NHS
Derbyshire Healthcare
NHS Foundation Trust

Quality Report
2017/18

Making a positive difference

Part 1:
Statement on quality from the Chief Executive

I am pleased to present our Quality Report for the financial year 2017/18. The report is the opportunity for our Board to look back over the year, to reflect on some of our key achievements, to think about our priorities for the coming year, and to offer a view as to the quality of the healthcare that we have provided over the year. This is an annual report, and in it we note our formal regulatory requirements, areas that we have found challenging and areas that we see as high quality and innovative care for our communities.

In my role I have a clear view of the significant value of our staff and their commitment to patient care, irrespective of their role in the organisation. I was heartened to see this reflected in aspects of the staff survey, in particular staff feeling more engaged with the Trust, more connected with senior leaders, and better able to recommend the Trust as a place to work. Whilst there has been some improvement in areas of staff wellbeing, the level of improvement is lower than we want, and so staff wellbeing is a clear focus for all of us as we enter the next financial year.

We have seen several innovative developments over the year. These include the Family First model, a flexible and responsive approach to meet the needs of vulnerable families, supporting them to have a healthy pregnancy, to become a knowledgeable, responsive and sensitive parent and to develop positive health, social and economic outcomes for parents and their children. We have implemented the Red2Green initiative, a visual way of helping to minimise the number of days in hospital that do not directly contribute to that person's discharge. This is also reducing our need to admit people to hospital outside of the county, so when we do need to admit we can more often keep people in a hospital nearer home. We also have an innovative new partnership between the Trust and three third sector providers: Derbyshire Alcohol Advice Service (DAAS), Phoenix Futures and Intuitive Thinking Skills (ITS). This creates an integrated and coordinated drug and alcohol system for the first time in Derbyshire.

Over the coming year we will continue our review of Neighbourhood services. Other developments will include the anticipated Community Forensic Pathway and how we hope to use the Mental Health Investment Standard monies to augment our mental health community and crisis teams. We remain committed to working with our partners across the system to support the clinical model for Derbyshire, as part of our shared ambition to increase community resilience and offer more people the option of being cared for as close to home as possible.

I confirm that to the best of my knowledge, the information contained in this document is accurate. Grant Thornton will audit this report in accordance with relevant audit standards.

Ifti Majid
Chief Executive
30 March 2018

Independent practitioner's limited assurance report to the Council of Governors of Derbyshire Healthcare NHS Foundation Trust on the Quality Report

We have been engaged by the Council of Governors of Derbyshire Healthcare NHS Foundation Trust to perform an independent limited assurance engagement in respect of Derbyshire Healthcare NHS Foundation Trust's Quality Report for the year ended 31 March 2018 (the "Quality Report") and certain performance indicators contained therein against the criteria set out in the 'NHS foundation trust annual reporting manual 2017/18' and additional supporting guidance in the 'Detailed requirements for quality reports 2017/18' (the 'Criteria').

Scope and subject matter

The indicators for the year ended 31 March 2018 subject to the limited assurance engagement consist of the national priority indicators as mandated by NHS Improvement:

- Early intervention in psychosis (EIP): people experiencing a first episode of psychosis treated with a National Institute for Health and Care Excellence (NICE) approved care package within two weeks of referral; and
- Improving access to psychological therapies (IAPT): waiting time to begin treatment (from IAPT minimum dataset): within six weeks of referral.

We refer to these national priority indicators collectively as the 'Indicators'.

Respective responsibilities of the directors and Practitioner

The directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the 'NHS foundation trust annual reporting manual 2017/18' and supporting guidance issued by NHS Improvement.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Report is not prepared in all material respects in line with the Criteria set out in the 'NHS foundation trust annual reporting manual 2017/18' and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in NHS Improvement's 'Detailed requirements for external assurance for quality reports 2017/18'; and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the 'NHS foundation trust annual reporting manual 2017/18' and supporting guidance and the six dimensions of data quality set out in the 'Detailed requirements for external assurance for quality reports 2017/18'.

We read the Quality Report and consider whether it addresses the content requirements of the 'NHS foundation trust annual reporting manual 2017/18' and supporting guidance, and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with:

- Board minutes for the period 1 April 2017 to 24 May 2018;
- papers relating to quality reported to the Board over the period 1 April 2017 to 24 May 2018;
- feedback from commissioners dated 03/05/2018;
- feedback from governors dated 28/04/2018;
- feedback from local Healthwatch organisations dated 25/04/2018 and 30/04/2018;

- the Trust's complaints report published under regulation 18 of the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009, dated 04/05/2018;
- the national patient survey dated 01/08/2017;
- the national staff survey dated 26/03/2018; and
- the Head of Internal Audit's annual opinion over the Trust's control environment dated 03/05/2018.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively, the "documents"). Our responsibilities do not extend to any other information.

The firm applies International Standard on Quality Control 1 (Revised) and accordingly maintains a comprehensive system of quality control including documented policies and procedures regarding compliance with ethical requirements, professional standards and applicable legal and regulatory requirements.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Council of Governors of Derbyshire Healthcare NHS Foundation Trust as a body, to assist the Council of Governors in reporting Derbyshire Healthcare NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2018, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body, and Derbyshire Healthcare NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) 'Assurance Engagements other than Audits or Reviews of Historical Financial Information' issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators
- making enquiries of management
- limited testing, on a selective basis, of the data used to calculate the indicators tested against supporting documentation
- comparing the content requirements of the 'NHS foundation trust annual reporting manual 2017/18' and supporting guidance to the categories reported in the Quality Report; and
- reading the documents.

A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations
Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable, measurement techniques that can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the Quality Report in the context of the criteria set out in the 'NHS foundation trust annual reporting manual 2017/18' and supporting guidance.

The scope of our limited assurance work has not included governance over quality or non-mandated indicators, which have been determined locally by Derbyshire Healthcare NHS Foundation Trust.

Our audit work on the financial statements of Derbyshire Healthcare NHS Foundation Trust is carried out in accordance with our statutory obligations. This engagement will not be treated as having any effect on our separate duties and responsibilities as Derbyshire Healthcare NHS Foundation Trust's external auditors. Our audit reports on the financial statements are made solely to Derbyshire Healthcare NHS Foundation Trust's members, as a body, in accordance with paragraph 24(5) of Schedule 7 of the National Health Service Act 2006. Our audit work is undertaken so that we might state to Derbyshire Healthcare NHS Foundation Trust's members those matters we are required to state to them in an auditor's report and for no other purpose. Our audits of Derbyshire Healthcare NHS Foundation Trust's financial statements are not planned or conducted to address or reflect matters in which anyone other than such members as a body may be interested for such purpose. In these circumstances, to the fullest extent permitted by law, we do not accept or assume any responsibility to anyone other than Derbyshire Healthcare NHS Foundation Trust and Derbyshire Healthcare NHS Foundation Trust's members as a body, for our audit work, for our audit reports, or for the opinions we have formed in respect of those audits.

Conclusion
Based on the results of our procedures, as described in this report, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2018:

- the Quality Report is not prepared in all material respects in line with the Criteria set out in the 'NHS foundation trust annual reporting manual 2017/18' and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in NHS Improvement's 'Detailed requirements for external assurance for quality reports 2017/18'; and
- the indicators in the Quality Report identified as having been subject to limited assurance have not been reasonably stated in all material respects in accordance with the 'NHS foundation trust annual reporting manual 2017/18' and supporting guidance.

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25/05/2018

Part 2:
Priorities for improvement and statements of assurance from the board

2.1 Priorities for improvement in 2018/19

The report is required to start with a description of the areas for improvement in the quality of relevant health services that the Trust intends to provide or sub-contract in 2018/19.

Our priorities for improvement for 2018/19

Derbyshire Healthcare Quality Priorities 2018/19	
Priority	**Examples of what this will look like**
Physical healthcare	• Meeting Physical Healthcare Strategy standards • Delivering EHCP (Education Health and Care Plan) and conversions as per contract (Children's Services) • Meeting CQUIN requirements for health checks • Developing Electronic Patient Record (EPR) and technological solutions to help our teams

How we plan to measure physical healthcare:

Corporate	Children, young people and families	Learning Disabilities (Central)	Mental health inpatient	Mental health community	Central Services/ Substance Misuse
Developing EPR and technological solutions to help our teams	Agree minimum standards for each pathway and undertake a baseline measure. Set trajectory for improvement against baseline measure.	Agree minimum standards for each pathway and undertake a baseline measure. Delivering compliance with annual health checks and lead the Greenlight Toolkit action plan and complete actions	Agree minimum standards for each pathway and undertake a baseline measure (admission and LESTER). Set trajectory for improvement against baseline measure	Meeting Physical Healthcare Strategy standards and the CQUIN requirements for annual health checks. Agree minimum standards for each pathway and undertake a baseline measure	Meeting Physical Healthcare Strategy standards. Progress and work on the High Need Support Group (157) offering interventions

Priority	Examples of what this will look like
Deliver all named specific CQUINs or contractual targets	• Complete the Children and Young People (CYP) Transition CQUIN and succeed • Undertake Autism awareness training • Work on all other appropriate CQUINs • Deliver your TOPs (Treatment Outcomes Profile) outcomes (Substance Misuse Services).

How we plan to measure CQUINs and contractual targets:

Corporate	Children, young people and families	Learning Disabilities (Central)	Mental health inpatient	Mental health community	Central Services /Substance Misuse
Offer leads for each CQUIN and enable teams to succeed	Complete the CYP Transition CQUIN and enable teams to succeed. Undertake Autism awareness training	Work on all appropriate CQUIN and focus upon flu inoculations (75%). Undertake Autism awareness training	Work on all appropriate CQUIN and focus upon flu inoculations/ A&E reductions and risky behaviours. Undertake Autism awareness training	Work on all appropriate CQUIN and focus upon flu inoculations/ A&E reductions and risky behaviours. Undertake Autism awareness training	Deliver your TOPS outcomes. Undertake Autism awareness training

Priority	Examples of what this will look like
Relapse reduction and harm reduction	• Contribute to one of the following: Achieving Baby Friendly status/A personal health or family support plan/A plan to reduce deterioration which results in avoidable admission (Children's Services) • A well-rounded personal health plan that identifies prevention and reduction of avoidable admission • Develop Electronic Patient Record and technological solutions to help our teams care plan well

How we plan to measure relapse reduction and harm reduction:

Corporate	Children, young people and families	Learning Disabilities (Central)	Mental health inpatient	Mental health community	Central Services/ Substance Misuse
Develop Electronic Patient Record and technological solutions to help our teams care plan well	Contribute to one of the following: achieving Baby Friendly status/a personal health or family support plan/a plan to reduce deterioration which results in avoidable admission	A well-rounded personal health plan, that identifies prevention and reduction of avoidable admission	A well-rounded person-centred health plan, that identifies prevention and reduction of avoidable admission	A well-rounded health and psychological plan that identifies relapse signature and prevention and reduction of avoidable admission	A well-rounded psychological and health plan that identifies relapse signature and prevention and reduction of avoidable admission

Priority	Examples of what this will look like
Being effective Implement existing NICE or best practice/developing another team's good idea in your team	• Implement one NICE guideline per team or a named piece of research or best practice from another team and show outcomes • Revise the Quality Visit programme to a new model

How we plan to measure being effective:

Corporate	Children, young people and families	Learning Disabilities (Central)	Mental health inpatient	Mental health community	Central Services/ Substance Misuse
Revise the Quality Visit programme to a new model	Implement one NICE guideline per team or a named piece of research, or best practice from another team and showcase it	Implement one NICE guideline per team or a named piece of research, or best practice from another team and showcase it	Implement one NICE guideline per team or a named piece of research, or best practice from another team and showcase it	Implement one NICE guideline per team or a named piece of research, or best practice from another team and showcase it	Implement one NICE guideline per team or a named piece of research, or best practice from another team and showcase it

Priority	Examples of what this will look like
Quality improvement-	• Develop a pathway-specific clinical strategy and undertake

using your ideas Develop and implement using recommended methodology	one quality improvement project • Design a new Quality Improvement Strategy and define agreed methodologies that can be used

How we plan to measure quality improvement (QI):

Corporate	Children, young people and families	Learning Disabilities (Central)	Mental health inpatient	Mental health community	Central Services/ Substance Misuse
Design a new Quality Improvement Strategy and define agreed methodology	Develop a pathway-specific clinical strategy and undertake one QI project	Develop a pathway-specific clinical strategy and undertake one QI project	Develop a pathway-specific clinical strategy and undertake one QI project. CAMPUS – may use Red2Green	Develop a pathway-specific clinical strategy and undertake one QI project	Develop a pathway-specific clinical strategy and undertake one QI project

Our priorities for improvement from the 2016/17 Quality Report, and our progress against these:

Quality priority	Our progress against this priority during 2017/18
Well led **Trust-wide** **NHS staff health and wellbeing** – through a number of health-related behaviour modifications **1a Staff survey – HR and teams** **1b Sugary snacks and food, led by estates** **1c Flu vaccinations**	**CQUINs 1a, 1b, 1c: Improvement of health and wellbeing of NHS staff** Staff wellbeing is the vehicle through which all quality care is delivered. This CQUIN provides clear expectations of how we approach both the physical and the mental health of our staff. **CQUIN 1a: Staff survey** This aspect is based solely on our staff survey, and we needed to achieve a five percentage point improvement in two out of the following three questions in the staff survey, in comparison to our performance in 2015. A particular challenge for us was that our performance in these questions in 2015 was significantly better than in 2016, so this gave us a greater challenge to achieve it. Our scores for each question are in the tables below. **Question 9a: Does your organisation take positive action on health and wellbeing?** Providers were expected to achieve an improvement of 5% points in the answer "yes, definitely" compared to baseline staff survey results or achieve 45% of staff surveyed answering "yes, definitely".

2015	2016	2017	Average 2017
35%	24%	25%	32%

Question 9b: In the last 12 months have you experienced musculoskeletal problems (MSK) as a result of work activities? Providers were expected to achieve an improvement of 5% points in the answer "no" compared to baseline staff survey results or achieve 85% of staff saying 'no'. Below are the 'yes' answers.

2015	2016	2017	Average 2017
17%	18%	20%	21%

Question 9c: During the last 12 months have you felt unwell as a result of work-related stress? Providers were expected to achieve an improvement of 5% points in the answer "no" compared to baseline staff survey results or achieve 75% of staff surveyed answering "no". Below are the 'yes' answers.

2015	2016	2017	Average 2017
42%	43%	41%	40%

Progress against this priority
The question on whether our organisation takes positive action on health and wellbeing shows a small improvement on last year but a continuing lower score in comparison to 2015 and also national scores for equivalent Trusts. Musculoskeletal problems show some deterioration but remain below the average for similar Trusts, whilst we see a slightly improving picture in relation to work-related stress.

Whilst this is a mixed picture as an indicator of staff wellbeing, in addition to the work undertaken around staff wellbeing by the Workforce and Organisational Development department, there is an ongoing focus on the value of supervision and improving the rate of supportive, reflective supervision available to our staff. We are also aware that this has been a year of significant change for many staff around such as work base and team stability, so this will have affected these scores.

CQUIN 1b: Sugary snacks and food

This requires us to continue these previous initiatives from 2016/17:

a.) The banning of price promotions on sugary drinks and foods high in fat, sugar or salt
b.) The banning of advertisements on NHS premises of sugary drinks and foods high in fat, sugar or salt
c.) The banning of sugary drinks and foods high in fat, sugar or salt from checkouts
d.) Ensuring that healthy options are available at any point including for those staff working night shifts.

For 2018/19 we are also expected to introduce the following changes to food and drink provision:

a.) 70% of drinks lines stocked must be sugar free (less than 5 grams of sugar per 100ml). In addition to the usual definition of Sugar Sweetened Beverages (SSBs) it also includes energy

	drinks, fruit juices (with added sugar content of over 5g) and milk based drinks (with sugar content of over 10grams per 100ml). b.) 60% of confectionery and sweets do not exceed 250 kcal. c.) At least 60% of pre-packed sandwiches and other savoury pre-packed meals (wraps, salads, pasta salads) available contain 400kcal (1680 kJ) or less per serving and do not exceed 5.0g saturated fat per 100g. **Progress against this priority** We are anticipating that this priority will be achieved, together with much of what is required for next year already addressed. **CQUIN 1c: Improving the uptake of flu vaccinations for front-line clinical staff** 2017/18 – Expected achievement of an uptake of flu vaccinations by frontline clinical staff of 70%. 2018/19 – Expected achievement of an uptake of flu vaccinations by frontline clinical staff of 75%. This relates to the number of front-line healthcare workers (permanent staff and those on fixed contracts) who have received their flu vaccination by 28 February 2018. We can include staff who receive it from such as their GP or practice nurse. This is a public health initiative, both to keep our staff well and able to work, and also to reduce the opportunity for spread of any flu virus from our staff to others, including patients. **Progress against this priority** Our performance against this is much improved, with just over 50% of staff accepting the vaccination. Planning is already under way for how we promote and engage our colleagues in this for next year to improve our performance further.
Effective **Adult mental health** **b) Improving physical healthcare to reduce premature mortality in people with serious mental illness (SMI)**	**CQUIN 3a: Improving physical healthcare to reduce premature mortality in people with serious mental illness (SMI)** The rationale for this priority is that people with severe mental illness (SMI) are at increased risk of poor physical health, and their life expectancy is reduced by an average of 15–20 years mainly due to preventable physical illness. Two thirds of these deaths are from avoidable physical illnesses including heart disease and cancer, mainly caused by smoking. There is also a lack of access to physical healthcare for people with mental health problems. This requires a significant amount of data capture around physical health assessment, together with appropriate interventions for any indicators of ill-health, e.g. high blood pressure or high cholesterol. If any of these questions on the form are omitted or erroneous, the entire form fails. The requirement is that we demonstrate cardio metabolic assessment and (importantly) treatment for patients with psychosis in the following clinical areas: **Inpatients** 90% of people who have been admitted to the ward for at least seven

	days **Patients on CPA in all community-based mental health services** 65% of people who have been on the team caseload for a minimum of 12 months **Early intervention in psychosis services** 90% of people as per these teams' annual national service-specific self-assessment specification **Progress against this priority** Nationally, this is a challenging priority for providers to achieve, partly due to the detailed complexity of what is required when performance is audited. There has been much learning for our Trust this year. We are aware that we have pockets of strong physical health care, e.g. the London Road clinic, Chesterfield Central Neighbourhood Team's links with the Spireites initiative, the work offered by our colleagues in Early Intervention in Psychosis Teams. However, whilst what these teams offer is of great value, in many cases they do not quite answer each and every detailed requirement of the CQUIN. There is now a group, chaired by Dr Mark Broadhurst, Deputy Medical Director, overseeing all this work, but it remains a challenge. Current performance against this priority was recently reviewed as part of a national audit. These results have not been published at the time of writing. Much work has been undertaken in a range of teams over the year, but the audit results will focus on completeness of each and every aspect of the requirements being met. Therefore, early intelligence is that we will not meet these targets, and so work is already under way to plan for improved performance next year.
Safe **Adult mental health – liaison, Neighbourhoods and key services working in partnership** **c) Improving services for people with mental health needs who present to A&E**	**CQUIN 4: Improving services for people with mental health needs who present to A&E** This priority is about ensuring that people presenting at A&E with mental health needs have these met more effectively through an improved, integrated service, reducing their future attendances at A&E in line with improvement in capacity in our community services and the continued positive work of our effective mental health liaison teams. Working in partnership with our acute trust colleagues and other providers (primary care, police, ambulance, substance misuse, social care, voluntary sector), we aim to reduce by 20% the number of attendances to A&E for those within a selected cohort of frequent attenders who would benefit from mental health and psychosocial interventions, and establish improved services to ensure this reduction is sustainable. **Progress against this priority** There has been good partnership working towards this across the county and the Trust has been a strong partner in this work. All requirements have been achieved so far, and a final audit at the end of the year will review the clinical impact of all the work undertaken. There is also now planning for next year, as the focus broadens expectations of reduced A&E attendance to beyond the cohort and into a broader population of people with a primary mental health problem.

