Derbyshire Healthcare NHS Foundation Trust
Virtual meeting of the Board of Directors
held in pubic

To be held digitally via MS Teams
3 November 2020 09:30 - 3 November 2020 12:45

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NOTICE OF A VIRTUAL PUBLIC BOARD MEETING – TUESDAY 3 NOVEMBER 2020
TO COMMENCE AT 9:30am
Following national guidance on keeping people safe during COVID-19 this will be a virtual meeting conducted digitally via Microsoft Teams technology

	TIME	AGENDA	LED BY
1.	9:30	Chair's welcome, opening remarks and apologies, declarations of interest	Caroline Maley
2.		Patient Story – Individual Placement and Support	Carolyn Green
3.		Minutes of Board of Directors meeting held on 1 September 2020	Caroline Maley
4.		Matters arising – Actions Matrix	Caroline Maley
5.		Questions from governors or members of the public	Caroline Maley
6.	10:00	Chair's Update	Caroline Maley
7.	10:05	Chief Executive's Update and Strategy Refresh	Ifti Majid
STRATEGY AND OPERATIONAL PERFORMANCE			
8.	10:35	Integrated Performance and Activity Report	C Wright / J Lowe / C Green / M Powell
9.	10:50	Flu/COVID-19 Vaccination Programme update	Jaki Lowe
B R E A K			
QUALITY ASSURANCE			
10.	11:10	Annual Revalidation of Doctors – verbal update	John Sykes
11.	11:15	Learning from Deaths Mortality Report	John Sykes
12.	11:25	Guardian of Safe Working Report	John Sykes
13.	11:35	Quality and Safeguarding Committee assurance: - Safeguarding Children and Adults at Risk Annual Report - Derby City Children in Care Annual Report - Infection Control Annual Report	Carolyn Green
GOVERNANCE			
14.	11:45	Quality Report / Quality Account for 2019/20	Carolyn Green
15.	11:50	Month 7-12 2020/21 Financial Plan	Claire Wright
16.	12:00	Strategic implications of the outcomes of the 2019-20 WRES and WDES	Jaki Lowe assisted by Clare Meredith
17.	12:15	Board Assurance Framework - Issue 3	Justine Fitzjohn
18.	12:25	Board Committee Assurance Summaries: Mental Health Act 11 September, Quality and Safeguarding 8 September and 13 October, People and Culture 22 September, Finance and Performance 30 September, Audit and Risk 1 October 2020	Committee Chairs/ Justine Fitzjohn
CLOSING MATTERS			
19.	12:40	- Identification of any issues arising from the meeting for inclusion or updating in the Board Assurance Framework - Meeting effectiveness	Caroline Maley
FOR INFORMATION			
Register of Trust Sealings Summary Report from the Council of Governors meeting held 1 September 2020 Glossary of NHS Acronyms 2020/21 Forward Plan			

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

The next meeting will be held at 9.30am on 13 January 2021. It is anticipated that this meeting will be held digitally via MS Teams
Users of the Trust's services and other members of the public are welcome to attend the meetings of the Board.
Participation in meetings is at the Chair's discretion

Our vision

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

Our values

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

Our Trust values are:

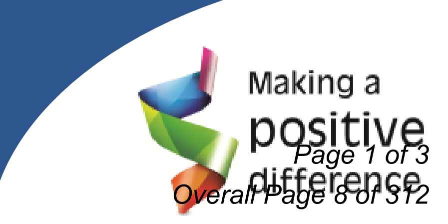
People first – We focus on our colleagues, in the knowledge that a well-supported, engaged and empowered workforce results in good patient care.
Respect – We respect and value the diversity of our patients, colleagues and partners and support a respectful and inclusive environment.
Honesty – We are open and transparent in all we do.
Do your best – We work closely with our partners to achieve the best possible outcomes for people.

DECLARATION OF INTERESTS REGISTER 2020/21		
NAME	**INTEREST DISCLOSED**	**TYPE**
Margaret Gildea Non-Executive Director	• Director, Organisation Change Solutions Limited (mentoring client from First Steps (Eating Disorders) as part of Organisation Change Solutions)	(a, b) (a)
Gareth Harry Director of Director of Business Improvement and Transformation	• Chair, Marehay Cricket Club • Member of the Labour Party • Mother is a member of Amber Valley Borough Council	(d) (e) (c, e)
Ashiedu Joel Non-Executive Director	• Trustee at The Bridge (East Midlands) in Loughborough • Director/Owner Ashioma Consults Ltd • Director/Co-owner Peter Joel & Associates Ltd	(a)
Geoff Lewins Non-Executive Director	• Director, Arkwright Society Ltd	(a)
Jaki Lowe Director of People and Inclusion	• General Medical Council Associate	(e)
Ifti Majid Chief Executive	• Board Member NHS Confederation Mental Health Network • Kate Majid (spouse) is Operations Director (North), Priory Group	(e) (a, e)
Mark Powell Chief Operating Officer	• Chair of Governors, Brookfield Primary School, Mickleover, Derby	(e)
Dr Julia Tabreham Non-Executive Director	• Director of Research and Ambassador Carers Federation	(a)
Dr John Sykes Medical Director	• Undertakes paid assessments of patients at the request of the local authorities under the Mental Health Act and Mental Capacity Act and acts likewise for solicitors representing patients	(e)
Richard Wright Deputy Trust Chair and Non-Executive Director	• Chair Sheffield UTC Multi Academy Trust • Board Member, National Centre of Sport and Exercise Medicine Sheffield • Member of the Advisory Panel, Sheffield Hallam Business School • Chair, System Finance Oversight Group, Joined Up Care Derbyshire (JUCD)	(a) (a) (d)

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

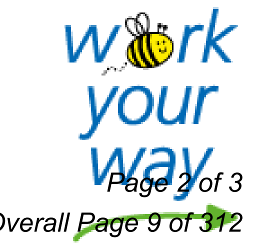
(a) Directorships, including non-executive directorships held in private companies or PLCs (with the exception of those dormant companies).
(b) Ownership or part ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS.
(c) Majority or controlling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

Work Your Way



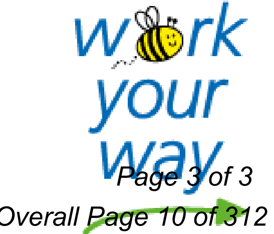
Work Your Way

- DHCFT's employment support service for people with severe mental health difficulties to gain paid work
- Internationally known as IPS (Individual Placement and Support)
- Launched on Thursday 12 March then paused for 3 months a week later
- Areas covered Bolsover and Clay Cross, Erewash, Amber Valley and Derby City. Partnership working with South Yorkshire Housing Association (SYHA) in Killamarsh and Chesterfield
- Non-clinical staff embedded into CMHT's
- Expansion of IPS as part of the NHS long term plan



Work Your Way

- Currently working with 95 clients (not including South Yorkshire Housing Association caseload)
- 12 people now in their dream job:
  - IT technician
  - delivery driver
  - gardener, painter
  - administrator
  - hairdresser
  - cleaner
- 7 clients in work have sustained 13 weeks +
- Client story



MINUTES OF A LIVE STREAMED

MEETING OF THE BOARD OF DIRECTORS

TUESDAY 1 SEPTEMBER 2020

MEETING LIVE STREAMED VIA MS LIVE EVENTS	
Commenced: 9.30am	Closed: 11.40pm

PRESENT	Caroline Maley	Trust Chair
	Richard Wright	Deputy Trust Chair and Non-Executive Director
	Margaret Gildea	Senior Independent Director and Non-Executive Director
	Ashiedu Joel	Non-Executive Director
	Geoff Lewins	Non-Executive Director
	Dr Sheila Newport	Non-Executive Director
	Ifti Majid	Chief Executive
	Claire Wright	Deputy Chief Executive & Director of Finance
	Mark Powell	Chief Operating Officer
	Carolyn Green	Director of Nursing & Patient Experience
	Gareth Harry	Director of Business Improvement & Transformation
	Jaki Lowe	Director of People and Inclusion
	Justine Fitzjohn	Trust Secretary
IN ATTENDANCE	Anna Shaw	Deputy Director of Communications & Involvement
	Sue Turner	Board Secretary
For DHCFT2020/078	Tamera Howard	Freedom to Speak Up Guardian
OBSERVERS	Governors, members of staff, the public via live streaming:	
	Lynda Langley	Public Governor, Chesterfield and Lead Governor
	Cllr Jim Perkins	Appointed Governor, Derbyshire County Council
	Valerie Broom	Public Governor, Amber Valley
	Andrew Beaumont	Public Governor, Erewash
	Susan Ryan	Public Governor, Amber Valley
	Rachel Leyland	Deputy Finance Director
	Susan Spray	People Services Programme Lead
	Barbara Chilvers	Programme Office
	Heather Key	Team Administrator
	Rubina Reza	Research and Clinical Audit Manager
	Sue Harrison	Observer
	Heather Key	Team Administrator

DHCFT 2020/068	**CHAIR'S WELCOME, OPENING REMARKS, APOLOGIES FOR ABSENCE AND DECLARATION OF INTERESTS** Due to the need for social distancing to help limit the spread of COVID-19, this was a virtual live streamed meeting, held via MS Live Events. The Trust Chair, Caroline Maley, welcomed the Trust's Lead Governor, other Governors and members of staff to the meeting, including those members of the public observing via live streaming. A warm welcome was extended to Jaki Lowe who has joined the Trust as the Director of People and Inclusion who Caroline looks forward to working with on the important programme for inclusion and the Trust's people strategy. Caroline gave thanks to all staff working during the pandemic and stressed how very proud of how the Trust has responded to the pandemic. She hoped that everyone involved in today's meeting had an opportunity over the summer months to have some time off to refresh take care of themselves, their families. This included all staff caring for service users and patients who have been working in the most challenging of times. No declarations of interest declared, other than those already recorded on the formal register of Directors' interests.
DHCFT 2020/069	**MINUTES OF THE BOARD OF DIRECTORS MEETING HELD ON 7 JULY 2020** The minutes of the previous meeting, held on 7 July 2020, were accepted as a correct record of the meeting.
DHCFT 2020/070	**ACTIONS MATRIX** The Board agreed to close all completed actions. Updates were provided by members of the Board and noted on the actions matrix. All completed actions were scrutinised to ensure that they were fully complete.
DHCFT 2020/071	**QUESTIONS FROM GOVERNORS OR MEMBERS OF THE PUBLIC** None received.
DHCFT 2020/072	**CHAIR'S UPDATE** Caroline's report provided the Board with reflections on her activity in terms of her role as Trust Chair since the previous Board meeting held on 7 July. The report outlined virtual engagement with colleagues during the ongoing pandemic. Caroline drew attention to the recent South Asian History month and reported on the events she attended to mark this celebration of cultures that were intertwined with histories of the UK. Of particular note was the event hosted by the Royal College of Psychiatrists on current and future challenges that was chaired by Subodh Dave, Teaching Fellow and Adult Consultant Psychiatrist from our Trust. Caroline also referred to stories that were told during the "Chat and Chai" she attended with Trust colleagues where she gained an insight into the origins of a number of staff. Caroline emphasised the importance of learning from their experiences of being in this country and the discrimination that they or their families have experienced. She urged the Board to ensure that the Trust focuses on inequalities and to make changes in how the organisation operates to remove inequalities in every aspect of its services. It is more important than ever to be inclusive and aim to live up to the Trust's vision to make a positive difference to the health and wellbeing of everyone in its communities. Attention was also drawn to the notes from the Joined up Care Derbyshire (JUCD) meeting held on 16 July.

	RESOLVED: The Board of Directors noted the content of the Chair's update.
DHCFT 2020/073	**<u>CHIEF EXECUTIVE'S REPORT</u>** This report provided the Board of Directors with feedback on changes within the national health and social care sector, and an update on developments occurring within the local Derbyshire health and social care community.as influenced by the NHS response to the pandemic, and how to learn lessons from the response. The report also updated the Board on feedback from external stakeholders and feedback from staff. **National Context** Ifti focused first of all on the letter received from Simon Stevens, NHS CEO and Amanda Pritchard, NHS Chief Operating Officer, outlining the next phase (phase 3) response to the COVID Pandemic. The letter outlined the key actions and priorities between now and the end of March 2021 and the need to return to pre-COVID-19 activity and prepare for what is anticipated to be a difficult winter. Ifti clarified that preparation within the Trust will take account of the lessons learned from the changes and innovations developed during the pandemic especially in supporting staff and in terms of health inequalities and prevention for people who use the Trust's services. With regard to lessons learned, the Trust will be strengthening its focus on inequalities. Now that Jaki Lowe has joined the Board, health and inequalities will sit within her portfolio and she will be ably assisted by the rest of the Executive Directors. In terms of how the phase 3 letter will affect the Trust, Ifti's report set out how the letter will impact each service particularly with regard to the priorities about returning to expected seasonal levels of activity. It was noted that the priority of the system and development of an Integrated Care System (ICS) continues to be as important as it was pre-COVID-19. There is no currently signalled legislative change but the drive towards having ICS signing off planning submissions and changes in clinical pathways and strategic direction continues to be the utmost priority as is the need to consider the broader system of Derbyshire and the infrastructure of the social economic system. Ifti highlighted how the people plan is absolutely in tune with the Trust's own direction of travel over the last two years, focussing on the people first culture and having inclusion at its heart. The focus on diversity is quite clear within the Board's agenda as it mirrors the support Caroline's Chair's Update report gives to the people plan, a big part of which describes the national people promise. The Board will progress with the Team Derbyshire promise as it is fully aligned with the national people promise. **Local Context** The last Joined Up Care Derbyshire (JUCD) Board meeting was held online on 16 July. Ifti reported that he expects to see increased activity in JUCD during the COVID response, especially when looking to ensure lessons learned from COVID are used to prepare for the winter pressure as well as enhancing a single approach to improving wellbeing for the Derbyshire population. Ifti formally welcomed Jaki Lowe to the Board. Jaki's portfolio covers People Services and organisational development, inclusion and communication and engagement. As Executive lead of the People and Culture Committee, Jaki will also have oversight of the people plan. The CEO report also provided an update on the Trust's response to COVID-19 in line with national guidance. Ifti commended the way colleagues within the Trust have worked flexibly with passion, drive and a positive "can-do" attitude during the pandemic. Due to colleagues adhering to strict processes the Trust has maintained very good compliance with infection control standards that has kept COVID infections as low as possible. The Trust's COVID-19 risk assessment processes have a safety first approach, for colleagues, both ward based and in the community. Thanks were extended to all colleagues for their

ongoing support.

The Trust is currently undertaking an update of the Trust Strategy to include its response to COVID. More feedback on the strategy will be given at the next Board meeting in November.

Questions from Non-Executive Directors included one from Julia Tabreham who is also the Chair of the People and Culture Committee. She referred to how Ifti had commended staff for keeping services running and asked what feedback was being received. Ifti drew attention to the last section in his report and talked about how proud he was of the live engagement events held over recent weeks especially as they have been very well attended by over 100 colleagues. He has also attended a number of Q&A sessions with the various networks within the Trust. He has listened to colleagues who have told him they are tired and he is supporting people to take breaks. A lot of discussion has taken place on the way the Trust's Estates facility has had to adapt to social distancing and how people can meet. It is clear that the Attend Anywhere system has been extremely successful although there are some people who need to be seen face to face and changes will need to be made to the Trust's estate to do this more effectively.

The Health Risk Assessments and BME Risk Assessments have received good feedback from colleagues. Some people have commented they are worried about privacy regarding these assessments due to the nature of the confidential conversations they generate. The health risk assessments have brought out the importance relationships between colleagues and their managers which is important in understanding individual concerns

Ifti asked Chief Operating Officer, Mark Powell for his opinion on staff relations. Mark responded that it has been a difficult time for people generally. The Trust's response moving to the winter will be challenging as colleagues are tired and it is important to support everyone in terms of their health and wellbeing so that the workforce can be kept safe and healthy. The importance of having good staff relations is one of the principal themes arising from health risk assessment conversations.

Caroline referred to the letter from Sir Simon Stevens, and Amanda Pritchard outlining the next phase (phase 3) of the response to the COVID Pandemic and asked for a summary of how the Trust will respond. Ifti outlined that firstly the Trust will have to comply with current levels of compliance set by NHSI and NHSE and demonstrate the Trust's Long Term Plan, expectations and finance arrangements to support the priorities set out in the letter. Ifti felt confident that the Trust will meet its long term investment requirements despite having to adapt the Trust's estate to maintain 2m distancing between beds which has inevitably reduced bed stock. Keeping people treated in Derbyshire and reducing the number of patients who have to be treated out of area was highlighted as one of the Trust's most significant risks.

Mark felt that the Trust was progressing well with the component parts of delivering the Long Term Plan. He will work through any complications regarding COVID or flu with the workforce so they are fully engaged with development plans.

Director of Nursing and Patient Experience, Carolyn Green added that it was important to maintain a clinical focus. She was conscious that community services have seen areas of particular isolation and higher than expected new referrals have entered the Trust's services. Carolyn emphasised how she will be looking for improved quality of care in service provision, particularly relapse prevention through an expansion of the community framework. The focus will be on medium and long term transformation of clinical services in order to navigate winter pressures.

In response to Non-Executive Director, Geoff Lewins asking when the Trust's recovery plan would be submitted to NHSI and NHSE, it was clarified that the financial draft was sent last week and the first draft recovery plan report will be submitted in three weeks' time.

Deputy Trust Chair, Richard Wright acknowledged the Trust's strong performance in

	responding to COVID emergency measures. Stripping back bureaucracy has been a feature of this and he wondered how governance administration will be treated now that services are returning to pre-COVID levels. Ifti outlined how in order to have sustainable changes there will have to be collaborated changes on the front line. He is in constant contact with leaders of the JUCD which helps decisions to be made as near to local places as possible. Leading up to the pandemic there had been an agreed process for Integrated Care Partnerships. There are now added layers of complexity of governance in the system which is looking to use PLACE (Patient Led Assessments of Care) as the system for assessing the quality of the patient environment, as well as Health and Wellbeing Partnerships to bring treatment into the communities, close where people live which will be the better way forward. Geoff Lewins supported Ifti's comments about wider work across the Derbyshire system and the real engagement that has been happening across the health and wellbeing system to help the most vulnerable people within the Derbyshire community more than before. Director of Business Improvement and Transformation, Gareth Harry referred to the high level of feedback from the recent Pulse Check. He saw this as a positive response to the way the Trust has strengthened communication methods. A significant vote of confidence has also been received from the way the Incident Management Team (IMT) has communicated its response to the pandemic which is a testament to the work of the Board and the wider management team over the last six months. It was noted that recent feedback from the Pulse Check showed over 96% of colleagues continue to feel well informed as a result of the engagement events held during the pandemic. The Board appreciated the feedback received from colleagues and key themes that have emerged during the live engagement events that have taken place during the pandemic and thanked colleagues who have participated and shared their views which have all contributed to the Trust's ongoing lessons learned. Caroline Maley commended the way the Trust has managed communications and involved staff. She drew attention to the request in the People Plan to appoint a Wellbeing Guardian. This is an action that remains outstanding that will be taken forward by the Board. **ACTION: Board to consider the appointment of the Trust's Wellbeing Guardian** **RESOLVED: The Board of Directors scrutinised and supported the action contained in the Chief Executive's report.**
DHCFT 2020/074	**<u>INCLUSION RELATED REPORTING REQUIREMENTS AND LEADERSHIP CHALLENGES</u>** Deputy Chief Executive and Director of Finance, Claire Wright provided an update to the Trust Board summarising progress in line with national reporting requirements on a range of inclusion priorities, particularly those which have been highlighted or made more pronounced by COVID-19. Claire took the Board through the individual documents summarised in the report while noting the Regional NHSIE letter's relevance and importance to the organisation's workforce and patients and families the Trust provides support for which are described in People Plan for 2020/21. The 'CO617' - WRES briefing for Board and COVID-19 Emergency Preparedness, Resilience and Response (EPRR) membership document also had broad links to the Trust Strategy which is currently undergoing review to align it more closely to COVID-19 emergency preparation and preparedness. The Board considered how the diversity advisory groups and the involvement of BAME, Disability and Wellness and LGBT+ networks are involved in COVID-19 and wider decision-making. Inclusion has always been a high priority for the Trust and the report will support further targeted actions. It was acknowledged that lessons learned throughout the pandemic will enable better understanding of representation which will produce positive aspects to build on that will result in wider changes.

	Julia Tabreham was pleased to see there is an appetite for important representation from BME colleagues in decision making in the Trust and questioned how this can happen more effectively and whether the different networks will be involved in measuring this and what that success will look like. Claire referred to the conversations that have already taken place within the Trust about intersectionality covering the importance of all communities. Her paper set out the Trust's current position and how the matrix has been sent to BME colleagues to receive their contribution to decision making. These discussions are evolving as more is learnt through the different views within the networks and some very honest and constructive comments have been received which will support decisions about how to take the next steps. Now that Jaki Lowe is in post she can help the Board understand how elements of bureaucracy can be streamlined within the system of governance. Claire assured the Board that the Trust will be able to make these changes by responding to the networks so they can advise on representation in decision making. Non-Executive Director, Ashiedu Joel asked how the Equality Impact Assessment is being used to identify real challenges to inclusion and cultural intelligence and confidence, and how this impacts on intersectionality. Claire assured her that the Equality Impact Assessment is being improved to enable a better understanding of intersectionality rather than individual characteristics in isolation. This is something that will be built on and will be talked more about in the future. Jaki Lowe added that since joining the Trust one of her key objectives will be to establish the new inclusion strategy which will be worked through the People and Culture Committee before it is brought to the Board. Ifti concluded that naturally the BME and LGBT networks for example will challenge intersectionality. He expects intersectionality to drive the Trust's values and the people first culture. Working to recognise intersectionality requires us to focus on individuals, not cohorts. Non-Executive Director, Sheila Newport observed that Claire's paper mentioned the wider system collaborating to address health inequalities. She wondered if JUCD and the Sustainability and Transformation Partnership (STP) are collaborating towards opposing inequalities. Claire responded by emphasising the importance of building on population health management. Healthcare intervention in people's wider health and wellbeing is only 20% of the whole impact and preventative conversations will play a significant part in understanding what health inequalities are and what the risks are and what needs to be done differently as part of the national reporting structure and making things better. The Board acknowledged the wide ranging reporting requirements and key inclusion priorities that are such an important part of the inclusion agenda. The Board was mindful that the issues that need responding to are historical and are not driven through COVID-19. The pandemic has provided the right to continue ongoing conversations about health inequalities within the workforce which will be driven within the Trust through the People and Culture Committee. How people can be included in decision making will be taken forwarded through Board Development. **RESOLVED: The Board of Directors:** **1) Noted the wide-ranging reporting requirements and signals on key inclusion priorities** **2) Considered the Trust's current position, future challenges and the strategic direction of travel on key inclusion priorities for the workforce and the communities that the Trust serves.** **3) Decided that inequalities within the workforce will be driven through the People and Culture Committee**
DHCFT 2020/075	**INTEGRATED PERFORMANCE AND ACTIVITY REPORT** This report updated the Board of Directors on the Trust's performance at the end of July 2020. The report focussed on key finance, performance and workforce measures during this extremely challenging period. The Executive Leads for operations, finance, quality and

	workforce drew attention to the key themes. Mark Powell updated the Board on operational activity and reported that gradual improvements are being seen, with activity levels now at the same levels as before the pandemic. Prior to July a significant number of staff were redeployed to support key services. Services and they are broadly back to the same levels of activity that were seen in March before the onset of the pandemic. There is now a backlog that is being worked through to provide quicker and improved services for patients. It is likely to take three to six months for some service areas to return to a level of normality and ongoing improvements are expected to be seen in the coming months. Claire Wright gave an overview of the Trust's financial position covering the first four months of the year. The Trust has had to accrue top-up income amounting to £364k for July 2020 to break even and the report set out how high COVID related specific costs are for the early part of the year. There is a need for the new financial envelopes to be bigger than they currently are as block income value will need to be increased in order to deliver the planned requirements and still achieve a position of break even by year-end. Claire outlined how for 'phase 3' planning, several templates are being completed by multi-disciplinary teams along with commissioners and partners in the system. These templates incorporate planning and financial assumptions related to the standing up of services, the COVID-19 response and winter planning. Assertive assumptions have been made for recruitment in year to deliver services. They also specifically include delivery of the Mental Health Investment Standard and relevant aspects of the Long Term Plan. The next stages of financial planning arrangements will be taken forward through the Finance and Performance Committee along with the capital submission for dormitory eradication capital so that work can commence at the pace to be expected. From a quality perspective Carolyn Green reported that feedback from patients' experience during the pandemic has been mixed. Care plans are continuing to be discussed with patients, families and carers. Positive feedback has been received about the Trust's new 24/7 mental health support line. The Trust is focussing on children and young people and she is anticipating an increase in referral rates once children return to school as well as needing to be mindful about increased disclosures from children who were not able to tell somebody of their distress during lockdown. Safe and therapeutic service training is being promoted within the organisation to ensure training levels return to the correct levels. Autism waiting times have elevated and this will be one of the key aspects that will be focussed on for improvement. The Trust will be working with Health Education England on improving access to nursing routes due to the expanding need for quality nurses. Jaki Lowe updated the Board on workforce and the situation regarding the suspension of appraisals and revalidation and reduction in mandatory training. Staff appraisals are being reinstated and will include conversations about health and wellbeing of individuals. Jaki will be working with colleagues to ensure that mandatory training is back on track and that rostering is tailored to achieve targeted compliance. She was pleased to report that staff absence is now at all-time low. It is understand that this is because people are working more flexibly and are able to more easily manage their home and work commitments which is something that the Trust will continue to build on. Another key focus will be on recruitment to ensure that vacancies are filled swiftly and appropriately. Senior Independent Director, Margaret Gildea saw that the report highlighted the scale of restoration that the Trust needs to achieve and how difficult it has been to maintain the level of appraisals, training and waiting times being aimed at. Despite the good efforts from staff there is a backlog and she asked what extra resource will be required to reach targeted restoration plans and what support and governance process will be in place to support the restoration cell in what will be very demanding times. Mark Powell assured Margaret that at the moment the restoration cell is linked to the phase 3 work described in the CEO report and Simon Stevens' letter. He is looking at a set of key programmes

	aligned to the Long Term Plan and demand and activity requirements based on Public Health information on the potential increase in mental health related activity in the coming months. This is being looked at in terms of resources and extra staffing and the Trust will work with other partners to sustain demand. This work has not yet been completed but it is the criteria being used to ensure transparent oversight of what is required for each of the Trust's services to achieve the set targets for rapid access to our services. From a governance point of view short, medium and long plans will be taken through the relevant Board Committees. Geoff Lewins questioned the waiting list operational indicators and asked why they showed an increase in the average wait time but the month end showed a more positive curve and asked if COVID had made it easier to defer the difficult wait times. Mark explained that although there had been a number of referrals to services over the COVID period, some had reduced quite dramatically. Fewer referrals meant the number of individuals waiting had reduced but this also meant not as many people were being seen and they were experiencing a longer than average wait time i.e. there are less referrals but the number of people waiting is increasing. Ifti referred to staffing levels and asked Jaki Lowe and Julia Tabreham to ensure that the People and Culture Committee seeks assurance from action plans to improve safer staffing levels to meet the requirements of the Long Term Plan. The Committee is to also obtain assurance from staff turnover levels and how the Trust can attract more people to the organisation. Mark Powell added that over the next two to three months the Trust will have a better understanding of winter pressures particularly through lessons learned from COVID. He will be looking to redesign this report from a performance perspective in a more COVID meaningful way i.e. reporting will focus on workforce, vacancy rates, sickness absence rate and how this will have an impact on the needs of the organisation. He proposed that the Board Committees consider how reporting can be improved and suggested that a Board Development session be arranged to focus on the lessons learned from COVID and how this can be reported through performance reports to the Board and the Board Committees. Having comprehensively reviewed and discussed the report, the Board agreed that limited assurance had been obtained from current performance across the Trust and that discussions had shown where further assurance was required. **ACTION: People and Culture Committee to seek assurance from action plans to improve safer staffing levels to meet the requirements of the Long Term Plan. The Committee is to also obtain assurance from staff turnover levels and how the Trust can attract more people to the organisation.** **RESOLVED: The Board of Directors confirmed that limited assurance had been obtained from current performance across the areas presented.**
DHCFT 2020/076	**FLU/COVID-19 VACCINATION PROGRAMME** This report provided an overview of the plans and preparation to deliver the Trust's comprehensive flu vaccination programme commencing in September 2020 to ensure that every colleague within DHCFT has access to a flu vaccine. The Board noted that the flu programme for 2020/21 will be a fully clinically based programme targeted to achieve 90% uptake by mid-November. Jaki Lowe reported that she will be working closely with the Executive Team to ensure the Trust achieves the anticipated target. The Trust has also been engaging and contributing to national and regional plans to prepare for a COVID-19 vaccination programme. Implementation of the flu campaign and preparations to support any future COVID vaccination programme will be closely monitored by the People and Culture Committee and the Incident Management Team and will be

	reported to the Board. Areas where there have been lower rates of vaccination in the past are being looked at to establish how some groups can be influenced so they are not so averse to having the vaccination. This will be a focus of reporting to the Board in November, together with a progress update against trajectory. The Board acknowledged that engagement with colleagues in the importance of being vaccinated to stay safe will be a central factor in achieving the 90% target rate and received significant assurance from the Trust's plans for flu vaccinations this winter. **ACTION: Flu programme for 2020/21 progress report to be submitted to the November meeting to focus on how to improve vaccination rates in areas with low vaccination uptake.** **RESOLVED: The Board of Directors:** **1) Reviewed the contents and approach being undertaken by the Trust** **2) Agreed to review progress against trajectory at November Board meeting.**
DHCFT 2020/077	**WORKFORCE RACE EQUALITY STANDARD (WRES)** **WORKFORCE DISABILITY EQUALITY STANDARD (WDES)** The Board received an update from Claire Wright on progress with both the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES). The Board reflected on the experiences colleagues have shared, with reference to the Trust's vision, values and wider inclusion ambitions. Delegated authority was granted to the People and Culture Committee meeting on 22 September to review and sign off the WRES and WDES October submissions. It was agreed that at the next Board meeting on 3 November, the Board will receive updates from the People and Culture Committee meeting regarding the 2019-20 WRES and WDES indicators underlining the key areas of improvement and areas for further improvement along with the actions plans and infograms. This will enable the Board to reflect on what the data reveals about the relative experiences of BME and disabled workforce colleagues within Team Derbyshire Healthcare when compared to the Trust's vision and values and wider inclusion ambitions as well as the NHS People Plan. **ACTION: Report to the November meeting from the People and Culture Committee regarding the 2019-20 WRES and WDES indicators is to underline key areas of improvement further improvement along with the actions plans and infograms.** **RESOLVED: The Board of Directors:** **1) Gave delegated authority to People and Culture Committee on 22 September to review and sign off the 2019/20 WRES and WDES submissions** **2) Agreed to consider the strategic implications of the outcomes of the 2019-20 WRES and WDES indicators and their action plans in light of the Trust vision, values and inclusion priorities and People Plan at the November Board meeting**
DHCFT 2020/078	**FREEDOM TO SPEAK UP GUARDIAN REPORT** This report produced by Tam Howard, the Freedom to Speak Up Guardian (FTSUG) was provided to the Board to ensure the Board is aware of Freedom to Speak Up (FTSU) cases within the Trust, trends within the organisation and actions being taken. The Board reflected on the emerging themes and issues regarding discrimination and inclusion and noted that generally less freedom to speak up concerns have been raised throughout the pandemic. It is expected that these will return to pre-COVID levels over the next few months. The positive response to concerns that are raised and their resolution was noted. There have been a higher number of concerns raised from admin and clerical staff. The Board

	was pleased to note that a live engagement event with admin and clerical staff is scheduled to take place on 7 September. Caroline Maley emphasised how FTSU is such an important area of work that gives staff the confidence to speak up so that emerging stories can be learned from and developed. She requested that more analysis covering emerging trends is included in the next six monthly report. Ashiedu Joel made reference to the risk and assurance section of the report relating to patient safety and clinical care of patients and the importance of staff feeling confident to speak up particularly on behalf of patients in more vulnerable groups and challenged whether staff might suffer any detriment if they speak up. Tam assured the Board that she guarantees staff that they will not suffer any disadvantage if they speak up. Julia Tabreham as FTSU NED lead was mindful that the last few months have been an unusual period for the FTSUG and congratulated Tam on her continued performance. She intended to drive forward the issues that need to be progressed with Tam and undertook to work closely with Jaki Lowe to develop FTSU reporting mechanisms further into key indicators that can be monitored by the People and Culture Committee. Ifti Majid was interested to note that 90% colleagues have raised their concerns elsewhere and was interested to know if the Trust was an outlier in concerns being reported in this way. Tam responded that it was common for staff to have raised concerns elsewhere. Sometimes concerns are made to her as FTSUG because colleagues have not received the response they had expected or wanted from their line manager. Having discussed the report, the Board valued the importance of the FTSUG role and in raising awareness and supported the work being carried forward on behalf of the Trust. **ACTION: FTSU reporting mechanisms to be further into key indicators that can be monitored by the People and Culture Committee.** **RESOLVED: The Board of Directors:** **1) Supported the current mechanisms and activities in place for raising awareness of the FTSU agenda** **2) Received sufficient assurance of the Freedom to Speak Up agenda at the Trust and that the proposals made by the Freedom to Speak Up Guardian promote a culture of open and honest communication to support staff to speak up.** **3) Supported the development of a more interactive and accessible communications route for Speaking Up through the use of a Trust Speaking Up App for workers.**
DHCFT 2020/079	**<u>BOARD COMMITTEE ASSURANCE SUMMARIES</u>** **Audit and Risk Committee held 2 July** Committee Chair, Geoff Lewins reported that the Committee had received a COVID edition of the Board Assurance Framework (BAF) while the BAF is being refreshed as part of the Board's review of the strategic building blocks, to extend it beyond the current 'COVID response' format. The Committee will receive the next iteration of the BAF for review on 1 October before it is submitted to the Board for approval in November. Discussions also covered an overview of the support being given to the Freedom to Speak Up Guardian role during the pandemic and the increase in previously unknown individuals accessing the Trust's services since the start of the pandemic. Both these issues are being looked at by the Medical Director. The broader implications are to be considered by both the Quality and Safeguarding Committee and the People and Culture Committee. Agreement of a recommendation to the Council of Governors to appoint Mazars LLP as the Trust's external auditor from 1 September 2020 will take place at this afternoon's meeting of the Council.

	Quality and Safeguarding Committee 14 July Chair of the Committee, Margaret Gildea drew attention to the letter from the CQC reporting on the exemplary practice of the care and treatment of patients detained under the Mental Health Act (MHA) during the COVID-19 outbreak at Cubley Court and commended the work of the team. The Committee also received a summary update on COVID-19 that covered specific quality, clinical and safety aspects of care provision. Areas covered were staff absences, use of 'Attend Anywhere' software for e-consultations, staffing and recruitment and the potential surge in cases of COVID-19, particularly amongst younger people. **Finance and Performance Committee 28 July 2020** Richard Wright as Chair of the Committee talked about the current situation with the Trust's dormitories and what is happening nationally and locally due to capital money being made available for the eradication of dormitories in mental health. The Committee continues to focus on the affect that COVID-19 is having on the Cost Improvement Programme and will continue to support operational innovations. The Committee discussed the arrangements for charitable funds and agreed to maintain the current arrangements and will take this forward once the Trust is not focussed on COVID-19 restoration and recovery. **RESOLVED: The Board of Directors noted the Board Assurance Summary report**
DHCFT 2020/080	**IDENTIFICATION OF ANY ISSUES ARISING FROM THE MEETING FOR INCLUSION OR UPDATING IN THE BOARD ASSURANCE FRAMEWORK (BAF)** No additional items were considered for inclusion or updating within the BAF. Discussions held today covering health inequalities, the availability of staff and access of services and the movement of the BAF away from the COVID BAF to focus on the revision of the Trust Strategy will be covered in the next iteration of the BAF that will be taken to the Audit and risk Committee for review in October and to the Board for approval in November.
DHCFT 2020/081	**2020/21 BOARD FORWARD PLAN** The 2020/21 forward plan outlining the programme for bi-monthly meetings was noted and will be reviewed further by all Board members throughout the financial year.
DHCFT 2020/082	**MEETING EFFECTIVENESS** All Board members agreed that the meeting had been successfully conducted via MS Live Events. Caroline Maley extended her thanks to the producers, Alex Rose, Denise Baxendale and Ashleigh Chrich for their technical support and for ensuring that the meeting ran smoothly. She asked Governors observing the meeting to offer their feedback at this afternoons' meeting of the Council of Governors. Caroline asked Carolyn Green and Trust Secretary, Justine Fitzjohn to consider how patient stories can be reinstated within a virtual setting.
The next meeting to be held in public session will take place at 10.30am on Tuesday 3 November 2020. Owing to the current coronavirus pandemic this meeting will be held digitally and will be live streamed via MS Live Events.	

				BOARD OF DIRECTORS (PUBLIC) ACTION MATRIX - NOVEMBER 2020			
Date	Minute Ref	Item	Lead	Action	Completion Date	Current Position	
4.2.2020	DHCFT/ 2020/008	Integrated Performance Report	Ifti Majid	Report on wider staffing and what the future will look like is to be brought back to the Board at a timeline to be decided by the Executive Team	5.1.2021	The People Plan will be taken to the People and Culture Committee on 24 November. This will enable a wider report on staffing and what the future will look to be brought to the Board in January.	Yellow
7.7.2020	DHCFT/ 2020/060	Annual Re-Validation Of Doctors	John Sykes	Report on the focus of inclusion within the revalidation process to be submitted to the next meeting in September	~~1.9.2020~~ 3.11.2020	3 November agenda includes a verbal update from the Medical Director on the status of annual revalidation.	Yellow
1.9.2020	DHCFT2 020/073	CEO Report	Board	Board to consider the appointment of the Trust's Wellbeing Guardian	TBC	Will be taken forward with delivery of the People Plan	Amber
1.9.2020	DHCFT2 020/075	Integrated Performance Report	Jaki Lowe	People and Culture Committee to seek assurance from action plans to improve safer staffing levels to meet the requirements of the Long Term Plan. The Committee is to also obtain assurance from staff turnover levels and how the Trust can attract more people to the organisation	22.9.2020	Assurance levels around safer staffing and the People Plan will be submitted to the People and Culture Committee on 24 November.	Yellow
1.9.2020	DHCFT2 020/076	Flu programme 2020/21	Jaki Lowe	Flu programme 2020/21 progress report to be submitted to the Board on 3 November to focus on how to improve vaccination rates in areas with low vaccination uptake	3.11.2020	People and Culture Committee have held discussions. A progress report has been received for the November meeting.	Green
1.9.2020	DHCFT2 020/076	WRES and WDES	Jaki Lowe Claire Wright	Report to the November meeting from the People and Culture Committee regarding the 2019-20 WRES and WDES indicators is to underline key areas of improvement further improvement along with the actions plans and infograms	3.11.2020	Received for 3 November meeting	Green
1.9.2020	DHCFT2 020/078	Freedom to Speak Up Guardian (FTSUG) Report	Jaki Lowe Julia Tabreham	PCC to develop FTSU reporting mechanisms further into key indicators	22.9.2020	FTSU reporting mechanisms are now being taken forward in new reporting structure to People and Culture Committee	Green

Resolved		**GREEN**	**3**	**43%**
Action Ongoing/Update Required		**AMBER**	**1**	**14%**
Action Overdue		**RED**	**0**	**0%**
Agenda item for future meeting		**YELLOW**	**3**	**43%**
			7	**100%**

Derbyshire Healthcare NHS Foundation Trust
Report to the Public Board of Directors – 3 November 2020

Trust Chair's report to the Board of Directors

Purpose of Report

This report is intended to provide the Board with the Trust Chair's reflections on my activity with and for the Trust since the previous Board meeting on 1 September 2020. The structure of this report reflects the role that I have as Trust Chair.

Our Trust and Staff

1. Given the on-going pandemic, I have agreed to discontinue my visits to teams across the Trust until such time as it is thought to be safe, both for staff and for myself, to visit. I am currently working with Carolyn Green on a way that the Non-Executive Directors (NEDs) can safely visit teams and services to maintain contact with staff and service users.

2. In the meantime, I have been attending as many of the team live engagement events being hosted via MS Teams. These meetings are very useful to me in terms of understanding how are staff are feeling and engaged with the Trust.

3. On 23 September along with NEDs Geoff Lewins and Richard Wright I took part in a MS Teams meeting chaired by Dr Mark Broadhurst, Deputy Medical Director, on the OnEPR implementation.

4. On 24 September, I joined the virtual Schwartz Round which was framed around the Pandemic: loss and hope. It was very moving to hear about the impact of the pandemic and in particular the redeployment of staff to other areas of our Trust. Again on 22 October I attended another virtual Schwartz Round. This too was on the theme of redeployment: Facing Redeployment – Back to where I escaped from. I hope that we are using these experiences to shape any future redeployment that may be necessary. Thank you for letting me join you.

5. I would like to thank the Trust Incident Management Team and Executive Leadership Team for their superb communications over the past six months, supported by Anna Shaw and her Communications Team. I know that this has been appreciated by staff. I too would like to thank all staff for their on-going commitment and dedication shown to the Trust and our service users over an extraordinary time. I also encourage them to be kind to themselves and to others whilst the pandemic continues to make an unprecedented impact on our lives.

Council of Governors

6. We held a virtual joint Council of Governors / Board meeting on 1 September 2020 following the public Board in the morning. This meeting was extremely well attended by Governors, who have embraced the use of technology superbly well. We streamed this meeting for the public to watch.

7. On 1 September we also held our Annual Members Meeting on MS Teams as a Live Stream event. It was attended by 60 people: five appointed governors, ten public governors, five staff governors, seven staff members, fourteen Trust members, six members of the public, five NEDs and eight Executive Directors. We hope that the 2021 meeting will be held as a face to face meeting.

8. At the end of September we said farewell to a number of our Governors: April Saunders, Staff Governor for Allied Professions leaves us after six years as a Governor. Adrian Rimington also leaves the Council at the end of his term of appointment. Elections to the Council of Governors were paused at the start of the pandemic as directed by NHS England / NHS Improvement (NHSE / I). Elections will be held in early 2021 to fill these vacancies and other constituencies which become vacant due to terms ending.

9. Angela Kerry, Appointed Governor from the voluntary sector, retired at the end of September, and we have welcomed Jodie Cook as her replacement. We have also welcomed Professor Stephen Wordsworth from the University of Derby as an Appointed Governor.

10. I held a virtual meeting with three of the Staff Governors on 15 October to understand how they are managing in their work both as a Governor and a member of staff. We continue to aim to meet quarterly, albeit in a virtual way. I really appreciate this contact and would like to thank them for the work that they do for the Council.

11. The Governance Committee of the Council met on 8 October. Richard Wright, Deputy Trust Chair, attended for me as I was attending the NHS Providers virtual conference. This meeting was chaired by Julie Lowe, as Kelly Sims, Chair for this Committee remains on redeployment supporting the PPE distribution in the Trust. I continue to be grateful to our Governors for their support for the Trust at this time.

12. On 21 October, the Council of Governors' Nomination and Remuneration Committee met to discuss and agree the processes that should be in place for the appraisal of myself (led by the Senior Independent Director (Margaret Gildea) and Lead Governor (Lynda Langley). These have been aligned with the national timeline and will be completed during the first quarter of 2021.

13. I have had regular meetings with Lynda Langley as Lead Governor to ensure that we were open and transparent around the challenges and issues that the Trust was dealing with. Regular meetings between the Lead Governor and Chair are an important way of building a relationship and understanding of the working of both governing bodies. I am pleased that Lynda has continued to work with other lead governors in the system over this period, helping to benchmark our processes for continued engagement with governors.

14. The next meeting of the Council of Governors will be on 3 November, following the Public Board meeting on that day. The next Governance Committee takes place on 10 December.

Board of Directors

15. All meetings continue to be held as virtual meetings using MS Teams, enabling Board members to keep connected whilst working remotely. We have continued to live stream our public board meetings to enable members of public and our

staff to observe the Board meeting. Our September meeting was observed by twelve people, of whom five were Governors.

16. On 16 September the Remuneration and Appointment Committee met to receive an update on executive appraisals. A further meeting of the Committee was held on 22 October to consider just one specific item.

17. On 6 October there was a Board Information Sharing session which looked at the Phase 3 Planning response for Mental Health, Learning Difficulties and Autism, and Children's Services. This was submitted on 21 September. This meeting was chaired by Richard Wright, Deputy Trust Chair.

18. A Board Development meeting took place on 20 October, which focused on the next steps in the development of the Derbyshire Integrated Care System (ICS).

19. The Non-Executive Directors have met regularly with Ifti Majid and me to ensure we have been fully briefed on developments as needed. I have also continued to meet with all NEDs individually over the past two months and I am grateful to them for the support and flexibility at this time. We use these quarterly meetings to review their progress against their objectives and to discuss any issues of mutual interest.

System Collaboration and Working

20. On 8 September I joined the University of Derby and Burton Hospitals Foundation Trust at their public board meeting. This was at the invitation of Dr Kathy McLean, Chair, following her attendance at our Board meeting in July.

21. Joined Up Care Derbyshire (JUCD) met on 17 September using MS Teams. Attached as Appendix 1 are the key messages noted from this meeting. In addition, the four Derbyshire Provider Chairs met with John MacDonald, Independent Chair JUCD, and Chris Clayton, Executive Lead JUCD, in advance of a workshop held on 15 October to consider the way forward for the system as it moves towards becoming an ICS.

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

23. I have also been joining the East Midlands Chairs Development network, which is sponsored by Prem Singh, Chair of Derbyshire Community Health Services NHS FT and David Pearson, Independent Chair of Nottinghamshire ICS and Councillor Sue Woolley, Chair of Lincolnshire Health and Wellbeing Board. This group has met three times now, twice as a virtual meeting. It has been a useful forum to see what other ICS and areas are doing to improve services. It includes NHS and local authority colleagues.

Regulators, NHS Providers and NHS Confederation and others

24. I attended, along with Jaki Lowe and John Sykes the annual NHS Provider conference. This year it was a virtual conference and took place over three days commencing 6 October. It offered a variety of topics to choose from, and I took part in a small invited roundtable with Prerana Issar, the NHS Chief People Officer. There was an inspirational session with John Amaechi talking about inclusive leadership.

25. I have attended regular briefings from NHSE / I for the Midlands region, which has been essential to understand the progress of the management of the pandemic. Conversations now have moved significantly on in terms of restoration of services and looking to the future delivery of services. A further regional meeting was held with Simon Stephens and his team. I have also attended a number of national webinars with Amanda Pritchard and the national team. It is notable how much more the centre is reaching out to talk to the provider sector, if only to brief on matters as consultation on these topics is not possible in these huge groups. These matters will be picked up within the Chief Executive report to the Board.

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

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

Assurances

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

Consultation

This report has not been to other groups or committees.

Governance or Legal Issues

None

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

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

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

Demonstrating inclusive leadership at Board level

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

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

Recommendations

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

Report prepared and presented by: **Caroline Maley**
Trust Chair

Appendix 1

Joined Up Care Derbyshire Board – 17 September 2020

Key Messages

Future steps for Joined Up Care Derbyshire

In the first public Joined Up Care Derbyshire Board meeting in public since the start of the COVID-19 pandemic, members took stock of the way in which COVID-19 has changed the way in which we make decisions and the priorities for the Derbyshire health and care system in the coming months and years.

The Board confirmed the drive to improve life expectancy and healthy life expectancy and to reduce the health inequalities that are driving these differences. There has been previous detailed work that had identified the main causes of ill health, the wider determinants that can affect people's health, including housing, education, income and employment and the way the health and social care system can act as an 'anchor' organisation, where we can make an offer to broader partnerships to support their work on employment opportunities, staff wellbeing, the Derbyshire economy, the environment and supporting thriving communities.

The Board will continue this conversation to ensure we are correctly set up to operate and deliver these ambitions. Our application to become an Integrated Care System will be submitted in September, with a bid to operate in shadow from 1 November 2020. Whilst initially there will be relatively little change, over time our role as ICS will mature and ensure that we are effectively operating as a health and care system first and foremost, but making the connections we need with other agencies to support those broader priorities identified above.

One thing COVID-19 has helped streamline is the decision-making processes within our system. It has been proven that we can make decisions more quickly, with fewer steps to the governance process and by making decisions more closely to the front-line. The Board is clear that this learning must be captured and retained and our meetings and decision making processes will be streamlined accordingly.

Providing Services in Challenging Conditions

COVID-19 has brought the absolute best out in our staff, and everyone is very proud of the way teams have responded to the demands placed upon them by the pandemic. It is vital that as we manage the on-going demands of the pandemic we take steps to restore those services which were stood down at the start of the pandemic to ensure we had capacity to treat people who have the COVID-19 infection.

All partners have been working on our restoration and recovery plan, which is the response to a number of objectives set by NHSE/I England/Improvement. This includes the recovery of our waiting times for operations and diagnostics, and our restoration of mental health, community health and primary care services. This is all being done in the context of an emerging comprehensive winter plan which seeks to ensure we have enough staff, beds and capacity in our community discharge pathways to manage the

flow of patients throughout the challenging winter months, all with an eye of the possibility of an increase in new COVID-19 cases as the numbers of infections begin to rise in the community.

It is a very complex planning process which requires a fine balance between the three elements of recovery, winter and COVID-19. The outcomes will also require a significant communications programme with our local patients, as well as staff and other stakeholders, to help ensure everyone is clear on what services are available to meet their specific needs and to be flexible enough to respond to quick change should the pandemic have resurgence.

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 3 November 2020

Chief Executive's Report to the Public Board of Directors

Purpose of Report

This report provides the Board of Directors with feedback on changes within the national health and social care sector, as well as providing an update on developments occurring within our local Derbyshire health and social care community. Given the COVID-19 pandemic much of the content is influenced by the NHS response to the pandemic and how to learn lessons from the response. The report also updates the Board on feedback from external stakeholders, such as our commissioners, and feedback from our staff. The report should be used to support strategic discussion on the delivery of the Trust strategy. The Board should note that the report reflects a wider view of the Trust's operating environment and serves to horizon scan for risks that may affect the organisation. Risks identified are highlighted in the report and taken forward to assess their operational and strategic impact, and recorded on operational risk registers, or the Board Assurance Framework (BAF), as appropriate.

National Context

1. During October the CQC released their annual State of Care Report. This report examines how well the system was working before the arrival of COVID-19, including improvements to the quality of care in the lead up to March 2020, and the impact of COVID-19 on providers, their staff, and the patients and communities they serve. The report also summarises findings from 11 provider collaboration reviews, carried out to assess the impact of joint working in systems on the care people received during the first wave of the pandemic. The key points from the report include:
    - The report describes the care people received in 2019/20 as being 'mostly of good quality'. It finds that the quality of care before the pandemic was largely good, but, unsurprisingly, identifies an overall lack of improvement during this time. Particular areas of challenge include care that is hard to plan for, and inpatient care for autistic people and people with a learning disability.
    - CQC notes that the pandemic has accelerated a number of changes in health and care which were already underway particularly in terms of collaboration and mainstreaming innovations that has been previously difficult to embed, such as remote consultations and 'triage-first' models of care in GP practices.
    - The report explores the impact of the pandemic on the workforce, including the need to adapt quickly, different ways of working during the first peak, and the emotional and physical toll of working through the pandemic.
    - The report explores the impact of COVID-19 on the levels of activity in the health service. At the beginning of the pandemic the number of referrals for treatment dropped from 1.6 million in February to 500,000 in April – a fall of 69%.

- There was a rise in the number of people waiting more than 6 weeks for diagnostic tests, from 10% in March to 58% of the waiting list in May.
- Demand for urgent primary medical services, such as NHS 111, urgent treatment centres and out of hours services, increased, with a large spike in demand in response to the public campaign to contact 111 with concerns about the virus.
- As part of the provider collaboration reviews, CQC found that areas coped better where there were well established working relationships among providers, with stronger collaboration and decision making. Where CQC found well planned governance, clear decision-making arrangements and escalation plans, the system wide responses were most effective. The report sets out a challenge to providers to learn from the crisis and maintain collaborative working at pace. This will need to be supported at a national, regional and local level, with recognition of the interdependency between health and care.

I was particularly pleased that the report highlights the challenges facing mental health, learning disability and children's trusts over the next 12 months as well as a real focus on support for our workforce. The Quality and Safeguarding Committee will be able to use the outcomes from the report to triangulate assurance within our Trust against these key findings.

2. During September NHS England and Improvement (NHSE/I) launched its 'Advancing Mental Health Equalities Strategy'. This strategy summarises the core enabling actions NHSE/I will take with the support of the Advancing Mental Health Equalities Taskforce – an alliance of sector experts, including patients and carers, who are committed to creating more equitable access, experience and outcomes in mental health services in England. It sits alongside the NHS Mental Health Implementation Plan 2019/20–2023/24 and as such is similarly focused in scope. This strategy is also an important element of the overall NHS plans to accelerate action to address health inequalities in the next stage of responding to COVID-19.

   The Board will recall that in August all systems were asked to take urgent action to address health inequalities focussed on eight areas that included paying particular attention to access, experience and outcomes for groups facing inequalities in mental health and this document builds on that. You may have also seen my national blog associated with the eight urgent actions. This strategy is clearly something we need to be considering in the work we are undertaking as a system linked to implementing the long term plan but moreover later in my report I talk about our refreshed Trust Strategy with the addition of a specific building block linked to health inequalities. This strategy gives us the clear direction of expectations for actions at a national, regional and local level as well as a commitment to look at available data and enhancing the Mental Health Minimum Data set to make it easier to interrogate from an inequalities perspective. In addition, the strategy contains a table that defines the most common mental health impact linked to access, experience and outcome by protected characteristic. This will significantly inform the work against our own inequalities building block.

Local Context

3. The Midlands Strategic Transformation and Recovery Board that I am a member of met for the second time in October. Some of the key points included:
    - The Board agreed it is important to continue at pace with the work of the STaR Board and the Working Groups, whilst acknowledging the pressures associated with COVID-19 Wave 2.
    - The recommendations contained within the Midlands COVID-19 Lesson Learned Report will be overseen by the Midlands Leadership Team
    - Staff wellbeing, mental health and morale were agreed as a key priority and regional support will be informed by discussions at the STaR Board and co-ordinated by the Regional People Board.
    - The Chairs of the Regional People Board and STaR Working Groups for Health Inequalities and for Safe Restoration and Recovery of Services will work collaboratively on our regional approach.
    - There are 4 working groups as follows:
        - Clinical Services and Commissioning Strategies
        - Strategies and Approaches to addressing health inequalities and prevention (I also sit on this group)
        - Timely and safe restoration and recovery of services
        - How we lead, organise and run NHS Midlands

4. On 17 September there was a full, virtual meeting of the Joined Up Care Derbyshire (JUCD) Board. Key areas for discussion at this meeting included:
    - Update around ongoing work to implement visibility of a shared care record for Derbyshire
    - Work underway to reduce waiting lists for elective care
    - Submission of the JUCD restoration and recovery plan
    - Update around the winter plan
    - Review of the draft Integrated Care System plan

    A more detailed update can be found in appendix 1.

5. On 15 October JUCD chairs and chief executives held a development session to continue discussions on new ways of system-first working. It’s important that we operate most effectively across the health and social care system in Derbyshire while also providing the necessary big picture oversight and assurance. The session also covered financial aspects including financial planning for the second half of this year and how we want to work with the system finances into next year and beyond. There is complexity in thinking how the same total resource can be looked at in many different ways; be that through individual organisations, pathways of care and/or populations for example. Despite the complexity, everyone agreed it was important to align the system financial arrangements with the wider system working so that finance is an ‘enabler’ in making sure we use the totality of the system financial resource in the best way we can. This session was augmented internally by a Board Development conversation with the focus on how we as Board level directors operate in this emerging system architecture.

Within our Trust

6. Between 7 and 10 September the CQC carried out a focussed inspection on the Hartington Unit reviewing two of the five domains, safety and parts of well-led. I have attached the full report at appendix 2 however in summary the CQC found several positive findings that included:

   - The ward environments were clean and generally well maintained
   - Staff recruitment was ongoing and new staff had been recruited which meant the wards had enough nurses and doctors
   - Staff minimised the use of restrictive practices and only used restraint as a last resort
   - Staff followed good practice with respect to safeguarding
   - Staff followed safe practice in prescribing, administering and recording of patients' medicines
   - Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services
   - They managed and were visible in the service and approachable for patients and staff
   - Most staff knew and understood our Trust's vision and values and how they were applied in the work of their team
   - Staff felt respected, supported and valued. They reported that the provider promoted equality and diversity in its day to day work and in providing opportunities for career progression
   - Staff felt able to raise concerns without fear of retribution.

   However, there were also some areas where improvement was required which included:

   - Staff had not assessed all ligature risks on the wards. The provider had installed closed circuit television cameras on the ward to reduce the risks of blind spots but the ligature risks of these had not been assessed on the ward ligature assessments.
   - Work to eradicate the dormitories had been halted in March 2020 due to COVID-19. Following this inspection, the trust told us they had submitted a funding bid in July 2020 for conversion of the inpatient service and extensive building programme. At the time of report publication, the trust awaits the decision.
   - Staff did not always complete all patient assessments to ensure they could manage risk well.
   - The provider had not trained sufficient numbers of staff in supporting patients safely, for example, moving and handling, positive and safe care, life support and safeguarding level 3.
   - Our findings demonstrated that governance processes did not always operate effectively at ward level and that risks were not always managed well. Staff did not always record the temperatures in clinic rooms and medicines fridges to ensure medicines were stored safely.

I would like to take this opportunity to thank all colleagues who were involved in the inspection for the professionalism, care and support of each other that was clearly demonstrated. As a Board we will monitor the improvement plan through our Quality and Safeguarding Committee escalating issues to the Board as required.

7. Board members will be aware of the development of the EQUAL Forum. The EQUAL Forum brings together patients, carers and nominated staff from across the Trust. It is an opportunity to create change in the Trust and shape the culture of our organisation through engagement. The EQUAL Forum works in partnership with leaders, including Executive Directors, and is in place to ensure that patients and carers feel able to raise issues, and can work together to plan ways to deliver improved services.

   The Forum was keen for the Board to hear their feedback on some of the areas of concern they have:

   - Lack of involvement in Pandemic and in restoration
   - Advertising senior jobs with no patient and carer involvement
   - The lack of involvement in induction noting some changes in junior doctor induction
   - Lack of support to EQUAL members to debrief after involvement, this is a key issue for EQUAL members.

   The CEO and Director of Business Improvement and Transformation met with the Forum to discuss the following questions:

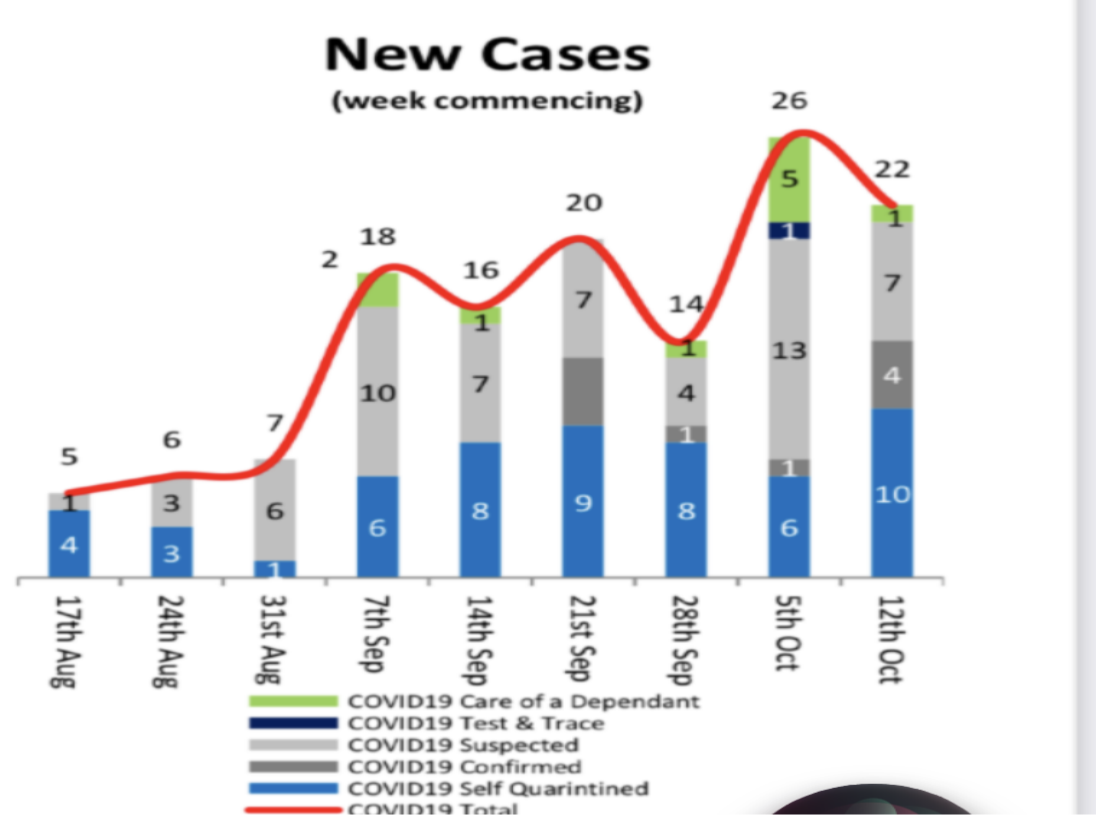
     - Can we have a commitment to involve people with lived experience in the decision making about how to reinstate/reinvent services please?
     - Can you confirm how this will happen? Both people with lived experience of mental illness AND carers and how they want to be involved?
     - Can the system restoration cell consider the recovery cell? I understand that it is health and social care?
     - Is this another consultation group?
     - Does this extend into decision making? Rather than giving feedback. If there isn't any, can this be reviewed? To consider decision making.

   The above areas were discussed and responded to and in addition the Executive Leadership Team (ELT) have agreed to fund a Band 5 post to support the work of the Forum.

8. It is important to clearly state in the public board the incredible response to the now protracted nature of this pandemic that colleagues from Team Derbyshire Healthcare continue to give. Even though this pandemic has had an impact on personal lives as well as work lives, has required working in significantly different ways and with higher demand for our services, colleagues have responded fantastically!

   As the number of community transmissions have raised very significantly, we have seen a slight upward turn in those colleagues who are away from work due

to COVID -19 related reasons either self-isolating pending test results or in a few cases having tested positive.



The number of patients in our inpatient facilities remains very low (0 at the time of writing the report). This is not fate but evidence of very robust and diligent infection prevention and control compliance by colleagues working in those areas and I am sure the Board would wish to extend thanks to them for the way they have approached delivering care to some of the most vulnerable people we support.

Given the rise in community transmission we have again enhanced our incident management processes extending them to seven days a week to ensure we are able to respond to and policy or risk based changes quickly and effectively. My thanks to members of the IMT for their ongoing support.

9. Board colleagues will be aware from my last Board report that work commenced in the July Board Development session to review and update our Trust Strategy in light of lessons learnt from our pandemic response as well as national policy changes. Following a range of discussion and consultation sessions with colleagues in the Trust this work is now completed. The work from the Board and from those colleagues who got involved clearly confirmed that the Trust vision, values and strategic objectives remained relevant and are well understood and ‘owned’ by colleagues throughout the organisation. This was reinforced both in our comprehensive CQC inspection but also more recently in the focussed inspection shared in this report from the Hartington Unit

   The full set of revised building blocks to deliver our 3 strategic objectives is shown in appendix 3. Board members will note the inclusion of the Team Derbyshire Healthcare promise as part of the ‘golden circle’ recognising the importance that the culture of our organisation plays in delivering the strategic

outcomes. Whilst all the building blocks have been slightly reviewed and amended perhaps the biggest change Board members should note relates to the people blocks and a move away from transactional focussed HR to developing the culture of the organisation

I can confirm that the board assurance framework is now referencing this revised strategy. Board members are requested to sign off this revised version of the Trust Strategy.

10. October is Black History month and I would like to express my thanks to everybody who has been involved in developing such a vibrant and energetic programme of celebration. The core purpose behind our programme has been all about experiential learning – getting to know more about our cultures and communities not by reading text by getting involved. Activities varied from book reading and discussion sessions to cookery master classes and a guest speaker session where Jennifer Izekor shared thoughts and led a discussion based around cultural intelligence (the full programme can be seen at appendix 4).

    On 23 October we launched our '***It's Not OK'*** Campaign. This campaign clearly outlines our commitment to reducing all incidents of discriminatory behaviour towards staff and to support our colleagues in actively addressing these issues. A number of colleagues have taken an active role in developing this campaign and I am really pleased to see the posters feature colleagues from our staff network groups, collectively and visibly taking a stand against discrimination. Thank you to all colleagues who worked together to develop this campaign

    This campaign aims to achieve the following:

    - To confirm that colleagues will be supported in addressing and reporting any examples of discriminatory behaviour, whoever they come from (this includes patients, carers or colleagues)
    - To increase the reporting of such incidents in the patient record
    - To take appropriate steps to tackle any discriminatory behaviour
    - To revisit any examples of discriminatory behaviour at a later stage (if it is not possible to do so at the time due to the delusional or compromised behaviour of someone in our care)
    - To be clear that any discriminatory behaviour is not okay and will not be accepted.

11. Over the last two months we have held several 'Live' Divisional Engagement Events that I have chaired with the aim of offering colleagues the chance to tell

us as a senior leadership team how they are finding working in the Trust at present along with an opportunity to ask questions, make suggestions and share innovations. I have been pleased to welcome Non-Executive Directors to these sessions as well. Engagement sessions have been held with:

- Older Adults Acute Services
- Older Adult Community Services
- Adult Acute Services
- Adult Community Services
- Specialist Services
- Children's Services
- Corporate Services
- Admin and Clerical Staff
- Colleagues working at St Andrews.

These events have been very well attended helped using a virtual format on Microsoft Teams. Whilst the topics discussed have varied to some degree depending on the group there have been common themes some of which include:

- What contributes to wellbeing and supports job satisfaction in a difficult environment
- Lots of conversations about flu vaccinations and how to ensure colleagues are supported to receive them
- Changes needed to accommodation to support team working in different ways
- Activity levels increasing across all service areas
- Leadership support
- Great opportunity for us to say thank you to colleagues directly.

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

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

Assurances

- Our strategic thinking includes national issues that are not immediately in the health or care sector but that could be of high impact.
- The Board can take assurance that Trust level of engagement and influence is high in the health and social care community.
- Feedback from staff, people who use our services, and members of the public is being reported into the Board.

Consultation

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

Governance or Legal Issues

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

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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. There are some great examples of good practice in this document. The co-development of the timetable of events for Black History Month and the launch of It's Not OK both demonstrate a drive to reduce bias and discrimination through emersion in stories and narrative to support increased understanding of the experience of discrimination as well as causes

It was good to get independent assurance from the CQC that *Staff felt respected, supported and valued. They reported that the provider promoted equality and diversity in its day to day work and in providing opportunities for career progression.*

One of the biggest changes in the Trust strategy discussed in this document relates to enhancing access to those most at risk from inequality – this is a vital and import shift and will require a different approach in resource allocation.

Recommendations

The Board of Directors is requested to:

1) Scrutinise the report, noting the risks and actions being taken.
2) Formally approve the refreshed strategy
3) Seek further assurance around any key issues raised.

Report presented by: **Ifti Majid**
Chief Executive

Report prepared by: **Ifti Majid**
Chief Executive

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 3 November 2020

Appendix 1 to the Chief Executive's Report to the Public Board of Directors

Purpose of Appendix 1

This report provides the Board of Directors with more detailed feedback on the Joined Up Care Derbyshire (JUCD) Board meeting which met on 17 September 2020.

Chair and STP Director Update

As JUCD seeks to re-establish some previous business, it is important to understand where JUCD sits in the current decision making processes and can capitalise on the new ways of working and partnerships. To lead this work, JUCD is appointing to an Executive Lead post and we are currently awaiting NHS England/Improvement (NHSE/I) approval for our preferred candidate following a selection process.

There are rapid developments taking place to implement a shared care record across Derbyshire, with procurements.

The Clinical Prioritisation Review Group has been reviewing backlog of secondary care patients to address quickly patients in areas of particular challenge in restoring services, particularly urology and neurology. This is to ensure patients are seen on a priority basis reflecting their condition.

System Restoration and Recovery Plan – Phase 3
System colleagues have devised the Derbyshire COVID-19 restoration and recovery plan, which sets out how we will seek to meet the requirements of restoration and recovery set out in the Phase 3 letter received from Sir Simon Stevens, Chief Executive of NHS England and Amanda Pritchard, Chief Operating Officer of NHS England in August. The plan in its current status was reviewed and endorsed by the JUCD Board, accepting the continued work taking place to continue to ensure compliance with the targets set for recovery, most significantly the recovery of elective care waiting times and backlog, ahead of final submission to regulators on 21 September. We expect to achieve all requirements for primary care, community care and mental health, learning disabilities and autism, with the exception of compliance with targets for Psychiatric Intensive Care Unit (PICU) patients, who are still cared for out of area as we progress plans for more local provision. The Board noted that there are other possibilities to support patients on top of the restoring operations, including enhanced public health interventions, and this work will be progressed to supplement our current planning activity.

Winter Planning
Developing the winter plan has been done in line with the emerging Phase 3 programme described above. It is a different winter plan than other years, taking into account three things:

1. Provide quality Urgent and Emergency Care during winter
2. Taking account of continued COVID presence
3. Delivering restoration of services while balancing with the requirement for seasonal pressure on UEC

The plan has been devised with full involvement of all system partners, and the collaboration reflects the role of all in primary care action, ambulance service see and treat and hear and treat, a robust set of discharge pathways, and the role of 111 in directing patients to appropriate care, among other elements.

A full review of potential demand has helped identify where the risks may occur on demand, and the focus of the Winter Planning Task and Finish Group has been to find mitigations to the risks. This has helped to reduce risks relating to acute bed capacity, theatre capacity, capacity in community discharge pathways and capacity challenges in primary care, amongst other things. The JUCD Board agreed it had been a very thorough planning process, managing the balance between very complex demands on services at this time.

Application to Become an Integrated Care System

Prior to COVID-19 JUCD had had discussions with NHS Midlands about becoming an Integrated Care System (ICS) in October 2020. This process was paused but following a discussion with NHS Midlands we have agreed to submit an application to become an ICS in November.

JUCD submitted a first draft of the ICS application to NHSE/I on 1 September. Feedback received on our initial draft submission highlighted some gaps in relation to the minimum operating standards which have now been closed and the JUCD Board has now approved the application to be taken forward.

If our application is approved it will enable us to progress the conversation with regulators about taking on responsibility for some of the oversight and assurance historically undertaken by NHS E/I. In reality nothing is likely to be different with immediate effect; this is a transition which reflects a journey towards increasingly mature partnership working.

