure to comply with MHRA patient safety 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 01.08.24: Agreed at Medicines Management Committee (MMC) that risk remains high and will be a standing agenda item for the time being. Action plan in place. Lead medic assigned to lead medical workforce improvement planning. Remain engaged with system-wide work on this matter	28.02.22	~~31.07.24~~ 01.11.24	HIGH
23251	Forensic and Mental Health Rehabilitation Services	Risk to public due to management of Section 37/41	01.08.24: Following a recent Section 37/41 audit it has highlighted that clinical documentation is not of the standard and completion that is felt to effectively support and manage this group of patients - Risks posed to members of the public. Action logged to discuss next steps, which will outline risks and benefits associated with current process of management of S37/41s and risk and benefits of all S37/41s being managed under the Forensic CMHT 02.10.24: 37/41 audit highlighted concerns around the clinical documentation and management of 37/41's in local CMHTs - Paper submitted to MHA ops group and recommendation for more robust hybrid working agreed	02.10.24	02.01.25	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: 24-25 1B	**Director Lead**: Vikki Ashton Taylor (CDO)	**Responsible Committee**: Finance and Performance Committee

Key Controls

Initial Risk Rating			Current Risk Rating			Target Risk Rating			Risk Appetite		
High	Likelihood 4	Impact 4	High	Likelihood 3	Impact 5	Moderate	Likelihood 3	Impact 4	Accepted	Tolerated	Not Accepted

Preventative – Routine environmental assessments for statutory health and safety requirements; environmental risk assessments reported through DATIX; 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	Assurances on controls – External
IPC risk assessments Health and safety audits Premises Assurance Model System (PAMS) reporting Estates Strategy	Mental Health Capital Expenditure bidding process External authorised reports for statutory health and safety requirements Estates and facilities management internal audit

Key gaps in control	Actions to close gaps in control	Impact on risk to be measured by	Expected completion or (review)	Progress against action	Action rating
Lack of adherence to emerging national guidance and policy requiring the elimination of mixed sex wards and dormitory style inpatient facilities	Deliver two new adult acute 54-bed units with ~~a~~ single room en-suite with additional staffing and new model of care [ACTION OWNER: CDO]	Delivery of approved business cases	~~01.12.24~~ 31.12.24	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. Planned to go live November 2024	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 the 12-bed service being isolated in otherwise vacated wards National PDC capital funding approval [ACTIONS OWNER: CDO]	Delivery of approved business case	~~02.09.24~~ 30.11.24	Older Adult service relocation FBC and revenue funding approved by ICS. National PDC capital funding approved by NHSE Scheme re-tendered due to affordability, refurbishment started on site December 2023. This aspect of the project is ~~progressing well and~~ on track to open Bluebell Ward in ~~September~~ October 2024	GREEN
	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	Delivery of approved business case	(30.11.24)	FBC and revenue funding approved by ICS. National PDC capital funding approved by NHSE Radbourne Ward 32 refurb commenced November 2023. Due to go live ~~summer~~ autumn 2025 ~~and live March 2025~~	RED

	National PDC capital funding approval [ACTIONS OWNER: CDO]			Ward 35 refurb scheduled January 2025 – ~~March~~for mid-~~-~~2026, subject to funding live ~~April~~ ~~March~~ summer 2026	
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) National PDC capital funding approval [ACTIONS OWNER: CDO]	Agreed programme of work with capital funding to support it	31.03.25	FBC approved by ICS PICU fully funded by national and Trust capital. On track and expected to be operational March 2025	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 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., flu vaccination, health risk assessments

BAF Ref: 24-25 1C	**Director Lead**: Vikki Ashton Taylor (CDO)	**Responsible Committee**: Finance and Performance Committee

Key Controls

Initial Risk Rating			**Current Risk Rating**			**Target Risk Rating**			**Risk Appetite**		
Moderate	Likelihood 3	Impact 4	Moderate	Likelihood 3	Impact 4	Moderate	Likelihood 2	Impact 4	Accepted	Tolerated	Not Accepted

Preventative – Trust utilises NHS provided solutions as widely as possible, i.e., Office 365, NHS Mail to ensure compliance with mandated requirements. Use of the secure Health and Social Care Network (HSCN) specified by NHS Digital. Staff training on data security and protection. Regular all staff communications regarding safe ways of working and phishing emails. Contract with NHS Arden and Greater East Midlands Commissioning Support Unit provides information governance and security services, includes review of risks and addressing of vulnerabilities. Subscription with NHS Digital Care Certification Programme highlights cyber vulnerabilities and monitors Trust's compliance against them
Detective – Cyber essentials framework: NHS Digital encourage all organisations to comply. Advanced Threat Protection (ATP) monitors every server and device to highlight threats and software vulnerabilities
Directive – Compliance with NHS Digital requirements. Monthly rigor review meeting with NHS Arden and Greater East Midlands Commissioning Support Unit. Security and Protection Policies and Procedures. Business continuity policy and procedure

Assurances on controls – Internal	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 (DSP) annual review by Internal Audit Compliance with DSP Toolkit; high levels of training compliance

Key gaps in control	Actions to close gaps in control	Impact on risk to be measured by	Expected completion or (review)	Progress against action	Action rating
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: CDO]	Reporting to the Divisional Performance Reviews (DPRs)	~~(30.09.24)~~ (31.12.24)	Business impact assessments collected. Business continuity training for Trust leads started~~s~~ March 2024. Revised business continuity policy was ratified April 2024. Wider business continuity work (e.g. a~~A~~udit) ~~will take~~has taken place in Quarter 2 as part of the EPRR Core Standards Recovery Action Plan – This is on track and expecting to be substantially compliant in the regional assessment due in October 2024	GREEN

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 capital 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: 24-25 1D	**Director Lead**: Dave Mason (Interim DON) / Vikki Ashton Taylor (CDO)	**Responsible Committee**: Quality and Safeguarding Committee

Key Controls

Initial risk rating			Current risk rating			Target risk rating			Risk appetite		
Moderate	Likelihood 3	Impact 4	Moderate	Likelihood 3	Impact 4	Moderate	Moderate 3	High 4	Accepted	Tolerated	Not Accepted

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. Board 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 CQC inspections

Detective – Quality dashboard reporting; Board visits 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	Assurances on controls – External
Trust quality and performance dashboards Bed Management processes Scrutiny of Quality Account by committees Programme of physical healthcare and other clinical audits Infection Control Board Assurance Framework reported to NHSE Positive and Safe self-assessment Head of Nursing/Matron compliance visits Cleaning and maintenance schedules IPC training Level 1 and 2 Trust targets of 85% compliance minimum	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 Estates and Facilities Management internal audit Transitional Monitoring Meetings with CQC (bimonthly) Patient Safety Incident Response Framework (PSIRF) implementation Monitoring of IPC standards compliance and reporting – ICS IPC Team

Key gaps in control	Actions to close gaps in control	Impact on risk to be measured by	Expected completion or (review)	Progress against action	Action rating
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/CDO]	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	Level 1 and level 2 IPC training are above compliance target Fully funded programme of work in place. Construction started in Chesterfield and Derby. Designs have been co-produced with construction experts, clinicians, carers, patients and people with lived experience Amended gatekeeping and purposeful admission process was launched in April 2024. This is having a positive impact on robust bed management processes Ward Health Check forums relaunched to monitor range of metrics including training compliance NHSE review of Trust's IPC approach (August 2024)	AMBER

				resulted in actions to take, e.g. stand-alone IPC group, review of IPC strategy and select policies	

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 cost-of-living crisis is not matched by compensatory solutions in national terms and conditions
f) The capacity of leaders to focus on supporting, engaging and developing people
g) Lack of consistency and expectations of people leaders
h) Lack of strategic development pathway for leaders
i) The volatile work environments where staff can be exposed to harm and trauma
j) The delivery of wellbeing, leadership, occupational health and engagement is led at arms-length with delivery through joint arrangements with DCHS and UHDB
k) Legacy team issues exist in areas across the Trust
l) 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
m) The long-term lack of investment in Organisational Development and Equality Diversity and Inclusion (EDI) teams, practices and solutions
n) Historical dual approach to bank staff which leads to differential treatment
o) The potential erosion of benefits and differentiation enjoyed by Trust staff, for example car parking
p) Limited representation of staff within networks and no clear and consistent operating framework

BAF Ref: 24-25 2A	**Director Lead**: Rebecca Oakley (DPOI)	**Responsible Committee**: People and Culture Committee

Key Controls

Initial risk rating			Current risk rating			Target risk rating			Risk appetite		
High	Likelihood 4	Impact 4	High	Likelihood 4	Impact 4	Moderate	Likelihood 3	Impact 3	Accepted	Tolerated	Not Accepted

Preventative – Freedom to Speak Up Guardian (FTSUG) self-assessment and six monthly reports; annual review of people development plan commissioned through People and Inclusion directorate; provision of information through induction processes for new staff; staff engagement sessions; Equality, Diversity and

Inclusion (EDI) Delivery Group meeting; supported networks for diverse staff groups and allies; Health and Well-being Network; workforce planning design meeting; Culture and Leadership Delivery Group **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	**Assurances on controls – External**
National staff survey and reporting into board, ELT and divisions Quarterly pulse check and action planning process Exit interview analysis and reporting	Benchmarking in mental health Trusts and at system level Staff survey analysis and reporting

Key gaps in control	Actions to close gaps in control	Impact on risk to be measured by	Expected completion or (review)	Progress against action	Action rating
Lack of planned leadership development growth, stretch programmes and opportunities including coaching and mentoring	Strategy developed to align to organisational leadership needs Review and development of Trust leadership offer and impact Re-establish leadership forum Development of coaching access at local, system and national [ACTIONS OWNER: DPOI]	Percentage of leaders with development plan as part of objectives	~~(30.09.24)~~ (31.01.25)	Third cohort of Aspiring-2-Be leadership course launched Leadership Strategic Approach finalised and signed off at ELT and PCC in June 2024 Senior leadership programme commissioned Leadership forum now embedded and running regularly	AMBER
Fully embedded person-centred culture of leadership and management	Review of policies to support a person-centred approach to leadership Introduce just and restorative culture approach Review of leadership development offer Re-establish line manager development sessions	Reduced number of formal staff relations issues/cases reported in monthly people assurance report to ELT Staff survey results ~~Reporting to TLT~~	(31.01.25) ~~(30.09.24)~~	Review of cases and case management reported to ELT bi-monthly with reasons for delays identified Civility, Respect and Resolution Policy to be launched ~~October 2024~~January 2025 – Organisational Development plan being developed to support	~~AMBER~~ RED

	Scrutiny of people data at divisional level [ACTIONS OWNER: DPOI]				
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: DPOI]	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	(31.01.25) ~~(30.09.24)~~	Collaborative staff network actions agreed and regular meetings with chairs and vice chairs taking place to align power of staff networks on Staff network guidance/framework developed and co-designed with networks	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: DPOI]	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	(31.01.25) ~~(30.09.24)~~	Contract review meetings established for Occupational Health and Payroll Services (UHDB) ~~New governance structure to be developed to manage the Joint Venture – Discussions commenced~~ Monthly payroll contract meetings in place - Improvement Manager appointed by UHDB for six months to support contract, data and system standardisation Quarterly governance meeting structure in place and meetings commenced for joint venture performance	AMBER
Lack of maturity of EDI framework	Produce and implement EDI framework with clear legislative, and mandated NHS national regional and local	Agree framework and capacity requirements to deliver	(31.01.25) ~~(30.09.24)~~	~~Trust Reducing Health Inequalities Board now established, meeting with Trust-wide and system~~	AMBER

	deliverables required for the EDI function and structure to deliver [ACTIONS OWNER: DPOI]	Regular wider engagement with EDI Delivery Group, and divisional leads taking place Final presentation to PCC Roll out of framework Delivery against the People Performance Dashboard		~~stakeholders to direct our response to reducing health inequalities~~ Framework, including clear actions to progress and signed off at PCC~~, being presented at PCC and due to go to Board Development July 2024~~	
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: DPOI]	Staff survey engagement scores Attendance at engagement sessions	(31.01.25) ~~(30.09.24)~~	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 - Complete Review of training competences for bank and agency commenced and nearing completion Service level agreement developed for temporary staffing with clear expectations on annual reviews, clinical supervision and regular engagement	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	(31.01.25) ~~(30.09.24)~~	New staff benefits programme ~~being~~ launched for staff including increased salary sacrifice options such as home electronics and gym membership	AMBER

	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: DPOI]				
Inconsistency in application of an inclusive approach impacting 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 [ACTION OWNER: DPOI]	Year on year change WRES/WDES, staff surveys and lived experience of staff through staff networks Data drawn from all engagement activities to identify impacts on staff experience and any inequalities that need to be closed	(31.01.25) ~~(30.09.24)~~	Work commenced - Divisional level EDI staff survey data shared with divisions. Divisional People Leads are leading discussions on actions on improvements and achievements	AMBER
Lack of ownership and embedded models of care and cultures across MRfD workforce resulting in retention and turnover challenges and inconsistency of approach across MRfD programme	Review of all commissioned and in house owned programmes both clinical and non-clinical to be clear of the 'ask' and the 'why' Clear framework to ensure alignment across all programmes Comprehensive plan of delivery and outcome measures [ACTIONS OWNER: DPOI]	Delivery against plan including attendance on programmes Staff survey measures Bespoke MRfD surveys to measure awareness and impact of programmes	01.04.25	Revised programme board and workstreams to ensure alignment and learning from gateway review	RED

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

Strategic Objective 2 – To be a GREAT place to work

There is a risk that we do not 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 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 requirements of 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
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: 24-25 2B	**Director Lead**: Rebecca Oakley (DPOI)	**Responsible Committee**: People and Culture Committee

Key Controls

Initial risk rating			Current risk rating			Target risk rating			Risk appetite		
High	Likelihood 4	Impact 4	High	Likelihood 4	Impact 4	Moderate	Likelihood 3	Impact 4	Accepted	Tolerated	Not Accepted

Preventative – Alliance, system and national Human Resources forums for sharing best practice and risk mitigation, website, workforce plan
Detective – People Performance Report in TLT, 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

Board Assurance Framework 2024/25 – Issue 3.3 Board November 2024

Assurances on controls – Internal	Assurances on controls – External
People Performance Report ~~in TLT,~~at 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 Regular NOF Level 3 meetings with NHSE and ICB (in relation to Making Room for Dignity (MRfD) recruitment)

Key gaps in control	Actions to close gaps in control	Impact on risk to be measured by	Expected completion or (review)	Progress against action	Action rating
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: DPOI]	Vacancy rates Time taken to fill vacant posts Transformational posts, e.g. apprenticeships all identified Reduction in agency costs	(30.01.25) ~~(30.09.24)~~	Work commenced to map apprenticeship plan and resources required Agency reduction plan in place and having impact Further agency summit planned for October 2024 to review ongoing spend Vacancy control process strengthened and ongoing	AMBER
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: DPOI]	Career conversations taking place Internal appointments/promotions Turnover rate Key staff survey measures	(30.01.25) ~~(30.09.24)~~	Talent Strategy finalised ~~Pilot launched for senior leaders in January 2023 – Phase one meetings with each executive taking place~~ ~~Deputy DPOI is system lead on talent management~~ ~~System appraisal developed to support system movements and talent management~~ Talent programme relaunched following learning from	RED

				previous pilot with clear engagement timescales and expectations Talent and succession planning part of every executive director objectives	
Lack of capacity, experience and plans for recruiting overseas	Develop International Recruitment (IR) plan and programme Appoint IR team to lead programme Engage with national IR support Access national IR funding Support Trust teams to prepare for IR arrivals [ACTIONS OWNER: DPOI]	Number of IR appointments Retention rate of IR	(30.01.25) ~~(30.09.24)~~	~~Regular meetings established with midlands IR lead~~ ~~System AHP IR bid successful~~ ~~IR pastoral support officer appointed~~ ~~Clinical Educator of IR appointed~~ ~~Recruitment and Retention Lead appointed~~ ~~Stay surveys regularly undertaken in teams~~ Successfully recruited and objective structured clinical examination (OSCE) conversion completed for ~~two~~ six IR candidates A further cohort of IR candidates will now be taking place ~~Further five candidates recruited and arriving July 2024~~	AMBER
Onboarding and retention process and planning needs to be embedded (this includes MRfD and challenges on	Understand the key retention issues for posts/teams/professions with the highest turnover	Improvements to turnover Staff survey engagement scores	(30.01.25) ~~(30.09.24)~~	~~Nursing retention framework self-assessment completed~~	~~AMBER~~ RED

retention of high numbers of newly qualified nurses)	Ensure 'stay conversations' form part of regular 1:1s Develop NHS retention framework for nursing [ACTIONS OWNER: DPOI]			~~System retention lead appointed to support Trust level and system work~~ ~~Recruitment and Retention Lead appointed~~ Additional posts added to the preceptorship team to support retention of high numbers of newly qualified	
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 [ACTIONS OWNER: DPOI]	Engagement of medical workforce Reduction in agency spend	Complete (30.01.25) ~~(30.09.24)~~	Further discussions held as part of the agency summit – Agreed action to support agency reduction	AMBER
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: DPOI]	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	(30.01.25) ~~(30.09.24)~~	Recruitment leads across the system all trained through Above Difference programme Inclusive recruitment for chairs training commenced	~~AMBER~~ 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: DPOI]	Time to recruit Number of applicants applying and successfully shortlisted Campaign impact and reach Financial savings through cohort recruitment	(30.01.25) ~~(30.09.24)~~	Trust Strategic Recruitment and Retention Lead appointed Successful recruitment events in place including attendance at universities A range of recruitment methods are being deployed to ensure we attract a diverse range of applicants On track with MRfD recruitment posts and plans in place for hard to recruit posts	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 caused by factors including non-delivery of Cost Improvement Programme (CIP) targets and increased cost pressures not mitigated resulting in a threat to our financial sustainability and delivery of our statutory financial duties

Impact: The Trust becomes financially unsustainable. The Trust's National Oversight Framework rating is at risk of deteriorating and this could lead to a lack of organisational direct control in the longer term via increased regional and national intervention

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
b) Non-delivery of expected financial benefits from transformational activities
c) Non-delivery of required levels of efficiency improvement
d) Lack of sufficient cash and working capital
e) Loss due to material fraud or criminal activity
f) 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
g) Costs to deliver services exceed the Trust financial resources available
h) Lack of cultural shift/behaviours to return to financial cost control regime
i) Inability to reduce temporary staffing expenditure

BAF Ref: 24-25 3A	**Director Lead**: James Sabin (DOF)	**Responsible Committee**: Finance and Performance Committee

Key Controls

Initial Risk Rating			**Current Risk Rating**			**Target Risk Rating**			**Risk Appetite**		
Moderate	Likelihood 2	Impact 5	Extreme	Likelihood 4	Impact 5	Moderate	Likelihood 2	Impact 5	Accepted	Tolerated	Not Accepted

Preventative – Operating plan and financial plan agreed for 24/25 in line with ICB requirement. 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;- CIP Monitoring, Performance management reviews, 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	Assurances on controls – External
Operational plan; financial planning including CIP planning, processes and delivery monitoring CIP programme group established to strengthen oversight Vacancy control process in place with Executive oversight Performance management processes in place and being refreshed to add to assurance levels Dormitory eradication and PICU programme monitoring and reporting 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 (F&P) 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	Monthly reporting into ICB and NHSE, in addition to Trust internal reporting All CIP plans and progress reporting into the EPMO for shared system oversight across the ICB 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 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 Programme Director, Senior Responsible Officer completed NHS Better Business Case Training Regular NOF Level 3 meetings with NHSE and ICB

Key gaps in control	Actions to close gaps in control	Impact on risk to be measured by	Expected completion or (review)	Progress against action	Action rating
Trust cash and capital risks related to national funded acute capital programme: - Inflation cost risk - Risk-share	Risk share arrangements with PSCP Programme approach and engagement with all stakeholders. Close involvement with NHSE	Cash and capital reporting as part of finance reporting into F&P and Board forecasting evidence of plan delivery and/or indicates areas of required management action	31.03.25	Regular oversight of capital and cash position. Reporting to Trust Programme meetings and Committees on risks and mitigations	AMBER

- Cashflow timings and variability - Guaranteed Maximum Price exceeds national funding envelope (due to hyperinflation and other factors) Increased cost pressure now aligned to final refurbishment project. Without national support, proceeding to contract in October is a challenge	Discussions ongoing with ICB and NHSE around the Making Room for Dignity cost pressure of c£7.5m Recent discussions held with NHSE and region around latest pressure. Decision pending and overdue Also progressing another VAT claim to part fund final stage [ACTIONS OWNER: DOF]			Hyper-inflation cost risk ~~remains – Due to world events and economy but this~~ is reducing ~~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 s~~Significant cost pressures on Radbourne Unit Refurb and Older Adults ward refurb requiring ongoing action ~~HMRC appeal on VAT abatement claim concluded and VAT abatement was agreed. This has reduced a major risk component. Currently in the process of recovering the VAT rebate~~ VAT rebate continues to flow to Trust. Still ongoing and reducing current/ongoing payments	
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~~ Access any new national funding streams (e.g digital or cyber) ~~-~~in year to maximise system capital plan in order to redirect CDEL capital for this cost pressure and other needed schemes [ACTIONS OWNER: DOF]	~~Ongoing reporting will ascertain how and when the shortfall can be bridged by additional capital sources~~ There remains a risk we will overcommit our CDEL allocation in 2024/25. Ward 35 decision is a key risk later this year and would have wider impact on the strategic objective to eradicate all dorms If not nationally funded and confirmed by October, we will have an issue to address with the ICB. To proceed at risk	31.03.25	System capital plan has been submitted as part of planning process. We have also fed in the 10 year capital plan as part of a wider ICB system wide return Risk remains in relation to the Making Room for Dignity cost pressure and discussions with ICB and NHSE remain ongoing	AMBER

		(affordability, cashflow and CDEL breach concerns) or pause/stop/abandon which would not deliver dormitory eradication and reduce bed capacity			
Additional revenue 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) as part of operating plan for 2024/25 [ACTIONS OWNER: DOF]	Monitoring and reporting of income allocations and expenditure in year Transparent reporting of position shared with ICB to reduce challenge and ensure joint understanding and support	31.03.25	Funding for PDC revenue from NHSE included in financial plan submission. Guidance change has removed £2.5m of income. Key driver of our underlying deficit MHLDA DB agreed to oversee revenue delivery contained within programme spend	RED
Insufficient substantive staffing into vacancies and temporary staffing costs for bank and agency staff do not reduce	Additional management action and oversight Agency progress monitored and strengthened links to CIP oversight group Direct engagement solution being implemented re medics [ACTIONS OWNER: DPOI/DOF]	Enhanced bank and agency costs reported as part of wider financial and workforce reporting Continued workforce strategies progressed to reduce agency and increase bank reducing risk	31.03.25	Reports to ELT and F&P outlining current areas of pressure and required actions to be taken- in year in order to remain on plan ~~as part of the financial planning decision making process~~ Funding contribution agreed with Eating Disorder Provider Collaborative for exceptional agency costs re 2023/24, further costs are being recharged but are in dispute. Discussions ongoing re 2025/26 costs. Transfer of patient is on track for September and we are expected to cover future costs ~~Patient is expected to move to a more appropriate provider during quarter 2~~	RED
Non-delivery of required recurrent cost reduction	Compilation and delivery of planned Trust efficiencies and quality improvements to deliver 2024/25 plan	Efficiency and QI reporting to Execs and F&P	31.03.25	CIP gap continues to reduce. The percentage which has been	RED

and improved efficiency and Quality Improvement	including recurrent long term cost reductions to return to breakeven Planning for 2024/25 has led to a recent ask for directorates to develop plans of 4% cost improvement in addition to various transformation schemes CIP governance and reporting processes strengthened. Close links to wider work re agency reduction, effective rostering and vacancy control [ACTIONS OWNERS: DOF/DPOI]			identified recurrently continues to increase Executive vacancy panel established in December 2023 Performance meetings are in place for clinical directorates and plans are being put in place in future for corporate areas Performance related additional controls are being developed to help close the CIP gap and ensure mitigation is in place	
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 Long list of unpalatable options drawn up and supported in principle by Board for further review. These are for consideration post planning nationally due to potential to impact patients and core Trust NHS offer. Need to develop these into costed and prioritised plans with clarity of patient and wider staff impact [ACTIONS OWNER: DOF]		31.03.25	The financial position for Derbyshire is a risk to the statutory duties for DHCFT to manage its financial position Financial plan for 2024/25 is concluded but we need to continue to work on reducing the deficit as part of our longer term financial sustainability All new investments to follow governance processes with business cases via ELT, F&P and Board where appropriate	RED

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

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 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, for example Provider Collaborative Leadership Board, may impact on provider Foundation Trust governance arrangements and decision-making processes
d) 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: 24-25 4A	**Director Lead**: Vikki Ashton Taylor (CDO)	**Responsible Committee**: Trust Board

Key Controls

Initial Risk Rating			Current Risk Rating			Target Risk Rating			Risk Appetite		
High	Likelihood 4	Impact 4	Moderate	Likelihood 3	Impact 3	Moderate	Likelihood 3	Impact 4	Accepted	Tolerated	Not Accepted

Preventative – Governance structures in place at a system and Delivery Board level. Ongoing close communication with NHSE, mental health and learning disability teams at a regional and national level. Assumed NHSE -led appointment process to new ICS Board positions
Detective – 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	**Assurances on controls – External**
Regular reporting of position to Board by CEO Regular ELT updates and discussions	Mental Health and Learning Disability assurance meetings with NHSE and ICB Gateway process run by NHSE prior to agreement to establish a Trust as

NED Board members on JUCD committees and Board Board agreement required prior to undertaking of lead-provider responsibilities	lead-provider in regional collaboratives Representation on system-wide governance groups

Key gaps in control	Actions to close gaps in control	Impact on risk to be measured by	Expected completion or (review)	Progress against action	Action rating
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/DCA]	~~Board level confidence in new and emerging governance structures and ability to gain assurance on DHCFT risks and issues via system level governance regime~~ Board level assurance that the Trust's corporate governance systems are compatible with the new ways of working that would allow both Trust and system objectives to be achieved Board level assurance that the Trust's risks have been fully articulated and understood within the wider integrated care system	~~(30.09.24)~~ (31.12.24)	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 Derbyshire Provider Collaborative Leadership Board have an agreed work programme as approved by ICB The Trust is an active member of and provides regular assurance to system-wide governance groups, e.g. their quality and safety group Memorandums of understanding and alliance agreements are in place where appropriate, i.e. LD Alliance Trust's risks reported to the ICB monthly for cross-reference with other providers for the ICB BAF	AMBER
~~Internal ICB capacity changes to achieve revised expenditure requirements in 20023/24 and 2024/25 may impact on capacity and~~	~~Keep changes to staffing levels and work programmes under regular review. This may lead to system wide agreement on priorities~~ ~~[ACTION OWNER: CDO]~~	~~Impact monitored through system wide MHLDA Delivery Board, Provider Collaborative Leadership Board and ICB~~	~~(30.09.24)~~	~~Escalation of risk and impact internally to ELT and Board as appropriate and to ICB~~	~~AMBER~~

~~capability to deliver key deliverables such as system planning, and programmes of transformation~~		~~Board, of which the CEO is a member~~		~~Review DHCFT staffing to identify succession planning opportunities and/or cover arrangements ongoing~~	

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. Possible organisational ability to influence developments within the ICS

Root causes:

a) Organisation historically too internally focused – Provider responsibilities impacting on executive and operational 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: 24-25 4B	**Director Lead**: Vikki Ashton Taylor (DSPT)	**Responsible Committee**: Trust Board

Key Controls

Initial risk rating			**Current risk rating**			**Target risk rating**			**Risk appetite**		
High	Likelihood 4	Impact 4	Moderate	Likelihood 3	Impact 3	Moderate	Likelihood 3	Impact 3	Accepted	Tolerated	Not Accepted

Preventative – Active membership in each Local Place Alliance; Active participation in Integrated Place Executive; 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	**Assurances on controls – External**
Appointment to Managing Director roles Regular TLT and ELT updates and discussions NED Board members on JUCD committees	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 CEO on ICB Board and Integrated Care Partnership (ICP) Regular NOF Level 3 meetings with NHSE and ICB

Key gaps in control	Actions to close gaps in control	Impact on risk to be measured by	Expected completion or (review)	Progress against action	Action rating
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 Improvement plan for joint autism service (with system partners) [ACTIONS OWNERS: CDO]	Improvement in performance in constitutional standards Recovery action plans in place in all required areas Feedback from social care on awareness of the Autism Strategy and autism waiting times reduce across the interagency investment plan	~~(30.09.24)~~ (31.12.24)	Integrated performance report allows insight on key areas of improvement, with actions and narrative around next steps. Progress with recovery action plans: Performance improvement in dementia diagnosis and perinatal access has resulted in DHCFT now delivering the core constitutional targets in this area and others Ongoing work to reduce inappropriate Out of Area Placements, underpinned by a Recovery Action Plan continues including a Multi-Agency Discharge Event and planned opening of local PICU, however inappropriate Out of Area placements remain above trajectory Autism waiting times continue to be achieved for the 26 contracted assessments per month. Internal quality improvement work has resulted in significant improvement in waiting times for assessment and reduction of wait lists	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: CDO]	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 Confirmation of frequency of contact, joint action / achievement log of issues raised and achieved Managing Directors reports to TLT with summary of impact to ELT	~~(30.09.24)~~ (31.12.24)	Managing Directors (MDs) actively engaging with Primary Care Networks (PCNs) MDs are ~~now~~ members of Derby City PLACE Board and PLACE County Partnership Board ~~Executive Directors are members of~~Senior representation at the Integrated Place Executive. Senior management representation named for all PLACE Alliance groups. City and County Partnership Board currently developing purpose, 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. GP support only in place until May 2024; case for the GP support to be presented to the MHLDA Board in April~~	GREEN
~~Social care partners have reported that the lack of progress on autism diagnostic reductions is difficult and~~	~~Improvement plan for joint autism service~~ ~~[ACTION OWNER: CDO]~~	~~Feedback from social care on awareness of the Autism Strategy and autism waiting times reduce across the interagency investment plan~~	~~(30.09.24)~~	~~November 2023 Derbyshire System Delivery Board: Agreement to recognise that the current commissioning landscape and output from~~	~~AMBER~~

~~would like to see increased pace of improvements~~				~~investment still has major gaps, with a subsequent impact on other local services. Support for the development of fuller proposal for re-use of resource allocated for an improved offer, recognising this may require reallocation of current spend~~ ~~Autism waiting times continue to be achieved for the 26 contracted assessments per month. Internal quality improvement work has resulted in significant improvement in waiting times for assessment and reduction of wait lists~~	
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 and support, communication and improved partnership working [ACTION OWNER: CDO]	Training sessions offered to Police partners: • Police mental health awareness training sessions • Suicide prevention work • Joint working with Trust safeguarding teams • Collaborative response to Right care Right Person (RCRP)	~~(30.09.24)~~ (31.12.24)	Police are a formal member of the MHLDA DB and attending and contributing Street triage pilot was established between Police and Trust. This ceased on 31.03.24 and will be replaced by Right Care Right Person (RCRP) Mental Health Response Vehicle (MHRV) to be implemented during 2024, to reduce pressure on Police to respond to mental ill health calls Crisis café have opened in Buxton, Ripley and Swadlincote	AMBER

				Trust is a member of the RCRP implementation executive group covering 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	~~(30.09.24)~~ (31.12.24)	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 DON has worked with the Patient and Carers Committee, EQUAL and the Carers Engagement Group to review their terms of reference and linkages to strengthen the cross-working of the groups and effectively use action logs to reflect improvements made in service developments and patient care	AMBER

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

Board Assurance Framework 2024/25 – Issue 3.3 Board November 2024

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 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
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) Derbyshire bedded care facilities for LD services had not had a full CQC inspection since 2016 as a core service
h) Health inequalities across our Derbyshire footprint – Initial insights show gaps in access to service, case load and worsening patient outcomes

BAF Ref: 24-25 MS1	**Director Lead**: Vikki Ashton Taylor (CDO)	**Responsible Committee**: Quality and Safeguarding Committee within DHCFT Quality and Performance Committee within the Derbyshire ICS Mental Health, LD and Autism Board in terms of system operational delivery

Key Controls

Initial Risk Rating			**Current Risk Rating**			**Target Risk Rating**			**Risk Appetite**		
High	Likelihood 4	Impact 4	High	Likelihood 4	Impact 4	Moderate	Likelihood 3	Impact 3	Accepted	Tolerated	Not Accepted

Preventative – Health and safety audits; risk assessments; investment in estates development; workforce plan covering recruitment and retention. Mental Health Act Code of Practice
Detective – CQC inspection reports; Board visits 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; Trust Policy Dashboard

Assurances on controls – Internal		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			
Key gaps in control	**Actions to close gaps in control**	**Impact on risk to be measured by**	**Expected completion or (review)**	**Summary of progress on action**	**Action rating**
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: CDO/DON/MD]	Outcome of review – Improved models of support	~~(30.09.24)~~ (31.12.24)	~~Review outcome: Services brought together across the North and South under a single manager and now have single clinical pathways~~ ICB have presented work to both providers which looks at how to ensure community offers like IST are enhanced further through the review of pathway offers where resource is disproportionately allocated Ongoing discussions to commit more resources to community pathways including IST is interdependent on the future bedded model which is being explored by the ICB. The Trust is now working alongside DCHS and has established an integrated service provision for neurodevelopmental	AMBER

				services across both organisations for the system~~.~~	
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: CDO]	Improvement plans developed and implemented resulting in a stabilised service and positive outcomes for patients working across partner systems Enhancing and reviewing Listening and Engagement Active Partnerships (LEAP) procedures Improvement plans in admission avoidance, crisis alternatives to admission and market stimulation and development, including improvement in the use of Dynamic Support Registers as a means of admission avoidance Make significant impacts on the number of stranded patients who have delayed discharges in units across the country resulting in the NHSE escalations	~~(30.09.24)~~ (31.12.24)	Derbyshire is no-longer in national escalation regarding performance with inpatient services after demonstrating significant progress and improvement against plans and clear grip. New Dynamic Support Pathway (DSP) launched following cross-agency redesign work Cross-system delivery plan 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	AMBER
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: CDO/DON]	Full compliance with safer staffing levels in line with the NHSI Workforce Safeguards	~~(30.09.24)~~ (31.12.24)	Reviews of safer staffing and stabilisation in non-DHCFT Derbyshire bedded LD facility - New period of service stabilisation underway with a focus on expediting discharge of current inpatients, and not accepting further admissions Workforce issues including recruitment and retention, staff wellbeing	AMBER

				and mitigations against use of agency staff being addressed with rapidly mobilised short-term leadership from DHCFT into the unit Improved engagement with universities and final year student nurses. The non-DHCFT bedded unit has now temporarily closed (August 2024); as agreed by the system whilst future models are evaluated.	
Clinical care standards in a non-DHCFT Derbyshire bedded care facility including care plans, levels of incidents, restrictive practices including the use of long-term segregation are not compliant with clinical care standards	Develop an improvement plan for all Derbyshire in-patient LD&A services [ACTION OWNERS: CDO/DON]	Full compliance with required care standards External review of Long-Term Segregation and review to end restrictive practices	~~(30.09.24)~~ (31.12.24)	Joint paper from Trusts to ICB regarding overall bedded offer and inpatient review discussed with ICB executives March 2024 Overall quality plan for improvement for LD&A inpatients in place following review by ICB - This includes trying to reduce the level of out of area care	AMBER
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: CDO/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	~~(30.09.24)~~ (31.12.24)	Partnership working with DCHS and ICB to agree future plans and direction of travel for bedded offer for Derbyshire patients continues. Executive level discussions are underway for the long term goal, whilst providers work together to stabilise	AMBER

				position in current unit and expedite discharges Broad expectations on model of care (bed 'type') agreed across partners, including offering community-house step up/step down options – Large scale ongoing work.	