Responsive **CAMHS and adult mental health** d) **Transitions out of children and young people's mental health services (CYPMHS/CAMHS)**	**CQUIN 5: Transitions out of children's and young people's mental health services (CYPMHS/CAMHS)** This priority aims to incentivise improvements to the experience and outcomes for young people as they transition out of Children and Young People's Mental Health Services (CYPMHS) into adult mental health services, other CCG commissioned services or primary care. This involves evidence of joint plans between services, surveys of young people with monies apportioned to how well we score on these surveys. **Progress against this priority** This has been approached creatively by our CAMHS colleagues, with much of the required developments, e.g. the creation of an audit to review the family experience of the transition, produced in partnership between young people, parents and our staff. We have achieved all requirements so far, and are optimistic that performance when audited will be strong and will meet our own and our commissioners' expectations. One potential area of concern that might potentially impact on experience is if the young person is trying to transition into a working age adult neighbourhood team, bearing in mind the current time taken to access some of these.
Effective **Adult mental health** – **18+ inpatient services** **e) Preventing ill health by risky behaviours – alcohol and tobacco**	**CQUINs 9a to 9e: Preventing ill health by risky behaviours – alcohol and tobacco** This CQUIN seeks to help deliver on the objectives set out in the Five Year Forward View (5YFV), particularly around the need for a '…radical upgrade in prevention…' and '…incentivising and supporting healthier behaviour'. The proposal also supports delivery against the 5YFV in how it is supporting people to change their behaviour to reduce the risk to their health from alcohol and tobacco. There are five parts to this CQUIN: **9a:** **Tobacco screening:** the percentage of unique adult patients who are screened for smoking status AND whose results are recorded (unique meaning that we exclude any repeat admissions) **9b:** **Tobacco brief advice:** the percentage of these patients who smoke AND are given very brief advice **9c:** **Tobacco referral and medication offer:** the percentage of these patients who are smokers AND are offered referral to stop smoking services AND offered stop smoking medication. **9d:** **Alcohol screening:** the percentage of unique adult patients who are screened for drinking risk levels AND whose results are recorded **9e:** **Alcohol brief advice or referral:** the percentage of unique patients who drink alcohol above lower-risk levels AND are given brief advice OR offered a specialist referral. **Progress against CQUINs 9a to 9e** This initially brought significant challenges and concerns for us around accessing the relevant sample for data screening, together with gaps in ward staff awareness of where in the electronic patient record system this would be recorded. Whilst recognising that we needed to report accurate data and improvement, these challenges have been approached through a combination of a focus on quality improvement

	and a focus on robust data. As a result, from a starting point of a high level of variance in performance, we are now much more confident in the approach to this on the wards and our ability to subsequently report our performance accurately.
Safe **G) Deliver specific NON CQUIN requirements Sign up to safety**	'Sign up to Safety' is a national patient safety campaign announced in March 2014 by the Secretary of State for Health. In signing up, the Trust has committed to strengthen patient safety by making initial pledges against each domain and describing the actions the Trust will undertake in response to the five campaign pledges (as detailed below). **1. To implement cardio-metabolic assessment and treatment for patients with psychoses in the following areas (as in the aforementioned CQUINs 3a and 9a to 9e)** As mentioned earlier, whilst this is a challenging pledge to meet all the expectations of, we have strong and creative progress in some areas around physical health assessment and interventions, with a plan to share this good practice across the Trust over 2018/19. As part of this pledge we now have a Physical Healthcare Strategy, and we have appointed a Clinical Skills Tutor in physical healthcare to develop staff around physical healthcare, including nutrition and hydration. As mentioned earlier, we are reporting quarter-by-quarter improvement in assessing and offering interventions to our inpatients around smoking and alcohol. **2. Reducing the number of suicides** The Suicide Prevention Strategy has been completed and is described elsewhere in this report in Part 3. Safety planning (the Trust's approach to risk assessment and risk management) training has been continuing, and clinical staff have been actively involved in adapting and amending our safety planning tool to ensure it meets clinical need. An amended version for CAMHS is being piloted, and was developed in partnership with staff, young people and parents using CAMHS services. Colleagues in our Centre for Research and Development continue to co-ordinate the East Midlands Self-harm and Suicide Research Network. **3. Reduce violence through an initiative called 'Positive and Safe'** We have now implemented a Positive and Safe Strategy, and we continue to audit if we have offered a de-brief to any of our service users who have spent time in our seclusion room. Seclusion training for doctors is planned, and we have implemented the bi-monthly Positive and Safe Steering Group. **4. Safety in transition from CAMHS to adult mental health services (as in the aforementioned CQUIN 5)** Our progress in this will be monitored via the same audits that are in place for CQUIN 5. The results of these will be published at the end of Quarter four, but initial expectations are positive. **5. Reduction in the number of patient safety incidents** Our external auditors have identified that in comparison to other similar Trusts we have a relatively low number of recorded incidents. Therefore, to offer assurance of a healthy reporting culture of all

	incidents, not just patient safety, we are spending time with areas of low incident reporting to review their approach. The Trust's Risk Management Team continues to support clinical areas in providing reports to enable analysis of themes and tends and identify any changes required as a result of incidents, risks or complaints. We are also exploring different ways of supporting teams to learn lessons from incidents. As part of this we have relaunched 'Practice Matters', a Trust publication that offers an overview and examples of learning from incidents, complaints or compliments. Another example is how our Medical Director hosted an event where he guided a large group of staff through the learning from a local homicide involving someone who used our services.
Effective **NICE guidelines**	Our goals from this year's review of NICE processes were: • People using our services receive NICE-guideline-informed interventions • We have processes that make it as easy as possible for staff to provide these interventions • That as part of routine practice, we support our staff to provide NICE-guideline-informed interventions when in their judgement it is clinically appropriate to do so, and when it is the service user's preference Some specific guidelines have been mapped within their respective clinical areas, with self-assessment guiding subsequent service planning. These include, but are not limited to: i. Looked after children and young people ii. Transition from children's to adults' services for young people using health or social care services iii. Eating disorders: recognition and treatment **Progress of the NICE Steering Group** A monthly NICE Steering Group has been established, a multi-disciplinary group that represents all divisions. The Terms of Reference for this group are in line with those expected from the NICE 'Into practice' guide Members of this group are prioritising guidance to be reviewed for compliance within the Trust, and also supporting Divisions in setting their own priorities of guidelines for compliance review. As an example, colleagues in Children's and Central Divisions have elected to review three guidelines each. All these reviews are being completed using the baseline audit tool supplied by NICE, to ensure that we have a clear and evidence-based system. We will be overseeing these compliance reviews centrally and are progressing with the development of an electronic database for how we monitor this. Within the NICE Steering Group we also monitor emerging guidance for compliance review, and opportunities for involvement in consultations around NICE Guidelines and NICE Quality Standards. As an example, we have recently submitted a co-ordinated response on behalf of the Trust to the consultation on the draft NICE Guideline on Decision-making and Mental Capacity. One agreed initial compliance assessment priority is the NICE Guideline for Psychosis and Schizophrenia in Adults, given the

	prevalence of this in our service user population and the national quality improvement focus for this population, including physical healthcare. Colleagues in Campus and Neighbourhood Divisions have elected to review this jointly, given the shared pathway. **Summary of progress against this priority** The Trust now has a structure to oversee assessments of compliance with appropriate NICE clinical practice guidelines. Some guidelines are being prioritised and these will be the ones mapped first. Given the number of existing and emerging guidelines that apply to the Trust, moving to a position of full compliance will not be achievable in the short term. However, how the NICE Steering Group prioritises guidelines to review in line with clinical need or organisational priority will help to mitigate any current risks, as will the structure now available to capture existing or current reviews that were being undertaken individually in teams but were previously not centrally held or reported.
Caring **Autism** All staff to have access to and undertake **autism awareness training**	"Improving training around autism is at the heart of the autism strategy for all public service staff but particularly for those working in health and social care. This includes not only general autism awareness training, but also different levels of specialist training for staff in a range of roles, where this is needed to fulfil their responsibilities and for those who wish to develop their knowledge of autism" (*Statutory guidance for Local Authorities and NHS organisations to support implementation of the Adult Autism Strategy 2015*). Commissioners set us a target to achieve 50% of all staff undertaking Autism Awareness Training by the end of 2017/18 to increase to 75% of all staff by 2018/19. As at 15 March 2018, 1,594 of our staff have completed this training, therefore our performance against this target is 65.2%.

2.2 Statements of assurance from the board

This section is a series of statements from the Board for which the format and information required is set out in regulations and therefore it is set out verbatim.

1.	During 2017/18 Derbyshire Healthcare NHS Foundation Trust provided and/or sub contracted four relevant health services. The Trust provided NHS services to children, young people and families, people with learning disabilities, people experiencing mental health problems, and people with substance misuse problems.

1.1	Derbyshire Healthcare NHS Foundation Trust has reviewed all the data available to them on the quality of care in all of these relevant health services.

1.2	The income generated by the relevant health services reviewed in 2017/18 represents 91% of the total income generated from the provision of relevant health services by Derbyshire Healthcare NHS Foundation Trust for 2017/18

National Clinical Audits & National Confidential Enquiries
Participation in clinical audits and national confidential enquiries

2	During 2017/18 four national clinical audits and two national confidential enquiries covered relevant health services that Derbyshire Healthcare NHS Foundation Trust provides

2.1	During that period Derbyshire Healthcare NHS Foundation Trust participated in 100% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

2.2	The national clinical audits and national confidential enquiries that Derbyshire Healthcare NHS Foundation Trust was eligible to participate in during 2017/18 are as follows: 1. POMH-UK (Prescribing Observatory for Mental Health-UK) Topic 17a: Use of depot/Long Acting Injectable (LAI) antipsychotic medication for relapse prevention 2. POMH-UK Topic 15b: Prescribing valproate for bipolar disorder 3. POMH-UK Topic 16b: Topic Rapid tranquillisation 4. National Clinical Audit of Psychosis (NCAP) 5. National Confidential Enquiry into Patient Outcome and Death: Young People's Mental Health study 6. National confidential inquiry into suicide and homicide by people with mental illness

2.3	The national clinical audits and national confidential enquiries that Derbyshire Healthcare NHS Foundation Trust participated in during 2017/18 are as follows: 1. POMH-UK (Prescribing Observatory for Mental Health-UK) Topic 17a: Use of depot/Long Acting Injectable (LAI) antipsychotic medication for relapse prevention 2. POMH-UK Topic 15b: Prescribing valproate for bipolar disorder 3. POMH-UK Topic 16b: Topic Rapid tranquillisation 4. National Clinical Audit of Psychosis (NCAP)

	5. National Confidential Enquiry into Patient Outcome and Death: Young People's Mental Health study 6. National confidential inquiry into suicide and homicide by people with mental illness

2.4	The national clinical audits and national confidential enquiries that Derbyshire Healthcare NHS Foundation Trust participated in, and for which data collection was completed during 2017/18, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry. 1. POMH-UK (Prescribing Observatory for Mental Health-UK) Topic 17a: Use of depot/Long Acting Injectable (LAI) antipsychotic medication for relapse prevention - 32/32, 100% 2. POMH-UK Topic 15b: Prescribing valproate for bipolar disorder 23/23, 100% 3. POMH-UK Topic 16b: Topic Rapid tranquillisation - the data collection for this audit is currently under way. The intention will be to enter 100% of patients identified. 4. National Clinical Audit of Psychosis (NCAP) – 166/200, 83% 5. National Confidential Enquiry into Patient Outcome and Death: Young People's Mental Health study – 21/21, (100% - sample for case selection) 6. National confidential inquiry into suicide and homicide by people with mental illness – (8/8, 100%)

2.5 2.6 2.7 2.8	The reports of two national clinical audits were reviewed by the provider in 2017/18 and Derbyshire Healthcare NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided: **POMH-UK Topic 16a: Rapid tranquillisation** Actions for improvement include dissemination of audit results by Medical Director to relevant Consultants and the Medicine Matters newsletter sent to relevant wards. Actions taken around debrief and review for implementation via Positive and Safe Group. Liaison with the Paris Electronic Patient Records, team to have available post-injection physical monitoring forms (these are currently paper). Assurances of monitoring as part of ward audit brought to Medicines Safety every quarter with local re-audit of prescribing with vignettes every six months. **Topic 1g & 3d: Prescribing high-dose and combined antipsychotics** Actions for improvement include wide dissemination to feed back audit results and actions for improvement, to be able to identify high-dose antipsychotics on PARIS, Electronic Patient Records, and as such need for e-prescribing. For Care Plans to be in place on PARIS for high-dose patients and mechanisms to be established at the PARIS Clinical Reference Group by which they can be readily identified. Assurance that as part of the inpatient clerking process ECGs are routinely being performed. The Drugs and Therapeutics Committee supports the proposal of the PARIS Clinical Reference Group to reconfigure capturing/reporting of physical monitoring. To determine the feasibility of carrying out the audit in Neighbourhoods through Neighbourhood COAT. For senior inpatient prescribers to review prescribing on their ward with a specialist pharmacist, working with Heads of Nursing to support the implementation of weekly prescribing meetings at ward level (this is also an action relating to rapid tranquilisation). The reports of 21 local clinical audits were reviewed by the provider in 2017/18 and Derbyshire Healthcare NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

	Title	Improvement actions
1.	Staff documentation of	Actions for improvement include dissemination of results to the Safeguarding Team including presentation of results at the

their roles, responsibilities and actions when involved in the child protection safeguarding process	safeguarding team meeting. Dissemination to the wider Trust community. Named nurses/advisers to lead for their respective localities to highlight areas for improvement at locality meetings, and to coordinate delivery of their respective safeguarding supervision sessions to act as a training forum covering the process of completing the forms comprehensively. The Chair of Safeguarding Operational Meeting to receive assurance by monitoring use of safeguarding supervision sessions as training forums to improve compliance. A new safeguarding unit to be developed within the SystmOne electronic patient record system in order to allow for comprehensive completion of safeguarding plans. To re-audit in order to establish that recommendations have been implemented and are established as best practice and look at the possibility of CAMHS inclusion.
2. On-call response time re-audit	Actions for improvement include dissemination of results to old-age consultants at the monthly consultant meeting and also to ward managers for discussion in team meetings, to encourage nursing staff to escalate any delays in contacting the Doctor on-call. Ward managers for old-age psychiatry wards (Kingsway) to use results of audit in ward meetings to reiterate policy of escalation to on-call consultant if no response from duty doctor within 20 minutes. Switchboard to be reminded if a Doctor is off site where telephone reception could be a problem (London Road Community Hospital/Royal Derby Hospital and Kingsway site). This will also be highlighted by the doctor explaining out-of-hours working at Junior Doctors induction.
3. Re-audit of Discharge documentation from Outpatients Department	Actions for improvement include dissemination of results to all Community Mental Health Teams/Consultants and presentation of the audit at the Trust Medical Advisory Committee. Development of an outpatient discharge summary template on PARIS with the PARIS Development Team. All Consultants to use this when discharging patients from out-patient clinics to GPs. This is for use when someone is completely discharged from service. Junior doctors to be made aware of the outpatient discharge summary template during induction/supervision. To re-audit in order to assess effectiveness of PARIS template in improving discharges from service.
4. Families' knowledge of and contribution towards their safeguarding plan	Actions for improvement include dissemination of results to the Safeguarding team and presentation at the Safeguarding Team Meeting as well as circulation to the wider Trust community. Named Nurses/Advisers to lead for their respective localities to highlight areas for improvement at Locality Meetings; and to coordinate delivery of their respective Safeguarding Supervision sessions to act as a training forum covering the process of completing the forms comprehensively. The Chair of the Safeguarding Operational Meeting to receive assurance by monitoring use of Safeguarding Supervision sessions as training

	forums to improve compliance. A new Safeguarding Unit to be developed within SystmOne to in order to allow for comprehensive completion of safeguarding plans. To re-audit in order to establish recommendations have been implemented and are established as best practice and look at the possibility of CAMHS inclusion.
5. Documentation of capacity and consent on PARIS in DHCFT inpatient units	Improvement actions include dissemination of the report to all inpatient wards, Area Service Managers, Associate Clinical Directors and medical staff. Enhanced training/support for all staff on capacity assessments and the means by which they must be recorded on PARIS. Further face-to-face teaching sessions to be made available. On-line Mental Capacity Act modules to be reviewed and streamlined. Continued direct support to all staff on inpatient units from the Medical Capacity Lead and the practice development and compliance lead for capacity, to allow staff to gain confidence and improve recording efficiency. Specific support to be offered to those inpatient units achieving lower audit scores. Specific staff groups to receive targeted training, especially with regard to the need to assess and record both the capacity to consent to assessment and for treatment. Also ensuring correct recording of "Referral ID" codes for each inpatient to allow all capacity entries appropriately. A formal decision to be made and disseminated determining which staff member is expected to take responsibility for the assessing and recording of capacity to consent to admission and capacity to consent to treatment, especially among junior doctors. Email prepared for Medical Director to send out to all junior staff detailing responsibilities. To re-audit in order to establish recommendations have been implemented and are established as best practice.
6. Documentation of Capacity and Consent on Paris in DHCFT community mental health teams	Improvement actions include dissemination of audit report to all community team managers, Area Service Managers and Associate Clinical Directors. In addition, reminding all staff not to use paper forms to record capacity. Cascade to all community team members the agreed advice as to the process of both performing and recording the assessment of capacity in community patients. Clear and unambiguous advice to be provided to all community team members as to the methods and systems in place for recording capacity. Enhanced training/support for all staff on capacity assessments and the means by which they must be recorded on Paris. Further face-to-face teaching sessions to be made available. On-line Mental Capacity Act modules to be reviewed and streamlined; continued direct support to all staff on inpatient units from the Medical Capacity Lead and the Practice Development and Compliance Lead for Capacity to allow staff to gain confidence and improve recording efficiency. Specific support to be offered

	to those inpatient units achieving lower audit scores. To re-audit in order to establish that recommendations have been implemented and are established as best practice with consideration to be given to establishing a similar audit of those community teams who were not included in this audit – CAMHS, children's services, substance misuse services and medical outpatients.
7. Infection control standards: CAMHS	Improvement actions include: Sandpits should only be used for therapeutic reasons. CAMHS to agree use and evidence this and keep to a minimum. If not required, to be disposed of. CAMHS to standardise approach to infection control across all sites to prevent variation occurring and reduce risk of infections occurring. CAMHS to agree & maintain standards/action points above and implement across all sites. A re-audit schedule is to be agreed.
8. Infection control standards: Special Schools	Improvement actions include: Completion of previous actions from audits to be added to the survey form to capture in subsequent audits. In discussion with the Trust Infection Control Committee (TICC) and Managers of Special Schools, to decide on frequency of audit and self-completion by staff. TICC to decide and recommend which actions raised by the audit can be met through the Trust and which through the schools.
9. Referral criteria to CRHTT	Improvement actions include: Dissemination of results to the teams/referrers identified in the audit in order to encourage debate and discussion for further improvement in performance. Presentation of the audit results at the Crisis Resolution Home Treatment Team (CRHTT) meeting. Visiting GPs to discuss the audit results and how to improve the referral process and develop referral criteria – doctors to visit the city and county GPs. Producing a survey to determine and collate what the expectations are of the referrers from the CRHTT. Produce an online questionnaire that will be e-mailed to the referrers. Developing an aide memoire or process chart to help referrers when considering whether patients are suitable for referral to the CRHTT. To refer to existing available documentation in order to see whether this is sufficient, can be adapted or whether something new is required. To re-audit in order to establish that recommendations have been implemented and are established as best practice.
10. Evaluation of patient information provision and the use of Nicotine Replacement	Improvement actions include: Dissemination of results to the Campus and Neighbourhoods Associate Clinical Directors, the Deputy Medical Director and Medical Educators for further distribution. Nicotine Replacement Therapy audit presentation to doctors/healthcare professionals Trust-wide and Friday afternoon doctors' educational meeting. Smoke-free audit

Therapy in adult mental health inpatients	presentation inviting ward managers of inpatient wards. Recommend staff participate in smoking cessation training, an e-learning module on Connect available, covering how to correctly prescribe and supply alternative therapies to smoking. Recognising early in an admission whether a patient smokes and what can be done to mitigate their inability to smoke in hospital - Added section on PARIS form for patients being referred for hospital admission by the community/crisis teams. Early provision of nicotine replacement therapy +/- counselling to assist patients in reducing their nicotine requirement which is currently already in place, performed by ward doctors, pharmacists and nurses. A printed information source for patients about the types and benefits of different types of nicotine replacement. Smoking leaflets with advice about quitting are already available - a supply should be printed and available on the ward.
11. Identification of Adverse Childhood Experiences of new inpatient admissions	**I**mprovement actions include: To generate debate on what constitutes a reasonable personal/biographical history by discussions amongst doctors at an appropriate forum/meeting. After discussion at the Hartington Unit Teaching Programme/Audit Meeting, the outcomes to be fed back to the schools of psychiatry that cover Derbyshire and that in turn feed into the Education Committee of the Royal College of Psychiatrists. Dissemination audit and action plan to the doctors at the Hartington Unit (Morton, Tansley & Pleasley Wards) and Radbourne Unit (Wards 33, 34, 35, 36 and the Enhanced Care Ward) and Campus and Neighbourhoods Area Service Managers as well as the Associate Clinical Directors. Presenting the audit at the Junior Doctors' Meeting. To explain the adverse childhood experiences study (many were present during a lecture on this early in the year) and the importance of ensuring our personal histories are more in-depth and include explicitly asking about the 10 childhood traumatic experiences. To re-audit in order to establish recommendations have been implemented.
12. Is the physical wellbeing of patients with an eating disorder assessed adequately in line with current guidelines?	Improvement actions include: Dissemination of report and action plan to the CAMHS Eating Disorder Team. Presenting to the Eating Disorder Team using audit findings to reinforce and increase the awareness of the importance of physical health and adhering to Management of Really Sick Patients with Anorexia Nervosa (MARSIPAN) guidelines. To devise a standard proforma for use by Eating Disorder professionals at CAMHS. The audit was presented and discussed at the CAMHS Consultant Meeting on 19/7/17 to gain consensus on this recommendation. Once the proforma has been devised the PARIS Development Team will be asked to help create this. To be discussed and implemented via the PARIS Development

