Derbyshire Healthcare
NHS Foundation Trust

Quality Report 2019/20

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Making a positive difference

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Part 1: Statement on quality from the Chief Executive

I am pleased to present our Quality Report for the financial year 2019/20. The report is the opportunity for the Trust Board to look back and offer a view as to the quality of the healthcare that we have provided over the past year, to reflect on some of our key achievements and to think about our priorities for our communities for the coming year. This is an annual report, and in it we note our formal regulatory requirements, areas that we see as high quality and innovative care, together with any areas that we have found challenging. I will be talking about how this has been a significant and exciting year for the Trust with regard to our updated CQC rating, and all the work that went into bringing this about. However, at the current time, the dominant issue for all of us is the COVID-19 virus, the enormity of the impact of this on our lives and our work, and the humbling responses from staff working in all areas of the Trust to pull together for the sake of the communities we serve.

I have been very aware in all my contacts with staff over the past few years that I have seen colleagues with high levels of motivation and dedication who are innovative and forward-thinking in their practice. I have also seen colleagues living the values of the Trust. For all this to be equally noted by our CQC inspector colleagues was validating, and is just reward for the hard work that colleagues have put in, day in, day out, over recent years. As a result of the inspection, as a Trust we can feel rightly proud that we are now rated 'good' and that we have two 'outstanding' service lines: community health services for children and young people (0-19 services and complex health services) and specialist community mental health services for children and young people. We can also feel rightly proud of the significant progress made across the entire Trust, whether that has been to hold previous ratings or to improve them. Colleagues in acute mental health services and learning disability services have shown clear and focused improvement. Mental health crisis services were noted to be "more effective", community mental health teams "more responsive". Whilst we remain committed to ongoing and continuous improvement, the clear message for people in our care is that they are in 'good' hands. An example to further illustrate this is that we are third in the country for the community mental health team patient satisfaction score.

A significant strength for us over the year has been the communication channels that we have developed. Maintaining our focus on 'people first', we now have a structured approach to hearing and acting on feedback, including through the number of forums now up and running. The results of our staff survey offer further evidence, in that we significantly improved in approximately a third of all the areas surveyed and didn't receive lower scores on any of the themes. I am most pleased to share that the two Friends and Family Test questions (recommending as a place to work and as a place to receive care) showed marked improvement, together with our year-on-year increased response rate since 2016.

We remain committed to working within and across the Derbyshire system at multiple levels, continuing to focus on our contribution to health and wellbeing through such initiatives as individual placement and support, the development of the mental health and wellbeing hubs and pilots into primary care network areas. In the context of pressures within the Derbyshire health and social care system we also face a challenge of delivering our control total requirements. We will approach this through engagement, openness and transparency about the risks that we will face together.

The situation with the COVID-19 is without doubt the biggest challenge we have faced as a healthcare community. The visible commitment to care for each other and to find creative ways to continue to provide care to our population, and the courage of staff to step in to entirely new areas of the Trust to

help maintain essential services has absolutely shone out. Knowing our staff as I do this does not in any way surprise me. However, I cannot fail to be once again impressed at what we achieve when we work together. Looking ahead, there will be much to learn from our response to COVID-19 and how we might apply that learning to future models. We will also need to focus on our community mental health provision in line with the NHS Long Term Plan, together with our interface with primary care. We have exciting but challenging opportunities around our changes in our electronic care record system and opportunities to review and improve our estate. We will continue to approach these and other developments by focusing on our vision and our values.

Ifti Majid
Chief Executive

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

2.1 Priorities for improvement in 2020/21

The report starts 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 2020/21. These are a continuation of the priorities from 2019/20 and are as follows:

1. **Physical healthcare**
2. **Deliver all named specific CQUINs or contractual targets**
3. **Relapse reduction and harm reduction**
4. **Being effective**
5. **Quality improvement (QI) – using your ideas**

Of note, these are now embedded within the Trust Strategy, as a way of integrating them more firmly into core business. Progress against all the Trust's quality priorities is reported to the Quality and Safeguarding Committee.

Priorities for improvement from the 2018/19 Quality Report and examples of our progress against these during 2019/20:

Priority 1: Physical healthcare

As part of our improvement approach, we have put in place building blocks to establish a good baseline standard of physical healthcare, to then be able to refocus our efforts on compliance with the Lester Tool (physical healthcare for people with severe or enduring mental health problems). This is also bringing a clear process that will enable us to identify people who have a level of additional need, so that we can then respond and also liaise with other providers to ensure those needs are being attended to.

We have developed the electronic patient record system to include the Initial Physical Health Assessment Tool, which gives us two aspects of data: firstly, that we are completing the form in a timely fashion; and secondly, an enhanced screen of such as Lester or other assessment tools e.g. frailty providing further detail around the quality of the content. We are now working to develop a framework so that we can identify the physical healthcare interventions that have been provided, and ultimately what difference these interventions have made, recognising that these interventions might be delivered within the Trust or in partnership with other providers in the system. Given that we have integrated the Initial Physical Health Assessment Tool and an updated Lester Tool into the electronic patient record system, and as we now know that we are moving care record systems, this will bring further opportunities for information sharing amongst our clinicians and with primary care colleagues.

We are continuing to apply divisional physical health priorities, examples including:

- Children – baseline interventions and minimum standards for each pathway
- Older people – frailty and falls
- Acute in-patients – rapid tranquilisation, adapting our handheld electronic devices that are currently used to record supportive observations so that they can also be used in a pilot to record physical health observations
- Community mental health – the enhanced physical health offer via our physical health focused staff recruitment

- Substance misuse – improving Hepatitis C monitoring and extending the liver screening pilot.

All of this work has been underpinned by a quality improvement approach. The Trust has quantitative measures of the number of physical health assessments undertaken within services, and is developing qualitative measures of the completeness of these assessments.

Other examples of physical healthcare initiatives include:

- The Kedleston Low Secure Unit has delivered a healthy weight programme, given the national concerns that people staying in low secure units might gain weight due to food choices, low physical activity levels and the effects of pharmacological treatment. People are supported to participate in a physical activity programme, focus groups and cooking sessions, with data measured at baseline and over time. The unit is also linking with dietician colleagues and the Derby County Community Trust.
- Nutrition support from the dietetics team. Team members attend wards to review patients that have poor intake or those at risk of malnutrition. They provide the nursing team with advice and prescribe supplements for the patients who are assessed to be at risk of malnutrition. They respond quickly to referrals and work closely with the multi-disciplinary team and the patients themselves. The team also provides training to ward staff. Evidence suggests that one in five people admitted to a mental health unit is at risk of malnutrition. Nutrition support also helps to reduce the risk of pressure sores, infections, falls, delayed wound healing, depression, increased length of stay and ultimately death (NICE clinical guideline 32, nutrition support for adults: oral nutrition support, enteral tube feeding and parenteral nutrition).
- Since January 2019 we have employed a system by which elevated early warning scores of physical health deterioration trigger an email alert to a senior nurse cohort across in-patient areas. This allows senior clinicians to be aware of changes and to track patients whose scores have elevated. Therefore, senior clinicians have opportunity to provide oversight and support and review episodes of care and with clinical teams to reflect upon practice and swiftly address any issues identified. A weekly summary report shows the initial score and the subsequent score as part of a summary oversight process. The approach has allowed for iterative learning and has highlighted additional support needs for areas which are addressed by the Physical Health Practice and Compliance Lead Nurse.

Priority 2: Deliver all named specific CQUINs or contractual targets

The Trust has a number of agreed initiatives in place to monitor improvements in the quality of the care we provide. These are called Commissioning for Quality and Innovation agreements (CQUINs). They are set either nationally, in agreement with NHS England, or locally in agreement with our CCG commissioners. CQUINs identify a proportion of the Trust's income as being conditional on demonstrating improvements in quality and innovation in specified areas of patient care. A particularly positive approach with our commissioners for 2019/20 was our agreement of a local CQUIN focussed on falls reduction.

CQUIN Dashboard 2019-20

Please note: Due to the COVID19 situation and the acknowledgement that reporting is not required in Quarter 4 a practical approach was taken to extrapolate CQUIN achievement for Q4 based on previous Quarters. Where DHcFT has been awarded full payment consecutively in previous quarters this has been proposed for Q4. This related to CCG3a/b/c, CCG4 and CCG7. For CCG2 (Flu) achievement was measured at a single point in time during February. This was prior to the pandemic period therefore this CQUIN can accurately be reported as below. For CCG 4,5a/b these require access to the national data set and for CCG4 and 5a the Q4 period has been extrapolated as an average from Q3 therefore both are considered full payment. Please also note that some quarters have been broken down into three in

agreement with CCG colleagues, in line with data availability.

Indicators	Summary of CQUIN achievement 2019-20									
	Quarter 1	Quarter 2			Quarter 3			Quarter 4		
CCG2: Staff Flu Vaccinations	N/A	N/A	N/A	N/A	N/A	N/A	N/A	71.1%		
CCG3a: Alcohol and Tobacco Screening	100%	100%			100%			Not required		
CCG3b: Alcohol and Tobacco Brief Advice	93%	94%			97%			Not required		
CCG3c: Alcohol and Tobacco Alcohol Brief Advice	91%	92%			94%			Not required		
CCG4: 72 hour follow up post discharge	N/A	N/A			88%	92.2%	78.3%	Not required		
CCG5a: Mental health data (Maturity index)	N/A	88.50%	91.00%	90.9%	96.2%	96.3%	96.2	Not required		
CCG5b: Mental health data (interventions)	N/A	N/A			100%	100%	100%	100%	100%	100%
CCG7: High impact actions to prevent hospital falls	100%	86%			85.3%			Not required		
CCG6: IAPT – use of anxiety disorder specific measures										
NHSE: The Low Secure 'healthy weight' CQUIN										

Key

Fully achieved		Not achieved	
Partially achieved		Not required	
Data not yet available			

There are some clear successes in this table, including our commitment to assess and appropriately intervene when people are admitted on to our wards and are drinking alcohol to harmful levels, or smoke. However, there are also challenges with our achievement of the IAPT CQUIN at the current time, with some concerns that this is related to the complexity and time requirement of the assessment tool as an additional measure within therapy. Performance with regards to CQUIN achievement is reported to the Trust Management Team, our commissioners and the Quality and Safeguarding Committee. Contractual targets are reviewed via the Integrated Performance Report that is submitted to Board.

Priority 3: Relapse reduction and harm reduction

This is a core component of our care planning processes and also integral to the Care Programme

Approach used in our mental health services. Harm reduction is also a core component of our substance misuse services. The continuing development of our approach to Safety Planning, and the work of colleagues in each division to ensure its applicability to their population is also integral to this work. Within the Trust strategy, this is encompassed by the clinical ambition to prevent ill-health, and within the building blocks of improved patient experience, improved access to services (including at times of any relapse), developing specific pathways to maximise the potential of positive outcomes, and monitoring of suicide rates of people open to our care. It also includes making improvements to the accommodation in our in-patient wards towards a single room model.

Other examples of relapse reduction and harm reduction initiatives include:

- The PARADES Bipolar psychoeducation group (Psycho-education, Anxiety, Relapse, Advance Directive Evaluation) has run in the Erewash Neighbourhood Team and is underway in the Bolsover Team, with a plan to roll it out in the north and in the south of the county once a year, with open access to people using all teams. This initiative was seed-funded by the East Midlands Academic Health Network, with an explicit focus of reducing the risk of relapse for people with bipolar disorder as their diagnosis. The approach is recognised as evidence-based best practice, and a recent review with the people who attended the group in the Erewash team provided the following feedback:

How would you rate:	**Score**
The content of the group sessions overall?	9.3/10
The venue/location of the group sessions overall?	9.2/10
The facilitation/running of the group sessions overall?	9.3/10
The organisation of the group sessions overall?	9.5/10
The handouts/other materials of the group sessions overall?	9.5/10
Your confidence in managing your bi-polar **before** attending the programme?	**4.8/10**
Your confidence in managing your bi-polar **after** attending the programme?	**7.5/10**

- The executive team has supported the pharmacy improvement plan, an additional programme of investment and quality improvement work within our pharmacy department. This includes the learning from the Chief Pharmacist quality improvement projects, the 'Vertical Observatory'. The investment in the community pharmacy team to specifically target individuals at risk of relapse and to work in partnership with community colleagues to reduce the risk of relapse has had a very positive effect on morale in clinical practice. Emerging clinical data is indicating a reduction in clinical relapse rates and an improvement in community patient experience.

- Killamarsh and North Chesterfield community mental health team for working age adults has developed the 7 Steps Group, a group informed by dialectical behaviour therapy, as a way of ensuring that people referred to the team with a diagnosis of a personality disorder are seen at the earliest opportunity, to improve the effectiveness of any intervention and to promote recovery. The approach has clarified the people who need further intervention within the personality disorder pathway, and has given those who do not need that intensity of intervention, basic skills to reduce the risk of further deterioration. The approach is underpinned by NICE guidance.

Priority 4: Being effective

NICE Guidelines are overseen by the NICE Steering Group, with identification of guidelines against which we need to consider a review of our alignment, and also consultation papers to which the Trust can contribute. A range of NICE Guidelines has been reviewed across the Trust as prioritised by the group, and NICE Guidelines are also being aligned to the action plans from the respective clinically led strategies. NICE is also an integral expectation of the content of a clinical team's Quality Visit, as described elsewhere in this document, as a way of both raising the profile of NICE Guidelines and their content, and capturing the NICE aligned work that is already being undertaken. The 'being effective' priority is in particular within the 'improve clinical outcomes' section of the Trust Strategy.

Examples of effective practice within services include:

- Introducing Quantitative Behaviour testing to aid in the assessment of the core symptoms of attention deficit hyperactivity disorder (ADHD): hyperactivity, inattention and impulsivity. The test helps healthcare professionals to more accurately identify or rule out ADHD in patients aged 6-60 years old
- The physiotherapy team had created a cerebral palsy integrated pathway to identify issues with hip dislocation more rapidly and enable earlier identification of emerging to prevent hip dislocation
- Introducing a change in the pathway for premature babies to implement general movement videos. The team films the baby at specific ages to aid earlier diagnosis of cerebral palsy or identification of movement difficulties
- A service known as 'Concordat' has been developed, where the Children in Care team worked with the police, youth offending service, local authority, education and the Crown Prosecution Service to try and reduce criminalisation within young people in care. In the six months post Concordat being set up, the team has seen a reduction in the number of offences involving young people in care, a reduction in the number of calls to the police and a reduction in the number of missing and absent young people.
- Derby City community mental health nurse-led clinics. This has been a new model in how we offer a service to people in secondary community mental health services that includes routine use of outcome measures. Initial indications are that this is having a positive impact on both service user experience and management of clinical demand on services.
- Supporting Derbyshire patients who are cared for in locked rehabilitation environments out of area. We have developed processes where each person is allocated a senior clinician who works with the patient, carers, provider, CCG, and multi-agency professionals to support the patient's goals to be met, so that discharge from hospital can be expedited to prevent long delays.
- The Trust's Psychiatric Liaison Team in the north of the county provides interventions structured around the NICE Guidelines for self-harm (2013), including the following expectations:
    - people who have self-harmed are cared for with compassion and the same respect and dignity as any service user
    - people who have self-harmed have an initial assessment of physical health, mental state, safeguarding concerns, social circumstances and risks of repetition or suicide
    - people who have self-harmed receive a comprehensive psychosocial assessment
    - Quality Statement 4: "People who have self-harmed receive the monitoring they need while in the healthcare setting, in order to reduce the risk of further self-harm.
- The Kedleston Low Secure Unit has expanded the range of interventions in order to meet the needs of patients, in line with best practice expectations of the NICE Guideline for psychosis and schizophrenia in adults, with a specific focus on improving access to psychological interventions

- Derbyshire Perinatal Community Mental Health Team provides an evidence-based approach called video interaction guidance (VIG). Interactions between a parent or carer and a child are recorded using audio visual equipment. This is later viewed and discussed, typically with a health or social care professional. Parents and carers are given a chance to reflect on their behaviour, with the focus on elements that are successful. The aim is to improve their communications and relationship with their child. A video feedback programme can help parents and carers nurture their child, understand their child's behaviour, respond positively and behave in ways that are not frightening. It can also improve how parents and carers respond to their own feelings when nurturing the child. The VIG process helps the mother to maintain her relationship with her baby whilst in a process of recovery. VIG is not a standalone therapy; it complements the work being carried out by the rest of the team, ward and community.

