NHS
Derbyshire Healthcare
NHS Foundation Trust

PUBLIC BOARD MEETING
TUESDAY 1 NOVEMBER 2022 TO COMMENCE AT 09:30
This will be a virtual meeting conducted via MS Teams

	TIME	AGENDA	LED BY
1.	9:30	Chair's welcome, opening remarks and apologies, declarations of interest	Selina Ullah
2.	9:35	Patient Story	Tumi Banda
3.		Minutes of Board of Directors meeting held on 6 September 2022	Selina Ullah
4.		Matters arising – Actions Matrix	Selina Ullah
5.		Questions from members of the public	Selina Ullah
6.	10:00	Chair's update	Selina Ullah
7.	10:10	Chief Executive's update	Ifti Majid
STRATEGY, OPERATIONAL PERFORMANCE AND QUALITY ASSURANCE			
8.	10:25	Integrated Performance report	R Leyland / J Lowe / Tumi Banda / A Odunlade
9.	10:45	Neurodevelopmental Services – update in response to Panorama and Dispatches programmes	Ade Odunlade
11:00 B R E A K			
10.	11:15	Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) submission retrospective sign off	Jaki Lowe
11.	11:25	Equality Diversity and Inclusion (EDI) update	Jaki Lowe
12.	11:35	Guardian of Safe Working Report	Arun Chidambaram
13.	11:45	Learning From Deaths Mortality Report	Arun Chidambaram
14.	11:55	Receipt of Annual Reports: - Annual Looked After Children Report - Safeguarding Children and Adults at Risk Annual Report-	 Becki Priest Becki Priest
GOVERNANCE			
15.	12:05	Board Assurance Framework Issue 3 2022/23	Justine Fitzjohn
16.	12:15	Policy for Engagement between the Board of Directors and the Council of Governors	Selina Ullah/Justine Fitzjohn
17.	12:20	Board Committee assurance summaries of meetings held during September and October 2022	Committee Chairs
CLOSING MATTERS			
18.	12:30	- Identification of any issues arising from the meeting for inclusion or updating in the Board Assurance Framework - Meeting effectiveness	Selina Ullah
FOR INFORMATION			
Trust Sealings (six month update) Summary of Council of Governors meeting held 6 September 2022 Glossary of NHS Acronyms 2022/23 Forward Plan			

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

The next meeting will be held at 09.30 on 17 January 2023. It is anticipated that this meeting will be held digitally via MS Teams
Users of the Trust's services and other members of the public are welcome to attend the meetings of the Board.
Participation in meetings is at the Chair's discretion+

NHS
Derbyshire Healthcare
NHS Foundation Trust

Our vision

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

Our values

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

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

TEAM
Derbyshire Healthcare

Making a positive difference

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

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

Derbyshire Healthcare NHS Foundation Trust

MINUTES OF A VIRTUAL MEETING OF THE BOARD OF DIRECTORS TUESDAY 6 SEPTEMBER 2022

VIRTUAL MEETING VIA MS TEAMS

Commenced: 09.30 . Closed: 12:55

PRESENT	Selina Ullah	Trust Chair
	Dr Sheila Newport	Non-Executive Director and Deputy Trust Chair
	Ralph Knibbs	Senior Independent Director
	Deborah Good	Non-Executive Director
	Ashiedu Joel	Non-Executive Director
	Geoff Lewins	Non-Executive Director
	Ifti Majid	Chief Executive
	Carolyn Green	Deputy Chief Executive and Chief Nurse
	Claire Wright	Executive Director of Finance
	Ade Odunlade	Chief Operating Officer
	Dr John Sykes	Medical Director
	Jaki Lowe	Director of People and Inclusion
	Vikki Ashton Taylor	Director of Strategy, Partnerships and Transformation
	Becki Priest	Interim Director of Quality and Allied Health Professionals
IN ATTENDANCE	Rachel Leyland	Deputy Director of Finance
	Lynn Andrews	Non-Executive Director Designate
	Anna Shaw	Deputy Director of Communications and Engagement
	Jas Khatkar	NExT Director
	Sue Turner	Board Secretary
	Dr Arun Chidambaram	Incoming Medical Director
	Rosie Roosevelt	Head of Nursing for Acute and Assessment Services
	Kyri Gregoriou	Deputy Director of Nursing and Quality Governance
For DHCFT2022/072	Michael	Service user
For DHCFT2022/085	Kel Sims	Risk and Assurance Manager
For DHCFT2022/086	Tam Howard	Freedom To Speak Up Guardian
APOLOGIES	Justine Fitzjohn	Trust Secretary
OBSERVERS*	Andrew Beaumont	Public Governor, Erewash
	Susan Ryan	Public Governor, Amber Valley
	Denise Baxendale	Membership and Involvement Manager
	Ian Strange	Technical Analyst
	Pete Henson	Head of Performance (Operational Services)
	Janet Dean	360 Assurance
	Joanne Foster	Staff Governor, Nursing
	Jan Nicolson	Staff Governor, Allied Professions
	Nicola Spriggs	Deputy Performance Manager

The Board meetings are broadcast via a MS Teams Live event. The names of some observers might not be identifiable from email addresses and may not be recorded as attendees

DHCFT 2022/072	**CHAIR'S WELCOME, OPENING REMARKS, APOLOGIES FOR ABSENCE AND DECLARATION OF INTERESTS** Trust Chair, Selina Ullah opened the COVID-secure meeting which was held via Microsoft Teams and livestreamed to the public. No declarations of interest were raised with any of the agenda items. Apologies were noted as listed. Carolyn Green was welcomed in her new role as Deputy Chief Executive. Selina welcomed and introduced a number of new members. They included new Non-Executive Directors, Lynn Andrews and Tony Edwards and Becki Priest in her new role as Interim Director of Quality and Allied Health Professionals. Selina was also pleased that Dr Arun Chidambaram was able to join the meeting prior to taking up his post as Medical Director in October when Dr John Sykes retires. Additional attendees included Deputy Director of Finance, Rachel Leyland who shadowed Director of Finance, Claire Wright in readiness for her upcoming role as Acting Director of Finance when Claire retires at the end of October. Rosie Roosevelt, Head of Nursing for Acute and Assessment Services shadowed Carolyn Green.
DHCFT 2022/072	**PATIENT STORY** Deputy Director of Nursing and Quality Governance, Kyri Gregoriou introduced Michael who shared his experience of being detained under the Mental Health Act and the challenges he had to overcome through voluntary admission and his experiences of seclusion at the Radbourne Unit and acute services and out of area Psychiatric Intensive Care Unit (PICU) settings. Michael was first sectioned at the age of 21 and was taken to a PICU in Bradford because he was so unwell. He has since been sectioned six times and has also spent time at a PICU in Northampton. Michael described how he had been put in seclusion a number of times while he was being treated at the Radbourne Unit, mainly for being 'loud', not because he was aggressive. He never resisted being secluded and felt that staff did not understand how ill he was and he would have benefitted more from being talked to and understood. Michael articulated how clinicians' complicated use of language, medication and the impact that substance misuse has had on his on mental health. He has since learned to recognise early signs of needing support and raised some important issues for the Board to consider on how to improve services. He did not think it was a good idea for patients to use social media when they are unwell as he had posted some very inappropriate messages on social media while he was sectioned. Michael also shared his concern that many people remain ignorant of what it is like to experience mental ill health. He felt strongly that there should be more opportunities for people with lived experience to have a role on the wards as they really understand patients' needs. Medical Director, Dr John Sykes agreed with Michael's observation that there needs to be more engagement with patients and more choice offered to them outside of the normal ward rounds. He referred to the quality improvement work that it is taking place to reduce restrictive practices and improve the process of being admitted to hospital and the quality of information given to patients before they are admitted. Members of the Board were moved by Michael's story and they thanked him for being so open and honest. His experience gave the Board a better understanding of how traumatising it is to be placed miles from home to be treated and underlined the lack of PICU in Derbyshire. The value of his lived experience would be used to improve the experience of patients and he would be supported with his wish to progress to peer support work.

	RESOLVED: The Board of Directors noted Michael's story which would enable an improved package of care for people sectioned under the Mental Health Act.
DHCFT 2022/073	**MINUTES OF THE BOARD OF DIRECTORS MEETING HELD ON 5 JULY 2022** The minutes of the previous meeting held on 5 July 2022 were accepted as a correct record of the meeting.
DHCFT 2022/074	**ACTION MATRIX AND MATTERS ARISING** The Board reviewed and closed completed actions. No actions remain outstanding.
DHCFT 2022/075	**QUESTIONS FROM MEMBERS OF THE PUBLIC** No questions had been submitted for a response ahead of today's meeting. Any questions raised with the Trust's Governors by members of the public are taken to the Council of Governors meeting.
DHCFT 2022/076	**CHAIR'S UPDATE** Selina Ullah's report summarised her activity since the previous meeting held on 5 July and marked her first year as Trust Chair. Her recent visits to services included the Kedleston Unit, the Adult Physiotherapy Hub, High Peak Adult Community Mental Health Team, High Peak Older Adult Community Mental Health Team, North Dales Dementia Rapid Response Team and Intensive Home Support Team and Bolsover Community Mental Health Team. Selina shared how impressed she has been by colleagues' approach when visiting services and gave thanks for their ongoing support and commitment providing quality services under challenging circumstances, particularly during the recent heatwave. She also spent time with office staff working in the Patient Bank, Stores, Catering and Estates and saw how they are at the forefront of our services providing patients with what they need. Selina was delighted that after a two year break, Quality Visits to services were being reinstated and thanked Carolyn Green and Kyri Gregoriou for ensuring Executives and Non-Executive Directors (NEDs) can safely visit teams and services and maintain contact with staff and service users. Selina was pleased to report that the Board's two newest NEDs, Ralph Knibbs, Chair of People and Culture Committee and Tony Edwards, Chair of Finance and Performance Committee have both made an excellent start. Lynn Andrews has joined the Board as a designate NED for Quality and will have a period of handover before she takes over as Chair of the Quality and Safeguarding Committee when Sheila Newport retires later in the year. Several meetings of the Remuneration and Appointment Committee have been held over the summer to receive updates on changes in the Executive Leadership Team and agree the plans to ensure continuity and leadership stability. Having already introduced new Executive Director appointments, Selina drew attention to Board members who will be saying farewell in the coming months. Dr John Sykes is retiring from his role as Medical Director and Dr Arun Chidambaram will join the Board as Medical Director in October and will work closely with John before he retires. Claire Wright recently took the decision to step away from the Deputy CEO part of her role to concentrate on the Director of Finance role. The recommendation to appoint Carolyn Green as Deputy Chief Executive was agreed and enacted with immediate effect. Since then Claire has taken the decision to retire from her role as Director of Finance and will depart the organisation on 31 October. To ensure the Trust's Finance function continues to run smoothly Deputy Director of Finance, Rachel Leyland will be appointed as Interim Director of Finance from 1 November . Although it is sad to see Ifti,

	John and Claire leave Selina welcomes the opportunity to have new members joining the Board and colleagues developing. Since Ifti Majid announced he would be leaving the Trust to take up the appointment as CEO with Nottinghamshire Healthcare NHS Foundation Trust in December, the Trust is in the process of recruiting his successor through an inclusive process that follows its people first philosophy. The report also included detail of a number of meetings related to System collaboration and working and meetings with Regulators, NHS Providers and NHS Confederation. Of special note was a Board to Board meeting with University Hospitals Derby and Burton (UHDB) which provided the opportunity to discuss many areas of common interest, concerns and opportunities to work together in a more joined up way. **RESOLVED: The Board of Directors noted the content of the Chair's update.**
DHCFT 2022/077	**<u>CHIEF EXECUTIVE'S REPORT</u>** Ifti Majid's CEO report provided the Board with an update on local and national developments within the national and local Derbyshire health and social care sector over the last two months. **National context** The Board has previously discussed that too many people with LD or Autism receive care and treatment in the wrong place. Ifti reported that through an amalgamation of the Trust's own governance and reporting mechanisms and those within the Joined Up Care Derbyshire Delivery Board people in Derbyshire will now receive care from the Trust's own specialised Neurodevelopmental workforce. The plan is to retain some inpatient capacity to meet the needs of people with co-occurring, treatable, mental health conditions. There will also be some capacity for forensic inpatient care so that people with LD or Autism who come into contact with the criminal justice system, have a safe and appropriate alternative to prison. At the end of July the Department of Health and Social Care published several pieces of guidance in the context of the Health and Care Act 2022 and the establishment of statutory Integrated Care Systems (ICSs). This guidance on integrated care strategies focusses on the social care environment that is being tackled through the Health and Wellbeing Board that the Trust will have further input into towards the end of the year. **Regional context** On 11 July the first of a series of development sessions for all NEDs across the Derbyshire system was held. This first session focussed on the establishment of NHS Derby and Derbyshire as the Integrated Care Body (ICB) its emerging interaction with the Integrated Care Partnership and the roles of the Provider Collaborative at Scale and at Place will ensure all NEDs are equally sighted on system developments. **Within the Trust** Ifti shared his excitement for the future, with regional and national recognition of the Trust's achievements, including being a finalist in the HSJ Trust of the Year Awards. On a sadder note, he reflected on the two moving memorial ceremonies that have taken place recently in our Memorial Garden at Kingsway Hospital in memory of our colleagues Prince Ncube, Patience Govera, Peter Sloan and Mark Wright. The Board shared their sincere thanks and best wishes with long-serving Medical Director, Dr John Sykes for his forthcoming retirement and reflected on John's person-centred and compassionate approach and his hard work in contributing to the Trust being the success it now is. John has been the Trust's Medical Director since it formed in 2001 and will continue to work in the Trust as a Consultant Psychiatrist in North Derbyshire.

	Dr Arun Chidambaram has been appointed as the Trust's new Medical Director and will take up his post on Monday, 3 October 2022. Ifti thanked colleagues for their ongoing response to the COVID-19 pandemic. Rates across the wards remain low and preparations are in place for the next offer of vaccinations to protect people this winter from both COVID-19 and flu. Ifti was pleased to get out and about to visit services. One of the things he picked up on how worried colleagues were about the cost of living, mileage reimbursement rates, the operational structure changes and proposed increased alignment with Place, the standard of some of our estate. Ifti assured the Board that these competing demands are all being focussed on openly with colleagues during this time of change. **RESOLVED: The Board of Directors:** **1) Scrutinised the report, noting the risks and actions being taken** **2) Sought assurance around key issues raised** **3) Signed off the Trust Strategy.**
DHCFT 2022/078	**<u>PERFORMANCE AND ACTIVITY REPORT</u>** The Board was updated on key finance, performance and workforce measures at the end of July 2022. **Operations** Chief Operating Officer, Ade Odunlade outlined the high demand for Trust services and his commitment to improve waiting times. Whilst the Trust is meeting national standards there is a continued desire to do more including reducing out of area placements through the development of a Derbyshire PICU. It is anticipated that services will see an increased demand as the cost of living crisis progresses. **Finance** Deputy Director of Finance, Rachel Leyland reported on the adverse variance to plan of £0.5m which relates to undelivered CIP (Cost Improvement Programme), agency expenditure, out of area placements and the containment of COVID-19 costs. Work continues with senior leaders across the organisation to identify further efficiencies to close this gap, with a focus on recurrent delivery. **People performance** Director of People and Inclusion, Jaki Lowe highlighted that People performance continues to focus on reducing staff absences with a continued focus on supporting colleagues with sickness absences. There is also a continued focus on increasing appraisal and supervision rates. Staff turnover showed an improvement during this period. The Trust has a stable workforce and is working closely with new starters to ensure they have a positive experience. Mandatory training continues to be a key focus and ongoing recovery position for the Trust. Overall, the 85% target level has been achieved for the last four months. **Quality** Deputy Chief Executive and Chief Nurse, Carolyn Green covered trends in quality performance. The early referral to treatment standard of 60% is at a national level and the Trust is focussing on improving this. Waiting lists are regularly reviewed and work continues to improve the waiting time for assessment and treatment for their psychosis. She referred to Michael's story which highlighted the importance of developing a Derbyshire PICU as having a local PICU would be critical in decreasing length of stay and improving access to acute mental healthcare. Non-Executive Director, Geoff Lewins as Chair of the Audit and Risk Committee referred to two risk areas relating agency costs and delays in CIP activity. Geoff wondered how the Trust was exposed to increased energy costs. Rachel Leyland assured Geoff that contracted agreements across the system were capped so there was no problem

	currently in terms of utilities. Rachel would work collaboratively with providers within the system to negotiate contracts and end dates. Geoff had observed missing data within the performance report that was as a result of the transition from Paris to SystmOne and asked when this would be resolved? Director of Strategy, Partnerships and Transformation, Vikki Ashton Taylor reported that good progress had been made with a revised monitoring process for addressing reporting issues. Of the 44 issues identified 19 have been resolved with the remainder on track for completion by the end of September Non-Executive Director, Ashiedu Joel wished to know how many staff absences were due to COVID-19 and how the Trust was supporting colleagues suffering from long COVID? She was advised that nine people were currently absent with long COVID and being supported in their return to work by the employee relations team. There are also a number of support networks and mechanisms that colleagues can access. Deputy Trust Chair, Sheila Newport asked about care planning and asked for a progress update on care plan reviews. Carolyn advised the Board that the Electronic Patient Record (EPR) Board had agreed a transition period for care plan reviews and the Heads of Nursing are continuing to ensure compliance is improved. Non-Executive Director, Tony Edwards was encouraged to hear how significant challenges were being addressed and asked if performance lead indicators could demonstrate that things are improving as intended? Ifti assured Tony that there were plans in place to improve performance reporting. This was being taken forward within the performance summits and the various metrics would in future not only define an issue but highlight intervention and outcomes. Selina referred to the Cost Improvement Programme (CIP) slippage and asked if the programme was on track for recovery? Rachel reported that the current forecast assumes CIP would be delivered in full. There is work ongoing to close the CIP gap and a paper will be received by the Executive Leadership Team setting out how this will be achieved. Selina also wanted to understand why restrictive practice had increased. Carolyn advised that Kyri Gregoriou and the Heads of Nursing were reviewing all incidents involving restraint and long term segregation in order to reduce restrictive practice. The acute service has had some extreme incidents involving certain individuals. This is taken forward though collateral skill mix to break up this cycle. Senior Independent Director, Ralph Knibbs asked if lessons were being learned from the transition from Paris to SystmOne so that improvements can be made when implementing future changes. Vikki outlined how an oversight board was overseeing the development and implementation of SystmOne post implementation to address issues to enable an understanding of the lessons learnt. She and Ade Odunlade were in the process of ensuring that all programmes benefit from the learning that has been covered through this transition and would capture learning for future use. Selina challenged the areas on the performance dashboard that have consistently failed to reach target. Ifti highlighted that performance data was not just targeted at process. The data concerns the impact that performance has on people's lives. The performance summits will carry forward the priorities for performance improvement as part of the culture of improvement delivery whilst trying to reduce the burden for staff. **RESOLVED: The Board of Directors received positive assurance with the action taken to address performance issues but received limited assurance from current performance across the areas presented.**

DHCFT 2022/079	**EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE CORE STANDARDS AND RATIFICATION OF EMERGENCY INCIDENT RESPONSE PLAN AND PROCEDURES** The Board received an overview of the Trust's Emergency Preparedness Resilience and Response (EPRR) portfolio and the outcome of the 2021/22 Core Standards Self-Assessment. Ade Odunlade reported that the Trust has continued to provide a level of incident response to COVID-19 over the last year to ensure the EPRR portfolio progresses. Learning taken during the response to COVID-19 has been incorporated within Core Standards and he was satisfied with the organisation's preparedness. The Board considered this an outstanding piece of work. Members of the Emergency Planning Team were credited for their exemplary performance in ensuring that the Trust continues to be fit for purpose with regard to emergency preparedness. The Board also received and approved the new EPRR Incident Response Plan that replaced the previous Emergency Incident Response Plan and Procedures that now includes aspects missing within the previous response plan, subject to minor amendments being approved by Trust Operational Oversight Leadership (TOOL) with major changes coming back to Trust Board. The Finance and Performance Committee would continue to have oversight of EPPR performance. **RESOLVED: The Board of Directors:** **1) Received the Core Standards self-assessment to be submitted to the Integrated Care Board and NHS England** **2) Received significant assurance from the ongoing work to improve and further enhance the Trust's compliance with the EPRR core standards** **3) Received the new EPRR Incident Response Plan for approval** **4) Agreed to minor amendments being approved by Trust Operational Oversight Leadership (TOOL) with major changes coming back to Trust Board** **5) Obtained assurance of ongoing work to improve and further enhance the Trust's EPRR Portfolio.**
DHCFT 2022/080	**WORKFORCE RACE EQUALITY STANDARD (WRES) AND WORKFORCE DISABILITY EQUALITY STANDARD (WDES) PRIOR TO SUBMISSION END OCTOBER 2022** The Board was updated on progress with the work on the 2021/22 Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) submissions. The Board discussed how the WRES and WDES plans have a new approach that builds on the previous processes created through a comprehensive engagement approach developed with networks, divisions and with Trust wide engagement. Ralph Knibbs as Chair of the People and Culture Committee supported the new approach that includes the wider inclusion agenda. He assured the Board that the Committee would monitor the overall plan and the activities. The Board considered the approach being taken to WRES and WDES to be one of the top priorities that is central to the Trust Strategy. Delegated authority was granted to the People and Culture Committee to review and sign off the WRES and WDES October submissions on 20 September 2022 for 31 October submission deadline. The Board will be presented with the WRES and WDES data submission on 1 November and will explore what it is telling us, share the priorities that have been identified and the full year plan.

	RESOLVED: The Board of Directors granted delegated authority to the People and Culture Committee on 20 September 2022 to approve the 2021/22 WRES and WDES Part 1 Plan.
DHCFT 2022/081	**2022/23 FLU CAMPAIGN** The Board received an overview of the organisation's approach to the Flu Campaign 2022/23 building from performance and experience in 2021/22 and previous years. The paper outlined the necessary steps to achieving the vaccination of frontline healthcare workers for Derbyshire Healthcare NHS Foundation Trust (DHCFT) to reach minimum expectations of 100% offered and 90% vaccinated. It was noted that opportunities will soon be available for colleagues and patients to receive flu vaccinations, providing vital protection for this winter. The Board discussed the expectation that all colleagues will take the opportunity to protect themselves against both COVID and the flu virus this autumn/winter, by receiving the vaccinations being made available to them and agreed that performance would be measured through TOOL and the People and Culture Committee. Significant assurance was obtained from the programme that will support the safety and wellbeing of patients and staff and thanks were made to Pharmacy, the Health Protection Unit, Communications team and DCHS who have been involved in the planning of this year's approach. **RESOLVED: The Board of Directors:** **1) Reviewed the approach to be taken and received significant assurance about the programme being undertaken by the Trust** **2) Agreed that this plan provides adequate protection the 'winter readiness' approach fits with DHCFT values and strategy** **3) Recognised that that costings for the campaign are unable to be determined at this time but include cost of bank staff, administration support, requirement for pharmacy support and transport / logistics** **4) Acknowledged the NHS England and Improvement (NHSEI) reporting requirements (100% offered, 85% vaccinated healthcare workers)** **5) Recognised the potential impact that concomitant administration may have on the programme.**
DHCFT 2022/082	**WORKFORCE PLAN FOR 2022/23** Jaki Lowe shared the Workforce Plan which outlines how the right workforce will be provided in the right place, delivering the right care for the population of Derbyshire. It also outlined how the objectives of the NHS Long Term Plan and People Plan would be delivered as well as enabling the delivery of the Making Room for Dignity Project and Living Well which is a crucial part of the self-assessment process for Workforce Standards which was discussed at Board in May this year. The plan brings together the Trust's plans for growth and activity. It also outlined how it would deliver the objectives of the NHS Long Term Plan (LTP) and the People Plan to ensure that these ambitious improvements can be achieved for the Trust's patients. Selina was interested to know more about the system architecture and where funding is coming from for the new posts. Jaki assured her that the system architecture has been established at system level within the Integrated Care Board (ICB) to address key challenges within the workforce. The Trust will be working together with the system to achieve its workforce plan. Carolyn saw the Workforce Plan as a great start at high level but would like to see the detail concerning future areas to grow the Trust's own preceptorships and outcome measures from the investment in a cohort of LD nurses and the impact of these new roles.

	Non-Executive Director, Debora Good was impressed by the comprehensive nature of the plan and found it helpful to see service level targets as it gave her an understanding of achievement so far and what the aims are going forward. Deborah was interested to know more about recruitment and agency costs and if there were any incentives being offered by other organisations and how incentives could make a difference. Jaki advised that a structured incentive scheme is being developed that could positively respond to competition and the pressure of staff moving from one NHS workforce to another. Claire Wright considered that the Workforce Plan should always align with financial planning and be owned throughout the organisation to support delivery of recruitment on the ground across the full range of roles and opportunities, both in our current establishments as well as recruitment to additional posts from new service development funding and investment standard funding as per the long term plan. In addition to those, the progress with workforce in support of the Making Room for Dignity programme was also welcomed. In support of Claire's comments Ifti thought the plan sat well within the Long Term Plan but perhaps not the Derbyshire Healthcare strategy. He proposed that the next iteration of the Workforce Plan sets out how it will support the delivery of the building blocks in the Trust Strategy. Having reviewed and discussed the Workforce Plan the Board acknowledged that significant assurance could be taken from the comprehensive development of the plan with limited assurance on its impact because this is the start of the plan and there will be significant multidisciplinary team work to deliver the plan as well as influence from national and regional supply. **RESOLVED: The Board of Directors** **1) Noted and supported the progress of the Workforce Plan** **2) Discussed further direction/comment on the delivery of the plan.**
DHCFT 2022/083	**<u>POSITION STATEMENT – IMPROVING SAFETY</u>** Dr John Sykes provided a deep dive into the Trust Strategy building block on improving safety, specifically looking at patient safety culture and systems. The report highlighted that the foundations of the National Patient Safety Strategy (2019) are based on a patient safety culture and patient safety systems and there is a clear link between these and what the Medical Director considered to be essential areas for development of safety standards in the Trust. Carolyn assured the Board that the findings of the report would be taken through the Quality and Safeguarding Committee by the new Medical Director, Dr Arun Chidambaram and Interim Director of Quality and Allied Health Professionals, Becki Priest to address the issues and gaps identified within the report. **RESOLVED: The Board of Directors:** **1) Confirmed their commitment to improved safety for staff and patients** **2) Noted that the Quality and Safeguarding Committee would review the gaps identified within the report.**
DHCFT 2022/084	**<u>DRAFT MENTAL HEALTH BILL</u>** The Board received an update on the draft Mental Health Act (MHA) Bill, intended to reduce the number of people detained under the Act by focusing on service developments, patient flow management and practice. The brief outlined the new statutory requirements which will require investment in infrastructure especially the MHA Office and clinical time including administrative support

	as the new Act will increase the number of tribunals and will create additional work of the MHA Office. The Board acknowledged that the Mental Health Act Committee is accountable for ensuring the Trust is compliant with the MHA and the Code of Practice and would ensure the Trust is prepared for these legislative changes. The Quality and Safeguarding Committee would be accountable for quality and safety issues concerned with culture, and practices. Workforce planning and training is to be monitored by the People and Culture Committee. It was noted that the Trust had been invited to become part of a pilot site programme related to the MHA amendments. The Board supported this action and accepted that this would be taken forward by the Mental Health Act Committee. **RESOLVED: The Board of Directors:** **1) Noted the content of this brief** **2) Agreed that the Mental Health Act Committee was accountable for the preparation required for changes to the Mental Health Act** **3) Supported the Trust's involvement in a pilot programme related to the amendments being made to the MHA.**
DHCFT 2022/085	**<u>BOARD ASSURANCE FRAMEWORK ISSUE 2, 2022/23</u>** Risk and Assurance Manager, Kel Sims joined the meeting and presented the Board with the third issue of the Board Assurance Framework (BAF) for 2022/23. The Board was pleased to note the closure of moderate rated risk 1c "*There is a risk that the Trust fails to maintain continuity of access to information to support effective patient care"* following updates from the Operational Leads and in consultation with the Chief Operating Officer. Risk 3b "*There is a risk that learning from the response to the COVID-19 outbreak, and transformation plans developed prior, does not lead to sustainable embedded transformation"* has also closed following review by the Finance and Performance Committee. The status of the actions to close the gaps in control of risk 3a "*There is a risk that the Trust fails to deliver its revenue and capital financial plans*" have worsened, two have reduced rag ratings (one from green to amber and one from amber to red). This was due to the escalation of the dormitories/Psychiatric Intensive Care Unit (PICU) risk. This extreme risk will be the subject of a deep dive within the Audit and Risk Committee. Ifti asked the Board to consider if risks relating to continuity and changes in Trust leadership should be included in the BAF. It was agreed that the Executive Directors would identify which strategic objectives would be impacted by the change in leadership and consider how this would be articulated in the BAF during the next round of updates to made to the BAF at the end of the month. **ACTION: Executive leads to consider how risks relating to continuity and changes to the Trust's leadership are to be reflected in the BAF with the Risk and Assurance Manager** **RESOLVED: The Board of Directors:** **1) Approved this first issue of the BAF for 2022/23 and received assurance the 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** **2) Agreed to continue to receive updates in line with the Board's forward plan.**
DHCFT 2022/086	**<u>FREEDOM TO SPEAK UP GUARDIAN REPORT</u>** Freedom to Speak Up Guardian, Tam Howard joined the meeting and presented her Freedom To Speak Up (FTSU) report to the Board which set out the number of cases

	and analysis of themes raised in the last six months from January to June 2022 at with the Trust and improvements made in response to the feedback received. As the NED responsible for FTSU, Geoff explained how he regularly meets with Tam and that part of his role is to ensure that she receives appropriate support from management. Tam also meets with Ifti on a regular basis which reiterates the importance of FTSU and Tam's consistent interaction with the Board. From Geoff's perspective the report gave a positive message and demonstrates the Trust's seriousness in this area. The increasing number of cases shows that people feel confident in speaking up especially with regard to cases of bullying and harassment. The key is to make sure that when cases are raised they are cleared quickly. It was evident from the report that FTSU is being treated with the right degree of seriousness and that actions taken to enhance visibility of FTSU will ensure FTSU culture is continuously improved. Tam referred to the publication of the updated universal Freedom to Speak Up Policy for the sector as an opportunity for the Trust to refresh the Freedom to Speak Up arrangements and was pleased to report that she was working on developing the FTSU strategy further with the Board through a Board Development session in the near future. Selina concluded that this was really clear report that showed activities in place for raising awareness of the FTSU agenda within the Trust. **RESOLVED: The Board of Directors** **1) Supported the current mechanisms and activities in place for raising awareness of the FTSU agenda** **2) Received significant assurance from the FTSU agenda within the Trust and the proposals made by the FTSUG to promote a culture of open and honest communication to support staff to speak up** **3) Supported the development of the FTSU strategy and the refresh of the FTSU policy as required by the National Guardian's Office.**
DHCFT 2022/089	**<u>BOARD COMMITTEE ASSURANCE SUMMARIES</u>** The Board Committee Assurance Summaries demonstrated the work of the committees since their last update to the Board. The Assurance Summaries were accepted and noted by the Board as a clear representation of the priorities that were discussed and will be taken forward in forthcoming meetings. The Committee Chairs highlighted the following: **Audit and Risk Committee:** Geoff reported on the good progress being made to ensure good quality data is maintained with the Trust. This was upheld by a cross cutting review of data quality by 360 Assurance, the Trust's internal auditor which provided substantial assurance that the Trust has adequate arrangements in place for data security and protection. **People and Culture Committee:** Ralph highlighted that despite the organisation being in recovery from the response to the COVID-19 pandemic, an improving picture was noted around performance. A number of deep dives were being undertaken by the Committee to understand the full scope of People Services. **Finance and Performance Committee:** Tony chaired his first meeting of the Committee since joining the Trust. He assured the Board that a number of issues discussed at today's meeting were being taken forward by the Committee **Quality and Safeguarding Committee:** Sheila reported that the Committee continues to monitor and develop the skill mix across the Trust to ensure safe services. The Committee continues to address compliance with mandatory training as this represents

	the majority of remaining outstanding CQC actions. If compliance levels are not resolved this will be escalated to the Board. **Mental Health Act Committee:** Ashiedu assured the Board of the preparations being made to ensure the Trust is prepared for the legislative changes within the new MHA and the Code of Practice No questions were raised with the Assurance Summaries. The Board was satisfied that it is within the Board Committees where much of the scrutiny and challenge takes place which is an important part of the Trust's governance requirements. **RESOLVED: The Board of Directors noted the Board Assurance Summaries.**
DHCFT 2022/090	**IDENTIFICATION OF ANY ISSUES ARISING FROM THE MEETING FOR INCLUSION OR UPDATING IN THE BOARD ASSURANCE FRAMEWORK (BAF)** Continuity and changes to the Trust's leadership are to be reflected in the BAF and will be taken forward by Executive Directors with the Risk and Assurance Manager.
DHCFT 2022/091	**2022/23 BOARD FORWARD PLAN** The 2022/23 forward plan outlining the programme for the remainder of the year was noted and will be reviewed further by all Board members for the financial year ahead.
DHCFT 2022/092	**MEETING EFFECTIVENESS** The Board agreed that the meeting had been successfully conducted as a live streamed meeting. New members of the Board felt that discussions held served as a useful part of their induction.
The next meeting to be held in public session will be held at 09.30 on 1 November 2022.	

				BOARD OF DIRECTORS (PUBLIC) ACTION MATRIX - NOVEMBER 2022			
Date	**Minute Ref**	**Item**	**Lead**	**Action**	**Completion Date**	**Current Position**	
6.9.2022	DHCFT 2022/085	Board Assurance Framework Issue 2, 2022/23	Executive Directors	Executive leads to consider how risks relating to continuity and changes to the Trust's leadership are to be reflected in the BAF with the Risk and Assurance Manager	1.11.2022	Actioned and reflected in updates'	Green

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

Derbyshire Healthcare NHS Foundation Trust
Report to the Public Board of Directors – 1 November 2022

Trust Chair's report to the Board of Directors

Purpose of Report

This report is intended to provide the Board with the Trust Chair's reflections on activity with and for the Trust since the previous Board meeting on 6 September 2022. The structure of this report reflects the role that I have as Trust Chair.

Our Trust and Staff

1. On 7, 12 and 13 September we undertook an exercise to involve as many of our staff colleagues as possible in thinking in about what we want to see in our future Chief Executive Officer (CEO) as we look to replace Ifti Majid. Over 200 colleagues from across the Trust joined online over five sessions including staff side colleagues, consultant colleagues, staff networks and our Non-Executive Directors and governors. Colleagues identified the key skills, experience and priorities they wanted in the new CEO. Other colleagues who were unable to attend, emailed me with their thoughts. The feedback was then collated and fed into the person specification and outline for the job. For a summary of what our colleagues valued and stated as key skills and attributes please see Appendix 1. The recruitment process for Trust CEO role went live on 7 October. The full details can be viewed via https://derbyshire-futures.com/ I am grateful to Jaki Lowe, Director of People and Inclusion for the assistance she has provided me in this process.

2. Ifti and I visited the Radbourne Unit on 20 September. Visiting services and speaking to colleagues, patients and carers gives an invaluable insight and provides a way of triangulating the reports we receive in committees and at Board. Ifti and I witnessed first-hand the prompt response by the ward staff when a patient unexpectedly became physically unwell. It was very reassuring to see the speed, calmness and compassionate professionalism of our staff colleagues.

   We also visited the Medical Annex where the training and education of junior doctors and nurses takes place. The passion and effort that goes into training and developing our future workforce is both inspiring and reassuring.

   Our newest Non-Executive Directors (NEDs) are also beginning to visit services as part of their induction.

3. On 13 September I attended the Memorial Wreath laying service in tribute to Her Majesty the Queen. It was a very moving event and it was important the tremendous legacy of the Queen and her unstinting service to the nation was marked by the Trust. This event was live streamed and as a result over 300 members of our colleagues were able to participate and pay their last respects.

Phil Toker (pictured), on behalf of the Trust's Armed Forces Network, laid a wreath at the tree of reflection and celebration.

4. I have also been attending as many of the team live engagement events being hosted via MS Teams. I attended the live engagement sessions held for the Adult Community Service and the All Staff Q&A with Executive Directors. These meetings are very useful to me in terms of understanding how staff are feeling and hearing first-hand about the challenges they are experiencing as well as how engaged they are with the Trust.

5. On 21 September I presented my first Annual Members Meeting (AMM). This meeting was held online via Microsoft Teams. The theme for our meeting this year was building the future after the challenges of living through a pandemic and the positives we have achieved during this time were highlighted. The AMM is an opportunity for us to share key developments and themes from the last 2021/22 financial year but is also an opportunity to look forwards. We heard about our new builds and how our service users and carers were and continue to be involved. We also heard about the Trust's 'Work your way' employment service. I would like to thank our colleagues, our governors and our leadership for all their efforts and commitment in providing safe and quality services in exceptional circumstances all the while also continuing with our ambitious transformation and development programmes.

   We also had an Art Competition with some breath taking entries from our patients and colleagues. Celia Brookes was the winner with her entry 'Jumping for Joy'. (pictured) We are looking at how to incorporate these pieces of artwork in our new builds.

6. On 5 October I had my introductory meeting with Arun Chidambaram, our new Medical Director who commenced his post on 3 October. I would like to welcome Arun to the Trust and I look forward to working with him on the Board.

7. The Trust is in the process of implementing its Quality Improvement Strategy. On 4 October I met with Joe Wileman, Head of Programme Delivery to better understand how the Board can support and champion this critical strategy and the Trust's quality improvement ambitions.

8. October was Freedom to Speak Up Month, and our Freedom to Speak Up Guardian Tamera Howard has been busy with a month long programme of events and communications to raise awareness of all the ways our colleagues can raise a concern and all that the Trust is doing to enable an open culture where staff feel safe. The theme for Speak Up Month was 'freedom to speak up for everyone'.

9. On 14 October we celebrated national Allied Health Professionals (AHPs) Day. There are 14 AHP professions which together make up the third largest workforce in the NHS. Within the Trust, our AHPs include Occupational Therapists, Physiotherapists, Speech and Language Therapists and Dietitians. AHPs are key part of providing holistic care to our patients and service users. Many of our Derbyshire Healthcare AHPs work closely with our social work colleagues and there are now nearly 50 social workers within the Trust. By adopting a holistic approach to healthcare, AHPs and social workers are able to help manage patients' care throughout the life course from birth to palliative care. Their focus is on prevention and improvement of health and wellbeing to maximise the potential for individuals to live full and active lives within their family circles, social networks, education/training and the workplace.

10. Finally, we said goodbye to Dr John Sykes, Medical Director who retires from the Trust after a long service to the Trust. Under his leadership there have been many developments and improvements in our services over the years. We thank him for his many years of sterling service to the Trust and we look forward to welcoming him back as a consultant in Older People's Services. The Trust and his patients will continue to benefit from his extensive experience and knowledge.

Council of Governors

11. I meet regularly with the Lead Governor and Deputy Lead Governor. These meetings are an important way of building the relationship and understanding of the working of the Board and the Council of Governors. On 26 September I met with Lead Governor, Susan Ryan to update and inform her of issues and developments in the Trust as well as hear from her about any key issues the governors may have had raised with her or the Deputy Lead Governor. I am grateful to our governors for all their work and for ensuring the needs of their constituents and all of the Derbyshire communities are at the forefront of our service planning and delivery.

12. I met with Ruth Grice and Denise Baxendale to discuss the agenda and work of the Governance Committee on 27 September. Ralph Knibbs, Non-Executive Director and Senior Independent Director attended on my behalf. The Governance Committee was held on 12 October. My thanks to Ralph for stepping in for me.

13. In preparation for our Well Led inspection we have established a governors working group to consider their development needs in relation to this. The group met on 27 September. This provided an opportunity for the newer governors to understand what 'Well Led' entails, examples of what we are doing and its relation to the CQC inspection.

14. On 21 October the Governors' Nominations and Remunerations Committee reviewed NED remuneration against the national framework. The Committee

also supported the re-appointment of Ashiedu Joel for a second term of office. Ashiedu's first term as NED comes to an end in January 2023. Both these items and the recommendations will be discussed and approved as determined by the Council of Governors later today. The process for the Chair/NED appraisal in 2022/23 was agreed which would be similar to last years. I was also able to provide assurance to the committee that the Fit and Proper Persons Test for Tony Edwards and Lynn Andrews (NEDs) had been conducted in accordance with the national guidance and had been met by both Tony and Lynn.

15. The next meeting of the Council of Governors will be on 1 November, following the Public Board meeting on that day. The next Governance Committee takes place in December.

Board of Directors

16. We have begun to have a mixed approach to meetings; meeting in person for our development sessions when we can but also virtually using MS Teams. This enables Board members to keep connected whilst working remotely. We have continued to hold our public board meetings virtually as we have found that we have had an increased attendance of members of public and our staff observing the Board meetings this way.

17. On 14 September the Board held an extraordinary confidential board meeting to receive plans regarding the recruitment process for our new CEO. An update was also received regarding the key priorities, experiences and attributes and competencies our staff said was important to them. At the request of the Board Ifti provided his insight and analysis of the environment and the challenges ahead for the Board to consider while determining priorities for the new CEO.

18. The Board had its first full day workshop as part of the Board Leadership for Inclusion Initiative (BLFII) on 14 September. This is part of a twelve month programme that the Board has embarked upon with the aim to focus on addressing inequalities in access, experience and outcomes for our patients and staff colleagues.

19. On 20 October the Remuneration and Appointments Committee met to receive an update on progress with the CEO and Director of Finance (DoF) appointments, interim leadership arrangements post 1 December, Executive Director appraisals and updates on national instructions and guidance regarding Very Senior Managers pay awards (VSM). The Committee also reviewed mandatory training for the Board and plans for future Board development. The Committee was assured that the necessary plans were in place and being actioned as agreed to ensure continuity, leadership stability and delivery of Trust priorities.

20. On 23 September and 4 October I met with the respective recruitment agencies for the recruitment of our new CEO and Director of Finance to finalise the briefs. Jaki Lowe, Director of People and Inclusion and I are continuing to meet regularly with the recruitment agencies to ensure this key recruitment is on track. The final interviews for the CEO will be held on 20 December.

21. A second Board session on Quality Improvement took place took place on 4 October, which focused on the Trust's programme of building quality

improvement capability. This is key aspect of the Trust's Quality Improvement Strategy and an important enabler in our quality improvement and sustainability drive.

22. I continue to meet with my NED colleagues on a quarterly basis to review their objectives, development needs and discuss their perspectives on how the board and trust is delivering Trust priorities. This Quarter I met with Deborah Good, Ashiedu Joel and Ralph Knibbs.

23. The onboarding of our new NED, Lynn Andrews is well underway, I met with her on 29 September. Lynn has begun to meet key individuals and visit services. Lynn has made an excellent start and she is making a strong contribution to the Trust and the Board.

System Collaboration and Working

24. The four Derbyshire Provider Chairs continue to meet monthly with John MacDonald, Chair of the Integrated Care Board (ICB) /Joined Up Care Derbyshire (JUCD). This provides an opportunity for the system leaders to discuss and agree approaches to system issues affecting patients.

25. I have continued to meet regularly with the Chairs of the East Midlands Alliance of Mental Health Trusts, which has been a very useful source of sharing best practise and peer advice.

Regulators, NHS Providers and NHS Confederation and others

26. I attended, the NHS Providers Board meeting on 5 October. It is an invaluable opportunity to understand the impact of what is a rapidly changing political environment. The key concerns of NHS leaders and the likely policy direction and priorities for the new Health Secretary was discussed.

27. I have attended regular briefings from NHS England for the Midlands region, which has been essential to understand the impact of ongoing pandemic pressures on services, other system pressures e.g. ambulance waits, elective recovery, workforce issues, out of area placements of complex patients and waiting times in mental health and autism services.

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

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

Assurances

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

Consultation

This report has not been to other groups or committees.

Governance or Legal Issues

Covered as part of the individual items.

Public Sector Equality Duty and Equality Impact Risk Analysis

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

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

This report reflects a wide range of activities across the Trust, and consideration relating to ensuring inclusion is embedded in operational work of the Trust. The specific services visited provide support to those with protected characteristics by the nature of their work. I have supported the work of the Trust in promoting an inclusive culture and an inclusive Board. I have also continued to develop my own awareness and understanding of the inclusion challenges faced by many of our staff.

With respect to our work with governors - we work actively to encourage a wide range of nominees to our governor elections, and strive that our Council of

Governors is representative of the communities they serve. We also provide support to any current or prospective governors to enable them to carry out their role to address any specific needs they may have. This includes providing transport for those who may not be able to access public transport due to physical needs, accommodating communication requirements and providing support workers at meetings.

Demonstrating inclusive leadership at Board level

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

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

Recommendations

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

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

Appendix 1

Key Messages from Staff engagement sessions for CEO recruitment

We held five engagement events in total, attended by nearly 200 colleagues. Thank you to everyone who took part; I was so pleased to see colleagues from a range of professional backgrounds in attendance, and colleagues who have special roles within the Trust – including governors, trade union representatives and staff network members.

At the sessions, we asked for feedback on the strengths and personal characteristics the new Chief Executive should bring, as well as priorities for the role. There were quick polls on Slido as well as opportunities for open conversation.

The feedback has been collated with some themes emerging quite consistently across all five sessions.

For example, in terms of the most important **strengths** of the Chief Executive, four of the most common themes were:

- Patient care
- Staff engagement
- Being a strategic thinker
- And being a good communicator.

In terms of **personal characteristics**, the four areas that were most regularly mentioned were:

- Integrity
- Being open and approachable
- Adhering to Trust values
- And having an engaging style.

When it came to the **priorities** for the role, three main priorities stood out:

- Patient care
- Staff engagement
- And system working;
- Several groups also identified the importance of stakeholder and partner relationships, and the importance of delivering on the Making Room for Dignity programme, to develop our new hospital facilities.

This valuable feedback has been used to shape the recruitment process. Our Communications have filmed a video featuring colleagues from different services, which captures many of these themes – so potential candidates know immediately what we are expecting.

The ‘strengths’ and ‘personal characteristics’ that colleagues came up with will be incorporated into the written person spec for the role, while the priorities will be included in the job description.

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 1 November 2022

Chief Executive's Report

Purpose of Report

This report provides the Board of Directors with feedback on changes within the national health and social care sector, as well as providing an update on developments occurring within our local Derbyshire health and social care community. The report should be used to support strategic discussion on the delivery of the Trust strategy. The Board should note that the report reflects a wider view of the Trust's operating environment and serves to horizon scan for risks that may affect the organisation. Risks identified are highlighted in the report and taken forward to assess their operational and strategic impact, and recorded on operational risk registers, or the Board Assurance Framework, as appropriate.

Personal Reflections

This is the last CEO Board report I will write and present for Derbyshire Healthcare and I thought I would take a moment to reflect on the last seven years.

I took up post at a point of intense scrutiny for the organisation. A time when the governance of the organisation and the quality of the services we were delivering were under question. There was a lot of negative media coverage and almost more importantly than all of that it felt like we had lost the following and confidence of colleagues in our organisation. My role was one of stabilisation, confidence building and delivering improvements in governance and quality.

In terms of the Executive Team and the Board, this challenge was the first of three 'rallying cries' I have observed and noted. The focus, commitment and sheer hard work demonstrated by the Executive Team and direct reports was astounding and I now reflect how the Non-Executive Directors, many new to their roles, developed quickly ensuring a single Board focus and avoiding the trap of falling into detail that can paralyse improvement. The speed with which we were able to turnaround licence requirements and inadequate core services was a testimony to the expertise and motivation of all involved.

As we came out of this period of rapid improvement, confidence in the organisation was growing, a belief that we needed to and should do things our way, linked to an emerging strategy that focussed on 'people first' (our second 'rallying cry') and by that, meaning our colleagues, as through that we improve outcomes for local residents. We took some difficult decisions as a Board, and I thank colleagues for their support and trust as we developed our People First approach. I was, and still am, a strong advocate of the work of West et al, but I don't think even I expected the culture shift, the sense of growing confidence in the Trust direction that this brought about. No doubt the fact that we entered a significant period of stability in both Executive and Non-Executive leadership helped significantly.

And then came the COVID pandemic (the third 'rallying cry') and I absolutely believe the way we were starting to operate and the culture we were developing was the single most important factor in getting the outcomes we did during the

pandemic. The trust that was growing between colleagues and the most senior leaders blossomed, meaning we were able to manage through the pandemic with comparatively lower levels of absence, simply outstanding infection prevention and control compliance throughout the Trust, and a huge amount of good will, flexibility and discretionary effort from each and every colleague. The biggest driver of the culture was our leadership style and approach, and I would like to pay personal tribute to our Executive Team who, whilst managing different ways of working, compassionately and capably led through the pandemic. I relied so heavily on their knowledge expertise and connections to always keep us operating proactively.

A word about our core leaders, assistant directors, general managers, area service managers and our clinical and professional leaders who also stepped into the pandemic challenge with such commitment, dealing with situations never been seen before and making and recommending decisions that daily impacted on peoples' lives. The sense of togetherness was palpable, and I know colleagues put the Trust, our patients and each other, ahead of their own needs on many occasions.

On reflection, the Board had to cope with working in a very different way, receiving assurance against a national escalation plan rather than our own strategy, no face to face activities and not being able to visit services. I think the fact that the Board was well established, with strong relationships, contributed to that being manageable. I know that myself and Executive colleagues felt supported and 'backed up' through our interactions as a Board.

Some of my most difficult moments as CEO happened during the pandemic, some of the early decisions to ask people to stay at home, the vaccination approach and, in particular, our two colleagues dying due to COVID. That said, some of my proudest moments also happened during the pandemic, the two staff surveys with some of the best scores in the country, the increasing number of awards colleagues are getting in the Trust, being shortlisted for Trust of the Year and, as I started to spend more time out and about again in our Trust, the level of innovation on show to improve outcomes for local people was amazing to see.

In terms of regrets, I will challenge myself continually about what more I/we could have done to keep colleagues safe during COVID, did I do enough to challenge growing health inequalities early enough? I am disappointed that I will not see the two new hospitals, the Psychiatric Intensive Care Unit (PICU) and Radbourne refurbishment built as CEO. This is going to be the biggest and most exciting change in mental health care for people of Derbyshire in 50 years and will deliver a step change in the experience people who are admitted to hospital will have.

There are far too many people to thank who have really helped me to operate successfully as the CEO in our Trust, however, a couple of quick mentions: Our Communications Team led by Anna Shaw. Over the years we have worked together Anna, Richard and the team have an unerring way of predicting my response to things, being able to phrase things as I would and above all stopping me from saying things or expressing things I shouldn't. My PA, Ali Tuckley, ably supported by colleagues in our Exec Admin Team for being willing to take on the challenge of managing my time and commitments, always getting me to the right place and ensuring priority was always given to colleagues from the Trust or patients who wanted to speak with me.

Looking forward, I am genuinely confident the Trust will continue to go from strength to strength. We have a great, predominantly new cadre of Non-Executives and experienced and highly capable Executive Directors supported by strong deputies and operational/clinical leaders and so the scene is set for the Trust to 'kick on' to become that 'outstanding' Trust we have aspired to (thank goodness I managed to avoid needing to dance on the tables!!) that is one of the best places to work in the NHS.

National Context

1. The Board has previously been alerted to the COVID-19 Inquiry. The UK Covid-19 Inquiry held a preliminary hearing on 4 October to look at the scope and procedures for the forthcoming public hearing for module 1. Module 1 will investigate government planning and preparedness, including resourcing, risk management, pandemic readiness and lessons learned from previous pandemics, and simulations and modelling. In her opening remarks, the Inquiry Chair, Baroness Hallett, acknowledged that the pandemic has had an immense impact on the NHS and today's care.

   There will be at least one further preliminary hearing for module 1 early in the new year. The public hearing which will formally hear evidence, including from witnesses under oath, has been provisionally scheduled for four weeks in May.

   Module 2 will cover core political decision making and module 3 will cover the health care system. Details about additional modules will be announced in the coming months, one of which is likely to be system issues (such as the care sector, the vaccination programme, test and trace, and PPE) and impact issues (such as health inequalities, children and young people, public services and other public sector bodies).

   The Board will be aware that as an organisation we may need to submit evidence under 'Rule 9' though it is expected that any NHS provider evidence call will be handled through NHS England.

2. The new Operating Model for the NHS was released on 12 October. This is an important document for Board to be aware of as it starts to define the relationships and expectations of NHS Provider Organisations, Integrated Care Boards (ICBs) and the Regional and National NHS Team. The Board should note that this model has been developed in consultation with providers and systems, with the purpose of supporting devolving as much responsibility and accountability away from the centre, as possible.

   In its approach to system working, NHSE has committed to the following:

   - Proportionate and streamlined approach to oversight and performance management between ICBs and NHS England, using the System Oversight Framework (SOF), to avoid duplication and reduce unnecessary bureaucracy.
   - Devolved approach, whereby the primary relationship with NHS England for both ICBs and their partner NHS providers will be through the relevant regional team. The arrangements between regional teams, ICBs and providers will be set out in Memoranda of Understanding.

- ‘No surprises’ approach and mature, respectful and collegiate relationships between NHS England, ICBs and providers, underpinned by effective lines of communication
- ICB annual assessments that NHS England has a duty to complete, with the first one due to be completed in Q1 of 2023/24.

For our Board the document clarifies the expectations on providers:

- Retain their statutory responsibilities for the delivery of safe, effective, efficient, high-quality services
- Continue to comply with the provider licence, Care Quality Commission (CQC) standards and NHS planning guidance requirements
- Contribute to effective system working via integrated care system (ICS) strategies and plans
- Remain accountable to people, communities, services users, board of governors and ICS partners
- Be accountable to ICBs for ‘business as usual’ delivery of services and performance, and for their agreed contribution to the system strategy and plan
- Be accountable to NHSE as regulator by escalation/exception or agreement with ICB
- Deliver some of these accountabilities and responsibilities with the support of provider collaboratives

This is something we should spend some time discussing in Board Development sessions, as well as being involved in conversations through system meetings particularly, to manage risk of duplication and assurance routes within an emerging system approach.

East Midlands Region and Derbyshire Context

3. The Joined Up Care Derbyshire System Delivery Board for Mental Health, Learning Disability and Autism continued to meet during September and October. As a partnership we were focussing on preparation for winter and best use of the winter monies to support discharge and alternatives to hospital admission. We also noted plans linked to the £2.37m of new money over three years to support the mental health urgent care pathway.

   The Delivery Board is adopting an approach known as Recovery Action Planning to ensure that all areas, where we are not performing to the required level, have a clear plan with improvement milestones. During October’s meeting, for example, we focussed on access to Children and Young People’s Eating Disorder services and our Perinatal Community services. We also spent time reviewing, then approving, the new Dementia Strategy for Derbyshire (Appendix 2) noting that dementia diagnosis rates are not where we would want them to be post COVID.

   The Delivery Board received an update on the Mental Health, Neurodiversity and Learning Disability Alliance Festival that took place on 23 September. Over 220 people attended the day, representing 77 different organisations. The key outputs of the day are currently being collated, to ensure they can be taken forwards in an integrated way across all organisations involved.

A short animation that discusses the cultural changes being promoted by the Alliance is available via the Derby & Derbyshire's All Age Mental Health, Neurodiversity and Learning Disability Alliance YouTube account. Appendix 1 attached is the newsletter following October's meeting for information.

4. The Provider Collaborative for Derbyshire continues to meet monthly. The Provider Collaborative Programme Director, Tamsin Hooton, is now in post and has conducted a light touch stocktake of the Collaborative's development in her first month in post, reflecting on what has been achieved so far within the collaborative, as well as setting out some suggested areas for development. This will support the Provider Collaborative Leadership Board in agreeing next steps including developing a more formal delivery programme.

   The Chairs and Chief Executives of the six NHS providers met for one of their regular quarterly meetings on 12 October and had a very productive discussion about the core purpose and priorities of our Joined Update Care Derbyshire (JUCD) Provider Collaborative. There was a consensus that the Collaborative should focus on a small number of priorities, concentrating on doing those things that only the six providers can achieve by working together. Through adopting this approach, it was agreed that we will build confidence in the collaborative and in our ability to achieve real change.

   Over the next few weeks we will be creating a short list of priorities to select two or more areas as our clinical priorities for collective delivery of change, and concentrating on achieving material and tangible progress on those areas. This will be in addition to the work that is already taking place within the System Delivery Boards and will be something which has the potential to add real value and bring benefits to patients and staff across our system. As part of this work to develop the content of the Collaborative's delivery plan we have also agreed to explore a particular area where we can deliver efficiencies through working together differently across corporate functions.

   The NHS Executive has recently agreed that the three main System Delivery Boards (which include the Mental Health, Autism and Learning Disability, Urgent, Emergency and Critical Care and Planned Care groups) will be hosted by and accountable to the Provider Collaborative. It has also been agreed to create a new Transformation Group for the system which will play a lead role in overseeing any transformation changes where the work spans more than one of the Delivery Boards, as well as providing senior leadership to develop the system transformation programme, transformation capability and resources for the ICS.

Within our Trust

5. Colleagues will be aware that this is the first Board Meeting without Claire Wright as our Director of Finance. Claire retired on 31 October 2022 and we now have Rachel Leyland as our interim Director of Finance. I am sure the Board would like to join me in formally thanking Claire for her massive contribution to our Trust, our System and to improving the lives of Derbyshire residents. Claire has spent much of her considerable career working in Derbyshire between Derby Hospitals and ourselves. Not only did

she lead us in consistently achieving our financial plan, she did so by leading with compassion and integrity, always with a focus on people's experiences of using our services. – thank you Claire.

6. 15 September 2022 was an important day for our Trust as a significant number of colleagues came together, both in our Memorial Garden and online, to commemorate the death of Her Majesty Queen Elizabeth. We spent some time in quiet personal reflection, listened to poetry and readings and Phil Toker laid a wreath on behalf of our Armed Forces Network and the whole Trust. My sincere thanks to all who were involved in attending and organising this event.

7. On 21 September we held our Annual Members meeting and again this year we held that virtually. As has become tradition, we showcased a service – the Trust's 'Work Your Way' Employment Service, as well as sharing more details about our Making Room for Dignity Programme. It was a great opportunity to spend a little time reflecting on last year, the challenges and achievements, and an opportunity to thank all colleagues in our Trust for their help and support in continuing to innovate and focus on delivering good timely care to local residents even in continually testing times. We also looked forward to the rest of this year and those things we expected to achieve, including completing our rollout of our new electronic record system and the sign off of our business cases and 'spades in the ground' on our ambitious Making Room for Dignity Programme. We also reviewed quality and innovation during the last year, as well as more broad performance and financial management.

   For me, the highlight of the event was the arts and crafts competition, and we had some simply stunning entries. The overall winner was '*Jumping For Joy'* by Celia Brookes pictured below.

8. Over the last month I have been fortunate to be able to accept a number of opportunities to speak at external events. I presented a session on inclusive leadership at Birmingham and Sandwell NHS Hospitals Trust annual leadership event, spoke at NHS England's Pharmacy Advisory Board

Meeting about practicalities that support colleagues to feel improvements in inclusive culture and I chaired a session of the NHS Confederation BME Leaders Network focussed on the Shattered Hopes Report (which I commissioned as Co-Chair of the Network). This report is a review of the experiences of over 100 BME NHS leaders at Band 9 or on VSM/Boards and disturbingly shows discrimination continues to be felt regardless of seniority in the NHS.

In addition, it was a privilege to be interviewed for the NHS Providers Podcast celebrating World Mental Health Day, in which I was asked about the challenges and opportunities facing our sector, as well as how we continue to tackle stigma.

9. On World Mental Health Day I was fortunate, along with Carolyn Green, to attend celebrations at Temple House in Derby – one of our Child and Adolescent Mental Health Services (CAMHS) bases organised in conjunction with young people from the CAMHS participation group. It was a sensational event where we had an opportunity to meet and hear what a whole range of partners do to support young people, increase understanding of the different components of our CAMHS service, and hear how new innovations such as our Day Service are going. There was a real buzz as everybody was working together to challenge stigma.

   Over 150 visitors attended the day and I understand from that, at least ten new collaborations have been planned to benefit young people. It was a real privilege to open the event with Derby's Youth Mayor, Omar Aslam, who was a really inspiring young person.

   My thanks everybody who worked so hard to make the event such a success.

10. In the last month we have seen a gradual increase in the number of colleagues away from work due to a COVID based absence. At the time of reporting, this stood at around 45, which is double where we were at the last Board meeting. Since the last Board, we have had a couple of spikes of positive patients in our in-patient facilities and, as I write the report, we are down to two positive patients. This oscillation is absolutely in line with what we expect to see as we head into winter months and prepare for an expected steady increase in both COVID and flu impacting on our patients and colleagues.

    We have continually reviewed our use of PPE, including face masks and, whilst remaining rigorously compliant with national guidelines, we have not as yet returned to universal face mask wearing, though we do encourage colleagues to make a personal choice if they wish to wear a face covering in non-clinical settings.

    Our fantastic vaccination hub at Kingsway is in full swing delivering COVID boosters and flu vaccinations to colleagues and patients and we continue to encourage all colleagues to make an appointment to receive their vaccinations.

11. Since the last Board Meeting I have been fortunate to visit the following teams:

    - Radbourne Unit
    - Medical Annex
    - Information Management and Technology Team
    - St Andrews House – Community Team
    - Temple House as part of the World Mental Health Day celebrations

    During the visits we were able to have conversations with many colleagues covering broad areas such as gaining a better understanding of the service, the challenges and importantly hearing about innovation and things colleagues were proud of. It was helpful to see first-hand what happens when somebody is brought to the Radbourne Unit under a section 136 by the police and I was particularly impressed with the calm professional way a medical emergency was handled by colleagues whilst we were on one of the wards. While it was clear current recruitment challenges added pressure for colleagues, there was also examples of colleagues working very hard to ensure patients were able to have meaningful occupation during the day, for example.

12. We have continued to hold regular all colleagues Q&A sessions during September and October, including in October our 'all staff farewell to Claire Wright'. We have continued to have high levels of attendance with between 150 and 200 colleagues joining both calls.

    Key points we discussed included:

    - An update about the living well programme
    - An update linked to making room for dignity programme
    - A lengthy and emotional discussion about the various Panorama/Dispatches exposes and what colleagues' responses were to that and how we can continue to evolve and develop our open cultures
    - Cost of living and the widening impact on colleagues and people who need our services
    - Car parking.

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

Risks and Assurances

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

Consultation

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

Governance or Legal Issues

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

Public Sector Equality Duty and Equality Impact Risk Analysis

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

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

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

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

The national COVID Inquiry is going to be a vital plank in our understanding of health inequalities, what has worked and not worked prior to COVID, as many of the issues we saw were not new - just not adequately addressed.

We must do more to reflect as an organisation on how we continue to develop an open culture to ensure colleagues and those who use are services are able to speak up when things are not right and, as importantly, that we take action to

address issues that are raised. This has to be a central plank of our response to having an inclusive culture.

Recommendations

The Board of Directors is requested to:

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

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

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

Your e-newsletter ***October 2022***

The Mental Health, Learning Disabilities and Autism Delivery Board brings together partner organisations working across health and social care in Derby and Derbyshire. The Board is responsible, on behalf of JUCD, for overseeing system wide delivery, performance improvement and transformation. The Board's aim is to collectively make improvements to outcomes for people with mental illness, learning disabilities and/or autism and to implement the requirements of the NHS Long Term Plan.

The Delivery Board met on 6 October 2022. This update shares key points of discussion from that meeting.

Planning for Winter

The Delivery Board were pleased to confirm that additional funding of £2.37m over a three-year period had been agreed to develop a non-clinical crisis house/café or safe haven in Chesterfield.

This has been a gap in collective service provision for some time and the Delivery Board will be looking to go to competitive tender shortly to identify a preferred delivery partners to develop this integrated offer.

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Performance of local mental health providers

Performance across local mental health providers is meeting (or exceeding) national targets in most areas. The number of people with a learning disability who are receiving annual health check is above the national average.

The Delivery Board have previously identified the need for Recovery Action Plans to focus on under-performance relating to time taken to access children and young people's eating disorder and perinatal services. This will continue to be monitored by the Delivery Board.

Rates of dementia diagnosis continue to be slightly lower than target. This is being proactively addressed through the development of a new Dementia Strategy – see below for more details.

It was agreed that a Recovery Action Plan is required for Learning Disabilities and Autism inpatient performance as we continue to struggle to meet this target for our population. This Recovery Action Plan will be considered at the next Delivery Board.

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A new Dementia Strategy for Derbyshire

The Dementia Strategy has been revised in order to address additional challenges that have emerged during the COVID-19 pandemic, including people who have missed being diagnosed over the last two years and a potential increase in prevalence of dementia.

A number of priority actions have been agreed for 2022-25, in line with NHS England and Improvement dementia priorities and the NHS Long Term Plan. These aim to:

- Recover services to previous levels and embed learning and blended approaches
- Mitigate the impact of the last two years and prioritise people missed or lost to services and prioritise carers
- Initiate work planned in response to the demand created in the wake of the pandemic.

The Derby and Derbyshire Emotional Health and Wellbeing website helps people identify signs of dementia and signposts to appropriate support: https://derbyandderbyshireemotionalhealthandwellbeing.uk/

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Planning for Winter

The Delivery Board received an update on the Mental Health, Neurodiversity and Learning Disability Alliance Festival that took place on 23 September. Over 220 people attended the day, representing 77 different organisations.

The key outputs of the day are currently being collated, to ensure they can be taken forwards in an integrated way across all organisations involved.

A short animation that discusses the cultural changes being promoted by the Alliance is available via the Derby & Derbyshire's All Age Mental Health, Neurodiversity and Learning Disability Alliance YouTube account.

Thank you to everyone who took part!

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If you have any questions or comments on this bulletin, please email **dhcft.communications@nhs.net**

NHS | DERBYSHIRE County Council | Derby City Council | The Derbyshire VCSE sector Alliance

Derbyshire Dementia & Delirium Pathway Strategic refresh 2022-25

The impact of the Covid-19 pandemic on the population of people living with dementia and their carers in Derbyshire requires a revision of the Derbyshire Dementia Strategy originally planned to run from 2020-25.

The partnership of organisations that deliver services for the dementia pathway want to ensure all services are **Recovered** as quickly as possible with learning and positive developments consolidated and embedded, that problems caused by the pandemic are **Mitigated** actively and new work is **Initiated** swiftly to improve opportunities, wellbeing, and care and treatment for people living with dementia in Derbyshire.

Background

Dementia is a key priority for both NHS England and the Government. In 2015 the Prime Minister launched the Challenge on Dementia 2020, to build on the achievements of the previous Challenge on Dementia 2012-2015, which included the following key ambitions:

- Two thirds of people with dementia should have received a diagnosis
- Equal access to diagnosis for everyone
- GPs playing a lead role in ensuring coordination and continuity of care for people with dementia
- Every person diagnosed with dementia having meaningful care following their diagnosis

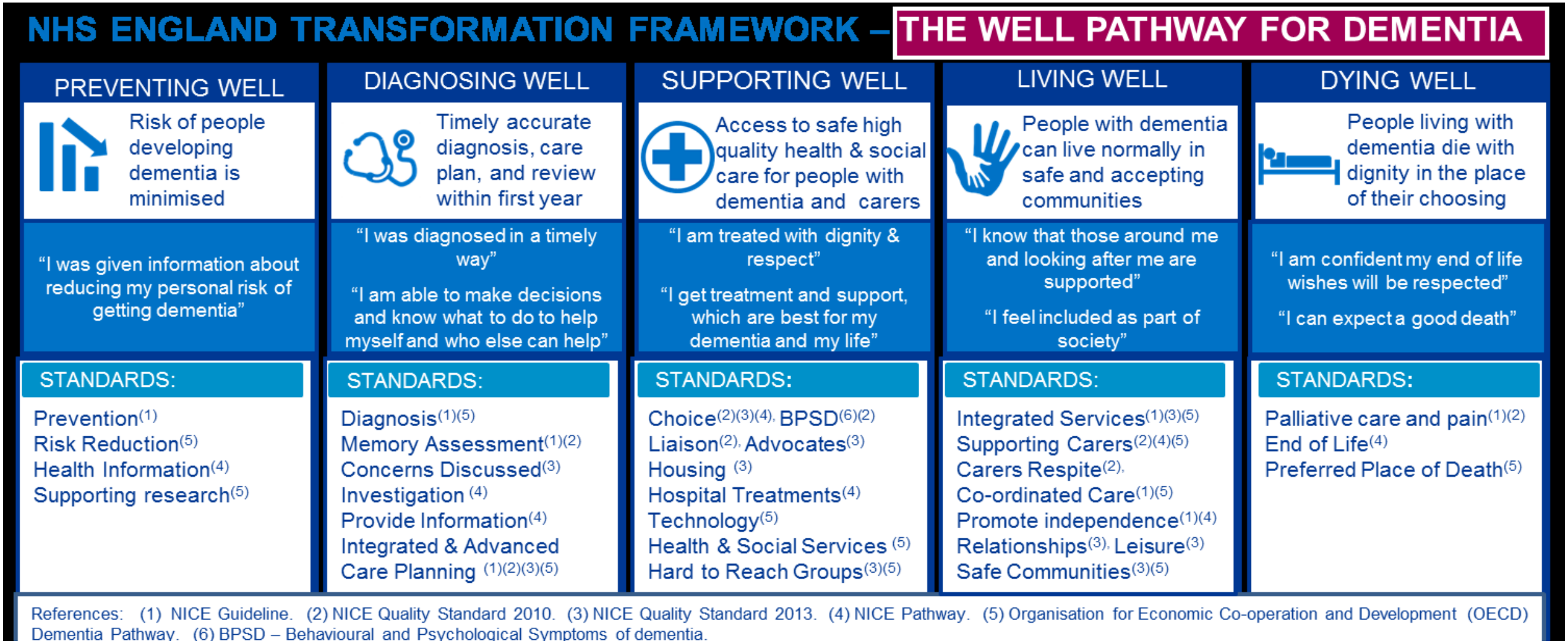
These themes continue in the NHS Long Term Plan and the Mental Health Delivery Plan 2021/22 with a focus on increasing diagnosis rates and ensuring that people have access to pre and post diagnostic support.

At the same time we know people are living longer, whilst this is good news, increasing longevity means that a significant proportion of people are living with a number of long term conditions, including dementia. This demands a health, care and voluntary sector response that integrates skills, knowledge and ways of working to deliver the best chance individuals with dementia have to live well.

Dementia is the leading cause of death in the UK with 850,000 people living with dementia today. The condition costs £26bn from the UK economy each year and a quarter of all hospital beds are occupied by someone with dementia over the age of 65.

It is estimated that there are approximately 17,000 people living with dementia in Derby and Derbyshire and this will rise to 23,000 by 2030.

Services and support for people living with Dementia and their carers in Derbyshire follow the NHS England framework of the Well Pathway for Dementia



Aims of strategy revision

- **Recover** all services to previous levels and embed learning and blended approaches
- **Mitigate** impact of last two years and prioritise people missed or lost to service, and prioritise carers
- **Initiate** work planned in 20-25 strategy and in response to demand created in the wake of the pandemic

Pandemic Impact

- Drop in numbers diagnosed with dementia
- Reduced referrals to **M**emory **A**ssessment **S**ervice (MAS)
- Reduced & altered Living Well pathway services
- Reduced & altered Supporting Well pathway services
- Changes to the way the cohort of older people engage with, or can access services
- Carer burden significantly increased
- Reduced home care availability
- Care home negative outcomes & reduced places
- Mortality rate of People living with dementia initially
- Increase in use of Antipsychotic medication
- Physical and cognitive risk factors for dementia in population increased
- Workforce issues

Consequences

- Missed Cohort
  - Loss of opportunity for diagnosis
  - Loss of opportunity for early information & support
  - Time to requirement for care reduced
  - Impact on non-specialist parts of system
- Acceleration of condition
- Steep worsening of Neuropsychiatric symptoms
  - Acuity
  - Increased episodes of crisis
- Carers
  - Significant burn out
  - Significant adverse impact on mental health
- Lost opportunities of 20-25 Strategy
  - Improving accessibility for diverse and minority communities
  - Brain Health & Risk reduction messaging
  - Improving access & bespoke services for people with young onset dementia

Pandemic Impact – some positive

- Accelerated employment of virtual technology to support health, care and voluntary sector intervention
- Improved collaboration between pathways and between sector providers
- Development and deployment of critical services at speed
- Development of e-resources
- Opening of new pathways for people living with dementia & carers

Dementia Pathway Partner Actions to Date

- MAS has been transforming to increase capacity and offers blended service
- MAS work to reduce Did Not Attend
- Additional MAS waiting list support – pre-diagnosis
- Multiple approaches in development to improve rate of referral
- All services in Recovery & offering blended service
- Dementia Rapid Response Teams
- Dementia Palliative Care Team pilot
- Dementia Support Service (DSS) pilots
- Improving Access to Psychological Therapies (IAPT) dementia pathway
- Delirium rolling programme
    - http://surveys.derbyshcft.nhs.uk/s/ERGOX/
    - https://www.youtube.com/watch?v=Lfkr-0I50HY
- Improving access to information
    - https://derbyandderbyshireemotionalhealthandwellbeing.uk/adult/brain-health

Priorities 2022-2024 Recovery

Recover Dementia Risk Reduction planning

- Build on work commenced in sharing risk reduction messages eg https://derbyandderbyshireemotionalhealthandwellbeing.uk/adult/brain-health
- Further develop strategic goals on wider community knowledge and understanding of risk reduction messages
- Link risk reduction messaging to wider lifestyle messaging and accessible health education literature

Preventing well

Recover the Dementia Diagnosis Rate

- MAS transformation & blended offer to continue
  - Support those waiting – monitor new resource impact
  - Reduce waiting times to pre-pandemic timescales (October 22)
  - Build on strategies to reduce DNA & promote cohort confidence
  - Continue to ensure Dementia Support Services (DSS) are hooked in at point of diagnosis
  - Build on current MAS 24 (care home diagnosis)
  - Ensure diagnoses made in all specialist services are effectively coded, communicated & supported
  - Monitor demand in relation to capacity

Diagnosing well

Recover the Dementia Diagnosis Rate

- Recover referral rates
  - Review referral gateway
  - Review Acute care referral pathway to ‘capture’ missed cohort members & reduce pressure on acute beds
  - Pilot DSS into Place – focus on identifying and supporting people in Primary Care
  - Develop a unified approach to messaging, for example Brain Health on the pathway - https://derbyandderbyshireemotionalhealthandwellbeing.uk/adult
  - Review how the new Derbyshire Dementia Support Website & other web access points could communicate directly with the public to prompt self or carer identification
  - Work with system partners to communicate the benefits of memory assessment & diagnosis to the population

Diagnosing well

Recover Supporting Well Services

- Continue Recovery in Specialist teams and services
  - Blended offer
  - Build on opportunities created
- Continue Dementia Palliative Care pilot development
- Recover specialist support to Care Homes

Supporting well

Recover Living Well Services

- Continue post diagnostic specialist education group blended delivery
  - Recover Cognitive Stimulation offer, continue to work needs led
- Continue Recovery in post diagnostic Live Well pathway services
  - Improve referral rates to DSS
  - DSS continue recovery of group offers & blended delivery
  - Build in operationalisation of new dementia support service resource in Place Alliance/Primary Care (April 22)
  - Establish links with any additional Place Alliance or Primary Care Network resources for dementia
- Implement actions from initial minority group work & move this work on
  - Include review of how service for younger adults is provided, accessed & individualised
  - Action recommendations from National report on ethnic minorities access to services
- Recover non-pharmacological approaches education across services
- Re-focus the assistive technology offer and accessibility within the pathway

Living well

Priorities 2022-2024
Mitigate

- Mitigate Acuity across the system
  - Monitor increased demand in primary care and approaches to support
  - Dementia Palliative Care Team roll out to continue
  - Investigate the impact of acuity on highly complex, high need cohort
  - Investigate the impact of acuity on non-specialist health & care, and ways to truly integrate care and treatment
  - Develop plans in partnership with care homes and improve competence and confidence as dementia care partners
  - Accelerate Integration with other pathways, prioritise Frailty, Primary Care & Care Homes
  - Review how specialist day services can shape offer to reach more people stranded by the pandemic

- Mitigate increased use of Antipsychotic medication
  - Implement recommendations in Derbyshire report on *Use of Anti-psychotic medication*
  - Further improve collaborative working with key health partners

Cross Pathway Actions

- Mitigate adverse health and wellbeing impact on carers*
  - Undertake engagement to identify improved supportive offers
  - Prioritise education & support programmes
  - Seek co-production in support offers
  - Continue to embed the IAPT dementia pathway offer for people newly diagnosed and carers
  - Prioritise carers and explore ways to extend the offer of education, information and support

*Carers have borne the burden of pathway services move to respond to urgent care, this has been at the cost of carers' own health and wellbeing and has created a gap in the knowledge, education and support of carers which has been compounded by the acceleration of the dementia condition in people they care for. If mitigating actions don't address this time to care will be further reduced for both carer and persons with dementia.

Priorities 2022-2024 Initiate

System Impact

- Across all areas of health & care activity there is an urgent need to develop, initiate and integrate approaches responding to people living with dementia –
  - 92% of whom have at least 1 co-morbid condition
  - 17% have 6+
  - the average is 4

- Prevalence is increasing at a rate of 2% per year

Dementia can’t be managed in isolation, single condition silos are leading to poor outcomes for individuals' and system failure

System Approach

- Initiate work on integrated care & treatment protocol/s with a multiple disease approach
- Develop education and resources at all levels to improve knowledge, skills and understanding of dementia
- Work to ensure people living with dementia have care plans that are up to date and reflect totality of their need, their wants and advance wishes
- Create and investigate opportunities to integrate the work of teams responding to the health and care needs of people living with dementia

Initiatives underway or planned

- Initiate work on integrated treatment protocol/s with a multiple disease approach
- Initiate Support at Primary and Community level
  - Review and develop models of primary and community support (DSS & TeamUp)
  - Roll out Advanced Care Planning in Dementia training
- Develop and embed engagement approaches
  - Build on initial work undertaken during the past two years
  - Improve co-production of services and support with more engagement opportunities with PLWD and their carers
- Improve awareness and take up of services and support in hard to reach communities
  - Work with NHSE to review data and investigate variations in DDR
- Improve and focus the offer and uptake of assistive technology for people living with dementia to increase their independence
- Work with partners, particularly District and Borough Councils to develop new extra care accommodation options for people living with dementia
- Continue expansion of virtual offers of dementia education and support

Cross Pathway Actions

Risks

- Loss of community resilience
- Threat to voluntary sector offer & recovery
- Workforce
  - Health, wellbeing & resilience
  - Recruitment & retention
  - Skill set & education
- Further increases in prevalence
- Increased demand
- Reluctance of cohort to engage in traditional manner
- Continued reduction in rate of referral to MAS
- Further or apparent acceleration of reduced time to care

Key National Measures

Descriptor	National Target	Current position June 22	April 21 position	Baseline position April 2020	Target March 23
Dementia Diagnosis Rate	67%	63%*	65%	**69.2%**	67%
Care plan review	Not specified	49%	35.6%	71.9%	
% PLWD prescribed Antipsychotic medication	Not specified UK rate 10% Ap 20 currently 9.2%	9.3%	10.3%	10%	9%
Wait for MAS	6 weeks aspirational, 14 week National average pre-pandemic	21 weeks average (range 15 -24 weeks)	22 weeks Varies across County	16 weeks	16 weeks

*Represents 94% of National Standard

This Strategic Vision has been developed in partnership by:

NHS Derbyshire Healthcare NHS Foundation Trust

Alzheimer's Society United Against Dementia

NHS Derbyshire Community Health Services NHS Foundation Trust

healthwatch Derbyshire

Derbyshire Carers Association

Derby City Council

NHS Derby and Derbyshire Clinical Commissioning Group

Derby & Derbyshire ageUK

DERBYSHIRE County Council

NHS University Hospitals of Derby and Burton NHS Foundation Trust

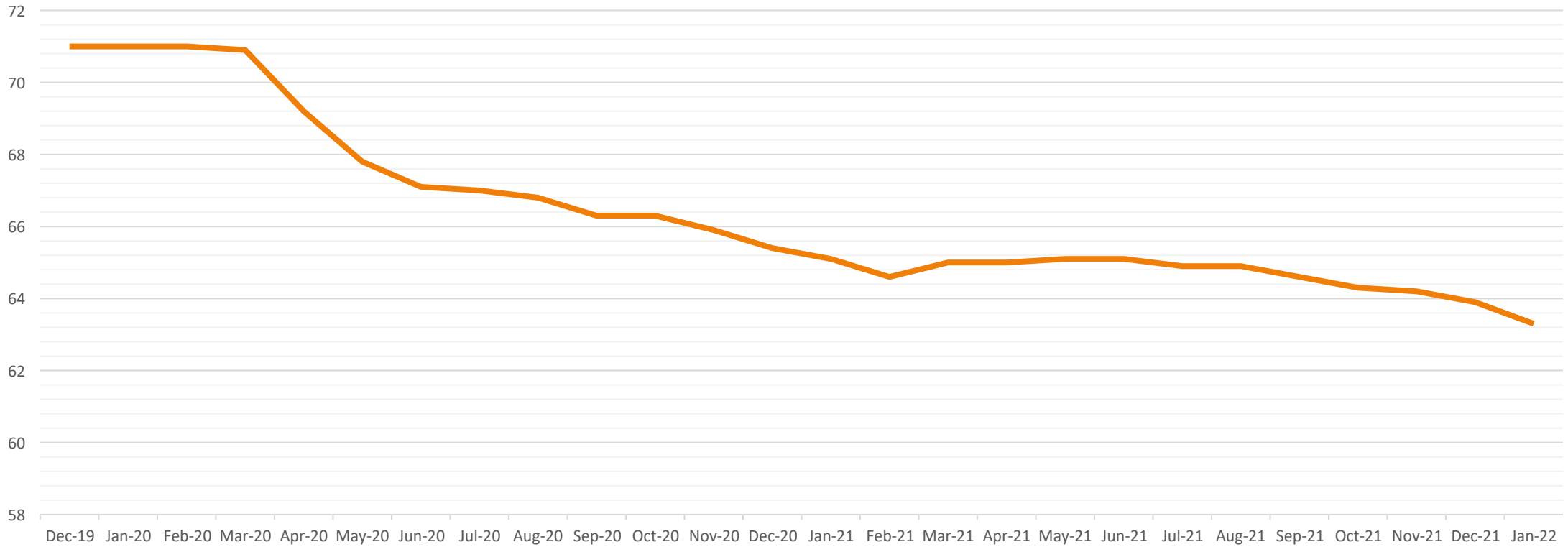
Ashgate Hospicecare Every Person Matters

MakingSpace

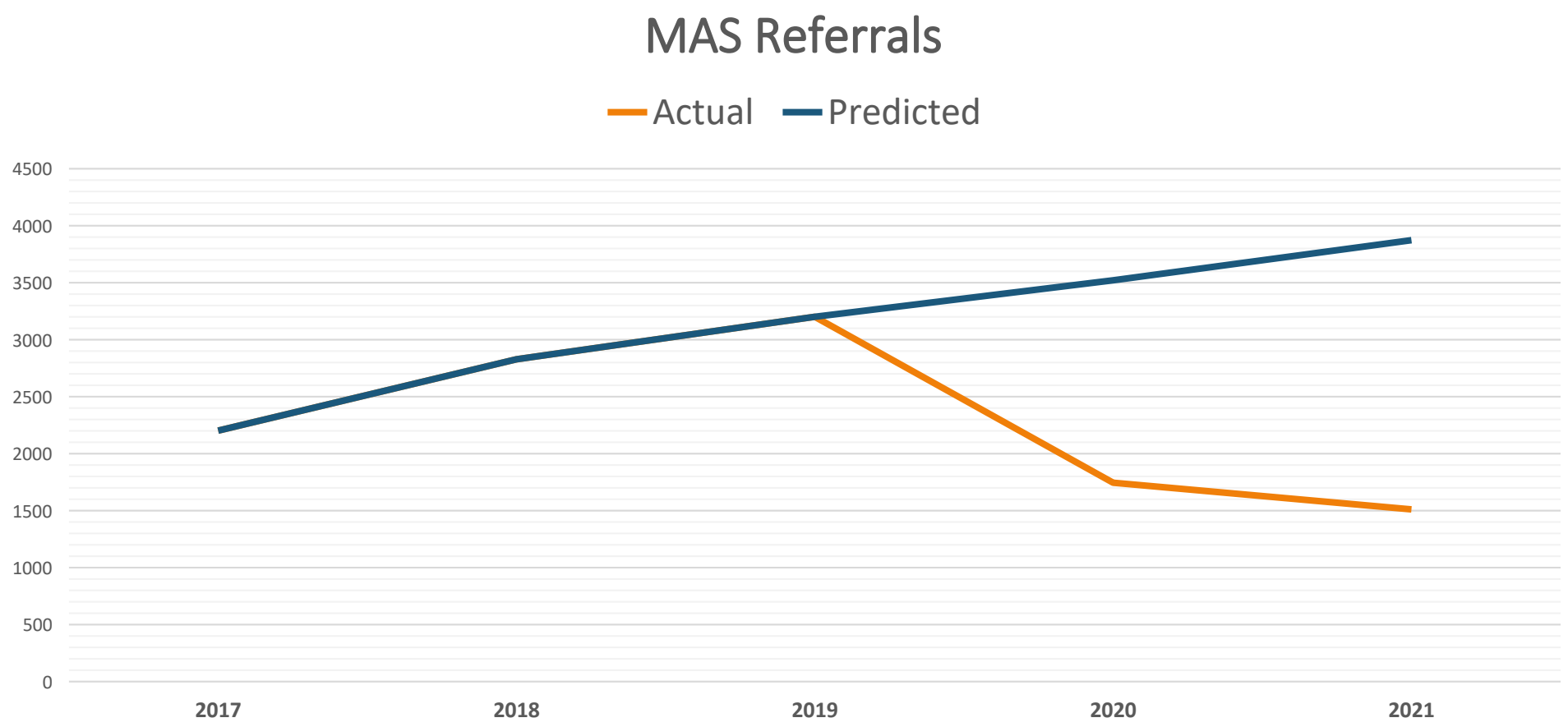
NHS Chesterfield Royal Hospital NHS Foundation Trust

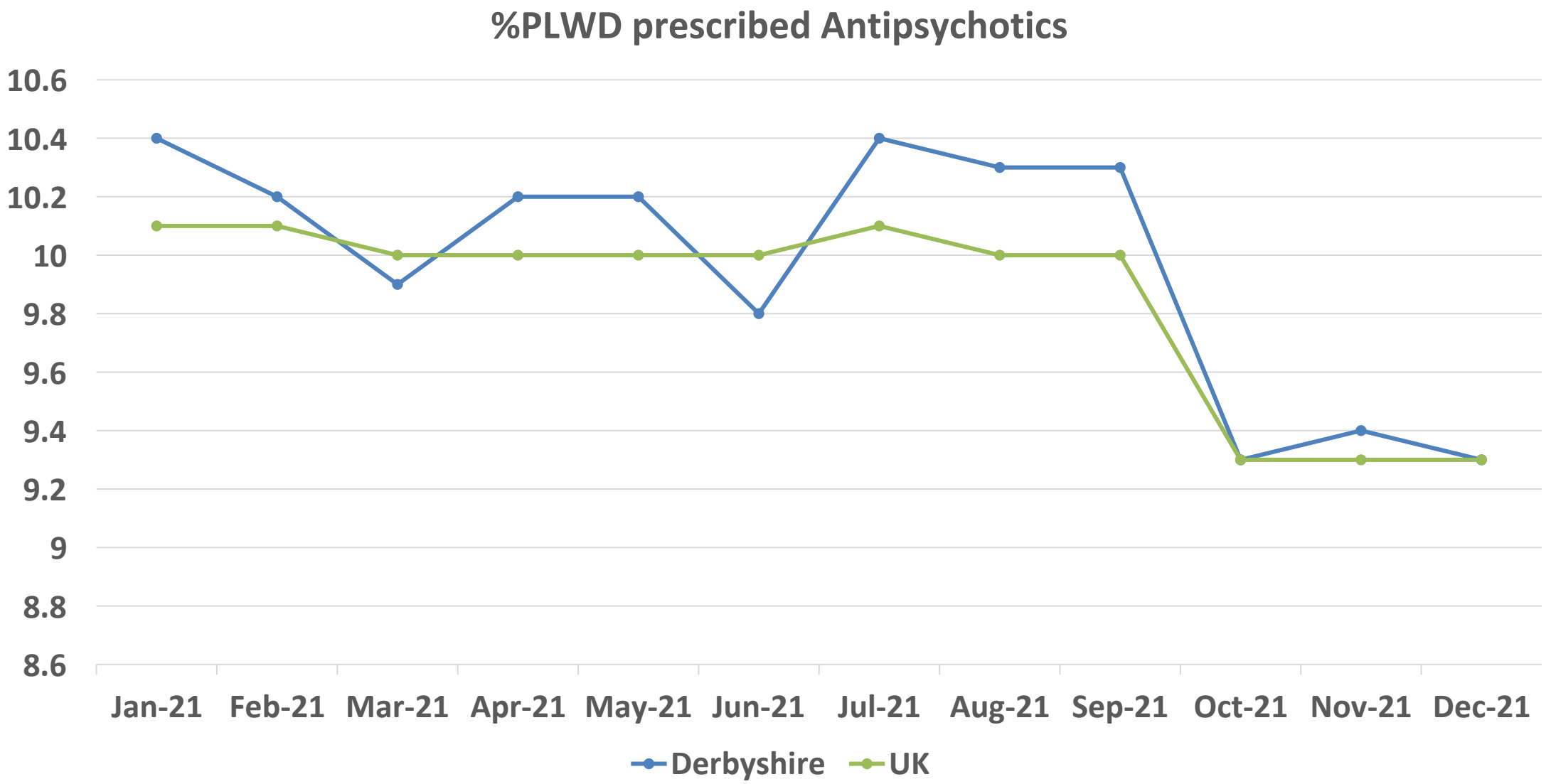
Appendices

Derbyshire DDR Dec 19-Jan22



Current DDR
Derbyshire CCG 63.3% (Highest Aug 2019 72%)
UK 61.8% (Highest Aug 2019 68.8)


MAS Referrals
Actual
Predicted
4500
4000
3500
3000
2500
2000
1500
1000
500
0
2017
2018
2019
2020
2021


%PLWD prescribed Antipsychotics
10.6
10.4
10.2
10
9.8
9.6
9.4
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9
8.8
8.6
Jan-21
Feb-21
Mar-21
Apr-21
May-21
Jun-21
Jul-21
Aug-21
Sep-21
Oct-21
Nov-21
Dec-21
Derbyshire
UK

Delirium Awareness Training

Monthly Completions

Completion Status	Oct, 2021	Nov, 2021	Dec, 2021	Jan, 2022	Feb, 2022	Total
completed	89	76	35	109	91	400
Total	**89**	**76**	**35**	**109**	**91**	**400**

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 1 November 2022

Performance Report

Purpose of Report

The purpose of this report is to provide the Board of Directors with an update of how the Trust was performing at the end of September 2022. The report focuses on key finance, performance and workforce measures.

