Derbyshire Healthcare NHS Foundation Trust

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

	TIME	AGENDA	LED BY
1.	9:30	Chair's welcome, opening remarks, apologies and declarations of interest	Selina Ullah
PATIENT STORY			
2.	9.35	Team Story "ASD Assessment Services"	Kyri Gregoriou
STANDING ITEMS			
3.	10.00	Minutes of the Board of Directors meeting held on 16 January 2024	Selina Ullah
4.		Matters arising – Action Matrix	
5.		Questions from members of the public	
6.	10.05	Chair's update	Selina Ullah
7.	10.15	Chief Executive's update	Mark Powell
STRATEGY, PERFORMANCE AND RISK			
8.	10.25	Integrated Performance report to include Finance, People Performance and Quality 25/30 minutes	Lee Doyle/David Tucker/Kyri Gregoriou/Rebecca Oakley/James Sabin
9.	10.50	Strategy Update – Quarter 3, 2023/24	Vikki Ashton Taylor
10.	10.55	Continuous Quality Improvement: A Stocktake	Vikki Ashton Taylor
11.	11.00	Staff Survey	Rebecca Oakley
12.	11.05	Outcome of Patient Stories	Kyri Gregoriou/ Joe Thompson
13.	11.10	Position Statement focussing on CQC domains - Effective	Kyri Gregoriou /Arun Chidambaram/ Rebecca Oakley
11:20 BREAK			
GOVERNANCE AND COMPLIANCE			
14.	11.30	Board Assurance Framework update	Justine Fitzjohn
15.	11.40	Freedom to Speak Up Guardian Report (six monthly)	Tam Howard
BOARD COMMITTEE ASSURANCE			
16.	11.55	Board Committee Assurance Summaries (meetings held during January and February 2024)	Committee Chairs
REPORTS FOR NOTING ON ASSURANCE FROM BOARD COMMITTEES			
17.	12.20	Quality and Safeguarding Committee: • Learning from Deaths Mortality report	Arun Chidambaram
CLOSING BUSINESS			
18.	12.25	Identification of issues arising for inclusion or updating in the BAF	Selina Ullah
19.		Meeting effectiveness	
FOR INFORMATION			
Glossary of NHS Acronyms 2024/25 Forward Plan			

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

The next meeting will be held at 9.30am on 7 May 2024 in Conference Rooms A&B, Centre for Research and Development, Kingsway. Arrangements will be notified on the Trust website 7 days in advance of the meeting.

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

Our vision

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

Our values

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

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

DECLARATION OF INTERESTS REGISTER – CURRENT BOARD MEMBERS- MARCH 2024		
NAME	INTEREST DISCLOSED	TYPE
Lynn Andrews Non-Executive Director	• Trustee for Ashgate Hospice in Chesterfield	(e)
Vikki Ashton Taylor Director of Strategy, Partnerships and Transformation	• Magistrate covering mainly Derbyshire and Nottinghamshire Courts	(e)
Tony Edwards Deputy Trust Chair	• Independent Member of Governing Council, University of Derby	(a)
Deborah Good Non-Executive Director	• Trustee of Artcore – Derby • Director of Craftcore Derby	(e) (e)
Ashiedu Joel Non-Executive Director	• Director, Ashioma Consults Ltd • Director, Peter Joel & Associates Ltd • Director, The Bridge East Midlands • Director, Together Leicester • Lay Member, University of Sheffield Governing Council • Fellow, Society for Leadership Fellows Windsor Castle • Elected Member, Leicester City Council	(a) (a) (a) (a) (a) (a) (a)
Ralph Knibbs Senior Independent Director	• Vice Chair, RFU Diversity & Inclusion Implementation Group, England Rugby Football Union (voluntary position) - ended June 2023. • Head of HR, UK Athletics (employed position). • Founding member and Steering Group Member, The Rugby Black List (voluntary position). • Trustee of Star* Scheme Charity (voluntary position) - from December 2023.	(e) (e) (e) (e)
Geoff Lewins Non-Executive Director	• Director, Arkwright Society Ltd • Director, Cromford Mill Limited (wholly owned trading subsidiary of Arkwright Society)	(a) (a)
Mark Powell Chief Executive	• Treasurer, Derby Athletic Club	(d) (e)
James Sabin Director of Finance	• Spouse works at Sheffield Health & Social Care NHS Foundation Trust as Head of Therapeutic Environments	(e)
Selina Ullah Trust Chair	• Non-Executive Director, Solicitors Regulation Authority • Director/Trustee, Manchester Central Library Development Trust • Non-Executive Director, General Pharmaceutical Council • Non-Executive Director, Locala Community Partnerships CIC • Non-Executive Director, Accent Housing Group • Director, Muslim Women's Council • Trustee and Board member of NHS Providers representing Mental Health Providers	(a) (e) (e) (e) (e) (e) (e)

(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).

Other Board members have submitted nil returns.

v2.1 DRAFT MINUTES

Derbyshire Healthcare NHS Foundation Trust

MINUTES OF A MEETING OF THE BOARD OF DIRECTORS

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

Tuesday 16 January 2024

MEETING HELD IN PUBLIC

Commenced: 09.30 Closed: 12:34

PRESENT	Selina Ullah	Trust Chair
	Tony Edwards	Deputy Trust Chair
	Lynn Andrews	Non-Executive Director
	Deborah Good	Non-Executive Director
	Geoff Lewins	Non-Executive Director
	Mark Powell	Chief Executive
	Vikki Ashton Taylor	Director of Strategy, Partnerships and Transformation
	Dr Arun Chidambaram	Medical Director
	Lee Doyle	Interim Director of Operations
	Justine Fitzjohn	Trust Secretary
	Rachel Leyland	Interim Director of Finance
	Dave Mason	Interim Director of Nursing and Patient Experience
	Rebecca Oakley	Acting Director of People and Inclusion
	David Tucker	Interim Director of Operations
	Joanne Wilson	Interim Director of Finance
IN ATTENDANCE	Anna Shaw	Deputy Director of Communications and Engagement
For DHCFT2024/002	Vicki Baxendale	Deputy Director of Regulated Practice
For DHCFT2024/002	Nicky Bunning	Guest for Patient Story
	Jo Bradbury	Corporate Governance Officer
APOLOGIES	Ashiedu Joel	Non-Executive Director
	Ralph Knibbs	Senior Independent Director
OBSERVERS	Sandra Austin	Volunteer, Carers Forum
	Rachel Leyland	Interim Director of Finance
	Sue Ryan	Lead Governor
	Rachel Yates	Living Well Practice Lead

DHCFT 2024/001	CHAIR'S WELCOME, OPENING REMARKS, APOLOGIES FOR ABSENCE AND DECLARATION OF INTERESTS Trust Chair, Selina Ullah welcomed Board colleagues and observers to the meeting. Selina opened the meeting by wishing members of the Board, Trust staff colleagues, Governors and stakeholders a very Happy New Year! She went on to recognise that the Trust is fortunate to have dedicated colleagues who continue to deliver excellent service throughout challenging and often unplanned circumstances. She reiterated the Board's responsibility to undertake self-reflection and critique itself in order to remain a high performing organisation delivering for its patients.

	Apologies were noted as listed. There were no declarations of interest on items on the current agenda.
DHCFT 2024/002	PATIENT STORY Vicki Baxendale, Deputy Director of Regulated Practice, introduced Nicky Bunning, who had had an inpatient stay in Nottingham after her son was born and who has been a very active Expert by Experience advocate within the perinatal collaborative. Vicki advised that on 1 October 2023, the inpatient mental health services for perinatal services in the East Midlands region became a provider collaborative, led by Derbyshire Healthcare. Nicky joined the meeting remotely, via Microsoft Teams and opened her presentation with a short video, which showed a moving and thought-provoking journey of her experience of using our perinatal mental health services. Following a difficult birth in 2022, Nicky had been diagnosed with postpartum psychosis. The experience was heart-breaking and not the way Nicky would have wanted to begin motherhood. Nicky was inspired by the excellent care and compassion she had received to help her through this dark time of her life. Once on the road to recovery, she joined the Experts by Experience group, to offer support to others. As the group struggles to recruit Experts by Experience, Nicky has redesigned the promotional leaflet, to make it more eye-catching and simpler to read, in the hope of encouraging a broader representation of the community for the group. The Board noted that Connections magazine had featured Nicky's experience in November 2023 and that she has recently been appointed with the Trust as a Peer Support Worker in the Perinatal Mental Health services. The opportunity to be an Expert by Experience, has given Nicky purpose, passion and a voice, and she looks forward to helping mums and families in the future. A few moments of silence were observed to remember those lives lost to perinatal mental illness. The Board applauded Nicky's courage for sharing her story and were keen to learn her vision for the year ahead, which included attendance on the wards to engage with mothers and listen to and value their voices and feedback. Vikki Ashton Taylor, Director of Strategy, Partnerships and Transformation, highlighted how instrumental Nicky had been as the driving force behind the revised leaflet and overall strategy, supporting the Trust as Lead Provider within the East Midlands Perinatal Collaborative. Mark Powell, Chief Executive, supported this recognition and was keen to witness Nicky's positive influence over the coming year. Dave Mason, Interim Director of Nursing and Patient Experience asked for Nicky's thoughts on her initial priorities. Nicky explained that due to a child's crucial first years, it was key that momentum and effective processes are in place to ensure accountability for providing a safe and effective service. On behalf of the Board, Selina thanked Nicky for sharing her powerful story and her moving film which gave the context for Nicky's purpose, passion and voice that was so evident. The board looked forward to seeing this passion being maximised for improvement of perinatal care and services.

	RESOLVED: The Board of Directors were greatly inspired by Nicky's presentation and were keen to support development of the patient voice in perinatal support services.
DHCFT 2024/003	MINUTES OF THE PREVIOUS BOARD OF DIRECTORS MEETING The draft minutes of the previous meeting held on 7 November 2023 were accepted as a correct record of the meeting. However, Selina asked for clarification on the following minutes: DHcFT2023/107, Care Quality Commission (CQC) Inspection Assurance Update: Selina felt the minute should have reflected that supervision and other areas of practice had been identified as themes for concern and asked for an update. Dave confirmed these areas were being addressed via a targeted action plan which focussed on the potential, contributing factors. A new process of internal, self-assessment had been introduced, along with a quality surveillance dashboard. Mark added that further assurance of training compliance is being overseen through the Executive Leadership Team (ELT). DHcFT2023/108, Position Statement – CQC Safe Domain: Selina asked Arun Chidambaram, Medical Director for an update on how the Trust would deliver its commitment to improving safety. Arun explained that a plan was being finalised and that national directives like the National Patient Safety Strategy will help ensure alignment with national policy, to ensure the best offer for the Derbyshire population. Selina suggested that the minutes should reflect fundamental discussion points, with the inclusion of timelines. She apologised on this occasion for raising at the meeting, rather than at the stage the minutes were sent out for comment and asked Board members to continue to review the draft minutes when first circulated. The Board agreed to Selina amending the minutes to reflect the discussions above and the new version would be circulated and agreed as the correct record.
DHCFT 2024/004	ACTION MATRIX There were no outstanding actions.
DHCFT 2024/005	QUESTIONS FROM MEMBERS OF THE PUBLIC No questions had been received.
DHCFT 2024/006	CHAIR'S UPDATE Selina provided the Board with her reflections on activity since the previous Board meeting on 7 November 2023 and drew attention to the points below: Industrial action and the impact on care, services, finances and morale had been discussed at a recent NHS Providers (NHSP) Board meeting Selina had attended. The key concerns of NHS leaders centred on winter and system pressures, along with the long period of industrial action announced by Junior Doctors. Despite the challenges, East Midlands was the second-best performing region over that period due to the collective efforts of Joined Up Care Derbyshire (JUCD). Selina was delighted to announce that she had been elected as Chair of the NHS Providers Race Equality Board Advisory Group, which champions the need for race equality and would provide opportunities for the sharing of good practice. In the wake of the Lucy Letby case, the Board noted that NHS Providers had set up a newly constituted Manager Regulation Steering Group of which Selina is a member. At the

	group's inaugural meeting, the key considerations for introducing a regulation system for NHS managers was discussed and a scoping exercise was underway. Selina reported that she regularly attends regional NHS England (NHSE) meetings, and that productivity was always a key emphasis, she stressed that the Trust had a responsibility to be clearly accountable and to make a difference in the metrics, particularly around waiting lists and timescales. Following a positive meeting with Chris Dzikiti, National Director for Mental Health at the CQC, Selina looked forward to a visit from him in spring 2024 and asked Arun and Dave to support with facilitation of this. Deborah Good, Non-Executive Director, congratulated Selina on the election and observed that improved data would influence progress in addressing inequalities within the Black, Asian and Minority Ethnic group (BAME) community. Selina responded that the challenge over the next 12 months would be to look at disaggregated data with targeted interventions, to better manage waiting times and resources. The Board agreed that productivity post-COVID-19 was the biggest driver on inequalities. The issue would be covered further at the Finance and Performance Committee and later at this meeting in the Operational Integrated Performance report. Further to the recent Health Inequalities session, with Professor Bola Owolabi, Director of Health Inequalities at NHS England, Mark was keen to demonstrate the Trust's intent to improve outcomes and took this as an action to prioritise with the Executive Team. RESOLVED: The Board of Directors noted the content of the Chair's update.
DHCFT 2024/007	<u>CHIEF EXECUTIVE'S REPORT</u> Mark's report covered current local issues and national policy developments. The report also reflected a wider view of the Trust's operating environment. Mark expressed appreciation for colleagues support during the recent industrial action. He observed that the Trust's response had become so proficient, the amount of effort and hard work required to manage the challenges effectively can go unrecognised. He explained that during the period, there had been three meetings each day, including during weekends and bank holidays, and these meetings continued to ensure the safety of patients and colleagues. The immense amount of time was difficult to articulate in a numeric way. Mark wished to record his thanks and for the Board to be aware of the huge effort involved in keeping the Trust and the Derbyshire system safe. The significant increase in Staff Survey response rate to 62% was testament to the dedication of a small, committed group who had been driving reminders and promoting the completion of the survey but ultimately Mark was thankful to all staff who had taken the time to fill it in. He reported that early feedback had highlighted improvements and challenges and represented progression in engagement, whilst the number of non-responses was also recognised. The Board noted the need to share the results promptly. The Board noted the revised format of Board visits, which will be informal. Board members will be joined by Carers, Experts by Experience and Governors. The focus of the visits will be on free-flowing conversations with staff, patients and carers. Where concerns arise, they will be escalated through the Trust-wide Learning, Culture and Safety Group. Mark was pleased to report his invitation to join a national group, providing the opportunity to influence discussions around the Mental Health Long-Term Plan. The Board recognised the evolving work of the East Midlands Alliance (EMA), which focussed on the best use of resources. The EMA had acknowledged that there was duplication of effort, with time being tied up in governance and this must be released to

	areas which focus on benefit to patients. The EMA had requested Board approval of the draft vision, values, purpose and strategic objectives, which provided a more strategic building block for the coming year. Mark reported on the progress of the work of the JUCD provider collaborative, and it was noted that the new procurement contract award regulations were aimed at commissioners rather than the Trust and the aim was to simplify processes and reduce competitiveness. Mark welcomed Geoff Lewins' offer of engagement and expertise support with the ICB. Tony Edwards, Deputy Chair, commented that he had recently attended an EMA meeting and it was disappointing to see duplication of work; he suggested the vision needed more clarification around the need for the alliance to add value. The Board scrutinised the EMA draft vision and agreed it could be improved upon with the inclusion of a more detailed reference to value for money. Lynn Andrews, Non-Executive Director, pointed out that Allied Health Professionals (AHPs) would be instrumental in taking the vision forward and recommended a stronger emphasis on them within the Strategy. Lynn also stated that the benefits were unclear. ACTION: draft response to include the more explicit commentary around outcomes, duplication, Allied Health Professionals and added value, to be shared for input, prior to feeding back to the EMA. RESOLVED: The Board of Directors: 1. Noted the report. 2. Approved the draft vision, values, purpose and strategic objectives for the East Midlands Alliance for mental health, learning disabilities and autism presented as Appendix 2 (subject to more explicit commentary around outcomes, the inclusion of Allied Health Professionals within network groups, avoidance of duplication and added value). 3. Noted the progress made within the JUCD provider collaborative, including the ongoing maturity of system working which the collaborative facilitates. 4. Supported and agreed to promote the strategic direction and development of the JUCD collaborative, raising the profile of the work being done to improve services for local patients. 5. Noted that delivering against future priorities will require providers to commit time and resources to specific projects.
DHCFT 2024/008	<u>TRUST STRATEGY PROGRESS UPDATE</u> This Board received an update on progress in delivering the priority actions identified in the organisational strategy, the strategy has been simplified following an organisational reset in October 2023. Vikki reported that at the end of quarter two (Q2), there were three priorities due to be delivered, one of which, the implementation of SystmOne and Electronic Prescribing had been completed, resulting in the integration of clinical systems/standardisation of reporting and approach to patient care pathways. It was noted that work continues to optimise the benefits of the new system through supporting teams to adhere to the jointly developed Standard Operating Procedures (SOPs) and to support staff in the use of the Brigid Application. In terms of the two undelivered priority actions from Q2: • Improving processes and support for people experiencing matters that could cause stress reactions: this will be achieved in Q4 2023/24, and it is anticipated to be reflected by improved staff survey results. A Trust-wide process to oversee the agency

	workforce requests has been implemented alongside an agency control panel that meets every week to consider applications received. • Using 2022/23 as year one, agree our three to five-year financial plan:the Trust has agreed an in-year financial recovery plan to deliver the required financial efficiencies for 2023/24. However, the position remains challenged with a projected year end deficit now being reported. In this context, external support is being sought to help the Trust to develop a longer-term financial plan. Vikki gave details of the significant staff engagement work in relation to the new strategy, which is expected to go live in October/November 2024. Justine Fitzjohn, Trust Secretary, was pleased to see progress on developing the new strategy and the discussions on culture including clearly defining 'People First' through the engagement sessions as this linked in with recommendations from the Well Led review. It was noted that the Non-Executive Directors had been invited to the engagement sessions and Mark welcomed their involvement in leading these. RESOLVED: the Board of Directors: noted the 2023/24 Q2 progress in delivering the priority actions as set out in the Trust's 2022–2025 organisational strategy.
DHCFT 2024/009	<u>INTEGRATED PERFORMANCE REPORT (IPR)</u> The IPR provided an update on key finance, performance and workforce measures at the end of November 2023. Executive Directors drew attention to the following areas and responded to questions: Operations Lee Doyle, Interim Director of Operations, highlighted that demand for adult autistic spectrum disorder (ASD) assessment continues to outstrip commissioned capacity; however, the number of assessments undertaken had increased significantly. The implementation of the Management and Supervision Tool (MAST) would provide improved data quality and support a reduction in waiting times. MAST is forecasted to be fully embedded within the next 12 months. Lee commented on the recent media attention in relation to Refer to Treatment (RTT) data, which had prompted a deep dive into Community Paediatrics. David Tucker, Interim Director of Operations, highlighted the significant reduction in the use of bank and agency staffing, reducing from £1m spend in August to £540k in December, with a further reduction of £120k forecasted for March 2024. David explained the range of factors affecting the increase in inappropriate out of area placements, including the absence of a Psychiatric Intensive Care Unit (PICU) provider in Derbyshire at present, along with an increase in patient acuity. This has impacted on an increased Length of Stay (LoS), peaking at 50 days. LoS is currently below 40 days. Whilst the overall goals are to prevent admission to hospital and help patients to get home quickly, the main challenges are placement issues, with around a third of patients having no employment or accommodation status. Tony observed the number of actions and predictions, however there was insufficient detail around the quantum of improvement. Mark added that the Trust is looking at commissioning some beds closer to home until the new build is completed. Geoff Lewins, Non-Executive Director, praised the tremendous improvement in ASD assessments but recognised the receipt of over 100 referrals per month. Arun stated that there was a significant overlap between ASD and ADHD and an integrated approach, as

	opposed to a silo offer would help to address this. Finance. Jo Wilson, Acting Interim Director of Finance, reported impact of the reduction in agency spend had decreased the deficit from £5.8m to £5m. The Board noted the importance of advance workforce planning, along with the excellent achievement in lowering agency spend. Selina observed that the paper indicated many assumptions and made a plea for increased focus, along with the inclusion of plans to mitigate with future reports. People Rebecca Oakley, Acting Director of People and Inclusion, reported that as the Staff Survey results were under embargo by NHS England, the information had been purposely excluded and would be covered mid-year. It was noted that future reports would contain more explicit language in relation to targets, rather than expectations. Quality Dave highlighted that the Trust had received significantly more compliments than complaints, and that there was to be increased focus on early resolution of complaints, in line with the national model. It was noted that this would improve oversight of complaint themes, timescales, whether or not a complaint has been upheld and how responded to. Dave accepted the fair challenge from Geoff, that there was insufficient trajectory around Care Plan reviews. Lynn confirmed that there is a review of the risk assessment and plan of care at every Quality and Safeguarding Committee meeting and that the assurance and confidence is there, although this may not be recorded appropriately. Lynn was satisfied that these areas are progressing as quickly as possible. The Board discussed the improvement work to transform the Care Programme Approach (CPA) which would simplify collaborative care planning, recording of information and introduce safety planning training. Arun agreed to feedback on timescales for implementation. Deborah raised concern at the poor emphasis around patient employment and accommodation and the lack of improvement. ACTION: provide more detail on the employment/ accommodation position in the next report. Deborah was also disappointed that the 27% of readmissions to acute within 30 days was not included in the reporting. Lee confirmed that readmissions information will very much form part of the flow model and is an area of focus. ACTION: It was agreed to include re-admission data into future reports. There was further scrutiny around patients clinically ready for discharge, falls and self-harm data. It was agreed that improved reporting would benefit understanding of how to ensure patient safety whilst in the Trust's care. It was noted that a bi-weekly group had oversight of falls and that Care Plans and circumstances were immediately reviewed following all incidents. Mark suggested a more strategic approach to patients clinically fit for discharge, to include an analysis of the numbers involved, the length of wait time and timescales for escalation to relevant partners. ACTION: Quality and Safeguarding and Finance and Performance Committees to investigate and report on the barriers delaying the discharge of clinically ready patients. RESOLVED: the Board of Directors: 1. Confirmed a level of limited assurance on current performance across the areas presented. The level of activity was recognised, however, this has yet to imbed.

	2. Formally agreed that this report incorporates the key elements of assurance to the Trust Board that would otherwise have come from Finance and Performance Committee and People and Culture Committee reporting.
DHCFT 2024/010	<u>POSITION STATEMENT – CQC – RESPONSIVE</u> The report focussed on the Trust's evidence on how the seven requirements within the CQC's responsive domain are being met. The report also included an update on the development of a comprehensive self-assessment framework, with a team level quality surveillance dashboard, which will provide early warnings for teams to seek support. Dave commented that the revised self-assessment process aligned with the new, single assessment of CQC. The process maps the "I" and "we" statements and the new CQC scoring process. In response to Selina challenging that a third of the Trust's data on the requirements fall below and the remaining sit on the cusp of the national average, Mark iterated that the starting point was getting assurance to the Board, which would be achieved via the process described by Dave, supported with oversight by Quality and Safeguarding Committee and Executive governance. RESOLVED: the Board of Directors: 1. Noted the contents of the report and agreed a level of limited assurance regarding the Trust's position against this domain.
DHCFT 2024/011	<u>LEARNING FROM DEATHS MORTALITY REPORT – VERBAL UPDATE</u> Arun presented a verbal overview of the latest mortality data adding there were no concerns he needed to escalate. He commented that due to an anomaly with the governance trail, it had not been possible to present the usual written report. The data required more than a week to prepare and the usual process was to go through the Quality and Safeguarding Committee (QSC) which would then present assurance on the report to the Board. Justine agreed there was a scheduling issue and the options were for either delayed presentation to the Board or for delegated authority to QSC. The Patient Safety Team would be checking against the regulations and adjusting the reporting schedule as appropriate. Selina pointed out that the Patient Safety Team also gave assurance and escalated any concerns outside of the Board process, as required. RESOLVED: The Board of Directors noted the verbal update.
DHCFT 2024/012	<u>FREEDOM TO SPEAK UP (FTSU) STRATEGY</u> In the absence of Tam Howard, Freedom to Speak Up Guardian, Justine presented the FTSU Strategy for approval in principle with a request for delegated authority for the Audit and Risk Committee to sign off the final version which will then form part of the National Guardian Office (NGO) toolkit requirements for completion by the end of January 2024. Lynn commented that it was an excellent strategy but queried how success was to be measured and gave an example of how the Trust demonstrates that staff have been listened to with compassion and without judgment, that they have received feedback in a timely manner, that the feedback meets the Trust values and that there is feedback from managers on how the approach has influenced their learning. Lynn went on to suggest that whilst this may be stated as part of measures presented to the Board through the FTSU reports, the strategy would benefit from the inclusion of additional clarity around the principles. Geoff agreed that there was a great deal included in the bi-annual FTSU reports, however, it would be useful for the strategy to be more explicit on measuring success.

	RESOLVED: The Board of Directors approved the FTSU Strategy in principle and gave delegated authority to the Audit and Risk Committee to sign off the final version.
DHCFT 2024/013	MENTAL HEALTH BILL – VERBAL UPDATE It was noted that the reforms proposed in Mental Health Bill were currently paused meaning that legislation will not be passed before the next General Election. Briefing on a recent High Court Judgement regarding virtual detentions Arun presented an update on a recent judgement relevant to practice of Mental Health Law. He added that following the Judgement, the Trust has undertaken a scoping exercise of any patient's section who may have impacted by the decision. This has necessitated a review of patents from the commencement of the COVID-19 pandemic, given that colleagues were shielding and therefore, more likely to utilise remote working opportunities. The Mental Health Act Office is working closely with clinical teams to ensure that patients are aware of this change, receive the appropriate clinical contact and are signposted to independent sources of advice. For those patients whose Community Treatment Order (CTO) was created without a face-to-face appointment, the Trust will review the circumstances of that renewal to determine what, if any, action is required. RESOLVED: The Board of Directors noted the update on the Bill and on the Judgement and the Trust's planned response.
DHCFT 2024/014	BOARD COMMITTEE ASSURANCE SUMMARIES The Board Assurance summaries from recent meetings of the Trust Board Committees were accepted as a clear representation of the priorities that were discussed and will be taken forward in forthcoming meetings. The following points were brought to the attention of the Board by Committee Chairs: Quality and Safeguarding Committee: Lynn highlighted that there were a few areas where the Committee had received limited assurance and wished to point out that this was not cause for concern, many actions were underway but not yet completed. Finance and Performance Committee: Tony commented that the current financial challenges had been the main focus and would be discussed further at the following Council of Governors meeting. The Board was delighted to learn of an HMRC landmark judgement, which confirmed that VAT would be excluded from the Making Room for Dignity project, reflecting an £18m benefit for the Trust. The Board also noted that there was to be higher emphasis on strategy around digital conversations. People and Culture Committee: in the absence of Ralph Knibbs, Committee Chair, Rebecca confirmed that the Training Evaluation Trainer vacancy had now been appointed to. 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 2024/015	ASSURANCE FROM THE QUALITY AND SAFEGUARDING COMMITTEE

	Guardian of Safe Working (GOSW) Report: this quarterly report provides data about the number of Junior Doctors in training with 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. As Chair of the Quality and Safeguarding Committee, Lynn reported that the Committee had received significant assurance from the GOSW Report. RESOLVED: The Board of Directors received significant assurance that the duties and requirements as set out in the 2016 Junior Doctor terms and conditions of service are being met.
DHCFT 2024/016	<u>IDENTIFICATION OF ANY ISSUES ARISING FROM THE MEETING FOR INCLUSION OR UPDATING IN THE BOARD ASSURANCE FRAMEWORK (BAF)</u> Due to the scheduling of information, the BAF was not included in today's meeting.
DHCFT 2024/017	<u>2023/24 BOARD FORWARD PLAN</u> The forward plan outlining the programme for 2023/24 was noted and would be reviewed further by all Board members for the financial year ahead.
DHCFT 2024/018	<u>MEETING EFFECTIVENESS</u> The Board agreed that the lighter agenda and focused reports had provided the opportunity for constructive and compassionate scrutiny and challenge. Observers at the meeting had been inspired by the patient story and commented on the fair balance of recognition and challenge throughout the meeting. Sandra Austin, Volunteer, Carers Forum, was encouraged to learn of the 40% saving on agency spend, along with the plans to reduce the use of out of area beds. Sue Ryan, Lead Governor, was impressed with how the NEDs interacted, with effective questioning and observations. Rachel Yates, Living Well Practice Lead, commented that more accessible papers would support engagement with Trust employees and the public.
The next public Board meeting will be held in person at 9.30am on 5 March 2024 in Conference Rooms A and B, Centre for Research and Development, Kingsway, Derby.	

ACTION MATRIX - BOARD OF DIRECTORS (PUBLIC) - MARCH 2024							
Date	**Minute Ref**	**Item**	**Lead**	**Action**	**Completion Date**	**Current Position**	
05-Sep-2023	DHCFT/ 2023/101	Action Matrix - BAF Update	Trust Secretary	Triangulation of BAF and scheduling of Board Committee meetings to be assessed.	31-Mar-2024	A similar issue around scheduling of Finance and Performance reporting has been raised. Discussions are taking place outside of the Board meeting.	Amber
16-Jan-2024	DHCFT/ 2024/007	Chief Executive's Report	Director of Strategy, Transformation and Partnerships	Draft response to include the more explicit commentary around outcomes, duplication, Allied Health Professionals and added value, to be shared for input, prior to feeding back to the EMA.	31-Jan-2024	Response included points raised by the board.	Green
16-Jan-2024	DHCFT/ 2024/009	Integrated Performance Report (IPR)	Interim Director of Nursing and Patient Experience	Increased detail on the employment/accommodation position to be included in future reporting.	05-Mar-2024	Ward managers have been asked to ensure improvements are made on the completion of this data as part of the admissiion information.	Green
16-Jan-2024	DHCFT/ 2024/009	Integrated Performance Report (IPR)	Interim Director of Operations	Future reports to include an update on readmissions.	07-May-2024	Update will be included in next version of the IPR.	Yellow
16-Jan-2024	DHCFT/ 2024/009	Integrated Performance Report (IPR)	Finance and Performance and Quality and Safeguarding Committees	Investigate and report on the barriers delaying the discharge of clinically ready patients.	05-Mar-2024	Referred to the Committees for scheduling.	Green

Key:	**Action Overdue**	RED		**0**	**0%**
	Action Ongoing/Update Required	AMBER		**1**	**20%**
	Resolved	GREEN		**3**	**60%**
	Agenda item for future meeting	YELLOW		**1**	**20%**
				5	**100%**

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

Chair's update

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 16 January 2024. The structure of this report reflects the role that I have as Trust Chair.

Our Trust and Staff

1. On 7 February, I attended the first of a series of meetings regarding the financial reset and our financial plan. These meetings have been scheduled at the request of Tony Edwards, Chair of the Finance and Performance Committee, to better understand any issues arising, and also to monitor the progress of the approach being taken to achieve the Trust's objectives and greater financial sustainability.
2. On 15 February, I visited our Making Room for Dignity new build facility, the Derwent Unit. I invited newly appointed Chair, Mahmud Nawaz of Chesterfield Royal Hospital, to accompany me. We were impressed with the considerable progress being made and in particular, the attention to incorporating the feedback of service users and carers in the design of the facility, making it very user friendly, inclusive and responsive to diverse needs. My thanks to Geoff Neild and Ollie, Senior Site Manager, for showing us around the facility.
3. I was scheduled to undertake some service visits in Chesterfield with the Liaison Team in the North, followed by a visit to the Hub and Occupational Therapy in the Hartington Unit on 21 February. Unfortunately, due to a virus infection, I was unable to visit. The visits are being rescheduled.
4. On 29 February, I visited Tissington House, our 18 bedded assessment and treatment ward for people over the age of 65 with functional mental health problems, such as depression, schizophrenia, mood disorders or anxiety. This is a mixed sex ward with gender specific sleeping areas, with single ensuite rooms. I was pleased to see the strong focus on recovery and hear about how discharge planning begins from admission.
5. I also attended the Trust Strategy engagement session on Vision and Values, as we embark on the new strategy for the Trust. There have been a number of sessions with widespread engagement across the Trust. The Non-Executive Directors have also attended these sessions. A full update on this work is provided in the Chief Executive's report. These engagement sessions are critical in establishing the foundations of the strategy and the bottom-up ownership of it, setting the priorities and ultimately, the delivery of the strategy going forward.
6. I attend the online Chief Executive Officer (CEO) engagement sessions which have focused on the financial reset. These meetings are very useful to me in terms of understanding how staff are feeling and are engaged with the Trust. The real time Q and A has been particularly noteworthy, as emergent issues are raised by colleagues and addressed immediately, which helps to address uncertainty and confusion. The issues raised are followed through on the written briefings, so all staff have access to the information.
7. Our hospital hub for vaccinations has continued to deliver an outstanding service and I recognise all the hard work and effort that has gone into it. It is also good to see the number of our colleagues who have been vaccinated against flu and COVID.

8. Finally, I would like to thank all our colleagues for their on-going commitment and dedication shown to the Trust and our patients and service users. Their commitment and passion for patient care and safety is always tangible to me and the Non-Executive Directors on our service visits.

Council of Governors

9. On 6 February I was pleased to welcome our newly elected Governors with Justine Fitzjohn, Trust Secretary. Our newly elected public Governors are Dave Allen (Chesterfield), Simon Hinchley (Erewash), Fiona Birkbeck (High Peak and Derbyshire Dales) and Anson Clark (Rest of England). We also have new staff Governors - they are, Fiona Rushbrook (Allied Health Professions), Claire Durkin (Admin and Allied Support) and Sifo Dlamini (Nursing) and finally we have joining us Appointed Governor, Dr David Robertshaw from the University of Derby. I am grateful to our Governors for all their work and for ensuring the needs of their constituents and all Derbyshire communities are at the forefront of our service planning and delivery.
10. The induction for the new governors is important in assisting them in developing their understanding of the Trust, its services and more importantly the role of the governors in representing the views of the public and in holding the Chair and the Non-Executive Directors to account.
11. On 7 February, the Governance Committee met, and David Charnock and Marie Hickman were re-elected as co-chairs of the Committee, thank-you to them both for this commitment. Once again, it was heartening to see the level of attendance and participation from so many of our Governors at this meeting and a warm welcome was given to the newly elected Governors. On 13 February, the Governors' Nominations and Remuneration Committee met to discuss the forthcoming appraisal process for the Chair and Non-Executive Directors (NED)s.
12. Due to illness, I was unable to meet with the Lead Governor, Susan Ryan and Deputy Lead Governor, Hazel Parkyn, as I normally do. The meeting is being rescheduled. These meetings are an important way of building the relationship and understanding of the working of the Board and the Council of Governors.
13. Following the Governance meeting, I held a scheduled informal meeting with Governors. This is an opportunity to talk about the Trust, our services and hear from Governors on their perspective, in an open and informal format.
14. After today, the next Council of Governors meeting is on 7 May 2024.

Board of Directors

15. On 13 February, I observed the Quality and Safeguarding Committee. I am grateful to Lynn Andrews, Chair of Quality and Safeguarding Committee, for the rigour in seeking assurance on quality and safety that I observed in the business of the Committee.
16. On 14 February, the Board held its development session, which covered Quality Improvement. Mark Powell, Chief Executive, provides an overview in his report. We also had a presentation on the development of the new Trust Strategy and a presentation on the Trust's objective for financial sustainability. The presentations stimulated lots of discussion and reinforced the importance of having this protected time to delve into the detail.
17. 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 Lynn Andrews, Ashiedu Joel, and Ralph Knibbs. I will be meeting with them all over the next month for their annual appraisal.

System Collaboration and Working

18. The four Derbyshire Provider Chairs continue to meet monthly with Richard Wright, Interim 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.
19. On 29 January, Mark Powell and I attended the Provider Collaborative Leadership Board. There are some changes to the membership, as Helen Phillips' tenure as Chair of Chesterfield Royal Hospital NHS Foundation Trust, ended in January, with Mahmud Nawaz joining as Chair from February. Kathy McLean will be stepping down as Chair of the University Hospitals of Derby and Burton NHS Foundation Trust to take on the role of ICB Chair from March.
20. On 30 January, I spent the day with Rachel Bounds, Appointed Governor, Derbyshire Voluntary Action, at the Chesterfield Hub. I had a very energising and fulfilling day with Rachel, meeting members of the voluntary sector, service users, carers and Trust staff. I observed some of the classes taking place. I was warmly received, and I am very grateful for the hospitality and time that was given to me so freely by everyone. A special thanks to Rachel, who was an impeccable host.

21. A system wide development event was held on 15 February in Chesterfield. At this meeting, we continued the ongoing discussion about the financial challenge the system and the wider NHS is facing and the reality of having to make some difficult choices and the opportunities.
22. I have continued to meet regularly with the Chairs of the East Midlands Alliance of Mental Health Trusts, which has been a very useful source of sharing best practice and peer advice.
23. I met with Paul Devlin, Chair of Nottinghamshire Healthcare NHS Foundation Trust and Kevin Lockyer, Chair of Lincolnshire Partnership NHS Foundation Trust, to discuss greater system collaboration and the challenges we face as Mental Health Provider Trusts.
24. I met separately with Julie Houlder, Chair of Derbyshire Community Health Services

NHS Foundation Trust, and we explored some areas of mutual interest and the progress of other areas of work we had identified as of interest.

Regulators, NHS Providers, NHS Confederation and others

25. I attend fortnightly briefings from NHS England/NHS Improvement for the Midlands region, which has been essential to understand the challenges, NHS England's perspective and expectations, and tools for ongoing improvement and productivity.
26. I have also joined the weekly calls established for Chairs of Mental Health Trusts, hosted by the Mental Health Network in collaboration with the Good Governance Institute where support and guidance and the opportunity to share experience and good practice has been invaluable.

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 & 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 the 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 instigated a Board Development programme on inclusion which will assist in developing the Board's understanding and response to 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 Non-Executive Directors are also engaged and involved in supporting inclusive leadership within the Trust.

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

Recommendations

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

Report prepared and presented by: Selina Ullah
Trust Chair

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

Chief Executive's Report

Purpose of Report

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

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

Our Trust and Staff

Industrial Action

We continue to have further disruption to our services following another period of Junior Doctors' industrial action. I am extremely grateful to colleagues who continue to support our services to maintain patient safety. Thank you to members of our Incident Management Team (IMT) who continue to make preparations ahead of industrial action taking place. Unfortunately, a number of patient appointments were cancelled as a result of the industrial action. We will be ensuring these appointments are rescheduled and take place as soon as possible.

New Services

The range of local support services for people with immediate mental health needs has been expanded in Derby and Derbyshire, as part of a wider programme of partnership activity led by Joined Up Care Derbyshire which aims to improve outcomes for people with immediate mental health needs.

Recent developments include:

- Two new Mental Health Crisis Support Drop-In Services are now available in Ripley and Swadlincote, in addition to the service in Buxton, which opened earlier this year.
- A new Safe Haven is now running in Chesterfield every evening from 4.30pm to 12.30am. This is in addition to the Safe Haven already in place in Derby.
- A new Crisis House has opened in Chesterfield for adults with mental health issues who will be offered short-term residential accommodation to support with their mental health needs to promote better stability and wellbeing. The facilities aim to reduce the need for inpatient care.
- The Derbyshire Mental Health Helpline and Support Service has a new deaf or hearing loss access route, where callers can connect with a member of the helpline team by using SignVideo, which will connect a BSL interpreter to the call.

Focused promotion of the new Gambling Harms service has taken place across the East Midlands over recent months. This has included trialling the use of an iVan at a Nottingham Forest match in November which, given the level of interest gained, was being used again on 17 February at Leicester.

The new service is also being successfully promoted at universities across the East Midlands. Digital advertising is in place at the University of Northamptonshire, with the service being involved in mental health awareness days at both Northamptonshire and De Montfort University. Many of the region's larger businesses are also posting details of the service on their intranet.

A new website has been developed by the Derbyshire Recovery Partnership, which offers free support to people struggling with alcohol and drug use. The website, at www.derbyshirerecoverypartnership.co.uk, offers simple tips on drinking less, and for those who are really worried about their drinking, there is also a team of professionals available to offer face-to-face guidance.

Key Developments

- Earlier this year, a team of Occupational Therapists working at Derbyshire Healthcare had an article published in the latest edition of the British Medical Journal on how to improve the occupational therapy admission process in an older adult inpatient service, after significantly speeding up the time taken to carry out a first assessment with patients.

  The team, which included Dr Joshua Ige, Dr David Hunt, Amanda Mitchell, Emma Eaton, Anne Walker, Rachael Fearn, Lizzie Kirkham, Abigail Staples, Adam Giles and Bethany Wilson, wrote the article on improving the standardisation, timeliness and efficiency of the occupational therapy admission process across the two healthcare facilities at Kingsway Hospital in Derby where they work, Cubley Court, which specialises in acute dementia care and Tissington House, which specialises in acute mental health care for older people.

- Through a process of quality improvement, the team increased the percentage of patients benefiting from occupational therapy initial assessments within seven days of admission from 47.65% to 78%.

- In January, our Perinatal service held a stakeholder engagement day at the Post Mill Centre, South Normanton. The event was attended by over 70 people, including GPs, healthcare professionals, partners and Trust colleagues. At a time when the perinatal service is seeking to increase referrals in line with the NHS Long Term Plan, the day was an opportunity for stakeholders to offer feedback, share ideas and raise awareness of the support on offer.

The event ended with an awards ceremony recognising colleagues who have performed at a consistently high level over the last year. The innovation award went to Peer Support Worker, Kelia O'Brien and Nursery Nurse, Ginette Varty, for launching a walking group which supports new mothers who lack the confidence to leave the house and socialise. The scheme allows people to meet other mums in a safe space, without the pressures of sitting in a group and gives them the opportunity to walk and talk.

- My congratulations to Rakhi Ravindran (pictured), for passing her Objective Structured Clinical Examination (OSCE) earlier this year. This means that Rakhi, who is originally from India, is now able to work as a registered Nurse in the UK. The Observed Structured Clinical Examination (OSCE) is a competence-based assessment used to assess overseas nurses' clinical skills and to check their current registration against the expected English nursing standards of practice.

For an international nurse to be able to register in the UK, they must meet the minimum nursing standards to practice and the OSCE is a comprehensive and detailed set of practice exercises. It covers the nursing process, professional behaviours and attitudes of a registered Nurse, key clinical skills and communication is a core component.

As a Trust, we highly value skilled international nurses coming to work for us, to provide the best quality of care to our local communities. Rakhi, who works on Pleasley Ward at the Hartington Unit in Chesterfield, will be a huge credit not only to her team but the Trust as a whole. This is only the start of Rakhi's journey, and we look forward to seeing her future achievements.

- In response to feedback, a monthly winner of the Trust's DEED staff recognition scheme was re-introduced at the start of 2024. Congratulations to Michelle Smith (pictured) from the Intensive Support Team in our Neurodevelopmental Services, who is the first DEED winner of the month winner for 2024. Michelle has been recognised for her hard work, commitment and dedication – not only to her job, but also to her team and the carers and families within her service. Michelle was described as being exemplary in taking the time to recognise everyone as individuals, with particular note of how she listens carefully to people's needs, thoughts, and feelings.

- The Trust's Work Your Way team support patients in our Working Age Adults Community Mental Health Teams, Living Well and Early Interventions to find sustainable paid employment as part of their recovery. To date, the team have supported 421 people to find work, which is a brilliant achievement that makes a positive difference to people's lives.

  One of the people supported by the team recently shared the following feedback, *"The support I have received has been very helpful and has helped me feel comfortable with getting back into work. As I am someone who suffers from mental health issues, it has been helpful to get support with getting back into work."*

- The Trust has also continued to promote important, health related messages over recent months. We started the year by encouraging people with a learning disability to get a free physical health check. We have also recently recognised Time to Talk Day, LGBTQ+ history month, Holocaust Memorial Day and Race Equality Week.

Board of Directors and Council of Governors

Board Appointment

I am pleased to confirm that James Sabin started as the Trust's new Director of Finance on 5 March. A warm welcome to James. I would also to give my thanks to Rachel Leyland and Jo Wilson, both of whom have led the Trust's finance function over the last few months. I am extremely grateful to both of them for their immense effort and commitment in supporting the Trust and me during this time.

Developing our New Strategy

Engagement on developing a new Trust Strategy started in February, with a series of focused sessions taking place with staff to gain their feedback and ideas in key areas, including the Trust's culture, vision and values and how we can work together and with others to address health inequalities. These initial themes were identified through conversations that took place in the Staff Conference, which took place in October 2023.

Positive engagement has taken place so far, with feedback received about the Trust's culture, including what feels unique about Derbyshire Healthcare that people do not want to lose. Key themes about the areas colleagues would like to improve include strengthening individual and collective accountability, reducing the number of meetings that take place, thinking more about how we respond when things go wrong and providing clarity on actions or behaviours that will not be tolerated.

There is great appetite amongst our teams to have an increased understanding of our local communities, their population needs and use of our services. Feedback on the health inequalities sessions to date include identifying potential barriers to accessing our services and thinking creatively about how we remove these, agreeing what tools and data we will use to determine our approach, having greater flexibility on how we structure our services to meet local needs and increasing our collaboration with system partners, the voluntary sector and external businesses. This feedback will also support the approach outlined in a new Clinical Strategy that is being developed alongside the new Trust Strategy.

At the time of writing the sessions focused on our vision and values were due to start, where we will be seeking feedback on whether the current vision and values are right to create the culture we want to have in place. After Easter there will be further sessions where we will start to co-design our new priorities through the lens of partnerships and collaboration and review the Trust's brand identity. We will also start to engage external stakeholders at this point.

We plan to have the final Trust Strategy ready to bring to the Board of Directors for approval after the summer 2024.

Continuous Improvement Session

A Trust Board Development Session on 14 February, focused on building a system and culture for improvement. This was the fourth Quality Improvement (QI) based Board Development Session in the current strategic cycle.

It was good that we could see the progress that has been made in building capability as an integral component of our QI journey. There has been good progress in developing our people and we want to further develop our learning culture and be better at sharing improvement and best practice across the organisation. Good progress has been made with over 500 staff trained in QI (excluding induction) and expected to reach around 700 in the next couple of months with those in progress or booked on.

We agreed that there are many examples of good practice in QI but there is more to do to translate the investment in people and building of QI capability into greater transformation through scale and spread. We also agreed to include more service users in improvement and develop leaders that use data to drive decision making and improvement.

System Working, Regulators, NHS Providers, NHS Confederation and others

Planning 2024/25

As a Trust we continue with developing our plans, whilst we await formal national planning guidance to be issued from NHSE. This includes developing our priorities for 2024/25 including:

- Areas for continued investment linked to Mental Health Investment Standard and other national priorities.
- The development of our capital investment priorities, in addition to the continued Making Room for Dignity developments across the estate and in consideration of our other digital needs.
- Developing our cost improvement plans in supporting and ensuring we deliver value and reduce waste.

At the same time, we are working to develop a longer-term view of our financial sustainability and help us move towards financial balance.

Supporting People with a Learning Disability and Autistic People

In January 2024, NHS England set out the following five key elements to support discharge for people with a learning disability and autistic people to leave hospital:

1. Seeing a delayed discharge as a 'harm' event.
2. Agree how people will work together to plan a person's discharge.
3. Coproduction.
4. Strong partnerships to support timely discharge.
5. Holistic, person centred care in hospital.

As a Health and Social Care system, we have been asked to check what more we need to do to put the five key elements in place with a concerted focus to ensure that these things are happening for everyone with a learning disability and every autistic person in a mental health hospital.

Reaching Out: Improving the Physical Health of People with Severe Mental Illness

In January, Equally Well published a new report *Reaching out: Improving the physical health of people with severe mental illness.* It sets out that people living with severe mental illness (SMI) have a life expectancy that is 15-20 years shorter than the general population. This disparity is largely due to preventable or treatable physical illnesses. Providing annual physical health checks and follow up interventions is an important part of how the NHS is seeking to tackle this inequality, and this is a key focus of Core20PLUS5 (a National NHS England approach to inform action to reduce healthcare inequalities).

Mental Inpatient Culture of Care Improvement Programme

We have been in discussion with NHSE about getting involved in a number of national quality improvement programmes. I am pleased that we will be involved in the Inpatient Culture of Care programme which will be delivered through a trauma-informed, autism-informed, and racial equity perspective. More details about the programme will be provided to the quality and safeguarding committee over the coming months.

Care Quality Commission (CQC) New Regulatory Approach

The CQC have confirmed that they are now using their new single assessment framework in the Midlands. The CQC's expectations of care are not changing, and their current ratings and five key questions will stay central to their approach. Comprehensive guidance has been issued to support providers and the Trust has been running engagement events with staff so they can understand and prepare for the new assessments.

Speaking Up Support Scheme

The Trust promotes the Speaking Up Support Scheme as part of its speaking up culture. The scheme is for past and present NHS colleagues who have experienced a significant adverse impact on both their professional and personal lives following a formal speaking up process.

