NHS
Derbyshire Healthcare
NHS Foundation Trust

Quality Report
2018/19

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 2018/19. The report is the opportunity for our Board to look back and offer a view as to the quality of the healthcare that we have provided over the year, to reflect on some of our key achievements and to think about our priorities for the coming year for our communities. This is an annual report, and in it we note our formal regulatory requirements, areas that we see as high quality and innovative care and areas that we have found challenging. I cannot think of an area of the Trust that has seen reduced demand over the year, this including our mental health, children's, substance misuse and learning disability services. Alongside this, we share the national challenge around recruitment and retention. Overall, our vacancy rate as a Trust is very healthy, supported by many new initiatives such as targeted use of social media and front line staff attending career fairs. In spite of this, there are still clear hot spots on the ground where staffing challenges are very much felt.

During the past year we received a comprehensive inspection from the Care Quality Commission. Whilst our headline rating remains 'requires improvement', it is important to read behind that to the detailed feedback provided to our hard working teams. The report highlighted a number of significant improvements that have taken place across the majority of services since the last inspection in 2016 and overall our results have improved, with eight domain areas moving from 'requires improvement' to 'good', and three 'outstanding' ratings for community mental health services for children and young people. The 'inadequate' rating for our acute wards for adults of working age is disappointing for everyone and clearly a challenge, but one that colleagues have responded to very positively indeed. It is important to remember that the staff in these services were still awarded 'good' for caring, something that tallies with the passion I see and hear from colleagues in our adult acute care services.

If ever I'm asked what keeps me awake at night, it is usually the ever increasing demand for our services leading to waiting times for people to access our services. This, along with care planning, how we assess risk and mental capacity must remain a key priority for us moving forward. We are also still challenged by some of our recruitment processes, as we seek to get the right people, in the right place, at the right time, as quickly and smoothly as possible. Within the environment that we find ourselves operating in, we remain committed to the requirement for collaboration in the broader healthcare system. We have very clear examples of the positive outcomes that are achieved by meeting people's needs earlier in the pathway and in partnership with other providers, these being our approach to the High Impact User population in Accident and Emergency, the implementation of our Dementia Rapid Response Teams and the Joint Engagement Team (a pilot project joint working between Derbyshire Healthcare Foundation Trust and Derbyshire Police).

We welcome the NHS Long Term Plan and the continued focus it has on our portfolio of services, and I note we are at a pivotal point in the way we deliver healthcare. As one of our quality priorities, we have launched our clinically led strategy development work-streams and our leadership and management internal development programme, to move us further towards a culture of collaboration and continuous quality improvement, whilst at the same time defining our response to the Long Term Plan. Our staff survey has seen a 9% increase in responses and there is evidence of early growth in improvement in some areas, in particular our fair approach to career progression and staff sense of being valued. We remain committed to staff wellbeing as the way of supporting high quality care. Whilst we continue to recognise our areas of high pressure, celebration events associated with the celebration of NHS70 such as fun runs, bake offs, the summer fete and Big 7Tea Party were an important part of how we work together as Team Derbyshire Healthcare.

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
1 April 2019

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 2019 (the "Quality Report") and certain performance indicators contained therein against the criteria set out in the 'NHS foundation trust annual reporting manual 2018/19' and additional supporting guidance in the 'Detailed requirements for quality reports 2018/19' (the 'Criteria').

Scope and subject matter

The indicators for the year ended 31 March 2019 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
- Inappropriate out-of-area placements for adult mental health services.

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 2018/19' 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 2018/19' 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 2018/19'; 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 2018/19' and supporting guidance and the six dimensions of data quality set out in the "Detailed requirements for external assurance for quality reports 2018/19'.

We read the Quality Report and consider whether it addresses the content requirements of the 'NHS foundation trust annual reporting manual 2018/19' 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 2018 to 23 May 2019;
- papers relating to quality reported to the Board over the period 1 April 2018 to 23 May 2019;
- feedback from NHS Derby and Derbyshire Clinical Commissioning Group dated 24/04/2019;
- feedback from governors dated 16/04/2019;
- feedback from local Healthwatch organisations dated 02/05/2019 (Healthwatch Derby), and 09/05/2019 (Healthwatch Derbyshire);

- the Trust's complaints report published under regulation 18 of the Local Authority, Social Services and National Health Service Complaints (England) Regulations 2009, dated 07/05/2019;
- the national patient survey dated 22/11/2018;
- the national staff survey dated 26/02/2019;
- the Head of Internal Audit's annual opinion over the Trust's control environment dated 30/04/2019; and
- the Care Quality Commission's inspection report dated 28/09/2018.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with these 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 2019, 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 2018/19' and supporting guidance to the categories reported in the Quality Report; and
- reading the documents.

A limited assurance engagement is narrower 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 2018/19' 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 and is subject to separate terms and conditions. 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 2019:

- 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 2018/19' 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 2018/19'; and
- the indicators in the 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 2018/19' and supporting guidance.

Grant Thornton UK LLP

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24 May 2019

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

2.1 Priorities for improvement in 2019/20

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 2019/20. These are a continuation of the priorities from 2018/19.

<table>
<tr><th colspan="6">Priority 1: Physical healthcare</th></tr>
<tr><td colspan="6">Examples of what this will look like
Meeting Physical Healthcare Strategy standards
Delivering EHCP (Education Health and Care Plan) and conversions as per contract (Children's Services)
Meeting Commissioning for Quality and Innovation (CQUIN) requirements for health checks
Developing Electronic Patient Record (EPR) and technological solutions to help our teams</td></tr>
<tr><td colspan="6">How we plan to measure physical healthcare:</td></tr>
<tr><td>Corporate</td><td>Children, young people and families</td><td>Learning Disabilities (Central)</td><td>Mental health inpatient</td><td>Mental health community</td><td>Central Services/ Substance Misuse</td></tr>
<tr><td>Developing EPR and technological solutions to help our teams</td><td>Agree minimum standards for each pathway and undertake a baseline measure

Set trajectory for improvement against baseline measure</td><td>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</td><td>Agree minimum standards for each pathway and undertake a baseline measure (admission and Lester).

Set trajectory for improvement against baseline measure</td><td>Meeting Physical Healthcare Strategy standards and the CQUIN requirements for annual health checks

Agree minimum standards for each pathway and undertake a baseline measure</td><td>Meeting Physical Healthcare Strategy standards

Progress and work on the High Need Support Group (157) offering interventions</td></tr>
</table>

Priority 2: Deliver all named specific CQUINs or contractual targets

Examples of what this will look like:

- 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 CQUINs and focus upon flu inoculations (75%) Undertake autism awareness training	Work on all appropriate CQUINs and focus upon flu inoculations/ A&E reductions and risky behaviours Undertake autism awareness training	Work on all appropriate CQUINs and focus upon flu inoculations/ A&E reductions and risky behaviours Undertake autism awareness training	Deliver your TOPS outcomes. Undertake autism awareness training

Priority 3: Relapse reduction and harm reduction

Examples of what this will look like

- 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 signatures and prevention and reduction of avoidable admission	A well-rounded psychological and health plan that identifies relapse signatures and prevention and reduction of avoidable admission

Priority 4: Being effective

Examples of what this will look like:

- Implement one National Institute for Health and Care Excellence (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 5: Quality improvement (QI) – using your ideas

Examples of what this will look like:

- Develop a pathway-specific clinical strategy and undertake one quality improvement project
- Design a new Quality Improvement Strategy and define agreed methodologies that can be used
- Develop and implement using recommended methodology

How we plan to measure quality improvement:

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 teams 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

Priorities for improvement from the 2017/18 Quality Report and our progress against these:

Priority 1: Physical healthcare examples of progress during 2018/19:

Children, young people and families

Our practice for naso-gastric feeding against policy has been reviewed. CAMHS have an Occupational Therapist in post and are recruiting a band 6 in order to deliver the enhanced care pathway. Their primary role will be to provide additional support to those already open to CAMHS.

Learning Disabilities (Central)

The dysphagia waiting list has a long and short-term plan to mitigate risk, but remains a service risk/priority. The waiting is now decreasing and a fixed term Speech and Language Therapist (with dysphagia training) has been recruited to support this work. The Strategic Health Facilitation Team supports local GP practices to provide Annual Health Checks (AHCs).

Mental health inpatient

Physical healthcare monitoring systems are in place to provide assurance that any gaps in care are being addressed including regular health checks, the Lester tool (our approach to physical health care for people with severe mental ill-health) and NEWS (for early warning signs of physical health deterioration). A Paris (EPR) solution for physical health assessment on inpatient clerking-in proforma is still under development. We seek to continue our strong performance around assessment and intervention for alcohol and cigarette use on admission to inpatient wards. Liver scanning is taking place in the Liaison Team.

Ward based Occupational Therapists are connecting with the physical health agenda and the importance of physical activity. There is a current review of physical health checks on admission, led by the Heads of Nursing, and a recent focus on 136 Suite physical health assessment. Recreation Workers are now in post working within Jackie's Pantry at the Radbourne Unit, to improve access to activities, including physical exercise.

To recognise physical health deterioration, prior to the Derbyshire Early Warning System (DEWS) being replaced by the National Early Warning Score (NEWS2), those patients who have a raised DEWS score are now having notifications sent to the physical health care team and Heads of Nursing. The physical healthcare lead is currently auditing a random selection of patients for the actions completed when DEWS score is raised.

The new International Dysphagia Diet Standardisation Initiative (IDSSI) guidance is to be implemented from 1 April with a 'Champions' model used to train a selection of staff members.

A Standard Operating Procedure (SOP) for dysphagia screening and initial management has been agreed with Speech and Language Therapy (SLT) for older peoples' services acknowledging the link between dysphagia and dementia. This SOP includes a screening tool for use on admission to the service and an escalation flowchart for referral to SLT and modified diet/fluids.

An SOP for inter-organisation transfer has been developed to support the return of patients admitted to the acute hospitals for assessment and treatment.

Mental health community

This remains an on-going challenge, but with some promising developments. We have recruited into defined 'physical health in mental health' roles in the community teams and continue to

engage our primary care colleagues. Results of the National Clinical Audit of Psychosis will not be available until after the publication of this report, but this will show our progress against a sample of our service user population. The Lester tool pilot is now complete in Early Intervention and the Dementia Rapid Response service now has a pharmacy technician. A new tool has been developed to capture baseline physical health observations when service users are admitted.

Central Services/Substance Misuse

Liver scanning is in place in the Substance Misuse teams. The Derbyshire Recovery Partnership has offered training sessions for Trust staff around low level alcohol interventions. Health Improvement Team (HIT) nurses have begun to provide targeted three-monthly physical health assessments for the high risk service user cohort.

The inpatient Physical Health Policy has been reviewed and perinatal section has been updated with reference to Royal College of Psychiatrists' guidelines.

Corporate

We have reviewed the structure of our current electronic record system with regards to physical healthcare. We continue to develop this and are also now developing a hand held device for recording food and fluids.

Priority 2: Deliver all named specific CQUINs or contractual targets Examples of progress during 2018/19:

Children, young people and families

The transition CQUIN from children's to adults' mental health services has been co-produced with young people and their families, with robust questionnaires developed to gather feedback on their experiences. There has been strong achievement throughout the year.

Learning Disabilities (Central)

The team have experienced some recent challenges with the autism training, but we understand that this is now addressed.

Mental health inpatients

- There has been a significant reduction in the need for attendance at Accident & Emergency for a cohort of previously high users of this service. Our acute mental health inpatient colleagues have taken an approach of assessing and offering interventions around a person's alcohol or tobacco use.
- Staff health and wellbeing – Improvements have been identified in the uptake of supervision.
- Implementation of a Police Community Support Officer (PCSO) on the Hartington Unit to offer support and advice to all staff and patients during difficult situations.
- Healthy food – Healthy food options are available for both staff and patients.
- Flu vaccinations – Flu vaccinations are available for all staff, with drop -in clinics held on each campus site in order to improve accessibility. Vaccinators and Peer Vaccinators are also going around all wards to promote uptake.
- Physical healthcare – Several work streams are currently in progress to improve the quality of physical observations and the frequency and quality of recording. This also includes the implementation of bitesize training by medical staff to nursing and nursing assistant staff to improve education on physical healthcare and conditions. A pilot is current underway on Tansley Ward where a junior doctor is carrying out weekly in-house drop-in physical health

clinics for patients to access.

- Tobacco and alcohol screening and interventions for all people admitted to services have shown improved performance over the year, with fully compliant performance across the reported period.
- We have improved access to training for all staff, with audits in place to provide assurance.
- A weekly physical observations report is produced to ensure all patients have received initial physical observations at the point of admission.
- The weekly physical observations report is also produced to ensure all patients have had physical observations completed within the last seven days
- Recovery College in Low Secure services – this is now in place and being accessed by inpatients at the Kedleston Unit.
- Reducing restrictive practice in Low Secure services – this is reviewed on a weekly basis within the multi-disciplinary meeting. There is a very low use of seclusion and restraint on the unit and positive feedback from patients and carers.
- Discharge and resettlement in Low Secure services – a pathway is being developed to improve the journey of patients from low secure services back into the community. This includes the establishment of a new community forensic team.

Mental health community

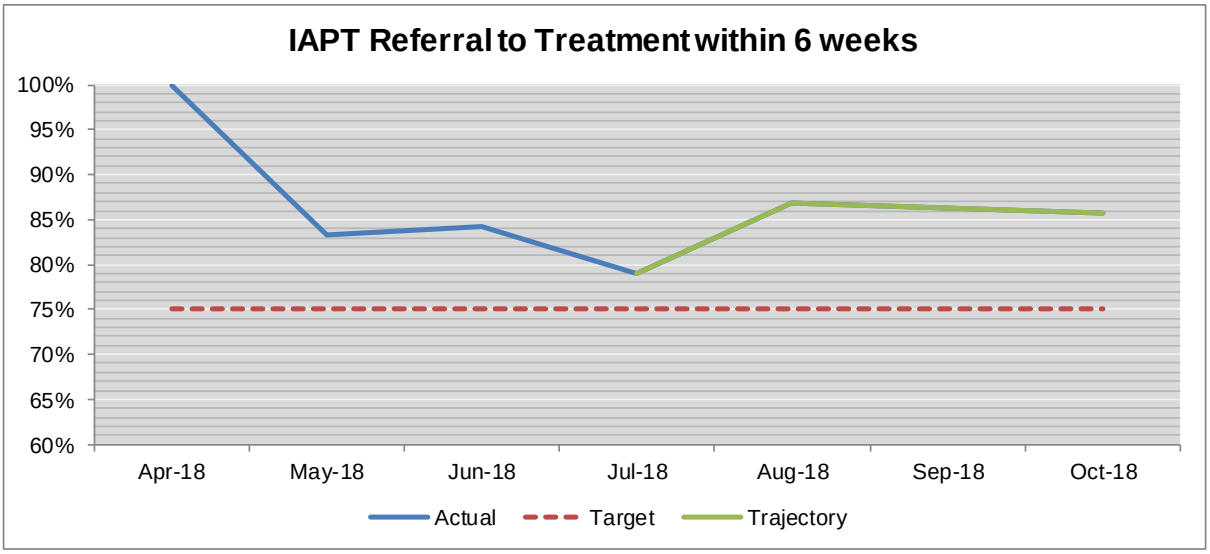
Work on the physical health agenda will help to support CQUIN expectations around physical healthcare. Neighbourhood teams are working with our Liaison teams to support the attendance at A&E of high intensity users of services. CQUIN 3b (physical health – communicating with primary care) is progressing fairly well, in spite of some of our challenges in engaging GPs across the full footprint of the Trust. CQUIN 3a (physical health assessment and intervention for people with severe mental ill health) remains a concern. The introduction of Physical Health in Mental Health practitioners should support this. Local clinics are being reviewed as per Lester compliance and Early Intervention in Psychosis (EIP) teams are part of a pilot to implement this in full.

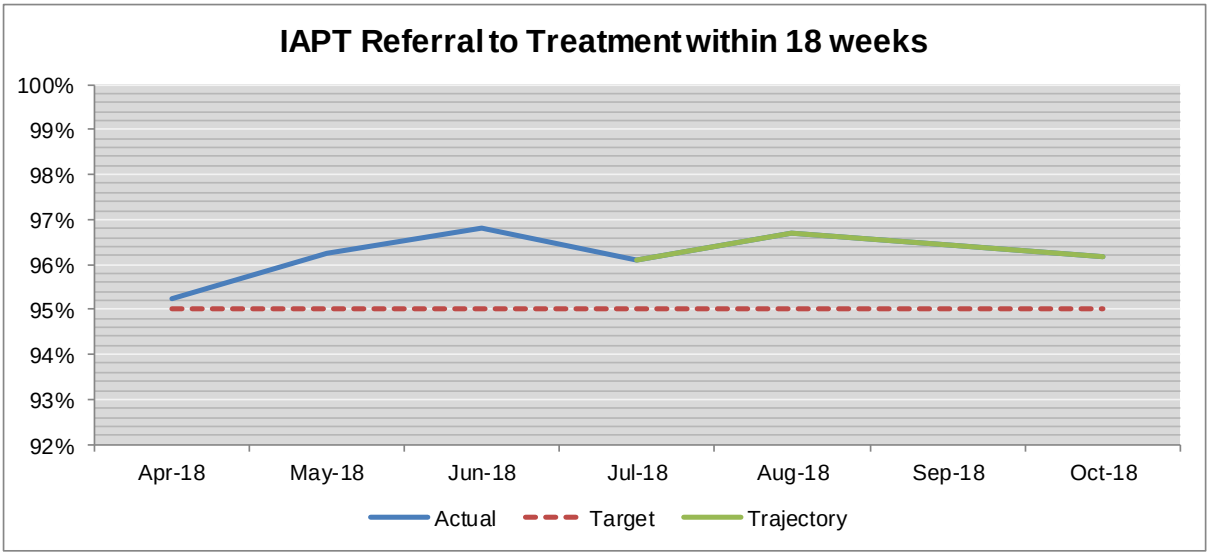
Central Services/Substance Misuse

A new Proactive Engagement & Enforcement Programme (PEEP) includes closer work between Derby Substance Misuse Service's new outreach services and Liaison teams to support further admission avoidance for alcohol and drug High Intensity Users (HIUs).

NHSE CQUIN MH1 perinatal training: 80% of staff have now completed the Video Interaction Guidance (VIG) training (80% target). There are a further two training sessions provided to Improving Access to Psychological Therapies (IAPT) colleagues working in the south, Neighbourhood teams and midwives.

Examples of performance of our IAPT services are in the following tables:





In published national data, 89.4% of people waited less than six weeks and 98.9% waited less than 18 weeks to enter treatment. The Trust was in the top 32% of performers for the six-week target and joint top performer for the 18-week target. Waiting lists are monitored regularly to ensure the targets are met.

Corporate

We have continued to support teams to achieve and report on expected CQUINs. Our staff wellbeing survey has shown improvement of between 2% and 4% in the three questions that we are required to report on. Whilst this is less than we would hope for, it is encouraging given the ongoing clinical and staffing pressures of the past year. Our healthy food for patients CQUIN continues to go well. The final results for our flu vaccination programme show a figure of 54%, a 4% improvement on last year. We will be reviewing our approach for 2019/20 to increase uptake.

Leads and support staff are identified for each CQUIN. Staff health and well-being CQUIN 1a (stress, musculoskeletal injury) and 1c (flu jabs): Continued annual promotion of flu jabs and local clinics facilitated at team bases where possible. A CQUIN scorecard has been developed.

Priority 3: Relapse reduction and harm reduction
Examples of progress during 2018/19

Children, young people and families

A health passport for over six-year-olds is currently being trialled, with a pilot from January 2019.

Learning Disabilities (Central)

There are some challenges around the development of a rounded care plan as LD services are currently managed in professional lines. Not all professions use the terminology of care plans and not all service users see all professions. However, care plans are delivered in an easy read format, including pictorially when required, and the electronic care record has been updated to accommodate accessible care plans that can be scanned in and easily found.