JUCD Priorities

The JUCD Board is taking stock of its general direction in light of recent developments to review, streamline, consolidate and empower our approach. The key questions being considered are:

1. Who/what is the JUCD system and what are its priorities?
2. If this is who we are and we have these priorities, how are we going to operate as a system?
3. If this is how we are going to operate, what actions do we need to take?

This month, the Board confirmed the drive to improve life expectancy and healthy life expectancy and to reduce the health inequalities that are driving these differences. There has been previous detailed work that had identified the main causes of ill health, the wider determinants that can affect people's health, including housing, education, income and employment and the way the health and social care system can act as an 'anchor' organisation, where we can make an offer to broader partnerships to support their work on employment opportunities, staff wellbeing, the Derbyshire economy, the environment and supporting thriving communities.

Further discussions will be held on questions 2 and 3 above in this context, including broader discussions with groups within our partnership, including Non-Executive/Lay Members.

JUCD Governance Review

In November 2019 the JUCD Board agreed to undertake the Board Governance and Effectiveness review; this was concluded and the recommendations approved in March 2020. At this time the revised Shadow ICS Partnership board Governance arrangements (Appendix 1) were also approved. The actions were defined pre-COVID-19, therefore the impact of the pandemic has in some instances required a change in approach and/ or modifications to ensure JUCD is responsive to the lessons learnt from the experience.

In June 2020 the JUCD Board agreed the principles for 'Restoration and Recovery Ways of Working':

- Our transition out of COVID-19 will retain the agile decision making approach experienced over the last few months
- We will pay as much attention to ways of working/behaviours as we do to the governance/ structures
- We will continue to think: People, Patients and Staff first
- Increased connectivity between 'experts' often clinicians, practitioners and leaders to speed up decision making and pace of change
- The governance/structures agreed reflect the way we do our work including planning, decision making, monitoring - we won't revert back to parallel processes e.g. bilateral contract management
- Data led intelligence will be the main driver of system actions and change
- We will optimise the JUCD role within the wider partnership to address poor determinants of health, by using the established Local Resilience Forums (LRF) governance
- These ways of working are important as we move forward and are consistent with any adaptations which have been made to the Board Governance and Effectiveness review actions.

In view of the revised next steps set out in the stocktake in relation to some actions (e.g. Integrated Care Providers (ICPs)) and need for further national clarity and local Board development (e.g. in relation to the future financial regime and system savings approach) and changes which have resulted from the COVID-19 experience, some component parts of the agreed governance will be reviewed following agreement at the June JUCD Board Development session. This review will cover the System Savings Group, ICPs, System Executive: CEO meeting and System Escalation call which will be reviewed between October and December 2020.

Finance
The system is reporting a deficit of £6.4m at Month 4 (end of July) but this position does not include the COVID-19 recharge the system will make, which will effectively see us achieve mean a breakeven position. Guidance has now been received on the second half of the financial year, with allocations being made on a system basis, and we are reviewing this against our operational plans.

Attract into the system colleagues who have been displaced in others areas and sectors colleagues who have been displaced through COVID.

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

Assurances

Our strategic thinking includes consideration of issues emerging from Joined Up Care Derbyshire.

Consultation

The report details discussions already had within Joined Up Care Derbyshire Board and a similar paper has been presented to all statutory Boards in Derbyshire.

Governance or Legal Issues

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

Public Sector Equality Duty & Equality Impact Risk Analysis

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

This document is a mixture of a strategic scan of key policy changes nationally and changes in the Derbyshire Health and Social Care environment

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

It is positive to be able to be clear that reducing health inequalities is a key priority for the Joined Up Care Derbyshire System, more than that the opportunity to understand the wider determinants of health such as housing, employment and income start to enable conversations about biological weathering and the impact that has on health inequalities.

There are risks when discussing and agreeing any plan that is associated with self-determined access to treatment such as the winter plan that it doesn't take into account differential access rates relating to members of our local communities – this is something that has been raised within the Joined Up Care Derbyshire System.

Recommendations

The Board of Directors is requested to:

1) Scrutinise appendix 3, noting the risks and actions being taken.
2) Seek further assurance around any key issues raised.

Report presented by: **Ifti Majid**
Chief Executive

Report prepared by: **Ifti Majid**
Chief Executive

Derbyshire Healthcare NHS Foundation Trust

Acute wards for adults of working age and psychiatric intensive care units

Hartington Unit
Chesterfield Royal Hospital
Calow
Chesterfield
S44 5BL
Tel: 01246 512563
www.derbyshirehealthcareft.nhs.uk

Date of inspection visit: 7th September to 10th September 2020
Date of publication: xxxx> 2020

Ratings

Overall rating for this service	
Are services safe?	
Are services effective?	
Are services caring?	
Are services responsive?	
Are services well-led?	

Summary of findings

- We inspected Morton and Tansley Wards following information of concern received that staff were inexperienced, were not supported by the provider to manage patient risks and were not provided with appropriate training. Also, between March and August 2020 three patients who were detained under the Mental Health Act 1983 at the Hartington Unit had died. The trust is continuing to investigate these deaths.
- We inspected the Safe and parts of the Well led key questions at this inspection. We visited Morton and Tansley Wards at the Hartington Unit at this inspection as these were the wards which we received the information of concern about. We also spoke with staff, patients and their relatives by telephone from all three wards prior to the inspection visit. During the week of this inspection we spoke with 34 staff including doctors, nursing staff, social workers, occupational therapists and managers. We also spoke with an advocate from Mind and a social worker who worked for the local authority. We spoke with 12 patients and one of their relatives with their permission. At the inspection visit we looked at eight patient records, 12 patients medicine records and observed a staff handover between shifts.
- At our previous inspection of this core service (acute wards for adults of working age) in November 2019 we rated the Hartington Unit and the Radbourne Unit as requires improvement. We did not re-rate at this focused inspection. During this inspection we identified areas for improvement which were:
- Staff had not assessed all ligature risks on the wards. The provider had installed closed circuit television cameras on the ward to reduce the risks of blind spots but the ligature risks of these had not been assessed on the ward ligature assessments.
- Work to eradicate the dormitories had been halted in March 2020 due to COVID-19. Following this inspection, the trust told us they had submitted a funding bid in July 2020 for conversion of the inpatient service and extensive building programme. At the time of report publication, the trust awaits the decision.
- Staff did not always complete all patient assessments to ensure they could manage risk well.
- The provider had not trained sufficient numbers of staff in supporting patients safely, for example, moving and handling, positive and safe care, life support and safeguarding level 3.
- Our findings demonstrated that governance processes did not always operate effectively at ward level and that risks were not always managed well. Staff did not always record the temperatures in clinic rooms and medicines fridges to ensure medicines were stored safely.

However:

- The ward environments were clean and generally well maintained.
- Staff recruitment was ongoing and new staff had been recruited which meant the wards had enough nurses and doctors.
- Staff minimised the use of restrictive practices and only used restraint as a last resort.
- Staff followed good practice with respect to safeguarding.
- Staff followed safe practice in prescribing, administering and recording of patients' medicines.
- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for patients and staff.
- Most staff knew and understood the provider's vision and values and how they were applied in the work of their team.
- Staff felt respected, supported and valued. They reported that the provider promoted equality and diversity in its day-to - day work and in providing opportunities for career progression.
- Staff felt able to raise concerns without fear of retribution.

Summary of findings

- Staff engaged actively in local and national quality improvement activities.

Acute wards for adults of working age and psychiatric intensive care units

Summary of this service

- The acute wards for adults of working age are based on two sites: the Hartington Unit is located on the Royal Chesterfield Hospital site and the Radbourne Unit is located on the Royal Derby Hospital site. We only inspected the Hartington Unit at this inspection. There are three wards there:
- Pleasley Ward- 20 beds mixed gender – there are 12 beds for older adults.
- Tansley Ward- 22 beds mixed gender (reduced to 19 during COVID-19 pandemic)
- Morton Ward – 22 beds mixed gender (reduced to 21 during COVID-19 pandemic)
- The provider is registered to provide at the Hartington Unit the Regulated Activities of:
- Treatment of disease, disorder or injury;
- Assessment or medical treatment for persons detained under the Mental Health Act 1983;
- Diagnostic and screening procedures
- At our previous inspection in November 2019 we rated the core service of acute wards for adults of working age as requires improvement overall; requires improvement for Safe and Well led and Good for effective, caring and responsive.

Is the service safe?

The Hartington Unit was rated requires improvement for safe at our previous inspection in November 2019. We did not re-rate at this inspection.

- Staff had not assessed all ligature risks on the wards. The provider had installed closed circuit television cameras on the ward to reduce the risks of blind spots but the ligature risks of these had not been assessed on the ward ligature assessments.
- Work to eradicate the dormitories had been halted in March 2020 due to COVID-19. There was no date to recommence this work. Following this inspection, the trust told us they had submitted a funding bid in July 2020 for conversion of the inpatient service and extensive building programme. At the time of report publication, the trust awaits the decision.
- Staff did not always complete all patient assessments to ensure they could manage risk well.
- The trust had stopped face to face training to staff in March 2020 due to COVID-19. This was due to infection control practice and that some accredited training needed adaptation to ensure staff could be trained safely. This had recently restarted but this meant several staff needed to attend mandatory training and updates to know how to keep patients safe.
- Staff did not always record the clinic room and medicine fridge temperatures to ensure medicines were stored safely.

However:

Summary of findings

- The ward environments were clean and generally well maintained.
- Staff had followed infection control procedures and reduced the risks of transmission of COVID-19.
- Staff recruitment was ongoing and new staff had been recruited which meant the wards had enough nurses and doctors. Newly qualified nurses were supported in their development and not left to manage shifts without the support of senior nurses.
- Staff minimised the use of restrictive practices and only used restraint as a last resort.
- Staff followed medicine management policies to safely prescribe, administer and record patients' medicines.

Is the service well-led?

- Our findings demonstrated that governance processes did not always operate effectively at ward level and that risks were not always managed well. Managers had completed care plan audits but in two of the eight records we looked at the patient did not have a care plan. One patient care plan had not been updated following administration of rapid tranquilisation. Staff had not fully completed an assessment for another patient. Staff did not always record the temperatures in clinic rooms and medicines fridges to ensure medicines were stored safely.
- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for patients and staff.
- Most staff knew and understood the provider's vision and values and how they were applied in the work of their team.
- Staff felt respected, supported and valued. They reported that the provider promoted equality and diversity in its day-to - day work and in providing opportunities for career progression.
- Staff felt able to raise concerns without fear of retribution and knew how to contact the Freedom to Speak Up guardian.
- Staff engaged actively in local and national quality improvement activities.

Detailed findings from this inspection

Is the service safe?

Safe and clean environment

Safety of the ward layout

- Staff had not updated the ligature risk assessment on the wards following the installation of closed-circuit television cameras. This meant that staff may not be aware of these risks and take action to reduce them. The trust had installed the cameras to reduce the risks of blind spots so that staff could see patients in these areas and ensure they were safe. However, the cameras could be used as an anchor to tie a ligature. On Morton Ward there were ligature points near the handwashing station, on the closed-circuit television cameras in the male bedroom corridor and television lounge, the air conditioning unit, ceiling tiles and suspended ceilings. All these risks except the closed-circuit television cameras were included in the ligature assessment dated October 2019 on Morton Ward and on Tansley Ward dated November 2019. The trust had reviewed the ligature risks of specific types of patients' beds. They planned to remove these and replace with fixed beds during the work to remove dormitories but due to COVID-19 this work had stopped. Staff told us they were aware of the ligature risks and increased patient observations where needed.
- There were blind spots on both wards which were reduced by mirrors and cameras.
- On both wards inspected work to remove the dormitories had stopped in March 2020 due to COVID -19. The trust had planned to create a bed space for each patient by installing partition walls. There was no date to restart this work. However, the trust told us following this inspection that they have submitted a large-scale funding bid to redesign the acute wards and provided evidence of this. The bed replacement programme is active, and the phasing of this work is continuing and awaits the next batch and delivery from the manufacturer.
- The assisted bathroom in Morton Ward was still not working as at our previous inspection In November 2019. The display board was broken in the patient corridor.
- The wards complied with guidance on mixed sex accommodation. Each ward had a separate lounge for female and male patients. There were separate male and female toilets and bathrooms and patients did not have to walk through an area occupied by patients of another sex to access these.
- Staff had easy access to alarms and the trust had recently provided new alarms for staff use. Patients had easy access to nurse call systems.

Maintenance, cleanliness and infection control.

- Both wards were clean, cleaning records were up to date and showed the wards were cleaned regularly.
- Staff adhered to infection control procedures, including hand washing, and these had been updated since the start of the COVID-19 pandemic. There were hand washing stations on the wards and adequate supplies of hand sanitiser. Staff told us there had been adequate stocks of personal protective equipment throughout the pandemic. We observed staff wearing personal protective equipment and this was also available for patients. Patients were initially admitted to Morton Ward in side rooms to isolate until the test results for COVID -19 were available. There had been separate rooms on each ward made available to accommodate patients who tested positive for COVID -19 so they could be nursed safely. There were no patients who tested positive at the time of our inspection.

Clinic room and equipment

- Clinic rooms were fully equipped with accessible resuscitation equipment and emergency drugs that staff checked regularly. Staff maintained equipment well and kept it clean. Clinic rooms were clean and well organised.

Safe staffing

Detailed findings from this inspection

Nursing staff

- Managers had calculated the number and grade of nurses and healthcare assistants required. Recruitment of staff was ongoing in Hartington Unit and had improved since our previous inspection. Staff told us that staffing levels had been increased during COVID-19. On Tansley Ward at the time of our inspection all but one band 5 registered nurse post had been recruited to. We requested staffing rotas for four weeks for Morton and Tansley wards. These showed that staffing levels were met on day shifts. However, for four night shifts during the period there was not a registered nurse available for Morton Ward. The provider told us that due to short notice staff sickness there was not a bleep holder and a registered nurse on Morton Ward for these nights. However, the registered nurse who was the bleep holder for the unit was based on Morton Ward to ensure safe staffing levels were met. Ward managers could adjust staffing levels daily to meet patients' needs.
- When necessary managers deployed bank and agency nursing staff to maintain safe staffing levels, those staff had received an induction and were familiar with the ward. Staffing levels allowed patients to have regular one to one time with their allocated nurse. Staff shortages rarely resulted in staff cancelling escorted leave or ward activities. There were enough staff to carry out observations and restraint when needed safely. Patients said that staff were always available which made them feel safe.

Medical staff

- The service had enough medical staff, who knew the patients to keep them safe from avoidable harm. A doctor could attend the wards quickly in an emergency. There was also an additional doctor based at the Hartington Unit who focused on patient's physical health needs.

Mandatory training

- The trust told us that compliance by staff overall in mandatory training in August 2020 at the Hartington Unit was 75%. This was under the trust target of 85%. For Morton Ward it was 73% and Tansley Ward was 70%. Face to face training had been suspended in March 2020 due to COVID-19. Staff said they had more opportunities to do e-learning during this period and that face to face training was restarting.
- The trust told us that only 65% of staff on Morton Ward and 53% of staff on Tansley Ward had completed updated training in basic life support. However, ward managers told us that staff had been booked to attend this now that face to face training had restarted. The trust told us that overall 34% of staff had received updated training in moving and handling. This was also under the trust target at our inspection in November 2019 when 58% of staff had received this training. The trust acknowledged this and told us the training had continued through COVID-19 with staff wearing personal protective equipment. They had also provided additional investment due to size restrictions of training due to COVID-19.

Assessing and managing risks to patients and staff

Assessment of patient risk

- We looked at eight patient records. Staff had not always fully assessed patient risk. For example, one patient had signed a disclaimer to say they would be responsible for looking after their own money (large amount of cash). Staff had not completed an assessment of the patient's mental capacity to make this decision. For another patient, staff had not fully completed their assessment of the risks of the patient's withdrawal from alcohol. Another two patient's records did not include a care plan for the patient, one patient had been admitted five days before and the other was admitted three days before. Another patient did not have a care plan as to how staff were to support them to manage their aggression.

- We found that staff discussed discharge planning and the risks of this at each patient's ward round, at staff handover meetings and at daily 'rapid review' meetings. 'Rapid review' meetings had started since our previous inspection and were held daily so that all staff were aware of patients risks and the multidisciplinary team reviewed these. The community teams, social workers and representatives from housing teams also attended these.
- Records we looked at included safety assessments that had been reviewed and updated as needed. These were reviewed at least weekly and when needed, for example, following an incident. Staff discussed patient risks at daily 'rapid review' meetings.

Management of patient risk.

- Staff managed risks to patients and themselves well and followed best practice in anticipating, de-escalating and managing behaviour that could challenge the service. All staff told us that restraint was only used as a last resort and after all other ways to de-escalate the behaviours had failed. Patients were encouraged to talk with staff about what worked best for them as an individual to help them calm down when they felt agitated or distressed.
- Records included personal emergency evacuation plans for patients, so staff knew how to support each patient in an emergency.
- Records included assessments of patient's physical health needs. These included assessments of the patient's nutrition and assessment of their skin to identify if there were any risks of the patient developing a pressure ulcer. Staff had assessed and developed care plans where needed for care of patients with diabetes.
- Staff followed good policies and procedures for use of observation and for searching patients and their bedrooms.
- Staff applied blanket restrictions on patients' freedom only when justified. Patients and their visitors told us that during the COVID-19 pandemic the ward doors had been locked and this was restrictive. We saw that ward doors were locked so that staff were aware of who was going on and off the ward. This was needed to reduce the risk of transmission of COVID-19 and the trust had risk assessed this. We saw that staff responded quickly when the doorbell to the ward went and when patients asked to leave the ward. Visiting arrangements had been restricted but this was in line with the government guidance on COVID-19.
- Staff adhered to best practice in implementing a smoke free policy. Staff had offered smoking cessation support to patients who smoked cigarettes on admission. Care plans showed how staff were to support the patient.

Use of restrictive interventions.

There are no seclusion facilities at the Hartington Unit.

The ward staff participated in the provider's restrictive interventions reduction programme. Staff used restraint only after attempts at de-escalation had failed. The provider trained staff in the positive and safe approach. However, the trust told us as at August 2020 that 17% of staff had completed their positive and safe breakaway annual update and 57% of staff had completed their positive and safe teamwork annual update. This training had recommenced five weeks before our inspection and staff who needed to attend this training had been booked on to this.

On Tansley Ward there was a room called 'The sanctuary.' This included soft seating, a wall with a photo of Chatsworth House and another wall with a write on/ wipe off board where patients could write on. There was also a view to outside of the courtyard. Patients and staff told us this was a helpful space for patients to relax and spend time if they wanted to if they were feeling agitated or over anxious.

Detailed findings from this inspection

Staff followed National Institute for Health and Care Excellence on administering rapid tranquilisation. We observed staff deciding on using this for a patient during our inspection to keep the patient and other safe after other attempts to deescalate the patient had failed. However, staff did not record on the electronic record their monitoring of the patient's physical observations. This meant that staff may not have been able to support the patient to reduce risks to their physical health if needed.

At our previous inspection we found that staff did not keep seclusion records appropriately. However, we did not look at this during this inspection as there are no seclusion facilities at the Hartington Unit.

Safeguarding

- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse. However, as with other training the figures of staff compliance were low as face to face training had been stopped due to COVID-19.
- Staff knew how to identify adults and children at risk of, or suffering, significant harm. This included working in partnership with other agencies. There were six staff on Morton and Tansley wards who needed to complete training in safeguarding adults' level 3. Only two of six had completed this due to suspension of training because of COVID-19. To minimise the risks of this staff had access to social workers within the Hartington Unit and social workers attended the daily 'rapid review' meetings. This meant that if staff were unsure about whether a safeguarding concern should be raised, they could get advice and discuss their concerns with the social worker. Social workers told us that staff sought their advice as needed and appropriately reported safeguarding concerns and risks.

Staff access to essential information.

- All staff had access to clinical information on the patient electronic record system. Staff said they knew how to use the system and staff from crisis and community teams could access the information about the patient and vice versa.
- We found that staff had not fully completed assessments and care plans in four of the patients records we looked at. For example, staff had not followed the trust policy and completed the withdrawal scale and dependency tool for one patient who was having treatment for alcohol detoxification. For another two patients staff had not completed a care plan as to how staff were to support the patient to meet their needs. Staff had not completed an assessment of another patient's mental capacity to make a decision about looking after their money (large amount of cash).

Medicines management

- The service used systems and processes to safely prescribe, administer and record medicines. Staff regularly reviewed the effects of medications on each patient's physical health. Patients told us that doctors discussed their medicines with them.
- Pharmacy staff visited each ward twice daily to review medicine management processes, complete audits and advise staff and patients on prescribing of medicines and any side effects or treatment. However, on Tansley Ward staff did not always ensure that medicines were stored safely. We found 17 occasions where staff had not recorded the temperature of the clinic room and medicines fridge to ensure medicines were stored safely. Pharmacy staff had completed incident forms for seven of these.
- Staff reviewed the effects of medication on patients' physical health regularly and in line with NICE guidance, especially when the patient was prescribed a high dose of antipsychotic medication. Records showed staff monitored the physical health of patients prescribed Clozapine (anti-psychotic medication).
- Nursing and medical staff reviewed 'as required' medicines with the patient, and these were not used regularly. Since our previous inspection, the trust had ensured staff had access to the British National Formulary through an app on their mobile phones, a paper copy of this was also kept in the clinic room for staff to refer to.

Detailed findings from this inspection

- At our previous inspection we found that ward staff did not always store and dispose of illicit substances in line with the trusts policy. We observed improved practice with the storage and disposal of illicit substances at this inspection.

Track record on safety.

- The provider had reported three deaths of patients detained under the Mental Health Act 1983 at the Hartington Unit from March to July 2020. These were in the process of being investigated at the time of this inspection.

Reporting incidents and learning from when things went wrong

- Staff recognised incidents and reported them appropriately. All staff we spoke with told us that they knew what incidents to report and how to do this on the providers electronic incident reporting system. Staff told us that managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Is the service well-led?

Leadership

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for patients and staff. Staff said managers had an open-door approach and they could seek their advice and support. Staff told us that senior managers had increased their visibility during the COVID-19 pandemic using video calls and adding podcasts and messages to the staff intranet.
- The trust had employed a Matron for the Hartington Unit who had been in post since November 2019. Staff told us they valued this role and it had increased the visibility of senior leaders within the Hartington Unit. The trust had also recruited a clinical lead for the Hartington Unit. They had started in post the week of our inspection and were focussed on the physical health needs of patients and on the needs of older adults.

Vision and strategy

- Most staff knew and understood the provider’s vision and values and how they were applied in the work of their team. However, some staff told us they did not know what these were.

Culture

- Staff felt respected, supported and valued. They reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression.
- Staff felt able to raise concerns without fear of retribution. Staff knew how to use the whistle blowing process. They knew why they would contact the Freedom to Speak Up Guardian and how to contact them.
- Staff told us how the trust managers had supported them during the COVID-19 pandemic and communicated well through the use of the staff intranet and social media. Staff who were shielding due to COVID-19 had regular supervision where they discussed coping strategies with their manager. They were also included in teams reflective practice sessions via telephone and video calls and paid their usual enhancements, so their health needs did not affect their financial situation. They were also involved in developing activities for patients, for example, quizzes for patients quiz nights. The trust offered all staff a health and wellbeing assessment.
- Ward managers had developed the staff managerial supervision template which was more detailed, reviewed the actions from the previous session and recorded all the discussion. Managers told us they were aware that supervision needed to be recorded and formalised and that this needed to improve.

- Staff had access to resolve (employee assistance programme) where they could access counselling and support for work related and personal issues.
- Some staff told us before this inspection that issues were not always dealt with appropriately. We saw that managers dealt with poor staff performance where needed and made referrals when needed to regulators, for example, the Nursing and Midwifery Council. The outcomes of investigations into staff performance were not always shared with all staff to maintain confidentiality.

Governance

- There was not a clear framework for both wards we inspected of what must be discussed at ward level in team meetings to ensure that essential information, such as learning from incidents and complaints, was shared and discussed. We looked at notes from team meetings for the last six months. These had changed during the COVID-19 pandemic as staff were not all able to meet due to social distancing. On Morton Ward we saw that staff had access to a comprehensive 'team brief' and included information needed in the absence of regular team meetings. However, on Tansley Ward the information provided for staff was brief and it was not clear how staff would access all the information provided to staff on Morton Ward.
- Our findings demonstrated that governance processes did not always operate effectively at ward level and that performance and risk were managed well. Care plan audits did not ensure that staff always completed assessments and care plans for patients. Medicine audits did not always help to improve staff recording of the clinic room and medicine fridge temperatures to ensure medicines were safely stored.
- Staff understood the arrangements for working with other teams, both within the trust and external, to meet the needs of patients. Staff had developed the daily 'rapid review' meetings for patients which included staff from within the Hartington Unit, crisis and community teams as well as social services, housing services and local voluntary services that supported the patients.

Management of risk, issues and performance

- The service had plans for how to support patients and staff and had regularly reviewed and updated these during the COVID-19 pandemic. Staff were informed of changes via the staff intranet and social media.
- **Information management**
- Ward teams had access to the information they needed to provide safe and effective care and used that information to good effect. Team managers had access to information to support them in their management role. This included information on the performance of the service, staffing and patient care.

Learning, continuous improvement and innovation

- Staff engaged actively in local and national quality improvement activities. In response to a previous cohort of junior doctors feeling unsupported the matron had started a quality improvement project with the current cohort. They had surveyed the junior doctors at the start of their time at the Hartington Unit and in response to this had provided more alarms. They were working with nursing staff to identify why they need to call the doctor and what they can get prepared including the necessary information to help the doctor quickly identify and treat the patient when they arrive on the ward. This was more of a team approach to meet the patients' needs.
- The wards at the Hartington Unit were working towards Accreditation for Inpatient Mental Health Services (AIMS) for acute mental health wards.

Detailed findings from this inspection

Areas for improvement

- The trust must ensure that ward ligature risk assessments record all ligature risks and staff are aware of how to reduce these. (Regulation 12)
- The trust must ensure that sufficient staff are trained in moving and handling, positive and safe care, basic life support, intermediate life support and safeguarding level 3. (Regulation 12)
- The trust must ensure that staff complete and record assessments for all of patients needs and risks and record physical health monitoring following administration of rapid tranquilisation. (Regulation 17)
- The trust must ensure that staff record the temperature of the clinic room and medicines fridge daily to ensure medicines are stored safely. (Regulation 17)

Should do

The trust should ensure that staff on all wards have access to the information they need about the COVID-19 pandemic and other information needed in absence of whole team meetings.

Our inspection team

Two CQC inspectors and two specialist advisors who are registered nurses working in acute mental health services visited the Hartington Unit on 10th September 2020. Before the visit four CQC inspectors and one inspection manager spoke with staff by telephone and reviewed documents requested from the provider. An expert by experience spoke with patients and their relatives (where patients had agreed with this) by telephone.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

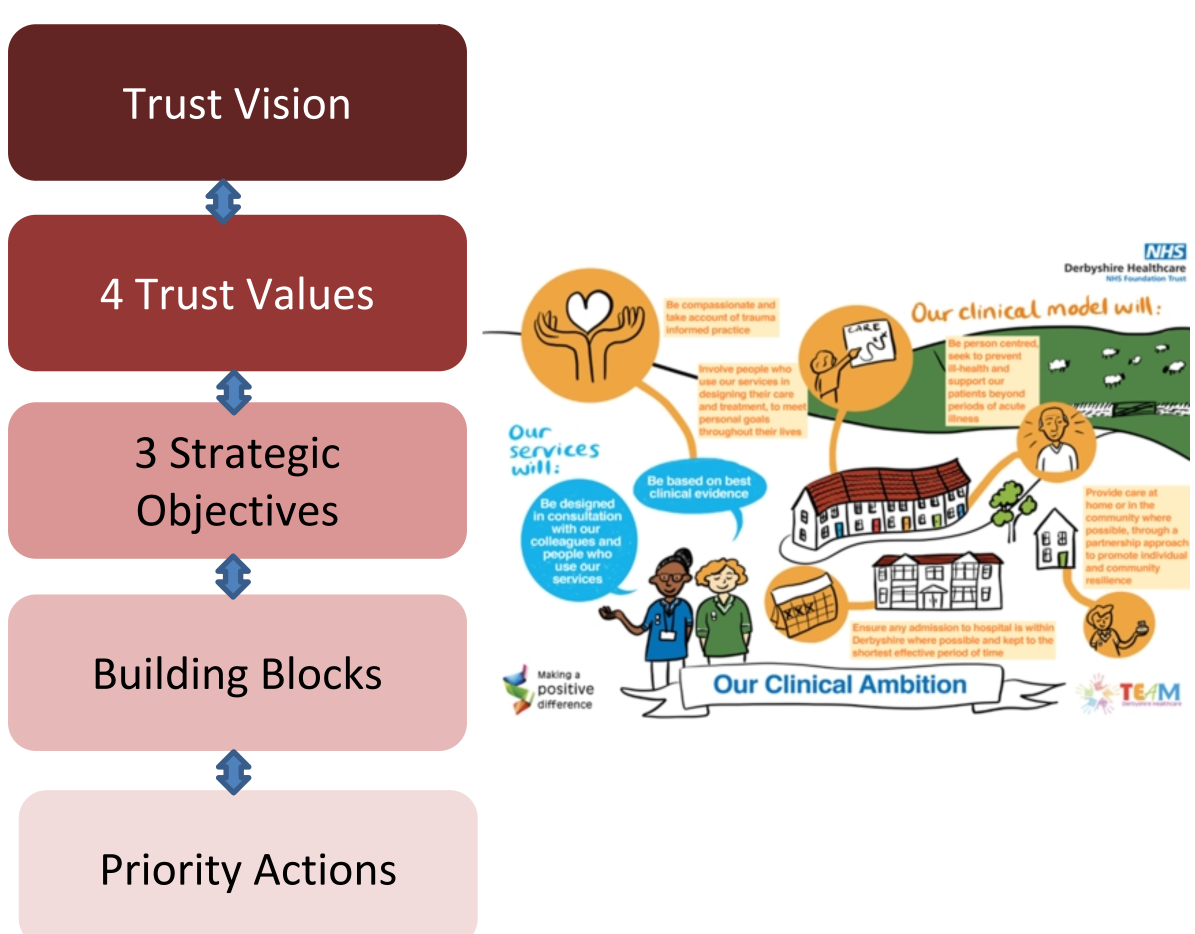
Regulated activity	Regulation
Treatment of disease, disorder or injury	Choose regulation from this dropdown

Appendix 3

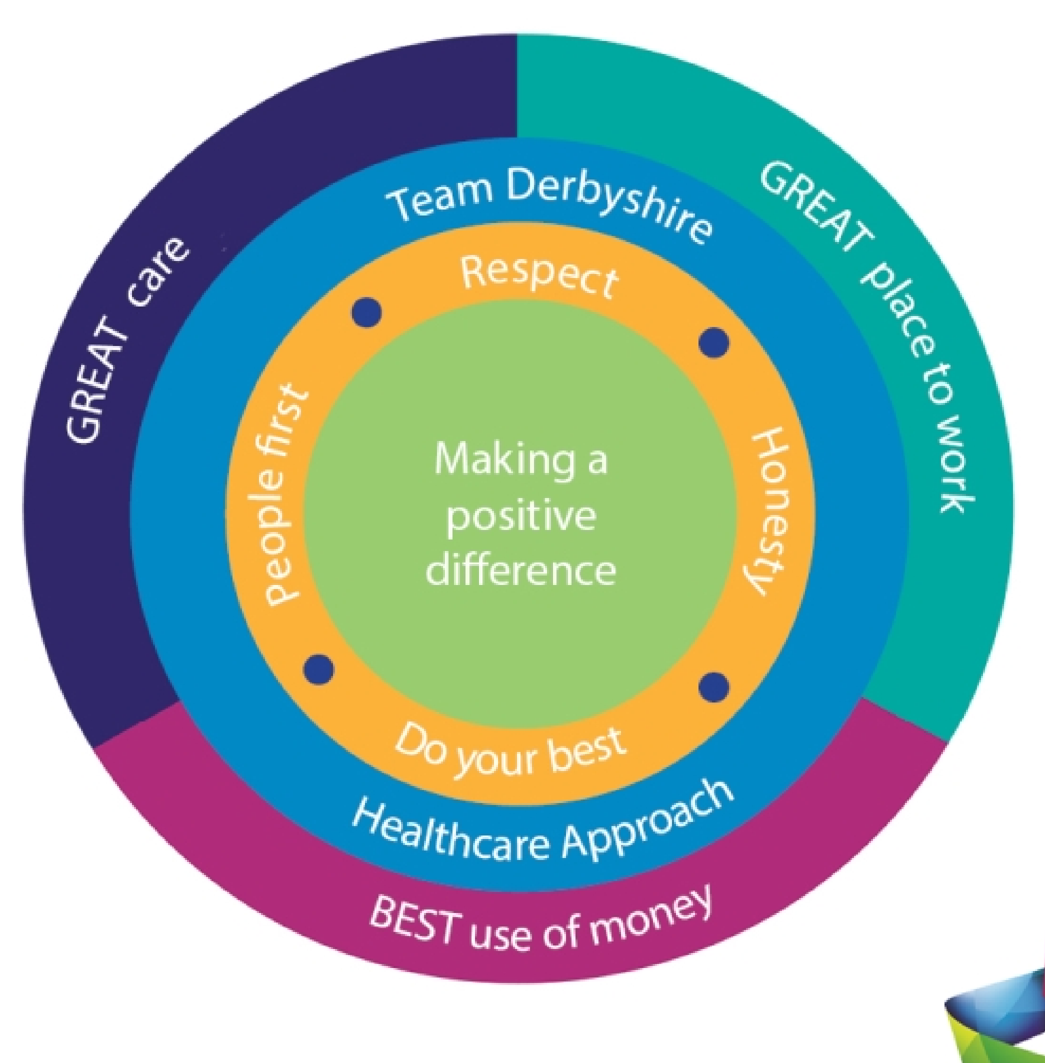
Refreshed Trust Strategy November 2020

www.derbyshirehealthcareft.nhs.uk

Our Approach



Our Golden Circle



Making a
positive
difference

The building blocks to...

An inclusive vibrant culture for all

People first leadership

Improve our estate

Best value

Enhanced learning & innovation

A healthy place to work & thrive

Purposeful partnerships

Embrace new technology

Improve psychological & physical safety

Sustainable transformation

Improve services for those most at risk of inequality

A place where people are proud to work & grow

Team Derbyshire Healthcare Promise

GREAT place to work • GREAT care • Best use of money

TEAM Derbyshire Healthcare

Team Derbyshire Healthcare celebrates Black History Month

Black History Month book readings: Colleagues will come together to discuss a number of titles focused on the lives and experiences of Black people and communities.

Featuring (dates and links will be shared shortly):

- Dr Chinwe Obinwa and Carolyn Green
- Sharon Rumin and Justine Fitzjohn
- Dr Deep Sirur and Gareth Harry
- Elsie Gayle and Mark Powell.

A new **Black Lives Matter library** collection is now available and can be accessed via the Black History Month page on Focus. Why not loan a book from Kingsway Hospital library and share your views!

You can also join the library's next staff book club where colleagues are reading 'To Kill a Mockingbird' by Harper Lee. The group will meet via Teams at 12.30pm on 4 November. Please let marie.hickman1@nhs.net know if you would like to join in.

A cookery class: 'Rice, chicken and peas with Rumin'! - See the ingredients you will need on Focus and join in live on the day!

Thursday 15 October, 6.30pm - Join the cookery class. Or call 020 3321 5208, Conference ID: 960 984 434#.

Show racism the red card by wearing something red: Friday 16 October.

Black History Month Quizzes: how much do you know about how Black people have shaped our society? Prizes available for winning participants!

Dates and times to be confirmed – please look out for details in Weekly Connect and the Team Derbyshire Healthcare Facebook page.

'Black Lives Mentored' video (around Black Lives Matter) - Earl Douse: Friday 16 October, 12.30 pm - Join the session. Or call 020 3321 5208, Conference ID: 660 311 592#.

Gospel Choir singalong supported online cultural song with Derby Community Choir: Contact zadams@nhs.net to access the lyrics and for further information on practice you will need – no singing experience necessary!

Concert: Thursday 28 October, 5pm.
The song proposed is 'I'm your brother, your sister'.

Invitations to the practice sessions will be shared with colleagues who request the lyrics.

Guest speaker Jennifer Izekor talks with colleagues about cultural intelligence: Friday 30 October, 1pm – 2.30pm - Join this meeting or call 020 3321 5208, Conference ID: 553 440 367#.

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 3 November 2020

Performance Report

Purpose of Report

The purpose of this report is to provide the Board of Directors with a brief update of how the Trust was performing at the end of September 2020 during this extremely challenging period. The report focuses on key finance, performance and workforce measures.

Executive Summary

The report provides the Board of Directors with information that demonstrates how the Trust is performing against a suite of key targets and measures. Performance is summarised in an assurance summary dashboard with targets identified, where a specific target has been agreed. Where a specific target has not been agreed or specifically commissioned, colleagues will be able to track performance over time and discuss/challenge any specific variation that may be of concern or unusual. Further detailed statistical process control charts for the measures are included in appendix 2. The main areas to draw the Board's attention to are as follows:

Finance

Revenue: In order to 'true-up' to breakeven we accrued top-up income amounting to £458k for September 2020. This brings the top ups that have been required in the first half of the financial year to a total of £2.5m.

Within the overall costs for the month we incurred £780k for COVID-19-related costs. For the first half of the financial year our COVID-19-related costs have been £4.5m. Agency costs, particularly COVID-19-related, are quite high for the early part of the year which means that we have spent £1.7m on agency staff in the first half of the financial year compared to the ceiling of £1.5m. The forecast assumes agency costs are above the ceiling of £3.03m by £265k (8.7%), however this does include a level of contingency of £325k for any current unknown agency posts.

Our Adult Acute out of area costs are also increasing which is above the planned reducing trajectory by £0.8m. Out of area placements are required because not all Trust beds are available for use due to the need to maintain COVID-19-secure inpatient environment. This is the case even if 'vacant' bed numbers exceed the number of out of area placements.

The forecast at month 6 is in line with the recent month 7-12 plan submission (see separate paper) with a deficit of £0.6m. The forecast is based on the block income payments which have been notified to us by NHSI along with Local Authority income based on agreed contracts and an assumption for other non-clinical income. The forecast income does include a COVID-19 top up allocation of £0.7m per month (£4.2m), which has been agreed by the System and a share of the System top up allocation of £0.7m. There is also £3.1m of income included in the forecast from the System growth allocation in order to fund the MHIS investments. These investments have been covered in month 1-6 through the 'true-up' to breakeven financial regime.

From an expenditure point of view there are some costs that are unfunded that are included in the forecast, which mainly relate to the revenue consequences of the national Capital bids for the Eradication of Dorms. The bids have been submitted but not yet approved by the Treasury, so this is a prudent approach to include these costs in the forecast.

Capital: For 'business and usual' capital we are behind plan by £1.2m. However this is offset by the unfunded COVID-19 capital expenditure for laptops of £1.2m. The COVID-19 capital bid has been approved by the NHSI regional Team for submission to the National team, of which we are still waiting confirmation of funding.

Beyond the 'business as usual' capital requirements, the Board will be aware of our need for substantial refurbishment and new build in order to eradicate dormitories. We have submitted several versions of the bids following discussions with the regional capital team, however at the time of writing we have not heard an outcome. We are told that the size of our requirements mean that our submission will have a longer national approval process.

A verbal update will be provided to Board on any further feedback or progress on these matters.

Operations

Seven day follow-up of patients on CPA, up to March 2020, then three day follow-up of all patients, from April 2020

To date the revised standard has consistently been achieved.

Data quality maturity index

The level of data quality remains well above target and within normal variation. Services are being restored and patient contact activity is increasing, which should start to positively impact on data quality.

IAPT six week referral to treatment and people completing treatment who move to recovery

With the service having re-opened to digital referrals on 6 July and all staff having returned to their substantive posts by 6 September, this meant that there was capacity to achieve the two targets, with further improvement expected next month.

Patients placed out of area – adult acute

The number of patients in acute out of area beds has been reducing. We have increased commissioning of beds at Mill Lodge Hospital, Kegworth. Work is underway to improve the interface with Mill Lodge in order to enable the delivery of continuity of care.

Patients placed out of area – Psychiatric Intensive Care Units (PICU)

The number of patients in PICU out of area beds is reducing. We are holding weekly meetings with the Clinical Commissioning Group (CCG) in order to monitor bed use and explore alternative arrangements.

Waiting list - Child and Adolescent Mental Health Services (CAMHS)

CAMHS continue to utilise telephone and Attend Anywhere as vehicles to support clinical contacts; face to face appointments are offered only when clinically indicated. This is having a positive impact on the size of the waiting list.

Waiting list for community paediatrics

Significant progress continues to be made to reduce waits and the volume of activity undertaken in September was the highest to date. At the end of September the number of children on the waiting list was at the lowest level achieved to date. When the neurodevelopmental assessment pathway opens we anticipate a large increase in the

number of referrals.

Waiting list for autistic spectrum disorder (ASD) assessment

Following the return of redeployed ASD staff to the team and a successful pilot of Attend Anywhere, the team has been undertaking ASD assessments since September, either remotely or where required via home visit. The current ASD waiting list is 972. The longest wait is around 2.5 years, with the assessment hiatus in March-July having had a further negative impact on overall waiting times.

Waiting list for psychology

The average wait to be seen continues to increase and has been higher than normal for the last 5 months. Conversely the number of patients on the waiting list has been lower than normal for the past four months. Activity is largely being undertaken remotely using telephone or video (Attend Anywhere), with a phasing down of non-critical work.

Admissions

a. Adult Acute

There has been a sustained level of acuity in adult acute inpatients, which can be seen in the reasons for admission, with "in crisis" or "ongoing or recurrent psychosis" accounting for over two thirds of all admissions. In September almost half of the admissions were people admitted under the Mental Health Act. This increased acuity results in an associated increase in activity, clinical care and observations.

b. Older Adult

There has also been a sustained level of acuity in older adult inpatients, with the majority of admissions being under the Mental Health Act. This increased acuity results in an associated increase in clinical care, observations and activity and has also resulted in an increase in incidents of patient aggression towards staff and other patients.

Phase 3 of the NHS response to the COVID-19 pandemic

As reported previously, to help address some of the wider health inequalities persisting in society that have been exposed by COVID-19, the NHS has been tasked with a number of actions. One of these is that all NHS organisations should proactively review and ensure the completeness of patient ethnicity data. Although as a Trust our level of data completeness has been consistently high for a number of years, the pandemic is having a negative impact on recorded ethnicity. Despite this slight deterioration in recorded ethnicities during the pandemic, the large volume of ethnicities that have been recorded is statistically reflective of the patient population as a whole.

Workforce

In order to reduce the burden and release capacity to manage the COVID-19 pandemic, all NHS organisations were instructed to suspend appraisals and revalidation and to reduce the volume of mandatory training as appropriate. This "pause" has now been re-started and the backlog that has resulted is now being addressed.

Compulsory training

As part of the restoration phase a Training Cell within the Incident Management Team (IMT) has been convened to support the Divisions with regards to critical areas covering statutory, mandatory and role-specific training for professional development. The Cell will monitor progress against agreed training recovery plans following the period where training was paused owing to the pandemic. Particular focus is being given to ILS and

Infection control training in our inpatient areas. All areas of training where there is lack of compliance are being monitored weekly through a dashboard. There are ongoing efforts to address demand and capacity to ensure there is enough face to face training being delivered. Further support is being given to encourage the use of E Learning where this is a suitable alternative in many of the areas showing low levels of compliance.

Staff absence

This month's sickness absence levels have risen above the Trusts target to 5.12%. Sickness absence rates increased by 1.15% when compared to last month. Generally over the last 6 months the absence rates for short and long term sickness have improved with August 2020 showing the lowest rate of absence at 3.97%. COVID-19 absence includes both suspected and confirmed cases with suspected cases accounting for 4.38% of the total absence figure and confirmed cases accounting for 1.91%. There is now a slight rise in cases being reported which is in line with national test and trace results and the increase nationally in COVID-19 cases.

Annual appraisals

The level of annual appraisals completed dropped below normal for the first time in almost 2 years. Appraisals both medical and non-medical were paused as part of the COVID-19 response, these have now been stood back up as part of the recovery phase and efforts are ongoing to improve levels of compliance

Supervision

The levels of compliance with the clinical and managerial supervision targets have remained lower than normal since the start of the pandemic.

Quality

Incidents

We are currently seeing an increase in the number of incidents of moderate to catastrophic harm, this being significantly impacted by deaths of people within our substance misuse services.

Seclusion and restraint

The use of seclusion and restraint was within normal variation, although with a potentially reducing trend in physical restraint and prone restraint linked to ongoing reducing restrictive practice work being undertaken.

Complaints, concerns and compliments

The number of complaints increased between June and September to more usual levels as we began to re-establish services, with a particular theme in both concerns and complaints being around access to services

Number of falls on inpatient wards

Reported falls are increasing over recent months, linked to enhanced reporting and a national increase in falls due to older people being less active during COVID-19 lockdown.

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

Assurances

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

Consultation

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

Governance or Legal Issues

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

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

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

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

Recommendations

The Board of Directors is requested to:

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

Report presented by:	**Mark Powell** **Chief Operating Officer**
Report prepared by:	**Peter Henson** **Head of Performance** **Claire Wright** **Director of Finance/Deputy CEO** **Darryl Thompson** **Deputy Director of Nursing & Quality Governance** **Kyri Gregoriou** **Interim Assistant Director of Clinical Professional Practice** **Celestine Stafford** **Assistant Director of People & Culture Transformation**

1. Assurance Summary

Indicator	Rating[1]	Data Quality	Indicator	Rating[1]
Operational				
CPA 7 day follow-up to Mar 20, then 3 day follow-up all patients	?		Waiting list for care coordination – number waiting	See chart
Data Quality Maturity Index (DQMI) - MHSDS data score	P		Waiting list for care coordination – average wait	See chart
Early Intervention (EIP) RTT within 14 days - complete	P		Waiting list for ASD assessment – number waiting	See chart
EIP RTT within 14 Days - incomplete	P		Waiting list for ASD assessment – average wait	See chart
IAPT referral to treatment (RTT) within 18 weeks	P		Waiting list for psychology – number waiting	See chart
IAPT referral to treatment within 6 weeks	P		Waiting list for psychology – average wait	See chart
IAPT people completing treatment who move to recovery	?		Waiting list for CAMHS – number waiting	See chart
Patients placed out of area - adult acute	See chart		Waiting list for CAMHS – average wait	See chart
Patients out of area at month end - adult acute	See chart		Waiting list for community paediatrics – number waiting	See chart
Patients placed out of area - PICU	See chart		Waiting list for community paediatrics – average wait	See chart
Patients out of area at month end - PICU	See chart			
Workforce				
Annual appraisals	F		Clinical supervision	F
Annual turnover	?		Management supervision	F
Compulsory training	?		Vacancies	F
Sickness absence	?		Bank staff use	?

[1]The rating symbols were designed by NHS Improvement

Key:

The system is expected to consistently pass the target

The system may achieve or fail the target subject to random variation

The system is expected to consistently fail the target

2. Detailed Narrative

Operations

A. Seven day follow-up of patients on CPA, up to March 2020, then three day follow-up of all patients, from April 2020

In line with the recommendations of the annual National Confidential Inquiries[1], which have consistently found that people are at most risk of self-harm or suicide in the first two to three days following discharge, from April 2020 the national standard for follow-up post discharge from inpatient wards was reduced from seven days to 72 hours and revised to include all patients, not just those on the Care Programme Approach (CPA). To date the revised standard has consistently been achieved. Confidence limits will be calculated for the new standard once there are enough data points: SPC charts require a minimum of 10 data points in order to create a valid chart, although there is increased reliability when using 20 or more data points[2].

B. Data quality maturity index

The level of data quality remains well above target and within normal variation. Services are being restored in line with national instruction[3] and patient contact activity is increasing. This will positively impact on data quality, which is likely to start to be reflected next month.

C. IAPT 6 week referral to treatment and people completing treatment who move to recovery

With the service having re-opened to digital referrals on 6 July and all staff having returned to their substantive posts by 6 September, this meant that there was capacity to achieve the two targets, with further improvement expected next month.

D. Patients placed out of area – adult acute

The number of patients in acute out of area beds has been reducing. We have increased commissioning of beds at Mill Lodge Hospital, Kegworth and this is now stands at 11. Work is underway to improve the pathway to and from Mill Lodge and also on how DHCFT services keep in touch with patients at Mill Lodge. This will enable the delivery of continuity of care and enable beds to be regarded as appropriate out of area beds.

E. Patients placed out of area – Psychiatric Intensive Care Units (PICU)

The number of patients in PICU out of area beds is reducing. Currently there are 10 male and 8 female patients which is a significant change to the previous gender profile. We are holding weekly meetings with the Clinical Commissioning Group (CCG) in order to monitor bed use and explore alternative arrangements. The CCG are looking to block contract with providers. There may be an opportunity to develop “continuity of care” principles with providers in order to enable placements to be regarded as “appropriate” out of area beds.

F. Waiting list - Child and Adolescent Mental Health Services (CAMHS)

CAMHS continue to utilise telephone and Attend Anywhere as vehicles to support clinical contacts; face to face appointments are offered only when clinically indicated. This is having a positive impact on the size of the waiting list and for the last 3 months the waiting list has remained within normal levels (appendix 2 page 16.)

The number of referrals dropped significantly for several months as a result of the pandemic but has started to return to normal. However CAMHS Eating Disorder referrals over the last 3 months have increased in both number and acuity.

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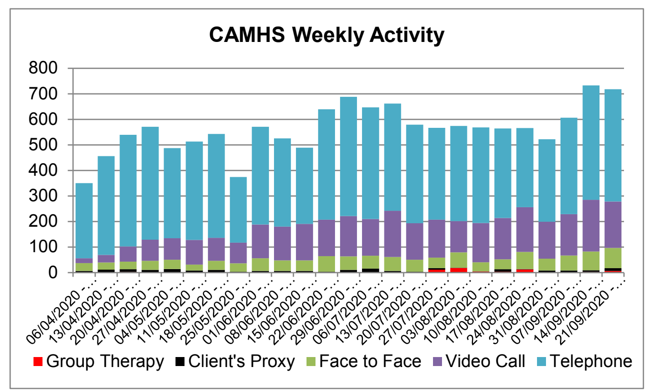
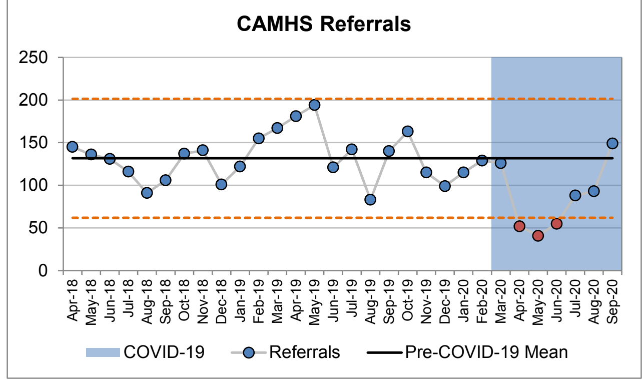
[1] https://sites.manchester.ac.uk/ncish/reports/annual-report-2019-england-northern-ireland-scotland-and-wales/

[2] https://www.england.nhs.uk/improvement-hub/wp-content/uploads/sites/44/2017/11/An-Overview-of-Statistical-Process-Control-SPC.pdf

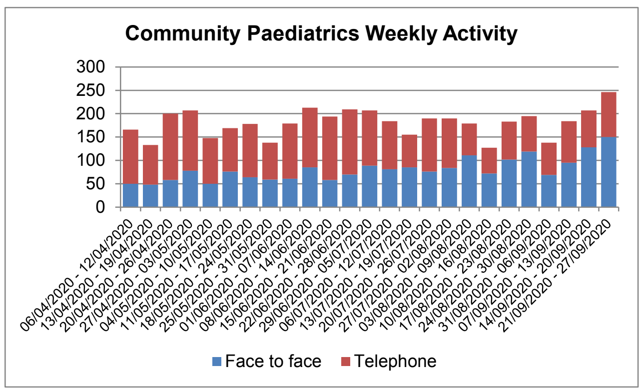
[3] https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/07/Phase-3-letter-July-31-2020.pdf

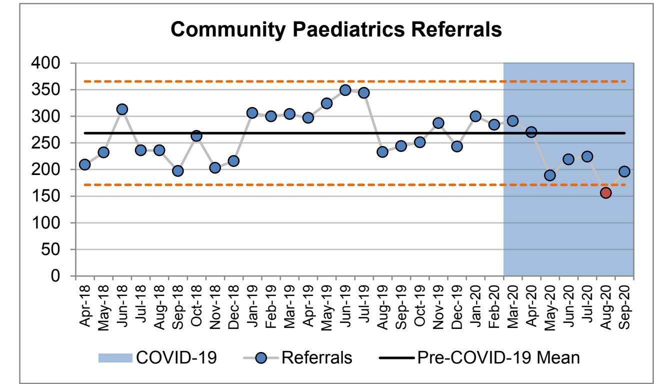




G. Waiting list for community paediatrics

Significant progress continues to be made to reduce waits and the volume of activity undertaken in September was the highest to date. At the end of September the number of children on the waiting list was at the lowest level achieved to date. The number of referrals received has been below average for the last 5 months and was significantly low in August 2020. This reduction was expected because of cross-service closure of the neurodevelopmental assessment pathway. Community paediatrics have agreed to be the service which opens for the starting point (the assessments of children under 6 years old) and so when the full pathway opens we anticipate a large increase in the number of referrals.



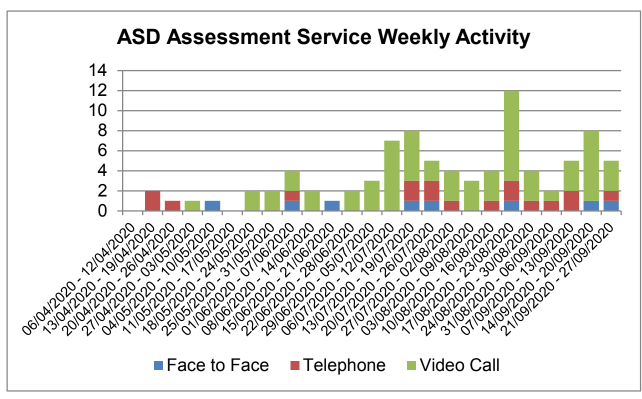


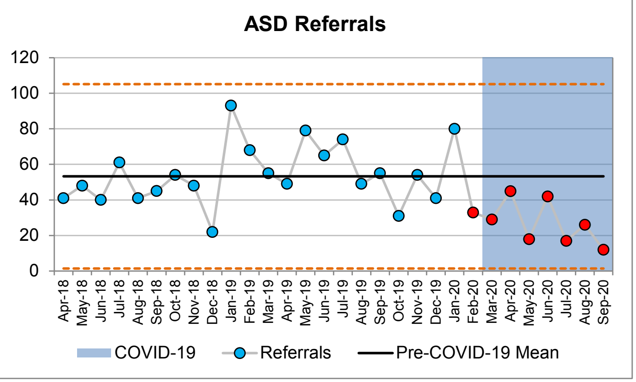
H. Waiting list for autistic spectrum disorder (ASD) assessment

ASD assessments were suspended in mid-March whilst the staff were redeployed. Referrals however continued to be processed remotely by the team administrator. From July the partial team undertook a successful limited pilot on the feasibility of using Attend Anywhere for ASD assessments alongside a new DHCFT assessment tool. Following the return of the ASD staff and the successful pilot the team has been undertaking ASD assessments since September, either remotely or where required via home visit.

The referral rate for 2020/21 is currently the lowest over the past 24 months but still averaging over 150 in 2020/21 so far. The current ASD waiting list is 972 with the longest wait being around 2.5 years, with the assessment hiatus in March-July having had a further negative impact on overall waiting times.

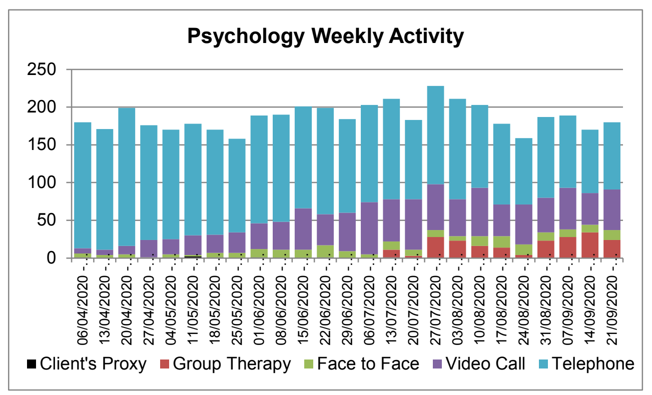
The length of face to face time required for ASD assessments (4 hours) has meant remote assessments are preferred at present whilst a pilot of face to face assessments is being planned to be undertaken at Rivermead to consider viability. There is a potential likelihood that this may lead to a two tier assessment waiting list, with more rapid access for those who can access remote technology.

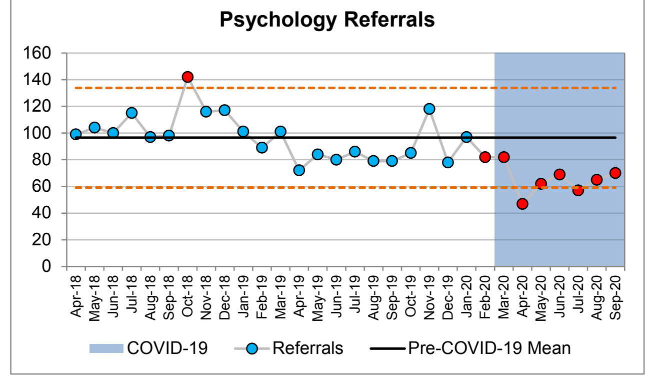




I. Waiting list for psychology

The average wait to be seen continues to increase and has been higher than normal for the last 5 months. Conversely the number of patients on the waiting list has been lower than normal for the past four months. The number of referrals received each month during the pandemic is also lower than normal. Activity is largely being undertaken remotely using telephone or video (Attend Anywhere), with a phasing down of non-critical work.

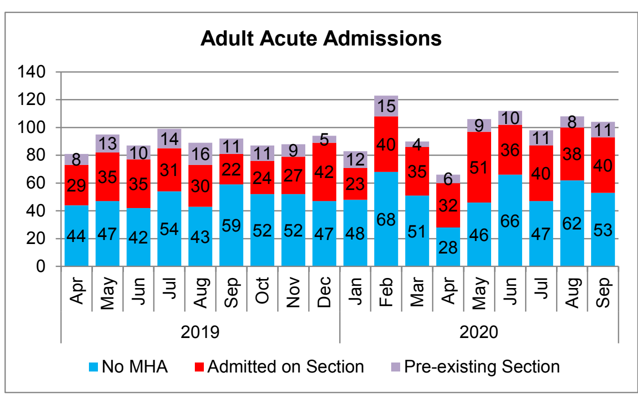


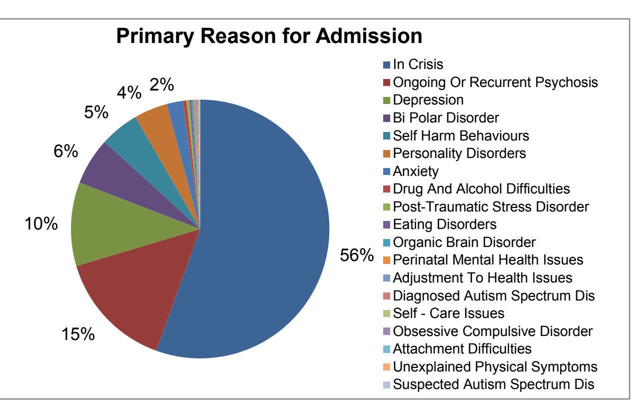


J. Admissions

Adult Acute

There has been a sustained level of acuity in adult acute inpatients, which can be seen in the reasons for admission, with "in crisis" or "ongoing or recurrent psychosis" accounting for over two thirds of all admissions. In September almost half of the admissions were people admitted under the Mental Health Act. This increased acuity results in an associated increase in activity, clinical care and observations.

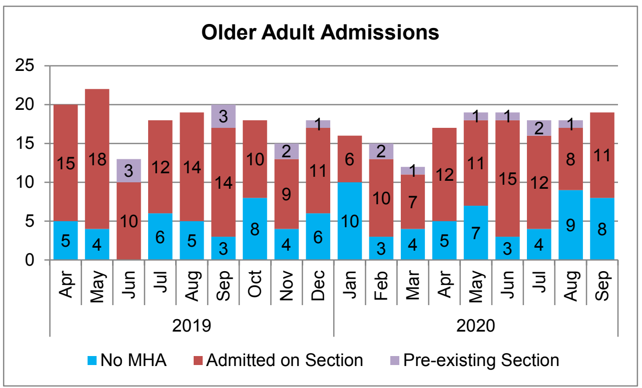


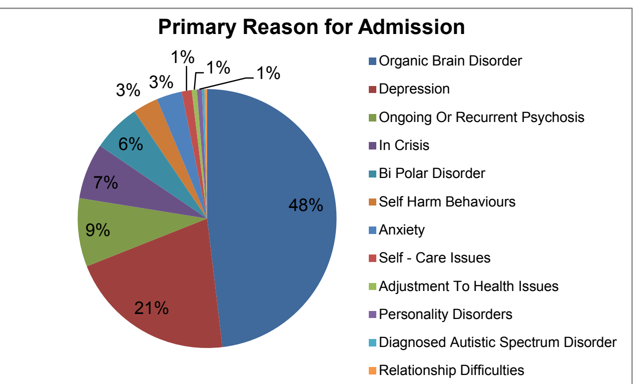


Older Adult

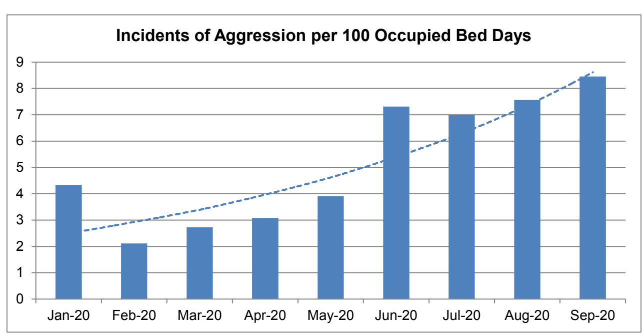
There has also been a sustained level of acuity in older adult inpatients, with the majority of admissions being under the Mental Health Act. This increased acuity results in an associated

increase in clinical care, observations and activity and has also resulted in an increase in incidents of aggression towards staff and other patients.





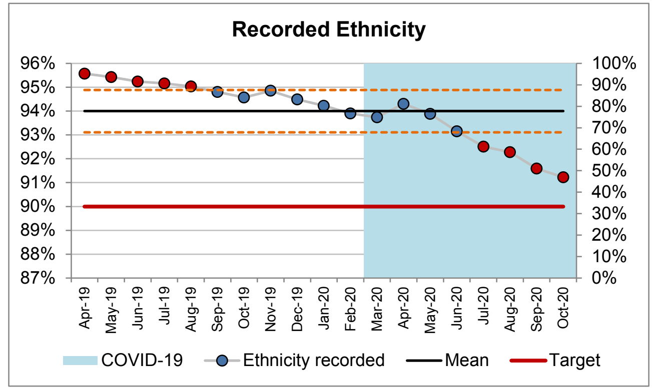
Incidents of aggression:



K. Phase 3 of the NHS response to the COVID-19 pandemic

As reported previously, to help address some of the wider health inequalities persisting in society that have been exposed by COVID-19, the NHS has been tasked with a number of actions[4]. One of these is that all NHS organisations should proactively review and ensure the completeness of patient ethnicity data by no later than 31 December 2020, with general practice prioritising those groups at significant risk of COVID-19 from 1 September 2020.

Although as a Trust our level of data completeness has been consistently high for a number of years, the pandemic is having a negative impact on recorded ethnicity:



The majority of patients without their ethnicity recorded are people who have been referred to us but who are yet to be seen. Up to now GPs have not been required to provide patient ethnicity when making referrals to mental health services and there is no option for the GP to provide ethnicity if they use the national electronic referral system, even if they wanted to. An exception report is sent out weekly to the relevant teams to enable data quality improvement action to be undertaken where possible.

Despite this slight deterioration in recorded ethnicities during the pandemic, the large volume of ethnicities that have been recorded means that statistically we can be 99.9% confident that the known patient ethnicity breakdown is within 0.3% of the ethnicity breakdown of the patient population as a whole. The patient ethnicity breakdown compared with the population we serve is as follows:

[4] https://www.england.nhs.uk/wp-content/uploads/2020/08/implementing-phase-3-of-the-nhs-response-to-covid-19.pdf

Ethnic Group	Patients	Derby & Derbyshire Population
Asian or Asian British	2.8%	3.9%
Black or Black British	1.4%	1.0%
Mixed	1.9%	1.4%
Other Ethnic Group	1.3%	0.4%
White	92.6%	93.3%

Workforce

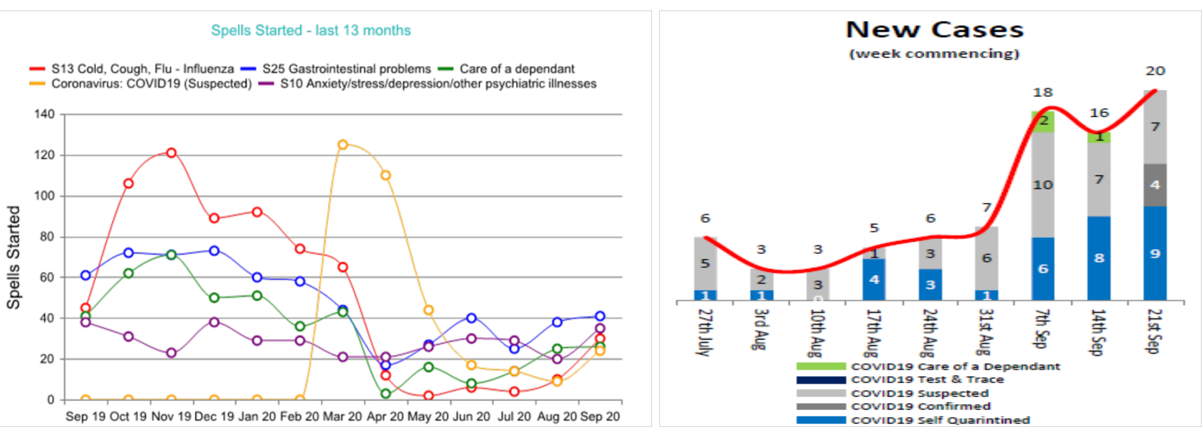
In order to reduce the burden and release capacity to manage the COVID-19 pandemic, all NHS organisations were instructed by Amanda Pritchard, Chief Operating Officer, NHS England and NHS Improvement[5], to suspend appraisals and revalidation and to reduce the volume of mandatory training as appropriate. This has naturally resulted in a backlog of training and appraisals, which now need to be addressed over the coming months. Recent communications have now confirmed that appraisals and revalidations need to recommence and work is ongoing to get the levels of compliance back on track.

A. Compulsory training

As part of the restoration phase a Training Cell, part of the Incident Management Team (IMT) has been convened to support the Divisions with regards to critical areas covering statutory, mandatory and role-specific training for professional development. The Cell will monitor progress against training recovery plans following the period where training was paused for four months owing to the pandemic. The Divisions are now being provided with regular reports of available training slots and of staff members who did not attend their booked training slot. A Marquee has been installed at Kingsway Hospital to enable delivery of face-to-face training in a safe environment, including induction of new starters.

B. Staff absence

Sickness levels have reduced over the last 6 months with August showing the lowest percentage for the last two years at 3.94%, of which COVID-19 related absence was at 2.86%. This month's sickness levels (September) have begun to rise with the monthly rate of 5.12% of which COVID-19 absence accounted for 6.29% of the absences. Having fallen steadily for a number of months, COVID-19 related absences are now beginning to rise in line with increased numbers of staff self isolating, symptomatic staff and confirmed cases which is in line with the local and national picture. As part of the Incident Management Team response, a Staff Check and Trace cell has been set up to trace and check in with any staff who may have been exposed to the virus, to be able to offer support and guidance and to ensure staff are complying with our infection prevention and control rules and guidance.



C. Annual appraisals

[5] https://www.england.nhs.uk/coronavirus/publication/reducing-burden-and-releasing-capacity-at-nhs-providers-and-commissioners-to-manage-the-covid-19-pandemic/

The level of annual appraisals completed fell below normal for the first time in almost 2 years. This is now an area of focus to get compliance back on track across all medical and non-medical appraisals.

D. Supervision

The levels of compliance with the clinical and managerial supervision targets have remained lower than normal since the start of the pandemic.

Quality

A. Incidents

We are currently seeing an increase in the number of incidents of moderate to catastrophic harm. Part of this increase when comparing data for the August and September period is due to an increase in deaths, in particular within our substance misuse population.

B. Seclusion and restraint

The use of seclusion and restraint was within normal variation, although with a potentially reducing trend in physical restraint and prone restraint. This might be in line with pieces of work that have been ongoing with regards to reducing restrictive practices such as the introduction of body worn cameras, monitoring of restrictive practice within the "reducing restrictive practice forum" and monthly thematic reviews carried out by the Head of Nursing. This may also be linked to ongoing projects to reduce the need for prone restraint, such as the introduction of safety pods and alternative depot medication injection site procedure and training.

C. Patients in settled accommodation and patients in employment

There are some slight variances in this data, but the very small range on the vertical axis of the graph means that the significance of visible change needs to be approached with some caution. Accommodation and employment will clearly be affected by the current pandemic and its financial consequences, so this data will continue to be monitored closely.

D. Care plan reviews

The proportion of patients whose care plan has been reviewed continues to be lower than usual. Teams have been prioritising essential tasks, with reduced routine contact, and also trying to engage with people who use our services in different ways, e.g. in virtual ways using Attend Anywhere. We will monitor this over the coming months as teams restore services in line with national expectations, whilst continuing to be impacted by the COVID-19 situation.

E. Complaints, concerns and compliments

The number of compliments decreased in line with the emergence of COVID-19 and the significant changes to many of our clinical services. The number of complaints increased between June and September to more usual levels as we began to re-establish services, and a particular theme around both concerns and complaints was around access to services. Derbyshire Healthcare NHS Foundation Trust continues to work with Health Watch, including receiving regular feedback through governance structures and service user and carer surveys.

F. Duty of Candour

In this report there are two instances of Duty of Candour. The first of these relates to a patient who killed themselves whilst on leave from one of our wards. We treat this as Duty of Candour and record as such by the very nature of the incident. We have met with the person's family and the serious incident investigation is ongoing.

