Derbyshire Healthcare NHS Foundation Trust
Board of Directors Meeting

Conference Rooms A and B, Centre for Research and Development, Kingsway Hospital

5 November 2019 09:30 - 5 November 2019 12:45

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NOTICE OF PUBLIC BOARD MEETING – TUESDAY 5 NOVEMBER 2019
TO COMMENCE AT 9:30am
CONFERENCE ROOMS A & B, CENTRE FOR RESEARCH AND DEVELOPMENT, KINGSWAY, DERBY

	TIME	AGENDA	LED BY
1.	9:30	Chair's welcome, opening remarks, apologies and Register of Interests	Caroline Maley
2.	9:35	Patient Story	Carolyn Green
3.	10:00	Minutes of Board of Directors meeting held on 1 October 2019	Caroline Maley
4.		Matters arising – Actions Matrix	Caroline Maley
5.		Questions from governors or members of the public	Caroline Maley
6.	10:05	Chair's Update	Caroline Maley
7.	10:10	Chief Executive's Update	Ifti Majid
8.	10:25	STP final document	Vikki Taylor
OPERATIONAL PERFORMANCE, QUALITY, STRATEGY AND GOVERNANCE			
9.	10:45	Integrated Performance and Activity Report	C Wright/A Rawlings/ C Green/M Powell
11:00 B R E A K			
10.	11:15	Clinical Service Strategies: Eating Disorders (All Age) Services; Perinatal Service	Gareth Harry
11.	11:35	Learning from Deaths Mortality Report	John Sykes
12.	11:50	2019/20 Flu Campaign	Amanda Rawlings
13.	12:00	Revised Workforce Race Equality Standards (WRES) action plan	Amanda Rawlings
14.	12:10	Revised Engagement between the Trust Board and the Council of Governors policy	Justine Fitzjohn
15.	12:20	Board Assurance Framework (BAF) - Fourth Issue for 2019/20	Justine Fitzjohn
16.	12:30	Board Committee Assurance Summaries and Escalations: People & Culture Committee 24 September, Audit & Risk Committee 3 October, Quality Committee 8 October, Safeguarding Committee 15 October, 2019 *(minutes of these meetings available upon request)*	Committee Chairs
CLOSING MATTERS			
17.	12:40	- Identification of any issues arising from the meeting for inclusion or updating in the Board Assurance Framework - Meeting effectiveness	Caroline Maley
FOR INFORMATION			
Use of emergency powers by the Chief Executive and the Chair			
Glossary of NHS Acronyms			
Forward Plan for 2019/20			

Questions that are applicable to the agenda, and at the Chair's discretion, can be sent by email to the Board Secretary up to 48 hours prior to the meeting for a response provided by the Board at the meeting. Email: sue.turner17@nhs.net

The Trust Chair may, under the Foundation Trust's Constitution, request members of the public to withdraw for the Board to conduct its remaining business in confidence as special reasons apply or because of information which is likely to reveal the identities of an individual or commercial bodies.

The next meeting will be held at 9.30am on 3 December 2019 in
Conference Rooms A & B, Centre for Research and Development, Kingsway, Derby DE22 3LZ
Users of the Trust's services and other members of the public are welcome to attend the meetings of the Board.
Participation in meetings is at the Chair's discretion

Our vision

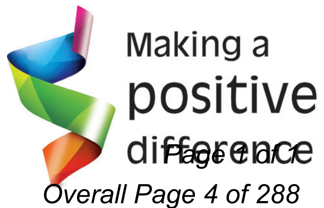
To make a positive difference in people's lives by improving health and wellbeing.

Our values

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

Our Trust values are:

People first – We focus on our colleagues, in the knowledge that a well-supported, engaged and empowered workforce results in good patient care.
Respect – We respect and value the diversity of our patients, colleagues and partners and support a respectful and inclusive environment.
Honesty – We are open and transparent in all we do.
Do your best – We work closely with our partners to achieve the best possible outcomes for people.



DECLARATION OF INTERESTS REGISTER 2019/20		
NAME	**INTEREST DISCLOSED**	**TYPE**
Margaret Gildea Non-Executive Director	• Director, Organisation Change Solutions Limited (mentoring client from First Steps (Eating Disorders) as part of Organisation Change Solutions)	(a, b) (a)
Gareth Harry Director of Director of Business Improvement & Transformation	• Chairman, Marehay Cricket Club • Member of the Labour Party • Mother is a member of Amber Valley Borough Council	(d) (e) (c, e)
Geoff Lewins Non-Executive Director	• Director, Arkwright Society Ltd	(a)
Ifti Majid Chief Executive	• Board Member NHS Confederation Mental Health Network • Kate Majid (spouse) is Hospital Director, The Priory Group	(e) (a, e)
Mark Powell Chief Operating Officer	• Chair of Governors, Brookfield Primary School, Mickleover, Derby	(e)
Amanda Rawlings Director of People and Organisational Effectiveness (DHCFT)	• Director of People and Organisational Effectiveness, Derbyshire Community Healthcare Services (DCHS) • Co-optee Cross Keys Homes, Peterborough	(e) (e)
Dr Julia Tabreham Non-Executive Director	• Non-Executive Director, Parliamentary and Health Service Ombudsman • Director of Research and Ambassador Carers Federation	(a) (d)
Dr John Sykes Medical Director	• Undertakes paid assessments of patients at the request of the local authorities under the Mental Health Act and Mental Capacity Act and acts likewise for solicitors representing patients.	(e)
Richard Wright Deputy Trust Chair and Non-Executive Director	• Executive Director, Sheffield Chamber of Commerce • Chair Sheffield UTC Multi Academy Trust • Board Member, National Centre of Sport and Exercise Medicine Sheffield	(a) (a) (d)

All other members of the Trust Board have nil interests to declare.

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

MINUTES OF A MEETING OF THE BOARD OF DIRECTORS

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

Tuesday 1 October 2019

MEETING HELD IN PUBLIC	
Commenced: 9.30am	Closed: 12 noon

PRESENT	Caroline Maley	Trust Chair
	Richard Wright	Deputy Trust Chair and Non-Executive Director
	Margaret Gildea	Senior Independent Director and Non-Executive Director
	Geoff Lewins	Non-Executive Director
	Dr Julia Tabreham	Non-Executive Director
	Dr Anne Wright	Non-Executive Director
	Suzanne Overton-Edwards	Non-Executive Director
	Ifti Majid	Chief Executive
	Claire Wright	Deputy Chief Executive & Director of Finance
	Carolyn Green	Director of Nursing & Patient Experience
	Mark Powell	Chief Operating Officer
	Dr John Sykes	Medical Director
	Amanda Rawlings	Director of People Services & Organisational Effectiveness
	Gareth Harry	Director of Business Improvement & Transformation
	Justine Fitzjohn	Trust Secretary
IN ATTENDANCE	Perminder Heer	NExT Director
	Dr Sheila Newport	Non-Executive Director Designate (shadowing Anne Wright)
	Anna Shaw	Deputy Director of Communications & Involvement
	Steve Jones	Chief Pharmacist (shadowing Mark Powell)
	Sharon Rumin	Team admin support (shadowing Caroline Maley)
	Jake Chilvers	Graduate Management Trainee (shadowing Ifti Majid)
	Shirley Parker	Named Nurse Safeguarding (shadowing Carolyn Green)
VISITORS	John Morrissey	Public Governor, Amber Valley
	Julie Lowe	Public Governor, Derby City East
	Christopher Williams	Public Governor, Erewash
	Sandra Austin	Derby City & South Derbyshire Mental Health Carers Forum and Trust Volunteer
	Grace Constantinou	Graduate Management Trainee
	Kevin Parkinson	CEO, First Steps
	Nicola Fletcher	Assistant Director of Clinical Professional Practice for item DHCFT2019/131
	Peter	For item DHCFT2019/131
	Narinder Kaur	Service Manager for item DHCFT2019/131

DHCFT 2019/130	**<u>CHAIR'S WELCOME, OPENING REMARKS, APOLOGIES FOR ABSENCE AND DECLARATION OF INTERESTS</u>** The Trust Chair, Caroline Maley, welcomed everyone to the meeting and introductions were made. There were no apologies for absence and no declarations of interest were made on the agenda items.
DHCFT 2019/131	**<u>PATIENT STORY</u>** Caroline welcomed Peter to the meeting who shared his experiences of the Living Well Programme, run at Dovedale Hospital. Being from a management training and personal development background he was able to assess the effectiveness of the programme from both a personal and professional perspective. Peter felt his medical diagnosis fitted the Living Well Programme well and despite his initial concerns about how his behaviour would be viewed he was very complimentary on how the programme was delivered and felt better for taking part. He gave praise to the trainer, Jess Whittaker, for running the well prepared participative programme adding it had clear objectives and structure. His one observation was that the quality of the presentations by external speakers was more varied. Peter suggested that a solution to this might be for the trainer to act as the lead co-ordinator for all elements of the programme. Mark Powell, Chief Operating Officer, agreed to follow up on this point. **Action: MP to feedback comment on quality of external presentations and suggestion for an overall lead co-ordinator for the programme.** Ifti Majid, Chief Executive, asked if the Trust had offered a place on the programme fast enough and Peter responded that the timing had been right for him, coming some while after diagnosis. He added he might not have benefitted as much if he had done it earlier. Peter explained that he had been offered the next stage of the programme and may take this up at some time in the future. Carolyn Green, Director of Nursing & Patient Experience, asked a question about participation rates and waiting times. Narinder Kaur responded that it was usually around 20 people for each intake (10 participants and their carers/partner) but there can be a large fall out rate. The waiting times were around 2 months but she added that this time can allow a positive opportunity to absorb a diagnosis and think about the programme and if it is right for them. Peter was thanked for attending and sharing his story with the Board.
DHCFT 2019/132	**<u>MINUTES OF THE BOARD OF DIRECTORS MEETING HELD ON 3 SEPTEMBER 2019</u>** The minutes of the previous meeting, held on 3 September 2019, were accepted as a correct record of the meeting.
DHCFT 2019/133	**<u>ACTIONS MATRIX</u>** The Board agreed to close all completed actions. Updates were provided by members of the Board and noted on the actions matrix. All completed 'green' actions were scrutinised to ensure that they were fully complete and actions that were not complete

	were challenged with Executive Director leads. There was a correction to the date for the WRES (Workforce Race Equality Standards) Action Plan to come to the Board on 5 November, not October. **MATTERS ARISING** No items outside of the actions matrix.
DHCFT 2019/134	**QUESTIONS FROM GOVERNORS OR MEMBERS OF THE PUBLIC** None received.
DHCFT 2019/135	**CHAIR'S UPDATE** Caroline's report provided the Board with the Trust Chair's summary of activity and visits to the Trust's services undertaken since the previous Board meeting held on 3 September. The following issues were highlighted: • An overview of two visits to the Mental Health Liaison Team based at the Royal Derby Hospital – Caroline added how impressed she had been with dedication and commitment of the team. She referred to the target of seeing/assessing the patients within one hour and some of the challenges of having to work with 4 – 5 different IT systems. Key achievements were a significant reduction in the number of A&E attendances by patients who attend frequently, in some cases by up to 70% and the teaching and training of the hospital staff on mental health issues. Caroline stated that it felt like one team and was a good example of system working. • An update on the matters discussed at the last Council of Governors meeting, including the Non-Executive appointments of Dr Sheila Newport and Suzanne Overton-Edwards and an update on waiting lists. Caroline had recently met with Staff Governors and she also gave an update on recent governor elections. • Annual Members Meeting (AMM) – held on 11 September. Attendees had commented that it had been the best ever AMM meeting. The writing competition had been a huge success as had the showcase to celebrate equality, diversity and inclusion. Caroline gave her thanks to the governors and the Communications and Involvement team who had been involved in the planning and delivery of the meeting. • Board Development on 18 September had focussed on living our values – People First and Respect. The focus was on developing a person centred leadership culture and using a feedback model to be open and honest in terms of providing feedback – both appreciative and constructive feedback were explored. • Non-Executive Director development – quarterly meetings continue and the appraisal process had recently commenced for the Chair and NED appraisals for Julia Tabreham, Margaret Gildea . A 360 new tool is being used. • Recent Joined Up Care Derbyshire (JUCD) events – including a stakeholder event and a JUCD Board meeting, highlights of which had been included as an appendix. • Discussion items at a Chief Executive and Chairs meeting hosted by NHS Providers had included a strategy and policy update from Chris Hopson, CEO of NHS Providers with a panel session exploring Primary Care Networks and a Briefing on Brexit planning and the No Deal implications.

	Mark reminded the Board that the Liaison Team was funded by national transformation monies as part of the Mental Health element of the Long Term Plan. The funding was circa £0.5m to bring service standards up and shows really positive working with partners. John Sykes, Medical Director, added that it was an example of two cultures coming together to get a better result. **RESOLVED: The Board of Directors noted the activities of the Trust Chair since the last meeting held on 3 September 2019.**
DHCFT 2019/136	**CHIEF EXECUTIVE'S UPDATE** Ifti's report gave a summary of the changes within the national health and social care sector, as well as an update on developments within the local Derbyshire health and social care community. The report also includes feedback from external stakeholders, such as commissioners, and feedback from staff. The following issues were highlighted: • National context – the shift in focus in regulators and regulatory activity, shown in the NHS Providers annual survey into regulation and the revised oversight framework. The Board noted the different approach for Performance Review Meetings (PRMs) which would now be done as a system rather than with individual Trusts Ifti added that regulators, in some areas, were coming straight to providers on services instead of the CCG. • Local context – progress on developing Integrated Care Partnerships (ICPs) in Derbyshire. ICPs are a formal alliance of a number of providers, often including statutory NHS, Local Authorities and the voluntary and independent sector that come together to deliver an agreed specification for a range of services for an agreed population National Guidance on how to create ICPs has been issued and options need to be agreed in Derbyshire within the next few months. • Preparing for CQC inspection – the information requests had been completed and signed off. Work was in hand to ensure colleagues are confident to outline where they are 'Making a Positive Difference". A series of newsletters have been launched to remind colleagues of some of the great initiatives from the last year that have had an impact on culture, leadership, innovation and quality as well as supporting the delivery of the Trust strategy. • Annual Members Meeting – Ifti agreed with the view that it had been the best one yet, he thought it matched the Trust's culture of being person centred. • The formation of an East Midlands Mental Health and Learning Disability Alliance. A Memorandum of Understanding will be submitted to the next Board meeting. • An update was given on communication activities including Ifti's TV interview on inclusion and his speech at the First Steps Eating Disorder Conference. The Trust had been operating in partnership with First Steps for a long time. • 'Ifti on the road' – Ifti had been to the Hartington Unit and the Kingsway site, he was pleased that this was now part of the fabric; reaching colleagues and service users. Feedback from 'Ifti on the road' was noted. Julia Tabreham, Non-Executive Director, added that it was good to see momentum and clarity as well as focus on communities both locally and nationally. It was important to align the work to supporting infrastructures such as estates, IT, workforce and organisational development. A discussion took place on ICPs and the need to deliver infrastructure and harmonise

	policies and procedures. Suzanne Overton-Edwards, Non-Executive Director, added that it was interesting to learn what other local ICPs are doing and how we are learning from them. Following hearing about the Patient Story on the Street Health Project at JUCD, the Board agreed that it was important to have the voluntary sector on the programme delivery board, for example Angela Kerry and Roger Kerry. Claire Wright, Deputy Chief Executive and Director of Finance, commented on the success of the recent annual BME Network Conference which had also given the Executives the opportunity to share their show cased experiences with their mentors in the Reverse Mentoring programme and she also noted the positive work on the updates on the WRES (Workforce Race Equality Standards) Action Plan. She added that there had been a good turnout of Executive Directors. Ifti reflected that he would have liked to have seen a wider attendance from Non-Executive Directors and thanked Caroline and Suzanne-Overton Edwards for attending. Richard Wright, Deputy Chair and Non-Executive Director, referred to the changes to the oversight framework and the implications on the Trust. Ifti outlined the system challenges and the shift in the role of the strategic commissioner, for example transferring the management of the mental health investment standards direct to the Mental Health Alliance, away from the CCG. Richard highlighted the potential conflict between the system and individual Trusts and the challenge to the role of directors in Sovereign Boards. Ifti added that the contract round will be a test of the current provider/commissioner relationship versus the strategic system. Mark added that the regulators were shifting to system performance management and gave the example of urgent care and the need to own and resolve the issues as a system. **RESOLVED: The Board of Directors scrutinised the Chief Executive's update, noting the risks and actions being taken.**
DHCFT 2019/137	**STP REFRESH SUMMARY AND UPDATE** The Board received the JUCD report on the STP Refresh. This was in essence an advance report, the final version of which would be submitted for sign off at the next meeting. System partners were required to feedback to next JUCD Board ahead of the formal submission. Ifti summarised the content adding that the original quadruple aims were still as relevant. The biggest shift had been in focus to people from patients and the refresh included a greater emphasis on prevention and public health. The system had learnt from the way the strategy had been first communicated; the focus on bed reduction figures in the system had taken the focus away from other elements. It was noted that the JUCD five year plan reflected the NHS long term plan. Carolyn Green added that she would provide her comments formally on elements of the paper including the Clinical professional reference group and the need for the diagrams to reflect services, for example in in early intervention. She added that although there had been good progress in connecting services, not all system partners were repositioning and this was impacting on services, for example school nurses. Richard commented that the paper needed to reflect more of the fundamental society issues; not just health. Geoff Lewins, Non-Executive Director, added that this was a very ambitious programme

	with lots of actions and needs to be fully co-ordinated. Ifti responded that the paper does describe the challenges but JUDC was trying to create an infrastructure based on population outcomes. He explained the role of ICS, Strategic Commissioning and Primary Care Networks (PCNs) adding that none of these are statutory organisations with specialist knowledge, as that sits with the providers. The Board had discussed the system versus sovereign issues previously and it was hoped that this will shift when better results are seen. The Board noted the key role of the Mental Health System Delivery Board to focus on mental health outcomes for the Derbyshire system. Gareth Harry, Director of Business Improvement & Transformation, felt that we were moving into a different place, a good example being PICU (Psychiatric Intensive Care Unit) and Out of Area (OOA) placements, the system had worked together and had seen some short term improvements in terms of clinical outcomes and transformational opportunities. He added that he was leading a piece of work to look at how the system can work differently to the current transactional/contractual relationship and at the same time act within a Mental Health Alliance. The Board would receive a report proposing this shift in the near future. Julia welcomed the population outcomes focus around prevention and best care for end of life. The Board felt that the messages needed to be simplified around the STP Strategy particularly in the public communications and Ifti agreed to talk to John MacDonald, JUCD Independent Chair. **Action: Ifti to raise the matter of simplifying the messages contained in the JUCD five year plan with John MacDonald.** Mark added that the strategy needed further narrative about people, particularly the vital role of leadership and how we develop people to work in collaboration. It was agreed that all comments should be sent to Claire Wright and Richard Wright for them to report into JUCD. **RESOLVED: The Board of Directors:** **1) Noted the summary of the STP refresh requirements** **2) Noted that owing to the delay in guidance being received and scheduling the draft plan is still in development; The Board therefore acknowledged the submission will come to the meeting for approval in early November** **3) Supported the direction of travel set out in the journey to become an ICS by April 2021.**
DHCFT 2019/138	**INTEGRATED PERFORMANCE AND ACTIVITY REPORT** The Integrated Performance Report (IPR) provided the Board of Directors with an overview of Trust performance at the end of August 2019. The main areas drawn to the Board's attention were: • Finance - Claire reported that the surplus of £1.2m was ahead of plan by £0.2m but there are significant cost pressures and risks to be mitigated in the months ahead. She referred to the deep dives and additional analysis for forecasting that had been undertaken. In addition she noted the level of confidence to meet the year-end target would need to improve in order to achieve the planned outturn. She emphasised that the risk rating of 'Extreme' on the Board

	Assurance Framework remained at that level and that a key review point would be around mid-November following two additional months of financial performance to be reflected in the forecasting deliberations. This would allow the Board to discuss at its December meeting. • Operations - Patients placed out of area – PICU (Psychiatric Intensive Care Unit) and adult acute – Mark reported that the work of the two focused task and finish groups had already seen significant reductions in these areas. Waiting list for autistic spectrum disorder (ASD) assessment – there had been a detailed discussion at the Finance and Performance Committee (FPC) and the Executive Leadership Team were currently looking at options for reporting back to FPC. Waiting list for psychology – there had been discussions at both the Quality Committee and FPC on improving access to therapies. Mark explained that referrals from November to February had increase by 20 % but this had not continued so the actions being taken would show improvements in waiting times, An update was also given on current waiting lists for Child and Adolescent Mental Health Services (CAMHS) and community paediatrics. • Workforce - The Board received the latest performance figures for annual appraisals, Staff sickness and vacancies, noting the development areas for improvement. • Quality - Following the changes to the single oversight framework, an extensive mapping exercise has been undertaken to analyse the reporting systems and required indicators. Results will be reported back to the Quality Committee in October and the IPR will be updated to include a detailed quality section. **RESOLVED: The Board of Directors received assurance on current performance across the areas presented.**
DHCFT 2019/139	**CLINICAL STRATEGIES 2019-22** Gareth presented for agreement the first two Clinical Service Strategies created through the Clinically-Led Strategy Development (CLSD) process, those for the Older Age Adult Service and the Working Age Adult Service. The Board noted the involvement of patients and carers in the development and the arrangements that maximised engagement of clinical teams, with over 500 colleagues being involved in the development process. The Strategies set out the vision of where the Trust wants to be for these services in next 3 – 5 years with alignment to the Trust Strategy building blocks and other key requirements including NICE guidance and the Long Term Plan. Gareth explained that the next steps were to move to implementation and he outlined the key roles of the Transformation Board and the working groups to take forward at clinical level. It was noted that these were the first 2 of 8 enabling strategies to come through for approval. Caroline asked about the links with the JUCD system work and Gareth responded that there was there was nothing in the strategies that contradicts the system or the Long Term Plan. Margaret Gildea, Non-Executive Director, added that the methodology

	included partners and it was essential to carry on the links into system within the working groups. It was noted that a wider discussion on the Trust Strategy and enabling strategies and the impact of the Integrated Care Partnership(s) would take place at the Board Development Session in November. **Action: Gareth to produce an update on the clinical and enabling strategies for Board Development Session in November** Caroline challenged whether there was capacity in Trust to deliver everything and Gareth responded that prioritisation was required as not everything could be done at once. Richard was conscious that the strategies were high level but referred to the challenges of recruiting staff and the investment needed in psychological therapies and stated that there needed to be more detail provided to the Board on the investment needed and the return on investment. Gareth added that there was already investment in psychological disorders. Geoff made a challenge on management bandwidth, resourcing and prioritisation adding that the Board is key to this. Ifti stated the importance of the 8 enabling strategies as being the foundation for everything the Trust is trying to achieve. Carolyn remarked on the progress made in the last 18 months and commended staff. She stated that the principle of listening to the staff voice and the patient voice is critical to delivery. Margaret requested that additional comments be notified to Gareth to build into Programme Board. **Action: Comments from Trust Board Members on Clinical Service Strategies for Older Adults and Working Age Adults to be built into Programme Board** **RESOLVED: The Board of Directors:** **1) Agreed the Clinical Service Strategies for Older Adults and Working Age Adults** **2) Noted the process undertaken to develop the strategies and the extent to which they have been developed by colleagues in frontline service delivery roles** **3) Agreed to the establishment of the Clinical Services Strategies Transformation Board** **4) Noted the need for working groups established at clinical service level, reporting to the Clinical Services Strategies Transformation Board, to lead implementation of the service development plans and the importance of leadership in this process of Clinical Directors, Clinical leads and other clinical leaders in delivering.**
DHCFT 2019/140	**<u>LOOKED AFTER CHILDREN ANNUAL REPORT 2018/19</u>** The Board received an overview of the progress, challenges, opportunities and future plans to support and improve the health and wellbeing of Looked After Children in Derby City via the 2018/19 Annual Report. The report had been scrutinised by the Safeguarding Committee which was assured by the sustained and improved performance and governance safeguards in place, set in the context of a 12% increase in Children Looked After. Carolyn was assured that the

	Trust provided a strong service and there were some marginal areas for improvement as set out in the report. The CCG had also confirmed and have been assured that the service is overall at a good standard. Anne Wright, Non-Executive Director, referred to the continual increase in demand and challenged whether the Trust has the workforce to deal with this. Carolyn responded that staffing was marginally under establishment but highlighted that the Health Visitor and School Nurses service was under pressure and that the risks would need to be managed. Relating to the equality-related impacts in the report, Ifti asked about the services to support for the children of people seeking asylum and it was noted that there was a social care offer for unaccompanied children following investment by the Local Authority. This meant that more children are able to have help earlier but this needs to be monitored and the Quality and Safeguarding Committee would keep a watching brief on the issue. **RESOLVED: The Board of Directors:** **1) Received assurance of the work completed in the Safeguarding Committee, the external review by commissioners and the work within the Trust around looked after children and young people and the continued partnership working to ensure the best outcome is achieved for this vulnerable group of children and young people** **2) Accepted the annual report in the public domain as required by the Trust's statutory duties.**
DHCFT 2019/141	**<u>A FRAMEWORK OF QUALITY ASSURANCE FOR PATIENT STORIES TO THE BOARD</u>** The Board received an overview and assurance regarding patient stories and the impact they have. It was agreed that the stories were extremely helpful in setting the scene at Board meetings, helping the Board to understand why certain issues matter and to make sure that the improvements to the services are based on their respective feedback. Carolyn explained that the CQC would be looking to hear that these stories make a difference and the report set out the evidence that patient stories do influence the Board in their strategic intent and direction of travel. There is also evidence of clinical strategy improvement plans and impacts on services and on individuals. It was noted that some equality gaps remain and are known areas of risk in the Board Assurance Framework with requirements outlined in the Trust strategy to continually improve and reduce this inequality. Richard was pleased to see such a positive paper and Caroline added that she could still visualise people who have shared their stories, such was their impact. It was agreed that patient stories would be helpful in JUCD so there can be learning from system failures in order to make improvements. Carolyn asked Board members to let her know if there were any specific services they would like to see covered by patient stories and she would continue to cover all areas and strategic aims. It was agreed that it was useful to have a mix of positive and not so positive stories and to schedule an update in twelve months or then receive a report every two years.

	Action: Update report on Patient Stories to Board to be scheduled in the forward plan in October 2020. **RESOLVED: The Board of Directors accepted the report and received assurance that patient stories continue to have an impact and do influence the Board in their strategic intent and direction of travel.**
DHCFT 2019/142	**<u>BOARD COMMITTEE ASSURANCE SUMMARIES AND ESCALATIONS</u>** Assurance summary reports were received as follows: <u>Mental Health Act (MHA) Committee</u> Anne Wright, Committee Chair, highlighted the following matters: • S117 – rising aftercare costs and the impact on people being placed in “rehabilitation” nursing homes but not being reviewed with an aim of returning to community living. The CCG was undergoing a review which the Trust would be involved in. • Work between the Trust and the University Hospitals of Derby and Burton Trust on the increasing MHA assessment activity in A&E and the implications for planning of integrated care services as part of JUCD. • Training compliance - targets and trajectories were being reviewed. More mandatory fields would be introduced into the EPR (Electronic Patient Record) to help maintain high compliance standards. Caroline Maley referred to the recruitment of seven new Associate Hospital Managers (AHM) and a recent training session. <u>Quality Committee</u> Margaret Gildea, Committee Chair, highlighted the following matters: • Focus on BAF risk 1A – this would also be done as a deep dive to the January Audit and Risk Committee. • Acute Care Pathway – significant discussions took place on improvements and how they will be achieved. • Reverse Commissioning Mentoring report on the health needs and inequalities in the BME population within Derbyshire. Reverse Commissioning Group Terms of reference agreed. • Clinical Audit – The interconnection of continuous and quality improvement plan was endorsed as the correct direction of travel, subject to a business case. • Annual Reports received for Complaints and Compliments, Health & Safety Report, Chief Pharmacist’s and Clinical Audit. <u>Finance and Performance Committee</u> Richard Wright, Committee Chair, highlighted the following matters: • BAF risks - Finance plan risk – being ‘Extreme’ the Committee had asked for additional gap to be articulated with measures to achieve target rating (taking account of the top rated risk in the finance risk table on cost pressures). Claire Wright confirmed this had been actioned. • 2019/20 Financial Performance – discussions on year to date performance and the forecast assumptions. Remains a requirement to deliver significant cost

	reduction in order to achieve plan (due to cost pressures required for quality and strategic priorities) as discussed earlier in the meeting. • Equality, Diversity and Inclusion (EDI) reporting discussed: both in individual reports to Committee and the collation of a mid-year report in line with Committee EDI objective. Geoff Lewins would be raising this at the Committee Chairs meeting to ensure mid-year discussions for all Committees so it is not left till year end. • Review of updated Terms of Reference - added CEO's right to attend any meeting. Caroline Maley remarked on the significant amount of work done by the Board through its Committee structures. **RESOLVED: The Board of Directors received and noted the Board Committee Assurance Summaries.**
DHCFT 2019/143	**IDENTIFICATION OF ANY ISSUES ARISING FROM THE MEETING FOR INCLUSION OR UPDATING IN THE BOARD ASSURANCE FRAMEWORK (BAF)** There were no additional items for inclusion and updating within the BAF on the basis that there had been an enhancement focus on the BAF at last meeting.
DHCFT 2019/144	**2019/20 BOARD FORWARD PLAN** The 2019/20 forward plan was noted and will continue to be reviewed further by all Board members.
DHCFT 2019/145	**MEETING EFFECTIVENESS** Board members felt that appropriate amounts if time was given to items. There was a comment that the JUCD refreshed strategy, running at over 100 pages was not in the right format for discussions at a Public Board. Caroline invited feedback from the people shadowing at the meeting. Steve Jones had been impressed with the scope and width of the issues discussed but stressed the need to get pharmacy in everyone's line of sight. Jake Chilvers thanked the Board for the invite adding it was good to see where matters are escalated how information gets to the Board from ground up. Sharon Rumin agreed to take matters back to her workplace and the BME networks but reminded the Board of the importance of using plain English to help with communications of some of the more complex issues. Shirley Parker added that it was useful to hear the discussions on Children's Services, family thinking and seeing how Trust services joined up. Attendees and visitors were thanked for their attendance at today's meeting.
The next meeting of the Board to be held in public session will take place at 9.30am on Tuesday 5 November 2019 2019 in Conference Rooms A and B, Centre for Research and Development, Kingsway Hospital, Derby DE22 3LZ	

				BOARD OF DIRECTORS (PUBLIC) ACTION MATRIX - NOVEMBER 2019			
Date	**Minute Ref**	**Item**	**Lead**	**Action**	**Completion Date**	**Current Position**	
3.9.2019	DHCFT20 19/122	Workforce Race Equality Standards (WRES) 2018/19	Ifti Majid/ Amanda Rawlings	A revised WRES action plan to be presented to the Board for approval that is applicable to the Trust rather than the national position at the Board meeting to be held on 5 November	5.11.2019	Revised WRES action plan submitted to November meeting.	Green
1.10.2019	DHCFT20 19/131	Patient Story	Mark Powell	MP to feedback comment on quality of external presentations and suggestion for an overall lead co-ordinator for the programme	5.11.2019	Feedback provided to the team. Facilitator will continue to lead sessions and is to refocus external speakers where needed to ensure every aspect is covered.	Green
1.10.2019	DHCFT20 19/137	STP Refresh and Update	Ifti Majid	Ifti to raise the matter of simplifying the messages contained in the JUCD five year plan with John MacDonald	5.11.2019	The need for simplified messaging relating to wider communications to the public has frequently been discussed in system meetings and CEO meetings	Green
1.10.2019	DHCFT20 19/139	Clinical Strategies 2019-22	Gareth Harry	Gareth to produce update on Clinical Strategies and enabling strategies for Board Development Session in November	5.11.2019	Emerging models of integration and the implications for DHcFT facilitated by Gareth Harry is scheduled for November Board Development day	Green
1.10.2019	DHCFT20 19/139	Clinical Strategies 2019-22	All	Board Members to provide additional comments to Gareth on Clinical Service Strategies for Older Adults and Working Age Adults for addressing at the Programme Board	5.11.2019	Comments from Trust Board Members on Clinical Service Strategies for Older Adults and Working Age Adults are being dealth with through the Programme Board by Gareth Harry.	Green
1.10.2019	DHCFT20 19/141	A Framework of Quality Assurance for Patient Stories to the Board	Sue Turner	Update report on Patient Stories to Board to be scheduled in the forward plan in October 2020	5.11.2019	Scheduled into 2020/21 forward plan	Green

Resolved	**GREEN**	**6**	**100%**
Action Ongoing/Update Required	**AMBER**	**0**	**0%**
Action Overdue	**RED**	**0**	**0%**
Agenda item for future meeting	**YELLOW**	**0**	**0%**
		3	**100%**

Derbyshire Healthcare NHS Foundation Trust
Report to the Public Board of Directors – 5 November 2019

Trust Chair's report to the Board of Directors

Purpose of Report

This report is intended to provide the Board with the Trust Chair's reflections on my activity with and for the Trust since the previous Board meeting on 1 October 2019. The structure of this report reflects the role that I have as Trust Chair.

Our Trust and Staff

1. I continue to make a point of visiting as many front line services as possible, so that my leadership is grounded on the reality of what our staff face every day, and also to ensure that I have a good understanding of the services provided by the Trust.

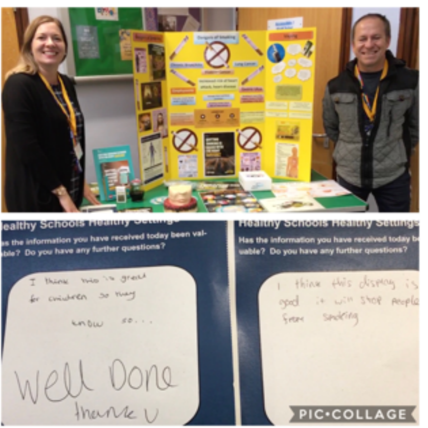
2. On 25 September I attended the Black and Minority Ethnic (BME) conference held in the R&D Centre. It was really good to see the commitment to making a positive difference for those who work for us, and to address some of the issues that we see in the Workforce Race Equality Standards (WRES) data which we are addressing – such as equal opportunities for development and promotion; recruitment which is done differently to remove any unconscious bias, and the reviewing the processes which result in BME staff experiencing more disciplinary processes than others. This work is now progressing with real focus. I have also taken time over the past month to talk to some of our BME staff who have experienced racism so that I can understand their stories. I am determined that we have a zero tolerance of racism in our Trust, including from service users to staff, and we must learn the lessons from incidents where this has happened so that the way that we work recognises and welcomes the diversity of our staff. It was a pleasure to welcome Sharon Rumin, the Vice Chair of the BME Network as my shadow at the last Board.

3. On 26 September 2019 I attended the Schwartz Round held at the Radbourne Unit. This was a powerful and emotional story from a staff member, under the title of "Are you OK?". It reminded me that we need to ensure that our culture is compassionate, and that we do look after the wellbeing of all of our staff, as the work that they are required to do is in a tough environment with lots of demands - physical and mental.

4. On 4 October, I observed an outpatient clinic at Matlock, where in the course of a morning a wide range of patients was seen. It was noticeable that the consultant was familiar with his patients, and also was taking an interest in their physical as well as mental health.

5. On 15 October I joined the Healthy Schools team delivering a Hand Washing session that St Martins School. The classes were keen to participate in the hands on work, especially when the hand box showed them where they had missed when washing their hands.

This was followed by a Stoptober display at the Bemrose School where lunch time was an opportunity to encourage the students to live a healthy lifestyle and not to smoke, or give up smoking. This second visit was a clear reminder of the diversity of our population, with many different languages and groups being evident as they "mobbed" our table. Our staff clearly built good rapport with the students and the messages were unmissable. It was evidence of our staff working to prevent future ill-health.



6. On 22 October I visited Rivermead where I met with Learning Disability staff and Child and Adolescent Mental Health Services (CAMHS) Family Practice staff. I find that there is always something that I learn from meeting our staff and hearing what is concerning them. In the afternoon I visited the CAMHS Rise team who are based on the Puffin Children's ward at the Royal Derby Hospital. They provide the liaison support for the Children's Emergency Department and also services which help to reduce the likelihood of admission.

7. On 24 October I visited the Hartington Unit and was able to shadow the bleep holder for a few hours. This was a great insight into the work of our staff on the unit and a salutary reminder to me of the challenges that they deal with on a daily basis. It was good to see the continued improvements that are being made as part of the transformation programme.

   My thanks go out to all of the staff I met for making me so welcome during the many and varied activities and visits that I undertook, and also for being so open and honest with me about what they thought of the Trust and how we are doing in delivering services and putting our people first.

Council of Governors

8. During the month I met with Lynda Langley, Lead Governor and Kelly Sims, Chair of the Governance Committee. Both of these Governors are working well to support the Council of Governors to deliver their duties. In these meetings we share thoughts on the agendas for the various governors meetings and discuss opportunities and challenges. This is an important part of my role in supporting the Council and I thank Lynda and Kelly for the work that they do.

9. The Governance Committee met on the 10 October, and was well attended. Time was spent at this meeting considering the progress made on the Membership Engagement Plan, as well as the Membership Strategy.

10. The Council of Governors and Board met together on 16 October to consider progress that is being made on the Clinical Strategies which were conceived at the similar meeting last year; the estates strategy, and the work that has started to assess our Electronic Patient Record implementation.

11. On Thursday 17 October we welcomed two new Governors following the recent public elections, and one returning Governor to the Trust. We provide a comprehensive induction for all our Governors at the start of their term.

12. The next meeting of the Council of Governors will be on 5 November after the

public Board meeting. The next Governance Committee takes place on 10 December. The Nominations and Remuneration Committee will be meeting as required over the course of November to appoint a new Non-Executive Director (NED) and to receive my appraisal and the appraisal of two of the NEDs.

Board of Directors

13. Board Development on 16 October was spent considering our performance against the Key Lines of Enquiry in preparation for the Well Lead Review by the CQC expected over the next few months. This time was valuable in reminding us how much we have done since our last review and the progress that we continue to make against our values and our strategy.

14. In October I have completed the appraisals of Margaret Gildea and Julia Tabreham, and my own appraisal is substantially complete. During these meetings we review our performance against objectives set at the beginning of the appointment / review cycle, as well as discuss generally mutual views on the progress of the NED and the Trust and any personal development requirements. I have also met with Perminder Heer, our NExT Director to consider the progress she has made on her placement with us.

15. During the next month we will be recruiting a sixth NED, with the aim of ensuring that we improve the diversity of our Board. Suzanne Overton-Edwards is filling this gap with an interim appointment, and we have Perminder Heer with us as our NExT Director through to August 2020.

System Collaboration and Working

16. On 2 October, I joined a large gathering of leaders arranged by NHS Improvement / NHS England (NHSI/E) from across with Midlands to hear more about the journey we are all on to becoming integrated care systems (ICS). As always, these events are useful opportunities to hear from others who may be further along the journey, or have introduced useful place based service delivery. In the evening the provider chairs in Derbyshire met with John MacDonald, the Joined Up Care Derbyshire (JUCD) Independent Chair to consider ways in which we could make further progress on our journey to becoming an ICS.

17. On 18 October, JUCD Board met and Richard Wight attended as my deputy. Attached as Appendix 1 are the key messages noted from this meeting.

Regulators; NHS Providers and NHS Confederation and others

18. On 8 and 9 October, I attended the NHS Providers Conference in Manchester, being joined by Claire Wright, Geoff Lewins and Justine Fitzjohn. A highlight for all of us was the plenary session with Isabel Hardman and Sue Baker OBE. This session focussed on how prevention can play a key role in managing mental health, both for individuals managing their own mental health issues, and more broadly in society. It was also a reminder of the support that an organisation can give their staff who are suffering with mental ill-health. It was a powerful session. We also heard from the Secretary of State for Health and Social Care, Matt Hancock.

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

innovative and safe care	
2) We will ensure that the Trust is a **great place to work** by attracting colleagues to work with us who we develop, retain and support by excellent management and leadership	X
3) We will make the **best use of our money** by making financially wise decisions and will always strive for best value to make money go further	X

Assurances

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

Consultation

This report has not been to other groups or committees.

Governance or Legal Issues

None

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

This report reflects a wide range of activities across the Trust, and consideration relating to ensuring inclusion is embedded in operational work of the Trust. The specific services visited provide support to those with protected characteristics by the nature of their work.
With respect to our work with governors - we work actively to encourage a wide range of nominees to our governor elections, and strive that our Council of Governors is representative of the communities they serve. We also provide support to any current or prospective governors to enable them to carry out their role to address any specific needs they may have. This includes providing transport for those who may not be able to access public transport due to physical needs, accommodating communication requirements and providing support workers at meetings.

Demonstrating inclusive leadership at Board level

Through the Trust's involvement in the NExT Director scheme we are supporting the

development of those who may find it more difficult to be appointed as a NED in the NHS. Perminder Heer has a placement with us thereby continuing to support the system development of future potential NEDs from diverse backgrounds.

New recruitment for NEDs and board members will proactively seek to appoint people from protected characteristics, thereby trying to ensure that we have a Board that is representative of the communities we serve.

Recommendations

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

Report prepared and presented by: **Caroline Maley**
Trust Chair

Appendix 1

Board Update on Joined Up Care Derbyshire – October 2019

PURPOSE

This report provides an update on key developments related to Joined Up Care Derbyshire, the local Sustainability and Transformation Partnership. The aim is to ensure partnership boards, cabinets and governing body are kept abreast of progress.

MATTERS FOR CONSIDERATION

Integrated Care System/STP Chairs Meetings
John Macdonald, Joined Up Care Derbyshire (JUCD) Chair, has attended a number of national and regional events where experience and issues have been shared across leaders from the NHS and local authorities. Themes emerging from these discussions which are consistent with the outputs from Derbyshire's local Integrated Care System (ICS) development programme in relation to those things we said we would do over the next 6 months on our journey to become an ICS by April 2021. These include:

- Agree our 5 year System Transformation Strategy
- Be able to evidence the impact of our Transformational Change Programmes
- Be clear on the role of Primary Care Networks (PCN) and how they work with other community providers
- Continue to build resilience and services provided at Place Alliance level
- Embed Population Health Management at Place Alliance and PCN level
- Describe how many Integrated Community Providers Derbyshire will have and what benefits they will offer for our communities
- Implement a system wide Board level OD programme to help organisations increasingly work in the system space
- Develop a shared system financial plan for future years

JUCD Board will review progress at its November Board meeting and consider the next steps.

Delivering the NHS Long Term Plan: Financial Regime
NHSE/I have published details of Future financial architecture, system planning and FRF allocations. This reshapes financial support for the provider sector moving from centrally controlled totals and PSF to a targeted financial recovery fund (FRF). The recent announcement on capital for a number of hospitals across England and discussions about a strategic approach to improving our hospitals and health infrastructure within the Department of Health and Social Care may also have implications for the way the ICS accesses capital. The implications of this for how we operate as a system will need to be considered at the JUCD Finance Committee before coming to the JUCD Board.

Joined Up Care Derbyshire Refresh - draft submitted
The Joined Up Care Derbyshire Plan has been refreshed this summer and our first draft has been submitted to NHS England/Improvement for review. We've taken the step of adding the draft plan to the Joined Up Care Derbyshire website, please visit https://joinedupcarederbyshire.co.uk/about/our-plans to review it.

Our overarching priorities remain the same, but this refreshed plan also includes details of how the system is to deliver the NHS Long Term Plan (LTP), published in January.

Following feedback from NHSE/I, the final plan will be submitted on 15 November and formally published later in the month. The regional assurance review meeting took place on 10 October 2019 where feedback in relation to the draft submission was received. The narrative plan was well received, although there were some programme specific areas where suggestions were made to strengthen demonstrable delivery of the LTP commitments. These will be developed further as appropriate in the next iteration of the plan. We will work through those areas deemed necessary and continue to work on the finance and activity elements of the submission.

JUCD Board Patient Story
The Joined Up Care Derbyshire Board has started to hear a patient story at the start of every meeting, to bring home the successes of implementing our integrated working, along with any emerging challenges faced in delivering our strategy.

This month, the Board heard about the work of the integration that has taken place between Derby City Council, Derbyshire Community Health Services and University Hospitals of Derby and Burton in supporting patients who are in hospital to be supported through the correct discharge pathway. The integration has seen the team challenging traditional roles and boundaries of working, finding workarounds for barriers such as IT systems. The team has won awards for the approach and were congratulated by the Board on their vision and desire to make progress. The Board also reflected that it was great example of where team shaving permission to innovate often result in the greatest results.

End of Life Strategy
A system-wide End of Life Strategy has been approved by the JUCD Board to ensure there is a standardised, Derbyshire-wide approach to supporting people at the end of their lives, personalised to allow people to die in their preferred place of care.

Actions will include improved sharing of records relating to end of life care plans, 24/7 access to critical services, increased support for families and carers as part of the person's 'dying team' and a greater understanding of what matters to the person most at the end of their life.

The strategy will be circulated across the system partners shortly and also be accompanied by a broad campaign to continue to help raise awareness of the need to talk about and plan our death.

Financial Position
The Derbyshire system remains in financial challenge as we reach the half way point of the year. £43m has been saved across the Derbyshire system in the first half of 2019/20, against a £48m target year-to-date. This is an improvement against plan; however, due to further emerging risks to the savings plan, the system is forecasting outturn position of £106.9m against a savings target of £145.8m. Savings so far have been delivered a cross a wide range of transactional and contractual changes, along with ongoing drive to improve efficiency in all of the partner organisations.

The JUCD Board continues to work to track progress and to understand how the system working together can collectively address the deficits. The System Savings Group is undertaking a deep dive programme which will conclude in November 2019. The transformation agenda is crucial to delivering better outcomes for the communities we serve whilst at the same time making a significant contribution to closing the financial gap. The system clinical transformation schemes have been reviewed with recovery action plans requested via STP Delivery Boards to seek assurance on actions in place to mitigate risk.

Delivering the NHS Long term Plan: Personalised Care in Derbyshire
A system wide review of personalised care in Derbyshire has been completed. The review was based on the key commitments and actions required by 2023/24 of delivering universal implementation of the Comprehensive Model of Personalised Care across England, which fully embeds the six standard components, including shared decision making, personalised care and support planning, enabling choice, social prescribing, supported self-management, personal health budgets and integrated personal budgets across the NHS and the wider health and care system. Over the next five years the NHS will ramp up support for people to manage their own health, starting with diabetes prevention and management, asthma and respiratory conditions, maternity and parenting support, and online therapies for common mental health problems.

The Derbyshire review identified that within each of the 5 year long term plans for the relevant JUCD STP work-streams (Place, Primary Care, Maternity, LD and Autism, Mental Health, Prevention) examples such as health coaching, peer support and education

programmes that support personalised support planning featured strongly. Additionally the required commitments to support care quality and outcomes within the Long Term Plan were clearly included within a number of the work-stream plans.

Whilst examples in relation to community pharmacies, bespoke wheelchairs, community-based packages of personal and domestic support and Mental Health PHB's were more limited, further work is planned to develop a system wide approach to fully embed and align the personalisation agenda across JUCD. The outputs of the system review were shared with NHS England and identified as an example of good practice, and will support a workshop planned with Jim Manton, NHS England National Personalised Care Team.

Health and Care Expo 2019
The national Health and Care Expo Event took place in September 2019. JUCD presented on the evolving Derbyshire Citizen's Panel. The focus of the presentation was about how Citizen's Panels can bring communities and decision makers together. Colleagues from Derbyshire shared their experience and learning from this new approach and based on the early successful rollout of our Citizen's Panel described how Citizen's Panels can create a shift in patient and public involvement. The presenters also described how they have helped make involvement more inclusive, reducing the risk of the unconscious bias and ensuring a greater balance of views. The presentation was really well received and we lots of questions and positive feedback from those who attended.

People Metrics
Further to a request from the JUCD Board for a regular overview of people (workforce) metrics from across the JUCD system, it has been announced there will be a new approach nationally to people metrics as part of the Long-Term Plan (LTP) and Interim People Plan (IPP). Previously the JUCD Board were updated on the development of a system-wide integrated workforce dashboard. The report included the intention to develop a tracker to monitor key people metrics, including metrics developed via the LTP and IPP national approach.

Supporting General Practice: Staff Wellbeing and Engagement Offer
A new scheme is being offered as a pilot to four Derbyshire practices which supports the development and implementation of a bespoke wellbeing package. The programme is funded by NHS England Retention monies and delivered though the new single Primary Care Training Hub for Derbyshire.

Studies have shown that 80% of people feel more positive in their employment if they are offered meaningful health and wellbeing benefits. This evidence also points towards reduced sickness, absence, job satisfaction and staff retention when a formal staff wellbeing programme is in place. This sort of scheme has already been piloted at Cripps Health Centre at the University of Nottingham and produced encouraging results. Following the Cripps model, the wellbeing scheme aims to make transformational and sustainable changes in 6 key areas:

- Communication
- Promoting a culture of self-reliance and care
- Making the multi-disciplinary team work
- Colleague driven change
- Perceived inequalities in reward, workload and working conditions
- Tackling evidence of burn out early.

An evaluation of the success in the pilot practices will allow a decision to be made about wider roll out with Derbyshire.

Population Health Management (PHM) Update
Derbyshire is one of eight areas participating in the PHM Programme commissioned by NHS England and NHS Improvement (Midlands) taking place during 2019/20. It is a one-year programme with the outcome to increase the PHM capacity and capability within the systems participating. The focus of the Derbyshire project is to develop and embed a PHM approach at Place level and in doing so creating a PHM framework or 'blueprint' for practical

use and application locally. The SRO for this programme of work for the system is Dean Wallace, Director of Public Health, Derbyshire County Council.

Clinical and Professional Reference Group Update

Members of the CPRG are currently in the process of developing an overarching Joined Up Care Derbyshire Clinical Care Strategy, which demonstrates a combined approach to deliver the Model of Care. The strategy will describe the ambition as system clinicians to clinically enable the changes identified within the STP refresh.

Integrated Volunteering Approaches Programme - Memorandum of Understanding

NHS England and NHS Improvement have launched a programme to explore integrated volunteering approaches across Sustainability and Transformation Partnerships (STP). This is to support the delivery of the NHS Long Term Plan commitments and provides additional resource to enable STP's to explore the addition of volunteering approaches to ongoing transformation work. It will help systems to realise the impact and value that this can add, as well as the opportunities and benefits that come from developing greater connections with the voluntary sector.

JUCD have been successful in securing funding for year one of this initiative up to the end of March 2020. Year 1 funding is to give 'thinking space' to understand the potential for developing integrated volunteering approaches in Derbyshire. Year 2 and 3 funding will only be provided to 7-10 STPs whose approaches show the greatest promise and potential for impact. For year 1, up to 31 March 2020 we have committed to employing someone to:

- Explore how the current 'community connector' programme (Erewash) operates, and look at the potential for growth
- Map other volunteering schemes operating in each of our Places
- Identify any gaps or challenges, which could be addressed by volunteering initiatives, particularly at PCN level
- Identify possible new initiatives and interventions
- Liaise with key partners to identify opportunities for further development

Our expression of interest focused on a commitment to identify volunteering approaches, that:

- Support public health ambitions
- Access and developing community assets
- Support integrated care, particularly in relation to the impact of the wider determinants of health on a person's health and wellbeing

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 5 November 2019

Chief Executive's Report to the Public Board of Directors

Purpose of Report

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

National Context

1. NHS England and NHS Improvement (NHSE/I) have published the community mental health framework for adults and older adults, which describe the NHS long term plan's vision for a place-based community mental health model in more detail, and how the NHS can modernise community mental health services to shift to whole person, whole population health approaches.

   Key points from the report:

   - The community and mental health framework sets out a new approach in which place-based and integrated mental health support, care and treatment for adults and older adults are situated and provided in the community.
   - The framework places a renewed focus on people living in their communities with a range of long-term severe mental illnesses. It also places a focus on people whose needs are deemed too severe for improving access to psychological therapies (IAPT) services but not severe enough to access services in secondary care.
   - These new models of care will span both core community provision and also dedicated services, where the evidence supports them, and they will be built around primary care networks (PCNs).
   - The overall approach will be tested using targeted central transformation funding over the next two years. However, NHS England expects that, as a minimum, all local systems start by using the new CCG baseline funding starting from 2019/20 to expand community mental health teams (CMHTs) and align them with PCNs.
   - In line with the clinically-led review of NHS access standards, four-week waiting times for adult and older adult CMHTs will be tested in 12 selected areas over the next two years as part of wider testing of these new models in 2019/20 and 2020/21, supported by over £70m new funding.
   - A key component of the framework is setting out a method for coordination of care that will replace the care programme approach (CPA). The new

approach intends to enable high-quality, personalised care and support planning in line with the NHS England comprehensive model of personalised care.

- Staff currently working in secondary care community mental health services are the starting point for the workforce of these new models. However, to implement the joined-up approach the framework sets out, it is expected that these teams would "fully integrate" their working with other local services.
- The framework states that a specific community connector or social prescribing link worker may need to be created, or these functions carried out by existing staff, for example peer support workers or care coordinators.

Within Derbyshire we will be implementing the plan via the Mental Health System Delivery Group

2. NHS England and NHS Improvement (NHSE/I) have released the quarter one (Q1) financial figures for the provider and commissioning sectors this month.

The key headlines include:

- The provider sector is forecasting a deficit of £279.8m, slightly ahead of the planned outturn of a £281.8m deficit. If achieved, this would be a significant improvement on last year's year-end deficit of £575m.
- In Q1 the provider sector was £805.8m in deficit after provider sustainability fund (PSF), financial recovery fund (FRF), and marginal rate emergency tariff (MRET) allocations. This position is £26m better the planned figure of £832m.
- Across the NHS, including the commissioner aggregate position, the Q1 run rate is largely consistent with plan. The forecast overspend by the end of the year is expected to be £84m – against a planned breakeven. NHSE/I say this 0.1% variance is "due largely to technical reasons".
- PSF, FRF and MRET allocations amounted to £421m in Q1. This is 95% of the total planned allocations for Q1.
- A total of £2.7bn of PSF/FRF/MRET funding is available for 2019/20.
- The sector position includes £35m of uncommitted PSF/FRF, which is £22m more than planned. A total of £81m of PSF/FRF/MRET funding is expected to be uncommitted at the end of the year.
- There are 20 trusts currently reporting a financial position worse than plan, after PSF/FRF/MRET allocations. In 2018/19 at year end, 61 trusts reported a position worse than the plan.
- Total capital departmental expenditure limit (CDEL) spend for Q1 is £651m. This is 34% below the planned level of £984m for the quarter.
- The provider deficit is largely concentrated in the acute sector. Of the total reported financial deficit position across the provider sector, 95% is accounted for by acute providers. The acute sector's deficit in Q1 is 7.1% higher than forecast.
- The remaining deficit position is attributed to the mental health sector, although its £18.7m deficit position is almost £9m better than plan. The mental health sector is forecasting a year-end surplus position.
- The ambulance and community sectors are both reporting surpluses for Q1 and are forecasting they will finish the year in surplus.

- Total employee expenses were £14.45bn in Q1 – not significantly different from plan – and forecast spend for the year is on track to meet plan at £57bn.
- Agency ceiling performance spend was 6% over plan at £595m, though is projected to be within the forecast plan by year-end at £2.14bn. Separately, providers overspent by 9.7% on bank staff costs. This is driving an expected 4% overspend on temporary staff by year end.
- Providers achieved £439m of cost improvement plan savings in Q1, which was 88% of the target. The year-end forecast is for providers to achieve 97% of their £3.18bn efficiency savings target.
- Providers spent £45m more than planned on purchasing healthcare from other providers. At a total of £881, this is £41m more than in Q1 in 2018/19.

This national data is of relevance to our Trust as we must now start to consider our performance in the context of the system we operate within enhancing the importance of the Board understanding performance in other sectors.

Local Context

3. Claire Wright attended the October Joined Up Care Derbyshire (JUCD) Board on my behalf and the highlights included:

- Success of patient story as described through Perth House example – Integrated working of Derbyshire Community Health Services NHS Foundation Trust (DCHS), Derby City Council and University Hospitals of Derby and Burton NHS Foundation Trust (UHDB) team and the positive impact on patients' experience and outcomes
- We discussed at length the challenges of achieving the 2019/20 financial positions for providers and commissioner due to increasing demand, capacity, winter planning and cost pressures
- Progress with 5 year plan. Good feedback had been received from NHSE/I on the initial submission and work continues on November submissions. Main submission is 15 November although an additional 1 November submission was also required, which complicated governance sign-off processes that had been previously agreed. Therefore it was pragmatic to delegate sign-off of the interim submission to CEOs. Triangulation between activity, workforce and financial information continues. JUCD Board members agreed that JUCD would not be supportive of heroic assumptions for efficiency requirements in the November submission. At the same time discussions continue regarding the next stage of evolution in the Derbyshire system-working and how best to make that as effective as possible including how best to value the impact of the workstreams. To put Derbyshire in good stead for becoming an ICS in 2021 it is hoped to put as many pieces of the jigsaw in place by April 2020 as possible.
- New End of Life Strategy was approved – this will now go to implementation planning to ensure that patients have a personalised advanced care plan that includes identifying their place of choice for death; these services will be provided through a model of care that is community based with specialist outreach. Implementation will involve changes for all system partners in terms of additions to personalised care planning, education and training, 24/7 access to end of life (EOL) services and access to shared records.

Within our Trust

4. An action that came out of the BME staff conference was to rapidly set up a group to look at disruptive recruitment. The purpose of our Recruitment Action Steering is going to be to challenge our recruitment processes to maximise our workforce diversity so that is more representative of the population we serve across all roles. I am delighted that the group met for the first time this month and is chaired by Suki Khatkar. The meeting made some key decisions, one of which for example is to introduce ‘inclusion advocates’ (or similar) into the processes for both shortlisting and interviewing for (initially) band 7 and above. This steering group will ensure that disruptive actions are devised and overseen in order to address improvement areas. Given the importance of the group it will report directly into the Executive Leadership Team (ELT).

5. The Board is aware that we are progressing to phase two of our Reverse Mentoring Programme. We have had great success in progressing with our next cohort of Reverse Mentors and Mentees. We expect to have 17 or 18 pairs for the cohort. We now move into implementation phase; where the mentors and mentees will receive training and the allocations of pairs will take place. The progress of the programme will be overseen by our Reverse Mentor Steering Group, chaired this quarter by Bal Singh which reports directly into ELT.

6. I am delighted that Rubina Reza has agreed to represent Derbyshire Healthcare NHS Foundation Trust (DHCFT) on the latest cohort 3 of the NHS Workforce Race Equality Standard (WRES) Expert Programme. The comprehensive 16-day programme is delivered in seven modules over a period of nine months. The aim of the WRES expert programme will be to support the Trust and the wider health economy in our area to improve workforce race equality and fairness.

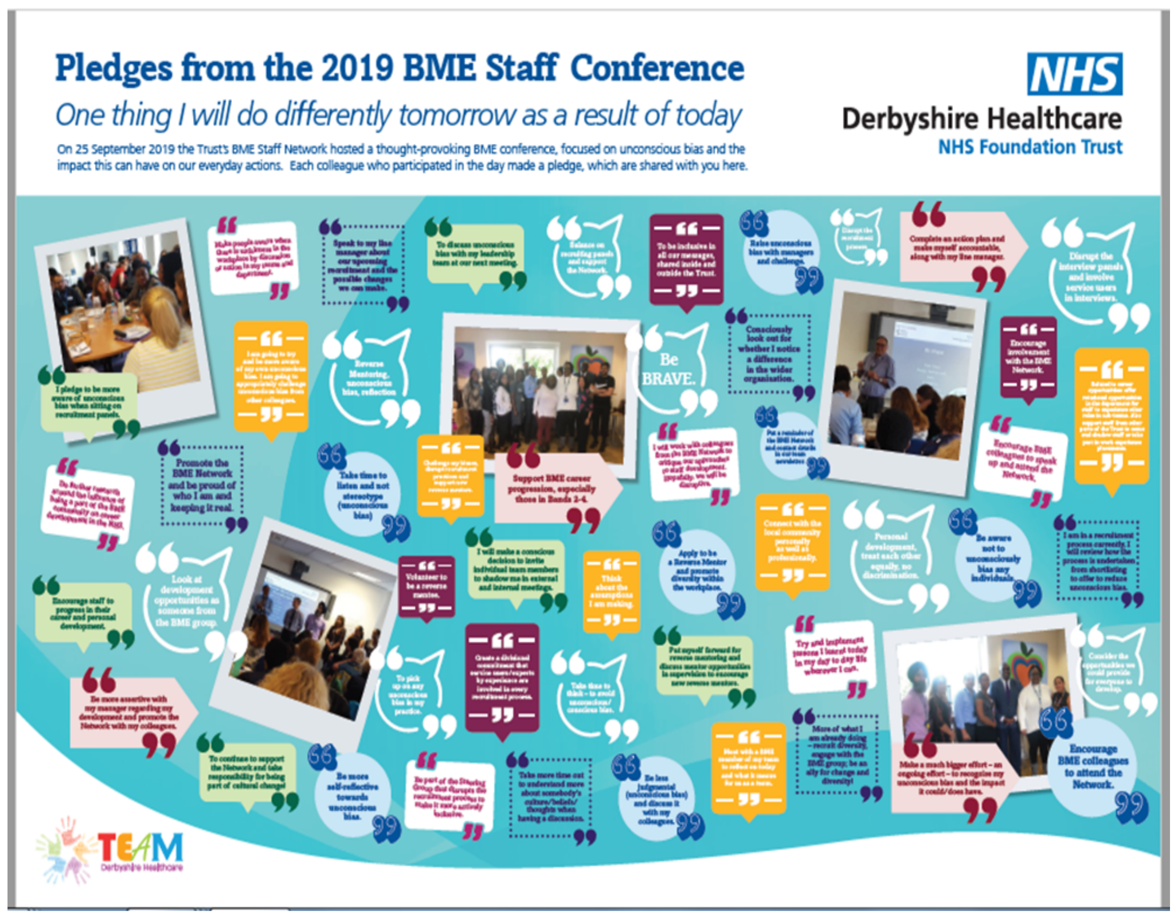
   Rubina has written a communication that will be shared with the whole Trust and I have attached this at appendix 1. Such is the importance for us of this programme that I am keen to share regular updates with the Board about Rubina’s progress and learning but also she has to complete an assignment relating to our Trust that I feel we should extend the invitation to her to present that directly to the Board.