Priority 5: Quality improvement (QI) – using your ideas

Clinically Led Strategy Development

The focus of our quality improvement approach over the past year has been on clinically led strategy development. Eight pathways completed the two-day clinically led strategy development process, to cover all services within the Trust. The structure and processes with regard to how we approached this were firmly underpinned by the principles of the Quality Improvement Strategy and the expectations of a structured approach to quality improvement. As an example, each day also began using a model of Appreciative Inquiry, where attendees interviewed each other within a defined structure as explained below:

- Tell the story of what happened
- Who else was involved?
- What was your role?
- What is the difference that you made?
- What was most satisfying/what did you get a warm glow from?
- What qualities did you draw upon in yourself that enabled you to be effective in that situation?
- What would you say are your three biggest strengths as a leader?
- What gives meaning to you in your work and makes you feel most alive?

This presented a shift away from a problem focused / transactional approach to change to one based on strengths and therefore opportunity. Time was also purposefully built into each event to allow for dialogue, and through this to generate discussions and actions to drive improvement in the respective areas. These events directly engaged colleagues working at the point of care and included service user or carer representation, and each pathway has also had a subsequent stakeholder event, to engage further across the broader system. We are now underway with follow-up events for each pathway to identify the priority actions and apply a structured model of improvement to these priorities. One particular example, the working age adult community mental health workstream, is being supported by a planned away day in the spring with input from an external expert consultant in quality improvement. This has been facilitated and funded through the Deputy Director of Nursing and Quality Governance's Health Foundation fellowship in leadership and quality improvement.

Quality Visits

The Trust's approach to Quality Visits (our structure for enabling teams to engage with directors and colleagues from elsewhere in the system and present their work) continues to have a clear focus on quality improvement. The guidance for teams includes the following text:

- “Each visit will need to include a minimum of two topics to present, a maximum of three, and we will ask that these are structured around how you’ve approached improving the quality of service in your team, particularly in response to problems or challenges that you have faced
- For clinical teams, at least one presentation must be either a Quality Improvement initiative, or the application of a NICE Guideline compliant intervention
- For non-clinical teams, at least one presentation must be a Quality Improvement initiative.”

Of note, two of the awards categories for Season 9 also had a clear focus on quality improvement:

- The Improving and Innovating Award - where a team’s presentation evidenced how they have improved or developed their service offer, and where they have been able to show positive outcomes from the improvement
- The Green Shoots Award - presentations shortlisted for this award showed innovative practice, but where it might be too soon to yet see the full outcomes or benefits

Other examples of our approach to Quality Improvement

- There is a new project management system and dashboard developed and going live week commencing 13 January, with some follow-on elements being developed afterwards. This will provide oversight of the Trust and system programme, and will also provide tools and support for quality improvement. All schemes will complete quality improvement documentation that identifies metrics and measurement to evaluate delivery against predictions and aims. A Programme Board is established to seek assurance.
- Quality improvement is being built into the Leadership and Management Masterclasses as part of the leadership development programme, with the first session scheduled for February 2020. The new intranet is also seen as a key enabler for communication, with opportunities with regard to how we raise the profile of quality improvement, knowledge and information, and evidence-based practice.
- Other examples of quality improvement focused work include:
    - E-job planning for medical colleagues
    - Increased admin productivity through Voice Recognition (20% improvement)
    - The Personality Disorder pathway planning
    - Enhanced pharmacy input in community mental health teams
    - Revision and redevelopment of the Trust’s rehabilitation model
    - Agile working in corporate services and on the Kingsway site
    - Expansion in IAPT reducing impact on community mental health teams
    - E-bikes pilot in Bolsover for 2020

The Bright Ideas model

Delivered by a Peer Volunteer colleague, this is a structured approach to capturing both feedback and suggestions from people in receipt of our care, as to how the quality of what we provide can be improved or made more efficient. All of these suggestions are reviewed by the Executive Director of Nursing and Patient Experience, and then within the Equal service user forum.

In summary

A focus on quality improvement continues to gain ground within the Trust. Challenges will include maximising the benefits by utilising a structured model of improvement, and options with regard to additional staff training in quality improvement methodology are being further explored. Ensuring a strategic and improvement focused approach to clinically led strategy development is now overseen by the recently formed Clinically Led Strategy Board, and an important task of this group will be to ensure a

sustained focus on using clinically led, quality improvement methodology as we approach both quality improvement and the pressures of cost improvement initiatives.

There are also plans to replicate the 'Bright Ideas' system for ideas from people using our services with a system to equally capture and share ideas from colleagues, and discussions are underway as to how this might be integrated into the new intranet, clearly linked with evidence, knowledge, research national guidelines, quality improvement methodology resources and policy expectation.

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 2019/20 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 2019/20 represents 92% of the total income generated from the provision of relevant health services by Derbyshire Healthcare NHS Foundation Trust for 2019/20.

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

2	During 2019/20, 10 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 2019/20 are as follows: 1. POMH-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 9d: Antipsychotic prescribing in people with a Learning Disability 4. POMH-UK Topic 17b: Use of depot / long acting antipsychotic injections for relapse prevention 5. POMH-UK Topic 19a: Prescribing for depression in adult mental health services 6. National Confidential Enquiry into Patient Outcome and Death: Young People's Mental Health study 7. National Clinical Audit of Anxiety and Depression (NCAAD) 8. National Clinical Audit of Psychosis Early Intervention in Psychosis (NCAP EIP) spotlight audit 9. National Clinical Audit of Psychosis Early Intervention in Psychosis (NCAP EIP): Service user survey and Case note audit and contextual data questionnaire - phase 2 audit 10. National Clinical Audit of Anxiety and Depression - Psychological Therapies Spotlight Audit 11. Falls and Fragility Fracture Audit Programme: National audit of inpatient falls (NAIF)

2.3	The national clinical audits and national confidential enquiries that Derbyshire Healthcare NHS Foundation Trust participated in during 2019/20 are as follows: 1. POMH-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 9d: Antipsychotic prescribing in people with a Learning Disability 4. POMH-UK Topic 17b: Use of depot / long-acting antipsychotic injections for relapse prevention 5. POMH-UK Topic 19a: Prescribing for depression in adult mental health services 6. National Confidential Enquiry into Patient Outcome and Death: Young People's Mental Health study 7. National Clinical Audit of Anxiety and Depression (NCAAD) 8. National Clinical Audit of Psychosis Early Intervention in Psychosis (NCAP EIP) spotlight audit 9. National Clinical Audit of Psychosis Early Intervention in Psychosis (NCAP EIP): Service user survey and Case note audit and contextual data questionnaire - phase 2 audit 10. National Clinical Audit of Anxiety and Depression - Psychological Therapies Spotlight Audit 11. Falls and Fragility Fracture Audit Programme: National Audit of Inpatient Falls (NAIF)

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 2019/20, 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 Topic 6d: Assessment of the side effects of depot antipsychotic medication – 256/256, 100% 2. POMH-UK Topic 7f: Monitoring of patients prescribed lithium – 93/93, 100% 3. POMH-UK Topic 9d: Antipsychotic prescribing in people with a Learning Disability - 171/171, 100% 4. POMH-UK Topic 17b: Use of depot / long acting antipsychotic injections for relapse prevention – 174/174, 100% 5. POMH-UK Topic 19a: Prescribing for depression in adult mental health services – 63/100, 63% 6. National Confidential Enquiry into Patient Outcome and Death: Young People's Mental Health study – 6/17, 35% 7. National Clinical Audit of Anxiety and Depression (NCAAD) - 40/85, 47% 8. National Clinical Audit of Psychosis Early Intervention in Psychosis (NCAP EIP) spotlight audit – 182/182, 100% 9. National Clinical Audit of Psychosis Early Intervention in Psychosis (NCAP EIP): Service user survey and Case note audit and contextual data questionnaire - phase 2 audit – Service user survey 211/211, 100%, case note audit 211/211, 100%, contextual data questionnaire 2/2, 100% 10. 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 21/100, 21%. 11. Falls and Fragility Fracture Audit Programme: National audit of inpatient falls (NAIF) – 0/0 currently and dependent on number of fractured neck of femur occurring during audit period

2.5	The reports of three national clinical audits were reviewed by the provider in 2019/20 and Derbyshire Healthcare NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided: **POMH-UK Topic 6d: Assessment of the side effects of depot antipsychotics** Actions for improvement include: • Dissemination of results to all teams, including those that didn't participate in the audit, in order to share the learning and to inform them of the solutions for improving practice • Side effects ratings scale to be developed in the Paris electronic record system • To promote the ratings scale in the outpatient depot clinic and community mental health teams • Hand-held diary insert to be piloted at St Andrews House community team base • Community psychiatric nurses at Bolsover to share their good practice with other teams and to promote the use of the electronic care record care document • To review the Trust position on approved side effect rating scales and disseminate appropriate via the Medicines Management Committee. A report to be completed reviewing GASS (Glasgow Antipsychotic side effect Scale) versus LUNSERs (Liverpool University Neuroleptic Side Effect Rating Scale) to determine which should be used in practice. **National Confidential Enquiry into Patient Outcome and Death: Young People's Mental Health study** Actions for improvement include: • Circulated audit via e-mail for acknowledgement and reference only due to the low participation numbers (only six patients met the eligibility criteria) **National Clinical Audit of Psychosis Early Intervention in Psychosis (NCAP EIP) spotlight audit** • Discussing physical health assessments with the South EIP Team, providing clinicians with a full guide to the work required for people on their caseload and for the Derby physical health clinic to address these gaps • Sharing of good practice between the North and South EIP Teams. There are a number of changes in practice, particularly around physical healthcare and monitoring, that are not reflected in the current audit but are expected to influence the results positively when we re-audit.

Title	Improvement actions
1. **Section 17 leave documentation re-audit**	Actions for improvement include: • Dissemination and discussion of the audit results to the areas that participated in the audit, as well as the clinical directors and medical education leads • Liaising with the responsible clinicians in the various wards and units highlighting areas of compliance that require improvement • Looking at a means within the electronic record system to ensure the Section 17 form is not locked and remains editable following responsible clinician data entry • The development of a form relating to recording the appearance of patients to be used Trust-wide. • Re-auditing in order to establish recommendations have been implemented and are established as best practice.

2. **Section 117 Meetings re-audit**	Actions for improvement include: • Re-audit with a larger sample size. • Professionals need to be made aware of the importance of documenting Section 117 meetings, including information and criteria gathered such as documenting timing of meeting, attendees and discussion points, as junior doctors who are documenting the majority of meetings may not be aware of this. Perhaps this could be included in junior doctor induction. • Professionals should be educated on criteria to be discussed in meetings, including drug and alcohol use, due to poor compliance. • Continue to ensure written invitations are consistently made to section 117 meetings.
3. **Quality of Safeguarding Children referrals into Safeguarding Children by DHCFT and response by Children's Social Care**	Actions for improvement include: • For a subsection of the 'safeguarding concerns' template to be constructed for ease and accessibility for all practitioners. The feasibility and implementation of this to be discussed with the SystmOne [the planned new electronic records system] Administrator. • The 'referral to CYPD' read code box to be placed within this area, as its completion will aid future accurate data collection. • This information to then be cascaded to staff and delivered during in-house safeguarding training sessions. • Staff to receive further training around the availability of the 'threshold document' and its use, so that sharing of safeguarding information is uniform between services and accurate decision making is consistent.
4. **Graded care profile audit**	Actions for improvement include: • Presentation of results at the operational team meeting • To be clear on process of recording action plans from supervision and sharing information with managers. This will be achieved by ensuring that the recording and sharing process and responsibility is negotiated in the supervision contract, in line with expectations of the supervision policy • Consistent tools to use in safeguarding supervision, accessible on SystmOne. Supervisors to audit clinical records with practitioners in supervision • Redesign the recording of supervision document, to give more guidance around clinical/safeguarding supervision as well as managerial, therefore ensuring priority topics are covered • Band 7 and 8 staff and managers working in 0 – 19 services to attend level four training on effective clinical supervision • Group / team supervision, sharing best practice, themes and challenges.
5. **Case conference reports submitted are of an acceptable quality standard**	Actions for improvement include: • Teams to ensure they are aware of how to update safeguarding markers on SystmOne and amend referrals as appropriate. This will be achieved by staff having access to SystmOne User Guides • Where a family have a health visitor, a copy of their report for the RCPC [Review Child Protection Conference] should be uploaded onto all the siblings' records, including school-aged children. A template has been developed for health visitors to identify all siblings and request administrator colleagues to upload and report on all records • Sample cases of good quality reports are available for sharing, to include what life is like from the child's perspective living in the conditions that are cause for concern and to demonstrate plans and timescales are SMART

	(specific, measurable, relevant, achievable and timely). The safeguarding team to provide sample cases of good quality completed reports and to cascade to all teams for reference.
6. **Management of Borderline personality disorder in community mental health services**	Actions for improvement include: • To give clear guidance to clinicians involved in the management of borderline / emotionally unstable personality disorder on the pharmacological guidelines as per expectations of NICE (the National Institute for Health and Care Excellence) • The diagnostic framework and documentation should clearly match the prescribing guidelines • Long-term therapies should be easily accessible for people with this diagnosis • The Care Programme Approach framework and criteria should be more effective • Having a specific personality disorder service will help establish diagnosis, provide better support for patients and offer intensive care packages for people with high needs.
7. **Audit of Transition Process - CAMHS to Adult Services**	Actions for improvement include: • Dissemination of results to the CAMHS (child and adolescent mental health services) and AMHS (adult mental health services) to involve colleagues in formulating the solutions for improving practice • Identifying a 'transition worker' for each patient to coordinate transition care and support. The transition worker could be an existing keyworker or another practitioner, depending on the young person's needs. The key worker will perform the role of a transition worker. There is staff training provided by the transition advisor and a transition checklist so the key worker understands their role in the transition • For there to be evidence of a practitioner from the relevant adult services meeting the young person before transfer from CAMHS. There is now an agreement with AMHS in regarding the adult duty worker or service manager attending joint transition meetings, especially for patients where there is risk of disengagement. The Trust is developing transition champions in adult mental health services to help facilitate joint planning meetings • The transition worker should convene a transition meeting, inviting the young person, family/carers and the practitioner(s) from the relevant adult services before transfer from CAMHS. The discussions in transition should be clearly documented in the patient records. The reason should be clearly documented if there was no transition meeting • The key worker from CAMHS or the transition worker should create a personal folder that they share with adult services. A template of the personal folder could be kept in the CAMHS shared drive. This will contain no personal data • Adult Mental Health Services should write to the referrer / transition worker along with the person's GP (General Practitioner) once an appointment is offered or a referral is declined, so that the referring team is involved in supporting the young person in the process • There should be clear documentation of family/carer involvement and information sharing in the transition process. This will be achieved via a training-transition checklist • To re-audit in order to establish recommendations have been implemented and are established as best practice.

8. **Clinical notes re-audit - Neighbourhoods**	Actions for improvement include: • To explore with Information Technology (IT) the possibility of identifying within Paris when there is no identified next of kin, to allow practitioners to record when there is no next of kin rather than it just be left blank and appearing to have been missed. • To explore with IT the availability of 'how to' guides to support practitioners in recording the mental health minimum data set. • Consider the inclusion of capacity status in the new care plan template. • Request 'how to' guides from IT for recording alerts and circulate to all teams. Review audit tool next year, including rephrasing of advance directive/advance decision question.
9. **Clinical notes audit – Learning Disability Service**	Actions for improvement include: • To discuss with the Paris Development Team the option to record when there is no next of kin, this will provide additional assurance that if there is no next of kin recorded it is because there is no next of kin not a lack of compliance in recording. • Refresher training to be delivered to learning disability colleagues across all professional lines on the principles of the Care Programme Approach (CPA), introduce the refreshed policy and reinforce the need to include and record involvement. • Clarify standard to colleagues that safety audits are to be reviewed every six months. • Clarify standard to colleagues that care planning should be reviewed every three months and adjust audit tool accordingly for next year. • Circulate staff briefing regarding adult safeguarding, how to recognise it and how to respond. • To include the recording of Best Interest decisions in next year's audit tool. • Occupational Therapy notes to be re-audited in September 2019 and December 2019. Revise audit tool for next year with support from the audit group to ensure questions are clear for colleagues and that all needs are included.
10. **Graded care profile audit**	Actions for improvement include: • Presentation of results at the Operational Team Meeting • To be clear on process of recording action plans from supervision & sharing information with managers. This will be achieved by ensuring that the recording & sharing process and responsibility is negotiated in the supervision contract. • Consistent tools to use in Safeguarding Supervision, accessible on SystmOne. Supervisors to audit clinical records with practitioners in supervision. • Redesign the Recording of Supervision Document. Give more guidance around clinical/safeguarding supervision as well as managerial supervision, ensuring priority topics are covered. • Band 7 & 8 staff and managers in 0 -19 services to attend level four training on effective clinical supervision. • Group / team supervision sharing best practice, themes and challenges.