The second incident relates to concerns with regards to an inpatient's care and determining the person's potential risk to health through re-feeding and their need for subsequent transfer to an acute hospital. This patient safety incident is being finalised and we are looking at the systemic learning and how we can reduce this type of incident reoccurring.

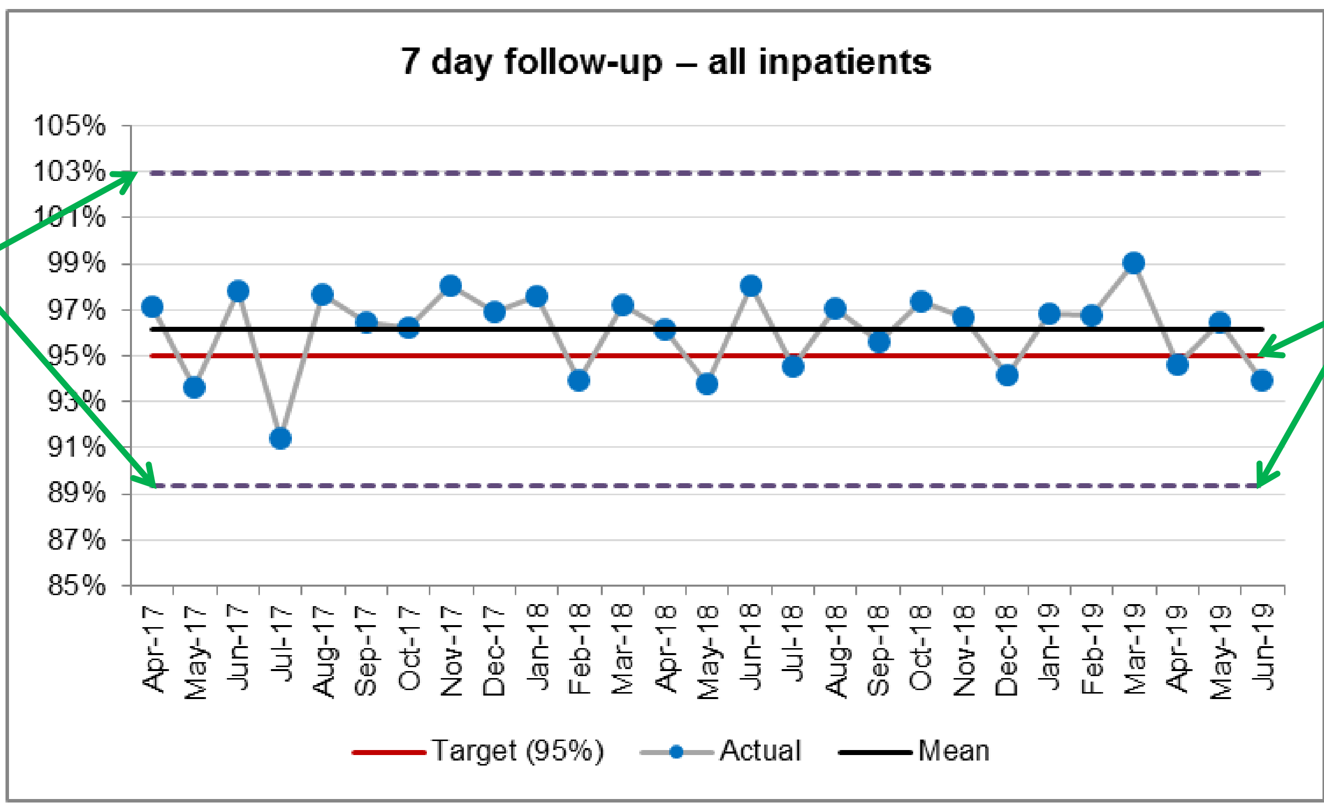
G. Number of falls on inpatient wards

We are reporting an overall increase over recent months, and three things are likely to be influencing this. The first is a particular promotion in training of the good practice of staff recording all falls, including where a person might have only lowered themselves to the floor. The second is the presence of one particular patient on a ward who recorded multiple falls each day, including lowering themselves to the floor, in spite of significant efforts in how that person's care was approached. The third is that nationally we are likely to see an increase in falls generally. This is as a result of people being de-conditioned from exercising less and not going out during the COVID-19 lockdown.

Appendix 1

How to Interpret a Statistical Process Control Chart (SPC)

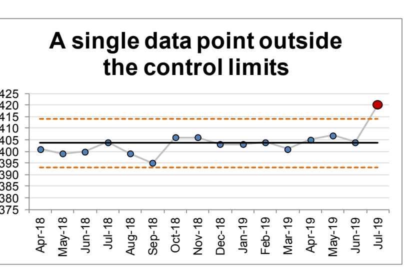
The dotted lines are the "control limits". Any performance between these 2 lines is normal for the current system. This is known as "normal variation"

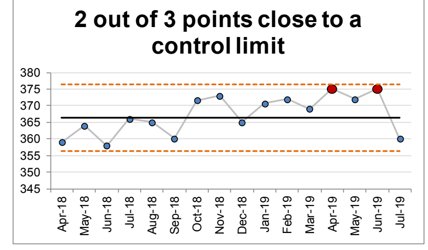


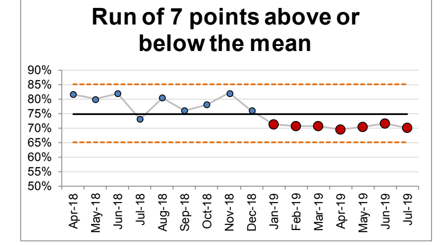
If the system is effective, the **lower** control limit will be above the target line (for targets where higher is better) or the **upper** control limit will be below the target line (for targets where lower is better). In that scenario we have nothing to worry about and can be assured our system is performing well.

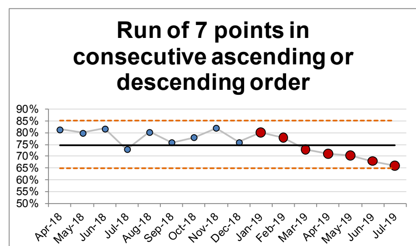
In this case the target line is above the lower control limit which indicates that the system is ineffective.

A run chart also enables us to see when something unusual has happened in the system. This is known as "special cause variation". This can be seen in 4 ways:

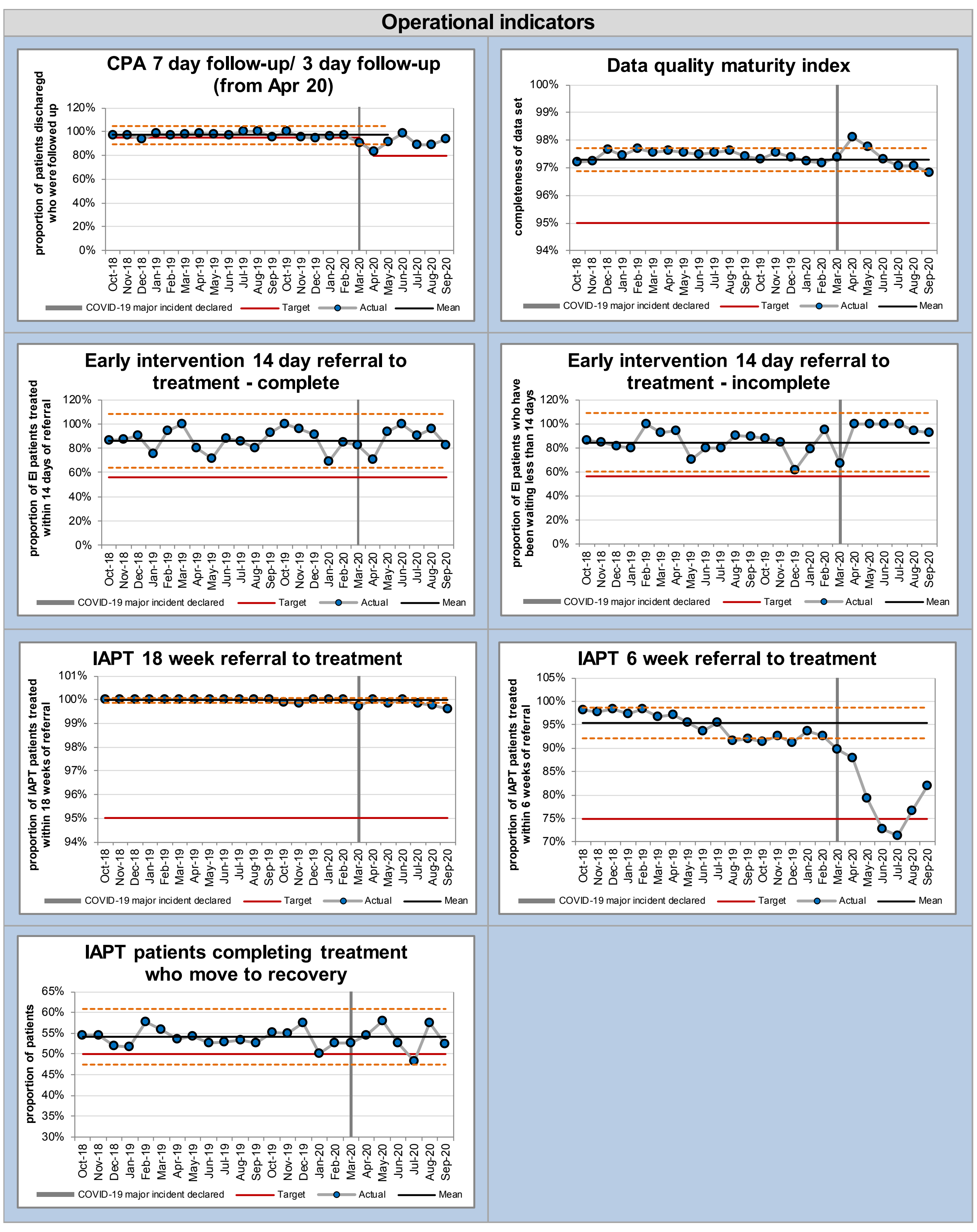




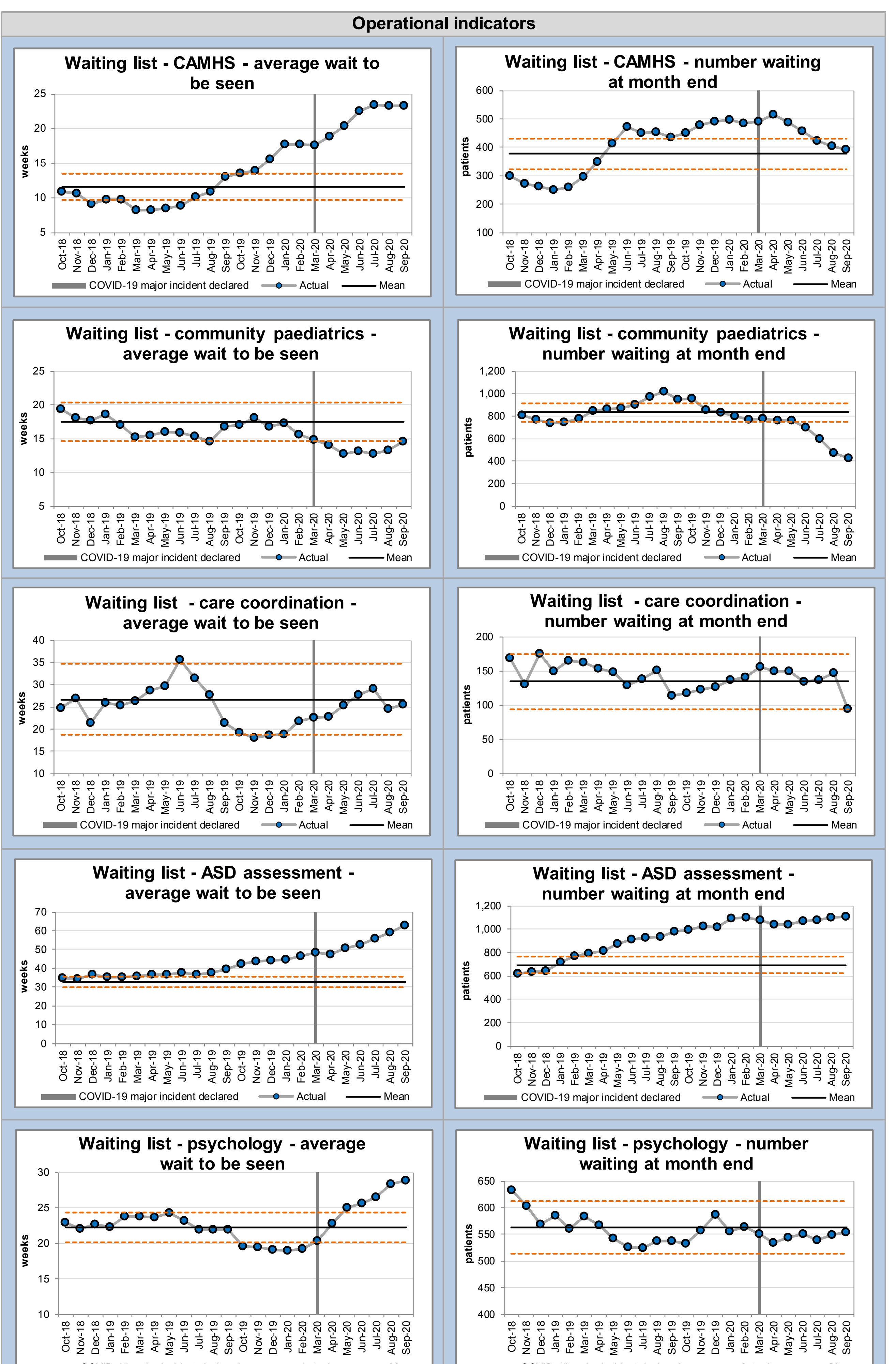


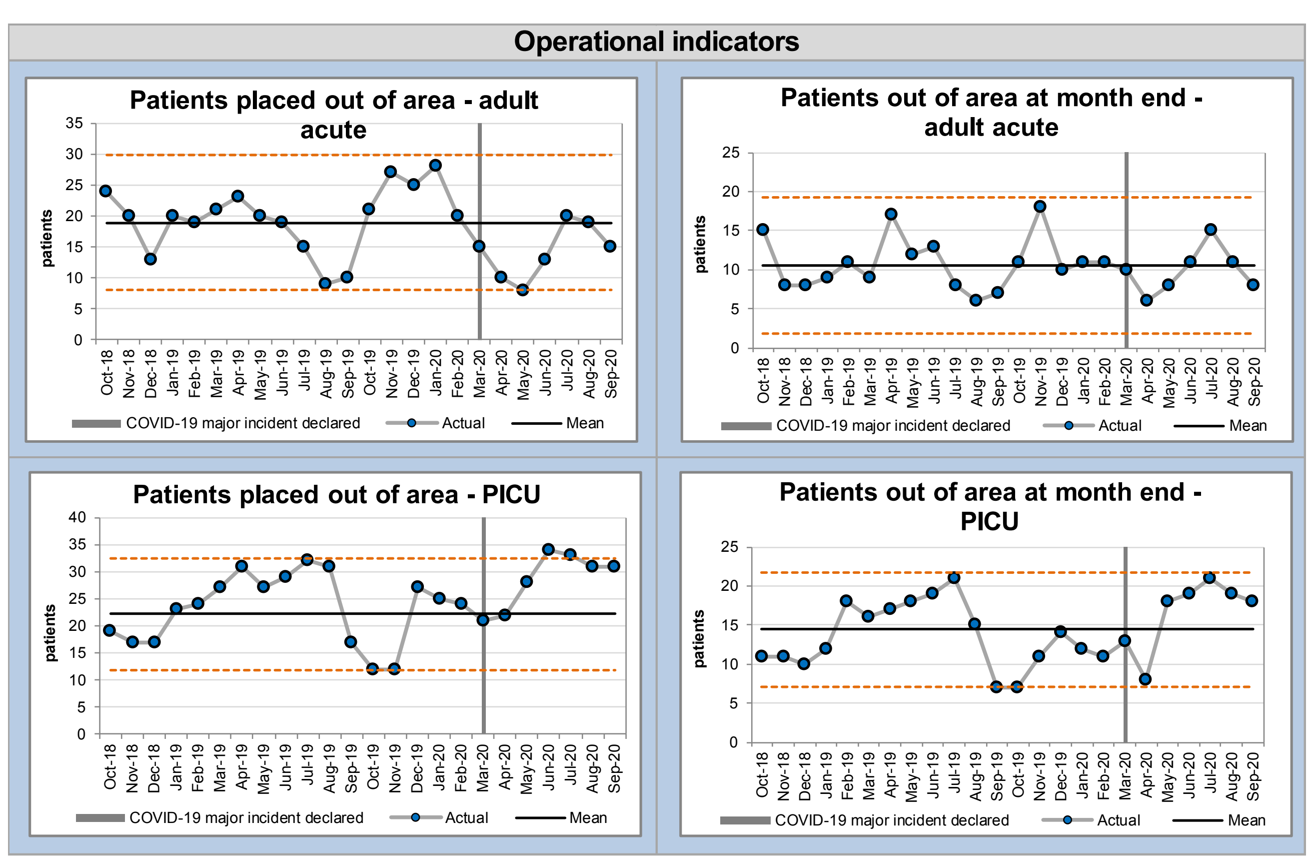


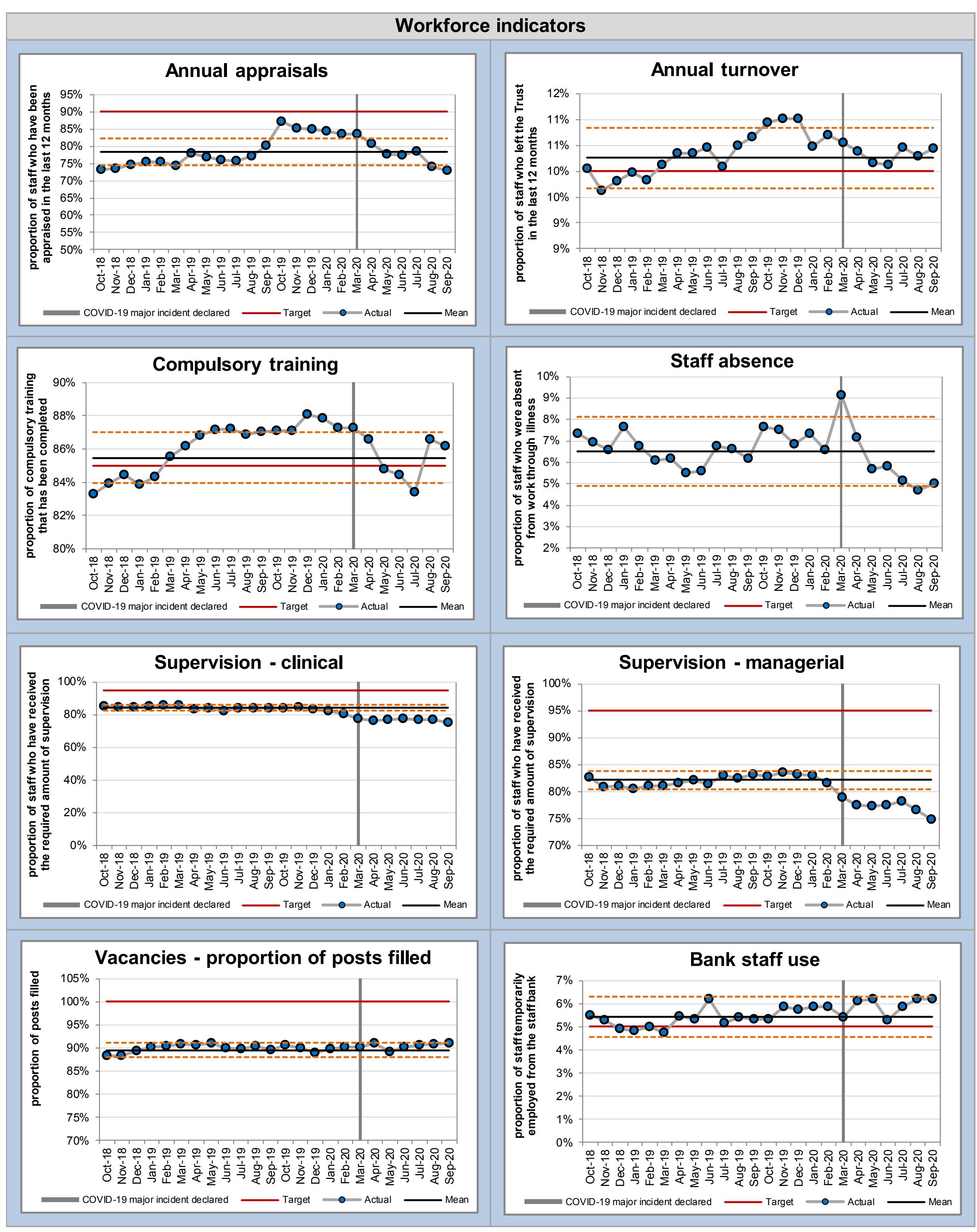
Appendix 2 – Charts[6]



[6] The control limits have been fixed at pre-COVID-19 levels to enable tracking of performance against the norm during the pandemic.


Operational indicators
Waiting list - CAMHS - average wait to be seen
weeks
Waiting list - CAMHS - number waiting at month end
patients
Waiting list - community paediatrics - average wait to be seen
weeks
Waiting list - community paediatrics - number waiting at month end
patients
Waiting list - care coordination - average wait to be seen
weeks
Waiting list - care coordination - number waiting at month end
patients
Waiting list - ASD assessment - average wait to be seen
weeks
Waiting list - ASD assessment - number waiting at month end
patients
Waiting list - psychology - average wait to be seen
weeks
Waiting list - psychology - number waiting at month end
patients
COVID-19 major incident declared
Actual
Mean


Operational indicators
Patients placed out of area - adult acute
Patients out of area at month end - adult acute
Patients placed out of area - PICU
Patients out of area at month end - PICU
patients
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
Mar-19
Apr-19
May-19
Jun-19
Jul-19
Aug-19
Sep-19
Oct-19
Nov-19
Dec-19
Jan-20
Feb-20
Mar-20
Apr-20
May-20
Jun-20
Jul-20
Aug-20
Sep-20
COVID-19 major incident declared
Actual
Mean


Workforce indicators
Annual appraisals
proportion of staff who have been appraised in the last 12 months
Annual turnover
proportion of staff who left the Trust in the last 12 months
Compulsory training
proportion of compulsory training that has been completed
Staff absence
proportion of staff who were absent from work through illness
Supervision - clinical
proportion of staff who have received the required amount of supervision
Supervision - managerial
proportion of staff who have received the required amount of supervision
Vacancies - proportion of posts filled
proportion of posts filled
Bank staff use
proportion of staff temporarily employed from the staff bank
COVID-19 major incident declared
Target
Actual
Mean

Quality Indicators

Safe

No of incidents of moderate to catastrophic actual harm

Target — Actual — Mean

Number of medication incidents

Actual — Mean

No of new episodes of patients held in seclusion

Target — Actual — Mean

No of incidents involving physical restraint

Target — Actual — Mean

No of incidents involving prone restraint

Target — Actual — Mean

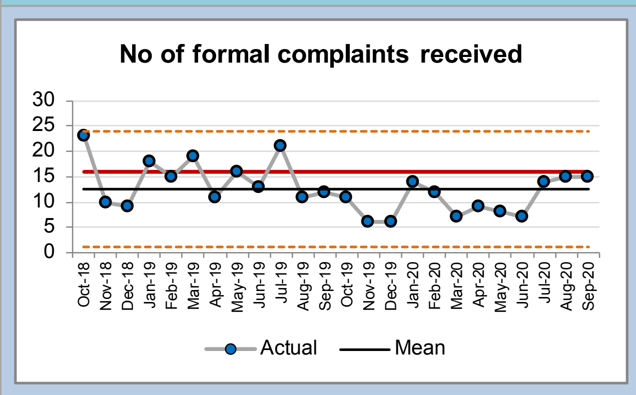
No of incidents requiring Duty of Candour

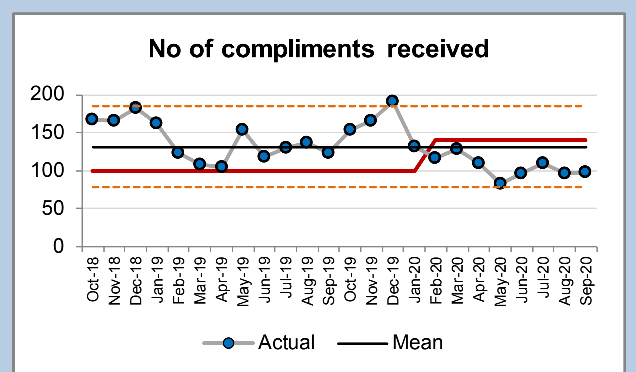
Target — Actual — Mean

No of falls on in-patient wards

Actual — Mean

Caring



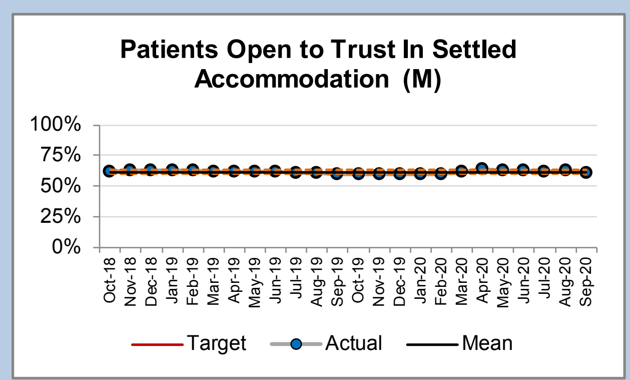


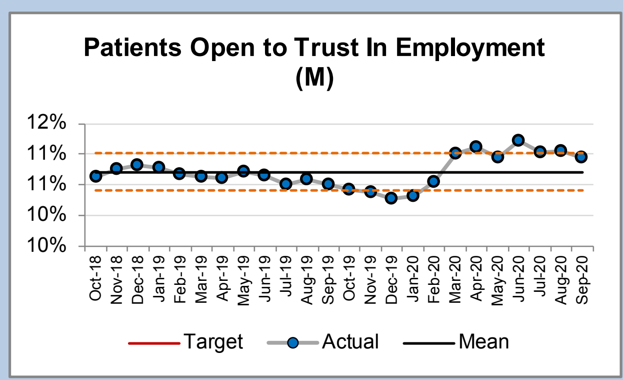
Staff Friends and Family Test - Recommending Care

100%
75%
50%
25%
0%
2014/15 qtr1
2014/15 qtr2
2014/15 qtr4
2015/16 qtr1
2015/16 qtr2
2015/16 qtr4
2016/17 qtr1
2016/17 qtr2
2016/17 qtr4
2017/18 qtr1
2017/18 qtr2
2017/18 qtr4
2018/19 qtr1
2018/19 qtr2
2018/19 qtr4
2019/20 qtr1

National average
Actual
Mean

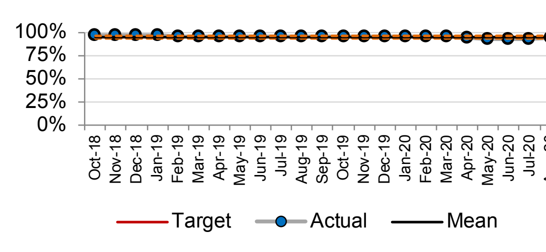
Effective



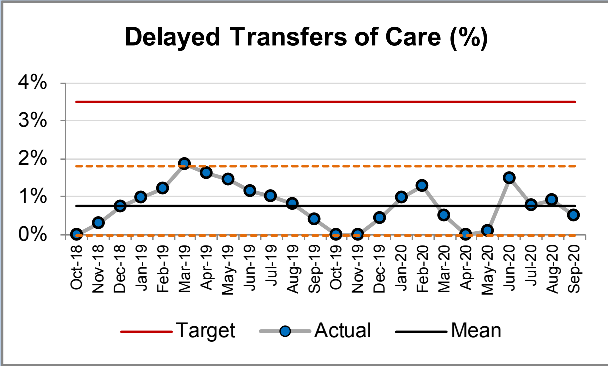


Responsive

% of patients who have had their care plan reviewed and have been on CPA > 12months



Target
Actual
Mean



Appendix 3 – Data Quality Kite Mark

Background

A number of Trusts prepare data quality kite marks to support members' review and assessment of performance indicator information reported in performance reports. Alternative methods include a simpler data quality scoring in a range, such as 1-5 which are more reliant on judgement. The kite mark is used to assess the system against six domains: timeliness, audit, source, validation, completeness and granularity to provide assurance on the underlying data quality.

Approach

Assessment of each domain will be based on the following criteria:

Data Quality Indicator	Definition	Not yet assessed	Sufficient	Insufficient
Timeliness	Is the data the most up to date and validated available from the system?	Not yet assessed	The data is the most up to date available.	Data is not available for the current month due to the time taken to extract / prepare from the system.
Audit	Has the system or processes used to collect the data been subject to audit (Internal Audit/ External Audit / self-audit) in the last 12 months?	Not yet assessed	The system and processes involved in the collection, extraction and analysis of the data have been audited and presented to the oversight committee.	No formal audit has taken place in the last 12 months. Exceptions have been identified and corrective action has not yet been implemented.
Source	Is the source of the data fully documented and understood?	Not yet assessed	All users understand how to extract the data in line with the indicator definition. The data source is well documented in the event that there is a change in personnel producing the indicator.	The data source is poorly documented and could be inconsistently extracted.

Data Quality Indicator	Definition	Not yet assessed	Sufficient	Insufficient
Validation	Prior to publication, is the data subject to validation, e.g. spot checks, random sample checks, involvement of a clinician, the associated service or approval by Executive Director?	Not yet assessed	The data is validated against a secondary source. The indicator owner can assure the data is a true reflection of performance, supported by a sign off process and underlying information.	No validation has taken place. The information owner cannot assure that the data truly reflects performance. A random sample may reveal errors.
Completeness	Is the indicator a reflection of the complete performance of the Trust	Not yet assessed	All the appropriate activity has been included within the indicator	A material amount of activity has not been included within the indicator that may alter the Trust level performance.
Granularity	Can the data be disaggregated into smaller parts? E.g. evaluated at a division or ward level as well as a Trust level.	Not yet assessed	Data can be drilled down to a division or ward level in order to understand and drive performance improvement.	Data is only available at a Trust level.

KPI Data Quality Reviews

A review will ordinarily be undertaken every 6 months of 5 to 10 indicators to review their compliance with the defined indicators of quality. This will complement any reviews undertaken by internal or external audit. The results will be shared with the Finance and Performance Committee together with any remedial action necessary. Reviews are currently on hold owing to the pandemic.

Derbyshire Healthcare NHS Foundation Trust

Report to the Board of Directors – 3 November 2020

Flu 2020 vaccination programme update and COVID vaccine preparedness report

Purpose of Report

The report is to provide an update on the progress and delivery of the Trust's comprehensive flu vaccination programme. In addition the Trust has been engaging and contributing to national and regional plans to prepare for a COVID vaccination programme and the report will give a brief update upon progress towards potential delivery of the COVID vaccine.

Executive Summary

Flu programme updates

The flu delivery programme commenced on 13 October using the booking system developed for this year's campaign.

686 staff members have been vaccinated as of 27 October. A further 184 slots have been booked.

2,094 bookable clinic slots remain currently available across the county including the Trust's High Peak and South County sites.

There are pop up clinics in inpatient areas which enable frontline ward and Crisis Resolution and Home Treatment Teams (CRHT) colleagues to access a vaccine at their convenience.

The Trust has received approximately 70% of the vaccinations ordered with the remainder expected to arrive shortly.

The staff Facebook page has had a number of positive comments posted about the efficiency of the clinics and colleagues attending have noted and commented that they are clean, efficient and well run.

We have evolved the IT system as we have progressed and used regular debriefs and huddles to identify areas for learning and improvement.

The reporting system is live, allowing internal oversight of how many vaccines have been undertaken, how many are booked and who has attended.

Patient vaccine updates

Public Health England (PHE) is working with Trust clinicians and services to develop a business case for supporting at risk clients who may not meet the criteria for at risk groups. This will be presented as a national example to hopefully influence wider policy change.

PHE are supporting the work being undertaken within substance misuse services and the Clozapine and depot clinics as an example of good practice for other providers.

COVID vaccine updates

We are currently working to develop the national reporting framework with partners at the CCG. This will be the system used to track flu vaccinations and subsequently COVID vaccines.

COVID vaccine preparedness has been increasing over recent weeks with increased

impetus. The national team have regarded the Derbyshire work in positive regard and the system has been advised to expect to be able to deliver initial doses in limited quantity at first from December onwards.

Details are being finalised but the Trust is contributing to regional plans and implementation strategies to support Derbyshire Community Health Services NHS Trust (DCHS) and DHU Health Care as lead providers.

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

Assurances

- Compliance with COVID-19 IPC (infection prevention control) guidance and staff safety are core to model
- Ambition is to vaccinate all staff (we have vaccine capacity to do this)
- Systematic approach being taken and transparent reporting of those booked in and those who have attended
- Cold store issues and medicines management integral to model to avoid waste and efficiency
- Regular updates using Assurance tool are being submitted to STP Flu Cell monthly.

Consultation

- Colleagues through the antibody and antigen testing models provided valuable feedback regarding approach and learning.
- Review of previous season's performance and opportunities for improvement.
- Discussions with colleagues at DCHS.
- Guidance and support from Pharmacy department.
- Discussions with people services and contracting team in regards to collegiate working and legislative challenges.

Governance or Legal Issues

- Adherence to the Medicines Act legislation.
- Green Book Immunisation guidance
- COVID-19 Infection prevention Control guidance

- Trust strategy 2020.

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.

- In light of the high level of concern related to COVID-19 transmission risk the approach to flu planning has been underpinned by IPC guidance compliance. In addition the respective needs of all staff have been considered and the ability to access clinics which are socially distanced, IPC compliant, able to offer time and one to one support for those with significant health concerns vulnerabilities if required (longer appointment etc.) have been factored in.
- The team have consulted with a cross section of the Trust who have attended for anti-body and antigen testing, this has included a diverse range of staff demographically and professionally, their observation and comments have informed the approach being taken.
- The IPC guidelines are intentionally rigid in order to protect all people within our community. Our clinic sites are in access able ground floor sites with adjacent parking / transport links. There are opportunities ahead of booking or attendance to speak to someone about specific requirements and these will be accommodated wherever possible or a suitable alternative explored (egg free vaccine is a known challenge).
- The use of rapid learning following huddles and feedback is being utilised to good effect to develop the system and evolve the approach in light of pending COVID vaccine implantation and roll out.

Recommendations

The Board of Directors is requested to:

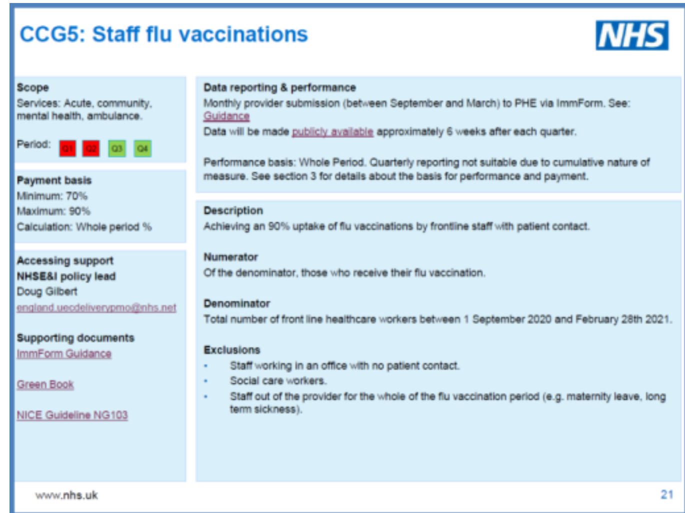
1) Review the contents and approach being undertaken by the Trust.
2) Comment in regards to whether assurance that adequate protection has been considered.
3) Review progress against trajectory at today's meeting.

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

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

Flu Campaign and COVID Vaccination preparedness 2020/21 DHCFT- October update

The 2020/21 campaign is set to run between September 2020 and February 2021 with a national aspiration to vaccinate 90% of the NHS workforce across all sectors. DHCFT achieved 71.9% in 2019/20 having increased uptake from 54% the previous year. In addition there are preparations to enable deployment a COVID vaccine being worked through regionally and nationally.



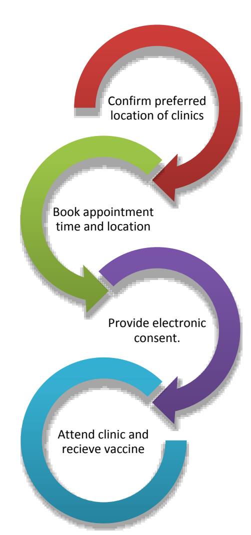
The flu reporting period began in October 2020 with the first submission on 13 October. In light of the National Pandemic response to COVID-19 and significantly increased health concerns about respiratory disorders and illness it is assumed that everyone who works for the trust (all colleagues groups) will want and have access to a vaccine. We have received 1875 vaccines (2625 ordered) for 2639 colleagues. Despite our best efforts we have been unable to access the egg free vaccine, this appears to be a regional challenge. Occupational Health services are unable to provide these so we will be referring these colleagues to their GP.

Date	**18/9/2020**	**22.09/2020**	**9/10/2020**	**23/10/2020**	**6/11/2020**
Quantity	**630**	**125 – Trivalent for over 65s**	**500**	**630**	**740**
Percentage	**25%**	**100%**	**20%**	**25%**	**30%**

The method

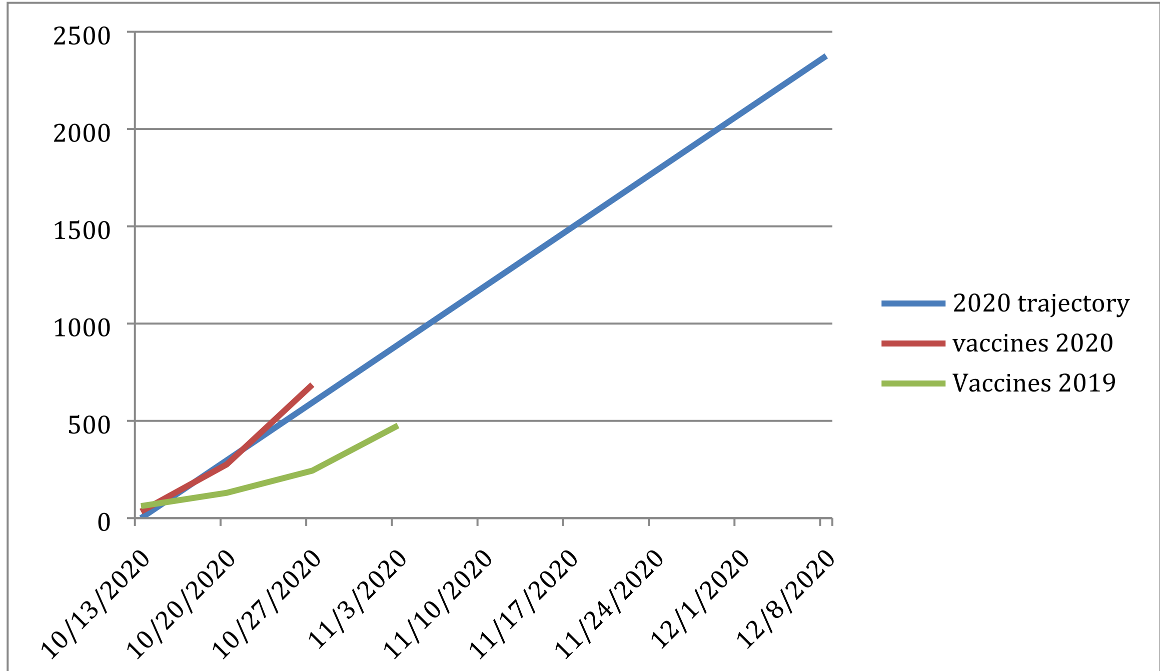
The experience gained during the national level 4 incident in regards to antigen and antibody testing clinics has seen rapid learning to realise IPC compliant and efficient clinic models which:

- Identify likely numbers per location via an online survey – completed
- Pre-book appointments to allow clinics to match demand. In development for launch early September. - completed
- Virtual registration and consent process to manage IPC concerns / streamline process. - completed
- Allocated vaccine awaiting colleagues on attendance. Clinics starting as vaccines arrive. - completed
- Support vaccinators to manage capacity and demand and rapid administration of vaccines. - ongoing



The clinics utilise a locally developed system of booking, administration, logistics oversight and internal reporting which are adapted to suit a flu clinic approach. This gives opportunity to deliver high turnover clinics with minimal contact points. **DHCFT is working closely with DCHS to deliver a vaccination programme for colleagues across both organisations.**

27 October - we have administered 686 vaccinations with a further 184 staff booked in since we launched the first clinic on 13 October. There was a slight delay in launch as we finalised clinic availability with partners at DCHS as we are operating from shared spaces. The delivery trajectory has been adjusted to reach a target of 90% by 8 December 2020.



The model from our Occupational Health Provider (University Hospitals of Derby and Burton (UHDB)) is limited compared to previous years. It is anticipated that they will be supporting those with specific health requirements such as needle phobia, we have also agreed a support package with Thrive (provider of support for children and young people's social and emotional development) via the Health and Wellbeing team as well as for those who are in a high risk category.

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

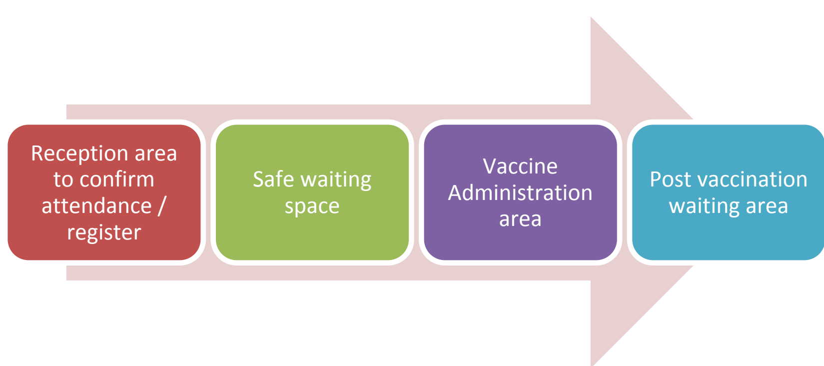
This is a key focus of this year's approach and whilst IPC considerations have been at the forefront of previous years peer vaccinator approaches, this year we have taken additional steps to make sure that all colleagues will feel safe to attend. In order not to make the clinics impersonal we will be seeking to ensure that colleagues know who the 'people behind the mask' are as part of our communications strategy. The flu campaign is committed to ensuring that the trusts **People First** commitment is core to all messages.

27 October – the staff face boom page has had many likes and positive comments about the clinics with people commenting on cleanliness, efficiency and the attending staff being friendly and helpful. We have also had a number of staff come forwards to offer their stories in relation to having the vaccine for the first time.

The FAQs page has been helpful and we have had very few questions flagged this year. It was anticipated that some of the more prevalent anti-vaccine messages and misinformation stories would have been prevalent, however to date these have been mutes and largely self-policed by staff supporting each other on social media.

Communications
The communication strategy for 2020/21 has been intentionally simple; the focus is on ease of access, safe attendance and administration – the visual campaign is simply the arm of a health care worker ready to receive their vaccine. From a people first perspective we are seeking to be inclusive and additionally want to focus on the people behind the masks in subsequent communications to colleagues to reaffirm the importance of IPC, but also not to lose the compassionate reasons that underpin why we are seeking to vaccinate everyone. As in previous years, colleague's stories (first time vaccination, face behind the mask etc.) are a key part of the communication strategy and will be shared along the way. We will be ramping up the push to get people booked in, in order to have the vaccinations completed by year-end.

Clinic settings



Currently we have a number of sites across Derbyshire which are being used.

- The clinic settings provide a clean room in line with COVID-19 IPC clinical guidance for the administration of vaccines and account for privacy and dignity requirements.
- The clinics operate a high throughput model with sufficient room for people to wait in a socially distanced and comfortable manner.
- Separate access and egress points and flow have been provided where possible.
- The clinics will have adequate cold storage capacity for the flu vaccines and fridges are temperature checked and monitored in accordance with the medicines code.
- Anticipating that a COVID vaccine may be approaching release the database of vaccinated colleagues is able to indicate when someone had their flu vaccine so that any mandated time periods between Flu vaccine and COVID vaccine administration can be accounted for.

Resources
The approach utilises some peer vaccinators (released from usual duties) and some bank nursing colleagues who are being recruited for the sole purposes of providing clinic support. In light of the additional pressures on services due to COVID the clinic model is far more efficient in regards to undertaking the vaccination programme as we can vaccinate more people with less impact on service delivery but we are having to convince colleagues of the benefits of this where they have previously found it convenient to receive a vaccine at base. The vaccinators will be released for attendance at the bookable clinics and matched to the capacity requirements of the clinic. This is to enable the clinics to be accessible, efficient, IPC compliant and minimise disruption to service delivery.

The option for colleagues to attend in an ad hoc fashion (drop in or pop up) is also available so that we do not limit the opportunity for people to attend but in order to manage the IPC challenge of large unregulated attendances this will be mitigated through communications and the offer of ease of attendance through the booking system. Inpatient colleagues will have on site vaccinators able to facilitate vaccines in pop up clinics; we will have similar provision for trust induction.

Patient vaccinations
We are targeting flu vaccination for our known high risk patients this year. This includes our high risk service users in substance misuse services, those who attend the Depot and Clozapine clinics and our Older Adult and Adult Acute inpatient services. We encourage all care coordinators to advocate for their patients to access a flu vaccine through their local GP and Community Pharmacy services. PHE do not currently identify SMI (severe mental health illness) or specific mental health conditions within the at risk groups.

27 October - PHE are supporting the approach and also the development of business case to formalise the approach and ensure the trust receive payment for its work.

COVID vaccine programme
There is significant national planning and infrastructure work to ensure the NHS is able to deliver a widespread vaccination programme when a COVID vaccine is released for clinical use. The trust is liaising at National and regional level to ensure we are part of those preparations. At this stage the Flu programme work is underpinning regional efforts to become system ready for a mass administration programme. DHCFT are part of the discussions, work and exploration to remove barriers which may inhibit a rapid and widespread roll out.

27 October – the Derbyshire STP submission has been met favourably at national level with the representative bodies being seen "to push up with solutions". The delivery of vaccines is indicated to begin in December and upscale over coming months. DHCFT are finalising its front line worker database and identifying staffing support for the regional vaccination plan to support DCHS and DHU as lead providers. Details are still emerging but the marked increase in pace indicates that steps are being finalised to deliver within coming weeks.

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

The regional flu vaccination group are meeting weekly currently and have initiated the development of a national reporting process based upon a national reporting database. The Trust is confident that we can meet the reporting requirement and are linked in to the regional team to support. In the meantime we are reporting weekly (Wednesday close of play) against the vaccination administered and those planned.

Challenges
The system has been developed quickly, any issues have been attended to quickly and the ability to track progress live is invaluable.

There was an initial challenge for staff to access the e-learning platform as ESR required some upgrades however this has now been attended too.

Staff resource is a challenge and the regional and local workforce teams have flagged that the risk to successful delivery of flu and subsequent COVID vaccination programmes is reliant to a workforce already stretched by the impact of COVID-19. The trust has developed a more efficient system of delivery through the use of clinics and sessional attendance but relies on existing staff with some support from bank. This model is at risk from wider demands and constraints.

Local leadership
The programme has DHCFT Executive leadership from Jaki Lowe (Director of People and Inclusion) and is supported by;

- the Infection Prevention and Control team
- Information Management and Technology team
- People Services
- Pharmacy department
- Communications team
- the Peer vaccinators
- Flu clinic administration team
- Working in partnership with colleagues at DCHS.

Thank you for taking the time to read this paper and we look forward to updating you on the progress we have made to have vaccinated 90% of our colleagues by 8 December 2020.

Report prepared by Richard Morrow, Assistant Director of Public and Physical Healthcare
27 October 2020

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 3 November 2020

Learning from Deaths - Mortality Report

Purpose of Report

The 'National Guidance on Learning from Deaths' requires each Trust to collect and publish specified information on a quarterly basis. This report covers the period 1 June to 24 August 2020.

Executive Summary

During the Covid-19 pandemic, the learning from deaths process continued to be undertaken but slight changes to the process were initially made to allow for colleagues to undertake other duties. Activity has now resumed back to normal with weekly case note reviews and the daily reviewing and grading of all new deaths taking place.

Since the last report the mortality group has reviewed and agreed a 2 stage process for screening new deaths. New deaths have always been reviewed by the mortality technician but this process has been further formalised and strengthened. If a patient does not meet a Datix or mortality red flag after the mortality technician has reviewed the patients Electronic Patient Record the death is now closed at stage 1 and this review is documented within the case note review form. If the death meets any of the mortality flags then a case note review is conducted (also referred to as stage 2 review). If any death meets the Datix red flag then this is investigated under the Untoward Incident and Reporting Policy and Procedure. An audit of the deaths closed at stage 1 will be undertaken by members of the patient safety team to ensure compliance with the policy.

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 will be reviewed under the Untoward Incident Report Reporting Policy and Procedure. The mortality reviewer produces a weekly Covid-19 death report which is shared with the incident management team. This report includes but is not limited to patient demographics, patient conditions, diagnosis and vulnerabilities, allowing the team to draw comparisons to identify themes and trends.

- From 1 June to 24 August 2020 there has been 1 death reported where the patient tested positive for covid-19. This patient was a White- British 88 year old female with a diagnosis of Alzheimer's dementia.
- From 1 June to 24 August 2020, the Trust received 370 death notifications of patients who had been in contact with our service in the last six months
- Two Inpatient deaths were recorded. One patient died whilst on home leave from an inpatient ward and one patient died on the Cubley Male ward- this was an expected end of life death.
- The Mortality Review Group reviewed 41 deaths. These reviews were undertaken by a multi-disciplinary team and it was established that of the 41 deaths reviewed, 40 were not due to problems in care. One death was referred to Serious Incident Group for further review.

- The Trust has reported three Learning Disability deaths from 1 June to 24 August 2020
- There is very little variation between male and female deaths; 185 male deaths were reported compared to 184 female. One death had no gender specified or recorded; this was the death of a baby.
- Good practice identified through case note reviews is fed back to clinicians involved as part of our appreciative learning.

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

Assurances

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

All inpatient deaths are reviewed and quarterly reports received by the Executive Leadership Team (ELT) in addition to coroner's inquest updates. Medical availability for mortality reviews has improved and there will now be a focus on selecting cases where physical health care was a prominent feature of care.

Governance or Legal Issues

There are no legal issues arising from this Board 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 & 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.

- From the 1 June to 24 August 2020 there is very little variation between male and female deaths; 185 male deaths were reported compared to 184 female. One death had no gender specified or recorded, this was the death of a baby.
- No unexpected trends were identified according to ethnic origin or religion.

Recommendations

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

Report presented by: **Dr John R Sykes**
Medical Director

Report prepared by: **Rachel Williams**
Lead Professional for Patient Safety and Patient Experience

Aneesa Akhtar-Alam
Mortality Technician

Learning from Deaths - Mortality Report

1. Background

In line with the CQC's recommendations in its review of how the NHS investigates patient deaths, the National Quality Board published a framework for NHS Trusts - 'National Guidance on Learning from Deaths[1]'. The purpose of the framework is to introduce a more standardised approach to the way NHS Trusts report, investigate and learn from patient deaths, which should lead to better quality investigations and improved embedded learning.

To date the Trust has met all of the required guidelines.

The report presents the data for 1 June to 24 August 2020.

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

- The Trust is still waiting to ascertain if Cause of death (COD) will be available through NHS digital. Currently COD is been ascertained through the coroner officers in Chesterfield and Derby but only a very small number of COD have been made available.

- Medic rotas have been made available for the north and south of the county and this did initially improve the number of case note reviews completed. Since the pandemic and the reduction to monthly case note reviews from weekly, the number of case note reviews has decreased. During this period only eight case note reviews have taken place this has been mainly due to the unavailability of medics.

- 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.

- Due to the current circumstances surrounding Covid-19, the Mortality Review Group along with other departments has followed government guidance to allow staff to work remotely. As of 24th June 2020 the Mortality group has agreed to a new formalised process strengthening the work already being undertaken. A 2 stage process involving an initial screening of the patient's Electronic Patient Record is undertaken to determine if the death meets any red flags, if no flags are met, the death is closed at a stage 1 review. If the death meets any of the mortality flags then a case note review is conducted (also referred to as a stage 2). If the death meets a datix red flag then this is investigated under the Untoward Incident Reporting Policy and Procedure. This process will be audited by members of the patient safety team to ensure compliance with policy.

- The Trust has also made a decision to return to grading all new deaths identified through the NHS Spine daily and conducting Case note review meetings twice weekly. All deaths directly relating to Covid-19 will be

[1] National Guidance on Learning from Deaths. National Quality Board. March 2017

reviewed initially through the Learning from Deaths procedure unless they also meet a Datix red flag , in which case they will be reviewed under the Untoward Incident Reporting Policy and Procedure. The mortality reviewer will also produce a weekly Covid-19 death report to be shared with the incident management team. This report will include but is not limited to patient demographics, patient conditions, diagnosis and vulnerabilities, allowing the team to draw comparisons to identify themes and trends. From 1 June to 24 August 2020 there has been 1 death reported where the patient tested positive for covid-19.

3. Data Summary of all Deaths

Note that inpatients and LD are based upon whether the patient has an open inpatient or LD referral at time of death.

	June	July	August
1. Total Deaths Per Month	150	129	91
5. LD Referral Deaths	1	1	1

The table above shows information for 1 June to 24 August 2020. *Correct as at 24 August 2020 2020*

From 1 June to 24 August 2020, the Trust received 370 death notifications of patients who have been in contact with our services.

4. Review of Deaths - 1 June to 24 August 2020

Total number of Deaths from 11 June to 24 August 2020., reported on Datix	29 (of which 12 are reported as "Unexpected deaths"; 11 as "Suspected deaths"; 6 as "Expected - end of life pathway" NB some expected deaths have been rejected so these incidents are not included in the above figure.
Number reviewed through the Serious Incident Group	22 (7 pending for a review).
Number investigated by the Serious Incident Group	9 did not require an investigation; 6 underway and 14 pending for a review
Number of Serious Incidents closed by the Serious Incident Group?	9 (13 currently opened to SI group and 7 pending for a review, as of 24/08/2020)

There are currently 7 incidents that have not yet been reviewed by the SI Group*

Since 1 June to 24 August 2020 the Trust has recorded 2 inpatient deaths. One patient died whilst on home leave from an inpatient ward and the second patient died on the Cubley male ward, this death was an expected end of life death. These deaths have been reviewed under the *Untoward Incident Reporting and Investigation Policy and Procedure*.

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.

5. Learning from Deaths Procedure

From 1 June to 24 August 2020, the Mortality Review Group reviewed 41 deaths. These reviews were undertaken by a multi-disciplinary team and it was established that of the 41 deaths reviewed, 40 have been classed as not due to problems in care. One death was referred to Serious Incident Group for further review under the Untoward Incident and Reporting Policy and Procedure.

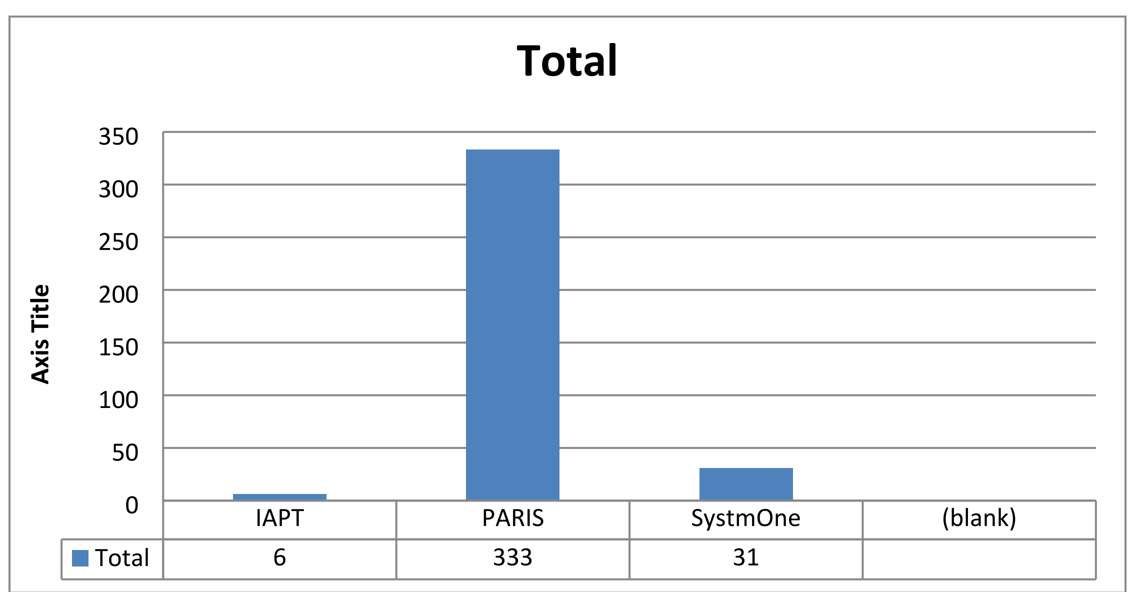
The Mortality Group review the deaths of patients who fall under the following 'red flags' as from 24th June 2020 these are as follows:

- Patient taking an anti-psychotic medication
- Death of a patient with a learning disability
- Patients with chronic pain
- Patients only open to outpatient services
- Patients with covid19 (this is a temporary flag)

From 1 June to 24 August 2020 there has been 1 death reported where the patient tested positive for covid-19. This patient was a White- British 88 year old female with a diagnosis of Alzheimer's dementia.

6. Analysis of Data

6.1 Analysis of deaths per notification system since 1 June to 24 August 2020



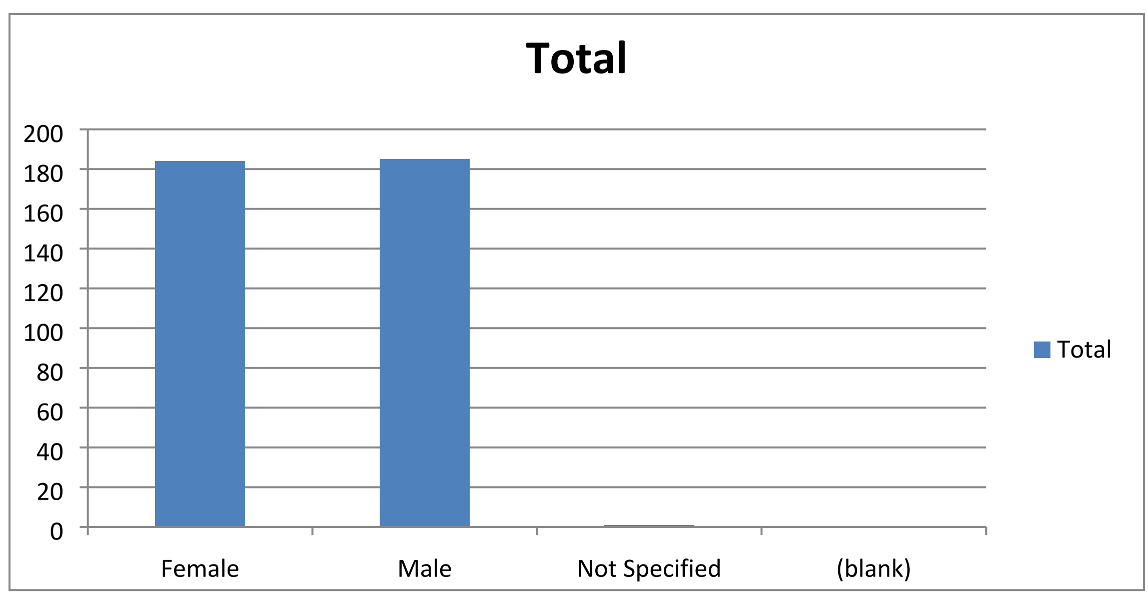
Row Labels	Count of Source System
IAPT	6
PARIS	333
SystmOne	31
Grand Total	**370**

The data above shows the total number of deaths reported by each notification system. The majority of death notifications were predominately pulled from PARIS. 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. 31 death notifications were extracted from SystemOne and 6 death notifications were extracted from Improving Access to Psychological Therapies (IAPT).

6.2 Deaths by Gender since 1 June to 24 August 2020

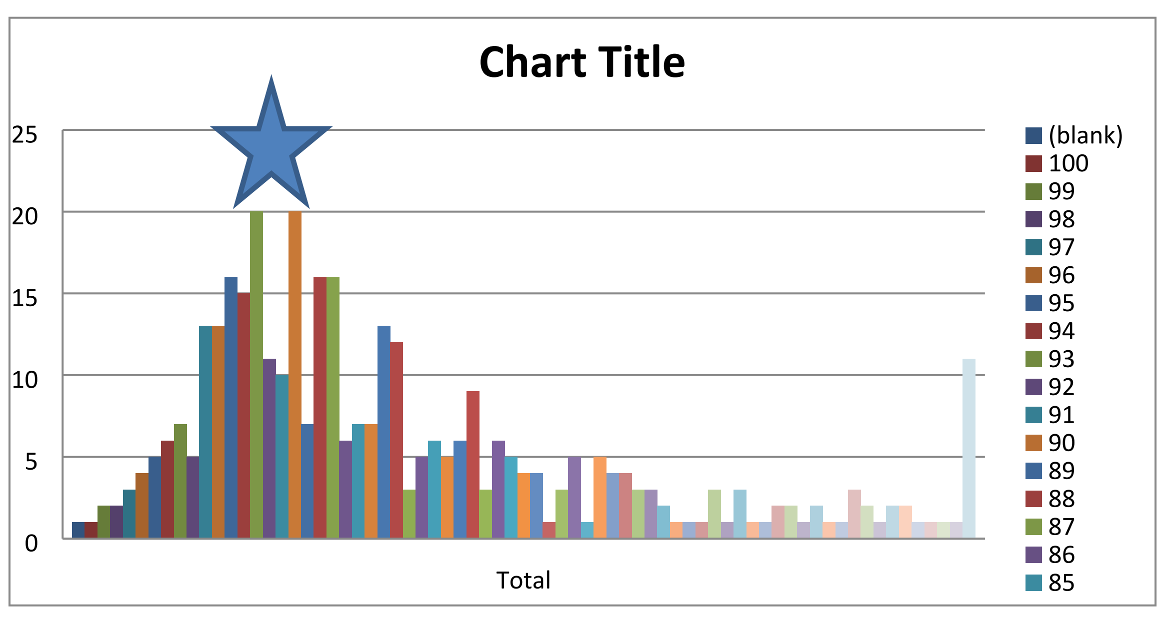
The data below shows the total number of deaths by gender 1 June to 24 August 2020. There is very little variation between male and female deaths; 185 male deaths were reported compared to 184 female. One death had no gender specified / recorded; this was the death of a baby.

Row Labels	Count of Gender
Female	184
Male	185
Not Specified	1
Grand Total	**370**



6.3 Death by Age Group since 1 June to 24 August 2020

The youngest age was classed as 0, and the oldest age was 100 years. Most deaths occur within the 84-87 age groups (indicated by the star).



6.4 Learning Disability Deaths since 1 June to 24 August 2020

	June 2020	July 2020	August 2020
LD Deaths	1	1	1

The Trust reviews all deaths relating to patients diagnosed with a Learning Disability. The Trust also currently sends all Learning Disability deaths that have been reported through the Datix system to the Learning Disabilities Mortality Review (LeDeR) programme. We are unable to ascertain how many of these deaths have been reviewed through the LeDeR process. The Trust continues to share relevant information with LeDeR when requested which is used to inform their reviews . Since 1 June to 24 August 2020, the Trust has recorded 3 Learning Disability deaths. The Trust now receives a quarterly update from LeDeR which highlights national good practice and identified learning.

6.5 Death by Ethnicity since 1 June to 24 August 2020

White British is the highest recorded ethnicity group with 278 recorded deaths, 63 deaths had no recorded ethnicity assigned, and 4 people did not state their ethnicity. The chart below outlines all ethnicity groups.

Row Labels	Count of Ethnicity
Indian	1
Asian or Asian British - Pakistani	1
Asian or Asian British - Indian	1
Any other black background	2
Pakistani	2
Other ethnic groups - any other ethnic group	3
Not stated	4
White - Irish	4
Caribbean	5
White - any other white background	6
Not known	63
White - British	278
Grand Total	**370**

6.6 Death by religion since 1 June to 24 August 2020

Christianity is the highest recorded religion group with 61 recorded deaths, 177 deaths had no recorded religion assigned and 8 people refused to state their religion. The chart below outlines all religion groups.

Row Labels	Count of Religion
Muslim	1
Pentocostal Christian	1
Christian religion	1
Sikh	1
Catholic: Not Roman Catholic	1
Sikh religion	1
None	2
Pentecostalist	2
Baptist	2
Atheist movement	3
Agnostic	3
Methodist	4
Roman Catholic	5
Not given patient refused	8
Not Religious	25
Unknown	26
Church Of England	46
Christian	61
(blank)	177
Grand Total	**370**

6.7 Death by sexual orientation since 1 June to 24 August 2020

Heterosexual or straight is the highest recorded sexual orientation group with 138 recorded deaths. 224 have no recorded information available. The chart below outlines all sexual orientation groups.

Row Labels	Count of Sexual Orientation
Homosexual	1
Unknown	1
Bi-Sexual	1
Not appropriate to ask	2
Not Stated (declined)	3
Heterosexual or straight	138
Blank	224
Grand Total	**370**

6.8 Death by disability since 1 June to 24 August 2020

Behavioural and emotional problems were the highest recorded disability group with 16 recorded deaths.

Top 6 recorded deaths by disability groups	Count of Disability
Sight	2
Self-care and continence	2
Mobility and gross motor	4
Hearing	6
Dementia	8
Behaviour and emotional; learning disability (dementia)	16
Grand Total	**38**

7. Recommendations and Learning

Below are examples of the recommendations that have been undertaken following the review of deaths. These recommendations are monitored by the Patient Safety Team and are allocated to a specific team, and individuals to be completed. This is not an exhaustive list.

- To clarify in the appropriate policy, Section 17 leave and the involvement of police on wards (e.g. liaison, individual roles and responsibilities, when to escalate and involve the police on the ward, and, how this should be managed, minimised and situations de-escalated)

- To provide clarification of the role of the responsible clinician in patient transfers between Trusts and other provider services.

- For bank staff to routinely work alongside a substantive member of the team when carrying out assessments. In the rare event that this is not possible, assessment outcomes and significant changes to care plans should be discussed within the team daily

- Procedure to identify a defined response and actions for administrators if an urgent call is received for patients who are open to outpatient clinics only. This should include triage by a clinician.

- Local protocol for staff in the event a patient reports a sexual assault

- Education and training on the complexity and dilemmas faced when confidentiality, capacity and family/carer involvement collide is needed.

- Assurances are required that there is parity of services and consistency in how services run in terms of Crisis team north and south.

- Community Mental Health Teams (CMHTs) referrals process to be mapped to achieve consistency amongst all teams.

- Consideration for virtual attendance at ward rounds from CMHTs.

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 3 November 2020

Guardian of Safe Working Quarterly Report

Purpose of Report

This report from the Trust's Guardian of Safe Working (GOSW) provides data about the number of junior doctors in training in the Trust, full transition to the 2016 junior doctor contract and any issues arising therefrom.

The Quality and Safeguarding Committee accepted this report on 13 October 2020 as assurance of the Trust's approach and recommended that the report be considered by the Board of Directors.

Executive Summary

The report details measures that are in place to ensure safe working within the new junior doctor contract and arrangements to identify, quantify and remedy any risks to the organisation. The report highlights the following points:

- There are a few vacancies in trainee posts that reflect the national issue with recruitment in psychiatry
- Trainees are being supported with exception reporting (ER) and these have been resolved in a timely fashion. There have been no ERs during the last quarter
- The British Medical Association (BMA) Fatigue and Facilities Charter for junior doctors is being carefully considered and a recent issue concerning space for juniors in the south has been successfully resolved.
- Issues persist with Allocate, the software for logging in ER. Regular communications have taken place with the software provider. They have also and they have attended one of the Junior Doctor Forum (JDF) meetings recently.
- During the COVID-19 pandemic, junior doctors have raised issues about their work environment and situation with PPE. The JDF has provided them with an additional, neutral and supportive platform to raise any such issues. This is important as they have felt able to come forward and speak about their concerns without feeling anxious or worried about any impact on their assessments (a concern that has been previously highlighted. These issues have been heard by the Director Medical Education (DME), Associate Director Medical education (ADME), Nursing Matron from the Hartington Unit and Freedom to Speak Up Guardian. The junior doctors have been supported by the GOSW to speak freely and the issues raised have been escalated to respective responsible persons. JDF meetings will continue to be held at approximately 4 - 6 weekly intervals for the rest of the year.
- During the COVID-19 pandemic junior doctors have been risk assessed for potential complications which may have arisen through existing health conditions or from them being in the BAME group. The risks highlighted have been addressed and suitably managed/mitigated. The JDF has monitored this closely.

- Junior doctors have successfully completed virtual induction and have given positive feedback.

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

Assurances

The report details arrangements made to ensure safe working within the new contract and arrangements in place to identify, quantify and remedy any risks to the organisation.

Consultation

- The JDF discussed relevant issues contained in the report
- Local Negotiating Committee (LNC) discussions have taken place regarding the smooth running of the consultant on call rota while there have been so many vacancies on the higher trainee rota
- Discussions with DME, ADME regarding the concerns raised by junior doctors.

Governance or Legal Issues

The GOSW has attended local and national conferences to gain more knowledge and experience through discussions with other Guardians. More recently the meetings have been virtual. Discussions have been helpful as similar issues affecting junior doctors at other trusts have been discussed.

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.

The report clearly addresses the impact of COVID on BAME group amongst the junior doctors. No other equality issues have been raised during this period.

Recommendations

The Board of Directors is requested to:

1) Note the contents of the report as assurance of the Trust's approach in discharging its statutory duties regarding safe working for medical trainees.
2) Note that on 13 October 2020 the Quality and Safeguarding Committee received significant assurance from the contents of the report.

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

Report prepared by: **Dr Smita Saxena**
Guardian of Safe Working

GUARDIAN OF SAFE WORKING QUARTERLY REPORT
(Extended April to September 2020)

1. Trainee data

Extended information supplied from 1 April to 30 September 2020

1.1 Number of posts for doctors in training (numbers in post)

Grade	Number of posts for doctors in training (total)			
	NORTH		SOUTH	
CT1-3	8		11	
ST4-7	2		7	
GP Trainees	4		7	
Foundation	5		9	

2. Exception Reports (with regard to working hours)

There were no reports during this period. No fines were levied.