7. Claire attended a NHS Leaders roundtable event on my behalf to discuss the NHS People Plan, in particular the ‘core offer’ and ‘leadership compact’ parts of ‘Best Place to Work’ where I know that she talked about some of the best practice we have developed for example our values driven leadership development sessions, reverse mentoring and recruitment and retention incentives.

8. The BME Staff Network Conference took place on 25 September 2019 at Kingsway Hospital in Derby. Approximately 130 people attended the event, where the agenda included a thought-provoking and emotive session on ‘Unconscious Bias’ from an external facilitator and speaker, David Shosanya; updates on the 2018-19 Reverse Mentoring programme and their plans for Cohort 2 in 2019; and two action-planning workshops to address key areas in the Workforce Race Equality Standard, focusing on workforce diversity and representation and career development opportunities for BME colleagues.

The actions developed by the Network at the Conference have been used to develop the WRES Action Plan 2018-19, which will be discussed later in the Board

As part of the conference colleagues pledged to do something different straight away and a selection are shown below:



9. During October I was on leave from the September Board almost until Board deadline and hence did not hold any on the road sessions. Claire visited Janet and Abbey in our paediatric occupational therapy service where she witnessed person-centred and family-focussed care for a range to young people with a range of complexity but always making such a positive difference to their physical health. I visited our new North Derbyshire perinatal team to hear about some of the really innovative work the team is doing. It was great to see partnership in action with pre-natal joint clinics now being run with Chesterfield Royal Hospital.

Strategic Considerations	
1) We will deliver **great care** by delivering compassionate, person-centred innovative and safe care	X
2) We will ensure that the Trust is a **great place to work** by attracting colleagues to work with us who we develop, retain and support by excellent management and leadership	X
3) We will make the **best use of our money** by making financially wise decisions and will always strive for best value to make money go further	X

Assurances

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

Consultation

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

Governance or Legal Issues

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

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

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

As such implementation of national policy in our Trust would include a repeat Equality Impact Assessment, even though this will have been completed nationally. The new framework for community mental health care is directed at closer working with local communities and more naturally meeting the needs of communities we have a history of not engaging with – I believe this should be seen as a positive step towards better inclusion at a community level.

This paper demonstrates some strong features of good practice relating to inclusion and diversity. The BME staff conference focussing on unconscious bias created an opportunity for learning not just in relation to race to but bias in its broadest sense. Rubina's position on the WRES expert programme gives us a real opportunity to challenge our practice and understand what has worked elsewhere. It is also recognition of the level of importance the Trust places on inclusion.

The development of disruptive recruitment interventions, an action coming out of the BME conference is another example of positive practice around equality and inclusion.

There is a risk around the submission of the long term plan for Derbyshire that we don't spend enough time thinking about the equality impact of the plan on local communities and colleagues from all Organisations from protected groups. This is something I will raise at the Local Workforce Action Board and the CEO meetings to ensure we consider, document and mitigate any potential negative impacts on particular communities.

Recommendations

The Board of Directors is requested to:

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

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

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

Claire Wright
Deputy Chief Executive

BME STAFF NETWORK

Dear Colleagues

My name is Rubina Reza and I am representing Derbyshire Healthcare NHS Foundation Trust (DHCFT) on the latest cohort 3 of the NHS Workforce Race Equality Standard (WRES) Expert Programme. My role as a WRES expert will be to support the Trust and the wider health economy in our area to improve workforce race equality and fairness.

As I start this 16-day programme delivered in seven modules over a period of nine months, with lots of work in between, I'd like to introduce myself and share my thoughts and learning with you as things progress. I also hope to use this opportunity to connect with as many colleagues as possible and to start those every day conversations which will enable us to work comfortably with race equality and to change the deep rooted cultures of race inequality in the system.

The WRES expert role will be alongside my usual day job at DHCFT which is leading the Research & Development (R&D) function, including Clinical Audit and Library & Knowledge services; I have been in this role since 2011 although I first started working for this Trust in 2003 and for the NHS in 1995. More recently, since 2016, I have also been providing a similar research leadership and management function, 2 days a week, to our neighbouring community Trust (DCHS). My own work experiences and those of many more BME people have led me to take on this challenging new opportunity.

My Executive Board sponsor on the programme is our Chief Executive, Ifti Majid and I am looking forward to working with Ifti on this shared vision for race equality at DHCFT.

So the programme launched with a day in London on the 9th of October. It was an inspiring and emotional experience for me, and to have shared the experience with my sponsor for the day, Amanda Rawlings, Director of People Services and Organisational Effectiveness, made this day a really important one.

The messages around why race equality matters to the NHS, I'd heard before, but the delivery was so powerful and there was such a clear expectation for change, for the NHS to be the model employer. I was particularly moved when reminded of 'biological weathering' by Yvonne Coghill, Director, WRES Implementation, NHS England. This is the term used to describe the deterioration of our physical health as a result of an accumulation of lifelong stress-mediated physiological damage from being exposed to systemic racism.

It was a great introduction on what to expect over the next nine months and my main message back to the organisation from the day was said by Baroness Dido Harding, Chair, NHS Improvement, when it comes to workforce race equality in the NHS 'accept that being impatient for change is important'.

Joined Up Care Derbyshire Board: STP Refresh Summary for Boards and Governing Body					
DATE OF MEETING:	5 November 2019		AGENDA ITEM NO:	8	
DOCUMENT/REPORT TITLE:	**STP Refresh Summary and Update**				
PRESENTER	Vikki Taylor				
SENIOR RESPONSIBLR OFFICER	Vikki Taylor				
CONTENTS OF PAPER WERE PREVIOUSLY DISCUSSED BY:	Ongoing discussions and updates at the Joined Up Care Derbyshire Board. Previous draft versions of narrative plan circulated to all CEOs for Board / Governing Body discussion. Also taken to both Health and Wellbeing Board and Health Overview and Scrutiny Committees.				
AUTHOR/TITLE:	Sukhi Mahil, JUCD STP Assistant Director				
CONTACT EMAIL AND TELEPHONE NUMBER:	sukhi.mahil@nhs.net 07967 252111				
DOCUMENT IS FOR: (MORE THAN ONE BOX CAN BE TICKED)	INFORMATION	⚐	DECISION	⚐	ASSURANCE ⚐

PURPOSE
This report provides Joined Up Care Derbyshire partner Boards, Governing Body and committees with an update on progress in refreshing the Derbyshire 5 year Strategy Delivery Plan. Boards, Governing Body and committees have seen earlier versions of the plan and organisations are asked to confirm support in relation to the content of the plan as it currently stands; noting further work is ongoing which will require delegated authority for approval as set out below. This cover sheet is supplemented with a summary presentation from the overall plan, highlighting the key changes to the plan since the previous iteration. This report also provides a summary of any outstanding areas requiring resolution along with further actions being taken by the system, ahead of the final submission on 15 November 2019.

BACKGROUND

Our 2016 STP plan has been refreshed in response to the ambitions set out in the NHS Long Term Plan published in January 2019.

As a reminder, the Derbyshire system, through the Joined Up Care Derbyshire Board agreed that our plan will be a refresh of the original STP rather than a complete re-write which:

- Has a shift in focus to people not patients
- Localises care delivery, building on progress made since the 2016 plan
- Is outcomes driven to ensure so that the people of Derbyshire ***'have the best start in life, stay healthy, age well and die well'***
- Demonstrates our strive to offer excellent services and make improvements in the key determinants of health leading to improved outcomes for people in Derbyshire; with a stronger focus on prevention, addressing inequalities and population health management
- Ensure our key priority areas support the delivery of our new approach, and will include the wider determinants of health such as housing and air pollution management
- Our transition to becoming an Integrated Care System by April 2021; adopting and implementing our core principles for how we will work together and challenging each other to upholding them
- Demonstrates how commissioners will increasingly move towards an integrated commissioning budget across health and social care to jointly commission at place and make strategic commissioning decisions in the deployment of that budget
- Demonstrates how providers will increasingly move to integrate provision and delivery in order to deliver the outcomes for the population of Derbyshire at both footprint and Place levels within allocated resources
- The refresh will be informed and developed through strong engagement with people, patients, staff and wider stakeholders – this will drive our approach. In doing so, ALL partners will be involved in developing and subsequently delivering our 5 year plan.

The NHS Long Term Plan Implementation Framework (LTP IF)

The NHS Long Term Plan Implementation Framework was published on 27 June which sets out the specific requirements that must be evidenced in our 5 year Strategy Delivery Plan submissions; supporting technical guidance was released on 27 August. There are three components:

1. Strategic Narrative
2. Strategic Planning Tool (Activity, Finance and Workforce) - to set the plan for delivery of finance, workforce and activity, providing an aggregate system delivery expectation and setting the basis for the 2020/21 operational plans for providers and CCGs. The system delivery plan will also cover the LTP 'Foundational Commitments' and commitment for use of additional LTP funding allocations for specific deliverables; see Appendix 1.
3. Strategic Planning LTP Collection Tool (Metrics) – 30 specific metrics have been identified. There are further metrics still in development nationally and it is expected that these will be covered in our narrative plan whilst the measures are developed. A breakdown of the full set of metrics can be found at Appendix 2.

In addition, Health Education England (HEE) has issued an e-workforce toolkit which is required to be submitted to the same timescales. It is expected that the granular level detail in this toolkit will be used to populate the data in the strategic planning tool.

As described previously, the agreed approach in Derbyshire is for the plan to be considered a 'refresh' rather than a re-write; fundamentally because our model of care remains valid and provides the foundations on which our plan is based. We are however developing the plan to ensure we respond to the requirements set out in the NHS LTP.

The draft narrative plan has been shared with the Joined Up Care Derbyshire Board during its development and the initial draft, consisting of the four component parts described above was submitted to NHSE/I on 26 September 2019. The narrative element was also circulated the system CEOs at this time to enable ongoing consideration and discussion of the draft plan within respective organisations.

MATTERS FOR CONSIDERATION

The regional assurance review meeting took place on 10 October 2019 where feedback in relation to the draft submission was received. The narrative plan itself was well received, although there were some programme specific areas where suggestions were made to strengthen demonstrable delivery of the LTP commitments. These areas have been further developed in the latest version of the plan. We are continuing to work through those areas deemed necessary as there continue to be some conflicting messages in relation to the level of detail expected (i.e. strategic versus operational) and the approach being taken is to maintain the integrity of this as our locally owned system strategic plan.

The draft plan submitted on 27 September and previously reviewed by Boards, Governing Body and committees has been available for review on the JUCD website - https://joinedupcarederbyshire.co.uk/about/our-plans. The updated plan based on regulator feedback is attached for reference and transparency. Reflecting that members have previously read the detail of the first draft submission, **the updates to the plan narrative are not considered fundamental or material changes, as essentially they are changes which strengthen specific deliverables in response to regulator feedback.**

The attached summary slides do however provide an extract from the overall plan in relation to the Integrated Care Partnership (ICP) development, as this section has been updated based on 2 recent workshops which have taken place to progress consideration of the options in this area.

Further developments ahead of final submission

The particular areas of concern highlighted during the regulator review are in relation to finance/ activity, workforce and performance modelling and triangulation. This was expected as the initial draft was submitted with an unmitigated ‘do nothing’ position. It was noted that further work would rapidly be undertaken to develop the mitigated ‘do something’ position to clearly articulate the impact of the deliverables, including utilisation and allocation of the additional LTP investment (set out in Appendix 1).

Whilst regulators could see the planning assumptions that had been used to get to the unmitigated activity, finance and workforce model for the system, the key area of concern was the modelling of the mitigation work. This work has not yet concluded and further rapid work is taking place involving all partners to develop the agreed system mitigated position.

At the JUCD Board meeting it was requested that the plan be brought back, with a better understanding of any contentious issues which required resolution for discussion. The plan as it stands is essentially based on delivery of our agreed model of care and system priorities which are entwined with delivering the long term plan commitments; however due to the development of the finance and activity modelling it has not been possible to incorporate any potentially challenging areas at this stage.

The financial modelling for the long term plan assumes delivery of the 2019/20 Derbyshire financial plan, including all the required 2019/20 savings. This is a key risk and sensitivity to the model. It is important to note that if the system is unable to deliver £151m in 2019/20, 2020/21 and beyond will be more challenging as a result of this shortfall; these are part of the considerations being worked through at present.

As a result of the work still taking place in relation to the triangulated finance, activity and workforce modelling, the JUCD Board agreed at the meeting on 18 October, to delegate authority for approval of the final submission to the System Executive: CEOs group. This will include the detailed modelling to be incorporated alongside into the plan narrative; ensuring that any contentious issues are resolved with appropriate risk mitigations where necessary. Where issues cannot be resolved ahead of inclusion in the final plan, through these delegated authority arrangements, then an extraordinary urgent JUCD board meeting will be convened. **As the plans need to be approved by system leaders and regulators ahead of the submission of 15 November, this process will need to conclude by 13 November.**

As a system we are required regardless to demonstrate our commitment to delivering the LTP commitments and therefore each organisation is asked at this stage to confirm support for the direction set out in the plan narrative in principle.

Timetable for STP plan approvals and submissions

Owing to the lateness of guidance being received and the ask of systems still occasionally being confused, the timeframe

for development has been extremely challenging. This therefore means we are having to operate in a fluid and reactive way to ensure response to guidance as it is received.

The plan (all component parts) will need to be approved with regulators **before** the submission date of 15 November and we are therefore in discussion with regulators to confirm this date. In addition we are now required to make an interim submission on 1 November; the timeline and process to take the final plan for approval through our organisational governance processes is already challenging, as set out in the table below.

Action	Deadline
Submission to JUCD Board	**13 September**
Derbyshire County Council Adults Health Improvement and Scrutiny Committee *(1)*	**16 September**
JUCD Board sign off (draft plan)	**20 September**
Derby City Council Adults Health Improvement and Scrutiny Committee *(1)*	**24 September**
Submission to NHSE/I (draft plan)	**27 September**
Submission to JUCD Board for approval	**11 October**
JUCD Board *(2)*	**18 October**
Trust Boards, Governing Body, Local Authorities and Health & Wellbeing Boards approval *(3)*	
Derbyshire County Health & Wellbeing Board	**3 October**
DCHS	**31 October**
Submission to NHSE/I (interim plan submission)	**1 November**
DHcFT	**5 November**
CRH	**6 November**
DHU	**6 November**
CCG	**7 November**
UHDB	**12 November**
Derby City Health & Wellbeing Board	**14 November**
Submission of Final Plan to JUCD Board *(4)*	**14 November**
Final submission to NHSE/I *(5)*	**15 November**
Final JUCD Board *(6)*	**21 November**
EMAS *(7)*	**3 December**

Notes:

1. Both Scrutiny Committees do not sit again ahead of final submission (the next county meeting is on 25 November and City do not meet again until February 2020). However the draft plan has been taken to both committees in September and further updates will also be taken to future meetings
2. The JUCD Board received and approved further amendments to the plan to confirm version being taken through organisational governance processes
3. Due to the scheduling; particularly with regards to feedback from region, it may be necessary for Boards/ Governing Body to receive the final plan which is subject to further amendments (depending on the nature of the feedback). The principles in terms of the narrative have been supported by the JUCD Board with delegated authority to the System Executive to approve the financial modelling and triangulation (impact of the plan) as these areas develop prior to 15 November
4. Papers will be submitted to the Board one day before final submission to NHSE/I but the Board meeting itself will take place after. The JUCD Board have agreed that the System Executive: CEO group will have delegated authority for final sign off of the plan ahead of the submission.
5. Although this is the final submission to NHSE&I discussions will need to take place before this date to ensure plans are agreed with system leads and the regional team ahead of the actual submission date.
6. The JUCD Board will receive the final plan; hopefully with any final feedback from region
7. The EMAS Board date falls after the plan submission and therefore consideration/ agreement is required in relation to interim approach ahead of the plan being published to ensure fit with timescales

As our plan will require system leaders support prior to submission the approach described above in relation to the System Executive: CEO group having delegated authority for sign off, will also be the approach to ensure organisational endorsement of the plan. We are therefore requesting, through the Board/Governing Body meetings, support in principle for the direction set out in the plan with the recognition that further development of the financial, activity and workforce triangulation will be approved by system leaders as part of the final sign off process.

Publication of the Plan

Systems are required to provide an indication of the date on which we will publish our plans; it is proposed that we do this on 28 November 2019 following the November JUCD Board. However, following the announcement on 30 October 2019 regarding an early general election on 12 December 2019, due consideration will need to be made to the impact of purdah on the final sign off, agreement and publication of System Strategic Plans. We are awaiting further guidance from our regional communications team. In the meantime have been advised to continue to work to previously agreed deadlines for submission, but also to be conscious of the approach that local NHS systems are advised to take during the pre-election period.

RECOMMENDATIONS

The Derbyshire Healthcare NHS Foundation Trust Board of Directors is asked to:

- **Provide any feedback in relation to considerations of the plan narrative to date; and note this to be considered and reflected where appropriate in the final version**
- **Approve the content of the draft narrative plan; noting that detailed modelling of finance and activity in particular are still in the process of development, as set out above**
- **Note the approvals process and delegated authority as agreed by the JUCD Board.**

FINANCIAL IMPACT

Any financial implications will be considered as part of the STP refresh

FURTHER INFORMATION AND APPENDICES

301019 Derbyshire STP Refresh - 2019 to 2024 DRAFT V2 CURRENT
301019 Board discussions - STP Refresh Update Oct19
Appendix 1: **Additional LTP Funding for specific commitments**
Appendix 2: **LTP Metrics**

MONITORING INFORMATION	
PATIENT, PUBLIC AND STAKEHOLDER INVOLVEMENT	Ongoing as part of the STP refresh and embedded into respective programmes of work going forward.
EQUALITY AND DIVERSITY IMPACT	To be undertaken as part of the submissions as necessary.
ENVIRONMENTAL IMPACT	To be reviewed as part of specific activities where necessary / appropriate.

Appendix 1

Additional LTP Funding for specific commitments

Code	STP / ICS / Region	Commitments to be delivered through additional LTP funding allocations	1 2019/20 LTP allocation £000	2 2020/21 LTP allocation £000	3 2021/22 LTP allocation £000	4 2022/23 LTP allocation £000	5 2023/24 LTP allocation £000
QJ2	Joined Up Care Derbyshire STP		10,464	10,801	14,978	22,025	31,836
	1. Mental Health	The expansion of community mental health services for Children and Young People aged 0-25; funding for new models of integrated primary and community care for people with SMI from 2021/22 onwards; and specific elements of developments of the mental health crisis	1,107	1,196	3,785	7,590	10,175
	(a) CYP community and crisis			58	1,161	1,792	2,948
	(b) Adult Crisis			1,138	540	722	941
	(c) New integrated models of Community and Primary care for SMI				2,084	5,076	6,286
	2. Primary Medical and Community Services		6,456	7,205	8,284	10,822	13,180
	(a) Primary Care	This funding includes the continuation of funding already available non-recurrently to support Extended Access and GP Forward View funding streams, (eg practice resilience programme), and associated commitments must be met. Additional funding is also included to support the development of Primary Care Networks.	6,456	6,677	7,051	7,225	7,125
	(b) Ageing Well	Deployment of home-based and bed-based elements of the Urgent Community Response model, Community Teams, and Enhanced Health in Care Homes.		528	1,233	3,597	6,055
	3. Cancer	Rapid Diagnostic Centres funding in 2019/20 only; Cancer Alliance funding to support screening uptake delivery of the Faster Diagnosis Standard and timed pathways, implementation of personalised care interventions, including personalised follow up pathways and Cancer Alliance core teams.	2,139	1,601	1,250	1,199	1,200
	4. Other	CVD, Stroke and Respiratory - Increased prescribing of statins, warfarin and antihypertensive drugs; Increased rates of cardiac, stroke and pulmonary rehabilitation services; increased thrombolysis rates; and early detection of heart failure and valve disease. CYP & Maternity - Local Maternity Systems funding; Saving Babies Lives Care Bundle funding from 2021/22; postnatal physio funding from 2023/24; funding for integrated CYP services from 2023/24. LD Autism - Funding for rollout of community services for adults and children and keyworkers from 2023/24. Prevention - Tobacco addiction - inpatient, outpatient/day case and Smoke Free pregnancy smoking cessation interventions. **We will need to decide as a system how this funding will be apportioned across each of the key deliverables**	763	799	1,659	2,415	7,280

Appendix 2

LTP Metrics

***In addition to the areas identified below the final LTP Collection (metrics) tool includes a number of further metrics which will be submitted through the planning tool submission via SDCS. These are included in table 2 for ease of reference (for the avoidance of doubt the areas highlighted in yellow in table 1 are also covered in the collection tool; table 2)**

The metrics listed below have been taken from https://www.longtermplan.nhs.uk/headline-metrics/	**KEY:**	
	(grey)	**To be included in the Strategic Planning Tool (Submitted through SDCS)**
We have added these to an excel table and highlighted in yellow those measures that will be in the LTP Performance measures collection.	(yellow)	**To be included in Strategic Planning -LTP Collection (submitted through SDCS) ***
	(blue)	**To be covered in plan narrative**
Please note the list does not include the additional measures we will also be collecting in that template. *	(green)	**Out of scope for system plans**

<u>Table 1: Headline Metrics</u>

Agreed Headline	Potential Measure description	Comments
Primary and community services: annual implementation milestones for 5 year GP contract; new community services response times	Percentage of overall NHS revenue spent on primary medical and community health services	To be included in the Strategic Planning Tool (Submitted through SDCS)
	GP contract / Primary Care Network Patient reported access measure – measure to be confirmed*	To be covered in plan narrative whilst measures still under development
	Community rapid response 2 hour/2 day measure to be confirmed	To be covered in plan narrative
Comprehensive ICS coverage	Percentage of population covered by ICS	Out of scope for system plans because this will be assessed nationally
Emergency care: on agreed trajectory for Same Day Emergency Care	Percentage of non-elective activity treated as Same Day Emergency Care cases	To be covered in plan narrative whilst measures still under development
Prevention: increase uptake of screening and immunisation;	Population vaccination coverage – MMR for two doses (5 years old)	To be covered in plan narrative
	Bowel screening coverage, aged 60-74, screened in last 30 months	To be covered in plan narrative
	Breast screening coverage, females aged 50-70, screened in last 36 months	To be covered in plan narrative
	Cervical screening coverage, females aged 25-64, attending screening within target period (3.5 or 5.5 years)	To be covered in plan narrative
Inequalities: inequalities reduction trajectory	Measure that reflects the inequalities focus of local plans – measure to be confirmed	To be covered in plan narrative whilst measures still under development
Prevention: Alcohol care teams, tobacco treatment services, and diabetes prevention programme	Coverage of ACTs – percentage of hospitals with the highest rate of alcohol dependence-related admissions with ACTs in place	To be covered in plan narrative
	Number of people supported through the NHS Diabetes Prevention programme	To be included in Strategic Planning - LTP Collection (submitted through SDCS)
	Percentage of people admitted to hospital who smoke offered NHS funded tobacco treatment services	To be covered in plan narrative

Agreed Headline	Potential Measure description	Comments
Maternal and Children's health: On agreed Trajectory for 50% reduction in stillbirth, neonatal and maternal deaths and brain injury by 2025	Reduction in stillbirth, maternal mortality, neonatal mortality and serious brain injury, based on MBRRACE data	To be included in Strategic Planning - LTP Collection (submitted through SDCS) Stillbirth and Neonatal mortality only
Improve cancer survival: on agreed trajectory so that 75% of cancer patients diagnosed at stage 1 or 2 by 2028	Proportion of cancers diagnosed at stages 1 or 2	To be included in Strategic Planning - LTP Collection (submitted through SDCS)
	Proportion of people that survive cancer for at least 1 year and 5 years after diagnosis	To be included in Strategic Planning - LTP Collection (submitted through SDCS)
Learning disability and autism: on agreed trajectory for halving inpatient rate by 2023/24 and increasing learning disability physical health checks to 75% of people over 14	Reliance on specialist inpatient care for people with a learning disability and/or autism	To be included in Strategic Planning - LTP Collection (submitted through SDCS)
	Proportion of people with a learning disability on the GP register receiving an annual health check	To be included in Strategic Planning - LTP Collection (submitted through SDCS)
Mental health: on track for locally agreed service expansion, and increase in investment for mental health services as a share of the NHS budget over the next five years, worth in real terms at least a further £2.3 billion a year by 2023/24	Number of people accessing IAPT services	To be included in Strategic Planning - LTP Collection (submitted through SDCS)
	Number of children and young people accessing NHS funded mental health services	To be included in Strategic Planning - LTP Collection (submitted through SDCS)
	Mental health access standards once agreed	To be covered in plan narrative whilst measures still under development
	Percentage of overall NHS revenue funding spent on mental health services	To be included in the Strategic Planning Tool (Submitted through SDCS) - depends on definition
Implementation of agreed waiting times (new clinical standards for urgent and emergency care, elective care, cancer and mental health from April 2020)	Percentage of patients in A&E transferred, discharged or admitted within four hours	Out of scope because Clinical Review of Standards has not reported
	Percentage of patients starting cancer treatment within 62 days of GP referral	Out of scope because Clinical Review of Standards has not reported
	Percentage of patients with incomplete pathway waiting 18 weeks or less to start consultant led treatment	Out of scope because Clinical Review of Standards has not reported
	Patients waiting more than 52 weeks to start consultant-led treatment	Out of scope because Clinical Review of Standards has not reported
	Elective waiting list size	Out of scope because Clinical Review of Standards has not reported
Workforce metrics will be agreed through development of the NHS People Plan. Interim placeholder metrics to support development of local plans will be:	Staff retention rate	To be covered in plan narrative
	Proportion of providers with an outstanding or good rating from the CQC for the "well led" domain	To be covered in plan narrative
	Workforce diversity measure to be agreed	To be covered in plan narrative whilst measures still under development
	Number of GPs employed by NHS	To be covered in plan narrative
	Number of FTEs, above baseline, in the Primary Care Network additional role reimbursement scheme	To be covered in plan narrative
	Nurse vacancy rate	To be covered in plan narrative
	Staff well-being measure to be agreed as part of the People Plan	To be covered in plan narrative whilst measures still under development
	Sickness absence	To be covered in plan narrative
Outpatient reform: Avoidance of up to a third of outpatient appointments (including outpatient digital roll out)	Percentage reduction in the number of face to face outpatient attendances	To be covered in plan narrative whilst measures still under development
Empowering People: Summary care Record roll out, EPR roll out	Proportion of population registered to use NHS App	To be included in Strategic Planning - LTP Collection (submitted through SDCS)
Access to online/telephone consultations in primary care	Proportion of the population with access to online consultations	To be included in Strategic Planning - LTP Collection (submitted through SDCS)
	Access to general practice appointments	To be covered in plan narrative
The NHS will return to financial balance:	Percentage of organisations in financial balance	To be included in the Strategic Planning Tool (Submitted through SDCS)

Agreed Headline	Potential Measure description	Comments
NHS in overall financial balance each year	Aggregate forecast end of year financial position of providers, commissioners and NHSE central budgets against agreed budgetary limits	To be included in the Strategic Planning Tool (Submitted through SDCS)
The NHS will achieve cash-releasing productivity growth of at least 1.1% per year	Total Cash releasing productivity growth (covering acute, mental health and community providers initially)	To be included in the Strategic Planning Tool (Submitted through SDCS)
The NHS will reduce growth in demand for care through better integration and prevention	Cost weighted non-elective activity growth	To be included in the Strategic Planning Tool (Submitted through SDCS)
The NHS will reduce variation in performance across the health system	Measure on reduction in unwarranted variation achieved by the NHS	To be covered in plan narrative
The NHS will make better use of capital investment and its existing assets to drive transformation	[Metrics to support this test to be confirmed following the Spending Review and the development of the new NHS capital regime]	To be covered in plan narrative whilst measures still under development

Table 2: Strategic Planning - LTP Collection (metrics) tool

Lead Programme Area	
Digital	E.D.16: Proportion of the population with access to online consultations E.D.20: Citizen facing tools: Proportion of the population registered to use NHSApp E.D.21. Cyber Security
Metal Health	E.A.3: IAPT Roll-Out E.H.9: Improve access to Children and Young People's Mental Health Services (CYPMH) E.H.12: Inappropriate adult acute mental health Out of Area Placement (OAP) bed days E.H.13: People with severe mental illness receiving a full annual physical health check and follow up interventions E.H.15: Perinatal mental health: Access rate to specialist perinatal mental health services E.H.16: Mental Health Liaison services within general hospitals meeting the "core 24" service standard E.H.17: Number of people accessing Individual Placement and Support E.H.18: EIP Services achieving Level 3 NICE concordance E.H.19: Number of people receiving care from new models of integrated primary and community care for adults and older adults with severe mental illnesses E.H.20: Coverage of 24/7 age-appropriate crisis provision for children and young people which combines crisis assessment, brief response and intensive home treatment functions
Learning Disabilities & Autism	E.K.1: Reliance on inpatient care for people with a learning disability and/or autism E.K.3: Learning Disability Registers and Annual Health Checks delivered by GPs
Urgent & Emergency Care	E.M.23: Ambulance Conveyance to ED E.M.24: Delayed Transfers of Care E.M.25: Length of stay for patients in hospital for over 21 days
Personalised Care/ Primary Care (PCNs)	E.N.1: Personal Health Budgets E.N.2: Social prescribing referrals E.N.3: Personalised Care and Support Planning
Cancer	E.P.1: One year survival from cancer E.P.2: Proportion of cancers diagnosed at stages 1 or 2
Maternity	E.Q.1: Stillbirth Rate E.Q.2: Neonatal Mortality Rate E.Q.3: Percentage of women placed on a continuity of carer pathway E.Q.4: Brain Injury Rate
Diabetes	E.R.4: Number of people supported through the NHS Diabetes Prevention Programme
Stroke	E.S.1: Proportion of patients directly admitted to a stroke unit within 4 hours of clock start E.S.2: Percentage of applicable stroke patients who are assessed at 6 months

Joined Up Care
Derbyshire

Joined Up Care Derbyshire

5 Year Strategy Delivery Plan: 2019/20 to 2023/24

Framing The Joined Up Care Derbyshire Strategy Refresh

- Our plan is outcomes driven so that the citizens of Derbyshire ***'have the best start in life, stay well, age well and die well'***

- We are not 'throwing baby out with bathwater' - The 2016 plan provided the foundations for the next iteration and development of our five year Strategy Delivery Plan in response to the NHS Long Term Plan (LTP) published in January 2019. **The agreed Derbyshire model of care remains valid and will provide the basis by which we will continue to transform the health and wellbeing of our population and improve outcomes as set out in the refreshed five year plan.** We are therefore refreshing rather than re-writing our plan.

- The Derbyshire ambition to deliver the Quadruple Aim remains at the forefront
- We have learned from the 2016 STP Plan
- We have built on that which we believe still holds true

- We have focused on making improvement in wider determinants of health such as housing, education and air pollution management leading to improved outcomes for people in Derbyshire, including the partnerships needed to progress this work.

- We have ensured there is a stronger focus on addressing inequalities and population health management

- The refresh has been informed and developed through strong engagement with people, patients, staff and wider stakeholders and this will continue to drive our approach

- **We recognised that the 5 year plan is a requirement to demonstrate how we will implement the NHS Long Term plan – we will take a whole population approach ensuring this is done with our Local Authority partners**

- **We have focussed on people not patients**

This plan sets out our response to the NHS Long Term Plan published in January 2019. To better enable delivery of the ambitions set out the Derbyshire system has agreed to ensure a broader population health and wellbeing approach in our plan. Fundamentally, this 5 year plan sets out:

- Our response to implementing the commitments set out in the to the NHS Long Term Plan to 2023/24, with 2019/20 as the transitional year
- Our plan to become and Integrated Care System (ICS); including how we will bring together local organisations to redesign care and improve population health, creating shared leadership and action
- An outcomes driven approach so that the people of Derbyshire **'have the best start in life, stay well, age well and die well'**. These are the three population level outcomes which the Derbyshire system has agreed and are consistent with the NHS LTP ambition to ensure that we give everyone the best start in life, deliver world-class care for major health problems, such as cancer and heart disease, and help people to age well.
- Our approach to growing and transforming our workforce in line with the NHS Interim People Plan
- Our approach to developing stronger links and improvements in the wider determinants of health, leading to improved outcomes for people in Derbyshire which include housing, education and air pollution management.
- Our approach to using our resources wisely and living within our financial allocation as a system
- A stronger focus on addressing inequalities through population health management, embedding the personalised care model as an enabler to improve outcomes through segmentation approaches.
- Our engagement and involvement approach to ensure strong collaboration and coproduction with our public and stakeholders

Importantly, we recognise the cultural shift required to enable wellbeing rather than solely fixing ill health, throughout our plan and our approach going forward will focus on people not just patients.

Towards a Healthier Derbyshire

"The longstanding aim has been to prevent as much illness as possible. Then illness which cannot be prevented should where possible be treated in community and primary care. If care is required at hospital, its goal is treatment without having to stay in as an inpatient wherever possible. And, when people no longer need to be in a hospital bed, they should then receive good health and social care support to go home'. NHS Long Term Plan, January 2019.

The Health and Care case for change is strong; we know that:

- By 2033 it is forecast that a quarter of the population will be over 65 years old
- Life expectancy in Derby and Derbyshire is significantly lower than the national average for both men and women and is no longer improving
- People die earlier than they should in some parts of Derby and Derbyshire from respiratory, mental health, falls, CVD and MSK related conditions compared to national average

Demand on services has been increasing, but much of that extra demand is for treatment of conditions which are preventable. At its heart, the NHS remains a treatment service for people when they become ill. Our ambition is to develop a system in Derbyshire which shifts the focus from treating ill-health to enabling wellness; to improve the health of local people, reduce health inequalities and stem the rising demand for health and care services. If we are serious about improving population health, health inequalities and stem the demand for services, we need to take action across the four domains:

Vision	A Vision for Population Health in Derbyshire – that people in Derbyshire have the best start, stay well, age well and die well Delivered through improving population health and reducing inequalities		
Outcomes (what)	1. Have the best start in life	2. Stay well	3. Age well and die well

4 pillars (how)	Wider determinants of health	Health Behaviours & lifestyles	Integrated health and care system	Our Communities
	e.g. Income, housing, environment, transport, education, work	e.g. Diet, smoking, physical activity, alcohol and drug use	e.g. Integrate care around need, ability to manage multi-morbidity, services effective and efficient	e.g. Planning, licensing, relationships, community networks, asset-focussed.

The Derbyshire ambition to deliver the **Quadruple Aim - Improving experience of care (quality & satisfaction), Improving the health of the population, Improving staff experience and resilience, Reducing the per capita cost of healthcare**; will remain at the forefront in our approach and will be underpinned by our five strategic priorities: **Place based care, prevention and self management, population outcomes, system efficiency and system management**. In addressing the quadruple aim and delivering the ambitions set out in our plan, Derbyshire will be a great place to grow up in, work and live.

Our plan will continue to evolve and there will be opportunities for Derbyshire people to share their views to help make services the best they can be. For more information, and to find out in coming months about how to get involved please visit https://www.joinedupcarederbyshire.co.uk/

Any changes proposed to current services would involve local engagement and, if appropriate, consultation. Any consultation would follow legal guidance, and involve as many local people as possible.

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Derbyshire STP – 'plan on a page'

The summary below provides a high level overview of the five year Joined Up Care Derbyshire Strategy Delivery Plan

(1) The Quadruple Aim: Challenges

The health and care challenges we face, and our plans for addressing them, are rooted in the particular needs of the County:

- Fundamentally, we know that across Derbyshire people are living longer in ill health and significant inequalities exist; the are areas of significant rurality which create access challenges.
- We have made significant progress with beginning to 'join up care'; however, there remain many opportunities to integrate care more effectively and consistently.
- We also know we have significant improvements to make in Primary Care and Urgent Care, as well as ongoing improvements in a number of other areas
- The financial gap if we do nothing for the Derbyshire health system is anticipated to be £105m by 2023/24 , with a further £XXX (TBC ahead of final submission) gap across the two local authorities (LAs) - there are a number of factors that are driving this position

To tackle the gaps requires transformational changes to the way in which care is provided.

To direct the changes we have defined an aiming point - a place-based care system which is effectively joined up with specialist services and managed as a whole.

(2) Our priorities

Five priorities form the core of our 5 Year Joined Up Care Derbyshire Strategy Delivery Plan:

- **Place-based care:** We will accelerate the pace and scale of the work we have started to 'join up' care to transform out of hospital care and fully integrate community place based care by operating as a single team to wrap care around a person and their family, tailoring services to different community requirements across our 8 Places, underpinned by Primary Care Networks
- **Prevention and self-management:** By preventing physical and mental ill health, intervening early to prevent exacerbation and supporting self-management, we will improve health and wellbeing
- **Population Outcomes:** We will focus on improving the outcomes for the people of Derbyshire by applying an effective Population Health Management approach, embedding the personalised care model as an enabler to improve outcomes
- **System efficiency:** We will ensure ongoing efficiency improvements across commissioners and providers
- **System Development**: We will come together to manage the Derbyshire system through an Integrated Care System (ICS), develop Integrated Care Providers (ICPs) and our Strategic Commissioning function through aligned leadership and governance

(3) Impact & Implications

Delivering our plan will help us to:

- Meet our aims to keep people: (i) **safe & healthy** – free from crisis and exacerbation; (ii) **at home – out of social and health care beds**; and (iii) **independent – managing with minimum support**. We will begin to address lifestyle issues related to poor health and will improve access to urgent and routine care.
- Achieve a financially sustainable system: the combined impact of the priorities described will enable us to achieve a financially balanced health system by 2023/24

We will significantly change the 'shape' of the system:

- With more care delivered through Place based care (growing from 30% to 39% of all care delivered) and a reduction in care delivered in specialist settings.
- Major changes to the workforce – more staff delivering place-based care (c.10% of our current workforce)
- Changes to the physical configuration of place-based services
- Greater integration and streamlined commissioning across health and local authority driven by a population health management approach
- Increased integrated provision of services wrapped around people and their communities

(4) Next steps

Delivering the STP:

- The work over the next five years to deliver our plan is part of and consistent with our ongoing journey to deliver our model of care which will transform 'out of hospital care' through fully integrated place based care and reduce reliance on institutional care.
- We will accelerate the pace and scale of these changes to have the necessary transformational impact to build upon progress made to date to establish our Place Alliances and develop these further in light of new models which include Primary Care Networks (PCNs) and Integrated Care Providers (ICPs)
- Our approach will be facilitated by the development of our Integrated Care System by April 2021 to now begin the transition from planning into delivery.
- During the next 6 months we will:
  - Align system capacity and capability to enable even greater focus on delivery
  - Progress delivery of a number of high impact transformation schemes to support future sustainability.
  - Continue our localised engagement programme focussing on staff, stakeholders and our local population.

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What is Joined Up Care Derbyshire?

Our partnership is made up of providers (NHS, Local Authority and Voluntary Sector) and commissioners; Joined up Care Derbyshire is the identity by which we work together in this partnership.

Joined Up Care Derbyshire

What Will Be Different

- Our system will jointly plan for the health and social care needs of the population; moving from fixing illness to enabling wellness
- We will develop an agile workforce to meet the changing approach to population health and system working
- The focus of delivery will be PLACES rather than organisations where appropriate, supported by strong Primary Care Networks and Integrated Care providers
- We will adopt and implement core principles for how we work and challenge each other to upholding them
- We will establish strong system governance with decision making arrangements agreed
- We will live within our means
- Commissioners will increasingly move towards an integrated commissioning budget across health and social care to jointly commission at Place and make strategic commissioning decisions in the deployment of that budget
- Providers will increasingly move to integrate provision and delivery in order to deliver the outcomes for the population of Derbyshire at both footprint and Place levels within allocated resources
- We will move towards Integrated Care Partnerships being at the heart of care pathway delivery to meet the local needs of individuals

Our Guiding Principles: We will...

- Be driven by the interests of the people and communities we serve
- Support each other to address barriers to system transformation
- Ensure services are provided as close as possible to the places people live
- Design health and care services to meet the needs and wants of the people who use them, not the organisations who provide them

The Derbyshire Model of Care

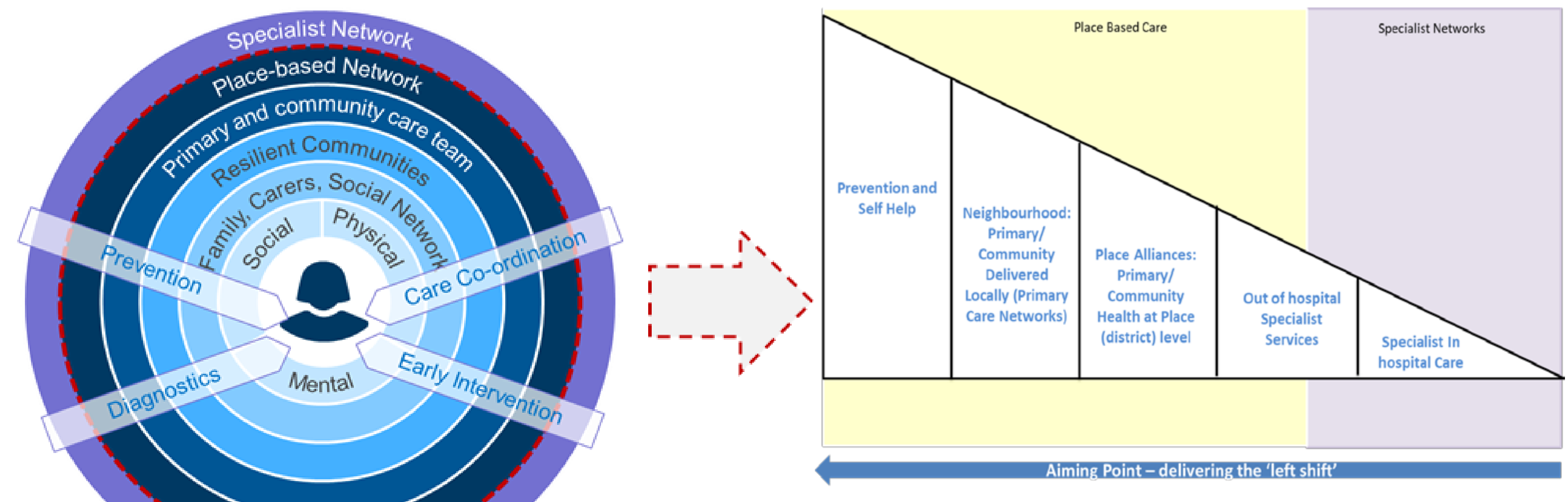
Joined Up Care Derbyshire

We will accelerate the pace and scale of the work we have started to 'join up' care; transforming out of hospital care which fully integrates community place based primary care, mental health, community services, social care and the third sector. Services will operate as a single team, wrapping care around a person and their family, tailoring services to different community requirements across our 8 Places and 15 Primary Care Networks.

Our model of care defines a placed based system which is effectively joined up with specialist services and managed as a whole. So that, fundamentally, the Derbyshire system would aim to keep people:

- **Safe & healthy** – free from crisis and exacerbation.
- **At home** – out of social and healthcare beds.
- **Independent** – managing with minimum support.

... founded on building strong, vibrant communities.



Strategic Priority: System Development

We will come together to manage the Derbyshire system through an Integrated Care System (ICS), develop Integrated Care Providers (ICPs) and our Strategic Commissioning function through aligned leadership and governance

Why is this a priority for Derbyshire?

Many of the initiatives within the NHS LTP are not new to Derbyshire as we have been working on these since developing our last STP plan. However, so far they have not yet been implemented to deliver the necessary transformational impact – in either care quality or financial improvement terms. And, we believe that this is significantly due to our existing system infrastructure, which drive competing organisational priorities and an inability to divert funding and investment from historical patterns of provision that do not meet the changing needs of the population.

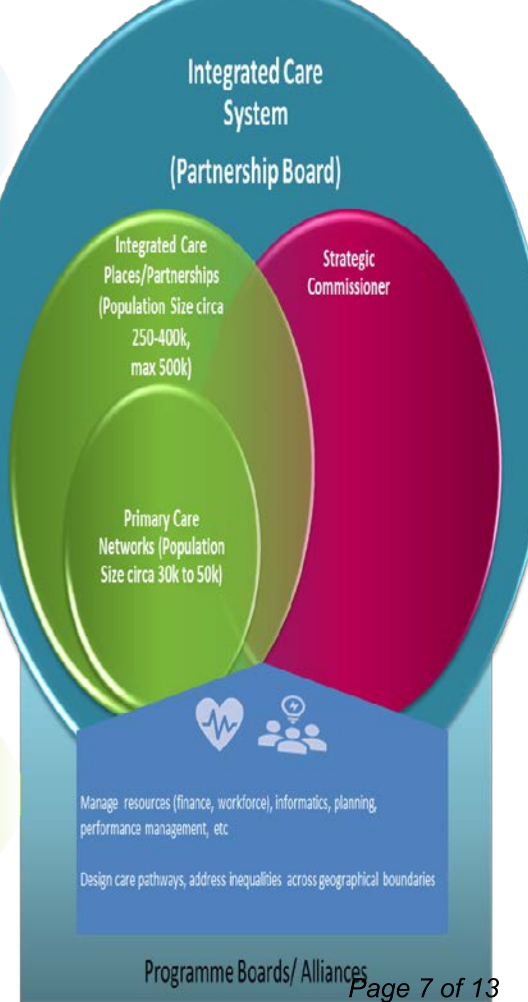
So, we need to ensure that this time we put the arrangements in place to drive sustainable, embedded change. These arrangements must address past barriers to change including the lack of cross-system working, misaligned incentives and the predominant organisational focus over system-wide and patient-centred perspectives.

Transforming how we work together across organisations to manage the system is therefore a priority for our STP. We must make system-level working the default option - 'business as usual' - as an approach for managing all of the care we commission and provide. We will do this by developing as an Integrated Care System by April 2021.

The NHS LTP provides us with the catalyst required for this system change to create a strong underpinning infrastructure which supports transformation and improvements for our population without the historic barriers we have faced.

To facilitate our transition towards an ICS, we have agreed the Derbyshire ICS framework and constituent job cards.

<u>Integrated Care System (ICS): Job Cards</u>



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Strategic Priority: System Development

We will come together to manage the Derbyshire system through an Integrated Care System (ICS), develop Integrated Care Providers (ICPs) and our Strategic Commissioning function through aligned leadership and governance

Our Approach

Place based care will remain at the heart of our approach to meet the local needs of individuals; developing our Neighbourhoods through Primary Care Networks (PCNs) within our Integrated Care Partnerships (ICPs) and the wider Integrated Care System (ICS).

Our ICS Development Plan: Headlines

- We have successfully completed the ICS Development Programme and Commissioning Capability Programme
- We are increasingly engaged General Practice leadership in system decision making
- Our ICP configuration is being progressed through the ICP Development Group, and is described further on the following page
- We have launched a System OD programme, including transformation workstreams, Executives, and NEDs/Lay members events
- We have strengthened our governance which now includes a finance sub-committee, Quality and Performance Group and Chairs

Furthermore, we have identified the following key milestones in the next quarter:

- Agree our system clinical strategy (December 2019 STP Board)
- Continue to build resilience and services provided at Place level
- Approve STP OD strategy and roll out system wide OD programme to help partners increasingly work in the system space (November 2019 LWAB/STP Board)
- Develop a single system financial savings plan for 2020/21
- Review of STP Board governance and ways of working
- Streamlining of ways of working: HR processes, procurement

Our aim is to be an Integrated Care System which is built around care close to home, where hospital beds are only used where somebody cannot be cared for safely in their own environment

Characteristics of an Integrated Care System

- System Leadership, Partnerships & change capability
- System architecture & strong Financial Management & planning
- Track Record of Delivery
- Integrated Care Models
- Coherent & defined Population

Key Deliverables to enable Derbyshire to become an ICS

Transformation Workstreams

- Planned Care
- Improving Flow
- Urgent & Emergency Care
- Place/ Primary Care Networks
- Children & Young People
- Maternity
- Mental Health
- Learning Disabilities & Autism
- Cancer
- End of Life
- Disease Management

Enablers

- Prevention & Population Health Management
- Workforce
- Digital
- Communications & Engagement
- Estates
- Finance

Enabling development programmes

- ICS Development Programme ✓
- Commissioning Capability Programme ✓
- Population Health Management Programme
- System wide OD Programme

Enabling work

- System Savings Approach ✓
- Outcomes Based Accountability ✓
- Business Intelligence/PHM
- Development of Place Alliances and Primary Care Networks ✓
- Derbyshire Clinical Care Strategy
- Shared finance plan and risk share agreement ✓
- Integrated Care Partnership development
- Profiling system wide demand, capacity and workforce

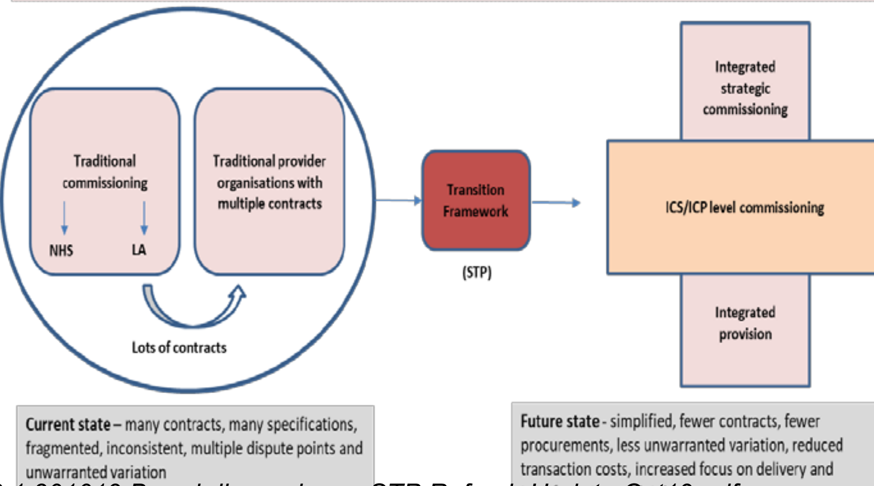
Strategic Priority: System Development

We will come together to manage the Derbyshire system through an Integrated Care System (ICS), develop Integrated Care Providers (ICPs) and our Strategic Commissioning function through aligned leadership and governance

We will develop our partnership to become an ICS by April 2021 which is central to the delivery of the LTP; our future arrangements will include the following components.

Streamlined Strategic Commissioning

- We have already streamlined our commissioning arrangements with the merger of four Clinical Commissioning Groups (CCG) into one. Derby and Derbyshire CCG formally came into existence on 1 April 2019. These arrangements enable a single set of commissioning decisions at system level.
- Commissioners will make shared decisions with providers on how to use resources, design services and improve population health. We will increasingly move towards an integrated commissioning budget across health and social care to jointly commission at place and make strategic commissioning decisions in the deployment of that budget.
- We will further develop our joint commissioning arrangements with Local Authorities.



Streamlined Provision

Providers will increasingly move to integrate provision and delivery in order to deliver the outcomes for the population of Derbyshire at both footprint and Place/PCN levels within allocated resources – known as Integrated Care Partnerships (ICPs). All PCNs will be integral to ICPs; which will be designed to deliver localised place based care.

Our ICPs will provide a fundamental shift in the way care provision is designed and organised with all partners playing an equal role. This inclusive approach will not only drive our approach to longer term care redesign but will also be the basis on which we agree our ICP configuration.

We will confirm our ICP configuration during quarter 3 of 2019/20, in doing so we will describe the functions of our ICPs, ready for shadow running from 1 April 2020. This approach is underway and will build upon the key things we want our ICPs to address/deliver for our population:

- Understand our population and their health and social care needs (link to Population Health Management)
- Use place alliance intelligence
- Focus on care models not clinical pathways in isolation
- Recognise that there needs to be a service redesign
- Shared workforce, planning and assets
- Need to consider what is done at different levels within/across the system
- Don't lose gains developed over the years
- Need staff and public engagement
- Engage professional and clinical leadership

Our ICP development Plan: Headlines:

We have;

- Agreed the case for change
- Agreed a working hypothesis of either 3 or 4 ICPs, to be further developed
- Committed to further discussions with constituent partners to inform thinking re the options of 3 or 4 ICPs (GP Provider Alliance, Erewash Place, Amber Valley Place, South Derbyshire Place, Derbyshire Dales Place, High Peaks Place and respective PCNs)

It is intended that the above will enable a single preferred option to be agreed for recommendation to the December JUCD Board.

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The impact of our plan [DN we will further review and refine this ahead of the final submission]

Joined Up Care Derbyshire

Delivering our Joined Up Care mission to improve population health outcomes for the people and communities we serve will enable us to ensure that the people in Derbyshire have the best start in life, stay well, age well and die well. Working together, and with strong and vibrant communities, we will keep people safe and healthy – free from crisis and exacerbation, at home – out of social and healthcare beds and independent – managing with minimum support. To do this we will ensure all our services are well run, integrated and make the best use of the available resources.

So what is our plan saying?

Population Level Outcome	For the people of Derbyshire this means that…..
Best Start in Life A healthy pregnancy, a safe environment, a nurturing and secure relationship with caregivers, good nutrition, healthcare and support	Expectant mothers will be better supported through personalised care planning, continuity of the person caring for them and access to digital health records and enhanced postnatal support .
	Children and young people will receive improved mental and emotional wellbeing support, and with improved access to urgent care and psychological support when they need it; providing 24/7 mental health crisis provision
	A Community Wellness approach will be developed where individuals and families can receive the support they need to improve and support their physical and emotional health and wellbeing; ensuring there are appropriate community based health services
Stay Healthy Helped to live a healthy life, make healthy choices and protected from threat. Able to maintain quality of life and recover from ill health or injury	Care for people with learning disabilities and autism will be transformed. Intensive support teams will be developed to support independent living in the community
	Mental Health services will receive increased investment . We will reduce the length of time people spend in hospital and end the need for out of area placements. More people will be supported through a Primary Care and Mental Health wellbeing approach, including increasing access to psychological therapies
	People have access to care at the right time and in the right place. With more staff, and through a diverse skill mix we will improve access to General Practice including same day urgent care services in primary care and treating people within community-based Urgent Care Treatment centres.
	Where people do need hospital care access to urgent and routine care, will be improved and services will be tailored to their needs. This way we will enable people to recover from ill health or injury quickly and to return home at the earliest opportunity. We will transform the way outpatient services are delivered, reducing the need for face to face outpatient appointments by a third and using digital technology to support prevention and self-management
	Primary Care Networks will develop and deliver multidisciplinary care and services that meet the needs of the patients and communities and operate as a single team to wrap care around a person and their family. Care and treatment will be provided closer to home, such as treating minor eye conditions and support patients wellbeing through social prescribing.
	Cancer outcomes will be improved. We will improve the early diagnosis of cancer by increasing the uptake of screening programmes and extending access to diagnostic tests. We will ensure that people living with cancer will have improved access to high quality treatment and care, including psychological support.
Age Well, Die Well Fit, safe and secure, able to maintain independence and actively participate. A personalised, comfortable and supported end of life	People with dementia will be supported through the Derbyshire Well Pathway for Dementia ; providing the best care possible for people living with dementia, their carers and those important to them.
	Older people will received proactive, person centred and integrated care. We will embed the frailty model of care for Derbyshire to manage frailty as a long term condition in its own right, rather than a label
	People living in care homes will receive more NHS support to care homes, ensuring that their needs assessed and met and reducing the need for unnecessary and avoidable hospital admissions
	People approaching the end of their life will have fair access to personalised end of life care and support and to die in their preferred place of care. We will promote honest and open conversations about death across communities. and that those caring for the dying person are involved and supported .

Reducing the per capita cost of healthcare

Derbyshire STP

LTP - Key Finance Numbers - 27th September Submisison

Joined Up Care Derbyshire

System Efficiency Target

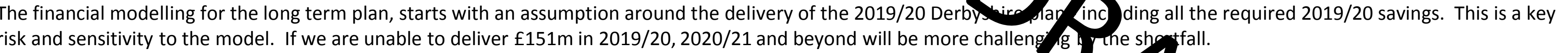
	2019/20 Plan £'000s	2019/20 FOT £'000s	2020/21 Plan £'000s	2021/22 Plan £'000s	2022/23 Plan £'000s	2023/24 Plan £'000s
NHS Derby and Derbyshire CCG	69,500	69,500	61,536	64,300	62,480	68,566
Chesterfield Royal Hospital NHS FT	9,831	9,831	3,597	3,573	3,422	3,497
Derbyshire Community Healthcare Trust	6,082	6,082	6,284	3,890	3,446	3,901
Derbyshire Healthcare NHS FT	4,599	4,599	4,583	2,045	2,690	5,554
East Midlands Ambulance Service	4,64[illegible]	[illegible],647	8,176	9,258	8,326	8,518
University Hospitals of Derby and Burton NHS FT	56,30[illegible]	56,300	1[illegible],212	19,431	15,296	14,676
	150,959	**150,959**	**[illegible]01,388**	**102,497**	**95,660**	**104,712**

System In Year Underspend/(Deficit)

	2019/20 Plan £'000s	2019/20 FOT £'000s	2020/21 Plan £'000s	2021/22 Plan £'000s	2022/23 Plan £'000s	2023/24 Plan £'000s
NHS Derby and Derbyshire CCG	(29,000)	(29,000)	0	(0)	0	0
Chesterfield Royal Hospital NHS FT	1,975	1,975	1,975	1,975	1,975	1,975
Derbyshire Community Healthcare Trust	1,832	1,833	1,833	1,833	1,833	1,833
Derbyshire Healthcare NHS FT	615	615	(0)	0	(1)	1
East Midlands Ambulance Service	(5,069)	(5,068)	45	66	90	121
University Hospitals of Derby and Burton NHS FT	(22,469)	(25,649)	(16,414)	(11,377)	(5,027)	859
Underspend / (Deficit) - **(excluding CSF/PSF/MRET/FRF)**	**(52,116)**	**(55,294)**	**(12,560)**	**(7,503)**	**(1,129)**	**4,789**

	2019/20 £'000s	2019/20 £'000s	2020/21 £'000s	2021/22 £'000s	2022/23 £'000s	2023/24 £'000s
CCG Allocation	1,651,446	1,657,251	1,678,594	1,722,1[illegible]0	1,7[illegible],079	1,846,908

	2019/20 Plan £'000s	2019/20 FOT £'000s	2020/21 Plan £'000s	2021/22 Plan £'000s	2022/23 Plan £'000s	2023/24 Plan £'000s
Recurrent	132,193	105,022	114,378	89,637	83,164	90,999
Non Recurrent	18,766	45,937	(12,990)	12,860	12,496	13,713
Total Efficiency Target	**150,959**	**150,959**	**101,388**	**102,497**	**95,660**	**104,712**
% of CCG Allocation	**9.1%**	**9.1%**	**6.0%**	**6.0%**	**5.4%**	**5.7%**



The financial modelling for the long term plan, starts with an assumption around the delivery of the 2019/20 Derbyshire plan, including all the required 2019/20 savings. This is a key risk and sensitivity to the model. If we are unable to deliver £151m in 2019/20, 2020/21 and beyond will be more challenging by the shortfall.

Activity growth rates which have been agreed with all the NHS statutory bodies and have then been modelled, including mental health, community services and ambulance services, which create the unmitigated overall savings challenge for 20/21 to 23/24 - £101m, £102m, £96m and £105m. We have used commissioner spend as a proxy for system marginal costs which looks broadly reasonable on review. This has generated a broadly triangulated, activity, workforce and financial model, pre required transformational changes.

Next we will model the impact of the transformation described elsewhere in our Long Term Plan submission, to generate a mitigated, agreed and triangulated position, which we aim to complete by the November submission, including a firmer view on the 19/20 savings sensitivity. This will include demonstration of our commitment to allocating the additional LTP investment funding in relation to specified key deliverables.

In terms of the status of the mitigation the system believes it can consume the provider CIP requirement of either 1.1% (or 1.6% in the case of UHDB) via the delivery of reduced unit costs for the existing models of care. At this stage there is also a tentative assumption around the unplanned, planned and place workstreams delivering £10m of savings in each of the four financial years. This would leave a residual system challenge of £32m, £34m, £32m and £39m in 20/21 to 23/24.

These savings are not modelled in the table above or the planning workbook and the key work in the system is now the valuation of the workstreams and the broader redesign initiatives for 20/21 and beyond, adding to and firming up those plans.

Derbyshire STP – financial plan

The summary below provides a high level overview of the financial plan for the Derbyshire STP.

PLACEHOLDER/DRAFT

Impact on capacity (including beds)

The 535 beds calculation originally submitted in the Derbyshire STP is no longer credible. The landscape has changed since then and we have done further modelling on growth of admissions which shows that if we do nothing and activity grows by 4.2% then we will need 2546 beds in the Derbyshire system in five years' time compared with 2345 today, an increase of 286 beds. The 2546 figures quoted are total beds across the system, including community, mental health and acute beds.

We know that our main pressure on beds is happening in acute trusts, and this is where the anticipated growth will take place as greater numbers of poorly people require admission to an acute hospital bed. Our proactive and preventative work, and linking into the wider determinants of health are crucial parts of the plan to ensure that we are not 'doing nothing' and are actively tackling the growth in admissions.

In addition, our model of care in the community remains that care is better provided closer to home. We are therefore introducing more Pathway 1 (Home) and Pathway 2 (Care Home) care to ensure that patients can be discharged to the most appropriate care setting. This results in a net reduction of community hospital beds.

The two issues – acute beds and community beds – are clearly inter-related but we can reduce the number community beds at the same time as needing more acute beds as they provide different types of care. Retaining community hospital beds does not solve the acute hospital bed issue and it is our work in other programmes – disease management, prevention and planned care - which will help to solve the acute bed issue. The above provides a baseline position from which we will model our assumed growth rates for 2020/21 and beyond to better understand the anticipated bed capacity requirements for Derbyshire.