Mental health inpatient

- A daily quality monitoring report is now in place
- Weekly quality report on visual observations – performance and recording monitoring
- Weekly care plan report – information on last seven days
- Weekly clinical meetings on Hartington and Radbourne Units
- Implementation of a Complex Risk Panel on both units which occurs monthly
- Training on personality disorder is being offered to staff
- A new safety assessment trial has commenced in March 2019. The content of the new assessment has been driven by staff comments, a CAMHS pilot and evidence-based practice.

Mental health community

Crisis, contingency and staying well planning work is underway. This is including frontline clinicians from a variety of teams including Crisis Resolution Home Treatment Team and support from the Electronic Patient Record (EPR) team. A wellbeing plan that summarises the care plan, staying well plan and safety plan has been developed for use. The Safety Plan has been reviewed and is currently being piloted across community and inpatient teams.

The PARADES Bipolar psychoeducation group (Psycho-education, Anxiety, Relapse, Advance Directive Evaluation) has started running in the Erewash Neighbourhood Team with interest from other neighbourhood teams to start their own groups later this year. It is likely to start in Bolsover in April/May. Derby City and Chesterfield are also exploring how to begin delivering this.

Central Services / Substance Misuse

This is a core part of care planning in this clinical area.

Corporate

Care planning standards work is underway and national standards will be cross-referenced. The wellbeing plan development work is also underway with colleagues in Information Management and Technology - this will feed into the Care Programme Approach review and improvements. This will be a document that summarises a person's care plan, early warning signs of relapse and risk management plan. The summaries are populated from the original source documents, and have been structured and written to support a shared understanding between people in our care, family members and our staff.

Priority 4: Being effective
Examples of progress during 2018/19:

Children, young people and families

NICE guidelines are reviewed at the Clinical Reference Group on a monthly basis with work underway in service lines to contribute to action plan updates for the Clinical and Operational Assurance Team meeting. Reviews of looked-after children and young people (PH28) and attention deficit hyperactivity disorder (CG72) have been completed.

Learning Disabilities (Central)

Several NICE Guidelines are being evaluated in Learning Disability services to assess their alignment with NICE. The Strategic Health Facilitation Team is supporting the STOMP (Stop Over Medicating People who have learning disabilities with psychotropic medication) agenda by raising awareness and closely working with partners to provide resources to partners and develop a video for NHS England.

Mental health inpatient

Both Neighbourhood and Campus Divisions have chosen to focus on reviewing alignment with the NICE Guideline for Psychosis and Schizophrenia in Adults. This initially started well, but was interrupted by CQC preparations and then the team feeling overwhelmed with the task of reviewing this.

A task and finish group has been arranged to develop the psychosis-based care pathways in line with best practice and NICE guidelines; this is due for completion by June 2019.

Mental health community

Both Neighbourhood and Campus Divisions have chosen to focus on reviewing our alignment with the NICE Guideline for Psychosis and Schizophrenia in Adults. This initially started well, but was interrupted by CQC preparations and then the team feeling overwhelmed with the task of reviewing this.

A task and finish group has been arranged to develop the psychosis based care pathways in line with best practice and NICE guidelines; this is due for completion by June 2019.

The Trust's Occupational Therapists are working with NHS England to support the evaluation of the Long Term Condition Questionnaire.

Central Services/Substance Misuse

The accreditation of both our inpatient and community perinatal mental health services (see elsewhere in this report) is a strong example of progress in this area. Work is underway to review alignment with NICE Guidelines in Substance Misuse.

Corporate

The Quality Visit programme was reviewed and updated for 2018/19, further to consultation with staff who participated in these visits. It will be reviewed again as we proceed towards the 2019/20 season.

Priority 5: Quality improvement – using your ideas
Examples of progress during 2018/19:

Children, young people and families

Participation strategy – work is underway to look at the involvement of children, young people and parents in gathering feedback on the services they receive.

Learning Disabilities (Central)

The Strategic Health Facilitation Team has developed a website with all the appropriate information to support GPs in providing the LD Annual Health Check (AHC). The team has also developed easy read templates for GPs to use and has provided training. This has led to an increase of up to 33% of service users accessing health screening, including cancer screening.

Mental health inpatient

All acute inpatient services are participating in the development work required to Royal College of Psychiatrists Accreditation for Inpatient Mental Health Standards (AIMS). The Red2Green patient flow initiative is also being revitalised across inpatient care.

An acute inpatient Complex Care Panel has been commenced to review service users who present with high risk and/or have complex needs. Within the Kingsway campus older persons' service, a complex patient case review has commenced on the male ward; this multi-disciplinary review focuses on those patients with the most complex needs and allows for dedicated time on specific areas of care to inform formulation and care delivery.

Accreditation for Inpatient Mental Health Services-Older People's Services (AIMS-OP): work has begun to benchmark the Trust's older adult inpatient service against identified best practice standards with a view to working towards accreditation and continuing to drive improvement.

There has been a review of supportive observations within in-patient environment for people with organic illness: a 'Zonal Nursing' pilot has been proposed and agreed with a plan for implementation.

Investment has been agreed to trial the Reminiscence Interactive Therapeutic Activities (RITA) system. This will see the opportunity to improve the diversity and responsiveness to patient interests across the unit, supported by the ward based Recreation Workers.

Mental health community

An example of a Quality Improvement (QI) project is Neighbourhood City Team C, who are using a QI process to develop a nurse-led clinic. This has been launched and early indicators are that it is having a positive impact on secondary waiting lists for all disciplines. This and other QI examples from other teams are to be gathered and supported. There are further opportunities for QI models to be used as part of the Neighbourhood Review task and finish groups. Work is being completed to improve duty processes; this is starting with the Chesterfield Team with a view to extending across the division.

Central Services / Substance Misuse

Eating disorder services are agreeing a new outcome tool with clinicians, with joint development of Key Performance Indicators (KPIs).

Corporate

A Quality Improvement Strategy has been developed and agreed. Within this, approved Quality Improvement approaches are identified and listed. The next steps are how we integrate this

strategy into improvement initiatives.

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 2018/19 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 2018/19 represents 90% of the total income generated from the provision of relevant health services by Derbyshire Healthcare NHS Foundation Trust for 2018/19.

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

2.	During 2018/19, seven national clinical audits and one national confidential enquiry 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 2018/19 are as follows: 1. POMH-UK (Prescribing Observatory for Mental Health-UK) Topic 6d: Assessment of the side effects of depot antipsychotics 2. POMH-UK Topic 7f: Monitoring of patients prescribed lithium 3. POMH-UK Topic 18a: Prescribing clozapine 4. National Clinical Audit of Anxiety and Depression (NCAAD) 5. National Clinical Audit of Psychosis Early Intervention in Psychosis (NCAP EIP) spotlight audit 6. Falls and Fragility Fracture Audit Programme: National audit of inpatient falls 7. National Clinical Audit of Anxiety and Depression Psychological Therapies Spotlight Audit 8. 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 2018/19 are as follows: 1. POMH-UK (Prescribing Observatory for Mental Health-UK) Topic 6d: Assessment of the side effects of depot antipsychotics 2. POMH-UK Topic 7f: Monitoring of patients prescribed lithium 3. POMH-UK Topic 18a: Prescribing clozapine 4. National Clinical Audit of Anxiety and Depression (NCAAD) 5. National Clinical Audit of Psychosis Early Intervention in Psychosis (NCAP EIP) spotlight audit 6. Falls and Fragility Fracture Audit Programme: National audit of inpatient falls 7. National Clinical Audit of Anxiety and Depression Psychological Therapies Spotlight Audit 8. 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 2018/19, 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 6d: Assessment of the side effects of depot antipsychotics –234/420, 56% 2. POMH-UK Topic 7f: Monitoring of patients prescribed lithium – 97/120, 81% 3. POMH-UK Topic 18a: Prescribing clozapine – 44/44, 100%

4. National Clinical Audit of Anxiety and Depression (NCAAD) – 44/50, 88%
5. National Clinical Audit of Psychosis Early Intervention in Psychosis (NCAP EIP) spotlight audit – 189/189, 100%
6. Falls and Fragility Fracture Audit Programme: National audit of inpatient falls – 0/0 currently and dependent on number of fractured neck of femur occurring during audit period
7. National Clinical Audit of Anxiety and Depression Psychological Therapies Spotlight Audit – case note review 70/70, 100%; therapist survey 29/41, 71%; service user survey currently 21/100 21%.
8. National confidential inquiry into suicide and homicide by people with mental illness - 16/19, 84%

2.5 The report of one national clinical audit was reviewed by the provider in 2018/19 and Derbyshire Healthcare NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

2.6 **POMH-UK Topic 18a: Prescribing clozapine**

Actions for improvement include:

2.7
- Dissemination of results to the areas that participated in the audit
- Update the Trust Clozapine guideline
- Physical health requirements specified in clozapine guideline to be aligned with Lester/new Trust guideline

2.8
- Include off-label use
- Monitoring of side effects in section 3 (inpatient initiation) to include for circumstances when titration is completed within two weeks
- Add consideration of changes to smoking status
- Consider whether daily blood pressure, pulse and temperature (including weekends) should be mandated for every initiation; for those undertaken in outpatients/via the hub the guideline currently requires monitoring on Saturday and Sunday 'according to individual need'. This is also the recommendation of the Maudsley guidelines.
- Review the available side effect monitoring tools (existing tool, GASS, GASS-C) and make recommendations for inclusion in the updated guideline.
- Consider mandating annual review by a 'senior clinician'. Liaise with primary care regarding improving the accuracy of the Summary Care Record (SCR).

Title and improvement actions

1. Nutritional risk screening re-audit

Actions for improvement include: Dissemination of results to the Ward Managers. Further training to be delivered at ward level to support staff completing nutritional risk screening using the Malnutrition Universal Screening Tool (MUST) on Paris and assurance from ward managers/heads of nursing, so that improvement is being made at ward level to improve nutrition risk screening. Nutrition and

hydration teaching session delivered on block training to inpatient nursing staff to be updated to incorporate completing nutritional risk screens electronically. Nutrition and Dietetics Team to work with Paris team to improve electronic nutritional screening, including considering the use of an electronic alert system to prompt the named nurse to complete or repeat screening. The Trust will continue to review the choice of an approved nutritional risk screening tool for use in a mental health setting that will identify other nutritional risk factors e.g. obesity, cardiovascular disease and anti-psychotic medication in addition to malnutrition. A nutritional risk screening audit should be repeated in 2018/19 including all inpatient ward and 24-hour care settings.

2. Clinical notes audit - Neighbourhoods

Actions for improvement include: Dissemination of results to the individual Neighbourhood Teams. The CHIME (Connectedness, Hope, Identity, Meaning, Empowerment) framework to be more evident in care planning. The Trust is to consider a communication strategy in relation to CHIME in order to promote use of the approach across the workforce. Teams are to be encouraged to promote use of Wellness Recovery Action Plans with service users as a tool to facilitate recovery. To improve patients' involvement in contingency planning. Improvements are required in involving patients and families/carers in safety planning. Improvements to be made in care planning and associated recording, including development of Wellness Recovery Action Plans. For staff to ensure advanced decisions are discussed with people and for records to reflect the outcome of discussions.

3. Physical health monitoring of patients on Venlafaxine

Actions for improvement include: Education for all consultants, trainees and other doctors working in community mental health teams to be aware of the guidance regarding Venlafaxine initiation and monitoring. This could be achieved by presenting at local teaching sessions. To ensure correct equipment is available in Community Mental Health (Neighbourhood) Teams (CMHT) locations. For electronic blood pressure cuffs to be available in clinic rooms or patients who require blood pressure to attend clozapine clinic (if convenient) to have their blood pressure taken prior to outpatient appointment (if agreed by the nurse running clozapine clinic). To have an extra box on the clinical letter for any monitoring for medications including blood pressure for venlafaxine and blood tests for clozapine or lithium. To edit the safety box entitled 'Diagnoses' to state both psychiatric and physical conditions to be recorded - this may also act as a prompt for physical health monitoring.

4. Documentation of capacity and consent on Paris in Derbyshire Healthcare Foundation Trust CMHTs

Actions for improvement include: Dissemination of results to all CMHT managers, Service Line Managers and Associate Clinical Directors (ACDs). The results and recommendations to be cascaded to all CMHT staff. For clear and unambiguous advice to be provided to all CMHT members as to the systems in place for recording capacity - if the patient clearly possesses the appropriate capacity to consent to their personalised care plan, then the relevant tick box should be completed to indicate this as capacity can be assumed. In such cases there will therefore be no clinical need to complete a "Record of Capacity to Consent" form - If the patient clearly lacks the capacity to consent to their personalised care plan, then the relevant tick box should be completed to indicate this and it will be imperative to complete a "Record of Capacity to Consent" form to document this. If it is clear that the patient is extremely unlikely ever to regain capacity (e.g. is suffering from severe dementia, a significant learning disability etc.) then there is an option to complete on the "Record of Capacity to Consent" form which indicates this clinical finding and negates the need to fill a full "Record of Capacity to Consent" form on each contact with the patient unless there is a significant change in the patient's presentation or a new, significant intervention is being considered. In such cases a Best Interest decision may need to be considered. If the determination of a patient's capacity to consent is more challenging or contentious, then it is good clinical practice to complete a "Record of Capacity to Consent" form, regardless of the outcome of the capacity assessment. There is now a tick box option within the "Activity by Case notes" section of Paris which allows a CMHT member to acknowledge that a patient does possess capacity but that a "Record of Capacity to Consent" form has been completed to indicate the clinical reasoning behind that decision. 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 (MCA) modules remain available. Continued direct support to all CMHT members from the Medical Capacity Lead and the Practice Development and Compliance Lead for

Capacity to allow staff to gain confidence and improve recording efficiency. A further audit of all these capacity assessment standards within DHCFT CMHTs is to be repeated later in the year. Consideration to be given to establishing a similar audit of those CMHTs who were not included in this audit – CAMHS, Children's Services, Substance Misuse Services and Medical Outpatients.

5. Documentation of capacity and consent on Paris in DHCFT inpatient units - September 2018 re-audit

Improvement actions include: Dissemination of the report to all inpatient wards, Area Service Managers, Associate Clinical Directors (ACDs) and medical staff. ACDs to encourage ward consultants to support junior medical staff in completing capacity forms in a complete and high quality manner. Enhanced training/support is to be made available for all staff on capacity assessments and the means by which they must be recorded on Paris. Further face-to-face teaching sessions are to continue with greater emphasis to be placed on ensuring staff are aware of the existence of the "Capacity Manuals" on Connect (the Trust intranet) and the MCA podcasts, both of which provide clear detail on the means by which capacity should be recorded on Paris. This will be supported by 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 is to be offered to those inpatient units achieving lower audit scores. Specific staff groups are to receive targeted training, especially with regard to the need to assess both the patient's capacity to consent to assessment and treatment and the means by which this should be accurately and effectively recorded on Paris: this is now established and on-going. Consideration is to be given to streamlining the "Record of Capacity to Consent" forms to make the process of capacity assessment documentation more effective, user friendly and less duplicative. We are also designating the responsibility of assessing and documenting admission and treatment capacities to specific staff groups – e.g. ward doctors (not on-call doctors), admitting nurses etc. A further audit of all the capacity standards is to be repeated in four to six months.

6. Infection control standards: Substance Misuse Teams

Improvement actions include: Dissemination of audit report to all of the services that participated in the audit. Tools to be reviewed and amalgamated. Naloxone storage/distribution and Adrenaline storage will be added to the tool for all areas, as will counselling, blood spill kits and sharps bin labelling. Red bag provision will be added due to changes in the Trust's resuscitation policy. The Trust to standardise Rounding of Community services for Health and Safety, Infection Control and service User experience as re-audit In the future.

7. Documentation of Capacity and Consent on Paris in DHCFT CMHTs re-audit

Improvement actions include: Dissemination of the audit report to all CMHT managers, SLMs and ACDs. The results and recommendations to be cascaded to all CMHT staff. Clear and unambiguous advice to be provided to all CMHT members as to the systems in place for recording capacity. If the patient clearly possesses the appropriate capacity to consent to their personalised care plan, then the relevant tick box should be completed to indicate this as capacity can be assumed. In such cases there will therefore be no clinical need to complete a "Record of Capacity to Consent" form. If the patient clearly lacks the capacity to consent to their personalised care plan, then the relevant tick box should be completed to indicate this and it will be imperative to complete a "Record of Capacity to Consent" form to document this. If it is clear that the patient is extremely unlikely ever to regain capacity (eg is suffering from severe dementia, a significant learning disability, etc) then there is an option to complete on the "Record of Capacity to Consent" form which indicates this clinical finding and negates the need to fill a full "Record of Capacity to Consent" form on each contact with the patient unless there is a significant change in the patient's presentation or a new, significant intervention is being considered. In such cases a Best Interest decision may need to be considered. If the determination of a patient's capacity to consent is more challenging or contentious, then it is good clinical practice to complete a "Record of Capacity to Consent" form, regardless of the outcome of the capacity assessment. There is now a tick box option within the "activity by case notes" section of Paris which allows a CMHT member to acknowledge that a patient does possess capacity but that a "Record of Capacity to Consent" form has been completed to indicate the clinical reasoning behind that decision. Consideration will be given to streamlining the "Record of Capacity to Consent" forms to make the process of capacity assessment documentation more effective, user friendly and less duplicative. 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 are also to be made available and on-line MCA modules remain available. Continued direct support is available to all CMHT members from the Medical Capacity Lead and the Practice Development and Compliance Lead for Capacity to allow staff to gain confidence and improve recording efficiency. A further audit of all these capacity assessment standards within DHCFT CMHTs is to be repeated later in 2019. Consideration is to be given to establishing a similar audit of those CMHTs who were NOT included in this audit – CAMHS, Children's Services, Substance Misuse Services and Medical Outpatients.

8. Multi-agency audit into procedures for safeguarding medicals for suspected physical abuse

Improvement actions include: Dissemination of the audit report to the services that participated in the audit to involve them in the solutions for improving practice (Dr Julie Mott, Consultant Paediatric Emergency Medicine, Trust Named Doctor for Safeguarding Children, Royal Derby Hospital, Paula Lievelsey, Locality Head of Service, Derbyshire Children's Social Care and Kate Twells, Multi-Agency Safeguarding Hub Manager, Derby City Council), as well as highlighting the high standards that they are currently achieving in terms of timeliness of arranging and performing child protection medicals. We are making Children's Social Care teams aware of the likelihood of a longer wait for a medical should it need to be done outside of working hours, and may wish to consider ensuring their referrers are aware of this to encourage referrals as early in the day as is possible once concerns are identified. This will be achieved by sharing the report with Social Care Managers in order that they can disseminate to teams and discuss with their referrers as they feel appropriate.

9. Was not brought

Improvement actions include: Staff training, ensuring cover on patients' capacity, analysis and safe guarding consideration. We are highlighting a clear detailed and specific action plan with time scales and changing the language from 'did not attend' to 'was not brought'. We will re-audit and undertake a specific audit to assess capacity documentation. We will agree an action plan in the CAMHS teams of informing the GP and other appropriate professionals of the episodes of not being brought. The need to consider discussion within teams and safeguarding regarding DNA. We will invite Dr Edward Komocki (the capacity team) to the consultant's meeting and contact the Paris team and suggest a customisation of the capacity option in the appointments outcomes (capacity for over 16s and competence for under 16 year olds). We will disseminate the rethinking "did not attend" video to the CAMHS consultants.

10. Handover information for older adult admissions from the Liaison South Team

Improvement actions include: Dissemination of results to the Liaison Team following multi-disciplinary team (MDT), to ensure all disciplines see it. E-mail staff to ensure people who are not at the presentation will see it. For the MDT who admit older adults to the psychiatric wards - to document handover information in Paris regarding: Physical healthcare, Physical healthcare medications, Psychiatric medications, Risk assessments, Recommendations of levels of observation, Fluid intake, Recommendations of fluid charts, if appropriate. If fluid intake for example has not been a problem; to document this, so that it demonstrates it has been enquired about. (The same would be true for physical healthcare and physical healthcare medications). To risk assess 100% of admissions. To re-audit in six months and consider repeating the audit to include the North Liaison Team.