Exception Reports				
Location	**No of exceptions carried over from last report**	**No of exceptions raised**	**No of exceptions closed**	**No of exceptions outstanding**
North	0	0	0	0
South	0	0	0	0
Total	0	0	0	0

Exception Reports by Grade				
Location	**No of exceptions carried over from last report**	**No of exceptions raised**	**No of exceptions closed**	**No of exceptions outstanding**
CT1-3	0	0	0	0
ST4-7	0	0	0	0
GPVTS	0	0	0	0
Foundation	0	0	0	0
Total	0	0	0	0

Exception Reports by action				
	Payment	**TOIL**	**Not agreed**	**No action required**
North	0	0	0	0
South	0	0	0	0
Total	0	0	0	0

Response time				
Grade	**48 hours**	**7 days**	**Longer than 7 days**	**Open**
CT1-3	0	0	0	0
Foundation	0	0	0	0
ST4-6	0	0	0	0

3. Work schedule reviews

No formal work schedule reviews needed during this period.

4. Fines

No fines imposed.

5. Locum/Bank Bookings

North - 98 shifts totalling £42,306.43
South - 129 shifts totalling £58,369.50

The locum spend is increased significantly in this period due to COVID-19 related absence or junior doctors shielding and not being able to undertake their out of hours duties. There was just one occasion in the south when cover could not be sourced and this resulted in the consultant stepping down and covering the shift.

6. Agency Locum

North – seven shifts totalling £3,217.50

7. Vacancies

	North Mar 2020 – Sept 2020	**South Mar 2020 – Sept 2019**
CT1-CT3	1	1
GP Trainees	1	0
Foundation	0	0

8. Qualitative information

The Junior Doctor Forum (JDF) has been meeting monthly over the past three months due to COVID-19 and this has been held virtually. As always, active representation is sought with each changeover of new doctors in accordance to the Forum JDF constitution.

This has been well attended by the juniors both in north and south. A representative from British Medical Association (BMA) has also been present on all occasions. The Freedom to Speak up Guardian was also present at the last meeting.

9. Issues arising

9.1 Compliance of Rota

Some trainees had previously raised concerns that the rest requirements for the on call rota were still not in line with the recent recommendations i.e. trainees to have 48 hours of rest after seven consecutive days of work.

The Medical Staffing Manager informed the group that they were aware of the above change in the junior doctor contract and looking at implementing these changes in readiness for August 2020 which is consistent with what our local counterparts doing currently. The JDF has been reassured that that the on call rota would be compliant from August and that she was looking at for the trainees to return on the Wednesday as at present they are off Tuesday and Wednesday when post weekend nights.

Action completed: current rota is fully compliant from August 2020

9.2 Lack of PPE initially and risk assessment for trainees during COVID-19

The Guardian of Safe Working (GOSW) informed the group that Walton Hospital doctors had struggled initially to get the correct PPE but that this had now been resolved after having met with Derbyshire Community Health Services NHS Trust (DCHS). The British Medical Association (BMA) representative informed the group that in the future should we face a similar problem to contact BMA and they would assist.

The Director Medical education (DME) asked medical staffing to send an email to all trainees asking if they have had a risk assessment with his/her clinical supervisor

Action complete: Email sent out as above on 9 June. All trainees had risk assessment completed followed by recommendations for safe working during COVID-19.

9.3 Vacancies in south

People Services informed the group that the South was carrying vacancies, thus some rota gaps. They would try to fill these internally and if unsuccessful then try the agencies. People Services confirmed that we were waiting for the final validation lists for the allocation regarding Higher Trainees from August and it seemed that we would have few gaps just like some neighbouring trusts.

9.4 Induction for August 2020

Discussion then took place as to how the Induction Programme for August would be delivered which is via MS Teams. It was confirmed that where possible joint sessions have been scheduled for both north and south trainees.

At the last JDF, junior doctors gave a positive feedback about the induction.

DME queried whether it would be useful for the trainees to have a virtual Junior Doctors Mess. Trainees reported that they uncertain whether this would enhance anything as both North and South have a trainees 'WatsApp' group and the JDF meetings happen frequently to enable them to raise any concerns.

9.5 Fatigue and facilities

The GOSW queried that the Walton Hospital trainees were still awaiting a microwave and fridge as discussed in the last meeting and raised this with the junior doctor rep in the North who was leading this. There were some items that were still waiting to be delivered to Walton. The GOSW has also since sent an email advising/asking the current trainees on placement at Walton for sorting the fatigue and facilities issue at Walton and to also have a think about what else is required.

The new trainees were made aware that there is still a substantial amount of money to be used from this fund and to forward their ideas.

One of the trainees based at Hartington Unit raised concerns about poor network connectivity (see action point at the side) and phone/TV not working. The trainee himself is happy to raise this with relevant departments and chase IT.

Action(s) pending: The trainee above will liaise with IT regarding poor connectivity and feedback at next JDF

Action completed: Items have now been delivered to Walton Hospital.

9.4 During the COVID-19 period

Exception Reports are encouraged as usual so we can highlight areas of increased demand and impact of response during this period. No face to face contact needed unless we identify a risk that would benefit from this. A telephone discussion with educational supervisor is mandatory with usual information to be submitted on ALLOCATE (the software for logging exception reports) by the trainees and supervisors.

As usual we propose a timely resolution of exception reports with either time off in lieu or where time off in lieu is not possible an overtime payment will be arranged as usual at some point in future as circumstances permit.

The timescales for taking action for junior doctors' exception reports have been relaxed by NHS employers.

Action complete: Email sent to all trainees and supervisors.

10. Other concerns raised with the GOSW

Following an email sent by the GOSW confidentially in order to support trainees to raise their concerns, several common themes emerged. These are as follows:

- **Being fearful of speaking up about their concerns/being seen as uncooperative** – that if they did this it may impact on their Mini PAT (Peer Assessment Tool)
- **Unprofessional/open hostility and rude behaviour from nursing staff**
- **Reluctance from nursing staff to take ownership regarding** management of patients with Personality Disorder(PD) supporting the juniors as chaperones when they are clerking
- **Handover from nursing staff inadequate**
- **Being asked to do things that trainee did not feel competent enough** i.e. discharging patients, sectioning and being looked down by the nursing staff if request not completed or being impatient with them while they are busy doing other tasks
- **Recruiting issue in the future – possible implication on future recruitment of trainees due to perceived poor treatment by nursing staff**
- **Issues with staffing levels on ward during COVID-19.**

All these issues were discussed at length with the Guardian, ADME, DME and Nurse Matron of the Hartington unit at the JDF.

11. Actions for the future:

11.1 Clinical Matron, Hartington Unit will now attend induction to introduce herself to trainees and give reassurance that they can raise concerns directly with her. She will also be attending the ADME meetings and future JDF meetings

11.2 DME encouraged all trainees to voice their concerns at all the different platforms available to them i.e. ADME Meeting, JDF, medical education team, experimental sessions and that it would be really useful if trainees were able to report these issues as they were happening so that the relevant action could be taken straightaway rather than having to wait until the trainee's placement was drawing to an end.

11.3 GOSW reiterated that JDF can be used as a neutral platform to discuss any relevant themes and these can be discussed with her or the Freedom to Speak Guardian confidentially.

11.4 DME has suggested that perhaps the above issue should also be discussed at Medical Staffing Committee (MSC) / Trust Medical Advisory Committee (TMAC) for clinical supervisors to enable all trainees to have confidence to be able to discuss these concerns at supervision.

11.5 With regards to issues with the vacancies on wards during COVID, ADME explained that this was due to redeployment of two trainees and need to shield another one. This was proactively filled in with suitable locums.

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 3 November 2020

Safeguarding Children and Adults Annual Report

Purpose of Report

The annual production of this report is a governance requirement of both the Trust and the Safeguarding Children and Adults Boards. It provides assurance that the Trust is meeting its legal and statutory performance and governance requirements in a consistent and reliable manner.

Executive Summary

- This report has been reviewed and scrutinised at the Quality and Safeguarding committee and this paper was endorsed.

  The Trust has had a successful year and continues to fully discharge its 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, assessed and inspected. The positive findings have been included in the report and provide significant independent assurance by the CQC, Clinical Commissioning Group Specialists in Children's and Adult named and designated staff.
- The report describes the context and population health needs and risks for children and families in Derby and Derbyshire. It is benchmarked against other regions and national levels to outline the conditions and risk to children and families to set the context of safeguarding in our community. The outcomes for children in our county particularly in the city are worse than other parts for England. The report sets the tone and the context of safeguarding in Derbyshire Healthcare in a city with significantly deprived wards and children living in poverty.
- 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 the executive lead offered significant assurance.
- Safeguarding Unit including Multi Agency Safeguarding Hub (MASH) health activity over the year 2019-t20 and the learning from this activity and confirmation that this is incorporated this into Trust developments.
- 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 to provide assurance to the Quality and Safeguarding Committee and Board.
- The year ended with COVID-19 Contingency and Business Continuity Plans that have continued into the current year and will be reported on in future Children and Adults Reports.
- Audit activity and audit and inspection visit results are included in the report which are positive in their findings and demonstrate the Trusts learning l approach. A full and expansive programme of audit has been included in the report to provide evidence on the internal governance process and how the Unit

provides quality improvement of practice.

The Safeguarding Strategy has been designed to target the organisational response and in 2020 as the full strategy year is implemented, the future reports will fully measure how the strategy pillars have been implemented and the committee have received and will continue to receive reports on progress and achievements for 2020.

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

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, is meeting its legal and statutory duties and obligations.

Consultation

- The team has consulted with partners throughout the year as appropriate to specific areas of activity, for example, policy development, public protection developments, refining processed within the MASH

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 in itself 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 i.e. Safe, Caring, Effective, Responsive, Well-led and Safeguarding are one of the gold threads that runs throughout. We apply national guidelines and evidence based best practice e.g. NICE, DoH, National Statistics.

The Trust contributes as an equal partner in Multi-Agency forums e.g. MAPPA; MARAC; Channel; Child and Adult Safeguarding Boards and 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 belief, Disability and Sexual orientation), including risks, and say how these risks are to be managed.

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

The field of safeguarding adults at risk of abuse is underpinned by the following six key principles:

- **Empowerment** - of the individual to make decisions.

- **Protection** - support and representation for those in need.
- **Prevention** - of abuse / neglect as well as helping the person to reduce the risks of harm and abuse that are unacceptable to them.
- **Proportionality -** responses should be least restrictive to the person's rights.
- **Partnerships -** working collaboratively to prevent, identify and respond to harm.
- **Accountability** - and transparency in delivering safeguarding. Safeguarding is intended to support those most vulnerable to being at risk of abuse, many of whom have protected characteristics relating to age, gender, disability, religion and sexual orientation. The intention of safeguarding governance and due diligence is to recognise the vulnerability to abuse of people engaging with Trust services and apply the principles to all aspects of safeguarding practice.

The Trust cannot mitigate all of 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) Receive the report which is offered by the Executive Lead with significant assurance from the report regarding the fulfilment of legal and statutory duties.

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

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

Members of the
Safeguarding Unit, including MASH Health

Safeguarding Children and Adults at Risk

Annual Report

INTRODUCTION

The safeguarding of all our patients, both adults and children remains a high priority for DHCFT. Safeguarding and 'Think Family' is the 'Golden Thread' throughout the care provided. The purpose of this report is to provide a review and analysis of the year's Safeguarding activity and an update of Safeguarding developments across the Trust and the progress against the Trust Safeguarding Strategy.

This report sets out the work of DHCFT in relation to safeguarding and the necessary frameworks in place to continue to 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 a busy 12 months characterised by high levels of activity, increased complexity of calls for advice and referrals and many areas of development, which we use to inform our learning and to form our organisational growth.

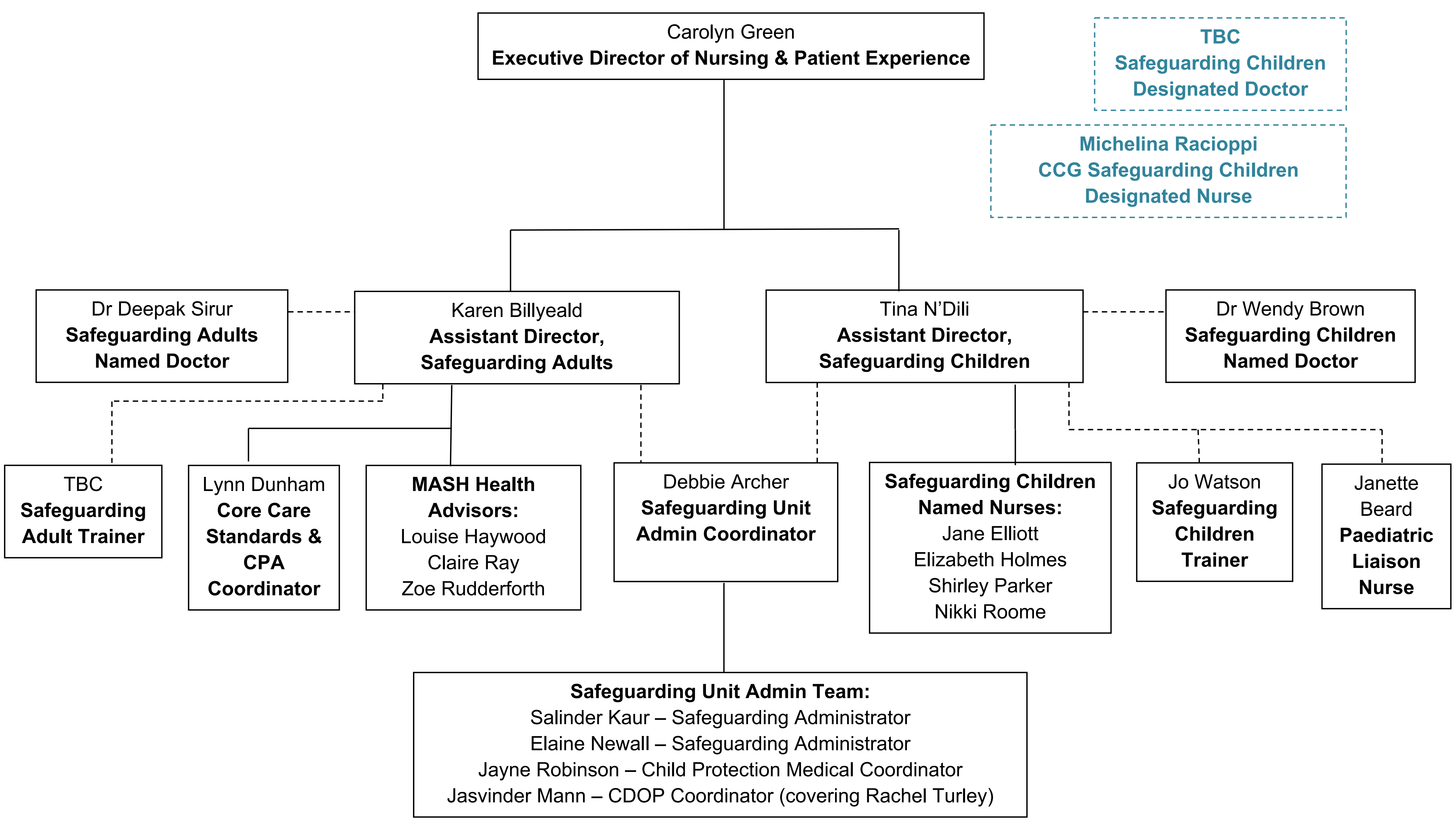
SAFEGUARDING UNIT REPORTING STRUCTURE

During the year the Trust reviewed its internal governance structure and aligned Committees across the organisation. Safeguarding children and adults operational groups report on a quarterly basis to the Quality and Safeguarding Committee which reports directly to the Trust Board.

DHCFT is committed to partnership working to discharge its statutory duties with Derby City & Derbyshire Safeguarding Children and Adult Boards. There is Trust representation and attendance at all sub group and multi-agency meetings. Effective Safeguarding relies on strong partnerships within the Trust and with other agencies and the Safeguarding Boards in a culture of consistent, respectful cooperation.

The Safeguarding Unit prepare a monthly report that is issued to all Clinical Operational Assurance Team (COAT) meetings for the Trust which includes Specialist, Childrens, Neighbourhood, Forensic and Campus divisions/ The leads provide organisational scrutiny, guidance and learning and includes points for action for the divisions representatives as well as points for information. Both safeguarding operational groups can escalate matters that require executive or committee consideration / inclusion in the Trust Risk Register but, equally, can escalate good news stories, lessons learned to share across the organisation.

SAFEGUARDING UNIT STRUCTURE



The period covered by this report saw the following changes to the Safeguarding Unit structure and responsibilities:

- June 2019 – Appointment of Safeguarding Adult Named Doctor – Dr Deepak Sirur
- November 2019 – Appointment of Child Death Overview Panel (CDOP) Coordinator on a 12 month fixed term contract to cover sickness.
- March 2020 – Appointment of Safeguarding Unit Administrator Coordinator
- March 2020 – Appointment of Safeguarding Children Named Doctor – Dr Wendy Brown
- April 2020 – Vacancy – Safeguarding Adult Trainer (secondment post ended at the end of March 2020)

SAFEGUARDING CHILDREN'S PERFORMANCE DASHBOARD

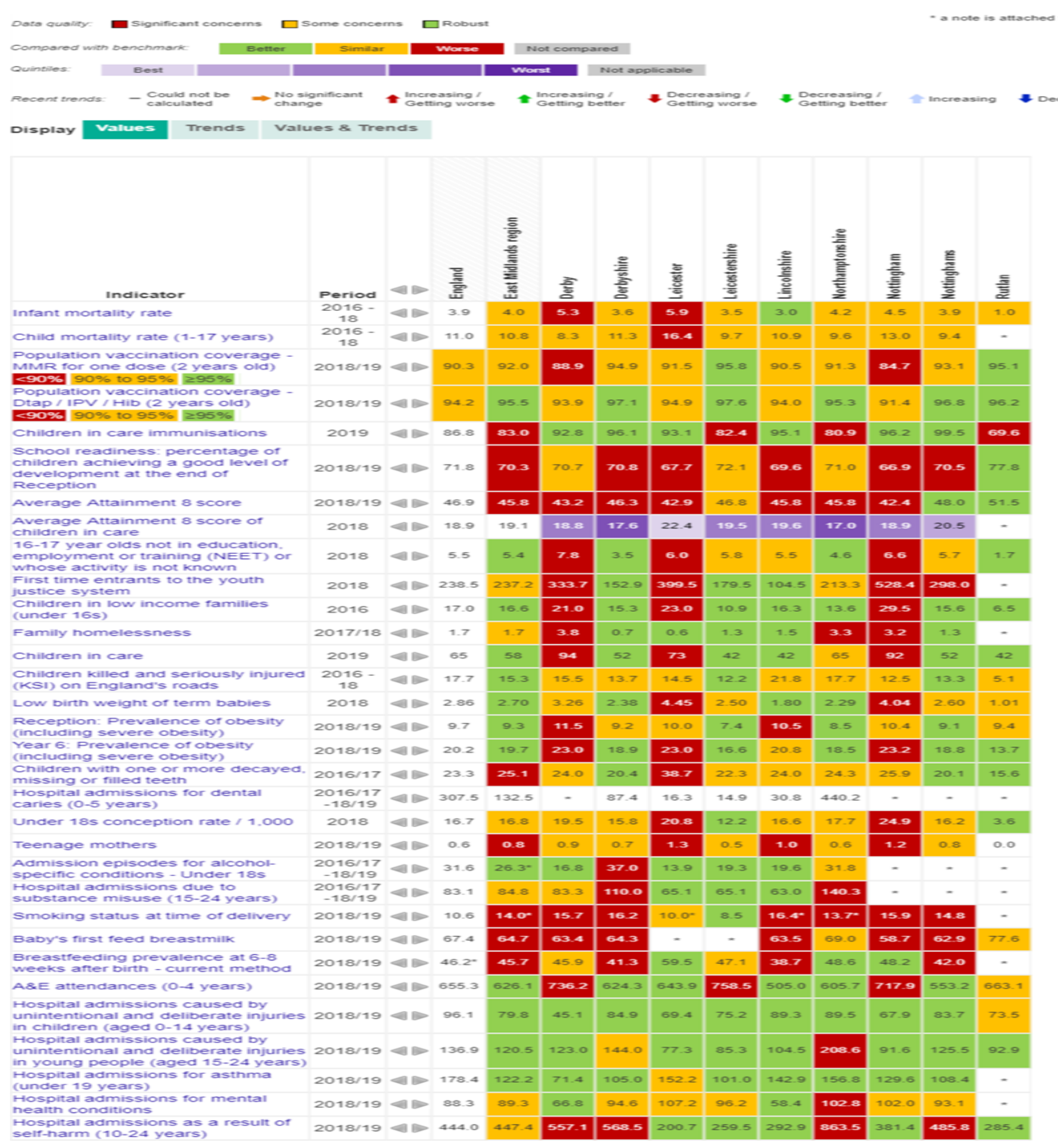
Item	Metric	Quarter 1 2019-20	Quarter 22019-20	Quarter 3 2019-20	Quarter 4,2019-20
1	Number of advice calls received and reported	178	199	358	309
2	Number of supervision/group sessions	98	119	116	133
3	Number of attendance at MDMs/team meetings/ward rounds	7	7	26	19
4	Number of MASH sessions covered by the safeguarding children's team	0	1	4	1
5	Number of strategy discussions/meetings	5 Strats 130 S47s 2 I/RCPC	3 Strats 139 S47s 2 ICPC	3 Strats 171 S47s 0 I/RCPC	5 Strats 138 S47s 1 I/RCPC
6	Number of safeguarding meetings attended by the safeguarding team	19	15	14	15
7	Number of safeguarding children's training/workshops delivered	3	0	1	0
8	Number of child protection medical - suspected NAI	44	31	39	46
9	Number of CHANNEL referrals	8	2	20	7
10	Number of MARAC cases with children discussed at MARAC	130	200	217	97
11	Number of referrals to CSC	4	6	9	5
12	CIC Caseload - Born In Lives In	218	207	202	213
	CIC Caseload - Born In Lives Out	353	351	357	373
	CIC Caseload - Born Out Lives In	8	3	4	2
	CIC Caseload - Unknown	0	0	0	0
	Total CIC Caseload	579	561	563	588
13	Number of Child Deaths	6	3	6	6
14	Number of children referred for risk of FGM	3	1	0	1
15	Number of children on a child in need plan	885	852	821	677
16	Distinct count of children affected by DV during the Quarter	957	644	645	575
17	Number of children in an adult bed	1	0	0	0
18	Number of young carers	4	4	4	4
19	Number of children on a child protection plan	533	537	554	545

Analysis of the main features within the safeguarding children dashboard:

- Supervision figures show increased compliance.
- Increase in S47s and strategy meetings in Q3 which contributes to the pressure on the resources of the Safeguarding Children Nursing Team.
- Domestic Violence and MARAC case continue to be at a consistently high level, however have reduced over the end of the year.
- Channel Referrals show a significant increase in Q2, this was partly attributable to a specific piece of work. These patterns are indicative of continued improved knowledge of this agenda and the collaboration and joint working with clinical teams on vulnerability assessments and subsequent action plans.

POPULATION AND FAMILY VULNERABILITY IN THE CHILDREN'S DIVISION AND THE TRUST

This Public Health England Dashboard has been incorporated in to the annual report to give a population health and outcome perspective into the importance of safeguarding clinical practice in our Trust. As the leading provider of Children's and CAMHS services with double outstanding rated services, the Trust's contribution to the welfare of children is paramount. The outcomes for children in Derby are worse and our focus on how we reduce the harm of so many children living in poverty, monitoring for neglect and supporting individuals to not enter into youth justice systems. Monitor and intervene to reduce family homelessness, support emotional well-being and psychological support/ early access and support wider uptake of breastfeeding.


Data quality: Significant concerns | Some concerns | Robust

* a note is attached t

Compared with benchmark: Better | Similar | Worse | Not compared

Quintiles: Best | | | | Worst | Not applicable

Recent trends: — Could not be calculated | No significant change | Increasing / Getting worse | Increasing / Getting better | Decreasing / Getting worse | Decreasing / Getting better | Increasing | Deci

Display: Values | Trends | Values & Trends

Indicator	Period	England	East Midlands region	Derby	Derbyshire	Leicester	Leicestershire	Lincolnshire	Northamptonshire	Nottingham	Nottinghams	Rutlan
Infant mortality rate	2016 - 18	3.9	4.0	5.3	3.6	5.9	3.5	3.0	4.2	4.5	3.9	1.0
Child mortality rate (1-17 years)	2016 - 18	11.0	10.8	8.3	11.3	16.4	9.7	10.9	9.6	13.0	9.4	-
Population vaccination coverage - MMR for one dose (2 years old) <90% 90% to 95% ≥95%	2018/19	90.3	92.0	88.9	94.9	91.5	95.8	90.5	91.3	84.7	93.1	95.1
Population vaccination coverage - Dtap / IPV / Hib (2 years old) <90% 90% to 95% ≥95%	2018/19	94.2	95.5	93.9	97.1	94.9	97.6	94.0	95.3	91.4	96.8	96.2
Children in care immunisations	2019	86.8	83.0	92.8	96.1	93.1	82.4	95.1	80.9	96.2	99.5	69.6
School readiness: percentage of children achieving a good level of development at the end of Reception	2018/19	71.8	70.3	70.7	70.8	67.7	72.1	69.6	71.0	66.9	70.5	77.8
Average Attainment 8 score	2018/19	46.9	45.8	43.2	46.3	42.9	46.8	45.8	45.8	42.4	48.0	51.5
Average Attainment 8 score of children in care	2018	18.9	19.1	18.8	17.6	22.4	19.5	19.6	17.0	18.9	20.5	-
16-17 year olds not in education, employment or training (NEET) or whose activity is not known	2018	5.5	5.4	7.8	3.5	6.0	5.8	5.5	4.6	6.6	5.7	1.7
First time entrants to the youth justice system	2018	238.5	237.2	333.7	152.9	399.5	179.5	104.5	213.3	528.4	298.0	-
Children in low income families (under 16s)	2016	17.0	16.6	21.0	15.3	23.0	10.9	16.3	13.6	29.5	15.6	6.5
Family homelessness	2017/18	1.7	1.7	3.8	0.7	0.6	1.3	1.5	3.3	3.2	1.3	-
Children in care	2019	65	58	94	52	73	42	42	65	92	52	42
Children killed and seriously injured (KSI) on England's roads	2016 - 18	17.7	15.3	15.5	13.7	14.5	12.2	21.8	17.7	12.5	13.3	5.1
Low birth weight of term babies	2018	2.86	2.70	3.26	2.38	4.45	2.50	1.80	2.29	4.04	2.60	1.01
Reception: Prevalence of obesity (including severe obesity)	2018/19	9.7	9.3	11.5	9.2	10.0	7.4	10.5	8.5	10.4	9.1	9.4
Year 6: Prevalence of obesity (including severe obesity)	2018/19	20.2	19.7	23.0	18.9	23.0	16.6	20.8	18.5	23.2	18.8	13.7
Children with one or more decayed, missing or filled teeth	2016/17	23.3	25.1	24.0	20.4	38.7	22.3	24.0	24.3	25.9	20.1	15.6
Hospital admissions for dental caries (0-5 years)	2016/17 -18/19	307.5	132.5	-	87.4	16.3	14.9	30.8	440.2	-	-	-
Under 18s conception rate / 1,000	2018	16.7	16.8	19.5	15.8	20.8	12.2	16.6	17.7	24.9	16.2	3.6
Teenage mothers	2018/19	0.6	0.8	0.9	0.7	1.3	0.5	1.0	0.6	1.2	0.8	0.0
Admission episodes for alcohol-specific conditions - Under 18s	2016/17 -18/19	31.6	26.3*	16.8	37.0	13.9	19.3	19.6	31.8	-	-	-
Hospital admissions due to substance misuse (15-24 years)	2016/17 -18/19	83.1	84.8	83.3	110.0	65.1	65.1	63.0	140.3	-	-	-
Smoking status at time of delivery	2018/19	10.6	14.0*	15.7	16.2	10.0*	8.5	16.4*	13.7*	15.9	14.8	-
Baby's first feed breastmilk	2018/19	67.4	64.7	63.4	64.3	-	-	63.5	69.0	58.7	62.9	77.6
Breastfeeding prevalence at 6-8 weeks after birth - current method	2018/19	46.2*	45.7	45.9	41.3	59.5	47.1	38.7	48.6	48.2	42.0	-
A&E attendances (0-4 years)	2018/19	655.3	626.1	736.2	624.3	643.9	758.5	505.0	605.7	717.9	553.2	663.1
Hospital admissions caused by unintentional and deliberate injuries in children (aged 0-14 years)	2018/19	96.1	79.8	45.1	84.9	69.4	75.2	89.3	89.5	67.9	83.7	73.5
Hospital admissions caused by unintentional and deliberate injuries in young people (aged 15-24 years)	2018/19	136.9	120.5	123.0	144.0	77.3	85.3	104.5	208.6	91.6	125.5	92.9
Hospital admissions for asthma (under 19 years)	2018/19	178.4	122.2	71.4	105.0	152.2	101.0	142.9	156.8	129.6	108.4	-
Hospital admissions for mental health conditions	2018/19	88.3	89.3	66.8	94.6	107.2	96.2	58.4	102.8	102.0	93.1	-
Hospital admissions as a result of self-harm (10-24 years)	2018/19	444.0	447.4	557.1	568.5	200.7	259.5	292.9	863.5	381.4	485.8	285.4

ADULTS DASHBOARD

The safeguarding adults dashboard has become established over the past year and, whilst, ambitious in some of the data it seeks to capture that may not currently be achievable, it reflects the expected performance requirements of commissioners and some aspirational targets for data in the future.
Can we just use initials for all names in first column?

ANNUAL SAFEGUARDING DASHBOARD – 2019/20

	DUTY/REQUIREMENT	METRIC	DEFINITION OF METRIC	TARGET GROUP	TARGET	Q1	Q2	Q3	Q4	NOTES
1. Statutory Duties Regulatory Body Requirements - Safe? Effective?										
1	Data received from TS.	**Adult Safeguarding Level 1 Training (3 yearly)**	Adult Protection training allows staff to be able to identify early any safeguarding risks and to know what actions to take	Q1: 659 Q2: 623 Q3: 587 Q4: 590	85%	91.14%	92.66%	93.75%	93.56%	Target group = **Average** staff number required to complete training over the 3 month period
2	Data received from TS	**Safeguarding Adults Level 1 + 2 (3 yearly)**	Adult Protection training allows staff to be able to identify early any safeguarding risks and to know what actions to take	Q1: 1905 Q2: 1807 Q3: 1764 Q4: 1758	85%	90.66%	88.35%	86.94%	85.99%	Target group = **Average** staff number required to complete training over the 3 month period
3	Data received from TS	**Safeguarding Level 3 (3 yearly)**	Enquirers training in order to be compliant with Care Act and Derbyshire Adult Safeguarding Policy and Procedures	Q1: 131 Q2: 129 Q3: 130 Q4: 132	85%	52.29%	70.01%	72.38%	71.89%	Target group = **Average** staff number required to complete training over the 3 month period
4	Data received from CE	**Number of urgent DoLS authorised -** Urgent DoLS are authorised by the Trust on the day we request an assessment (as we are the managing authority)	Accurate recording of number of DoLS applications ensures compliance and appropriate application of legislation	N/A	N/A	13	5	6	4	
5	Data received from CE	**Number of standard DoLS applied for to the LA**	Accurate recording of number of DoLS applications ensures compliance and appropriate application of legislation	N/A	N/A	13	5	6	4	
6	Data received from CE – To be included in quarterly total report only	**Number of people with an authorised DoLS granted by Supervisory body as at end of quarter**	Accurate records and monitoring of numbers ensures good governance and compliance with legislation	N/A	N/A	1	1	1	0	

DUTY/REQUIREMENT		METRIC	DEFINITION OF METRIC	TARGET GROUP	TARGET	Q1	Q2	Q3	Q4	NOTES
7	Data received from CE – To be included in quarterly total report only	**Number of referrals to coroner for people who have passed away and have an authorised DoLS granted by Supervisory body as at end of quarter**	Accurate records and monitoring of numbers ensures good governance and compliance with legislation	N/A	N/A	0	0	1	0	
8	Data received from HC/TS	**DoLS training for frontline / clinical staff**	DoLS awareness ensures compliance with legislation in relation to people who lack capacity to make decisions at appropriate time	Q1: 1081 Q2: 984 Q3: 956 Q4: 951	85%	85.17%	87.98%	89.15%	89.87%	Target group = **Average** staff number required to complete training over the 3 month period
9	KS to provide data on breaches reported by CQC (through inspection reports), based on inspection dates	**Compliance with CQC requirements, Regulation 13, (Safeguarding people who use services from abuse)**	All providers are required to reach compliance with CQC Essential Standards of Quality and Safety in all Areas of the Service	N/A	0	0	0	0	0	
13	Data received from CG	**Numbers of staff referred to their professional body due to safeguarding concerns**	Total number staff referred due to concerns about their ability to practice safely	N/A	N/A	1	0	1	2	
2. Regulatory Body Compliance - Safe? Effective? Caring? Responsive? Well-led?										
16	Data received from HC/TS	**Positive and Safe – Training compliance for PACE & SCIP and Positive and Safe**		Q1: 496 Q2: 457 Q3: 452 Q4: 450	85%	59.61%	58.42%	71.41%	70.19%	Target group = **Average** staff number required to complete training over the 3 month period
3. Partnerships - Responsive? Well-led?										
17		**Provider has a fully resourced and authorised PREVENT Lead**	Provider identify name of lead	N/A	N/A	KB	KB	KB	KB	Karen Billyeald is lead
18	Data received from TS - All new staff attending induction	**Number of staff who have received induction / basic awareness in Prevent (Level 1, 3 yearly)**	All staff should have a basic awareness of Prevent	Q1: 667 Q2: 631 Q3: 597 Q4: 605	85%	94.50%	95.05%	96.03%	94.88%	Target group = **Average** staff number required to complete training over the 3 month period
19	Data received from TS	**Prevent Wrap Training to be delivered to all front-line staff (Level 3, 3 yearly)**	Number of identified staff group who require WRAP training from an accredited WRAP facilitator	Q1: 1889 Q2: 1788 Q3: 1741 Q4: 1731	85%	91.09%	90.51%	89.33%	88.60%	Target group = **Average** staff number required to complete training over the 3 month period
22	Data received from KB	**Full attendance at MARAC meetings (fortnightly)**	Fulfilling our Public Protection responsibilities alongside partner agencies	N/A	100%	100%	100%	100%	100%	
23	Data received from KB	**Full attendance at MAPPA 3**	Fulfilling our Public Protection	N/A	100%	66.66%	100%	100%	100%	

DUTY/REQUIREMENT		METRIC	DEFINITION OF METRIC	TARGET GROUP	TARGET	Q1	Q2	Q3	Q4	NOTES
		meetings (monthly)	responsibilities alongside partner agencies							
24	Data received from KB	**Full attendance at DSAB, City and County**	Fulfilling our responsibilities as full and equal members	N/A	100%	See notes	See notes	See notes	See notes	City: 100% County: N/K
25	MASH KPIs - Children and Young People Performance Data MASH provide data	**The number of Adult Safeguarding information sharing requests for Health received**	Evidence to be gathered to ascertain demand for and effectiveness of this partnership initiative to present to Commissioners	N/A	N/A	489	437	562	714	
26		Monitor the number and type of requests for information coming through to the Derby City MASH Health team from Children Social Care	Record of number of request for information for children and young people	N/A	N/A	61	74	121	92	
27		Time to conduct research (mins)	Record of the time taken to gather information / analysis	N/A	N/A					Not recorded
28		Monitor the number of strategy discussions for safeguarding children	Record of the number of strategy discussions pertaining to children and young people	N/A	N/A	60	72	119	91	
29		How many children, young people, parents/ carers were discussed	Record of the number of children, young people and parents discussed	N/A	N/A	305	328	541	362	
30		Time in strategy meetings (mins)	Record of time in strategy meetings	N/A	N/A					Not recorded
31		Number of professionals liaised with	Record of the number of professionals liaised with for the strategy discussions / meetings	N/A	N/A	40	30	27	46	
32		Number of complex strategy meetings that involve both children and adults	Requested for 2018/19 onwards	N/A	N/A					Not recorded
33	**MASH KPIs – Adult Performance Data** MASH provide data	Time to conduct research (mins)	Record of the time taken to gather information / analysis	N/A	N/A					Not recorded
34		Monitor the number of strategy discussions for adults at risk	Record of the number of strategy discussions pertaining to adults at risk	N/A	N/A	18	19	21	16	
35		How many adults were discussed	Record of the number of adults at risk discussed	N/A	N/A	62	43	64	51	
36		Time in strategy discussion/ meetings (mins)	Record of time in strategy discussion /meetings	N/A	N/A					Not recorded
37		Number of professionals liaised with	Record of the number of professionals liaised with for the strategy discussions / meetings	N/A	N/A	389	296	157	189	

	DUTY/REQUIREMENT	METRIC	DEFINITION OF METRIC	TARGET GROUP	TARGET	Q1	Q2	Q3	Q4	NOTES
38	**MASH KPIs - Domestic Violence Performance Data** MASH provide data	Number of domestic violence standard cases discussed at triage	Record of the number of *standard* domestic violence discussed	N/A	N/A	368	374	185	324	
39		Number of domestic violence medium cases discussed at triage	Record of the number of *medium* domestic violence discussed	N/A	N/A	304	332	332	358	
40		Number of hours spent in domestic violence triage meetings	Record of time spent in domestic violence triage meetings	N/A	N/A					Not recorded
41		Time taken to conduct research for domestic violence cases (mins)	Record of the time taken to gather information / analysis for domestic violence cases	N/A	N/A					Not recorded
42	**MASH KPIs – Other Performance Data** MASH provide data	Training, shadowing, supervision (hours)	Number of hours for training, shadowing and supervision	N/A	N/A	82.5	68.5	19	14	
43		Tasks received from DHCFT safeguarding service	Number of hours for processing tasks from DHCFT	N/A	N/A					Not recorded
44		Number of times when the Safeguarding Health advisor / Named Nurse was not available within the MASH Service (hours)	Number of hours that the MASH service did not have face to face presence in the MASH Service	N/A	0	0	14	29.5	15	
4. Workforce - Safe? Well-led?										
45	Data received from KJ	Number of DBS risk assessments carried out	Target group includes all new starters/routine checks each month Data to include all DBS checks for new staff and (separately recorded) all DBS checks for existing staff. Exceptions reporting required if any non-standard checks are made	Q1: 63 Q2: 71 Q3: 79 Q4: 99	100%	90%	91%	95%	81%	Q1: 4 in progress and two working on a DBS waiver Q2: 2 waivers in place and 4 retire and return in progress Q3:1retire and return in progress and 3 not required for role Q4:3 retire and return in progress and 14 not required for role
5. Making it Personal – Additional voluntary information from safeguarding leads, link workers and teams										
46	See notes from KB	Stories, feedback, early indicators of potential abuse, trends, application of best practice, good news stories		N/A	N/A	See notes	See notes	See notes	See notes	KB to generate these from logs

Over time this data will have further analysis and will be continually developed so benchmarking with other organisation can be explored to further consider trends and patterns to enable the Trust to plan and predict levels of care needed.

Analysis

This performance dashboard continues to provide some core information and we are now able to commence run charts and improvement SPC charts to analyse our information for specific trends. Our level 3 safeguarding training compliance remains our specific improvement challenge and we are hopeful of recruiting to the vacant Safeguarding Adults Trainer vacancy in Q1 of the next year. The MASH Health Advisors continue to consistently meet commissioner – led Key Performance Indicators and are now reporting as part of Trust contracted activity.

The performance and narrative evidence provided in this annual report demonstrates that we are meeting 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

TRAINING - ADULTS AND CHILDREN

ADULTS – TRAINING POSITION

This provides an update to the safeguarding adults training provision, compliance and action plan in the Trust as at March 2020

Training Name	Target Group	Compliant	Non-Compliant	Compliant %
Safeguarding - Adults Level 1 3 Yearly	589	548	41	93.04%
Safeguarding - Adults Level 1+2 3 yearly	1754	1523	231	86.83%
Safeguarding - PREVENTing Radicalisation - Level 1 3 yearly	604	572	32	94.70%
Safeguarding - PREVENTing Radicalisation/WRAP Level 3 3 yearly	1727	1543	184	89.35%
Safeguarding - Adults Level 3 3 Yearly	128	94	34	73.44%

This year has seen the on-going delivery of face to face sessions for all levels of safeguarding training.

E-Learning is currently available for level 1 learners.

Safeguarding adults training continues to be delivered during the induction block training week as well as individual dates. From September 2019, level 3 to reflect the need to include the higher requirements of the intercollegiate document was offered as a full day to include level 1, 2, MCA, DoLS, and Prevent Wrap. This was until COVID 19 changes in March 2020

Staff who require training continue to be targeted by email reminders and guidance.

DHCFT SAFEGUARDING CHILDREN TRAINING POSITION

This provides an update to the safeguarding children training provision, compliance and action plan in the Trust as at March 2020

Training Name	Target Group	Compliant	Non-Compliant	Compliant %
C Safeguarding Children Level 1 Annual	527	483	44	91.65%
C Safeguarding Children Level 1 once only	1811	1782	29	98.40%
R Safeguarding - Children Level 2 3 yearly	489	378	111	77.30%
R Safeguarding - Children Level 2 once only	1352	1311	41	96.97%
R Safeguarding - Children Level 3 3 yearly	1031	778	253	75.46%
R Safeguarding - Children Level 3 Annual	319	282	37	88.40%
R Safeguarding - Children Level 4 Annual	9	8	1	88.89%

This year has seen the ongoing delivery of face to face sessions for all levels of safeguarding children training. This period has seen an improvement in competency rates for level 3 training for both annual and 3 yearly learners, which is delivered face to

face only, prior to the COVID pandemic. E-Learning is currently available for level 1 learners.

Level 2 training continues to be delivered during the induction block training week and individual dates. Block training includes two training sessions. Staff who require training continue to be targeted by email reminders and guidance. Training continues to be delivered in an assortment of venues for ease of accessibility for staff.

SECTION 11 AUDIT

Section 11 of the Children Act 2004 places duties on a range of organisations, agencies and individuals to ensure their functions, and any services that they contract out to others, are discharged having regard to the need to safeguard and promote the welfare of children. The CCG discharges its duties through the Section 11 audit.

The DHCFT Safeguarding Children team undertook the Section 11 self-assessment on the 13 December 2019 in a quality visit led by NHS Derby and Derbyshire Clinical Commissioning Group (DDCCG) and Derby and Derbyshire Safeguarding Children Partnership (DDSCP).

The team gave full assurance of compliance and demonstrated how we are achieving compliance and making a difference by, with the evidence provided in the self-assessment and within further information/assurance presented and submitted.

The table below shows full compliance in all five standards was achieved.

Section 11 compliance rating (2019)	
Standard 1	9 Green (Full Compliance)
Standard 2	4 Green (Full compliance)
Standard 3	3 Green (Full compliance)
Standard 4	5 Green (Full Compliance)
Standard 5	4 Green (Full compliance)

SAFEGUARDING ADULTS ASSURANCE FRAMEWORK (SAAF)

Following a very successful assessment visit in 2018 we received a follow-up review of our Action Plan on 30/09/2019. Our Action Plan was approved we were congratulated on the strategic and operational work of the Safeguarding Unit in safeguarding children, adults and families.

SAAF follow up visit feedback

Thank you for your welcome and hospitality during our SAAF follow up visit on 30 September 2019.

We welcomed your comprehensive action plan which took us through the Trust's progress in implementing the priorities that you identified within the SAAF document completed during 2018-19 along with the progress and development in your adult safeguarding work.

You began our meeting by providing an overview detailing how your Operational Safeguarding Group has evolved into the Link Workers Network using the Safeguarding link workers to feedback to their local teams. The Trust has 65 teams and 50% of these now have link workers and you further explained that you are seeking a remit to extend the role of the link workers from your Trusts internal Safeguarding Committee which will help reduce the workload of the safeguarding team.

Review the safeguarding families' strategy in 2019 – apply a collaborative approach
Following an analysis of calls for advice you explained many are historical and are then referred to IAPT services. This evidence tells you that staff are now more confident in that they will call for advice, also that some of the historical abuse calls for advice can be triggered by the Media or if the perpetrator has died. Calls for advice involving MCA are referred to Dr Deep Sirur to give advice.

To increase the number of staff learning events from DHRs, SARs, Serious Incidents etc
You explained that the Trust are looking to increase the number of staff learning events. Radbourne and Hartington Units already have monthly network meetings where learning is discussed. A learning event is planned to look at the 'use of physical intervention' for staff.

The intercollegiate document has necessitated a review of adult safeguarding training content and delivery
You further explained that Safeguarding Adults continues to enjoy a high priority within the training programme and that Lee Smith's secondment into training is to continue for now. It has been agreed that Safeguarding Adults Level 3, MCA/DOLs, WRAP training are all covered in a one day course which all clinically registered staff attend. There is a new 3 years training compliance programme in place for staff in the Trust.

Aston Hall – new cohort following further media coverage in July 2019
It was good to hear that you have a positive feel about the DHcFT Board who are keen to know everything that is happening including the Trusts CEO organising an internal Aston Hall learning review for the Board.

You explained that Clare Ray from the Crisis Team is working with you 2 days a week until mid-December but the work with survivors will need to continue beyond this date which may be an issue.

MASH Health Advisor role
Interesting to hear that MASH activity when it started 3 years ago was around safeguarding children and is now mainly around safeguarding adults. Also good to hear about the massive

interest and number of candidates applying for the 15hr post in the MASH that you are recruiting to, we wish you every success in getting the right candidate.

Continued development of Trauma Informed practice across the Trust
I was pleased to hear that TRAUMA informed practice, now have a working group and are looking to develop a strategy and embed principles for the Trust.

Finally in summing up you shared that Cubley and Hartington wards are back on the radar of safeguarding in the last quarter, i.e. allegations against staff. However the Trust are seeing this as a positive in that patients feel able to speak out. It is mainly adult mental health patients so could be related to their illness or condition, so management have needed to remind staff about including the patient's illness and condition in their care notes so that all staff are aware.

You and your team continue to have an important presence at the safeguarding adult's boards and contribute to MARAC, MAPPA and the Channel panel which is valued by all the multi-agency partners. However there is still a real issue of pressure due to the lack of capacity to meet these and other demands.

The CCG Safeguarding Adults Team hope to introduce 1:1 supervision from April 2020 on quarterly basis which we hope will provide some further support.

Once again we were assured by the work being done by yourself Karen to ensure that DCHFT maintains its profile and helps to influence local safeguarding arrangements in Derby and Derbyshire.
Yours sincerely

Bill Nicol

Bill Nicol
Assistant Director for Safeguarding Adults
NHS Derby and Derbyshire Clinical Commissioning Group

AREAS OF CONCERN/CHALLENGE OR PREVIOUS CHALLENGE AND SUCCESS

COVID-19 Contingency Plans

At the end of February the national pandemic of COVID-19 emerged and was constantly changing. We as a Trust continue to access national advice. All departments were instructed to draw up service contingency plans for the prolonged period ahead of extraordinary and unprecedented times. The Safeguarding Unit had its plans in place very quickly which has been updated as need arose. Core functions and activity continued virtually with staff working at home and meetings, supervision and the advice line continuing with a combination of phone calls and virtual meetings via Microsoft teams.

Safeguarding Department's Prioritised Activities:

- Membership of safeguarding partnership meetings.

- Specialist advice to the Trust.
- Full MASH activity
- Section 47 Strategy Discussions:
- Adult Strategy Discussions
- Safeguarding Children Advice Duty Rota
- On Call Consultant Community Paediatrician 24/7 Rota
- Child Protection Medicals – NAI
- Domestic Violence Triage
- Safeguarding Adult Advice
- MAPPA/MARAC/PREVENT/CHANNEL
- Court advice/Court support for Care Proceedings
- Safeguarding Children Supervision

The Safeguarding Children Partnership also required evidence of children services which were submitted to give Partnership assurance.

Safeguarding training was temporarily postponed and competency extensions were given for up to 4 months.

Implementation of the changes to the Child Death Overview Panel Statutory Responsibilities & Arrangements

Main changes being:
- Implementation of an electronic case management system called eCDOP which automatically reports into National Child Mortality Database.
- Funding for CDOP Designated Doctor and CDOP Lead Nurse.
- Tighter timescales.

This was a challenging time for the Safeguarding Admin Team as the changes commenced whilst the CDOP Coordinator was on long term sick. Cover arrangements were put into place via the existing staff team and then later a 12 month fixed term contract. These individuals had to learn a new electronic system via teaching manuals as no training was provided. All existing records had to be transferred onto the new electronic system within a short timeframe. This put pressure on the whole team however the timeframe was met. Following the recruitment of the CDOP Designated Doctor and CDOP Lead Nurse, clear guidelines needed to be established as to roles and responsibilities. The timescales have become shorter which involves constant monitoring and active engagement from partner agencies.

Public health nursing for school age children

The Public health service offer remains under pressure and challenge. The Trust continues to work in partnership with public health commissioners to find solutions to caseload size, safeguarding practice and pressure and continues to maintain and make improvements to the school nursing offer.

CAMHS Waiting Lists

Over the past 12 months there has been continued change across the system as a whole, cuts and changes to access thresholds across the LA (MAT and social care), education academies working in silo's and spot purchasing commissioning. There is a need for whole system thinking to reduce the impact on CAMHS, 0-19 services, OT, SEND etc. There is a potential risk that health is filling the gaps creating additional work and not focusing on the priority health needs of children and young people.

We have seen an increase in waiting times in CAMHS across both Derbyshire providers DHCFT and CRH. With regard to actions to mitigate this and reduce waiting lists we have been actively recruiting and sought central support to promote working for CAMHS via social media and trust website. We have also been successful in gaining CCG funding for 6.6 additional posts at band 5 and band 6 and have recruited a waiting list coordinator to support the management of the waiting lists. We have developed a CAMHS specific induction programme, CPD sessions, and supervision to support staff retention. However we are working within a backdrop of a national shortage of trained staff.

MARAC/MAPPA

MARAC - We have reviewed our internal system to align with the Derby and Derbyshire MARAC process to ensure that we have representation and are able to contribute fully as a key partner agency. This has included a review of the administrative function that supports the Safeguarding Unit contribution towards MARAC.

MAPPA 3 – The Trust continues to maintain 100% attendance at MAPPA 3 panel meetings and case reviews.

MAPPA 2 – We continue to experience some challenges regarding panel and individual case attendance at MAPPA 2 but we are addressing these challenges in collaboration with the newly established Trust Forensic Community Team.

INNOVATIONS

Amalgamation of children and adults safeguarding teams:

A closer alignment and amalgamation of our safeguarding service teams has been designed and continue to work collaboratively and creatively where safeguarding concerns are across families with complex needs. There has been some very complex cases were the cross working has proven to achieve better outcomes.

Think Family Think Tank:

As an organisation we review learning from our practice, audits and any incidents. Due the Safeguarding team have maintained its focus on think family and practise across our services maintaining the think family agenda. From 2015 we focussed on this within the context of a CQINN, training was mandatory for all clinical staff and the Trust undertook a self-evaluation pre and post the training delivery. The results showed a great improvement within the trust services thinking family and assessing and care planning accordingly. Now in 2020 we have decided to revisit this work and look and what are the next steps a team of interested interdisciplinary professionals with specialised knowledge now play a fundamental role in shaping policy agenda, practice and come together to introduce new ideas and debate. Work which has been undertaken includes:

- standardising risk assessments and care planning
- analysis training
- adult assessment framework group
- statement examples when assessing clients
- a Trust statement of family inclusive practice being a golden thread of clinical practice.

Safeguarding Team Training on: Contemporary developments and challenges for safeguarding in the wider health community:

The training received excellent evaluations. Key aims were:

- Explore and understand key issues in contemporary safeguarding practice and their implications for the health and wider safeguarding systems in Derbyshire
- Identify priority development areas for the wider health and safeguarding system and the contribution which can be made by Safeguarding staff.
- Identify practical actions to take forward a response to these issues, individually, in teams and across the system.
- Explore how to take forward issues in a way which promotes compassionate and resilient practice, management and leadership.

SAFEGUARDING CHILDREN ADVICE THEMES

We continue to analyse the calls for advice into the Unit – the top 5 themes have to a large extent remained the same however physical injury/abuse has now superseded neglect as the top advice topic:

- Physical Injury/Abuse
- Neglect
- Domestic Violence
- Sexual Abuse/Exploitation

- Parenting skills/capacity/Basic Care
-

SAFEGUARDING ADULTS ADVICE THEMES

The Safeguarding team at Derbyshire Healthcare Foundation Trust receive requests for advice regarding safeguarding concerns, referrals and ongoing cases. Requests are received in several different ways and from various sources. All of the adult related requests are logged and remain open to the Safeguarding advisor/s until resolved. The Assistant Director for Safeguarding Adults takes the lead on this.

From 1 April 2019 to 31 March 2020, 145 requests were logged; data analysis has been completed on them and presented in this report.

This does not include specific work streams that have been developed in response to particular specific issues e.g. requests for agency information from the Prevent Counter-Terrorism Team.

The overall number of advice requests has decreased slightly, from 151 in 2018/19 to 145 in 2019/20 – This is due to the increased stability of support offered by the MASH Health Advisors and greater integration across children and adult safeguarding in the Trust. However, the advice requests that are received outside of these processes are generally regarding cases that are of a much greater intensity than in previous years, and the majority are responded to by the Assistant Director for Safeguarding Adults.

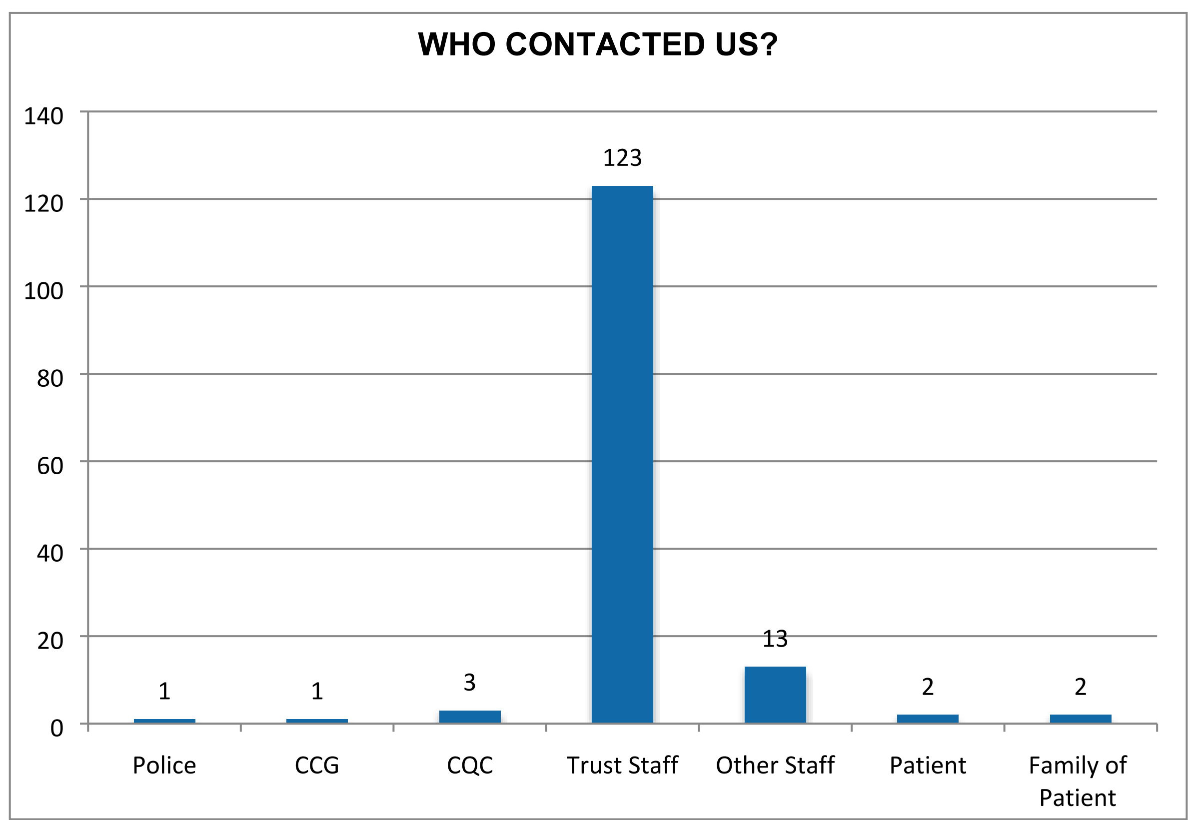
How are requests received?

The method of contact for requests is usually via Trust staff. Third parties may approach staff who then log the request, or staff themselves often request advice for service users, carers and family members that they are working with and have concerns for.

The majority of cases that the MASH team receive are not included in this log as that would be a duplication of the number of concerns raised. However, there are a small number of advice requests that the MASH team have logged as advice from the Assistant Director of Safeguarding Adults was required, these are included in the total number of requests for advice by ‘Trust Staff’.

The number of requests for advice received directly from patients has remained the same. There are now concerns being received from family members of patients too – This is an indicator of a general raised awareness of safeguarding concerns and is a reassuring trend from a Making Safeguarding Personal perspective.

Requests are also received from sources external to the Trust such as other organisations, for example Social Services, the CQC or CCGs.

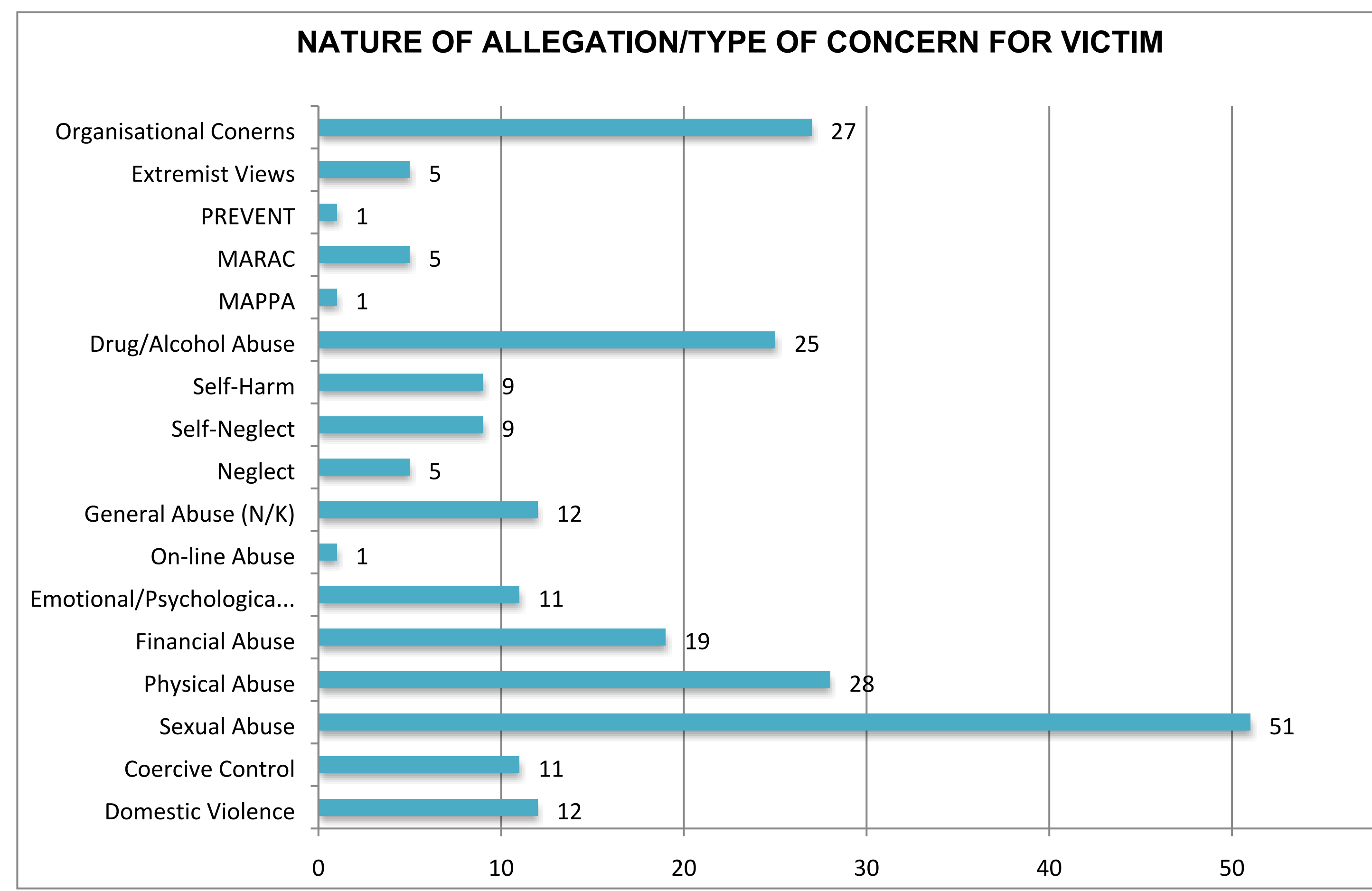


What are the requests about?

Advice is sought on all aspects of safeguarding. There may be more than one reason for concern in each request. For example, one request for advice might be made for one client, but that client might be experiencing domestic violence, sexual abuse and financial abuse, so all three of these issues would be logged – one request, three types of concern. So, the total number in the chart below exceeds the total number of cases within the analysis period.

In some cases the type of concern raised has not been clearly noted. For example, there may be reference to 'General Abuse' but the nature of the abuse has not been identified/recorded.

The chart below indicates the nature of the concerns raised for the 145 requests logged in 2019/20.



Sexual abuse remains the most common type of concern. There is an increase 'Organisational Concerns', these are mostly regarding private care homes, but the higher rate of requests for advice does demonstrate an increased awareness of safeguarding issues and a more open approach to reporting concerns.

All other categories of concern remain of a similar percentage to the previous annual report findings.

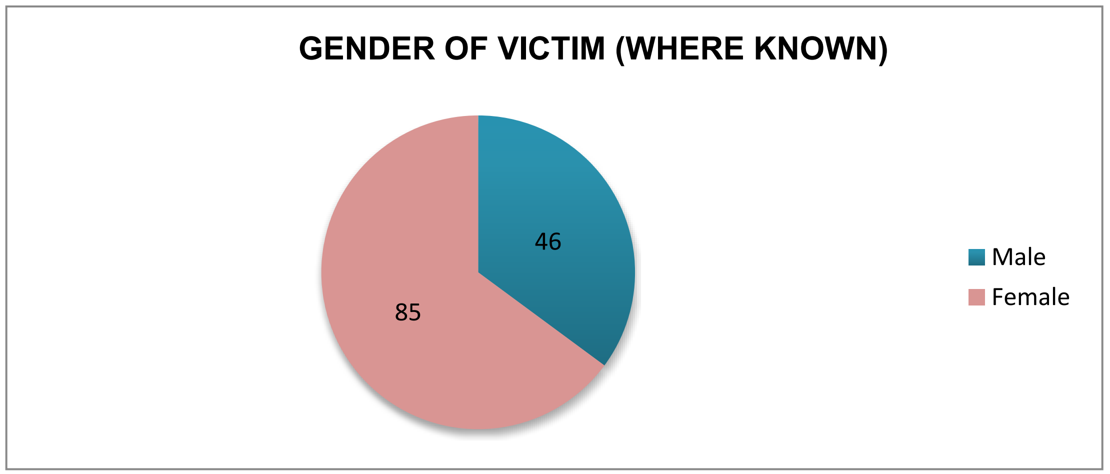
Who are the requests about?

Information is recorded about those that concerns are about, referred to here as 'victims', and also those that are of risk to others, referred to here as 'perpetrators'.

Who are the victims?

The victims of individual perpetrators (not organisations) are most commonly family members or partners of the perpetrators.

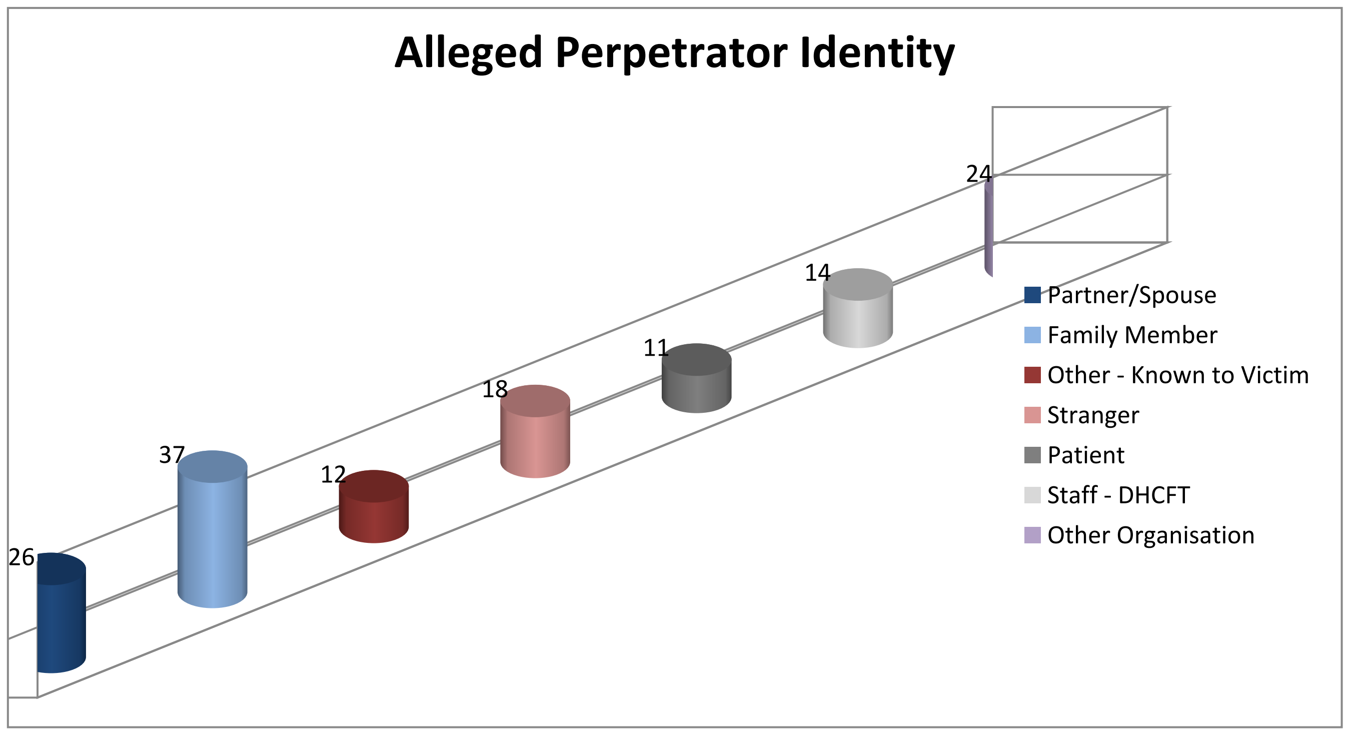
The gender of victims isn't always recorded in advice requests, but where the records specify, which was the case for 131 victims, the data has been included in the chart below.



The percentage split of male/female is similar to previous years, but there has been a slight increase in the number of male victims, from 28% in 2018/19 to 32% in 2019/20.

Who are the perpetrators?

Where recorded, the data shows that the majority of the alleged perpetrators are family members or partners of the victims. Individual Trust staff, patients and other organisations have also been recorded as being alleged perpetrators. Concerns have also been raised about the Trust and other organisations as a whole, e.g. specific service provisions within the Trust or general care and safety standards at a specific care home. Where known, the alleged perpetrator identities are shown in the chart below.



In the 145 requests the gender of 89 individual alleged perpetrators was recorded.

GENDER OF ALLEGED PERPETRATOR (WHERE KNOWN)

Gender	Number
Male	67
Female	21

The percentage split of male/female is similar to previous years, but there has been a slight increase in the number of male perpetrators, from 82% in 2018/19 to 86% in 2019/20.

Summary of Findings

This last 12 months of data demonstrates activity in all areas of safeguarding including Public Protection and Counter-Terrorism.

The types of concern are of an ever-increasing complexity and intensity. Partnership working in raising and addressing these concerns is continually strengthening. One example of this heightened awareness is the increase in concerns raised about organisations and the standards of service, safety and care they offer.

It is anticipated that in the next 12 months the trend of a gradually decreasing number of advice requests will continue in the City as the MASH Health Advisors are now very much embedded into the interagency process

There is an anticipated increase of the number of domestic violence cases in 2020/21 due to Covid19 and national lockdown and the importance of multi-agency responses and potential intervention will be even more significant.

Recommendations

- It is recommended that this process of data collection and analysis be continued annually in the same format so that direct comparisons of findings can be made

- To benchmark against nationally collected data from the Local Authorities of England regarding trends and local phenomena

Prepared by: **Kelly Sims, CQC and Governance Coordinator on behalf of Karen Billyeald, Assistant Director for Safeguarding Adults**

DHCFT SAFEGUARDING PRIORITIES

Safeguarding Strategy and Implementation Plan:

The implementation plan is complete. Steps taken to achieve this were:
Objectives:

- Review the strategy and add description of the strategy's intent.
- Obtain authorisation from the Safeguarding Executive lead to go to wider consultation.
- Full Implementation plan and amended Strategy submitted to the October 2019 Safeguarding Committee and November 2019 Trust Board.

Consultation Plan is also complete. Steps taken to achieve this were:

Strategy to be presented to the:

- Safeguarding Operational meetings by assistant directors
- COATS by Safeguarding representatives
- Professional meetings by Safeguarding named nurses
- Via general managers to all teams
- Via Adult Safeguarding link workers
- Via Trust Equal Group and Carer Engagement Group
- News story on CONNECT, October 2019
- Presented in the Safeguarding newsletter, November 2019
- Named and Designate Meetings by Trust representatives
- Strategy on the Safeguarding pages on Connect in October 2019
- Safeguarding Board managers, November 2019

Sexual Safety Strategy/Safeguarding Inpatient Audit:

This work has focused on Trust in-patient services and is guided by CQC Sexual Safety on Mental Health Wards published in 2018.

The Assistant Director and the Named Doctor have focused efforts on supporting a small working group that has, so far, achieved work towards development of a policy and a guidance leaflet for patients.

Assurance is given that sexual safety issues, whether as a preventative care plan or as a response to an alleged or actual incident is reported and investigated in accordance with safeguarding adult policies and procedures.

We work closely with our colleagues in the police to maximise on opportunities to ensure safe fact finding and progression to a criminal case if the findings are founded.

This year has seen the development and production of a joint policy, Allegations Against Staff, Carers and Volunteers, Local Area Designated Officer (LADO) and Person in a Position of Trust (PiPoT).