3	The number of patients receiving relevant health services provided or sub-contracted by Derbyshire Healthcare NHS Foundation Trust in 2019/20 that were recruited during that period to participate in research approved by a research ethics committee – 2,140
3.1	**Listening and Acting on staff and patient experience** Our Research and Development Strategy has been refreshed this year. The strategy has in part been informed by the feedback from a recent survey in which we asked our colleagues across the Trust "what support do you need to deliver high quality patient care, develop efficient services and propel personal growth?" More specifically, in response to the feedback from our colleagues, we have undertaken a number of new initiatives. These include: • The all-staff 'Connect with Research' newsletter (the first edition included a summary of our survey findings) • Fortnightly drop-in advice sessions • A presentation slot on the monthly clinical induction in addition to our usual presence at the induction marketplace • Research noticeboards on inpatient wards and other staff areas • A greater presence through our Twitter account • A growing network of Research Links through which key research news is shared with clinical teams. During the year, we also began inviting patients to give us feedback on their research experience once their participation in a research project ended. We have done this using a three-question feedback form asking: 'how was your experience of taking part?'; 'would you be willing to take part in another research project?' and 'what could we do better?' Responses have been positive and we are now beginning to use the feedback to enable us to continuously review and improve our practice. The Library and Knowledge Service received 150 responses to our annual impact survey in 2019. This is a survey tool being used in many libraries across the NHS, to capture some information on the impact and value of NHS library services. For the question on "Did your use of library resources or services contribute to any of the following impacts?" 100% of respondents said that it 'contributed to personal or professional development'; 81% said it 'Improved the quality of patient care' and 74% said it contributed to 'More informed decision making'. These were the top three responses to the question. **Patient Research Ambassador and Research Volunteer** We are fortunate to have a patient research ambassador supporting research in our organisation. A patient research ambassador is someone who supports health research from a patient point of view drawing on their experiences as a patient and research participant. In May 2019, our research ambassador, along with members of the research team, presented a workshop at the Derbyshire Patient, Carer and Citizen Networking Event on 'The importance of Patient and Public Involvement in NHS Research'. The event was run by the East Midlands Academic Health Science Network and East Midlands Patient and Public Involvement Senate, in partnership with local healthcare organisations. This year a research volunteer has also joined our team, providing us further opportunities to work together and learn from another perspective on the work we are doing, as well as further connecting our work to patient experiences. **Supporting Students, Prospective Employees and Partners** We have worked with key academic partners (e.g. the University of Derby and Nottingham Trent University) to support students to undertake projects whilst on placement within our clinical services. This work aims to contribute to embedding an evaluative, evidence-based culture, in which research is visible, is seen as core business within the Trust, enhances the experience of students on placement and strengthens partnership working across sectors. It also increases the capacity of services to undertake key pieces of service evaluation and have access to necessary analytical skills. During the year we have also continued to provide placements for nursing students, giving them

an insight into the clinical research nurse role as well as the wider research experience, and supported medical trainees to gain clinical research skills, enabling them to support clinical trials and take on investigator roles. Our Research Occupational Therapist has also supported a trainee occupational therapist this year.

Embedding research into clinical service delivery
The number of research roles embedded within clinical services has increased this year. Following the success of research posts already working with liaison psychiatry and Criminal Justice Liaison and Diversion services, new roles with the Crisis Resolution and Home Treatment service and the perinatal services have been commissioned. These posts work to a 'hub and spoke model', which means that whilst the post-holder is embedded within the clinical team and their work focus determined by the needs and priorities of that service, they also connect the clinical and research services together by maintaining a strong research focus through a hub of research peers and experienced research colleagues. These posts enable us to enhance services through more evidence-based approaches, robustly demonstrate quality of care delivery and to be research active services for the benefit of our service users.

Reading and Wellbeing
We have extended the reading and wellbeing section in the library this year to include the inspirational series, a series of books written by people with lived experience of mental health problems. We have also launched the staff book club, which meets every month at lunchtime, to talk about a book chosen by the group.

The Multicentre Study of Self-harm in England
The Trust continues to be a partner in the Department of Health and Social Care 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. Five new studies were published and two further studies have been accepted for publication in high ranking journals by the study team over the past year. The importance of the study was noted in the Minister for Suicide Prevention's recent address at the National Suicide Prevention Alliance Conference (February 2020), and remains the number one indicator for self-harm rates in the country (Public Health England, 2014).

Promoting Activity, Independence and Stability for Early Dementia (PrAISED)
This is a collaborative clinical trial with University of Nottingham. We are supporting 80 people with mild to moderate cognitive impairment/dementia to participate in the trial, which is testing an intervention designed to increase activity and independence, reduce falls and maintain physical and mental health. This trial has been received very well by clinical services (memory assessment services largely) and by the people who use those services. It has involved also intensive occupational therapy and physiotherapy for those participants who receive the intervention. This offers an opportunity to be part of something innovative and also to receive potentially beneficial input at home that would not otherwise be available to the participants.

Enhancing Cognition and quality of LIfe in early PSychosEs (ECLIPSE)
We have participated in the evaluation of the feasibility and acceptability of a new online Cognitive Remediation Therapy (CRT) training programme for mental health professionals. CRT was developed in order to address and maintain cognitive health in schizophrenia and has been shown to help with thinking skills and everyday activities in previous studies. The study was led by Kings College London and University College London and offered clinicians working with people suffering with psychosis the opportunity to receive training in CRT. Eleven clinicians from the Trust took part in this and received the training, adding this therapy to their competencies.

4	A proportion of Derbyshire Healthcare NHS Foundation Trust's income in 2019/20 was conditional on achieving quality improvement and innovation goals agreed between Derbyshire Healthcare NHS Foundation and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.
4.1	Further details of the agreed goals for 2019/20 and for the following 12-month period are available electronically at https://www.derbyshirehealthcareft.nhs.uk/

The monetary total for income in 2019/20 conditional on achieving quality improvement and innovation goals	£1,525,340
The monetary total for the associated payment in 2018/19 (please note a reduction from 2018/19 due to CQUINs reducing from 2.5% to 1.25% of the Trust's budget)	£2,813,578

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 Good overall. Derbyshire Healthcare NHS Foundation Trust has no conditions on registration. The Care Quality Commission has not taken enforcement action against Derbyshire Healthcare NHS Foundation Trust during 2019/20.

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

7. 7.1	Derbyshire Healthcare NHS Foundation Trust submitted records during 2019/20 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 99.7% ii. General Medical Practice Code 100% Figures based on provisional April to December 2019 data at the Month 9 inclusion date (Inpatient Admitted Patient Care APC and Outpatient Commissioning Data Set CDS)

8	The Data Security and Protection Toolkit requires compliance against assertions and mandatory evidence items. The amount of Toolkit completed each year is shown below, comparing favourable with other Trusts whose reported completion rate average 80%. The 2019/20 Toolkit produced by Derbyshire Healthcare NHS Foundation Trust was audited and given "Significant Assurance"; and NHS Digital shows "Standards met". A key enquiry line for the toolkit is to ensure the Trust has 95% staff in-date with their data security and protection training. The Trust is required to achieve this once in a 12 month period. The Trust achieved this for over 300 days in total, 240 of them consecutively. The Data Security & Protection team is now working to ensure the delivery of the Toolkit for 2020-21 will continue and that staff and service users continue to benefit from the increased protection of their data which a completed toolkit helps to provide.

Time period	Trust Score
2017/18	98%
2018/19	100%
2019/20	100%

9

9.1

Derbyshire Healthcare NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2019/20 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. Please note, with regard to our secondary diagnosis correct score, just two records needed to be updated, one error at a third character position and one error at fourth character position.

	Mandatory	Advisory	Trust Score
Primary diagnosis correct	>= 85%	>= 90%	100%
Secondary diagnosis correct	>= 75%	>= 80%	99.41%
Primary procedure correct	>= 85%	>= 90%	100%
Secondary procedure correct	>= 75%	>= 80%	100%

Please note with regard to our secondary diagnosis correct score, just two records needed to be updated, one error at a third character position and one error at fourth character position.

10

Derbyshire Healthcare NHS Foundation Trust will be taking the following actions to improve data quality:

We continue to strive to achieve the highest quality of data, with consistent information using enhanced integration between internal and external systems. We run continued campaigns to ensure awareness of the importance of ensuring our data is accurate, benchmarking against 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 the 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

Within 2019/20 there has also been the continued use of a data quality kite mark to help provide the Board with the necessary assurance around the main Trust performance operational indicators and there is an established data assurance audit cycle in place every six months.

Further actions:

- Information campaigns for patients, carers and families, to let us know if their details change and to verify contact details such as mobile phone number and email
- Information campaign for staff, raising awareness of the need to continue to ask patients, carers and families if we have the most up to date and accurate details
- Continued emphasis on data quality to support Trust OnEPR project (development of the new electronic care record) and data migration to this new system
- Reduction of the number of electronic patient record systems in the Trust, therefore resulting in enhanced standardisation
- Continued integration between our electronic patient record systems so that demographics for service receivers are synchronised and up to date
- Further enhancement of the online information system. This is a single reference point to show all the different services and electronic patient record systems and paper records involved for the patient, accessible directly from within an electronic patient record
- Integration with external organisations and enhanced used of secure electronic processes. Examples of this include automating test results, MESH (Message Exchange for Social

	Care and Health) and messaging primary care systems directly • Enhanced use of the national Spine (the system to enable information to be shared securely through national services such as the electronic prescription service, summary care record and the e-referral service) and update of our electronic patient record systems • Continued and improved use of existing data quality and performance management exception reporting • Continued and improved use of external data quality reports and benchmarking to maintain high standards • Review of registration and data collection forms to help capture information for new patients. This is in addition to capturing changes and confirming current information for existing patients • To improve data security and protection mandatory induction and refresher training and improve Trust compliance levels • Continued reconciliation and validation work for Trust data submission process end to end. This also complements the data quality six-monthly audit cycle, where the focus can help move from the key performance indicator dashboard to specific data sets such as the MHSDS (Mental Health Services Data Set) • 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.

Mortality data

Ifti Majid (Chief Executive) has overall responsibility for the implementation of the Learning from Deaths Policy and Dr John Sykes (Medical Director) is the responsible Patient Safety Director, taking responsibility for the learning from deaths agenda. Sheila Newport 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 with regard to deaths of patients who are currently open to services, or who have been open to services within the preceding 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 with regard to potential learning (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 the mortality procedure. Red flags are chosen and periodically reviewed by the Mortality Review Group.

Red flags from 28 March 2019:

- Patients prescribed anti-psychotic medication
- Patients with a long term physical condition
- Patients in chronic pain
- Patients whose care plan was not reviewed in the 6 months prior to their death
- Patients whose risk plan and or safety plan was not in place or updated as per policy, prior to death
- Deaths of a patient under learning disability services

Red flags from 27 February 2020:

- Patients prescribed anti-psychotic medication
- Deaths of patients up to six months post discharge
- Patients only seen as an out-patient
- Patients with a long term physical condition
- Patients with long term chronic pain

Deaths identified as 'red flag' in terms of mortality are reviewed using a Trust mortality developed tool through case record reviews completed by medical and mental health nursing colleagues. Information for these reviews is taken from the Electronic Patient Record (EPR).

'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 procedure 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

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 of the team concerned / involved in the patient's care. Dependent on the detail of the serious incident, review teams will consider family engagement on a case-by-case basis, working in partnership with our Family Liaison Team. In the majority of cases the Family Liaison Team initiates contact with family to offer either its 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.

In cases where a death meets external reporting requirements, a full report will be submitted to commissioners and all additional enquiries addressed. Within the reporting period there have been 154 investigations carried out in relation to deaths under the Serious Incident process. Thirty of these 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.

11	During 2019/20, 2,002 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: • 475 in the first quarter; • 443 in the second quarter; • 502 in the third quarter; • 582 in the fourth quarter

12	91 case record reviews and 1 investigations have been carried out in relation to 2002 of the deaths included in item 27.1 In one case 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: • 24 in the first quarter • 20 in the second quarter • 19 in the third quarter • 28 in the fourth quarter

13	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. Of those reviewed, 91 deaths are judged not to be due to problems in care. 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's Mortality Review Group has developed 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 casenotes, 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.

14	The Mortality Review Group has reviewed 91 deaths. This was undertaken by a multi-disciplinary team and established that of the 91 deaths reviewed, 0 have been classed as due to problems in the care provided to that patient and 1 has been sent to the Serious Incident Group for further investigation under the Untoward Incident Reporting and Investigation Policy and Procedure and this was also determined not to be due to problems in care. The Mortality Review Group is currently reviewing deaths of patients who are covered by the following 'red flags': • Diagnosis of learning disability • Safety assessment out of date • Care plans out of date • People taking anti-psychotic medication Initial analysis of death notification information shows the most common causes of death are: • Bronchopneumonia • Heart disease • Dementia

15	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. A minimum of ten staff members from each neighbourhood are required to attend a team based training session based upon this case and to establish whether this practice could happen today 2. Medical staff on ward to provide assurance in terms of supervision structure 3. Team to review safeguarding practices within the team 4. Multi-agency review with the Trust, NHSE and CCG 5. Ward staff to be offered attendance at the Chesterfield Royal Basic Life Support/Immediate Life Support sessions as supplementary training/support 6. Feedback to the clinical team and/or individuals 7. Further senior review of this report and the issues highlighted to provide assurance and outcome 8. Review and re-audit the application of the guidance on prescribing of benzodiazepines 9. Medical management to meet with the consultant involved to undertake a reflective learning session on the person's care. 10. Existing and future projects to resolve staff shortages at the Radbourne Unit should proceed at pace 11. Further exploration of this incident in relation to safeguarding 12. Ensure staff comment on Care Programme Approach consideration and rationale for not placing on CPA (CPA Lead with support from the Service Manager) 13. Implement existing development of Advanced Clinical Practitioner role 14. Development of operational policy for the team including escalation processes and support with high risk patients 15. Feedback to the carers/ family/ patient 16. Review and update the roles, responsibilities and training requirements of inpatient nurses as part of the existing programme of work being undertaken at the unit and campus services 17. Choking risk alert on electronic patient record system 18. Amend Trust preceptorship handbook 19. Standard operating procedure for dysphagia screening and initial management for older people's services 20. Learning from the incident and required record keeping standards to be addressed with registered practitioner on the unit 21. For ward nursing staff to have knowledge and an understanding of autistic spectrum disorder. 22. For service users to be involved in the implementing and reviewing of their care plans and safety assessments. For this to be clearly documented 23. Consultant psychiatrist training in relation to trauma and its impact on self-harm behaviours 24. Consideration of risks associated with quantities of opiate discharge medication and the pharmacist ability to challenge to address accidental overdose risks with patients on opiate medication prior to discharge 25. The investigation team recommend the ward team should exercise more vigilance and take into account the medications prescribed and their frequency from primary care, as part of the clinical risk management strategy on discharge 26. Learning from this incident with regard to record keeping and family communication to be addressed in reflective discussions with registered practitioners on the unit 27. Review of resuscitation management 28. Review of suction machine and associated equipment 29. Reflective discussions with individuals in the older adult community teams 30. Further reflection with the CPN in relation to the quality of assessment and development

	of any action plan required as a result of this 31. All bleep-holders to maintain accurate records, in particular when there are disagreements between clinicians 32. Clarify where and with whom the responsibility for care cluster training sits and communicate this to teams 33. Communicate to clinicians about the importance of formally recording decision-specific capacity assessments 34. Discuss with the team the value of undertaking home visits at review for people who are only seen in clinics 35. Discuss with the team the importance of including retrospective information in safety assessments 36. Team review of patients in relation to physical healthcare clinic requirements 37. Remind the community team of the process for and importance of accurate care clustering 38. The team to be briefed on the incident for learning 39. For the team to review safety plan completion 40. Communication is needed regarding the role of 1st on-call and 2nd on-call managers, to Bleep-holder and ward staff 41. New Preceptorship Policy 42. Feedback to the General Practitioner 43. More standardised process for message taking across teams 44. Review and implementation of training in relation to continuing professional development and trauma 45. Trust to consider re-issuing guidance on what abbreviations are acceptable to use when making entries on Paris 46. Ensuring that training in Electronic Patient Recording is up to date and that inconsistencies and deficiencies in record keeping as highlighted during this investigation are addressed with the practitioner by their line manager 47. Ensuring that training in clinical risk assessment is up to date 48. Exploration of crisis and contingency planning in this case and the worker's wider practice 49. Exploration of carer's support and referral and access to carer's assessment in this case and the worker's wider practice 50. Exploration in this case of memory assessments and the risks to individuals of accidental and or intentional overdose 51. The patient's safety plan and falls risk assessment need to be reviewed and a care plan summarising their needs should be completed by the current care team and also that alerts are identified on Paris to inform clinical staff who may not be familiar with the history of this case 52. The team should give due consideration to where an individual is placed when there is a risk of harm to themselves or others as based the documented history 53. Consideration required for further exploration around the impact of Personal Independence Payment assessments on risks for patients whom are at high risk of harm 54. Update Minimum Standards for Record Keeping Policy