11. Use of the graded care profile by 0-19 Children's Services

Improvement actions include: Level Four Training is being delivered to Managers on Effective Supervision. Standard supervision tools have now been ratified through the Clinical Reference Group (CRG) and are on System One. Positive anecdotal feedback has been received from staff on use of new Supervision Tools. Tools need to be used consistently by Supervisors and support the process of analysis. A new record audit tool has been ratified which was re-designed to support with the process of analysis. There was a lack of analysis/action planning demonstrated in this audit and in serious case reviews. Analysis is imperative to the positive outcomes and safeguarding for children and families, therefore plans have been made to deliver further support on analysis skills to all staff. The proposed new supervision recording document and clinical audit tool will promote standardised record keeping and identify areas of growth for practitioners. The use of supervision contracts will formalise responsibilities for recording and focus on areas based on supervisees' specific needs/strengths, assets

and areas of improvement. The development of new tools into the service, i.e. outcome tools and supervision tools, has only been recent, therefore time is needed to embed into practice. With the planned reconsolidation of learning for managers and promotion of tools to staff at relevant meetings, this will support an increase in use.

12. Therapeutic activity within inpatient mental health services

Improvement actions include: Each patient dorm/single room to have in place a copy of the ward and recreational activities programme by end of March 2019. We will note if a recreation team is not currently available; although posts are being recruited to. Once the recreation team is established this will form part of the ward activity schedule. This level of structure will meet patients' needs and offer structured daily activity over a seven-day period. In order to continue to establish meaningful patient centred offer, the interest checklist will provide a basis for this. This can be administered by all ward team members. To establish core self-management groups; suggested activities could include wellness planning, anxiety coping skills, mindfulness skills, distress tolerance, a pre-discharge group and behaviour activation. Certain interventions will support everyday coping skills and teams will also seek the viewpoint of the unit's Clinical Psychologist. We will re-visit and review patient specific questions; to agree the focus to include either ward specific or both including unit wide provision. All clinical ward areas are to have a visual seven-day programme of timetabled activity in place, realistically based around current staffing levels. This clearly highlights what is offered and at what time of day. This is easily viewable by all staff and patients in the patient area. In order to deliver this; it is important that this provision is equally prioritised alongside other daily allocated tasks. Recovery boards offer signposting and access to community information that promotes social inclusion and also identifies where more detailed information is accessible in the unit. To discuss with hub team how access to this information can be readily available; perhaps offering a drop in service to ward patients via a booking system than referral based as currently available. This will avoid delay in accessing information resources in a timely manner. All activity groups to include group profiles; these will identify who delivers certain groups and assurance that all staff have the right skills in place. To also adhere to the trust group work policy. To establish a method of recording information e.g. evidence when activity is occurring versus not and to offer assurance at senior level. Teams to continue to maintain currently established feedback methods and establish others if required to capture all patients' views. To measure effectiveness of audit recommendations via a further re-audit recommended in April 2019 and follow up at regular periods.

13. Safeguarding Children's Supervision / Advice Audit

Improvement actions include: the annual completion of Trust Supervision contracts, and presentation of results at the Operational Team Meeting. To have a clearer process of recording action plans from supervision and sharing information with managers. We aim for consistent tools to use in safeguarding supervision, which are accessible on SystmOne. We will support staff with action planning through use of analysis and redesign the recording of supervision document. We aim to give more guidance around clinical safeguarding supervision, as well as managerial, ensuring priority topics are covered. Band 7 and 8 staff/managers attend Level Four training on effective clinical supervision and analysis.

14. Clinical audit of section 58 mental health act – updated plan for 2018/19 fifth re-audit

Improvement actions include: That the audit is presented at the relevant meetings and also to the Trust's Mental Health Act Committee, in order to agree the action plan. Continued use of the Section 58 flow chart incorporated into the reminder letters sent to Responsible Clinicians (RCs) by the MHA Office when Section 58 needs to be considered. To continue with the practice of utilising "MHA Supporters" to engage with all appropriate RCs to encourage compliance with the necessary audit standards. Given the regularity of contact and the supportive relationship between consultants and the Ward Managers of the wards on which they work, to continue engaging the services of 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) to their consultants in a timely manner. To engage the services of relevant ACDs to encourage good practice amongst the ward-based 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 and sharing of the findings and recommendations of this audit to all inpatient RCs. Given that the Trust is utilising an Electronic Patient Record (EPR) system, the process of electronically documenting all the relevant details needs to

be fully incorporated into daily practice. There should be only one location in which consent to treatment with psychotropic medication details are 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 audit will be repeated annually to ensure compliance.

15. Re-audit on documentation of capacity and consent for Compulsory Treatment Order (CTO) patients

Improvement actions include: Disseminating findings of this audit to consultants to influence change in practice and the specific criteria for a robust documentation of capacity and consent to treatment which has been completed. Presentation of audit results at the North and South Academic Meetings. For the Mental Health Act Office to notify the Responsible Consultant to complete the form in EPR whenever they receive a CTO form for at least next six months to one year. The MHA Office Is to ensure comprehensive completion of CTO forms designed by Dr Edward Komocki on Paris and by escalating any issues to the appropriate Responsible Consultant.

16. Discharge summaries for patients who have been discharged from Ward 34 (Radbourne Unit)

Improvement actions include: for the results of the audit to be shared with the medics on Ward 34. The current template for discharge summaries to be updated. Junior doctors to be educated about the importance of and standard required for the discharge summaries in their initial meeting with Clinical Supervisor at the start of their placement. Each member of the medical team is to have a protected admin time each week (minimum of half a day) to dedicate to completing at least two discharge summaries. To improve accountability among junior doctors for completion of discharge summaries. To re-audit in nine months after all of the actions have been implemented.

17. Safety Plan and Care Plan audit

Improvement actions include: presenting the audit findings at the CAMHS management meeting and to disseminate information to Consultants and teams to highlight the areas that need improving to facilitate the enhancement of the delivered and documented standard of care (Dr McPhail). To present the audit findings to the Safety Planning Group for further discussion and debate. To re-audit using the same data source to check improvement in practice within the next six months (Dr McPhail). To consider training on the expectations around frequency and quality of safety assessments, safety plans and care plans (to consider in team meeting). To consider whether a documented review date could be made a required data field before saving the form (to consider at next divisional meeting when Paris representative present).

3.	The number of patients receiving relevant health services provided or sub-contracted by Derbyshire Healthcare NHS Foundation Trust in 2018/19 that were recruited during that period to participate in research approved by a research Ethics Committee and/or the Health Research Authority – 2,504
	Embedding research into everyday practice This year our clinical services have continued to find ways to embed research into practice and offer research opportunities to colleagues and service users. Our Memory Assessment Service was short-listed as a finalist in the Clinical Research Network: East Midlands Research Awards in the category of 'significant contribution to research'. This was in recognition of the team's achievement in ensuring every person seen by the Memory Assessment Service since the past 18 months is being offered the choice to hear about research as part of their routine assessment. **Research in care homes** Improving the lives and health of older people living in care homes is a major UK government priority. The Enabling Research in Care Homes (ENRICH) initiative aims to support care homes to improve the quality of life, treatments and care for all residents. In the last year, we hosted two

collaborative ENRICH forums at the Centre for Research and Development, bringing together care home colleagues across Derbyshire and Nottinghamshire to share current research and best practice. These have been a great success and well attended. We have also worked with some of our Derbyshire care homes to deliver two National Institute of Health Research (NIHR) studies.

Improving the wellbeing of NHS staff – Working in the NHS can be stressful and this can have an impact on our wellbeing. Researchers at the University of Sussex have been conducting a study to investigate the effectiveness of two online interventions in improving wellbeing and reducing stress among NHS staff. In total, 65 of our clinical colleagues participated in this study using mindfulness-based self-help interventions and accessing online advice and exercises designed to help manage work-related stress.

Cultural adaptations in clinical interactions – Researchers from Southern Health NHS Foundation Trust have been leading this study to investigate the extent to which culturally informed interactions (assessment, formulation and treatment) are used by clinicians in engaging people from minority communities and how patients experience these interactions. As a participating organisation this involved our clinical staff (25) and service users of Black and Minority Ethnic (BME) backgrounds (14).

Multicentre Study of Self-harm

The Trust continues to be a partner in the Department of Health funded 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, clinical management, pharmaco-epidemiology and outcomes, including repeat self-harm and suicide. Six new studies were published in high ranking journals by the study team over the past year.

HSJ Award finalist

Derby and Derbyshire Suicide Prevention Partnership Forum was shortlisted for a Health Service Journal award for its work in training local GP practice staff in suicide awareness and responses. Members of the Trust's research team worked with other members of the partnership to create, deliver and evaluate a model of peer-delivered suicide prevention training for all GP care practices across Derbyshire. Feedback from trainees shows increased understanding, confidence and capability. They say they are better equipped and motivated to identify and respond to suicidal thoughts and behaviours in their patients.

Working Together Suicide Prevention Conference

The Suicide Prevention Strategy group, led by members of the research team, hosted a national one day suicide prevention conference at Pride Park Stadium in Derby. The aim of the conference was to highlight why partnership working across communities, healthcare services, the voluntary sector and with individuals is fundamental to suicide prevention. Keynote speakers included international experts in suicide research addressed the importance of such precipitants and protective factors in relation to suicide preventative strategies. Over 100 delegates attended from across the UK.

East Midlands Self harm and Suicide Prevention Partnership Forum

The Research team continue to co-ordinate the East Midlands Self-harm and Suicide Prevention Research Network (EM-SRN). The EM-SRN aims to provide a single point of contact for all professionals, to encourage greater collaboration across the region and facilitate the sharing and implementation of research and best practice. In January 2019, the team hosted a network event to discuss current key issues e.g. the zero suicide ambition for inpatient areas, and the latest research from across the region. Around 50 delegates from across the region attended the event, free of charge.

4. 4.2	A proportion of Derbyshire Healthcare NHS Foundation Trust's income in 2018/19 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. Further details of the agreed goals for 2018/19 and for the following 12-month period are available electronically at [web link is planned as part of new internet development].

The monetary total for income in 2018/19 conditional on achieving quality improvement and innovation goals	£2,813,578
The monetary total for the associated payment in 2017/18	£2,710,443

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 taken enforcement action against Derbyshire Healthcare NHS Foundation Trust during 2018/19. On 2 July 2018, Derbyshire Healthcare NHS Foundation Trust received a Section 29a Warning Notice with regards to the following: "Staff did not complete or record observations of patients in a timely way. Staff reported issues with access to electronic devices to record observations at the time. The Care Quality Commission had previously issued a Requirement Notice in relation to this issue following an unannounced inspection of Cubley Male ward on 13 March 2018". The Trust made changes in response and the Warning Notice was lifted on 11 September 2018.

7.	Derbyshire Healthcare NHS Foundation Trust has not participated in any special reviews or investigations by the CQC during the reporting period. Although not a special review, we did have a targeted inspection in 2018 which reviewed the Radbourne Unit, which gave the CQC some assurance that there was an improving picture. The report was published in January 2019 and is available on the CQC website. This resulted in some improvement actions.

8. 8.1	Derbyshire Healthcare NHS Foundation Trust submitted records during 2018/19 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 – 99.8% ii. General Medical Practice Code – 100% The percentage of records relating to outpatient care which included the patient's i. Valid NHS number – 100% ii. General Medical Practice Code – 100%

9 The Information Governance (IG) Toolkit is now the Data Security & Protection Toolkit, and the % reference has disappeared. The old IG toolkit assessed performance against three levels: 1, 2 and 3. The new toolkit does not include levels and instead requires compliance against assertions and mandatory evidence items. The Trust increased its score of 98% completion during 2017-18 to 100% completion in 2018-19.

Derbyshire Healthcare NHS Foundation Trust's Data Security and Protection Assessment Report overall score for 2018/19 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 2018/19 by the Audit Commission. We now have mandatory scores and advisory targets. The table shows the new scoring system. Previously the percentage scores equated to Level 0 (not achieved) Level 1 (under achieved) Level 2 (satisfactory) and Level 3 as the top attainment. We achieved well above both the mandatory and advisory targets.

10.1

	Mandatory	Advisory	Trust score
Primary diagnosis correct	>= 85%	>= 90%	98%
Secondary diagnosis correct	>= 75%	>= 80%	94.53%
Primary procedure correct	>= 85%	>= 90%	100%
Secondary procedure correct	>= 75%	>= 80%	100%

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, within 2018/19 there has also been the continued use of a Data Quality kite mark to help provide the Trust Board with the necessary assurance around the Main Trust Performance Operational Indicators and there is an embedded six-monthly data assurance audit cycle in place.

Further actions:

- Continued integration between our electronic patient record systems so that demographics for service receivers are synchronised and up to date.
- Enhancement of the new online information system, a single reference point to show all

	the different services and electronic patient record systems and paper records 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, messaging Primary Care systems directly). • 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 a wider inclusive approach to improve carer information, family members and other associated 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 Data Security and Protection mandatory induction and refresher training and Trust compliance levels. • 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 Data Security mandatory and yearly training results and remove barriers to this aspiration.

Mortality data

Chief Executive Ifti Majid has overall responsibility for the implementation of the Learning from Deaths Policy and Medical Director Dr John Sykes is responsible for acting as Patient Safety Director, taking responsibility for the learning from deaths agenda. Anne Wright is the appointed Non-Executive Director who also oversees the learning from deaths agenda.

Process
The Trust employs a Mortality Technician who is responsible for extracting the data from the NHS Spine on a daily basis (Monday to Friday), regarding deaths of patients who are currently open to services, or have been open to services within the last six months. From this, a Trust mortality database is populated. Each case is assessed by the Mortality Technician using the 'red flags' for incident reporting and mortality review, to determine if the death should be reported as an untoward incident or should be subject to scrutiny by the Mortality Review Group (see red flags below).

Red flags for deaths to be reviewed by the Mortality Review Group
When a death does not meet the criteria for reporting under the *Untoward Incident Reporting and Investigation Policy and Procedure* (as detailed below*)*, the scrutiny of the death will be undertaken in line with this procedure. Every six months a selection of red flags are chosen by the Mortality Review Group.

'Red flags' for mortality review are as follows:

- Referral made, but patient not seen prior to death
- Patient referred to services, then assessed and, discharged without referral onto other mental health services (including liaison team)
- Patient diagnosed with a severe mental illness

- Death of patient on clozapine
- Death of patient on olanzapine
- Anti-psychotic medication
- Substance misuse death
- Patient only seen as an outpatient
- Patient with a long term physical condition
- Patient in chronic pain
- Deaths up to six month post-discharge
- Patient on end of life pathway, subject to palliative care
- Patient died while on an out of area transfer
- Patients whose care plan was not reviewed in the six months prior to their death
- Patient whose risk plan and or safety plan was not in place or updated as per policy, prior to death
- Death listed for review at inquest
- Death of a patient with an eating disorder.

Deaths identified as 'red flag' in terms of mortality are reviewed using a Trust mortality developed tool through case note reviews completed by medical and mental health nursing colleagues. Information for these reviews is taken from the EPR. To date the Trust has completed 117 case note reviews since the initiation of the process in 2017. Over the period 2018/19, 70 case note reviews have concluded at point of writing, and of these six relate to deaths within this reporting period. During case note reviews, recommendations may be made which could include referral into the Serious Incident Process.

On review through the Serious Incident process an investigation may be commissioned. When an investigation is commissioned under this process the review team is independent to the team concerned/involved in the patient's care.

Red flags' for deaths to be reported as untoward incidents (Datix)

An incident form (Datix) must be completed if the death meets any of the following criteria listed below. In these cases the process outlined in the *Untoward Incident Reporting and Investigation Policy and Procedure* must be followed:

'Red flags' for deaths to be reported as untoward incidents (Datix)

Any patient open to services within the last six months who has died and meets any of the following criteria:

- Homicide – perpetrator or victim
- Domestic homicide - perpetrator or victim
- Suicide/self-inflicted death, or suspected suicide
- Death following overdose
- Death whilst an inpatient
- Death of any inpatients who died within 30 days of discharge from a Trust ward
- Death following an inpatient transfer to an acute hospital
- Death of a patient on a section of the Mental Health Act or Deprivation of Liberty authorisation
- Death of a patient following absconsion from an inpatient unit
- Death following a physical restraint
- Death of a patient with a learning disability
- Substance misuse death (interim position)
- Death of a patient where there has been a complaint by family, carer or Ombudsman, or if staff have raised a significant concern about the quality of care provision to that person
- Death of a child (and will also likely be subject to scrutiny by the Child Death Overview Panel)
- Death of a patient open to a safeguarding procedures at the time of death, which could be related to the death
- Death of a patient with historical safeguarding concerns, which could be related to the death
- Death where a previous Coroner's Regulation 28 (Prevention of Future Deaths) has been issued
- Death of a staff member whilst on duty

- Death of a child under the age of 18 of a current or previous service user, who has died in suspicious circumstances
- Where an external organisation has highlighted concerns following the death of a patient, whether they were open to the Trust at time of death or not.

Dependant on the detail of the serious incident, review teams will consider family engagement on a case by case basis, in conjunction with the Family Liaison Team. In the majority of cases the Family Liaison Team initiates contact with family to offer either family an involvement in the review or feedback on the outcome, dependent on family wishes. Where family members have identified a wish for involvement or feedback, they are supported and updated throughout the process. All investigations commissioned through the serious incident process are instructed within the terms of reference to consider this point, as well as the involvement of other external providers such as General Practitioners.

As with family involvement, the Trust is now moving towards feedback to external providers when involved in the review process. In cases where a death meets external reporting requirements a full report will be submitted to commissioners and all additional enquiries addressed. To date, since 1 April 2018 there are have been 47 investigations concluded in relation to deaths under the Serious Incident process. Of these, 15 relate specifically to incidents which occurred during 2018/19. All reviews are given consideration to Duty of Candour and actively seek to identify issues early on in the process. All serious incident investigations are reviewed via either the Operational Serious Incident Group or the Executive Serious Incident Group.

27.1	During 2018/19, 1878 of Derbyshire Healthcare NHS Foundation Trust's patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period: • 495 in the first quarter; • 458 in the second quarter; • 558 in the third quarter; • 367 in the fourth quarter

27.2	Six case record reviews and 15 investigations have been carried out in relation to 1,878 of the deaths included in item 27.1. In three 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: • 0 in the first quarter • 3 in the second quarter • 7 in the third quarter • 11 in the fourth quarter A further 44 investigations are on-going
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 130 deaths. This was undertaken by a multi-disciplinary team and established that of the 130 deaths reviewed, 0 have been classed as due to problems in the care provided to that patient and three have 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 are covered by the following 'red flags': • Patient referred to services, then assessed and, discharged without referral onto other mental health services (including liaison team) • Patient diagnosed with a severe mental illness • Patient only seen as an outpatient • Patient taking anti-psychotic medication Initial analysis of death notification information shows the most common causes of death are: • Alzheimer's dementia/vascular dementia • Old age • Ischaemic heart disease

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. Examples of actions taken and that will be taken: 1. Review of blood-borne virus policy. 2. Review and audit of Safety Box use on the Paris electronic patient record system. 3. Review of communication practices between inpatient areas and community teams. 4. Review standards, training and audit relapse prevention plans with community mental health teams 5. Explore with commissioners with regards to the commissioning of a community forensic team and the potential risks and benefits of this model of practice. 6. Advice to be provided for nursing and medical staff in relation to patients suffering from health anxiety and referral for cognitive behavioural therapy (CBT). 7. Discussion with commissioners regarding specific services/pathways for individuals with a diagnosis of personality disorder. 8. Review the number of funded care programme approach co-ordinators in community teams benchmarked against comparable trusts per hundred thousand population. 9. Review expected standards of practice for patients on a Community Treatment Order. Complete a Trust-wide audit of these revised standards and then monitor via a six-monthly audit cycle. 10. Education/information on the referral process to Improving Access to Psychological

Therapies (IAPT) for inpatient areas.