East Midlands Alliance – EMA Today e-newsletter launched

Board members may be interested in subscribing to the above newsletter, which covers the latest work of the East Midlands Alliance for Mental Health, Learning Disability & Autism.

In the first edition there are articles on the launch of the perinatal mental health collaborative for which the Trust is the Lead Provider and the recently launched East Midlands Gambling Harms Service run by the Trust on behalf of the collaborative. It also promotes Op COURAGE. Our Armed Forces Network regularly signposts to this specialist mental health service for individuals who are due to leave the military, reservists and those who've served in the armed forces and are struggling with their mental health.

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

Risks and Assurances

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

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

Consultation

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

Governance or Legal Issues

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

Public Sector Equality Duty and Equality Impact Risk Analysis

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

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

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

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

Recommendations

The Board of Directors is requested to:

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

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

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

Integrated Performance Report

Purpose of Report

The purpose of this report is to provide the Board of Directors with an update of how the Trust was performing at the end of January 2024. The report focuses on key finance, performance, and workforce measures.

Executive Summary

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

Operational Performance

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

Most challenging areas:

- Waiting times for adult autistic spectrum disorder assessment – demand continues to outstrip commissioned capacity and as a result, the average wait to be seen is around 76 weeks. Activity levels have increased significantly, which is having a positive impact, and over the last six months, the waiting list has reduced by 27%.
- Community paediatric waiting times – ongoing high levels of demand, pathway issues and recruitment challenges.
- NHS Talking Therapies waiting times – recent recruitment should start to have a positive impact on waits from the end of January.
- Memory Assessment Service waiting times – waits from referral to actually being assessed are currently around 32-34 weeks. There is ongoing significant demand for the service which exceeds funded capacity.
- Inappropriate out of area placements and inpatient bed occupancy levels – enduring high level of need for inpatient treatment

Most improved areas:

- CAMHS waits continue to reduce and over the last 12 months the average wait to be seen has halved.
- Dementia diagnosis rate continues to exceed target.
- Community perinatal access levels continue to increase. Capacity continues to be demonstrated within the system to offer over 90 assessments a month. Achieved target within service level data in 6/23 and 1/24. Currently achieving 9.4% of the 10% target, with 127% growth in activity over the years 2020/21 to 2023/24.

Finance

At the end of January 2024 (month 10), the year to date (YTD) position is a deficit of £2.3m (after adjusting for the impairment loss on Audrey House) against a planned surplus of £1.0m, an adverse variance of £2.9m.

Last month (month 9) the forecast position moved from being breakeven to a deficit of £4.4m, with the Derbyshire system reporting a forecast deficit position of £47.7m. This is due to emerging cost pressures now being recognised in the forecast outturn.

The year end deficit position of £4.4m is driven by the following:

- Public Dividend Capital (PDC) funding withdrawal of £2.5m.
- Complex Eating Disorder patient income risk of £2.5m.
- Industrial action of £0.2m.
- Pay award cost pressures of £0.2m.
- Excess inflation related to the Private Finance Initiative (PFI) contract of £0.4m.
- IFRS16 accounting benefit of £0.8m non-recurrent (change to right of use accounting for Saint Andrew's House).
- Management of operational cost pressures offset by vacancies, interest income, cost reductions and release of balance sheet items.

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

A deep dive into this BAF risk was presented to the Audit and Risk Committee in January 2024.

Efficiencies

The plan includes an efficiency requirement of £8.8m phased equally across the financial year. As at the end of January, £7.5m was achieved against a YTD target of £7.3m. The full £8.8m of savings has been identified and the forecast assumes that they are delivered in full, although the risk remains that a significant proportion of these savings is being delivered non-recurrently, impacting adversely into next financial year.

Key next steps:

- **Development of recurrent plans to minimise the adverse impact into 2024/25 as currently 75% are being delivered non recurrently.**

Agency

Agency expenditure YTD totals £7.8m against a plan of £4.4m, an adverse variance to plan of £3.4m. This includes £2.4m of additional costs to support a complex patient on one of the wards. The two highest areas of agency usage continue to relate to Consultants and Nursing staff. The agency expenditure as a proportion of total pay for January is 4.1%. The agency plan for the year is set at 3.5% of total pay expenditure, which is just below the target set by NHSE in the planning guidance of 3.7%. Agency is forecast to be above plan by £3.7m, of which £2.9m relates to the complex patient that is being supported.

Out of Area Placements

The plan for out of area expenditure has been reduced by £1.0m in 2023/24, as part of the £8.8m efficiency programme. As at the end of January, there was an overspend against the reduced plan of £1.8m, with a forecast overspend of £2.5m for the end of the financial year. The forecast assumes 22 out of area patients each month for the remainder of the financial year.

Capital Expenditure

Capital expenditure at the end of January is slightly behind plan due to the impact of IFRS16 leases. The IFRS16 lease change along with additional IT expenditure impacts on the forecast with capital expenditure for the year being slightly above plan by £0.5m.

Better Payment Practice Code (BPPC)

In January, the target of 95% was exceeded by value by 97.3% but was very slightly under at 94.9% on volume.

Cash and Liquidity

Cash at the end of January is at £38.5m and is forecast to be at planned levels of £23.7m by the end of the financial year.

Quality

Compliments and Complaints

The number of compliments and complaints received remains within common cause variation. Complaints have fallen for the last three months.

Clinically Ready for Discharge

The number of service users meeting the criteria of clinically ready for discharge (CRD) has been significantly high for the last nine months. The most common reason for patients meeting the criteria for CRD continues to be the identification of appropriate housing or social care placements.

Key next steps:

- ***Twice weekly CRD meeting where any barriers to discharge are identified and discussed to support resolution.***
- ***The Older People's division continues to work in collaboration with Joined Up Care Derbyshire to identify patient-centred solutions for those service users awaiting placements that meet their needs.***

Care Plan Reviews

The current percentage of patients who have had their care plan reviewed and have been on CPA for over 12 months is 70%, an increase of 9% between November 2023 and January 2024.

Key next steps:

- ***A new data hub was introduced to the Trust for each team to use to review the new report and cleanse the data.***
- ***A process for monitoring compliance and quality has been implemented in each division and monitored via the monthly Fundamentals of Care meeting, (in Inpatients, the Clinical Reference Group) and the Divisional Clinical Operational Assurance Team (COAT) meetings.***
- ***The Community Mental Health Teams have been set a target to achieve 85% compliance by April 2024. It is expected that this target will be met within the identified time frame (currently 70%).***

Patients in Employment and in Settled Accommodation

Following an update in how the data related to patients having their accommodation status recorded as was completed in December 2023, the number has increased by 20%. There has been no change in the number of patients recorded as in employment.

Medication Incidents

The number of medication incidents reported is now back in line with common cause variation.

Incidents of Moderate to Catastrophic Actual Harm

There has been an increase in the number of incidents routinely reported by staff, following support from the Patient Safety team, and a rise in incidents recorded as “self-harm” and physical assault of staff by patients. The Trust Positive and Safe team are to complete a thematic review to identify learning points to reduce incidents of this type. The results of this review are expected in April 2024.

Duty of Candour

The number of incidents meeting the threshold for Duty of Candour has remained within expected thresholds.

Prone Restraint

Prone restraint remained consistently under the Trust target of 12 incidents between November 2023 and January 2024.

Key next steps:

- ***a project to introduce simulation-based training is expected to start in March 2024. This will include interventions that would be expected to maintain low levels of prone restraint.***

Physical Restraint

Incidents involving physical restraint have increased by 4% between November 2023 and January 2024. This is continuously reviewed within the Reducing Restrictive Practice Group and the Trust Positive and Safe Support team continue to offer extra training sessions to improve training availability for staff.

Seclusion

Seclusions between November 2023 and January 2024 have increased from eight to 15 but are still below the mean average of 20 episodes of seclusion.

Falls on Inpatient Wards

The number of falls recorded between November 2023 and January 2024 has reduced from 39 to 29 and is below the Trust target of 30.

Care Hours Per Patient Day (CHPPD)

In the latest published national data, when benchmarked against other mental health trusts, our staffing levels remained below average overall.

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

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

Risks and Assurances

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

Consultation

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

Governance or Legal Issues

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

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

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

Recommendations

The Board of Directors is requested to:

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

Report presented by: **Lee Doyle**
Interim Executive Director of Operations

David Tucker
Interim Executive Director of Operations

James Sabin
Executive Director of Finance

Rebecca Oakley
Acting Director of People & Inclusion

Kyri Gregoriou
Deputy Director of Nursing and Quality Governance

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

Rachel Leyland
Deputy Director of Finance

Rebecca Oakley
Acting Director of People & Inclusion

Liam Carrier
Interim Deputy Director of People & Inclusion

Joseph Thompson
Assistant Director of Clinical Professional Practice

Performance Summary

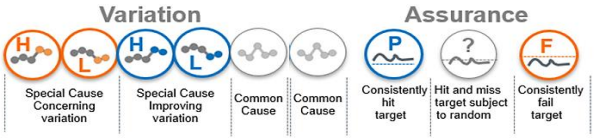
Areas of Improvement	Areas of Challenge
Operations	
• Transforming care programme – discharges and annual health checks • Psychology waiting times • CAMHS waiting times • Dementia diagnosis rate • Perinatal access	• Community mental health waiting times • Adult ASD assessment waiting times • Community paediatric waiting times • NHS Talking Therapies waiting times • Memory Assessment Service waiting times • Inappropriate out of area placements • Inpatient bed occupancy levels
Finance	
• Efficiency • Better Practice Payment Code	• Financial deficit • Agency expenditure • Liquidity
People	
• Annual appraisals • Compulsory training • Filled posts • Reduction in agency staff use	• Staff absence • Bank staff use • Supervision
Quality	
• Duty of candour incidents • Care plan reviews	• Clinically ready for discharge • Incidents of moderate to catastrophic harm

Assurance Summary

A. Operations

	Metric Name	Performance	Assurance	Latest Value	Target	Lower process limit	Upper process limit	Mean
1a	Waiting list - care coordination - average wait to be seen					23	35	29
1b	Waiting list - care coordination - number waiting at month end					60	104	82
2a	Waiting list - ASD assessment - average wait to be seen			73		70	76	73
2b	Waiting list - ASD assessment - number waiting at month end			1,593		1782	2040	1911
2c	ASD assessments			66	26	7	52	30
3a	Waiting list - psychology - average wait to be seen			34		2	69	36
3b	Waiting list - psychology - number waiting at month end			556		728	971	849
4a	Waiting list - CAMHS - average wait to be seen			14		16	24	20
4b	Waiting list - CAMHS - number waiting at month end			328		402	590	496
5a	Waiting list - community paediatrics - average wait to be seen			43		24	31	27
5b	Waiting list - community paediatrics - number waiting at month end			2,220		1931	2348	2139
6	Outpatient appointments cancelled by the Trust			7%	5%	3%	12%	7%
7	Outpatient appointment "did not attends"			14%	15%	10%	15%	12%
B1	3 day follow-up			93%	80%	77%	96%	86%
D1	Community Mental Health Access (2 plus contacts)			11,820	11,899	9410	10165	9787
E1	Children & Young People Mental Health Access (1 plus contact)			3,405		2949	3144	3046
E4	Children & Young People Eating Disorder Waiting Time - Routine			100%	95%			
E5	Children & Young People Eating Disorder Waiting Time - Urgent			n/a	95%			
G3	Early intervention 14 day referral to treatment - complete			79%	60%	64%	106%	85%
G3	Early intervention 14 day referral to treatment - incomplete			81%	60%	56%	117%	86%
H0	IAPT 6 week referral to treatment			61%	75%	55%	73%	64%
H1	IAPT 18 week referral to treatment			99%	95%	98%	101%	99%
H2	IAPT 1st to 2nd Treatment over 90 Days			26%	10%	6%	24%	15%
H7	IAPT patients completing treatment who move to recovery			55%	50%	43%	59%	51%
I1	Individual Placement and Support Access			485	343	130	400	265
K2	Total inappropriate out of area bed days			3,285	0	1,384	2,170	1,777
K2	Average patients out of area per day - adult acute			17	0	0	14	7
K2	Patients placed out of area - adult acute			28	0	0	23	11
K2	Average patients out of area per day - PICU			20	0	8	21	14
K2	Patients placed out of area - PICU			35	0	14	33	23
L1	Perinatal Rolling 12 Months Access			9%	10%	5%	6%	5%
L2	Perinatal Access Year to Date			875	1,070	219	575	397
N4	Data quality maturity index			99%	95%	98%	99%	99%

Key to symbols[1]:



Blue dots indicate special cause variation, better than expected.

Orange dots indicate special cause variation, worse than expected.

[1]The rating symbols were designed by NHS Improvement

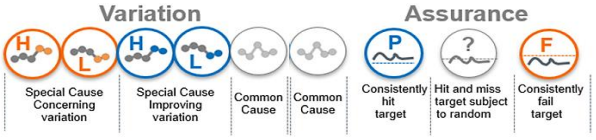
B. People

	Metric Name	Variation	Assurance	Latest Value	Target	Lower process limit	Upper process limit	Mean
1	Annual appraisals			86%	90%	77%	82%	79%
2	Annual turnover			13%	8-12%	12%	14%	13%
3	Compulsory training			91%	85%	87%	89%	88%
4	Staff absence			7%	5%	5%	8%	6%
5	Clinical supervision			82%	95%	73%	78%	76%
6	Management supervision			80%	95%	71%	77%	74%
7	Filled posts			94%	100%	90%	95%	93%
8	Bank staff use			5%	5%	4%	7%	6%

C. Quality

	Metric Name	Performance	Assurance	Latest Value	Target	Lower process limit	Upper process limit	Mean
1	Compliments received			90	119	72	165	118
2	Formal complaints received			9	13	4	32	18
3	Proportion of patients clinically ready for discharge			11%	3.5%	4.1%	11.6%	7.9%
4	CPA reviews			67%	95%	62%	77%	69%
5	Patients in employment			12%		9%	13%	11%
6	Patients in settled accommodation			49%		32%	48%	40%
7	Number of medication incidents			87		51	113	82
8	No. of incidents of moderate to catastrophic actual harm			94	48	26	87	56
9	No. of incidents requiring Duty of Candour			0	1	0	5	1
10	No. of incidents involving prone restraint			10	12	0	24	11
11	No. of incidents involving physical restraint			75	46	33	113	73
12	No. of new episodes of patients held in seclusion			15	14	3	35	19
13	No. of falls on inpatient wards			29	30	16	55	36

Key to symbols[1]:



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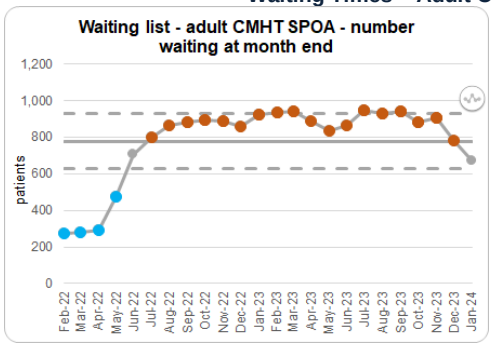
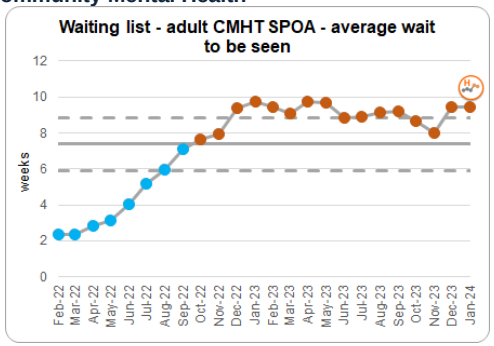
NHS
Derbyshire Healthcare
NHS Foundation Trust

Operations

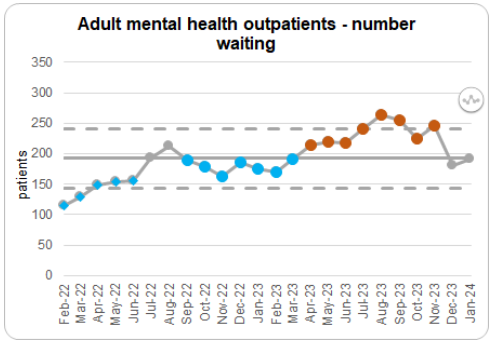
Operational Performance

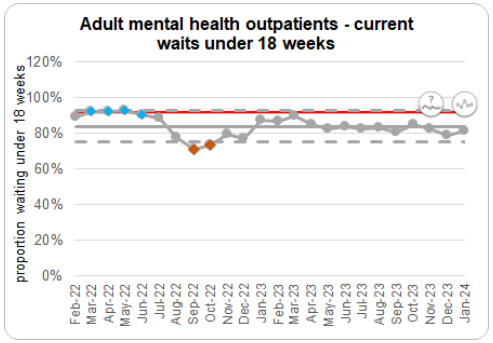
Waiting Times – Adult Community Mental Health





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





Summary

For adult CMHT, the number waiting has been on a downward trajectory, although the average wait has started to increase again since November 2023. The outpatient waiting lists have been increasing significantly for the last 9 months, although had a reduction in December 2023. The proportion of people waiting over 18 weeks remains too high.

The working age adult community teams continue to receive more referrals in comparison with the older adult teams. Working age adult teams also hold a significant number of patients over the age of 65, accounting for 4% of the total caseload and these continue to be reviewed on an individual basis to assess the most appropriate service to meet their needs.

In the most recently published national benchmarking data, the Trust's median length of stay in community mental health services from referral to discharge was 111 days, which is considerably higher than the national median of 57 days. The Trust's average community mental health caseload size as a proportion of total trust caseload was 42.8%. In comparison, the national median was 30.5% (https://model.nhs.uk/)

Outpatient caseloads are particularly high in some teams, and with high caseloads it is difficult for teams to have capacity to pick up new cases and be responsive to those most in need. To address the waiting lists, reducing numbers waiting and length of time waiting, there needs to be a focus on productivity within all parts of the service pathway to ensure we increase flow, reduce unwarranted variation, and get best value for money.

The Adults of Working Age Community Mental Health Services division have developed a productivity plan on a page and associated action plan:

3-month plan:

- Targeted messaging – accountability, back to basics, getting it right
- Implementation of MaST*
- Setting expectations – number of contacts; caseload numbers vs productivity
- Understanding reporting and variance
- Increased face to face training and support around recording in SystmOne
- Commence scoping for screens in team bases to display compliance with KPIs**

6-month plan:

- Consistent continued messaging around accountability, back to basics, getting it right
- Embedding MaST into business as usual*
- Regular monitoring of performance against agreed expectations for contacts, caseloads and productivity
- Consistent use of the Employee Improvement Policy and Procedure
- Improved data accuracy
- Roll out of screens in team bases displaying data, productivity and performance**
- QI approach to outpatient caseload management

12-month plan:

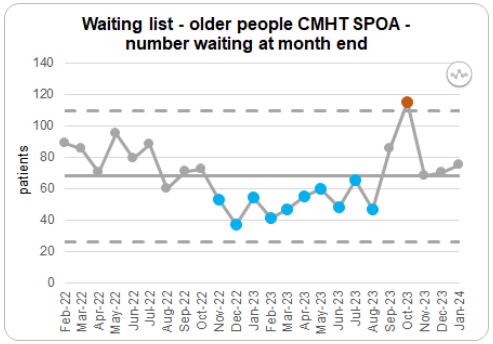
- Data, productivity and performance conversations are business as usual via use of screens in team bases displaying relevant dashboards**
- Fully embedded use of MaST*
- Optimised caseloads within the long-term offer
- Increased compliance with 4-week referral to treatment
- Accurate waiting lists that are reflected across all reporting dashboards
- Improved staff wellbeing – increase in positive response in staff survey
- Apply the learning from the outpatient caseload management QI project and embed as business as usual

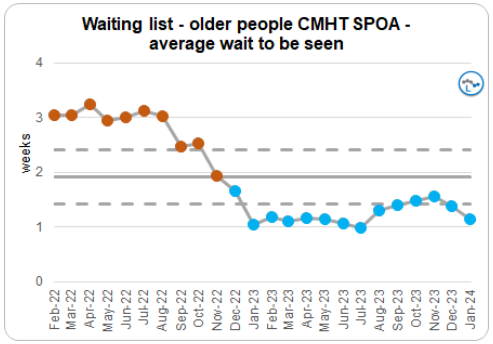
*The funding for year 1 of MaST comes to an end in May 2024 and there is a significant risk that the funding for year 2 will not be approved (business case currently being written). The benefits of MaST will not be seen until at least year 2, so if funding is not approved it will have a significant impact on the productivity action plan.

**This project is for Adult and Older Adult CMHTs. Given the current financial position of the Trust, there is a risk that funding will not be agreed to support the implementation of the data screens. 12 screens have been identified by IM&T that could be repurposed for this project, however, the CMHTs would be charged full price for these screens. 3 pilot sites have been identified for this project in the first instance.

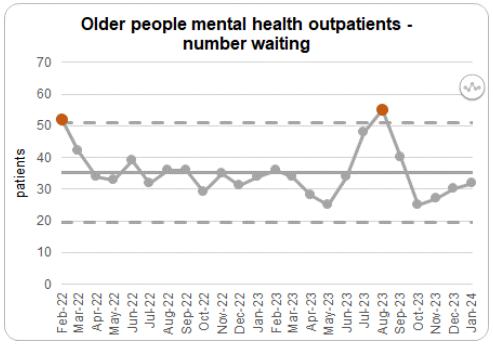
Operational Performance

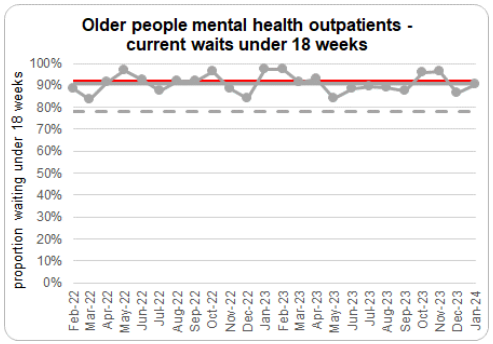
Waiting Times – Older People Community Mental Health





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

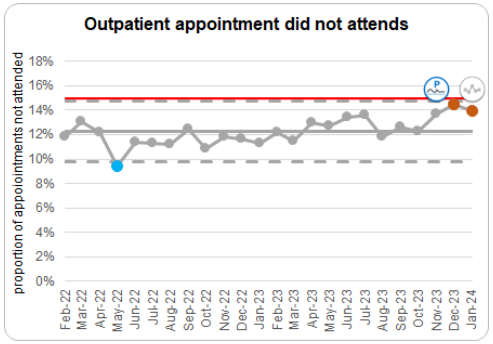


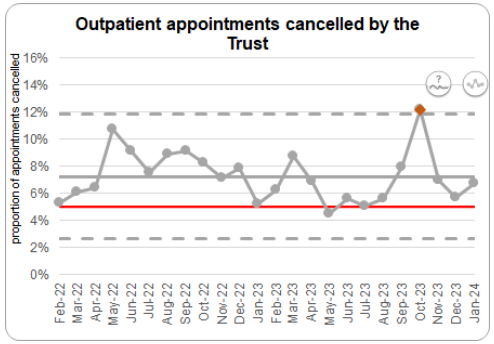


Summary

The number waiting is continuing to reduce in older adult SPOAs. The average wait remains very low at around 1 week. A small number of people are waiting for each outpatient service.

Outpatients



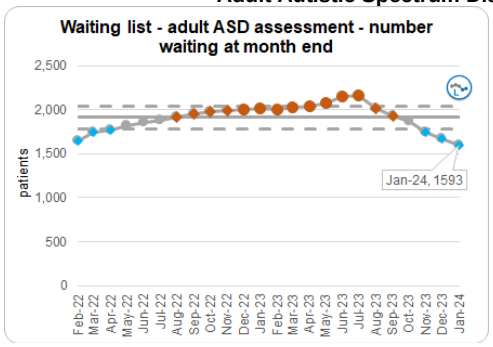


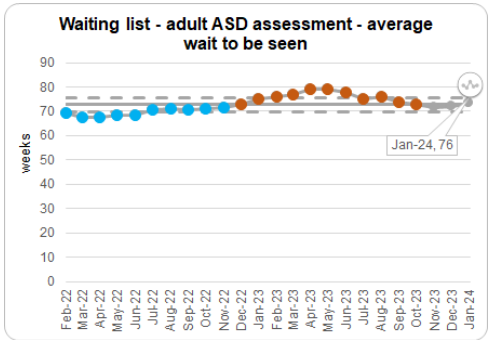
Summary

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

Operational Performance

Adult Autistic Spectrum Disorder Assessment Service





Referrals

Year	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2016				18	15	20	23	28	31	26	27	18
2017	19	17	9	20	23	21	25	22	27	43	30	29
2018	29	34	32	41	47	40	62	41	45	54	48	22
2019	92	65	52	50	82	71	77	49	59	34	55	46
2020	83	32	28	45	20	46	17	27	14	48	77	74
2021	43	56	58	59	85	80	64	56	51	70	55	114
2022	62	62	141	74	100	97	50	70	88	65	70	52
2023	40	10	43	42	111	125	122	58	160	115	166	87
2024	93											

Assessments

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2016				19	7	22	5	4	19	20	15	13
2017	35	37	47	22	22	18	30	16	24	34	30	12
2018	20	15	23	18	19	20	22	11	13	14	20	20
2019	33	24	25	24	19	18	15	11	26	30	34	15
2020	28	27	22	1	5	11	20	16	18	29	18	15
2021	20	17	22	22	17	12	14	14	24	24	15	6
2022	12	12	21	13	10	14	8	6	20	22	20	15
2023	22	28	24	22	18	31	30	35	65	54	70	50
2024	66											

Summary

Demand for the service continues to outstrip capacity (commissioned to undertake 26 assessments per month but now receiving around 100 referrals per month this financial year). The process for assessments has been significantly streamlined to reduce assessment time and create capacity to carry out more assessments hence seeing an increase in recent months. At the end of January 2024 there were 1,593 adults waiting for assessment, which is a significant reduction. The number of completed assessments per month has increased and the full year contractual target has already been achieved. Due to data quality issues and some changes at point of entry there continues to be some slight anomalies in data accuracy, and we continue to run a manual and automated report whilst we work through this. Month on month this is improving, and the trends and data are close to alignment.

Actions

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

Transforming Care Programme

Summary

Current inpatient numbers are: ICB +1 over stretch trajectory, spec com is +2 over trajectory and CYP +1 over stretch trajectory.

Actions

Reducing Inflow

- LD&ASC Support and Intervention Team (SIT) continues to support hospital avoidance with positive impact.
- Enhanced Community Support (ESC) workstream co-led with revised action plans on Local Area Emergency Protocol (LAEP), Dynamic Support Pathway (DSP) and Care (Education) and Treatment Reviews (C(E)TRs) near completion.
- The DSP re-design is near completion. New DSP Standard Operating Procedure (SOP) and all linked DSP documentation are currently out for final comments from key stakeholders across the system, with the aim to go 'live' in March 2024, with a review in 12 months' time allowing time for the new process to be embedded. Workshops and training will then be developed and fully launched together with the LAEP and CTR processes across the system.
- JUCD webpage currently being developed to present all DSP information and 'house' all related documentation for ease of access for people with a learning disability and/or autism, families, carers and health and social care colleagues across Derby & Derbyshire

Improving Flow

- Substantial work undertaken to improve flow with dedicated leads coordinating all the AMH, out of area locked rehabs/ATU and spec com beds and plan repatriation back to Derbyshire. Including setting up community services for individuals including contracting linking in with ICB. Significant improvements in out of area over the last 8 months (June 2023 – 14 February 2024).
- No of discharges into the community by hospital type:
    - Locked Rehab = 5 discharges
    - ATU = 5 discharges
    - Spec Comm = 2 discharges
    - CYP = 1 discharge

- The combined total length of stay (LoS) for all discharges since June 23 is just over 30 years. As part of that total LoS, there have been some significant discharges from Assessment and Treatment Unit (ATU) and Locked Rehab (LR) which totalled Locked Rehab = 7426 and ATU = 3517, there was also provider collaborative patients who combined LoS was 145 days. Progress has also been made on transferring from MSU to locked rehab, with one patient LoS in MSU of 2159 days stepping to LR. In addition to this there was also a step down from Tier 4 to LR. This patient had a LoS in Tier 4 of 841 days (these are not counted in the 30 years above as these patients are still in a hospital setting).

Expediting complex discharges / Improving outflow

- To eliminate MFFDs due to placement availability, system work to improve provider capacity and capability. Stratification and discharge planning workshop took place in November for all ATU, Locked Rehab & Secure inpatients and community placements and this work continues. This is now fed into the Joint Solutions Group (JSG) meeting where it continues to be reviewed to ensure continued progress & links are made to strategic commissioning as needed. The JSG meeting, also allows for any 'themes' that are raised through the DSP, LAEPs, C(E)TRs and hospital discharge planning to be discussed and reviewed.

Annual health checks:

*AHCs - Q3 target = 1338, Q3 actual completed = 1256. 94% of Q3 target. In January 24, achieved 666 against a target of 714.

Operational Performance

Psychology & Psychological Therapies

Introduction
The Division has maintained its excellent reputation in the region for being a fantastic place for psychologists to work and is the employer of choice. We currently have 4.5% vacancy. We are working hard to manage the shrinking budgets to still maintain our values, support and deliverables. CIP plan currently in place to meet required amount recurrently. There is still some further work to do on correctly aligning the divisional structures.

Workforce update
Sickness & morale: Sickness within the division was unusually high at 7.2% in January as a result of coughs, colds and influenza. We also have staff off with physical health issues. Although finding the workplace tough, there are no staff off with stress and anxiety related issues. We have little long-term sickness. Morale remains largely positive, but staff are worried about the financial situation and the impact of the cost improvement plan. The staff survey shows positive feedback about the formation of the division and immediate managers and teams. It does, however, reflect challenges relating to high workloads, parking and accommodation.

Trainees: we continue to take a wide range of trainees into our services as part of our sustainability plan. They include CBT, DClinPsy and psychotherapy trainees. We also continue to provide training for professional courses locally.

Hybrid working and travel: Staff in the division continue to work broadly to a 60/40 split. The aim is to maintain this.

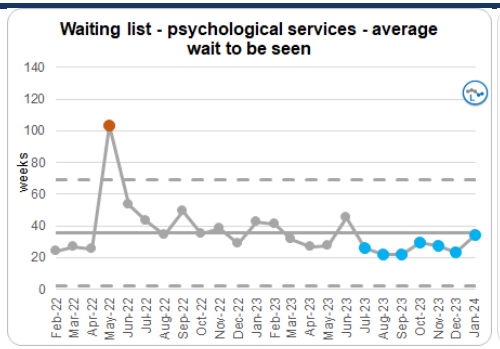
LD psychology in the North of the county: We have started the recruitment for posts in the north of the county. Over the next 6 months we will build a service to support people with a learning disability to parallel the service in the south and city. Whilst we will work hard to provide equity of care across the county, the financial envelope is notably small.

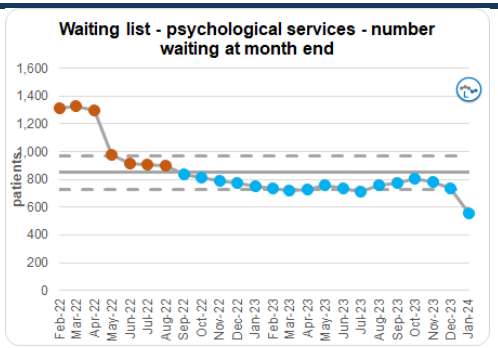
Health psychology: The heath psychology team continue to work with the ICB and partners in the system to provide care across a range of specialities (stroke, pain, cancer). They remain engaged in a JUCD review of all stroke services in the county.

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

- Cognitive Behavioural Therapy received 27 responses and 100% were positive
- Amber Valley Adult Psychology received 11 responses and 100% were positive
- Psychodynamic Psychotherapy received 4 responses and 100% were positive
- NHS Talking Therapies received 1,797 responses and 98% were positive.
- South & Dales Older Adult Psychology received 1 response which was positive

Partnership, system and PLACE working
This continues to grow and develop in line with the living well. Staff are working across the landscape and linking in with GP services and VCSE sector. We are providing support to our police colleagues working with homelessness by way of reflective practice sessions, and looking to see how we can partner up for further MH support and prevention work in the system.





Waiting lists and referrals
Overall, there has again been a reduction in the number of people waiting for psychological input, although the average wait to be seen has risen slightly. Focused quality improvement work around older adult, learning disability and some working age adult teams to manage and reduce the waiting lists across the division has resulted in a significant reduction in waiting times and numbers waiting. Referral numbers remain high.

Trust wide staff wellbeing
Wellbeing, trust wide remains a priority for all teams. Our in-house service provision of psychological support is actively working with the sickness specialists within the employee relations team, to plan a pathway to support those people with anxiety / depression / stress at the heart of their challenge. This service continues to support individuals with psychological needs within our workforce.

Supervision & appraisal
Clinical supervision is currently at 96.2% for the division. Whilst this remains above trust target, our aim is for 100% to be maintained. This is raised at the monthly Leads meeting as well as within our Divisional COAT. Management supervision is at 94.7% whilst appraisal completion currently stands at 89.3%. We are tackling the issue with recording and uploading the IPRs through the system.

Increasing psychological awareness
The Bite size psychological teaching sessions continue to have good attendance with a range of topics being delivered. The timetable for 24/25 is now out.

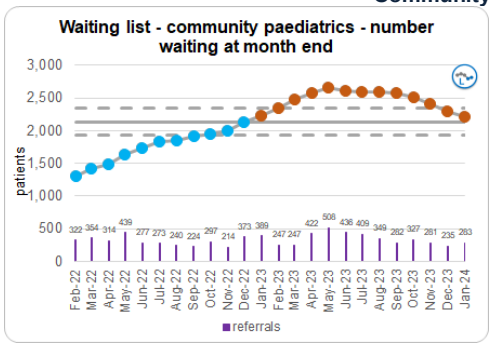
The trauma informed Board has developed the strategy and plans for training regarding Trauma informed working and this has been reviewed and agreed at Trust Leadership Team.

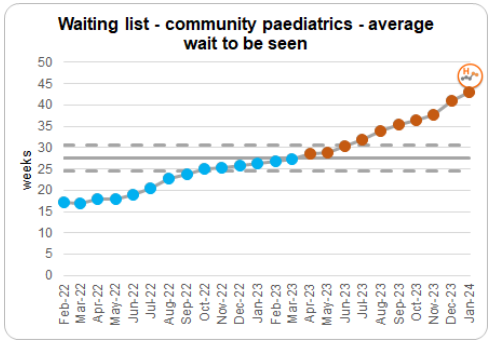
Benchmarking, Productivity & Finance
This is part of an ongoing national discussion. Financially, we remain within budget, have no unfunded posts or roles, agency or bank. We have submitted a full CIP plan for the required recurrent CIP to 2025. BPS guidance being used to consider benchmarking.

Safety and quality
We remain focused on productivity. The SOP for EMDR was completed and shared at COAT and Trust Leadership Team for approval. Preparation is underway for the Divisional Review in April. Governance processes are in place. Teams also complete a monthly managers update with all performance metrics.

Operational Performance

Community Paediatrics





Summary

At the end of January 2024 there were 2,220 children waiting. The average wait time was 43 weeks. The ongoing shortage of ADHD medication has meant that children on specific medications have been reviewed as a matter of urgency as withdrawal has physical health implications. Children on current prescriptions have therefore been prioritised. There has been an increase in calls and demand on the medical secretaries, admin, Dr's and the ADHD nursing team in order to manage this subsequently further impacting on waiting times for children – as medications now start to become available the retitration of this will continue to have an impact on waiting times.

Internal factors:

- There is limited triage of cases coming into services prior to them being placed on the paediatricians waiting lists. Some of the internal pathways are unclear.
- Difficulty in discharging children under NICE guidance and shared care agreements in relation to medication for ADHD – specialist nursing team caseloads continue to expand causing problems with flow from the Comm Paeds service.
- Community Paediatrician vacancies and skill mix.

External factors contributing to increased demand on Community Paediatricians:

- Prior to March 2021 the referrals received was a level of demand that the service could manage, however Since March 2021 the volume of referrals received has risen and this higher level of demand has persisted to date.
- ASD/ADHD demand for specialist assessment increased 400% from 2018 to 2023 (22/23 4575 referrals per annum) with maximum South Derbyshire system capacity to assess 1900 per year)
- Developmental delay referrals to community paediatricians increased following the pandemic.
- Appointment duration has increased due to the increased complexity of children & young people (CYP) presenting needs post the pandemic.
- Demand for ASD and ADHD assessments is linked to an increase in SEND in schools, school pressures, cost of living crisis and reduced community support.

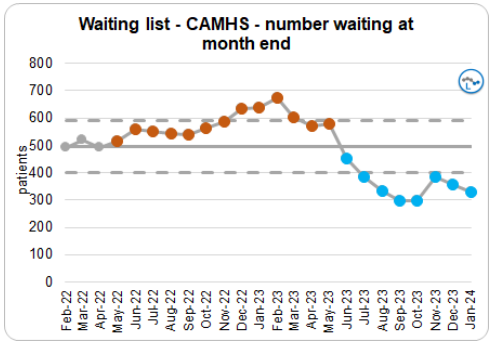
Mitigation:

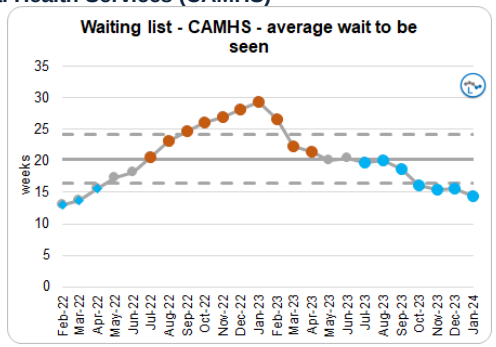
- Deputy Area Service Manager is now leading on transformation work for the CYP neurodevelopmental (ND) pathway, an oversight group has been set up for governance and clinical decision making, ongoing review of pathways active signposting and resources for families to access for support, advice and information and updates to website. This will also include ongoing quality improvement for the CYP ND transformation.

Mitigation (cont.):

- Recruitment update – Psychologist, Triage Nurse x 2 are now in post. Of the 2 Consultant vacancies – 1 applicant will be offered fixed term SAS Dr with a view to becoming substantive Consultant due to limited experience at Consultant level. Conditional offer to be sent next week. Second Consultant post is being reinterviewed in Feb/March 2024.
- Triage work is currently reviewing long waiters, system decision to focus on education / schools in order to prevent referrals by offering advice, support and signposting as needed. Pilot will be implemented over coming weeks targeting schools with high levels of referrals.
- Senior leadership attendance at system ND meetings to highlight risks and increase the Local Authority, Education and Primary Care accountability for the increasing demand.
- Clinic space remains under constant review.
- Review of vacant consultant posts and workforce continues, including consideration for skill mixing some of these posts. Working with recruitment team to update job descriptions to make them more attractive to potential applicants. Currently advertised posts include Specialty Doctor, Consultant Paediatrician ND & generic work and also Named Doctor for safeguarding – consultant.

Child & Adolescent Mental Health Services (CAMHS)





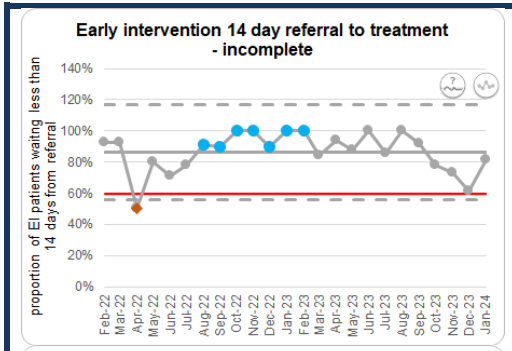
Summary

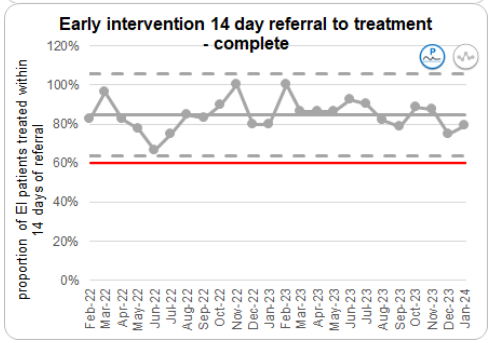
At the end of January 2024, 328 children were waiting to be seen. The average wait time was 14 weeks.

Actions

The triage and assessment team is now fully recruited into. They have been continuing to make strides with the external waits and are adhering to the Trust waiting well policy. They have though, due to the efficiency of the service, noted that waits for input from other services further along the pathway have increased. As a result, the team has decided to reduce the number of assessments the clinicians are doing per week, from 8 to 6. The aim is to stem the flow. This will be assessed at regular intervals, although inevitably, the external wait list will likely increase.

Operational Performance

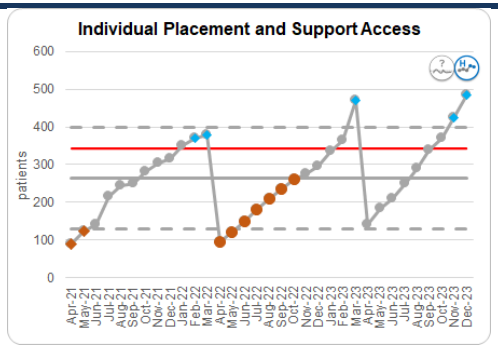




Summary

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

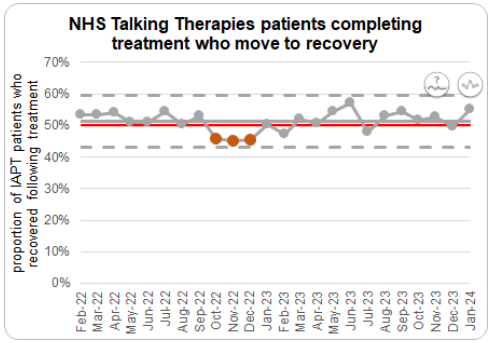
The service continues to be extremely responsive and has exceeded the national 14-day referral to treatment standard of 60% or more people on the waiting list to have been waiting no more than 2 weeks to be seen in all but one month over the past 2 years.



Summary

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

NHS Talking Therapies

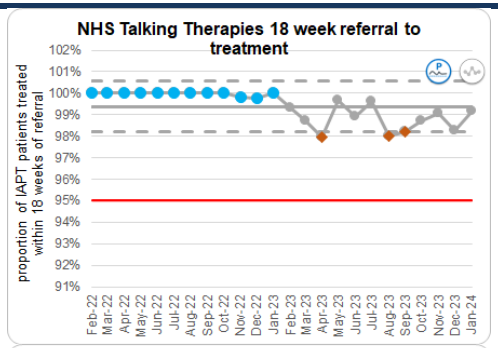


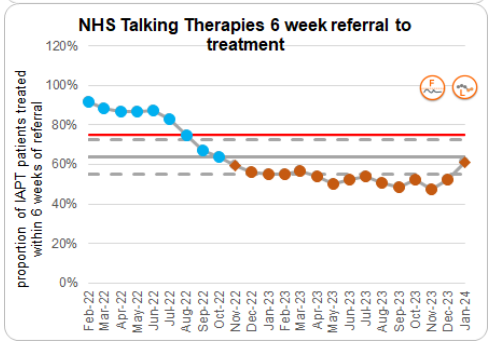
Summary

Recovery rates exceeded the 50% target in January achieving 54.9% with a year to date performance of 52.6%.

Actions

- Monthly performance reports are shared with individual managers, and with the Head of Psychological Therapies.



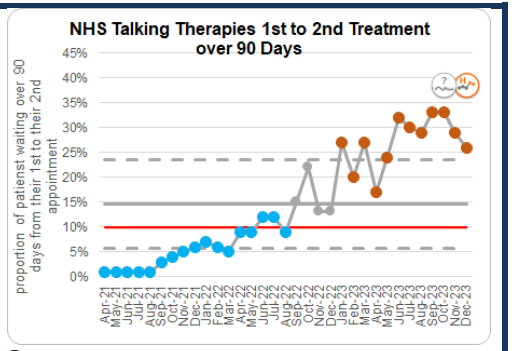


Summary

- 18-week referral to treatment performance continues to exceed target. This is for people who have been discharged. Those entering treatment have maintained the improvement in recent months and should show a continued improvement in the coming months reporting.
- The 6 week wait from referral to treatment has now shown improvement for the last two months for those discharged in month. Those entering treatment continues to show marked improvement which is now starting to show in the discharge figures.
- Referrals are slightly below pre pandemic levels, however the reduction in capacity within sub contractors and increased maternity leave remains challenging.

Actions

- The PWP recruitment has reduced the need for support within the Step 2 team for assessment to bridge the gap. Both recent recruits are now in post and are working towards their target contacts.
- The use of spot purchasing for assessments has now come to an end as the allocated number have been used up.



Summary

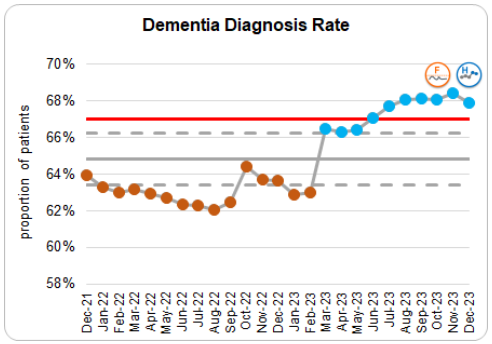
1st to 2nd treatment waits have been significantly high and above target for the last 11 months.

Actions

- Monthly Service Manager review of longest waiters to reduce outliers. This has had a significant impact on the longest waiters particularly for CBT.
- Supportive caseload management frameworks introduced to give better scrutiny of productivity re average contacts.
- IESO, one of our sub contractors continues to have some spare capacity for CBT treatment and awareness sessions at regional staff meetings have been booked.
- Maintain a focus on attendance and reduction of DNAs. DNA information is now circulated to service managers. This too forms part of caseload management.
- Further information is also circulated on booked contacts versus agreed targets broken down by clinician and month to promote individual improvements in performance.
- Review of acceptance criteria to achieve more appropriate referrals is ongoing and will include updated treatment contracting with patients. Assessment workshops have commenced with the first ones with PWPs in early Feb.
- Bookable appointment slots rolled out to all PWP assessors, these now allow for re-booking of appts and confirmation of appt dates and times.
- Average wait times for referral to assessment and referral to treatment are now shared with commissioners awaiting publication on the ICB website to promote patient choice.
- Wait list clarification for longest waiters has commenced to clarify if patients still require a service, this has been rolled out for the trauma wait list and a staged approach is being undertaken geographically.

Operational Performance

Dementia Diagnosis Rate



Summary

There has been a national drive to increase the proportion of people estimated to have dementia, who have a coded diagnosis of dementia. The target for Derby & Derbyshire ICB has been achieved since June 2023.

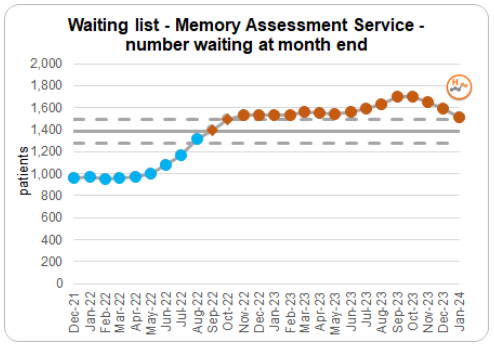
Dementia Diagnosis Benchmarking Data

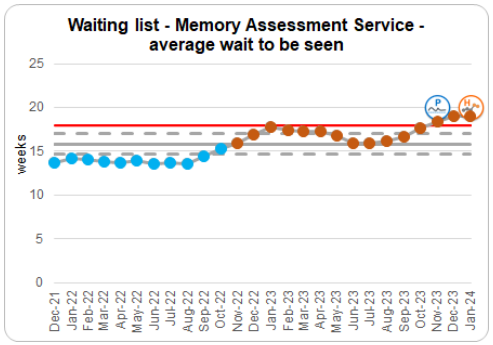
Type	ODS Code	Diagnosis rate (%)
National	ENGLAND	64.6
Region	LONDON	66.7
Region	SOUTH WEST	59.7
Region	SOUTH EAST	62.8
Region	MIDLANDS	64.3
Region	EAST OF ENGLAND	62.9
Region	NORTH WEST	69.3
Region	NORTH EAST AND YORKSHIRE	67.4
ICB	QE1	68.8
ICB	QF7	74.7
ICB	QGH	53.7
ICB	QH8	64.9
ICB	QHG	67.8
ICB	QHL	60.7
ICB	QHM	68.6
ICB	QJ2	67.9
ICB	QJG	60.3
ICB	QJK	57.7
ICB	QJM	65.6
ICB	QK1	65.8
ICB	QKK	69.6
ICB	QKS	59.4
ICB	QM7	64.8
ICB	QMF	60.4
ICB	QMJ	68.2
ICB	QMM	61.4
ICB	QNC	72.2
ICB	QNQ	67.6
ICB	QNX	63.7
ICB	QOC	60.8
ICB	QOP	73.0
ICB	QOQ	59.0
ICB	QOX	58.7
ICB	QPM	64.3
ICB	QR1	63.7
ICB	QRL	62.1
ICB	QRV	63.6
ICB	QSL	55.3
ICB	QT1	70.7
ICB	QT6	59.2
ICB	QU9	62.0
ICB	QUA	64.1
ICB	QUE	58.4
ICB	QUY	68.7
ICB	QVV	56.5
ICB	QWE	72.6
ICB	QWO	69.2
ICB	QWU	57.3
ICB	QXU	67.0
ICB	QYG	66.4

Primary Care Dementia Data, December 2023 - NHS Digital

The diagnosis rate in Derby & Derbyshire compares very favourably with other areas.