	Team. To re-audit in order to establish that recommendations are embedded.
13. Section 17 of the Mental Health Act leave documentation re-audit	Improvement actions include: Dissemination of results to areas that participated in audit and to the Associate Clinical Directors and Medical Education Leads. Presentation of audit at the Hartington Unit clinical governance meeting. Address issues of Section 17 (S17) forms being completed by Nurses and then signed by a doctor by ensuring multi-disciplinary teams discuss the decision and risk-related issues and make a decision and then the RC (Responsible Clinician) completes the S17 based upon this collective decision to raise at MHAC in order to agree remedial action(s). Amending the electronic S17 form on PARIS to indicate a multi-disciplinary discussion and decision was made prior to the S17 being initiated. Refinement to the S17 electronic record so that form is intuitive and helpful to all clinicians and emphasis of the use of the electronic form. Wards to have electronic whiteboard screens that prompt/alert clinicians on different aspects of patients' stay e.g. S17 leave review date, Mental Health Act status, T3/T2 status (patient's consent to treatment or not), etc. Since the form is now electronic, the review dates might get missed and there isn't a physical paper form to cross out. The electronic whiteboard will prompt staff when S17 leave has expired so it will have to be reviewed. The Hartington Unit has had screens for six months. Rollout under way (Radbourne, Kingsway and London Road Community Hospital). Practicality and application to be discussed at the Mental Health Act Committee Meeting of taking photographs of patients when they are admitted for identification purposes (currently done on the older adult dementia wards). The patient can decline, but this makes identification to the police easier if a patient absconds whilst on leave. To re-audit or audit as to whether multi-disciplinary team meetings are happening prior to S17 being completed.
14. Physical health monitoring of patients on Clozapine	Improvement actions include: To create a checklist that focuses on the areas of poor compliance, to reference when treating patients with psychosis and schizophrenia. This would be for patients not just on Clozapine. Screening checklists to be placed on clinic room walls. To ask all inpatient medical staff at the point of patient discharge to book a follow-up appointment with the Physical Healthcare Clinic in Derby City within three months. The Consultant lead has actioned this as part of the 'physical health handover on discharge in patients commenced on antipsychotic medication' audit. An email was sent to consultants covering the Derby city area in the first instance.
15. Venous	Improvement actions include: Dissemination of audit outcome to

Thromboprophyl-axis Older Adults	Cubley Court and Ward 1 staff. Presentation at the postgraduate meeting. Focussing on the venous thromboembolism (VTE) admission statement. To have VTE discussed at the north and south inductions. As no facility exists to provide blood tests at London Road Community Hospital or Kingsway site the junior doctors are to be made aware that they need to do the bloods urgently and prescribe Enoxaparin if a patient were to become eligible for prophylaxis. To work with the PARIS development team to make changes to the clerking proforma in order to reduce the admission clerking burden. Consultant Lead to work with PARIS Developer. VTE assessment split into three steps. If the patient scores negative in the first step (mobility), steps two and three won't appear in the VTE assessment ends for those patients. This will be the case in 90% of patients who have normal mobility and so these assessments will be complete with one tick box. Assessments will be required dependent on positive patient scores. To re-audit.
16. Establish the quality of Safeguarding Children and Clinical Supervision	Improvement actions include: Presentation of results at the Operational Team Meeting. Managers to ensure all staff have a supervision contract completed. Each Locality Manager to lead for their respective localities to utilise locality meetings as forums to highlight the areas of improvement. Consistent tools to use in clinical supervision, accessible on SystmOne. Supervisors to promote and use ratified supervision tools. Clinical record audit tool – supporting staff with analysis of records and identifying areas of record keeping that need improvement. Supervisors to audit clinical records with practitioners in supervision. Re-design recording of supervision document. Give more guidance on clinical and managerial supervision, ensuring priority topics are covered. To present draft supervision record to the Clinical Reference Group. Band 7 & 8, 0 -19 staff/managers to attend level four training on effective clinical supervision (ensure consistent approach to supervision within service). Consolidation of supervision training/workshop for managers. To deliver workshop revisiting tools and exploring challenges and successes. To develop a training package to improve understanding and implementation of analysis in record keeping and supervision for delivery to 0 -19 staff.
17. Clinical audit of section 58 mental health act – updated plan for 2017/18 fourth re-audit	Improvement actions include: Disseminate results to inpatient Responsible Clinicians (RCs). Continued use of the Section 58 flow chart incorporated into the reminder letters. The Mental Health Act (MHA) Office to continue providing reminder letters to relevant RCs at appropriate times. To continue with the practice of utilising "MHA Supporters" to engage with RCs. Continue engaging the ward managers to act as "MHA supporters" with copies of "prompt letters" being sent to them at the relevant time

		so they can provide regular reminders of the need to complete the process (especially in regard to the early securing of a Second Opinion Appointed Doctor (SOAD)). Consultant Lead to attend Medical Management Committee meeting to disseminate results and arrange plan of support for inpatient RCs. To continue the electronic alert on PARIS that reminds clinicians what they need to discuss with the patient when consenting them to treatment and of the need to record evidence effectively. There should be only one location in which consent to treatment with psychotropic medication details is recorded – the "consent to treatment with psychotropic medication" section of the "capacity and consents" stem within the "central index". Regular and clear indicators and reminders should be utilised to ensure all RCs are aware of and follow this process and of the need to acknowledge formally a referral to a SOAD in the relevant PARIS section. The development of a failsafe to avoid breaches of the MHA where patients do not have a T2/T3 or Section 62 of the MHA [which allows for emergency treatment of a detained patient]**.** The MHA office has a system in place to remind RCs and advise them accordingly if the forms are not received and inform the ward and community team staff accordingly and advise them not to administer any further medication until the correct paperwork is in place. Provide assurance on improvements through annual audits. A re-audit towards the end of 2019.
	18. Physical activity in Care Programme Approach (CPA) care plans	Improvement actions include: Dissemination via Medical Staff Committee. Presentation of poster at physical health in psychiatry meeting. Although there are various interventions under way looking at improving the recording of physical health observations, the physical activity question remains unanswered. There is a national initiative called Moving Medicine, from Public Health England, and the different Royal Colleges are being approached about the promotion of physical activity. Propose to set up, in this context, a national survey of psychiatrists (a copy of one done by Public Health England last year for GPs) as part of this. This will focus on exercise and physical activity and the immense potential benefits this can bring both for our patients' physical health and also the growing evidence for mental health, e.g. in depression studies coming up with effect sizes of 0.8. To re-audit.
	19. Patient awareness of smoke-free Trust status	Improvement actions include: Evaluation of patient information provision and the use of Nicotine Replacement Therapy in adult mental health inpatients
	20. Self-harm in Older Adults in DHCFT; Liaison	Improvement actions include: Present audit at the Campus Clinical and Operational Assurance Team (COAT) meeting. Disseminate and promote discussion of key findings to the

North	Mental Health Liaison Team (MHLT) at team meeting and via email. Any action required to be managed through 'internal' operational/clinical processes. To disseminate key findings to the older adult community team managers and older adult functional ward (North) via email for wider dissemination to their teams. Dissemination of aide memoire to MHLT, older adults community team, older adults functional wards and consultant lead to disseminate at junior doctor induction. Re-audit of both adults and older adults north and south liaison self-harm assessments in MHLT.
21. Audit of pre- and on-admission assessments of capacity to consent to admission and treatment on a Derbyshire Old Age Psychiatry functional ward	Improvement actions include: Disseminate results to participating services via email including link to Mental Capacity Policy. There is now a standardised form on Paris ("Record of Capacity to Consent" in the "Consents and Capacity" section of PARIS) and an accompanying manual to explain its use has been launched for all the medical staff. Training on assessment of capacity to become part of mandatory training/the induction process, as well as interplay between the Mental Health Act and Mental Capacity Act. Providing patients with information on admission relating to their capacity to consent. If patients are not clerked in at all this needs to be reported as an incident on Datix by the Ward Manager. To re-audit in order to establish recommendations have been implemented.

3	The number of patients receiving relevant health services provided or sub-contracted by Derbyshire Healthcare NHS Foundation Trust in 2017/18 that were recruited during that period to participate in research approved by a research ethics committee – 1,543.

4	A proportion of Derbyshire Healthcare NHS Foundation Trust's income in 2017/18 was conditional on achieving quality improvement and innovation goals agreed between Derbyshire Healthcare NHS Foundation and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.
4.2	Further details of the agreed goals for 2017/18 and for the following 12-month period are available electronically at [weblink is being explored].

The monetary total for income in 2017/18 conditional on achieving quality improvement and innovation goals	£2,710,443
The monetary total for the associated payment in 2016/17	£2,648,944

5 5.1	Derbyshire Healthcare NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is a registered organisation assessed as Requires Improvement overall. Derbyshire Healthcare NHS Foundation Trust has no conditions on registration.

	The Care Quality Commission has not taken enforcement action against Derbyshire Healthcare NHS Foundation Trust during 2017/18.

7	Derbyshire Healthcare NHS Foundation Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

8. 8.1	Derbyshire Healthcare NHS Foundation Trust submitted records during 2017/18 to the Secondary Uses Service for inclusion in the hospital episode statistics, which are included in the latest published data. The percentage of records relating to admitted patient care which included the patient's: i. Valid NHS number - 99.7% (based on April 2017 – November 2017 published dashboard) ii. General Medical Practice Code – 100% (based on April 2017 – November 2017 published dashboard) The percentage of records relating to outpatient care which included the patient's i. Valid NHS number - 100% (based on April 2017 – November 2017 published dashboard) ii. General Medical Practice Code – 100% (based on April 2017 – November 2017 published dashboard)

9	Derbyshire Healthcare NHS Foundation Trust's Information Governance Assessment Report overall score for 2017/18 was 98% and was graded Satisfactory (so a green rating)

10	Derbyshire Healthcare NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2017/18 by the Audit Commission. However, the Trust underwent the annual clinical coding audit as part of the V14.1 IG Toolkit and attained the highest Level Three score.

11	Derbyshire Healthcare NHS Foundation Trust will be taking the following actions to improve data quality: We continue to strive to achieve high quality, consistent information via increased integration between systems, both internal and external, and will include use of the summary care record as a source. We run continued campaigns to ensure awareness of the importance of ensuring our data is accurate, benchmarking other Trusts and learning from exemplars. The Trust's Data Quality Policy will continue to be implemented, with the following aims: • To ensure that there is a shared understanding of the value of high-quality data on improving service delivery and quality and outcomes of care • To ensure that the focus of improving data quality is on preventing errors being made wherever possible; • To ensure that regular validation, feedback and monitoring processes are in place to identify, investigate and correct data errors when they occur. • The policy has also been updated around the Accessible Information Standards. • Following internal audit recommendations the Trust has implemented a new data assurance and data quality kite mark process. This is based on Trust performance dashboard indicators and covers: o Granularity o Timeliness o Audit

	○ Source ○ Validation ○ Completeness ○ Sign Off **Further actions:** • Integration between our electronic patient record systems so that demographics for service receivers are synchronised and up to date • Introduction of a new online information system, a single reference point to show all the different services and electronic patient record systems involved for the patient. This is accessible directly from within an electronic patient record. • Integration with external organisations and enhanced used of secure electronic processes (e.g. automating test results) • Enhanced use of the National SPINE and update of our electronic patient record systems • Continued and improved use of existing data quality and performance management exception reporting • Improved records and supervision audit functionality supporting minimum standards and Accessible Information Standard, Dual Diagnosis (links between mental health and drug and alcohol services) as well as wider inclusive approach to improve carer information, family members and other associate people • Continued and improved use of external data quality reports and benchmarking to maintain high standards • Improved registration and data collection forms to help capture information for new patients as well as capturing changes and confirming current information for existing patients • To improve Information Governance mandatory and yearly training results and remove barriers to this aspiration.

Mortality data

The following data presents the Trust position around deaths and serious incidents. We are looking at similar information published by other Trusts and a regional meeting is planned. Lincolnshire, for example, reported 834 deaths compared to our 2,282 in the same period. However, direct comparisons cannot be made due to differences in Trusts' portfolio of services and the variation in background demographic profiles.

We investigate all deaths which seem untoward including of course suicides, homicides and inpatient deaths. There are many more deaths, particularly in older people and in those with learning disability that would be expected due to physical co-morbidities at that age. We are undergoing case reviews of selected cases and, for example, are scrutinising deaths where there may have been delay in speech and language therapy assessments in patients with a learning disability. We are working with NHS Digital to obtain the cause of death for all our patients so we can compare this against the demographic background patterns of death on a geographical basis. This will tell us whether our patients are dying prematurely compared to their population cohort. This will inform public health information and we have had preliminary discussions with public health about this. We have modified a tool for the review of deaths in this way and will be looking at the Royal College of Psychiatrists' version which has recently been published and to which we contributed.

We think the most relevant comparison is between the death rates of our patients (broken down into such as different clinical groups according to age, gender, ethnicity and diagnosis) and that of the rate of the background population from which they come. This will only be possible when we obtain the data of Cause of Death for all our patients from NHS Digital, as has been applied for. Once we have obtained the data we will link with public health colleagues in Derbyshire and Derby city as discussed at the Trust Board.

As regards death in the older population we are often engaged with people until their death through our dementia and liaison services, and therefore we would expect this population to form part of our overall death rate.

We will pilot the Mortality Review Tool published by the Royal College of Psychiatrists, comparing this to the one we have developed locally. The Mortality Reviews completed to date have given assurance based on an absence of concerns – one issue of Learning Disability Speech And Language Therapy assessments was picked up by the external Learning Disabilities Mortality Review (LeDeR) Programme, and are a draw on existing commissioned resources.

It takes a senior nurse and doctor 30 minutes to complete a review supported by admin colleagues who take considerably longer to prepare these and process the outcome. A review of 100 deaths would take a senior nurse and doctor a week to complete and administration would take significantly longer as they also have to take part in the reviews. Once we have completed the pilot phase a decision will be required as to whether we roll out the process, its scale and how this can be resourced. We will discuss this with other similar trusts to benchmark our approach.

The main learning from our reviews of deaths is that systems and processes to prevent deterioration and crises are far more likely to be effective than acute interventions based on risk assessments. This is because in mental health it is inherently unreliable to try and predict rare events such as suicides in individual cases. There will be many false negatives with adverse outcomes in apparently low risk

patients, and false positives which could lead to risk adverse practices which would be paradoxically ineffective or could even increase the risk. Our priority initiatives such as the review and relaunch of the Care Programme Approach, the development of safety planning and improvements in physical healthcare are therefore likely to save more lives than specific interventions in acute situations. This is not to say, of course, that we would not attempt to meet the needs of patients in crisis and do so regularly, e.g. through the application of the Mental Health Act. Our approach to risk assessment to underpin safety planning highlights the importance of seeing the patient in the context of their own life story with emphasis on historical risk factors, current risk factors and mitigation and diagnosis leading to a formulation including contingency plans. Communication is key, particularly with family and carers where the patient allows. We have also engaged in broader public health awareness through our suicide prevention strategy.

In order to enhance prevention we are developing a compassionate approach with our staff which we hope will engage them and be transmitted through patient care. A compassionate approach decreases stigma for patients suffering from mental illness and therefore helps enhance access. Following serious incidents, we approach investigations using compassionate principles to support staff and bereaved families. The compassionate approach is underpinned with clear lines of responsibility and accountability. In addition, we have a robust system of ensuring that individual clinicians and teams engage in reflective practice and quality improvement based on feedback from individual serious incident investigations.

27.1	During 2017/18, 2,472 of Derbyshire Healthcare NHS Foundation Trust's patients died (to be updated at year end). This comprised the following number of deaths which occurred in each quarter of that reporting period: • 638 in the first quarter; • 576 in the second quarter; • 578 in the third quarter; • 680 in the fourth quarter

27.2	31 case record reviews and 39 investigations have been carried out in relation to 2,472 of the deaths included in item 27.1. In 2 cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was: • 12 in the first quarter • 11 in the second quarter • 9 in the third quarter • 38 in the fourth quarter A further 46 investigations are ongoing.

27.3	None, representing 0% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient. In relation to each quarter, this consisted of: • None representing 0% for the first quarter

	• None representing 0% for the second quarter • None representing 0% for the third quarter • None representing 0% for the fourth quarter These numbers have been estimated using an amended form based on a national review tool called PRISM. The Trust has developed a Mortality Review Group which has been focusing on developing the systems and processes to support review and learning from deaths. This tool was chosen by The Mortality Review Group in preference to The Structured Judgement Review tool, as it was decided that the latter did not meet the requirements for mental health case note reviews. The Prism tool is a structure to support a multi-disciplinary review of a person's case records, to determine if there might have been any problems in health care, including acts of omission (inactions) or acts of commission (affirmative actions), to help us consider the proportion of any deaths that are avoidable.

27.4	The Mortality Review Group has case reviewed 37 deaths. This was undertaken by a multi-disciplinary team and it established that of the 37 deaths reviewed, 36 have been classed as unavoidable and 1 has been sent for further investigation under the Untoward Incident Reporting and Investigation Policy and Procedure. The Mortality Review Group is currently reviewing deaths of patients who fall under the following 'red flags': • Patient on end of life pathway, subject to palliative care • Anti-psychotic medication • Referral made, but patient not seen prior to death • Death of patient on Clozapine. Initial analysis of death notification information shows the most prevalent causes of death are: • Alzheimer's Dementia • Old Age • Pneumonia.

27.5	Below are examples of the recommendations following the review of deaths, through either the Untoward Incident Reporting and Investigation Policy and Procedure or Learning from Deaths Procedure. These recommendations are monitored by the Patient Safety Team. Actions taken and that will be taken: 1. Briefing to be circulated regarding 'Duty of Candour' and the MHA 1983: Code of Practice (Department of Health, 2015),'patients should be fully involved in decisions about care, support and treatment', and that the 'views of families, carers and others should be fully considered when taking decisions'. 2. Inpatient teams to be re-briefed on the principles of Clinical risk management and relapse planning, specifically in relation to inpatient care planning and discharge planning. 3. Inpatient team to be briefed on record keeping standards, specific involvement of patient and views of carers. 4. The Clinical and Operational Assurance Teams to consider/review the communication problems identified in the report between the Inpatient and Outpatient team and advice as to systems that need to be in place to overcome/address potential communication barriers 5. The Clinical and Operational Assurance Teams to consider the need for identifying patients who due to their complexity require a comprehensive case

	summary to inform clinicians in situations (frequent occurrence) when it would not be possible to review all records in the timespan available, for example, admitting doctors/nurses 6. Confirmation required in relation to requirements for the Trust when a patient has a diagnosis of Hepatitis C positive and our responsibilities to notify statutory bodies 7. To review the arrangements within the team where the Care Co-ordinator is a part-time worker 8. Access across both Paris and SystmOne electronic patient care records for all children's services staff to be considered 9. A communication system in the team to be considered which is consistent and includes a back-up to ensure the team know messages have been received such as a 'read message' response set up as a default on the email system for all clinicians 10. Consideration needs to be given to maximum caseloads and workload in general and the impact of this 11. Liaison Team Wi-Fi and accessibility to main computer to be reviewed 12. It is recommended that CRHTT (Crisis Resolution Home Treatment Team) develops how it offers support and makes contact with families and carers at assessment, including an information leaflet 13. The depth and assessment of suicidal thoughts needs exploration alongside consideration of protective factors when assessing suicidal ideation 14. Exploration of consent regarding families and carer with the service receiver, especially when a person has not given consent to contact 15. To approve an Operational Policy for Liaison South 16. To scope the possibility of being able to share information between Paris and SystmOne for community patients 17. The lead for Positive and Proactive Support Training to review the training requirements for all Rehabilitation services 18. Service planning for people with highly complex non-psychosis mental illness to be included in the responsive communities sustainability and transformation plan 19. The purpose and quality of inpatient admissions to be addressed collectively through the Bed Optimisation Project and the CRHTT review 20. To review policy in relation to relapse signature and guidance on relapse reduction, care planning and reviewing clinical history 21. Possibility of an information sharing agreement to be pursued with Pennine Care Trust. This would include reciprocal system access 22. Learning review to discuss importance of exploring family/carer concerns regarding relapse indicators, when it is advisable to access previous paper records and reciprocal communication with other organisations that work with service users on clinician caseloads 23. Scope an improvement project with three outcomes: (i) Staff support in waiting list management; (ii) Improvement on patient flow and discharge; (iii) Improvement work on support worker role including scope of practice on what work cannot be undertaken 24. Information sharing from Derbyshire Constabulary in relation to the Peer Review has been identified as an issue and will need to be addressed within the multi-agency partnership 25. For Substance Misuse services to undertake an audit to establish if physical health monitoring is undertaken on assessment and at least annually, which would include staff ensuring annual reviews have been completed via the GP 26. It is recommended that there is greater exploration around family involvement when a person is open to CRHTT. There needs to be a change with regards to viewing family involvement on a continuum rather than a 'yes or no' answer 27. Scope the possibility of a message system built into PARIS which is easily

	accessible and which flags up urgent messages 28. Liaison Team South to utilise a standard assessment proforma 29. Consider the notification system for MHA expiry of detention as well as the regularity of reviews of the Safety Assessment for inpatients 30. Revisit policies in relation to transfer, both operationally and clinically, to ensure that they include systems – particularly in relation to communication that would mitigate against such gaps in care occurring in the future 31. Paris to develop a way of tracking actions related to admission or care stays 32. Reiteration of standards for assessment of Waterlow Score as an assessment for Tissue Viability as per Trust policy 33. Body Map to be completed within four hours of admission

27.6	An assessment of the impact of the actions described in item 27.5 which were taken by the provider during the reporting period. In line with other Trusts, we are at the beginning of our learning journey around the impact of our actions with regards to learning from deaths. So far we have identified areas where lessons could be learned e.g. smoking cessation initiatives in nursing homes, but have found nothing untoward in any individual case. We have applied to NHS Digital to have information regarding the cause of death in all our patients and they have appointed a case manager and reviewed our Information Governance and declared that they are satisfied with this. Once we have this information we will be able to benchmark causes of death in patients with mental ill health compared to that of the background population in each locality. Learning from deaths will be a particular focus for 2018/19.