16	An assessment of the impact of the actions described in item 27.5 which were taken by the provider during 2019/20. Examples are below: 1. A local falls CQUIN was negotiated following a joint review of falls between CCG colleagues and the patient safety team. This has been highlighting the national expectations of quality care 2. In eating disorder services a proposal has been made to the CCG's clinical reference

	group for improved physical health screening in primary care, and there have been meetings with acute hospitals to improve liaison with gastroenterology 3. Review of the clinical pathway for people with a diagnosis of emotionally unstable personality disorder. Commissioners have supported a small but innovative pilot scheme for intensive support of high impact service users with this diagnosis and recruitment is underway in our community teams 4. Our approach to the management of people subject Section 37/41 of the Mental Health Act has been developed following learning from investigations, supported by quality improvement and audit work. 5. The installation of OxeHealth monitors (an electronic system to monitor a patient's vital signs without disturbing them) in bedrooms within Cherry Tree Close 6. Staff awareness and competency with regards to the Derbyshire Early Warning System (DEWS) of physical health deterioration, and the manner in which scores should be escalated resulted in a revision to the Paris system. The acknowledgement tick box feature has been replaced with an E signature field, communications have notified all users and training for Paris and DEWS has been amended. DEWS and ILS training has also been adapted to include visuals of the DEWS and the 'pop up' alerts, thus allowing staff to be aware of how the actual system works and the visuals to expect. Any DEWS ratings of concern are also immediately forwarded electronically to the relevant Head of Nursing and the Assistant Director for Physical and Public Health 7. In community mental health services, physical health clinics have been developed in the north and south as an enhancement of community teams.

17	91 case record reviews and 32 investigations were completed after 1 April 2019, which related to deaths which took place before the start of the reporting period.

18	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).

19	None representing 0% of the patient deaths during 2018/19 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:

1	**Seven-day follow-up for those on CPA** This is included as an indicator in response to concerns that the highest risk of suicide for a person discharged from psychiatric inpatient care is within the first seven days after discharge. Derbyshire Healthcare NHS Foundation Trust considers that this data is as described for the following reasons: It calculates the seven-day follow-up indicator based on the national guidance / descriptors. Numerator: Number of patients on the care programme approach (CPA) who were followed up within seven days after discharge from psychiatric inpatient care. Denominator: Total number of patients on CPA discharged from psychiatric inpatient care. Derbyshire Healthcare NHS Foundation Trust intends to take the following actions to improve this percentage, and so the quality of its services, by continuing to work to maintain our performance and ensure that all patients discharged from our inpatient care on CPA are followed up within seven days, embedding a patient focused care approach, ensuring patient safety and

	mitigating risk. N.B this indicator will be incorporated into our new contractual expectation to follow up everyone discharged from our wards within 72 hours.

CPA seven day follow-up					
Indicator	2017/18	2018/19	2019/20	National Provider Average (Q3 latest quarter as at 27/04/20)	Highest and lowest scores of NHS Trusts and NHS Foundation Trusts (Q3 latest quarter as at 27/04/20)
The percentage of patients on Care Programme Approach who were followed up within seven days after discharge from psychiatric inpatient care during the reporting period	98.51%*	96.69%*	95.99% (against a target of 95%)	96.2%	86.3% and 100%
*please note a variance here with the figures in Quality Report for these years due to subsequent data refreshes					

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

2	**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: continuous monitoring to maintain the high performance against this indicator.

Crisis gatekeeping					
The percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team acted as a gatekeeper during the reporting period	2017/18	2018/19	2019/20	National Provider Average (as at 06/12/19)	Lowest and Highest Scores of Providers (Q2 as at 06/12/19)
	99.74%	100%	100%	97.6%	80% and 100%

3	**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	2017/18	2018/19	2019/20	National Provider Average	Lowest and Highest Scores of Providers
28-day re-admission rates for patients aged 16 and over (at the point of writing we have had no under-16 admissions).	7.68%	6.25%	6.66% (against a target of less than 10%)	not available	not available

4	**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 6.8, 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 within the clinically-led strategy development workstreams and also through the Equal groups.

5	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 April 2019 and 30 September 2019].	
Patient safety incidents per 1,000 bed days	1,718 incidents reported during this period = reporting rate of 38.12 incidents per 1,000 bed days
Degree of harm of the patient safety incidents reported to the NRLS between 01 April 2019 and 31 September 2019	
Degree of harm indicated as a percentage of the total number of incidents reported.	

None	Low	Moderate	Severe	Death
63.9% (1,098)	27.3% (470)	7.0% (120)	0.6% (10)	1.2% (20)

Source: Organisation 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

2.4 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:

The Freedom to Speak Up Guardian at DHCFT is one of the routes for speaking up within the Trust. There are other options available and these include speaking up directly to line managers, clinical leads, senior leads including the Chief Executive, the Non-Executive Lead for Speaking Up, to unions / staff-side representatives, People Services and the forums and networks available to staff, students, preceptor or junior doctors, and also through incident reporting tools. The FTSUG has also created a network of FTSU champions across the Trust who listen and signpost workers to the FTSUG for further support. There will also soon be a reporting form for speaking up on the Trust's new intranet page: 'Focus'.

The FTSUG has recently renewed the Freedom to Speak Up Policy which includes information for staff on speaking up and escalation routes. It also covers external bodies to speak up to and provides guidance on what detriment is and how to report it.

How feedback is given to those who speak up:

The FTSUG ensures that feedback has been provided. This is done by keeping in touch with workers who have spoken up and those leaders who have had concerns escalated to them, to gain an insight into what support and outcomes have been offered. For some workers, this might simply involve a discussion with their manager, whilst for others it might involve a more formal process involving an investigation or other human resource process, to effectively provide outcomes, learning and development. The FTSUG does not carry out investigations and is unlikely to have sight of an investigatory report, but will ensure that those who have spoken up have had some closure in relation to the speaking up part of the process. The FTSUG logs any feedback, records when feedback has been provided and reports this to Trust Board. The FTSUG also makes a six-monthly report to the Board and to the Risk and Audit Committee and yearly to the People and Culture Committee, to enable oversight of common themes and how feedback has been acted on in terms of learning and improvement.

How we ensure staff who speak up do not suffer detriment:

The FTSUG records whether a worker believes they are suffering, or have suffered, detriment for speaking up. Detriments are taken seriously and are reported directly to the Executive Lead for Speaking Up to enable responsive action to be taken. The Executive Lead for Speaking Up is committed to making sure that barriers to speaking up are removed, where detriment is experienced that this is addressed and

explored, and that appropriate and relevant lessons are learned. The FTSUG actively promotes the role across the Trust through speaking to a range of workers face-to-face and through communications bulletins. In this way, the FTSUG is able to address the issue of detriment and to ensure that workers understand that those who speak up should not suffer a detriment for doing so.

Concerns with regards to quality of care, patient safety or bullying and harassment

If the FTSUG receives a concern around patient safety and quality this is escalated to the Director of Nursing and Patient Experience. If the worker's concern is around bullying and harassment then, with their consent, this is shared with their line manager and/or appropriate senior leader – it may also be shared directly with Employee Relations. The FTSUG Guardian also works to triangulate data around patient safety so that a broader picture of FTSU culture, barriers to speaking up, potential patient safety risks and opportunities to learn and improve can be built on.

Where workers have a specific concern around bullying and harassment they can approach the FTSUG, their line manager, senior leaders, unions/staff-side representatives, and the People Services Employee Relations Team for advice and support. They would be guided to the Dignity at Work policy and our recently produced Bullying and Harassment booklet. They could also discuss concerns with our Resolve Staff Support service or our Employee Assistance Line, 'Vivup', in confidence.

The FTSUG also reports directly to the National Guardian's Office (NGO) on numbers of workers speaking up around patient safety and quality and bullying and harassment to support the national picture of concerns raised across all NHS Trusts and Foundation Trusts in England.

2.5 Progress in bolstering staffing in our adult and older adult community mental health team services, following additional investment from local CCGs' baseline funding.

We received recurrent monies to sustain posts in our crisis services over 2019/20. However, we have not received additional investment over 2019/20 specifically for our adult and older adult community mental health team services.

2.6 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 continue to 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. 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. Trying to fill all gaps as best we can and encourage locums to join the East Midlands or North Humberside training scheme.
5. 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.

In addition, we are also holding an event for trainees in the region to encourage them to think about future consultant jobs, what their ideal job plan would be and to encourage recruitment to the Trust.

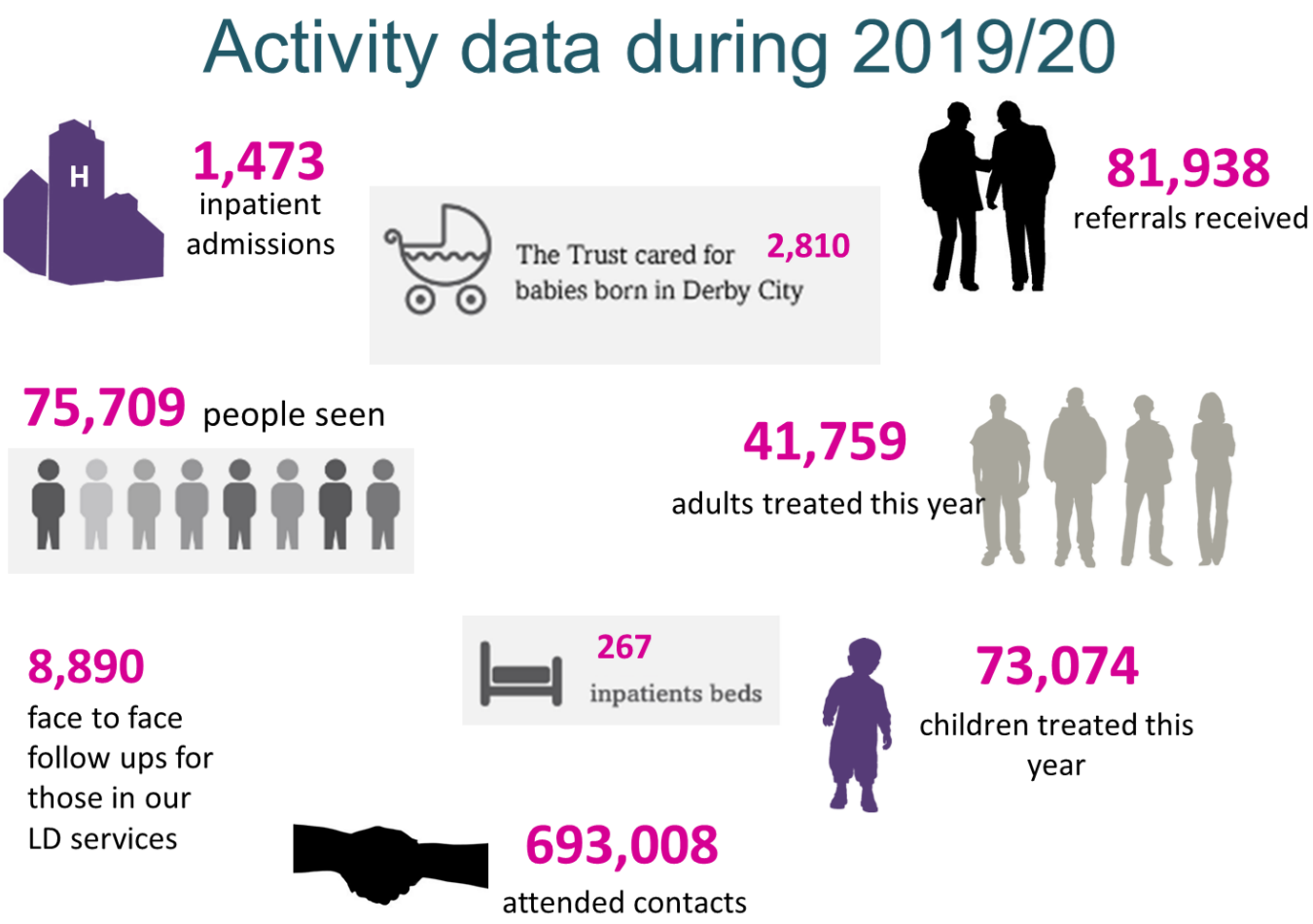
Rota gaps over the reporting period:

Time Period	Rota gaps
April 2019	30
May 2019	14
June 2019	14
July 2019	22
August 2019	20
September 2019	33
October 2019	19
November 2019	20
December 2019	22
January 2020	14
February 2020	17
March 2020	26

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



3.1 Patient safety

Patient safety 1: Positive and Safe – reduced use of seclusion and restraint

The Mental Health Act Code of Practice (2015) and NICE guideline for violence and aggression: short-term management in mental health, health and community settings (NG10, 2015) both called for a reduction in the use of prone restraint. It is also highlighted in NICE guideline NG10: "1.4.30 Consider rapid tranquillisation or seclusion as alternatives to prolonged manual restraint (longer than 10 minutes)."

The Positive and Safe Steering Group

The Positive and Safe Steering Group has continued to meet and has continued to have service user representation from the Kedleston Unit. Both representatives have experienced restrictive interventions and are keen to support developments in clinical practice across the Trust. A sub-group has also been developed within the acute inpatient settings based on improving local practice and engaging clinicians in development of strategy, practice, policies, procedures, projects and NICE guidelines. This group is known as the Reducing Restrictive Practice Working Group and is focused on involving clinicians and experts by experience in the development of clinical practice to reducing restrictive practices such as seclusion and prone restraint. Along with the Clinical Reference Group and Complex Risk Panel, improved structures around governance have been created to inform our level of assurance.