Dementia Diagnosis Waiting Times





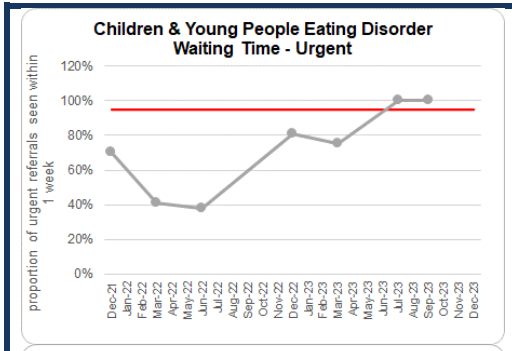
Summary

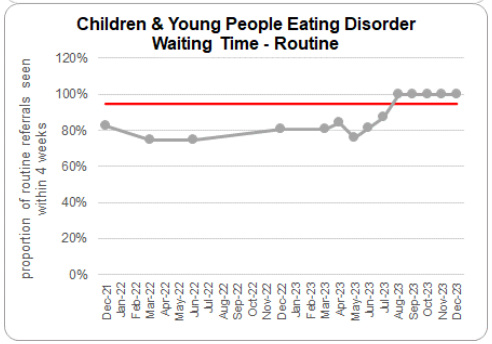
There continues to be an extremely high demand for the service which exceeds funded capacity, and at the end of January 2024 there were 1,511 people on the waiting list, with an average wait of just over 19 weeks, which includes people currently waiting as well as those who were assessed in month. Waits from referral to actually being assessed are currently around 32-34 weeks.

Actions

- Completion of quality improvement project to maximise and make best use of current resource, to ensure maximum capacity and quality of current provision
- Move diagnostic pathway for MAS 24 into CMHT: patients requiring diagnosis who are residing in 24 hour care will now be assessed and diagnosed under the care home project based in CMHTs
- Review of referral criteria for CMHTs and MAS, leading to a review of triaging to ensure robust processes are in place. 2 away days with CMHT and MAS managers have now taken place which involved reviewing referral criteria and review of triaging. Task & finish group led by Head of Nursing.
- Reducing the DNA rate
- Weekly emails to staff with individual performance data to ensure individual accountability for service provision
- Regular monitoring of wait times and data cleansing
- Continued focus on staff wellbeing and support

Operational Performance

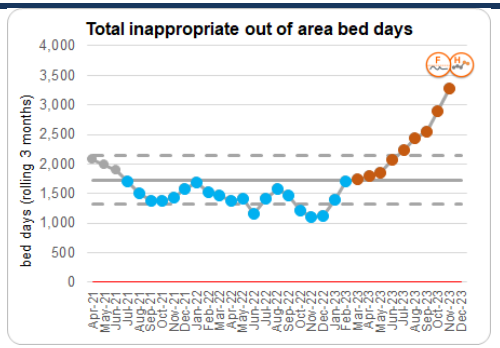




Summary

The waiting time standards are that children and young people (up to the age of 19), referred for assessment or treatment for an eating disorder, should receive NICE-approved treatment with a designated healthcare professional within one week for urgent cases, and four weeks for every other case (target 95%). The Trust's Child & Adolescent Eating Disorder Service is generally achieving around 100% for both standards, but unfortunately although the NHS England national standard states that *"CLOCK STARTS on the date the referral is received by the Community Eating Disorder Service for Children & Young People (CEDS-CYP) or generic CAMHS where the reason for referral is for a suspected eating disorder"*, the national measure is not based on service, it is purely based on anyone under 19 with a referral reason of eating disorder, and so referrals made to adult services are being included and are negatively impacting on the reported position. NHSE have switched to monthly reporting from April 2023.

The Division internally monitors the C&YP Eating Disorder Service waits from 1st to 2nd contact. In quarter 1 the average wait was 11 days, quarter 2 was 4 days and quarter 3 was 4 days.

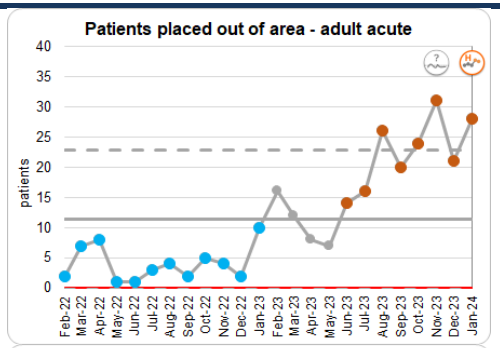


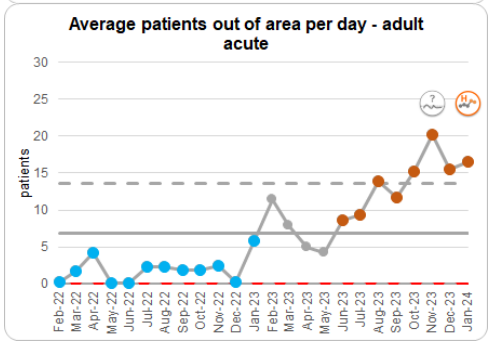
Summary

This is a national measure giving a combination of inappropriate out of area adult acute placements and inappropriate out of area psychiatric intensive care unit placements, calculated on a rolling 3 months' basis. There is an ongoing high level of demand for acute and PICU beds. The level of acuity is high necessitating the need for PICU beds and represented in the increase in admissions under the mental health act. There are no PICU beds in Derbyshire at this time and therefore all patients placed in PICU are placed in Out of area beds. Currently adult acute wards are working on capacity of around 108% as leave beds are utilised to support additional admissions. This has been a consistent factor over several months now. The opening of additional Step Down and Crisis House beds has not impacted this. As yet the impact of the crisis cafes on admissions is also yet to be established. The levels of acuity also results in people often taking longer to recover. The crisis teams continue to work with higher than usual caseloads in an attempt to avoid admissions to hospital wherever possible and appropriate.

Actions

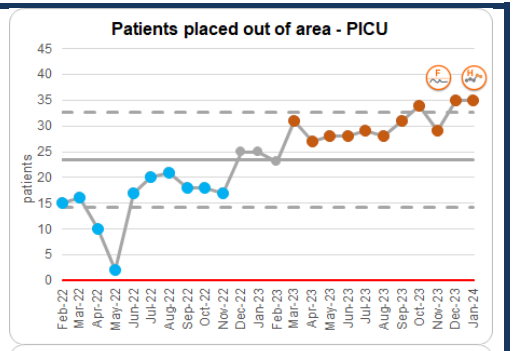
- The opening of the Ripley and Swadlincote crisis café was delayed but opened in December 2023.
- The demand for inpatient beds for LD&A patients continues. Changes to the pathway to improve assessment and decision making have been implemented which have helped to manage this to ensure community alternatives are explored prior to admission.
- Fiona White and Dr Rais Ahmed have been appointed to roles to support the flow of patients into and out of hospital.
- Liaison with the ICB regarding commissioning of inpatient service for people living in High Peak

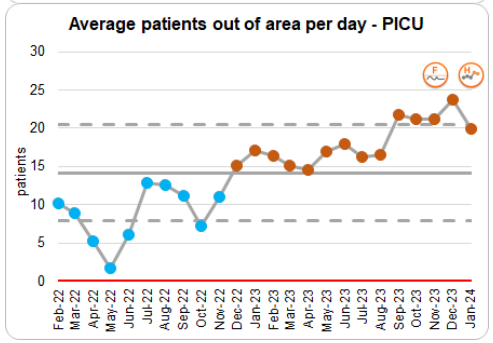




Actions (cont.)

- Flow structure to be implemented to provide a multi-agency response to the admission and discharge challenges.
- Implementation of community based Clozaril initiation, avoiding need for admission to hospital.
- Review gatekeeping function and purposeful admission to comply with the crisis fidelity model. Pilot due to commence on 1st March 24, full roll out planned for 1st April 2024.
- Enhance the impact of the Emotional Regulation Pathway to support prevention of admission to hospital and/or facilitate early discharge.
- Derbyshire Mental Health Response Vehicle is due to be implemented in June 24. This will be one vehicle staffed by a paramedic and a mental health nurse. Currently there are 2 street triage cars operating in Derbyshire staffed by police officer and mental health nurse which is expected to stand down when Response Vehicle is established. Both services operate 7 days a week covering 4pm to midnight.
- To implement MAST in CMHTs ensuring focused input to those at greatest need and risk of admission.
- To enhance the inpatient offer regarding Trauma Informed Care - to pilot on ward 33.





Summary

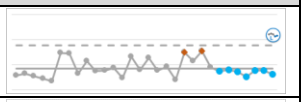
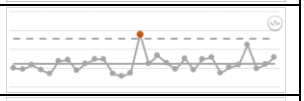
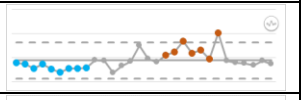
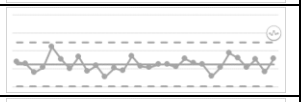
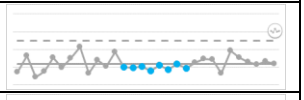
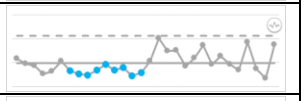
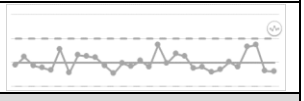
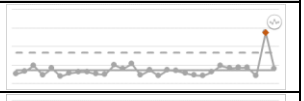
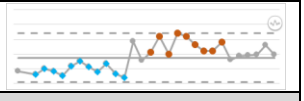
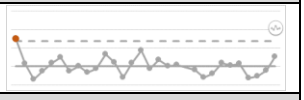
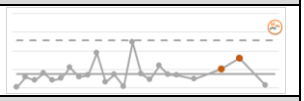
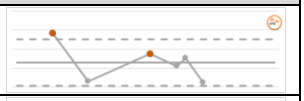
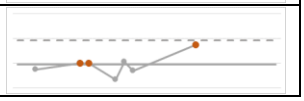
There is no local PICU provision, so anyone needing psychiatric intensive care must be placed out of area, however, work continues on the provision of a new build PICU in Derbyshire.

Actions

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

Operational Performance

Length of stay (days)

Clinical area	Beds	Bed occupancy Jan-24	Average duration of stay to date (days) of current inpatients	Average length of stay (days) Jan-24 discharged	Change versus previous month discharged	Change over time – average length of stay of discharged inpatients
Adult Acute						
Morton	20	104%	34	31	↘	
Pleasley	21	95%	68	78	↗	
Tansley	21	102%	47	37	↘	
Ward 33	20	105%	89	78	↗	
Ward 34	20	110%	59	60	↘	
Ward 35	21	116%	54	87	↗	
Ward 36	21	109%	82	31	↘	
Older People						
Tissington	18	96%	106	77	↘	
Cubley Female	18	81%	89	87	↘	
Cubley Male	18	92%	66	98	↘	
Perinatal						
The Beeches	6	87%	28	77	↗	
Rehabilitation						
Cherry Tree Close	23	72%	356	n/a	n/a	
Low Secure						
Curzon Ward	8	100%	517	n/a	n/a	
Scarsdale Ward	10	83%	849	n/a	n/a	

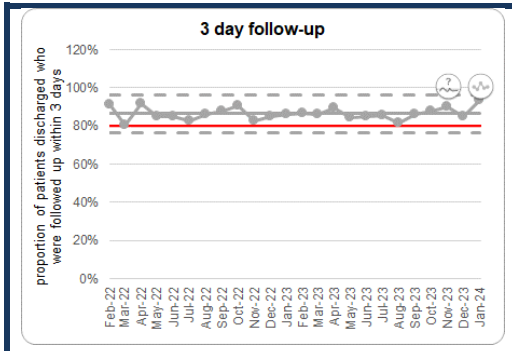
Explanatory note: where occupancy is over 100% this means that patients are on periods of trial home leave and their beds are being used for new admissions while they are at home. Leave beds used are predominantly safe planned leave, so leave would normally be extended, where safe to do so, to prevent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

NHS England measure and publish discharges per 100,000 population of adult acute inpatients with a length of stay of 60 plus days and of older adult inpatients with a length of stay of 90 plus days. The latest published position was as follows:

Indicator	Target	Actual	National Benchmark	Latest period
Adult Acute Long LoS (60+ days)	8	10	10	Nov-23
Older Adult Acute Long LoS (90+ days)	8	9	11	Nov-23

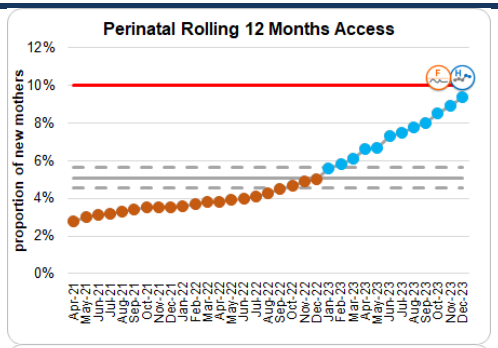
Research based on Erlang's queuing theory suggests that with the size of our bed base there should be a maximum occupancy of 85% in order to have readily available beds to enable management of acutely ill patients to occur in a safe and appropriate setting, and in order to protect both patients and staff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

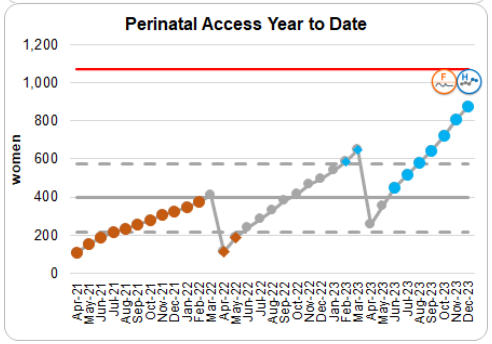
Operational Performance



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

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





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

The number of live births in Derby & Derbyshire has been lower each subsequent year than when the target was set, which makes it more challenging to achieve as there are fewer and fewer mothers who potentially need perinatal mental health support. 2022 data has now been published and there were over a thousand fewer births than when the target was set:

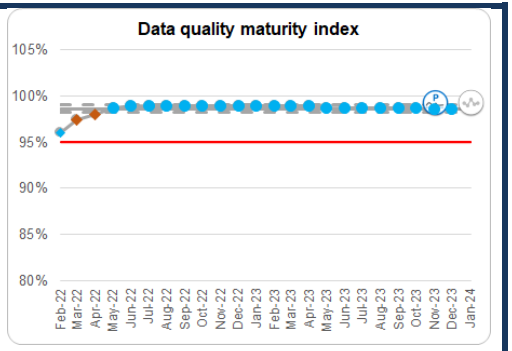
Live Births	Derby	Derbyshire	Total	Difference v 2016
2022	2864	7217	10081	-1033
2021	2896	7366	10262	-852
2020	2908	7002	9910	-1204
2019	3009	7336	10345	-769
2018	3174	7416	10590	-524
2017	3184	7563	10747	-367
2016	3294	7820	11114	

Referrals into the service continue to remain on an upward trajectory. Referral rates have been positively impacted by self-referral process, stakeholder engagements and community outreach workstreams.

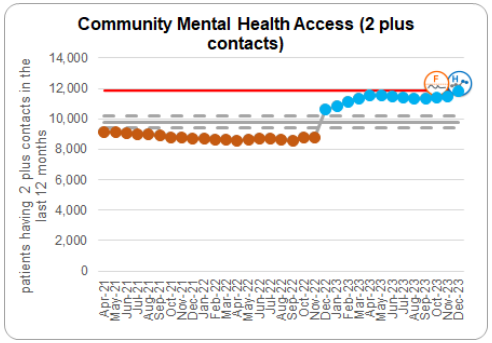
Capacity continues to be demonstrated within the system to offer over 90 assessments a month. Achieved target within service level data in 6/23 and 1/24. Currently achieving 9.4% of the 10% target and 127% growth in activity over the years 2020/21 to 2023/24 as of 10/23.

Current factors impacting achievement of target include DNA rates, staff sickness, vacancies, and delays in current Trust recruitment processes.

Actions
- CPN job plans and target caseloads in place based on demand and capacity modelling and the need to reduce unwarranted variation and improve patient flow.
- Identified need for specialist assessor role across North and South Teams.
- Stakeholder event, to ensure referrers are up to date with care pathways and referral processes.
- Service has strategic direction to address health inequalities and potential barriers to access.
- Recovery action plan in place regarding community waiting lists (referral to assessment and referral to treatment). Service wide approach to support waiting lists across both teams, has included additional clinics and support from inpatient team.
- Waiting well offer in place to support patients whilst on the waiting lists.
- DNA action plan



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



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

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

Operational Performance

Patients not seen for over 12 months

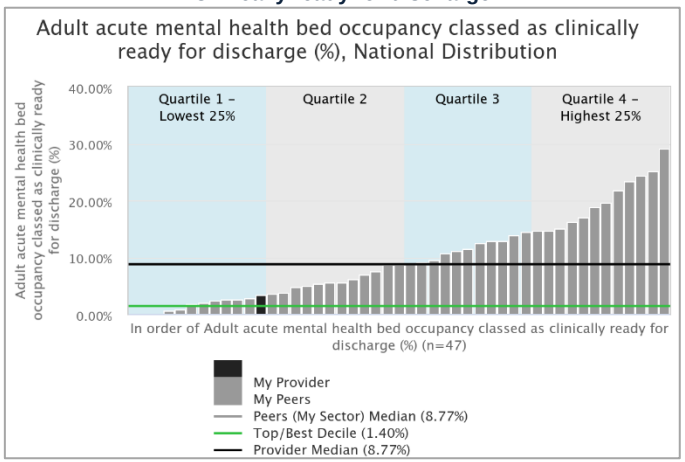
Summary

There are 268 patients on community mental health caseloads who have not been seen for over 12 months, according to their records. This is a reduction since last time. The majority are patients open to outpatients. Some will be people who have been discharged but the discharge has not been recorded correctly on the electronic patient record. Patient choice is a significant factor: over 60% of these patients did not attend, or cancelled, their planned appointments.

Actions

- The performance team escalate weekly to the senior managers concerned.
- Services to review the cases concerned and correct any errors on the patient records.
- Services to arrange appointments where required.
- Action is being taken to embed a culture of team caseload ownership, review and management within all services of the organisation.
- To be monitored at Trust Leadership Team Committee meetings
- MaST,
- Weekly IM&T data quality reports to managers and clinicians
- Weekly monitoring and progress updates by the Performance Manager
- Productivity plan on a page and action plan, as well as
- review of the lists by the clinical leads and offers of recovery focused assessments where appropriate

Clinically ready for discharge



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

Summary

This shows the proportion of adult acute mental health patients classed as clinically ready for discharge but continuing to reside in mental health hospitals against the total number of occupied beds. In the most recently published data, the Trust's clinically ready for discharge rate was 3.4%, which compares favourably with the overall provider median of 8.8% but continues to negatively impact on bed availability for people who need inpatient care. At the time of writing there are 25 patients clinically ready for discharge, which is an increase of 7 since the last report. The reasons for delay are as follows:

Delay reason	Rehabilitation	Older Adult	Adult	Grand Total	Average Days Delayed
Awaiting care package in own home		4	1	5	89
Awaiting further non-acute care	1		2	3	108
Awaiting nursing care home placement		4	1	5	82
Awaiting public funding			1	1	25
Awaiting residential care home placement		2	3	5	87
Disputes			1	1	29
Patient or family choice - care home with nursing placement		5		5	86
Grand Total	**1**	**15**	**9**	**25**	**84**

Actions

- In adult acute inpatients, a twice weekly clinically ready for discharge meeting is held with the discharge coordinators, and with attendance from social care. Actions are then taken away to escalate as required. There is also a weekly multi agency meeting to review all admission and discharges too.
- In older adult inpatients, delays in discharge are predominately placement issues in specialist 24-hour care settings. The teams hold twice weekly rapid review meetings with social care in attendance. Actions are taken from this and escalated as necessary. Ward flow coordinators chase placements requests and funding processes. On average every successful placement has been preceded by 8 to 10 providers declining to offer placement. Other reasons for delay are funding related, social care delays and family related issues.

Appointments not reconciled

Service	Appts	Change
ACUTE INPATIENT NORTH	271	↘
ACUTE INPATIENT SOUTH	170	↗
ADULT URGENT ASSESSMENT	25	↘
CAMHS	160	↘
COMPLEX CARE	94	↘
COUNTY NORTH	385	↗
COUNTY SOUTH	572	↘
DERBY CITY	196	↘
LEARNING DISABILITIES	139	↗
NOT KNOWN	287	↗
OLDER PEOPLES ACUTE CARE	55	↘
OLDER PEOPLES COMITY CARE	427	↗
PERINATAL	150	↘
PSGY ASM1	26	↗
PSGY ASM2	60	↗
PSGY ASM3	184	↘
SPECIALIST CARE	30	↗
SPECIALIST CARE MGT	31	↗

Summary

There is a large number of past appointments where the attendance outcome of the appointment has not been recorded, i.e. whether the patient attended or not. This continues to impact on reported waits, activity levels and reported did not attend rates. This data quality issue is linked to the move to SystmOne and people getting used to how to record activity. There has been significant improvement over the last 12 months, however further improvement is needed.

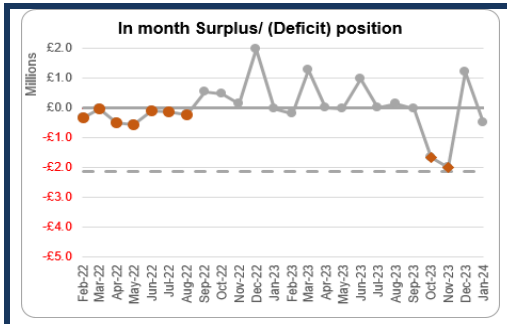
Actions

- IM&T have developed a weekly automated report to individual clinicians and managers which highlights any data quality issues within their caseload on SystmOne, to enable ongoing monitoring by managers and individual clinicians and identify areas where corrective action should be taken. The report includes unreconciled appointments. The report became fully operational 2 months ago following a successful pilot and over time should start to have a positive impact on data quality. It is early days and there are mixed results so far, with 50% of services showing an improvement but the other 50% showing an increased number of unreconciled appointments.
- Performance reports and MaST are helping to identify where the issue is a team or individual, enabling targeted training plans

Derbyshire Healthcare
NHS Foundation Trust

Finance

Financial Performance



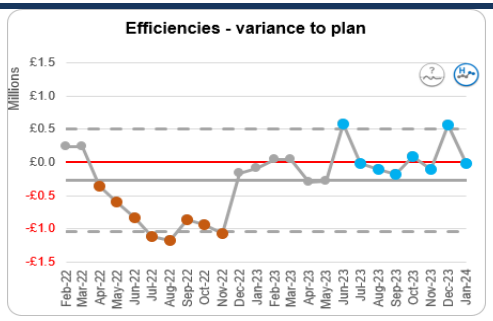
Summary
At the end of January, the YTD position is a deficit of £2.3m (after adjusting for the impairment loss on Audrey House) against a planned surplus of £1.0m, an adverse variance of £2.9m. In October we recognised the YTD impact of the PDC income loss and in November we recognised the YTD impact of the income risk for the complex eating disorder (ED) patient.

Last month (month 9) our forecast position moved from being breakeven to a deficit of £4.4m, with the Derbyshire system reporting a forecast deficit position of £47.7m. This is due to emerging cost pressures now being recognised in the forecast outturn.

Our forecast deficit position of £4.4m is driven by the following:

- PDC funding withdrawal £2.5m.
- Complex ED patient income risk £2.5m
- Industrial action £0.2m
- Pay award cost pressure £0.2m
- Excess inflation related to PFI £0.4m
- IFRS16 benefit £0.8m non-recurrent (change to Right of use accounting for St Andrews)
- Management of operational cost pressures offset by vacancies, interest income, cost reduction and release of balance sheet.

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



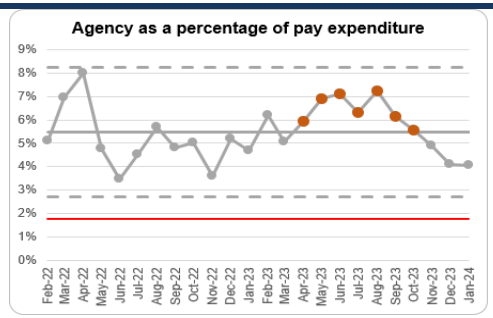
Summary
The plan includes an efficiency requirement of £8.8m phased equally across the financial year. As at the end of January £7.5m was delivered against a target of £7.3m. The requirement of £8.8m has been delivered in full, however the risk remains that a significant proportion of savings are non-recurrent in nature.

Further work is required to ensure plans are delivered recurrently as approximately 75% of the forecast is identified as non-recurrent adversely impacting 2024/25.

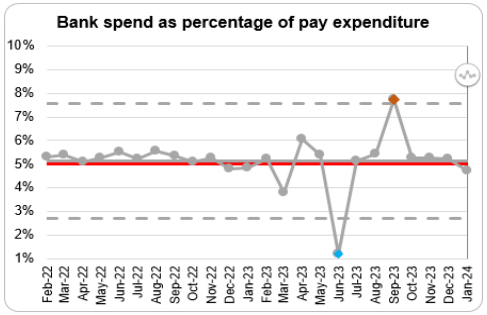
An executive vacancy panel which was established in December continues.

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

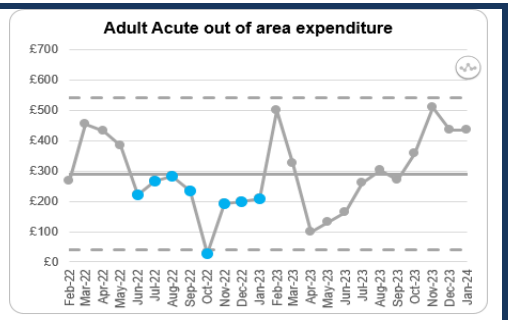
The group seeks assurance that initiatives are on track and identifies additional support and intervention where schemes are off trajectory. Initiatives which are off trajectory and/or forecast to be off trajectory are expected to provide a situation, background, assessment, and recommendation report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



Summary
Agency expenditure YTD totals £7.8m against a plan of £4.4m, an adverse variance to plan of £3.3m. This includes £2.4m of additional costs to support a complex eating disorders patient. The two highest areas of agency usage continue to relate to consultants and nursing staff. The agency expenditure as a proportion of total pay for January is 4.1%. The agency plan for the year is set at 3.5% which is just below the target set by NHSE in the planning guidance of 3.7%.
Agency is forecast to be above plan by £3.7m, of which £2.9m relates to the complex patient that is being supported.

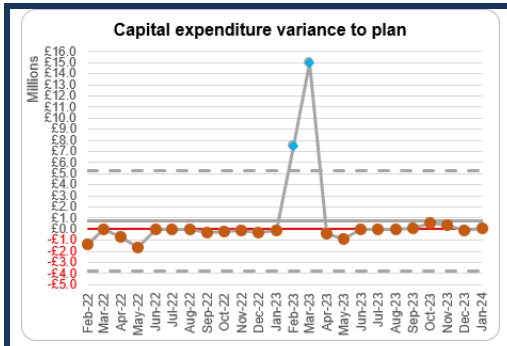


Bank expenditure YTD totals £6.9m against a plan of £6.5m, an adverse variance to plan of £0.4m. In July there was an accrual release for backdated pay which then was partially reversed in September due to an agreement to backdate the Band 2-Band 3 increase to April 2022. The forecast is an adverse variance of £0.5m.



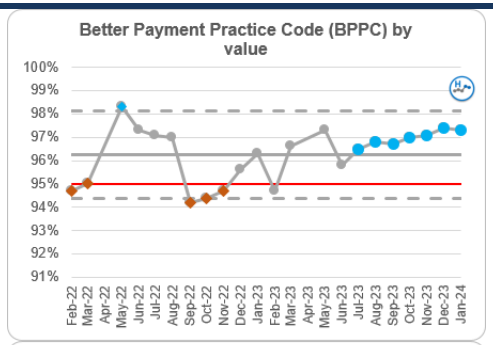
Summary
The plan for out of area expenditure has been reduced by £1.0m in 2023/24 as part of the £8.8m efficiency requirement. As at the end of January there was an overspend against the reduced plan of £1.8m with a forecast overspend of £2.5m. The forecast assumes 22 placements in the last two months of the financial year.

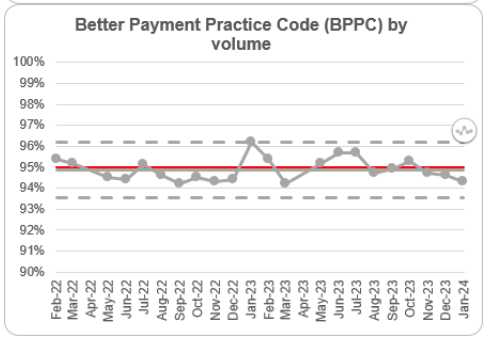
Financial Performance



Summary
Capital expenditure at the end of January is slightly behind plan by £0.7m due to the impact IFRS16 leases. Against the revised reduced system allocation, we are forecasting an overspend due to increases in IT equipment prices. There is also additional central funding that was not in the original plan.

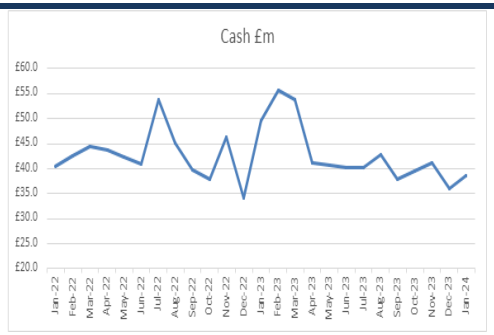
Capital expenditure was above plan in the last two months of 2022/23 due to the additional capital expenditure related to the dorms project (which came with additional funding that was not originally in the plan).



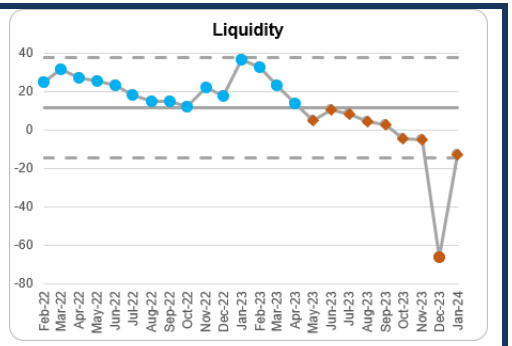


Summary
The Better Payment Practice Code (BPPC) sets a target for 95% of all invoices to be paid within 30 days. BPPC is measured across both invoice value and volume of invoices.

At the end of January, the value of invoices exceeded the target at 97.3% and by volume was slightly under the target at 94.3%.



Summary
Cash increased in February 2023 and March 2023 due to the additional funding for the Dorms capital projects that was drawn down. Cash reduced in April and May due to payment of capital invoices. Cash at the end of January is at £38.5m and is forecast to be at planned levels of £23.6m by the end of the financial year. The in-year reduction is driven by the reduction in capital accruals and the level of capital expenditure planned for 2023/24.



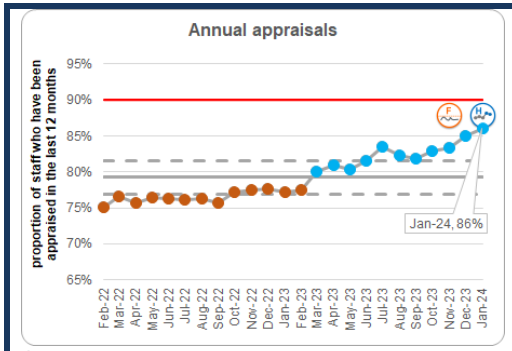
Summary
The chart above shows the liquidity levels over the last two years. Liquidity levels were high in 2021/22 however in 2022/23 the liquidity reduced until the last quarter due to the timing of cash receipts related to the centrally funded capital schemes for the eradication of dorms. The Public Dividend Capital (PDC) drawdown requests caught up in January which drove the increased level in January. The PDC drawdown for 2023/24 came into effect in June. Liquidity level reductions were included within the plan. Levels are forecast to continue to reduce during the remainder of 2023/24.

Derbyshire Healthcare
NHS Foundation Trust

People

People Performance

Annual appraisals



Summary

Operational Services currently at 88% and Corporate Services at 76%, against a target of 90%. Overall, significant improvement has been seen month on month for the last 11 months.

Actions

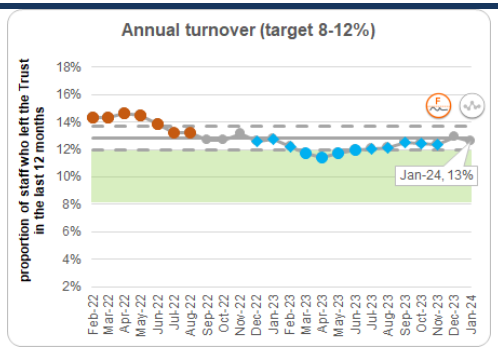
To both maintain and improve compliance the following actions have been completed or remain in progress to assist managers:

- Horizon scanning of appraisal dates that will expire over the next three months has been completed by contacting both managers and employees directly.
- A targeted campaign of appraisals that have already lapsed has been completed
- Work continues to address data quality challenges with recording of appraisal dates within the Electronic Staff Record (ESR) system
- Compliance also continues to be monitored by the People & Culture Committee and through the Trust Leadership Team Committee.

The low compliance rate within Corporate Services remains a particular challenge and the following measures have been put in place to increase compliance:

- Reports on lapsed appraisals regularly sent to operational managers to request completion dates along with support to record on ESR.
- Regular oversite and monitoring with local operational managers to agree plans increase compliance rates.
- Since the last reporting period, Corporate compliance has increased by 7% so far.

Annual turnover (target 8-12%)



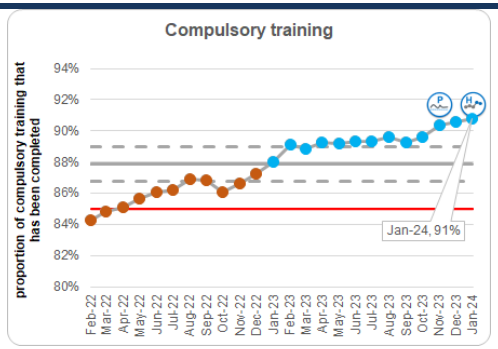
Summary

Overall turnover has been slightly above 12% for the last 7 months but remains in line with national and regional comparators.

Actions

- A workforce planning review has taken place to assist with the current and future workforce challenge. The programme will initially focus on workforce supply, internal turnover and develop a case study to demonstrate the impact of new ways of working and embracing flexible working has already had on staff satisfaction and retention for teams within the Trust.
- The latest staff survey results for 2023/24 were released in January 2024 and are now forming part of an overall action plan at Trust and Divisional levels to improve retention and reduce turnover.
- Work continues to strengthen and grow wellbeing champions in every team to support health and wellbeing, the impact on teams who have already increased champions has been evidenced in their improved staff survey health and wellbeing results.
- A review of staff benefits to support engagement and retention has commenced, which includes a review of the Trusts salary sacrifice schemes. A new intranet page is being developed to promote all options and packages available on one page for ease of use.

Compulsory training



Summary

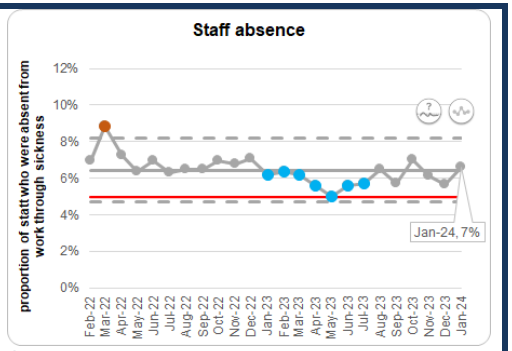
Overall, the 85% compliance target has been achieved for the last 20 months. Operational Services are currently 92% compliant and Corporate Services are 86%.

Actions

Whilst overall compliance of the 22 training elements remains high, there have been challenges with two role specific compulsory training elements which are classroom based. To both maintain and significantly improve compliance the following actions have either been completed or are in progress to assist managers:

- Horizon scanning of compulsory training elements that will expire over the next three months has been completed and will ensure employees are pre-booked in classroom courses.
- A review and monitoring of all 'Did Not Attend' (DNA's) occurrences continues, to ensure all employee's re-book in a timely manner.
- A targeted campaign of prioritising compulsory training elements that have been out of date the longest is underway.
- The Training and Education Group continue to oversee and review training compliance, changes and challenges.
- During a short absence of a trainer due to promotion we have engaged with Derbyshire County Council to provide additional support to ensure we minimise the gap and impact on training compliance. This has proved successful and ongoing work is taking place on how we can work in partnership with other providers on training requirements.

Staff absence



Summary

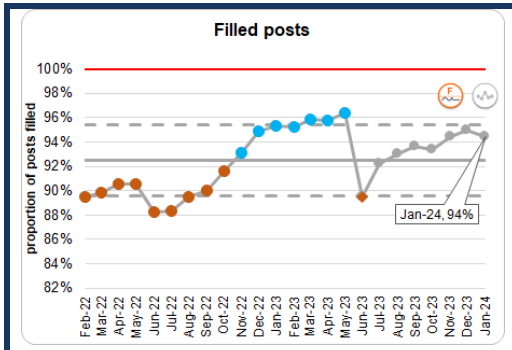
Sickness absence returned to common cause variation for the last 6 months and has averaged 6.4% over the 24-month period. In January 2024 the overall absence rate was 6.6% (Operational 6.8%, Corporate 5.6%). The absence rate in January 2024 was 0.42% higher than in the same period last year, which will slightly increase the annual sickness absence rate. The annual sickness absence rate has risen by 0.01% to 5.99%.

Anxiety / stress / depression related illness remains the highest reason for sickness absence, followed by Cold, Cough, Flu – Influenza, Other Musculoskeletal problems and Surgery. The highest three reasons for absences remain the same as last reported.

Actions:

- Using existing resource within the Trust a clinical psychologist is now aligned with the Employee Relations team to support absences relating to anxiety /stress / depression related illness, with a particularly focus on early intervention.
- All long-term absences are now reviewed each month with the Interim HRD and ER lead to ensure a supportive and robust approach is being taken to managing all absences.

People Performance

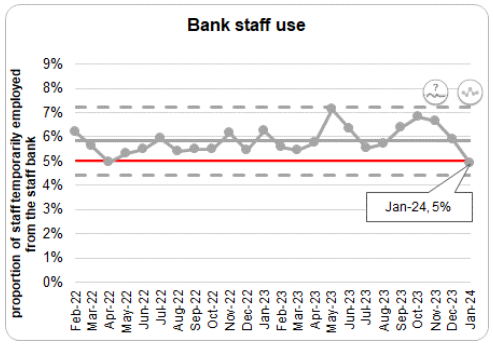


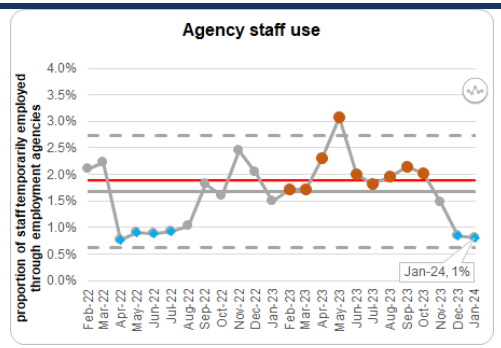
Summary

At the end of January 2024, 94% of posts overall were filled.

Actions

- Work continues towards planning for recruiting into the Trusts transformation projects which includes the Living Well programme and the Making Room for Dignity programme.





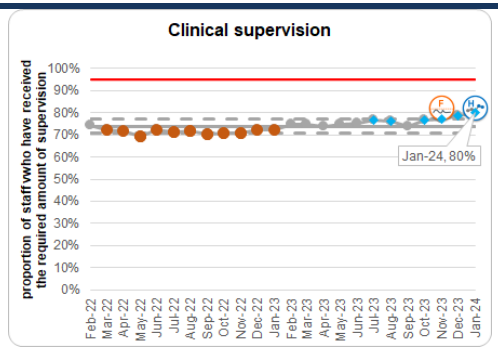
Summary

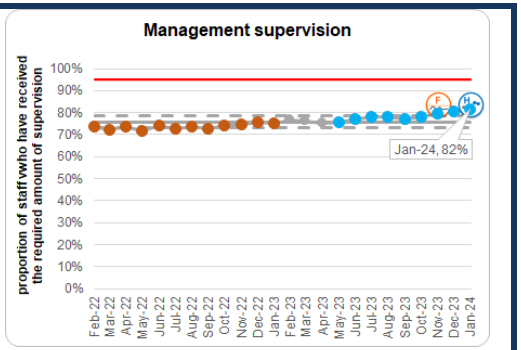
Agency usage has fallen significantly for the last 2 months. Agency usage still remains high and further work is required, particularly on longer term agency usage, to reduce this further.

Actions

The actions previously identified below, are now all in place and operational.

- Authorisation Panel meets weekly to oversee agency requests across the Trust.
- All admin and clerical agency usage has been eliminated.
- All facilities and IT agency usage has been eliminated.
- Clear protocols are in place to cover the circumstances where the various levels of Agency workforce (including Thornbury) relate to enhanced, safer and emergency staffing levels.
- Ongoing actions are taking place to support the reduction in medical agency, these include creative recruitment campaigns and alternative workforce roles where appropriate.





Summary

Overall compliance is 80% for clinical supervision and 82% for management supervision. 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: 86% versus 60% and clinical: 83% versus 28%).

Actions

A recovery action plan was implemented in Operational Services several months ago and continues to make incremental improvements to both positions. Monitoring of progress takes place at operational meetings and via the weekly report to senior operational management for review and action.

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

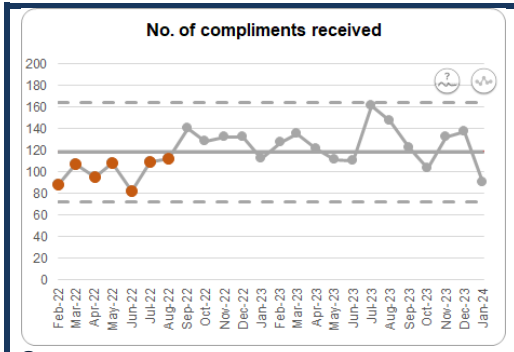
This includes:

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

Derbyshire Healthcare
NHS Foundation Trust

Quality

Quality Performance



Summary
Between November 2023 and January 2024, the number of compliments has fallen from 140 to 90.

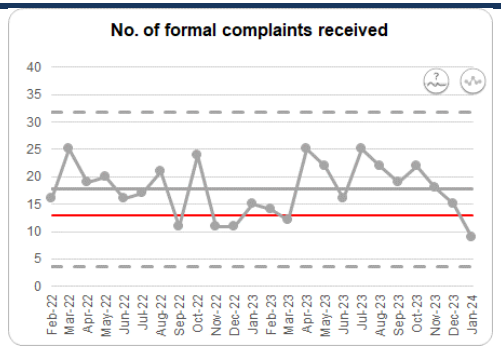
It is not possible to identify a specific reason for the fluctuation in compliments recorded as compliments are mostly received verbally and staff do not always accurately record them and there is no consistent process of recording them across the Trust, however, actions are being taken to ensure that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

Actions

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

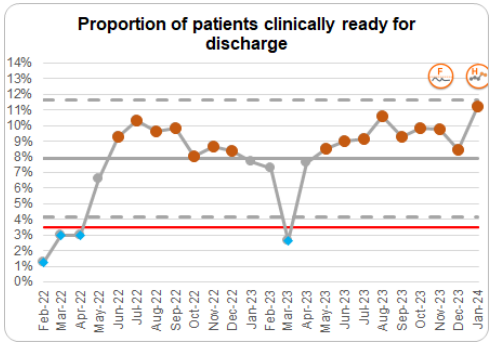
- An option for teams to use an Electronic Patient Survey (EPS) went live in July 2023 and provides another method for Trust services to obtain feedback including compliments and concerns.

  So far over 100 teams have signed up to this platform. The EPS platform gives teams the opportunity to create a QR code which allows service users to feedback directly to the team. service receivers are also given the opportunity to feedback verbally and via paper forms if this is preferred. A thematic review of the feedback from the EPS along with any actions or learning identified by services is included in the quarterly Patient Experience Committee report.



Summary
The number of formal complaints received by the Trust has fallen from 17 to 9 between November 2023 and January 2024. This continues the trend of being under the Trust target of 12 complaints and below the mean of 19.

Actions
The complaints team monitor complaints and where specific themes are identified, these are passed on to the HoN/P Team and explored in a quarterly Patient Experience Committee (PEC) report which is sent to both the PEC and the Trust Quality and Safeguarding committee for assurance.



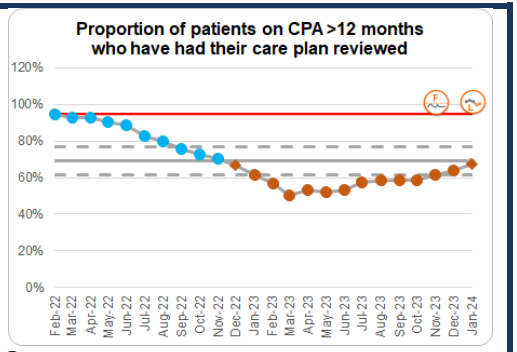
Summary
Between September and November, the number of service users meeting the criteria as clinically ready for discharge (CRD) (formally called delayed transfers of care) has Increased from 10% to 12%. A fluctuation of between 2% and 4% has been consistent over the past 12 months and a new mean has been established due to more accurate reporting by services since June 2022.

The most common reason for patients meeting the criteria for CRD continues to be the identification of appropriate housing or social care placements.

The OA division were involved in the scoping of a Dementia Care Unit for Derbyshire, however there are no plans to Commission this in the foreseeable future

Actions

- The Trust has a Twice weekly CRD meeting where any barriers to discharge are identified and discussed to support resolution.
- The OA division continue to work in collaboration with Joined Up Care Derbyshire to identify patient centred solutions for those service users awaiting placements that meet their needs.



Summary
The current percentage of patients who have had their care plan reviewed and have been on CPA for over 12 months is 70%, an increase of 9% between November 2023 and January 2024.

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

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

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

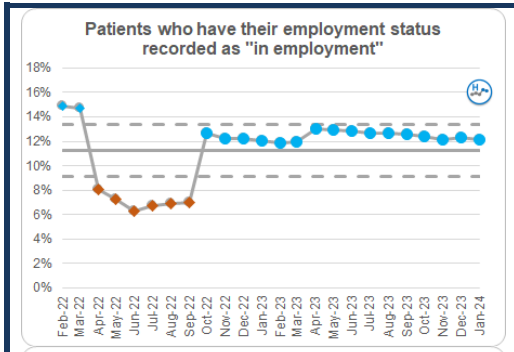
.

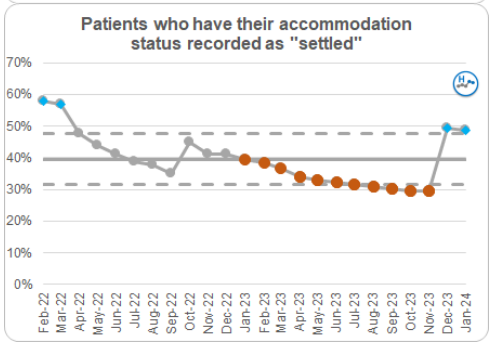
- A new data platform was introduced to the Trust in November 2023 so each team has been asked to review the new report and cleanse the data to ensure that non-eligible patients are excluded.

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

- The Community Mental Health Team have a target to achieve 60% compliance for patients who have had their care plan reviewed and have been on CPA for over 12 months by the end of December 2023 and 85% compliance by April 2024. It is expected that this target will be met within the identified time frame.

Quality Performance



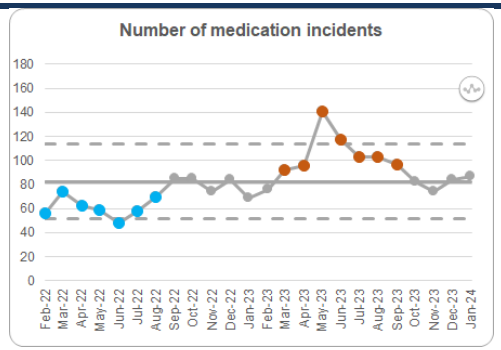


Summary

Following an update in how the data related to patients having their accommodation status recorded as was completed in December 2023, the number has increased by 20%. There has been no change in the number of patients recorded as in employment between November 2023 and January 2024.