27.7	13 case record reviews and 25 investigations were completed after 1 April 2017, which related to deaths which took place before the start of the reporting period.

27.8	None representing 0% of the patient deaths before the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient. This number has been estimated using an amended form based on a national review tool called PRISM (see section 27.3 for further detail)

27.9	None representing 0% of the patient deaths during 207/18 are judged to be more likely than not to have been due to problems in the care provided to the patient.

2.3 Reporting against core indicators

13	**Seven-day follow-up for those on CPA** This is included as an indicator in response to concerns that the highest risk of suicide for a person discharged from psychiatric inpatient care is within the first seven days after discharge. Derbyshire Healthcare NHS Foundation Trust considers that this data is as described for the following reasons: It calculates the seven-day follow-up indicator based on the national guidance / descriptors. Numerator: Number of patients on the care programme approach (CPA) who were followed up within seven days after discharge from psychiatric inpatient care. Denominator: Total number of patients on CPA discharged from psychiatric inpatient

	care. Derbyshire Healthcare NHS Foundation Trust intends to take the following actions to improve this percentage, and so the quality of its services, by continuing to work to maintain our performance and ensure that all patients discharged from our inpatient care on CPA are followed up within seven days.

CPA seven day follow-up					
Indicator	End of 2015/16	End of 2016/17	End of 2017/18	National average	Highest and lowest scores of NHS Trusts and NHS Foundation Trusts
The percentage of patients on Care Programme Approach who were followed up within seven days after discharge from psychiatric inpatient care during the reporting period	96.98%	96.48%	98.68% (against a target of 95%)	95.94% (Quarter three national publication)	100% and 69.2% by region (Quarter three national publication)

https://www.england.nhs.uk/statistics/statistical-work-areas/mental-health-community-teams-activity/

17	**Crisis gatekeeping** Crisis gatekeeping ensures that least restrictive and community-based options to support the person at home are explored before a hospital admission is agreed. Derbyshire Healthcare NHS Foundation Trust considers that this data is as described for the following reasons: It calculates the crisis gatekeeping indicator based on the national guidance/descriptors. Numerator: Number of admissions to acute wards that were 'gate kept' by the Crisis Resolution and Home Treatment teams; Denominator: Total number of admissions to acute wards; Derbyshire Healthcare NHS Foundation Trust intends to take the following actions to improve this percentage, and so the quality of its services, by continuous monitoring to maintain the high performance against this indicator.

Crisis gatekeeping					
	End of 2015/16	End of 2016/17	End of 2017/18	National average	Highest and lowest scores of NHS Trusts and NHS Foundation Trusts
The percentage of admissions to acute wards	100%	98.87%	99.74 (against	98.3% (Quarter	100% and 84.3%

for which the Crisis Resolution Home Treatment Team acted as a gatekeeper during the reporting period.			a target of 95%)	three national publication)	(Quarter three national publication)

19	**Twenty-eight day re-admission rates (aged 16 and over)** Whilst we try to ensure hospital admissions do not go on for any longer than is required, if a person is discharged too quickly, or if plans are not robustly put in place or resources are not available to support that person after discharge, then this can make it more likely that they will be readmitted to hospital quite quickly. Derbyshire Healthcare NHS Foundation Trust considers that this data is as described for the following reasons: It calculates the re-admission rates based on the national guidance/descriptors. Numerator: Number of re-admissions to a Trust hospital ward within 28 days from their previous discharge from hospital; Denominator: Total number of finished continuous inpatient spells within the period; Derbyshire Healthcare NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of its services, by continuing to monitor and develop pathways of care. Whilst our percentage of people re-admitted within 28 days remains lower than in 2015/16, we note a slight increase here in comparison to 2016/17. One area that might challenge our progress on this is our current waiting times for a care co-ordinator in our Neighbourhood Teams, and therefore the waiting time for a person to access a comprehensive package of after-care. Our neighbourhood teams continue to work to find best ways forward within commissioned resources, and there is a current broad review of Neighbourhood Services.

Twenty-eight day re-admission rates (aged 16 and over)					
Indicator	End of 2015/16	End of 2016/17	End of 2017/18	National average	Highest and lowest scores of NHS Trusts and NHS Foundation Trusts
28-day re-admission rates for patients aged 16 and over	9.85%	8.25%	9.1%	Not available	Not available

22	**Community Mental Health Survey** The Trust's 'Patient experience of community mental health services' indicator score with regard to a patient's experience of contact with a health or social care worker during the reporting period was 7.3, which is deemed to be 'about the same as other Trusts'. The Trust considers that this data is as described for the following reason: it is provided by an external organisation whom we commission to undertake the survey. Derbyshire Healthcare NHS Foundation Trust has taken the following actions: the Trust will promote the Friends and Family test as a way of monitoring our progress. Also, the

	Trust is third out of all Trusts surveyed nationally with regards with regards to the question: “Overall view of mental health services – feeling that overall they had a good experience”

Benchmarking Network

Quality

While productivity and cost are important considerations, the safety and quality of services remains of central importance as a benchmarking theme. A wide range of quality metrics are available in the mental health benchmarking toolkit, and providers may find it useful to consider the findings in this section of the tool.

The score for community patient satisfaction comes from the National CQC survey, results of which are published on its website. The question asks *"Overall view of mental health services - feeling that overall they had a good experience"*. This metric has ranged from 69% to 73% in recent years. This year's position is 70.1%.

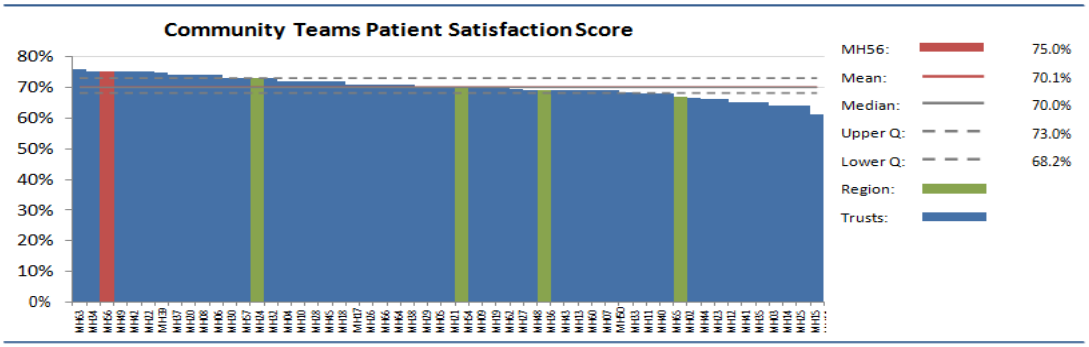


Figure 106

An alternative measure newly introduced to mental health providers is the NHS Friends and Family Test. This question asks *"How likely are you to recommend to friends and family if they needed similar care or treatment?"*

The average position this year was 85.3% would be likely or extremely likely to recommend.

25	The number and, where available, rate of patient safety incidents reported within the Trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death.

Patient Safety Incidents reported by Derbyshire Healthcare NHS Foundation Trust to the National Reporting and Learning System (NRLS) between 1 April 2017 and 30 September 2017

Patient Safety Incidents per 1,000 bed days	1,533 incidents reported during this period = reporting rate of 34.76 incidents per 1,000 bed days

Degree of harm of the patient safety incidents reported to the NRLS between 1 April 2017 and 30 September 2017

Degree of harm indicated as a percentage of the total number of incidents reported.

None	Low	Moderate	Severe	Death
72.7% (1,115)	17.7% (272)	5.8% (89)	2% (31)	1.7% (26)

Source: https://improvement.nhs.uk/resources/organisation-patient-safety-incident-reports-21-march-2018/

The Trust considers that this data is as described for the following reason: it is taken directly from the Health and Social Care Information Centre.

Derbyshire Healthcare NHS Foundation Trust data for the number and rate of patient safety incidents reported within the Trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death.

Information sourced from https://improvement.nhs.uk/resources/organisation-patient-safety-incident-reports-27-september-2017/

We have reported our national benchmarks in suicide, sudden death and homicide rates.

Part 3:
Other information

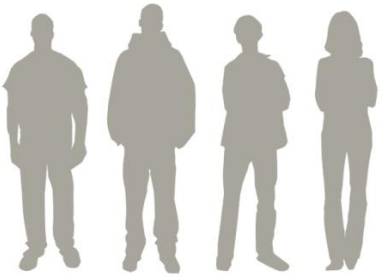
Activity data during 2017/18

1,471
inpatient admissions

80,340
referrals received

The Trust cared for **3,023** babies born in Derby City

39,504
adults treated at any one time



75,857 people seen

271
inpatients beds

69,7014
attended contacts

65,618
children treated at any one time

12,874
face to face follow-ups for those in our Learning Disability services

This section looks back over the last 12 months and reports on the quality of care that we have provided. It will detail an overview of the quality of care offered by the Trust based on performance in 2017/18, with a minimum of three indicators chosen for each of the following:

1. Patient safety
2. Clinical effectiveness
3. Patient experience

Patient Safety

Suicide prevention

The Trust identified 10 priorities for 2016-2018 as part of the Suicide Prevention Strategy, which were informed by consultation with stakeholders, and influenced by both the national and regional strategy developed with Public Health Derbyshire. Progress against these priorities is monitored via a clinical dashboard that is reviewed monthly at the Suicide Prevention Strategy Group.

The 10 priorities

1. To develop a strategic approach to self-harm across all areas of the Trust
    a. e.g. raising awareness and providing education around self-harm and the increased risk of future suicide
2. To support frontline workers with suicide prevention training
    a. As at 31 December 2017 we have trained 70.08% of the eligible staff, which already exceeds our target of 69% for March 2018.
3. To offer suicide preventing safety planning and means restriction to individuals experiencing suicidal thoughts
    a. once they have completed the connecting with people training, practitioners are licensed to use the associated evidence-based clinical tools. Work is under way to add these to our electronic patient record systems.
4. To increase identification of and relationship between physical health conditions amongst individuals with depression and other long-term mental health needs
    a. The relationship between physical health and mental health is well-established and a priority for the Trust in other forums. There are effective communication systems between forums to share progress.
5. Exchange information about high-risk locations and methods in Derbyshire with the Derbyshire Suicide Prevention Strategic Framework and wider groups
    a. partnership working with colleagues in such as Network Rail, British Transport Police, ambulance services, the police, local authority colleagues and public health.
6. To reduce access to means in healthcare and other settings, especially opportunities for hanging and strangulation
    a. working in partnership with the Trust's Health and Safety Manager
7. To promote staff education and awareness of importance of supporting those bereaved by suicide including staff
    a. The first colleague, carer and service receiver surveys were undertaken within September 2017
8. To use opportunities like World Suicide Prevention Day (WSPD) to build community resilience
    a. The Chesterfield FC vs Coventry FC Fixture on 02/09/17 accessed a potential crowd of 5,167. At half time the club screened a suicide prevention video made by the players from a script we developed
    b. The Derby County FC vs Hull City FC on Friday 08/09/17 accessed a crowd of 25,346

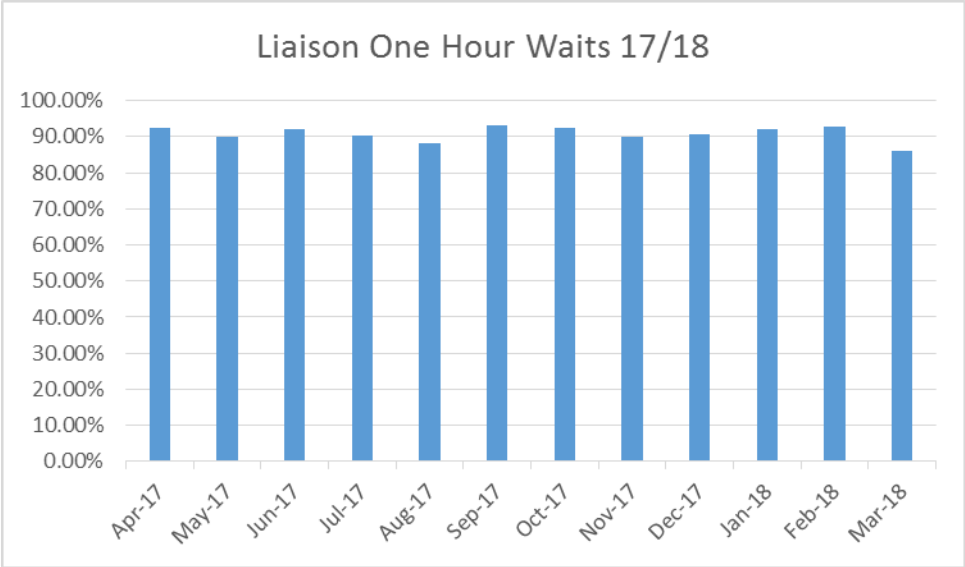
9. To use communications approaches to promote support available to those in distress and those concerned about an individual e.g. World Suicide Prevention Day
    a. The communication team has worked to improve how suicide is reported, with newspapers now regularly including crisis telephone numbers and rarely describing the means of suicide.
10. Reduce staff stigma – staff to feel able and supported to be open about their own mental health and wellbeing
    a. e.g. Schwartz Rounds, "a structured forum where all staff, clinical and non-clinical, come together regularly to discuss the emotional and social aspects of working in healthcare…..evidence shows that staff who attend Rounds feel less stressed and isolated with increased insight and appreciation of others' roles"

The Trust continues to be a partner in the Multicentre Study of self-harm in England alongside the University of Oxford and the University of Manchester. The aim of this programme of research is to conduct a series of related studies on the epidemiology, causes, clinical management, outcome and prevention of self-harm.

Psychiatric Liaison Team responsiveness

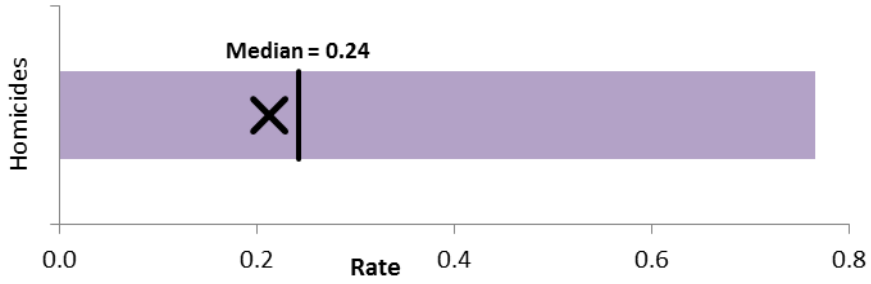
Our accredited Psychiatric Liaison Teams at the Royal Derby Hospital and Chestefield Royal Hospital provide comprehensive advice, support and a signposting service, where potential mental health and/or drug and alcohol issues are identified. Following referral from a health professional in Accident and Emergency (A&E) or an inpatient ward within the general hospital, the team will offer an evidence-based intervention, assessment and discharge process that covers all aspects of mental health. The longer a person is waiting in A&E or in a bed within the general hospital clearly the less positive their experience will be. Also, research shows that untreated mental health issues can lead to people spending longer in hospital and to poorer physical health outcomes. Working in partnership with other clinical colleagues, the Liaison Teams are making sure that patients get the right help, at the right time, in the right place. They also provide a vital educational resource to staff throughout the hospital to raise awareness and understanding of mental health needs and recognising the signs and symptoms. The teams' continuing performance around seeing people referred within one hour is depicted in the tables below:

Month	Number of A&E Liaison Referrals	Number of referrals seen within one hour	% of referrals seen within one hour
Apr-17	364	336	92.31%
May-17	405	364	89.88%
Jun-17	374	344	91.98%
Jul-17	385	348	90.39%
Aug-17	343	302	88.05%
Sep-17	310	289	93.23%
Oct-17	332	307	92.47%
Nov-17	345	311	90.14%
Dec-17	355	321	90.42%
Jan-18	358	330	92.18%
Feb-18	331	307	92.75%
Mar-18	407	351	86.24%



Serious incidents and quality initiatives in 2017

The annual national suicide and homicide enquiry published report scorecard is presented here:



The national scorecard reports data through the year of conviction not the year of the offence or occurrence. Mental health homicides are analysed over three-year periods to see trends. The chart is a longer period to show the incidence over a longer period, due to the lower number of occurences.

There was a cluster of mental health related homicides in the Trust in 2017. The details of these cases cannot be published in depth due to on-going police investigations and/or court proceedings.

These coincided with the publication of the NHS England commissioned independent reports into two historical homicides from 2010 and 2013. Since then NHS England has commissioned an independent report into a near-miss homicide following concerns raised by the Trust around prison releases in 2016 and has been raising with our lead commissioners the commissioning gaps and the lack of a dedicated community forensic team in Derbyshire. Commissioners have recently confirmed that there will now be funding available to establish such a service in 2018.

The mainstay of homicide prevention in general services is the Care Programme Approach underpinned by capacity assessments, risk assessments and safety planning. Our approach to CPA has been revised to be fully compliant with the latest guidelines and implementation will be supported by training, compliance checks and audit. In 2018 we are going further to review a new model of practice.

There has been a significant improvement in the application of the Mental Capacity Act in inpatient units following extensive practice development and quality improvement measures. The focus is now shifting to the community.

Safety planning has been rolled out and is progressing with real-time feedback and development from clinical staff to ensure longitudinal analysis of risk. The focus is now shifting to compliance checking and audit to continually improve clinical practice. The risk profile of individuals is key to effective clinical management and national mental health patient homicides are analysed to demonstrate risk history. It is evident that individual risk profiling is not a preventative strategy in homicides as a substantial level of individuals have a risk profile but would be statistically unlikely to go onto commit this level of crime. In addition, just over 30% of cases had no previous history of a forensic offence (Prison or Forensic service). However, over a decade, more than 80% of cases had co-morbid substance misuse and mental health conditions.

Table 2: Characteristics of patient homicide offenders in England (2005-2015)

	Number =641 Number	%
Demographic features:		
Age: median (range)	32 (13-83)	
Male	548	85
Not currently married	301 /375	80
Living alone	102 /338	30
Unemployed/on long-term sick	301 /366	82
Black and minority ethnic group	122	19
Homeless	26 /349	7
Behavioural features:		
History of self-harm	308	50
History of violence	332	53
Any previous convictions	469	77
History of alcohol misuse	455	73
History of drug misuse	489	78
Abnormal mental state at the time of offence	229	36
Offence variables:		
Age of victim: median (range)	43 (0-89)	
Male victim	438	68
Victim was a stranger	93	16
Sharp instrument used	345	56
Final Outcome:		
Murder	325	51
Manslaughter (diminished responsibility)	104	16
Manslaughter (other including provocation, self-defence)	196	31
Infanticide	4	1
Unfit to plead/not guilty by reason of insanity	12	2
Sentencing Outcome:		
Prison	468	73
Hospital order (with or without restriction)	153	24
Other non-custodial sentence	17	3

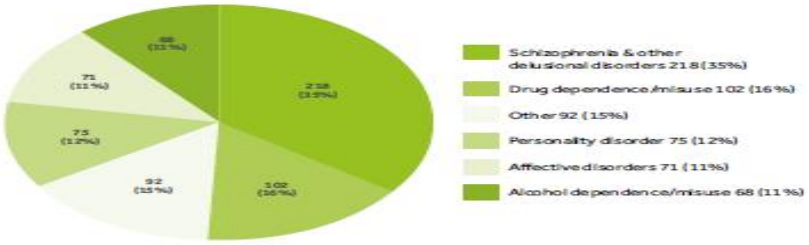


Figure 32: Patient homicide in England: primary psychiatric diagnosis

The above initiatives are supported by development of the electronic patient record and consideration is being given to the appointment of a Chief Clinical Information Officer (CCIO). In addition, there has been specific work around aspects of the Mental Health Act with the forensic focus.

- All Sections 37/41s have been audited and re-audited as part of a quality improvement cycle. This work has been presented to the Mental Health Act Committee and its new operational group. A register of people subject to Section 37/41 is held by the Mental Health Act office.
- Ongoing compliance checking with community treatment orders has seen an improvement in compliance and a re-audit is due in the next few months.
- Consultant caseload reviews have been conducted in those areas where homicides clustered and recommendations for a 'healthy caseload' approach is being made to the Trust Management Team and will inform the neighbourhood review and medical workforce review.

- In addition, there has been a peer review of our overall processes and oversight commissioned from a forensic psychiatrist and Medical Director and a Nurse Consultant with extensive experience in Serious Incidents investigations.
- The outcome of the individual serious incident investigations is on trajectory for completion.

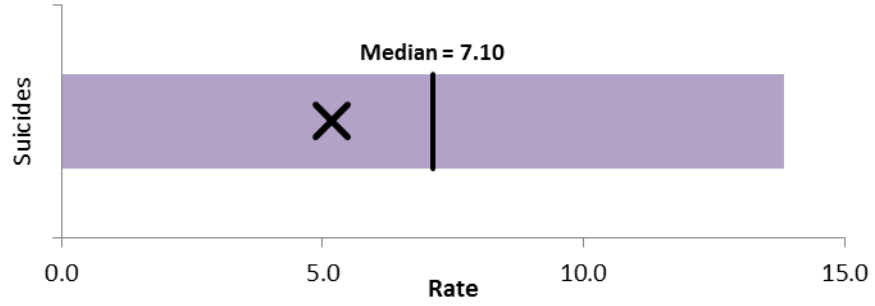
The Executive Lead for this work is Dr John Sykes and it will be monitored in the Quality Committee.

