Derbyshire Healthcare
NHS Foundation Trust

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

To be held digitally via Microsoft Teams
5 May 2020 10:30 - 5 May 2020 12:00

INDEX

Derbyshire Healthcare
NHS Foundation Trust

NOTICE OF A VIRTUAL PUBLIC BOARD MEETING – TUESDAY 5 MAY 2020
TO COMMENCE AT 10:30am

Following national guidance on keeping people safe during covid-19 all face to face meetings have been cancelled.
This will be a virtual meeting conducted digitally via Microsoft Teams technology.
This agenda has been streamlined to enable continuity of essential business assurance and decisions.

	TIME	AGENDA	LED BY
1.	10:30	Chair's welcome, opening remarks and apologies - Register of Directors' Interests Report 2019/20	Caroline Maley
2.		Minutes of Board of Directors meeting held on 3 March 2020	Caroline Maley
3.		Matters arising – Actions Matrix	Caroline Maley
4.		Questions from governors or members of the public	Caroline Maley
OPERATIONAL PERFORMANCE, QUALITY, STRATEGY AND GOVERNANCE			
5.	10:35	General Update on the impact of Covid-19 from the Incident Management Team: - National picture – context - Latest Trust data - Governance – compliance against guidance	Ifti Majid
6.	10.50	Restoration and recovery - Locally and nationally	Ifti Majid
7.	11:00	Quality Assurance - Mixed sex accommodation - Infection control checklist and assurance - Quality and Safeguarding Committee escalations - Learning from Deaths Mortality Report	Carolyn Green / John Sykes
8.	11.20	Board Assurance Framework Update	Justine Fitzjohn
9.	11.25	Integrated Performance and Activity Report - Finance and Performance review escalations - People and Culture Committee escalations	C Wright / C Stafford / C Green / M Powell
10.	11.45	Year-End Governance Reporting from Board Committees and approval of ToRs	Justine Fitzjohn
CLOSING MATTERS			
11.	11:50	- Identification of any issues arising from the meeting for inclusion or updating in the Board Assurance Framework - Meeting effectiveness	Caroline Maley
FOR INFORMATION			
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 7 July 2020 in
Conference Rooms A & B, Centre for Research and Development, Kingsway, Derby DE22 3LZ
Users of the Trust's services and other members of the public are welcome to attend the meetings of the Board.

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.

Derbyshire Healthcare NHS Foundation Trust
Report to Board of Directors – 5 May 2020

Corporate Governance
Register of Directors' Interests 2019/20

Purpose of Report

This report provides the Trust Board with an account of Directors' interests during 2019/20.

Executive Summary

- It is a requirement that the Chair and current Board members who regularly attend the Board should declare any conflict of interest that may arise in the course of conducting NHS business.
- The Chair and Board members should declare any business interest, position of authority in a charity or voluntary body in the field of health and social care, and any connection with a voluntary or other body contracting for NHS services. These should be formally recorded in the minutes of the Board and entered into a register which is available to the public.
- Directorship and other significant interests held by NHS Board members should be declared on appointment and kept up to date.

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

- Directors are asked to disclose to the meeting any changes to the Register of Directors' Interests during the course of the year.
- When declaring any interest, each Board member affirmed their agreement to comply with the NHS Codes of Conduct and Accountability, and the Seven Principles of Public Life (Nolan), and to state whether there is any relevant audit information of which the Trust's Auditors are unaware.

Governance or Legal Issues

The disclosure and statements referenced within this report are subject to the NHS Code of Conduct and Accountability and Licence Conditions of the Trust.

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 impact to those with protected characteristics arising from this report.

Recommendations

The Board of Directors is requested to approve and record the declarations of interest as disclosed. These are recorded in the Register of Interests which is accessible to the public at the Trust Head Office and will be listed in the Trust's annual report and accounts for 2019/20.

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

Report prepared by: **Sue Turner**
Board Secretary

Derbyshire Healthcare
NHS Foundation Trust

DECLARATION OF INTERESTS REGISTER 2019/20		
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 & 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)
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)
Amanda Rawlings Director of People and Organisational Effectiveness (DHCFT)	• Director of People and Organisational Effectiveness, Derbyshire Community Healthcare Services (DCHS) • Co-optee Cross Keys Homes, Peterborough	(e) (e)
Dr Julia Tabreham Non-Executive Director	• Non-Executive Director, Parliamentary and Health Service Ombudsman • Director of Research and Ambassador Carers Federation	(a) (d)
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).

Derbyshire Healthcare NHS Foundation Trust

MINUTES OF A MEETING OF THE BOARD OF DIRECTORS

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

Tuesday 3 March 2020

MEETING HELD IN PUBLIC

Commenced: 9.30am Closed: 12.15pm

PRESENT	Caroline Maley	Trust Chair
	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
	Dr Julia Tabreham	Non-Executive Director
	Richard Wright	Deputy Trust Chair and Non-Executive Director
	Ifti Majid	Chief Executive
From DHCFT2020/026	Claire Wright	Deputy Chief Executive & Director of Finance
	Carolyn Green	Director of Nursing & Patient Experience
	Dr John Sykes	Medical Director
	Mark Powell	Chief Operating Officer
	Justine Fitzjohn	Trust Secretary
IN ATTENDANCE	Perminder Heer	NExT Director
	Anna Shaw	Deputy Director of Communications & Involvement
	Celestine Stafford	Assistant Director, People and Culture Transformation
	Sue Turner	Board Secretary
	Charlotte Kawalek	Lead Nurse, Dementia Rapid Response Team South
	Mellissa Edwards	Cognitive Behavioural Therapist
	Susan Krause	Children's Occupational Therapist
For DHCFT2020/019	Emily	Service User
For DHCFT2020/019	Kyri Gregoriou	Interim Assistant Director for Clinical and Professional Practice
For DHCFT2020/027	Tamera Howard	Freedom to Speak Up Guardian
VISITORS	Lynda Langley	Lead Governor and Public Governor, Chesterfield
	Andrew Beaumont	Public Governor, Erewash
	Valerie Broom	Public Governor, Amber Valley
	Susan Ryan	Public Governor, Amber Valley
	Jo Foster	Staff Governor, Nursing
	April Saunders	Staff Governor, Allied Professions
	Orla Smith	Public Governor, Derby
	Christopher Williams	Public Governor, Erewash
	Jaswinder Banya	Catering Assistant and Reverse Mentor
	Wayne Swan	Finance Assistant
	Kay Jones	Finance Manager
	Carl Jones	Senior Systems Analyst, Information Management and Technology (IM&T)
	Sandra Austin	Derby City and South Derbyshire Mental Health Carers Forum and Trust volunteer
	Sue Elson	Member of the public
	Matthew Holton	Visconn Clinic
	Eddie Staully	Visconn Clinic
APOLOGIES	Gareth Harry	Director of Business Improvement and Transformation

DHCFT 2020/018	**CHAIR'S WELCOME, OPENING REMARKS, APOLOGIES FOR ABSENCE AND DECLARATION OF INTERESTS** The Trust Chair, Caroline Maley, welcomed everyone to the meeting. Introductions were made to Charlotte Kawalek, Lead Nurse, Dementia Rapid Response Team who shadowed Caroline, Melissa Edwards, Cognitive Behavioural Therapist who was shadowing Chief Operating Officer, Mark Powell and Susan Kraus, Children's Occupational Therapist shadowing Director of Nursing and Patient Experience Carolyn Green. Assistant Director, People and Culture Transformation, Celestine Stafford was thanked for attending in her acting post whilst the Trust looks to appoint a new Director of People and Inclusion following the departure of Amanda Rawlings. Apologies for absence were noted from Director of Business Improvement and Transformation, Gareth Harry who was representing the Trust at a national workshop on out of area placement reduction. Caroline informed the Board that the Deputy Chief Executive and Director of Finance, Claire Wright would join the meeting following her attendance at an operational plan submission meeting. No declarations of interest were made with regard to the agenda items and no adjustments were made to the register. Caroline highlighted that following the positive feedback received from the CQC Well Led inspection the Trust Board has taken the decision to revise its schedule of meetings from the new financial year to reduce public board meetings to six times a year from the current ten times a year. The rationale behind this decision is to provide greater time for the Board to hold additional strategy and planning sessions, including system working. This frequency would also put us in line with other Foundation Trusts who meet in public every other month, including University Hospitals of Derby and Burton (UHDB) and Derbyshire Community Health Services (DCHS). The next meeting will be held on 5 May 2020. Meetings will then be scheduled on a bi-monthly basis in July, September, November, January and March and dates are now displayed on the Trust's website.
DHCFT 2020/019	**PATIENT STORY** Interim Assistant Director for Clinical and Professional Practice, Kyri Gregoriou introduced Emily who talked about her experience of Derbyshire Healthcare over the last fifteen years. Emily focussed mainly on her last two admissions to the Radbourne Unit and some of the challenges she faced with her diagnosis of Premenstrual Dysphoric Disorder (PMDD) of which the cause is still unknown but is thought to be caused by a genetic sensitivity to hormone fluctuations. She also described the challenges in accessing services and getting the appropriate treatment due to the rarity of her diagnosis that affects one in twenty menstruating individuals (it is not that it is rare, but more that the awareness is not there so people do not get the correct diagnosis). Emily also talked about her experience of raising a concern and how well she was responded to by Chief Operating Officer, Mark Powell which led to a meeting between Emily, Kyri and Area Service Manager, Hannah Burton which resulted in her being involved in service development forums which has helped resolve some of her concerns. Emily shared a key example of some of the challenges she experienced in hospital to give the Board an understanding of where her concerns came from. There were times when she felt that patients' visual checks were not carried out thoroughly enough by bank staff, mainly because they were not familiar enough with the patients to know their true needs. Towards the end of her admission Emily decided to write a letter which she addressed to Mark Powell and gave him an insight into her personal experience of her time on the ward as she wanted her voice to be heard and to gain the reassurance that things were going to be put in place to make changes to try and prevent the same happening again. Following receipt of the letter a meeting was arranged that enabled Emily to talk through her concerns with Kyri and Hannah when she was invited to work with them in a collaborative

	and lessons to be learned manner. Through her letter and during the discussion Emily highlighted five key areas that were the focus of a CQC visit and subsequent report on the Radbourne Unit concerning staffing levels, recreational and meaningful activity, safety and the basic need to feel safe, the importance of good communication between mental health and physical health teams and looking beyond the obvious when assessing patients' needs. Emily also talked about the importance of continuity of care and for patients getting to know the staff and for them to get to know their patients which allows for good person centred care. Emily feels very passionate about patient engagement and has actively raised the profile of recreational and meaningful activity for patients for the purpose of distraction. The Board recalled that she ran a project at the end of the year putting together hampers containing games, books, puzzles writing and colouring materials and toiletries to entertain and keep patients positively occupied on the wards. Emily's involvement in reducing restrictive practice has also been very well received by trainee doctors on the expert patient programme and through her attendance at the monthly involvement meetings a number of Emily's concerns have now been addressed. Chief Executive, Ifti Majid referred to Emily's suggestion that clinical staff should look beyond the obvious and urged her to give examples of how this can be done. Emily's recommendation was that clinicians should think and ask about women's menstrual cycles as many women suffer from various forms of PMDD. Service users should also be encouraged more to help understand what works best for them. Research can provide the knowledge and expertise but patients are experts at telling you what their needs are. Emily also stressed the importance of providing continuity of care and having therapeutic relationships with clinical staff who can also advocate for you. Director of Nursing and Patient Experience, Carolyn Green thanked Emily for sharing her story and assured her that she and her Board colleagues will work to resolve her concerns. She described how she and the Medical Director, John Sykes have carried out some work on PMDD which enabled them to discover some emerging themes. They are in the process of arranging a conference on PMDD and would like to involve Emily and work with gynaecology colleagues to develop integrated pathways on PMDD. Caroline Maley thanked Emily for engaging with Kyri and the team to help the Trust improve the communication and transitions that are helping psychiatrists and nurses think about the menstrual health of women and for giving the Board an insight into PMDD.
DHCFT 2020/020	**MINUTES OF THE BOARD OF DIRECTORS MEETING HELD ON 4 FEBRUARY 2020** The minutes of the previous meeting, held on 4 February 2020, were accepted as a correct record of the meeting.
DHCFT 2020/021	**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 'green' actions were scrutinised to ensure that they were fully complete. **MATTERS ARISING** Richard Wright referred to a discussion at the previous meeting that clean air is one of the wider determinations of good health and asked what the Trust would be doing to improve air quality and reducing waste. Ifti outlined that there is a stream of work that the Trust is involved in both internally via the estates strategy and our health and wellbeing strategy and in partnership within the JUCD which will drive forward improvements.
DHCFT 2020/022	**QUESTIONS FROM GOVERNORS OR MEMBERS OF THE PUBLIC** None received.

DHCFT 2020/023	**CHAIR'S UPDATE** Caroline Maley's report provided the Board with a summary of her activity and visits to the Trust's services undertaken since the previous Board meeting in February. Caroline reported on the quality visit she chaired at the Memory Assessment Service (MAS) that highlighted the important work that admin colleagues undertake. Caroline highlighted that the admin team had mentioned that they would like to be trained in conducting difficult conversations with patients and was pleased to hear from Carolyn Green that work is taking place with the People Services team to initiate a training programme specifically designed to cover this area of an administrator's work. Another visit took place at the Chesterfield Dementia Rapid Response team (DRRT) when Caroline and attended the team's Multi-Disciplinary Team (MDT) meeting where all patients on the list were reviewed. Caroline was impressed with the review of patients within their care and saw that the meeting reflected the culture of the Trust by recognising people's different contributions to discussions. Caroline welcomed new members of the Council of Governors following recent elections and requested that interested Trust members living in Bolsover consider standing in future elections. Key messages from the Joined Up Care Derbyshire (JUCD) Board meeting held in February were appended to Caroline's report. These meetings now take place in public session and governors and members of the public were urged to attend so they can see how the Trust is working in a more integrated way. **RESOLVED: The Board of Directors noted the activities of the Trust Chair since the last meeting held on 4 February 2020.**
DHCFT 2020/024	**CHIEF EXECUTIVE'S UPDATE** Ifti Majid's report gave a summary of the changes within the national health and social care sector, as well as an update on developments within the local Derbyshire health and social care community. The report also included feedback from external stakeholders, such as commissioners, and feedback from staff. The following issues were highlighted: **National context** The 2019 Workforce Race Equality Standard (WRES) has been released by the WRES Implementation Team. Ifti discussed how national issues are reflected locally, up to April 2019 and outlined how improvements and initiatives arising from the NHS Long Term Plan will improve representation at senior levels in the NHS and the experience of BME colleagues. Overall Ifti remains disappointed that a steeper trajectory of improvements has not been seen within our own organisation and highlighted that there is still a considerable amount of work to do to improve representation and experience of BME colleagues within the Trust. However, he was pleased to see that a review that took place at the People and Culture Committee had showed that the likelihood of BME staff entering a formal disciplinary process compared to white staff has reduced. **Local Context** Ifti's report detailed key items discussed by the JUCD Board which focused on prevention and the wider determinants of ill health, He was pleased to report that the JUCD Board had signed off the leadership model for Integrated Care Systems (ICS) following collaboration with key stakeholders. **Within our Trust** The draft CQC inspection report has now been received and has been returned ahead of schedule following factual accuracy checks. Ifti looked forward to being able to announce the results of the inspection in the public domain once the period of embargo has been

	lifted. Ifti was delighted that the staff survey produced the highest ever response rate and the feedback received from staff is very positive. The results showed an improvement in a third of all areas and deterioration in none and gave a positive reflection on the organisation's culture and put the Trust above average when compared with the results received by other trusts that provide similar services. Particular highlights included positive feedback about staff morale, quality of care and equality, diversity and inclusion. Ifti referred to the financial challenges being felt by the Trust and highlighted how all colleagues within the organisation have been updated about the financial requirements for next year 2020/21. In line with Trust values this information has also been shared with the Trades Unions and has been discussed within the Staff Forum so that colleagues are aware of these pressures and all staff will continue to be updated with progress. Non-Executive Director, Julia Tabreham challenged the Trust's preparedness to maintain effective service delivery in the event of an outbreak of Novel Coronavirus (Covid-19). Mark Powell as Emergency Prevention, Preparedness and Response (EPPR) lead assured her that the Trust is working in line with the guidance that is being issued by NHS England and Improvement and Public Health England to ensure we are prepared and compliant with the latest national guidance. Mark and his team are fully engaged in ensuring that services are prepared especially due to the case reported in Buxton last week. Regular briefings are being communicated to all colleagues across the Trust. The Trust has set up its own Management Response Team and will not deviate from the guidance being issued by Public Health England. Mark referred the Derbyshire County Council Director of Public Health's annual independent report 'Stronger for Longer' concerning the health and wellbeing of the local population and challenged if the differences between the wellbeing of people in the county of Derbyshire and the city of Derby are being factored into to JUCD working. Ifti advised that the work of the Health and Wellbeing Boards for the county and the city will be brought to the JUDC Board to understand how health and wellbeing differs across the city and the county which will outline individual local needs. This work will sit with the integrated care partnerships that will look at related themes with public health and will implement local actions to drive forward the priorities in local areas. This work will also be part of the Trust's investment in cost interventions. Deputy Trust Chair, Richard Wright referred to the CQC's recent mandate on how the Mental Health Act (MHA) is to be applied and monitored by services in England and asked if this will mean that complying with the MHA will be less complex. John Sykes advised that a recommendation from the review of the MHA has shown that the Code of Practice is to be revised and that this is an action for the Secretary of State. The MHA is to include a greater emphasis on advocacy which will become increasingly important when developing patient care plans. **RESOLVED: The Board of Directors scrutinised the Chief Executive's update, noting the risks and actions being taken.**
DHCFT 2020/025	**<u>INTEGRATED PERFORMANCE AND ACTIVITY REPORT</u>** The Integrated Performance Report (IPR) provided the Board of Directors with an overview of Trust performance at the end of January. The report set out how the Trust is performing well against a set of key national and local targets and measures. Main areas of performance referred to by Mark Powell highlighted the following: **Finance** The Trust is still planning to achieve the year-end control total. The key financial risk is being driven by the number of patients placed out of area in adult acute beds although a

reduction has been seen in out of area placements in the last six weeks. Other financial challenges are due to the Sustainability Transformation Programme (STP) position which is currently off plan by £36.3m due mainly to Chesterfield Royal being £9.7m off plan because of tariff changes and University Hospitals of Derby and Burton (UHDB) being off plan by £26.1m due to the impact of undelivered savings.