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

Board Assurance Framework 2024/25 – Issue 3.3 Board November 2024

Risk Rating
The full Risk Matrix is included in the Trust's Risk Management Strategy

Risk Assessment Matrix						
Risk Score = Consequence Rating X Likelihood Rating						
	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 RATING	RISK APPETITE
Very Low	Accepted
Low	
Moderate	Tolerated
High	Not Accepted
Extreme	

Actions Against Gaps in Key Controls - Expected completion dates to be included or next review dates to be shown in brackets	Action 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	DON	Director of Nursing, AHPs and Patient Experience – Interim
MD	Medical Director	DPOI	Director of People, Organisational Development and Inclusion
CDO	Deputy Chief Executive / Chief Delivery Officer	DCA	Director of Corporate Affairs and Trust Secretary

Definitions

Preventative	A control that limits the possibility of an undesirable outcome	Directive	A control designed to cause or encourage a desirable event to occur
Detective	A control that identifies errors after the event		

Board Committee Assurance Summary Reports to Trust Board – 5 November 2024

The following summaries cover the meetings that have been held since the last public Board meeting held on 1 October 2024 and are received for information.

- Mental Health Act Committee 13 September
- People and Culture Committee 24 September
- Finance and Performance Committee 30 September (verbal update for 4 November)
- Audit and Risk Committee 10 October
- Quality and Safeguarding Committee 15 October

Key:

	Full Assurance received during the meeting with the accompanying report
	Significant assurance received during the meeting with the accompanying report
	Limited assurance received during the meeting with the accompanying report
	No Assurance received during the meeting with the accompanying report
	items shared **for information** to advise the committee on progress and next steps

Mental Health Act Committee - key assurance levels for items – 13 September 2024	
	Mental Health Act (MHA) 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: • The analysis of rapid tranquilisation data by the Deputy Chief Pharmacist • The use of Section 5(4) Nurses' holding power was noted • The results of the audit into the use of Section 62 Urgent Treatment Requests were presented • Community Treatment Order (CTO) activity • Details on the Associate Hospital Managers (AHM) training session • The possible impact of the Moon legal case on the worker status of AHMs is being assessed by Employee Relations • Section 132 and 132a performance was noted and the Committee requested an interim report in 6 weeks' time. **Significant assurance** was agreed on the improvements identified in the report and **Limited assurance** on the reading of rights as there were still data quality issues and missing of deadlines.
	Section 12 Doctor Assurance Report – Verbal Update A review has been undertaken to embed compliance with S12(2) / Approved Clinician status. This includes a centralised monitoring system overseen at the MHS Operational Group. Progress against the eight actions was noted. The MHA operational group was monitoring compliance. **Limited assurance** was given while the system embeds.
	Training Report The Committee was unable to give any assurance as the report was incomplete, lacking the details to support targeted improvement actions. There had been a request to improve the level of data in the report and this had been escalated to improve the report for submission to the next Committee.

	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 MHA Committee, oversight of the Code of Practice or concerns highlighted within MHA 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 including the connectivity for the data recording system. The Blanket Restriction on locked doors was being closely monitored and there had been improvements in seclusion figures and a reduction in prone restraints and absconsion rates. The Committee agreed that **significant assurance** could be taken from overall performance progress.
	Report on Use of Section 135/136 Suites The report showed an upward trend in the use of S136. This reflects the increased complexity in the Community and the increased demand. The Joint Nurse/Police risk assessment is likely to improve the quality of the Section 136 detentions and may lead to reduced numbers. Physical health checks in Section 136 suites continue to be positive. The Committee asked for EDI data to be included in future reports in order to assess whether there is a disproportionate proportion of certain ethnic groups using the suites. The Committee noted the current position and supported the continued ongoing work and improvements for the Section 135/136 Group, agreeing significant assurance.
	Verbal Update from Associate Hospital Managers (AHM) The AHMs gave a verbal update on their activities, including numbers of AHMs in post and an assessment of their workload.
	Policies: There are two outstanding policies, they are joint policies managed by partners. It was agreed to escalate via the Chief Executives. However, in terms of governance, the content of the policies are fit for purpose by use by the Trust staff. The Section 5 (4) and Section 5 (2) policies were approved.
	Escalations to Board or other Committees: None
	Items added to the Board Assurance Framework: None
	Next scheduled meeting: 13 December 2024
Committee Chair: Deborah Good	**Executive Lead: Arun Chidambaram, Medical Director**

People and Culture Committee – key assurance levels agreed – 24 September 2024	
	People and Inclusion Assurance Dashboard The Committee reviewed the current performance shown in the dashboard, which highlighted the following: • Staff Turnover – remains in line with benchmarking. A Task and Finish group will undertake further analysis in relation to specific groups, including Allied Health Professions and Additional Clinical Services • Vacancies and Recruitment – although the Trust benchmarks well in most areas an outlier is the time taken to shortlist, so a deep dive into divisional areas is to be undertaken. International recruitment had seen success with the appointment of newly qualified Mental Health Nurses and OSCE (Objective Structured Clinical Examination) passes • Attendance and Absence –regional benchmarking data has helped to highlight the areas of focus • Bank and Agency usage – the agency summit continues to measure the position. There has been a reduction in agency use across nursing and medics and the drive to use bank in place of agency continues • Employee Relations – a summary of the cases was noted including what support is given to individuals involved in processes • Clinical Supervision - work progresses on a new policy to improve compliance • Annual Appraisals – there had been significant improvement during the last year but there were still pockets of low compliance • Freedom to Speak Up (FTSU) – in response to an increase in the number of colleagues speaking up around racial discrimination, an Organisational Development Programme is now in place to support and drive improvement. **Significant assurance** was agreed for the progress shown for mandatory training, staff turnover, vacancies and recruitment, attendance and absence, bank usage and FTSU and **limited assurance** Employee Relations, Clinical Supervision and Annual Appraisals.
	System Developments – Verbal Update The Committee noted any updates on the people projects being led by the system. The Human Resource Directors (HRD) across the system meet regularly, which fosters good relationships, shared learning and mutual challenge, which is beneficial.
	Making Room for Dignity – Programme Update Updates focused on progress on recruitment initiatives and an update on the cultural and service transformation work for the acute inpatient mental health services, incorporating the model of care. Training for the transformational work had started and will focus on purposeful admission, trauma-informed and sensory care. The Committee agreed there is a fantastic opportunity to broadcast the Trust's pioneering work in recruitment and the cultural and service transformation and this could attract additional support and resources from other organisations. A one-page summary explaining the work is being produced. **Limited assurance** was agreed on the actions and progress being taken to mitigate the risk of significant numbers of 'hard-to-recruit' and 'national workforce shortage' posts required. **Limited assurance** was also agreed on the development of, and progress with, the service and cultural transformation work.

	Deep Dive - Employee Relations The deep dive covered the length of time taken to resolve case work for Disciplinary, Dignity at Work and Grievance and Performance cases. It also included the level of support available for managers on how to manage and respond to raised grievances to enable clear understanding prior to commissioning, and also how to conduct those difficult conversations. Priorities for the next 12 months is to ensure a broader ethnicity of those conducting the investigations, when cases should be commissioned and mitigation of delays though non attendances and absences.
	Deep Dive – Sickness Absence The deep dive covered analysis of the Trust's sickness absence data, following an increase in the annual sickness absence rate. The data identified the outliers and plans to support teams working in these areas. In comparison with the system and regional alliance, it was noted that the Trust measures around mid-point for long-term absence and higher for short-term absence. The Trust is being pro-active in managing sickness absence including a review of policies.
	Triangulation of Leaver Data – Allied Health Professionals (AHP) The Committee received triangulated workforce data on the Trust's Allied Health Professional (AHP) staff group, following concerns raised at the previous meeting regarding the high annual turnover rate. Analysis had shown that the main reasons for leaving are promotion and relocation, however it was importance for all staff to feel valued and have succession plans to demonstrate career prospects. Recently there had been a positive reduction on turnover rates for this group but the situation will continue to be monitored, including through the AHP Working Group.
	Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) Reports and Action Plans The WRES and WDES reports that had been submitted to NHSE were received. These nationally-mandated data collection frameworks allow measurement of race and disability equality in organisations. The reports contained the indicators and any key trends in the data. The Committee discussed what was needed to improve moving forward and have accountability throughout the organisation, this included training Trust leaders to equip them with the right skills and data. The Trust's Equality, Diversity and Inclusion (EDI) Steering Group has quarterly oversight on progress towards action areas with progress updates to the People and Culture Committee. **Limited assurance** was agreed due to the lack of improvement on the action plan.
	Board Assurance Framework (BAF) – key risks identified: A number of revisions were agreed to the BAF, including increasing risk ratings in line with the current challenges within the People and Inclusion risk portfolio.
	Escalations to Board or other Committees: None. **Items added to the Board Assurance Framework**: None in addition to the above. **Next scheduled meeting:** 26 November 2024.
Committee Chair: Ralph Knibbs	**Executive Lead: Rebecca Oakley, Director of People, Organisational Development and Inclusion**

Finance and Performance Committee – key assurance levels for items – 30 September 2024	
	Assurance on Estate Strategy – specifically Making Room for Dignity Programme (MRfD) The latest position on the programme was discussed. The Bluebell Ward go live date has been delayed pending the issue of water testing results and building certification. Compliance checks for the Derwent and Carsington Units have been rescheduled, this will impact on go live dates. The provisional opening date for Kingfisher House, Psychiatric Intensive Care Unit (PICU), is the end of April 2025. The Committee received an update on the bid to NHS England for the cost pressure monies of £6.5m. **Limited assurance** was received on the progress to date and associate risks.
	Delivery of Information Management, Technology and Records (IMT&R) Strategy and Wider Digital Strategy – Progress Update The Committee considered the roadmap and what has been delivered so far on digital transformation. Delivered projects included electronic transfer of prescriptions and digitalising text messages. The next focus will be in pathology systems, rolled out as part of the plan this year. The communication annex roll-out will be fully implemented this year. The Committee received assurance on how the Trust is managing cyber security issues. Compliance is primarily through the annual data security toolkit. This is regularly monitored through the Data Security and Protection Group and reported to the Audit and Risk Committee. The Trust's focus is on preventing cyber-attacks and works closely with Arden Gem. As a Trust, we make sure devices are compliant with security measures. By February 2025 the Trust Digital Plan (Strategy) will be confirmed.
	Financial Performance – Month 5 Finance Report It was reported that the Trust remains on plan for the forecast position of £6.4m deficit. There is continued focus on out of area reductions. The latest information was shared on the system's collective deficit plan, noting the system will be held to account to break-even. Progress in delivering the Cost Improvement Programme shows gaps in productivity and an agency summit is to be held along with scrutiny of the costs through a deep dive process.
	Operational Performance It was reported that an effective recovery action plan to improve patient flow has reduced inappropriate out of area placements to five. The new PICU will support those patients having to go out of area. Also reported was an increase in home treatments and a reduction in mental health liaison presentations, attributable to the Living Well programme. Reductions in bed occupancy and improvements in length of stay were welcomed. As the only provider exceeding national targets for the Memory Assessment service (MAS), the Trust has been asked to share best practice with regional partners.
	Procurement Update The report highlighted challenges with the current level of staffing, and it was noted that the Executive Leadership Team is currently considering an improved structure.
	System Update: Integrated Care Board (ICB) Finance Committee and System Directors of Finance (DoF) The Committee noted that financial sustainability remains the focus point.

	Collaborations and Other Alliances <u>Derbyshire Integrated Adult Neurodevelopmental Service</u> The significant progress was noted. <u>Perinatal – Lead Provider Collaborative</u> It was noted that in October 2023, the arrangement was changed to a block contract and the Trust is working towards a cost and volume arrangement from April 2025, which will allow a thorough bed modelling review and the ability to make recommendations in-year on bed capacity.
	Board Assurance Framework (BAF) 2024/25 Risks Overview The main updates were around Risk 3A. There was scrutiny around the Making Room for Dignity Programme.
	Escalations to Board or other Committees: None. **Items added to the Board Assurance Framework:** None. **Next scheduled meeting:** 4 November 2024.
Committee Chair: Tony Edwards	**Executive Lead: James Sabin, Executive Director of Finance**

Audit and Risk Committee - key assurance levels for items – 10 October 2024	
	Review of Board Assurance Framework (BAF) Issue 3, Version 3.2, 2024/25 The Committee reviews the BAF in advance it being sent to the Board for approval. It noted the changes made since the previous version and suggested a further review of the references to the funding, recruitment and quality elements of the Making Room for Dignity (MRfD) programme within the BAF to ensure triangulation. The rescheduling of the Public Board meeting from September to October had impacted the updates. The Committee agreed the version in principle but noted a number of additional items needed to be worked up for inclusion in version that would go to the 5 November Board. An addendum was issued in advance of the Board meeting. The Committee received **significant assurance** on the process of the review, scrutiny and update in identification and mitigation of risks to achieving the Trust's strategic objectives.
	Operational Risk Management (Quarterly Update) Concerns were raised at the number of overdue risk reviews but noted that work is ongoing with relevant managers to complete the reviews, however, discipline is required to ensure the Datix system is kept updated. The Committee supported a revised compliance target for risk reviews handlers. Contingency planning to maintain the process in the absence of risk handlers would be looked at. Risks that fall outside of the Trust's responsibility would be removed. The report provided **significant assurance** regarding the risk management process and the efforts made by the Risk and Assurance Manager to drive that process. **Limited assurance** was allocated around the overdue risks.

	Risk Management Strategy 2023-2025 – Annual Monitoring Report All objectives set in the strategy are being met. The Committee suggested that as the 'how to manage safely' training module sat outside the Risk Management team it should be taken off the compliance report with the assurance it is monitored elsewhere. The Committee agreed **significant assurance** on the progress made against the 2023-2025 Risk Management Strategy and would receive the next progress report in October 2025.
	Review of 2023/24 Annual Report and Accounts Production The Committee acknowledged that the Trust has robust processes in place to effectively deliver the requirements of the Annual Report and Accounts and noted the learning identified from the 2023/24 Annual Report and Accounts, ahead of the process commencing for 2024/25.
	Six-Month Update on the Implementation of the Freedom to Speak Up (FTSU) Policy Framework The FTSU Guardian report presented the six-monthly report along with an update on the NHS England/NHS Improvement FTSU Reflection and Planning Tool. The Committee was pleased to see the considerable number of FTSU Champions in comparison even with much larger Trusts. There is a champion in each Division and the ambition is for one for each team, making sure the distribution is geographic, rather than purely by division. It was suggested that future reporting includes a measure on the timescales to provide feedback to those who raised a concern. The paper provided **significant assurance** to the Committee that the Trust has adequate arrangements in place for speaking up and summarises the work that is being carried out under the FTSU policy framework within the Trust for the period reported.
	Well Led Action Plan The Committee monitors compliance against the plan and many of the actions have now been marked as completed in line with the work on the new Trust Strategy. All remaining elements should be completed by the end of the year with the exception of the review work on the constitution which is scheduled to be completed by the end of March. The Committee gave **limited assurance** based on the fact that actions remain in progress.
	Data Security and Protection (DS&P) Report The submission and positive outcome of the 2023/24 Toolkit was acknowledged, noting an update on audit recommendations and the progress for the new DS&P toolkit 2024/25. The update also covered the work of the DS&P Group, DS&P risk and incident management and Information Commissioner's Office (ICO) concerns. The Trust's mandatory training for DS&P and processing of Subject Access Requests (SARs) continue to show excellent compliance. The Trust is looking to reduce paper communications and streamline some of the processes around with a move to "hybrid" mail, whereby users can install some software, set up an account and this enables printing at a trusted supplier, thereby reducing the risk of human, manual error. NHSE have recently released a framework around digital transformation, the legalities, safeness, proportion and relevance, highlighting partnership working between corporate and clinical governance.

	Data Quality Update The Committee received an update on activities which have been undertaken over the last six months to ensure the Trust maintains good data quality. One success had been the review of mobile 'phone numbers to identify those either not in use or associated with people who no longer work for the Trust. This had resulted in cost savings due to cancelled contracts. It was noted that the team has developed several dashboards to improve management referrals and significant testing has been undertaken to ensure an accurate reflection of the Trust's position and the Committee was given a demonstration of the dashboards to show the level of detail, including the demographic view, population equality provision and different cohorts.
	Internal Audit Progress Report The key messages and progress made against the Internal Audit Plan since the last meeting were noted.
	External Audit Progress Report Focus is on the early stages of planning and there is no change in accounting policies and just a minor change in annual reporting.
	Counter Fraud and Bribery Policy and Procedures The Committee ratified the policy.
	Escalations to Board or other Committees: None. **Items added to the Board Assurance Framework:** None. **Next scheduled meeting:** 23 January 2025.
Committee Chair: Geoff Lewins	**Executive Lead: Justine Fitzjohn, Director of Corporate Affairs and Trust Secretary**

Quality and Safeguarding Committee – key assurance levels for items – 15 October 2024	
	Verbal Update – Director of Nursing, Allied Health Professions (AHP), Quality and Patient Experience An update on visits to the Radbourne and Hartington Units with colleagues was given. The purpose of the visits was to thank staff face to face for their support in progressing the Care Quality Commission (CQC) action plan. It had also been an opportunity for staff to feedback on a number of other issues. Plans regarding preceptee placement on wards were shared.

	Fundamental Standards Report An update was given on actions taken to improve quality of care arising from the findings of the Care Quality Commission's (CQC) inspections. Actions are monitored on a weekly basis by the CQC Oversight Group. There had been a CQC Mental Health Act visit to Tissington Ward in October, the inspector had recognised the improvements made since the last visit and recommendations from this visit will be added to the action plan. The Committee noted positive informal feedback from the Special Educational Needs and Disabilities (SEND) review in September. Discussions focussed on potential metrics to gauge success, which included the quarterly pulse check, embedding the learning, how quality improvement methodology is embraced, the number of incidents and leadership effectiveness, it was agreed this needs further consideration, and the Committee will be making an escalation to the People and Culture Committee. **Limited assurance** was accepted that the Trust is comprehensively addressing the concerns identified by the CQC and working with all clinical areas to review fundamental standards with assurance that improvement plans are in place and being monitored through internal governance.
	Guardian of Safe Working Hours Report The Committee received the latest report from the Trust's Guardian of Safe Working Hours, which provided data about the number of resident doctors in the Trust and the arrangements made to ensure safe working within the new contract and arrangements in place to identify, quantify and remedy any risks to the organisation. The term 'Resident Doctor' would be used in place of 'Junior Doctor' going forwards. It was noted that there had been five exception reports from the same doctor on a recurring issue. This has now been resolved. A national proposed change for breaches of less than two hours was noted. The Committee accepted **significant assurance** that the duties and requirements as set out in the 2016 Junior Doctor terms and conditions of service are being met.
	Infection Prevention and Control (IPC) Annual Report A summary of activity over the preceding 12 months of work related to infection control was presented and the Committee noted that the Trust benchmarks well with other organisations with low levels of infection and outbreaks. As a result of recommendations from NHS England, the Trust had reconvened its IPC Committee. It was noted that the Trust is compliant with the Health and Social Care Act IPC requirements. The Committee agreed **significant assurance** that approaches and learning are evolving in accordance with emerging evidence and international/national and regional learning and agreed **significant assurance** on standards of cleanliness of clinical areas and food preparation areas.
	Safer Staffing Review (Six-Monthly) A report summarised the work being undertaken to monitor and develop the skill mix of staff across the Trust to ensure safe services. The Committee noted the challenge to achieve 100% staffing levels within inpatient Services. Medical rosters are covered and there are mitigations at various levels, and it was noted that all staff need to be rostered to see the full picture. The Committee discussed the Nursing Associate Apprentices roles and also noted the recruitment challenges for the Making Room for Dignity (MRfD) programme as well as existing wards where it was crucial to recruit to reduce agency and temporary staffing use. **Limited assurance** was agreed on the issues highlighted.

	SEND – COAT Report and Self-Assessment The Committee received an update on progress of the Trust's SEND requirements, following the annual report in May. The Integrated Care Board (ICB) requires a six-monthly update with the self-assessment, which is then shared externally. The Trust is performing well around all areas, with 96%-100% compliance and there are plans in place to address those areas of non-compliance. The Committee accepted **significant assurance** on the compliance.
	Care Planning/Person-Centred Care The report provided a quarterly update on progress made regarding person-centred care and care planning delivery across the Trust. 100% compliance had only been achieved within Perinatal Services and the challenges around others' compliance are discussed in weekly divisional meetings. The Heads of Nursing are supporting improvements which are linked to an issue around the template and SystmOne training. The Committee stressed the need to have definitions and clarity on who needs a care plan. It was agreed that every patient needs to understand what their care is and how it being managed. The Committee accepted **limited assurance** on the basis that additional consideration is required to improve the processes and controls.
	Quality Improvement Strategy **Limited assurance** was agreed on the progress of activities to date in delivery of the 2021-2024 Quality Improvement Strategy. The Committee was pleased to see how well the training has been accessed but there was a need to see what those fundamental skills bring to the organisation.
	Quality and Equality Impact Assessment (QEIA) Assurance Relating to Cost Improvement Programmes (CIP) QEIA submissions are reviewed by the Medical Director and the Director of Nursing Directors, and the Committee noted a summary of the outcomes and agreed it was helpful to see the scrutiny, along with the explanatory justification for those programmes that are rejected. **Full assurance** was agreed.
	Intensive and Assertive Community Mental Health Treatment The Committee was given an overview of current practices, areas for improvement and action plans for enhancing mental health services, following the CQC's review of community services in Nottinghamshire. The ICB is required to carry out a review and the Trust has submitted its information as part of this. The internal review work has confirmed the Trust is not positioned as an outlier and the business case for the management and supervision tool (MAST), has been shared, as this has been highlighted as a beneficial resource. **Significant assurance** was agreed on the processes to understand the current position but **limited assurance** on progress of the actions.
	Deep Dive – Children and Adolescent Mental Health Services (CAMHS) Access to Tier 4 Beds The Committee received the report associated with the challenges access a tier 4 inpatient bed. The Trust CAMHS is part of the East Midlands Collaborative, of which Northamptonshire Healthcare is the lead provider. The Trust is one of three providers that does not have its own beds.

	Deep Dive – Dementia Services An overview of the current service delivery position for Dementia Services provided by the Trust was received. The rise in demand was expected to continue over the next five years and availability of suitable accommodation and care home beds was an issue, impacting length of stay with a number of patients deemed clinically ready for discharge (CRFD). The Committee valued the update, adding that the Governors have a particular interest in this area. **Significant assurance** was agreed on the work and process with a note about the risks associated with the current demand on services.
	Patient and Carers Race Equality Framework (PCREF) The Committee received a briefing on the requirements of PCREF, how these align with the current function of Board committees and the need for central oversight. The three domains are: Part 1 – Leadership and Governance Part 2 – National Organisational Competencies Part 3 – The Patient and Carers Feedback Mechanism The Committee welcomed the information and the development of an action plan for this work.
	Board Assurance Framework (BAF) – key risks identified: The Committee reflected if any there were any changes needed to the BAF following its discussions and a review was suggested in light of the Intensive and Assertive gaps that have been identified. As the deadline for implementation of the PCERF is March 2025, it was suggested this can be revisited if there is a risk this will not be met.
	Escalations to Board or other Committees: None **Items added to the Board Assurance Framework:** None. **Next scheduled meeting:** 12 November 2024.
Committee Chair: Lynn Andrews	**Executive Lead: Tumi Banda, Director of Nursing, AHPs, Quality and Patient Experience**

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 5 November 2024

Guardian of Safe Working Hours Report (Quarterly) (October 2024)

Purpose of Report

This quarterly report from the Trust's Guardian of Safe Working (GOSW) provides data about the number of resident doctors in the Trust, full transition to the 2016 Resident Doctor contract (Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016) and any issues arising therefrom. The report details arrangements made to ensure safe working within the new contract and arrangements in place to identify, quantify and remedy any risks to the organisation.

Executive Summary

The Board is requested to note:

1. The Junior Doctor Forum has been formally renamed the Resident Doctor Forum. The term 'resident doctor' refers to the group previously known as 'junior doctors'. This term was put forward by the British Medical Association (BMA) at their Annual Representatives Meeting and has been adopted by the Department of Health and Social Care (DHSC) as part of the agreed pay deal, which has ended industrial action.
2. Medical Education colleagues are transitioning to use this term, and it is requested that The Committee supports this.
3. Exception reports were owing to doctors staying late on their core placements, resulting in time off in lieu (TOIL).
4. There were five exception reports from the same doctor, which resulted in a formal work schedule review. The post has since been changed and current issues appear to have been resolved (no longer a split post with just one supervisor). This required escalation to both Medical Education and Medical Director structures.
5. Eight of the nine exception reports took longer than 14 days to formally resolve on the exception reporting system. Five of these involved the formal work schedule review. The remainder were delays due to supervisors completing the forms on the system. It is agreed that the GOSWH provides a visible comment on each exception report within a few days to guide both the doctor and supervisor, but it is still expected that supervisors engage in the system.
6. There are proposed changes to the exception reporting system as part of the pay deal that ended industrial action. One of the changes is that hours breaches of less than two hours are sent for TOIL/payment automatically, bypassing the supervisor step that currently exists. This would improve times to process exception reports. However. detail is not yet finalised. These will be commented on further when known within future reports.
7. The GOSWH chairs the Improving Working Lives of Doctors in Training task and finish group. This is a formal response to NHS England's communication in April 2024 (https://www.england.nhs.uk/long-read/improving-the-working-lives-of-doctors-in-training/). It will report back at the end of this calendar year against the workplan at the end of this report.

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 from the Trust's Guardian of Safe Working Hours provides data about the number of resident doctors in the Trust, full transition to the 2016 Resident Doctor contract and any issues arising therefrom. The report details arrangements made to ensure safe working within the contract and arrangements in place to identify, quantify and remedy any risks to the organisation.

Consultation

- The GOSWH has shared the previous annual report to this Committee, with the Joint Local Negotiating Committee, the Trust Medical Training Committee, the Resident Doctor Forum and its constituent resident doctors. Following presentation to this Committee, this report will be shared at the next Resident Doctor Forum and its constituent resident doctors
- The Quality and Safeguarding Committee, 15 October 2024.

Governance or Legal Issues

None.

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

None.

Recommendations

The Board of Directors is requested to:

1. Note the contents of this report
2. Support the transition to using the term ‘Resident Doctor’ in place of ‘Junior Doctor’
3. Accept significant assurance that that the duties and requirements as set out in the 2016 Resident Doctor contract are being met.

Report presented by: **Arun Chidambaram**
Medical Director

Report prepared by: **Dr Kaanthan Jawahar**
Guardian of Safe Working Hours

GUARDIAN OF SAFE WORKING REPORT (QUARTERLY)
October 2024

1. Trainee data

Extended information supplied from 10 June 2024 to 8 October 2024.