11. All services contracted to provide IAPT services should be given training and read-only access to Paris.
12. For interagency communication to be improved so information can be shared in a timely manner.
13. Review of home leave care plan to include explicit completion of parent/carer contact or to actively state why not required.
14. To clarify in the seclusion policy the reasons why all seclusions are to be detailed as moderate harm.
15. To consider developing new incorporating within training already provided a module about the Mental Health Act paperwork linked to seclusion, including seclusion exception reporting and the seclusion policy.
16. To share with commissioners the impact and access of community based psychological therapy for interfamilial childhood trauma.
17. Where there are co-morbid complex physical health issues in someone with a severe mental illness, the care plan and safety plan must reflect any concerns or risk related to the management of that physical health need. This includes any concerns around medication.
18. To identify the threshold for Forensic Service input and method of referral and dissemination of information.
19. To gain an understanding of the issues related to being a veteran and our responsibilities with regard to the Armed Forces Covenant.
20. Development of a Safeguarding Protocol which would include details regarding how to access safeguarding advice and support which would complement information already available via the Safeguarding intranet page.
21. The process for managing 'Front Door Presentations' to Psychiatric Units needs to be clarified and reviewed.
22. An offer of psychiatric advice around complex medication issues should form part of the discharge information sent to primary care for patients who have a severe mental illness.
23. There is a waiting list for psychological therapy, for Eye Movement Desensitisation Reprogramming (EMDR). Review with commissioners potential solutions to reduce the waiting time.
24. A team awareness raising session regarding the frequent revisiting of a service user's decision to withhold information from family and carers using the 'Advanced Planning for People with Bipolar Disorder Guide' from the East Midlands Academic Health Science Network, and also the 'Sharing information with family and carers' booklet and the 'Advance Statement about information sharing and involvement of family carers'.
25. To review the multi-disciplinary team (MDT) documentation processes with regard to the decision making actions when there are patient safety concerns. This should take into account the immediate action taken by medical colleagues, care co-ordinators and supervisors.
26. For Trust staff who work in out of hours services (mental health triage hub, Crisis team) to have access to IAPTUS notes (a care record system for psychological therapy services) as read-only.
27. Trust to ensure development of clinical standards for personality disorder and a robust Personality Disorders Pathway and appropriate training for staff and teams.
28. For the MHA Office to develop a system of escalation for confirmation that sections are invalid.
29. Ensure family are involved in assessments and decision making processes wherever

possible, in line with Think Family and Triangle of Care approach, and also making sure that support is offered to carers and children

30. Review of the Care Programme Approach (CPA) policy in terms of transfer between secondary services to provide clarity. Transition policy to be updated to include process in the event of a dispute between services in transition. Clarity required for services regarding dispute resolution in transition.
31. If it is considered that withholding a prescription is in the interest of safety for a service user, then prior to this decision being made it is imperative that this is discussed with a consultant, senior practitioner or manager; all options need exploring before coming to this decision.
32. Discuss the importance of using the analgesic ladder to manage pain in older people with dementia. Review use of pain management tools.
33. The Eating Disorder Team to facilitate a reflective session with the Neighbourhood teams in relation to managing eating disorder patients and timely referrals.
34. To review the monitoring and communication process to patients with suicidal thoughts following the administration of medication where there are known suicidal side effects.
35. Develop an operational policy that clarifies the roles and responsibilities of the organisation, teams and individuals in the delivery of care to forensic patients in the community.
36. The development of a Trust infrastructure that supports staff in providing safe, effective care to community forensic patients.
37. Clinical guidelines that reflect the specific needs of forensic patients in the community, including CPA and risk management.
38. A programme of education and training that reflects the expertise required working with community forensic patients.
39. A clinical supervision framework that ensures clinicians have routine access to professionals with clinical expertise in forensic care.
40. To explore the development of eating disorder awareness training package to the relevant Trust teams.
41. Eating Disorder Service to raise with Management of Really Sick Patients with Anorexia Nervosa (MARSIPAN) lead and Derby Hospitals Mental Health Steering Group, the need to establish joint protocols for patients to be directed to appropriate support/services, and joint clinics and/or regular review meetings.
42. Discuss with the multidisciplinary team the importance of adopting a broader approach to advanced decision making which is discussed in conjunction with do not attempt resuscitation (DNAR) decisions.
43. Where Social Care are involved with a client, a multi-disciplinary team and multi-agency meeting should be arranged once a year or more frequently if required due to significant change in accordance with CPA guidelines. CPA Review to be multi-disciplinary and multi-agency where relevant.
44. The Trust requires an adequately commissioned community forensic team that addresses the gaps identified within this report, so that community forensic care is safe and effective.
45. Consideration should be given to whether Section 37 or Section 41 patients discharged into the community should ever be transferred directly to non-forensic, generic teams, or whether all such cases should at least initially be under the care of a forensic psychiatrist.
46. Develop the role of end of life link workers or champions on the ward, to promote a culture of positive end of life care.
47. To request commissioners to review contracts to include direction as to the expected

	level of discharge information and the timeliness of the communication from private providers.

27.6	An assessment of the impact of the actions described in item 27.5 which were taken by the provider during 2018/19. Over the last 12 months, in response several of these actions we are establishing a Community Forensic Mental Health Team, and have already recruited to some posts. There has been a review of our CPA process and this is ongoing, informed by these actions. There has been an adjustment in thresholds for recovery and maintenance treatments in substance misuse services, in line with learning around links with heightened risk of death for those on lower dose maintenance treatment. We have been working to implement the Physical Healthcare Strategy and there has been significant investment in establishment, including the creation of a physical healthcare clinic in the north of the county, together with enhancements to community mental health teams. There have also been extensive developments of the electronic patient care records system to accommodate recording of physical healthcare assessments and interventions. We have invested in Oxehealth patient monitoring. This is the use of an optical sensor to remotely measure a person's pulse and breathing rate without disturbing them. We have reviewed and updated our approach to Safety Planning, with new formats agreed and informed by front line practitioners. Complex Case Reviews have been established within inpatient units, to review how we are approaching people in our care who present with higher levels of risk.

27.7	70 case record reviews and 47 investigations were completed after 1 April 2018, 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 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, embedding a patient-focused care approach, ensuring patient safety and mitigating risk.

CPA seven day follow-up					
Indicator	End of 2016/17	End of 2017/18	2018/2019 (Q1,2 & 3 Published as at 08/05/19)	National provider average (as at 08/05/19)	Highest and lowest scores of NHS Trusts and NHS Foundation Trusts (Q3 as at 08/05/19)
The percentage of patients on CPA who were followed up within seven days after discharge from psychiatric inpatient care during the reporting period	96.48%	98.51%*	96.47% (against a target of 95%)	96.3%	100% and 81.6%

*please note a variance here with the figure in the 2017/18 Quality Report of 98.68%, due to subsequent data refreshes https://www.england.nhs.uk/statistics/statistical-work-areas/mental-health-community-teams-activity/

17 **Crisis gatekeeping**

Crisis gatekeeping ensures that the 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				
Indicator	2017/2018	2018/2019 (Q1, 2 and 3 Published as at 08/05/19)	National provider average (as at 08/05/19)	Lowest and highest scores of providers (Q3 as at 08/05/19)
The percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team acted as a gatekeeper during the reporting period	99.74%	100.00%	98.30%	78.8% and 100%

19	**28-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, 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: continuing to monitor and develop pathways of care. Our percentage of people re-admitted within 28 days has continued to reduce since 2016/17, in spite of some challenging demand and staffing issues within our community mental health teams.

28-day re-admission rates (aged 16 and over)				
Indicator	2017/2018	2018/2019	National provider average	Lowest and highest scores of providers
28-day re-admission rates for patients aged 16 and over	7.68%*	6.26% (against a target of 10%)	not available	not available

*Please note a variance here with the figure in the 2017/18 Quality Report of 9.1%, due to subsequent data refreshes

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 7.2, which is deemed to be 'about the same as other Trusts nationally'. The Trust considers that this data is as described for the following reason: it is provided by an external organisation who we commission to undertake the survey. Derbyshire Healthcare NHS Foundation Trust has taken the following actions: the Trust will continue to promote the 'Friends and Family test' as a way of monitoring our progress, and seek opportunities for service user involvement in pathway development work streams.

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 01 04 2018 and 30 09 2018.

Patient safety incidents per 1,000 bed days	1,842 incidents reported during this period = reporting rate of 40.86 incidents per 1,000 bed days

Degree of harm of the patient safety incidents reported to the NRLS between 01 April 2018 and 30 September 2018

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

None	Low	Moderate	Severe	Death
66.7% (1,229)	27.5% (507)	4.2% (78)	0.4% (8)	1.1% (20)

Source: https://improvement.nhs.uk/resources/national-quarterly-data-patient-safety-incident-reports/

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

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

Additional considerations

2. Speaking up

The different ways in which staff can speak up if they have concerns over quality of care, patient safety or bullying and harassment within the Trust:
Staff can raise any concerns with their line manager, with anyone else in their management line, with colleagues from the Nursing and Quality Directorate, or directly with our Freedom to Speak Up Guardian (F2SUG). The role of the Freedom to Speak Up Guardian has been promoted through communication via the staff newsletters Weekly Connect and Monthly Team Brief, Trust-wide email promotion with posters attached, payslip notification, screen savers and face to face meetings as well as team meeting presentations. There has also been direct communication by letter to service specific areas. The role is also highlighted at Trust Induction for all new staff. For those finding it difficult to speak up or who may want to raise concerns confidentially/anonymously, a PO Box address has been communicated where people may choose to write to the F2SUG directly without exposure. This as yet had not been utilised, but will continue to be promoted as being available.

The Raising Concerns/Speaking Up (Whistleblowing) Policy has been updated to ensure that the process to manage a concern that is raised is clearly defined. Where there is no requirement for terms of reference to be written, the practice of fact finding is defined to enable the concern to be considered against any corroborating evidence, which does not require Terms of Reference to be drawn up.

How feedback is given to those who speak up:
At each stage of the process we aim to deal with the concern promptly and without unreasonable delay. However, the Trust recognises that in exceptional circumstances timescales may need to be extended by either party. Any extensions must be mutually agreed.

Our aim at each stage is to:

- Acknowledge the concern in writing within five working days after the day on which it is received. (Please note some delays are unavoidable i.e. annual leave or unplanned absence).
- Upon conclusion/ investigation the individual should be informed of the outcome through feedback, following which a feedback letter outlining any action will be provided in writing within five working days.

How we ensure staff who speak up do not suffer detriment:
If a concern is raised, the Raising Concerns/Speaking up (Whistleblowing) Policy is clear that the member of staff will not be at risk of losing their job or suffering any form of reprisal as a result. The Trust will not tolerate any attempt to bully an employee into not raising any such concern. Any such behaviour would be a breach of our Trust values and if upheld following investigation could result in disciplinary action. Provided that the staff member is acting in good faith (that is, honestly), it does not matter if they are mistaken or if there is an innocent explanation to the concerns. Of course, we do not extend this assurance to someone who may maliciously raise a matter they know is untrue. We hope that our staff will feel supported and comfortable raising a concern openly; however we do understand that there may be occasions where a staff member may wish to remain anonymous or confidential. We can keep their identity confidential, if they choose to, unless we are required to disclose it by law (for example by the Police).

Conditions of service for NHS Doctors and Dentists in training (England)

"A consolidated annual report on rota gaps and the plan for improvement to reduce these gaps shall be included in a statement in the Trust's Quality Account".

The Trust's plans to reduce gaps in rotas include the following:

1. High quality training to attract trainees.
2. Active involvement of our Guardian of Safe Working with regular feedback from trainees on their work patterns.
3. We have regular engagement events with trainees on their experience in the Trust, for example, in our acute inpatient settings ensuring that any concerns and ideas for improvement are recognised and acted upon.
4. We are trying to fill all gaps as best we can and encourage locums to join the East Midlands or North Humberside training scheme.
5. We are liaising with both of these schemes regarding what we see as the best structure to aid recruitment and retention. We are engaging with regional workforce planners on this.
6. To continue to engage with trainees and to encourage them to understand the purpose and process of exception reporting when this is a valid option.

Rota gaps over the reporting period:

Time period	Rota gaps
April 2018	13
May 2018	14
June 2018	18
July 2018	25
August 2018	19
September 2018	19
October 2018	18
November 2018	11
December 2018	17
January 2019	17
February 2019	14
March 2019	22

Part 3: Other information

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 2018/19, with a minimum of three indicators chosen for each of the following:

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

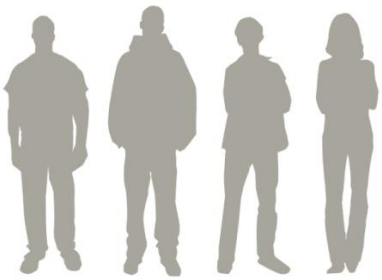
Activity data during 2018/19

1,477
Inpatient admissions

84,774
referrals received

The Trust cared for **3,165** babies born in Derby City

48,984
adults treated this year



78,106 people seen

271
inpatients beds

758,432
attended contacts

71,365
children treated this year

13,120
face to face follow-ups for those in our Learning Disability services

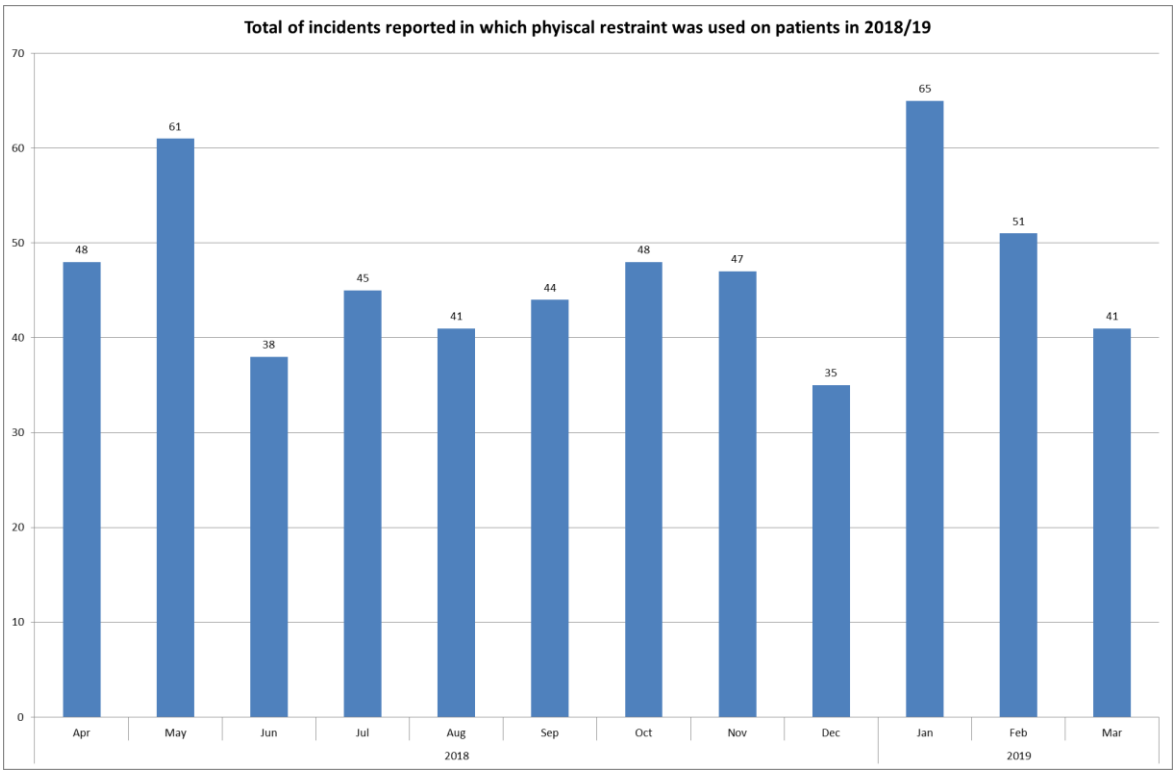
Patient safety

Patient safety 1: Positive and Safe – reduced use of seclusion and restraint
The Positive and Safe programme aims to end the unnecessary use of restrictive interventions. Our aim as a healthcare provider is to develop a culture where restrictive interventions are only ever used as a last resort, and only then for the shortest possible time. The Trust's Positive and Safe Steering Group has continued to meet and has been able to have service user representation from the Kedleston Unit. Both representatives have lived experienced of being subject to restrictive interventions and are keen to support developments in clinical practice.

Over the year, we have continued to clarify our clinical practice and determine the compliance of our practice against current guidance. A number of audits have been completed that give us data in addition to that gained by reviewing incidents. These include:

- Seclusion audit – looking at de-escalation and the subsequent use of seclusion
- Rapid Tranquillisation (RT) Audit – examining the clinical practice and technique used in RT
- Locked door audit – reviewing the practice of keeping ward doors locked, how this is decided and how it is communicated to both people on the ward and those trying to enter the ward.

As a result of this clarification of practice, we have improved data around the differing practice between the inpatient areas in the north and south, with initial interpretations that this might be attributable to differing demographics of the respective inpatient population, and the presence of seclusion facilities in the south. Below is an example as to the clarity with which we can now see restraint use in the Trust.



Other initiatives:

- A Police Liaison Officer has been assigned to work closely with the Hartington Unit. The officer attends the weekly clinical review meeting and has developed police relationship with the ward staff and some of the patients. She has worked on improving police visibility across the unit and can identify where relevant sharing of intelligence and information can be of use in managing incidents or people's situations. Work is currently underway to look at replicating this in the Radbourne Unit
- The revised Positive and Safe Management of Violence and Acute Psychological Distress (PMVA) training continues to run but with variable attendance levels. This has been partly attributable to the staffing difficulties over the summer and autumn periods within inpatient areas. Work is underway at the Radbourne Unit to enable staff to be released to attend the training. The bite size simulation training has continued and funding has been given from the Trust's Innovation Fund for a six-month pilot using actors. This has allowed for more realistic incidents to be worked through, that have the elements of surprise and unpredictability that the use of a colleague would not bring
- Older adult services access tactics training, incorporating Strategies in Crisis Intervention and Prevention (SCIP) techniques and Learning Disabilities staff access PACE which also incorporates SCIP. Person centred care is an explicit theme across all modules and the training also looks at the cultural aspects of ward life. Previous sessions have looked at the causes of distress and how language can be used to marginalise people even if this is not done consciously. Feedback on the training is taken from staff on each module and the results have all been positive with staff reporting an improvement in understanding and confidence.
- The use of prone restraint has been reviewed and a report was provided to the Quality Committee in May 2018 that detailed the frequency and context of the use of prone restraint. There will be a further paper in May 2019.
- The audit of staff understanding of seclusion and segregation remains part of the Nursing and Quality Directorate's audit plan and will be completed in 2019.
- Safety pods – a demonstration of safety pods was arranged for 2018. A safety pod is a large bean bag that enables the restraint to take place on the pod itself rather than on the floor. Clinical trials in learning disability and adult mental health services have proved very positive, with fewer restraints leading to seclusion, a reduction in injury to patients and staff and the interventions reported as feeling less traumatic. We are arranging to meet again with the suppliers to look at trialling the pods in a number of different clinical areas.

Conclusion

The last 12 months have seen a high level of activity looking at restrictive interventions across our clinical areas. We have established a robust audit structure that has given us a sound baseline of data from which to work. We have also identified that we have a number of different areas of work that require a greater degree of improvement than we previously thought. However, we can identify why this is and have work underway to address the concerns. The Positive and Safe group has maintained a close awareness of the practice issues in clinical areas. The group has a work plan that identifies the key points to focus on over the next year and can link this work into the overall work plan for the directorate.