Executive Summary

The report provides the Board of Directors with information that demonstrates how the Trust is performing against a suite of key targets and measures. Performance is summarised in an assurance summary dashboard with targets identified, where a specific target has been agreed. Where a specific target has not been agreed or specifically commissioned, colleagues will be able to track performance over time and discuss/challenge any specific variation that may be of concern or unusual. The charts have been generated using an adaptation of a tool created by Karen Hayllar, NHS England and NHS Improvement (NHSEI), which enables much easier interpretation of how each process is performing. The main areas to draw the Board's attention to are as follows:

Operations

The transition to SystmOne in May 2022 resulted in a large number of recording errors which have affected some of the performance measures. The SystmOne project team are making good progress working to address these issues. Two performance summits have been held and a third is due in November with an overall project plan with aim to deliver and coordinate across four workstreams: data optimisation, quality improvement, review of metrics and engagement. A survey on current ways of working for performance reporting and improvement was shared with staff and is being analysed for learning and themes.

Various Recovery Action Plans (RAP) across metrics are in development/have been drafted and will be monitored via TOOL, as well as being reported to external boards. These are:

- Learning Disability and Autism (LDA) patient admission avoidance, inpatient performance and care and accommodation (x3 individual RAPs)
- Psychiatric Intensive Care Unit (PICU) spend RAP
- LDA Inpatients RAP including expected discharge date/plan by patient
- Adult Community Mental Health Team (CMHT) Access RAP progress against actions and activity trajectory, and risks to delivery
- Children and Young People (CYP) Eating Disorder Access RAP progress against actions and activity trajectory, and risks to delivery
- Perinatal Community Access RAP progress against actions and activity trajectory, and risks to delivery

- Adult Autistic Spectrum Disorder (ASD) and Attention Deficit Hyperactive Disorder (ADHD) waiting list RAP
- CYP waiting list RAP

A revised approach to waiting list management is being mobilised and should start to have an impact from quarter 4.

Three-day follow-up of all discharged inpatients
The national standard for follow-up has been exceeded throughout the 24-month period. The position in May to September 2022 has been manually calculated by auditing all of the reported breaches. It was found that patients are being followed up, but SystmOne is not being used correctly which impacts on reporting. Educative and corrective action is in progress.

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

Early intervention 14-day referral to treatment
Patients with early onset psychosis are continuing to receive very timely access to the treatment they need.

Early intervention 14-day referral to treatment – incomplete (people currently waiting to be seen)
The service has exceeded the national 14-day referral to treatment standard of 60% or more people on the waiting list to have been waiting no more than two weeks to be seen in all but one month. Occasional delays are a result of difficulties contacting patients to arrange appointments, or patients not attending their planned appointments.

IAPT 18-week referral to treatment
This continues to be an example of a very tightly controlled process, and it is expected that the 95% standard will be consistently.

IAPT 6-week referral to treatment
There has been a significant increase in waits over the last few months. This was as result of a combination of annual leave, plus an unprecedented number of Psychological Wellbeing Practitioners (PWPs) leaving over the past six months. Currently there are seven whole time equivalent PWP posts vacant. Actions are underway to fill these posts. In addition, IAPT has been identified in the Trust to pilot an elective recovery module from NHS England and NHS Improvement to support waiting list improvements and will also undertake a Recovery Action Plan monitored via TOOL.

IAPT patients completing treatment who move to recovery
This is an annual target and year to date we are exceeding target and for the past 24 months the national standard has been achieved.

Patients placed out of area – adult acute
Currently we have one patient in an inappropriate out of area acute bed. The inappropriate out of area patient is on a pathway to repatriate them to a Derbyshire bed, however at the moment repatriation is not possible owing to pressures elsewhere: University Hospitals of Derby and Burton and Chesterfield Royal Hospital are both declaring critical incidents and struggling to cope. Therefore, any

requests received from these organisations for beds are our highest priority to ensure system flow. There has been an increase in patients with COVID-19 recently. This is likely to have an impact on bed capacity. Further work on flow is required, including supporting the reduction of people clinically ready for discharge who remain on wards for extended periods of time, including some delayed in the LDA cohort. A new internal acute transformational delivery board will be established (terms of reference in draft) which will aim to bring together improvement and transformation workstreams to enable further improvements in flow.

Patients placed out of area – Psychiatric Intensive Care Units (PICU)
There is no local PICU provision, so anyone needing psychiatric intensive care needs to be placed out of area, however, work continues on the provision of a new build PICU in Derbyshire. NHS Improvement continuity of care principles have been established with two PICU providers - Northamptonshire Healthcare NHS Foundation Trust and Elysium - as agreed in partnership with Derbyshire Urgent Care Steering Board. A Recovery Action Plan has been developed specifically regarding PICU spend for the Joined Up Care Derbyshire Finance subgroup and includes actions to support flow to enable a reduction in use of PICU where there are delays with step down into acute beds.

Waiting list for care coordination
The significant increase in waiting times coincides with the transition to SystmOne. A large piece of work is in progress to improve people's understanding of how to use the new system properly and update and correct records in line with the numerous standard operating procedures, which should result in an improvement to data quality and enable data optimisation.

Waiting list for adult autistic spectrum disorder (ASD) assessment
Demand for the service continues to outstrip capacity (commissioned to undertake 26 per month but currently receiving referrals 86 per month this financial year to date). However, in September for the first time in three years the number of assessments completed exceeded the commissioned number at 28. At the end of September 2022 there were 1,970 adults waiting for adult ASD assessment, which is an increase of 32 on the previous month.

Improvements in performance have been due to action plans to bring together two specialist teams into one (Specialist Autism Team and ASD assessment), providing a more flexible team to take on the range of tasks. To continue to support improvements, the service is undertaking a recruitment drive for the nine vacant posts currently out to advert and are increasing the number of people able to diagnose through ASD assessment training to up to 25 trust staff (mainly psychologists and nurses) across all CMHTs. Further funding to support Attention deficit hyperactivity disorder (ADHD) assessment model will be used flexibly to support across neurodevelopmental diagnostic needs and includes Voluntary Community and Social Enterprise (VCSE) posts to go out shortly to ensure waiting well and post-diagnostic aftercare. A Recovery Action Plan is being developed and will be monitored via a waitlist improvement function at Trust Operational Oversight Leadership (TOOL).

Waiting lists for psychological services
At the end of last month, 565 people were waiting to be seen by psychological services with an average wait of 325 days. The waiting list is hugely variable according to team and service. The areas with the greatest wait time are Amber

Valley, Bolsover, Killamarsh, South Dales and the City adult services, where the wait is up to three years (Amber Valley). This is largely due to vacancies, and we are therefore focusing recruitment and other efforts on the hard to fill vacancies across these areas, as well as asking others to input into these areas where they can. Over the last twelve months, the number of people waiting has continued to gradually reduce. The recruitment drive has led to some positive results. Working to Place will in the longer term alleviate some of these waiting times as population health statistics will be used to guide needs and therefore required responses and resources. There remains a national shortage of qualified psychologists, with all Trusts struggling to recruit. We currently have less vacancies in psychological services than our regional colleagues. This position is unlikely to change until 2025 when those new places commissioned by Health Education England (HEE) for training output qualified staff. In the meantime, we are utilising other roles to try and plug our gap in delivery of psychological care. We continue to build some psychological knowledge and capacity in our nursing, occupational therapy and medical colleagues through use of HEE monies for training, as well as development and delivery of a range of inhouse training. Longer term it is hoped this will reduce the referrals to specialist psychological services. We continue to review the waiting lists in line with trauma sensitive working in considering how we manage people on a waiting list, and we are developing a new waiting well guide for those service users.

<u>Waiting list for Child and Adolescent Mental Health Services (CAMHS)</u>
CAMHS continue to receive a high volume of referrals through the routine and urgent care pathways. The decision was made in August to focus on urgent/priority assessments, and all internal unallocated cases, with staff moving temporarily for 3 months into locality teams. This provides assurance that all children requiring an urgent assessment are being prioritised, in addition to those children accessing Children's Emergency Department. We are also continuing to prioritise cases open to the service with no allocated worker. Processes continue to be in place to manage the waiting list in accordance with the waiting well policy. This issue of high demand for the service has been raised via Joined Up Care Derbyshire and is on the Integrated Care Board (ICB) risk register. A system meeting is to be held shortly, specifically around support for waiting lists, county wide (so including Chesterfield Royal Hospital CAMHS). CAMHS has also been identified in the Trust to pilot an elective recovery module from NHS England and NHS Improvement to support waiting list improvements and will also undertake a Recovery Action Plan monitored via TOOL.

<u>Waiting list for community paediatrics</u>
We continue to see a steady rise in waiting times for referral to treatment in community paediatrics with over 1,600 children now waiting. The longest wait time is now in excess of 62 weeks and currently sits on the risk register as a high risk. Capacity is being impacted upon by ongoing very high levels of sickness absence. We have a regular locum in post and a further locum request to support the Neuro-disability pathway is also approved, but not yet filled. We have successfully appointed to the substantive Specialty Doctor post. The neuro-developmental pathway development is ongoing. The business case includes a second fixed term Speciality Doctor to focus on the autistic spectrum disorder pathway. Securing these posts will have an impact on the waiting list. This is a really positive development for the service line. We await final Integrated Care Board approval for the investment requested this month.

Outpatient appointments cancelled by the Trust
The level of cancellations has remained within common cause variation for most of the time.

Outpatient appointment did not attends
The level of defaulted appointments has remained within common cause variation for the majority of the time and in the current process the trust target of 15% or lower is likely to be consistently achieved.

Finance

At the end of September, the overall year to date (YTD) position is a deficit of £1.0m compared to the plan deficit of £0.8m, an adverse variance to plan of £0.2m. The main driver for the YTD adverse variance to plan is related to the undelivered CIP which is being slightly offset by some additional income. The forecast remains a breakeven position as per the plan.

However, there are significant areas of risk in and outside of that plan driven by the planning assumptions that have been followed, such as the delivery of the required 3% efficiencies, Agency expenditure and the containment of COVID costs.

Efficiencies
The full year plan includes an efficiency requirement of £6.0m phased equally across the financial year. There has been a particular focus on actions required to close the remaining efficiency gap which is required to achieve the overall breakeven plan. This has now been achieved and full plans have been developed. However, a significant proportion of the efficiencies are non-recurrent in nature 70%.

Whilst the full requirement for efficiencies has now been identified the majority of the schemes are non-recurrent and there is need to take action to ensure the costs are reduced to match the planned delivery.

Agency
Agency expenditure YTD totals £3.7m against a plan of £1.3m, an adverse variance to plan of £2.4m. The two highest areas of agency usage relate to Consultants mainly in CAMHS and Nursing staff. NHS England (NHSE) have confirmed that tighter agency controls will be introduced from September.

COVID costs
The financial plan assumes no expenditure for COVID after the end of May as per the planning guidance. There has been a significant reduction in covid related expenditure in August and September.

Out of Area Placements
Expenditure for adult acute out of area placements totals £1.8m to date. The forecast assumes a reduction in expenditure in the second half of the financial year.

Capital Expenditure
Following the resubmission of the capital plan in June expenditure has slightly below plan at the end of September. The forecast assumes full spend to plan by the end of the financial year.

Better Payment Practice Code (BPPC)
In September the target of 95% was missed on both value and volume mainly due to some outstanding Pharmacy invoices which have now been paid.

Cash and Liquidity
Cash remains high at £40m at the end of September however this is expected to reduce in line with capital expenditure. The liquidity ratio has reduced in 2022/23 mainly driven by the timing of cash receipts related to the centrally funded Making Room for Dignity capital scheme.

People

Annual appraisals
Appraisal levels continue to be below our expectations with Operational Services currently at 82% and Corporate Services at 49%. There is however a significant improvement over the last nine months.

Annual turnover
Turnover remains high and above the Trust target range of 8-12%. There has been a small improvement from the previous month with a 0.6% reduction. We have now launched the new exit interview process to ensure we capture a higher percentage of interviews from leavers and learn more about why colleagues are leaving the organisation. Nationally, we are achieving the lowest leaver rate for any mental health and learning disability trust.

Compulsory training
Compulsory training continues to be a key focus and an ongoing recovery position for the Trust. Overall, the 85% target level has been achieved for the last seven months. Operational Services are currently 89% compliant and Corporate Services slightly lower at 77%.

Staff absence
Sickness absence remains high and above the 5% target threshold. September sickness was 7.4%. We have been working closely with divisions to understand the challenges in managing absence and identified key areas that need some focused improvement work.

Supervision
The levels of compliance with the clinical and management supervision targets have remained low since the start of the pandemic. As seen with compulsory training and appraisals, Operational Services continue to perform at a considerably higher level than Corporate Services for both types of supervision (management: 73% versus 58% and clinical: 70% versus 19%).

Proportion of posts filled
Staffing levels continue to improve and gradual reductions in vacancy rate have continued over the last quarter. Time to hire is now standing at 57.1 days. There are still improvements be made, with a focus now on pre-employment checks stage and further streamlining to take pressure off front-line managers. We are participating in a national programme ‘Good

Recruitment for Older Workers' (GROW) which aims to minimise age bias in the recruitment process.

Bank staff
Bank listening event themes are being collated and will be reviewed and actioned within the Temporary Workforce Strategy Group. The listening events will now take place monthly, as requested by bank colleagues to ensure we can respond in a timely way to concerns and make improvements to colleagues' working lives. Capacity and demand remain misaligned and fill performance is below benchmark at 68%. Within the integrated care system (ICS) an analysis of temporary workforce capacity within Derbyshire is underway.

Quality

Compliments
The number of compliments continues to remain below the expected level. With an increase in accessibility, it is expected that a natural increase in compliments, complaints and concerns will occur over the next six months.

Complaints
The number of formal complaints received continues to be within common cause variation in relation to the mean with a decline in the number recorded between August and September 2022. The number of formal complaints is now below the Trust target. This could be due to the number of face-to-face contacts increasing as services stand back up.

Delayed transfers of care (DTOC)
Although the number of DTOC has increased between August and September, the number is still low when compared with the national picture and continues to be below the Trust target of 3.5%. Work continues within the rapid review processes and clinical meetings and a Housing Officer was recruited in May 22.

Care plan reviews
The proportion of patients whose care plans have been reviewed continues to be recorded as lower than expected and is currently on a downward trajectory. This is likely due to care plans that have not yet been migrated over to SystmOne and data quality issues with how this information is being captured.

Patients in employment
Around one third of patients have no employment status recorded at present and the decline in patients recorded as being in employment coincides with the data migration to SystmOne. Therefore, this may be a data quality issue. This will be investigated and reviewed during the next quarter. The Individual Placement Support (IPS) Service continues to have success in supporting people into employment even during the pandemic and the service is currently expanding.

Patients in settled accommodation
Around one third of patients have no accommodation status recorded and the decline in patients with a recorded settled accommodation status again coincides with the data migration to SystmOne. Issues around imputing data have been identified and an improvement plan has was implemented in the Older Adult Division in October including regular audit. The other Trust Divisions will be asked to review their own data, and this will be monitored over the next quarter.

Medication incidents
Although there is fluctuation with the number of medication incidents recorded, they are within the common cause variation in relation to the mean. In October 2022 the Children's Division have started electronic prescribing and medicines administration (EPMA), a solution which digitises the process of prescribing and recording medication administered to patients within the Division. This will be rolled out across the trust and should help reduce the number of medication incidents over the next six months.

Incidents of moderate to catastrophic actual harm
The number of reported incidents of moderate to catastrophic harm increased from April 2022 with a spike between June and July. This increase appears to be related to repeated incidents involving a small number of patients. The number of incidents has reduced over August and September, but it will continue to be monitored by the Head of Nursing team on a quarterly basis and will be fed into the relevant Clinical Operational Assurance Team (COAT) meetings.

Duty of Candour
The increase in Duty of Candour (DOC) reported incidents as anticipated in the previous report is due to a change in how DOC incidents are reported on the DATIX reporting system and a greater awareness around reporting in clinical teams.

Prone restraint
There are ongoing workstreams to support the continuing need to reduce restrictive practice, including the work around introducing body worn cameras. The monitoring of restrictive practice takes place within specific forums and data analysis and review has shown that incidents involving prone restraint have increased between June and July 2022 related to repeated incidents involving a small number of patients. This will continue to be monitored.

Physical restraint
The number of reported incidents involving restraint have remained within common cause variation throughout the reporting period. The changes in numbers are linked to the data above relating to prone restraint and below relating to seclusion. It is important to highlight that a common impacting factor to restrictive practice is increased use of bank staff, vacancies, increased sickness, staffing challenges and concerns relating to closed culture. Over the last quarter the Positive and Safe team have increased their presence on inpatient wards to offer advice following incidents which will help staff to identify alternative ways of managing situations that could potentially involve physical restraint.

Seclusion
The use of seclusion has been above the mean due to a small number of patients who had been placed in seclusion on more than one occasion on an acute ward and then the Enhanced Care ward. From July 2022 the number of seclusions is on a downward trajectory and is now below the Trust target. Further auditing will be carried out by the Head of Nursing for Acute and Assessment Services and they are currently leading on a thematic review of seclusions to identify further learning.

Falls on inpatient wards
After an abnormal spike of incidents in March 2022, a review of falls was commissioned and identified that a high number of falls were related to the same

small number of patients. From this review a bi-weekly falls review meeting, chaired by the Matron for older adult services, has been established to identify any specific needs for those patients falling regularly. This appears to have had a positive impact with incidents related to falls reducing and continuing a downward trajectory.

Care hours per patient day (CHPPD)
CHPPD is rolling data updated monthly, to show staffing levels in relation to patient numbers on an inpatient ward. In the latest published national data when benchmarked against other mental health trusts, our staffing levels were below average.

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

Risks and Assurances

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

Consultation

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

Governance or Legal Issues

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

Public Sector Equality Duty and Equality Impact Risk Analysis

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

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

- This report reflects performance related to all of the Trust's service portfolio and therefore any decisions that are taken as a result of the information provided in this report is likely to affect members of those populations with protected characteristics in the REGARDS groups.
- Any specific action will need to be relevant to each service and considered accordingly, so for example, as parts of the report relate specifically to access to Trust services; we will need to ensure that any changes or agreed improvements take account of the evidence that shows variable access to services from different population groups.

Recommendations

The Board of Directors is requested to:

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

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

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

Faye Rice
Managing Director, Delivery, Performance & Transformation

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Director of Finance

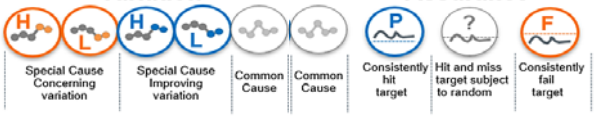
Rebecca Oakley
Head of Organisational Effectiveness

Joseph Thompson
Assistant Director of Clinical Professional Practice

Assurance Summary

	Metric Name	Variation	Assurance	Latest Value	Target	Lower process limit	Upper Process limit	Mean
1	3 day follow-up			96%	80%	78%	102%	90%
2	Data quality maturity index			98%	95%	97%	98%	98%
3	Early intervention 14 day referral to treatment - complete			83%	60%	67%	106%	86%
4	Early intervention 14 day referral to treatment - incomplete			90%	60%	55%	113%	84%
5	IAPT 18 week referral to treatment			100%	95%	100%	100%	100%
6	IAPT 6 week referral to treatment			67%	75%	82%	95%	89%
7	IAPT patients completing treatment who move to recovery			53%	50%	47%	62%	54%
8a	Average patients out of area per day - adult acute			5	0.0	-2	11	5
8b	Patients placed out of area - adult acute			5	0.0	-2	19	9
9a	Average patients out of area per day - PICU			14		7	20	13
9b	Patients placed out of area - PICU			20		13	33	23
10a	Waiting list - care coordination - average wait to be seen			42		13	31	22
10b	Waiting list - care coordination - number waiting at month end			100		29	67	48
11a	Waiting list - ASD assessment - average wait to be seen			72		63	68	66
11b	Waiting list - ASD assessment - number waiting at month end			1,978		1357	1582	1470
11c	ASD assessments			94	26	4	52	28
12a	Waiting list - psychology - average wait to be seen			51		36	49	42
12b	Waiting list - psychology - number waiting at month end			515		688	909	799
13a	Waiting list - CAMHS - average wait to be seen			25		12	21	16
13b	Waiting list - CAMHS - number waiting at month end			519		356	522	439
14a	Waiting list - community paediatrics - average wait to be seen			25		12	17	14
14b	Waiting list - community paediatrics - number waiting at month end			1,662		822	1147	984
15	Outpatient appointments cancelled by the Trust			9%	5%	4%	11%	8%
16	Outpatient appointment "did not attends"			12%	15%	10%	14%	12%
17	Annual appraisals			76%	85%	71%	75%	73%
18	Annual turnover			13%	8-12%	12%	13%	12%
19	Compulsory training			87%	85%	83%	87%	85%
20	Staff absence			6%	5%	5%	8%	7%
21	Clinical supervision			70%	95%	69%	77%	73%
22	Management supervision			73%	95%	72%	78%	75%
23	Filled posts			93%	100%	87%	92%	90%
24	Bank staff use			6%	5%	5%	7%	6%
25	Compliments received			107	119	58	132	95
26	Formal complaints received			7	13	6	28	17
27	Delayed transfers of care			2%	3.5%	-0.6%	2.0%	0.7%
28	CPA reviews			76%	95%	86%	94%	90%
29	Patients in employment			7%		10%	14%	12%
30	Patients in settled accommodation			35%		51%	59%	55%

Key to symbols[1]:



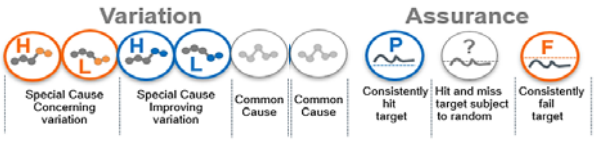
Blue dots indicate special cause variation, better than expected.

Orange dots indicate special cause variation, worse than expected.

[1]The rating symbols were designed by NHS Improvement

	Metric Name	Variance	Assurance	Latest Value	Target	Lower process limit	Upper process limit	Mean
31	Number of medication incidents			72		27	86	57
32	No. of incidents of moderate to catastrophic actual harm		P	37	48	18	85	51
33	No. of incidents requiring Duty of Candour		?	3	1	-3	12	5
34	No. of incidents involving prone restraint		?	12	12	-2	19	8
35	No. of incidents involving physical restraint		?	36	46	-2	95	47
36	No. of new episodes of patients held in seclusion		?	8	14	-1	32	15
37	No. of falls on inpatient wards	H	?	39	30	18	46	32

Key to symbols[1]:



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Operational Services Performance Summary

Indicator	Target	Position Sep 2022	National benchmark	Divisional Breakdown[1] AA	AC	Ch	F&R	OP	Psy	SC	Run Chart
● 3-day follow-up	80%	96%	75%								
● Data quality maturity index	95%	97%	75%	90%	98%	85%	92%	98%	99%	98%	
● Early intervention 2-week referral to treatment	60%	83%	68%		83%						
● Early intervention current waits under 2 weeks	60%	90%	28%		90%						
● IAPT 18-week referral to treatment	95%	99.6%	98%							99.6%	
● IAPT 6-week referral to treatment	75%	67%	89%							67%	
● IAPT recovery rate	50%	53%	50%							53%	
● Adult acute out of area placements – daily average	0	5	7	5							
● PICU out of area placements – daily average	0	14	3	14							
● Adult ASD assessment average wait (weeks)	n/a	72	n/a						72		
● Adult ASD assessments	26	28	n/a						28		
● Psychological services average wait to be seen (weeks)	n/a	51	n/a						51		
● CAMHS average wait to be seen (weeks)	4[2]	25	n/a			25					
● Paediatrics average wait to be seen (weeks)	18	25	17			25					
● Outpatient appointment Trust cancellations	5%	9%	n/a		9%	6%		15%		21%	
● Outpatient appointments not attended (DNAs)	15%	12%	n/a		19%	4%		6%		11%	

[1] Key: AA Adult Acute Care, AC Adult Community Care, Ch Children's Services, F&R Forensic & Mental Health Rehabilitation, Psy Psychology and SC Specialist Care Services
[2] Proposed access standard (NHSE)

Performance Summary

3-day follow up of all discharged inpatients
The national standard for follow-up has been manually audited and exceeded the national average by 22% at Trust level in September. This process is tightly monitored by Samantha Shaw, the Trust's Performance Analyst, who routinely chases up the relevant teams prior to any potential breaches to ensure patients get timely support post discharge. Educative and corrective action is in progress which should result in improvement in recording accuracy over time as people get used to using the new system and the change to how things need to be recorded.

Data quality maturity index
The level of data quality has been significantly better than expected for the last 5 months. It is expected that the national target will be consistently exceed overall. Some services experience difficulty in collecting data owing to the nature of presentation, for example where people are presenting in crisis and their mental state makes it inappropriate at that time.

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

IAPT 18-week referral to treatment
This continues to be an example of a very tightly controlled process, and it is expected that the 95% standard will be consistently.

IAPT 6-week referral to treatment
There has been a significant increase in waits over the last few months. This was as result of a combination of annual leave, plus an unprecedented number of Psychological Wellbeing Practitioners (PWPs) leaving over the past 6 months. Currently there are 7 whole time equivalent PWP posts vacant. Actions are underway to fill these posts.

IAPT patients completing treatment who move to recovery
This is an annual target and year to date we are exceeding target and for the past 24 months the national standard has been achieved.

Patients placed out of area – adult acute
Currently we have 1 patient in an inappropriate out of area acute bed. The patient is on a pathway to repatriate them to a Derbyshire bed, however at the moment repatriation is not possible owing to pressures elsewhere. There has been an increase in patients with Covid-19 recently. This is likely to have an impact on bed capacity.

Patients placed out of area – Psychiatric Intensive Care Units
There is no local PICU provision, so anyone needing psychiatric intensive care needs to be placed out of area, however, work continues on the provision of a new build PICU in Derbyshire.

Waiting list for adult autistic spectrum disorder (ASD) assessment

In September, for the first time in 3 years, the number of assessments completed by the team and psychology staff exceeded the 26 required. At the end of September 2022 there were 1,970 adults waiting for adult ASD assessment, which is an increase of 32 on the previous month. Last month we reported that we have pulled the two specialist teams into one (SAT and ASD assessment), providing a more flexible team to take on the range of tasks. This is supporting more team members and making recruitment for this service more attractive. There are 9 vacant posts currently out to advert. To support the development of psychological skills, and increase the number of people able to diagnose, ASD assessment training will be delivered to up to 25 trust staff (mainly psychologists & nurses) across all CMHTs.

Waiting lists for psychological services

At the end of last month, 565 people were waiting to be seen by psychological services with an average wait of 325 days. The waiting list is hugely variable according to team and service. The areas with the greatest wait time are Amber Valley, Bolsover, Killamarsh, South Dales and the City adult services, where the wait is up to 3 years (Amber Valley). This is largely due to vacancies, and we are therefore focusing recruitment and other efforts on the hard to fill vacancies across these areas, as well as asking others to input into these areas where they can. Over the last 12 months, the number of people waiting has continued to gradually reduce. The recruitment drive has led to some positive results. Working to Place will in the longer term alleviate some of these waiting times as population health statistics will be used to guide needs and therefore required responses and resources. There remains a national shortage of qualified psychologists, with all Trusts struggling to recruit. We currently have less vacancies in psychological services than our regional colleagues. This position is unlikely to change until 2025 when those new places commissioned by Health Education England (HEE) for training output qualified staff. In the meantime, we are utilising other roles to try and plug our gap in delivery of psychological care. We continue to build some psychological knowledge and capacity in our nursing, occupational therapy, and medical colleagues through use of HEE monies for training, as well as development and delivery of a range of inhouse training. Longer term it is hoped this will reduce the referrals to specialist psychological services. We continue to review the waiting lists in line with trauma sensitive working in considering how we manage people on a waiting list, and we are developing a new waiting well guide for those service users.

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

CAMHS continue to receive a high volume of referrals through the routine and urgent care pathways. The decision was made in August to focus on urgent/priority assessments, and all internal unallocated cases, with staff moving temporarily for 3 months into locality teams. This provides assurance that all children requiring an urgent assessment are being prioritised, in addition to those children accessing Children's Emergency Department. We are also continuing to prioritise cases open to the service with no allocated worker. Processes continue to be in place to manage the waiting list in accordance with the waiting well policy. This issue of high demand for the service has been raised via Joined Up Care Derbyshire and is on the Integrated Care Board (ICB) risk register. A system meeting is to be held shortly, specifically around support for waiting lists, county wide (so including Chesterfield Royal Hospital CAMHS).

Waiting list for community paediatrics

We continue to see a steady rise in waiting times for referral to treatment in community paediatrics with over 1,600 children now waiting. The longest wait time is now in excess of 62 weeks and currently sits on the risk register as a high risk. Capacity is being impacted upon by ongoing very high levels of sickness absence. We have a regular locum in post and a further locum request to support the Neuro-disability pathway is also approved, but not yet filled. We have successfully appointed to the substantive Specialty Doctor post. The neuro-developmental pathway development is ongoing. The business case includes a second fixed term Speciality Doctor to focus on the autistic spectrum disorder pathway. Securing these posts will have an impact on the waiting list. This is a really positive development for the service line. We await final Integrated Care Board approval for the investment requested this month.

Outpatient appointments cancelled by the Trust
The level of cancellations has remained within common cause variation for most of the time.

Outpatient appointment did not attends
The level of defaulted appointments has remained within common cause variation for the majority of the time and in the current process the trust target of 15% or lower is likely to be consistently achieved.

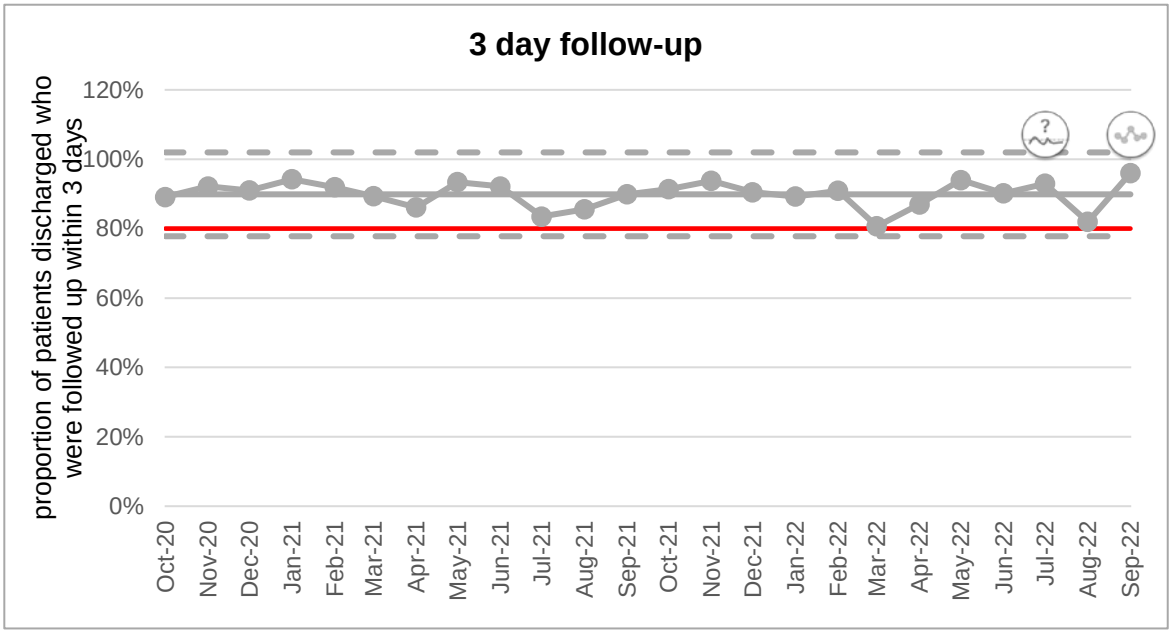
Benchmarking Sources

Measure	Data source	Date
3-day follow-up	Mental Health Statistics	June 22
Data quality maturity index	Data quality - NHS Digital	June 22
Early intervention 2-week referral to treatment	MHSDS Monthly Statistics	June 22
Early intervention current waits under 2 weeks	MHSDS Monthly Statistics	June 22
IAPT 18-week referral to treatment	Psychological Therapies: reports	June 22
IAPT 6-week referral to treatment	Psychological Therapies: reports	June 22
IAPT recovery rate	Psychological Therapies: reports	June 22
Adult acute out of area placements – daily average	Out of Area Placements	June 22
PICU out of area placements – daily average	Out of Area Placements	June 22
Paediatrics average wait to be seen (weeks)	Referral to Treatment Waiting	July 22

Detailed Narrative

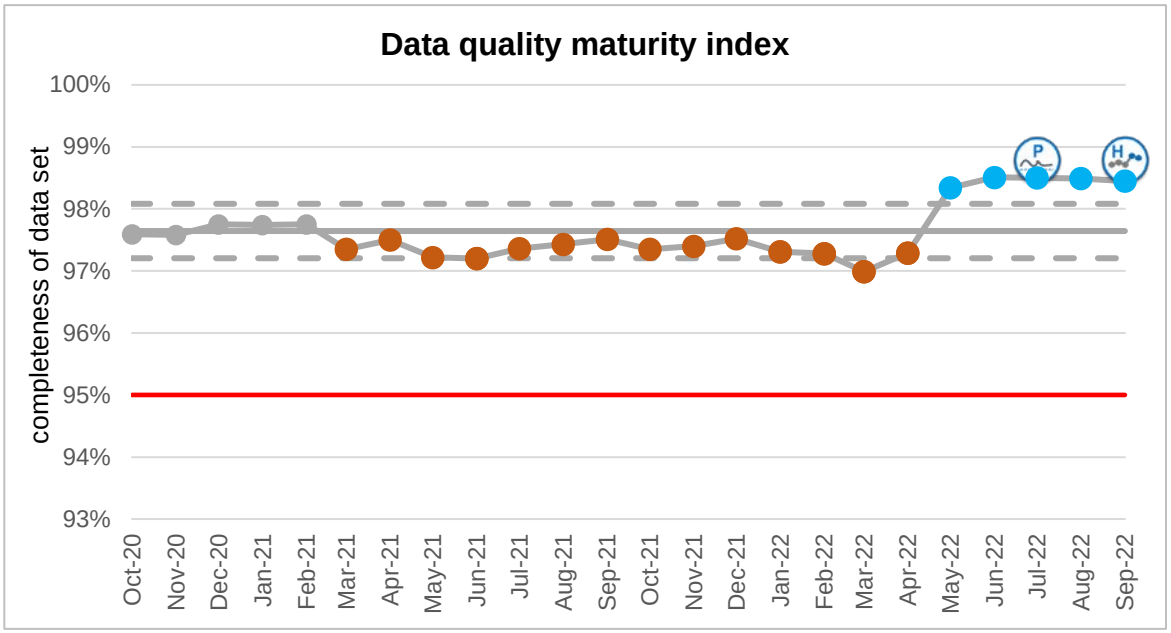
Operations

1. Three-day follow-up of all discharged inpatients



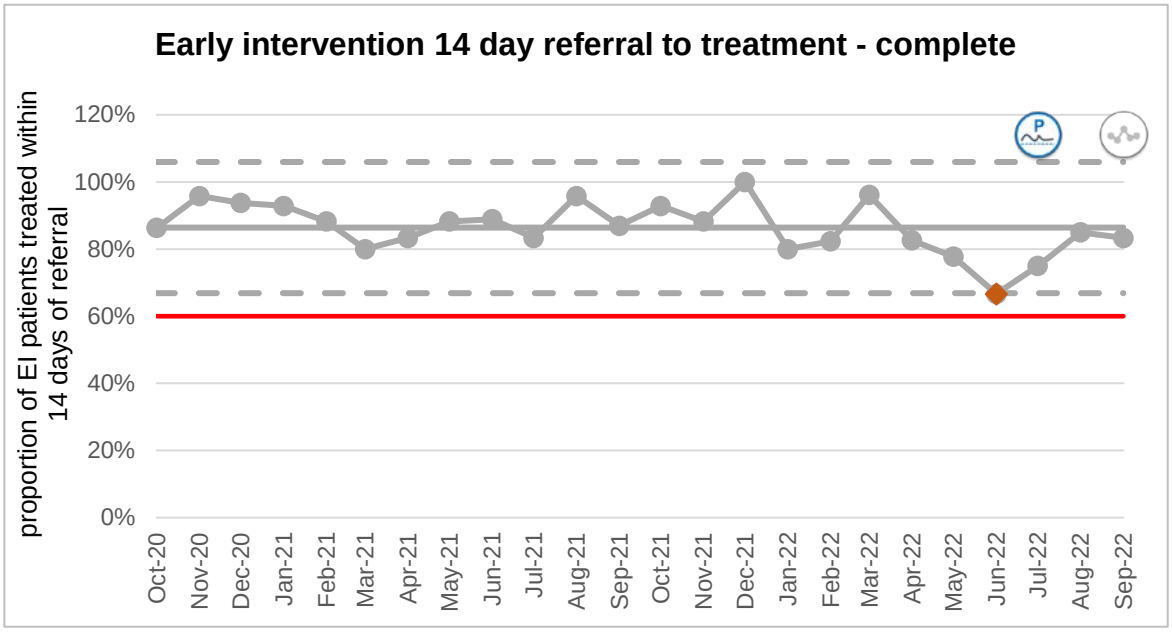
Patients are followed up in the days following discharge from mental health inpatient wards to provide support and ensure their wellbeing during the period when they are potentially at their most vulnerable. The national standard for follow-up has been exceeded throughout the 24-month period. The position in May to September 2022 has been manually calculated by auditing all of the reported breaches. It was found that patients are being followed up, but SystmOne is not being used correctly which impacts on reporting. Educative and corrective action is in progress.

2. Data quality maturity index



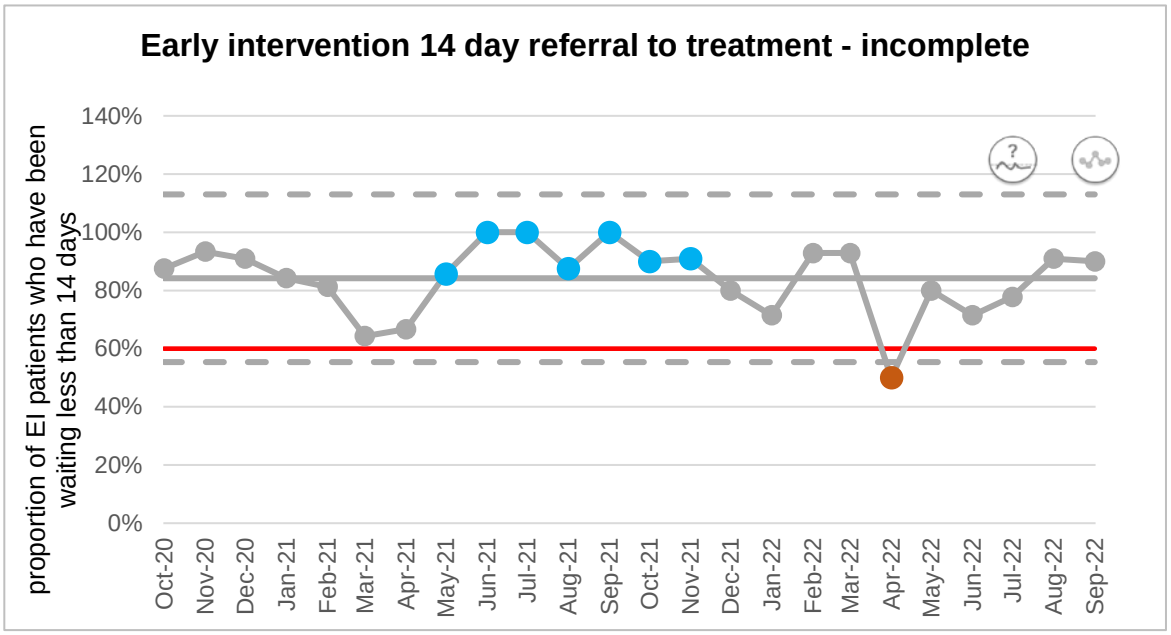
The level of data quality has been significantly better than expected for the last 5 months. It is expected that the national target will be consistently exceed.

3. Early intervention 14-day referral to treatment



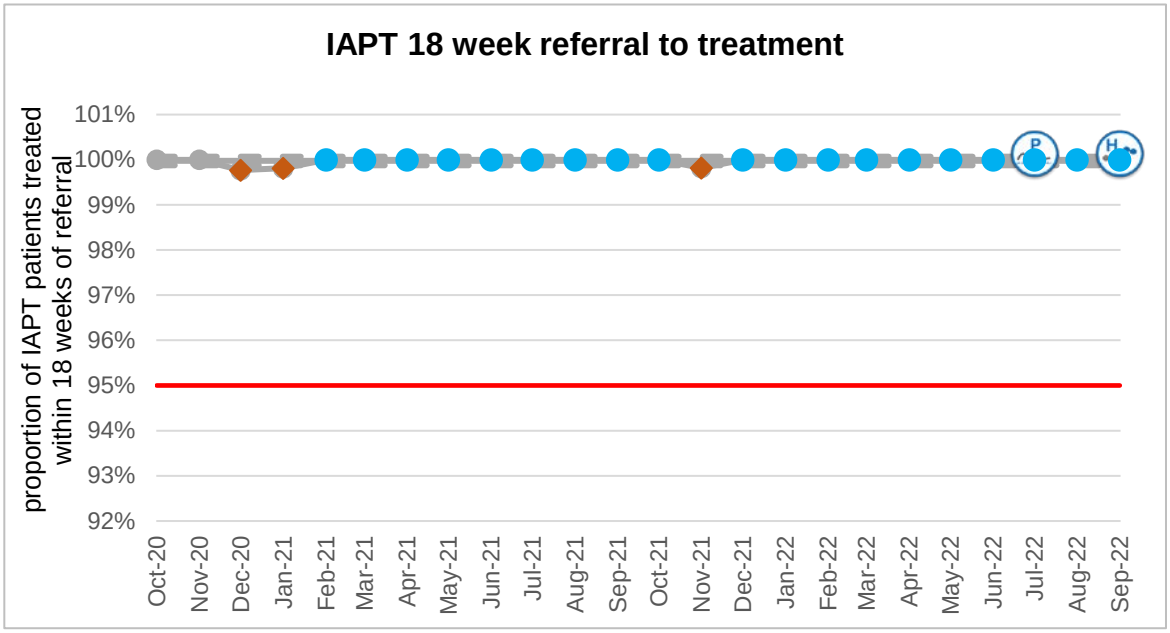
Patients with early onset psychosis are continuing to receive very timely access to the treatment they need.

4. Early intervention 14-day referral to treatment – incomplete (people currently waiting to be seen)



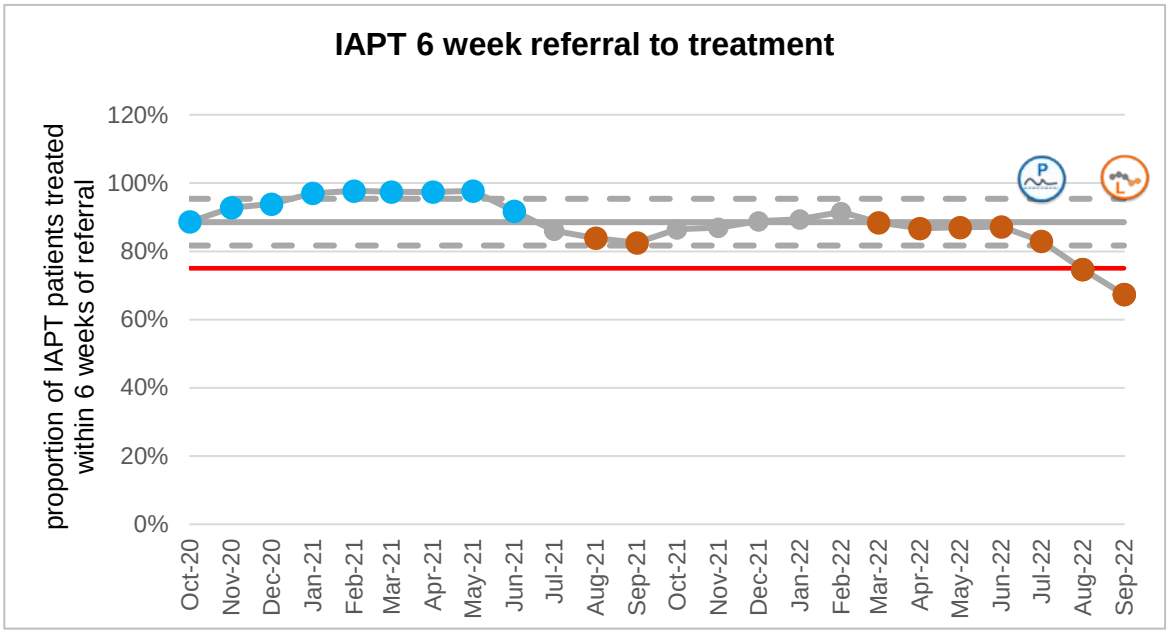
The service has exceeded the national 14-day referral to treatment standard of 60% or more people on the waiting list to have been waiting no more than 2 weeks to be seen in all but one month. The service has capacity to see everyone in a timely manner. Occasional delays are a result of difficulties contacting patients to arrange appointments, or patients not attending their planned appointments.

5. IAPT 18-week referral to treatment



This continues to be an example of a very tightly controlled process, and it is expected that the 95% standard will be consistently.

6. IAPT 6-week referral to treatment



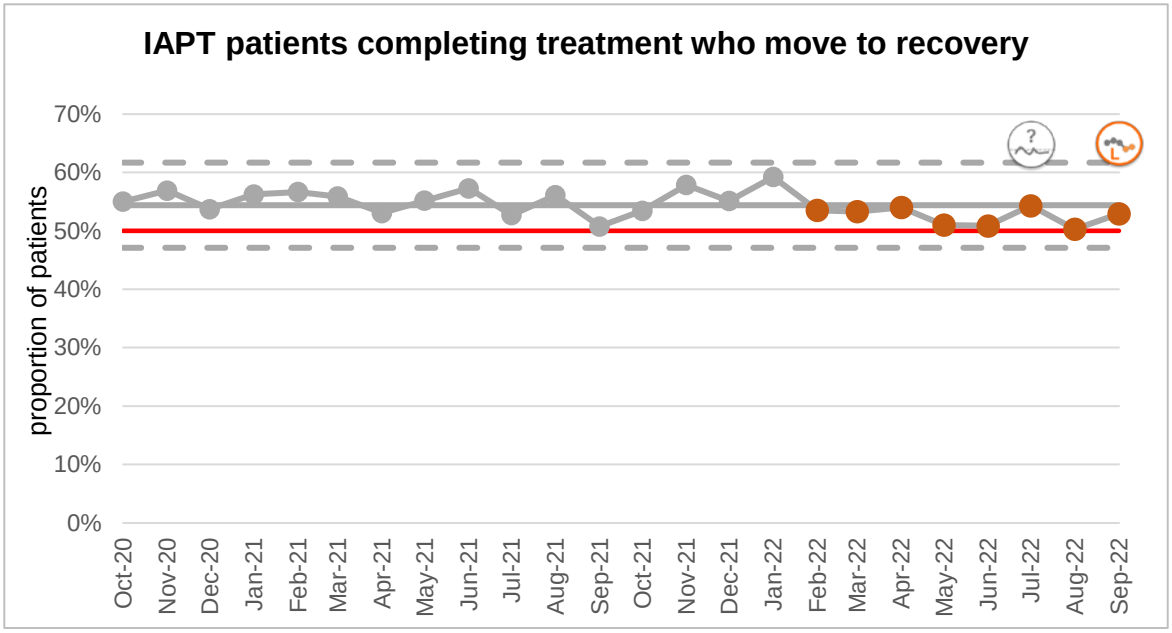
There has been a significant increase in waits over the last few months. The reasons for this are as follows. Firstly, the impact of annual leave being taken over the summer holidays and the impact of bank holidays (including the additional bank holiday, which resulted in us having to reschedule a significant number of appointments). Secondly, we lost a considerable number of Psychological Wellbeing Practitioners (PWPs) over the past 6 months: 9 members of staff in total due to them getting onto high intensity training and/or moving into other roles). This is somewhat unprecedented for the service given that there is usually a high level of staff retention. Currently there are 7.02 wte PWP posts vacant.

Actions taken to recover the position:

- Actively recruiting to the qualified PWP posts –1 WTE has been successfully recruited to date, who should be starting in service at the start of next month. A further round of recruitment is underway, with posts open to advert currently.
- 3 new PWP trainees have been taken on. It will take a little while for them to be in a position to provide assessments and treatments, but they will begin their clinical activity as soon as appropriate to do so.
- Recruitment of an agency staff member proved successful, however they discontinued after being offered a longer contract elsewhere. The use of agency staff will be revisited if wait times from referral to treatment do not improve.
- A booking clerk is in post to book short notice appointments into cancelled slots, so as to improve efficiency and reduce wait times.

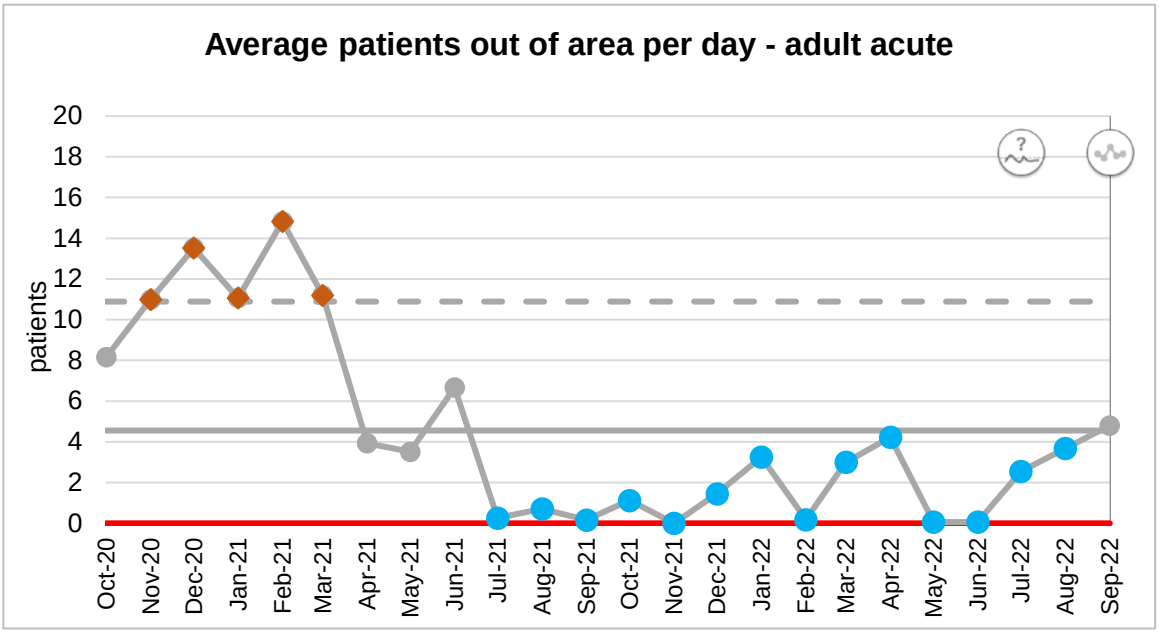
In addition, IAPT has been identified in the Trust to pilot an elective recovery module from NHS England and NHS Improvement to support waiting list improvements and will also undertake a Recovery Action Plan monitored via TOOL.

7. <u>IAPT patients completing treatment who move to recovery</u>



This is an annual target and year to date we are exceeding target and for the past 24 months the national standard has been achieved.

8a. Average number of patients placed out of area per day – adult acute



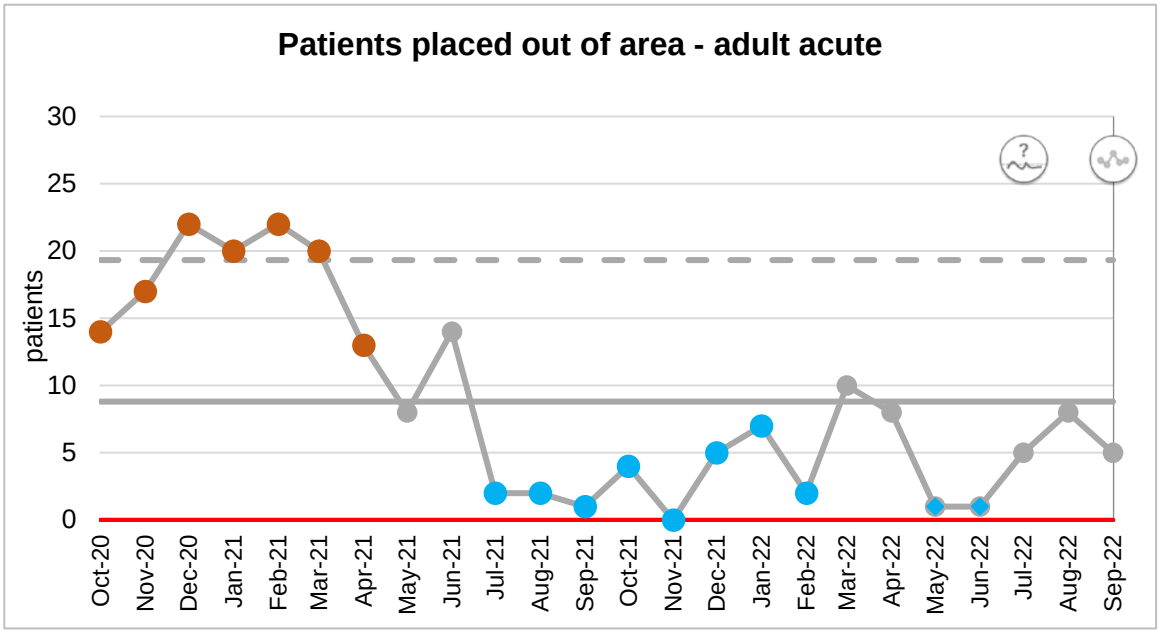
Currently we have one patient in an inappropriate out of area acute bed. During September the exit strategy from the Mill Lodge contract has been worked on. This has been successful, and the 11 block contract beds will be exited from 1st October. There is one remaining patient at Mill Lodge. The placement is being funded on a spot purchase basis and the patient is expected to be discharged on 7 October 2022.

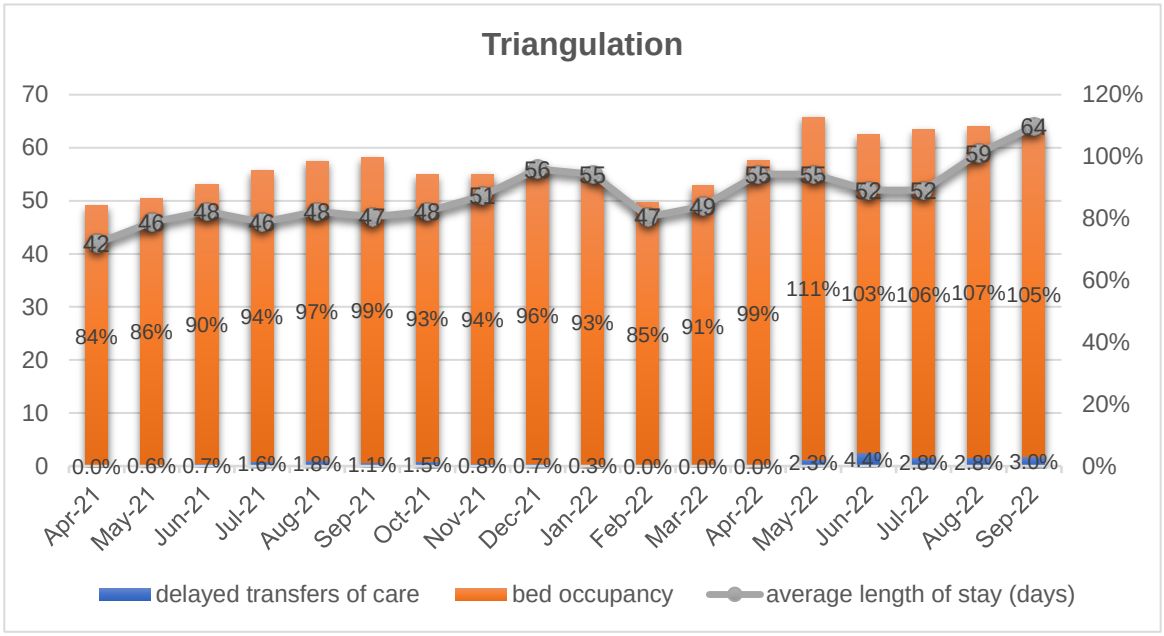
The inappropriate out of area adult acute patient is on a pathway to repatriate them to a Derbyshire bed, however at the moment repatriation is not possible owing to pressures elsewhere. University Hospitals of Derby & Burton and Chesterfield Royal Hospital are both declaring critical incidents and struggling to cope. Therefore, any requests received from these organisations for beds are our highest priority to ensure system flow.

There has been an increase in patients with Covid-19, rising to 14 today. This is likely to have an impact on capacity, as in the past an increase in COVID-19 has resulted in beds being closed owing to our reliance on dormitory accommodation.

Further work on flow is required, including supporting the reduction of people clinically ready for discharge who remain on wards for extended periods of time, including some delayed in the LDA cohort. A new internal acute transformational delivery board will be established (terms of reference in draft) which will aim to bring together improvement and transformation workstreams to enable further improvements in flow.

8b. Patients placed out of area per month – adult acute

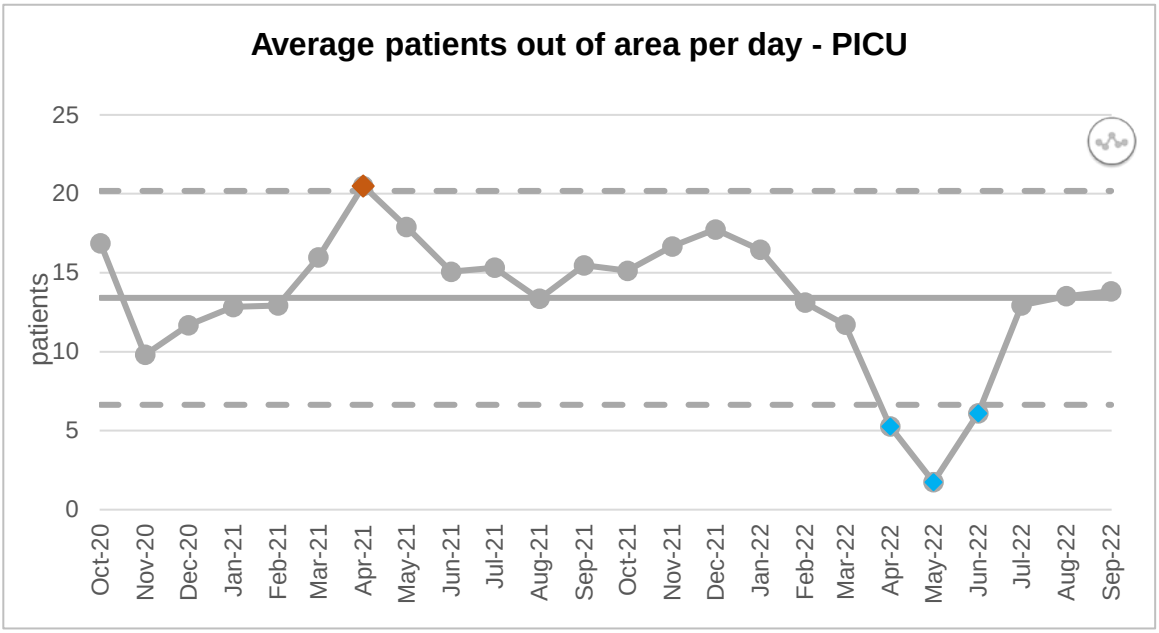




The level of inappropriate out of area acute placements is also being impacted upon by high levels of bed occupancy, delayed transfers of care and above average length of stay. In recent months there has been an increase in delayed transfers of care, and bed occupancy has exceeded 100%. This is where patients have returned home for a period of trial home leave and their beds have been occupied by new admissions. From queueing theory, to enable flow of patients through the system the Trust's adult acute bed occupancy level should not exceed 85% (the Erlang equation)[1].

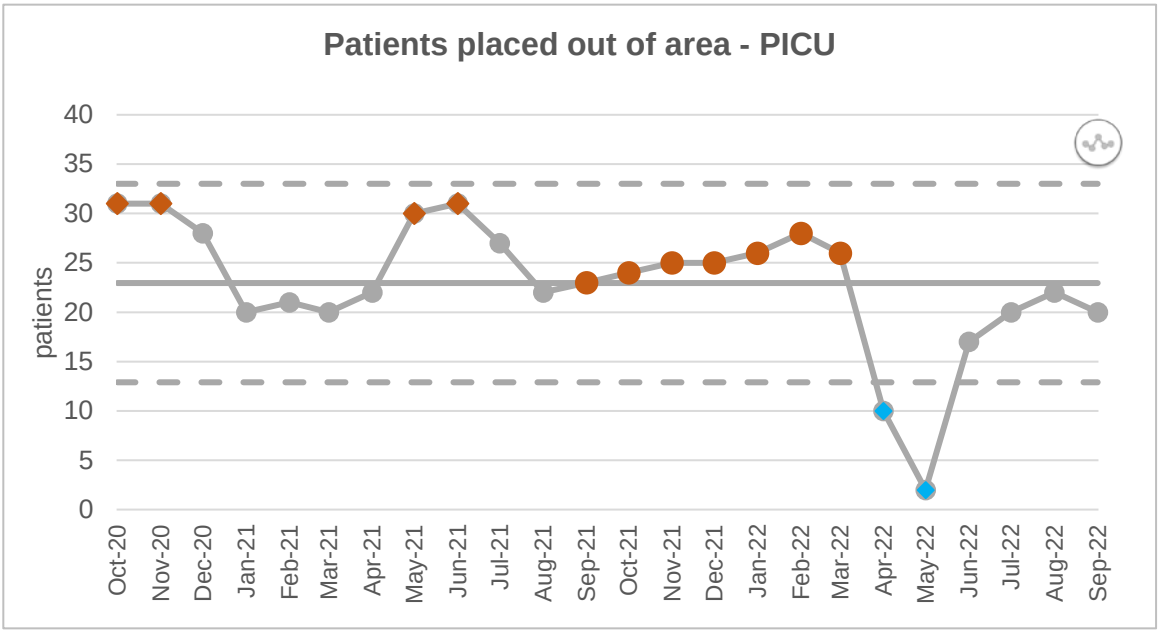
[1] Jones R (2013) Optimum bed occupancy in psychiatric hospitals. Psychiatry On-line http://www.priory.com/psychiatry/psychiatric_beds.htm

9a. Average number of patients placed out of area per day– Psychiatric Intensive Care Units

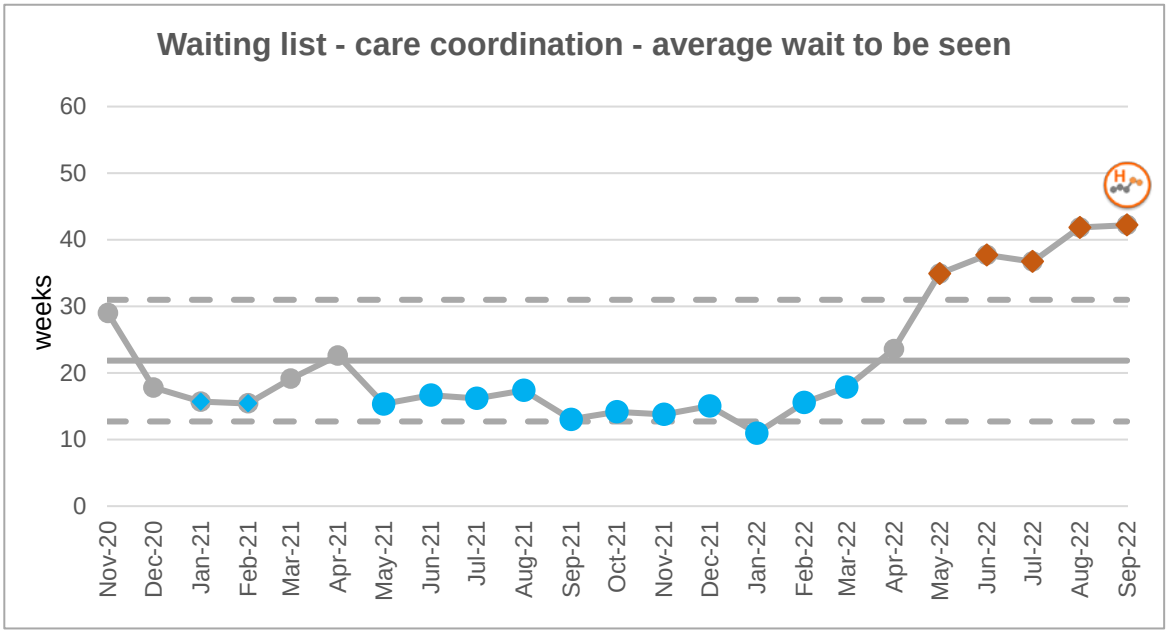


There is no local PICU provision, so anyone needing psychiatric intensive care needs to be placed out of area, however, work continues on the provision of a new build PICU in Derbyshire. NHS Improvement continuity of care principles have been established with 2 PICU providers - Northamptonshire Healthcare NHS Foundation Trust and Elysium - as agreed in partnership with Derbyshire Urgent Care Steering Board. Trusts are required to submit a snapshot every month of the number of patients placed out of area at month end. The Trust's position for inappropriate out of area PICU placements at month end over the last few months was as follows: May 23, June 25, July 7, August 14, and September 6.

9b. Patients placed out of area per month – Psychiatric Intensive Care Units (PICU)

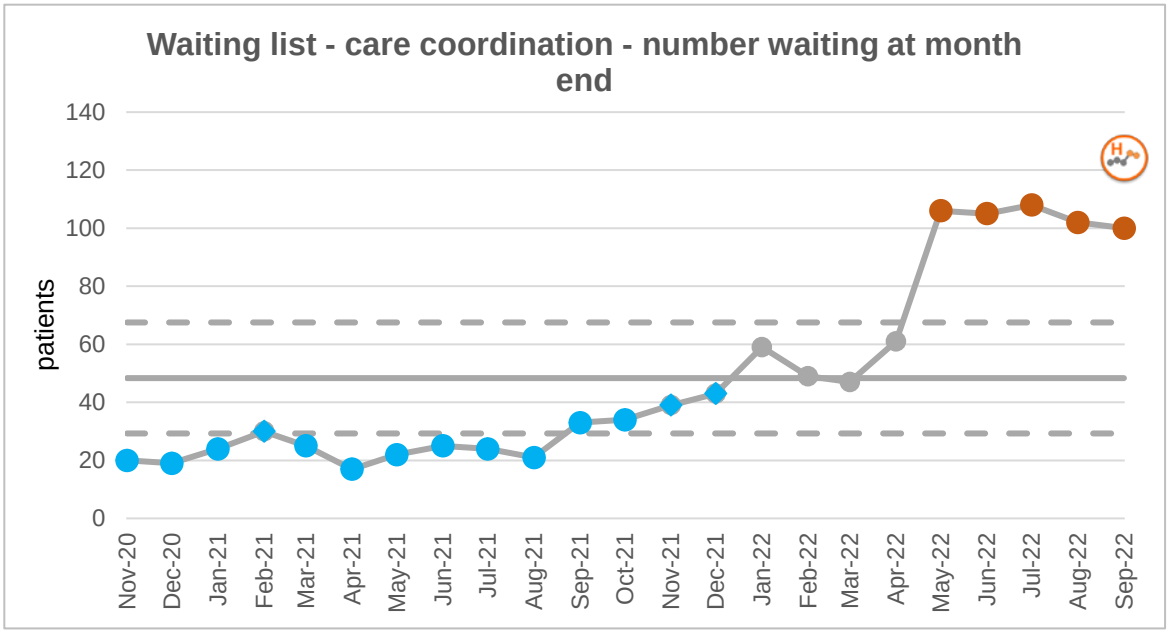


10a. Waiting list for care coordination – average wait



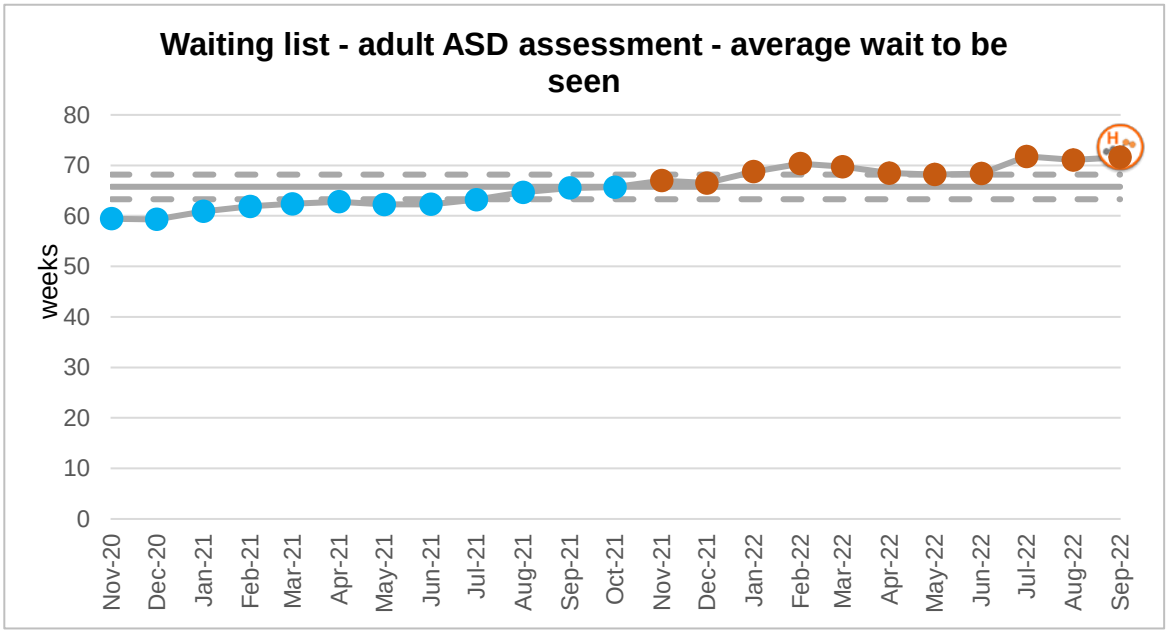
The significant increase in waiting times coincides with the transition to SystmOne. A large piece of work is in progress to improve people's understanding of how to use the new system properly and update and correct records in line with the numerous standard operating procedures, which should result in an improvement to data quality and enable data optimisation.

10b. Waiting list for care coordination – number waiting



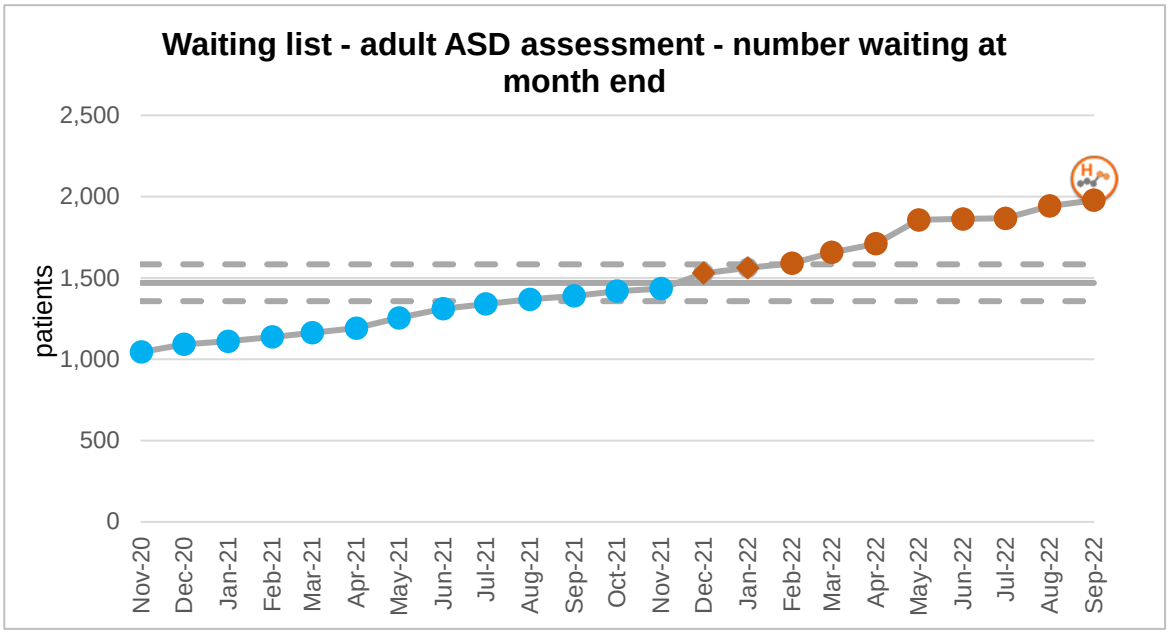
The significant increase in numbers waiting coincides with the transition to SystmOne. A large piece of work is in progress to improve people's understanding of how to use the new system properly and update and correct records in line with the numerous standard operating procedures, which should result in an improvement to data quality and enable data optimisation.

11a. Waiting list for adult autistic spectrum disorder (ASD) assessment – average wait

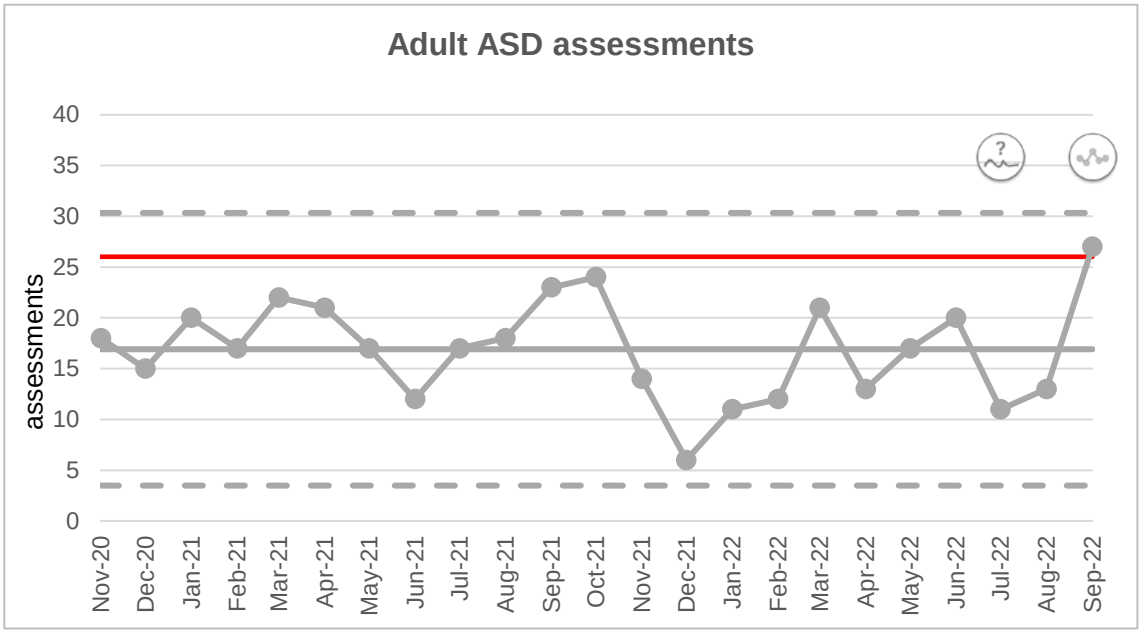


Demand for the service continues to outstrip capacity (commissioned to undertake 26 per month but currently receiving referrals 86 per month this financial year to date). However, in September for the first time in 3 years the number of assessments completed exceeded the commissioned number at 28. At the end of September 2022 there were 1,970 adults waiting for adult ASD assessment, which is an increase of 32 on the previous month. A revised approach to waiting list management is being mobilised and should start to have an impact from quarter 4.

11b. Waiting list for adult autistic spectrum disorder assessment – number waiting

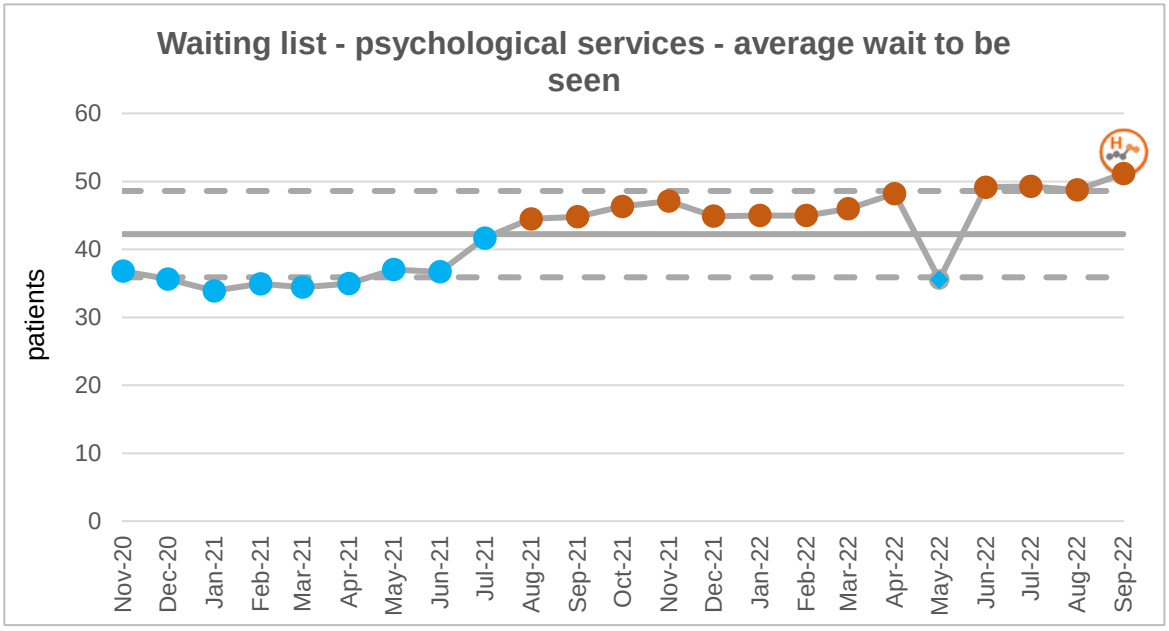


11c. Adult autistic spectrum disorder assessments per month



Improvements in performances have been due to action plans to bring together two specialist teams into one (SAT and ASD assessment), providing a more flexible team to take on the range of tasks. To continue to support improvements, the services is undertaking a recruitment drive for the 9 vacant posts currently out to advert, and are increasing the number of people able to diagnose through ASD assessment training to up to 25 trust staff (mainly psychologists & nurses) across all CMHTs. Further funding to support ADHD assessment model will be used flexibly to support across neurodevelopmental diagnostic needs and includes VCSE posts to go out shortly to ensure waiting well and post-diagnostic aftercare. A Recovery Action Plan is being developed and will be monitored via a waitlist improvement function at TOOL.

12a. Waiting list for psychological services – average wait

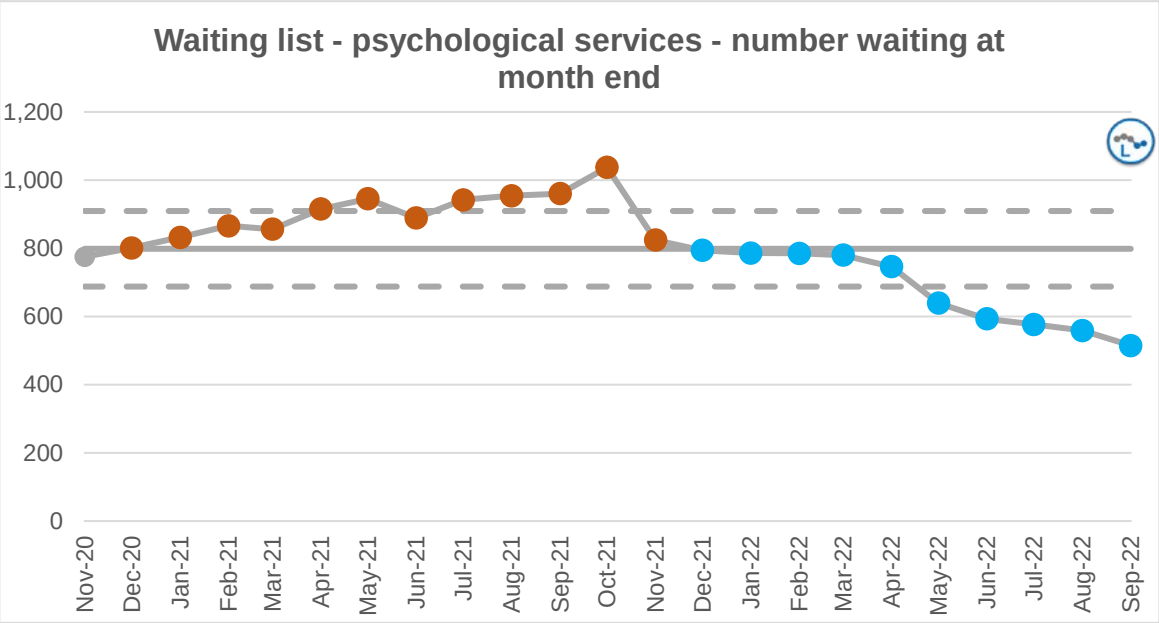


At the end of last month, 565 people across Derbyshire were waiting to be seen by psychological services with an average wait time of 325 days. Many patients are still waiting owing to the pandemic and a personal preference to be seen face to face as opposed to by video call. There is a further impact due to vacant posts as we continue to struggle to recruit qualified staff.

The waiting list is, however, hugely variable according to team and service. The areas with the greatest wait time are Amber Valley, Bolsover, Killamarsh, South Dales and the City adult services, where the wait is up to 3 years (Amber Valley). This is largely due to vacancies, and we are therefore focusing recruitment and other efforts on the hard to fill vacancies across these areas, as well as asking others to input into these areas where they can.

A revised approach to waiting list management is being mobilised and should start to have an impact from quarter 4.

12b. Waiting list for psychological services – number waiting



Over the last 12 months, the number of people waiting has continued to gradually reduce and the reduction is statistically significant. Although this is the correct trajectory, there is clearly more to be done. As mentioned above, one of the pockets of challenge where the waiting times are above the average are the city teams. The new psychological therapies website and recruitment drive has indeed led to some positive results in recruitment and at least 4 staff over the last 6 weeks have been recruited through this drive. However, none are for the city teams.

Working to Place will in the longer term alleviate some of these waiting times as population health statistics will be used to guide needs and therefore required responses and resources.

We have recruited assistant psychologists to deliver some of the more general psychological components and we have expanded the roles to include counselling psychologists and cognitive behavioural therapy (CBT) therapists within working age adult teams. Those adverts are currently live and aim to fill the gap.

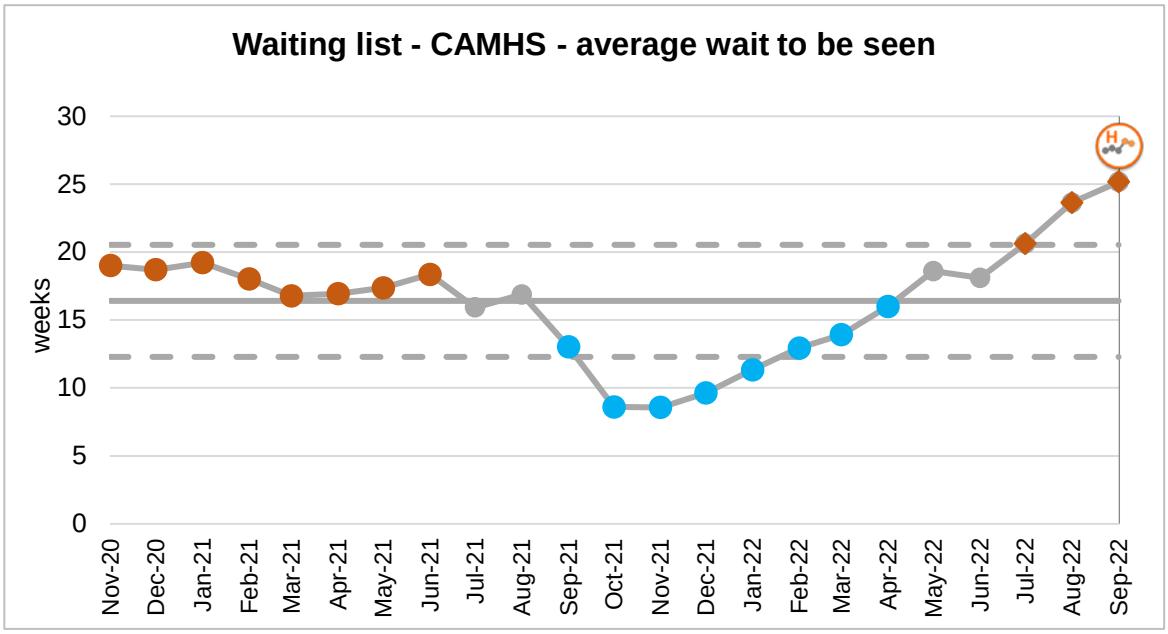
There remains a national shortage of qualified psychologists, with all Trusts struggling to recruit. We currently have less vacancies in psychological services than our regional colleagues. This position is unlikely to change until 2025 when those new places commissioned by Health Education England (HEE) for training output qualified staff. In the meantime, we are utilising other roles (as above) to try and plug our gap in delivery of psychological care.

We continue to build some psychological knowledge and capacity in our nursing, occupational therapy, and medical colleagues through use of HEE monies for training, as well as development and delivery of a range of inhouse training. Longer term it is hoped this will reduce the referrals to specialist psychological services.

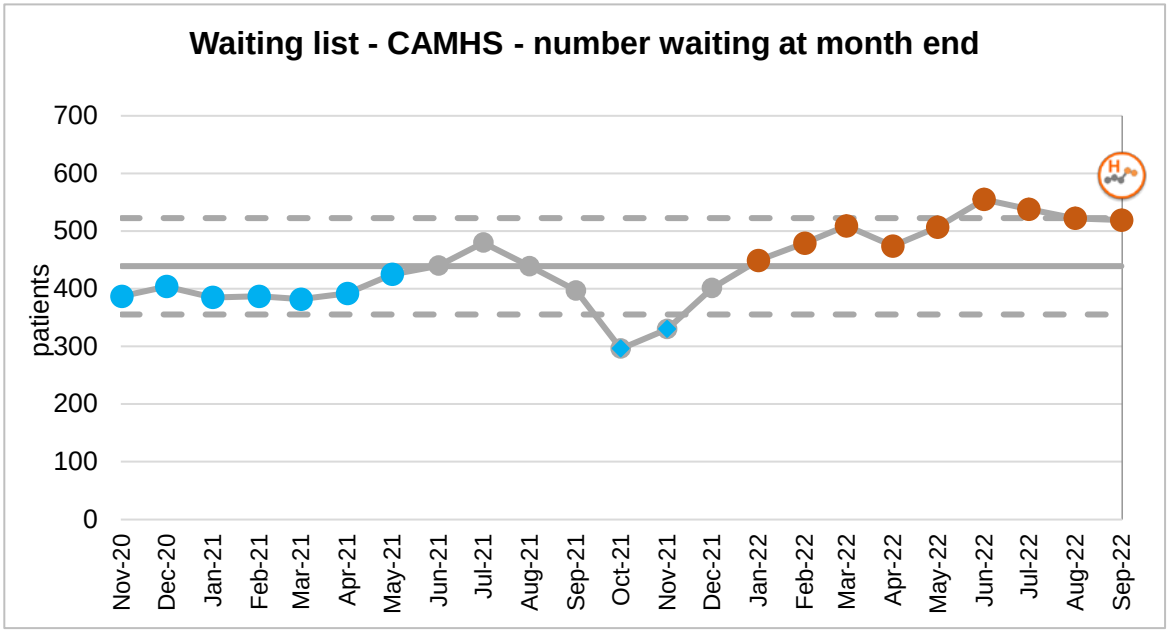
We continue to review the waiting lists in line with trauma sensitive working in considering how we manage people on a waiting list, and we are developing a new waiting well guide for those service users. Barriers of movement between services remain high priority to remove. This work continues to develop as the Living Well transformation takes place.

As previously reported, we are reviewing the structure of psychological service to create a division to try and better utilise the skills we have in supporting people across the Derbyshire landscape and making sure it is sustainable for the future. We are waiting for guidance as to when we can progress this. Having a division will also mean that data can be more accurately analysed.

13a. Waiting list for Child and Adolescent Mental Health Services (CAMHS) – average wait



13b. Waiting list for Child and Adolescent Mental Health Services – number waiting



CAMHS continue to receive a high volume of referrals through the routine and urgent care pathways. As previously stated, workforce challenges, increased complexity of presentations and reduced community services for additional support have resulted in the CAMHS external waiting list increasing by 10% per quarter. The decision was made in August to focus on urgent/priority

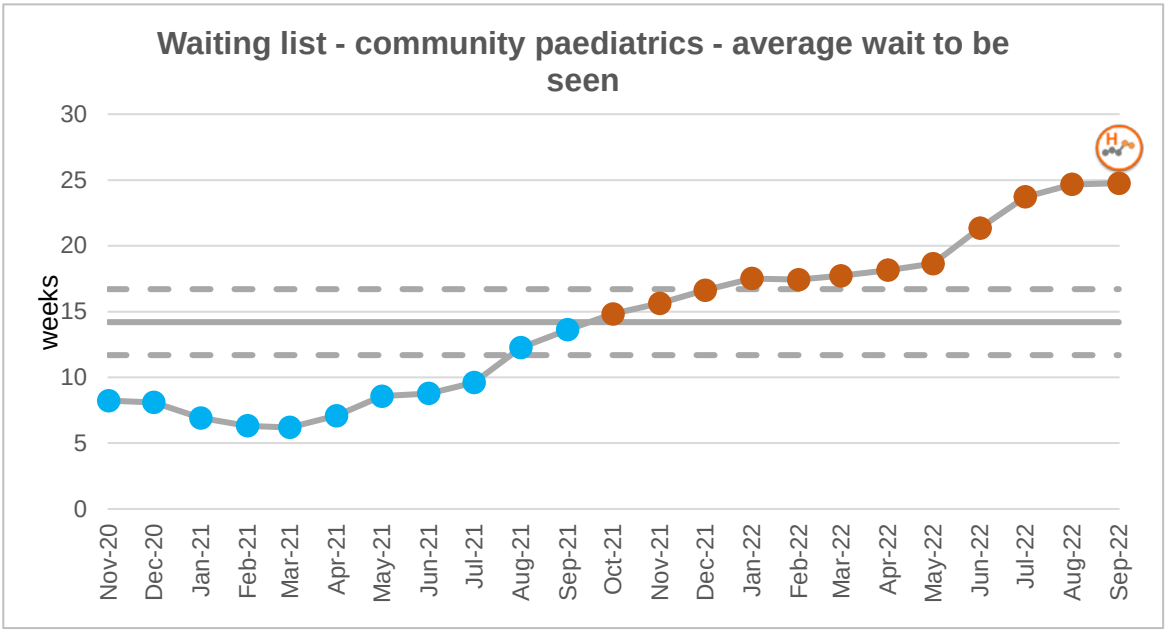
assessments, and all internal unallocated cases, with staff moving temporarily for 3 months into locality teams where they have a team manager, senior colleagues and a consultant to provide operational and clinical oversight of all patients waiting and open for the allocated geographical patch. This provides assurance that all children requiring an urgent assessment are being prioritised, in addition to those children accessing Children's Emergency Department. We are also continuing to prioritise cases open to the service with no allocated worker. Processes continue to be in place to manage the waiting list in accordance with the waiting well policy.