As outlined by Ifti earlier the financial position for next year has determined that the required cost improvement plan (CIP) needed for 2020/21 is £6.8m (4.2%). Director of Business Improvement and Transformation, Gareth Harry is leading this cost reduction work and we expect to be in a position from 1 April to have a scheme that will deliver this £6.8m shortfall which stands at £4.5m at the moment. Ifti added that there is a real risk that this could increase by over £0.3m due to International Financial Reporting Standards (IFRS) changes. Claire Wright is working to understand the impact this will have on the Trust as well as ensuring the Trust is in the best place possible.

Quality and Operations

From an operational point of view the Trust is performing well against national standards. Although there are a number of patients placed out of area the Acute Services Management Team are working ensure the flow of patients is planned in such a way to reduce the amount of time patients are out of area. Mark was pleased to report that the Trust is in the final stages of producing a business case for the development of a Psychiatric Intensive Care Unit (PICU) in Derbyshire which is being taken through the Mental Health Systems Delivery Board. A full outline business case for consideration with the CCG and system partners is due to be completed in the next four to six weeks. In the meantime the Trust is looking at developing an interim service for individuals who require this level of care which will negate the need to place patients out of area.

Non-Executive Director, Geoff Lewins acknowledged that activity is improving the position on out of area placements and requested that reporting shows the numerate position of individuals placed out of area and for how long. Mark added that a number of projects are ongoing to offer a personality disorder service within the Trust rather than out of area. People who require this service will have their needs cared for in a way that Emily described earlier by understanding what works best for them. There are also a number of patients admitted to inpatient wards that no longer require inpatient care but have significant housing needs. The Trust is seeking to improve the needs of these individuals so they are not unnecessarily in the wrong place. The number of individuals involved will be reported to the Finance and Performance Committee and their care will be personalised through the staff recruitment work being done in these service areas.

With regard to an Autism Spectrum Disorder (ASD) assessment service and the number of people waiting to access the service, the Trust is working on developing a future service model that will care for people with ASD within core services.

Julia Tabreham challenged if anything more can be done to improve the waiting list for Child and Adolescent Mental Health services (CAMHS). Mark reported that investment is being made in the service so that young people can access this service quicker and improvements are expected to be seen in this service line in the coming months. The Trust is also working with partners in the STP to make strategic improvements to how children's services operate. Carolyn Green gave further context to the CAMHS team capacity and explained that the Trust has invested in primary care mental health workers and aligned support and investment in mental health in schools. These are all interventions that have increased referrals to CAMHS and have increased the demand on our service. The CAMHS team have done well not to make the waiting list worse.

Mark updated the Board of discussions that have taken place within the Quality and Safeguarding Committee about the increase in the number of medication incidents. It is believed that the number of incidences have increased due to better recording of incidents. The Board was assured that medication incidents are all reviewed quarterly by the Heads of Nursing and as a trend, this looks to be currently stabilising.

	Workforce Attention was drawn to hotspots in current vacancy rates. These include inpatient areas at the Radbourne Unit and in Children's services. The People and Culture Committee is closely monitoring turnover and is expecting to see developments due to improvements being seen in the recruitment processes that will fill vacancies at a faster rate. Supervision levels have increased due to improvements having been made in the appraisal process and the push to ensure colleagues are correctly supervised. Richard Wright sought assurance on the management of sickness absence. He was advised that sickness absence is discussed regularly at performance review meetings and by the Executive Leadership Team as well as the People and Culture Committee. Discussion took place on the main cause of sickness absence being due to anxiety/stress/depression although most long term absences are non-work related. The Employee Relations team are providing advice and guidance to managers for managing long term sickness cases that is supportive of people with long term conditions. Carolyn Green outlined how the Trust is retaining staff in their sixties and sometimes seventies through the retire and return scheme. Some of these colleagues have some have long term conditions and the Trust is working to support colleagues with these conditions in a positive way. Work is also taking place to understand if we are generating stressful conditions for staff and are supporting colleagues through difficult stages in both their personal lives and professional roles. Ifti was aware of regulatory interest in how the Trust supports staff on all aspects of occupational health and suggested that this is reported through the IPR to prompt further discussions in this area by the Board. Ifti raised concern with the recent increase in falls on inpatient wards. Carolyn Green explained that there are some patients with complex conditions on wards. The Trust has a falls reduction Commissioning for Quality and Innovation (CQUIN) in place. Although the number of falls is low, improved reporting mechanisms have highlighted these complex conditions. Carolyn was not unduly concerned and assured the Board that we are comparing a particularly low rate with a moderate rate and the Quality and Safeguarding Committee is maintaining a monitoring brief to look at the harm caused by falls. Caroline Maley queried the number of incidents requiring Duty of Candour. She was advised by Carolyn Green that over the last three months the Quality and Safeguarding Committee and Serious Incident Group (SIG) have reviewed a number of inpatient deaths within the acute care service that have not been straight forward and the Trust has worked closely with families and carers to explore any issues. Caroline concluded the lengthy discussion on the Trust's performance. She proposed that that limited assurance be taken from the report but noted the significant improvement being made in out of area placements and the positive progression in recruiting to vacant roles and with staff retention. **ACTION: Numerate data on out of area placements to be included in the IPR** **ACTION: Staff occupational health data to be included in the IPR** *Claire Wright joined the meeting at this point (11am)* **RESOLVED: The Board of Directors received limited assurance on current performance across the areas presented.**
DHCFT 2020/026	**<u>QUALITY REPORT - CARING</u>** Carolyn Green provided the Board with a focussed report on 'Caring' as one of the CQC's domains that summarised the Trust's current level of performance and future direction. The report also evidenced that the Trust has achieved strong compliance and internal and external assurance as demonstrated by the retention of the Trust's wide overall 'good' rating in this area.

	Carolyn gave a live interactive demonstration of the new text message system that showed how immediate patient feedback can be enabled across the Trust's services. This system is due to go live in April and will provide greater opportunity to analyse patient experience of over 20,000 patients within the Trust's care and will be incorporated within patient experience reporting to the Quality and Safeguarding Committee. Thanks were made to Carl Jones, Senior Systems Analyst within Information Management and Technology (IM&T) who designed the system to ensure that it complied with General Data Protection Regulation rules. Caroline questioned why the response to the Trust's community health survey was so low. Carolyn outlined that responses were received from 289 people and demonstrated improved practice in all areas bar one. This is significantly different to a number of higher performing mental health trusts and sometimes the Trust does not score highly on this type of feedback. She anticipates that a text messaging model will demonstrably improve the Trust's position over the next twelve months. Senior Independent Director, Margaret Gildea could not see how the focus on caring could be triangulated with Emily's patient story and proposed that the Quality and Safeguarding Committee ensures that the learning from Emily's story is taken forward within the Trust's services. Carolyn assured the Board that themes arising around staffing will be worked through the Crisis Team and will be reported to the Quality and Safeguarding Committee to do justice to Emily's story. The Board welcomed the use of the interactive data system and received significant assurance from the quality improvement achieved within the domain of caring. **RESOLVED: The Board of Directors considered the current priorities for quality improvement in the domain of 'Caring' and received significant assurance with the areas presented.**
DHCFT 2020/027	**<u>FREEDOM TO SPEAK UP GUARDIAN REPORT</u>** Freedom to Speak Up Guardian (FTSUG), Tam Howard joined the meeting and presented the Board with her second six-monthly update report. The Board was pleased to note the increasing number of people who are coming forward to speak up and that key themes had been identified over the last six months. It was noted that some concerns have been raised by admin staff who feel their skills are not being effectively utilised and have limited opportunities to progress. The Board was assured that the Executive Leadership Team is establishing solutions to support admin colleagues with their development to ensure they feel valued in the organisation. Positive indications show that bullying and harassment had reduced in Q3. Tam highlighted that some BME colleagues felt treated differently and some people with protected characteristics are not feeling as included as they should be and were concerned about how inclusivity featured in the recruitment process. Geoff Lewins acknowledged the positive aspects of the speaking up process and referred to the table that implied that 97 cases were reported to the FTSUG and 54 were dealt with and asked if 46 remain outstanding. Tam responded that these were cases that had been escalated and might be being dealt with by senior leaders within the Trust. She does not always see the outcome of all cases and confirmed that she was closing out these cases within the remit of her role. Assistant Director, People and Culture Transformation, Celestine Stafford echoed Tam's comment and added that it would not be appropriate for actions arising from investigations to be included in reporting or for them to be relayed to FTSUG. Margaret Gildea agreed that confidentiality cannot be breached but requested that future reports show when cases are closed to give assurance to the Board. FTSU champions will help to support Tam in her role in widening access across the Trust. The Board acknowledged that one of main purposes of FTSU is concerned with patient

	safety and that demand for support from the FTSUG will grow. It was noted that appropriate systems and support is in place thorough the use of FTSU Champions to increase FTSU capacity and help colleagues feel safe raising concerns. The Board noted the emerging themes and actions that are being taken in response to colleagues raising concerns and supported the mechanisms and activities that are in place to encourage colleagues to speak up. Thanks were extended to Tam for the work she undertakes in raising awareness of speaking up and ensuring that staff felt more confident in raising concerns. **ACTION: FTSUG reports to indicate when cases are closed** **RESOLVED: The Board of Directors:** **1) Supported the current mechanisms and activities in place for raising awareness of the FTSU agenda.** **2) Supported the use of a rolling improvement / action plan for Speaking Up which feeds into Trust's wider improvement strategy** **3) Supported the development of a Speaking Up Strategy during 2020/21 which will be shared with key stakeholders, discussed and agreed by the Board, and is linked to or embedded within other relevant strategies.**
DHCFT 2020/028	**<u>PUBLIC SECTOR EQUALITY DUTY, GENDER PAY GAP AND INCLUSION STRATEGY FOR 2020</u>** Claire Wright's report outlined compliance with mandatory reporting requirements for Public Sector Equality Duty requirements, Gender Pay Gap (GDP) and included a new action plan to close the gap. It also included the Inclusion Strategy that incorporates some of the Trust's Equality objectives. **Public Sector Equality Duty (PSED)** The Board noted the excellent inclusion practice work that is evident from the Board Committees' business in considering inclusion by driving improvements in staff and patient experience which is evident through the publication of information that has demonstrated compliance through report cover sheets. **Gender Pay Gap** Claire's report showed an overall improvement in comparator areas for March 2019 compared to March 2018. Whilst this showed some improvement it was not considered enough. After discussion with the Gender Network a Gender Pay Gap Action Plan was developed that will cover six action areas: 1. Data Analysis 2. Branding communication and transparency 3. Recruitment and promotion processes 4. Policy review including maternity, paternity and parental leave 5. Wellbeing and retention 6. Supporting female staff Julia Tabreham challenged whether the action plan will adequately address gender pay gaps associated with clinical excellence awards. John Sykes commented that having an integrated workforce and effective job planning will help provide good work life balance. It was also thought that new consultant training will deliver a fairer delivery of the Gender Pay Gap especially as the Trust is working to support staff needs for flexible working. **Inclusion Strategy** It was noted that the objectives contained in the Inclusion Strategy are featured during the Trust's corporate induction process to demonstrate how inclusion is at the heart of Derbyshire Healthcare and is supported by a short film of our colleagues talking about what inclusion means to them.

	Having agreed the Trust's compliance with PSED, the Board supported the actions that have been put in place to close the Gender Pay Gap and approved the new Inclusion Strategy. It was noted that the Inclusion Strategy will be refreshed in twelve months' time to include additional learning. It is intended that the strategy will increase in visibility to escalate oversight of progress and will celebrate inclusive actions through regular reporting. Caroline concluded that it was good to see inclusion being incorporated within the Trust and reported to the Board in this way and hoped that Ashiedu Joel will help shape inclusivity within the Trust in her role as NED lead for inclusion. The Trust is required by the Government Equalities Office to publish its Gender Pay Gap report by the deadline of 30 March 2020 using data taken from 31 March 2019 and will post the Public Sector Equality Duty, Gender Pay Gap And Inclusion Strategy report on the Trust's website. **RESOLVED: The Board of Directors:** **1) Discussed and agreed compliance with the Public Sector Equality Duty** **2) Noted the gender pay gap information including its movement from prior year** **3) Endorsed the GPG action plan and committed to receive regular updates** **4) Formally approved the Inclusion Strategy and committed to receive regular updates.**
DHCFT 2020/029	**<u>WORKFORCE STANDARDS FORMAL SUBMISSION</u>** In October 2019, NHS Improvement (NHSI) wrote to all trusts asking them to review their workforce safeguards and implement some formal recommendations. This report outlined how the Trust is formally assessing its compliance and is a self-assessment of the workforce safeguards. This is the Trust's 2020 formal submission. The Board reviewed the self-assessment and was assured that the People and Culture Committee scrutinises and reviews all workforce information, systems and process of staff deployment, rostering and skill mix of the Trust's services at each meeting. Through the report the Director of Nursing and Medical Director confirmed to the Board that they are satisfied with the outcome of any assessment that staffing is safe, effective and sustainable. **RESOLVED: The Board of Directors reviewed the self-assessment and the briefing contained in the report and was appraised of the compliance areas and the key areas of significant assurance and safer staffing.**
DHCFT 2020/030	**<u>FIT AND PROPER PERSON TEST POLICY RENEWAL</u>** The Trust's Fit and Proper Persons Policy and Procedures document is due for renewal. Justine Fitzjohn, Trust Secretary confirmed that it is still compliant with the guidance and regulations and has been corrected to replace references throughout the document made to Director of Corporate Affairs with Trust Secretary. A correction has also been made to the name of a linked policy. The Board was satisfied with the minor amendments that have been made and approved the renewal of the policy for three years. It was noted that the Trust Chair will make the annual declaration and assurance that Fit and Proper Persons requirements (FPPR) are being met by the Trust's Executive Directors and Non-Executive Directors at the July meeting. **RESOLVED: The Board of Directors ratified the renewal of the Trust's fit and proper person's policy and procedures and approved the renewal of the policy for three years.**
DHCFT	**<u>BOARD COMMITTEE ASSURANCE SUMMARIES AND ESCALATIONS</u>**

2020/031	The Board received assurance summary updates from recent meetings of the following Board Committees. Caroline noted that verbal updates were made in respect of the Audit and Risk Committee held on 16 January and People and Culture Committee on 28 January at the previous meeting and were extensively included in the minutes and is repeated below for reference. The assurance summaries were correctly presented to the Board at today's meeting. **Audit and Risk Committee** The Committee discussed how the impact that proposed changes in Accounting Standards will involve a significant amount of work for the Finance team and External Auditors, particularly for IFRS16 which is being planned for. A Deep Dive report on BAF 3a (financial plans) outlined the key controls and mitigating action that is in place, The Committee received significant assurance regarding the range of focus being applied to mitigate risk 3a. The Committee carried out its first review of its Equality Diversity and Inclusion objectives and found this to be a useful exercise. The Internal Audit report provided a good level of assurance on the way Datix is being used as an operational risk system. A review of JUCD Planning Process was seen as a useful piece of work. **People and Culture Committee** A watching brief is being kept on sickness absence management. The building blocks are in place to deliver a more person centred approach in managing attendance. The Committee is expecting to see progress over the next three to six months and will receive a further report in order to obtain further assurance. A first look at the results of the staff survey showed positive engagement scores. The Committee took the opportunity to congratulate Amanda Rawlings on the work that has focussed on producing better data and reducing timescales to bring resolutions and outcomes to employee relations cases. **Quality and Safeguarding Committee** Margaret Gildea reported that at the inaugural meeting of the newly combined Quality and Safeguarding Committee held on 11 February significant assurance had been received with safeguarding children activity but limited assurance with safeguarding adults due to the low compliance in safeguarding adults level 3 training. A report on the independent investigation into the care and treatment of a mental health service user in Derbyshire which highlighted the need for Derbyshire PICU was received and discussed. Two specific risk changes to the Board Assurance Framework were escalated to the Board. These were gaps in control in the management of patients with eating disorders and safety issues arising from the investigation and treatment of a mental health service user in Derbyshire and the action plan for improvement. **RESOLVED: The Board of Directors received and noted the Board Committee Assurance Summaries.**
DHCFT 2020/032	**ANY OTHER BUSINESS** Mark Powell gave the Board a further update on plans that are continuing to develop at a national level in response to the increasing number of confirmed cases of Coronavirus (Covid-19). He assured the Board that the Trust will comply with the guidance that is being issued by NHS England/Improvement and Public Health England to ensure the Trust is prepared and compliant with the latest national guidance. The Trust has established an incident management response team to ensure we have local plans in place that are in line with the guidance being shared with the NHS nationally. A communication will be issued to all staff outlining the measures being to be put in place so the Trust can be vigilant.
DHCFT 2020/033	**IDENTIFICATION OF ANY ISSUES ARISING FROM THE MEETING FOR INCLUSION OR UPDATING IN THE BOARD ASSURANCE FRAMEWORK (BAF)** There were no additional items for inclusion or updating within the BAF.
DHCFT	**2019/20 BOARD FORWARD PLAN**

2020/034	The 2020/21 forward plan outlining the programme for bi-monthly meetings was noted and will continue to be reviewed further by all Board members.
DHCFT 2020/035	**MEETING EFFECTIVENESS** Colleagues shadowing Board members at today's meeting were invited to offer their comments. Susan Krause shadowing Carolyn Green committed to cascade discussions held during today's meeting to the Children's Occupational Therapist (OT) team. Themes arising from Emily's story had resonated with her particularly regarding the significant role that OTs on the Radbourne Unit perform in engaging patients in meaningful activity. She thought it was interesting to hear that admin staff will receive training in holding difficult conversations as she was aware that members of the admin team work well calming patients on the ward. Responses to the staff survey indicating that people want to work at the Trust was particularly relevant as her team had found it difficult to recruit to Band 6 OTs and have since had nine applications for a band 6 role. Mellissa Edwards shadowing Mark Powell thought that Board discussions gave a positive insight into how reactive the Board is to matters concerning patients. She echoed Susan's comments about concerns mentioned in Emily's story as they were especially relevant to her as she had cared for a lady with the same condition. Melissa was also interested to see how the text messaging system would work in her area. Charlotte Kawalek shadowing Caroline Maley was pleased to hear that concerns raised by front line staff are being addressed by the Board. She was interested to hear Emily's story and felt that her feedback about listening to patient needs was extremely important in understanding what works best for them.
The Board will meet in public every two months from April 2020. The next meeting to be held in public session will take place at 9.30am on Tuesday 5 May 2020 in Conference Rooms A and B, Centre for Research and Development, Kingsway Hospital, Derby DE22 3LZ	

				BOARD OF DIRECTORS (PUBLIC) ACTION MATRIX - MAY 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	TBC	To allow greater focus on the critical issues related to COVID-19 this item will factored into the forward plan when normal business is resumed.	Amber

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

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 5 May 2020

Quality Position Statement – Quality issues

Purpose of Report

The Trust remains in a pandemic Level 4 incident management and emergency planning. This is a briefing to advise the Trust Board of Directors and the public on some core quality and safety issues. This includes assurances on infection control, the safety standards in managing mixed sex accommodation in a pandemic situation and Quality and Safeguarding Committee summary.