Patient safety 2: Psychiatric Liaison team responsiveness

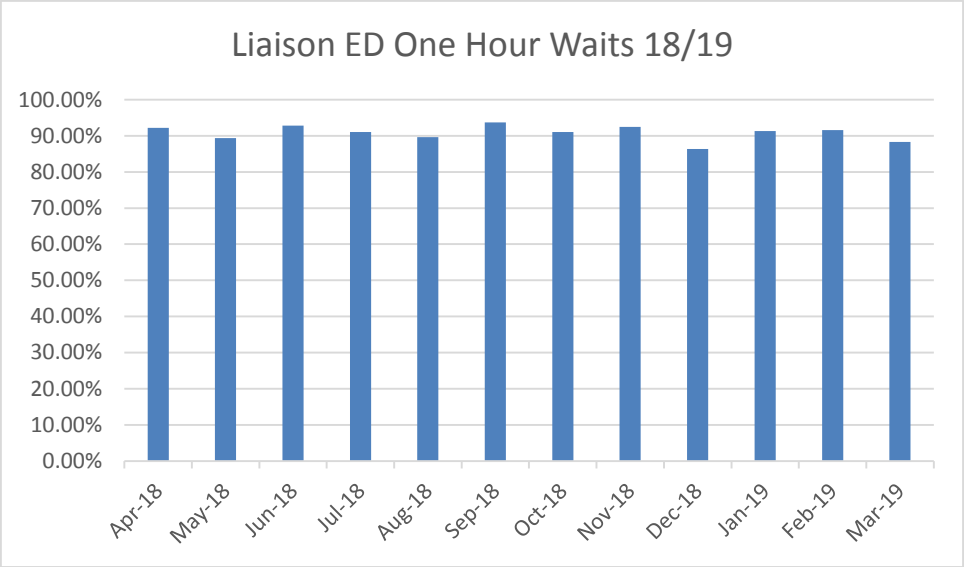
Our colleagues in the North Derbyshire Liaison team provide advice and guidance to hospital staff, external partner organisations, patients, families and carers around mental illness and substance misuse for patients within the Emergency Department and on acute hospital wards. They also provide specialist psychosocial assessments for patients with mental health or substance misuse needs, will support patient discharge with necessary community referral and signposting and will liaise with mental health professionals if the person presenting needs admission to a mental health inpatient ward. Training of hospital staff is a fundamental part of the work, together with ongoing service evaluation and research.

Both teams have been part of the High Impact User (HIU) model. People in this HIU cohort are defined by their repeated attendance at general hospital emergency departments. Locally, this is defined by repeated attendance at emergency departments as either three times in one month or five times in six months. The approach brings multi-agency working, in partnership with acute hospital, police and ambulance colleagues. As an example of the outcome of this work, findings that were reported at the beginning of this financial year (and therefore not possible to include in last year's Quality Report) for our Liaison Team North, show the following results for this cohort of people:

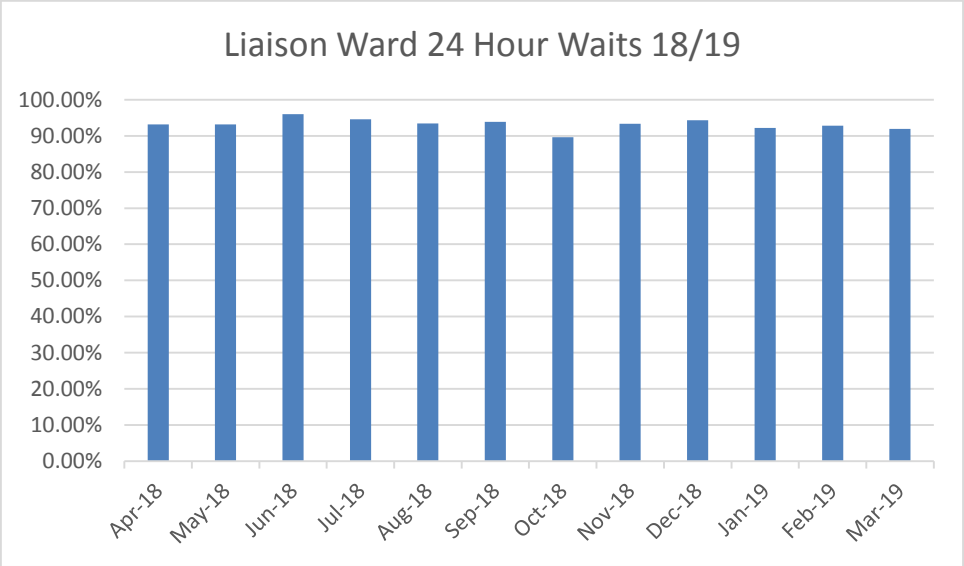
From 1 April 2016 to 31 March 2017 the selected cohort who would benefit from mental health and psychosocial interventions attended the Emergency Department of Chesterfield Royal Hospital on 288 separate occasions. From 1 April 2017 to 31 March 2018 this same cohort attended the Emergency Department of Chesterfield Royal Hospital on 71 separate occasions. This resulted in a reduction of 75%, against a target of 20%.

Results around overall responsiveness for the teams:

Month	Number of ED liaison referrals	Number one hour wait compliant	%
April 2018	373	344	92.23%
May 2018	480	429	89.38%
June 2018	416	386	92.79%
July 2018	447	407	91.05%
August 2018	445	399	89.66%
September 2018	411	385	93.67%
October 2018	424	386	91.04%
November 2018	413	382	92.49%
December 2018	439	379	86.33%
January2019	438	400	91.32%
February 2019	403	369	91.56%
March 2019	453	400	88.30%



Month	Number of ward liaison referrals	Number 24-hour wait compliant	%
April 2018	467	435	93.15%
May 2018	413	385	93.22%
June 2018	500	480	96.00%
July 2018	522	494	94.64%
August 2018	366	342	93.44%
September 2018	445	418	93.93%
October 2018	463	415	89.63%
November 2018	494	461	93.32%
December 2018	422	398	94.31%
January 2019	489	451	92.23%
February 2019	448	416	92.86%
March 2019	433	398	91.92%



Improving services for people with mental health needs who present to A&E (Accident & Emergency)

This initiative is to ensure that the Trust and local acute hospital providers work together with other partners

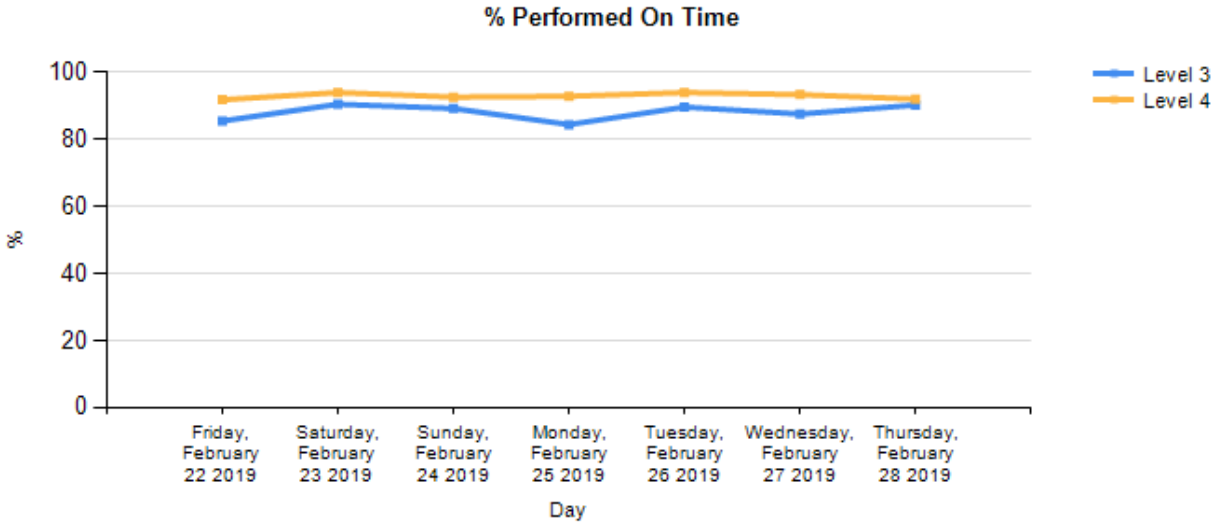
(such as primary care, IAPT services, police, ambulance, substance misuse, social care, voluntary sector), to ensure that people presenting at A&E with primary or secondary mental health and/or underlying psychosocial needs have these needs met more effectively through an improved, integrated community service offer, with the result that attendances at A&E are reduced. Our goals were a reduction of 20% reduction in A&E attendances for a targeted group of people. Our Psychiatric Liaison Teams, located in Chesterfield and Derby, both surpassing this target by a significant margin. Across the two teams, reductions for the cohorts ranged between 25% and 75%. The Liaison Team North team is specifically mentioned in the Urgent and Emergency Mental Health Pathway Compendium 2018/19, as an example of good practice around the approach to this.

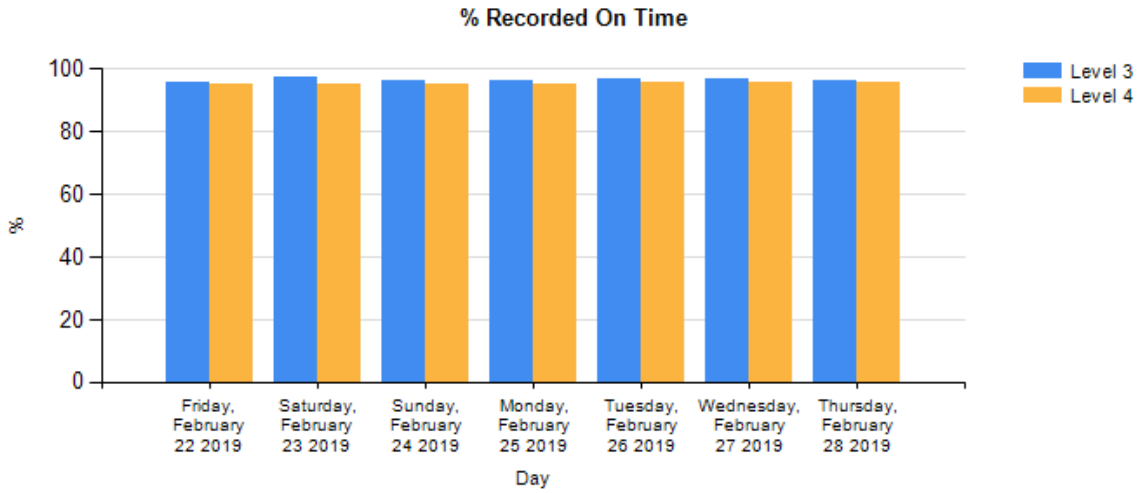
Patient safety 3: Ward-based supportive observations
On 2 July 2018, Derbyshire Healthcare NHS Foundation Trust received a warning notice from the Care Quality Commission (as outlined below). The notice identified that:

"Staff did not complete or record observations of patients in a timely way. Staff reported issues with access to electronic devices to record observations. The Care Quality Commission had previously issued a Requirement Notice in relation to this issue following an unannounced inspection of Cubley Male ward on 13 March 2018."

We initially reported our progress on 8 August 2018, and then submitted a further performance report on 5 September of three weeks of practice from 13 August onwards. Following review of this evidence, we were informed by our regulators that they were "satisfied the Trust has taken appropriate measures in response to the warning notice".

Further to the lifting of the warning notice, we have continued to monitor data daily to assess compliance with observations being recorded as being within the 15-minute time period for Level 3 and the 60-minute time period for Level 4, and our performance measure for undertaking both Level 3 and Level 4 observations has included a five-minute tolerance beyond their respective times. We have also continued to monitor how quickly our front line staff enter the recorded observation into the current system. To build in a tolerance for allowing time for staff to enter the data, our calculations have assumed that a 15-minute gap from the observation to the entry in the person's care record is acceptable. As an example of current Trust-wide performance, please see the following graphs for data for a recent one week period:





Our front-line colleagues continue to maintain a strong commitment to supportive observations. However, there has also been significant learning for us as a Trust. The plan to introduce handheld devices utilising an 'app' to record observations has been well received by staff, but as would be expected in a pilot their introduction was not without teething problems. We are also aware that the devices are only part of the solution, and that our focus remains on the clinical importance of observations as opposed to the technical response.

Whilst on one level, our overall performance has remained consistently strong in the recording of observations, we remain aware of periods of time where it is more of a challenge to record observations within the expected time period. The significant level of detail that is available to the Trust highlights clearly both strong performance and any short-term challenges. We supply each ward manager with a daily run chart as to their performance, to ensure that there is local understanding and response as required. The narrative about the clinical importance of supportive observations has continued to be our focus, and our challenge will be to retain this as we also expect further improving standards of performance.

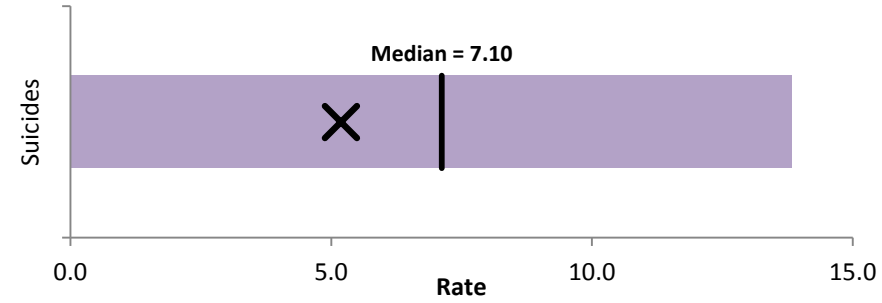
The hand-held device recording solution

We formally piloted these on the Kingsway site and prior to extending this to the Radbourne, Hartington and London Road sites, we conducted a comprehensive review of their use on the Kingsway wards, as we wanted to thoroughly test them before we shared them Trust wide. Representatives from the Nursing and Quality team and the Information Management and Technology team visited every ward that had been using the devices; we spoke to nurses and healthcare assistants on each ward to gather feedback and suggestions for improvement. From this, it was clear that staff liked the hand held device, but also that it needed some adjustments to make sure it does what we need it to do in all clinical areas. Triangulating the verbal feedback with performance feedback for the wards, we updated the devices and have now rolled them out across all inpatient areas. In response to patient feedback, we have also covered the camera lens to alleviate any anxieties around being photographed, and developed posters to explain to patients what the devices are being used for.

Patient safety 4: National benchmarking on very serious incidents in the Trust

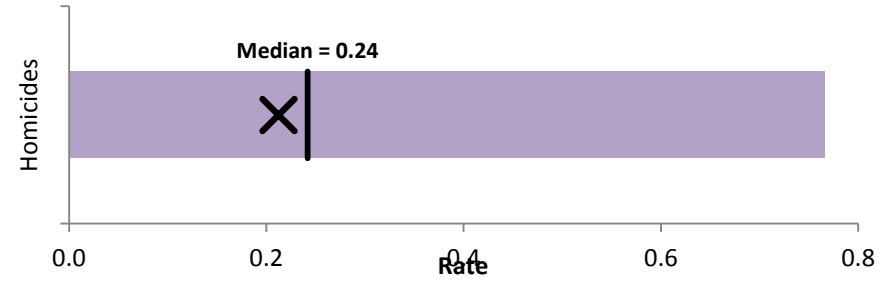
Trust Scorecard: Derbyshire Healthcare NHS Foundation Trust

The NCISH Safety Scorecard has been developed in response to the request from our commissioners, the Healthcare Quality Improvement Partnership (HQIP), for benchmarking data to support quality improvement. In particular, whilst we have our own significant level of concern with regards to any suicide or homicide connected to someone in our care, you'll see in the tables below that in comparison to national figures, our incidents of suicide and homicide are below the median figure.



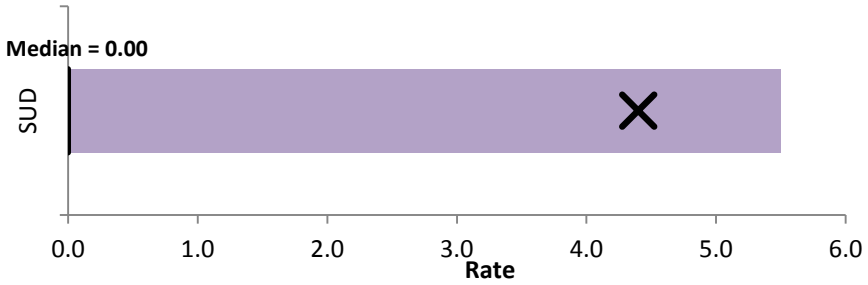
Suicide rate

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



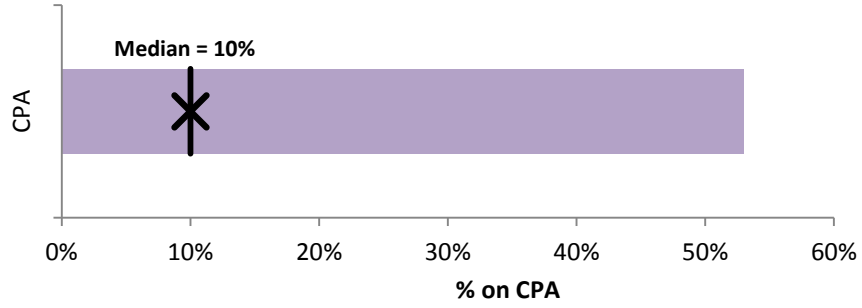
Homicide rate

The homicide rate was 0.21 (per 10,000 people under mental health care) between 2013-15.



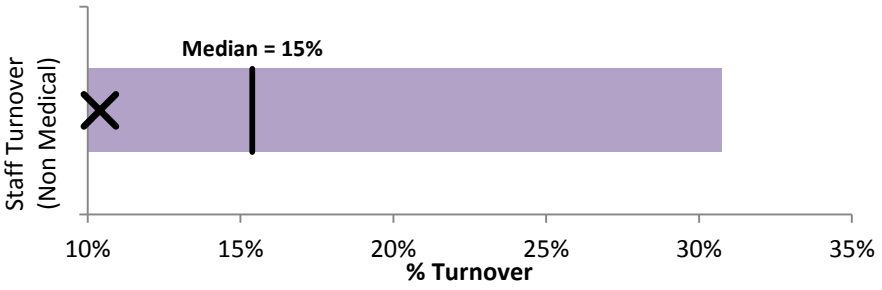
Sudden unexplained deaths (SUD)

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



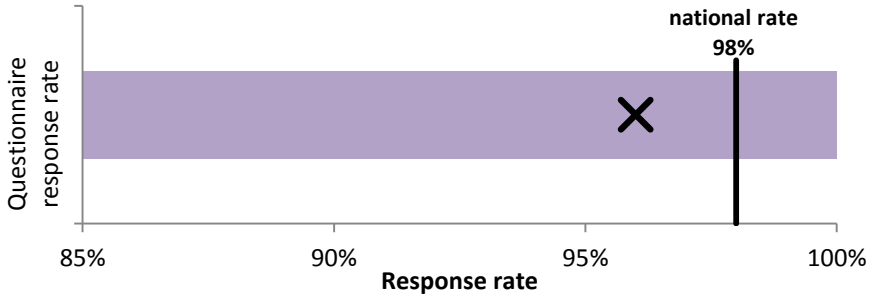
% on CPA

The % of patients on CPA was 10% in 2016-17.



Staff Turnover

Non-medical staff turnover was 10% between 31 October 2016 – 31 October 2017.



NCISH questionnaire response rate

You have returned 96% of NCISH questionnaires between 2012-17.

Clinical effectiveness

Clinical effectiveness 1: Breastfeeding – baby friendly
Our coverage to promote breastfeeding is good, with work alongside partner agencies to enable peer support for breastfeeding as a way to encourage higher rates with support. Breastfeeding prevalence (as recorded by our service) in the City of Derby is approximately 55% at 10-14 days, and approximately 45% at six - eight weeks. Our Health Visiting teams secured 'Baby Friendly' accreditation status in August 2018.

Within the service we have an infant feeding lead and an infant feeding team who provide breastfeeding support, in addition to the support from the Health Visiting team with regards to one-to-one breastfeeding support in the home, at clinic and breastfeeding clubs within the locality. Our health visiting teams have also delivered support and guidance around the risk of postnatal depression.