National benchmarking on very serious incidents in the Trust

Trust Scorecard: Derbyshire Healthcare NHS Foundation Trust

Suicide

The figures give the range of results for mental health providers across England, based on the most recent available figures: 2013-2015 for suicides, homicides and sudden unexplained deaths (SUD), 2016-17 for people on the Care Programme Approach (CPA), 31 October 2016 – 31 October 2017 for non-medical staff turnover and 2012-17 for trust questionnaire response rates. 'X' marks the position of Derbyshire Healthcare NHS Foundation Trust. Rates have been rounded to the nearest 1 decimal place and percentages to whole percentage numbers.

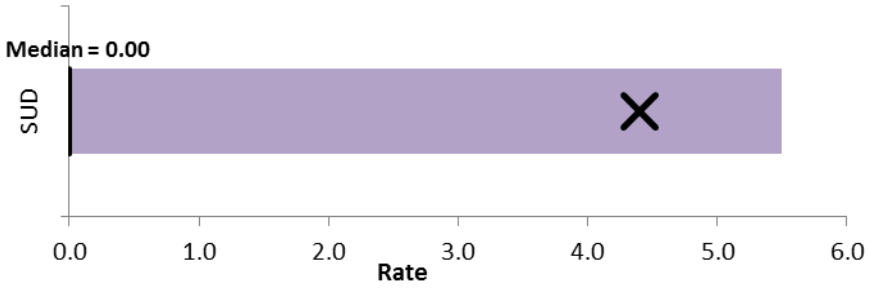


Suicide rate

The suicide rate in your Trust was 5.1 (per 10,000 people under mental health care) between 2013-15.

Sudden unexplained death (SUD)

All individuals who die on an inpatient mental health ward are identified from the Hospital Episode Statistics (HES) database. From these data, we identify the clinician who had been caring for each patient. Based on the information from the clinician, we determine whether the patient meets the criteria for inclusion in the study. Where the patient meets the criteria, detailed clinical information about their care is collected.



Sudden unexplained deaths (SUD)

The SUD rate was 4.4 (per 10,000 hospital admissions) between 2013-15.

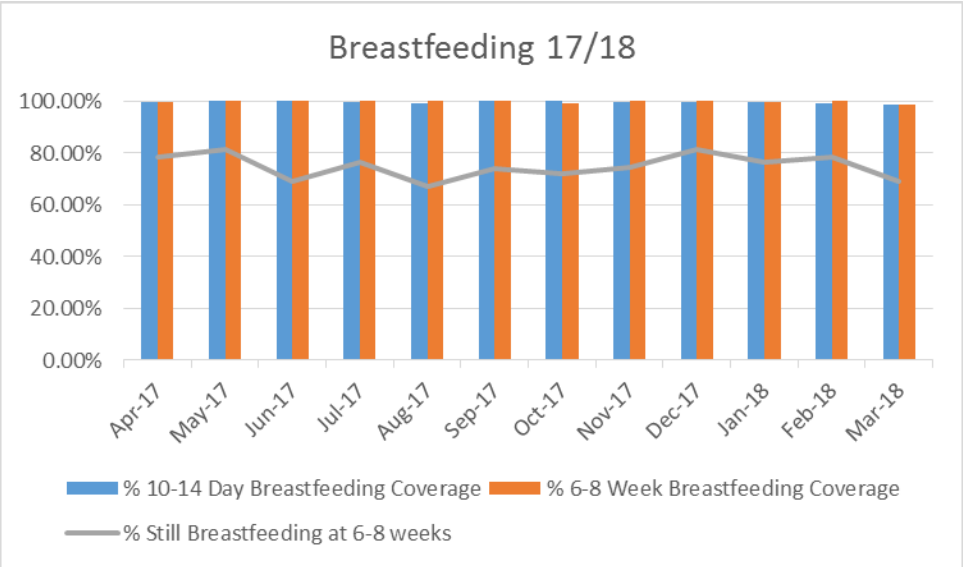
Clinical effectiveness

Breastfeeding

Through the work of our Health Visitor colleagues, we support the right of all parents to make informed choices about infant feeding. All parents have the right to make informed choices on how to feed their baby, and all our staff will support parents in their decisions. Breastfeeding is the healthiest way to feed a baby and we recognise the important benefits which health breastfeeding provides for both the mother and the baby. As part of encouraging new mothers to breastfeed, we share ways in which we help mothers to breastfeed successfully and all the midwifery and health visiting teams have been specially trained to help mothers to breastfeed their baby.

Within the next year the service is looking to recruit a Senior Infant Feeding Lead who will explore mechanisms for increasing the prevalence data further. Our sustained progress month on month is as shown in the tables below. Please note that >100% can be reflected due to data recording and also moves between Local Authority areas:

Month	% 10-14 day breastfeeding coverage	% 6-8 week breastfeeding coverage	% still breastfeeding at 6-8 weeks
Apr-17	99.59%	99.63%	78.21%
May-17	100.43%	100.45%	81.40%
Jun-17	100.00%	100.44%	69.01%
Jul-17	99.65%	100.35%	76.28%
Aug-17	99.24%	100.00%	66.89%
Sep-17	100.00%	100.00%	73.79%
Oct-17	100.75%	99.33%	71.76%
Nov-17	99.60%	100.41%	74.67%
Dec-17	99.58%	100.37%	81.21%
Jan-18	99.60%	99.60%	76.39%
Feb-18	99.07%	100.00%	78.57%
Mar-18	98.61%	98.77%	69.03%



The Dementia Rapid Response Team (DRRT)

In the Trust, we saw an opportunity to redesign our services. We developed this over 2014 and 2015 into a service model, were unable to secure funding from our commissioners so we pump-primed the service ourselves and tested the model.

In response to its effectiveness, it was later fully funded by our Clinical Commissioning Groups in the south of the county and then in 2018 we are expanding to the north of the county.

The purpose of the Dementia Rapid Response Team is to respond quickly to people who have dementia illness, who are experiencing some degree of crisis or difficulty and who require health intervention. The intent is to reduce the need for hospital admission and therefore reduce hospital bed numbers.

The Team works in a person's own home (this may be a nursing or residential home) providing prompt interventions (treatments) aimed at resolving the individual's immediate difficulties and improving their situation. The main purpose of the service is the provision of care and treatment at home for people with dementia who are experiencing an acute difficulty. Treatment at home enables the patients to have a new option for treatment, which is sensitive to an individual's needs and wishes and which can prevent the need for hospital admission.

There are clear benefits in home treatment for people with dementia. Treatment at home can more readily involve carers and can prevent the disorientation of leaving a familiar environment. It can promote the patient's independence, enhancing the prospect of re-enablement, and enables retention of control. In certain situations it may not be possible for the patients to remain at home and admission to hospital is necessary. The service provides multi-disciplinary assessment and treatment and works jointly with local services carried out in the person's own home (or residential home or nursing home). Once a person is accepted by the team, assessments, interventions and treatments will be informed by evidence-based best practice (from research and associated guidance including that provided by the National Institute for Health & Care Excellence)

The Dementia Rapid Response Team works with patients who have a diagnosis of dementia (or 'a working diagnosis'), who are registered with a South Derbyshire GP and who are experiencing some degree of crisis or difficulty affecting their wellbeing. Older Adult Community Mental Health Teams act as a gatekeeper to referrals from primary care. Referrals are also accepted from:

- Community Mental Health Teams
- Inpatient Wards
- The Psychiatric Liaison Teams within Accident & Emergency Departments.

Some of the DRRT Achievements

- At the time of this report, the team had supported 1018 individuals in total.
- Reduction in unnecessary admissions to hospital
- Reduced length of stay in hospital
- Provision of timely assessments and treatment
- Improved care in all care environments
- New ways of working
- Better coordination of care

- Collaborative working between professionals
- Provide alternative support in the community
- Education and support for carers.

Feedback about the team, gathered through the NHS Friends and Family Test, has been very positive: 98% of people who have completed the Friends and Family Test survey to date have said they are likely or extremely likely to recommend the service.

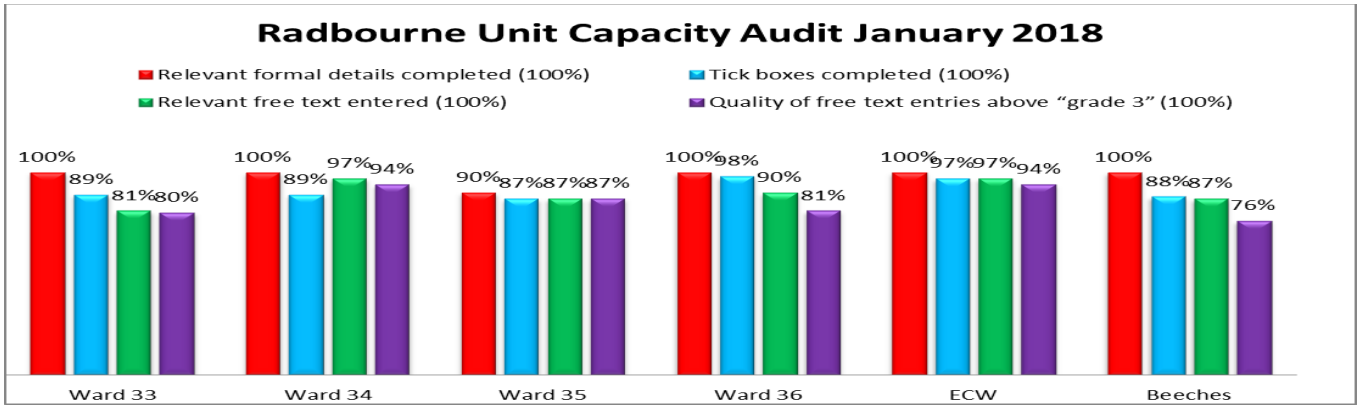
These are other comments recorded by carers:

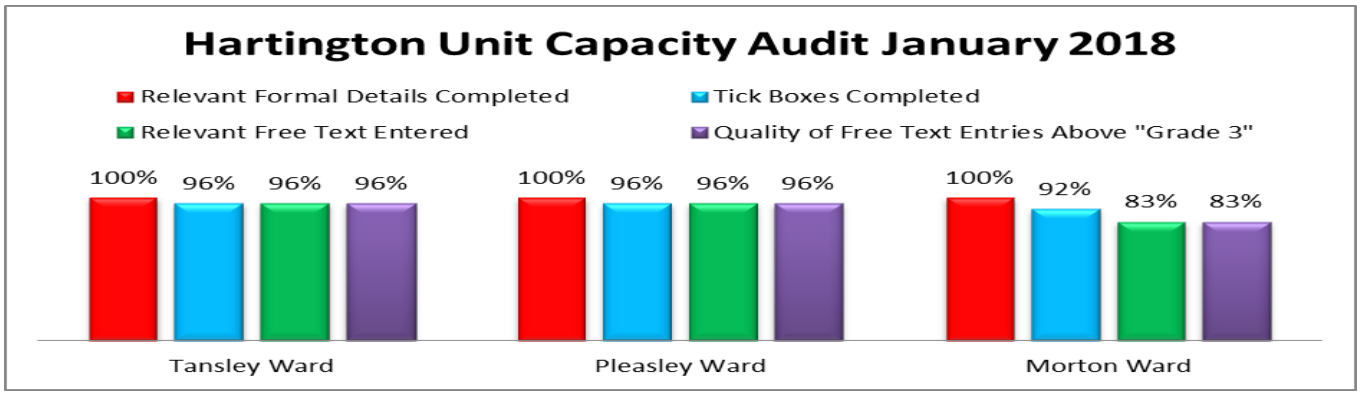
- Without your help and understanding we wouldn't have coped.
- All your services have been outstanding.
- Thank you to the entire team
- Good communicators
- A great team that helped manage the situation without medication
- Keep informed about their care.

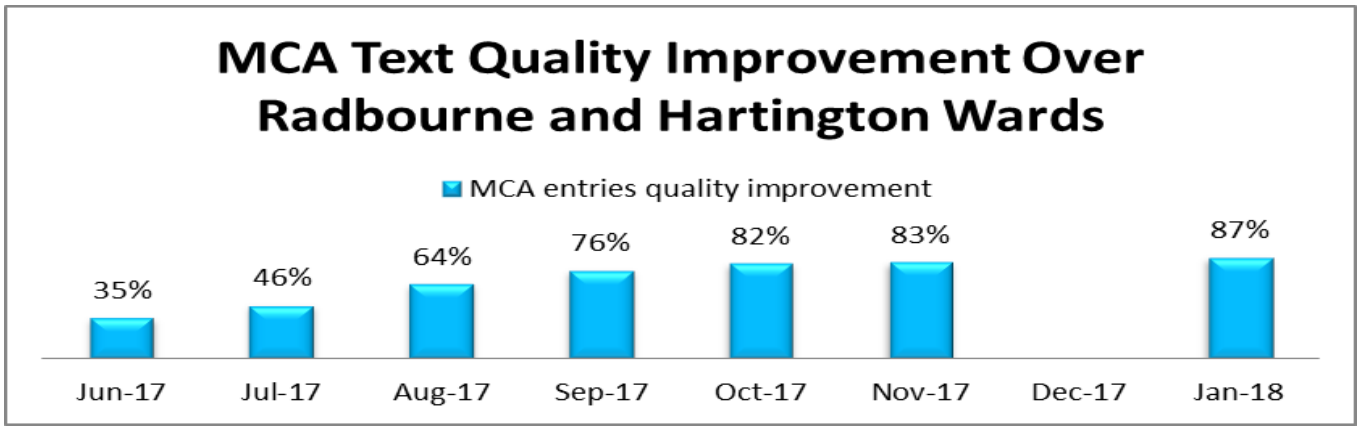
In addition, the team has received more than 190 written compliments since April 2015 for the quality of its work. The team was so effective, that one of our wards, a 14-bed unit, was emptied and had no clinical referrals within six months of the DRRT opening. The staff were retained in our extended DRRT service and in other areas. In addition, our dementia wards have reduced occupancy to less than 80%.

The clinical application of the Mental Capacity Act

This has been a particular and sustained focus for the Trust over 2017/18, which has included not only audits of the presence of assessments of capacity, but also the quality of these assessments. Within the graphs below, you will see both presence of assessments of capacity, and also reporting of those deemed to be at 'grade three" or above, so therefore of an acceptable quality.







We can also confirm the following on the Kingsway site wards:

- Scores are comparable with those achieved during full audit of Sept/Oct 2017. Apart from one instance, scores on all measures were either maintained or improved on second and third reviews
- All wards scored 100% for the QUALITY of their free text entries (i.e. on average each ward scored higher than 3 or above, the score for quality which is deemed acceptable). Throughout the audit period the span of average quality scores ranged from 3.13 – 4-75 with a mean of 3.88
- Of the staff groups completing the “Record of Capacity to Consent” EPR forms, junior medical staff scored within the lower ranges of the rating scale in the earlier spot checks. Since then it is to be noted that the standard of entries made by junior doctors had improved. Consultants, nurses, psychologists and physiotherapists continue to show high rates of compliance with all audit scores

Significant progress has been made with inpatient practice and will be reported to the Mental Health Act Committee in February. The evidence suggests that improvement in clinical practice can be brought about by a combination of:

- Policy revision
- Development of electronic patient records and relevant training to facilitate application of new policy and procedures
- Compliance checks and audits with timely feedback and support of clinicians through coaching to improve their performance

Next steps

- Continued support and training for all staff to maintain generally positive results led by clinical leads.
- Further encouragement to junior medical staff to promote better quality free text entries
- Continuing positive feedback to staff for the above progress
- A similar approach to that described above will now be applied to community teams

The Family First Model

As part of its 0-19 years integrated public health nursing contract, Derby City Council commissioned an Intensive Home Visiting programme, focused on reaching and supporting vulnerable pregnant families with a range of health needs. It had been recognised at stakeholder pregnancy pathway meetings that not all vulnerable first-time parents meet the criteria for the Family Nurse Partnership programme and a more equitable, flexible and responsive approach to service delivery was required to meet the needs of vulnerable families.

The Family First Model was developed through shared learning of Public Health Nurses, Health Visitors, School Nurses and Family Nurses. Most importantly, service users have been involved in all workshops. This process was to ensure the service was responsive to best quality practice and service user need. Commissioners were consulted and involved in service development, and this approach has allowed practitioners and service users to have ownership.

The aims are to ensure that Family First time parents:

1. Have a healthy pregnancy
2. Become a knowledgeable, responsive and sensitive parent
3. Develop positive health, social and economic outcomes for parents and their children.

Impact of partnership working - reflections

- It's the sharing of skills, workforce development and expertise between Family Nurse Partnership and the 0-19 service
- It's a strengthening of relationships
- Promoting innovative practice
- Enhancing practice and client's experience
- Promotes a more equitable service for families within the city
- It is a consistent approach within the workforce.

There was a lot of concern re the roll-out of the new model of practice and this featured in the June 2016 comprehensive visit.

The voice of our staff, now:

- Change in delivery style for universal contacts
- Increased morale and job satisfaction
- Professional development
- New group work initiated within the Children's Centre for antenatal contact which has improved partnership working
- Better understanding of and relationships with specialised services within 0-19 partnerships
- Supervision - Using the new tools (vulnerability matrix and the seven Ps) has enhanced supervision sessions and directly impacted on the positive outcomes for families
- Child protection contacts have more focus with the use of PIPE (Partners in Parenting Education) tool
- The tools have enabled the Trust to start an antenatal group at a local Children's Centre. This has benefited the clients by increasing their knowledge base before the baby is born. It has also promoted partnership working with the Children's Centre and increased the access antenatal clients have to their centres

Impact on the Family First model for parent(s)

- These tools have been used within the Family First model and also some universal contacts
- The families report that they really like this delivery style as they are able to participate in the games and let the practitioner know what they have learned. It is easier for them to say if they do not understand an aspect of the visit
- Information is elicited from the client to check their understanding of topics
- New information is being delivered in a fun way.

Impact on workforce - Mobilisation of knowledge

- Staff members have been curious to explore the different ways of working - enhanced team morale
- Enhanced the quality of visits they offer for both practitioner and clients
- Job satisfaction increased
- Team dynamics improved
- Enabled a new way of working - further developments of model to explore a second tier relating to the healthy child programme contents, enabling the family first style to reach more families within the 0-19 service.

Additional information

This service is having positive outcomes following substantial re-modelling and a significant period of instability and change for our teams. This feedback is starting to show stability and positivity, and this has been achieved through the solid and effective leadership of managers in the Children's Division.

External feedback

Derby has been recognised as taking a lead on integration and partnership working by Professor Derek Ward, Family Nurse Partnership National Unit and National research Clinical psychologist Dr Crispin Day. A new Consultant level Social worker and Lead for Children's and CAMHS has also been appointed.

The Steroid Clinic within Substance Misuse Services

In response to this emerging problem, colleagues in Substance Misuse Services have achieved the following outcomes (some of the numbers are an approximation but are an accurate reflection of the work undertaken):

- There are 150 clients currently accessing the needle exchange
- This is an average of two visits per year to access needle exchange for these 150 clients
- Since February 2017 when the Steroid Clinic started, 72 appointments have been offered
- Out of these 72 appointments, 55 have been booked
- Out of these 55 appointments, all have had Blood Pressure checked and blood tests
- Blood Borne Virus testing has been offered with a 25% uptake of this
- 100% of clients who were tested for Blood Borne Virus were followed up and received their results
- Two client's GPs were contacted due to serious health concerns following physical examination
- Since August 2017 when the service first began to offer electrocardiograms (ECGs), 15 clients have received an ECG – no follow-up was required
- Since starting, 16 hours of outreach have been offered at two gyms
- During outreach, 10 – 15 clients were seen during each two-hour session
- Outreach has predominantly focused on blood pressure monitoring and steroid advice.

Patient experience

Moves at night: an audit and review of all patient transfers falling outside of working hours

Out-of-hour transfers are patient moves between the hours of 22:00hrs and 08:00hrs. Any moves between these times may result in significant compromise for the patient in terms of comfort and provision. For these reasons, it is important that we are able to assure that these moves only occur if there is a clear clinical rationale and no safer alternative.

Moves can occur for a variety of reasons and can include moves between wards on the same unit, moves between wards on Trust sites, transfers to and from Trust wards and local units and transfers to and from external provider units some distance away. In order to provide assurance that these moves are exceptional rather than routine, our entire out-of-hour transfers dating from June 16 until July 17 were audited and reviewed. This totalled 13 incidents recorded.

Findings:

- Two moves were found to have been inputted as out of hours but the records clearly indicated that the transfers had taken place within usual working hours
- Of the remaining 11, three were individuals being returned to their respective beds by police following a period of being absent without leave. Five transfers were to areas of increased security such as the Enhanced Care Ward or a Psychiatric Intensive Care Unit as an urgent response to risk.
- Two transfers were following the ceasing of seclusion. These moves were facilitated as soon as it was safe to return the patient to their own bed, so they fell outside of working hours.
- Only one transfer was found to be due to bed pressure to ensure safe admission or care and this occurred at 19:50hrs, so before 22.00hrs.
- The final transfer out of hours which was not justified clinically was dictated by another Trust and so was outside our control. It is noted that our clinicians argued for it to be delayed until the morning but this request was denied.