Numbers in post for doctors in training

Numbers of doctors in post WTE	North	South
FY1	3	5
FY2	3	5
GP ST	4.10 (headcount 5)	6.4 (headcount 7)
CT	10.4 (headcount 11)	12.8 (headcount 13)
HSTs	8	7.6 (headcount 8)
Paediatrics ST	0	2 (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 10 June 2024 to 8 October 2024. Total number of exception reports =

Location	No of exceptions raised	No of exceptions closed	No of exceptions outstanding
North	1	1	0
South	8	7	1
Total	**9**	**8**	**1**

Grade	No of exceptions raised	No of exceptions closed	No of exceptions outstanding
CT1-3	2	0	2
ST4-7	0	0	0
GP	5	5	0
Foundation	2	2	0
Total	**9**	**8**	**1**

Action taken

Location	Payment	TOIL	Not agreed	No action required
North	0	1	0	0
South	5	2	1	1
Total	**5**	**3**	**1**	**1**

Response time

Grade	48 hours	7 days	Longer than 7 days	Open
CT1-3	0	0	0	1
Foundation	0	1	2	0
ST4-7	0	0	0	0
GP	0	0	5	0

No NROC rest requirement exception reports were submitted in this period. There is a monitoring exercise currently underway for all the out of hours medical rotas to form baseline data about activity – this is for prospective monitoring as our inpatient and healthcare-based place of safety provision increases over the next 18 months as part of the Making Room for Dignity Programme within the Trust.

Five exception reports highlighted a timetabling issue for one resident doctor. This triggered a formal work schedule review (see section 3). The doctor was also not able to take TOIL as they had rotated out of the Trust, as such payment was made.

The remaining exception reports resulted in TOIL for overtime during core hours.

3. Work schedule reviews

The work schedule review saw the GOSWH collect relevant facts on the issue, and then share with colleagues in Medical Education. There was a timetabling issue with weekly clinical supervision, which routinely saw the doctor stay after their rostered finish time. They also had to use their non-working day to complete clinical admin tasks in a timely manner. Medical Education colleagues sought to address the issue via the relevant supervisor's clinical director, however, this yielded few results. The issue was then formally escalated to the Medical Director who sought advice from the Responsible Officer's Advisory Group. Ultimately, Medical Education has changed the post so that there is only one supervisor (it was previously a split role), and feedback so far has been positive.

4. Fines

- The current total of fines available for the JDF to spend is £960.92 through cost code G62762
- Fines' money set aside for a Board-supported away day for resident doctors
- No new fines in the period covered by this report.

5. Locum/Bank Shifts covered (10 June 2024 to 8 October 2024)

	North	Cost	South	Cost
Locum/bank shifts covered	2	£1,500	56	£30,627.35
Agency locum shifts covered	0	0	0	0

6. Agency Locum

Nil during the current financial year.

7. Vacancies (10 June 2024 to 8 October 2024)

	North	South
CT1-CT3	0.4	0.2
ST4-7	3	0
GP Trainees	0.4	0.6
Foundation	0	0

8. Qualitative information

- The Junior Doctor Forum has been formally renamed the Resident Doctor Forum. The term ‘resident doctor’ refers to the group previously known as ‘junior doctors’. This term was put forward by the BMA at their Annual Representatives’ Meeting and has been adopted by the DHSC as part of the agreed pay deal, which has ended industrial action
- Medical Education colleagues are transitioning to use this term, and it is requested that the Committee supports this
- Exception reports were owing to doctors staying late on their core placements, resulting in TOIL
- There were five exception reports from the same doctor, which resulted in a formal work schedule review. The post has since been changed and current issues appear to have been resolved (no longer a split post with just one supervisor). This required escalation to both Medical Education and Medical Director structures
- Eight of the nine exception reports took longer than 14 days to formally resolve on the exception reporting system. Five of these involved the formal work schedule review. The remainder were delays due to supervisors completing the forms on the system. It is agreed that the GOSWH provides a visible comment on each exception report within a few days to guide both the doctor and supervisor, but it is still expected that supervisors engage in the system
- There are proposed changes to the exception reporting system as part of the pay deal that ended industrial action. One of the changes is that hours breaches of less than two hours are sent for TOIL/payment automatically, bypassing the supervisor step that currently exists. This would improve times to process exception reports, however detail is not yet finalised. These will be commented on further when known within future reports
- The GOSWH chairs the Improving Working Lives of Doctors in Training task and finish group. This is a formal response to NHS England’s communication in April 2024 (https://www.england.nhs.uk/long-read/improving-the-working-lives-of-doctors-in-training/). It will report back at the end of this calendar year against the workplan at the end of this report.

9. Compliance of rotas

Current work schedules are compliant with the 2016 resident doctor contract.

10. Other concerns raised with the Guardian of Safe Working (GoSW)

None that are not already covered in section 8.

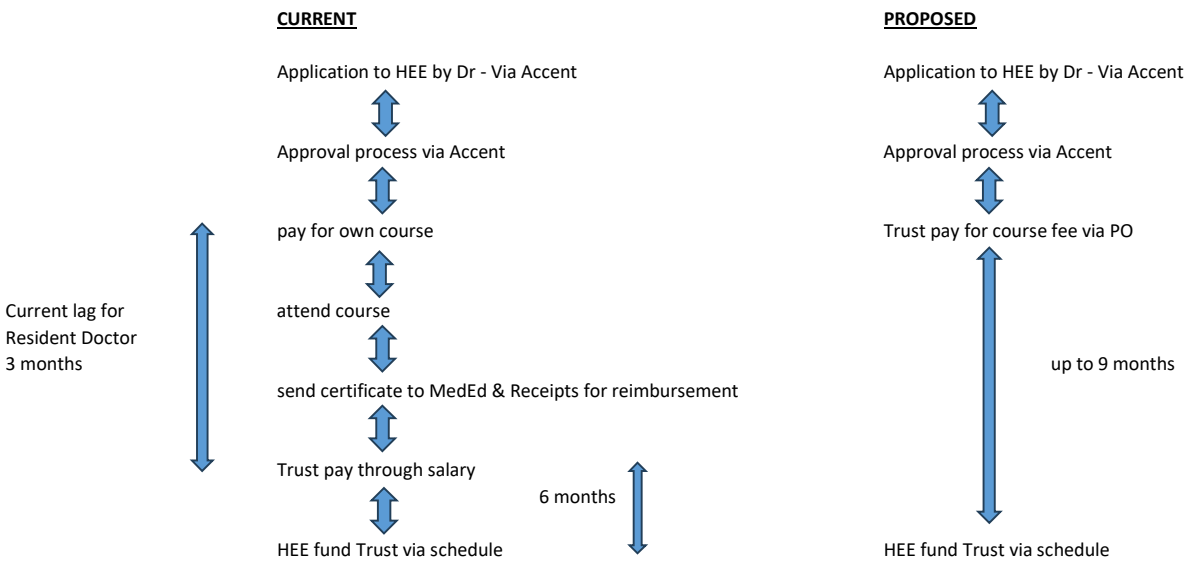
IMPROVING WORKING LIVES OF DOCTORS IN TRAINING

ACTION PLAN

Item	Narrative	Actions	Lead	Expected Completion/Timescales
Work schedules at eight weeks and rosters by six weeks.	Work schedules (determines pay and repeating pattern of shifts) drawn up by Medical Staffing. Rosters (live rotas) drawn up by Medical Education.	• Explore with both medical staffing and medical education the barriers to meeting their respective targets.	Medical Staffing and Medical Education.	November 2024.
Live rotas.	Rotas are already live for south resident doctors, but this piece of work could galvanise the remainder of rotas also going live.	• Agree a roll-out of live rotas for the north resident doctor rotas based on previous meetings had on this topic • This group may then consider supporting the rest of the Trust to deliver the same for psychiatry consultant rotas.	Medical Education.	November 2024.
Better rota management.	Example given of self-rostering (locally this could be picking rota lines?)	• Explore what currently happens with rota lines when rosters are drawn up (Medical Staffing and Medical Education).	TBC.	TBC.
Rota Coordinator.	Currently this role is fulfilled through a combination of Medical Education and Medical Staffing. It is recognised that the ideal scenario is to have dedicated resource for this.	• Create a job description specific to DHcFT by codifying what work is currently done by whom re: rota management in the Trust.	TBC.	TBC.
Payroll accuracy.	Rotating doctors are more at risk of such errors. Board governance framework for monitoring payroll errors has been asked for.	• **Pay arrangements for resident doctors** Foundation and GP trainees are paid under lead employer arrangements. GP trainees by	Medical Staffing.	December 2024 for Board Governance Framework to include procedures to decrease delays/errors.

	Policies/procedures to identify and swiftly correct payroll errors.	Mersey and West Lancs teaching hospitals and foundation trainee south by UHDB and north by Chesterfield Royal Hospital. There is no lead employer arrangement for cores and higher psychiatry trainees. The doctors rotate between DHcFT, Notts HC and Lincoln and are paid by the relevant Trust where they are working on placement. • Exploration on whether a board governance framework already exists.		
Protecting training time.	Rotating doctors will have specific training requirements for their programmes (eg portfolio, mandatory training, regional teaching, etc).	• Personalised work schedules as an enabler.	TBC.	TBC.
Onboarding processes.	Ensuring these are swift and efficient. Provision of practical information, such as rest facilities, parking and similar.	• Induction content can be looked at with Medical Education • Onboarding can be looked at with Medical Staffing and Medical Education • Resident doctors to review both general and local inductions. The latter is particularly key, with the ask being what an ideal local induction would look like.	Resident doctors (led by Dr Omesili), supported by Medical Education.	November 2024.

Stat-mandatory training.	Ensure rotating doctors learning passports are aligned with the CSTF. Using e-LfH/ESR as the default. Adopting the NHS Digital Staff passport.	• Review of learning passports against the CSTF (Statutory and Mandatory Training – e-learning for healthcare (e-lfh.org.uk)) • Look into the NHS Digital Staff passport (what is happening nationally, as the group felt this was key).	GOSWH, with Medical Education Support.	December 2024.
NETS and GMC surveys.	Parity with Friends and Family Test.	• Embed Board-reporting and sanctioned action plans • Explore with Medical Education what currently happens now.	TBC.	TBC.
BMA Wellbeing guidance.	Five priorities for improving wellbeing in the workplace (bma.org.uk)	• Revisit and see what can be implemented. Medical Education, Medical Staffing, JDF, LNC • Work has been done previously, but perhaps needs reinvigorating.	TBC.	TBC.
Reversing payments for course fees during study leave.	Currently doctors pay course fees up front and a reimbursed after attending the course. NHS England have put this down as an action for them rather than for trusts, however DHcFT was exploring this beforehand and wishes to pursue this independently.	• GOSWH will liaise with the Deanery on what is being done centrally about this • Process mapping by Medical Education and Finance.  Process Map.xlsx	Finance and Medical Education.	December 2024.



Questions / concerns

If crosses over financial periods work required around the accrual process. (Finance)

A new training policy required - specific to this area - especially with regards to non attendance and returning funds to the Trust
If on our payroll can be through salary deductions
If not on our payroll we will need inter Trust agreement with regards to salary deduction
or will the person return this directly to us?
if the latter we are at risk of not none payment.

Are we consistent with other Trusts - could cause problems if staff in DHCFT are given different processes due to employer

lag between cost to trust and reimbursement to Trust from HEE increased from 6 to 9 months

Only applies to our cores and highers (we don't reimburse foundation, GP, etc) where we are lead employer, unless lead employer status is changed (ES)

This would only apply to the course booking itself. The hotel/travel/subsistence costs would still have to use another system (at the moment retrospective reimbursement) or we could go over to travel warrants, but that takes it out of our hands and creates more work for somebody else.

DMEs/Deputy DMEs will need to spend time signing off purchase orders. Med Ed team for receipting.

How will the claims be logged and reclaimed from HEE will that be in med ed or finance - Assume current system unless ACCENT is changing.

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 5 November 2024

Learning from Deaths - Mortality Report - 1 April to 31 July 2024

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 April 2024 to 31 July 2024.

Executive Summary

- All deaths directly relating to COVID-19 are reviewed through the Learning from Deaths procedure unless they also meet a Datix red flag, in which case they are reviewed under the Incident Reporting and Investigation Policy and Procedure. During 1 April to 31 July 2024 there were no deaths reported where the patient tested positive for COVID-19
- The Trust received 689 death notifications of patients who had been in contact with our services in the last six months. There is very little variation between male and female deaths; 359 male deaths were reported compared to 330 females
- One inpatient death (expected – end of life) and one inpatient death (suspected suicide) died following transfer to the acute hospital for further treatment
- The Trust has reported nine Learning Disability deaths in the reporting timeframe and the death of one patient with a diagnosis of autism
- 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 comes into force on 9 September 2024. 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
- A process has been implemented within the patient Electronic Record which 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.

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.	

Risks and Assurances

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

Consultation

- This report has been reviewed by the Medical Director
- This report has been reviewed by the Quality and Safeguarding Committee, 10 September 2024.

Governance or Legal Issues

There are no legal issues arising from this report.

The Care Quality Commission Regulations - this report provides assurance as follows:

- Outcome 4 (Regulation 9) Care and welfare of people who use services
- Outcome 14 (Regulation 23) Supporting staff
- Outcome 16 (Regulation 10) Assessing and monitoring the quality of service provision
- Duty of Candour (Regulation 20).

Public Sector Equality Duty and Equality Impact Risk Analysis

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

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

- During 1 April 2024 to 31 July 2024, there was very little variation between male and female deaths; 359 male deaths were reported compared to 330 female deaths
- No unexpected trends were identified according to ethnic origin or religion.

Recommendations

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

Report presented by: **Arun Chidambaram**
Medical Director

Report prepared by: **Louise Hamilton**
Safer Care Co-ordinator

Learning from Deaths - Mortality Report

1. Background

In line with the Care Quality Commission's (CQC) 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'. The purpose of the framework is to introduce a more standardised approach to the way NHS trusts report, investigate, and learn from patient deaths, which should lead to better quality investigations and improved embedded learning. To date, the Trust has met all of the required guidelines.

The report presents the data for 1 April 2024 to 31 July 2024.

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

- 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. This will improve once Medical Examiners commence the process of reviewing the Trust's non-coronial deaths in September 2024. The Trust continues to meet with the Medical Examiners on a regular basis.

- 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 14 August 2024.

- A process has been implemented within the patient Electronic Record which 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 Case Record review panel process has been evaluated and plans are in place to re-design this to act as an assurance and audit panel over incidents closed through the Operational Incident Review group.

- The Trust Mortality Committee has been evaluated and developed into a Learning the Lessons Oversight Committee which will improve governance around learning and drive quality improvement.

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 from 1 April 2024 to 31 July 2024.

	Apr	May	Jun	Jul
Total Deaths Per Month	184	169	169	167
LD Referral Deaths	4	2	3	0

Correct as at 7 August 2024

From 1 April 2023 to 31 March 2024, the Trust received 689 death notifications of patients who have been in contact with our services. Of these deaths 359 patients were male, 330 female, 511 were white British and 9Asian British. The youngest age was 0 years, the oldest age recorded was 101. The Trust has reported nine Learning Disability deaths in the reporting timeframe and the death of one patient with a diagnosis of autism.

4. Review of Deaths

Total number of Deaths from 1 April 2024 to 31 July 2024 reported on Datix.	53 “Unexpected deaths”. 0 COVID deaths. 10 “Suspected deaths”. 7 “Expected - end of life pathway”. NB some expected deaths have been rejected so these incidents are not included in the above figure. One inpatient death (expected – end of life) and one inpatient death (suspected suicide) died following transfer to the acute hospital for further treatment.
Incidents assigned for a review.	71 incidents assigned to the operational incident group.

Only deaths which meet the criteria below are reported through the Trust incident reporting system (Datix) and these are also reviewed using the process of the *Untoward Incident Reporting and Investigation Policy and Procedure.*

Any patient, open to services within the last six months, who has died, and meets the following:

- Homicide – perpetrator or victim
- Domestic homicide - perpetrator or victim
- Suicide/self-inflicted death, or suspected suicide
- Death following overdose
- Death whilst an inpatient
- Death of an inpatient who died within 30 days of discharge from a DHcFT hospital
- Death following an inpatient transfer to acute hospital
- Death of patient on a Section of the Mental Health Act or Deprivation of Liberty Safeguards (DoLs) authorisation
- Death of patient following 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.

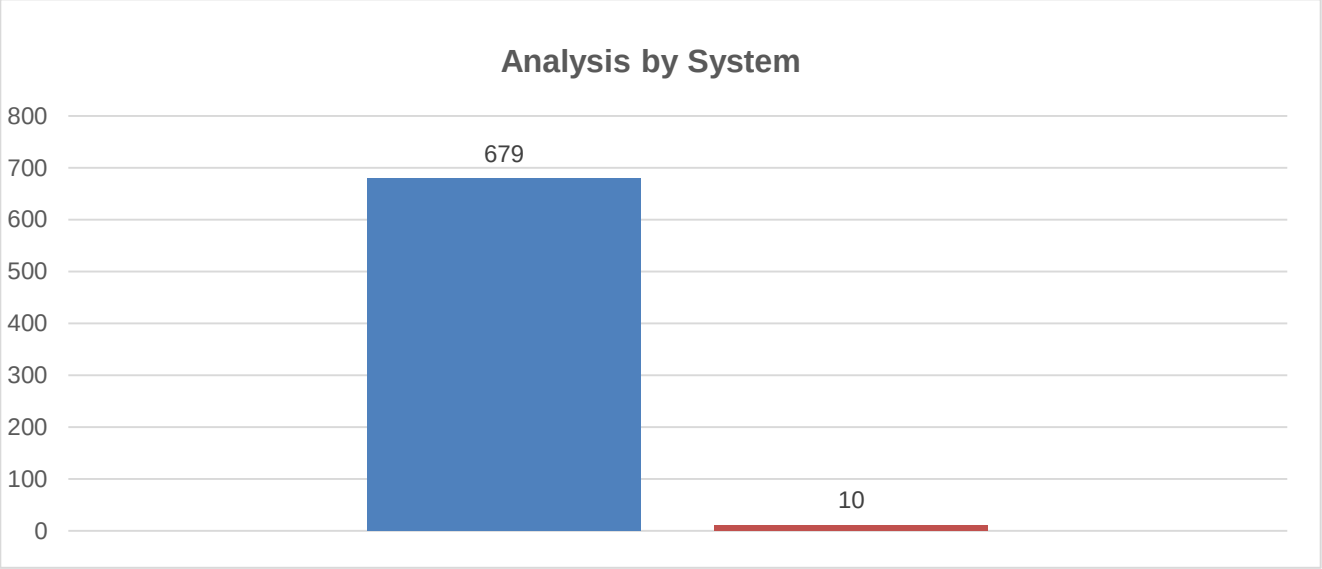
5. Learning from Deaths Procedure

The Trust has now completed a move in terms of its mortality process, a process has been implemented within the patient Electronic Record which 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.

There is a process for weekly random audits of deaths against the Red Flags to provide assurance that the new process is working as intended however this has been impacted by long term sickness over recent weeks however a plan is in place to address this.

6. Analysis of Data

6.1 Analysis per notification system since 1 April 2024 to 31 July 2024



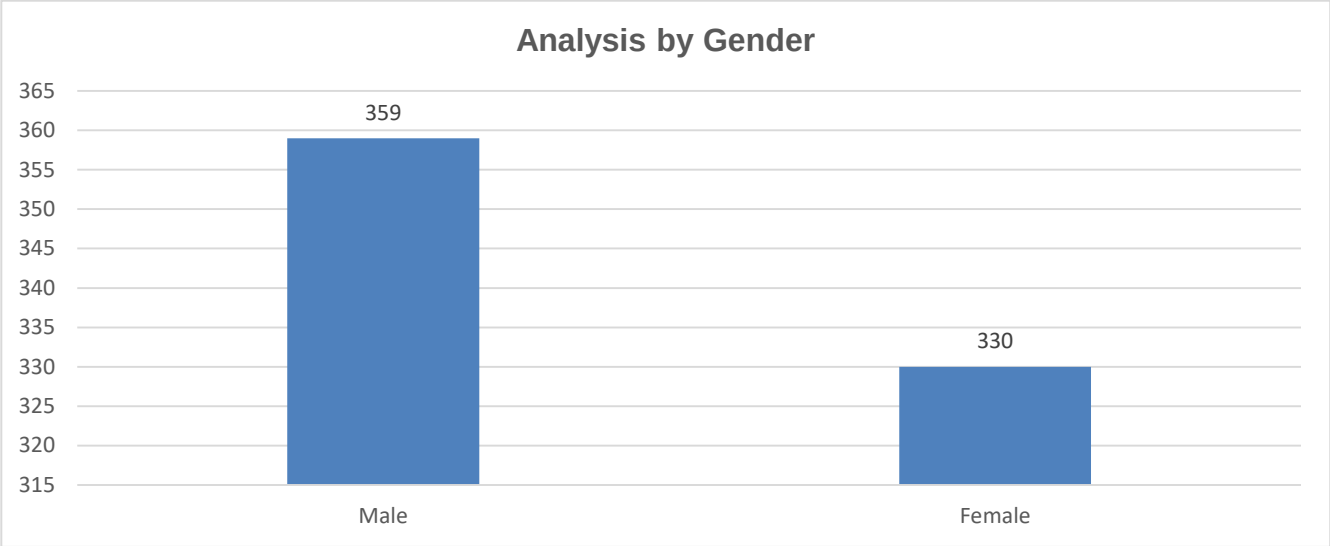
System	Number of Deaths
SystmOne	679
IAPT	10
Grand Total	**689**

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

From the 1 April 2024 to 31 July 2024, there has been no deaths reported where the patient tested positive for COVID-19.

6.2 Analysis by Gender

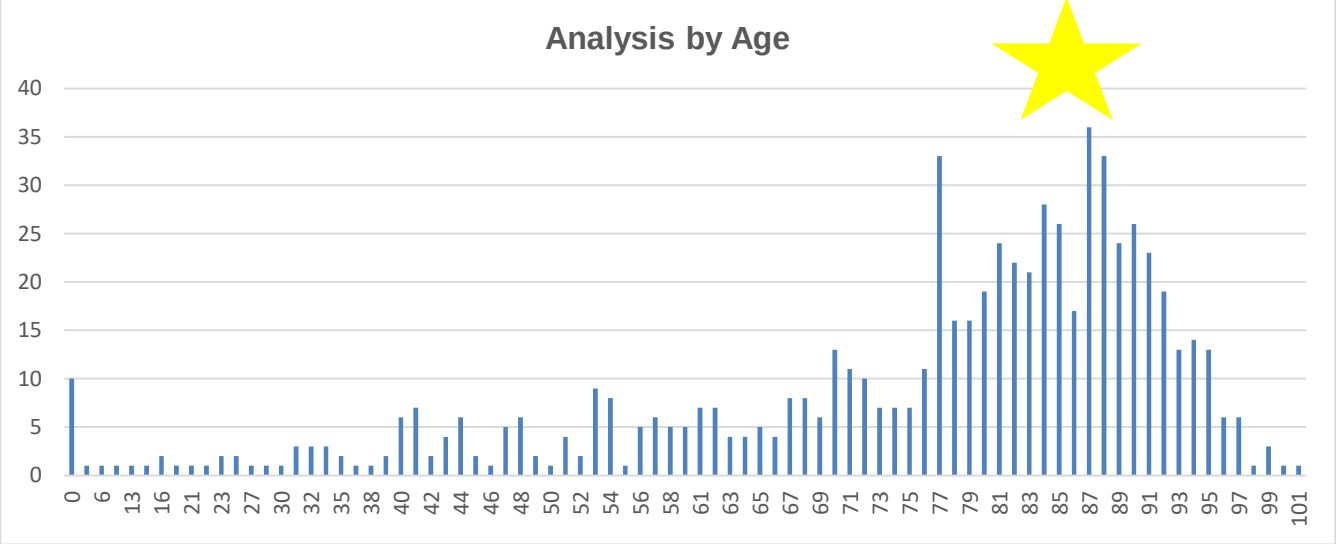
The data below shows the total number of deaths by gender 1 April 2023 to 31 March 2024. There is very little variation between male and female deaths; 330 female deaths were reported compared to 359 males.



Gender	Number of Deaths
Male	359
Female	330
Grand Total	**689**

6.3 Analysis by Age Group

The youngest age was classed as 0, and the oldest age was 101 years. Most deaths occurred within the 81 to 90 age groups (indicated by the star).



6.4 Learning Disability Deaths (LD)

	Apr	May	Jun	Jul
LD Deaths	4	2	3	0
Autism	0	0	0	1

The Trust reviews all deaths relating to patients diagnosed with a Learning Disability. The Trust also currently sends all Learning Disability deaths that have been reported through the Datix system to the LeDeR programme. Scoping is planned with operational services through their Learning the Lessons subgroups to consider the most appropriate management process for Learning Disability deaths moving forward.

From 1 January 2022, the Trust has been required to report any death of a patient with autism. To date, eleven patients have been referred.

During 1 April 2024 to 31 July 2024, the Trust has recorded 9 Learning Disability deaths. The Trust now receives a quarterly update from LeDeR which highlights national good practice and identified learning; this is shared in the Mortality monthly meeting.

6.5 Analysis by Ethnicity

White British is the highest recorded ethnicity group with 511 recorded deaths, 41 deaths had no recorded ethnicity assigned, and 8 people did not state their ethnicity. The chart below outlines all ethnicity groups.

Ethnicity	Number of Deaths
White – British	511
Other Ethnic Groups - Any other ethnic group	82
Not Known	41
White - Any other White background	12
White – Irish	9
Not stated	8
Black or Black British – Caribbean	6
Asian or Asian British – Pakistani	5
Black or Black British – African	5
Asian or Asian British - Indian	4
Mixed - White and Black Caribbean	3
Black or Black British - Any other Black background	1
Mixed - Any other mixed background	1
Mixed - White and Asian	1
Grand Total	**689**

6.6 Analysis by Religion

Christianity is the highest recorded religion group with 267 recorded deaths, 174 deaths had no recorded religion assigned. The chart below outlines all religion groups.

Religion	Number of Deaths
Christian	264
Not religious	195
(blank)	169
Church of England, follower of	20
Church of England	12
Patient religion unknown	5
Catholic religion	4
Muslim	3
Roman Catholic	3
Christian, follower of religion	2
Sikh	2
Spiritualist	1
Buddhist	1
Baptist	1
Religion NOS	1
Christian	1
Jehovah's Witness	1
Methodist	1
Agnostic	1
Church of Scotland	1
Hindu	1
Grand Total	**689**

6.7 Analysis by Sexual Orientation

Heterosexual or straight is the highest recorded sexual orientation group with 441 recorded deaths. 245 have no recorded information available. The chart below outlines all sexual orientation groups:

Sexual Orientation	Number of Deaths
Heterosexual	441
(blank)	210
Sexual orientation not given - patient refused	25
Sexual orientation unknown	5
Unknown	5
Homosexual	1
Bisexual	1
Lesbian or gay	1
Grand Total	**689**

6.8 Analysis by Disability

The table below details the top eight categories by disability. Gross motor disability was the highest recorded disability group with 129 recorded deaths.

Disability	Number of Deaths
Gross motor disability	129
Intellectual functioning disability	40
Disability	39
Emotional behaviour disability	17
Disability Questionnaire - Behavioural and Emotional	15
Hearing disability	15
Disability Questionnaire - Mobility and Gross Motor	9
Disability Questionnaire - Progressive Conditions and Physical Health	8

There were a total of 319 deaths with a disability assigned and the remainder 284 were blank (had no assigned disability).

7. Recommendations and Learning

The table below outlines the current themes arising from incidents.

Improvement issue	Improvement plan
Transfer, Leave and Discharge.	**Transfer of the deteriorating patient.** Internal investigations highlighted themes around the transfer and return of patients between inpatient services for the Trust and Acute providers. This includes handover of information, and the way patients are conveyed. A quality improvement project has been undertaken between Derby Hospital and DHcFT to develop a transfer and handover proforma which is now in place. **Self-harm of patients whilst on leave from inpatient services and Section 17 leave arrangements** Several investigations have highlighted issues in relation to leave arrangements for inpatient services including follow up. A further thematic review was completed on conclusion of a cluster of inpatient suspected suicide incidents. An action plan was developed. The works will include review of the pathway of communication and documentation (including risk assessments and care plan) between Crisis Resolution and Home Treatment/Community teams and Inpatient services when a patient is due to be on s17 leave/discharged. This will be reviewed within the Adult Acute Learning the Lessons Subgroup.
Suicide Prevention.	**Suicide Prevention training** The Trust has identified the need to re-establish Suicide Prevention training across services, this is being led by the Trust Medical Director. A Trust Suicide Prevention Lead has now been appointed and this links into current training development in relation to Safety Planning, Risk Assessment and Suicide Prevention expected for Nov 2024.
Training and awareness of Emotionally Unstable Personality Disorder.	The Trust will develop a training and awareness package for all services in relation to EUPD which is being led by the Trust Medical Director.
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.
Physical Health management within inpatient environments.	Quality improvement work in relation to improving physical healthcare management, observation, and care planning within Older People's services. Enhancement of wound care management and infection prevention and control investigation and follow up within inpatient services. Introduction of RESTORE2 into ILS training framework including review of current ILS provision. Establish a physical health reporting working group to establish the new system one reporting frameworks to improve reports for assurance. Introduction of RESTORE2 into ILS training framework including review of current ILS provision.

Improvement issue	Improvement plan
	Notification of increased NEWS score via system one to senior colleagues to be reviewed. Improving knowledge, skills, and technological support such as NEWS2 within System1.
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.
Self-harm within inpatient environments including management of contraband.	Improvement works in relation to Ligature risk assessment and care planning within inpatient services. Quality Improvement programme in relation to self-harm via sharps of females within inpatient services (local priority). Improvement to environment. Improvement to therapeutic engagements. Improvement to risk assessment and management including observation levels. To continue commissioned working group to review handheld clinical devices and compliance with observations including physical health observations.
Dissemination of learning and service improvements following incidents including assurance and governance.	Work is underway to improve the way in which the Trust learning improves from incidents, this will include a revision to the processes in place in relation to internal investigation recommendations, Case Record Review learning, Incident Review Tool learning and the revised Trust Mortality process. Develop pathway to offer clear governance processes. Develop service line learning briefings specific to service learning. Trust-wide learning the lessons to share high level responses and learning. Develop better ways for monitoring and reporting emerging themes. Joined up working between services. Improved monitoring of high-profile cases and joined up working between services involved. Development of more collaborative Learning Responses.
Application of red flags and flow of incidents resulting in death.	Improvement in the application and identification of red flags for reporting death. Revision of current red flags for relevance given changes both nationally and locally. Redesign the function of the 'Mortality' process within structures through the Learning the Lessons subgroups. Review the purpose and function of the Mortality Case Record Review panel and redesign this to one of audit and assurance.
Interface between Mental Health and Substance Misuse service.	Suspected Suicide of a patient who has a dual diagnosis of substance misuse and mental health but has been rejected by Community Mental Health services is an area which has been noted through Case Record Review. This has been selected as a new local priority for the trust. Themes will be feed into Learning the Lessons subgroups for both services to jointly develop and improvement plan.

Improvement issue	Improvement plan
Substance Misuse services and Adult Acute Inpatient environments.	Learning Responses for unexpected deaths post discharge/ whilst on leave have highlighted gaps around knowledge, support and process for the management and support of risk in relation to addiction and substance misuse. Currently, several actions in place. Improvement plan to be developed and managed through the services Learning the Lessons subgroup.
Risk assessment, management, and care planning.	This is an area which repeatedly shows need for improvement and the trust is currently finalising a Safety Planning training package which will consist of four modules and incorporate suicide prevention.