Actions

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



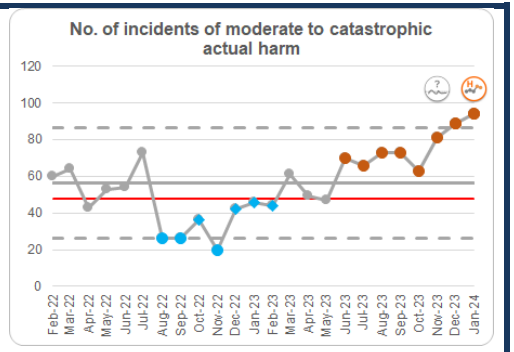
Summary

Between November 2023 and January 2024, there has been a 17% increase in the number of medication incidents reported. However, following a deep dive into this data by the Pharmacy team, the evidence suggests this rise is attributed to a small number of patients who have care plans in place in relation to medication management. It should be noted that the medication incidents reported are largely of low-level harm.

The number of medication incidents reported is now back in line with common cause variation when compared with data from the past 18 months.

Actions

- To support services, the Pharmacy team have developed a medicine ward folder where the medicine management quick reference guides relating to key policies and procedures including the process for Clozapine initiation, monitoring and bloods, Storage of medicines and temperature monitoring are available to all inpatient areas of the Trust
- To improve medicine temperature monitoring a task and finish group including heads of nursing, pharmacy and clinical leads started in January 2024 and is expected to reduce the number of incidents recorded following its conclusion. This is expected to have an impact from May 2024
- DHCFT Pharmacy are feeding back to ward managers on a quarterly basis about shared learning from Monthly meetings with Chesterfield Royal Hospital pharmacy.
- A Process for Clozapine initiation, monitoring and bloods, Storage of medicines and Temperature monitoring has been developed and was ratified by the medicines management committee in January 2024
- The number of medication incidents is reviewed via the monthly medication management subgroup and is reported on within the quarterly thematic “Feedback Intelligence Group” (FIG) report by the Heads of Nursing/Practice and is included in the Serious Incidents Bi-monthly report. Any actions identified are reviewed via the medicines management subgroup and the Serious Incidents Bi-monthly report is taken quarterly to the Quality & Safety Committee (QSC) for assurance.



Summary

This data demonstrates the number of DATIX incidents occurring recorded as moderate to catastrophic harm. There has been an increase of 15 incidents between November 2023 and January 2024 which indicates an increasing trend in this category of incident.

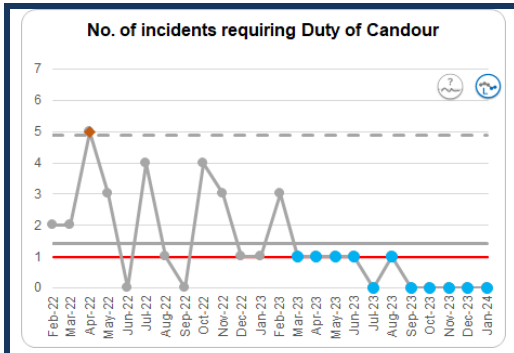
Analysis suggests that this is due to an increase in the number of incidents routinely reported by staff following support from the Patient Safety team and a rise in incidents recorded as “self-harm” and physical assault from patients to staff.

The Trust Positive and Safe team agreed to do a thematic review of this data and identify learning points to reduce incidents of this type. The results of this review are expected in April 2024

The increase in self-harm incidents is attributed to a high number of repeated incidents involving to a small group of patients. This is consistent with anecdotal reports from staff that acuity on the inpatient wards is increasing. The overall increase in reported incidents can also be attributed to increased reporting from the mental health helpline and support service.

This data is monitored by the Patient Safety Team and the Heads of Nursing/Practice via the monthly Reducing Restrictive Practice meeting.

Quality Performance

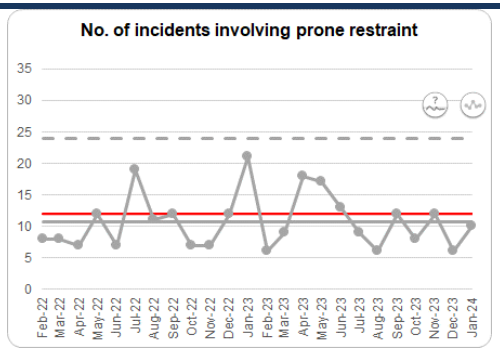


Summary

Between November 2023 and January 2024 the number of incidents meeting the threshold for Duty of Candour (DoC) has remained within expected limits. The Trust Family Liaison Office has created information leaflets and standing operating procedures to support staff in completing duty of candour communications. Furthermore, these are reviewed twice weekly within serious incident groups.

Actions

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



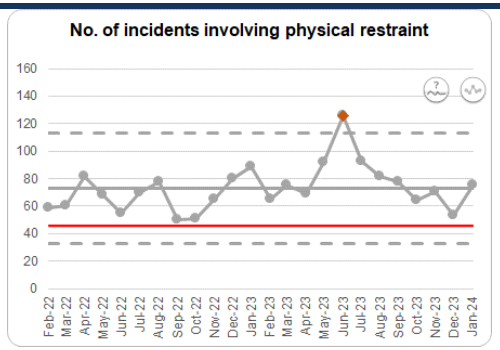
Summary

Prone restraint remained consistently under the Trust target of 12 incidents between November 2023 and January 2024.

Actions

- Following a successful funding bid from the South London and Maudsley Trust (SLaM) the Assistant Director for Digital Clinical Practice is leading a project to introduce simulation-based training is expected to start in March 2024. This will include interventions that would be expected to maintain low levels of prone restraint.

- The PSST are in the process of planning training around alternative injection sites which should reduce the need for prone restraint, and this is expected to start in March 2024.



Summary

Incidents involving physical restraint have increased by 4% between November 2023 and January 2024.

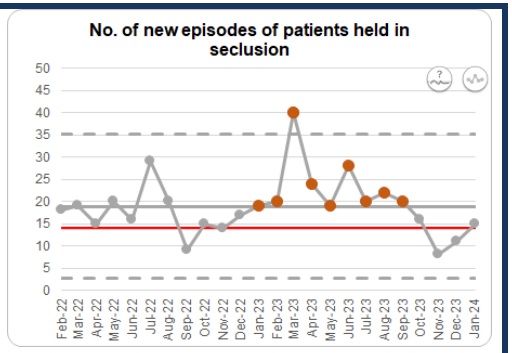
Recruitment has improved in the inpatient services which means less bank and agency staff are being used which has also had a positive impact.

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

Actions

- The Trust Positive and Safe Support Team continue to offer supplementary training sessions to improve training availability for staff and compliance with positive and safe training is currently at 75% for teamwork and 61% for breakaway training. The drop in compliance in training was due to a new staff group being added to the mandatory cohort who are all non-compliant until they have received the training, however, compliance is increasing every month by around 4% respectively and the PSST team expects to increase both breakaway and teamwork training to 85% by April 2024

- The PSST continue to spend time in clinical areas to support and train clinical staff, live during practice.



Summary

Seclusions between November 2023 and January 2024 have increased from 8 to 15 but are still under both the mean average of 20 episodes of seclusion.

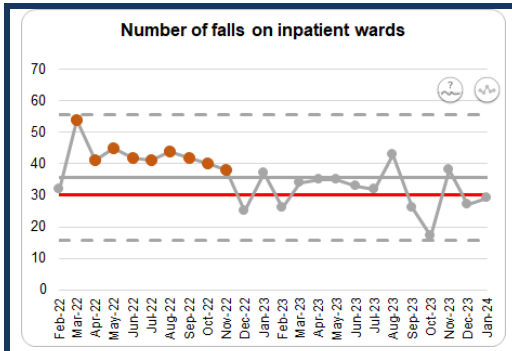
Actions

- Episodes of seclusion will continue to be monitored via the reducing restrictive practise group.

- A review focused on peer support including debrief started in May 2023 and is expected to have an impact on further reducing the number of seclusion incidents when it is completed at the end of 2023.

- This review will be presented and monitored through the Trust Reducing Restrictive Practise Group

Quality Performance



Summary

The number of falls recorded between November 2023 and January 2024 has reduced from 39 to 29 and is under the Trust target of 30.

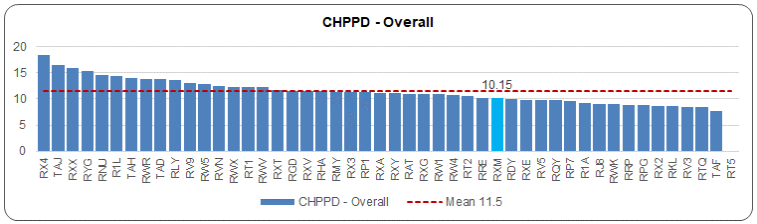
Actions

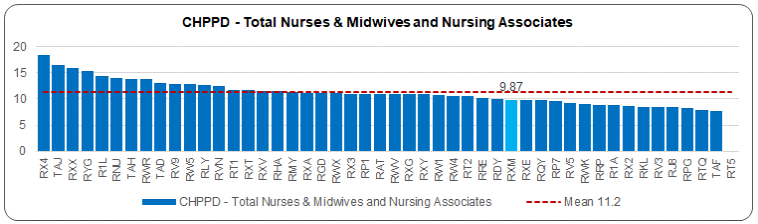
The number of falls reported is monitored via the Head of Nursing and Clinical Matron and learning from the Biweekly falls meeting is reviewed in the monthly Divisional COAT meeting.

Care Hours per Patient Day (CHPPD)

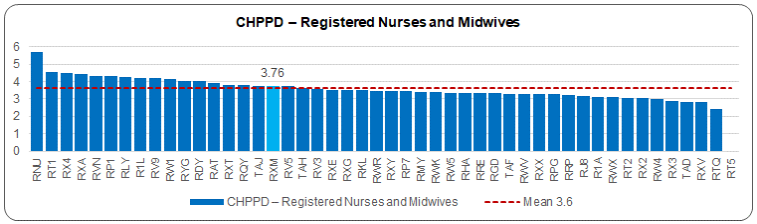
CHPPD is rolling data updated monthly, to show staffing levels in relation to patient numbers on an inpatient ward. Every month, the hours worked during day shifts and night shifts by registered nurses and midwives and by healthcare assistants are added together. Each day, the number of patients occupying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

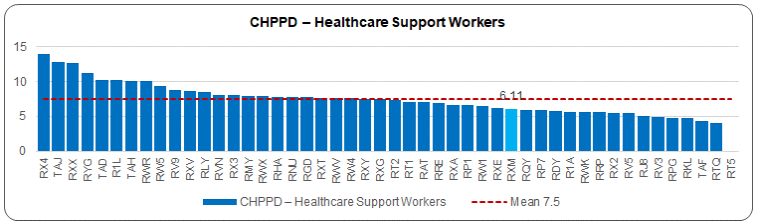
The charts below indicate that the Trust's CHPPD overall achieved 10.15 hours, which was below average when benchmarked against other mental health trusts in the country. For total nurses and nursing associates the Trust achieved 9.87 hours against the national average of 11.2 hours:





For registered nurses the Trust achieved 3.76 hours against the national average of 3.6 hours. For healthcare support workers the Trust achieved 6.11 hours against the national average of 7.5 hours:





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

Quality Performance

Friends and Family Test

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

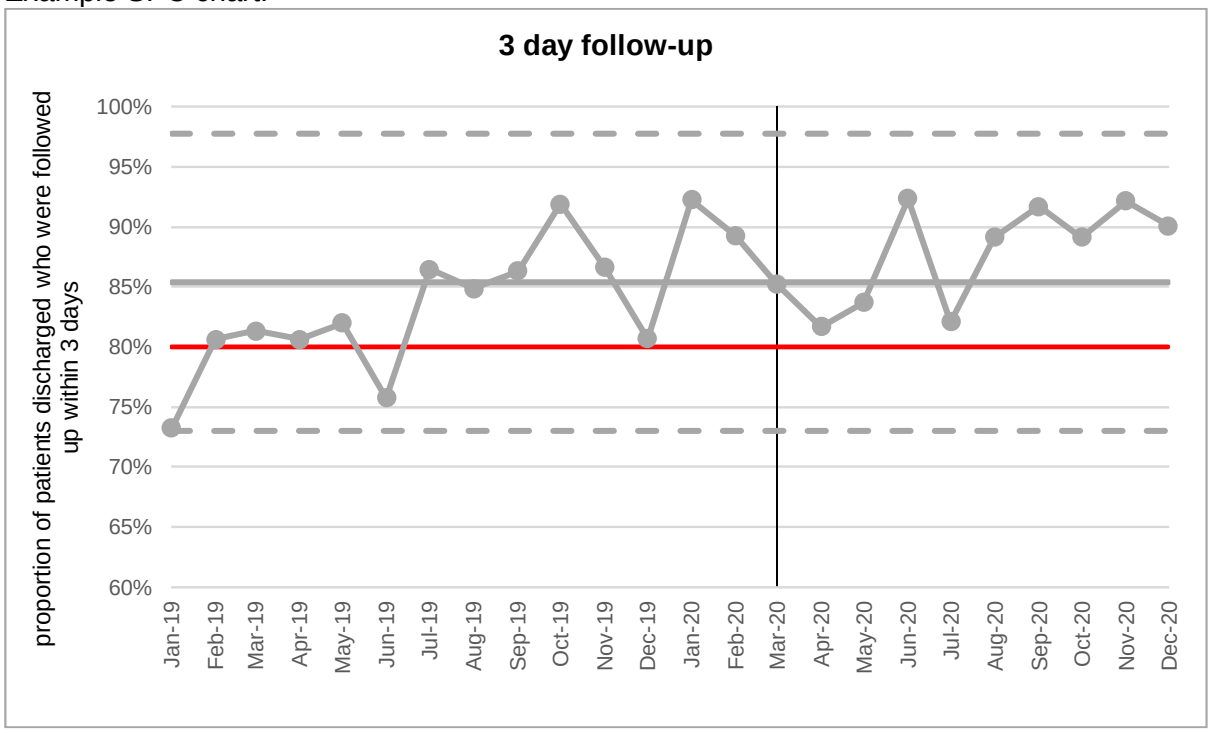
Trust Code	Total Responses	Total Eligible	Percentage Positive	Percentage Negative	Mode of Collection						
					Mode Electronic Discharge	Mode Electronic Home	Mode Paper Discharge	Mode Paper Home	Mode Telephone	Mode Online	Mode Other
	22,083	**889,823**	**88%**	**6%**	**2,171**	**128**	**6,283**	**2,102**	**522**	**6,565**	**1,970**
	21,397	**878,043**	**88%**	**6%**	**1,983**	**128**	**6,262**	**2,070**	**522**	**6,453**	**1,675**
	22,083	**889,823**	**88%**	**6%**	**2,171**	**102**	**6,283**	**2,096**	**522**	**6,565**	**1,970**
TAH	26	4,082	100%	0%	*	*	*	*	*	*	0
RY4	13	835	100%	0%	0	0	0	0	0	13	0
RH5	17	8,080	100%	0%	0	0	0	0	0	17	212
RYK	24	1,901	100%	0%	0	0	0	0	0	0	*
NDK	5	10	100%	0%	0	0	5	0	0	0	*
NQL	142	3,434	98%	1%	0	0	0	0	0	0	0
TAJ	244	18,169	97%	2%	0	0	0	0	0	0	0
NNF	192	3,271	97%	2%	0	0	0	32	0	112	0
R0B	148	2,058	96%	1%	0	0	101	0	0	47	0
RX2	408	15,126	96%	2%	0	0	0	0	0	408	0
R1F	113	2,578	96%	1%	0	0	0	113	0	0	0
RP7	465	4,892	94%	1%	12	0	452	0	0	0	8
RXL	125	1,127	94%	1%	0	0	0	84	0	38	0
RJ8	17	5,099	94%	0%	0	0	5	0	0	12	0
RX3	1,777	146,195	94%	2%	393	0	1,123	0	0	86	0
RT1	215	2,735	93%	1%	55	0	5	89	0	50	0
RNK	46	3,072	93%	2%	0	0	0	46	0	0	76
RW4	717	21,487	93%	1%	472	0	193	0	0	52	0
RRP	650	9,094	93%	2%	0	0	650	0	0	0	0
RXM	299	18,207	92%	2%	0	0	145	0	0	154	0
R1L	86	15,828	92%	1%	0	0	0	37	0	49	0
RDY	251	7,261	92%	6%	37	0	17	0	0	196	0
RQ3	59	30	92%	3%	0	0	0	0	0	59	0
RRE	317	24,395	91%	3%	0	0	0	0	0	298	0
RT2	1,127	12,417	91%	2%	0	0	522	0	138	298	353
RV9	208	5,105	91%	3%	0	0	208	0	0	0	19
RWV	276	6,002	90%	4%	0	0	74	0	0	202	1
RXA	748	13,072	90%	5%	0	0	0	0	0	1	0
RP1	172	8,659	90%	1%	0	3	0	122	0	47	0
TAF	253	1,615	89%	5%	2	0	0	37	0	214	565
RXY	631	14,773	89%	3%	0	0	602	0	0	29	0
RHA	132	15,014	89%	3%	0	0	0	104	0	0	0
RXG	353	13,449	88%	6%	41	0	102	0	0	209	0
RWX	493	29,113	88%	6%	6	0	16	0	0	471	0
RW5	1,373	46,802	88%	8%	83	0	0	0	336	954	0
RX4	492	36,291	88%	7%	0	0	280	0	0	0	0
RVN	606	6,628	88%	4%	0	0	111	427	0	68	0
RQY	777	22,215	87%	6%	469	0	0	0	0	0	0
RXV	565	35,910	87%	7%	0	0	0	0	0	0	0
R1C	236	2,033	87%	7%	0	0	115	0	0	66	0
RY6	52	724	87%	12%	0	0	0	0	0	52	0
RXX	379	9,190	86%	5%	56	0	83	0	0	234	0
RXT	622	20,219	86%	7%	0	0	587	0	0	35	0
RV5	318	37,664	86%	4%	0	0	114	0	0	204	244
RWR	316	12,805	86%	7%	0	0	0	211	0	54	24
RV3	313	25,011	86%	6%	0	0	112	0	0	201	0
RXE	339	19,470	86%	6%	0	0	339	0	0	0	0
RW1	809	11,603	86%	9%	0	0	94	389	21	305	173
RTF	54	961	85%	6%	*	*	*	*	*	*	0
RGD	228	7,627	85%	4%	0	0	0	89	0	139	0
TAD	119	10,059	84%	10%	93	0	0	0	13	13	0
RAT	660	8,442	84%	8%	0	0	0	0	0	660	0
RMY	353	28,977	83%	12%	0	0	0	0	0	0	0
NR5	143	2,315	81%	10%	0	0	0	0	0	0	0
RLY	387	13,498	80%	9%	0	0	0	212	0	0	0
RRV	5	14	80%	20%	0	0	0	0	0	0	0
RTQ	149	1,386	80%	10%	0	0	0	0	0	149	48
RNU	228	10,781	80%	6%	81	0	99	0	0	48	0
RWK	495	37,045	79%	12%	67	0	0	0	0	259	0
RKL	9	10,017	78%	22%	0	0	9	0	0	0	0
NMJ	188	2,118	77%	8%	188	0	0	0	0	0	105
RPG	627	14,717	76%	9%	98	99	104	104	0	5	142
O2F3D	16	192	75%	13%	0	0	16	0	0	0	0
RT5	470	12,176	67%	22%	18	0	0	0	14	57	0

Data source: NHS England » Friends and Family Test data – November 2023

Appendix 1

Statistical Process Control Chart (SPC) Guidance

Example SPC chart:



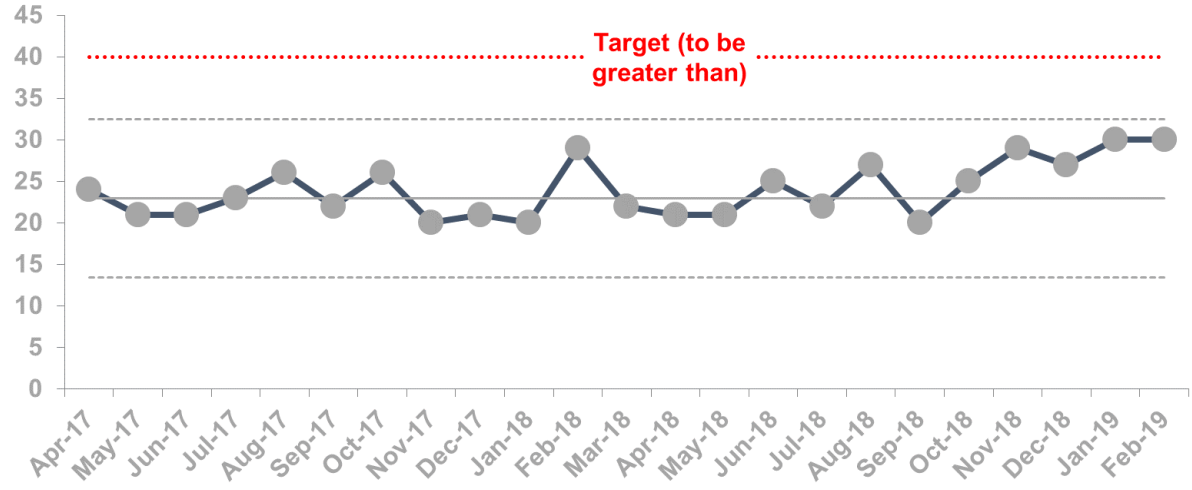
- The red line is the target.
- The grey dots are the actual performance each month. They are coloured grey as performance each month is normal in this example.
- The solid grey line is the average (mean) of all the grey dots.
- The grey dotted lines are called process limits, or control limits.

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

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

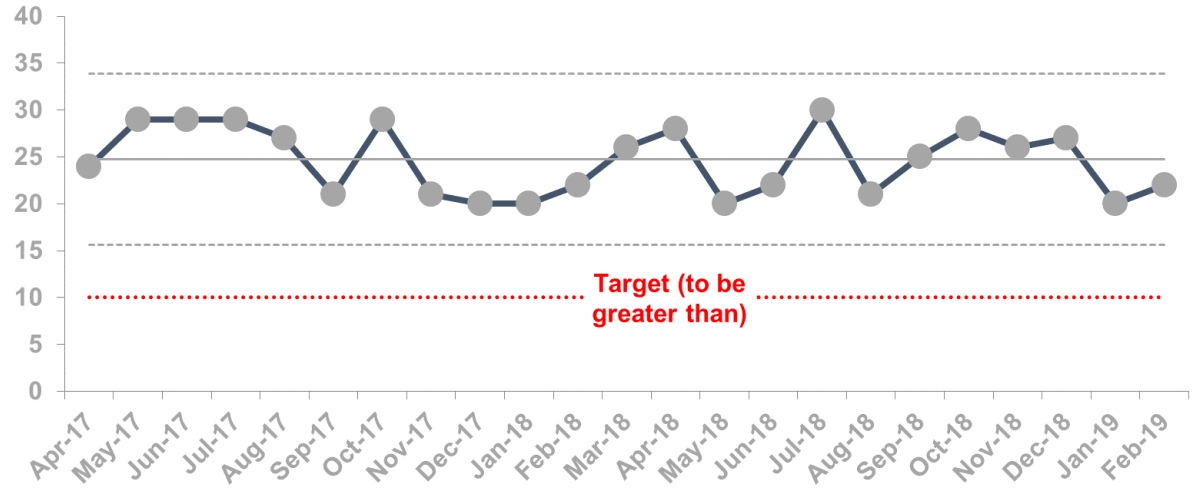
Things to look out for:

1. A process that is not working



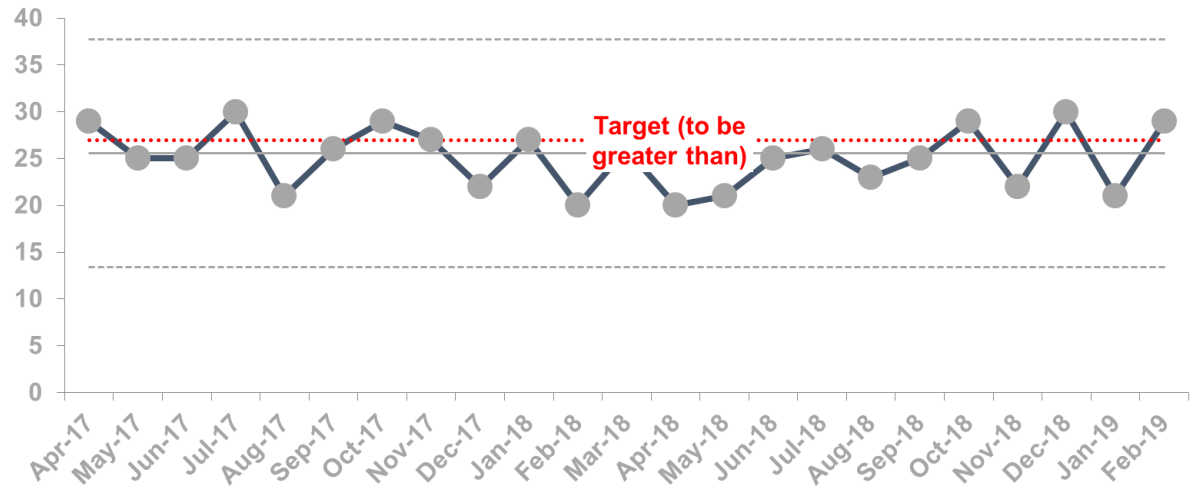
In this example the target is higher than the upper dotted grey line. This means that the target will never be achieved. To achieve the target, we need to change how we do things.

2. A capable process



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

3. An unreliable system

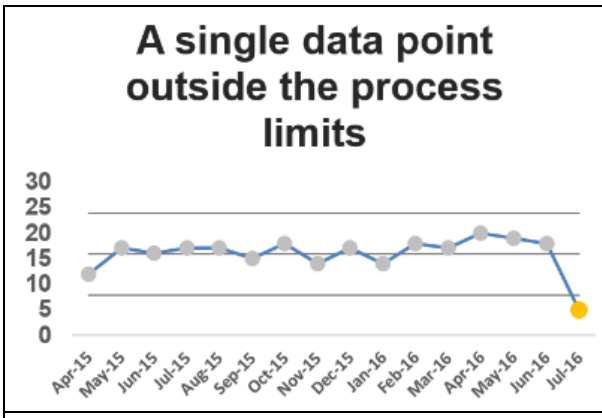
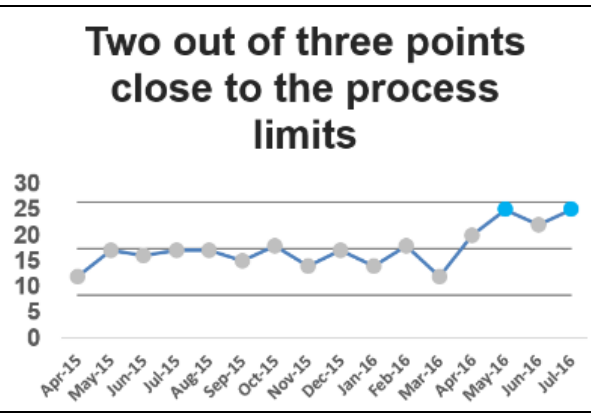
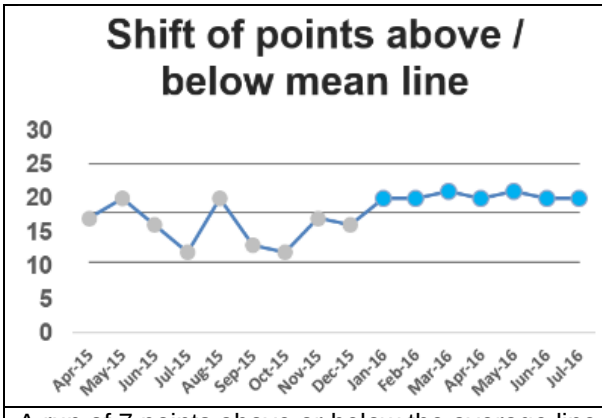
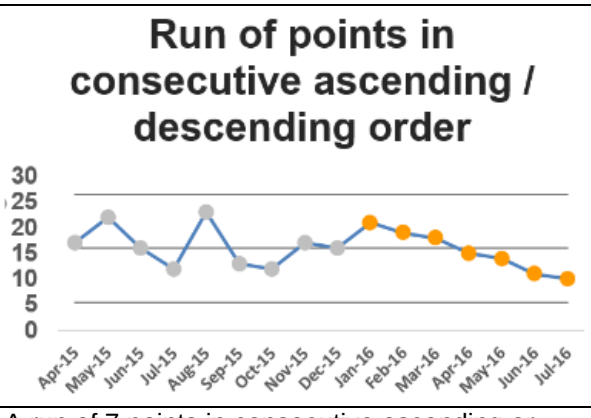


In this example the target line sits between the 2 grey dotted lines. As it is normal for the grey dots to fall anywhere between the 2 dotted grey lines, this means that it is entirely random as to whether or not the target will be achieved. So, this system is unreliable and needs to be redesigned if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

4. Unusual patterns in the data

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

There are four scenarios where this can happen:

<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> 
</td>
<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>

Frequently seen in the NHS:

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

Spuddling leads to tampering and tampering nearly always increases variation.

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

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

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

Trust Strategy 2022–2025: 2023/24 Quarter 3 Progress Report

Purpose of Report

To provide the Board with an update on progress in delivering the priority actions identified in the Trust Strategy.

Executive Summary

The Trust Strategy was published in 2022 having been approved by the Board in July 2022, following an engagement process with staff. It set out four strategic outcomes to deliver great care, be a great partner, a great place to work and to make best use of our resources.

Following feedback from staff, the strategy was updated to reflect the organisational reset in quarter 3 2023/24. The updated strategy retains the agreed vision, values and strategic objectives, whilst simplifying our priorities, in response to feedback received by colleagues, ensuring clarity on our work for the year ahead. The agreed priorities are set out in Appendix 1, which highlights those priorities that have been delivered to date, priorities that are partially completed, and priorities that are in progress but with significantly more work to enable delivery by the agreed delivery date.

At the heart of the Trust Strategy was, and continues to be, a collective commitment to continue improving our organisational culture, and to embedding new ways of working where our values and 'people first' approach are central to all we do. In addition, over the life of this strategy we continue to deliver our commitment to inclusion for our patients, our colleagues and our communities.

The Trust has commenced the development of a new Trust Strategy to be launched in September 2024. Development of our new Trust Strategy will build on our organisation's recent reset and will need to set out our Trust response to national policy and our contribution to the system level Joint Forward Plan, namely addressing health inequalities and collaboration.

The development of a new Trust Strategy was discussed at the 2023 Staff Conference, where colleagues provided suggestions about the approach of developing a new Trust Strategy, together with potential content, including a review of the Trust values (particularly People First, in order to clarify its meaning).

Our process has been informed by the feedback from the Staff Conference to ensure that the views of staff are in the centre of how we develop the Trust Strategy. The Trust Strategy will be developed through ongoing engagement with staff, stakeholders and external partners. This will include feedback gained through the national NHS Staff Survey.

The Board is asked to note the 2023/24 Q3 progress in delivering the priority actions as set out in the updated 2022–2025 Trust Strategy, and the progress to develop a new Trust Strategy.

Strategic Considerations	
1) We will deliver **great care** by delivering compassionate, person-centred innovative and safe care.	X

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

Risks and Assurances

Aligns with and seeks to deliver against the Trust's strategy.

Consultation

- Staff engagement to inform the updated strategy as a result of the organisational reset.
- Ongoing staff engagement to enable and report delivery of individual priority actions.

Governance or Legal Issues

None identified.

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 Trust's strategy embeds the Trust's commitment to Equality, Diversity and Inclusion.

Recommendations

The Board of Directors is requested to note the 2023/24 Q3 progress in delivering the priority actions as set out in the updated 2022–2025 Trust strategy and the progress to develop a new Trust Strategy.

Report presented and prepared by: **Vikki Ashton Taylor**
Director of Strategy Partnerships and Transformation

Priorities we will deliver in 2023/24

Improve processes for those experiencing stress in and out of work

Successfully implement and lead the provider collaborative for Perinatal inpatient services

Making Room for Dignity: Improve the safety, privacy and dignity of patients through our Making Room for Dignity programme

Deliver perinatal community mental health access standard of 10% of prevalence

Develop a consistent approach to people-centred leadership

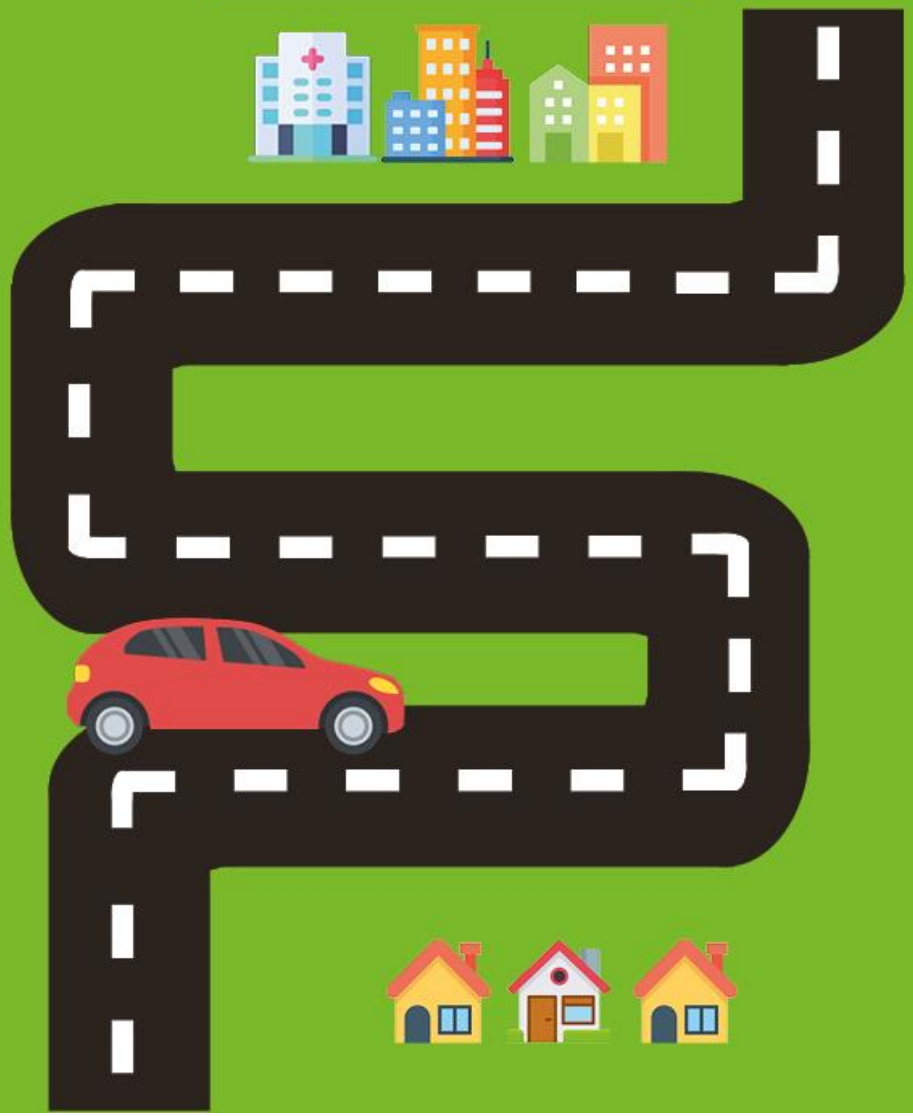
Develop a workforce plan

Each division will have its own specific quality requirement standards

Work in partnership to progress the harmonisation of Learning Disabilities and Autism services

Deliver a less than 32 days average length of stay on our acute mental health wards

These priorities were partially completed in 2022/23 and will be completed during 2023/24



Deliver electronic prescribing and transfer prescriptions element of the OnEPR programme

Recover dementia diagnosis rates to national target of 67%

Improve recruitment and retention to support new services and ensure safer staffing levels

Be a compassionate and inclusive organisation where staff feel they belong, thrive and are valued

Optimise the use of SystmOne across the Trust

Deliver our Long Term Plan Commitments including Transforming Care Partnership (TCP) and Living Well

Deliver planned financial efficiencies to ensure the Trust is a sustainable organisation. Agree our 3-5 year financial plan

Focusing on the safety domain of practice and preparing for changes in mental health legislation

- Completed
- Partially completed
- In progress
- Not to be progressed

Progress in Delivering 2023/24 Priorities

Priority	Progress	Delivery Date	Assurance Committee
Making Room for Dignity: Improve the safety, privacy and dignity of patients	On track for delivery. Construction / refurbishment commenced at all sites. Recruitment commenced for posts required early to shape new services. Bluebell Ward, Walton Hospital Derwent Unit, Chesterfield Royal hospital Audrey House Enhanced Care Unit Carsington Unit, Kingsway Hospital Kingfisher House PICU, Kingsway Hospital Jasmine Ward, Radbourne Unit Orchid Ward, Radbourne Unit – pending additional capital	 Ongoing 19 August 2024 4 November 2024 18 November 2024 18 November 2024 3 March 2025 3 March 2025 2 March 2026	Finance & Performance Committee Quality and Safeguarding Committee
Deliver Perinatal community MH access standard of 10% of prevalence	On track for delivery. The target is measured on a rolling 12 month period. Currently achieving 9.4% of the 10% target (Dec 23). A Recovery Action Plan is in place with all actions either delivered or on track for delivery by year end. The recovery has been underpinned by Continuous Quality Improvement methodology	March 2024	Finance and Performance Committee
Develop a consistent approach to people centred leadership	On track for delivery. Leadership development strategy scoped and will be finalised by end of March for launch 1st April. Ongoing leadership programmes on offer to colleagues and bespoke team development in place.	April 2024	Quality People Committee
Develop a Workforce Plan	Delivered. Annual process embedded for continual learning.	Delivered	Quality People Committee
Work in partnership to progress the harmonisation of learning Disabilities and Autism services	In progress. In January 2024, executives from both organisations discussed a variety of issues that have remained within the Alliance arrangement and came to a joint agreement to move forward with actively addressing these and fully committing to the running of a cross-organisational integrated service. It was recognised that moving away from the terminology 'Alliance' and focussing on collaboration as a single integrated service will better demonstrate the intent of the working arrangements.	October 2024	Trust Board
Deliver less that 32 days average length of stay on our acute MH wards	In progress. There is work underway to reduce the average LOS. Launch of Gatekeeping Framework and Purposeful Admission commences March 2024. Progress being made re trauma informed care in adult acute inpatient. Also commenced work analysing data from each inpatient wards to share learning. As a result improvements have been noted and average LOS has reduced to 48 days. Achieving 32 day average Length of Stay will be a challenge	September 2024	Finance and Performance Committee
Each division will have its own specific quality requirement standards	On track for delivery. The Trust wide fundamental standards group is in operation and provides oversight, monitoring and sign-off of actions arising from regulatory activity. A Trust wide self assessment framework has been established, which will be underpinned by a quality surveillance dashboard. The intention therefore is not that each division has its own standards, but that each division will be measured against the core fundamental standards as established in the CQC's single assessment framework.	April 2024	Quality and Safeguarding Committee
Improve processes for those experiencing stress in and out of work	Delivered. In house staff clinical psychologist in place and offering support to colleagues both in and out of work. This is to complement the existing offer via EAP and Resolve. Alignment with long term absences in place.	February 2024	Quality People Committee
Successfully implement and lead the provider collaborative for perinatal inpatient services	Delivered. Approval granted by NHS England for DHcFT to become Lead Provider in October 2023. Future work will include the development of an Experts by Experience Strategy and delivery of improved access for service users across the region	Delivered	Finance and Performance Committee
Deliver electronic prescribing & transfer prescriptions of the OnEPR programme	Delivered. Successful implementation and roll out. Optimisation work underway.	Delivered	Finance and Performance Committee
Recover dementia diagnosis rates to national target of 67%	Delivered. month on month achievement of target. December 2024 performance was 67.9%	Delivered	Finance and Performance Committee

Progress in Delivering 2023/24 Priorities

Priority	Progress	Delivery Date	Assurance Committee
Focusing on the safety domain of practice and preparing for changes in mental health legislation	No immediate progress as legislation has been deferred. This priority will be paused until further national guidance is issued.	N/A	Quality and Safeguarding Committee
Improve recruitment and retention to support new services and ensure safer staffing levels	Delivered. New approaches developed and embedded that consider a more creative and innovative way to attract and recruit and allow a more diverse pool of candidates both at application through to appointment. Ongoing work to improve retention in place, targeting key professions and teams where turnover is above Trust average.	February 2024	Quality People Committee
Be a compassionate and inclusive organisation where staff feel they belong, thrive and are valued	We have strengthened our communication and engagement channels to colleagues, including introducing a face to face leadership forum. Our staff survey 2023 measures indicate improvements across our key engagement and belonging measures. We have worked with a number of teams to develop bespoke programmes where there have been areas of concern or development needed for the team to move to a more compassionate and inclusive place. We have further work to do to strengthen our approaches on discrimination and bullying which will form part of our strategy in 2024/25.	April 2024	Quality People Committee
Deliver planned financial efficiencies to ensure the Trust is a sustainable organisation. Agree our 3-5 year financial plan	On track for delivery but non recurrent risk issue. CIP delivery in 2023/24 is on track in quantum terms but off track from the point of recurrency. We have the lowest rate of recurrency across Derbyshire providers, at only c25%. A stepped change on progress is needed in 2024/25 if we are to make inroads into the underlying deficit. 3 - 5 year high level plan due for completion February 2024, more detailed plan target completion date September 2024. The Trust's 5 year plan has been completed based on simplistic national assumptions (high level and basic) as part of an ICB wide submission. (Board sign off February 27th Feb). The full Trust LTFM updated 5 year financial plan is still outstanding. This is likely to be progressed during April – June given delayed planning process and a year 1 focus in March and April. Whilst not alone, the underlying deficit highlights there is further work to do to achieve a fully identified robust CIP plan in place to provide assurance around financial sustainability.	September 2024	Finance and Performance Committee
Optimise the use of SystmOne across the Trust	On track to deliver. Training to new starters Ongoing training to staff and review of standard operating procedures to improve data quality.	September 2024	Finance and Performance Committee
Deliver our Long term Plan commitments including TCP and Living Well	On track for delivery. The Living Well final wave (wave 3) mobilised fully week effective 19th February 2024. Continuous improvement approach with model partners – social care, VCSE. Work continues with Place, and PCNs. TCP - New, challenging trajectories were agreed from July 2023 onwards. Currently adult inpatient numbers are on target. LD&ASC Support and Intervention Team (SIT) continues to support hospital avoidance. Demonstrable evidence of preventing admissions going into hospital.	March 2024	Finance and Performance Committee

Continuous Quality Improvement – A Stocktake

Purpose of Report

This report updates on the delivery of the current 2021-2024 Quality Improvement Strategy, work which has taken place to date, ongoing evaluation of impact including examples, and next steps informing the next strategy later in 2024.

Quality Improvement (QI) Strategy

The current QI strategy agreed in November 2021 (2021-2024) set out the ambition to create the right conditions for staff and teams to feel empowered to develop and improve the services they provide. Integral to this were core principles focusing on:

- developing a culture where ideas can come from anyone in any role.
- having systems in place that facilitate and support idea development.
- training in QI methodology and ongoing support and coaching.
- communicating, sharing QI stories and growing a QI network.
- nurturing a shared commitment to a model of continuous improvement at all levels.

Delivery of the QI strategy strengthens our QI capability and increase the opportunities to put those skills to use in delivering the Trust strategic objectives of providing great care, being a great place to work, making the best use of resources and being a great system partner.

Implementation

The 14-point action plan to deliver the current QI Strategy identified activities relating to building QI capability through training/procuring training capacity, incorporating QI training into roles, building intranet space and functionality, quality awards, transformation of the programme management office and function, building on learning, creating improvement opportunities and joint working with JUCD partners on QI initiatives.

12 of the 14 actions are complete and the two remaining are in progress. These two areas relate to further development of infrastructure and sustaining capability for the long-term. Further development of infrastructure looks at how we can better support larger numbers of staff to progress and share learning on their ideas, and refining processes that makes it easier. Sustaining capability looks at leadership, setting expectations and QI training being a mandated competence for key roles and levels in the organisation.

As we have progressed the implementation of the strategy and completed actions that were originally set, it is the case also that we revisit what we have implemented and identified areas we can go further on. NHS Impact which has been developed during this cycle sets out a useful framework for identifying areas of strength and potential weakness. This has been explored in 2023-24 and at the most recent Board development session in February.

Executive Board/Senior Leader Development

A Trust board development session on 14 February focused on building a system and culture for improvement. This was the fourth QI based board development session in the current strategic cycle and identified the following focus areas aligned to NHS Impact domains for progression in the next phase:

Developing a Shared Purpose and Vision

There has been great focus on building capability as an integral component of our QI journey but there are some other areas which may not have progressed at the same pace. Shared purpose is vital and there is a desire to ensure continuous quality improvement is embedded into the new refreshed strategy and not appear a standalone aim. In this we will also consider language and how we clearly articulate our continuous quality improvement ambition.

Investing in People and Building and Improvement Focussed Culture

There has been good progress in developing our people, and we want to further develop our learning culture and be better at sharing improvement and best practice across the organisation. We will consider an organisational development approach to inform compassionate, inclusive improvement culture, a key aim being that we can clearly describe a shared vision of our quality improvement culture across all roles and levels in the organisation.

Developing Leadership Behaviours

There are a number of examples of good practice in QI but there is more to do to translate our investment in people and building of QI capability into greater transformation through scale and spread. We aim to include more service users in improvement and develop leaders that use data to drive decision making and improvement. We will particularly articulate the responsibilities for leading improvement among the leadership triumvirate of nursing, medical and operations. There will be a clear link with the clinical strategy, with improvement as a key enabler to achieve this. We will also further develop the coaching style of leadership with high performance and support expectations.

Building Improvement Capability and Capacity

Good progress has been made with over 500 staff trained in QI (excluding induction) and is expected to reach around 700 in the next couple of months with those in progress or booked on. There is further to do to ensure capacity is always where it needs to be or deployed in a way that aligns to priorities. Ongoing development of the programme will ensure an easy-to-understand approach strongly linked to selected basic tools and PDSA (Plan, Do, Study, Act) and aimed at the right staff working on the right improvements.

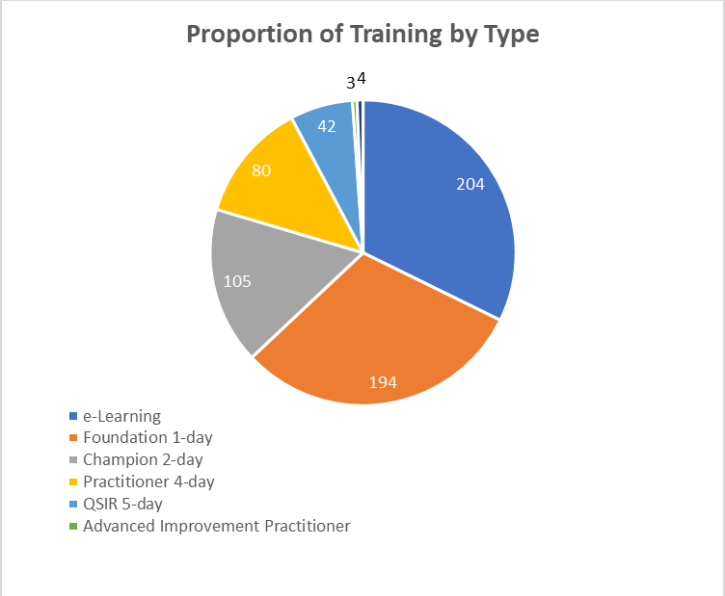
Embedding Improvement into Management Processes so it Becomes the Way in Which we Work in the Long-Term

There are many examples of good practice, but they can often happen in pockets or be an add on. There is an aim to see improvement as part of daily work, using data and technology for analysis and actionable insight, providing future focus as well as ‘rear view’. We will understand better, and adapt, our processes where we see they can inhibit improvement rather than support it. We will also look at the employee annual review process for greater focus on QI capability and further development of culture and the conditions for sustaining a QI way of working.

Whilst focusing on where we are at, we do not want to lose sight of where we have come from. The current cycle of the QI strategy set out to build capability and infrastructure where the was little and has made great progress. We now need to turn that capability into greater meaningful transformation for patients, staff, partners, and our use of public money. This will be through building on our vision, developing our leadership and creating the conditions and opportunities for staff to use their QI skills and knowledge, and continuing to shape our QI culture.

QI Training Programme

At the launch of the QI strategy, there were around a dozen staff identified as having recognised improvement methodology training. Over the first two years of the QI strategy, we will have trained over 500 staff (by the end of February) and we are on track for around 700 in the next quarter. These are colleagues trained across one of several levels of either AQuA (Advanced Quality Alliance) or QSIR (Quality Service Improvement and Redesign).