Assumptions: The key planning assumptions driving the financial model are:

- FOT based on month 3
- All 19/20 QIPP is delivered in the position
- £5m set aside for investment (in addition to LTP Investments)
- 0.5% contingency per annum
- MHIS is met
- Acute growth based on 3 year average (avg 3.72%)
- Ambulance 6.8%
- Prescribing 5%
- CHC 4.5% to 5.8%
- Community 1.1%
- Running costs 3%

Investments

We will commit the additional LTP investments as identified in the table below to support delivery of specific LTP commitments. Where appropriate further targeted investment opportunities will also be explored.

	2019/20 LTP allocation	2020/21 LTP allocation	2021/22 LTP allocation	2022/23 LTP allocation	2023/24 LTP allocation
	£000	£000	£000	£000	£000
Joined Up Care Derbyshire STP	10,464	10,801	14,978	22,025	31,836
1. Mental Health	1,107	1,196	3,785	7,590	10,175
(a) CYP community and crisis		58	1,161	1,792	2,948
(b) Adult Crisis		1,138	540	722	941
(c) New integrated models of Community and Primary care for SMI			2,084	5,076	6,286
2. Primary Medical and Community Services	6,456	7,205	8,284	10,822	13,180
(a) Primary Care	6,456	6,677	7,051	7,225	7,125
(b) Ageing Well		528	1,233	3,597	6,055
3. Cancer	2,139	1,601	1,250	1,199	1,200
4. Other	763	799	1,659	2,415	7,280

Financial Plan

- The STP will use the financial plan as the basis for agreeing contracts with providers to ensure the sustainability of the system
- 2019/20 will be the baseline period which will form future year projections based on forecast out-turn
- The baseline will be uplifted for growth (based on activity assumption identified earlier) and inflation
- Commissioners and providers will also deliver technical efficiencies within their own organisations
- The future financial plan will be underpinned by agreed risk share and risk management arrangements; managed through the system governance
- Work is now underway to map the impact of the transformational changes to mitigate the challenges identified in our case for change including financial, workforce and activity

Timetable for STP plan approvals

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The draft plan has been shared and considered by all partner organisations as part of ongoing engagement and involvement into the development of the final plan. There is a need for the plan to be agreed by system leaders ahead of the 15 November submission and the JUCD Board agreed at the meeting on 18 October that the System Executive: CEOs group would have delegated authority to approve the detailed modelling and triangulation required to be incorporated into the plan narrative. This would ensure that contentious issues were understood by system partners and collectively managed with appropriate risk mitigations where necessary.

Action	Deadline
Submission to JUCD Board	13 September
Derbyshire County Council Adults Health Improvement and Scrutiny Committee ***(1)***	16 September
JUCD Board sign off (draft plan)	20 September
Derby City Council Adults Health Improvement and Scrutiny Committee ***(1)***	24 September
Submission to NHSE/I (draft plan)	27 September
Submission to JUCD Board for approval	11 October
JUCD Board ***(2)***	18 October
Trust Boards, Governing Body, Local Authorities and Health & Wellbeing Boards approval ***(3)***	
Derbyshire County Health & Wellbeing Board	3 October
DCHS	31 October
Submission to NHSE/I (interim plan submission)	1 November
DHcFT	5 November
CRH	6 November
DHU	6 November
CCG	7 November
UHDB	12 November
Derby City Health & Wellbeing Board	14 November
Submission of Final Plan to JUCD Board ***(4)***	14 November
Final submission to NHSE/I ***(5)***	15 November
Final JUCD Board ***(6)***	21 November
EMAS ***(7)***	3 December

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Notes:

1. Both Scrutiny Committees do not sit again ahead of final submission (the next county meeting is on 25 November and City do not meet again until February 2020). However the draft plan has been taken to both committees in September and further updates will also be taken to future meetings
2. The JUCD Board received and approved further amendments to the plan to confirm version being taken through organisational governance processes
3. Due to the scheduling; particularly with regards to feedback from region, it may be necessary for Boards/ Governing Body to receive the final plan which is subject to further amendments (depending on the nature of the feedback). The principles in terms of the narrative have been supported by the JUCD Board with delegated authority to the System Executive to approve the financial modelling and triangulation (impact of the plan) as these areas develop prior to 15 November
4. Papers will be submitted to the Board one day before final submission to NHSE/I but the Board meeting itself will take place after. The JUCD Board have agreed that the System Executive: CEO group will have delegated authority for final sign off of the plan ahead of the submission.
5. **Although this is the final submission to NHSE&I discussions will need to take place before this date to ensure plans are agreed with system leads and the regional team ahead of the actual submission date.**
6. The JUCD Board will receive the final plan hopefully with any final feedback from region
7. The EMAS Board date falls after the plan submission and therefore consideration/ agreement is required in relation to interim approach ahead of the plan being published to ensure fit with timescales

Joined Up Care
Derbyshire

Joined Up Care Derbyshire

5 Year Strategy Delivery Plan:

2019/20 to 2023/24

DRAFT v2: Interim 1 November Submission

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Executive Summary

This plan sets out our response to the NHS Long Term Plan published in January 2019. To better enable delivery of the ambitions set out the Derbyshire system has agreed to ensure a broader population health and wellbeing approach in our plan. Fundamentally, this 5 year plan sets out:

- Our response to implementing the commitments set out in the to the NHS Long Term Plan to 2023/24, with 2019/20 as the transitional year
- Our plan to become and Integrated Care System (ICS); including how we will bring together local organisations to redesign care and improve population health, creating shared leadership and action
- An outcomes driven approach so that the people of Derbyshire **'have the best start in life, stay well, age well and die well'**. These are the three population level outcomes which the Derbyshire system has agreed and are consistent with the NHS LTP ambition to ensure that we give everyone the best start in life, deliver world-class care for major health problems, such as cancer and heart disease, and help people to age well.
- Our approach to growing and transforming our workforce in line with the NHS Interim People Plan
- Our approach to developing stronger links and improvements in the wider determinants of health, leading to improved outcomes for people in Derbyshire which include housing, education and air pollution management.
- Our approach to using our resources wisely and living within our financial allocation as a system
- A stronger focus on addressing inequalities through population health management, embedding the personalised care model as an enabler to improve outcomes through segmentation approaches.
- Our engagement and involvement approach to ensure strong collaboration and coproduction with our public and stakeholders

Importantly, we recognise the cultural shift required to enable wellbeing rather than solely fixing ill health, throughout our plan and our approach going forward will focus on people not just patients.

Towards a Healthier Derbyshire

"The longstanding aim has been to prevent as much illness as possible. Then illness which cannot be prevented should where possible be treated in community and primary care. If care is required at hospital, its goal is treatment without having to stay in as an inpatient wherever possible. And, when people no longer need to be in a hospital bed, they should then receive good health and social care support to go home'. NHS Long Term Plan, January 2019.

The Health and Care case for change is strong; we know that:

- By 2033 it is forecast that a quarter of the population will be over 65 years old
- Life expectancy in Derby and Derbyshire is significantly lower than the national average for both men and women and is no longer improving
- People die earlier than they should in some parts of Derby and Derbyshire from respiratory, mental health, falls, CVD and MSK related conditions compared to national average

Demand on services has been increasing, but much of that extra demand is for treatment of conditions which are preventable. At its heart, the NHS remains a treatment service for people when they become ill. Our ambition is to develop a system in Derbyshire which shifts the focus from treating ill-health to enabling wellness; to improve the health of local people, reduce health inequalities and stem the rising demand for health and care services. If we are serious about improving population health, health inequalities and stem the demand for services, we need to take action across the four domains:

Vision	**A Vision for Population Health in Derbyshire –** that people in Derbyshire have the best start, stay well, age well and die well Delivered through improving population health and reducing inequalities			
Outcomes (what)	1. Have the best start in life	2. Stay well		3. Age well and die well
4 pillars (how)	Wider determinants of health	Health Behaviours & lifestyles	Integrated health and care system	Our Communities
	e.g. Income, housing, environment, transport, education, work	e.g. Diet, smoking, physical activity, alcohol and drug use	e.g. Integrate care around need, ability to manage multi-morbidity, services effective and efficient	e.g. Planning, licensing, relationships, community networks, asset-focussed.

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The Derbyshire ambition to deliver the **Quadruple Aim - Improving experience of care (quality & satisfaction), Improving the health of the population, Improving staff experience and resilience, Reducing the per capita cost of healthcare**; will remain at the forefront in our approach and will be underpinned by our five strategic priorities: **Place based care, prevention and self management, population outcomes, system efficiency and system management**. In addressing the quadruple aim and delivering the ambitions set out in our plan, Derbyshire will be a great place to grow up in, work and live.

Our plan will continue to evolve and there will be opportunities for Derbyshire people to share their views to help make services the best they can be. For more information, and to find out in coming months about how to get involved please visit https://www.joinedupcarederbyshire.co.uk/

Any changes proposed to current services would involve local engagement and, if appropriate, consultation. Any consultation would follow legal guidance, and involve as many local people as possible.

What is Joined Up Care Derbyshire?

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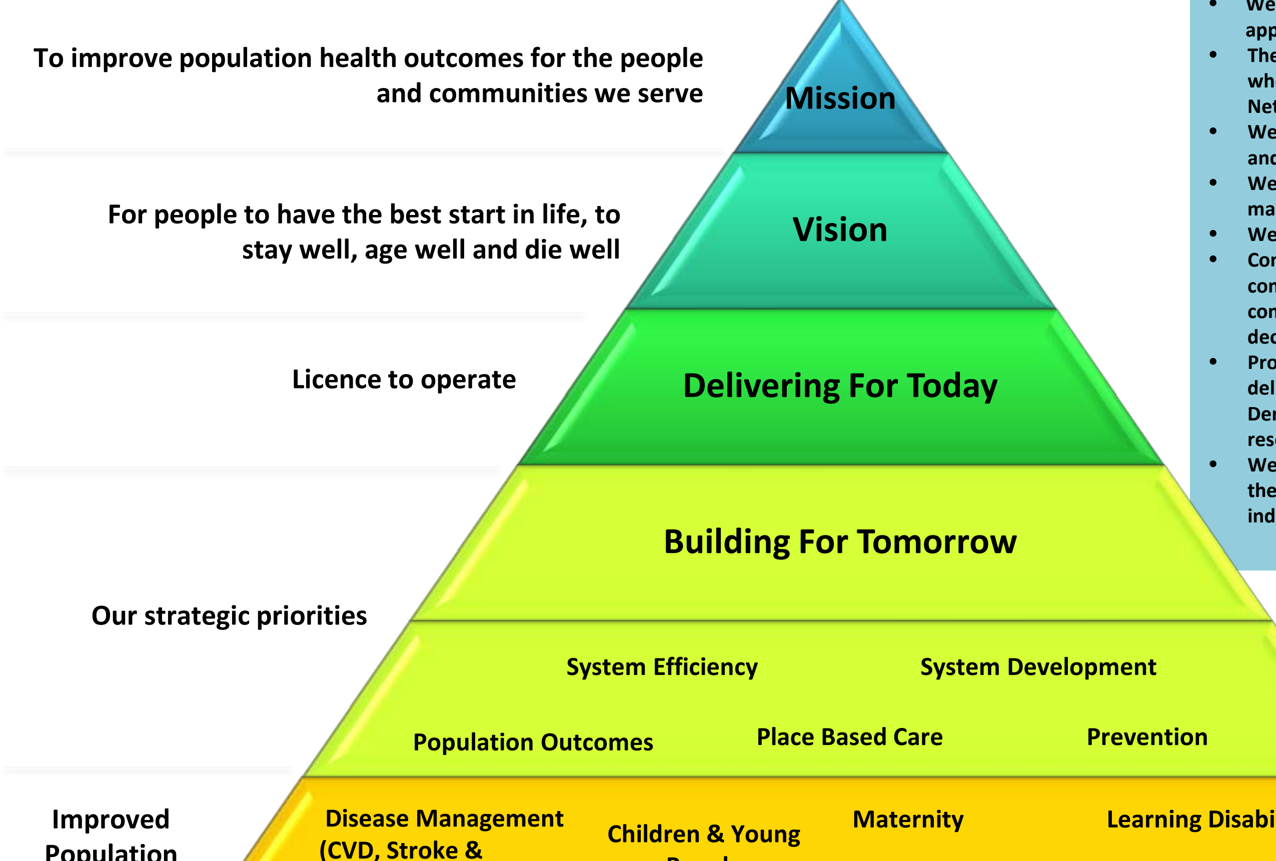
Our partnership is made up of providers (NHS, Local Authority and Voluntary Sector) and commissioners; Joined up Care Derbyshire is the identity by which we work together in this partnership.



What Will Be Different

- Our system will jointly plan for the health and social care needs of the population; moving from fixing illness to enabling wellness
- We will develop an agile workforce to meet the changing approach to population health and system working
- The focus of delivery will be PLACES rather than organisations where appropriate, supported by strong Primary Care Networks and Integrated Care providers
- We will adopt and implement core principles for how we work and challenge each other to upholding them
- We will establish strong system governance with decision making arrangements agreed
- We will live within our means
- Commissioners will increasingly move towards an integrated commissioning budget across health and social care to jointly commission at Place and make strategic commissioning decisions in the deployment of that budget
- Providers will increasingly move to integrate provision and delivery in order to deliver the outcomes for the population of Derbyshire at both footprint and Place levels within allocated resources
- We will move towards Integrated Care Partnerships being at the heart of care pathway delivery to meet the local needs of individuals

Our Guiding Principles: We will...

- Be driven by the interests of the people and communities we serve
- Support each other to address barriers to system transformation
- Ensure services are provided as close as possible to the places people live
- Design health and care services to meet the needs and wants of the people who use them, not the organisations who provide them

Derbyshire STP – 'plan on a page'

The summary below provides a high level overview of the five year Joined Up Care Derbyshire Strategy Delivery Plan

(1) The Quadruple Aim: Challenges

The health and care challenges we face, and our plans for addressing them, are rooted in the particular needs of the County:

- Fundamentally, we know that across Derbyshire people are living longer in ill health and significant inequalities exist; the are areas of significant rurality which create access challenges.
- We have made significant progress with beginning to 'join up care'; however, there remain many opportunities to integrate care more effectively and consistently.
- We also know we have significant improvements to make in Primary Care and Urgent Care, as well as ongoing improvements in a number of other areas
- The financial gap if we do nothing for the Derbyshire health system is anticipated to be £105m by 2023/24 , with a further £XXX (TBC ahead of final submission) gap across the two local authorities (LAs) - there are a number of factors that are driving this position

To tackle the gaps requires transformational changes to the way in which care is provided.

To direct the changes we have defined an aiming point - a place-based care system which is effectively joined up with specialist services and managed as a whole.

(2) Our priorities

Five priorities form the core of our 5 Year Joined Up Care Derbyshire Strategy Delivery Plan:

- **Place-based care:** We will accelerate the pace and scale of the work we have started to 'join up' care to transform out of hospital care and fully integrate community place based care by operating as a single team to wrap care around a person and their family, tailoring services to different community requirements across our 8 Places, underpinned by Primary Care Networks
- **Prevention and self-management:** By preventing physical and mental ill health, intervening early to prevent exacerbation and supporting self-management, we will improve health and wellbeing
- **Population Outcomes:** We will focus on improving the outcomes for the people of Derbyshire by applying an effective Population Health Management approach, embedding the personalised care model as an enabler to improve outcomes
- **System efficiency:** We will ensure ongoing efficiency improvements across commissioners and providers
- **System Development**: We will come together to manage the Derbyshire system through an Integrated Care System (ICS), develop Integrated Care Providers (ICPs) and our Strategic Commissioning function through aligned leadership and governance

(3) Impact & Implications

Delivering our plan will help us to:

- Meet our aims to keep people: (i) **safe & healthy** – free from crisis and exacerbation; (ii) **at home – out of social and health care beds**; and (iii) **independent – managing with minimum support**. We will begin to address lifestyle issues related to poor health and will improve access to urgent and routine care.
- Achieve a financially sustainable system: the combined impact of the priorities described will enable us to achieve a financially balanced health system by 2023/24

We will significantly change the 'shape' of the system:

- With more care delivered through Place based care (growing from 30% to 39% of all care delivered) and a reduction in care delivered in specialist settings.
- Major changes to the workforce – more staff delivering place-based care (c.10% of our current workforce)
- Changes to the physical configuration of place-based services
- Greater integration and streamlined commissioning across health and local authority driven by a population health management approach
- Increased integrated provision of services wrapped around people and their communities

(4) Next steps

Delivering the STP:

- The work over the next five years to deliver our plan is part of and consistent with our ongoing journey to deliver our model of care which will transform 'out of hospital care' through fully integrated place based care and reduce reliance on institutional care.
- We will accelerate the pace and scale of these changes to have the necessary transformational impact to build upon progress made to date to establish our Place Alliances and develop these further in light of new models which include Primary Care Networks (PCNs) and Integrated Care Providers (ICPs)
- Our approach will be facilitated by the development of our Integrated Care System by April 2021 to now begin the transition from planning into delivery.
- During the next 6 months we will:
  - Align system capacity and capability to enable even greater focus on delivery
  - Progress delivery of a number of high impact transformation schemes to support future sustainability.
  - Continue our localised engagement programme focussing on staff, stakeholders and our local population.

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Partners involved in Joined Up Care Derbyshire

Primary Care Networks Place Alliances

Derbyshire Health United

Derbyshire Healthcare Foundation Trust EMAS

Chesterfield Royal Hospital General Practice

Derbyshire Community Hospitals Services

Derby and Derbyshire CCG GP Provider Alliance

Derbyshire District and Borough Councils

Derby City Council Derbyshire County Council

University Hospitals of Derby and Burton LMC

Voluntary Sector NHS England Direct Commissioning

We are in this together…..

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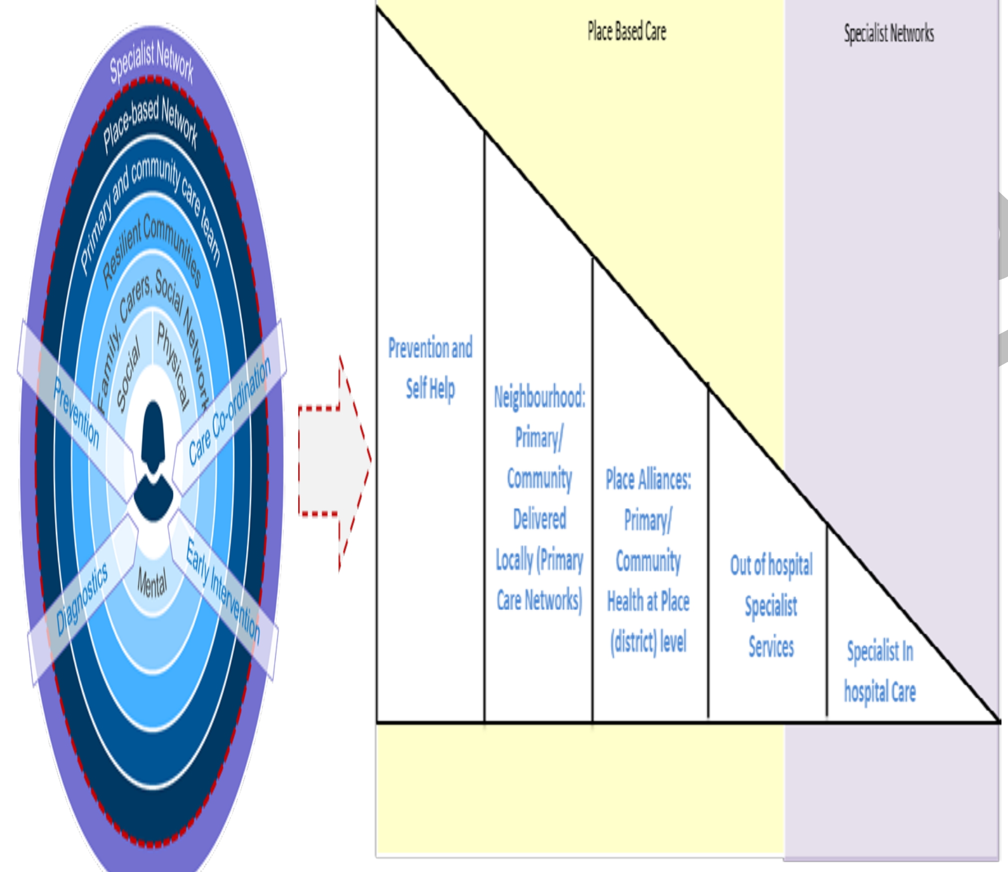
Journey So Far (1)

Health and social care organisations across England have been working together more closely than ever as Sustainability and Transformation Partnerships (STPs), to look at improving care and services for people, making them as effective and efficient as possible. In Derbyshire, organisations came together in 2016, as the Derbyshire STP and developed **Joined Up Care Derbyshire** as our identity. Since this time we have been working hard to break down traditional organisational boundaries to develop greater integrated care for the population we serve. Together, we have made some progress but there is significantly more to be done.

The Derbyshire Model of Care



The 2016 plan provided the foundations for the next iteration and development of our five year Strategy Delivery Plan in response to the NHS Long Term Plan (LTP) published in January 2019. **The agreed Derbyshire model of care remains valid and will provide the basis by which we will continue to transform the health and wellbeing of our population and improve outcomes as set out in this refreshed five year plan.** We are therefore refreshing rather than re-writing our plan.

Our model of care defines a placed based system which is effectively joined up with specialist services and managed as a whole. So that, fundamentally, the Derbyshire system would aim to keep people:

- **Safe & healthy** – free from crisis and exacerbation.
- **At home** – out of social and healthcare beds.
- **Independent** – managing with minimum support.

... founded on building strong, vibrant communities.

Working together to deliver our model of care

Our plan is underpinned by a system wide Clinical Care Strategy developed through our Clinical and Professional Reference Group (CPRG). This is based on a set of agreed care principles and standards which fully support the model of care. The role of CPRG is to provide clinical and professional leadership to support development and implementation of service changes required to deliver the system objectives.

Both Local Authorities are members of the Joined Up Care Derbyshire Board and have been fully engaged in the STP to date, in addition have leadership roles at Place level and are SROs for specific workstreams. We expect these relationships to mature further as we continue on our journey towards an Integrated Care System.

We are actively engaging with broader representatives in relation to our plan. We intend to develop our approach in relation to the wider determinants of health and have progressed collaborative working with partners in areas such as housing, air pollution, fire services etc. This work will be led through the Director of Public Health at Derby City on behalf of the system. We will continue to discuss the plan with both Health and Wellbeing Boards and Health Scrutiny.

Our eight Places and Primary Care Networks will increasingly take a leadership role and will be integral in delivering our model of care.

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Journey So Far (2)

Whilst we recognise there is a lot more to be done; since the publication of our STP Plan in October 2016 we have made significant progress which provides a solid foundation going forward…

We set out some bold ambitions in our 2016 plan including that we would:

- *Achieve a financially sustainable system*
- *Significantly change the 'shape' of the system:*
  - More care delivered through Place (growing from 30% to 39% of all care delivered) and a reduction in care delivered in specialist settings
  - Major changes to the workforce – 2,500 more staff delivering place-based care (c.10% of our current workforce)
  - Reduction of bed-based care – 535 fewer beds
  - And, changes to the physical configuration of place-based services

In response we have:

- Remodelled our bed requirements and recognised that our position has now changed, confirming that a reduction of 535 beds is no longer credible and we will refine our plans going forward
- Delivered a major transformation programme; Better Care Closer to Home in the North which has resulted in a reduction in Pathway 3 beds and resources converted into providing additional Pathway 1 and Pathway 2 capacity and additional staff for both Pathways 3 and 2 to provide equitable staffing across the pathways
- Established " Joined Up Careers" a collaborative system approach to recruitment, retention and development
- Established a specialist inpatient OPMH Centre of Excellence (Walton Hospital)
- Established Community Dementia Rapid Response Teams to work across each of the eight communities; supporting Place based care for older people with mental ill health rather than traditional inpatient bedded care
- Lung cancer diagnostics (molecular testing) have reduced from a 22 day test result turnaround down to 6 days
- Derbyshire wide FIT testing for colorectal cancer to speed up early diagnosis implemented
- Place based integrated care teams including general practice, community, fire and voluntary services, housing and social care established to support people in their own communities
- Intensive Home Support service for children and young people in mental health crisis has led to a reduction in use of in-patient beds
- More efficient use of our emergency departments with GP streaming, and an enhanced emergency department 'pit stop' at CRH
- More than 3,700 online holistic wellbeing assessments have been completed in Derbyshire, helping to prevent ill-health
- 100% coverage across Derbyshire for extended access to GP practices, leading to 108,264 additional GP appointments available a year
- A reduction in the stillbirth rate, exceeding the local target of 4.79 stillbirths per 1,000 birth set for 2019
- Access and recovery rates for Improving Access to Psychological Therapies are above national average
- 1,422 members of the health, social care and voluntary sector have completed online delirium awareness training
- We have established a Derbyshire-wide aging well programme which was previously referred to as our Frailty Model. Implementation of this model of care has been recognised nationally as an example of best practice
- A Clinical Assessment Triage Service for MSK has been implemented across Derbyshire
- 6 sites have been sold c£20m disposal value

By working more closely together over the past 3 years, we have developed a better understanding of the services offered already, where gaps might be, and what changes should be considered to offer everyone the best care, now and in future, using all available resources to maximum effect. This understanding balanced alongside the LTP commitments have enabled us to challenge our assumptions and recognise that some of our original ambitions need to change as we move forward. Joined Up Care Derbyshire is therefore in a strong position to accelerate plans and implementation to achieve the desired outcomes for our population.

Challenges and lessons learnt

Whilst we have delivered real change, there have been challenges along the way and it is important that as a system we learn from these challenges as it will affect the way in which we succeed in delivery of our plan going forward. The following table demonstrates some of the key lessons learnt. This is based on feedback received directly from within the system from individuals implementing transformational change and also recognising the change in the environment in which we are now operating.

Lessons Learnt
Capacity and Resourcing: • Delivering the scale and pace required for transformation programmes requires capacity to deliver • Dedicated Clinical Leadership is required to ensure clinical credibility in our plans
Communication and Wider Relationships: • Stronger system wide communication and engagement, so everyone is moving in the same direction • Effective system working - needs to be based on solid, open communication across all levels.
Finance and Contracting: • There is a need to establish a single system control total. • We must continue to move away from a focus on short-term, organisational level transactional savings plans and adopt behaviours which enable larger/ longer term transformation and system savings • We need to consider alternative contracting mechanisms which better support the model of care which we are trying to achieve
Workforce: • We need radical change to our workforce; to build resilience and to enable greater flexible working practices

These lessons learned have informed our approach to the refresh of our plan and more importantly the way we organise ourselves as we move towards becoming an Integrated Care System (ICS).

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Overview of the Derbyshire STP Footprint

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The health and care challenges we face, and our plans for addressing them, are rooted in the particular needs of the county.

Demography and Diversity

- As at April 2019, our registered population was 1.05 million people
- By 2033, a quarter of the population will be 65+ years (275,000 people)
- Over the next 5 years, the number of people aged 75+ years is expected to increase by around 23% to more than 116,000
- High deprivation in Derby and the North East contrasts with affluence in the Dales and South West
- Dense urban communities in Derby and North East; Rural comparatively isolated communities in the North and West; Smaller urban centres a mix of more affluent market towns and more deprived ex-mining areas
- Rich cultural mix across Derby City; 97.5% White British in the County

Our plan must be flexible to meet diverse needs – in relation to both geography and population. To achieve consistent quality we must not take a 'one size fits all' approach.

A wide range of health and care commissioners & providers

The statutory organisations within Derbyshire are:

- NHS Derby and Derbyshire Clinical Commissioning Group (CCG), two local authorities (Derby City, Derbyshire County, Borough and District Councils)
- Two acute Foundation Trusts in Derby (Royal Derby Hospitals) and Chesterfield (Chesterfield Royal Hospital)
- One community Foundation Trust (Derbyshire Community Health)
- One mental health Foundation Trust (Derbyshire Healthcare)
- 115 GP practices (reg. pop. ranges (2-25k) forming 15 Primary Care Networks, plus Out of Hours provider
- Residential and care home providers
- Ambulance Trust – East Midlands-wide
- Multiple voluntary and independent sector organisations

Our plan must provide a common framework – and, importantly, aligned incentives - for us to work together.

Health of our population

- Life expectancy in Derby and Derbyshire is significantly lower than the national average for both men and women and is no longer improving. The national average is 79.5 years and 83.1 years for men and women; in Derbyshire this is 79 years and 82.8 years respectively.
- The gap in healthy life expectancy between the most and least deprived areas is approximately 19 years and 14 years in City and County respectively
- The rate of infant mortality is gradually worsening; in Derby it is significantly higher than the national average. Premature mortality rates, for example, from cardiovascular disease, liver disease and respiratory disease in Derby and parts of Derbyshire are significantly worse than the national average.
- Around two thirds of our adult population are estimated to be overweight or obese, significantly higher than the national average (Derbyshire County: 63.8%, Derby City: 65.1%, England: 61.3%)
- 15.7% of mothers are recorded as smoking at time of delivery, significantly higher than the national average of 10.8% and more than double the national ambition of 6% or less
- Around 40% of people diagnosed with Type 2 diabetes did not receive all 8 care treatment processes in 2017/18

Our plan must be both realistic about the challenges we face, and ambitious in tackling them – particularly in addressing the causes of ill health to slow future increases in demand.

'Out of county' healthcare provision

- Significant patient flows to acute hospitals in Sheffield, Nottingham, Mansfield, Burton and Stockport
- Specialist/tertiary care is provided from Sheffield and Nottingham

Our plan must be sensitive to reflect the current flows between Derbyshire and neighbouring footprints.

Health and care spending

We have used agreed growth rates for all services across the system to provide estimates of the costs of NHS treatment and care for 2020/21 to 2023/24.

These estimates generate a need for NHS savings of £101m, £102m, £96m and £105m in 20/21 to 23/24. This assumes delivery of the 19/20 system savings plan and does not model any potential shortfall in social care provision and commensurate need for savings.

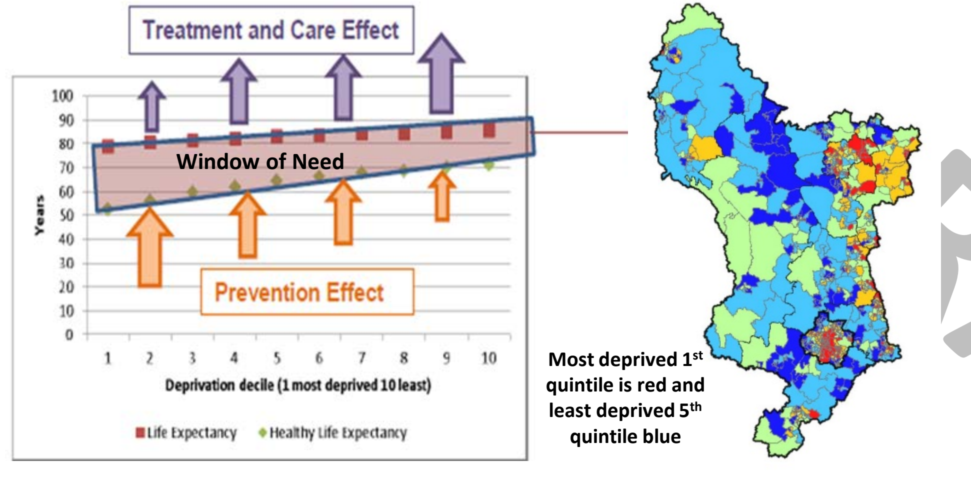
Based on our current assumptions we have a need for additional savings of £32m, £34m, £32m and £39m in 20/21 to 23/24, to live within the current Derbyshire resources.

Our plan must tackle and address the forecast growth in health and care service demand.

Improving the health of the population

Fundamentally we know that across Derbyshire people are living longer in ill health and significant inequalities exist…

More people in Derbyshire are living longer in poor health due to a combination of increasing life expectancy and decreasing healthy life expectancy and persisting inequalities. The period in people's lives when they require health and social care support, the 'Window of Need', is steadily rising. We also know there are marked inequalities in healthy life expectancy. People who live in the more deprived communities in the footprint or are part of certain groups such as those with severe and enduring mental health or learning disabilities spend more of their lives in ill health.



Most deprived 1st quintile is red and least deprived 5th quintile blue

We are in the worst quartile of STP areas for key indicators of preventing disease (e.g. the number of mothers smoking at time of delivery) and reducing the impact of established disease (e.g. the number of diabetes patients to achieve all three NICE-recommended treatment targets). Lifestyle risk factors such as smoking, physical inactivity and poor diet is more prevalent in our deprived communities. There are currently 49,500 unidentified cases of hypertension across the Derbyshire footprint.

26% and 45% cases of hypertension are due to obesity in men and women respectively

There is increasing evidence of the importance of emotional health and wellbeing in early years. Having the best start in life has a major impact on health and life chances, as children and adults, so early intervention and prevention can significantly improve population health and reduce inequalities. Deprived communities have greatest exposure to a range of factors that impact adversely on the health of individuals, families and communities, including fuel poverty, poor housing, higher unemployment and low paid jobs, lower educational attainment and poorer access to services. These wider determinants of health underpin lifestyle risk factors such as smoking, physical inactivity and poor diet, which are most prevalent in these communities.

The table below shows the variation in lifestyle and behaviour between our most and least deprived areas. Almost all are notably higher in the deprived

Averages of MSOA rates	10% most deprived	STP average	10% least deprived	England average
Binge drinking adults (%)	18.9	20.8	19.6	20.0
Healthy eating adults (%)	23.2	28.2	36.0	28.7
Obese adults (%)	26.5	24.9	20.7	24.1
Obese Children (Reception) (%)	10.4	8.4	5.8	9.3
Obese Children (Year 6) (%)	23.9	18.0	13.6	19.3
Regular smoker (Age 15) (%)	10.0	9.5	7.3	8.9
Deliveries to teenage mothers (%)*	2.2	1.0	0.0	1.1
Teenage Conceptions (rate per 1,000)*	41.7	24.4	15.4	20.0

*affected by suppressed values

It is known that a small proportion of the population accounts for a high proportion of use of health and social care resources as people are living longer with ongoing needs and increased risk of developing one or more chronic conditions. Lifestyle factors are also contributing to a rise in long-term conditions among younger people.

Men and women living in deprived areas are 4.5 and 3.9 times more likely to die from an avoidable cause compared with those living in the least deprived areas respectively

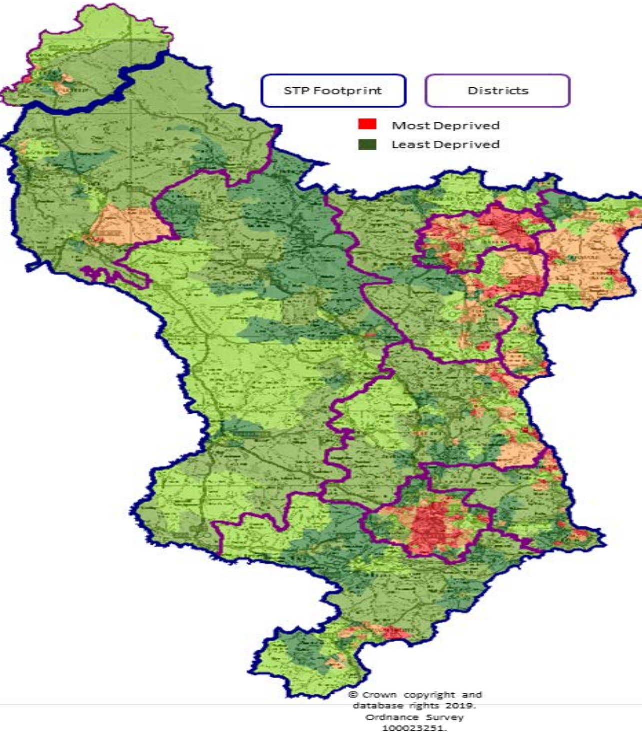
Bolsover and North East Derbyshire
Bolsover: Population ↑ 2.3% next 5 years, 75+ years ↑ to 8.5K. High deprivation, significantly lower average weekly earnings, significantly higher premature mortality and significantly lower overall life expectancy. However, the self-rated happiness score is highest in the county.
NE Derbyshire: Population ↑ 1.4% next 5 years, 75+ years ↑ to 14K. Largely rural and prosperous area but pockets of deprivation in and around Clay Cross and Grassmoor. 6.6% ESA claimants. Highest adult excess weight in county. Significantly higher rates of hospital admissions for self harm and alcohol.

High Peak Population ↑ 0.9% next 5 years, 75+ years ↑ to 10.5K. Sparsely populated areas reflected in above average travel times to key services. Generally better than or similar to England, but alcohol specific hospital admissions remain significantly higher than average. The gap in employment for people with a long-term condition is in the highest 20% in England.

A more detailed breakdown across each of our areas can be found at Appendix 1

South Derbyshire Population ↑ 4.3% next 5 years, Two thirds of the population are working age, but the number 65+ will increase by 12% to 21.6K. Relative job density is low and it is the only county district with a significantly higher rate of homelessness. Female life expectancy is significantly below average.

'Double jeopardy'; we know that far shorter lives are spent in far poorer health in the most deprived areas . Much of the increasing demand for health and care services is for treatment of preventable conditions.
Men and women living in deprived areas are 4.5 and 3.9 times more likely to die from an avoidable cause compared with those living in the least deprived areas respectively



The life expectancy of someone living in Derbyshire Dales is three to four years longer than someone living in Bolsover.

There is up to a 10-year gap in life expectancy in different parts of Derby (between Allestree and Arboretum).

Chesterfield Population ↑ 0.9% next 5 years, 75+ years ↑ to 12K. Clear areas of high deprivation throughout the district. 8% of people claiming employment support benefits and 20% of children in low income families. Average life expectancy significantly lower for men and women. Premature mortality from CVD highest in the county.

Derbyshire Dales Population ↑ 0.6% in 5 years, 75+ increase to 11K, around 15% of total population. Though a largely prosperous area, the older population, rurality, inaccessibility to key services and hidden pockets of deprivation present their own challenges.

Amber Valley Population ↑ 1.9% next 5 years, 75+ years ↑ to 15.5K. Deprivation in and around Alfreton, Somercotes, Ripley and Heanor reflected in stark inequalities in average life expectancy. Gap in life expectancy for females is in the highest 20% nationally. Smoking significantly higher in both R&M occupations and pregnant women.

Derby City Population 26% 16-34 years. Population ↑ 2% next 5 years, 75+ years ↑ to 23K. Around a quarter of the population from BME groups. Significant areas of deprivation in and around the city centre and higher proportions of children in lower income families and ESA claimants. Significantly lower life expectancy and higher premature mortality from CVD and respiratory disease. Smoking prevalence, alcohol and self-harm admissions all worse than average.

Erewash Population ↑ 2.4% next 5 years, 75+ years ↑ to 13K. Deprivation exists around the 2 towns of Ilkeston and Long Eaton. Job density is relatively low for an area with a younger population. 18% of women are smoking at time of delivery, and a quarter of 4-5 year olds are overweight/obese. Self harm admissions are significantly higher.

Improving experience of care (quality & satisfaction)

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80% of a persons good health is influenced by social, behavioural and environmental factors as set out previously; 20% of health outcomes are determined by level of access and quality of care received. We have made significant progress in 'joining up care'; however, many opportunities remain to integrate care more effectively and consistently.

Why do we need to change?

The lack of joined up care results in…

Services which are not integrated effectively:

- Fundamentally, our health and care services have been set up to help sick people get well, often in a hospital setting (reactive episodic care). These services are often characterised by organisation and role boundaries, not a system that is centred on people and communities.
- Individuals and teams do not yet work in a fully integrated way and are often conflicted and constrained by organisational priorities.
- Our services are struggling to meet the increasing demand for ongoing complex care (social, physical and mental) the way they are currently delivered.
- People with such needs often experience care that:
  (i) does not support their independence and control;
  (ii) is fragmented and difficult to navigate;
  (iii) results in a poor quality of life for both the patients and their carers.

Care is not proactive:

- We do not routinely and systematically identify and support people with complex ongoing needs.
- Mechanisms for information sharing, care planning and care coordination are generally ineffective.
- There are occasions where harm could be prevented for vulnerable people (e.g. pressure ulcer and falls)

Frail elderly patients decompensate:

- Elderly patients sometimes spend too long in bed-based care (acute and community) causing physical, psychological, cognitive and social deconditioning resulting in lost independence.

Our system being overly reliant on bed-based care…

Patients are not supported to be independent:

- Derbyshire is an outlier for numbers of people admitted to care homes, key drivers are long-term stays and overprescribing of care home use on discharge from hospital.
- We have made improvements with Better Care Closer to Home in North Derbyshire but too many people with dementia continue to be hospitalised particularly in the south of the county which can have negative impacts on both physical and mental health, making a return home difficult.
- Reported 'Delayed Transfers of Care' performance is in line with the standard and the Derbyshire System remains in the top quartile nationally. However, local experience highlights flow and discharge issues.

We don't always provide care in the right settings or give people alternative ways to access information about care…

- Patients being admitted to hospital when they could be cared for in alternative, more appropriate ways if the necessary services were available. This includes care for our frail elderly patients but also ambulatory care for acute conditions (in particular UTIs and pneumonia) and chronic conditions (in particular CVD and Respiratory).
- Poor access to services which would prevent crisis and exacerbation
- Within Derbyshire, 45% of all deaths occurred in hospital (PHE, Fingertips 2017 data) a significant proportion of these will be individuals on our palliative/supportive care registers
- There is no single record of an individual's health and care that is accessible to the person and care professionals in the system.
- Use of telehealth and telecare to support people, particularly those with long- term conditions, is still embryonic.
- Individuals are often provided prescriptions and interventions with limited health education and implementation support. Lack of follow-through on provider recommendations is a key contributor to negative health outcomes

What does this mean for our services and our people?

We are not consistently providing the right services, in the right place at the right time…

Urgent & Emergency Care

- An inconsistent integrated urgent care offer 7 days a week In Derbyshire's most rural areas MIUs are not fully utilised; there are uncoordinated points of delivery, inequitable access and limited integration which results in confusion with A&E departments remaining the default.
- System 4 hour wait A&E performance as at July 2019 is 84.1% , with A&E attendances at CRH increasing by 9% and UHDB 7% year on year
- Reliance on acute and community (health and social care) beds placing patient safety at risk as alternatives are not clear, easy to access or responsive and integrated.

Cancer

- Inconsistent delivery of Cancer waiting times standards
- Around 79% of deaths from lung cancer and COPD can be attributed to smoking; estimated that 43% of people with a mental illness smoke

Mental Health

- Overreliance on bed based care; the Length of Stay in Derbyshire acute beds is around 45 days compared to a national average of 32, which is above the 85% threshold
- There is a high reliance on admission for older adults due to lack of crisis intervention services.
- Adults requiring acute, Psychiatric Intensive Care Units (PICU) and rehabilitation services continue to be treated out of Derbyshire
- Mental health hospital admission rates per 100,000 are higher than the England average; as are emergency hospital admission for self–harm.
- Disjointed community pathways for individuals with severe functional presentations often outside of 'Place' still exist and there is inequity in provision across the county.

Planned Care

- Meeting RTTs in some specialties for example urology, lung and Gynae
- Contacts with secondary care are not always valuable.
- Elective services largely delivered within acute hospital.
- Over 25% of surgical interventions are considered unnecessary due to a lack of end-to-end integration.

Learning Disabilities & Autism

- People with a learning disability and/or autism in Derbyshire are more likely than the national average to be receiving care in inpatient settings.
- More likely to also suffer with physical health problems such as epilepsy, hypothyroidism, diabetes, heart failure, chronic kidney disease or stroke.
- Less likely to receive cancer screening.
- Are more likely to be obese between the age of 18-35 and more likely to be underweight once they are over 64.

Children & Young People

- Services focus heavily on provision rather than on enabling children, young people and families to respond to their own needs.
- High-cost placements for vulnerable groups create pressure on provision.
- Inconsistent support for children with SEND

Condition Specific:

- Lack of preventative interventions which avoid late diagnosis and sub-optimal management

Primary Care:

- Variation in screening, early diagnosis and chronic disease management , means impact on quality of life, independence and life expectancy.
- Quick access to see GPs varies

Workforce

- We have an aging general practice workforce
- Our workforce is not as adaptable and resilient as needed to cope with increasing demand, expectations and increasing clinical needs

Reducing the per capita cost of healthcare

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Derbyshire STP

LTP - Key Finance Numbers - 27th September Submisison

System Efficiency Target

	2019/20 Plan £'000s	2019/20 FOT £'000s	2020/21 Plan £'000s	2021/22 Plan £'000s	2022/23 Plan £'000s	2023/24 Plan £'000s
NHS Derby and Derbyshire CCG	69,500	69,500	61,536	64,300	62,480	68,566
Chesterfield Royal Hospital NHS FT	9,831	9,831	3,597	3,573	3,422	3,497
Derbyshire Community Healthcare Trust	6,082	6,082	6,284	3,890	3,446	3,901
Derbyshire Healthcare NHS FT	4,599	4,599	4,583	2,045	2,690	5,554
East Midlands Ambulance Service	4,647	4,647	8,176	9,258	8,326	8,518
University Hospitals of Derby and Burton NHS FT	56,300	56,300	17,212	19,431	15,296	14,676
	150,959	**150,959**	**101,388**	**102,497**	**95,660**	**104,712**

System In Year Underspend/(Deficit)

	2019/20 Plan £'000s	2019/20 FOT £'000s	2020/21 Plan £'000s	2021/22 Plan £'000s	2022/23 Plan £'000s	2023/24 Plan £'000s
NHS Derby and Derbyshire CCG	(29,000)	(29,000)	0	(0)	0	0
Chesterfield Royal Hospital NHS FT	1,975	1,975	1,975	1,975	1,975	1,975
Derbyshire Community Healthcare Trust	1,832	1,833	1,833	1,833	1,833	1,833
Derbyshire Healthcare NHS FT	615	615	(0)	0	(1)	1
East Midlands Ambulance Service	(5,069)	(5,068)	45	66	90	121
University Hospitals of Derby and Burton NHS FT	(22,469)	(25,649)	(16,414)	(11,377)	(5,027)	859
Underspend / (Deficit) - (excluding CSF/PSF/MRET/FRF)	**(52,116)**	**(55,294)**	**(12,560)**	**(7,503)**	**(1,129)**	**4,789**

	2019/20 £'000s	2019/20 £'000s	2020/21 £'000s	2021/22 £'000s	2022/23 £'000s	2023/24 £'000s
CCG Allocation	1,651,446	1,657,251	1,678,594	1,722,139	1,785,079	1,846,908

	2019/20 Plan £'000s	2019/20 FOT £'000s	2020/21 Plan £'000s	2021/22 Plan £'000s	2022/23 Plan £'000s	2023/24 Plan £'000s
Recurrent	132,193	105,022	114,378	89,637	83,164	90,999
Non Recurrent	18,766	45,937	(12,990)	12,860	12,496	13,713
Total Efficiency Target	**150,959**	**150,959**	**101,388**	**102,497**	**95,660**	**104,712**
% of CCG Allocation	**9.1%**	**9.1%**	**6.0%**	**6.0%**	**5.4%**	**5.7%**

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The financial modelling for the long term plan, starts with an assumption around the delivery of the 2019/20 Derbyshire plan - including all the required 2019/20 savings. This is a key risk and sensitivity to the model. If we are unable to deliver £151m in 2019/20, 2020/21 and beyond will be more challenging by the shortfall.

Activity growth rates which have been agreed with all the NHS statutory bodies and have then been modelled, including mental health, community services and ambulance services, which create the unmitigated overall savings challenge for 20/21 to 23/24 - £101m, £102m, £96m and £105m. We have used commissioner spend as a proxy for system marginal costs which looks broadly reasonable on review. This has generated a broadly triangulated, activity, workforce and financial model, pre required transformational changes.

Next we will model the impact of the transformation described elsewhere in our Long Term Plan submission, to generate a mitigated, agreed and triangulated position, which we aim to complete by the November submission, including a firmer view on the 19/20 savings sensitivity. This will include demonstration of our commitment to allocating the additional LTP investment funding in relation to specified key deliverables.

In terms of the status of the mitigation the system believes it can consume the provider CIP requirement of either 1.1% (or 1.6% in the case of UHDB) via the delivery of reduced unit costs for the existing models of care. At this stage there is also a tentative assumption around the unplanned, planned and place workstreams delivering £10m of savings in each of the four financial years. This would leave a residual system challenge of £32m, £34m, £32m and £39m in 20/21 to 23/24.

These savings are not modelled in the table above or the planning workbook and the key work in the system is now the valuation of the workstreams and the broader redesign initiatives for 20/21 and beyond, adding to and firming up those plans.

Case for Change: Improving staff experience and resilience

To genuinely deliver 21st century integrated care, will require growth in our workforce, transformation in the roles and ways of working. We need to make the health and care system a better place to work to be able to recruit and retain the staff we need…

Recruitment and attraction

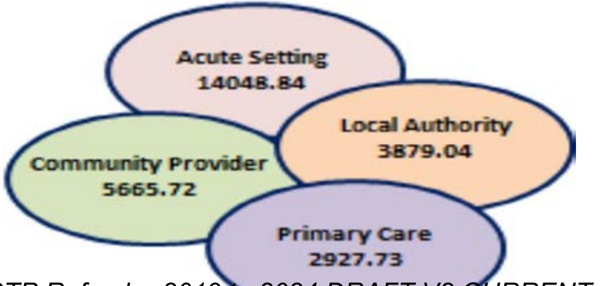
In health and care, we operate in multiple labour markets for different types of staff. In Derbyshire, employment is at 79%, compared to 76% nationally with the number of vacancies steadily increasing across all sectors, so we have to rethink how we can attract people into health and care, to develop and support our people and make the health and care system a great place to work. For those roles where we operate in regional and national labour markets, we need to develop a strong brand awareness to present Derbyshire as a great place to live and work to keep students who train here and attract from elsewhere. There are particular national shortages in doctors in psychiatry and learning disabilities which impact on our area.

The Long term Plan envisages 20,000 more staff working in Primary Care Networks, 6,500 more staff in children and young peoples mental health services, 25,000 more staff in mental health services, 4000 more staff to support faster diagnosis and treatment and 10,000 more community staff to support the ageing population. We need to identify what our contribution towards these targets is and to ensure we can recruit and retain those staff.

Transforming the way in which staff work

'There is a shortage of key clinical roles and increasing demand for NHS services. Care is increasingly delivered in the community, and our staff are treating a wider range of clinical conditions and in ever more complex environments.'
DCHS Clinical Strategy 2019

Out of a current total health and care workforce of 19,625 (contracted available FTE), 14, 048 work in an acute setting. As the expected growth in workforce is predominantly expected to be in community and non bedded care settings, this presents a big challenge in terms of shifting staff into different settings, and working alongside a more diverse team from health, care and the voluntary sector. We can also expect significant developments in technology which will mean many tasks become automated, significantly changing the content of established jobs.



Changing the skill mix and introducing new roles

Many of our services are run on a traditional medical model, particularly in General Practice and Mental Health and LD and some acute specialties. Shortages in GP's and consultants due to changes in training numbers mean that we need to develop new roles to operate in holistic, multi disciplinary teams. Roles such as Advanced Practitioners take a number of years to train, and require similar levels of supervision and assessment to medics which is currently not funded. Other roles such as Physicians Associates are not currently trained in Derby, so we do not have a supply pipeline, and they also require significant post qualification training which is not currently funded.

We need to maintain our supply of nurses through a number of routes, a key one will be Trainee Nursing Associates, but we are constrained by the number of clinical placements in the system, particularly in the PVI sector and General Practice

Even in the best-performing health care organisations, staff burnout has a direct negative effect on the experience of care for the patient. There's also a correlation between high levels of staff engagement and high level of patient engagement. Staff are much more likely to be enthusiastic and positive about securing the best outcomes for patients when they feel supported, empowered, and respected.' Institute for Healthcare Improvement.

Making the NHS a great place to work

Our levels of employee satisfaction and indicators such as absence and turnover are similar in comparison with other health and care employers e.g.

	Range in Derbyshire NHS Trusts	Comparator
Sickness absence	4.27% - 5.9%	NHS East Midlands 4.40%
Turnover	9.42% - 10.52%	NHS Midlands & East 13%

There is more we can do to improve the staff experience by supporting and developing our staff. In particular we need to focus on the health and wellbeing of our staff and make it easier for staff to progress their careers by reaching their full potential along less linear professional and organisational boundaries, we need to modernise our offer for the future workforce including more flexible working patterns to appeal to generation X and Y , and we need to promote greater diversity and inclusion by ensuring all our organisations have a positive, person centred leadership culture. We are developing a system workforce dashboard to enable us to identify risks and opportunities across the whole health and care workforce and measure the impact of changes we introduce.

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Our Strategic Priorities

*To deliver our vision for people to have **the best start in life, to stay well, age well and die well**, and address the challenges identified in our case for change (quadruple aim), requires major changes to the way care is provided and the way in which we are organised.*

As set out earlier in this document the agreed Derbyshire model of care remains valid and will provide the basis by which we will continue to transform the health and wellbeing of our population and improve outcomes. Enabling the 'left shift', to deliver a new service model for the 21st century, will be underpinned by five interdependent strategic priorities:

We will come together to manage the Derbyshire system through an Integrated Care System (ICS), develop Integrated Care Providers (ICPs) and our Strategic Commissioning function through aligned leadership and governance

System Development

We will ensure ongoing efficiency improvements across commissioners and providers are a key component of ensuring we address the Derbyshire financial challenge

System Efficiency

We will focus on improving the outcomes for the people of Derbyshire by applying an effective Population Health Management approach, embedding the personalised care model as an enabler to improve outcomes

Population Outcomes

By preventing physical and mental ill health, intervening early to prevent exacerbation and supporting self-management, we will improve health and wellbeing as well as supporting redesigned care models and improved efficiency through moderating demand

Prevention & Self Management

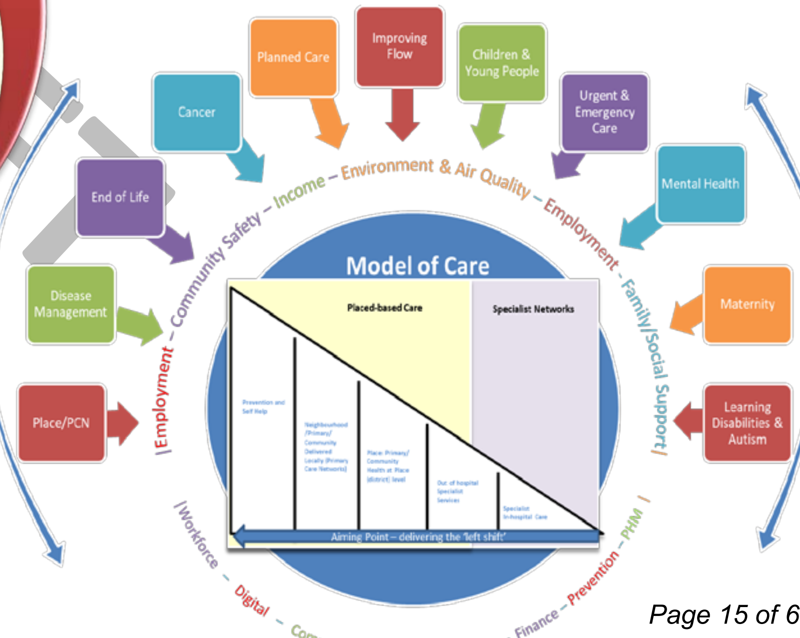
We will accelerate the pace and scale of the work we have started to 'join up' care; transforming out of hospital care which fully integrates community place based primary care, mental health, community services, social care and the third sector. So that services operate as a single team, wrapping care around a person and their family, tailoring services to different community requirements across our 8 places and 15 Primary Care Networks

Place Based Care

Our strategic priorities enable delivery of the commitments set out in the NHS LTP. For the purpose of this five year Strategy Delivery Plan , some of the core elements, set out as 'foundational commitments' in the NHS LTP are described within our strategic priorities; namely our approach to place based care, prevention and self-management and system development. Whilst these are delivered as a whole, they are also embedded within more specific programmes of work, described later in this document. Furthermore, our model of care is based on delivering more personalised care which is also embedded within our programmes of work.

We are organised into ten key programme areas alongside seven enabler programmes designed to deliver our priorities, as set out in the diagram below. The workstreams are fully aligned to the LTP commitments and framed around delivering the agreed model of care for Derbyshire. This five year plan therefore describes our approach based on these key programme areas and is structured to demonstrate the commitments in the LTP and interdependencies between programmes of work.

Joined Up Care Derbyshire Programme Areas



Delivering transformed out of hospital care through fully integrated place based care

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We will accelerate the pace and scale of the work we have started to 'join up' care; transforming out of hospital care which fully integrates community place based primary care, mental health, community services, social care and the third sector. Services will operate as a single team, wrapping care around a person and their family, tailoring services to different community requirements across our 8 Places and 15 Primary Care Networks.

To meet the changing needs of our population (growing demand for ongoing complex care – social, physical and mental) and make our system sustainable, we will continue with our approach to make a transformational shift from fragmented care based around institutions and beds, to coordinated community based care wrapped around people and communities; ensuring our hospitals and specialist providers deliver the specialist care only they can.

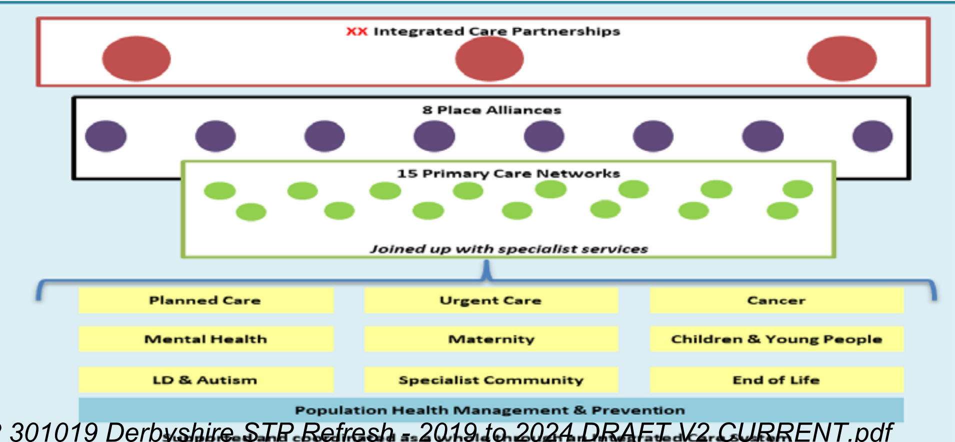
The Derbyshire Model of Care is essentially designed to deliver more localised place based care, whereby we will keep people:

- ***Safe & healthy*** *– free from crisis and exacerbation.*
- ***At home*** *– out of social and healthcare beds.*
- ***Independent*** *– managing with minimum support.*

...which will be founded on building strong, vibrant communities.

We have already established 8 Places across Derbyshire which have been focused on developing care closer to home and integrating services in the community, through multidisciplinary teams/ approaches to anticipatory care, which include housing and the fire service for example.

This is a journey which will evolve as our system architecture develops. Fundamentally our model of care will underpin our approach across each of our strategic priorities and enable delivery of the commitments for each of our programmes of work, as described below.



Personalised Care

To achieve the 'step change' in preventing ill health and supporting people to live healthier lives; delivery of our model of care will enable a cultural shift for health and care professionals, to promote 'wellness' in the public and patients in developing the confidence to self-manage and take a lead role in decisions about their health. This will be at the heart of delivery within our Places/ Primary Care Networks, with personalised care in the broader sense embedded throughout. Our approach is described further in the prevention strategic priority section which follows.

By 2023/24 we are committed to the implementation of The NHS Comprehensive Model for Personalised Care's 6 principles; namely shared decision making, personalised care and support planning, enabling choice, social prescribing, supported self-management, personal health budgets and integrated personal budgets across the NHS and the wider health and care system. Specifically:

Principle	Commitment
Personal Health Budgets	• Derbyshire has a commitment to achieve 3,240 PHB's by 2023/24. • PHB as default in Continuing Healthcare (Domiciliary), continuing care (children) and Wheelchair budgets are already implemented in Derbyshire. • There will be an NHSE accelerated roll out of 'legal right to have' e.g. for people with entitlement to Section 117 aftercare (mental health).
Social Prescribing (SP)	• Derbyshire has a commitment to achieve 16,419 referrals to SP by 2023/24 and provide SP link workers to meet this need via PCNs • SPs will be embedded within Derbyshire PCNs through the Network Contract Direct Enhanced Service (DES)
Personalised Care and Support Planning (PCSP)	• Derbyshire has a commitment to achieve 18,086 PCSP by 2023/24 • PCSP and its 5 essential criteria will be embedded in 100% of service specifications and care pathways, especially where people have long term conditions or complexity of care. A local CQUIN could support changes in healthcare culture required to meet commitment.
Shared decision making (SDM)	• To become business as usual for healthcare and therefore will be embedded in 30 of Derbyshire's clinical situation service specifications and care pathways.
Enabling choice	• Expansion of choice will include Maternity and End of Life Services therefore this will be embedded in Derbyshire's Maternity Transformation Programme and the End of Life Services Strategic Vision.
Supported self-management	• Derbyshire have a target of 15,393 usage of the NHSE provided Patient Activation Measure (PAM) to identify improved knowledge and skills in people with long term conditions (LTC) via PCN's and LTC care pathways.

We believe that to deliver personalised care effectively will require a universal whole system approach. We will build our approach based on a review undertaken of the key components of personalised care which feature strongly within our programmes of work including examples such as health coaching, peer support and education programmes that support personalised support planning. A summary of how these approaches are embedded within our programmes of work can be found at Appendix 2.

Delivering transformed out of hospital care through fully integrated place based care

We will accelerate the pace and scale of the work we have started to 'join up' care; transforming out of hospital care which fully integrates community place based primary care, mental health, community services, social care and the third sector. Services will operate as a single team, wrapping care around a person and their family, tailoring services to different community requirements across our 8 places and 15 Primary Care Networks.