In conclusion, through this audit it is evidenced that all moves facilitated by ourselves have a clear rationale and offer no safer alternative than to transfer out of hours. It is further reassured that the one case whereby no clinical rationale can be found to transfer out of hours was instigated by a different area and our clinicians made every attempt to delay this.

Safewards

A group of 18 managers, clinicians and medics from the Northern Zeeland Mental Health Services in Denmark visited the Hartington Unit in Chesterfield in November 2017 to discuss and explore the use of the Safewards methodology across the unit. Safewards is a model explaining variation in conflict and containment that uses 10 easy interventions to pre-empt and reduce conflict in clinical settings. The team approached the staff at the Hartington unit following a previous visit by colleagues from the Southern Region of Denmark. Clinical practice in Denmark has higher levels of restraint and use of mechanical methods and they were interested in the Safewards methodology to try and change this practice.

The team at Chesterfield was led by Vicki Miller, one of the lead nurses on the unit. She coordinated a programme that looked at the baseline theories of Safewards, had visits to the wards and discussion with patients (all patients had been asked if they wanted to meet the group and if they were happy with them participating in the activities), attending mutual help meetings and mindfulness groups and a question and answer session.

The Danish visitors were also given some of the debrief balls that assist with debriefing sessions held after restraint or seclusion incidents. The balls have questions printed on the surface that prompt and support the conversation and exploration of the incident. Staff are encouraged to use these to enable discussion and to move away from superficial issues to those that might have a deeper impact on their wellbeing and clinical practice.

The team from Denmark was very complimentary about what they had seen and keen to look at how they could implement the Safewards methodology. Vicki Miller and Dave Harrison (Practice Development & Compliance Lead for Restrictive Practice/Positive and Proactive Tutor) will be remaining in contact with them to offer support and advice.

Complaints and compliments

The patient experience team is the central point of contact for people to provide feedback and raise concerns about the services provided by the Trust. The team sits within the Nursing and Patient Experience Directorate.

The team's aim is to provide a swift response to concerns or queries raised and to ensure a thorough investigation takes place when required, with complainants receiving comprehensive written responses including any actions taken.

We are aware that there have been issues providing timely responses to some of our complaints during the year and we have worked hard with operational staff to reduce the time taken for investigations. Progress is being monitored and reported on in quarterly reports to the Patient Experience Committee and Quality Committee.

During the year the following contact has been made:

	2017/18	2016/17	2015/16
Compliments	1222	1,215	1,016
Concerns	451	420	352
Complaints	191	146	115

Complaints are issues that need investigating and require a formal response from the Trust. Investigations are coordinated through the patient experience team. Concerns can be resolved locally and require a less formal response; this can be through the patient experience team or directly by staff at ward or team level within our services. Of the 191 formally investigated complaints 16 were upheld in full, 88 upheld in part, 40 not upheld, five complaints closed without investigations and 42 complaints are still being investigated.

Themes from compliments received reflect general gratitude and appreciation for support provided. A high number comment on the care, kindness and compassion of Trust staff.

During the year, the Trust discussed five cases with the Parliamentary and Health Service Ombudsman. Two investigations are being undertaken and three are being assessed to see if they will proceed.

Actions taken to improve the timeliness of complaints responses

Over 2017/18, the Trust has implemented more robust escalation procedures and supported investigating staff by providing timely reminders of expected timeframes. The Trust has also utilised extra staff to complete the chronologies of complaints for the investigating officers as a way of reducing their workload. There is now a more engaged process between the Patient Experience department and senior operational managers, with the result being a much improved service to people who make complaints about our services.

Comparison of concerns and complaints by top subjects 2016/17 and 2017/18:
Concerns and complaints in relation to availability of services have increased compared to 2016/17.

Themes from compliments received reflect general gratitude and appreciation for support provided. A high number comment on the care, kindness and compassion of our staff. For a full breakdown on the issues raised through our concerns and complaints, please see page 76 of the Trust's Annual Report.

During the year, the Trust discussed five cases with the Parliamentary and Health Service Ombudsman. Two investigations have been undertaken, three are being assessed to see if they will proceed.

Community mental health survey

Derbyshire Healthcare NHS Foundation Trust ranks as the third highest performing trust in the country with regards to patient satisfaction. This is all the more impressive given the known pressures in our community teams and the relatively limited third sector alternative services compared to other regions. In the graph overleaf, the Trust is represented by the vertical red line, MH56.

Benchmarking Network

Quality

While productivity and cost are important considerations, the safety and quality of services remains of central importance as a benchmarking theme. A wide range of quality metrics are available in the mental health benchmarking toolkit, and providers may find it useful to consider the findings in this section of the tool.

The score for community patient satisfaction comes from the National CQC survey, results of which are published on its website. The question asks *"Overall view of mental health services - feeling that overall they had a good experience"*. This metric has ranged from 69% to 73% in recent years. This year's position is 70.1%.

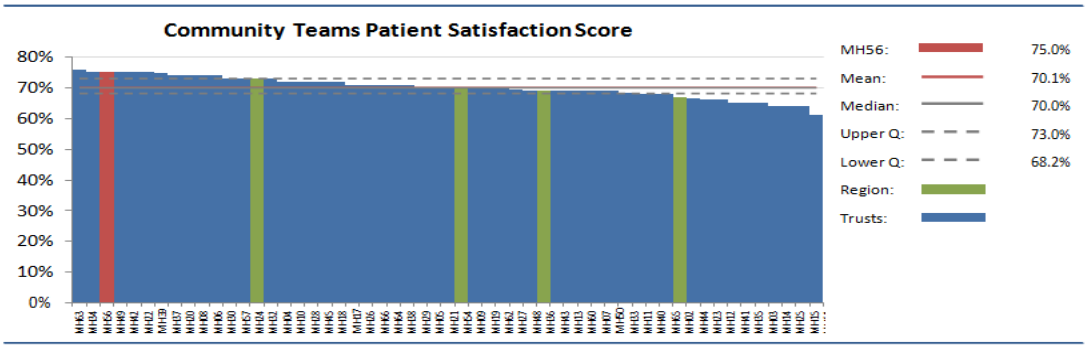


Figure 106

An alternative measure newly introduced to mental health providers is the NHS Friends and Family Test. This question asks *"How likely are you to recommend to friends and family if they needed similar care or treatment?"*

The average position this year was 85.3% would be likely or extremely likely to recommend.

Adverse childhood experiences

Adverse childhood experiences (ACE) is an increasingly used term which describes the experience of range of adversity in childhood including abuse, neglect but also parental substance misuse, parental separation or incarceration, parental mental illness and living in care.

How common is this?
Living through abuse and trauma is more common than often previously recognised. The World Health Organisation reports that 20% of girls and up to 10% of boys experience sexual abuse in their childhood. In some specialist services, prevalence rates are often much higher, for instance 75% of women and men in substance misuse services report abuse and trauma in their lives (WH0 2014).

It is now a well-researched and robust finding that survivors of trauma and complex trauma are at higher risk of a range of health, mental health and social difficulties (e.g. WHO 2014, Scot PHN 2016). It is important to stress that this does not mean any particular individual survivors will develop these difficulties but that they are at a higher risk and that the more trauma and complex trauma that is experienced by individuals, the higher the risk becomes. It is now well recognised that there is a common pattern of mental health difficulties which has been called Complex Post Traumatic Stress Disorder. Following many years of research this is to be included in the International Classification of Diseases (ISD-11) which is due to be published in 2017.

A recent survey in Wales (2015 Public Health Wales NHS trust), replicated the international research and found that those with four or more experiences of adversity and abuse in childhood were:

- 4 x more likely to be a high-risk drinker
- 6 x more likely to have had or caused an unintended teenage pregnancy
- 6 x more likely to smoke
- 14 x more likely to be a victim of violence
- 15 x more likely to be a perpetrator of violence
- 16 x more likely to have used heroin
- 20 x more likely to be incarcerated

The development of these high-risk health behaviours is easier to understand when viewed through the lens of being a survivor. For individuals affected this is likely to be complex and unique but overall we can start to think about these risky behaviours being a result of the impact of trauma or an attempt to cope with this impact.

Why is this relevant?
Survivors experience two significant areas of difficulty in relation to their health

1. Increased risk of health and social difficulties because of the direct and indirect consequences of their experience

Direct impacts might include; difficulties in developing safe and trusting relationships, post-traumatic stress difficulties, disruptions to education, lack of capacity to develop skills in managing distress and emotional reactions (due to being subjected to 'insurmountable challenges' which overwhelm survivors' coping strategies, particularly for those affected in childhood). Indirect impacts can include; unsafe coping strategies developed to manage their distress, this can include reliance on alcohol or drugs, self-harm and an impact on their eating patterns and all of these can have long-term health and mental health harming consequences. Poorer relationships with others is crucial as we know that safe and supportive relationships are a key predictor of resilience in the face of difficulties, that is, turning insurmountable challenges into manageable ones (Couper and Mackie 2016).

2. Difficulties accessing services or maintaining access with services

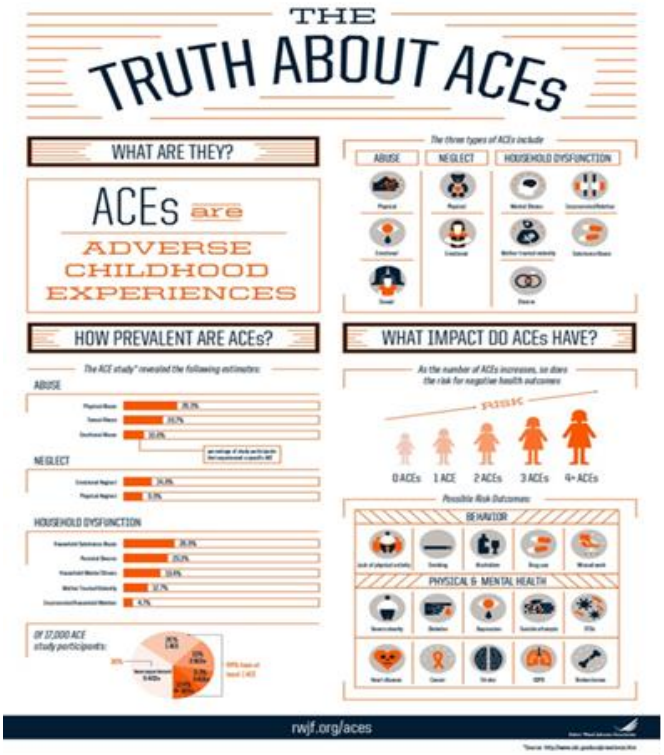
This is again a complex area, but some elements which might be important include difficulties with trusting staff, difficulties with procedures that involve touch, not feeling understood by services and frequent disengagement, for instance difficulties attending appointments. This is a similar concept as outlined in the recent publication on 30 October 2017, Independent enquiry into child sexual abuse Inquiry report, 'Victim and Survivor Voices from the Truth Project'

The report considers some of the accounts of victims and survivors taking part in the Truth Project. It provides the inquiry with insight and information into the child sexual abuse experienced by those coming forward.

This report from the inquiry's research team draws together statistical data from the Truth Project sessions that took place between June 2016 and June 2017. Information contained within the report includes participants' ethnicity, age, and disability status. This information will help us understand if there are sections of society we need to reach so we can engage with a wide range of victims and survivors across England and Wales.

The report looks at participants' experiences of child sexual abuse, as well as its short and longer-term impacts including on socio-economic outcomes and intimate relationships. The report includes comments from a number of participants who speak movingly about their experiences. It includes how victims and survivors have been trying to tell us for decades of their experiences. It includes individuals giving a narrative of talking to agencies, GPs and other professional and not being listened to, individuals often not taking a trauma informed approach and not being able to access psychological therapy, and the longer-term impact upon people of child sexual abuse.
https://www.iicsa.org.uk/news/inquiry-publishes-report-%E2%80%98victim-and-survivor-voices-truth-project%E2%80%99

The interagency trauma conference



The Trust and Derbyshire Police jointly held an interagency trauma-informed conference in October 2017. This was a day to reflect on learning from significant safeguarding incidents that have occurred both nationally and locally. It was to hear from the voice of the expert who has experienced safeguarding investigations by multi-agency reviews, and two very brave individuals shared their lived experiences of abuse and the impact of adverse childhood events.

This event introduced participants to the ACEs research and the Welsh research, and replication of the same findings. This was a powerful day for Police, social care, third sector and health partners to listen and learn from the experience of our safeguarding and police investigations and the experiences of our support services.

Actions from the conference

1. We have agreed, as Team Derbyshire interagency partners, to host a further event 12 months on to review progress. This will be in 2018 and will be at Police Headquarters in Ripley.
2. We have agreed to set up a social media Trauma-Informed Network to share practices from all members of the attendees. In addition, we are linking to schools who have just undertaken some trauma-informed training in education.
3. We have developed a list of areas to work on over the year, based upon conference participants undertaking a quality improvement interagency brainstorm.
4. The learning and ideas will be incorporated into a Derbyshire-wide development of a Strategy and Practice Guidance for staff, to enable survivors of non-recent abuse in childhood to be effectively supported. This will be led by the Clinical Commissioning group.
5. We have agreed that safeguarding training in external partners will be reviewed to include Adverse Childhood Experiences and practice, agreed October 2017, timescale for commencement to be agreed.
6. We will review our own safeguarding training to include ACE thinking and Trauma Informed practice, to be agreed.
7. We will be using the ACE framework in developing CPD for our staff in disclosure and formulation. We will be using this framework in the development of our Physical healthcare strategy, in development October / November 2017.
8. We will be using the ACE framework in analysis and a review of suicide in our Trust as part of mortality analysis, January to March 2018.

Performance against the indicators which are being reported as part of NHS Improvement's oversight for the year. Where any of these indicators have already been reported on in Part 2 of the quality report, in accordance with the quality accounts regulations, they do not need to be repeated here.

Early intervention in psychosis (EIP): people experiencing a first episode of psychosis treated with a NICE-approved care package within two weeks of referral

	Number	Actual	Target
EIP RTT Within 14 Days - Complete	264	89.39%	50%
EIP RTT Within 14 Days - Incomplete	169	81.66%	50%

Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in the following service areas (Chosen as the Quality Indicator for 2017/18 by Trust Governors, as part of the Trust's internal and external audit of data quality checks):

	Actual	Target
a) inpatient wards	11.1%	90%
b) early intervention in psychosis services	25.5%	90%
c) community mental health services (people on care programme approach)	6.7%	65%

The Trust was aware of the challenges that it would face with regards to the performance around cardio-metabolic assessment and expected these results. Plans are in place to significantly improve this performance over 2018/19. These figures are not an indicator that no physical healthcare is being

undertaken, but that the entirety of assessment and intervention as per the Lester Tool is not being completed. The EIP is an average of the scores of the two EIP teams.

Improving access to psychological therapies (IAPT):

- people with common mental health conditions referred to the IAPT programme will be treated within six weeks of referral
- people with common mental health conditions referred to the IAPT programme will be treated within 18 weeks of referral

	Actual	Target
IAPT – referral to treatment within 18 weeks	99.91%	95%
IAPT – referral to treatment within six weeks	93.64%	75%

Care Programme Approach (CPA) follow-up: proportion of discharges from hospital followed up within seven days
Reported in Part 2, not required to be repeated here

Admissions to adult facilities of patients under 16 years old	
	Number of admissions under 16 years old
2017/18	0

Inappropriate out-of-area placements for adult mental health services (due to unavailability of bed) - bed days by month												
Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Average
171	384	172	75	242	243	114	9	0	36	21	82	129.08

Significant variance is observable in this data, with significant improvement in the Trust's use of out of area beds since October 2017. Some of this could be explained by a seasonal variation, but it might also be as a result of an enhanced focus on initiatives such as Red2Green, and other ward-based quality improvements. Red2Green is a visual management system to assist in the identification of wasted time in a patient's journey. This approach is used to reduce internal and external delays. This is a significant improvement in the quality and safety of our services as we have less than one patient out of area at any given period. Emergency admisison to enable immediate safety and rapid transfer or direct admission to Derbyshire is now the norm within our Trust.

Additional information

Out-patient letters

In response to feedback from the Governors with regard to the 2015/16 Quality Report: "In future reports we would like to see improvements in the performance on outpatient letters". As at end of February 2018:

	2016/17	2017/18	Target
Outpatient letters sent in 10 working days	87.28%	88.36	90.00%
Outpatient letters sent in 15 working days	93.88%	94.12	95.00%

Given the volume of letters that we produce (between approx 2,500 and 3,000 a month) even this relatively small percentage increase is a meaningful improvement, and it is clearly a step towards the Trust target for each measure. Challenges remain, however, and will be influenced by such as the volume of administrative work that comes with changes in locum consultant cover.

Friends and Family Test

The Friends and Family Test asks people if they would recommend the services they have used to others who are close to them if they were also in need of similar care and treatment. It offers a range of responses to choose from, and when combined with supplementary follow-up questions, provides an indicator of good and poor patient experience. The results of the Friends and Family Test are published each month by NHS England.

Of note this year is the reduced number of responses in comparison to the last year. Front line staff are keen to explore how to improve this, and have requested a mechanism for this to be completed via such as a mobile phone, and this, along with how else we might promote this is being explored. We also plan to build a particular focus on the Friends and Family test into a revised Quality Visit model.

Month	No. F&F Surveys	No. With Recommendation of Likely/Extremely Likely	%
Apr-17	69	59	85.51%
May-17	104	85	81.73%
Jun-17	76	57	75.00%
Jul-17	73	63	86.30%
Aug-17	62	54	87.10%
Sep-17	58	52	89.66%
Oct-17	49	42	85.71%
Nov-17	74	57	77.03%
Dec-17	41	35	85.37%
Jan-18	60	52	86.67%
Feb-18	56	46	82.14%
Mar-18	81	66	81.48%
Total 17/18	**803**	**668**	**83.19%**
Total 16/17 for Comparison	**1475**	**1262**	**85.56%**

Child & Adolescent Mental Health Services (CAMHS)

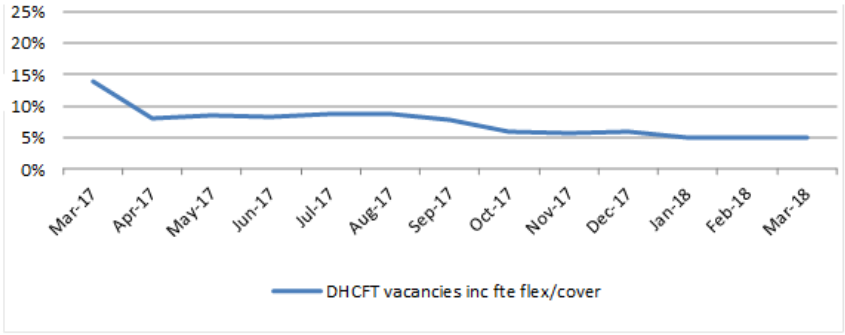
Colleagues in CAMHS community teams and in the CAMHS RISE Team (Rapid Intervention, Support and Empowerment), have shown effectiveness in reducing admissions as shown in the table below.

	Number of admissions	Average length of stay
2014/15	56	106
2015/16	106	56
2017/18	52	68

Staffing levels, recruitment and retention

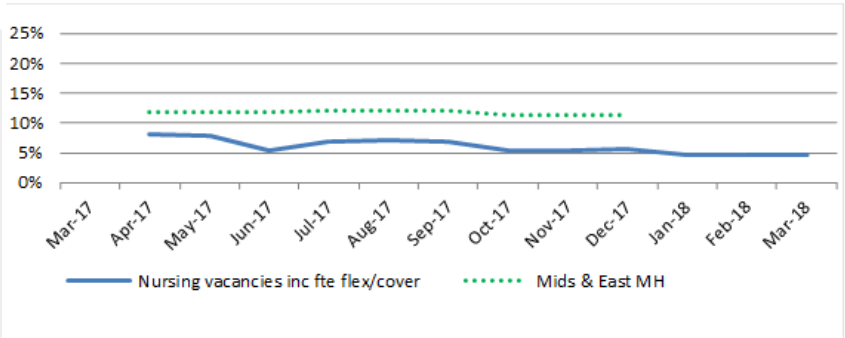
VACANCIES

Mar-18 **5.00%** ↗
Trust



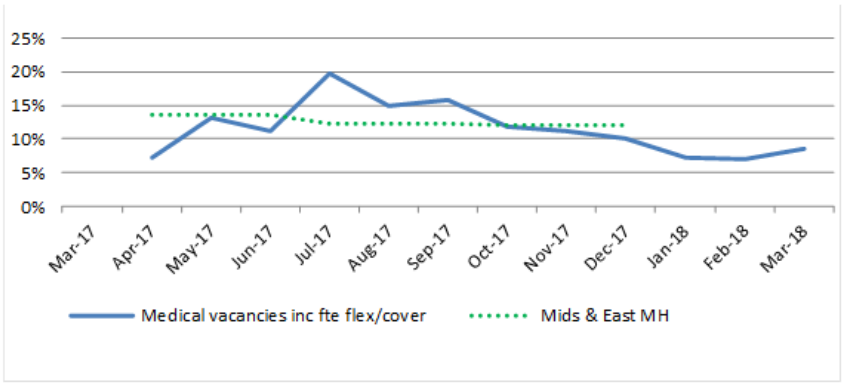
Mar-18 **4.69%** ↗
Qualified Nursing

NHS	10.30%
National MH	11.10%
Mids & East MH	11.20%



Mar-18 **8.66%** ↗
Medical

NHS	7.90%
National MH	12.00%
Mids & East MH	12.10%



Several initiatives to assist recruitment are in place and further developments are planned, including:

- Recruitment fairs · University link working encouraging students to commit to posts on completion of studies
- Local advertising · Enhanced Nurse placement support offered by practice facilitators
- Block advertising
- Exploration of recruitment overseas
- Retire and return scheme
- Review of advertisements and “attractors”

This is resulting in some recruitment to all areas including inpatients, but there are options to move on to other Trust areas and staff are opting to move from inpatients for posts in community settings. This has always been a recruitment pathway, but the pace of movement is much faster currently. Skill mixing has been implemented in the inpatient areas, for example Occupational Therapists working within ward numbers and work continues to develop alternative options. Schwartz rounds are embedded in practice as part of supporting emotional wellbeing for staff, and psychology drop in/consultation sessions have been established.