The plan for 2024-25 considers changes to QSIR now NHSE has transferred its operation to AQuA. This has introduced some additional annual cost, which needs to be factored along with system partners in the longer-term training plan. We are scheduled to continue work on this over the coming months.

In addition to QSIR, we have developed a Trust QI training offer based on QSIR and AQuA methodologies, which is tailored to DHcFT needs. Feedback suggested teams welcomed an option for a half-day training offer to be taken to them (rather than them coming to it) for use in development days and as initial stages in team improvement initiatives and this is rolling out from April.

Training Type	Completed	In Progress	Booked and Waiting	Total
e-Learning	149	55		204
Foundation 1-day	184		10	194
Champion 2-day	64	4	37	105
Practitioner 4-day	63	6	11	80
QSIR 5-day	26	5	11	42
Advanced Improvement Practitioner	3			3
QSIR Associate	3		1	4
Total	492	70	70	632

LifeQI

LifeQI is the Trust platform for working on and sharing Trust improvement ideas and represents a key component of the QI infrastructure. The more people trained in QI leads to more QI initiatives, which means greater use of the LifeQI platform.

- There are 185 registered Trust users of the LifeQI system.
- There are 104 live initiatives on the LifeQI system.
- Those 104 initiatives identify 164 Trust strategic objective benefits between them (see below).
- 73% of initiatives identify improved care as a primary outcome (76 of 104 initiatives).

Active projects that support Trust objectives:

GREAT Partnerships	GREAT care	GREAT place to work	BEST use of money
25	76	29	34

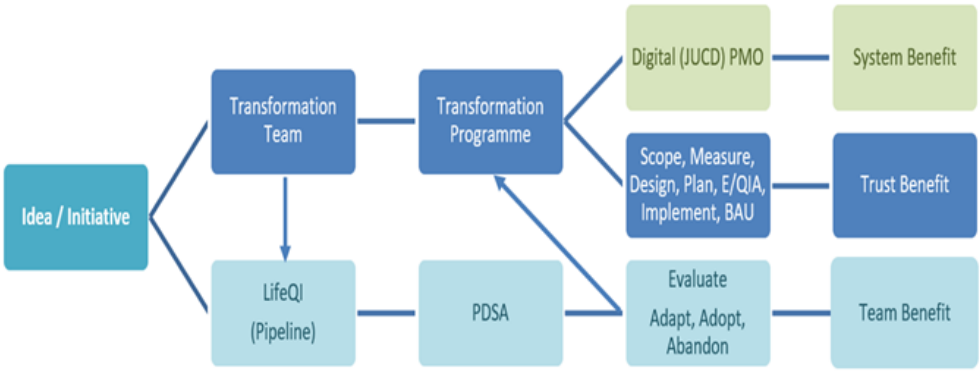
It should be noted that use of LifeQI is only an indication of QI initiatives being worked on by colleagues and the actual number will be higher than this. We know now that we have greater QI capability, that many improvement initiatives of low complexity and risk are 'got on with' at a local level requiring little support, and it is not the intention of any QI infrastructure to be unduly burdensome or inhibit idea progression. We are therefore looking at the system and process in 2024/25 to make the progression and sharing of learning easier and more accessible.

ePMO

ePMO is the electronic Programme Management Office. It is an on-line system used for managing improvement and transformation work, developed and used by all Derbyshire system partners. It has similarities to LifeQI in that it is a repository for improvement work but goes further to incorporate governance tools and processes, recognising that most of the content is transformational, has system interdependencies and typically has a significant financial element.

The use of both LifeQI and ePMO recognises that improvement initiatives exist on a continuum from pipeline to full transformational projects. They can be small or big or sometimes can start small and spread or be scaled up, becoming bigger and more complex.

The diagram below plots the path initiatives might typically take and the relationship between stages. Pipeline or local initiatives which are tested and developed may progress to the transformation programme, in turn these may advance further to the Derbyshire system space where there are significant system benefits or interdependencies.



The ePMO has been used for the management of the Trust 2023/24 transformation and CIP programme and is currently configuring the 2024/25 programme.

Impact

In evaluating the impact of the QI strategy, we are considering the 'so what'. Where and to what extent has delivering it to this point, had a positive impact on Trust strategic objectives.

Great System Partner

This strategy recognised the benefits of working with system partners. In this cycle we have:

- Developed and implemented a new system ePMO (from 2022).
- Expanded the QSIR offer and faculty (Quality Service Improvement and Redesign), developing three QSIR Associates and delivering an annual programme of QSIR training (currently planning 2024/25 schedule).
- Developed QI training for joint venture leadership programmes.
- Currently developing a long-term system offer for QI capability and sustainability.

An example of partnership working delivering benefits to our community:

Clean Air at Schools

Issue: vehicles idling (stationary with engines running) outside special schools, contributing to greater emissions and lower quality air.

Solution: we have worked with system partners to install and monitor air quality outside two schools in a pilot study (Stanton Vale School and Brackenfield School). The project is still underway, but findings are expected to inform attitudes, behaviours and practice of transport staff, school staff, parents and caregivers. The children at the schools have been active in designing posters and banners which are placed at typical stopping areas and also even produced a song at Christmas which has circulated on X (formerly Twitter).

Great Care

As previously highlighted, 73% of initiatives on the LifeQI platform identify great care as a primary aim of the work. Examples include:

Improving SMART Person-Centred Occupational Therapy Care-Planning

With robust care plans in place, staff from different shifts, rotas or visits can use the information to give the same quality of care and support. This allows people to receive a high standard of safe, effective and responsive care in a service which is well-led.

Solution: improve the efficiency, person-centeredness and sustainability of care-planning through optimising assessment process. Integrate an evidence-based audit tool to improve person-centredness. Ensure interventions as SMART (specific measurable, achievable, reasonable and timely) and are sustained.

ECG Screening

Issue: lack of rapid ECG screening means there is a missing piece of information available when needed in relation to a patient's physical health. Acquiring this information necessitates referral for ECG which takes time and sometimes do not happen after they have been arranged.

Solution: rapid ECG screening enables both the clinician and patient to access the right support at the right time for any potential unidentified cardiac condition by conveniently enabling rapid screening at the point of contact. It provides assurances on health or indicates further diagnostic intervention required. Early identification of cardio problems can provide better outcomes for the patient and incurs less net cost to the health and care system.

Creation of an Easy Read Standard for Neuro Developmental Services (ND)

Issue: inequity within the ND service in terms of who has access to tools to develop easy read information. There was also differing knowledge and experience in how to create best practice easy read information. Communication of reasonable adjustments are a shared specialist competency when working with people with learning disabilities. All professionals working within the ND service should be equipped and confident to make high quality easy read information for people with learning disabilities.

Solution: develop and coproduce an evidence based easy read standard, so that all professionals within the ND service can make high quality easy read information. Training in how to produce easy read information will be co-developed and co-facilitated with Experts by Experience. Assistants and professionals throughout the ND service are trained in how to create easy read to this shared standard and given access to visual symbol packages and photo resources in order that each team can make their own resources - with access to drop -in support sessions.

Great Place to Work

Over 500 colleagues have had a level of QI training to date, equipping them with the skills, permission and opportunity to explore how they work and develop it aligned to recognised methodology.

29 of the 104 initiatives on LifeQI identify great place to work as a deliverable benefit.

Voice Recognition Transcription (being piloted to reduce workload)

Issue: many clinicians and clinical teams use digital voice recorders for the transcribing of clinical records and letters with no integration with the electronic patient record. This requires additional process steps to convert audio to text via keyboard and lengthens the time it takes to get the clinical record to its destination/s.

Solution: use voice recognition technology, integrated with SystmOne, to minimise keyboard entry (replaced by proof reading and editing where required), reducing workload through fewer process steps and letter transcription turnaround time by 10 mins per letter (data from pilot study).

Improving Junior Doctor Induction Process (a supported QI initiative raised by doctors' experience of the induction process)

Issue: minimising lost time and enabling doctors to engage in meaningful, value adding activity during the induction period.

Solution: explore system accounts set-up pre-start, accessing e-learning from day one, shadowing on-call, virtual tour pre-start, one-stop shop for collecting equipment, smart-card provision (or transfer from other trust) in advance.

Trust Meetings (in progress to optimise capacity)

Issue: meetings are a significant part of many roles. It can be the case that whilst they are necessarily introduced to monitor and address organisational issues, they can also become less effective over time. It is important that meetings add sufficient value relative to their cost (staff time and money).

Solution: exploration of the number, type, purpose, duration, frequency and membership (cost) of meetings. Ensuring clear, value adding terms of reference and appropriate membership, avoiding unnecessary duplication. Predicted fewer meetings with fewer attendees will release time to undertake more value-added activity in respective roles.

Best Use of Money and Resources

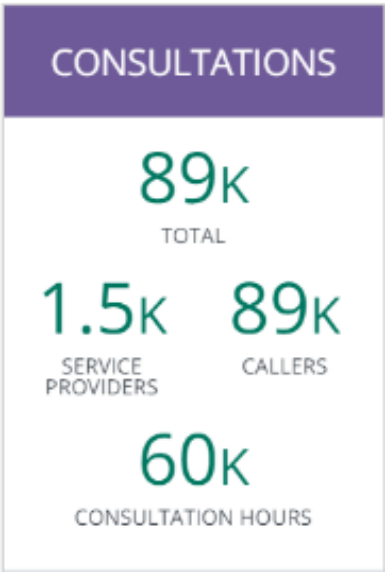
Productivity and Unwarranted Variation

Issue: benchmarking highlights service areas that appear to operate at greater cost and less output than provider peers (note there are also areas where we benchmark favourably). Internal analysis of activity and cost in these areas supports the benchmarking and identifies significant variation across like for like teams with respect to contacts, caseload, length in treatment, staff numbers and cost and other key metrics.

Solution: explore practice across teams and work to a standard (within agreed tolerances to reduce variation) that optimises cost to output ratio, eg cost per completed treatment. Reducing cost per completed treatment allows for more patients to be treated for similar cost or similar numbers of patients to be treated at lower cost or a combination of both.

Video Consultation

Issue: patient contact via video on-line platform was introduced at the start of the COVID pandemic response. At its peak, around 15% of patient contact in the Trust was via this method. Since COVID, response measures were scaled down, patient contact via video has fallen to around 4%. This results in more clinicians travelling to patients at greater financial and environmental cost (fuel, time spent travelling and carbon emissions) and more patients travelling to Trust sites putting greater demand on Trust estate.



Solution: since the introduction of video consultation in 2020, there have been over 89,000 video consultations at over 60,000 hours to date. A survey of Trust patients and clinicians returned 8,119 responses, indicating 93.7% in favour of being offered video appointments in the future. We are now exploring opportunities where video consultation can be a primary offer in the long-term

Dementia Diagnosis – Service Achieving Above National Target of 67%

Issue: people diagnosed over 65, and particularly over 85, are at increased risk of having additional health conditions, frailty and of experiencing complex needs as a result. People diagnosed under 65 have different needs and commitments; they often follow a different clinical pathway and may also need different forms of support. People living with dementia can experience poor outcomes, as a result of having delirium.

Solution: early diagnosis to enable informed decision making and facilitate advance care planning. Post diagnosis support and timely information on an ongoing basis. Support for carers, targeted support for under 65s. Seamless working across of health and social care. Good training for staff, sharing specialist skills. Promotion of prevention and risk reduction.

Next Steps for QI Strategy

The next QI strategy will be developed towards the end of 2024 and will be informed by the 2024 Trust strategy within which QI will be a key component.

Progression against existing aims will be evaluated for evidence of impact, as well as opportunities where we think these can be pushed further, particularly around wider stakeholder involvement, sharing stories and learning, and leadership for a QI culture. The NHS Impact framework is an excellent tool in evaluating and understanding our QI maturity and will be a useful guide in determining our strengths as well as highlighting the work to do.

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

- Aligns with and seeks to deliver against the Trust's strategic aims.

Consultation

- High level aims have been outlined in the QI strategy and more detailed plans have been discussed at Trust Leadership Team (TLT), Executive Leadership Team (ELT) and Board Development.

Governance or Legal Issues

- None

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

- None.

Recommendations

The Board of Directors is requested to:

1. Note the progress of activities to date in delivery of the 2021-2024 Quality Improvement Strategy, and the development of a new strategy in 2024.

Report presented by: Vikki Taylor
Director of Strategy, Partnerships and Transformation

Report prepared by: Joe Wileman
Head of Programme Delivery

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

National NHS Staff Survey 2023

Purpose of Report

To update the Board on the headlines from the NHS Staff Survey – NHS England results, which show our position based on the 2023 all staff survey.

Executive Summary

A summary of the the National NHS Staff Survey 2023 results for Derbyshire Healthcare will be presented at the meeting. The survey was conducted between September and November 2023.

The results are compared against 51 organisations in our benchmarking group - Mental Health & Learning Disability and Mental Health, Learning Disability & Community Trusts.

The Staff Survey results are presented in the context of best, average and worst results for similar organisations where appropriate. Data is weighted to allow for fair comparisons between organisations. A small number of questions are not weighted or benchmarked because these questions ask for demographic or factual information.

The results are divided into the People Promise themes, which cover areas of staff experience helping to present results in these areas in a clear and consistent way. All of the themes are scored on a 0-10 scale, where a higher score is more positive than a lower score. These theme scores are created by scoring question results and grouping these results together.

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

- There is a risk that the response rate does not provide survey results for a number of teams that didn't meet the response threshold to receive data.

Consultation

- All eligible staff were invited to participate in the National NHS Staff Survey.

Governance or Legal Issues

- CQC analyse the NHS Staff Survey results.
- Staff FFT questions are reported and benchmarked nationally.
- NHS England will publish these results publicly on the 7 March.

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

Our NHS Staff Survey results are be broken down by protected characteristics and further analysis is done by the Equality, Diversity and Inclusion Team in conjunction with all Staff Network Groups and EDI Steering Group.

Recommendations

The Board is requested:

1. To receive a summary of the National 2023 Staff Survey results.

Report prepared and presented by:	Rebecca Oakley Acting Director of People and Inclusion

A Framework of Quality Assurance for Board Stories Sharing Service Receiver, Carer and Staff Experiences to Trust Board

Purpose of Report

To provide an overview of the Board stories that have been brought to the Derbyshire Healthcare NHS Foundation Trust (DHcFT) Public Board between November 2022 and March 2024.

Executive Summary

Listening to what is important to the storyteller, helps the Board to understand why certain issues matter and to make sure that improvements to Trust services are based on their respective feedback. This is reflective of our Trust Vision of “making a positive difference in people’s lives by improving health and wellbeing” and the strategic objectives of “providing great care, being a great place to work, making the best use of resources, and being a great partner”.

The Board story format is also reflective of the Trust Patient and Carer strategy and aims to meet the Trust Clinical Ambition of designing services in consultation with our colleagues and people who use our services.

Trust staff are encouraged to identify individuals who would like to tell their story. Those who express an interest in participating are given an overview of what they can expect and what support is in place for them during and after the process.

The staff member, carer or service user is supported to write down their story and they have the option to present it themselves or have someone read it aloud. After sharing their experiences, the Board may ask questions and often make a commitment to take these experiences into account and improve services or influence developments to improve the patient experience. Each person who tells their story has a “post board debrief” and is given the option to feed back on their experience and become involved in other Trust projects at their discretion.

Feedback from those who have told their stories to the Board have been largely positive about the experience, although one person expressed frustration about the lack of services for trans people in Derbyshire, however, they have been supported to raise this in the most appropriate forum.

Of the eight stories taken to Board since November 2022, five have been Patient Stories, two have been from Experts by Experience, working within the Trust and one was from a carer. A staff story is scheduled for March Board 2024.

To ensure that the diversity of the services provided by the Trust are reflected in the stories, an attempt is made to present a variety of experiences. Of the eight stories taken to Board since November 2022, the Working Age Adult Acute, Working Age Adult Community, Children and Young Persons service, Perinatal service, Psychological Therapy service and Older People’s service have been represented. If a person comes forward but the story would not be appropriate for the Board setting, they are supported to either tell their story in a more appropriate forum or are invited to raise any concern or complaint they may have with the Patient Experience team.

This variety and diversity of individuals presenting to Board is expected to continue in 2024/25.

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

Risks and Assurances

- A service receiver attends the Board meeting to give an insight into their experience whilst in care. The Board listens to the experiences of individuals and asked questions to understand and receive assurance that the knowledge imparted is used to triangulate and to influence the Trust strategy and improve performance where indicated.

Consultation

- Director and Deputy Director of Nursing and Patient experience

Governance or Legal Issues

- The essential standards of quality and safety consist of 28 regulations (and associated outcomes) that are set out in two pieces of legislation: the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.
- The CQC regulates the Trust and when an essential standard is not met, the Trust is in legislative breach.
- The provider must have plans that ensure they can meet these standards. They must have effective governance and systems to check on the quality and safety of care. These must help the service improve and reduce any risks to people using the service in their health, safety and welfare.

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

- The information supplied must be viewed with the consideration that certain REGARDS groups may feel less enabled to share their feedback and that these groups may be under-represented in the feedback.
- The Trust seeks the opinions of people who use its services through non- trust organisations and using a variety of different methods to try to encourage broad participation.

Recommendations

The Board of Directors is requested to:

1. Review the content of the report and seek clarification where necessary.
2. Make any recommendations for further improvement of the model.

Report presented and prepared by:	Joseph Thompson Assistant Director of Clinical Professional Practice

Overview of Board Stories
November 2022 to January 2024

Date	Storyteller	Division	Service	Brief overview including any actions following story
Nov-2022	Michael Kelly	Working Age Adult Acute	Radbourne Unit	Michael spoke to the Board about his experience of being an inpatient within an acute working age adult ward.
Jan-2023	Simon Rose	Expert by Experience	Trustwide	Simon spoke to the Board about his experience of using Trust services and then during his recovery, working as an Expert by Experience first in medical teaching and later as the Trust Service User Committee Lead (EQUAL).
Mar-2023	Tom Cormer	Working Age Adult Acute	Radbourne Unit	Tom spoke to the Board about his experience of being a service user with a diagnosis of Autism Spectrum Disorder (ASD) on an inpatient ward. Tom described this experience as challenging as the environment did not meet his sensory needs and was keen to reiterate the importance of recognising the needs of those with an ASD diagnosis. Following Tom's story and recognising the needs of those on the ASD spectrum, the Making Room for Dignity Programme has sensory environments as an integral part of the new wards.
May-2023	Anthony Doleman	Working Age Adult Community	Early Intervention	Tony spoke to the Board about his experience of being a carer for someone using Trust services. Tony spoke about realising that he was a “carer” and how lonely this felt in relation to support. However, he talked about things improving when he came across Derby City mental health carers forum and he now attends the DHcFT Carers Engagement Meeting. Following the telling of his story, Tony is now an active member of the Trust Patient and Carers Experience Committee and is part of the group currently coproducing the Patient and Carer Strategy for 2024-27.
Jul-2023	Nikki Ball	Older Adult Community	High Peak CMHT	Nikki spoke to the board about her experience of being a trans person using mental health services and about how she was is passionate about educating people about supporting those who have transitioned and supporting those who are on a similar journey. Nikki reiterated the mantra that she has printed on cards and often gives out; “*tolerate, educate. Here I am, see me. Say hello, learn, change the world*”. Following Nikki’s story, she has been in regular contact with the Assistant Director for Clinical Professional Practice and has voiced her frustration at the lack services she perceives are available for the trans community. Nikki has been signposted to Healthwatch so she can continue to support those in the trans community in relation to their mental health.

Sep-2023	Jill Wilkes	Psychology	Psychology	Jill spoke to the board about her experience of using several Trust services and the important of a trauma informed approach. Jill spoke of some of the challenges she experienced while using Trust inpatient services and how this was different to the positive experience using the urgent Assessment, Community and Psychology services. Jill spoke of the respect she has for staff who work in a difficult and demanding environment and had praise for the innovations that she had seen within the community service backed by senior leaders within the Trust. Jill continues to work with the Psychology department on spreading the message of trauma informed care.
Nov-2023	Cordelia Szeles	Children and Young People's Services	Complex Health Occupational Therapy	Cordelia (who is known as Dee) spoke to the Board about her experience of using the Trust Physiotherapy and Occupational Therapy services, as someone diagnosed with Cerebral Palsy from being a child to a young adult. Dee spoke about some of the initial challenges she had and reiterated the importance of being given information about different resources available to people under services, such as the personal wheelchair budget, as this a contributing factor to her well-being. Following the story, Dee agreed for her story to be shared within the wider Children's division for learning and insight and was signposted to the Trust IPS service to further support her independence.
Jan-2024	Nikki Bunning	Expert by Experience	Perinatal service	Nikki spoke about her journey from using perinatal services to becoming an Expert by Experience in the Perinatal Collaborative and of being an active part of developing this collaborative led by DHcFT.

Service User
Carer
Expert by Experience
Staff Member

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

Quality Position Statement - Effectiveness

Purpose of Report

This paper provides the Trust Board with a Quality Position statement in respect of the Trust's effectiveness as assessed against the Care Quality Commission's (CQC) Effectiveness domain. It is intended to provide an overarching assessment, recognising areas of strength and improvement whilst outlining areas where further improvements are needed in order to achieve better outcomes for people who use our services.

Executive Summary

It has been several years since the Trust has been subject to a comprehensive inspection by the CQC, although in recent months it has received a responsive review as a result of a routine mental health act related ward visit, and continues to receive periodic, routine, mental health act related reviews.

The Trust retains its overall rating of "Good."

This paper therefore provides an assessment of the Trust's current status against the CQC's effective domain.

According to the CQC, "Effective" is defined as:

"People's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence."

Specifically considering the following key lines of enquiry:

- Assessing needs and delivering evidence-based treatment
- Monitoring outcomes and comparing with similar services
- Staff skills and knowledge
- How staff, teams and services work together
- Supporting people to live healthier lives.
- Consent to care and treatment

Taking these key lines of enquiry into account, the Trust is able to demonstrate that it meets the requirements of the effectiveness domain through a combination of governance infrastructure including the recording, monitoring and benchmarking of activity.

In addition, this is underpinned by the delivery of training and professional development and the clinical frameworks within which referral, assessments, admissions, and discharge are managed.

In recognising that these aspects enable the Trust to meet the requirements of the effective domain, there is also a recognition that there are aspects of performance such as length of stay, time waiting, number of out of area placements and some training compliance levels that indicate the need for further work to manage these to a level the Trust finds acceptable.

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.	

Risks and Assurances

This report is offered with assurances around contained data and metrics of national benchmarking.

Consultation

The evidence provided is a collection of evidence, published through NHS Benchmarking, Trust data and existing public health profiles.

Governance or Legal Issues

- Health and Social Care Act 2008 (Regulated
- Activities) Regulations 2014 (Part 3) (as amended)
- Care Quality Commission (Registration)
- Regulations 2009 (Part 4) (as amended)

Public Sector Equality Duty 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:

- Whilst the report provides and overview of the Trust's effectiveness as assessed against the key lines of enquiry as established by the CQC's Effective Domain, it will recognise the potential disproportionate impact upon particular patient groups, for example as a result of potential protracted waits for assessment and treatment.

Recommendations

The Board of Directors is requested to:

1. Consider and determine the level of assurance against the Effectiveness domain. The proposed level of assurance for consideration is significant assurance, on the basis that that there is a generally sound system of control designed to meet the requirement of the domain however, there are some weaknesses which put the achievement of specific outcomes at risk.

Report presented by: **Kyri Gregoriou**
Deputy Director of Nursing and Quality Governance

Report prepared by: **Dave Mason**
Interim Director of Nursing and Patient Experience

Quality Position Statement - Effectiveness

It has been several years since the Trust has been subject to a comprehensive inspection by the CQC, although in recent months it has received a responsive review as a result of a routine mental health act related ward visit, and continues to receive periodic, routine, mental health act related reviews.

The Trust retains its overall rating of “Good” and this paper therefore provides an assessment of the Trust’s current status against the CQC’s effective domain.

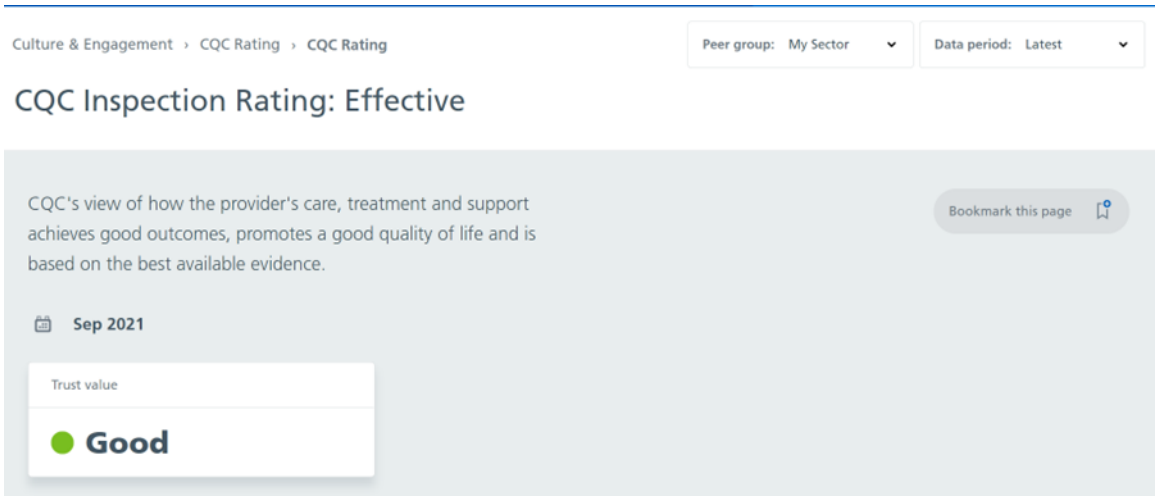
According to the CQC, by “Effective” is defined as:

“People's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.”

Specifically considering the following key lines of enquiry:

- Are people's needs assessed and care and treatment delivered in line with current legislation, standards and evidence-based guidance to achieve effective outcomes?
- How are people's care and treatment outcomes monitored and how do they compare with other similar services?
- How does the service make sure that staff have the skills, knowledge and experience to deliver effective care, support and treatment?
- How well do staff, teams and services work together within and across organisations to deliver effective care and treatment?
- How are people supported to live healthier lives and, where the service is responsible, how does it improve the health of its population?
- Is consent to care and treatment always sought in line with legislation and guidance?

The Trust’s rating in context with Mental Health Trust’s nationally

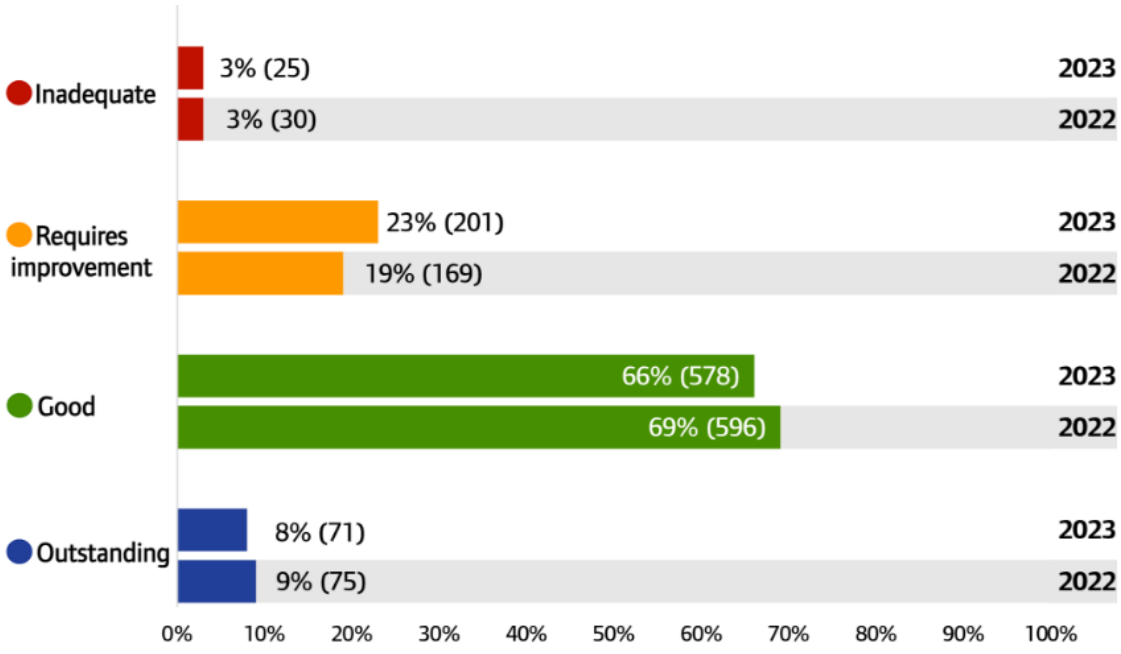


Safe	Requires improvement
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good

As the tables show the CQC at its last comprehensive inspection assessed the Effective Domain as “Good”.

In the context of similar, mental health Trust’s, the CQC’s state of care report indicates as shown in the following table, that the majority of mental health Trusts, rated overall as within the “Good” category, a high proportion of which have also been rated as “Good” within the Effective category.

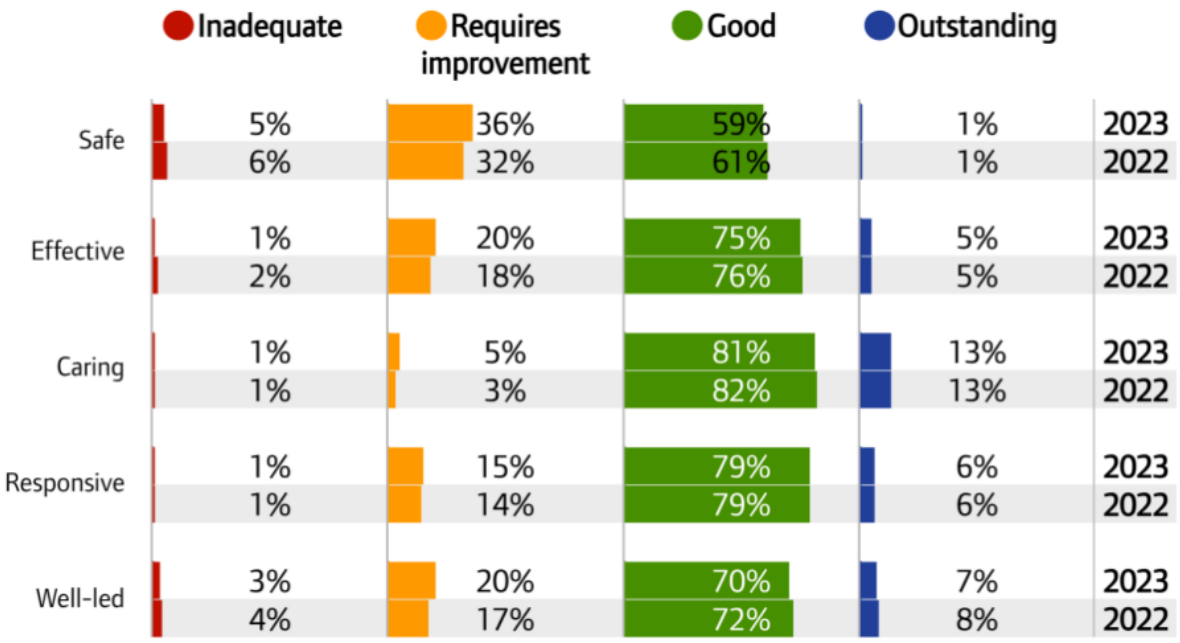
NHS and independent mental health core services, overall ratings, 2022 and 2023



Source: CQC ratings data, 31 July 2022 and 7 September 2023

Note: Percentages may not add to 100 due to rounding.

NHS and independent mental health core services, key question ratings, 2022 and 2023



Source: CQC ratings data, 31 July 2022 and 7 September 2023

Note: Percentages may not add to 100 due to rounding. Percentages between 0.01% and 1% have been rounded up to 1%.

Are people's needs assessed and care and treatment delivered in line with current legislation, standards and evidence-based guidance to achieve effective outcomes?

Of the 6 key lines of enquiry considered within the effective domain, the first considers questions about the extent to which the Trust delivers care within current legislation, standards and evidence based guidance to achieve effective outcomes. It also considers the extent to which care is delivered in a way that meets individual needs in terms of nutrition and hydration, giving due regard to cultural needs and where they may be detained under the mental health act, that there rights are understood and protected.

In respect of ensuring that care and treatment needs are assessed and that treatment delivered is evidence based, the Trust ensures that it has in place governance which ensures compliance with NICE guidance.

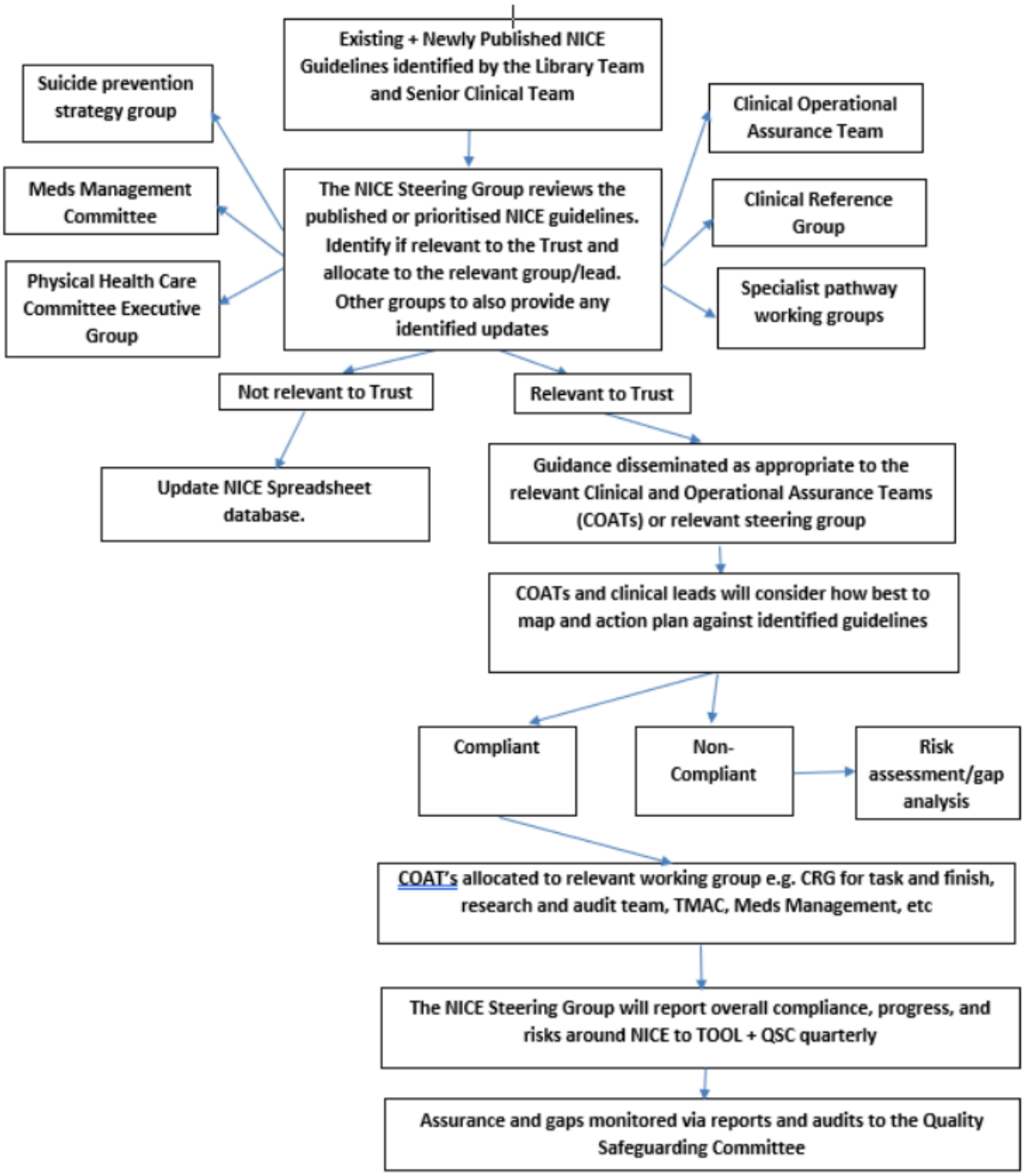
Assessing needs and delivering evidence-based treatment

Adherence to NICE Guidance

It is a regulatory requirement that Trusts must demonstrate that NICE guidance is being implemented and this is increasingly subject to scrutiny by the CQC.

For the Trust to demonstrate its compliance with NICE guidance. there needs to be a clear goverance framework. The Trust has in place a NICE Steering Group which has established am audit frameworks which has been embedded into divisional governance. The structure

below illustrates the process in operation to assess relevance and adherence to relevant NICE guidance.



Access to Assessment and Treatment

How are people's care and treatment outcomes monitored and how do they compare with other similar services?

Critical to this element of the effective domain is the ability of the Trust to assess and treat patients in a timely way, providing access to the right treatment pathways at the right time.

To increase visibility and reduce length of waits, on 9 November 2023, NHS England made data publicly available for the first time on waits for community mental health, learning disability and autism services. The data provides median and 90th percentile waiting times for a first contact for children & young people's services (CYP) and waiting times for a second contact for adult and older adult services. NHS England published these metrics to provide initial insights on waiting times to support investigation of pathway and data quality issues.

The Trust therefore has arrangements in place for the monitoring of these metrics and benchmarks with services nationally.

More recently this benchmarking and local scrutiny has led to the prioritisation of working age adults and memory assessment services to improve service recovery and waiting times during Q3 & Q4 of 2023/24.

CYP waiting times in Derbyshire Healthcare NHS Foundation Trust were not been identified as an outlier, however NHSE reported on long waits for adult and older adult patients still waiting to receive their second contact with services

Responding to high demand for inpatient treatment and mitigating out of area placements

In addition, and linked with this, the need to provide care and treatment close to home where patients may benefit from the additional support of carers and relatives, places a clear focus on the avoidance of placing patients requiring inpatient care, in placements out of the derby and derbyshire area.

It has however been the case that due to high levels of demand for inpatient placements and the high levels of occupancy, the Trust has seen an increase in out of area placements, which has led to a deeper analysis of the needs of people requiring inpatient services, a focus on the more effcicient management of patient flow and consideration of opportunities for alternatives to admission.

In addition to these wider considerations of how the Trust will meet the demands of a more complex and dependent population, contingencies have been progressed to provide additional bedded capacity closer to home for Derby and Derbyshire residents.

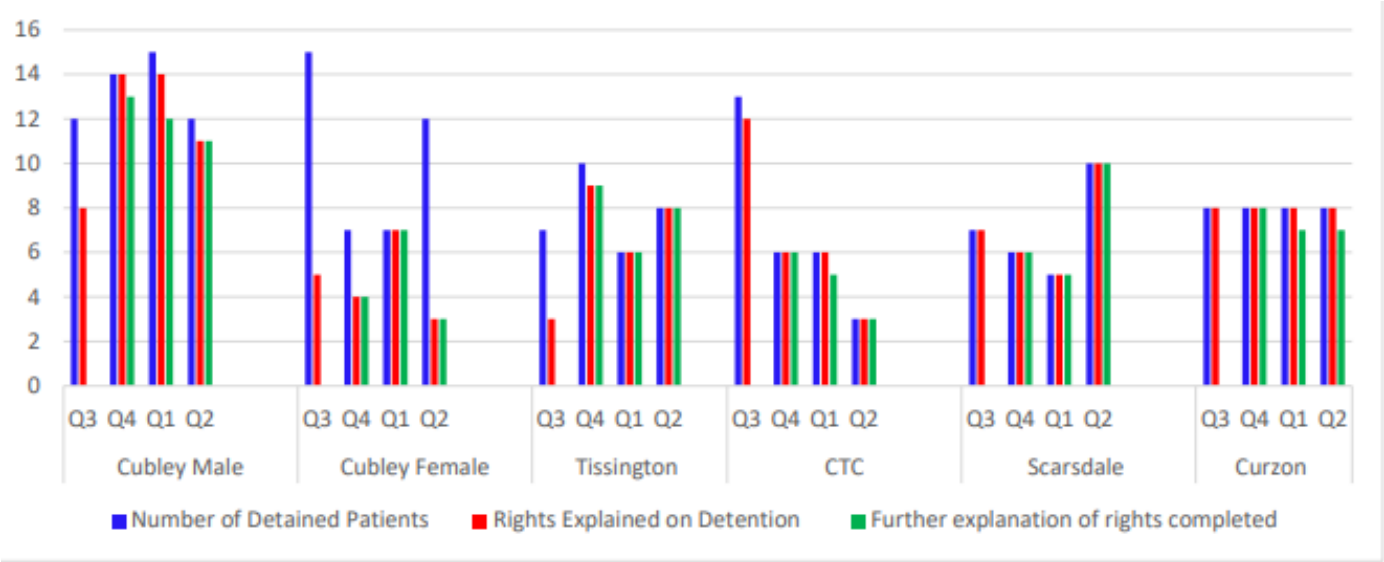
Mental Health Act compliance

The Trust has a Mental Health Act Committee which monitors the application of the act in terms of the numbers of people admitted to hospital either on a detained or informal basis and in respect of people in the community who may be treated under a community treatment order. The committee also monitors compliance with requirements to ensure patients have been made aware of the rights under the act, in addition providing oversight of the use of restrictive interventions, such as restraint and the use of seclusion.

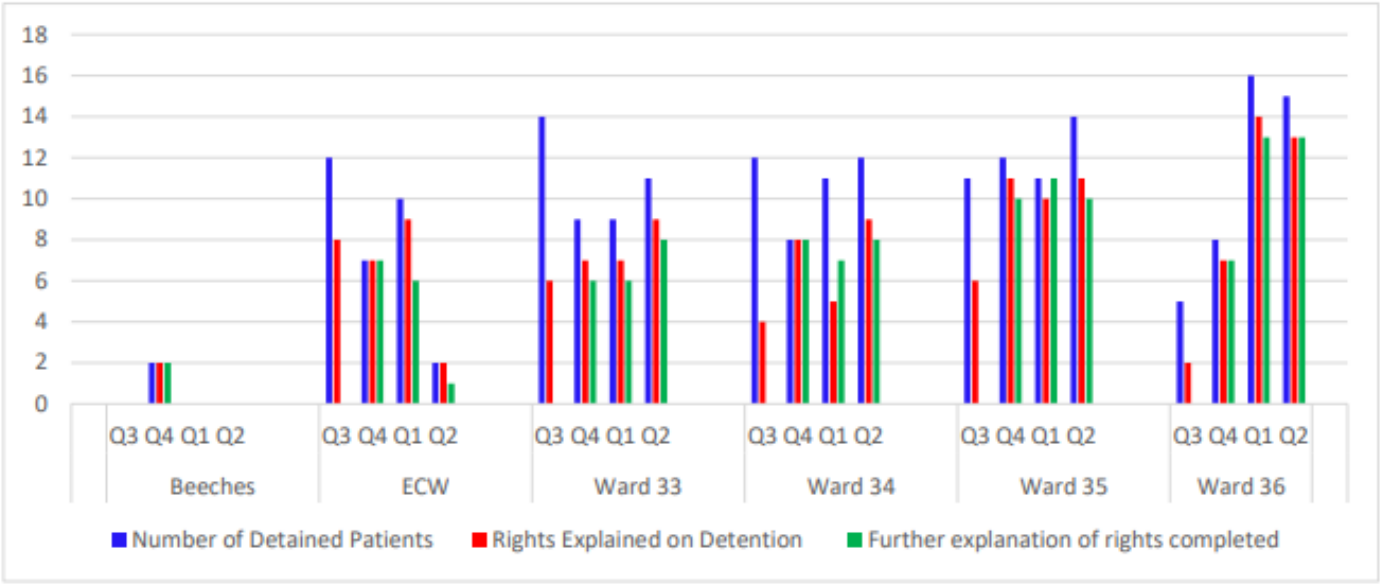
In respect of the requirement under section 132 of the act, the patients' rights should be explained on admission and then a further follow-up should be undertaken at 3 months.

The following charts indicate the level of compliance by ward by quarter and indicate that there is variation in consistency of achieving this requirement, with some areas achieving evidence of rights having been explained on admission and the follow up, however, there are examples where the evidence is not present that rights have not been explained, therefore work has been undertaken with individual wards to address this issue of compliance.

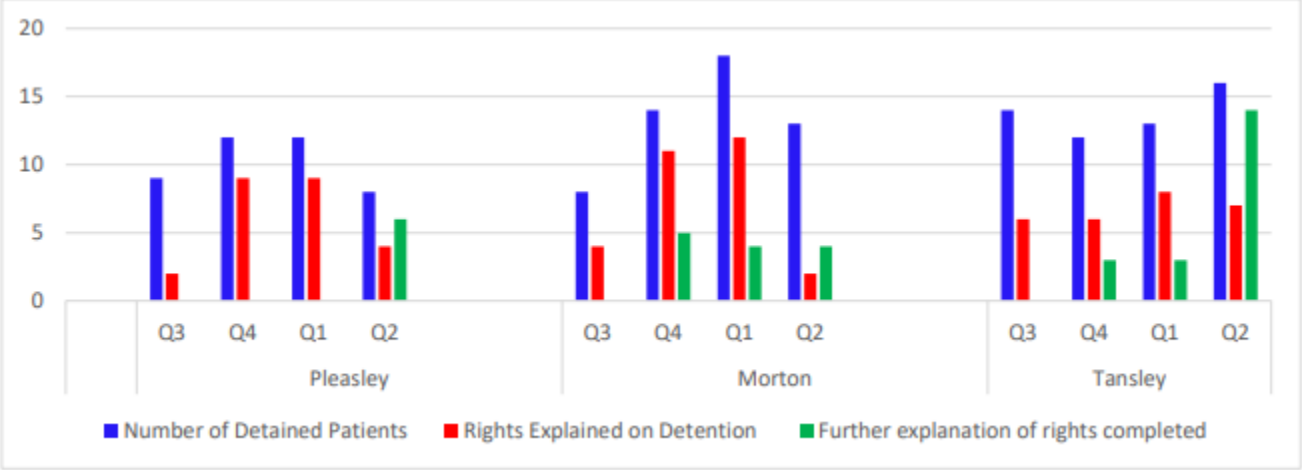
Section 132 explanation of rights on detention by wards for quarters 3, 4, 1 and 2 and further explanation of rights for quarters 4, 1 and 2 - Kingsway Hospital



Section 132 explanation of rights on detention by wards for quarters 3, 4, 1 and 2 and further explanation of rights for quarters 4, 1 and 2 Radbourne Unit



Section 132 explanation of rights on detention by wards for quarters 3, 4, 1 and 2 and further explanation of rights for quarters 4, 1 and 2 - Hartington Unit



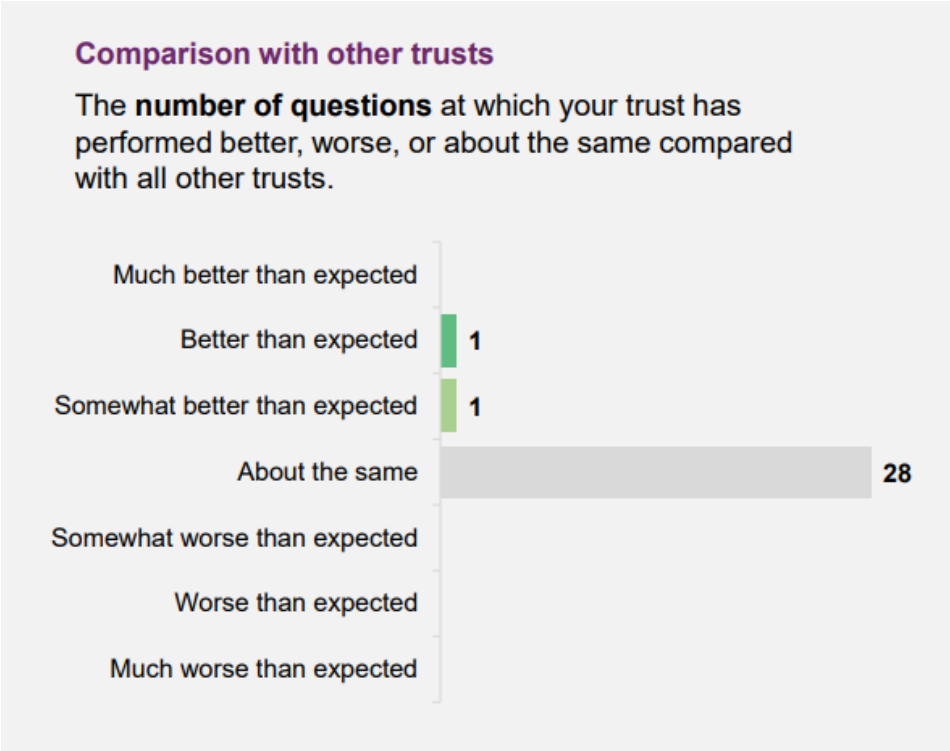
How are people's care and treatment outcomes monitored and how do they compare with other similar services?