Primary Care Networks (PCNs)

Central to achieving transformed out of hospital care is primary care. The establishment of our 15 PCNs will be key enablers in delivering our model of place based care. The role of our PCNs is described in our system development strategic priority later in this document; underpinned by the Derbyshire Primary Care strategy (July 2019).

Our PCNs were established in July 2019 and each have appointed Clinical Directors. We will continue to support our PCNs to grow from an embryonic state to mature integrated community care providers and funding has been committed to enable this. PCNs will benefit from the Additional Roles Reimbursement Scheme, which was announced in the 2019 GP Contract Framework. Under this scheme, additional funding will be made available to PCNs for the following five roles:

- 2019/20 Clinical Pharmacist and Social Prescriber
- 2020/21 Physician Associates and First Contact Physiotherapists
- 2021/22 First Contact Community Paramedics

This builds on our positive progress towards our GPVF workforce trajectories. Currently, Derbyshire is above target in achieving its GP workforce trajectories, as follows:

- GPs (excluding registrars), above target by 2.4%
- Nursing, above target by 1%
- Direct patient care staff, above target by 5%
- Admin/non-clinical staff, above target by 2.8%

PCNs as part of the Derbyshire Place are now receiving data packs to assist in assessment of local populations at risk and are working with community services to develop approaches for targeted support.

Against the minimum requirements for 'out of hospital care' Derbyshire STP is committed to:

1. **Meet the new funding guarantees for primary medical and community health services**

- Committed to the continuation of funding currently available non-recurrently to support Extended Access and GP Forward View funding streams, (e.g. practice resilience programme). Additional funding is also included to support the development of Primary Care Networks.
- Identified Rapid Diagnostic Centres funding in 2019/20; Cancer Alliance funding to support screening uptake delivery of the Faster Diagnosis Standard and timed pathways, implementation of personalised care interventions, including personalised follow up pathways and Cancer Alliance core teams.

2. **Support the development of PCNs**

- The Derbyshire STP is on target to fully meet the requirements for PCNs and their development

3. **Improve the responsiveness of community health crisis response services to deliver the services within two hours of referral, and reablement care within two days of referral**
   - Within the Derbyshire STP there are interdependencies with the Urgent Care and Mental Health Work streams. The PCNs have identified key personnel who work directly with these areas to ensure effective development of rapid response teams.

4. **Create a phased plan of the specific service improvements and impacts they will enable primary and community services to achieve, year by year, taking account of the national phasing of the new five-year GP contract.**
   - Plans in-place for roll-out of digital services to increase patient access and improve productivity. We are progressing the implementation of online consultations by April 2021, which is a key deliverable in our digital strategy.
   - In addition to the service requirements, changes in 2020/21 will include the introduction of the Network Dashboard and the Impact and Investment Fund which will complement service requirements. The service specifications will set minimum requirements within the DES. The dashboard will include measures of success to allow PCNs to benchmark their performance and monitor their delivery of the five service specifications.
   - We are committed to investing the Impact and Investment Fund (IIF) to provide additional funding to PCNs and deliver the national service specifications once developed; incentivising PCNs to reduce unwarranted demand on NHS services, including overprescribing and inappropriate A&E attendances. The IIF is expected to commence in April 2020, and will develop over the subsequent four years. Once access measures are confirmed these will be implemented to ensure target is met.
   - Development of new service models to improve rapid response and greater community offering

Our Places/ PCNs will be central to the delivery of our comprehensive frailty pathway focusing on the Ageing Well programme to support an efficient, high quality, multi-disciplinary response to people who have an urgent need that is best provided in their own home (even if that's a care home).

Enhanced Health in Care Homes

Work is underway to develop the approach in 2019/20 which will be aligned to the national Ageing Well programme and the publication of a maturity matrix for full delivery of the EHCH model . We will commission PCNs to work together to develop, at scale, models of pro-active, integrated care to support care homes residents by:

- Developing models which are integrated into community services.
- Ensuring that care is based on a CGA style of care planning that is MDT based, holistic and includes residents wishes / preferences.
- Developing and monitoring a set of outcomes consistently across Derbyshire. Ensuring that PCNs are well prepared to adopt the new NHS England specification from April 2020.

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Strategic Priority: Prevention and Self-management

By preventing physical and mental ill health, intervening early to prevent exacerbation and supporting self-management, we will improve health and wellbeing as well as supporting redesigned care models and improved efficiency through moderating demand.

Why is this a priority for Joined Up Care Derbyshire?
Our public health challenges are significant, and the widening 'window of need' described in our case for change, means that many people across the county are living longer in ill health, with significant inequalities in life expectancy and Healthy Life Expectancy (HLE) within and between areas in Derby and Derbyshire. We must act now to address these inequalities and move from a system which is focused on solely fixing ill health to a proactive one which enables wellness and reduced dependency.

Our Approach
To address the challenges, our ambition is to embed prevention across all programmes of work and for all organisations to champion the priority by working together to create healthy, resilient communities and populations.

Primary Prevention – Risk Factors	• Those with diagnosed conditions who would benefit from an intervention that would support them to be as healthy as they can be (e.g. pulmonary or stroke rehabilitation).
Secondary Prevention – Early Detection	• Spot variation in screening uptake to identify those who may benefit from a screening or diagnostic intervention (to help treat, delay or reduce any disease symptoms).
Tertiary Prevention – Condition Management	• Identify disease risk factors to inform preventative action before a disease is present (e.g. smoking cessation)
Wider Determinants	• Understand what makes communities or individuals susceptible to poor health. This helps strengthen population health outcomes.

We will continue with our collective commitment (Health and LAs) to develop a systematic approach to prevention at pace and scale by enacting our agreed system wide prevention strategy and delivering the four priority areas:

- Enable people in Derbyshire to live healthy lives
- Build mental health, wellbeing and resilience across the life course
- Empower the Derbyshire population to make healthy lifestyle choices
- Building strong and resilient communities where people are supported to maintain & improve their own wellbeing

In doing so we will:

- Further embed prevention across all workstreams and organisations within JUCD; led by the Prevention Board.
- Ensure additional investment specifically directed for prevention initiatives will be provided to achieve the step-change required, recognising that many benefits (including financial benefits) may take time to realise. These commitments are necessary to ensure a sustainable health and care system into the future.
- Work together to enable a 'whole-pathway' approach to prevention, particularly recognising the role and impact of wider determinants on morbidity, premature mortality, health inequalities and service utilisation. We will embed a comprehensive approach to prevention (primary, secondary, tertiary where appropriate) across all areas of care delivery.
- Support primary, community and secondary care in the development of pathways that include referral to healthy lifestyle services and community initiatives; so they are applied systematically and delivered at scale to have a level of impact that will reduce the gaps in life expectancy and healthy life expectancy and reduce the demand for health and care services. We will also develop place-based initiatives where appropriate and feasible.
- Work as a system and in conjunction with Public Health England to maximise the opportunities of national and local campaigns aimed to improve health and wellbeing and promote healthy lifestyles through a range of media on a national scale.

Specific interventions include (note many of our approaches are also aligned to our programmes of work):

- Access to wellness services: creation of a network of community venues where local residents can receive information and advice to 'wellness services'
- Falls prevention: (i) Systematic promotion of and signposting to physical activity opportunities across JUCD partners to increase the number of people being active as they approach older age, (ii) referral & signposting to falls prevention services and (iii) implementation of the Derbyshire falls pathway
- Cardiovascular Disease (CVD) Prevention: Determine current prevalence and associated mortality of a range of CVD conditions, and evidence for effective and efficient services
- • Primary care to maximise CVD prevention opportunities across the CVD prevention pathway e.g. AF detection
- Suicide Prevention & Mental health awareness : Embed self-harm and suicide awareness as an organisational priority by recognising key campaigns, sharing information and messages, training all staff and supporting people in more vulnerable groups e.g. people diagnosed with a long-term condition, those with substance misuse issues. Help to build the mental health literacy of the wider workforce and the public challenging stigma and discrimination and promoting positive mental wellbeing
- Healthy Workplaces: Support to employers to develop a positive proactive and responsive approach to mental health and wellbeing in the workplace

Prevention and Place based care
We have a history of delivering preventative activities, however our efforts to prevent ill health have been small scale; we are now in a position to develop a more systematic approach to preventative services. This will be supported by better coordination of preventive efforts through full alignment and integration in our approach to Place based care; described earlier.

Public Health, within Local Authorities, ensure services are in place to support healthy lifestyles. These include a wide range of locality-based services and activities run by the public sector, voluntary and grant aided organisations – all of which have a role in primary and secondary prevention of ill health and support either physical or mental wellbeing. We will build on this through the application of an effective Population Health Management, approach as set out later in this document; so that primary prevention and early intervention is fully embedded in place based care delivery to ensure targeted efforts are developed within our 'wellness system'.

All professionals that come into contact with patients and the wider public will play a critical role in the promotion of healthy choices, healthy environments and resilient communities. We will support staff to feel confident and have the skills and knowledge to have 'quality conversations' with individuals and communities about their opportunities to improve their health and wellbeing .

Furthermore, prevention and proactive identification of patients, combined with risk stratification, and effective care planning will continue to provide the best approach to supporting patients and carers with the most complex needs; enabling them to take an active part in decisions concerning their health and wellbeing and subsequently reducing the demand for health and social care services.

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Derbyshire's public health challenges are significant, and the widening 'window of need' means that many people across the county are living longer in ill health – with the greatest impact in our most deprived communities.

Delivering national priorities - The NHS Long Term Plan provides a renewed focus on prevention, highlighting the need to reduce inequalities and enabling people to stay healthier for longer; setting out the following risk factors as priorities for the prevention agenda; screening and immunisation, smoking, obesity, alcohol, air pollution, anti-microbial resistance (resistance to some anti-biotics). There are also national NHS initiatives that support prevention including Cancer Screening, National Diabetes Prevention programme and NHS Health Checks.

Our strategic approach to the key deliverables set out in the LTP are descried below, with more specific prevention deliverables described later and embedded within our respective programmes of work. Or Prevention Strategy (2018) sets out the vision for 'Derbyshire that champions prevention across all organisations and works together to create healthy, resilient communities and populations'. We aim to eliminate unwarranted variation by working with our partners to identify any health inequalities in our patient population. Together we will develop a detailed and measurable delivery plan with milestones and trajectories for how we will contribute to narrowing the health inequalities gap over the next 5 to 10 years.

Embedding preventative approaches in everything we do, has the potential to make the greatest impact to the overall health and welling of our population, reduce inequalities (geographical and for high risk/use groups) and wider determinants which affect use of our systems finite resources. Staff training will include an awareness of the importance of personalised care and self-management.

Key indicators which will demonstrate our progress can be found in **our Population Outcomes,** which include life expectancy, healthy life expectancy, Emergency admissions due to falls, smoking at time of delivery, population vaccination and screening.

Smoking: We will enable staff, patients and visitors to become smoke-free through:
- Implementing smoke free sites polices, normalising smoke-free
- Provision of pharmacotherapy for inpatients
- Systematic promotion, signposting and referral to stop smoking services will continue and will be built upon to deliver more targeted smoking cessation services in selected sites and smoking cessation services for all inpatients who smoke, pregnant women and users of high risk outpatient services from 2020/21. These will be confirmed in our final submission.

Obesity: We will develop a greater focus on obesity by 'upscaling' support to people who are overweight or obese within a 'whole systems' approach, for example, planning, licencing, access to green space, active travel and policy. JUCD system organisations will be a leader in enabling staff, patients and visitors to be active and eat healthy through:
- Ensuring organisational policies and infrastructure create an environment that enables healthy eating and active travel
- Ensuring weight management services are promoted and signposting/referring into services is systematic, including links to other programme area deliverables such as the diabetes weight management which includes a targeted plan, delivered by a 'Prevention Facilitator' and agreed referral trajectories which contribute to the national Diabetes Prevention Programme to support 525 people through the programme by 2019/20.
- Utilising nationally developed resources such as fitter, better sooner/stop before any surgical interventions.
- Develop a Derbyshire wide Childhood Obesity Strategy, to include treatment service pathways which is coordinated through public health, local authority and health

Alcohol: Alcohol admissions are significant issue for the City and to some degree the County; we have prioritised this in our prevention strategy to enable healthier choices which result in:
- Increased numbers of adults in Derbyshire drinking within the recommended limits
- Decreased rates of alcohol related admissions
- Increased rates of dependent drinkers accessing services

The targeted investment for Alcohol Care Teams (ACTs) from 2020/21 to 2023/24 will also be explored as an option for further development; subject to further national information and requirements to access the funding.

Substance Misuse Services across the City and County are currently provided by a partnership led by DHcFT and there are potential opportunities for greater integration into the new models of Adult Community SMI services after April 2021.

Air Pollution

Air pollution is the biggest environmental health risk, contributing to an estimated 530 deaths and 5400 life years lost in Derbyshire County and City. Our vision is to reduce the health impact of poor air quality for the people of Derbyshire. As partners we will use our individual and collective influence as employers, providers and commissioners, to reduce our own contribution to local air pollution, facilitate change, influence others and protect health. We plan to engage through our Air Quality Working Group, to focus on protection from pollution and prevention, specifically for people with long term conditions to raise awareness of triggers. Our key areas of focus being taken forward by the Health and Wellbeing Board include:
- Travel behaviours with partners facilitating sustainable and healthy travel options through healthy eating and active travel policies
- Reducing sources of air pollution
- Proportion of people living in a smoke control zone
- Mitigating the health impacts of air pollution

The Derbyshire Air Quality Working group will be responsible for implementation of the Derbyshire County and Derby City Air Quality Strategy (2020-2030).

Antimicrobial resistance (AMR)

We recognise the threat that AMR has on the effective prevention and treatment of an ever-increasing range of infections. We will establish a system wide AMR steering group, and determine a baseline position from each provider to build upon work undertaken to tackle AMR and related Gram Negative Blood Stream Infection (GNBSI). We will use this forum to fully implement the Governments national action plan 'Tackling Antimicrobial Resistance' to reduce overall antibiotic use, health care associated GNBSI and drug resistant infections.

We will target approaches for high risk populations and areas of high variation, key priorities include:
- Further reducing antimicrobial use in the community, tackling unwarranted clinical variation and outlier prescribers
- Enhancing the role of pharmacists in primary care to review antimicrobial prescriptions working with prescribers to review those that are inappropriate through evidence-based, system-wide interventions.
- Raising public awareness to encourage self-care

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Strategic Priority: Population Outcomes

We will focus on improving the outcomes for the people of Derbyshire by applying an effective Population Health Management approach

Effective Population Health Management (PHM) to improve population outcomes

We recognise that a focus solely on healthcare provision will not solve the significant challenges we face given the relative contribution of other factors to our health. We will therefore further develop our PHM approach to maximise data and intelligence to strengthen our communities so that we:

- Better co-ordinate system wide action to create healthy places
- Improve population health and wellbeing and tackle health inequalities.
- Effectively allocate resources and support service redesign
- Evaluate the impact of interventions and identify system savings
- Understand the population and sub-population need
- Understand the use of, and demand for, services across the health and care system; including where there is variation (warranted and unwarranted)
- Identify best practice, effective interventions and promote innovation

Our Approach

Whilst we have many important elements of a PHM approach already in place, we recognise that we are early in the journey to develop a comprehensive local cross-system PHM function to deliver the appropriate intelligence which effectively supports local planning and decision-making. To achieve this we will prioritise development of the following:

Culture and leadership

- Engaging and supporting change in the system to embed effective PHM.
- Better use of clinical leadership to drive transformation.
- An approach rooted in an understanding of equality and inclusion

Workforce

- Understand and building on, the capacity and capability of the knowledge and intelligence workforce.
- Understand and develop the capability of the wider workforce to effectively engage with and use intelligence and data tools.

Technical & infrastructure

- Relevant data sources and flows and system requirements are required (understanding what we have now and how to get to where we need to).
- Understand the 'products'/ end user(s) needs to enable accessible and meaningful knowledge and intelligence to support effective decisions.

By applying an effective PHM approach, we will develop a broad set of indicators that measure local conditions for wellbeing and whether those conditions are being delivered fairly and sustainably and build on our outcomes based accountability approach described below.

Outcomes Based Accountability (Whole System Outcomes)

The Derbyshire system has agreed to apply an outcomes based accountability approach to ensure everything we do is outcomes led, with multiple accountability across partners as appropriate.

We will continue to develop this approach to ensure shared accountability for delivery of the LTP commitments and our broader approach to improving the health of our population. This approach which will be further enhanced through the development of PHM in Derbyshire to ensure our approach is fully aligned and agreed across all parts of the system, including our local Health & Wellbeing Boards and Local Authority (for instance in relation to Housing, Education, Air Quality).

We have agreed a set out outcome indicators across our existing programmes which are aligned to improvements in our three overarching population outcomes for people to have the best start in life, stay healthy, age well and die well. These indicators are also consistent with the LTP metrics. Our framework is set out on the following pages. By delivering the collective transformation programmes as set out in our plan, we will make real improvements in the health outcomes for the people of Derbyshire.

Derbyshire Wide Quality impact Assessment (QIA) tool

We have developed a system wide QIA approach which sets out how interdependencies and impacts across all component parts of our plan will be managed. This process enables quality and equality implications to be considered more effectively; where potentially negative quality impacts are identified either at organisational or cross system level, robust mitigations will be developed collaboratively across system partners.

We have identified three quality components which underpin the QIA process:

- Patient Safety – there will be no avoidable harm to patients from the healthcare they receive. This means ensuring that the environment is clean and safe at all time and the harmful events never happen.
- Effectiveness of care – the most appropriate treatments, interventions, support and services will be provided at the right time to those patients who will benefit.
- Patient Experience – the patient's experience will be at the centre of the organisation's approach to quality.

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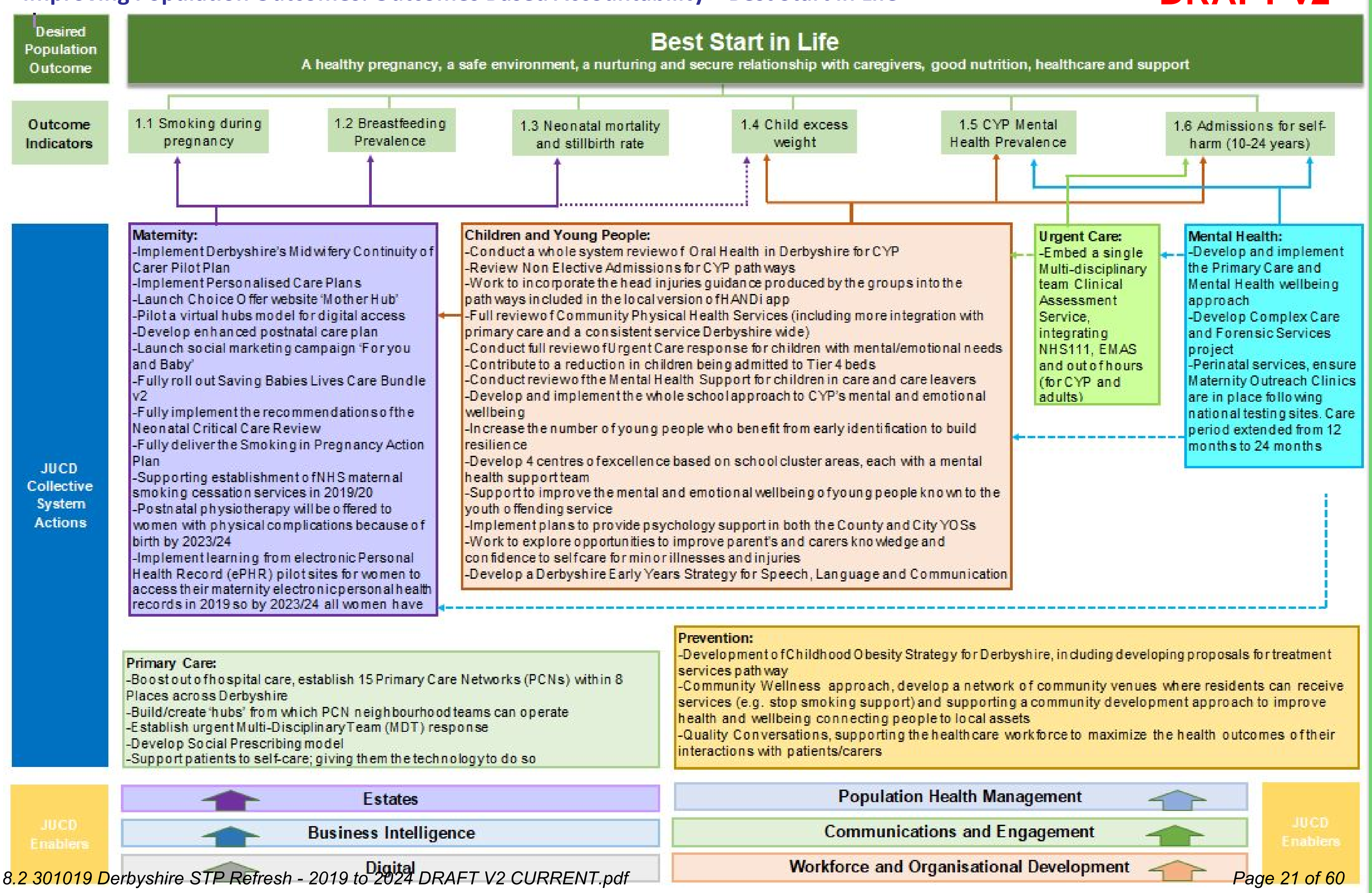
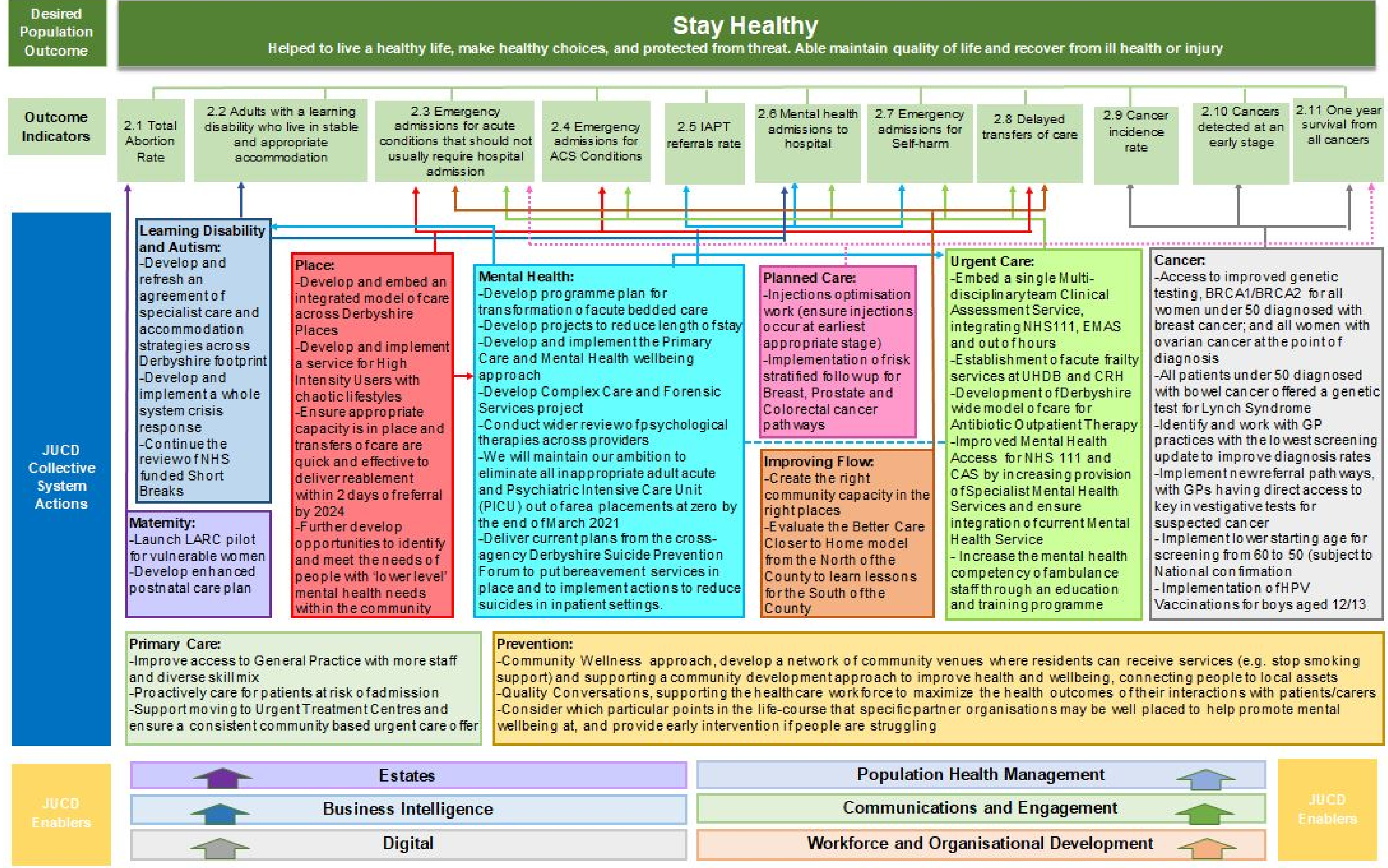
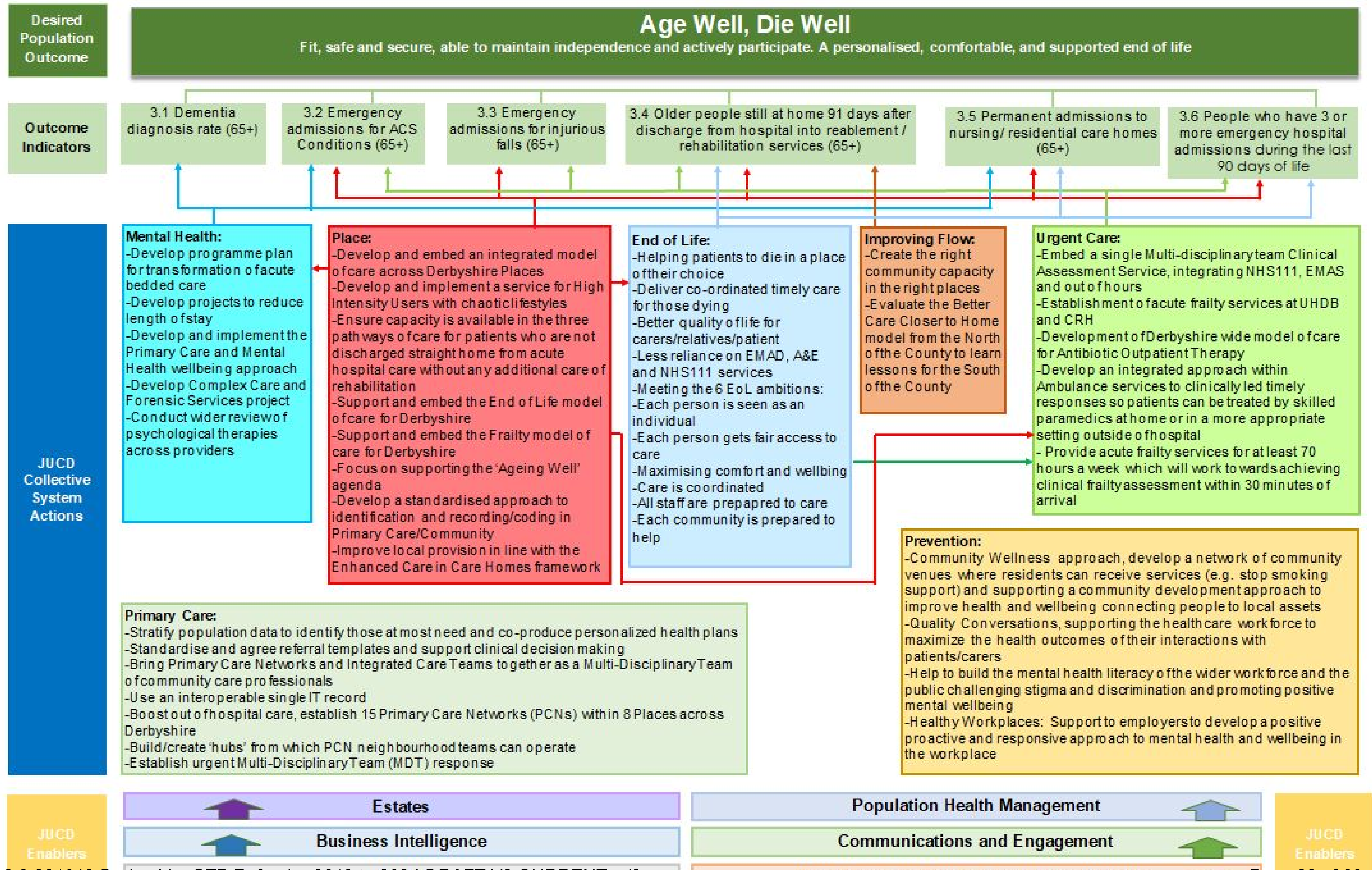

Desired Population Outcome
Best Start in Life
A healthy pregnancy, a safe environment, a nurturing and secure relationship with caregivers, good nutrition, healthcare and support
Outcome Indicators
1.1 Smoking during pregnancy
1.2 Breastfeeding Prevalence
1.3 Neonatal mortality and stillbirth rate
1.4 Child excess weight
1.5 CYP Mental Health Prevalence
1.6 Admissions for self-harm (10-24 years)
JUCD Collective System Actions
Maternity:
-Implement Derbyshire's Midwifery Continuity of Carer Pilot Plan
-Implement Personalised Care Plans
-Launch Choice Offer website 'Mother Hub'
-Pilot a virtual hubs model for digital access
-Develop enhanced postnatal care plan
-Launch social marketing campaign 'For you and Baby'
-Fully roll out Saving Babies Lives Care Bundle v2
-Fully implement the recommendations of the Neonatal Critical Care Review
-Fully deliver the Smoking in Pregnancy Action Plan
-Supporting establishment of NHS maternal smoking cessation services in 2019/20
-Postnatal physiotherapy will be offered to women with physical complications because of birth by 2023/24
-Implement learning from electronic Personal Health Record (ePHR) pilot sites for women to access their maternity electronic personal health records in 2019 so by 2023/24 all women have
Children and Young People:
-Conduct a whole system review of Oral Health in Derbyshire for CYP
-Review Non Elective Admissions for CYP pathways
-Work to incorporate the head injuries guidance produced by the groups into the pathways included in the local version of HANDi app
-Full review of Community Physical Health Services (including more integration with primary care and a consistent service Derbyshire wide)
-Conduct full review of Urgent Care response for children with mental/emotional needs
-Contribute to a reduction in children being admitted to Tier 4 beds
-Conduct review of the Mental Health Support for children in care and care leavers
-Develop and implement the whole school approach to CYP's mental and emotional wellbeing
-Increase the number of young people who benefit from early identification to build resilience
-Develop 4 centres of excellence based on school cluster areas, each with a mental health support team
-Support to improve the mental and emotional wellbeing of young people known to the youth offending service
-Implement plans to provide psychology support in both the County and City YOSs
-Work to explore opportunities to improve parent's and carers knowledge and confidence to self care for minor illnesses and injuries
-Develop a Derbyshire Early Years Strategy for Speech, Language and Communication
Urgent Care:
-Embed a single Multi-disciplinary team Clinical Assessment Service, integrating NHS111, EMAS and out of hours (for CYP and adults)
Mental Health:
-Develop and implement the Primary Care and Mental Health wellbeing approach
-Develop Complex Care and Forensic Services project
-Perinatal services, ensure Maternity Outreach Clinics are in place following national testing sites. Care period extended from 12 months to 24 months
Primary Care:
-Boost out of hospital care, establish 15 Primary Care Networks (PCNs) within 8 Places across Derbyshire
-Build/create 'hubs' from which PCN neighbourhood teams can operate
-Establish urgent Multi-Disciplinary Team (MDT) response
-Develop Social Prescribing model
-Support patients to self-care; giving them the technology to do so
Prevention:
-Development of Childhood Obesity Strategy for Derbyshire, including developing proposals for treatment services pathway
-Community Wellness approach, develop a network of community venues where residents can receive services (e.g. stop smoking support) and supporting a community development approach to improve health and wellbeing connecting people to local assets
-Quality Conversations, supporting the health care workforce to maximize the health outcomes of their interactions with patients/carers
JUCD Enablers
Estates
Business Intelligence
Digital
Population Health Management
Communications and Engagement
Workforce and Organisational Development
JUCD Enablers


Desired Population Outcome
Stay Healthy
Helped to live a healthy life, make healthy choices, and protected from threat. Able maintain quality of life and recover from ill health or injury
Outcome Indicators
2.1 Total Abortion Rate
2.2 Adults with a learning disability who live in stable and appropriate accommodation
2.3 Emergency admissions for acute conditions that should not usually require hospital admission
2.4 Emergency admissions for ACS Conditions
2.5 IAPT referrals rate
2.6 Mental health admissions to hospital
2.7 Emergency admissions for Self-harm
2.8 Delayed transfers of care
2.9 Cancer incidence rate
2.10 Cancers detected at an early stage
2.11 One year survival from all cancers
JUCD Collective System Actions
Learning Disability and Autism:
-Develop and refresh an agreement of specialist care and accommodation strategies across Derbyshire footprint
-Develop and implement a whole system crisis response
-Continue the review of NHS funded Short Breaks
Maternity:
-Launch LARC pilot for vulnerable women
-Develop enhanced postnatal care plan
Place:
-Develop and embed an integrated model of care across Derbyshire Places
-Develop and implement a service for High Intensity Users with chaotic lifestyles
-Ensure appropriate capacity is in place and transfers of care are quick and effective to deliver reablement within 2 days of referral by 2024
-Further develop opportunities to identify and meet the needs of people with 'lower level' mental health needs within the community
Mental Health:
-Develop programme plan for transformation of acute bedded care
-Develop projects to reduce length of stay
-Develop and implement the Primary Care and Mental Health wellbeing approach
-Develop Complex Care and Forensic Services project
-Conduct wider review of psychological therapies across providers
-We will maintain our ambition to eliminate all inappropriate adult acute and Psychiatric Intensive Care Unit (PICU) out of area placements at zero by the end of March 2021
-Deliver current plans from the cross-agency Derbyshire Suicide Prevention Forum to put bereavement services in place and to implement actions to reduce suicides in inpatient settings.
Planned Care:
-Injections optimisation work (ensure injections occur at earliest appropriate stage)
-Implementation of risk stratified follow up for Breast, Prostate and Colorectal cancer pathways
Improving Flow:
-Create the right community capacity in the right places
-Evaluate the Better Care Closer to Home model from the North of the County to learn lessons for the South of the County
Urgent Care:
-Embed a single Multi-disciplinary team Clinical Assessment Service, integrating NHS111, EMAS and out of hours
-Establishment of acute frailty services at UHDB and CRH
-Development of Derbyshire wide model of care for Antibiotic Outpatient Therapy
-Improved Mental Health Access for NHS 111 and CAS by increasing provision of Specialist Mental Health Services and ensure integration of current Mental Health Service
- Increase the mental health competency of ambulance staff through an education and training programme
Cancer:
-Access to improved genetic testing, BRCA1/BRCA2 for all women under 50 diagnosed with breast cancer; and all women with ovarian cancer at the point of diagnosis
-All patients under 50 diagnosed with bowel cancer offered a genetic test for Lynch Syndrome
-Identify and work with GP practices with the lowest screening update to improve diagnosis rates
-Implement new referral pathways, with GPs having direct access to key investigative tests for suspected cancer
- Implement lower starting age for screening from 60 to 50 (subject to National confirmation
- Implementation of HPV Vaccinations for boys aged 12/13
Primary Care:
-Improve access to General Practice with more staff and diverse skill mix
-Proactively care for patients at risk of admission
-Support moving to Urgent Treatment Centres and ensure a consistent community based urgent care offer
Prevention:
-Community Wellness approach, develop a network of community venues where residents can receive services (e.g. stop smoking support) and supporting a community development approach to improve health and wellbeing, connecting people to local assets
-Quality Conversations, supporting the health care workforce to maximize the health outcomes of their interactions with patients/carers
-Consider which particular points in the life-course that specific partner organisations may be well placed to help promote mental wellbeing at, and provide early intervention if people are struggling
JUCD Enablers
Estates
Business Intelligence
Digital
Population Health Management
Communications and Engagement
Workforce and Organisational Development
JUCD Enablers



Improving Population Outcomes: Outcomes Based Accountability - – Age Well and Die Well
DRAFT v2
Desired Population Outcome
Age Well, Die Well
Fit, safe and secure, able to maintain independence and actively participate. A personalised, comfortable, and supported end of life
Outcome Indicators
3.1 Dementia diagnosis rate (65+)
3.2 Emergency admissions for ACS Conditions (65+)
3.3 Emergency admissions for injurious falls (65+)
3.4 Older people still at home 91 days after discharge from hospital into reablement / rehabilitation services (65+)
3.5 Permanent admissions to nursing/ residential care homes (65+)
3.6 People who have 3 or more emergency hospital admissions during the last 90 days of life
JUCD Collective System Actions
Mental Health:
-Develop programme plan for transformation of acute bedded care
-Develop projects to reduce length of stay
-Develop and implement the Primary Care and Mental Health wellbeing approach
-Develop Complex Care and Forensic Services project
-Conduct wider review of psychological therapies across providers
Place:
-Develop and embed an integrated model of care across Derbyshire Places
-Develop and implement a service for High Intensity Users with chaotic lifestyles
-Ensure capacity is available in the three pathways of care for patients who are not discharged straight home from acute hospital care without any additional care of rehabilitation
-Support and embed the End of Life model of care for Derbyshire
-Support and embed the Frailty model of care for Derbyshire
-Focus on supporting the 'Ageing Well' agenda
-Develop a standardised approach to identification and recording/coding in Primary Care/Community
-Improve local provision in line with the Enhanced Care in Care Homes framework
End of Life:
-Helping patients to die in a place of their choice
-Deliver co-ordinated timely care for those dying
-Better quality of life for carers/relatives/patient
-Less reliance on EMAD, A&E and NHS111 services
-Meeting the 6 EoL ambitions:
-Each person is seen as an individual
-Each person gets fair access to care
-Maximising comfort and wellbing
-Care is coordinated
-All staff are prepapred to care
-Each community is prepared to help
Improving Flow:
-Create the right community capacity in the right places
-Evaluate the Better Care Closer to Home model from the North of the County to learn lessons for the South of the County
Urgent Care:
-Embed a single Multi-disciplinary team Clinical Assessment Service, integrating NHS111, EMAS and out of hours
-Establishment of acute frailty services at UHDB and CRH
-Development of Derbyshire wide model of care for Antibiotic Outpatient Therapy
-Develop an integrated approach within Ambulance services to clinically led timely responses so patients can be treated by skilled paramedics at home or in a more appropriate setting outside of hospital
- Provide acute frailty services for at least 70 hours a week which will work towards achieving clinical frailty assessment within 30 minutes of arrival
Prevention:
-Community Wellness approach, develop a network of community venues where residents can receive services (e.g. stop smoking support) and supporting a community development approach to improve health and wellbeing connecting people to local assets
-Quality Conversations, supporting the health care workforce to maximize the health outcomes of their interactions with patients/carers
-Help to build the mental health literacy of the wider workforce and the public challenging stigma and discrimination and promoting positive mental wellbeing
-Healthy Workplaces: Support to employers to develop a positive proactive and responsive approach to mental health and wellbeing in the workplace
Primary Care:
-Stratify population data to identify those at most need and co-produce personalized health plans
-Standardise and agree referral templates and support clinical decision making
-Bring Primary Care Networks and Integrated Care Teams together as a Multi-Disciplinary Team of community care professionals
-Use an interoperable single IT record
-Boost out of hospital care, establish 15 Primary Care Networks (PCNs) within 8 Places across Derbyshire
-Build/create 'hubs' from which PCN neighbourhood teams can operate
-Establish urgent Multi-Disciplinary Team (MDT) response
JUCD Enablers
Estates
Business Intelligence
Digital
Population Health Management
Communications and Engagement
Workforce and Organisational Development
JUCD Enablers

Strategic Priority: System Efficiency

We know our health system is inefficient in a number of ways, and therefore improved efficiency must be a key part of our plan.

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The financial gap across the Derbyshire healthcare system is forecast to be £105m by 2023/24. We know our health system is inefficient in a number of ways, and therefore system efficiency is embedded throughout our plan and can be evidenced in the specific sections, for example we will:

- Streamline care pathways to reduce duplication and hand-offs; with aligned clinical governance processes
- Align and optimise 'back-office' services (HR, PMO, Business Intelligence)
- Optimise integrated care provision including the alignment of clinical support services with a specific focus on diagnostics
- Streamline organisational governance process and shared decision making
- Develop our place based/PCN networks to improve anticipatory care
- Reduce reliance on agency/locum staffing
- Rationalise and optimise estate
- Make better use of digital technology

Furthermore as a system we have agreed to develop our approaches to improve ways of working, including:

- Commitment to improving operational ways of working, underpinned by the People Plan
- Aligned organisational HR process which will include 'staff passports' to facilitate moving between jobs more easily
- System PMO
- Streamlined organisational contracting, performance management and planning to enable a single system approach

As well as being demonstrated throughout our plan the table below identifies key efficiency opportunities.

Efficiency Initiatives	Supporting Deliverables
Care Pathways	• Same Day Emergency Care • Theatre efficiencies • Efficiency and cost reduction through digitalisation and modernisation of outpatient appointments
Optimised use of clinical workforce	• Workforce & team efficiency • Align to demand (rotas, job plans) • Skill mix / working to top of license • Sickness levels and turnover
Estates and facilities management	• Community hospital/facility rationalisation • Acute hospital (incl. PFI) optimisation • Technology to support agile working
Agency Costs	• Better control of staffing through e-rostering systems • Improved workforce planning to ensure substantive staff are recruited and trained • Cost control through agency caps
Digital Technology	• Reduction in wasteful duplication by integrating clinical systems and making clinical time more effective
Reduction in local health inequalities and unwarranted variation	• Applying Rightcare data to make improvements in MSK and CVD pathways • Improved cancer wellbeing with Derby County Community Trust working on the 'Wellbeing for All' project targeting seldom heard groups

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Strategic Priority: System Development

We will come together to manage the Derbyshire system through an Integrated Care System (ICS), develop Integrated Care Providers (ICPs) and our Strategic Commissioning function through aligned leadership and governance

Why is this a priority for Derbyshire?

Many of the initiatives within the NHS LTP are not new to Derbyshire as we have been working on these since developing our last STP plan. However, so far they have not yet been implemented to deliver the necessary transformational impact – in either care quality or financial improvement terms. And, we believe that this is significantly due to our existing system infrastructure, which drive competing organisational priorities and an inability to divert funding and investment from historical patterns of provision that do not meet the changing needs of the population.

So, we need to ensure that this time we put the arrangements in place to drive sustainable, embedded change. These arrangements must address past barriers to change including the lack of cross-system working, misaligned incentives and the predominant organisational focus over system-wide and patient-centred perspectives.

Transforming how we work together across organisations to manage the system is therefore a priority for our STP. We must make system-level working the default option - 'business as usual' - as an approach for managing all of the care we commission and provide. We will do this by developing as an Integrated Care System by April 2021.

The NHS LTP provides us with the catalyst required for this system change to create a strong underpinning infrastructure which supports transformation and improvements for our population without the historic barriers we have faced.

To facilitate our transition towards an ICS, we have agreed the Derbyshire ICS framework and constituent job cards.

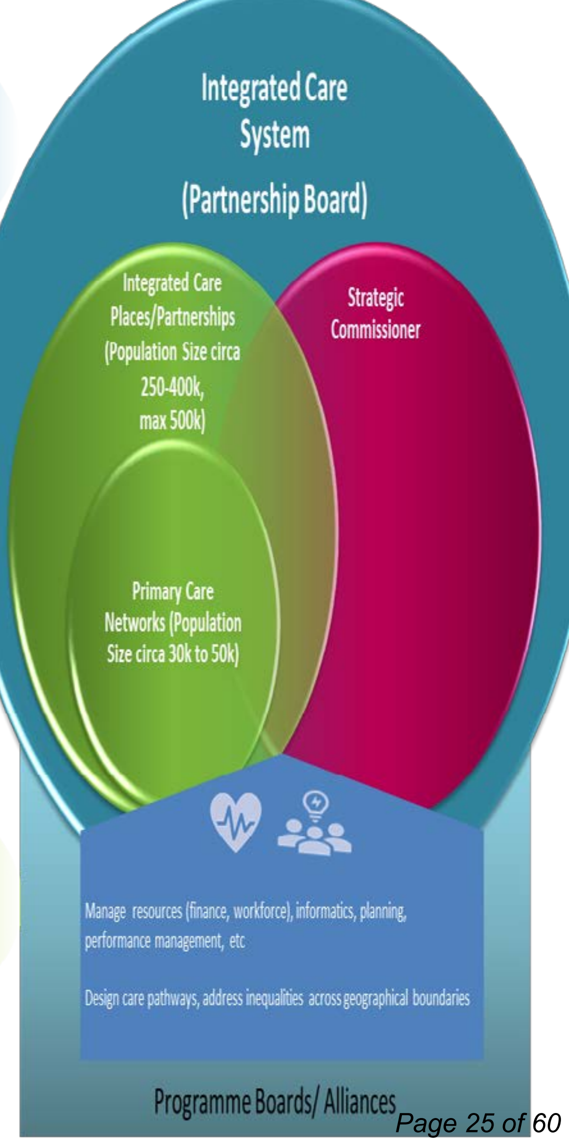
Integrated Care System (ICS): Job Cards

Strong partnership of NHS organisations, local councils & others
Roles/Functions: Collective responsibility for managing resources, set framework for delivering integrated care for ICPs and PCNs, managing performance of the ICS, holding to account and accountability to regulators

Local Authority, CCG, Public Health, Direct Commissioning
Roles/Functions: Define strategic outcomes, health of the population, national best practice in delivering care

Acute, community and mental health providers
Councils, inc social care, housing, education, primary care/PCNs, independent and voluntary sector
Roles/Functions: Customise and implement care pathways and lead transformation programme. Build and maintain the 'supply chain' of providers and actively support PCNs.

GP practice, community and community, mental health, social care, voluntary sector and cute (e.g. disease management)
Roles/Functions: Deliver Primary Care (out of hospital services) through integrated care teams.



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Strategic Priority: System Development

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We will come together to manage the Derbyshire system through an Integrated Care System (ICS), develop Integrated Care Providers (ICPs) and our Strategic Commissioning function through aligned leadership and governance

Our Approach

Place based care will remain at the heart of our approach to meet the local needs of individuals; developing our Neighbourhoods through Primary Care Networks (PCNs) within our Integrated Care Partnerships (ICPs) and the wider Integrated Care System (ICS).

Our ICS Development Plan: Headlines

- We have successfully completed the ICS Development Programme and Commissioning Capability Programme
- We are increasingly engaged General Practice leadership in system decision making
- Our ICP configuration is being progressed through the ICP Development Group, and is described further on the following page
- We have launched a System OD programme, including transformation workstreams, Executives, and NEDs/Lay members events
- We have strengthened our governance which now includes a finance sub-committee, Quality and Performance Group and Chairs group
- We intend to be operating as a shadow ICS from 1 April 2020

Furthermore, we have identified the following key milestones in the next quarter:

- Agree our system clinical strategy (December 2019 STP Board)
- Continue to build resilience and services provided at Place level
- Approve STP OD strategy and roll out system wide OD programme to help partners increasingly work in the system space (November 2019 LWAB/STP Board)
- Develop a single system financial savings plan for 2020/21
- Review of STP Board governance and ways of working
- Streamlining of ways of working: HR processes, procurement

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Our aim is to be an Integrated Care System which is built around care close to home, where hospital beds are only used where somebody cannot be cared for safely in their own environment

Characteristics of an Integrated Care System

- System Leadership, Partnerships & change capability
- System architecture & strong Financial Management & planning
- Track Record of Delivery
- Integrated Care Models
- Coherent & defined Population

Key Deliverables to enable Derbyshire to become an ICS

Transformation Workstreams
- Planned Care
- Improving Flow
- Urgent & Emergency Care
- Place/ Primary Care Networks
- Children & Young People
- Maternity
- Mental Health
- Learning Disabilities & Autism
- Cancer
- End of Life
- Disease Management

Enablers
- Prevention & Population Health Management
- Workforce
- Digital
- Communications & Engagement
- Estates
- Finance

Enabling development programmes
- ICS Development Programme ✓
- Commissioning Capability Programme ✓
- Population Health Management Programme
- System wide OD Programme

Enabling work
- System Savings Approach ✓
- Outcomes Based Accountability ✓
- Business Intelligence/PHM
- Development of Place Alliances and Primary Care Networks ✓
- Derbyshire Clinical Care Strategy
- Shared finance plan and risk share agreement ✓
- Integrated Care Partnership development
- Profiling system wide demand, capacity and workforce

Strategic Priority: System Development

We will come together to manage the Derbyshire system through an Integrated Care System (ICS), develop Integrated Care Providers (ICPs) and our Strategic Commissioning function through aligned leadership and governance

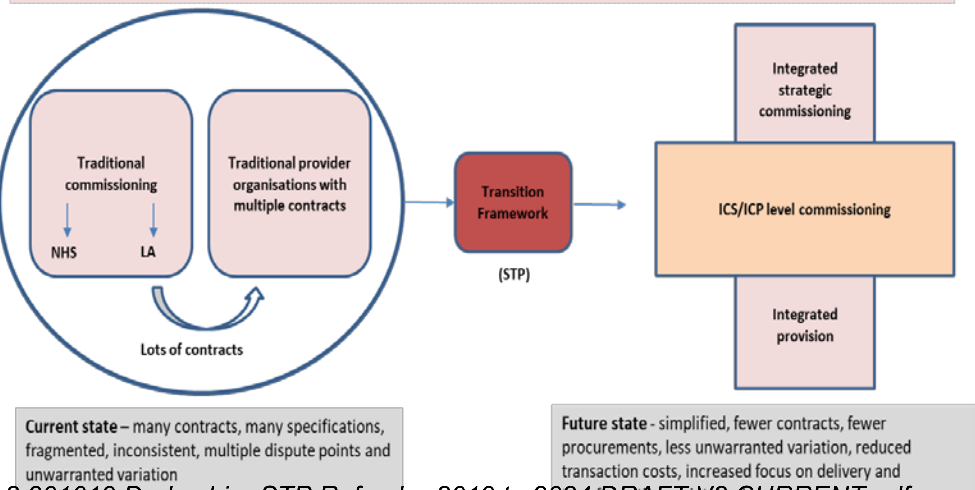
We will develop our partnership to become an ICS by April 2021 which is central to the delivery of the LTP; our future arrangements will include the following components.

Streamlined Strategic Commissioning

- We have already streamlined our commissioning arrangements with the merger of four Clinical Commissioning Groups (CCG) into one. Derby and Derbyshire CCG formally came into existence on 1 April 2019. These arrangements enable a single set of commissioning decisions at system level.
- Commissioners will make shared decisions with providers on how to use resources, design services and improve population health. We will increasingly move towards an integrated commissioning budget across health and social care to jointly commission at place and make strategic commissioning decisions in the deployment of that budget.
- We will further develop our joint commissioning arrangements with Local Authorities.

Strategic commissioning architecture in Derbyshire

How strategic commissioning will look for Derbyshire
Strategic commissioning will be a departure from the current state for both the NHS and LA. There will no longer be a focus on **detailed contract specification, negotiation and monitoring** or the **routine use of tendering**. Rather, the emphasis will shift to **defining and measuring outcomes, putting in place capitated budgets, assigning appropriate incentives for providers** and **using longer term contracts** extending over five to ten year timelines.



Streamlined Provision

Providers will increasingly move to integrate provision and delivery in order to deliver the outcomes for the population of Derbyshire at both footprint and Place/PCN levels within allocated resources – known as Integrated Care Partnerships (ICPs). All PCNs will be integral to ICPs; which will be designed to deliver localised place based care.

Our ICPs will provide a fundamental shift in the way care provision is designed and organised with all partners playing an equal role. This inclusive approach will not only drive our approach to longer term care redesign but will also be the basis on which we agree our ICP configuration.

We will confirm our ICP configuration during quarter 3 of 2019/20, in doing so we will describe the functions of our ICPs, ready for shadow running from 1 April 2020. This approach is underway and will build upon the key things we want our ICPs to address/deliver for our population:

- Understand our population and their health and social care needs (link to Population Health Management)
- Use place alliance intelligence
- Focus on care models not clinical pathways in isolation
- Recognise that there needs to be a service redesign
- Shared workforce, planning and assets
- Need to consider what is done at different levels within/across the system
- Don't lose gains developed over the years
- Need staff and public engagement
- Engage professional and clinical leadership

Our ICP development Plan: Headlines:
We have;

- Agreed the case for change
- Agreed a working hypothesis of either 3 or 4 ICPs, to be further developed
- Committed to further discussions with constituent partners to inform thinking re the options of 3 or 4 ICPs (GP Provider Alliance, Erewash Place, Amber Valley Place, South Derbyshire Place, Derbyshire Dales Place, High Peaks Place and respective PCNs)

It is intended that the above will enable a single preferred option to be agreed for recommendation to the December JUCD Board.

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Delivering further progress on fully integrated Place Based Care

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Key deliverables	Milestones				
As described in our strategic priorities, we will deliver transformed out of hospital care; through place based care, underpinned by our model of care with a focus on supporting the national 'Ageing Well' programme.	19/20	20/21	21/22	22/23	23/24
Urgent Community Response - Assess and improve capacity and quality of key community crisis response and reablement services, developing our integrated community rapid response provision to support the 2 hour response standards where clinically appropriate by 2024					✓
Ensure appropriate capacity is in place and transfers of care are timely and effective in order to implement the urgent community response standards for reablement within 2 days of referral by 2024					✓
Progress towards the ambition of an integrated service model available 24/7 as appropriate					✓
Co-design our urgent community response with all of our stakeholders. The aim being to develop a set of standards, outcomes and a governance framework which will allow our system to commission a community urgent care response from Primary Care Networks in a way that allows local delivery to an STP framework, with a target to implement across Derbyshire by April 2021.	✓	✓			
Work with PCNs to develop multi-disciplinary, cross sector teams of community care professionals and review options for greater integration within the emerging ICP structure		✓			
Consistent proactive identification and management of people at risk of unwarranted health outcomes through risk stratification, assessment and care planning in line with the anticipatory care element of 'Ageing Well'	✓	✓			
Improve local provision in line with the Enhanced Care in Care Homes framework and publication of a maturity matrix for full delivery of the EHCH model as part of the national Ageing Well Programme		✓			
Expression of Interest submission to the Community Heath and the Ageing Well programme Urgent Community Response Accelerator Site Proposal for 2020/21. Key elements include: A single number within the system for patients and professionals to access a same day response, a GP led clinical assessment/triage, locally based integrated rapid response teams that, where clinically appropriate, will provide care in people's homes.	✓	✓			
Implement and review targeted case management approach to the most severe 'high intensity users'. Expand if successful	✓	✓			
Ensure community assets are understood and widen the support available for social prescribing link workers to access in each Place.					
Utilise Population Health Management embedding the personalised care model as an enabler to improve outcomes through segmentation approaches to understand the use of, and demand for services across the health and care system to inform planning and prioritisation / development of provision for out of hospital care.	✓	✓			
Further develop opportunities to identify and meet the needs of people with 'lower level' mental health needs within the community			✓		
Maximise the benefits of access to the single health care record by integrated community teams and ambulance staff				✓	
Consider the opportunities, and maximise the benefits, of digitally enabled care in the community promoting early adoption		✓			
Contribute to continued reductions in the number / proportion of delayed transfers of care to achieve Derbyshire share of the national target through ensuring appropriate range and capacity of provision to support people leaving hospital	✓	✓			
Leaders will feel equipped to deliver in a collaborative and transformative way agnostic of organisation, with a focus on people and communities	✓	✓			
Ensure continuation of the well-developed wider partnership role in place based working that has been built in Derbyshire to ensure we draw on the widest range of community assets in developing and delivering improvements in care and outcomes adopting the Ageing Well best practice tools and supporting service guidance for urgent community response, reablement care and community multidisciplinary teams	✓	✓			
Support and manage Places in the transition to a new governance structure in the emerging system architecture, ensuring that the structures and frameworks of ICS/ICP enable true integration of planning and delivery of local services.	✓	✓			
Identify where increased resource in community could deliver impact on system costs, outcomes and experience and agree mechanisms to plan and manage that shift, incentivising preventative and proactive care.	✓	✓			

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Key Deliverables	Milestones				
Delivering our vison through the combined deliverables below which are aligned to the LTP commitments will improve Urgent & Emergency Care for our citizens	19/20	20/21	21/22	22/23	23/24
• A Clinical Assessment Service (CAS), accessible via 111 for Derbyshire is in place with people able to speak directly to a clinician; supporting navigation to the optimal service 'channel' so that only those with more serious or life threatening physical or mental health needs present at A&E with the majority of people accessing suitable alternatives within the community and self-care options. • The CAS clinician will seek to complete the call there and then without the need to transfer the patient elsewhere, ensuring 50% plus of calls receive a clinical assessment of this nature and more than 40% of appointments booked direct (extension of Direct booking in GP in-hours primary care and extended access). • Where face to face contact is deemed necessary the CAS will advise on the most appropriate services including UCTCs, GP both in and out of hours, community care, pharmacy, emergency dental and will directly book more than 40% of those requiring urgent appointments in services alternative to A&E. NHS111/CAS will also be able to directly book into the acute SDEC assessment function where appropriate. • By 2023, our CAS will typically act as the single point of access for patients, carers and health professionals for integrated urgent care and discharge from hospital care. This will include all adults, children and young people experiencing mental health crisis, with access to mental health triage and crisis care available 24 hours a day, seven days a week by calling 111.	✓	✓	✓	✓	
• A 24/7 Clinical Assessment, Advice and Treatment Hub (including dental, pharmacy, paramedics) that supports 111, 999 and out-of-hours calls from the public and all healthcare professionals will be in place**;** including support for people with known and/or long-term conditions or additional vulnerabilities (such as learning disability and mental health) will be offered enhanced planning and support to avoid acute presentations. • Increasing capacity to deliver hear and treat and increase see and treat services with the support of the clinical advice hub.					
• Delivering the optimal level of on day urgent primary care appointments and home visits to patients (at local/PCN level) to meet the anticipated demand, including the provision of extended access at weekends and evenings. • Strengthen our Primary and Community offer so that a broader range of integrated services (GP Access Hubs/UCTCs, mental health crisis clinics etc.) are all in one location for patients within their communities, supporting both physical and mental health urgent needs by when. • All Derbyshire localities will have a consistent offer for out-of-hospital same day urgent care. ***NB this deliverable is linked to developments in place based** care*					

• Delayed Transfers Of Care (DTOC) are further reduced, in partnership with local authorities by:
  • Reducing hospital care and resourcing integrated community services capacity within each Place, to meet demand closer to home and support patients to be discharged to a new long term place of care with minimal transfers; improving patient and carer experience, and increasing capacity and flow out of acute hospital settings. The focus will be on the south of the county, building on the Better Care Closer to Home transformation in the north.
  • Mapping resources and capacity across community and intermediate care to better identify and access capacity as part of the Improving Flow work to therefore effectively utilise services better in the community by March 2020
	✓				

• We will further develop a comprehensive model of Same Day Emergency Care (SDEC) for medical and surgical pathways, in both our acute hospitals so that there is 100% provision of SDEC services least 12 hours a day, 7 days a week and work towards agreed trajectories for the percentage of non-elective activity treated as SDEC which is subject to technical guidance being released. • This will ensure effective flow through the system from acute bedded facilities and integrated discharge pathways into the community. The SDEC model will provide people who access acute services with new diagnostic and treatment practices, allowing patients to spend just hours in hospital rather than being admitted to a ward; increasing the proportion of acute admissions discharged on the day of attendance from a fifth to a third so that the there is a 40% reduction in the long length of stays compared to those our patients experienced in 2018, by March 2020. • Complete the expansion and redesign of our Emergency Departments and acute front door services which will facilitate the delivery of comprehensive patient assessments and on-going quality urgent health care. This will include on-going development of a co-located Primary Care Streaming Service, improved frailty assessment, pharmacy and mental health, plus greater integration between the Emergency Department and wider emergency provision in the hospital, specifically ambulatory care services, Acute Frailty Service providing assessment within 30 minutes of arrival and Paediatrics. • The redesign of our front door services will support us to ensure that patients who arrive at A&E via ambulance have their care transferred from paramedics to A&E staff within 15 minutes of arrival. • This comprehensive model for medical and surgical pathways will relieve pressure elsewhere in our hospitals and free up beds for patients who need quick admission either for emergency care, or for a planned operation.	✓	✓			
• Fully implementing Urgent Care Treatment Centres (UCTC), operating to the national specification by autumn 2020 as part of our integrated community urgent care offer; designation based on comprehensive urgent care review.	✓	✓			
• Efficient A&E departments which are appropriately resourced and are fully meeting the emergency and urgent care standards arising from the national Clinical Standards Review	✓				
• Introduce mental health nurses in ambulance control rooms to improve triage and response to mental health calls, and increase the mental health competency of ambulance staff through an education and training programme. As a result people with a mental health crisis, will be able to consistently access alternative services to A&E, reducing the need for conveyance to A&E.					
• Introduce new mental health transport vehicles to reduce inappropriate ambulance conveyance or by police to A&E.					