Whilst recognising our strong position around overall vacancy rates, we are acutely aware of staffing pressures in particular teams and in particular staff groups and the impact of vacancies upon the service and team morale. There are recruitment challenges around nursing and medical staff, a challenge that is shared with Trusts across the country. However, over the past year, 100 more staff joined the Trust than left, and we plan to build on this further via our focus on staff wellbeing, and via the Trust's continuing review of roles and skills to ensure alignment with the needs of our population.

Investing in our staff – The Care Certificate

The Care Certificate was introduced in April 2015 and is now the expectation of all those working as healthcare assistants and adult social care workers. It was created as a result of the Cavendish Review which was published in July 2013. This review was part of the response to the Francis Inquiry into the failings of care at the Mid-Staffordshire NHS Trust.

The Cavendish Review found that the training and development of healthcare assistants and adult social care workers was often not consistent or good enough. A new 'Certificate of Fundamental Care' was created to improve this, resulting in the Care Certificate. It covers the learning outcomes, competencies and standards of behaviour that must be expected of support workers in health and social care. It aims to make sure that you are caring, compassionate and provide quality care in your work. It builds on and replaces the earlier induction programmes: Common Induction Standards (CIS) and National Minimum Training Standards (NMTS).

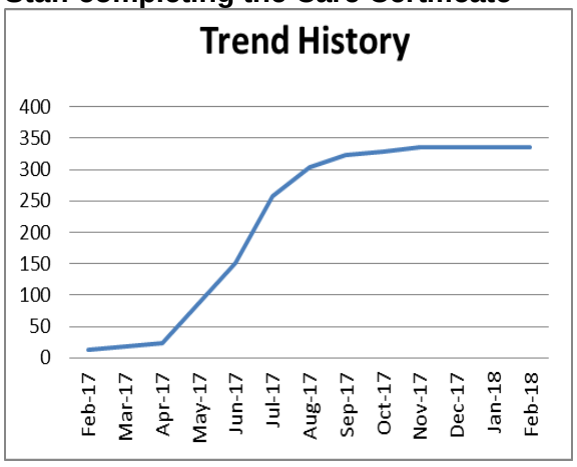
The investment in training in our support workforce was raised as a concern by our health regulator, specifically around uptake of the Care Certificate. A Care Certificate market stall is now available for all new healthcare support workers where they can meet the Care Certificate Facilitator who will give them information on the Care Certificate Framework and the 15 standards, and the Code of Conduct for Health and Social Care Support Workers, and also the Care Certificate Workshop. The workshop includes:

- The Care Certificate and how it can support staff in their career development, their role and in identifying knowledge gaps
- Interactive activities including group discussions and videos
- Covers nine of the Care Certificate standards.
- Team participation using the Care Certificate game, which is an innovative practical learning tool endorsed by Health Education England
- Sharing experiences of compassion, care, dignity and values in their day to day work and to help the Trust provide the best care possible to patients and carers
- Identify compassionate behaviours that reflect the Code of Conduct for Healthcare Support Workers
- Good and bad practice
- Lessons learnt from the Francis Report
- Complete the e-learning so they are compliant (if they have previous care experience)

This includes group discussions about understanding your role, duty of care and the following videos:

1. The launch of the Care Certificate
2. Robert Francis - lessons learned interview
3. Dignity - The tale of two wards film depicting good and bad practice in one hospital

Staff completing the Care Certificate



Care and Treatment Review: Systems and processes

Care and Treatment Reviews (CTRs) are part of NHS England's commitment to transforming services for people with a learning disability, autism or both. CTRs are for people whose behaviour is seen as challenging and/or for people with a co-existing mental health condition. They are used by commissioners for people living in the community and in learning disability and mental health hospitals. CTRs are designed to help improve the quality of care people receive in hospital by asking key questions and making recommendations that lead to improvements in safety, care and treatment. They are designed to help improve current and future care planning, including plans for leaving hospital, to help to reduce the amount of time people spend in hospital and help to sort out any problems which can keep people in hospital longer than necessary.

CTRs are carried out by an independent panel of people. This includes an expert by experience (a person with a learning disability or autism, or a family member or carer of someone with lived experience of services). The panel also includes a clinical expert and the commissioner who pays for the person's care. Our responsibility as a Trust is to notify our commissioners when a CTR is required (for example, when a person who meets the above criteria has been referred for inpatient care, or when a learning disability or autism is identified as part of a current inpatient's presentation).

The Trust has developed a Paris functional process designed and launched in 2017/18. This gives the inpatient wards the function to electronically request a CTR to the Trusts' CTR team (overseen by the Service Line Manager in Learning Disabilities) who checks the clinical appropriateness of the person's referral for inpatient care and ensures that the Clinical Commissioning Group is electronically notified. This notification activates a request for a CTR including the date of referral, following up with weekly Winterbourne Assuring Transformation information for submission to NHS England. The electronic system also then runs a report every week based on ICD10 [diagnostic] coding of people detained in hospital under the Mental Health Act, to ensure that no one who is entitled to a CTR misses out. This is overseen by a CTR team of nurses for accuracy.

The Service Line Manager also then attends the inpatient mental health service Red2Green meeting (around patient flow) for feedback and discussion on the TCP cohort and escalates any blockages or delays in the discharge process to the commissioners. The impact of this development has been that we

are able to ensure that all people with a known learning disbility being referred for a mental health inpatient admission are then flagged for a Care and Treatment Review.

The Forensic Learning Disability/Autistic Spectrum Disorder Team

This is new investment for the development of a forensic LD/ASD team, which has recently been recruited to. The staff team will include an Approved Clinician, Speech and Language Therapy, Occupational Therapy and Nursing. The team will focus predominantly on the Transforming Care cohort of people who are identified as being expected to be discharged from NHS England Specially Commissioned beds, secure provisions and private beds. The focus of this work will be moving people to a more community-focused package of care within the county.

Dementia training in our older people's wards

"Dementia is a typically progressive clinical syndrome of deteriorating mental function significant enough to interfere with activities of daily living. Impairment in mental function due to dementia is more severe than that expected with normal ageing" (from the Trust's Dementia Diagnosis, Treatment and Management Training resource for nurses). This training includes the most common types of dementia, how dementia affects the brain, and behavioural symptoms that would be expected. Bearing this in mind, it is imperative that staff on our older people's wards have access to such training. On our Kingsway site, see below for an example of what our staff have achieved with regards to compliance with Dementia Level 1 and Level 2 on Cubley Court Male:

Please see below compliance % for

Competence Name	Does not meet requirement	Meets Requirement	Grand Total	Compliance %
383|LOCAL|R Dementia Awareness Level 1 (Once Only)|	2	36	38	94.74%
383|LOCAL|R Dementia Awareness Level 2 (Once Only)|	1	11	12	91.67%

STopping Over-Medication of Patients with Learning Disabilities (STOMPwLD)

Working in partnership with medical colleagues in Derbyshire Community Health Services NHS Foundation Trust, a local audit was undertaken in August 2017 of 42 patients and 98 prescriptions (37 outpatients and five inpatients). Those in the sample were agreed to be reasonably representative of the service. At these reviews, 10% of prescriptions were stopped or reduced.

Derbyshire Recovery Partnership (DRP)

This is our new drug and alcohol treatment service for Derbyshire which started on 1 April 2017. It is an innovative new partnership between the Trust and three third sector providers: Derbyshire Alcohol Advice Service (DAAS), Phoenix Futures and Intuitive Thinking Skills (ITS). This partnership focuses on the existing key strengths of each organisation to create an integrated and coordinated drug and alcohol system for the first time in Derbyshire. The teams are based across Derbyshire, and offer different levels of support from brief advice and harm reduction to intensive structured one-to-one and group work for those requiring support with drug or alcohol issues. Staff are co-located and work to integrated and agreed processes and pathways supported by the Trust's clinical governance structures. Whilst the Trust nursing and prescribing team provides medical interventions, the partner services' work focus on key areas of support for individuals using the same information technology systems, policies and procedures to support quality care. Within the partnership, different partners lead on specific key areas:

- Phoenix Futures has been a partner of the Trust since 2012. Working in partnership with the Trust's medical team, the Phoenix keyworkers provide therapeutic treatment for individuals with drug or alcohol problems, including one-to-ones and group sessions, which work alongside medical treatment as well as specialist services such as needle exchange. The keyworkers are the backbone of the service and work alongside Trust nursing and prescribing staff to form a holistic care package for service users.
- Intuitive Thinking Skills (ITS) employ peers to deliver group work courses with the aim of supporting individuals to develop key life skills and independence, not just from substance misuse but across life in general. The group facilitators have passion for recovery, have a background in addiction or offending and so can use their own learning to support others to make key steps to changing their lives.
- Derbyshire Alcohol Advice Service (DAAS) provides three key elements within the new service: The Hub, a counselling service and a training team. The Hub is the single point of contact for all referrals into the Derbyshire Recovery Partnership. Staff at the Hub provides immediate advice and information and can help individuals to access support for recovery from problematic drug or alcohol use. In addition, DAAS provides a substance misuse counselling service aimed to help service users to understand some of the underlying factors which may have contributed to their substance misuse and help them work through these in order to maximise their long-term recovery. For health professionals the training team provides training in substance misuse. Current training courses include: basic alcohol awareness; substance misuse education; substance misuse brief interventions training; working with families affected by alcohol misuse and working with change-resistant substance misusers.

Support from Healthwatch Derby and Healthwatch Derbyshire

We have continued to have a very positive and constructive relationship with both Healthwatch Derby and Healthwatch Derbyshire. Examples of our contact and feedback are as below:

Healthwatch Derby's visit to London Road Community Hospital, October 2017

The Resource Centre

- Mixture of first-time attendees and veterans of the service - all positive
- No concerns with regards to the service or complaints. Comments were around how good the service was, empathetic, caring and responsive
- One area of negative feedback was the waiting period - Waiting for up to a year for appointments - GP PTS Referral, 18-month wait then finally appointment

- We did hear that patients felt they had no crisis support at weekend going to A&E NHS 111 assessment for over an hour then going to A&E, but there was some consideration if this was more a case of patients not knowing very much about the weekend support rather than it being the case that there is no support.

Wards 1 & 2

- There was a recurring theme in patients not knowing why they were there
- Patients said the service was very good and they felt very safe, cared for, looked after, and 'felt at home'
- People seen 60, people spoken to 55, feedback taken 105.

Healthwatch Derbyshire's visit to Derbyshire Recovery Partnership (Substance Misuse & Alcohol Abuse Services)

Four visits, both announced and semi-announced, were completed to different bases across the county over November 2017. Each took between four and six hours.

Summary of findings and themes across all visits:

- Treatment centre locations are difficult to find on initial visits
- Treatment centres are considered to be easily accessible to clients by public transport but sometimes distance and the costs incurred can be financially challenging
- The buildings used by the treatment centres all, to varying degrees, need further attention to design, disability access, adequacy of facilities, furnishing and general décor
- Access to toilet facilities and refreshments is an issue for clients across most of the treatment centres
- The provision of 'family-friendly' facilities at treatment centres needs review across all sites
- Clients were not always aware of the range of facilities/support that could be accessed within or via the treatment centres
- Clients were complimentary about the support provided by key workers
- Generally, both clients and staff were very satisfied with the service and have noted mainly positive improvements since the new DRP service structures were introduced
- In the main, appointment systems appeared to work satisfactorily for most clients but some issues across sites were raised as concerns
- There appear to be good communication links maintained with GPs
- Key workers acknowledged the benefits to their work that the new DRP service has provided but also sensed that increased workload demands have been created
- The DRP service has withdrawn home visiting for those with alcohol dependency problems which staff state has resulted in reduced attendance of such individuals
- Clients felt comfortable about raising concerns but were not always aware of the procedure for doing so
- There are particularly good rehabilitative/recovery services links from the Ilkeston Treatment Centre.

DHCFT Trust Performance Dashboard 2017/18

DHCFT Trust Performance Dashboard YTD (03/05/18)	No.	%	Target
- NHS I Targets - Single Oversight Framework			
- CPA seven day follow up	610	98.69%	95.00%
- Data Quality Maturity Index (DQMI) - MHSDS Data Score	288,583	96.50%	95.00%
- IAPT referral to treatment within 18 weeks	8,088	99.91%	95.00%
- IAPT referral to treatment within six weeks	8,088	93.64%	75.00%
- EIP RTT within 14 days - complete	264	89.39%	50.00%
- EIP RTT within 14 days - incomplete	169	81.66%	50.00%
- Patients open to Trust in employment	40,919	8.90%	N/A
- Patients open to Trust in settled accommodation	40,919	52.46%	N/A
- Under 16 admissions to adult inpatient facilities	0	N/A	0
- IAPT people completing treatment who move to recovery	7,751	53.21%	50.00%
Physical Health - Cardio-Metabolic - Inpatient	*Currently monitored by audits*		
Physical Health - Cardio-Metabolic - EI	*Currently monitored by audits*		
Physical Health - Cardio-Metabolic - on CPA (Community)	*Currently monitored by audits*		
- Locally Agreed			
- CPA settled accommodation	34,067	96.29%	90.00%
- CPA employment status	34,067	97.71%	90.00%
- Patients clustered not breaching today	181,483	76.40%	80.00%
- Patients clustered regardless of review dates	192,564	94.25%	96.00%
- 7 day follow up – all inpatients	1,319	96.29%	95.00%
- Ethnicity coding	288,583	91.26%	90.00%
- NHS number	63,372	100.00%	99.00%
- CPA review in last 12 months (on CPA > 12 months)	2,860	94.30%	95.00%
- Clostridium Difficile incidents	1	N/A	7
- 18 week RTT greater than 52 weeks	0	N/A	0
- Schedule 6 Contract			
- Consultant outpatient appointments Trust cancellations (within six weeks)	54,234	9.09%	5.00%
- Consultant outpatient appointments DNAs	36,663	15.53%	15.00%
- Under 18 admissions to adult inpatient facilities	1	N/A	0
- Outpatient letters sent in 10 working days	33,231	88.36%	90.00%
- Outpatient letters sent in 15 working days	33,231	94.12%	95.00%
- Inpatient 28 day readmissions	1,484	9.10%	10.00%
- MRSA - blood stream infection	0	N/A	0
- Mixed sex accommodation breaches	0	N/A	0
- Delayed transfers of care	4,594	2.19%	0.80%
- 18 week RTT less than 18 weeks - incomplete	3,565	95.15%	92.00%
- Fixed submitted returns			

18 week RTT greater than 52 weeks	0	N/A	0
18 week RTT less than 18 weeks - incomplete	4,940	94.94%	92.00%
Mixed sex accommodation breaches	0	N/A	0
Completion of IAPT data outcomes	8,015	96.31%	90.00%
Ethnicity coding	288,241	92.05%	90.00%
NHS number	63,969	100.00%	99.00%
CPA 7 day follow up	605	98.51%	95.00%

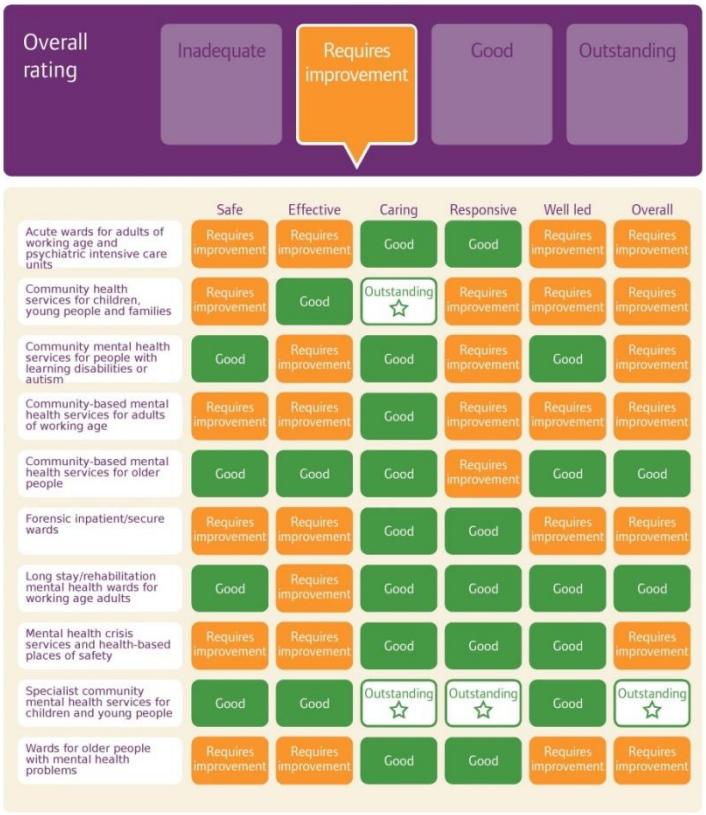
The Trust's CQC rating

The result of our 2016 inspection was that the CQC rated our organisation as requiring improvement. Ratings for individual areas have been upgraded in response to subsequent announced and unannounced visits, and quality improvement work has been undertaken to address the actions from the 2016 visit and from subsequent visits, as shown in the tables below.

Overall rating for services at this Provider	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Requires improvement
Are services caring?	Good
Are services responsive?	Requires improvement
Are services well-led?	Inadequate

Our clinical service reports

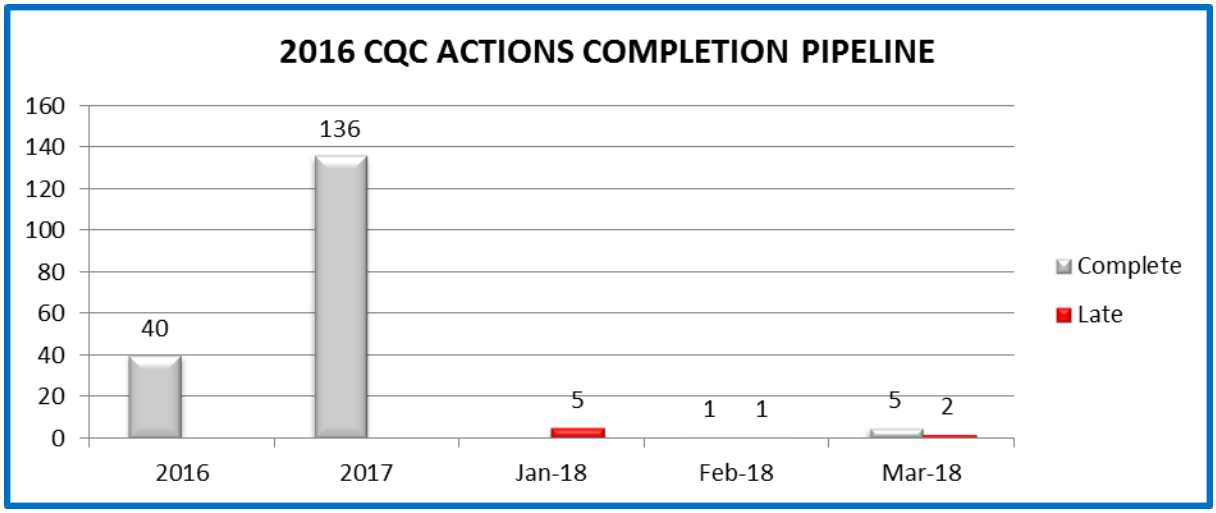
These are the current results for the comprehensive inspection in June and service revisitied and regraded in visits in December (2016) and January (2017).