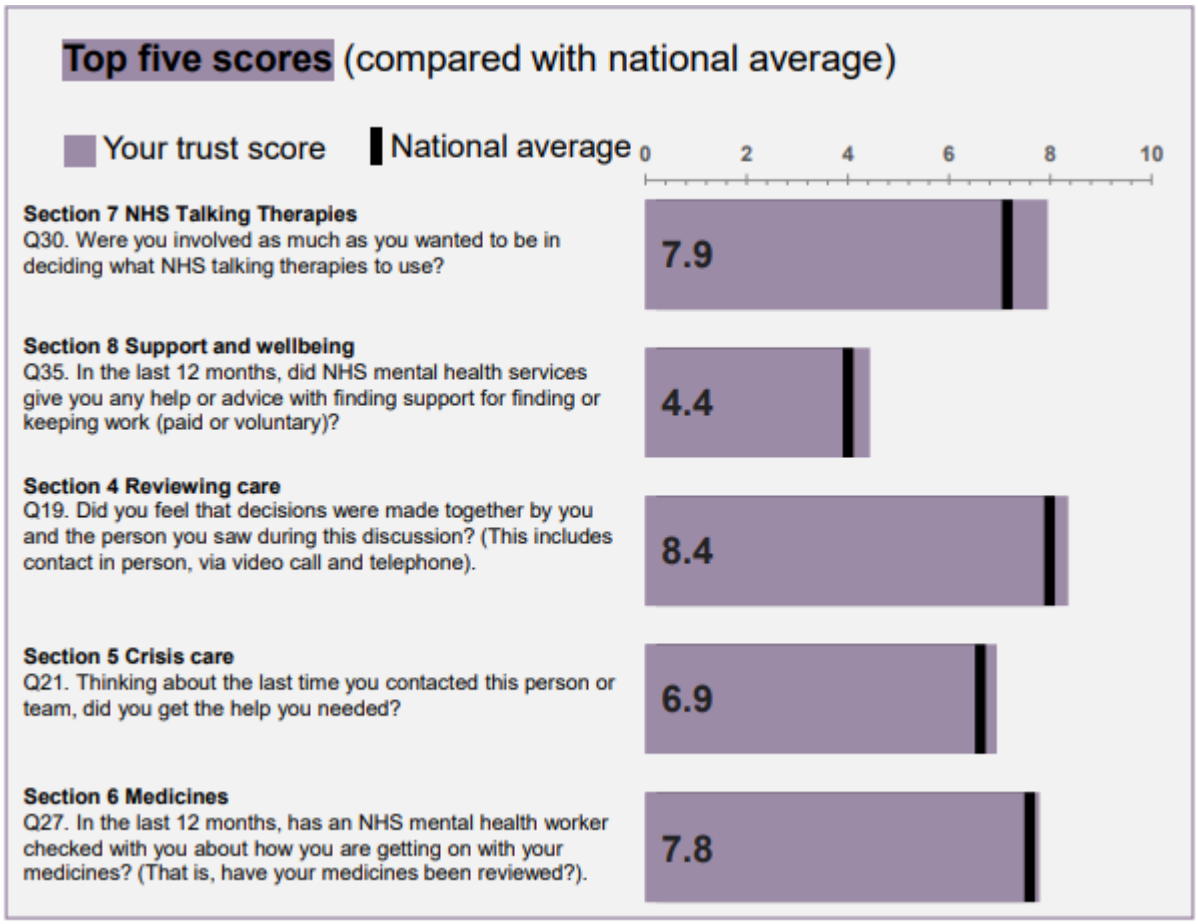
The second of the key lines of enquiry relates to the extent to which the Trust monitors treatment outcomes and how we compare with other similar services.

As such, the Trust monitors, and reports outcomes against the nationally agreed data sets and as a result is able to review its performance against similar services.

The Trust is also submits evidence to the NHS community mental health survey.

The most recent report indicating the following in respect of the Trusts performance against similar organisations.





This line of enquiry also considers the extent to which the Trust is involved in relevant quality improvement initiatives and has in place governance arrangements to respond to areas where improvements are required.

In addition to the Trust's investment in developing a quality improvement culture, specific governance arrangements have been established to identify areas where improvement is needed and to support the management of improvement actions.

These include the fundamental standards group which is focused on responding to and addressing clinical quality concerns in addition to coordinating quality surveillance activity and managing a schedule of self-assessment reviews against the CQC's single assessment framework.

In addition, the Trust participates in specific quality networks which are established to raise clinical standards through benchmarking activities and shared learning, the organisation has enrolled in NHS England's Culture of Care programme which is a national programme focused on supporting leadership to meet the national mental health and learning disability inpatient standards.

A further key element of this aspect of the domain is the extent to which the Trust is able to learn from adverse events including deaths.

The National Guidance on Learning from Deaths requires each Trust to collect and publish specified information on a quarterly basis. The Trust therefore publishes a quarterly mortality report.

Due to the number of active Case Record Reviews the function of the weekly Mortality Review Group supported by medical staff has been adapted to allow Investigation Facilitators to take specific active complex cases for medical opinion or input to offer a more timely resolution.

Medical Examiner officers have been established at all Acute Trusts in England and their role will be extended to include deaths occurring in the community, including at NHS Mental Health and Community Trusts. The implementation of this process had been expected by April 2023 however due to the complexities involved in data sharing this has been paused Nationally for community-based services. The Trust's Patient Safety team however continue to work with Medical Examiners to ensure the Trust is prepared for the implementation of this.

The case note reviews which are undertaken are instrumental in identifying areas of good practice and areas where learning can be shared, these are fed back to clinicians involved as part of the Trust's approach of appreciative inquiry. The Trust also contributes to suicide prevention working closely with Public Health colleagues and wider system partners.

How does the service make sure that staff have the skills, knowledge, and experience to deliver effective care, support, and treatment?

The third area of focus within the Effective domain relates to the extent to which staff are appropriately trained to meet the diverse needs of the patient populations, the Trust serves. Linked with this is the degree to which staff are able to develop professionally and to take up opportunities which enable them to grow and take on greater responsibility and more complex work.

These contribute to the extent to which staff enjoy their role, feel fulfilled in the work they do and the likelihood that their services will be retained, and they will contribute fully and positively to the care of patients receiving services and to the wider team Derbyshire ethos.

The Trust provides a comprehensive package of mandatory and role specific training in addition to opportunities for staff to undertaken higher level training which will prepare them for more senior or advances roles, with investment in roles such as apprenticeship routes, which have widened access to training alongside opportunities for coaching, mentoring and the revalidation process.

In addition, for clinical staff, the Trust supports the requirement that staff are able to access clinical supervision in order that they are able to actively reflect on their clinical practice, learning and developing through their professional experience.

Access and uptake of core training, supervision and appraisal are monitored at service and Trust level, with mechanisms in place to respond and address performance if levels of compliance are not achieved.

The following chart relating to training compliance levels indicate an overall compliance of 89.09%, however there are specific types of training where work is underway to recover level of staff trained. This is particularly critical to ensuring sufficient numbers of staff are trained in resuscitation and basic life support.

Training Compliance February 2024

Type of Course	Competence Name	Name	Expiry Date	Cohort	Compliance (n)	Compliance (%)
Compulsory Training	⊞383|LOCAL|C Fraud Awareness (3 yearly)|	Competence Total		2223	2076	93.39%
	⊞383|LOCAL|C Safeguarding - Adults Level 1 (Non Clinical) (3 Yearly)|	Competence Total		308	279	90.58%
	⊞383|LOCAL|C Safeguarding - Adults Level 1+2 (All Clinical) (3 yearly)|	Competence Total		1701	1605	94.36%
	⊞383|LOCAL|C Safeguarding - Children - Level 1 (Annual)|	Competence Total		232	221	95.26%
	⊞383|LOCAL|C Safeguarding - Children Level 1 (once only)|	Competence Total		1845	1807	97.94%
	⊞NHS|CSTF|Dementia awareness - No Specified Renewal|	Competence Total		1968	1825	92.73%
	⊞NHS|CSTF|Equality, Diversity and Human Rights - 3 Years|	Competence Total		2609	2353	90.19%
	⊞NHS|CSTF|Fire Safety - 2 Years|	Competence Total		2609	2373	90.95%
	⊞NHS|CSTF|Health, Safety and Welfare - 3 Years|	Competence Total		2609	2322	89.00%
	⊞NHS|CSTF|Infection Prevention and Control - Level 1 - 3 Years|	Competence Total		2609	2399	91.95%
	⊞NHS|CSTF|Infection Prevention and Control - Level 2 - 3 Years|	Competence Total		1210	1075	88.84%
	⊞NHS|CSTF|Information Governance and Data Security - 1 Year|	Competence Total		2609	2527	96.86%
	⊞NHS|CSTF|Moving and Handling - Level 1 - 3 Years|	Competence Total		2609	2341	89.73%
	⊞NHS|CSTF|Moving and Handling - Level 2 - 2 Years|	Competence Total		872	725	83.14%
	⊞NHS|CSTF|NHS Conflict Resolution (England) - 3 Years|	Competence Total		2609	2297	88.04%
	⊞NHS|CSTF|Resuscitation - Level 1 - 1 Year|	Competence Total		327	154	47.09%
	⊞NHS|CSTF|Resuscitation - Level 2 - Adult Basic Life Support - 1 Year|	Competence Total		1206	818	67.83%
	⊞NHS|CSTF|Resuscitation - Level 2 - Paediatric Basic Life Support - 1 Year|	Competence Total		376	263	69.95%
	⊞NHS|CSTF|Resuscitation - Level 3 - Adult Immediate Life Support - 1 Year|	Competence Total		315	241	76.51%
	⊞NHS|CSTF|Safeguarding Adults (Version 2) - Level 2 - 3 Years|	Competence Total		10	7	70.00%
	⊞NHS|CSTF|Safeguarding Adults (Version 2) - Level 3 - 3 Years|	Competence Total		1471	1332	90.55%
	⊞NHS|CSTF|Safeguarding Children - Level 3 - 1 Years|	Competence Total		2	1	50.00%
	⊞NHS|CSTF|Safeguarding Children (Version 2) - Level 1 - 3 Years|	Competence Total		143	106	74.13%
	⊞NHS|CSTF|Safeguarding Children (Version 2) - Level 1 - No Specified Renewal|	Competence Total		1	1	100.00%
	⊞NHS|CSTF|Safeguarding Children (Version 2) - Level 2 - 3 Years|	Competence Total		147	102	69.39%
	⊞NHS|CSTF|Safeguarding Children (Version 2) - Level 2 - No Specified Renewal|	Competence Total		216	3	1.39%
	Type of Course Total			32836	29253	89.09%

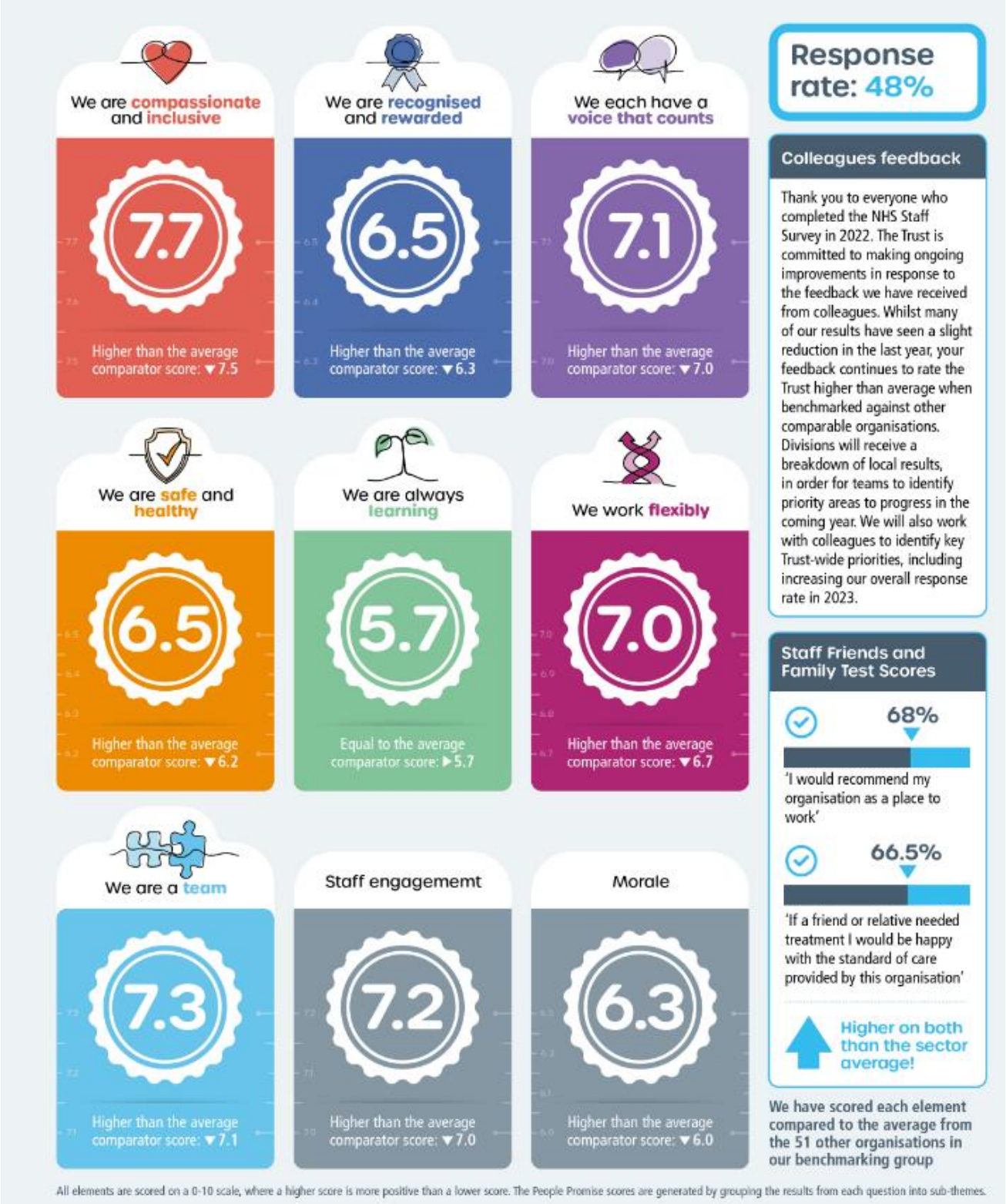
Supervision Compliance February 2024

Staff Professional Group	Oct-2023		Nov-2023		Dec-2023	
	Managerial Supervision	Clinical Supervision	Managerial Supervision	Clinical Supervision	Managerial Supervision	Clinical Supervision
Add Prof Scientific and Technic	237 / 287 (82.58%)	229 / 281 (81.49%)	251 / 291 (86.25%)	244 / 285 (85.61%)	249 / 290 (85.86%)	236 / 285 (82.81%)
Additional Clinical Services	419 / 531 (78.91%)	391 / 530 (73.77%)	424 / 530 (80.00%)	397 / 529 (75.05%)	435 / 531 (81.92%)	408 / 530 (76.98%)
Administrative and Clerical	525 / 639 (82.16%)	2 / 5 (40.00%)	524 / 633 (82.78%)	2 / 6 (33.33%)	518 / 633 (81.83%)	1 / 4 (25.00%)
Allied Health Professionals	208 / 229 (90.83%)	200 / 229 (87.34%)	207 / 231 (89.61%)	199 / 231 (86.15%)	210 / 229 (91.70%)	193 / 229 (84.28%)
Estates and Ancillary	106 / 157 (67.52%)	0 / 0 (N/A)	117 / 159 (73.58%)	0 / 0 (N/A)	114 / 157 (72.61%)	0 / 0 (N/A)
Medical and Dental	69 / 151 (45.70%)	0 / 0 (N/A)	73 / 153 (47.71%)	0 / 0 (N/A)	74 / 155 (47.74%)	0 / 0 (N/A)
Nursing and Midwifery Registered	984 / 1152 (85.42%)	905 / 1147 (78.90%)	981 / 1165 (84.21%)	919 / 1161 (79.16%)	1001 / 1151 (86.97%)	920 / 1148 (80.14%)
Students	13 / 23 (56.52%)	7 / 23 (30.43%)	11 / 23 (47.83%)	7 / 23 (30.43%)	10 / 23 (43.48%)	7 / 23 (30.43%)
Total	**2561 / 3169 (80.81%)**	**1734 / 2215 (78.28%)**	**2588 / 3185 (81.26%)**	**1768 / 2235 (79.11%)**	**2611 / 3169 (82.39%)**	**1765 / 2219 (79.54%)**

Underpinning the provision of core training and the achievement of continuous professional development is the Trust's commitment to ensuring that all staff receive a regular and meaningful appraisal.

A key indicator of the Trust's impact and effectiveness in this area, is the annual staff survey result.

The following infographic illustrates the Trust's performance in the Staff Survey conducted at the end of 2022. (the 2023 results are currently embargoed although will shortly be available)



The 2022 staff survey results are notable in that they indicated that in eight of the nine categories, the Trust was higher than the national average comparator score whilst in the ninth category, relating to learning, the Trust was equal to the average national comparator.

How well do staff, teams and services work together within and across organisations to deliver effective care and treatment?

The fourth key line of enquiry in the effective domain considers the extent to which staff, teams and services work together to deliver effective care and treatment.

In the Trust's context, this relates to the relationships within teams and the degree to which teams and clinicians will come together around the needs of individual patients, but it also relates to the ways in which services are spanning organisational boundaries and collaborating to deliver services for wider catchments.

This includes the Trust's involvement in joint ventures within the Derby and Derbyshire system, both corporate and clinical , including the Trust's collaboration with DCHS on the delivery of neurodevelopmental services, in addition to the Trust's involvement as lead provider for the east midlands perinatal collaborative and as a partner in the IMPACT forensic collaborative.

Within the Trust, there are examples of where clinicians from different teams have come together to meet the range of needs an individual patient may have.

This line of enquiry also considers how decisions are made, who is involved and consideration of how and when people are discharged including day of the week and time of day to ensure potential rtisks are managed.

This is coordinated currently through the care programme approach which is an established process by which all of the individuals concerned with the care of the patient are engaged and a holistic assessment of the patients needs are addressed. It is of note that natiuonally the Care programme approach is being phased out of operation and therefore the Trust is engaged in planning for the replacement of this model.

In addition, the Trusts development of the living well model in the community alsongside the revised clinical model for inpatient services linked with the making room for dignity project has enabled a renewed focus on the model of care and the way in which we engage patients in the inpatient setting and how they navigate community based pathways.

How are people supported to live healthier lives and, where the service is responsible, how does it improve the health of its population?

The fifth key line of enquiry associated with the effective domain relates to the extent to which the Trust's services identify people who may need extra support, which may be in the last months of their lives or at risk of developing a long term condition.

In respect of this, the domain considers how people are empowered to monitor their own health and how changes in people's care are discussed and enacted and considers how wider determinants of health such as smoking cessation, obesity and and drug and alcohol dependency.

The core multi-disciplininary model which is established within the Trust , underpinned by the care programme approach and person centred planning, provides the holistic assessment and treatment framework against which patients needs are identified and met. The multi-disciplinary team in considering alongside the patient their physical and emotional needs will identify any areas of need that the service cannot meet and will work in partnership with other services to meet the whole patient's needs.

In addition, baseline metrics are recorded in respect of the completion of physical health assessment upon admission and period reviews alongside a range of health promotion interventions supported by the Trust's health protection team, who will provide support in

relation to smoking cessation, obesity and vaccination programmes which contribute to population wellbeing.

Is consent to care and treatment always sought in line with legislation and guidance?

The final key line of enquiry within the domain relates to the extent to which the service ensures that consent to treatment is managed in line with the requirements of the legislation and guidance, including the Mental Capacity Act 2005 and the Children's Acts 1989 and 2004 and other relevant national standards and guidance.

The Trust is therefore able to demonstrate through its policy framework which provides clear guidance for staff on the assessment of capacity and the ability to consent and through its engagement in system wide partnership working in relation to safeguarding vulnerable adults and safeguarding children memoranda of understanding and information sharing arrangemnents.

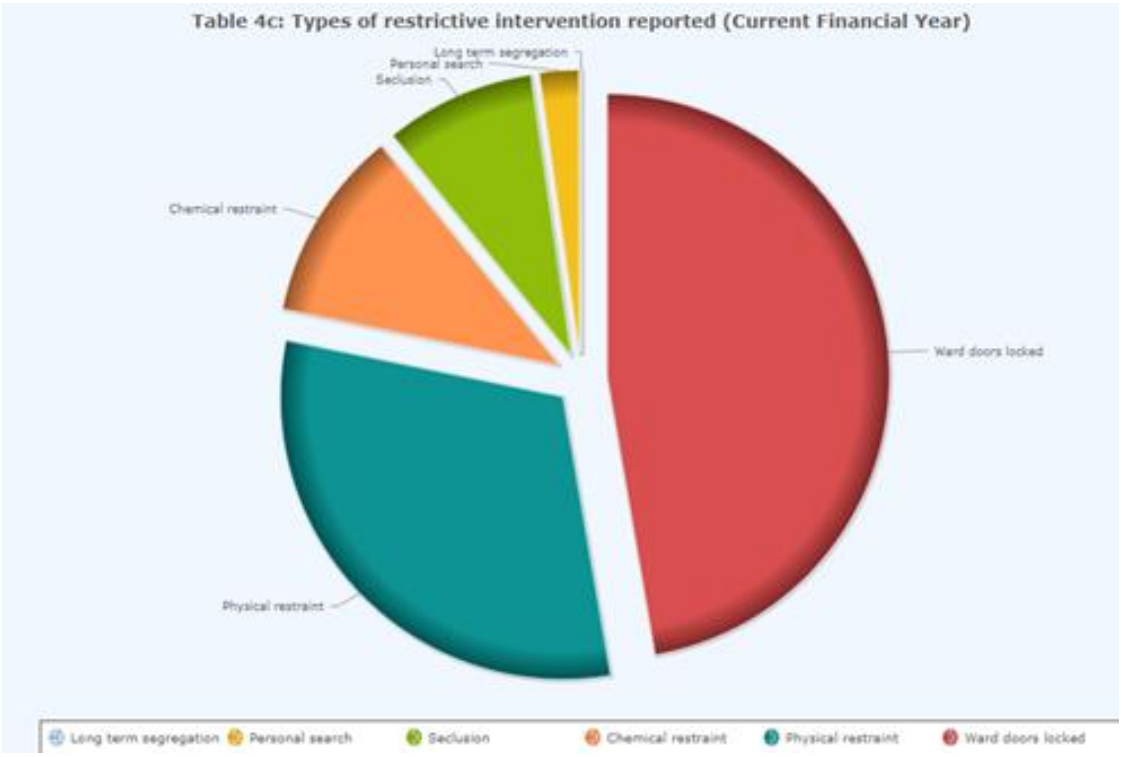
The framework supports people to make decisions in line with mental capacity act and mental health act requirements and sets out how a potential lack of mental capacity to make a particular decision should be assessed and recorded.

This line of enquiry also considers the ways in which the Trust manages the use of restrictive interventions and its wider ambition to bring about a reduction in restrictive practise recognising the potential for such interventions to further traumatise patients. Restrictive practices include the use of interventions such as Physical Restraint, Rapid Tranquillisation, Searching, Locking Ward Doors on Open wards, Seclusion, Segregation and high dependency observations. The data included in the following charts relates to the periods from April to December 2022 and April to December 2023 to provide comparitive data.

The first chart provides an overview of the types of restrictive interventions reported.

Analysis of the use of restriction is undertaken via the Trust's reducing restrictive practice group, on behalf of the Mental Health Act Committee.

Types of Restriction



Summary

This paper provides an assessment of the Trust's current status against the CQC's effective domain.

According to the CQC, by "Effective" is defined as:

"People's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence."

Specifically considering the following key lines of enquiry:

- Assessing needs and delivering evidence-based treatment
- Monitoring outcomes and comparing with similar services
- Staff skills and knowledge
- How staff, teams and services work together
- Supporting people to live healthier lives.
- Consent to care and treatment

Taking these key lines of enquiry into account, the Trust is able to demonstrate that it meets the requirements of the effectiveness domain through a combination of governance infrastructure including the recording, monitoring and benchmarking of activity.

In addition, this is underpinned by the delivery of training and professional development and the clinical frameworks within which referral, assessments, admissions, and discharge are managed.

In recognising that these aspects enable the Trust to meet the requirements of the effective domain, there is also a recognition that there are aspects of performance such as length of stay, time waiting, number of out of area placements and some training compliance levels that indicate the need for further work to manage these to a level the Trust finds acceptable.

Derbyshire Healthcare NHS Foundation Trust
Report to the Trust Board 5 March 2024

Board Assurance Framework (BAF)
Issue 4, 2023/24 – Version 4.3

Purpose of Report

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

Executive Summary

Executive Director Leads, Deputy Directors, Operational Leads and Trust Senior Managers have reviewed the risks and provided comprehensive updates. Issue 4 (version 4.1) was reviewed by the Executive Leadership Team (ELT) on 9 January 2024, who noted the thorough refresh that had been undertaken over the last month and was approved by the Audit and Risk Committee on 25 January 2024.

There has been overall improvement in the status of the risks in the BAF report, five areas of improvement in the status of actions and one improved overall risk rating.

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

Two of the actions have improved RAG ratings, both from Amber to Green:

- In December contractors started work on site for the Older Adult service relocation.
- The Audrey House refurbishment work has funding agreed and is on track to go live in November 2024.

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

One of the actions to close key gaps in control has an improved RAG rating, from Red to Amber, work progresses on improving staff benefits and responsive support, the latest achievement being a review of the lease car scheme to offer more attractive rates.

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

One action has an improved RAG rating, going from Red to Amber, as work on the recruitment process progresses and innovations are starting to be trialled, such as one page job descriptions.

One action has a worsened RAG rating, from Amber to Red, as the talent management process are still in the development and piloting stages and progress has not been made over the last quarter.

Risk 3A – There is a risk that the Trust fails to deliver its revenue and capital financial plans.

One action to close key gaps in control has a worsened RAG rating, from Amber to Red. This is due to a guidance change that has removed £2.5m of income that was originally included in the financial plan related to the new builds, refurbishments and Psychiatric Intensive Care Unit (PICU).

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

The following key gap in controls has been closed:

GP networks and partners report they do not feel connected to the MHLDA DB and are not aware of strategic decisions that are made.

Communication and engagement with GP networks have greatly improved and the Trust has membership on the Patient-Led Assessments of the Care Environment (PLACE) Alliance Boards and system-wide Primary and Community Care Delivery Board. GP and DHcFT engagement events have now been paused as such significant progress has been made.

There is also sustained improvement in the reduction of autism wait times, the target for assessments completed within the month has been exceeded for several months now.

The overall rating of Risk 4B has been reduced, from High to Moderate, as both the likelihood and consequence scores have been reduced from four to three.

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.

One of the actions has an improved RAG rating, from Red to Amber, as improvements have been made with the new assessment platform, supported by the System Quality Group. NHSE assurance sessions have been reduced in recognition of the progress.

Operational Risks – The following have been removed from the BAF report as they have both been reduced to moderate following review this month:

- National shortage of medicines to treat ADHD.
- Industrial action.

BAF Reporting Cycle/Format – All changes/updates to this issue of the BAF, compared with Issue 3 2023/24, are indicated by blue text. All text that has been stricken through will be removed from the next issue (Issue 1 2024/25).

Board Committees also receive extracts from the BAF to review the risks they are responsible for at all of their meetings. All updates received from the Board Committees will be incorporated into the next issue of the BAF.

BAF 2024/25

The Board is required to review all risks included in this report and decide which should be carried forward into the 2024/25 BAF. Following Board decision, the Risk and Assurance Manager will refresh the BAF report in readiness for the Director reviews to prepare Issue 1 2024/25.

In February, a BAF Board development session was facilitated by 360 Assurance (internal auditors). At that session, the following improvements to the BAF report were agreed, for Directors to note at each quarterly update:

- Progress updates should be more succinct in order to present the current position and shorten the report. To note, all issues and versions of the BAF report are archived so historical updates are not lost.
- Key controls, internal and external assurances should be reviewed and refreshed to ensure they are current.

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

Risks and Assurances

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

Consultation

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

Formal Reviews:

- Executive Leadership Team, Issue 4.1: 9 January 2024
- Audit and Risk Committee, Issue 4.2: 25January 2024

Governance or Legal Issues

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

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

Recommendations

The Trust Board is requested to:

1. Review and approve this fourth issue of the BAF for 2023/24 and the assurance the paper provides of the process of the review, scrutiny and update of the BAF in seeking to identify and mitigate risks to achieving the Trust's strategic objectives.
2. Review all risks within the report to consider which should be carried forward to the 2024/25 BAF.
3. Continue to receive updates in line with the forward plan for the Trust Board.

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

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

Board Assurance Framework 2023/24 – Issue 4.3 Board March 2024

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

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

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

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

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

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

Root causes:

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

BAF Ref: 23-24 1A	**Director Lead**: Dave Mason (Interim DON) / Dr Arun Chidambaram (MD)	**Responsible Committee**: Quality and Safeguarding Committee

Board Assurance Framework 2023/24 – Issue 4. 3 Board March 2024

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

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

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

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

Key gaps in control	Key actions to close gaps in control	Impact on risk to be measured by	Expected completion date (Action review date)	Summary of progress on action	Action on track
Inability to complete physical health checks for patients whose consultations remain undertaken virtually	Improvement plan to be developed and implemented to ensure required physical health care checks are completed [ACTION OWNER: MD]	Compliance with physical healthcare checks, reported in the Quality Dashboard	~~(31.12.23)~~ 31.03.24	Revised metrics now form part of the quality dashboard and are reported regularly to the	AMBER

		A 360 audit has been commissioned to review whether these improvements are embedded		Quality and Safeguarding Committee Implementation of coaching and self-report pilot model of care ~~in~~ underway to improve compliance and patient empowerment via the Health Protection Unit Targeted actions now in place across all service lines to improve on physical health checks 360 Assurance audit completed and actions implemented Quality improvement targeted work in September 2023, which has demonstrated improvement in clinical standards	
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	~~(31.12.23)~~ 31.03.24	~~New strategy actions published and being reviewed in mock CQC visit programme Quality Visit programme and in Divisional Achievement Reviews~~ ~~Progress made in recovering the five essential standards. Intermittent non-compliance is a re-occurring theme exacerbated by clinical~~	AMBER

				~~activity. Sustained improvement work continues~~ ~~Improvements identified within core services, including Neurodevelopmental services~~ Following the CQC inspection of ward 35, the Trust has reviewed its governance structures relating to meeting the fundamental standards Quality Surveillance Dashboard revised (programme of ward visits which are assessed against the CQC's single assessment framework). A CQC/Fundamental Standards Trust Oversight Group has been established, which scrutinises progress of actions arising from regulatory inspections and Mental Health Act visits and provides sign-off of completed actions DARs have been reviewed and going forward will become Divisional Performance Reviews (DPRs) and the Trust Operational	

				Oversight Leadership (TOOL) group has been reviewed and will provide a combined quality and operational function	
Insufficient investment in autism assessment and treatment services to meet demand. No commissioned treatment services Waiting time increased over Covid-19 period, exacerbated by underlying demand – ASD diagnostic waiting lists remain high	Investment required by ICS to meet assessment and treatment demands [ACTION OWNERS: DO/DSPT]	Agreed funding allocation has occurred, recruitment to posts is active	~~(31.12.23)~~ (31.03.24)	~~Funding for additional investment in autism diagnostic services no-longer available. Revised Recovery Action Plan (RAP) developed with ICB in September 2023 to undertake fuller case for investment in autism offer in Quarter 2~~ ~~new Specialist Well-being Navigator (SWN) service to support people with 'waiting well' has been mobilised~~ ~~Escalations and discussions with the MHLD AB to ensure the system is able to respond to the need of the population using current resources~~ ~~Recent amendments to assessment framework has resulting in increased number of contact and assessment, reducing waiting lists and times~~ Commissioned target of 26 assessments per month now being sustainably exceeded.	AMBER

				Discussions underway with ICB commissioners and executives on next steps to bolster ASD investment through contractual changes. Positive engagement session with GPs on their role in future pathways including need to include ADHD	
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	~~(31.12.23)~~ 31.03.24	Significant improvement in all services. ~~There has been a programme of mock CQC inspections in hotspot inpatient areas and community services. A thematic report will be presented to TOOL. The inspections are identifying areas of action~~ Three CQC actions remain open due to intermittent compliance Following the CQC inspection of ward 35, the Trust has reviewed its governance structures relating to meeting the fundamental standards Quality Surveillance Dashboard revised (programme of ward visits which are assessed against the CQC's single assessment framework).	AMBER

				A CQC/Fundamental Standards Trust Oversight Group has been established, which scrutinises progress of actions arising from regulatory inspections and Mental Health Act visits and provides sign-off of completed actions DARs have been reviewed and going forward will become Divisional Performance Reviews (DPRs) and the Trust Operational Oversight Leadership (TOOL) group has been reviewed and will provide a combined quality and operational function ~~A recent CQC visit has identified further actions. Work underway to complete through CQC Oversight Forum and Divisional Assurance Review (DAR)~~ ~~Review of governance framework, roles and accountabilities complete~~ ~~Creation of core service improvement plans underway, with oversight and assurance at DAR~~	

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

				3 2023/24). System Programme Team now established Next stage of mobilisation is Amber Valley, Erewash, South Derbyshire and Derbyshire Dales – Planned for Quarter 4 2023/24 ~~Revised approach which entails a phased roll-out of the service model agreed and being implemented across sites~~ ~~Additional clinical and quality scrutiny and management support in place to support the transformation plan~~	
Implementation of clinical governance improvements with respect to: - Outcome measures - Clinical service reviews including reduction in excess waiting times - Getting it Right First Time (GIRFT) reviews	Develop and implement an improvement plan [ACTION OWNERS: MD/DON/DO/DSPT]	Compliance with suite of metrics and reporting schedule	~~(31.12.23)~~ (31.03.24)	NICE guideline mapping established, governance work continues Programme of work in place from Performance Summit continues to progress RAP plans in place and regularly reviewed	AMBER
Implementation of new quality priorities for: - Sexual safety - Implementing CQUINS and Clinical outcome measures	Develop and implement an improvement plan to enable all quality priorities to be implemented [ACTION OWNER: DON]	Compliance with suite of metrics and reporting schedule	~~(31.12.23)~~ 31.03.24	~~Reducing violence – Body worn camera investment in place~~ The Trust is developing a sexual safety plan and	GREEN

- Recovering services – equally well - New Trust strategy and priorities - Dormitory eradication programme				has agreed to sign up to the sexual safety charter Sexual safety – Improvement work (dashboard, preceptorship training and protocols) commenced. Sexual safety on professional standards video launched with new training Sexual safety checklist for services in design Dormitory eradication programme in construction Trauma informed practice conference and work programme commenced in May 2023. Trauma lead in post for six months to develop training and strategy Plan for existing dormitory stock and to maintain and improve dignity for active bed stock assessed and presented to the ICB	
There is a risk that patients in our care in Derbyshire or commissioned services may receive poor care due to experiencing abuse or professional misconduct. Learning from other independent and national exposures of abuse	Revisit all assurances and scrutinise practice, gathering intelligence and implement an improvement plan to enable all services to provide the highest standard of care which would be expected [ACTION OWNERS: DON/MD]	Engagement and mobilisation of the organisation to discuss learning from recent exposes Discuss and activate colleagues to revisit what compassionate care means and actively encourage, inspire, reward –	~~(31.12.23)~~ 31.03.24	Wide range of options for colleagues to have conversations about care delivery and raise concerns available, including Trust-wide and divisional engagements, Freedom to Speak Up, Schwartz Rounds	AMBER

		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 Professional leads are in place to ensure that registered professional staff practice in line with their professional codes Review reports and allegations in multi-disciplinary manner and include safeguarding and security specialist with effective recording and monitoring		Improvements in engagement of temporary staff identified Increased visibility of senior staff through ~~Quality Visits,~~ Board visits and mock CQC inspections and out of hours visits Robust oversight of patient safety incidents, concerns, complaints, and compliments with scrutiny from independent partners, e.g. Healthwatch and experts by experience being core members of Patient and Carer Experience Committee External partnership working including Healthwatch, Advocacy services and statutory services within safeguarding and secure services. The Trust provides assurance and participates in external reviews alongside the ICB and Adult Safeguarding Board Trust-wide Learning, Culture and Safety Group ~~to be~~ established,	

				providing oversight of teams/services with repeating patterns for improvements to be made	
Clinical improvement in the current use and transformation of Care Programme Approach (CPA), to support safe community practice	Identify the Trust's preferred alternative model to replace CPA Establish transition plan which includes communications and training strategy and clear timeline for go live of the new system and detailing when use of CPA will cease Implement an improvement plan to enable all services to provide the highest standard of care [ACTIONS OWNERS: DON/MD]	Review of changes to national policy to replace CPA Safe and effective practice is in place	~~(31.12.23)~~ 31.03.24	Ongoing oversight of CPA continues with focus on care planning and risk assessment Planning discussion has taken place in relation to the transition from CPA to the preferred alternative model, Dialogue Plus ~~Review of new/alternative models underway with plans to replace CPA in the future~~ Fundamentals of Care group oversight of key core aspects of CPA CPA training continues at present until alternative identified	AMBER
Clinical improvement in the current practice standards for new mental health in-patient standards released by NHS England	Scrutinise new practice standards and develop a new improvement plan, which establishes the Trust's baseline position against the standards, identifies the gaps in compliance and details specific actions needed to achieve the standard, to enable all services to provide the highest standard of care [ACTION OWNERS: DON/MD]	Review new standards and new reporting requirements with the clinical improvement team	~~(31.12.23)~~ 31.03.24	Review of new standards underway Commencement of the implementation of the national in patient standards from January 2024. Arrangements in place for the national lead to present to the executive team and operational leads	AMBER

				Request for Trust to become pilot site for new standards framework, once formally available	
Review of the new Major Conditions Strategy and Suicide Prevention Strategy for England: To consider a reset of the Trust Strategy	Scrutinise new policy direction and develop new plans Routinely review incidents for learning in suicide prevention including cluster analysis and benchmarking [ACTIONS OWNERS: DON/MD]	Adjust strategy and policy to meet requirements Undertake a cluster analysis of in-patient and acute care pathway deaths	~~(31.12.23)~~ 31.03.24	Review of new strategy for Major Conditions and Suicide Prevention PSIRF priorities for 2024/25 focusing on prevention and oversight, linked to new strategies Trust clinical strategy to be reviewed and implemented and to include relevant national strategies	AMBER
Review of Patient Carer Race and Equality Framework and develop implementation plan	Revisit new policy direction and develop new plans [ACTION OWNER: MD]	Review framework and develop implementation plan	~~(31.12.23)~~ 31.03.24	Patient Experience Strategy event completed Patient Experience Strategy to be renewed, with the voice of patient and carers at the forefront, ensuring race and equality clearly referenced	AMBER

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

Record ID	Service Line	Title	Risk: Summary of Progress	Date Risk Created	Date of Next Review	Residual Risk Rating
3009	Learning Disabilities Services	Demand for Autism Spectrum Disorder (ASD) assessment service far outstrips contracted activity	20.06.23: There has been no increase in budget but the team now at a full complement of staff after a long period of shortages due recruitment problems and sickness. The team are making changes to pilot alternative assessment processes which should be faster but are admin-heavy. Additional funding has been provided on a one-year basis to employ someone who can complete some research to evaluate the changes that are going to be implemented 09.01.24: Pilot assessment is continuing and waiting list has reduced to 2.5 years. Outstanding risks - Waiting time continues to be above NICE targets. Risks mainly related to continued complaints about waiting times and criticism in national press	01.01.16	01.04.24	HIGH
22790	Corporate Services – Pharmacy	Prescribing Valproate to women of child-bearing potential: Failure to comply with regulations	24.05.23: ePMA now deployed to all services in the Trust which will help with our understanding of valproate use and can be incorporated into planning. Reporting will need to be constructed as part of the optimisation of ePMA 18.12.23: Trust plan drafted and agreed in principle - To be ratified at Medicines Management Committee in January. System level planning being led by ICS Chief Medical Officer and involving Trust Medical Directors. Pharmacy currently reviewing SystmOne for information to quantify the level of risk of non-compliance	28.02.22	18.03.24	HIGH
23145	Adult Community Care	Risk of treatment breaks/missed doses due to reauthorisation of repeat templates	Clozapine and antipsychotic long-acting injections for outpatients are prescribed on Repeat Templates within SystmOne. These have a duration of 365 days before requiring re-authorisation to remain active There is currently no automated system prompting clinical teams to re-authorise Repeat Templates, therefore risking the prescriptions becoming inactive and no longer being able to be legally supplied or administered. Risk of missed doses and treatment breaks	21.12.23	21.03.24	HIGH

Strategic Objective 1 – To Provide GREAT Care in all Services

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

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

Root causes:

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

BAF Ref: 23-24 1B	**Director Lead**: Lee Doyle/David Tucker (Interim DOs)	**Responsible Committee**: Finance and Performance Committee

Key Controls

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

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

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

Key gaps in control	Key actions to close gaps in control	Impact on risk to be measured by	Expected completion date (Action review date)	Progress against action	Action on track
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 VAT abatement appeal – Combined capital funding shortfall risk of £14.2m if appeal unsuccessful [ACTION OWNER: DO]	Delivery of approved business cases	~~(31.12.23)~~ (31.03.24)	Two new build adult acute unit FBCs nationally approved September 2022, funded by £80m national PDC and £18.6m CDEL. ICS supported and approved revenue funding Delay in national approval and redesign of foundations. Planned to go live November 2024 HMRC appeal on VAT abatement concluded and VAT abatement agreed for Adult Acute Units ~~claim in process. The risk is monitored through Making Room for Dignity, reporting to each F&P Committee meeting~~	AMBER
	Older Adult service relocation to refurbished ward with single room en-suite and gender segregation, with additional staffing and new model of care, by September 2024 to eradicate dormitories in Northern Derbyshire and avoid this 12-bed service being isolated in otherwise vacated wards, increasing service user safety issues National PDC capital funding approval [ACTIONS OWNER: DO]	Delivery of approved business case	~~(31.12.23)~~ (31.03.24)	Older Adult service relocation FBC and revenue funding approved by ICS National PDC capital funding approved by NHSE Scheme re-tendered due to affordability, ~~contractor appointed,~~ refurbishment started on site ~~November~~	~~AMBER~~ GREEN

				December 2023, planned go-live August 2024	
	Audrey House refurbishment as decant ward to enable Radbourne Unit dormitory eradication refurbishment. Dormitories cannot be fully eradicated without use of this decant ward National PDC capital funding approval [ACTIONS OWNER: DO]	Delivery of approved business case	~~(31.12.23)~~ (31.03.24)	National PDC capital funding approved by NHSE No longer required for decant, completion as enhanced care unit November 2023, go-live November 2024	~~AMBER~~ GREEN
	Radbourne Unit dormitory eradication refurbishment to provide two 17-bed wards with single room en-suite, with additional staffing and new model of care, to complete dormitory eradication in Southern Derbyshire. Service users continue to receive care in non-compliant wards until this refurbishment is completed National PDC capital funding approval [ACTIONS OWNER: DO]	Delivery of approved business case	~~(31.12.23)~~ (31.03.24)	FBC and revenue funding approved by ICS. National PDC capital funding approved by NHSE December 2022. Radbourne Ward 32 refurb commenced November 2023 – January 2025 and live March 2025. Refurb Ward 35 scheduled January 2025 – March 2026, subject to funding live April 2026 Significant cost pressure being actioned, contracts split, Ward 32 continuing as planned whilst cost pressure resolved for Ward 35	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) £3.5m national capital agreed November 2022. Derbyshire CDEL flexibility agreed for Trust to fund £10.9m remaining capital from cash reserves 2022/23 and 2023/24. VAT abatement risk National PDC capital funding approval	Agreed programme of work with capital funding to support it	~~(31.12.23)~~ (31.03.24)	FBC approved by ICS in June 2022 PICU fully funded by national and Trust capital November 2022. HMRC appeal on VAT abatement sufficient for PICU ~~claim in process – Capital funding shortfall risk if appeal unsuccessful.~~ Practical completion expected November 2024,	AMBER

	[ACTIONS OWNER: DO]			live March 2025. ~~Acute Plus~~ Audrey House Enhanced care Unit national PDC capital funding approved by NHSE December 2022 – Goes live November 2024	

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

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

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

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

Root causes:

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

BAF Ref: 23-24 1C	**Director Lead**: Lee Doyle/David Tucker (Interim DOs)	**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

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

Key gaps in control	Key actions to close gaps in control	Impact on risk to be measured by	Expected completion date (Action review date)	Progress against action	Action on track
Business continuity plans reflect changes to service delivery such as increased phone and video contacts	All services to review business continuity plans to ensure they take account of the increased use of phone and video contacts for care provision and also use of video conferencing for operational delivery [ACTION OWNER: DO]	Reporting to the Divisional Achievement Reviews (DARs)	~~(31.12.23)~~ (31.03.24)	The majority of Business Impact Analyses have been received and are subject to quality spot checks. Business Continuity Plans to be developed by mid-January – Drafts received from some divisions EPRR Steering Group ~~to~~ monitor and updated TOOL in ~~October/~~ November 2023. Overdue plans have been followed up, with revised trajectory for completion in line with core standards feedback in Quarter 4 ~~Reviews of Business Continuity Plans took place as part of submission of Core Standards in August 2023, following discussion at TOOL. Areas with outstanding work required to complete by end September 2023 with support from EPRR teams~~	AMBER

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

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

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

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

Root causes:

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

BAF Ref: 23-24 1D	**Director Lead**: Dave Mason (Interim DON) / Lee Doyle/David Tucker (Interim DOs)	**Responsible Committee**: Quality and Safeguarding 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	Moderate 3	High 4	Accepted	Tolerated	Not Accepted

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

Board Assurance Framework 2023/24 – Issue 4. 3 Board March 2024

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

Key gaps in control	Key actions to close gaps in control	Impact on risk to be measured by	Expected completion date (Action review date)	Progress against action	Action on track
Inpatients care is delivered in wards with dormitories, that compromise on patient dignity, privacy and effective IPC practice	Implement bed management process that ensure that admissions are screened to comply to gender, safety and IPC requirements Ensure that the environments are routinely check by clinicians, estates, and domestic staff Infection Prevention and Control monitoring, and training compliance Effective monitoring of the clinical environments by clinical, estates and domestic staff [ACTIONS OWNERS: DON/DO]	Monitor and report breaches of same sex admission breaches Monitoring of maintenance and cleaning schedules Head of Nursing and Matron environmental walk abouts Infection and Prevention and Control reports and monitoring of infections Individual screening of admissions to appropriate ward environments to ensure gender needs, safety needs and IPC needs are met Provision of other rooms for privacy and confidentiality	31.03.25	Head of Nursing and Matron reviews ~~walkabouts~~ routinely conducted Level 1 and level 2 IPC training are above compliance target Fully funded programme of work in place: 'Making Room for Dignity'. Construction started in Chesterfield and Derby. Designs have been co-produced with construction experts, clinicians, carers, patients and people with lived experience The new environments will require more staff – Recruitment is underway	AMBER

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

Strategic Objective 2 – To be a GREAT place to work

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

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

Root causes:

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

BAF Ref: 23-24 2A	**Director Lead**: Rebecca Oakley (Interim 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

Preventative – Freedom to Speak Up Guardian (FTSUG) self-assessment and six monthly reports; annual review of people development plan commissioned through People and Inclusion directorate; provision of information through induction processes for new staff; staff engagement sessions; Equality, Diversity and Inclusion (EDI) Delivery Group meeting; supported networks for diverse staff groups and allies; Health and Well-being Network; workforce planning design meeting; Culture and Leadership Delivery Group
Detective – Quarterly Pulse Checks, FTSUG log and escalations; staff network engagement; WRES, WDES, wellbeing champion network, executive led engagement sessions; non-executive, executive and deputy visits to teams
Directive – Joined Up Care Derbyshire (JUCD) People Strategy, National People Plan; People building blocks and priorities; Strategic people priorities, Communications Strategy, ICS People 5x7 plan

Assurances on controls (internal)	Positive assurances on controls (external)
National staff survey and reporting into board, ELT and divisions Quarterly pulse check and action planning process Staff survey analysis and reporting Exit interview analysis and reporting	Benchmarking in mental health and at system level Outstanding results from 2021 staff survey, identifying significant improvements across all themes

Key gaps in control	Key actions to close gaps in control	Impact on risk to be measured by	Expected completion date (Action review date)	Progress against action	Action on track
Lack of planned leadership development growth and stretch programmes and opportunities including coaching and mentoring	Strategy developed to align to organisational leadership needs Review of system level leadership offer and impact Review and development of Trust leadership offer and impact Re-establish leadership forum Development of coaching access at local, system and national [ACTIONS OWNER: DPI]	Percentage of leaders with development plan as part of objectives Percentage of leaders attending local, system or national leadership programmes	~~(31.12.23)~~ (31.03.24) Complete	Deputy Director of People is part of system leadership workstream to review current offer and develop 12 month plan on leadership offer – Draft proposal to be finalised New leadership programme (aimed at band 8B staff) completed Leadership forum revised and first forum took place December 2022 with monthly forums now planned throughout 2023. First face to face forum took place June 2023 Third cohort of Aspiring-2-Be leadership course launched	RED