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 5 November 2024

Children in Care Annual Report 2023/24

Purpose of Report

The purpose of this report is to provide the Trust with 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 is an assurance report to provide the Committee with scrutiny of 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. All Health performance have been maintained to ensure outcomes for our children
- 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
- The Designated Nurse for Children in Care and Named Nurse for Children in Care have been involved in the roll out of the Dental Pathway to support the improvement of children and young people being seen by a dentist
- The Designated Nurse for Children in Care and the Sexual Health service have met and discussed the sexual health needs for Children in Care. It has now been agreed that some of our most vulnerable children and young people can be offered an ACORN Card which provides an opportunity for the young person to have priority access to the Sexual Health service.

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 provided and scrutinised, in order, to achieve outcomes
- Training compliance will be scrutinised 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
- Quality and Safeguarding Committee, 10 September 2024.

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, ie, 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, eg, NICE, DoH, National Statistics
- The Trust contributes as an equal partner in multi-agency forums, eg, 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 & 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. Give appropriate feedback
2. Receive 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
3. Accept the Annual Report and agree on the key priorities set for 2024/25.

Report presented by: **Tumi Banda**
Director of Nursing, AHPs, Quality and Patient Experience

Report prepared by: **Kelly Thompson**
Named Nurse Children in Care

ANNUAL REPORT FOR DERBY CITY LOOKED AFTER CHILDREN PROVISION

Year 2023/24

Contributors:

Kelly Thompson (Named Nurse for Children in Care – DHcFT)

Dr S Mehta (Medical Advisor for Children in Care – DHcFT)

Natalie Legge (Administration 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 (2024/25) 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 well-being 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) argues 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: P romoting the health and well-being 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 83,840 Looked after Children on 31 March 2023, an increase of 2%, compared to 31 March 2022. (Department for Education DfE, Department of Health DH, 2023).

3.2 **Number of children looked after in England from 31 March 2015 to 2023**

2015	**69,540**
2016	**70,440**
2017	**72,670**
2018	**75,420**
2019	**78,150**
2020	**80,080**
2021	**80,850**
2022	**82,170**
2023	**83,840**

Ref: Data made available from Derby City Local Authority Informatics Department

3.3 **Number of children looked after in Derby from 31 March 2017 to 31 March 2024**

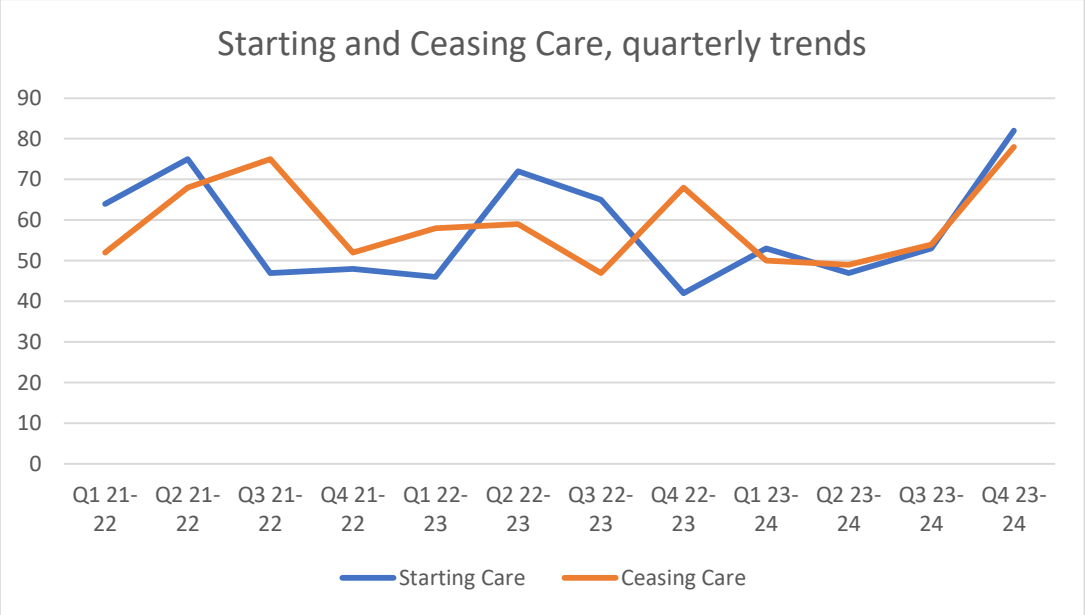
2017	**448**	**0.8% decrease from 2016**
2018	491	8% increase from 2017
2019	562	12% increase from 2018
2020	588	4.6% increase from 2019
2021	642	9.4% increase from 2020
2022	627	2.3% decrease from 2021
2023	621	1.1% decrease from 2022
2024	598	3.7% decrease from 2023

Ref: Data made available from Derby City Local Authority Informatics Department

There has been a decrease of 23 cases compared to twelve months ago (31 March 2023) when there were 621 cases. This equates to a decrease of 3.7%.

3.4 **Children in Care - starting and ceasing care - quarterly trends**

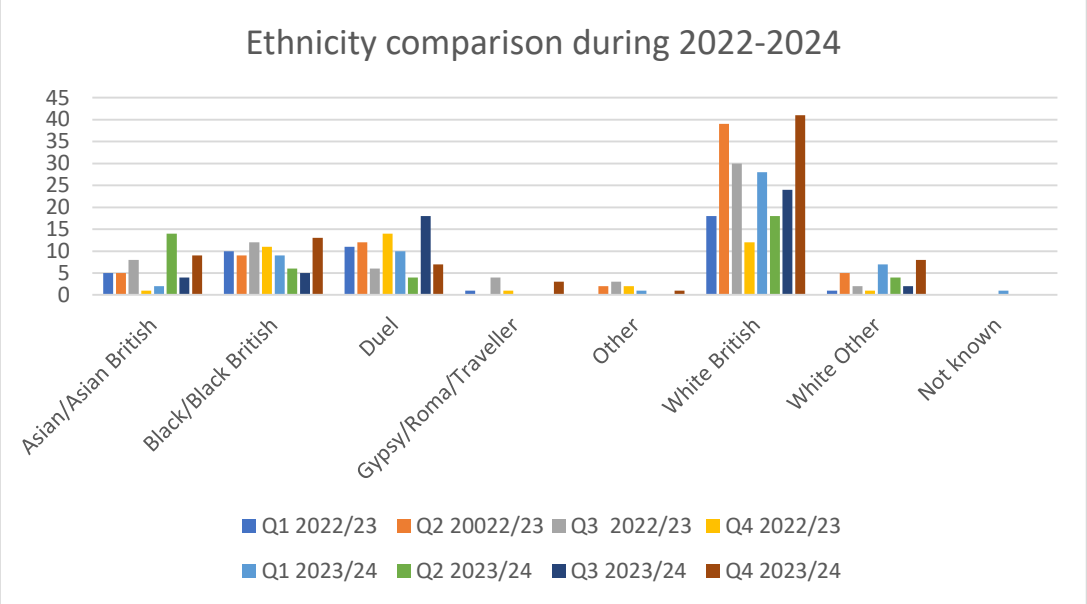
There was a large increase in the number of entrants into care during Q4 2023/24. There was a total of 82 entrants into care compared to 53 seen in the previous quarter. On average there are around 56 new entrants per quarter, so this quarter is much higher than the current quarterly average. During Q4 there were more entrants into care than exits.



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

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 tries 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 is linked to the East Midlands Migration group. Any relevant information is distributed to the Designated Nurse for Looked after Children and shared with the Children in Care team.

The Local Authority has employed a specific UASC team, in order, to support the continuity and cultural compatibility.

The percentage of children from a White British ethnicity decreased slightly during Q4 from 52.1% to 51.2% (306 children and young people). The number of children from a Black or Black British ethnicity increased from 36 to 42 as of 31 March 2024. This equates to 7.0% of the overall CIC cohort. The number of children from an Asian or Asian British ethnicity has decreased to 47 as of 31 March 2024. This equates to 8% of the overall CIC cohort.

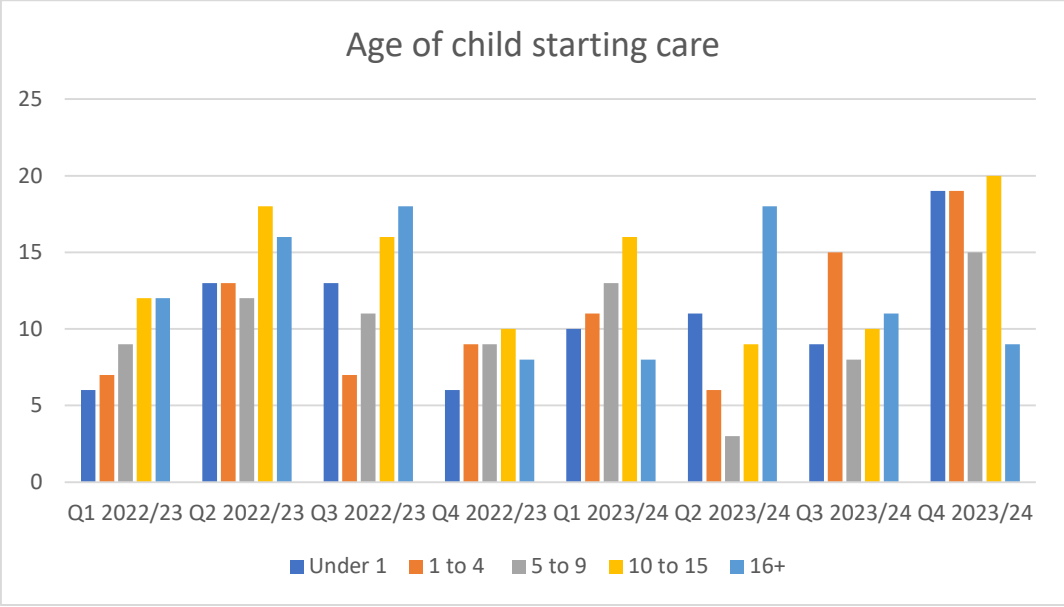
3.6 **Gender of looked after children in March 2024**

Gender	
Male	55%
Female	44%

Ref: Data made available from Derby City Local Authority Informatics Department

There were 330 males and 263 females in care on 31 March 2024. This equates to a split of 55% male versus 44% female. There were 67 more boys than girls in care on 31 March 2024.

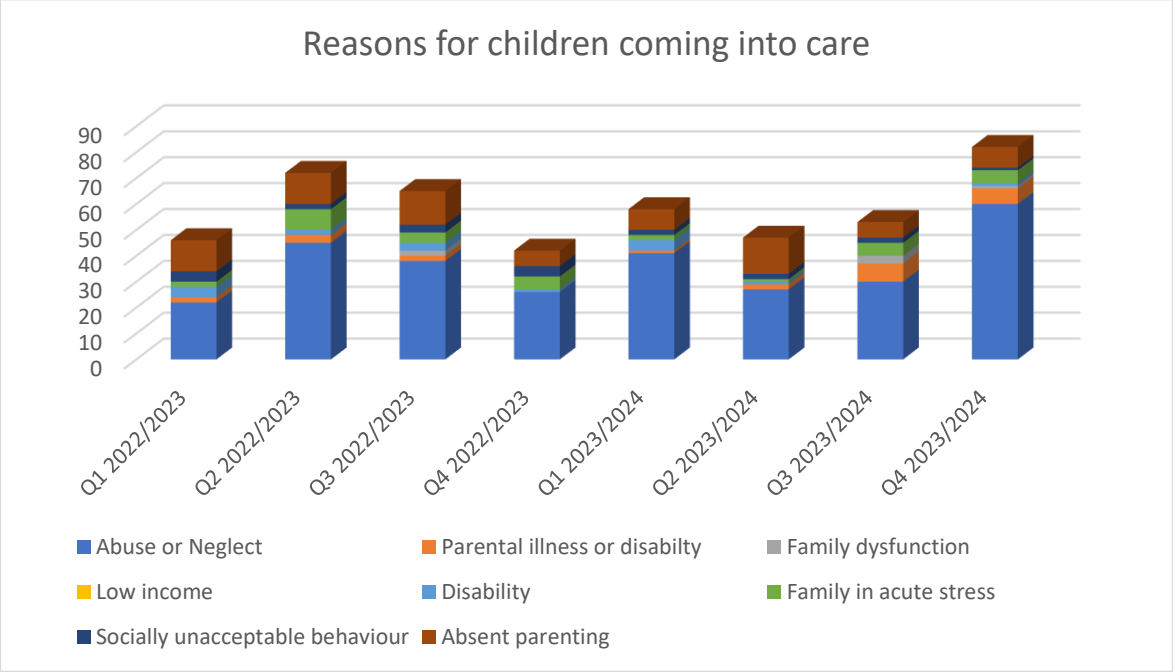
3.7 **Age comparisons over the last two years:**



Ref: Data made available from Derby City Local Authority Informatics Department

The number of babies in care aged less than one year old increased during Q4. There has been an increase in the number of children aged one to four years old in Q3 and Q4. The 10-15 age group has increased during Q4. The number of young people aged 16 or over has decreased in Q3 and Q4 compared to Q2.

3.8 **Reasons for children coming into care and ceasing care – comparison per quarter over the last two years:**



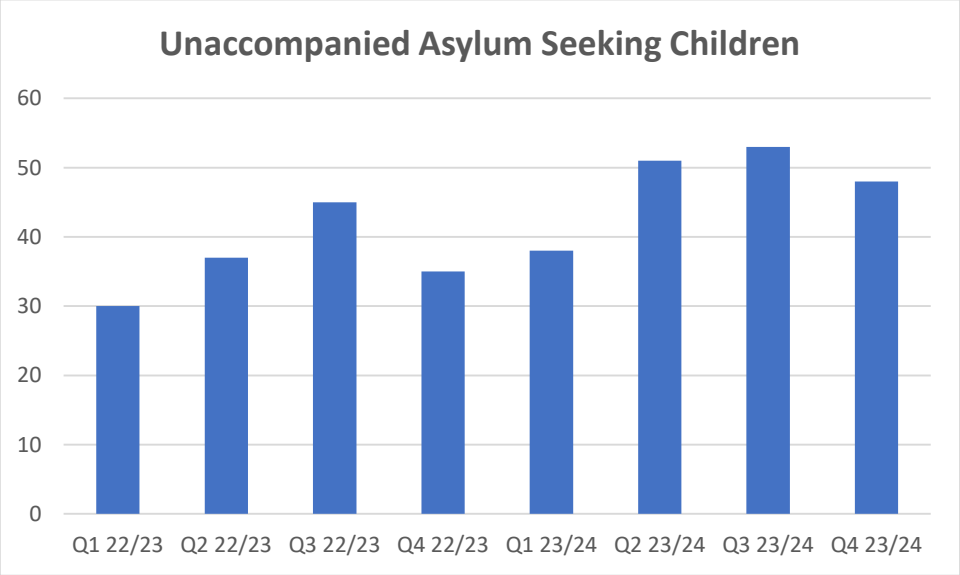
Ref: Data made available from Derby City Local Authority Informatics Department

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.

3.9 **Unaccompanied Asylum Seeker Children 2022/24**

There were 48 UASC in care on 31 March 2024. This equates to 8.0% of the overall cohort.

This is a reduction from 53 UASC seen in the previous quarterly report. There were 35 UASC in care 12 months ago, 31 March 2023 (5.6% of the overall cohort).

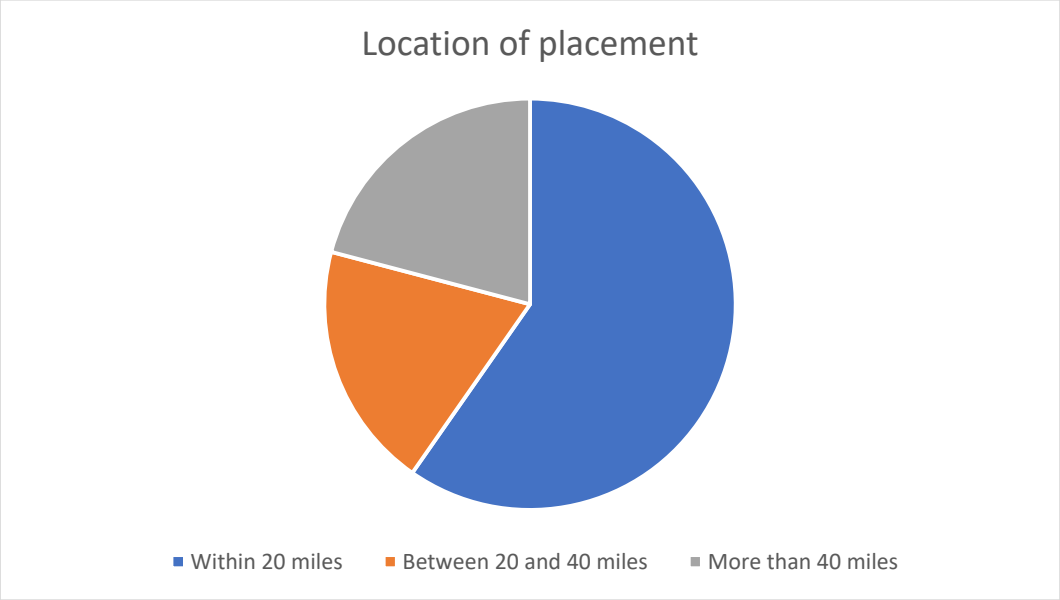


Ref: Data made available from Derby City Local Authority Informatics Department

There were 48 UASC in care on 31 March 2024. This equates to 8.0% of the overall cohort.
This is a reduction from 53 UASC seen in the previous quarterly report. There were 35 UASC in care 12 months ago, 31 March 2023 (5.6% of the overall cohort).

3.9 Location of Placement

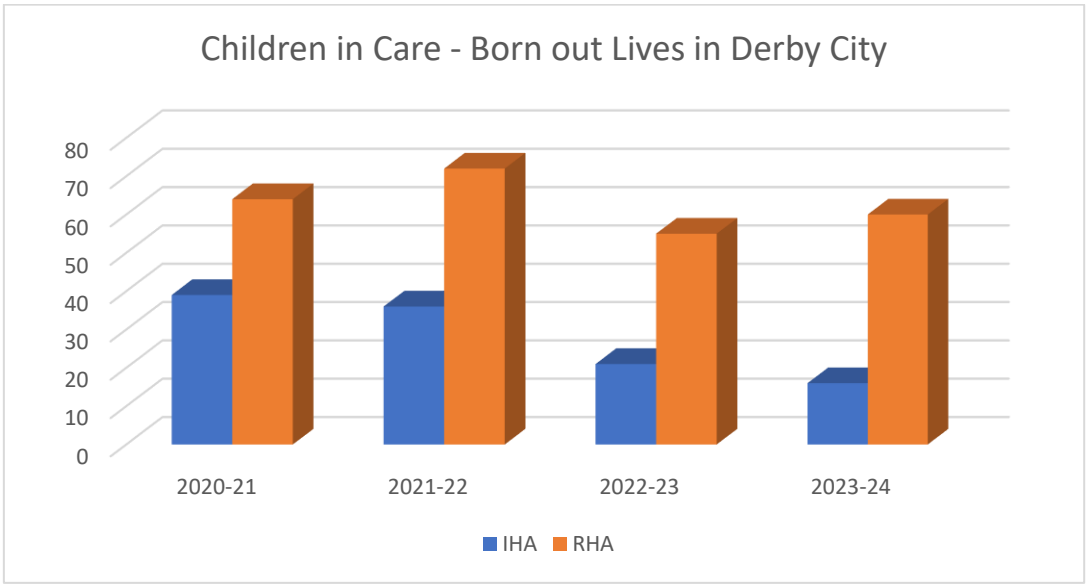
A total of 221 placements were located within the Derby City boundary on 31 March 2024. This equates to 37.0% of all placements. This is the same number and percentage seen at the previous quarter end. It is a slight decrease of 1.2% when compared to 12 months ago.



Ref: Data made available from Derby City Local Authority Informatics Department

- 59.7% of all placements are within 20 miles of the home address (357 out of 598)
- 19.4% of all placements are between 20 and 40 miles of the home address (116 out of 598)
- 20.9% of all placements are more than 40 miles of the home address (125 out of 598)

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 Initial Health Assessments and an increase in requests for Review Health Assessments to be completed by the Children in Care team. The number of 'was not brought' to appointments for 2023/24 was 15 for the initial Health Assessment and 20 for the Review Health Assessment. It is the responsibility of the originating Local Authority to ensure children and young people placed in Derby City have an Initial Health Assessment and Review Health Assessment within the statutory requirement.

Section 4: DHcFT Service Provision for Looked After Children

4.1 The DHcFT Children in Care health team has 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 contributes to healthcare plans for all looked after children, including children with special educational needs and/or disabilities.

4.2 The team continues 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 2024) 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	37.5 hours	1
Specialist Nurse	26 hours	0.7
Specialist Nurse	22.5 hours	0.6
Specialist Nurse	22.5 hours	0.6
Band 4 Administrator 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 (Band 3). The team is now fully staffed and works extremely well together.

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. The administration team has built close working relationships with the local authority to help deliver the highest standard of service.

5.3 The administration team strives to deliver the best possible service and make improvements to our administration systems and processes. The Administration Coordinator 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 Administration Coordinator 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 and Blood Born Infection consent and information forms to ensure that correct consent is obtained by the Social Worker in a timely manner to ensure compliance. The Administration Coordinator has updated the consent process and the Blood Born Infection testing process to ensure that information is gathered in a timely manner.

The Administration Coordinator and Team Administrators continue to dedicate time to ensure ‘Groups and Relationships’ within the electronic patient record are kept up to date.

Section 6: Health Data and Performance for Year 2023/24

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 2023/24 is provisional until submitted to the Department for Education **

Health Data Indicator	Year 2019/20	Year 2020/21	Year 2021/22	Year 2022/23	Year 2023/24
Annual health assessments	93.5%	93.8%	92.6%	92.9%	93.8%
Dental checks	92.3%	29.2%	77%	90.6	85.3%
Immunisations up to date	92.3%	93.1%	94.1%	95.3%	96.1%
Development checks (two RHAs in the 12 months for under 5 years old)	90.2%	96.6%	86.9%	98.6%	94.1%

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 remained stable at 93.8%. The local target is 90%. The latest comparator authority average for 2022/23 was 91%, so Derby is above this.

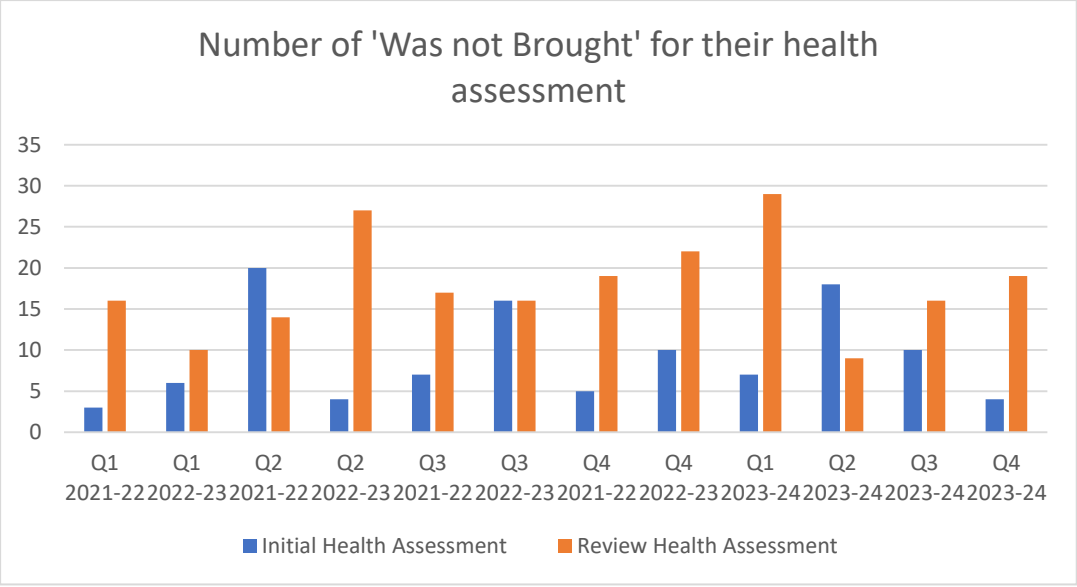
Dental Checks - The performance for Dental checks is 85.3%, which is above the 2022/23 comparator authority average of 83%.

Immunisations - The performance for up-to-date Immunisations has increased to 96.1%. The local target is 92%. The comparator authority average for 2022/23 was 90% so Derby is above this.

Development Checks - The performance for Health Development Checks remains high at 94.1%. The local target is 87%. The comparator authority average for 2022/23 was 93% so Derby is above this.

6.3 Since the Children in Care team has 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, 2022/23 and 2023/24:



Ref: Data made available from Derby City Local Authority Informatics Department

The above includes children born in Derby living within a 20-mile radius and children from out of area placed within Derby City.

Some of the reasons for 'was not brought' to their 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 has a 'was not brought' pathway to follow if a child is not brought to their appointment.

Over the past year, the Children in Care team has changed to hybrid printing, this is a more efficient way of sending appointment letters out for Review Health Assessments. The aim is to prevent carers not receiving the appointment letter in a timely manner, resulting in a decrease in 'was not brought'. Despite the change to hybrid printing of appointment letters, there is still a high number of 'was not brought' particularly in quarter one for the Review Health Assessments and quarter two for the Initial health Assessments. The Named Nurse CiC will continue to work closely with the Designated Nurse CiC, the Local Authority and the team to look at the reasons for 'was not brought' and how we can reduce the numbers over 2024/25.

Section 7: Analysis of Adoption and Medical Advisor Activity

This section is compiled by Derby City Medical Advisor
Dr S Mehta,
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

The planned changes to the report format of the reports provided for the Agency Decision Maker (ADM) has been working well over the past year and the feedback from the agency has been positive. This has proved to be helpful to the Medical Advisors who provide the report and to the readers of these reports as they are more comprehensive and nicely summarised in the beginning of the report. The workload has also been more manageable, and reports have generally been going out on time, meeting strict deadlines.

7.1 There have been two Medical Advisors contributing to the Adoption work for Derby city until December 2023. 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 Advisor in role of panel member, on an alternate monthly basis.

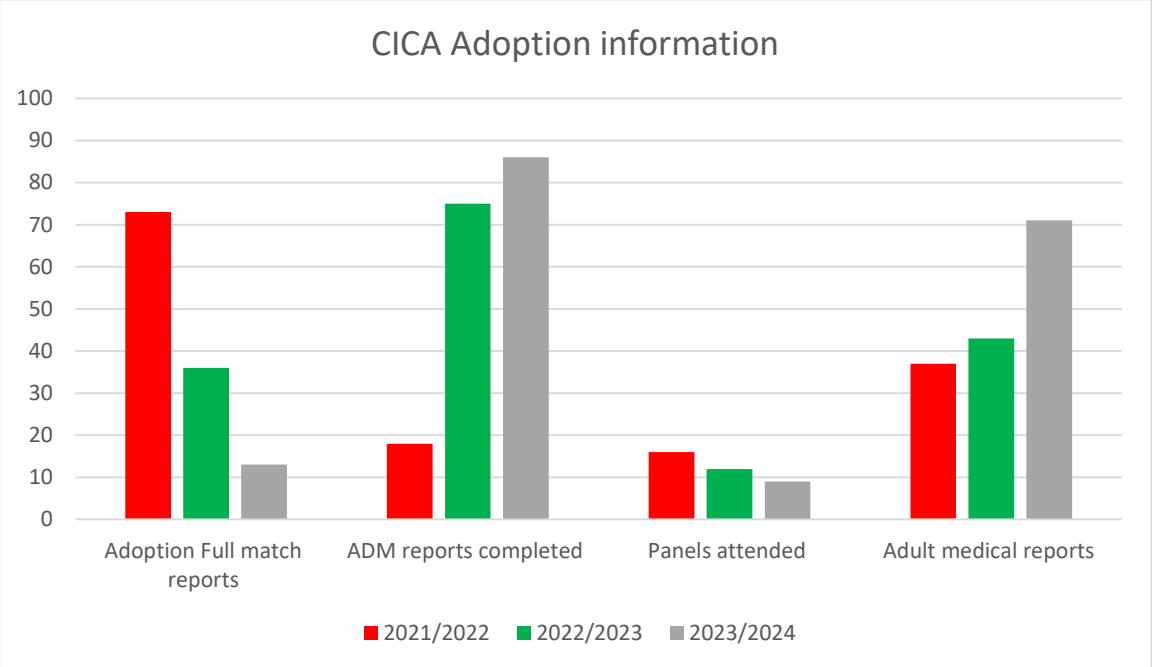
Medical Advisors' attendance at Adoption panels has been optional, with Derby Medical Advisors not attending due to their workload, but this is to be encouraged. The medical reports for the children to be matched are still provided in the usual manner and panel advice is still given, based upon the paperwork provided by Adoption East Midlands. The panel continues to be held remotely and the Medical Advisor has been available for advice if needed, but not always attending in person.

From January 2024, one of the Medical Advisors has left to take on a new role and the other has gone on maternity leave. A new Medical Advisor started in post from October 2023 and has been contributing to the adoption work by preparing the reports for those coming up for adoption at the ADM and matching stage. However, attending or contributing to Adoption panels has not been happening since January 2024 due to shortage of staff.

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 Advisors. An efficient and timely liaison between different Medical Advisors is needed to explore and clarify any issues in advance of panel, which may get affected by the capacity issues, requiring Medical Advisors 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 1 April 2023 to 31 March 2024).

- Total number of adoption children's medical reports (Matching reports) 13 – (36 in 2022/23)
- Total number of ADM Reports – 86 (75 in 2022/23, this was new additional work following Somerset ruling since January 2022)
- Total number of adult medical reports – 71, which includes reports for fostering and adoptive parents, (61 in 2022/23)
- Total number of panels attended (advice provided by Derby City Medical Advisors) – 9 (12 in 2022/23)
- Number of prospective adopter consultations undertaken 4 - (5 in 2022/23).



There continues to be a rise in the number of reports at the ADM stage and adult medical reports which includes reports for fostering and adoptive parents.

There were four 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 Advisors for prospective adopters, foster carers and Social Workers were re-commenced last year, with the training provided virtually three times during this period as agreed, incorporating training on common clinical issues in an adoption scenario, ie, 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 Advisors attend regular quarterly AEM meetings with other Medical Advisors 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: Derby and Derbyshire Development Day

8.1 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.

8.2 The Asylum-Seeking Families team delivered a session on their role, what the service offers and how they support these families. The challenges they face and how they have overcome these challenges, common themes, and case studies.

8.3 The Emotional Wellbeing service known as the 'DECC' delivered a session on their service, what they deliver and the referral process. There are plans for this service to deliver a reflective session to the Derby City and Derbyshire Children in Care team during 2024/25.

8.4 There was an opportunity for networking, Nurse, Doctors, and admin got into separate groups to look at challenges, best practice, and priorities for the year ahead. The aim from this was to develop a plan on a page for the children in care teams to look at joint working in improving outcomes for our children in care.

Section 9: Links to the Residential Children's Homes

Over the last year, the Specialist Nurses for Children in Care continue to offer drop-in sessions to all Local Authority Residential Children's Homes. Discussions with the home managers continue to identify health 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.

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.

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 the topics being delivered.

The timing of the drop-in session continues to be offered 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 individuals.

Section 10: Summary of Achievements in Year 2023/24

10.1 During the period of 2023/24 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:

10.2 The end of year Health Performance Data continues to remain positive as shown in section 6.

10.3 The Designated Nurse for Children in Care and Named Nurse for Children in Care have been involved in the roll out of the Dental Pathway to support the improvement of children and young people being seen by a dentist.

10.4 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).

10.5 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.

10.6 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.

10.7 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 2023/24 the Link Nurses have continued to offer 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.