Breastfeeding summary report

10 - 14 days activity	Quarter 1, 2018-2019	Quarter 2, 2018-2019	Quarter 3, 2018-2019	Quarter 4, 2018-2019
Number of infants due for a check	748	833	826	751
Breast fed at 10 days	311	349	311	260
Breast and supplement fed at 10 days	143	159	209	205
Total breastfed	**454**	**508**	**520**	**465**
Bottle fed at 10 days	285	324	310	282
Not known	9	1	-4	4
10-14 day - Coverage (%)				
Total breastfed Plan	98.00%	98.00%	98.00%	98.00%
Total breastfed Actual	**98.80%**	**99.88%**	**100.48%**	**99.47%**
Breastfed at 10 days	41.58%	41.90%	37.65%	34.62%
Breast and supplement fed at 10 days	19.12%	19.09%	25.30%	27.30%
Bottle fed at 10 days	38.10%	38.90%	37.53%	37.55%
Not Known	1.20%	0.12%	-0.48%	0.53%
10-14 day - prevalence (%)				
Plan	**65.00%**	**65.00%**	**65.00%**	**65.00%**
Actual	60.70%	60.98%	62.95%	61.92%

Clinical effectiveness 2: Dementia Rapid Response Team development in North Derbyshire The Dementia Rapid Response Teams in North Derbyshire have been established over the last 12 to 14 months in a phased approach. This was to ensure parity of service across the county, and to support the approach of treating people closer to home. There has been an active recruitment process, given that we needed to recruit a complete multidisciplinary team of skilled professionals. The teams are now almost fully recruited and moving towards extended operating hours.

The High Peak and North Dale Team has begun a seven-day service, working from 8am to 8pm Monday to Friday and 9am to 5pm at weekends. The Chesterfield and North East Team has moved to working 8am to 8pm Monday and Friday with a plan to move to weekend working at the beginning of April 2019. The teams have been building relationships with our partners in the community mental health team and inpatient areas, in order to support appropriate transfer between services and strong joint working.

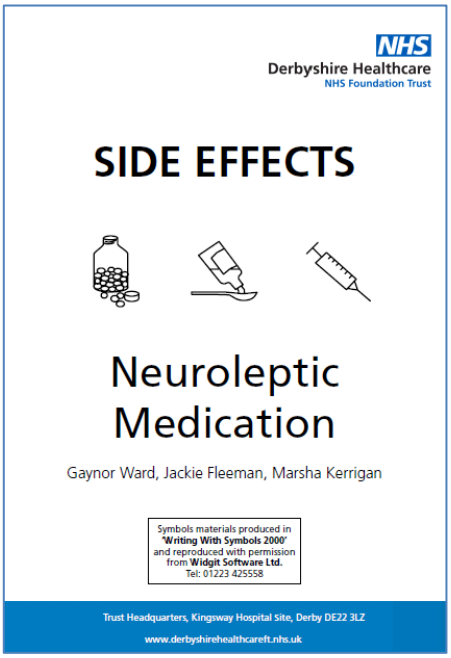
Since the teams' inception there has been a reduction in inpatient bed usage and the teams have also supported a large number of service users and carers who are in 24 hour care. Initial feedback from service users, carers and other stakeholders has been generally very positive, and we look forward to further embedding and developing the teams over 2019/20.

Clinical effectiveness 3: STOMP and exercising independently in Learning Disability services

Part of the work of the Learning Disability Strategic Health Facilitation team is to support the national campaign: **ST**op **O**ver **M**edicating **P**eople who have learning disabilities with psychotropic medication (STOMP). This is a national response to the paper 'Transforming care: A national response to Winterbourne View Hospital', to improve the quality of life of people with a learning disability from the use of inappropriate psychiatric medication.

What we have done

- Told carers and people with a learning disability about STOMP
- Informed care services e.g. the local Care Home Forum
- Informed the Medicines Management teams in four Clinical Commissioning Groups
- Informed GPs and Practice Nurses
- Added STOMP to the Learning Disability Clinical Reference Group work plan
- Informed Community Teams Learning Disability
- Worked with Clinical Commissioning Group Pharmacy Teams
- Created new resources – a video for NHS England, and a podcast.



How do we know what we're doing is making a difference?

- People are getting better reviews and better checks
- We are undertaking audits via Clinical Commissioning Group Pharmacy Technicians
- People with a learning disability are on less medicine or different medicine.

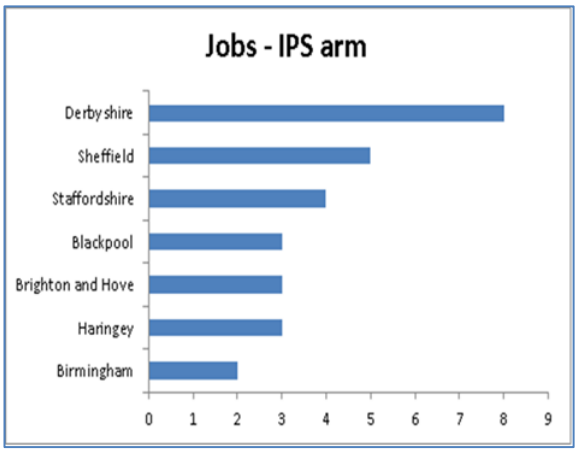
Clinical effectiveness 4: Individual Placement and Support in Substance Misuse services

Derbyshire Recovery Partnership is a consortium of four organisations providing recovery based treatment and support to service users experiencing drug and alcohol problems. In collaboration with Derbyshire County Council, it has been awarded the contract by Public Health England to be an Individual Placement and Support (IPS) trial site, this being a two year randomised control trial. Derbyshire Recovery Partnership is one of only six sites in the country to be awarded this contract.

The trial is to provide employment support to a group of service users in treatment with drug and alcohol services. Their outcomes will be compared with a group of service users who will be receiving treatment as usual (TAU). The outcomes measured are the numbers who are in employment in the trial group as opposed to the TAU group.

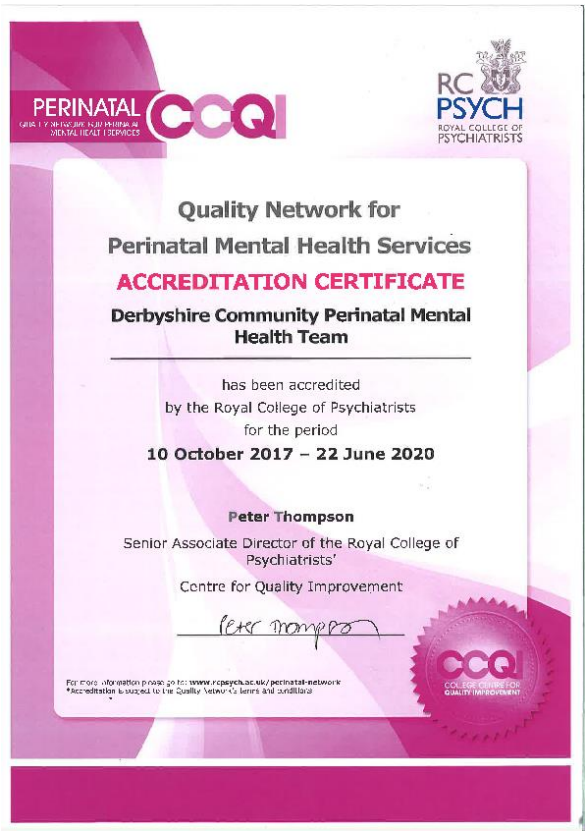
The staff in the trial are employed by Intuitive Thinking Skills (ITS), one of the Derbyshire Recovery Partnership partners, all of whom have an employment support background. They have worked successfully with the treatment staff within the service to recruit the required numbers of participants.

In comparison to the other trial sites, our performance has been one of the most successful. As at December 2018 we have had 259 referrals, of which 174 have enrolled in the trial. This includes 86 people enrolled into the intervention group and 84 into the control group. The interventions have resulted in 49 interviews, which led to 22 job starts (25% of intervention group). The graphs below detail the activity from the first two quarters of the trial (April – September 2018) in comparison to the other trial sites:



Clinical effectiveness 5: Mother and baby services accreditation to national scheme
The newly formed county-wide community team for perinatal services has been accredited by the Royal College of Psychiatrists Perinatal Mental Health Care Quality Network. There are very few teams (fewer than five) across the UK who are accredited and there are now 38 teams with the development programme for perinatal services. The accreditation will last until 2020, and the following are extracts from our report and an explanation of the process:

The accreditation process
There are three main phases of the accreditation review: a detailed self-review, a detailed peer review and a decision about accreditation category and feedback. These reviews are more thorough than the usual quality improvement reviews in that they require more evidence to validate self-ratings and use more information sources and more methods of data collection.


PERINATAL CCQI
RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS
Quality Network for
Perinatal Mental Health Services
ACCREDITATION CERTIFICATE
Derbyshire Community Perinatal Mental Health Team
has been accredited
by the Royal College of Psychiatrists
for the period
10 October 2017 – 22 June 2020
Peter Thompson
Senior Associate Director of the Royal College of Psychiatrists'
Centre for Quality Improvement
CCQI

Types of standards
During the self-review phase, teams measure their performance against the Perinatal Quality Network service standards, and these are then verified at the peer review visit. For the purpose of accreditation these standards comprise of three types:

- **Type 1:** failure to meet these standards would result in a significant threat to patient safety, rights or dignity and/or would breach the law
- **Type 2:** standards that an accredited service would be expected to meet
- **Type 3:** standards that an excellent service should meet or standards that are not the direct responsibility of the service

The Derby City Perinatal Community team is a well-established team who continue to provide a high quality level of care to patients and staff. The team was well prepared for their accreditation visit and keen to be involved and have input into the day. This was the team's first Community Accreditation visit and they are already meeting a large number of the Perinatal Quality Network standards.

Patient experience

Patient experience 1: Family liaison:
The Trust is named for best practice nationally in the NHS Resolution publication 'Learning from suicide-related claims: A thematic review of NHS Resolution data' (September 2018, page 108):

"Derbyshire NHS Foundation Trust has led the way in developing a family liaison service with which to support bereaved families through an SI investigation and the inquest process if necessary. The model is based on the concept of family inclusive practice and the knowledge gaps in engaging with families in all aspects of mental healthcare. The model was created on behavioural family intervention concepts developed in the Lambeth Early Intervention Services in 2001 by the Trust's Director of Nursing and influenced by direct experience of meeting siblings who had not wanted to engage with mental health services due to historical experiences and loss through completed suicide. Following bereavement, the family is offered the services of a family liaison officer (FLO). The FLO acts as the link between the Trust and the family, keeping them informed as to the progress of the SI [serious incident] investigation and supporting them through the inquest process."

From this experience, we have been happy to share our learning and model nationally as other trusts develop a similar model. Likewise, in the recent CQC publication 'Learning from deaths. A review of the first year of NHS trusts implementing the national guidance (March 2019, page 13)', the Trust was commented on for having "…strong processes in place for engaging with bereaved families and carers. Feedback from families about support received from the family liaison team was overwhelmingly positive".

Patient experience 2: 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 and its 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 being informed of any actions taken. In our CQC report last year, our inspectors made reference to how they found that there "was good management of complaints and there was an increase in compliments."

We are aware that there have been issues providing timely responses to some of our complaints during the year and we are working closely 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.

Comparison of contacts through the year:

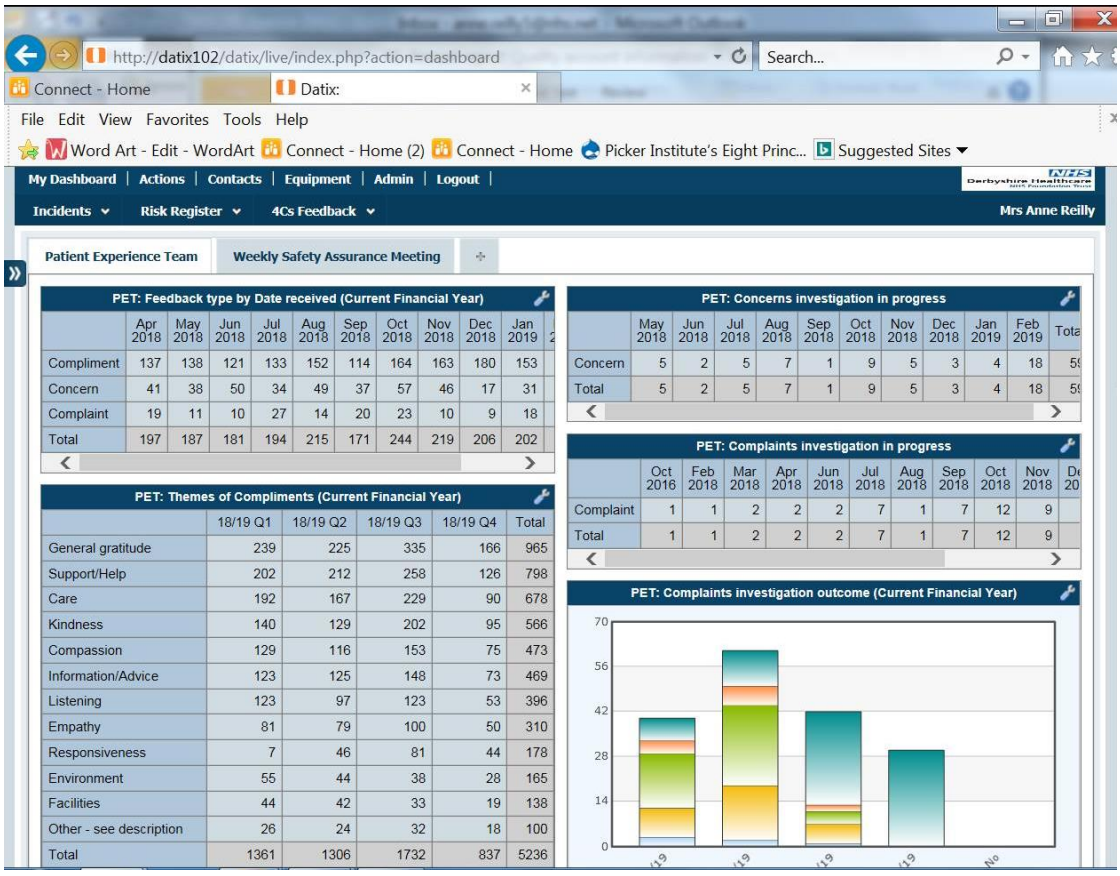
	2016/17	2017/18	2018/19
Compliments	1215	1244	1684
Concerns	420	452	475
Complaints	146	192	197
Total	1781	1888	2356

Complaints are issues that need investigating and require a formal response from the Trust and investigations are co-ordinated 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.

Number of complaints	Outcome
22	Upheld in full
62	Upheld in part
50	Not upheld
8	Closed with investigation
55	Still being investigated
197	Total

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 2018-19, the Patient Experience Team experienced a long period of being short staffed for a range of reasons. This has now been resolved and robust processes are in place to support staff to provide timely responses to complaints and concerns. We expect the result to be a much improved service to people who raise concerns and make complaints about our services over 2019/20. In addition, we have developed a dashboard to enable us to track complaints progress much more effectively. An example of what this can look like is below:



Ombudsman
During the year, the Trust discussed nine cases with the Parliamentary and Health Service Ombudsman. One investigation is being undertaken and eight have been assessed. Five assessments have been closed with no further action.

Comparison of concerns, complaints and compliments by top issues raised 2017/18 and 2018/19
Issues raised in concerns in 2017/18 related to the availability of services. However, in 2018/19 the top issue raised was in regard to appointment delays/cancellations.

The top subject from complaints raised in 2017/-18 and in 2018/19 was in relation to staff attitude.
The top themes from the compliments received in 2017/18 and 2018/19 identify general gratitude for staff and an appreciation for the support/help provided. A high number also comment on the care and kindness shown by our staff.

Patient experience 3: Community mental health survey:
This annual report is undertaken on our behalf by a company called Quality Health. From a sample of 850 people, our response rate was 33% (270 usable responses). The overall results for the Trust present a mixed picture. The majority of scores are in the intermediate range but there are some scores in both the top and bottom 20% ranges of those in the Quality Health database. As examples, we were the highest scoring Trust nationally with regards to if a mental health worker had checked how the person was getting on with their medicines, but we scored in the median range for being involved in decisions about medication. With regards to the person being told who is in charge of organising their care we scored in the bottom 20%. However, in relation to how well the person's care is organised we scored in the top 20%.

The Trust scores in the top 20% for involving family and friends in care, but in the bottom 20% for about being signposted for support around employment. The results are fed back into services via the Neighbourhood Clinical and Operational Assurance Team meeting, and our overall results show that we are in line with other Trusts.

Category of experience	Our score	Comparison to other trusts nationally	Nottinghamshire Healthcare NHS Trust	Leicestershire Partnership NHS Trust
Health and social care workers	7.2 / 10	About the same	7.3 / 10	6.4 / 10
Organising care	8.4 / 10	About the same	8.3 / 10	8.1 / 10
Planning care	7.0 / 10	About the same	6.8 / 10	6.2 / 10
Reviewing care	7.5 / 10	About the same	7.2 / 10	6.7 / 10
Changes in who people see	5.9 / 10	About the same	6.3 / 10	6.1 / 10
Crisis care	6.3 / 10	About the same	5.9 / 10	5.8 / 10
Medicines	7.6 / 10	About the same	7.3 / 10	6.8 / 10
NHS Therapies	7.2 / 10	About the same	8.0 / 10	7.6 / 10
Support and wellbeing	4.4 / 10	About the same	4.7 / 10	3.3 / 10
Overall view of care and services	7.1 / 10	About the same	7.6 / 10	6.6 / 10
Overall experience	6.9 / 10	About the same	7.2 / 10	6.1 / 10

Patient experience 4: Trauma conference in partnership with Police colleagues

CONFERENCE AGENDA

Derbyshire Healthcare NHS Foundation Trust and Derbyshire Constabulary present:

Inter-Agency Conference on Trauma

Monday 25th February 2018, 9.30am - 4.30pm at The Post Mill Centre, South Normanton, DE55 2EJ

- **09:45 Welcome and Opening Remarks.**
  Presented by Tina Ndili (DHCFT Assistant Director for Safeguarding Children) and Matt Thompson (T/Detective Superintendent, Head of Public Protection, Derbyshire Constabulary)

- **10:00 The Derbyshire Trauma Strategy and Guidance for Survivors of Non-Recent Abuse (Overview and current position)**.
  Presented by: Michelina Racioppi (Assistant Director for Safeguarding Children/ Lead Designated Nurse – Safeguarding Children).
  10:45 Refreshment Break
- **11:00 Learning from the National Agenda in Safeguarding and Trauma.**
  Presented by Dr Kenny Gibson (Head of Safeguarding, NHS England)

  12:30 Lunch: networking

- **13:00 A strategic overview of high profile non-recent trauma cases- a local complex case - 12 months on**.
  Presented by Karen Billyeald (DHCFT Assistant Director for Safeguarding Adults) & DS Steve Judge (Derbyshire Constabulary)
- **13:45 Learning from the most important voice. The Truth Project – Data Analysis**
  Presented by Linda Kelsall, Sophia King and Beth Mooney
  14:45 Refreshment Break
- **15:00 Trauma and Neighbourhoods work and learning for others**
  Presented by Paul Langthorne (DHCFT Highly Specialist Clinical Psychologist) & Gina Campion (DHCFT Highly Specialist Clinical Psychologist)

- **16:00 What next from today? …and closing statements.**
  Presented by Carolyn Green, (DHCFT Executive Director of Nursing & Patient Experience)

In February 2019, the Trust hosted an inter-agency event on trauma in partnership with Derbyshire Constabulary. This was underpinned by our strategic aims to:

- Promote a culture which embraces the principles of safeguarding children and adults.
- Develop a workforce who are able to recognise the impact of early trauma in early years which can continue into adult life.
- Develop a trauma informed workforce who are able to recognise non recent abuse and support the individual and their families – Think! Family principles.
- Develop a workforce who are aware of adverse childhood experiences and the impact of these on adult life.
- Promote a culture that supports victims of non recent abuse in a way which encompasses honesty, integrity, transparency and learning from adversity.
- Promote clear lines of communication, information sharing and the management of difference in opinions.
- Promote the use of clear multiagency responses to media requests/enquiries/challenge.
- Inform the development and commissioning of services.