				Second leadership conference ~~planned for~~ October 2023 on Just and Restorative Culture for Leaders Development of Leadership Development strategy has commenced to be ready January 2024	
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	~~(31.12.23)~~ (31.03.24)	Review of cases and case management reported to ELT bi-monthly with reasons for delays identified Deep dive on employment review cases and processes took place at PCC in February 2023 Respect policy published System funding secured for Just and Restorative Culture training programme and materials	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	~~(31.12.23)~~ (31.03.24)	New executive model implemented in December 2022. Draft framework ~~now~~ developed and engagement with key stakeholders commenced New EDI steering group established; ~~and~~ meetings commenced Network chair meetings operating and attended by DPI and Head of EDI	AMBER

				Staff network conference held May 2023 Collaborative staff network actions agreed and regular meetings with chairs and vice chairs taking place to align power of staff networks on	
The current capacity and structure of the People and Inclusion directorate is not able to meet the Trust, system, regional and national demands alongside challenges from outsourcing key services via People Services in DCHS and UHDB	Review of current People and Inclusion structure to align to needs and priorities of Trust, identify gaps and develop plan to mitigate Review of gaps in services delivered by People Services or UHDB and develop accountability framework Formalise existing governance meetings to ensure clear processes in place for People and Inclusion Services contract and UHDB key service contracts Review of current communications and engagement and people priorities across the Trust and system [ACTIONS OWNER: DPI]	A People and Inclusion structure that can support the Trust to deliver against the people priorities Accountability dashboard presented to ELT quarterly Terms of reference in place and regular meetings A People and Inclusion structure that can support system-wide priorities People and Inclusion staff survey results	~~(31.12.23)~~ (31.03.24)	Contract review meetings established for Occupational Health and Payroll Services (UHDB) New governance structure to be developed to manage the Joint Venture – Discussions commenced Monthly payroll contract meetings in place - Improvement Manager appointed by UHDB for six months to support contract, data and system standardisation	RED
Lack of maturity of EDI framework	Produce and implement EDI framework with clear legislative, and mandated NHS national regional and local deliverables required for the EDI function and structure to deliver [ACTION 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	~~(31.12.23)~~ (31.03.24)	Trust Reducing Health Inequalities Board now established, meeting with Trust-wide and system stakeholders to direct our response to reducing health inequalities Draft framework outlines measures	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	Complete ~~(31.12.23)~~ (31.03.24) ~~(31.12.23)~~ (31.03.24)	Engagement sessions held October 2022 to January 2023 Partaking in first national bank staff survey Aligned all bank staff bands 2, 3, 4 and 7 to Agenda for Change pay scales Band 5/6 bank pay approved for alignment to Agenda for Change Review of bands 2 and 3 roles on bank versus substantive roles and agreement on transition into band 3 with training - Complete Review of training competences for bank and agency commenced	AMBER
Lack of visible and differential staff benefits and responsive support for staff that reflects current working conditions, e.g., cost of living crisis	Review of gaps in benefits to realign to staff needs Review of current reward and recognition framework Develop range of staff benefits that align to Trust values and 'people first' approach Develop the salary sacrifice offer to support colleagues with cost of living crisis [ACTIONS OWNER: DPI]	Staff survey engagement score Staff turnover Pulse check scores	~~(31.12.23)~~ (31.03.24)	Delivering Excellence Every Day awards (DEEDs) revised and re-launched System-wide discussions commenced regarding a benefits package Mileage rates adjusted to reflect cost of living crisis National pay award approved and implemented Review of lease cars with view to offer a more attractive rate as a retention tool completed ~~has commenced~~	~~RED~~ AMBER

				Learning shared from UHDB survey on what matters most to colleagues when at work Flexible working engagement programme planned for launch	
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 to identify impacts on staff experience and any inequalities that need to be closed	~~(31.12.23)~~ (31.03.24)	Work commenced - Divisional level EDI staff survey data shared with divisions. Divisional People Leads are leading discussions on actions on improvements and achievements	AMBER
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	~~(31.12.23)~~ (31.03.24)	New reporting processes in for TOOL, PCC and Board – Now embedded with triangulation on staffing/agency/bank to be included at PCC Shift and break consultation being planned to commence 2023 Training lead meeting regularly with all service managers to review staff training plans Meetings scheduled with neighbouring mental health Trusts to compare training offers and delivery modes	AMBER

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

Strategic Objective 2 – To be a GREAT place to work

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

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

Root causes:

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

BAF Ref: 23-24 2B	**Director Lead**: Rebecca Oakley (Interim 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

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

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

Key gaps in control	Key actions to close gaps in control	Impact on risk to be measured by	Expected completion date (Action review date)	Progress against action	Action on track
An integrated workforce plan and planning process that feeds into pipeline plans and ensures we have the right people in the right place with the right skills	Develop a Trust Workforce Plan linking demand and capacity, workforce redesign to ensure a fully funded workforce Develop vacancy rate data and breakdown variances in vacancy data Establish a workforce transformation group to develop workforce development plans and ownership at divisional level [ACTIONS OWNER: DPI]	Vacancy rates Time taken to fill vacant posts Transformational posts, e.g. apprenticeships all identified Reduction in agency costs	~~(31.12.23)~~ (31.03.24)	Workforce transformation group commenced 2022 - Divisional workforce plans being developed to support 2023/24 workforce plan System workforce conference took place February 2023 with key speakers from DHCFT Workforce summit held August 2023 to review new roles and implementation. Divisional workforce plans and associated actions were reviewed 2023/24 Trust workforce plan developed and presented at PCC	AMBER

				Work commenced to map apprenticeship plan and resources required Agency reduction plan in place	
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	~~(31.12.23)~~ (31.03.24)	Talent Strategy finalised Pilot launched for senior leaders in January 2023 – Phase one meetings with each executive taking place Deputy DPI is system lead on talent management System appraisal developed to support system movements and talent management ~~Trust talent pilot with senior leaders running up to September, following which data will be presented to ELT~~	~~AMBER~~ RED
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	~~(31.12.23)~~ (31.03.24)	IR pastoral support officer appointed Funding secured for four IRs Regular meetings established with midlands IR lead System AHP IR bid successful Clinical Educator of IR appointed Recruitment and Retention Lead appointed	RED

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	~~(31.12.23)~~ (31.03.24)	'Stay' survey piloted with Allied Health Professionals and 1-2 year starters New starter survey completed with all started in six months and learning shared at Trust and divisional level Nursing retention framework self-assessment completed System retention lead appointed to support Trust level and system work Recruitment and Retention Lead appointed	AMBER
Medical staffing team and role not sufficiently developed Workforce plan for medical staff not in place	Review existing medical staffing team and workforce support and identify gaps Develop new model to support and maximise the medical workforce Develop medical agency model to ensure efficient usage Develop a medical staff workforce plan [ACTIONS OWNER: DPI]	Engagement of medical workforce Reduction in agency spend	Complete ~~(31.12.23)~~ (31.03.24)	Terms of reference agreed by MD and DO for review of existing medical staffing team and creation of a medical workforce plan. Resources identified and funding agreed for the review by ELT First medical staffing workshop completed March 2023 Further discussions held as part of the agency summit – Agreed action to support agency reduction	AMBER
Lack of culturally competent recruitment processes	Completion and implementation of recommendations of the Above Difference recruitment and retention system pilot Wider engagement with recruiting managers, staff networks, clinical leads and operational leads	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	~~(31.12.23)~~ (31.03.24)	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	~~RED~~ AMBER

	Quartile monitoring of utilisation of Above Difference recruitment and retention tools Continuous improvement approach to implementing learning [ACTIONS OWNER: DPI]	shortlisting and reduce disparity in all areas		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	
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	~~(31.12.23)~~ (31.03.24)	KPI review commenced Indeed piloted for hard to fill posts in acute Cohort recruitment successfully piloted for Health Care Assistants and Human Resources apprenticeships System recruitment post approved with funding to pilot a cohort recruitment approach including writing inclusive adverts and job descriptions Trust Strategic Recruitment and Retention Lead appointed	AMBER

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

Strategic Objective 3 – To Make BEST use of Our Resources

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

Impact: Trust becomes financially unsustainable

Root causes:

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

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

Key Controls

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

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

Detective – Risk logs and programme-reporting (capital/transformation) informs ongoing financial risk assessment: Audits (internal, external and in-house); scrutiny of financial delivery, bank reconciliations; continuous improvement including cost improvement planning (CIP) and efficiency / QI delivery; contract performance, local counter fraud scrutiny

Directive – Business plans and templates set out clear financial plans and assumptions: Standing financial instructions; Treasury management procedures, budget control, delegated limits, recruitment approval processes; business case approval process; invest to save/Quality Improvement methodology and protocol and Plan Do Study Act. Risk and gain share agreements, Local Operating Procedure for Acute Capital Programme

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

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

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

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

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

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

Record ID	Service Line	Title	Risk: Summary of Progress	Date Risk Created	Date of Next Review	Residual Risk Rating
23067	Corporate - Finance	The Trust fails to deliver its revenue and capital plans	Financial detriment resulting from: - Large capital development programme - Commissioning decisions, including tender processes or wider system first decisions - Non-delivery of transformational and efficiency schemes - Loss of income and required service developments - Costs to deliver services exceed income Efficiency and transformation programme monitoring and escalation process in place. Cost pressures are currently being managed in the overall position 20.12.23: Capital funding remains in place for the new builds and refurbs, and risks are being regularly reported and managed, discussions to continue with regional and national colleagues Plans in place to reduce agency over remaining months. CIP gap expected to be closed. Executive vacancy control panel established System has submitted a deficit figure of £47m to NHSE/I, of which DHCFT is £5.0m 23.02.24: Position remains stable, we are on track to deliver our deficit forecast. Some risks to delivery have been managed and no longer a concern. We continue to meet with the ICB and wider NHSE region to discuss the capital pressure which remains a risk for 2024/25. Rating and controls remain pending further year-end review	21.06.23	15.03.24	EXTREME

Strategic Objective 4 - To be a GREAT Partner

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

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

Root causes:

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

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

Key Controls

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

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

Board Assurance Framework 2023/24 – Issue 4. 3 Board March 2024

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 Representation on system-wide governance groups

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
Increased decision-making at a system and/or provider alliance level may create conflicting accountabilities with the Trust-level governance structures which could result in an increased governance burden	Keep Trust structures under continuous review against the wider governance landscape, including the provider collaboratives and alliance arrangements – This in turn may lead to a formal change of DHCFT governance arrangements [ACTION OWNERS: CEO/Trust Secretary]	Board level confidence in new and emerging governance structures and ability to gain assurance on DHCFT risks and issues via system level governance regime	~~(31.12.23)~~ (31.03.24)	Ongoing review of Trust governance to ensure operational performance delivery of MHLDA constitutional standards that DHCFT is a lead or main provider of the performance Trust CEO is a member of ICB Board Derbyshire Provider Collaborative Leadership Board have an agreed work programme as approved by ICB The Trust is an active member of and provides regular assurance to system-wide governance groups, for example their quality and safety group	AMBER

Internal ICB capacity changes to achieve revised expenditure requirements in 20023/24 and 2024/25 may impact on capacity and capability to deliver key deliverables such as system planning, and programmes of transformation	Keep changes to staffing levels and work programmes under regular review. This may lead to system wide agreement on priorities [ACTION OWNER: DSPT]	Impact monitored through system wide MHLDA Delivery Board, Provider Collaborative Leadership Board and ICB Board, of which the CEO is a member	~~(31.12.23)~~ 31.03.24	Escalation of risk and impact to ICB The Trust has the opportunity to comment on the emerging ICB organisational structures Review DHCFT staffing to identify succession planning opportunities and/or cover arrangements	RED

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

Board Assurance Framework 2023/24 – Issue 4. 3 Board March 2024

Strategic Objective 4 – To be a GREAT partner

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

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

Root causes:

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

BAF Ref: 23-24 4B	**Director Lead**: Vikki Ashton 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~~ Moderate	Likelihood ~~4~~ 3	Impact ~~4~~ 3	Direction ↓	Moderate	Likelihood 3	Impact 3	Accepted	Tolerated	Not Accepted

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

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

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

				purpose which MDs are actively involved in. MDs are also linking in with local GP forums within the City and County CEO meeting with GP network monthly Appointment of a Lead GP – Mental Health specifically for Derby City Place to support relations, pathways and opportunities between the Trust and primary care	
Social care partners have reported that the lack of progress on autism diagnostic reductions is difficult and would like to see increased pace of improvements	Improvement plan for joint autism service [ACTION OWNER: DO]	Feedback from social care on awareness of the Autism Strategy and autism waiting times reduce across the interagency investment plan	~~(31.12.23)~~ (31.03.24)	~~Autism investment no-longer available from ICB, revised discussions in place from September 2023~~ Discussion at November 2023 Derbyshire System Delivery Board - Agreement to recognise that the current commissioning landscape and output from investment still has major gaps in provision, with a subsequent impact on other local services. Support for the development of fuller proposal for re-use of resource allocated for an improved offer, recognising this may require reallocation of current spend Autism waiting times ~~have now been~~ continue to be achieved for the 26 contracted assessments per month, and sustained for year to date	AMBER

~~GP networks and partners report they do not feel connected to the MHLDA DB and are not aware of strategic decisions that are made~~	~~Communication and engagement plan with GP networks~~ ~~[ACTION OWNER: DSPT]~~	~~Feedback form GP networks on connectivity to the MHLDA DB and DHCFT named leads, information supplied~~ ~~GP networks reflect that they are briefed and actively engaged~~	~~(31.12.23)~~	~~MD membership in PLACE Alliance Boards agreed in January~~ ~~GP and DHCFT engagement events were established to receive feedback and answer any strategic or system questions on DHCFT and the MHLDA DB~~ ~~– Now paused as progress made~~ ~~Collaborative working with PCNs to appoint to mental health practitioners as part of the additional roles reimbursement scheme (ARRS) roles~~ ~~Organisational representation on system wide primary and community care delivery Board~~	~~GREEN BLUE~~
Police partners report they do not always feel supported by mental health services and are under pressure to respond to mental health crisis	Police Education, support, communication and improvement plan with MH Delivery Board and Trust Directors [ACTION OWNER: DSPT]	Inter-agency meeting and review of a joint way forward in 2023 including • Police Training • Suicide prevention work • Joint co-produced outcomes Agreed outcomes are monitored and reported through the MHLDA DB with liaison with DHCFT Police Liaison group	~~(31.12.23)~~ 31.03.24	Police ~~now~~ are a formal member of the MHLDA DB and attending and contributing New national guidance in draft and collaborative approaches including staffing of 136 suites included in programme level investment Street triage pilot was established between Police and Trust but this will be replaced by Right Care Right Place (RCRP) Mental Health Response Vehicle (MHRV) to be implemented from April 2024,	AMBER

				to reduce pressure on Police to respond to mental ill health calls Crisis cafe~~s planned for opening in near future~~ has opened in Buxton. Ripley and Swadlincote planned to open Trust chairing the ~~Right Care Right Place~~ (RCRP~~)~~ implementation group across the Derbyshire system with Police stakeholders and system colleagues	
Patient and carers groups report that they would like to see more progress in service user and carer involvement and moving from engagement to decision making	Peer support strategy and objectives for EQUAL and the Mental Health Engagement Group [ACTION OWNERS: DON/MD]	Peer support strategy Co-production in Patient and Carer Race Equality Framework (PCREF) requirements	~~(31.12.23)~~ 31.03.24	EQUAL group established to support service user and carer engagement. EQUAL has created several sub committees and informs future service improvements across the East Midlands Perinatal Mental Health Provider Collaborative	AMBER

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

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

Multiple System Strategic Risk

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

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

Root causes:

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

BAF Ref: 23-24 MS1	**Director Lead**: Lee Doyle/David Tucker (Interim DOs)	**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	Likelihood 4	Impact 4	Direction ⬌	Moderate	Likelihood 3	Impact 3	Accepted	Tolerated	Not Accepted

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

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

Key gaps in control	Key actions to close gaps in control	Impact on risk to be measured by	Expected completion date (Action review date)	Summary of progress on action	Action on track
The community Intensive Support Team and Learning Disability models require improved models of support	Review all models of support offered by the Intensive Support Team (IST) [ACTION OWNERS: DO/DON/MD]	Outcome of review – Improved models of support	~~(31.12.23)~~ (31.03.24)	Review outcome: Services brought together across the North and South under a single manager and now have single clinical pathways. ~~Work still to do to ensure final stages of parity~~ ~~Data reviews show significant improvement the flow of patients through IST to support admission avoidance and early discharge, particularly from adult mental health wards~~ ICB have presented work to both providers on future vision of the pathway, which looks at how to ensure community offers	AMBER

				like IST are enhanced further through the review of other pathway offers where resource is disproportionately allocated DCHS launched a new operational structure in November 2023, which has initiated further discussion on integrated working going forward, to be discussed over Quarter 4	
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: DO]	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	~~(31.12.23)~~ (31.03.24)	Full cross-system delivery plan continues to be monitored through Neurodevelopmental Delivery group Board – Includes action plan in response to inflow, flow and outflow as discussed with NHSE and ICB leaders Refining use of platform criteria to ensure best application for autistic patients on mental health wards supported at November Clinical Quality Reference Group, with ratification at System Quality Group in December 2023 Focussed ICB-led session on care and accommodation work scheduled for December	~~RED~~ AMBER

				2023. NHS England assurance sessions reduced to quarterly in recognition of progress ~~Enhanced community support workstream focussing on improvements for delivery of LEAPs and optimal use of Dynamic Support Register~~ ~~Market engagement workshops held with partners to drive improvements in provider options. Further work required by local authority and ICB to ensure impact – Trust supporting~~ ~~New co-hosting approach for discharge planning, attached to length of stay metrics and 12 point discharge plan to be introduced from September 2023~~	
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: DO/DON]	Full compliance with safer staffing levels in line with the NHSI Workforce Safeguards	~~(31.12.23)~~ (31.03.24)	Reviews of safer staffing and stabilisation in non-DHCFT Derbyshire bedded LD facility - Some stabilisation achieved, further work under new structures required Workforce issues including recruitment and retention, staff wellbeing and mitigations against	AMBER

				use of agency staff considered. Ongoing commitment to working in an alliance with DCHS to support a resolution for future bedded care for LD&A services across Derbyshire	
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: DO/DON]	Full compliance with required care standards External review of Long-Term Segregation and review to end restrictive practices	~~(31.12.23)~~ (31.03.24)	~~External review of Long-Term Segregation and review to end restrictive practices complete~~ Joint paper from Trusts to ICB regarding overall bedded offer and inpatient review is with ICB for feedback and due for joint discussion in January 2024 Overall quality plan for improvement for LD&A inpatients including out of area in place following review by ICB quality team - Reporting to JUCD Clinical Quality Reference Group in September 2023. This includes trying to reduce the level of out of area care ~~Ward recruitment and management responsibility has returned to DCHS, they are considering their model on the unit. DHCFT General Manager supporting~~	AMBER

				~~Work on future model for inpatient care continues, Further capacity to support developments to be identified across partners~~	
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: DO/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	~~(31.12.23)~~ (31.03.24)	Work to provide facilities that meet national standards to be completed ~~Joint proposal paper providing an overview of the work to date across the system being co-developed with recommended next steps for executive discussion in October 2023~~	AMBER

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

Board Assurance Framework 2023/24 – Issue 4. 3 Board March 2024

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

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

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

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

Action Owners

CEO	Chief Executive Officer
DOF	Director of Finance – Currently Interim
MD	Medical Director
DSPT	Director of Strategy, Partnerships and Transformation
DON	Director of Nursing and Patient Experience – Currently Interim
DPI	Director of People and Inclusion – Currently Interim
COO	Chief Operating Officer – Currently Interim Executive Director of Operations (DO)

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

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

Freedom to Speak Up Guardian (FTSUG) – half yearly report

Purpose of Report

This paper is a half yearly report to the Board of Directors to ensure the Board is aware of Freedom to Speak Up (FTSU) cases within the Trust; an analysis of trends within the organisation and actions being taken to improve speaking up culture.

Executive Summary

This FTSU report to Board sets out the number of cases and FTSU themes raised in the last six months from July to December 2023 at Derbyshire Healthcare NHS Foundation Trust (DHcFT).

Total case numbers, 66 cases, seen in this report to Board for the period are a decrease on the 72 cases reported in the September 2023 FTSU report to Board for the period January to June 2023.

Emerging, or ongoing, themes include:

- **Bullying and harassment / attitudes and behaviours / worker safety and wellbeing:** a number of staff have spoken up about perceived bullying and harassment. A few staff did not wish to escalate further but were looking to 'move' roles internally. Several staff were distressed in discussing their experiences. Some cases involved Administrative and Clerical staff.
- **Policy, process and procedure: reasonable adjustments / worker safety and wellbeing:** several staff approached the FTSUG with long term conditions. They had asked for reasonable adjustments and were feeling that these requests were not being responded to in a timely or compassionate manner. Staff discussed the impact and distress that these situations can cause.

The report also contains a comprehensive list of actions taken to enhance visibility and promote FTSU to ensure that speaking up culture is continuously improved.

The Speaking Up Champions network also supports workers to raise their concerns at the earliest opportunity and signposts workers to the FTSUG for advice and guidance.

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.	

Risks and Assurances

Reporting on speaking up is presented to the Trust Board and the Audit and Risk Committee (ARC) every six months to provide assurance on progress made. The People and Culture Committee (PCC) also receives FTSU information as part of the wider staff feedback dashboard.

The Board completed the Freedom to Speak Up Reflection and Planning Tool in January 2024. The Reflection and Planning Tool provides a benchmark and assurance that works to promote and respond to how speaking up at work is progressing. The Audit and Risk Committee continues to monitor the progress of the FTSU action plan.

There are risks to having a culture where workers do not feel able to safely voice their concerns. There are potential impacts on patient safety, clinical effectiveness and patient and staff experience, as well as possible reputational risks and regulatory impact.

Consultation

- Executive Leadership Team.

Governance or Legal Issues

- Trusts are required to have a FTSUG as part of the NHS standard contract terms and conditions.

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

- The joint working of the Equality Diversity and Inclusion (EDI) team and FTSUG supports future ways of working to support staff with protected characteristics to raise concerns.
- Assurance is sought by the FTSUG that concerns logged from staff with protected characteristics are supported by Employee Relations/EDI processes; and that any wider issues are being considered by senior Trust leadership.
- This report highlights some areas of good practice including having FTSU Champions from a diverse range of backgrounds, as well as numbers of Black and Minority Ethnic group (BME) colleagues speaking up.

Recommendations

The Board of Directors is requested to:

1. Support the current mechanisms and activities in place for raising awareness of the FTSU agenda.
2. Discuss the report and determine whether it sufficiently assures the Board of the FTSU agenda at the Trust and that those proposals made by the FTSUG promote a culture of open and honest communication to support staff to speak up.

Report presented and prepared by:	**Tamera Howard** **Freedom to Speak Up Guardian**

Derbyshire Healthcare NHS Foundation Trust
Public Trust Board – 5 March 2024

Freedom to Speak Up Freedom to Speak Up Guardian (FTSUG) – half yearly report

1. Introduction

1.1 The Freedom to Speak Up Guardian (FTSUG) is part of a culture of speaking up and acts to enable patient safety concerns to be identified and addressed at an early stage. Freedom to Speak Up (FTSU) has three components: improving and protecting patient safety, improving and supporting worker experience and visibly promoting learning cultures that embrace continual development. The Care Quality Commission (CQC) assesses an NHS Trust's speaking up culture under the Well-Led domain of its inspections.

1.2 The FTSU report covers the period from July to December 2023: Quarters 2 and 3 2023/24. Reporting to Board is on a six-monthly basis.

2. Aim

2.1 This report aims to provide the Board with:

- Information on the number of cases being dealt with by the FTSUG and themes identified from July to December 2023.
- Information on what the Trust has learnt and what improvements have been made as a result of workers speaking up.
- Actions taken to improve FTSU culture in the Trust, including progress in the promotion of the FTSUG role and addressing barriers to speaking up.
- Updates from the National Guardians Office (NGO).
- Key recommendations to Board.

3. Summary of Freedom to Speak Up Concerns

3.1 Concerns are categorised in accordance with NGO guidance. The NGO requires concerns relating to Patient Safety, Bullying and Harassment, Worker Safety and Wellbeing, Public Interest Disclosure Act (PIDA) concerns, anonymous concerns and those suffering detriment or demeaning treatment, as a result of speaking up, to be recorded on a quarterly basis.

3.2 **Table 1** shows that the FTSUG logged 38 cases in Q2 2023/24 and 28 cases in Q3 2023/24. In Quarter 4 2023/24, 20 cases have been logged. The average number of cases per quarter for a Mental Health Trust is 29.3. In 2023, DHcFT averaged 34.5 cases per quarter. The average number of cases per quarter for small NHS trusts (less than 5,000 staff) in 2022/23 is 17.3 per quarter. (Source: NGO Annual Report 2022/23).

3.3 **Patient Safety and Quality:** During Q2 and Q3 of 2023/24, patient safety and quality concerns represented 6.1% of cases. From January to June 2023, they represented 6.9% of cases. Patient safety and quality concerns are directed to the Director of Nursing and Patient Experience. According to the NGO Annual Report 2022/23, patient safety concerns represented 19.3% of all concerns nationally.

Table 1: FTSU Data Q2 and Q3 2023/2024

Types of Concerns	Q2 2023/24	Q3 2023/24
With an element of **Bullying & Harassment (NGO/PIDA)**	**7**	**6**
With an element of **Patient Safety & Quality (NGO/PIDA)**	**2**	**2**
With an element of **Worker Safety & wellbeing (NGO)**	**9**	**10**
Potential Fraud or Criminal Offence (PIDA)	**0**	**0**
Attitude & Behaviours	18	20
Compassionate Leadership Issues	14	7
Culture	16	13
Health and Safety	1	1
Policy, Process and Procedure	10	7
Total Cases reported to FTSUG*	**38**	**28**
Public Interest Disclosure Act (PIDA) concerns	**9**	**8**
Reportable to NGO: Bullying and Harassment / Patient Safety / Worker Safety	20	18
Anonymous / Other	1	2
Person indicates suffering a detriment as a result of speaking up	0	0
Number of cases that have received feedback	34	33

***Individuals (cases) approaching FTSUG may log more than one concern.**

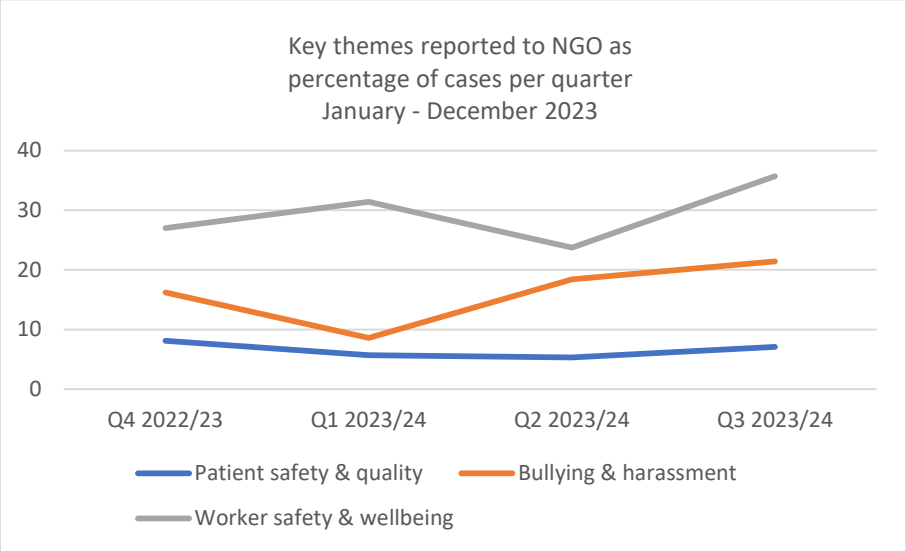
3.4 **Bullying and Harassment Concerns** represented 19.7% of cases raised to the FTSUG from July to December 2023, which is lower than the 22% raised nationally to FTSUGs during 2022/23. (Source: NGO Annual Report 2022/23). This is an increase on the 16.7% of cases raised from January to June 2023. Bullying and harassment levels for the 12 months from January to December 2023 were 18.1%

The FTSUG promotes the Trust's Dignity at Work policy, Trust wellbeing offers, staff-side/union support and Employee Relations, where staff require information and support around bullying and harassment matters.

3.5 **Worker Safety and Wellbeing Theme:** 28.8% of cases in Q2 and Q3 2023/24 involved an element of worker safety and wellbeing. This is a decrease on the 34.7% of cases seen in Q1 2023/24 and Q4 2022/23. Nationally, in 2022/23, the average for worker safety and wellbeing was 27.4%. (Source: NGO Annual Report 2022/23).

Figure 1 shows Bullying and Harassment, Patient Safety and Worker Safety and Wellbeing cases as a percentage of the number of cases per quarter as reported to the NGO over the January to December 2023 period.

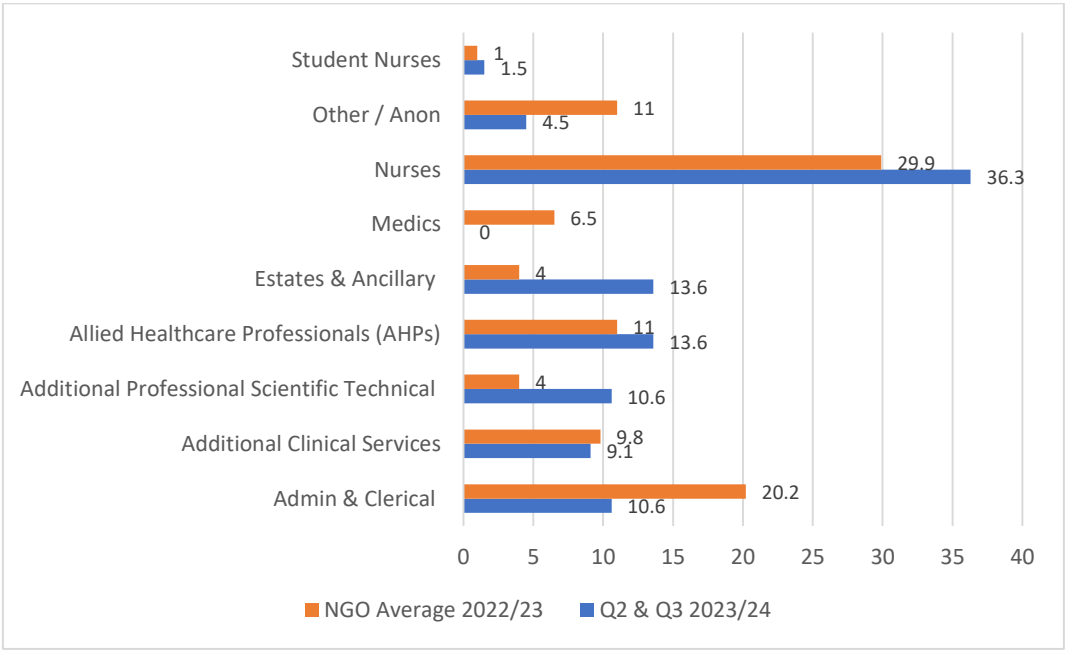
Figure 1



3.6 **Professional Groups**: in Q2 and Q3 2023/24, 36.4% of staff approaching the FTSUG were nurses. This is higher than in Q4 2022/23 and Q1 2023/24, where 30.5% of staff approaching the FTSUG were nurses. It is also higher than the national average reported by the NGO at 29%. (Source: NGO Annual Report 2022/23). See Figure 2.

Higher numbers of estates and ancillary staff speaking up (13.6%) in comparison to the NGO (4%) average reflects several staff approaching the FTSU in Q2 2023/24.

Figure 2: Professional groups speaking up in Q2 and Q3 2023/24 as percentage of total cases per quarter in comparison to NGO 2022/23 data.



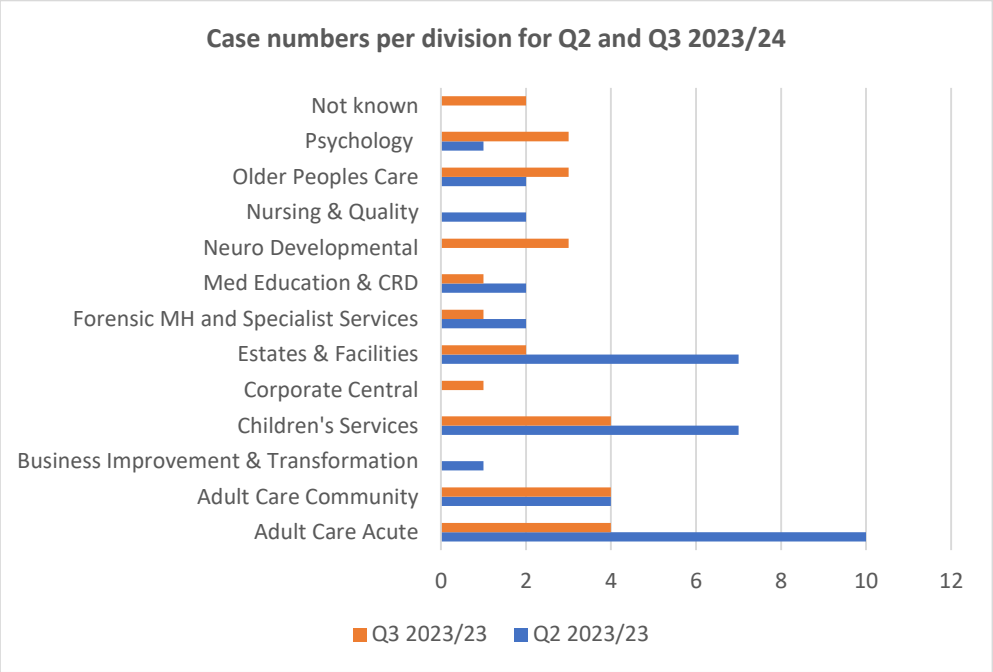
3.7 **Experiencing Detriment or Demeaning Treatment:** in Q2 and Q3 of 2023/24, 0% of workers reported that they had experienced a detriment or demeaning treatment as a result of speaking up. NGO average for detriment in 2022/23 was 3.9%. (Source: NGO Annual Report 2022/23).

3.8 **Ethnicity of Workers:** in Q2 and Q3 of 2023/24, 24.2% of colleagues speaking up identified as Black and Minority Ethnic (BME). This is a decrease on Q4 2022/23 and Q1 2023/24, where 33.3% of staff speaking up identified as BME. According to DHcFT's WRES Annual Report and Action Plan 2021/22, 16.7% of the workforce are from Black, Minority Ethnic backgrounds (BME).

3.9 **Anonymous, Confidential or Open Concerns:** anonymous concerns decreased slightly to 6.1% of concerns for In Q2 and Q3 of 2023/24. From January to June 2023, they were 6.9% of cases. However, this is lower than anonymous concerns reported nationally in 2022/23 which were 9.3%. (Source: NGO Annual Report 2022/23).

3.10 **Concerns Raised by Division:** figure 3 shows the number of cases from divisions across the Trust. Estates and Facilities was higher in Q2 2023/24 due to a number of staff from one area speaking up.

Figure 3



4. Emerging or Ongoing Themes with Learning/Action Points

4.1 **Bullying and Harassment / Inappropriate Attitudes and Behaviours / Worker Safety and Wellbeing**

A number of staff have spoken up about perceived bullying and harassment. A few staff did not wish to escalate further but were looking to 'move' roles internally. Several staff were distressed in discussing their experiences. Several cases involved Admin and Clerical staff.

Learning/Action:

- Admin leads aware and supportive when cases escalated. Plans put in place to address concerns.
- Workers signposted to sources of support, including in-house counselling service, Resolve, union/staff-side support, health and wellbeing service and Employee Relations.

- Some staff chose to enter into an informal or formal HR process.

4.2 **Policy, Process and Procedure / Worker Safety and Wellbeing: Additional Payment Delays**

Five staff from one area raised concerns regarding a delayed one-off payment. They had repeatedly raised their concerns, but management had not been able to resolve. Staff were frustrated by the delays and the mixed messages they felt they were receiving. Concern was also voiced about lack of empathy and the understanding that these payments were of importance to the lower banded staff involved. Three of the staff were from BME communities.

Learning/Action:

- FTSUG escalated to senior leader.
- Situation resolved for the next payday.
- Wider understanding now of issue within ESR that caused initial issue.
- Issues and culture in area discussed with Acting Director of People and Inclusion and also Divisional People Lead for the area.

4.3 **Policy, Process and Procedure: Reasonable Adjustments / Worker Safety and Wellbeing**

Several staff approached the FTSUG with long term conditions. They had asked for reasonable adjustments and were feeling that these requests were not being responded to in a timely or compassionate manner. Staff discussed the impact and distress that these situations can cause.

Learning/Action:

- All cases escalated, where consent given, to senior leaders, employee relations or EDI Lead. All supported with requests.
- Reasonable adjustments and responses being considered by Acting Director of People and Inclusion and EDI Lead. EDI lead is working to improve the process and response.
- The Trust currently has several projects relating to assistive technology, reasonable adjustments, inclusive recruitment and eliminating discrimination in place.

5. Improving Speaking Up Culture

5.1 **Improving Visibility and Networking:** the FTSUG presents at monthly Trust Inductions and to Junior Doctors. The FTSUG attends team meetings on request. The FTSUG is now holding regular face-to-face drop-ins in some acute settings and is involved in listening events in specific areas of the Trust in relation to concerns.

5.2 **Board Culture:** a well-received Board development session was delivered by the FTSUG and Trust Secretary in October 2023. The Board Development Session was themed around the contents of the FTSU Reflection and Planning Tool which was completed by the Board for January 2024.

5.3 **Supporting Communities who Face Barriers to Speaking Up:** the FTSUG engages with the Equality, Diversity and Inclusion (EDI) Team to address inclusion issues and share themes for diverse groups. The FTSU attends the EDI steering group regularly and reaches out to the staff network leads and also attends staff network meetings.

5.4 **Triangulation of Data and FTSU:** the FTSUG is meeting regularly with senior leaders including the Deputy Director of Nursing and the Acting Director of People and Inclusion to discuss triangulation of data. The FTSUG produces a report for the People and Culture Committee to support the triangulation of data from FTSU.

5.5 **Network of FTSU Champions:** the FTSUG holds monthly catch-up meetings with Speaking Up Champions to share good practice, support any speaking up matters and to share NGO information**.** Champions referred in 22% of concerns during Q2 and Q3 2023/24. DHcFT currently has 26 FTSU Champions who come from a range of divisions across the Trust. Children's Services have created their own network of divisional champions and the FTSUG meets bi-monthly with this group.

5.6 **Non-Executive Directors:** the FTSUG is supported by a Non-Executive Director (NED) lead for Speaking Up, Geoff Lewins. The FTSUG holds monthly meetings with the NED to share FTSUG practice and areas for support and development.

5.7 **Speaking up Month October 2023**: the Trust produced an exciting and informative new video with the support of the communications team and a range of leaders and staff across the Trust. This video is now used as part of the FTSU induction training. The video can be accessed on the FTSU page on Focus, staff intranet. Senior leaders and staff also supported the Speak Up wear green theme at the Trust's staff conference on 11 October 2023 and a presentation was provided on the importance of psychological safety.

6. Learning, Improvement and Development in Relation to Speaking Up Culture within the Trust.

6.1 **Evaluation Feedback on Speaking Up:** an evaluation form for individuals who have spoken up is sent out following contact with the FTSUG using an online link. 33% of those responding from July to December 2023 said 'yes' they would speak up again. 62% of those invited to respond gave did not complete the evaluation. These specific questions are required by the NGO.

6.2 **DHcFT Freedom to Speak Up Strategy:** the FTSUG Strategy and Vision 2024-2026 has been approved and will be promoted. The Board has asked for updates through this report on how the Strategy is being measured and this will be done by reporting on the FTSU action and improvement plan and measurable objectives. The Audit and Risk Committee and the Board will be kept up to date on the FTSU action and improvement plan at future meetings.

6.3 **Derbyshire Integrated Care System (ICS):** the FTSUG meets monthly with other ICS FTSUGs to discuss system arrangements around FTSU. The Trust Secretary has also recently completed a return, requested by the Integrated Care Board's (ICB) People and Culture Committee, that sought assurance that providers have appropriate arrangements in place to implement the recommendations in the letter received from the Secretary of State regarding the Lucy Letby case. The assurance had previously been presented to the Board.

6.4 **Staff Survey 2023: Raising Concerns:** there are several questions linked to the staff survey on raising concerns. As the results are still under embargo, the FTSUG will report on the outcomes and themes in relation to speaking up in the next report to the Board, together with any actions taken in relation to the results.

7. National Guardian's Office and Related National Changes

7.1 **FTSU Reflection and Planning Tool:** the Board completed and adopted the NHSE FTSU Reflection and Planning Tool by the deadline of 31 January 2024.

The improvement tool is designed to help the Trust identify strengths in the leadership team and the organisation – and any gaps that need work. It should be used alongside Freedom to speak up: A guide for leaders in the NHS and organisations delivering NHS services.

An action and improvement plan has been created and monitoring of compliance of the actions will be through the six-monthly reporting by the FTSUG to the Audit and Risk Committee.

7.2 **Lucy Letby Response:** all NHS Trust Boards and senior leaders were required to urgently consider the following points in relation to FTSU as result of the Lucy Letby case. The Trust has factored these into the Board Reflection and Planning tool and action planning.

1. All staff have easy access to information on how to speak up.
2. Relevant departments, such as Human Resources, and Freedom to Speak Up Guardians, are aware of the national Speaking Up Support Scheme and actively refer individuals to the scheme.
3. Approaches or mechanisms are put in place to support those members of staff who may have cultural barriers to speaking up or who are in lower paid roles and may be less confident to do so, and also those who work unsociable hours.
4. Boards seek assurance that staff can speak up with confidence and are treated well.
5. Boards are regularly reporting, reviewing and acting upon available data.

7.3 Dr Jayne Chldgey-Clark (NGO Lead) has responded to the Too hot to Handle report by brap and Roger Kline on why concerns about racism in the NHS are not heard or acted upon.

This report includes sections specifically looking at speaking up and raising concerns about racism and discrimination, and includes a recommendation for better use of Freedom to Speak Up Guardians.

Next year's mandatory annual NGO refresher training for FTSUGs is focused on equity, diversity and belonging in order to give all Guardians an understanding of discrimination.

The Trust will respond to the report as part of its existing EDI processes and will involve the FTSUG.

8. Conclusion

8.1 Feeling free to speak up represents a significant cultural change across the NHS. Success is not only the responsibility of the FTSUG. It is important that the Trust continues to learn from concerns that workers raise and to build an environment where workers know their concerns, and feedback, are taken seriously and welcomed as an opportunity to guide service improvement and development.

8.2 The Board will continue to use the positive culture around speaking up to drive recommendations from the report forward and to deliver meaningful and visible responses to Trust wide concerns.

9. Recommendations

The Trust Board is asked to:

1. Support the current mechanisms and activities in place for raising awareness of the FTSU agenda.
2. Discuss the report and determine whether it sufficiently assures the Board of the FTSU agenda at the Trust and that those proposals made by the FTSUG promote a culture of open and honest communication to support staff to speak up.

Tamera Howard
Freedom to Speak up Guardian
Derbyshire Healthcare NHS Foundation Trust

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

The following summaries cover key items discussed at the meetings that have been held since the last public Board meeting held on 16 January 2024 and are received for information.

- Finance and Performance Committee – 23 January 2024
- Audit and Risk Committee – 25 January 2024
- People and Culture Committee – 30 January 2024
- Quality and Safeguarding Committee -13 February 2024

Key:

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

Finance and Performance Committee – key assurance levels for items - 23 January 2024	
	Making Room for Dignity Programme (MRfD) Programme Report The on-going tribunal appeal process with HMRC, related to the VAT abatement, has been resolved. via the Alternative Dispute Resolution securing £18m of VAT abatement. There remains an unmitigated cost pressure of £7.5m driven by construction inflation and adverse weather conditions. The NEC contracts for Ward 32 and the Bluebell Ward have been signed by both parties and work has started. The licence to occupy and agreement to lease for the Bluebell Ward has been signed. Focus now moves to recruitment and service transformation. **Limited assurance** was received on the progress of the programme and the risks associated with it. The Committee supported the urgent prioritisation of the next stages of this programme of work, which are in line with the delivery of the component parts of the Trust Strategy and supporting building blocks.
	Financial Report The Committee received the Month 9 position reported against the breakeven plan, noting the Month 9 YTD position is £2.6m worse than plan and the forecast outturn for 2023/24 has moved from breakeven to a deficit of £4.4m. This is being driven by emerging cost pressures that are outside of the Trust's control such as reduced income, support for a complex patient, excess inflation and pay awards. The report highlighted the additional actions that had been taken to address the financial risk such as the introduction of the vacancy control panel and change of authorisation limits. There has been a positive reduction on agency expenditure since month 6. CIP has been delivered in full, but the risk remains that a significant amount is non-recurrent. Out of area expenditure continues to be a concern. Options are being explored to secure additional beds. The Committee gained **limited assurance** on delivery of the financial plan due to the level of risks that are being managed that were highlighted at the time of the plan submission.
	National Cost Collection submission

	The final report on the 2022/23 national cost collection submission was presented to the Committee. The approved costing guidance has been followed with all validations cleared and the quantum of costs reconciled to audited accounts. The Committee acknowledged the amount of worked involved in this submission and approved the final report.
	Improvement and Transformation Report Since the last meeting, the team has been working to close the gap and the full plan of £8.77m has been achieved. Recurrent delivery has increased from 22% to 24%. There are a number of initiatives in the programme for 2024/25 which are being developed. The Committee was assured of processes to complete 2023/24 programme and develop the programme for 2024/25.
	Operational Performance The report covers the performance as at the end of November, which was presented to the last Trust Board meeting. The most challenged area is related to the autism provision and features heavily in the Integrated Care Board (ICB) reporting and discussions with NHS England. A significant amount of work has been done to improve performance. Discussions took place on continuous improvement and areas to focus on which some services have already done. Some areas relating to productivity were highlighted such as missed appointments and cancellations. Solutions to address these issues will be taken through the Clinical Digital Board. An understanding of the restructuring of teams was requested for the next meeting. The support of the complex patient continues to remain an issue, and this has been escalated through various routes. Based on current performance levels of the issues presented the Committee gained **limited assurance.**
	Neurodevelopmental Community Hub update The service was commissioned in February last year and the Trust has been working with Citizens Advice and Derbyshire Autism Services. This project is about reducing the demand on Paediatric services. The paper was noted, an assurance level was not assessed.
	Inpatient Bed Utilisation and Flow – Deep Dive The Committee was given a depth of insight into the factors impacting on the use of inappropriate out of area beds. The trajectory is to reduce to 11 beds, but numbers are significantly above that currently. Length of stay is reducing. There is a focus on early discharges and the support of stepdown beds. The Committee agreed a level of **limited assurance** on current performance.
	Productivity Programme Board The Committee noted the Productivity Programme Board has been stood down due to overlap with the efficiency delivery group. Oversight going forward will be through the Trust Leadership Team Committee. The three main areas of focus are community productivity, looking at flow and length of stay and agency reduction and the model hospital and Real World Health data, along with support from the transformation team, will take this work forward. The digital strategy will be key to support delivery of transformation and productivity improvements.
	Business Environments

	East Midlands Perinatal Mental Health Provider Collaborative The transition since 'go-live' has gone very well. The contract has been signed. Work will now take place to understand ways of working to draw out opportunities to make quality improvements and address any inequalities. The programme lead will now step away and the Committee gave thanks for the work that has taken place. The Committee received **significant** assurance on progress and mobilisation.
	Operational and Financial Planning The draft planning timeline for 2024/25 was presented to the Committee. The timetable is still a work in progress as the planning guidance has not yet been published. Due to the tight timescales and the complexity of the planning process, it was proposed to include weekly updates to the Non-Executive Directors during this process. The Board needs to have a good understanding on the main issues and clarity around the options and choices available so that it is clear on the decisions that will need to be made. Work is on-going to understand the recurrent deficit, which is driven by the lack of recurrent CIP delivery, non-recurrent income and slippage on investments that have taken place in 2023/24.
	Board Assurance Framework, 2023/24 Risks Overview The three BAF risks for this Committee have been reviewed and updated. A deep dive into the finance risk will be presented to the Audit and Risk Committee.
	Escalations to Board or other Committees: None. **Items added to the Board Assurance Framework**: Nothing further to update. **Next scheduled meeting:** 19 March 2024.
Committee Chair: Tony Edwards	**Executive Leads: Rachel Leyland, Interim Director of Finance and Jo Wilson, Acting Interim Director of Finance**

Audit and Risk Committee - key assurance levels for items - 25 January 2024	
	Board Assurance Framework Issue 4 (version 4.2) of the BAF for 2023/24 was reviewed and the Committee agreed **significant assurance** that the paper provided 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.
	Finance BAF – Deep Dive In line with the Trust's Risk Policy all extreme risks are subject to a deep dive requirement through the Audit and Risk Committee. The component elements within BAF Risk 3A – '*There is a risk that the Trust fails to deliver its revenue and capital financial plans'* were reviewed in a presentation provided by Interim Director of Finance. The 'Extreme' risk level was confirmed and the Committee received **significant assurance** on the process for the robust review of this risk through the Finance and Performance Committee.
	Operational Risk Management The Committee received an update on the effectiveness of the risk management processes and Datix record keeping in reference to the 360 Assurance internal audit

	recommendations. The report also showed the current status of all Trust risk registers mapped against the 360 Assurance Risk Management Audit Report and actions within it. **Limited assurance** was obtained from the report due to the lack of improvement in reviewing overdue risks.
	Annual Report Planning - Year End Timetable Planning The year-end timetable and key dates associated with the approval of the annual report and accounts provided **significant assurance** that year-end planning in relation this element is under control, noting the issues that were currently being work through on the operational plan submission.
	Approve Accounting Standards/Policies for 2023/24 Annual Accounts The Committee agreed the Trust's accounting policies for the 2023/24 Annual Accounts and took **significant assurance** these were in line with the Department of Health's Group Accounting Manual (GAM) and would reflect any future changes in the GAM before final accounts submission.
	Data Quality Update The Committee agreed **significant assurance** on the report which outlined the activities which have been undertaken over the last 6 months to ensure the Trust maintains good data quality. Support was given on the ambition to keep the amount of manual data processing to a minimum to reduce the potential for errors and also for operational teams to follow Standard Operating Procedures to ensure that electronic records are complete, accurate and up to date.
	Salary Overpayments - update on current position and actions taken The Committee agreed **limited assurance** on the impact of actions already taken for the management and prevention of overpayments. An update was requested in six months' time.
	Commercial/Top Up Insurance Appraisal This report gave an overview of insured risks the Trust has covered. Having thoroughly reviewed insurance options, the Committee recommended that appropriate property insurance is procured upon completion of the hospital new builds and requested that the Data Protection and Security Committee (DS&P) continues to keep the possible procurement of cyber insurance under review.
	Waiver Report The Waiver Register for quarters 1, 2 and 3 for the financial year 2023/24 provided **significant assurance** that tendering and contracting processes are conducted in accordance with the Trust's Standing Financial Instructions and any waivers and non-competitive quotations have been logged and are presented for regular review by the Audit and Risk Committee.
	Freedom to Speak Up (FTSU) compliance and strategy approval **Significant assurance** was accepted in terms of the Trust having adequate arrangements in place for speaking up and also compliance with the following mandated requirements set out by NHS England and the National Guardian's Office (NGO): • Update the local FTSU policy to reflect the new national template. • Completion and adoption of an FTSU Reflection and Planning tool. • All NHS Trusts advised to have a Vision and Strategy for FTSU in place.