The Area Service Manager will be submitting a paper to the Clinical and Operational Oversight Team Meeting (COAT) in November around the CAMHS waiting list and proposed models for the future, to the Trust Operational Oversight Leadership Team (TOOL).

This issue of high demand for the service has been raised via Joined Up Care Derbyshire and is on the Integrated Care Board (ICB) risk register, and a system meeting is to be held in the next week or so, specifically around support for waiting lists, county wide (so including Chesterfield Royal Hospital CAMHS).

A revised approach to waiting list management is being mobilised and should start to have an impact from quarter 4.

14a. Waiting list for community paediatrics – average wait



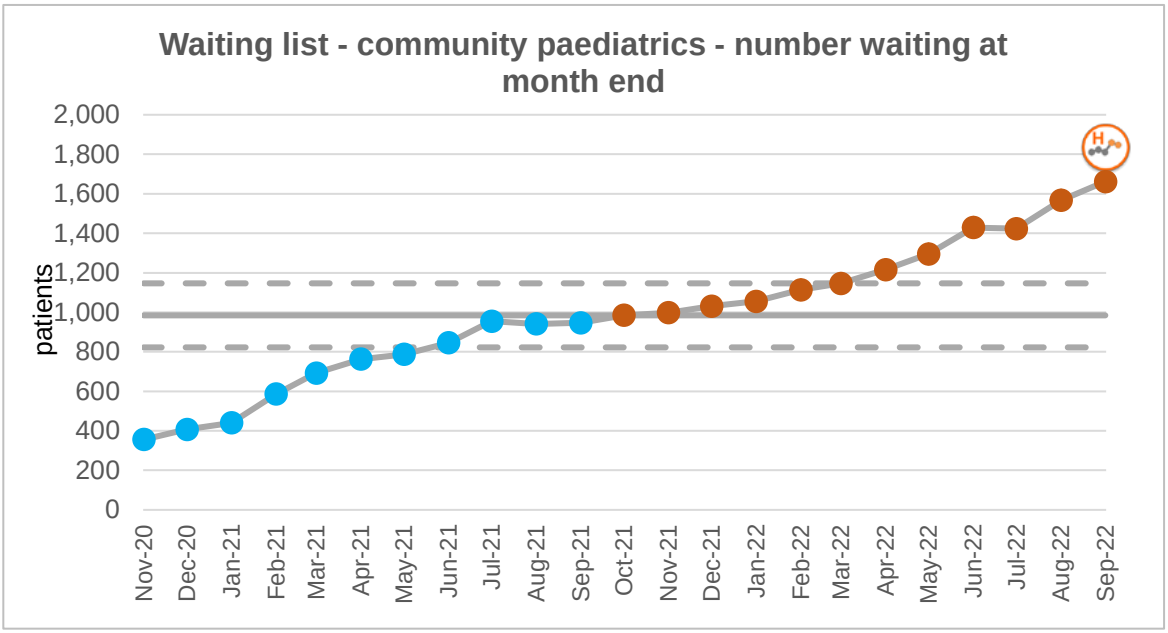
We continue to see a steady rise in waiting times for referral to treatment in community paediatrics with over 1,600 children now waiting. The longest wait time is now in excess of 62 weeks and currently sits on the risk register as a high risk. We are still carrying a vacancy: although we successfully recruited in the summer, we also lost one of our experienced Paediatricians to another trust citing work/life balance as a reason. We also have another Paediatrician retiring in March 2023 who is returning on 4 PA's which is a reduction of her current substantive post and on call requirements.

Sickness absences are now sitting at 30% which continues to have an impact on clinics and overall wellbeing. Health issues will continue to impact on the availability of new appointment and follow-up clinic slots. Sickness is a combination of long-term and short-term absences. We hope that some of the long-term absences will end over the coming months and before the end of the year. We have a regular locum in post and a further locum request to support the Neuro-disability pathway is also approved, but not yet filled.

We have successfully appointed to the substantive Specialty Doctor post, with a proposal to increase Specialty Doctors further both as a development opportunity and to support the Adoption being considered.

A revised approach to waiting list management is being mobilised and should start to have an impact from quarter 4.

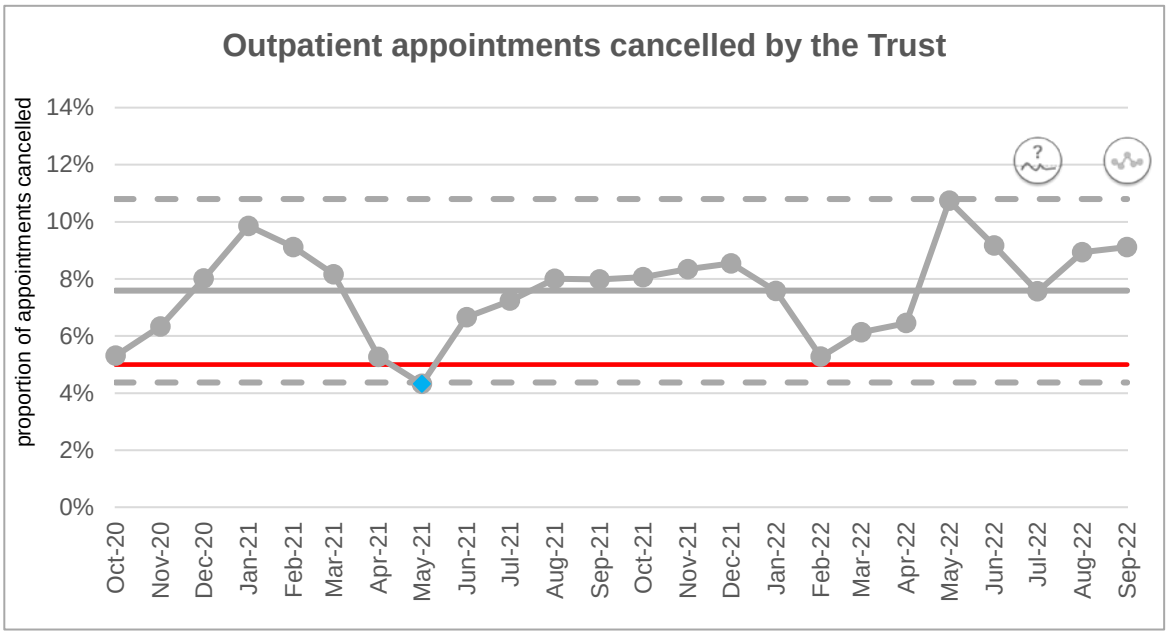
14b. Waiting list for community paediatrics – number waiting



The neuro-developmental pathway development is ongoing. The business case includes a second fixed term Speciality Doctor to focus on the autistic spectrum disorder pathway. Securing these posts will have an impact on the waiting list. This is a really positive development for the service line. We await final Integrated Care Board approval for the investment requested this month.

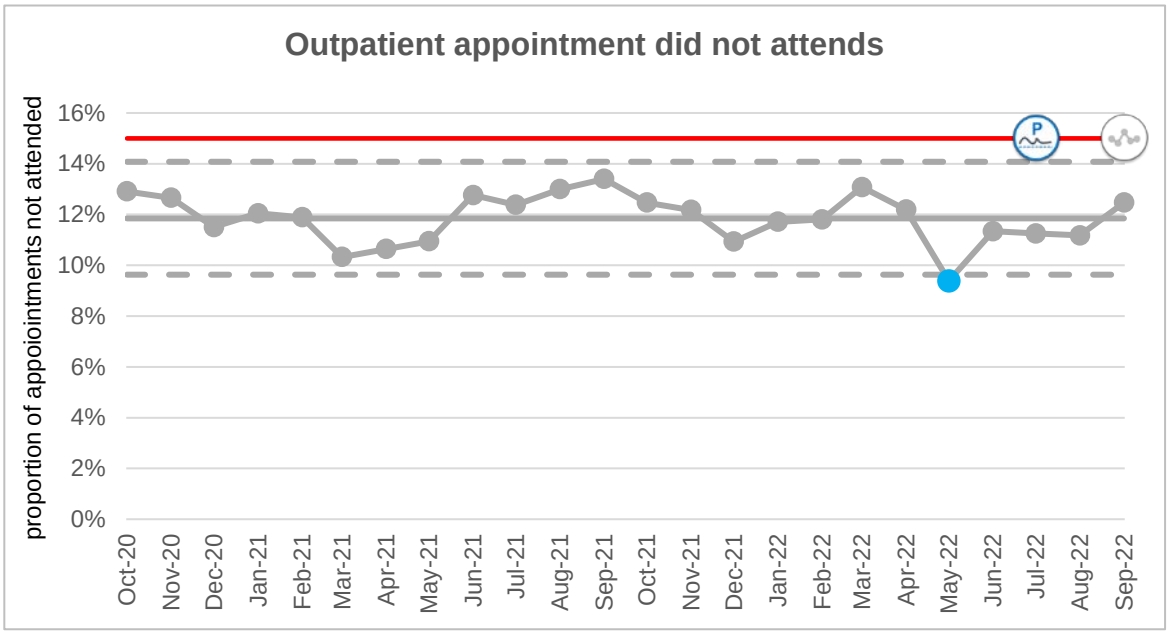
We recognise that flow is an issue for the service and are working to review the Core offer and what we could do differently to help manage the increasing waiting list, with an initial review of the single point of access and a working group being set up to look at this. Plans to further review the whole medical structure continue: what is working well, where the gaps are and where we need more support. Review of the referral pathways and website is ongoing. We hope to improve the experience for children, families, carers, and professionals who access our services.

15. Outpatient appointments cancelled by the Trust



The level of cancellations has been within common cause variation for most of the time.

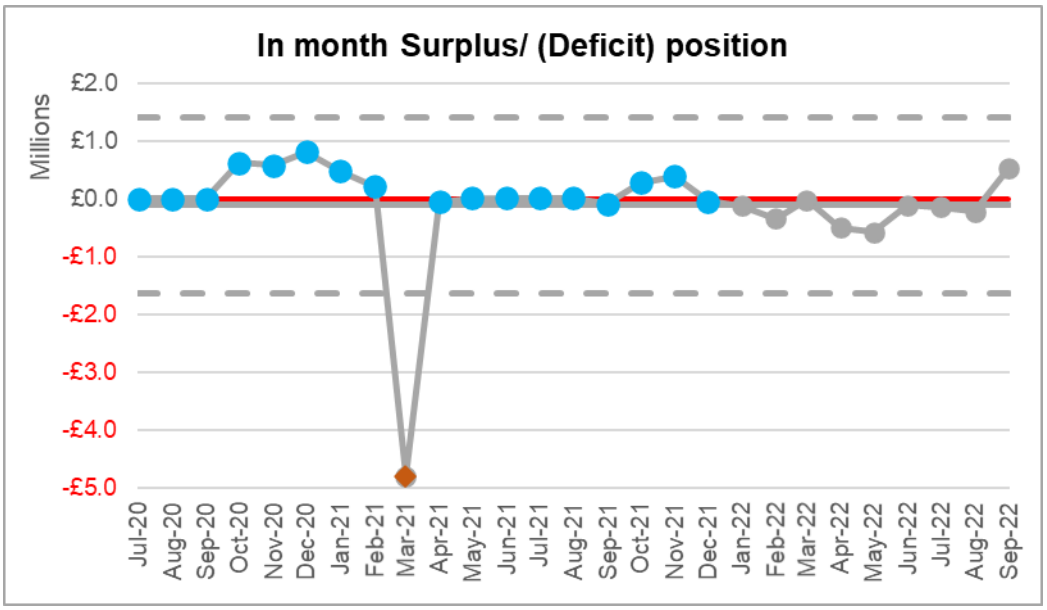
16. Outpatient appointment did not attends



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

Finance

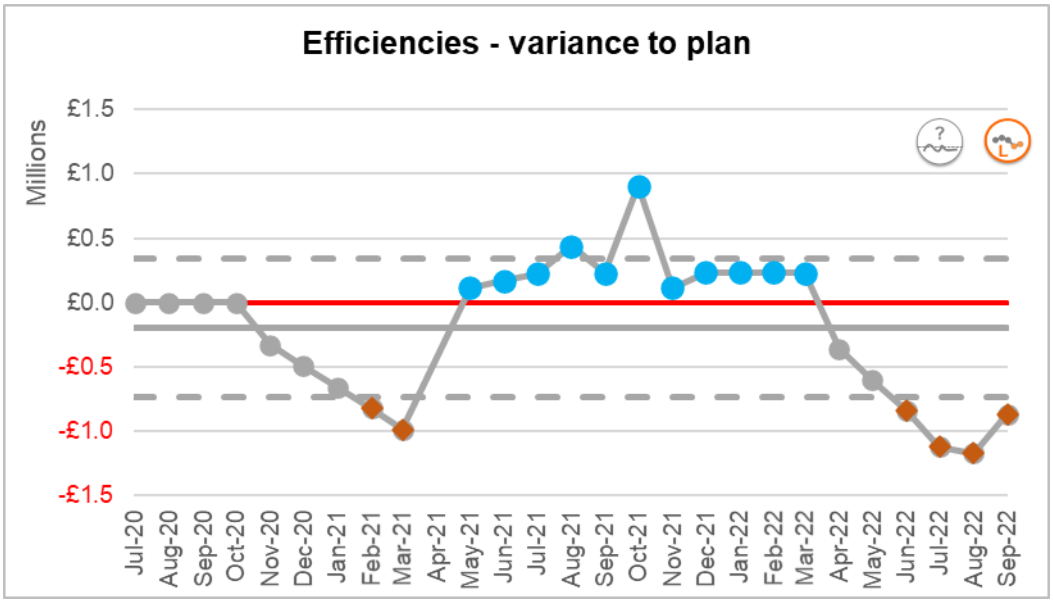
Overall Financial Position



At the end of September, the overall year to date (YTD) position is a deficit of £1.0m compared to the plan deficit of £0.8m, an adverse variance to plan of £0.2m. The main driver for the YTD adverse variance to plan is related to the undelivered CIP which is being slightly offset by some additional income. The forecast remains a breakeven position as per the plan.

However, there are significant areas of risk in and outside of that plan driven by the planning assumptions that have been followed, such as the delivery of the required 3% efficiencies, Agency expenditure and reducing the risk around the containment of Covid costs, which are all shown below. Whilst the full requirement for efficiencies has now been identified the majority of the schemes are non-recurrent and there is need to take action to ensure the costs are reduced to match the planned delivery.

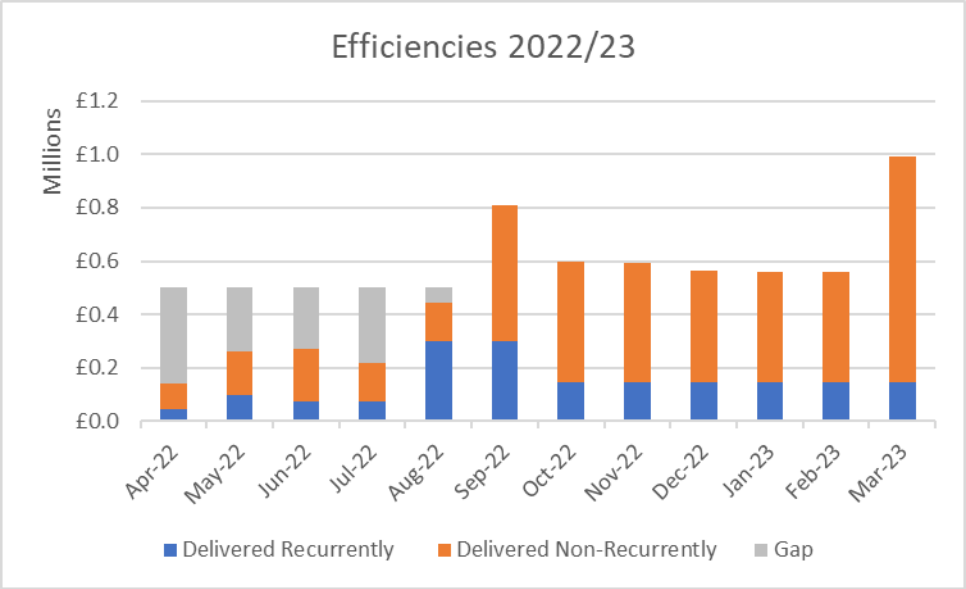
Efficiencies



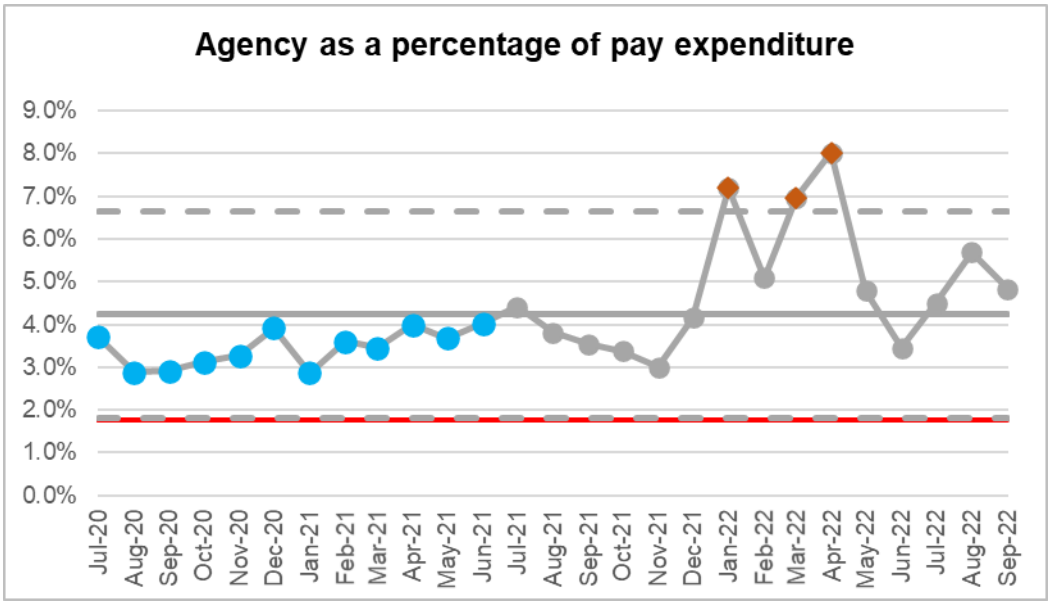
The full year plan includes an efficiency requirement of £6.0m phased equally across the financial year. At the end of September £2.1m had been transacted in the ledger leaving a gap to delivery of £0.9m YTD. This has been an improvement in month with the new schemes being transacted with a catch up. There has been a particular focus on actions

required to close the remaining efficiency gap which is required to achieve the overall breakeven plan. This has now been achieved and full plans have been developed. However, a significant proportion of the efficiencies are non-recurrent in nature 70%.

The table below shows that the new schemes that have been identified will be transacted in the second half of the financial year.



Temporary Staffing

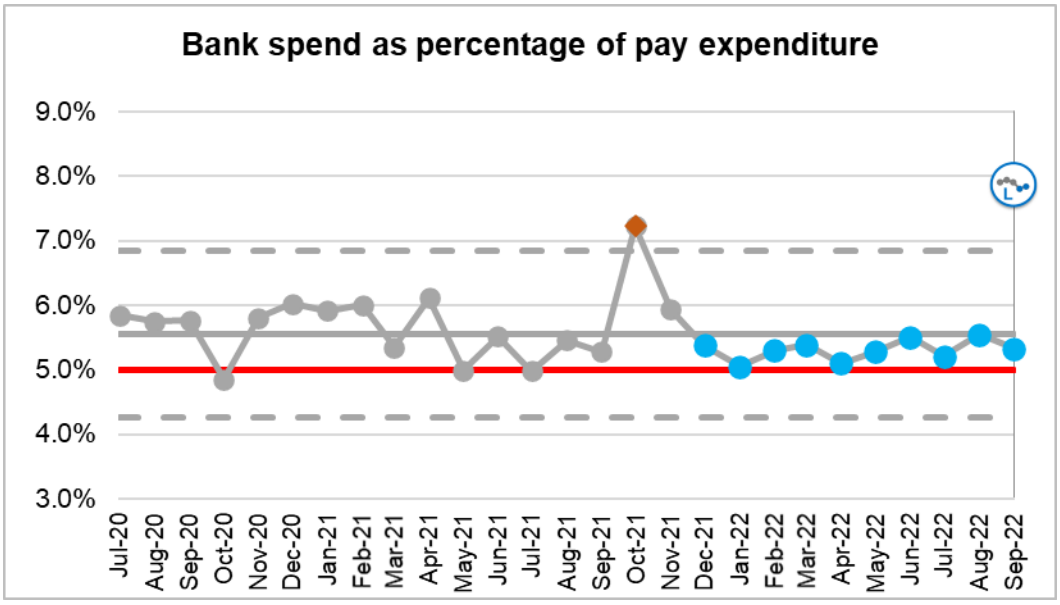


Agency expenditure year to date (YTD) totals £3.7m against a plan of £1.3m, an adverse variance to plan of £2.4m. The two highest areas of agency usage relate to Consultants mainly in CAMHS and Nursing staff on the wards. Agency expenditure did reduce significantly in June to £0.4m but increased in July to £0.5m and increased again in August and September to £0.6m.

Agency expenditure as a percentage of pay did reduce in September but that is driven by the increase in pay expenditure related to the backdated pay award being paid in September.

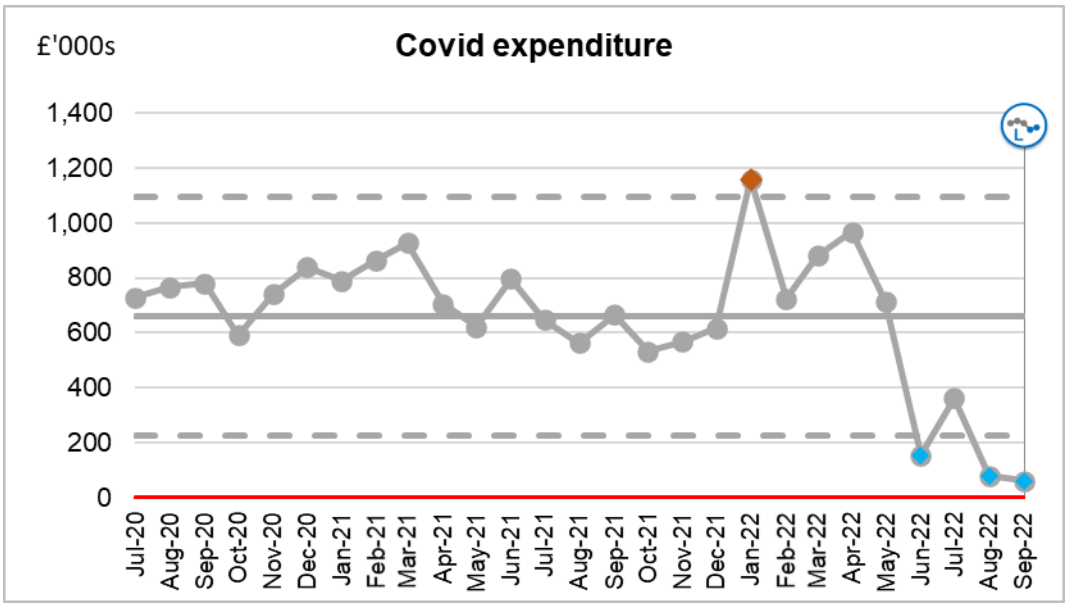
NHSE have confirmed that tighter agency controls will be introduced from September covering the following:

- establishing agency expenditure limits at system level with the JUCD limit confirmed at £22.462m
- reintroducing agency staffing performance and monitoring within the NHS Oversight Framework
- monitoring performance against existing requirements on agency shifts through on-framework providers and within national capped rates, allowing for existing 'break glass' rules
- implementing toolkits and resources to help systems and providers to better utilise substantive and bank staff.



Bank staff expenditure YTD totals £3.8m against a plan of £3.5m with average spend of £0.6 per month, except for October 2021 where that increased to £0.8m. The main areas of bank spend relates to Nursing on the wards along with Domestics.

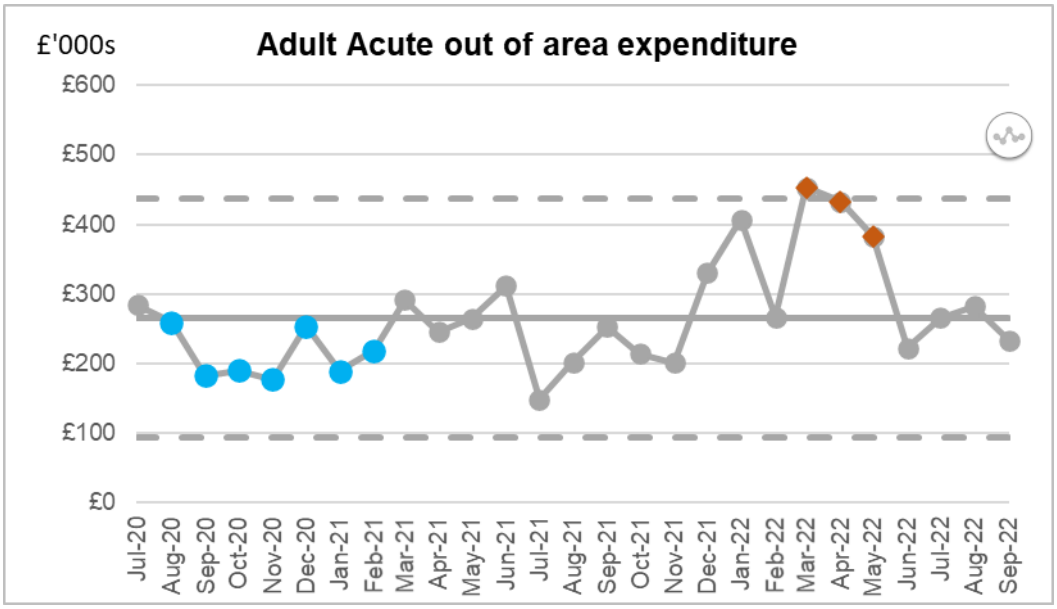
Covid costs



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

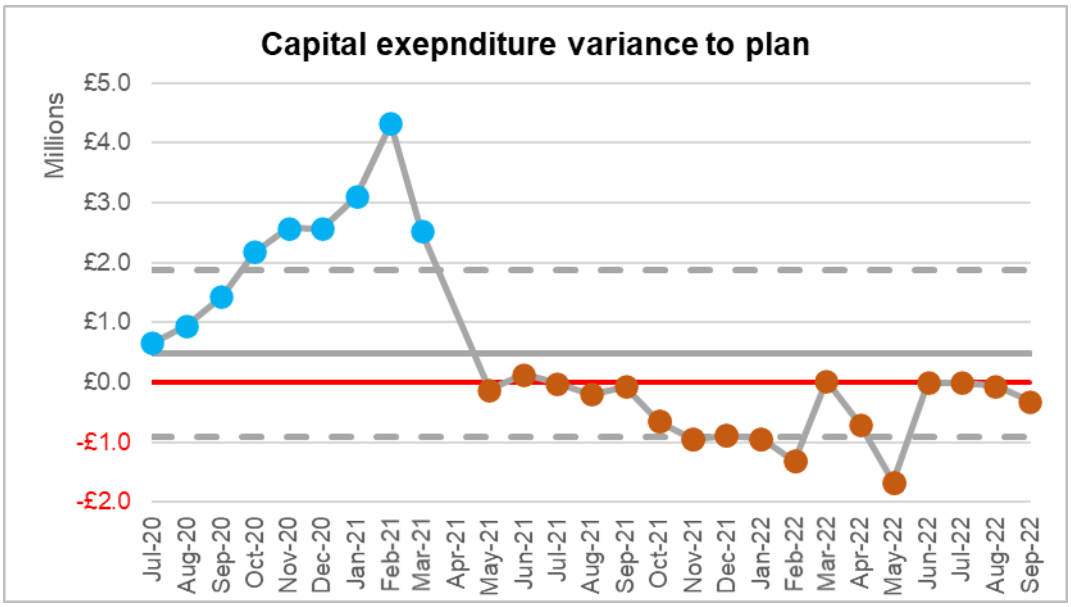
The above chart shows that expenditure has been reducing throughout this financial year with expenditure in August and September significantly lower than in previous months.

Out of Area Placements



Expenditure for adult acute out of area placements including block purchased beds and cost per case beds has started to reduce compared to previous levels. YTD £1.8m has been spent on placements. The forecast assumes that expenditure levels will continue to reduce following the end of the block contract for 11 beds at the end of September.

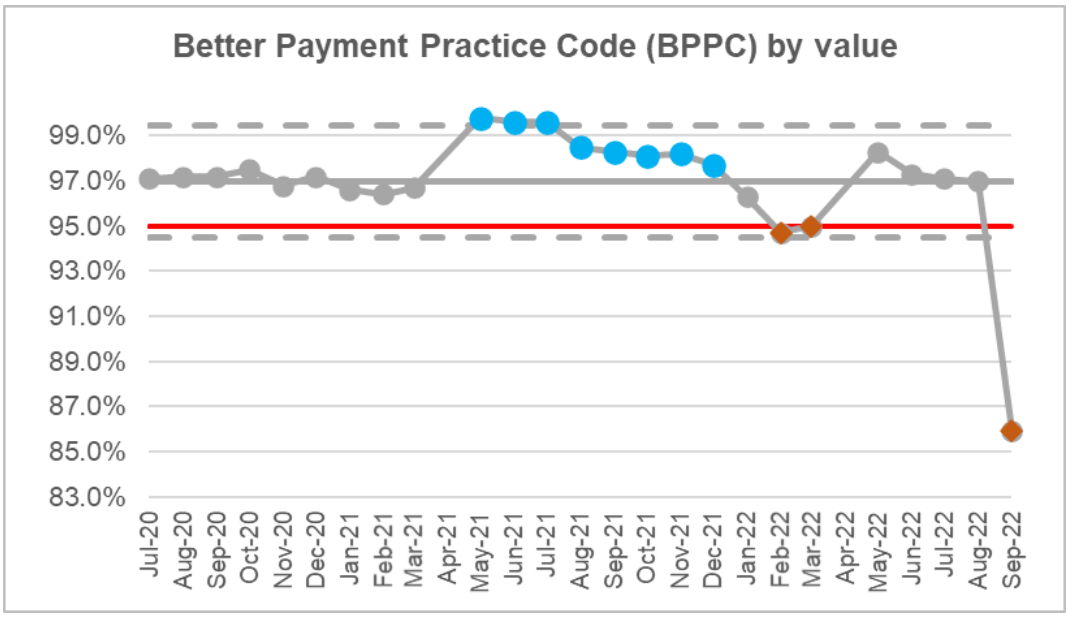
Capital Expenditure

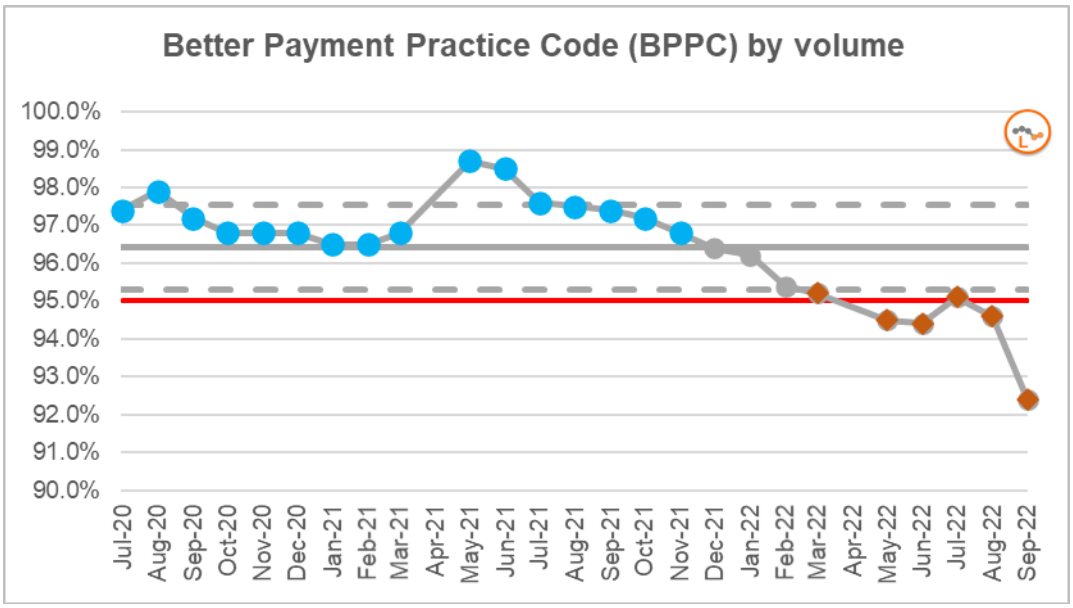


Capital expenditure was showing behind plan in April and May, however that was against the April plan submission. The capital plan was resubmitted in June which changed the capital system allocation to reflect the requirement of the self-funded elements of the Making Room for Dignity project.

Capital expenditure is slightly behind plan YTD but is forecast to achieve full planned spend by the end of the financial year.

Better Payment Practice Code (BPPC)



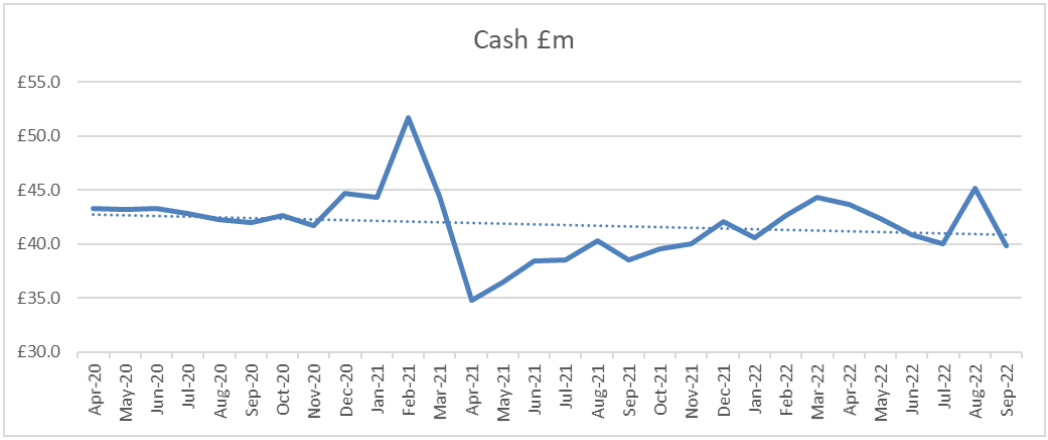


The Better Payment Practice Code sets a target for 95% of all invoices to be paid within 30 days. BPPC is measured across both invoice value and volume of invoices.
At the end of September Non-NHS invoices were slightly below target for volume at 93.0% and exceeded the target by value at 97.4%. However, NHS invoices were below target for volume at 79.7% and below the target by value at 69.2%. This has been driven by 3 months of Pharmacy related invoices which were being accrued and have now been paid.

Cash

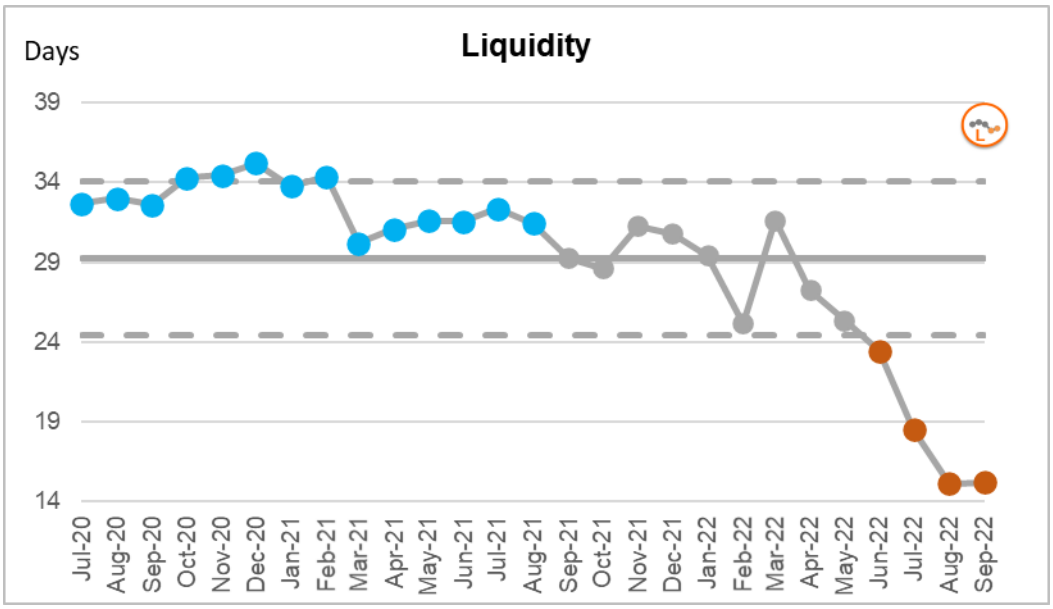
The chart below shows the levels of cash over the last two years. It is important to remember that in April 2020 CCGs paid the block contract amounts in advance, so 2 months were received in April 2020 and then no payment in March 2021 which brought the cash back down to the same level in March 2020. During 2021/22 cash slowly increased, however due to the deficits in each month since April 2022 this has driven the reduction in cash.

At the end of September cash is currently at £40m which is above plan by £13m. September's levels reduced as expected due to some high payment runs due to catch up payments related to Pharmacy invoices and SLA invoices following agreement of inflationary increases, along with the usual Public Dividend Capital (PDC) half year payment.



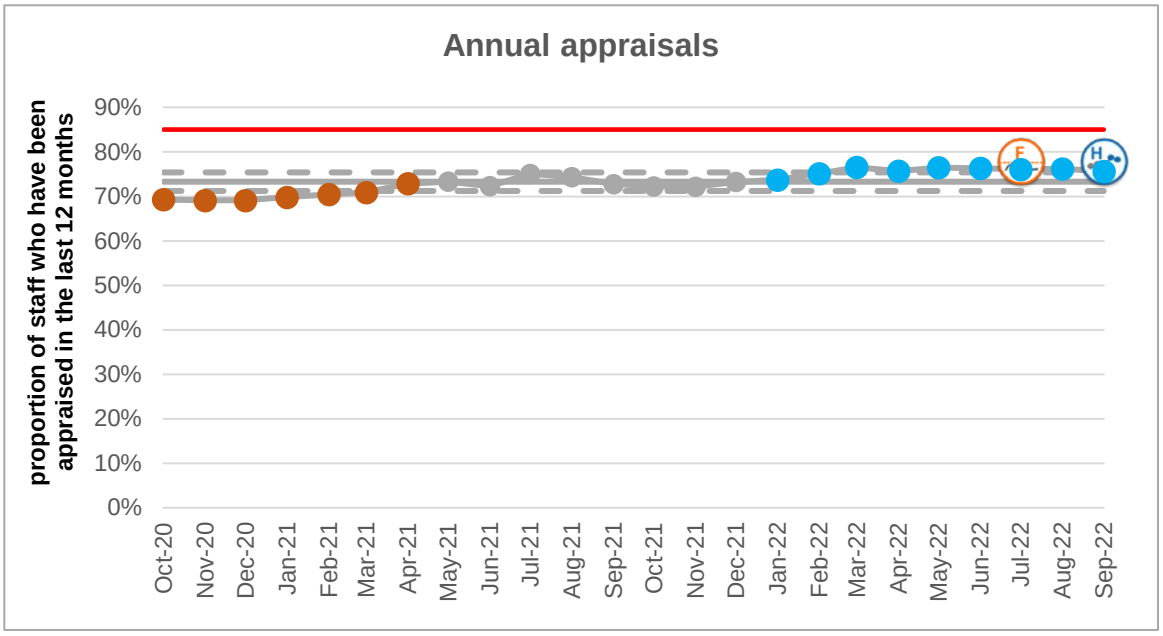
Liquidity

The chart below shows the liquidity levels over the last two years. Liquidity levels were high in 2020/21 and have started to reduce during 2021/22, which is due to two main factors, not making a surplus and the level of capital expenditure being above depreciation levels. The reason for the downturn in 2022/23 is due to deficit position each month and the timing of cash receipts related to the centrally funded capital schemes for the eradication of dorms. The PDC forms are due to be completed at the end of quarter 2. If the cash had been received, then the position would be around 30 days. Moving forward as construction costs increase the drawdown of funding will need to be completed on a monthly basis



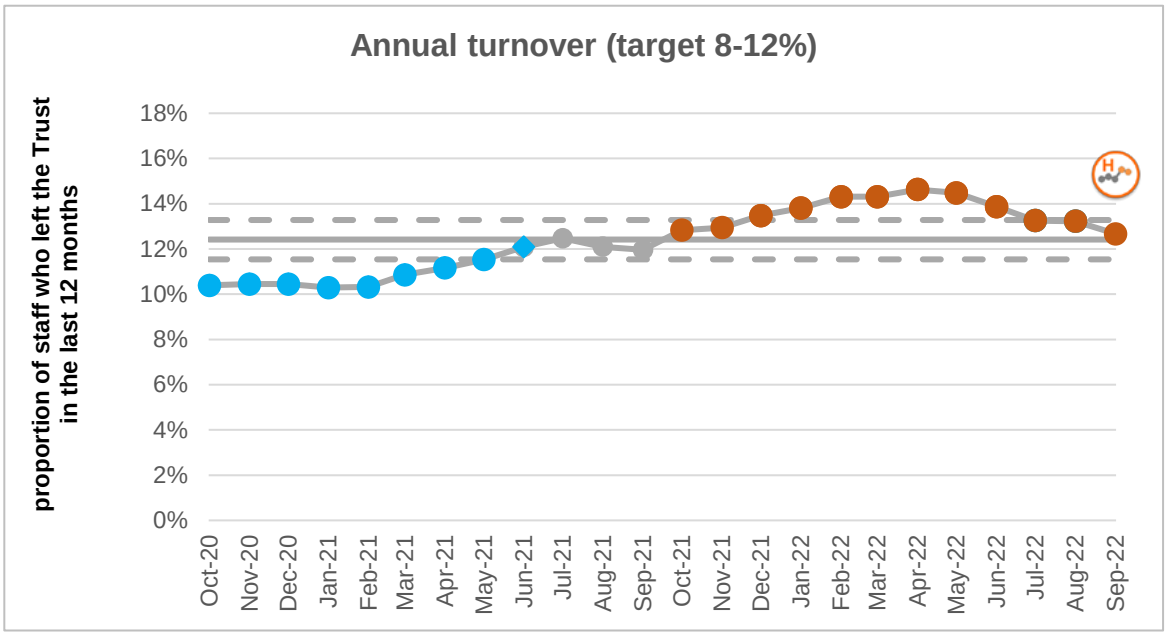
People

17. Annual appraisals



Appraisal levels continue to be below our expectations with Operational Services currently at 82% and Corporate Services at 49%. There is however a significant improvement over the last 9 months. Focused work on understanding why appraisals remain low has been taking place through September at divisional and team level. As a result, there has been feedback that more appraisals have been completed than recorded due to challenges with inputting on the ESR system. In response to this, there has been increased communication, including how to videos and guides. Compliance continues to be monitored at Divisional Achievement Reviews and via TOOL.

18. Annual turnover

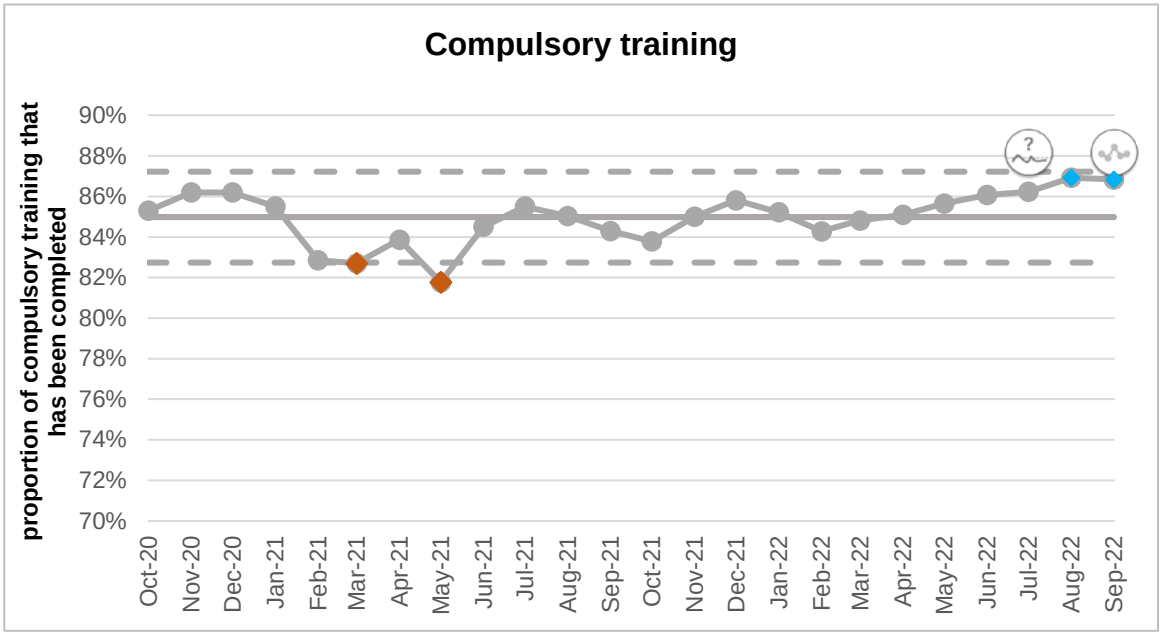


Turnover remains high and above the Trust target range of 8-12%. There has been a small improvement from the previous month with a 0.6% reduction. We have now launched the new exit interview process to ensure we capture a higher percentage of interviews from leavers and learn more about why colleagues are leaving the organisation. The STAY survey has now been rolled out

wider to support actions to take place before colleagues leave the Trust. Nationally, we are achieving some of the highest retention rates. Data released this month, highlight Derbyshire Healthcare NHS Foundation Trust as achieving the lowest leaver rate for any mental health and learning disability trust and in the bottom percentile across all NHS Trusts.

Ranking	Trust code	Trust name	Type	Region	June 22 Leaver Rate
Highest leaver rates (Top 10th Percentile)	RY4	Hertfordshire Community NHS Trust	Community	East of England	18.1%
	RTF	Northumbria Healthcare NHS Foundation Trust	Acute - Large	North East and Yorkshire	13.4%
	RWX	Berkshire Healthcare NHS Foundation Trust	Mental Health and Learning Disability	South East	11.7%
	RHW	Royal Berkshire NHS Foundation Trust	Acute - Large	South East	11.6%
	RJR	Countess of Chester Hospital NHS Foundation Trust	Acute - Small	North West	11.4%
	RA2	Royal Surrey County Hospital NHS Foundation Trust	Acute - Medium	South East	11.1%
	RNU	Oxford Health NHS Foundation Trust	Mental Health and Learning Disability	South East	11.0%
	RVN	Avon and Wiltshire Mental Health Partnership NHS Trust	Mental Health and Learning Disability	South West	11.0%
	RJ8	Cornwall Partnership NHS Foundation Trust	Mental Health and Learning Disability	South West	10.9%
	RVJ	North Bristol NHS Trust	Acute - Large	South West	10.9%
	RPY	The Royal Marsden NHS Foundation Trust	Acute - Specialist	London	10.8%
	RNZ	Salisbury NHS Foundation Trust	Acute - Small	South West	10.6%
	RLQ	Wye Valley NHS Trust	Acute - Small	Midlands	10.4%
	RGM	Royal Papworth Hospital NHS Foundation Trust	Acute - Specialist	East of England	10.2%
	RNS	Northampton General Hospital NHS Trust	Acute - Medium	Midlands	10.0%
	RA7	University Hospitals Bristol and Weston NHS Foundation Trust	Acute - Teaching	South West	9.9%
	RTD	The Newcastle Upon Tyne Hospitals NHS Foundation Trust	Acute - Teaching	North East and Yorkshire	9.7%
	RYJ	Imperial College Healthcare NHS Trust	Acute - Teaching	London	9.7%
Lowest leaver rates (Bottom 10th percentile)	RXE	Rotherham Doncaster and South Humber NHS Foundation Trust	Mental Health and Learning Disability	North East and Yorkshire	7.7%
	RRE	Midlands Partnership NHS Foundation Trust	Mental Health and Learning Disability	Midlands	7.6%
	RXT	Birmingham and Solihull Mental Health NHS Foundation Trust	Mental Health and Learning Disability	Midlands	7.5%
	RX1	Nottingham University Hospitals NHS Trust	Acute - Teaching	Midlands	7.3%
	RHQ	Sheffield Teaching Hospitals NHS Foundation Trust	Acute - Teaching	North East and Yorkshire	7.2%
	RLY	North Staffordshire Combined Healthcare NHS Trust	Mental Health and Learning Disability	Midlands	7.2%
	RWA	Hull University Teaching Hospitals NHS Trust	Acute - Teaching	North East and Yorkshire	7.2%
	RXL	Blackpool Teaching Hospitals NHS Foundation Trust	Acute - Teaching	North West	7.2%
	R0B	South Tyneside and Sunderland NHS Foundation Trust	Acute - Medium	North East and Yorkshire	7.2%
	RX4	Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust	Mental Health and Learning Disability	North East and Yorkshire	7.1%
	RVW	North Tees and Hartlepool NHS Foundation Trust	Acute - Medium	North East and Yorkshire	6.9%
	RXM	Derbyshire Healthcare NHS Foundation Trust	Mental Health and Learning Disability	Midlands	6.8%
	RRF	Wrightington, Wigan and Leigh NHS Foundation Trust	Acute - Medium	North West	6.7%
	RFS	Chesterfield Royal Hospital NHS Foundation Trust	Acute - Small	Midlands	6.7%
	RK5	Sherwood Forest Hospitals NHS Foundation Trust	Acute - Medium	Midlands	6.7%
	RL4	The Royal Wolverhampton NHS Trust	Acute - Large	Midlands	6.3%
	RGP	James Paget University Hospitals NHS Foundation Trust	Acute - Small	East of England	6.3%
	RCU	Sheffield Children's NHS Foundation Trust	Acute - Specialist	North East and Yorkshire	5.4%

19. Compulsory training

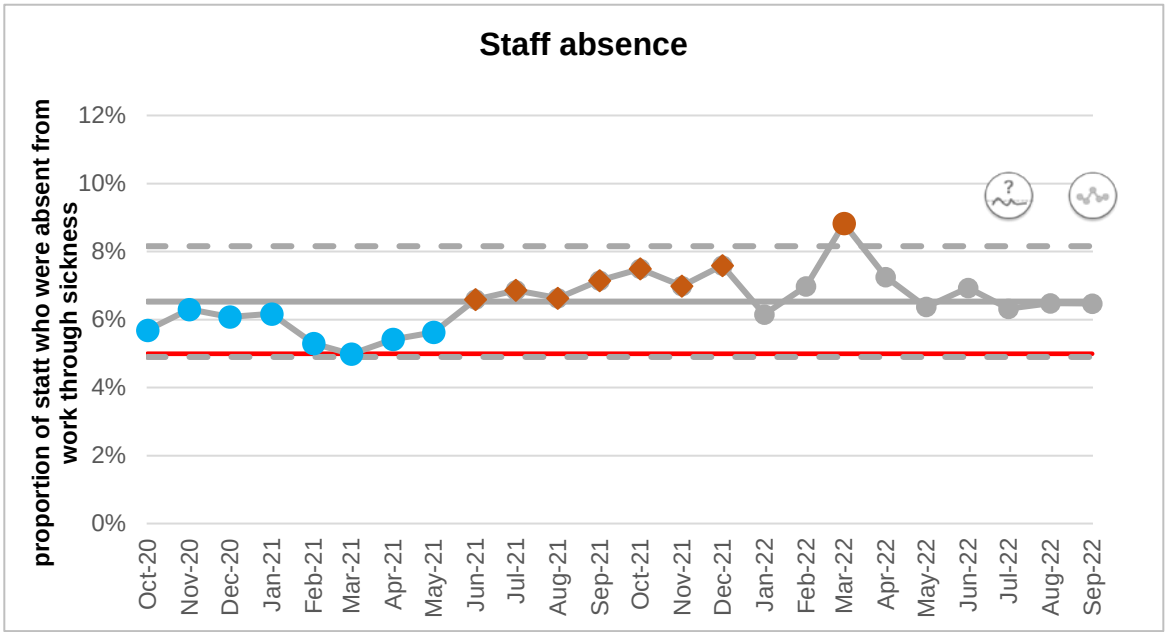


Compulsory training continues to be a key focus and an ongoing recovery position for the Trust. Overall, the 85% target level has been achieved for the last 7 months. Operational Services are currently 89% compliant and Corporate Services slightly lower at 77%.

Immediate Life Support and Positive and Safe training continue to improve, however remain below compliance at 71% and 68% (data as at 10th October). All inpatient colleagues have been allocated to a block training session which aligns to the rostering system, ensuring capacity to release for training. The block sessions cover all training requirements – both elearning and face to face sessions – ensuring every colleague has completed all elements of their training passport within the allocated sessions. We are confident that all appropriate actions are in place to enable people to attend the training. The training team have worked closely with operational managers to understand the challenges in releasing colleagues. We are starting to see that we are overcoming some of the

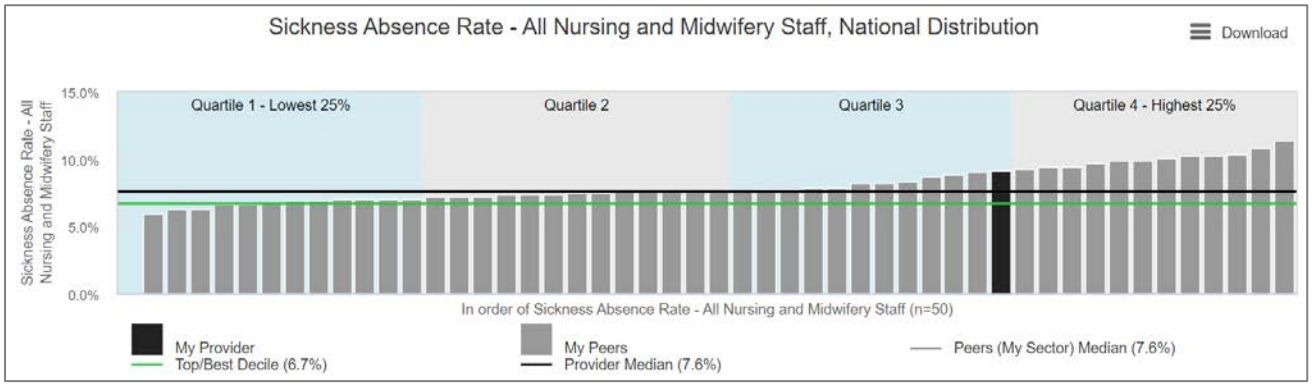
long-standing performance challenges, however we recognise that there are still design challenges that will need a deep dive in the next quarter to ensure we have the most efficient and effective training.

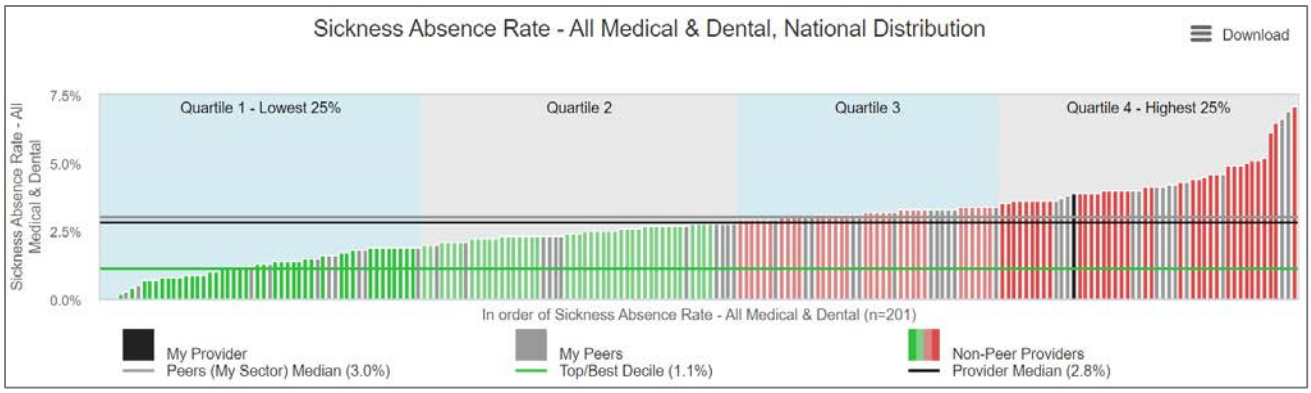
20. Staff absence

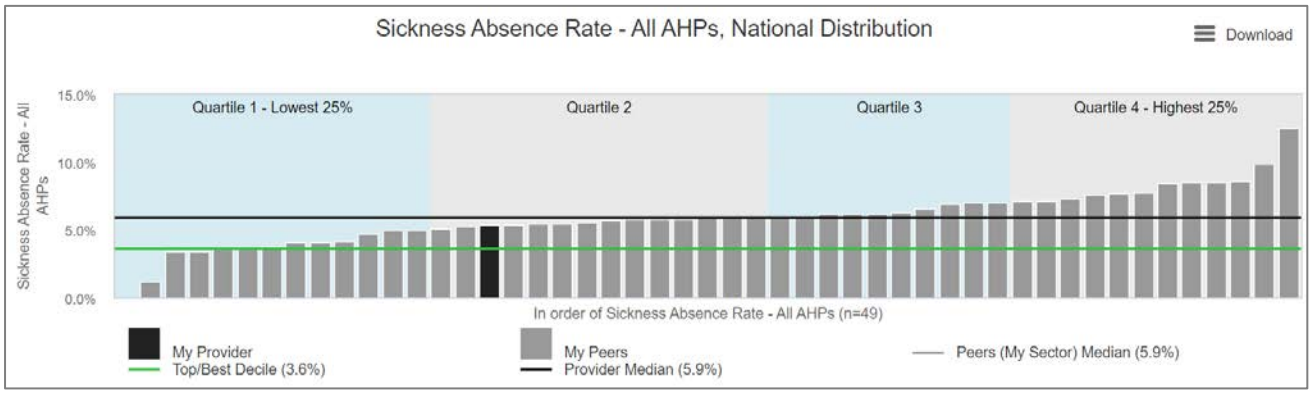


Sickness absence remains high and above the 5% target threshold. September sickness was 7.4%, an increase of 0.44% since last month. We have been working closely with divisions to understand the challenges in managing absence and identified key areas that need some focused improvement work. These include leaders understanding of the policy and how to apply, awareness of the full potential of GoodShape, absence and return to work recording challenges and data accuracy between Goodshape and ESR. A 360 audit took place in August and September on absence and findings from the audit aligned to the areas already identified as needing focused attention. The People and Inclusion team and Operational leads are now working together on an action plan that will address all of these areas.

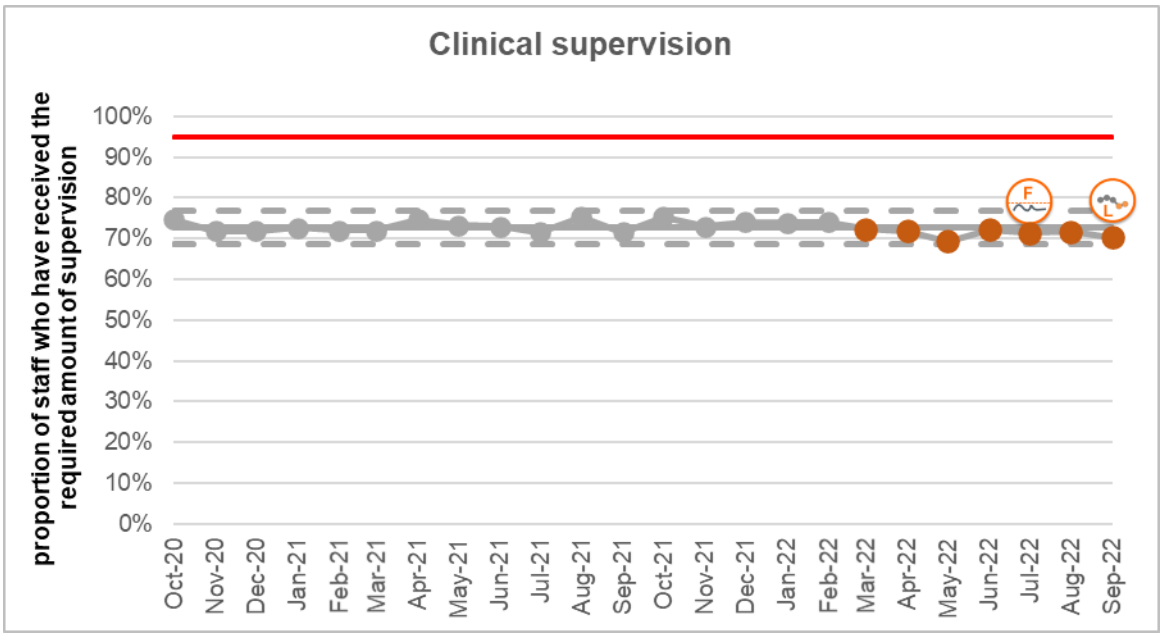
The benchmarking data below compare the sickness absence levels of the Trust by different staff groups, with the absence levels of other organisations. The Trust is denoted by the black columns. (Data source: https://model.nhs.uk/).







21. <u>Clinical supervision</u>

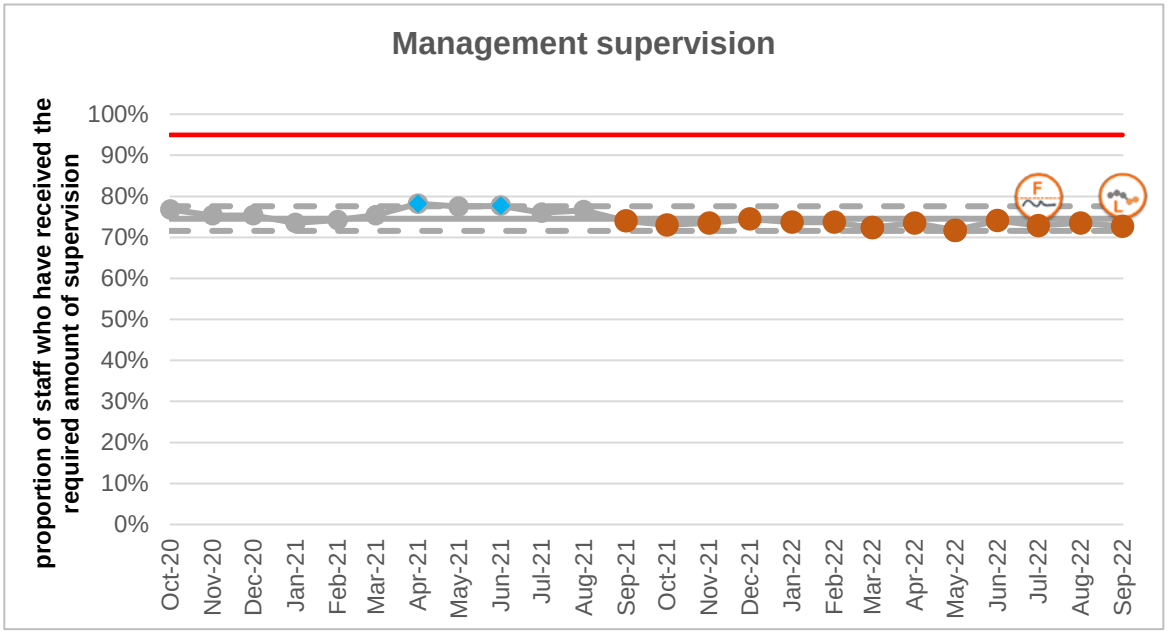


The required amounts of supervision per 12 months - in line with the Trust's Supervision Policy - are as follows:

- Management supervision – a minimum of 5 hours per 12 months, adjusted for part-time staff
- Clinical supervision – a minimum of 6 hours per 12 months, adjusted for part-time staff

Compliance is the percentage of staff who have completed the amount of supervision required over the 12-month period. Data is adjusted to allow for staff who are not at work and the appropriate levels of supervision required are also flexed if returning to work following a period of absence. Staff who are unable to be supervised based on their assignment status or owing to long term sickness are excluded.

22. Management supervision

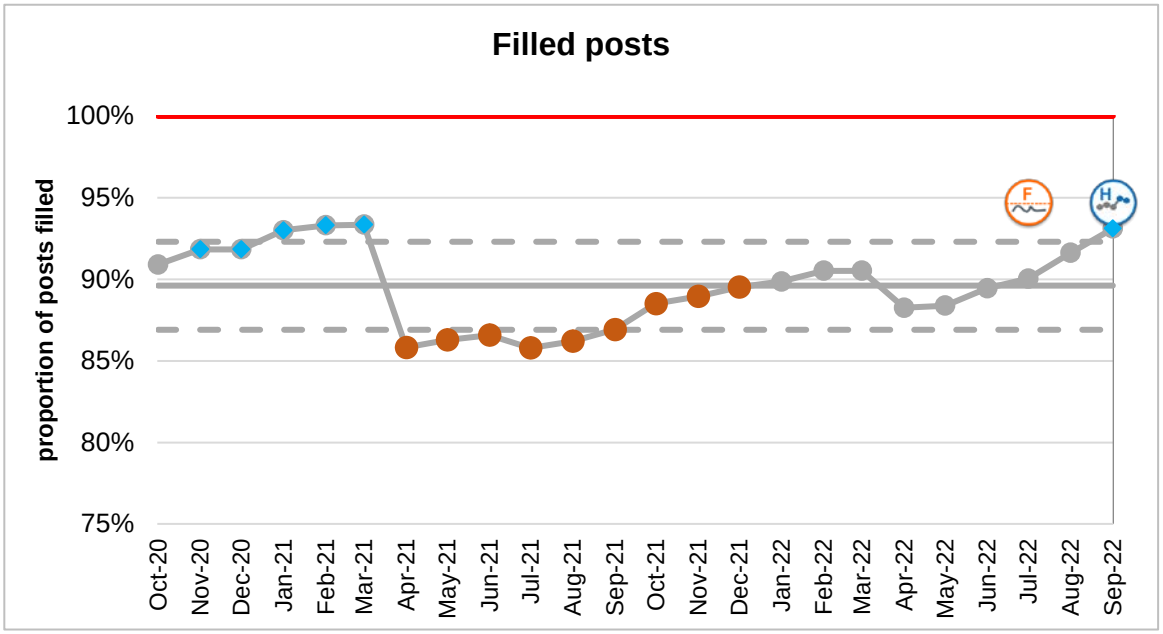


The levels of compliance with the clinical and management supervision targets have remained low since the start of the pandemic. As seen with compulsory training and appraisals, Operational Services continue to perform at a considerably higher level than Corporate Services for both types of supervision (management: 73% versus 58% and clinical: 70% versus 19%). As with the appraisal data, intelligence from divisional and team level indicates that management supervision is taking place, however recording it not always happening. Communications on how to record is now being shared wider and leadership induction is being updated to include information on expectations on management supervision.

Compliance with the 12-month supervision targets by Division:

Division	Service Line	Staff	Management	Clinical
Corporate Services	Business Improvement + Transformation	**11**	82%	0%
	Corporate Central	**57**	70%	0%
	Estates + Facilities	**175**	65%	N/A
	Finance Services	**22**	95%	N/A
	Med Education & CRD	**127**	27%	22%
	Nursing + Quality	**58**	57%	31%
	Ops Support	**57**	93%	0%
	People + Inclusion	**44**	32%	9%
	Total	**551**	58%	19%
Operational Services	Adult Care Acute	**479**	66%	63%
	Adult Care Community	**366**	74%	82%
	Children's Services	**498**	79%	68%
	Clinical Serv Management	**15**	60%	0%
	Forensic + MH Rehab	**128**	80%	80%
	Neuro Developmental	**125**	70%	70%
	Older Peoples Care	**421**	90%	87%
	Performance Delivery Clustering	**4**	100%	N/A
	Psychology	**119**	71%	79%
	Specialist Care Services	**232**	74%	70%
	Total	**2387**	76%	74%
Total		**2938**	73%	70%

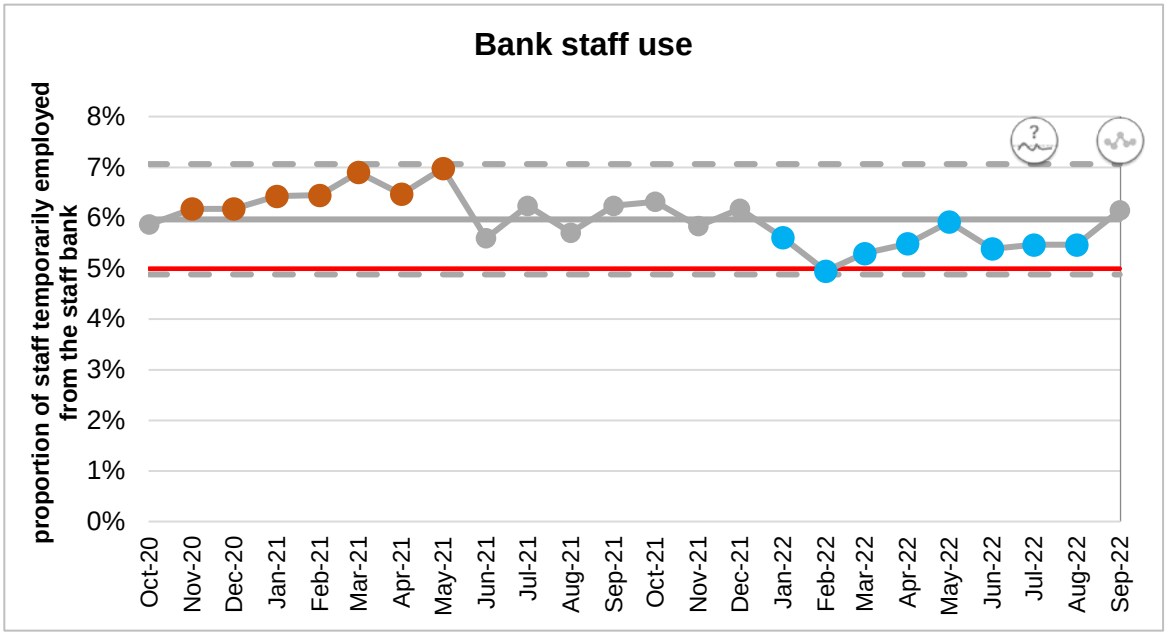
23. Proportion of posts filled



Staffing levels continue to improve and gradual reductions in vacancy rate have continued over the last quarter. The impact of looking at different ways to recruit including cohort recruitment and utilising different platforms for advertising and job application processes has demonstrated significant impact, particularly for Health Care Support Workers, where recently 14 people were appointed from one campaign. This approach is now being rolled out to other Support roles. Time to hire is now standing at 57.1 days (significant improvement decrease of 9 days from 12 months ago despite volume increase). There are still improvements be made, with a focus now on pre-employment checks stage and further streamlining to take pressure off front-line managers.

We are participating in a national programme 'Good Recruitment for Older Workers' (GROW) which aims to minimise age bias in the recruitment process. Working with the Behavioural Insights Team Grow will work with employers and recruiters to collaboratively design and user-test solutions to reduce age bias against older workers in recruitment.

24. Bank staff

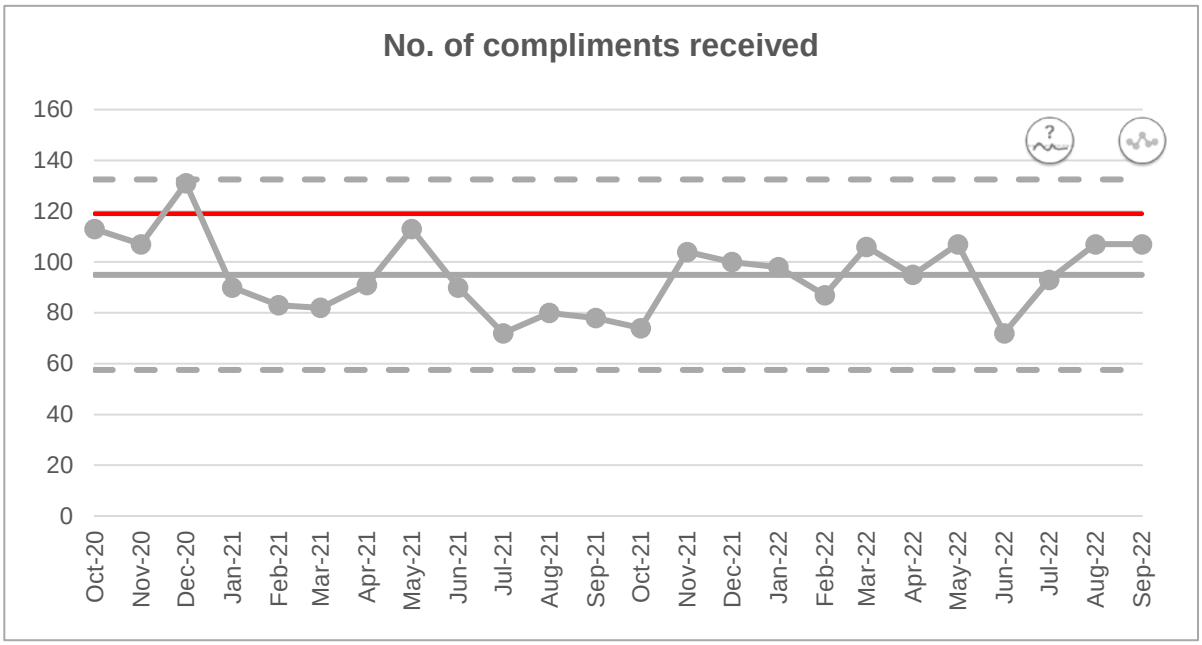


Bank listening event themes are being collated and will be reviewed and actioned within the Temporary Workforce Strategy Group. The listening events will now take place monthly, as requested by bank colleagues to ensure we can respond in a timely way to concerns and make improvements to colleagues' working lives. Capacity and demand remain misaligned and fill performance below benchmark at 68% - this is in a context of increased shift requests. Agency use has increased; the proportion of high-cost agency is still less but not at its lowest, however there has been no ancillary agency activity.

Within the contingent workforce strand of the resourcing and recruitment hub within the ICS, an analysis of temporary workforce capacity within Derbyshire is underway. Alongside supporting work to create incentive options and wider contingent workforce mechanisms such as the reservist workforce, which will create capacity that will protect the bank workforce from being diverted to surge response requirements from core service delivery.

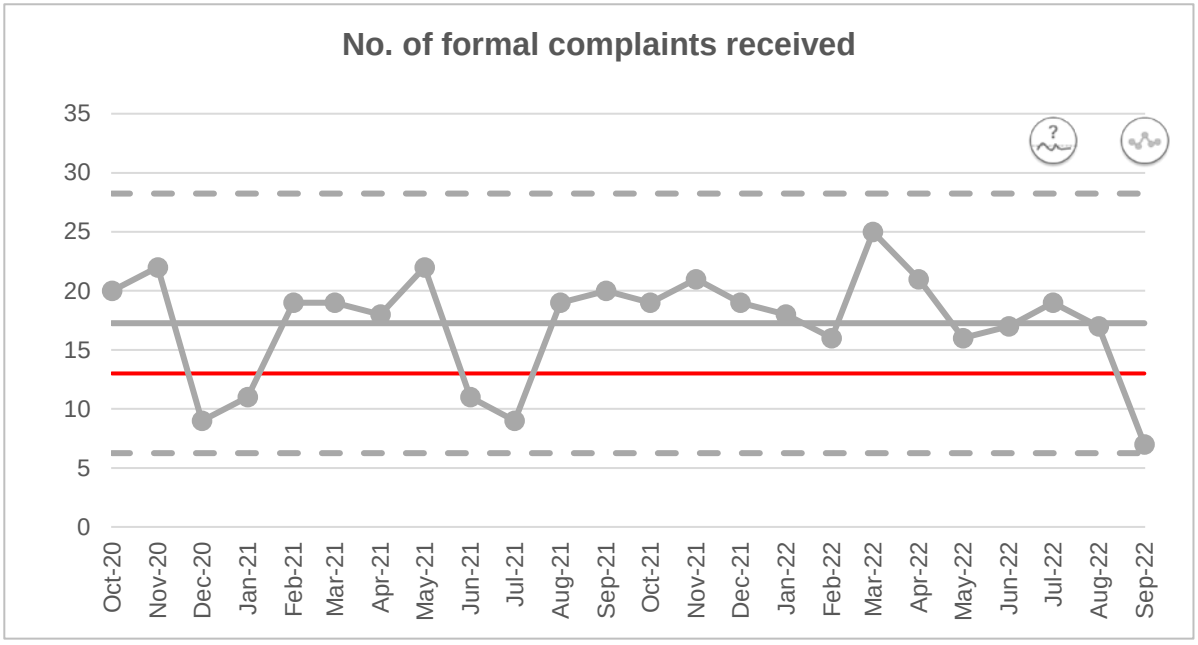
Quality

25. Compliments



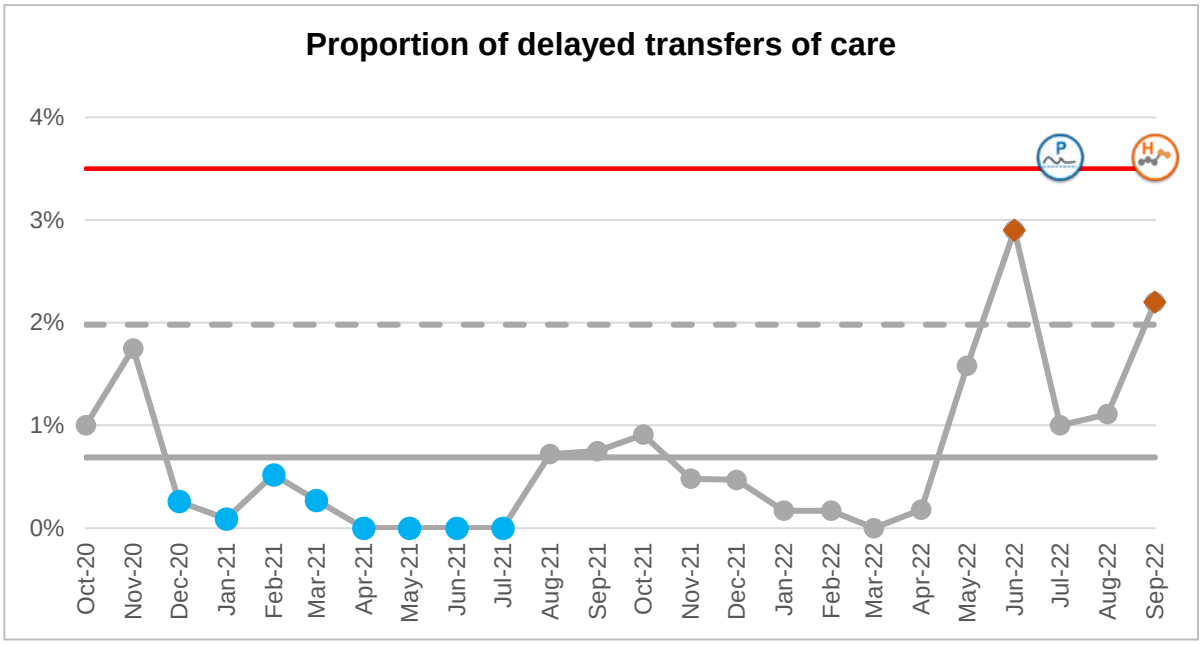
The number of compliments continues to remain below the expected level. This is due to compliments mostly being received verbally and staff not accurately recording them. The Heads of Nursing have been asked provide assurance that compliments are accurately recorded and a project supporting the electronic patient survey will provide a further method of receiving compliments, complaints, and concerns. With an increase in accessibility, it is expected that a natural increase in compliments, complaints and concerns will occur over the next 6 months.

26. Complaints



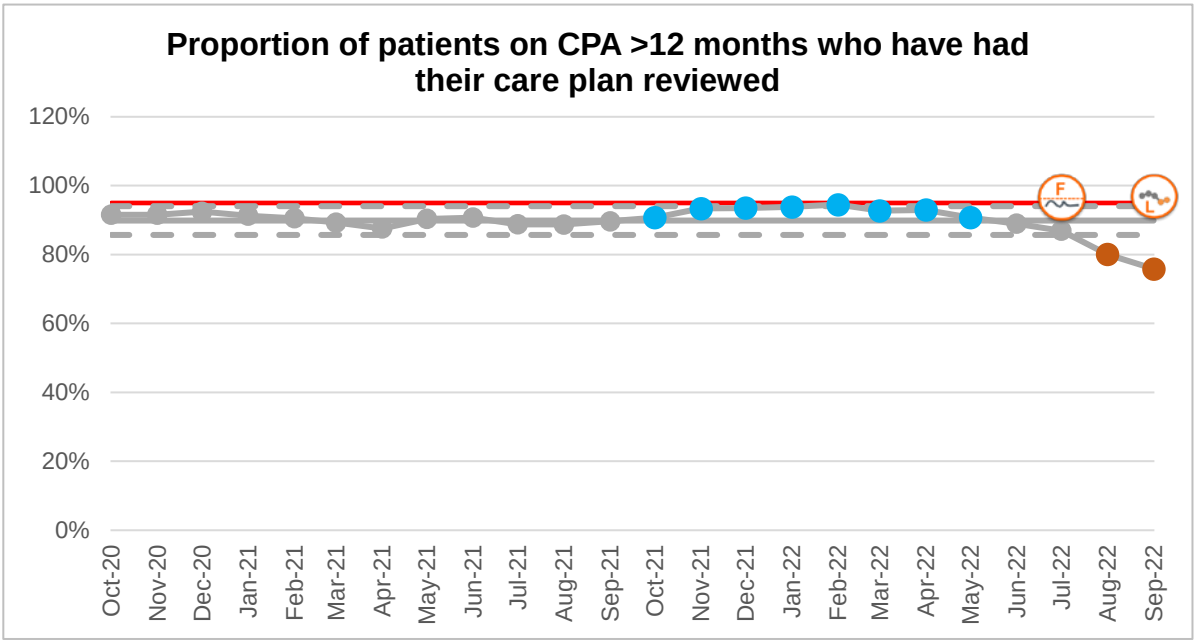
The number of formal complaints received continues to be within common cause variation in relation to the mean with a decline in the number recorded between August and September 2022. The number of formal complaints is now below the Trust target. This could be due to the number of face-to-face contacts increasing as services stand back up and a previous theme identified as patients having difficulty in accessing services. The implementation of the electronic patient survey should also give patients another way of feeding back without having to make a formal complaint. The number complaints recorded will continue to be monitored.

27. Delayed transfers of care (DTOC)



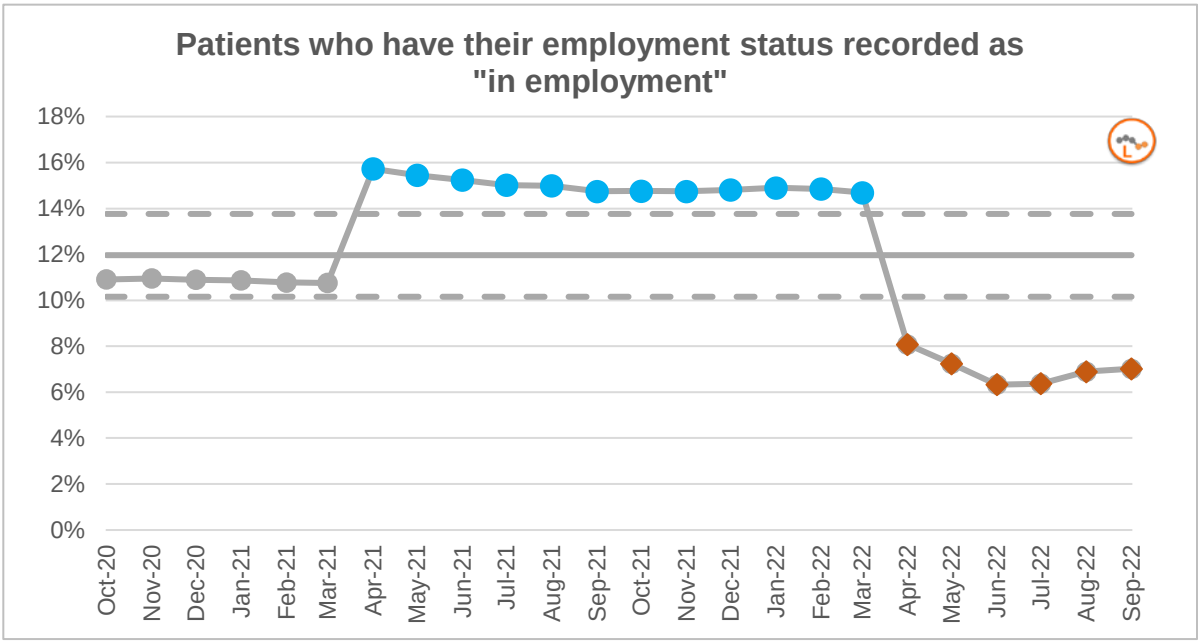
Although the number of DTOC has increased between August and September, the number is still low when compared with the national picture and continues to be below the Trust target of 3.5%. Work continues within the rapid review processes and clinical meetings and a Housing Officer was recruited in May 22 and they will support the identification of placements for patients who do not need to be on a hospital ward. The Trust has also has a “medically fit for discharge” meeting where any barriers to discharge are identified and discussed. The way DTOC is reported has also recently changed so this could account for the sudden increase recorded from April 2022. It is expected that this will reduce over the next Quarter.

28. Care plan reviews



The proportion of patients whose care plans have been reviewed continues to be recorded as lower than expected and is currently on a downward trajectory. This is likely due to care plans that have not yet been migrated over to SystmOne and data quality issues with how this information is being captured. A programme of clinical quality audit is being implemented across the trust divisions, led by the Heads of Nursing, which will help to identify those patients whose care plans require review. This will be monitored over the next six months, and we expect the trajectory to improve.

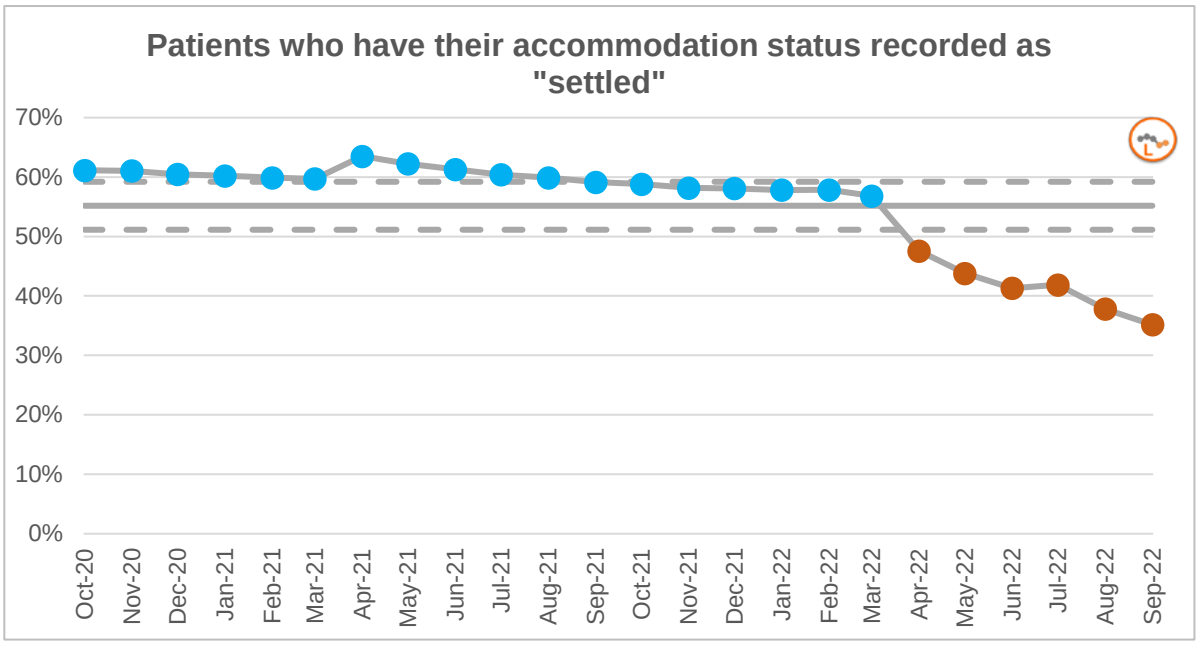
29. Patients in employment



Around one third of patients have no employment status recorded at present and the decline in patients recorded as being in employment coincides with the data migration to SystmOne. Therefore, this may be a data quality issue. This will be investigated and reviewed during the next quarter. The Individual Placement Support (IPS) Service continues to have success in supporting people into employment even during the pandemic and the service is currently expanding. They currently have 11 employment support workers, and this is planned to expand to 18 by March 2023

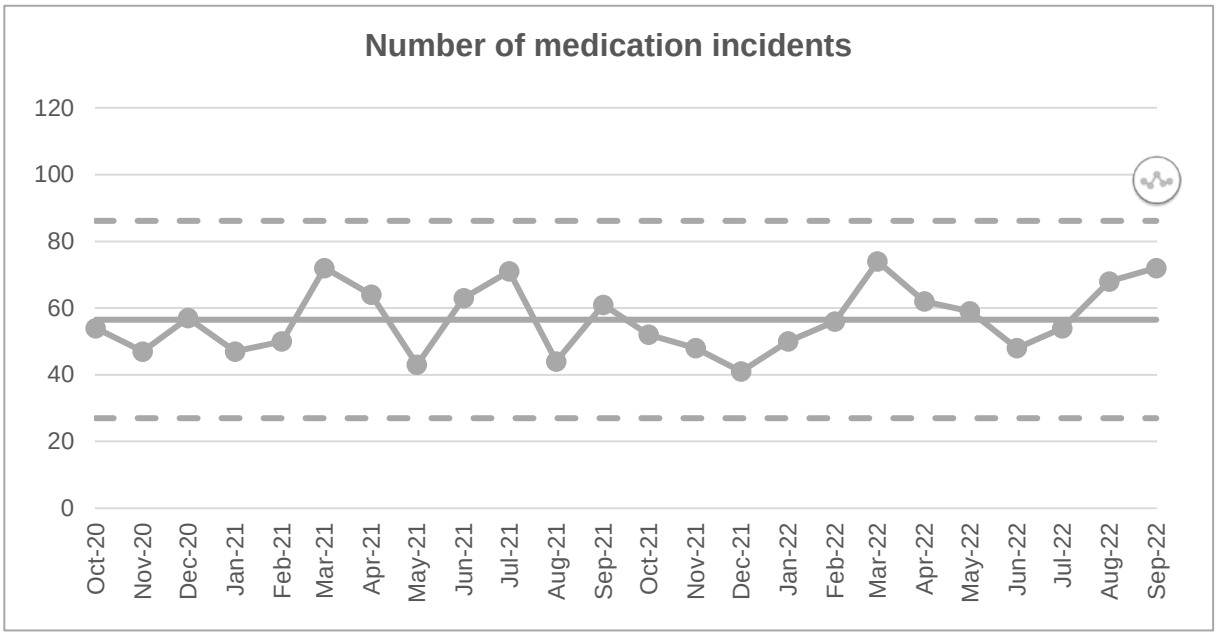
and to 23 by March 2024. The IPS Service has employed 2 peer support workers to support service users back into work and to help them manage worries and anxieties and two team leaders have now been appointed. The Trust has also employed two experts by experience to focus on the implementation and management of Health Education England training in relation to Peer Support working and Apprentices. As a result, the number of patients in employment is expected to improve over the six months.