Key Deliverables	Milestones				
We will deliver the foundational commitment in relation to Cancer across the system, by continuing to prioritise improvements across the footprint (including East Staffordshire) through Prevention, Early Diagnosis & Treatment and Living With Cancer in line with the National Ten Year Cancer Plan; working in partnership with the East Midlands Cancer Alliance.	19/20	20/21	21/22	22/23	23/24
HPV will be a primary screen in the cervical screening programme with the implementation of HPV screening as a more sensitive and reliable test for Cervical Cancer, HPV Vaccinations for girls (complete and in place) and for boys aged 12/13 (Sept 19)	✓				
We will improve bowel, breast and cervical screening uptake by working with GP practices with the lowest cancer screening uptake from national programmes to optimise the uptake of cancer screening programmes to increase the number of cancers diagnosed at an early stage so that 62% of cancers are diagnosed at Stages 1 and 2 by 2020, increasing to 75% by 2028; enabled by increase uptake so that by 2021 there will be 80% uptake of Breast and Cervical Screening and 75% Bowel Screening uptake. This will include continuation of a programme of support to GP practices, particularly within hard to reach communities, facilitated by CRUK and Public Health (City & County)	✓	✓			
Identify opportunities within screening and two week wait pathways to support staff to provide lifestyle advice so by March 2021 all staff are routinely providing lifestyle advice	✓	✓			
Gather data and develop population characteristics for Breast Cancer screening to develop information for professionals to engage key target groups so by March 2022 more tailored information will be in place to enable targeted interventions for key groups			✓		
Hard to reach communities, specifically BAME will have access to the 'Wellbeing for All' programme facilitated by Derbyshire Community Trust so that by March 2022 seldom heard communities will be encouraged to lead healthy lifestyles and early presentation to health services			✓		
We will work to improve GP referral practice and GP direct access to key investigative tests for suspected cancer					
Continue to develop and deliver GP cancer education / learning programmes with dedicated sessions across the footprint	✓	✓	✓	✓	✓
Work with the Digital Workstream to support the implementation of two week wait forms in the GP Referral Support System in Primary Care	✓				
We will roll out implementation of Faecal Immuno-chemical Testing (FIT) testing for symptomatic and non-symptomatic populations in line with national policy so patients have access to non-invasive, hygienic test, with only one sample required. Starting with all patients with bowel cancer symptoms and (complete and in place) extended to Bowel Cancer Screening	✓				
Implement lower starting age for screening from 60 to 50 and increase sensitivity level (Timescales subject to national confirmation)					
We will implement optimal and best practice pathways to facilitate early diagnosis and better outcomes, with patients surviving longer after diagnosis by implementing pathways to enable faster investigation, diagnosis and treatment.	✓	✓			
Direct access MRI Brain Pathway	✓				
Implementation of RAPID Prostate Pathway; implemented at UHDB (Derby) and work has commenced to implement consistently in Burton; straight to Test at CRH implemented	✓	✓			
National Optimal Lung Pathway: Year 1 of two year programme completed. Work progressing to deliver Year 2, embedding efficient and effective lung cancer pathway	✓				
Upper GI Pathway: Pathways to be reviewed and refined		✓			
Direct access to Vague Symptoms Pathway, supporting regional development. Programmes in place; to be clinically evaluated (Sept/ Oct 19)	✓				
Improve access to Genetic Testing (BRCA1/BRCA2) for all women diagnosed with breast cancer who meet the Mainstreaming Criteria and all women with ovarian cancer. Work through ECAG (Expert Clinical Advisory Group) to establish protocol and commission services so that By April 2020 any familial risk of cancer in this group of patients will be identified through this improved Genetic Testing		✓			
Work with Cancer Alliances to provide Lynch Syndrome testing for all patients under 50 diagnosed with bowel cancer		✓			
We will work with the EMCA so that by 2020 one RDC will be implemented in each Cancer Alliance with further rollout by 2023/24. Development of clinical and delivery models for Rapid Diagnostic Centres (RDC); pilot sites will be agreed within the EMCA region to deliver national implementation plans across the footprint, together with any additional cohorts based on local need, capability and capacity; Pilot sites within the East Midlands Cancer Alliance region to be agreed, with at least one RDC to start accepting patients by January 2020 and National evaluation of pilot sites to support further rollout thereafter	✓	✓	✓	✓	✓
We will improve access to high quality treatments, including through rollout of Radiotherapy Networks, strengthening of Children and Young People's Cancer Networks, and reform of Multi Disciplinary Team meetings. Continue to work with Specialised Commissioning to ensure patients have access to high quality personalised treatment/therapies for radiotherapy, chemotherapy and immunotherapy.	✓	✓	✓	✓	✓
Support develop and effective functioning of EMCA Radiotherapy networks	✓	✓	✓	✓	✓
We will implement the National Specification for Early Diagnosis from the GP Contract Reform in line with NICE guidance, for children, young people and adults at risk of cancer by working with Primary Care Networks (PCNs) to review and implement DES and seek a cancer champion in each PCN group to encourage and support implementation at a local level.	✓	✓			
We will deliver the updated Service Specification for children and young people's cancer services subject to national specification timescales					
We will address unwarranted variation, improve patient experience and be supported by an appropriate workforce and support implementation of National Cancer Workforce Plan and changes as they evolve	✓	✓	✓	✓	✓

Key Deliverables	Milestones				
We will deliver the foundational commitment in relation to Cancer across the system, by continuing to prioritise improvements across the footprint (including East Staffordshire) through Prevention, Early Diagnosis & Treatment and Living With Cancer in line with the National Ten Year Cancer Plan; working in partnership with the East Midlands Cancer Alliance.	**19/20**	**20/21**	**21/22**	**22/23**	**23/24**
Maintain, deliver and improve the position against National Cancer Patient Experience Survey and develop ongoing programmes to incorporate focus groups, questionnaires and engagement events; to demonstrate a year on year improvement (national average currently 8.8). Build on stakeholder events such as focus groups, patient involvement events and react to national and local surveys. There are currently four Health & Wellbeing events planned which will involve patients, carers, clinical stakeholders and third party providers (by Dec 19). Feedback obtained from these events will inform where gaps exist, with focus groups implemented to progress work to fill these gaps. Active Recovery and 'Wellbeing for All' programmes will also support improvements in patient experience and satisfaction.	✓	✓	✓	✓	✓
Ensure all those diagnosed with cancer have the opportunity to undertake a Holistic Needs Assessment (HNA) and Care Plan throughout their diagnosis, treatment and follow up; with 75% of all new cases being offered a HNA.		✓			
Ensure all patients are given the opportunity to join a Physical Activity Programme facilitated by Community Trusts; all patients provided with information on this service. Work towards developing a service for the north of the county		✓			
Ensure all cancer patients are offered access to health and wellbeing support appropriate to their needs at the time. Events publicised through the hospital and primary care. Four events to be held throughout the year (2 Burton/2 Derby) with programme expanded across the footprint	✓	✓			
Develop and implement a pathway to ensure all patients receive a Treatment and End of Treatment (EoT) Summary (EoT only at CRH)		✓			
GP practices to undertake Cancer Care Reviews for all patients within six months of a Cancer Diagnosis. Improved support for patients in the community through joined up care between secondary and primary care	✓				
Improve engagement with Carers and develop plans for ongoing support so that by September 2020 focus groups for carers of children, young people and adults with cancer to support further development	✓	✓			
Undertake Bowel Health Equity Audit; identify recommendations and implement action plan so that by March 2022 actions have been fully implemented	✓	✓	✓		
Ensure patients have access to enhanced supportive care with links to End of Life (subject to links with newly established EoL workstream)					✓
We commit to delivery of the cancer performance standards including 14, 31 and 62 day standards and, from 2020/21, compliance with the 28 day Faster Diagnosis Standard. Ongoing - To achieve required national targets of 93% (2ww), 96% (31 day), 85% (62 day target - recovery action plan in place). Ensure actions are taken to meet current constitutional targets for Cancer Waiting Times (CWT) and implement any revised CWT targets in 2020/21.	✓	✓	✓	✓	
Implement recording of the 28 day Faster Diagnosis Standard with shadow monitoring of data in 2019/20 and full implementation from 2020/21.	✓	✓			
Work with stakeholders to produce a Derbyshire-wide report looking at predictive modelling for cancer referrals for next 5-10 years, in order to support commissioning of activity and workforce development	✓				
We will ensure that from April 2020 two thirds of patients who finish treatment for breast cancer will be on a supported self-management follow-up pathway. Also, all trusts will have in place protocols for personalising/stratifying the follow-up of prostate and colorectal patients and systems for remote monitoring for patients on supported self-management. Develop and implement personalised follow-up pathways of care for people with cancer so that by April 2020, 75% Breast patients will be on a personalised self-management follow-up pathway tailored to their needs and by April 2021 Prostate and Colorectal patients will be on a personalised self-management follow-up pathway tailored to their needs. By April 2024, all those diagnosed with cancer will be on a personalised self management follow-up pathway tailored to their needs		✓	✓	✓	
Implementation of Supported Self-Management with Remote Monitoring across remaining tumour sites starting with Breast and Urology and all remaining tumour sites implemented by 2021/22		✓			
New Quality of Life (QoL) Metric in use locally for all Providers to submit QoL data from April 2020		✓			
Working with the EMCA to deliver the National programme (national guidance is awaited) to ensure Genome Sequencing will be offered to all children diagnosed with cancer from April 2020		✓	✓	✓	
By 2023 the first phase of the Targeted Lung Health Checks Programme will be completed, with plan for wider rollout (depending on evaluation)					✓
EMCA will implement one of the ten projects involved in the first phase of delivering targeted lung health checks. Extended lung health check model in place (subject to EMCA plans). Interim evaluation of first phase of projects, implementation plan/approach for further rollout 22/23 and final evaluation of first phase 23/24			✓	✓	✓

Better Care for Major Health Conditions: Improving Mental Health Services

DRAFT v2

Delivery of our plan will be supported by our continued commitment to the Mental Health Investment Standard (MHIS)

Key Deliverables	Milestones				
We will deliver the foundational commitment in relation to Mental Health across the system; achieving access standards as defined nationally. We will continue development of the Derbyshire Mental Health Alliance to include all statutory and voluntary sector providers and commissioners of mental health services across health and care will participate in the emerging regional collaborative around Forensic, CAMHS, Eating Disorder services and future waves, to include Perinatal and Learning Disabilities services.	**19/20**	**20/21**	**21/22**	**22/23**	**23/24**
Perinatal Mental Health: Derbyshire will be lead provider across the region for Tier 4 services once phase 2 of NCMs opens. We will increase access to specialist community perinatal mental health services with performance meeting 5% target of birth rate coverage and Psychological therapy input into the team by the end of 2019/20. Community Perinatal coverage already across the County and performance close to national ambition. Maternity Outreach Clinics will be in place following national testing sites with the care period extended from 12 months to 24 months by the end of 2023/24.	✓				✓
Adult SMI Community Care: We will bolster adult Severe Mental Illnesses (SMI) integrated models of primary and community mental health care with investment in specialist Personality Disorder (PD) support teams in place in Community Mental Health Teams (CMHTs) from 2019/20 onwards. We will link closely with Lincolnshire and other pilot sites to be ready to start implementation of the new models from April 2021 and fully established by the end of 23/24. We will maintain national performance standards and sustain fidelity of the model for the Early Intervention Psychosis (EIP) service and Individual Placement and Support (IPS). An IPS wave 2 service is being established in line with national model in 19/20. Pilots in digital contacts testing model will take place in 2019/20, enabling EIP Level 3 compliance, with roll out of digital contacts subject to evaluation by 2020/21.	✓	✓			✓
Mental Health Primary Care and Physical Healthcare: IAPT services continuing to meet all national targets, with IAPT therapists into integrated PCN teams, Long Term Conditions (LTC) service in place and IAPT accessed by more older people and people in care homes. National access ambitions met in full by end of 23/24. SMI Physical Health checks at 60% from April 20/21 onwards. Wellbeing approaches (Tower Hamlets and GM models) prototyped in two PCN areas 2019/20 and rolled out across the County in 2020/21, engaging fully with communities and the voluntary sector. This will provide individualised opportunities for people to live full and well lives in their communities without recourse to statutory services. Link CMHT staff with GP practices to provide advice and guidance. Close relationship and interaction between this work and the work to implement new models of Adult SMI Community Care.	✓	✓			✓
OPMH, Dementia and Delirium: Integrated Care Homes training package in place, including Frailty, EoL and OPMH. Training package in place across all providers by 2020/21 to support care staff in identification of delirium and dementia. Consistent and equitable crisis response services (Dementia Rapid Response Teams and Functional Rapid Response Teams) for Older People using CRHTT Transformational monies in 19/20 and 20/21 (see below). Implementation of Day Services changes to deliver single countywide model across the County in 2019/20. Furthermore, we will agree system wide Derbyshire Well Pathway for Dementia as a whole systems approach to Frailty, OPMH and End of Life and sustain transformation of MAS service and continue to meet diagnosis targets.	✓	✓			
Mental Health Urgent Care: We will maintain our ambition to eliminate all inappropriate adult acute and Psychiatric Intensive Care Unit (PICU) out of area placements to zero by the end of March 2021. The longer term solution for sustainable zero out of area placements, will be a NHS PICU developed in Derbyshire by the end of 23/24; whilst this is established we will need to use local private provider PICU beds. With regard to adult OOA the programme of work to reduce the LoS will increase local capacity to ensure care is delivered closer to home and also eradicate dormitories over time. These are all key components in the Estates Strategy (Dec). Crisis Teams across the county in fidelity with the model across all age groups and alternatives to A&E attendances in place, with 1 alternative to A&E in 2019/20 increasing to two by 2020/21. 100% coverage of 24/7 adult Crisis Resolution and Home Treatment Teams (CRHTTs) operating in line with best practice by 2020/21 and maintaining coverage to 2023/24. These will be accessed via a single point of entry for crisis response via 111 by 2023 and supported by Core 24 Mental Health Liaison Services at CRH and DRH sites and PD specialist resource in place in CMHTs from 2019/20. For people with Personality Disorder, only those with exceptional circumstances will require admission to hospital settings. We will also develop innovative digital alternatives to physical observations (Oxehealth) across all seclusion rooms.	✓	✓			✓
Suicide Reduction and Bereavement Support: We will deliver current plans from the cross-agency Derbyshire Suicide Prevention Forum to put bereavement services in place and to implement actions to reduce suicides in inpatient settings. Trailblazer funding used to establish RTS service with Derbyshire Police and BPT resulting in bereavement support provided within 72 hours in 2019/20 with new services sustained and learning shared with NHSE/I in 2020/21.	✓	✓			
Problem Gambling and Rough Sleeping: Should Derbyshire be identified as one of the 15 problem gambling sites or one of the 20 areas for increased rough sleeping provision, then the JUCD MH Programme will be ready to respond with proposals to address either or both areas, building on our existing links and strong relationships with the voluntary sector in both areas of work.					✓

Our Planned Care Programme of work is designed to enable significant transformation in end to end pathways so that we fundamentally modernise outpatient care (including through digital options) and ensure shorter waits for planned care when required.

Key Deliverables	Milestones				
Through delivery of our Planned Care programme of work, we will ensure that no patient waits more than 52 weeks from referral to treatment and offer choice where patients reach a 26 week wait	19/20	20/21	21/22	22/23	23/24
We will redesign and transform 'end to end' MSK clinical pathways to reduce variation, improve self-management and shared decision making, and reduce avoidable clinical interventions by: 2019/20: Further developing our Clinical Assessment and Triage Services(CATS), maintaining First Contact Practitioner (FCP) Pilot, reviewing and enhancing adherence with clinical policies and optimising use of injections 2020/21: Implementing 'end to end' MSK pathways by working with PCNs and review current physiotherapy to deliver FCP ambitions, aligned to CATS 2021/22: Implementing a hub delivery model incorporating MSK Triage, Assessment and Treatment utilising FCP, CATs and Physiotherapy models to complement PCN and Place Based Care; including implementation and monitoring of injections policy within primary care 2022/23: Monitoring effectiveness of the hub delivery model and refine / enhance with additional services to include podiatry, orthotics and paediatric MSK and incorporate International Consortium for Health Outcomes Measurement models for delivery within MSK pathways 2023/24: Monitoring progress and developing the contracting model to support outcomes based pathways, further developing services for alignment with outcomes based pathways and monitor progress of hub model at PCN/Place to review and inform future delivery	✓	✓	✓	✓	✓
Design and deliver sustainable solutions to close the gap in capacity vs demand for ophthalmology services by annually reviewing the plan to address the imbalance in capacity vs demand by 2025 and: 2019/20: Completing a capacity and demand review and establish strategic and responsive plan to address the gap, reviewing and redesign ophthalmology pathways, launching a pilot for Minor Eye Conditions service, extending tele ophthalmology pilot (evaluating and establish sustainable service solution) and developing digital solutions to support virtual management of patients 2020/21: Standardising and optimising pathways across the system, evaluating Minor Eye Conditions pilot and establish plan to sustain, implementing virtual appointments for agreed pathways and evaluating digital pilots and establish JUCD specification and strategy for digital solutions 2021/22: Scale up and optimise use of virtual appointments, modernise workforce models in line with pathway redesign, work with optometrists and primary care to support 'left shift' of services and procedures, implement JUCD strategy to standardise and optimise digital solutions 2022 – 2024 : Scale up and optimise use of virtual appointments, modernise workforce models in line with pathway redesign, work with optometrists and primary care to support 'left shift' of services and procedures, explore opportunities to further maximise effective utilisation of resources across the system	✓	✓	✓	✓	✓
Subject to confirmation of specific national metrics; we will modernise, digitally enable and redesign services to deliver the NHS Long Term Plan ambition of avoiding a third of face to face outpatient visits in a secondary care setting by 2025 by: 2019/20: Review and redesign four 'end to end' clinical pathways, Pilot digital solutions to support modernisation and redesign of secondary care, Pilot NHS Attend Anywhere to support alternative virtual model for secondary care attendances, Design and implement a digital solution to support referral management in primary care, Develop and implement enhanced advice and guidance services, Scope opportunities to design new co-morbidity clinics 2020/21: Agree and deliver annual plan to review and redesign 'end to end' clinical pathways, prioritised by opportunity to deliver long term plan, Implement virtual appointments for agreed pathways, Implement risk stratified and patient initiated follow up for agreed pathways, evaluate digital pilots and establish JUCD specification and strategy for digital solutions, establish plan to develop co-morbidity clinics 2021/22: Agree and deliver annual plan to review and redesign 'end to end' clinical pathways, prioritised by opportunity to deliver long term plan ambition, Scale up and optimise use of virtual appointments, Scale up and optimise use of risk stratified and patient initiated follow up pathways, Implement JUCD strategy to standardise and optimise digital solutions, modernise workforce models in line with pathway redesign, pilot new co-morbidity clinics 2022/23: Agree and deliver annual plan to review and redesign 'end to end' clinical pathways, prioritised by opportunity to deliver long term plan ambition, Scale up and optimise use of virtual appointments, Scale up and optimise use of risk stratified and patient initiated follow up pathways, Modernise workforce models in line with pathway redesign, Work with primary care and place to support 'left shift' of services and procedures, Extend co-morbidity clinics 2023/24: Agree and deliver annual plan to review and redesign 'end to end' clinical pathways, prioritised by opportunity to deliver long term plan, Scale up and optimise use of virtual appointments, Scale up and optimise use of risk stratified and patient initiated follow up pathways, Modernise workforce models in line with pathway redesign, Work with primary care and place to support 'left shift' of services and procedures, Scale up and optimise use of co-morbidity clinics	✓	✓	✓	✓	✓
Maximise effective and efficient use of theatre capacity across the system so as to deliver the NHS Long Term Plan ambition for improved patient access to Planned Care by: 2019/20: Agree and enact Derbyshire Theatres Strategy, Optimise utilisation of theatre resources at each provider Deliver strategic shift of services from DCHS to UHDB, Agree strategy on fit for surgery and shared decision making, Review and agree strategic approach on national policy for faster treatment offer 2020/21: Agree and deliver annual plan to scale up pooling of theatre resources across the system, Review and standardise pre operative assessment processes across the system, Implement national policy on faster treatment offer, develop and implement best practice principles across Derbyshire 2021/22: Agree and deliver annual plan to scale up pooling of theatre resources across the system, Explore opportunities for redesign and modernisation of theatre workforce across the system, Optimise use of virtual pre assessment processes across the system 2022 - 2024: Agree and deliver annual plan to optimise utilisation of theatre resources across the system, Work with primary care and place to support 'left shift' of services and procedures, Explore opportunities to further optimise theatre efficiency via digital or workforce solutions	✓	✓	✓	✓	✓

Delivering Further Progress on Care Quality and Outcomes: Maternity and Neonatal Services

The Derbyshire Local Maternity and Neonatal System (LMNS) is responding to the recommendations of Better Births (2016), the Planning Guidance key deliverables and the new LTP commitments 2020-2024. Work is delivered through 21 individual workstreams coordinated by a structure of groups which are held to account by Programme Board which reports into STP governance structures, with parallel alignment to commissioning quality governance.

Key Deliverables	Milestones				
	19/20	20/21	21/22	22/23	23/24
Safety and the 'Halve it' ambition: A single SI process is now in place across the footprint and an established Maternity Quality Review group provides a forum for system wide learning and sharing. The implementation of PROMPT (PRactical Obstetric Multi Professional Training) enables those who work together to learn together and implementation of the Saving Babies Lives Care Bundle v1 is complete. Stillbirths at our two maternity providers have reduced to 2.5 per 1,000 births (2018/19), and neonatal deaths; however, SATOD figures remain static (14% Q2 19/20). We will implement the Saving Babies Lives Care Bundle v2 (March 2020), expand the offer of NHS maternal smoking cessation services (2019/20)/implement an improved local smoking in pregnancy pathway and play a role in the development of Maternal Medicine Networks (fully operational by 2023/24) to maintain our commitment to a reduction in stillbirth, neonatal death, maternal death and brain injury during birth by 20% by the end of 2020/21, and a 50% reduction by 2025; a 50% reduction in serious neonatal brain injuries by 2025.	✓	✓			✓
Neonates: We will work with Operational Delivery Networks to implement fully the recommendations of the Neonatal Critical Care Review in 2019/20, including delivery of the ATAIN programme to reduce avoidable admissions of term babies to neonatal unit to no more than 5% by 2019/20 (current performance 3%).	✓				
Community Hubs and SPoA: We have begun by scoping 'virtual' community hubs which foster closer working between staff groups in a particular locality and supporting our emerging Continuity of Carer teams, to set the foundation for a physical community hubs network offering a 'one stop shop' facility. Our aim is that services are coordinated by a single point of access and initially we will investigate how women may self refer for midwifery care and how contact with their midwife during pregnancy can be streamlined. We will develop the model based on the availability of digital infrastructure, estate (including our role in the OPE initiative) and the feasibility to coordinate care across our LMS and our borders, so that 50% of care is coordinated through a hubs and SPoA network by 2020/21.	✓	✓	✓		
Choice and Personalised Care Plans (PCP): All women can currently make choices about their maternity care, during pregnancy, birth and postnatally and utilise a variety of providers (ahead of national milestone for 100% of women by 2021), with the Mother Hub Derbyshire website providing trusted, unbiased information on the choices available since April 2019. We aim to empower women to take control of their birth choices and encourage more women to give birth in midwifery settings (at home and in midwifery units); 19% by 2020/21 increasing to 20% in 2021/22. At Q1 2019/20, 14% of women had been issued with a paper-based personalised maternity care plan (PCP), the design of which has been coproduced by service users. We will further develop the PCP in response to feedback from women and midwives and ensure that 100% are offered one by 2020. We will also consider how to digitise the PCP, alongside the development of ePHR (see below).		✓	✓		
Continuity of Carer (CofC): At March 2019, Derbyshire reported 14% women booked onto a CofC pathway, which is set to increase to 17% in March 2020. We have calculated a 5yr trajectory for expanding the offer of CofC to ensure more women can benefit, although we recognise tour ambition falls outside of national milestones. We will implement locality based model of team continuity and further address inequalities and support some of the most deprived families, including targeted funding which will be applied to ensure 75% from vulnerable and BAME Groups benefit from CofC by 2023/24.	✓	✓	✓	✓	✓
Postnatal care: In response to guidance, we will develop a postnatal care improvement plan agreed by commissioners and providers by February 2020, to include postnatal physiotherapy offered to women with physical complications because of birth by 2023/24. All Derbyshire maternity services are accredited under the UNICEF Baby Friendly initiative. Maternity outreach clinics are in place in the south of the county for women experiencing mental health difficulties arising from or related to, the pregnancy or birth experience and by November 2019 will have been rolled out to all women in the footprint.	✓				✓
Digital: Currently, <10% of women benefit from access to an Electronic Personal Health Record (ePHR). We will learn from our pilot site and consider expanding the offer at each of our units, so by 2023/24 all women have to access ePHR which includes a digitised version of their personalised care plan (PCP) – see above.					✓

Key Deliverables	Milestones				
We will continue to develop age-appropriate integrated care, integrating physical and mental health services, enabling joint working between primary, community and acute services, and supporting transition to adult service. This will be achieved through a clinically led, holistic approach to improve outcomes for children and young people; delivered through four workstreams (SEND, Emotional Health & Wellbeing, Community Provision for physical health and Urgent Care)	19/20	20/21	21/22	22/23	23/24
Supporting the expansion of Children and Young People's mental health services - We will review community provision to inform development of a transformed model that meets the needs of children consistently across Derbyshire with greater integration between primary, community and specialist care; including local council provision.	✓				
We will engage with clinical networks as they are rolled out to support the work being led through the condition specific workstreams, to improve the quality of care for children with long term conditions such as asthma, epilepsy and diabetes. In doing so we will improve care for children with diabetes and complex needs, reviewing the pathway and services for treating and managing childhood obesity by 2022/23. This will be supported by a clearly defined childhood obesity strategy at all levels of need, implemented across the system. We will also work across the children's and condition specific workstream for Respiratory conditions to review pathways for children/ young adults with Respiratory Conditions.	✓	✓		✓	
We will develop a comprehensive offer for 0-25 year olds that reaches across mental health services for CYP and adults by 2023/24. This will be developed with SEND strategic boards so that the mental offer is also responsive to 0-25 year olds that also have SEND needs. This will mean both SEND and mental offers will be aligned and integrated where appropriate with clear pathways that are effective, responsive to need and maximise resource.	✓	✓	✓	✓	✓
We will review and establish a clear understanding of need of the Mental Health Support for Children in Care and care leavers who are placed in care out of area. We will work with our locally commissioned Emotional Health and Wellbeing Service to ensure each child place d out of area has a good quality effective and appropriate service that will be able to address assessed mental and emotional needs with a view to improving placement stability and reducing out of area placements from the baseline.	✓				
We will undertake an Eating Disorder service review to improve access and wait times, actively promoting the THRIVE model to deliver early interventions, with a new service by Sept 2019 to achieve the 95% standard in 2020/21 which will be maintained thereafter.	✓	✓			
Implementation of the system wide long term plan will be delivered and monitored through the STP and fully aligned with the Future in Mind local transformation plan. It will be refreshed annually.	✓	✓	✓		
Linking with the urgent care workstream and the estates enabler workstream, we will ensure the estates redesign across emergency departments and in the Paediatric wards align to the STP strategy.	✓	✓	✓	✓	✓
CYP mental health plans will align with those for children and young people with learning disability, autism, special educational needs and disability (SEND), children and young people's services, and health and justice [from 2022/23]. We will improve the mental and emotional well-being of young people known to the Youth Offending Service, ensuring support is in place in both CAMH Services and training in place across the JUCD system and review arrangements for children in care and care leavers who are in care out of area. During 2019/20 we will reduce waiting times by ensuring adequate access to community based early effective intervention services, ensuring an understanding of roles and responsibilities and clear timed process for completing Education Health & Care Plans; consistent service specifications and processes will be developed across the footprint as well as a review of core CAMH services.	✓			✓	
We will develop keyworkers for children and young people with the most complex needs and their carers/families from 2020/21 by developing robust multi-agency community provision that wraps around the child to effectively address their mental health needs and keep them safe. There will be 24/7 mental health crisis provision for children and young people accessible via NHS 111 by 2023/24, that combines crisis assessment, brief response and intensive home treatment functions. So that by 2028 we move towards a service model for young people that offers person-centred and age appropriate care for mental and physical health needs, rather than an arbitrary transition to adult services based on age not need.	✓		✓		✓
We will develop a robust multi-agency community provision that wraps around the child to effectively address their mental health needs and keep them safe by developing our whole school approach to CYP's mental and emotional wellbeing. This will be done by implementing 4 x Mental Health Support Teams (MHSTs) The MHST's will be implemented within education settings across Derby & Derbyshire by January 2020 with full mobilisation from April 2020.	✓	✓			
We will work with Public Health commissioning colleagues to increase uptake, coverage for childhood vaccinations; diphtheria, tetanus, poliomyelitis, pertussis, HiB, hepatitis B, rotavirus, MenB, MenC, pneumococcal, MMR by 2020/21.	✓	✓			

Delivering Further Progress on Care Quality and Outcomes: Learning Disabilities & Autism

Key Deliverables	Milestones				
We will reduce the causes of morbidity and preventable deaths and transform care for people with learning disabilities & / or autistic spectrum conditions who display behaviour that challenges including a mental health condition	19/20	20/21	21/22	22/23	23/24
We will ensure that at least 75% of people per year with a Learning Disability and/or Autism aged over 14 years receive an annual health check, carried out to a consistently high standard, and make sure that people with a learning disability get timely access to the healthcare they need in the right place, at the right time by : Improving access to annual health checks and diagnostic services, monitoring contracts held with primary care practices to ensure achievement of 75% uptake rate. Review of performance to identify best practice in increasing uptake for health checks for those with a learning disability and identification of areas of poor uptake to provide additional support to PCNs by 2020/21. We will also implement national guidance regarding eye, hearing and dental checks for young people in residential schools by 2021/22	✓	✓	✓		
We will ensure that we continue to learn from the deaths of people with Learning Disabilities; ensuring all deaths are reviewed within 6 months by 2019/20 which will be supported by the recruitment of a dedicated Learning Disabilities mortality review (LeDeR) reviewer and support	✓				
We will work collaboratively to reduce reliance on inpatient services so that by 2020/21 no more than 28 (currently 48) people are receiving inpatient care within both secure and acute hospital facilities, as they will be better supported in the community; leading to the eventual closure of hospital facilities from 2021/22. We will achieve this by: - Completing a Specialist LD inpatient Assessment and Treatment service review and agreeing a delivery plan for improvement in specialist LD inpatient services in 2019/20 We will continue to work as a system to reduce restrictive practices including the use of seclusion and long term segregation, ensuring all providers are using the 12 point discharge planning guidance. Put procedures in place to audit compliance with PBS training requirement in 2019/20 and develop plans based on outcome of audit by 2020/21. Further development of intensive support teams (crisis and forensic) to support greater levels of independent living in the community by: - Full implementation of new service model across counselling and psychology services - Standard multi-disciplinary intensive support service offer in place across both providers to provide intensive assessment and treatment for individuals within their own home and respond to urgent care needs to avoid admissions wherever appropriate. - Undertaking LD short breaks service user reviews and assessments to develop options regarding LD Short Breaks services in 2020/21	✓	✓			
We will further develop intensive support teams (crisis and forensic) to support greater levels of independent living in the community by 2020/21 by: - Undertaking a review of system wide crisis response (including feedback from individuals and carers) to develop the model for the integrated wrap round offer in 2019/20; ensuring mental health services offer crisis support for people with autism without a learning disability, LD & ASD forensic service in place with clearer links into mental health forensic services - Development of an Integrated earlier intervention model for crisis, further development of care provider market to increase personalised community care provision	✓	✓			
We will further develop our approach to personalised care and support planning by embedding the use of PHB's to deliver interventions as identified in individuals care and support plans, alongside CHC and S117 entitlements by 2020/21. This will be supported by comms plan to support roll out of key tools to support development of Personalised care and support / stay well plans and work with key providers to embed use of PCSP for all individuals on DSR, confirming the system approach to CPA and review of current use of PHB's to support people with LD &/or ASD outside of CHC.	✓	✓			
We will monitor and reduce the over prescribing of anti-psychotic medication (STOMP / STAMP) by establishing a baseline in 2019/20 and re-audit in 2020/21. A stakeholder group has been established, including PCN Clinical Directors to progress the areas identified in the national STOMP audit 2018/19	✓	✓			
We will ensure local systems are updated to meet national requirements of digital flag to identify patients who require reasonable adjustments by raising awareness and skills to establish a system wide action plan to enable use of digital flags by 2020/21, by developing a system wide workforce action plan and undertaking a skills audit across statutory health and social care services to identify areas for further training re LD & ASD in 2019/20 and developing a system wide training plan by 2020/21 to support.	✓	✓			
We will ensure all LD quality standards are met by undertaking a system wide audit/collation of performance against LD quality standards in 2019/20 to inform development of short and medium term action plans to deliver standards by 2020/21. This will include the digital flag to identify patients who require reasonable adjustments	✓	✓			
We will develop a system wide engagement strategy to support improvements and support quality monitoring and improvements by 2020/21	✓	✓			
We will continue to ensure Care and Treatment Reviews/Care Education and Treatment Review's (CTR/CETR) are undertaken when considering admission and in community settings so that 75% of adults and CAMHS patients have an inpatient CTR/CETR within agreed timeframes and 75% of adults and 90% of CAMHS patients having a pre or post admission CTR/CETR.	✓	✓			
Implementation of Key Worker role for all C&YP with complex needs by developing of business case and delivery plans based on national guidance to ensure rollout by 2023/24		✓		✓	
We will continue to ensure dynamic risk stratification and registers are in place throughout 2019/20 and maintained thereafter	✓	✓			

Delivering Further Progress on Care Quality and Outcomes: CVD and Stroke

Key Deliverables	Milestones				
Over the next five years, we will support people to manage their own health and train staff to have the conversations which help patients make the decisions that are right for them. As a system, we will improve the prevention, early detection and treatment of cardiovascular disease (CVD) through :	19/20	20/21	21/22	22/23	23/24
Improving prevention and early detection of Cardiovascular disease (CVD): During 2019/20 we will strengthen links to be part of the Local ISDN development and redesign our current Cardiac Rehab Model, supporting improvements in Heart Failure pathways, implementation of community BP screening and a Familial Hypercholesterolemia Genetics Diagnostics Service. We also plan to implement a programme of workforce upskilling in relation to hypertension diagnosis and management, promoting increased AF detection in primary care. Our digital technology offer will be expanded from 2020/21 to further support prevention, self-management and early diagnosis through systematic case finding and risk stratification of people with hypertension, Blood Pressure Screening in community settings / pharmacies. We will expand our work with stakeholders to support readily accessible tests of high risk conditions with particular focus on people from deprived and disadvantages groups.	✓	✓			
We will improve treatment of CVD and increase the number of people with CVD who are treated for the cardiac high-risk conditions; Atrial Fibrillation, high blood pressure and high cholesterol by reviewing and redesigning our CVD services for people with SMI and developing our workforce upskilling plans aligned to CVD interventions during 2020/21. We will work with the national stroke team to develop and roll out a digital approach to improving stroke pre-hospital pathways and communication, and work alongside the national CVD and Respiratory programme to implement the CVDprevent audit, delivering improved outcomes for CVD . We also plan to work with voluntary sector partners to launch a campaign to increase number of volunteer responders to help improve outcomes of out-of-hospital cardiac arrests. During 2021/22 we will develop the Derbyshire CVD Risk Stratification Strategy, review and scope to increase Defibrillator usage across Derbyshire, working with PCNs on Digital Apps expansion to increase referral and uptake of cardiac rehabilitation. We will further develop the House of Care model across Derbyshire to support all LTCs, including CVD. From 2022/23 we will work with providers to support the training of hospital consultants to offer mechanical thrombectomy, improving and configuring stroke services, to ensure that all patients who need it, receive mechanical thrombectomy and thrombolysis. We will further improve and align services to the GP Contract and allocate fair shares funding allocation (from 2019/20 to 2023/24) to support workforce development. We will review and identify further opportunities for Enhanced Services aligned to improved end to end pathways including the EoL CVD pathway. This will ensure that by 2023/24 our plans will be built on the increased availability of technology that will assist the expansion of life-changing treatments to more patients.		✓	✓	✓	✓
As a system, we have developed robust plans, and effective local clinical and system leadership to develop and improve stroke services, centred around delivering Integrated Stroke Delivery Networks (ISDNs) and built upon the NHS Rightcare Stroke resource pack to identify further opportunities. We will continue to work with national stroke team during 2019/20 to implement revised payment structures for stroke services and the development of the CQUIN for post-stroke reviews and Thrombectomy staffing. We plan to facilitate Early Supported Discharge (ESD) for all patients for whom it is appropriate, during 2020/21, developing plans to integrate ESD and community services through revising and redesigning our post-hospital stroke rehabilitation models and further developing our community placed base services. During 2022/23, we will review and identify further opportunities for Enhanced Services aligned to improved end to end pathways. From 2023/24, we will commission to support an increase in the proportion of patients who receive a thrombectomy after a stroke so that year on year more people will be independent after their stroke, promoting the best performance in Europe for delivering thrombolysis to all patients who could benefit. We will develop and implement higher intensity care models for stroke rehabilitation, building on increased availability of technology that will assist the expansion of life-changing treatments to more patients.	✓	✓	✓	✓	✓

Delivering Further Progress on Care Quality and Outcomes: Diabetes

Key Deliverables	Milestones				
Derbyshire's approach for delivering improved services in line with the Long Term Plan commitments for people with Type 1 and 2 diabetes:	19/20	20/21	21/22	22/23	23/24
We have set out local referral trajectories that will contribute to the national Diabetes Prevention Programme (DPP) to support 525 people through the programme by 2019/20. In order to achieve our trajectories, we will implement a targeted plan to increase uptake, which will be delivered by a 'Prevention Facilitator'. During the year we will recruit a second Prevention facilitator to provide greater impact with delivery of the targeted plan. We have established a communication plan to launch the updated Derbyshire wide prevention pathway and will complete the Phase 3 local procurement against the 2019 NDPP framework, which includes both a face to face and a digital offer. From 2020/21 Phase 3 NDPP roll out will commence and continue to deliver the targeted plan in primary care, improving quality of referrals to NDPP and increasing course take up as per our trajectories and in line with the national plan.	✓	✓	✓	✓	✓
Support for more people living with diabetes to achieve the three recommended treatment targets (3TTs); We plan to support improvement in achievement of the 3TTs during 2019/20, based on a review of the impact and learning from our north quality scheme, which supports practices to undertake more patient reviews. We will also review the impact and learning from the proof of concept in the south in which practices are delivering innovative 12 month Place level schemes to improve 3TTs. We will continue to up skill and support Primary and Community care staff to enable up to 20% of people living with Type 1 diabetes who are eligible under the clinical criteria for that funding, to access flash glucose monitoring devices and to better enable people with diabetes to self-manage their condition. Working alongside the maternity work stream, from April 2020 we will ensure that pregnant women with Type 1 diabetes are offered continuous glucose monitoring , where clinically appropriate, establishing baseline data. During 2020/21 we will take learning from the 2019-20 primary care schemes to develop our PCN approach, continuing to support more people living with diabetes to achieve the 3TTs. Alongside this, we will continue to deliver the upskilling workforce training programme and monitor to ensure that all pregnant women with type 1 diabetes are being offered continuous glucose monitoring, reviewing the pathway for type 1 pre-gestational women in conjunction with maternity work stream to identify any areas of variation. We will review our pathway and services for treating and managing childhood obesity during 2021/22 in order to improve care for children with diabetes and complex needs; we will continue to monitor to ensure that all pregnant women with type 1 diabetes are being offered continuous glucose monitoring and develop our pathway for type 1 pre-gestational women in line with outcome of review completed in 2020/21.	✓	✓	✓	✓	✓
We will improve access to Diabetes Structured Education by expanding the provision of digital and face-to-face structured education and self-management support tools for people with Type 1 and Type 2 diabetes; providing access for those living with Type 2 diabetes to the national HeLP Diabetes online self-management platform, which will commence phased roll out in 2019/20. We will utilise transformation funding to increase course capacity and reduce waiting lists for type 1 DAFNE courses, engaging with stakeholders to develop a strategy for delivering a range of type 1 structured education courses including DAFNE and digital, and a range of type 2 structured education courses including face to face and digital. In order to develop our sustainability plan to increase capacity for structured education across a variety of options, from 2019/20 we will support the roll out of clinical networks to ensure we improve the quality of care for children with diabetes. Our sustainability plan will be implemented in 2020/21 and will focus on increasing the uptake and completion of type 1 structured education courses by offering a range of course formats and making them more accessible and rolling out the National HeLP - Healthy Living for People with Type 2 Diabetes online self-management support programme and accompanying structured education pathway, Commencing in 2021/22, we plan to review our structured education options for children, parents, women with pre-gestational diabetes and women with diabetes planning pregnancy further increasing the update of structured education. From 2022 we plan to continue to use Tapered Diabetes Transformation funding to support increased capacity of type 1 and type 2 structured education	✓	✓	✓	✓	✓

Key Deliverables	Milestones				
Derbyshire's approach for delivering improved services in line with the Long Term Plan commitments for people with Type 1 and 2 diabetes:	19/20	20/21	21/22	22/23	23/24
Our plans for 2019 onwards include targeting variation in the achievement of diabetes management, treatment and care processes and addressing health inequalities through the commissioning and provision of services. We will continue to provide a targeted support offer and access to weight management services in primary care for people with a diagnosis of type 2 diabetes or hypertension with a BMI of 30+, which will be adjusted appropriately for ethnicity and will have a significant impact on improving health, reducing health inequalities and reducing costs. We will reduce existing health inequalities by introducing a standardised care approach within GP systems, catering for multiple languages, and providing options for patients without digital skills. We also aim to engage more young people with type 1 and type 2 diabetes to improve self-management, attend clinic appointments and improve use of medication through a dedicated Transition worker.	✓	✓	✓	✓	✓
We will continue to make improvements to the foot care pathway across Derbyshire with the aim of reducing episodes of foot disease by ensuring universal coverage of multidisciplinary footcare teams (MDFTs) and diabetes inpatient specialist nurses (DISN) teams, for those who require support in secondary care. We plan to work with Diabetes UK to complete a review of our current (four) foot care pathways in 2019/20 in order to understand where there is variation in service delivery and outcomes and to articulate one Derbyshire diabetes foot care pathway. Based on our review, we will develop a programme of consistent foot care training for primary and community care staff, enabling staff to complete good quality foot assessments and provide consistent self-management advice. We plan to transfer our outpatient activity to community podiatry and will develop a sustainability plan to be proposed for delivery in 2020 when the current licence expires. Following this, we will review the impact of the expanded north community interdisciplinary foot care team and develop a further sustainability plan proposal. From 2020, we plan to identify efficiency opportunities within the pathway and improve integration between providers. This will enable us to communicate a clear accessible Derbyshire foot care pathway to people with diabetes and healthcare professionals, which will raise awareness about diabetic foot risks. Diabetes Inpatient Specialist Nurse (DISN) pathways will be developed from 2019/20 with EMAS which will enable ambulance staff to speak directly to DISN from the persons home with aim to prevent conveyance, the aim is to prevent admission for people who can be managed from a rapid access clinic. We will continue to develop our plans to maintain increased capacity DISN within the acute hospitals, improving support for long term condition management for those with diabetes.	✓	✓	✓	✓	✓

Key Deliverables	Milestones				
The Derbyshire Respiratory System plan sets out how we will support local identification of respiratory disease and increase associated referrals to pulmonary rehabilitation services for those who will benefit, supporting people to manage their own health, particularly for the most socio-economically disadvantaged people who are disproportionately represented in this patient cohort:	19/20	20/21	21/22	22/23	23/24
By ensuring 76% of patients seen in HOT clinic are discharged home the same day, we aim to see a reduction in respiratory related non-elective spend from 2019. Following a review of the National Network Service Specification for Medication, we will adapt and develop the implementation strategy to localise it for Derbyshire during 2020/21. This will lead to a review of the Derbyshire Breathlessness pathway, and plans to utilise more digital technology, increasing the use of appointments and telehealth. During 2021/22, we plan to expand our pulmonary rehabilitation services and test new models of care for breathlessness management in patients with either cardiac or respiratory disease, working with the national Respiratory Team to test A1 technologies to interpret lung function test and support diagnosis. We will also complete a review of national programmes for respiratory diseases with testing in order to improve services in Derbyshire. We plan to commence a review of children/young adults with respiratory conditions during 2022/23, enabling us to complete a service benefit review of the existing respiratory model for Derbyshire, and working closely with providers we will ensure our models of care and pathways are efficient and effective. This will enable us to implement a 'new' respiratory service model for Derbyshire during 2023/24, based upon RightCare data, Model Hospital data packs and increased availability of technology which will assist us in providing life changing treatments to more patients.	✓	✓	✓	✓	✓
Our respiratory priorities for 2019/20 are focused on adopting a ‘whole person’ approach to respiratory care whereby those at risk of lung disease, or those with confirmed disease, are proactively supported earlier in their pathway to prevent health deterioration and unnecessary admissions. We will ensure that all people admitted to hospital who smoke are offered NHS-funded tobacco treatment services via provision of an inpatient smoking cessation service (currently at UHDB). We will continue to improve support for patients, carers and volunteers to enhance ‘self-management’ and increase systematic signposting to lifestyle services to support people to access stop smoking services, with the aim of improving upstream prevention of avoidable illness and its exacerbations through smoking cessation. It is our aim that 40% of patients who start inpatient smoking cessation successfully quit at 4 weeks. Our plans will be developed during 2021/22 in partnership with Public Health to increase uptake of flu vaccinations to meet and exceed PHE immunisation targets and also to support expectant mothers, and their partners, with a new smoke-free pregnancy pathway including focused sessions and treatments implemented.	✓	✓	✓		
Alongside the above, we will continue to support implementation and delivery of the government’s five-year action plan on Antimicrobial Resistance developing local plans to tackle Antimicrobial Resistance and reduce overall antibiotic use and drug-resistant infections.	✓	✓	✓	✓	✓

Delivering Further Progress on Care Quality and Outcomes: End Of Life Care

Key Deliverables	Milestones				
The Derbyshire End of Life System plan is based on Personalised Care and Support - The National Framework for End of Life (EoL), therefore, our plan is themed on the six ambitions set out within it. Our ambition is to provide truly collaborative, co-ordinated care, standardised County wide but personalised to the person. The aim is to allow people to die in their preferred Place of Care with support, care and maximising symptom control. To enable this ambition:	19/20	20/21	21/22	22/23	23/24
Based on the foundations that support the ambitions for Palliative and EoL care, we will ensure that everybody approaching the end of their life is seen as an individual and offered the chance to create a personalised care plan based on their needs, preferences and wishes. We will ensure that opportunities for informed discussion and planning are universal and ongoing with options regularly reviewed. To ensure the plan guides a person centred approach we will ensure it is available to the person and, with their consent, can be shared with all those who may be involved in their care. We will utilise our IT infrastructure to share care plans and reduce unwarranted, unnecessary, expensive hospital admissions and so giving better quality of life to the person and their family. We have developed an electronic ReSPECT form which is ready and planned for County wide distribution in 2019/20. This will ensure a focus at all times on the person and their wishes, promoting advance care planning, including advance directives, lasting powers of attorney and 'living wills'. The use of technology and other mechanisms will continue to be a priority to ensure those wishes are known and adhered to wherever an individual enters the health and care system.	✓	✓	✓	✓	✓
We recognise that there is currently a wide variation on the services available for EoL across the county and also by condition. Cancer EoL services are, in most cases, more available than those for Long Term Conditions for example. Therefore we will review services county wide to ensure we are consistently meeting the standards to provide the care that patients and their carers need to die comfortably, in the setting of their choice and with dignity.	✓	✓	✓	✓	✓
We plan to review and accelerate the roll out of Personal Health Budgets to give people greater choice and control over how care is planned and delivered. This will include expanding the offer for people receiving specialist end of life care, maximising comfort and wellbeing. We recognise that timely CHC input reduces inappropriate admissions, carer crisis, stress and distress. Therefore, we have developed an electronic Fast Track form which decreases the time needed to complete and process the form and will implement its use across the county during 2019/20. Further, we will develop a county wide policy of filling syringes based on the service established in the South of the County to ensure geographical consistency.	✓	✓	✓	✓	✓
The Derbyshire STP EoL Strategy will be signed off during 2019/20 with the aim of delivering consistent care across the county by 2020/21 and delivery of strategic intentions across the system by 2021/22. We will continue to build on the strategy which emphasises local leadership, service delivery and accountability. We recognise that Palliative and EoL care requires collaboration and cooperation to create the improvements we all want. Therefore, cross-organisational collaboration is vital to design new ways of working that will enable each community to achieve better EoL care. We will consistently enable this through the STP EoL group which facilitates joint working by being a focal point for delivery.	✓	✓	✓		
In Derbyshire we will ensure 'All staff are prepared to care' by completing a review of education requirements for the system, subsequently we will continue to roll out training to help staff identify and support relevant patients, and continue to promote proactive and personalised care planning for everyone identified as being in their last year of life. From 2021 we will develop a County education plan which will support and train staff to have personalised care conversations, helping them to identify and care for patients in their last year of life with personalised, proactive care planning.	✓	✓	✓		
We will continue to develop a county wide approach that supports open and honest conversations about death across the diverse communities we serve through engagement, education and communication, leading to a significant increase in the number of people actively articulating their wishes for end of life care. This will ensure that each community is prepared and that opportunities for informed discussion and planning are universal. Our plans are focused around the individual and those important to them, so they will be locally led and delivered, supported by us all across all communities. We will continue to develop a county wide approach that supports open and honest conversations about death across the diverse communities we serve through engagement, education and communication, leading to a significant increase in the number of people actively articulating their wishes for end of life care.	✓	✓	✓	✓	✓

Giving our staff the backing they need

The value we place on our collective workforce is of significant importance to Joined Up Care Derbyshire and is reflected in our ambition to deliver the quadruple aim…

The Derbyshire system has come together to develop our strategic approach in relation to workforce which is overseen by the Local Workforce Action Board (LWAB). We have made significant improvements since our original STP plan in 2016, although we recognise that there is a considerable shift required to truly implement the broader workforce changes required to deliver the LTP ambitions and continue to ensure we improve overall staff experience and resilience.

We intend to make our health and social care system the best place to work, which is consistent with the ambitions set out in the NHS Interim People Plan. Our workforce plan will be structured to enable the system to:

- Improve our leadership culture at all levels
- Tackle the nursing challenge
- Deliver 21st century care
- Develop a new operating model for workforce

Our Strategic Approach

We have agreed a set of system workforce objectives which move us towards a new operating model for workforce; these include:

- Streamlined recruitment and employment processes so that we 'recruit once for Derbyshire' wherever possible, enhanced mobility around the system and eliminating non value adding processes and duplication
- One set of employment policies and contract documentation for all organisations (starting with the Disciplinary policy).
- A single workforce dashboard which identifies a set of key system workforce metrics which will evidence workforce transformation and progress against shared objectives
- A whole system approach to developing new roles, specifically ACPs and advanced practice, Trainee Nursing Associates, including recruitment, training and deployment
- A whole system approach to the delivery of mandatory training
- A system well being offer for staff in Derbyshire including general practice

Transforming the way in which our staff work

We recognise that we have challenges in certain areas such as recruitment and retention; specifically medical staff in ED, qualified nurses, Ophthalmology, Urology, LD and Psychiatry. The local labour market in Derbyshire has high employment levels (79%, compared to 76% nationally) with the number of vacancies steadily increasing across all sectors, making recruitment of care staff increasingly difficult.

Building leadership across all levels

The Derbyshire offer for our future workforce will include more flexible working patterns to appeal to generation X and Y, and we will ensure all our organisations have a positive, inclusive, person centred leadership culture at all levels. To enable this, we are developing a longer term system Organisation Development Plan which will complement existing OD and leadership plans within Trusts; building on the significant work undertaken to date within the system to develop the capability within the system to enable transformation. The system plan will be going to the STP Board in November 2019.

A collaborative approach to attraction and retention under the banner *'Joined Up Careers Derbyshire'*, with an initial focus on apprenticeships and promoting careers in health and care to school leavers, piloting an integrated health and care apprenticeship

Improving mental and physical health and enabling flexible working

We have commissioned Sheffield Hallam University to support Derbyshire in developing a system wide approach to wellbeing. Through this approach we will:

- Develop a better understanding of how the organisations support workforce wellbeing; the current offer
- Derive data to determine need, improve monitoring and evaluation of impact
- Align approach to examples of best practice (within organisations/other NHS organisations/research)
- Identify gaps between current service provision and best practice (Overall wellbeing and OH)
- By the end of 2019/20 the Derbyshire system will have proposals and recommendations with regards to the next steps for workplace wellbeing.

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Giving our staff the backing they need

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The value we place on our collective workforce is of significant importance to Joined Up Care Derbyshire and is reflected in our ambition to deliver the quadruple aim…

Enabling transformation and delivering our Model of Care

We have identified a number of actions earlier in this section to demonstrate our strategic approach to workforce which will enable transformational improvements, deliver our model of care along with the ambitions of the NHS LTP. In addition we will:

- Further develop our system approach to retention and wellbeing in general practice in collaboration with the LMC overseen by the GP Workforce Steering Group (e.g. first 5 years support, practice manager development programme)
- Explore the opportunity to develop a lead employer model to support increased training and deployment of Advanced Clinical Practitioners in collaboration with Nottinghamshire ICS to strengthen our capability and resilience
- Build on the Physician Associate training programmes in the north of the county and raise awareness of the potential of the role in all care settings
- Build postgraduate assessment and supervision into job plans
- Develop new approaches to expand capacity for trainee nursing associate placements in the private, voluntary and independent sector
- We will introduction of new roles e.g. Psychology led services

Changing the Skill Mix and Introducing New Roles

Out of a current total health and care workforce of 19,625 (contracted available FTE), circa 14.5k work in an acute setting. As the expected growth in workforce is predominantly expected to be in community and non bedded care settings, this presents a challenge in terms of shifting staff into different settings, and working alongside a more diverse team from health, care and the voluntary sector. It is important to note that future year workforce projections will be developed further and reflected in our final plan.

We will continue to work closely with the Programme Leads for each of our programme areas to ensure the workforce implications in relation to the key deliverables set out in this plan are genuinely supported; we will identify how they envisage growing and transforming the workforce in line with the LTP ambitions, which will be triangulated with the organisational numerical forecasts. Appendix 4 summarises the key workforce implications identified from the delivery plans.

From the strategic planning work we have done to date, we envisage a greater increase at advanced and foundation level roles than in core and extended level practitioners.

We have plans to further extend the Public Health and wellbeing agenda over the next two years by equipping 1400 Derbyshire health care, Derbyshire social care and primary care practitioner partners with skills in having 'Quality Conversations'. This will support person-centred interactions underpinned by a broader awareness of the wider social determinants of health and of asset and strength-based approaches to communication.

Furthermore, we will support the transformation programmes and our workforce through digital technology and innovation, through a digital skills training bid for European Social Fund funding, integrated health and care apprentice pilot, system wide Return to Practice scheme.

Local metrics

We are in the process of further developing our local metrics which will be reflected in our overarching workforce dashboard and will be aligned to national measures as and when these are confirmed. This will include measures in relation to staff well-being.

The following table summarises the current position for our 4 Foundation Trusts against some high level indicators:

Measure	Current position *	Planned actions
Staff retention rate	88% retention rate	We will further examine the figures by job type to identify any significant variances and address these
Workforce who identify as BAME	No specific targets currently although collectively there is a 11.5% average	We are developing our approach to enable agreed targets to be in place by 2021/22; including both leadership and overall workforce.
Vacancy rates and specifically nurse vacancy rates	Overall average 7% Nursing average 7.12%	We will identify specific hot spots e.g. LD and MH and refine current plans to address the gaps
Turnover rate	Average 9.65% compared with average for NHS Midlands & East of 13%	As above
Sickness absence/ attendance	95.01%	We will identity areas of concerns and agree a sensible local target
Well Led Ratings	1 Outstanding, 2 Good, 1 requires Improvement	Programme of leadership development at system and organisational levels

In addition the Derbyshire system:

- Has low staff turnover rate compared to other Midlands systems
- Is on plan or ahead of plan for GP recruitment (3% improvement on plan), Physician Associates (0% variance from plan)
- Has recruited 2 Social Prescribers and 2 clinical pharmacists under the PCN additional role reimbursement scheme with a further 2 social prescribers to be in post by the end of November 2019.
- Respond to the requirements of the new Workforce Disability Equality Standard: All trusts will implement the requirements of the Standard and this will be incorporated into our work on EDS3

Using our estates to maximum effect to support a 21st Century model of care

Working through our Local Estates Forum (LEF) we will continue to adopt our whole system approach in relation to our estates, ensuring opportunities to support integration are maximised…

In response to our 2016 STP plan, Derbyshire established a Local Estates Forum (LEF) consistent of all system partners. Our LEF includes strong relationships with our local One Public Estates (OPE) as key strategic partners in our approach and we have strengthened this link through a jointly funded programme manager to support the entire STP and OPE work programme and ensure the link is maintained in everything we do.

The core purpose of the LEF is:

- Reshaping the estate to support wider system service redesign
- Improving effective utilisation of the estate
- Rationalising estate

We were required to develop a Local Estates Strategy (LES) in July 2018, which set out our current position and provided a stronger foundation to support and enable delivery of individual organisation, STP and the wider NHS and Government key priorities. The LES was rated as **good** by regulators and therefore provides us with a solid foundation. In response to the national requirement for all areas to update local LES' to reflect feedback received, the LES was further refreshed in July 2019. These updates included:

- Development of a Primary Care Strategy
- Articulation of the wider STP clinical strategy
- Progress on Disposals/improved use of the estate
- Revised governance arrangements
- Reflection of closer working with the One Public Estate

The Derbyshire Estate

Acute and Community Care:

- 352 premises occupied
- 87 Ha known premises footprint
- 613,892 m2 gross internal floor area
- c£136m estate costs
- 30-33% non clinical space
- C£11m backlog maintenance

Primary Care:

- 160+ premises occupied
- C£2m backlog maintenance

Disposals opportunities: 36 Sites have been declared/identified for disposal which translates to 20 Ha total land area, c£19m estimated disposal value, 670 housing Units, and c£4.1m reduced running costs

During 2017/18 and 2018/19 we have delivered:

- 6 sites have been sold c£20m disposal value
- Circa 600 housing units
- Circa £250k reduced running costs
- Achieved the national Naylor fair share allocation
- Secured funding for bids in each of the first 4 waves of STP funding (total capital funding circa £60M)

Our 2019/20 LES Implementation Plan contains the following key workstreams which will guarantee best use of the NHS estate and ensure the estate is a key driver in ensuring the STP/ICS clinical need is met:

- Improving estate efficiencies
- The realisation of disposals to directly improve patient care and further investment
- Capital pipeline and funding, including accessing further S106 monies
- Development of a Capital Financing Strategy encompassing BAU, equipping, BLM, capital developments etc across all sectors
- Further partnering with Local Government colleagues via OPE and LEPs

Specific areas of LEF focus within the Implementation Plan include:

- Reduction in non clinical space
- Reduction in unoccupied floor space
- Space utilisation review of South Derbyshire LIFT Co premises
- A better understanding of current and emerging Clinic Service Strategies
- Improved support and oversight of the LEF and One Public Estate
- Support of a part time Programme Manager – STP/OPE
- OPE Grant Funding for feasibility studies – Health and Social Care Hubs
- Better relationships and knowledge sharing
- Commissioning of a Primary Care Estates Strategy
- Working towards a more cohesive approach to s106 applications
- ETTF secured to make improvements in GP Estate

The LEF continues to support Trusts in the delivery of existing capital developments:

- Acute Front Door redesign – UHDB
- Urgent Care Village – UHDB
- Outwoods Development – UHDB (within Staffordshire STP)
- Improved Urgent Care Pathways – CRH
- Belper Community Hub – DCHS
- Additional bed capacity/Recommissioning of Endoscopy Services - UHDB
- Bakewell Community Hub – DCHS/EMAS

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Delivering Digitally Enabled Care

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We will further develop our comprehensive approach to joined up digital care acting as a true enabler for transformation.

Our Vision and Priorities

- Digital services are at the heart of the JUCD **shift from Managing Illness to Supporting Wellness** – A clear Clinical Digital Vision underpins the Digital strategy, demonstrating how the 'quadruple aim' will be delivered;
- A Clear Digital Strategy has identified **5 themes – Citizens, Professionals, Foundations, Innovation and Analytics** – that together build a robust approach to delivery of vital new services and technologies;
- **The Derbyshire Digital family** – Commissioners, providers and local government working together at every level to ensure seamless integration of products and services for end-users throughout Derbyshire, delivering fully integrated care records
- Flexibility to changing digital circumstances – through a principle of **'converge and connect'** – implementing common shared systems wherever possible, and providing excellent interoperability products where necessary
- **Value for money** – Ambitious investment plans for Digital services are balanced with careful financial stewardship of existing resources;

Leadership and Governance

- Strong System Governance – A JUCD Digital Board, chaired by a provider Chief Executive, and with senior representation from all partners;
- The Digital board has a clear mandate (with TORs) a set attendance with Agenda / Minutes. All System organisations are represented and the board receives timely and accurate updates on Transformation programmes, finances, risks, issues, workforce, clinical priority changes etc.
- Clinical Leadership – Through a JUCD Chief Clinical Information Officer (CCIO) group, chaired by the CCG Medical Director;
- Technical leadership through the Derbyshire Heads of IT (HoIT) group;
- There is ICS board visibility of digital programmes and initiatives across the system and the associated detailed plans are regularly discussed and monitored.
- There is appropriate ICS Digital Board representation from AHSNs and strong evidence of close liaison between system organisations, digital leaders and AHSNs. There is a clear ambition on partnership working with research and industry partners.