	The Committee approved the FTSU Vision and Strategy 2024-2026 under powers delegated by the Trust Board meeting.
	Well Led Action Plan The Committee noted good progress against the initial six-month recommendations from the External Development Review of Leadership and Governance using the Well led framework, with a plan in place to review and progress the longer term 12-month recommendations (deadline 30 September 2024).
	Internal Audit The Internal Auditor (360 Assurance) report identified progress made in relation to completion of work from the Trust's 2023/24 Internal Audit Plan. The Head of Internal Audit Stage Two work was now complete with a positive overview of the Trust's BAF process. Planning for 2024/25 was in progress. The follow up rate for actions remains at 100%.
	External Audit The External Auditor, Mazars confirmed that the scope of the audit and timetable is consistent with the previous year and will be completed in June in line with reporting deadlines and set out the emerging areas for the financial statement audit.
	Accessing Legal Advice Policy The Committee approved the revised Accessing Legal Advice Policy
	Escalations to Board or other Committees: None **Board Assurance Framework –** key risks identified: None **Next scheduled meeting:** 25 April 2024
Committee Chair: Geoff Lewins	**Executive Leads: Justine Fitzjohn, Trust Secretary and James Sabin, Director of Finance**

People and Culture Committee – key assurance levels agreed - 30 January 2024	
	People and Inclusion Assurance Dashboard The Committee noted the partnership with Derbyshire County Council to support with delivery of Safeguarding Children training. Deep dives are to be performed to identify challenges that remain around training compliance and recruitment. Key performance indicators to also include triangulation of the relevant metrics to identify any correlations of underperformance around Supervision and appraisals. The Committee received **significant assurance** on the progress shown for mandatory training, staff turnover, vacancies and recruitment, attendance and absence, bank usage and Freedom to Speak Up and **limited assurance** for Employee Relations cases, clinical supervision and annual appraisals.
	Deep Dive on Team Cultures - Trust Wide Learning, Culture and Safety In response to recent and past national concerns, such as the Lucy Letby case, the Trust has reviewed immediate lessons learned and identified the need to strengthen governance in which patterns, concerns and patient safety matters can be collated in one space and responded to. The process aims to create two groups:

	• One group to collate intelligence across the Trust, focused on key areas linked to culture, safety and the Key Lines of Enquiry. • One group to respond to this intelligence, with clear plans and governance frameworks to track progress and completion. The Committee received **limited assurance** on the impact and outcomes of the establishment of the strengthened governance around team cultures and safety due to the infancy of the groups and **significant assurance** at the establishment and proposed strengthening of process and governance to identity, support and hold teams at risk and in need of such support.
	Communications Strategy The Committee noted the Communications Strategy which outlines internal and external communication priorities for 2024. It is a one-year strategy, to ensure plans are in place to support delivery of the overarching Trust Strategy, and the development of a new Trust Strategy for Autumn 2024. The Strategy will be accompanied by a detailed plan outlining activities to be undertaken by the Communications team, in order to achieve the aims outlined.
	Staff Survey The Organisational Development Lead presented the high-level data report which showed an increased response to 62% compared to 48% last year. The specific results are confidential until the embargo is lifted by NHS England. The Committee took **significant assurance** from the improved response rate and plans to share the results in a timely manner, noting that the national results are still awaited.
	Assurance on Contracted Services In order to support delivery of the people requirements within the Trust, for a number of years, some services have been externally contracted. Services included the People Services Joint Venture with Derbyshire Community Health Services (DCHS), the largest, along with Occupational Health and Payroll (University Hospitals of Derby and Burton (UHDB), Counselling (DCHS) and Absence and Wellbeing management (Good-Shape). Due to the gaps in governance, the Committee accepted **limited assurance** on the current governance process of external contracts commissioned to deliver key elements of the people function for Derbyshire Healthcare and **significant assurance** on the proposal to move to a more robust quarterly review through the formal people contract performance review meeting.
	Review of People and Culture Committee Board Assurance Framework (BAF) Risks This report provided a summary of the BAF risks allocated to this Committee. It was reported that the first draft of the Leadership Strategy had been submitted to the Executive Leadership team for initial review. Bank staff engagement through the joint venture would be looked at and a review of staff benefits was underway to redress any differentials between staff groups. The workforce plan will include work undertaken across the system in relation to the Making Room for Dignity (MRfD) and the Committee agreed that the risks associated with MRfD should be included on the BAF.
	Escalations to Board or other committees: None. **Board Assurance Framework – key risks identified:** The risks associated with the MRfD programme to be included. **Next Meeting:** 26 March 2024.

Committee Chair: Ralph Knibbs	**Executive Lead: Rebecca Oakley, Acting Director of People and Inclusion**

Quality and Safeguarding Committee – key assurance levels for items - 13 February 2024	
	Quality Dashboard Discussions focussed on complaints data, the improved dashboard format and governance on managing performance via the Divisional Performance Review process. In terms of complaints, the Committee noted that overall these had been on a downward trajectory since August 2023. The Patient Experience Team is now focusing on improving the quality of response and timeliness of closing complaints. This included prioritisation methods to expediate early resolution of the high number of overdue complaints. In response to addressing identified themes, for example poor staff attitude, it was also noted that collective/Trust-wide action plans are being considered. The Committee agreed **significant assurance** on the basis that there is a generally sound system of control. However, it was recognised there may be some inconsistencies in the application of controls.
	Regulation Compliance (CQC, Mental Health Act, Ward 35) The Committee noted the progress with implementation of the new self- assessment process and the ongoing work to increase pace. A quality surveillance dashboard will support sight of early concerns, priorities and offer of support The Committee agreed **significant assurance** on compliance based on the strengthened governance and oversight of CQC related actions and on the progress of actions from the CQC's inspection.
	Patient Safety Incident Report It was noted that the Patient Safety team continue to support operational services to establish quality improvement programmes, which included enhancements to DATIX, finalising the revised Patient Safety Incident Response Framework plan and local priorities, improved processes, oversight groups and training needs. This is resulting in overdue timescales for completion of actions. The team are working with the Divisions to embed ways of working and the agreed improvements. Due to the need to accelerate processes and embed the lessons learnt, **limited assurance** was agreed in relation to the current processes for managing Patient Safety incidents.
	Positive and Safe Annual Report The Committee discussed the introduction of a pilot of a locked doors policy which would bring the Trust in line with local and national peers. Progress in Reducing Restrictive Practise was also a focus of the committee's noting while this has improved recently there has been an overall rise in physical restraint and seclusion since last year, which appear to be related to increased patient acuity. The Committee also discussed the partnership work between the Trust and the East Midlands Alliance focusing on improving restrictive practice and the six core strategies around sexual safety and the restraint reduction standards. **Significant assurance** was received from the progress made with the training and standards in respect to reducing restrictive practices within the Trust and the connecting work with the East Midlands Alliance.
	Regulation 28 Notice Based on the outcomes of the initial audit of compliance with reporting requirements. The Committee agreed **limited assurance** on the basis that although the revised protocol has been established and communicated, monitoring has shown there is currently an inconsistent application of the controls, however, these have been identified and addressed with staff.
	Learning from Deaths/Mortality Report

	The mortality report covered 1 September to 31 December 2022 and evidenced a robust process which was embedded via the Learning the Lessons group. Data around Learning Disabilities was now included in the reporting. The Committee accepted **significant assurance** of the Trust's approach and agreed for the report to be considered by the Trust Board of Directors and then published on the Trust's website in line with national guidance.
	Roll Out of Electronic Patient Survey A progress update was provided on the roll out of the Electronic Patient Survey. The collection of patient feedback is listed as a requirement for Trusts by NHS England and NHS Improvement and is a key part of the Trust's Patient and Carer Experience Strategy. The Committee noted the position, the further work being considered, to include all patient groups, opportunities for further improvement work and the positive impact so far.
	Divisional Performance Reviews (DPRs) The report gave an overview of the recent changes in Divisional governance and the new focus of performance reviews. The Divisional reviews will cover a wide range of quality and performance issues and have Executive oversight. The Committee noted the desired direction of travel noting the contents of this report and discussions and will receive assurance as these mature.
	Making Room for Dignity (MRfD) Programme (to include Model of Care update) The latest report focused on the models of care and gave an update on recruitment towards the workforce plan noting that appointed staff to date have slotted into existing vacancies. The Committee asked for the information to be mapped to safe staffing and service transformation for the adult acute care pathway to ensure there is confidence in meeting care performance targets and our cultural . The committed noted the progress and sought further assurance on the alignment to quality standards on the desired clinical and cultural mode and the associated risks. The Committee agreed **limited assurance** on elements of the information presented
	Service Model Delivery – Children's Services – 0-19 Years Following a previous report to committee which requested further assurance on actions taken to mitigate the clinical and operational risks experienced by the service the committee heard about the impact on outcomes and the good work the team have been involved with.. The discussion and report demonstrated the service has continued to evaluate its performance using KPIs, national benchmark data, staff feedback, clinical audits and patient experience feedback. The Committee received **significant assured** of robust actions to address the risks.
	Chief Pharmacist's Report The committee discussed the report which outlined the work of the Trusts Medicines Optimisation, Medicines Management and Pharmacy strategy. The report detailed assurances on governance, medicines optimisation and the actions being taken to strengthen assurances on risk areas. The committee noted and agreed on the revised reporting style of Assure, Alert and Advise. **Significant assurance** was agreed on the quarterly report on medicines and pharmacy management.
	Medicines and Pharmacy Governance Oversight The Committee supported the proposal to reform annual and interim reporting to provide clear escalation and corporate visibility around medicines and pharmacy. The first "new" report would be submitted to Committee following the Medicines Management Committee in April.

	Community Mental Health Framework (CMHF) The Committee noted the bi-annual update on the statutory objectives of the CMHF and delivery against local plan. This was on the basis that Derbyshire is on track to have delivered the majority of the CMHF requirements by March 2024 and, staff are now more engaged and partner organisations are more willing to work collaboratively to co-develop and implement multi agency operational ways of working. In addition, extensive engagement with Carers Groups and EQUAL have resulted in a more positive perception of the Living Well programme.
	Board Assurance Framework (BAF) – key risks identified: the Committee considered the items discussed throughout the meeting in relation to the BAF risks and recommended a review of the BAF to ensure gaps in controls and mitigating actions relating to the management of complaints, risks around the MRfD service transformation. The capacity to match the delivery of autism assessments with demand was discussed and it was agreed the BAF was a good reflection of the current position however this should stay front and foremost in our discussions within the Integrated System given the response is a partnership approach. **Escalations to Board or other committees:** None **Next Meeting:** 12 March 2024
Committee Chair: Lynn Andrews	**Executive Lead: Dave Mason, Interim Director of Nursing and Patient Experience**

Learning from Deaths - Mortality Report

Purpose of Report

The 'National Guidance on Learning from Deaths' requires each Trust to collect and publish specified information on a quarterly basis. This report covers the period 1 September 2023 to 31 December 2023.

Executive Summary

- All deaths directly relating to COVID-19 are reviewed through the Learning from Deaths procedure unless they meet an additional Incident Red Flag, in which case they are reviewed under the Incident Reporting and Investigation Policy and Procedure. From 1 September to 31 December 2023 there has been one death reported where the patient tested positive for COVID-19.
- The Trust received 722 death notifications of patients who had been in contact with our services within the six months prior to their death. There is little variation between male and female deaths; 358 male deaths were reported compared to 364 females.
- Two inpatient deaths were recorded.
- The weekly Mortality Review Group meetings have been redesigned from direct case review to one of assurance and audit with plans in place to utilise this forum more effectively to review deaths closed at Incident Review Tool level and monitor compliance to Trust Red Flags.
- Learning the Lessons committee and service line subgroups are under development, the committee replaces the Trust Mortality Committee however was struggling to gain momentum therefore this has been re-designed to form an off shoot of the Trust Executive Incident review group on a monthly basis thus allowing for appropriate senior leadership and ownership.
- The Trust has reported eight Learning Disability deaths in the reporting timeframe and two patients with a diagnosis of Autism Spectrum Disorder (ASD).
- Medical Examiner officers have been established at all Acute Trusts in England and their role will be extended to include deaths occurring in the community, including at NHS Mental Health and Community Trusts. The implementation of this process had been expected by April 2023 however due to the complexities involved in data sharing this has been paused Nationally for community-based services. The Patient Safety team will continue to work with Medical Examiners to ensure the Trust maintains momentum in this area.
- Good practice identified through case note reviews is fed back to clinicians involved as part of our appreciative learning.

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

Assurances

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

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:

- 1 September to 31 December 2023. There is very little variation between male and female deaths; 358 male deaths were reported compared to 364 females.
- No unexpected trends were identified according to ethnic origin or religion.

Recommendations

This report was reviewed by the Quality and Safeguarding Committee, which met on 13 February 2024 and received significant assurance from this report.

We request the Board to note the contents and to approve the publication of the mortality statistics.

Report presented by: Arun Chidambaram
Medical Director

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

Louise Hamilton
Safer Care Coordinator

Learning from Deaths - Mortality Report

1. Background

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

To date, the Trust has met all the required guidelines. The report presents the data for 1 September to 31 December 2023.

2. Current Position and Progress (including COVID-19 Related Reviews)

- Discussions with the Regional Medical Examiners have taken place to discuss the implementation of the Medical Examiner process within our Trust. A standard operating procedure will be developed between Chesterfield Royal Hospital and University Hospital of Derby and Burton. The implementation of this process had been expected by
  April 2023. However, due to the complexities involved in data sharing this has been paused Nationally for community-based services. The Patient Safety team will continue to work with Medical Examiners to ensure the Trust maintains momentum in this area.

- Cause of death information is currently being sought through the Coroner's offices in Chesterfield and Derby but only a very small number of cause of deaths have been made available. It is hoped that this will improve once Medical Examiners commence the process of reviewing the Trust's non-coronial deaths.

- Regular audits continue to be undertaken to ensure compliance with policy and procedure and any necessary amendments made. This has included auditing complaint data against names of deceased patients to ensure this meets the requirements specified in the National guidance. The last audit was completed on 22 January 2024.

3. Data Summary of all Deaths

Note that inpatients and learning disability (LD) data is based upon whether the patient has an open inpatient or LD referral at time of death. The table below outlines information for
1 September to 31 December 2023.

	September	October	November	December
Total Deaths Per Month	162	169	183	208
LD Referral Deaths	2	1	2	3
Inpatient Deaths	2	0	0	0

Correct as of 19 January 2024

358 patients were male, 364 were female, of these 542 were white British, 135 were any other ethnic group and 45 had no known ethnicity assigned. The youngest age was 0 years, the eldest age was 101.

From 1 September to 31 December 2023, the Trust received 722 death notifications of patients who have been in contact with our services.

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

4. Review of Deaths

Total number of Deaths from 1 September to 31 December 2023 reported on Datix	62 “Unexpected deaths” (includes 2 inpatient deaths) One COVID-19 deaths 19 “Suspected deaths” Nine “Expected - end of life pathway”. NB some expected deaths have been rejected so these incidents are not included in the above figure. Two Inpatients deaths
Incidents assigned for a review	73 incidents assigned to the operational incident group. 16 incidents assigned to the executive incident group. 0 did not meet the requirement. Two incidents to be confirmed

Only deaths which meet Trust Red Flags are reported through the Trust incident reporting system (Datix) and are reviewed through the Untoward Incident Reporting and Investigation Process. These Red Flags apply to any patient open to services within the last six months prior to their death:

- Homicide – perpetrator or victim.
- Domestic homicide - perpetrator or victim.
- Suicide/self-inflicted death, or suspected suicide.
- Death following overdose.
- Death whilst an inpatient.
- Death of an inpatient who died within 30 days of discharge from a DHcFT hospital.
- Death following an inpatient transfer to acute hospital.
- Death of patient on a Section of the Mental Health Act or Deprivation of Liberty Safeguards (DoLs) authorisation.
- Death of patient following absconsion from an inpatient unit.
- Death following a physical restraint.
- Death of a patient with a learning disability.
- Death of a patient where there has been a complaint by family/carer/the Ombudsman or where staff have raised a significant concern about the quality-of-care provision.
- Death of a child (this will also be subject to scrutiny by the Child Death Overview Panel).
- Death of a patient open to safeguarding procedures at the time of death, which could be related to the death.
- Death of a patient with historical safeguarding concerns, which could be related to the death.
- Death where a previous Coroners Regulation 28 has been issued.
- Death of a staff member whilst on duty.
- Death of a child under the age of 18 of a current or previous service user who has died in suspicious circumstances.
- Where an external organisation has highlighted concerns following the death of a patient whether they were open to the Trust at time of death or not.
- *Death of a patient with Autism.*
- *Death of a patient who had a diagnosis of psychosis within the last episode of care.*

The last two red flags have been added this year to ensure that the Trust meets the Learning from Deaths guidance and recent changes to the LEDER reporting requirement of patients who have a diagnosis of autism.

5. Learning from Deaths Procedure

The Trust has now completed the move of its mortality process which has been implemented within the patient Electronic Record, this aids staff in identifying deaths which meet the threshold for DATIX reporting.

This process fulfils stage one of the Learning from Deaths, in that all deaths are considered for Red Flags, as identified under the national Learning from Deaths procedure.

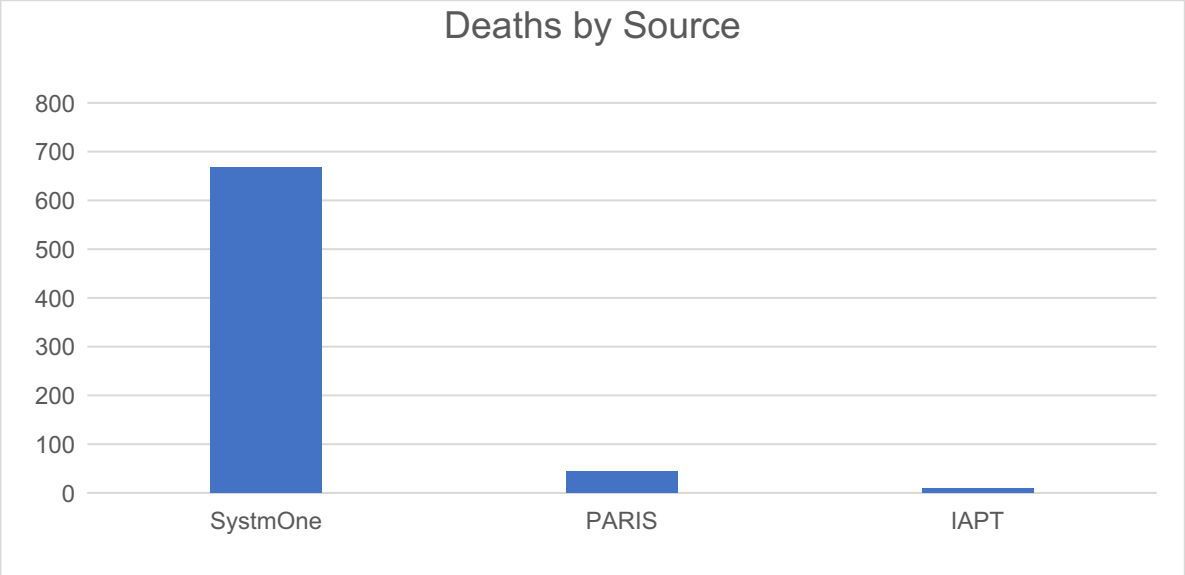
This is a significant improvement in process and will release some capacity within the service to re-deploy into other priorities such as actions and high-profile incident management. The plan will also allow for more joined up working with Corporate and Legal services, ensuring better sharing of information and identification of priorities for both services.

The Mortality team is conducting random weekly audits of deaths against the Red Flags to provide assurance that the new process is working as intended and changes will be made accordingly.

From 1 September to 31 December 2023, there has been one death reported where the patient tested positive for COVID-19.

6. Analysis of Data

6.1 Analysis of Deaths per Notification System 1 September to 31 December 2023

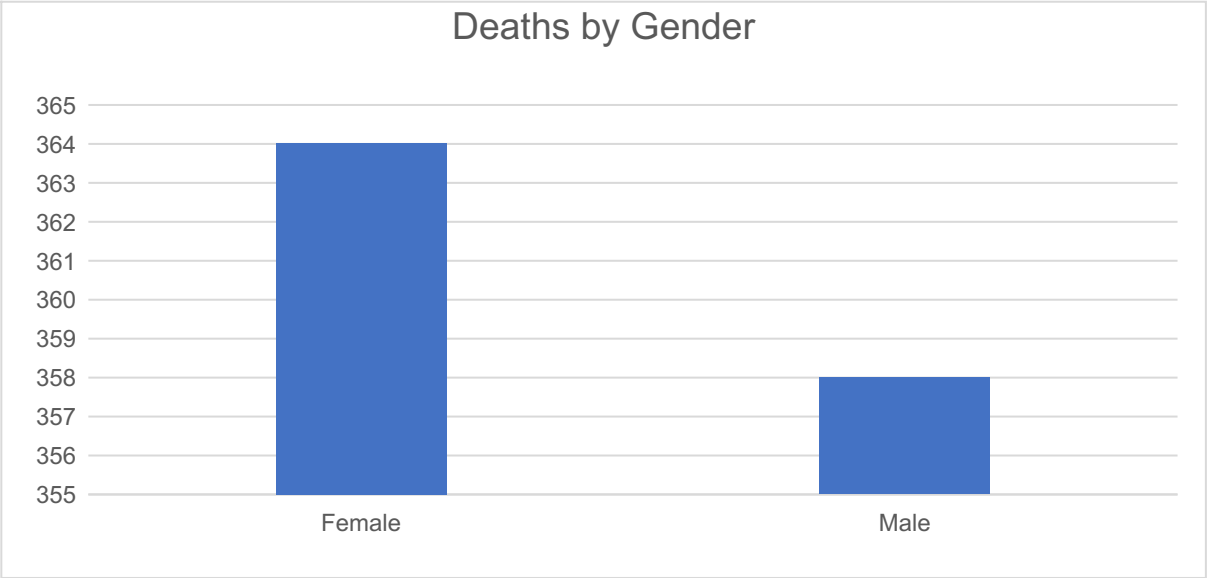


System	Number of Deaths
SystmOne	668
PARIS	45
IAPT	9
Grand Total	722

The data above shows the total number of deaths reported by each notification system. The majority of death notifications were predominately pulled from SystmOne which is not unexpected, given the Trust's move to one EPR.

6.2 Deaths by Gender

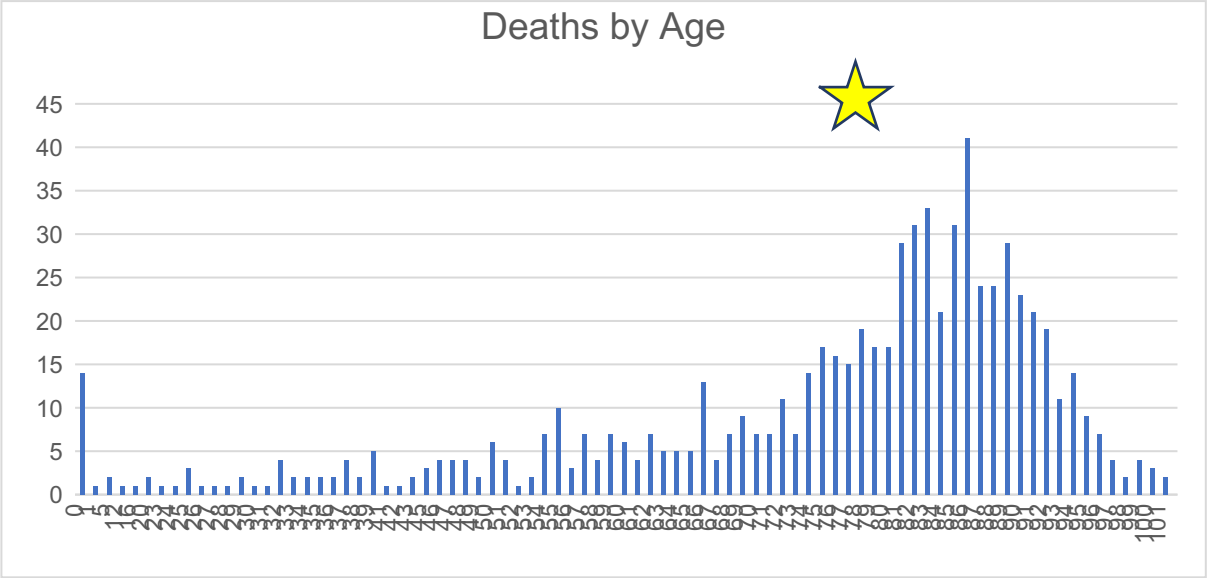
The data below shows the total number of deaths by gender for 1 September to 31 December 2023. There is very little variation between male and female deaths; 364 female deaths were reported compared to 358 males.



Gender	Number of Deaths
Male	358
Female	364
Grand Total	722

6.3 Death by Age Group

The youngest age was classed as zero, and the oldest age was 101 years. Most deaths occurred within the 81-86 age groups (indicated by the star).



6.4 Learning Disability Deaths (LD)

	September	October	November	December
LD Deaths	2	1	2	3

The Trust reviews all deaths relating to patients diagnosed with a Learning Disability. The Trust also currently sends all Learning Disability deaths that have been reported through the Datix system to the Learning Disabilities Mortality Review (LeDeR) programme.

During 1 September to 31 December 2023, the Trust has recorded eight 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 Trust Executive Incident Review group. Plans are now in place to re-assign one meeting per month within this forum to be a dedicated Learning the Lessons Committee which will have oversight of the operational Learning the Lessons subgroups.

From 1 January 2022, the Trust is also required to report deaths of patients who have a diagnosis of Autism Spectrum Disorder (ASD). For this reporting period the Trust has reported two deaths.

Health Inequalities within the Adult Neurodevelopmental Division (ND)

As part of the neurodevelopmental transformation programme, there is a whole system approach to addressing health inequalities via the health inequality workstream, set up to identify key areas of improvement and work together to make whole system changes.

One of the key areas of improvement over the last year has been implementing actions taken from national reviews, primarily, The Oliver McGowan review and the Clive Treacey report, as well as the Stopping The Over-Medication of children and young People with a learning disability, autism or both (STOMP) and Supporting Treatment and Appropriate Medication in Paediatrics (STAMP) work. This work has been highlighting the inequalities that people with learning disabilities and autistic people face in accessing health and social care, their experiences, and the outcomes. Through the workstream, we have developed action plans to ensure we are addressing these inequalities. Some of these actions include supporting the rollout of the mandatory Oliver McGowan training, improving reasonable adjustments, and implementing the STOMP/STAMP framework.

The ND health inequality workstream has developed a reasonable adjustments steering group. This group has been involved in initiatives such as the new NHS reasonable adjustment flag work. Alongside this, within DHcFT and DCHS ND, the new reasonable adjustment lead, Trainee ACP, has developed an ‘easy read’ champion programme. ND colleagues have been trained and equipped with skills and resources to improve written information across the division. This work directly supports health inequalities.

Another area of improvement has been around improving annual health checks (AHC) for people with a learning disability. This has included new data reporting on population statistics in relation to AHC within DHcFT, a codesigned quality improvement project looking at why people are not accessing annual health checks as well as scoping out existing programmes such as social prescribing as potential support mechanisms for improving AHCs.

Within DHcFT we have also been working on gathering baseline data intelligence through our own data hub and using NHS Model Hospital to establish better information on who is accessing our services which is informing action plans.

Recognising that people with LD/A often experience health inequalities within health inequalities and underpinned by the ‘We Deserve Better’ report, the health inequality workstream has begun to map out the different strands of work happening across the system, specifically around health inequalities for ethnic minority groups.

The health facilitation team have been building links with the BAME networks within Derbyshire and Derby Health Inequality Partnership (DHIP), a co-led and a joint initiative between Derby City Council (Public Health) and Community Action Derby with a view to working alongside these groups to understand our population better and develop strong links to improve our services.

6.5 Death by Ethnicity

White British is the highest recorded ethnicity group with 542 recorded deaths, 39 deaths had no recorded ethnicity assigned, and 6 people did not state their ethnicity. The chart below outlines all ethnicity groups.

Ethnicity	Number of Deaths
White - British	542

Other Ethnic Groups - Any other ethnic group	110
Not Known	39
White - Any other White background	8
Not stated	6
Asian or Asian British - Indian	4
White - Irish	4
Black or Black British - Caribbean	2
Asian or Asian British - Pakistani	2
Black or Black British - Any other Black background	1
Mixed - White and Black Caribbean	1
Mixed - White and Asian	1
Asian or Asian British - Bangladeshi	1
Mixed - White and Black African	1
Grand Total	722

6.6 Death by Religion

Christianity is the highest recorded religion group with 324 recorded deaths, 280 deaths were (blank) with no recorded religion assigned. The table below outlines all religious groups.

Religion	Number of Deaths
Christian	324
(blank)	280
Church of England, follower of	33
Church of England	15
Roman Catholic	8
Not Religious	6
Christian religion	6
Atheist movement	5
Methodist	5
Christian, follower of religion	4
Agnostic	4
Religion NOS	4
Sikh	3
Catholic religion	3
Jehovah's Witness	3
Unknown	3
Buddhist	2
Patient religion unknown	2
Muslim	2
Not Given Patient Refused	2
Pentecostalist	1
Sikh religion	1
Nonconformist religion	1
Protestant	1
None	1
Jewish	1
Baptist	1

Atheist	1
Grand Total	722

6.7 Death by Sexual Orientation

Heterosexual or straight is the highest recorded sexual orientation group with 458 (444+14) recorded deaths. 246 (245+1) had no recorded information available. The chart below outlines all sexual orientation groups:

Sexual Orientation	Number of Deaths
Heterosexual	444
(blank)	245
Heterosexual Or Straight	14
Sexual orientation not given - patient refused	12
Sexual orientation unknown	3
Bisexual	3
Unknown	1
Grand Total	722

6.8 Death by Disability

The table below details the categories by disability. Gross motor disability was the highest recorded disability group with 136 recorded deaths.

Disability	Number of Deaths
(Blank)	437
Gross Motor Disability	136
Intellectual Functioning Disability	50
Patient Reports No Current Disability	43
Hearing Disability	21
Emotional Behaviour Disability	17
Physical Disability	5
Learning Disability	2
Registered Disabled	1
Dementia; Other	1
Walking Disability	1
Behaviour And Emotional; Learning Disability (Dementia); Learning Disability (Dementia); Other; Self Care and Continence	1
Progressive (Lt) Conditions; Other; Mobility and Gross Motor; Other; Other	1
Mobility And Gross Motor	1
Sight	1
Other; Other	1
Fine Motor Disability	1
Hearing; Sight	1
Learning Disability (Dementia); Learning Disability (Dementia)	1
Grand Total	722

There was a total of 285 deaths with a disability assigned and the remainder 437 were blank (had no assigned disability).

7. Medical Examiners

Medical Examiner officers have been established at all Acute Trusts in England. The role of these offices is now being extended to also cover deaths occurring in the community, including at NHS Mental Health and Community Trusts.
Medical Examiners are to provide independent scrutiny of deaths not taken at the outset for coroner investigation. They will carry out a proportionate review of medical records and give families and next of kin an opportunity to ask questions and raise concerns. This process will inform learning to improve care for future patients, or, in a smaller number of cases, may be referred to others for further review. Their involvement will also provide reassurance to the bereaved.

Overall Medical Examiners will seek to answer the following three questions:

- What caused the death of the deceased?
- Does the coroner need to be notified of the death?
- Was the care before death appropriate?

Discussions with the Regional Medical Examiners have taken place to discuss the implementation of the Medical Examiner process within our Trust. A standard operating procedure will be developed between Chesterfield Royal Hospital and University Hospital of Derby and Burton. The implementation of this process had been expected by April 2023. However, due to the complexities involved in data sharing this has been paused Nationally for community-based services. The Patient Safety team will continue to work with Medical Examiners to ensure the Trust maintains momentum in this area.

8. Recommendations and Learning

Changes have been implemented within the DATIX system to support early identification of themes and learning from incidents which are not taken to further Patient Safety learning review, this information will be fed into Learning the Lessons subgroups alongside themes and recommendations from Learning Reviews to support the development of Quality Improvement programmes.

A review of the Trust Mortality Committee showed that it was no longer performing as intended, following enhancements to the mortality and incident process to better align the two, that the meeting was surplus. Therefore, it has been dissolved and has been replaced with a monthly Learning the Lessons Committee, to oversee the works of the operational service line Learning the Lessons subgroups, which will be the working forums for sharing learning, quality improvement plans and actioning the implementation of actions following Learning Reviews. This work is currently in its infancy and Patient Safety will be working with service lines for a period of six months to support establishment. Current themes within the system remain unchanged however we expect this information will evolve over the coming 18 months.

Improvement Issue	Update on Actions Required
Transfer of the deteriorating patient	Internal investigations have highlighted themes regarding the transfer and return of patients between inpatient services for the Trust and acute providers such as Chesterfield Royal Hospital. This includes handover of information, and the way patients are conveyed. A printable handover document is now available in SystmOne, changes to the ward handover document has been completed.
Self-harm of patients whilst on leave from inpatient services	Investigations have highlighted issues in relation to adult inpatient leave arrangements, including section 17 leave arrangements. A further thematic review has been completed, on conclusion of current inpatient, suspected suicide incidents active at present. An action plan has been developed. The Patient Safety Team is leading on the coordination of the review of the current processes and quality improvement actions.
MDT process improvements within CMHTs	Investigations have highlighted themes in relation to MDT processes within CMHTs and works are currently underway to review the EPR and recording documentation and MDT process to ensure this is fit for purpose and being adhered to.
Falls prevention	Pockets of increased falls have been noted and currently there are pilots underway within Older Adult in patient service for the use of bed and chair sensors. A Trust Falls Group meets regularly to discuss improvements and themes.
Family liaison and engagement	The package of support available to families involved in an internal investigation/ review has been reviewed and changes made. This includes consistency of support, timeframes and establishing a pathway for escalation.
Multi-agency engagement following incidents	It is known that patients are often known to multiple services, both internally and externally. Works have been commissioned to consider agreements needed to enhance multi-agency working with partner agencies, when an incident investigation has been commissioned to improve shared learning and enhance family liaison and support.
Relapse prevention and MDT resource management within Amber Valley Adult Community Mental Health Services	As a result of an internal investigation and concerns raised by staff, a piece of work is being commissioned to consider themes in relation to the resource and function of the MDT process within the Amber Valley CMHT.
Integrated care services	Investigations have highlighted the need for improvements in the care pathway of patients open to more than one service. A conference will be held, which will include representation from all service lines, Clinical Directors, the Medical Director and Deputy Director of Nursing and Quality, as well as incident investigation leads to review themes and devise a plan of action to enhance internal integrated care. This conference will also include external integrated care with providers such as Social Care.
Inappropriate admission to inpatient adult ward	Investigations into high profile incidents of inappropriate admissions to Adult Mental Health inpatient services, brought to attention an on-going issue in this area. Review of lower grade incidents and discussions with the service line have confirmed a long-standing theme in this area. A review of inappropriate admissions is currently underway.

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
A	
A&E	Accident & Emergency
ACCT	Assessment, Care in Custody & Teamwork
ACE	Adverse Childhood Experiences
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
ATU	Acute Treatment Unit
B	
BAF	Board Assurance Framework
BLS	Basic Life Support (ILS Immediate Life Support)
BMA	British Medical Association
BME	Black and Minority Ethnic group
BoD	Board of Directors
BPPC	Better Payment Practice Code
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
CDEL	Capital Departmental Expenditure Limit
CDMI	Clinical Digital Maturity Index
CE	Chief Executive
CEO	Chief Executive Officer
CGA	Comprehensive Geriatric Assessment
CHPPD	Care Hours Per Patient Day
CIN	Children in Need
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
CP	Child Protection
CPA	Care Programme Approach
CPD	Continuing Professional Development

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
CPN	Community Psychiatric Nurse
CPR	Child Protection Register
CQC	Care Quality Commission
CQI	Clinical Quality Indicator
CQUIN	Commissioning for Quality and Innovation
CRD	Clinically Ready for Discharge
CRG	Clinical Reference Group
CRH	Chesterfield Royal Hospital
CRHT	Crisis Resolution and Home Treatment
CRR	Case Record Reviews
CRS	(NHS) Care Records Service
CRS	Commissioner Requested Services
CSF	Commissioner Sustainability Fund
CTO	Community Treatment Order
CTR	Care and Treatment Review
D	
DAR	Divisional Assurance Review
DAT	Drug Action Team
Datix	Trust's electronic incident reporting system of an event that causes a loss, injury or a near miss to a patient, staff or others
DBS	Disclosure and Barring Service
DBT	Dialectical Behavioural Therapy
DfE	Department for Education
DCHS	Derbyshire Community Health Services NHS Foundation Trust
DDCCG	Derby and Derbyshire Clinical Commissioning Group
DHCFT	Derbyshire Healthcare NHS Foundation Trust
DIT	Dynamic Interpersonal Therapy
DNA	Did Not Attend
DoC	Duty of Candour
DOF	Director of Finance
DoH	Department of Health
DOL	Deprivation of Liberty
DoLS	Deprivation of Liberty Safeguards
DON	Director of Nursing
DPA	Data Protection Act
DPI	Director of People and Inclusion
DPS	Date Protection and Security
DRRT	Dementia Rapid Response Team
DSPT	Director of Strategy, Partnerships and Transformation
DTOC	Delayed Transfer of Care
DVA	Derbyshire Voluntary Action (formerly North Derbyshire Voluntary Action)
DWP	Department for Work and Pensions
E	
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

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
EIP	Early Intervention In Psychosis
ELT	Executive Leadership Team
EMDR	Eye Movement Desensitising and Reprocessing Therapy
EMR	Electronic Medical Record
EPMA	Electronic Prescribing and Medicine Administration
ePMO	Electronic Programme Management Office
EPR	Electronic Patient Record
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
GMP	Guaranteed Maximum Price
GP	General Practitioner
GPFV	General Practice Forward View
H	
HCA	Healthcare Assistant
HCP	Healthy Child Programme
H1	First half of a fiscal year (April through September)
H2	Second half of a fiscal year (October through the following March)
HEE	Health Education England
HES	Hospital Episode Statistics
HoNOS	Health of the Nation Outcome Scores
HSCIC	Health and Social Care Information Centre
HSE	Health and Safety Executive
HWB	Health and Wellbeing Board
I	
IAPT	Improving Access to Psychological Therapies
Icare	Increase Confidence, Attract, Retain, Educate
ICB	Integrated Care Board
ICM	Insertable Cardiac Monitor
ICS	Integrated Care System
ICT	Information and Communication Technology
ICU	Intensive Care Unit

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
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
IRHTT	In-reach Home Treatment Team
IPP	Imprisonment for Public Protection
IPR	Integrated Performance Report
IPT	Interpersonal Psychotherapy
IRT	Incident Review Tool
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
LAC	Looked After Children
LCFS	Local Counter Fraud Specialist
LA – CYPD	Local Authority – Children and Young People Divisions
LD	Learning Disabilities
LD/A	Learning Disability and Autism
LeDeR	Learning Disabilities Mortality Review
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

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
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
MMC	Medicines Management Committee
MoU	Memorandum of Understanding
MSC	Medical Staff Committee
MSK	Musculoskeletal (conditions)
MSU	Medium Secure Unit
N	
NCRS	National Cancer Registration Service
NED	Non-Executive Director
NETS	National Educational Training Survey
NICE	National Institute for Health and Care Excellence
NHS	National Health Service
NHSE	National Health Service England
NHSI	National Health Service Improvement
NHSEI	NHS England and NHS Improvement
NIHR	National Institute for Health Research
O	
OBC	Outline Business Case
ODG	Operational Delivery Group
OOA	Outside of Area
OPMO	Older People's Mental Health Services
OP	Outpatient
OSC	Overview and Scrutiny Committee
OT	Occupational therapy
P	
PAB	Programme Assurance Board
PAG	Programme Advisory Group
PALS	Patient Advice and Liaison Service
PAM	Payment Activity Matrix
PARC	Psychosis and the reduction of cannabis (and other drugs)
PARIS	This is an electronic patient record system
PbR	Payment by Results
PCC	Police & Crime Commissioner
PCC	People and Culture Committee
PCN	Primary Care Networks
PDSA	Plan, Do, Study, Act
PFI	Private Finance Initiative
PHC	Public Health Commissioners
PHE	Public Health England
PICU	Psychiatric Intensive Care Unit
PID	Project Initiation Document
PiPoT	People in Positions of Trust
PLACE	Patient-Led Assessments of the Care Environment
PLIC	Patient Level Information Costs
PMF	Performance Management Framework
PMLD	Profound and Multiple Disability
PPE	Personal Protection Equipment

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
PPI	Patient and Public Involvement
PPT	Partnership and Pathway Team
PREM	Patient Reported Experience Measure
PROMS	Patient Reported Outcome Measure
PSF	Provider Sustainability Fund
PSII	Patient Safety Incident Investigations
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
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
RRP	Recruitment Retention Proposal
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
STOMP/STAMP	Stopping The Over-Medication of children and young People with a learning disability, autism or both / Supporting Treatment and Appropriate Medication in Paediatrics
STP	Sustainability and Transformation Partnership
SUI	Serious (Untoward) Incident
SW	Social Worker
SystmOne	Electronic patient record system
T	
TAV	Team Around the Family
TARN	Trauma Audit and Research Network
TCP	Transforming Care Partnerships

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
TCS	Transforming Community Services
TDA	Trust Development Authority
TLT	Trust Leadership Team
TMT	Trust Management Team
TUPE	Transfer of Undertakings (Protection of Employment) Regulations 1981
TMAC	Trust Medical Advisory Committee (now Medical Senate)
TOOL	Trust Operational Oversight Leadership
U	
UDBH	University Hospitals of Derby and Burton
UEC	Urgent and emergency care
V	
VARM)	Vulnerable Adult Risk Management
VO	Vertical Observatory
VTE	Venous Thromboembolism
W	
WDES	Workforce Disability Equality Standard
WRES	Workforce Race Equality Standard
WTE	Whole Time Equivalent
Y	
YTD	Year to Date

(updated February 2024)

FORWARD PLAN - BOARD - 2024/25		07-May-2024	02-Jul-2024	03-Sep-2024	05-Nov-2024	14-Jan-2024	04-Mar-2025
	Paper deadline	25-Apr-2024	20-Jun-2024	22-Aug-2024	24-Oct-2024	02-Jan-2025	20-Feb-2024
Trust Sec	Declaration of Interests	X	X	X	X	X	X
DON	Patient/Staff Story	X	X	X	X	X	X
CHAIR	Minutes/Matters Arising/Action Matrix	X	X	X	X	X	X
CHAIR	Board Review of Effectiveness of Meeting	X	X	X	X	X	X
CHAIR	Board Forward Plan (for information)	X	X	X	X	X	X
CHAIR	Summary of Council of Governors Meeting (for information)	X	X		X	X	X
CHAIR	Chair's Update	X	X	X	X	X	X
CEO	Chief Executive's Update	X	X	X	X	X	X
STRATEGIC PLANNING AND CORPORATE GOVERNANCE							
DSPT	Trust Strategy Progress update (approval Sep, launch thereafter)	X		X		X	X
DPI	Staff Survey Results (following assurance at People and Culture Committee)						X
DPI	Annual Gender Pay Gap Report for approval (following assurance at People and Culture Committee)	X					
DPI	Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) request for Board delegated authority for People and Culture Committee meeting on 19 September to approve the October submissions			X			
DPI	Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) Strategic implications/retrospective sign off after PCC on 19 September				X		
DPI	Workforce Plan for 2024/25				X		
DPI	Annual Approval of Modern Slavery Statement following assurance at People and Culture Committee (to be published on Trust website on approval)	X					
DPI	2024/25 Flu Campaign	Summary of 2023/24 campaign		X			
Trust Sec	Corporate Governance Report (to be published on Trust website on approval)	X					
Trust Sec	NHS Improvement Year-End Self-Certification (within Corp Gov Report)	X					
Trust Sec	Year-end Governance Reporting from Board Committees and Approval of ToRs (within Corp Gov report)	X					
Trust Sec	Trust Sealings (six monthly - for information - also within May Corp Gov report)	X			X		
Trust Sec	Annual Review of Register of Interests	X					
Trust Sec	Board Assurance Framework Update	X		X	X		X
Trust Sec	Freedom to Speak Up Guardian Report (six monthly)			X			X
Trust Sec	Board Effectiveness Report				X		
Trust Chair	Fit and Proper Person Declaration			X			
DPSPT/DoF	Operational/Financial Plan	X					
Committee Chairs	Board Committee Assurance Summaries	X	X	X	X	X	X
OPERATIONAL PERFORMANCE							
DON/DOF/ DPI/COO	Integrated performance and activity report to include Finance, People performance and Quality	X	X	X	X	X	X
DSPT	ICB Joint Forward Plan (included in CEO Update)		X				
COO	Emergency Preparedness, Resilience and Response (EPRR) Core Standards			X			
COO/Prog Director	Making Room for Dignity progress	X			X		
DON/COO/ DPI	Workforce Standards Formal Submission/Safer Staffing (prior to publishing on website) following assurance at PCC	X					
QUALITY GOVERNANCE							
EXEC	Position Statement - focus on CQC domains (Well Led CQC & NHSI) as per schedule	Caring DON	Well Led Trust Sec		Safe MD	Responsive DoOs	Effective DON MD & DPI
MD	Learning from Deaths Mortality report on assurance from Quality and Safeguarding Committee	AR		X	X	X	X
MD	Guardian of Safe Working Report on assurance from Quality and Safeguarding Committee		AR		X	X	
DON	Receipt of Annual Reports on assurance from Quality and Safeguarding Committee: - Annual Looked After Children - Safeguarding Children and Adults at Risk				X		
DSPT	Continuous Quality Improvement: A Stocktake						X
DON	Infection Prevention and Control Annual Report and BAF				AR		
MD	Re-validation of Doctors Compliance Statement		X				
MD	Update on Mental Health Bill					X	
DON	Outcome of Patient Stories - every two years - due March 2026						
POLICY REVIEW							
DOF/ Trust Sec	Standing Finance Instructions Policy and Procedures (Jul 2024)		X				