30. Patients in settled accommodation



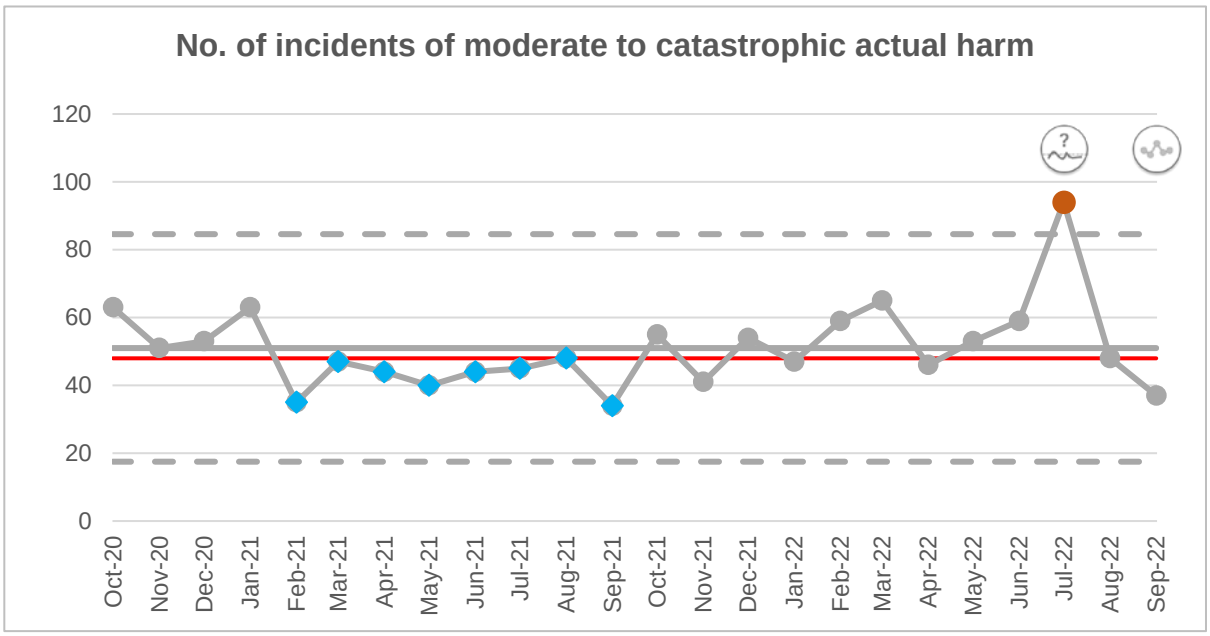
Around one third of patients have no accommodation status recorded and the decline in patients with a recorded settled accommodation status again coincides with the data migration to SystmOne. Issues around inputting data have been identified and an improvement plan was implemented in the Older Adult Division in October including regular audit. The other Trust Divisions will be asked to review their own data, and this will be monitored over the next Quarter, and we expect to see an increase in accurate recording.

31. Medication incidents



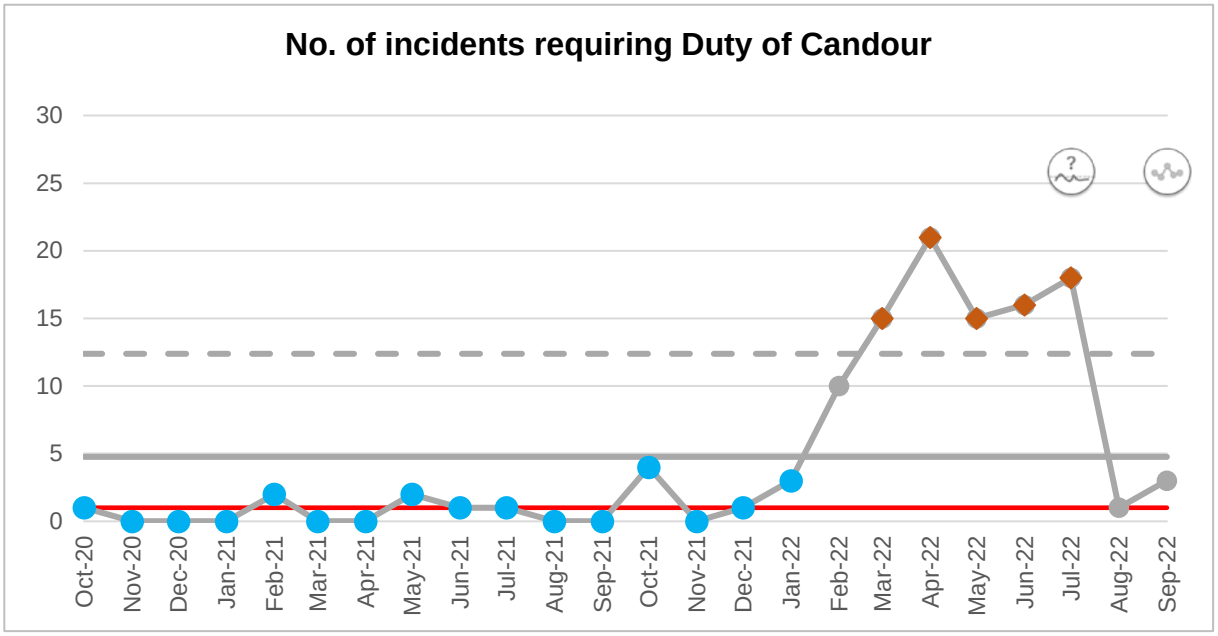
Although there is fluctuation with the number of medication incidents recorded, they are within the common cause variation in relation to the mean. When looking into medication incidents, they take a variety of forms, from missed doses, wrong medication administration, missed fridge temperature recording, prescription error and documenting errors. The Medicines Management Operational Subgroup is currently revising the medications error procedure, considering Trust values, and the Acute Inpatient Matrons and Head of Nursing are in the process of updating the relevant policies which will reduce the number of insignificant incidents. In October 2022 the Children's Division have started electronic prescribing and medicines administration (EPMA) a solution which digitises the process of prescribing and recording medication administered to patients within the Division. This will be rolled out across the trust and should also help reduce the number of medication incidents over the next six months. A report on incidents is also reviewed within the Monthly COAT meeting for each division.

32. Incidents of moderate to catastrophic actual harm



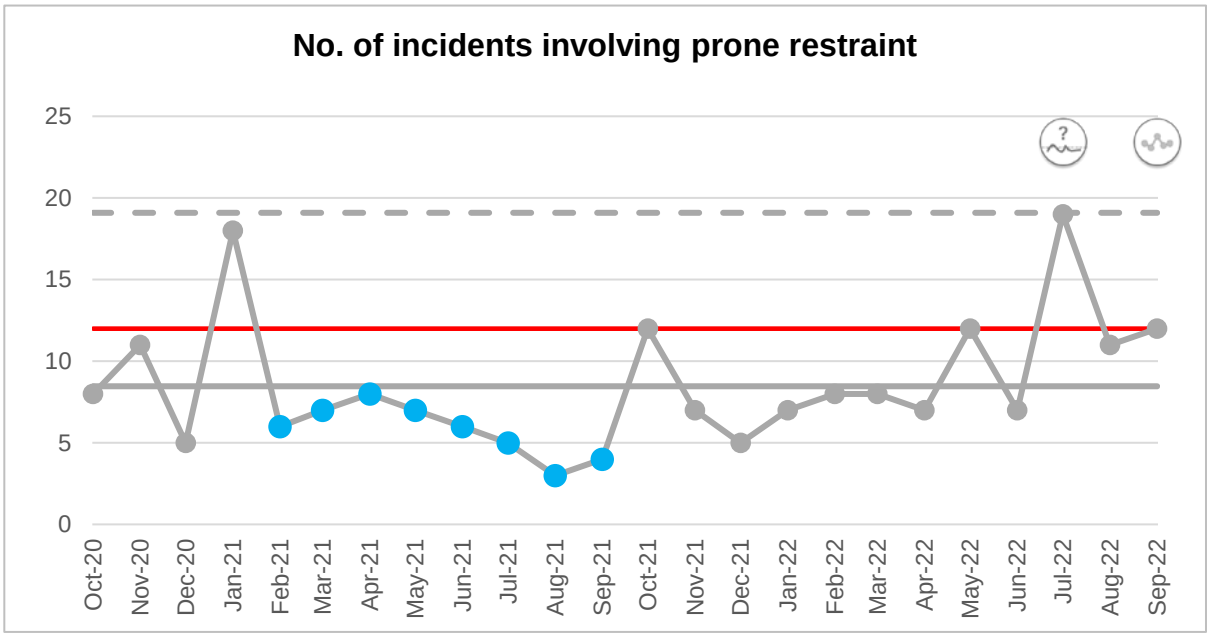
The number of reported incidents of moderate to catastrophic harm increased from April 22 with a spike between June and July. This increase appears to be related to repeated incidents involving a small number of patients. The number of incidents has reduced over August and September, but it will continue to be monitored by the Head of Nursing team on a Quarterly basis and will be fed into the relevant COAT meetings.

33. Duty of Candour



The increase in Duty of Candour reported incidents as anticipated in the previous report is due to a change in how DOC incidents are reported on the DATIX reporting system and a greater awareness around reporting in clinical teams. This commenced in February 2022. From May 2022, the Patient Safety Team have undertaken training with Service Managers and Heads of Nursing to support them in understanding and interpreting new national guidance related to DOC which has allowed for a more accurate and consistent approach to DOC and better adherence to policy. Training around accurately reporting DOC continues within clinical teams and a new Family Liaison Officer has now commenced in post and a review into the current process of quality assurance, auditing and reviewing of incidents is underway. Due to these developments, as expected the number of incidents reported requiring DOC has stabilised and it is likely that a more accurate mean will be established.

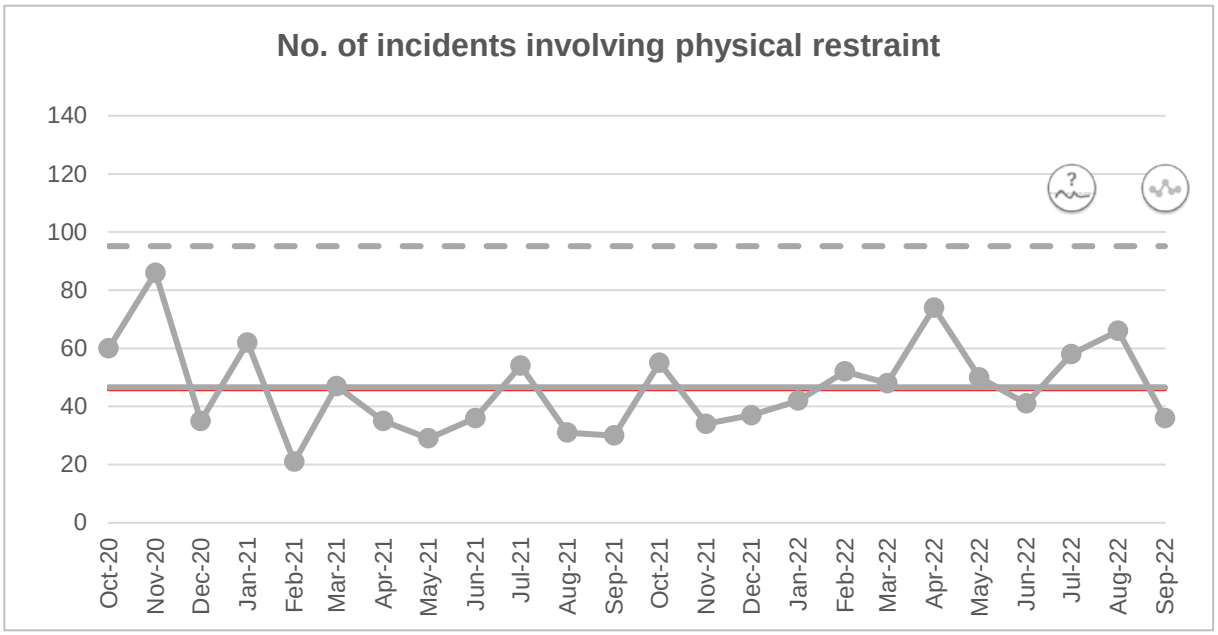
34. Prone restraint



There are ongoing workstreams to support the continuing need to reduce restrictive practice, including the work around introducing body worn cameras. The monitoring of restrictive practice is

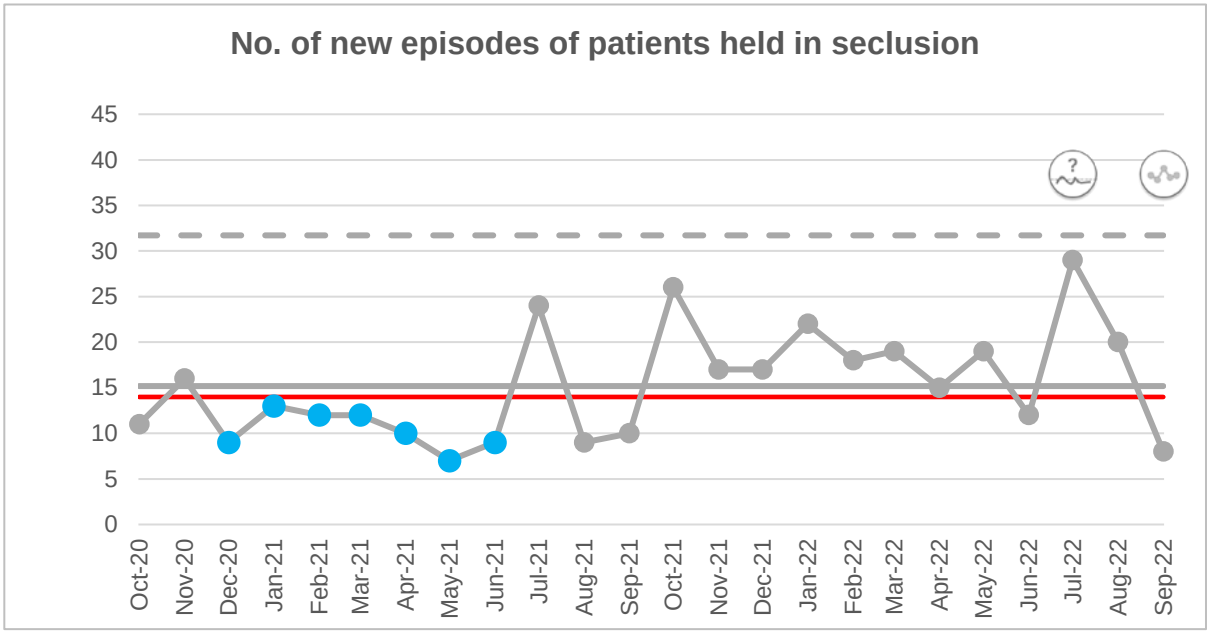
done within specific forums and data analysis and review has shown that incidents involving prone restraint have increased between June and July 22 related to repeated incidents involving a small number of patients. This will continue to be monitored. The Positive and Safe team have also changed the way staff are taught to support service users into seclusion. This means that prone restraint in these circumstances will no longer be necessary in all situations. The overall numbers of prone restraint are lower than the regional average per bed numbers and it is expected that incidents related to prone restraint will continue to reduce on average over the next six months.

35. Physical restraint



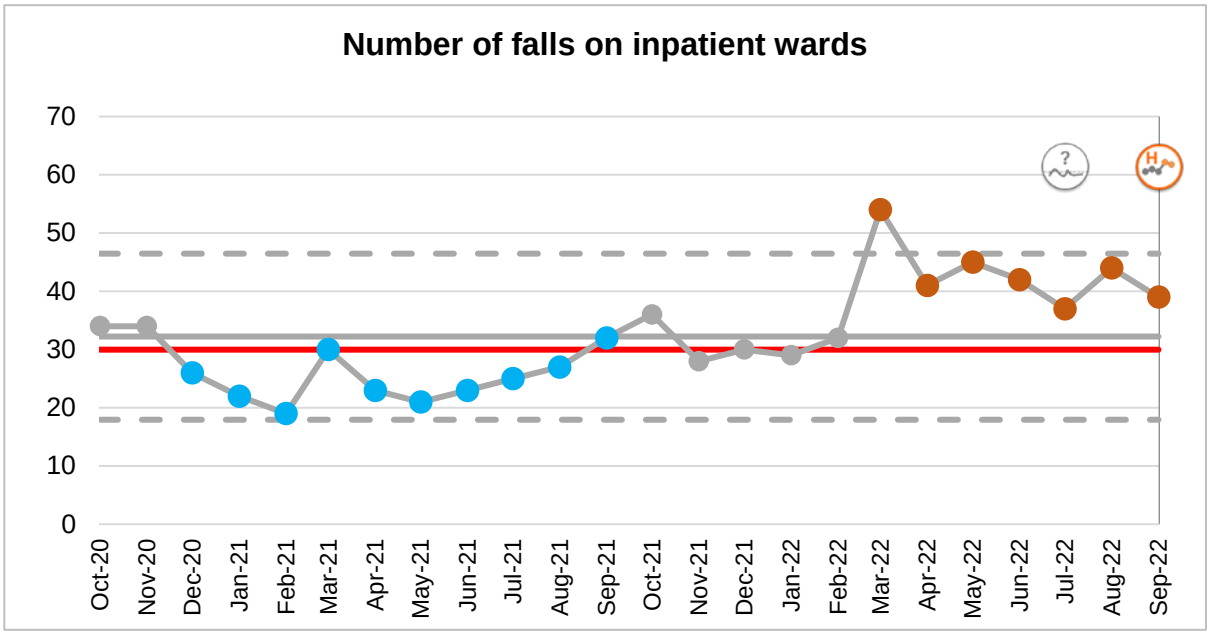
The number of reported incidents involving restraint have remained within common cause variation throughout the reporting period. The changes in numbers are linked to the data above relating to prone restraint and below relating to seclusion. It is important to highlight that a common impacting factor to restrictive practice is increased use of bank staff, vacancies, increased sickness, staffing challenges and concerns relating to closed culture. A working group has been created to put together a working procedure for assessing closed cultures and what needs to be done where closed cultures are identified. This work aims to improve patient feedback along with reducing restrictive practice both in Inpatient and Community Services. Over the last quarter the Positive and Safe team have also increased their presence on inpatient wards to offer advice following incidents which will help staff to identify alternative ways of managing situations that could potentially involve physical restraint.

36. Seclusion



The use of seclusion has been above the mean common cause variation from October 2021 due to a small number of patients who had been placed in seclusion on more than one occasion on an acute ward and then the Enhanced Care ward. From July 2022 the number of seclusions is on a downward trajectory and is now below the Trust target. Further auditing will be carried out by the Head of Nursing for Acute and Assessment Services and they are currently leading on a thematic review of seclusions to identify further learning.

37. Falls on inpatient wards



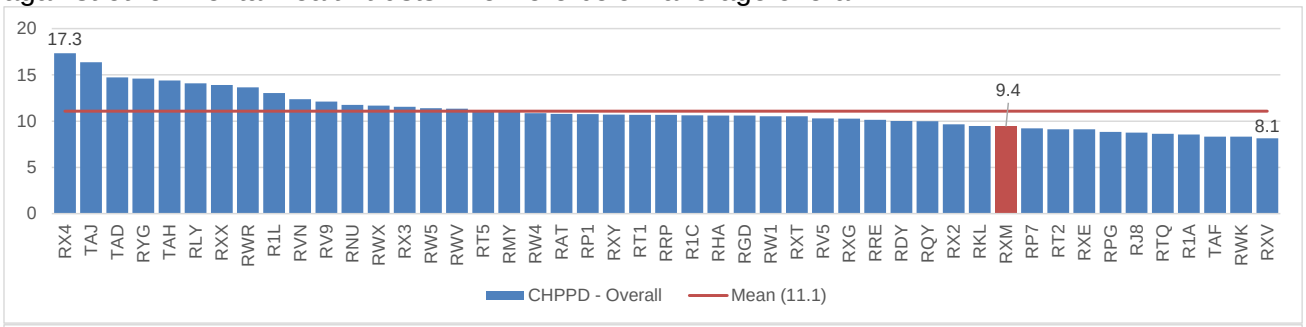
After an abnormal spike of incident in March 2022, A review of falls was commissioned and identified that a high number of falls were related to the same small number of patients. From this review a bi-weekly falls review meeting, chaired by the Matron for older adult services, has been established to identify any specific needs for those patients falling regularly. This appears to have had a positive impact with incidents related to falls reducing and continuing a downward trajectory between April and July 22. This will continue to be monitored over the next quarter. It was also

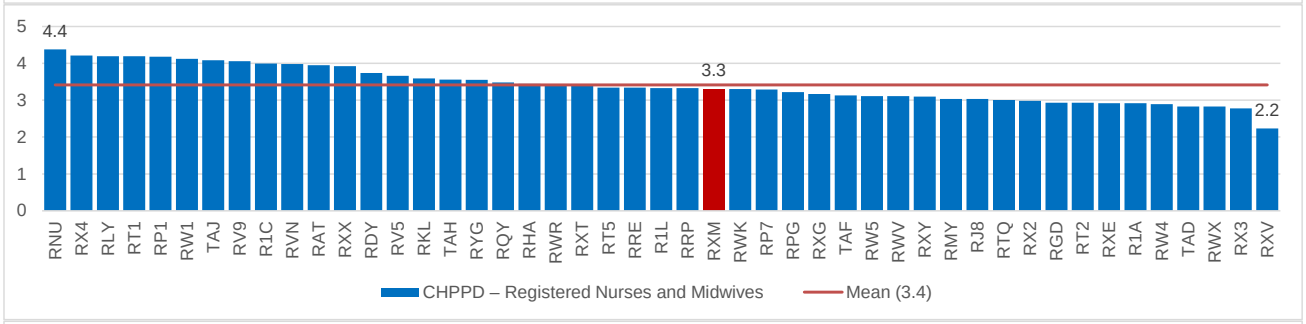
identified that a Physiotherapist had been recruited to support the inpatient wards in managing falls risks but that they had been off sick for the last 12 months. A new Physiotherapist has now been allocated to this role from October 2022.

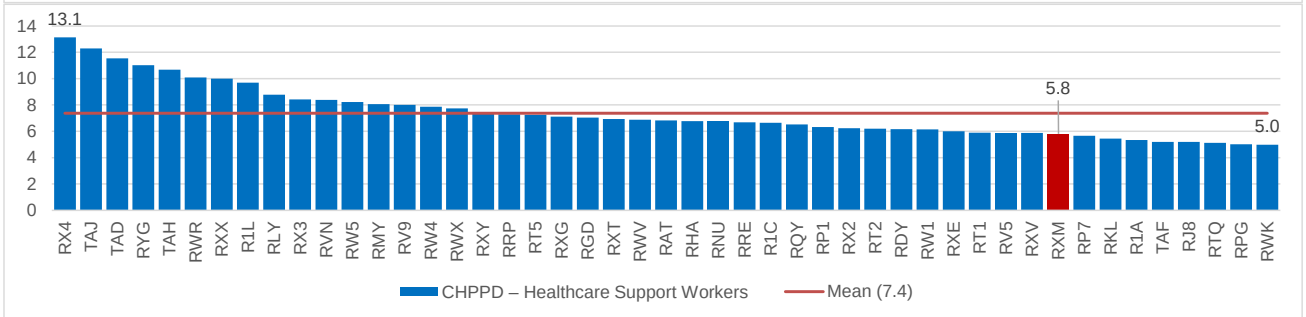
Care Hours Per Patient Day (CHPPD)

CHPPD is rolling data updated monthly, to show staffing levels in relation to patient numbers on an inpatient ward. Every month, the hours worked during day shifts and night shifts by registered nurses and midwives and by healthcare assistants are added together. Each day, the number of patients occupying beds at midnight is recorded. These figures are added up for the whole month and divided by the number of days in the month to calculate a daily average. Then the figure for total hours worked is divided by the daily average number of patients to produce the rate of care hours per patient day. Work is underway to implement processes relating to staffing levels and how they are recorded in line with CHPPD and patient acuity. This will be in the form of the MHOST reporting system and SafeCare module within E-Roster. The Trust have MHOST training organised for October with participants identified from all inpatient areas. The Trust has also employed a new e-roster manager who came into post in July.

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





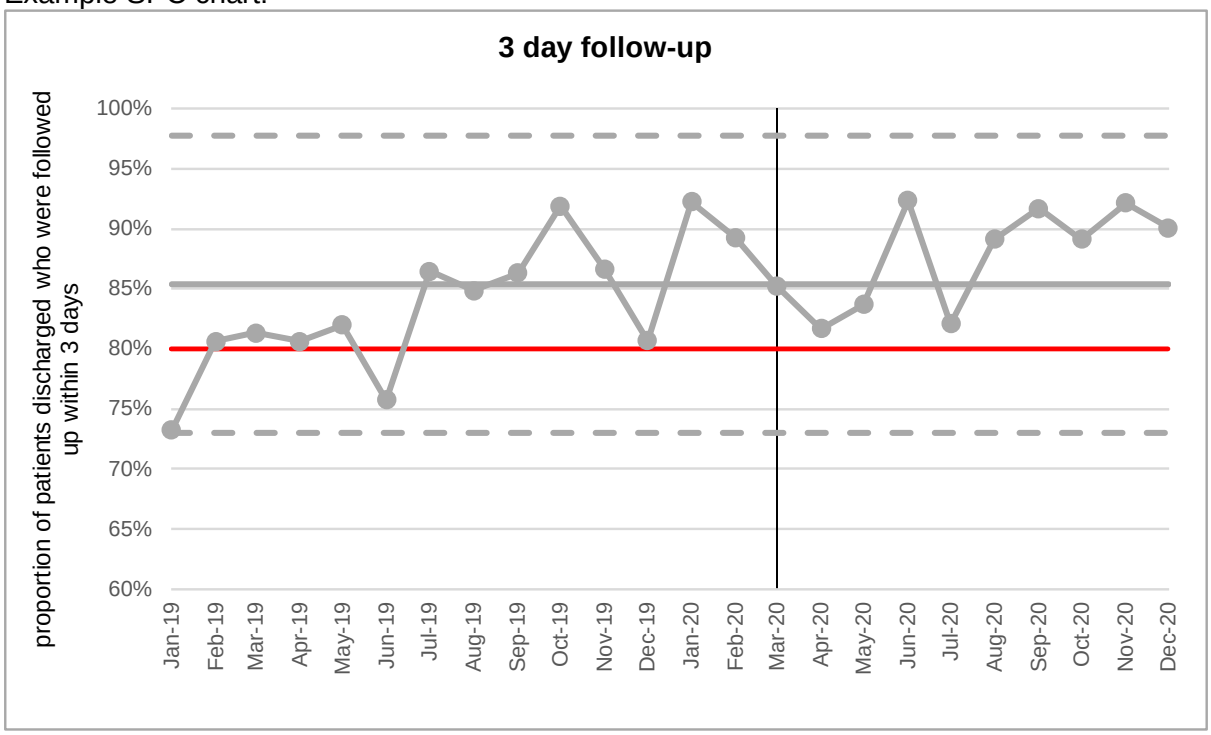


Data source: NHS England » Care hours per patient day (CHPPD) data

Appendix 1

Statistical Process Control Chart (SPC) Guidance

Example SPC chart:



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

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

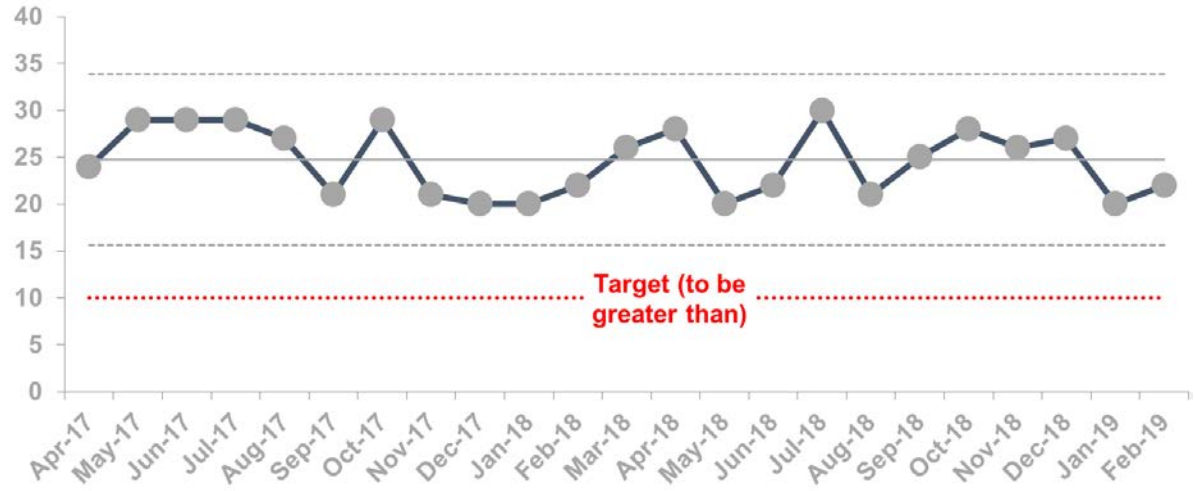
The closer the two grey dotted lines are together, the less variation there is and therefore the more tightly controlled is the process.

Things to look out for:

1. A process that is not working

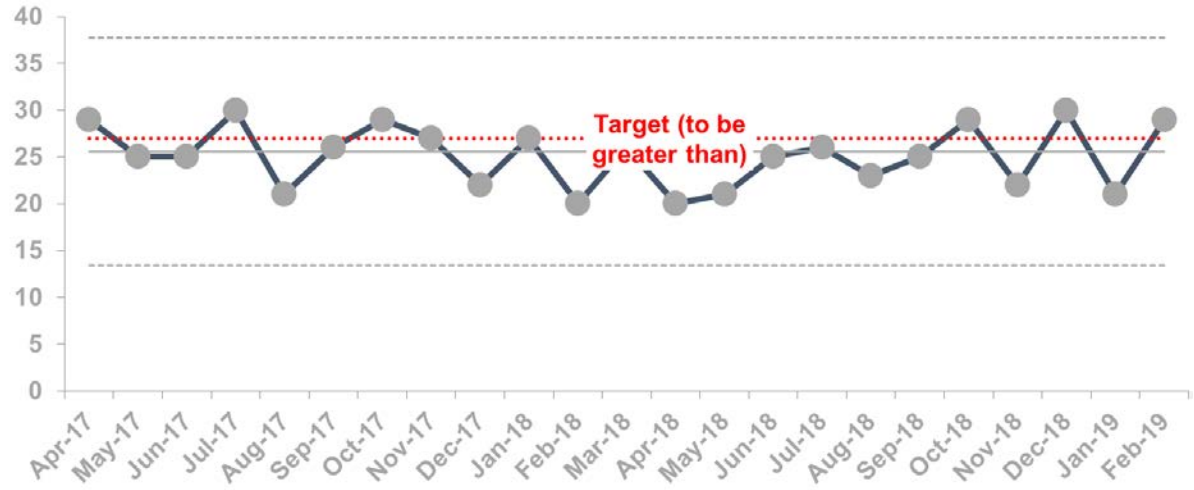
In this example the target is higher than the upper dotted grey line. This means that the target will never be achieved. To achieve the target, we need to change how we do things.

2. A capable process



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

3. An unreliable system

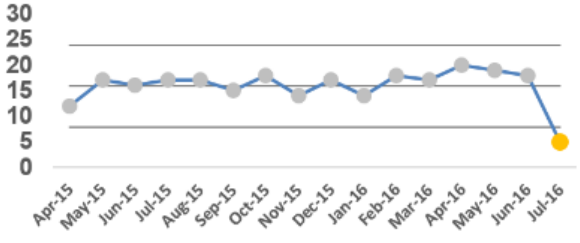
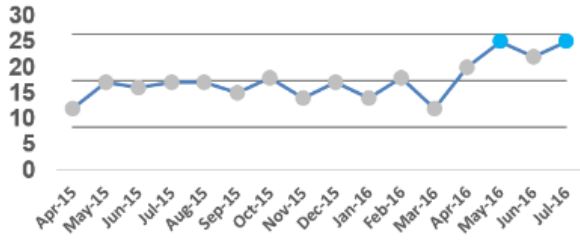
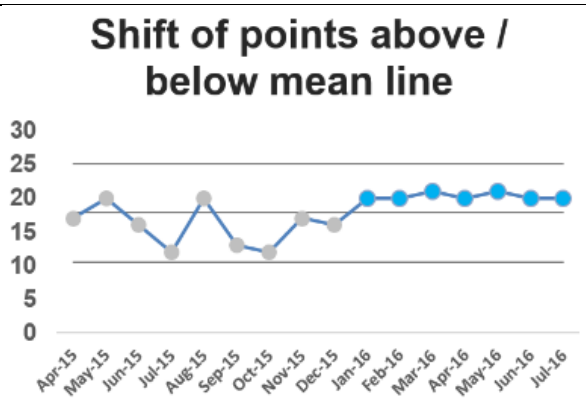


In this example the target line sits between the 2 grey dotted lines. As it is normal for the grey dots to fall anywhere between the 2 dotted grey lines, this means that it is entirely random as to whether or not the target will be achieved. So, this system is unreliable and needs to be redesigned if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

4. Unusual patterns in the data

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

There are four scenarios where this can happen:

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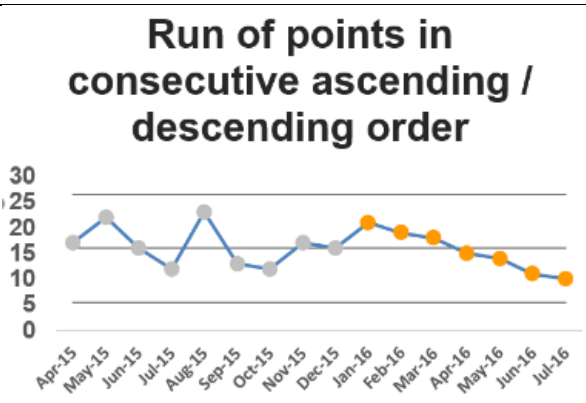
<td> 
</td>
</tr>
<tr>
<td>A run of 7 points above or below the average line is significant. In this example it might indicate that an improvement was made to the process in Jan 16 that has proven to be effective.</td>
<td>A run of 7 points in consecutive ascending or descending order is significant.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

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

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 1 November 2022

Neurodevelopmental Services
Learning Disability and Autism (LDA) specific assurance
(Panorama and Dispatches Case)

Purpose of Report

This paper is to provide assurance to the Board in response to the BBC Panorama programme featuring Edenfield and the Panorama and Channel 4 Dispatches programmes aired on10 October 2022.

The Panorama programme on 10 October detailed the death of a patient who was in Stepping Hill Hospital, Stockport in 2018. The patient sadly died of complications of the chicken pox virus. Learning across sectors and organsiations is really important to services continually improving.

Executive Summary

The report contains a summary of an anonymous case with coroner findings with details on provisions and commissioned Provisions and Commissioned Services in 2018 and Current Position

- Prevention and Management of Violence and Aggression (PMVA) policy and Use of Force Act reviewed for Hillside
- Safe and Well Checks/5 Eyes Approach
- Review of all Derbyshire patients in Stepping Hill including face to face safe and well checks
- Derbyshire acute hospital review of Learning Disability liaison team
- Support for staff.

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

Risks and Assurances

- Actions for assurance and mitigation against any risks are listed in detail in the report. Plans and responses have been coordinated between partners and agreed and signed off by senior executive leads.

- The Trust's Safeguarding unit is aware and sighted of plans around risk and assurance

Consultation

N/A

Governance or Legal Issues

The Assistant Director of Legal, Governance and Mental Health Legislation is sighted on the programmes and signed off on the responses to date.

Public Sector Equality Duty and Equality Impact Risk Analysis

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

The cohort of patients this report is focussed on are those with protected characteristic. This report outlines specifics which could have impact locally, and aims to provide assurance that additional work is in place to ensure this is mitigated and/or addressed.

Recommendations

The Board of Directors is requested to:

1) Note the update and overview given in this paper
2) Provide any comment or steer on any further actions the Board requires for assurance regarding specifics on LD&A due to the case

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

Report prepared by: **Libby Runcie**
General Manager

Faye Rice
Director for Neurodevelopmental

Neurodevelopmental Services
Learning Disability and Autism (LDA) specific assurance
(Panorama and Dispatches Case)

Following the Panorama and Dispatches programmes listed below are the actions which will provide a level of assurance to Board that we are doing the right things in respect to ensuring our patients are being cared for correctly and safely. Health Science Journal (HSJ) website that indicates that NHS England's National Mental Health Director, Clare Murdoch will be contacting all trust boards to gain assurance about safeguarding 'Appalled' NHSE director orders safety review at all providers | News | Health Service Journal (hsj.co.uk) so we can rightly expect more actions as a result.

Summary of Case

J had learning disabilities and Downs Syndrome. She was a resident in a 24/7 care and support provision and was under a long term Deprivation of Liberty (DoLs). She has an allocated social worker and was under the care of a mmunity Learning Disability Team. From June 2018 she began to deteriorate in her physical presentation and a bed in a Learning Disability (LD) Assessment and Treatment Unit (ATU) was requested.

The Coroner's report stated that a LD ATU bed service was closed to admissions at the time. A trust have confirmed that they have documentation concerning J and state that she could not be admitted due to the complexities and dynamics of the other patients in the unit.

On 21 August 2018 on medical advice with no LD ATU bed found, J was admitted to Stepping Hill hospital. On 6 September 2018 she was deemed medically fit for discharge.

Whilst waiting for discharge on 13 September 2018 J developed a rash. A specialist dermatologist registrar believed this was a medication reaction and her medications were stopped. She deteriorated quickly and on 23 September 2018 she died at Stepping Hill Hospital from Pneumonitis.

Provisions of services and current position in our county

Since January 2022 DHCFT/DCHS have been working more closely together through an alliance style approach with senior leadership from DHCFT supporting the wards and across community teams resulting in demonstrable evidence that improvements have been made. DHCFT is also offering intensive support to Hillside to ensure the flow of patients and has seen significant improvements in presentations and is opening a further bay for capacity. Acute beds in Adult Mental Health can be used effectively with adjustments in cases as we have LDA in reach clinician dedicated to wards as well as Intensive Support Team wraparound pre and post discharge. DHCFT also dedicated case managers in Derbyshire who attend out of area hospitals to assure patients who are accessing beds outside of Derbyshire so they have the right care and treatment in place and have their needs appropriately and safely met.

Derbyshire remain committed to principle of home first.

ACTIONS

Work with DCHS around joint Derbyshire response

Learning from this case

- Care coordination
- Access to Hillside (LD ATU)
- Psychiatric input into clinical teams
- Access to the chicken pox vaccine
- Electronic communication

Prevention Management of Violence and Aggression (PMVA) policy and Use of Force Act reviewed for Hillside

Since the alliance style of working began there have been fortnightly governance meetings between both organisations led by the Trust's Deputy Chief Executive and Chief Nurse, Carolyn Green to work through operational challenges bringing our services together. Michelle Bateman as the Executive Director of Nursing, AHP and Quality for DCHS is confirmed as the responsible person for DCHS for the Mental Health Use of Force Act.

The PMVA policy at Hillside and all other Mental Health Act related policies are being reviewed as part of the alliance style of working. This will ensure that the polices across both organisations align with each other and are safe and strongly embed the principle of least restrictive practice as business as usual.

Safe and Well Checks/5 Eyes Approach

All three patients in Hillside Ward at Ashgreen are seen routinely face to face by members of the multiagency MDT. All three have had face to face safe and well checks including additional due diligence checks week commencing 10 October in response to the Panorama programme and focused on the physical health of the patients.

DHCFT Consultant Psychiatrist, is completing a review of the patients as a critical friend to assure that we have covered everything and that we have accurate profiles around their risks and how this can be supported to discharge safely.

All Care and Treatment Reviews are face to face and are carried out yearly as per new Care and Treatment Review (CTR) policy. However members of the Transforming Care Partnerships (TCP) team who conduct CTRs are updated weekly on their progress and attend ward rounds and meetings in addition to the yearly required CTRs as additional checks and balances.

Review of all Derbyshire patients in Stepping Hill

Stepping Hill is contracted to provide up to six beds for DHCFT which can be for acute mental health and/or older adult mental healthcare. The beds are commissioned for those patients within High Peak and Dales and North of the County as it is acknowledged that accessing Stepping Hill beds (rather than Hartington or Radbourne) would ensure patients are actually closer to family and circles of support.

It has been established that DHCFT currently has six patients in Stepping Hill. One patient who has Autism, has had a review on 26 September 2022 face to face for his CTR which included a review of physical healthcare needs and management of any incidents. No concerns were raised and evidence of reasonable adjustments, good care planning and good communication was clear.

The General Manager for Adult Mental Health has requested that the remaining five AMH patients have safe and well checks to ensure that those at Stepping Hill are receiving the right care, treatment and support.

Derbyshire acute hospital review of Learning Disability liaison team

If in the event a patient is admitted to Chesterfield Royal Hospital or Royal Derby Hospital, a review is carried out to ensure that LD hospital liaison teams are in place and that they influence and support patients with LD to access good, safe care making reasonable adjustments as required.

Chesterfield Royal have a LD liaison team that supports all wards/areas and can be called on for advice and support. This is a well-established team with positive outcomes.

Up until 2021 Royal Derby Hospital relied on one nurse facilitating LD liaison for the whole hospital. Libby Runcie (General Manager in Neurodevelopmental) has been supporting University Hospitals of Derby and Burton (UHDB) in looking at what a good service looks like, and they are currently developing a new service. DHCFT has offered to support recruitment with experts by experience on the panel and also offered to provide clinical supervision and access to LD training, meetings, and groups without charge as a system wide support.

LD/A support into DHCFT Mental Health Beds

There is now also a new Neurodevelopmental (ND) liaison team for hospital avoidance and clinical in-reach into the Acute Mental Health beds. This conduit between health services and feeding into the wider system has proved invaluable in supporting Delayed Transfer of Care (DTOC) cases on the ward, barriers to social care for medically fit for discharge patients and to ensure that ward rounds/MDT are making reasonable adjustments and meeting these needs of patients with LD and or Autism.

Senior Leadership reflective Session and supporting front line support

On 17 October 2022 the Chief Psychologist led a reflective practice session with clinical and operational leaders across the services. This will focus on learning the lessons from the cases highlighted and reviewing and updating our systems to make sure that ill patients are safe.

As part of this reflective session senior leads are also preparing to begin offering night and weekend presence for staff and patients to have the opportunities to speak to leaders and gain additional support.

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 1 November 2022

Workforce Race Equality Standard Report and Action plan (WRES) 2021/22

Purpose of Report

This report and action plan highlights the key findings from the Trust's 2021/22 Workforce Race Equality Standard (WRES). It showcases areas where the Trust has improved and where further work is required for the Trust Board for review and approval. This report presents the data and the actions, which include those rolling over from the last WRES Report 2020/21, those deriving from the Joined Up Care Derbyshire (JUCD) Equality, Diversity and Inclusion (EDI) Strategy 'Creating a Sense of Belonging' and strategic outcomes identified from this year's WRES 2021/22 data.

Trust Board is to note the engagement with the BME Network to identify priorities and actions for 2022/23. Following the approval by Trust Board, the action plan will be reviewed and updated every quarter and reported to People and Culture Committee. The report and action plan will be published on the public-facing website by 31 October 2022 and sharing with commissioners and NHS England and NHS Improvement (NHSEI).

Executive Summary

The WRES submission identifies the experiences of the Trust's Black, and Minority Ethnic (BME) colleagues in comparison with their White colleague counterparts.

The WRES data informing this report has been submitted, as mandated to the National NHS WRES Team by 31 August 2022. The WRES Report and Action Plan has had input via engagement with the BME Network prior to the final full report submission to the Trust Board in November 2022 and is to be published on the public-facing website.

The data is taken from 1 April 2021 to 31 March 2022.

The 2022 data submission has shown some areas of improvement these include:

- The overall BME representation across the Trust has risen from 15.5% in 2020-21 to 16.7%.
- The representation of colleagues from a BME background in non-clinical Band 6 has increased from 1.8% in 2020-21 to 5.66% in 2021/22. The representation of colleagues from a BME background in clinical Bands 8a and 8c has increased by 4.5%, and 11%
- The data shows the likelihood of BME staff entering the formal disciplinary process compared to white staff has significantly reduced from 10.52 times more likely (2020/21) to 0.00 times more likely (2021/22)
- The data show's a decrease of BME colleagues experiencing harassment, bullying or abuse from staff in the last 12 months since 2020/21, from 27.5% to 22.6%.

- The percentage of BME colleagues who have personally experienced discrimination at work from their manager/team leader or other colleagues has decreased by 0.8% since 2020/21 when it was 15.5% for BME staff.
- BME colleagues are represented at board level positions, with a positive increase by 16.6% in comparison to the workforce representation

The 2022 data submission has shown some areas of concerns, these include:

- The relative likelihood of white candidates being appointed from shortlisting compared to BME candidates has increased from 1.6 times more likely (2020/21) to 1.78 times more likely (2021/22)
- The relative likelihood of White candidates being appointed from shortlisting compared to BME candidates has increased from 1.6 times more likely (2020/21) to 1.78 times more likely (2021/22).

Please refer to the attached WRES Report 2021/22 which includes the action plan and three Strategic Outcomes highlighting the suggested key focus of work to address the areas of concerns.

The Board is to note engagement with the BME Network has taken place to develop the detailed action plan around the three priorities 2022/23 (see appendix 1). This will be updated every quartile to the People and Culture Committee. Publication of this report on the public-facing website has taken place and shared with commissioners.

Summary of The Trust's proposed WRES Strategic Outcomes:

The 2022/23 WRES action plan has been developed with several considerations taken into account, these are:

- Our legal and compliance requirements (i.e., EDS Domain 3, NHS People's Plan, Care Quality Commission Regulations, JUCD three-year EDI plan, NHSEI Mental Health Advancing Equalities Strategy, Regional Workforce Race Equality Action Plan)
- The data from our latest WRES Report
- The voice of our staff networks and colleagues

The WRES Report consists of recommended strategic outcomes. These outcomes are:

1. **Improve understanding** of local issues across the Trust, learning from current lived experience, to implement best practice responses with a full evaluation of the impact (Measures: Improvement in Indicators 2, 6 and 8 by December 2023)
2. **Improve leadership** approach and response to improve ethnic minority colleague experience through a consistent, Trust-wide approach to developing and supporting ethnic minority allies (Measures: Improvement in Indicators 5 - 8 by December 2023)
3. DHCFT colleagues **consistently demonstrate inclusive behaviours** and leadership, in line with the good practice 'Behavioural Standard Framework' (Measures: Improvement in Indicators 5 – 8 by December 2023)

4. **Building of relationships and trust** with BME colleagues (Measure: Improvements in overall BME staff engagement score (National Staff Survey) by December 2023.
5. **Improved wellbeing support for BME colleagues**, particularly in relation to bullying, harassment and abuse. (Measure: Improvement in indicators 5-8 and increase in proportion of colleagues accessing wellbeing and support services who are from a BME background).
6. **Increase diverse representation** in roles at Bands 6 and above and improve confidence in fair recruitment and promotion of diverse colleagues. (Measures: Improvement in Indicators 1, 7, 9 and RDR by December 2024, and sustained positive score in Indicator 2. Meeting Model Employer targets at Bands 6 and above).
7. **Maintain Indicator 3**, with an equal and proportional number of ethnic minority staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation. (Measure: Maintain Indicator 3 to no difference between BME and white colleagues by December 2023).
8. **Improve data quality and usage,** with a focus of improving monitoring of access to training, development opportunities and better information at a divisional level.

In addition, three priority areas (listed below) have been identified by the Staff network and the Trust WRES Expert which have been incorporated, where appropriate into the action plan above (appendix 1).

The three priority areas:

1. Anti- racism approaches are embedded across the DHCFT to address workforce race inequalities
2. Use of Quality Improvement where appropriate to demonstrate impact and sustainability
3. Increase diverse representation through improved career progression in roles at Bands 6 and above and improve confidence in fair recruitment and promotion of diverse colleagues.

The Board is requested to note this report and action plan will be incorporated into wider EDI work with is in progress including:

- Staff Network framework
- EDI Framework

Strategic Considerations	
1) We will deliver **great care** by delivering compassionate, person-centred innovative and safe care.	x
2) We will ensure that the Trust is a **great place to work** by creating a compassionate, skilled and empowered leadership, creating a vibrant culture where colleagues feel they belong, thrive and are valued.	x
3) The Trust is a **great partner** and actively embraces collaboration as our way of working.	x

4) We will make the **best use of resources** by making financially wise decisions and avoiding wasting resources to ensure financial recovery and long term sustainability.	x

Assurances

- The WRES dataset has been submitted to NHS England in time for the deadline of 31 August 2022
- The Trust has signed up to the WRES Experts Programme to facilitate best practice and guidance
- The has been worked up into a detailed action plan. This will be a live document subject to quarterly review and engagement opportunities during the review process. This will ensure that the Trust's plan includes staff and stakeholders' voice at every stage of the development and implementation processes.

Consultation

- The Trust's WRES Expert will be consulted on the data and on the areas on which to conduct further investigation and will continue to be involved in the WRES submission going forward
- Consultation on the data and action plan has taken place with the BME Network, EDI Group, operational leaders at the Trust Operational Oversight Leadership meeting and the Executive Leadership team as part of ongoing engagement to ensure that action plans remain effective throughout the year
- The Staff Networks' Chairs has also been consulted on the data and action plan priorities during the Staff Networks' Chairs' Monthly meeting held on 18 August 2022. An open engagement session was also held on 24 August 2022.
- Engagement with the Staff Network Chairs, WRES Expert and Dr Aicha Riaz, around the three priorities actions, 17 October 2022.

Governance or Legal Issues

- WRES reporting is a mandatory requirement of the NHS Standard Contract. The Trust is required to submit the WRES dataset to NHS England by 31 August 2022 and publish the report and action plans on the public-facing website by 31 October 2022.
- Undertaking the WRES demonstrates the Trust's commitment to the Equality Act 2010 and Public Sector Equality Duty.

Public Sector Equality Duty and Equality Impact Risk Analysis

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

The WRES is a set of indicators related to the workplace experience of staff from a BME background, ranging from opportunities for career progression, to harassment, bullying and abuse. The differential impact is evidenced by the dataset in the Executive Summary above and in appendix 1, which includes:

- BME colleagues experience consistently higher rates of harassment, bullying and abuse than white colleagues
- BME colleagues' representation at Senior levels is still a big area for improvement where further work is required.

The purpose of the WRES is to identify areas in workplace experience that negatively impact BME staff compared to white staff and target actions to close the gaps.

Monitoring the WRES annually allows the Trust to assess the impact of targeted actions to create a more inclusive culture. This is achieved alongside further reporting requirements such as the Race Disparity Ratio that give a more in depth understanding of the workplace experience for BME staff.

The actions as part of the WRES action plan will be further enhanced by the Trust's investment in the Above Difference, Cultural Intelligence programme (CQ) that started in September 2021 and is still ongoing to conclude in October 2022 as well as the system-wide pilot into developing culturally intelligent recruitment practices. This is also expected to have a positive impact on intersectional staff with other protected characteristics.

The Trust's BME Network have had the opportunity to review and comment on this year's updated data and feedback on whether it is reflective of their lived experience.

Recommendations

The Board of Directors is requested to:

1) Review and approve the WRES Report and Action Plan 2022/23 (appendix 1) and note the publication on the Trust's public-facing website.
2) Note the engagement and development of the action plan with the BME Network
3) Consider and discuss the strategic implications of the WRES 2022/23.

Report presented by: **Jaki Lowe**
Director of People and Inclusion
Report prepared by: **Samina Arfan**
Head of Equality, Diversity and Inclusion
Amany Rashwan
Equality, Diversity and Inclusion Advisor

NHS
Derbyshire Healthcare
NHS Foundation Trust

Workforce Race Equality Standard (WRES)

Annual Report 2021/22

October 2022

Making a positive difference

Contents

1. Background

The Workforce Race Equality Standard (WRES) is an annual data collection exercise which highlights the experiences of Black, and Minority Ethnic (BME) compared to their white counterparts within an organisation. The standard is a requirement for all NHS health care providers through the NHS standard contract.

The WRES requires organisations to demonstrate progress against nine metrics specifically focused on race equality and suggests actions to address the disparities identified.

The data and statistics used in this report reflect Workforce indicators, NHS staff survey Indicators and a Board representation indicator.

> We collected our data on 31 March 2022 when our workforce consisted of **2879 colleagues. 16.7% were black ethnic minority, 80.83% were white,** and **2.47% of colleague's ethnicity is unknown.**

Workforce data:

The period the organisation's data refers to is Staff in post as of 31 March 2022; Financial Year 2020/22 for all relevant indicators with the exception of Indicator 3, which may require a two-year reporting period.

Note - Indicator 7: There has been a change in the reporting mechanism of this indicator this year, which affected the percentages as shown in the report. In previous years, the percentage reported was those saying, 'yes' as a proportion of all staff excluding those who said, 'don't know'. For this year's reporting, the figure reported is the percentage saying 'yes' as a proportion of all those who responded (including 'don't know'). This approach has been applied to the historical data in the 2021 reports.

1.2 National, regional and local context

National research suggests, diverse organisations that attract and develop individuals from the widest pool of talent consistently perform better. Baroness McGregor-Smith, Race in the Workplace: The McGregor-Smith review (2017)[1]. In the case of ethnic and cultural diversity, our business-case findings are equally compelling: in 2019, top-quartile companies outperformed those in the fourth one by 36 percent in profitability, slightly up from 33 percent in 2017 and 35 percent in 2014. As we have previously found, the likelihood of outperformance continues to be higher for diversity in ethnicity than for gender McKinsey 2020 report, Diversity Wins: How inclusion matters: (2020)[2]

[1] https://www.gov.uk/government/publications/race-in-the-workplace-the-mcgregor-smith-review
[2] https://www.mckinsey.com/featured-insights/diversity-and-inclusion/diversity-wins-how-inclusion-matters

Despite this, evidence persists of continuing racial injustice and inequalities in UK society and in our workplaces. Recent events such as the Windrush scandal[3] and the Grenfell Tower disaster[4], the COVID-19 pandemic[5], and the major 2020 anti-racism protests have highlighted the range of continuing racial injustice experienced in the UK. The COVID-19 crisis has shown how intertwined economic and social indicators such as low pay, inadequate housing and poor health and wellbeing are with ethnicity and ethnic pay and representation gaps. They have also underlined the need for stronger action to be taken in society and in its workplaces to address these areas and to implement lasting and effective solutions.

The 'No More Tick Boxes' report published by NHS East of England in September 2021, identifies the challenges BME people face throughout the recruitment process. Alongside data gathered from previous years of the WRES, there's evidence which shows that simply getting to an interview is an immense achievement for BME candidates, considering the cumulative lack of support and opportunity they may have had. Unfortunately, BME candidates remain less likely to be appointed in posts compared to their white counterparts.

The NHS constitution has a specific section that refers to the rights of staff. It recognised that it is the commitment, professionalism and dedication of staff working for the benefit of the people the NHS serves which really make the difference. High quality care requires high quality workplaces, with commissioners and providers aiming to be employers of choice. The WRES is important because research shows that a motivated, included and valued workforce helps to deliver high quality patient care, increased patient satisfaction and improved patient safety.

The main purpose of the WRES is:

- To compare the experiences of BME colleagues compared to their white counterparts.
- To better understand the experiences of BME staff and enable a more inclusive environment.
- To identify good practice and compare our performance with similar Trusts and use the information derived from the metrics to develop a local action plan and demonstrate progress against the indicators of racial equality.
- To help local, and national, NHS organisations (and other organisations providing NHS services) to review their data against the nine WRES indicators.

[3] : https://www.jcwi.org.uk/windrush-scandal-explained
[4] https://www.bbc.co.uk/news/uk-53320082
[5] https://www.gov.uk/government/publications/covid-19-understanding-the-impact-on-bame-communities

- To produce an action plan to address any differences in the workplace experienced by BME colleagues and their white counterparts and, improve BME representation at the Board level of the organisation.

At a Joined-Up Care Derbyshire, system and organisational level, we believe every person, of all backgrounds, should be able to fulfil their potential at work and feel a true sense of belonging. That is the business case as well as the moral case and it is in line with our values in Derbyshire Healthcare of being an inclusive and compassionate employer with a 'People First' approach and our system wide EDI Strategy 'Creating a sense of belonging with 4 strategic priorities listed below and attached action plan:

- Attracting and recruiting diverse talent
- Inclusive and accountable leadership and decision-making
- Supporting and valuing people
- Building authentic connections and shared understanding

The Trust Board's commitment to addressing racial inequality for patients and staff and is reflected in its vision and ambitions to grow and increase our workforce to meet DHCFT's Acute Dormitory Eradication and PICU programme. This aims to address inequalities patients face in acute mental health inpatient settings by improving patient outcomes and experience

There is a recognition that to change culture takes time however incremental change towards race equality is not enough and that transformation change is essential to create a great place to be cared for and a great place to work.

Last year, this approach included supporting the Trust's WRES Expert, who worked with divisions to support development of their plans to address race inequality; a designated Non-Executive Director for Equality, Diversity and Inclusion; and system investment in the Cultural Intelligence to review the recruitment pathway and the JUCD EDI strategy was developed with extensive engagement across the system and provides our approach to delivery of the Midlands Race Equality and Inclusion Strategy, WRES, WDES and Model Employer targets.

2: Reporting Requirements

The following table sets out the reporting requirements for the WRES:

The first 4 indicators are workforce indicators.	
1.	Percentage of staff in each of the AfC Bands 1-9 or Medical and Dental subgroups and VSM (including executive Board members) compared with the percentage of staff in the overall workforce
2.	Relative likelihood of staff being appointed from shortlisting across all posts
3.	Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation
4.	Relative likelihood of BAME staff accessing non mandatory training and CPD compared to white staff.
National NHS Staff Survey indicators (or equivalent)	
5.	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months
6.	Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months
7.	Percentage believing that trust provides equal opportunities for career progression or promotion
8.	Percentage of staff experiencing discrimination from managers and team leaders
Indicator 9 focuses on board membership make up	
9.	Percentage difference between the organisations' Board membership and its overall workforce disaggregated: • By voting membership of the Board • By executive membership of the Board

The national data submission was completed by 31 August 2021 to the national WRES team, and this report and action plan will be published on the internet by 31 October 2022 as required.

2.1 Summary of Data: DHCFT and MIDLANDS 2020/21

Derbyshire Healthcare NHS Foundation Trust
Midlands

Summary for the 2020/21 reporting year RXM

Indicator number and description			Trust	Midlands	National	Percentile rank*
Indicator 1: BME representation in the workforce by pay band						
BME representation in the workforce overall			15.5%	21.6%	22.4%	
Pay band at which BME under-representation first occurs	Non-clinical	Band 4 and under	Band 3	Band 4	Band 3	
		Band 5 and over	Proportional	Band 8C	Band 8B	
	Clinical	Band 4 and under	Band 4	Band 3	Band 3	
		Band 5 and over	Band 6	Band 6	Band 6	
	Medical		Proportional	Consultant	Consultant	
Race disparity ratios	Non-clinical	Lower to middle	5.05	1.02	0.91	100%
		Middle to upper	0.33	1.43	1.39	89%
		Lower to upper	1.68	1.46	1.27	48%
	Clinical	Lower to middle	2.35	1.84	1.59	71%
		Middle to upper	1.17	1.23	1.36	16%
		Lower to upper	2.75	2.27	2.16	46%
Indicator 2: likelihood of appointment from shortlisting						
likelihood ratio White / BME			1.60	1.57	1.61	57%
Indicator 3: likelihood of entering formal disciplinary proceedings						
likelihood ratio BME / White			10.52	1.09	1.14	100%
Indicator 4: likelihood of undertaking non-mandatory training						
likelihood ratio White / BME			1.52	1.04	1.14	68%
Indicator 5: harassment, bullying or abuse from patients, relatives or the public in last 12 months						
BME			28.0%	26.8%	28.9%	44%
White			22.8%	25.8%	25.9%	29%
Indicator 6: harassment, bullying or abuse from staff in last 12 months						
BME			27.5%	28.5%	28.8%	47%
White			16.2%	22.8%	23.2%	6%
Indicator 7: belief that the trust provides equal opportunities for career progression or promotion						
BME			72.9%	69.5%	69.2%	48%
White			90.6%	87.8%	87.3%	20%
Indicator 8: discrimination from a manager/team leader or other colleagues in last 12 months						
BME			15.5%	16.9%	16.7%	39%
White			4.9%	5.9%	6.2%	21%
Indicator 9: BME representation on the board minus BME representation in the workforce						
Overall			-2.2%.	-7.7%.	-9.8%.	11%
Voting members			+1.2%.	-8.4%.	-10.0%.	5%
Executive members			-3.0%.	-12.1%.	-13.5%.	9%

* ranks the Trust from 0% (best in the country) to 100% (worst in the country) on each indicator.

2.2: Summary of Data JUCD and MIDLANDS 2020/21

Derbyshire
Midlands

Summary for the 2020/21 reporting year

Indicator number and description			ICS	Midlands	National	Percentile rank*
Indicator 1: BME representation in the workforce by pay band						
	BME representation in the workforce overall		13.9%	21.6%	22.4%	
Pay band at which BME under-representation first occurs	Non-clinical	Band 4 and under	Proportional	Band 4	Band 3	
		Band 5 and over	Proportional	Band 8C	Band 8B	
	Clinical	Band 4 and under	Band 3	Band 3	Band 3	
		Band 5 and over	Band 6	Band 6	Band 6	
	Medical		Consultant	Consultant	Consultant	
Race disparity ratios	Non-clinical	Lower to middle	1.04	1.02	0.91	12%
		Middle to upper	1.64	1.43	1.39	71%
		Lower to upper	1.70	1.46	1.27	63%
	Clinical	Lower to middle	2.53	1.84	1.59	90%
		Middle to upper	0.74	1.23	1.36	51%
		Lower to upper	1.89	2.27	2.16	24%
Indicator 2: likelihood of appointment from shortlisting						
	likelihood ratio White / BME		1.27	1.57	1.61	17%
Indicator 3: likelihood of entering formal disciplinary proceedings						
	likelihood ratio BME / White		0.36	1.09	1.14	100%
Indicator 4: likelihood of undertaking non-mandatory training						
	likelihood ratio White / BME		0.41	1.04	1.14	93%
Indicator 5: harassment, bullying or abuse from patients, relatives or the public in last 12 months						
	BME		29.0%	26.8%	28.9%	41%
	White		26.5%	25.8%	25.9%	27%
Indicator 6: harassment, bullying or abuse from staff in last 12 months						
	BME		29.3%	28.5%	28.8%	73%
	White		21.0%	22.8%	23.2%	10%
Indicator 7: belief that the organisation provides equal opportunities for career progression or promotion						
	BME		75.2%	69.5%	69.2%	15%
	White		89.4%	87.8%	87.3%	3%
Indicator 8: discrimination from a manager/team leader or other colleagues in last 12 months						
	BME		17.3%	16.9%	16.7%	66%
	White		5.4%	5.9%	6.2%	7%
Indicator 9: BME representation on the board minus BME representation in the workforce						
	Overall		0.0%.	-7.7%.	-9.8%.	0%
	Voting members		-3.5%.	-8.4%.	-10.0%.	27%
	Executive members		-5.8%.	-12.1%.	-13.5%.	32%

* ranks the ICS from 0% (best in the country) to 100% (worst in the country) on each indicator.

2.3: Summary of Data DHCFT WRES 2021/22

	Improvements and sustained positive outcomes:
	Indicator 1: The overall BME representation across the Trust has risen from **15.5% in 2020-21 to 16.7%.**
	Indicator 1: The representation of colleagues from a BME background in non-clinical Bands 6 has increased from **1.8% in 2020-21 to 5.66% in 2021-22.** The representation of colleagues from a BME background in clinical Bands 8a and 8c has increased by **4.5%, and 11% than 2020-21**
	Indicator 3: The likelihood of BME staff entering the formal disciplinary process compared to white staff has significantly reduced from **10.52 times more likely (2020/21) to 0.00 times more likely (2021/22).**
	Indicator 6: A decrease of BME colleagues experiencing harassment, bullying or abuse from staff in the last 12 months since 2020/21, from **27.5% to 22.6%.**
	Indicator 8: A decrease of BME colleagues who have personally experienced discrimination at work from their manager/team leader or other colleagues, by **0.8% since 2020/21 when it was 15.5% for BME staff.**
	Indicator 9: BME colleagues are represented at board level positions, standing at 33.33%, with a positive increase by 16.6% in comparison to the workforce representation

	Deterioration and/or sustained negative outcomes:
	Indicator 2: The relative likelihood of white candidates being appointed from shortlisting compared to BME candidates has **increased from 1.6 times more likely (2020/21) to 1.78 times more likely (2021/22).**
	Indicator 6: An increase of White colleagues experiencing harassment, bullying or abuse from staff in the last 12 months since 2020/21**, from 16.2% to 17.7%.**

2.4: WRES Data 2021/2022 comparative with 2020/21

Detailed below is the organisation's WRES data submitted on 31 August 2022 covering the period 1 April 2021 to 31 March 2022.

	2020/21	2021/22
Number of staff employed within Trust	2795	2879
Proportion of BME staff employed within Trust as of 31 March 2022	15.49% (433 people)	16.7% (481 people)
Indicator 1: Percentage of staff in each of the AfC Bands 1-9 and VSM compared with the percentage in the overall workforce	Please see table below (4b, page 11)	
Indicator 2: Relative likelihood of staff being appointed from shortlisting across all posts *[A figure above "1" would indicate white candidates are more likely to be appointed from shortlisting]*	1.60	1.78
Indicator 3: Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation *[A figure above "1" would indicate BME staff are more likely to enter the formal disciplinary process]*	10.52 *[Note: This indicator is based on data from the current year only, in line with the updated WRES guidance for 2020/21]*	0.00
Indicator 4: Relative likelihood of staff accessing non-mandatory training and CPD compared to BME staff *[A figure above "1" would indicate BME staff are less likely to access non-mandatory training and CPD]*	1.52	0.73
Indicator 5: Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or members of the public	BME: 28.0% White: 22.8%	BME: 28.7% White: 25.4%
Indicator 6: Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months	BME: 27.5% White: 16.2%	BME: 22.6% White: 17.7%
Indicator 7: Percentage believing that the Trust provides equal opportunities for career progression or promotion	BME: 72.9% **(45.3%)** White: 90.6% **(66.3%)**	BME: 46.8% White: 67.7%
Indicator 8: Percentage of staff who have personally experienced discrimination at work from their manager/team leader or other colleagues in the last 12 months	BME: 15.5% White: 4.9%	BME: 14.7% White: 5.6%
Indicator 9: Percentage difference between the organisation's Board voting membership and the overall workforce	1.2% (Board Voting Membership from a BME background: 16.7% Overall workforce from a BME background: 15.49%)	16.6% (Voting Board Membership from a BME background: 33.33. BME% of overall workforce is 16.71)

3: Representation, recruitment and progression

3.1. Indicator 1: Representation

	The overall BME representation across the Trust has risen from **15.5% in 2020-21 to 16.7%.**
	The representation of colleagues from a BME background in non-clinical Bands 6 has increased from **1.8% in 2020-21 to 5.66% in 2021-22.**
	The representation of colleagues from a BME background in clinical Bands 8a and 8c has increased by **4.5%, and 11% than 2020-21**

3.1.2. Indicator 1 - Breakdown of representation by banding: non-Clinical

NON-CLINICAL						
	2020/21			2021/22		
Band	White %	BME %	Unknown %	White %	BME %	Unknown %
Under Band 1	0.0%	0.0%	0.0%	100.00%	0.00%	0.00%
Band 1	40.0%	20.0%	40.0%	0.00%	0.00%	100.00%
Band 2	72.2%	24.6%	3.2%	67.80%	28.25%	3.95%
Band 3	90.3%	8.7%	1.0%	89.95%	9.05%	1.01%
Band 4	91.3%	7.9%	0.8%	89.44%	9.15%	1.41%
Band 5	85.5%	11.8%	2.6%	84.71%	12.94%	2.35%
Band 6	89.1%	1.8%	9.1%	88.68%	5.66%	5.66%
Band 7	84.6%	7.7%	7.7%	91.30%	4.35%	4.35%
Band 8a	100.0%	0.0%	0.0%	100.00%	0.00%	0.00%
Band 8b	88.9%	11.1%	0.0%	90.00%	10.00%	0.00%
Band 8c	84.6%	15.4%	0.0%	92.86%	7.14%	0.00%
Band 8d	85.7%	14.3%	0.0%	87.50%	12.50%	0.00%
Band 9	0.0%	0.0%	0.0%	0.00%	0.00%	0.00%
VSM	87.5%	12.5%	0.0%	75.00%	25.00%	0.00%

3.1.3. Indicator 1 - Breakdown of representation by banding: Clinical

CLINICAL						
	2020/21			2020/21		
Band	White %	BME %	Unknown %	White %	BME %	Unknown %
Under Band 1	62.	37.5	0.0	62.5	37.50	0.00
Band 1	0.	0.0	0.0	0.0	0.0	0.0
Band 2	66.0	27.7	6.4	75.0	12.50	12.50
Band 3	72.9	23.4	3.6	71.6	25.34	3.03
Band 4	86.9	11.1	2.0	87.4	10.81	1.80
Band 5	79.7	16.3	4.0	75.2	21.22	3.54
Band 6	88.3	8.9	2.8	87.5	10.75	1.77
Band 7	87.0	10.6	2.5	88.6	9.84	1.59
Band 8a	90.5	8.3	1.2	84.9	12.79	2.33
Band 8b	88.6	8.6	2.9	87.8	7.32	4.88
Band 8c	92.9	0.0	7.1	88.9	11.11	0.00
Band 8d	50.0	50.0	0.0	50.0	50.00	0.00
Band 9	0.0	0.0	0.0	0.00	0.00	0.00
VSM	0.0	0.0	0.0	0.00	0.00	0.00
of which Medical and Dental						
Consultants	40.3	57.1	2.6	39.7	57.69	2.56
of which senior medical manager	100.0	0.0	0.0	100.0	0.00	0.00
Non-consultant career grade	31.3	65.6	3.1	43.8	53.13	3.13
Trainee grades	28.6	64.3	7.1	33.3	56.67	10.00
Other	0.0	0.0	0.0	0.00	0.00	0.00

3.2 Indicator 9 - Voting Board membership

Indicator 9: BME colleagues are represented at board level positions, standing at 33.33%, with a positive increase by 16.6% in comparison to the workforce representation

	2020/21	2021/22
Indicator 9: Percentage difference between the organisation's Board voting membership and the overall workforce	1.2% (Board voting membership from a BME background: 16.7%. Overall workforce from a BME background: 15.49%)	16.6% (Voting Board Membership from a BME background: 33.33%. BME of overall workforce is 16.71%)

The table below reflects board membership and the difference between BME representation on the board and BME representation in the workforce from across the JUCD system, for 2020/21.

	BME %	**White %**	**Overall %**
Chesterfield Royal Hospital NHS FT	5.5	5.5	8.8
University Hospitals of Derby and Burton NHS FT	-5.9	-15.8	-21.7
East Midlands Ambulance Service NHS Trust	10.9	-3.3	-3.3
Derbyshire Healthcare NHS FT	-2.2	1.2	-3.0
Derbyshire Community Health Services NHS FT	7.4	10.3	7.4

3.3. Indicator 2 - likelihood of appointment from shortlisting

	The relative likelihood of white candidates being appointed from shortlisting compared to BME candidates has **increased from 1.6 times more likely (2020/21) to 1.78 times more likely (2021/22).**
	The relative likelihood of White candidates being appointed from shortlisting compared to BME candidates has **increased from 1.6 times more likely (2020/21) to 1.78 times more likely (2021/22).**

	Annual - Mar 2022			Annual - Jun 2022			Annual - Sep 2022		
	White	BME	Unknown	White	BME	Unknown	White	BME	Unknown
Number of Shortlisted Applicants	2289	871	48	2171	786	40	2263	824	48
Number Appointed from Shortlisting	491	105	19	432	94	7	453	118	9
Relative Likelihood of appointment from Shortlisting	21.45%	12.06%	39.58%	19.90%	11.96%	17.50%	20.02%	14.32%	18.75%
Relative Likelihood of White Staff being appointed from Shortlisting compared to BME Staff	1.78			1.66			1.40		

The Trust has been introducing several measures that aim at improving the recruitment process and creating a more inclusive approach to it, including mandatory recruitment and selection training with emphasis on Inclusive Recruitment, which now includes modules on unconscious bias and values-based recruitment.

Recruitment Inclusion Guardians (RIGs) were also introduced to recruitment panels at Band 7 and above from February 2020 to address the underrepresentation of BME staff at senior levels. This was expanded to include panels at Band 6 and above in April 2021. The process will be undergoing a review to identify barriers, opportunities and recommending improvements with the aim of widening impact and embedding inclusion to be everyone's responsibility throughout the recruitment process.

The Trust is taking part in a Above Difference Recruitment and Selection Pilot to review the process and propose positive, culturally intelligent, and inclusive initiatives and interventions that will be implemented across NHS Providers in the ICS (Integrated Community System known as Joined Up Care Derbyshire - JUCD). The impact of this initiative is expected to return positive results by 2023 at the earliest.

3.4 Indicator 4 - access to non-mandatory training and CPD

	2020/21	2021/22
Indicator 4: Relative likelihood of staff accessing non-mandatory training and CPD compared to BME staff *[A figure above "1" would indicate BME staff are less likely to access non-mandatory training and CPD]*	1.52	0.73

			2021			2022		
DATA ITEM		MEASURE	WHITE	BME	ETHNICITY UNKNOWN/NULL	WHITE	BME	ETHNICITY UNKNOWN/NULL
	1a) Non Clinical workforce		Verified figures	Verified figures	Verified figures	Verified figures	Verified figures	Verified figures
42	Number of staff in workforce	Auto calculated	2278	433	84	2327	481	71
43	Number of staff accessing non-mandatory training and CPD:	Headcount	128	16	6	327	92	9
44	Likelihood of staff accessing non-mandatory training and CPD	Auto calculated	5.62%	3.70%	7.14%	14.05%	19.13%	12.68%
45	Relative likelihood of White staff accessing non-mandatory training and CPD compared to BME staff	Auto calculated	1.52			0.73		

The relative likelihood is derived by dividing the percentage of White staff who undertook non-mandatory training by the percentage of BME staff who undertook non-mandatory training.

Though our data suggests that BME staff are more likely to access training and CPD through the Training Management System. **Note:** that this measure does not record access to wider non-mandatory training and CPD and may offer a misleading picture. Also, despite being more likely to access non-mandatory training, BME staff are still less likely to progress through the organisation and less likely to be appointed from shortlisting (see Indicator 2, page 12).

3.5. Indicator 7: fairness in career progression

Percentage believing that the Trust provides equal opportunities for career progression or promotion	BME: 72.9% **(45.3%)** White: 90.6% **(66.3%)**	BME: 46.8% White: 67.7%

Note: Indicator 7: There has been a change in the reporting mechanism of this indicator this year, which affected the percentages as shown in the report. In previous years, the percentage reported was those saying, 'yes' as a proportion of all staff ***excluding*** *those who said, 'don't know'.* For this year's reporting, the figure reported is the percentage saying 'yes' as a proportion of all those who responded (including 'don't know'). This approach has been applied to the historical data in the 2021 reports.

	Indicator 9: BME colleagues are represented at board level positions, standing at 33.33%, with a positive increase by 16.6% in comparison to the workforce representation

4: Formal disciplinary processes

4a. Indicator 3 - likelihood of entering the disciplinary process

	The likelihood of BME staff entering the formal disciplinary process compared to white staff has significantly reduced from **10.52 times more likely (2020/21) to 0.00 times more likely (2021/22).**

The likelihood of BME staff entering the formal disciplinary process compared to white staff has significantly reduced from 10.52 times more likely (2020/21) to 0.00 times more likely (2021/22) which is a very positive improvement in this area, especially with the Trust having been on the top worst performing Trusts in this area last year.

5: Behaviours and discrimination

5a. Indicator 5 - bullying and harassment from the public

	An increase of BME colleagues experiencing harassment, bullying or abuse from patients, relatives or members of the public, since 2020/21 **from 28% to 28.7 %.** And an increase for White staff since 2020/21**, from 22.8% to 25.4%.**

5b. Indicator 6 - bullying and harassment from staff

	A decrease of BME colleagues experiencing harassment, bullying or abuse from staff in the last 12 months since 2020/21, from **27.5% to 22.6%.**

5c. Indicator 8 - bullying and harassment from Managers

	A decrease of BME colleagues who have personally experienced discrimination at work from their manager/team leader or other colleagues, by **0.8% since 2020/21 when it was 15.5% for BME staff.**

The National NHS Staff survey provides an insightful view about how staff are feeling working within the Trust. It should be noted that the survey takes place during a set period and highlights the feelings of staff during that time.

6. Conclusion

Overall, the WRES collection for 2021/22 has shown several improvements compared to figures previously which is good to see. However, the Trust recognises that it's on a journey and more needs to be done to improve experiences of our BME workforce. Below list some of the progress the BME network has made over the past year

- Some of the network members have just finished the Networks' Chairs Development programme and the outcome is positive. Specially that the programme emphasised on the concept that networks members need to be active and participate. The Trust WRES Expert stated that more members are putting themselves forward more and willing to participate more.
- The Chairs of the BME Networks across the system have been coming together to discuss and plan Black History Month
- The Network has recently submitted their nomination for Midlands Inclusivity and Diversity Award (MIDAS) Scheme and awaiting the response.
- The Network has collaborated with the Women's Network and commissioned a 1-day Training Workshop titled "Leadership for Women of Colour "which was very well attended.

7. Key priorities and actions

The Action Plan, in Appendix 1, identifies key actions which will be undertaken over the next 12 months, supporting the organisation to improve.

The action plan (attached Appendix 1) includes those rolling over from the last WRES Report 2020-21, those deriving from the JUCD EDI Strategy 'Creating a Sense of Belonging' and 3 priorities identified by the BME Network from this year's WRES 2021/22 data.

Derbyshire Healthcare NHS Foundation Trust

Provider Organisation: **Derbyshire Healthcare NHS Foundation Trust**

Date of Report: **August 2022**

Board Lead for the Workforce Race Equality Standard: **Jaki Lowe, Director of People and Inclusion**

Lead Manager/s compiling this report: **Samina Arfan, Head of EDI /Amany Rashwan, Equality, Diversity and Inclusion Advisor**

Document Control			
Date	**Amendment**	**Version**	**Comments/Author**
08/22	**Data analysis and draft report**	V0.1	Amany Rashwan
8/22	**Report narrative and review**	V0.2	Jaki Lowe
14/09/22	**Report narrative and review**	V0.3	Samina Arfan,
15/09/22	**Amendments**	V0.4	Samina Arfan, Jaki Lowe
20/09/22	**For review and endorsement**	V0.5	People and Culture Committee
17/10 /22	**For engagement**	V0.4	Black Minority Ethnic Staff Network
25/10/22	**ELT**	**Final Draft**	Samina Arfan
01/11/22	**Final for endorsement**	**Final**	**Trust Board**
31/10/22	**For publication**	**Final**	**DHCFT Communications team**

Workforce Race Equality Standard (WRES)

Appendix 1: Action Plan 2022/23

October 2022

Making a positive difference

Appendix 1: Action Plan

The action plan below has been developed with the Black and Ethnic Minority staff network, with a focus on improving indicators relating to developing anti racism approaches, the improved usage of data to drive change and create impact (incorporating quality improvement principles), representation in roles band 6 and above, addressing bullying, harassment or abuse and career progression. Improvements in these areas should impact on the overall engagement, experience and feelings of value for colleagues from a BME background and be reflected in these metrics accordingly.

Appendix 1: WRES Action Plan 2022/23				
	Outcome	Actions	Leads	Timescales
1	**Improve understanding** of local issues across the Trust, learning from current lived experience, to implement best practice responses with a full evaluation of the impact. **Measures:** Improvement in Indicators 2, 6 and 8 by December 2023	Continued focus in addressing race inequality and the wider EDI agenda through the dedicated designation of a Non-Executive Director as a lead for Equality, Diversity and Inclusion; Executive Sponsor for the BME Network, WRES Experts; Freedom to Speak Up: EDI team.	Chief Executive/ Director of People and Inclusion and Head of EDI	31 October 2023 Quarterly updates
		Building accountability for EDI in every manager's role.	Head of EDI, and Acting Deputy Director of People and Inclusion	31 October 2023 Quarterly updates
		To improve access to the voices of all BME staff (across the breadth BME groups and work status: Bank, junior doctors, apprenticeships etc)	Head of EDI, Freedom to Speak up Guardian, BME Network	31 October 2023 Quarterly updates
		Review previous mentoring programme and propose revised approach for ELT	Head of EDI	January 2022
2	**Improve leadership approach** and response to improve ethnic minority colleague experience through a consistent, Trust-wide approach to anti racism.	Take stock of current work and set ambition to become a proactive anti-racist organisation aligned with JUCD system approach and good practice anti racism toolkits including Race Code.	Head of EDI, WRES Expert, BME Network,	31 October2023 Quarterly updates

Appendix 1: WRES Action Plan 2022/23				
	Measures: Improvement in Indicators 5-8 by December 2023.	Promote resources, guides and tools including the best practice Anti Racist education and knowledge to help leaders and individuals have productive conversations about race.	Head of EDI/ WRES Expert/ BME Network	31 October 2023 Quarterly updates
		Development of Anti-Racism Influencers consisting of White colleagues to provide support to potential and developing allies, utilising the Anti-Racist approaches.	Head of EDI/ WRES Expert/ BME Network	31 October 2023 Quarterly updates
3	DHCFT colleagues **consistently demonstrate inclusive behaviours** and leadership, in line with the good practice 'Behavioural Standard Framework'. **Measures:** Improvement in Indicators 5 – 8 by December 2023	Development and rollout of training materials (new and existing) to improve support for bystanders on how to safely intervene in conflict situations and support colleagues involved, with accompanying comms campaign.	Head of EDI/Sponsor for BME Network/Chair of BME Network	31 October 2023 Quarterly updates
		Review the evaluation of the development programme for staff network members and deliver lunch and learn session on how to handle micros aggressions	Head of EDI, Head of EDI DCHS	December 2022
		Deliver further lunch and learn session on how to handle micros aggressions internally	Head of EDI/Team	31 October 2023 Quarterly updates
		Review and enhance current 'it's not ok' to include the best practice Behavioural Standard	Head of EDI/Team	31 October 2023 Quarterly updates
4	**Building of relationships and trust** with black and ethnic minority colleagues. **Measure:** Improvements in overall BME staff engagement score (National Staff Survey) by December 2023.	Increase and maximise usage of the existing CQ (Cultural Intelligence Facilitators to raise awareness across the Trust about the Cultural Intelligence principles	Head of EDI/ Acting Deputy Director of People and Inclusion/ CQ Facilitators	31 October 2023 Quarterly updates
		Build relationships and trust with BME colleagues by improving timescale and to take an active anti-racism approach to responded to concerns raised and to close the loop in Datix	Head of EDI, Freedom to Speak Up Guardian, BME Network, Datix Lead	31 October 2023 Quarterly updates
5	**Improved wellbeing support** for BME colleagues, particularly in	Deep dive to understand BME staff (including Bank, Junior Doctors, Apprenticeships) an	Head of EDI/Health and Well-Being Lead/ Freedom	31 October 2023 Quarterly updates

Appendix 1: WRES Action Plan 2022/23				
	relation to bullying, harassment and abuse. **Measure:** Improvement in indicators 5-8 and increase in proportion of colleagues accessing wellbeing and support services who are from a BME background	access to wellbeing services, allowing design of better service provision. Especially those experiencing bullying and harassment from patients/relatives/members of the public	to Speak -Up Lead/ Sponsor for BME Network/Chair of BME Network	
		Providing support to staff in roles which are directly supporting colleagues, developing confidence talking about race.	Head of EDI/Health and Well-Being Lead/ Freedom to Speak -Up Lead/ Sponsor for BME Network/Chair of BME Network	31 October 2023 Quarterly updates
6	**Increase diverse representation in roles at Bands 6** and above including Bands 7-8d and improve confidence in fair recruitment and promotion of diverse colleagues. **Measures:** Improvement in Indicators 1, 7, 9 and RDR by December 2024, and sustained positive score in Indicator 2. Meeting Model Employer targets at Bands 6 and above.	Propose improvements in BME representation (and other under-represented groups) to be included as part of objectives and appraisal for VSMs.	Head of EDI and Acting Deputy Director of People and Inclusion, BME Network Sponsor	31 October 2023 Quarterly updates
		Review of the RIGs process to identify barriers, opportunities and recommending improvements with the aim of widening impact and embedding into the recruiting chair's responsibility	Head of EDI/ Recruitment Lead/Staff Network Chairs	31 October 2023 Quarterly updates
		Introduce a system of 'comply or explain' to ensure fairness during interviews.	Head of EDI/ Recruitment Manager/Staff Network Chairs	31 October 2023 Quarterly updates
		Agree with SMT priority focus to align increased representation with addressing inequalities for example increase BME recruitment to support service delivery across Derby City	Head of EDI/Medical Director	31 October 2023 Quarterly updates
		Inclusive recruitment workshops with appointing managers with a particular focus on disrupting bias within recruitment and CQ (Cultural Intelligent) Principles	Head of EDI/ Recruitment Manager/Staff Network Chairs	31 October 2023 Quarterly updates
		Further develop the Cultural Intelligence HR/Recruitment National Pilot across the Derbyshire system with Above Difference to recruit and progress inclusively with Cultural	Head of EDI, Acting Deputy Director of People and Inclusion and Recruitment Manager	31 October 2023 Quarterly updates

Appendix 1: WRES Action Plan 2022/23				
		Intelligence. Ensure the next stage is aligned with the model employer		
		To ensure the organisational new approach for talent and succession planning supports under representative EDI staff groups including BME staff in their career development aspirations and supports future proofing of the Trust as an employer of choice and inclusive	Head of EDI and Acting Deputy Director of People and Inclusion, WRES Expert and BME Network	31 October 2023 Quarterly updates
		Enhance EDI support available to: - Train HR policy teams on how to complete robust and effective EIA of recruitment and promotion policies - Ensure that for Bands 8a and above, hiring managers include requirement for candidates to demonstrate EDI work/legacy during interviews.	Head of EDI/ Recruitment Lead/Policy Lead	31 October 2023 Quarterly updates
		Improved understanding of what constitutes non- mandatory training	Head of EDI/Training and Development Lead	31 October 2023 Quarterly updates
		Review implementation of just and learning culture to ensure a proactive anti-racist approach	Head of EDI and Acting Deputy Director of People and Inclusion, WRES Expert and BME Network	31 October 2023 Quarterly updates
		Review the work around raising concerns, complaints and allegations to fast-track racial related abuse and bullying formal and informal	Head of EDI and Acting Deputy Director of People and Inclusion, WRES Expert and BME Network	31 October 2023 Quarterly updates
		Review the formal disciplinary procedure for staff including medical and Bank staff to ensure parity between procedure and processes, and integrated support and monitoring of wellbeing alongside all formal HR processes e.g., performance and pathway for bank staff	Head of EDI, Acting Deputy Director of People and Inclusion, Freedom to Speak Up Guardian, BME Network	January 2022

Appendix 1: WRES Action Plan 2022/23				
		To agree and have dashboard with the KPIs	Head of EDI, Acting Deputy Director of People and Inclusion, Freedom to Speak Up Guardian, BME Network	
		Agree divisional People EDI plans to include, WRES KPIs	Head of EDI, Senior Employee Relations Manager, Health and Wellbeing Lead and BME Network	31 October 2023 Quarterly updates
7	**Maintain Indicator 3,** with an equal and proportional number of ethnic minority staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation. **Measure:** Maintain Indicator 3 to no difference between BME and white colleagues by December 2023.	Deep dive to understand BME staff access to wellbeing services, allowing design of better service provision. Increase knowledge and representation of wellbeing Champion, providing support and training to champions, increasing diversity, and using data to tackle issues strategically and proactively.	Head of EDI, Acting Deputy Director of People and Inclusion/Divisional Leads	January 2023
		Review the formal disciplinary procedure for staff including medical and Bank staff to ensure parity between procedure and processes, and integrated support and monitoring of wellbeing alongside all formal HR processes e.g., performance and pathway for bank staff	Head of EDI, Divisional People Leads, WRES Expert	31 October 2023 Quarterly updates
		To agree and have dashboard with the KPIs	Head of EDI, Acting Deputy Director of People and Inclusion, Freedom to Speak Up Guardian, BME Network	January 2022
8	**Improve data quality and usage**.	Review 6-month new starter review meetings for BME staff	Head of EDI, Acting Deputy Director of People and Inclusion, Head of	31 October 2023 Quarterly updates

Appendix 1: WRES Action Plan 2022/23				
			Systems & Information BME Network	
		Improve monitoring of access to training, development opportunities, career progression and better information at a divisional level	Head of EDI, Acting Deputy Director of People and Inclusion, Head of Systems & Information, Divisional People Leads BME Network	31 October 2023 Quarterly updates
		Improve the disaggregation of our BME Staff data by specific groups	Head of EDI, Acting Deputy Director of People and Inclusion, Head of Systems & Information BME Network	31 October 2023 Quarterly updates

Below lists the 3 priority areas identified by the Staff network and the Trust WRES Expert which have been incorporated, where appropriate into the action plan above.