10.8 Foster carer sessions have been delivered face to face over 2023/24. Some of the topics covered have included, mental health, attachment, and Re-Solv. 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 some have been supported by external services.

10.9 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 as discussed in section 8.

10.10 The Children in Care team has provided opportunities for students to shadow the team throughout 2023/24.

10.11 The Designated Nurse for Children in Care and the Sexual Health service have met and discussed the sexual health needs for Children in Care. It has now been agreed that some of our most vulnerable children and young people can be offered an ACORN Card which provides an opportunity for the young person to have priority access to the Sexual health Service. ACORN cards should be only given to those Children in Care/Care Experienced Young People who are struggling to access sexual health—needing quicker appointments, support with accessing and those not previously engaged with the service.

10.12 Enhanced Case Management meetings have continued. These are a multi-disciplinary meeting focusing on certain topics appropriate to the young person using an outcomes-based tool.

Section 11: Priorities for Year 2024/25

11.1 **DHcFT Provider key priorities for 2024/25:**

- To work closely with the Designated Nurse CiC, the Local Authority, and the Children in Care team to reduce ‘was not brought’ to appointments
- To continue to deliver health promotion within the Local Authority Residential Children’s Homes
- To roll out the ACORN card for access to Sexual Health services
- To roll out the Dental Pathway
- 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 towards the Joined-up Care Derbyshire approach
- To build relationships with the leaving care team to improve support around transition
- 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 – 5 November 2024

Safeguarding Children and Adults at Risk Annual Report 2023/24

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 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 2023/24 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 2023/24 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
- Overall, this report is offered with significant assurance to the Board of Directors on Trust 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 Board can obtain 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
- Quality and Safeguarding Committee, 10 September 2024.

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 Trusts
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 Practice, ie, 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, eg, NICE, DoH, National Statistics.

The Trust contributes as an equal partner in multi-Agency forums eg, MAPPA; MARAC; Channel; Child and Adult Safeguarding Boards and sub groups 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 & 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 believe, Disability and Sexual orientation), including risks, and say how these risks are to be managed.

Below is a summary of 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:

1. Receive and approve the Safeguarding Children and Adults Annual Report
2. Accept with significant assurance regarding the fulfilment of legal and statutory duties.

Report presented by: **Tumi Banda**
Director of Nursing, AHPs, Quality and Patient Experience

Report prepared by: **Safeguarding team, including MASH Health, Safeguarding Trainers and the Operational team members**

Derbyshire Healthcare
NHS Foundation Trust

Safeguarding Children and Adults at Risk

Annual Report 2023/24

MAP OF TRUST LOCALITY

INTRODUCTION

The safeguarding of all Derbyshire Health Care Foundation NHS Trust patients, adults, children and young people and their families remains the highest of priorities. Safeguarding and 'Think Family' is integrated within all divisions. 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.

A big thank you to all the staff within the Trust for all their commitment and hard work that goes towards safeguarding our staff, communities and people who use our services. As a Trust team we will to do our upmost to continue '*keeping up the great work'* so we can continue to move forward together and with our partners agencies.

This report sets out the work of DHCFT in relation to safeguarding and the 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 working, open culture, transparency, consistency, respectful challenge, and cooperation.

Safeguarding Children and Adults Operational Groups report on a twice-yearly 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, CAMHS, Older Adults, Working Age Adults, Forensic, Psychology and Learning Disabilities. The report ensures that all new guidance, legislation, policy, learning, and relevant information is circulated to ensure staff are aware and updated as necessary. Both Safeguarding Operational Groups 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 CHILDREN'S PERFORMANCE DASHBOARD – 2023/24

Item	Metric	Quarter 1, 2023/24	Quarter 2, 2023/24	Quarter 3, 2023/24	Quarter 4, 2023/24
1	Number of advice calls received and reported	147	188	195	203
2	Number of supervision/group sessions	96	126	140	137
3	Number of Information Exchange Form Research completed / strategy discussions or meetings attended	126	125	126	135
4	Number of child Protection medicals – Suspected NAI & Neglect	49	51	51	58
5	Number of children discussed at CHANNEL	6	14	12	9
6	Number of MARAC cases with children discussed at MARAC	168	197	153	304
7	Number of referrals to CSC	8	20	13	11
8	CIC Caseload - Born In Lives In	254	254	243	246
	CIC Caseload - Born In Lives Out	352	342	347	348
	CIC Caseload - Born Out Lives In	8	9	10	13
	CIC Caseload – Unknown	11	2	0	1
	Team Unknown-	1	0	0	0
	Total CIC Caseload-	626	607	600	608
9	Number of Child Deaths	20	12	15	5
10	Number of children referred for risk of FGM	1	1	3	3
11	Number of children on a child in need plan	187	162	172	171
12	Number of Early Help Assessments	226	135	163	157
13	Distinct count of children affected by DV during the Quarter	413	273	234	232
14	Number of children on a child protection plan	363	363	359	361
15	Number of children admitted to an adult inpatient bed	0	1	0	0
16	Number of young carers	15	13	16	17
17	How many babies on the Trust Mother & Baby Unit	20	12	18	13
	How many of these are on a Child Protection Plan	1	2	0	1
18	Number of LADO Referrals made.	0	1	1	1

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, consisting of group and 1-1, a cascade model is place. This has worked extremely well ensuring staff received their safeguarding supervision in a timely manner. Drop-in sessions have been trialled throughout the year at the Trust inpatient sites. This has been successful in raising the safeguarding teams profile supporting staff off site and face to face.
- S47s and strategy meetings remains high and complex.
- MARAC cases and families impacted by Domestic Abuse continues to fluctuate but remains at a consistently high level.

SAFEGUARDING ADULTS' PERFORMANCE DASHBOARD – 2023/24

	METRIC	DEFINITION OF METRIC	QTR1	QTR2	QTR3	QTR4
1	Number of adult safeguarding referrals made where allegation is within their own service.		108	97	111	100
2	Number of PiPoT referrals made by the Trust.		1	0	0	0
3	Full attendance at MAPPA 3 meetings (monthly).		100%	100%	100%	100%
4	Number of MAPPA cases within the Trust.		6	3	3	3
5	Number of cases discussed at CHANNEL.		12	22	18	18
6	MASH Health strategy discussions for children.		127	119	134	142
7	MASH Health strategy discussions for adults.		31	21	18	20
8	Number of domestic violence medium cases discussed at triage.		213	280	260	352
9	Number of urgent DoLs authorised.		7	5	2	0
10	Number of Standard DoLs applied for to the LA.		3	0	1	0
11	Number of people with an authorised DoLS granted by Supervisory body.		0	0	1	0
12	Number of referrals to coroner for people who have passed away and have an authorised DoLS granted by Supervisory body.		0	0	0	0
13	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	6	6	10	6
		Patient to Other Party	2	1	0	0
		Patient to Patient	6	7	16	4
		Patient to Staff	5	4	4	0
		Staff to Patient	2	3	1	0
		Staff to Staff	1	0	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. We have provided training to the I-care programme around sexual safety and boundaries which has had positive feedback.

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

The safeguarding children training provision and compliance for 1 April 2023 to 31 March 2024.

During these dates: there was 12 weeks where Safeguarding Children Level 1 and 2 virtual classroom training was not offered due to the absence of a Safeguarding Childrens Trainer being in post. This was due to the Trainer moving roles within the Trust and a new Trainer being appointed.

Safeguarding Children Level 1

There was an overall increase in Level 1 Safeguarding Children Training the financial year. This is due to the early stages of safeguarding training alignment work, Level 1, 3 yearly competence was aligned to 14 staff towards the end of the financial year, and there was no data to compare with the previous year.

Safeguarding Children Level 2

Slight decrease since the last financial year, this due to the due gap between trainers and there not being a trainer and face to face sessions were not available and some colleagues potentially not being able to access the eLearning.

During this financial year 335 Safeguarding Children Level 2 virtual classroom spaces were offered and 151 taken up, leaving just over half the seats unoccupied. If these seats were utilised compliance figures would have been significantly higher. It is unclear why the 185 seats were unoccupied.

Safeguarding Children Level 3

There was an overall 11% decrease in the Safeguarding Children Level 3 training. The biggest decrease was in the Level 3 annual, being 48% compared to last year's 84%. This again was due to the 12 weeks vacancy, a potential loss of 400 spaces, if 16 sessions with a capacity of 25 was offered during this period. Staff in the Trust were advised access the Level 3 training via the Derby and Derbyshire Safeguarding Partnership. However, there were challenges for staff accessing this training as courses were fully booked, this contributes to this data. The gap is being address by the new appointed trainer by offering regular Level 3 training with increased capacity. This has been effective as current compliance has increased. In addition to scheduled training, bespoke training has been delivered to some teams.

During this financial year 1118 Safeguarding Children Level 3 virtual classroom spaces were offered, and 641 seats were occupied, leaving 477 unoccupied. If these seats were utilised compliance figures would have been higher. It is unclear why the seats were unoccupied.

Safeguarding Children Level 4

Safeguarding Level Children Level 4 training delivered by an external independent trainer annually. Two staff were unable to attend and were advised to access the level 4 training from the Derby and Derbyshire Safeguarding Partnership.

For further details please see Table 1 for competency data and Table 2 for Capacity data.

Table 1

Competency name	Target Group	Compliant	Non-Compliant	Compliant 31/03/2024	Compliant 31/03/2023
SAFEGUARDING CHILDREN LEVEL 1					
Safeguarding Children - Level 1 - annual	565	504	61	89%	89%
Safeguarding Children Level 1 - once only	2115	2030	85	96%	97%
Safeguarding Children Level 1 - 3 Yearly	14	11	3	79%	0%
Total	**2694**	**2545**	**149**	**94%**	**81%**
SAFEGUARDING CHILDREN LEVEL 2					
Safeguarding Children Level 2 - once only	1638	1549	89	95%	96%
Safeguarding Children Level 2 -3 yearly	765	610	155	80%	81%
Total	**2403**	**2159**	**244**	**90%**	**92%**
SAFEGUARDING CHILDREN LEVEL 3					
Safeguarding - Children Level 3 - 3 yearly	1485	1160	325	78%	85%
Safeguarding Children Level 3 - annual	533	257	275	48%	84%
Total	**2018**	**1417**	**600**	**70%**	**81%**
SAFEGUARDING CHILDREN LEVEL 4					
Safeguarding Children - Level 4 - annual	23	21	2	91%	100%
Total	**23**	**21**	**2**	**91%**	**100%**

Table 2

Virtual Classroom based Capacity	Capacity	Number of staff who 'completed' (n)	Number of staff who 'completed' (%)	Seats not used (n)	Seats not used (%)
Safeguarding Children - Level 2	**335**	**151**	**45%**	**184**	**55%**
Safeguarding Children - Level 3	**1118**	**641**	**57%**	**477**	**43%**
Safeguarding Children - Level 4	**23**	**21**	**91%**	**2**	**9%**

DHCFT SAFEGUARDING ADULTS – TRAINING POSITION

Purpose of the report

This report provides an update to the 383 Safeguarding Adults Level 3 (including Level 1&2 plus DOLS, MCA & Wrap/PREVENT) training in DHCFT covering dates 1 April 2023 to 31 March 2024.

Target Audience for Safeguarding Adults (UKL Skills for Health – Core Skills Training Framework [v1.6.2])

- Level 1: All staff working in health care settings
- Level 2: All practitioners who have regular contact with patients, their families or carers, or the public
- Level 3**:** Registered health care staff who engage in assessing, planning, intervening and evaluating the needs of adults where there are safeguarding concerns (as appropriate to role).

April 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%

April 2024

Training Name	Target Group	Compliant	Non-Compliant	Compliant %	Change from last year
NHS|CSTF| Safeguarding Adults - Level 1 - 3 Years|	773	643	130	83%	Down 7%
NHS|CSTF| Safeguarding Adults (Version 2) - Level 2 - 3 Years|	543	487	56	90%	Down 2%
NHS|CSTF| Safeguarding Adults (Version 2) - Level 3 - 3 Years|	1776	1551	225	87%	Down 5%

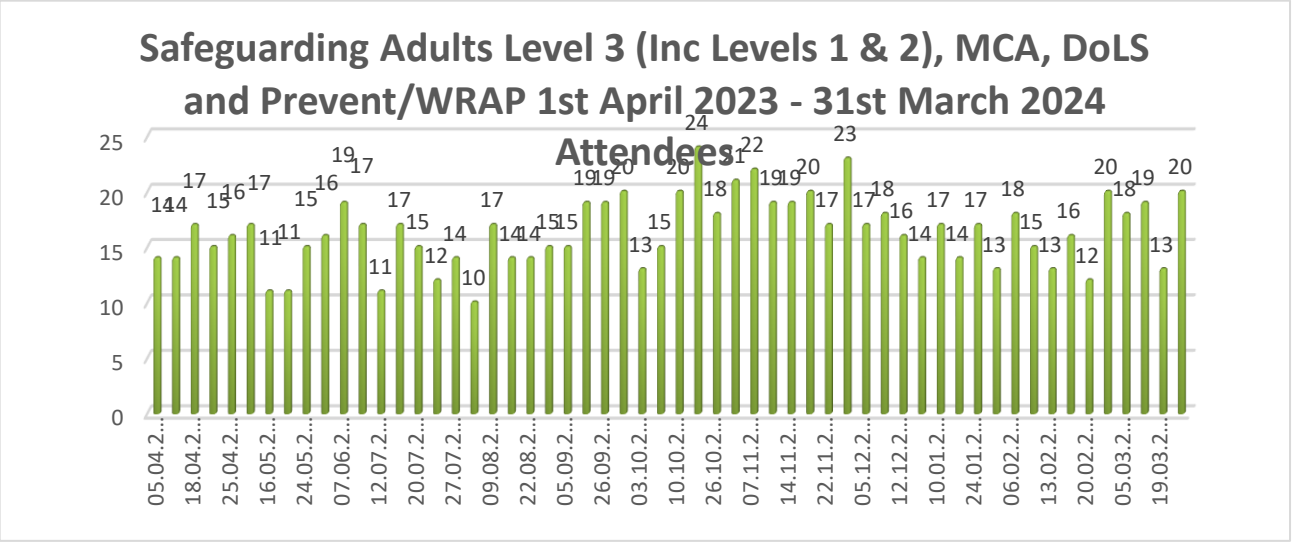
30 April 2023

	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 2024

Competency	Does Not Meet Requirement	Meets Requirement	Target Group	%
NHS|CSTF| Safeguarding Adults - Level 1 - 3 Years|	130	643	773	83%
NHS|CSTF| Safeguarding Adults (Version 2) - Level 2 - 3 Years|	56	487	543	90%
NHS|CSTF| Safeguarding Adults (Version 2) - Level 3 - 3 Years|	225	1551	1776	87%

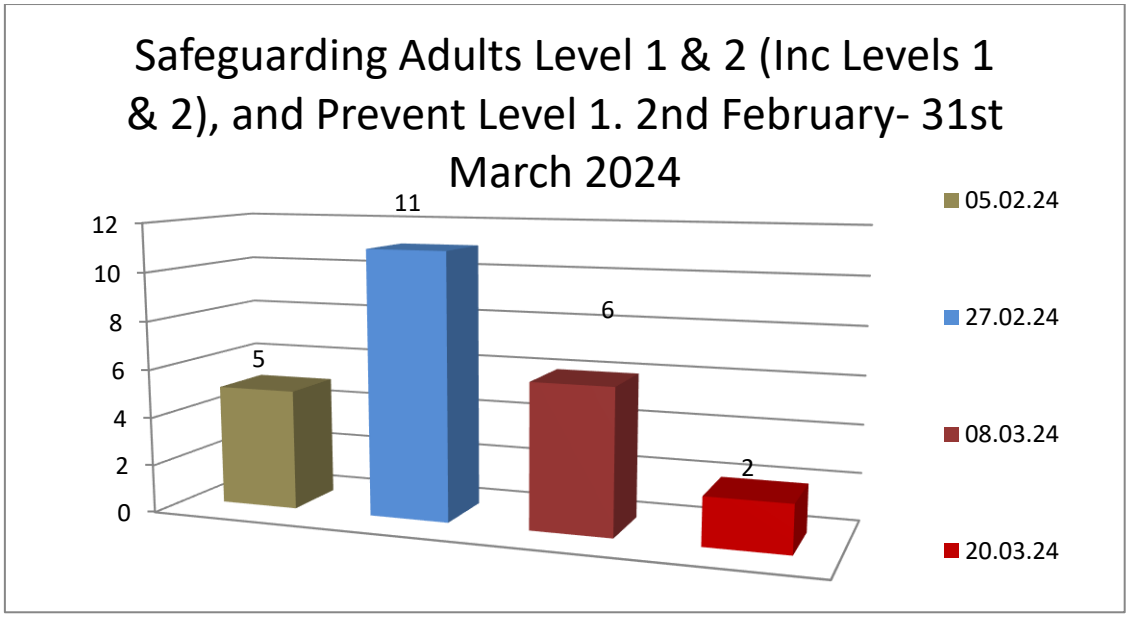
The figures show a greater number of professionally registered staff requiring Safeguarding Adults at Level 3 being added to the target group from September 2023. This has been linked to the national requirements and is echoed in the change from 383[LOCAL] to NHS [CSTF] Safeguarding.



In the period 1 April 2023 to 31 March 2024 there have been 56 classes with an initial maximum enrolee numbers of 24, but this has been increased to 28 since February, giving a potential 1,384 attendees over the year. However, there have been 915 attendees achieving compliance in this subject which is a 66% attendance rate. Most common reasons given by staff for withdrawing are staffing/work commitments/sickness. Attendance is up on the general average based on last yearly figures and remains a constant direction for the last three quarters.

All MCA, DoLs and PREVENT training at Level 3 has been included in a full day training package alongside the Safeguarding Adults level 3, all staff members attending the class will receive full compliance in Safeguarding Adults Level 3 (including Levels 1 & 2), MCA, DoLs, Prevent and WRAP. This has proved to be effective in Training Passport compliance.

I have also created half day Level 2 classes specifically for non-registered staff delivered via MS Teams. These are separate to eLearning Level 1&2 classes available and has slowly increased in numbers since 1 April, but remains low, as staff are citing work commitments/or alternatively use eLearning option for convenience.



Actions taken to increase attendance

There are still a number of staff that either book and do not attend with often little or no notice, or staff that decline the class invite on the day or morning before. Reasons given are (in order of activity): work commitments/staff shortages; illness; lack of child care; personal reasons; no reason given.

I am also offering 'bespoke' classes for specific Safeguarding Adults requirements to teams/units in the Trust, as requested by managers.

SAFEGUARDING CHILDREN ADVICE THEMES

Top 5 Advice Themes:

	2022/23	2023/24
1	Parenting Skills/Capacity/Basic Care	Parenting Skills/Capacity/Basic Care
2	Neglect	Neglect
3	DHCFT procedures	Physical Injury/Abuse
4	Physical Injury/Abuse	Domestic Abuse
5	Community Resources	Emotional Abuse

We continue to analyse the calls for advice into the Safeguarding unit:

- In comparison to the last annual report period Domestic Abuse is again in the top 5 themes. Staff are becoming more confident and competent in dealing with Domestic Abuse in their practice, are more familiar with procedures and the impact on families. Domestic abuse remains a Trust priority and is covered extensively in safeguarding training. The high number of calls related to physical injury and or emotional abuse also relates to Domestic abuse.
- Neglect is still a significant issue/challenge within our organisation. This is partially around staff's understanding around impact and thresholds. Parenting skills/capacity, basic care, and self-neglect features regularly.
- Due to the nature of a large proportion of the Trust patient group we have a large number of staff concerns around our patients/client's capacity to parent were mental health, substance misuse and or learning disability features.

CHILDREN'S AUDITS

Trust Internal Audits:

Audit Title: Do referrals to Adult Social Care consider the impact of the cause for referral on children within the family (Think Family).

Aims and Objectives:
To establish if professionals document / consider / analyse the impact of the adult's mental health issue / substance misuse / learning disability / reason for referral on the person's child / young person/ other vulnerable people within the household when making a safeguarding referral to Adult Social Care.

Purpose:
In accordance with Working Together to Safeguard Children 2023, DHCFT as a health care provider, has a duty under Section 11 of the Children Act 2004 to ensure our staff consider the need to safeguard and promote the welfare of children when carrying out their functions. Therefore, cases will be reviewed to establish whether safeguarding referrals to Adult Social Care include consideration of the needs of other vulnerable people in the family and impact of the reason for the referral on them, in accordance with Think Family.

Conclusion:
In accordance with safeguarding legislation and guidance (including Working Together 2023, Care Act 2014, Information Sharing guidance and Think Family) it is appropriate for details of the safeguarding referral and the potential impacts on others within the family/ household to be clearly documented. Whilst this audit has not demonstrated this overall, it is positive that there was evidence of Think Family in relation to concerns about children being noted in some referrals to ASC and subsequent safeguarding children referrals being made.

There is evidence that appropriate messages regarding the need to do so are routinely shared in training.

It is unclear why the majority of cases had no copy of the safeguarding referral to Adult Social Care (ASC) on the individual's record. The majority of the cases audited (86.36%) included detail of the impact of the reason for referral on adults at risk in the household, although it would be expected for every safeguarding referral to ASC to include this.

It is positive that 100% of cases audited had evidence of information sharing in the records and that the quality of this information was noted as minimum and above.

Recommendations:
- Each staff member making a safeguarding referral must ensure that they have added a copy (either electronic or scanned) of the referral on the person's record.
- Managers must ensure the necessity of staff putting the referral on the patient's record.
- Managers/ Clinical Leads/ Heads of Nursing to audit that safeguarding referrals are on patient records as part of the existing record keeping audits. For this information to be shared with the COATS annually.
- To ensure the referrer capture the individual's capacity to consent, consent and people's wishes and feelings when making a safeguarding referral.
- To ensure the referrer receive a response of the referral from Adult Social Care, share this with the individual / their representative as appropriate and that the outcome is documented in the person's record.

The Trust took part in a Safeguarding Children Partnership Audit.

ADULT AUDITS

Multi-agency audits are undertaken 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.
- Transitions
- Self-neglect
- Domestic Abuse in over 65-year-olds
- Financial abuse

SECTION 11 AUDIT

Below is the outcome of DHCFT held for 2023/2024

NHS Derby and Derbyshire integrated Care Board (DDICB) and Derby and Derbyshire Safeguarding Children Partnership (DDSCP) would like to thank you and your Safeguarding and Children in Care Teams, for completing the Section 11 self-assessment which included specific questions, this year, relating to Looked after Children/Children in Care, and for undertaking the virtual safeguarding children quality meeting on 20 March 2024, to go through the evidence that has been provided for the assurance process.

We are very pleased to report that we were assured with the evidence provided in your Section 11 self-assessment and the further information / assurance we received from you and your Safeguarding Children team during the safeguarding children quality meeting. We are also pleased to report that we were assured with evidence provided in the Section 11 tool, relating to Looked after Children/ Children in Care.

Section 11 compliance rating 2023/2024	
Standard 1 **Accountability Structure:**	**Full Compliance**
Standard 2 **A culture of listening to children, young people and carers, staff:**	**Full compliance**
Standard 3 **Information Sharing:**	**Full compliance**
Standard 4 **Safe Recruitment and Dealing with Allegations Against People working with children:**	**Full Compliance**
Standard 5 **Effective appropriate supervision and support for staff including safeguarding training:**	**Full compliance**

SAFEGUARDING ADULTS' ASSURANCE FRAMEWORK (SAAF)

The SAAF was reported on in last year's report. The next SAAF is due September 2024.

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.

DHCFT has produced a video 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 DHCT and Inpatient Units for patients to increase understanding about their sexual safety.

Sexual safety has been embedded in to the I-care programme. Following the success of the I-care 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.
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.

DHCFT has signed up to the sexual safety in healthcare charter which makes clear its intention and commitment to provide a safe environment for staff, patients, carers, and visitors which is free of unwanted sexualised behaviour. NHS England has established a national charter for sexual safety in healthcare which is based upon 10 core principles.

Derbyshire Healthcare has become a signatory of the charter. To meet our organisational obligations as signatories, we are committed to a zero-tolerance approach to any unwanted, inappropriate and/or harmful sexual behaviours towards our workforce, which we will achieve through establishing a clear plan demonstrating the actions we will take to embed the charter's 10 principles.

The Sexual Safety and Personal Boundaries Policy and Procedure has been ratified and is in place for our Organisation. The Policy has been developed to promote the sexual safety, and sexual health of individuals who use our services as well as staff members and visitors to our Trust Services.

The Policy also aims to support staff in responding to incidents or concerns regarding behaviours that may have an impact on the sexual safety and sexual health of patients, staff members and others.

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. The MARAC functions on the collective understanding that no single agency or individual can see the complete picture of the life of a victim or is able to identify and manage the risks, but all agencies may have insights that are crucial to the persons safety and risk management plan.

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.
The Trust MARAC lead and safeguarding coordinator has developed a clear procedure for the MARAC process, this includes guidance on the MARAC checks and meeting preparation.

For the period 4 April 2023 to 19 March 2024, there were 953 MARAC referrals for South MARAC (Erewash, Derby City and South Derbyshire), which is a significant increase from the previous year; 748 cases were referred to South MARAC last year for the period 5 April 2022 to 21 March 2023.

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.

In relation to the increase in cases, this is a result of an inspection by His Majesty's Inspectorate of Constabulary (HMIC) where it was identified that there were too many Domestic Abuse incidents which were being incorrectly graded at medium risk rather than high risk.

The Domestic Abuse Review Team (DART) within the police were provided with some training to better identify high-risk cases. This resulted in a large spike of high-risk cases which eventually filtered their way through to MARAC resulting in a large increase in referrals.

This created an increase average of 30-35 cases up to over 60. Due to this it has been necessary to hold two MARACs per week, which has had a significant impact on resources, within the DHCFT Safeguarding Unit, and the wider partnership supporting MARAC.

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 has a prevent policy which reflects our commitment to the strategy.

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.

SOCEX:

SocEX tactical meeting which has replaced the Mult-Agency CRE Tasking and Local Organised Crime Partnership Boards. The Aim is to create a single whole system response, working in
partnership to reduce the threat of serious organised crime and exploitation, protecting our communities.

The Multi-Agency Serious Organised Crime and Exploitation Meeting (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.

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. We have an information sharing agreement in place to allow our health colleagues in DCHS to share information on our behalf and vice versa if required.

MASH HEALTH ADVISORS 2023/24

The aim of this report is to reflect on the Health Advisors activity from 1st April 2023 to 31st March 2024.

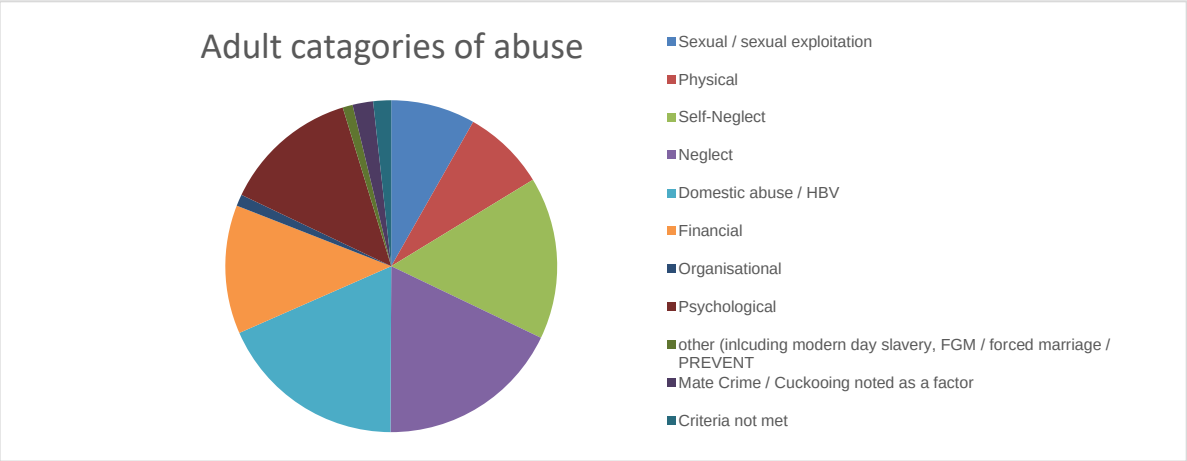
MASH Health consists of two whole time equivalent posts covered by three MASH Health advisors.

<u>MASH Adults</u>
MASH health received approximately 1600 referrals from Adult Social Care. This is around a 37% decrease from the previous year however it must be noted that last year MASH health received a backlog of around 700 referrals. If this is taken into consideration, MASH health received a very similar numbers of referrals to the previous annum.

In addition, 1109 professionals were liaised with which equates to around 70% of referrals needing further correspondence compared to around 55% on the previous year.

MASH health attended a total of 87 adult strategy meetings during this annum.

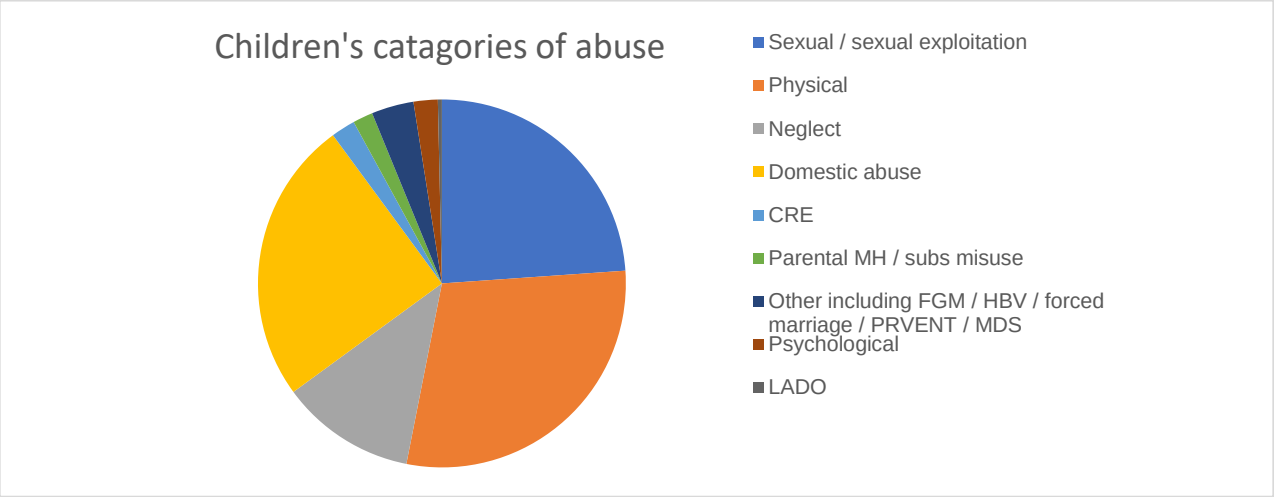
Adult Social Care within the MASH continue to alter processes to attempt to streamline the number of referrals and reduce the risk of creating a backlog of referrals as seen in previous years.



MASH Children

MASH health attended a total of 544 strategy meetings. The figure for attendance is around a 20% increase from the previous year.

MASH continue to see a rise in children being injured through knife crime which is categorised as 'physical' below.



Domestic Abuse (DA)

Around 1105 medium risk domestic abuse notifications were triaged which is around 100 more from the previous year.

During this annum, triage continued to take place twice weekly and consisted of MASH health, Social Care, Police, and Education. Police input in relation to arrest outcomes / updates has been invaluable for safety planning for families.

The DARA has not yet been implemented and therefore the DASH is still being used to assess risk in relation to Domestic Abuse.