Where allegations involve current or past staff members we apply rigorous standards to protecting patients, supporting staff through the investigation process and share information appropriately. We have been involved in initial discussions regarding the Trust's adoption of Just Culture principles whilst being mindful that safeguarding and the protection of children and adults at risk is paramount.

A key objective for the year ahead is the development of a safeguarding audit that will be piloted initially in in-patient areas.

Carer Strategy:

This year marked a review point for the Trust Carer's Strategy. The Carer's Engagement Group, chaired by the Assistant Director for Safeguarding Adults and Carer Representatives, continued to meet monthly up to Covid-19 lockdown. Derbyshire County Council have, this year, produced a draft County-wide Carer's Strategy and it has been agreed that DHCFT Carer's Engagement Group will align with this strategy and refresh the Trust Carer's Operational Policy in the year ahead to reflect the strategic aims therein.

Resilience:

The Safeguarding Assistant Directors commissioned Resilience training for the Safeguarding Team and successfully recommended that it be cascaded out within the organisation, especially Children's Services as it was apparent from safeguarding supervision sessions that staffs were becoming more anxious, stressed and less resilience. The workshops look at 'coping with Corona, Resilience and sustainability in unprecedented times'. The focus is recognising the world has changed and working within it.

Annual report for MASH Health Advisors 2019-2020

The aim of this report is to reflect on the Health Advisors activity from 1 April 2019 to 31 March 2020; some of the content will overlap with the quarter reports provided throughout the year.

MASH health consists of three advisors:
Louise Haywood WTE
Zoe Rudderforth 0.6 WTE
Claire Ray 0.4 WTE

MASH Adult

Approximately 2200 referrals were received for information exchange during the financial year via an information exchange form (IEF). Over a thousand other health colleagues were liaised with as part of the safeguarding process by health advisors (mostly GPs).

MASH social care are currently sending the initial referral, requesting information and then re sending the completed form. Although this is felt best practice so all information can be gathered prior to a safety plan, this has created an increase in referrals received to health advisors. Data collection is currently completed by a Health Advisor physically counting how many emails have been received on a weekly basis; it is therefore currently not feasible to breakdown which referrals are a duplicate of those already received. Furthermore, work is completed by health advisors for every email, whether it be to share information or liaise with other professionals and therefore our data is in relation to referrals received for further work and not for general referrals to MASH; our figures would therefore not be congruent with social care data.

Adult social care has undergone several changes including new starters, new senior practitioner and a new manager. The team is therefore in development and changes are expected to be forthcoming over the next year.

Health Advisors have noted an increase in inappropriate referrals for safeguarding which are being progressed for formal information exchange. This is being reviewed and health would envision a more robust triage screening similar to that of children's services where referrals can be signposted if they are not of a safeguarding concern. Examples of this are from EMAS referrals where someone has self-harmed.

Due to the amount of referrals received to MASH, there is a backlog of referrals that are awaiting allocation from social care.

As per last financial year, trafficking, modern day slavery, honour based violence and forced marriage remains low due the current pathways and cultural complications that are associated with forced marriage / HBV. The British Red Cross support MDS cases and adults will be offered a National Mechanism Referral (NMR).

74 safety planning meetings were held in MASH in which 220 individuals were discussed in this year. A common theme for convening a meeting was neglect or self-neglect in which it was helpful to have agencies together to ensure a robust safety plan could be implemented.

MASH Children

There were 350 section 47 referrals to MASH and of these, 342 strategy meetings were held. For those that a meeting was not required, there were legitimate reasons i.e.

further information provided so threshold was not met for a meeting. Health Advisors liaised with 119 other professionals in addition to GP's, named nurses and allocated teams (Health visiting or school nurses). These other professionals included specific calls to a team rather than normal tasking, CAMH's or adult services as part of a think family approach.

MASH noted there appears to be an influx in certain types of abuse i.e. physical or sexual in weekly cycles. The rationale for this is unknown however there are some thought sexual abuse referrals increased around those times when families / friends spend more time together such as school holidays.

The usual fluctuations of referrals remains consistent with school term times and expected themes for children's services as per previous years.

Social care managers are currently on a rotational basis meaning MASH is covered by different duty managers. Although all work to the same threshold document, Health Advisors notice a minor difference in meetings and threshold decisions due to the autonomy and experiences of the individual duty manager.

The FGM procedures changed in this financial year and all cases where mother had suffered FGM and had gave birth to a female then a section 47 strategy meeting is held. Of these cases, parents appear to have been non supportive of FGM and all cases have been closed following a social worker visit.

Themes for Adult and Children MASH (Think Family /Family Focused approach)

Within strategy meetings, 1756 individuals were discussed; for both adults and children, physical abuse remains to be the most reported type as per previous years.

MASH continued to receive several referrals where 'cuckooing' has been a factor; although this term has been around for several years, it appears to be more widely recognised by professionals working in the community and on several occasions police have taken swift actions to ensure the protection of the individual.

Discussions between children's and adult services remain a frequent occurrence to ensure all those that meet criteria are safeguarded from harm. We remain passionate that the MASH is an excellent resource to ensure timely information sharing, providing a coordinated response and enabling all agencies to work together as one team. An example of excellent joint working was a referral received to children's due to alleged sexual abuse and neglect, on health research it was evidenced vulnerable adults were also in the house, adult MASH therefore joined the meeting and a children and adult social worker completed a joint visit to ensure all people that needed safeguarding were protected.

Domestic Abuse (DA)

There were approximately 1250 standard risk incidents reviewed and 1326 medium risk triaged. For the standard risk notifications, this figure is not reflective of police figures as the last few weeks triage was not complete and all standards were accepted to systems due to the Covid-19 crisis. This may continue as it has been contemplated that the standards not accepted could be detrimental to building a bigger picture for families. This will be reviewed by the multi-agency team involved in triage.

Medium risk domestic abuse takes place twice weekly to ensure notifications are reviewed in a timelier manner. Medium triage now consists of Social Care senior practitioner, police (administrator for updates), education and a Health Advisor. A strength based approach has been adopted to ensure children are safeguarded from witnessing domestic abuse, to minimise Adverse Childhood Experiences (ACE) and to ensure parents are protecting the children from harm.

It must be noted that domestic abuse figures are only in relation to the households in which children are named on the DASH's. Moreover, medium risk triage is only for those children not already open to services (either early help or social care). The Police figures for domestic abuse in Derby City will therefore be significantly higher than that collected by health advisors.

Other

Advice calls
Health Advisors received 101 calls for advice; 80% of these were in relation to adults, 16 % in relation to adults and children and 4% for child concerns. These percentages were expected as the Safeguarding unit continue to receive the calls in relation to children.

Data collection
Data continues to be collated to monitor activity levels. Health Advisors produce a quarterly report and send the monthly raw data to the required professionals. The data is designed to reflect the activity of Health Advisors and does not evidence activities for MASH as a wider multi agency team.

468 face to face discussions were held between health and, either social care or police, which have been invaluable in ensuring relevant information is shared. This is reciprocated with MASH colleagues and Health Advisors will also request information from colleagues when -required. Due to Covid-19 measures, these requests were complete via email in the last few weeks and it was difficult to monitor given Health Advisors were working remotely.

Within this year, MASH has seen challenges from all agencies in terms of staff turnover. The impact on service delivery has been minimised by colleagues from all agencies

offering a safe and welcoming environment to work in whilst sharing knowledge and skills and building on each other's strengths. The fundamental philosophy of the MASH remains to improve the safeguarding journey of individuals by providing a timely, co-ordinated and consistent approach to safeguarding concerns.

During the last few weeks of this financial year, the normal working environment was considerably changed due to the Covid-19 outbreak. This time was clearly very challenging for all and the impact on the MASH was noticeable. The core principles to bringing agencies together for timely information sharing and safeguarding was disrupted by agencies working from home or different bases to protect staff. The impact was minimised by ensuring staff from all agencies had remote equipment and meetings were held via telephone. This change in working demonstrated how valuable the model of MASH is under normal circumstances.

Testimonies

Health Advisors always share timely, relevant and proportionate information. They are always approachable, they provide valuable input within team meetings. They are always pro-active, and take steps to safeguard vulnerable adults and also children when required. They are very much part of the team.

Becky Smith, Senior Practitioner, MASH adults

In my opinion, the MASH Health Advisors are great to work with. They are always happy to help when police request checks and information, the information we receive is always detailed and relevant. Communication is always important when multi-agency working and I feel MASH health communicate well with police when it comes to strategy meetings, sending referrals, and information sharing. In addition, the MASH Health Advisors are really friendly and easy to get along with, which to me is a really important aspect of the working environment!

Laura Jackson, Police administrator

Health Advisors remain key partners of the domestic abuse triage meetings which operate within the MASH. They demonstrate their skills and professionalism working closely alongside social care and education by sharing relevant information enabling important decision to be made as a collective for the best possible outcomes for children, families and adults. They remain very focused and passionate about the roles they play in safeguarding vulnerable children and adults which is demonstrated in their practice. The Health Advisors are always accessible despite the demands of their roles, and also accommodating of the changes there have been within the meetings in relation to frequency of the meetings held weekly and staff changes.

Health Advisors are confident to challenge decisions if and when they feel necessary and do so in a professional manner.

It is pleasure to work alongside them.

Rohan Giles, Education Welfare Officer

LEARNING FROM REVIEWS

Safeguarding Children Serious Case Reviews

Working with complex features in families

The Trust were part of the Derby Safeguarding Children Board who carried out serious case reviews (SCR) to understand the lived experiences of children living in different unconnected families in Derby and consider in detail multi-agency practice over a number of years. This is an overview of the two SCR which took precedence within the timescale of this annual report. The SCR were undertaken due to the complexity and range of concerns that were known during the period of time and that became more clearly evident during the process of the reviews are unusual. The abuse and neglect experienced by many of the children in the families is significant and has been investigated.

Two separate authors were appointed for the separate overview reports for each of the reviews. The full reports have not been published due to the identification of the families, however reports and action plans have been signed off by the Derby Safeguarding Children Board partner agencies. The Trust can ensure that all actions are completed.

To improve our practice we need to understand about work with families in cases like these:

- Knowledge of the individuals in a family in terms of their identity, race, gender, age, disability, sexuality and culture is sometimes addressed superficially and features that would not be considered usual for family life, some known to be positively harmful, were accepted for many years by professionals.

- Professional assessment of the family culture was at times a stereotypical one where chaos and marginally neglectful care was overcompensated for. Assumptions were made about the warmth and support of a large family. Were some family members invisible and was one parent colluding with the abuse of children.

- Professionals were not always sufficiently respectfully curious about what was going on or respectfully challenging of what was happening. One reason for this may be an unwillingness to appear judgmental or patronising of what could have been seen merely as a different lifestyle rather than one that posed risks. This unwillingness could be heightened by a feeling of class divide between professionals and the family.

- Promoting professional practice based on an objective assessment framework such as the Graded Care Profile which is a tool used by Childrens services within the trust can help to overcome a lack of confidence in discussing diversity and difference with families.

- Sometimes professionals felt intimidated and threatened by family members and did not discuss this and how it might affect their interaction with family members with their managers or professionals involved in the case.

- Narratives focussing on children in a family solely as problematic, engaging in anti-social behaviour, and beyond parental control may miss the vulnerability of children whose needs are not being met and who are being physically, sexually and emotionally abused.

- Failure to follow procedures was common to many cases where children were not protected from serious harm. It remains unclear as to why this occurs despite continual procedural revision and tightening. All organisations must understand that having a professional approach to using procedures in day to day practice is essential. Lack of appropriate supervision being available and being asked for were key features in these cases.

- The extent and effectiveness of agencies sharing information and working together to protect children was variable. Poor recording of professional interactions was a significant feature at times as was a failure to make linkages with past referrals/contacts and with information about all the children within the family.

Key learning for professionals that was highlighted and cascaded throughout the Trust:

- Always take children and young people seriously if they tell us about sexual abuse or any other kind of abuse;

- Make sure that telephone referrals made to Children's Social Care are followed up within 48 hours; If you do not receive feedback on a referral in 3 days informing you what action is being taken make sure you follow this up;

- The use of chronologies and genograms are particularly important to help understand complex and/or large families;

- When working with a child at all times consider '*What is life like for this child, in this family?*' Be respectfully curious about their lived experience and make sure you consider risks to children from their siblings as well as any adults in the family. This is particularly important in cases of child sexual abuse; The Trusts

‘think Family’ approach to care continues to be the golden thread throughout our care.

- Plans to talk to a child or young person about possible abuse in their life has to **explicitly considered the possibility** that:
    - other children in the family may also be subject of abuse,
    - boys in the family may be at risk, even where concerns were initially raised about girls,.
    - self – harm, substance misuse and criminal behaviour may be indicators of abuse;
    - parents may be threatening them to keep quiet and not tell you what is going on

- Practitioners are trained to be respectfully curious when considering the circumstances of women during pregnancy. During routine enquiry use the opportunity to identify vulnerabilities:

- The identity of the father is an important factor when assessing families, has this been shared? If not, is this an indication of coercion or abuse? If there has been a delayed or concealed pregnancy, is there sufficient understanding for why this has occurred? Has this occurred on more than one occasion? Is this an indication of coercion or abuse?

- The circumstances of a teenage mother needs to be understood, is there cause for concern? Are they isolated? Are sources of support from family members judged to be protective and acting in the interests of the mother and unborn baby?

- Timely accurate records need to be maintained of any involvement with a child and their family and include explicit analysis (or formulation) where it is needed;

- Assessments and plans need to be explicit about how children will be kept safe from harm, especially where there are concerns about child sexual abuse and it has not been possible to obtain criminal convictions;

- The use of key identified assessment tools are encouraged internally to help understand the lived experience of children.

- Raise the awareness to seek advice/supervision and consider whether a multi-agency meetings is needed to help plan what everyone is doing; especially where there are concerns about neglect, drift in a case or complex/multiple types of abuse and offending behaviour within the family;
- When there are differences of opinion about the safety of a child use the Escalation Policy.

- Trust staff keeping up to date with safeguarding training, especially training about child sexual abuse is vital.

❖ Health workers linking up with the schools where the children attend, as it is extremely likely that they will have an excellent understanding of what life has been like for the children and siblings in their school over a number of years;

❖ Safeguarding Children Procedures are made available on the trust web pages to help staff raise safeguarding concerns, including the complex abuse section if it is relevant to the vulnerabilities in a large/complex family. This should form part of every day practice.

❖ The Trust is signed up to online processes so that we receive automatic notification when the Procedures are updated.

Another SCR and a number of the recently undertaken SCR's have identified that Practitioners are not seeking the safeguarding supervision readily available to them to discuss complex cases and complex families. The Trust have undertaken work and audits to establish the barriers to Professionals seeking Safeguarding supervision and the reasons for not bringing these complex cases to supervision. This work will continue in order to raise the awareness of the importance of safeguarding and the guidance on cases to bring to supervision.

Further actions have been undertaken from SCRs the Trust has been involved in and the learning disseminated throughout the organisation.

Practice guidance has been developed to aid practitioners in understanding when Social Emotional ASQ assessments may be beneficial in evidencing emotional harm in safeguarding and complex cases.

Fathers of children remain 'hidden' within Trust Professional assessments. There has been a drive to register all the family on electronic systems, but especially fathers,
Adverse Childhood Experiences (ACE's) Training has been tailored and delivered to Child and Family Teams.

Formal guidance is available for practitioners regarding weight loss in infants and a clear pathway agreed by Child and Family Teams, GP's and Paediatricians.

The Derby/Derbyshire Safeguarding Children Board Pre-birth protocol is operating effectively within the Trust and audits on the usage have been undertaken to show improvement in compliance across the partnership.
The Trust can give assurance that staff dealing with adults takes into account and fully understand the risk that adult may pose to children. Then share those concerns with relevant partners.

The Trust have in place the ‘suspicious mark/bruising in pre-mobile babies policy available for staff.

The Trust can ensure the awareness of the vulnerability of babies is reinforced and that parents see and sign they have seen the shaken baby DVD.

The Trust has in place processes that ensure all domestic abuse incidents are reviewed and processed.

There is an amalgamated SCR Action Plan in place that ensures all recommendations are completed. Any exceptions are highlighted to Safeguarding Committee. All recommendations are either implemented or nearing completion, a detailed analysis and evidence of this work is maintained at the operational safeguarding group.

Safeguarding Adults Homicide Reviews & Safeguarding Adult Reviews [SARs]

The Trust has been actively involved in 5 Adult Homicide / Domestic Homicide Reviews this year and 2 Safeguarding Adult Reviews. The Assistant Director for Safeguarding Adults is a member of the County Safeguarding Adults Board Safeguarding Adults Review Panel.

Learning from SARs and Homicide Reviews is shared with the workforce via the Safeguarding Adults Link Worker Network, the Trust Clinical and Operational Assurance Teams (COATS), in safeguarding supervision and in learning and development activities.

The Trust has contributed to the continued development of the Derbyshire approach to SARs and learning events are occurring earlier in the process with good effect. Close working relationships have developed between the Safeguarding Unit and the newly established Community Forensic Mental Health Team.

AUDITS

We are currently working on the following audits on behalf of the Trust:

TITLE	AIMS/OBJECTIVES
Patients with complex needs are allocated a Care Coordinator; Cases discussed at MDMs/ Clinical Case discussion includes analysis and action; and are documented within EPR.	• To clarify and provide evidence that cases are discussed at MDMs and are documented in the EPR re concerns/analysis/actions • Provide evidence to ensure that all complex community cases have a Care Coordinator
Quality of Safeguarding Children referrals into Safeguarding Children by DHCFT	To ensure high quality referrals are being documented in line with Safeguarding procedure
The usage of the CSE (Child Sexual Exploitation) tool kit	To evaluate the usage and impact of the CSE tool kit used by Public Health Nursing Teams, CAMHS and

TITLE	AIMS/OBJECTIVES
	Children's Specialist Nursing Teams
Quality of Case Conference Reports for ICPC & RCPC. Case conference reports submitted are of an acceptable quality standard.	To establish the quality of reports submitted to child protection conferences and to ensure that an acceptable standard of report writing is consistent across the teams.
To clarify criteria of cases bought to Supervision against the guidance is met	Review cases bought to supervision against the criteria of guidance audit
All staff is fully aware of their role and responsibility if they are part of a core group or children in need plan.	To include: 0-19 Services CAMHS Substance Misuse Adult Mental Health Learning Disability
Do referrals to Adult Social Care consider the impact of this on children within the family (Think Family)?	To establish if professionals document/consider / analyse the impact of the adults mental health issue / substance misuse / learning disability on their child / young person making a referral to Adult Social Care.
Multi-agency case file audits	The audit sub-groups of the Adult Boards meet quarterly and conduct both randomised and themed audits of safeguarding policies and processes.

CQC

The regulator visited the Trust throughout 2019 and into the early part of 2020. They assessed the Trust as GOOD overall and found that internal safeguarding practice is good and described the work of the Safeguarding Unit as “solid”. Policies and procedures are in place and are being implemented, staff in all areas visited knew how to recognise signs and indicators of abuse, receive disclosures, make referrals, contribute to child and adult strategy meetings and S42 enquiries. Developments that had been agreed for adult safeguarding had been achieved i.e. the ability to make referrals directly from the Electronic Patient Record (EPR) and the development of “Safeguarding” and “Public Protection” applications on Paris EPR.

NEW INITIATIVES/OBJECTIVES 2020/2021

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

Objective / Initiative	
1.	To continue to develop and integrate the Children's and Adults Safeguarding team within the Trust.
2.	To ensure that succession planning, develop expertise within the workforce and consider talent management and support development.
3.	To continue to build resilience in the workforce and support staff around complex work, especially around Covid-19 pandemic and the challenges to safeguarding work that brings. To provide leadership post 'lockdown'
4.	To continue to work in partnership with all agencies around the challenges of working with emerging and new communities.
5.	For safeguarding representatives to provide a report and attend monthly COAT meetings. From April 2020, due to Covid-19,reports will be submitted as meetings have temporarily been postponed.
6.	To cascade safeguarding learning throughout the Trust and to work with People Services to ensure safe and effective training. From March 2020 training was postponed due to Covid-19. From July 2020 level one and two safeguarding children training will be on-line. Safeguarding children level three training will be delivered via Microsoft teams and will be reviewed March 2021.
7.	To ensure the Think Family remains a key clinical safeguarding standard and the established 'think family think tank' will continue to function maintaining links with clinical practice.
8.	To continue to undertake a joint City / County Section 11 and SAFF, and provide effective evidence of the Trust compliance. To ensure any recommendations are acted upon.
9.	To develop and undertake the 'Safeguarding Inpatient Audit' as a key component of the Trust's focus on sexual safety
10.	Children & Obesity Strategy to continue contribute to its development and implementation
11.	To continue to support the Trust's intention to move to one Electronic Patient Record [EPR]. This work involves both Assistant Director.
12.	To continue to work closely with the newly established Community Forensic Team to meet Trust public protection duties and generally enhance the Trust's management and monitoring of the most forensically complex patients.
13.	To work in partnership on the development of Trauma Informed Approaches (TIA) and update the Survivor Strategy to reflect lessons learnt from the Complex Case Team
14.	To work towards our third and final "Carer's Trust Triangle of Care" star. We note there are potential risks given the Carer's Trust new hosting arrangements.
15.	Implement and improve Sexual Safety in Trust Services.

OVERALL

As the year ended, although we were implementing Covid-19 measures, we are able to reflect on what has been another highly successful year and we will continue to be committed to setting and providing the very best standards of clinical and safeguarding practice that as a team we can deliver.

REPORT PREPARED BY:

Tina Ndili - Assistant Director Safeguarding Children
Karen Billyeald - Assistant Director Safeguarding Adults
Debbie Archer - Safeguarding Unit Administrative Coordinator
Zoe Rudderforth - MASH Health Advisor
Louise Haywood - MASH Health Advisor
Jo Watson - Safeguarding Children Trainer
Dr Wendy Brown – Named Doctor for Safeguarding Children
Dr Deepak Sirur – Named Doctor for Safeguarding Adults
Kelly Sims - CQC and Governance Coordinator/Staff Governor
Carolyn Green - Director of Nursing and Patient Experience.

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 3 November 2020

Annual Report for Derby City Looked After Children Provision 2019/20

Purpose of Report

The purpose of this report is to provide the Trust Board of 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.

Executive Summary

This report was presented to the September Quality and Safeguarding Committee which approved the report for submission to the Trust's Board of Directors on 3 November 2020.

The report includes all cohorts of looked after children that Derby City Local Authority is responsible for, no matter where they live.

The report provides significant assurance on the provision, screening and outcomes for children in the service.

The report is provided to the Board to scrutinise and ensure that the Trust has discharged its formal statutory duties to vulnerable children.

It is known that looked after children are at elevated risk of worse health outcomes. Children in care health screening services are in place to reduce and mitigate this risk. The health outcomes for our community in Derby are above our regional comparator and demonstrate above average performance and good outcomes. The increase in children who are looked after should be noted.

It is recognised that the Looked after Children Health Team have core competencies, specialist skills, knowledge and attitudes to act as advocates, undertake health assessments, identify and manage health needs and provide support/training to foster carers.

The adoption process is outlined in the report and an analysis of adoption activity is shown and is meeting required outcomes.

A summary of achievements for 2019/2020 are outlined:

- Health performance although provisional until submitted in July 2020 continues to remain high. Unfortunately the immergence of COVID-19 Pandemic had a slight impact for some data, especially children who live away from Derby; despite this the performance overall is positive.
- Since the Children in Care Team have access and the mechanism to update Liquid Logic (Local Authority IT system), the accuracy of heath data has significantly improved. The Named Nurse for Children in Care and the Designated Nurse for Looked after Children meet on a quarterly basis to ensure all the correct information is recorded and any outstanding information is passed onto the Children in Care Nurses and admin to chase.
- Over 2019/2020 additional nursing and doctors hours have been utilised to capture the requests for review health assessments and initial health assessments for the 'Born-out-lives in' (BOLI) children and young people. There have been 54 completed review health assessments and 21 initial

health assessments for the BOLI cohort during 2019/20 and the Provider has received funds at the National Tariff payment rates.

- The Clinical Commissioning Group have been assured that the Children in Care service provision is overall at a good standard and the health provider is working in partnership in all areas that have been identified as requiring further progression or improvement
- The average score for the strengths and difficulties questionnaire during 2019/20 was 14.7 which is a significant drop from 2017/18. The local target for 2019/20 was 14.5 so an improved performance. However, this result is significantly improved. This potentially indicates improved emotional health and wellbeing of children and young people in care.
- The Derby City Children in Care Team have worked in partnership with Derbyshire Children in Care Team to develop new Review Health Assessment paperwork which is more children friendly and provides a more standardised approach across the two boundaries. The new Review Health Assessment paperwork has been approved by the Children's Services Clinical Reference Group and the Children in Care Council. The emojis proved really popular with both the children and foster carers. The Named Nurse for Children in Care attended one of the Children in Care Council meetings to obtain feedback which can be found in the report.
- Foster carer drop in health sessions are delivered by the Named nurse for Children in care and the Designated Nurse for Looked after Children. These sessions are well received by Local Authority foster carers.
- Priorities for 2020/21 are outlined which include a range of quality improvements or learning.

An additional recommendation has been added by the Director of Nursing in advance of the Board's review of the report. This is to further respond to the change in demographics that children from different ethnicities is changing. The Children in Care Team are not able to impact upon this finding, however they must ensure that the care they offer is culturally adapted and offer a culturally competent service. The team have been requested to include in this year's work plan and in next year's formal report how they will assure the lead that this is in place and how to promise this.

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

Assurances

- The compliance for both Initial Health Assessments and Review health assessments have improved over 2019/20, therefore over 2020/21 the Designated Doctor for Looked after Children and the Named Nurse for Children in Care will continue to focus on quality of initial health assessments and review health assessments. Audits will be completed to ensure the quality of health assessments are consistent across the service.
- The Trust will assure measures are put into place in accordance of the service specification.
- Maintain working relationships with other partner agencies/services.
- The statutory timescales will be monitored and evidence is provided and scrutinised in order to achieve outcomes.
- Training compliance will be scrutinized to ensure competency of staff to the right level.

Consultation

- This report has been developed by the Named Nurse for Children in Care with information that is held by both provider and local authority.
- Various members of the wider Children in Care Team have contributed to the report.
- A child friendly Annual Report will be developed in a leaflet form.
- The Trust Quality and Safeguarding Committee.

Governance or Legal Issues

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, which are reviewed in this report:

- 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.

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.

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.

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.

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, Service Providers and NHS England.

Looked after children: Knowledge, skills and competences of health care staff intercollegiate role framework (March 2015) this is the formal practice guide used by the CQC/ as health regulator. This document sets out specific knowledge skills and competencies for professionals working in dedicated roles for looked after children.

The Children and Social Work Act (2017) improves decision making and support for looked after and previously looked after children in England and Wales.

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:

1. The cohort with the most significant increase is those children coming into care as a result of child disability. On average we have two new entrants into care, per quarter, due to child disability. During quarter 4 we had six new cases due to child disability. This is the highest quarterly number of cases we've seen over the past two and half years.
2. Abuse or neglect remains the most dominant reason for children/young people coming into care, with the percentages remaining relatively stable.
3. The number of children in care has increased by 14 cases during Q4 to 588. This is the highest quarterly snapshot that we have seen in Derby. This is an increase of 26 cases compared to the 2018-19 year end figure of 562.
4. The Children in Care Team attend relevant multi-agency meetings to gather and share appropriate information with professionals involved, identifying risks using the risk assessment matrix and completing any health actions.

The number of children from different ethnicities is changing. The Children in Care Team are not able to impact upon this finding, however these must ensure that the care they offer is culturally adapted and offer a culturally competent service. The team has been requested to include in this year's work plan and in next year's formal report how they will assure the lead that this is in place and how they know, and assure this.

Recommendation

The Board of Directors is requested to:

1) Receive assurance of the work within DHCFT around looked after children and young people and the continued partnership working to ensure the best outcome is achieved for this vulnerable group of children and young people.
2) To accept the annual report and agree on the key priorities set for 2020/21.

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

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

13.1 Looked after Children Annual Report

Year 2019/20

Contributors:

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

Dr Corina Teh (Designated Doctor for Looked after Children – DHcFT)

Dr A Marudkar (Medical Advisor for Children in Care – DHcFT)

Dr V Kapoor (Medical Advisor for Children in Care – DHcFT)

Emma Fennell (Specialist Nurse for Children in Care – DHcFT)

Nicola Robbins (Specialist Nurse for Children in Care – DHcFT)

Vicky Rice (Specialist Nurse for Children in Care – DHcFT)

Kirsty Annable (Administrator Coordinator – DHcFT)

Section 1: Introduction and context

1.1. 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 appendix 1 for explanation of the differing cohorts).

1.2. 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 (2019/20) for looked after children in Derby City.

1.3. This report has been compiled in partnership with the Named Nurse for children in care; Designated Doctor for looked after children, the Medical Advisors and Specialist Children in Care Nurses.

1.4. 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

1.5. **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 residential children's homes
- other residential settings like 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

1.6. 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

1.7. The Royal College of Paediatrics and Child Health (2015) states that looked after children and young people have greater mental health problems, along with developmental and

physical health concerns such as speech and language problems, bedwetting, coordination difficulties and sight problems. Furthermore the Department for Education and Department of Health (2015) argue that almost half of children in care have a diagnosable mental health disorder and two thirds have special educational needs. When there are delays in identifying or meeting the emotional and mental health needs this can have a detrimental effect on all aspects of their lives leading to unhappy unhealthy lives as adults.
Ref: Promoting the health and 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, March 2015, 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, Service Providers and NHS England.

2.6 Looked after children: Knowledge, skills and competences of health care staff intercollegiate role framework (March 2015)

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

3.1 National and local data

The number of looked after children has increased steadily over the past eight years. There were 78,150 looked after children on 31 March 2019, an increase of 3.6%, compared to 31 March 2018. The most up to date national figures for 2019/20 are not yet available from the Department for Education (Stats: Looked after Children, Department for Education, 2019), the usual publication date being December 2020.

3.2 Number of children looked after in England at 31 March 2013 to 2019

2013	68,080
2014	68,800
2015	69,540
2016	70,440
2017	72,670
2018	75,420
2019	78,150

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

3.3 Number of children looked after in Derby at 31 March 2013 to 31 March 2020

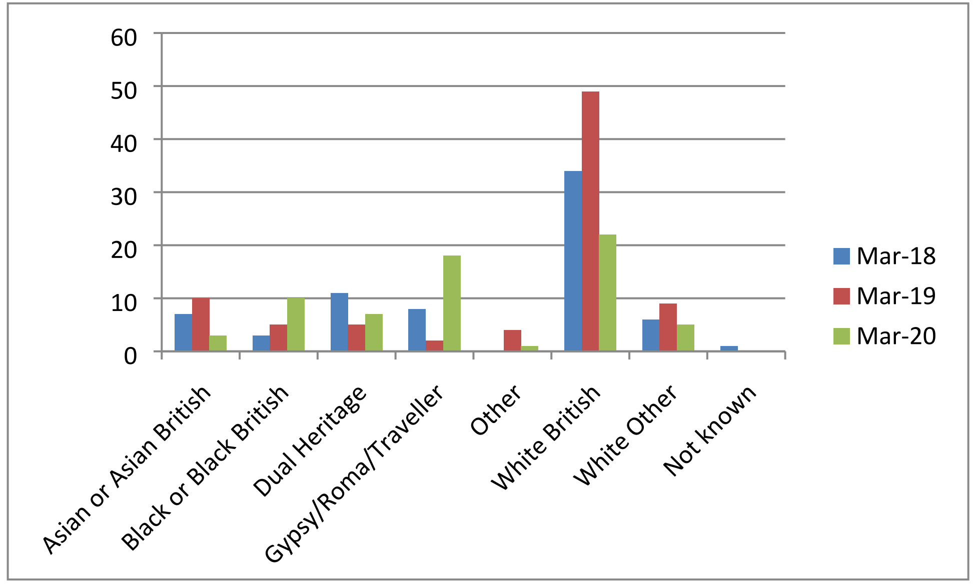
2013	465	
2014	445	4% decrease from 2013
2015	470	5% increase from 2014
2016	452	4% decrease from 2015
2017	448	0.8% decrease from 2016
2018	491	8% increase from 2017
2019	562	12% increase from 2018
2020	588 (provisional)	4.6% increase from 2019

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

The number of Children in Care has increased by 14 cases during Q4 to 588. This is the highest quarterly snapshot that we have seen in Derby. This is an increase of 26 cases compared to the 2018-19 year end figure of 562.

Profile of looked after children in Derby City

3.4 Ethnicity comparisons over the last three years:



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

On analysing the data, it is clear that there is an increase of looked after children from the Gypsy/Roma/Traveller, Black/Black British and Dual Heritage ethnic group; this reflects the Derby City picture of the diverse demographics within Derby City and the new emerging communities. There have been significant cultural differences found in the new emerging communities, in relation to childcare, parenting, discipline and safety aspects. This has resulted in an increase of cases being referred to Children's Social Care and involvement at all levels of intervention; in some cases children/young people taken into care. The number of White British children coming into care has decreased within this financial year, after an increase over previous years.

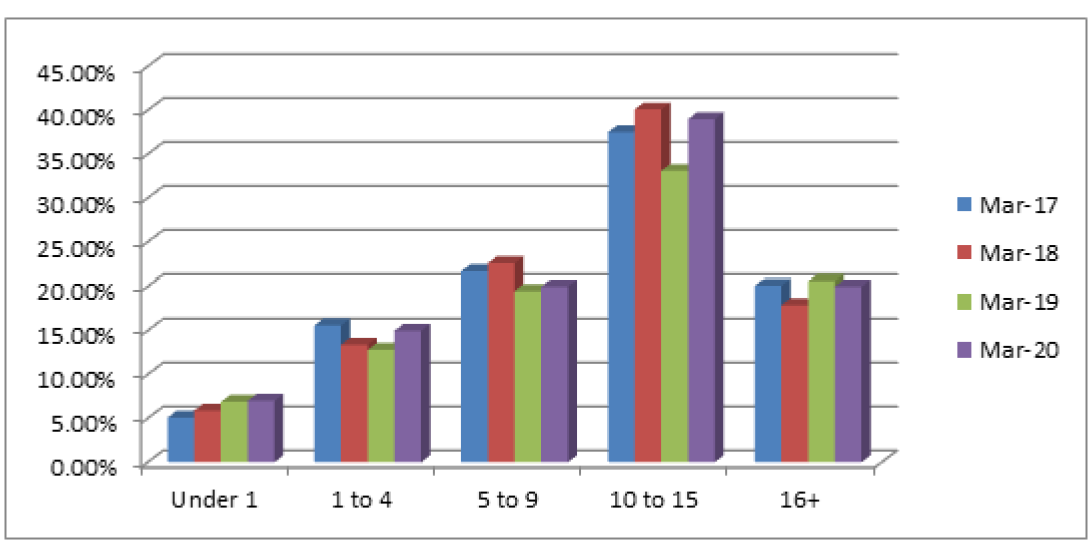
3.5 Gender of looked after children in March 2020

Gender	
Male	54%
Female	46%

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

This data indicates that there is a static gender split between males and females (which mirrors previous years) and the national picture.

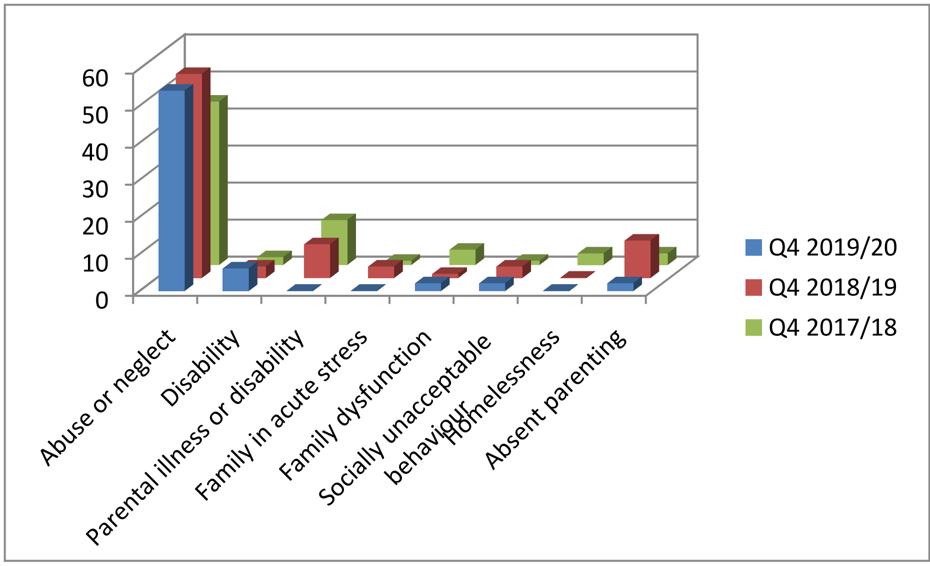
3.6 Age comparisons over the last four years:



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

In comparing the data for the past four years, the 10 to 15 year old age group consistently remain the highest number of children/young people coming into care. It is difficult to determine the definitive reasons for this but it may be linked to the increase in socially unacceptable behaviour, abuse/neglect, acute stress within the family home vocalised by children/young people and family dysfunction identified as a reason for coming into care. There is a slight decrease in the 16 years + cohort compared to 2018/19, this may be as a result of the increased Unaccompanied Asylum seeking Children coming into care during 2018/19 (as a direct result of the local dispersal centre that opened in 2018), who have all been aged 16 years or above. The number of new unaccompanied asylum seeking children (UASC) admissions into care has reduced during 2019/20 with just 15, this compares to 46 during the previous year.

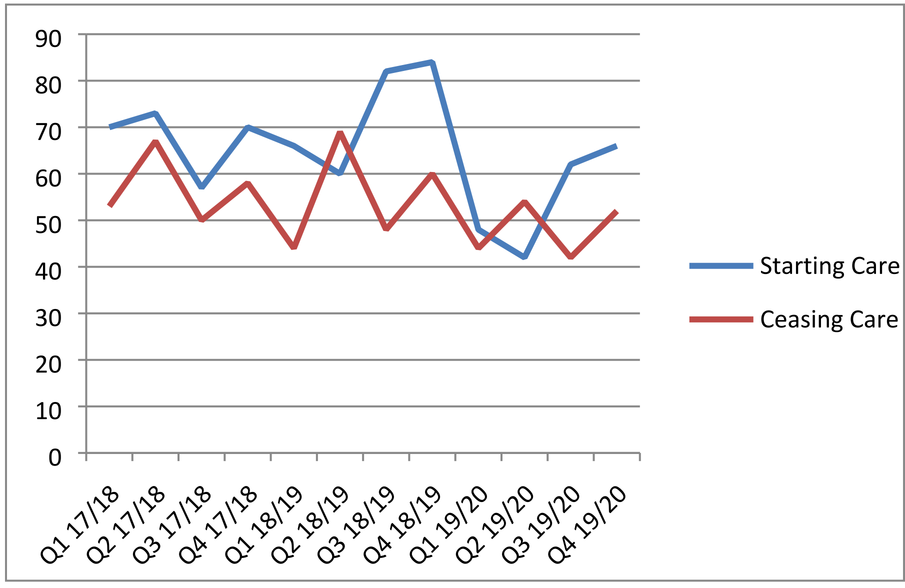
3.7 Reasons for children coming into care – comparison in quarter 4 data over last three years



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

Abuse or neglect remains 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. There has been an increase in children coming into care due to Child Disability. On average we have two new entrants into care, per quarter, due to Child Disability. During quarter 4 we had six new cases due to Child Disability. This is the highest quarterly number of cases we've seen over the past two and half years.

3.8 Children in Care - starting and ceasing care - quarterly trends



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

3.9 Distribution of Looked after Children placed In and Out of Derby City

	Mar 2020	Mar 2019	Mar 2018	Mar 2017	Mar 2016
Within Derby City	32.8%	39.7%	36.3%	38.6%	42%
Outside of Derby City	67.2%	60.3%	63.7%	61.4%	58%

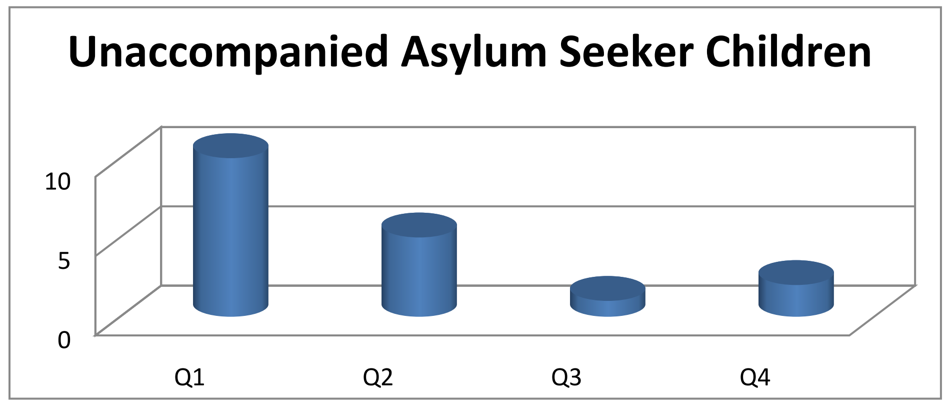
Ref: Data made available from Derby City Local Authority Informatics Department

3.10 The Local Authority has acknowledged that the shift of Looked after Children placed out of Derby City has been increasing over recent years; this is not always in the best interests of the child. Children placed out of Derby City can potentially not receive a timely service or have access to timely specialist services this is due to the child having to be referred to services in the area they are residing in; this clearly needs addressing and resolving as all looked after children should wherever they reside receive services they need in order to meet their individual identified needs. Derby City Local Authority continues to work in partnership with Derby City Foster Carers and Independent Fostering Agencies, in order to increase the level of Foster Carers /placements within the City or placements close to Derby City, which has had a positive impact on the availability of suitable placements within the local area.

3.11 The Local Authority also continues to make progress in placements within a 20/40 mile radius of Derby City and indeed has approximately 62% of Derby City Looked after Children placed within that parameter. The continuation of the Children in Care health team undertaking health assessments at a 20 mile radius of Derby City; has had a positive impact on improved quality and timely health assessments for those living within an approximate 30 mile radius.

3.12 Unaccompanied Asylum Seeker Children 2019/20

Derby City Local Authority is in the process of developing a new team to support Unaccompanied Asylum Seeking Children. Since the local dispersal centre opened in 2018 there has been an increase of Unaccompanied Asylum Seeking Children coming into care, however the numbers have slowed down during the latter part of 2019/20. The reasons for this may be linked to a newly introduced process within the Immigration team at the point of entry. If there is any doubt about the age of a young person and the Immigration team assess the young person to be under the age of 25 years in appearance and states they are under 18 years, they are accommodated as a child at the point of entry rather than dispersed as an adult.



A health based leaflet for Unaccompanied Asylum Seeker Children has been developed by DDCCG Designated Nurse for Looked After Children (LAC). This leaflet has now been produced and is available in various languages. A new LAC Emotional Health and wellbeing service is currently being commissioned with a planned launch in April 2020, postponed in March 2020 due to Covid-19 and is now planned for Autumn 2020, and will support UASC/care leavers up to the age of 25 years old with their needs (including PTSD).

A development day was held in November 2019 with Derby City and Derbyshire CiC Teams (DDCCG) hosted by DDCCG. The New Arrivals Team who supports UASC in Derby City delivered a presentation on UASC. As a result of this presentation the CIC team gained a greater understanding of the potential emotional and physical health needs of UASC, the legal process for asylum seekers and how to support integration into our communities.

Section 4: Summary of achievements in year 2019/20

4.1 During the period of 2019/20 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:

4.2 The role of the newly appointed Administrative Coordinator for Children in Care and Adoption commenced during the middle of quarter 3. During quarter 3 and 4 the Administrative Coordinator and Named Nurse have worked internally with the provider to continue working with the Initial Health Assessment Pathway. These changes have resulted in more efficient working, improved compliance with initial health assessment statutory timescales and improved service delivery across administration and clinical areas.

4.3 The provider has continued to use a flexible approach in the use of resources by increasing the number of clinic slots to reach the demands of the increase in children entering care and to improve compliance for statutory initial health assessments. The Children in Care Specialist Nurses have continued to adapt their way of working with Review Health Assessments by looking at what is required to engage young people to attend their Review Health Assessments working in partnership with the Local Authority to improve overall health compliance.

4.4 Completion of the CCG 'Markers of Good Practice' assurance framework in quarter 4 (detailed in section 10, page 18).

4.5 The Named Nurse for Children in Care and the Designated Nurse for Looked after Children continued to develop the training programme for Foster Carers and Residential Care Workers which commenced in March 2018 and continued throughout the year 2019/20.

4.7 Action learning sets facilitated by the Designated and Named Nurse have continued within the service. Sessions have focussed on a variety of relevant topics, for example: Special Educational Needs (SEND) and immunisations. One of the Medical Advisors has also delivered sessions to the Children in care Nurses on Blood Born Infections and Foetal

Alcohol Syndrome. This also acts as an assurance that the Children in Care health team undertake required specialist training and maintain their skills and knowledge.

4.8 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).

4.9 Health access to Liquid Logic Child Social Care system has been established, which has been proven to improve information sharing between agencies (in the best interest of looked after children) and had 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.

4.10 The health history booklet and process has been improved in partnership with the Provider, Local Authority, leaving care teams (recommended in Ofsted inspection). The Designated Nurse for Looked after Children secured funding in 2018/19 to purchase Health History folders which will follow the child/young person through their time whilst in care. Throughout 2019/20 the Designated Nurse Looked after Children has worked closely with publishers to develop the Health History folders and with the Named Nurse for Children in Care in planning to roll these out in 2020/21.

4.11 Reporting and assurance into the DDCCG 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.

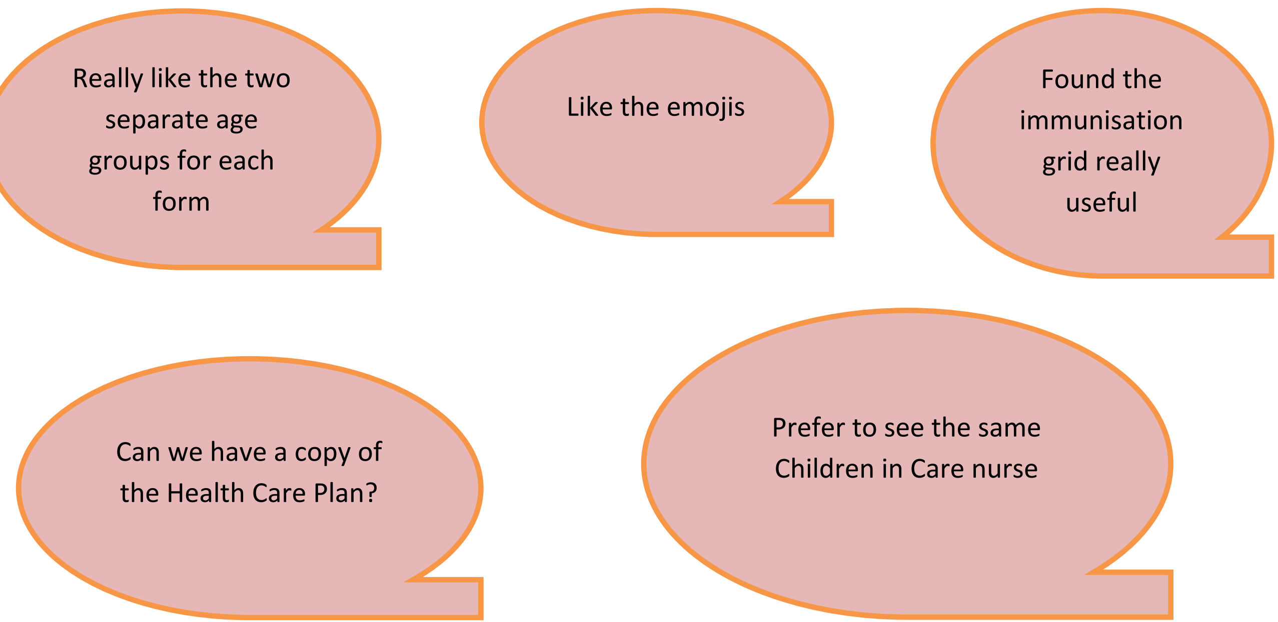
4.12 Health performance although provisional until submitted in July 2020 continues to remain high. Unfortunately the immergence of Covid-19 Pandemic had a slight impact for some data, especially children who live away from Derby; despite this the performance overall is positive.

4.13 The Children in Care and Adoption administration team have worked exceptionally hard over the past 6 months to ensure all the out of area requests for review health assessments covering children placed outside of a 20 mile radius are sent out in a timely manner (by 8 weeks of the due date) and this has seen a marked improvement in the amount of review health assessments being sent back within the statutory timescale and admin being more proactive around chasing any outstanding review health assessments completed by outside providers. This process has since changed in April 2020 to requesting all out of area review health assessments by 12 weeks of the due date.

4.14 The Derby City Children in Care Team have worked in partnership with Derbyshire Children in Care Team to develop a new Review Health Assessment paperwork which is more children friendly and provides a more standardised approach across the two boundaries. The paperwork has been piloted by both teams in quarter 3 and 4. The new Review Health Assessment paperwork has been approved by the Children's Services Clinical Reference Group and the Children in Care Council. The emojis proved really

popular with both the children and foster carers (Appendix 1). The Named Nurse for Children in Care attended one of the Children in Care Council meetings and the feedback was gathered as below:

Feedback was obtained from foster carers during one of the sessions as below:



4.15 Recent SEND (Special Educational Needs) inspection report outcome states that the Children in Care team have 23 Education Health and Care Plans (EHCPs) that were Children in Care and were satisfactory/good. The Designated Nurse LAC, Local Authority and Named Nurse Children in Care continue to work together to develop a flow chart for alignment of the IHA - RHA and LAC reviews/EHCP review meetings. A patient status alert flag is documented on the Electronic Patient Record to identify Children in Care with Special Educational Needs or an Education Health Care Plan. All available copies of individual Education Health Care Plans are attached to the health records.

4.16 A request for Lorenzo training for the doctors to access hospital records was approved and delivered to all doctors within the Children in care Team.

4.17 The Named Nurse Children in Care and the Designated Nurse LAC deliver 'Children's Journey' training alongside two Independent Reviewing Officers to a multiagency audience. Over the past year this was put on hold due to the Safeguarding Children's Board City / County merge.

4.18 A Development half day was held by DDCCG for both Derby City and Derbyshire Children in Care Teams. External speakers were invited to deliver information around their services. There were opportunities to mix City and County into groups to look at the service we provide, 'what is working well and what do we need help with'.

4.19 Over 2019/2020 additional nursing and doctors hours have been utilised to capture the requests for review health assessments and initial health assessments for the 'Born-out-lives in' (BOLI) children and young people. There have been 54 completed review health assessments and 21 initial health assessments for the BOLI cohort during 2019/2020 and the Provider has received funds at the National Tariff payment rates

4.20 During quarter 3 the Operational Lead joined the Children in Care team to support and work alongside the Named Nurse CiC and Clinical Lead. The Operational Lead, Clinical Lead and Admin Coordinator meet on a weekly basis to monitor and review compliance, clinic slot capacity and all other workload. This supports the development or review of any processes within the CiCA team and enables a joint approach in providing solutions or escalating to higher management as required.

Section 5: Provider and Partnership Working

5.1 A joint protocol has been developed between Derbyshire Police, Derby City Council, Derby Youth Offending Service and the Crown Prosecution Service. This is a multi-agency approach to prevent the unnecessary 'criminalisation' of children in care. The Concordat helps people working with our children in care in deciding on the most appropriate response to challenging any behaviour in the home or community. We have successfully piloted this approach in two of our residential homes, with a big reduction in the criminalisation of young people in those homes and alternative support made available to them (The Corporate Parenting Strategy 2019-21)

The Concordat pilot started in October 2018 and continues to be rolled out within Derby City. During 2019/20 the Named Nurse for Children in Care has been involved and attended Operational Meetings around Concordat.

Section 6: DHcFT service provision for Looked after Children

6.1 The DHcFT Children in Care health team have core competencies, specialist skills, knowledge and attitudes to act as advocates, undertake health assessments, identify and manage health needs and provide support/training to Foster Carers and Children's homes (in line with the Intercollegiate Role Framework, RCN, RCGP, 2015). The team also contribute to health care plans for all looked after children including children with special educational needs and/or disabilities.

6.2 The team continue to improve their offer for Children in Care by including; the delivery of health promotion to children and young people, support for care leavers,

development of a robust system to collate health histories for care leavers, improved identification of risk of child sexual exploitation (including boys/young men) and provision for children who have special needs and/or disability.

6.3 The staffing levels for the health team at the end of the financial year (March 2020) were as follows:

Designation	Hours	WTE
Designated Doctor	4 hours (1 session)	
Designated Nurse (SDCCG)	37.5 hours	1 (From May 2017)
Named Nurse	30 hours	0.8
Specialist Nurse	14 hours	0.37
Specialist Nurse	22.5 hours	0.6
Specialist Nurse	32 hours	0.85
Specialist Nurse	26 hours	0.7

Section 7: Children in Care and Adoption Administrators

7.1 The Children in Care administrative team consists of an Administrator Coordinator (Band 4) and two Administrators (two at Band 3). During September 2019 to November 2019 the Children in Care Administrator Co-ordinator role was a vacancy due to the previous Co-ordinator leaving the service. A successful candidate was appointed in November 2019. In June 2020, the previous Band 2 Administrator was successful at being appointed to a Band 3 position.

7.2 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 follow 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.

7.3 Improvements have been made over the last six months to ensure robust administration systems are in place. The Admin Co-ordinator and Named Nurse have worked in conjunction to update and develop all administrative processes. A new initial health assessment process has been created to ensure the 20 day compliance is met as much as possible.

Section 7: Strength and Difficulties Questionnaire (SDQ)

7.1 This questionnaire was introduced by the Department of Education's data collection for Looked after Children after 31 March 2008. This tool is an outcome measure that is used for tracking the emotional and behavioural difficulties of Looked after Children and Young People at a national level and its completion is a statutory requirement. The SDQ is a clinically validated behavioural screening questionnaire for use with 4 to 16 year olds.

7.2 Social Care has a statutory responsibility to send the questionnaire to carers and should be completed in time to support inform emotional health assessment element of the review health assessment and health care plan. The SDQ assists to inform the health professional's decisions about possible referrals to specialist mental health and psychological services. It is recognised as best practice to have sight of the completed SDQ at the point of the review health assessment, as this can aid evaluation of the child's emotional health and well-being.

7.3 The Local Authority, Designated Nurse and Named Nurse have continued to work together to strengthen the Strengths and Difficulties Questionnaire (SDQ) pathway in order to ensure a more robust process and increase the completion rate of the questionnaire. This process ensures that the SDQ score provided by the Local Authority was in line with the Review Health Assessment and supported the Specialist Nurse identifying any emotional or behavioural difficulties of the child/young person and assessing the impact of support provided (or if required). The SDQs are being completed in good time to enable this information to feed into other work, such as the health assessment.

7.4 All data shown below for 2019/20 is provisional until submitted to Department for Education in July;

Year	SDQ received	Percentage of completion rate	Average score (higher the score = higher need)
2016-2017	189	79%	16.3
2017-2018	236	93.6%	16.2
2018-2019	268	92.7%	14.8
2019-2020	322	92.5%	14.7

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

7.5 From the table above the overall completion rate for 2019-20 was 92.5%; this is slightly lower than 2018-19, however much higher than previous national and comparator figures. The average score for 2019-20 was 14.7 which is a significant drop from 2017-18. The local target for 2019-20 was 14.5 so we're slightly over this. However, this is our lowest average score ever! This potentially indicates improved emotional health and wellbeing of children and young people in care.

Section 8: Analysis of Adoption and Medical Adviser Activity

This section compiled by Derby City medical advisers Dr A Marudkar and Dr V Kapoor, CICADerby 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

8.1 There are two medical advisers (Dr Marudkar and Dr Kapoor) contributing to the Adoption work for Derby city. This includes attending the Adoption panels and preparing the reports for the children coming for adoption panel. The Adult health reports are prepared separately by GP specialist Dr MacLachlan. One adoption panel per month is attended by either of medical adviser in role of panel member, on alternate month basis.

8.2 From 1 April 2019, The Adoption services have become regionalised and are now part of Adoption East Midlands (AEM). The regionalised working has meant that the Derby City children can be presented and discussed at any of five AEM panels within the region, this in the best interests of the child , to prevent delay in placement, as the child doesn't have to wait a month to go to panel in their area. This also ensures a more uniform approach in managing the panels across the region. This may lead to the medical advisers hearing the case, which is prepared by another medical adviser and therefore efficient and timely liaison is needed between different medical advisers to explore and clarify any issues in advance of panel. This means medical advisers need to spend more time in liaison and be available all the time, as queries may arise from any panel.

8.3 From 1 April 2019 to 31 March 2020, as per data provided by Derby City social care,

- Number of matching reports provided to AEM – 27
- Number of Adult health reports completed by Dr MacLachlan – 98
- Number of prospective adopter consultations (telephonic) - 2

There has not be a significant change in the number of matching reports provided for the year as compared to last year for Derby city, ensuring that the children continue to be progressed to permanence within the new system, possibly with a positive impact on the timescales.

The number of adult health reports has reduced slightly (by 10%), reason not formally explored, but complete change is assessment process with start of AEM might have contributed to it.

Since starting the AEM in April 2019, a new regional process was agreed for prospective adopter consultation requests. Now initially questions are invited in writing from adopters via social worker, which are responded to in writing, also the report format is very comprehensive and includes history and implications in detail. A telephonic consultation is only provided in selected cases to answer any specific queries which remain. This explains

the drop in number of actual telephone / face to face pre-adoption consultations, although pre-adoption advice is still given, rather in a more targeted and formal way in writing.

8.5 The two medical advisers also provide regular training sessions for prospective adopters, foster carers and social workers 3 times a year regarding common clinical issues in adoption scenario, i.e. Impact of maternal smoking, alcohol and drug misuse in pregnancy and Blood borne infection screening in vulnerable and high risk children. Two such training sessions were provided last year, third one being cancelled by social care

8.6 Dr Kapoor (Medical Advisor) and Named Nurse for Children in Care also deliver a training lecture on Children in Care as a part of GP vocational training course in Derby.

8.7 Both the medical advisers attend regular quarterly AEM meetings with other medical advisers and panel advisors (plus commissioners if appropriate). They also attend panel training days twice a year.

Section 9: Health Data and Performance for Year 2019/20

9.1 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 three years:

*please note all health data for 2018/19 is provisional until submitted to the Department for Education in July 2019

Health Data Indicator	Year 2017/18	Year 2018/19	Year 2019/20
Annual health assessments	92.7%	96.1%	93.5%
Dental checks	87.6%	91.4%	92.3%
Immunisations up to date	93.9%	92.8%	92.3%
Development checks (two RHAs in the 12 months for under 5 years old)	87.5%	91.9%	90.2%

NB: the data is only mandatory for those children/young people in care for a period of 12 months or more

9.2 **Annual Health Assessments** – Although Derby's completion rate of annual health assessments has decreased from 96.1% in 2018-19 to 93.5% in 2019-20 the 2019-20 percentages remain higher than the national average (89.9%).

Dental Checks - Derby's completion rate of dental checks (92.3%) has increased for the fourth year running.

Immunisations - Derby's completion rate of immunisations has decreased slightly during 2019-20 to 92.3% from 93.8% in 2018-19. Even after a slight decrease Derby's 2019-20 performance remains higher than the comparator (91.1%) and national averages (86.8%) for the eighth year running.

Development Checks - Derby's completion rate of health development assessments has decreased slightly, decreasing from 91.9% in 2018-19 to 90.2% in 2019-20. The 2019-20 percentage remains above the national (88.1%) and comparator authority average (84.1%) for the third year running.

9.3 Since the Children in Care team have access and the mechanism to update Liquid Logic (Local Authority IT system), the accuracy of heath data has significantly improved. The Named Nurse for Children in care and the Designated Nurse for Looked after Children meet on a quarterly basis to ensure all the correct information is recorded and any outstanding information is passed onto the Children in Care Nurses and admin to chase.

Section 10: Markers of Good Practice (MOGP)

10.1 In April 2020 the Children in Care team submitted the Markers of Good Practice – self assessment tool for Children in Care within Derby City. The Markers of Practice tool, which is ‘RAG’ rated, provides the Children in Care Team with a productive opportunity to showcase their service to the Clinical Commissioning Group and Designated Professionals.

10.2 With the submission of evidence and ‘RAG’ rating, the tool supports the Children in Care team highlight progress, any gaps or improvements that are required to assure the commissioners our service is working towards a ‘gold standard’ delivery and that the needs of the Children in Care are being met and identified in line with the statutory guidance.

10.3 Following the MOGP submission, representatives from the Clinical Commissioning Group and Designated Professionals completed the feedback in written format due to the Covid-19 pandemic. A discussion was held between the commissioners from DDCCG. Each standard was discussed and it was confirmed whether or not the ‘RAG’ rating provided by the Provider was in line with that of the commissioners’ assessment.

10.4 Strengths and challenges were identified, agreed by both parties and an action plan developed for the provider to work through within the year to achieve compliance in the areas that were not yet rated as green. The Markers of Good Practice Tool and action plan will be fed back to the Safeguarding Children’s Committee by the Head of Safeguarding Children's Service and at the Safeguarding Operational Leads meeting held by the organisation by the Named Nurse Children in Care. The action plan will continually be discussed at the Safeguarding Operational Leads Meeting and with the Designated Nurse for Looked after Children.

10.5 The Clinical Commissioning Group have been assured that the Children in Care service provision is overall at a good standard and the Health provider is working in partnership in all areas that have been identified as requiring further progression or improvement.

Section 11: Quality Assurance Processes

11.1 For quality assurance of the statutory Initial Health Assessments for Looked after Children, a monthly timeliness of Initial Health Assessment audit is completed by the DDCCG Designated Nurse LAC, with the intent of contemporaneous feedback to social care and the health team as to where in the process has had either a positive or negative impact on timeliness. Obtaining timely consent from parents by social care is being noted to be a key factor that does impact on subsequent timeliness for completion of the Initial Health

Assessment as an appointment can only be undertaken when the consent for the statutory Initial Health Assessment is in place.

11.2 In tandem with the monthly timeliness audit, the Designated Doctor LAC completes an annual audit of a random sample in Quarter 2/3 of 10 Looked after Children using the Initial Health Assessment quality checklist tool. Once key factors are identified within the audit that has had either a positive or negative impact, internal action plans are put into place for forward planning for the next financial year to ensure we able producing Initial Health Assessments of a good enough standard that reflects the needs of the individual Looked after Child. (See Appendix 2 and 3 for Initial Health Assessment paperwork and audit tool)

Section 12: Voice of the child

12.1 The voice of the child/young person is embedded in all aspects of the Children in Care service development and delivery. It is essential that children and young people are listened to and their views responded to in order to promote and respect the rights of children.

12.2 The voice of the child is obtained through a variety of mechanisms (dependent on their age, capacity, levels of understanding, analysis of non-verbal cues and body language):

- The child/young person is offered the opportunity where age appropriate to be seen alone
- At each appointment confidentiality is explained to the child or young person
- Identification in collaboration with the child/young person of their own strengths, wishes, feelings and their needs
- Use of the evaluation form after health assessments or any individual contact with a child or young person
- Clear documentation of the child's voice by using direct speech quotes or agreed summary of conversations

Section 13: Priorities for Year 2019/20

13.1 **DHcFT Provider key priorities for 2019/20:**

- New in-house adoption work process
- To identify champions within the Children in Care Team
- To deliver health promotion within the Local Authority Residential Children's Homes focusing on Healthy Eating initially
- To introduce ourselves to new children when they arrive at a children's home explaining our role and involvement.
- To increase attendance at planning meetings and children in care review meetings for the children in the Local Authority Residential Children's Homes.
- Continue with foster carer sessions
- To roll out and implement the use of the new health passports

- To continue to be part of the CONCORDAT operational meetings to ensure this is adhered to for Children in Care
- To build relationships with the leaving care team to improve support around transition
- To continue to deliver quarterly action learning sets for all Children in Care Nurses in collaboration with the Designated Nurse for Looked after Children

13.2 These key priorities are an overview of some of the on-going work and strong commitment to improving the health and welfare of children in care. The vision continues to be that we ensure all children in care reach their natural potential through the interventions of competent, skilled, compassionate professionals and their drive to make a difference to this vulnerable group of children and young people.

Section 15: References

Keep on Caring: Supporting Young People from Care to Independence, June 2016, Department for Education

Promoting the health and well-being of looked-after children, March 2015, Department of Health and Department of Education

Looked after children: Knowledge, skills and competencies of health care staff, Intercollegiate Role Framework, March 2015, Royal College of Paediatrics and Child Health

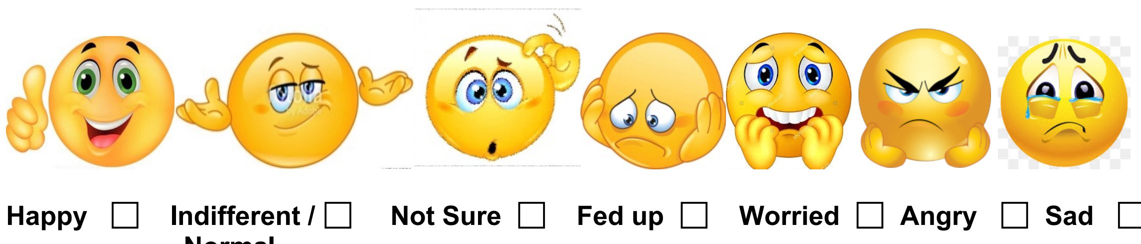
Stats: looked after children, Department for Education, 2017
https://www.gov.uk/government/collections/statistics-looked-after-children

The Corporate Parenting Strategy 2019-2021, Derby City Council

Appendix 1

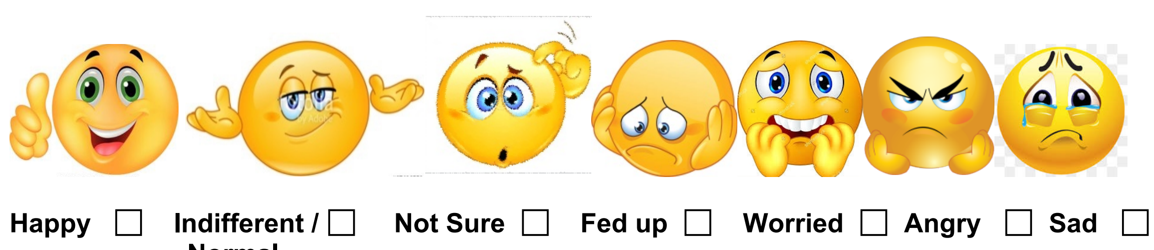
How do you see yourself?

Now:



Happy ☐ **Indifferent / Normal** ☐ **Not Sure** ☐ **Fed up** ☐ **Worried** ☐ **Angry** ☐ **Sad** ☐

Most of the time:



Happy ☐ **Indifferent / Normal** ☐ **Not Sure** ☐ **Fed up** ☐ **Worried** ☐ **Angry** ☐ **Sad** ☐

Appendix 2

Initial Health Assessment Documentation – adapted from coramBAAF (2016 version)

CONFIDENTIAL

<table>
<tr><td colspan="3">Health advisors name:</td></tr>
<tr><td colspan="2">Clinic date:</td><td>Date documentation completed:</td></tr>
<tr><td colspan="2">Like to be known as:</td><td>Age:</td></tr>
<tr><td colspan="2">Ethnic Origin:</td><td>Sex:</td></tr>
<tr><td colspan="2">Language: Main spoken language English</td><td>Interpreter used: YES / NO</td></tr>
<tr><td colspan="2">Current legal proceedings:</td><td>Date entered into care:</td></tr>
<tr><td colspan="3">Person (s) with parental responsibilities:</td></tr>
<tr><td colspan="2">Venue of IHA:</td><td rowspan="7">People present and their roles:</td></tr>
<tr><td colspan="2">IHA based on information taken from:</td></tr>
<tr><td>Hospital notes</td><td>YES / NO</td></tr>
<tr><td>Electronic records of the child</td><td>YES / NO</td></tr>
<tr><td>PH form</td><td>YES / NO</td></tr>
<tr><td>Form M</td><td>YES / NO</td></tr>
<tr><td>Form B</td><td>YES / NO</td></tr>
<tr><td colspan="3">GP: GP/Clinician</td></tr>
</table>

Confidentiality:

If the child or young person wishes for confidential information to be omitted from this documentation (and it is appropriate or necessary to be omitted), this will be recorded with the child/young person's health record with an analysis for the reasoning behind the decision.

Consent to the initial health assessment:
Does the young person have capacity to consent? **YES / NO** (if not, consent should have been obtained in the child's best interest)

Consent by the young person: I understand the reason for this health assessment and I agree for it to take place. I understand that the following assessment the documentation and my health care plan will be completed. A copy of this will be given to me and my social worker. I consent to copies of my health care plan to my carer, birth parent(s), GP and school nurse (delete or add as necessary)

Signed: **Date:**

Has consent been obtained from birth parent/other person with parental responsibility/person authorised by Local Authority to give consent (where the child does not have capacity to consent): **YES / NO / NA**

Child / young person seen alone: **YES / NO**	If no, please give reason:
Carer seen alone: **YES / NO**	If no, please give reason:
Significant people around the child / young person:	
Carer's details	
Biological mother	
Biological father	
Mother's current partner	
Siblings	
Other children living in the household	
Social Worker	
Responsible Local Authority	
Independent reviewing officer	

Reasons for child / young person entering care:
Relevant social history:

Health Professionals Involved:

	Name	Address	Date of last visit / due to be seen again?
Dentist			
Optician			
Audiology			
Paediatrician			
CAMHS / independent counsellor			
Other (state speciality)			
Other (state speciality)			

Medications:	**Allergies:**

Current health issues / diagnoses:
Does the child / young person have any health concerns? If so, what, how does it affect them and what would they like to do about it?
Antenatal/Birth/Neonatal history:
Past medical history (include relevant A&E, GP, MIU, WIC attendances):

Neonatal hearing screening: Normal / Abnormal / Unknown If abnormal, was the appropriate actions taken: YES / NO / UNKNOWN	**Vision:** Has the child / young person advised to wear glasses by optician: YES / NO Are glasses worn as advised: YES / NO Current concerns:
Guthrie test: Normal / Abnormal / Unknown If abnormal, was the appropriate actions taken: YES / NO / UNKNOWN	**Current or previous dental health:**

Family health history or relevant lifestyle issues (consider potential health impact and implications for the child/young person):	
Biological mother	
Biological father	
Paternal grandparents	
Maternal grandparents	
Siblings	

Immunisations:

Is the child / young person fully immunised for their age?	YES / NO	If no, what immunisations are required?