Risks, Issues and Constraints

- Citizen Engagement – continue the development a digital awareness amongst citizens, building on the strong achievements made to date
- Staff Engagement – At a time of significant change, the digital strategy recognises the need to support colleagues through the complex changes;
- Specialist Digital Skills – Maximising the use of scarce human resources;
- Resourcing – demonstrating clear value for money is essential if the ambitious funding needs of the system are to be met;

2019/20 Operational risks

Delays in the release of national capital (HSLI – Health System Led Investment in Provider Informatics, ETTF – Estates and Technology Transformation Fund, BAU – GP Business as usual) may delay delivery of respective programmes of work;

- Emergency Care Data Set (ECDS) – delivery of ECDS for University Hospitals of Derby and Burton is delayed, with a current projected delivery date of M6/19

Next Steps

- Apply to participate in the Global Digital Exemplar (GDE) programme;
- Work towards integrating Digital services across the Derbyshire ICS, providing seamless services to health professionals throughout the county;
- Delivery of an ambitious work programme of activities based around the following work programmes:
  - Convergence at scale of out of hospital care records, through standardisation on a single platform throughout community, mental health and (where appropriate) primary care settings;
  - Increasing the digital maturity of Secondary care acute providers in the Derbyshire footprint, moving to a true 'paper free' status by ;
  - Delivery of a comprehensive package of interoperability tools, including fully supporting social care integration;
  - Support for ambulance service integration with local providers;
- Active participation in the Local Health Care Record Exchange programme, supporting care for Derbyshire patients in out of County locations;
- Continuing to strengthen system resilience and security to achieve 100% compliance by summer 2021;

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Our Achievements – the journey so far

- *Clear Digital Leadership and Governance*
- *28% of patients have electronic access to GP systems, via POLAR project;*
- *100% of GP practices are enabled to have access to NHS app;*
- *100% of GP practices have patient Wi-Fi available;*
- *100% of GP practices offering extended hours appointments;*
- *35% of patients already have access to online consultation, with plans to reach 100% by 31/01/20;*
- *20% of GP practices are enabled to receive appointment from 111 services, with plans to reach 100% by 31/01/20;*
- *Preparations in hand for implementing GP futures and Digital first;*
- *HSCN data networks in deployment;*
- *Delivery of the MIG Interoperability system;*
- *Delivery of windows 10 upgrade programme is on track to meet national deadlines Q4 2019/20;*
- *Strengthening cyber security capabilities;*
- *Delivery of year 1 HSLI projects;*
- *Commitment to supply NHS mail accounts to all Derbyshire care homes that wish to use the service. So far, 46 (out of an estimated 310) care homes have been issued with accounts.'*
- *Agreed an ambitious new digital strategy, which has significant resource implications. System-wide discussions are taking place to review options for prioritising current digital spend across all partner organisations, to enable local resources to be released to support key deliverables*

Detailed information in relation to workstream alignment and our digital strategy can be found in appendix 3.

Moving forward enabled by the Joined Up Care Derbyshire Digital Strategy

System Outcomes: *'For people to have the best start in life, stay healthy, age well and die well'*

Clinical Priorities: Quadruple Aim: Improve Population Health; Patient experience; Staff Experience and per Capita Cost

Digital Health Vision: *"We will use digital services to facilitate system change, across the whole health and social care economy. To ensure appropriate and accurate information is available and accessible to our patients and their clinicians, supporting the provision of high quality outcomes, in the delivery of joined up care"*

Strategic Themes:

Citizens

Professionals

Foundations

Innovation

Analytics

Leadership | Governance | Accountability | Skills & Resources

Principles: Patient centric | Safe & Secure | Collaborative & Integrated | Efficient delivery

Digital offers:

Citizens	Professionals	Foundations	Innovation	Analytics
Digital Channels	Integrated Care Records	Identity, security & privacy	Partners / industry	Population Health
Self-care Management	Provider Maturity	Infrastructure	Ecosystem	Operational Analytics
Prevention & Wellness	Efficient operations	Collaboration	Disruptive Technology	Clinical data analytics
PHR	Digital ready workforce		Incubators	

Communication and Engagement Approach

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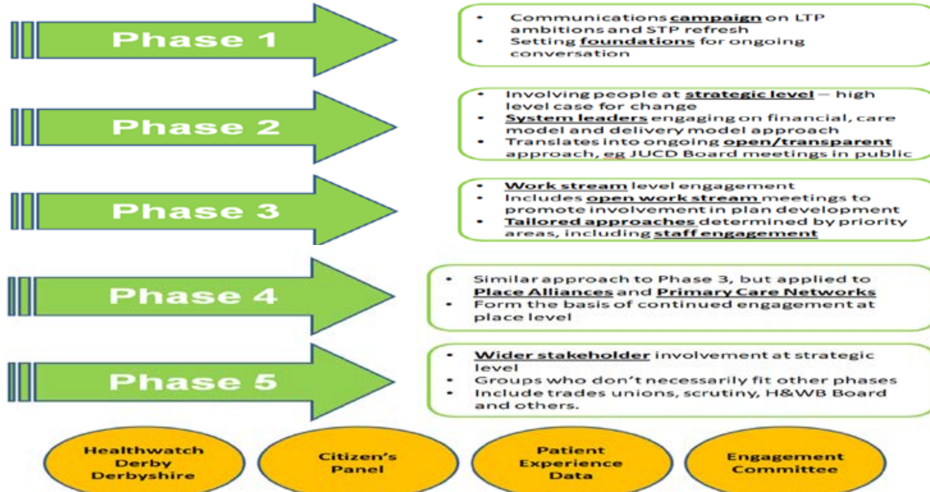
We have undertaken a comprehensive engagement approach in developing our 5 year plan and will continue to build upon this going forward.

Our approach

- Took place between April and September 2019.
- Ensured that a wide range of stakeholders, including staff, patients, their carer's and members of the public had the opportunity to help shape the plan.
- Underpinned by 5 phases, inviting engagement at a variety of different levels.
- Included the development of the Joined Up Care Derbyshire (JUCD) Citizens' Panel, which now has in excess of 1,600 members
- Supplemented by engagement conducted by Healthwatch Derby and Derbyshire, which included workshops aimed at seldom heard and marginalised groups.
- Will form the basis of continuous engagement in the work of JUCD going forward.



What engagement took place?

- All work streams utilised either established engagement mechanisms, open meetings and/or confirm and challenge sessions with their stakeholders to test out thinking and priorities during July and August
- Five Place Alliances held events during July 2019 to discuss the model of care, the NHS long Term Plan and wider determinants of health. Two other places used existing engagement forums and south Derbyshire will hold their event shortly. 35 - 60 people attended per event.
- 80 stakeholders from broad range of backgrounds (politicians, voluntary sector, NHS staff, patient groups) attended discussion session with JUCD Board in September 2019 to comment on strategic aims of the plan
- Healthwatch received input from more than 500 people through surveys and focus groups. Key questions included:
    - What services can do to provide better support (particularly for specific conditions, such as cancer, mental health, dementia, heart and lung conditions, learning disabilities and autism)
    - How the NHS can make it easier for us to take control of our health and wellbeing
    - How they people be supported to live healthier lives from birth to old age
- 40 members of Citizen's Panel attended confirm and challenge sessions, hearing the details of urgent care, children, Learning Disability and disease management plans
- First Citizen's Panel issued in August on 'online access to health services'.

Governance

- The JUCD Board received monthly updates on the communications and engagement approach.
- The joint DDCCG and JUCD Engagement Committee had oversight and sought assurance on the process.
- The operational implementation of the approach was overseen by the JUCD Communications and Engagement Group, which acts as a coordinating body for all system-relevant communications and engagement activity.

Key stakeholders

A wider range of stakeholders have been involved in the 5 phases of our approach, including MP's, Local Councillors, campaigners with an active interest in health and care services, Foundation Trust Governors, CCG lay members, Local Authority partners, clinicians, VCS, Healthwatch, Patient Participation Group members, clergy, carers and the general public.

A media release and stakeholder briefing were issued in June promoting to a wide external audience the aims of the refresh and the opportunities to get involved.

There was also a drive via the partner communications and engagement teams to use all existing channels and opportunities to promote the STP refresh to system staff and encourage them to get involved in the opportunities available, or feedback via staff discussions and online.

Beginners Guide to JUCD

We have developed a 'Beginners Guide to JUCD' to send out to Citizens Panel members, give out during workshops and display at events, to give people an understanding of our work and what we are aiming to achieve in terms of improvements in services for people in Derbyshire.

It covers the case for change, the need to consider the wider determinants of health, our priorities, our journey to becoming and Integrated Care System (ICS) and an overview of the work taking place in JUCD work-streams.

It will be available on our website https://www.joinedupcarederbyshire.co.uk/application/files/3415/6750/5838/Introduction_to_JUCD_leaflet_Sep_2019.pdf

Newsletters

JUCD has a quarterly newsletter which is distributed to a wide range of stakeholders and the latest edition can be found on the website here https://www.joinedupcarederbyshire.co.uk/news/newsletters

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The impact of our plan [DN we will further review and refine this ahead of the final submission]

Delivering our Joined Up Care mission to improve population health outcomes for the people and communities we serve will enable us to ensure that the people in Derbyshire have the best start in life, stay well, age well and die well. Working together, and with strong and vibrant communities, we will keep people safe and healthy – free from crisis and exacerbation, at home – out of social and healthcare beds and independent – managing with minimum support. To do this we will ensure all our services are well run, integrated and make the best use of the available resources.

So what is our plan saying?

Population Level Outcome	For the people of Derbyshire this means that…..
Best Start in Life **A healthy pregnancy, a safe environment, a nurturing and secure relationship with caregivers, good nutrition, healthcare and support**	Expectant mothers will be better supported through personalised care planning, continuity of the person caring for them and access to digital health records and enhanced postnatal support .
	Children and young people will receive improved mental and emotional wellbeing support, and with improved access to urgent care and psychological support when they need it; providing 24/7 mental health crisis provision
	A Community Wellness approach will be developed where individuals and families can receive the support they need to improve and support their physical and emotional health and wellbeing; ensuring there are appropriate community based health services
Stay Healthy **Helped to live a healthy life, make healthy choices and protected from threat. Able to maintain quality of life and recover from ill health or injury**	Care for people with learning disabilities and autism will be transformed. Intensive support teams will be developed to support independent living in the community
	Mental Health services will receive increased investment . We will reduce the length of time people spend in hospital and end the need for out of area placements. More people will be supported through a Primary Care and Mental Health wellbeing approach, including increasing access to psychological therapies
	People have access to care at the right time and in the right place. With more staff, and through a diverse skill mix we will improve access to General Practice including same day urgent care services in primary care and treating people within community-based Urgent Care Treatment centres.
	Where people do need hospital care access to urgent and routine care, will be improved and services will be tailored to their needs. This way we will enable people to recover from ill health or injury quickly and to return home at the earliest opportunity. We will transform the way outpatient services are delivered, reducing the need for face to face outpatient appointments by a third and using digital technology to support prevention and self-management
	Primary Care Networks will develop and deliver multidisciplinary care and services that meet the needs of the patients and communities and operate as a single team to wrap care around a person and their family. Care and treatment will be provided closer to home, such as treating minor eye conditions and support patients wellbeing through social prescribing.
	Cancer outcomes will be improved. We will improve the early diagnosis of cancer by increasing the uptake of screening programmes and extending access to diagnostic tests. We will ensure that people living with cancer will have improved access to high quality treatment and care, including psychological support.
Age Well, Die Well **Fit, safe and secure, able to maintain independence and actively participate. A personalised, comfortable and supported end of life**	People with dementia will be supported through the Derbyshire Well Pathway for Dementia ; providing the best care possible for people living with dementia, their carers and those important to them.
	Older people will received proactive, person centred and integrated care. We will embed the frailty model of care for Derbyshire to manage frailty as a long term condition in its own right, rather than a label
	People living in care homes will receive more NHS support to care homes, ensuring that their needs assessed and met and reducing the need for unnecessary and avoidable hospital admissions
	People approaching the end of their life will have fair access to personalised end of life care and support and to die in their preferred place of care. We will promote honest and open conversations about death across communities. and that those caring for the dying person are involved and supported .

Derbyshire STP – financial plan

The summary below provides a high level overview of the financial plan for the Derbyshire STP.

Impact on capacity (including beds)

The 535 beds calculation originally submitted in the Derbyshire STP is no longer credible. The landscape has changed since then and we have done further modelling on growth of admissions which shows that if we do nothing and activity grows by 4.2% then we will need 2546 beds in the Derbyshire system in five years' time compared with 2345 today, an increase of 286 beds. The 2546 figures quoted are total beds across the system, including community, mental health and acute beds.

We know that our main pressure on beds is happening in acute trusts, and this is where the anticipated growth will take place as greater numbers of poorly people require admission to an acute hospital bed. Our proactive and preventative work, and linking into the wider determinants of health are crucial parts of the plan to ensure that we are not 'doing nothing' and are actively tackling the growth in admissions.

In addition, our model of care in the community remains that care is better provided closer to home. We are therefore introducing more Pathway 1 (Home) and Pathway 2 (Care Home) care to ensure that patients can be discharged to the most appropriate care setting. This results in a net reduction of community hospital beds.

The two issues – acute beds and community beds – are clearly inter-related but we can reduce the number community beds at the same time as needing more acute beds as they provide different types of care. Retaining community hospital beds does not solve the acute hospital bed issue and it is our work in other programmes – disease management, prevention and planned care - which will help to solve the acute bed issue. The above provides a baseline position from which we will model our assumed growth rates for 2020/21 and beyond to better understand the anticipated bed capacity requirements for Derbyshire.

Assumptions: The key planning assumptions driving the financial model are:

- FOT based on month 3
- All 19/20 QIPP is delivered in the position
- £5m set aside for investment (in addition to LTP Investments)
- 0.5% contingency per annum
- MHIS is met
- Acute growth based on 3 year average (avg 3.72%)
- Ambulance 6.8%
- Prescribing 5%
- CHC 4.5% to 5.8%
- Community 1.1%
- Running costs 3%

Investments

We will commit the additional LTP investments as identified in the table below to support delivery of specific LTP commitments. Where appropriate further targeted investment opportunities will also be explored.

	2019/20 LTP allocation	2020/21 LTP allocation	2021/22 LTP allocation	2022/23 LTP allocation	2023/24 LTP allocation
	£000	£000	£000	£000	£000
Joined Up Care Derbyshire STP	10,464	10,801	14,978	22,025	31,836
1. Mental Health	1,107	1,196	3,785	7,590	10,175
(a) CYP community and crisis		58	1,161	1,792	2,948
(b) Adult Crisis		1,138	540	722	941
(c) New integrated models of Community and Primary care for SMI			2,084	5,076	6,286
2. Primary Medical and Community Services	6,456	7,205	8,284	10,822	13,180
(a) Primary Care	6,456	6,677	7,051	7,225	7,125
(b) Ageing Well		528	1,233	3,597	6,055
3. Cancer	2,139	1,601	1,250	1,199	1,200
4. Other	763	799	1,659	2,415	7,280

Financial Plan

- The STP will use the financial plan as the basis for agreeing contracts with providers to ensure the sustainability of the system
- 2019/20 will be the baseline period which will form future year projections based on forecast out-turn
- The baseline will be uplifted for growth (based on activity assumption identified earlier) and inflation
- Commissioners and providers will also deliver technical efficiencies within their own organisations
- The future financial plan will be underpinned by agreed risk share and risk management arrangements; managed through the system governance
- Work is now underway to map the impact of the transformational changes to mitigate the challenges identified in our case for change including financial, workforce and activity

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Issues and Next Steps [insert status position in terms of outstanding triangulation issues and system approach to addressing these ahead of finalisation].

Timetable for STP plan approvals

The draft plan has been shared and considered by all partner organisations as part of ongoing engagement and involvement into the development of the final plan. There is a need for the plan to be agreed by system leaders ahead of the 15 November submission and the JUCD Board agreed at the meeting on 18 October that the System Executive: CEOs group would have delegated authority to approve the detailed modelling and triangulation required to be incorporated into the plan narrative. This would ensure that contentious issues were understood by system partners and collectively managed with appropriate risk mitigations where necessary.

Action	Deadline
Submission to JUCD Board	13 September
Derbyshire County Council Adults Health Improvement and Scrutiny Committee ***(1)***	16 September
JUCD Board sign off (draft plan)	20 September
Derby City Council Adults Health Improvement and Scrutiny Committee ***(1)***	24 September
Submission to NHSE/I (draft plan)	27 September
Submission to JUCD Board for approval	11 October
JUCD Board ***(2)***	18 October
Trust Boards, Governing Body, Local Authorities and Health & Wellbeing Boards approval ***(3)***	
Derbyshire County Health & Wellbeing Board	3 October
DCHS	31 October
Submission to NHSE/I (interim plan submission)	1 November
DHcFT	5 November
CRH	6 November
DHU	6 November
CCG	7 November
UHDB	12 November
Derby City Health & Wellbeing Board	14 November
Submission of Final Plan to JUCD Board ***(4)***	14 November
Final submission to NHSE/I ***(5)***	15 November
Final JUCD Board ***(6)***	21 November
EMAS ***(7)***	3 December

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Notes:

1. Both Scrutiny Committees do not sit again ahead of final submission (the next county meeting is on 25 November and City do not meet again until February 2020). However the draft plan has been taken to both committees in September and further updates will also be taken to future meetings
2. The JUCD Board received and approved further amendments to the plan to confirm version being taken through organisational governance processes
3. Due to the scheduling; particularly with regards to feedback from region, it may be necessary for Boards/ Governing Body to receive the final plan which is subject to further amendments (depending on the nature of the feedback). The principles in terms of the narrative have been supported by the JUCD Board with delegated authority to the System Executive to approve the financial modelling and triangulation (impact of the plan) as these areas develop prior to 15 November
4. Papers will be submitted to the Board one day before final submission to NHSE/I but the Board meeting itself will take place after. The JUCD Board have agreed that the System Executive: CEO group will have delegated authority for final sign off of the plan ahead of the submission.
5. **Although this is the final submission to NHSE&I discussions will need to take place before this date to ensure plans are agreed with system leads and the regional team ahead of the actual submission date.**
6. The JUCD board will receive the final plan, hopefully with any final feedback from region
7. The EMAS Board date falls after the plan submission and therefore consideration/ agreement is required in relation to interim approach ahead of the plan being published to ensure fit with timescales

Monitoring Delivery of Our Plan

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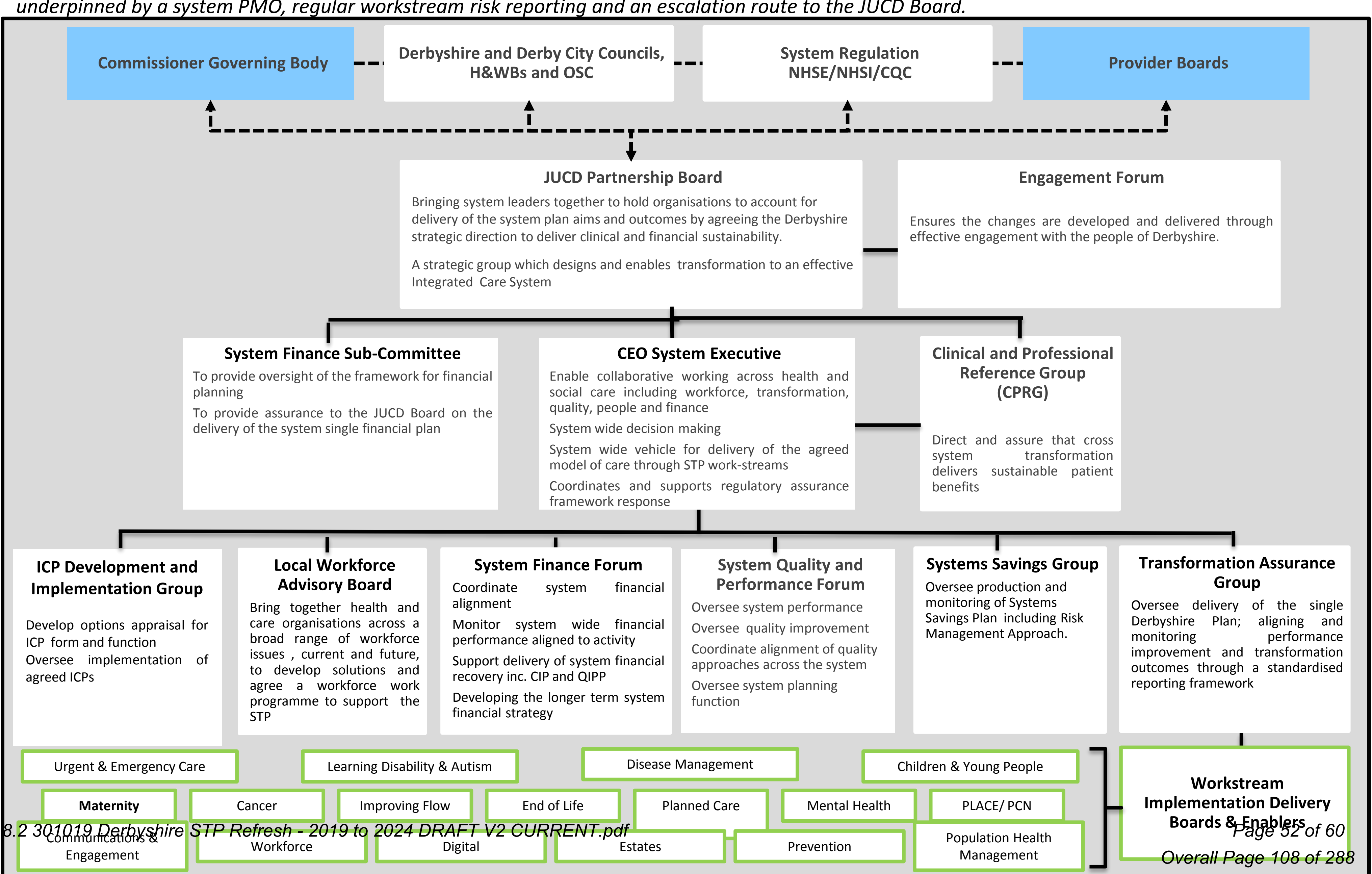
Our existing governance structure will be the mechanism by which we hold each other (the system) to account for delivery of our plan. This will be underpinned by a system PMO, regular workstream risk reporting and an escalation route to the JUCD Board.



APPENDIX 1

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Profile of Environmental, Behavioural and Socio-economic Determinants of Health and Wellbeing Outcomes at Place Level

Structural Socio-Economic Factors	England	Derby City	Amber Valley	Bolsover	Chesterfield	Derbyshire Dales	Erewash	High Peak	North East Derbyshire	South Derbyshire
Working age adults with HND, Degree and Higher Degree level qualifications	39.0	34.6	31.8	28.7	28.7	48.2	34.1	42.5	34.1	34.7
Working age adults with no formal qualifications	7.6	9.1	5.9	6.7	8.4	4.0	3.8	4.9	4.7	5.7
Employment rate (aged 16+)	75.4	74.2	83.5	77.7	72.0	84.0	78.3	75.2	78.0	82.4
Unemployment rate (aged 16+)	4.1	4.6	3.6	4.4	5.2	2.8	5.0	3.9	4.0	3.3
Workless Households (Unemployed/Inactive)	14.0	16.5	11.5	11.1	22.1	10.8	14.4	14.0	11.6	10.7
Job Density	0.87	0.89	0.75	0.65	0.87	1.03	0.62	0.65	0.54	0.55
Gap in the employment rate between those with a long-term health condition	11.5	9.0	13.3	16.5	10.6	15.0	16.6	17.8	15.5	11.6
Average weekly earnings	£440	£444	£417	£355	£388	£438	£423	£429	£395	£466
Gender pay gap	19.1	38.3	31.5	17.7	12.1	17.2	29.5	21.6	16.1	25.6
Children in low income families	17.0	21.0	15.1	19.8	19.6	9.4	17.2	11.9	15.3	11.9
Income Deprivation Affecting Older People	16.2	18.6	13.8	17.0	17.6	9.1	14.4	12.7	13.6	11.6
Employment and Support Allowance Claimants	5.4	7.2	6.0	8.0	8.4	4.0	5.3	5.4	6.6	4.4
Health Behaviours										
Smoking prevalence in adults	14.4	19.2	15.4	18.2	17.3	9.5	11.0	15.5	9.3	14.4
Smoking prevalence in adults - Routine and Manual Occupations	25.4	33.2	31.0	25.1	34.2	22.2	13.5	30.3	9.6	16.8
Smoking in pregnancy	10.8	16.2	16.2	18.6	11.7	13.5	18.1	13.1	15.6	16.2
Excess weight in children (4-5 year olds)	22.4	22.4	21.2	25.3	25.5	23.4	24.9	24.9	23.1	23.5
Excess weight in children (10-11 year olds)	34.3	36.8	31.1	39.5	34.1	26.5	33.9	31.3	33.6	33.2
Excess weight in adults	62.0	65.5	62.8	69.7	71.1	54.2	65.8	57.3	70.8	66.9
Physically inactivity, 18+ years	22.2	65.1	21.3	25.3	19.8	19.0	22.6	21.6	21.2	23.7
Alcohol specific hospital admissions - Under 18 years	32.9	33.8	27.9	53.1	46.7	31.5	30.3	61.7	50.8	27.7
Alcohol specific hospital admissions	569.9	780.4	491.9	577.3	938.2	471.0	553.8	644.0	551.6	430.1
Chlamydia detection rate (15-24 years)	19.7	22.3	19.7	16.6	22.7	13.1	22.1	9.4	17.6	18.8
Self-harm - emergency admissions	185.5	259.2	179.7	288.5	444.5	166.5	226.0	183.4	229.0	172.7
Suicides	9.6	7.3	8.7	8.9	10.8	8.5	7.8	7.1	9.2	9.0
Natural, Built and Living Environment										
Mortality attributable to air pollution	5.1	5.7	4.8	4.6	4.0	3.8	5.6	3.5	4.1	5.1
Average particulate matter	9.3	11.3	9.7	9.3	8.5	7.9	11.1	7.4	8.7	10.3
Density of fast food outlets	88.2	104.2	78.3	86.8	117.9	67.3	87.7	98.5	68.4	59.0
Average minimum travel time in minutes by public transport or walking to reach key services	17.7	16.5	19.0	20.0	16.2	25.6	18.9	19.8	19.3	21.6
Housing affordability ratio	7.9	5.1	5.3	5.3	5.5	7.9	5.4	6.1	6.6	6.3
Owner occupied tenure	62.9	60.2	76.5	63.1	61.1	75.7	64.9	69.1	68.7	78.3
Older people living alone - Estimated Households (65+ years)	45.1	47.2	41.7	44.9	45.7	42.7	43.9	44.6	41.2	39.1
Emergency admissions due to falls, 65+ years	2170.0	2306	2071	2343	2678	2118	2242	2327	2172	2390
Statutory homelessness	2.4	4.5	1.4	0.8	0.5	1.4	0.3	0.8	0.3	2.9
Housing in non-decent condition - proportion of LA owned housing stock	4.4	0.0	0.0	7.2	0.0	0.0	0.0	16.3	10.3	0.0
Fuel poverty	11.1	13.2	12.4	11.7	11.9	10.9	12.3	10.6	11.4	10.5
Crime Severity Score	3.8	16.7	9.5	9.9	10.7	6.9	10.3	8.1	7.3	9.2

Health Outcomes - Length and Quality of Life	England	Derby City	Amber Valley	Bolsover	Chesterfield	Derbyshire Dales	Erewash	High Peak	North East Derbyshire	South Derbyshire
Life Expectancy at birth - Females	83.1	82.7	82.6	81.5	82.1	84.2	83.4	83.3	82.9	82.5
Life Expectancy at birth - Males	79.6	78.5	79.6	77.9	77.9	80.8	79.5	79.9	79.7	79.3
Difference in average life expectancy years between most and least deprived - Females	7.4	8.5	8.5	4.5	8.1	3.0	4.6	7.5	7.6	7.7
Difference in average life expectancy years between most and least deprived - Males	9.4	10.0	10.0	6.2	9.9	3.5	9.6	9.1	8.2	6.9
Neonatal Mortality and Stillbirths	7.1	8.2	7.3	7.1	5.4	2.1	7.2	7.6	4.3	9.1
Premature Mortality - CVD	72.5	83.5	69.6	68.2	89.7	48.1	73.6	62.3	61.2	58.6
Premature Mortality - Respiratory	34.3	42.9	34.6	44.2	49.4	20.9	26.9	34.2	29.2	32.3
Premature Mortality - Cancer	134.6	142.2	127.5	169.3	155.7	121.6	138.4	130.3	129.6	142.6

Sources: Public Health Profiles, Available at: https://fingertips.phe.org.uk and NOMIS Local Authority Profiles, Available at https://www.nomisweb.co.uk/ , Accessed September 2019

Personalised Care

The Derbyshire Model of Care is built upon delivering more personalised care approaches and this is embedded throughout our programmes of work and our focus on prevention.

JUCD have clear trajectories to underpin its strategic planning for achieving The Long Term Plans and the intertwined personalised care principles. Mapping and self-assessment, across the JUCD programmes of work, is essential to provide an explicit and quality response to the delivery of the key commitments. A summarised snapshot of personalised care covered by JUCD programmes of work is provided below.

	A Snapshot Summary of JUCD programmes of work in relation to the 6 principles of personalised care.
Personal Health Budgets	▪ PHB as default in Continuing Healthcare (Domiciliary care) and Wheelchair budgets are already implemented in Derbyshire. Children & Young People with Continuing Care eligibility are also offered a PHB. ▪ LD/ Autism – Where possible people will be enabled to have a personal health budget, with plans to review current use of PHB's to support people with LD &/or ASD outside of CHC, identify gaps (19/20) and develop implementation plan (20/21). ▪ Mental Health – People entitled to Section 117 aftercare have been identified as the next cohort of people who will have a legal right to have PHBs; implementation plan is in development.
Social prescribing	▪ Primary Care Networks - formation and the roll out of employing Social Prescribing link workers ▪ Place - identify the action to understand the existing Social Prescribing offer and identify potential improvements to support Frailty. ▪ Social Prescribing and Health Coaching is included in Future Service Model for Long Term Conditions (Disease) Management.
Personalised Support and Care Planning (PSCP) and Enabling choice	Approaches are identified in many care pathways via JUCD workstream Outline Business cases – examples of which are: ▪ Maternity - Continuity of Carer model and Derbyshire Personalised Maternity Care Plan. ▪ CVD - upskilling and building confidence for front line staff in early identification and personalised support of people with CVD conditions. ▪ MSK Individual Placement and Support (IPS) in regard to peoples goals about work. ▪ Learning Disability/Autism People with learning disabilities and/or autism must feel that they own their (co-produced) plans so we all know how best to look after them. ▪ EoL Care Planning and Respect: Ensure a focus at all times on the person and their wishes, promoting advance care planning, including advance directives, lasting powers of attorney, 'living wills' and Respect Forms ▪ PHB SEC 117 aftercare PSCP is integral to all PHB offers
Shared Decision Making	▪ We will work with RightCare colleagues to identify the most impactful situation to develop Shared decision Making in Derbyshire in order to reduce clinical variation. ▪ This will be based on completion of the SDM checklist and self assessment to support the Derbyshire System in establishing a baseline and next steps.
Supported self - management	Health coaching, peer support, education programmes: ▪ Public Health - Staff trained in coaching approaches. This allows service users and service providers to work together to work out what matters most to them. These conversations take place in a wider context of health messaging, conversation tools and promotion of NHS digital resources. ▪ Living well with autism self-management programme in place for all recently diagnosed adults ▪ LD/ Autism - Develop a greater focus on person centred care across the system. including digital flag to identify patients who require reasonable adjustments. ▪ Self-management, Education, Social Prescribing and Health Coaching etc. included in Future Service Model for Long Term Conditions Management ▪ CRHFT Transition worker to engage young people with type 1 and type 2 diabetes to improve self-management attend clinic appointments and improve use of medication. ▪ Staff to complete good quality foot assessments and provide consistent self-management advice and Health Coaching (diabetes). ▪ Providing access for those living with Type 2 diabetes to the national HeLP Diabetes online self-management platform, which will commence phased roll out in 2019/20; ▪ Maternity - Information & involvement – Personalised care planning; every woman and her partner feels they were listened to and involved in their care ▪ CYP - Advice and prevention – Parents and practitioners will be able to obtain advice within the community to give them the confidence to support the child appropriately. If they are still not confident in addressing the need they will know when, where and how to seek early intervention. ▪ MSK - Improved self-management by patients and reduced necessity to access services and clinically avoidable interventions ▪ Mental Health - Plans for the delivery and required investment for digitally enabled transformation across mental health pathways will be developed in 2019/20:: - Pathways identified to test digitally enabled care - Every person will be able to access their care plans - Digitally enabled models of therapy being rolled out in specific mental health pathways. - Digital processes to support clinical monitoring - A range of management apps/ digital consultations - Digital clinical decision making tools ▪ Cancer - Patients are supported to live well for longer in the community through the offer of a health and wellbeing programme - Active Recovery and 'Wellbeing for All' programmes will also support the patient experience and satisfaction ▪ Respiratory - Expanded provision of access to digital and face-to-face structured education and self-management support tools. ▪ Dementia extend Dementia Connect programme

Sequential planning of the Personalised Care trajectories for the Derbyshire system. As part of this planning we will confirm governance processes for managing the programmes of work and how they will feed into system priorities and reporting structures to monitor progress:

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5 year ambition – Personalised Care and Support Planning	19/20	20/21	21/22	22/23	23/24
PCSP trajectory	2,996	4,404	8,307	13,342	18,068
Personal Health Budgets	Target 1,080 to be met by: ▪ Confirming priority cohorts and trajectories ▪ Developing s.117 PHB offer ▪ Reviewing current use of PHBs to support people with LD &/or ASD outside of CHC, identify gaps and developing plan.	Target 1,620 to be met by: ▪ Development of implementation plan based on gaps identified within review of current use of PHBs outside of CHC. ▪ Commencing s.117 PHB offer implementation. ▪ Identifying new s.117 cohort. ▪ Embedding PHB's to deliver interventions as identified in individuals care and support plans, alongside CHC and S117 entitlements.	Target 2,160 to be met by: ▪ Rolling out s.117 PBH's ▪ New cohort in place, further priority cohort identified.	Target 2,700 to be met by: ▪ s.117 fully in place ▪ Two cohorts fully in place, final priority cohort identified.	Target 3,240 to be met by: ▪ s.117 fully in place ▪ All additional cohorts in place.
Social prescribing (SP)	▪ Complete recruitment of SP link workers ▪ SP advisory group and agreed plan developed. ▪ Recruit to Mental Health SP roles in Hubs. ▪ Plans identified for targeting 1,026 referrals through SP link workers. ▪ Scope 'community connector' programmes across system via Integrated Volunteering Approaches Programme.	▪ Plans identified for targeting 4,150 referrals through SP link workers and MH link workers in MH Hubs. ▪ Replicate and develop best practice, by exploring current programmes such as 'community connectors', and adding value to social prescribing services and outcomes.	▪ Plans identified for targeting 8,209 referrals including SP link workers, community connectors and MH link workers. ▪ Scope the next LTC pathway to target for PCSP development ▪ Develop at scale implementation plan for community connectors	▪ Plans identified for targeting 12,314 referrals through current and new routes.	▪ Plans identified for targeting 16,419 referrals through current and new routes.
Personalised Support and Care Planning (PSCP) and Enabling choice	▪ Work with the national team to develop planned cohorts for interventions. ▪ SEND - Review the graduated approach to ensure the right support is available at the earliest opportunity and ensure access to therapy services is available, personalised, in the right place and at the right time to help C&YP access education. ▪ Confirm our approach to ensuring everybody approaching the end of their life is offered opportunity to create a personalised care plan. ▪ LD/ Autism - Development of comms plan to support roll out of key tools to support development of Personalised care and support / stay well plans. ▪ Cancer - Patients will have a follow-up pathway in the right setting for them.	▪ Community provision for Physical Health Services - Review of top 5 'high needs ' C&YP and their combined packages to establish pathways specific to them. ▪ Disease management - support upskilling and building confidence for front line staff in early identification and personalised support ▪ LD/ Autism - Further development care provider market to increase personalised community care provision ▪ Cancer - All patients will be offered the opportunity to undertake a holistic needs assessment and care plan at throughout the pathway. ▪ All pregnant women have a personalised care plan. ▪ Confirm system approach to supporting patients with cancer to undertake a holistic needs assessment and care plan based on examples of good practice.	▪ Cancer - All patients will be offered the opportunity to undertake a holistic needs assessment and care plan at different stages throughout the pathway. ▪ All pregnant women have a personalised care plan.	▪ Cancer - All patients will be offered the opportunity to undertake a holistic needs assessment and care plan at different stages throughout the pathway. ▪ All pregnant women have a personalised care plan.	▪ Cancer - All patients will be offered the opportunity to undertake a holistic needs assessment and care plan at different stages throughout the pathway. ▪ All pregnant women have a personalised care plan
Shared Decision Making	▪ Liaise with Rightcare colleagues to establish areas of unwarranted clinical variation, checking alignment with the national 30 'high value' clinical situations. ▪ Engage with national team to source Shared Decision Making checklist and self assessment	▪ Develop action plan based on SDM checklist and self assessment.	▪ Implement action plan	▪ TBC	▪ TBC
Supported self - management	PAMS target - 2,052 to be met by: ▪ Engaging with national team for support on PAMs. ▪ Identify priority area for implementation – potentially this would be the Long term Conditions pathway ▪ Reviewing work completed in other areas with cancer survivors including peer support and social prescribing to inform a Derbyshire approach. ▪ Cancer - patients will be offered enhanced supportive care at the earliest opportunity and will be supported to self-manage their condition following treatment.	PAMS target - 4,105 to be met by: ▪ Development of plan for PAMS training implementation in priority area. ▪ Identify additional priority area. ▪ Share success of PAMs impact to build system wide support. ▪ Cancer -Breast patients will receive personalised care, tailored to their needs.	PAMS target - 7,183 to be met by: ▪ Development of implementation plan for second priority area ▪ Identify additional priority area and PAMs administrators ▪ Cancer - Prostate and Colorectal patients will receive personalised care, tailored to their needs.	PAMS target - 11,288 to be met by: ▪ Development of a plan to for PAMs implementation in third priority area ▪ Identify additional priority area and administrators	PAMS target - 15,393 to be met by: ▪ Development of a plan to for PAMs implementation in fourth priority area ▪ Identify additional priority area and administrators

Delivering digitally enabled care

APPENDIX 3 **DRAFT v2**

Our digital strategy themes have been aligned to key deliverables set out in this plan, which is demonstrated in the table below; the funding streams where relevant are also highlighted.

Key:

Funding Sources: 111 booking resources ✓ On-line consultation funding ✓ ETTF ✓ GPFV ✓ GP Business as Usual ✓ TBA ✓ HSLI ✓ Local Resources ✓ STP Resources ✓

Links to Strategy Themes: Citizens ▲ Professionals ▲ Foundations ▲ Analytics ▲ Innovation ▲

	Key Deliverables	Year 1 2019/20	Year 2 2020/21	Year 3 2021/22	Year 4 2022/23	Year 5 2023/22
Primary Care Priorities	NHS app ▲	100% of practices engaged with NHS app 1% of patients using NHS app	5% of patients using NHS app NHS app used for all Online consultation products	20% of patients using NHS app	50% of patients using NHS app No excluded patients	NHS app used for all routine non face to face contacts
	111 Direct Booking ✓ ▲ ▲	100% of GP practices receiving direct booking from 111 service	111 service booking all relevant patient contacts into GP practices	Business As Usual	Business as Usual	Business as Usual
	Online Consultation ✓✓✓ ▲ ▲ ▲	100% of practices engaged with online booking programme 70% of Derbyshire population with access to Online consultations All GP extended access hubs engaged with Online consultations	100% of Derbyshire patients with access to online consultations, either directly with the practice or through the extended access hubs	Business as Usual	Business as Usual	Business as Usual
	GP connect ✓ ▲ ▲	GP Connect deployed in EMIS GP Practice sites	GP connect deployed in all practices	Business as Usual	Business as Usual	Business as Usual
	GP systems ✓ ▲ ▲	TPP S1 75%; EMIS 25%	GP Futures contract implemented	Business as Usual	Business as Usual	Business as Usual
	Referral Support ✓ ▲	Local Referral support system 'Pathfinder' deployed in pilot practices	Pathfinder used throughout Derbyshire	National products phasing in	National products	National products
	Lloyd George Record Scanning ✓ ▲	Evaluation of local scope	Pilot project(s) implemented	100% LG records scanned	Fully electronic records	N/A
Common Applications (Cross-workstream support)	Single Health Record ✓ ▲ ▲ ▲	Consolidation of non-acute patient records on TPP S1 platform Acute secondary care systems interfacing across UHDB (South Derbyshire) Review GDE FF bid options	Implement GDE FF bid recommendations Develop LHCRE response including review of MIG (Medical Interoperability Gateway) future development/replacement	Procure/early adopter single patient record system	Single health record in place across all key services/sites	Completion of Single health record deployment and move to Business as Usual
	Patient access ✓✓ ▲	NHS app deployed in primary care (see above) Patient direct access to maternity systems (North Derbyshire) Patient access to UHDB letters via PKB	Expansion of secondary care patient access systems via PKB and other systems	Combined primary care/secondary care access projects	National applications available (working assumption)	National applications adopted
	Specialist Analytics ✓ ▲	Local models based on RAIDR and other supplementary systems	Pan-Derbyshire data model Procurement of joint system early adoption of national products (working assumption)	Pan-Derbyshire data service supplemented by implementation of national 'data lake' applications	Full adoption of national models	Business as Usual
	Telehealth ✓✓ ▲ ▲	Pilot projects, based on individual workstream needs Early adopter GP practices	Roll-out of telehealth through primary care & secondary care settings	Integrated options available for patients participating in MDT consultations	Business as Usual	Business as Usual

DRAFT

Delivering digitally enabled care

APPENDIX 3 DRAFT v2

Our digital strategy themes have been aligned to key deliverables set out in this plan, which is demonstrated in the table below; the funding streams where relevant are also highlighted.

Key:

Funding Sources: 111 booking resources ✓ On-line consultation funding ✓ ETTF ✓ GPFV ✓ GP Business as Usual ✓ TBA ✓ HSLI ✓ Local Resources ✓ STP Resources ✓

Links to Strategy Themes: Citizens ▲ Professionals ▲ Foundations ▲ Analytics ▲ Innovation ▲

	Key Deliverables	Year 1 2019/20	Year 2 2020/21	Year 3 2021/22	Year 4 2022/23	Year 5 2023/22
Non-Core Functionality (specific to individual Workstreams)	Cancer ✓ ▲ ▲	Define requirements for patient apps Procure pilot apps	Deploy apps at scale	Business as Usual	Business as Usual	Business as Usual
	Children's ✓ ▲ ▲	Define requirements for patient apps Procure pilot apps Develop 'patient story' specification	Deploy apps at scale procure and implement 'patient story' functionality	Business as Usual	Business as Usual	Business as Usual
	CVD ✓ ▲ ▲	Define requirements for patient apps Procure pilot apps	Deploy apps at scale Develop a business case for 'intelligent devices'	Deploy 'intelligent devices'	Business as Usual	Business as Usual
	Diabetes ✓ ▲ ▲	Specify telehealth options Develop 'patient story' specification	Procure and implement 'patient story' functionality Telehealth functionality in place	Patients routinely communicate blood results electronically	Business as Usual	Business as Usual
	End of Life ✓ ▲ ▲	Implement cross organisational EoL functionality	All partners have online access to patient care preferences Review assisted technology options	Implement assisted technology to patients	Business as Usual	Business as Usual
	Improving Flow ✓ ▲	Full specification of 'Improving flow' requirements	Implementation of 'Improving flow' recommendations Review assisted technology options	Implement assisted technology to patients	Business as Usual	Business as Usual
	LD and Autism ✓ ▲ ▲	Define requirements for patient apps Procure pilot apps Ensure patient 'reasonable adjustment' flag is provided	LD and Autism patient records fully integrated (with appropriate security) within overall patient record Deploy apps at scale. Implement data set for flag to indicate where patients have needs for 'reasonable adjustment'	Business as Usual	Business as Usual	Business as Usual
	Maternity ✓ ▲ ▲	Three separate maternity systems in place) Complete deployment of electronic access to patients in North of the County	Review options for single Pan-Derbyshire maternity system (either fully integrated within mainstream patient record, or as interfaced offer) Expand patient access to UHDB patients	Implement combined maternity digital offer	Business as Usual	Business as Usual
	Mental Health ✓ ▲	Consolidation of mental health systems on TPP S1Review future of 'locked estate' systems	Define requirements for patient appsProcure pilot apps	Business as Usual	Business as Usual	Business as Usual
	Place ✓ ▲ ▲ ▲	Strengthen 'Place-based' Digital option through consolidation on TPP S1 platform and MIG (Medical Interoperability Gateway)	Single 'Place' platform throughout Derbyshire MIG (Medical Interoperability Gateway) phased-out except in exceptional circumstances	Review unified 'Place' system requirement, potentially moving to procurement of new system	Implement review implementations	Business as Usual
	Planned Care ✓ ▲ ▲	Define planned care-specific options for integrated patient record Specify 'tactical' PBC apps with aim of supporting specific patient channel offers	Utilise 'pathfinder' referral support systems, together with cross-setting joint working solutions to develop strategic planned care systems Integrate planned care systems with intelligence-based analytic systems	Implement strategic planned care system	Business as Usual	Business as Usual
	Respiratory ✓ ▲	Specify telehealth options Develop 'patient story' specification	Implementation of 'Improving flow' recommendations Review assisted technology options	Patients routinely communicate respiratory results electronically	Business as Usual	Business as Usual
	Urgent Care ✓ ✓ ▲ ▲ ▲	Define Urgent care-specific options for integrated patient record Specify 'tactical' UEC (Urgent and Emergency Care) apps with aim of supporting specific patient channel offers	Utilise 999 and 111 system integration with local systems, supported by online patient access offer to develop strategic urgent care systems Integrate UEC (Urgent and Emergency Care) systems with intelligence-based analytic systems	Implement strategic urgent care system	Business as Usual	Business as Usual
Other	Support for Social Care achieving DSPTK ✓ ▲	Social Care (Derbyshire County Council and Derby City Council) achieves minimum DSPTK standards in all areas	Social Care (Derbyshire County Council and Derby City Council) achieves minimum DSPTK standards in all areas	Social Care (Derbyshire County Council and Derby City Council) achieves minimum DSPTK standards in all areas	Social Care (Derbyshire County Council and Derby City Council) achieves minimum DSPTK standards in all areas	Social Care (Derbyshire County Council and Derby City Council) achieves minimum DSPTK standards in all areas

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Workforce Implications of transformation delivery plans

APPENDIX 4 **DRAFT v2**

Workforce Development Leads from across the system are working with Transformation Workstreams to identify and implement the implications of the transformation plans on our people, and to ensure that our workforce and OD support offer is aligned to their needs.
The following table summarises the key workforce themes from the delivery plans set out previously in this document and gives examples under each which will be addressed through our workforce and OD plans:

Introducing New Roles	Establishing New Teams	Changes in care setting	Training and Development
We have run a pilot for a Health and Care Worker apprentice who we envisage working in our integrated Place based teams	LD and autism - development of intensive support teams (crisis and forensic)	Mental Health focused Maternity Outreach Clinics	New cancer screening pathways, increasing uptake of screening and self management particularly among BME communities
Implementation of Key Worker role for all C&YP with LD and autism complex needs	increase access to specialist community perinatal mental health services	Left shift of ophthalmology and MSK services	changes in the models of care for CVD and stroke
Develop keyworkers for children and young people with the most complex needs and their carers/families	Bring IAPT therapists into integrated PCN teams,	County wide approach to theatre utilisation	Recognising and addressing cognitive impairment as part of the Aging Well Programme
Consider increase in midwife sonographers	Establish MH Urgent Care Crisis Teams across the county	Urgent Care Treatment Centres as part of integrated urgent care community offer	Introduce 'All staff are prepared to care' education programme to promote proactive and personalised care planning for everyone identified as being in their last year of life.
Diabetes Inpatient Specialist Nurse (DISN) pathways will be developed from 2019/20 with EMAS which will enable ambulance staff to speak directly to DISN from the persons home with aim to prevent conveyance	4 x Mental Health Support Teams (MHSTs) The MHST's will be implemented within education settings	Introduce mental health nurses in ambulance control rooms to improve triage and response to mental health calls	Support the optimisation of digital solutions across all care settings specifically in CVD, stroke, planned care, cancer, LTC's, Diabetes
Trial a Medical Assistant role as part of the General Practice team	Clinical Assessment Service accessible via 111	Enhanced provision in Care Homes	System training plan for midwifery staff to support Continuity of Care

Themes arising from engagement in the plan

Our plan was underpinned by a comprehensive programme of engagement activities (see pages??), which resulted in the themes below being highlighted. This table indicates how these themes have shaped and informed the plan, or have influenced on-going planning work for the STP.

Theme	Engagement Activities	Response/Outcome
PRIORITIES • **People generally welcomed all the priorities in the plan but wanted more assurances that the programmes of work would be 'joined up', and not working in silos.** • **It was felt that it would be a good idea to identify extra-ordinary priorities requiring extra-ordinary effort, as it is unlikely that we can focus on all the priorities at once.** • **The 'how' was important to people, i.e. how would the priorities be implemented.**	STP Board Refresh Event 13th Sept 2019	• The JUCD Programme Leads meetings will continue to understand mutual priorities to support joint working • The JUCD Board is assessing all priorities to understand the priority order and those key challenges which need to be addressed as a system. • Each priority will have its own implementation plan and where these represent service change these will be delivered in collaboration with local people.
COMMUNICATION AND ENGAGEMENT • **People welcomed the opportunity to comment on the plans, but wanted more ongoing communication and the opportunity to get involved, so they could influence decision making.** • **It was felt that more engagement was needed to change mind-sets, behaviours, and promote self-care.** • **People want to be engaged in a timely manner about potential cuts, and changes to services. They want to be informed about the benefits to them of the changes. Where they have been asked about their experience or opinion, they would like to have feedback.**	• STP Board Refresh Event 13th Sept 2019 • Healthwatch Long Term Plan Report July 2019	• The engagement in the plan refresh is only the start of the engagement on JUCD business and the JUCD Board is committed to continuous engagement where the feedback loop is closed with those who give their views. • The communications and engagement team in JUCD have developed a comprehensive communications and engagement offer which is available to all programme leads. This includes Joined Up Care Derbyshire's Citizens Panel, which currently has in access of 1,500 members. JUCD has developed the Citizens' Panel to ensure that we can listen to and learn from our local residents, ensuring the design and delivery of services takes into account 'what matters to people'. We will continue to grow the membership of this panel, promoting the opportunities to get involved to a diverse range of people. Also included in the offer is an interactive workshop which is currently travelling around the county being delivered to a diverse range of groups, with a specific focus on seldom heard groups, and a developing Patient Leadership programme. • Engagement priorities include cultural discussions with Derbyshire people to understand behaviours, set out the service offer and ensure the model of care is easily understand and accessed by all. • Each priority will have its own implementation plan and where these represent service change these will be delivered in collaboration with local people

Appendix 6 - Summary of strategic risks to delivery

Date	Theme	Risk Description	High Level Mitigation Plans
01/03/2017	Strategy	Risk that STP Programmes of work will not deliver the agreed model of care and system wide transformational change.	STP plan refresh to strengthen alignment of transformation programmes with delivery of the model of care and financial recovery, with associated Outcomes Based Accountability (OBA) approach to clearly identify outcome indicators and performance measures. Workstream confirm and challenge meetings scheduled to take place before the end of December 2019 to support development of workstream maturity.
22/08/2019	Strategy	Efforts need to be focused on ensuring that pathway and activity changes result in removal of cost across the system not simply a shift in cost.	The action required to ensure cost out across the whole system will be established on an individual pathway and specialty basis as the opportunities are validated
22/08/2019	Strategy	Assumptions in relation to activity and finances are at a high level, the actual benefits from the initiatives described can only be accurately worked up at a specialty or procedure level as the work progresses	The activity and financial impact will be established on an individual pathway and specialty basis as the opportunities are validated.
01/03/2017	Delivery	There is a risk that insufficient programme resourcing across the system compromises delivery and implementation at the pace and scale required	All workstreams submitted their capacity requirements which have been reviewed by the CEO/FDs Group. Agreed to consider what organisations need to stop doing or do differently to release this capacity. Gaps continue to be reviewed and addressed through the CEOs group to ensure workstreams are properly resourced.
09/09/2018	Delivery	Constitutional standards and key performance indicators will not be met	Workstream plans for 2019/20 developed which incorporate OBA indicators some of which are also constitutional standards. Improved monitoring and reporting of delivery through the Transformation Assurance Group to support earlier identification of remedial actions required. Quality & Performance Group established with responsibility for ongoing monitoring and reporting of system level constitutional standards.
14/12/2018	Delivery	There is a risk that failure to deliver the prevention agenda by embedding within all areas of work will fail to deliver the upstream changes required to improve longer term sustainable outcomes	The increased focus on the prevention agenda will be driven through the Prevention strategy which was approved through JUCD Board and continues to be embedded locally with all organisations taking this through internal governance arrangements. The System Opportunities Programme identified the need to focus on the prevention agenda given the priority areas identified; this provides the opportunity to develop pathways end to end to include primary and secondary prevention. Through the Prevention Board greater alignment to workstreams taking place with named public health colleagues working with programme leads to ensure delivery plans include prevention and make stronger links to the strategy.
19/08/2019	Delivery	That the plans in neighbouring LMS will not fit well with those in Derbyshire, jeopardising what JUCD wishes to achieve and creating inequity in the offer to women who choose to access care over the Derbyshire borders.	Liaison with neighbouring LMS PMOs and sight of transformation plans. Detailed discussions over shared opportunities and risk and issues, regarding border flows. Stronger relationship and exploration of shared opportunities with Pan-Staffordshire LMS in particular.
16/09/2019	Delivery	Continued increase in demand for Mental Health (MH) inpatient service means that LoS reduction outweighed by admissions resulting in inability to reduce out of area placements	Crisis and Home treatment service investments during the course of 19/20 and 20/21.
12/09/2019	Delivery	Risk to patient safety & system reputation due to the potential cessation of inpatient MH and LD services by independent providers as a result of the national transformational care partnership work.	Attendance at national & regional NHS E contracting meetings to gather intelligence Development of system wide contingency plan
06/08/2019	Delivery	Changes to models of care, activity growth, and/or commissioning adversely impacts upon the future efficiency, capacity and suitability of the project design.	Close working with users and commissioners to understand the direction of healthcare service provision, along with a flexible design solution. Monitoring of actual activity growth compared to forecasts used in modelling.
01/03/2017	Engagement	Lack of 'buy-in' to STP due to inadequate engagement with stakeholders	Engagement Committee established as part of revised STP governance. Communications and engagement (C&E) strategy refreshed. Significant engagement undertaken to support the STP Plan refresh, including the using members of the citizens panel (1500 members) to hold confirm and challenge sessions, wider stakeholder events including members of the public, MPs, voluntary sector. C&E alignment to transformation programmes strengthened with offer developed for all workstreams to utilise as part of their ongoing approach. Improved GP representation throughout STP governance
22/02/2018	Digital Technology	Service delivery and transformational change programmes are compromised due to inadequate digital technology strategy and operationalization	Strengthened governance in place and workstream now gathering momentum and making stronger links to workstreams. Digital strategy developed with alignment of digital technology plans to workstream transformation priorities and plans; decreasing the risk that products and services will not meet the evolving needs of the system. Pathway transformation is being designed in alignment with the Digital programme of work and the development of a digital solution to support delivery.
25/07/2019	Analytics	Access to data and the ability to use this to provide intelligence will prevent effective planning and monitoring of delivery	Considerations taking place through the CEO/FDs meetings to review capacity available across the system and how it is being utilised, taking into account various strands of work in train. Meeting arranged to review and align approaches; with a proposal to be taken back to CEOs.
09/08/2018	Workforce	Increasing trend for GPs to retire early/work significantly less than full time hours impacting on primary care capacity within the system	GPFV workforce plan focused on retention of GPs in the latter part of their career Programme of work commissioned through the LMC to implement targeted interventions for that cohort.
16/05/2019	Workforce	Insufficient emphasis and consideration of workforce challenges across the system will result in integrated care delivery being compromised	Given the increasing focus on workforce in response to the NHS People Plan, a focused workforce discussion took place at the July JUCD Board. Through the STP refresh greater alignment and understanding of workstream plans undertaken to support development of workforce plans in response. Ensure a suitable programme of staff engagement, training, recruitment and retention is implemented

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 5 November 2019

Performance Report 2019/20

Purpose of Report

The purpose of this report is to provide the Board of Directors with an overview of Trust performance at the end of September 2019.

Executive Summary

The report provides the Board of Directors with information that shows how the Trust is performing against a set of key targets and measures.

Performance is summarised in an assurance summary dashboard with targets identified where a specific target has been agreed. Where a specific target has not been agreed or specifically commissioned, colleagues will be able to track performance over time and discuss/challenge any specific variation that may be of concern or unusual. Further detailed run charts for the measures are included in appendix 1.

The main body of the report provides detail on a number of the key measures. Board members are also able to triangulate information from this report with the assurance summaries from each Committee, where more in depth reports have been provided for assurance.

The main areas to draw the Board's attention to are;

<u>Finance</u>

As at the end of September the surplus of £1.3m is ahead of plan by £0.1m. The forecast assumes the planned surplus of £1.8m is achieved. However there are significant cost pressures and risks to be mitigated. Therefore in order to achieve the planned surplus the forecast assumes the requirement to reduce expected costs by £0.7m during the remainder of the financial year and to mitigate £0.4m of delivery risk on Cost Improvement Programme (CIP). The financial risk is generated by unfunded cost pressures partially offset by contingency reserves leaving a net cost pressure of £1.4m.

There are several emerging risks that need to be managed in order to achieve that forecast position in particular is the unfunded cost pressures, potential for CQUIN income loss, CIP delivery and the reduction of Out of Area (OOA) expenditure. OOA and Stepdown expenditure budget is overspent year to date but is forecast to breakeven by the end of the financial year.

Agency is forecast to remain below the ceiling of £3.03m. Year to date agency expenditure equates to 2.7% of total pay expenditure.

The cost improvement programme (CIP) is behind plan year to date but forecast to deliver in full, however there is a risk to delivery of between £0.3m and £0.4m. Capital is behind plan year to date but forecast to spend to plan by the end of the financial year.

Quality and Operations

Out of Area – Psychiatric Intensive Care Units (PICU)

Since June 2019 there has been a steady decline in the number of patients who have been placed in a PICU facility - from 23 in June to an average of eight patients in October. Part of the repatriation process is for patients to be admitted to the Enhanced Care Ward or to return to an acute ward where this is clinically appropriate. Due to vacant beds during the summer months DHCFT were able to repatriate patients through these routes.

Out of Area – Acute Placements

While the average number of patients in OOA acute beds was maintained at eight for July, August and September, October saw an increase in requests for acute beds. There was high demand over the weekend of 4 - 6 October resulting in four patients being placed out of area with a further five patients requiring admission over the weekend 11- 13 October. This increased the number of OOA acute placements during October to an average of 13 patients at any time.

Throughout October there was a decrease in the number of available beds reducing the capacity to return patients from the OOA acute beds.

The Acute Services Management Team have clear systems and processes to ensure the flow of patients is planned to reduce the amount of time patients are out of area and to optimise beds in the acute units:

- Monday morning clinical meetings with ward based consultants, senior nurses,local authority (LA) social care workers and Assessment Services
- Daily ward rounds
- Daily senior nurse meetings to discuss patient flow
- Daily assurance calls with senior management team to discuss bed availability
- Weekly discussion with case managers, flow coordinators and senior managers

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

The waiting list and capacity to meet demand continue to be a challenge for CAMHS. Vacancy and some sickness continues to impact on capacity to undertake assessments. All vacancies are now recruited to, with start dates finalised. Once these staff are in post we should start to see some improvement. We continue to await the CCG release of agreed additional investment into CAMHS for this financial year which will afford us some additional capacity, in advance of the CCG planning for next year.

Waiting list for community paediatrics

Progress continues to be made. The longest waits remain below 52 weeks, and we continue to focus on those children waiting in excess of 26 weeks. Managing the capacity centrally is a key action, and we are currently recruiting a waiting list coordinator to better manage resource and capacity. An update paper was presented to the Trust Management Team (TMT) on 24 October which set out a

series of actions being taken to manage this challenge. Further assurance will be provided to November's meeting of the Finance and Performance Committee.

Workforce

Annual appraisals

Divisional People Leads (DPLs) continue to work with all divisions to track and monitor appraisal completion and provide support to signpost when there are issues with Electronic Staff Record (ESR) inputting. New starter appraisal dates is one of the areas where there has been some correction to the data, this is now being corrected through ESR working with the ystems and Information Team and operational managers.

Staff sickness

DPLs working with the divisions highlight sickness trends and hot spots and provide support and advice. Increases in long term sickness cases with support is also being provided by the employee relations team. Managers are encouraged to attend the mandatory People Masterclass "Managing Attendance". Occupational health response times and referrals are also being monitored to ensure this is within the Service Level Agreement (SLA) with Occupational Health.

Vacancies

Focus on inpatient areas to recruit and initiatives to recruit and retain now in place. Rolling adverts have been refreshed and managers are being supported directly to move through the recruitment stages by the People Resourcing team where there may be shortlisting delays due to capacity issues.

However, this remains a significant challenge for the Trust and this is in line with ongoing national recruitment challenges.

Additional items have been added to the report this month. A number of new quality measures have been included for consideration.

In addition, this month's integrated performance report includes an accompanying report showing the specific progress that has been made regarding the implementation of the acute care service transformation plan.

Strategic Considerations (All applicable strategic considerations to be marked with X in end column)	
1) We will deliver **great care** by delivering compassionate, person-centred innovative and safe care	X
2) We will ensure that the Trust is a **great place to work** by attracting colleagues to work with us who we develop, retain and support by excellent management and leadership	X
3) We will make the **best use of our money** by making financially wise decisions and will always strive for best value to make money go further	X

Assurances

This report relates directly to the delivery of the Trust's strategy by summarising performance across the four key performance measurement areas. This report should be considered in relation to the relevant risks in the Board Assurance Framework.

As an integrated performance report the content provides assurance across several BAF risks related to workforce, operational performance, quality performance, financial performance and regulatory compliance. The use of run charts will provide the Board with a more detailed view of performance over time as it enables the differentiation between normal and special cause variation.

Consultation

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

Governance or Legal Issues

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

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

This report reflects performance related to all of the Trust's service portfolio and therefore any decisions that are taken as a result of the information provided in this report is likely to affect members of those populations with protected characteristics in the REGARDS groups.

Any specific action will need to be relevant to each service and considered accordingly, so for example, as parts of the report relate specifically to access to Trust services; we will need to ensure that any changes or agreed improvements take account of the evidence that shows variable access to services from different population groups.