Executive Summary

- An assessment against NHS England recommended checklist of infection control measures and controls has been included and an assessment of the current performance. Our organisation has a strong history of solid infection control, low levels of outbreaks, strong performance in cleanliness standards in national independent audits. In our historical core service CQC reviews, there have been improvements in tidiness and on ward areas for cleanliness. This was rectified in 2020 inspections. However, overall our Trust sites and services have strong performance and outcomes in this area. In summary, the checklist demonstrates solid performance. Our clinical management of COVID-19 in our in-patient and community settings has not resulted in large scale outbreaks and our level of mortality associated with in-patient care is one of the lowest in the region.
- Mixed sex accommodation - the Department of Health requires all providers of NHS-funded care to confirm that they are compliant with the national definition "to eliminate mixed sex accommodation except where it is in the overall best interests of the patient or reflects the patient's choice". Organisations that either do not make a declaration or declare that supporting note: mixed sex accommodation 1 they are not compliant will face penalties. Declarations must be clearly visible on the organisation's website. The declaration should be accompanied by a commitment to audit data quality and publish results. The consequences of non-compliance are fines for an organisation, but these penalties are the responsibility of the Department of Health and not CQC.
- Health regulators in the pandemic emergency require that all providers should be aware of the current guidance on the management of COVID-19 for healthcare and the standards. To achieve effective infection control through the cohorting of patients with, or suspected to have, COVID-19, the restrictions on mixed sex accommodation may be challenged. As long as the individual patients continue to be risk assessed (with any particular vulnerabilities or risks associated with being in a mixed gender environment taken into consideration) mixing the sex of patients in a cohorted ward should be considered a reasonable and proportionate response to the immediate risk presented by the infection.
- NHS England have announced that they will not be collecting data on any breaches of the eliminating mixed sex accommodation.

Due to the recent outbreak of COVID-19, Derbyshire Healthcare NHS Foundation Trust has need to implement new ways or working and plans in place for possible outbreaks. The risk of COVID-19 is broken down into two separate areas:

1. Those who are needing to isolate because they are suspected or confirmed to have COVID-19
2. Those who need to shield as a result of being in a very high risk vulnerability group if they were to get COVID-19.

As a result, this provides a challenge within our current inpatient settings. For our older adult inpatient population, this is both a risk relating to a large number of the patients being within the 'Very High Risk Group' and so if a patient were to become positive of COVID-19, this provides a significant risk to the rest of the patients within that ward. To ensure that risk is reduced and managed in a safe way the Cubleys and Ward 1 have adopted a "POD" management system. This means that one area of the ward is utilised to manage positive cases of COVID-19, one is used to manage those who are suspected and one pod is used to manage those with no symptoms or a negative test result, ensuring that the risk of transference is minimal. This has shown a positive result as Ward 1 has moved from having several positive cases of COVID-19 to none and Cubley has moved from 6 positive cases to 4 and this continues to decline in numbers. In doing this, the Trust has needed to alter its approach to single sex areas or sections of a ward and new risk management plans have been put in place to manage this including sexual safety. As a result, at present where needed a POD or area of a ward has a mix of both male and female patients.

For the Acute inpatient areas, wards are being managed in the same way. However, plans are in place to manage very high risk patients and positive cases of COVID-19. Within these plans, there are options to move to a model where both male and females are nursed within the same area of a ward, however, never in a mixed sex dormitory. The Trust's Privacy and Dignity Policy has also been updated to highlight this possible change in practice and how this should be managed.

In our Trust, we are complaint with COVID-19 for healthcare and the standards. We have adapted our Trust policy on mixed sex adaptations and we are monitoring this and will report on these changes to offer full transparency on these changes. All National COVID-19 management guidelines published by Public Health England in this area are consistently reviewed to ensure compliance.

The Quality and Safeguarding Committee continues to meet and receive summaries of practice and safety concerns including quality metrics.

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 infection control, the safety standards in managing mixed sex accommodation in a pandemic situation

Governance or Legal Issues

Health Act 2006. The Code of Practice relating to health care associated infections. The code may in particular make such provision as the Secretary of State considers appropriate for the purpose of safeguarding individuals (whether receiving health care or otherwise) from the risk, or any increased risk, of being exposed to health care associated infections or of being made susceptible, or more susceptible, to them;

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

- Outcome 4 (Regulation 9) Care and welfare of people who use services
- Outcome 16 (Regulation 10) Assessing and monitoring the quality of service provision

Public Sector Equality Duty and Equality Impact Risk Analysis

In compliance with the Equality Delivery System (EDS2), reports must identify equality-related impacts on the nine protected characteristics, namely 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:

Mixed sex accommodation is a formal duty, although the COVID-19 management guidelines over rule this health standard. It has been reported to the Trust Board to ensure clarity and good governance of this significantly changed practice. There are risks associated with this changed practice and monitoring over sight is in place to mitigate this risk.

Recommendations

The Board of Directors is requested to accept this focused Quality Position Statement 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: **Carolyn Green**
Director of Nursing and Patient Experience

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

1. Background

Trust Board – Infection Control report April 2020

Ten elements that all Boards should seek assurance on	Executive lead response
1. There are 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.	Risk assessments have been initiated and reviewed and are subject to repeat review as part of our standard operation and clinical practice. We review and monitor training and compliance for level 1 Infection control. Ad hoc audits for IPC compliance, hand washing etc and structured visits to our clinical areas through PLACE scheme and Head of Nursing rounds to look at cleaning, condition and upgrade requirements. The COVID-19 outbreak has included a revision of these risk assessments considering access to facilities, Universal Infection Prevention Control Measure Compliance and concordance with guidance changes. We have also risk assessed access to PPE (Personal Protective Equipment) and this has an impact upon compliance and adherence to IPC (Infection Prevention Control) and PPE guidance issued by PHE (Public Health England). Compliance with these matters has been overseen by the Physical Care and Infection Control Committee (PHCICC). This group has stood down during the outbreak. However the elements are being picked up through the IMT (Incident Management Team) and PPE / IPC Cell.
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.	The Trust has an established mechanism for maintaining and monitoring cleaning standards. This is reviewed nationally through the PLACE scheme and locally through the PHCIC. In response to the COVID-19 outbreak, Estates and Facilities have extended the cleaning service provision for the rigour of cleaning and the frequency of cleaning. This has been ahead of guidance issued by PHE and the Estates team have employed additional staff through agency recruitment to increase the availability and standards of cleaning across all inpatient and community settings. They have also provided an on-call deep clean team available across our services.

Ten elements that all Boards should seek assurance on	Executive lead response
	Special consideration has been given to the management of Estates to ensure that clinical and staff changing environments are clean, in good repair and condition (upgraded showers at Hartington) and that personal safety and security is at the forefront of decisions to revise provision, particularly where same sex accommodation breaches have been considered.
3. Ensure appropriate anti-microbial use to optimise patient outcomes and to reduce the risk of adverse events and anti-microbial resistance.	The Trust has very low anti-microbial use. However, we are a committed partner and attend the regional Clinical Reference Group to support and learn from local and national practice and guidance changes. We submit reports to the Clinical Commissioning Group on a quarterly basis outlining our use of anti-microbial and our stewardship and audit work in accordance with national guidelines.
4. 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.	The IPC team will provide or source bespoke advice for practitioners and clients as required. The team are members of the Infection Prevention Society and receive regular national updates from PHE and NHSE through the IPC forums which have links, information and posters which have been peer reviewed by other clinicians and Trusts. This allows information to be updated and refreshed from contemporaneous and reliable sources.
5. 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.	The Trust has implemented a more clinically robust assessment tool for identifying the aspects of someone's physical health presentation that would give concern to indicators of risk such as familial factors, pre-diabetes screening, increasing frailty scores, pain management issues and oral hygiene and sexual health and well-being indicators. In addition Trust clinicians complete national indicator tools such as MUST and Waterlow scores, body mapping for skin deterioration as well as medication assessments and cross reference with General Practice notes via the summary care record. Newly admitted patients are swabbed for MRSA and monitored using Early Warning Scores to highlight infection markers. This monitoring can be increased at any point during an admission to reflect the concerns of their clinical team. Early detection of infection is crucial as this limits the impact and improves the outcomes. The Trust has made significant headway with improving the monitoring and early detection

Ten elements that all Boards should seek assurance on	Executive lead response
	of SEPSIS and has been part of the regional group to deliver improved outcomes for Derbyshire residents. Testing for all new admissions, cohort management plans including barrier nursing are in place and there has been good compliance with isolation.
6. 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.	The Trust induction programme has key information about infection prevention and control. Hand hygiene, use of PPE and observing restrictions in place if an infection control outbreak is highlighted are all covered. In all ward readiness of new starters and 3rd year students, programmes supply this information and this is repeated in local induction.
7. Provide or secure adequate isolation facilities.	The Trust has facilities to be able to nurse a limited number of individuals in isolation with access to independent bathroom and toilet facilities across its estates. The Acute provision has less available spaces and this is an area for consideration as we revise cohorting and isolation management plans as part of the pandemic response. Next stage plans are in design, should our single room bed stock and isolation plans require further additions due to demand.
8. Secure adequate access to laboratory support as appropriate.	The Trust has access to microbiology and virology services through the Service level Agreements with University Hospital derby and Burton (UDHB) and Chesterfield Royal Hospital (CRH). This provides a sample, results and analysis service to Trust Clinicians. There are on-going discussions about improving the access to results which are held in a different clinical system to reduce transcription error potential and improve visibility. As all patients in testing increases, we continue to be in negotiation on testing requirements.
9. Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.	The Trust has a number of policies related to Infection Control, Prescription of Medicines and Use and Management of Estates and Facilities. The policies are reviewed tri-annually or in the event of a significant national directive. The oversight for the review of the documents and underpinning audits to confirn adherence to policy sits with the Physical care and Infection Prevention Control Committee. Some Police have joint oversight with the Health and Safety Committee and both committees report

Ten elements that all Boards should seek assurance on	Executive lead response
	to the Trust Quality & Safeguarding Committee and provide bi-annual updates in order to provide assurance to a Board reporting Committee for assurance. A summary of the annual work is also included in the annual Quality & Safeguarding Committee report.
10. Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection	The Trust employs occupational health services through a partner provider. The Health and safety Team and IPC team will also seek advice or respond to requests for review of Trust operating standards based upon their guidance. New guidance for at risk staff was issued on 29 April 2020. The Trust has already proactively implemented this guidance at the initial stages of incident management. There are policies in place to make sure the Trust has oversight and understanding of infections impacting upon staff wellbeing through the People and Culture Committee and the Staff Forum. The Trust works with teams to ensure they have understanding and access to suitable work wear and personal protective equipment, are aware of up to date policies and guidance and respond to queries and concerns through communications policy updates and meeting and review. This is under pinned by clinical audits.

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 5 May 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 December 2019 to 25 February 2020.

Executive Summary

- From 1 December 2019 to 25 February 2020, the Trust received 497 death notifications of patients who have been in contact with our service in the last six months.
- There has been one inpatient death following transfer to the acute hospital for further medical treatment. (Incident did not occur following a ward/ward transfer - patient was AWOL at time of incident.)
- The Mortality Review Group reviewed 33 deaths. These reviews were undertaken by a multi-disciplinary team and it was established that of the 33 deaths reviewed, none were classed as not due to problems in care.
- The Trust has reported 0 Learning Disability deaths from 1 December 2019 from 25 February 2020.
- There is very little variation between male and female deaths; 238 male deaths were reported compared to 259 female.
- 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.

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

From the 1 December to 25 February 2020 there is very little variation between male and female deaths; 238 male deaths were reported compared to 259 female. 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: **Dr John R Sykes**
Medical Director

Rachel Williams
Lead Professional for Patient Safety and Patient Experience

Aneesa Akhtar-Alam
Mortality Technician

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.

The Guidance has outlined specific requirements in relation to reporting requirements. From April 2017, the Trust is required to collect and publish each quarter, specified information on deaths. This is through a paper and Board item to a public Board meeting in each quarter, and should include the total number of inpatient deaths and those deaths that the Trust has subjected to case record review. Of these deaths, subject to review, we are asked to consider how many of these deaths were judged more likely than not to have been due to problems in care. The above has been completed as outlined in the national guidance.

The report presents the data for 1 December to 25 February 2020

2. Current Position and Progress

- As a way of accessing a national database for cause of death, our application for NHS Digital continues, but has not been given priority at national level the emphasis being on acute Trusts. The patient safety Lead and Medical Director will be meeting the regional medical examiner to discuss the role of a local medical examiner working with the Trust and whether this could facilitate access to Cause of Death data.

- A northern consultant mortality meeting rota has been in place since November 2018, organised by Dr Sugato Sarkar. . A southern consultant mortality meeting rota has been in place since December 2019, organised by Dr Rais Ahmed.

- Regular audits continue to be undertaken to ensure compliance with policy and procedure and any necessary changes made. This has included auditing complaint data against names of deceased patients to ensure this meets the National guidance.

- All deaths that are received through the NHS spine have been reviewed to date. The mortality technicians review the case notes to identify patients who meet *the learning from deaths* or *Datix* red flags and raise any concerns if identified. This process ensures that the Trust is complaint with the National Guidance so that all deaths are scrutinised for learning opportunities.

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

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.

Month	2019-12-01	2020-01-01	2020-02-01
1. Total Deaths Per Month	191	182	124
5. LD Referral Deaths	0	0	0

The table above shows information for 1 December to 25 February 2020

Correct as at 25 February 2020

From 1 December to 25 February 2020, the Trust received 497 death notifications of patients who have been in contact with our service. There has been 1 inpatient death, the patient died following transfer to the acute hospital after requiring urgent medical attention. (Incident occurred after ward/ward transfer- patient was AWOL at time of incident.)

4. Review of Deaths

1 December to 25 February 2020

Total number of Deaths from 1 December to 25 February 2020 reported on Datix	Total 42 34 Unexpected 6 suspected 2 as “Expected - end of life pathway”
Of above, number reviewed through the Serious Incident Group	39 (3 to be reviewed at the next meeting)
Of above, number investigated by the Serious Incident Group	25 did not require an investigation; 3 underway and 14 pending a review)
Of above, number of Serious Incidents closed by the Serious Incident Group?	25 (As of 25/02/2020, 14 currently opened to SI group and 3 pending for a review)

From 1 December 2019 to 25 February 2020, the Trust has received 497 death notifications of patients who have been with our service within the previous 6 months. 42 deaths were reported through our DATIX system of which 34 were recorded as unexpected deaths, 6 suspected deaths and 2 expected deaths (end of life).

Since 1 December to 25 February 2020 the Trust has recorded 1 inpatient death, the patient died following transfer to the acute hospital for further medical treatment (patient was AWOL at time of incident), which is 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

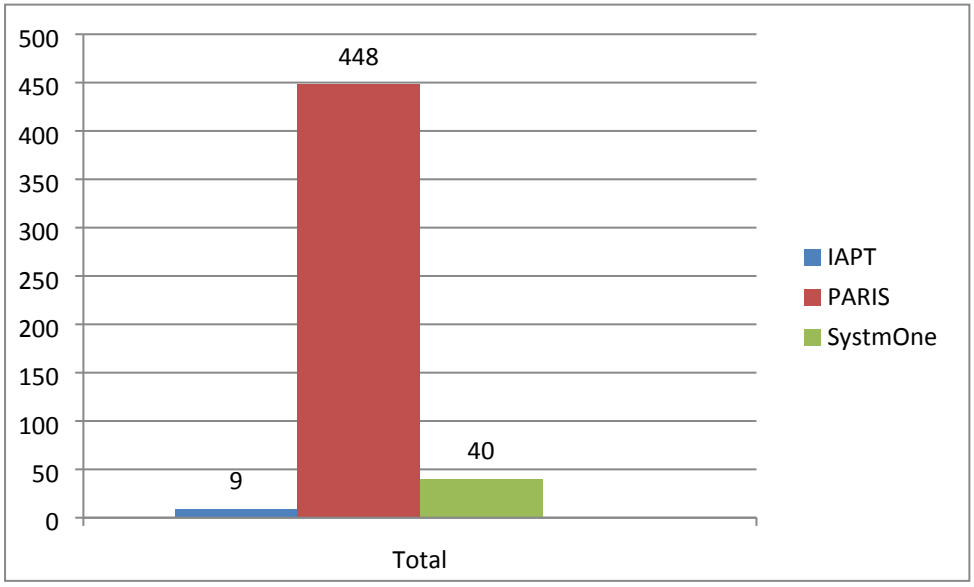
1 December to 25 February 2020, the Mortality Review Group reviewed 33 deaths. These reviews were undertaken by a multi-disciplinary team and it was established that of the 33 deaths reviewed, 33 have been classed as not due to problems in care.