Vaccination	**8 wks**	**12 wks**	**16 wks**	**12 mths**	**40 mths**	**13-18 yrs**
Diphtheria						
Tetanus						

Pertussis						
Polio						
HIB						
Hep. B						
Pneumococcal						
Rotavirus						
Men. A						
Men. B						
Men. C						
Men. W						
Men. Y						
Measles						
Mumps						
Rubella						

Physical health and examination:

Describe general appearance/presentation/demeanor:

Physical examination summary:

Eyes	
Ears	
Respiratory system	
Cardiovascular system	
Abdomen	
Genitalia	
Nervous system	
Musculoskeletal system	

Significant findings:

Height	cm	centile	Weight	kg	centile
BMI		centile	Head Circumference	cm	centile
Previous measurements:					

Concerns regarding growth/weight measurements:

Child / young person's dietary/fluid intake:

Child / young person's level of exercise and what sort:

Child / young person's sleep pattern:

Developmental/functional assessment:

Gross motor skills	
Fine motor skills	
Communication skills	
Cognitive skills	

Social and self-care skills	

Significant findings:

Does the child/young person receive any extra support with learning? YES / NO

Is the child/young person likely to require any extra support with learning? YES / NO / POSSIBLY

Has the child been referred to the education department for further assessment: YES / NO / NA

Are there any difficulties in accessing extracurricular activities or additional needs? YES / NO / NA

School/nursery:

Attendance:

Attainment:

Relationships at school (positives and negatives - friendships, bullying, etc):

Emotional Assessment (include behaviour, identity, attachment, concentration, relationship with carer, how is the child coping at the moment, who does the child talk to?)**:**

How is the child/young person feeling at the moment?

Impact of contact with the birth family:

Keeping healthy and safe:

Does the child/young person smoke?	YES / NO / DECLINED TO SAY / E-CIGARETTES
If smoking, give detail of how many, what and where do they buy them from	
If smoking, does the child/young person want to stop?	YES / NO / MAYBE
Does anyone smoke in the household?	
Does the child/young person drink alcohol?	YES / NO / DECLINED TO SAY
If drinking, give detail of how much, what and where do they buy it from	
If drinking, does the child/young person want to stop?	YES / NO / MAYBE
Is daily functioning affected by the alcohol consumption?	YES / NO / UNKNOWN
Does the child/young person use any substances?	YES / NO / DECLINED TO SAY
If using substances, give detail of how much, what and where do they buy/get it from	
If using substances, does the child/young person want to stop?	YES / NO / MAYBE
Is daily functioning affected by the substance use?	YES / NO / UNKNOWN

Actions required or taken:	
Relationships, puberty and sexual health:	
Has the child/young person had relationship and sex education (RSE) at school or from another adult?	YES / NO / UNKNOWN / NA If NA, why:
Has the child/young person started menstruating?	YES / NO / DECLINED TO SAY / NA If yes, what age?:
Is the child/young person struggling with menstruation?	YES / NO / MAYBE / DECLINED TO SAY / NA If yes, in what way?:
Is the child/young person worried about or doesn't understand anything in relation to RSE?:	
Does the child/young person have a partner? (consider safeguarding)	YES / NO / DECLINED TO SAY / NA
Is the child/young person sexually active?	YES / NO / DECLINED TO SAY / NA
Is the child/young person using contraception?	YES / NO / DECLINED TO SAY / NA
Is the child/young person practicing safe sex every time they have sexual intercourse?	YES / NO / DECLINED TO SAY / NA
Is the child/young person at risk of sexual infections?	YES / NO / UNKNOWN / NA
Has the child/young person been pregnant or fathered a pregnancy?	YES / NO / UNKNOWN / DECLINED TO SAY / NA If yes, outcome of pregnancy:
Is the child/young person currently pregnant or thinks they may be pregnant (or father to a current pregnancy)?	YES / NO / UNKNOWN / DECLINED TO SAY / NA Wishes/feelings:
Does the child/young person require further advice re: safe sex, pregnancy, contraception, sexual infection screening?	YES / NO / DECLINED / NA
Referrals made	

Any other risk taking behaviours or safeguarding issues disclosed? (exploitation, domestic violence, radicalisation, forced marriage, FGM, e-safety concerns): **Actions taken:**	
Child exploitation risk	YES / NO / MAYBE If yes or maybe, follow the CSE safeguarding policy

Carer's feedback or comments:

Child/young person's wishes and feelings:
Conclusion and analysis:

Name of Health Professional completing assessment:	
Designation:	
Qualifications:	
Registration: GMC	Number:
Date:	
Address:	
Telephone number:	
Signature:	

HEALTH RECOMMENDATIONS FOR YOUNG PERSON CARE PLAN

Personal or sensitive health topics should not be included in this plan or discussed in group settings without the express knowledge and consent of the young person.

Date of health assessment (date/s young person seen): Example

Date of next health assessment:

Health issues	Action required	By when	Person responsible
Test to have a review health assessment in line with statutory requirements	Test should have their health assessment in one year / in 6 months	Due by:	LAC nurse
GP registration	Test should stay registered with GP at all times	On going	Carer
Ensure Test has the 6 week old GP check	Carer to await appointment and liaise with GP/ health visitor	6-8 weeks age	Carer
Growth and development	Test should have regular ASQ assessments (or equivalent) as per Healthy Child Programme	To start at 3-4 months or earlier assessment if concerns	Health visitor
Vitamin and nutrient supplements as per Department of Health guidance which recommends Vitamin D drops for all children from 6 months to 5 years of age	Once formula intake is less than 500 ml/ day, then Carers to access: 'Health Start Children's Vitamin Drops' (find your local distributor at 'NHS Choices' online) or purchase equivalent vitamins drops from the pharmacist (speak to the pharmacist prior to purchase)	On-going basis from 6months to 5 years of age	Carer in liaison with health visitor

Health issues	**Action required**	**By when**	**Person responsible**
Immunisation	Test remains up to date with immunisations as per UK immunisation schedule Currently up to date Or Status unknown	Next due at ….. age	Carer/ GP Or I will write to GP
Maintain dental health	Maintain dental hygiene by regular brushing twice daily. Ensure registration with dentist and regular 6 monthly reviews or as advised by dentist Or Requires registration and regular 6 monthly reviews or as advised by dentist. Or Action for future(delete if appropriate)-- Every child from aged 12 months should be registered with a dentist and have a dental review every 6 months	Due ….. On going Or Carer to register within 2 weeks Carer to register after 12 months age	Carer/ young person Carer/ young person Carer/ young person Carer
Maintain vision/optical health	Ensure registration with optician and yearly reviews or as advised by optician Wear glasses as / if prescribed	On going Or Carer to register	Carer
Physical health issues (STATE DETAILS) Diagnosis:	For Test to attend all health appointments as required	On-going basis and be reviewed at the next health review	Test, carer, health professionals and Social Worker

Health issues	**Action required**	**By when**	**Person responsible**
Medication:	Test to take all medication as prescribed and to highlight any adverse reactions/side effects with health professionals		
Hearing concerns noted at Initial Health Assessment	Arrange hearing test Referral to Audiology/ school nurse	Within 2 weeks	I will write to Audiology/ school nurse
Mental health			
Sexual health issues	Test to be supported to attend the Integrated Sexual Health Services	Within 4 weeks	Test and Carer
Emotional health/ behaviour	Carer to monitor emotional health and behaviour closely and seek help as required	On-going Review at LAC review	Carer and Social worker
Lifestyle issues Smoking Alcohol Drug misuse Sexual Health	Advice given about appropriate services to access if wishes to stop misuse. Test should always be aware of and mindful of safe sexual practices, contraception, infection risks and the risks of exploitation. Advice given.	Carer to monitor and liaise with Social Worker. To be reviewed at next LAC review	
Learning/ Education	Ensure consistent school attendance and accessing support for learning as appropriate	Termly school reviews	Test, School and Carer
General health and well being	Ensure Test has a healthy balanced diet, regular meals including 5 portions of fruit and vegetables. Ensure Test participates in physical activity for at least 30-60 min a day.	Daily	Test and Carer

Health issues	**Action required**	**By when**	**Person responsible**
Parental health forms - form PH, M B and consent to share information not available at the Initial Health Assessment	Forms given to (OR Forms to be sent to) social worker to get completed by mother/ father and send to CICA admin team at Sinfin Health Centre	Within 2 weeks	Social worker to send completed forms
Blood borne infection screening required for Test High risk due to……	Consent form given to social worker to get consent from birth mother or appropriate consent from social care manager/ court and send to CICA admin team at Sinfin Health Centre Or Consent obtained from mother/ young person in clinic	Within 4 weeks	Social worker I will arrange blood tests once consent is received Or I will send blood forms to social worker OR Blood form given in clinic
Blood borne infection risk cannot be assessed due to lack of information	Social worker to explore further information from mother and send information to CICA admin team at Sinfin Health Centre	Within 4 weeks	Social worker
TB screening required as status unknown and at risk (Unaccompanied Asylum Seeking Child/young person)			
Sexual health clinic referral for Unaccompanied Asylum Seeking Young Person			

Appendix 3

Initial Health Assessments Quality Checklist

	Completed	Improvements required
Name of child correct		
DOB correct		
NHS number correct		
Due Date		
Date Completed		
On time		
Venue		
People present and role		
Legal Status		
Date when entered care		
Reason for entering into care		
Language		
Carers details		
GP details noted		
School/nursery – detailed and discussed		
Offered to be seen alone		
Offered carer to be seen alone		
Families details noted		
Ethnicity		
Confidentiality discussed (as appropriate)		
Consent discussed and gained		
Consent signed as appropriate by child/young person		
Document typed and understandable		
Family History noted and impact on child/young person		
Past medical history noted		
Pre-existing health or current issues		
How is the child feeling at the moment		
SEND needs considered		
Immunisations discussed – UTD / NTD		
Growth measurements		
Growth with centiles (inc BMI)		
Growth assessment		
Last dentist attendance noted		
Dentist name / address detailed		
Dental health discussed		
Last Optician attendance noted		
Optician name / address detailed		
Optical health discussed		
Emotional Health discussed		
Appropriate actions taken		
Risky behaviours discussed		
Appropriate actions taken		
Lifestyle issues discussed		
Appropriate actions taken		
Onward referrals completed		

	Completed	Improvements required
Sense of the voice of the child (first name, wishes/feelings)		
Voice of the carer included		
Summary and implications for the future		
HCP timescales		
HCP responsible person		
HCP action appropriate and representative of child's needs		
Comments		

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 3 November 2020

Infection Prevention and Control (IPC) Annual Report 2019/20

Purpose of Report

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

Executive Summary

- This report has been received by the Quality and Safeguarding Committee and was reviewed and confirmed and recommended for submission to the Trust Board
- The Trust continues to provide a consistent high level of performance against infection control standards and related management activities.
- The number of reported cases of key alert organisms is very low.
- As in the previous year there has been very little interruption to service delivery due to infection control matters, although a contained flu outbreak did lead to a brief ward closure at Hartington Unit
- Inspection of clinical areas remains of a good standard and PLACE scores continue to show that the Trust performs at a higher than national average level with some improvements on last year's scoring
- The emergence of COVID-19 has been managed well and the Trust has been able to maintain a high level of compliance with expected standards due to swift and decisive actions undertaken by the Incident Management Team (IMT)
- The Director of Infection Prevention Control has supported the recruitment of a significant number of hotel service staff to deliver an enhanced cleaning programme. This has been a substantial investment in safety by the Trust Board to keep patients and staff safe. This is a key factor in the Trust's significant success in maintaining its safe environments.
- The Trust has maintained its five-star rating for kitchen cleanliness awarded by the local authority.
- The Trust is contributing to local learning and has developed new systems and processes to ensure IPC standards and COVID secure guidelines are adhered to for the safety of all service users and colleagues
- The Board can be assured that the Trust's compliance with standards has had oversight from the regulators during the inspection visit in 2019, and subsequent visits since the onset of COVID-19
- The resilience of staff remains the Trust's key priority and as such work is progressing towards achieving the highest ever compliance figure for flu vaccinations.
- The potential impact of further resurgence of the pandemic outbreak is a key risk and safety of service receivers and colleagues remains the Trust's

highest priority.

Additional investment in IPC approaches and equipment remains a priority for 2020/21 to ensure the safety of the Trust's community and colleagues.

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

Assurances

- 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 current COVID guidance.

Consultation

- This paper provides the annual update for the financial year 2019/20 and was deferred from the last meeting due to the Level 4 incident response.
- This paper was reviewed by the Quality and Safeguarding Committee on 8 September 2020.

Governance or Legal Issues

- This paper brings an update on regulatory aspects around standards which may form part of a CQC inspection or enquiry. These would be around patient safety, leadership, responsiveness and effectiveness. Standards are set in the Healthcare Associated Infections Code of Practice for Infection Prevention and Control 2015.
- There is a 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 is emerging. DHCFT have incorporated learning where possible and remain open to improving approaches to improve outcomes for those who access our services and colleagues who provide them.
- Key stakeholder groups have been formed to contribute towards and review emerging evidence.
- The Infection Prevention and Control 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; **Carolyn Green**
Executive Director of Nursing and Patient Experience

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

Infection Prevention and Control
Annual Report – 2019/20

Report prepared by Richard Morrow, Assistant Director of Public and Physical Health (lead for Infection Prevention and Control) on behalf of Carolyn Green, Director of Nursing and Patient Experience, Director for Infection Prevention and Control.

1. Introduction

1.1 2019/20 has been a challenging year across health care providers due to the emergence of the Novello – Coronavirus Wuhan strain (COVID-19). This report summarises the approaches to Infection Prevention Control at Derbyshire Healthcare NHS Foundation Trust (DHCFT).

1.2 Preventing the spread of infection has been a key focus in healthcare for a good number of years, 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 Code of Practice: Prevention and Control of Healthcare Associated Infections (2015) 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 & Control considerations are part of the ongoing framework of improvements undertaken by the organisation.

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. DHCFT is proud of the high standards we continue to achieve and the comparatively low rates of infection we see.

1.5 We are beginning to see changes to monitoring frameworks and greater attention paid to communicable infections, particularly those where increasing anti-biotic resistance is flagged as a containment and treatment risk.

Health and Social Care Act 2012 Standards

Standard	Actions
Systems in place 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.	• PHCIC meeting has been reviewed, meeting more frequently, with a broader membership and improved attendance. • 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. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.
Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.	• PLACE annual reviews. • Head of nursing walk arounds and cleanliness and estates checks. • Supportive and responsive estates and facilities teams.
Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.	• Updated guidance reviewed when circulated and policies adjusted. Focus on CPE for 2019 alongside increased vigilance against hospital acquired infections. • Annual audit plan and report in regards to antibiotic stewardship
Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion.	• Updated and accessible policies are available through updated trust intranet and internet site. • Infection control link nurses and support nurse 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.
Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to 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. • Trust links into Public Health England and Health Protection Team to ensure national or regional concerns are responded to appropriately.
Systems 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 regularly reviewed updated and accessible policies and procedures. • Al colleagues have access to PPE and hand cleaning 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.
Provide or secure adequate isolation facilities.	• Individual rooms available with bathroom facilities where required. • Cohort Nursing facility available if required.
Secure adequate access to laboratory support as appropriate.	• PHE and regional IPCSAG support available. • National network and support system linked in to NHSI / E available,
Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.	• Ensure individual management plans using physical health management tool guidance are in place. • Monitoring of changes to infection control guidance. • Identifying new products and approaches to limit the spread of infection.
Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection.	• DHCFT have an established relationship with Occupational Health provision locally. • 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,

2. National context

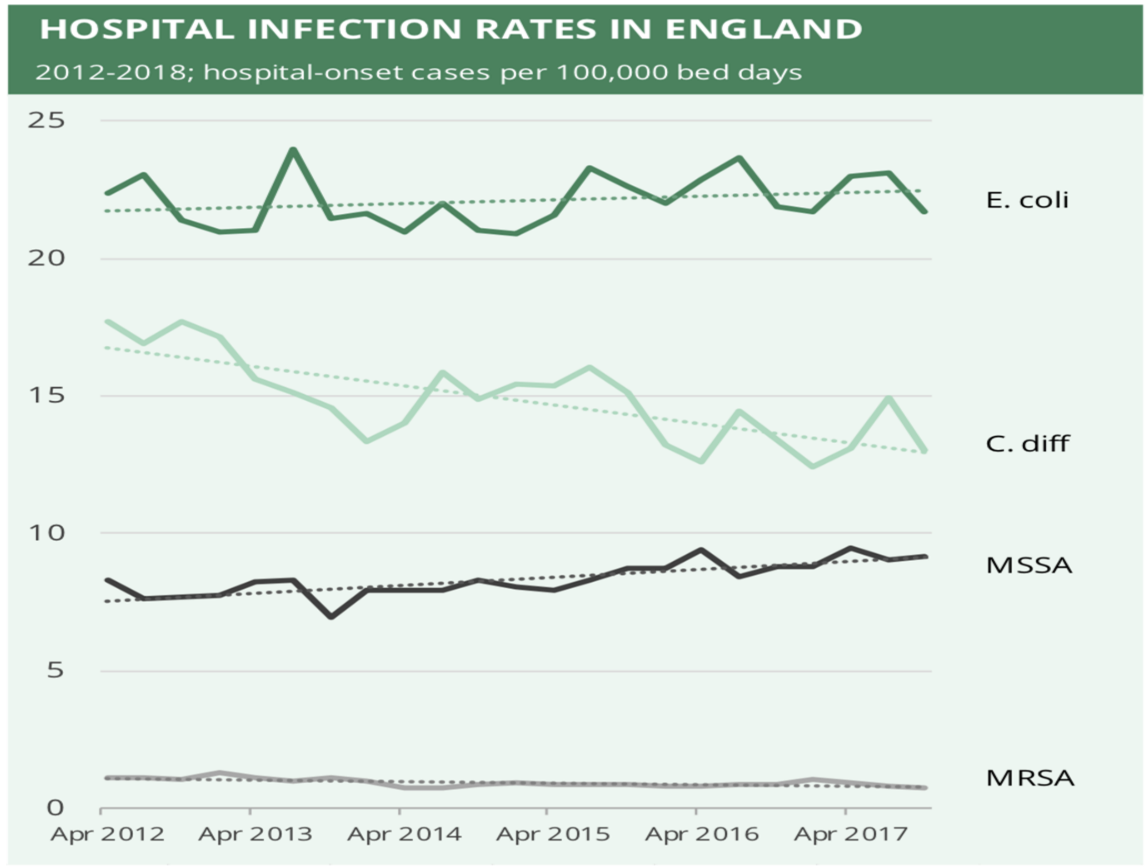
2.1 Over recent years, through sustained progress against challenging expectations, the rates of healthcare associated infection reported nationally have continued to fall (source Public Health England 2014, updated 2016). Cleanliness in healthcare facilities remains a high priority, with the well-established 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 seen as largely preventable. There is on-going focus by NHS England on pandemic influenza preparedness.

The term HCAI (Healthcare associated infections) covers a wide range of infections. The most well-known include those caused by meticillin-resistant *Staphylococcus aureus* (MRSA), meticillin-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
- as a result 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.

Statistically, overall case numbers are falling as shown in the following table from the parliamentary debate paper from 2018 to raise standards of infection control (raising standards of infection control). The focus and concern is shifting to the treatment resistant variants nationally. This is underpinned by an on-going push to focus on basic principles of infection control containment and management to prevent cross contamination and spread of infections.



Recent focus on the impact of healthcare associated infection has now shifted somewhat from MRSA bacteraemia and *Clostroides difficile* to looking now at other emergent resistant organisms such as *Escherichia coli,* and the significant impact the communicable conditions such as Norovirus have on delivering health care.

3. 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 Lead for Infection Prevention & Control (DIPC), this is undertaken by the Director of Nursing 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 also involved in delivery of training, clinical advice and planning.

3.3 Since September 2013, an Infection Control Support Nurse (currently 0.6wte, increased hours from last year) has been in post to assist the Assistant Director of Public and Physical Health in the delivery of clinical support, advice, training and audit of standards.

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

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

3.6 In 2018/19 the infection Control Committee and the Physical Healthcare Committee were combined in order to make better use of clinician's time and also to broaden the attendance of Infection Control Committee. The combined group link to the divisional COAT meetings and Trust Management team (TMT) as before.

3.7 In addition to this, the meeting has support and oversight from an Executive Committee formed to support the delivery of the wide reaching agenda of the Physical Health Care and Infection Control Committee (PHCIC). This meets bi-monthly as an adjunct to the main clinical PHCIC meeting.

3.8 An annual report detailing the work of the Infection Control Team and the PHCIC is submitted to the Quality and Safeguarding Committee as part of the Trust's oversight and governance approach.

4. Key achievements of 2019/20

4.1 Continued investment in the capital programme has seen sustained improvement in the care environment in a number of locations, through a dedicated capital expenditure allocation for Infection Control in 2019/20.

- Replacement furniture and flooring within the in-patient units as part of a rolling programme of upgrade and improvement
- Furniture and equipment has been provided for newly established physical health monitoring clinics in Community.
- Flooring and fittings upgrades have taken place in the private finance initiative (PFI) sites on Kingsway site.
- Physical health monitoring equipment from OxeHealth has been installed; this enables remote monitoring of patients with elevated physical health risks or those recovering from episodes of ill-health to be monitored in an unobtrusive manner to promote rest without compromising clinical safety.
- Radbourne and Hartington Units have had furniture replaced and there is currently a bed replacement programme underway to improve the safety and Integrated Personal Commissioning (IPC) standards within the inpatients areas.
- Ward 1 and the older adult wards at Kingsway site have furniture upgraded and underwent a bed replacement programme in March 2020.
- Implementation of Sepsis policy and coalition with regional Sepsis Best Practice Implementation group.

4.2 Continued delivery of training programmes for clinical and support staff who are identified as requiring the training. Training sessions are largely delivered

as either ‘face to face’ taught session, via the ‘block’ training methodology; there is an e-learning option for staff to access. This year we have included some additional information which specifically talks through water born Pathogen and the methods employed by the Trust to manage these risks, namely temperature control and chemical dosing. This is being actively promoted as the Trust attempts to ensure that training is delivered in a manner which maintains the capacity for people to socially distance and reduce any transmission spread related to COVOD- 19 secure guidelines.

4.4 In December 2019, we had a flu strain which was an outbreak on one of our acute in-patient wards at the Hartington Unit.

- Staff have been encouraged to have flu vaccination across the unit if they haven’t already had it.
- The affected patients were nursed in isolation.
- All patients who were safe to receive care at home were encouraged to take leave.
- Signage was displayed alerting visitors, relatives and carers.
- Everyone visiting, staying and working on the ward was continually advised in regards to hand washing and reducing traffic on and off the ward.
- The outbreak was contained to one ward with no spread to other areas.
- NHSE and CCG were kept informed as per winter pressures and contractual guidance.
- A post-incident review was conducted and many positive lessons learnt in regards to good communication and prevention of cross contamination.
- The Estates team were responsive and enhanced cleaning off hand rails, etc which was pivotal in managing cross contamination risks.
- Patients on the ward were also vaccinated.

In keeping with the Flu campaign for 2019/20 we used the HOPE acronym;

- **H**and washing (not just hand gel) and PPE are key. Wash them well, wash them often!

- **O**bserve basic infection control standards, bare below the elbow, be aware of what you touch and minimise unnecessary contact.

- **P**lease remember - Jewellery, watches and nail varnish can harbour infection and reduce the effectiveness of good hand washing.

- **E**veryone can help! The more we can all do to limit spread the better, literally share hope, not flu!

4.5 Surveillance of Healthcare Associated Infections (HCAI Alert Organisms) have seen no cases of MRSA bacteraemia acquired within the Trust between

April 2019 – March 2020 – this has been the case for seven consecutive years.

4.6 A patient with Campylobacter was identified on Ward 34 in December. The Infection Control Support Nurse was able to support the Infection Prevention Control Link Nurse and advise on clinical management strategies. Public Health England (PHE) were alerted and no other patients were affected.

4.7 Cleaning scores, measured against the national standards of cleanliness, have continued to meet the nationally defined 'excellent' standard in clinical areas across the year (see detailed performance in the section 'Assurance').

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

4.9 Patient Led Assessment of the Care Environment (PLACE) inspections took place in September and October 2019. The 2020 inspection programme has yet to be announced in light of Level 4 pandemic. The teams undertaking PLACE typically consist of Service User representatives, Estates, Nursing and Domestic Services as well as Infection Control representation. An action plan is drawn up after the assessments, which then feed into the allocation of capital funds, support for larger capital bids and inform backlog maintenance priorities.

4.10 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 a national safety standards audit and is undertaken annually by all in-patient areas. The 2019 audits are uploaded centrally for assurance and accessibility and this year's schedule although delayed due to COVID-19 has seen assurances regarding hand hygiene and COVID assessments reviewed and submitted to CQC as part of their IPC health check framework.

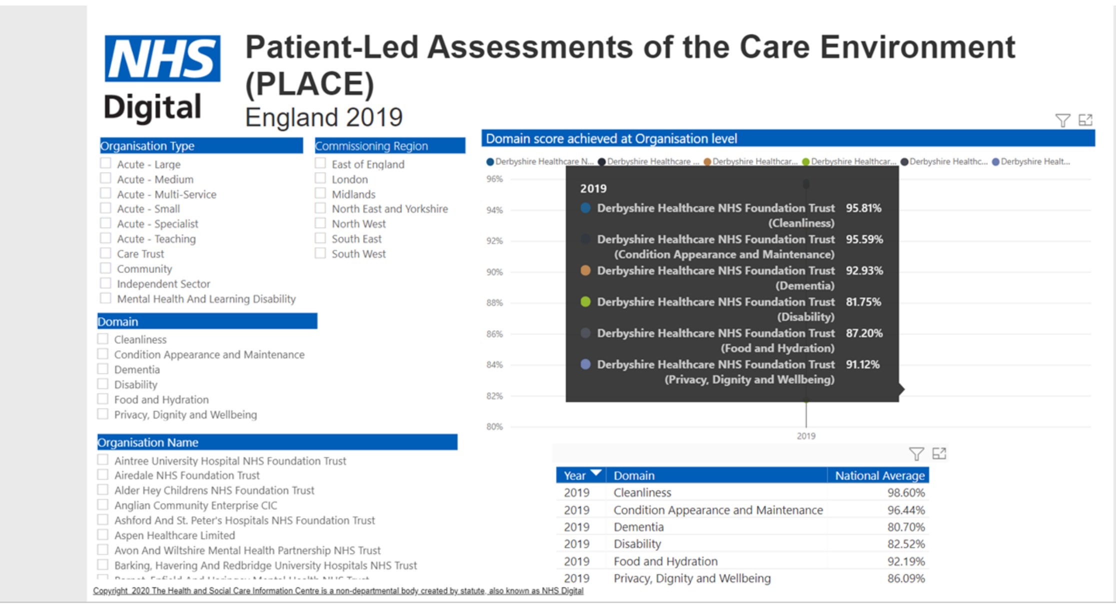
4.11 The CQC have feedback through their IPC health check report and also thorough mental health act visits that they are satisfied with the approaches being taken by the Trust. This is in addition to the inspection report which saw the Trust's rating improve to Good in February 2020.

4.12 This year, we have identified new Infection Control Link Nurses and are developing an enhanced programme to improve the skill set and impact the link workers have within their respective clinical teams.

5. Assurances

5.1 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 this year's PLACE inspections. The highest standards and greatest cleaning services input are delivered in inpatient wards and patient facilities.

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



Year	Domain	National Average
2019	Cleanliness	98.60%
2019	Condition Appearance and Maintenance	96.44%
2019	Dementia	80.70%
2019	Disability	82.52%
2019	Food and Hydration	92.19%
2019	Privacy, Dignity and Wellbeing	86.09%

The food score for the 2019 was the only area below national average. However, we remain conversely proud that the reason is not one of quality.

The comment from the Estates and Facilities Manager sums up the reason that the score is reduced;

"Food and Organisation Food section - this is not the food that patients eat (Ward Food section). This section is about things such as, having a cooked breakfast every day, if we serve hot desserts at every main meal and do patients receive snacks three times a day. Things like having a cooked breakfast every day, hot desserts at each main meal we do not do, or three snacks, this is at the choice of the patients, clinical staff and dieticians and is

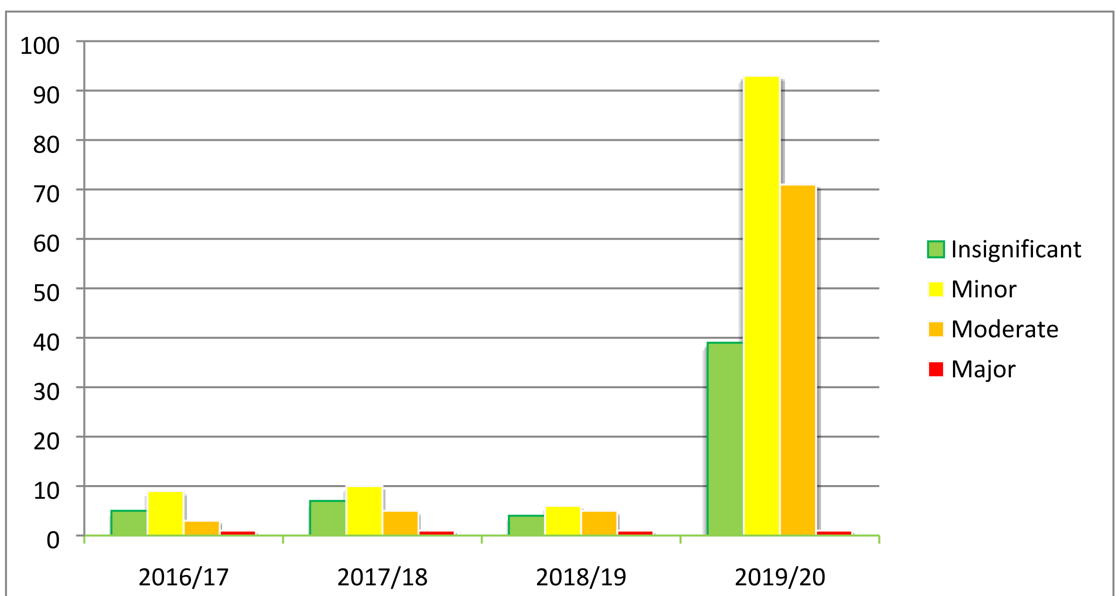
a considered choice to promote a healthy diet. We hope that following the National Catering Standards release, PLACE will alter these questions. We have given feedback in regards to this previously. We also lose marks for not having an 'a la carte menu' - a 24 hour menu that never changes and the patients can pick from 16 or so choices for each course. For patients that are in hospital for several days or more this very quickly becomes repetitive. We operate a four week menu which gives a much larger variety but impacts upon our scores. I do raise this annually as well and it was pleasing to hear that the Dietetic Association have also been raising this."

5.2 The Heads of Nursing rounds have continued to provide assurance of key standards in the inpatient wards, where on a twice yearly basis, representatives from Infection Control and Hotel Services join the Heads of Nursing to inspect the clinical areas from an environmental quality perspective. In 2019, the Acute wards at Radbourne and Hartington Units benefitted from the appointment of two Clinical Matrons covering each respective area. They provide a proactive and engaged oversight of way of their respective environments, anticipating maintenance and quality issues at an early stage (and ensuring action is taken) and also the opportunity to seek informal feedback from patients on the wards as to the comfort and cleanliness of the wards. Following on from last year's report, this has seen a significant increase in the oversight of IPC and cleanliness in these areas.

5.3 Healthcare associated infection (HCAI) surveillance demonstrates our performance, as reported to the Commissioning organisation. 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.

Table summarising infection control incidents recorded on DATIX:

The significant rise in reporting relates to COVID-19 related concerns. DATIX now has a category for COVID-19 related matters as our reporting framework has evolved.



5.4 During 2019/20, there has been 1 ward closure as a result of diarrhoeal illness (suspected Norovirus). This was very short in duration and once identified, no new cases arose within the 48 hour monitoring period.

All infection control issues are reviewed and there have been no outbreaks of MRSA bacteraemia and 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.

5.5 Clinical audit specifically to infection control is focussed on two key areas during the year:

- Infection control general standards (hand hygiene, sharps, decontamination equipment). Thematic review of the general infection control audit saw areas of work needed in regards to the storage of equipment. There has been a focus upon maintaining clutter free environments within clinic spaces.
- Last year an audit of toy cleaning highlighted some challenges for the clinical team in evidencing after each play contact that toys had been cleaned. This has been amended in the current protocol to show that toys

are being cleaned in accordance with the policy and this is recorded weekly.

- Hand hygiene audits are being undertaken across the organisation and the light box and dye are utilised to good effect.

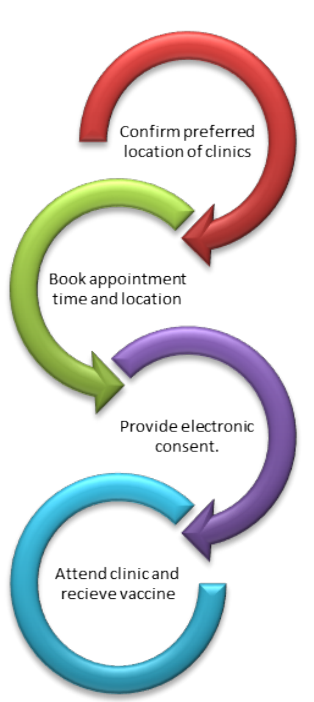
5.6 Clinical compulsory training continues to take place for those staff who are required to attend, as identified as part of the training framework and administrated via the training passport system. Compliance is monitored via the Physical Health Care and Infection Control Committee at a strategic level, and attendance is managed by each of the Divisions. Frequency of attendance is currently agreed as every 3 years, and these are largely taught sessions via the 'block training' method.

5.7 An influenza vaccination campaign was delivered for staff and patients who met the criteria. The final staff uptake figures significantly increased to 71.9% in 2019/20 (was 54% in previous year).

As in previous years, we adopted a Peer Vaccinator model for the majority of vaccinations provided. For the 2020/21 campaign we are taking a significantly different approach and setting up more IPC and COVID secure compliant focus. Whilst the Peer support model remains central, the approach is to give attending colleagues assurance that they will be vaccinated in a COVID secure environment using a no touch point method, no paperwork (virtual registration, socially distanced queuing and PPE for attendees and vaccinators.

The target set by the organisation is 90% this year and it is anticipated that we will meet this target.

The following outlines the approach being developed for this year's flu approach:



- The experience gained during the national level 4 incident in regards to antigen and antibody testing clinics has seen rapid learning to realise IPC compliant and efficient clinic models which:

- Identify likely numbers per location via an online survey – Being rolled out (21/08/20)

- Pre-book appointments to allow clinics to match demand. In development for launch early September.

- Virtual registration and consent process to manage IPC concerns / streamline process.
- Allocated vaccine awaiting colleagues on attendance. Clinics starting as vaccines arrive.
- Support Vaccinators to manage capacity and demand and rapid administration of vaccines.
- The Trust will utilise its social media platforms (Facebook, Twitter, LinkedIn) and Communications team to ensure colleagues are aware of how and when to book into clinics.
- The Communication strategy for 202/21 is intentionally simple; the focus is on ease of access, safe attendance and administration – the visual campaign is simply the arm of a Health Care Worker ready to receive their vaccine.

5.8 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. Pest Control contractors call outs have reduced this year and the estates and facilitated department have arranged for replacement bins and refuse collection vessels to reduce pest control incidents.

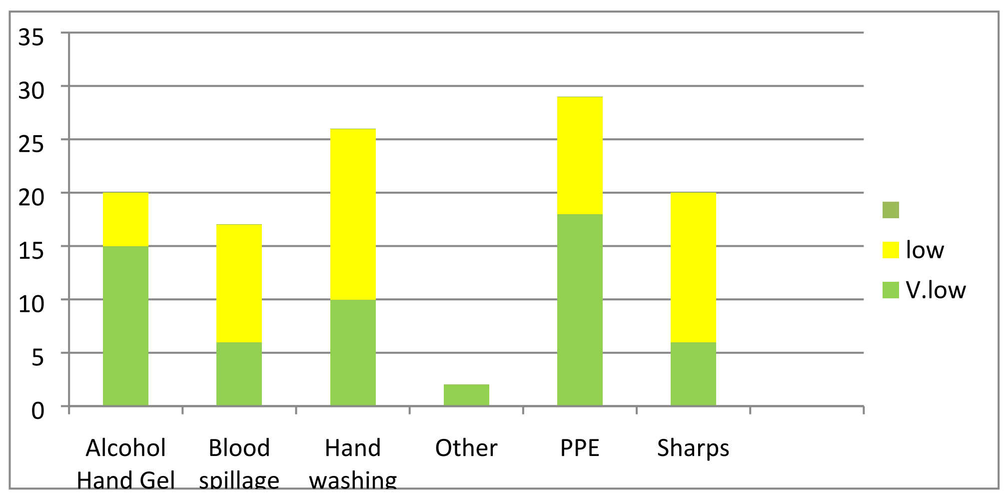
Planned inspections of kitchen areas taking place as a preventative measure measures this year and the Estates team have been very proactive in dealing with the small number of incidents reported in order to ensure that issues are addressed quickly and effectively to maintain confidence from the people who access and work with our services.

5.9 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

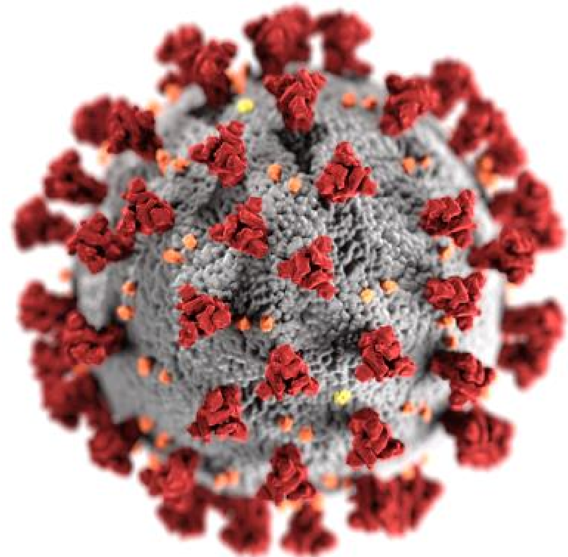
with focussed prevention of Legionella and also other issues with potable water such as Pseudomonas.

5.10 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 a number of 'required' risk assessments that wards/teams must complete and review at least annually.

There are currently 114 risks on DATIX relating to infection control, all of which are currently rated as low or very low risk (**see table below**)



6. Coronavirus Level 4 pandemic



6.1 During early 2020 the emergence of the Novello-Coronavirus Wuhan strain was recognised and by March 2020 the NHS had entered level 4 pandemic with significant changes to service delivery and the implementation of significant measures to reduce the spread of the virus and protect NHS emergency services to enable them to cope with the international outbreak.

The Trust has taken significant steps and had to provide assurances to the CQC that we were managing the impact of the outbreak in the best way possible for patients and colleagues at DHCFT. This work has been overseen by the Incident Management Team which was implemented in late February 2020.

6.2 The Trust has taken a significant number of actions since the outbreak and the rapidly emerging and changing picture and guidance meant that we required and implemented a strategic and tactical group (GOLD Command) within the Incident Management Team to co-ordinate with other groups to monitor and manage Infection and Prevention Control approaches as well as Personal Protective Equipment procurement and guidance.

A summary of our interventions was reviewed by the CQC ,who were satisfied with no additional recommendations in regards to the approaches being taken by the trust. The questions posed by the CQC and the responses provided during interview are summarised here;

1. Has the Trust's Board of Directors received or carried out an assessment of the infection prevention and control procedures and measures in place across all services since the COVID-19 pandemic was declared? Does this include an assessment of the estate/isolation facilities?
In response to the COVID-19 pandemic Derbyshire Healthcare NHS Foundation Trust (DHCFT) has completed individual infection control risk assessments for each inpatient area and community setting. These risk assessments have been collated together and monitor regularly for oversight and assurance. Furthermore, an Infection Prevention and Control Management checklist has been put in place in all inpatient areas to ensure adequate availability of PPE which is linked to the daily PPE stock returns and deliveries. In order to ensure the working environment is "COVID secure" the Trust Estates department has completed an environment review for all DHCFT settings, including community and inpatient. These have set out to ensure the environments are safe for patients, staff and any others using these settings. For clinical inpatient areas, cohorting procedures have been implemented to ensure a minimal risk of transmission of COVID-19 from one patient to another and furthermore, to enable staff to monitor and manage the spread of infection. The NHSI/E BAF tool has been received by Public Board twice and submitted to the CQC with additional data and outcomes. In addition, each Quality and Safeguarding Committee receives a COVID incident management up-date. These have been supplied.
2. Are there systems in place to manage and monitor the prevention and control of infection? Do 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?
In order to monitor infection control rates, the Trust has implemented a daily report

identifying any positive or suspected cases of COVID-19 which is reviewed by the Incident management team and local areas on a daily basis. In addition existing monitoring process are in place to monitor flu, CDIFF, MRSA, Norovirus, etc. to also monitor none COVID-19 related outbreaks. Any outbreaks will continue to be monitored through existing escalating procedures.

For those patients that are highly vulnerable or have significant physical health comorbidity, we have reviewed screening tools and the Trust has a process for referencing the national database both shielding and elevated risk to monitor our most vulnerable patients.

There have also been cohorting processes put in place to ensure vulnerable patient are cared in the least risky environments.

Dormitories have been reviewed the 2m rule applied and reductions in beds. Bed usage are monitored daily.

Furthermore, regular and routine screening for COVID-19 is in place for all patients, at the point of admission, 5-7 days post admission, following any period of leave and any transfers between clinical environments. If a case is identified, then an area would cohort swab all staff and patients for that area. Escalation would also been completed with Public Health England, using appropriate national templates.

- SOP created and in place regarding IPC
- Risk assessments created and in place relation to cohorting - with designated wards
- COVID care plans
- Capacity for isolation and shielding along with additional care plans / support guides in this area.
- Paris vulnerable patients checklist with assurance reviews of this
- Inpatient bed management reporting system - live data
- Breakout management report – Live data
- Encouraging isolation for any symptoms from staff - paying bank rates and protecting pay
- PPE process for all clinical and none clinical areas
- Category A and B staff working from home or in low risk areas
- BAME risk assessment and adaptations
- At risk health risk assessments and adaptations
- Clear testing guidance for staff and patients.

3. Are there systems in place to provide and maintain a clean and appropriate environment in managed premises, facilitating the prevention and control of infections?

Since the start of the outbreak, changes were made to the frequency and extent of cleaning to include the standard use of the cleaning agent Acti-chlor.

Cleaning review by the Director of Infection and Control.

Targeted increases in ward areas and shared bathrooms.

Significant investment until November and March 2021 (depending on the management of the pandemic). Additional staff have also been introduced into the Estates and Facilities roster to enabled increased frequency and visibility of cleaning.

A deep clean team is also available when required 24/7.

COVID secure guidelines – room assessment. Measurements and room occupancy guides are all undertaken and in place. Working from home guidance and review. New technology - Attend Anywhere and Teams.
4. Is there appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance?
The Trust monitors the use of antibiotics and is represented at the regional AMR group. We report to the CCG quarterly and there are trackers in place through our Pharmacy team and Medicines Management Committee in relation to anti-biotic use. We have always seen low use in the Trust by virtue of the clients we typically work with. Our Chief Pharmacist supports our organisation and the programme and is able to provide full details if required. This was reviewed by the CQC in 2020 and you commented positively on this work.
5. Does the Trust provide suitable accurate information on infections, in a timely way, to service users, their visitors and any person concerned with providing further support or nursing/medical care?
All patients are made aware of any results relating to infection, within a variety of communication formats and with appropriate levels of support. Derbyshire Healthcare NHS Foundation Trust has a designated COVID-19 page on the Trust internet and intranet sites with all updates available and any changes to service during the pandemic. - Designated COVID page on the Trust website - Daily brief and emails - IMT - Patient meetings with updated information - Letters - Posters - Care plans - Vulnerable patient checklist - Visitor guidance - Visitors leaflet - Pre-booking visiting confirms the ward status - PPE available to visitors in all areas - Introduction of admission ward - Trust Board data and quality reports - Information sharing with CCG, Safeguarding Boards and partners including Public Health.
6. Is there a system in place that ensures prompt identification of people who have, or are at risk of developing an infection, so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people?
An EPR system has been developed to flag testing status and history.

Evidence of this is apparent in our inpatient and community settings.

An audit of this and postcode monitoring of any cases is in roll out learning from Leicester.

Alert system in place

Ward signs

A variety of screening tools such as MUST, Waterlow, physical health questionnaires, baseline observations and the use of an early warning score system are used across the Trust. Medical colleagues will also assess for acute kidney infection, review baseline bloods for infection markers and arrange any further investigations.

7. Are there systems 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?

No access to wards without an induction and assessment if required work remains in place.

Universal infection control measures such as hand washing and hand sanitisation are available at reception areas, for all Trust facilities, access to face coverings or where required PPE.

Contractor induction also includes the appropriate use of PPE include Trust expectation, procedures and national guidelines. Donning and Doffing areas are identified across the Trust within appropriate areas as required.

- PPE guidance
- SOP guidance regarding symptoms
- SOP regarding new admissions and isolation
- SOP regarding contact and managing time off wards
- Management of open wards to increase oversight of people in and out and encouragement of IPC guidance
- PARIS guidance and high risk patients

Bank induction requires - shadow shifts

Agency requires – shadow shifts

All volunteers – working from home or not in areas - this was reviewed at the end of July 2020.

8. Are there secure or adequate isolation facilities?

Each clinical area has a Standard Operating Procedure related to its management of COVID cases and also the protection of patients who are assessed as being at higher risk based upon their physical health determinants. Cohorting arrangements are in place and evidenced in your visit to Cubley Court Mental Health Act.

The Trust has established principles for cohorting as outlined in this diagram;

New admissions, repatriations of suspected cases from clear areas

- Test and await result
- Nurse in isolation until confirmed

Move patient to appropriate setting.

Confirmed area

- Confirmed cases only
- Single room or cohort area with +ve cases (individual needs assessment).
- Step down when clinically appropriate.

Clear tested area

- Single sex mix reviewed / risk assessment depending upon case numbers.
- COVID-ve environment with testing for return from leave.
- Ward operation as normal with IPC and PPE guidance as per national guidance.

Considerations

- PPE in use in all clinical areas
- Patients and visitors to be offered face coverings.
- Promotion of hand hygiene for all.
- Clear access to testing available.

9. Is there adequate access to laboratory support?

The Trust has a regional agreement relating to access to laboratory testing. This is facilitated by UDHB/CRH. The Trust regularly liaises with these areas to ensure there is adequate capacity in the system for all teams and organisations.

The Trust has been testing all patients on admission / repatriation, after 5-7 days, return from leave and if symptomatic.

All results on EPR for rapid access - with summary report

East Midlands and Derbyshire – one of the best rated areas for testing in NHSE/ I benchmarking.

Week commencing 20/7 we will move to routine weekly testing of all COVID-VE patients throughout their admission.

10. Is there evidence that the Trust has policies designed for the individual's care that will help prevent and control infections?

Trust policies for Infection Prevention and Control, Special Infection Prevention and Control measures, Cleaning and Decontamination support the teams and individuals caring for patients. Reference is made to the use of individualised care plans to discuss, document and communicate and persons care needs and management of infection prevention and control risks within inpatient areas and community settings,

including the person's home setting.

The following processes also reference the infection prevention and control standards:

- Risk assessments.
- SOPs.
- Shielding SOP.
- Health risk assessment.
- Working from home policy

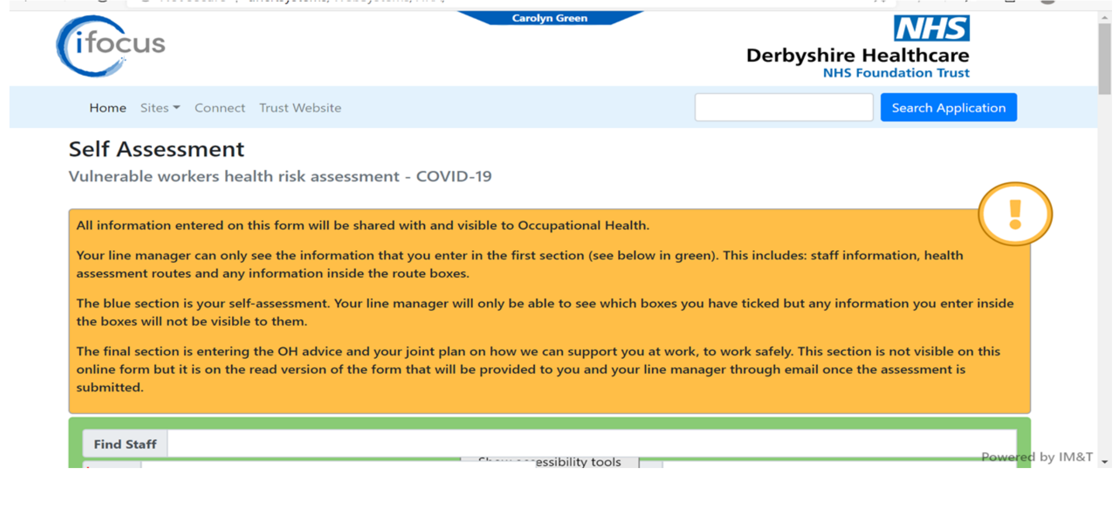
Documents are available at request.

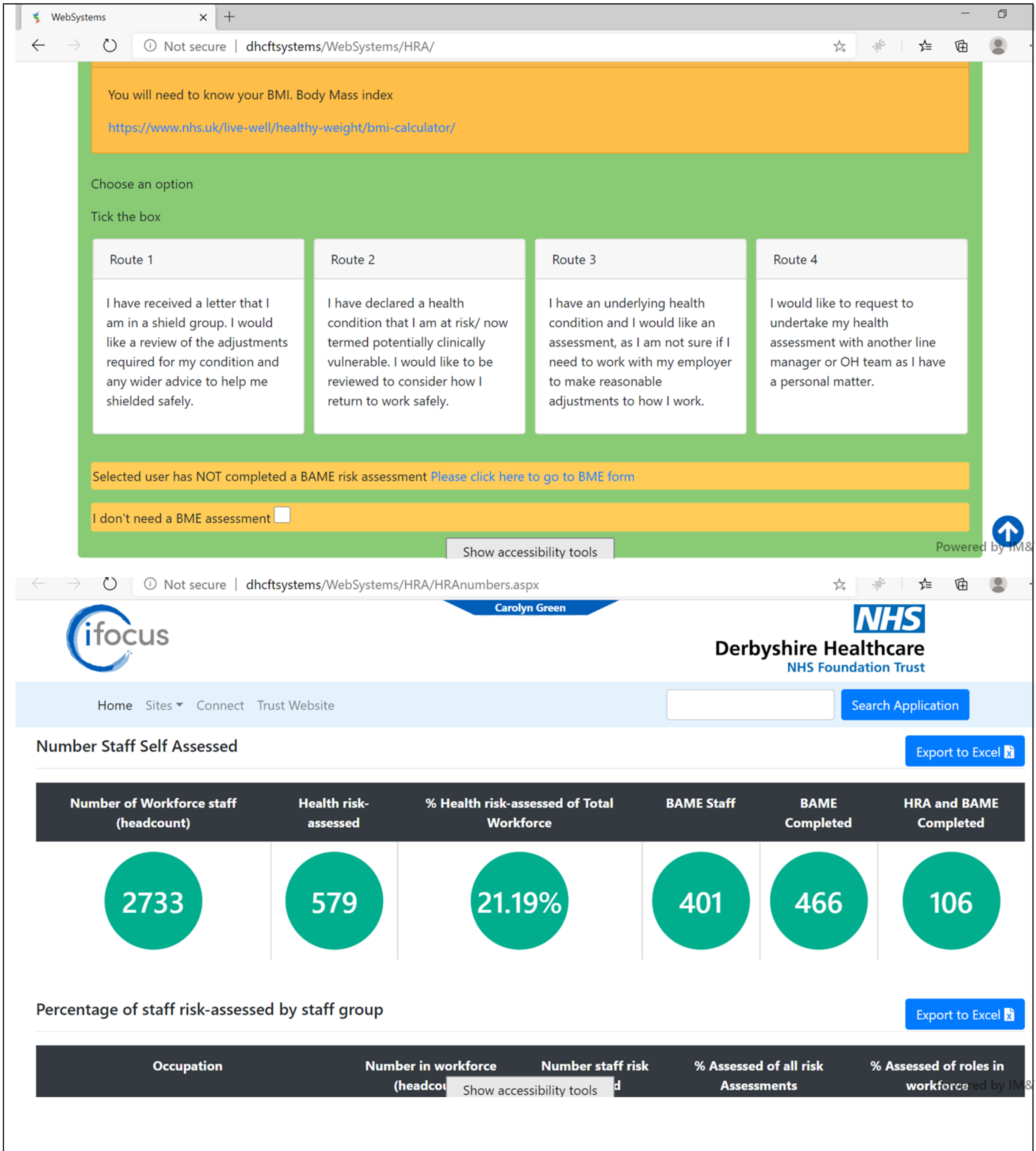
11. Does the Trust have a system to manage the Occupational Health needs of staff regarding infection?

The Trust has a contract with UDHB Occupational Health Services for the support of any health related support needs of its staff, including infection control advice and assessment.

Since COVID level 4 incident, the Trust has implemented the BAME and Health Base risk assessments which working with Occupational Health and an individual's Manager focuses on keeping every staff member safe and supporting them back into work where it is safe to do so and the staff member feels able to do so safely.

- Health risk assessment
- BAME risk assessment





6.3 As the Pandemic outbreak continues, we continue to operate within the Incident Management Team and ensure that service users and staff at DHCFT are in receipt of the most up to date evidenced based approaches and support.

7. 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 in emerging areas such as antimicrobial resistance.

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 health 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 in learning from COVID-19.

7.6 There is on-going support for the developmental work undertaken to meet nutritional standards by the Nutrition Steering Group. There remains a strong focus is on improving diabetes care and management, particularly pre-diabetes assessment and intervention as this is recognised to have a high comorbidity with COVID-19.

7.7 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. The trust has seen significant increases in the number of contracted staff working in our hotel services to deliver the enhanced cleaning requirements of COVID-19 secure services and IPC guidelines.

7.9 Increasing the number of IPC Link workers to support the additional work and physical health monitoring requiring during the pandemic and endemic related to COVID-19.

7.10 Increasing the access and availability of physical health monitoring equipment for clinical staff in community settings to improve both assessment and intervention for service receivers of the organisation. This will be coupled to robust cleaning schedules for the equipment to assure against IPC standards.

7. Potential risks in delivery

7.1 Operational support for the Infection Control Support Nurse role is pivotal in the ability to deliver the programme of work and level of clinical support and responsiveness needed to meet clinical demand.

7.2 The uptake of the 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.

7.3 Continued operational support to achieve compliance with compulsory training.

7.4 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.

7.5 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.

7.6 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.

Report prepared and submitted by Richard Morrow
Assistant Director of Public and Physical Health Care
1 September 2020

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 3 November 2020

Quality Report 2019/20

Purpose of Report

To present the version of the Quality Report / Quality Account for 2019/20, that is currently out for consultation following a revised timetable due to COVID-19, and to seek permission from the Board to delegate authority to the Quality & Safeguarding Committee to approve the final version for publication on 15 December 2020.

Executive Summary

To explain the revised timetable it will be helpful to clarify the difference between the Quality Report and Quality Accounts.

Quality Accounts are required by the Department of Health and Social Care (DHSC) and are controlled by legislation, which also sets out the consultation and submission deadlines. The Quality Report is a requirement set by NHS Improvement (NHSI) and is based on the Quality Account but has additional content, including mandatory assurance for foundation trusts (FTs) and a requirement to include both elements within the annual report and accounts document. Once prepared, the Trust's Quality Report also meets the definition of a Quality Account, so can be used for both purposes.

Due to COVID-19, NHSI have confirmed in their timetable letter and the revised FT ARM (Annual Reporting Manual) that there is no requirement for a Quality Report in 2019/20. This therefore means that there is no expectation for the Trust's external auditors to audit any elements, including the Council of Governors' chosen indicator. As work was well underway for our Quality Report, we continued to update this document for the purposes of the Quality Accounts and therefore this document continues to meet the requirements of a Quality Report (incorporating the Quality Account), aside from the external audits. Please also note that due to the competing demands of the COVID-19 response, the report has less additional information than it would have ordinarily but still meets the requirements and expectations of NHSI / DHSC.

Regulations making revisions to quality account deadlines for 2019/20 are now in force as a result of COVID-19. While primary legislation continues to require providers of NHS services to prepare a quality *account* for each financial year, the amended regulations mean there is no fixed deadline by which providers must publish their 2019/20 quality account. NHS England (NHSE) recommends that NHS providers adopt a revised deadline of 15 December 2020 for publication, in light of pressures caused by COVID-19. NHSE also recommends that draft quality accounts should be provided to stakeholders (for 'document assurance' as required by the quality accounts regulations) in good time to allow scrutiny and comment. For finalising quality accounts by 15 December, a date of 15 October was suggested, and so the Trust distributed the Quality Report for consultation on that date. The closing date for comments and feedback is 15 November, and so a final version, incorporating any requested amendments, could be presented at the Quality and Safeguarding Committee on 8 December, prior to publication on 15 December.

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

Assurances

- The report has been written in line with the expectations of the Detailed requirements for quality reports 2019/20 (NHSI), including the amended regulatory timeframes.
- Examples of best practice from clinical areas and the Quality Visit programme are also included, and provide positive assurance of the quality of care being delivered to our patients, their families and carers.

Consultation

The Quality and Safeguarding Committee has received earlier drafts, including the draft that has gone to external consultation. The report has been distributed as required, including to our Governors, colleagues at Derby and Derbyshire Clinical Commissioning Group, Derby City Council, Derbyshire County Council, and NHS England.

Governance or Legal Issues

The report has been written in line with the expectations of the detailed requirements for quality reports 2019/20 (NHSI), as revised for COVID-19.

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.

The report has been written in line with the specific and detailed expectations of NHSI. There are no specific elements of the report which may have an impact on those with protected characteristics.

Recommendations

The Board of Directors is requested to:

1. Note the update on the Quality Report/Quality Account for 2019/20 following a

revised timetable due to COVID-19.

2. Agree to give delegated authority to the Quality & Safeguarding Committee to approve the final version of the Quality Report / Quality Account for 2019/20 before submission

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

Report prepared by: **Darryl Thompson**
Deputy Director of Nursing and Quality Governance

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 3 November 2020

Month 7-12 2020/21 Financial Plan

Purpose of Report
This report focuses on the financial plan for month 7-12 which is in line with the system financial plan.

Executive Summary

The system financial plan for month 7-12 was submitted on 5 October with an aggregate deficit or 'gap' of £43m. Individual organisational plans were submitted on 22 October in line with that system plan. In response to regulator feedback, the system finance lead also submitted a letter outlining the system's current work around some potential mitigations for the £43m gap which at the time of writing total £25m.

Our organisation financial plan for month 7-12 generates an organisational deficit of £0.6m after a fair share of the system top up allocation and COVID allocation, along with funding from the growth allocation to cover MHIS investments. There are some costs that are included in the plan which are unfunded and are therefore the drivers for the deficit of £0.6m. This 0.6m deficit is included within the £43m gap.

There is system acknowledgement that the £43m deficit is a 'system problem to solve' irrespective of where that gap manifests itself in individual organisation plans.

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

Assurances
This report should be considered in relation to the Finance risk in the Board Assurance Framework.

Consultation

- The Executive Leadership Team (ELT) have considered drafts of the provider and system plan.
- Directors of Finance (DoFs) and Deputy DoFs have been challenging the assumptions and drivers of the system and provider plans, as they have been building them.
- Derbyshire Accountable Officers have been briefed by the System Finance Lead and Joined Up Care Derbyshire Board have discussed the plan and the associated financial gap.
- The Trust's Deputy CEO and Director of Finance has briefed committee and board members as the system financial plans and associated analysis have progressed
- A paper updating Executives and members of Finance and Performance Committee on the key components of the Trust submission has been circulated virtually ahead of its submission.

Governance or Legal Issues

There is a requirement from NHSEI to submit two plans: a system wide financial plan for month 7-12; and individual provider plans for the same period. Both sets of plans reconcile to each other and have been submitted to time.

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:

Equality, diversity and inclusion (EDI) issues affect our whole workforce. Workforce costs are 75-80% of our overall costs. Therefore they are a major part of the efficient and effective use of resources. EDI factors can have a negative or positive impact.

This report covers the entire Trust financial performance and does not focus on specific data that explores the relationship between EDI factors and financial performance.

Actions to Mitigate/Minimise Identified Risks

The Board are aware that primary actions being taken are to our people-first related actions such as:

- Investment in wellbeing offers to support workforce
- Improving recruitment and retention including our Recruitment Action Steering Group
- Trust Strategy refresh with updates to workforce-related building blocks and associated priority actions

- Workforce Race Equality Standard and Workforce Disability Equality Standard improvement actions

Inclusion strategy; further development and action planning.

Recommendations

The Board of Directors is requested to note the organisational financial plan for month 7-12 along with the progress on potential mitigations for the system gap and the approach to financial management for the second half of 2020/21

Report presented and prepared by:	**Claire Wright** **Deputy Chief Executive and Director of Finance** **Rachel Leyland** **Deputy Finance Director**

System financial plan

On 15 September NHSE&I published financial envelopes for month 7-12 2020/21. The envelopes comprise of:

- CCG allocations and at system level;
- System top up to bring the system to a breakeven position
- Additional growth funding
- Additional non-recurrent funding for additional COVID-19 costs, distributed on a fair share basis.

It is expected that systems deliver plans to achieve overall financial balance within the envelope; within that, organisations are permitted, by mutual agreement, to deliver a surplus or deficit position. For month 7-12 there will no longer be retrospective top ups and all system costs are to be met from the envelope, including additional COVID-19 related costs on primary care, mental health and community services and the delivery of Mental Health Investment Standard (MHIS).

However, rather than breakeven, the system financial plan was submitted on 5 October with a deficit/'gap' of £43m.

On face-value this sits primarily sits with one organisation within the system. Open-book peer review has taken place of forecast assumptions and further analysis has determined some thematic reasons for the gap, these include:

- Hospital Discharge programme costs and Enhanced care home support
- Non-NHS/trading income loss
- Phase 3/winter additional operational costs some being at premium costs
- Elective Incentive Scheme impacts

It should be noted that the system submission has not included costs for increased annual leave provision and also assumes provisions for WIP (work in progress) year-end will not increase.

The agreed approach was to submit individual plans that add up to the system gap of £43m but to include an accompanying letter from the STP Finance Lead on mitigations that could be available to close that gap further. The content of this letter was agreed by all Directors of Finance in the system and was also signed off by the Joined Up Care Derbyshire Accountable Officer

For illustration: the following is an extract from the letter that confirms the 'system' approach to closing the gap:

"In summary, each organisation has reviewed their financial position to identify mitigations and sensitivities that could result in an improved financial performance and a reduction in the £43.3m. Although the table shows the position by organisation, this is for reconciliation purposes only, as we agreed at the JUCD Board on 15 October that we would regard the overall allocation as "one pot of money" and seek to reduce the £43.3m unencumbered by the notional allocations to individual organisations. Although, therefore, the residual financial imbalance sits predominantly in one organisation, there is an understanding (and Chair and CEO mandate to acknowledge,) this is everyone's problem to solve."

(See later section for description of Trust potential mitigations.)

System representatives meet with NHSIE on 29 October in the regular System Review Meeting where regulator response to the plans submissions will be further discussed.

Provider Plans

Provider plans were submitted on 22 October 2020.

Our plan is based on the same values that were submitted in the system plan and generate a deficit of £611k which equates to 0.7% of turnover. See summary table below.

Statement of comprehensive income	Plan 31/10/2020 Month 7 £'000	Plan 30/11/2020 Month 8 £'000	Plan 31/12/2020 Month 9 £'000	Plan 31/01/2021 Month 10 £'000	Plan 28/02/2021 Month 11 £'000	Plan 31/03/2021 Month 12 £'000	Plan 31/03/2021 Year Ending £'000
Operating income from patient care activities	13,364	13,364	13,364	13,364	13,364	13,365	**80,185**
Other operating income	553	553	553	553	552	552	**3,316**
Employee expenses	(10,297)	(10,137)	(10,137)	(10,120)	(10,122)	(10,182)	**(60,995)**
Operating expenses excluding employee expenses	(3,354)	(3,327)	(3,286)	(3,355)	(3,381)	(4,542)	**(21,245)**
OPERATING SURPLUS/(DEFICIT)	**266**	**453**	**494**	**442**	**413**	**(807)**	**1,261**
FINANCE COSTS							
Finance income							**0**
Finance expense	(181)	(175)	(181)	(180)	(164)	(181)	**(1,062)**
PDC dividends payable/refundable	(135)	(135)	(135)	(135)	(135)	(135)	**(810)**
NET FINANCE COSTS	**(316)**	**(310)**	**(316)**	**(315)**	**(299)**	**(316)**	**(1,872)**
Other gains/(losses) including disposal of assets	0	0	0	0	0	0	**0**
SURPLUS/(DEFICIT) FOR THE PERIOD/YEAR	**(50)**	**143**	**178**	**127**	**114**	**(1,123)**	**(611)**

Key assumptions:

Income from patient care activities

- Derby and Derbyshire CCG block contract value of £60.88m,
- £3.1m for the PYE of the MHIS investments. These investments relate to the FYE of 2019/20 investments plus new investments for 2020/21. To note this does not include funding for IPS service as that is funded from Transformation monies which is included in the system plan.
- System top up income of £731k, based on the split from NHSEI
- COVID top up income of £4.2m based on the average of month 4 and 5
- NHSE income of £3.5m based on block contract values
- Local Authorities income of £7.7m based on agreed contract values

Other income is based on the forecast assumptions at month 5 and is in line with month 1-5 run rates.

Pay and non-pay costs were based on the month 5 forecast. These include an assumption for COVID costs running at the same levels as the average of the prior two months, as this is in line with the COVID top up income.

Pay expenditure is broken down into substantive, bank and agency across various staff groups. The reporting of costs to the staff group level is based on an apportionment of costs at month 6.

There is a requirement to record efficiencies that have been generated in month 7-12. Within the pay category savings of £564k have been identified in the submission in relation to E Roster, which is based on the draft budget that has not yet been allocated, along with £420k of travel savings which is based on the average spend since lockdown compared to the average for previous years.

The capital plan is based on the resubmission of the capital plan in July totalling £8.7m. It is important to note that £2.5m of this relates to schemes that are included in the current dorms capital bids (Tissington, single room and Psychiatric Intensive Care Unit (PICU)).

Cash at the end of the financial year is forecast at £24m. Cash levels are £42m at the end of September. The reduction in cash by year end is due to: the full capital spend of £9m plus Public dividend capital (PDC) dividend to be paid later in the financial year of £2m and the release of the deferred income from CCG block payment advance payment of £10m.

The plan in the financial ledger will be updated to reflect this plan submission and reporting from month 7 onwards will report actuals against the updated plan.

Other supporting information

Deputy Finance Directors in each organisation have been working closely on a weekly basis to share and review each organisation's forecast / plan assumptions, particularly around COVID costs to date, drivers of the forecast positions, changes in run-rate between H1 (first half of the year) and H2 (second half of the year) and any potential mitigations to improve the system plan.

For us the key drivers in our forecast deficit of £0.6m compared to the original NHSEI calculation are shown below:

	Intra-System Blocks	Block Income From Outside Of System - CCG	Block Income From Outside Of System - SpecComm	Block Income From Outside Of System - DC	Income From Outside Of System - Other	Expenditure	Initial Surplus Deficit
Plan	**60.9**	**0.0**	**2.2**	**1.3**	**13.1**	**-78.2**	**-0.7**
24/7 helpline not funded in growth allocation of £3.1m						-0.2	-0.2
IPS funding from SDF not in growth allocation of £3.1m						-0.1	-0.1
Dorms Capital bids revenue impact						-0.4	-0.4
Impairment						-0.3	-0.3
Other					0.0	0.6	0.6
Catering income					-0.1		-0.1
STP hosting (Workforce funding received month 10 and charged out)					-1.9	1.9	0.0
Forecast	**60.9**	**0.0**	**2.2**	**1.3**	**11.1**	**-76.8**	**-1.3**
Variance	**0.0**	**0.0**	**0.0**	**0.0**	**2.0**	**-1.4**	**0.6**

The changes from the H1 to the H2 run rate for us are summarised below:

	H1 £m	H2 £m	Change £m	Change %
Pay	9.7	10.2	0.5	5.3%
Non Pay	3.6	3.9	0.2	6.3%
Total Cost	**13.3**	**14.0**	**0.7**	**5.6%**

The main changes impacting in H2 relate to:

- MHIS investment for two services starting from October: Older Adult Crisis and Community Forensic
- Revenue expenditure related to the dorms capital bids, in month 12
- Impairment related to Tissington works, included in month 12
- Full recruitment of 24/7 helpline, additional cleaners and recruitment assumptions in the second half of the financial year.

Our mitigations to date

The proposed mitigations for us are shown in the table below along with a (RAG) Red Amber Green rating on risk of delivery.

DHcFT Summary mitigations for H2 plan		
	(Surplus)/deficit	**Mitigation Risk Rating**
Forecast H2 shortfall	**0.6**	
Mitigations		
Slippage on recruitment	-0.3	Amber
Impairment	-0.3	Amber
Deferred income release	-0.2	Red
Total mitigations	**-0.8**	
Revised H2 position post mitigations	**-0.2**	

Mitigation: 'Slippage on recruitment':

There has been some peer challenge about organisations' assumptions of achieving the H2 recruitment plans (and therefore incurring the associated increased pay costs) due to the potential for non-availability of additional workforce. Therefore most organisations have put in a mitigation related to slippage on recruitment.

Whilst there is potential for slippage on recruiting to our new services and all vacancies, as a Trust we are acting to optimise recruitment and are using bank and agency, therefore only £0.3m felt a reasonable level of slippage. This will be kept under review.

Mitigation: 'impairment':

Works on Tissington House have commenced but it may not be completed in full when the valuation takes place and therefore the previous anticipated impairment may not be required in the current year.

Mitigation:' Deferred income release':

In addition as discussed at Audit and Risk Committee there is work progressing to review our deferred income, so there is a potential of some income to be released.

In aggregate, should our mitigations be realised they will take us to a better than break even position of £0.2m surplus. This will support the overall system position.

In total, at the time of writing, there were potential mitigations across the system that reduce the £43m by £25m, thereby leaving a revised 'gap' of c£18m.

Forecasts will be regularly reviewed by all parties in the system so that the most up to date view of mitigations and sensitivities are maintained.

It should be borne strongly in mind, that the delivery of the planning assumptions will almost certainly be impacted by the second wave of COVID-19.

With regard to the oversight of Trust performance against the month 7-12 plan, the Trust Board will be updated on actual performance within the Integrated Performance Report and in detail at Finance and Performance Committee. The Board Assurance Framework Risk will be reviewed as informed by this performance.