1	**Anti- racism approaches** are embedded across the DHCFT to address workforce race inequalities: Work towards the good practice anti racism toolkits including Race Code and quality mark accreditation **Please note**, the priority for 2023 is to develop and align anti racism approaches to the JUCD working towards the Race code Quality Mark will need to be reviewed and agreed for 2024
2	**To utilise quality improvement approaches (QI) where appropriate** to demonstrate impact and sustainability
3	**Increase diverse representation through improved career progression** in roles at Bands 6 and above and improve confidence in fair recruitment and promotion of diverse colleagues.

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 1 November 2022

Workforce Disability Equality Standard Report and Action Plan (WDES) 2021/22

Purpose of Report

This report highlights the key findings from the Trust's 2021/2022 Workforce Disability Equality Standard (WDES). It showcases areas where the Trust has improved and where further work is required.

This report presents the data and action plan for the Board to note the engagement with the Disability and Wellness Network (DAWN) Staff Network that has taken place in order to shape the action plan for 2022/23 in appendix1. The WDES report and action plan will be published on the website.

Executive Summary

The WDES submission identifies the experiences of the Trust's Disabled colleagues in comparison with their non-disabled counterparts.

The WDES data informing this report has been submitted, as mandated to the National NHS WDES Team by 31 August 2022. The WDES Report and Action Plan has had input via engagement with the DAWN Staff Network prior to the final full report submission to the Board in November 2022 and is to be published on the public-facing website.

The 2022 data submission has shown some areas of improvement these include:

- Metric 1: The number of staff who have declared a disability on ESR has increased slowly but consistently over the last four years, since 2018 where 115 colleague declared a disability to 194 declarations status 2021.
- Metric 4b: The percentage of staff saying the last time they experienced harassment, bullying or abuse, they or a colleague reported it, increased since 2020/21 from 54.8% for disabled and 62.0% non-disabled colleagues to 64% for disabled and 63.1% non-disabled colleagues in 2021/22
- Metric 5: The percentage of staff believing the Trust provides equal opportunities for career progression, increased since 2020/21 from 60% for disabled and 64.4.0% non-disabled colleagues to 63.4% for disabled and 65.7% non-disabled colleagues in 2021/22
- Metric 8: The percentage of disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work, increased since 2020/21 from 86.6% for disabled colleagues to 89.5% for disabled 2021/22.

The 2022 data submission has shown some areas of concerns, these include:

- Metric 4a: The percentage of staff experiencing harassment, bullying or abuse from - Patients, service users or members of the public, increased since 2020/21 from 27.6% for disabled and 21.9% non-disabled colleagues to 30.9% for disabled and 23.8% non-disabled colleagues in 2021/22

- Metric 4a: The percentage of staff experiencing harassment, bullying or abuse from -Manager increased since 2020/21 from 11.2% for disabled and 5.7% non-disabled colleagues to 12% for disabled and 4.9% non-disabled colleagues in 2021/22
- Metric 4a: The percentage of staff experiencing harassment, bullying or abuse from - Other colleagues, increased since 2020/21 from 20.6% for disabled and 11.8% non-disabled colleagues to 19.7% for disabled and 12.1% non-disabled colleagues in 2021/22

Please refer to the attached WDES Report and action plan 2021/22 which includes the suggested key focus of work to address the areas of concerns.

Summary of The Trust's proposed WDES Outcomes:

The 2022/23 WDES action plan has been developed with several considerations, these are:

- Our legal and compliance requirements (i.e., EDS Domain 3, NHS People's Plan, Care Quality Commission Regulations, JUCD Three-year EDI plan, NHSE/I Mental Health Advancing Equalities Strategy)
- The data from our latest WDES Report
- The voice of our staff networks and colleagues

The WDES action plan consists of five main recommended outcomes, that underpin the actions the plan. These proposed outcomes are:

1. An increase in the disclosure rate on ESR to 50% by March 2023.
2. Improvement shown in Staff Survey 2022, bullying and harassment experienced by Disabled colleagues from their managers and colleagues (Metric 4)
3. Improvement shown in Staff Survey 2022, in career progression opportunities between Disabled and non-disabled colleagues (Metric 5)
4. A reduction in the number of Disabled staff reporting that they felt pressure to come into work despite not feeling well enough (Metric 6)
5. Improvement of at least 5% shown in Staff Survey 2021, adequate adjustments and Engagement (Metric 8)

Over the past year the DAWN Network has:

- Reasonable Adjustments Plan and accompanying Managers Guide has been reviewed and signed off by the Network – this will be requested to be incorporated into the leadership passport with attendance training etc. by the Leadership Development team

- The promotional video has been recorded and will be circulated within the current membership as well as via Communications, weekly focus email and on the intranet

The action plan (Appendix 1) will be a live document throughout the year which will be reviewed quarterly and reported to the People and Culture Committee.

The Board is requested to note this report and action plan will be incorporated into wider Equality Diversity and Inclusion (EDI) work with is in progress including:

- Staff Network framework
- EDI Framework

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

Assurances

- The WDES dataset has been submitted to NHS England in time for the deadline of 31 August 2022
- The Trust has achieved Disability Confident Employer status (Level 2), which means it is recognised as going the extra mile to make sure disabled people get a fair chance
- The action plan will be a live document subject to quarterly review and engagement opportunities during the review process. This will ensure that the Trust's plan includes staff and stakeholders' voice at every stage of the development and implementation processes.

Consultation

- Two engagement sessions were held for the Staff Network Chairs on 18 August 2022 and members of the staff networks and stakeholders on 24 August 2022 to discuss the data and action plan for the 2021/22 submission. This forms part of ongoing engagement to ensure the actions in the action plan remain effective throughout the year. A one-to-one session has also been held with the Chair of the DAWN Network on 22 August 2022 for this purpose
- Engagement with the DAWN Network on the action plan, took place 13 October 2022.

Governance or Legal Issues

- Section 149 of the Equality Act sets out the Public Sector Equality Duty (PSED), which offers protection in relation to employment, as well as access to goods and services. The PSED strengthens the duty on employers to eliminate discrimination and advance equality of opportunity for staff with protected characteristics, including disability
- Implementing the WDES assists DHCFT to ensure compliance with the provisions of the Equality Act 2010, and the aims of the PSED.

Public Sector Equality Duty and Equality Impact Risk Analysis

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

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

There have been historic challenges for disabled people in accessing employment. According to **the Office for National Statistics - Labour market A08 dataset**, between July and September 2021, 53.5% of disabled people aged 16 to 64 years in the UK were employed compared with 81.6% of non-disabled people. While similar patterns were seen for both sexes, a larger gap was seen in the employment rate between disabled and non-disabled men (31.1 percentage points) than for women (24.8 percentage points). The larger disparity was driven by the higher employment rate for non-disabled men (84.9%) than for non-disabled women (78.1%) while the employment rates for disabled people of both sexes were similar (53.8% for men and 53.3% for women).

The national WDES data analysis for all NHS Trusts in England highlights the disparity in workplace experience between disabled and non-disabled staff. Disabled NHS staff are:

- More likely to go through the capability procedure
- More likely to feel pressured to come to work, despite not feeling well enough
- Staff on the highest pay bands are less likely to report that they have a disability

Implementing the WDES at a local level ensures targeted actions to improve the workplace experience for our workforce.

The WDES will also drive improvements for Disabled patients and their care, as it encourages the development of a more diverse, empowered, and valued workforce, and a better understanding of disability equality across the NHS workforce.

Recommendations

The Board of Directors is requested to:

1) Review and approve the WDES Report and Action Plan 2022/23
2) To note publication on the Trust's public-facing website
3) Note the engagement and development of the action plan with the DAWN Network
4) Consider and discuss the strategic implications of the WDES 2022/23.

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

Report prepared by: **Samina Arfan, Head of Equality, Diversity and Inclusion**

Amany Rashwan, Equality, Diversity and Inclusion Advisor

NHS
Derbyshire Healthcare
NHS Foundation Trust

Workforce Disability Equality Standard (WDES)

Annual Report 2021/22

October 2022

Report publishing date: October 2022

Making a positive difference

Contents

1. Introduction

The Workforce Disability Equality Standard (WDES) is an annual data collection exercise which highlights the experiences of disabled colleagues compared to their non-disabled counterparts within an organisation. The standard is a requirement for all NHS health care providers through the NHS standard contract.

The WDES requires organisations to demonstrate progress against the ten metrics specifically focused on disability equality and suggest actions to address gaps.

The data and statistics used in this report reflect Workforce indicators, NHS staff survey Indicators and a Board representation indicator.

The Workforce Disability Equality Standard (WDES) report provides an overview of the data from April 2020 to March 2021 and progress against the ten metrics of the WDES.

Our commitment as a Trust to improve the employee experience for colleagues with disabilities, the WDES will help foster a better understanding of the issues faced by disabled colleagues and the inequalities they experience and supports the Trust to take action to create an inclusive and diverse leadership, which is in line with Derbyshire Healthcare's mission to be 'positively inclusive'. It involves a continued approach to monitoring our attraction, recruitment and retention initiatives, eliminating unlawful discrimination, harassment and victimisation and to improve year-on-year the reported experience of Disabled colleagues. We will only then be a great place to work and a great place to be cared for.

Our Disability & Wellness Network (D.A.W.N) Staff Network continues to have executive sponsorship from the Director of People and OD. As a network, they have and will be instrumental in putting together the resulting action plan for 2022/23.

Reliability of Data

As a significant number of colleagues have not self-reported whether they are Disabled, data used for these metrics may not truly reflect the experience of Disabled colleagues at DHCFT.

> We collected our data on 31st March 2022 when our workforce consisted of 2879 colleagues. **6.7%** of our workforce disclosed that they are Disabled.

This is the fourth year of the WDES, and it has been consistently identified that the number of DHCFT colleagues who have declared a disability or long-term condition on ESR is much lower than that of colleagues declaring a disability anonymously via the NHS Staff Survey.

	2018	2019	2020	2021
ESR	115	117	149	194
NHS Staff Survey	288	371	440	522

Note: Indicator 5: There has been a change in the reporting mechanism of this indicator this year, which affected the percentages as shown in the report. In previous years, the percentage reported was those saying, 'yes' as a proportion of all staff ***excluding*** *those who said, 'don't know'.* For this year's reporting, the figure reported is the percentage saying 'yes' as a proportion of all those who responded (including 'don't know'). This approach has been applied to the historical data in the 2021 reports

2. Background

The Equality Act, which came into force in 2010, strengthened the duty on employers to eliminate discrimination and advance equality of opportunity for Disabled employees. In the Act, disability is one of the nine protected characteristics, and employers are required to pay 'due regard' to eliminating unlawful discrimination, advancing equality of opportunity and fostering good relations between groups.

In November 2017, there was a pledge by the Government to increase the number of Disabled people in employment by one million. Recent data (Oct – Dec 20) shows 52.3% of disabled people were in employment, down from 54.1% a year previously. The employment rate for people who are not disabled was 81.1%, down from 82.2%. COVID-19 has had an impact on disabled and non-disabled people and employment, however, ONS have reported that a higher proportion of disabled employees have been made redundant than employees who are not disabled. Research tells us that the disability employment gap has increased over 2020 year from 28.1% to 28.8% nationally.

Following through the Governments pledge, the Workforce Disability Equality Standard (WDES) came into force on 1 April 2019 introducing a set of ten specific measures (metrics) that will enable NHS organisations to compare the experiences of Disabled and Non –Disabled staff. This information will then be used to develop a local action plan and enable us to demonstrate progress against the indicators of disability equality as a means by which we will improve and enhance the experience of disabled staff within our workforce.

The 'social model of disability[1]' identifies that it is the societal barriers that Disabled people face which is the disability and not an individual's medical condition or impairment. 'Nothing about us without us' is a phrase used by the disability

[1] https://www.scope.org.uk/about-us/social-model-of-disability/

movement to denote a central principle of inclusion: that actions and decisions that affect or are about Disabled people should be taken with Disabled people.

The NHS constitution has a specific section that refers to the rights of staff. It recognised that it is the commitment, professionalism and dedication of staff working for the benefit of the people the NHS serves which really make the difference. High quality care requires high quality workplaces, with commissioners and providers aiming to be employers of choice. The Workforce Disability Equality Standard (WDES) is important because research shows that a motivated, included and valued workforce helps to deliver high quality patient care, increased patient satisfaction and improved patient safety.

The main purpose of the WDES is:

- To compare the experiences of Disabled and Non – Disabled staff.
- To better understand the experiences of Disabled staff and enable a more inclusive environment
- To identify good practice and compare our performance with similar Trusts and use the information derived from the metrics to develop a local action plan and demonstrate progress against the indicators of disability equality.
- To help local, regional and national, NHS organisations (and other organisations providing NHS services) to review their data against the ten WDES indicators,
- To produce an action plan to address any differences in the workplace experienced by Disabled and Non – Disabled staff, and,
- Improve Disabled representation at the Board level of the organisation.

Over the past year the DAWN Network has:

- Reasonable Adjustments Plan and accompanying Managers Guide has been reviewed and signed off by the Network – this will be requested to be incorporated into the leadership passport with attendance training etc by the Leadership Development team

- The promotional video has been recorded and will be circulated within the current membership as well as via Communications, weekly focus email and on the intranet

3. Reporting requirements

The following table (pages 5 and 6) sets out the reporting requirements for the WDES:

Workforce Metrics For the following three workforce metrics, compare the data for both Disabled and non-disabled staff.	
Metric 1	**Percentage of staff in AfC pay-bands or medical and dental subgroups and very senior managers (including Executive Board members) compared with the percentage of staff in the overall workforce**. Organisations should undertake this calculation separately for non-clinical and for clinical staff. Cluster 1: AfC Bands - under 1, 1, 2, 3 and 4 Cluster 2: AfC Band 5, 6 and 7 Cluster 3: AfC Band 8a and 8b Cluster 4: AfC Band 8c, 8d, 9 and VSM (including Executive Board members) Cluster 5: Medical and Dental staff, Consultants Cluster 6: Medical and Dental staff, Non-consultant career grade Cluster 7: Medical and Dental staff, Medical and dental trainee grades **Note:** Definitions for these categories are based on Electronic Staff Record occupation codes with the exception of medical and dental staff, which are based upon grade codes.
Metric 2	**Relative likelihood of non-disabled staff compared to Disabled staff being appointed from shortlisting across all posts.** **Note:** i) This refers to both external and internal posts
Metric 3	**Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure.** **Note:** i) This metric was mandated in 2020. ii) This metric is based on data from a two-year rolling average of the current year and the previous year. iii) **It must be noted that this metric looks at capability on the grounds of performance, rather than ill health.** Therefore, we request that organisations **only** submit data on those staff who are within performance management capability processes.
National NHS Staff Survey Metrics For each of the following four Staff Survey Metrics, compare the responses for both Disabled and non-disabled staff.	
Metric 4 Staff Survey Q13a-d	**a) Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from:** i. Patients/Service users, their relatives or other members of the public ii. Managers iii. Other colleagues **b) Percentage of Disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it.**

Metric 5 Staff Survey Q14	**Percentage of Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion.**
Metric 6 Staff Survey Q11e	**Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.**
Metric 7 Staff Survey Q5f	**Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work.**
The following NHS Staff Survey metric only includes the responses of Disabled staff	
Metric 8 Staff Survey Q26b	**Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work.**

NHS Staff Survey and the engagement of Disabled staff For part a) of the following metric, compare the staff engagement scores for Disabled and non-disabled staff For part b) add evidence to the Trust's WDES Annual Report	
Metric 9	a) **The staff engagement score for Disabled staff, compared to non-disabled staff.** **Note:** This part of the metric is now solely a comparison between the engagement score for Disabled staff and non-disabled staff. b) **Has your Trust taken action to facilitate the voices of Disabled staff in your organisation to be heard? (Yes) or (No)** **Note: For your Trust's response to b)** **If yes,** please provide at least one practical example of current action being taken in the relevant section of your WDES annual report. **If no**, please include what action is planned to address this gap in your WDES annual report. Examples are listed in the national WDES 2019 Annual Report.
Board representation metric For this Metric, compare the difference for Disabled and non-disabled staff.	
Metric 10	Percentage difference between the organisation's Board voting membership and its organisation's overall workforce, disaggregated: • By voting membership of the Board. • By Executive membership of the Board.

4. Summary of Data 2021/22

	Improvements and sustained positive outcomes:
	Metric 1: The number of staff who have declared a disability on ESR has increased slowly but consistently over the last four years, since **2018** where **115** colleague declared a disability to **194** declarations status **2021**.
	Metric 4b: The percentage of staff saying the last time they experienced harassment, bullying or abuse, they or a colleague reported it, increased since 2020/21 from **54.8%** for disabled and **62.0%** non-disabled colleagues **to 64%** for disabled and **63.1%** non-disabled colleagues in **2021/22**
	Metric 5: The percentage of staff believing the Trust provides equal opportunities for career progression, increased since **2020/21 from 60%** for disabled and **64.4.0%** non-disabled colleagues **to 63.4%** for disabled and **65.7%** non-disabled colleagues in **2021/22**
	Metric 8: The percentage of disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work, increased since **2020/21** from **86.6%** for disabled colleagues to **89.5%** for disabled **2021/22.**

	Deterioration and sustained negative outcomes:
	Metric 4a: The percentage of staff experiencing harassment, bullying or abuse from - **Patients, service users or members of the public**, increased since **2020/21** from **27.6%** for disabled and **21.9%** non-disabled colleagues to **30.9%** for disabled and **23.8%** non-disabled colleagues in **2021/22**
	Metric 4a: The percentage of staff experiencing harassment, bullying or abuse from -**Manager** increased since **2020/21** from **11.2%** for disabled and **5.7%** non-disabled colleagues to **12%** for disabled and **4.9%** non-disabled colleagues in **2021/22**
	Metric 4a: The percentage of staff experiencing harassment, bullying or abuse from **- Other colleagues,** increased since 2020/21 from 20.6% for disabled and 11.8% non-disabled colleagues to 19.7% for disabled and 12.1% non-disabled colleagues in 2021/22

4.1 WDES Data 2021/2022 comparative with 2020/21

Detailed below is the organisation's WDES data to be submitted by 31 August 2022 covering the period 1 April 2021 to 31 March 2022.

	2020/21	2021/22
Number of staff employed within Trust	2795	2879
Proportion of disabled staff employed within Trust as of 31 March 2022	5.3% (149 people)	6.7% (194 people)
Metric 1 Percentage of staff in each of the AfC Bands 1-9 and VSM compared with the percentage in the overall workforce	Please see table below	
Metric 2 Relative likelihood of non-disabled staff compared to disabled staff being appointed from shortlisting across all posts Note: A figure above "1" would indicate non-disabled candidates are more likely to be appointed from shortlisting	1.05	1.04
Metric 3 Relative likelihood of disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure. Note: A figure above "1" would indicate that disabled staff are more likely to enter the formal capability process	0.00	0.00
Metric 4a **Percentage of staff experiencing harassment, bullying or abuse from:** **i)** Patients, service users or members of the public **ii)** Manager **iii)** Other colleagues	**i)** Disabled: 27.6% Non-disabled: 21.9% **ii)** Disabled: 11.2% Non-disabled: 5.7% **iii)** Disabled: 20.6% Non-disabled: 11.8%	**i)** Disabled: 30.9% Non-disabled: 23.8% **ii)** Disabled: 12% Non-disabled: 4.9% **iii)** Disabled: 19.7% Non-disabled: 12.1%

	2020/21	2021/22
Metric 4b Percentage of staff saying the last time they experienced harassment, bullying or abuse, they or a colleague reported it	Disabled: 54.8% Non-disabled: 62.0%	Disabled: 64% Non-disabled: 63.1%
Metric 5 Percentage of staff believing the Trust provides equal opportunities for career progression.	Disabled: 85.1% **(60%)** Non-disabled: 89.6% **(64.6%)**	Disabled: 63.4% Non-disabled: 65.7%
Metric 6 Percentage of staff saying they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.	Disabled: 17.1% Non-disabled: 11.1%	Disabled: 17.2% Non-disabled: 10.9%
Metric 7 Percentage of staff saying they are satisfied with the extent to which the organisation values their work.	Disabled: 50.3% Non-disabled: 59.2%	Disabled: 51.4% Non-disabled: 58.1%
Metric 8 Percentage of disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work.	Disabled: 86.6%	Disabled: 89.5%
Metric 9a Staff engagement score for disabled staff, compared to non-disabled staff.	Disabled: 7.1 Non-disabled: 7.5	Disabled: 7.1 Non-disabled: 7.4
Metric 9b Has your Trust taken action to facilitate the voices of disabled staff in your organisation to be heard? (yes/no)	Yes	Yes
Metric 10 Percentage difference between the organisation's Board voting membership and its organisation's overall workforce.	+ 20 % (25% of Board voting membership declared a disability compared to 5% of overall workforce)	10 % (16.67% of Board voting membership declared a disability compared to 6.74% of overall workforce)

5.0 Representation, recruitment and progression

Metric 1: Representation Breakdown of the workforce by AfC clusters, Medical and Dental subgroups and very senior managers (including Executive Board members) –split between non-clinical and clinical groups

NON-CLINICAL						
	2020/21			2021/22		
Band	Disabled %	Non-disabled %	Unknown/ Null %	Disabled %	Non-disabled %	Unknown/ Null %
Cluster 1 (Bands <1 - 4)	5.3%	71.5%	23.2%	6.5%	72.5%	21.0%
Cluster 2 (Band 5 - 7)	4.9%	70.8%	24.3%	6.8%	77.6%	15.5%
Cluster 3 (Bands 8a - 8b)	3.7%	66.7%	29.6%	6.7%	56.7%	36.7%
Cluster 4 (Bands 8c - 9 & VSM)	7.1%	64.3%	28.6%	10.0%	70.0%	20.0%

CLINICAL						
	2020/21			2021/22		
Band	Disabled %	Non-disabled %	Unknown/ Null %	Disabled %	Non-disabled %	Unknown/ Null %
Cluster 1 (Bands <1 - 4)	4.4%	65.9%	29.8%	6.1%	68.8%	25.1%
Cluster 2 (Band 5 - 7)	6.0%	71.0%	23.0%	7.5%	73.8%	18.7%
Cluster 3 (Bands 8a - 8b)	5.9%	76.5%	17.6%	6.3%	79.5%	14.2%
Cluster 4 (Bands 8c - 9 & VSM)	6.3%	68.8%	25.0%	5.0%	75.0%	20.0%
Cluster 5 (Medical & Dental Staff, Consultants)	3.9%	61.04%	35.06%	3.85%	60.26%	35.9%
Cluster 6 (Medical & Dental Staff, Non-Consultants career grade)	0.0%	50.0%	50.0%	0.0%	59.38%	40.63%
Cluster 7 (Medical & Dental Staff, Medical and dental trainee grades)	0.0%	50.0%	50.0%	0.0%	56.67%	43.33%

In line with the national reporting guidance, the workforce information has been clustered into groups. These are as follows:

- Cluster 1 (Bands 1-4)
- Cluster 2 (Bands 5-7)
- Cluster 3 (Bands 8a – 8b)
- Cluster 4 (Bands 8c –9 &VSM)
- Cluster 5 (Medical & Dental Staff, Consultants)
- Cluster 6 (Medical & Dental Staff, Non-Consultants career grade)
- Cluster 7 (Medical & Dental Staff, Medical and Dental trainee grades)

Given the low number of staff reporting a disability it is difficult to draw any patterns or conclusions from the data. However, the largest proportion of people with a disability relative to the staff group numbers are within Clinical Clusters 2, 3 and 5.

Metric 2: Recruitment

Metric 2	2020/21	2021/22
Relative likelihood of non-disabled staff compared to disabled staff being appointed from shortlisting across all posts **Note**: A figure above "1" would indicate non-disabled candidates are more likely to be appointed from shortlisting	1.05	1.04

A marginal increase from 2021, when disabled candidates were 5% (1.05x) more likely to be appointed.

Metric 5: Progression.

Metric 5	2020/21	2021/22
Percentage of staff believing the Trust provides equal opportunities for career progression.	Disabled: 85.1% **(60%)** Non-disabled: 89.6% **(64.6%)**	Disabled: 63.4% Non-disabled: 65.7%

Whilst the perception of fairness with regard to career progression indicates an increase, we will need to ensure that as a Trust our Disabled staff are not prevented from development opportunities that may arise as a result of not being able to 'act up' or take on varied responsibilities during the Covid-19 pandemic.

Note: **Indicator 5:** There has been a change in the reporting mechanism of this indicator this year, which affected the percentages as shown in the report. In previous years, the percentage reported was those saying, 'yes' as a proportion of all staff ***excluding*** *those who said, 'don't know'.* For this year's reporting, the figure reported is the percentage saying 'yes' as a proportion of all those who responded (including 'don't know'). This approach has been applied to the historical data in the 2021 reports

Metric: 10 – Board Representation

Metric: 10	2020/21	2021/22
Percentage difference between the organisation's Board voting membership and its organisation's overall workforce.	+ 20% (25% of Board voting membership declared a disability compared to 5% of overall workforce)	10 % (16.67% of Board voting membership declared a disability compared to 6.74% of overall workforce)

Amongst voting Board members, disclosure of disability status is much higher than the overall workforce at 5% in 2021 and 6.74% in March 2022 due to the small numbers involved across the organisation, any changes in appointments have a significant impact on reported proportions.

6.0 Formal disciplinary processes

Metric 3	2020/21	2021/22
Relative likelihood of disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure. Note: A figure above “1” would indicate that disabled staff are more likely to enter the formal capability process	0.00	0.00

The data shows there has been no formal capability cases in the reporting period and previous period

7.0 Behaviours and discrimination

Metric 4a – Bullying and Harassment

Metric 4a: The percentage of staff experiencing harassment, bullying or abuse from – **Patients, service users or members of the public**, increased since 2020/21 from 27.6% for disabled and 21.9% non-disabled colleagues to 30.9% for disabled and 23.8% non-disabled colleagues in 2021/22

Metric 4a: The percentage of staff experiencing harassment, bullying or abuse from -**Manager** increased since 2020/21 from 11.2% for disabled and 5.7% non-disabled colleagues to 12% for disabled and 4.9% non-disabled colleagues in 2021/22

Metric 4a: The percentage of staff experiencing harassment, bullying or abuse from **– Other colleagues,** increased since 2020/21 from 20.6% for disabled and 11.8% non-disabled colleagues to 19.7% for disabled and 12.1% non-disabled colleagues in 2021/22

Overall, across the three areas for metric 4a, a decline in the majority of the indicators on rates of harassment and abuse against disabled staff, which remain higher than rates against non-disabled staff even when the non-disabled staff rate increases. Whilst this reflects the national trend and may seen to be as a result of pressures during the Covid-19 pandemic, the significant increase reported at DHCFT by Disabled staff is an outlier and needs to be addressed.

Metric 4b – Bullying and Harassment

	Metric 4b: The percentage of staff saying the last time they experienced harassment, bullying or abuse, they or a colleague reported it, increased since 2020/21 from **54.8%** for disabled and **62.0%** non-disabled colleagues **to 64%** for disabled and **63.1%** non-disabled colleagues in **2021/22**

A higher figure than the national benchmark of 46%. Whilst this is promising and reflects the work done at the Trust to encourage and empower staff to report these incidents, the, Speak Up Guardian and *It's not ok* programme will play a key role in developing colleagues' confidence to raise and resolve issues and conflict early, with assurance that Trust approaches will be compassionate and just.

Metric 6 – Pressure to come back to work

Metric 6	2020/21	2021/22
Percentage of staff saying they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.	Disabled: 17.1% Non-disabled: 11.1%	Disabled: 17.2% Non-disabled: 10.9%

A marginal increase from 2021 for disabled staff and a decrease for non-disabled staff.

Metric 7- Feeling valued

Metric 7	2020/21	2021/22
Metric Percentage of staff saying they are satisfied with the extent to which the organisation values their work.	Disabled: 50.3% Non-disabled: 59.2%	Disabled: 51.4% Non-disabled: 58.1%

A marginal increase for disabled staff and decrease for non – disabled staff since 2020/21. In the context of the Covid-19 pandemic, where many staff have been redeployed away from their usual roles or required to shield following risk assessment, this is somewhat expected but we must ensure improvement is seen beyond the recovery phase.

Metric 8 – Adequate adjustments

	Metric 8: The percentage of disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work, increased since **2020/21** from **86.6%** for disabled colleagues to **89.5%** for disabled **2021/22.**

An increase of almost 3% in 2022 and higher than the national benchmark of 75%.

Indicator 9 -Staff engagement

Metric 9a	2020/21	2021/22
Staff engagement score for disabled staff, compared to non-disabled staff.	Disabled: 7.1 Non-disabled: 7.5	Disabled: 7.1 Non-disabled: 7.4

The scores have remained static albeit slightly lower for disabled staff compared to staff without a disability

8.0 Conclusion

Improving the experience of Disabled colleagues is a core element of the Trust's Towards Inclusion Strategy. We continue to work in partnership with the Disability and Wellness Network (DAWN) staff network, who are instrumental in helping to drive forward this agenda.

Although the number of staff who have declared a disability on the NHS Staff Survey has increased consistently over the last four years, the number of DHCFT staff who have declared a disability or long-term condition on ESR remains significantly lower than that of staff declaring a disability anonymously via the NHS Staff Survey.

Actions to encourage disclosure of protected characteristics on ESR include engagement sessions with the Disability and Wellness Network (DAWN) on the importance of disclosing protected characteristics, and a disclosure campaign launched in May 2021 which includes monthly drop-in sessions for staff to receive support and information. "How to guides" have also been produced and shared via comms to encourage colleagues to be able to declare their status via Employee Self-Serve (EESR).

The Disability and Wellness Network (DAWN) has produced a video to raise awareness about Disability and it is impact with the aim to encourage colleagues to disclose their disability, raise the network's profile and improve engagement levels and impact.

Overall, the WDES collection for 2021/22 has shown some areas of improvements compared to figures previously which is good to see. However, the Trust recognises that it's on a journey and as a priority more needs to be done to improve experiences of our disabled workforce.

The WDES Action Plan below has been co-produced with the developed with the Disability & Wellness Network (DAWN) staff network, (Appendix, page 18) and identifies key actions which will be undertaken over the next 12 months, supporting the organisation to improve.

Provider Organisation: **Derbyshire Healthcare NHS Foundation Trust**

Date of Report and Action Plan: **August 2022**

Board Lead for the Workforce Disability Equality Standard: **Jaki Lowe, Director of People and Inclusion**

Lead Manager/s compiling this report: **Samina Arfan, Head of EDI** and **Amany Rashwan, Equality, Diversity and Inclusion Advisor**

Document Control			
Date	**Amendment**	**Version**	**Comments/Author**
08/22	**Data analysis and draft report**	V0.1	Amany Rashwan
14/09/22	**Report narrative and review**	V0.2	Samina Arfan, Jaki Lowe
20/09/22	**For review and endorsement**	V0.3	People and Culture Committee
13/10/22	**For engagement**	V0.4	Disability & Wellness Network (DAWN) Staff Network
25/10/22	**ELT Approval of Action Plan**	**Final Draft**	Samina Arfan
31/10/22	**For publication on website**	**Final**	**DHCFT Communications team**
01/11/22	**Final for endorsement**	**Final**	**Trust Board**

Workforce Disability Equality Standard (WDES)

Appendix 1: Action Plan 2022/2023

October 2022

Making a positive difference

Appendix 1: Action Plan

The action plan below has been developed with the Disability & Wellness Network (D.A.W.N) staff network, with a focus on improving indicators relating to disability declaration rates, representation in leadership roles, addressing bullying, harassment or abuse and, ensuring colleagues with a disability have appropriate adjustments made to enable them to do their job. Improvements in these areas should impact on the overall engagement, experience and feelings of value for colleagues with a disability and be reflected in these metrics accordingly.

Appendix 1: Phase WDES Action Plan 2022/23				
	Outcome	Actions	Leads	Timescales
1	An increase in the disclosure rate on ESR to 50% by March 2023.	Increase the number of staff disclosing their disability status on ESR	Disability & Wellness Network (D.A.W.N) staff network /Head of EDI/Acting Deputy Director of People and Inclusion People and Inclusion Directorate	31st March 2023
		Apply for Disability Confident Scheme Level 3 (Leader) – Become a Disability Confident leader by 2023	Recruitment Lead/Head of EDI	31st March 2023
		Implement findings from the Cultural Intelligence review of the recruitment pathway	Recruitment Lead/Head of EDI/ Disability & Wellness Network (D.A.W.N) staff network	31st March 2023
2	Improvement shown in Staff Survey 2022 (Metric 4)	Address the increased levels of bullying and harassment experienced by Disabled colleagues from their managers and colleagues	Acting Deputy Director of People and Inclusion People and Inclusion Directorate / Head of EDI	31st March 2023
3	Improvement shown in Staff Survey 2021 (Metric 5)	Review succession planning and talent management approach to reduce inequalities in career progression opportunities between Disabled and non-disabled colleagues	Acting Deputy Director of People and Inclusion People and Inclusion Directorate /Head of EDI	31st March 2023

Appendix 1: Phase WDES Action Plan 2022/23				
4	A reduction in the number of Disabled staff reporting that they felt pressure to come into work despite not feeling well enough (Metric 6)	Improve the presenteeism experienced by Disabled colleagues to improve wellbeing and ensure that they can flourish at work	Acting Deputy Director of People and Inclusion People and Inclusion Directorate/Head of EDI/ Disability & Wellness Network (D.A.W.N) staff network	31st March 2023
5	Improvement of at least 5% shown in Staff Survey 2021 (Metric 8)	Increase the percentage of Disabled staff who are able to reach their full potential because appropriate adjustments have been made for them at work	Head of EDI/Acting Deputy People and Inclusion Directorate/ Disability & Wellness Network (D.A.W.N) staff network	31st March 2023
		Raise Awareness of Neurodiversity across the Trust and recruitment processes	Head of EDI/Acting Deputy Director of People and Inclusion People and Inclusion Directorate/ Disability & Wellness Network (D.A.W.N) staff network	31st March 2023
		Increase participation in the Disability & Wellness Network (D.A.W.N) staff network	Head of EDI/ Disability & Wellness Network (D.A.W.N) staff network	31st March 2023

Below (page 4) lists the workplan identified by the Disability & Wellness Network (D.A.W.N) staff network, which have been incorporated into the action plan above.

DAWN Group– Future Plans 2022 -2023

- We are going to be providing a forum for people to tell their story of working with a disability/long term condition and how they felt, how they overcame any obstacles and what support was given - if any.

  We intend to use these to look at how the Trust provide support through different levels of staffing and different roles. We will be able to build a plan to see where the gaps in knowledge and support are within the Trust and look at how we are able to provide training and guidance to both staff and managers. We will be creating an action plan consisting of learning taken from these discussions and building this into possible future training and development opportunities

- We will be looking at ways to increase staff declarations regarding any disabilities/long term conditions when applying for positions within the Trust and for current staff that have not declared this, we will be looking at how mangers can provide a more inclusive culture to allow members of staff declare any disability/long term condition without the worry of a negative outcome

- We are going to be working with Recruitment and Selection to look at how we can improve the recruitment process for people with a disability/long term condition

- We are discussing including a brief section for promoting the Network during Induction and providing promotional information after the session

- We are looking to provide some products to promote the Network including wrist rests and mouse mats and ergonomic pens

Making a positive difference

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 1 November 2022

Equality Diversity and Inclusion (EDI) Update October 2022

Purpose of Report

This paper is to provide an update to the Trust Board of EDI work undertaken, ongoing and work planned this year.

Executive Summary

Derbyshire Healthcare NHS Foundation Trust (DHCFT) as a public sector body, governed by the Equality Act 2010 and the Public Sector Equality Duty (section 149 of the Equality Act 2010) in relation to its equality duties. The general duties are:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act
- Advance equality of opportunity between people who share a protected characteristic and those who do not
- Foster good relations between people who share a protected characteristic and those who do not.

The specific duties under the Equality Act 2010 require the Trust to:

- Publish information to demonstrate compliance with the general equality duty. This information must include information relating to people who share a protected characteristic who are our employees or are people affected by our policies and practices
- Prepare and publish equality objectives to achieve any of the aims of the general equality duty.

In addition to the general duty DHCFT is mandated to implement:

- WRES
- WDES
- Accessible Information Standard
- Equality Delivery System
- Gender Pay Gap
- Sexual Orientation Monitoring Standard
- Advancing Equalties in Mental Health
- Midland's WRES Strategy
- JUCD EDI Sense of Belonging strategy

Below sets out the work undertaken and planned up until March 2023.

The Board is requested to note that DHCFT has lean EDI resource, the EDI advisor came into post January 2022 and the Head of EDI May 2022.

EDI Governance and Regulatory Updates

- The Public Sector Equality Duty Report to be published on 31 March 2022. The Public Sector Equality Duty (PSED) report presents all the equality-related activity in the Trust over the last year to comply with the Trust's mandatory reporting requirements.
- The Gender Pay Gap report for 2021 is to be published by 31 March 2022. A Gender Pay Gap Action Plan has been produced to narrow the pay gap, and the Women Staff Network will be launched on International Women Day 2022 is open to all colleagues to discuss any gender related issues
- Engagement with the DAWN and BME network has taken place to inform the action plans for the WRES and WDES 2022/23. These reports and action plans will be presented to Board in November and uploaded on to the Trust Website
- Work is under way to produce the next PSED Annual report for March 2023. This will require coordination across service and workforce areas.

Wider EDI work to shape culture, recruitments and sense of belonging

- The Trust's Above Difference Cultural Intelligence programme began with the Board on 15 September. 24 senior leaders completed the programme, and 4 Facilitators have been trained to deliver the Programme to the wider Trust. Furthermore; 20 senior leaders completed the programme in June 2022. This will now be reviewed to explore increasing facilitators and utilising the existing facilitators.
- The Above Difference has been commissioned to support the systems work around cultural intelligence including DHCFT, with a view to interrupt bias across the recruitment pathway end to end. Five working groups have been set up to review process and look at good practice in line with the model employer and other frameworks in the following pathway areas:

    1. Vacancies and advertising
    2. Job descriptions
    3. Interview process (interview questions and panel preparation)
    4. Selection and shortlisting
    5. Retention

- The next steps to the Above Difference work will look at how the learning can be implemented across the recruitment pathway with tools, training and guidance for staff.
- The Trust commissioned a joint development programme for staff network members in DHCFT and Derbyshire Community Services (DCHS). This comprises of comprising of different training series to equip delegates with tools and strategies for handling racial inequities and wider inclusion areas, building their personal confidence, strengthening the networks and leadership skills in the NHS. This programme is funded through the Charitable Fund which has recently been granted. An elevation has taken place and a celebration event took place 11 October. In addition to this a lunch and learn around Microaggressions is being planned for December 2022.
- International Women's Day 2022: The Trust held numerous events between 8 and 11 March 2022 to mark IWD and launch the Trust's Women Staff Network, one of the events was facilitated by an external speaker

- The Trust WRES Expert has been working with divisional managers to identify areas of work. This will be reviewed into wider piece of work and incorporated into EDI People Divisional Plans.
- EDI input into the OCCG Strategy March 2022
- The Trust's Executive Leadership Team (ELT) approved allocating five hours of protected time for each Staff Network Chair and Vice-Chair to carry out the duties of their Staff Network throughout their term in post. By releasing Staff Network Chairs from their main duties to support the work of the Network and participate in decision-making forums on behalf of their memberships, we are embedding inclusion in our everyday processes, in line with our 'positively inclusive' commitment as a Trust, as well as forming part of our wider People Plan commitment to support and develop staff networks across NHS Trusts in England.
- Engagement with the Staff Network Chairs took place 20 October to help shape a Staff Network Framework which will provide consistency and support across all networks including their sponsors. The Sponsors are also being engaged with around this framework. The draft framework will be discussed at ELT 8 November.
- Our LGBT+ and BME Staff Networks are being considered for "Outstanding Staff Network Award" at the Midlands Inclusion and Diversity Scheme Awards taking place on 18 November 2022
- Funding was agreed to establish a part-time Band 3 Administrative Assistant to support the work of the Networks' Chairs. This is a development opportunity for 12 months which would provide a development opportunity for someone from the networks. The Chair of the BME Network was appointed but due to sickness and personal reasons has not yet started the role. Short term Bank resource has supported this area of work.
- ILDBO Board Diagnostic Sessions took place in June 2022
- Gender Identity and LGBT+ workshops (in July and September 2022)
- In-house Women of Colour in Leadership 12 July 2022
- EDI WORKSHOPS (We commissioned Deliver, 60x Workshops. (30 in-tact teams, two workshops per team). Four Workshops are already scheduled to take place in November, December and January
- Leadership Conference, with a focus on Restorative just culture took place on 4 October 2022, further work will take place to develop the approach for DHCFT
- An EDI framework is being drafted to share at ELT for December, this will provide an overview of the full scope of EDI work and the resources to deliver
- The Equality Impact Assessment process REGARDS will be reviewed and updated for the Quality and Safeguarding Committee, which will be presented in December 2022
- The new Health and Care LGBTQ+ Framework has been launched a meeting with the LGBT+ network will take place in November to discuss how to take it forward
- The NHS EDS has been reviewed nationally the head of EDI is arranging a system wide session with the national Lead.

Appendix 1 is an overview of progress by the Staff networks please note the bullets below for the BME Network.

- Some of the network members have just finished the Networks' Chairs Development programme and the outcome is positive. Specially that the programme emphasised on the concept that networks members need to be active and participate. Rubina stated that more members are putting themselves forward more and willing to participate more.
- The Chairs of the BME Networks across the system have been coming together to discuss and plan Black History Month
- The Network has recently submitted their nomination for Midlands Inclusivity and Diversity Award (MIDAS) Scheme and have been nominated
- The Network has collaborated with the Women's Network and commissioned a one-day training workshop titled "Leadership for Women of Colour "which was very well attended
- WRES Expert has been working with the JUCD EDI Group working towards an anti-racism approach.

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

Assurances

- The Board Assurance Framework (BAF) is updated to capture the work around EDI
- JUCD EDI Sense of Belonging Action plan
- Midland WRES Action Plan.

Consultation

N/A

Governance or Legal Issues

This update feeds into a range of reports including our PSED reports, WRES, WDES and the Gender Pay Gap.

Public Sector Equality Duty and Equality Impact Risk Analysis

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

The EDI Update covers impacts related to the nine protected characteristics listed above.

Recommendations

The Board of Directors is requested to note the EDI work undertaken, ongoing and planned.

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

Report prepared by: **Samina Arfan, Head of Equality, Diversity and Inclusion**

Amany Rashwan
Equality, Diversity and Inclusion Advisor

NHS
Derbyshire Healthcare
NHS Foundation Trust

EDI Delivery Group

Update from Staff Networks
17 October 2022

DHCFT @derbyshcft
www.derbyshirehealthcareft.nhs.uk

Making a positive difference

Armed Forces Community

In the last 6 months, the Armed Forces Community Staff Network has:

- Appointed a new Chair, Deputy Chair (veteran) and Executive Sponsor (family member).
- An increased membership of 30 members.
- Hosted the first remembrance event “Falklands 40”
- Achieved the silver award from Defence’s Employer Recognition Scheme.
- Started a monthly peer support session for its members.
- Been recognised as a “Veteran Aware” Trust by the VCHA.
- Facilitated a workshop at 103 REME Btn (Reserve Centre) on mental wellbeing.

Continued…

Making a positive difference

Armed Forces Community

Making a positive difference

DAWN Group - Update

The DAWN Group now has a Vice Chair (Barbara Chilvers), which will allow us to drive some of the work forward.

Past Year:

- Reasonable Adjustments Plan and accompanying Managers Guide has been reviewed and signed off by the Network – this will be requested to be incorporated into the leadership passport with attendance training etc by the Leadership Development team

- The promotional video has been recorded and will be circulated within the current membership as well as via Communications, weekly focus email and on the intranet

Continued…

DAWN Group – Future Plans

- We are going to be providing a forum for people to tell their story of working with a disability/long term condition and how they felt, how they overcame any obstacles and what support was given - if any.

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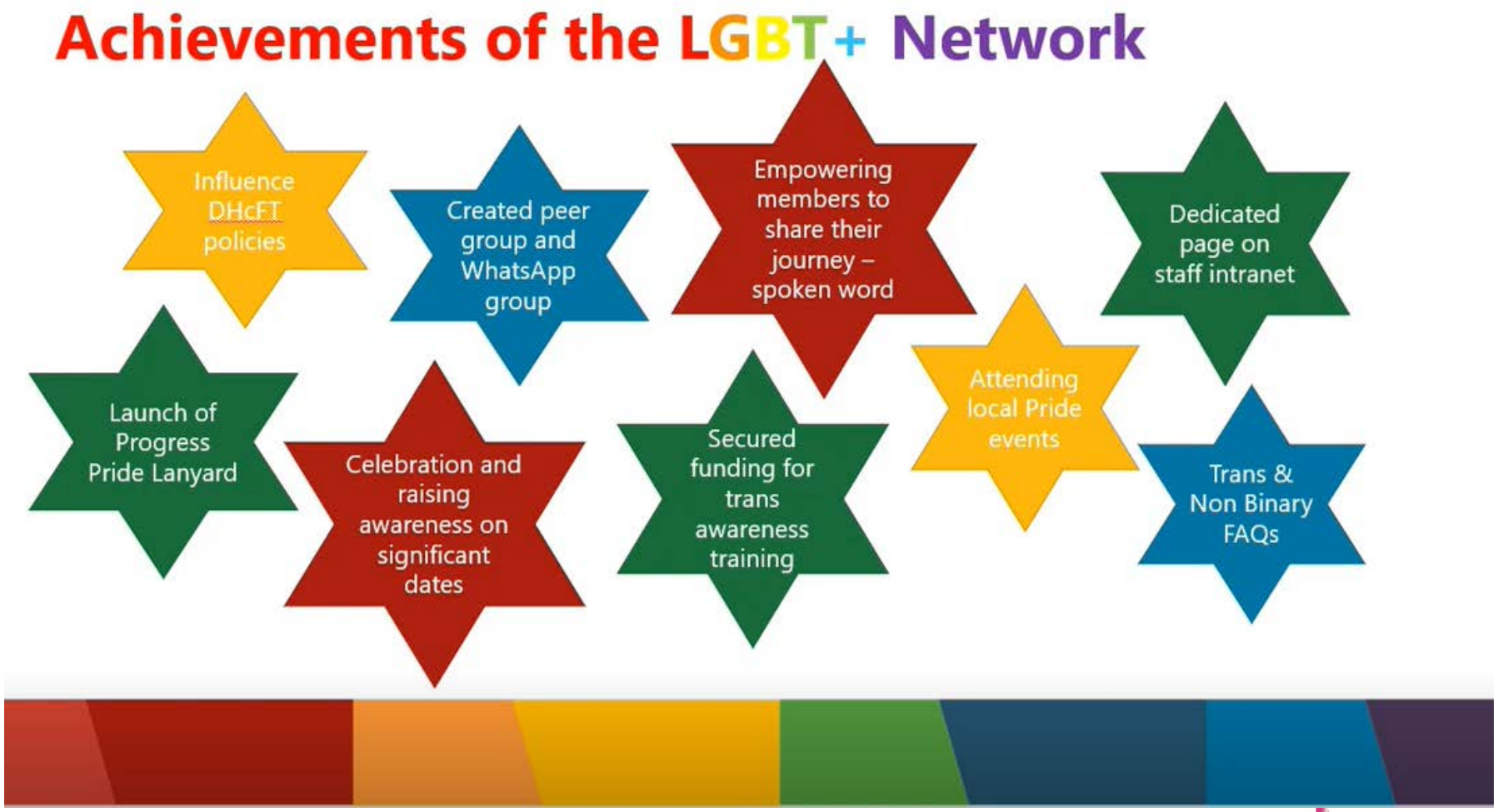
Making a positive difference

LGBT+



Making a positive difference

LGBT+

- The LGBT+ network commissioned training for staff to attend about LGBT+ identities with a focus on gender identities. These sessions were well attended and future sessions are being planned for 2023.

- We celebrate awareness days and events by creating infographics, hosting a quiz for LGBT+ History Month, an informative video and Q&A sessions for Pride Month, and inviting in an inspirational guest speaker to discuss their experience as an LGBT+ and BME person.

- We attended Chesterfield and Belper pride to meet our community and share some of the good work we do. At Belper pride we also created and distributed a questionnaire about LGBT+ people's experience of mental healthcare to shape our aims for the next year.

- Other things we have done include sending out over 190 progressive pride flag lanyards, purchasing and disseminating merchandise to make ourselves visible and supporting LGBT+ colleagues, other staff networks and staff who have questions about the LGBT+ community.

Multi Faith Forum & Christian Network

Multi Faith Forum

- Developing slowly. Quarterly meeting
- MFF survey in the summer (22 respondents).(Needs to be actioned)
  - Various people are interested in finding out more about faith / different faiths to support service users
  - Education to help develop knowledge and understanding leading to equality and dignity for all groups

Christian Network

- Small group continues to meet Wed am 8.30-9
- Easter reflection led by DHCFT but included DCHS & UHDB
- Monthly lunch time reflections continue (albeit small numbers)

Making a positive difference

Women's Network

We formally launched the Women's Network during International Women's Day in March 2022. We launched the network via a number of MS Teams events and a Speakers who focused on:

- What the biases are that hold women back
- Why they occur
- Why the intersectionality identity of women matters
- What we can do to challenge bias in our daily work lives

Since then, we have formally held two Networks which have increased in numbers and focussed mainly on:

- Completing the Terms of Reference
- Identifying focus for the Network – questionnaires to be sent out to gather feedback to ensure the Network is representing the needs of female workforce
- Considering our visibility – raising awareness, marketing
- Building on awareness of current groups already working in the trust that align with the Women's Network aims to support them and not replicate work

Continued…

Making a positive difference

Women's Network

Moreover; we successfully collaborated with the EDI Team and the BME Network in commissioning a the Training Programme **Women of Colour in Leadership** which took place in **July 2022** and was very well attended.

- The training programme was a joint-venture between the Women's and the BME Networks. The aim of the programme was to help participants in
  - Identify practical strategies in managing the spoken and unspoken challenges of their role
  - Defining their own personal brand and authentic leadership style; aligning this with the organizational objectives
  - Developing new habits that enhances their effectiveness as a leader
  - Develop a framework for building stronger interpersonal relationships fueled by trust
  - Connect and share experiences with other female leaders, gaining connections that can support their journey
  - Gain courage and momentum to pursue future leadership aspirations with great success

Making a positive difference

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- Gain courage and momentum to pursue future leadership aspirations with great success

Making a positive difference

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 1 November 2022

Guardian of Safe Working Quarterly Report (October 2022)

Purpose of Report

This extended report from the DHCFT Guardian of Safe Working provides data about the number of Junior Doctors in training in the Trust, full transition to the 2016 Junior Doctor contract and any issues arising therefrom. The report details arrangements made to ensure safe working within the new contract and arrangements in place to identify, quantify and remedy any risks to the organisation.

Executive Summary

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

The Board is requested to note:

1) There are vacancies in higher trainee posts that reflect the national issue with recruitment in psychiatry
2) Trainees are supported with exception reporting and these have been resolved in a timely fashion. The number of exception reports have increased. This is seen more for the higher trainee group usually and is mostly to do with having busy on call (usually due to Mental Health Act related work) breaching the rest requirements. Discussions are ongoing within the Local Negotiating Committee (LNC), with the trainees, Director Medical Education (DME) and the Trust lead for the Mental Health Act as to how the higher trainees can be supported with this. Other exception reports have been made by foundation doctors who also happen to be the most junior medics in the teams. These are usually around lack of support for foundation doctors which has arisen out of gaps (lack of staffing either due to sickness or a service gap). In these cases, the doctors have been supported by other members (cross covering) of the clinical team. The service gaps have been filled by locum. However in some cases finding a suitable agency replacement been challenging to recruit.
3) The British Medical Association (BMA), Fatigue and Facilities (F&F) Charter for junior doctors is regularly discussed in Junior Doctors Forum and changes have been implemented with view to improve the junior doctors mess and rest areas. The allocated money for this purpose has been spent well on improving facilities for junior doctors, both in the north and south.
4) There have been fewer issues with Allocate, the software for reporting exceptions, however we are still running into minor problems with logging Exception Report (ER) and with closing them which causes slight delay in the process.
5) The junior doctors have not raised any concerns recently. During the COVID-19 pandemic – some concerns were raised with the work environment, situation with PPE and some training issues. The Junior Doctors Forum has

continued to provide them with a neutral platform to raise any such issues. They have been able to express their concerns freely. The Director Medical Education (DME), Associate Director Medical Education (ADME), Nursing Matron from Hartington unit and Freedom to speak up Guardian continue to support the trainees.

6) Junior doctors have been successfully completing their virtual induction and have given positive feedback

7) The Freedom to speak up Guardian has met up with junior doctors recently and explained her role to them. She has also attended Junior Doctors Forum (JDF) and meets up with the Champions for Freedom to speak up on regular basis.

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

Assurances

This extended report from the DHCFT Guardian of Safe Working provides data about the number of junior doctors in training in the Trust, full transition to the 2016 Junior Doctor contract and any issues arising therefrom. The report details arrangements made to ensure safe working within the new contract and arrangements in place to identify, quantify and remedy any risks to the organisation.

Consultation

- Relevant issues in the report are discussed at the Junior Doctors Forum
- At the LNC discussions take place regarding the smooth running of consultant on call rota while we have so many vacancies on the higher trainee rota
- The DME and ADME discuss concerns raised by Junior Doctors
- The report is received by the Quality and Safeguarding Committee to provide assurance of the Trust's approach in discharging its statutory duties regarding safe working for medical trainees.

Governance or Legal Issues

- As the Guardian, I have been attending the local and national conferences to gain more knowledge and experience through discussions with other Guardians. More recently the meetings have been virtual, but the discussions have been helpful as a lot of similar issues affecting juniors elsewhere have been discussed
- I am also undertaking the role of a FTSU (Freedom to Speak Up) Champion as I feel this will encourage juniors to use the Freedom To Speak Up Guardian whose role currently seems to be less understood by junior doctors.

Public Sector Equality Duty & Equality Impact Risk Analysis

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

The report addresses the impact of COVID-19 on BAME group amongst the junior doctors. No other equality issues have been raised during this period.

Recommendations

The Board of Directors is requested to note the contents of the report as assurance of the Trust's approach in discharging its statutory duties regarding safe working for medical trainees.

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

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

GUARDIAN OF SAFE WORKING QUARTERLY REPORT
(June 2022)

1. Trainee data

Extended information supplied from 1 June to 31 August 2022

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

Grade	Number of posts for doctors in training (total)			
	NORTH		SOUTH	
CT1-3	9.4		14.4	
ST4-7	2.6		6.4	
GP Trainees	5		9.6	
FT	5		8	

Key:
CT = Core trainee years 1-3
FT = Foundation trainee years1-2
ST = Speciality trainee years 4-7
GP = General practice trainee

2. Exception Reports (with regard to working hours)

There have been following reports during this period. No fines were levied.

Exception Reports				
Location	No of exceptions carried over from last report	No of exceptions raised	No of exceptions closed	No of exceptions outstanding
North	0	7	7	0
South	0	2	2	0
Total	0	9	9	0

Exception Reports by Grade				
Location	No of exceptions carried over from last report	No of exceptions raised	No of exceptions closed	No of exceptions outstanding
CT1-3	0	3	3	0
ST4-7	0	0	0	0
GP	0	0	0	0
Foundation	0	6	6	0
Total	0	9	9	0

Exception Reports by action				
	Payment	TOIL	Not agreed	No action required
North	0	7	0	0
South	1	1	0	0
Total	1	8	0	0

Response time

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

- The exception reports completed by Foundation year 1 trainee were over a week as the trainee was on their own due to understaffing on Tansley Ward which was a result of sickness and inability to fill the gap with an agency or recruitment despite efforts to do so. Most of the overtime was between 30 minutes to one hour and there was one missed educational opportunity which was timely reviewed by the clinical supervisor. These exception reports were by Time off in Lieu (TOIL) and opportunity given later to attend the missed educational activity. Also, assurance provided to Foundation Trainee (FT) and increased support provided by the Consultant.

- There is one exception report by a Core Trainee (CT) in south where they had to do an overtime during an evening shift until a Speciality Trainee (ST) was able to step down to cover the gap overnight. It was agreed to give the trainee a double TOIL due to difficulties with locum payment due to them being employed by a different trust.

- The other exception report by Core trainee (CT) in the south was paid at locum rate for differences in hours worked during long day shift.

- It has taken longer than 7 days to resolve two exception reports due to Allocate related issues – logging in problems.

3. Work schedule reviews

No formal work schedule reviews needed during this period.

4. Fines

One fine has been levied and this is being currently calculated by the medical staffing .

5. Locum/Bank Shifts covered

North 24 shifts totalling £8749.40
South 34 shifts totalling £15202.76

6. Agency Locum

North nil - South 9 shifts totalling £6221.49

7. Vacancies

	North June 22 – Aug 22	South June 22 – Aug 22
CT1-CT3	1	0
ST4-7	2	1.6
GP Trainees	0	0
Foundation	0	1

The Speciality trainee (ST) vacancies are a reflection of national issue with recruitment. The Director Medical Education (DME) at local level and the Royal College of Psychiatry, at a national level are working towards improving this situation.

8. Qualitative information

The Junior Doctor Forum (JDF) has been meeting 6-8 weekly during COVID-19 and this has been held virtually. As always, active representation is sought with each changeover of new doctors in accordance to the Junior Doctor Forum (JDF) constitution.

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

9. Issues arising

9.1 Compliance of Rota

Current rota is fully compliant since August 2020

9.2 Currently there is adequate PPE availability.

The trainees have not reported any concerns.

9.3 Vacancies

As described above, Director of Medical Education is addressing the issues around higher trainee recruitment.

9.4 Induction for August 2022

Induction is being held virtually during COVID and the junior doctors have given positive feedback.

9.5 Fatigue and Facilities

This is regularly visited at JDF. The trainee reps have asked for assurance that the budgets for Fatigue and Facilities (F&F) are ring fenced and has been kept rolling onwards for time being.

The Guardian of Safe Working has encouraged trainees to find a representative each from north and south to take the initiative to liaise with other trainees about the budget spend in future.

Action completed: The budget for F&F for trainees has now been spent completely. We have reassured the trainees that we welcome any reasonable suggestions they have with regards to further improvement of their working life and these should be included for future discussions at Junior Doctor Forum.

9.4 Exception reports

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

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

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

Action complete: Trainees are encouraged at induction and JDF to use Exception Reporting

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

Following concerns raised by the trainees at previous JDF about issues relating to their relationships with nursing staff, the trainees have discussing these at other meetings such as – with directors of medical education, the tutors, within peer group/ junior doctor representatives . More recently the Freedom to speak up Guardian (FTSU) has spoken to the trainees about her role with such issues.

There have been no recent such issues brought forwards to the JDF

Action completed:

- The Clinical Matron, Hartington Unit is meeting with trainees and works closely with nurses to address such issues
- Meeting held between the trainee representatives and FTSU Guardian. Feedback will be given at next JDF.
- We continue to encourage trainees to speak up at the Junior Doctors Forum about any issues at place of work

- Junior Doctors representatives along with the British Medical Association (BMA) have presented at the JDF about the well -being checklist for juniors. There are ongoing discussions about improving the doctors' working lives.

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 1 November 2022

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 31 May to 31 July 2022.

Executive Summary

Due to recent sickness within the mortality team, there is a backlog of non Datix reportable deaths that require reviewing against the red flags outlined in the Royal College of Psychiatrists Care Review Tool and the internal Trust red flags. All deaths reported through the Incident Reporting and Investigation Policy and Procedure (Datix) continue to be reviewed.

All deaths directly relating to Covid-19 are reviewed through the Learning from Deaths procedure unless they also meet a Datix red flag, in which case they are reviewed under the Incident Reporting and Investigation Policy and Procedure.

- From 31 May to 31 July 2022 there has been one death reported where the patient tested positive for COVID-19
- The Trust received 361 death notifications of patients who had been in contact with our service in the last six months. There is very little variation between male and female deaths; 188 male deaths were reported compared to 172 females.
- No Inpatient deaths were recorded
- The Mortality Review Group reviewed seven deaths through a Stage 2 Royal College of Psychiatrists Care Review Tool. These reviews were undertaken by a multi-disciplinary team and it was established that of the seven deaths reviewed, none were due to problems in care.
- The Trust has reported three Learning Disability (LD) deaths in the reporting timeframe and two patient with a diagnosis of Autism Spectrum Disorder (ASD).

Good practice identified through case note reviews is fed back to clinicians involved as part of our appreciative learning.

Strategic Considerations	
1) We will deliver **great care** by delivering compassionate, person-centred innovative and safe care.	x
2) We will ensure that the Trust is a **great place to work** by creating a compassionate, skilled and empowered leadership, creating a vibrant culture where colleagues feel they belong, thrive and are valued.	
3) The Trust is a **great partner** and actively embraces collaboration as our way of working.	

4) We will make the **best use of resources** by making financially wise decisions and avoiding wasting resources to ensure financial recovery and long term sustainability.	

Assurances

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

Consultation

Quality and Safeguarding Committee 11 October 2022.

Governance or Legal Issues

There are no legal issues arising from this report.

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

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

Public Sector Equality Duty and Equality Impact Risk Analysis

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

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

- 31 May 2022 to 31 July 2022 There is very little variation between male and female deaths; 188 male deaths were reported compared to 172 females.
- No unexpected trends were identified according to ethnic origin or religion.

Recommendations

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

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

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

Louise Hamilton
Mortality Technician

Learning from Deaths - Mortality Report

1. Background

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

To date the Trust has met all of the required guidelines. The report presents the data for 31 May to 31 July 2022.

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

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

- Seven Case Note Review sessions were undertaken, where seven incidents were reviewed. Unfortunately, six sessions did not take place due to lack of medic availability and one session did not take place due to Paris being offline.

- Regular audits continue to be undertaken to ensure compliance with policy and procedure and any necessary amendments made. This has included auditing complaint data against names of deceased patients to ensure this meets the requirements specified in the National guidance. The last audit was completed 17 June 2022.

- The monthly mortality review group meetings resumed in November 2020. These were put on hold during the Covid pandemic but have now resumed. During this period one meeting took place and one was cancelled due to the Medical Director been unavailable.

3. Data Summary of all Deaths

Note that inpatients and learning disability (LD) data is based upon whether the patient has an open inpatient or LD referral at time of death. The table below outlines information for 31 May to 31 July 2022.

	31 May	June	July
Total Deaths Per Month	2	171	188
LD Referral Deaths	0	2	1
ASD referral to LeDeR	0	2	0
Inpatient Deaths	0	0	0

Correct as of 2 August 2022

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

188 patients were male, 172 were female, 267 were white British and 5 Asian/Asian British Pakistani. The youngest age was 0 years, the eldest age was 105.

From 31 May to 31 July 2022, the Trust received 361 death notifications of patients who have been in contact with our services.

4. Review of Deaths

Total number of Deaths from 31 May 2022 to 31 July 2022 reported on Datix	51 "Unexpected deaths" 1 COVID-19 death 7 "Suspected deaths" 3 "Expected - end of life pathway" NB some expected deaths have been rejected so these incidents are not included in the above figure 0 Inpatient deaths
Incidents assigned for a review	54 incidents assigned to the operational incident group 0 did not meet the requirement 1 incident is to be confirmed

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

The mortality team review identified deaths against the 'red flags' outlined in the Royal College of Psychiatrists Care Review Tool.

- All patients where family, carers or staff have raised concerns about the care provided.

- All patients with a diagnosis of psychosis or eating disorders during their last episode of care, who were under the care of services at the time of their death or have been discharged within 6 months prior to their death.

- All patients who were an in-patient in a mental health unit at the time of death or who had been discharged from in-patient care within the last month.

- All patients who were under a Crisis Resolution and Home Treatment Team (or equivalent) at the time of death.

Those patient deaths which meet these 'red flag' criteria above should be subject to a review process if they are not already under the Incident process. At the stage of determining if a death meets the criteria for reporting as an incident, teams are required to review all deaths against the Trust Incident 'Red Flags'.

Over the last 12 months the Patient Safety Team with support from NHSE Patient Safety team have been considering current Trust identified Mortality red flags against the red flags identified in the Royal College of Psychiatrists Care Review Tool for mortality reviews. This tool was developed following the publication of the Learning from Deaths Guidance for Mental Health Trusts to use when undertaking mortality reviews It has become clear that the Trust has overcommitted its resources in this area and a redesign of the Mortality (learning from deaths) process is required.

The red flags identified within the care review tool are met under the Trust Incident review process with the exception of psychosis within the last episode of care which has now been added as a Datix red flag.

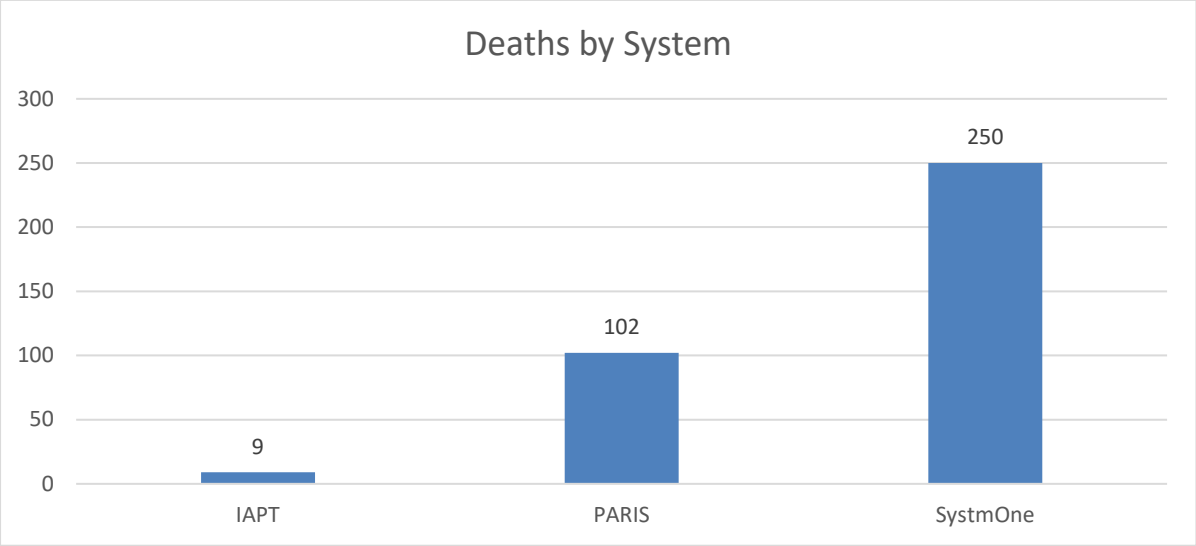
The form based on section 1 of the Royal College of Psychiatrists Care Review Tool for mortality reviews still remains under development, the intention is that this form will be added to the Electronic Patient Record . It is important to note that clinical teams already assess each death when determining if a DATIX incident is required. This will release capacity within the Patient Safety team and allow for greater return on the Case Record Review process.

For the period 31 May to 31 July 2022, the Mortality Review Group reviewed 7 deaths through a Stage 2 Case Note Review. These reviews were undertaken by a multi-disciplinary team and it was established that of the 7 deaths reviewed, none were due to problems in care.

From the 31 May to 31 July 2022 there has been one death reported where the patient tested positive for Covid-19. The patient was female and from a White British background.

6. Analysis of Data

6.1 Analysis of deaths per notification system since 31 May to 31 July 2022

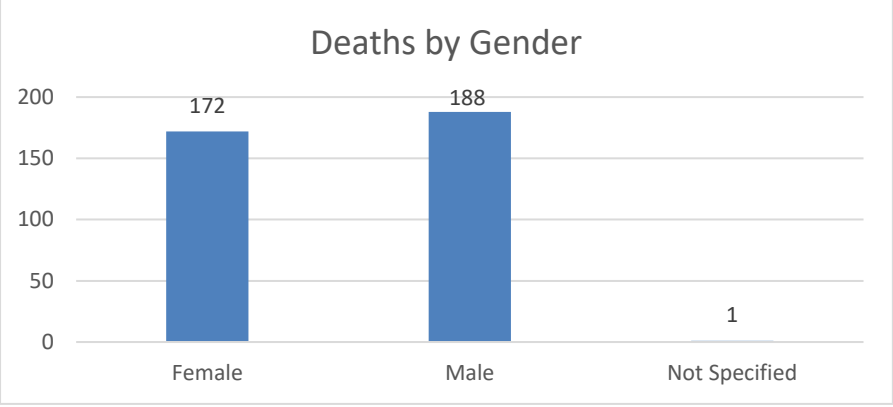


System	Number of Deaths
IAPT	9
PARIS	102
SystmOne	250
Grand Total	**361**

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

6.2 Deaths by Gender

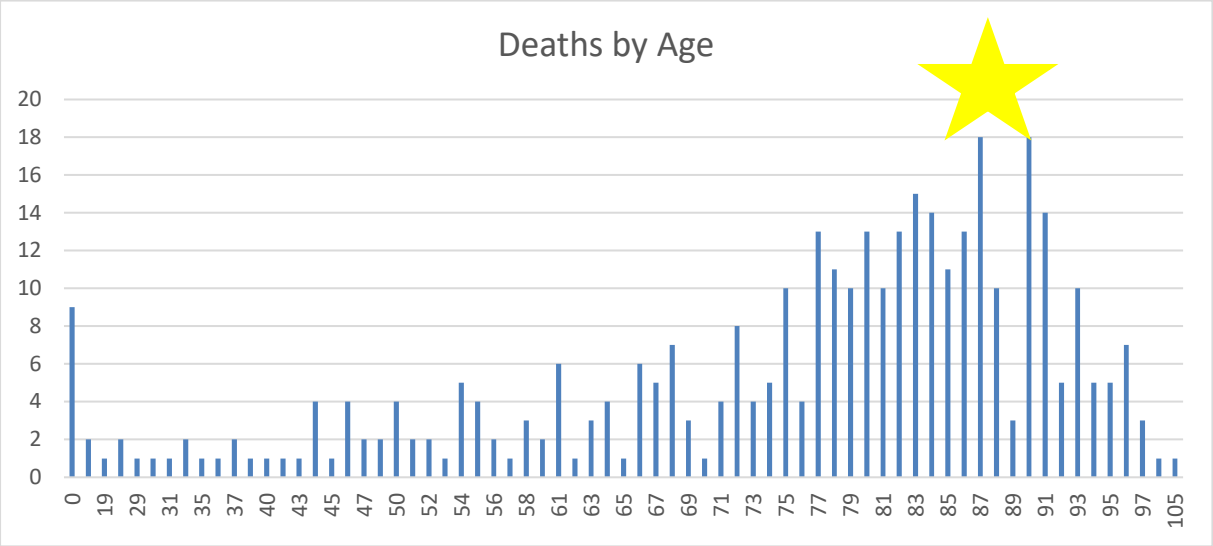
The data below shows the total number of deaths by gender 31 May to 31 July 2022. There is very little variation between male and female deaths; 188 male deaths were reported compared to 172 females and 1 not specified.



Gender	Number of Deaths
Male	188
Female	172
Not Specified	1
Grand Total	**361**

6.3 Death by Age Group

The youngest age was classed as 0, and the oldest age was 105 years. Most deaths occurred within the 80 to 91 age groups (indicated by the star).



6.4 Learning Disability Deaths (LD)

	31 May	June	July
LD Deaths	0	2	1
Autism Spectrum Disorder	0	2	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. Due to challenges in reporting out from the LeDeR programme, we are unable to ascertain how many of our Trust's deaths have been reviewed through the LeDeR process. The Trust continues to share relevant information with LeDeR when requested which is used to inform their reviews.

During 31 May to 31 July 2022, the Trust has recorded 3 Learning Disability deaths. The Trust now receives a quarterly update from LeDeR which highlights national good practice and identified learning; this is shared in the Mortality monthly meeting.

The Trust also is required from 1 January 2022 to report deaths of patients who have a diagnosis of Autism Spectrum Disorder (ASD) for this reporting period the Trust has reported 2 deaths.

6.5 Death by Ethnicity

White British is the highest recorded ethnicity group with 267 recorded deaths, 30 deaths had no recorded ethnicity assigned, and 6 people did not state their ethnicity. The chart below outlines all ethnicity groups.

Ethnicity	Number
Asian or Asian British - Pakistani	1
Mixed - Any other mixed background	2
Black or Black British - Any other Black background	2
White - Irish	2
Asian or Asian British - Indian	4
Not stated	6
White - Any other White background	7
Not Known	30
Other Ethnic Groups - Any other ethnic group	40
White - British	267
Grand Total	**361**

6.6 Death by Religion

Christianity is the highest recorded religion group with 132 recorded deaths, 168 deaths had no recorded religion assigned. The chart below outlines all religious groups.

Religion	Number
Jewish	1
Agnostic movement	1
Methodist	1
Buddhist	1
Sikh	1
Mormon	1
Hindu	1
None	1
Baptist	2
Muslim	2
Catholic religion	2
Jehovah's Witness	2
Atheist	2
Christian religion	2
Roman Catholic	2
Religion NOS	2
Not stated	3
Patient Religion Unknown	3
Not Religious	7
Church Of England	11
Church of England, follower of	20
Unknown	23
Christian	132
Grand Total	**223**

6.7 Death by Sexual Orientation

Heterosexual or straight is the highest recorded sexual orientation group with 157 recorded deaths. 193 have no recorded information available. The chart below outlines all sexual orientation groups.

Sexual Orientation	Number
(blank)	193
Lesbian or gay	1
Not Stated (declined)	2
Unknown	3
Sexual orientation not given - patient refused	5
Heterosexual Or Straight	18
Heterosexual	139
Total	**361**

6.8 Death by Disability

The table below details the top 5 categories by disability. Gross motor disability was the highest recorded disability group with 27 recorded deaths.

Disability	Number
Behaviour and emotional	2
Hearing disability	6
Emotional behaviour disability	7
Intellectual functioning disability	18
Gross motor disability	27

There was a total of 77 deaths with a disability assigned and the remainder 284 were blank (had no assigned disability).

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.

- Record Keeping – Safety Assessment To advise of the importance of collaborative safety assessment formulation within the electronic patient record to enable risk information, risk management and risk mitigation to be conveyed in an easily accessible way; risk information to include current risk and where available historical risks.

- Consultant Psychiatrist – Older Adult services to led on an educational session with medics in relation to the treatment and management of hyponatraemia, this should include specialist input from an Endocrinologist.

- For the General Manager and Clinical Directors for the inpatient services to collaboratively develop and implement a quality improvement programme in relation to multidisciplinary team meetings and documentation, this should include the engagement of Pharmacy.

- Review Trust Respect policy and increase understanding and confidence around end of life discussions and care and treatment.

- Joint working / learning with General Practitioners in relation to when referrals are needed. This includes individual feedback supported by the review lead to the practice in question and wider learning in relation to referrals into service for General Practitioners.

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 1 November 2022

Children in Care Annual Report 2021/22

Purpose of Report

The purpose of this report is to provide Derbyshire Healthcare NHS Foundation Trust (DHCFT) with an overview of the progress, challenges, opportunities, and future plans to support and improve the health and wellbeing of looked after children in Derby City. This is an assurance report to provide the Board with scrutiny of this on how this service is discharging its legal duties and clinical standards requirements.

Executive Summary

- The report includes all cohorts of looked after children that Derby City Local Authority are responsible for, no matter where they live
- The report provides significant assurance on the provision, screening and outcomes for children in the service. All Health screening have been maintained and exceeded the levels set to ensure outcomes for our children which is commended in such a difficult year.
- The report is provided to Trust Board following review at the Quality and Safeguarding Committee in September. The Committee scrutinised and ensured that the Trust had discharged our formal statutory duties to our vulnerable children.
- It is known that Looked after Children are at elevated risk of worse health outcomes. Children in care health screening services are in place to reduce and mitigate this risk. The health outcomes for our community in Derby are above our regional comparator and demonstrate above average performance and good outcomes. The Committee was assured by the report on the significant impact of the team to disrupt this risk.
- It was recognised that the Looked after Children health team have core competencies, specialist skills, knowledge and attitudes to act as advocates, undertake health assessments and identify and manage health needs
- The report describes the challenges faced following on from the Covid Pandemic and the mitigation plans for the unprecedented times for the service
- The Children's and Safeguarding team are commended for their continued hard work in this area to support and protect our children.

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

Risks and Assurances

- The organisation will assure measures are put into place in accordance with the service specification
- Maintain working relationships with other partner agencies/services
- The statutory timescales will be monitored, and evidence is provided and scrutinised, in order, to achieve outcomes
- Training compliance will be scrutinized to ensure competency of staff to the right level.

Consultation

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

Governance or Legal Issues

- The Trust meets statutory obligations and legal duties with regard to: Mental Health Act [1983]; Mental Capacity Act [2005]; The Care Act [2014]; Children and Families Act [2014]; Human Rights Act [1998] Domestic Violence, Crime and Victims Act [2004] and our internal systems, structures and processes are joined up and effective.
- The Trust meets the required standards for our Regulators and our Professional Regulatory bodies Codes of Practice i.e. Safe, Caring, Effective, Responsive, Well-led and Safeguarding are one of the gold threads that runs throughout. We apply national guidelines and evidence based best practice e.g. NICE, DoH, National Statistics.

- The Trust contributes as an equal partner in Multi-Agency forums e.g. MAPPA; MARAC; Channel; Child and Adult Safeguarding Boards and sub-groups and takes part in peer assessment, benchmarking and self-assessment and assurance.
- The Trust invests in staff across multiple agencies and services to ensure high levels of competence and confidence and achieve consistently good practice that is constantly updated and refreshed within a culture of learning from both successful and adverse situations.

Public Sector Equality Duty and Equality Impact Risk Analysis

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

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

- Empowerment - of the individual to make decisions.
- Protection - support and representation for those in need.
- Prevention - of abuse / neglect as well as helping the person to reduce the risks of harm and abuse that are unacceptable to them.
- Proportionality - responses should be least restrictive to the person's rights.
- Partnerships - working collaboratively to prevent, identify and respond to harm.
- Accountability - and transparency in delivering safeguarding

Recommendations

The Board of Directors is requested to receive assurance of the work within DHCFT around looked after children and young people and the continued partnership working to ensure the best outcome is achieved for this vulnerable group of children and young people.

Report presented by: **Becki Priest**
Interim Director of Quality and Allied Health Professionals

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

ANNUAL REPORT FOR DERBY CITY LOOKED AFTER CHILDREN PROVISION

Year 2021/22

Contributors:

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

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

Natalie Legge (Admin Coordinator – DHcFT)

Section 1: Introduction and context

1.1. The purpose of this report is to provide Derbyshire Healthcare NHS Foundation Trust (DHcFT) an overview of the progress, challenges, opportunities and future plans to support and improve the health and wellbeing of looked after children in Derby City. This includes all cohorts of looked after children that Derby City Local Authority are responsible for, no matter where they live (see section 10 for explanation of the differing cohorts).

1.2. The report will outline how Commissioners, Designated Professionals, Local Authority and Health Providers have worked together in partnership to meet the health needs of children in care in Derby City; in line with the statutory guidance 'Promoting the health and wellbeing of looked after children' (DH, 2015).

It will summarise key improvements, service performance; along with setting out the objectives and priorities for the next financial year (2022/23) for looked after children in Derby City.

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

1.4. Within all national and local policies and guidance the service is known as Looked after Children, however within Derbyshire Healthcare NHS Foundation Trust the service is known as Children in Care.

Context

1.5. **Definition of a looked after child/ child in care**

A child that is being looked after by the Local Authority; they might be living with:

- Foster parents
- At home with their parents under the supervision of Children's Social Care
- In Local Authority or private residential children's homes
- Other residential settings such as schools or secure units.

They might have been placed in care voluntarily by parents struggling to cope, or Children's Social Care may have intervened because a child was at significant risk of harm.

Health and wellbeing of looked after children

1.6. It is well recognised that children's early experiences have a significant impact on their development and future life chances. As a result of their experiences and blended effects of poverty, poor parenting, chaotic lifestyles, abuse and neglect, looked after children often are at greater risk and have poorer health than their peers (DfE, DH, 2015).

Ref: Promoting the health and well-being of looked-after children, March 2015, Department for Education and Department of Health

1.7. The Royal College of Paediatrics and Child Health (2020) states that looked after children and young people have greater mental health problems, along with developmental and physical health concerns such as speech and language problems, bedwetting, coordination

difficulties and sight problems. Furthermore, the Department for Education and Department of Health (2015) argue that almost half of children in care have a diagnosable mental health disorder and two thirds have special educational needs. When there are delays in identifying or meeting the emotional and mental health needs this can have a detrimental effect on all aspects of their lives leading to unhappy unhealthy lives as adults.

Ref: Promoting the health and well-being of looked-after children, March 2015, Department for Education and Department of Health

Ref: Looked after children: Knowledge, skills and competencies of health care staff, Intercollegiate Role Framework, December 2020, Royal College of Paediatrics and Child Health

Section 2: Statutory Framework, Legislation and Guidance

The statutory guidance focused around Looked after Children is in abundance; the key documents and legislation are outlined as follows:

2.1 Children Act (1989)

Under this Act a child is defined as being 'looked after' by the local authority if the child or young person is in their care for a continuous period of more than 24 hours by the authority.

There are four main groups:

- **Section 20** children who are accommodated under a voluntary agreement with their parents
- **Section 31 and 38** children who are subject to an interim care order or care order
- **Section 44 and 46** children are subject to emergency orders
- **Section 21** children who are compulsory accommodated including children remanded to the care of the local authority or subject to criminal justice supervision with a residence requirement.

2.2 Adoption and Children Act (2002)

This Act modernised the law regarding adoptive parenting in the UK and international adoption. It also enabled more people to be considered by the adoption agency as prospective adoptive parents. This Act also places the needs of the child being adopted above all else.

2.3 Children and Young People's Act (2008)

The purpose of the Act is to extend the statutory framework for children in care in England and Wales and to ensure that such young people receive high quality care and services which are focused on and tailored to their needs

2.4 Children and Families Act (2014)

This Act strengthens the timeliness of processes in place to ensure children are adopted sooner. Due regard is given to the greater protection of vulnerable children including those with additional needs

2.5 Promoting the health and wellbeing of looked after children (March 2015)

This guidance was issued by the Department of health and Education. It is published for Local Authorities, Clinical Commissioning Groups now Integrated Care Boards (ICB), Service Providers and NHS England (NHSE).

2.6 **Looked after children: Knowledge, skills and competences of health care staff intercollegiate role framework (December 2020)**
This document sets out specific knowledge skills and competencies for professionals working in dedicated roles for looked after children

2.7 **The Children and Social Work Act (2017)**

Improves decision making and support for looked after and previously looked after children in England and Wales

- Improve joint work at local level to safeguard children and enabling enhanced learning to improve practice in child protection
- Enabling the establishment of new regulatory regime for the social work profession
- Improve the provision of relationship and sex education in schools

Section 3: Looked after Children data and profile

National and local data

3.1 The number of looked after children has increased steadily over the past eight years. There were 80,850 looked after children on 31 March 2021, an increase of 1%, compared to 31 March 2020. (Department for Education DfE, Department of Health DH, 2021).

3.2 **Number of children looked after in England from 31 March 2015 to 2021**

2015	**69,540**
2016	**70,440**
2017	**72,670**
2018	**75,420**
2019	**78,150**
2020	**80,080**
2021	**80,850**

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

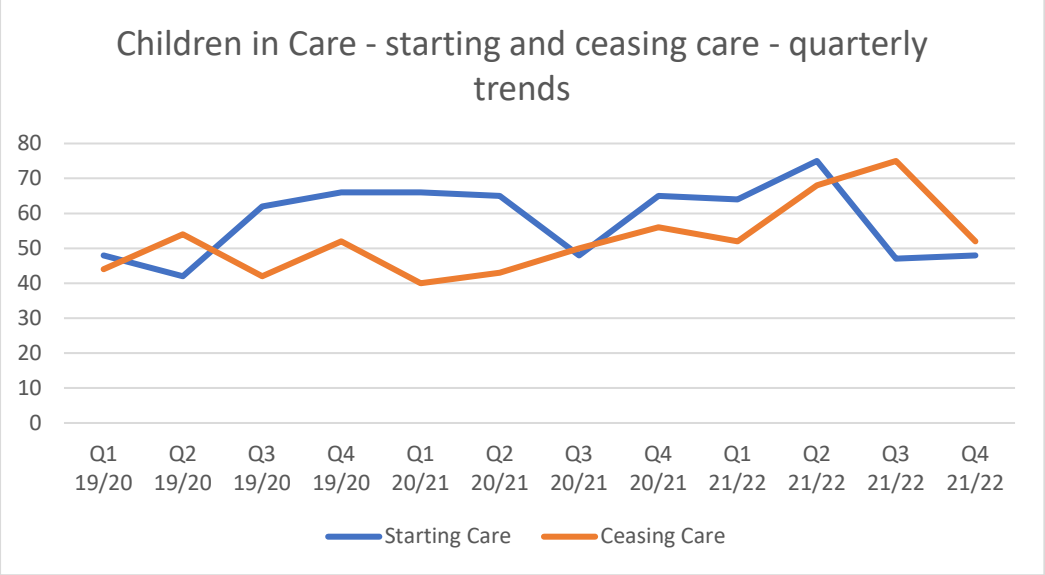
3.3 **Number of children looked after in Derby from 31 March 2016 to 31 March 2022**

2016	**452**	**4% decrease from 2015**
2017	448	0.8% decrease from 2016
2018	491	8% increase from 2017
2019	562	12% increase from 2018
2020	588	4.6% increase from 2019
2021	642	9.4% increase from 2020
2022	627	2.3% decrease from 2021

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

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

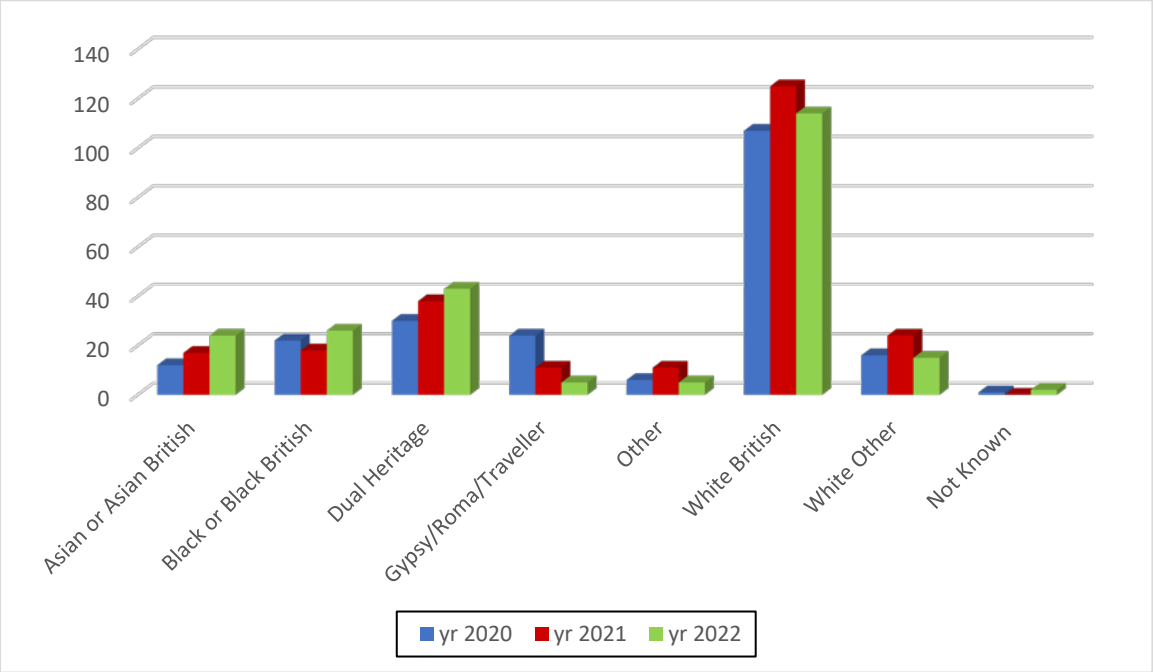
The number of Children in Care decreased by 24 cases during Q3 to 637. This is the biggest quarterly reduction seen over the past four financial years. The number of Children in Care decreased by 10 cases during Q4 to 627. This is a decrease of 15 cases compared to twelve months ago (31 March 2021) when we had 642 cases. This equates to a reduction of 2.3%.



On average there are around 60 entrants per quarter. There were 75 new entrants into care during Q2 2021-22, so this quarter is much higher than the current quarterly average. There were 47 new entrants into care during Q3 2021-22, so this quarter is much lower than the current quarterly average. There were 48 new entrants into care during Q4 2021-22, so this quarter is much lower than the current quarterly average. Previously Q4 had high numbers of entrants in Q4 2020 we had 66 and in Q4 2021 we had 65.

Profile of looked after children in Derby City

3.5 Ethnicity comparisons over the last three years:



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

The Children in Care team acknowledge, adapt and respond to the many changes in demographics of children in care, and understand that different ethnicities are changing. The Children in Care team are dedicated to ensuring that the care offered is culturally adapted to each ethnicity demographic and offer a culturally competent service.

The placement team try to match ethnicity/culture where they can, however this is not always possible due to the balancing of availability and timings. Culture and identity are always discussed at Looked after Children reviews and plans are put in place to ensure the child's needs are being met and fulfilled. The Review Health Assessment pre-checklist has a section to prompt the nurses to confirm the ethnicity and to consider if care offered is culturally adapted and offers a culturally competent service

Unaccompanied Asylum-Seeking Children (UASC) leaflets (gender specific and general health) are available in different languages for our children in care.

Derby City Local Authority are linked to the East Midlands Migration group and the team manager attends the meetings. Any relevant information is distributed to the Designated Nurse for Looked after Children and shared with the Children in Care Team.

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

On analysing the above data, it is clear that there is an increase of children in care from the Asian/Asian British, Black/Black British and Dual Heritage ethnic groups; this reflects the diverse demographics within Derby City and the new emerging communities. The number of White British children coming into care has decreased within this financial year, after an increase over previous years.