A strength-based approach continues to be adopted to ensure children are safeguarded from witnessing domestic abuse, to minimise Adverse Childhood Events (ACE's) and to ensure parents are protecting children from harm.

Think Family / themes of abuse

Around 25% of referrals received for adults and children's were in relation to domestic abuse (this figure is in relation to high risk for children's and does not include medium / standard risk domestic abuse as they are processed differently).

As expected, physical abuse remains the highest category referred into MASH for children's and neglect for adults (discounting domestic abuse). (See charts above for reference).

Other

- Delegated section 42 enquiries

MASH health continue to complete section 42 delegated enquiries for incidents that take place on DHCFT wards. During this annum, MASH health returned approximately 109 enquiries. Most referrals were in relation to peer on peer physical or sexual assaults and concerns in relation to Staff (PIPOT – person in position of trust).

- PCOT – protecting children online team.

A total of 52 PCOT referrals were discussed this annum which is consistent with that of the previous year. PCOT is booked in daily, but agencies only join if the PCOT forms have been received for discussion.

- Advice Calls

MASH health received approximately 85 advice calls from Trust colleagues.

- Data collection

MASH health completed around 760 face to face or email checks for Social Care / Police during this annum. Most of these originated from Adult MASH Social Care and were in relation to demographic checks / check of GP / involvement from the Trust to enable section 42 enquiries to be commenced or safety planning to be complete without delay.

MASH health continue to support colleagues with insight visits to the MASH to aid understanding of safeguarding processes in Derby city.

LEARNING FROM REVIEWS

Child Safeguarding Practice Reviews (CSPR):

DHCFT have been involved in eight Child Safeguarding Practice Reviews (CSPR) throughout the year. The reviews are at different stages of completion within the formal processes. The Trust are fully engaged with all Partnership activity.

DHCFT has engaged with all relevant reviews and shared and applied the learning from these reviews into the Organisation and teams. The Quality and Safeguarding Committee within the Trust are kept abreast of all CSPR via reports which intern updates the Trust Board. Actions and recommendations are shared with the appropriate teams, evidence of actions is then collated and shared with the Safeguarding Children Partnership as a way of quality assurance.

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. This process ensures the Trust have strong oversight of the actions, and assurance regarding embedded learning.

Domestic Homicide Reviews (DHRs) & 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.

We have a consultant nurse sitting on a Violence Against Women and Girls Board and the Domestic abuse and partnership Board. This enables the learning from DHRs to have further flow into DHCFT.

DEVELOPMENT OPPORTUNITIES AND SUCCESSION PLANNING

Due to a secondment opportunity, we were able to offer development opportunities working within the Safeguarding Team. This consisted of a total of five days. We interviewed and offered positions to two Health Visitors covering a total of three days undertaking activity on the advice line, which incorporate Strategy meetings. Also, a Social Worker covering MARAC responsibilities and MASH activity.

This has provided an excellent opportunity for staff interested in safeguarding to join the team to gain an insight, experience, skills, and competencies within this exciting area of work.

The rationale behind this initiative is for the members of the team to take their expertise gained by this opportunity back into the workforce to support and advice their colleagues at base.

The success of this has also led to succession planning as one of the workers were successful in successfully getting a Named Nurse position within the team.

Due to the stage of several team members leading up to retirement age, this is also planning ahead to increase the skills, experience and competencies for the future of safeguarding within the Trust.

OBJECTIVES 2024/25

Led by the operational group and assurance on progress provided to the Quality Committee.

Objective / Initiative
1. To provide strategic influence and support to DHCFT. 2. To strengthen and improve the quality of safeguarding across DHCFT. 3. To respond to national amendments to legislation and statutory guidance. 4. To continue to develop and integrate the Children's and Adults Safeguarding Team within the Trust. Option paper available.
5. To ensure that succession planning, develop expertise within the workforce and consider talent management and support development by secondments into the safeguarding unit.
6. To continue to support staff around complex cases and to provide safeguarding leadership to the organisation.
7. To support CQC actions / standards / improvements and initiatives and ensure it remains a golden thread throughout the organisation.
8. To work in partnership with agencies with regards to multi agency audits and to continue to undertake internal safeguarding audits and disseminate the learning.
9. To continue to ensure that Think family remains the focus in everything we do.
10. To continue to undertake a joint City / County Section 11 and SAAF. To ensure actions are identified and completed.
11. Assuring Sexual Safety within Trust services continue for patients and staff, in line with this being a Trust Quality priority.
12. To work alongside staff around quality of referrals, threshold, and escalation
13. To commission annual level4 safeguarding training 2024.
14. 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.
15. To work alongside both Children's safeguarding partnership and the Adult safeguarding board around their agreed priorities for 24/25.
16. To ensure safeguarding representation on relevant internal, external meetings and subgroups. Carry out any related activity/actions.
17. To ensure quality, assurance and governance to the Trust Quality and Safeguarding Committee.

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
Charlie Hall – Safeguarding Advisor/MARAC
Zoe Rudderforth - MASH Health Advisor
Louise Haywood - MASH Health Advisor
Jo Watson - MASH Health Advisor
Chetna Mistry – Safeguarding Children Trainer
Dave Ensor – Safeguarding Adult 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
Dave Mason – Executive Director of Nursing and Patient Experience/Board Safeguarding lead

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 5 November 2024

Annual Report of Special Educational Needs and Disabilities (SEND)

Purpose of Report

To meet the quality requirement in schedule from the Derby and Derbyshire Integrated Care Board (ICB) to provide an annual report of SEND

Executive Summary

The requirement from the ICB state that our current position and future plan of development in relation to SEND in the follow areas.

1. SEND self-assessment and action plan
2. Quality Assurance of health advice - audit
3. KPI performance- SEND Dashboard
4. Staff training
5. CYP/families' satisfaction, feedback and co-production
6. Governance - how does the SEND workstream fit within the organisation
7. Transition to adult services.

This was a new requirement for 2022/23. Therefore, this is the second annual report.

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 Trust has limited assurance in some areas of the report due to the new nature of the requirements.

Consultation

- All service lines within the Children's Division have been consulted and some limited involvement from Adult Learning Disability and Neurodevelopmental services. Feedback from children/young people and their families has been included
- Quality and Safeguarding Committee, 18 June 2024.

Governance or Legal Issues

- Children and Families Act 2014
- Ofsted and Care Quality Commission (CQC) SEND inspection framework.

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

The aim of the report is to improve access and outcomes for children with Special Educational Needs and Disabilities in Education and Health. No protected characteristics should be disadvantaged by this report, but it is limited to under 25 years of age. This limit is set by legislation.

Recommendations

The Board of Directors is requested to review the report and accept significant assurance on progress and the actions to address the gaps.

Report presented by: **Tumi Banda**
Director of Nursing, AHPs, Quality and Patient Experience

Report prepared by: **Susan Walker**
SEND Clinical Co-ordinator

Annual Report of SEND

Introduction

This is the second annual report for Derbyshire Healthcare NHS Foundation Trust (DHcFT) regarding Special Education Needs and Disability (SEND). The Children and Families Act 2014 Section 3 first introduced significant responsibilities for health, social care and education to work closely together to improve outcomes for children and young people (0-25 years old) who have special education needs or disabilities.

These reforms were monitored through the first round of local area SEND inspections (joint CQC and Ofsted) up to 2022. The new Framework of SEND inspection has been in place now for just over 12 months. The learning from the local areas which have been inspected during this time, is that there is an assumption that the statutory process is in place and the inspection is more focused on how services work together to improve outcomes for children and young people. Focus has been on how the local area can demonstrate it makes a positive impact on outcomes for this group of people.

In response to the new SEND inspection framework, the Integrated Care Board for Derbyshire (ICB) has updated some of its requirements as part of the quality assurance for services who see people up to the age of 25. This report has been completed to meet this requirement.

The requirements for this report are:

1. *SEND self-assessment and action plan*
2. *Quality Assurance of health advice- audit*
3. *KPI performance- SEND Dashboard*
4. *Staff training*
5. *CYP/family's satisfaction, feedback & co-production*
6. *Governance- how does the SEND workstream fit within the organisation*
7. *Transition to adult services.*

SEND Self-Assessment and Action Plan

The SEND self-assessment for the last four years has been regularly completed by the SEND Clinical Co-ordinator and was updated March 2024. Please see Appendix A. This is reviewed by the Senior Leadership team in the Children's Division and updated of progress report are sent quarterly to the Children's COAT.

Significant progress has been made on this self -assessment, particularly around the access of information to be able to identify children and young people with an Education, Health and Care Plan (EHCP) and having clearly and reliable processes to meet our statutory responsibilities in regard to the EHCP assessment process. We have a good relationship with the ICB and both Derby City and Derbyshire Councils' SEND departments and supporting initial assessment and those which are going the SEND extend tribunal appeals through our well establish SEND Single Point of Access (SPA).

To support the assurance of this, the SEND oversight group meets monthly to work through the self-assessment to identify areas of further development. SEND Champions have been identified in each of the service lines in the Children's Division to support the work of the SEND Clinical Co-ordinator. We currently have limited involvement from the Adult Divisions, but the Deputy Director for Practice Regulation has attended.

From this action plan, a SEND Policy with SEND standards is currently in draft and is ready to go to the next Children's Clinical Reference Group (CRG) for approval, which would apply across the Trust to ensure we meet our responsibilities under the Children and Families Act 2014 and ensure that we support the "Local Areas" of Derbyshire and Derby City to be inspection ready.

Planned Development

The SEND Policy also gives more standards of care that we can develop audit processes around to be able to demonstrate we are meeting the wider SEND agenda responsibilities.

Quality Assurance of Health Advice - Audit

The quality schedule from the ICB and the Children and Families Act 2014 states that we must provide good quality health advice for Children and Young People, who are receiving a service from the Trust, within six weeks of request as part of the statutory assessment process for EHCP. An audit tool was developed in partnership with the ICB and other local health providers to meet the NHS standards for reporting. We have also completed random sample audits in each service and results have been fed back to services.

Service	**Compliance in audit**
Children's Occupational Therapy	99%
Children's Physiotherapy	99%
Community Paediatrician	97%
ADHD Nurses	96%
CAMHS	100%

Other services have not been randomly audited as they complete less than 10 reports per year.

Most services in the Trust are using the check list of NHS standards to have quality assurance by the clinical lead before every report is sent to the Local Authority. This is reflected in the results of the audit. These are very positive results. We are still getting the occasional abbreviation and unexplained medical diagnosis slipping through the checking, but generally, the reports are of a high standard, and we have received positive feedback from the ICB in relation to the high quality.

Currently, there is no standard template for providing the advice and services have developed templates which comply with the audit. However, there is no consistency to the format across the Trust or local area. This was an area of development identified in the last SEND annual report. The SEND Clinical Co-ordinator raises this with the two Local Areas and has worked with the ICB, local authorities and other NHS providers to develop a standard format which is consistent across both local areas and was finally agreed at the last SEND Footprint on 13 March 2024.

Planned Development

This standardised format is aimed to reduce the time spent on writing the report. The plan is to have a standardised offer to all children and young people on agreed pathways across Derby and Derbyshire.

This standard format will support the development of the Derby City electronic EHCP system as the form is planned to be built into their system and should help improve quality of the health input in the final EHCP.

Derbyshire has bought a new electronic package to manage their EHCP process. It is proposed to introduce this in September 2024. The current proposal is for health professionals to write directly into the new software. The DCO (SEND) and all health providers within Derbyshire have significant concerns about this as it would potentially reduce the amount of oversight and assurance around the reports being written on behalf of the Trust. We are currently meeting with Derbyshire County Council to understand how we can work together with this, to ensure we maintain the current quality assurance, and also make use of the package to improve the quality of their EHCP reports, in terms of timeliness as well as quality.

KPI Performance- SEND Dashboard

The only KPI we are currently being asked to report on is the compliance with the statutory six-week timescale for providing EHC health advice as part of the initial EHCP assessment.

Letter Requests/ Number of Plans	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Letter1	75	75	76	84	36	31	72	81	57	67	42	72
Letter2	133	177	144	129	161	114	110	105	106	111	119	165
EHCP Draft	28	31	39	95	73	78	92	127	49	54	67	57
EHCP	39	45	66	59	53	77	98	149	133	102	117	71

Response Times (by Month of Response) for Children Open in Reporting Year	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
No. Letter 2 Responses with Preceding Letter 2	111	158	206	131	175	105	135	120	111	103	131	107
No Letter 2 Responses within 42 Days	111	158	206	131	175	105	134	120	111	103	131	107
Letter 2%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	99.26%	100.00%	100.00%	100.00%	100.00%	100.00%
No Letter 2s where Response Date Deadline Falls in Month (42 days after Letter 2 Request)	114	120	140	144	172	141	117	101	125	113	81	111
No Letter 2s Due where Response Recorded and Within 42 Days	114	120	140	144	172	141	117	101	125	113	81	111
% Letter 2s Due where Response Recorded and Within 42 Days	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%

This compliance is a significant achievement, particularly as the demand for EHC health report has grown by 41% in 12 months. This has been achieved partially by the support of the temporary role of SEND Process Co-Ordinator, but identified funding for this runs out December 2024. This will present a challenge in how the Trust will continue to maintain this compliance.

There is other data which we needed to develop to give a wide picture to evidence we are meet SEND requirements. This includes the statutory requirement to notify the local authority of children under statutory school age who have or may have SEND. The 0-19 service now notifies the local authority when they refer an under 5 to a specialist service or receive correspondence to indicate they have a disability from a specialist service not within our organisation as part of the disability pathway in the 0-19. The Community Paediatricians also complete this notification if a child is diagnosed with a disability, their SystmOne template was not able to be record the notification read code. This has been updated and we are able to provide data on the number of notifications we have completed.

The other request for data is for waiting times for children and young people who have SEND. There is significant difficulty in identifying this cohort of children and young people. We can identify children and young people who have an EHCP, but it is significantly more difficult to identify children and young people who have a special educational need without disability or those who have SEND but being supported at SEND support/graduated response level. This is a national issue as the definition of SEND is that the health or social care need, needs to be having a significant impact on education which cannot be met through normal reasonable adjustments and it's not diagnosis led. Therefore, without education data of which children are considered to have SEND we are unable to identify accurately which children we should be reporting on. Clarification from the ICB is needed to be able to finalise the SEND dashboard as to if they want reporting on normal waiting times for services or if they want waiting times for children with an EHCP.

Our data around statutory compliance for EHCP should be considered an area of strength as we are able to provide consistent good quality data to the ICB.

<u>Planned Development</u>

As we continue to develop our Neurodevelopmental pathway the SEND Footprint Assurance Group has asks to have a quarter report on Care Education and Treatment Review (CETR) and the dynamic support register to be presented at this meeting.

The SEND inspection will be looking for data which shows the impact services have on outcomes for young people with SEND. Currently the SystmOne modules in the Children's Services have not been updated for a significant length of time. Therefore, this needs to be reviewed and further developed to ensure we have the data needed to mean this requirement.

Staff Training

The Children and Families Act 2014 puts a requirement that those working in health services are aware of their responsibilities regarding SEND. Ad hoc training has been provided by the SEND Clinical Co-ordinator for CAMHS, Children's Continence, Children's Occupational Therapy and Physiotherapy teams.

We have also added to the Children's Division SEND Basic Awareness for all staff, which differs to the training last year, as it is now the recommended Council of Disabled Children's e-learning.

Number of staff in Children's Division	Completed SEND e-learning	To complete SEND e-learning	Percentage compliance
493	315	178	63.9%

However, there is other training available in Training passports which support the SEND and reasonable adjustments agenda. This is across the whole of the Trust (all ages):

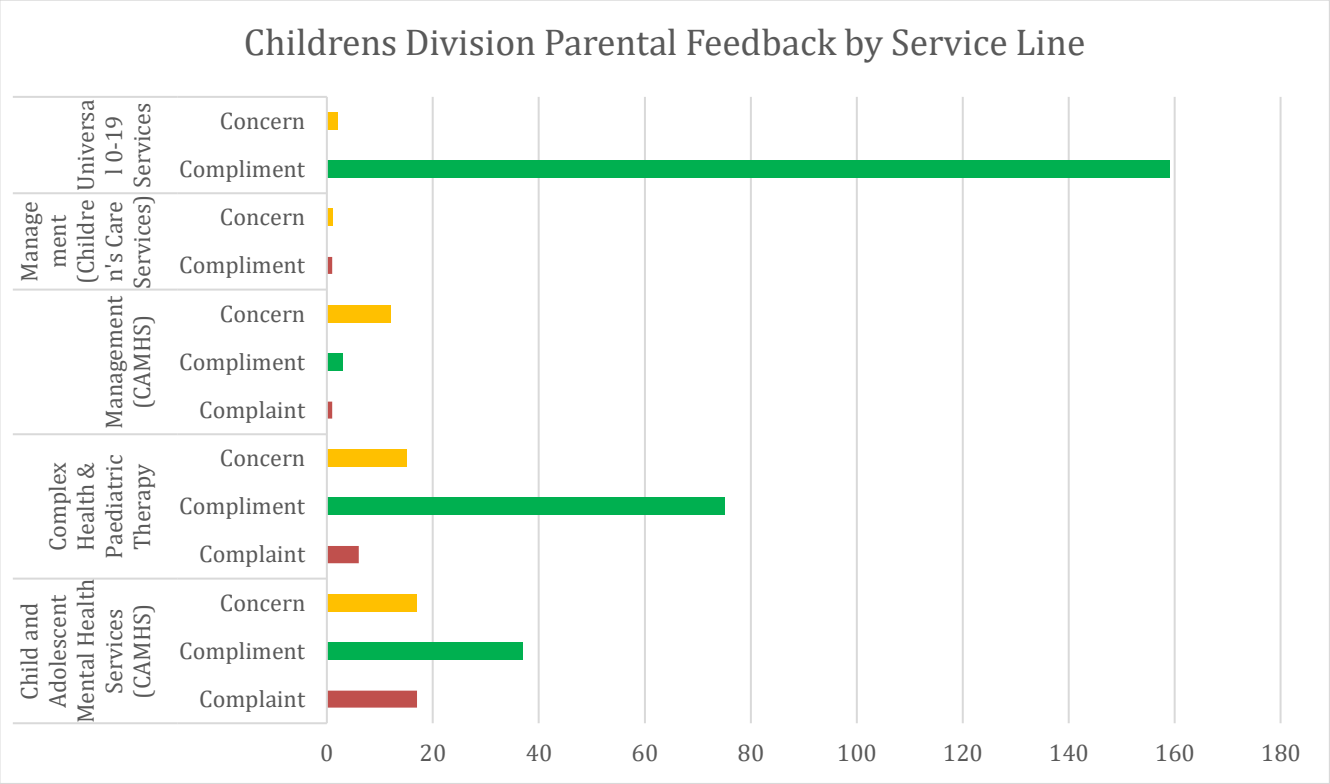
Course	Not completed		Completed		Total	
The Oliver McGowan Mandatory Training on Learning Disability and Autism	767	24.6%	2345	75.4%	3112	100%

Planned Development

The new SEND policy will need to be audited to provide assurance that we are compliant with our responsibilities. From this audit process, any further training needs will be identified, and we aim to develop an action plan for this.

CYP/Families' Satisfaction, Feedback and Co-production

Within the Trust we have a range of methods to receive feedback and satisfaction. Datix is used to record compliments, concerns, and complaints. This system allows the monitoring of themes and that actions have been completed around areas of development identified:



The 0-19 service had no complaints and only two concerns raised and 159 compliments.

Complex Health and Therapists received six complaints and 15 concerns. The themes for these were waiting times and assessment processes. There were also 75 compliments recorded. CAMHS received 17 complaints and 17 concerns, again waiting times and assessment/care planning were themes. There were also 37 compliments recorded.

The Friends and Family test is operational across all services although its use and feedback is inconsistent across services.

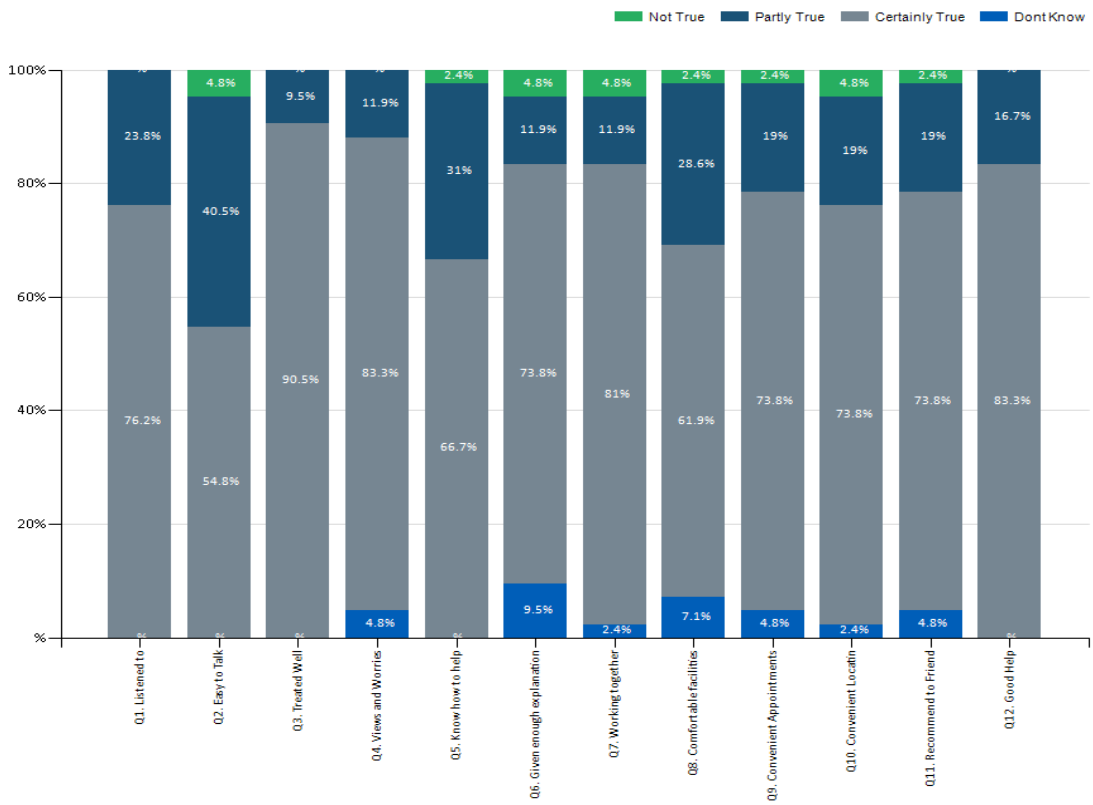
Response to Friends and Family test April 2023-March 2024

Count of Response	Column Labels					
Row Labels	Very poor	Poor	Neither Good nor Poor	Good	Very Good	Grand Total
CAMHS	1		6	11	15	32
CIC THERAPY & COMPLEX NEEDS	1	1	3	2	8	15
UNIVERSAL 0-19				2	4	6
Grand Total	**2**	**1**	**9**	**15**	**27**	**54**

This test also only provides a snapshot about how an individual feels around the appointment they have just had does not give a detailed outcome or feedback.

More detailed feedback is available from some individual services.

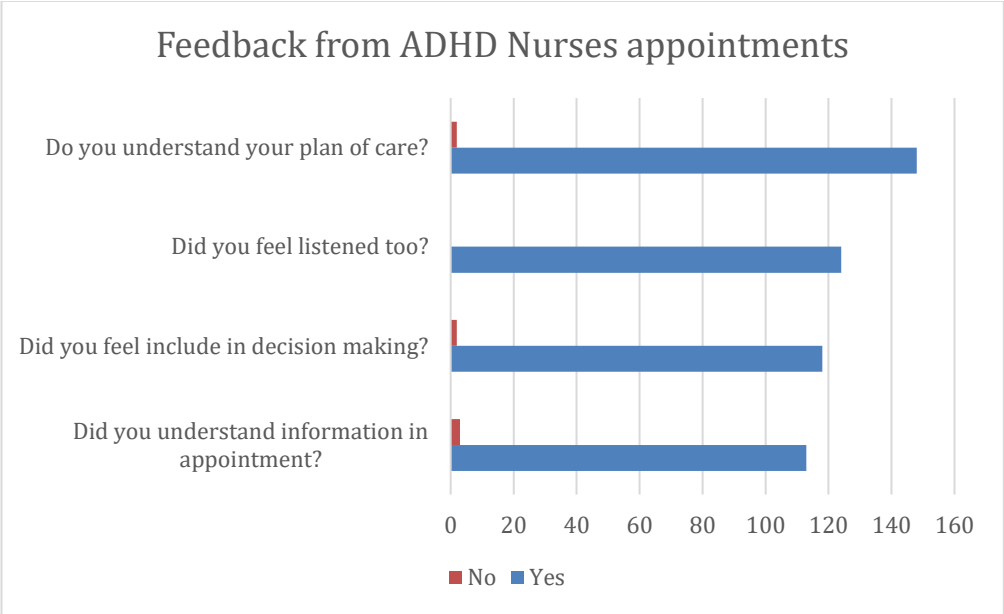
Feedback from CAMHS appointments April 2023-March 2024



Feedback from ADHD Nurses

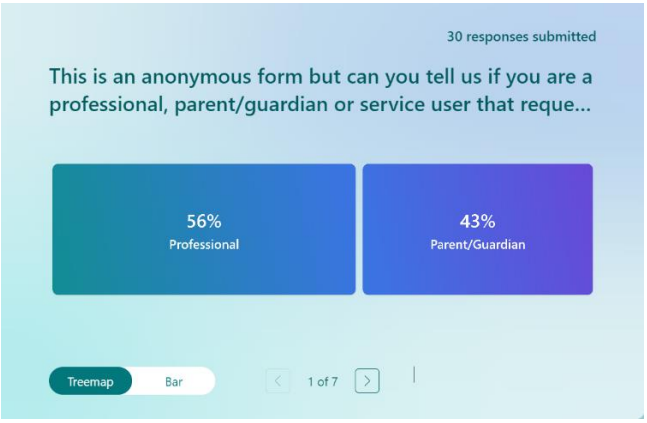
This feedback has been completed via survey monkey between January and March 2024.

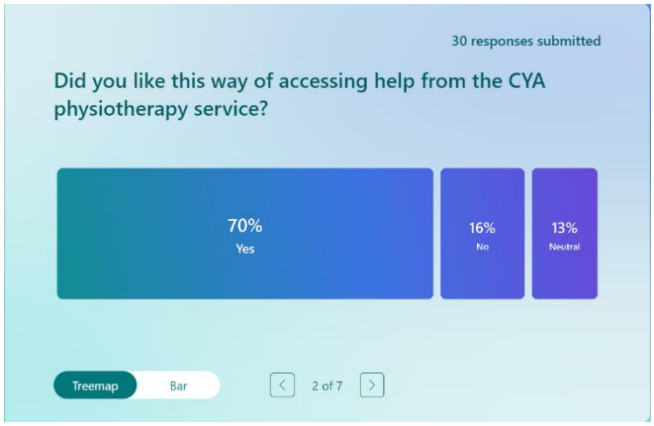
How do you rate your appointment 4.9 / 5

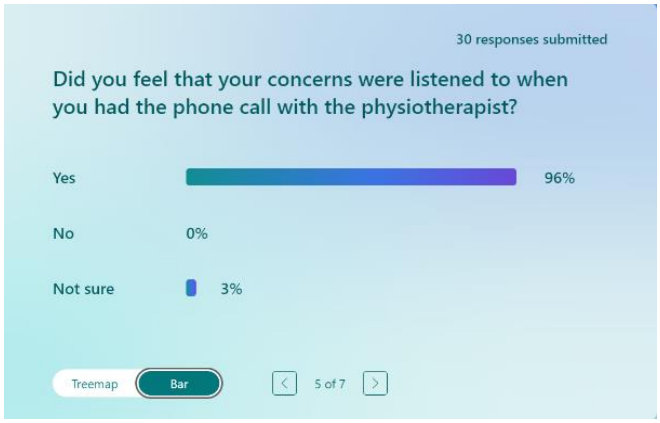


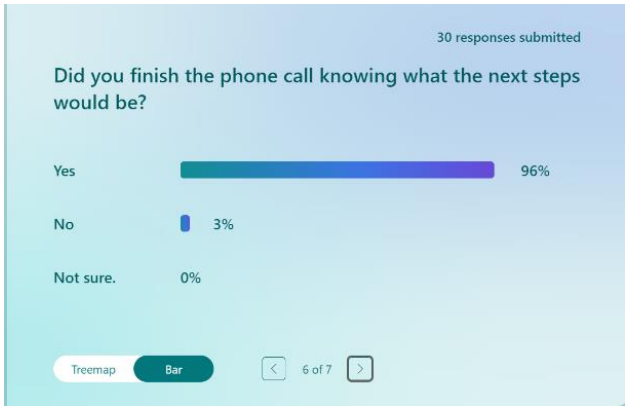
The Children's Physiotherapy and Occupational Therapy have following feedback from a range of stakeholders including families, professional referring and staff within the team have redesigned their referral process removing all referral form and offering triage calls instead.

The feedback from Children's Physiotherapy Triage process is below:









As the data shows, most feedback, particular from families, is that it was an easy and quick process, by which they felt valued and knew what to do following the calls. Some professionals felt a form would be easier and quicker.

This year, the Trust has introduced an electronic patient survey report which is now operational across most services, and this is expected to improve the amount of feedback received developing a more detailed survey which will be team based to identify what is working well and areas of development. The surveys are set to go out every three to six months to all those currently on caseload and on discharge. The implementation of this survey has been delayed in Children's services due to work on the demographics data, this has now been resolved and we are beginning to see some returns.

Within the Trust there is a range of co-production activities. This includes involvement of carers in particular projects such neurodevelopmental pathway transformation. Feedback from families has influenced the support being offered whilst they are awaiting assessment and the use of the ND Hubs. Initially, the waiting well letter for the Neurodevelopmental pathway signposted them to the ND Hubs. There was poor engagement with this and feedback from parents indicated a lack of confidence about contacting the hubs. Therefore, the process was changed to asking parents to consent to the ND Hubs contacting them. This has just been implemented and hopefully, will result in better use of this community resource.

Derby City has been working really hard to strengthen the offer for families who have children with SEND and also the preventative measures that can be put into place to support families before they hit crisis. The Family Hubs have a range of services based there, including Health Visiting and some specialist health services, alongside early years support from Derby City Council. The Family Hubs have a regular parent-carer panel, where they discuss support needs and where the gaps/improvements in service are needed. From these meetings, the Hub has had significant investment in parenting courses covering helping to manage children's behaviour, sleep and toileting support.

There is an offer for support with children who struggle to eat a balanced diet. There has been investment in specific support for children with neurodiversity who struggle with sleep.

Some feedback from families:

"It helps me a lot in that regard because they give me some tricks and some tips and I used to do it at home. So it really helps me. And now she start talking in sentences".

"That group really helped me a lot …. It was a wonderful experience".

"So from there, I learned that how I can make her respond to my words. To go to her level, to play with her like that, because before that I was just saying (child's name) do it like that. But she was not interested in it. Now I'll goi into sit down with her and do whatever she is doing".

"If you notice something like that in your kid, you must go to this kind of programmes, it really helps you because my experience was very good".

A significant project has been undertaken around Derby and Derbyshire decline in uptake of their annual health checks for those with a Learning Disability from the age of 14. Although the annual health is the responsibility of GP to complete, the Trust was asked to support understanding of why those with a Learning Disability are not accessing their health checks. A survey was completed, available online and an easy read version in out-patient appointments and distributed to stakeholder groups to collect the views about the annual health check.