A quote from a psychologist colleague who presented at the event was “it was a privilege to be part of and great to see the energy in the room for moving the trauma informed care agenda forwards.”

Patient experience 5: Partnership working with East Midlands Ambulance Service (EMAS)
In Day Hospital Services, EMAS transport is used for our clientele who don’t have transport or have mobility issues to attend our groups. It was highlighted last year that our patients were not prioritised, resulting in journey’s being changed or delayed, hence having a negative impact on patient experience. We were concerned that people would be put off from attending our groups due to transport issues, and were keen to develop an improved joint working arrangement between both services.

A colleague from EMAS attended this year’s Quality Visit for Day Hospital Services. Trust staff have spent time with ambulance control room staff to gain more insight of the pressures for EMAS and, in return, control room staff will spend a day at the Day Hospital. Working together has had a tangible impact on patient care. There is much improved communication and relationships, and induction for new EMAS transport staff will include a day in the Day Hospitals. We can change the form of transport more easily now and there are some good examples of person centred responses, and examples of how the approach is overcoming the stigma attached to being transported by ambulance. There is also much greater clarity now so patients are aware of waits and reasons. Some issues still remain but they are being actively addressed as part of working together.

Responsiveness

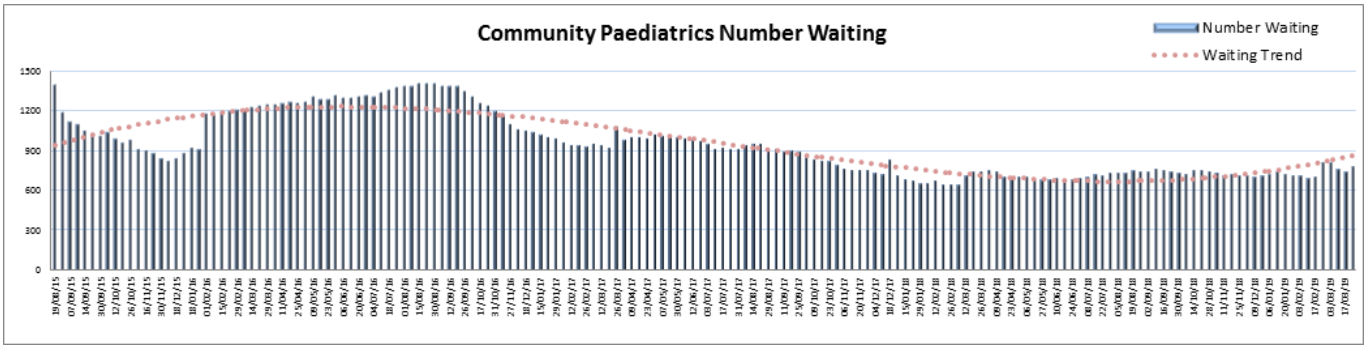
Responsiveness 1: Waiting lists:
The Paediatric Outpatients service has consistently struggled to cope with demand over many years. Recruitment to community paediatric roles is problematic, with only 9.6% of trainees in paediatric specialities progressing to community based roles. Waiting list initiative short term funding was granted in 2016, which did have an significant impact on the overall size and length of the waiting list to achieve an improved position, however we have reached a plateau, with the number of new referrals received each month continuing to exceed capacity. The effect on the waiting list is an increase in the number of children currently waiting to be seen who have been waiting longer than 18 weeks. As 27 March 2019, the percentage of referrals who have been waiting for longer than 18 weeks currently stands at 38.79% (average across geographical teams). There are 10 children who have been waiting over a year to be seen, identified in two geographical areas.

A national study (Royal College of Paediatrics and Child Health, 2017) found that community paediatric referral to treatment waiting time ranged from six - 33 weeks with an average wait of 14.6 weeks. The Trust's average wait in 2017/18 was 33 weeks, therefore at the top of the national range. Whilst we recruited to one of the vacant posts in community paediatrics in 2018, recruitment remains challenging in this specialist field for Consultant Paediatric posts.

The Neurodevelopmental Pathway was launched in early September 2018 to coincide with the new academic year, to help ensure correct allocation of referrals for children with a neurodevelopmental profile, who have traditionally come to Community Paediatrics but may be better suited in other services. Cases who are more appropriate to clinical psychology have been identified and we have agreement to transfer cases to their care. These referrals make up a considerable element of the workload into paediatrics, but are not its entirety.

The pathway, whilst providing some standardisation and integration of systems and process, has not reduced the rate or volume of referrals; these have correlationally increased over the last year. In October 2018 the average number of referrals being processed through the multi-disciplinary meeting was 37; it has now risen to 70. The appointment of a Neurodevelopmental Co-ordinator has ensured a more timely response to Nerodevelopemental referrals, waiting lists management and ensuring clinical information has been gathered in advance of the appointment. However, the increased numbers of referrals for processing is putting added pressure on the capacity of the systems.

The paediatric team continues to work tirelessly to manage workloads and long waiting times. Doctors have worked additional sessions and across their usual work and geographical team, to support colleagues and manage challenging scenarios. Our longer term performance trend from August 2015 to March 2019 is as shown in the table below:



3.2 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 referral to treatment (RTT) Within 14 Days - Complete	271	87.45%	53%
EIP RTT Within 14 Days - Incomplete	150	86.67%	53%

Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in the following service areas		
	Actual	Target
a) Inpatient wards	Data not available to report at time of this draft. All sample data has been submitted to the Royal College of Psychiatrist's National Clinical Audit of Psychosis	90%
b) Early intervention in psychosis services		90%
c) Community mental health services (people on care programme approach)		65%

Improving access to Psychological Therapies (IAPT):

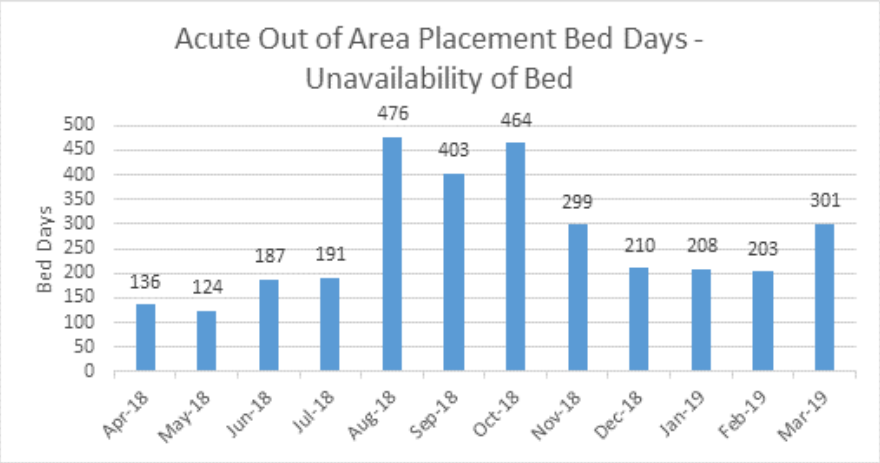
- People with common mental health conditions referred to the IAPT programme will be treated within six weeks of referral
- People with common mental health conditions referred to the IAPT programme will be treated within 18 weeks of referral

	Actual	Target
a) Proportion of people completing treatment who move to recovery (from IAPT dataset)	54.62%	50%
b) (i) IAPT – referral to treatment within 18 weeks	99.96%	95%
b) (ii) IAPT – referral to treatment within six weeks	97.14%	75%

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	
2018/19	Number of admissions under 16 years old 0

Inappropriate out-of-area placements for adult mental health services (due to unavailability of bed) - bed days by month												
Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Average bed days
136	124	187	191	476	403	464	299	210	208	203	301	266.83



It is clear that there have been challenges in our inpatient mental health services. Within the Trust a number of initiatives are in place to optimise bed use and free up capacity, which include a complex case panel meeting that has been established to review patients with a length of stay over 50 days and our Red2Green initiative. The latter is as a way of improving patient flow and therefore liberating space on the wards for people who would otherwise be accomodated outside of Derbyshire. The Trust continues to take part in the regional learning and benchmarking collaborative that is focused on supporting Trusts to reduce out of area placements. Our out-of-area bed use in comparision to other providers is highlighted in the following table:

Out of area bed usage (in days)			
Provider	**Aug to Oct 2018**	**Sep to Nov 2018**	**Direction of travel**
Trust D	3,795	3,795	◀▶
Trust F	2,665	2,970	▲
Trust P	1,910	1,980	▲
Trust H	2,030	1,785	▼
Derbyshire Healthcare NHS Foundation Trust	**1,820**	**1,640**	▼
Trust B	1,295	1,545	▲
Trust N	1,160	1,435	▲
Trust G	590	1,115	▲
Trust K	695	585	▼
Trust O	235	200	▼

Trust Q	80	155	▲
Trust C	215	150	▼
Trust E	510	140	▼
Trust M	25	40	▲
Trust J	15	20	▲
Trust L	50	5	▼
Trust I	0	0	◀▶

Additional information

Health Service Journal Awards 2018 – winner for Innovation in Mental Health
The Trust has worked in partnership with the East Midlands Academic Health Science Network to spread the use of the QBTest, a pioneering project to support diagnosis of Attention Deficit Hyperactivity Disorder (ADHD). The QB test is a computerised system (alongside traditional observation and interviews) to evaluate the symptoms of ADHD by combining motion tracking analysis with a specifically designed task. The aim of this is to reduce the time it takes to either diagnose or rule out ADHD. Dr Helen Jacques, Consultant Paediatrician, is pictured at the awards ceremony.

Children and young people initial health assessment improvement work
The initial health assessment is required to take place within 20 working days. As outlined in the statutory guidance all initial health assessments should be completed by a Registered Medical Practitioner (Statutory Guidance: Promoting the health and well-being of looked after children, March 2015). A range of indicators was influencing our ability to respond in a timely way, including increased referral rates, late cancellations by partner providers, children not being brought, limited clinic slot availability, children being out of area and reporting issues.
An improvement plan encompassed recruiting an admin co-ordinator and an additional Community Paediatrician. We arranged increased clinic slots, introduced a new admin and consent process, added reason for delay onto the referral and made a change so that a Specialist Nurse for Children in Care completed the majority of the assessment, aside from exceptional circumstances. In addtion, we arranged additional training to improve reporting, and improved communication with local authority colleagues. The outcomes on our performance is as shown below:

Initial Health Assessments Summary													
Compliance	**Apr 2018**	**May 2018**	**Jun 2018**	**Jul 2018**	**Aug 2018**	**Sep 2018**	**Oct 2018**	**Nov 2018**	**Dec 2018**	**Jan 2019**	**Feb 2019**	**Mar 2019**	**Total YTD**
Compliant	0	0	1	3	3	11	16	16	10	13	13	16	**102**
Non-Compliant	5	12	16	21	19	14	16	5	6	4	1	3	**122**
% Compliant	**0%**	**0%**	**6%**	**13%**	**14%**	**44%**	**50%**	**76%**	**63%**	**76%**	**93%**	**84%**	**46%**
Total	**5**	**12**	**17**	**24**	**22**	**25**	**32**	**21**	**16**	**17**	**14**	**19**	**224**

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

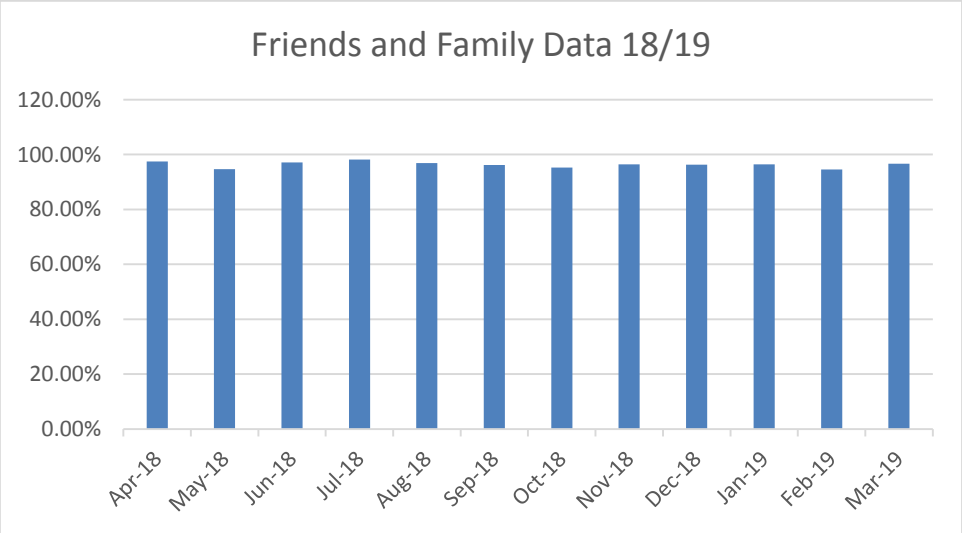
	2016/17	2017/18	2018/19	Target
Outpatient letters sent in 10 working days	87.28%	87.97%	87.68%	90.00%
Outpatient letters sent in 15 working days	93.88%	93.07%	92.83%	95.00%

Overall, this is strong performance. However, challenges remain, 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, and we have also incorporated the expectation of feedback where possible from the Friends and Family test into the revised Quality Visit model.

A significant increase in volume of responses is visible in comparison to last year. This is due to ensuring that feedback from people who use our Improving Access to Psychological Therapies (IAPT) service meets the criteria of the Friends and Family Test so can now be included in our data. However, we also continue to promote this in non-IAPT services.

Month	No. F&F Surveys 2017/18	No. F&F Surveys 2018/19	% of likely / extremely likely to recommend 2017/18	% of likely / extremely likely to recommend 2018/19
Apr	69	397	85.51%	97.48%
May	104	375	81.73%	94.67%
Jun	76	377	75.00%	97.08%
Jul	73	386	86.30%	98.19%
Aug	62	382	87.10%	96.86%
Sep	58	368	89.66%	96.20%
Oct	49	401	85.71%	95.26%
Nov	74	447	77.03%	96.42%
Dec	41	301	85.37%	96.35%
Jan	60	390	86.67%	96.41%
Feb	56	369	82.14%	94.58%
Mar	81	415	81.48%	96.63%
Totals	**803**	**4608**	**83.19%**	**96.62%**



Integrating physical and mental health in long term conditions:
In 2017/2018 Derbyshire CCG's secured funding for a programme to more closely integrate physical and mental health focusing on people living with long term conditions (LTCs). Based on RightCare information, two conditions were chosen to focus upon; diabetes and respiratory and chronic obstructive pulmonary

disease (COPD). Clinicians from three of the providers in Derbyshire (Derbyshire Healthcare NHS Foundation Trust, Derwent Rural Counselling Services and Insight Healthcare) have taken part in this project.

This is the second wave of a national project but is specific to Derbyshire. Clinicians within the service attended LTC specific training provided by Health Education East Midlands at Sheffield and Nottingham Universities in order to work on the project. We appointed a Clinical Lead from within the service and a project manager to oversee the implementation. The service launched as "Fusion" in October 2017 and officially runs to 31 March 2019 when we expect the work to continue as part of our core work in talking therapies. In order to release clinicians to work on the project we appointed trainee Cognitive Behavioural Therapy therapists on a 2:1 ratio funded through NHS England and the Clinical Commissioning Groups. This allowed us to ring-fence time in clinicians' calendars to work with people with the two specific conditions and to work in partnership with physical health clinicians. The physical health clinicians could then refer people with diabetes and respiratory and COPD across Derbyshire via a single point of access set up through Insight Healthcare. There were several aims of the project:

- To trial a single point of access where there are multiple providers, both private and NHS.
- To establish if having a team of therapists across multiple providers works
- The value of linking in with physical health teams and/or co-location Efficacy of therapy when working with those groups of patients
- Whether outcomes are the same or better than the core IAPT service
- Whether the outcomes are the same or better for one particular area of disease
- Whether savings have been made within the wider healthcare system as a result of the integrated models.

"Fusion" specifically received 292 referrals between November 2017 and November 2018 from physical health teams, and core services continued to receive referrals through other referral routes into the service. The physical health team referrals can be broken down as:

Referral Source	Number
Diabetes acute provider (Chesterfield Royal Hospital)	19
Diabetes community providers/nurses	34
Respiratory acute providers (Royal Derby Hospital)	69
Respiratory community providers/nurses/impact	139
Respiratory voluntary sector provider (British Lung Foundation Breatheasy Groups)	2

An evaluation survey amongst clinicians concluded the following outcomes of the project:

- The Single Point of Access was deemed to be a success, however there are competing priorities when working across private and public sector organisations.
- The project worked having a team of therapists from multiple providers.
- Levels of integration between physical health and mental health teams are heavily reliant on "high levels of integration and 'buy in' from physical healthcare teams, in particular at a senior management level".
- The integrated approach was effective for patients and received positive feedback.
- Early indications based on small numbers are that outcomes were not improved against the wider services within the time frame of the study. However, this was not unexpected due to the complexity and co-morbid ongoing physical health problems of this client base.

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 Derbyshire undertook a review of our Memory Assessment Service at the end of March 2018. Whilst this is outside of the timescale of this report, it was not possible to reflect this visit in last year's Quality Report as it went out to consultation on 1 April 2018. Feedback was as follows, and we developed an action plan in response:

- Increase information and communication around all types of dementia and provide clear information on all signs and symptoms.
- Ensure initial concerns around suspected dementia are listened to.
- Work to reduce language barriers to ensure this does not delay diagnosis and to ensure people are fully supported throughout their journey.
- Consider and evaluate the amount of information provided following diagnosis, and to consider whether the information is delivered at the right time.
- Ensure there is opportunity for PLWD (People Living With Dementia), carers and family members to ask questions following the diagnosis:

    - At a later date rather than immediately after diagnosis
    - Ensure carers and family members are able to ask questions around their loved ones diagnosis in private

- Promote the Living Well Programme and the question and answer sessions.

There is a current mental health and crisis survey being undertaken by Healthwatch Derby. At the time of writing this survey has not been completed as it did not close until 28 February 2019. Any results received before the final publication data for the report will be included if available.

Selection of Quality Indicators for the Quality Account
NHS foundation trusts providing mental health services should select indicators to be reviewed by our auditors for assurance around data quality. For 2018/19, our mandated indicators are:

1. Early intervention in psychosis (EIP): people experiencing a first episode of psychosis treated with a NICE-approved care package within two weeks of referral
2. Inappropriate out-of-area placements for adult mental health services

An additional indicator was chosen for data quality audit by the Council of Governors:

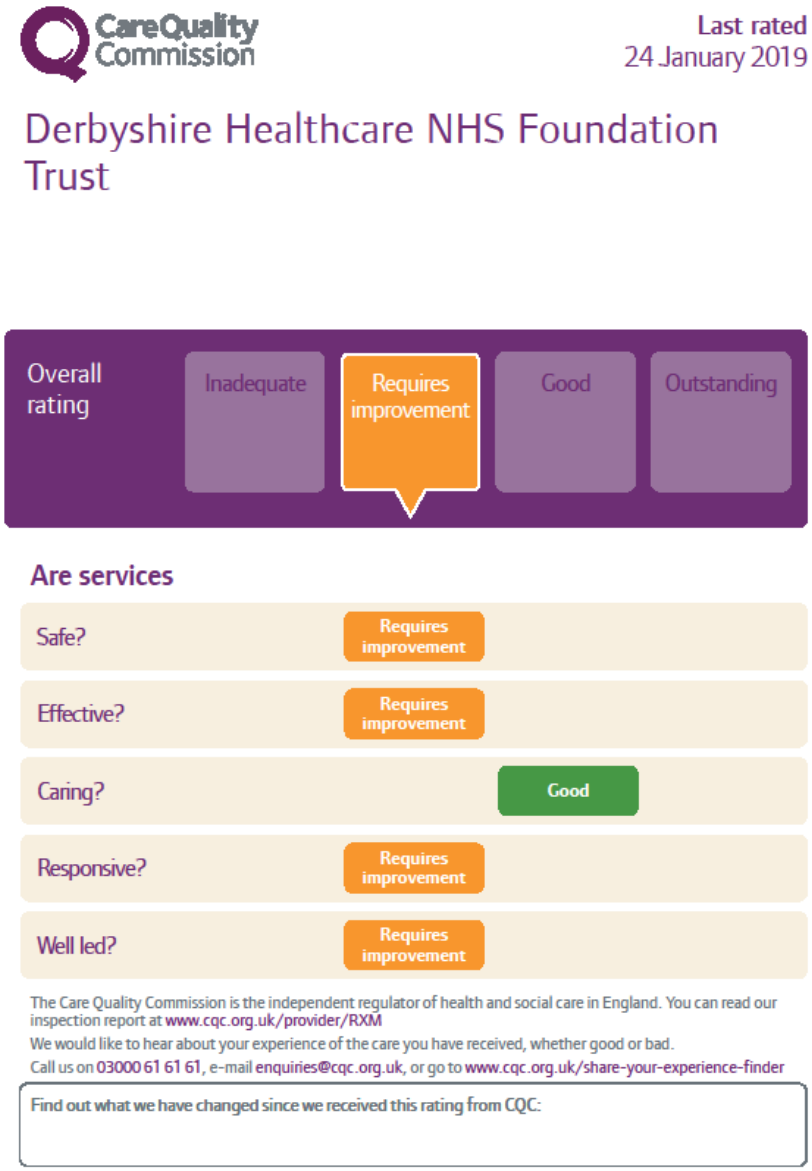
3. 100% enhanced Care Programme Approach patients receiving follow-up contact within seven days of discharge from hospital during the reporting period.