Since the update to the committee in January 2019 the following have been achieved:

- Practice review
- Seclusion audits
- Rapid tranquillisation (RT) audit
- Locked door audit
- Blanket restriction Audit
- Annual inpatient audit plan
- Restrictive practice dashboard

Changes in practice over time

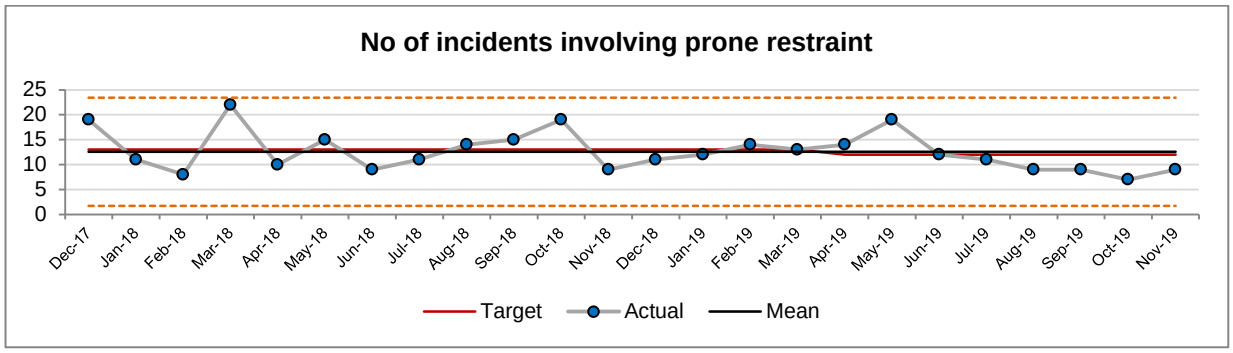
	16-17	17-18	18-19	19-20*
Physical restraint	558	584	564	408
Chemical restraint (includes rapid tranq. and non-rapid tranq.)	252	269	290	130
Seclusion	190	230	280	139
Ward doors locked	44	33	60	140
Personal search	0	0	10	44
Total	**1044**	**1116**	**1204**	**861**

*data available for Apr-Nov 2019

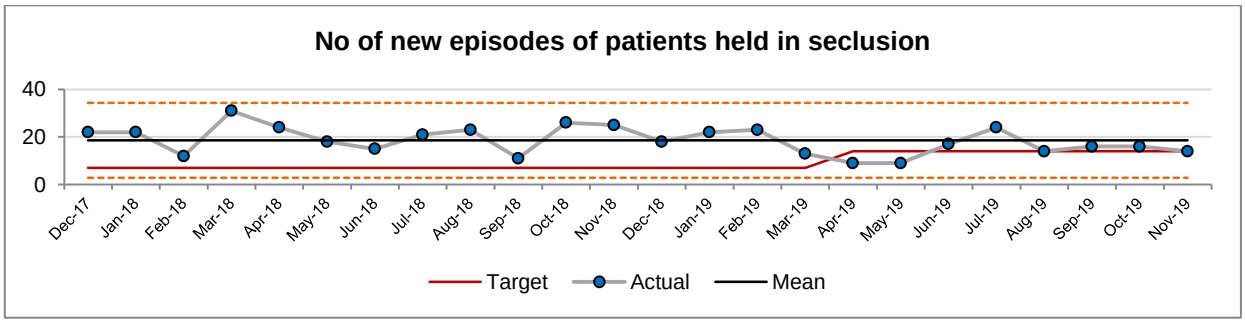
Please note the decrease restraint and seclusion over time. Please also note that the increase in 'ward doors locked' is an indicator that doors are locked more frequently, but for a shorter period of time. A range of approaches including the following has also been put into place to reduce restrictive practice:

- **Police involvement** – A Police Community Support Officer has been assigned to work closely with the Hartington Unit.

- The revised **Positive and Safe Supporting Training Programme** continues to run and still has improved attendance although some attendance problems remain, together with some challenges in achieving full training compliance in teams
- The use of **prone restraint** has been reviewed and there is evidence of reductions in the use of prone restraint within the SPC chart below.



- There is evidence of a greater working knowledge of seclusion and segregation in staff working at point of care, which has been picked up from ward walk arounds. This is also further evidenced in that there are no Datix relating to segregation. The SPC chart below shows a continuing reduction in the use of seclusion and appears to have a downward trajectory. The bar chart also indicates that our rates of restraint are below the benchmarked average.



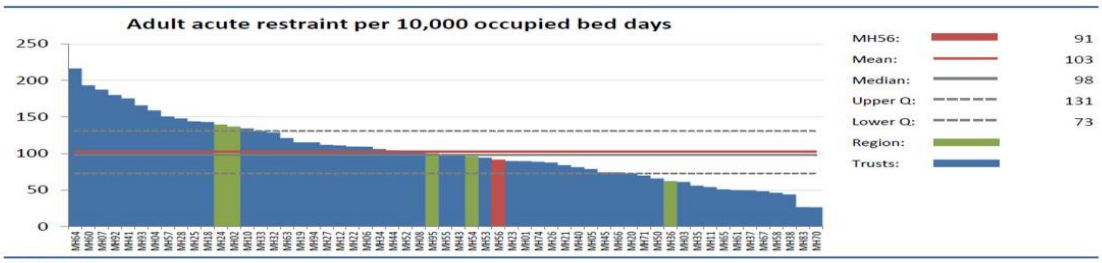


Figure 84

- **Safety Pods** – The Safety Pods are large bean bags specially made for the use of restraint within a clinical setting and were originally piloted at Broadmoor Hospital. They provide an alternative to prone restraint and aim to improve patient dignity and safety of patients and staff. T
- **Injection site** – Training Lead has worked alongside the pharmacy department in developing training and accessible information for clinicians on alternative injection sites for depot and rapid tranquilisation medication. This results in patients having the option of choosing a minimum of two possible injection sites for their medication which reduces restrictive practice and may lead to improved medication concordance. Moreover, this provides alternative methods for administering rapid tranquilisation where prone restraint is needed.
- **Seclusion Sensory improvements** – With the current seclusion suites available at the Radbourne Unit and the Kedleston Unit, staff have the ability to introduce sensory improvement

mechanisms for patients. These come in the form of changing the lighting in both brightness and colour, changing the smell in the room and also introducing music to aid in reducing a person's time in seclusion.

- **Simulation training** – Plans are in place to reintroduce simulation training and make this more available for staff to access. Simulation furniture has been ordered to allow the current Positive and Safe Support Trainers to bring the training to individual areas to improve access.
- **Body-Worn Cameras** – A pilot is due to commence across five inpatient wards including forensic and older adults. The pilot is expecting to reduce the number of violence incidents towards staff and also provide a forum for the Trust to review current practice and improve the link between clinical practice needs and training delivery.

Conclusion

The last 12 months have presented a significant shift in restrictive practice across our inpatient wards and have shown reducing trends in restrictive practice. A robust audit structure is in place and this has given us a clear basis of data from which we are able to continually develop. The way in which information is disseminated across a variety of professionals has also significantly improved through the Positive and Safe Group, Reducing Restrictive Practice Working Group and Clinical Reference Group. These forums have introduced a significant increase in service user/expert by experience involvement in developing our services.

With the changes to practice and introduction of clinical devices the data above shows improvements in the use of restrictive practice across our inpatient areas; however, some outliers in data remain. With further audits and developments in practice these are expected to improve further.

Patient safety 2: Physical Health in Mental Health (PHiMH) Clinics

The physical health in mental health (PHiMH) clinics have been introduced to address the needs of people under the care of secondary mental health services who are being treated with anti-psychotic or mood stabilising medication. They are community-based clinics covering all of the community mental health teams. They are managed within the working age adult community mental health division and referrals can be made by the secondary care services who are already in contact with the service user. The clinics are staffed by support workers who have received appropriate training for the physical health assessment and interventions.

The primary focus of the clinics is the completion of the Lester Tool assessment and interventions. The Lester Tool has been introduced to assess and intervene in cardiac and metabolic health in an attempt to reduce mortality for people with a severe mental illness, who are ordinarily taking anti-psychotic or mood stabilising medication. People in this population have been shown to have a reduced life expectancy and are at risk of dying 15-20 years earlier than the general population.

The clinics were recruited to and initiated in a staggered approach as funding allowed. There was a phasing period of introducing the concept of the clinics to services and clarifying the referral process and criteria. The table below shows the data of referrals, discharges and caseload of the team in the completed operational quarters.

	Quarter 2, 2019-2020	Quarter 3, 2019-2020
Referrals	108	103
Discharges	5	37
On Caseload	104	202

There have been some challenges acquiring appropriate equipment that would support outreach work and colleagues understanding of the role of the clinic. These are currently being addressed by utilising community bases to deliver assessments and interventions and a plan to reinforce the function of the team is in development.

Patient safety 3: Criminal Justice Liaison Teams

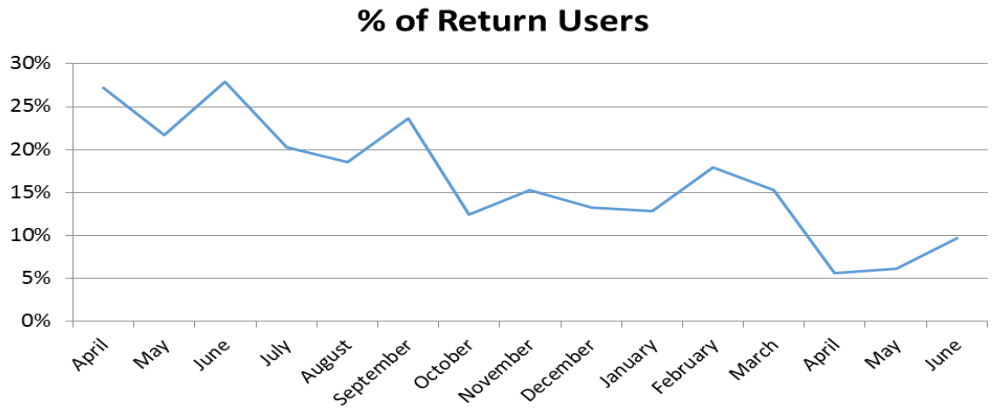
There are well-documented high levels of health and care needs within youth and adult offender populations, a higher prevalence than in the general population. Of young people (aged 13-18) who offended, 31% of were identified as having a mental health need and prevalence rates for diagnoses such as personality disorder, psychosis, attention deficit disorders, post-traumatic stress disorder (PTSD) and self-harm are notably higher than in the general population. Learning disability is also more common in young people in custody and in addition, almost 50% of adult prisoners suffer from anxiety and/or depression compared with a rate of 15% of the general population.

The Criminal Justice Liaison Team provides an end to end intervention for vulnerable people from the age of 10 (criminal responsibility) as they come to the attention of the criminal justice system, and provides timely advice to criminal and youth justice for informed decision making. Addressing a wide range of vulnerabilities when people first come into contact with the youth and adult justice systems hopes to support how offending behaviours will be addressed, contributing to reductions in future arrests and in the use of police and court time.

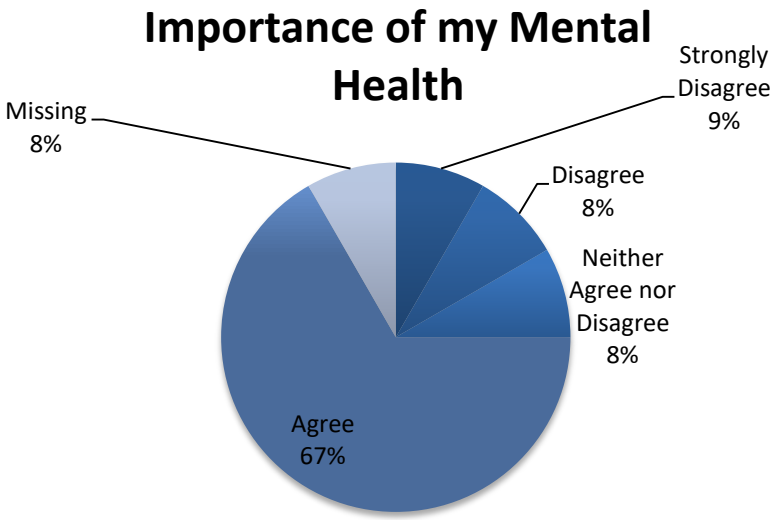
The service operates seven days a week across Derbyshire within the police custody suites, magistrates courts and recently Derby Crown Court. Referrals are received at any point across the criminal justice pathways from suspicion of offence to community disposal.

Progress over 2019/20

As seen below, national data would suggest a significant drop in return users to the service since the team was launched in Derbyshire in 2017, indicating that the team are appropriately diverting and supporting individuals as they enter the criminal justice pathway. Whilst we have no specific key performance indicators as a team with regards to this, reducing reoffending and supporting vulnerable individuals is the main outcome of the service.



Feedback - Staff recognised the:



Feedback from partners and police custody staff remains positive, and we have been told that the team provides a responsive service to detainees. Police colleagues have told us that the team engaged with them, were helpful and provided useful advice and information when dealing with challenging detainees. They have also fed back that there iss effective communication between the service and custody sergeants, which ensured good identification of the needs and care of vulnerable detainees.

Some quotes from people who have used the service includes how the service was “life changing”, they “believed in me”, and went “far beyond what was required”.

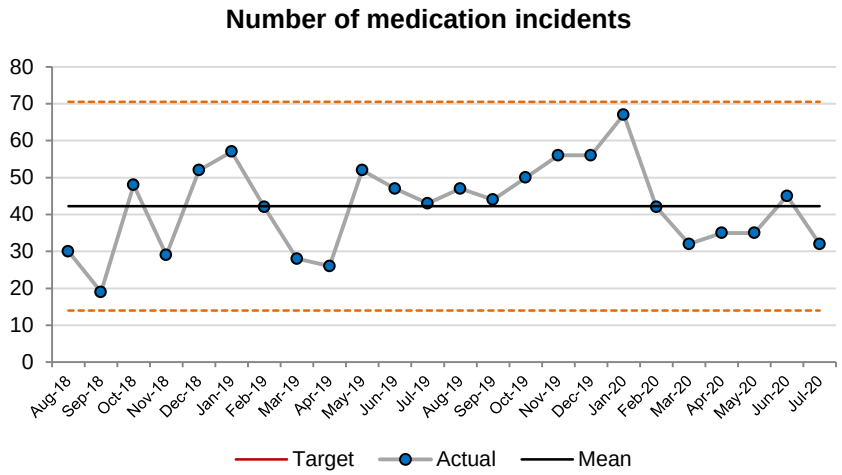
The Healthwatch Derbyshire Offender Health Report (published 9 December 2019) highlights the needs of and challenges for this population in accessing generic mental health services. A specific quote offers the following: “Since I have been involved with the criminal justice system it has been very shocking to see how many people have mental health problems. This should have been sorted out when they were children as there are so many people who are not well and so if they got the help they needed they would not have been involved in crime. There should be more emphasis and support from workers to improve your whole life e.g. smoking, drinking, drugs, exercise, diet etc rather than just focus on the crime as these are often a factor why people do things as there are gaps in their lives”.

Patient safety 4: Medicines Safety

The NHS patient safety strategy was launched in November 2019, and together with the NHS Improvement Medicines Safety Programme 2019/20 it has been used as a basis for the Trust Medicines Safety Strategy. It is underpinned by expected principles that require both a safe culture and safe systems, and comprises of three distinct elements: insight, involvement and improvement. It sets a clear plan to enhance our understanding of safety by drawing insight and evidence from multiple sources of patient safety information.

The pharmacy team works with wards and teams to follow up medicines incidents and facilitate learning, and this work feeds into the medicines management committee. The Chief Pharmacist is leading further development and embedding of the ‘vertical observatory methodology of aligning evidence, policy and practice expectations and audit, as a way of monitoring and improving clinical practice in key high risk areas of medicines use (initially these have been rapid tranquillisation in acute situations and treatment with high dose antipsychotic medication).

Medication incidents are reported to the Board via the integrated performance report. It is important to note that not all medication incidents are Trust incidents, the majority of specialist (and a number of community, including older adults) are other agency incidents discovered by our staff, e.g. community pharmacy making dispensing errors, domiciliary care agencies making errors etc. Medication incidents are all reviewed quarterly by the Heads of Nursing. Therefore, as a trend, following the recent increase attributable to the above, this now looks to be stabilising.