Recommendations

The Board of Directors is requested to:

1) Confirm the level of assurance obtained on current performance across the areas presented.
2) Determine whether further assurance is required and if so, at which Committee this needs to be provided and by whom.

Report presented by:	**Mark Powell, Chief Operating Officer** **Claire Wright, Director of Finance/Deputy CEO** **Amanda Rawlings, Director of People and Organisational Effectiveness** **Carolyn Green, Director of Nursing and Patient Experience**
Report prepared by:	**Peter Henson, Head of Performance, Delivery & Clustering** **Kathryn Lane, Deputy Director of Operational Services** **Rachel Leyland, Deputy Director of Finance** **Catherine Pynegar, Business Intelligence Manager** **Celestine Stafford, Assistant Director of People & Culture Transformation** **Nadeem Mirza, Safety and Risk Systems Administrator** **Darryl Thompson, Deputy Director of Nursing & Quality Governance**

1. Assurance Summary

Indicator	Rating[1]	Data Quality	Indicator	Rating[1]	Data Quality
Financial					
Cumulative surplus / (deficit)	n/a		Liquidity		
Agency expenditure against ceiling			Cumulative cost improvement programme	n/a	
Agency costs as a proportion of total pay expenditure			Cumulative capital expenditure	n/a	
Out of area and step down expenditure					
Operational					
CPA 7 day follow-up			Waiting list for care coordination – number waiting	See chart	
Data Quality Maturity Index (DQMI) - MHSDS data score			Waiting list for care coordination – average wait	See chart	
Early Intervention (EIP) RTT within 14 days - complete			Waiting list for ASD assessment – number waiting	See chart	
EIP RTT within 14 Days - incomplete			Waiting list for ASD assessment – average wait	See chart	
IAPT referral to treatment (RTT) within 18 weeks			Waiting list for psychology – number waiting	See chart	
IAPT referral to treatment within 6 weeks			Waiting list for psychology – average wait	See chart	
IAPT people completing treatment who move to recovery			Waiting list for CAMHS – number waiting	See chart	
Patients placed out of area - PICU	See chart		Waiting list for CAMHS – average wait	See chart	
Patients placed out of area - adult acute	See chart		Waiting list for community paediatrics – number waiting	See chart	
			Waiting list for community paediatrics – average wait	See chart	

[1]The rating symbols were designed by NHS Improvement

Key:

	The system is expected to consistently pass the target
	The system may achieve or fail the target subject to random variation
	The system is expected to consistently fail the target

Indicator	Rating[1]	Data Quality	Indicator	Rating[1]	Data Quality
Workforce					
Annual appraisals	F		Clinical supervision	F	
Annual turnover	?		Management supervision	F	
Compulsory training	?		Vacancies	F	
Sickness absence	?		Bank staff use	F	
Quality					
A. Safe					
Incidents of moderate to catastrophic actual harm	?		Medication errors	?	
Episodes of patients held in seclusion	?		Incidents involving physical restraint	?	
Incidents involving prone restraint	?		Incidents requiring duty of candour	?	
Falls on inpatient wards	?				
B. Caring					
Formal complaints received	?		Compliments received	?	
Staff friends and family test - recommended care	F		Friends and family test – positive responses	P	
C. Effective					
Patients in settled accommodation			Patients in employment		
D. Responsive					
Patients on CPA whose care plan has been reviewed	?		Delayed transfers of care	P	

[1]The rating symbols were designed by NHS Improvement

Key:

	The system is expected to consistently pass the target
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2. Detailed Narrative

Finance

As at the end of September the surplus of £1.3m is ahead of plan by £0.1m. The forecast assumes the planned surplus of £1.8m is achieved. However there are significant cost pressures and risks to be mitigated. Therefore in order to achieve the planned surplus the forecast assumes the requirement to reduce expected costs by £0.7m during the remainder of the financial year and to mitigate £0.4m of delivery risk on Cost Improvement Programme (CIP). The financial risk is generated by unfunded cost pressures partially offset by contingency reserves leaving a net cost pressure of £1.4m.

There are several emerging risks that need to be managed in order to achieve that forecast position in particular is the unfunded cost pressures, potential for CQUIN income loss, CIP delivery and the reduction of out of area (OOA) expenditure. OOA and Stepdown expenditure budget is overspent year to date but is forecast to breakeven by the end of the financial year.

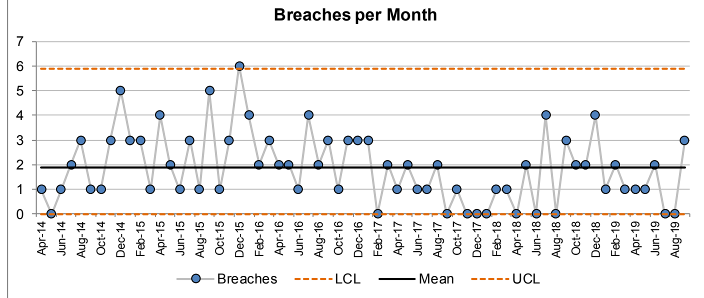
Agency is forecast to remain below the ceiling of £3.03m. Year to date agency expenditure equates to 2.7% of total pay expenditure.

The cost improvement programme (CIP) is behind plan year to date but forecast to deliver in full, however there is a risk to delivery of between £0.3m and £0.4m. Capital is behind plan year to date but forecast to spend to plan by the end of the financial year.

Operations

A. 7 day follow-up

The purpose of CPA 7 day follow-up is to check the wellbeing of patients and provide support during the period where they are feeling most vulnerable in the first few days post discharge. In the case of the three patients ostensibly not followed up in September, two had been transferred to acute inpatient wards for physical health treatment and regular contact has been made with clinicians on the acute wards for updates on their wellbeing during their time on the acute wards. The third patient had a period of trial home leave, with support from the CPN, which went well and so did not need to return to the ward.



B. IAPT people completing treatment who move to recovery

Talking Mental Health Derbyshire continues to achieve in excess of its performance targets for both recovery rates (target >50%) and reliable improvement (target >65%) in every month of 2019/20. We monitor both the Trust performance and that of our sub-contractors with regular contract and operational meetings internal to the service and with our partners.

As previously decribed at last month's Board meeting, it is expected that performance against this trajectory will continue to improve.

C. Patients placed out of area – PICU and adult acute

The team understand the distress that can be caused for patients and families when placed miles from home and aim at all times to place patients as close to home as possible. However, there are times when due to no beds being available on the acute wards out of area placements will be sought. The team review placements daily of all patients who are placed out of area to repatriate them as quickly as possible back to their local community.

DHCFT discuss the use of leave beds and aim to utilise clinically safe leave beds to admit into. A safe bed is one where a patient may have had two or more successful leaves home and may be on extended leave prior to discharge.

There are occasions that patients may require detention under the Mental Health Act in a Psychiatric Intensive Care Unit (PICU). A PICU is designed to offer a higher level of environmental and relational security to keep the patient and others safe. DHCFT are not currently commissioned to provide this service so any one requiring a PICU will be placed out of area.

All patients who are placed out of area receive visits from a member of the DHCFT out of area care managers. It is their role to ensure that patients receive high quality safe care while not directly in our care.

Out of Area – Psychiatric Intensive Care Units (PICU)

Since June 2019 there has been a steady decline in the number of patients who have been placed in a PICU facility - from 23 in June to an average of 8 patients in October. Part of the repatriation process is for patients to be admitted to the Enhanced Care Ward or to return to an acute ward where this is clinically appropriate. Due to vacant beds during the summer months DHCFT were able to repatriate patients through these routes.

Out of Area – Acute Placements

While the average number of patients in out of area (OOA) acute beds was maintained at eight for July August and September, October saw an increase in requests for acute beds. There was high demand over the weekends of 4 to 6 October resulting in four patients being placed out of area with a further five patients requiring admission over the weekend 11 and 13 October. This increased the number of OOA acute placements during October to an average of 13 patients at any time.

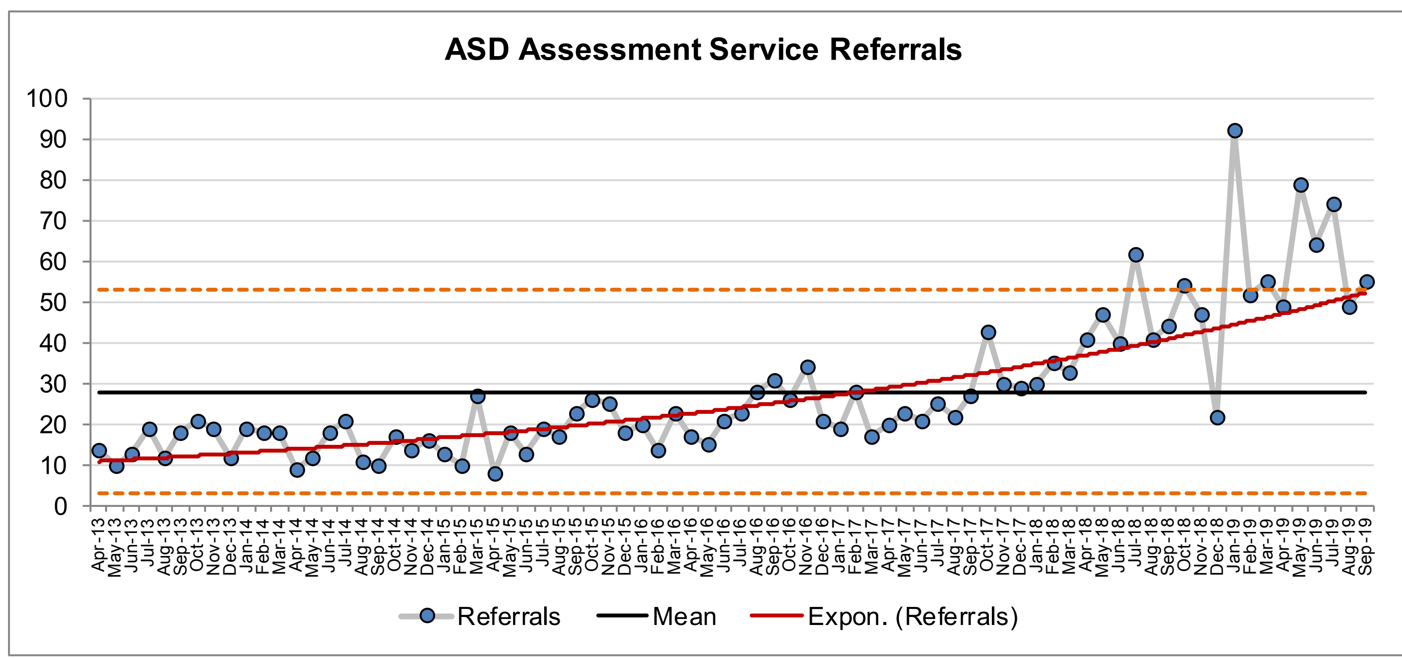
Throughout October there was a decrease in the number of available safe beds reducing the capacity to return patients from the OOA acute beds.

The Acute Services Management Team have clear systems and processes to ensure the flow of patients is planned to reduce the amount of time patients are out of area and to optimise beds in the acute units:

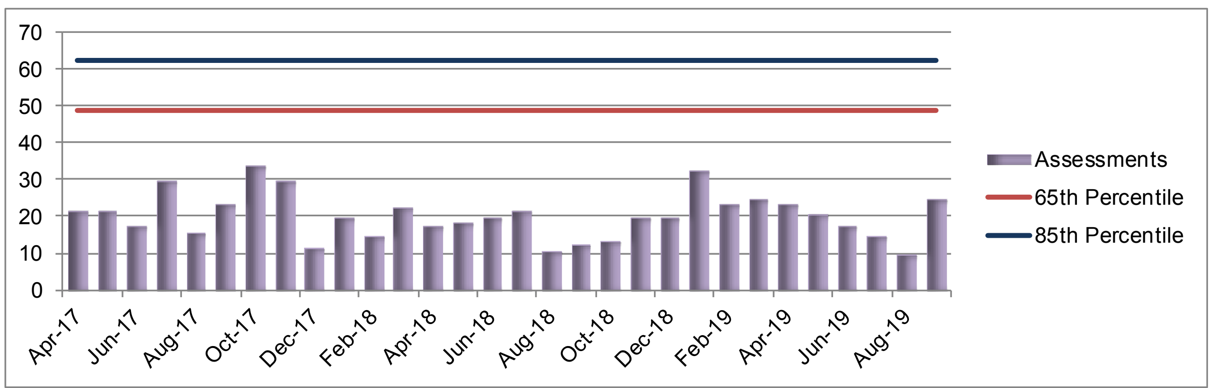
- Monday morning clinical meetings with ward based consultants, senior nurses, LA social care workers and Assessment Services
- Daily ward rounds
- Daily senior nurse meetings to discuss patient flow
- Daily Assurance Calls with senior management team to discuss bed availability
- Weekly discussion with case managers, flow coordinators and senior managers

D. Waiting list for autistic spectrum disorder (ASD) assessment

From November 2019 the team will be back to full capacity with the commencement of a 0.5wte assessor who has recently been recruited. The team also achieved their monthly target in September. However, it is important to note that full commissioned capacity is not enough to meet the ongoing and increasing levels of demand for this service. We continue to meet with a stakeholder group of commissioners to review the role and function of the team, but as yet this has not resulted in any changes to the "assessment only model". The number of referrals to the service continues on an increasing trajectory. The service has been asked to prepare a paper for ELT in November setting out options that could or have been considered in respect of the future of the service.



To meet demand, the service would need capacity to assess between 49 and 62 patients per month, whereas the service has averaged around 20 assessments per month, with 34 being the highest level ever achieved.



E. <u>Waiting list for psychology</u>

Over the past 2 years the numbers of patients waiting for a psychology service and the average waiting times has reduced slightly, however, unfortunately still remain high.

Actions to improve the service offered have included developing group interventions where possible (Compassion Focussed Therapy and Acceptance and Commitment Therapy in the north of the county) and offering training and supervision to MDT staff in stabilisation work to use as part of their usual contacts to try to reduce length of therapy with psychologists.

We have 1.8 new wte psychologists in post and are expecting another wte in November. On a national basis the demand for psychologists outstrips supply and vacancies are currently out to advert, or being reconfigured prior to advertisement in order to enhance the likelihood of recruitment.

Cases are prioritised within teams with those with highest risk being seen as soon as possible after referral which means that some more routine cases have longer to wait. Most cases are open to the CMHT's and advice/consultation is a key part of the psychologists' role in order to support MDT staff in working in a more psychologically informed way.

In addition alongside the routine information offered in relation to waiting well, psychology services are exploring the possibility and value of creating more bespoke advice/ self-help materials which they can offer on assessment.

There is ongoing work in relation to recruitment for Personality Disorder pathway and once in place (December 2019/January2020), it is anticipated that the broader spectrum of offer will impact positively on psychology waiting times.

F. Waiting list for child & adolescent mental health services (CAMHS)

The waiting list and capacity to meet demand continue to be a challenge for CAMHS. Vacancy and some sickness continue to impact on capacity to undertake assessments. All vacancies are now recruited to, with start dates finalised. Once these staff are in post we should start to see some improvement. We continue to await the CCG release of agreed additional investment into CAMHS for this financial year which will afford us some additional capacity, in advance of the CCG planning for next year.

G. Waiting list for community paediatrics

Progress continues to be made. The longest waits remain below 52 weeks, and we continue to focus on those children waiting in excess of 26 weeks. Managing the capacity centrally is a key action, and we are currently recruiting a waiting list coordinator to better manage resource and capacity. An update paper was presented to the Trust Management Team on 24th October which set out a series of actions being taken to manage this challenge. Further assurance will be provided to November's F&P Committee.

Quality

This is the first Board Report with this list of Quality Indicators. They are shown in Statistical Process Control chart form. Particular measures of note are as follows:

A. Number of new patients held in seclusion and number of incidents involving physical restraint

It is observed that there is apparent correlation between these measures; bring some assurance as to both of these sets of data. Of note, the number of incidents involving physical restraint remains largely stable, and increases in specific months will be attributed to temporarily increased acuity and challenge from specific people in our care.

B. Number of incidents requiring Duty of Candour

There have been no incidents requiring Duty of Candour for the past two months, and given the low incident rate this measure will be reviewed as to its appropriateness to be interpreted via an SPC chart.

C. Number of falls on in-patient wards

Overall, a reducing trend is apparent over recent months, with one particularly elevated measure in May 2019. Falls reduction is a local Commissioning for Quality and Innovation (CQUIN) target and so is being reviewed with our commissioners. We have also recently appointed to a vacant post of Moving and Handling / Falls Prevention Lead.

D. Complaints and compliments

The number of complaints and compliments received by the Trust has remained largely stable over recent months.

E. Patients open to Trust in employment and in settled accommodation

The current trend for these measures have been reducing for the past year. One response to this is the Trust's participation in the Wave 2 transformation funding for the expansion of Individual Placement and Support services which is expected to help improve employment opportunities for service users.

F. Delayed transfers of care

This continues to be an overall downward (and therefore improving) trend, within target.

Workforce

A. Annual appraisals

Divisional People Leads (DPLs) continue to work with all Divisions to track and monitor appraisal completion and provide support to signpost when there are issues with ESR inputting. New starter appraisal dates is one of the areas where there has been some correction to the data, this is now being corrected through ESR working with the systems and Information Team and operational managers.

B. Turnover

Turnover is below the national average for mental health Trusts and we continue to manage at a local level with particular focus on retention initiatives in our acute inpatient areas.

C. Compulsory training

Increases in compliance for Mandatory training in 6 out of 8 mandated courses. Steady improvement to increase compliance in acute inpatient areas

D. Staff sickness

DPLs working with the Divisions highlighting sickness trends and hot spots and providing support and advice. Increases in long term sickness cases with support also being provided by the employee relations team. Managers are encouraged to attend the mandatory People Masterclass “Managing attendance”. Occupational health response times and referrals are also being monitored to ensure this is within the SLA with Occupational Health.

E. Supervision

Supervision levels are monitored at performance reviews and monthly operational meetings.

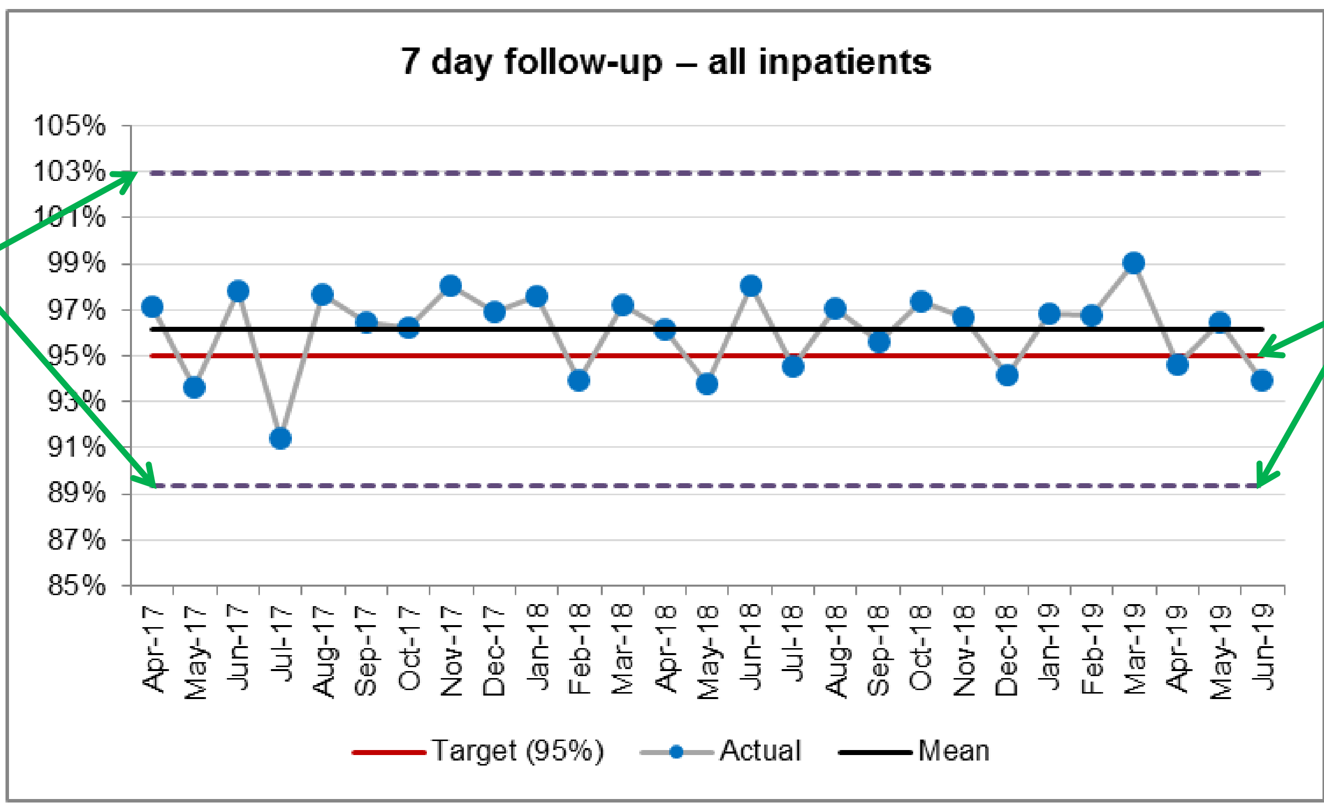
F. Vacancies

Focus on inpatient areas to recruit and initiatives to recruit and retain now in place. Rolling adverts have been refreshed and managers are being supported directly to move through the recruitment stages by the People Resourcing team where there may be shortlisting delays due to capacity issues.

Appendix 1

How to Interpret a Run Chart (also known as an SPC chart)

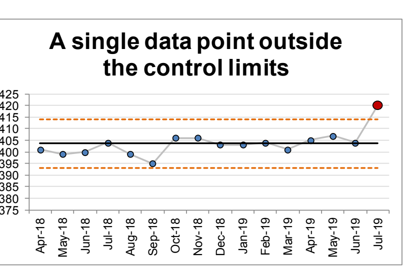
The dotted lines are the "control limits". Any performance between these 2 lines is normal for the current system. This is known as "normal variation"

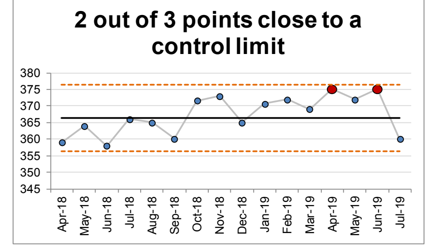


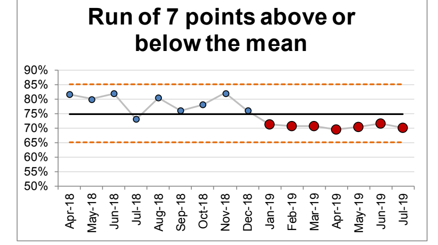
If the system is effective, the **lower** control limit will be above the target line (for targets where higher is better) or the **upper** control limit will be below the target line (for targets where lower is better). In that scenario we have nothing to worry about and can be assured our system is performing well.

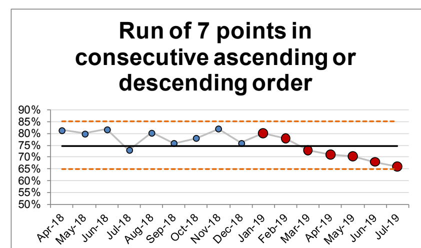
In this case the target line is above the lower control limit which indicates that the system is ineffective.

A run chart also enables us to see when something unusual has happened in the system. This is known as "special cause variation". This can be seen in 4 ways:

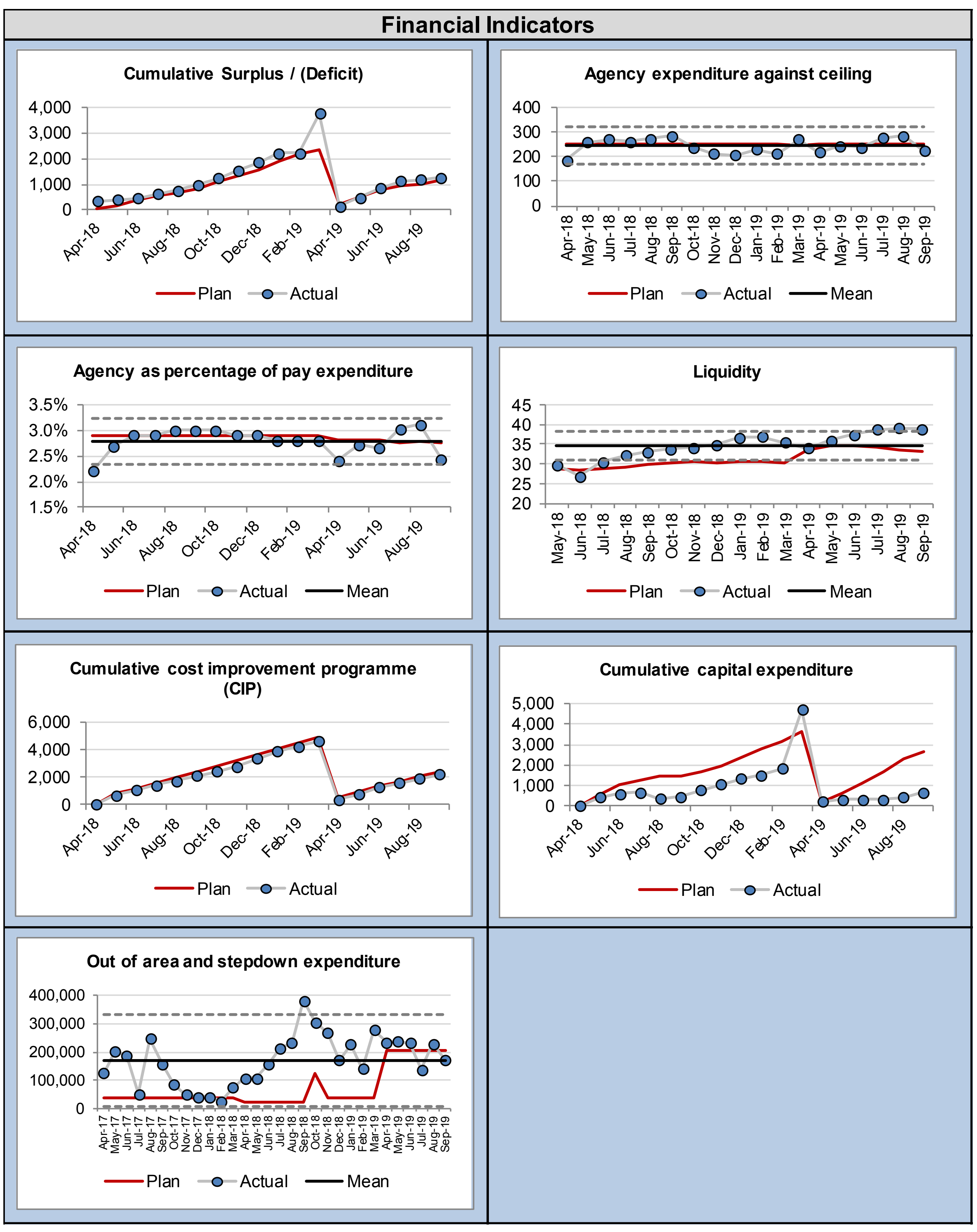


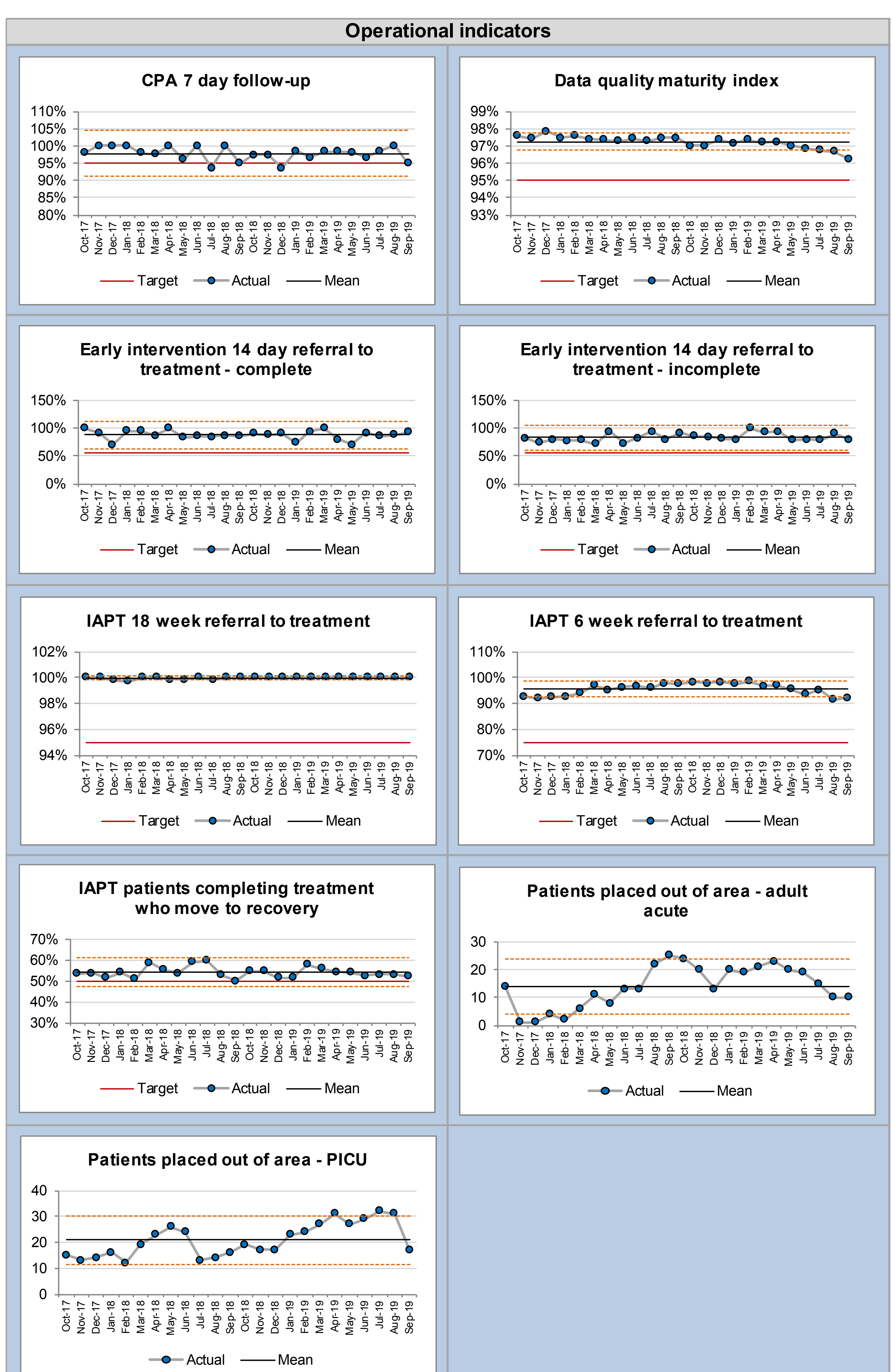






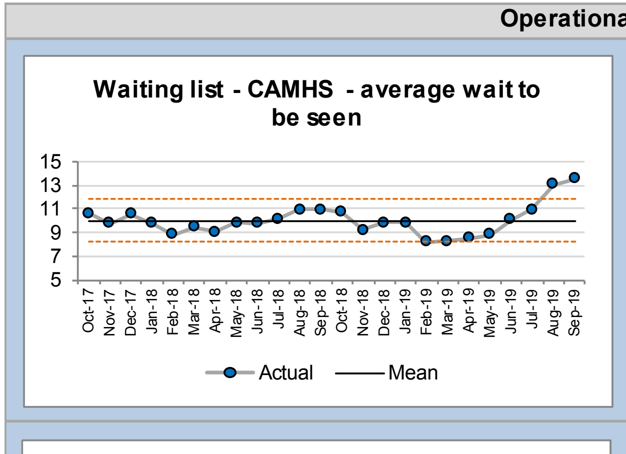
Appendix 2 – Run Charts

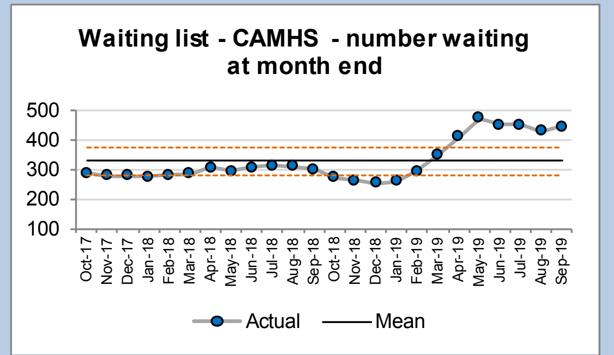


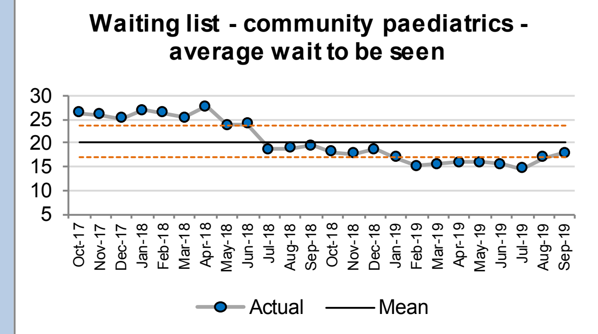


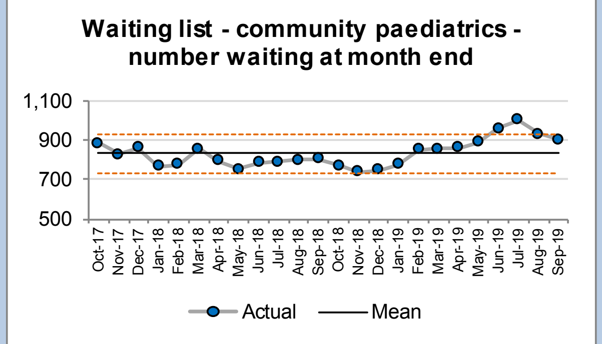
Operational indicators
CPA 7 day follow-up
Data quality maturity index
Early intervention 14 day referral to treatment - complete
Early intervention 14 day referral to treatment - incomplete
IAPT 18 week referral to treatment
IAPT 6 week referral to treatment
IAPT patients completing treatment who move to recovery
Patients placed out of area - adult acute
Patients placed out of area - PICU
Target
Actual
Mean

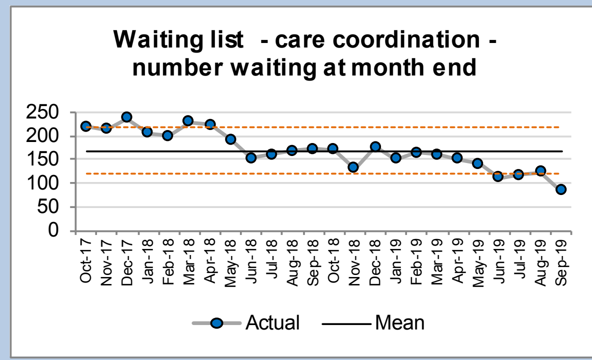
Operational indicators

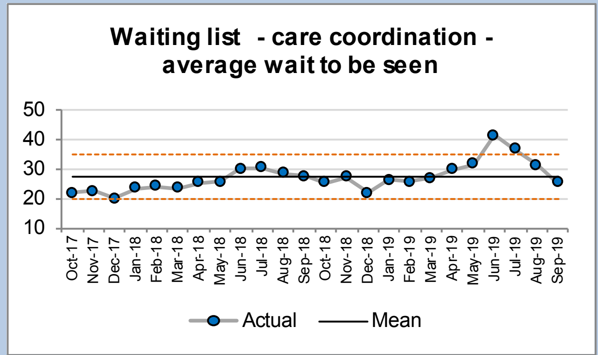


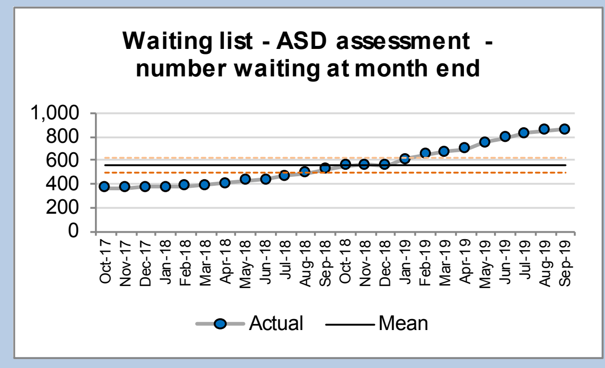


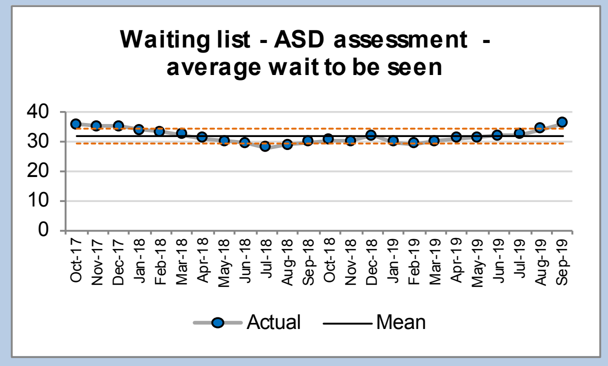


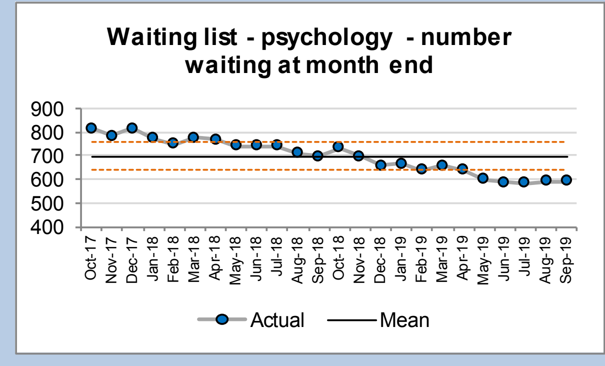


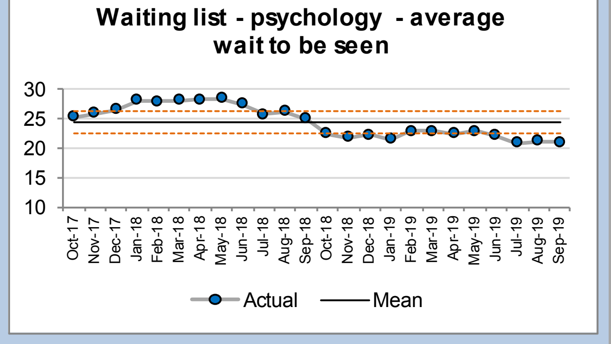


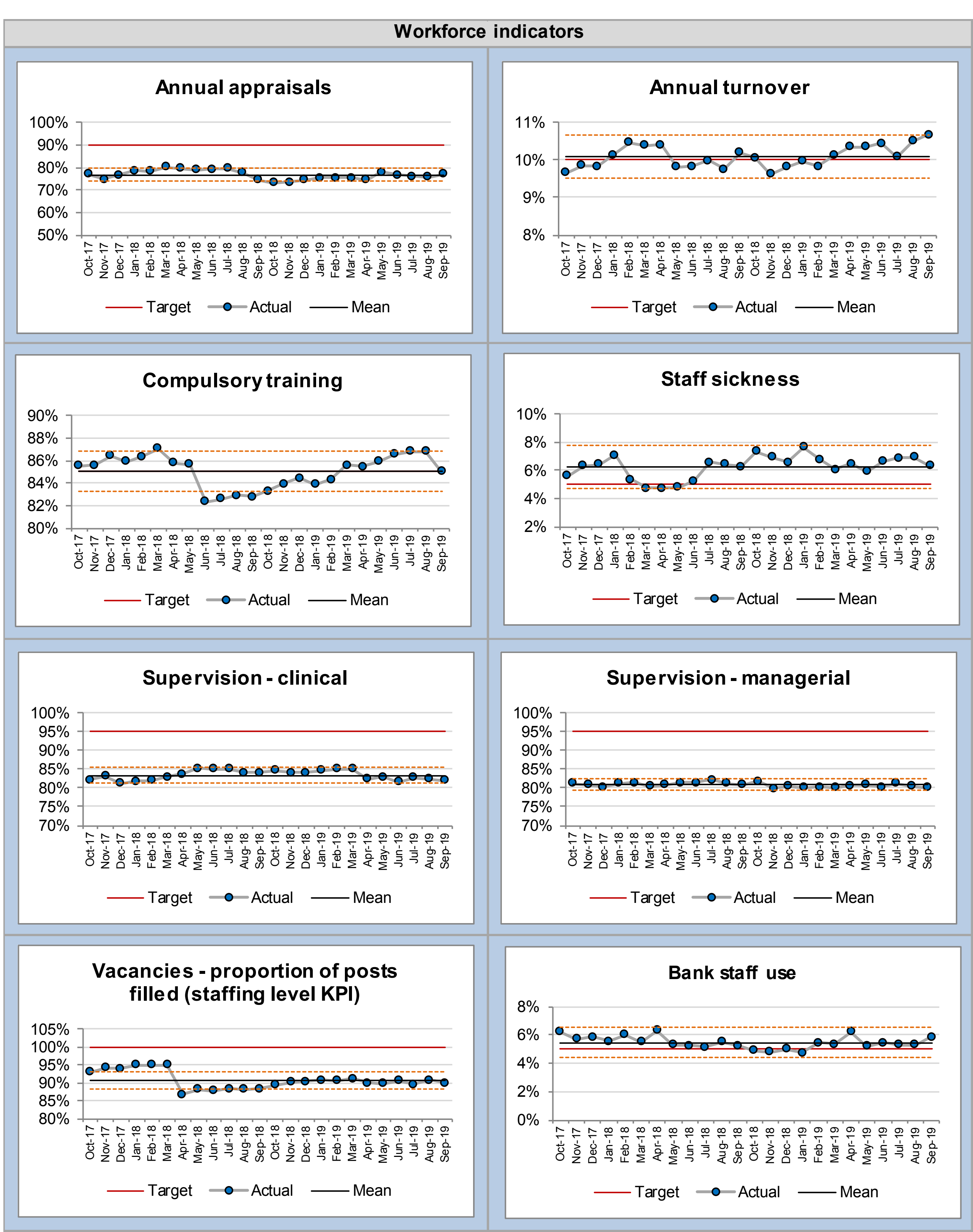






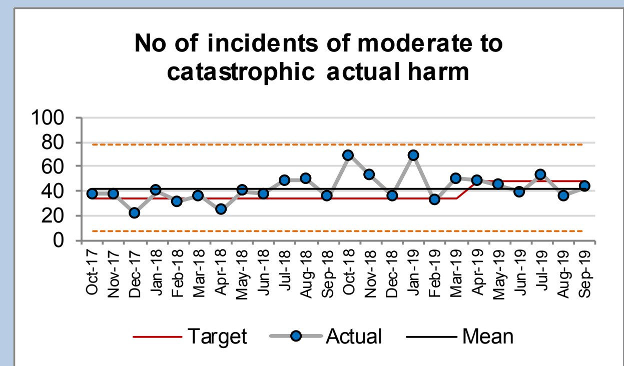


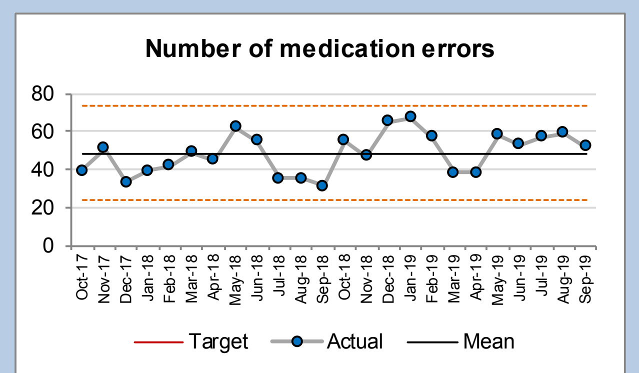


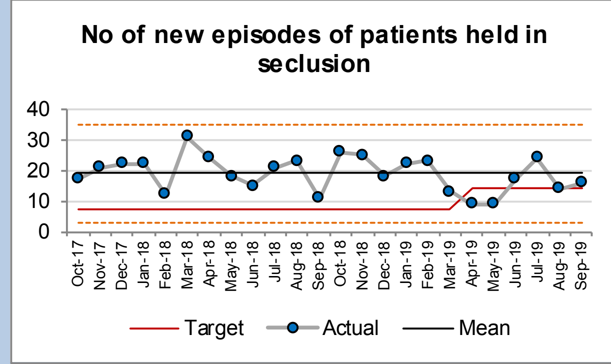

Workforce indicators
Annual appraisals
Annual turnover
Compulsory training
Staff sickness
Supervision - clinical
Supervision - managerial
Vacancies - proportion of posts filled (staffing level KPI)
Bank staff use
Target
Actual
Mean

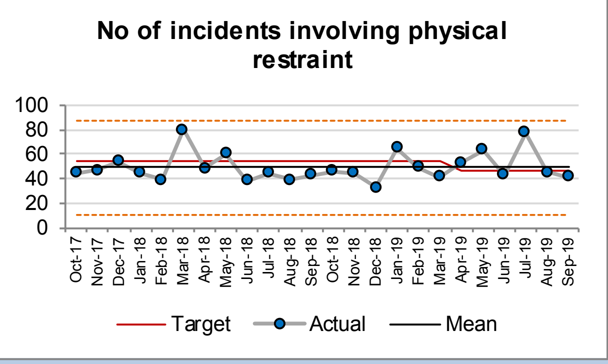
Quality Indicators

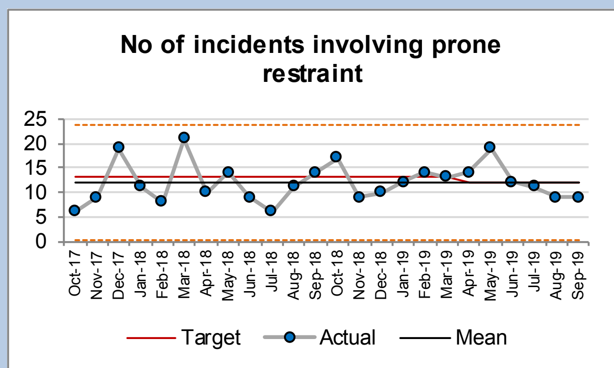
Safe

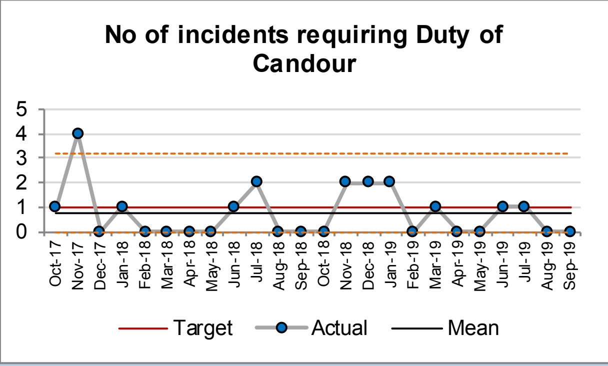


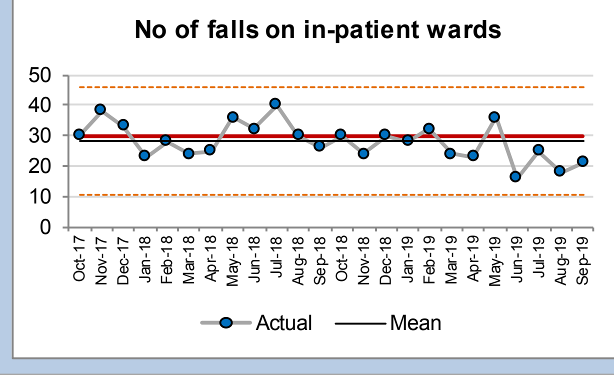






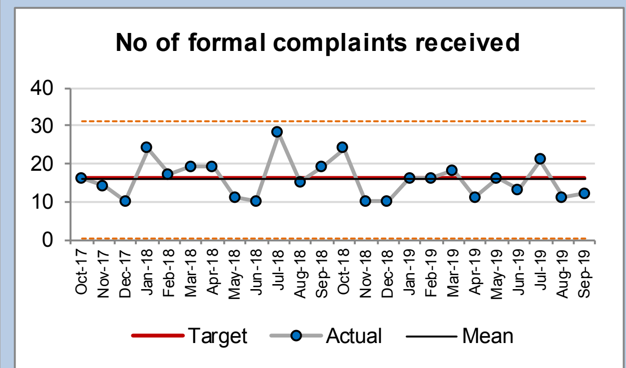


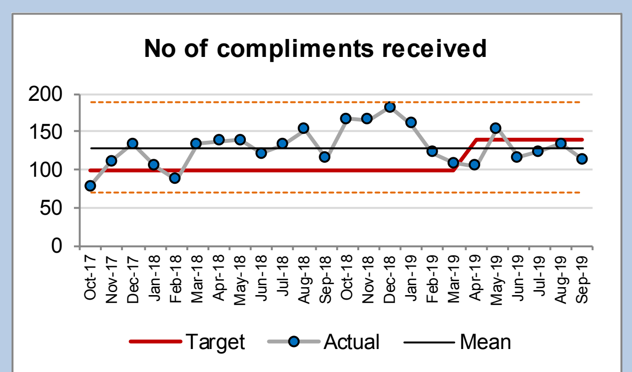


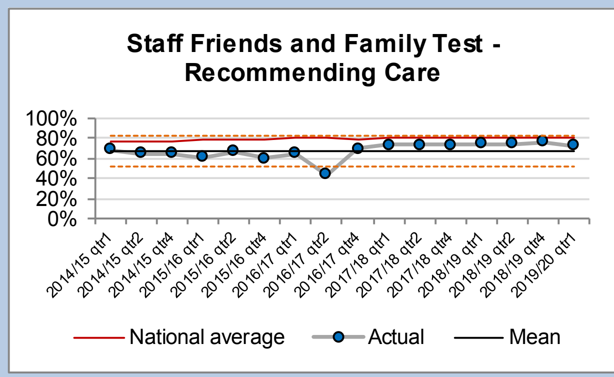


Quality Indicators

Caring







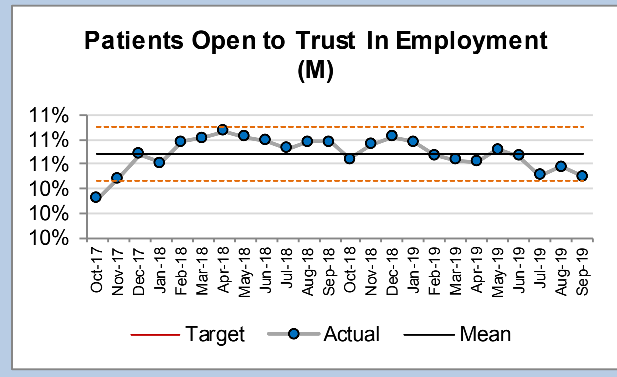
Effective

Patients Open to Trust In Settled Accommodation (M)

68%
66%
64%
62%
60%
58%
56%

Oct-17 Nov-17 Dec-17 Jan-18 Feb-18 Mar-18 Apr-18 May-18 Jun-18 Jul-18 Aug-18 Sep-18 Oct-18 Nov-18 Dec-18 Jan-19 Feb-19 Mar-19 Apr-19 May-19 Jun-19 Jul-19 Aug-19 Sep-19

Target Actual Mean



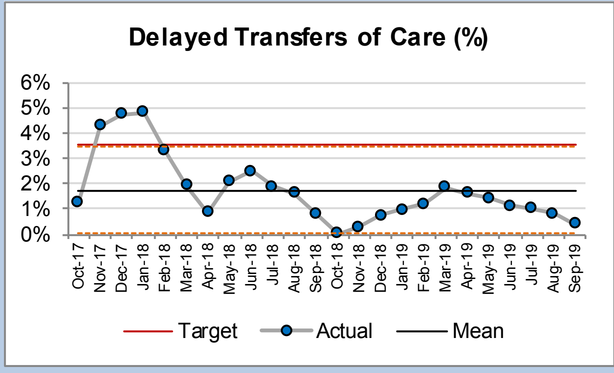
Responsive

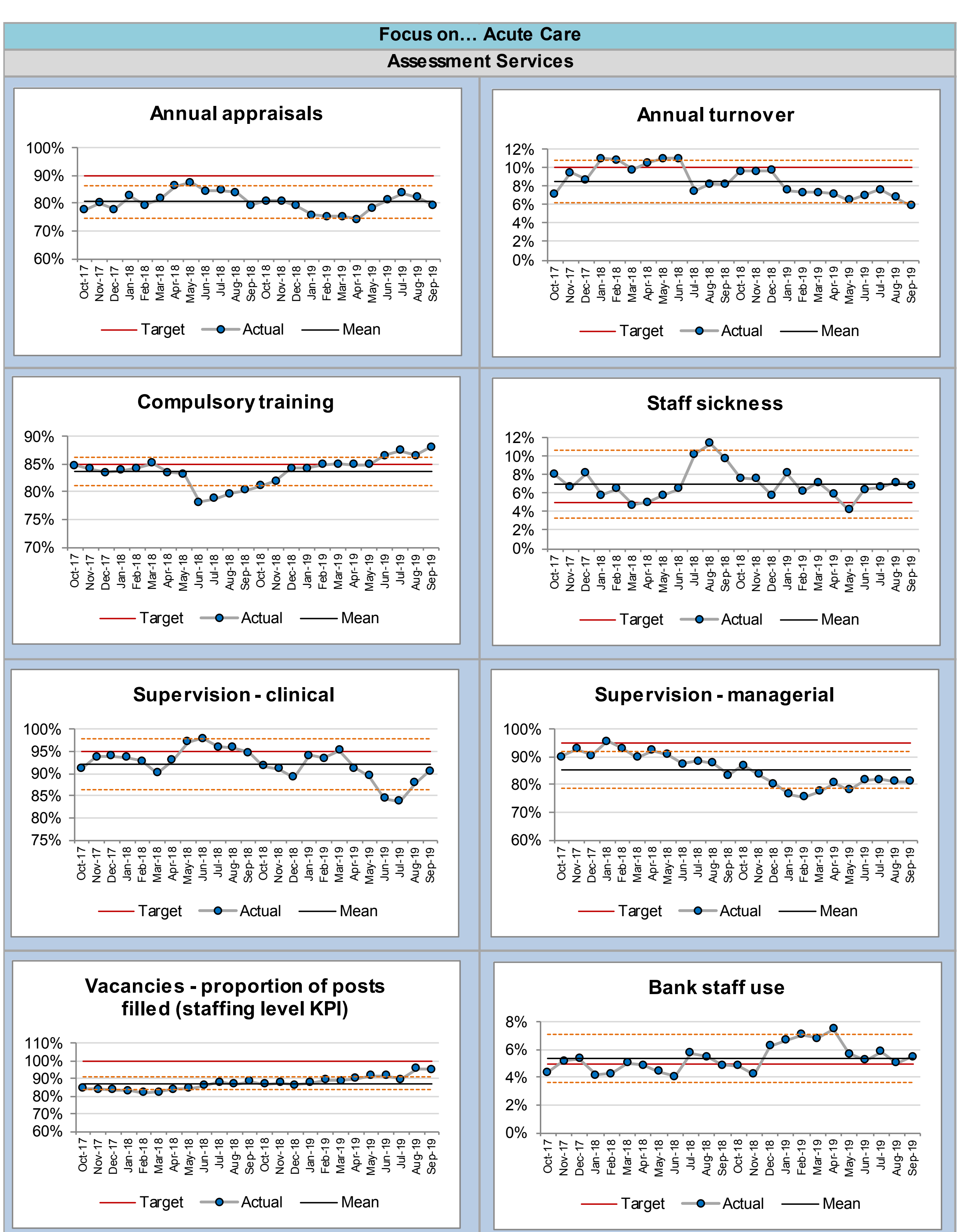
% of patients who have had their care plan reviewed and have been on CPA > 12months

98%
96%
94%
92%

Oct-17 Nov-17 Dec-17 Jan-18 Feb-18 Mar-18 Apr-18 May-18 Jun-18 Jul-18 Aug-18 Sep-18 Oct-18 Nov-18 Dec-18 Jan-19 Feb-19 Mar-19 Apr-19 May-19 Jun-19 Jul-19 Aug-19 Sep-19

Target Actual Mean





Focus on... Acute Care
Assessment Services
Annual appraisals
Annual turnover
Compulsory training
Staff sickness
Supervision - clinical
Supervision - managerial
Vacancies - proportion of posts filled (staffing level KPI)
Bank staff use
Target
Actual
Mean

Appendix 3 – Data Quality Kite Mark

Background

A number of Trusts prepare data quality kite marks to support members' review and assessment of performance indicator information reported in performance reports. Alternative methods include a simpler data quality scoring in a range, such as 1-5 which are more reliant on judgement. The kite mark is used to assess the system against six domains: timeliness, audit, source, validation, completeness and granularity to provide assurance on the underlying data quality.

Approach

Assessment of each domain will be based on the following criteria:

Data Quality Indicator	Definition	Not yet assessed	Sufficient	Insufficient
Timeliness	Is the data the most up to date and validated available from the system?	Not yet assessed	The data is the most up to date available.	Data is not available for the current month due to the time taken to extract / prepare from the system.
Audit	Has the system or processes used to collect the data been subject to audit (Internal Audit/ External Audit / self-audit) in the last 12 months?	Not yet assessed	The system and processes involved in the collection, extraction and analysis of the data have been audited and presented to the oversight committee.	No formal audit has taken place in the last 12 months. Exceptions have been identified and corrective action has not yet been implemented.
Source	Is the source of the data fully documented and understood?	Not yet assessed	All users understand how to extract the data in line with the indicator definition. The data source is well documented in the event that there is a change in personnel producing the indicator.	The data source is poorly documented and could be inconsistently extracted.

Data Quality Indicator	Definition	Not yet assessed	Sufficient	Insufficient
Validation	Prior to publication, is the data subject to validation, e.g. spot checks, random sample checks, involvement of a clinician, the associated service or approval by Executive Director?	Not yet assessed	The data is validated against a secondary source. The indicator owner can assure the data is a true reflection of performance, supported by a sign off process and underlying information.	No validation has taken place. The information owner cannot assure that the data truly reflects performance. A random sample may reveal errors.
Completeness	Is the indicator a reflection of the complete performance of the Trust	Not yet assessed	All the appropriate activity has been included within the indicator	A material amount of activity has not been included within the indicator that may alter the Trust level performance.
Granularity	Can the data be disaggregated into smaller parts? E.g. evaluated at a division or ward level as well as a Trust level.	Not yet assessed	Data can be drilled down to a division or ward level in order to understand and drive performance improvement.	Data is only available at a Trust level.

KPI Data Quality Reviews

A review will be undertaken every 6 months of 5 to 10 indicators to review their compliance with the defined indicators of quality. This will complement any reviews undertaken by internal or external audit. The results will be shared with the Finance and Performance Committee together with any remedial action necessary.

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 5 November 2019

Acute Inpatient Transformation Action Plan – November 2019

Purpose of Report

The purpose of this report is to inform the Board of Directors of progress made against the Acute Inpatient Services Transformation Plan.

Executive Summary

The Acute Transformation Action Plan has been live since 1 July 2019.

From previous reports the Board of Directors will know that the plan is segmented into five sections, specifically related to the Care Quality Commission (CQC) core domains of Safe, Effective, Care, Responsive and Well Led.

The table below summarises the progress against the plan up to the 31 October 2019. In total there are 53 actions. 38 actions are complete, 13 are on track with 2 actions currently rated as amber. Further detail on a number of actions, including the amber actions is described under each specific CQC domain.

KLOE	Actions	Completed	On track	Amber	Red	Total
Safe	17	12	3	2	0	17
Effective	13	10	3	0	0	13
Caring	6	4	2	0	0	6
Responsive	5	5	0	0	0	5
Well Led	12	7	5	0	0	12

Colour	Code
Red	Off target and lacks substantive plan to get back on track
Amber	Slippage against target but plan in place to address
Green	On target for completion
Grey	Completed

Completed actions, where relevant, are monitored by the relevant groups within the acute services i.e. Clinical Reference Group, Operations Meetings and Transformation Assurance Meeting.

Board members will note that significant progress has been made in nearly every part of the plan. In particular, training, appraisal and supervision compliance have all improved considerably and are all above 80%, with some above 90%. This is in line with the agreed improvement trajectory.

The report also briefly sets out other innovative work that the leadership team have progressed at the same time as delivering core improvements.

One item that continues to be challenging is recruitment of qualified practitioners to minimise the number of vacancies across our acute wards. The report provides an overview of this issue and sets out actions being taken to improve our position. It is worth noting that our position is not uncommon and similar issues are being experienced by other Trusts.

Strategic Considerations	
1) We will deliver **great care** by delivering compassionate, person-centred innovative and safe care	X
2) We will ensure that the Trust is a **great place to work** by attracting colleagues to work with us who we develop, retain and support by excellent management and leadership	X
3) We will make the **best use of our money** by making financially wise decisions and will always strive for best value to make money go further	

Assurances

The CCG and NHSI/E undertook a quality visit at the Radbourne Unit during August 2019. The written feedback from the visit was very positive and provides evidence of improvement.

Mental Health Act CQC Commissioner attended W35 in September and gave a verbal report of the positive changes she had observed during her unannounced visit. The team is still waiting for the final written report.

Non-executive Director visit to W36 on 30th October who observed the positive changes that have taken place in line with the Transformation Plan

Consultation

This report has not been presented at any other forums. The Leadership Team continue to consult and engage widely with colleagues and feedback on the delivery of action.

Specific newsletters are provided each week to colleagues across the acute units for two way feedback.

Governance or Legal Issues

Information supplied in this paper is consistent with the Trust's responsibility to deliver compliance against CQC regulations.

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

This report reflects performance and improvement across the acute service. It is therefore likely that actions taken as part of this plan are likely to affect members of

those populations with protected characteristics in the REGARDS groups. The leadership team are aware of this and will ensure that any changes or agreed improvements take account of this. Involving patients and carers in their care planning is one way of ensuring that risks are mitigated.