This was chosen 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. Therefore, ensuring that we have contact with the person is part of our attempt to reduce this risk. This indicator also aligns with our Relapse Reduction Quality Priority.

DHCFT Trust Performance Dashboard YTD (08/05/19)	No.	%	Target
- NHS I Targets - Single Oversight Framework			
- CPA 7 Day Follow Up	725	96.83%	95.00%
- Data Quality Maturity Index (DQMI) - MHSDS Data Score	287,478	96.47%	95.00%
- IAPT Referral to Treatment within 18 weeks	8,336	99.96%	95.00%
- IAPT Referral to Treatment within 6 weeks	8,336	97.14%	75.00%
- EIP RTT Within 14 Days - Complete	271	87.45%	53.00%
- EIP RTT Within 14 Days - Incomplete	150	86.67%	53.00%
- Patients Open to Trust In Employment	42,503	9.00%	N/A
- Patients Open to Trust In Settled Accommodation	42,503	50.06%	N/A
- Under 16 Admissions To Adult Inpatient Facilities	0	N/A	0
- IAPT People Completing Treatment Who Move To Recovery	7,981	54.62%	50.00%
Physical Health - Cardio-Metabolic - Inpatient	*monitored by audits*		
Physical Health - Cardio-Metabolic - EI	*monitored by audits*		
Physical Health - Cardio-Metabolic - on CPA (Community)	*monitored by audits*		
- Out of Area - Number of Patients Non PICU	209	N/A	N/A
- Out of Area - Number of Patients PICU	243	N/A	N/A
- Out of Area - Average Per Day Non PICU	8.77	N/A	N/A
- Out of Area - Average Per Day PICU	11.33	N/A	N/A
- Locally Agreed			
- CPA Settled Accommodation	31,990	94.30%	90.00%
- CPA Employment Status	31,990	96.43%	90.00%
- Patients Clustered not Breaching Today	172,565	74.40%	80.00%
- Patients Clustered Regardless of Review Dates	187,589	91.99%	96.00%
- 7 Day Follow Up – All Inpatients	1,308	96.33%	95.00%
- Ethnicity Coding	287,478	90.63%	90.00%
- NHS Number	66,115	99.98%	99.00%
- CPA Review in last 12 Months (on CAP > 12 Months)	2,639	95.45%	95.00%
- Clostridium Difficile Incidents	0	N/A	7
- 18 Week RTT Greater Than 52 weeks	0	N/A	0
- Schedule 6 Contract			
- Consultant Outpatient Appointments Trust Cancellations (Within 6 Weeks)	54,391	11.34%	5.00%
- Consultant Outpatient Appointments DNAs	35,794	16.20%	15.00%
- Under 18 Admissions To Adult Inpatient Facilities	1	N/A	0
- Outpatient Letters Sent in 10 Working Days	32,472	87.68%	90.00%
- Outpatient Letters Sent in 15 Working Days	32,472	92.83%	95.00%
- Inpatient 28 Day Readmissions	1,470	6.26%	10.00%
- MRSA - Blood Stream Infection	0	N/A	0
- Mixed Sex Accommodation Breaches	1	N/A	0
- Discharge Email Sent in 24 Hours	1,470	81.70%	98.00%
- Delayed Transfers of Care	4,774	1.24%	0.80%
- 18 Week RTT Less Than 18 Weeks - Incomplete	3,443	94.83%	92.00%
- Fixed Submitted Returns			
18 Week RTT Greater Than 52 weeks	0	N/A	0
18 Week RTT Less Than 18 weeks - Incomplete	4,610	93.71%	92.00%
Mixed Sex Accommodation Breaches	0	N/A	0
Completion of IAPT Data Outcomes	8,386	97.93%	90.00%
Ethnicity Coding	311,013	91.63%	90.00%
NHS Number	66,465	99.98%	99.00%
CPA 7 Day Follow Up	728	96.70%	95.00%

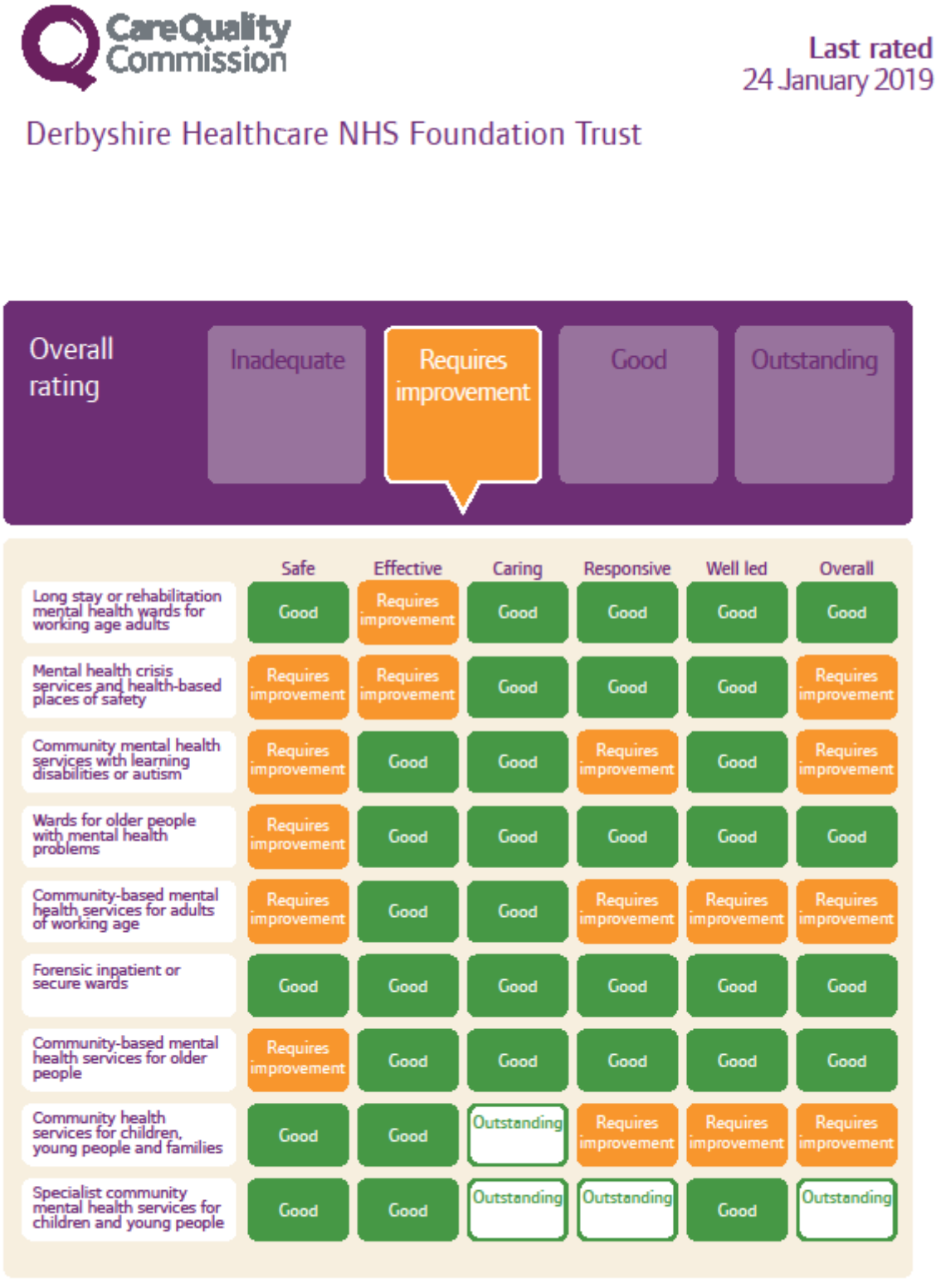
Annex 1

The Trust's CQC rating
The result of our 2018 inspection was that the CQC rated our organisation as requiring improvement. Quality improvement work has been undertaken to address the actions from the 2018 visit and from subsequent visits. Our ratings tables are as below:



Our clinical service reports

These are the current results for the comprehensive inspection in 2018:



	Safe	Effective	Caring	Responsive	Well led	Overall
Long stay or 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
Community mental health services with learning disabilities or autism	Requires improvement	Good	Good	Requires improvement	Good	Requires improvement
Wards for older people with mental health problems	Requires improvement	Good	Good	Good	Good	Good
Community-based mental health services for adults of working age	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Forensic inpatient or secure wards	Good	Good	Good	Good	Good	Good
Community-based mental health services for older people	Requires improvement	Good	Good	Good	Good	Good
Community health services for children, young people and families	Good	Good	Outstanding	Requires improvement	Requires improvement	Requires improvement
Specialist community mental health services for children and young people	Good	Good	Outstanding	Outstanding	Good	Outstanding

This detailed ratings poster was retrieved from the CQC website on 20 May 2019. The rating for acute wards for adults of working age is currently missing, as the service was recently being revisited by CQC colleagues. The ratings for these services following our 2018 inspection were Requires improvement for

the Effective and Responsive domains, Inadequate for Safe and Well-led, Good for Caring, with an overall rating of Inadequate.

CQC actions progress

The Trust-wide inspection in July 2018 resulted in 91 actions being logged. Along with the seven actions from the Cubley Male visit in March and the Warning Notice served in May, the total actions received in 2018 were 99. Colleagues from Divisions and from Nursing and Quality have been meeting over the past two weeks to review the current level of evidence that has been submitted, and agreed to either sign off actions or agreed that others continue to require specific evidence to provide assurance of improvement. We are making significant headway and remain focussed on delivering on all the areas that we are required to improve.

Feedback from the Council of Governors

Governors' Response to the 2018/19 Quality Report
Governors recognised that all areas of the Trust's business are covered in the Quality Report. The view is that overall the report is very balanced, gives clear reasoning and definition, with good clarification of what work is taking place and why. The narrative is supported by the evidence, and the content of the report triangulates with other documents that have been received by the Council of Governors, or that governors are aware have been reviewed by Trust Board.

Issues that stood out for the governors included waiting lists, as probably the most frequently commented aspect of feedback that they receive. An example of this was the section on paediatric waiting times, which was considered to be a transparent representation of the challenges being faced by that service. The governors wished to state that as a Council of Governors they remain concerned about our communities being able to access the care that they need in a timely manner.

Whilst partnership working within our broader health community is mentioned in different sections of the Quality Report, governors fed back that overall the report does not fully do justice to the Trust's high level of engagement across a range of work streams, including as part of Joined Up Care Derbyshire/Derbyshire's Sustainability and Transformation Partnership (STP). Governors recognised the essential value of partnership working when planning and providing healthcare in Derby and Derbyshire.

Governors were pleased to see our contribution to health research, and are interested in exploring the broader undertaking and embeddedness of research beyond our Research and Development department, and the difference this is making to the quality of care we provide.

For next year's Quality Report governors suggested including the following for clarity:

- A separate section for partnership working, including work undertaken as part of Joined Up Care Derbyshire
- Include an additional column showing comparative data from the previous year on the Trust's Performance Dashboard.

John Morrissey
Lead Governor, Derbyshire Healthcare NHS Foundation Trust

Feedback from Derby and Derbyshire Clinical Commissioning Group

The Derby and Derbyshire Clinical Commissioning Group (DDCCG) welcome the opportunity to provide a statement in response to the presented draft Quality Account (QA) from Derbyshire Healthcare Foundation Trust (DHCFT). The CCG have worked closely with Derbyshire Healthcare Foundation Trust throughout 2018/19 to gain assurances that the services delivered were safe, effective and personalised to service users. The data presented has been reviewed and is in line with data provided and reviewed through the regular contractual performance meetings and quality assurance meetings.

DDCCG has noted the progress and achievements on the six quality priorities set out last year, which the Trust has rolled over into 2019/20. There are clear examples with relevant evidence to support the statements. Commissioners acknowledge the achievements and the use of national CQUINs to progress the quality priorities over the past 12 months. The Trust acknowledges where there continues to be areas of concern or development. Whilst the priorities have been rolled over to 2019/20, identified concerns do not easily read across to provide assurances that they will be addressed. In 2018/19, Priority 2 identified that CQUIN 3a remained a concern and the introduction of Physical Health in Mental Health practitioners should support this. However, Priority 2 for 2019/20 does not reflect that this will be addressed. Whilst some improvements in the Flu vaccination rates have been observed it would have beneficial to have more detail as to how the Trust will improve the uptake rates amongst frontline staff in 2019/20. The CCG is keen to see an increase in the uptake next year as part of the national requirements through the CQUIN.

Commissioners agree that the Quality Account provides a good overview of the overall Trust's Strategy, Vision, Values and work that is making a difference in services that DHCFT provides to the local population. Key improvements in enhancing quality, particularly joint working and networking to share quality improvements include hosting the East Midlands Self harm and Suicide Prevention Partnership Forum and participating in the Enabling Research in Care Homes (ENRICH) initiative.

The national and local challenge to recruitment of healthcare staff against a background of increased demand is reflected within the QA, throughout the year the Trust has looked at and implemented a range of alternative employment methods to fill vacancies. It is felt that the Trust has missed an opportunity to highlight the workforce development, including the role of the advanced medical practitioner and Occupational Therapists against a positive retention rate.

The NCISH Safety Scorecard shows that the Trust rate of incidents of suicide and homicide are below the national median figure. Over the past twelve months the organisation has continued its focused work to continue to embed learning from serious incidents and it is of particular note that there were 'nil' never events reported in 2018/19. The recent CQC publication 'Learning from deaths' noted that the Trust has strong processes in place for engaging with bereaved families and carers. Feedback from families about support received from the family liaison team was overwhelmingly positive. This narrative could have been enhanced if the Trust had recognised the work undertaken in relation to embedding the learning from a number of high profile independent homicide investigation reports which were published during 2018/19.

The results of the 2018 CQC inspection and subsequent visits are reflected throughout the Quality Account and the areas requiring improvement. Whilst Commissioners note the overall rating, we recognise the quality improvement work undertaken throughout the year and will continue to be a critical friend to ensure improvements are embedded.

In 2018 the Trust commenced a review of their Neighbourhood Service which proposed to re-introduce Community Mental Health Teams for Adults of Working Age and Community Mental Health Teams for Older People. The changes will address a number of known shortcomings which are likely to need resolving regardless of the future service delivery model. Commissioners felt that this key piece of work should have been covered within the overview of 2018/19 and going forward into 2019/20 to show how the Pathways of Care will offer a more clear meaningful dialogue with stakeholders.

This quality account reflects progress to date and the Commissioners are pleased to endorse the quality account for 2018/19. We look forward to continue working in partnership with DHcFT to support the quality improvements planned for 2019/20.

Phil Sugden
Assistant Director of Quality - Community
NHS Derby and Derbyshire Clinical Commissioning Group

Feedback from Healthwatch Derby

Healthwatch Derby response to DCHFT Quality account 2018/19

Healthwatch Derby has noted that DCHFT have made improvements throughout the year and are working hard to continually improve the experiences of those that use their services. Healthwatch Derby will continue to work in partnership to aid the Trust in their ongoing endeavour.

James Moore
CEO Healthwatch Derby

Feedback from Healthwatch Derbyshire

DHCFT Quality Account – HWD Response:

Healthwatch Derbyshire (HWD) is an independent voice for the people of Derbyshire. We listen to the experiences of Derbyshire residents using health and social care services and give them a stronger say in influencing how local health and social care services are provided.

All of the experiences we collect are shared with the providers and commissioners of the services, who have the power to make change happen.

Experiences from patients and members of the public are collected through our engagement team, which is supported by volunteers. We undertake engagement in two ways:

1. General engagement in which we collect a variety of different experiences on a number of services. Experiences from our general engagement are shared with providers on a regular basis to provide 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.

2. Themed engagement is where we explore a particular topic in more detail and the findings from our themed engagement are analysed and written up into reports which included recommendations for improvement. Service providers and commissioners are asked to respond to the recommendations outlined in the reports.

All of our reports are published onto our website.

We have read the Quality Account for 2018-19 prepared by the Trust with interest. We have considered if, and how the content reflects some of the themes which have emerged in the feedback that HWD has collected during the past year.

A number of themes that we continue to be aware of, are directly addressed in the priorities sections of the Quality Accounts:

- Autism awareness training for all staff
- Relapse reduction and harm reduction
- Children and Young People (CYP) Transition.

The Quality Account highlights the top theme raised as a concern to be around appointment delays and cancellations, HWD welcome any work and efforts planned to help address this issue. At HWD we often hear from people who have had to wait a long time for an appointment, with many explaining they would have liked to have received honest and realistic waiting times from the start and/or if appropriate, if long waits are anticipated to receive appropriate information and signposting support during their waiting period.

By way of summary, during the period April 2018 - March 2019, a total of 43 comments were received about the Trust. We received (11) positive comments, (24) negative comments and (8) mixed comments. The most frequent negative comments were regarding information and communication. The most frequently made positives comments were in relation to the quality of care provided by members of 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 in relation to the experiences of people living with dementia, their carers and family members. This piece of engagement highlighted a number of key themes and findings, to which the Trust provided a detailed response, outlining their actions to improve future experiences.

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

Kind regards

Hannah Morton
Intelligence and Insight Manager
healthwatch Derbyshire

Response to consultation feedback

The Trust thanks all parties for their comprehensive review of this year's Quality Report. All suggestions for additional sections will be taken into account in the preparation of next year's report.

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 2018/19* and supporting guidance *Detailed requirements for quality reports 2018/19*
- The content of the quality report is not inconsistent with internal and external sources of information including:

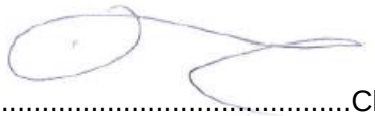
    - Board minutes and papers for the period April 2018 to [the date of this statement]
    - papers relating to quality reported to the board over the period April 2018 to [the date of this statement]
    - feedback from commissioners dated 24/04/2019
    - feedback from governors dated 16/04/2019
    - feedback from local Healthwatch organisations dated 02/05/2019 and 09/05/2019
    - the trust's complaints report published under Regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 07/05/2019
    - the national patient survey 11/2018
    - the national staff survey 12/2018
    - the Head of Internal Audit's annual opinion of the Trust's control environment dated 22/05/2019
    - CQC inspection report dated 28/09/2018

- 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
- 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

23 May 2019…….Date.....  .....Chairman



23 May 2019.....Date.....Chief Executive

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