From a system perspective; the System Finance Oversight Group, chaired by Richard Wright will consider the H2 planning and mitigations from a strategic perspective. The system Directors of Finance supported by their Deputies will continue their open book overview and management of the system financial performance.

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 3 November 2020

Workforce Race Equality Standard (WRES) 2019-20

Purpose of Report

To update the Trust Board on progress with the work on the 2019-20 Workforce Race Equality Standard (WRES) for information and discussion.

Executive Summary

The WRES has nine evidence-based indicators focusing on the experience of Black and Minority Ethnic (BME) colleagues in the workplace. The WRES is in its sixth year of implementation, and shows there is considerable work to be done to address the variations in recruitment, opportunities for progression and development and working conditions for people from a BME background.

The WRES Report and Action Plan 2019/20 (Appendix 1) has been published on the Trust's public facing website in line with the deadline, after being reviewed and approved at People and Culture Committee on 22 September 2020. For a visual summary of this year's data, please refer to the WRES infographic (Appendix 2).

The Trust's approach throughout previous submissions has been to focus on engagement through the Staff Networks and action planning processes in order to drive long term change.

The data shows that we have been seen a very positive change in the indicator on disciplinary processes and we will continue to focus on this indicator through the work to be done in establishing Just Culture.

The data shows that much more needs to be done to significantly impact all indicators. The next part of our journey will be to establish inclusive decision making, create pathways for talent and for embedding EDI at the heart of our systems, processes and plans and for celebrating cultural difference.

A new people operating model has been developed and that presents an integrated inclusive process for developing strategy and plans and for overseeing delivery. Colleagues from our network groups will be part of the new meeting structure.

We will develop a new people strategy with a dedicated focus on Equality, Diversity and Inclusion. We are approaching it this way as we acknowledge that to achieve our ambition we have to align all parts of the People Strategy to EDI as well as having a dedicated and focussed chapter specifically setting out our EDI ambition.

We will be embedding inclusive participatory decision making in IMT. This initially will incorporate BME staff so that we can reduce health inequalities where they have been identified. We will then extend this to embrace all diversity.

We will embed cultural intelligence so that we develop our people at all levels to be:

- A place where people are proud to work and grow
- People first leadership
- An inclusive vibrant culture for all
- A healthy place to work and thrive

We will also, following the success of our immersive Black History Month celebration, develop a highly engaging programme of events that embrace all diversity across the twelve months of the year.

Taking the learning from the work done to create Recruitment Inclusion Guardians we will be creating a talent proposition to bring inclusive decision making and approach to people embedded within divisions of the organisation.

These areas will be developed further for People and Culture Committee as part of the WRES Action Plan.

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

Assurances

- NHS organisations had to submit the WRES dataset to NHS England by 31 August 2020. The submission for DHCFT was completed on 26 August.
- Iterations of the WRES report and action plan have been discussed with the BME Network, the Equality Forum, the Executive Leadership Team and the People and Culture Committee. The final iteration was reviewed and approved by the Committee on 22 September for publication by 31 October 2020, the deadline.
- Amendments have been made to the action plan based on the feedback from each of the groups above, including the addition of more targeted actions to address the high rates of bullying and harassment of BME colleagues.
- The Trust has signed up to the national WRES Experts programme to facilitate best practice and guidance.
- The WRES is performance managed through the Equality Forum which has trust-wide membership and is part of the governance structure and sub-group of the People and Culture Committee.

Consultation

- Consultation has included engagement sessions with the BME Network, which forms part of ongoing engagement to ensure that the action plans remain effective throughout the year.
- The datasets, reports and action plans have been reviewed by the Equality Forum, the Executive Leadership Team and People and Culture Committee.

Governance or Legal Issues

- WRES reporting is a mandatory requirement of the NHS Standard Contract. The Trust was required to submit the WRES dataset to NHS England by 31 August and publish the report and action plans on the public-facing website by 31 October.
- Undertaking the WRES demonstrates the Trust's commitment to the Equality Act 2010 and Public Sector Equality Duty.

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.

The WRES is a set of indicators related to the workplace experience of staff from a BAME background compared to white staff. The differential impact is evidenced through the indicators; they capture ethnicity data and identify the disparities.

The indicators support the Trust to identify and target actions to close the gaps. Consultation has been carried out with colleagues in the BME Network on whether the data evidenced in the indicators is a true reflection of their lived experience and has supported engagement to create effective action plans.

Monitoring the WRES data allows the Trust to assess the impact of targeted actions and ensure that they remain effective, and is essential to improving the experiences of staff at Derbyshire Healthcare to create a more 'positively inclusive' culture.

Improving the indicators in the WRES assists the Trust in meeting its duties as set out by the Equality Act 2010.

Recommendations

The Board of Directors is requested to:

1) Consider and discuss the strategic implications of the WRES 2019/20.
2) Consider a review of the Inclusion Strategy to create the leverage and improvements that the Trust is expecting.
3) Consider that as part of the strategy review we will develop our approach to inclusive leadership and embed Cultural Intelligence throughout our organisation.

Report presented by:	**Jaki Lowe** **Director of People and Inclusion**
Report prepared by:	**Jaki Lowe** **Director of People and Inclusion** **Clare Meredith** **Equality, Diversity and Inclusion Advisor**

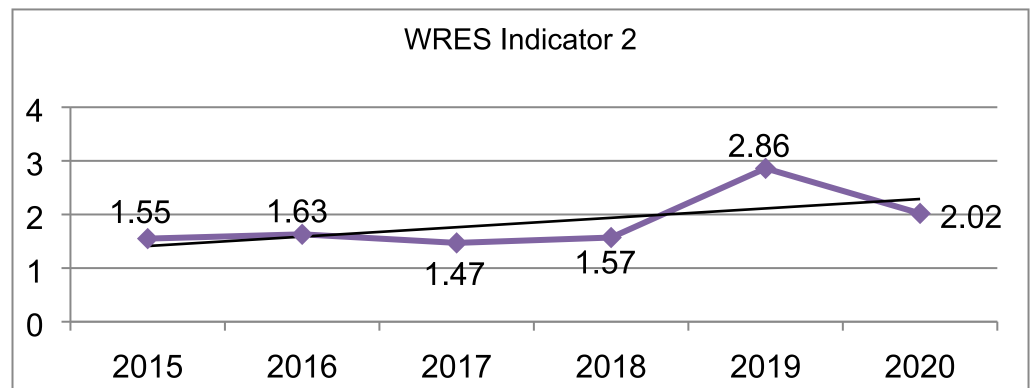
Appendix 1: WRES Report and Action Plan 2019/20
Appendix 2: WRES Infographic 2019/20

Workforce Race Equality Standard (WRES) 2019-20

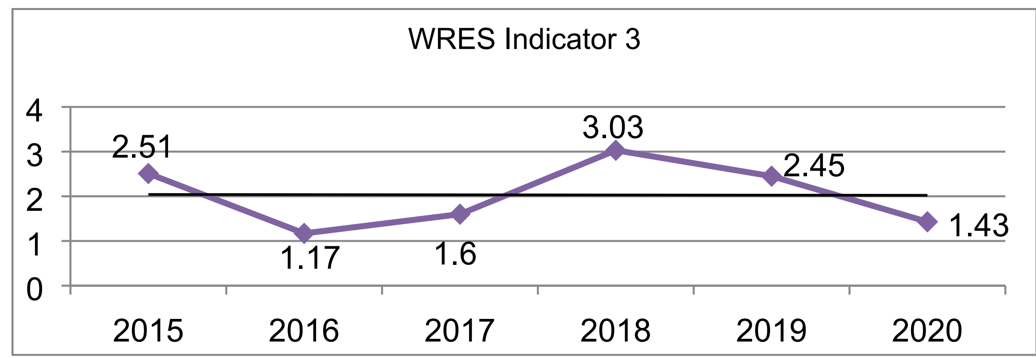
Key Headlines

Below are the key headlines from this year's data showing the underlying performance since 2015, shown with a trend line in each of the charts. Engagement with the Trust's BME Network has also spotlighted these indicators as being the most representative of our colleagues' lived experience.

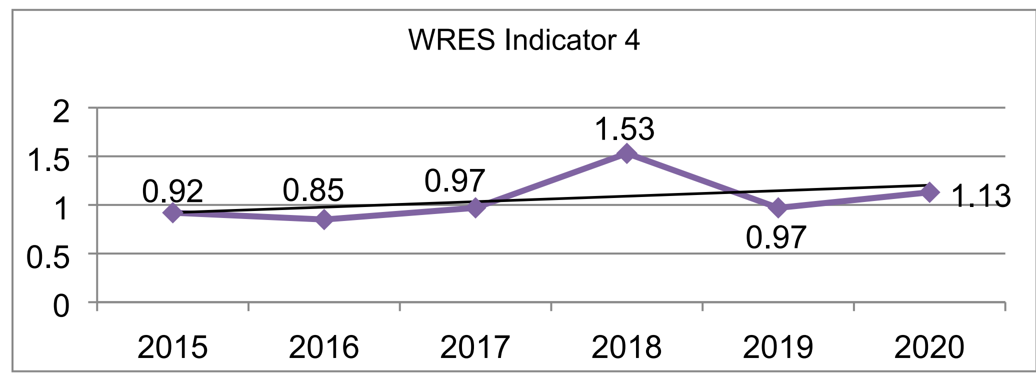
- **Recruitment:** White colleagues are 2.02 times more likely to be appointed from shortlisting compared to BME colleagues. This figure has reduced slightly from 2.86 in 2018/19 (WRES Indicator 2).



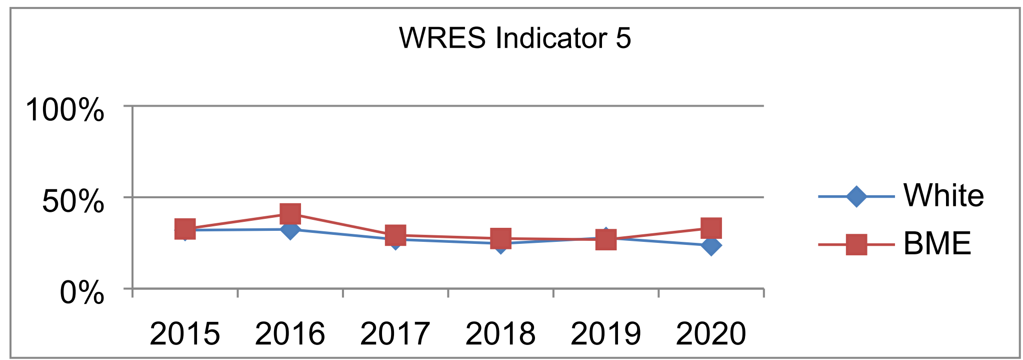
- **Disciplinary processes:** The relative likelihood of BME colleagues entering the formal disciplinary process has significantly improved from 2.45 times more likely in 2018/19 to 1.43 times more likely in 2019/20 (WRES Indicator 3).



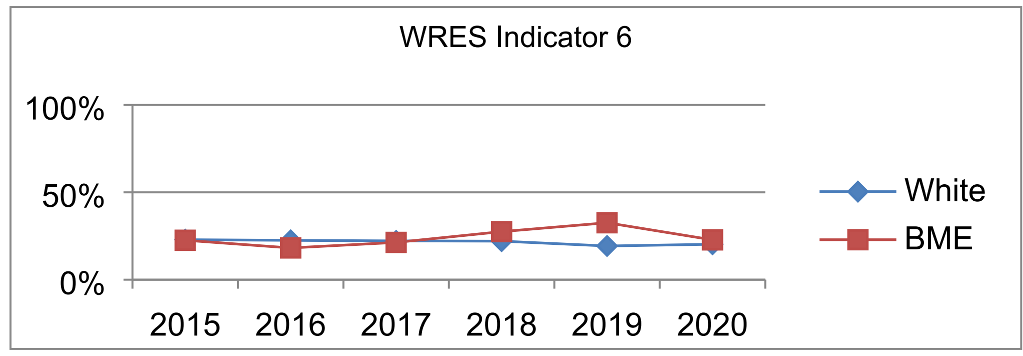
- **Access to training:** White colleagues are 1.13 times more likely to access non-mandatory training and CPD compared to BME staff in 2019/20, rising from 0.97 in 2018/19 (WRES Indicator 4).



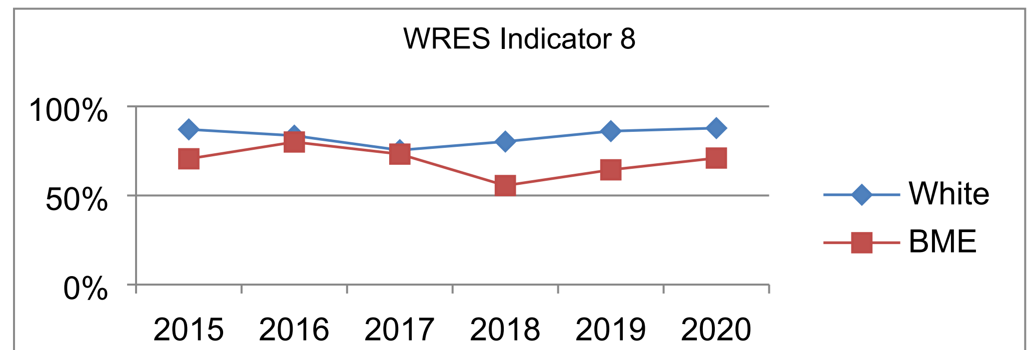
- **Bullying, harassment and abuse** in the organisation is still high:
  - 1 in 3 BME colleagues (33.1%) have experienced harassment, bullying or abuse from patients, relatives or members of the public in the last 12 months, compared to 23.7% of white colleagues (WRES Indicator 5)



  - Almost 1 in 4 BME colleagues (22.8%) have experienced harassment and abuse from staff; a reduction from 32.6% last year (WRES Indicator 6).



  - The percentage of BME colleagues who have personally experienced discrimination at work from their manager/team leader has decreased to 11.3% this year, but is still more than double that of white colleagues (5.4%) (WRES Indicator 8)


WRES Indicator 8
100%
50%
0%
2015
2016
2017
2018
2019
2020
White
BME

Workforce Race Equality Standard (WRES)

Annual Report and Action Plan

2019/20

Report publishing date: October 2020

What is the WRES?

The WRES is a set of nine mandatory indicators that enable the Trust to compare the workplace experiences of black and minority ethnic (BME) and white staff.

The WRES has four indicators specifically focusing on workforce data, four from the NHS Staff Survey, and one requiring organisations to ensure that their Boards are broadly representative of the overall workforce. It requires NHS organisations to close the gap between the workplace experience of BME and white staff for those indicators.

The main purpose of the WRES is to:

- Identify the gap in treatment and experience between white and BME staff;
- Allow Trusts to make comparisons with similar organisations on levels of progress over time;
- Enable NHS organisations to take remedial action on causes of ethnic disparities in WRES indicator outcomes.

WRES Report 2019/20

Detailed below is the organisation's WRES data which was submitted in August 2020 covering the period 1 April 2019 to 31 March 2020.

	2018/19	2019/20
Number of staff employed within Trust	2586	2672
Proportion of BME staff employed within Trust as at 31 March 2020	12.99% (336 people)	13.81% (369 people)
Indicator 1 Percentage of staff in each of the AfC Bands 1-9 and Very Senior Managers (VSM) compared with the percentage in the overall workforce	Please refer to Appendix 1	
Indicator 2 Relative likelihood of staff being appointed from shortlisting across all posts [A figure above "1" would indicate white candidates are more likely to be appointed from shortlisting]	2.86	2.02
Indicator 3 Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation Note: This indicator is based on data from a two year rolling average of the current year and the previous year. [A figure above "1" would indicate BME staff are more likely to enter the formal disciplinary process]	2.45	1.43
Indicator 4 Relative likelihood of staff accessing non-mandatory training and CPD [A figure above "1" would indicate BME staff are less likely to access non-mandatory training and CPD]	0.97	1.13
Indicator 5 Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or members of the public	BME: 26.8% White: 27.8%	BME: 33.1% White: 23.7%
Indicator 6 Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months	BME: 32.6% White: 19.3%	BME: 22.8% White: 20.3%
Indicator 7 Percentage believing that the Trust provides equal opportunities for career progression or promotion	BME: 64.4% White: 86.1%	BME: 71.0% White: 87.8%
Indicator 8 Percentage of staff who have personally experienced discrimination at work from their manager/team leader or other colleagues in the last 12 months	BME: 16.4% White: 5.4%	BME: 11.3% White: 5.4%
Indicator 9 Percentage difference between the organisation's Board voting membership and the overall workforce	-3.9%	+2.9%

Action Plan

This action plan was co-produced with members of the BME Network and senior leadership at the BME Network Annual Conference on 25 September 2019 and updated in July and August 2020.

Please note that this action plan is a live document that will be updated and amended throughout the year to ensure that the actions and outcomes remain effective in closing the gaps in racial inequality in our Trust.

Objective	Action/s	Timescales	Lead/s	Update (September 2020)	Position
WRES Indicator 1: Improve workforce diversity and representation.	Introduction of BME Inclusion target of 15% BME representation in each of the AfC pay bands across the Trust by 2028. Recruitment Action Steering Group (RASG) established in September 2019 to achieve greater diversity and improve workforce equality at all levels of the organisation. Actions identified: 1) Disruption of the interview panel with inclusion advocates; 2) Non-traditional interview process to meet diverse needs; 3) Adapting external and internal advertisement of posts to reach out to the local community.	Ongoing	Recruitment Action Steering Group: Suki Khatkar (Chair) Claire Wright (Executive Sponsor) + Representatives from People Services, BME Network and senior leadership.	1) 16 Recruitment Inclusion Guardians have been trained to take part in recruitment process for all vacancies of Band 7 and above with further training across the Staff Networks planned for 2020/21. 2) In development; equality interview questions have been introduced to all interview panels. 3) Advertising poster has been amended to be more culturally sensitive and distributed to local community groups.	Ongoing
WRES Indicator 4: Improve career development opportunities for BME colleagues.	1) Masterclasses from April 2020 to support people to progress in the organisation, to include support with job applications and interview skills. Career coaching in appraisals, even for those who are not sure if they would like to progress. 2) Promotion of development opportunities: Managers and leaders need to know what is available for staff, to include shadowing and secondments to learn about and gain access to other services. 3) Streamline Training Needs Analysis	Report to Equality Forum quarterly on progress.	Faith Sango, Head of People Development With support from EDI Service and BME Network	1) FS is taking this to the next BME Network meeting in October 2020 for a check and agreement and to discuss a small pilot group. 2) A career development page will be updated on the new intranet site and this link will be shared. FS to discuss in detail at the next BME Network meeting. 3) Completed. A new electronic application has	Ongoing

Objective	Action/s	Timescales	Lead/s	Update (September 2020)	Position
	process: Managers need to be asked more disruptive questions before they refuse an application, and must give a reason why it has been refused.			been introduced and allows People Development Team to track applications activity. This process now includes questions on REGARDS.	
WRES Indicator 5, 6 and 8: Target and reduce bullying and harassment in the Trust.	1) Work to be undertaken to identify themes and hotspots across the Trust through triangulation of data from sources including WRES, WDES, Gender Pay Gap, Staff Survey and Freedom to Speak Up Guardian. 2) Implementation of a 'Just and Learning Culture' in the Trust to bring about an inclusive culture that focuses on a remediation approach rather than administering blame when things go wrong. 3) Review leadership development offer to ensure inclusion and compassionate leadership is central to our development offer. 4) 'It's not okay' campaign to be launched to confirm the Trust's zero tolerance approach to any form of harassment, discrimination or violence against its staff, visitors, carers and also towards any individuals who are in receipt of our services.	2020/21	Jaki Lowe, Director of People & Inclusion EDI Service Leadership Development Team Communications Team	4) 14 members of the Staff Networks participated in the campaign.	
All indicators:	Reverse Mentoring for Equality, Diversity and	Q3-4 2020	Reverse	Cohort 2 was launched in	Ongoing

Objective	Action/s	Timescales	Lead/s	Update (September 2020)	Position
Promote understanding of lived experience of our colleagues from different groups.	Inclusion programme: To be rolled out to wider Trust, especially senior leaders at Band 7 and above, mentored by a second cohort of colleagues from a BME background.		Mentoring Steering Group	December 2019 with 16 pairs of mentors and mentees. Paused in March 2020 due to COVID-19 and relaunched on 31 July 2020 to start taking place virtually. Cohort 3 is planned to include BME mentors and mentors from wider protected characteristics, to be launched in 2020.	
Review and learn from WRES good practice.	1) WRES Experts Programme, designed to support the organisation to embed best practice with regards to race equality. 2) WRES Frontline Staff Forum, representative from DHCFT attends to support the Trust to learn from other organisations' qualitative experience of the WRES. 3) Review WRES National Report for learning what works in other organisations with improving scores.	Oct 2019-present Ongoing When released on NHS WRES website.	Rubina Reza Tray Davidson EDI Service	1) Programme launched on 9 October 2019. Paused for COVID-19. WRES Expert involved in RASG and Action Planning as part of BME Network. 2) Programme started up again in April to focus on supporting members and share organisational updates, including good practice. 3) Replicable good practice case studies published on WRES website. EDI Service to share with WRES working groups e.g. RASG and BME	

Objective	Action/s	Timescales	Lead/s	Update (September 2020)	Position
				Network Steering Group.	

Appendix 1:

NON-CLINICAL						
	2018/19			2019/20		
Band	White %	BME %	Unknown %	White %	BME %	Unknown %
Under Band 1	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Band 1	64.7%	30.6%	4.7%	54.5%	18.2%	27.3%
Band 2	79.2%	15.3%	5.6%	73.6%	22.8%	3.6%
Band 3	90.9%	8.5%	0.6%	89.6%	9.9%	0.5%
Band 4	91.1%	7.1%	1.8%	89.9%	8.4%	1.7%
Band 5	80.8%	13.5%	5.8%	80.7%	14.0%	5.3%
Band 6	97.4%	2.6%	0.0%	93.8%	2.1%	4.2%
Band 7	100.0%	0.0%	0.0%	94.7%	0.0%	5.3%
Band 8a	94.4%	5.6%	0.0%	94.4%	5.6%	0.0%
Band 8b	100.0%	0.0%	0.0%	87.5%	12.5%	0.0%
Band 8c	100.0%	0.0%	0.0%	100.0%	0.0%	0.0%
Band 8d	100.0%	0.0%	0.0%	83.3%	16.7%	0.0%
Band 9	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%
VSM	85.7%	14.3%	0.0%	83.3%	16.7%	0.0%

CLINICAL						
	2018/19			2019/20		
Band	White %	BME %	Unknown %	White %	BME %	Unknown %
Under Band 1	50.0%	50.0%	0.0%	0.0%	0.0%	0.0%
Band 1	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Band 2	76.8%	19.6%	3.6%	70.4%	25.9%	3.7%
Band 3	76.3%	17.3%	6.4%	76.1%	19.3%	4.6%
Band 4	87.6%	8.6%	3.8%	85.7%	11.2%	3.1%
Band 5	83.7%	11.5%	4.8%	83.4%	12.3%	4.2%
Band 6	88.0%	8.7%	3.3%	88.9%	8.4%	2.7%
Band 7	86.4%	10.5%	3.1%	86.2%	11.2%	2.6%
Band 8a	88.9%	6.2%	4.9%	92.6%	6.2%	1.2%
Band 8b	95.2%	0.0%	4.8%	93.5%	3.2%	3.2%
Band 8c	87.5%	0.0%	12.5%	90.9%	0.0%	9.1%
Band 8d	100.0%	0.0%	0.0%	100.0%	0.0%	0.0%
Band 9	0.0%	0.0%	0.0%	0.0%	100.0%	0.0%
VSM	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%
of which Medical & Dental						
Consultants	44.0%	46.7%	9.3%	50.0%	42.3%	7.7%
of which senior medical manager	100.0%	0.0%	0.0%	100.0%	0.0%	0.0%
Non-consultant career grade	30.3%	54.5%	15.2%	29.0%	58.1%	12.9%
Trainee grades	38.9%	44.4%	16.7%	39.1%	52.2%	8.7%
other	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

NHS Workforce Race Equality Standard (WRES) 2019-2020 – Page 1 of 3

The WRES provides a framework to ensure that Black and Minority Ethnic (BME) staff receive fair treatment in the workplace and have equal access to career opportunities.
The data presented here provides an overview of the Trust's performance against the 9 WRES indicators.

Indicator 1: Overall BME representation in our workforce and across the Bands

Overall workforce
2672 people

BME: 13.8% (369 people)

White: 82.7% (2211 people)

Unknown: 3.4% (92 people)

Non-Clinical Workforce

100%
75%
50%
25%
0%

Band 1, Band 2, Band 3, Band 4, Band 5, Band 6, Band 7, Band 8a, Band 8b, Band 8c, Band 8d, Band 9, VSM

15% target

6% of our staff in Non-Clinical Bands 7 to VSM are from a BME background (4 in 70 roles)

Clinical Workforce

100%
75%
50%
25%
0%

Band 1, Band 2, Band 3, Band 4, Band 5, Band 6, Band 7, Band 8a, Band 8b, Band 8c, Band 8d, Band 9, VSM, Medical & Dental

15% target

9% of our staff in Clinical Bands 7 to VSM are from a BME background (37 in 396 roles)

For more information, please contact the Equality, Diversity and Inclusion Team at dhcft.equality@nhs.net or visit https://www.derbyshirehealthcareft.nhs.uk/about-us/equality-and-diversity for the full WRES report and action plan

Making a positive difference

NHS Workforce Race Equality Standard (WRES) 2019-2020 – Page 2 of 3

The WRES provides a framework to ensure that Black and Minority Ethnic (BME) staff receive fair treatment in the workplace and have equal access to career opportunities.
The data presented here provides an overview of the Trust's performance against the 9 WRES indicators.

Workforce Data

Indicator 2

White candidates are
2.02 times more likely
to be appointed from shortlisting compared to BME candidates.

The gap has narrowed from 2.86 in 2018-19

Better

Indicator 3

BME staff are
1.43 times more likely
to enter the formal disciplinary process compared to white staff.

The gap has narrowed from 2.45 in 2018-19

Better

Indicator 4

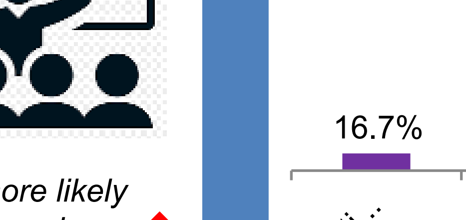
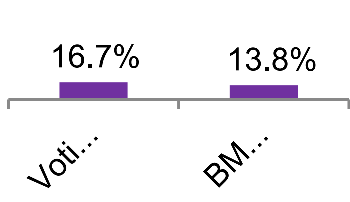
This year, white staff are
1.13 times more likely
to access non-mandatory training and CPD compared to BME staff.

This figure has increased from 0.97 times more likely in 2018-19 because this year, the Trust is only reporting on funded training courses.

Worse

Indicator 9

The percentage difference between our voting Board and overall workforce is **+2.9%**

*This means our Voting Board is **representative** of our workforce because 16.7% of our Voting Board and 13.8% of our workforce are BME.*

Better

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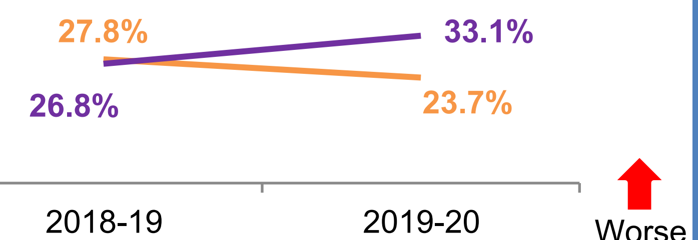
NHS Workforce Race Equality Standard (WRES) 2019-2020 – Page 3 of 3

The WRES provides a framework to ensure that Black and Minority Ethnic (BME) staff receive fair treatment in the workplace and have equal access to career opportunities.
The data presented here provides an overview of the Trust's performance against the 9 WRES indicators.

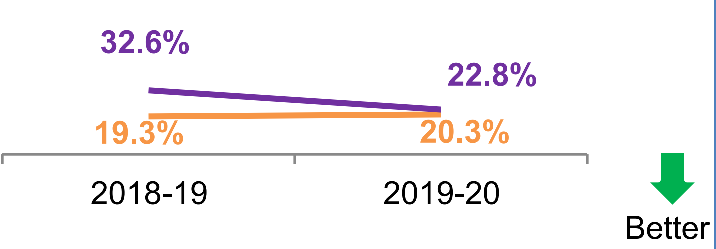
Staff Survey Results 2019

Key

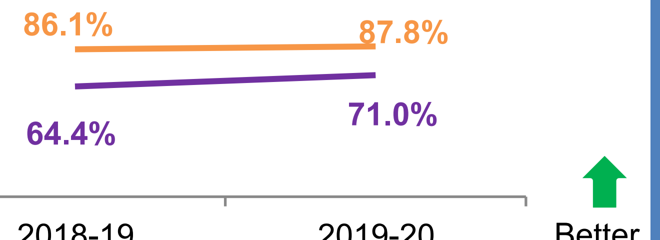
Indicator 5
The percentage of BME staff experiencing harassment, bullying or abuse from patients, relatives or the public has increased in the last 12 months



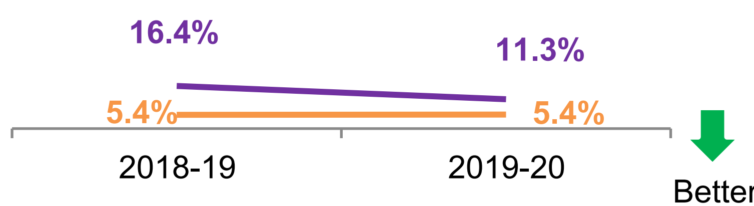
Indicator 6
The percentage of BME staff experiencing harassment, bullying or abuse from staff has decreased in the last 12 months



Indicator 7
The percentage of staff believing that the organisation provides equal opportunities for career progression or promotion has increased in the last 12 months



Indicator 8
Percentage of BME staff experiencing discrimination at work from manager/team leader or other colleagues has decreased in the last 12 months



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Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 3 November 2020

Workforce Disability Equality Standard (WDES) 2019-20

Purpose of Report

To present the 2019-20 Workforce Disability Equality Standard (WDES) to the Trust Board for information and discussion.

Executive Summary

This is the second year of the WDES implementation and the data shows that there is considerable work to be done to address the variations in experience, workforce representation, progression and development for staff with disabilities and long term conditions.

This year's data and actions can be found in the WDES Report and Action Plan 2019/20 in Appendix 1. It has also been published on the Trust's public facing website in line with 31 October 2020 deadline, following approval at People and Culture Committee on 22 September. For a visual summary of this year's data, please refer to the WDES infographic in Appendix 2.

The implementation of the Trust's Health Risk Assessment as a result of COVID-19 has highlighted the high number of staff in the Trust with disabilities and long term conditions and a considerable gap in the number of staff that have declared their disability and/or long term condition. If we are to understand the needs of our people and create the right approaches and programmes of support, we must improve our declaration rates. The actions from this are embedded in the action plan.

The data and the information from our network indicate that we must adopt an individualised approach that ensures every member of staff has a co-developed plan that meets specific needs and is adaptive as conditions and disabilities change. We will review our processes, development and also raise awareness to achieve this.

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

Assurances

- Making improvements on the WDES indicators signifies an improvement of colleagues' experiences working in our Trust. This is important to ensure all colleagues are living the Trust's values and putting people first in line with our Inclusion Strategy.
- NHS organisations must submit the WDES dataset to NHS England by 31 August 2020. The submission for DHCFT was completed on 26 August.
- Iterations of the WDES report and action plan have been discussed with the Disability & Wellness Network, the Equality Forum, the Executive Leadership Team and the People and Culture Committee. The final iteration was reviewed and approved by the Committee on 22 September for publication by 31 October 2020 deadline.
- Amendments have been made to the action plan based on the feedback from each of the groups above, including the addition of more targeted actions to address the high rates of bullying and harassment of colleagues with a disability and/or long term condition.
- The WDES is performance managed via the Equality Forum which has trust-wide membership and is part of the governance structure and sub-group of People and Culture Committee.
- The Trust has achieved Disability Confident Employer status (Level 2), which means it is recognised as going the extra mile to make sure disabled people get a fair chance. The EDI Service is currently working to gather the evidence to achieve 'Leader' status (Level 3), the highest level, and has been liaising with the Disability & Wellness Network.

Consultation

- Consultation has included engagement sessions with the Disability & Wellness Network on 28 July, 5 August and 14 October, which form part of ongoing engagement to ensure that the action plans remain effective throughout the year.
- The datasets, reports and action plans have been reviewed by the Equality Forum, the Executive Leadership Team and People and Culture Committee.

Governance or Legal Issues

- WDES reporting is a mandatory requirement of the NHS Standard Contract. The Trust is required to submit the WDES dataset to NHS England by 31 August 2020 and publish the report and action plans on the public facing website by 31 October 2020.
- Undertaking the WDES demonstrates the Trust's commitment to the Equality Act 2010 and Public Sector Equality Duty.

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.

The WDES is a set of indicators related to the workplace experience of colleagues with a disability and/or long term condition.

The indicators demonstrate the inequalities experienced by people from different protected characteristics, and support the Trust to identify and target actions to close the gaps. Consultation has been carried out with colleagues in the Disability & Wellness Network on whether the data evidenced in the indicators is a true reflection of their lived experience and has supported engagement to create effective action plans.

Monitoring the WDES data allows the Trust to assess the impact of targeted actions and ensure that they remain effective, and is essential to improving the experiences of staff at Derbyshire Healthcare to create a more 'positively inclusive' culture.

Improving the indicators in the WDES assists the Trust in meeting its duties as set out by the Equality Act 2010.

Recommendations

The Board of Directors is requested to:

1) Consider and discuss the strategic implications of the WDES 2019/20.
2) Strengthen the Trust's approach through the development of the new People Strategy.

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

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

Clare Meredith
Equality, Diversity and Inclusion Advisor

Appendix 1: WDES Report and Action Plan 2019/20
Appendix 2: WDES Infographic 2019/20

Workforce Disability Equality Standard (WDES) 2019-20

Key Headlines

Below are the key headlines from this year's data. The indicators have been highlighted for their lack of progress since last year and as a reflection of the conversations with the Disability & Wellness Network, which identify the areas below as in need of improvement. The rest of the indicators and a comparison of this year's data compared to last year can be found in Appendix 2.

- **Declaration rates:** Declaration rates of staff with disabilities in the Trust are low, with 26.9% of the Trust (720 people) not declaring their disability status. This is a slight improvement from last year, where the disability status of 31.3% of staff was unknown. We know that there are more disabled colleagues in our Trust than have declared themselves on ESR: 25.1% of respondents (371 people) on the NHS Staff Survey 2019 said they had a physical or mental health condition, disability or illness, compared to only 4.4% (117 people) of the workforce declaring themselves as disabled on ESR (WDES Indicator 1).

- **Bullying and harassment:**
  - Our WDES Staff Survey indicators tell us that almost 1 in 3 disabled staff (30.4%/112 people) has experienced harassment, bullying or abuse from patients, their relatives of members of the public, compared to 23.0% of non-disabled staff (WDES Indicator 4a i)
  - 22.6% of disabled staff (83 people) have experienced bullying and harassment from other colleagues, compared to 14.6% of non-disabled staff. The figures have increased for both disabled and non-disabled staff compared to last year (WDES Indicator 4a iii).

- **Career progression:** There has been an improvement for disabled and non-disabled staff believing the Trust provides equal opportunities for career progression or promotion, but there is still a gap between their experiences, with 87.6% of non-disabled respondents and 81.2% of disabled respondents (WDES Indicator 5).

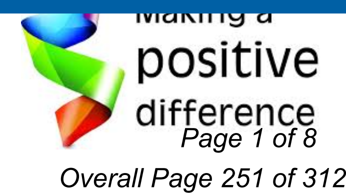
- **Feeling valued:** Only 43.9% of disabled staff compared to 54.1% of non-disabled staff says they are satisfied with the extent to which the organisation values their work (WDES Indicator 7).

Workforce Disability Equality Standard (WDES)

Annual Report and Action Plan

2019/20

Report publishing date: October 2020



Introduction

The WDES requires all NHS organisations to demonstrate progress against a set of ten indicators in order to assess the experiences of disabled and non-disabled staff. The aim of the WDES is to ensure employees who have a disability have equal access to opportunities and receive fair treatment in the workplace.

The standard has been implemented across all NHS trusts in response to research that shows that disabled staff have poorer experiences in areas such as bullying and harassment, feeling pressure to come to work despite not feeling well enough and in access to opportunities for career progression when compared to their non-disabled colleagues.

The WDES will help foster a better understanding of the issues faced by disabled colleagues and the inequalities they experience, and supports trusts to take action to create an inclusive and diverse leadership, which is in line with Derbyshire Healthcare's mission to be 'positively inclusive'.

WDES Report 2019/20

Detailed below is the organisation's WDES data which was submitted in August 2020 covering the period 1 April 2019 to 31 March 2020.

	2018/19	2019/20
Number of staff employed within Trust	2586	2672
Proportion of disabled staff employed within Trust as at 31 March 2020	4.5% (115 people)	4.4% (117 people)
Indicator 1 Percentage of staff in each of the AfC Bands 1-9 and VSM compared with the percentage in the overall workforce	Please refer to Appendix 1	
Indicator 2 Relative likelihood of non-disabled staff compared to disabled staff being appointed from shortlisting across all posts Note: A figure above "1" would indicate non-disabled candidates are more likely to be appointed from shortlisting	2.88	1.40
Indicator 3 Relative likelihood of disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure. Note: A figure above "1" would indicate that disabled staff are more likely to enter the formal capability process	0.00	0.00
Indicator 4a **Percentage of staff experiencing harassment, bullying or abuse from:** **i)** Patients, service users or members of the public **ii)** Managers **iii)** Other colleagues	**i)** Disabled: 33.8% Non-disabled: 26.0% **ii)** Disabled: 14.0% Non-disabled: 8.8% **iii)** Disabled: 17.0% Non-disabled: 14.5%	**i)** Disabled: 30.4% Non-disabled: 23.0% **ii)** Disabled: 11.8% Non-disabled: 8.0% **iii)** Disabled: 22.6% Non-disabled: 14.6%
Indicator 4b Percentage of staff saying the last time they experienced harassment, bullying or abuse, they or a colleague reported it	Disabled: 55.0% Non-disabled: 53.2%	Disabled: 53.9% Non-disabled: 51.2%
Indicator 5 Percentage of staff believing the Trust provides equal opportunities for career progression.	Disabled: 78.5% Non-disabled: 85.2%	Disabled: 81.2% Non-disabled: 87.6%
Indicator 6 Percentage of staff saying they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.	Disabled: 20.4% Non-disabled: 14.6%	Disabled: 16.4% Non-disabled: 12.3%
Indicator 7 Percentage of staff saying they are satisfied with the extent to which the organisation values their work.	Disabled: 37.2% Non-disabled: 48.9%	Disabled: 43.9% Non-disabled: 54.1%
Indicator 8 Percentage of disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work.	Disabled: 83.3%	Disabled: 84.6%
Indicator 9a Staff engagement score for disabled staff, compared to non-disabled staff.	Disabled: 6.5 Non-disabled: 7	Disabled: 6.9 Non-disabled: 7.2

	2018/19	2019/20
Indicator 9b Has your Trust taken action to facilitate the voices of disabled staff in your organisation to be heard? (yes/no)	Yes • Disability & Wellness Staff Network • Executive Sponsor of disability equality • Equality Forum • Staff Forum • Freedom to Speak Up (F2SU) Guardian & F2SU Champions	Yes • Disability & Wellness Staff Network • Executive Sponsor of disability equality • Equality Forum • Staff Forum • Freedom to Speak Up (F2SU) Guardian & F2SU Champions
Indicator 10 Percentage difference between the organisation's Board voting membership and its organisation's overall workforce.	- 4% (0% of Board voting membership vs. 4% of overall workforce)	+ 4% (8% of Board voting membership vs. 4% of overall workforce)

Action Plan

This action plan has been created in partnership with the Disability & Wellness Staff Network in August 2019 and amended on 28 July and 5 August 2020.

Please note that this action plan is a live document that will be updated and amended throughout the year to ensure that the actions and outcomes remain effective in closing the gaps in disability inequality in our Trust.

Objective	Action/s	Timescale	Lead/s	Update (September 2020)	Position
Indicator 1: Improve declaration rates across the Trust	Improve declaration rates on ESR using a campaign to promote the importance of colleagues declaring their disability status with a 'how to' document and a simplified process to enable staff to do so easily and quickly.	Ongoing	EDI Service Disability & Wellness Network		Ongoing
Indicator 2: Improve the likelihood of disabled staff being appointed from shortlisting	Aligned to the current WRES work programme: 1) Recruitment Inclusion Guardians for vacancies at Band 7 and above to include colleagues with disabilities and long term conditions to challenge bias in the recruitment process. 2) Equality interview questions introduced to interview panels 3) Advertisement to appeal to candidates from diverse communities, including candidates with disabilities 4) The Trust is a Disability Confident Employer (Level 2), looking to progress to Disability Confident Leader (Level 3). The Disability Confident Scheme is designed for organisations to demonstrate their commitment to	Ongoing	Recruitment Action Steering Group	1) 16 Recruitment Inclusion Guardians have been trained to take part in recruitment processes for all vacancies of Band 7 and above with further training across Staff Networks planned for 2020/21. 2) In development; equality interview questions have been introduced to all interview panels. 3) Advertising poster has been amended to be more culturally sensitive and distributed to local community groups.	Ongoing

Objective	Action/s	Timescale	Lead/s	Update (September 2020)	Position
	inclusive recruitment and development practices				
Indicators 4a, 4b, 6 & 8: Target and reduce bullying and harassment in the Trust.	1) Work to be undertaken to identify themes and hotspots across the Trust through triangulation of data from sources including WRES, WDES, Gender Pay Gap, Staff Survey and Freedom to Speak Up Guardian. 2) Implementation of a 'Just and Learning Culture' in the Trust to bring about an inclusive culture that focuses on a remediation approach rather than administering blame when things go wrong. 3) Review leadership development offer to ensure inclusion and compassionate leadership is central to our development offer. 4) 'It's not okay' campaign to be launched to confirm the Trust's zero tolerance approach to any form of harassment, discrimination or violence against its staff, visitors, carers and also towards any individuals who are in receipt of our services.	2020/21	Jaki Lowe, Director of People & Inclusion EDI Service Leadership Development Team Communications Team	4) 14 members of the Staff Networks have participated in the campaign.	
Indicators 7 & 9b: Support colleagues to feel valued and heard.	1) Establish a newsletter for Trust staff to include case studies/staff stories to raise awareness of challenges faced by colleagues with disabilities and long-term conditions; information on opportunities for flexible working and training opportunities. 2) Aligned to actions from NHS People Plan	2020/21	Disability & Wellness Network		Ongoing

Objective	Action/s	Timescale	Lead/s	Update (September 2020)	Position
	2020/21 and NHS People Promise: 'We are compassionate and inclusive' and we are 'safe and healthy'.				
All indicators: Promote understanding of lived experience of our colleagues from different groups.	Reverse Mentoring for Equality, Diversity and Inclusion programme: Cohort 3 to be rolled out in 2020 with mentors to include colleagues with wider protected characteristics, including disabilities and/or long term conditions.	Q3-4 2020	Reverse Mentoring Steering Group		Ongoing
Review and learn from WDES good practice.	Review WDES National Report for learning what works in other organisations with improving scores.	When released on NHS WDES website.	EDI Service		

Appendix 1

NON-CLINICAL						
	2018-19			2019-20		
Band	Disabled %	Non-disabled %	Unknown/ Null %	Disabled %	Non-disabled %	Unknown/ Null %
Cluster 1 (Bands 1 - 4)	4.0%	66.6%	29.4%	4.7%	69.9%	25.4%
Cluster 2 (Band 5 - 7)	4.6%	69.4%	25.9%	3.2%	71.0%	25.8%
Cluster 3 (Bands 8a - 8b)	2.9%	68.6%	28.6%	3.8%	65.4%	30.8%
Cluster 4 (Bands 8c - 9 & VSM)	0.0%	60.0%	40.0%	8.0%	72.0%	20.0%

CLINICAL						
	2018-19			2019-20		
Band	Disabled %	Non-disabled %	Unknown/ Null %	Disabled %	Non-disabled %	Unknown/ Null %
Cluster 1 (Bands 1 - 4)	3.3%	57.1%	39.6%	2.8%	65.9%	31.3%
Cluster 2 (Band 5 - 7)	5.4%	66.7%	27.9%	5.2%	70.4%	24.4%
Cluster 3 (Bands 8a - 8b)	5.9%	68.6%	25.5%	4.5%	76.8%	18.8%
Cluster 4 (Bands 8c - 9 & VSM)	0.0%	50.0%	50.0%	0.0%	53.3%	46.7%
Cluster 5 (Medical & Dental Staff, Consultants)	2.7%	56.0%	41.3%	2.6%	57.7%	39.7%
Cluster 6 (Medical & Dental Staff, Non-Consultants career grade)	0.0%	48.5%	51.5%	0.0%	41.9%	58.1%
Cluster 7 (Medical & Dental Staff, Medical and dental trainee grades)	0.0%	16.7%	83.3%	0.0%	34.8%	65.2%

NHS Workforce Disability Equality Standard (WDES) 2019-2020 – Page 1 of 3

NHS
Derbyshire Healthcare
NHS Foundation Trust

The WDES is a set of ten measures to enable NHS organisations to compare the workplace and career experiences of disabled and non-disabled staff.
The data presented here provides an overview of the Trust's performance against the 10 WDES indicators.

Indicator 1: Representation of disabled staff in our overall workforce and across the bands

Non-Clinical Workforce

100%
75%
50%
25%
0%

Under Band 1, Band 1, Band 2, Band 3, Band 4, Band 5, Band 6, Band 7, Band 8a, Band 8b, Band 8c, Band 8d, Band 9, VSM, Other

Clinical Workforce

100%
75%
50%
25%
0%

Under Band 1, Band 1, Band 2, Band 3, Band 4, Band 5, Band 6, Band 7, Band 8a, Band 8b, Band 8c, Band 8d, Band 9, VSM, Consultants*, Career grades*, Trainee grades*, Other

*Medical & Dental staff

DHCFT overall workforce: 2672 people

Disabled: 4.4% (117 people)

Non-disabled: 68.7% (1835 people)

Unknown: 26.9% (720 people)

Declaration rates on ESR are low in the Trust (26.9% unknown). This information is valuable for understanding the diversity of our workforce and is confidential.

DHCFT staff declared disabled on ESR compared to Staff Survey 2019

100%
50%
0%

ESR: 4.4% (117 people)

Staff Survey 2019: 25.1% (371 of 1477 respondents)

20.4% of Derbyshire & Derby City's combined population across all age groups has a limiting health problem or disability
Source: Census 2011.

For more information, please contact the Equality, Diversity and Inclusion Team at dhcft.equality@nhs.net or visit https://www.derbyshirehealthcareft.nhs.uk/about-us/equality-and-diversity for the full WRES report and action plan

NHS Workforce Disability Equality Standard (WDES) 2019-2020 – Page 2 of 3

The WDES is a set of ten measures to enable NHS organisations to compare the workplace and career experiences of disabled and non-disabled staff.
The data presented here provides an overview of the Trust's performance against the 10 WDES indicators.

Workforce Data

Indicator 2
Non-disabled staff are
1.4 times more likely
to be appointed from shortlisting compared to disabled staff.

The gap has narrowed from 2.88 in 2018-19

Better

Indicator 3
Disabled staff are
0.0 times more likely
to enter the formal capability process compared to non-disabled staff
for the second consecutive year.

No change

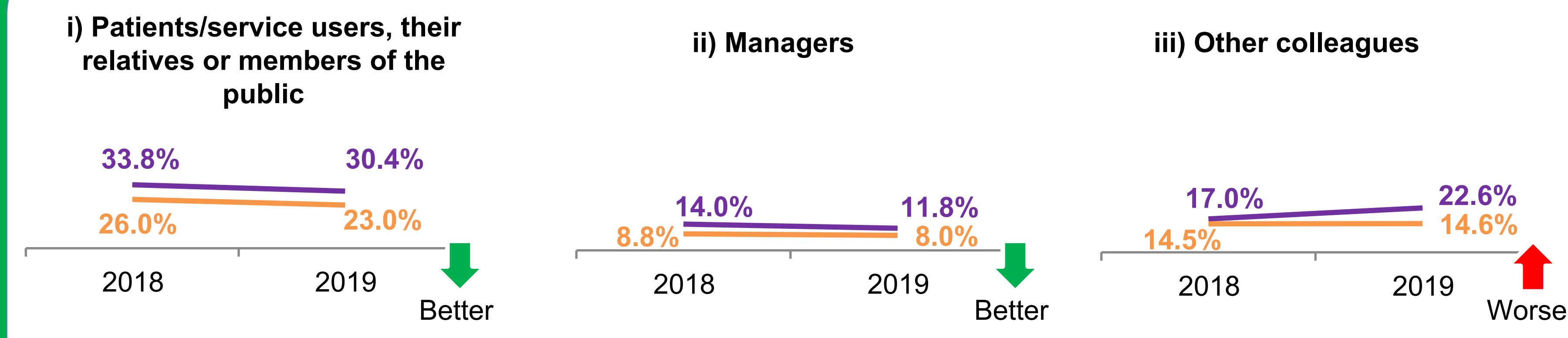
Indicator 10
The percentage difference between our voting Board and overall workforce is **+4%.**
Our voting Board is **representative** of our workforce.

Voting Board	Overall Workforce
8%	4%

Better

Staff Survey 2019

Key: Disabled, Non-disabled



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NHS Workforce Disability Equality Standard (WDES) 2019-2020 – Page 3 of 3

The WDES is a set of ten measures to enable NHS organisations to compare the workplace and career experiences of disabled and non-disabled staff.
The data presented here provides an overview of the Trust's performance against the 10 WDES indicators.

Staff Survey Results 2019

Key: Disabled (purple), Non-disabled (orange)

Indicator 4b
Percentage of staff saying the last time they experienced harassment, bullying or abuse, they or a colleague reported it.

	2018	2019
Disabled	55.0%	53.9%
Non-disabled	53.2%	51.2%

Worse

Indicator 5
Percentage of staff believing the Trust provides equal opportunities for career progression.

	2018	2019
Non-disabled	85.2%	87.6%
Disabled	78.5%	81.2%

Better

Indicator 6
Percentage of staff saying they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.

	2018	2019
Disabled	20.4%	16.4%
Non-disabled	14.6%	12.3%

Better

Indicator 7
Percentage of staff saying they are satisfied with the extent to which the organisation values their work.

	2018	2019
Non-disabled	48.9%	54.1%
Disabled	37.2%	43.9%

Better

Indicator 8
Percentage of disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work.

	2018	2019
Disabled	83.3%	84.6%

Better

Indicator 9
Staff Engagement score based upon NHS Staff Survey results.

	2018	2019
Non-disabled	7	7.2
Disabled	6.5	6.9

Better

For more information, please contact the Equality, Diversity and Inclusion Team at dhcft.equality@nhs.net or visit https://www.derbyshirehealthcareft.nhs.uk/about-us/equality-and-diversity for the full WRES report and action plan

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 3 November 2020

Board Assurance Framework (BAF)
Third issue for 2020/21

Purpose of Report

To meet the requirement for Boards to produce an Assurance Framework. This report details the third issue of the BAF for 2020/21.

Executive Summary

Issues 1 and 2 of the BAF for 2020/21 focused on the risks faced by the organisation in response to the COVID-19 pandemic. This was due to the obvious consuming impact of the pandemic earlier this year and in line with the national directive for a governance 'light' approach across organisations.

Issue 3 has now been developed in line with the broader revised objectives which support delivery of the Trust Strategy, and in line with the recovery and restoration phase for NHS services. Seven risks have been identified in relation achievement of the three strategic objectives of Great Care; Great Place to Work; and Best Use of Money.

There are currently sixteen operational risks rated as high or extreme, updated as of 23 October. These have been aligned to the related BAF risk.

The direction of travel for each risk is shown as NA (Not Applicable) as although this is Issue 3 of the BAF for 2020/21, this is the first full articulation of these risks.

Usually a programme of deep dives for each BAF risk to the relevant Board Committees is undertaken, spread throughout the year. However, due to the impact of the COVID-19 pandemic on the Trust's usual governance arrangements, and the likelihood that the risks currently identified will span into 2021/22, it is proposed that only the risks rated as extreme be subject to deep dives this year. Therefore the proposed timetable for deep dives is as follows:

Deep Dive proposed timetable for 2020/21		
Risk 20_21 2a There is a risk that we do not create a healthy vibrant culture and conditions to make DHCFT a place where people want to work, thrive and to grow their careers	Director of People and Inclusion	Audit and Risk Committee 21 January 2021
Risk 20-21 3a There is a risk that the Trust fails to deliver its revenue and capital financial plans.	Director of Finance.	Audit and Risk Committee 18 March 2021

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

Assurances

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 – During September 2020
- Executive Leadership Team 15 September
- Audit and Risk Committee 1 October

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.

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

Recommendations

The Board is requested to

1) Approve this third issue of the BAF for 2020/21 and gain 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) Agree the timetable for deep dives for 2020/21
3) Continue to receive updates in line with the forward plan for the Board.

Report presented by: **Justine Fitzjohn**
Trust Secretary

Report prepared by: **Rachel Kempster**
Risk and Assurance Manager

Summary Board Assurance Framework Risks 2020_21 Issue 3 Board

Ref	Principal risk	Director Lead	Current rating (Likelihood x Impact)	Responsible Committee
Strategic Objective 1. To provide GREAT care in all services				
20_21 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/Medical Director	HIGH (4x4)	Quality and Safeguarding Committee
20_21 1b	There is a risk that the Trust estate does not comply with regulatory and legislative requirements	Chief Operating Officer	HIGH (4x4)	Finance and Performance Committee
20_21 1c	There is a risk that the Trust fails to maintain continuity of access to information to support effective patient care	Chief Operating Officer	MODERATE (3X4)	Finance and Performance Committee
Strategic Objective 2. To be a GREAT place to work				
20_21 2a	There is a risk that we do not create a healthy vibrant culture and conditions to make DHCFT a place where people want to work, thrive and to grow their careers	Director of People and Inclusion	EXTREME (4x5)	People and Culture Committee
20_21 2b	There is a risk of continued inequalities affecting health and well-being of both staff and local communities	Director of People and Inclusion	HIGH (4x4)	Trust Board
Strategic Objective 3. To make BEST use of our money				
20_21 3a	There is a risk that the Trust fails to deliver its revenue and capital financial plans	Executive Director of Finance	EXTREME (4x5)	Finance and Performance Committee
20_21 3b	There is a risk that learning from the response to the COVID-19 outbreak, and transformation plans developed prior, does not lead to sustainable embedded transformation	Director of Business Improvement and Transformation	HIGH (4x4)	Finance and Performance Committee

Strategic Objective 1. To provide GREAT care in all services

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

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) Financial settlement in contracts chronically underfunded for population need
b) Workforce supply and lack of capacity to deliver effective care across hotspot areas
c) Substantial increase in clinical demand in some services and post COVID-19 mental health surge
d) Changing demographics of population and substantial impacts of inequality
e) Intermittent lack of compliance with CQC standards specifically the safety domain
f) Lack of embedded outcome measures at service level
g) Known links between SMI and other co-morbidities, and increased risk factors in population including inequality/ intersectionality
h) Lack of compliance with physical healthcare monitoring in primary and secondary care
i) Restoration and recovery of access standards due to COVID-19 pandemic
j) New and emerging risks related to potential second wave of COVID-19, excess deaths associated with winter, impact of substantial economic downturn
k) Increased safeguarding related investigations as a result of harm to our patients and their families related to the impact of lockdown

BAF ref: 20_21 1a	**Director Lead**: Executive Director of Nursing/Medical Director	**Responsible Committee**: Quality and Safeguarding Committee

Inherent risk rating:			**Current risk rating:**				Target risk rating:			Risk appetite:		
Rating HIGH	Likelihood 4	Impact 4	Rating HIGH	Likelihood 4	Impact 4	Direction NA	Rating MODERATE	Likelihood 3	Impact 4	Accepted	Tolerated	Not accepted

Key controls:

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

Detective – Quality dashboard reporting; quality visit programme; Incident, complaints and risk investigation; FSR compliance checks; mortality review process; physical health care monitoring clinics pilots; Safety check log

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; CAS alerts; Clinical Sub Committees of the Quality Committee

Corrective – Board committee structures and processes ensuring escalation of quality issues; six monthly skill mix review; CQC action plans; learning from incidents, complaints and risks; actions following clinical and compliance audits; workforce issues escalation procedures; reporting to commissioners on compliance with quality standards; learning from other Trust experiences and national learning

Assurances on Controls (internal):	Positive assurances on Controls (external):
Quality and Trust dashboard Scrutiny of Quality Account (pre-submission) by committees and governors Programme of physical healthcare and other clinical audits and associated plans	National enquiry into suicide and homicide NHLSA Scorecard demonstrating low levels of claims Safety Thermometer identifies positive position against national benchmark Mental Health Benchmarking data identifies higher than average qualified to unqualified staffing ratio on inpatient wards CQC comprehensive review 2020 trust is rated Good; two remaining core services rates as require improvement; Identified Trust fully compliant with NQB Learning from Deaths guidance. 2019/20 internal audits: Datix Risk Management; Data Security and Protection; Schedule 4/6 analysis and scrutiny by commissioners

Key gaps in control:	Key actions to close gaps in control:	Impact on risk to be measured by:	Expected completion date./(Action review date):	Summary of progress on action:	Action on track:
Embedded learning from CQC regulatory actions, particularly in relation to improvement of training governance	Review operational governance of training compliance [ACTION OWNER: DPI] Develop and implement improvement plan to ensure sustained compliance with mandatory training [ACTION OWNER: DPI/COO]	Embedded compliance with mandatory training and compliance rates Lack of recurrence of common themes regarding training compliance	(30/11/2020)	ELT review of required training for recovery and restoration plans completed. Additional resources authorised to support implementation	
Inability to complete physical health checks for patients whose consultations remain undertaken virtually	Improvement plan to be developed and implemented to ensure required physical health care checks are completed [ACTION OWNER: MD]	Compliance with physical healthcare checks	31/12/2020	Updates on implementation of physical health care strategy scheduled	
Implementation of revised priority actions for 'Good Care' which support the trust strategy	Redesign improvement plans to align to revised building blocks which support the Trust Strategy [ACTION OWNER: DON]	Compliance with suite of metrics and reporting schedule (to be set)	30/11/2020		
Insufficient investment in Community Forensic Rehabilitation Team	Significant investment (est. £1m+) required by CCG to meet demand as outlined in new national specification. [ACTION OWNER: DBI&T]	Agreed funding allocation	(30/11/2020)	The MHSDB agreed £800k FYE of investment into Community Forensic Services in 20/21 as Phase 2 of a 3 phase investment plan. The recruitment into this team commenced in September. Approx £500k of	

				the investment is likely to be committed in 20/21 with FYE funding picked up from April 21/22. Mental Health/Learning Disability Autism Board considering in Nov 2020. Brief to DHCFT Board planned for Nov 2020	
Key gaps in assurance:	**Key actions to close gaps in assurances:**	**Impact on risk to be measured by:**	**Expected completion date./(Action review date):**	**Summary of progress on action:**	**Action on track:**
Six service areas assessed as 'Requires Improvement' by CQC in relation to safety	Develop and implement an improvement plan to enable all six service areas to reach 'Good' for safety in relation to the CQC standards [ACTION OWNER: DON]	CQC inspection and assessment	29/02/2021	COVID-19 pandemic has hampered pace of actions. Plan in place to recover this position.	
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 OWNER MD/DON/COO] Implement 2019 Community Mental Health Framework [ACTION OWNER: DBI&T]	Improvement in operating standards compliance. To be confirmed by external CQC inspection and assessment of at least 'Good' Implemented Acute Inpatient Mental Health Service Accreditation (RCP Standards) Implemented Mental Health Community Framework	31/03/2021 (30/11/2020) (date tbc) (30/11/2020)	Increased performance management scrutiny and unannounced site visits	
Implementation of clinical governance improvements with respect to: - Outcome measures - Clinical service reviews including reduction in excess waiting times - Getting it Right First Time (GIRTH) reviews - PSIRF implementation - CQUIN - NICE guidelines	Develop and implement an improvement plan to enable all governance improvement plans to be implemented [ACTION OWNERS MD/DON/COO/DBI&T]	Compliance with suite of metrics and reporting schedule (to be set)	(30/11/2020)	Still in recovery and restoration of governance systems, metrics and reporting schedule to be planned	

Related operational high/extreme risks:

Record ID	Service Line	Title	Risk: Summary of progress	Date of next review
3009	Learning Disabilities Services	Demand for ASD assessment Service far outstrips contracted activity	[20/07/2020] No change to Adult ED CCG funding. Clinical staffing remains below capacity to support full service delivery in line with NICE BMI guidance.	21/12/2020
21189	Management (Specialist Services)	Admission criteria to Eating Disorders Service	[18/09/2020] Request made to General manager to seek an update on the current progress of discussions with the CCG. Inequity of provision of the adult eating disorders service in Derbyshire compared to of the geographical areas.	31/03/2021
21586	Community Care Services (Older People)	Wait times breaching CCG contract	[19/08/2020] MAS service was closed in MARCH 2020 due to COVID. Remains relevant. COVID impacted ability to continue clinics and new referrals.	18/12/2020
22045	Acute Inpatient Services (Older People)	Covid-19	[02/09/2020] Shielded staff have now returned to work. They have individual work plans to maintain their safety. Cleaning rota commenced to ensure enhanced cleaning is in situ. All staff have now been offered the opportunity of a health risk assessment to assess if any extra measures are required to ensure safety.81	30/11/2020
22081	Child and Adolescent Mental Health Services (CAMHS)	Medical Staffing On call rota/Covid 19	[01/10/2020] Consultants have undertaken HRA's and risk being managed via Covid secure working environments and AA, telephone reviews. This has increased the availability of consultants who can offer face to face assessment. OOH rota remains under review by Medical Director, rota remains fragile. Recruitment to CAMHS Rise team progressing to support restoring out of hours support to CED until 10pm	06/01/2021
22151	Child and Adolescent Mental Health Services (CAMHS)	Family Therapy Provision	[06/10/2020] Raised with DDoN & DoN for update. Position now provided but need further info to progress. General Manager will follow up.	02/11/2020
22154	Community Paediatrics Teams	ND Assessment Pathway - operational delivery & capacity risks	[05/10/2020] Capacity is outstripping demand; referrals almost doubled over 3 years. Pressure pre COVID was increasing to a tipping point, now making restoration difficult. In discussion with CCG and CSTP to bring forward a system resolution, including a business case for investment (non-recurrent recovery & recurrent to seek to resolve shortfall. Recovery plan (internal) being developed	18/12/2020

Strategic Objective 1. To provide GREAT care in all services

Principal risk: There is a risk that the Trust estate does not comply with regulatory and legislative requirements

Impact: Low quality care environment specifically related to dormitory wards
Crowded staff environment and non-compliance with COVID secure workplace environments
Non-compliance with statutory care environments
Non-compliance with statutory health and safety requirements

Root causes:

a. Long term under investment in NHS capital projects and estate
b. Limited opportunity for Trust large scale capital investment
c. Increasing expectations in care and working environments
d. National capital funding restrictions for business as usual capital programme
e. Gaps in relation to the revised Premises Assurance Model (PAM)

BAF ref: 20_21 1b	**Director Lead**: Chief Operating Officer	**Responsible Committee**: Finance and Performance Committee

Inherent risk rating:			**Current risk rating:**				Target risk rating:			Risk appetite:		
Rating HIGH	Likelihood 4	Impact 4	Rating HIGH	Likelihood 4	Impact 4	Direction NA	Rating MODERATE	Likelihood 3	Impact 4	Accepted	Tolerated	Not accepted

Key controls:

Preventative – Routine environmental assessments for statutory health and safety requirements; Environmental risk assessments reported through Datix; COVID secure workplace risk assessments;
Detective – Reporting progress against Premises Assurance Model (PAM) to ELT; Weekly IMT reporting against COVID secure workplace compliance
Directive – Capital Action Team role in scrutiny of capital projects; IMT Estates Cell implementing all relevant COVID secure guidance; COVID secure workplace policy and procedure
Corrective – Short term investment agreed to support key risk areas including provision of equipment to ensure COVID secure workplace environments

Assurances on Controls (internal):	Positive assurances on Controls (external):
- COVID secure workplace assessments - Health and Safety Audits - Premises Assurance Management System (PAMS) reporting providing updates on key priority areas	- Mental Health Capital Expenditure bidding process - External authorised reports for statutory health and safety requirements

Key gaps in control:	Key actions to close gaps in control:	Impact on risk to be measured by:	Expected completion date./(Action review date):	Progress against action:	Action on track:
Estates Strategy delivery recommendations may not fully take account of all COVID secure guidance.	Review of Estates Strategy delivery recommendations to ensure compliance with COVID secure guidance [ACTION OWNER COO]	Revised COVID compliant delivery recommendations	31/12/2020		
Key gaps in assurance:	**Key actions to close gaps in assurances:**	**Impact on risk to be measured by:**	**Expected completion date./(Action review date):**	**Progress against action:**	**Action on track:**
Lack of adherence to emerging national guidance and policy requiring the elimination of mixed sex wards and dormitory style inpatient facilities.	Deliver a single room en-suite delivery plan and programme of work [ACTION OWNER COO]	Agreed programme of work with capital funding to support it	(30/11/2020)	Bid submitted against the national mental health capital expenditure allocation. System sign off of capital bids. Weekly dormitory eradication board in place.	
Lack of an accessible Derbyshire wide Psychiatric Intensive Care Unit (PICU)	Take forward approved outline business case as part of delivery of single room en-suite plan [ACTION OWNER COO]	Agreed programme of work with capital funding to support it	(30/11/2020)	Bid submitted against the national mental health capital expenditure allocation. System sign off of capital bids. Weekly dormitory eradication board in place	
Lack of assurance on full cycle of governance for estate compliance with statutory legislation	Premises Assurance Model assessment to be completed [ACTION OWNER COO] Review of current estates and facilities governance structures [ACTION OWNER COO]	Completed self-assessment reported into Finance and Performance Committee Governance structure in place	31/03/2021 31/03/2021	PAM assessment underway Management audit to be undertaken by internal auditors in Q4 20/21	

Related operational high/extreme risks:

Record ID	Service Line	Title	Risk: Summary of progress	Date of next review
21467	Acute Inpatient Services (Older People)	Workplace Health, Safety and Welfare	[12/10/2020] Continuing to use CMHT space to allow for us to fit safely in an office as per Covid restrictions/guidance. Project to move accommodation continues but no moving date yet.	31/01/2021
22086	Acute Inpatient Services (Older People)	Accommodation space and potential IG breach	[02/08/2020] Potential accommodation at Scarsdale now being considered. Estates proposing lease agreements. Still awaiting sneeze screens to be erected.	31/10/2020
22109	Estates & Facilities Management	Failure to maintain Systems and Equipment at the Hartington unit	[10/09/2020] Attached (to risk form on Datix) chain of requests to CRH Estates for evidence	31/10/2020

Strategic Objective 1. To provide GREAT care in all services

Principal risk: There is a risk that the Trust fails to maintain continuity of access to information to support effective patient care

Impact: Inability of staff to access patient records from the right place at the right time

Root causes:

a. Transfer to new electronic patient record provider
b. Inefficient access to clinical information in current system
c. Interoperability of systems with partner organisations
d. Current significant number of forms and processes resulting in issues regarding the consistency of recording of information

BAF ref: 20_21 1c	**Director Lead**: Chief Operating Officer	**Responsible Committee**: Finance and Performance Committee

Inherent risk rating:			**Current risk rating:**				Target risk rating:			Risk appetite:		
Rating MODERATE	Likelihood 3	Impact 4	Rating MODERATE	Likelihood 3	Impact 4	Direction NA	Rating LOW	Likelihood 2	Impact 3	Accepted	Tolerated	Not accepted

Key controls:

Preventative – Local Implementation Groups (LIG) and overarching Clinical Design Authority (CDA) ensuring all forms and processes have been rigorously tested and signed off by representatives of the clinical services

Detective – NED Board member on OnEPR Programme Delivery Board (PDB) providing project expertise and direct link to Board

Directive – OnEPR PDB governance oversight with respect to delivery of the new EPR with secured expert and experienced third party provider; Fully resourced project management team within the third party provider and DHCFT; Reporting on progress to Finance and Performance Committee and fortnightly updates to ELT; rapid escalation of issues to ELT;

Corrective – Phased approach to delivery (four phases over 18 month project delivery plan); 'Go/No Go' rationale agreed and measures for decision making, ahead of each delivery phase.

Assurances on Controls (internal):	Positive assurances on Controls (external):
- Weekly project update report and wider project progress report highlighting current position against delivery plan	-

Key gaps in control:	**Key actions to close gaps in control:**	**Impact on risk to be measured by:**	**Expected completion date./(Action review date):**	**Progress against action:**	**Action on track:**
Capacity within the IM&T Team to support programme delivery to the level required by the project plan	Identify and agree priorities and release of staff [ACTION OWNER: COO]	Compliance with the agreed resource plan for the project	30/11/2020		

Maintaining level of engagement with clinicians throughout the project	Maintaining the commitment to protect clinical time within the programme. [ACTION OWNER: MD/DON] Continued communication as to how staff can be involved and on decisions being made [ACTION OWNER: COO]	Monitoring of attendance at the LIG and CDA Feedback from clinical staff during project delivery	Ongoing Monthly	Current high levels of attendance and engagement Issues reported by exception to OnEPR Programme Delivery Board	
Key gaps in assurance:	**Key actions to close gaps in assurances:**	**Impact on risk to be measured by:**	**Expected completion date./(Action review date):**	**Progress against action:**	**Action on track:**
Adherence to the project delivery plan due to unforeseen circumstances	Close monitoring of the project risk register and issues log/regular updates with potential to adjust phasing of 'go live' decisions for each phase [ACTION OWNER: COO]	Adherence to the project delivery plan	(30/11/2020)	Risk register and issues log. Weekly and monthly updates in place. Plan for learning disability and CAMHS to commence using new EPR on track for 30/11/2020	
Ability for new EPR to meet operational and assurance reporting requirements	Diagnostic project to be undertaken to identify which current reports can be replaced, removed or replicated. [ACTION OWNER: COO]	Delivery of required operational and assurance reports	(30/11/2020)	Weekly and monthly updates in place.	