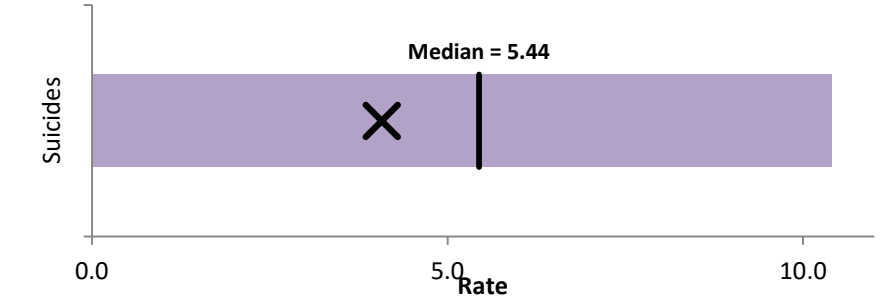
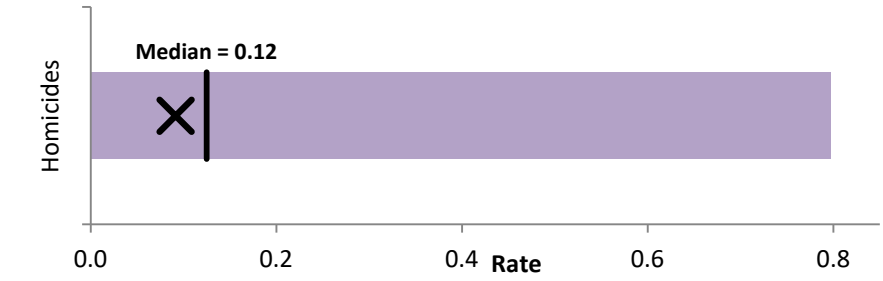
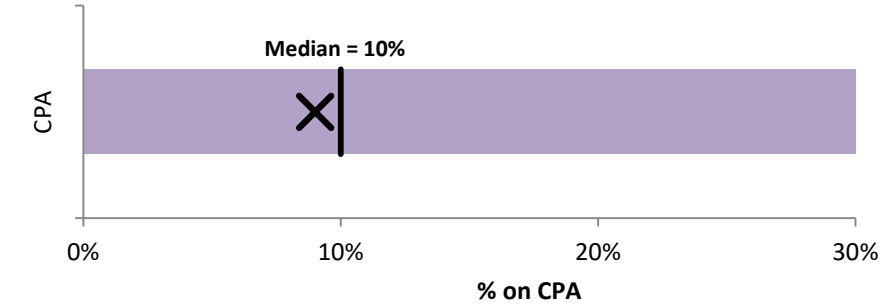
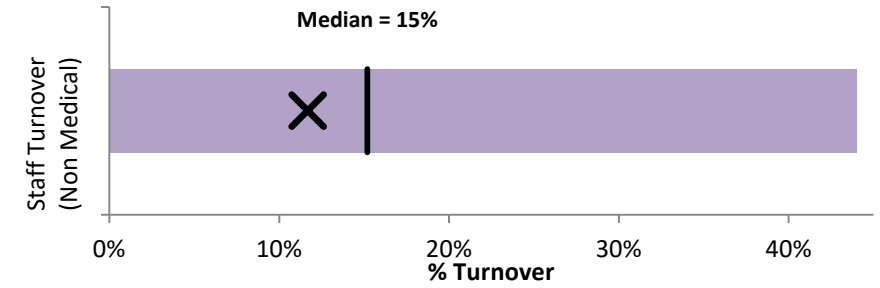
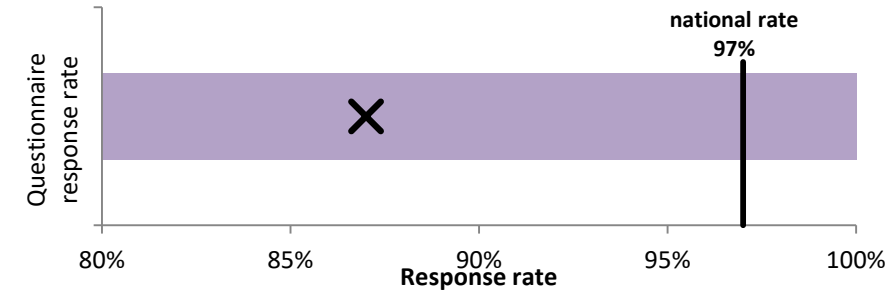


An example of pharmacy integration into our teams is the newly developed pharmacy technician and pharmacist input to the Chesterfield and High Peak Crisis Resolution and Home Treatment Team (all community mental health teams, crisis reolution and home treatment teams and dementia rapid response teams now have an allocated clinical pharmacist). This has supported both enhanced medicines management and stock control in the team, but also been a gateway to pharmacist advice. It has contributed to expert advice to re-adjust medication regimes to prevent in-patient admissions.

Patient safety 5: Suicide and homicide safety

Trust Scorecard: Derbyshire Healthcare NHS Foundation Trust

The NCISH Safety Scorecard has been developed to enable benchmarking data to support quality improvement. 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 remain below the median figure. The figures below give the range of results for mental health providers across England, based on the most recent available figures: 2015-2017 for suicides and homicides, 2018-2019 for people on the Care Programme Approach (CPA), 31 October 2018 – 31 October 2019 for non-medical staff turnover and 2015-2019 for trust questionnaire response rates. 'X' marks the position of Derbyshire Healthcare Foundation Trust. Rates have been rounded to the nearest two decimal places and percentages to whole percentage numbers.

	**Suicide rate** The suicide rate in your Trust was 4.07 (per 10,000 people under mental health care) from 2015-2017.
	**Homicide rate** The homicide rate was 0.09 (per 10,000 people under mental health care) from 2015-2017.
	**% on CPA** The % of patients on CPA was 9% in 2018-2019.
	**Staff Turnover** Non-medical staff turnover was 12% between October 2018 and October 2019.
	**NCISH questionnaire response rate** You have returned 87% of NCISH questionnaires from 2016-2019.

Patient safety 6: Falls

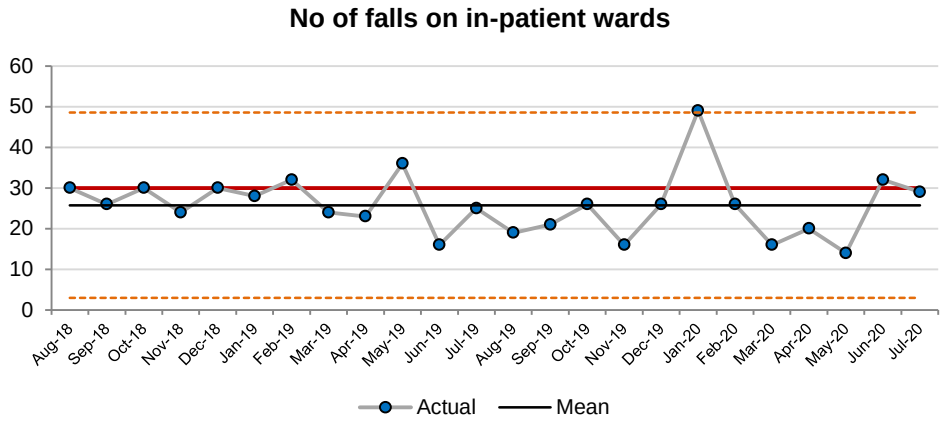
Following a desktop of review of in-patient falls, undertaken in partnership between the Trust's patient safety lead and a CCG colleague, we agreed to adapt an acute or community trust CQUIN for our use,

as a structured quality improvement initiative. Two of the measures were adaptable to us, but the third was not appropriate for our ambulant in-patient population. Therefore, informed by the NICE Quality Standard for falls in older people (QS86), we adapted one of the quality standards as the third metric. This approach is in line with the expectations of NICE quality standards as vehicles to improve quality and reduce variation in care.

Taking these three key actions is part of a comprehensive multidisciplinary falls intervention with a goal of fewer falls, which subsequently brings improved patient safety, improved patient experience, length of stay improvements and reduced treatment costs:

1. Lying / sitting and standing blood pressure to be recorded at least once during admission
2. No hypnotics or anxiolytics to be given during stay OR rationale documented
3. Older people who are seen by a health or social care practitioner are asked about falls when they have regular check-ups or if they attend hospital. This should include being asked:
    a. if they have fallen in the past year
    b. how many times this has happened
    c. what caused them to fall
    d. what happened when they fell
    e. whether they ever lose their balance or feel unsteady on their feet

We have reported against these expectations and have achieved this CQUIN in all three quarters. The expectations are now incorporated into the in-house falls training. Whilst we are yet to note clinically significant reductions in our falls reporting (recent data has been influenced by a small number of patients with particular challenges), vigilance with regards to falls prevention is increasing and we continue to monitor our progress using statistical process charts as below. Further to our reducing trend we are noting an increase in January 2020. This seemed to be linked to an increase in occupied bed days (greater occupation statistically increasing the risk of a recorded fall). Our records also show that there is a small number of patients across our older people's wards accounting for these falls, rather than a large number of people falling. We are also seeking to maintain a balance between encouraging mobility and maintaining a level of observation and proximity to the person that does not cause distress and confusion for the patient.



3.2 Clinical effectiveness

Clinical effectiveness 1: Individual Placement Support for people receiving mental health services

Individual Placement and Support (IPS) is the nationally recommended, evidence-based approach to supporting people using mental health services back into employment. This model of working is recommended as part of the NHS Long Term Plan, as part of a new care model for mental health.
A Derbyshire-wide partnership working group, reporting to the Primary Care Mental Health STP (Sustainability and Transformation Partnership) workstream and led by Derbyshire Public Health, submitted an application for NHS England for Wave 2 funding for expansion of IPS services. We have been successful in gaining the requested funds. The service will comprise of an 'employment team', and must adhere to the eight IPS key principles:

1. It aims to get people into competitive employment
2. It is open to all those who want to work
3. It tries to find jobs consistent with people's preferences
4. It works quickly
5. It brings employment specialists into clinical teams
6. Employment specialists develop relationships with employers based upon a person's work preferences
7. It provides time-unlimited, individualised support for the person and their employer
8. Benefits counselling is included.

Monitoring and outcome reporting
To ensure that services are adhering to IPS principles, the programme will be monitored and assessed against the internationally validated 25-point fidelity scale. The Derbyshire STP Mental Health System Delivery Board will provide governance to the project, and the Derbyshire IPS mental health STP steering group will continue to provide support.

A mixed monitoring framework will be developed using an Outcomes Based Accountability (OBA) approach to identify headline performance areas. Key indicators such as gaps in the employment rate for those in contact with secondary mental health services, and the overall employment rate (Public Health Outcomes Framework, 2019) will be used to monitor progress against longer term outcomes. Quantitative and qualitative data will be collected to show progress and describe the story for service users, e.g. case studies. Quarterly progress reports will be sent to NHSE to include, but not limited to:

- number of referrals
- number of clients engaged
- number of clients placed into paid work
- number of 13-week job sustainments
- number of 26-week job sustainments
- number of 52-week job sustainments.

The service went 'live' at the beginning of Quarter 4 (January 2020) with employment specialist roles fully recruited to as well as a service manager with experience in IPS to lead on the initiative. Within the working age adult services, the Trust is providing the service for the majority of areas. However, we are working in close partnership with South Yorkshire Housing as they provide IPS services in two of the community mental health teams in the north of the county. Substance misuse service also participated in

an NHS England research project of using IPS with people within their services, but this was a time-limited project.

Clinical effectiveness 2: Health Visiting (0-19 Years)

Colleagues in Derby City have developed a website, designed to inform parents on important public health topics. The website is easily accessible in various formats and offers:

- Accurate, evidence based, up-to-date information on health promotion topics
- Accurate and up-to-date information on how to access a health visitor or associated support network
- Links to other evidence-based sites offering advice
- information about feeding, immunisations, alternative apps, safe sleep and other public health topics
- actions that parents can take to reduce the risk of sudden infant death
- reinforces messages about not shaking a baby

Health visitors need to share a large amount of information to parents of a new-born baby, at a time when the parents are still adjusting to the major change in their lives. The website is designed to make the information readily accessible to parents so that they can look at it whenever they have a query, and in a format that is user-friendly. This enables parents to be in control with regards to what information they receive and when, and so ensure that they are not being 'talked at' or given piles of leaflets that might be filed away or forgotten. The website has a translation application so other languages can be used. This is of clear value given that over 75 languages are spoken in Derby.

This way of working enables us to fit in best practice in a short time, as we are offering the same information in all teams across the city, as accurately as possible, and clients can return to check it at any time. The overall aim of this website is to improve outcomes for children, and is underpinned by the ambition of NICE Clinical Guidelines.

Feedback from parents has been very positive, with examples as below:

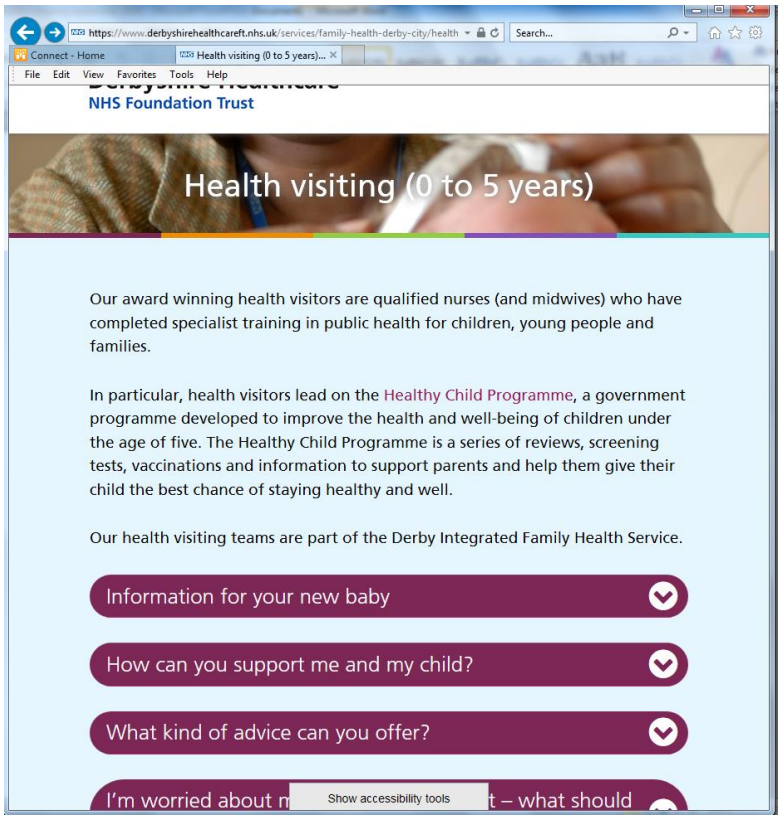
A very anxious first time mother who was delighted to have a reference point on her phone which is always at her side

A father who immediately put the site onto his and his partner's phone

A young mother who loves her apps etc. but doesn't read paper copies of anything

A situation where people were constantly turning up for a clinic that had to be temporarily closed. They were delighted to discover they could look up a clinic on the day they wanted to go

A small number of paper copies are retained for those families who do not have access to the internet or who do not have a ‘smart phone’. Overall, however, the website has brought an innovative, modern, more accessible method of communication which is cost effective, efficient, evidence based and multi-professional. An example of the home page is as below:



Clinical effectiveness 3: Our approach to Autism Spectrum Disorder (ASD)

The Adult ASD Assessment Service continues to provide an assessment-only service, based on the national autism strategies, the NICE guideline for autism spectrum disorder in adults: diagnosis and management (CG142) and the NICE quality standard for autism (QS51). The referral rate to this service has grown exponentially, significantly beyond the capacity of the commissioned service. Therefore, we have been working with commissioners to identify strategies to reduce this within the current budget. A Trust-wide ASD group has been established, with membership of operational and clinical colleagues from all divisions. One of the key products of this group is an Autism Health Passport, which indicates person-centred reasonable adjustments that should be provided to anyone presenting within the Trust with autism. The group has also developed a document that identifies a position statement in respect of autism and suggests reasonable adjustments required for someone with autism and a co-existing mental health diagnosis, linked to the mental health clusters.

Across the Trust, ‘autism boxes’ have been made available at both inpatient and community sites. These provide objects to help people with sensory needs whilst they are waiting for an appointment or staying with us as an in-patient, together with information about autism support services. In addition, from January 2020 an Autism Forum is planned for patients, carers and staff members with ASD, with a vision of creating change and shaping the culture of our organisation, focusing on the experience of autism care in Trust services. The Trust’s learning disability service has a new service specification that

incorporates providing advice and consultation to other Trust services for people who have autism and a co-existing mental health problem, but in the absence of a diagnosed learning disability. This is in addition to the work that the service will undertake for those with both a learning disability and autism.

Within the last year a speech and language therapist has been employed to provide support to the acute adult inpatient wards for those with autism and to offer resources, advice and training to staff in these settings. All clinical staff in the Trust are required to undertake Level 2 training in autism. This was initially being delivered in a classroom setting, but an e-learning package has now been developed and is in place for all staff to access. This will release time for specialist ASD staff to provide targeted support and bespoke training across the Trust.

Similarly to other trusts nationally, it is recognised that there remains a commissioning gap in terms of assessment and post-diagnostic services for those with an autism-only diagnosis, and this is a continuing conversation between the Trust and our commissioners.

Clinical effectiveness 4: Development of the Personality Disorder Pathway

The Trust is developing an enhanced offer for people with borderline personality disorder (BPD) / emotionally unstable personality disorder (EUPD). This includes a clear structured pathway with a choice of evidence-based treatments. Borderline personality disorder and emotionally unstable personality disorder are medical labels to describe ways in which a person thinks, feels and behaves. We are aware that a personality disorder diagnosis can be hugely stigmatising and impact on how people view themselves and how others view them. The diagnosis can also be very useful, in that it can help in understanding lifelong problems, suggests evidence-based interventions and can allow access to services and therapies.