The Mortality Group review the deaths of patients who fall under the following 'red flags' from 28 March 2019:

- Patient taking an anti-psychotic medication
- Patients whose care plan was not reviewed in the 6 months prior to their death
- Patient whose risk plan and or safety plan was not in place or updated as per policy, prior to death
- Death of a patient with a learning disability

6. Analysis of Data

6.1 Analysis of deaths per notification system since 1 December to 25 February 2020

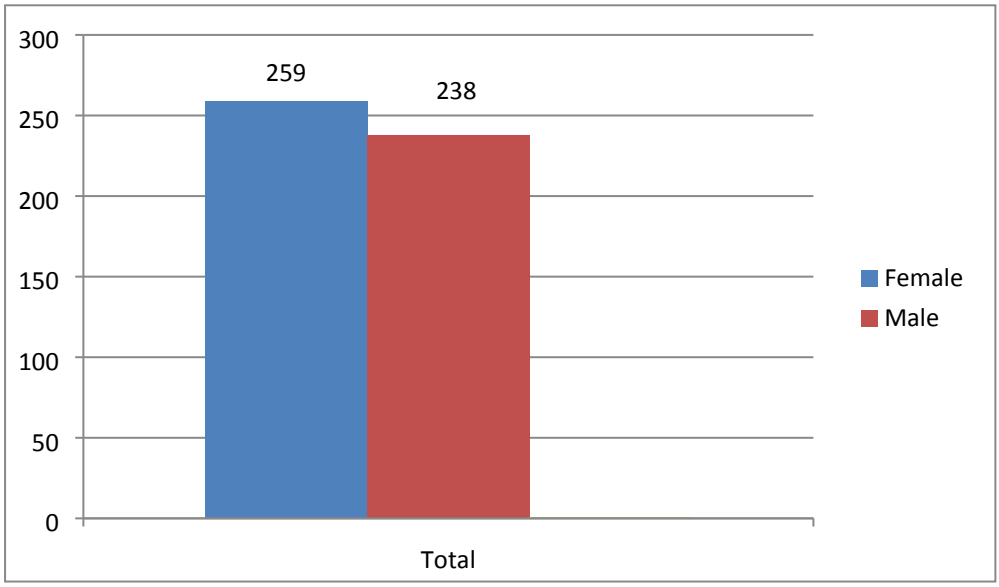


	IAPT	PARIS	SystmOne	Grand Total
Count	9	448	40	497

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. 40 death notifications were extracted from SystmOne and 9 death notifications were extracted from IAPT.

6.2 Deaths by Gender since 1 December to 25 February 2020

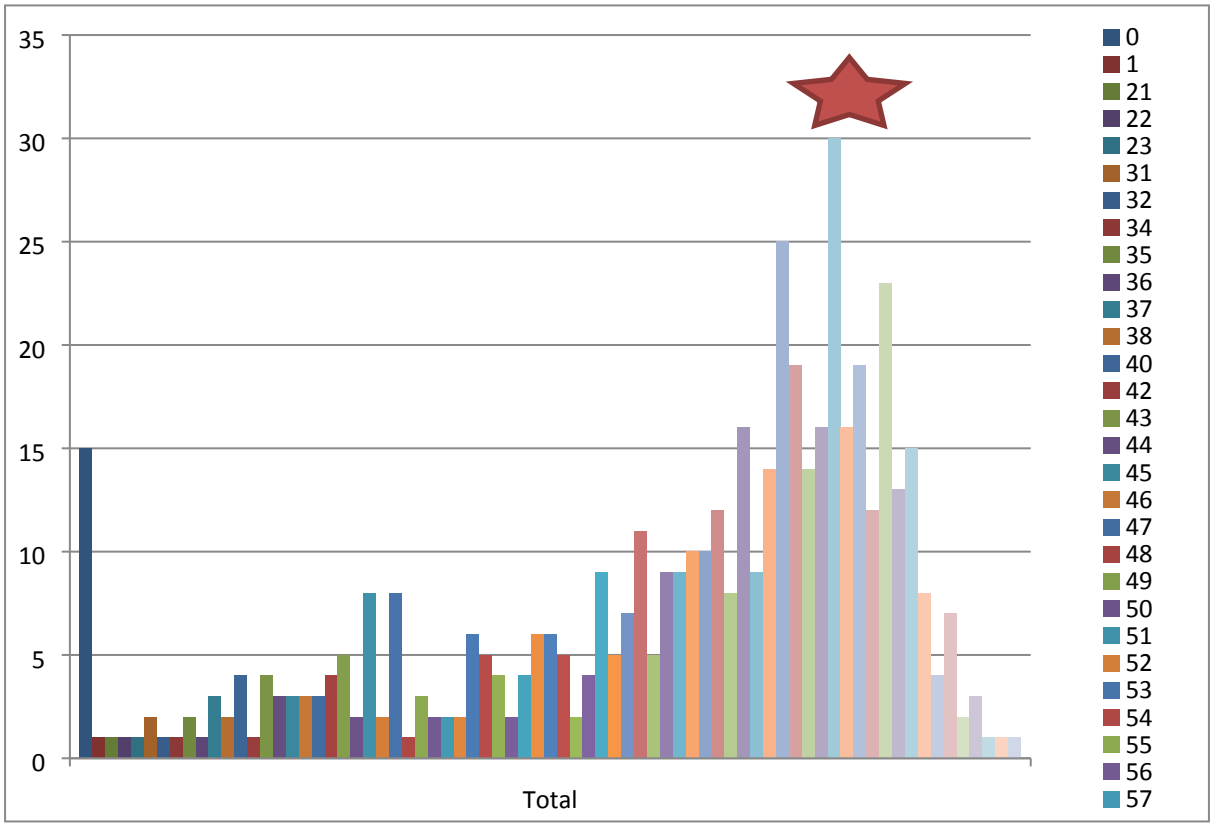
The data below shows the total number of deaths by gender 1 December to 25 February 2020. There is very little variation between male and female deaths; 238 male deaths were reported compared to 259 female.



	Female	Male	Grand Total
Count	259	238	497

6.3 Death by Age Group since 1 December to 25 February 2020

The youngest age was classed as 0, and the oldest age was 103 years. Most deaths occur within the 85-90 age groups (indicated by the star).



6.4 Learning Disability Deaths since 1 December to 25 February 2020

	December 2020	January 2020	February 2020
LD Deaths	0	0	0

The Trust reviews all deaths relating to patients diagnosed with a Learning Disability. The Trust also currently sends all Learning Disability deaths that have been reported through the Datix system to the Learning Disabilities Mortality Review (LeDeR) programme. However, we are unable to ascertain how many of these deaths have been reviewed through the LeDeR process, as LeDeR only looks at an undisclosed sample of overall deaths. Currently the Lead Professional for Patient Safety and Experience is working closely with LeDeR so that the Trust can be involved moving forward in the review process. The Trust is continuing to share relevant information with LeDeR which is used in their reviews. Since 1 December to 25 February 2020, the Trust has recorded 0 Learning Disability deaths.

The Trust now receives a quarterly update from LeDeR which highlights good practice and identified learning.

6.5 Death by Ethnicity since 1 December to 25 February 2020

White British is the highest recorded ethnicity group with 386 recorded deaths, 65 deaths had no recorded ethnicity assigned, and 5 people did not state their ethnicity. The chart below outlines all ethnicity groups.

Row Labels	Count of Ethnicity
White - British	386
Not Known	65
White - Any other White background	11
Other Ethnic Groups - Any other ethnic group	10
White - Irish	4
Not stated	5
Asian or Asian British - Pakistani	1
Caribbean	2
Indian	4
Mixed - White and Asian	1
Asian or Asian British - Any other Asian background	2
Mixed - Any other mixed background	1
Mixed - White and Black Caribbean	2
Other Ethnic Groups - Chinese	3
Grand Total	**497**

6.6 Death by religion since 1 December to 25 February 2020

Christianity is the highest recorded religion group with 100 recorded deaths, 52 deaths had no recorded religion assigned and 3 people refused to state their religion. The chart below outlines all religion groups.

Row	Count of Religion
Christian	100
Church Of England	59
Unknown	52
Not Religious	27
Roman Catholic	10
Catholic: Not Roman Catholic	4
Sikh	3
Methodist	3
None	3
Not Given Patient Refused	3
Hindu	2
Muslim	2
Advaitin Hindu	1
Agnostic movement	1
Anglican	1
Atheist	1
Christian religion	1
Jehovah's Witness	1
Lutheran	1
Nonconformist	1
Not stated	1
Pentecostalist	1
Protestant	1
Spiritualist	1
Zoroastrian	1
Grand Total	**281**

6.7 Death by sexual orientation since 1 December to 25 February 2020

Heterosexual or straight is the highest recorded sexual orientation group with 164 recorded deaths. The chart below outlines all sexual orientation groups.

Row Labels	Count of Sexual Orientation
Heterosexual Or Straight	164
Heterosexual	27
Not Stated (declined)	4
Gay Or Lesbian	2
Not Appropriate To Ask	2
Person Asked And Does Not Know	2
Patient unsure	1
Unknown	1
Grand Total	**203**

6.8 Death by disability since 1 December to 25 February 2020

Behavioural and emotional problems were the highest recorded disability group with 41 recorded deaths.

Row Labels	Count of Disability
Behaviour and emotional	41
Other	33
Dementia	26
Mobility and gross motor	9
Hearing	16
Progressive (LT) Conditions	7
Sight	5
Walking Disability	1
Grand Total	**138**

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.

- Review of the neighbourhood operating policy in regard to how caseloads are considered for reallocation when staff are absent in terms of their presentation of risk.
- To expand the substance misuse engagement team to focus on GP and hospital appointments.
- Review of access and availability of ligature hooks in inpatient areas
- Develop a clinical competency framework for inpatient senior nurses, lead nurses registered nurses and preceptorship nurses, commensurate with their roles and responsibilities
- Review of the Trust guidelines for the management and treatment of opiate use with consideration to the inclusion of a withdrawal scale assessment tool (I.E. COWS)
- Communication process on admission between primary and secondary care to be reviewed.
- Trust wide assessment of bed stock and market analysis of new equipment to further improve our resources
- To Audit the application of Section 17 leave
- Review of Discharge, transfers and transitions and leave policy and procedures with particular reference to transfer between trust teams, cultural improvement in the ‘safe and efficient hand over of care and communication and information sharing with partner agencies.
- Standard Operating Procedure for Dysphagia Screening and Initial Management for Older Peoples Services
- Development of a criteria and referral process for ECW to support decision making in relation to admissions authorisation in these situations
- For an audit of safety plans on the ward to be completed and the results discussed with the qualified nursing team.

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 5 May 2020

Board Assurance Framework (BAF)
First issue for 2020/21

Purpose of Report

To meet the requirement for Boards to produce an Assurance Framework. This report details the first issue of the BAF for 2020/21

Executive Summary

A Board Development session was undertaken on 19 February 2020 to commence development of the BAF risks for 2020/21. However, the outbreak of the COVID-19 virus and subsequent world-wide pandemic has resulted in significant changes to the governance and operational processes in trusts, with a national directive to trusts to operate on a governance 'light' framework.

Therefore, this first issue of the BAF for 2020/21 is proposed as a COVID-19 specific response BAF, outlining the key risks to achieving the Trusts Strategic Objectives to providing GREAT care in all services, being a GREAT place to work, and making the BEST use of money in this phase of emergency response to the pandemic.

Following discussion of this Issue of the BAF by the Audit and Risk Committee on 30 April 2020, it was noted that the Trust is in discussion with its BME network to fully understand any disproportionate risks to BME colleagues and is undertaking individual risk assessments. This will inform an addition to the people risk on the BAF going forward.

As the Trust moves into a restoration and recovery phase, the wider emerging risks, controls and assurances will be further developed to populate a broader BAF, in line with the previous approaches the trust has developed and implemented to ensure a robust BAF framework is in place.

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 provides an update on 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, during this current response to the COVID-19 pandemic

Consultation

- Directors with lead responsibility to populate the BAF (April 2020)
- Executive Leadership Team - 22 April 2020
- Audit and Risk Committee - 30 April 2020

Governance or Legal Issues

Governance or legal implications relating to individual risks are referred to in the BAF itself

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

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

Recommendations

The Board of Directors is requested to:

1) Approve this initial issue of the BAF for 2020/21 and the assurance the paper provides of the process of the review, scrutiny and update of the BAF in seeking to identify and mitigate risks to achieving the Trust's strategic objectives, during this phase of response to the COVID-19 pandemic
2) 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

Board Assurance Framework (COVID-19 response) 2020/21_May 2020 (Issue 1)

Ref	Principal risk	Director Lead	Current rating (Likelihood x Impact)	Responsible Committee
Strategic Objective 1. To provide GREAT care in all services				
20_21 SO1	There is a risk that the Trust will fail to provide essential standards for patient safety and effectiveness during the COVID-19 pandemic	Executive Director of Nursing/Medical Director, Overseen by Director of Business Improvement and Transformation.	HIGH (4x4)	Quality and Safeguarding Committee
Strategic Objective 2. To be a GREAT place to work				
20_21 S02	There is a risk that the Trust will fail to maintain enough staff to deliver essential services during the COVID-19 pandemic, and that staff wellbeing and resilience is directly affected by the crisis response required	Assistant Director of People and Culture Transformation. Overseen by Chief Executive	EXTREME (4x5)	People and Culture Committee/ Board
Strategic Objective 3. To make BEST use of our money				
20_21 SO3	There is a risk that the Trust fails to deliver its financial obligations during the COVID- 19 pandemic	Executive Director of Finance	MODERATE (2x5)	Finance and Performance Committee

Board Assurance Framework (COVID-19 response) 2020/21_May 2020 (Issue 1)

Strategic Objective 1. To provide GREAT care in all services

Principal risk: There is a risk that the Trust fails to provide essential standards for patient safety and effectiveness during the COVID-19 pandemic and then during the potential surge in demand for unplanned mental health services due to the repercussions of COVID-19

Impact: May lead to increased 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) Global outbreak of COVID-19 virus leading to significant pressures on local and national healthcare systems
b) National response to pandemic focused on maintaining essential services, resulting in closure or reduction of non-essential services and redeployment of staff
c) Impact of COVID-19 on workforce availability and supply
d) Reduced access to full range of diagnostic and treatment services in relation to physical and mental health care needs
e) Increased demand for mental health services linked to the COVID-19 pandemic

BAF ref: 20_21 SO 1	**Director Lead**: Executive Director of Nursing/Medical Director. Overseen by Director of Business Improvement and Transformation.	**Responsible Committee**: Quality and Safeguarding Committee

Inherent risk rating:			**Current risk rating:**		
Rating MODERATE	Likelihood 3	Impact 4	Rating HIGH	Likelihood 4	Impact 4

Key controls

- Trust Incident Management Team (IMT) established. Command and control of Trust response to local and national issues and risks and management of key Trust communications.
- 'Light' governance framework and committee structure ensuring key risks and impact on clinical quality are continuing to be identified and managed, including quality performance reporting as part of the Integrated Performance Report to the Board. Quality and Safeguarding Committee continuing to meet.
- Regular briefings from IMT to Executive Directors/Executive Leadership Team, includes risks and mitigations in relation to patient safety and effectiveness. Daily IMT briefings direct to CEO.
- IMT monitoring of key quality indicators in relation to COVID-19 response i.e. staffing levels; infection rates; PPE management; bed occupancy; infection control compliance; monitoring of patient deaths linked to COVID-19.
- Director led 'Ethics Cell' within the IMT considering ethical implications of incident related operational decisions and national guidance which may impact on patient care. Links to system wide Ethics Cell.
- Daily system escalation call for Derbyshire involving CEO and Incident Director. Regional and national escalation calls involving CEO.
- Continued incident and risk reporting (including modified serious incident investigation and mortality monitoring), modified response to complaints

- Timely changes to policies relating to COVID-19 response
- Continued recruitment of staff, incident related essential training maintained. Redeployment and retraining of staff to support essential services.

Assurances on Controls

- Performance report, including key quality indicators
- Daily SITREP reports to NHSE/I
- Daily Action Logs formally recording actions required and taken in the Incident Management Team
- CQC Mental Health Act Visits continuing
- 'Freedom to Speak Up' processes and assurances continue to be evidenced

Key gaps in control:	Key actions to close gaps in control:	Impact on risk to be measured by:	Progress against action:	Action on track:
Clear plan for post incident recovery of services	Develop and implement plan for post incident recovery of services [ACTION OWNERS: COO/CEO]	Exit from incident response phase with quality of care and patient safety maintained.	Cell established as part of the IMT to consider incident recovery. System wide incident recovery cell established. Demand and capacity plan in place for potential 'double impact' if a second wave of staff absence coincides with increased demand for mental health services.	
Adequate and appropriate PPE (Personal Protective Equipment) available to ensure staff and patient safety	Ensure close stock control of PPE within the trust. [ACTION OWNER: COO] Work with local and national partners to ensure adequate availability and appropriate use of PPE [ACTION OWNER: COO]	Minimise no of concerns raised by staff in relation to availability of PPE Minimise COVID-19 infections amongst patients and staff from contact in ward and home environments	Close control of distribution of stock. Daily monitoring reporting to IMT, daily regional SITREP that drives supply. Escalation to regional and national supply chain where shortages identified. Use of mutual aid process if supply can't be obtained nationally.	
Ability to identify patients with physical health care needs which results in their being vulnerable to COVID-19	Populate the Trust's EPR record with patients identified as specifically vulnerable to COVID-19, in line with national recommendations [ACTION OWNERS: COO]	Population of PARIS and other trust EPR's with alerts for patients vulnerable to COVID-19	List of patients identified as vulnerable received from CCG. Alert flag added to PARIS and other Trust EPR's to staff involved in the patients care are aware.	
Yet to understand the impact the	Continue to develop elements of the OnEPR	Agreement of clear set	Programme Board in April as	

COVID-19 pandemic will have on the Trust's plans to develop and implement a revised Electronic Patient Record (EPR) - known as OnEPR	programme within resources available, given focus on emergency response to the current pandemic [ACTION OWNER: DBI&T (temp)] Agree the conditions which would signal the need for a revised programme timescale and develop revised plan as required [ACTION OWNER: DBI&T (temp)]	of circumstances that would require revised plan to be formulated Achievement of revised milestones	planned. Presentation to May 2020 Programme Board of consultation and engagement work to date and circumstances that would require an alteration to the programme	
Inability to complete all actions from the CQC comprehensive inspection in a timely manner due to the unprecedented response to the COVID-19 pandemic as part of level 4 emergency preparedness	The CQC actions are part of the activities to be reviewed under the Trust Restoration and Recovery plan currently under development [ACTION OWNER: DBI&T (temp)]	Recovery and Restoration plan detailing revised timescales around CQC action plan completion Completion of key actions, in particular those related to essential training	Improvement plan in place to significantly increase resuscitation training compliance within next month.	
Key gaps in assurance:	**Key actions to close gaps in assurances:**	**Impact on risk to be measured by:**	**Progress against action:**	**Action on track:**
Reduction in the mechanisms available for feedback and engagement with patients and cares, including reduced response to complaints investigation, ceasing of CQC and HealthWatch core visits	Develop alternative routes to ensure patient and carer feedback is maintained in relation to the response to the pandemic [ACTION OWNERS: DoN/DBI&T]	Feedback from patients as to how well they have been informed about service changes and new ways of accessing services when they need them.	HealthWatch approached to conduct qualitative work to identify the impact on individuals know to services. iPads available to patients in inpatient areas to ensure they are able to maintain contact with relatives and friends.	
'Light' governance structures may result in less scrutiny on quality and effectiveness assurances. Use of remote technologies for committees impact on usual confirm and challenge interactions.	Commence enhancement of governance structures as as part of recovery and restoration work [ACTION OWNER: TS]	Assurances continuing to be reported for key area of risks. Regular feedback from committee members on effectiveness of meetings.	Business as usual updates part of weekly ELT meetings	
Decreasing demand for services	Implementation of national and local communication	Increase in demand for	Campaigns to commence over next	

such as IAPT and CAMHS and reduced GP referrals. No evidence of equivalent reduction in illness raising concern that people may not be accessing services they need	campaigns that the NHS is still open for business [ACTION OWNERS: CEO/MD/DoN]	IAPT and CAMHS services. Increase in GP referrals.	2-3 weeks.	