Results from the survey were fed back at the Derby City Learning Disability Partnership Board. Present were around fifty people, including local people with LD, carers of, and professionals working with people with LD. We asked those present to consider our findings and give us suggestions on what/how improvements might be made to increase the attendance of AHCs in Derbyshire. Five groups of around 8-10 people discussed our key survey findings and then fed back their thoughts and ideas to everybody. This successful event gave us valuable co-produced ideas in identifying and prioritising potential solutions. From this, an action plan has been completed in March 2024. Actions include to increase people awareness of annual health checks, particular in the 14-17 age group and to look at the transition for Children's specialist services to GP care.

Employed Parent Carer Peer Support Workers in CAMHS provide weekly support groups and 1:1 support for any parent or carer with a child open to the CAMHS service whilst the employed Young Person Expert by Experience leads the fortnightly "Our Peer Space" group which offers a social space where participation occurs organically and, again, is open to any young person open to CAMHS; these groups are supported by the Lundy model and incorporate occasional formal working groups run by the Young Person Expert by Experience, which are well attended by a diverse mix of young people. There are clear feedback loops into clinical and operational structures in relation to the work undertaken within these groups and the CAMHS Advisory Board (chaired by the Lead Young Person Expert by Experience and attended by a diverse workforce including managers) is an integral part of this process.

The participation team is also proud to be piloting voluntary roles for people with lived experience and is the first service within the Trust to implement this within their work.

In addition to facilitating specific spaces for parents and carers, all members of the participation team offer lived experience consultancy within all service developments across CAMHS and the wider network, representing the voice of children, young people and families. Some examples of this include being on interview panels, completing audits of clinical environments from a lived experience perspective, working with the complaints team to improve communications between systems and diverse families, and sitting within the working groups which are focussed upon QNCC accreditation.

There is also have a formal voice through the Patient and Carer Experience Committee which feeds into the Quality Safety Committee and Trust Board.

The Trust is also working closely with the ICB and stakeholders in the development of “Place” within Derbyshire to identify and prioritise local needs.

Planned Development

The services will be receiving feedback from the electronic patient survey. It will be the responsibility of individual teams to review the feedback, and then send to the HoN/P to collate for their division, this is then reported on at the Patient Experience Committee (PEC) through the PEC report. The proposal is to develop a “you said we did” section for each service on the Trust website to complete the circle of feedback to the local area. This will be managed by an identified clinician within the team for each team/service.

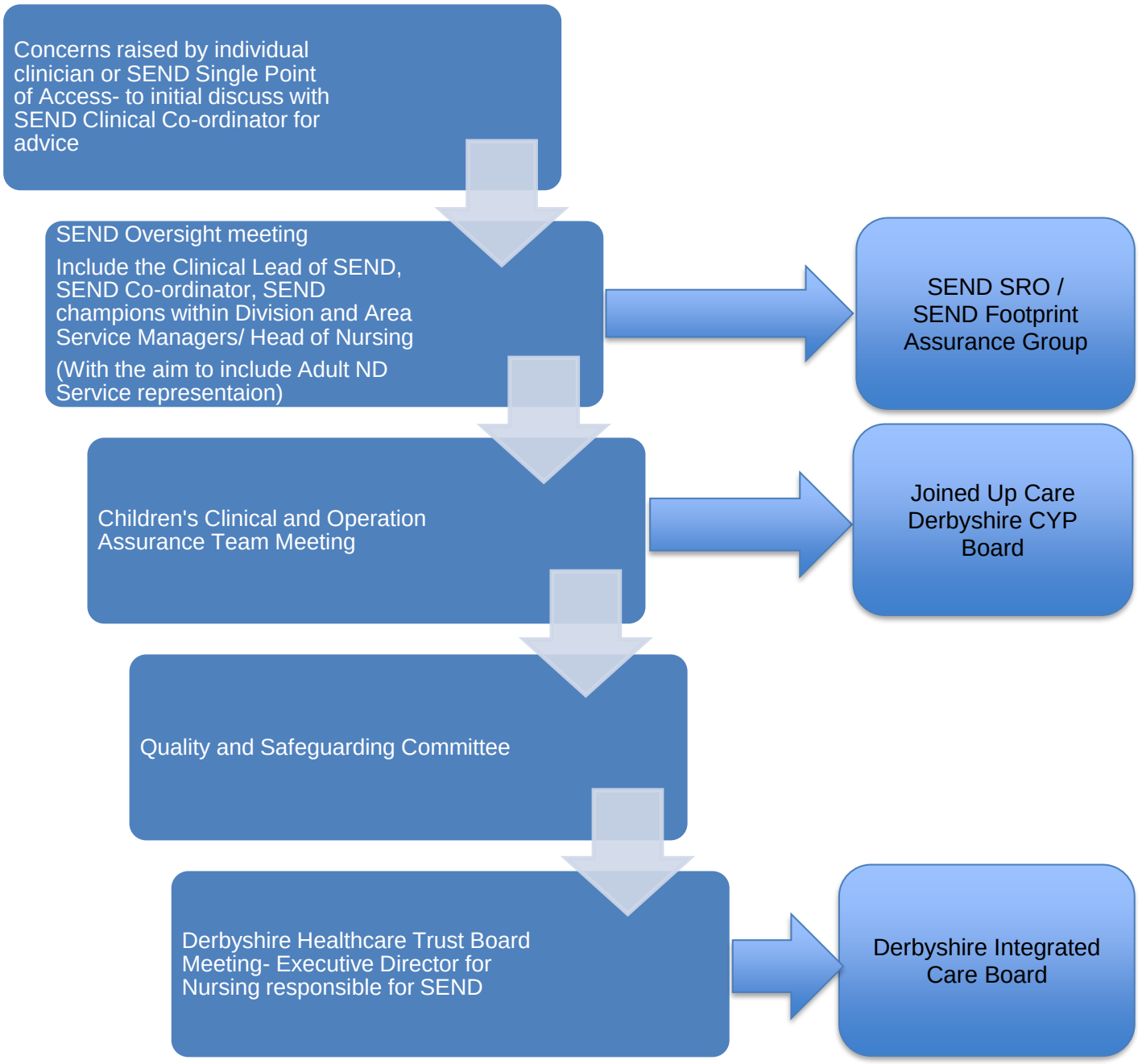
The development of the neurodevelopmental pathway will be continued in a co-produced manner. Supporting families while waiting with the new ND hubs is work that will be continued which will hopefully support the themes from the concerns/complaints around waiting times.

The action plan recently developed around annual health check needs to be implemented.

At present we are unable to identify outcome measures across some of the service lines, work is needed to support the use of tools in all units across SystmOne to support this.

Governance - How Does the SEND Workstream Fit within the Organisation

Derbyshire Healthcare FT SEND Escalation Standard Operating Procedure



Transition to Adult Services

We currently have a transition from CAMHS to adult mental health service policy. This policy has been reviewed and updated.

The numbers of young people who are needing to be transitioned from CAMHS to Adult Mental Health services is low. The Care Co-ordinator can develop an individual plan with the young person and adult services to transition them across. There has been an improvement in the transition for those who need attention deficit hyperactivity disorder (ADHD) medication. Previously there has been issues with referrals from the ADHD Nurses/Community Paediatricians for young people who wish to continue medication, but do not have a presenting mental health need. This pathway has now been implemented and there is good communication between the services.

There does remain a significant issue though for those wishing to start ADHD medication or who are not on a stable dose, as our Adult Mental Health teams are not commissioned to support this. The global shortage of ADHD medication has made this a more significant issue impacting on more young people. The ADHD Nurses and Community Paediatricians are working hard to get young people back onto medication safely as the supply chain becomes more stable. However, this has created a significant back log of young people who need titrating back on to medication or those newly diagnosis starting medication and there currently is no service to support this once the young person turns 18 years old.

There is now a Trust-wide transition group, which has supported networking between the divisions and developed some understanding about the challenges different areas face, where pathways are being developed. We are represented at the ICB Transition network for the Derby and Derbyshire area and work is continuing in this network. We are currently in the process of working through the rag rated audit from this network to identify more accurately where we are as a Trust.

Planned Development

Most services have locally held standard operating procedures or processes for transition to the equivalent adult service where it exists normally in our partner health providers. We also have a young adult service cover, up to the age 25 for Occupational Therapy (physical health) and Physiotherapy. However, this is not currently captured in an overarching policy. This was identified in the previous SEND report and remains work to be completed.

The most challenging areas around transition remain where there is no equivalent adult service. Clinicians work with the young person and family to find the best available support on an individual basis. Predominantly, these are young people with an intellectual disability or neurodiversity which does not meet the criteria for specialist services. There is further work needed to be done with universal services, predominately GP services, in how we support transfer back to universal services, having been supported by Children's specialist services, building on the work done around annual health checks. The Living Well service is now up and running and transition from Children's services will need to be incorporated.

Summary and Future Plans and Developments

The previous SEND Inspection framework focused on quantitative measures around timeliness of EHCP and quality of contributes from professionals. We have completed this successfully and received some positive feedback from the DCO (SEND).

The new inspection framework is more focused on outcomes and the experience of young people and their families. As a health provider we are seen as responsive to adapting to develop processes which support the SEND agenda. However, there is still a significant amount of work to do in maintaining the compliance and quality for the EHCP processes and developing the evidence of timely responsive support, leading to good outcomes for children and young people. There will be more focus on waiting times for children with SEND.

An in-depth analysis of any additional safeguarding vulnerabilities of children with SEND needs to take place and be highlighted within their plan. W*e* need to be conscious that children with SEND are not a group with identical needs*.* Ensuring effective safeguarding requires us to consider their individual needs, strengths and difficulties*.*

Priorities for the next 12 months need to be:

- training of all staff on the principles of SEND
- smooth transition to the new EHCP process in Derbyshire
- development of SEND standards to support the self-evaluation, including the development of SystmOne to be able to capture this data across the Trust
- transition from Children's to Adult services.

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 5 November 2024

Infection Prevention and Control (IPC) Annual Report 2023/24

Purpose of Report

This paper summarises the activity over the preceding 12 months of work related to infection control.

Executive Summary

- We continue to provide a consistent high level of performance against infection control standards and related management activities
- Our number of reported cases of key alert organisms is very low
- We have seen a limited number of outbreaks and continue to monitor local and national data
- Inspection/audit of clinical areas has been maintained and essential works have been maintained
- The teams have worked with NHSE and UKHSA to ensure that learning and challenge and scrutiny can be provide and assured against
- We have maintained our five-star rating for kitchen cleanliness awarded by the local authority
- The potential impact of further resurgence of the pandemic outbreak is a key risk and safety of service receivers and colleagues remains our highest priority
- The Trust continue to be an active part of the System IPC Strategic Action Group (IPCSAG)
- The Trust is regularly in attendance at the regional learning and information sharing events hosted by NHSE and partner providers across the midland's region
- The Trust has convened a standalone IPC Committee, this was previously part of the Physical Health and Infection Control Committee
- The Trust has worked closely with partner providers and NHSE to ensure readiness for emerging disease concerns ranging from new respiratory virus threats and other High Consequence Infectious Diseases.

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

- We have reviewed the current audit programme against National infection control guidance, and it is contemporaneous and compliant
- There are evidently robust cleanliness measures in place
- There continues to be robust oversight of infection control incidents or outbreaks
- All infection control policies are in date and have been reviewed to ensure they are compliant with National Infection Control guidance.

Consultation

- This paper provides the annual update since September 2023 to present
- Discussed at Quality and Safeguarding Committee on 15 October 2024, then as part of a report to the Trust Board of Directors. IPC SAG
- Divisional colleagues
- Physical Healthcare Committee
- Health Protection Unit.

Governance or Legal Issues

This paper provides update on regulatory aspects – identifying compliance with standards which may form part of a CQC inspection or enquiry. These would include patient safety, leadership, responsiveness, and effectiveness. Standards are set in the Healthcare Associated Infections Code of Practice for Infection Prevention and Control 2015.

There are both governance and contractual element to the emergency preparedness planning and work.

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

- The report is not felt to have a negative impact on any persons with protected characteristics. The learning and evidence base regarding the disproportionate impact upon some communities related to COVID-19 continues to be relevant and informative of current approaches. DHcFT has incorporated learning where possible and remain open to improving approaches to improve outcomes for those who access our services and colleagues who provide them
- There has been significant learning and understanding garnered from the UIPC work and vaccination programmes. Local evidence has highlighted that people who experience health inequalities require additional and focussed support either directly from healthcare providers or amongst the resources within key groups in the local community
- Key stakeholder groups have been formed to contribute towards and review emerging evidence
- The Health Protection Unit team are grateful for the support of colleagues across the Trust to identify ways our approach can be improved and embrace any learning which contributes to better outcomes and learning.

Recommendations

The Board of Directors is requested to:

1. Note the reporting of key areas, such as surveillance of healthcare associated infections – alert organisms, outbreaks of infection, staff training
2. Receive significant assurance that approaches and learning are evolving in accordance with emerging evidence and international/national and regional learning
3. Receive significant assurance on standards of cleanliness of clinical areas and food preparation areas.

Report presented by: **Tumi Banda**
Director of Nursing, AHPs, Quality and Patient Experience

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

Infection Prevention and Control Annual Report – 2023/24

Report prepared by Richard Morrow Assistant Director of Public and Physical Health (lead for Infection Prevention and Control), on behalf of Tumi Banda – Director of Nursing, Allied Health Professions (AHP), Quality and Patient Experience, Director for Infection Prevention & Control.

Contents

Health and Social Care Act 2012 Standards	
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 that their environment and other users may pose to them.	• A standalone IPC committed has been formed following feedback and discussion with NHSE to oversee IPC matters. • Review and update of local policies and inclusion of revised and updated national guidance. • Regular incident reviews through SI and DATIX flags. • Tissue viability and infection control support network (internal champions, and link to regional and national networks). • Annual training updates and policy and procedure updates. DHcFT provides and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.
The provision and maintenance of a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.	• PLACE annual reviews, regular walk arounds - cleanliness / estates checks. • National Cleaning standards and cleanliness ratings are displayed for each ward. • Supportive and responsive estates and facilities teams.
Appropriate antimicrobial use and stewardship to optimise outcomes and to reduce the risk of adverse events and antimicrobial resistance.	• Updated guidance reviewed when circulated and policies adjusted. Increased vigilance for c. diff and oversight of hospital acquired infections. • Annual audit plan and oversight of antibiotic stewardship.
The provision of suitable accurate information on infections to service users, their visitors and any person concerned with providing further social care support or nursing / medical care in a timely fashion.	• Updated and accessible policies are available through updated trust intranet site. • Infection control link nurses and support nurses to discuss / assess and liaise with colleagues to provide advice and support for techniques, interventions and unusual or unclear presentations. • Support to develop management plans to compliment care planning around the holistic needs of service receivers.
That there is a policy for ensuring that people who have or are at risk of developing an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of transmission of infection to other people.	• VTE assessments are carried out as an assessment baseline when people come into our in-patient services. • Prophylactic prescribing is in place to ensure that risks are mitigated where possible. • EPR enables alerts to be flagged for conditions where transmission or susceptibility is identified on a medium- or long-term basis. • Liaise with ICB, Public UKHSA and NHSE to ensure national or regional concerns are responded to appropriately.
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.	• DHcFT has updated and reviewed policies and procedures. • All colleagues have access to standard and transmission-based PPE and hygiene products. • Blended model of e-learning and face to face training. • Post incident analysis and shared learning following infection control incidents. • Signage displayed in high traffic and vulnerable areas.
The provision or ability to secure adequate isolation facilities.	• Individual rooms available with bathroom facilities when required. • Isolation / Cohort Nursing plans implemented as required.
The ability to secure adequate access to laboratory support as appropriate.	• UKHSA and regional IPCSAG support available. • National network and support system linked into NHSE available,
That they have and adhere to policies designed for the individual's care, and provider organisations that will help to prevent and control infections.	• Individual management plans using Heath Protection Unit guidance are in place. • Monitoring of updates to infection control guidance. • Updated IPC BAF submitted to Board.
That they have a system or process in place to manage staff health and wellbeing, and organisational obligation to manage infection, prevention, and control.	• DHcFT Health Protection Unit (HPU) have an established relationship with Occupational Health provision. • Swift access to assessment and advice is available. • Feedback to managers and colleagues is provided to ensure swift resolution to concerns and adjustments can be made.

1.0 Introduction

1.1 2023/24 has been a challenging year across health care providers due to the legacy impact of COVID-19, significant financial pressures, and new and emerging disease threats. This report summarises the approaches to Infection Prevention Control at DHcFT.

1.2 Preventing the spread of infection remains a key focus in healthcare, with a statutory requirement to fulfil mandated standards for all healthcare providers. The Health and Social Care Act 2008 enabled a code of practice to be established with standards which are overseen by the Care Quality Commission (CQC).

1.3 The Health and Social Care Act 2008; Code of Practice on the Prevention and Control of Infections and related guidance (2022) provides the framework for the standards we are required to achieve, and this report will detail the actions and on-going work which underpins the achievement of this. The regulation of this activity falls as part of the inspection programme undertaken by the CQC. Infection Prevention and Control considerations are part of the ongoing framework of improvements undertaken by the organisation. The table outlines the key elements of the guidance and the work undertaken by the Trust.

1.4 Preventing the spread of infection is an integral aspect of both patient safety and patient experience, providing assurance and a visible marker of standards and the quality-of-care service users should expect to receive. Derbyshire Healthcare NHS Foundation Trust is proud of the high standards and low incidences we see.

1.5 As learning and guidance has been developed following the COVID-19 pandemic there is greater attention paid to communicable infections. In addition, the this work there remains a significant focus upon the management of disease where increasing anti-biotic resistance is flagged as a containment and treatment risk.

1.6 National Infection Prevention and Control Manual (NIPCM) was updated in May 2024, this was a minor amendment to include the specification for Personal Protective Equipment (PPE) for managing High Consequence Infectious Disease presentations (HCIDs).

1.7 The Trust continues to monitor sickness an absence rate. The HPU provide advice and guidance to clinicians and services around suspected symptoms and presentations for colleagues and service users. The Trust continues to advise people with symptoms of respiratory illness to take time to recover at home before coming into the workplace, working from home if they are able.

1.8 The reduced use of COVID test in response to changes to guidelines issued by UKHSA has been challenging as the message has been to give gravitas to the impact of all respiratory virus threats; Flu, CSV etc rather than focus on COVID.

2.0 National context

2.1 The term HCAI covers a wide range of infections. The most well-known include those caused by methicillin-resistant *Staphylococcus aureus* (MRSA), methicillin-sensitive *Staphylococcus aureus* (MSSA), *Clostroides difficile* (C. diff) and *Escherichia coli (E. coli)*. HCAIs cover any infection contracted:

- as a direct result of treatment in, or contact with, a health or social care setting
- as a direct result of healthcare delivery in the community

- because of an infection originally acquired outside a healthcare setting (for example, in the community) and brought into a healthcare setting by patients, staff or visitors and transmitted to others within that setting (for example, norovirus)
- HCAIs pose a serious risk to patients, clients, staff and visitors to health and social care premises. They can incur significant costs for the NHS and others and cause significant morbidity and mortality for those infected.

2.2 Post pandemic, the rates of healthcare associated infection reported nationally rose slightly in 2023, This has been noted for hospital onset methicillin-resistant Staphylococcus aureus (MRSA), methicillin-sensitive *Staphylococcus aureus* (MSSA) and *Escherichia coli (E. coli)* have reduced for the first time (source - MRSA, MSSA and Gram-negative bacteraemia and C. difficile infections: 2022 to 2023 report) DHcFT have very low incidences of these infections and this remains the case with no statistically relevant shift in infection rates.

Cleanliness in healthcare facilities remains a high priority, with the well-established links between poor environmental standards and rates of infection. The emphasis on the speciality and related work is now much more proactive, rather than reacting to events after the fact. This has seen a considerable focus now on ‘zero tolerance’ of healthcare associated infections, with healthcare associated infection now being largely preventable. There is ongoing focus by NHS England on pandemic influenza preparedness and the NIPCM is broadly focussed on measures to reduce the risk and impact of respiratory threats in healthcare settings and amongst healthcare workers and patients.

Statistically overall case numbers are rising or on an upward trend across a broad range of known infectious diseases. From 2022 there has been a concerted effort at local and national level to clarify how socio-economic factors, geography, ethnicity, and antimicrobial resistance influence the prevalence of Gram-negative bacteraemia, Staphylococcus aureus bacteraemia, and C. difficile infections.

There is a planned project to further investigate risk factors and other potential drivers of this disparity by ethnicity and socio-economic factors. The Trust works closely with UKHSA and NHSE through its local and regional networks to understand emerging evidence and learning and apply it to services delivered by DHcFT.

3.0 Structures within Derbyshire Healthcare NHS Foundation Trust

3.1 The Chief Executive holds the responsibility for overall standards; however, the Trust is required to designate a Director for Infection Prevention and Control (DIPC), this is undertaken by the Executive Director of Nursing, AHPs, Quality and Patient Experience.

3.2 The Assistant Director of Public and Physical Health is responsible for the day-to-day delivery of the plan of work and ensuring this meets the required standards. This role is both strategic and involved in supporting the delivery of training, clinical advice, and planning.

3.3 The Assistant Director of Public and Physical Health has delegated authority to liaise with NHSE and UKHSA regarding Outbreaks and monitoring of cases, initiate ward closure with escalation to Executive colleagues and ICB colleagues for awareness of system impact and to oversee Trust-wide programmes such as vaccination delivery and screening programmes alongside Occupational Health.

3.4 The Heads of Nursing have directorate oversight and responsibility for IPC and will deputise for the AD of Public and Physical health Care and link with the Health Protection Unit as and when required.

3.5 The Trust recruited a dedicated Health Protection Unit team to ensure that the vaccination programmes: track and trace follow up, infection incidence monitoring and advise and additional Infection Prevention and Control support alongside this team is made up of one band 7 whole time equivalent (WTE) clinical lead, 2.6 WTE band 6 colleagues and one 0.6 WTE band 5 colleague.

3.6 The Head of Estates and Facilities oversees the maintenance, cleanliness and support services which are vital aspect of meeting high standards.

3.7 The programme of work has been previously devised and delivered by the Physical Health and Infection Control Committee (PHCIC), which formed a key component of the Governance structure. This committee has been reporting via the Divisional Clinical Operational Assurance Teams (COAT) as required.

3.8 The Physical Health and Infection Control Committee (PHCIC) group link to the divisional COAT meetings and report directly to the Quality and Safeguarding Committee.

3.9 In October 2024 a dedicated Infection Control Committee has been convened as this is contemporaneous with other organisations following advice and guidance from NHSE.

3.10 An annual report detailing the work of the Infection Control Team is submitted to the Quality and Safeguarding Committee as part of the Trust's oversight and governance approach. This report is submitted for board approval alongside the Board Assurance Framework (BAF).

4.0 Key achievements of 2023/24

4.1 Continued investment in the capital programme has seen sustained improvement in the care environment in several locations, through a dedicated capital expenditure allocation for Infection Control in 2023/24.

- Replacement furniture and flooring within some of our in-patient units as part of a rolling programme of upgrade and improvement.
- Equipment has been provided for newly established physical health monitoring clinics in Community.
- Flooring and fittings upgrades have taken place in the PFI sites at Audrey House as part of the making room for Dignity work stream.
- Physical health monitoring equipment from Oxehealth has been extended and is in use across the existing wards at Kingsway site. The preparatory work for installation into new builds has been undertaken whilst the business case for extended use is explored further.
- Making Room for Dignity Programme has seen the building work commence across four sites at Kingsway hospital, Walton Hospital, Chesterfield Royal Hospital and Radbourne embarking on an ambitious programme to build and upgrade fatalities across a range of Acute, Older Adult and PICU care provision.
- The Making Room for Dignity Programme which eradicates dormitories from outer Hospital estates also helps reduce the spread of infection as there is reduced exposure risk from the removal of multiple occupancy bedrooms.
- Policies and clinical guidelines have been updated in line with National and local guidelines.

4.2 Continued delivery of training for clinical and support staff. Training sessions are largely delivered through e-learning to give greater flexibility.

4.3 There remains a focus on water born pathogen and the methods employed by the Trust to manage these risks, namely temperature control and chemical dosing. This has oversight from the Water Safety Group and the Statutory Standards Group.

4.4 Since September 2023 we have had a small number of respiratory illness and inconclusive D and V presentations affecting 2 or more service users (see table below). The suspected outbreaks in some cases were inconclusive however staff were fast to respond and implement Transmission Based Precautions, Enhanced monitoring, and cleaning. The incidents were short duration and beyond the initial cohort further spread or concern was not identified. HPU were notified and advice and support provided alongside monitoring and escalation to AD Public and Physical Health acre and Director of Infection Prevention and Control.

Clinical Team	Date	Patients affected	Staff affected	Comments
Pleasley Ward – Hartington Unit	28/09/2023	3 patients	2 staff	Suspected D & V outbreak. Unclear route of transmission as symptom profile and patient contacts were difficult to establish. Transmission Based Precautions (TBPs) implemented. No samples able to be obtained and symptoms resolved quickly.
Tissington Ward	07/10/2023	2 patients	0 staff	Potential contact between lunch items belonging to COVID positive patient and another patient on the ward who had gained access to an isolation area. Precautionary post incident monitoring, no evidence that transmission had taken place.
Cubley Female – Kingsway Site	18/10/2023	4 patients	2 staff	Staff member felt unwell whilst at work and went home with sickness. Another colleague on duty reported sickness the following day and 3 patients had singular episodes of sickness or diarrhoea over the following 24-hour period. No samples able to be obtained as single episodes. Isolation implemented and TBP's, monitoring forms in situ and inconclusive cause.
Pleasley Ward 29/04/2024	29/04/2024	5 patients	0 staff	5 patients with symptoms of either D or V and 2 with both. Cases emerged within a short space of time 6 – 8 hours. Tracking sheets and TBPs applied. Ward closed to admissions for duration. Symptoms appeared to resolve quickly – no samples able to be obtained. Inconclusive cause but treated as outbreak.
Morton Ward	13/06/2024	5 patients	7 staff	Staff member confirmed they were COVID positive, and several others absent with respiratory illness symptoms. 5 patients with cold symptoms. Ward closure initiated and managed as outbreak for duration. Symptoms resolved quickly with no marked significant illness. Manged in accordance with current UKHSA guidance and wider testing not initiated on advice from UKHSA. Spread was reduced through TBP's, enhanced cleaning and managed access to the ward.
Cubley Female - Kingsway	24/06/2024	4 patients' staff	0 staff	4 patients identified with either D, V, or both. Monitoring, TBP's and enhanced cleaning initiated. Some samples obtained but no pathogens of concern identified. Short duration and symptomatic patients managed with reduced access and no admission for the duration.

4.5 Useful interventions.

- Review of IPC compliance through routine audit and walk arounds.
- Use of lightbox to ensure standards of hand hygiene are understood and maintained.
- Review cleaning schedules and roster cover within hotel services.
- Initiate TBPs when a potential infection is identified.
- Redirect admissions to other available areas until extent of concern and impact has been established.
- Liaise with DiPC, UKHSA and ICB regarding ward closure status and seek advice / support where appropriate.
- Share any learning with Communications team for immediate dissemination.
- Ensure staff well-being plan is paramount.

4.6 Learning from incidents

- Hand hygiene and PPE compliance is crucial first line defence.
- Limiting spread through cleaning of environment and equipment is a key management tool within our services.
- Respiratory viruses are opportunistic and indiscriminate, preventative measures remain paramount.
- Encouraging people to be honest about potential contact helps us to reduce risk of spread.
- Paying attention to the needs of staff groups who are tired and working hard, helps them to maintain focus.
- Reducing occupancy reduces risk of IPC concerns.
- Staff and patients who are eligible are encouraged to have flu and COVID vaccinations across the unit if they haven't already had it.
- Signage is displayed alerting visitors, relatives, and carers.
- Everyone visiting, staying, and working on the ward is advised about hand washing and reducing traffic on and off the ward.
- NHSE, UKHSA and ICB are kept informed as per winter pressures and contractual guidance.
- A post incident reviews are conducted, and lessons learnt regarding good communication and prevention of cross contamination are shared.
- The estates team were responsive and enhanced cleaning off handrails etc. was pivotal in managing cross contamination risks.

4.7 The Flu campaign for 2023/24 has seen a significant reduction in uptake compared to previous years uptake rates for Flu (44%) and COVID (33%). The CQUIN target for 2023/24 has been removed with an expectation that all employees will have an offer and support to receive a vaccination. For 2024:

- The HPU will lead on the work with support from peer vaccinators in key sites.
- The Trust has purchased sufficient vaccinations based upon lessons learned for the 2022/23 campaign to ensure adequate supply and minimise waste.
- The NHSE foundry portal will be the principal reporting platform at ICB level, to allow comparison data against other organisations and COVID19 programme.
- ImmForm data submission is being reviewed by the National team.
- Blended working and reduced footfall on key sites are an area of focus for the planning of this campaign.
- The underpinning message of the campaign is on informed choice, to support discussion of facts and evidence and to respect personal choice.

- We work closely with DCHS with an MOU to support and maximise opportunities for both providers and their staff and patients across the County.

4.8 Surveillance of healthcare associated infections (HCAI alert organisms) have seen four cases of MRSA bacteraemia acquired within the Trust between September 2023 – September 2024.

4.9 Surveillance of HCAI has identified two cases of C. Diff within the Trust between September 2023–September 2024.

4.10 Cleaning scores, measured against the national standards of cleanliness, are displayed on the entrance to wards as per the current guidance and exceed the standards set. (see detailed performance in the section 'Assurance').

4.11 Cleaning schedules remain consistent with national guidance and are held at ward level for access by staff and patients / visitors.

4.12 Patient Led Assessment of the Care Environment (PLACE) inspections were undertaken in November 2023. The scores are published on the NHSE portal. (see detailed performance in the section 'Assurance').

4.13 Continued development of the skills and leadership of the Infection Control Link Nurses programme brings a strong focus of clinical leadership and a conduit for information between the specialist team and clinical level. The infection control audit has been reviewed as the safety of sharps was highlighted last year by the infection control link nurses. The audit is derived from national safety standards audit and is undertaken annually by all in-patient areas.