The underlying principles of our pathway are drawn directly from the best available evidence, particularly from NICE guideline for Borderline Personality Disorder (2009 and reviewed in 2018), and the 'Shining Lights' Personality Disorder Consensus Document (2018). The pathway will be staffed from a combination of new and existing posts. As of December 2019, we have appointed into eight of these posts with start dates of January 2020. In addition, we are recruiting into three 0.4WTE clinical psychologist posts to provide additional therapy capacity and support to those community mental health teams without existing clinical psychology time. Structured Clinical Management (SCM) is the evidence-based approach that enables generalist mental health practitioners, the staff working in this pathway, to work effectively with people with borderline personality disorder. We are committed to developing our staff's understanding, confidence and skill. The pathway will develop a modular training strategy in line with core competencies as defined by the 'Personality Disorder Capabilities Framework' (National Institute for mental health in England 2003) and informed by 'Meeting the Challenge, Making a Difference' (Department of Health, 2014).

3.3 Patient experience

Patient experience 1: The Equal forum

The EQUAL Forum was launched following engagement with patient groups and colleagues from our community and voluntary sector organisations. It is the new patient council for Derbyshire Healthcare, and brings together patients, carers and nominated staff from across the Trust. It is an opportunity to create change in the Trust and shape the culture of our organisation through engagement. The forum works in partnership with leaders, including executive directors, and is in place to ensure that patients and carers feel able to raise issues, and can work together to plan ways to deliver improved services.

As a Trust we have done this because we know that it's the right thing to do – to give people a voice to be able to influence and improve the way things are done. Forum members are able to ask for more information and question the Trust's strategy and performance on behalf of those they represent, ensuring that the Trust continues to work in the best interests of patients, carers, families, staff, and the whole organisation. It is our way of making sure that patients and carers have an opportunity to feedback, to contribute to solutions, and to be able to influence decisions; making improvements in service delivery by raising issues and problem-solving together. Feedback is provided to the Quality and Safeguarding Committee and directly to the Trust Board.

Examples of the work undertaken by the Forum so far include the 'Bright Ideas' notebook which has been distributed to the Trust's wards and services. It is aimed at giving service users and anyone else a place to record any thoughts and ideas that might in any way improve the service that we offer and the experience of people in our care. The Trust Peer Support Volunteer also collects patient and carer feedback and ideas from across our in-patient areas, again with the focus of Quality Improvement. There is now an Equal Forum in the north and in the south of the county, and a developing Equal Patients and Carers Autism sub-group and Forum.

Patient experience 2: Learning from Board Stories

The Trust Board is an open forum where the public has the opportunity to see what developments and processes are occurring within the Trust. As part of this, the Board Stories process is an opportunity for people who have worked, been cared for or experienced care within the Trust to tell their story and offer opportunities for the Board to improve care for others or highlight good practice. Over the 2019/20 year, eight Board Stories have been presented, ranging from service users talking about the positive experience they had within psychological programmes and requesting that more have access to this, to family members talking about the experience they had caring for a relative and the support they received from the Trust after that family member had passed away while still under our care.

Facilitating people to come and communicate their experience of the Trust brings an opportunity for the Board to create actions and service changes to improve care, prevent incidents occurring again in the future and create a co-produced approach based on feedback and evaluation. Some examples of how Board Stories has impacted on the Trust and the services it provides include:

1. A drive to commission preparation-based psychology input for people who have experienced abuse and are struggling to engage in psychological therapies. An example of this is the creation of the emotional regulation pathway
2. The development of physical health clinics within community mental health teams to prevent any delays in physical health monitoring and testing
3. The creation of the EQUAL forum to improve the dialogue opportunity for experts by experience and carers and to implement the 'Treat me well' campaign
4. Improvements in family support pre- and post- incidents or challenging situations, implemented through the story of a Trust staff member who was also a family member of a relative in our care
5. Continued and further roll-out of the 'Living Well Programme'
6. Implementation of new NICE guideline-based clinical care that has been further supported by the Board after positive patient feedback.

In addition to the positive outcomes displayed from the Board Stories presented within 2019/2020, the person presenting also has the opportunity to engage in reflective supervision and post-event debrief with support from the relevant clinicians, the Assistant Director of Clinical and Professional Practice and a Family Liaison Officer. This has also provided people involved to positively work through their experiences and promote a supportive open culture within the Trust, not only to allow learning from practice and incidents but to promote it.

Patient experience 3: The Patient Experience Strategy

The aim of the Strategy is to further develop a culture throughout the Trust that places the quality of patient and carer experience at the heart of everything we do and always strives to exceed expectations with the belief that 'good enough' never is. The strategy has been designed to support the delivery of the Trust's three strategic objectives:

1. Great care
2. Great place to work
3. Best use of money

One element of providing Great care is to improve the patient and carer experience by routinely receiving feedback and acting on what people are telling us. Improving the patient and carer experience is a continuous cycle of listening and learning from the people who use our services. By working with patients and carers the strategy provides a structure to develop and change the quality and safety of our services.

In order to ensure that our patients and carers receive the best possible experience we have developed our strategy using the principles from the NHS England document 'Ask Listen Do - Making conversations count' and through consultation with patients and staff. In order to achieve the goals within the 'Ask Listen Do' document, we have committed to the following pledges.

- **Pledge 1:** We will promote shared values in respect of a positive patient experience
- **Pledge 2:** We will introduce a range of ways that patients and carers can give feedback about their experience
- **Pledge 3:** We will use the feedback we gather to improve our services.

This strategy is now directly influencing the work of the Trust, and the approach and focus of the Patient Experience Committee.

Patient experience 4: Care planning

The Trust Care Programme Approach (CPA) policy has been reviewed to take account of learning from serious incidents, updated required standards and to ensure it is a clear, easy to follow policy. There was a wide consultation across the Trust prior to it being finalised. Service users were actively involved as part of the development of the care plan, providing ideas of what they would want in a care plan and the language used. Healthwatch Derbyshire colleagues have agreed to support consultation on a template when it is ready.

As part of this work the care plan template has also been reviewed and developed, and a shared governance approach was used with the intention of engaging frontline colleagues to develop a template that is usable and meets quality and clinical standards. The project lead visited other trusts to

understand how CPA works elsewhere and viewed their care plan templates and this provided ideas on layout and language used. The template will be used for care under both CPA and non CPA. This supports the ethos of Core Care Standards and aligns with The Community Mental Health Framework for Adults and Older Adults (NHSEI 2019) plans to remove this demarcation in levels of care. It will also streamline the number of care plan templates within the electronic care record system.
It is planned that once a suitable template for adult and older adult services has been developed it will be able to be used in other services with the minimum of adaptations. It is also anticipated that the template will be used as the person's overarching care plan and that interventions will be updated as needs change, for example when people are admitted into hospital or in need of services at times of crisis.
The language used in the care plan template supports ownership of the plan by the service user, strengthens the need for service users to be involved in the development of their care plan, and reinforces that the focus of the plan is on it being a helpful resource for the person accessing our services.

To illustrate this, below are the first two questions in the template, written in the first person to capture this focus:

1. What matters to me and what would I like to achieve in the next 12 months?
2. What skills, strengths and experiences do I have to help me achieve my goals?

The template developed encompasses all of the standards set out in the Mental Health Code of Practice. The group is working with colleagues in Information Management and Technology to develop the template reporting in both the Paris and SystmOne electronic care records system, which will also enable audits of completion to be completed easily. These will be further supported by annual qualitative audits. The annual audits of the quality of care planning across the Trust are led by the Heads of Nursing, primarily utilising a peer audit approach (colleagues auditing each other's work) to identify and recognise good practice, provide learning opportunities for colleagues and give the opportunity to participate in audit as per regulatory requirements. This will continue with the new template.

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

Early intervention in psychosis (EIP): people experiencing a first episode of psychosis treated with a NICE-approved care package within two weeks of referral			
	Number	Actual	Target
EIP RTT Within 14 Days - Complete	272	84.56%	56%
EIP RTT Within 14 Days - Incomplete	168	82.14%	56%

Improving access to Psychological Therapies (IAPT):

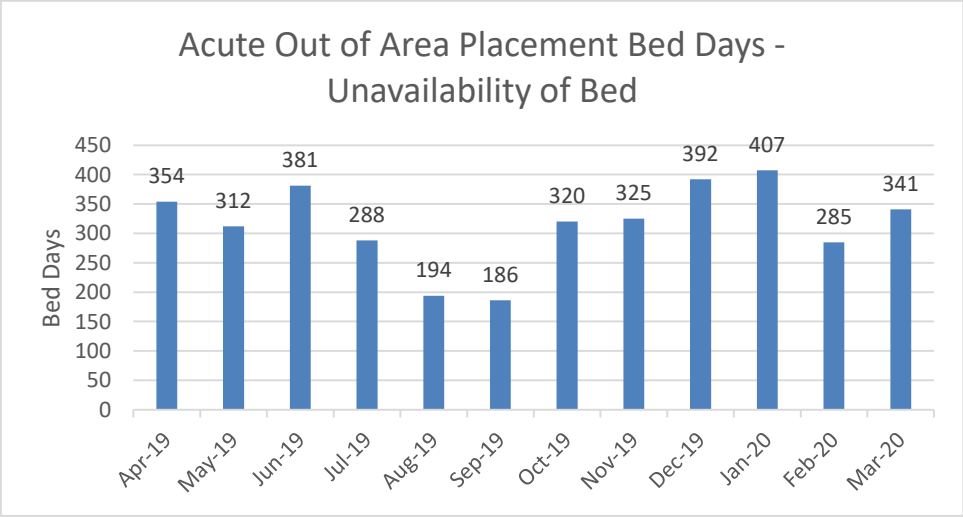
- People with common mental health conditions referred to the IAPT programme will be treated within six weeks of referral
- People with common mental health conditions referred to the IAPT programme will be treated within 18 weeks of referral

	Actual	Target
a) Proportion of people completing treatment who move to recovery (from IAPT dataset)	53.5%	50%
b) (i) IAPT – referral to treatment within 18 weeks	99.95%	95%
b) (ii) IAPT – referral to treatment within six weeks	93.1%	75%

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

Admissions to adult facilities of patients under 16 years old	
	Number of admissions under 16 years old
2019/20	0

Inappropriate out-of-area placements for adult mental health services (due to unavailability of bed) - bed days by month												
Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20	Average bed days
354	312	381	288	194	186	320	325	392	407	285	341	315.42



It is clear that there have been challenges for our inpatient mental health services to have the capacity to meet the needs of our population locally. 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.

3.5 Additional information

Partnership working – Joined Up Care Derbyshire

The health and wellbeing of our population is shaped by many things, including where we live, decisions we make, how much money we earn, the food we eat and the aire we breathe, amonghst other factors. To meet these challenges, local councils, care homes and different parts of the NHS in Derby and Derbyshire, including hospitals, family doctors, mental health teams and others, are working together more closely than ever before. We have formed a partnership, known as Joined Up Care Derbyshire, and this is Derby and Derbyshire's Sustainability and Transformation Partnership (STP).

Joined Up Care Derbyshire is made up of different workstreams. The Trust's Chief Executive Office, Ifti Majid, is the Senior Responsible Officer for the Mental Health, Learning Disability and Autism workstream. The Trust is also a key partner in the Childrens, Urgent Care and Place Workstreams. Examples of the work undertaken by the mental health workstream includes the following:

- supporting people to recover well from conditions such as anxiety, depression and stress through accessing talking therapies, meeting all national access and recovery targets;
- providing a Dementia Rapid Response Team, delivering intensive support to people with dementia at times of crisis in an individual's own home, therefore keeping them at home and independent for longer;
- providing training to staff across Derbyshire to raise awareness about patients with delirium – a medical condition causing people to present as confused, disorientated and unable to concentrate.
- Seeking to ensure that people in crisis get a number of options for support, in a timely way, thereby avoiding emergency departments where possible;
- testing an approach to support people with self-care, recovery and resilience in primary care.

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 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 Trust's Quality Visit model.

The increase in volume of responses is visible from 2017/18 to 2018/19. 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	No. F&F Surveys 2019/20	% of likely / extremely likely to recommend 2017/18	% of likely / extremely likely to recommend 2018/19	% of likely / extremely likely to recommend 2019/20
Apr	69	397	360	85.51%	97.48%	95.56%
May	104	375	446	81.73%	94.67%	96.64%
Jun	76	377	378	75.00%	97.08%	96.03%
Jul	73	386	460	86.30%	98.19%	96.74%
Aug	62	382	407	87.10%	96.86%	96.81%
Sep	58	368	425	89.66%	96.20%	95.29%
Oct	49	401	553	85.71%	95.26%	95.30%
Nov	74	447	403	77.03%	96.42%	97.27%
Dec	41	301	356	85.37%	96.35%	92.98%
Jan	60	390	394	86.67%	96.41%	94.67%
Feb	56	369	415	82.14%	94.58%	95.18%
Mar	81	415	403	81.48%	96.63%	93.30%
Totals 19/20	**803**	**4608**	**5000**	**83.19%**	**96.62%**	**95.52%**

Delivering Excellence Award Winners 2019

Compassion in Practice Award
Joanna Miatt, Service Manager and Consultant Clinical Psychologist, Eating Disorders Service
For being a truly caring, supportive and dedicated member of staff, she demonstrates unwavering patience and relentless support in the face of challenges and setback.

DEED of the Year Award
Alex Patrick for consistently providing the highest level of care and following best practice to support patients with dedication and compassion.

Enhancing our Workforce Award
Nicola Lewis, Occupational Therapist, Ward 1, London Road Community Hospital
For her outstanding contribution to the education of Occupational Therapy students. Nicola is involved in student forums and has made valuable contributions to the education of other educators.

Going the Extra Mile Award
Peter Matkin, Chargehand Porter, Estates and Facilities Portering Team
For leading by example in the way he interacts within the team, wider colleagues and service users, and giving 100% to every task.

Inclusion and partnership award
Karen Wheeler, Occupational Therapy Lead, Neighbourhood and Central Services

For the huge impact she has made on the inclusion and partnership agenda, leading to the development of a range of projects within the community.

Innovation Award
Martyn Revis, Receptionist and Admin Support, Hartington Unit
For independently researching the effects of virtual reality (or VR) on improving physical health conditions and overall wellbeing of patients, and for piloting VR at the Hartington Unit.

Inspirational Leader Award
Ruth Crawford, Service Manager, Killamarsh and North Chesterfield Adult CMHT
For her approach to staff wellbeing and happiness and for always making sure that everyone feels recognised and valued.

Rising Star Award
Grace Clements, Mental Health Practitioner, Enhanced Home Support Service
For her work in setting up a new service looking at supporting young people and families at risk of tier 4 hospital admissions.

Volunteer of the Year Award
Simon Dean, Volunteer Support Worker, Hope and Resilience Hub, Radbourne Unit
For his positive attitude and his openness in sharing his daily coping strategies. Simon is always professional in his approach and his peers find him sensitive and compassionate.

Support from Healthwatch Derby and Healthwatch Derbyshire

The work of the Trust has been referred to in the following Healthwatch publications over the past year:

Healthwatch Derbyshire – 'Carers Report. Understanding the quality of life for carers in Derbyshire'
Colleagues from Healthwatch Derbyshire spoke to 428 carers about their experiences. The report highlighted the negative impact on the individual's quality of life of being a carer and the sacrifices made by carers. This negative impact included on the person's physical and mental health. There was concern that mental health carers explained they did not know where to go for support, which was often made worse because of the potential stigma of mental health and people not wanting to talk about it. A number of carers felt the carer's assessments were focused more towards caring for people with a physical illness and not a mental illness. Whilst a high proportion of carers explained they did not feel their views or opinions were considered or valued by professionals, carers of people living with dementia felt very involved with their loved ones care. One carer talked of attending a carers group specific to mental health, and how this peer support is invaluable, that the people who attend are very understanding as they have similar experiences. Feedback from carers of those accessing our community mental health teams including some that shared positive experiences, whereas others felt that they had to become "experts".

Healthwatch Derbyshire – 'Ex-offender Report. Experiences of ex-offenders using health services in Derbyshire'
Colleagues from Healthwatch Derbyshire engaged with 64 ex-offenders and youth offenders about their experiences of health services in Derbyshire. Highlights from their report include how many adult ex-offenders felt there was limited support for people with mental health issues, and felt there should be

more emphasis on preventing mental ill health and ensuring people are signposted to appropriate support. Some also felt that if they asked for help, they were offered medication rather than support to help with any underlying problems.