Strategic Objective 2. To be a GREAT place to work

Principal risk: There is a risk that we do not create a healthy vibrant culture and conditions to make DHCFT a place where people want to work, thrive and to grow their careers

Impact: Risk to the delivery of high quality clinical care
Inability to deliver transformational change
Exceeding of budgets allocated for temporary staff
Loss of income

Root causes:

a. National shortage of key occupations and registered professions
b. Future commissions of key posts insufficient for current and expected demand
c. Sufficient funding to deliver alternative workforce solutions
d. Retention of staff in some key areas
e. Overdependence on registered professions
f. Impact of COVID-19 pandemic
g. Increase in mental health demand and associated funding
h. Increase in use of technology
i. Person centred culture not yet fully embedded

BAF ref: 20_21 2a	**Director Lead**: Jaki Lowe, Director of People and Inclusion	**Responsible Committee**: People and Culture Committee

Inherent risk rating:			**Current risk rating:**				Target risk rating:			Risk appetite:		
Rating EXTREME	Likelihood 4	Impact 5	Rating EXTREME	Likelihood 4	Impact 5	Direction NA	Rating HIGH	Likelihood 3	Impact 5	Accepted	Tolerated	Not accepted

Key controls:

Preventative –Workforce Plan covering wide range of recruitment channels including targeted campaigns, refreshed 'Work For Us' internet page, leadership development, new role and skill mix changes, leadership development programme, increased well-being support.
Detective – Performance report identifying specific hotspots and interventions to increase recruitment and retention, Freedom to Speak Up Guardian role, Peoples Services Leadership Team meeting to oversee delivery of the People agenda
Directive – Wellbeing Strategy, infrastructure and programmes to support staff health and wellbeing. Workforce plan to grow and develop the workforce.
Corrective – Leadership and Management Strategy and development programmes to build inclusive and engaging leadership and management. Leadership Programme Launch – Core Leaders. Joint Venture Leadership Team (JVLT) overseeing delivery of Peoples Services.

Assurances on Controls (internal):	Positive assurances on Controls (external):
Bi Monthly People Performance Report to Trust Management Team, Executive Leadership Team and People and Culture Committee, includes recruitment tracker and deep dives Workforce Supply Hot Spot report to Trust Management Team and People and Culture Committee ELT rolling programme of deep dives of strategic building blocks STP People and Culture Board overseeing workforce supply	Significant improvement in levels of engagement and feedback from 2019 staff survey Internal Pulse Checks. External People Pulse Check Latest CQC visit identified improved employee relations and staff engagement

	Safe staffing reports and CHPPD reporting (planned v's actual staff) WRES, WDES and Gender pay gap reporting Internal Audit: Freedom to Speak Up (limited assurance); Freedom To Speak Up Index

Key gaps in control:	Key actions to close gaps in control:	Impact on risk to be measured by:	Expected completion date./(Action review date):	Progress against action:	Action on track:
Effective recruitment and retention plan to all posts Time taken to recruit to new and vacant posts	Review of Recruitment Strategy [ACTON OWNER:DPI] Review weekly recruitment activity in IM&T and by Peoples Services leadership team [ACTON OWNER:DPI] Review of recruitment activity and timelines by People and Culture Committee [ACTON OWNER:DPI]	Vacancy rates Diversity in appointments	31/01/2021 30/11/2020	Recruitment campaign available via Trust website and on social media IM&T review in place. Peoples Services leadership team review to be developed To be presented to People and Culture Committee Nov 2020	
Embedded flexible workforce arrangements in place	Implementing the learning from flexible working arrangement in response to the COVID-19 pandemic, i.e. home working, redeployment [ACTON OWNER:DPI] Review of policies/processes and contracts of employment to embed flexible working [ACTON OWNER:DPI]	Sickness absence rate. Staff survey responses Pulse and people pulse check responses % of people working on flexible contracts with respect to hours and location.	31/01/2021	Flexible working already in place as a result of COVID-19 with many people working from home.	
Fully embedded person centred culture of leadership and management	Review of policies and processes to support a person centred approach to leadership and management [ACTON OWNER:DPI] Review of leadership development offer [ACTON OWNER:DPI]	Reduced number of formal staff relations issues/cases	31/03/2021	"People First - Supporting colleagues fairly through workplace situations" model developed. Presentation and training plan in progress to support delivery.	

Development of a funded Workforce Plan that delivers on new role development	Develop and implement 2020/21 of the Workforce Delivery Plan [ACTON OWNER:DPI]	Vacancy rate of registered posts. No of new roles in place	(31/01/2020)	Annual revision underway, aligning reset programme to Phase III response.	
People services shaped to deliver against future needs of the organisation	Review of Peoples Services model and plans [ACTON OWNER:DPI] Identify resources required to shape culture locally [ACTON OWNER:DPI] Develop performance framework to support delivery of revised model [ACTON OWNER:DPI]	Implemented performance framework	31/03/2021 31/12/2020	Recruitment to Director of People and Inclusion. Cross organisational joint venture leadership meeting in place.	
Consolidate health and wellbeing provision and infrastructure, ensuring learning from COVID-19 pandemic is incorporated	Align well-being offer to local STP and national offers [ACTON OWNER:DPI] Publish well-being offer via new intranet pages and through social media. Roll out of health and wellbeing plans for all staff [ACTON OWNER:DPI] Review management of change policy to incorporate health and well-being discussions. Similar review of appraisal policy and processes [ACTON OWNER:DPI] Review Occupational Health contract [ACTON OWNER:DPI] Roll out of flu vaccination plan for autumn 2020 and any subsequent COVID-19 vaccine [ACTON OWNER:DPI]	Maintain sickness absence rates to below 5% or below Reduction in sickness absence as a result of anxiety and stress % uptake of health and well- being plans. % uptake of health risk assessments Reduction in sickness absence rates as a result of MSK issues Increased uptake of staff flu vaccination to 100% by 01/03 2021 and 90% by 30/11/2020	(30/11/2020) 30/11/2020 28/02/2021 (tbc) 30/11/2020	Health risk assessments underway Review of management of change policy underway.	

Key gaps in assurance:	Key actions to close gaps in assurances:	Impact on risk to be measured by:	Expected completion date./(Action review date):	Progress against action:	
Training compliance in key areas below target set by the Trust	Recovery plan to be implemented. Mandatory training to be rostered. [ACTION OWNER: DPI/COO]	% compliance with mandatory training. Forward planning for training compliance	30/11/2020	Recovery plan in place. Forward plans to include rostering of training to be developed.	
Evidence of safer staffing levels of suitably qualified staff	Compliance with NHSI Workforce Safeguards requirements [ACTION OWNER DPI]	Full compliance with safer staffing levels in line with the NHSI Workforce Safeguards	31/03/2021		

Related operational high/extreme risks:

Record ID	Service Line	Title	Risk: Summary of progress	Date of next review
21222	Peoples Services	Compliance - Resus Training(ILS & BLS)	[06/07/2020] APBLS was paused over the COVID pandemic initial months resulting in only APBLS for new inductees occurring. From 7th of July 2020 all APBLS session are open for staff to book onto. In March service areas were asked to send the names of staff to book onto APBLS. Not all service areas replied. For those who did a place has been secured, although in light of social distancing, places have been reduced to enable this to occur. During the COVID pandemic, ILS has continued to be delivered, although those allowed to attend has been restricted due to social distancing. The resuscitation lead and people development lead highlighted that some medical staff potential were allocated the incorrect level of resuscitation, i.e. ILS rather than APBLS. Awaiting an update from deputy medical director to support this. Once completed ESR will be amended to reflect the level.	31/10/2020
21510		Delivery of Positive and Safe and Training Compliance	[01/10/2020] The team JD has been agreed and to be advertised. It is anticipated to have the team fully inducted by March 2020, should the positions be appointed to in the first scheduled interviews. Currently the two trainers are being supported by a fixed term contract until March 2021 and during this time each positive and safe update is accommodating 15 learners and this is why an external venue is being used to safely maximise within social distancing rules the number which the team can accommodate. But there needs to be 100 % attendance to ensure that the compliance begins to be achieved. This has been raised to ELT. Each ward manager has been contacted to inform of the new method of delivery and liaising is constant to ensure all staff are gaining a place on Positive and Safe.	31/12/2020

1569	Community Care Services - County South	Work related stress	[14/10/2020 Progress on improving the environment is on hold due to the coronavirus situation. H&S Team supporting escalation. Staff are reporting a far higher level of work related stress due to the imposed restrictions currently and also the uncertainty over future plans. Many staff are having to try to work in unsuitable environments away from the workplace which are causing additional stress and which are often out of our control as an organisation.	31/12/2020
2772	Child and Adolescent Mental Health Services (CAMHS)	Insufficient resources CAMHS workforce	[01/06/2020] Recruitment to vacancies remains unchanged and challenging. Vacancies covered by 2.6 wte long term locums. Rota cover remains fragile and further impacted by Covid 19. Separate risk assessment completed regarding on call rota and Covid 19. NMP training commenced as planned.	01/10/2020
22168	Urgent Assessment Services: Mental Health Triage Hub	Health and safety lone working	[13/10/2020] Not all staff have had any training or updates with breakaway/PSTS training. This has been raised to senior management/ASM who is liaising with training department.	01/02/2021

Strategic Objective 2. To be a GREAT place to work

Principal risk: There is a risk of continued inequalities affecting health and well-being of both staff and local communities

Impact: Risk to the delivery of high quality clinical care
Inability to attract, recruit and retain a motivated and diverse workforce
Risk to the health and wellbeing of our staff
Risk to patients and communities having access to the right services
Escalation in formal cases impacting on individuals and teams
Reduced confidence by our communities in our Trust

Root causes:

a. Commissioning of services leads does not meet the need of diverse communities
b. Change management and transformation programmes lead to deterioration in experience
c. Processes and policies have inbuilt bias
d. Processes for advocacy and raising issues not clear or dealt with well
e. Gaps in cultural competence of leaders and managers

BAF ref: 20_21 2b	**Director Lead**: Jaki Lowe, Director of People and Inclusion	**Responsible Committee**: Trust Board

Inherent risk rating:			**Current risk rating:**				Target risk rating:			Risk appetite:		
Rating HIGH	Likelihood 4	Impact 4	Rating HIGH	Likelihood 4	Impact 4	Direction NA	Rating MODERATE	Likelihood 3	Impact 4	Accepted	Tolerated	Not accepted

Key controls:

Preventative – Freedom to Speak Up Guardian (FTSU) self-assessment and 6 monthly reports; annual review of people development plan commissioned through People Services; provision of information through induction processes for new staff; staff engagement sessions; Recruitment Action Steering Group meeting fortnightly; supported Networks for diverse staff groups and allies; Health and Well-being Network;
Detective – Weekly recruitment report to IMT; Fortnightly performance report to ELT; monthly performance report to Board; Reverse Commissioning Project Group; Reverse Commissioning Steering Group; Equality Forum; Attendance management monitoring; Take up of Reasonable Adjustment Passports; Updating of ESR regarding disability and long term conditions;
Directive – People Strategy; Inclusion strategy; Joined Up Care Derbyshire People Strategy;
Corrective – Leadership and management development strategy ensuring inclusion is at the heart of all development; Exit interview feedback

Assurances on Controls (internal):	Positive assurances on Controls (external):
Executive Leadership Team rolling programme of deep dives on strategic building blocks	Gender Pay Gap annual assessment and report; Assessment and report annually for EDS2 WRES and WDES annual report

Key gaps in control:	Key actions to close gaps in control:	Impact on risk to be measured by:	Expected completion date./(Action review date):	Progress against action:	Action on track:
Refresh and expand Inclusion Strategy	Establish approach for refreshing and expanding the inclusion strategy Establish a steering group to oversee refresh of the inclusion strategy Develop a communication and engagement plan to support the refreshed inclusion strategy Refreshed inclusion strategy completed Launch events for the Inclusion Strategy [ACTION OWNER FOR ABOVE: DPI]	Improved position regarding staff motivation in Staff Survey Freedom to Speak Up Index Positive Pulse Check Positive Inclusion Recruitment report Positive Family and Friends Test % of exit interviews completed Metrics within the employee relations report	30/11/2020 31/01/2021 31/03/2021		
Refresh and expand Engagement Strategy. Include lessons learnt from response to COVID pandemic	Establish approach for refreshing and expanding the engagement strategy Establish a steering group to oversee refresh of the engagement strategy Develop a communication and engagement plan to support the refreshed engagement strategy Refreshed Engagement Strategy completed Launch events for the Engagement Strategy [ACTION OWNER FOR ABOVE: DPI]	Improved Staff survey results Positive Family and Friends Test Positive Pulse Check	30/11/2020 31/01/2021 31/03/2021		
Gaps in the cultural competence of leaders and managers resulting in staff reporting being disadvantaged due to their protected characteristics	Diagnostic exercise to identify gaps around culture and identify how to build on current approaches Roll out of cultural competence training to equip leaders and managers to be able to lead and support staff and provide the best experience for service users	Metrics within the employee relations report Metrics within the Freedom to Speak Up report Annual publication of Workforce Race Equality Standard data, identifying an improved position	31/03/2021	BAME risk assessments offer completed. Health risk assessments nearing completion.	

	[ACTION OWNER: DPI] BAME and health risk assessments offered for staff [ACTION OWNER: DPI]	Live WRES monitoring to ensure consistent capture and monitoring of data			
Key gaps in assurance:	**Key actions to close gaps in assurances:**	**Impact on risk to be measured by:**	**Expected completion date./(Action review date):**	**Progress against action:**	**Action on track:**
Unequal experience of people with protected characteristics through recruitment process	Review of recruitment strategy and plans [ACTION OWNER: DPI]	Improved BME recruitment process outcomes	31/3/2021		

Related operational high/extreme risks:

Record ID	Service Line	Title	Risk: Summary of progress	Date of next review
21816	Universal 0-19 Services	Services provided to the Asylum Centre in Derby	[13/02/2020] Reviewed and risk elevated to high. Visit by ASM to the overflow accommodation quantified some risk around infant feeding, lack of oversight, safe sleep. records provided by home office and GP do not always correlate so not always clear on families who need intervention & visits. Activity is not commissioned. Reporting to TMT. Involved in meeting with commissioners re this service provision.	31/05/2020

Strategic Objective 3. To make BEST use of our money

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

Impact: Trust becomes financially unsustainable

Root causes:

a) Financial detriment (revenue, cash and/or capital) resulting from large capital development programme, in particular dormitory eradication and patient record investment
b) Organisational financial detriment created by commissioning decisions or wider 'system-first' decisions including enactment of risk-sharing agreement in partnership arrangements or changes in NHS financial arrangements during and beyond the pandemic
c) Non-delivery of expected financial benefits from transformational activity
d) Non-delivery of standard financial efficiency requirements
e) Lack of sufficient cash and working capital
f) Loss due to material fraud or criminal activity
g) Unexpected income loss or non-receipt of expected transformation income (e.g. LTP and MHIS) without removal of associated costs
h) Costs to deliver services exceed the Trust financial resources available, including contingency reserves.

BAF ref: 20_21 3a | **Director Lead**: Claire Wright, Executive Director of Finance | **Responsible Committee**: Finance and Performance Committee

Inherent risk rating:			**Current risk rating:**				Target risk rating:			Risk appetite:		
Rating EXTREME	Likelihood 4	Impact 5	Rating EXTREME	Likelihood 4	Impact 5	Direction NA	Rating MODERATE	Likelihood 2	Impact 5	Accepted	Tolerated	Not accepted

Key controls:

Preventative – 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 counterfraud training and annual counterfraud 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 CIP planning and delivery; Contract performance, Local counterfraud scrutiny.
Directive – Business plans and templates set out clear financial plans and assumptions: Standing financial instructions; budget control, delegated limits, recruitment approval processes; Business case approval process; Invest to save/Quality Improvement methodology and protocol- Plan Do Study Act. Risk and gain share agreements.
Corrective – Risk mitigation activity and oversight at ICS system/other partnership level. Proactive reporting and forecasting of capital and wider transformation programme progress enabling remedial activity to take effect. General corrective management action; Use of contingency reserve; Disaster recovery plan implementation; Performance reviews and associated support/ in-reach.

Assurances on Controls (internal):	Positive assurances on Controls (external):
- 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	- Internal Audits– Financial integrity and key financial systems audits - External Audits – strong record of high quality statutory reporting with unqualified opinion

- Delivery of Counterfraud and audit work programme with completed and embedded actions for all recommendations - Independent assurance via internal auditors, external auditors and counterfraud specialist that the figures reported are valid and systems and processes for financial governance are adequate	- NHSI Finance Rating Metrics – shows good performance - National Fraud Initiative – no areas of concern - Local Counterfraud work – Referrals show good counterfraud awareness and reporting in Trust and no material losses have been incurred. Green rated CounterFraud Risk rating for 'Self Review Tool' Information Toolkit rating – evidencing strong cyber risk management (ref fraud/criminal financial risk)

Key gaps in control:	**Key actions to close gaps in control:**	**Impact on risk to be measured by:**	**Expected completion date./(Action review date):**	**Progress against action:**	**Action on track:**
'Best Value' building block - Use of resources priorities not yet achieved 1. Increase wellbeing and reduction in sickness absence 2. Inclusive leadership/retention 3. Deliver e roster and e job planning 4. Eliminate out of area placements 5. Optimise digital technology 6. Medicines optimisation and e prescribing 7. Streamline access to services 8. Optimise use of estate 9. Consider size and function of corporate services 10. Improve administration and communication	Delivery of 'Use of Resources (UoR)' Top Ten priorities along with other transformation programme (as informed by the lessons learned cell) [ACTION OWNERS: DOF/DPI/MD]	Improvement in related UOR metrics as reported to - Board - Finance and Performance Committee People and Culture committee	Bi-annual UoR reporting, but monthly reporting on some of metrics (UOR priorities overlap with key change programmes – so this might be duplicative)	Sickness levels improving but at risk due to COVID-19 pandemic Leadership development to continue E roster – specific programme Out of area placements – linked to eradication of dormitory accommodation and Covid secure environment Digital – Attend Anywhere in place, MS Teams in place Medicine optimisation ongoing, E prescribing part of OnEPR later Access – lessons learned/business as usual. Waiting lists impacted by Covid Estate – Impacted by: social distancing requirements, remote working and home working, dorms eradication work Corporate services – some STP work (e.g. payroll) Admin and communications – engagement and communications – are of high focus and success	
'Best Value' building block - delivery of planned benefits of specific change programmes	Delivery of planned benefits realisation for change programmes in particular: - Dormitory eradication programme - Delivery of OnEPR programme - Delivery of enhanced E-Roster and	Achievement of planned benefits of change programmes as reported to Programme Boards and Finance and Performance Committee at key milestone points (and by exception)	Most are Multi-year and not all set out yet (quarterly – tbc)	- OnEPR is on track (see separate BAF risk) - Dorms is at bidding stage - E roster is in place but changes were not enacted and consultation to be revisited	

	e job planning - Delivery of planned MHIS/LTP service changes [ACTION OWNERS: DOF/COO]			- E job planning not in place - MHIS and LTP recruitment is proceeding at risk. Some funding confirmation awaited.	
Key gaps in assurance:	Key actions to close gaps in assurances:	Impact on risk to be measured by:	Expected completion date./(Action review date):	Progress against action:	Action on track:
Changing and unknown future NHS financial arrangements during and after pandemic National clarity needed Local / system clarity needed on financial arrangements including the mechanics for allocation of system financial envelopes and any risk share/gain (where applicable)	Assimilation of new guidance when received System Financial Oversight and Planning [ACTION OWNERS: DOF]	Agreed financial arrangements being enacted	M7	Guidance for M7-12 issued and system plan submitted 5 October. Organisational plans submission date 22 October aligned to system total. Financial gap for system as whole. Forecast management and challenge taking place to reduce gap	

Strategic Objective 3. To make BEST use of our money

Principal risk: There is a risk that learning from the response to the COVID-19 outbreak, and transformation plans developed prior, does not lead to sustainable embedded transformation

Impact: Improvements in the quality of care, working lives and service efficiencies are lost

Root causes:

a) Impact of the COVID-19 pandemic and adherence to directives including COVID secure environments
b) Increased use of clinical consultations and interventions using virtual technology in response to COVID-19
c) Increased use of videoconferencing for clinical and corporate meetings in response to COVID-19
d) Closer relationships between community teams and inpatient services developed as a result of working within COVID-19 guidance
e) Less miles travelled miles on trust business due to greater use of virtual technology and videoconferencing
f) Flexible working arrangements for colleagues increased in response to COVID-19
g) Understanding of factors which have led to the reduction in sickness and absence of colleagues
h) Historical reliance on staff based in trust estate
i) Limited team autonomy to make local improvements at pace

BAF ref: 19_20 3b	**Director Lead**: Gareth Harry, Director of Business Improvement and Transformation	**Responsible Committee**: Finance and Performance Committee

Inherent risk rating:			**Current risk rating:**				Target risk rating:			Risk appetite:		
Rating HIGH	Likelihood 4	Impact 4	Rating HIGH	Likelihood 4	Impact 4	Direction NA	Rating MODERATE	Likelihood 3	Impact 4	Accepted	Tolerated	Not accepted

Key controls:

Preventative – Adherence to national and local guidance in relation to responding to the COVID-19 pandemic
Detective – Lessons Learnt Cell of the Incident Management Team; EQUAL Forum; Regular reporting to Finance and Performance Committee on pipe line to include future transformation; Home Working and COVID Secure policies and procedures
Directive – Estates Cell of the Incident Management Team has established principles for home working and estates optimisation; Quality Improvement Strategy; Clinical Strategies
Corrective - Fortnightly System Restoration Cell focused on joint plans; restoration plans in line with Phase 3 national planning; Evidence of local improvements at team level i.e. risk stratification of caseloads, discharge processes

Assurances on Controls (internal):	Positive assurances on Controls (external):
- Regular reporting of impact of measures taken to IMT	- Patient Surveys for patients with learning disabilities and SMI conducted by HealthWatch

Key gaps in control:	Key actions to close gaps in control:	Impact on risk to be measured by:	Expected completion date./(Action review date):	Progress against action:	Action on track:
Implementation of the Estates Strategy in relation to community and corporate estate	Conduct estates optimisation work for community and corporate services [ACTION OWNER: COO]	Less corporate estate	(31/01/2021)	Management of change process underway	
Embedding of current ways of working in a post COVID environment	Maintain directives on virtual meetings and non-patient facing activities to support new ways of working [ACTION OWNER: DBI&T]	Less miles travelled on trust business compared to a pre COVID baselines More hours working from home compared to a pre COVID baselines	(31/01/2021)	Organisation is operating under COVID secure guidelines	
Consistency of application with respect to use of videoconferencing software for patient consultations vs face to face in person consultations	Agreed protocol for when face to face in person appointments are necessary for patient safety with the understanding all other contacts would be via video or phone [ACTION OWNER: DON/MD]	% use of video/phone contacts with patients in line with the agreed protocol	(30/11/2020)	IMT restoration cell have commenced work	
Key gaps in assurance:	**Key actions to close gaps in assurances:**	**Impact on risk to be measured by:**	**Expected completion date./(Action review date):**	**Progress against action:**	**Action on track:**
Learning from COVID-19 pandemic outbreak against available self-assessments	Undertake self-assessment using recommended rating tools , and review learning from staff feedback [ACTION OWNER: COO]	Positive staff feedback on learning from COVID-19. Completed actions identified through self-assessment	31/12/2020 (31/10/2020)	Positive staff feedback via Pulse check. Self-assessment underway	
Implemented clinical strategies and quality improvement strategies and sign off all actions	Refresh quality improvement strategy and implementation plan. [ACTION OWNER: DBI&T] Build in prioritised actions from clinical improvement strategies into divisional business plans	Increase in no of people trained and supported to undertake QI actions at a local team level Delivery against the divisional business plans	(31/12/2020) (31/12/2020)	Group established to work on refreshed QI strategy Planning process agreed and in place between finance , transformation and planning teams	

Risk Rating:
The summary score for determining the risk ratings for each risk is shown below. The full Risk Matrix, including descriptors, is shown in the Trusts Risk Management Strategy

Risk Assessment Matrix

The Risk Score is simply a multiplication of the Consequence Rating x the Likelihood Rating.
The Risk Grade is the colour determined from the Risk Assessment Matrix below.

LIKELIHOOD	CONSEQUENCE				
	INSIGNIFICANT 1	MINOR 2	MODERATE 3	MAJOR 4	CATASTROPHIC 5
RARE 1	1	2	3	4	5
UNLIKELY 2	2	4	6	8	10
POSSIBLE 3	3	6	9	12	15
LIKELY 4	4	8	12	16	20
ALMOST CERTAIN 5	5	10	15	20	25

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

Action progress:
The colour ratings are based on the following descriptors.

Actions on track for delivery against gaps in controls and assurances:	Colour rating
Action completed	Blue
Action on track to completion within proposed timeframe	Green
Action implemented in part with potential risks to meeting proposed timeframe.	Amber
Action not completed to original or formally agreed revised timeframe. Revised plan of action required.	Red

Action owners:

CEO	Chief Executive Officer	COO	Chief Operating Officer
DOF	Deputy Chief Executive and Executive Director of Finance	DON	Executive Director of Nursing and Patient Experience
MD	Medical Director	DPI	Director of People and Inclusion
DBI&T	Director of Business Improvement and Transformation		

Board Committee Assurance Summary Reports to Trust Board – 3 November 2020

The following summaries cover the meetings that have been held since the last Public Board meeting.

Audit and Risk Committee - key items discussed 1 October 2020
Review of Board Assurance Framework (BAF) The third issue of the BAF for 2020/21 was presented. Issues one and two of the BAF for 2020/21 had focused on the risks faced by the organisation in response to the COVID-19 pandemic. The third issue was being developed in line with the broader revised objectives which support delivery of the Trust Strategy, and in line with the recovery and restoration phase for NHS services. Seven risks have been identified in relation achievement of the three strategic objectives of Great Care; Great Place to Work; and Best Use of Money. The BAF will be refreshed as part of the Board's review of the strategic building blocks, extending the BAF beyond the current 'COVID-19 response' format. The Committee also received the detail on the current operational risks rated as high or extreme, which had been aligned to the related BAF risk. The Committee agreed the revised programme of deep dives for each BAF risk up to the end of the 2021/22. Only the risks rated as extreme would be subject to deep dives this year. The Committee queried the rating allocated to BAF Risk 1a given the significant increase in demand for the Trust's services due the impact of COVID-19. It was requested that the Quality and Safeguarding closely monitors this risk and provides assurance to the Committee that it was rated and scrutinised at a high enough level.
Progress against Risk Management Strategy 2019 – 2022 Overall the pace of progress has been impacted by the COVID-19 pandemic, affecting training compliance; governance related meetings; and the capacity to introduce improvements to embedded processes which are low risk to the organisation. The Committee noted that the Trust Management Team meetings would recommence in October, which would improve oversight of the reporting. Progress against the objectives set out in the Risk Management Strategy is reported annually to the Committee.
Review of 2019/20 Annual Report and Accounts Production Despite the challenges of the pandemic and the changes to the guidance, overall, the production of the 2019/20 Annual Report and Accounts went well, with leads for each section working effectively together in order to ensure statutory requirements were met. Some areas of learning have been identified and will be taken forwards for the development of the report for 2020/21.
Freedom to Speak Up Update Report The six monthly report covered the implementation of the Trust's Freedom to Speak Up (FTSU) policy framework and an update on the NHS England/NHS Improvement FTSU review tool. The Freedom to Speak Up Policy and Procedure is available on the Trust intranet.
Data Security & Protection Q1 – Q2 (April – September 2020) Report This provided a performance update on the Trust's progress towards meeting the requirements of the new 2020-21 Data Security & Protection [DS&P] Toolkit. This includes work of the DS&P Committee and incident breach monitoring. Although the Trust completed and submitted the 2019-2020 DS&P Toolkit successfully, many organisations have suffered and incurred delays due to the impact of COVID-19. The DS&P Committee has supported the Trust response to the COVID-19 emergency. This has been important not just for service receivers, carers and families, but also for staff. Virtual

online training for DS&P has been implemented to improve compliance. Work on additional projects including support to focus on secure electronic solutions and safe remote working was outlined.

Update on 2020/21 objectives for the Audit and Risk Committee

The Committee carried out a six-month review of achievement against its objectives. Good progress had been made and a final year end effectiveness report will be prepared by the Committee in March 2021. They build upon previous years' objectives but two new objectives were added for 2020/21. These were in relation to the appointment of the new external auditor (objective 1) and covering any gaps in assurance identified in the internal audit plan (objective 3).

Overpayments

The Finance Team had carried out a detailed piece of work analysing the overpayments and the main drivers, along with reviewing those processes linked to the main factors for overpayments.

Standing Financial Instructions (SFI) Update

The Committee supported an extension of the emergency SFIs reflecting the emergency decision making powers of the Incident Management Team as part of the Trust's response to the pandemic.

Intellectual Property Policy and Procedure

A revised version of the above policy was approved. The amendments had no substantial impact on the substance of the Policy but rather remove reference to older Framework guidance.

Internal Audit Progress Report

The Internal Audit Progress Report was presented by 360 Assurance. The impact of the pandemic had required a rescheduling of the 2020/21 Internal Audit plan. The Committee supported replacing the sickness absence management audit with a review of Quality of Workforce Race Equality Standard and Workforce Disability Equality Standard Data. The days in the Governance review would be used to expand the scope of the Head of Internal Audit (HOIA) Opinion which will need to include an assessment on the Trust's governance, risk management and control arrangements in a period where there has been a global pandemic. Revised terms of reference for the HOIA Opinion were received.

The Committee confirmed that the priority for 2020/21 is to have a core Internal Audit plan and ensure there are not any areas of exposure.

Counter Fraud, Bribery and Corruption Progress Report

The Counter Fraud Service continues to progress investigative work and address referrals of alleged fraud, bribery and corruption. Alerts and fraud warning intelligence has been appropriately communicated to the Trust. As part of the NHS Counter Fraud Managers Group, 360 Assurance has developed a weekly briefing paper being used to collate and share information about new issues identified across the national group. The Committee noted that the Conflicts of Interest Review has commenced and fraud prevention training has been provided to the Finance and Procurement teams.

External Auditor's Outline Audit Strategy

The Chair welcomed representatives from Mazars to their first meeting since the award of the external audit contact to them on 1 September 2020. They presented the outline audit strategy document that gave a summary of the engagement and responsibilities; the audit scope, approach and timelines; significant risks, key audit matters and other key judgement areas; value for money conclusion and information on materiality and misstatements.

Assurance/lack of assurance obtained

- The Committee agreed that the BAF report provided 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.
- The Committee noted the impact of pandemic on progress against the objectives set out in the Risk Management Strategy but were assured by the recovery plan.

- Significant assurance was received on the production of the 2019/20 Annual Report and Accounts.
- Assurance was received on the framework to support Freedom to Speak Up, noting that all recommendations from the 360 Assurance report have successfully been implemented.
- In relation to progress with new DS&P Toolkit; full assurance on progress on the Data Security agenda through the DS&P Committee; full assurance the risks of data security are recognised by the team; Full assurance that Data Security breaches are monitored and responded to appropriately including any actions required, and full assurance that cyber security has the priority it needs.
- Limited assurance on progress against the work on overpayments.

Key risks identified

As identified in the BAF.

Decisions made

- Approval of the third issue of the BAF for 2020/21
- Approval of the six month progress report against Committee objectives

Escalations to Board or other Committee

- Risks relating to the significant increase in demand due to COVID-19 to be closely monitored by the Quality and Safeguarding Committee and factored into BAF risk 1a.

Next meeting – 21 January 2021

Committee Chair: Geoff Lewins	**Executive Leads: Claire Wright, Deputy Chief Executive and Director of Finance and Justine Fitzjohn, Trust Secretary**

Quality and Safeguarding Committee - key items discussed 8 September 2020

Board Assurance Framework (BAF)

The Committee regularly monitors the BAF risks allocated to it and considers them in the context of Committee discussions and work programme and was mindful of the emergent risks to fully deliver the March 2021 long-term plan. The Trust's clinical teams will be exploring impactful clinical interventions to reduce the risk.

COVID-19 Summary Update

This briefing on COVID-19 activity relating to specific quality, clinical and safety aspects of care provision provided significant assurance with regard to ethical decision making across the Trust's services.

Quality Performance Dashboard

The dashboard summarised highlights and challenges through the use of high level quality indicators, identified in line with the quality elements of the Trust Strategy and the Trust's Quality Priorities. The dashboard also included an update on current CQC actions that require a response and have since been completed for sign off.

Learning from Deaths Mortality Report for the period 1 June to 24 August 2020

During the COVID-19 pandemic, the learning from deaths process continued to be undertaken but slight changes to the process were initially made to allow for colleagues to undertake other duties. Activity has now resumed to normal levels with weekly case note reviews and the daily reviewing and grading of all new deaths taking place. The report was approved for submission to the Board on 3 November.

Infection Control Annual Report The report summarised the activity over the preceding twelve months of work related to infection control. All standards are above the national level and are fully compliant with the audit programme against national infection control guidance. Significant assurance was obtained from the report and approval was given for the report to be submitted to the next Trust Board meeting on 3 November.
View of Clinical Research Programme during 2019-20 and plans for 2020-21 The report was credited with giving the Committee significant assurance from the design, application and controls within the Trust's clinical audit objectives.
Patient Experience Quarterly Report The Committee was updated regarding the themes and changes made to Trust services as a result of feedback on incidents and complaints made to the Patient and Carer Experience Committee. The Committee discussed how incidents and complaints are communicated. It was understood that communication from service users and carers helps identify where service improvements need to be progressed.
Safer Staffing and Skill Mix Review The Committee was updated on work being undertaken to monitor and develop the skill mix of staff across the Trust to ensure safe services. The Committee was satisfied that standards are in line with the COVID-19 emergency plan which is set as the safe minimum level of operating rather than normal operating standards. Services have remained safe for patients and staff to prevent harm to anyone and to ensure all receive the appropriate level of care during challenging times.
Quality Account 2019/20 Reporting for 2019/20 is out of flow due to responding to COVID-19. The report was circulated to Committee members for comments prior to the next meeting on 13 October.
Safeguarding Children Quarterly Report The Committee noted the activity set against the Safeguarding Children Strategy and was satisfied that the Trust is fully compliant in line with statutory and legislative requirements. Discussion involved the response received from the mental health support line that related to children and how the CAMHS Hub was dealing with responses. Training compliance was raised as an issue as some training programmes have been temporarily suspended due to COVID-19.
Safeguarding Adults Quarterly Report The report covered progress on how the Safeguarding Adult leads are discharging their legal duties on behalf of the Trust. The Safeguarding Adult team has continued to provide a full service during this pandemic period despite the surge in demand.
Response to the Special Educational Needs and Disabilities (SEND) Derby City Council – Written Statement of Action (WSoA) The Trust is fully compliant with SEND statutory duties and is working with local authority partners to focus on outstanding points on this action plan. Limited progress has been made and a further update to ensure progress will be made.
Safeguarding Children and Adults Annual Report The report confirmed that the Trust has discharged its contractual and regulatory duties. The Committee gave its approval for the report to be submitted to the Board on 3 November.
Derby City Children in Care Annual Report The Committee noted that the Trust is fully compliant and has discharged its formal statutory duties to vulnerable children. The key priorities for 2020/21 were supported and approval was given for the

report to be submitted to the Trust Board on 3 November.

Assurance/lack of assurance obtained

- Infection Control Annual Report provided significant assurance that approaches and learning are evolving in accordance with emerging evidence and international / national and regional learning. Significant assurance also obtained from standards of cleanliness of clinical areas and food preparation area
- Patient Experience Quarterly Report provided significant assurance due to the previous scrutiny of the Patient and Carer Experience Committee
- Clinical Research Programme during 2019-20 and plans for 2020-21 provided significant assurance with governance plans and actions
- Safer Staffing and skill mix review provided limited assurance due the gaps that were noted in training and supervision.
- Safeguarding Children Quarterly Report provided limited assurance due to the small gaps in control relating to training compliance with significant assurance obtained from Safeguarding Children activity, systems and controls within the Trust
- Safeguarding Adults Quarterly Report provided significant assurance but there are residual gaps in control relating to training and these are being responded to as a matter of priority
- Safeguarding Children and Adults Annual Report provided significant assurance
- Derby City Children in Care Annual Report provided significant assurance of the work within DHCFT around looked after children and young people and the continued partnership working to ensure the best outcome is achieved for this vulnerable group of children and young people.

Key risks identified

None

Decisions made

Mortality Report, Infection Control Annual Report, Safeguarding Children and Adults Annual Report and Derby City Children in Care Annual report were all approved for submission to the Board on 3 November.

Escalations to Board or other Committee

The need for solutions to be found for improving training compliance levels was raised as a concern for the People and Culture Committee to address. On the understanding that the People and Culture Committee is closely monitoring gaps in control in training no further issues were raised for escalation to the Board Committees

Next Meeting – 13 October 2020

Committee Chair: Margaret Gildea	**Executive Lead: Carolyn Green, Director of Nursing and Patient Experience**

Quality and Safeguarding Committee - key items discussed 13 October 2020

Board Assurance Framework (BAF)

The Committee regularly monitors the BAF risks allocated to it and considers them in the context of Committee discussions and work programme and is satisfied with the way risks have been articulated.

COVID-19 Summary Update

This was a briefing on COVID-19 activity relating to specific quality, clinical and safety aspects of care provision. Two outbreaks have occurred in inpatient settings and are being well controlled and managed. Concern was raised that staff cannot be expected to be able to sustain this level of intense

work to maintain these levels of control.

Quality Account 2019/20

The Committee noted the update on the Quality Report/Quality Account for 2019/20 following a revised timetable due to COVID-19 and approved the version that would then go out to external consultation. The Board will be asked to delegate authority to the Committee to approve the final version of the Quality Account for 2019/20 at the Committee's December meeting in time for submission on 15 December.

CQC Actions Update

The report updated the Committee on current CQC actions that require a response. A significant amount of work has progressed in completing the CQC actions as part of general improvement work or as part of the COVID response.

Report from the Guardian of Safe Working

The Committee obtained significant assurance from the arrangements made to ensure safe working of junior doctors. It was requested that the report be anonymised and the cover sheet be revised in readiness for the report to be submitted to the Trust Board on 3 November.

Patient Experience Strategy

A number of actions have been delayed due to the COVID-19 pandemic but work is underway to make progress and recover some of the de-prioritised requirements.

Briefing on Ligature Position

Following receipt of the CQC Briefing for NHS Mental Health Trusts in relation to expectations to manage ligature risks, this briefing enabled the Committee to be satisfied with the progress that has been made. A ligature update report is due to be received at the next meeting in November and an assurance level will be given when this report is received.

Assurance/lack of assurance obtained

- COVID-19 Summary Update provided significant assurance that the Trust's operating mechanisms in dealing with COVID-19 are working well
- CQC Actions; limited assurance was received from the report on the basis that evidence had not yet been signed off
- Report from the Guardian of Safe Working provided significant assurance from the arrangements made to ensure safe working of junior doctors.
- Patient Experience Strategy provided significant assurance that the correct work plan is in place

Key risks identified

No additional items were considered necessary for updating in the BAF. A watching brief will be kept on the systematic investment of a forensic service to fully deliver the long term plan.

Decisions made

- Approved the Quality Account 2019/20 to go out to external consultation.
- Approved the report from the Guardian of Safe Working for submission to the Board on 3 November

Escalations to Board or other Committee

No items were considered necessary for escalating to the Board or other Board Committees.

Next Meeting – 10 November 2020

Committee Chair: Margaret Gildea	Executive Lead: Carolyn Green, Director of Nursing and Patient Experience

People and Culture - key items discussed 22 September 2020
Board Assurance Framework (BAF) Issue 3 of the BAF was currently being developed in support delivery of the Trust Strategy with the recovery and restoration phase for the Trust's services. No changes were considered necessary to BAF risks 2a and 2b assigned to the Committee.
Staff Story The General Manger of Children's Division shared their perspective of leading a team while responding to the level 4 COVID-19 incident and the specific lessons learned from this period to be taken forward. These included the quick redeployment of staff and the importance of having training in place to enable staff to move to new roles quickly.
Workforce Performance Report The Committee discussed how sickness absence had considerably reduced which is thought to be due to the increased level of flexibility being offered to staff working from home. The Executive Lead outlined how the implementation of a new dashboard will provide assurance on delivery of the workforce strategy and people performance. The strong connective working between the Incident Management team (IMT) and People Services also provided assurance.
Workforce Safety Standards - Response to COVID-19 This was the first draft of the Trust's 2020/21 formal submission to be made to NHS Improvement (NHSI) in February 2021 outlining the Trust's compliance against each standard. The self-assessment showed gaps in control experienced in July that is currently preventing full sign off. The new performance dashboard will articulate how the workforce safety standard gaps are being managed until the metrics reach full compliance ready for the submission to be made to NHSI in February/March 2021.
Verbal Update on the Flu Campaign This year's flu campaign is taking a more stringent approach using lessons learned from previous years. Communications have now been released highlighting key reasons for getting vaccinated and how colleagues can have easy access to a vaccine via clinics that are convenient to attend with the aim for all staff to be vaccinated with 90% completed by the end of November.
2020 NHS Staff Survey and plans The launch of the survey is being extensively promoted throughout the organisation and has been built into staff engagement sessions and has also been discussed with the various staff networks.
Workforce Race Equality Standard (WRES) The Committee was granted delegated authority from the Board to approve the WRES for publication on the Trust's website by 31 October and shared with lead commissioners as part of the quality schedule. Although the submissions show an improved position, there are still some areas that require development to address the variations in recruitment, opportunities for progression and development and working conditions for people from a BME background. The BME Network is keen to ensure that the actions contained in the action plans will be taken forward through to completion. The Committee fully supported this approach and approved the WRES 2019/20 and the action plan for publication.
Workforce Disability Equality Standard (WDES)

The annual Workforce Disability Equality Standard (WDES) 2019/20 was also received for consideration and approval for publication on the Trust's public-facing website by 31 October 2020 and shared with lead commissioners as part of the quality schedule. WDES data showed there is work to be done to address the variations in experience, workforce representation, progression and development for staff with disabilities and long term conditions. There are gaps in the data concerning declarations which could be due to reluctance from some people to declare their disabilities. COVID-19 has also highlighted the high number of staff in the Trust with disabilities and long term conditions through the implementation of the Trust's Health Risk Assessment, designed to support colleagues to feel safe at work and secure in their environments.

The Committee noted the findings of the report and the need to improve the disclosure rate so that adjustments can be made for staff and approved the WDES for 2019/20 for publication.

Assessment of the People Plan

The People Plan from NHS England / NHS Improvement (NHSEI) and Health Education England sets out what NHS people can expect from their leaders, each other and from the Trust. The Committee welcomed this approach which is focused primarily on the immediate term (2020-21). The plan also has a great focus on inclusion which is very central to the Trust's own agenda so people can thrive both in health and equalities.

Freedom to Speak Up (FTSU) Activity and Impact of the FTSU Guardian Role

The Committee was updated on themes and trends taken to the Guardian over the past twelve months. Reporting anonymously will be made easier as some colleagues have asked for their identity to remain confidential. Bullying and Harassment is an important issue, although this has reduced in both Q4 2019/20 and Q1 2020/21. It was pleasing to see that the People Plan will be focussing on bullying and harassment which will tie in with FTSU work.

The Committee supported the planned approach for FTSU reporting mechanisms and agreed that significant assurance can be provided to the Board that the Committee has full oversight for FTSU and that cases are being followed through and managed proactively.

Strategic Workforce Report

The Strategic Workforce Report provided an update on recent development happening nationally across the NHS and the impact this will have on the Trust. Progress contained in the report was noted for information and was not discussed.

Employee Relations (ER) Assurance Update

In line with increased national focus on improved management of employee relations cases this report gave high level oversight of current cases progressed as at 31 August 2020. Significant assurance was received that the Trust is managing cases in line with expectations, particularly during the COVID-19 period when agreement was reached nationally to pause investigations unless clinically necessary. Learning from restorative practice from this period that will be taken forward within the Trust.

The Committee felt confident with the approach being taken in managing cases and received significant assurance from the management of the Trust's ER cases.

Training Compliance Delivery

Head of People Development took the Committee through the current position. Training plans are under daily review and are updated to add more training places to accommodate current non-compliant staff and high numbers going out of date between now and December. Training was suspended when the COVID-19 crisis started. Training delivery has now resumed and it is expected that a significant improvement will be seen in compliance levels. The Committee will be observing how training compliance develops owing to the increases in the number of staff being diagnosed with COVID and having to self-isolate. The Committee took limited assurance from plans to deliver and improve training compliance and will continue to closely monitor training as the second wave of the pandemic develops.

Assurance/lack of assurance obtained • Limited assurance was received from workforce performance due to the due to gaps in control relating to training that had been suspended due to COVID-19. Significant assurance was received with plans to develop a performance dashboard. • Workforce Safety Standards - Response to COVID-19 provided limited assurance due to gaps in control in July. Significant assurance that the performance dashboard will articulate how the workforce safety standard gaps are being managed until the metrics reach full compliance • 2020 NHS Staff Survey briefing provided significant assurance for the launch of this year's survey. • Significant assurance can be provided to the Board that the Committee has full oversight for FTSU and that cases are being followed through and managed proactively. • Plans to deliver and improve training compliance provided limited assurance. • Employee Relations report provided significant assurance from the management of the Trust's ER cases	
Key risks identified As identified in BAF risks 2a and 2b	
Decisions made WRES and the WDES 2019/20 and the action plans for publication were approved on behalf of the Trust Board.	
Escalations to Board or other Committee No matters were considered necessary for escalating to the Board or other Committees.	
Next Meeting – 24 November 2020	
Committee Chair: Julia Tabreham	**Executive Lead: Jaki Lowe, Director of People and Inclusion**

Finance and Performance Committee - key items discussed 30 September 2020
Assurance on Estate Strategy Discussion of status of business cases and considerations with regulators. Programme Management process and progress outlined. Discussed system support. The Committee expressed strong preference for single new build approach.
IMPACT partnership update Progress with risk and gain share discussions. Update on lead provider discussions. Sub-contract process progressing. The Committee agreed the need to understand the risk and gain share position ahead of signing sub-contract.
Phase 3 planning update Discussion of narrative submission and separate mental health submissions evidencing the Long Term Plan position for 2020/21. Flagged areas of concern Perinatal access, Physical Healthcare for Severe Mental Health Illness (SMI), Employment Individual Placement and Support (IPS), Dementia Diagnosis rates all accepted to be affected by COVID impact and some Mental Health Investment Standard (MHIS) envelope constraints. Discussed continuity of care and out of area placements.
Operational performance Discussed levels of out of area placements and IAPT as well as levels of referrals and restoration

levels. Further discussions on progress on continuity of care requirements for placements. Areas of focus included Autism Spectrum Disorder (ASD) and Child and Adolescent Mental Health Services (CAMHS) as well as wait times. SPS charts (charts to monitor process performance) discussed with regard to statistics and corresponding narrative. Evidence of increasing levels of acuity and complexity across various services. Discussed bed numbers and ward sizes and future building environment approach. Emphasised the need to further outline benefits realisation and measurement thereof. Supporting staff resilience is an area of focus.

Move to System One and EPR assurance

On track for delivery of first phase go live end of November. Weekly go/no-go meetings. COVID-related risks discussed and acknowledged. Levels of clinical engagement in programme confirmed.

Financial Governance

Discussed first half and second half of year financial arrangements. Discussed items on the balance sheet. System approach to financial planning and the need to understand the whole system picture as well as our own within it.

Noted that although the Committee had confidence in Trust financial governance the amount of unknowns at this point for system revenue and dorms capital meant that the Committee can't take assurance on plan delivery until funding is confirmed. Discussed the enormous workload and short timeframes for which the Committee acknowledged and expressed its gratitude.

CIP and Continuous Improvement

Discussed the progress made on transformation schemes and the scope for future savings in the context of COVID. Discussed examples such as Attend Anywhere growth rates and the scope to further describe transformation and efficiency in the digital transformations including OnEPR. Considered the need for more widely embedding a culture of continuous improvement. Future updates will be informed by the system financial 'gap' for 20/21 in-year efficiency as well as a more general transformation update with overt reference to the evidence of quality and efficiency gains therein and how they may be measured.

Also discussed the need to design-out efficiencies in the new build programme and ensure wide clinical involvement with that focus to further enhance staff and patient experience.

Board Assurance Framework

The Committee was content with the draft BAF risks it has oversight for, and was satisfied with the suggestion for enhancing non-COVID content of the transformation risk.

The Committee Noted the timing of the finance deep dive would mean a more forward looking perspective, with an alternative of the potential for the risk level to reduce, dependant on finalising the next financial plan submissions for system and organisation.

EPRR Annual Assurance

The Committee took full assurance from the Emergency Preparedness, Resilience and Response (EPRR) annual submission.

Escalations to Board or other Committee

No formal escalations; discussion about leadership capacity given breadth of large programmes of work.

Next Meeting: 17 Novembers 2020

Committee Chair: Richard Wright	**Executive Lead: Claire Wright, Deputy Chief Executive / Director of Finance**

Mental Health Act (MHA) Committee - key items discussed 11 September 2020

MHA Operational Group Minutes

The Committee received and discussed the minutes of the MHA Operational Group held on 17 August 2020.

Mental Health Act Manager's Report

The report contained an analysis and assessment based on the period from 1 July 2019 to 30 June 2020 and was considered section by section. The report had been extensively covered by the MHA Operational Group.

Patient Experience Complaints Report

This was the first report to have been produced for review by the Committee which showed data comparing complaints, the background and type of complaints which were considered to be low.

Training Compliance

Due to COVID-19, all non-essential training has been paused so that services concentrate on the immediate task of supporting vital areas of service.

Satisfactory training rates in Deprivation of Liberty Standards, Mental Capacity Act and Mental Health Act have been achieved during the four month suspension of training during the pandemic.

Reducing Restrictive Practices Update

Discussion concluded that seclusion and restrictive practices are reducing and services are starting to use methods to bring levels back down to pre-COVID-19 levels.

Use of Section 135/136 in Derbyshire

The complexity of the work being undertaken by the 136 team and the work completed by the Section 136 Implementation Group was discussed. An increase in the number of detentions had been seen since the start of the pandemic and this was reflected nationally. The approach being taken towards managing the situation was supported and the Committee will monitor progress being made with the Police including training for mental health 136 issues.

Update from Associate Hospital Mangers (AHM)

AHM representatives reported that although there had been some technical issues regarding virtual access of mental health tribunals the system is working well using MS Teams. Hearings and renewals are up to date and the quality of reports has improved quite significantly. There are now nine AHMs and the team is working well.

Assurance/lack of assurance obtained

- Mental Health Act Manager's report provided significant assurance that the safeguards of the Mental Health Act are appropriately applied across the Trust.
- Limited assurance received from training compliance levels during the four month suspension of training due to COVID-19
- Significant assurance was obtained from the rationale behind restrictive practice and seclusion and comparisons made between the Hartington Unit and the Radbourne Unit.
- Limited assurance was obtained from training compliance due to suspension of training during COVID-19. Compliance rates for training will be closely monitored now that training has resumed.

Key risks identified

None

Decisions made • Patient Experience Complaints reporting will take place on a six monthly basis with reporting aligned with the Advocacy Service • Levels of seclusion and restrictive practices will be reported through the data contained in the MHA Manager's quarterly reports	
Escalations to Board or other Committee None	
Next Meeting – 11 December 2020	
Committee Chair: Sheila Newport	**Executive Lead: John Sykes, Medical Director**

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 3 November 2020

Register of 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 5 November 2019.

Executive Summary

In July 2019 Section 8.18 of the Standing Financial Instructions and Standing Orders of the Board of Directors was amended and the contract value for when the Trust seal is required was increased from £100,000 to £500,000. Therefore, every contract which exceeds £500,000 shall be executed under the Common seal of the Trust and be signed by the Trust Secretary and an Executive Director (voting or non-voting) duly authorised by the Chief Executive and not from the originating department (as set out in the Board's Standing Financial Instructions point 8.18).

These transactions will apply where the Board has previously approved the business through the Capital Expenditure Plan or the Estates and Agile Working Strategy. In accordance with the Standing Orders of the Board (section 12 point 6) a report of all sealing shall be made to the Trust Board twice a year. The report will contain details of the seal number, the description of the document and date of sealing. The register will be retained by the Trust Secretary.

A report on use of the seal was last made to the Board on 5 November 2019. A six month report had been due to be received by the Board in May 2020 but this was deferred due to COVID-19. Since the last report, the Trust Seal was affixed three times on 30 November, 19 December in 2019 and on 20 August 2020 as follows (the contract value for these transactions were valued at over £500,000):

1. DHCFT70 Unit 13, 14 and 15 Rinkway Business Park, Swadlincote
2. DHCFT71 TPP Control for Electronic Patient Record (EPR)
3. DHCFT72 Lease of the Electricity Sub-station at Derby City General Hospital

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

Assurances

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 & 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 November 2019 and receive full assurance that this has been undertaken in accordance with the Standing Financial Instructions and Standing Orders of the Board of Directors.

Report presented by: **Justine Fitzjohn**
Trust Secretary

Report prepared by: **Sue Turner**
Board Secretary

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 3 November 2020

Report from the Council of Governors meeting held on 1 September 2020

The Council of Governors met on Tuesday 1 September 2020. Following national guidance on keeping people safe during COVID-19 and the need for social distance, this was a virtual meeting conducted digitally.

Chief Executive Update

Ifti Majid provided the meeting with an update on the current situation regarding the COVID-19 pandemic which included:

- The COVID-19 figures for Derbyshire (4.27) and Derby City (10.1).
- Strict infection control and prevention measures are in place.
- The Trust has a Covid Secure Policy in place.
- Services are beginning to be restored to pre-COVID-19 levels. However the Trust is anticipating an increase in referrals to the Child and Adolescent Mental Health Services (CAMHS) as children and young people return to school.
- A number of development projects have been progressing during the COVID-19 period including the move to replace the patient record system from Paris to OnEPR
- Estate work in the Trust is ongoing to ensure that staff can see patients in a COVID-19 secure way; some of the clinical bases need to be re-located. Community bases are also being reviewed to ensure that both patients and staff can meet in a safe environment.
- The Trust has submitted a capital bid for the eradication of dormitories; there is a national focus on this. The Trust has also bid for capital monies to provide a Psychiatric Inpatient Care Unit (PICU) in order to reduce the out of area figures and to support Primary Care.
- NHS England (NHSE) has published a Phase 3 Restoration Plan letter and actions for this need to be undertaken and completed between now and the end of March 2021. The Trust's restoration plan is due to be submitted imminently.

Presentation of the Annual Report and Accounts 2019/20 and Report from the external auditors, Grant Thornton

Claire Wright, Deputy Chief Executive/Director of Finance presented the accounts to the Council of Governors; and Mark Stocks, Grant Thornton provided a summary of the Annual Audit letter.

Governors Annual Effectiveness Survey

Denise Baxendale, Membership and Involvement Manager explained that the survey was being launched beginning of September, the results of which will be presented to the Governance Committee and Council of Governors.

Non-Executive Director Deep Dive Report

Geoff Lewins provided his Deep Dive Report which included the annual report of the Audit and Risk Committee.

Integrated Performance Report

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

Governance Committee Report

Kel Sims, Chair of the Governance Committee presented a report of the meetings held on 2 April, 9 June and 11 August 2020. The Council of Governors approved the minor amendments to the Committee's Terms of Reference.

Governor Elections Update

Denise Baxendale gave a verbal update on the situation regarding governor elections. She explained that two governors' terms of office end on 25 September and this will mean there will be two vacancies in the following constituencies:

- Chesterfield – one public governor vacancy
- Allied Professions – one staff governor vacancy

The process to begin the elections for the two vacancies above was planned to begin in June 2020 but national guidance issued in March, advised foundation trusts to delay governor elections. Governors were made aware of the delay at the Governance Committee in April. Denise confirmed that in addition to the vacancies outlined above, there is also a vacancy in Bolsover and North East Derbyshire. This seat remains vacant following on from the winter 2019 elections when no nominations for the seat were received.

All three vacancies will be included in the 2021 elections by which time there will be a further five vacancies:

- Bolsover and North East Derbyshire – one public governor vacancy (this means there will be two vacancies for this area)
- High Peak and Derbyshire Dales – one public governor vacancy
- Administration and Allied Support Staff – one staff governor vacancy
- Nursing – two staff governor vacancies

The process for all eight public and staff governor elections will begin in the spring and will be run in line with the guidance included in the Constitution.

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Term / Abbreviation	**Terms in Full**
A	
A&E	Accident & Emergency
ACCT	Assessment, Care in Custody & Teamwork
ACE	Adverse Childhood Experiences
ACP	Accountable Care Partnership
ACP	Advanced Clinical Practitioner
ACS	Accountable Care System (now known as ICS)
ADHD	Attention Deficit Hyperactivity Disorder
AfC	Agenda for Change
AHP	Allied Health Professional
AIMS	Royal College of Psychiatrists Accreditation for Inpatient Mental Health Services Standards
ALB	Arms-length body such as NHS Improvement (NHSI) and NHS England (NHSE)
AMM	Annual Members' Meeting
AMHP	Approved Mental Health Professional
ANP	Advanced Nurse Practitioner
AO	Accountable Officer
ARC	Audit and Risk Committee
ASD	Autism Spectrum Disorder
ASM	Area Service Manager
B	
BAF	Board Assurance Framework
BLS	Basic Life Support (ILS Immediate Life Support)
BMA	British Medical Association
BME	Black Minority Ethic
BAME	Black, Asian & Minority Ethnic
BoD	Board of Directors
C	
CAMHS	Child and Adolescent Mental Health Services
CASSH	Care & Support Specialised Housing
CBT	Cognitive Behavioural Therapy
CCG	Clinical Commissioning Group
CCT	Community Care Team
CDMI	Clinical Digital Maturity Index
CE	Chief Executive
CEO	Chief Executive Officer
CGA	Comprehensive Geriatric Assessment
CIP	Cost Improvement Programme
CMDG	Contract Management Delivery Group
CMHT	Community Mental Health Team
CNST	Clinical Negligence Scheme for Trusts
COAT	Clinical Operational Assurance Team
COF	Commissioning Outcomes Framework
CoG	Council of Governors
CPA	Care Programme Approach
CPD	Continuing Professional Development
CPN	Community Psychiatric Nurse
CPR	Child Protection Register
CQC	Care Quality Commission

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS

NHS Term / Abbreviation	Terms in Full
CQI	Clinical Quality Indicator
CQUIN	Commissioning for Quality and Innovation
CRB	Criminal Records Bureau
CRG	Clinical Reference Group
CRHT	Crisis Resolution and Home Treatment Teams
CRS	(NHS) Care Records Service
CRS	Commissioner Requested Services
CSF	Commissioner Sustainability Fund
CTO	Community Treatment Order
CTR	Care and Treatment Review
D	
DAT	Drug Action Team
DBS	Disclosure and Barring Service
DBT	Dialectical Behavioural Therapy
DfE	Department for Education
DCHS	Derbyshire Community Health Services NHS Foundation Trust
DHCFT	Derbyshire Healthcare NHS Foundation Trust
DIT	Dynamic Interpersonal Therapy
DNA	Did Not Attend
DH	Department of Health
DoLS	Deprivation of Liberty Safeguards
DNA	Did not attend
DPA	Data Protection Act
DRRT	Dementia Rapid Response Team
DTOC	Delayed Transfer of Care
DVA	Derbyshire Voluntary Action (formerly North Derbyshire Voluntary Action)
DWP	Department for Work and Pensions
E	
ECT	Enhanced Care Team
ECW	Enhanced Care Ward
ED	Emergency Department
EDI	Equality, Diversity and Inclusion
EDS2	Equality Delivery System 2
EHIC	European Health Insurance Card
EHC	Education, Health and Care (plans)
EHR	Electronic Health Record
EI	Early Intervention
EIA	Equality Impact Assessment
EIP	Early Intervention In Psychosis
ELT	Executive Leadership Team
EMDR	Eye Movement Desensitising & Reprocessing Therapy
EMR	Electronic Medical Record
EPRR	Emergency Preparedness, Resilience and Response
EPR	Electronic Patient Record
ERIC	Estates Return Information Collection
EQAL	Forum where we can seek patient engagement
ESR	Electronic Staff Record
EUPD	Emotionally Unstable Personality Disorder
EWTD	European Working Time Directive
F	

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Term / Abbreviation	**Terms in Full**
FBC	Full Business Case
FFT	Friends and Family Test
FOI	Freedom of Information
FRRT	Functional Rapid Response Team
FSR	Full Service Record
FT	Foundation Trust
FTE	Full-time Equivalent
FTN	Foundation Trust Network
FTSU	Freedom to Speak Up
FTSUG	Freedom to Speak Up Guardian
F&P	Finance and Performance
5YFV	Five Year Forward View
G	
GDPR	General Data Protection Regulation
GGI	Good Governance Institute
GMC	General Medical Council
GP	General Practitioner
GPFV	General Practice Forward View
H	
HCA	Healthcare Assistant
HEE	Health Education England
HES	Hospital Episode Statistics
HoNOS	Health of the Nation Outcome Scores
HSCIC	Health and Social Care Information Centre
HSE	Health and Safety Executive
HWB	Health and Wellbeing Board
I	
IAPT	Improving Access to Psychological Therapies
ICM	Insertable Cardiac Monitor
ICS	Integrated Care System (formerly ACS)
ICT	Information and Communication Technology
ICU	Intensive Care Unit
IDVAs	Independent Domestic Violence Advisors
IG	Information Governance
ILS	Immediate Life Support (BLS – Basic Life Support)
IM&T	Information Management and Technology
IMT	Incident Management Team
OOA	Outside of Area
IPC	Integrated Personal Commissioning
IPP	Imprisonment for Public Protection
IPR	Individual Performance Review
IPT	Interpersonal Psychotherapy
J	
JNCC	Joint Negotiating Consultative Committee
JTAI	Joint Targeted Area Inspections
JUCB	Joined Up Care Board
JUCD	Joined Up Care Derbyshire
K	
KPI	Key Performance Indicator
KSF	Knowledge and Skills Framework

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Term / Abbreviation	**Terms in Full**
L	
LA	Local Authority
LCFS	Local Counter Fraud Specialist
LD	Learning Disabilities
LHP	Local Health Plan
LHWB	Local Health and Wellbeing Board
LOS	Length of Stay
M	
MARS	Mutually Agreed Resignation Scheme
MAS	Memory Assessment Service
MAU	Medical Assessment Unit
MAS	Memory Assessment Service
MAPPA	Multi-agency Public Protection Arrangements
MARAC	Multi-agency Risk Assessment Conference (meeting where information is shared on the highest risk domestic abuse cases between representatives of local police, probation, health, child protection, housing practitioners, Independent Domestic Violence Advisors (IDVAs) and other specialists from the statutory and voluntary sectors.
MASH	Multi-Agency Safeguarding Hub
MCA	Mental Capacity Act
MDA	Medical Device Alert
MDM	Multi-Disciplinary Meeting
MDT	Multi-Disciplinary Team
MFF	Market Forces Factor
MHA	Mental Health Act
MHAC	Mental Health Act Committee
MHIN	Mental Health Intelligence Network
MHIS	Mental Health Investment Standard
MHRT	Mental Health Review Tribunal
MSC	Medical Staff Committee
MSK	Musculoskeletal (conditions)
N	
NCRS	National Cancer Registration Service
NED	Non-Executive Director
NICE	National Institute for Health and Care Excellence
NGO	National Guardians Office
NHS	National Health Service
NHSE	National Health Service England
NHSI	National Health Service Improvement
NIHR	National Institute for Health Research
O	
OBC	Outline Business Case
ODG	Operational Delivery Group
OPMH	Older People Mental Health
OP	Out Patient
OSC	Overview and Scrutiny Committee
OT	Occupational therapy
P	
PAB	Programme Assurance Board
PAG	Programme Advisory Group

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Term / Abbreviation	**Terms in Full**
PALS	Patient Advice and Liaison Service
PAM	Payment Activity Matrix
PARC	Psychosis and the reduction of cannabis (and other drugs)
PARIS	This is an electronic patient record system
PbR	Payment by Results
PCC	Police & Crime Commissioner
PCN	Primary Care Networks
PCC	People and Culture Committee
PDSA	Plan, Do, Study, Act
PHE	Public Health England
PICU	Psychiatric Intensive Care Unit
PID	Project Initiation Document
PiPoT	People in Positions of Trust
PLACE	Patient Led Assessments of Care
PLIC	Patient Level Information Costs
PMLD	Profound and Multiple Disability
PPE	Personal Protective Equipment
PPI	Patient and Public Involvement
PPT	Partnership and Pathway Team
PREM	Patient Reported Experience Measure
PROMS	Patient Reported Outcome Measure
PSF	Provider Sustainability Fund
PSIRF	Patient Safety Incident Review Framework
Q	
QAG	Quality Assurance Group
QC	Quality Committee
QIA	Quality Impact Assessment
QIPP	Quality, Innovation, Productivity Programme
QSC	Quality and Safeguarding Committee
R	
RAID	Rapid Assessment, Interface and Discharge
RCGP	Royal College of General Practitioners
RCI	Reference Cost Index
REGARDS	Race, Economic disadvantage, Gender, Age, Religion or belief, Disability and Sexual orientation
RIDDOR	Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013
RTT	Referral to Treatment
S	
SAAF	Safeguarding Adults Assurance Framework
SBARD	Situation, Background, Assessment, Recommendation and Decision (SBARD) tool
SBS	Shared Business Services
SEND	Special Educational Needs and Disabilities
SI	Serious Incident(s)
SID	Senior Independent Director
SIRI	Serious Incident Requiring Investigation
SLA	Service Level Agreement
SLR	Service Line Reporting
SMI	Serious Mental Illness
SOAD	Second Opinion Appointed Doctor

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Term / Abbreviation	**Terms in Full**
SOC	Strategic Options Case
SOF	Single Operating Framework
SPL	Shielded Patient List
SPOA	Single Point of Access
SPOE	Single Point of Entry
SPOR	Single Point of Referral
STEIS	Strategic Executive Information System
STF	Sustainability and Transformation Fund
STP	Sustainability and Transformation Partnership
SUI	Serious (Untoward) Incident
T	
TARN	Trauma Audit and Research Network
TCP	Transforming Care Partnerships
TCS	Transforming Community Services
TDA	Trust Development Authority
TMT	Trust Management Team
TUPE	Transfer of Undertakings (Protection of Employment) Regulations 1981
TMAC	Trust Medical Advisory Committee
U	
UDBH	University Hospitals of Derby and Burton
V	
VO	Vertical Observatory
W	
WDES	Workforce Disability Equality Standard
WRES	Workforce Race Equality Standard
WSoA	Written Statement of Action
WTE	Whole Time Equivalent
Y	
YTD	Year to Date

2020-21 Board Annual Forward Plan

Exec Lead	Item	5 May 20	7 Jul 20	1 Sep 20	3 Nov 20	13 Jan 21	2 Mar 21
	Paper deadline	**27 Apr**	**29 Jun**	**24 Aug**	**28 Oct**	**4 Jan**	**22 Feb**
Trust Sec	Declaration of Interests	X	X	X	X	X	X
CG	Patient Story	X	X	X	X	X	X
CM	Minutes/Matters arising/Action Matrix	X	X	X	X	X	X
CM	Board review of effectiveness of meeting	X	X	X	X	X	X
CM	Board Forward Plan (for information)	X	X	X	X	X	X
CM	Summary of Council of Governors meeting (for information)	X		X	X	X	X
CM	Chair's Update	X	X	X	X	X	X
IM	Chief Executive's Update	X	X	X	X	X	X
STRATEGIC PLANNING AND CORPORATE GOVERNANCE							
MP/CW	NHSI Financial Annual Plan Month 7-12 2020/21				X		
JL	Staff Survey Results		X				
JL	Equality Delivery System2 (EDS2) update						X
JL	Annual Gender Pay Gap Report for approval						X
JL	Workforce Race Equality Standard (WRES) prior to submission 31.10.20			X			
JL	Workforce Disability Equality Standard (WDES) prior to submission 31.10.20			X			
JL	2020/21 Flu Campaign (summary of 2020/21 to go to May 2021 meeting))			X	20/21 update		
JL	People Plan					X	
Trust Sec	NHS Improvement Year-End Self-Certification	X					
Trust Sec	Year-End Governance Reporting from Board Committees and approval of ToRs	X					
Trust Sec	Corporate Governance Framework						X
Trust Sec	Review SOs, SFIs, SoD plus review/ratify SFI Policy (as Policy Review section below)		X				
Trust Sec	Trust Sealings (six monthly - for information - defer to November due to Covid-19)	X			X		
Trust Sec	Annual Review of Register of Interests	X					
Trust Sec	Board Assurance Framework Update	X	X		X		X
Trust Sec	Freedom to Speak Up Guardian Report (six monthly)			X			X
Trust Sec	Fit and Proper Person Declaration		X				
Trust Sec	Annual Approval of Modern Slavery Statement				X		
Committee Chairs	Board Committee Assurance Summaries (following every meeting) - Audit & Risk, Finance & Performance, Mental Health Act, Quality & Safeguarding, People & Culture (due to Covid-19 Board Assurance Summaries are suspended)	X	X	X	X	X	X
MP	Annual Emergency Planning Report (EPPR)					X	
GH	Business Plan Monitoring close down of 2019/20 (May) Proposal for 2020/21 (Jul) 2020/21	X	X				
GH	Learning Disabilities Clinical Strategy	X					
GH	Trust Strategy Review	X			X		

2020-21 Board Annual Forward Plan

Exec Lead	Item	5 May 20	7 Jul 20	1 Sep 20	3 Nov 20	13 Jan 21	2 Mar 21
OPERATIONAL PERFORMANCE							
CG/CW/CS/ MP	Integrated performance and activity report to include Finance, Workforce, performance and Quality Dashboard	X	X	X	X	X	X
CG/MP/CS	Workforce Standards Formal Submission/Safer Staffing (prior to going on website)						X
QUALITY GOVERNANCE							
Execs	Quality Position Statement Report - focus on CQC domains (Well Led CQC & NHSI (Trust Sec) as per schedule	Safety JS	Responsive MP	Well Led JF	Effective CG &JL	Use of Resources CW	Caring CG
JS	Learning from Deaths Mortality report (quarterly publication of information on death) (Jul/Nov/Jan/Mar)		X		X		
JS	Guardian of Safe Working Report	X	A		X		X
JS	NHSE Return on Medical Appraisals sign off - delayed for 2020/21						
CG	Control of Infection Report			A			
JS	Re-validation of Doctors		Update re delay		Verbal update		
CG	Receipt of Annual Reports: - Annual Looked After Children - Safeguarding Children and Adults at Risk				X		
CG	Outcome of Patient Stories					X	
POLICY REVIEW							
CW	Standing Finance Instructions Policy and Procedures		X				
JF	Engagement between the Board of Directors and CoG (Nov 2022)						
JF	Fit and Proper Person Policy						X

Key: Items deferred/cancelled to allow greater focus on the critical issues related to COVID-19 — X