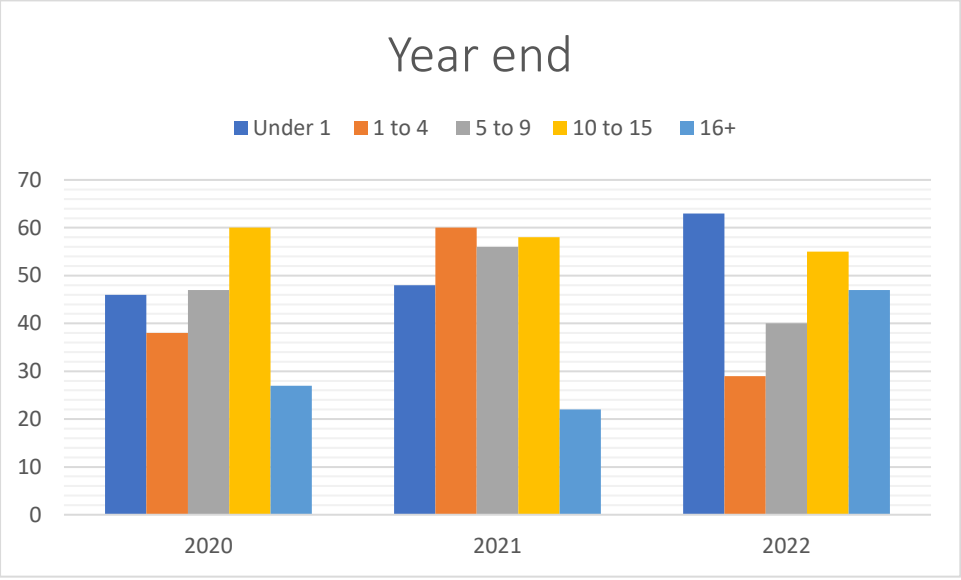
3.6 **Gender of looked after children in March 2022**

Gender	
Male	55%
Female	45%

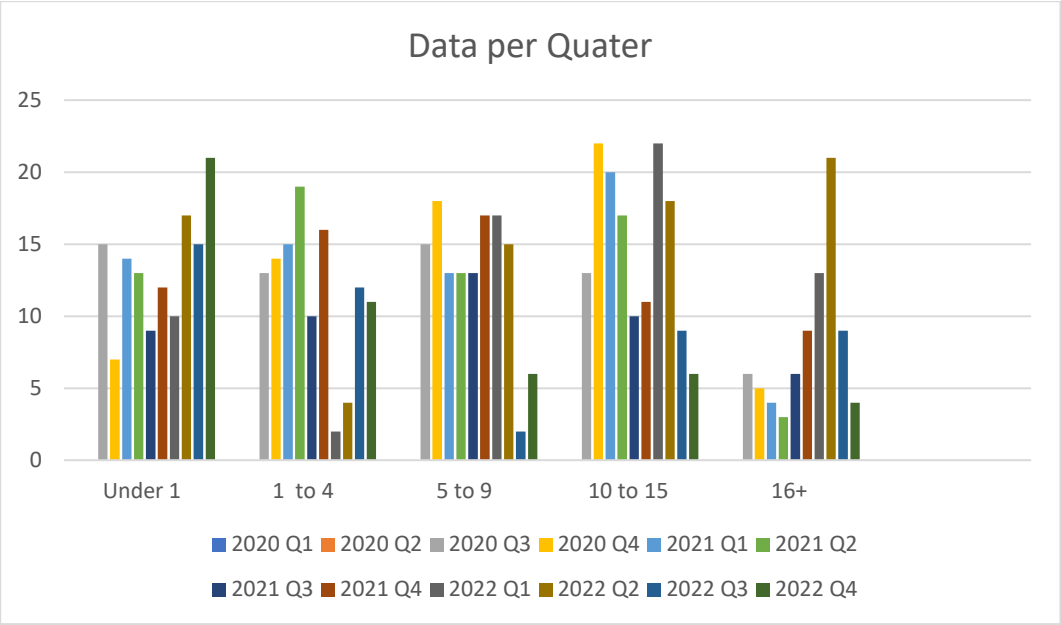
Ref: Data made available from Derby City Local Authority Informatics Department

There were 343 males and 283 females in care on 31 March 2022. This equates to a split of 55% male versus 45% female. There were 60 more boys than girls in care on 31 March 2022.

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



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

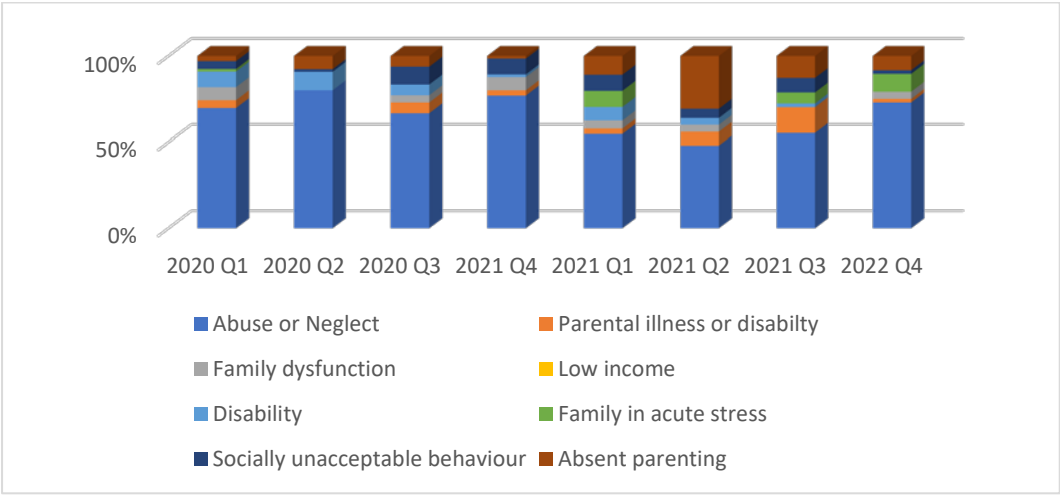


Ref: Data made available from Derby City Local Authority Informatics Department

In comparing the data over the last two years, the number of babies in care aged less than 1 years old is increasing over time showing a significant increase in quarter 4 2022. It is dificult to determind the definitive reasons for this but it may be linked to the increase in abuse/neglect, acute stress and family dysfunction within the family home.

Whereas there has been a decrease in children coming into care in the age group 5 – 9, 10 – 15 and 16+. There has been a slight increase in the number of children aged 1 – 4 years old. There is a steady increase in the number of 16+ children coming into care, which may be as a result of the increased unaccompanied asylum seeking children that are coming into care.

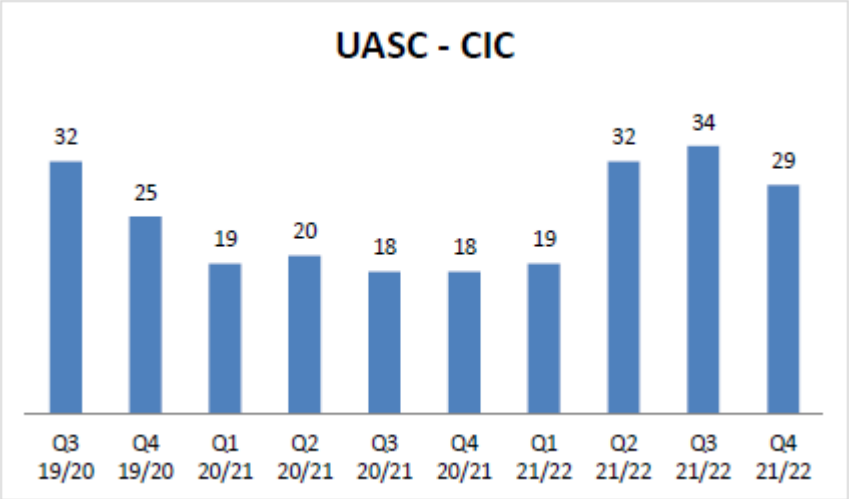
3.8 **Reasons for children coming into care and ceasing care – comparison per quarter over the last two years:**



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

Abuse and neglect remain the most dominant reason for children/young people coming into care, with the percentages remaining relatively stable in reason categories reflected in the above data. In the first half of the year 2021 there was an increase in children coming into care due to absent parenting the figures tripled compared to the previous quarter, however these percentages have started to decrease towards the end of 2021/22.

3.9 **Unaccompanied Asylum Seeker Children 2021/22**

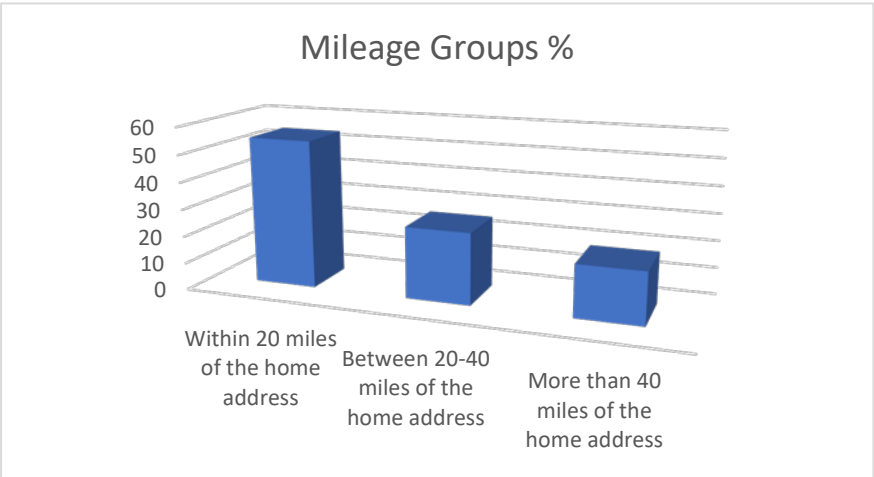


Ref: Data made available from Derby City Local Authority Informatics Department

There were 29 Unaccompanied Asylum Seeker Children (UASC) in care on 31 March 2022. This equates to 4.6% of the overall cohort. On the 31 March 2021 there were 18 Unaccompanied Asylum Seeker Children which equated to 2.8% of the overall cohort.

Location of placement

A total of 212 placements were located within the Derby City boundary on 31 March 2022. This equates to 33.8% of all placements. This shows an increase of placements within Derby City compared to 30.4% of all placements on the 31 March 2021.

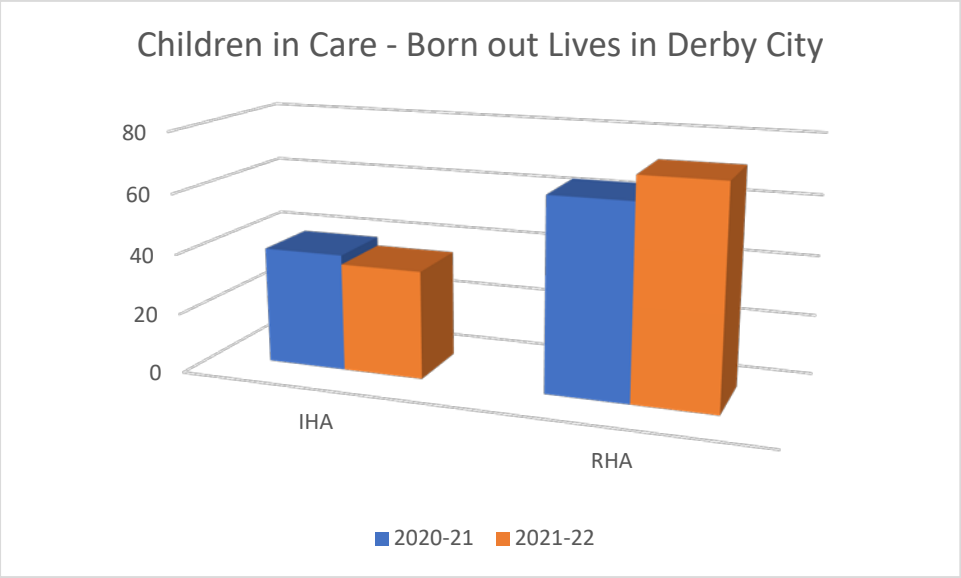


Ref: Data made available from Derby City Local Authority Informatics Department

120 children were placed more than 40 miles from their home address on 31 March 2022:

- 87 were in a foster placement (4 were DCC foster provision whilst 83 were IFA)
- (Independent Fostering Agency)
- 20 were in an agency residential home
- 7 were placed for adoption
- 2 were in Secure units, YOI or Prison
- 2 were in an Unregulated Placement with a family member
- 1 was in a semi-independent living placement
- 1 was placed with parents

3.10 **Children in Care – Born out Lives in Derby City**



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

BORN OUT, LIVES IN – Looked after Children that were born in another area outside of Derby City (or taken into care by an external Local Authority) but reside in Derby City. Children in Care placed in Derby City from other Local Authorities are supported by the 0-19 Service. Derby City Children in Care Team will undertake Health assessments on behalf of other Local Authorities upon request. In 202/22 there was an increase in requests for Review Health Assessments to be completed by the Children in Care Nurses.

Section 4: DHcFT service provision for Looked after Children

4.1 The DHcFT Children in Care health team have core competencies, specialist skills, knowledge and attitudes to act as advocates, undertake health assessments, identify and manage health needs and provide support/training to Foster Carers and Children's homes (in line with the Intercollegiate Role Framework, RCN, RCGP, 2020). The team also contribute to health care plans for all looked after children including children with special educational needs and/or disabilities.

4.2 The team continue to improve their offer for Children in Care by including the delivery of health promotion to children and young people, support for care leavers, development of a robust system to collate health histories for care leavers, improved identification of risk of child exploitation (including boys/young men) and provision for children who have special needs and/or disability.

4.3 The staffing levels for the health team at the end of the financial year (March 2022) were as follows:

Designation	**Hours**	**WTE**
Designated Doctor	4 hours (1 session)	**0.1**
Designated Nurse (DDCCG, now DDICB)	37.5 hours	1
Named Nurse	30 hours	0.8
Specialist Nurse	26 hours	0.7
Specialist Nurse	25 hours	0.67
Specialist Nurse	22.5 hours	0.6
Specialist Nurse	15 hours	0.2
Specialist Nurse	14 hours	0.37
Band 4 Admin Coordinator	30 hours	0.8
Band 3 Administrator	30 hours	0.8
Band 3 Administrator	26 hours	0.7

4.4 BORN IN, LIVES IN – Looked after Children born in Derby City (or taken into care by Derby City Local Authority) and reside within the City.

BORN IN, LIVES OUT (placed near home) – Looked after Children that were born in Derby City (or taken into care by Derby City Local Authority) but reside within approximately 20 miles away from Derby City in another Local Authority area.

BORN IN, LIVES OUT (at a distance) – Looked after Children that were born in Derby City (or taken into care by Derby City Local Authority) but reside in another Local Authority area over 20 miles away from Derby City.

BORN OUT, LIVES IN – Looked after Children that were born in another area outside of Derby City (or taken into care by an external Local Authority) but reside in Derby City. Children in Care placed in Derby City from other Local Authorities are supported by the 0-19

Service. Derby City Children in Care Team will undertake Health assessments on behalf of other Local Authorities upon request.

Section 5: Children in Care and Adoption Administrators

5.1 The Children in Care administrative team consists of an Administrator Coordinator (Band 4) and two Administrators (two at Band 3). During Quarter 4 2021/22 the Children in Care Administrator Coordinator role had a vacancy due to the previous Administrator Coordinator leaving the service. A successful candidate was appointed in April 2022.

5.2 The purpose of all three roles is to provide a comprehensive administrative support service to the Children in Care Health team, ensuring that all administration needs are fully met and that the administrative processes and procedures run smoothly. Responding and making decisions where necessary and following up any actions from health professionals from local and external areas with confidentiality, discretion, and diplomacy due to the sensitive information being shared regarding these vulnerable children.

5.3 The Covid pandemic provided many challenges within the administration team. The team have continued to work incredibly hard whilst trying to provide some normality and stability to the way that our clinics now run following Covid to provide a strong support to the clinical staff and a safe and supportive environment for children and carers alike. The team are continually trying to make improvements to the way that they work and ensure robust administration systems and processors are in place. The Admin Co-ordinator has worked hard to maintain an oversight of compliance and has highlighted any issues or challenges to both the Operational Lead and Named Nurse/Clinical Lead. The Admin Co-ordinator, Named Nurse and Operational Lead have weekly compliance meetings to discuss any concerns (Consent issues, Initial health assessment compliance, Review health assessments, Local authority responses). We have improved the initial health assessment consent form allowing for verbal consent to be obtained by the social worker. This has helped to support the timeliness for consent ensuring compliance is met. The Admin Co-ordinator has updated the blood borne virus (BBV) testing process to ensure that the test and results are gathered in a timely manner. The Admin Coordinator and Team Administrators continue to dedicate time to ensure 'Groups and Relationships' within the patients electronic record are kept up to date.

Section 6: Covid 19 Pandemic

6.1 The Covid 19 Pandemic resulted in changes to the way we delivered the statutory service, ensuring service users and practitioners were kept safe.

6.2 Following on from the COVID-19 pandemic the Children in Care Team have developed a new way of working. The children and young people may be reviewed either by face to face, video, or telephone contact as per clinical, digital, and social need dictates, with an appointment in a follow up clinic if required. A benchmark was agreed between the Named Nurse, Operational Lead and Designated Nurse for LAC as a guide for the Children in Care Nurses to follow when looking at offering a face-to-face appointment. Restoration is underway and flexed to the needs of the child/young person, depending on individual choice and to capture those out of area when waiting lists are long or the out of area provider are unable to complete the Review Health Assessment within a timely manner.

Initial Health Assessment	Quarter 1 Apr - Jun 21	Quarter 2 Jul - Sep 21	Quarter 3 Oct - Dec 21	Quarter 4 Jan – Mar 22
Face to face	34	46	45	32
Telephone contact	9	4	1	4
Video Contact	0	0	0	0

Review Health Assessment	Quarter 1 Apr - Jun 21	Quarter 2 Jul - Sep 21	Quarter 3 Oct - Dec 21	Quarter 4 Jan – Mar 22
Face to face	64	54	39	47
Telephone contact	41	43	47	45
Video Contact	8	20	2	3

6.3 Foster carer sessions were delivered virtually throughout 2021-22. The sessions are chosen by the foster carers and some of the topics covered were emotional wellbeing, minor ailments, behaviour, physical exercise, and adverse childhood experiences. The sessions are co-ordinated by the Designated Nurse LAC, Named Nurse for Children in Care and the Training and Education Office. The plan is to resume face to face sessions once Covid restrictions allow

6.4 The health history booklet and process has been improved in partnership with the Provider, Local Authority, leaving care teams (recommended in Ofsted inspection). The Designated Nurse for Looked after Children secured funding in 2018/19 to purchase Health History folders which will follow the child/young person through their time whilst in care. Throughout 2019/20 the Designated Nurse Looked after Children has worked closely with publishers to develop the Health History folders and with the Named Nurse for Children in Care in planning to roll these out from June 2021.

Section 7: Health Data and Performance for Year 2021/22

7.1 Health data and Local Authority performance is a mandated submission to the Department for Education on a yearly basis and the table below summarises the performance over the last three years:

** Please note all health data for 2021/22 is provisional until submitted to the Department for Education in July 2022 **

Health Data Indicator	Year 2019/20	Year 2020/21	Year 2021/22
Annual health assessments	93.5%	93.8%	92.6%
Dental checks	92.3%	29.2%	77%
Immunisations up to date	92.3%	93.1%	94.1%
Development checks (two Review Health Assessments in the 12 months for under 5 years old)	90.2%	96.6%	86.9%

NB: the data is only mandatory for those children/young people in care for a period of 12 months or more

7.2 **Annual Health Assessments** – The performance for Health Assessments improved during Q4 increasing from 79.5% to 92.2%. The target for 2021-22 is 90% so the current performance is above the target.

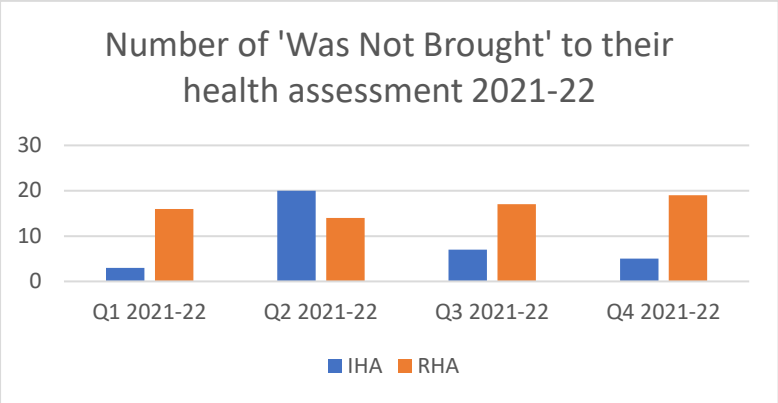
Dental Checks - Derby's completion rate of dental checks has increase slightly during 2021-22. Dental practices have been recovering from the impact of the COVID-19 pandemic. The performance for Dental checks continued to improve during Q4 rising from 49.3% to 67.0%. The target for 2021-22 is 92%.

Immunisations - The performance for up-to-date Immunisations improved further during Q4 increasing from 89.3% to 94.1%. The target for 2021-22 is 92%.

Development Checks - The performance for Health Development Checks improved during Q4 increasing from 64.5% to 86.9% The target for 2021-22 is 87% so we are just below the target. This indicator is currently provisional and is likely to increase further during the year end data submission process.

7.3 Since the Children in Care team have access and the mechanism to update Liquid Logic (Local Authority IT system), the accuracy of heath data has significantly improved. The Named Nurse for Children in care and the Designated Nurse for Looked after Children meet on a quarterly basis to ensure all the correct information is recorded and any outstanding information is passed onto the Children in Care Nurses and admin to chase.

7.4 Shown in the table below are the number of children in care who were not brought to their health assessments during 2021-22.



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

- **IHA - Initial Health Assessment**
- **RHA – Review Health assessment**

Some of the reasons for 'was not brought' to appointment are shown below:

- Young person refused to attend
- Foster carer not aware of the appointment – it is the responsibility of the social worker to inform the foster carer of the appointment date and time
- Foster carer forgot to cancel
- Child placed with parent

Any 'was not brought' or cancellation of the health assessment appointment, for whatever reason, can have a huge impact on our compliance.

Section 8: Analysis of Adoption and Medical Adviser Activity

This section is compiled by Derby City medical advisers
Dr A. Marudkar and Dr P Vundela ,
Children in Care and Adoption Team, Derby City

This section of the report has been prepared based upon the information available from DHCFT data and data provided by the Local Authority regarding adoption related work,

ADOPTION ACTIVITY

There have been some changes to the adoption activity during the Pandemic period from April 2020, which continued this year These reflect the changes made nationally to the Adoption regulations by the Department of Health in liaison with Coram BAAF, to accommodate the unprecedented major changes in working patterns and the restricted capacity of the available medical workforce during the Pandemic, while still satisfying the requirements of Adoption regulations.

In addition to these, there were major changes nationally in the way medical reports are provided for the ADM (Agency decision Maker) following a court ruling (called Somerset ruling). This has affected the medical adviser's workload in an unprecedented way since January 2022 requiring a large number of additional medical reports to be done within strict deadlines, which was achieved with making adjustments in the workforce resources.

8.1 There are two medical advisers contributing to the Adoption work for Derby city. This includes attending the Adoption panels and preparing the reports for the children coming up for adoption panel. The Adult Health Reports are prepared separately by a GP specialist. One adoption panel per month is attended by either medical adviser in role of panel member, on an alternate monthly basis.

There have been some temporary changes to this practice as agreed by Adoption East Midlands due to the limitations of physically attending the adoption panels as panel members. The medical reports for the children to be matched are still provided in the usual manner and panel advice is still given, based upon the paperwork provided by Adoption East Midlands There are stricter timescales to this new process due to the inherent issues of remote working and technology.

8.2 The Regionalised Adoption service (Adoption East Midlands) continues to work incorporating four neighbouring regions of Derby City, Derbyshire, Nottingham City and Nottinghamshire. The cases for matching the Derby City children continue to be heard at any of the panels within the region, attended by different medical advisers. An efficient and timely liaison between different medical advisers is needed to explore and clarify any issues in advance of panel, which may get affected by the capacity issues, requiring Medical Advisers to be available all times as queries may arise from any panel.

8.3 The following adoption activity data is provided by Adoption East Midlands (From 1 April 2021 to 31 March 2022)

- Total number of adoption children's medical reports (Matching reports) – 73 (52 in 2020-2021, 27 in 2019-2020)
- Total number of ADM Reports – 18 (this is new additional work following Somerset ruling)
- Total number of Adult medical reports – 88 (93 in 2020-21, 98 in 2019-20)
- Total number of panels attended (advice provided by Derby City medical advisers) – 16 (11 in 2020-21, 12 in 2019-2020)
- Number of Prospective adopter consultations undertaken - 2 (none in 2020-21, 1 in 2019-20)

There has been a very significant increase of 39% in the numbers of matching reports provided for the year 2021-22 as compared to last year for Derby city, additionally 18 reports were made for ADM urgently within 3 months at short notice with minimal admin resources, to avoid children's permanency plans getting affected while complying with the adoption regulations. This has made a very significant impact on the medical adviser's capacity to provide these reports in a timely manner, further affected by the unprecedented periods of absences during the ongoing pandemic and the medical advisers covering other generic duties eg. safeguarding rota within the department. Lots of adjustments had to be made in the Medical Adviser's time tabled job plan, the flexibility offered by them has enabled the service to achieve this in a satisfactory manner.

The number of adult health reports has further reduced slightly (again by just under 5%), these figures have remained more or less stable over the last 2 years, indicating ongoing recruitment of adopters during the Pandemic.

There were 2 prospective adopter consultations undertaken formally (by telephone, none face to face) during this period, as the previously agreed regional process continued for prospective adopter consultations providing the preadoption advice in a targeted and formal way in writing. We continue to invite questions in writing from adopters via the social worker, which are responded to in writing, included on the report if possible, or separately if received later, also the report format is very comprehensive and includes any history and implications in detail. A telephonic consultation is only provided in selected cases, if requested, to answer any specific queries which remain or if the child has a very significant or complex medical condition. This process commenced at the start of AEM in April 2019 and a significant reduction in this activity was already noted since then.

8.4 The training sessions by medical advisers for prospective adopters, foster carers and social workers were re commenced this year, with the training provided virtually once in March 2022. This training was suspended in the previous year due to the pandemic pressures and restrictions These training sessions are aimed to be delivered 3 times a year, incorporating training on common clinical issues in an adoption scenario, i.e. impact of maternal smoking, alcohol and drug misuse in pregnancy and Blood Borne Infection screening in vulnerable and high-risk children and 2 further sessions are planned for this year.

8.5 Both the Medical Advisers attend regular quarterly AEM meetings with other Medical Advisers and panel advisors (plus commissioners if appropriate). They also attend panel training days twice a year. This training was suspended during COVID-19 Pandemic period., but has resumed by AEM and was attended once recently.

18.6 The Named Doctor for Children in Care and the Named Nurse for Children in Care also deliver a training lecture on Children in Care and Adoption as part of the GP vocational training course in Derby.

Section 9: Derbyshire Integrated Sexual Health Service Accessibility and Engagement Fund

9.1 Children in care are one of the most vulnerable groups in our society, more at risk of health inequality and can be hard to reach as they do not always engage with professionals involved in their care.

It is recognised that young people are often reluctant to attend for sexual health screening, however, is it is acknowledged to be a very important key performance indicator within our service. Sexual health can be an 'embarrassing' subject for many of our vulnerable children and young people and 'myths' about what happens during sexual health screening can result in young people being either unaware or reluctant to seek testing. Some young people in the service may have experienced sexual abuse or trauma which may present as a barrier to access sexual health support. Many young people and their carers are unaware of the many different forms of contraception. Issues around body image and self-esteem, not helped by unrealistic, manipulated images on social media, can greatly impact on the young people our service supports.

The Named Nurse for Children in Care met with the Accredited Provider Lead for the Sexual Health Promotion Team in January 2021 to discuss the application for Derby City. Following on from this, as a team we decided to apply for the Sexual Health Community Funding for 2021-22. Our application was successful in March 2021.

The main reason for applying was because of the unmet health needs of this group of young people and difficulty accessing or engaging with services together with vulnerability factors that may place them at high risk of sexual health problems or infection. Also, to promote and normalise sexual health as part of everyday health care.

The team wanted to develop a training/resource pack to educate and support foster carers and residential children care workers to support children and young people with their sexual health. To produce a training resource for foster carers and residential children care workers to use when supporting children and young people. The training would take place directly with young people using a range of literature to be developed and resources such as contraception teaching packs. The content will include:

- Increased knowledge and understanding around sexual health and risks
- Knowing when and where to seek sexual health screening as part of 'normal' healthcare
- Understanding the many forms of contraceptive choices and where to seek these
- Confidence around managing their sexual health
- An understanding around consent
- Building positive relationships with health professional

We want to improve sexual health outcomes by:

- Educating children and young people to understand sexual health and the risks
- Supporting carers, residential care workers, foster carers and parents to educate some of the most vulnerable young people who are at risk of sexual health infections how to prevent and test for such infections
- Enhance professional's knowledge and understanding of sexual health within the Derby CICA team to ensure they are up to date with current knowledge around sexual health to ensure they are best equipped to support and signpost carers and young people.

Section 10: Summary of achievements in year 2021/22

10.1 During the period of 2021/22 the Children in Care health team have continued to experience some changes and it has been acknowledged despite this the Specialist Nurses, Medical Advisors and Administration Team have shown innovation and marked improvements within their service delivery.

The following are an indication of the progress made and not an exhaustive list of achievements:

10.2 Improved compliance with initial health assessment statutory timescales and improved service delivery across administration and clinical areas.

10.3 Completion of the CCG now ICB 'Markers of Good Practice' assurance framework in quarter 4 (detailed in section 11, page 22/23).

10.4 The end of year Health Performance Data was positive as shown in section 7 considering the challenging year following on from the pandemic and vacancies within the team.

10.5 The Children in Care Team applied for the Sexual Health Community Funding and were successful as discussed in Section 8.

10.6 The Designated Nurse, Designated Doctor, Named Nurse, and the Administrator Coordinator have continued to strengthen existing relationships and networks with key professionals, local partners and agencies locally and regionally, which has facilitated information sharing, health outcomes and the voice of the child (including those out of area).

10.7 Health access to Liquid Logic Child Social Care system continues to improve information sharing between agencies (in the best interest of looked after children) and has a positive impact on the accuracy and validity of health data reportable to Department for Education. At the end of each quarter health information is uploaded onto Liquid Logic and any missing information is followed up by the Children in Care Team.

10.8 Reporting and assurance into the DDCCG (now DDICB) Quality and Performance Committee have been strengthened via quarterly reporting of performance and quality of the Children in Care service. This has allowed the Named Nurse for Children in Care the opportunity to access and interrogate health data more robustly internally within the Trust, using relevant and useful reporting systems. This in-depth provision of evidence has enabled a more robust way of working at both team and service level and influenced improvements.

10.9 Health performance although provisional until confirmed in November 2022 continues to remain high despite recovery from the Covid-19 Pandemic. Although there has been some improvement, due to dental practice restrictions, there continues to be a huge impact on the dental data for 2021/22.

10.10 Foster carer sessions have continued virtually over 2021-22. Some of the topic covered have included, emotional wellbeing, minor ailments, behaviour, physical exercise, and adverse childhood experiences. The foster carers choose the topics for the year, and these have been delivered by the Designated Nurse CiC, Named Nurse CiC, Specialist Nurses for CiC and the doctors within the CiC team.

10.11 The Named Nurse from Derby City and Derbyshire held a successful development day for both Children in care teams which was funded by Derby and Derbyshire Children's Commissioning Group.

10.12 The children in Care Team have provided opportunities for students to shadow the team throughout 2021-22.

10.13 The Children in Care Team have been nominated for Trust DEED awards both individually and as a team.

10.14 Access and training has been provided for all doctors on the Integrated Clinical Environment pathology system. This has improved internal systems and timeliness of Blood Born Infection screening and results.

10.15 Health meetings have continued between the children in care Nurses and the Residential Children's Homes Managers.

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

10.17 Survey monkey questionnaire developed to capture feedback from children and young people and foster carers on their experience of having an Initial Health Assessment and Review Health Assessment.

Section 11: Markers of Good Practice (MOGP)

11.1 In February 2022 the Children in Care team submitted the Markers of Good Practice action plan for 2021-2022 instead of the full self-assessment tool for Children in Care within Derby City, this was a joint agreement due to the Covid 19 Pandemic. The Markers of Good Practice Action Plan, which is 'RAG' rated, provides the Children in Care Team with a productive opportunity to showcase their service to the Clinical Commissioning Group and Designated Professionals.

11.2 With the submission of evidence and 'RAG' rating, the action plan supports the Children in Care team to highlight progress, any gaps or improvements that are required to assure the commissioners our service is working towards a 'gold standard' delivery and that the needs of the Children in Care are being met and identified in line with the statutory guidance.

11.3 Following the MOGP action plan submission, representatives from the Clinical Commissioning Group and Designated Professionals completed the feedback in written format due to the Covid-19 pandemic. A discussion was held between the commissioners from DDCCG (now DDICB). Each standard was discussed, and it was confirmed whether the 'RAG' rating provided by the Provider was in line with that of the commissioners' assessment.

11.4 Strengths and challenges were identified, agreed by both parties and an action plan developed for the provider to work through within the year 2021-2022 to achieve compliance in the areas that were not yet rated as green. The Markers of Good Practice action plan will be fed back to the Safeguarding Children's Committee by the Director of Nursing and Patient Experience, Lead Director for Infection, Prevention and Control, and at the Safeguarding Operational Leads meeting held by the organisation by the Named Nurse Children in Care. The action plan will continually be discussed at the Safeguarding Operational Leads Meeting and with the Designated Nurse for Looked after Children.

11.5 The Clinical Commissioning Group have been significantly assured that the Children in Care service provision is overall at a good standard and the Health Provider is working in partnership in all areas that have been identified as requiring further progression or improvement.

11.6 One of our Specialist Nurses for Children in Care had the opportunity to attend a funded Sleep Practitioner Course. This was delivered through the Sleep Charity and the Children in Care Nurse expressed a particular interest in this area. Once trained the Children in Care Nurse will be able to train and cascade knowledge and resources down to the rest of the team.

Section 12: Priorities for Year 2022/23

12.1 **DHcFT Provider key priorities for 2022/23:**

- To deliver health promotion within the Local Authority Residential Children's Homes focusing on Healthy Lifestyle and Sexual Health
- To continue to represent health at the Enhanced Case management Meetings and Health Meetings with the Local Authority Children's Residential Homes
- To resume foster carer sessions face to face
- To continue to provide health passports and health history summaries
- To continue to work closely with the County Children in Care Team working towards the Joined-up Care Derbyshire Approach
- To build relationships with the leaving care team to improve support around transition
- To continue to deliver quarterly action learning sets for all Children in Care Nurses in collaboration with the Designated Nurse for Looked after Children
- To roll out the training resource for foster carers and residential children care workers to use when supporting children and young people with sexual health.
- ICE system (Integrated Clinical Environment) – to allow access to the electronic pathology system to enable doctors to request Blood Born Virus tests and results electronically, this will be rolled out during 2022
- To submit the Markers of Good Practice Assurance Tool
- Access to LA to ensure up to date information is recorded in the health records

- To review and improve processes to ensure the service is robust, efficient, and effective
- Newly appointed Doctor for Adoption
- Continue to provide opportunities for students

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 1 November 2022

Safeguarding Children and Adults Annual Report 2021/22

Purpose of Report

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

Executive Summary

- The Trust has had a successful year and continues to fully discharge its statutory safeguarding duties
- The Trust officers have discharged the required duties as set in legislation and requirements outlined by the Health Regulator, the Care Quality Commission (CQC). The Annual Report includes how the Trust has been independently scrutinised and assessed. The positive findings have been included in the Report and provide significant independent assurance to the Children's and Adult Named and Designated staff.
- The report describes the challenges and achievements faced in the year
- The report monitors trends in activity and analyses the themes from this activity and use the referral information and helpline activity to adapt training, plan clinical audits or develop policy and procedure from learning reviews
- Safeguarding Unit including Multi Agency Safeguarding Hub (MASH) health activity over the year 2021/22.
- The report provides quantitative, qualitative, and narrative evidence of the scope and extent of work undertaken within the year and how the Safeguarding Unit assures itself that it is meeting its duties by development of its staff who work with children, young people, adults and their families.
- Audit activity is included in the report. Feedback of audit has been included in the report to provide evidence on the internal and external governance process and how the Unit provides quality improvement of practice.
- The report describes the new initiatives/objectives/priorities 2022/23
- The report was received with significant assurance by the Quality and Safeguarding Committee on our systems, governance, learning and improvement of standards of practice. We believe as a collection of health professionals that their report demonstrates a robust system of scrutiny and a commitment to sound practice.

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

Risks and Assurances

- The Safeguarding Unit seeks to actively mitigate and manage risk. Where necessary risks are escalated to the Quality and Safeguarding Committee as part of the reporting process from the Safeguarding Children and Safeguarding Adults Operational Groups.
- The Quality and Safeguarding Committee obtained assurance that the Safeguarding Unit, including MASH Health, Section 11 Audit, Looked After Children (LAC) Markers of Good Practice (MOGP) and the Safeguarding Adults Assurance Framework (SAAF) is meeting its legal and statutory duties and obligations.

Consultation

- The team has consulted internally and with partners throughout the year as appropriate to specific areas of activity, for example, policy development, public protection developments, refining processed within the MASH.
- The paper presented is the quarterly report presented to the Quality and Safeguarding Committee
- The report is written after consultation between the Assistant Directors for both Safeguarding Adults and Children
- The Named Doctors for Safeguarding Children and Adults.

Governance or Legal Issues

The Trust meets statutory obligations and legal duties with regard to: Mental Health Act [1983]; Mental Capacity Act [2005]; The Care Act [2014]; Children and Families Act [2014]; Human Rights Act [1998] Domestic Violence, Crime and Victims Act [2004] and our internal systems, structures and processes are joined up and effective.

Statutory guidance issued under Section 29 Of The Counter-Terrorism And Security Act 2015
Section 26 of the Counter-Terrorism and Security Act 2015 (the Act) places a duty on certain bodies (“specified authorities” listed in Schedule 6 to the Act), in the

exercise of their functions, to have “due regard to the need to prevent people from being drawn into terrorism”. This guidance is issued under section 29 of the Act. The Act states that the authorities subject to the provisions must have regard to this guidance when carrying out the duty.

Health Specified Authorities
80 - The Health specified Authorities in Schedule 6 to the Act are as follows:

NHS Trusts and NHS Foundation Trusts

- NHS England has incorporated ‘Prevent’ into its safeguarding arrangements, so that Prevent awareness and other relevant training is delivered to all staff who provide services to NHS patients. These arrangements have been effective and should continue.
- The Chief Nursing Officer in NHS England has responsibility for all safeguarding and a Safeguarding Lead, working to the Director of Nursing, is responsible for the overview and management of embedding the Prevent programme into safeguarding procedures across the NHS. This is replicated in our Trust.

Section 325 to 327B of the Criminal Justice Act 2003 (CJA) established multi-agency public protection arrangements (MAPPA) in each of the 42 criminal justice areas of England and Wales. These arrangements are designed to protect the public, including victims of crime, from serious harm by sexual or violent and other dangerous offenders. MAPPA are the statutory arrangements for managing sexual and violent offenders. MAPPA is not a statutory body but is a mechanism through which agencies can better discharge their statutory responsibilities and protect the public in a co-ordinated manner.

The Trust meets the required standards for our regulators and our professional regulatory bodies Codes of Practice i.e. Safe, Caring, Effective, Responsive, Well-led and Safeguarding are one of the gold threads that runs throughout. We apply national guidelines and evidence based best practice e.g. NICE, DoH, National Statistics.

The Trust contributes as an equal partner in multi-Agency forums e.g. MAPPA; MARAC; Channel; Child and Adult Safeguarding Boards and sub groups and takes part in peer assessment, benchmarking and self-assessment and assurance.

The Trust invests in staff across multiple agencies and services to ensure high levels of competence and confidence and achieve consistently good practice that is constantly updated and refreshed within a culture of learning from both successful and adverse situations.

Public Sector Equality Duty and Equality Impact Risk Analysis

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

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

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

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

The Trust cannot mitigate all the population health outcomes for children and adults in our community. However, it can influence the wider system and put in place preventative or detective measures to reduce preventable harms.

The Trust cannot stop abuse, but it can assess, engage, offer early detection, and intervene to reduce the impact of abuse and monitor the harms associated with being at risk of harm.

Recommendations

The Board of Directors is requested to:

1) Receive the 2021/22 Safeguarding Children and Adults Annual Report
2) Receive the report which is offered by the Executive Lead with significant assurance from the report regarding the fulfilment of legal and statutory duties.

Report presented by: **Becki Priest**
Director of Quality and Allied Health Professionals

Report prepared by: **Members of the Safeguarding Team, including MASH Health, Safeguarding Trainers and the Operational Team members**

NHS
Derbyshire Healthcare
NHS Foundation Trust

Safeguarding Children and Adults at Risk

Annual Report 2021/22

INTRODUCTION

The Safeguarding of all our patients, both adults and children remains a high priority for DHCFT. Safeguarding and 'Think Family' is the 'Golden Thread' throughout the care standards and practice reviews and analysis provided. The purpose of this report is to provide a review and analysis of the year's safeguarding activity and an update of safeguarding developments across the Trust. We can give assurance that the adaptation to practice due to the ongoing impact of the Covid pandemic occurred smoothly and with no known adverse impacts.

Firstly, we would like to give thanks: huge thanks to you all for your impactful safeguarding practice, during what has been a difficult year for us all. Many of our staff and clients have been left with exacerbated vulnerabilities that have required, and will continue to require, support and attention to safeguard.

We have seen an increase abuse and neglect in many forms, including, exploitation, online grooming, scams, frauds, adult abuse, family poverty, mental health issues, domestic abuse and all the consequences that those things bring for families and communities.

This report sets out the work of DHCFT in relation to safeguarding and the necessary frameworks in place to continue to learn, develop and refine the service. The Trust continues to work in partnership with statutory and voluntary partners across Derbyshire and bordering localities to discharge its responsibilities in relation to safeguarding children and adults at risk - We have had a busy 12 months characterised by high levels of activity, increased complexity of calls for advice, strategy discussions and referrals and many areas of development, which we use to inform our learning and to form our organisational development and growth. We would also like to support everyone in the Trust in 'keeping up the great work' so we can continue to move forward together.

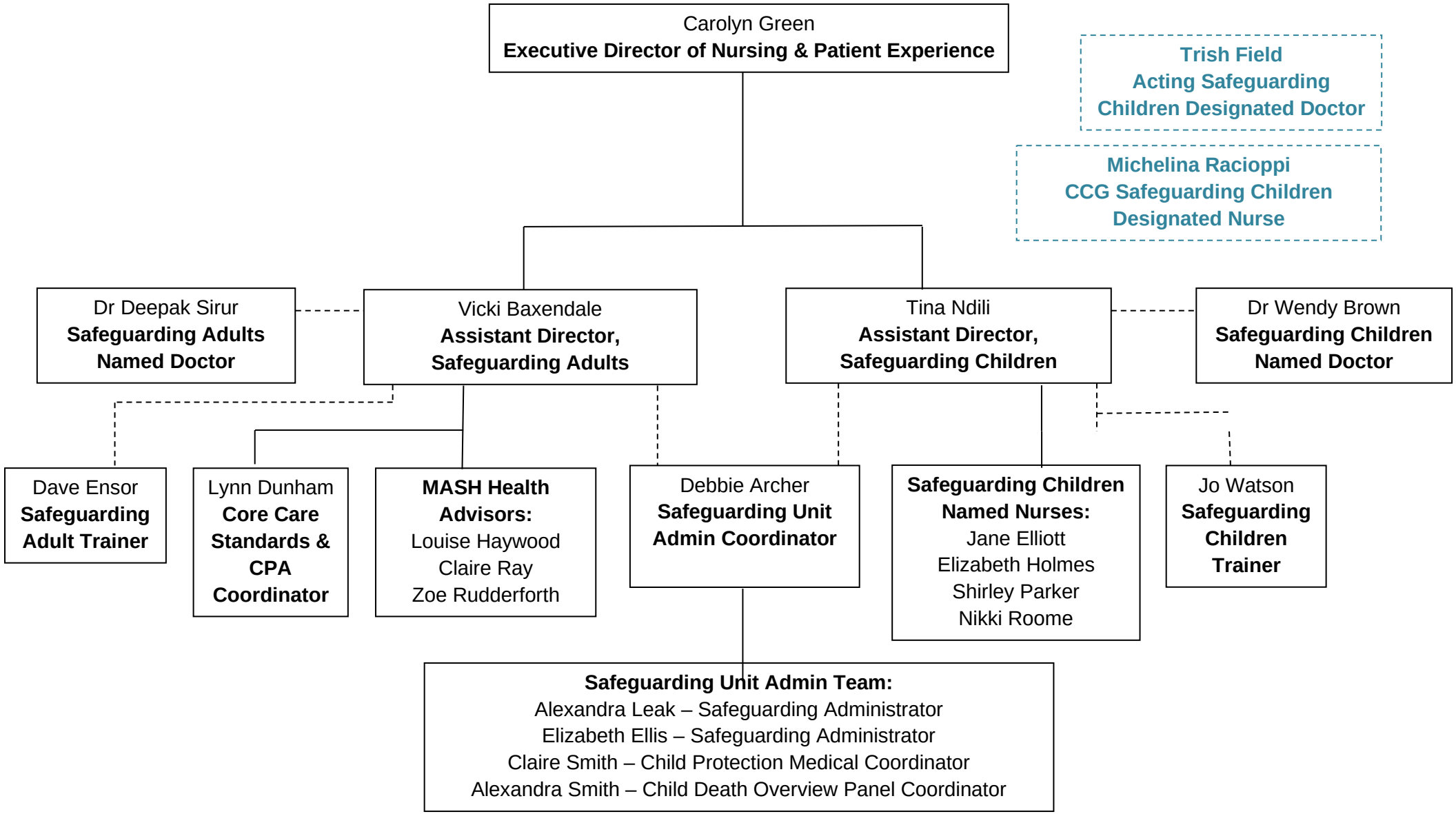
SAFEGUARDING UNIT REPORTING STRUCTURE

Safeguarding Children and Adults Operational Groups report on a quarterly basis to the Quality and Safeguarding Committee which reports directly to the Trust Board.

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

The Safeguarding Unit prepare a monthly report that is issued to all Clinical Operational Assurance Team (COAT) meetings for the Trust which includes Specialist, Children's, Neighbourhood, Forensic and Campus Divisions. The leads provide organisational scrutiny, guidance and learning and includes points for action for the Divisions representatives as well as points for information. Both Safeguarding Operational Groups can escalate matters that require executive or committee consideration / inclusion in the Trust Risk Register but, equally, can escalate good news stories, lessons learned to share across the Organisation. The structure below for 2022/23 has changed significantly.

SAFEGUARDING UNIT STRUCTURE



SAFEGUARDING CHILDREN'S PERFORMANCE DASHBOARD – 2021/22

	Metric	Quarter 1 2021-22	Quarter 2 2021-22	Quarter 3 2021-22	Quarter 4 2021-22
1	Number of advice calls received and reported	232	224	221	256
2	Number of supervision/group sessions	119	92	133	103
3	Number of attendance at MDMs/team meetings/ward rounds	49	52	38	39
4	Number of MASH sessions covered by the safeguarding children's team	0	0	0	0
5	Number of strategy discussions/meetings	117	125	121	147
6	Number of safeguarding meetings attended by the safeguarding team	15	27	15	18
7	Number of safeguarding children's training/workshops delivered	0	0	0	0
8	Number of child protection medical - suspected NAI	24	28	33	44
9	Number of CHANNEL referrals	4	1	2	0
10	Number of MARAC cases with children discussed at MARAC	168	139	192	127
11	Number of referrals to CSC	28	30	20	6
12	CIC Caseload - Born In Lives In	229	253	242	231
	CIC Caseload - Born In Lives Out	425	420	420	397
	CIC Caseload - Born Out Lives In	4	6	5	3
	Total CIC Caseload	658	679	667	631
13	Number of Child Deaths	9	5	0	3
15	Number of children on a child in need plan	378	283	286	248
16	Distinct count of children affected by DV during the Quarter	1236	941	722	927
17	Number of children in an adult bed	0	1	0	1
18	Number of young carers	12	12	12	10
19	Number of children on a child protection plan	588	588	585	572

Key for acronyms within Dashboard:

MDMs	Multi-Disciplinary Meetings
MASH	Multi Agency Safeguarding Hub
NAI	Non-Accidental Injury
MARAC	Multi Agency Risk Assessment Committee
CSC	Children's Social Care
CIC	Children in Care
DV	Domestic Violence

Analysis of the main features within the safeguarding children dashboard:

- Supervision figures show compliance remains stable.
- There is a significant increase in S47s and strategy meetings which contributes to the pressure on the resources of the Safeguarding Children Nursing Team, the number of large families and the complexity of issues adds significant pressure.
- MARAC cases and children impacted by Domestic Abuse continue to be at a consistently high level.

SAFEGUARDING ADULTS' PERFORMANCE DASHBOARD – 2021/22

The safeguarding adult's dashboard has become established over the past year and, whilst, ambitious in some of the data it seeks to capture that may not currently be achievable, it reflects the expected performance requirements of commissioners and some aspirational targets for data in the future.

ANNUAL SAFEGUARDING DASHBOARD – 2021/22

DUTY/REQUIREMENT		METRIC	DEFINITION OF METRIC	TARGET GROUP	TARGET	Q1 %	Q2 %	Q3 %	Q4 %	NOTES
1. Statutory Duties Regulatory Body Requirements - Safe? Effective?										
1	Data received from People Development Lead	**Adult Safeguarding Level 1 Training (3 yearly)**	Adult Protection training allows staff to be able to identify early any safeguarding risks and to know what actions to take	Q1: 649 Q2: 650 Q3: 654 Q4: 659	85%	90.6	87.8	86.3	85.7	Target group = **Average** staff number required to complete training over the 3-month period
2	Data received from People Development Lead	**Safeguarding Adults Level 1 + 2 (3 yearly)**	Adult Protection training allows staff to be able to identify early any safeguarding risks and to know what actions to take	Q1: 1547 Q2: 1881 Q3: 1909 Q4: 1886	85%	84.2	87.15	86.62	85.54	Target group = **Average** staff number required to complete training over the 3-month period
3	Data received from People Development Lead	**Safeguarding Level 3 (3 yearly)**	Enquirer's training in order to be compliant with Care Act and Derbyshire Adult Safeguarding Policy and Procedures	Q1: 130 Q2: 130 Q3: 130 Q4: 129	85%	84.83	88.43	93.00	91.76	Target group = **Average** staff number required to complete training over the 3-month period
4	Data received from MCA/MHA Team Leader	**Number of urgent DoLS authorised -** Urgent DoLS are authorised by the Trust on the day we request an assessment (as we are the managing authority)	Accurate recording of number of DoLS applications ensures compliance and appropriate application of legislation	N/A	N/A	4	8	2		
5	Data received from MCA/MHA Team Leader	**Number of standard DoLS applied for to the LA**	Accurate recording of number of DoLS applications ensures compliance and appropriate application of legislation	N/A	N/A	4	8	2		
6	Data received from MCA/MHA Team Leader – to be	**Number of people with an authorised DoLS granted by Supervisory body**	Accurate records and monitoring of numbers ensure good governance and compliance with legislation	N/A	N/A	0	0	0		

DUTY/REQUIREMENT		METRIC	DEFINITION OF METRIC	TARGET GROUP	TARGET	Q1 %	Q2 %	Q3 %	Q4 %	NOTES
	included in quarterly total report only									
7	Data received from MCA/MHA Team Leader - to be included in quarterly total report only	**Number of referrals to coroner for people who have passed away and have an authorised DoLS granted by Supervisory body**	Accurate records and monitoring of numbers ensure good governance and compliance with legislation	N/A	N/A	0	0	0		
8	Data received People Development Lead	**DoLS training for frontline / clinical staff**	DoLS awareness ensures compliance with legislation in relation to people who lack capacity to make decisions at appropriate time	Q1: 1007 Q2: 1013 Q3: 1032 Q4: 1033	85%	82.88	84.54	84.14	81.79	Target group = **Average** staff number required to complete training over the 3-month period
9	Risk & Assurance Manager to provide data on breaches reported by CQC (through inspection reports), based on inspection dates	**Breaches of CQC requirements, Regulation 13, (Safeguarding people who use services from abuse)**	All providers are required to reach compliance with CQC Essential Standards of Quality and Safety in all Areas of the Service	N/A	0	0	0			
10	See notes from Assistant Director for Safeguarding Adults	**The provider will complete SSASPB Safeguarding Adults Self-Assessment and share actions with the CCGs**	To support Health Services to meet Safeguarding Adult responsibilities and to demonstrate improved outcomes in preventing harm	N/A	N/A					
11	See notes from Assistant Director for Safeguarding Adults	**Number of adult safeguarding referrals made where allegation is within their own service**	Numbers of referrals from health staff to Social Care. Some providers beginning to collect this. Reliable source data is LA. However, this is not currently broken down into health providers	N/A	N/A					
12	See notes from Assistant Director for Safeguarding Adults	**Number of adult safeguarding referrals made by staff where allegation relates to other care providers**	Numbers of referral from health staff to Social Care. Some providers beginning to collect this. Reliable source data is LA. However, this is not currently broken down into health providers	N/A	N/A					

DUTY/REQUIREMENT		METRIC	DEFINITION OF METRIC	TARGET GROUP	TARGET	Q1 %	Q2 %	Q3 %	Q4 %	NOTES
13	Data received from Director of Nursing	**Numbers of staff referred to their professional body due to safeguarding concerns**	Total number staff referred due to concerns about their ability to practice safely	N/A	N/A	0	2			Q2: 1 informal, I referred
14	Data received from Assistant Director for Safeguarding Adults	**Number of current PiPoT investigations ongoing.**	Total number of current PiPoT investigations ongoing within the Trust.	N/A	N/A					Data received from Assistant Director for Safeguarding Adults
2. Regulatory Body Compliance - Safe? Effective? Caring? Responsive? Well-led?										
15	Data received from CPA, Core Care Standards and Carer Coordinator	**CPA Training Compliance**	Accurate records and monitoring of numbers ensure good governance and compliance with legislation	Q1:1320 Q2:1352 Q3:1364 Q4:1302		56.78	52.53	51.23	48.13	Target group = Average staff number required to complete training over the 3-month period
16	Data received from People Development Lead	**Triangle of Care – Training compliance / numbers trained in quarter**	Compliance with the Carer's Trust accreditation scheme	Q1:1248 Q2:1257 Q3:1259 Q4:1206		58	61.23	60.70	62.55	
17	Data received from People Development Lead	**Triangle of Care - % of teams with completed self-assessments**		N/A	100%	50	51.02	52.38	53.06	
3. Partnerships - Responsive? Well-led?										
18		**Provider has a fully resourced and authorised PREVENT Lead**	Providers identify name of lead	N/A	N/A					Vicki Baxendale is lead
19	Data received from People Development Lead - all new staff attending induction	**Number of staff who have received induction / basic awareness in Prevent (Level 1, 3 yearly)**	All staff should have a basic awareness of Prevent	Q1: 658 Q2: 655 Q3: 660 Q4: 666	85%	86.26	84.78	78.83	73.16	Target group = **Average** staff number required to complete training over the 3-month period
20	Data received from People Development Lead	**Prevent Wrap Training to be delivered to all front-line staff (Level 3, 3 yearly)**	Number of identified staff group who require WRAP training from an accredited WRAP facilitator	Q1: 1889 Q2: 1877 Q3: 1904 Q4: 1882	85%	82.41	87.55	84.62	84.16	Target group = **Average** staff number required to complete training over the 3-month period
21	Data received from Assistant Director for Safeguarding Adults	**Full attendance at MARAC meetings (fortnightly)**	Fulfilling our Public Protection responsibilities alongside partner agencies	N/A	100%	See notes	See notes	See notes	See notes	Under review
22	Data received from Assistant Director for Safeguarding Adults	**Full attendance at MAPPA 3 meetings (monthly)**	Fulfilling our Public Protection responsibilities alongside partner agencies	N/A	100%					

DUTY/REQUIREMENT		METRIC	DEFINITION OF METRIC	TARGET GROUP	TARGET	Q1 %	Q2 %	Q3 %	Q4 %	NOTES
23	Data received from Assistant Director for Safeguarding Adults	**Full attendance at DSAB, City and County**	Fulfilling our responsibilities as full and equal members	N/A	100%	See notes	See notes	See notes	See notes	City: 100% County: N/K
24	MASH KPIs - Children and Young People Performance Data MASH provide data	**The number of Adult Safeguarding information sharing requests for Health received**	Evidence to be gathered to ascertain demand for and effectiveness of this partnership initiative to present to Commissioners	N/A	N/A	793	592	527	598	
		Monitor the number and type of requests for information coming through to the Derby City MASH Health team from Children Social Care	Record of number of requests for information for children and young people	N/A	N/A	138	105	94	89	
		Monitor the number of strategy discussions for safeguarding children	Record of the number of strategy discussions pertaining to children and young people	N/A	N/A	134	105	93	86	
		How many children, young people, parents/ carers were discussed	Record of the number of children, young people and parents discussed	N/A	N/A	667	513	435	423	
		Number of professionals liaised with	Record of the number of professionals liaised with for the strategy discussions / meetings	N/A	N/A	20	40	33	39	
25	**MASH KPIs – Adult Performance Data** MASH provide data	Monitor the number of strategy discussions for adults at risk	Record of the number of strategy discussions pertaining to adults at risk	N/A	N/A	14	13	10	15	
		How many adults were discussed	Record of the number of adults at risk discussed	N/A	N/A	13	16	15	19	
		Number of professionals liaised with	Record of the number of professionals liaised with for the strategy discussions / meetings	N/A	N/A	312	196	329	326	
26	**MASH KPIs - Domestic Violence Performance Data** MASH provide data	**Number of domestic violence standard cases discussed at triage**	Record of the number of standard domestic violence discussed	N/A	N/A	No record due to covid	No record due to covid	No record due to covid	Not record due to covid	
		Number of domestic violence medium cases discussed at triage	Record of the number of medium domestic violence discussed	N/A	N/A	156	323	272	283	

DUTY/REQUIREMENT		METRIC	DEFINITION OF METRIC	TARGET GROUP	TARGET	Q1 %	Q2 %	Q3 %	Q4 %	NOTES
27	**MASH KPIs – Other Performance Data** MASH provide data	Training, shadowing, supervision (hours)	Number of hours for training, shadowing and supervision	N/A	N/A	55	47	59.5	78	
4. Workforce - Safe? Well-led?										
28	**Sexual Safety** Data from DATIX DA pull from DATIX Dashboard.	**Sexual Safety in Trust Inpatient Service. Incidents of alleged inappropriate sexual behaviour, sexual assault and sexual abuse to a patient by another patient or other party.**	Other Party to Patient	N/A	N/A	8	6	8	1	
			Patient to Other Party			3	3	7	1	
			Patient to Patient			4	1	4	2	
			Patient to Staff			1	0	1	0	
			Staff to Patient			1	4	1	1	
			Staff to Staff			0	0	1	0	
5. Making it Personal – Additional voluntary information from safeguarding leads, link workers and teams										
29	See notes from Assistant Director for Safeguarding Adults	Stories, feedback, early indicators of potential abuse, trends, application of best practice, good news stories		N/A	N/A	The AD for Safeguarding is a key member of the Dignity panel. Safeguarding link workers across the trust attend our safeguarding operational meeting. Continued work around seeking consent around making a safeguarding referral. Multi-agency training has been provided to staff around a focussed area. Attendance at the complex case panels for both Hartington and Radbourne units.				

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

Analysis

The performance dashboard continues to provide data that offers a level of assurance to the Trust regarding safeguarding activity, trends, and areas of challenge.

The adult safeguarding trainer remains in post and the safeguarding training compliance has improved. This is felt to be due to the delivery of safeguarding training on MS teams.

The operational meeting provides a safe space to discuss complex cases and safeguarding themes that may need to be raised with the safeguarding adults bord or require further focus in our training.

Ongoing work is required to ensure consent to refer to safeguarding is discussed with our services users.

Some of the training around CPA and carers were put on hold during COVID-19 therefore compliance has been affected.

MASH Health Advisors continue to consistently meet Key Performance Indicators as part of Trust contracted activity.

The performance and narrative evidence provided in this annual report demonstrates that we have continued to meet our statutory and public protection duties throughout the pandemic and also reflects the key strategic priorities of the Derby and Derbyshire Safeguarding Adult Boards, Prevention: Making Safeguarding Personal and Quality Assurance.

DEVELOPEMENT OF STAFF WHO WORK WITH CHILDREN, YOUNG PEOPLE AND THEIR FAMILIES

Supervision

Due to the Trust implementing a cascade model of Safeguarding Children Supervision more supervisors were having responsibility, this highlighted the need to ensure all supervisors were trained to the highest standard.

A specialist level 4 training to key members of the Trust who had a supervisory responsibility was commissioned. This was the Safeguarding Supervision Skills: two-day workshop facilitated by: Richard Swann, Independent Consultant and Trainer. This two-day course focused on the link between effective supervision and improved outcomes for vulnerable children. This course was focused to identify the core qualities of effective supervisors helping staff in making critical judgments when safeguarding children and young people.

The training received excellent evaluations and has continued to be commissioned by the Trust as required.

Resilience training

The COVID-19 Pandemic continues to have an impact on staff, staff anxiety and resilience became a key feature. Staff sickness and complex demand were prevalent. Practitioners at risk of burn out, ill health and unintentionally missing opportunities to see early warning signs and act.

The Safeguarding Team has commissioned resilience training from an external source which received excellent evaluation, therefore was recommended to other teams and front-line staff. This was taken up by various teams especially within the Children's Division and was received extremely well by all. The training was delivered via Microsoft Teams. Contents included:

- Towards another normal
- Resilience: Taking stock and moving forward
- Supporting staff, the organisation and wider system.
- Connecting to services we support and the wider system.
- Key impacts on our resilience, Emotional intelligence, Safety and belonging
- Coping with Compassion for ourselves and others, impact, intentions, and intelligent action.

SAFEGUARDING ADULTS' ADVICE THEMES

The Adult advice themes are around:

- Historical sexual abuse,
- Mental health,
- Modern slavery,
- Substance misuse,
- Financial abuse.

Further work is being undertaken to ensure the reporting of advice themes provides more information we can look at trends/themes which will influence training needs within DHCFT.

DHCFT SAFEGUARDING ADULTS – TRAINING POSITION

This report provides an overview to the 383 Safeguarding Adults Level 3 (inc. Level 1 and 2 plus DOLS, MCA and Wrap/PREVENT (Level 3) training in DHCFT from period 1 April 2021 to 31 March 2022

Since the start of the COVID-19 pandemic, all training classes at Level 3 have been delivered via Microsoft 'Teams'. This will continue as it provides a very effective delivery method, with feedback from attendees overwhelmingly endorsing this.

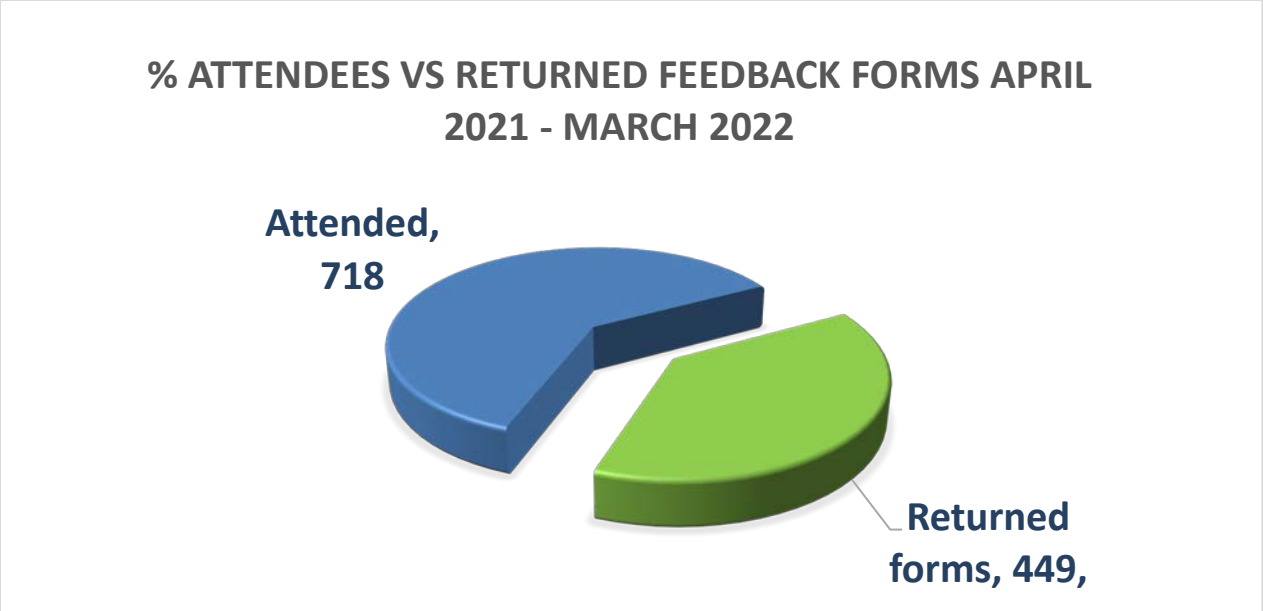
Levels 1 and 2 Safeguarding Adults and Prevent are still available separately to undertake via ESR online e-Learning. However, as all MCA and DoLs training at Level 3 has been included in a full day training package alongside the Safeguarding Adults level 3, all staff members attending the class will receive full compliance in Safeguarding Adults Level 3 (Inc. Levels 1 and 2), MCA, DoLs, Prevent and WRAP.

I also offer the Level 3 Prevent class to any staff having a compliance requirement for that alone. I provide an invite for that section and staff are able to log-in to that portion and access the class without requiring to attend the full day. This is due to Prevent being the last part of the day and has been reported as very positive in achieving training compliance.

All training was ceased after 27July 2021 due to COVID-19 and resumed in September. Training was again ceased due to COVID-19 in January 2022, resuming in February. This is noticeable on the graph.

The reduction in class attendance figures then becomes (and remains) inconsistent – my hypothesis is that this is possibly linked to staffing shortages- and is borne out by attendee withdrawals due to staffing and sickness as notified by attendees on ESR,

I am provided with training compliance figures weekly, and each month I send out (bcc'd) reminders to all staff showing non-compliance in all relevant competencies. This has proven positive and has encouraged staff to book onto classes. Further to this, I personally liaise with staff known to be out of date (using compliance reports) to offer them last minute class spaces and taking other blended approaches to encouraging staff participation. By offering places available to that particular week's classes, and offering to book candidates on, I have found staff are willing take up the offer. This 'sales' technique has also encouraged staff to book onto future class dates.



A selection of feedback responses:

- Before this training I am not very much clear on the topic ‘safeguarding adult and DOLs’. Once, Dave started to explain it in clear pictures with examples, then I could connect the actual scenarios and how to put it in big picture. I also have developed my understanding related to the legislations, which links with adult safeguarding through group discussion, which was offered during this class. The group was excellent as well to discuss and out all of our understandings to bring a conclusion. Thank you for this great experience.
- Well presented, with examples and interaction from participants
- Enjoyed the group time in rooms. Saved travel time on teams.
- I attended today’s training via Microsoft TEAMS, I have to say I was very surprised how much I enjoyed this online training.
- Trainer kept me engaged, probably more I would say than in a classroom environment
- I am new to this trust but have worked within the NHS for over 13 years – this was by far the most informative and interactive Safeguarding training that I have attended. Thank you.
- Some slight tech issues however this didn’t impact on the level of training. Group work went well, I didn’t feel we missed being in the classroom to do this.
- Today’s course was informative and personal. Very tailored to the group and their needs whilst working in the virtual environment. Good proportion of text/videos/break out rooms.
- A very informative course – which was easy to follow and interactive. I would highly recommend it to others. I feel that it works really well over MS Teams, and it felt more interactive than in a classroom environment.
- The course was very formative and even on MS Teams we were able to undertake group work which was an added bonus of change of teaching delivery style.

SAFEGUARDING CHILDREN ADVICE THEMES

We continue to analyse the calls for advice into the Unit. The top 5 themes have continued this year, however slight change in order.

Top 5 Advice Themes:

	2020/21	2021/22
1	Domestic Violence	Parenting Skills/Capacity/Basic Care
2	Parenting Skills/Capacity/Basic Care	Domestic Violence
3	Neglect	Neglect
4	Emotional Abuse	Child's Mental Health
5	Child's Mental Health	Emotional Abuse

DHCFT SAFEGUARDING CHILDREN TRAINING POSITION

This provides an update to the safeguarding children training provision, compliance and action plan in the Trust as of May 2022 and covers the period of April 2021 to April 2022

Training Name	Target Group	Compliant	Non-Compliant	Compliant %
C Safeguarding Children Level 1 Annual	603	479	124	79%
C Safeguarding Children Level 1 once only	1920	1870	50	97%
R Safeguarding - Children Level 2 3 yearly	494	436	58	88%
R Safeguarding - Children Level 2 once only	1421	1371	50	96%
R Safeguarding - Children Level 3 3 yearly	1162	907	255	78%
R Safeguarding - Children Level 3 Annual	315	253	62	80%
R Safeguarding - Children Level 4 Annual	7	7	0	100%

All level 1 and 2 training during this last year has been via E-Learning. Level 2 sessions are now being delivered by MS Teams.

During the last training year, there have been two periods of cancelled training by The Incident Management Team in response to the Covid 19 pandemic, which lasted eleven weeks in total.

Once training resumed additional session were offered and there have been forty-eight level 3 sessions offered in this last year. As a result, 720 staff have received their level 3 training. There were 1110 spaces made available, meaning 390 more staff could have attended a session. All sessions were via Microsoft Teams (MST). Despite pauses in training, all training is above 75%.

Training data is closely monitored, and staff and managers are liaised with regarding accessing sessions and addressing barriers to access. Bespoke sessions to address this are also in place for some staff groups.

LEARNING FROM REVIEWS

Child Safeguarding Practice Reviews (CSPR) Exception Report

There has been 8 Child Safeguarding Practice Reviews being worked upon during 2021/2022 all at varying stages. Cases progressed and some still are progressing as swiftly as possible and there are no issues or concerns. Delays are for various reasons: trail date delays, media planning, completion of reports and delayed responses from authors, are just some of the reasons. Actions are on target and are monitored via the multi-agency CSPR action planning group. The process and activity are very complex, and a process map was developed and is reviewed and circulated across all partners to ensure timescales are adhered to. This gives assurance across the partnership that actions are complete or give a progress position and enable agency challenge as necessary.

Learning briefs are developed by the Partnership to disseminate the learning throughout the organisations The Trust cascades learning via various routes including professional meeting and organisation reports.

Safeguarding Adults Homicide Reviews & Safeguarding Adult Reviews [SARs]

The Trust has been actively involved in Adult Homicide / Domestic Homicide Reviews this year and Safeguarding Adult Reviews. The Assistant Director for Safeguarding Adults is a member of the County Safeguarding Adults Board Safeguarding Adults Review Panel. Work continues to complete outstanding actions from previously published reports. These actions are overseen by the relevant Safeguarding Board or Community Safety Partnership

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

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

AUDITS

Two safeguarding children were allocated during the period of this report, see below, however the audits are not yet complete to due ongoing resource issues during and because of the Covid pandemic. These will take priority.

- Patients with complex needs are allocated a Care Coordinator; Cases discussed at MDMs/ Clinical Case discussion include analysis and action; and are documented within EPR.
- Do referrals to Adult Social Care consider the impact of this on children within the family (Think Family)?

The Trust took part in a safeguarding Children Partnership Audit: Keeping Babies Safe: Derby City and Derbyshire County Safeguarding Children Partnership (DDSCP) Multi-agency audit: Partnership effectiveness in protection of babies.

In May 2021, a multi-agency audit was undertaken as part of a package of work to obtain assurance that local safeguarding arrangements are keeping babies safe. This is in response to concern about the number of incidents and subsequent reviews involving babies. Between January 2018 and 25 December 2020 across Derby and Derbyshire, 11 babies have been seriously harmed or died because of abuse or neglect; 10 had either current or previous involvement from children's services.

Six cases were audited from each local authority; 3 were subject to child in need plans and 3 Early Help. The audits included Children's services, Health visiting teams, maternity units and probation. Alongside standard audit considerations, this audit focussed on key aspects of keeping babies safe, including safe sleep, safe handling, and safe space.

Below are the main features and themes:

Keeping babies safe:

- The **'Shaking the baby is just not the deal'** video is routinely delivered across both hospital trusts to mothers prior to discharge. Delivery to fathers and others directly involved in the care of baby (including through formal supervision arrangements) was not as consistent and it is important to ensure that both parents have adequately understood the messages.
- There is evidence of robust delivery of **parent education messages** including **safe sleep, safe handling and safe space** across the partnership. It is well considered in assessments and revisited regularly, including identification and discussion around factors that increase the risk of Sudden Unexplained Death in Infancy (SUDI). However, 3/12 cases had no **safe sleep assessment.**
- **Routine enquiry** around domestic abuse is routinely asked in both midwifery and health visiting services, however more consideration could be given to revisiting this where routine enquiry hasn't been conducted due to the presence of others.

Wider themes:

Think family:

- There is good consideration of baby when the focus of work is with an older child/children
- Large/complex families require more careful consideration in assessment and planning in terms of their role in the care of the child, as well as their impact on both the child and the parent's ability/capacity to care for them.

Hidden men:

- There were examples of tenacious work to engage reluctant fathers, but this is inconsistent. Conversely there are also examples of fathers not being spoken to prior to completion of assessment meaning that the risks/strengths are not well understood, and limited curiosity around other male 'visitors'

Domestic abuse:

- Consideration of the impact of domestic abuse on a household and their ability to facilitate change could be strengthened
- Practitioners should be aware of the risk of disguised compliance in situations where the victim may experience control from or fear of the perpetrator.

Professional optimism and curiosity:

- Good examples of professional curiosity uncovering risks that were either previously not known or well understood, particularly in midwifery and probation, alongside keen observations of the living areas and interactions, and using these to facilitate discussions and advice for parents, particularly in children's services and health visiting
- Some cases displayed a level of professional optimism that was not appropriately evidenced.

Multi-agency working:

- There were multiple examples across all agencies of regular and effective communication enabling a robust package of support.
- In complex cases, and where there are many practitioners involved with the family, joint supervision would be beneficial.
- There are inconsistencies in attendance/invites to multi-agency groups and attendees (particularly health visiting) receiving the minutes.
- Several plans were described as 'single agency' particularly around what was seen to be discrete pieces of work to be undertaken. However, in all these examples there were needs and/or risks that were not initially apparent and did require a full multi-agency approach.
- Escalation plans were clear in all cases that were reviewed. In a few the cases that remained open, there was no clear multi-agency plan for closure/exit strategy to universal services.

Barriers to engagement:

There were cases across both areas where one or both parents had had social care involvement as a child, specifically being looked after, which resulted in reluctance to engage with children's services and an element of mistrust and fear that their children would also be removed. This is challenging, particularly with non-statutory Early Help and Child in Need, but the impact of this on the parent's ability/willingness to engage was not well recognised/recorded as part of the planning and analysis. In most cases this was resolved by sensitive and creative multi-agency working, between children's services and health visiting in both areas.

As a result of the audit (DDSCP) has published the 'Three steps for baby safety' strategy which supports practitioners to confidently deliver messages of safe sleep, safe handling and safe space as well as recognising the specific vulnerabilities of babies and identifying risk at the earliest opportunity.

Multi-Agency Audit Themes – Safeguarding Adults

The Assistant Director participates in regular Multi-Agency Audits on behalf of DHCFT. These are organised by Derby Safeguarding Adults Board and Derbyshire safeguarding Adults Board. The themes in the last year 2020/21 for Derby SAB have been:

- Homelessness,
- Domestic Abuse - Older Adults

Themes for Derbyshire SAB are:

- Self-neglect
- Transitions
- Domestic abuse in Over 65's
- Domestic abuse - Learning Disability.

We have identified further multi-agency audits around "Safeguarding referrals/S42 enquiries for non-White British Derbyshire citizens". It was also agreed that after the audit in October 2022, the themes for the next three audits in 2023 will be "Learning Disability and Sexual Abuse"; "Domestic Abuse in over 65-year-olds"; and financial abuse. Learning from the audits will be shared by the Derby and Derbyshire Safeguarding Adults Board. Future learning will be shared across the Trust.

ACHIEVMENTS 2021/22

There has been a change of personnel within the Assistant Director safeguarding adult's role. A safe and smooth transition has been enacted to ensure partnership working.

SECTION 11 AUDIT

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

NHS Derby and Derbyshire Clinical Commissioning Group (DDCCG) and Derby and Derbyshire Safeguarding Children Partnership (DDSCP) completed the Section 11 self-assessment with DHCFT Safeguarding Team virtually on 25 June 2021.

We are very pleased to report that they were fully assured with the evidence provided in our Section 11 self-assessment.

I would like to thank Trust staff that all who took part in the self-assessment process at a period of high pressure due to COVID-19 pandemic.

Looked After Children Markers of Good Practice (MOGP)

In February 2022 the Children in Care team submitted the Markers of Good Practice action plan for 2021/22 instead of the full self-assessment tool for Children in Care within Derby City, this was a joint agreement due to the Covid 19 Pandemic. The Markers of Good Practice Action Plan, which is 'RAG' rated, provides the Children in Care Team with a productive opportunity to showcase their service to the Clinical Commissioning Group and Designated Professionals.

With the submission of evidence and 'RAG' rating, the action plan supports the Children in Care team to highlight progress, any gaps or improvements that are required to assure the commissioners our service is working towards a 'gold standard' delivery and that the needs of the Children in Care are being met and identified in line with the statutory guidance.

Following the MOGP action plan submission, representatives from the Clinical Commissioning Group and Designated Professionals completed the feedback in written format due to the COVID-19 pandemic. A discussion was held between the commissioners from DDCCG. Each standard was discussed, and it was confirmed whether the 'RAG' rating provided by the Provider was in line with that of the commissioners' assessment.

Strengths and challenges were identified, agreed by both parties and an action plan developed for the provider to work through within the year 2021-2022 to achieve compliance in the areas that were not yet rated as green. The Markers of Good Practice action plan will be fed back to the Safeguarding Children's Committee by the Director of Nursing and Patient Experience, Lead Director for Infection, Prevention and Control, and at the Safeguarding Operational Leads meeting held by the organisation by the Named Nurse Children in Care. The action plan will continually be discussed at the Safeguarding Operational Leads Meeting and with the Designated Nurse for Looked after Children.

The Clinical Commissioning Group have been significantly assured that the Children in Care service provision is overall at a good standard and the Health Provider is working in partnership in all areas that have been identified as requiring further progression or improvement.

SAFEGUARDING ADULTS' ASSURANCE FRAMEWORK (SAAF)

SAAF 2020/21

We have completed our assessment visit and are awaiting feedback. We were able to discuss strategic and operational work and give assurance that as a safeguarding unit we work very hard to meet all priorities to keep children, adults and family safeguarding a priority within the DHCFT.

We were informed that our presence is key in Safeguarding Adults Board subgroups to help influence local safeguarding arrangements and were able to offer assurance that this remains a priority for DHCFT

SAAF 2021/22 Feedback letter to Director of Nursing and Patient Experience dated 23 August 2022

Dear Carolyn,

May I begin by congratulating you and your team on a comprehensive SAAF submission, the evidence submitted provides significant assurance that DHCFT are supporting staff to protect patients from abusive/neglectful behaviour and practice.

We have scrutinised the evidence you provided and did so in parallel with your self-assessment RAG ratings. You rated yourself green against all criteria except for the implementation of Making Safeguarding Personal/Patient experience which you have rated as amber in both in 2018 and 2021. We recognise, as do the Derby and Derbyshire Safeguarding Adult Boards, that this is a challenging aspect of delivering effective Safeguarding Adult practice (MSP/patient experience). It should also be noted that the DSAB's continue to have as one of their strategic priorities the embedding of MSP. The ability to fully meet MSP criteria is further restricted by low rates of referral outcome feedback from the Local Authorities.

The previous SAAF denoted several areas such as Policies and Governance in addition to Training and Staff Development (Amber)– at which point there were several positives but also areas for improvement. The work over the past few years from the team have ensured that progress has been in these areas. This has resulted in your current rating as green.

In relation to MSP/Patient experience we recognise that your Safeguarding Unit alterations which now ask an additional question regarding patient awareness, will aid a demonstration *(in terms of recording)* that MSP related thought processes have occurred.

Given the uniqueness of Covid restrictions and pressures over the last two years we would agree with your current RAG ratings and look forward to your progression to green.

Your team's contribution to the wider safeguarding agenda is welcomed, and as discussed within the meeting the team are regarded as valued partners across all aspects of safeguarding work. We would also commend you for effective inter-agency working with agencies such as the Police, demonstrating a commitment to "Safeguarding being everybody's business" in order to achieve best outcomes.

You told us that the staffing alterations have seen significant changes within the Safeguarding team. Although demanding these changes have been seamless and have had no negative impact upon performance this significant achievement should be recognised and celebrated.

We noted that your policies are up to date and that staff training levels are at high levels. With regards to training, we noted the move to virtual training has greater outreach to ensure increased numbers but also demonstrates a commitment to safeguarding focus across the Trust. This eLearning and online training offer will continue.

You told us that you have seen a significant increase in domestic abuse referral rates over the last 2 years. This has arisen as a consequence of staff activity and in the requests for information sharing to support referrals that have been made within other agencies. As discussed, this is not a unique trend and is something that is being reported across Derby/Derbyshire and the UK during the Covid pandemic.

You explained that a key priority is in relation to Improving Sexual Safety within inpatient areas. This generated interesting discussions within the meeting and raised the dilemma of differing staff response given that all patients/staff may react differently in how they would like a situation to be managed. We agreed to discuss progress at the next SAAF catch up meeting in the New Year.

The 'Safeguarding unit' have demonstrated that active internal governance and assurance protocols are in place, given the regular Safeguarding link meetings that occur to discuss processes, procedures, cascade new information and to discuss complex cases in addition to the internal helpline that is in place for staff to contact.

Finally, please accept my congratulations on a comprehensive Safeguarding Adults Assurance Framework (SAAF) return and positive review meeting and the hard work and commitment demonstrated to ensuring that Safeguarding continues to play a key focus across the Trust.

Yours sincerely

Bill Nicol (MA)
Assistant Director for Safeguarding Adults (Prevent Lead)
NHS Derby and Derbyshire ICB

AMALGAMATION OF SAFEGUARDING CHILDREN AND ADULTS

A closer alignment and amalgamation of our Safeguarding Service Teams has been designed and continue to work collaboratively and creatively where safeguarding concerns are across families with complex needs. There have been some very complex cases where the cross working of the sub sections of our teams has achieved better outcomes. The safeguarding team continues to work with colleagues in complex case panels and discussion ensuring a richness in conversation and that safeguarding remains the golden thread. The safeguarding advice line supports both adult and children concerns, and support and advice given across the age and service range. We collate advice themes to give us a comprehensive picture of safeguarding concerns within the Trust and will inform safeguarding training in the future.

CARERS

The Assistant Director of Safeguarding Adults remains the Carers Lead and chairs the Carers Engagement Forum which meets monthly.

We have completed our self-assessment and analysis and once again regained our 2 stars for the Triangle of Care (TOC). The six key standards state that:

1) Carers and the essential role they play are identified at first contact or as soon as possible thereafter.
2) Staff are 'carer aware' and trained in carer engagement strategies.
3) Policy and practice protocols re: confidentiality and sharing information, are in place.
4) Defined post(s) responsible for carers are in place.
5) A carer introduction to the service and staff is available, with a relevant range of information across the care pathway.
6) A range of carer support services is available.

SEXUAL SAFETY

In anticipation of next year's quality priorities including sexual safety, work has begun around strengthening our culture of sexual safety. This work has focused on Trust in-patient services and is guided by CQC Sexual Safety on Mental Health Wards published in 2018.

The Assistant Director and the Named Doctor have focused efforts on supporting a small working group that has, so far, achieved work towards development of a policy and a guidance leaflet for patients. This work will maintain a strong focus next year.
Sexual Safety Update

The Mental Health Safety Improvement Programme have reduced the support to the sexual safety improvement programme in order to focus on reducing restrictive practice. However, the East Midlands Community of Practice is being maintained for the foreseeable future. The work towards aligning definitions across the region is continuing, however there has been an acceptance that there will need to be some slight variations as different trusts use incident reporting in different ways and use different systems. It has been agreed that the group will aim for as close alignment as possible.

A flow chart has been developed in conjunction with Derbyshire police on how to respond to a sexual safety incident on our inpatient areas including managing a potential crime scene. This is currently out for consultation with staff before final distribution.

On review of all the sexual safety incidents from April 2021 to February 2022 The Radbourne Unit had a low threshold for reporting sexual safety incidents such as hugging between patients. Incidents reported at the Hartington Unit appeared to be more significant. Both units reported incidents where it was likely to be because of illness, including patients themselves believing this to be the case, as well as more intentional incidents.

Of the 27 reported by Radbourne four were community based/non recent abuse and another was a duplicate.

All the sexual safety incidents across both units were referred for safeguarding appropriately.

A questionnaire has been developed for staff in the in-patient units to complete for us to assess the level of understanding staff have around sexual safety.

PREDICTING DEMAND, WORK AROUND THRESHOLDS AND REFERALS

Since the beginning of the COVID-19 pandemic during 2021 and 2022 and to date, a partnership meeting has been held with key partners of the DDSCP. These meetings have looked at what agencies are doing specifically to address the pressures being experienced by Derby and Derbyshire Children Social Care 'front door' services. The focus of the Predicting Demand Group is to formulate a partnership response in tackling the following aspects:

- Reducing the pressure on the 'front door' of both Derby and Derbyshire Children Social Care.
- To reduce the number of cases that resort to no further action or threshold not met.
- To raise further awareness around the identification of early vulnerabilities, the completion of early help assessments and the offer of early help intervention.
- To raise further awareness regarding the threshold document and aiding professionals to make threshold informed referrals
- The follow up of referrals that do not meet the threshold of intervention in order to explore the reasons for this outcome and if the decision made by Children Social Care needs to be challenged via the use of the escalation process.

Derbyshire Healthcare Foundation Trust (DHCFT) is fully engaged in this work.

The intention is that prior to every predicting demand meeting a health agency report is updated with any new actions/ progress being made within the health organisations against the following questions.

- What is your organisation doing to continue to raise awareness on the identification of early vulnerabilities, the completion of early help assessments, the offer of early help intervention?

- What is your organisation doing to continue to raise awareness of the Threshold document and aiding professionals to make threshold informed referrals? Specify training, advice, and supervision arrangements where staff are informed about early help and making threshold informed referrals.

- Do you have clear processes in place to follow up of referrals that do not meet the threshold of intervention and that need to be escalated?

Information with regards thresholds and quality of referrals has been an ongoing theme within the Trust and information circulated via, learning sheets, highlights within COAT reports, supervision, team meetings and multi-disciplinary meetings.

Training has been specifically updated focussing on threshold informed referrals, case examples, specific analysis training to support the referral process has been designed and delivered. Training continues to focus on tools to support referrals such as the graded care profile, clutter tools and early help assessments.

Staff vacancies, sickness and redeployment along with the addition of the potential increase in mental health issues, domestic abuse and child poverty, arising from the anticipated divergent effect of the economic recovery all contributed to the prediction for children's services will increase and the need for mitigation plans in place.

PUBLIC PROTECTION

MARAC:

The Multi Agency Risk Assessment Conference (MARAC) is a multi-agency approach to managing cases of domestic abuse where the victim has been identified as being at high risk of serious harm or homicide. The four aims of MARAC are to safeguard victims of domestic abuse, manage perpetrators' behaviour, safeguard professionals, and make links with all other safeguarding processes.

Within the two Derbyshire MARACs (North and South), local agencies met every other week to discuss the highest risk victims of domestic abuse in their area. There is an allocated Named Nurse who is a member of the MARAC panel and attendance by the Trust was consistent at every meeting. The DHCFT MARAC representative covered South MARAC, MARAC for Derby City (Children's Health; and Mental Health for those not able to attend/ send representative); Erewash and South Derbyshire (for Mental Health colleagues not able to attend/ send representative).

For South Derbyshire MARAC there were 768 Cases between 06/04/2021 and 22/03/2022.

Themes discussed at MARAC include:

- Physical assault/ abuse
- Sexual assault/ abuse
- Coercive control
- Use of mental health or threats to self-harm/ end their life (whilst this is a form of coercive control, this specifically came up fairly regularly)
- Abuse of the victim via the children
- Stalking
- Harassment
- Psychological abuse
- Strangulation
- Victim Pregnant
- Victim Isolated from friends/ family
- Victims prevented from attending health services
- Emotional abuse

- Threats to kill
- Honour based violence
- Use of weapons or items to harm the victim
- Use of drugs (victim/ alleged perpetrator)
- Use of alcohol (victim/ alleged perpetrator)

Challenges:

- Recording after MARAC remains a significant resource issue.
- MARAC Clinician Research can be lengthy.
- The COVID-19 Pandemic impacted on the MARAC process, this used to be face to face at Derbyshire Constabulary HQ in Ripley. The meetings developed via Teams and has been extremely successful enabling increased attendance.

Overall, the MARAC process is an excellent example of multi-agency working which DHCFT is fully committed.

MAPPA (Multi-agency Public Protection Arrangements):
The purpose of MAPPA is to "Protect the public, including previous victims of crime, from serious harm by sexual and violent offenders." (MAPPA Guidance (2012) Version 4.0, Section 1). These arrangements are statutory. It does this by ensuring that all relevant agencies work together effectively to:

- Identify all MAPPA offenders.
- Complete comprehensive multi-agency risk assessments.
- Devise, implement and review robust multi-agency risk management plans.
- Focus the available resources in a way which best protects the public from serious harm.

DHCFT continues to maintain 100% attendance at MAPPA 3 meetings and case reviews.

PREVENT:
The 2011 Prevent strategy has three specific strategic objectives:
Respond to the ideological challenge of terrorism and the threat we face from those who promote it prevent people from being drawn into terrorism and ensure that they are given appropriate advice and support work with sectors and institutions where there are risks of radicalisation that we need to address.

DHCFT is fully committed to attendance at the CHANNEL meetings. The Assistant Director of both Safeguarding Adults and Children and the Named safeguarding Doctor attend the Channel meetings. We continue to maintain 100% attendance at these meetings.

Our level 3 safeguarding adults training supports this process by focus on understanding the risk of radicalisation to ensure staff understand the risk and build the capabilities to deal with it, communicate and promote the importance of the duty; and ensure staff implement the duty effectively.