A number of adult ex-offenders described how it felt there was limited support for people with mental health, with many explaining there needs to be more emphasis on prevention and putting support in place for people at an early stage, so symptoms do not progress and they do not end up in a crisis or self-medicating with smoking, drugs or alcohol. There were also concerns raised about consistency about messages from crisis colleagues, and challenges when a person's diagnosis led to them not clearly meeting access criteria for mental health services. The overall message was a need to improve signposting to mental health support in primary care, provide quicker access to mental health support and provide more emphasis on preventing mental ill health and supporting people to deal with any underlying issues.

We continue to seek to learn from the work our colleagues from Healthwatch Derby and Healthwatch Derbyshire.

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 2019/20, our mandated indicators are:

1. Inappropriate out-of-area placements for adult mental health services
2. 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.

An additional indicator was chosen for data quality audit by the Council of Governors in March 2020:

3. 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.

This was chosen as an indicator in response our priority of patient safety, and our need for assurance that categorisation of incidents is accurate, so as to ensure the most appropriate response. It was also negotiated with our external auditors to consider any patterns of specific types of incident that would be more or less likely to be categorised inaccurately. However, in response to the COVID-19 pandemic all external auditing of Quality Reports, including auditing this indicator, was not undertaken this year.

3.6 DHCFT Trust Performance Dashboard 2019/20
(with 2018/19 performance included for comparison as requested by the Council of Governors)

DHCFT Trust Performance Dashboard YTD (06/12/19)	No. 19/20	% 18/19	% 19/20	Target 19/20
- NHS I Targets - Single Oversight Framework				
- CPA 7 Day Follow Up	725	96.83%	96.55%	95.00%
- Data Quality Maturity Index (DQMI)	7,111,260	96.47%	93.06%	95.00%
- IAPT Referral to Treatment within 18 weeks	8,113	99.96%	99.95%	95.00%
- IAPT Referral to Treatment within 6 weeks	8,113	97.14%	93.10%	75.00%
- EIP RTT Within 14 Days – Complete	272	87.45%	84.56%	56.00%
- EIP RTT Within 14 Days – Incomplete	168	86.67%	82.14%	56.00%
- Patients Open to Trust In Employment	42,490	9.00%	9.20%	N/A
- Patients Open to Trust In Settled Accommodation	42,940	50.06%	50.72%	N/A
- Under 16 Admissions To Adult Inpatient Facilities	0	N/A	N/A	0
- IAPT People Completing Treatment Who Move To Recovery	7,759	54.62%	53.50%	50.00%
Physical Health – Cardio-Metabolic – Inpatient	Monitored via national audit			
Physical Health – Cardio-Metabolic – EI	Monitored via national audit			
Physical Health – Cardio-Metabolic – on CPA (Community)	Monitored via national audit			
- Out of Area – Number of Patients Non PICU	232	N/A	N/A	N/A
- Out of Area – Number of Patients PICU	288	N/A	N/A	N/A
- Out of Area – Average Per Day Non PICU	10.66	N/A	N/A	N/A
- Out of Area – Average Per Day PICU	13.45	N/A	N/A	N/A
- Locally Agreed				
- CPA Settled Accommodation	29,356	94.30%	94.53%	90.00%
- CPA Employment Status	23,652	96.43%	95.33%	90.00%
- Patients Clustered not Breaching Today	171,584	74.40%	72.20%	80.00%
- Patients Clustered Regardless of Review Dates	185,533	91.99%	92.48%	96.00%
- 7 Day Follow Up – All Inpatients	1,349	96.33%	94.51%	95.00%
- Ethnicity Coding	289,607	90.63%	90.84%	90.00%
- NHS Number	63,905	99.98%	99.98%	99.00%
- CPA Review in last 12 Months (on CPA > 12 Months)	2,341	95.45%	94.87%	95.00%
- Clostridium Difficile Incidents	0	N/A	N/A	7
- 18 Week RTT Greater Than 52 weeks	0	N/A	N/A	0
- Schedule 6 Contract				
- Consultant Outpatient Appointments Trust Cancellations (Within 6 Weeks)	46,776	11.34%	12.58%	5.00%
- Consultant Outpatient Appointments DNAs	31,527	16.20%	15.51%	15.00%
- Under 18 Admissions To Adult Inpatient Facilities	1	1	N/A	0
- Outpatient Letters Sent in 7 Days	28,509		86.92%	90.00%
- Inpatient 28 Day Readmissions	1,531	6.26%	6.66%	10.00%
- MRSA – Blood Stream Infection	0	N/A	N/A	0
- Mixed Sex Accommodation Breaches	0	N/A	N/A	0
- Discharge Email Sent in 24 Hours	1,531	81.70%	87.92%	90.00%
- Delayed Transfers of Care [Target 18/19 was 0.80%]	4,826	1.24%	0.99%	3.50%
- 18 Week RTT Less Than 18 Weeks - Incomplete	3,072	94.83%	94.40%	92.00%
- **Fixed Submitted Returns**				
18 Week RTT Greater Than 52 weeks	0	N/A	N/A	0
18 Week RTT Less Than 18 weeks – Incomplete	4,095	93.71%	93.75%	92%
Mixed Sex Accommodation Breaches	0	N/A	N/A	0
Completion of IAPT Data Outcomes	8,180	97.93%	99.99%	90%
Ethnicity Coding	265,293	91.63%	91.68%	90%
NHS Number	63,935	99.98%	99.99%	99%
CPA 7 Day Follow Up	724	96.70%	95.99%	95%

The Trust's CQC rating

The result of our 2019 inspection was that the CQC rated our organisation as 'good'. Our ratings tables at at March 2020 are as below:

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires improvement ↔ Mar 2020	Good ↑ Mar 2020	Good ↔ Mar 2020	Good ↑ Mar 2020	Good ↑ Mar 2020	Good ↑ Mar 2020

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

Our clinical service reports

These are the results from the comprehensive inspection in 2019 (published March 2020):

Ratings for mental health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Requires improvement ↑ Mar 2020	Good ↑ Mar 2020	Good ↑ Mar 2020	Good ↑ Mar 2020	Requires improvement ↑ Mar 2020	Requires improvement ↑ Mar 2020
Long-stay or rehabilitation mental health wards for working age adults	Good Sept 2016	Requires improvement Sept 2016	Good Sept 2016	Good Sept 2016	Good Sept 2016	Good Sept 2016
Forensic inpatient or secure wards	Good Sept 2018	Good Sept 2018	Good Sept 2018	Good Sept 2018	Good Sept 2018	Good Sept 2018
Wards for older people with mental health problems	Requires improvement Sept 2018	Good Sept 2018	Good Sept 2018	Good Sept 2018	Good Sept 2018	Good Sept 2018
Community-based mental health services for adults of working age	Requires improvement ↔ Mar 2020	Good ↔ Mar 2020	Good ↔ Mar 2020	Good ↑ Mar 2020	Requires improvement ↔ Mar 2020	Requires improvement ↔ Mar 2020
Mental health crisis services and health-based places of safety	Requires improvement ↔ Mar 2020	Good ↑ Mar 2020	Good ↔ Mar 2020	Good ↔ Mar 2020	Good ↔ Mar 2020	Good ↑ Mar 2020
Specialist community mental health services for children and young people	Good Sept 2016	Good Sept 2016	Outstanding Sept 2016	Outstanding Sept 2016	Good Sept 2016	Outstanding Sept 2016
Community-based mental health services for older people	Requires improvement Sept 2018	Good Sept 2018	Good Sept 2018	Good Sept 2018	Good Sept 2018	Good Sept 2018
Community mental health services for people with a learning disability or autism	Requires improvement ↔ Mar 2020	Good ↔ Mar 2020	Good ↔ Mar 2020	Good ↑ Mar 2020	Good ↔ Mar 2020	Good ↑ Mar 2020

Overall ratings for mental health services are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Ratings for community health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for children and young people	Good ↔ Mar 2020	Good ↔ Mar 2020	Outstanding ↔ Mar 2020	Outstanding ↑↑ Mar 2020	Outstanding ↑↑ Mar 2020	Outstanding ↑↑ Mar 2020

*Overall ratings for community health services are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

CQC actions progress

The Trust-wide CQC inspection in July 2018 resulted in 91 actions being logged. There is one action remaining from the 2018 CQC inspection for older adult community mental health teams: 'The Trust should ensure that staff complete physical health questionnaires with all patients entering the service. Staff should record baseline physical observations, and undertake any necessary monitoring of physical health'. As a 'should do' action, this is defined by the CQC as "things that that the Trust should improve

to comply with minor breaches that do not justify regulatory action, to prevent breaching a legal requirement, or to improve service quality". We continue to make progress against this action, both with our confidence of our practice and also of our reporting of our performance.

The subsequent well-led inspection in November 2019, published on 6 March 2020, resulted in 10 'Must do' actions and 30 'should do' actions. Given that this report was published during a Level 4 National Incident, our work has been prioritised on managing our COVID response. As we restore services, structures and processes are being re-established to oversee and respond to these actions, as part of our overall qualtiy improvement approach. This progress is currently reported to our Executive Leadership Team and the Quality and Safeguarding Committee.

Annex 1: Statements from commissioners, local Healthwatch organisations and overview and scrutiny committees

Feedback from Council of Governors

An update from NHS England on 23 March 2020 highlighted that in light of expected amendments to quality accounts arrangements (due to COVID-19). This included there being no formal requirement for a limited assurance opinion or governors' report.

Therefore, a formal response has not been sought from the Trust's Council of Governors for the 2019/20 Quality Report. However, the report has been shared with Trust Governors, and over-arching feedback from the Trust's Lead Governor was that they found it a very informative and detailed document.

Feedback from Derby and Derbyshire Clinical Commissioning Group

General Comments

The Derby and Derbyshire Clinical Commissioning Group (DDCCG) welcome the opportunity to provide a statement in response to the 2019/20 Quality Account from Derbyshire Healthcare NHS FT (DHCFT). DDCCG has worked closely with the trust throughout the year to gain assurances that services delivered were safe, effective and personalised to service users. The data presented has been reviewed and is in line with information provided and considered through the regular contractual performance meetings and Clinical Quality Review Group.

The NHS will remember 2019/20 as the year it embarked on its response to the COVID-19 Pandemic. The Trust's response played an essential role in managing the pandemic and protecting the residents of Derbyshire. As a key partner of Joined-Up Care Derbyshire, DHCFT responded with distinction and DDCCG takes this opportunity to thank the Trust for its valued contribution.

Measuring and Improving Performance

DDCCG has noted the progress and achievements on the quality priorities set out last year, which the Trust has rolled over into 2020/21 to further implement. There are clear examples with relevant evidence to support statements of implementation and we recognise that the next year will concentrate on embedding these. Commissioners acknowledge the achievements and the use of national CQUINs to progress quality priorities over the past 12 months. There is clear evidence to show where the trust required making improvements in the next twelve months.

Commissioners agree that the Quality Account provides an overview of the Trust's Strategy, Vision, Values and work. These are now embedded within the Trust Strategy, as a way of integrating them more firmly into core business.

There are clear statements in relation to the achievements against National Commissioning for Quality and Innovation (CQUIN) schemes for 2019/20 which were in line with projections for achievement. In line with national guidance as required by the [COVID-19] National Prioritisation Framework all reporting was suspended for quarter 4. However, Commissioners acknowledge the key successes during the previous quarters, including the Trusts commitment to assess and appropriately intervene when people are admitted on to its wards and are drinking alcohol to harmful levels, or smoke tobacco / tobacco products. Unfortunately there was only a partial achievement of the Staff Flu Vaccination (CCG2) and the IAPT (CCG6) CQUINs.

In 2019/20 staff uptake of flu vaccinations was 71.1% which is a significant improvement on previous years but still below the national baseline. It would have been encouraging to see the actions been taken to this year to achieve the national baseline which is greater than previous years.

The Trust has reported non-achievement of the IAPT CQUIN, due to the complexity and time requirement of the assessment tool as an additional measure within therapy. However, in Q2 there was a partial achievement. This contract is monitored through a separate contractual route in line with other IAPT providers and not the main contract.

Despite national and regional challenges with recruitment the Trust adopted a proactive and innovative approach to employ qualified staff. For example, recruitment into their community team for a pilot project to monitor and support the physical health of high impact service users. A further achievement to note is the roll out in January 2020 of the Individual Placement and Support (IPS) assessment tool and full recruitment to these employment specialist roles as well as a service manager with experience in IPS to lead on the initiative.

Protecting Patients from Harm

The National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) Safety Scorecard shows that the Trust rate of incidents of suicide and homicide are below the national median figure. This achievement is reflective of the Trust strengthening its medical and therapeutic intervention offer and supervision of at risk patients. However, their response rate to the NCISH national questionnaire is 87% against the national median of 97%. The percentage of patients (9%) on the Care Programme Approach (CPA) is below the national median. Whilst the account highlights the challenges around the CPA, it also identifies actions to be implemented to improve performance. For example, a revised template and shared governance approach will be used for care under both CPA and non CPA to support the ethos of Core Care Standards and alignment with The Community Mental Health Framework for Adults and Older Adults (NHSEI 2019) plans to remove demarcation in levels of care.

Additionally through the diligent work of the Reducing Restrictive Practice Working Group and the Positive and Safe Supporting Training Programme there has been a reduction in the use of physical and chemical restraint and use of seclusion. Although, the account highlights an increase in ward doors being locked, albeit for shorter periods.

Over the past year the Trust have played a key role in the development of the new Patient Safety Incident Response Framework as one of the early implementers. It would have been good to see this reflected in the account to acknowledge the work of the Trusts Patient Safety Team.

Patient Engagement

The Trust launched the EQUAL Forum following engagement with patient groups and colleagues from its community and voluntary sector organisations. This is a new patient council that brings together patients, carers and nominated staff from across the Trust. It is an opportunity to create change in the Trust and shape the culture of the organisation through engagement. The forum works in partnership with leaders, including executive directors, and is in place to ensure that patients and carers feel able to raise issues, and can work together to plan ways to deliver improved services. The CCG recognises this as a positive example of patient engagement.

In 2019/20 the Trust Executive heard eight board stories from service users about their experiences of its services. These stories ranged from use of psychological programmes to family members talking about the experience they had caring for a relative and the support they received from the Trust after that family member had passed away while still under the care of the Trust. The Trust reports that it implements learning from these stories to improve patient services.

CQC Action Progress

Following the Trust-wide CQC inspection in July 2018 the trust have continued to implement the required improvements. It is noted that there is still one outstanding action remaining for the older adult community mental health teams in relation to completing physical health questionnaires with all patients entering the service and staff recording baseline physical observations, and undertake any necessary monitoring of physical health'.

A subsequent well-led inspection in November 2019, published on 6 March 2020, resulted in 10 'Must do' actions and 30 'should do' actions. Given that this report was published during a Level 4 National Incident, DDCCG notes the Trust prioritised its COVID response. Nonetheless, DDCCG will work with the Trust to monitor progress against these actions as it restores services, structures and processes.

Additional comments

This Quality Account 2019/20 statement provides assurance to members of the public that the CCG is committed to ensuring it assesses and provides a high quality of care across its commissioned services. Within this statement DDCCG recognise and thank DHCFT for working positively and collaboratively with commissioners and key stakeholders to ensure our patients receive a high quality of care at the right time and in the right care setting.

DDCCG looks forward to continuing to work with the Trust and the people it serves over the coming year and beyond.

Brigid Stacey
Chief Nursing Officer
On behalf of Derby and Derbyshire Clinical Commissioning Group

06th November 2020

Feedback from Healthwatch Derby

No specific feedback received from Healthwatch Derby, and this was not pursued given the current COVID-19 pandemic.

Feedback from Healthwatch Derbyshire

No specific feedback received from Healthwatch Derbyshire, and this was not pursued given the current COVID-19 pandemic.

Response to consultation feedback

No comments from the Trust

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 2019/20* and supporting guidance *Detailed requirements for quality reports 2019/20*
- 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 2019 to [the date of this statement]
    - papers relating to quality reported to the board over the period April 2019 to [the date of this statement]
    - feedback from commissioners dated 06/11/2020
    - feedback from governors dated (not applicable this year)
    - feedback from local Healthwatch organisations dated (not available this year)
    - the trust's complaints report published under Regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 2020
    - the national patient survey 11/2019
    - the national staff survey 02/2020
    - the Head of Internal Audit's annual opinion of the trust's control environment dated (not applicable for this year)
    - CQC inspection report dated 06/03/2020
- 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 by delegation to the Quality and Safeguarding Committee

8 December 2020.....Date.....Caroline Mabey.....Chairman

8 December 2020.....Date.....Chief Executive

Notes

Notes

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