Strategic Objective 2. To be a GREAT place to work

Principal risk: **There is a risk that the Trust will fail to maintain enough staff to deliver essential services during the COVID-19 pandemic, and that staff wellbeing and resilience is directly affected by the crisis response required**

Impact: May lead to: an inability to maintain essential services; increased staff sickness; delayed ability to 'step up' services once current pandemic response has reduced

Root causes:

a) Global outbreak of COV-19 virus leading to significant impact on morbidity and mortality impact across the general population
b) Increased numbers of staff falling ill as a result of contracting the virus
c) Requirement for staff to self-isolate if they are in a vulnerable category or if they or family members display symptoms
d) National issues with supply of PPE and consistent guidance, resulting in potential risks to exposure
e) Increased concern for staff's own well-being and staff concerns for their patients, family and friends

BAF ref: 20_21 SO 2	**Director Lead**: Assistant Director of People and Culture Transformation. Overseen by Chief Executive	**Responsible Committee**: Board on behalf of People and Culture Committee

Inherent risk rating:			**Current risk rating:**		
Rating HIGH	Likelihood 3	Impact 5	Rating EXTREME	Likelihood 4	Impact 5

Key controls

- Trust Incident Management Team (IMT) established. Command and control of Trust response to local and national issues and risks and management of key Trust communications.
- 'Light' governance framework and committee structure ensuring key risks and impact on people issues are continuing to be identified and managed, including people performance reporting as part of the Integrated Performance Report to the Board. Board are assuming the role of responsible committee for people related issues and assurances in response to the requirement for 'light' governance structures
- Nationally led initiatives to increase the number of staff available to support essential services i.e. return to work offers for those recently retired; early qualification of final year students; request for public volunteers
- System wide workforce group co-ordinating peoples related issues between organisations
- Regular, clear and focused communications with staff using a variety of methods including: all staff emails: podcasts; MS Teams; SMS texts
- Continued recruitment of staff, incident related essential training maintained. Redeployment and retraining of staff to support essential services.
- Extended well-being offer to staff including: availability of testing; self-care guidance; guidance on home working; free food for acute and community settings
- Strong relationship with staff side colleagues – key members of the Incident Management Team

- Regular communication between the Chief Operating Officer and Assistant Director for People and Culture Transformation and CEO

Assurances on Controls

- Integrated Performance Report to Board including people performance report to Board
- Daily Action Logs formally recording actions required and taken in the Incident Management Team

Key gaps in control:	Key actions to close gaps in control:	Impact on risk to be measured by:	Progress against action:	Action on track:
High levels of staff sickness absence	Continue to develop staff well-being offer and associated communications. [ACTION OWNER: AD P&CT] Ensure robust staff testing for COVID-19 is in place [ACTION OWNER: DoN]	Reduction in staff sickness absence rates	Considering increasing offer available from First Care to include nurse support Workforce and staff cell within IMT to ensure increase in staff well-being offer Availability of staff testing across multiple sites now in place and communicated to staff	
Pace of recruitment to new and vacant posts	Develop methods using 'remote' working to ensure pace of recruitment continues [ACTION OWNER: AD P&CT]	Maintained or improved position in relation to vacancy rates	Use of Microsoft Teams and Skype to support recruitment processes	
Along with the general public, staff may not be accessing health services they need and seeking support from their GP of specialist services	Implementation of national and local communication campaigns that the NHS is still open for business [ACTION OWNERS: CEO/MD/DoN]	Reduction in staff sickness absence rates, including those related to long term conditions	Campaigns to commence over next 2-3 weeks.	
Staff disconnect from their teams and patients due to remote working	Enable a range of communication tools to be available to support staff [ACTION OWNERS: COO]	Staff feedback	Purchase of laptops and mobile phones for staff working remotely. Implementation of MS teams, Skype, conference calling and video calling with patients	

Increased cyber security risks due to higher numbers of staff relying on technology and remote working during COVID pandemic response	Assessment of patch compliance of all Trust desktops and laptops and targeted contact to ensure compliance Enhancement of communications to ensure exposure to cyber security is minimised [ACTION OWNERS: COO via Incident Management Team]	% of Trust laptops and desktops that comply with patch testing Cyber related incidents	Assessment of all Trust laptops and desktops completed. Action plan for managing compliance. Non-compliant devices taken 'offline' after 12weeks. All staff communications regarding security patching	
Key gaps in assurance:	**Key actions to close gaps in assurances:**	**Impact on risk to be measured by:**	**Progress against action:**	**Action on track:**
Maintenance of training compliance due to reduction in training limited to essential. Skills/knowledge gaps of staff who have been redeployed	Identify and formalise training requirements during the COVID-19 response period. [ACTION OWNER: AD P&CT] Plan recovery and restoration phase [ACTION OWNER: AD P&CT]	Maintenance of training compliance in areas considered essential to the COVID-19 response	Training requirements reviewed and minimised to essential training to support COVID-19 response. Training licences extended where possible. Clear process for step up to training as part of recovery process to be developed.	

Strategic Objective 3. To make BEST use of our money

Principal risk: There is a risk that the Trust fails to deliver its financial obligations during the COVID- 19 pandemic

Impact: Trust becomes financially challenged during COVID-19 pandemic

Root causes:

a) Block and top up payments are insufficient to cover all Trust costs inclusive of Covid-specific costs (both capital and revenue)
b) Cash flow is negatively affected by income and cost flows during the temporary financial regime
c) Trust incurs financial loss due to theft or fraud

BAF ref: 20_21 SO3	**Director Lead**: Claire Wright, Executive Director of Finance	**Responsible Committee**: Board on behalf of Finance and Performance Committee

Inherent risk rating:			**Current risk rating:**		
Rating EXTREME	Likelihood 4	Impact 5	Rating MODERATE	Likelihood 2	Impact 5

Key controls

- Budget training, segregation of duties, mandatory counterfraud training and annual counterfraud work programme. Increased communications, scrutiny and awareness-raising in times of heightened fraud risk. Collation of Covid 19 specific costs to enable reimbursement. Compliance with temporary finance regime submissions requirements. Follow regulator guidance.
- Audits (internal, external and in-house); Scrutiny of financial delivery, bank reconciliations; Local counterfraud scrutiny. Additional financial governance oversight by DoF and finance team spot checks during and after the pandemic
- Standing financial instructions (including adjusted SFIs and operating protocols during pandemic) budget control, delegated limits, 'no-PO no pay' rules; Agency staff approval controls; Approval to appoint process
- Corrective management action; Disaster recovery plan implementation; Risk mitigation activity and oversight by finance team. Recovery of losses from perpetrators

Assurances on Controls

- Delivery of adjusted approach to financial planning, in-year and forecast reporting for overall Trust financial position
- Delivery of Counterfraud and audit work programme with completed and embedded actions for all recommendations.
- Counterfraud Self Review Tool assessed as green-rated

- 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				
Key gaps in control:	**Key actions to close gaps in control:**	**Impact on risk to be measured by:**	**Progress against action:**	**Action on track:**
There is suspension of normal financial and contracting regime in effect from April 1 2020	Maintain good financial governance practices with enhanced arrangements in areas of heightened risk (ACTION OWNER: DOF)	Ongoing reporting of actual costs and income received (also review business as usual costs with those expected at draft plan) Review 31/07/2020	Ongoing reporting of actuals and income	
Management of revenue and capital cost implications associated with emergency decision making powers of the incident management team (IMT)	Senior member of finance team is part of IMT (ACTION OWNER DOF)	All costs being appropriately reclaimed in time Review 31/07/2020	No unfunded revenue or capital costs Some actuals may differ to forecast	
Key gaps in assurance:	**Key actions to close gaps in assurances:**	**Impact on risk to be measured by:**	**Progress against action:**	**Action on track:**
To be regularly reviewed based on evolving situation				

Board Assurance Framework (COVID-19 response) 2020/21_May 2020 (Issue 1)

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	Executive Director of Finance	DON	Executive Director of Nursing and Patient Experience
MD	Medical Director	AD P&CT	Assistant Director of People and Culture Transformation
DBI&T	Director of Business Improvement and Transformation	TS	Trust Secretary

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 5 May 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 is performing at the end of March 2020. The report focuses on key financial and operational performance along with key workforce indicators.

In line with national guidance this report reflects the temporary streamlined Committee approach and therefore replaces separate reporting from the Finance and Performance Committee and the People and Culture Committee.

Executive Summary

The report provides the Board of Directors with information that shows how the Trust is performing against a set of key targets and measures. In line with recent instruction from NHS England & NHS Improvement[1], the standard report has been streamlined in order to reduce the burden on the regular contributors and release capacity to manage the COVID-19 pandemic.

Performance is summarised in an assurance summary dashboard with targets identified where a specific target has been agreed. Where a specific target hasn't 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 charts for the measures are included in appendix 2. (These have been updated to include a milestone point reference at the point of the covid major incident being declared.)

The main body of the report provides detail on a number of the key measures. The main areas to draw the Board's attention to are as follows:

Finance

The financial outturn for 2019/20 matched our planned outturn of £1.8m surplus. This was augmented by the £0.7m additional mental health cash allocation, making the final draft outturn position a surplus of £2.5m (excluding impairments). The position included £220k of Covid revenue costs that were reimbursed.

The 2019/20 draft accounts were completed on time and are subject to detailed scrutiny at the April meeting of the Audit and Risk Committee on behalf of the Trust Board. Audit and Risk Committee on 17 June will sign off the final audited accounts for the year, along with the Annual Report.

Looking to 2020/21: Nationally-determined block payments have been received in April for April and May estimated costs. We have been notified that we will receive no national top ups, therefore top ups will be claimed retrospectively if needed.

Recognising the temporary changes to the Standing Financial Instructions regarding the Incident Management Teams' decision-making authority during this period, the financial impact of Incident Management Team decisions will be regularly reported at Executive Leadership Team and assurance on financial governance will be provided to Audit and Risk Committee.

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

Operations

CPA 7 day follow-up

Although still within normal variation, in March the reported proportion of patients followed up within 7 days of discharge was at the lowest level to date. Of the 13 reported exceptions, 4 were recording issues rather than true breaches. The wellbeing of the remaining 9 patients has subsequently been established, albeit not within the 7 day standard. 1 of the exceptions was a result of the Community Psychiatric Nurse (CPN) being absent from work owing to COVID-19.

Data quality maturity index

Following a run of 4 consecutive months of deterioration, in March the position actually improved slightly. The postponement of certain non-critical mental health services during the COVID-19 pandemic may be resulting in record administrators having more capacity to update their records.

IAPT people completing treatment who move to recovery

Talking Mental Health Derbyshire (TMHD) continues to exceed the national standards for referral to treatment, however the rate achieved in March for both standards was lower than normal.

Although statistically the IAPT recovery target may pass or fail based on random variation, TMHD has continued to exceed the national standard every month.

Out of area – acute placements

Since reaching an all-time high back in January of 28 patients placed out of area in adult acute beds, the position has been improving and at the end of year 9 patients were placed in out of area acute beds. (We have been able to create a large number of empty Trust beds following the discharge initiative for Covid response, but out of area placements are still expected to be required in order to maximise and appropriately prioritise Trust staffing resources. This will be subject to regular review).

Out of area – PICU placements

There is currently no local PICU provision and is considered within the Estate Strategy. The number of patients in PICU placements has reduced in each of the last 3 months and at the end of the year there were 13 patients placed in PICUs.

Waiting list for child & adolescent mental health services (CAMHS)

The waiting list and capacity to meet demand were a significant challenge for CAMHS even before the current pandemic. Waits have been steadily increasing over time.

Waiting list for community paediatrics

Significant progress has been made and at the end of March the number of children on the waiting list was the lowest level achieved to date.

Waiting list for autistic spectrum disorder (ASD) assessment

The service is currently on hold to enable redeployment of staff to support our most vulnerable and high risk patients. As a result, the waiting list has been temporarily closed to new referrals. This is likely to result in an initial large increase in referrals received once the service is resumed in a few months' time.

Waiting times for psychology

For the last 6 months we have seen sustained improvement.

Referrals

We are currently experiencing a reduction in referrals received by many of our services.

Future impact – COVID-19 response

Our COVID-19 response means that we have segmented our services into critical and other tiers of urgency/priority – as a result it is expected that over the next few months the impact of the stratification of services will start to vary the associated KPIs such as waiting times.

Workforce

In order to reduce the burden and release capacity to manage the COVID-19 pandemic, all NHS organisations have been instructed by Amanda Pritchard, Chief Operating Officer, NHS England & NHS Improvement, to suspend appraisals and revalidation with immediate effect and to reduce the volume of mandatory training as appropriate.

Annual appraisals

For the last 5 months the completion rate has been above the upper control limit, which indicates significant and sustained improvement. Appraisals are now on hold.

Turnover

Turnover in March remained within normal variation and over the full financial year turnover consistently remained within the Trust target range of 8-12%.

Mandatory training

Following a period of sustained improvement since June 2018, this financial year the level of mandatory training has been maintained above Trust target every month. Essential mandatory training has been reviewed in the COVID-19 response and associated risks considered where extensions to compliance have been agreed.

Staff absence

COVID-19 is currently the most common reason for absence. At end of March the spread of COVID-19 within our workforce showed an increase of around 0.3% per day.

Supervision

As is to be expected in the current climate, the level of compliance with the clinical and managerial supervision targets has begun to drop.

Vacancies

In March the proportion of posts filled was within normal variation and has been gradually increasing for the last 5 months.

Employee Relations

Coronavirus (COVID-19) poses enormous challenges for the NHS workforce. As a result of this the Social Partnership Forum (SPF) have advised that partnership working in organisations may need to be streamlined and organisational change, employment processes and industrial disputes put on hold. The Employee Relations team have continued to advise on employee

relations matters where they have arisen and all other processes have been put on hold for this period.

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 aspects of Board Assurance 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

An earlier version of this report was considered by Board in April.

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: **Claire Wright**
Deputy CEO / Director of Finance

Report prepared by: **Peter Henson**
Head of Performance, Delivery & Clustering

Claire Wright
Deputy CEO / Director of Finance

Celestine Stafford
Assistant Director People and Culture Transformation

1. Assurance Summary

Indicator	Rating[1]	Data Quality	Indicator	Rating[1]
Operational				
CPA 7 day follow-up			Waiting list for care coordination – number waiting	See chart
Data Quality Maturity Index (DQMI) - MHSDS data score			Waiting list for care coordination – average wait	See chart
Early Intervention (EIP) RTT within 14 days - complete			Waiting list for ASD assessment – number waiting	See chart
EIP RTT within 14 Days - incomplete			Waiting list for ASD assessment – average wait	See chart
IAPT referral to treatment (RTT) within 18 weeks			Waiting list for psychology – number waiting	See chart
IAPT referral to treatment within 6 weeks			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 - PICU	See chart		Waiting list for CAMHS – average wait	See chart
Patients placed out of area - adult acute	See chart		Waiting list for community paediatrics – number waiting	See chart
			Waiting list for community paediatrics – average wait	See chart
Workforce				
Annual appraisals			Clinical supervision	
Annual turnover			Management supervision	
Compulsory training			Vacancies	
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. 7 day follow-up

The purpose of 7 day follow-up is to establish the wellbeing of patients and provide support during the period where they may be feeling most vulnerable during the first few days post discharge. In March there were 6 patients on CPA and 3 patients not on CPA who were not followed up within 7 days of discharge:

Discharge Date	Discharge Ward	On CPA at Discharge?	DCC Care Coordinator
19 Mar 2020	CUBLEY MALE KWAY	No	Patient was discharged to a dementia care home. A comprehensive proxy follow-up was completed with a Registered Nurse at the care home to ensure their wellbeing.
12 Mar 2020	ENHANCED CARE WARD RU	Yes	Patient did not attend the planned follow-up appointment at their home. Successful contact was made on day 11.
2 Mar 2020	MORTON WARD HU	Yes	Patient went to stay with friends in Burnley post discharge and did not return calls made by the CMHT. Successful contact has subsequently been made following their return to Derby.
20 Mar 2020	MORTON WARD HU	Yes	Patient was not at home for the planned follow-up appointment, however they attended the CMHT base to arrange an appointment and there were no concerns raised regarding their mental state.
3 Mar 2020	REHAB AUDREY KWAY	Yes	Patient did not attend the planned appointment. The residential home staff confirmed that they were safe and well and had settled in and made friends with the other residents. Successful contact has subsequently been made.
6 Mar 2020	TANSLEY WARD HU	No	Discharged following a successful period of home leave. Attempted to make contact by telephone but no response. Contact made with the DCHS community learning disability team on day 4 who confirmed they had made contact with the patient and they were fine. Contact has subsequently been made by the CPN.
16 Mar 2020	WARD 35 RU	Yes	Discharged to a private mental health rehabilitation residential care home. Unfortunately the planned follow-up did not take place owing to the CPN being off work with COVID-19.
23 Mar 2020	WARD 35 RU	Yes	Followed up by substance misuse service, however it should have been completed by a mental health professional.
17 Mar 2020	WARD 36 RU	No	Telephone contact was briefly made on day 2, but the patient was on a bus and said they would call back later, however they did not. Further attempts were made to make contact but proved unsuccessful. The patient has subsequently been in touch with the ward.