THINK FAMILY THINK TANK

Since the Think Family CQIN and mandatory training for all clinical staff on Think Family Principles 2015, Think Family remains a Trust priority with the agenda being a golden thread throughout. In 2020 decided to revisit this work and looked at next steps. A team of interested interdisciplinary professionals with specialised knowledge play a fundamental role in shaping policy agenda, practice and come together to introduce new ideas and debate.

Our aim is to hold an annual safeguarding conference 2023 with a revised Think Family agenda.

We continue working together in adult and children's services across Derbyshire to ensure that everyone **Thinks Parent, Thinks Child, Thinks Family**

MASH HEALTH ADVISORS 2022/22

The aim of this report is to reflect on the Health Advisors activity from 1 April 2021 to 31 March 2022. MASH Health consists of two whole time equivalent posts covered by three MASH Health advisors:

The MASH during and emerging from the Covid Pandemic

MASH Health Advisors continued to work on a rota basis between attending the Council House and Working from home due to covid restrictions in place at the time.

During this period, Children's Social Care have had practitioners and a Team Manager working within the Council House on a rota basis, Adult MASH also worked at the Council House on a rota basis. The Police have worked remotely throughout the period.

Strategy discussion for both children and Adults have continued to take place via Microsoft Teams, no face-to-face meetings took place within the MASH team during this period.

Both Health and partner agencies have ensured a multi-agency approach and that the general ethos of the MASH has been maintained throughout. Working relationships were strengthened due to the shared experience of working and managing the challenges of restrictions and emotional toll of safeguarding during the pandemic.

Adult MASH

Approximately 2578 referrals were received for Information Exchange during the year via an Information Exchange Form (IEF). This is a 28% decrease on the previous financial year. However Adult MASH continue to have a significant backlog of cases/Safeguarding referrals.

Over 1188 health colleagues, made up largely of DHCFT Staff involved with individuals and GPs were liaised with during this year. 54 Strategy meetings were attended by MASH Health which is

nearly a 60% decrease on the Strategy meetings attended within the previous year. Adult MASH had some difficulties with workforce staffing pressures during this period due to sickness and recruitment issues. It is not clear if this may have impacted on the Number of Adult Strategy discussions arranged.

As previously identified, referrals from Adult MASH are down 28% during this period. When this is further broken down it identifies the following themes when compared with last year's data.

Referrals for Self-Neglect have decreased by 29% when compared with last year (referrals for Self-Neglect had increased by 60% in the previous year likely to be linked to the effects of the Covid Pandemic).

Domestic abuse referrals decreased by 13% during this period. Referrals in relation to financial or material abuse decreased by 26%. Referrals in relation to organisational abuse tripled during the previous period but these have stayed at roughly the same level when compared with last year's data.

Referrals in relation to sexual abuse have increased by 18% from last year. Discriminatory abuse increased by 50% during this period whilst modern day slavery/trafficking referrals decreased by 40% when compared with last year's data. Many inappropriate referrals and referrals that were not safeguarding were identified by MASH Health Advisors, these were followed up accordingly.

MASH Children

There were 431 Section 47 referrals received into MASH Health and of these 423 strategy meetings were held. This is a 15% increase on the figures for the year previous. Further analysis of these figures when compared with last year's data identifies an increase of 18% for referrals relating to physical abuse and an increase of 38 % for referrals relating to neglect when compared with the previous year's data.

Referrals relating to sexual abuse showed a slight increase of 13% on the previous year. A possible explanation for this was felt to be due to children/young people returning to school following covid restrictions lifting enabling children to disclose for the first time since being locked down. However, referrals relating to child sexual exploitation (CSE) have risen exponentially on the previous year with an 80% increase. This is in line with the trends seen nationally regarding an increase in CSE.

Referrals relating to high-risk domestic abuse were down 14% on the previous year's data, please see narrative on domestic abuse data for possible clarification for this trend. Domestic abuse in Derby City will therefore be significantly higher than that collected by Health Advisors.

Standard risk incidents are now no longer triaged within the MASH. This was discussed within the multi-agency forum, and it was agreed that all standard risk referrals would be accepted at the point of contact from Police and entered within patient/agency records. Use of online platforms and the need to be alert to this when reviewing health records.

During this period at the request of and in collaboration with the Police a daily triage has been set up to review Police intelligence relating to concerning online activity such as the sharing of indecent images and/or videos of children/young people online. This was originally called POLIT- Police Online Investigation Team but has now been renamed PCOT – Protecting Children Online Team.

The Police will send a 'Police Intelligence Information Exchange Form' to MASH Health and Social Care which contains the Police intelligence relating to an individual – MASH Health will complete research prior to the PCOT triage. PCOT triage takes place daily if there are cases to discuss and a plan is agreed as to whether a Strategy discussion is required within the MASH relating to any Perpetrators or children identified as at risk. There have been 33 cases discussed at PCOT triage since it has commenced in August 2021.

Advice calls

MASH Health Advisors continue to offer Safeguarding Advice via Email and Phone – some of these requests are received directly to MASH Health Advisors with some requests via the Safeguarding Unit as a central Point of Access. 148 contacts where safeguarding advice was provided by MASH health was recorded during this period. A Safeguarding Adult Advice Theme Template was devised. Analysis of any data this produces will be analysed within the next annual report.

Data collection

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

8. NEW INITIATIVES/OBJECTIVES/PRIOTITIES 2022/23

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

Objective / Initiative	
1.	To continue to develop and integrate the Children's and Adults Safeguarding Team within the Trust.
2.	To ensure that succession planning, develop expertise within the workforce and consider talent management and support development.
3.	To continue to build resilience in the workforce and support staff around complex work. To provide leadership post 'lockdown'
4.	To continue to work in partnership with all agencies around the challenges of working with emerging and new communities in particular Ukraine refugees, ensuring work is done specifically with the Safeguarding Team around cultural competence.
5.	To continue to prepare for CQC audit.
6.	To work in partnership with agencies with regards multi agency audits and disseminated the learning from the:

	Neglect: DDSCP Multi-Agency Neglect audit December 2021 To undertake a safeguarding children supervision audit in October 2022.
7.	To ensure the 'think family think tank' continues to function maintaining links with clinical practice.
8.	To continue to undertake a joint City / County Section 11 and SAAF on a yearly basis and provide effective evidence of the Trust compliance. To ensure any recommendations are acted upon.
9.	To make further developments in assuring Sexual Safety within Trust services and produce a Sexual Safety Standard Operating Procedure to accompany our leaflet for people using our inpatient services, in line with this being a Trust Quality priority.
10.	To continue to contribute to improving safeguarding referrals, resulting in no further action, raising the awareness of thresholds and escalation. To continue to work with staff regarding the importance of discussing and documenting the discussion regarding the referral with the service user, and to record their consent to the referral being made.
11.	To continue to support the Trust's intention to move to one Electronic Patient Record [EPR]. This work involves both Assistant Directors.
12.	To commission level 4 safeguarding training for the safeguarding team.
13.	An information leaflet is in development to help raise awareness in relation to MARAC and related processes, including what MARAC is and is not, how to make a referral, frequency of meetings, and what types of information may be helpful to share at the MARAC.
14.	To continue to profile the voice and lived experience of young carers and care-experienced people in the NHS.
15.	To raise awareness of the vulnerabilities of young people to exploitation and abuse as they develop into adults and/or transition to adult services.
16.	To continue to support the full range of frontline staff in safeguarding children, young people, vulnerable adults, and their families.
17.	To ensure full participation in multi-agency child safeguarding practice reviews, leaving reviews and Domestic Homicide reviews and SARs.
18.	To work in line with the Derby and Derbyshire Safeguarding Children Partnership and agreed the following priorities for 2022/23: • Safeguard children at risk of exploitation reflecting additional features such as placed based risk (contextual safeguarding) and our understanding of emerging vulnerabilities • Promote and obtain assurance of early help arrangements (including responding to neglect) and response to requests for services • Reduce the adverse impact of domestic abuse and family conflict • Promote and improve the safety and welfare of babies
19.	To remain focussed on doing the very best for our carers to access the help and support they need to live their very best lives.
20.	To recognise the challenges faced by our carers, we are really pleased we have a great set of incredible carers champions and carers representatives from our forums. Our support for carers is really embedded and supported from our operational and clinical directors.

OVERALL

On reflection we have had another highly successful year despite the challenges that Covid issues continues to bring, safeguarding remains a priority to staff and the safeguarding team continue to support and advise, staff show their commitment, resilience and hard work safeguarding our vulnerable communities. We will continue to be committed to setting and providing the very best standards of clinical and safeguarding practice that as a team we can deliver.

We offer this report with significant assurance to the Quality and Safeguarding Committee on our systems, governance, learning and improvement of standards of practice. We believe that this report demonstrates a robust system of scrutiny and a commitment to sound practice.

GLOSSARY OF ACRONYMS

CCG: Clinical Commissioning Group
CIC: Children In Care
CQC: Care Quality Commission
COAT: Clinical Operational Assurance Team
CPA: Care Programme Approach
CSE: Child Sexual Exploitation
CSC: Children's Social Care
CSPR: Child Safeguarding Practice Review
DDSCP: Derby City and Derbyshire County Safeguarding Children Partnership
DDCCG: Derby and Derbyshire Clinical Commissioning Group
DHCFT: Derbyshire Health Care Foundation Trust
DHRS: Domestic Homicide Reviews
DV: Domestic Violence
DOLS: Deprivation Of Liberty Safeguards
ESR: Electronic Staff Records
IEF: Information Exchange Form
KPI: Key Performance Indicators
MDMs: Multi-Disciplinary Meeting
MAPPA: Multi-Agency Public Protection Arrangement
MARAC: Multi-Agency Risk Assessment Conference
MASH: Multi-Agency Safeguarding Hub
MCA: Mental Capacity Act
MHA: Mental Health Act
MOGP: Markers Of Good Practice
MSP: Making Safeguarding Personal
MST: Microsoft Team
NAI: Non-Accidental Injury
PDL: Professional Development Lead
PCOT: Protecting Children Online Team
POLIT: Police Online Investigation Team
RAG: Red Amber Green (rating)
SAAF: Safeguarding Accountability and Assurance Framework
SAPDB: Safeguarding Adults Performance Dashboard
SARS: Safeguarding Adults Reviews
TOC: Triangle Of Care
SUDI: Sudden Unexplained Death in Infancy
WRAP: Workshop to Raise Awareness of Prevent

REPORT PREPARED BY (and contributions from):

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Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors - 1 November 2022

Board Assurance Framework (BAF)
Issue 3, 2022/23

Purpose of Report

To meet the requirement for Boards to produce an Assurance Framework. This report details the third issue of the BAF for 2022/23.

Executive Summary

Each Director Lead has thoroughly reviewed the risks allocated to them and provided comprehensive updates.

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

Risks 2A, 2B, 2C, 2D – the Director of People and Inclusion has completely re-worked the risks under strategic objective 2 (to be a great place to work). All of the risks and root causes have been reviewed and incorporated into two new risks - Risks 2A and 2B have been closed and risks 2C and 2D have been added.

Risk 1B – one of the actions to close gaps in control has improved ragging, now showing as blue as the internal audit recommendations regarding evidence of assurance on estates maintenance and governance processes have been completed.

Risk 1D – three of the actions to close the gaps in assurance have improved ragging and are now blue as the actions relating to live testing of business continuity plans, an embedded programme of software and hardware upgrades, and Cyber Operational Readiness Support (CORS) have all been completed.

The system-based risk (2022/23 MS1) remains and is presented separately from the risks to the Trust strategic objectives. The current risk rating has been updated and demonstrates an improved position as the likelihood of the risk occurring has been reduced from high to moderate.

At the last Board meeting a discussion took place regarding the current changes to Board and the changes to operational structures and how they are captured in the BAF report. These changes do impact on all of the existing risks to the delivery of the Trust strategic objectives so all Executive Directors were asked to consider that when submitting Director Lead updates for Issue 3 of the BAF.

Operational Risks

There are eight Trust-wide operational risks rated as high linked to the Trust strategic objectives. Since the last BAF issue one operational risk has been added to Risk 1B. It relates to the impact of construction traffic on Kingsway Site and is linked to the dormitory eradication/PICU project.

The operational risk that was aligned to Risk 2A has been realigned to Risk 2D.

Deep Dives
At the Finance and Performance (F&P) Committee the merits of undertaking deep dives at Audit and Risk Committee for the two extreme risks were discussed. The Audit and Risk Committee would be looking through a different lens compared to F&P and our Trust risk management approach is that 'deep dives' remain fully embedded in the BAF process to enable review and challenge of the controls and assurances associated with each risk. Therefore, the expectation is to timetable deep dives for January 2023 Audit and Risk Committee for F&P extreme risks, should they still be extreme.

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

Risks and Assurances

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

Consultation

- Chief Executive
- Executive Directors
- Non-Executive Directors
- Trust Secretary
- Operational Risk Handlers
- Deputy Directors of Operations and Operational Leads

Formal Reviews:

- Executive Leadership Team, Issue 3.1: 11 October 2022
- Audit and Risk Committee, Issue 3.2: 13 October 2022

Governance or Legal Issues

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

Public Sector Equality Duty and Equality Impact Risk Analysis

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

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

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

Recommendations

The Board of Directors is requested to:

1) **Approve** this third issue of the BAF for 2022/23 and the assurance the paper provides of the process of the review, scrutiny and update of the BAF in seeking to identify and mitigate risks to achieving the Trust's strategic objectives
2) Continue to receive updates in line with the forward plan for the Trust Board.

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

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

Board Assurance Framework 2022-23 – Issue 3.3 Board 1 November 2022

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

Ref	Principal Risk	Director Lead	Rating (Likelihood x Impact)	Responsible Committee
Strategic Objective 1 - To Provide GREAT Care in all Our Services				
22-23 1A	There is a risk that the Trust will fail to provide standards for safety and effectiveness as required by our patients and our Board	Executive Director of Nursing (DON) / Medical Director (MD)	**HIGH (4x4)**	Quality and Safeguarding Committee
22-23 1B	There is a risk that the Trust does not deliver key regulatory and strategic requirements related to dormitory eradication and Psychiatric Intensive Care Unit (PICU) and that the Trust estate more generally is not maintained sufficiently well to comply with regulatory and legislative requirements	Chief Operating Officer (COO)	**EXTREME (4x5)**	Finance and Performance Committee
22-23 1D	There is a risk that the Trusts increasing dependence on digital technology for the delivery of care and operations increases the Trusts exposure to the impact of a major outage, i.e. cyber-attack, equipment failure	Chief Operating Officer (COO)	**MODERATE (3x4)**	Finance and Performance Committee
Strategic objective 2 - To be a GREAT Place to Work				
~~22-23 2a~~	~~There is a risk that we do not sustain a healthy vibrant culture and conditions to make Derbyshire Healthcare Foundation Trust (DHCFT) a place where people want to work, thrive and to grow their careers~~	~~Director of People and Inclusion (DPI)~~	~~**HIGH (3x5)**~~	~~People and Culture Committee~~
~~22-23 2b~~	~~There is a risk of continued inequalities affecting health and well-being of staff~~	~~Director of People and Inclusion (DPI)~~	~~**HIGH (4x4)**~~	~~Trust Board~~
22-23 2C	There is a risk that we are unable to create the right culture with high levels of staff morale	Director of People and Inclusion (DPI)	**HIGH (4x4)**	People and Culture Committee
22-23 2D	There is a risk that we do not have a diverse workforce with the right number of people with the right skills to support and deliver safe high-quality care	Director of People and Inclusion (DPI)	**HIGH (4x4)**	People and Culture Committee
Strategic Objective 3 - To Make BEST Use of Our Resources				
22-23 3A	There is a risk that the Trust fails to deliver its revenue and capital financial plans	Executive Director of Finance (DOF)	**EXTREME (4x5)**	Finance and Performance Committee
22-23 3C	Whilst there are significant benefits from the creation of the Integrated Care System (ICS) as an NHS body, there is a risk that the effects of the change on senior managers from across the system may impact negatively on the cohesiveness of the Derbyshire health and care system	Director of Strategy, Partnerships and Transformation (DSPT)	**HIGH (4x4)**	Trust Board
Strategic Objective 4 – To be a GREAT Partner				

Board Assurance Framework 2022-23 – Issue 3.3 Board 1 November 2022

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

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

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

Root causes:

a) Workforce supply and lack of capacity to deliver effective care across hotspot areas, increasing risks in the medical workforce
b) Risk of substantial increase in clinical demand in some services and COVID-19 and cost of living related mental health surge
c) Changing demographics of population and substantial impacts of inequality within the deprived wards of the city and county
d) Intermittent lack of compliance with Care Quality Commission (CQC) standards specifically the safety domain
e) Lack of embedded outcome measures at service level
f) Known links between Serious Mental Illness (SMI) and other co-morbidities, and increased risk factors in population including inequality/ intersectionality, with escalating risks in alcohol consumption
g) Lack of compliance with physical healthcare monitoring in primary and secondary care, has improved but not at the required level for reductions in mortality
h) Restoration and recovery of access standards in autism and memory assessment services, due to COVID-19 pandemic
i) New and emerging risks related to waves of COVID-19, excess deaths associated with winter, risks to people with SMI in heatwaves due to increased mortality, impact of substantial economic downturn
j) Increased safeguarding and domestic violence related investigations as a result of harm to our patients and their families related to the impact of lockdown and as we exit the active pandemic period
k) Lack of appropriate environment to support high quality care, i.e. single gender dormitories and PICU leading to out of area (OOA) bed use for PICU
l) Lack of capacity to meet population demand for community forensic team
~~m) Deterioration in national enquiry into homicide – November 2021, above median~~
n) Local NHS Trusts will offer Recruitment and Retention Premium to Consultant Psychiatrists in specialist services and other clinical staff due to competitive practices that destabilises Trust clinical services and leads to a deterioration in waiting time and potentially in safety
o) Violent crime in the community, sexual safety incidents and youth violent crime all increasing in Derby and Derbyshire

BAF Ref: 22-23 1A	**Director Lead**: Carolyn Green (DON) / Dr John Sykes (MD)	**Responsible Committee**: Quality and Safeguarding Committee

Key Controls

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

Board Assurance Framework 2022-23 – Issue 3.3 Board 1 November 2022

Preventative – Quality governance structures, teams and processes to identify quality related issues; mandatory training; Duty of Candour processes; clinical audits and research; health and safety audits; risk assessments; physical health care screening and monitoring; investment in COVID-secure environments and cleaning. EQUAL unannounced visits to services and anonymised bright ideas service improvement ideas. Feedback intelligence from independent advocacy, Director visits and Quality Visits

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

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

Corrective – Board committee structures and processes ensuring escalation of quality issues; six monthly safer staffing and skill mix review; CQC action plans; learning from incidents, complaints and risks; actions following clinical and compliance audits; workforce issues escalation procedures; reporting to commissioners on compliance with quality standards; learning from other Trust experiences and national learning

Assurances on controls (internal)	Positive assurances on controls (external)
Quality and Trust dashboards Scrutiny of Quality Account (pre-submission) by committees Programme of physical healthcare and other clinical audits and associated plans ~~COVID~~ Infection Control Board Assurance Framework reported to NHS England Positive and Safe self-assessment reported to the East Midlands Head of Nursing/Practice and Matron compliance visits	National enquiry into suicide and homicide NHS Litigation Authority (NHSLA) scorecard demonstrating low levels of claims Safety Thermometer identifies positive position against national benchmark Mental Health Benchmarking data identifies higher than average qualified to unqualified staffing ratio on inpatient wards CQC comprehensive review 2020 Trust is rated Good; two core services rated outstanding, two rated as require improvement Identified Trust fully compliant with National Quality Board (NQB) Learning from Deaths guidance 2020/21 Internal audits: Risk management; data security and protection 2020/21 Estates and Facilities Management internal audit (limited assurance) Transitional Monitoring Meetings with CQC (bi-monthly), no conditions Patient Safety Incident Response Framework (PSIRF) implementation and progress – Two years prior to national roll out in 2022

Key gaps in control	Key actions to close gaps in control	Impact on risk to be measured by	Expected completion date (Action review date)	Summary of progress on action	Action on track
Embedded learning from CQC regulatory actions, particularly in relation to improvement of training governance	Review operational governance of training compliance [ACTION OWNER: DPI]	Embedded compliance with mandatory training and compliance rates. Reported to	~~30.09.22~~ 31.12.22	Improved governance reporting to Board, PCC, ELT reintroduced through	AMBER

	Develop and implement improvement plan to ensure sustained compliance with mandatory training [ACTION OWNERS: DPI/COO]	People and Culture Committee (PCC) Lack of recurrence of common themes regarding training compliance. Reported to PCC and to be led by the operational leadership teams		performance reviews on key metrics, i.e. Positive and Safe and Immediate Life Support (ILS) training compliance continues being reported to Board The backlog from the pandemic and stop and start training ~~has~~ significantly impacted on compliance~~. ILS and BLS compliance continue to improve although covid absence and vacancies are having an effect preventing release of staff~~ 01.08.22: Manual handling training is now above the minimum required standard 26.09.22: Improvements have been made across all training compliance but not above the 75% minimum level at all times. Particular focus on ILS and positive and safe continues at every PCC Training for all inpatient colleagues is now being scheduled via the rostering system to ensure attendance is planned and staff are able to be released	

				Work continues to review the best way to deliver face to face training that reduces the impact on the delivery of clinical services, makes it easier for colleagues to attend and ensures we maintain the high level of clinical knowledge and expertise to develop excellence in our services	
The Trust has not embedded a robust system of operational management and educational governance and has not learnt lessons from the 2016 and 2020 inspections	Review operational governance of training compliance [ACTION OWNER: DPI & COO]	The Trust continues to have significant instability in training compliance and oversight of safety training The Trust management team need to move to a proactive oversight, projections of high-risk areas of safety training and advance management of risk Publication of ILS/ PSTS training as core risk areas in the Trust Board reporting until stability is achieved Sign off of the outstanding CQC actions (five overdue actions)	31.03.23	Repeat variations in operational delivery and practice in educational governance remain in acute care and older adult in-patient services. Grip and performance improvement of service level operational leaders still requires further improvement – A pervasive culture of minimising poor performance continues PCC receive a compliance report on all CQC outstanding actions and a plan is presented against any actions that are not compliant. A trajectory is prepared to establish when the training will achieve the required compliance standard and signed off by PCC	AMBER

Inability to complete physical health checks for patients whose consultations remain undertaken virtually	Improvement plan to be developed and implemented to ensure required physical health care checks are completed [ACTION OWNER: MD]	Compliance with physical healthcare checks, reported in the Quality Dashboard A 360 audit has been commissioned to review whether these improvements are embedded	~~(30.09.22)~~ (31.12.22)	Revised metrics included in Quality Dashboard reported to Quality and Safeguarding Committee. Maintenance to be monitored though dashboard data Remain under monitoring – Consistent approach formulated for physical assessments to be completed face to face prioritised by need. Full progression of improvements has been impeded by the January COVID wave Successful bid to region to implement a coaching and self-report pilot model of health care to improve compliance and patient empowerment – Implementation through the Health Protection Unit Additional audit and scrutiny of physical healthcare checks are now back in place to continually improve practice. ~~This follows unfavourable spot check audits and remains an area of performance improvement~~ Sustained improvement is not fully embedded. A pervasive culture of minimising poor	AMBER

				performance continues (inpatient acute) – Practice improvement most required at the Hartington Unit	
Implementation of revised priority actions for 'Good Care' which support the Trust strategy	Redesign improvement plans to align to revised building blocks which support the Trust Strategy [ACTION OWNER: DON]	Compliance with suite of metrics and reporting schedule detailed in quality dashboard	~~30.09.22~~ (31.12.22)	Very positive staff survey (2022) in learning, morale which all positive indicators for clinical stability and safer services New strategy actions published and will be reviewed in quality visit programme and in Divisional Achievement Reviews ~~in design and will be updated in June 2022 – Five quality actions and preparedness for changes to mental health legislation~~	AMBER
Insufficient investment in autism assessment and treatment services to meet demand. No commissioned treatment services Waiting time has increased over COVID-19 period, exacerbated by underlying demand	Investment required by CCG to meet assessment and treatment demands [ACTION OWNERS: COO/DSPT]	Agreed funding allocation has occurred, recruitment to posts is active	~~(30.09.22)~~ (31.12.22)	Mental Health and Learning Disability and Autism Board (MHLD AB) agreed investment in principle into autism services ~~Expansion of teams in place~~ ASD diagnostic waiting lists remain high~~, with a combination of referral rate is outstripping commissioned capacity, and issues with the delivery of commissioned capacity level due to~~	AMBER

				~~sickness and retirement of staff significantly impacting the ASD diagnostic service.~~ To support improving the position, the merger ~~of this team with the Specialist Autism Team into~~ to create a single Autism diagnostic and intervention offer ~~has taken~~ took place in July. ~~week beginning 05.07.22.~~ This includes shared resources and an overarching operational manager ~~has been put in post~~ to address the staffing issues and develop a recovery and improvement plan. Additional agencies are being explored to consider sub-contracting to release some immediate stress off the team and improve practice and assessment rate. Alternative providers for assessments are being considered at pace to lessen the impact on patient experience MHLD AB agreed a review and design of a new neuro diversity diagnostic pathway. Investment included in 2022/23 system operational plan. ~~There~~	

				~~was a requirement for us to submit a second version of the plan on 20.06.22~~ The proposed revised pathway will be reviewed at the System MHLD&A Delivery Board in October 2022 ICB will only part fund plan within existing programme spend. Awaiting confirmation of the impact of this on the improvement plan and trajectory	
Monitoring of changes and patterns in population need in relation in the potential deterioration and other negative impacts due COVID-19	Continued monitoring and focus by the operations team and Divisional Achievement Reviews (DARs) [ACTION OWNERS: COO/MD/DON]	Monitoring of waiting list targets and implementation of mitigating actions. Reporting through DARs DON continues arm's length monitoring of monthly NHS benchmarking which continue to not follow the national trend Backlog in serious incident investigations has a recovery plan but is under significant stress and requires additional investment to mitigate this risk	31.12.22	Safety standards remain in place for urgent referrals. Limited evidence of COVID related surge in demand. Robust oversight in place Community mental health team (working age) not having increase in referrals. Acuity and activity in existing patients is significant. Monitoring and team support in place Capacity against projected demand for non-inpatient contact and the inpatient demand is being reviewed. The Trust is feeding this work into the Strategic Operational Resilience Group (SORG)	GREEN

				DARs fully operational. Referrals and wait lists discussed and changes post-covid included ~~01.08.22:~~ The Serious Incident Team have returned to standard operating levels and backlog cleared Psychological surge is not occurring in all service lines. Tracking and detailed monitoring of impact, still being actively monitored (changes in complexity, increasing psychosis, Eating Disorders and CAMHS referrals, but across all services are not elevated Violent crime in the community, sexual safety incidents and youth violent crime all increasing in Derby and Derbyshire Covid vaccination booster programme commenced. Health Hub continues to support staff and promote within public health	
Six service areas assessed as 'Requires Improvement' by CQC in relation to safety	Develop and implement an improvement plan to enable all six service areas to reach 'Good' for safety in relation to the CQC standards [ACTION OWNER: DON]	CQC inspection and assessment	~~30.09.22~~ 31.12.22	Significant improvement in all services. Plan to meet training compliance is not fully compliant	AMBER

				Residual CQC actions still require further attention to embed and sustain improvements – There are currently five open actions for the acute and community service. The significant theme training compliance	
Gap in operating standards for acute and community mental health services	Enhanced monitoring of acute and community mental health services by the Nursing and Quality Directorate [ACTION OWNER: DON] Implement Royal College of Psychiatrists (RCP) Standards across Acute Services [ACTION OWNERS: MD/DON/COO] Implement 2019 Community Mental Health Framework [ACTION OWNER: DSPT]	Improvement in operating standards compliance. To be confirmed by external CQC inspection and assessment of at least 'Good' Implemented Acute Inpatient Mental Health Service Accreditation (RCP Standards) reported in Divisional Achievement Reviews and Quality Account Implemented Mental Health Community Framework to Quality and Safeguarding Committee	~~(30.09.22)~~ (31.12.22) (31.03.24) ~~(30.09.22)~~ (31.10.22)	Increased performance management scrutiny and unannounced site visits have been undertaken with compliance checks Standards compliance work continues. Gaps in Accreditation for Inpatient Mental Health Services (AIMS) due to accommodation requirements. Finance and submission for accreditation will occur by September 2022 – Confirming accreditation date with AIMS Medic availability for PSII and mortality reviews has deteriorated due to pressure of clinical demand. Deputy MD is leading engagement of consultant workforce via clinical directors. MD issuing guidance on streamlining outpatient caseload to increase availability for governance work	AMBER

				Active recruitment now underway and named specific pilot areas in roll-out Design of new fully integrated model completed. Implementation delayed by Voluntary, Community and Social Enterprise (VCSE) procurement processes, now resolved Sites for year-two roll-out agreed as Derbyshire Dales, Chesterfield and North East Derbyshire/Bolsover. Go-live expected in High Peak and Derby City The go-live sites have taken place in High Peak and Derby City – Further project support being explored to further support the improvement plan	
Implementation of clinical governance improvements with respect to: - Outcome measures - Clinical service reviews including reduction in excess waiting times - Getting it Right First Time (GIRFT) reviews	Develop and implement an improvement plan to enable all governance improvement plans to be implemented [ACTION OWNERS: MD/DON/COO/DSPT]	Compliance with suite of metrics and reporting schedule	~~(30.09.22)~~ (31.12.22)	Trust's COVID recovery roadmap outlines timescales for standing up of core clinical governance developments, commenced June 2021 PSIRF implementation continues – New processes in place. Staff	AMBER

- Patient Safety Incident Response Framework (PSIRF) implementation - Commissioning for Quality and Innovation (CQUIN) Framework - National Institute for Health and Care Excellence (NICE) guidelines				training on PSIRF has occurred and staff capacity in place CQUIN progress ~~to be~~ included in DARs ~~from 2022~~ NICE guideline mapping recommenced September 2021 Getting it Right First Time (GIRFT) reviews for Acute and Crisis were held in July 2021, action plan received Rehabilitation pathway, April 2022 – Revised as commencing in October 2022 due to unexpected absence Reduction in waiting times included in DARs. Work continues until the gap is significantly reduced. Progress in Older Adults pathways continues in MAS waiting times, Benchmarking against regions shows sustained improvement Performance summit held, the outcome will be an improved matrix to measure outcomes against clinical governance	

				improvements. Waiting times management reviewed, how to manage waiting times differently – Paper was presented at Quality and safeguarding Committee	
Implementation of new quality priorities for: - Sexual safety - Implementing CQUINS and Clinical outcome measures - Recovering services – equally well - New Trust strategy and priorities - Dormitory eradication programme	Develop and implement an improvement plan to enable all quality priorities to be implemented [ACTION OWNER: DON]	Compliance with suite of metrics and reporting schedule	~~(30.09.22)~~ (31.12.22)	Reducing violence - Body worn camera investment in place Sexual safety – Improvement work (dashboard, preceptorship training and protocols) all commenced. Sexual safety on professional standards video launched, feedback being collected ~~New advisory training video being recorded in August 2022~~ London Road Ward 1 Older Adult service dormitory beds ~~have~~ closed. ~~Update on dormitory eradication programme and clinical standards to be provided~~ Dormitory eradication programme in construction Plan for existing dormitory stock and a plan to maintain and improve dignity for active bed stock in design	GREEN

There is a risk that patients in our care in Derbyshire or commissioned services may receive poor care due to experiencing abuse or professional misconduct. Learning from other Independent and national exposures of abuse	Revisit all assurances and scrutinise practice, gathering intelligence and implement an improvement plan to enable all services to provide the highest standard of care which would be expected [ACTION OWNERS: DON/MD]	Development and implementation of an improvement plan which contains Engagement and mobilisation of the organisation to discuss learning from recent exposes Discuss and activate colleagues to revisit what compassionate care means and actively encourage, inspire, reward – Supervision, reflective practice and asking for help Mobilise and re-emphasise expectations of standards of care and Freedom to Speak Up Revisit system and process of governance and using intelligence to take oversight of services Inspire conversations re the risks of harm and closed cultures. Reset the culture and the tone of the requirement for professional scrutiny and all employee requirements to prevent harm and report poor care/ abuse Strengthen out of hours, weekends and night announced and unannounced visits. To promote access to multiple managers, relationships, so colleagues feel empowered to report any concerns	(31.12.22)	Programme of engagement and planning has commenced Delivery plan and progress will be reported to the Quality and Safeguarding Committee in November and December 2022	AMBER

		Review Learning Disability physical health care access, provision access to acute liaison nurses and inspire acute and community colleagues in this area of safety for our community			

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

Record ID	Service Line	Title	Risk: Summary of Progress	Date Risk Created	Date of Next Review	Residual Risk Rating
3009	Learning Disabilities Services	Demand for Autism Spectrum Disorder (ASD) assessment Service far outstrips contracted activity	04.04.22: The team is still not commissioned to provide the number of assessments which are required for the region. Demand continues to outstrip capacity. Working with CCG to develop a long-term plan. Complaints and concerns have been raised 23.06.22: As agreed with managers and commissioners the team is currently piloting use of a different assessment process with individuals identified from screening processes as being highly likely to meet the criteria for diagnosis. This is being done to see if it is possible to reduce the assessment and report writing time for some individuals and therefore increase the numbers of people that can be seen	01.01.16	28.10.22	HIGH
21586	Community Care Services (Older People)	Wait times breaching CCG contract	23.06.22: A new MDM model is established with a blended approach to clinical activity. The Service Manager & Dementia Nurse Specialist is working on a plan for a 'MAS Flow Coordinator' to support with efficiencies and flow through the service 10.08.22: Increased referrals in June and July. Current wait times are 16-18 weeks in the North, 26 weeks in the South (working on parity). The diagnostic rate for Derbyshire is 63% and this is predicted to increase in the next quarter	12.12.18	10.11.22	HIGH
21739	Operational Services	Emergency Preparedness, Resilience and Response (EPRR) Risks within Derbyshire	10.11.21: Risks locally still remain the same as there are external factors as well as internal ones. Any changes in national and regional risk registers and guidance will result in early review of this risk EPRR policies all reviewed and several (e.g. severe weather, heatwave) amalgamated. The priority has been the EPRR Incident Response Plan. Full review of business continuity management system is being undertaken	23.07.19	31.10.22	HIGH

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22838	Corporate Services - Pharmacy	Forced uninstall of pharmacy computer system: IE11 - EMIS	23.06.22: IE11 no longer supported by Microsoft, not yet removed from PCs by IM&T but expected to do so. Software patch not yet provided by EMIS, who we continue to chase. Replacement of the Pharmacy IT system is a possible solution but appears disproportionate in terms of team capacity and financial pressures. It would also be a protracted process and would not address the shorter-term risk of disruption to service provision 18.07.22: Patch received from EMIS and is now with ArdenGEM for testing 26.09.22: Second patch released due to an issue in some go-lives at other sites. Testing to be completed. If satisfactory, both patches then to be installed on all PCs/laptops running EMIS pharmacy software. Risk remains high until this work is completed	16.05.22	31.10.22	**HIGH**
22815	Corporate Services – Nursing and Patient Experience	Risk to patient safety and service delivery due to allocation of overdue incidents requiring investigation and Patient Safety staffing/resources	07.06.22: Inability to allocate over 30 overdue incidents for investigations due to lack of appropriately trained staff and operational capacity. Overdue investigations. An increase in complaints from families has been seen who are waiting to receive the outcome of investigations 02.08.22: DON reported to TOOL that risk has been mitigated and can be closed 20.09.22: Risk Handler completing final review with Deputy DoN and MD – Datix record to be updated	07.06.22	25.10.22	**HIGH**
22790	Corporate Services - Pharmacy	Prescribing Valproate to women of child-bearing potential: Failure to comply with regulations	24.06.22: Support for safe use of Valproate in compliance with MHRA in development 26.09.22: Current risk rating reviewed. Risk remains due to lack of IT system that will reconcile prescribing with patient identifying information (sex and age). Plan is currently for full roll-out of ePMA in 2023. To review in 6-months as reassess risk in the light of ePMA progress and any national work around valproate as an identified priority for patient/medicines safety	28.02.22	27.03.23	**HIGH**

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Strategic Objective 1 – To Provide GREAT Care in all Services

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

Impact:
Low quality care environment specifically related to dormitory wards
Crowded staff environment and non-compliance with COVID-secure workplace environments
Non-compliance with statutory care environments
Non-compliance with statutory health and safety requirements

Root causes:

a. Long term under investment in NHS capital projects and estate
b. Limited opportunity for Trust large scale capital investment
c. Increasing expectations in care and working environments as national capital strategy and surrounding legislative and regulatory requirements evolve
d. National capital funding restrictions for business as usual capital programme for Trusts and Integrated Care Systems
e. Gaps in relation to the revised Premises Assurance Model (PAM)

BAF Ref: 22-23 1B	**Director Lead**: Ade Odunlade (COO)	**Responsible Committee**: Finance and Performance Committee

Key Controls

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

Preventative – Routine environmental assessments for statutory health and safety requirements; environmental risk assessments reported through DATIX; COVID secure workplace risk assessments
Detective – Reporting progress against Premises Assurance Model (PAM) to the Executive Leadership Team (ELT); Dormitory Eradication Board reports into Trust Board
Directive – Capital Action Team (CAT) role in scrutiny of capital projects; COVID secure workplace policy and procedure
Corrective – Short term investment agreed to support key risk areas including provision of equipment to ensure COVID secure workplace environments

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

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Key gaps in control	Key actions to close gaps in control	Impact on risk to be measured by	Expected completion date (Action review date)	Progress against action	Action on track
Estates Strategy delivery recommendations will need to be updated for ongoing COVID secure requirements	Review of Estates Strategy delivery recommendations to ensure compliance with ongoing COVID secure guidance [ACTION OWNER: COO]	Revised COVID compliant delivery recommendations	(31.12.22)	Revised Estates Strategy is now complete and was approved by TOOL on 07.04.22	GREEN
Lack of adherence to emerging national guidance and policy requiring the elimination of mixed sex wards and dormitory style inpatient facilities	Deliver two new adult acute 54-bed units with ~~a~~ single room en-suite with additional staffing and new model of care ~~delivery plan and programme of work~~ [ACTION OWNER: COO]	Delivery of approved business cases ~~and surrounding associated schemes for dormitory eradication~~	Hard deadline for national funding of March 2024	Two new build adult acute unit FBCs nationally approved September 2022, funded by £80m national PDC and £18.6m CDEL. ICS supported and approved revenue funding Delay in national approval impact on practical completion – Now June 2024 ~~Allocation of £80m confirmed FBCs approved by JUCD for two new build 54-bed acute units nationally approved in September 2024, enabling works near completion. and in National approval process. Refurbishment of two existing acute wards. FBC approved by ICS subject to additional capital. FBC for Older Adult service relocation approved by ICS subject to additional capital~~	AMBER ~~Changed to GREEN~~
	Older Adult service relocation to refurbished ward with single room en-suite and gender segregation, with additional staffing and new model of care, by March 2024 to eradicate	Delivery of approved business case	(31.01.23)	Older Adult service relocation FBC and revenue funding approved by ICS	RED

	dormitories in Northern Derbyshire and avoid this 12-bed service being isolated in otherwise vacated wards, increasing service user safety issues [ACTION OWNER: COO]			Awaiting outcome NHSE national additional PDC bid to Treasury	
	Audrey House refurbishment as decant ward to enable Radbourne Unit dormitory eradication refurbishment. Dormitories cannot be fully eradicated without use of this decant ward [ACTION OWNER: COO]	Delivery of approved business case	(31.01.23)	Awaiting outcome NHSE national additional PDC bid to Treasury	RED
	Radbourne Unit dormitory eradication refurbishment to provide two 17-bed wards with single room en-suite, with additional staffing and new model of care, to complete dormitory eradication in Southern Derbyshire. Service users continue to receive care in non-compliant wards until this refurbishment is completed [ACTION OWNER: COO]	Delivery of approved business case	(31.01.23)	FBC and revenue funding approved by ICS Awaiting outcome NHSE national additional PDC bid to Treasury	RED
Lack of an accessible Derbyshire wide Psychiatric Intensive Care Unit (PICU)	Delivery of local PICU arrangements (new build and associated projects taking into account gender considerations) [ACTION OWNER: COO]	Agreed programme of work with capital funding to support it	~~(30.09.22)~~ (31.01.23) PICU delivery subject to national capital availability	FBCs approved by ICS in June 2022 for 14-bed male PICU and 8-bed Acute-Plus female facility, subject to additional capital availability. Additional national capital being sought for PICU foundations initially	RED
Internal Audit recommendations highlighted the need for evidence of assurance on estate maintenance and wider governance for estate compliance with statutory legislation	Deliver Internal Audit report recommendations in full Premises Assurance Model (PAM) assessment to be completed [ACTION OWNER: COO] Review of current estates and facilities governance structures [ACTION OWNER: COO]	Completion of agreed recommendations and management actions Reporting to Finance and Performance Committee twice yearly and any exceptions in between Governance structure in place	~~(30.09.22)~~ (31.01.23)	Agreed recommendations and management actions completed September 2021 Reporting to Finance and Performance Committee started May 2021 and now embedded ~~FBCs approved for two new build 54-bed acute units and refurbishment of two~~	~~AMBER~~ Changed to BLUE

				~~existing acute wards. FBC for Older Adult service relocation approved subject to additional capital availability will complete eradication of dormitories. FBCs approved for 14-bed male PICU and 8-bed Acute-Plus female facility in June 2022 subject to additional capital funding~~ Internal governance structure in place and meeting monthly Management audit undertaken by internal auditors Quarter 4 2020/21 – ~~Report and actions all agreed~~ All actions complete Governance reporting ~~will~~ includes audit recommendation response and delivery - Complete	

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

Record ID	Service Line	Title	Risk: Summary of Progress	Date Risk Created	Date of Next Review	Residual Risk Rating
22945	Nursing and Patient Experience	Traffic Impact Risk Assessment - Kingsway Site	Staff, patients and visitors are at risk from accident and injury caused by vehicles on the Kingsway Site Report to Trust HSSC 20/10/2022 highlighting risk, requesting action plan from Making Room for Dignity Director and Assistant Director of Estates & Facilities	06.10.22	01.11.22	HIGH

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

There is a risk that the Trust's increasing dependence on digital technology for the delivery of care and operations increases the Trust's exposure to the impact of a major outage i.e. cyber-attack, equipment failure

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

Root causes:

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

BAF Ref: 22-23 1D	**Director Lead**: Ade Odunlade (COO)	**Responsible Committee**: Finance and Performance Committee

Key Controls

Inherent Risk Rating			**Current Risk Rating**				**Target Risk Rating**			**Risk Appetite**		
Moderate	Likelihood 3	Impact 4	Moderate	Likelihood 3	Impact 4	Direction ⟺	Moderate	Likelihood 2	Impact 4	Accepted	Tolerated	Not Accepted

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

Assurances on controls (internal)	**Positive assurances on controls (external)**
IM&T Strategy delivery update to F&P – September 2021	- Templar Cyber Organisational Readiness Report (CORS) - Annual external cyber review by Dynac (vulnerability scan) - Data Security and Protection annual review by Internal Audit, weighted toward cyber security - Compliance with Data Security and Protection Toolkit, including high levels of training compliance

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Key gaps in control	Key actions to close gaps in control	Impact on risk to be measured by	Expected completion date (Action review date)	Progress against action	Action on track
Business continuity plans reflect changes to service delivery such as increased phone and video contacts	All services to review business continuity plans to ensure they take account of the increased use of phone and video contacts for care provision and also use of video conferencing for operational delivery [ACTION OWNER: COO]	Reporting to the Divisional Achievement Reviews (DARs)	~~30.09.22~~ 31.01.23	Programme of updating underway. Emergency Planning and Business Continuity Manager is reviewing each business continuity plan to ensure that they are appropriate and consistent Desk based exercise undertaken and reported to the Data Security and Protection (DSP) committee. Actions identified being progressed ~~Emergency Planning co-ordinating wider review~~ The priority has been the EPRR Incident Response Plan. This has resulted in a delay in the progression of the business continuity domain. Now additional resource is available within the EPRR team there is a workplan in place to rectify this area. Full review of business continuity management system is being undertaken	AMBER
Embedded programme of software and hardware upgrades	Prioritise work alongside organisational requirements and developments [ACTION OWNER: COO]	Information Technology Strategy (IT Strategy) 6-month update to Finance and Performance Committee	~~30.09.22~~	Continual review of hardware and software undertaken in conjunction with NHS Arden and Greater East Midlands	~~GREEN~~ Changed to BLUE

				Commissioning Support Unit monthly as part of our 'Rigor' programme. Actions agreed to ensure that we continue to comply with the NHS mandate to operate on supported software and platforms ~~Work ongoing – Examples of the progress being made would be EMIS Web and Dictate.IT which have both been upgraded in the last month~~ This work will be continuously ongoing. As weaknesses are identified in software patches and/or upgrades are undertaken – Action complete, BAU	
Live testing of business continuity plans	Desktop incident response exercise on IT failure to be completed [ACTION OWNER: COO]	Exercise evaluation report to Finance and Performance Committee	~~30.09.22~~	Desk based exercise undertaken and reported to the DSP committee. Actions complete ~~identified being progressed~~	~~GREEN~~ Changed to BLUE
Some gaps identified in Cyber Operational Readiness Support (CORS) review undertaken by Templar	Consideration of recommendations for asset owners and policies – Trust to develop own actions in response [ACTION OWNER: COO]	Response to CORS recommendations report to Data Security and Protection Committee	~~30.09.22~~	CORS recommendations and actions complete and improvements embedded ~~or underway and on target~~	~~GREEN~~ Changed to BLUE

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

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Strategic Objective 2 - To be a GREAT Place to Work

There is a risk that we do not sustain a healthy vibrant culture and conditions to make DHCFT a place where people want to work, thrive and to grow their careers

Impact: Risk to the delivery of high-quality clinical care
- Inability to deliver transformational change
- Exceeding of budgets allocated for temporary staff
- Loss of income

Root causes:

a. National shortage of key occupations and registered professions
b. Future commissions of key posts insufficient for current and expected demand
c. Sufficient funding to deliver alternative workforce solutions
d. Retention of staff in some key areas
e. Overdependence on registered professions
f. Impact of COVID-19 pandemic
g. Increase in mental health demand and associated funding
h. Increase in use of technology
i. Consistent person-centred culture not fully embedded

BAF Ref: 22-23 2A	**Director Lead**: Jaki Lowe (DPI)	**Responsible Committee**: People and Culture Committee

Key Controls

Inherent risk rating			Current risk rating				Target risk rating			Risk appetite		
Extreme	Likelihood 4	Impact 5	High	Likelihood 4	Impact 5	Direction	Moderate	Likelihood 2	Impact 5	Accepted	Tolerated	Not Accepted

Preventative – Workforce plan covering wide range of recruitment channels including targeted campaigns, 'Work For Us' internet page, leadership development, new role and skill mix changes, leadership development programme, increased well-being support, system workforce hub
Detective – Performance report identifying specific hotspots and interventions to increase recruitment and retention, Freedom to Speak Up Guardian role, Peoples Services Leadership Team meeting to oversee delivery of the People Agenda. Health risk assessments. Health and wellbeing conversations and well-being action plans. Black, Asian, and Minority Ethnic (BME) risk assessments
Directive – Wellbeing Strategy, infrastructure and programmes to support staff health and wellbeing. Workforce plan to grow and develop the workforce. Assurance reports on delivery of People Strategy to People and Culture Committee. Leadership support sessions. Staff engagement forums
Corrective – Leadership and Management Strategy and development programmes to build inclusive and engaging leadership and management. Leadership Programme – Core Leaders. Occupational health contract monitoring meeting

Assurances on controls (internal)	Positive assurances on controls (external)
Workforce Performance Report to Executive Leadership Team monthly Bimonthly People Dashboard to People and Culture Committee, includes recruitment tracker and deep dives ELT rolling programme of deep dives of strategic building blocks	Outstanding results from 2020 staff survey, identifying significant improvements across all themes Safe staffing reports and Care Hours Per Patient Day (CHPPD) reporting (planned versus actual staff)

~~Employee relations assurance report to ELT~~ ~~Deep dive review of the risk to Audit and Risk Committee (January 2021)~~	

~~Key gaps in control~~	~~Key actions to close gaps in control~~	~~Impact on risk to be measured by~~	~~Expected completion date (Action review date)~~	~~Progress against action~~	~~Action on track~~
~~Time taken to recruit to new and vacant posts~~ ~~Lack of a recruitment plan showing the vacancies and recruitment position~~ ~~Lack of correlation between finance, HR and operational systems and information~~ ~~Insufficient clarity on hotspot areas and what needs to be done to address these areas~~	~~Recruitment plans in place for workforce requirements related to capital projects and mental health investment plans (relating to PICU plans and dormitory eradication)~~ ~~Establish a Multi-Disciplinary Team Recruitment Task and Finish group to establish a clear position on vacancies, starting January and completing by end of March 2021~~ ~~[ACTONS OWNER: DPI]~~	~~Vacancy rates, time to recruit data within performance report to Board. People dashboard to PCC and monthly people assurance report to ELT~~ ~~Diversity in appointments. Target of 20% of workforce as BME~~	~~(30.09.22)~~	~~Recruitment processes working well. Plans in place for all new posts are being dynamically managed – Operational and 'business as usual' (BAU)~~ ~~A recruitment scrutiny meeting has been established, with a clear set of actions to address on the recruitment part of the process, to review vacancies and establishment controls.~~ ~~Recruitment KPIs are now being achieved. Recruitment summits have taken place with each division and actions developed to close the gap on vacancies~~ ~~Apprenticeship profiling plan has been captured and will go to ELT~~ ~~The BME staffing rate continues to improve and is now at 16.99%~~ ~~This risk has been reassessed and incorporated within the People Risk Plan on having a diverse workforce with the right people with the right skills~~	~~AMBER~~

~~Embedded flexible workforce arrangements in place~~	~~Implementing the learning from flexible working arrangement in response to the COVID-19 pandemic, i.e. home working~~ ~~Review of policies/processes and contracts of employment to embed flexible working~~ ~~Consultation taking place on hybrid working model~~ ~~Kingsway/Albany Temporary Home working consultation as a result of COVID-19~~ ~~[ACTONS OWNER: DPI]~~	~~Sickness absence rate reported in performance dashboards as outlined above~~ ~~Staff survey responses~~ ~~Pulse and people pulse check responses~~ ~~Percentage of people working on flexible contracts with respect to hours and location (reporting metric to be developed)~~	~~(31.12.22)~~ ~~30.09.22~~	~~DHCFT Promise for flexible working in place. Working from home and flexible working policies both updated.~~ ~~Guidance and advice for managers has been produced and focus groups on flexible working have been undertaken~~ ~~Pulse checks commenced and continue to take place quarterly~~ ~~Delay in review due to COVID-19 surge. Survey now taken place and results currently being analysed and Kingsway/Albany group~~ ~~Hybrid model moving forward is still in transition~~ ~~Piloting the Stay process looking at flexible working options~~ ~~Summary paper of the Kingsway/Albany review to be submitted to the Combined Leadership Group in October.~~ ~~Two separate matters foreseeable:~~ ~~1. An estates group with support for Estates and Facilities Management (EFM)~~ ~~2. An ongoing project group to look at blended working across the Trust~~ ~~This risk has been reassessed and incorporated within the~~	~~GREEN~~

				~~People Risk Plan on having a diverse workforce with the right people with the right skills~~	
~~Fully embedded person-centred culture of leadership and management~~	~~Review of policies and processes to support a person-centred approach to leadership and management~~ ~~Review of leadership development offer~~ ~~Re-establish line manager development sessions~~ ~~Scrutiny of people data at divisional level~~ ~~[ACTONS OWNER: DPI]~~	~~Reduced number of formal staff relations issues/cases. Reported in monthly people assurance report to ELT~~ ~~Reporting to TOOL~~	~~Ongoing~~	~~'People First - Supporting colleagues fairly through workplace situations' in place and disciplinary and incident polices reviewed in line with approved proposal with 'Above Difference' to review cultural intelligence~~ ~~Line manager development sessions are now up and running~~ ~~External review of workforce policies completed~~ ~~Cases now being escalated effectively to ensure timely and appropriate management~~ ~~This risk has been reassessed and incorporated within the People Risk Plan on having a diverse workforce with the right people with the right skills~~	~~GREEN~~
~~Development of a funded Workforce Plan that delivers on new role development~~	~~Develop and implement 2022/23 of the Workforce Delivery Plan (WDP)~~ ~~[ACTON OWNER: DPI]~~	~~Vacancy rate of registered posts reported in performance dashboards as outlined above and recruitment report to IMT~~ ~~No of new roles in place, metric to be developed. Apprenticeship student nurse uptake reported to Workforce Delivery Plan Group~~	~~Ongoing~~	~~Delivery of plan being monitored though Workforce Planning Delivery Group, through to ELT and PCC. Initial WDP reported to Board May 2021~~ ~~Medical Workforce Project Group review of all vacancies, recruitment and agency spend fortnightly~~	~~AMBER~~

				~~The Workforce Plan is included in the overarching People & Inclusion Services budget planning~~ ~~This risk has been reassessed and incorporated within the People Risk Plan on having a diverse workforce with the right people with the right skills~~	
~~People and Inclusion Directorate shaped to deliver against future needs of the organisation~~	~~Review of Peoples Services model and plans~~ ~~Identify resources required to shape culture locally~~ ~~Develop performance framework to support delivery of revised model [ACTONS OWNER: DPI]~~	~~Service line agreements~~ ~~KPIs~~	~~Ongoing~~	~~New schedule of service agreed~~ ~~New service level agreements and key performance indicators being finalised with some proposed changes on engagement~~ ~~A new commissioning process in place~~ ~~A review of the joint venture from perspectives of service user and employees in people services are part of the system plan. Oversight meetings have commenced~~ ~~Meetings between CEO and Human Resources leads in DCHS and DHCFT in place~~ ~~This risk has been reassessed and incorporated within the People Risk Plan on having a diverse workforce with the right people with the right skills~~	~~AMBER~~
~~Consolidate health and wellbeing provision and infrastructure, ensuring~~	~~Align well-being offer to local Sustainability and Transformation Plan (STP) and national offers~~	~~Maintain sickness absence rates to below 5% or below~~	~~(30.09.22)~~	~~Local, regional and national offer published via Trust intranet~~	~~AMBER~~

~~learning from COVID-19 pandemic is incorporated~~	~~Updating well-being offer, in particular mental health interventions~~ ~~Roll out of health and wellbeing plans for all staff~~ ~~Consider a reflective practice offer~~ ~~Review management of change policy to incorporate health and well-being discussions~~ ~~Similar review of appraisal policy and processes~~ ~~[ACTONS OWNER: DPI]~~	~~Reduction in sickness absence as a result of anxiety and stress~~ ~~Percentage uptake of health and wellbeing plans~~ ~~Published policies~~		~~Increase uptake of health risk assessments~~ ~~Wellbeing offer has been reviewed. Health & Wellbeing Framework has been rolled out~~ ~~Review RESOLVE contract to increase capacity for referrals~~ ~~Absence rates have not decreased as anticipated as COVID-19 and stress/burnout has been a key factor. Levels similar to pre-pandemic. Monitoring continues~~ ~~This risk has been reassessed and incorporated within the People Risk Plan on having a diverse workforce with the right people with the right skills~~	
~~Training compliance in key areas below target set by the Trust~~ ~~Long-term solution required for the training venues for mandatory training and induction~~	~~Recovery being implemented~~ ~~Mandatory training to be rostered~~ ~~Estates team to consider options for central room booking and for training~~ ~~[ACTION OWNERS: DPI/COO]~~	~~Percentage of compliance with mandatory training reported to ELT and bimonthly to Board as part of performance report~~ ~~Forward planning for training compliance~~	~~(30.09.22)~~ ~~(31.01.23)~~	~~Recovery plan implemented, particularly in relation to ILS and Positive and Safe training. Forward plans to include rostering of training to be developed~~ ~~Significant impact of COVID-19 on release of staff – Extra resource given to support the Training and Development Team in admin is now permanent~~ ~~Three additional trainers have been recruited. This will continue until March 2023~~	~~AMBER~~

				~~Target is 85% and we are below this~~ ~~A new training venue is required for Positive & Safe and Manual Handling training, this is being sourced, Manual handling currently at Midland House but this is due to close. Positive and Safe still at Kingsway~~ ~~Training – COO presented a paper to TOOL in September on how we're looking at training differently. No cited issues with room bookings currently~~ ~~This risk has been reassessed and incorporated within the People Risk Plan on having a diverse workforce with the right people with the right skills~~	
~~Evidence of safer staffing levels of suitably qualified staff~~	~~Compliance with NHS Improvement (NHSI) Workforce Safeguards requirements~~ ~~[ACTION OWNER: COO]~~	~~Full compliance with safer staffing levels in line with the NHSI Workforce Safeguards~~	~~30.09.22~~ ~~31.01.23~~	~~New reporting process started to incorporate ward level reporting. Board approval given to recruit two registered and two non-registered staff per ward. HCA recruitment almost complete, registered staff is delayed due to national shortages~~ ~~Monitoring of actions to ensure E-Roster has the correct safer staffing template for each ward continues~~ ~~Monthly safer staffing reports run and added to TOOL~~	~~GREEN~~

				~~agenda for continued monitoring and oversight~~ ~~This risk has been reassessed and incorporated within the People Risk Plan on having a diverse workforce with the right people with the right skills~~	

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

~~Record ID~~	~~Service Line~~	~~Title~~	~~Risk: Summary of Progress~~	~~Date Risk Created~~	~~Date of Next Review~~	~~Residual Risk Rating~~
~~22804~~	~~Corporate Services – Pharmacy~~	~~Pharmacy Staffing~~	~~There is a short-term deficit in our numbers of pharmacists and pharmacy technicians. Turnover has been increased by the growth of new posts within Primary Care Networks. We are not contributing to the training of pharmacy technicians within Derbyshire so recruitment is taking capacity from the acute Trusts who do provide training~~ ~~23.06.22: Plan was presented to ELT and TOOL. The pharmacy team are currently delivering a reduced service because of staffing pressures. There remains a risk of further staff losses and financial difficulties~~ ~~26.09.22: Pharmacist staffing remains pressured. Longer-term pharmacist numbers are likely to recover year on year, so some optimism for steady growth by 1-2 pharmacists a year, with full recovery to anticipated pharmacist staffing by 2026. Mitigation is to focus on recruitment and development of pharmacy technicians (PTs). Reduced level of service delivery expected to persist as predicted until at least Easter 2023~~	~~18.03.22~~	~~12.12.22~~	~~HIGH~~

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Strategic Objective 2 – To be a GREAT Place to Work

There is a risk of continued inequalities affecting health and well-being of staff

Impact:

Risk to the delivery of high-quality clinical care
Inability to attract, recruit and retain a motivated and diverse workforce
Risk to the health and wellbeing of our staff
Risk to patients and communities having access to the right services
Escalation in formal cases impacting on individuals and teams
Reduced confidence by our communities in our Trust

Root causes:

a. Commissioning of services does not meet the need of diverse communities
b. Change management and transformation programmes lead to deterioration in experience
c. Processes and policies have inbuilt bias
d. Processes for advocacy and raising issues not clear or dealt with well
e. Gaps in cultural competence of leaders and managers

BAF Ref: 22-23 2B	**Director Lead**: Jaki Lowe (DPI)	**Responsible Committee**: Trust Board

Key Controls

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

Preventative – Freedom to Speak Up Guardian (FTSUG) self-assessment and six monthly reports; annual review of people development plan commissioned through People and Inclusion Directorate; provision of information through induction processes for new staff; staff engagement sessions; Equality, Diversity and Inclusion (EDI) Delivery Group meeting; supported networks for diverse staff groups and allies; Health and Well-being Network; workforce planning design meeting; Culture and Leadership Delivery Group; Training and Education Delivery Group
Detective – EDI updates to ELT, monthly performance report to Board; recruitment reporting to TOOL; Reverse Commissioning Project Group; Reverse Commissioning Steering Group; Equality Forum; attendance management monitoring; take up of Reasonable Adjustment Passports; updating of Electronic Staff Record (ESR) regarding disability and long-term conditions
Directive – People Strategy; Inclusion Strategy; Joined Up Care Derbyshire (JUCD) People Strategy
Corrective – Leadership and management development strategy ensuring inclusion is at the heart of all development; exit interview feedback

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Assurances on controls (internal)		Positive assurances on controls (external)			
Executive Leadership Team rolling programme of deep dives on strategic building blocks		2020 staff survey results Gender pay gap annual assessment and report Assessment and report annually for Equality Delivery System (EDS2) WRES and WDES annual report 2020/21 Internal Audit WRES/Disability Worker Exclusion Scheme (DWES) data quality (significant assurance)			
Key gaps in control	**Key actions to close gaps in control**	**Impact on risk to be measured by**	**Expected completion date (Action review date)**	**Progress against action**	**Action on track**
Develop an Equality, Diversity and Inclusion Strategy (EDI Strategy) Insufficient resources in place to deliver the plans	Refresh and expanding the strategy Roll out review of cultural intelligence Launch events for the Equality, Diversity and Inclusion Strategy Development of directorate equality dashboards Recruitment process for the head of EDI and Race Equality Lead [ACTIONS OWNER: DPI]	Improved position regarding staff motivation in staff survey and pulse checks Freedom to Speak Up Index to People and Culture Committee and Board Inclusion Recruitment report Positive Friends and Family Test Percentage of exit interviews completed Metrics within the employee relations report	(30.09.22)	Strategy has been developed, engagement and embeddedness reviewed. EDI delivery group will oversee delivery of the strategy Strategic approach taken to Trust Board November 2021 Delivery group now stood up to full operating expectations and will oversee delivery of the strategy This risk has been reassessed and incorporated within the People Risk Plan on having a diverse workforce with the right people with the right skills	AMBER
Refresh and expand engagement plans. Include lessons learnt from response to COVID pandemic	Establish approach for refreshing and expanding the engagement plan and a group to oversee the refresh Refresh 12 month engagement plan	Improved staff survey results Positive Friends and Family Test Positive pulse check	(30.09.22)	Engagement plan for next 12 months to be developed in line with Trust roadmap Learning from COVID 19 has been completed and cultural	GREEN

	~~Develop a cultural sensitivity approach to health and wellbeing discussions [ACTIONS OWNER: DPI]~~			~~sensitivity to health and wellbeing discussions were undertaken – Progress reporting into TOOL~~	
~~Gaps in the cultural competence of leaders and managers resulting in staff reporting being disadvantaged due to their protected characteristics~~	~~Roll out of cultural competence training to equip leaders and managers to be able to lead and support staff and provide the best experience for service users~~ ~~Participation in the national pilot on disciplinary processes~~ ~~Training on acceptable behaviours in teams where there are issues [ACTIONS OWNER: DPI]~~	~~Live WRES monitoring at corporate and directorate level~~ ~~BME case numbers~~ ~~Setting of targets at divisional level~~ ~~Development of divisional WRES Action plans~~	~~30.09.22~~	~~Health risk assessment has been revisited and is now a dynamic process. Roll out of master classes for cultural intelligence start September 2021. Cultural workshops undertaken in areas of need (on disparity ratio of BME staff at Band 7 and above)~~ ~~This risk has been reassessed and incorporated within the People Risk Plan on having a diverse workforce with the right people with the right skills~~	~~AMBER~~
~~Unequal experience of people with protected characteristics through recruitment process~~	~~Review of assurance framework that inclusion and recruitment guardians will use~~ ~~Increase the number and availability of Recruitment Inclusion Guardians (RIGs)~~ ~~Establish an escalation process where a RIG is not in place~~ ~~System Recruitment Pilot to change the recruitment process~~ ~~Review of all data from the Freedom to Speak Up Guardian, disciplinary cases and grievances to identify areas to address [ACTIONS OWNER: DPI]~~	~~Improved BME recruitment process outcomes~~ ~~Improved disparity ratios~~ ~~Review the role of the RIG from a panel member to an assurance process~~	~~31.12.22~~	~~Increased the number of inclusion guardians to 50+~~ ~~System wide pilot on reviewing recruitment process was paused during the latest part of the pandemic. It will relaunch in June. Senior appointments disparity at the most senior level have improved~~ ~~This risk has been reassessed and incorporated within the People Risk Plan on having a diverse workforce with the right people with the right skills~~	~~AMBER~~

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

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Strategic Objective 2 - To be a GREAT place to work

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

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

Root causes:

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

BAF Ref: 22-23 2C	**Director Lead**: Jaki Lowe (DPI)	**Responsible Committee**: People and Culture Committee

Key Controls

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

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Preventative – Freedom to Speak Up Guardian (FTSUG) self-assessment and six monthly reports; annual review of people development plan commissioned through People and Inclusion directorate; provision of information through induction processes for new staff; staff engagement sessions; Equality, Diversity and Inclusion (EDI) Delivery Group meeting; supported networks for diverse staff groups and allies; Health and Well-being Network; workforce planning design meeting; Culture and Leadership Delivery Group
Detective – Quarterly Pulse Checks, FTSUG log and escalations; staff network engagement; WRES, WDES, wellbeing champion network, executive led engagement sessions; non-executive, executive and deputy visits to teams
Directive – Joined Up Care Derbyshire (JUCD) People Strategy, National People Plan; People building blocks and priorities; Strategic people priorities, Communications Strategy, ICS People 5x7 plan
Corrective – Leadership Development Forum, Leadership programmes at national and system level, chair network development programme

Assurances on controls (internal)	Positive assurances on controls (external)
National staff survey and reporting into board, ELT and divisions Quarterly pulse check and action planning process Staff survey analysis and reporting Exit interview analysis and reporting	Benchmarking in mental health and at system level Outstanding results from 2021 staff survey, identifying significant improvements across all themes

Key gaps in control	Key actions to close gaps in control	Impact on risk to be measured by	Expected completion date (Action review date)	Progress against action	Action on track
Lack of planned leadership development growth and stretch programmes and opportunities including coaching and mentoring	Review of system level leadership offer and impact Review and development of Trust leadership offer and impact Re-establish leadership forum Development of coaching access at local, system and national [ACTIONS OWNER: DPI]	Percentage of leaders with development plan as part of objectives Percentage of leaders attending local, system or national leadership programmes	01.02.23	Deputy Director of People is part of system leadership workstream to review current offer and develop 12 month plan on leadership offer New leadership programme (aimed at band 8B staff) launched and commences October 2022 Leadership forum revised and launch planned December 2022	AMBER

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Fully embedded person-centred culture of leadership and management	Review of policies and processes to support a person-centred approach to leadership and management Introduce just and restorative culture approach Review of leadership development offer Re-establish line manager development sessions Scrutiny of people data at divisional level [ACTIONS OWNER: DPI]	Reduced number of formal staff relations issues/cases reported in monthly people assurance report to ELT Staff survey results Reporting to TOOL	31.03.23	Just and restorative culture conference taken place Review of cases and case management to be reported into ELT in October 2022	AMBER
No operating framework through which to maximise the impact of staff networks	Collaboratively develop and Implement Staff Network Framework to provide consistency across the networks with clear framework, clarity of roles and objectives to increase engagement with under-represented staff Support to Bi-monthly network Chairs meetings through DPI, Head of EDI and EDI Manager [ACTIONS OWNER: DPI]	Engagement and buy-in by network Chairs Sign up to the framework by network Chairs and Executive Directors Annual updates by network Chairs of engagement undertaken to be included in annual reports	30.11.22 31.12.22 (31.03.22)	Discussions taken place on the need for a framework early summer Work paused during summer due to long term sickness of Head of EDI Discussions with network Chairs to progress timetabled for 20.10.22	AMBER
The current capacity and structure of the People and Inclusion directorate is not able to meet the Trust, system, regional and national demands alongside challenges from outsourcing key services via People Services in DCHS and UHDB	Review of current People and Inclusion structure to align to needs and priorities of Trust, identify gaps and develop plan to mitigate Review of gaps in services delivered by People Services or UHDB and develop accountability framework Formalise existing governance meetings to ensure clear processes in place for People and Inclusion Services contract and UHDB key service contracts	A People and Inclusion structure that can support the Trust to deliver against the people priorities Accountability dashboard presented to ELT quarterly Terms of reference in place and regular meetings A People and Inclusion structure that can support system-wide priorities	31.12.22	Contract review meetings established for Occupational Health and Payroll Services (UHDB) Governance meetings established for People and Inclusion Services	RED

	Review of current communications and engagement and people priorities across the Trust and system [ACTIONS OWNER: DPI]	People and Inclusion staff survey results			
Lack of maturity of EDI framework	Produce and implement EDI framework with clear legislative, and mandated NHS national regional and local deliverables required for the EDI function and structure to deliver [ACTIONS OWNER: DPI]	Agree framework and capacity requirements to deliver Regular wider engagement with EDI Delivery Group, and divisional leads taking place Final presentation to PCC Roll out of framework Delivery against the People Performance Dashboard	30.11.22 31.12.22 31.03.23 31.03.23 31.03.23	Draft framework is being presented to ELT in November 2022	AMBER
We have not engaged with our Bank staff to develop a strong sense of belonging, engagement and psychological contract with the Trust	Regular monthly engagement sessions Staff survey participation Clinical supervision and appraisal participation Alignment to Agenda for Change for pay and conditions [ACTIONS OWNER: DPI]	Staff survey participation response rates Staff survey engagement scores Attendance at engagement sessions	31.01.23 31.01.23 31.12.22	Engagement sessions commenced, sessions booked virtually for October, November and December 2022, and face to face session for January 2023 Partaking in first national bank staff survey Aligned all bank staff bands 2, 3, 4 and 7 to Agenda for Change pay scales	GREEN
Lack of visible and differential staff benefits and responsive support for staff that reflects current working conditions, e.g. cost of living crisis	Review of gaps in benefits to realign to staff needs Review of current reward and recognition framework Develop range of staff benefits that align to Trust values and 'people first' approach	Staff survey engagement score Staff turnover Pulse check scores	31.01.23	Delivering Excellence Every Day awards (DEEDs) have been revised and relaunched Staff awards taking place System-wide discussions commenced with regards a system wide benefits package	RED

	Develop the salary sacrifice offer to support colleagues with cost of living crisis [ACTIONS OWNER: DPI]			Mileage rates adjusted to reflect cost of living crisis	
Inconsistency in application of an in inclusive approach impact on developing and sustaining a sense of belonging	Embed an inclusive approach, promoting equality and ensuring diversity at all levels through learning and development, Schwartz Rounds, personal development reviews, mid-year reviews, rewards and awards, objective settings [ACTIONS OWNER: DPI]	Year on year change WRES/WDES, staff surveys and lived experience of staff through staff networks Data drawn from all engagement activities so we are able to identify impacts on staff experience and any inequalities that need to be closed	(31.03.23)	This work will need to commence in the last quarter of 2022/23	AMBER
Systematic planning and attendance of training	Training to be embedded in e-roster and designed to support safe staffing by minimising face to face sessions needed Progress the breaks and shift pattern change process [ACTIONS OWNER: DPI]	Full compliance with safer staffing levels in line with NHSI Workforce Safeguards Training compliance in line with CQC requirements Staff survey health and wellbeing scores Comprehensive system and trust level health and wellbeing offer Compliance with NHSI workforce safeguards requirements Staff are able to take breaks and access the right health and wellbeing support E-roster team appropriately resourced and supported	31.12.22	New reporting processes in place that feeds into TOOL, PCC and Board Work being done on a planned training day Shift and break consultation being planned	AMBER

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

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Strategic Objective 4 - To be a GREAT place to work

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

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

Root causes:

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

BAF Ref: 22-23 2D	**Director Lead**: Jaki Lowe (DPI)	**Responsible Committee**: People and Culture Committee

Key Controls

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

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

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

Key gaps in control	Key actions to close gaps in control	Impact on risk to be measured by	Expected completion date (Action review date)	Progress against action	Action on track
An integrated workforce plan and planning process that feeds into pipeline plans and ensures we have the right people in the right place with the right skills	Develop a Trust Workforce Plan linking demand and capacity, workforce redesign to ensure a fully funded workforce Develop vacancy rate data and breakdown variances in vacancy data Establish a workforce transformation group to develop workforce development plans and ownership at divisional level [ACTIONS OWNER: DPI]	Vacancy rates Time taken to fill vacant posts Transformational posts, e.g. apprenticeships all identified Reduction in agency costs	31.01.23	High level Workforce Plan developed and presented to Board Workforce transformation group commencing November 2022	RED
We do not have an effective and embedded succession talent management processes	Develop a Talent Management Strategy Pilot career conversations for senior leaders and roll out career conversations for all colleagues Work as a system to develop system-wide approach to talent management and align where best for the Trusts [ACTIONS OWNER: DPI]	Career conversations taking place Internal appointments/promotions Turnover rate Key staff survey measures	31.03.23	Strategy in draft Pilot ready to launch for senior leaders Deputy DPI system lead on talent management	AMBER

Lack of capacity, experience and plans for recruiting overseas	Develop International Recruitment (IR) plan and programme Appoint IR team to lead programme Engage with national IR support Access national IR funding Support Trust teams to prepare for IR arrivals [ACTIONS OWNER: DPI]	Number of IR appointments Retention rate of IR	31.01.23	IR pastoral support officer appointed and commenced in post Funding secured for four IRs Regular meetings established with national midlands IR lead	RED
The recruitment and retention scheme has not been fully embedded	Develop and launch a Recruitment and Retention Payment (RRP) scheme that provides clear guidance and a thorough process for appointing any RRP to a post(s) [ACTIONS OWNER: DPI]	RRP applied to high risk posts and successfully attracts applicants and leads to appointment	31.12.22	RRP approach approved by ELT	AMBER
Onboarding and Retention process and planning needs to be embedded	Understand the key retention issues for posts/teams/professions with the highest turnover Ensure 'stay conversations' form part of regular 1:1s Develop NHS retention framework for nursing [ACTIONS OWNER: DPI]	Improvements to turnover Staff survey engagement scores	31.01.23	'Stay' survey piloted with Allied Health Professionals and 1-2 year starters New starter survey completed with all started in six months and learning shared at Trust and divisional level Nursing retention framework self-assessment completed System retention lead appointed to support Trust level and system work	AMBER
Medical staffing team and role not sufficiently developed Workforce plan for medical staff not in place	Review existing medical staffing team and workforce support and identify gaps Develop new model to support and maximise the medical workforce Develop medical agency model to ensure efficient usage	Engagement of medical workforce Reduction in agency spend	31.01.23	Terms of reference agreed by MD and COO for review of existing medical staffing team and creation of a medical workforce plan	RED

	Develop a medical staff workforce plan			Resources identified and funding needs to be agreed for the review by ELT	
Lack of culturally competent recruitment processes	Completion and implementation of recommendations of the Above Difference recruitment and retention system pilot Wider engagement with recruiting managers, staff networks, clinical leads and operational leads Quartile monitoring of utilisation of Above Difference recruitment and retention tools Continuous improvement approach to implementing learning [ACTIONS OWNER: DPI]	WRES and WDES data shows year on year improvement, staff survey and lived experience of staff Increase the proportion of applications from ethnic minority groups, increase likelihood of shortlisting and reduce disparity in all areas	31.03.23	Recruitment leads across the system all trained through Above Difference programme Pilot nearing completion with six workstreams completing key learning to be shared at future system human resources meeting to agree actions and programme management to move forward at pace Examples of innovation already being trialled such as one page job description being piloted by two teams	RED
Effectiveness of recruitment policy, practice and processes	Review and develop existing recruitment Key Performance Indicators (KPIs) to ensure fit for purpose Where appropriate move away from TRAC to advertise jobs and use fast track processes, e.g. Indeed/MSforms Develop cohort recruitment for key posts Improve the multidisciplinary working (HR, communications and recruiting managers) to enable better planned and executed campaigns [ACTIONS OWNER: DPI]	Time to recruit Number of applicants applying and successfully shortlisted Campaign impact and reach Financial savings through cohort recruitment	31.01.23	KPI review commenced Indeed piloted for hard to fill posts in acute Cohort recruitment successfully piloted for Health Care Assistants and Human Resources apprenticeships	AMBER

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

Record ID	Service Line	Title	Risk: Summary of Progress	Date Risk Created	Date of Next Review	Residual Risk Rating
22804	Corporate Services – Pharmacy	Pharmacy Staffing	There is a short-term deficit in our numbers of pharmacists and pharmacy technicians. Turnover has been increased by the growth of new posts within Primary Care Networks. We are not contributing to the training of pharmacy technicians within Derbyshire so recruitment is taking capacity from the acute Trusts who do provide training 23.06.22: Plan was presented to ELT and TOOL. The pharmacy team are currently delivering a reduced service because of staffing pressures. There remains a risk of further staff losses and financial difficulties 26.09.22: Pharmacist staffing remains pressured. Longer-term pharmacist numbers are likely to recover year on year, so some optimism for steady growth by 1-2 pharmacists a year, with full recovery to anticipated pharmacist staffing by 2026. Mitigation is to focus on recruitment and development of pharmacy technicians (PTs). Reduced level of service delivery expected to persist as predicted until at least Easter 2023	18.03.22	12.12.22	HIGH

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Strategic Objective 3 – To Make BEST use of Our Resources

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

Impact: Trust becomes financially unsustainable

Root causes:

a) Financial detriment (revenue, cash and/or capital) resulting from large capital development programme, in particular dormitory eradication and associated capital schemes
b) Non approval of business case for national funding
c) Insufficient capital envelope for JUCD system that inhibits Trust capital spend requirements for required self-funded projects
d) Organisational financial detriment created by commissioning decisions or wider 'system-first' decisions including enactment of risk-sharing agreement in partnership arrangements or changes in NHS financial arrangements during and beyond the pandemic
e) Non-delivery of expected financial benefits from transformational activities
f) Non-delivery of required levels of efficiency improvement
g) Lack of sufficient cash and working capital
h) Loss due to material fraud or criminal activity
i) Unexpected income loss or non-receipt of expected transformation income (e.g. long-term plan (LTP) and Mental Health Investment Standard (MHIS) without removal of associated costs
j) Costs to deliver services exceed the Trust financial resources available
k) Lack of cultural shift/behaviours to return to financial cost control regime
l) Inability to reduce temporary staffing expenditure
m) Ongoing or re-emergence of COVID-related costs with insufficient covid funding

BAF Ref: 22-23 3A	**Director Lead**: Claire Wright (DOF)	**Responsible Committee**: Finance and Performance Committee

Key Controls

Inherent Risk Rating			Current Risk Rating				Target Risk Rating			Risk Appetite		
High	Likelihood 3	Impact 5	Extreme	Likelihood 4	Impact 5	Direction ↑	Moderate	Likelihood 2	Impact 5	Accepted	Tolerated	Not Accepted

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

Detective – Risk logs and programme-reporting (capital/transformation) informs ongoing financial risk assessment: Audits (internal, external and in-house); scrutiny of financial delivery, bank reconciliations; continuous improvement including cost improvement planning (CIP) and efficiency / QI delivery; contract performance, local counter fraud scrutiny

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Directive – Business plans and templates set out clear financial plans and assumptions: Standing financial instructions; budget control, delegated limits, recruitment approval processes; business case approval process; invest to save/Quality Improvement methodology and protocol and Plan Do Study Act. Risk and gain share agreements, Local Operating Procedure for Acute Capital Programme

Corrective – Risk mitigation activity and oversight at ICS system/other partnership level. Proactive reporting and forecasting of capital and wider transformation programme progress enabling remedial activity to take effect. General corrective management action; Use of contingency reserve (if available); Disaster recovery plan implementation; Performance reviews and associated support / in-reach

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

Key gaps in control	Key actions to close gaps in control	Impact on risk to be measured by	Expected completion date (Action review date)	Progress against action	Action on track
Trust cash and capital risks related to national funded acute capital programme: - Inflation cost risk - Risk-share	Risk share arrangements with PSCP Optimism bias and contingency discussions with NHSE/I on cash and capital	Cash and capital reporting and forecasting evidence of plan delivery and/or indicates areas of required management action	March 2024 and beyond (review quarterly)	Regular oversight of capital and cash position. Reporting to Trust Programme meetings and Committees on risks and mitigations	RED

- Cashflow timings and variability - Guaranteed Maximum Price exceeds national funding envelope (due to hyperinflation and other factors)				Hyper-inflation cost risk remains is very high due to world events and economy The affordability risk has escalated the wider programme risk to extreme This risk has crystalised: Confirmed hyperinflation significantly increased the price at FBC stage which resulted in need to reallocate Trust capital to augment the new build schemes. We are seeking additional national funding	
System capital programme funding shortfall for self-funded Trust capital programme: System Capital Departmental Expenditure Limit (CDEL) inadequacy for system capital requirements	System capital planning had included dorms/PICU self-funded elements which have had to augment the new build national schemes. But CDEL was constrained for the system. CDEL limits and are set against the hyperinflated costs for the programme as a whole, in order to ascertain the funding shortfall	Ongoing reporting will ascertain how and when the shortfall can be bridged by additional capital sources	March 2024 and beyond (review quarterly)	System capital plan submitted under constrained CDEL envelope Longer term planning commenced HMRC view awaited. NHSE~~/I~~ PICU capital information awaited guidance issued and urgent discussions with national and regional teams to seek additional national PDC to address the funding shortfall – ongoing This risk has crystalised, there is now a confirmed funding shortfall for the self-funded schemes within the overall programme	RED
Additional revenue not approved by System for Older Adults Service Relocation OBC and all non-national schemes	Close partnership working with CCG and System partners to agree OBCs and FBCs as System documents	System approvals of both OBCs and FBCs subject to capital funding sources ~~in June 2022~~	~~30.09.22~~ 31.12.22	CCG and DCHS partners contributing to OBC/FBC development MHLDA Delivery Board agreed to oversee revenue delivery contained within programme spend. However, note that all non-national FBCs are now require capital funding resolution before they can proceed	AMBER

FBCs do not achieve national approval	Programme approach and engagement with all stakeholders. Close involvement with NHSE/I	Approval in system and by national investment committee	~~30.09.22~~ 31.12.22	National submitted in May and national approval expected August 2022 Treasury approval may also be required given the value of the schemes which now include hyperinflation costs Notification of outcome ~~expected end of summer.~~ FBCs approved by NHSE, subject to conditions. HMRC ruling awaited	AMBER
Insufficient substantive staffing into vacancies and temporary staffing costs for bank and agency staff do not reduce	Additional management action and oversight	Enhanced bank and agency costs reported as part of wider financial and workforce reporting	March 2023 (Quarterly)	Reports to ELT and F&P outlining current areas of pressure and required actions in March and April will be ongoing	RED
Non-delivery of required recurrent cost reduction and improved efficiency and Quality Improvement	Compilation and delivery of planned Trust efficiencies and quality improvements to deliver 2022/23 plan including recurrent long term cost reductions to return to breakeven	Efficiency and QI reporting to Execs and F&P	March 2023 (Quarterly)	Partial delivery plan at time of draft and final plan submissions. Area of urgent work as reported to ELT and F&P	RED
Covid costs continue and exceed funding available	Return to pre-pandemic operating models and release of additional costs	Covid cost reporting as part of wider financial reporting	March 2023 (Quarterly)	Pandemic uptick in first quarter of 2022/23. Updated IPC guidance received. Covid costs scrutiny enhanced. Costs have been reducing but still remain.	RED
Financial cost pressure created by system-first decisions – Sharing of system planning gap	Additional 'stretch' management action required to reduce other costs to mitigate impact to achieve overall financial position	Achievement is incorporated into most likely forecast as reported to ELT and F&P (and system reporting)	March 2023 (Quarterly)	Governance process in train for system partners to consider and enact changes to financial plans and forecasts as of September 2022	RED
Financial cost pressure created by unfunded pay award	Additional 'stretch' management action required to reduce other costs to mitigate impact to achieve overall financial position	Achievement is incorporated into most likely forecast as reported to ELT and F&P (and system reporting)	March 2023 (Quarterly)	Pay award enacted September. Updates to forecasts will reflect actual increasing costs. Additional funding for relevant services will be explored with Local Authority	RED

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

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Strategic Objective 3 - To Make BEST use of Our Resources

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

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

Root causes:

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

BAF Ref: 22-23 3C	**Director Lead**: Vikki Taylor (DSPT)	**Responsible Committee**: Trust Board

Key Controls

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

Preventative – Governance structures in place at a system and Delivery Board level. Ongoing close communication with NHSE/I, mental health and learning disability teams at a regional and national level. Assumed NHSE/I-led appointment process to new ICS Board positions
Detective – Early meetings to be put in place with all new appointees at an executive level. Continuing engagement in all Joined up Care Derbyshire governance from DHCFT representatives. Due diligence processes undertaken prior to accepting any lead provider responsibilities
Directive – Mental Health, Learning Disability and Autism System Delivery Board to engage widely across membership on the development of any provider collaborative with agreed plans and processes. Gateway process run by NHSE prior to agreement to establish the Trust as lead-provider in any regional collaborative
Corrective – Weekly meetings of wider system transformation team to continue, providing support and advice to colleagues across the system. Regular meetings with system partners to plan and respond to risks and issues related to lead provider responsibilities

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

Key gaps in control	Key actions to close gaps in control	Impact on risk to be measured by	Expected completion date (Action review date)	Progress against action	Action on track
Maintenance of relationships with CCG/ICB colleagues during period of change and potential instability	Weekly meetings of wider MHLD system transformation team. Support and guidance provided from DHCFT Early meetings at DHCFT Board level with all new appointees into the ICB [ACTION OWNER: DSPT]	Staff turnover from wider transformational team, including CCG staff Positive working relationships formed with all new appointees in the Derbyshire system	(31.12.22)	Weekly meetings continuing ICB now formed and fully recruited to and great effort is being made on maintaining strong working relationships. However, there remains a potential risk around evolving ICB culture and impact on partnership working Emerging ICB and broader system governance ~~ICB Chair was appointed in July 2021. ICB CEO appointed in October 2021. Other executive posts now fully recruited. Three of the five full-time Executive Director posts appointed from the CCG, remaining two posts externally appointed. Chief People Officer a shared post between UHDB and ICB~~	~~AMBER~~ Changed to GREEN

				~~Non-Executive member recruitment process for the ICB now completed~~	
Plan required for the development of the Mental Health, Learning Disability and Autism System Delivery Board (MHLD SDB) to become a provider alliance	Plan to be developed in partnership with all other organisations in the alliance [ACTION OWNER: CEO]	Development and agreement of Mental Health, Learning Disability and Autism (MHLD&A) Provider Alliance before December 2021	(31.10.22)	All Boards in the Derbyshire system have agreed their support for the direction of travel for a single provider collaborative across the system and sitting below that it is explicit that there will be a MHLD&A Provider Alliance. Work is starting imminently on what that form would look like All Foundation Trusts and both Local Authorities, the Voluntary Community and Social Enterprise (VCSE), Police and Police and Crime commissioner, independent mental health providers in Derbyshire have now agreed a formal partnership agreement - Presented to Board July 2022 The ~~Alliance~~ JUCD Neurodiversity and LD Alliance Festival will be formally launched in September 2022 ~~at high profile event~~	GREEN
Increased decision-making at a system and/or provider alliance level may create conflicting accountabilities with the ~~impact on~~ Trust-level governance structures which could result in an increased governance burden ~~becoming~~	~~Review of Trust governance arrangements to be conducted in response to creation of ICS as an NHS Body with Non-Executive and Executive Director representation on the Board and the creation of a provider collaborative for Mental Health, Learning Disability and Autism~~	Board level confidence in new and emerging governance structures and ability to gain assurance on DHCFT risks and issues via system level governance regime	(31.12.22)	~~NHSE/I published ICS guidance documents and resources on 19.08.21 to support systems' transition into statutory ICBs by 01.04.22. This document summarises these resources and provides detailed~~	AMBER

~~obsolete without regular review and change~~	Keep Trust structures under continuous review against the wider governance landscape, including the provider collaboratives and alliance arrangements – This in turn may lead to a formal change of DHCFT governance arrangements [ACTION OWNER: CEO/Trust Secretary]			~~commentary on the ICB functions and governance guidance, model constitution and ICS people guidance~~ ~~A new series has been launched~~ Activity continues to help colleagues understand the ~~new~~ ICS. The CEO continues to update the Board and Council of Governors ~~updated. on the MHLD SDB. The series of engagement events with key system leaders continues during Quarter 2 and 3~~ ~~Monthly updates to Board as part of CEO reports continue~~ ~~Board/COG development session July 2022 focussed on changes to ICS and discussion about Governors' role. July 2022 session for all system NEDs to consider new working arrangements~~ The ongoing updates are contributing to our commitment to review DHCFT governance arrangements ~~DHCFT CEO has been formally appointed as partner member on ICD Board~~ ICB draft constitution approved in the inaugural ICB Board meeting in July	

				2022 ~~agreed with a go live July 2022 this will trigger relevant review of Trust governance.~~ Review of Trust governance pending subject to evolving ICB governance	

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

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

Multiple System Strategic Risk

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

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

Root causes:

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

BAF Ref: 22-23 MS1	**Director Lead**: Ade Odunlade (COO)	**Responsible Committee**: Quality and Safeguarding Committee within DHCFT Quality and Performance Committee within the Derbyshire ICS Mental health, LD and Autism Board in terms of system operational delivery

Key Controls

Inherent Risk Rating			Current Risk Rating				Target Risk Rating			Risk Appetite		
High	Likelihood 4	Impact 4	~~High~~ Changed to Moderate	Likelihood 4 ~~-3~~	Impact 4	Direction ⬌	Moderate	Likelihood 3	Impact 3	Accepted	Tolerated	Not Accepted

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Preventative – Health and safety audits; risk assessments; investment in estates development; workforce plan covering recruitment and retention. Mental Health Act Code of Practice **Detective** – CQC inspection reports; quality visit programme/virtual clinical service contact visits; incident, complaints and risk investigations; safety check log; Head of Nursing and Matron compliance visits **Directive** – Trust Strategy and commitments; Quality Improvement Strategy; Physical Health Care Strategy; Safeguarding Strategy; policies and procedures available via Trust intranet **Corrective** – Board committee structures and processes ensuring escalation of safety and quality issues; NICE Quality standards, Royal College of Psychiatrist standards for LD, CQC action plans; learning from incidents, complaints and risks; actions following clinical and compliance audits; workforce issues escalation procedures; reporting to commissioners on compliance with safety and quality standards					
Assurances on controls (internal)		**Positive assurances on controls (external)**			
Regional and national escalation process internal preparation		Advisory support provided by DHCFT to the system on bedded care standards for Learning Disability in-patient services Involvement of Local Government Association to deliver a peer review Involvement of external consultants – Two reports			
Key gaps in control	**Key actions to close gaps in control**	**Impact on risk to be measured by**	**Expected completion date (Action review date)**	**Summary of progress on action**	**Action on track**
The community Intensive Support Team and Learning Disability models require improved models of support	Review all models of support offered by the Intensive Support Team [ACTION OWNERS: COO/DON/MD]	Outcome of review – Improved models of support	~~(30.09.22)~~ (31.12.22)	Initial review taken place to bring together services in North and South under a single Area Service Manager and a deputy. Further work planned for both an operational delivery review (using activity follows and patient contact time reviews to support reducing unwarranted variation and increases productivity) and clinical delivery audit supported by NHSE national nurse lead Medical recruitment and retention is experiencing	GREEN

				stagflation – Fewer locums available, reduced applications for substantive appointments. Competitors offering inflated salaries. Full report to ELT due 07.06.22	
Improvements are required in rapidly returning patients who access Learning Disabilities and Autism (LD&A) services to local care to enable them to live their lives in the least restrictive manner as close to home as possible	Continue to work on developed delivery improvement plan, owned by system partners, to improve position. This includes new cohort stratification approach that has been developed – key action to implement and fully embed approach to ensure focussed system action on existing inpatients who are place inappropriately and out of area [ACTION OWNER: COO]	Improvement plans developed and implemented resulting in a stabilised service and positive outcomes for patients working across partner systems Enhancing and reviewing Listening and Engagement Active Partnerships (LEAP) procedures Improvement plans in admission avoidance, crisis alternatives to admission and market stimulation and development, including improvement in the use of Dynamic Support Registers as a means of admission avoidance Make significant impacts on the number of stranded patients who have delayed discharges in units across the country resulting in the NHSE escalations	~~(30.09.22)~~ (31.12.22)	Full cross-system delivery plan developed and being actively driven and monitored by revised Neurodevelopmental Delivery Board. Benefits realisation sessions being arranged Review of ways of working for Intensive Support Team as a productively drive to commence Full integrated operational pathway mapping workshops with all system partners completed and action plan to meet fidelity of optimal pathway being driven by General Manager and new system delivery manager. This is complemented by a single system delivery plan bringing together actions against all recent review outcomes/recommendations Improved oversight is in place but significant	RED

				improvement in performance and outcome is required in returning complex individuals with learning difficulties/autism and risks. Derbyshire ICS remain an outlier	
Current substantial staff vacancies are negatively impacting on safer staffing levels in a non-DHCFT Derbyshire bedded care facility	Compliance with NHS Improvement (NHSI) Workforce Safeguards requirements [ACTIONS OWNERS: COO/DON]	Full compliance with safer staffing levels in line with the NHSI Workforce Safeguards	~~(30.09.22)~~ (31.01.23)	Reviews of safer staffing and stabilisation in non-DHCFT Derbyshire bedded LD facility Part stabilisation achieved~~. Full stability will not occur until September 2022 – Appointed staff commencement dates~~ Improvements in recruitment but safer staffing data shows we are still vulnerable	AMBER
Clinical care standards in a non-DHCFT Derbyshire bedded care facility including care plans, levels of incidents, restrictive practices including the use of long-term segregation are not compliant with clinical care standards	Develop an improvement plan for all Derbyshire in-patient LD&A services [ACTION OWNERS: COO/DON)	Full compliance with required care standards External review of Long-Term Segregation and review to end restrictive practices	~~(30.09.22)~~ (31.01.23)	External review of Long-Term Segregation and review to end restrictive practices - Complete As part of LD&A alliance working with DCHS, a new clinical operational model has been mobilised, with a specific ASM for inpatient and short breaks in place This ASM is progressing an action plan to stabilise LD&A inpatient offer, which provides space and time for the longer-term approach to be worked	~~RED~~ Changed to GREEN

				through without delaying required response to challenges with this provision. Actions include: • Recruitment and stabilisation of workforce • Developing a multiagency plan for treatment and discharge of three patients • Responding to the recent CQC and Mental Health Act records review • Undertaking actions to address continuing safeguarding concerns • Support to enable restraint reduction • Address staff training requirements The Trust is working with JUCD on a strategic outline case for the future of bedded care for LD&A in Derbyshire. This is based on the principles of a clinical model where: 1. Where possible, most of the care and support is provided to people with a learning disability and / or autistic people is in the community and close to home. This	

				should be a holistic and responsive offer, built on community assets and the belief and understanding of what it means to have 'ordinary lives' 2. When specialist bedded care is absolutely needed, it is purposeful and delivered within a high quality, fit for purpose facility, that is responsive and flexible enough to meet a variety of needs, with an optimised length of stay, with commitment for continuation of appropriate support from community services throughout admission and beyond inpatient discharge 3. This specialist bedded care requires a range of options and facility types, including assessment and treatment, step down, crisis beds and – for a small number of people – specialist hospital placement options which are within Derbyshire	

				Some improvements in clinical standards Care plan work continues Some outstanding section 42 enquiry work to be completed Strategic Outline Case for the future of bedded care for LD&A in Derbyshire cleared at System Delivery Board to take into Outline Business Case	
Lack of adherence to national guidance and policy on in-patient care in a non-DHCFT Derbyshire bedded care facility	Deliver a single room en-suite delivery plan and programme of work [ACTION OWNER: COO/DON]	Delivery of approved business cases for development of single en-suite facilities, seclusion suite at specification standards and other improving the therapeutic and healing environment requirements Implementation of programme of work	~~(30.09.22)~~ (31.01.23)	Initial review and development of business plan to be undertaken, progress to reviewed Work to provide facilities that meet national standards to be completed – Expected completion date to be confirmed Single rooms, en-suite, seclusion room as outlined in MHA Code of practice	AMBER

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

Board Assurance Framework 2022-23 – Issue 3.3 Board 1 November 2022

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

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

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

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

Action Owners

CEO	Chief Executive Officer
DOF	Director of Finance
MD	Medical Director
DSPT	Director of Strategy, Partnerships and Transformation
COO	Chief Operating Officer
DON	Director of Nursing and Patient Experience
DPI	Director of People and Inclusion

Definitions

Preventative	A control that limits the possibility of an undesirable outcome
Detective	A control that identifies errors after the event
Directive	A control designed to cause or encourage a desirable event to occur
Corrective	A control to limit the scope for loss and reduce the extent of undesirable outcomes

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 1 November 2022

Revision of the Policy for engagement with the Board of Directors and Council of Governors

Purpose of Report

The Board of Directors, in consultation with the Council of Governors, approved the first version of the Policy for Engagement between the Trust Board and the Council of Governors in 2016 and it was further revised in 2019. The policy is now due for renewal and requires some minor amendments. The policy continues to reflect the current Foundation Trust Code of Governance and compliments the Trust Constitution, Standing Orders and locally agreed protocols developed by the Council of Governors, for example the process for the appointment of the Lead and Deputy Lead Governor.