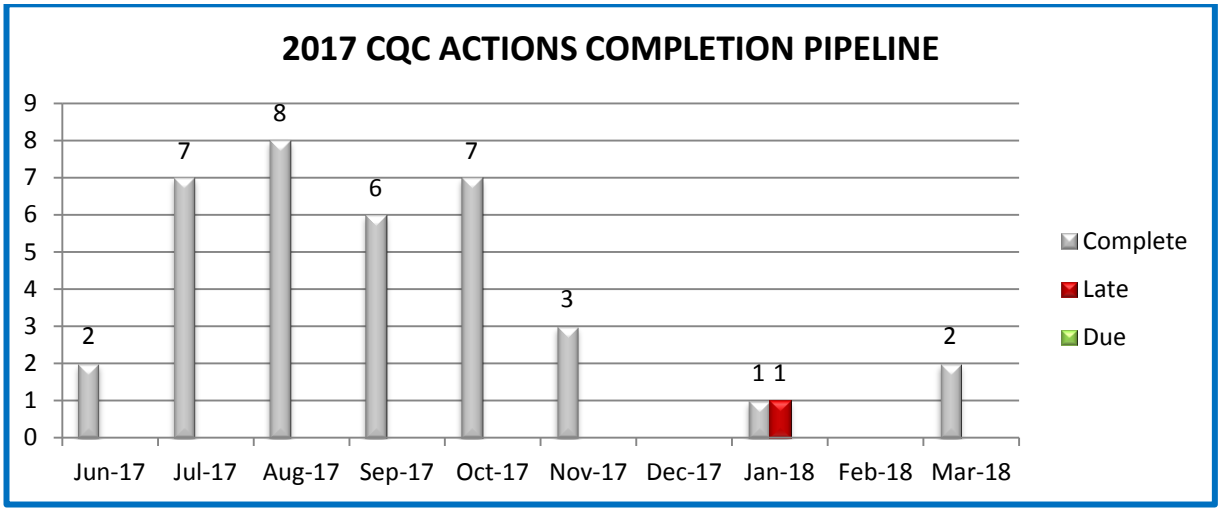


	Safe	Effective	Caring	Responsive	Well led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Community health services for children, young people and families	Requires improvement	Good	Outstanding ☆	Requires improvement	Requires improvement	Requires improvement
Community mental health services for people with learning disabilities or autism	Good	Requires improvement	Good	Requires improvement	Good	Requires improvement
Community-based mental health services for adults of working age	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Community-based mental health services for older people	Good	Good	Good	Requires improvement	Good	Good
Forensic inpatient/secure wards	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Long stay/rehabilitation mental health wards for working age adults	Good	Requires improvement	Good	Good	Good	Good
Mental health crisis services and health-based places of safety	Requires improvement	Requires improvement	Good	Good	Good	Requires improvement
Specialist community mental health services for children and young people	Good	Good	Outstanding ☆	Outstanding ☆	Good	Outstanding ☆
Wards for older people with mental health problems	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement

CQC actions progress

Our Quality Committee has led the oversight of the assurance systems of improving our practice around completing our CQC actions. Our current performance is as shown below. The data below is sourced from our CQC portal data management system, where we track and upload evidence to provide assurance (status as at 28/2/18). Our ambition is for all these actions to be closed by 31 March 2018.





Quality Visits

The Quality visit programme continued in 2017 and commissioners, non-executive directors and governors were involved in a significant number of our visits. The visits were moderated in October, and quality improvements made by teams were recognised at the annual award event held in December 2017. Between February and October 2017, 69 Quality Visits were undertaken across the Trust, each lasting between two and three hours. Teams being visited were asked to consider their implementation of family inclusive practice and/or Triangle of Care self-assessment, evidence of inclusivity for non-clinical teams, and the level of compliance with performance standards over the previous 12 months. Specifically, supervision, mandatory training and appraisal rates were reviewed.

Five teams did not receive a planned visit. For clinical teams, reasons for asking not to be visited were related to extra-ordinary clinical pressures affecting the team's ability to prepare for or to provide staff for the visit on the day. For non-clinical teams, reasons were relating to the move to the shared services with Derbyshire Community Health Services NHS Foundation Trust.

Visits were underpinned by written guidance, both around expected content of the visit and also how ratings would be calculated for each of the key lines of enquiry.

Over-arching themes across Season 8 Quality Visits

- The commitment of staff to their respective areas was clearly evident
- The value of the service provided to those receiving it was also evident in the feedback on the day
- Supervision statistics were often below the Trust target or not provided. This was attributed to a combination of:
    - Supervision not happening as much as would be expected
    - If it happens, it not being recorded
    - Team workforce data being out of date and including staff no longer in the team
    - Managers not being clear as to how to find this information on the intranet
    - Supervision recording systems not being sensitive to adjust for people on long-term leave
- Mandatory training can be difficult to access, either classroom or e-learning
- Recruitment challenges and managing staffing gaps
- There is an impact on many areas of the current waiting times to access working age adult Neighbourhood services
- Non-mental health areas of our Trust sometimes do not feel particularly part of the organisation. They can feel that the organisation and the developments have very much a mental health focus

- Staff in non-clinical teams also shared a commitment to the experience of the people who use our services
- Administrative colleagues were seen as a key contributor to a well-functioning team
- Where some teams are facing uncertain futures this brought particular concerns for staff
- Where initiatives are being developed, it's important that they are informed by an evidence base, that outcomes are captured and that the views of service users are also captured.
- Generally a need to improve the collation and reporting of the feedback that teams receive, including compliments
- Some challenges with Information Technology systems and compatibility across agencies.

Overall the themed approach of Think Family and family-inclusive practice has supported the Trust in achieving an organisational goal of the external verification of a Level two Triangle of care rating.

Examples of Quality Visits best practice showcases

- Introducing evidence based interventions
- Multi-agency training
- Shared training around clinical skills and expertise
- Developing profession specific roles
- Physical healthcare and health promotion
- Quality Improvement approaches to improving attendance to appointments
- Employment opportunities for people with mental health problems or learning disabilities
- Partnerships between staff, people using Trust services and carers to support service developments
- Training and education for service users and carers
- Raising awareness around mental health in schools and colleges
- Partnership working with community organisations.

The Team Awards – winners and runners up

PROMOTING SAFETY

- **Winner – Criminal Justice Mental Health Liaison Team:** For developing the team to encompass a broader patient base, and also for developing partnership arrangements across a wide variety of agencies. Members have embedded their practice in the police force in response to emergency situations, and have adapted what they are learning from implementing the model
- **The Safeguarding Children Team:** As a result of their ongoing, sustained and high quality work around safeguarding children, and for how they all work together, value and support each other
- **Talking Mental Health Derbyshire:** For triangulating high referral rates, retaining staff through difficult times, reducing their waiting times across all areas whilst not compromising their position regarding quality of care, and for describing a multi-agency approach to safety planning.

HEARING THE PERSON'S VOICE

- **Winner – Chesterfield Central Neighbourhood Team:** For triangulating and evidencing the views of the people who use their service, and for presenting extremely positive feedback around their work with partner providers. The team's presentation covered a range of different ways of hearing what it's like to be supported by them, including written narrative feedback, attendance at the visit from service users and carers, and Friends and Family Test results
- **Morton Ward:** For carefully collating evidence for each domain in the Triangle of Care, for maintaining a focus on quality improvement within a very busy clinical environment, and the description of a person's opportunity to be involved in developing coping strategies and writing their care plan
- **The Strategic Health Facilitation Team for Adults with Learning Disabilities:** For their caring attitude and inclusive way of working with individuals with learning disabilities, their engagement

with families, and their approaches to making sure people using services are able to give their feedback.

IMPROVING AND INNOVATING

- **Winner – Kedleston Low Secure Unit:** For working through a programme of impressive improvements across all aspects of care provision, and for doing this in a sustained and methodical manner. The team presented a significant amount of data, in a clear way, to highlight the quality improvement work the ward team members have undertaken. They have shown sustained development on the back of challenges, and they have involved former patients in the development of their Recovery College
- **The Beeches, Perinatal Mental Health:** For introducing examples of innovation including using Skype to allow mothers to read bedtime stories to their children at home, Open Lounge Sundays, where all family members are invited in, and their inclusion of a former inpatient who is now a volunteer in the care team
- **CAMHS County:** For their approach to Waiting Well and to psychological therapy for young people's needs, and their approach to service developments that have been undertaken in partnership with the young people who access the service, family members and staff.

OUTCOMES AND MEASUREMENT

- **Winner – Occupational Therapy & Recreation Service at the Hartington Unit:** For supporting patient flow and evidencing improvement in patient outcome and experience, whilst maintaining a person-centred and skills-based approach. The team have used outcome measures at the beginning and the end of the Food-Mood Group, and identified with people using the group the skills they would like to develop
- **CAMHS Liaison Team (CAMHS RISE):** For presenting data showing that the outcomes achieved were in the best interests of the young people accessing the service and their families. Also, for showing a strong theme of empowerment for the young person, the family, the support systems around them and for the RISE team themselves
- **The Nutrition and Dietetics Team**: For work around Healthy Food Benchmarking against hospital food standards, improved staff awareness of meal preparation for specific dietary needs, and an evaluated project around dietary and food preparation skills.

RESILENCE award (thriving in difficult times)

- **Winner – Liaison Team North:** For developing positive collaborative arrangements with colleagues in the Crisis Team and inpatient unit to ensure patient safety at times of staffing pressures, at the same time as developing a holistic needs assessment and high-impact user clinics. The team this year completed and achieved the Psychiatric Liaison Accreditation Network (PLAN) to assure and improve the quality of service. They have demonstrated a high level of innovation and evidence-based practice, and received very positive feedback from other teams and from people who have used the service
- **High Peak and North Dales Neighbourhood Team:** For their joined duty systems between working age and older adults, reduced work-related sickness, patient feedback, continued links with community projects and for being fully recruited. They maintain business as usual really well, and also manage to innovate
- **Physiotherapy Services, Kingsway:** The team has implemented a data analysis tool to help predict and track changes in capacity and demand for services, therefore allowing them to safely plan caseloads. They described involvement in research, publications, and use of NICE Guidelines.

CLINICAL TEAM OF THE YEAR

Winner – Liaison Team North: For all of the above, and for consistently 'delivering excellence' throughout the year.

NON-CLINICAL TEAM OF THE YEAR

- **Winner – The Finance Team:** For their very integrated approach with operational services and their connectedness to service delivery and the importance of patient experience. The team have offered opportunities to a service user, an apprentice and an undergraduate over the last 12 months, to experience the NHS finance workplace. The team have also developed 'drop in' training for budget holders which has been very much appreciated by operational managers, and also more efficient travel booking.
- **Information Management, Technology & Records Team**: For the outstanding work of the team to support and limit the impact of the cyber-attack on the Trust, and for developing an approach to real-time bed status, linking our clinical systems together, and ward status monitors.
- **Research and Development:** For integrating well within the Trust and with the wider health economy, and for the work they are doing to embed research and evaluation skills in the Trust, and to embed research into practice, together with their national work on self-harm.

Annex 1: Statements from commissioners, local Healthwatch organisations and Overview and Scrutiny Committees

As part of the process for developing this document, we are required to share the initial draft with a range of third parties and publish their responses. Below are the comments we received:

Feedback from Governors 28 April 2018

The text below is a summary of the discussion with Trust governors at the Governance Committee of 17 April 2018:

Overall comments

The report is seen as thorough, robust, comprehensive, detailed, open and honest. The governors acknowledged the prescribed content, and feel confident that the content is aligned with their knowledge of the Trust, including from other documents or meetings.

Quality priorities

With regards to whether or not the report has the right priorities to have the biggest impact in driving up quality in the Trust, governors feel reassured that the data was available to be able to be included in the report. The Governors ask that a table is added to more clearly show waiting list times, including if this is for a first appointment or a follow up appointment, plus what happens for people who need psychotherapy outside of the IAPT model. Agency spend was discussed, and we agreed that this will be covered in the broader annual report.

Suggestions for the 2018/19 Quality Report

- Waiting times and psychotherapy referrals as described above
- A description with a quality focus as to our performance around recruitment, retention and training
- The governors also ask if we can explore how we might be able to map any potentially hidden diminution of services e.g. twice yearly appointments from four times yearly appointments, that is driven by workload pressures rather than personal choice or reduced clinical need
- Work with other agencies around quality schemes, as part of the Sustainability and Transformation Programme.

Other suggestions

- Theme the best practice from the quality visits.

John Morrissey
Lead Governor, Derbyshire Healthcare NHS Trust

Feedback from Hardwick Clinical Commissioning Group

NHS Hardwick Clinical Commissioning Group (HCCG) is the lead commissioner for Derbyshire Healthcare NHS Foundation Trust on behalf of the four Clinical Commissioning Groups across Derbyshire. A key component of this role is the responsibility of monitoring the quality and performance of services provided by the Trust throughout the year. We welcome the opportunity to provide the narrative on the Quality Report for 2017/18 and provide the following comments:

We note that Derbyshire Healthcare NHS Foundation Trust continues to work constructively and collaboratively with Commissioners throughout the year to provide assurances on a wide range of indicators relating to quality, safety and performance. The trust has an open and transparent culture to safety and welcomes Commissioners' feedback and input. Inclusion in the Quality Visit Programme shows that these values are evident throughout the organisation.

The Trust continues to make good progress in relation to embedding the required actions resulting from CQC inspections in 2016 and 2017. The hard work from staff should be noted and commended, in that the Trust has implemented and embedded more than 200 induvial actions/recommendations. However, it should be noted whilst the ambition was to close all actions by the end of March 2018, there are a number which are overdue and have not been completed in the required timescales. Whilst the overall rating CQC has not changed, over the past 12 months subsequent inspections by the regulators have seen marked improvement in a number of individual services.

During 2017/18 a number of key workstreams were implemented by the Trust in response to service requirements. These included the support of vulnerable families through the Family First model, the commitment to minimise the number of days in hospital with the implementation of the national Red2Green initiative, a review of the Neighbourhood services and partnership working with third sector providers for an integrated drug & alcohol system in Derbyshire.

The Quality Report is an accurate and open account of the progress made against the quality improvements outlined for 2017/18. The report shows that progress has been made in the majority of priorities and recognises that the organisation needs to work with staff to improve their overall wellbeing. Commissioners acknowledge and support the five Quality Priorities identified by the Trust for 2018/19.

In 2017/18 the Trust participated in 100% of national clinical audits and national confidential enquires which covered relevant services provided by the Trust. These included POMH-UK Topic 16b: Topic Rapid tranquillisation, National Confidential Enquiry into Patient Outcome and Death: Young People's Mental Health study and the National confidential inquiry into suicide and homicide by people with mental illness. It was encouraging to note that the organisation followed up on its commitment made the previous year and reviewed two national audits. This has resulted in a number of actions in relation to POMH-UK Topic 16a: Rapid tranquillisation and Topic 1g & 3d: Prescribing high-dose and combined antipsychotics.

Overall the Trust continues to report positively against a number of core national and local quality indicators. The Trust and staff should be commended for once again having 'zero' reported cases of MRSA Mixed Sex Accommodation Breaches and minimal cases (one) of Clostridium Difficile and Admissions of an Under 16 to an Adult Inpatient Facility. Considerable improvements have also been noted in a number of areas including outpatient letters and discharge emails. The Trust continues to strive to improve key areas, such as Consultant Outpatient Appointment Cancellations and will continue to be monitored by Commissioners.

In line with national requirements, the 2017/18 Quality Report has a dedicated section outlining the work undertaken to understand the mortality data and systems and processes developed to meet the National Quality Board guidance (published March 2017) for Learning from Deaths.

Throughout the year the Trust has continued to face considerable pressure to maintain safe staffing levels within inpatient and community services. The Trust continues to look at alternative means of developing current staff skills sets, including development of the OT role and the continued development of the Nurse Associate role. There is a lack of focus on this key pressure within the report and commissioners feel that this should be reflected in the Quality Report.

Commissioners noted that the Quality Report acknowledges that the Trust has seen issues providing a timely response to some complaints. These have been monitored by Commissioners through contractual meetings and they feel that the report would benefit by highlighting some of the actions taken. This would provide a level of assurance currently missing in this section.

We believe that we have a highly positive relationship with the Derbyshire Healthcare NHS Foundation Trust, and we look forward to further developing this in the pursuit of high quality mental health services for the population of Derbyshire. We will continue to work with the Trust in the monitoring of progress against the priorities outlined in this report.

Phil Sugden
Deputy Director of Quality
NHS Hardwick CCG

3 May 2018

Feedback from Healthwatch Derby

Healthwatch Derby
The Council House
Corporation Street
Derby
DE1 2FS
Telephone: 01332 643989
Email:Samragi.Madden@healthwatchderby.co.uk

25th April 2017

Ms Carolyn Green
Director of Nursing
Derbyshire Healthcare NHS Foundation Trust
Trust HQ
Kingsway, Derby
DE22 3LZ

Dear Carolyn

Re Quality Report 2017/2018

On behalf of Healthwatch Derby, I would like to present our formal response to Derbyshire Healthcare NHS Foundation Trust's Quality Report 2017/2018.

We believe the good work observed during our outreach and observational engagements has been accurately reflected in the comprehensive Quality Report.

Healthwatch Derby has in the course of the last financial year picked up both positive and negative feedback relating to Trust services. I am pleased to report both positives and negatives were welcomed in an open and transparent manner. Where there were learning opportunities the Trust sought to establish contact at once, and listened to concerns and feedback. Strong and effective leadership taking responsibility and being accepting of critical feedback is often a difficult prospect for services in general – in our experience this has actually improved significantly in the last year for the Trust.

Derbyshire Healthcare NHS Foundation Trust is part of Derby city's changing landscape of health and social services aligning to provide a seamless, effective, and responsive service. We are also aware that some functions of the Trust such as Equalities have now merged with Derbyshire Community Health Services Trust. We continue to monitor each service, and provide feedback to all colleagues within established information sharing protocols.

Through our work we have been vocal in projects such as Reverse Commissioning, to highlight the importance of hearing from diverse backgrounds, ages, and varying communities of patients and carers. We have also taken part in the Trust EDS Grading events and provided honest feedback about services under review.

In the last year we undertook a series of outreach engagements, many of which were at the Radbourne Unit at the Royal Derby Hospital site. We have also liaised with the Trust's Breakout Services for young people based at Connexions. We also attended Wards 1&2, as well as the Resource Centre at the London Road Community Hospital site. Through all our outreaches significant feedback was fed directly to the Trust.

Overall the feedback has been very positive from patients and carers. Where there are areas for improvement we have highlighted this, and are pleased to see some of our feedback has been featured as part of the Quality Report.

Healthcare, especially mental healthcare services do not work in a vacuum, and are often dependant on the close integration of other services. Wherever possible Healthwatch Derby has acted as a conduit for information and intelligence exchanges, and championed patient engagement through its forums such as IDEN – Insight Derby Engagement Network. We are also working closely with the Trust's partners Derbyshire Community Health Services to ensure patient voices are not lost between pathways and services. We are pleased to report both Trusts have been very welcoming of patient feedback and all concerns highlighted have been acted upon without any delay. We appreciate the reality of delivering services, and the constraints Trusts have to work within – we are delighted that despite challenges such as funding, changes to services etc, our working partnership has only grown stronger and more robust in the last year.

We therefore look forward to another year of strong partnership work, and our joint efforts to hear from patients, and to improve services for all. If you have any enquiries about this response or require any further information please do not hesitate to contact me directly.

Yours Sincerely

Samragi Madden
Quality Assurance & Engagement Manager Healthwatch Derby

Company Registration Number: 8233546 Registered Office: The Council House, Corporation Street, Derby DE1 2FS

Feedback from Healthwatch Derbyshire 30 April 2018

Healthwatch Derbyshire (HWD) is an independent voice for the people of Derbyshire. We listen to what people like about health and social care services, and what they think could be improved. We share this feedback with those who have the power to make change happen.

We gather experiences from patients and members of the public through a team of Engagement Officers, supported by volunteers and experts by experience. We undertake both 'general engagement' to hear about a variety of different experiences, and 'themed engagement' which we use to explore a particular topic in more detail.

We also deliver Mental Health Together Derby and Derbyshire, working with people with first-hand experience of mental health conditions, and those who care for them. We believe that these are the people best qualified to help shape health and social care services to provide better care in the future.

The findings of our themed engagement work are analysed and written up into reports, which include recommendations for improvement. Service providers and commissioners are then asked to respond to these recommendations. All our reports, including the responses we receive, are published on either the Healthwatch Derbyshire, or Mental Health Together website.

The experiences gathered through our 'general engagement' are fed through to organisations on a regular basis throughout the year to give an independent account of what is working well, and what could be improved. Anyone who shares an experience with HWD is able to request a response, and we encourage organisations to consider responses carefully and indicate where learning has taken place as a result of someone's experience. The Trust replies to these comments thoroughly and with rigour, setting out learning and next steps that will follow.

We have read the Quality Account for 2017/18 prepared by the Trust with interest. We have considered if and how the content reflects some of the topics which have emerged in the feedback that we have collected during the past year. Many of the themes highlighted to us are directly addressed in priorities detailed in the Quality Account, specifically:

- Relapse reduction and harm reduction
- Improving services for people with mental health needs who present at A&E
- Autism awareness training for all staff

The Quality Account also highlights the constructive and positive relationship that we have with the Trust. We have had contact and feedback with the Trust around a programme of Enter and View visits to the Derbyshire Recovery Partnership (Substance Misuse and Alcohol Misuse Services) in January 2018. This piece of work highlighted a range of key themes and findings, to which the Trust has provided a detailed response, including a range of next steps and actions.

We look forward to working with the Trust in the year ahead.

Annex 2: Statement of directors' responsibilities for the quality report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- The content of the Quality Report meets the requirements set out in the NHS foundation trust annual reporting manual 2017/18 and supporting guidance
- The content of the Quality Report is not inconsistent with internal and external sources of information including:
    - board minutes and papers for the period 1 April 2017 to 24 May 2018;
    - papers relating to quality reported to the board over the period 1 April 2017 to 24 May 2018;
    - feedback from commissioners dated 03/05/2018;
    - feedback from governors dated 28/04/2018;
    - feedback from local Healthwatch organisations dated 25/04/2018 and 30/04/2018;
    - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 04/05/2018;
    - the national patient survey dated 01/08/2017;
    - the national staff survey dated 26/03/2018; and
    - the Head of Internal Audit's annual opinion of the Trust's control environment dated 03/05/18.

- The Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered
- The performance information reported in the Quality Report is reliable and accurate
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice
- The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and
- The Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the board

.....Date.....Caroline Meloy.....Chairman

.....Date.....Chief Executive

Notes

Notes

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