From April 2020 the national standard for follow-up will reduce to 72 hours with a target of 80%. (see https://www.england.nhs.uk/wp-content/uploads/2020/03/7-contract-technical-guidance-2020-21-210220.pdf page 156).

B. Data quality maturity index

The number of items NHS England are monitoring has increased over time from 6 items to 36. This creates a challenge in terms of collecting the new data; however we continue to perform well when benchmarked against other organisations. Following a run of 4 consecutive months of deterioration, in March the position actually improved slightly. The postponement of certain non-critical mental health services during the COVID-19 pandemic may be resulting in record administrators having more capacity to update their records.

C. IAPT 18 week referral to treatment

Talking Mental Health Derbyshire (TMHD) continued to exceed the national standard for 18 week referral to treatment, however the rate achieved in March was lower than normal, falling just below the lower confidence limit which indicates special cause variation.

D. IAPT 6 week referral to treatment

TMHD also continued to exceed the national standard for 6 week referral to treatment, however the rate achieved in March was also lower than normal, falling below the lower confidence limit which indicates special cause variation.

E. IAPT – people completing treatment who move to recovery

TMHD have achieved the target every month this financial year. This has been a result of the Area Service Manager tightly monitoring the position on a daily basis and reacting to address any deterioration. Performance has also been monitored at regular contractual and operational meetings.

F. Patients placed out of area – adult acute

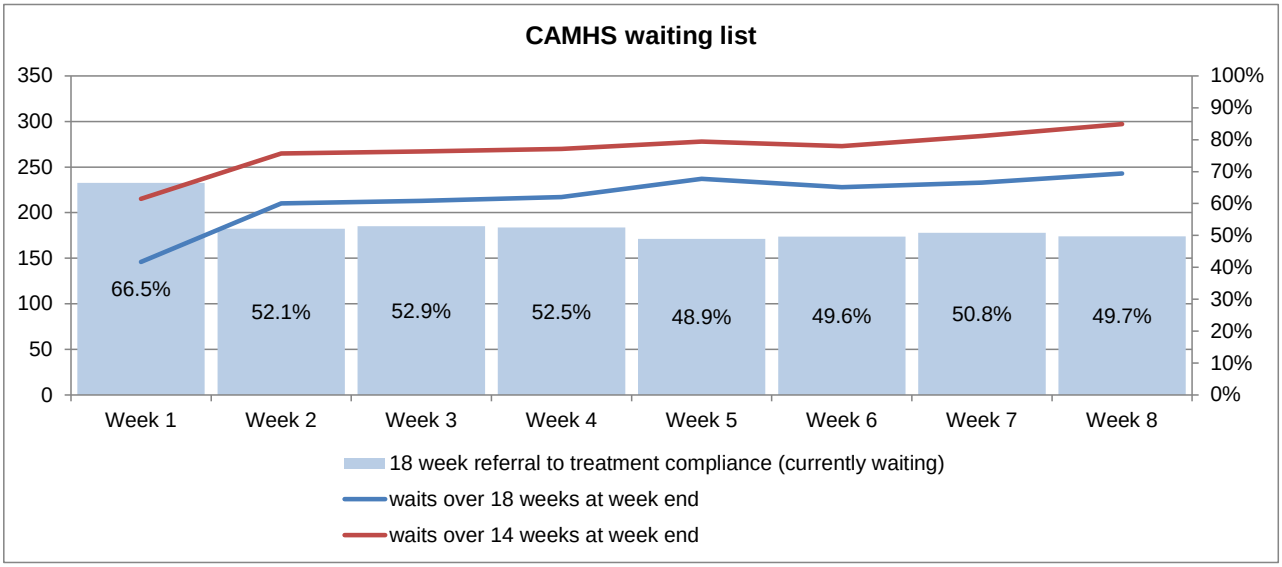
Since reaching an all-time high back in January of 28 patients placed out of area in adult acute beds, the position has been improving and at the time of writing there are just 9 patients placed in out of area acute beds.

G. Patients placed out of area – psychiatric intensive care (PICU)

There is currently no local PICU provision, however this is included in the Estate Strategy. The number of patients in PICU placements has reduced in each of the last 3 months and at the end of March there were 13 patients placed in PICUs.

H. Waiting list for child & adolescent mental health services (CAMHS)

The waiting list and capacity to meet demand were a significant challenge for CAMHS even before the current pandemic. The position over the last 8 weeks was as follows (week 8 being the most recent):



I. Waiting list for community paediatrics

Significant progress has been made and at the end of March the number of children on the waiting list was the lowest level achieved to date.

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

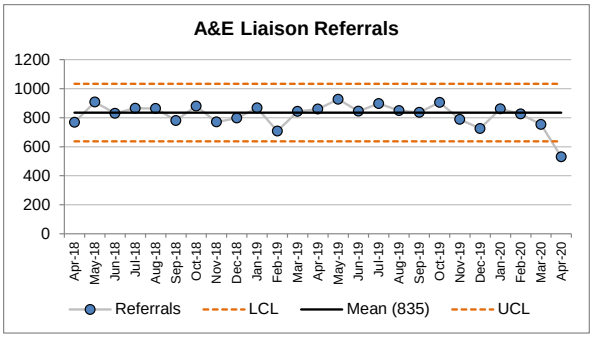
The service is currently on hold to enable redeployment of staff to support our most vulnerable and high risk patients. As a result, the waiting list has been temporarily closed to new referrals. This is likely to result in an initial large increase in referrals received once the service is resumed.

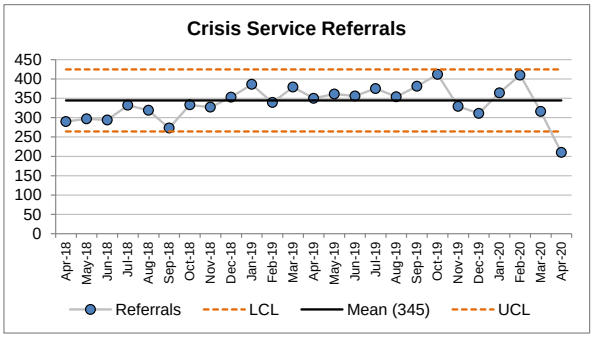
K. Waiting times for psychology

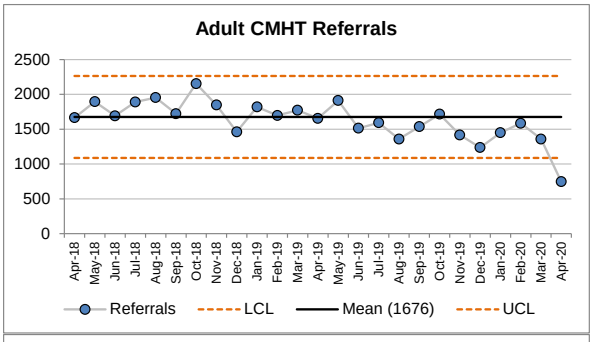
For the last 6 months the average wait to be seen has fallen below the lower confidence limit, which indicates sustained improvement. The reduction in number of patients waiting is also significant.

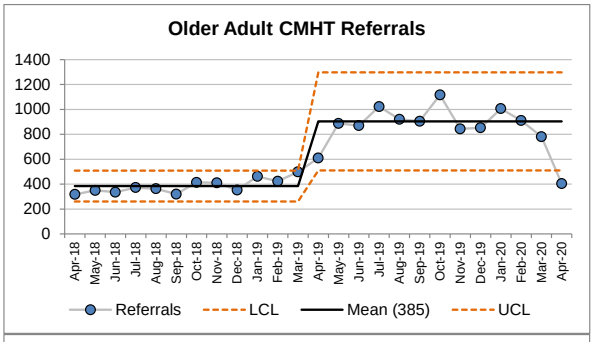
L. Demand and Activity

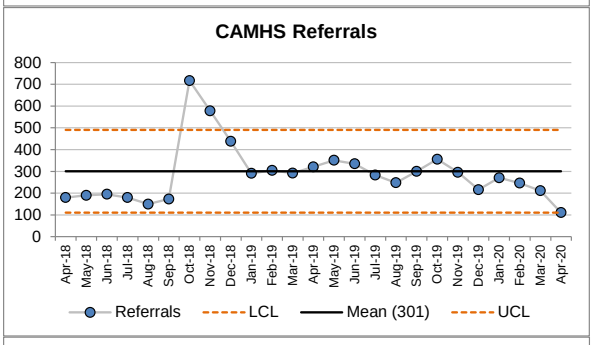
In most services during the pandemic there has been a reduction in the number of referrals received. Implications of this are being considered by the Incident Management Team. (April data in the charts below is a full month projection as at at the time of writing).

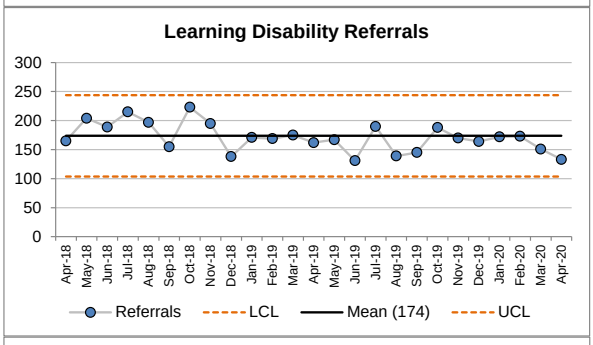


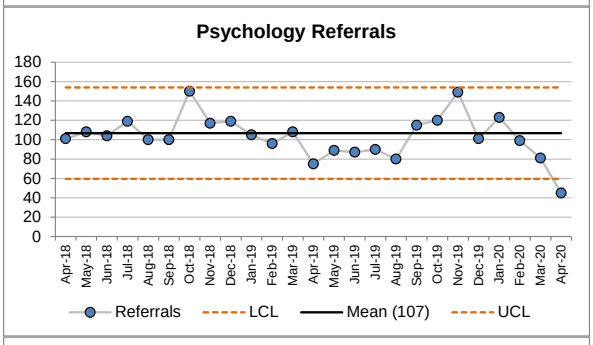


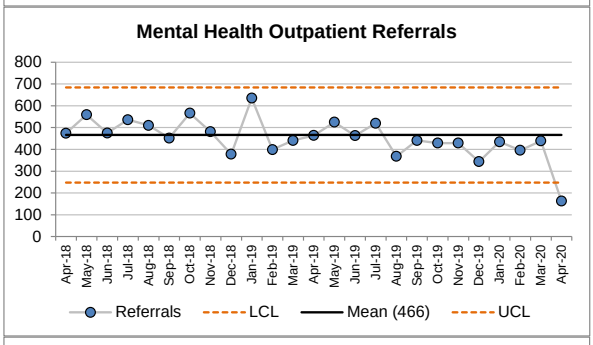

Adult CMHT Referrals
Referrals
LCL
Mean (1676)
UCL

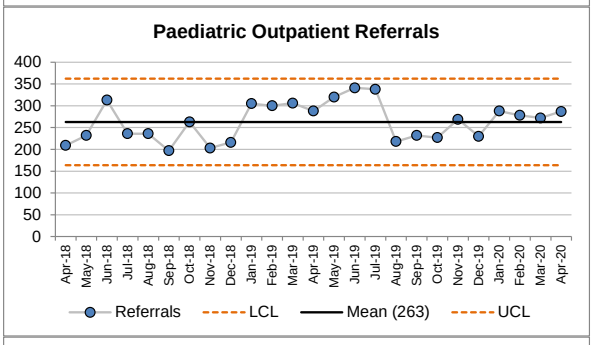

Older Adult CMHT Referrals
Referrals
LCL
Mean (385)
UCL

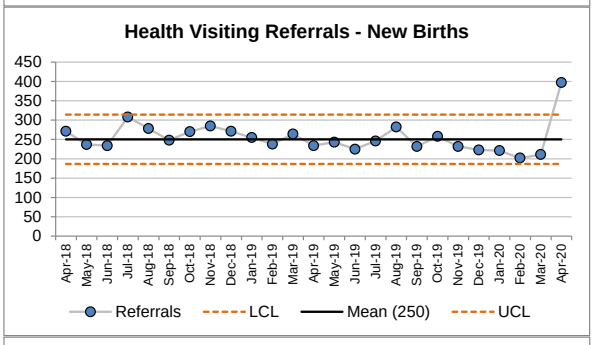

CAMHS Referrals
Referrals
LCL
Mean (301)
UCL

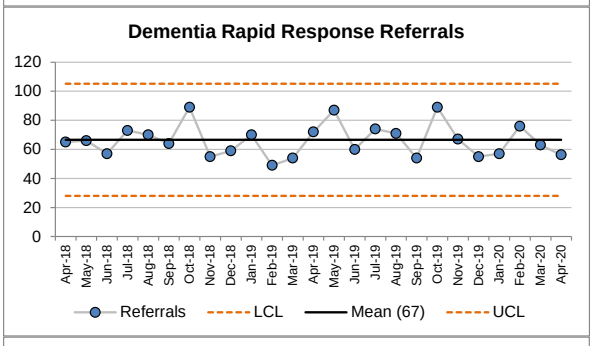

Learning Disability Referrals
Referrals
LCL
Mean (174)
UCL

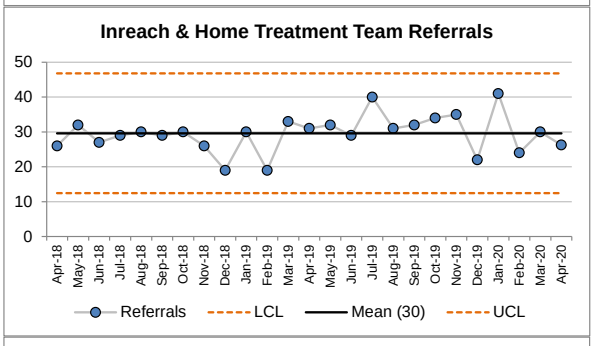

Psychology Referrals
Referrals
LCL
Mean (107)
UCL

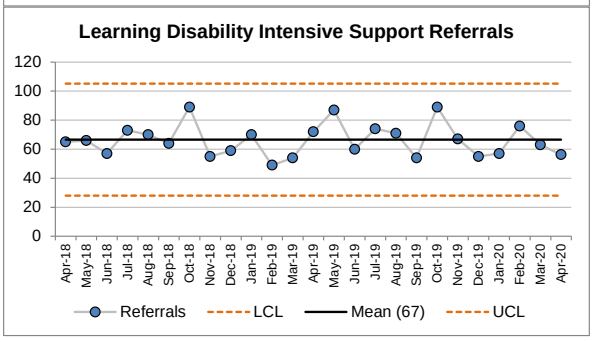

Mental Health Outpatient Referrals
Referrals
LCL
Mean (466)
UCL

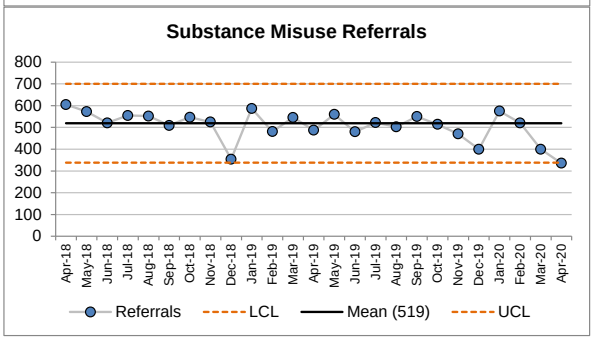

Paediatric Outpatient Referrals
Referrals
LCL
Mean (263)
UCL


Health Visiting Referrals - New Births
Referrals
LCL
Mean (250)
UCL


Dementia Rapid Response Referrals
Referrals
LCL
Mean (67)
UCL


Inreach & Home Treatment Team Referrals
Referrals
LCL
Mean (30)
UCL


Learning Disability Intensive Support Referrals
Referrals
LCL
Mean (67)
UCL


Substance Misuse Referrals
Referrals
LCL
Mean (519)
UCL

Workforce

In order to reduce the burden and release capacity to manage the COVID-19 pandemic, all NHS organisations have been instructed by Amanda Pritchard, Chief Operating Officer, NHS England & NHS Improvement[2], to suspend appraisals and revalidation with immediate effect and to reduce the volume of mandatory training as appropriate.

A. Annual appraisals

For the last 5 months the completion rate has been above the upper control limit, which indicates significant and sustained improvement. Factors which might have contributed to this improvement include appraisal training for managers and the streamlining of the appraisal paperwork. Appraisals are now on hold.

B. Turnover

Turnover in March was within normal variation and over the full financial year turnover consistently remained within the Trust target range of 8-12%.

C. Mandatory training

Following a period of sustained improvement since June 2018, this financial year the level of mandatory training has been maintained above Trust target every month.