Monthly Compliance %

Location	Apr, 2024	May, 2024	Jun, 2024	Jul, 2024	Aug, 2024	Sep, 2024	Oct, 2024
Cherry tree	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Cubley Female	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Cubley Male	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Kedleston Unit - Central Area	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Kedleston Unit – Scarsdale	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Morton ward	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Pleasely ward	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Tansley ward	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
The beeches	86.36%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Tissington	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Ward 34	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
ward 35	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Ward 36	86.36%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%

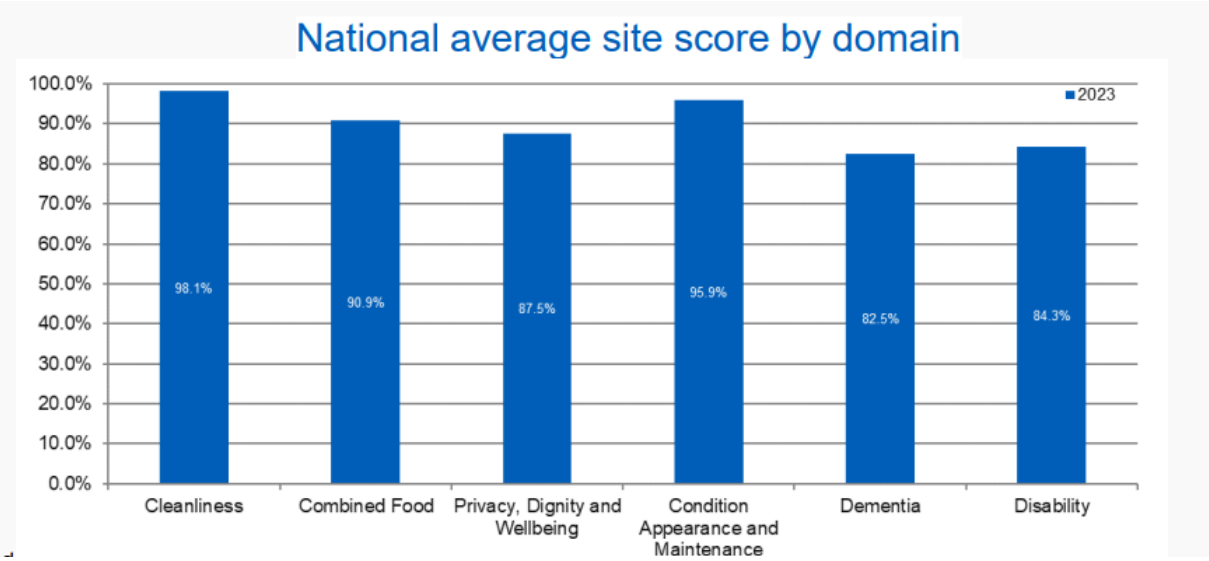
In addition to this we have a weekly audit cycle to ensure that areas are maintaining IPC signage / PPE/ hand washing standards, audits are uploaded centrally for assurance and accessibility.

5.0 Assurances

5.1 The Hotel Services and Estates teams continue to undertake visits to the Community Mental Health unit's premises to ensure all statutory environmental standards are being met and to check that all planned maintenance is in accordance with the proposed works schedule. Several improvements have been made to flooring, replacement of carpets and furniture which have improved the environment and reduced potential infection control risks.

5.2 The Facilities team continue to deliver high standards of cleanliness. This means we remain in the 'excellent' range which is supported by the findings in the last PLACE inspections.

Organisation	Cleanliness	Combined Food	Organisation Food	Ward Food	Privacy, Dignity and Wellbeing	Condition Appearance and Maintenance	Dementia	Disability
DHcFT	99.84%	93.06%	89.52%	97.22%	94.61%	99.38%	94.05%	89.00%



Data taken from the Microsoft Power BI PLACE inspection framework database published by NHSE. The data shows an improvement in cleanliness, condition / appearance and maintenance and combined food. There is a slight reduction in our scores in the other domains compared to the 2022 framework, however we are above National average and benchmark well against other MH providers across all domains.

5.3 The Heads of Nursing rounds continue to provide assurance of key standards in the inpatient wards, where on a regular, representatives from Infection Control, and Hotel Services join the Heads of Nursing to inspect the clinical areas from an environmental quality perspective. They provide a proactive and engaged oversight within their respective environments, anticipating maintenance and quality issues at an early stage (and ensuring action is taken) and the opportunity to seek informal feedback from patients on the wards as to the comfort and cleanliness of the wards. Considering the work plan around making room for dignity and pressures on budgets within estates and facilities and hotel services there is more focus around the oversight of IPC and cleanliness in these areas.

5.4 Healthcare associated infection (HCAI) surveillance demonstrates our performance, as reported to the ICB. We continue to show consistent performance here, with clinical focus on anticipation of possible infection risks and a swift, appropriate response, for example to suspected diarrhoeal illness. This has seen a significant emphasis on prevention of cross infection, and rising confidence in staff to deal with potential infection risks as they arise.

5.5 During 2023/24, there have been 2 ward closure because of D&V and respiratory illness, with minimal disruption to service delivery. The decisive action of clinicians, rapid implementation of TBPs and enhanced cleaning and screening assessment has meant that potential Outbreaks have not seen significant spread.

All infection control issues are reviewed and there have been no outbreaks of MRSA bacteraemia beyond single cases identified or Clostroides difficile. As in previous years, learning from Physical Health Care and Infection Control Committee (PHCIC) learning points are also distributed via the Infection Control link nurses and via clinical training.

The catheter passport was introduced last year and has been evaluated to have been a success. The infection control support nurse has been working with colleagues to increase awareness / confidence and skills related to catheter care.

5.6 Clinical audit specifically to infection control is focussed on 2 key areas during the year:

- Infection control general standards (hand hygiene, PPE use, donning and doffing, signage, sharps, decontamination equipment). Thematic review of the general infection control audit saw areas of work needed regarding the storage of equipment and patients' belongings. There has been a focus upon maintaining clutter free environments within clinic and communal spaces.
- Hand hygiene audits are being undertaken across the organisation and the light box and dye are utilised to good effect.

5.7 Clinical compulsory training continues to take place for those staff who are required to attend, as identified as part of the training framework, and administrated via the training passport system. Compliance is monitored via the Physical Health Care and Infection Control Committee at a strategic level, and attendance is managed by each of the Divisions.

Infection Control Level 1 – 91.72%
Infection Control Level 2 - 87.40%

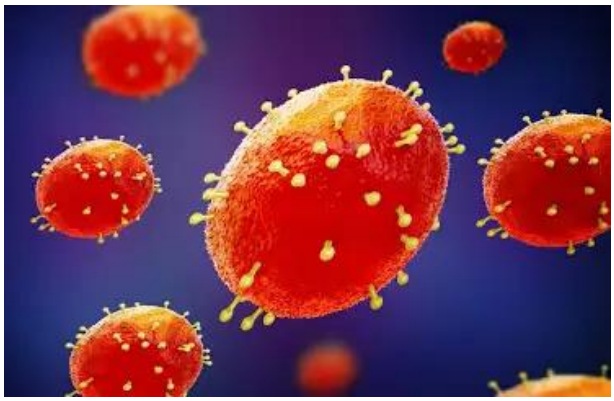
5.8 An influenza vaccination campaign was delivered for staff and patients who met the criteria.

5.9 Hotel services continue to provide assurance on key service delivery areas, such as food hygiene, pest control, laundry and linen supplies, and the duty of care audits required under the NHS Waste Management regulations. A full review of the laundry contract has taken place as a joint venture, with a single provider in place. The kitchens at Kingsway and Radbourne sites have had had environmental health inspections and were once again awarded 5-star ratings by Derby City Council. This is a very public method of demonstrating quality, as it is used across all food preparation establishments. We continue to gain additional assurance by using an independent Environmental Health officer to undertake inspections and guidance, as well as the local authority inspections.

5.10 Estates continue to provide a monitoring system and maintenance programme to maintain safe water quality. Focussed work in ensuring proactive flushing records are maintained have been a recent focus of the Estates planned, proactive management. A water safety group is established with focussed prevention of Legionella and other issues with portable water such as Pseudomonas.

5.11 Risks relating to infection control are recorded on the DATIX risk register against each Ward/Team in line with the Risk Assessment Policy and Procedures. This identifies several 'required' risk assessments that wards/teams must complete and review at least annually.

6.0 Emerging Diseases

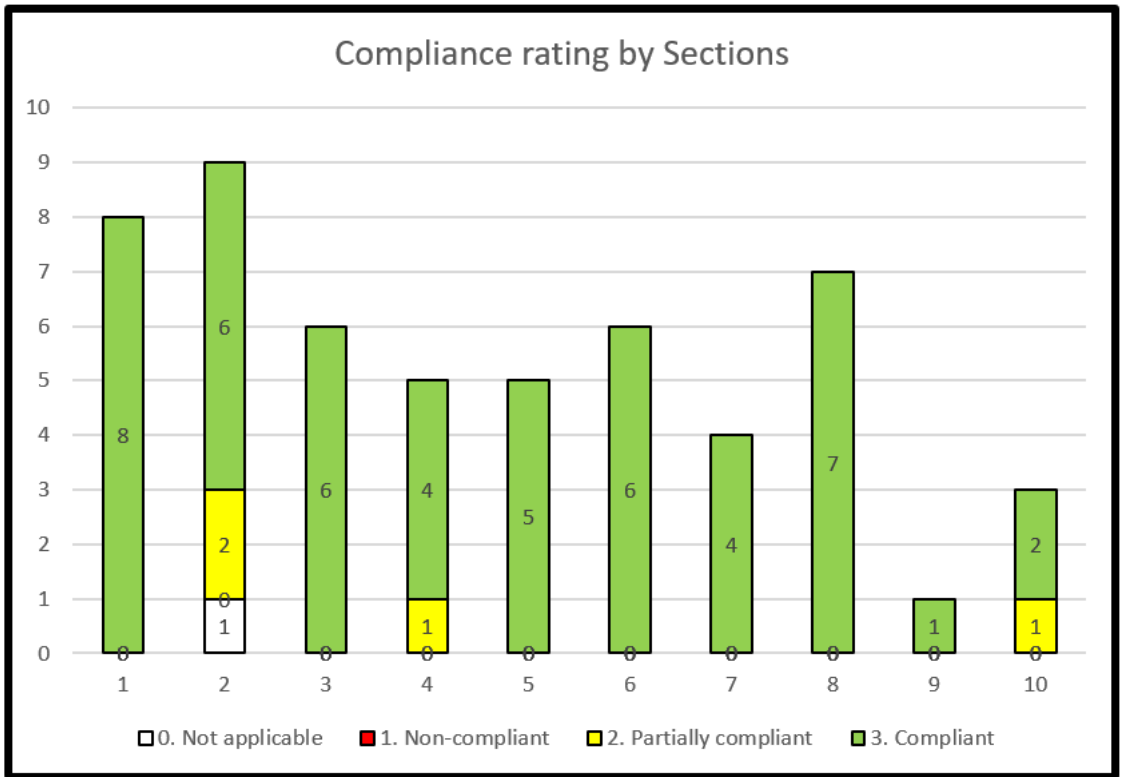


6.1 Post pandemic infectious disease surveillance in the UK has remained high. There have been regular meetings throughout the last year focussed upon the seasonal impact of respiratory illness as we have seen cases of Flu, COVID, CSV surge during winter 2023 and spring 2024.

6.2 Mpox Clade 1 is being monitored as an HCID of concern and this is an extension of work undertaken when case rates of Mpox Clade 2 increased during late Summer / Autumn 2023. Measles and Pertussis have also seen increased case rates in recent years. Flu remains a significant concern in the UK alongside other respiratory infections.

6.3 The Trust alongside other regional providers have evolved their Emergency Preparedness Response Plans in anticipation of future surges in infection. This is increasing as post-pandemic negativity towards vaccination programmes and a widening belief that they are not effective amongst society is reducing the resilience and safety net built up over years of previously wide reaching and successful vaccination programmes. The decline in vaccination uptake is a concern being explored across the health and social care community as it has significant patient safety implications.

6.4 The organisation has updated its Board Assurance Framework (BAF) (see attachment).



Areas of partial compliance (Numbers are linked to BAF reference see attached document.)

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.

Partial compliance – recent audits have highlighted gaps in frequency of checks.

Action – Estates and facilities monitoring for improvement.

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.*

Partial Compliance - Incidents of incorrectly labelled / stored food items have been reported within last 12 months.

Action – Increased frequency of checks and reminders / notices to colleagues.

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 (e.g. 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.

Partial compliance - HCID PPE requirements are being explored across MH providers to identify most appropriate / proportionate approach.

Action – Ongoing review of guidance and conversation with NHSE and other providers.

10.3 Staff have had the required health checks, immunisations and clearance undertaken by a competent advisor (including those undertaking exposure prone procedures (EPPs).

Partial compliance - MMR checks identified a number of colleagues within the organisation who have not got confirmed vaccinations status.

Action - Work is underway with OH colleagues to support bespoke clinics to address and clarify position. Wider HRD conversations happening at system level as this is also a workforce and OD challenge as increasing numbers of staff are not willing to be vaccinated for MMR, Hep B/C.

7.0 Next steps and priorities

7.1 The organisation continues to place prevention of infection, along with prevention of harm, as a central feature of clinical service delivery. A focus on continuing to equip the workforce is pivotal to this. The delivery of a compulsory training requirement means that staff are equipped to deliver care in a way that prevents the spread of infection and provides them with the clinical leadership to seek advice where required. Audit and ownership of the results by clinical teams through the infection control leads is a key part to improve safety and encourage curiosity.

7.2 Continued focus on strong, visible clinical leadership will continue to see practice at the highest standards, with staff empowered to seek advice and support where needed. Strong leadership also brings consistency of standards.

7.3 Continued commitment in capital expenditure on the Estate will ensure that environmental risk is kept to a minimum (for example on-going replacement schedule for furnishings), upgrade of ward and community facilities reduces the risk of poor environment and enhances patient experience. Work is underway and requires continued commitment to support safe practice. Monitoring of external contracted services ensures the highest standards are achieved on our behalf. This is an important aspect of quality assurance.

7.4 On-going support for the delivery of high standards of hotel services, and specialist infection control advice when needed.

7.5 Commitment to working with other providers, to ensure we play our part as a healthy economy in reducing the burden of healthcare associated infections, such as CPE, Norovirus, Clostrioides *difficile* and MRSA. In addition, we are engaged with other providers across Derbyshire and the region in improving these approaches.

7.6 A continued commitment to the provision of high standards of cleanliness in our premises with the ability to have highly trained and flexible staff helps us meet clinical need.

7.7 Increasing the number of IPC link workers to support the opening of new hospital environments to support the Making Room for Dignity work schedule.

7.8 Continue to develop vaccination programme work as a key public health intervention focussed upon promotion, myth busting and improved confidence and uptake. This is across all our service user cohorts.

8.0 Potential risks in delivery

8.1 Organisational capacity amidst increasing financial pressure and challenges to balance resource distribution, for the delivery of the IPC programme and capacity to be responsive to preparedness requirements for Winter planning, Vaccination work, Health promotion, IPC reviews and site visits and preparedness for new and emerging diseases.

8.2 The uptake of both the COVID and influenza vaccination by staff should be considered as a key protective and public health responsibility of the organisation and requires continued support to improve uptake.

8.3 Continued operational support to achieve compliance with compulsory training.

8.4 Any impact on ability to deliver cleaning services to the current high standard in the inpatient areas and clinical bases would have an impact on existing infection control standards.

8.5 The organisation needs to ensure that we maintain monitoring of externally provided contracts, such as laundry, cleaning (North County units), pest control and maintenance to ensure that that standards are not allowed to slip in extremely challenging operating environments.

8.6 The organisation needs to remain focussed that Hotel Services remain equipped to be able to continue to maintain the high standards of cleanliness we currently achieve.

8.7 The organisation needs to maintain support for the statutory standards groups and water safety programmes as these are a significant safeguard for both patient safety and operational sustainability.

Richard Morrow – Assistant Director of Public and Physical Health
11 October 2024.

FORWARD PLAN - BOARD - 2024/25		07-May-2024	02-Jul-2024	01-Oct-2024	05-Nov-2024	14-Jan-2025	04-Mar-2025
	Deadline for Approved Papers	**25-Apr-2024**	**21-Jun-2024**	**18-Sep-2024**	**24-Oct-2024**	**02-Jan-2025**	**20-Feb-2025**
DOCA/TS	Declarations of Interest	X	X	X	X	X	X
DON	Patient/Staff Story	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
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							
DCEO/CDO	Trust Strategy Progress update (on approval, launch Nov-2024)	X		X	X	X	X
DPODI	Staff Survey Results (following assurance at People and Culture Committee)						X
DPODI	Annual Gender Pay Gap Report for approval (following assurance at People and Culture Committee)	X					
DPODI	Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) *request for Board delegated authority for People and Culture Committee meeting Sep to approve the October submissions*			X			
DPODI	Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) Strategic implications/retrospective sign off after PCC Sep			X			
MD	Patient and Carers Race Equality Framework					X	
DPODI	Annual Approval of Modern Slavery Statement (following assurance at People and Culture Committee Mar - to be published on Trust website on approval)	X					
DPODI	2024/25 Flu Campaign	Summary of 2023/24 campaign		X			
DOCA/TS	Corporate Governance Report	X					
DOCA/TS	Year-end Governance Reporting from Board Committees and Approval of ToRs (within Corp Gov report)	X					
DOCA/TS	Trust Sealings (six monthly - for information - also within May Corp Gov report)	X			X		
DOCA/TS	Annual Review of Register of Interests	X					
DOCA/TS	Board Assurance Framework Update	X		X	X		X
FTSUG	Freedom to Speak Up Guardian Report (six monthly)			X			X
CHAIR	Fit and Proper Person Declaration		X				
DOF/DCEO/CDO/ DPODI	Planning Update	X (Finances)		X (Ops)			
Committee Chairs	Board Committee Assurance Summaries	X	X	X	X	X	X
DoF	Standing Financial Instructions (following assurance at ARC)			X			
OPERATIONAL PERFORMANCE							
DCEO/CDO/DON/ DOF/DPODI	Integrated Performance and Activity Report to include Finance, People performance and Quality	X	X	X		X	X
DCEO/CDO/DON	Focused Performance Report (in lieu of Integrated Performance and Activity Report)				X		
DCEO/CDO	ICB Joint Forward Plan (included in CEO Update)			Deferred to Jan-2025		X	
CEO	East Midlands Collaborative					X	
DCEO/CDO	Emergency Preparedness, Resilience and Response (EPRR) Core Standards			X			
Prog Director	Making Room for Dignity progress	X			Included with CEO's update		
DON/MD	Safer Staffing Annual Review (following assurance at QSC Jul)			X			
DPODI	Workforce Plan Annual Review (following assurance at PCC Jul)			X			
QUALITY GOVERNANCE							
DON	Fundamental Standards Report					X	
MD	Learning from Deaths Mortality Report on Assurance from Quality and Safeguarding Committee		AR		X	X	X
MD	Guardian of Safe Working Report on Assurance from Quality and Safeguarding Committee		AR		X	X	
MD	Improving the Working Lives of Doctors in Training		X				
DON	Receipt of Annual Reports on Assurance from Quality and Safeguarding Committee: - Annual Looked After Children (QSC Sep) - Annual Safeguarding Children and Adults at Risk (QSC Sep) - Annual Special Educational Needs and Disabilities (SEND) (QSC May/Jun) - Quality Account (Jul)		X		X		
DCEO/CDO	Continuous Quality Improvement: A Stocktake						X
DON	Infection Prevention and Control Annual Report and IPC BAF (QSC Oct)				AR		
MD	Re-validation of Doctors Compliance Statement (PCC May)		X				
DON	Outcome of Patient Stories - every two years - due Mar-2026						
POLICY REVIEW							
DOF	Standing Financial Instructions Policy and Procedures (Jul 2024)		Deferred to Oct-2024	X			

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
A	
A&E	Accident & Emergency
ACCT	Assessment, Care in Custody & Teamwork
ACE	Adverse Childhood Experiences
AC/RC	Approved Clinician/Responsible Clinician
ADHD	Attention Deficit Hyperactivity Disorder
ADI-R	Autism Diagnostic Interview-Revised
ADOS	Autism Diagnostic Observation Schedule (assessment)
AfC	Agenda for Change
AHP	Allied Health Professional
AI	Artificial Intelligence
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
AOVPN	AlwaysOn VPD (secure network access)
ASD	Autism Spectrum Disorder
ASM	Area Service Manager
ATR	Alcohol Treatment Requirement
ATU	Acute Treatment Unit
B	
BAF	Board Assurance Framework
BCP	Business Continuity Plan
BLS	Basic Life Support (ILS Immediate Life Support)
BMA	British Medical Association
BAME	Black, Asian and Minority Ethnic
BME	Black and Minority Ethnic group
BoD	Board of Directors
BPD	Borderline Personality Disorder
BPPC	Better Payment Practice Code
C	
CAMHS	Child and Adolescent Mental Health Services
CASSH	Care and Support Specialised Housing
CBT	Cognitive Behavioural Therapy
CBRN	Chemical, Biological, Radiological and Nuclear
CCG	Clinical Commissioning Group (defunct from 1 July 2022)
CCT	Community Care Team
CDEL	Capital Departmental Expenditure Limit
CD-LIN	Controlled Drug Local Intelligence Network
CDMI	Clinical Digital Maturity Index
CE	Chief Executive
CEO	Chief Executive Officer
CESR	Certificate of Eligibility for Specialist Registration
CGA	Comprehensive Geriatric Assessment
CHPPD	Care Hours Per Patient Day
CIN	Children in Need
CIP	Cost Improvement Programme

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
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
CP	Child Protection
CPA	Care Programme Approach
CPD	Continuing Professional Development
CPN	Community Psychiatric Nurse
CPR	Child Protection Register
CPRG	Clinical Professional Reference Group
CQC	Care Quality Commission
CQI	Clinical Quality Indicator
CQRG	Care Quality Review Group
CQUIN	Commissioning for Quality and Innovation
CRD	Clinically Ready for Discharge
CRG	Clinical Reference Group
CRH	Chesterfield Royal Hospital
CRHT	Crisis Resolution and Home Treatment
CROMS	Clinician Reported Outcome Measures
CRR	Case Record Reviews
CRS	(NHS) Care Records Service
CRS	Commissioner Requested Services
CSDS	Community Services Data Set
CSF	Commissioner Sustainability Fund
CSPR	Child Safeguarding Practice Review
CTO	Community Treatment Order
CTR	Care and Treatment Review
CYP	Children and Young People
D	
DAR	Divisional Assurance Review
DASP	Drug and Alcohol Strategic Partnership
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
DHR	Domestic Homicide Review
DISCO	Diagnostic Interview for Social and Communication Disorders (assessment)
DIT	Dynamic Interpersonal Therapy
DME	Director of Medical Education
DNA	Did Not Attend
DoC	Duty of Candour
DOF	Director of Finance
DoH	Department of Health

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
DOL	Deprivation of Liberty
DoLS	Deprivation of Liberty Safeguards
DON	Director of Nursing
DPA	Data Protection Act
DPI	Director of People and Inclusion
DPR	Divisional Performance Review
DPS	Date Protection and Security
DQMR	Data Quality Maturity Index
DRR	Drug Rehabilitation Requirement
DRRT	Dementia Rapid Response Team
DSAB	Derby and Derbyshire Safeguarding Adult Board
DSP	Data Security and Protection
DSCB	Derby and Derbyshire Safeguarding children Board
DSPT	Director of Strategy, Partnerships and Transformation
DTOC	Delayed Transfer of Care
DVA	Derbyshire Voluntary Action (formerly North Derbyshire Voluntary Action)
DWP	Department for Work and Pensions
E	
EbE	Expert by Experience
ECT	Enhanced Care Team
ECW	Enhanced Care Ward
ED	Emergency Department
EDS2	Equality Delivery System 2
EHCP	Education, Health and Care Plan
EHIC	European Health Insurance Card
EHR	Electronic Health Record
EI	Early Intervention
EIA	Equality Impact Assessment
EIP	Early Intervention In Psychosis
ELT	Executive Leadership Team
EMDR	Eye Movement Desensitising and Reprocessing Therapy
EMR	Electronic Medical Record
EPMA	Electronic Prescribing and Medicine Administration
ePMO	Electronic Programme Management Office
EPR	Electronic Patient Record
EPRR	Emergency Preparedness, Resilience and Response
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

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
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
GMP	Guaranteed Maximum Price
GP	General Practitioner
GPFV	General Practice Forward View
H	
HCA	Healthcare Assistant
HCP	Healthy Child Programme
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
HFMA	Healthcare Financial Management Association
HoNOS	Health of the Nation Outcome Scores
HoP	Head of Practice
HOPE(s)	The HOPE(s) model is an ambitious human rights-based approach to working with individuals in segregation, developed from research and clinical practice
HSCIC	Health and Social Care Information Centre
HSE	Health and Safety Executive
HV	Health Visitor
HWB	Health and Wellbeing Board
I	
IAPT	Improving Access to Psychological Therapies
Icare	Increase Confidence, Attract, Retain, Educate
ICB	Integrated Care Board
iCIMS	Internet Collaborative Information Management System
ICM	Insertable Cardiac Monitor
ICO	Information Commissioner's Office
ICS	Integrated Care System
ICT	Information and Communication Technology
ICU	Intensive Care Unit
IDVAs	Independent Domestic Violence Advisors
IFRS	International Financial Reporting Standards
IG	Information Governance
ILS	Immediate Life Support (BLS – Basic Life Support)
IMT	Incident Management Team
IMT&R	Information Management, Technology and Records
INQUEST	
IPP	Imprisonment for Public Protection
IPR	Integrated Performance Report
IPS	Individual Placement and Support
IPT	Interpersonal Psychotherapy
IRHTT	In-reach Home Treatment Team
IRT	Incident Review Tool
J	
JCVI	Joint Committee on Vaccination and Immunisation
JDF	Junior Doctor Forum

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
JLNC	Joint Local Negotiating Committee
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
LAC	Looked After Children
LCFS	Local Counter Fraud Specialist
LA – CYPD	Local Authority – Children and Young People Divisions
LADO	Local Authority Designated Officer
LD	Learning Disabilities
LD/A	Learning Disability and Autism
LeDeR	Learning Disabilities Mortality Review
LFPSE	Learn from Patient Safety Events
LHP	Local Health Plan
LHRP	Local Health Resilience Partnership
LHWB	Local Health and Wellbeing Board
LNC	Local Negotiating Committee
LOS	Length of Stay
LPS	Liberty Protection Safeguards
LTP	Long Term Plan
LTS	Long Term Segregation
LWSTO	Living Well Short-Term Offer
M	
MADE	Multi-agency Discharge Event
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
MARS	Mutually Agreed Resignation Scheme
MAS	Memory Assessment Service
MASH	Multi-Agency Safeguarding Hub
MAST	Management and Supervision Tool
MAU	Medical Assessment Unit
MBU	Mother and Baby Unit
MCA	Mental Capacity Act
MD	Medical Director
MDA	Medical Device Alert
MDM	Multi-Disciplinary Meeting
MDT	Multi-Disciplinary Team
MFA	Multi-Factor Authentication
MFF	Market Forces Factor
MHA	Mental Health Act
MHAC	Mental Health Act Committee

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
MHIN	Mental Health Intelligence Network
MHIS	Mental Health Investment Standard
MHLT	Mental Health Liaison Team
MHOST	Mental Health Optimal Staffing Tool
MHRA	Medical and Healthcare products Regulatory Agency
MHRT	Mental Health Review Tribunal
MHSDS	Mental Health Services Data Set
MMC	Medicines Management Committee
MoU	Memorandum of Understanding
MPAC	Multi-Professional Approved Clinician
MSC	Medical Staff Committee
MSK	Musculoskeletal (conditions)
MSP	Medicines Safety and Practice
MST	Multisystemic Therapy
MSU	Medium Secure Unit
N	
NCRS	National Cancer Registration Service
ND	Neuro-development
NED	Non-Executive Director
NETS	National Educational Training Survey
NHS	National Health Service
NHSCFA	NHS Counter Fraud Authority
NHSE	National Health Service England
NHSI	National Health Service Improvement
NHSEI	NHS England and NHS Improvement
NICE	National Institute for Health and Care Excellence
NIHR	National Institute for Health Research
NIMS	National Incident Management System
NIVS	National Immunisation and Vaccination System
NPS	National Probation Service
NQB	National Quality Board
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

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
PFI	Private Finance Initiative
PFF	Probation Feedback Form
PHC	Public Health Commissioners
PHCIC	Physical Healthcare and Infection Control Committee
PHE	Public Health England
PICU	Psychiatric Intensive Care Unit
PID	Project Initiation Document
PiPoT	Persons in a Position of Trust
PLACE	Patient-Led Assessments of the Care Environment
PLIC	Patient Level Information Costs
PMF	Performance Management Framework
PMH	Perinatal Mental Health
PMLD	Profound and Multiple Disability
PPE	Personal Protection Equipment
PPI	Patient and Public Involvement
PPT	Partnership and Pathway Team
PQN	Perinatal Quality Network
PREM	Patient Reported Experience Measure
PROMS	Patient Reported Outcome Measures
PSF	Provider Sustainability Fund
PSII	Patient Safety Incident Investigations
PSIRF	Patient Safety Incident Review Framework
PSQG	Patient Safety and Quality Group
Q	
QAG	Quality Assurance Group
QASI	Quality Assurance Serious Incidents
Q&SC	Quality and Safeguarding Committee
QEIA	Quality and Equality Impact Assessment
QIA	Quality Impact Assessment
QIPP	Quality, Innovation, Productivity Programme
R	
RAID	Rapid Assessment, Interface and Discharge
RAP	Recovery Action Plan
RCGP	Royal College of General Practitioners
RCI	Reference Cost Index
REGARDS	Race, Economic disadvantage, Gender, Age, Religion or belief, Disability and Sexual orientation
ReQoL	Recovering Quality of Life
ROM	Reported Outcome Measure
RRP	Recruitment Retention Proposal
RTT	Referral to Treatment
S	
s132	Section 132 of the Mental Health Act: As soon as a patient is detained under the Act the patient must be given their rights orally and in writing unless it is not practicable at that time. If this is the case, it must be documented in the patient's electronic care record
s136	Section 136 of the Mental Health Act: Police can use emergency powers if they think you have a mental disorder, you're in a public place and need immediate help. They can take you or keep you in a place of safety, where your mental health will be assessed.
SAAF	Safeguarding Adults Assurance Framework

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
SAR	Safeguarding Adult Review
SAS Doctor	Specialist, Associate Specialist and Specialty Doctor
SBARD	Situation, Background, Assessment, Recommendation and Decision (SBARD) tool
SBS	Shared Business Services
SCPHN	Specialist Community Public Health Nurse
SEND	Special Educational Needs and Disabilities
SFI	Standing Financial Instructions
SI	Serious Incidents
SIG	Serious Incident Group
SID	Senior Independent Director
SIDS	Sudden Infant Death Syndrome
SIRI	Serious Incident Requiring Investigation
SLA	Service Level Agreement
SLaM	South London and Maudsley NHS Trust
SLR	Service Line Reporting
SMI	Severe Mental Illness
SNOMED CT	Systemised Nomenclature of Medicine – Clinical Terms
SOC	Strategic Options Case
SOF	Single Operating Framework
SOP	Standard Operating Procedure
SPOA or SPA	Single Point of Access
SPOE	Single Point of Entry
SPOR	Single Point of Referral
SSQD	Specialised Services Quality Dashboards
STEIS	Strategic Executive Information System
STF	Sustainability and Transformation Fund
STOMP/STAMP	Stopping The Over-Medication of children and young People with a learning disability, autism or both / Supporting Treatment and Appropriate Medication in Paediatrics
STP	Sustainability and Transformation Partnership
SUI	Serious (Untoward) Incident
SW	Social Worker
SystmOne	Electronic patient record system
T	
TAV	Team Around the Family
TARN	Trauma Audit and Research Network
TCP	Transforming Care Partnerships
TCS	Transforming Community Services
TDA	Trust Development Authority
TIC	Trauma Informed Care
TLT	Trust Leadership Team
TMAC	Trust Medical Advisory Committee (now Medical Senate)
TMT	Trust Management Team
TMTC	Trust Medical Training Committee
TOIL	Time Off In Lieu
TOOL	Trust Operational Oversight Leadership
TUPE	Transfer of Undertakings (Protection of Employment) Regulations 1981
U	
UHDB	University Hospitals of Derby and Burton
UEC	Urgent and Emergency Care
V	

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
VARM	Vulnerable Adult Risk Management
VCOD	Vaccination as a Condition of Deployment
VFM	Value For Money
VO	Vertical Observatory
VTE	Venous Thromboembolism
W	
WDES	Workforce Disability Equality Standard
WRES	Workforce Race Equality Standard
WTE	Whole Time Equivalent
Y	
YTD	Year to Date

October 2024