Executive Summary

The policy covers a range of important areas including:

- Relationship between the Trust Board and the Council of Governors
- Handling of concerns
- Powers and duties, roles and responsibilities of the Trust Board and the Council of Governors
- Role of the Senior Independent Director
- Grounds and procedure for the removal of the Chair or a Non-Executive Director
- Dispute Resolution Procedure

The policy also encompasses those activities which we have developed within the Trust such as the joint Board/Council of Governor sessions and the 'holding to account' questions formulated at the Governance Committee and answered by the Non-Executive Directors at the Council of Governors.

The purpose of this policy is therefore to:

- Set out the systems and structures to promote a constructive working relationship between the Council of Governors and the Trust Board
- Set out a process for dealing with problems that may arise, as recommended by NHS Improvement's Code of Governance

Recommended changes highlighted in yellow in Version 3 (attached) are:

- Change of terminology to NHS England (NHSE) where appropriate.
- References to the Integrated Care System. The evolving role of the governor within the system governance is reflected in the draft 2022 Code of Governance which is awaiting adoption following the consultation that

ended in July 2022. The detail will be confirmed in the final version and within further guidance, for example the draft new Addendum to the existing guide to the duties of NHS Foundation Trust Governors covers the impact of system working on Councils of Governors. Of note however is that the statute which established the Integrated Care Systems on 1 July 2022 did not directly change the statutory duties of governors but the role of the governors within systems is likely to evolve over time and guidance is expected.

- Changes to the wording around governors asking questions at Public Board meetings. This is still an option, but governors have supported reserving that time on the Board agenda for questions from members of the public. This is on the basis that the Council of Governors meetings are also public meetings and the current process for submitting 'holding to account' questions work extremely well and demonstrates governors carrying out their statutory duties.

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

Strategic considerations and assurances

- This Policy for Engagement clarifies the respective roles and responsibilities of the Board and the Council of Governors
- This policy outlines the assurance of the Board and the Council of Governors to maintain commitment to the Nolan principles which are a foundation of our roles.

Consultation

This policy was originally developed through the Governance Committee and the revision has also been through this Committee.

Governance or Legal issues

This policy outlines the commitment by the Board of Directors and governors to developing engagement and two-way communication to carry out their respective roles effectively.

Public Sector Equality Duty and Equality Impact Risk Analysis

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

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

- The Policy includes an EIRA (Equality Impact Risk Analysis) that states that Governors are fully supported by the Trust and reasonable adjustments implemented. Governors are offered on-going support and training to ensure that they can carry out their role. This includes provision of support workers where required and working with individual governors to ensure they have access to information in a preferred format (for example, in hard copy rather than email). Governors are also supported to attend meetings where they have disability and/or access issues.

Recommendations

The Board of Directors is requested to approve the revised policy document.

Report prepared by **Justine Fitzjohn**
Trust Secretary

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

Derbyshire Healthcare NHS Foundation Trust

Policy for engagement between the Trust Board and the Council of Governors

See also:	Located in the following policy folder on the Trust Intranet
Trust Constitution	N/A – latest version is available on the NHSI website

Service area	Issue date	Issue no.	Review date	
Trust wide	November 2022	03	30 November 2025	
Ratified by	**Ratification date**	**Responsibility for review:**		
Board of Directors	1 November 2022	Board of Directors		

Document published on the Trust Intranet under: Corporate Policies and Procedures

Did you print this document?

Please be advised that the Trust discourages retention of hard copies of policies and can only guarantee that the Policy on the Trust Intranet site is the most up-to date version

ACCESSIBLE INFORMATION STANDARD

The Accessible Information Standard directs and defines a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of service users.

Ensure you have considered an agreed process for: sending out correspondence in alternative formats and appointments for patients / service users with communication needs, where this is applicable.

Making a positive difference

Checklist for Policy for engagement between the Trust Board and the Council of Governors

Summary (Plain English) Summarise the main points of the policy below in a style that is clear and easy to understand. Ensure the whole policy is written in plain English, using simple language where possible and avoiding convoluted sentences and obscure words. The resulting policy should be easy to read, understand and use.
The Policy outlines the commitment by the Board of Directors and governors to developing engagement and two-way communication to carry out their respective roles effectively.

Name / Title	Policy for Engagement between the Trust Board and the Council of Governors	
Aim of Policy	To outline the commitment by the Board of Directors and governors to developing engagement and two-way communication to carry out their respective roles effectively.	
Sponsor	Trust Secretary	
Author(s)	Trust Secretary	
Name of policy being replaced	Policy for Engagement between the Trust Board and the Council of Governors	**Version No of previous policy:** **02**

Reason for document production:	Governance best practise, requirement of Code of Governance.
Commissioning individual or group:	Trust Board and Council of Governors

Individuals or groups who have been consulted Issue 2		
Governance Committee	12 October 2022	Supported
Trust Board	1 November 2022	Approved

Version control (for minor amendments)

Date	**Author**	**Comment**
October 2019	Trust Secretary	Change from Director of Corporate Affairs and Trust Secretary to Trust Secretary Amendment to 3.4.1 to allow more flexibility on areas of focus when the Trust Board and Council of Governor meet jointly. Amendment to 3.8 to match with the changes agreed at the Council of Governors meeting in May 2019 regarding the Lead Governor and Deputy Lead Governor role.
October 2022	Trust Secretary	3 yearly review, minimal changes, references to Draft 2022 Code of Governance and Integrated System working added.

Policy for engagement between the Trust Board and Council of Governors

Table of Contents

Policy for engagement between the Trust Board and the Council of Governors

1. Introduction

The Trust Board is accountable to the community it serves and discharges that responsibility through its relationship with the Council of Governors. The Council of Governors represents the community and its major stakeholders, including staff, through elected and nominated members.

The Board leads the Trust by undertaking four key roles:

- setting strategy
- supervising the work of the executive in the delivery of the strategy and through seeking
- assurance that systems of control are robust and reliable
- setting and leading a positive culture for the board and the organisation
- giving account and answering to key stakeholders, particularly Councils of Governors.

The statutory general duties of the Council of Governors are:

- to hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors, and
- to represent the interests of the members of the corporation as a whole and the interests of the public.

The Trust Board recognises that it needs to enable the Council to hold it to account, in the first instance through the Non-Executive Directors. The Trust Board commits to consult governors on all strategic issues and material service developments before decisions are made, recognising that governor feedback enables a better informed and more effective Board.

Governors provide an important assurance role for the Trust by scrutinising the performance of the Board. The Trust Board and Council of Governors commit to work together constructively, based on openness and transparency, good communication and strong mutual understanding. They respect the different roles of each and the have common aim to work in the best interests of the organisation. The statute that established the Integrated Care Systems (ICS) on 1 July 2022 did not directly change the statutory duties of Governors but the role of the governors within systems is likely to evolve over time and guidance is expected. In the meantime. the Trust Board will continue keep governors updated on shared ICS plans, decisions and delivery that directly affect the Trust and its patients.

This policy outlines the commitment by the Board of Directors and governors to

developing engagement and two-way communication to carry out their respective roles effectively.

- The Trust Board and Council of Governors are committed to building and maintaining an open and constructive working relationship. Under-pinning such a relationship is the need for clarity on the respective roles and responsibilities.

  NHS Improvement's Code of Governance (last updated in 2014) recommends that each Foundation Trust should have a Policy for Engagement between the Trust Board and the Council of Governors, which clearly sets out how the two bodies will interact with one another for the benefit of the Trust. This is also replicated in the 2022 draft Code of Governance (the draft code), expected to be confirmed in late 2022/early 2023 following the end of the consultation period.

- This policy for engagement clarifies the respective roles and responsibilities of the Board and the Council of Governors, and describes the information flow between the two groups. The policy describes the involvement of governors in forward planning, and the role they plan in respect of holding the Trust Board to account.

- This policy for engagement also sets out a process should the governors have a concern about the performance of the Board, compliance with the licence or the welfare of the Trust. It also describes the process should the governors have significant concerns about the performance of the Chair or Non-Executive Directors.

- This policy is intended to provide clear guidance and a useful framework for both the Trust Board and Council of Governors and has been approved by each respectively.

The policy also encompasses those activities which we have developed within the Trust such as the Joint Board/Council of Governor sessions and Governor/Non-Executive Director informal sessions.

In developing this policy both the Board and the Council of Governors are keen to maintain commitment to the Nolan principles which are a foundation of our roles:

The Nolan Principles - The Seven Principles of Public Life

Selflessness
Holders of public office should take decisions solely in terms of the public interest. They should not do so in order to gain financial or other material benefits for themselves, their family, or their friends.

Integrity
Holders of public office should not place themselves under any financial or other

obligation to outside individuals or organisations that might influence them in the performance of their official duties.

Objectivity
In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit.

Accountability
Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.

Openness
Holders of public office should be as open as possible about all the decisions and actions that they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands.

Honesty
Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.

Leadership
Holders of public office should promote and support these principles by leadership and example.

2. Purpose

2.1 The Board is committed to building and maintaining an open and constructive working relationship with the Council of Governors. The Board believes that it is important that the respective powers and roles of the Trust Board and the Council of Governors are clear, and are followed in practice.

2.2 There may be times where the Council of Governors has concerns about the running of the Trust. NHS Improvement's Code of Governance recommends that the Council of Governors should establish a Policy for Engagement with the Trust Board for those circumstances when they have concerns about the performance of the Trust Board, compliance with its licence or the welfare of the Trust.

2.2 The purpose of this policy is therefore to:

- set out the systems and structures to promote a constructive working relationship between the Council of Governors and the Trust Board

- set out a process for dealing with problems that may arise, as recommended by NHS Improvement's Code of Governance.

2.3 This policy complements the Trust's arrangements for governor communication with NHS England (NHSE) (formerly NHS Improvement and before that Monitor) and the Care Quality Commission (CQC) where governors have concluded that a Trust has failed, or is failing, to act in accordance with its constitution, or Chapter 5 of the Health and Social Care Act (2006) and where it is considered that the intervention of NHSE or the Care Quality Commission may be appropriate. That is, it is the role of the Lead Governor to contact regulators in this instance.

3. Relationship between the Trust Board and the Council of Governors

3.1 Powers and Duties, Roles and Responsibilities

3.1.1 The respective powers and roles of the Trust Board and the Council of Governors are set out in their Standing Orders and the Trust Constitution.

3.1.2 The Trust Board and the Council of Governors should understand their respective roles and seek to follow them in practice. Any concerns or queries should be raised with the Chair, Trust Secretary or Lead Governor.

3.1.3 The Trust will provide induction and ongoing training regarding roles and responsibilities.

3.2 Trust Board and Council of Governors

3.2.1 In order to facilitate communication between the Trust Board and Council of Governors, governors can raise questions linked to the agenda of each public Trust Board meeting. As per established arrangements for public questions to the Trust Board, these should be submitted to Board Secretary at least 48 hours prior to the Board meeting.

3.2.2 Should a governor raise a question at the Trust Board, they will receive a response within seven working days of the meeting.

3.2.3 Governors may, by informing the Chair, request an item to be added to the agenda of the Council of Governors for discussion, or via the Governance Committee, or raise as 'any other business' at the Council of Governors meeting.

3.2.4 Governors will have the opportunity to raise questions about the affairs of the Trust with any Director present at a meeting of the Council of Governors. Wherever possible, questions should be submitted to the Chair in advance of

the meeting, to enable a reasonable time to be allocated during the meeting. Where this is not possible, a written response will be provided within seven days of the meeting. In practice governors raise formal 'holding to account' questions at Council of Governors meetings which are answered by Non-Executive Directors. These questions are formulated at Governance Committee meetings.

3.2.5 Whilst a confidential part of Board of Director meetings will be held in private the agenda from these meetings will be made available for governors, via the Lead Governor. The public Trust Board papers will be sent to governors electronically and are also available from the Trust website prior to the meeting.

3.3 Role of the Chair

3.3.1 The Chair is responsible for leadership of the Trust Board and the Council of Governors, ensuring their effectiveness on all aspects of the role and setting their agenda. The Chair is responsible for ensuring that the two groups work together effectively, and that they receive the information they require to carry out their duties.

3.3.2 In the Chair's absence meetings of the Council of Governors will be chaired by the Deputy Chair of the Trust Board.

3.3.3 The Chair will ensure that the views of governors and members are communicated to the Trust Board and that the Council of Governors is informed of key Trust Board decisions.

3.3.4 The Chair will meet with the Lead Governor and the Deputy Lead Governor, and will have 1:1 meetings with individual governors as reasonably requested.

3.4 Role of the Trust Board

3.4.1 The Trust Board will formally meet with the Council of Governors at least once a year to discuss areas of mutual benefit.

3.5 Role of Non-Executive Directors and the Senior Independent Director

3.5.1 Non-Executive Directors will be invited to attend meetings of the Council of Governors, make presentations and answer questions as appropriate.

3.5.2 Non-Executive Directors will commit time to build effective relationships with governors and governors and Non-Executive Directors will agree to spend time together to understand each other's perspectives and build good levels of mutual understanding.

3.5.2 The Senior Independent Director will be available to the Council of Governors and individual governors if they have concerns which contact through the normal channels of Chair has failed to resolve or for which such contact is inappropriate. The Senior Independent Director should attend sufficient meetings of the Council of Governors Council to listen to their views in order to help develop a balanced understanding of the issues and concerns of the governors and members.

3.5.3 The role of the Senior Independent Director is set out in Appendix B.

3.5.4 The process to be followed in dealing with concerns is set out in Section 4.

3.6 Role of Executive Directors

3.6.1 Executive Directors (including the Chief Executive or deputy) will be invited to attend Council of Governors meetings, and be asked to facilitate discussions and answer questions as appropriate.

3.7 Role of the Governors

3.7.1 Governors are required to meet the statutory duties as set out in Appendix A.

3.8 Role of the Lead Governor and Deputy Lead Governor of the Council of Governors

3.8.1 As Lead Governor:

- Act as a direct link between the governors and NHSE in situations where it would be inappropriate to go through the Chair
- Act as the point of contact between the Council of Governors and the CQC
- Prioritise agenda items for the Council of Governors and ensure action plans are followed
- In exceptional circumstances, act as deputy to the Trust Chair in situations relating to the Council of Governors when it is not appropriate for the usual Trust Deputy Chair to act into this role
- Maintain regular communication with the Chair, conducting regular reviews of the performance of the Trust
- Member of the Nominations and Remuneration Committee
- Member of the Governance Committee
- Represent concerns that governors may have (either as a body, or individually) to the Chair
- To undertake appropriate action where non-compliance or any misconduct is alleged under the Governors' Code of Conduct, as set out in the Code, which could include, together with the Chair addressing inappropriate action by any

Governor and raising the matter at the Governance Committee subject to Nominations and Remuneration Committee approval.

- Lead the appraisal process for the Council of Governors, and facilitate the Council of Governors review of effectiveness
- Maintain a close working relationship with the Senior Independent Director (SID) of the Board of Directors
- Together with the SID carry out the appraisal of the Chair
- Agree the format of regular Council of Governor/Non-Executive Director meetings
- As representative of the Trust's Council of Governors establish and maintain working relationships with Non-Executive Directors, the Board of Directors and forge links with external bodies such as CQC, ICS partners including Health and Wellbeing Boards and Council of Governors of other foundation trusts.
- Together with the Chair, mutually agree with a Governor any formal time away from the role. The Lead Governor will then provide support following return of that governor from a leave of absence.

3.8.2 Deputy Lead Governor

3.8.2.1 The Deputy Lead Governor is not a mandated role. The duties are:

- To deputise for the Lead Governor in their absence through illness or other clashing commitments

- To cover for the Lead Governor, where the Lead Governor may have a conflict of interest in taking part in an activity

- To offer support alongside the Lead Governor in maintaining working relationships with external bodies as detailed in the Lead Governor Role Description.

- To familiarise themselves with the workings of the Trust, NHSE/I and any other agencies in order to carry out their role.

3.9 Council of Governors involvement in forward planning

3.9.1 When the Trust Board is engaged in strategic planning (e.g. annual planning, strategic direction) governors will be involved in the process so that the views of members can be properly canvassed and fed into the process.

3.10 Accountability

3.10.1 The Council of Governors has a role to hold the Non-Executive Directors individually and collectively to account for the performance of the Trust Board, including ensuring the Trust Board acts so that the Trust does not breach its

licence. In order to carry out this role, the Council of Governors will be provided with high quality information that is relevant to the decisions they have to make. The information needs of the Council of Governors will be discussed as part of the induction process and subject to ongoing review, and the governors will be consulted in the planning of agendas of Council of Governors meetings.

3.10.2 The Foundation Trust Code of Governance provides that the Trust Board will notify the Council of Governors of any major new developments or changes to the Trust's financial condition, performance of its business or expectations as to its performance, that if made public would be likely to lead to a substantial change to the financial well-being, healthcare delivery performance or reputational standing of the Trust.

3.10.3 The Health & Social Care Act 2012 places a mandatory duty on the Board of Directors to consult with and seek the agreement of the Council of Governors on 'significant transactions' including mergers, acquisition, dissolution, separation, raising additional services from activities other than via its principal purpose and raising the threshold of funds raised from private patients as outlined in the Trust's Constitution.

3.10.4 The Council of Governors have the powers to call an Executive Director to the Council of Governors for the purpose of obtaining information about the Trust's performance of its functions or the Director's performance of their duties.

4. Handling of Concerns

4.1 A concern, in the meaning of this policy, must be directly related to either:

- The performance of the Trust Board, or
- Compliance with the licence, or
- The welfare of the Trust

Other matters that do not constitute a concern can be raised with the Chair to be discussed at the appropriate forum (see para 3.2.2-3.2.4).

4.2 Stage 1 – Informal

4.2.1 In the event that the Council of Governors has a concern of the type described above, every attempt should be made to resolve the matter firstly by discussion with the Chair. Where it affects financial matters, the Director of Finance should be involved. The Lead Governor should normally represent the Council of Governors in these matters, and they will consider whether additional representation is required.

4.2.2 Every attempt should be made to resolve concerns in an appropriate way, and as quickly as possible. This may involve the Chair convening a meeting with governors, and/or requesting reports from the Chief Executive, Director of Finance or another director or officer of the Trust, or a report from the Audit and Risk Committee or other committee, and providing comments on any proposed remedial action.

4.2.3 The outcome of the matter will be reported to the next formal meeting of the Council of Governors, who will consider whether the matter has been resolved satisfactorily.

4.3 Stage 2 – Formal

4.3.1 This is the formal stage where stage 1 has failed to produce a resolution and the services of an independent person are required. In this case the Senior Independent Director assumes the role of mediator, as recommended by the Code of Governance, and conducts an investigation.

4.3.2 The decision to proceed to Stage 2 and beyond will always be considered by the full Council of Governors, at an extraordinary, private meeting. This is to ensure that any decision is a collective Council of Governors decision. The decision to proceed to Stage 2 must be collectively agreed by a majority of the Council of Governors present at a meeting which is quorate. In the event that the Council of Governors does not agree to proceed to Stage 2, that decision is final.

4.3.3 Evidence requirements

Any concern should be supported by relevant evidence. It cannot be based on hearsay alone, and should meet the following criteria:

- Any written statement must be from an identifiable person(s) who must sign the statement and be willing to be interviewed under either stage of this process.
- Other documentation must originate from a bona fide organisation and the source must be clearly identifiable. Newspaper articles will not be accepted as prima facie evidence but may be admitted as supporting evidence.
- Where the concern includes hearsay, e.g. media reports, the Council of Governors may require the Trust Board to provide explanations and, if necessary, evidence to show that the hearsay reports are untrue.

4.3.4 Investigation and Decision of the Senior Independent Director.

4.3.4.1 The Senior Independent Director's role is to seek to resolve the matter in the best interests of the Trust.

4.3.4.2 The Senior Independent Director will produce a written report of their findings and recommendations and present it to the Council of Governors and Trust Board. The report will address the issues raised by the Council of Governors, and will also consider whether action is required to repair any breakdown in the relationship between the Trust Board and the Council of Governors.

4.3.4.3 The decision of the Senior Independent Director will be final in resolving the matter in the best interests of the Trust.

4.3.4.4 In the event that the Council of Governors' remain dissatisfied with the Senior Independent Director's decision, the options in paragraph 3.4 may be considered.

4.4 Action in event of Stage 2 failing to achieve resolution

4.4.1 If the Council of Governors does not consider that the matter has been adequately resolved, they have four options:

- Accept the failure to reach a resolution of the matter and consider the matter closed; or
- Seek the intervention of another independent mediator (i.e. a Chair or Senior Independent Director from another NHS Foundation Trust) in order to seek resolution of the matter, or
- Inform NHS Improvement if the Trust is at risk of breaching its licence.
- Follow the Dispute Resolution Procedure (as outlined at Appendix D).

4.5 Removal of the Chair or any Non-Executive Director

4.5.1 In relation to concerns raised in accordance with this policy, the Council of Governors should only exercise its power to remove the Chair or any Non-Executive Directors after exhausting all other means of engagement with the Trust Board.

4.5.2 The procedure for removing the Chair or a Non-Executive Director is set out in Appendix C.

Appendix A: Powers and duties of the Trust Board and the Council of Governors

Trust Board:	**Council of Governors:**
All the powers of the Trust are to be exercised by the Trust Board. The Trust Board may do anything which appears to it to be necessary or desirable for the purposes of or in connection with the functions of the Trust, subject to any restrictions in its licence. The powers of the Trust Board include, but are not limited to, the ability to borrow and invest money, acquire and dispose of property, enter into contracts, accept gifts of property (including property to be held on Trust for the purposes of the Foundation Trust or for any purposes relating to the health service), and employ staff.	The Council of Governors cannot veto decisions made by the Trust Board.
The Trust Board must submit forward planning information and annual reports and accounts to NHSE/I, after consulting with the Council of Governors and having regard to their views.	The Council of Governors is to be consulted on forward planning by the Trust Board, and the Trust Board must have regard to their views.
The Trust Board will present the annual report and accounts and the auditors report to the Council of Governors and will lay a copy of the annual accounts, and any report of the auditor on them before Parliament, and once it has done so, send copies of these documents to NHS Improvement, along with the annual report.	The Council of Governors is to be presented with the annual report and accounts and the report of the auditor on them, at a general meeting of the Council of Governors.
It is for the Non-Executive Directors to appoint and remove the Chief Executive. The appointment of the Chief Executive (by the Non-Executive Directors) requires the approval of the Council of Governors.	The Council of Governors is to approve the appointment of the Chief Executive by the Non-Executive Directors. The appointment requires the approval of a majority of the Council of Governors.

Trust Board:	Council of Governors:
It is for a committee consisting of the Chair, the Chief Executive and the other Non-Executive Directors to appoint or remove the Executive Directors	The Council of Governors is to appoint the chair and other Non-Executive Directors of the NHS Foundation Trust at a general meeting of the Council of Governors. The appointment requires the approval of a majority of the members of the Council of Governors. If the Council of Governors is to remove the Chair or Non-Executive Directors of the NHS Foundation Trust, such removal must occur at a general meeting of the Council of Governors and it requires the approval of three quarters of the members of the Council of Governors.
The Trust Board must establish a committee of Non-Executive Directors to decide the remuneration and allowances, and the other terms and conditions of office, of the Chief Executive and other Executive Directors	The Council of Governors is to decide the remuneration and allowances, and the other terms and conditions of office, of the Non-Executive Directors. The decision requires the approval of a majority of the members of the Council of Governors.
The Trust Board must establish a committee of Non-Executive Directors to act as an Audit Committee	The Council of Governors is to appoint or remove the external auditor at a general meeting of the Council of Governors. The appointment and removal requires the approval of a majority of the members of the Council of Governors.

Trust Board:	Council of Governors:
Provide active leadership of the Trust within a framework of prudent and effective controls which enable risk to be assessed and managed.	Represent the interests of the Trust's members and partner organisations in the local health economy. The 2022 draft Code of Governance sets out that the governors' duty to represent the interests of the public includes the population of the local system of which the trust is part and the whole population of England as served by the wider NHS. This is subject to being adopted within the new code when published.
Set the Trust's strategic aims, taking into consideration the views of the Council of Governors, ensuring that the financial and staffing resources are in place for the Trust to meet its objectives, and review management performance.	Regularly feedback information about the Trust, its vision and its performance to the constituencies and the stakeholder organisations that either elected or appointed them.
Ensure compliance by the Trust with its licence, its Constitution, mandatory guidance issued by regulators, relevant statutory requirements and contractual obligations.	Act in the best interests of the Trust and adhere to its values and governor Code of Conduct.
Ensure the quality and safety of healthcare services, education, training and research delivered by the Trust and apply the principles and standards of clinical governance set out by relevant NHS bodies.	Hold the Non-Executive Directors individually and collectively to account for the performance of the Trust Board including ensuring the Trust Board acts so that the Trust does not breach its licence.
Ensure that adequate systems and processes are maintained to measure and monitor the Trust's effectiveness, efficiency and economy as well as the quality of its healthcare delivery.	Acknowledge the overall responsibility of the Trust Board for running the Trust and should not try to use the powers of the Council of Governors to veto decisions of the Trust Board.
Regularly review the performance of the Trust in these areas against regulatory requirements and approved plans and objectives.	Establish a policy for engagement with the Trust Board for those circumstances when they have concerns about the performance of the Trust Board, compliance with its licence or the welfare of the Trust.

Trust Board:	Council of Governors:
Establish the values and standards of conduct for the Trust and its staff in accordance with NHS values and accepted standards of behaviour in public life, and operate a Code of Conduct that builds on the values of the Trust and reflects high standards of probity and responsibility.	Inform the Independent Regulator if the Trust is at risk of breaching its licence if these concerns cannot be resolved at a local level.
Ensure that there is a formal, rigorous and transparent procedure for the appointment or election of new members to the Trust Board, and satisfy itself that plans are in place for orderly succession of appointments to the Trust Board so as to maintain an appropriate balance of skills and experience within the Trust and on the Trust Board, and ensure planned and progressive refreshing of the Trust Board.	Agree a process for the evaluation of the Chair and the Non-Executive Directors, with the Chair and the Non-Executive Directors, and agree the outcomes of the evaluations.
Present a balanced and understandable assessment of the Trust's position and prospects.	Agree with the Audit and Risk Committee of the Trust Board the criteria for appointing, reappointing and removing external auditors.
Maintain a sound system of internal control to safeguard public and private investment, the Trust's assets, patient safety and service quality.	Work with the Trust Board on such other matters for the benefit of the Trust as may be agreed between them.
Establish formal and transparent arrangements for considering how they should apply the financial reporting and internal control principles and for maintaining an appropriate relationship with the Trust's auditors.	Assess its own collective performance and its impact on the Trust, and communicate this to the members of the Trust.
Consult and involve members, patients, clients and the local community, and monitor how representative the Trust's membership is and the level of effectiveness of member engagement.	Liaise with members via membership emails and publications. When appropriate hold meetings with members, which could include constituency meetings to ensure Member's interests are represented and Trust information is fed back.

Trust Board:	Council of Governors:
Ensure that the Trust co-operates with other NHS bodies, local authorities and other relevant organisations with an interest in the local health economy.	The 2022 draft Code of Governance suggests that the Council of Governors may look at the nature of the Trust's "collaboration with system partners" as an indicator of organisational performance. This is subject to being adopted within the new code when published.
Work with the Council of Governors on such other matters for the benefit of the Trust as may be agreed between them.	Raise issues and matters for discussion: Contact Chair/Membership and Involvement Manager to identify an appropriate forum and to submit items for meetings, eg • Request items to be included in the Council of Governors (or Governance Committee) agenda or raise matters under Any Other Business • Raise formal questions for response by the Trust Board • Ask questions of the Chief Executive at Council of Governors meetings.
Follow the principles of openness and transparency in its proceedings and decision making unless this conflicts with a need to protect the wider interests of the public or the Trust (including commercial in confidence matters) and make clear how potential conflicts of interests are dealt with.	
Undertake a formal and rigorous annual evaluation of its own performance and that of its committees and individual directors.	

Appendix B: Role of the Senior Independent Director

The Senior Independent Director (SID) will be a Non-Executive Director of the Trust Board.

The SID's role will be

- To be available to the Trust Directors if they have concerns which cannot be resolved through the normal channels (or is inappropriate) of the Chair or Chief Executive.

- To support the Chair in resolving disputes between individual Trust Board members in respect of their role as a director of the Trust.

In respect of the Council of Governors

- To be available to members and governors if they have concerns which cannot be resolved through the normal channels (or is inappropriate) of the Chair or Chief Executive. To maintain sufficient contact with governors to understand their issues and concerns, including building an effective relationship with the Lead Governor.

- To help resolving disagreements between the Council of Governors and Trust Board in accordance with the policy setting out the approach to be taken in these circumstances

- To agree a process for evaluating the performance of the Chair and to agree appropriate processes for reporting such evaluation annually to the governor Nominations and Remuneration Committee.

- To work with the Chair to establish a policy for engagement of the Council of Governors with the Trust Board.

APPENDIX C: Grounds and Procedure for the Removal of the Chair or any Non-Executive Director

Introduction

The Council of Governors has the power to remove the Chair and any Non-Executive Director of the Trust. Such removal must occur at a general meeting of the Council of Governors and requires the approval of three quarters of the members of the Council of Governors.

In relation to concerns raised under the Policy for Engagement, the Council of Governors should only exercise its power to remove a Non-Executive Director after exhausting all other means of engagement with the Trust Board, as set out in that policy.

Grounds for removal

The removal of a Non-Executive Director should be based on the following criteria. Grounds for removal can include the following:

a) they are not qualified, or are disqualified, from becoming or continuing as a Non-Executive Director under the Constitution
b) they have failed to attend meetings of the Trust Board for a period of six months
c) they have failed to discharge his/her duties as a Non-Executive Director
d) they have knowingly or recklessly made a false declaration for any purpose provided for under the Constitution or in the 2006 Act
e) they have knowingly or recklessly failed to declare a conflict of interest
f) their continuing as a Non-Executive Director would be likely to:
    I. prejudice the ability of the Trust to fulfil its principal purpose or other of its purposes under the Constitution or otherwise to discharge its duties or functions
    II. harm the Trust's work with other persons or bodies with whom it is engaged or may be engaged in the provisions of goods or services
    III. adversely affect public confidence in the goods and services provided by the Trust; or otherwise bring the Trust into disrepute
g) they have failed or refused to comply with the regulatory framework, the Standing Orders, or any Code of Conduct which the Trust shall have published from time to time
h) they have refused without reasonable cause to undertake any training which the Trust requires all Non-Executive Directors to undertake
i) they purport to represent the views of any professional body, political party or trade union of which he is a member
j) it is not in the interests of the Trust for the Non-Executive Director to continue to hold office
k) they do not meet the criteria as outlined in the Trust Fit and Proper Persons Test policy.

The following list provides examples of matters which may indicate to the Council of Governors that it is no longer in the interests of the Trust that a Non-Executive Director continues in office. The list is not intended to be exhaustive or definitive; the Council of Governors will consider each case on its merits, taking account of all relevant factors.

a) If an annual appraisal or sequence of appraisals is unsatisfactory
b) If the Non-Executive Director loses the confidence of the Trust Board
c) If the Non-Executive Director loses the confidence of the public or local community in a substantial way
d) If the Non-Executive Director fails to monitor the performance of the Trust in an effective way
e) If the Non-Executive Director fails to deliver work against pre- agreed targets incorporated within their annual objectives
f) If there is a terminal breakdown in essential relationships, e.g. between a Chair and a Chief Executive or between a Non-Executive Director and the Chair or the rest of the Trust Board.

Procedure

a) Any proposal to remove a Non-Executive Director can be proposed by a Council member, the Chair, or the Trust Board.
b) The Non-Executive Director will be notified in writing of the allegations, and be invited to submit a response.
c) The Non-Executive Director is entitled to address the Council of Governors at the meeting considering the proposal to remove him/her.
d) The Trust Board may make representations to the Council of Governors whether they are for, or against the resolution, or even if they are divided.
e) The Council of Governors may consider any relevant evidence, e.g. appraisal documentation or witness statements.
f) The Council of Governors should take professional advice, via the Trust Secretary, prior to removing a Non-Executive Director.
g) In relation to concerns raised in accordance with the Policy for Engagement, the Council of Governors should only exercise its power to remove a Non-Executive Director after exhausting all other means of engagement with the Trust Board.

Chair of meetings

The Chair may normally express an opinion on the appointment and removal of a Non-Executive Director, but does not have formal voting rights at the Council of Governors in a vote to remove the Non-Executive Director.

The Chair should also consider, however, whether in particular circumstances a conflict of interest arises in dealing with the removal of a Non-Executive Director, and if so, stand aside for that part of the meeting.

For the removal of the Chair, the Senior Independent Director will preside at meetings of the Council of Governors.

Removal and disqualification of governors

The process for the removal and disqualification of governors is covered in Annex 5 of the Trust's constitution.

Appendix D: Dispute Resolution Procedure

In the event of dispute between the Council of Governors and the Trust Board, where the above policy has been followed as appropriate through informal (Stage 1) and formal (Stage 2) procedures at outlined at 4.2 and 4.3, the dispute resolution procedure can be considered as a further option should Stage 2 procedures fail to achieve a resolution:

1. In the first instance the Chair on the advice of the Trust Secretary, and such other advice as the Chair may see fit to obtain, shall seek to resolve the dispute.

2. If the Chair is unable to resolve the dispute he shall appoint a special committee comprising equal numbers of Directors and Governors to consider the circumstances and to make recommendations to the Council of Governors and the Board of Directors with a view to resolving the dispute.

3. If the recommendations (if any) of the special committee are unsuccessful in resolving the dispute, the Chair may refer the dispute back to the Trust Board who shall make the final decision.

REGARDS EIRA: Assessing Equality Relevance (Stage 1)

1. Name of the service / policy / project or proposal (give a brief description):

Policy for Engagement between the Trust Board and the Council of Governors The policy was first developed in 2016 incorporating best practice and comments from governors through the Governance Committee. The Council of Governors supported the first version on 6 September and it was approved by the Board of Directors at its meeting on 5 October 2016. It will be reviewed at three year intervals.

2. Answer the questions in the table below to determine equality relevance:
Governors are fully supported by the Trust and reasonable adjustments implemented. Governors are offered on-going support and training to ensure that they can carry out their role. This includes provision of support workers where required and working with individual governors to ensure they have access to information in a preferred format (for example, in hard copy rather than email). Governors are also supported to attend meetings where they have disability and/or access issues.

	Yes	No	Insufficient data / info to determine
Does the project / proposal affect service users, employees or the wider community, and potentially have a significant effect in terms of equality?		x	
Is it a major project / proposal, significantly affecting how functions are delivered in terms of equality?		x	
Will the project / proposal have a significant effect on how other organisations operate in terms of equality?	x		See note above
Does the decision/ proposal relate to functions that previous engagement has identified as being important to particular protected groups?	x		See note above
Does or could the decision / proposal affect different protected groups differently?		x	
Does it relate to an area with known inequalities?	x		

Does it relate to an area where equality objectives have been set by our organisation?			

3. On a scale of high, medium or low assess the policy in terms of equality relevance.

	Tick below:	Notes:
High		If ticked all 'Yes' or 'Insufficient data'
Medium	Yes	If ticked some 'Yes' and / or 'Insufficient data' and some 'No'
Low		If ticked all 'No'

EIRA completed by: Trust Secretary
Date: Oct 2022

Derbyshire Healthcare
NHS Foundation Trust

Board Committee Assurance Summary Reports to Trust Board – 1 November 2022

The following summaries cover the meetings that have been held since the last public Board meeting held on 6 September 2022 and are received for information:

- Quality and Safeguarding Committee 13 September and 11 October
- Mental Health Act Committee 16 September and 10 June
- People and Culture Committee 20 September
- Finance and Performance Committee 27 September
- Audit and Risk Committee 13 October

Quality and Safeguarding Committee - key items discussed 13 September 2022
Summary of Board Assurance Framework (BAF) Risks The Committee reviewed BAF risk 1a *"There is a risk that the Trust will fail to provide standards for safety and effectiveness as required by our patients and our Board"* it has oversight of in the context of discussions and the current work programmes. A new pharmacy software system risk has been linked to Risk 1a as the risk relates to pharmacy service provision and patient safety *"There is a risk that the Trust's increasing dependence on digital technology for the delivery of care and operations increases the Trust's exposure to the impact of a major outage, i.e. cyber-attack, equipment failure".* Multiple System Risk Strategic risk MS1 *"There is a risk to safe, effective clinical care across Derbyshire impacting upon patients, due to not achieving national standards and variation of clinical practice and service commissioning in the Learning Disability (LD) Transforming Care Partnership and in ICS in-patient LD bedded care"* remains under the oversight of this Committee.
New Mental Health Act Bill Discussion took place on the Committee's accountability for the anticipated amendments to the new Mental Health Act that (MHA) that are expected to be introduced next year. The Quality and Safeguarding Committee (QSC) is accountable for quality and safety issues concerned with culture, and practices. Work associated with implementing the new MHA will be taken through the Mental Health Act Committee (MHAC) . The People and Culture Committee (PCC) will have oversight of training delivery of the new MHA. MHAC will be required to keep this QSC and PCC briefed on the preparation required for these changes. There are plans to commence an MHA Quality Improvement (QI) programme that will be piloted within a number of mental health trusts. QSC confirmed its interest in potentially becoming a pilot site programme related to the MHA amendments. This decision would however be made by MHAC.

Serious Incidents (SIs) Bi-Monthly Report

Various themes arising from SIs have been taken through engagement meetings with operational managers across the county. The results of this work will be the subject of a further report showing results of investigations and plan of action.

The report provided significant assurance from the learning gained from SIs with limited assurance in terms of investigations being completed in a timely way due to the specific gap in control being the medical contribution to investigations. Significant assurance was also taken from the framework, assessment and process of SIs despite gaps in control with medical engagement in completing investigations.

Safeguarding Children Assurance Report

The report highlighted the continued increase in family and domestic violence in city and rural areas. The number of children on a protection plan is high and increasing work continues around referrals that do not meet the threshold.

The school nursing service is experiencing a large amount of resource issues in terms of vacancies and sickness. In addition school nurses are spending so much time on safeguarding issues that it prevents them from performing their role as a public health/school nurse. This risk is being reviewed by the Safeguarding Board.

The Committee received significant assurance around Safeguarding Children activity, systems and controls within the Trust and acknowledged the demand on capacity and performance management of the safeguarding team.

Safeguarding Adults Assurance Report

Adult Safeguarding performance, including training, Mental Capacity Act performance, Person in Position of Trust (PiPoT) and Multi-Agency Safeguarding Hub (MASH) performance was reviewed. Excellent feedback was noted from the recent independent Safeguarding Assessment and Analysis Framework (SAAF) which provided assurance to the Committee that the Trust is fulfilling its statutory and legislative duties.

The Committee took full assurance that all Safeguarding Adults statutory duties are being met. Limited assurance was received with training compliance levels.

Safeguarding Children and Adults at Risk Annual Report

The annual production of this report is a governance requirement of both the Trust and the Safeguarding Children Partnership and Adult Safeguarding Boards. It provided full assurance that the Trust is meeting its legal and statutory performance and governance requirements in a consistent and reliable manner. No undue concerns were raised by the Committee.

The Committee received significant assurance from the report and approved the report for submission to the Board on 1 November.

Looked After Children Annual Report

This report provided an overview of the progress, challenges, opportunities and future plans to support and improve the health and wellbeing of looked after children in Derby City. The positive clinical outcomes and significant performance were noted.

Significant assurance was taken from the work of the Trust in discharging its formal statutory duties to vulnerable children. The key priorities and action plans for 2022/23 were agreed. Approval was given for the report to be submitted to the Board on 1 November to provide the Board with assurance on how this service is discharging its legal duties and clinical standards requirements.

Report on Sexual Safety and Trauma

The Committee noted the Trust's active work to promote best practice in sexual safety as a quality priority and viewed a training video put together by the Clinical Professional Leadership and the Safeguarding teams that will guide staff on this incredibly difficult and delicate area of practice.

Risk Register Escalation Assurance Quarterly Report

The report highlighted the high level risks aligned with quality and safeguarding at an operational level rather than a BAF level and evidenced how risks have been identified and the stable management of risk reporting. There are currently no gaps in control.

The Committee was significantly assured that the number of high/extreme risks identified by operational services remain stable. Significant assurance was also received with the risk management and reporting strategy and delivery of risk management training.

Model commissioned for Hyper-Activity Attention Deficit Disorder services outside of Derbyshire

The report outlined the new way of working to address the lack of Attention Deficit Hyperactivity Disorder (ADHD) services within Derbyshire and address waiting lists across Neurodevelopmental and Autism Spectrum Disorder (ASD) diagnostic service. This is a clinic-based approach, with a 'specialist bank' of clinicians, providing initial assessments and diagnosis with a focus on initiation and stabilisation of pharmacological treatment. The new approach involves Voluntary Community and Social Enterprise stakeholders and will provide both pre and post diagnostic 360° service treating people more quickly.

The Committee fully supported the mobilisation of the new model and considered this a creative way of bringing resource together from the Trust and the voluntary sector.

Status of outstanding CQC actions.

As of September 2022 there are ten outstanding actions and all are classed as overdue. All actions for 2018 have been completed. Outstanding actions remain from the 2019 inspections of the Acute Wards Report (one action), the Inspection Report (six actions), September 2020 inspection (three actions).

It was noted that the action relating to mandatory training cannot be signed off until compliance reaches a target of 75%. Agreement was reached on the need for more determination and progress to ensure minimum standards are met to address the residual outstanding CQC actions.

Quality Performance Dashboard

No concerns were noted with SIs. Although seclusion has increased the team have a tight grip and report specific case variations to the Mental Health Act Committee. The increase in the level of poverty is expected to increase the demand on services. A watching brief is being kept on falls. Although there are reductions in acute out of area placements, patients out of area in Psychiatric Intensive Care Units (PICU) remain high which is due to there being no PICU in Derbyshire until the NHS Derbyshire PICU build is fully funded. There is still work to do on medically fit for discharge. Bed occupancy needs to be under better control to improve quality metrics.

Board Assurance Framework – key risks identified: None
Escalations to Board or other committees: None
Next Meeting – 11 October 2022

Committee Chair: Dr Sheila Newport	**Executive Lead: Carolyn Green, Deputy Chief Executive and Chief Nurse**

Quality and Safeguarding Committee - key items discussed 11 October 2022

Summary of Board Assurance Framework (BAF) Risks

The Committee reviewed BAF risk 1a *"There is a risk that the Trust will fail to provide standards for safety and effectiveness as required by our patients and our Board"* it has oversight of in the context of discussions and the current work programmes.

The Committee is also responsible for oversight of the Multiple System Strategic risk MS1 *"There is a risk to safe, effective clinical care across Derbyshire impacting upon patients, due to not achieving national standards and variation of clinical practice and service commissioning in the Learning Disability (LD) Transforming Care Partnership and in ICS in-patient LD bedded care."*

Research and Development (R&D) Annual Report for 2021/22

A high level of assurance was obtained from the work of R&D team. The Committee considered that although the R&D portfolio and quality improvement (QI) were separate, both should be fully embedded within clinical audit.

Significant assurance was obtained from the controls and systems associated with research governance. 2022/23 plans are to continue to build on the progress achieved for recovery, resilience and growth in research.

Status of outstanding CQC Actions

There remain ten actions outstanding. Three relate to sustained compliance with care planning documentation, and five relate to training. The final action relates to governance process which will be closed once all other actions are completed. To move forward and complete these actions the Governance and Compliance Coordinator is meeting regularly with GMs and the Clinical Operations Team to progress these. Action is being taken to address lower areas of compliance.

The People and Culture Committee is monitoring the work being carried out to ensure there is enough capacity to deliver training especially in terms of compliance against CQC action areas relating to training.

Patient Experience Quarterly Report

This report sets out the themes and changes made to Trust services as a result of feedback on incidents and complaints made to the Patient and Carer Experience Committee.

Overall good governance is in place. Compliments and general positive attitude were recorded as high which is an encouraging indication of compassionate, person-centred, satisfactory care.

After robust discussion the Committee concluded that significant assurance could be taken from the report because systems for collecting information are in place but there are some areas for improvement.

Learning From Deaths / Mortality Report

This report detailed reportable deaths that occurred during the period 31 May to 31 July 2022.

The Committee was assured that appreciative learning and governance processes are fully embedded across the Trust. The Committee accepted the Mortality Report as assurance of the Trust's approach and agreed for the report to be considered by the Board of Directors and then published on the Trust's website as per national guidance.

Report from the Guardian of Safe Working

This report from the Guardian of Safe Working provided data about the number of Junior Doctors in training in the Trust, full transition to the 2016 Junior Doctor contract and any issues arising therefrom.

The report set out the arrangements in place to identify, quantify and remedy any risks to the organisation. The contents of the report were noted as assurance of the Trust's approach in discharging its statutory duties regarding safe working for medical trainees and the report was recommended for submission to the Board on 1 November.

Quality Visit process

The report summarised progress to date and outlined the relaunch for Season 11 plans over 2022/23 and included a summary of teams booked into visits and panel members approached to attend.

The current quality visit system ensures the Trust adheres to the expectations of commissioners in the Schedule 4 Quality Contract and provided significant assurance as to the quality visit process.

Care and Care Programme Approach [CPA] Policy and Procedure

The revised policy was reviewed. The Committee was satisfied with the revisions and ratified the policy in the interim until further national guidance is received.

Board Assurance Framework – key risks identified: None
Escalations to Board or other committees: None
Next Meeting: 8 November 2022

Committee Chair: Lynn Andrews on behalf of Dr Sheila Newport	**Executive Lead: Carolyn Green, Deputy Chief Executive and Chief Nurse**

Mental Health Act Committee - key items discussed 10 June 2022
Mental Health Act (MHA) Report The report covered the analysis and assessment of the Mental Health Act Office activity for the 12 month rolling period focusing on 1 January 2022 – 31 March 2022. Actions arising from CQC reports on Mental Health Act 1983 monitoring visits were being worked through. Overall the report gave significant assurance but the Committee noted the increase in seclusion and asked for assurance that this will be closely monitored and also stated that complacency should not set in when there are nil variations in certain areas and that a review should be undertaken.
Update on Mental Health legislation The Committee understood that the main aim of the new legislation is to have fewer detentions. Guidance has been issued to consultants that would enable them to make themselves more available for Mental Health Act Assessments which help avoid detentions and has also discussed this at the Trust Medical Advisory Committee.
Liberty Protection Safeguards and update on status of Code of Practice The Liberty Protection Safeguards (LPS) draft code of practice was out for consultation and the Trust would be co-ordinating a response. Identification of internal assessors is required, and the suggestion is to have a pool for this.
Reducing Restrictive Practice, Restraint And Seclusion and update on status of Code of Practice An update report was given on the progress made regarding implementation of the Positive and Safe Strategy. The focus was on visual and supportive observation and reducing restrictive practice.
Six monthly complaints report from patients detained under the Mental Health Act The report showed a comparison of complaints received during Quarter 3 and 4 of 2021/22 as well as complaints received regarding people on a Section of the Mental Health Act 1983.
Update on use of Section 136 suites/Section 135/136 The Committee noted the joint working in that there are monthly working groups with the Police, Social Care, and the helpline and that the Trust had some of the lowest rates for using Section 136. The figures showed that the intervention of the helpline has been able to decrease detentions.
Qualitative case review of different ethnic groups nursed in seclusion The Committee welcomed Khushbu Zia, currently a CTT Trainee in Psychiatry who shared her research “the Mirror and the Light” . She felt that some issues had improved since the project has completed around 2 years ago. It was a service evaluation project on the detention of patients from a BAME background under the Mental Health Act, the findings were also available on the Royal College website.
Training Compliance The report provided an update on compliance for Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) in the Trust February – April 2022. MCA/DoLS total compliance was 82.01% against a target of 90%. Other training rates have lower compliance rates and a range of initiatives are in place to improve performance.

Update from Associate Hospital Managers

Associate Hospital Managers gave a verbal update on their activities. Thy reported back from a contested hearing in April. Associate Hospital Managers asked or training once the new Mental Health Act was in force and this was agreed.

Any Other Business:

The Committee agreed that trainees could attend the committee as observers to assist in their development we are developing multi-professional clinicians.

John Sykes, retiring Medical Director was thanked for his significant contributions to the Trust and particularly for his work with the Committee.

Escalations to Board or other Committee(s): None
Next Meeting: 16 December 2022

Committee Chair: Ashiedu Joel	**Executive Lead: John Sykes, Medical Director**

Mental Health Act Committee - key items discussed 16 September 2022

Mental Health Act (MHA) Report

The report covered the analysis and assessment of the Mental Health Act Office activity for the 12 month rolling period focusing on 1 April – 30 June 2022. Some data issues had been picked up following the migration over to the new electronic patient record system. There had been an increase in Deprivation of Liberty Safeguards (DoLS) referrals which was being investigated. The data contained in the report was comprehensively reviewed and provided significant assurance that the safeguards of the MHA have been appropriately applied within the Trust.

Mental Health Act Bill

The Committee received a brief following the publication of the draft Mental Health Act Bill. It is anticipated the Bill will be introduced into Parliament in 2023. The brief concentrated on the new statutory requirements which will require investment in infrastructure especially the Mental Health Act Office and clinical time including administrative support.

Liberty Protection Safeguards and update on status of Code of Practice

The Trust's response to the Liberty Protection Safeguards consultation was noted.

Update on use of Section 136 suites/Section 135/136

A Deep Dive report into the use of Section 136 suites/Section 135/136 Nov 2021- August 2022 was presented. The Committee noted the link to the Joint Policy for Derbyshire on the Operation of Section 136 of the Mental Health Act 1983 Policy and Procedures, which is currently under review. The patient leaflet for those admitted to the 136 Suite had been revised.

Training Compliance

The report provided an update on compliance for Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) in the Trust May – July 2022. MCA/DoLS total compliance was 85.91% against a target of 90%. Other training rates have lower compliance rates and a range of initiatives are in place to improve performance.

Update from Associate Hospital Managers Associate Hospital Managers gave a verbal update on their activities. There have been no issues with either contested or uncontested hearings. The Committee also approved the renewal of the Associate Hospital Managers' Hearing Policy and Procedure.	
Escalations to Board or other Committee(s): None **Next Meeting:** 16 December 2022	
Committee Chair: Ashiedu Joel	**Executive Lead: Arun Chidambaram, Medical Director**

People and Culture Committee - key items discussed 20 September 2022

Summary of BAF Risks

The Committee reviewed BAF risk 2a it has oversight of in the context of discussions and the current work programmes. *"There is a risk that we do not sustain a healthy vibrant culture and conditions to make Derbyshire Healthcare Foundation Trust (DHCFT) a place where people want to work, thrive and to grow their careers."*

People and Inclusion Assurance Dashboard

The dashboard continues to show the position of the organisation in recovery from the response to the COVID-19 pandemic.

The data was noted with discussion centred around the processes developed for supervision and the need for the divide between managerial and clinical to be examined to ensure optimum efficiency of supervision.

Mandatory Training Compliance

The report provided an update on training compliance and action being taken to support staff to achieve and maintain training compliance.

A considerable amount of work has been carried out to ensure there is enough capacity to deliver training especially in terms of compliance against CQC action areas relating to training.

All appropriate actions are in place to enable colleagues to attend their training. However there are still issues with Positive and Safe and Immediate Life Support (ILS) training compliance levels. Current plans have a trajectory to hit target in November and if this is not achieved this will be looked at again to consider further options with design.

Significant assurance was received on the progress being made against the plans in place to increase compliance for key training with overall limited due to the lack of compliance against Positive and Safe training and ILS Level 3.

New approach to Mandatory Training

Staff training over a number of years has continued to be an area of poor performance. This is a high risk area for the Trust as the performance level consistently falls below the required target levels. The report set out the proposed new direction where the responsibility for training is jointly shared by staff and the organisation and ensures protected time for training.

Robust discussion took place as to how training expectations have been made clear to managers and staff while still upholding the Trust's people first values and maintaining performance improvement measures. The direct link was recognised between training performance and development objectives that are discussed during appraisals.

The Committee noted the step change to the way that mandatory training is managed and saw the benefit of the proposed approach.

Workforce Race Equality Standard / Workforce Disability Equality Standard Reports

Workforce Race Equality Standard (WRES) / Workforce Disability Equality Standard (WDES) reports and action planning processes were received prior to retrospective sign off by the Board.

Key findings from the 2021/22 WRES showcased areas where the Trust has improved and where further work is required. This year a more engaging process is taking place with the BME network.

The Committee endorsed the further engagement with the BME Network to develop a detailed action plan around the Phase One Strategic Priorities 2022/23. The WRES will be submitted to

the Trust Board for ratification in November. Publication of the report will be placed on the Trust's public-facing website and shared with commissioners.

The WDES submission identifies the experiences of the Trust's Disabled colleagues in comparison with their non-disabled counterparts. The 2022 data has shown some areas of improvement. Although disability declaration rates have increased they are not yet at the desired rate. Work will therefore take place to establish why colleagues are not disclosing their disabilities to ensure they are supported and feel comfortable to disclose any disabilities. A brief will be produced for managers that will set the expectations for senior managers/leaders and support them in dealing with issues.

The Committee approved further engagement with the Disability and Wellness Network (DAWN) Staff Network around the Phase1 action plan for 2022/23 prior to submission of the final full report and action plan to the Trust Board for ratification in November and publication on the public-facing website and sharing with commissioners.

Derbyshire Healthcare planned approach to talent and leadership

The report set out the specific priorities that will enhance the existing infrastructure and create the right conditions for effective talent management, ensuring appropriate systems, processes and support are in place that will measure success and link with Trust's aspirations around diversity.

The Committee considered the proposed approach to talent management and leadership a great initiative that demonstrates the Trust's putting people first principle. Significant assurance was obtained from the talent management strategy . Limited assurance was obtained from the current status of the implementation plan as it has not yet been finalised.

Strategic Priorities for People

The strategic people priorities have been developed by the Senior People and Inclusion team. The delivery of these plans will be within the context of the developing system infrastructure as well as through University Hospitals of Derby and Burton (UHDB) and Derbyshire Community Health Services NHS Foundation Trust (DCHS) where the majority of the People teams sit.

The People Strategy supports the building block of being a great place to work as well as being the main focus of our governance process. It also informs the action plans being delivered across the Trust. In addition to the national strategy there are priorities that will be dealt with internally by the Trust as a specialist organisation.

The Committee received significant assurance from the strategic priorities for people and acknowledged that this comprehensive plan will strengthen the Trust's overall objective to be a great place to work.

Staff Survey update

The 2022 staff survey will be launched on 26 September. This report covered areas of focus as well as the preparations being made for the 2023 survey.

The Trust received a high response rate to the previous staff survey and had reached the finals for the HR Professional Body awards (Chartered Institute of Personnel and Development) on staff engagement. This achievement was seen as an endorsement of the Trust's people first approach. It will be vital to maintain this good performance and identify further areas for improvement.

Full assurance was received from the preparation and plans for the launch of the 2022 NHS National Staff Survey.

Deep dive into recruitment challenges

This included a detailed overview of the strategic recruitment priorities at national, system and organisational level and the challenges facing clinical teams in recruiting to roles that previously had been hard to fill.

A staff story from a senior nurse from Morton Ward on the Hartington Unit described how a partnering approach was developed to address the issues faced when competing against the private sector and attractive packages being offered to students. The story also outlined how working with the recruitment lead had transformed the strategy for attracting applicants by making the process less cumbersome.

Full assurance was received from the innovative, collaborative and inclusive approach which has transformed the recruitment process to recruitment. The new approach being taken is now more inclusive and focusses more on the applicant's experience and has successfully attracted people into the organisation.

Escalations to Board or other committees:

- The WRES and WDES submissions to be submitted to the Board on 1 November 2022.
- The Quality and Safeguarding Committee would be notified of the action being taken to improve mandatory training compliance.

Board Assurance Framework – key risks identified: None
Next Meeting: 30 November 2022

Committee Chair: Ralph Knibbs	**Executive Lead: Jaki Lowe, Director of People and Inclusion**

Finance and Performance Committee - key items discussed 27 September 2022

Making Room for Dignity (MRfD) assurance on Estate Strategy

Success noted – full NHSE national approval of the adult acute unit new build Full Business Cases. The delayed receipt of approval created additional cost and time pressure impacts. Inflation and non-concurrent build affordability issues for Psychiatric Intensive Care Unit (PICU) project. VAT abatement outcome awaited. Funding sources still required for the remainder of the programme. National dormitory eradication programme affected in same way as ours due to hyperinflation. PICU funding requirements are separate to dormitory eradication.

The diversion of Trust cash and the knock-on risk for wider capital requirements such as estate and IM&T strategy delivery and risk mitigation. Continued efforts to source any additional funding remains crucial.

The Committee noted the key risks associated with the programme and the next steps and critical action. Received limited assurance on the progress of the programme to date and the risks associated with it. Approved the declaration of the gardeners shed at Kingsway as surplus.

OnEPR assurance update

Work continues to resolve the issues with some clinical, national and strategic reporting. Collaborative approach. 12 of 44 issues remain expected to be completed at end of September. Risk to completion is capacity. Standard Operating Procedures compliance is improving but is a key priority to embed consistent adherence across teams. Post implementation lessons learned exercise completed and themes shared with Digital Clinical Board.

Progress to date was noted along with the actions underway to resolve the reporting issues identified. Limited assurance was received on the progress of the programme to date and the risks associated with it.

Information Technology and Records Strategy 2021-2026 update

Progress over last six months across five themes, access, efficient processes, agile workforce, Business Intelligence and Underpinning technology. Main issues highlighted relate to technical and cultural aspects post-EPR transition. High level of organisational demands for IM&T teams. In-house and outsourced delivery blend and system collaboration for future discussion.

Operational Performance

Performance to end of July 2022. Reporting issues affecting measurement across a number of key areas. Waiting lists and future management of waiting list as discussed at Quality Committee. Waiting well approach and crisis support. Developing pool of resources to deploy. Improvement in psychology vacancy levels. Out of area levels and Mill lodge discussions progressing, noting winter capacity requirements and alignment with financial forecasts of related costs. Performance summits taking place. Wider divisional reviews with recovery action planning also taking place. Recruitment levels have improved, generally.

TCP proposal and update and LDA transition

TUPE agreement successfully completed 1 August 2022. Alliance working well in partnership. Committee in Common DCHS/DHCFT first meeting held. Increased admissions with highest number of neurodevelopment patients in beds which led to surge escalation planning which was implemented successfully. Geography and treatment stratification sets the priority patient cohorts. Independent Provider hospital closures continue to create pressure and risks for vulnerable patients.

Business Environments update

Progress with Perinatal Lead provider programme of work. Interim Business Case submitted to NHSE. Operational go live expected 1 October. Contract go live expected April 2023. Financial envelope information awaited. Standard Operating Procedures development. East Midlands IMPACT provider collaborative for adult low and medium secure services progress update noted following its first two years.

Financial plan update

Month 5 position reported against the breakeven plan. Month 5 adverse variance to plan of £0.9m, mainly driven by the unmet CIP at that date. Ongoing known financial risks of increasing temporary staffing costs particularly agency, unmet efficiency requirements and covid costs continue. Regional Quarterly Performance Meeting outlier status. This month additional cost pressures relating to unfunded pay award and system 'stretch' target have been assumed. The next update of the Board Assurance Framework will reflect these new risks.

Committee expressed concern related to the adverse movement of financial risk and may call an additional F&P Committee meeting depending on feedback from Executives Leadership Team.

Future reporting to include run rate review of progress to enable credibility and confidence testing of remedial financial gap closure plans.

National Cost Collection Submission related to 2021/22

Oversight of process and checks. Patient Level Information Costing System (PLICS) development update. Activity issues required some adjustments. Quantum of costs reconciles to audited accounts. Compliance with Approved Cost Guidance and standards. Submission uploaded 4 August signed off by Director of Finance.

Continuous Improvement update

Progress of Quality Improvement capability training and introductory work. AQuA programme. Training uptake slower than expected. LifeQI continues to grow with 102 users. Derbyshire ePMO is in use. CIP target for 2022/23 of £6m has a gap of circa £2m of schemes identified to date but with a requirement for circa £4m saving recurrently. Timing lag noted between scheme identification, validation and transaction into financial forecasting. Committee also noted the forward work underway for 2023/24.

Board Assurance Framework 2022/23 overview

The Committee has three risks, two of which are extreme. Following discussion with the Trust Secretary it is proposed that the extreme risk deep dives do go to Audit and Risk Committee in January. The moderate risk does not require deep dive. Next iteration of Finance risk on BAF will reflect the two new elements of in-year revenue financial risk (unfunded pay award and system 'stretch' contribution).

Escalations to Board or other Committees: None
Board Assurance Framework: – key risks identified: None
Next scheduled meeting: 24 November 2022

Committee Chair: Tony Edwards	**Executive Lead: Claire Wright, Director of Finance**

Audit and Risk Committee – key items discussed 13 October 2022

Board Assurance Framework (BAF) Issue 3, 2022/23

Issue 3 of the BAF for 2022/23 reflected the scrutiny of each lead executive and work allocated to the relevant Board Committees. The most significant change had been the re-write of the ' Great Place To Work' risks. The Committee agreed to receive the deep dive into the two finance extreme risks at its January 2023, should they still be extreme. The Committee also requested a review of the individual risk ratings relating to dormitory eradication within 'GREAT CARE' Risk 1b linked to fact that the outcome of the national additional funding bid was still awaited. The Committee approved the BAF for submission to the Board for approval on 1 November. Any amendments coming through Board Committees in next few weeks will be circulated separately.

Operational Risk Reporting Plan

The reporting plan would provide assurance of the effectiveness of the risk management processes and Datix record keeping in reference to the internal audit recommendations. There was an additional report on risk management which highlighted the challenges in training risk owners and users in the Datix system but a training plan was in place.

Risk Management Strategy 2019 – 2022 progress update and strategy refresh

The report set out progress against the main objectives set within the current strategy as well as presenting the new 2023 – 2025 strategy that would come into force on 1 January 2023. Significant assurance was obtained from the progress made against the current strategy and the revised Risk Management Strategy was approved.

Review of 2021/22 Annual Report and Accounts Production

A review of the production of the 2021/22 Annual Report and Accounts concluded that the process went well, with leads for each section working effectively together in order to ensure statutory requirements were met. Some areas of learning have been identified and will be taken forwards for the development of the report for 2022/23.

Freedom to Speak Up Update Report

The six-monthly report on the implementation of the Trust's Freedom to Speak Up (FTSU) policy framework evidenced the positive reaction to FTSU, especially at staff induction.

Significant assurance was obtained from the adequacy of the Trust's arrangements by which Trust staff may, in confidence, speak up about possible improprieties in matters of financial reporting and control and related matters or any other matters of concern.

Progress report on 2022/23 Audit and Risk Committee Objectives

The Committee confirmed it was satisfied with the progress made against its 2022/23 objectives.

Data Security and Protection Report

This report included an update on the completion of the 2021-22 Data Security and Protection (DS&P) Toolkit and current progress towards meeting the new requirements of the 2022-23 DS&P Toolkit. The Trust had a very successful 2021/22 DS&P year with standards met for the toolkit submission, including achievement of the minimum 95% training compliance target. The Committee noted the substantial assurance and high confidence from our internal auditors in this work. The Data Security and Protection Committee was keen to acknowledge the service and support from John Sykes and Claire Wright, who would be retiring from their roles and had both been instrumental and key contributors to the Trust's successful DS&P team.

Healthcare Financial Management Association self-assessment audit update

NHS England requires the above checklist to be reviewed by Executive Directors and signed off by the Chief Executive prior to submission to internal auditors. The Committee received an update on progress and noted that Internal Auditors will issue their final report by 30 November 2022, which are nationally set timescales.

Update report on Conflicts of Interest and Declarations includes Gifts and Hospitality reporting

This update was made to the Committee on the Trust's interest return for Decision Making Staff which at 132 was higher than in previous years and provided significant assurance that the Declaration of Interest Policy is implemented in respect of Decision Making Staff and is generating appropriate responses from those who hold that position. The Committee also noted that the return rate for private clinical practice and secondary employment and gifts were back to pre-pandemic levels. There had been one declaration of hospitality which had been assessed as having no impact on any Trust operations or financial expenditure.

Internal Audit update

Since the last meeting in July the Trust's Internal Auditor, 360 Assurance have issued a review of e-rostering, completed the stage one work against the Head of Internal Audit Opinion, completed the fieldwork on the sickness absence review and agreed terms of reference for two further reviews. Outstanding actions were still being chased with the action owners.

Counter Fraud update

Progress was given made in relation to completion of work from the Trust's Counter Fraud, Bribery and Corruption Plan. This included detail on the proactive work and how this relates to the Trust's past and projected future Counter Fraud Functional
Standard Return (CFFSR) scores, as well as giving summary information about allegations and investigations. Significant assurance was received that alerts and fraud warning intelligence have been appropriately communicated to the Trust.

External Audit briefing on mini budget 2022

The Trust's External Auditors, Mazars provided the above briefing for information and also gave assurance that they have resource in place to ensure reporting timelines are met.

Escalations to Board or other Committees: None
Next scheduled meeting: 26 January 2023

Committee Chair: Geoff Lewins	**Executive Lead: Justine Fitzjohn, Trust 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
ADHD	Attention Deficit Hyperactivity Disorder
AfC	Agenda for Change
AHP	Allied Health Professional
AIMS	Royal College of Psychiatrists Accreditation for Inpatient Mental Health Services Standards
ALB	Arms-length body such as NHS Improvement (NHSI) and NHS England (NHSE)
AMM	Annual Members' Meeting
AMHP	Approved Mental Health Professional
ANP	Advanced Nurse Practitioner
AO	Accountable Officer
ASD	Autism Spectrum Disorder
ASM	Area Service Manager
B	
BAF	Board Assurance Framework
BLS	Basic Life Support (ILS Immediate Life Support)
BMA	British Medical Association
BME	Black,& Minority Ethnic group
BoD	Board of Directors
C	
CAMHS	Child and Adolescent Mental Health Services
CASSH	Care and Support Specialised Housing
CBT	Cognitive Behavioural Therapy
CCG	Clinical Commissioning Group (defunct from 1 July 2022)
CCT	Community Care Team
CDMI	Clinical Digital Maturity Index
CE	Chief Executive
CEO	Chief Executive Officer
CGA	Comprehensive Geriatric Assessment
CHPPD	Care Hours Per Patient Day
CIP	Cost Improvement Programme
CMDG	Contract Management Delivery Group
CMHF	Community Mental Health Framework
CMHT	Community Mental Health Team
CNST	Clinical Negligence Scheme for Trusts
COAT	Clinical Operational Assurance Team
COF	Commissioning Outcomes Framework
CoG	Council of Governors
COO	Chief Operating Officer
CPA	Care Programme Approach
CPD	Continuing Professional Development
CPN	Community Psychiatric Nurse
CPR	Child Protection Register

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Term / Abbreviation	**Terms in Full**
CQC	Care Quality Commission
CQI	Clinical Quality Indicator
CQUIN	Commissioning for Quality and Innovation
CRG	Clinical Reference Group
CRH	Chesterfield Royal Hospital
CRHT	Crisis resolution and home treatment
CRS	(NHS) Care Records Service
CRS	Commissioner Requested Services
CSF	Commissioner Sustainability Fund
CTO	Community Treatment Order
CTR	Care and Treatment Review
D	
DAT	Drug Action Team
Datix	Trust's electronic incident reporting system of an event that causes a loss, injury or a near miss to a patient, staff or others
DBS	Disclosure and Barring Service
DBT	Dialectical Behavioural Therapy
DfE	Department for Education
DCHS	Derbyshire Community Health Services NHS Foundation Trust
DDCCG	Derby and Derbyshire Clinical Commissioning Group
DHCFT	Derbyshire Healthcare NHS Foundation Trust
DIT	Dynamic Interpersonal Therapy
DNA	Did Not Attend
DoH	Department of Health
DoLS	Deprivation of Liberty Safeguards
DSPT	Director of Strategy, Partnerships and Transformation
DOF	Director of Finance
DON	Director of Nursing
DPI	Director of People and Inclusion
DPS	Date Protection and Security
DNA	Did not attend
DPA	Data Protection Act
DRRT	Dementia Rapid Response Team
DTOC	Delayed Transfer of Care
DVA	Derbyshire Voluntary Action (formerly North Derbyshire Voluntary Action)
DWP	Department for Work and Pensions
E	
ECT	Enhanced Care Team
ECW	Enhanced Care Ward
ED	Emergency Department
EDS2	Equality Delivery System 2
EHIC	European Health Insurance Card
EHR	Electronic Health Record
EI	Early Intervention
EIA	Equality Impact Assessment
EIP	Early Intervention In Psychosis
ELT	Executive Leadership Team
EMDR	Eye Movement Desensitising & Reprocessing Therapy

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Term / Abbreviation	**Terms in Full**
EMR	Electronic Medical Record
EPR	Electronic Patient Record
ERIC	Estates Return Information Collection
ESR	Electronic Staff Record
EUPD	Emotionally Unstable Personality Disorder
EWTD	European Working Time Directive
F	
FBC	Full Business Case
FFT	Friends and Family Test
FOI	Freedom of Information
FSR	Full Service Record
FT	Foundation Trust
FTE	Full-time Equivalent
FTN	Foundation Trust Network
FTSU	Freedom to Speak Up
FTSUG	Freedom to Speak Up Guardian
F&P	Finance and Performance
5YFV	Five Year Forward View
G	
GDPR	General Data Protection Regulation
GGI	Good Governance Institute
GIRFT	Getting it Right First Time
GMC	General Medical Council
GP	General Practitioner
GPFV	General Practice Forward View
H	
HCA	Healthcare Assistant
H1	First half of a fiscal year (April through September)
H2	Second half of a fiscal year (October through the following March)
HEE	Health Education England
HES	Hospital Episode Statistics
HoNOS	Health of the Nation Outcome Scores
HSCIC	Health and Social Care Information Centre
HSE	Health and Safety Executive
HWB	Health and Wellbeing Board
I	
IAPT	Improving Access to Psychological Therapies
ICB	Integrated Care Board
ICM	Insertable Cardiac Monitor
ICS	Integrated Care System
ICT	Information and Communication Technology
ICU	Intensive Care Unit
IDVAs	Independent Domestic Violence Advisors
IG	Information Governance
ILS	Immediate Life Support (BLS – Basic Life Support)
IMT	Incident Management Team
IM&T	Information Management and Technology
OOA	Outside of Area

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Term / Abbreviation	**Terms in Full**
IPP	Imprisonment for Public Protection
IPR	Integrated Performance Report
IPT	Interpersonal Psychotherapy
J	
JNCC	Joint Negotiating Consultative Committee
JTAI	Joint Targeted Area Inspections
JUCB	Joined Up Care Board
JUCD	Joined Up Care Derbyshire
K	
KLOE	Key Lines of Enquiry (CQC)
KPI	Key Performance Indicator
KSF	Knowledge and Skills Framework
L	
LA	Local Authority
LCFS	Local Counter Fraud Specialist
LD	Learning Disabilities
LD/A	Learning Disability and Autism
LHP	Local Health Plan
LHWB	Local Health and Wellbeing Board
LOS	Length of Stay
LPS	Liberty Protection Safeguards
LTP	Long Term Plan
M	
MADE	Multi-agency Discharge Event
MARS	Mutually Agreed Resignation Scheme
MAU	Medical Assessment Unit
MAS	Memory Assessment Service
MAPPA	Multi-agency Public Protection Arrangements
MARAC	Multi-agency Risk Assessment Conference (meeting where information is shared on the highest risk domestic abuse cases between representatives of local police, probation, health, child protection, housing practitioners, Independent Domestic Violence Advisors (IDVAs) and other specialists from the statutory and voluntary sectors.
MASH	Multi-Agency Safeguarding Hub
MCA	Mental Capacity Act
MD	Medical Director
MDA	Medical Device Alert
MDM	Multi-Disciplinary Meeting
MDT	Multi-Disciplinary Team
MFF	Market Forces Factor
MHA	Mental Health Act
MHAC	Mental Health Act Committee
MHIN	Mental Health Intelligence Network
MHIS	Mental Health Investment Standard
MHLT	Mental Health Liaison Team
MHRT	Mental Health Review Tribunal
MSC	Medical Staff Committee

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Term / Abbreviation	**Terms in Full**
MSK	Musculoskeletal (conditions)
MSU	Medium secure unit
N	
NCRS	National Cancer Registration Service
NED	Non-Executive Director
NICE	National Institute for Health and Care Excellence
NHS	National Health Service
NHSE	National Health Service England
NHSI	National Health Service Improvement
NHSEI	NHS England and NHS Improvement
NIHR	National Institute for Health Research
O	
OBC	Outline Business Case
ODG	Operational Delivery Group
OPMO	Older People's Mental Health Services
OP	Outpatient
OSC	Overview and Scrutiny Committee
OT	Occupational therapy
P	
PAB	Programme Assurance Board
PAG	Programme Advisory Group
PALS	Patient Advice and Liaison Service
PAM	Payment Activity Matrix
PARC	Psychosis and the reduction of cannabis (and other drugs)
PARIS	This is an electronic patient record system
PbR	Payment by Results
PCC	Police & Crime Commissioner
PCC	People and Culture Committee
PCN	Primary Care Networks
PDSA	Plan, Do, Study, Act
PHE	Public Health England
PICU	Psychiatric Intensive Care Unit
PID	Project Initiation Document
PiPoT	People in Positions of Trust
PLIC	Patient Level Information Costs
PMLD	Profound and Multiple Disability
PPE	Personal Protection Equipment
PPI	Patient and Public Involvement
PPT	Partnership and Pathway Team
PREM	Patient Reported Experience Measure
PROMS	Patient Reported Outcome Measure
PSF	Provider Sustainability Fund
PSIRF	Patient Safety Incident Review Framework
Q	
QAG	Quality Assurance Group
Q&SC	Quality and Safeguarding Committee
QIA	Quality Impact Assessment
QIPP	Quality, Innovation, Productivity Programme

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Term / Abbreviation	**Terms in Full**
R	
RAID	Rapid Assessment, Interface and Discharge
RCGP	Royal College of General Practitioners
RCI	Reference Cost Index
REGARDS	Race, Economic disadvantage, Gender, Age, Religion or belief, Disability and Sexual orientation
RTT	Referral to Treatment
S	
SAAF	Safeguarding Adults Assurance Framework
SBARD	Situation, Background, Assessment, Recommendation and Decision (SBARD) tool
SBS	Shared Business Services
SEND	Special Educational Needs and Disabilities
SFI	Standing Financial Instructions
SI	Serious Incidents
SID	Senior Independent Director
SIRI	Serious Incident Requiring Investigation
SLA	Service Level Agreement
SLR	Service Line Reporting
SMI	Severe Mental Illness
SOC	Strategic Options Case
SOF	Single Operating Framework
SPOA	Single Point of Access
SPOE	Single Point of Entry
SPOR	Single Point of Referral
STEIS	Strategic Executive Information System
STF	Sustainability and Transformation Fund
STP	Sustainability and Transformation Partnership
SUI	Serious (Untoward) Incident
SystmOne	Electronic patient record system
T	
TARN	Trauma Audit and Research Network
TCP	Transforming Care Partnerships
TCS	Transforming Community Services
TDA	Trust Development Authority
TMT	Trust Management Team
TUPE	Transfer of Undertakings (Protection of Employment) Regulations 1981
TMAC	Trust Medical Advisory Committee
TOOL	Trust Operational Oversight Leadership (replaced IMT)
U	
UDBH	University Hospitals of Derby and Burton
UEC	Urgent and emergency care
V	
VARM)	Vulnerable Adult Risk Management
VO	Vertical Observatory
W	

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Term / Abbreviation	**Terms in Full**
WDES	Workforce Disability Equality Standard
WRES	Workforce Race Equality Standard
WTE	Whole Time Equivalent
Y	
YTD	Year to Date

(updated 14 June 2022)

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 6 September 2022

Report from the Council of Governors meeting

The Council of Governors has met one since the last report, on 6 September 2022. Following national guidance on keeping people safe during COVID-19 and the need for social distance, the meetings were conducted digitally via Microsoft Teams.

Chief Executive update

The Deputy Chief Executive provided governors with an update on the current situation regarding the COVID-19 pandemic; performance improvement; financial sustainability; Care Quality Commission forthcoming Inspection; system working; and winter pressure expectations.

Presentation of the Annual Report and Accounts 2021/22 and report from the External Auditors

Claire Wright, Director of Finance presented a summary on the financial performance of the Trust during 2021/22. Mazars, the Trust's External Auditors, delivered a presentation on the Trust's Annual Audit Letter, summarising the key findings of the audit.

Non-Executive Directors Deep Dive (including annual report of the Audit And Risk Committee)

Geoff Lewins, as Chair of the Audit and Risk Committee, presented the Deep Dive, which included the annual report of the Audit and Risk Committee, to governors.

Sheila Newport, clinical NED, Chair of the Quality and Safeguarding Committee (since February 2022) and Deputy Trust Chair (since July 2022) presented her Deep Dive to governors.

Escalation of items to the Council of Governors

One item of escalation was received from the Governance Committee meeting held 9 August:

Governors want to seek assurance around the implications of leadership changes and any potential impact these changes will have on the impending Care Quality Commission Inspection.

The response was tabled at the meeting.

Verbal Summary Integrated Performance Report

The Integrated Performance Report (IPR) was presented to the Council of Governors to provide an overview of the performance of the Trust. The NEDs reported on how the report had been used to hold Executive Directors to account in their respective Board Committees for areas with regards to workforce, finance, operational delivery and quality performance.

Annual Members Meeting (AMM) update

The Membership and Involvement Manager provided an update was given on the plans for the AMM including promotion and details of the programme.

Governance Committee Report

The Committee Chair presented a report of the meetings held on 8 June and 9 August 2022. The report included: a review of the Committee's terms of reference; the process for the Governors Annual Effectiveness Survey; an update on the Trust Quality Visits; discussion around the Strategy refresh.

Governors noted that the Committee's terms of reference remain fit for purpose.

Review of the Governors' Membership Engagement Action Plan

The Membership and Involvement Manager provided the Committee with an update on the Governors' Membership Engagement Action Plan, which was developed to increase engagement with members and to promote the governor role. It was noted that governors are elected to represent their local communities and the Action Plan has been developed to increase engagement with members and to promote the governor role.

RECOMMENDATION

The Trust Board is asked to note the summary report from the Council of Governors meeting held on 6 September 2022.

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 1 November 2022

Register of Trust Sealings

Purpose of Report

This report provides the Trust Board with a six month update of the authorised use of the Trust Seal since the last report to the Board on 10 May 2022.

Executive Summary

The Trust's Standing Financial Instructions (point 8.18) state that every contract which exceeds £500,000 shall be executed under the Common seal of the Trust and be signed by the Trust Secretary and an Executive Director (voting or non-voting) duly authorised by the Chief Executive and not from the originating department.

These transactions will apply where the Board has previously approved the business through the Capital Expenditure Plan or the Estates Strategy. In accordance with the Standing Orders of the Board (section 12 point 6) a report of all sealing shall be made to the Trust Board twice a year. The report will contain details of the seal number, the description of the document and date of sealing. The register will be retained by the Trust Secretary.

A report on use of the seal was last made to the Board on10 May. Since the last report, the Trust Seal was used as follows (where the contract value for these transactions exceeded £500,000 or where the nature of the transaction required a seal, ordinarily property transactions such as deeds or leases)

- DHCFT80: P22 Consultants Appointment for cost management and NEC3 project management services
- DHCFT81: Belper Developments Limited contract for extension at The Beeches
- DHCFT82: Stage 3 Contact P22 PICU 14 bed unit at Kingsway Hospital (Integrated Health Projects)
- DHCFT83: Stage 3 Contract P22 Southern Derbyshire Adult Acute Unit 54 bed unit at Kingsway Hospital (Integrated Health Projects)
- DHCFT84: Stage 3 Contract P22 Northern Derbyshire Adult Acute Unit 54 bed unit at Chesterfield Royal Hospital (Integrated Health Projects)
- DHCFT85: Deed of Release relating to an overage agreement affecting a property previously known as Bramble House, Kingsway, Derby
- DHCFT86: Lease of Units 13, 14 and 15 Rinkway Business Park, Swadlincote, Derbyshire.

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

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

Assurances

Use of the Trust Seal has been undertaken in accordance with the Standing Financial Instructions and Standing Orders of the Board of Directors.

Consultation

N/A

Governance or Legal Issues

The affixing of the seal is consistent with the Board's responsibilities outlined within the Standing Financial Instructions and Standing Orders of the Board of Directors.

Public Sector Equality Duty and Equality Impact Risk Analysis

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

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

Recommendations

The Board of Directors is requested to note the authorised use of the Trust Seal since May 2022 and receive full assurance that this has been undertaken in accordance with the Standing Financial Instructions and Standing Orders of the Board of Directors.

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

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

2022-23 Board Annual Forward Plan

Exec Lead	Meeting date	10 May 22	5 Jul 22	6 Sep 22	1 Nov 22	17 Jan 23	7 Mar 23
	Paper deadline	**25 Apr**	**27 Jun**	**29 Aug**	**24 Oct**	**9 Jan**	**27 Feb**
Trust Sec	Declaration of Interests	X	X	X	X	X	X
DON	Patient/Staff Story	X	X	X	X	X	X
CHAIR	Minutes/Matters arising/Action Matrix	X	X	X	X	X	X
CHAIR	Board review of effectiveness of meeting	X	X	X	X	X	X
CHAIR	Board Forward Plan (for information)	X	X	X	X	X	X
CHAIR	Summary of Council of Governors meeting (for information)	X	X		X	X	X
CHAIR	Chair's Update	X	X	X	X	X	X
CEO	Chief Executive's Update	X	X	X	X	X	X
STRATEGIC PLANNING AND CORPORATE GOVERNANCE							
DPI	Staff Survey Results	X					
DPI	Annual Gender Pay Gap Report for approval						X
DPI	Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) request for Board delegated authority for People and Culture Committee meeting on 20 September to approve the October submissions			X			
DPI	Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) Strategic implications/retrospective sign off after PCC on 20 September				X		
DPI	Workforce Plan for 2022/23			X			
DPI	2022/23 Flu Campaign			X			
Trust Sec	NHS Improvement Year-End Self-Certification	X					
Trust Sec	Year-end governance reporting from Board Committees and approval of ToRs	X					
Trust Sec	Corporate Governance Report	X					
Trust Sec	Review SOs, SFIs, SoD plus review/ratify SFI Policy (as Policy Review section below)						Amendment SFI
Trust Sec	Trust Sealings (six monthly - for information)	X			X		
Trust Sec	Annual Review of Register of Interests	X					
Trust Sec	Board Assurance Framework Update	X		X	X		X
Trust Sec	Freedom to Speak Up Guardian Report (six monthly)			X			X
Trust Chair	Fit and Proper Person Declaration		X				
Trust Sec	Annual Approval of Modern Slavery Statement	X					
Committee Chairs	Board Committee Assurance Summaries	X	X	X	X	X	X
OPERATIONAL PERFORMANCE							
DON/DOF/ DPI/COO	Integrated performance and activity report to include Finance, People, performance and Quality Dashboard	X	X	X	X	X	X
DPI	Equality Diversity and Inclusion (EDI) update				X		
COO	Emergency Preparedness, Resilience and Response (EPRR) Core Standards			X			
DON/COO/ DPI	Workforce Standards Formal Submission/Safer Staffing (prior to publishing on website)	X					

2022-23 Board Annual Forward Plan

Exec Lead	Meeting date	10 May 22	5 Jul 22	6 Sep 22	1 Nov 22	17 Jan 23	7 Mar 23
QUALITY GOVERNANCE							
EXEC	Position Statement - focus on CQC domains (Well Led CQC & NHSI) as per schedule - Use of Resources (DOF) deferred to April 2023	Caring DON	Well Led Trust Sec	Safe MD		Responsive COO	Effective DON MD & DPI
MD	Learning from Deaths Mortality report (quarterly publication) (Jul/Nov/Jan/Mar)	AR	X		X	X	X
MD	Guardian of Safe Working Report		X		X	AR	X
DON	Infection Prevention and Control Annual Report and BAF					AR	
MD	Re-validation of Doctors Compliance Statement		X				
MD	Draft Mental Health Bill			X			
DON	Receipt of Annual Reports: - Annual Looked After Children - Safeguarding Children and Adults at Risk				AR AR		
DON	Outcome of Patient Stories - every two years - next due March 2024						
POLICY REVIEW							
COO	Emergency Incident Response Plan and Procedures prior to expiry 01/10/2022			X			
Trust Sec	Policy for Engagement between the Board of Directors and the CoG				X		
DOF/ Trust Sec	Standing Finance Instructions Policy and Procedures Review						X
Trust Sec	Fit and Proper Person Policy prior to expiry 31/03/2023						X