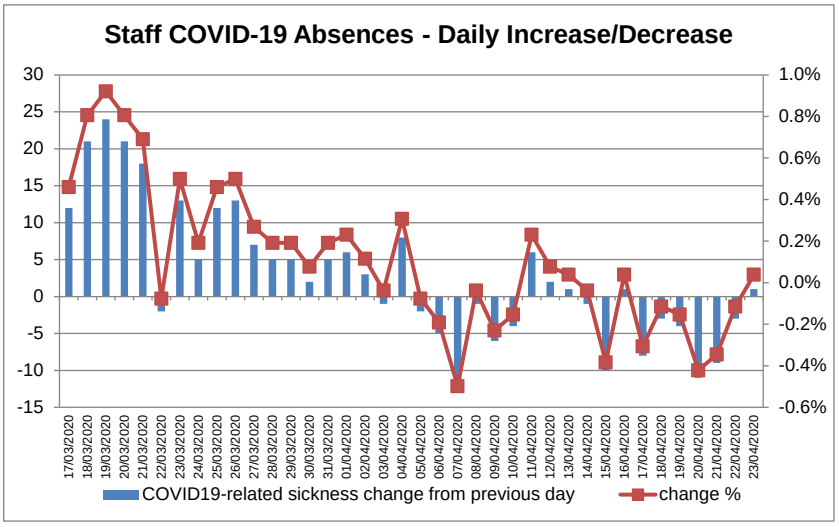
D. Staff absence

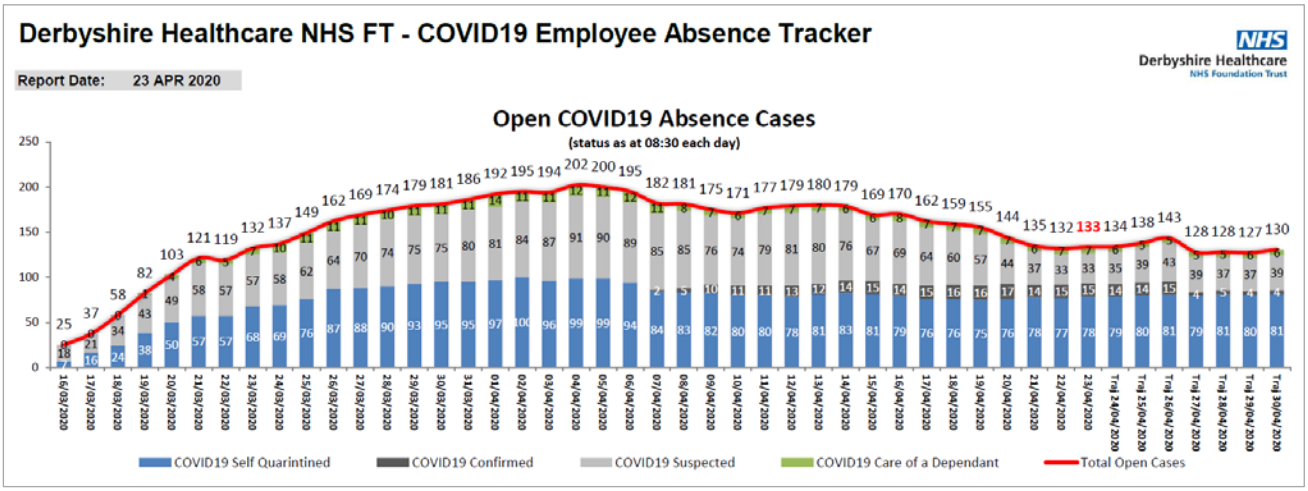
Historically, by far the greatest cause of sickness absence in Operational Services has been anxiety, stress, depression or other psychiatric illness; however COVID-19 is currently the most common reason for absence:

Absence reason - current absence (Ops)	No	%
COVID-19 related	102	46.8%
S10 Anxiety/stress/depression/other psychiatric illnesses	41	18.8%
S12 Other musculoskeletal problems	13	6.0%
Consent withheld	7	3.2%
Bereavement	6	2.8%
Surgery	5	2.3%
S17 Benign and malignant tumours, cancers	4	1.8%
S25 Gastrointestinal problems	4	1.8%
S28 Injury, fracture	4	1.8%
S29 Nervous system disorders	4	1.8%
S15 Chest and respiratory problems	4	1.8%
Care of a dependant	4	1.8%
Not Assigned	3	1.4%
S16 Headache / migraine	3	1.4%
S21 Ear, nose, throat (ENT)	2	0.9%
S31 Skin disorders	2	0.9%
S26 Genitourinary and gynaecological disorders	2	0.9%
S14 Asthma	1	0.5%
S23 Eye problems	1	0.5%
S30 Pregnancy related disorders	1	0.5%
S13 Cold, Cough, Flu - Influenza	1	0.5%
S98 Other known causes - not elsewhere classified	1	0.5%
S19 Heart, cardiac and circulatory problems	1	0.5%
Awaiting classification	1	0.5%
S11 Back Problems	1	0.5%

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

The spread of COVID-19 within our workforce remains fairly stable and our absence rates compare favourably with peers at the time of writing.





E. Supervision

As is to be expected in the current climate, the level of compliance with the clinical and managerial supervision targets has begun to drop.

F. Vacancies

In February the proportion of posts filled was within normal variation and has been gradually increasing for the last 5 months.

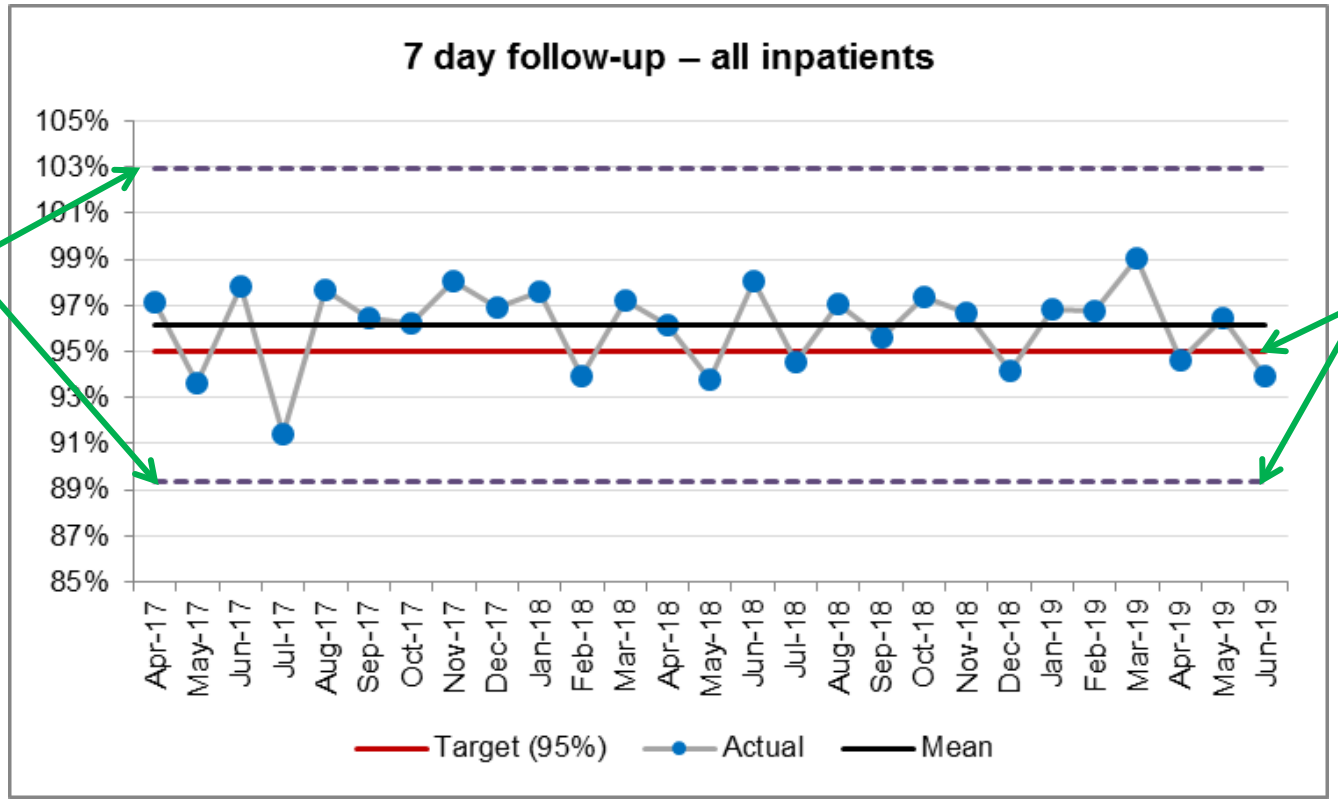
G. Employee Relations

The Employee Relations team (ER) have paused all ongoing work related to Disciplinary, Grievance, Dignity at Work and Capability matters whilst we are in the COVID19 crisis. It is only where the employee requests proceeding as it would otherwise cause additional anxiety, or where they are very serious or urgent that any further work is progressed. Where an issue is less serious or not urgent then pragmatic outcomes, with agreement of the employee, and after consultation with union representatives, will be considered. Where outcomes cannot be agreed in this way then processes may resume at a future date, without detriment or criticism of either side. There are some particular issues that the ER team will advise and this would be if there was a safety risk or an urgent grievance where the employee, staffside and the ER team would seek to address in the normal timescales.

Appendix 1

How to Interpret a Statistical Process Control Chart (SPC)

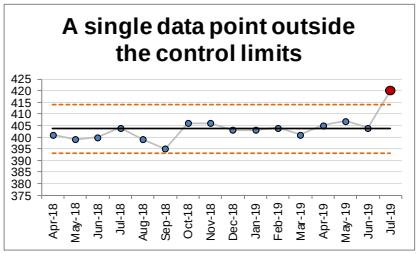
The dotted lines are the "control limits". Any performance between these 2 lines is normal for the current system. This is known as "normal variation"

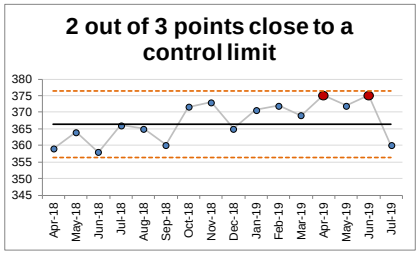


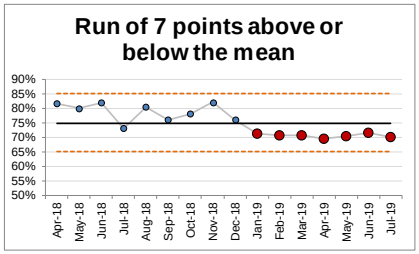
If the system is effective, the **lower** control limit will be above the target line (for targets where higher is better) or the **upper** control limit will be below the target line (for targets where lower is better). In that scenario we have nothing to worry about and can be assured our system is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

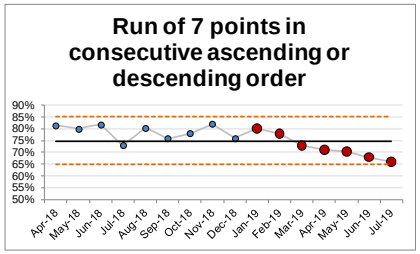
In this case the target line is above the lower control limit which indicates that the system is ineffective.

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:



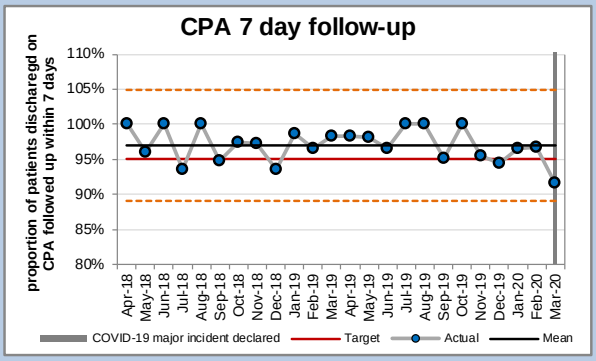


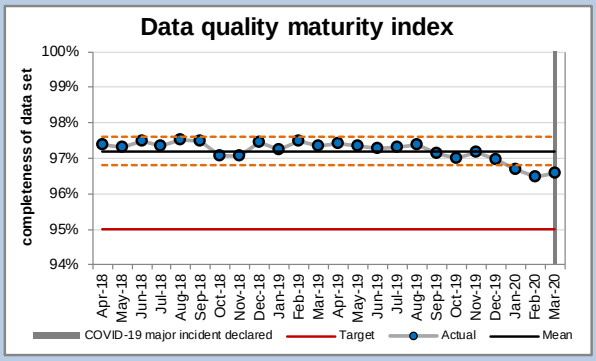


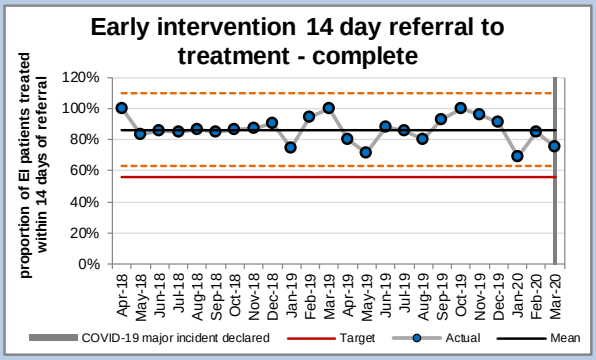


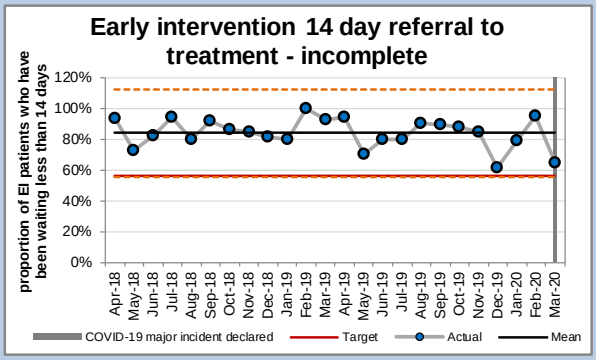
Appendix 2 – Charts

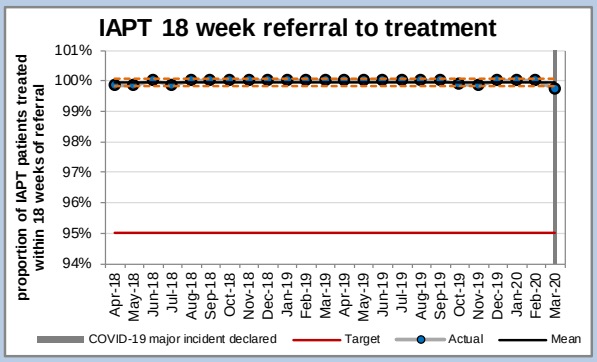
Operational indicators

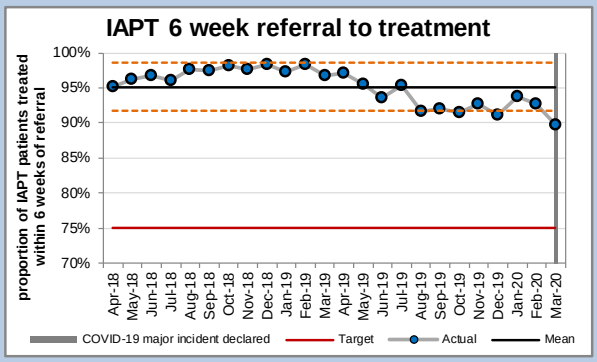


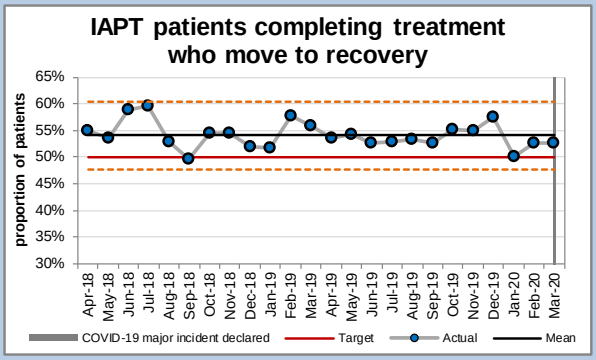


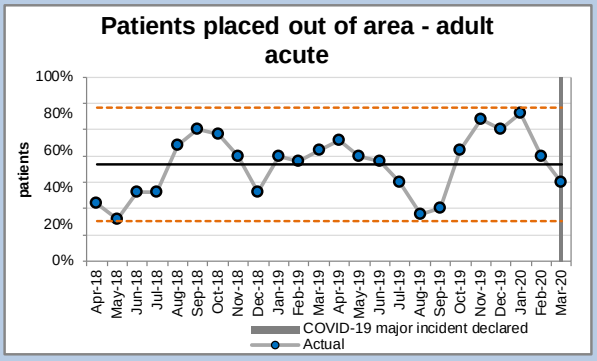


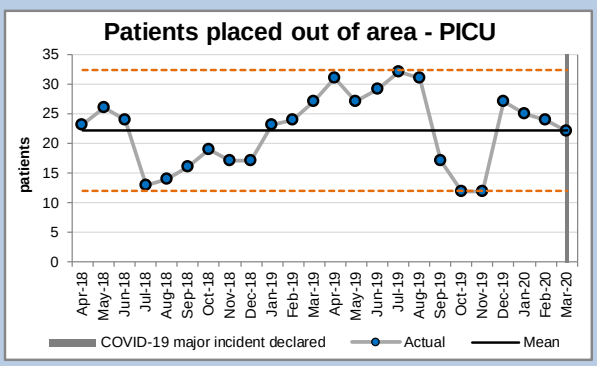




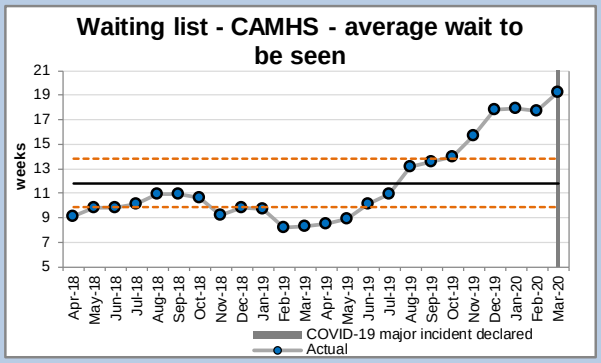


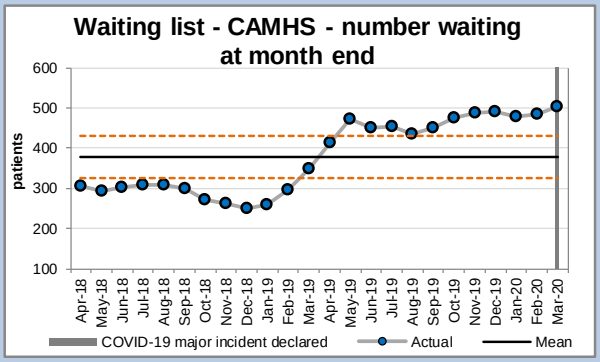


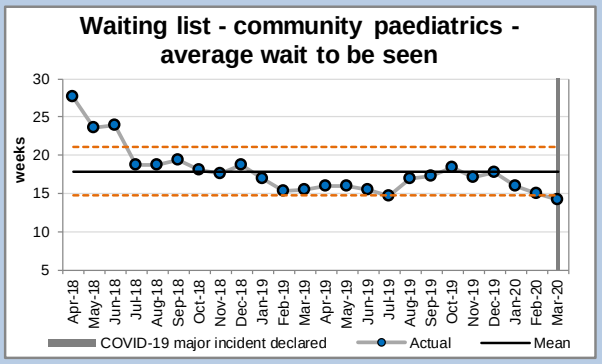


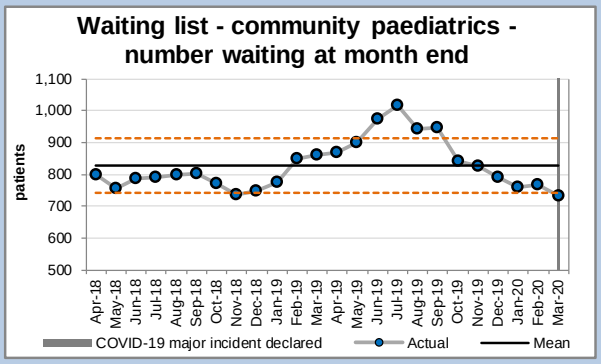


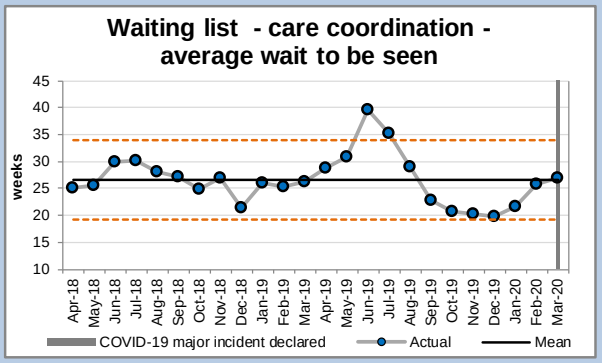
Operational indicators

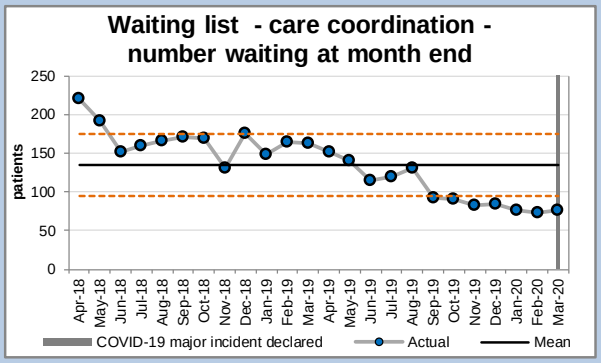


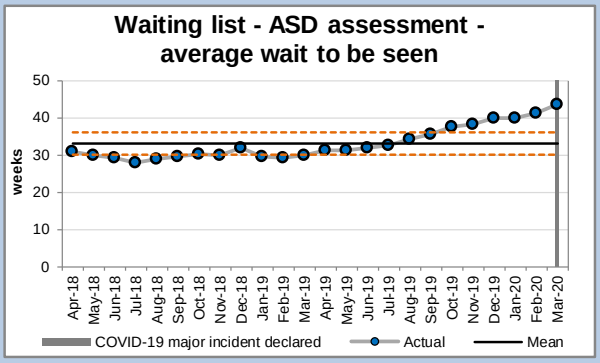


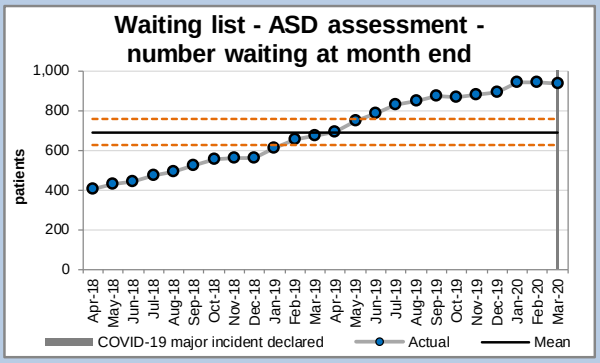


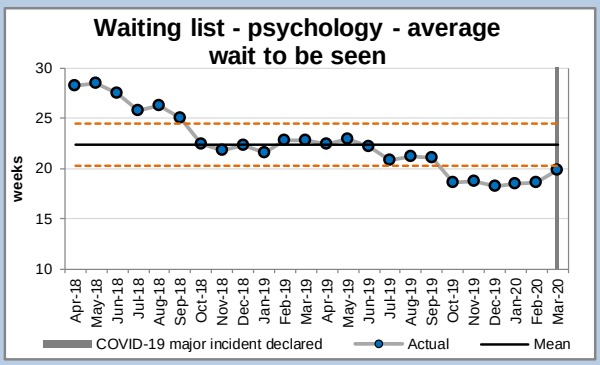


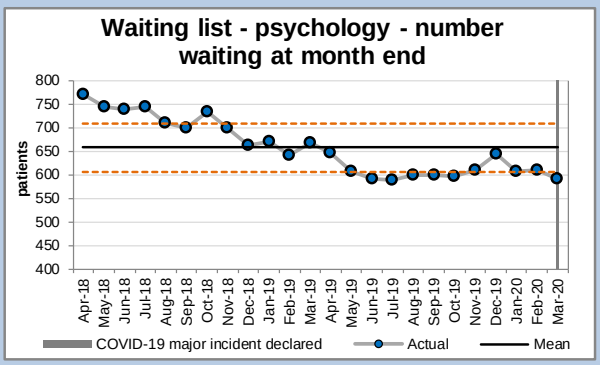




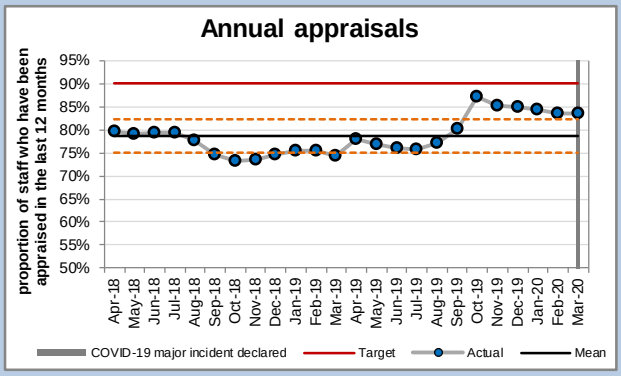


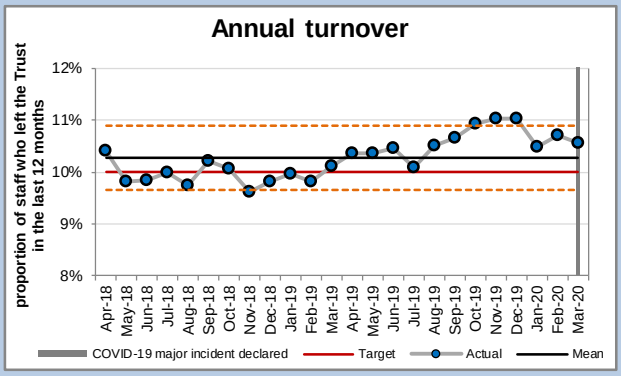


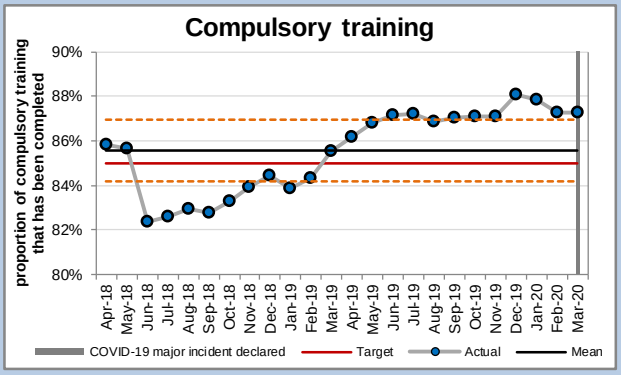


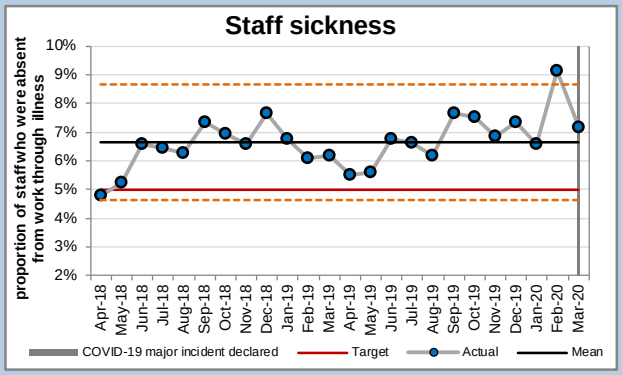


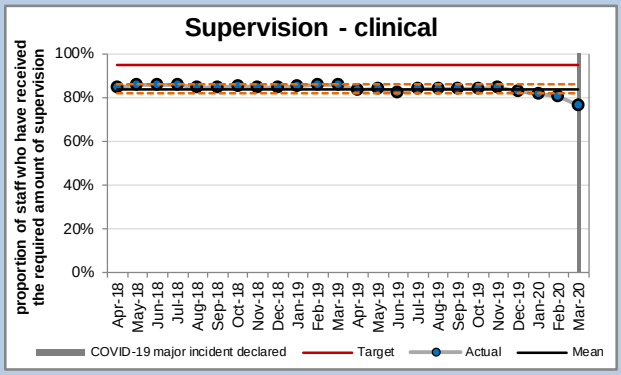
Workforce indicators

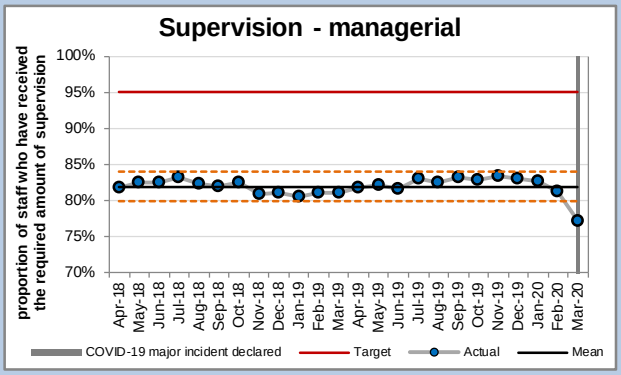


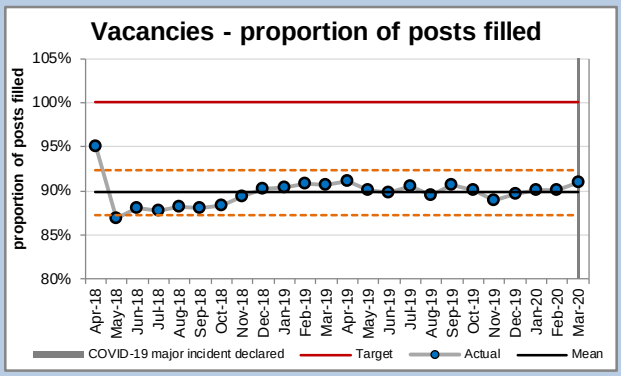


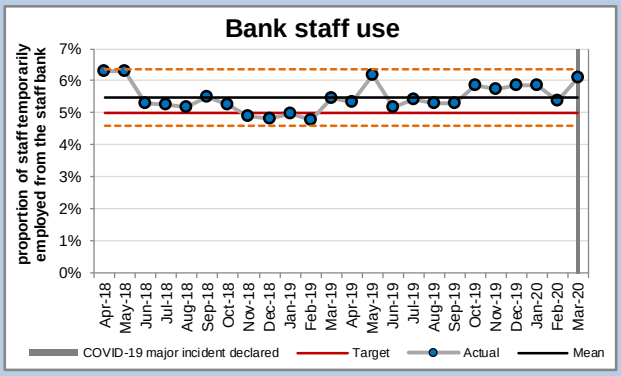












Appendix 3 – Data Quality Kite Mark

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 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.

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 5 May 2020

Year-end Governance Reporting - Board Committees

Purpose of Report

To present a summary of the year-end reports from Board Committees for noting.

Executive Summary

At its meeting on 30 April 2020, the Audit and Risk Committee (ARC) received the full year end reports for the following Committees as well as their Terms of Reference (TOR):

- Remuneration & Appointments Committee
- Finance & Performance Committee
- Audit & Risk Committee
- Quality Committee
- People & Culture Committee
- Mental Health Act Committee
- Safeguarding Committee

The Board Secretary and Executive Lead for each Committee have worked together to complete the end of year governance arrangements that are established good governance practice. There are several elements of work associated with each Board Committee that are required to be carried out at the end of each financial year, namely:

- Completion of a year-end review of effectiveness of the Committee – reporting against all elements of Committees' terms of reference (TOR)
- Review of the Committees' TOR
- Summary qualitative feedback from Committees
- Outline of objectives for 2020/21
- Development of a forward plan for 2020/21

ARC received assurance from the reports that the Committees have effectively carried out their role and responsibilities as defined by their ToR during 2019/20.

The Board Safeguarding Committee met for the final time on 15 October. Strategic oversight of safeguarding was brought into the Quality Committee and in line with the reporting regime the new Quality and Safeguarding Committee was formed from 1 February 2020 and ARC received the ToR for this combined Committee.

None of the Committees requested that any changes be made to their ToRs that were approved by the Board on 3 December 2019. All the Board Committees have developed a full future year's forward 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

Each Committee or Committee Chair has been assured through delivery of the Year-End Report that the Committees are working effectively and meeting the requirements of the Terms of Reference, as required per the Corporate Governance Framework.

Consultation

Through all of the Board Committees in March and April.

Governance or Legal Issues

Satisfactory governance performance underpins many aspects of statutory, regulatory and legal compliance for Foundation Trusts. The Audit & Risk Committee forms part of the Trust's Corporate Governance Framework as a Committee of the Board. The NHS Audit Committee Handbook advises that an Audit Committee, in line with best practice in other sectors, should prepare a report to the Board that sets out how the Committee has met its Terms of Reference. It is good governance practice to review effectiveness and provide assurance that Committees are fulfilling their purpose as defined by their TOR.

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:

There is no direct impact on those with protected characteristics arising from this report.

Recommendations

The Board of Directors is requested to consider and note the assurance received by the Audit and Risk Committee that all Board Committees have effectively carried out their role and responsibilities as defined by their ToR during 2019/20.

Report presented by: **Justine Fitzjohn**
Trust Secretary

Report prepared by: **Sue Turner**
Board Secretary

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
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
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
BAME	Black, Asian & Minority Ethnic group
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
CQI	Clinical Quality Indicator
CQUIN	Commissioning for Quality and Innovation
CRB	Criminal Records Bureau

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Term / Abbreviation	**Terms in Full**
CRG	Clinical Reference Group
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
EDS2	Equality Delivery System 2
EHIC	European Health Insurance Card
EHR	Electronic Health Record
EI	Early Intervention
EIA	Equality Impact Assessment
EIP	Early Intervention In Psychosis
ELT	Executive Leadership Team
EMDR	Eye Movement Desensitising & Reprocessing Therapy
EMR	Electronic Medical Record
EPR	Electronic Patient Record
ERIC	Estates Return Information Collection
ESR	Electronic Staff Record
EUPD	Emotionally Unstable Personality Disorder
EWTD	European Working Time Directive
F	
FBC	Full Business Case
FFT	Friends and Family Test
FOI	Freedom of Information
FSR	Full Service Record
FT	Foundation Trust
FTE	Full-time Equivalent
FTN	Foundation Trust Network
FTSU	Freedom to Speak Up

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Term / Abbreviation	**Terms in Full**
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
OOA	Outside of Area
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
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

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Term / Abbreviation	**Terms in Full**
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
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
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
OP	Out Patient
OSC	Overview and Scrutiny Committee
OT	Occupational therapy
P	
PAB	Programme Assurance Board
PAG	Programme Advisory Group
PALS	Patient Advice and Liaison Service
PAM	Payment Activity Matrix
PARC	Psychosis and the reduction of cannabis (and other drugs)
PARIS	This is an electronic patient record system
PbR	Payment by Results
PCC	Police & Crime Commissioner
PCN	Primary Care Networks
PDSA	Plan, Do, Study, Act
PHE	Public Health England
PICU	Psychiatric Intensive Care Unit
PID	Project Initiation Document
PiPoT	People in Positions of Trust
PLIC	Patient Level Information Costs
PMLD	Profound and Multiple Disability

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Term / Abbreviation	**Terms in Full**
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
R	
RAID	Rapid Assessment, Interface and Discharge
RCGP	Royal College of General Practitioners
RCI	Reference Cost Index
REGARDS	Race, Economic disadvantage, Gender, Age, Religion or belief, Disability and Sexual orientation
RTT	Referral to Treatment
S	
SAAF	Safeguarding Adults Assurance Framework
SBARD	Situation, Background, Assessment, Recommendation and Decision (SBARD) tool
SBS	Shared Business Services
SEND	Special Educational Needs and Disabilities
SI	Serious Incidents
SID	Senior Independent Director
SIRI	Serious Incident Requiring Investigation
SLA	Service Level Agreement
SLR	Service Line Reporting
SOC	Strategic Options Case
SOF	Single Operating Framework
SPOA	Single Point of Access
SPOE	Single Point of Entry
SPOR	Single Point of Referral
STEIS	Strategic Executive Information System
STF	Sustainability and Transformation Fund
STP	Sustainability and Transformation Partnership
SUI	Serious (Untoward) Incident
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	

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Term / Abbreviation	**Terms in Full**
VO	Vertical Observatory
W	
WDES	Workforce Disability Equality Standard
WRES	Workforce Race Equality Standard
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 Annual Plan - timing to be confirmed				X		
CS	Staff Survey Results (summary in July)		X				
CS	Equality Delivery System2 (EDS2) update						X
CS	Annual Gender Pay Gap Report for approval						X
CS	Workforce Race Equality Standard (WRES)			X			
CS	Workforce Disability Equality Standard (WDES)			X			
CS	Flu Campaign (summary of 2019/20 (May) progress update on 2020/21 (Nov))	19/20 Summary			20/21 update		
CS	Workforce 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)	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	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 Update (Nov)	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 &CS	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		X	X		X
JS	NHSE Return on Medical Appraisals sign off			X			
CG	Control of Infection Report			A			
JS	Re-validation of Doctors		A				
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			X			

Key:		
	Items deferred/cancelled to allow greater focus on the critical issues related to COVID-19	X