Recommendations

The Board of Directors is requested to:

1) Review the assurance provided in this report and assess whether the previously escalated Board Assurance risk associated with this service line can be reduced based on the significant improvements that have been made since July 2019.
2) Determine whether further assurance is required and if so, for which parts of the plan.

Report presented by: **Mark Powell, Chief Operating Officer**

Report prepared by: **Paula Holdsworth, Interim Improvement Director, Assessment and Acute Adult In Patient Services**

1. Purpose of Report

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2. Executive Summary

The Acute Transformation Action Plan has been live since 1 July 2019.

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Well Led	12	7	5	0	0	12

Colour	Code
(Red)	Off target and lacks substantive plan to get back on track
(Amber)	Slippage against target but plan in place to address
(Green)	On target for completion
(Grey)	Completed

3. Safe

Action 6 Tobacco Dependency Policy - amber

The tobacco dependency policy has been approved and is being implemented. There is a lead in time for the environmental works that have been agreed. Plans, drawings and costing have been prepared and designated areas agreed which include home office approved lighters, CCTV, improved lighting, low fence and gate with anti-ligature, seating and signage. This is expected to be completed in the few weeks.

As part of the new policy patients continue to be encouraged to take up the offer of nicotine replacement therapy options by the clinical team as an alternative to smoking.

Action 7 Seclusion Practice

This action has now turned to green as new actions have been added with regards to reviewing and monitoring of seclusion practice. The team are currently working with the Directorate of Nursing to improve the recording and experience of patients and to manage prolonged seclusions.

Action 9 Rapid Tranquilisation (RT) - amber

A meeting was held with IM&T and clinical staff on 23 October and an agreed specification for the data report was completed. A further meeting was held on 24th October with IM&T and clinical staff to revise the rapid tranquilisation case note to ensure the Multi-Disciplinary Team can see and sign off RT administration and monitor. It is expected that changes to the monitoring form will take two weeks with a further three to four weeks to build and test the data report. The next meeting is scheduled for 9 December to review the roll out of the reporting framework. As an interim measure the Clinical Directors for the two acute sites with clinical colleagues are to ensure that monitoring of rapid tranquilisation is part of nursing handovers and MDT meetings to ensure checks have been completed.

Action 13 Staffing Levels

This action was specifically related to reviewing night time staffing compliance against an 85% target of shifts covered with two qualified nurses. To meet 85% compliance equates to 6 out of 7 shifts per week covered with 2 RMN's per ward. Although the action has been marked as complete as the review has been undertaken, further oversight is required as the standard has not been consistently met.

Compliance is not being consistently met across both units as we still continue to have vacancies across all wards.

The review makes several recommendations:

- Bleep-holder function to return to its original purpose – co-ordination of the inpatient unit and staffing resource.
- B6 rotation across 24/7 period to support senior clinical expertise across the 24 hour period and support deficits that may arise in bleep cover.
- Wards with high RMN vacancy supported to rotate 2 0WTE regular staff and supplement with bank or RMN agency staff for night shift cover to try and balance regular staff across all shifts.
- Preceptorship nurses to be supported to rotate onto night shifts with their assigned mentor as far as possible.
- Crisis Resolution Home Treatment (CHRT) to support 136 suite
- 24/7 flow support to support bed finding across the 24/7 period and to support CRHT in the 136 suite
- CRHT to support external calls and all admission requests
- Clear guidance to be produced for bleep-holders regarding what support can be expected from the on call manager and on call Psychiatrist.

It is difficult to predict when wards are likely to reach compliance due to staffing fluctuations and turnover of staff. However, recruitment to vacancies remains in place with adverts on a rolling basis. Senior nurses continue to prioritise difficult to cover shifts and ensure rotation of staff as far as possible. Compliance against target will continue to be monitored.

Night shifts are prioritised through rostering process but will have the impact of reducing regular and consistent registered cover during the day shifts where activity is significantly higher.

A summary of vacancies by ward are provided below. Whilst some improvements have been made in recruiting, the required number of staff remains an ongoing concern. The current vacancy position has been broadly the same for 12 months.

<u>Radbourne Unit</u>

Wards	Lead Nurse	RMN	WBOT	LTS/ Mat leave/ Other	New recruits – not yet started
ECW	2.0	5.4	0	1.0	1
Ward 33	1.0	3.4	1.0	2.6	1
Ward 34	0.2	3.4	1.0	1.0	
Ward 35	1.0	7.6	0	0.8	
Ward 36	2.0	3.0	1.0	2.4	
Total	6.2	22.8	3	7.8	2

<u>Hartington Unit</u>

Wards	Lead Nurse	RMN	WBOT	LTS/ Mat leave/ Other	New recruits – not yet started
Tansley Ward	1	3		4	2
Morton Ward	1	2		1	3
Pleasley Ward	1	5.54			1
Total	3	10.54		5	6

Owing to the number of vacancies and sickness, bank usage remains consistently high.

UNIT	Bank usage
Radbourne	19.8%
Hartington	21.7%

Agency use remains low as it has been very difficult to secure suitable qualified staff through this route.

UNIT	Agency Use
Radbourne	1.3%
Hartington	2.2%

Actions continue to be implemented:

- Rolling adverts remain in place to recruit for HCA's and Qualified Practitioners
- 8 newly qualified nurses are commencing with the Trust
- Support is given to managers to ensure staff who are on Long Term Sickness are supported back to work
- Short term absence is managed with staff supported by line managers upon return
- 12 Week rosters are now in place and continue to be embedded to ensure staff can plan a work life balance
- Regular team meetings
- Continued improvements to ward based supervision
- Access to psychological support following serious incidents

Action 14 Alarm Installation

The alarm installation was reported as amber previously due to the extended time to carry out the works. However, the estates team have now confirmed that the alarm installation at the Hartington Unit will be completed and fully commissioned from 29th November as per project plan. This action has therefore turned to green.

Action 17 Staff Well Being

People Services alongside the Operational Management Team continue to monitor and review the key areas of bank and agency use, recruitment and retention and sickness.

The information below is taken from 30th September workforce data for the inpatient wards and is inclusive of HCA's and Qualified Practitioners.

Sickness remains high across both units during September against a Trust target of 5%.

UNIT	Sickness
Radbourne	11.3%
Hartington	11.8%

4. Effective

Action 3 Appraisals

Monitoring of compliance has continued throughout October and as of 31st October the overall compliance for the two units is:

UNIT	Compliance
Radbourne	93%
Hartington	89%

This is now amongst the best performance across the whole Trust.

Caring

Action 2 Involvement of Patients in Care Planning

The clinical teams continue to monitor involvement of patients in their care to ensure they fully embed patient involvement in care and treatment.

The 'One Out All Out' pilot is currently being implemented with the aim to facilitate pre-planned time for named nurse 1:1 sessions with patients.

5. Well Led

There continues to be a focus on meeting the key performance indicator of 85% for training, supervision and appraisals by the end of November. Staff are informed through team meetings and newsletters that training and supervision are important to ensure that they are supported and competent to carry out their duties.

Training

A meeting was held with the Head of Electronic Staff Records (ESR) to understand the data that is collated and the difference between ESR and local reporting as there are small discrepancies.

The ESR system cannot remove staff assessed as not being able to undertake some elements of training but can continue to carry out tasks on the ward safely. An example is for Positive and Safe training where it is a role-specific requirement. A member of staff may become medically exempt and therefore not expected to attend this training. An example is one ward that has three staff medically exempt and one staff who has not yet returned to work from long term sickness which reduces their compliance on ESR down to 73%. However, once manually adjusted this figure rises to 81% compliance.

To ensure accuracy of reporting local managers undertake weekly monitoring against ward staffing reports and discount exempt staff, staff that have left or moved but continue to be counted in the ESR compliance figures.
Compliance can also change significantly when units have a higher than average intake of staff. This is particularly prevalent throughout September and October when newly qualified practitioners join the team. Once new staff are added onto the ESR system they become non-compliant with immediate effect until having attended the relevant courses.

The ESR department are currently revising the system to re-align role specific training.

Therefore in order to provide transparency the following performance figures include information from ESR/Training data and adjusted local management data.

Safeguarding Adults Level 3

There are no exemptions for this course. Compliance as of 31st October 2019

UNIT	ESR/Training
Radbourne	93%
Hartington	89%

Immediate Life Support

Compliance as of 31st October 2019

UNIT	ESR/Training	Local / Management
Radbourne	80%	87%
Hartington	84%	84%

Positive and Safe

Compliance as of 31 October 2019. As described above the Hartington Unit Training figures does not include the staff that are exempt or excluded.

UNIT	ESR/Training	Local / Management
Radbourne	83%	88%
Hartington	76%	83%

Clinical and Management Supervision 1 May to 30 October 2019

To ensure data is captured to reflect the continued focus for supervision it was agreed to commence the data from 1 May 2019 to ensure compliance was improving as expected.

The target has been adjusted and rounded to take account of the time period being a partial year (181 days) and for maternity leave and any sickness absence recorded on First Care.

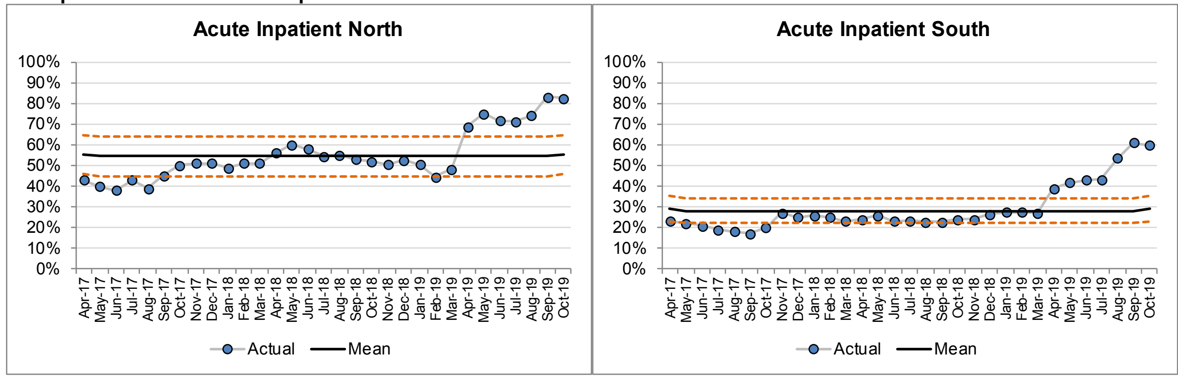
UNIT	Clinical	Managerial
Radbourne	88%	94%
Hartington	92%	93%

The Area Service Manager (ASM) for each unit continues to monitor compliance during weekly supervision with the senior nurses.

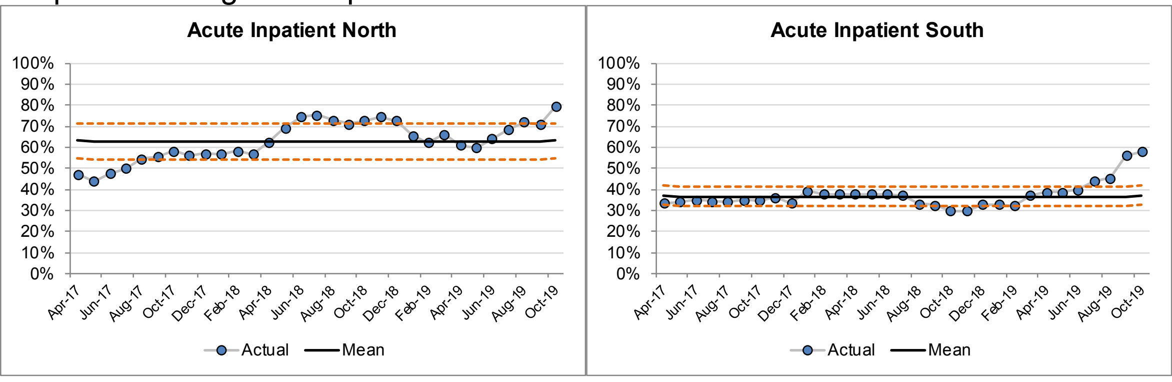
Clinical and Management Supervision Rolling 12 Month

Due to the low level of compliance for supervision prior to 1 May 2019 the rolling 12 month data continues to show non-compliance against the 85% target (graphs 1 and 2). What can be seen, however, is an upward trajectory for both management and clinical supervision:

Graphs 1 Clinical Supervision



Graphs 2 Managerial Supervision



Innovative Practice

The acute services transformation team continue to look at innovative practice to enhance patient care, support carers and improve colleague experience. Some of the innovations the team have been introducing are:

- "One out all out": implemented as part of the "you said, we did" initiative. Staff and patients reported that they would like time with staff that was dedicated. Every day for one hour all staff stop doing 'tasks' and make themselves available to patients. This can include carrying out 1:1 care plan sessions with patients, a therapeutic activity or anything else that patients may choose to do. This is very early in its development and will be evaluated in January 2020.

- Section 17 leave feedback: The team are currently implementing the option for patient and carers to complete a feedback form upon returning from leave. These then form part of the review of leave within the patients ward round taking into account carers views.

- Red folders: Patients are offered a red folder in which to keep care plans and other information about themselves. This includes a person-centred 'all about me' document.

- Midday mindfulness: This started on one ward and now takes place on two wards. Staff and patients join in on this activity.
- Weekly staff updates: Newsletters are completed each week for staff working within the acute services that is relevant and specific to them. This is part of the "you said, we did" for staff.

- Clinical Matrons: Two matrons have been recruited into post to add greater clinical leadership and oversight for the two units. They will be leading on clinical practice and developments as we continue on our transformation journey.

6. Acute Inpatient Operational Report (not contained in Transformation Plan)

Out of Area Placements

The team understand the distress that can be caused for patients and families when placed miles from home and aim at all times to place patients as close to home as possible. However, there are times when due to no beds being available on the acute wards out of area placements will be sought. The team review placements daily of all patients who are placed out of area to repatriate them as quickly as possible back to their local community.

DHCFT discuss the use of leave beds and aim to utilise clinically safe leave beds to admit into. A safe bed is one where a patient may have had two or more successful leaves home and may be on extended leave prior to discharge.

There are occasions that patients may require detention under the Mental Health Act in a Psychiatric Intensive Care Unit (PICU). A PICU is designed to offer a higher level of environmental and relational security to keep the patient and others safe. DHCFT are not currently commissioned to provide this service so anyone requiring a PICU will be placed out of area.

All patients who are placed out of area receive visits from a member of the DHCFT out of area case managers. It is their role to ensure that patients receive high quality safe care while not directly in our care.

Out of Area – Psychiatric Intensive Care Units (PICU)

Since June 2019 there has been a steady decline in the patients that have been placed in a PICU facility from 23 in June to an average of eight patients in October. Part of the repatriation process is for patients to be admitted to the Enhanced Care Ward or to return to an acute ward where this is clinically appropriate. Due to vacant beds during the summer months DHCFT were able to repatriate patients through these routes.

Out of Area – Acute Placements

While the average number of patients in Out of Area (OOA) acute beds was maintained at eight for July, August and September, October saw an increase in requests for acute beds. There was high demand over the weekends of 4 to 6 October resulting in four patients being placed out of area with a further five patients requiring admission over the weekend 11 and 13 October. This increased the number of OOA acute placements during October to an average of 13 patients at any time.

Throughout October there was a decrease in the number of available safe beds reducing the capacity to return patients from the OOA acute beds.

The Acute Services Management Team have clear systems and processes to ensure the flow of patients is planned to reduce the amount of time patients are out of area and to optimise beds in the acute units:

- Monday morning clinical meetings with ward based consultants, senior nurses, local authority social care workers and Assessment Services
- Daily ward rounds
- Daily senior nurse meetings to discuss patient flow
- Daily Assurance Calls with senior management team to discuss bed availability
- Weekly discussion with case managers, flow coordinators and senior managers

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 5 November 2019

Clinical Service Strategies:
Eating Disorders (All Age) Services; Perinatal Service

Purpose of Report

To receive and agree the next two Clinical Service Strategies created through the Clinically-Led Strategy Development (CLSD) process, those for the Eating Disorders Service(s) and the Perinatal Service.

Executive Summary

The Clinically-Led Strategy Development process has been running since February. The process was designed by a small working group, including Board membership, to maximise the engagement and ownership of frontline clinicians in the development of clinical strategies for each of our eight clinical services in the trust. The aim of the work was to fill the gap between the overarching Trust Strategy and the aims and objectives of individual teams and provide greater coherence and purpose to each service.

Over 500 colleagues from frontline roles, support functions such as finance and estates, alongside a small number of patient and carer representatives have been involved in the development process. The process included a two-day session, interspersed by a week to enable wider engagement from colleagues unable to attend. The products of the sessions were shared widely with all attendees. The products of the sessions were then developed into draft clinical service strategies, which were then shared with participants for comments. The second draft was then shared at specific stakeholder engagement sessions, where a wider group of patients and carers were able to influence the plans, alongside our partners in Local Authorities, the Clinical Commissioning Group (CCG) and the voluntary sector. Further drafts were shared with participants and the Executive Leadership Team (ELT) with comments feeding into the final versions which are attached.

The strategies include a vision of the future service, an outline of the development process, a summary of workforce, estate and Information Management and Technology (IM&T) implications and a more detailed Service Improvement Plan to deliver the strategy.

Each development within the Service Improvement Plan has come directly from ideas developed through the CLSD sessions, the NHS Long-term Plan for Mental Health or the Stakeholder sessions and each link in to a Building Block within the Trust Strategy.

Following the agreement of the Older Adults and Working Age Adults strategies in October and the Eating Disorders and Perinatal Strategies being presented today, the Forensic and Rehab, Substance Misuse and Children's Strategies will come to Board in December, with Learning Disabilities coming to Board in February. The Learning Disabilities (LD) Strategy is coming to Board later than originally planned to ensure that the stakeholder sessions are fully accessible to people with LD.

A Clinical Services Strategies Transformation Board will be established in November to oversee and assure delivery of the Service Improvement Plans by working groups established for each of the eight service areas. This is a month later than originally planned, due to scheduling issues.

Strategic Considerations	
1) We will deliver **great care** by delivering compassionate, person-centred innovative and safe care	X
2) We will ensure that the Trust is a **great place to work** by attracting colleagues to work with us who we develop, retain and support by excellent management and leadership	X
3) We will make the **best use of our money** by making financially wise decisions and will always strive for best value to make money go further	X

Assurances

- The overarching CLSD process was designed by a small working group including Exec and Non-exec Board members.
- Board has received informal updates on progress and emerging themes from the sessions at Board Development sessions in May and June.
- Emerging findings and themes have been shared with those developing our Estates, Workforce and EPR strategies.

Consultation

- Over 500 colleagues from across the Trust have been directly involved in the development of the Clinical Service Strategies. Many more have had their ideas included in the process through wider engagement in the week between the two-day sessions.
- Stakeholder sessions were held with a wider group of patients, carers and our partners in Local Authorities, CCG and the Voluntary Sector, where the service improvement plans were shared and comments received and included within the plans.
- Executive Leadership Team have reviewed a draft of the Strategies and the final draft reflects comments received.

Governance or Legal Issues

- Implementation of the Clinical Service Strategies will require the creation of a Transformation Board with Executive and Non-Executive membership to oversee and assure delivery of the plans.
- A service level working group will be established for each of the strategies to deliver the plans, with membership from Clinical Directors, Clinical Leads and other clinical leaders, alongside service managers and service users. Where existing working groups exist, such as the Older Adults and Dementia Board, these will be utilised.

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

The Clinical Service Strategy for Eating Disorders should have a positive impact on the experience and outcomes of people with eating disorders and their carers. It should have a positive impact on those adults with eating disorders whose BMI currently excludes them from the service.

The Clinical Service Strategy for the Perinatal Service should have a positive impact on people from BME backgrounds as it will use monitoring data to assess access from particular communities and then ensure future access is equitable.

It is not envisaged that the service improvements detailed in the two strategies would have adverse effects on people with any of the nine protected characteristics.

The Clinical Services Strategies Transformation Board will need to ensure that the implementation of each of the service improvement plans does not adversely impact on people with any of the nine protected characteristics and that the potential benefits to some groups are realised.

Recommendations

The Board of Directors is requested to:

1) Agree the Clinical Service Strategies for Eating Disorders and Perinatal Services
2) Note the process undertaken to develop the strategies and the extent to which they have been developed by colleagues in frontline service delivery roles.
3) Note the need for working groups established at clinical service level, reporting to the Clinical Services Strategies Transformation Board, to lead implementation of the service development plans and the importance of leadership in this process of Clinical Directors, Clinical leads and other clinical leaders in delivering

Report presented by: **Gareth Harry**
Director of Business Improvement and Transformation

Report prepared by: **Gareth Harry**
Director of Business Improvement and Transformation

EATING DISORDERS (All Ages) CLINICAL SERVICE STRATEGY 2019-2022

Introduction

The Eating Disorders (All Ages) Service Strategy has been developed in line with the DHcFT values, that by putting our people first, our colleagues, we are able to best meet the needs of the people who use our services. The process undertaken to develop this strategy prioritised the engagement of as wide a number of clinical colleagues working in the service as possible.

Over the same period, DHcFT refreshed its Trust Strategy to focus on three main strategic objectives:

- To provide Great Care;
- To be a Great Place to Work and;
- To make Best Use of our Money.

Underneath each of these strategic objectives, there are a number of building blocks which need to be in place to enable the objectives to be delivered. Each of the improvement ideas contained in this strategy will be linked to these Building Blocks.

Altogether there are nine separate Pathway Strategies that have been developed through this process. The aim is that general themes and common across the strategies and overlapping issues will be linked and where improvement ideas across pathways can be progressed, they are undertaken together in an open and collaborative way, building trust and understanding between services.

The initial development work of the strategy focussed mainly on frontline clinical staff in each of the pathway areas, with some patient and carer representatives at each of the session. The process included a stakeholder session, where an initial draft of the strategy could be shared, tested and improved through engagement with our commissioners, Local Authority and Voluntary Sector partners and a wider group of patients and carers.

Why develop clinically led pathway and service level strategies?

The Trust operates in an ever changing health and care environment. The NHS Long-term Plan, published in January 2019 outlined a number of commitments and improvements required of health systems alongside significant additional investments into mental health services. There is a new specific target within the NHS Long Term Plan for this service, that by March 2021, 95% of Children and Young People receive NICE concordant treatment within a maximum of four weeks from first contact with a health professional and one week for urgent cases.

Growth in resource available to health systems are unlikely to keep up with the growth in population or demand increases that we have seen in the recent past. The pressures on local authority funding means that social care availability is more limited than in the past and children's services across the City and County are under increasing pressure.

All of which, means that if Eating Disorder services are to continue to meet the needs of people needing the service, their families friends and carers in Derbyshire, services will need to find ways to continuously improve, to be as efficient and as effective as possible.

The methodology undertaken in developing these strategies enabled frontline clinicians to come together to identify and develop improvement ideas that could be delivered over the next three to five years, supporting the building blocks of the Trust's overall strategy and providing a sustainable base for the provision of services.

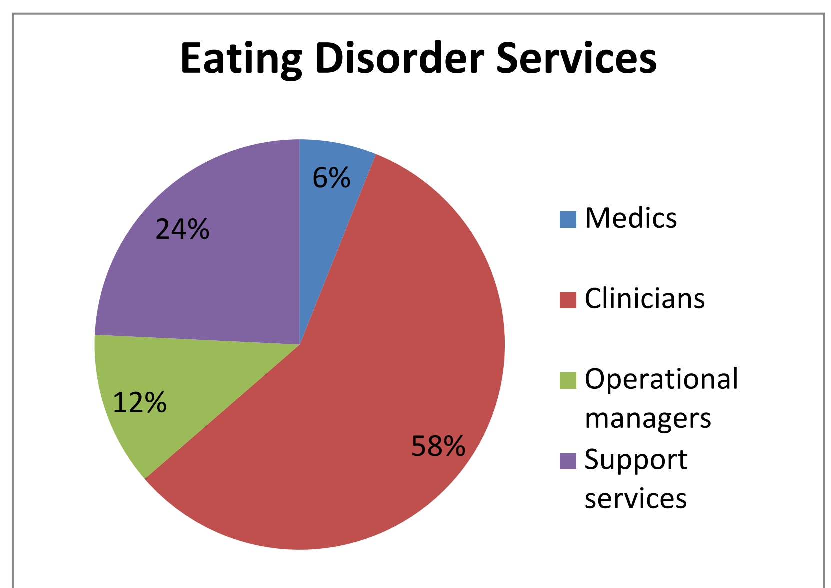
Development Process

Each of the service areas went through the same process of developing their service improvement ideas and strategic development:

- Two day development sessions, held a week apart with intervening time committed for seeking back to base input from team members unable to attend the sessions and feedback
- The direction of travel and the improvement ideas were led by clinical colleagues from all disciplines
- Service user and carer representation
- Support services such as finance, estates, HR, etc., were also engaged with the process.

N.B. When this document uses the term 'clinician', this refers to all our colleagues who are working at the point of care, therefore allied health professional, doctors, nurses, psychologists, and those without a formal professional qualification.

Percentage breakdown of attendances at strategy development sessions



The sessions provided the opportunity for clinicians to come together to acknowledge the good work already being done but also to build on this good work to look at where services could be improved. Time between the development days was built in, specifically to enable the learning from Day 1 to be taken back to the wider teams for discussion and collation of feedback to be put forward for inclusion into the second day and the strategy.

Attendance from clinicians has been prioritised for the sessions, providing a comprehensive understanding of the issues within each pathway and service area. Attendance from staff in support functions such as finance, HR, estates, etc., provided different perspectives and allowed workforce, estates and other strategic considerations to be part of the process.

The Purpose of the Service

The Eating Disorder Service operates across two separate teams, as part of the Childrens and Central Services Divisions. The services perform well in difficult circumstances and rising demand and both provide the best access they can to patients on the basis on which they are commissioned. An ongoing frustration and clinical concern for the adult service is the limitation placed on them by having a specified BMI level which a person has to fall below, before being able to access the service. Unlike the children's service, with no limit, this means that the service cannot engage with people with eating disorders on a preventative basis earlier in their illness nor work with people whose eating disorder is not related to low-weight.

The team thought through a single, cohesive purpose for the service:

We will work with compassion, commitment, ambition and be resilient. We will connect and engage with the community, service users and carers to get the best results for the people we work with. We will continue to find new, efficient and effective ways of working which will address issues currently being felt by service users, carers and staff.

The current issues the teams wanted to tackle were length of waiting times, staff feeling burnt out, lack of parity between adults and children's services, planning for the future and more collaborative working. We operate in a climate of restricting finances and increase in demand and it is right that we look for continual improvement in any of our services.

During the development days for the strategy, opportunities were identified for possible improvement. In conjunction with the NHS Long-term plan the aim for this strategy is to deliver an efficient and effective service using available resources and utilising our environment to the full. The service wants to continue to find new, efficient and effective ways of working which will address issues currently being felt by service users and staff

The team came up with overarching themes of work where they felt services could be improved:

- Broader use of service user participation in their own care with a structure for it
- Patients integrated in co-production of service changes
- Building value and capacity in clinicians and patients
- Biopsychosocial approach with a broader use of psychological interventions
- Greater training opportunities and potential for vocational skills training for service users
- Career development
- Change management training
- Experts by experience-led training
- Admission avoidance and links into Children & Young People Crisis responses
- Reductions in bed usage of Tier 4 beds for adults and CYP
- Improve links with primary care
- Greater use of data and measurement in team decision making (e.g., Statistical Process Control charts)

- Diagnosis informed pathways, using NICE Guidance
- Reducing unwarranted clinical variation
- Improve communications and links across children's and adults service
- Sharing improvements / expertise and successes
- Improve the Wellbeing of the teams

Ownership, development and implementation of small improvement ideas

During the process of the two development days it became clear that there are a number of small ideas which can be launched without any significant amount of project planning or authorisation.

For instance, using First Steps volunteers within our services, who are often experts by experience. Another simple idea is a light touch contact of either email or telephone call following discharge to avoid the feeling of falling into an "empty, lonely hole".

There is a keen understanding that small ideas do not need approval to happen. Discussions within teams can initiate the start of an idea, which may in turn, develop to a pilot scheme or even a bigger idea which requires more support.

Workforce and Estates Implications

Any move in resources from Tier 4 provision into community provision would require additional space for the accommodation of staff and provision of community and/or Tier 3 inreach services. There is potential within these plans for the colocation of adult and children's services at a locality or cross county level. This would need to be considered as part of any redesign or relocation of community based services. The access time commitments in the Mental Health Long-term Plan will require and increase in workforce. This will require additional accommodation and clinical space to provide a service in.

3-5 Year Service Improvement Plan

Based on the feedback from the wider teams and Day 2 work undertaken by participants, below is an outline Service Improvement Plan of the service improvements the Eating Disorder Services want to develop over the next three to five years. Each of these ideas was developed by teams and individuals within the service. An outline project scope is in place for each of these projects, from the work teams did in their Day 2 session.

Project	Benefits	DHcFT Trust Strategy Building Block	NICE Guidance/ Evidence Base	CLSD Improvement Idea Code(s) and originator(s)	Financial Implication	Estate Implication	Workforce Implication	Outline Timescale
Explore the options and cost/benefits of creating a single all ages ED service (link to BMI project, below). Extend children's services to 24 years of age if required.	Potential economies of scale; Increased staff resilience; Improved transition between children's and adults service when appropriate for the patient.	Improve clinical outcomes	Eating disorders: recognition and treatment NICE guideline [NG69] https://www.nice.org.uk/guidance/ng69	CLSD and stakeholder consultation event.	To be explored	To be explored	To be explored	Options appraisal to be conducted from January 2020 and completed by October 2020.
Training provided to A&E staff and GP practices on ED awareness and access and discharge processes	Increase knowledge of service provision across multi-services; Reduce wrong diagnosis when presented with CPD signs; Reduce inappropriate referrals. Support the GP to care for patient following discharge from secondary care services.	Improve clinical outcomes	Eating disorders: recognition and treatment NICE guideline [NG69] https://www.nice.org.uk/guidance/ng69	B25, S22 and stakeholder consultation event	Training costs	None	None known	From April 2020
Remove BMI	Wider range of	Improve	Eating disorders:	B2, B3, B37	Will require	None known	Will require	Business

Project	Benefits	DHcFT Trust Strategy Building Block	NICE Guidance/ Evidence Base	CLSD Improvement Idea Code(s) and originator(s)	Financial Implication	Estate Implication	Workforce Implication	Outline Timescale
criteria as a threshold for the adult service	skills and interventions available for patients; Improvement in staff wellbeing; Improved recruitment and retention; Reduce transition points between services Reduced inpatient referrals and admissions.	access to our services	recognition and treatment NICE guideline [NG69] https://www.nice.org.uk/guidance/ng69		“invest to save” Business Case to STP MH Delivery Board		enhanced staff teams to meet increased threshold.	case ready for consideration for 20/21 MHIS
Work within new regional collaboratives in CAMHS and ED Tier 4 to maximise opportunity to increase community investment to reduce Tier 4 bed base.	Tier 4 bed base reduced; More people supported in the community	Work with partners to achieve best value across Derbyshire			May result in increased investment in community teams as Tier 4 bed bases reduce	May require additional clinic space	May require enhanced staff teams.	From October 2019
95% of Children and Young People receive NICE concordant treatment within a maximum of four weeks from first contact with a health professional and one week for urgent cases.	Shorter waiting times for CYP; Greater awareness of ED;	Improve access to our services	Eating disorders: recognition and treatment NICE guideline [NG69] https://www.nice.org.uk/guidance/ng69		NHSE/I Transformational Monies and MHIS investments available	Will require additional clinic space	Will require enhanced staff teams and recruitment	By March 2021.
Nutrition Education for those with ED	Improve chance of recovery;	Improve clinical	Eating disorders: recognition and	B38	Limited	None	Possibly increased by one	By March 2021

Project	Benefits	DHcFT Trust Strategy Building Block	NICE Guidance/ Evidence Base	CLSD Improvement Idea Code(s) and originator(s)	Financial Implication	Estate Implication	Workforce Implication	Outline Timescale
and widen the service to include all cases of Anorexia Nervosa (see above link to BMI)	Increase self-care and resilience.	outcomes	treatment NICE guideline [NG69] https://www.nice.org.uk/guidance/ng69				member of staff. Currently there is some capacity to accommodate this increase in service.	
Dietetic support from ED team to First Steps Groups, including people above current BMI threshold	More people with knowledge base and capacity to answer diet related questions; Empower individuals to make changes if they are not being seen by the NHS; Increase self-care and resilience	Improve patient and carer experience	Eating disorders: recognition and treatment NICE guideline [NG69] https://www.nice.org.uk/guidance/ng69	B36	Potential need for Dietician role within the service	None	Specialist dietician	By March 2021
Managing inappropriate referrals and put clear criteria in place (link with GP training, above).	Release time taken up by inappropriate referrals	Improve access to our services	Eating disorders: recognition and treatment NICE guideline [NG69] https://www.nice.org.uk/guidance/ng69	S20	None	None	None	From January 2020
Deliver new service for bulimia and higher BMI.	Prevention of ill health and other presenting conditions from people with Bulimia; Savings in physical healthcare spends.	Improve clinical outcomes	Eating disorders: recognition and treatment NICE guideline [NG69] https://www.nice.org.uk/guidance/ng69	S4	Pilot achievable within current resource If successful, further financial planning is required	None	None currently	From March 2020
Use experts by experience as volunteers in group work	Add a valid direct experience to group sessions; Engage and	Improve patient and carer experience	Service user experience in adult mental health services	S23	Expenses required for volunteers.	None	Recruitment and training of Experts by Experience	From March 2020

Project	Benefits	DHcFT Trust Strategy Building Block	NICE Guidance/ Evidence Base	CLSD Improvement Idea Code(s) and originator(s)	Financial Implication	Estate Implication	Workforce Implication	Outline Timescale
	support current service receivers; Develop skills and confidence of service receivers to provide peer support		Quality standard [QS14] https://www.nice.org.uk/guidance/qs14					
Increase community support	Reduce length of stay by keeping the family together via community support; Daily support provided at Trust site(s). Reduction in admission costs.	Improve clinical outcomes		B24, B19	Invest to save business case required, linked to regional collaboratives on CAMHS and ED Tier 4 beds.	May require more clinical input on trust sites	May require enhanced teams and recruitment	Business case ready for consideration by regional collaboratives during 20/21.
Produce a Welcome pack for people entering the services. Accessible information about services provided at the beginning of care. This will help manage expectations and give clarity to our offer.	Greater awareness of the service; Greater understanding about what the aims of the care is at the start of the package; Aids active engagement with service user at the outset; Encourages jointly developed care plans.	Improve patient and carer experience		S25	Printing costs only	None	Small amount of admin time to produce the packs.	From January 2020
Partnership working with CMHTs, teams and neighbourhoods	Avoidance of conflict between services; More co-ordinated service presented to service receivers;	Improve patient and carer experience	Eating disorders: recognition and treatment NICE guideline [NG69] https://www.nice.org.uk/guidance/	S15 and S12	None	None	Management capacity to increase active engagement with other services within DHcFT	Immediate start

Project	Benefits	DHcFT Trust Strategy Building Block	NICE Guidance/ Evidence Base	CLSD Improvement Idea Code(s) and originator(s)	Financial Implication	Estate Implication	Workforce Implication	Outline Timescale
	Easier transitions between services will improve care.		ng69					
Waiting Well information giving more self-help information.	To add to the Welcome Pack initiative above it would provide another way of supporting patients whilst they wait for their case to be allocated.	Improving patient experience supporting People First and Honest values.	The Trust's Waiting Well Policy	Stakeholder consultation event	Development time and costs of website or printing costs	None	IT workforce time to complete the package	Conclude within 3-6 months
Increased signposting to alternative support services and charities	A flexible approach to caring and supporting patients and carers by providing choices. Also available following discharge.	Improving patient and carer experience.		Stakeholder consultation event	None	None	IT workforce time to develop the webpage	Conclude within 3 months
Provision of a triage service	Assisting in the appropriate signposting, waiting well and managing expectations for patients and carers.	Supporting clinical staff and improving patient and carer experience		Stakeholder consultation event	A business case would need to be developed and costs identified	None	Time investment for development and potential creation of triage post.	Within the year
Increase in psychological services support	Increase the access to more services as the need arises	People First and widening the support services we provide	Eating disorders: recognition and treatment NICE guideline [NG69] https://www.nice.org.uk/guidance/ng69 Eating disorders	Stakeholder consultation event	Increase demand on psychological services costs	Possible clinic space required	Increase in psychological staff demand.	Within a year

Project	Benefits	DHcFT Trust Strategy Building Block	NICE Guidance/ Evidence Base	CLSD Improvement Idea Code(s) and originator(s)	Financial Implication	Estate Implication	Workforce Implication	Outline Timescale
			Quality standard [QS175] https://www.nice.org.uk/guidance/qs175					

Governance

The improvement projects above will be delivered by a new Eating Disorders Working Group. This Group will be accountable to the Clinical Service Strategies Transformation Board, which will be established in September 2019 to oversee and assure the delivery of all the Clinical Service Strategies. The Transformation Board will have Executive and Non-Executive Trust Board representation and report directly to the Trust Board.

PERINATAL MENTAL HEALTH CLINICAL SERVICE STRATEGY 2019-2022

Introduction

The Perinatal Mental Health Service Strategy has been developed in line with the DHcFT values, that by putting our people first, our colleagues, we are able to best meet the needs of the people who use our services. The process undertaken to develop this strategy prioritised the engagement of as wide a number of clinical colleagues working in the service as possible.

Over the same period, DHcFT refreshed its Trust Strategy to focus on three main strategic objectives:

- To provide Great Care;
- To be a Great Place to Work and;
- To make Best Use of our Money.

Underneath each of these strategic objectives, there are a number of building blocks which need to be in place to enable the objectives to be delivered. Each of the improvement ideas contained in this strategy will be linked to these Building Blocks.

Altogether there are nine separate Pathway Strategies that have been developed through this process. The aim is that general themes and common across the strategies and overlapping issues will be linked and where improvement ideas across pathways can be progressed, they are undertaken together in an open and collaborative way, building trust and understanding between services.

The initial development work of the strategy focussed mainly on frontline clinical staff in each of the pathway areas, with some patient and carer representatives at each of the session. The process included a stakeholder session, where an initial draft of the strategy could be shared, tested and improved through engagement with our commissioners, Local Authority and Voluntary Sector partners and a wider group of patients and carers.

Why develop clinically led pathway and service level strategies?

The Trust operates in an ever changing health and care environment. The NHS Long-term Plan, published in January 2019 outlined a number of commitments and improvements required of health systems alongside significant additional investments into mental health services. There is a new specific ambition within the NHS LTP for Mental Health, which states that by 2023/24 at least 66,000 women (approx. 5% of births) with moderate to severe perinatal mental health difficulties will have access to specialist community care from pre-conception to 24 months after birth with increased availability of evidence-based psychological therapies.

Growth in resource available to health systems are unlikely to keep up with the growth in population or demand increases that we have seen in the recent past. The pressures on local authority funding means that social care availability is more limited than in the past and children’s services across the City and County are under increasing pressure.

All of which, means that if Perinatal services are to continue to meet the needs of women, their children and their families in Derbyshire, then they will need to find ways to continuously improve, to be as efficient and as effective as possible.

The methodology undertaken in developing these strategies enabled frontline clinicians to come together to identify and develop improvement ideas that could be delivered over the next three to five years, supporting the building blocks of the Trust's overall strategy and providing a sustainable base for the provision of services.

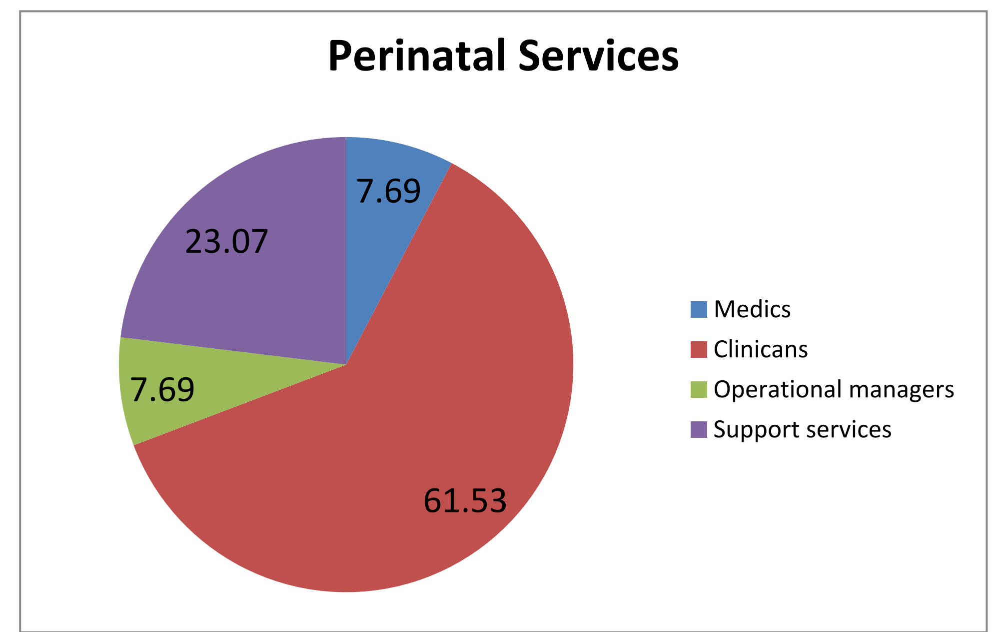
Development Process

Each of the service areas went through the same process of developing their service improvement ideas and strategic development:

- Two day development sessions, held a week apart with intervening time committed for seeking back to base input from team members unable to attend the sessions and feedback
- The direction of travel and the improvement ideas were led by clinical colleagues from all disciplines
- Service user and carer representation
- Support services such as finance, estates, HR, etc., were also engaged with the process.

N.B. When this document uses the term 'clinician', this refers to all our colleagues who are working at the point of care, therefore allied health professional, doctors, nurses, psychologists, and those without a formal professional qualification.

Percentage breakdown of attendances at strategy development sessions



The sessions provided the opportunity for clinicians to come together to acknowledge the good work already being done but also to build on this good work to look at where services could be improved, in line with best evidence and best practice. Time between the development days was built in, specifically to enable the learning from Day 1 to be taken back to the wider teams for discussion and collation of feedback to be put forward for inclusion into the second day and the strategy.

Attendance from clinicians has been prioritised for the sessions, providing a comprehensive understanding of the issues within each pathway and service area. Attendance from staff in support functions such as finance, HR, estates, etc., provided different perspectives and allowed workforce, estates and other strategic considerations to be part of the process.

The Purpose of the Service

The team thought through a single, cohesive purpose for the service:

“We are proud of our compassion, commitment, empathy, ambition and resilience. We demonstrate the Trust Values through the core of our pathway in how we connect and engage with the mums, partners and families with proven successful outcomes”.

The Perinatal Services is a high performing team and already provides a high quality service with a lot of things they are right to be proud of. The service is especially proud of the long standing Royal College of Psychiatrists accreditation of our services, one of only four in the country, ensuring stability in improving the wellbeing of women and their families. The service has expanded rapidly in the last two years following investment to expand the Community Team in the north of the County.

During the development days for the strategy, opportunities were identified for possible improvement. In conjunction with the NHS Long-term plan the aim for this strategy is to deliver an efficient and effective service using available resources and utilising our environment to the full. The service wants to continue to find new, efficient and effective ways of working which will address issues currently being felt by service users and staff. Issues such as length of waiting lists, use of our services by out of area mums, planning for the future and more collaborative working with other pathways.

The team came up with overarching themes of work where they felt services could be improved:

- A review of our signposting processes to ensure that the system is robust, improving the flow through of the service.
- Career development and support to ensure recruitment and retention of skilled and dedicated staff
- Sharing knowledge and ideas across the Trust.
- Active promotion of the services to improve understanding of the integration possibilities of this service with other services provided by the Trust.
- Community engagement, networking and use of social media to promote potential issues faced by new mothers to improve engagement and understanding of people’s needs and the service.

- Inclusion of partners and family in the recovery process.
- Use of Skype and other digital contacts.
- Rotation of staff around the service across the teams.
- Seek opportunities to improve the estate.
- Improve the ability to transport mums to community activities and appointments in the most efficient and costly manner.

Ownership, development and implementation of small improvement ideas

During the process of the two development days it became clear that there are a number of small ideas which can be launched without any significant amount of project planning or authorisation. Ideas such as a buddy-learning system, where members of staff can shadow another member of staff to increase the knowledge and understanding of other roles. The benefits of this increases awareness, fulfilment and job satisfaction, support of services and progression opportunities for staff. The teams also felt that it should do more to raise its profile within the Trust, in schools and other organisations, with families and carers. Creatively writing a bedtime story for siblings was an idea which the team undertook to start immediately, benefiting both the writer and the immediate families. There is a keen understanding that small ideas do not need approval to happen. Discussions within teams can initiate the start of an idea, which may in turn, develop to a pilot scheme or even a bigger idea which requires more support.

Estates and workforce implications

The NHS Long-term plan envisages a further expansion in activity and Perinatal Teams. This is likely to have a marginal impact on the Derbyshire service, as it has already undergone a significant expansion in our Community Services and the service is already providing access close to the national ambition. The current locations and estate of the Community Teams will need to be taken into account in the light of this likely marginal expansion in workforce.

With any future changes to the rest of the Acute Inpatient Services at the Radbourne Unit, the location of The Beeches, the Tier 4 inpatient perinatal facility will need to be taken into account. If there were to be any change in location, the service would need to be at a site close to the UHDB Maternity/ Obs and Gynae services.

3-5 Year Service Improvement Plan

Based on the feedback from the wider teams and Day 2 work undertaken by participants, below is an outline Service Improvement Plan of the service improvements the Perinatal MH Service wants to develop over the next three to five years. Each of these ideas was developed by teams and individuals within the service. An outline project scope is in place for each of these projects, from the work teams did in their Day 2 session.

For each idea, there is a reference to NICE Guidelines or other national expectations where available. Some ideas are more locally driven, and will be explored using Quality Improvement methodologies, e.g. the Institute for Health Improvement Model for Improvement, or Lean. This is to ensure a robust structured and evaluated approach, led by the voices of those in our care, their families, and colleagues working at the point of care, as supported by The Kings Fund document 'Quality improvement in mental health' (https://www.kingsfund.org.uk/publications/quality-improvement-mental-health). This is also in line with the Trust's Quality Improvement Strategy

NICE Guidelines will be a helpful baseline for our alignment against national best practice, and NICE Quality Standards will be a helpful way of prioritising and measuring specific improvement responses to any gaps, again underpinned by Quality Improvement methodologies.

Project	Benefits	DHcFT Trust Strategy Building Block	NICE Guidance/ Evidence Base	CLSD Improvement Idea Code(s) and originator(s)	Financial Implication	Estate Implication	Workforce Implication	Outline Timescale
Active promotion of the service and the importance of maternal MH, using social media, networks, trust communication methods, midwifery and HVs.	Increase in referrals; More mothers accessing the service; Greater awareness of the service; Greater awareness of the MH needs of mothers.	Improve access to our Services	Antenatal and postnatal mental health: clinical management and service guidance https://www.nice.org.uk/guidance/cg192		Increase in referrals may require additional capacity	Limited	Time committed to promote the service	From October 2019

Project	Benefits	DHcFT Trust Strategy Building Block	NICE Guidance/ Evidence Base	CLSD Improvement Idea Code(s) and originator(s)	Financial Implication	Estate Implication	Workforce Implication	Outline Timescale
Expand the capacity of the service to enable mothers of 5% of all births in Derbyshire to be able to access the service in line with LTP Target, including potential for Maternity Outreach Clinics.	More mothers accessing the service; Greater awareness of the service;	Improve access to our services			Increase in demand may require additional capacity. Transformational/ MHIS investment will be available	Limited	Need for expanded workforce to meet additional demand.	From October 2019 and by April 2021. 10% of births by 22/23
Increase psychological and other therapeutic input/ approaches into the teams	More effective treatments for patients; Alternatives to prescribing; Shorter LoS; Admissions reduced.	Improve clinical outcomes	Antenatal and postnatal mental health Quality standard [QS115], https://www.nice.org.uk/guidance/qs115		Non-recurrent transformational monies from NHSE/I for staff training in 2019/20	Limited	Expanded workforce/ teams with wider skills.	From October 2019 and by April 2020.
Prepare for the Derbyshire inpatients service to play a role as the lead provider across the East Midlands in Wave 2 of New Care Models	Improved recruitment and retention; Clinical leadership encouraged and motivated; Ability to influence clinical models and best practice across the region.	Work with partners to achieve best value across Derbyshire			Will require additional management resource, potentially from NHSE and from other regional partners	Limited	Limited	From initiation of Wave 2 in April 2020.
Assess and monitor access rates from BME and other groups with protected characteristics	Ensure equity of access; Inform focussed communications with particular communities	Improve access to our services	Promoting health and preventing premature mortality in black, Asian and other minority ethnic		Non-recurrent transformational monies from NHSE/I for this work in 2019/20.	Limited	Limited	From October 2019 and ongoing

Project	Benefits	DHcFT Trust Strategy Building Block	NICE Guidance/ Evidence Base	CLSD Improvement Idea Code(s) and originator(s)	Financial Implication	Estate Implication	Workforce Implication	Outline Timescale
			groups Quality standard [QS167]. https://www.nice.org.uk/guidance/qs167					
Inclusion of partners and family in the recovery process	Supportive environment for inpatients; Shorter LoS; Supportive discharge and resilient community support.	Improve patient and carer experience	Antenatal and postnatal mental health: clinical management and service guidance https://www.nice.org.uk/guidance/cg192		Potential benefits from shorter LoS and admission avoidance from resilient discharges	Limited	Limited	From October 2019 and ongoing
Digital contacts in community services	Alternative to face to face; Travel savings; Time and capacity released; Reduced DNAs;	Achieve best value from future investments and current resources	NHS Long Term Plan https://www.longtermplan.nhs.uk/wp-content/uploads/2019/07/nhs-mental-health-implementation-plan-2019-20-2023-24.pdf		Potential avoidance of investment to meet additional demand; Potential savings from reduced travel costs.	Potential for new estate planning to respond to new model of delivery	Released time to care from avoided DNAs.	Piloting in Autumn 2019 with potential roll out from 19/20 onwards.
Digital contacts for inpatients	Closer contact with friends and families for patients from outside Southern Derbyshire; Shorter LoS.	Improve patient and carer experience	NHS Long Term Plan https://www.longtermplan.nhs.uk/wp-content/uploads/2019/07/nhs-mental-health-implementation-plan-2019-20-2023-24.pdf		Potential benefits from shorter LoS.	Limited	Limited.	From January 2020.
Rotation of	Greater sense of	Attract new			Limited	Limited	Potential	From October

Project	Benefits	DHcFT Trust Strategy Building Block	NICE Guidance/ Evidence Base	CLSD Improvement Idea Code(s) and originator(s)	Financial Implication	Estate Implication	Workforce Implication	Outline Timescale
students around the whole service	integrated service across inpatient and community service; Learning shared across the service; Recruitment improved.	colleagues					improvement in recruitment	2020.
Improve waiting area at The Beeches	Improved environment for outpatients and friends and family.	Improve patient and carer experience	Service User Experience in Adult Mental Health: https://www.nice.org.uk/guidance/cg136 https://www.nice.org.uk/guidance/qs14		Potential inclusion in capital programme	Potential inclusion in capital programme	Limited	
Explore opportunities to develop services as part of any major redevelopment of the Radbourne Unit Estate	Retain accreditation; Retain essential close relationship with Maternity Unit;	Improve our estate to support new models of care	DHCFT Estates Strategy		Potential capital investment in any major development	Major development	May result in change of location of the service	From 2021 onwards.
Improve ability of mums to access community support and activities through improved access to transport and other constraints	Reduce barriers to recovery for mothers; More effective community support.	Improve clinical outcomes			May require additional expenditure on transport	Limited	Limited	From April 2020.
Quicker response	Waiting lists are	Improved		Stakeholder	None	None	Potential	Within 3

Project	Benefits	DHcFT Trust Strategy Building Block	NICE Guidance/ Evidence Base	CLSD Improvement Idea Code(s) and originator(s)	Financial Implication	Estate Implication	Workforce Implication	Outline Timescale
at point of crisis	too long and improved response times are required, especially in the cases of still births. More information in an easily accessible way when communication is difficult.	clinical outcomes and patient experience.		consultation event			increase in demand on capacity.	months
Share previous mental health history appropriately and co-morbidity. Specific attention to high functioning individuals who mask their condition.	To ensure the availability of the appropriate support as necessary.	Improving patient and their carers experience and improving outcomes with early intervention	Antenatal and postnatal mental health: clinical management and service guidance https://www.nice.org.uk/guidance/cg192	Stakeholder consultation event	None	None	None	Immediately
Comprehensive information on the website along with signposting	Enable comprehensive information to be accessible and services signposted.	Improving patient experience.		Stakeholder consultation event	None	None	Some development time for the website	Within 3 months
Joint working partnerships with SANDS (Stillbirth and neonatal death charity)	Sharing expertise and information to support mothers and their carers	Improving patient experience		Stakeholder consultation event	None	None	None	Immediately
Identify who is in a mother's support system. To ask	Case notes should include what support the mother	Improved experience for mothers	Antenatal and postnatal mental health: clinical	Stakeholder consultation event	None	None	None	Immediately

Project	Benefits	DHcFT Trust Strategy Building Block	NICE Guidance/ Evidence Base	CLSD Improvement Idea Code(s) and originator(s)	Financial Implication	Estate Implication	Workforce Implication	Outline Timescale
the patient who it is that would support them as it might not necessarily be their partner	has in place prior to pregnancy and build on this. A 'want' and 'don't want' list as coping strategies	and her carers.	management and service guidance https://www.nice.org.uk/guidance/cg192					
Working closely with midwives and sharing knowledge including Voluntary Community & Social Enterprise services (VCSE) on offer	Wider knowledge of professional services will support both clinical staff in conducting their work and also the mothers who are in need of the information.	Improved clinical outcomes, clinical staff support and patient/carer experience		Stakeholder consultation event	None	None	None	Immediately

Governance

The improvement projects above will be delivered by a new Perinatal Services Working Group. This Group will be accountable to the Clinical Service Strategies Transformation Board, which will be established in October 2019 to oversee and assure the delivery of all the Clinical Service Strategies. The Transformation Board will have Executive and Non-Executive Trust Board representation and report directly to the Trust Board.

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 5 November 2019

Learning from Deaths - Mortality Report

Purpose of Report

The 'National Guidance on Learning from Deaths' requires each Trust to collect and publish specified information on a quarterly basis. This report covers the period 1 April 2019 to 30 June 2019. This report was due to be considered by the Quality Committee in September 2019, but was deferred to the October meeting.

Executive Summary

- From 1 April 2019 to 30 June 2019, the Trust received 460 death notifications of patients who have been in contact with our service.
- There have been two inpatient deaths since 1 April 2019, these have been expected deaths.
- 1 April 2019 to 30 June 2019, the Mortality Review Group reviewed 27 deaths. These reviews were undertaken by a multi-disciplinary team and it was established that of the 27 deaths reviewed, 26 have been classed as not due to problems in care. One was referred to the Serious Incident Group and is currently under further investigation.
- The Trust has reported four Learning Disability deaths.
- There is very little variation between male and female deaths; 248 male deaths were reported compared to 212 female.
- During collection of the disability data it became apparent that when clinicians were choosing 'memory or ability to concentrate learn or understand, as a disability this was being categorised by the system as a 'learning disability'. Therefore the PARIS team to ensure that it is clearer for clinicians and to improve accuracy of data, the current option of "Learning Disability" will be changed to reflect the fact that it has historically included dementia. This will then be end dated and a new option of "Learning Disability" has now been added. A new code has been added specifically to allow clinicians to pick dementia. This change will allow the two disabilities to be independently analysed moving forward.
- Good practice identified through case note reviews is fed back to clinicians involved.
- The case note rota for medics was reviewed by the Executive Serious Investigation Group on 26 September 2019 and recommended further consideration of the extension of an organised rota for the north and commencement of a rota for the south, to the Trust Management Team (TMT) to establish an agreed process for consultant cover north and south.

Strategic Considerations	
1) We will deliver **great care** by delivering compassionate, person-centred innovative and safe care	x
2) We will ensure that the Trust is a **great place to work** by attracting colleagues to work with us who we develop, retain and support by excellent management and leadership	
3) We will make the **best use of our money** by making financially wise decisions and will always strive for best value to make money go further	

Assurances

- This report provides assurance that the Trust is following recommendations outlined in the National Guidance but that there is a bigger picture to consider related to developing a Safety Culture.
- From April 2019 to 30 June 2019, the Trust has received 460 death notifications of patients who have been with our service within the previous six months. 38 (8.26%) were reported through our DATIX system of which 9 (1.95%) warranted further investigation.
- All inpatient deaths are reviewed and quarterly reports received by the Executive Leadership Team (ELT) in addition to coroner's inquest updates. Medical availability for mortality reviews has improved.
- This report was reviewed by the Quality Committee in October.

Governance or Legal Issues

There are no legal issues arising from this Board report.

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

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

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

There is recognition that nationally mental health services have been under-resourced for decades and that this is now being addressed through commissioning and contract arrangements. The 'bigger picture' of safety culture requires a strategic approach which is being addressed by the Board.

Recommendations

The Board of Directors is requested to accept this Mortality Report as assurance of our approach and note that it is required to be published on the Trust's website in line with national guidance.

Report presented by: **Dr John R Sykes**
Medical Director

Report prepared by: **Dr John R Sykes**
Medical Director

Rachel Williams
Lead Professional for Patient Safety and Patient Experience

Nosheen Asim
Mortality Technician

Learning from Deaths - Mortality Report

1. Background

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

The Guidance has outlined specific requirements in relation to reporting requirements. From April 2017, the Trust is required to collect and publish each quarter, specified information on deaths. This is through a paper and Board item to a public Board meeting in each quarter, to set out the Trust's policy and approach (by end of Q2) 2017 - 2018 and publication of the data and learning points by Quarter 3 2017 - 18. The Trust should include the total number of inpatient deaths and those deaths that the Trust has subjected to case record review. Of these deaths, subject to review, we are asked to consider how many of these deaths were judged more likely than not to have been due to problems in care.

The report presents the data for the 1st Quarter of year 2019 - 20 from 1 April 2019 to 30 June 2019.

2. Current Position and Progress

- As a way of accessing a national database for cause of death, our application for NHS Digital continues, and the Trust is currently awaiting an outcome. This continues to be a slow process, to ensure that the Trust meets all of NHS Digital legal requirements.

- A northern consultant mortality meeting rota has been in place since November 2018, organised by Dr Sugato Sarkar. The rota for November 2018 to the end of October 2019 was distributed to the consultants in October 2018. On the whole the rota has worked well and the majority of the meetings have taken place, but unfortunately several meetings have been cancelled either the day before or on the actual meeting date. When the next rota is available for distribution to the consultants it will also be distributed to their medical secretaries to ensure that we have consultant cover for the meetings. Despite several attempts to put a rota in place for the southern consultants we have not managed to facilitate this to date. The case note rota was reviewed by the Executive Serious Investigation Group on 26th September 2019 recommended further consideration of this issue through TMT to establish an agreed process for consultant cover north and south.

- Regular audits continue to be undertaken to ensure compliance with policy and procedure and any necessary changes made.

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

3. Data Summary of all Deaths

Note that inpatients and LD are based upon whether the patient has an open inpatient or LD referral at time of death.

	April 2019	May 2019	June 2019
Total number of deaths per month	178	168	116
Inpatient deaths	1	1	0
Learning Disability Referral Deaths	0	4	4

The table above shows information for 1 April 2019 to 30 June 2019.

Correct as at 30 June 2019

From 1 April 2019 to 30 June 2019, the Trust received 460 death notifications of patients who have been in contact with our service.

There have been two inpatient deaths since 1 April 2019, these have been expected deaths.

4. Review of Deaths

1 April 2019 to 30 June 2019:

Total number of Deaths from 1 April 2019 – 30 June 2019 reported on Datix	38 (of which 19 are reported as "Unexpected deaths"; 13 as "Suspected deaths"; and 6 as "Expected - end of life pathway")
Number reviewed through the Serious Incident Group	36 (0 was not required to be reviewed by SI group and 2 pending for a review).
Number investigated by the Serious Incident Group	9 (0 did not require an investigation and 27 pending for a review)
Number of Serious Incidents closed by the Serious Incident Group?	9 (27 currently opened to SI group and 2 pending for a review, as at 26 June 2019)

The Trust has recorded two inpatient deaths April 2019 to 30 June 2019, of all which have been reviewed under the *Untoward Incident Reporting and Investigation Policy and Procedure*. None of these deaths have been due to problems in care.
Only deaths which meet the criteria below are reported through the Trust incident reporting system (Datix) and these are also reviewed using the process of the *Untoward Incident Reporting and Investigation Policy and Procedure*;
Any patient open to services within the last six months who has died, and meets the following:

- Homicide – perpetrator or victim
- Domestic homicide - perpetrator or victim
- Suicide/self-inflicted death, or suspected suicide
- Death following overdose
- Death whilst an inpatient
- Death of an inpatient who died within 30 days of discharge from a DHCFT hospital
- Death following an inpatient transfer to acute hospital
- Death of patient on a Section of the Mental Health Act or Deprivation of Liberty Safeguards (DoLs) authorisation
- Death of patient following absconsion from an inpatient unit
- Death following a physical restraint
- Death of a patient with a learning disability
- Death of a patient where there has been a complaint by family / carer / the Ombudsman, or where staff have raised a significant concern about the quality of care provision
- Death of a child (this will also be subject to scrutiny by the Child Death Overview Panel)
- Death of a patient open to safeguarding procedures at the time of death, which could be related to the death
- Death of a patient with historical safeguarding concerns, which could be related to the death
- Death where a previous Coroners Regulation 28 has been issued
- Death of a staff member whilst on duty
- Death of a child under the age of 18 of a current or previous service user who has died in suspicious circumstances

- Where an external organisation has highlighted concerns following the death of a patient whether they were open to the Trust at time of death or not

5. Learning from Deaths Procedure

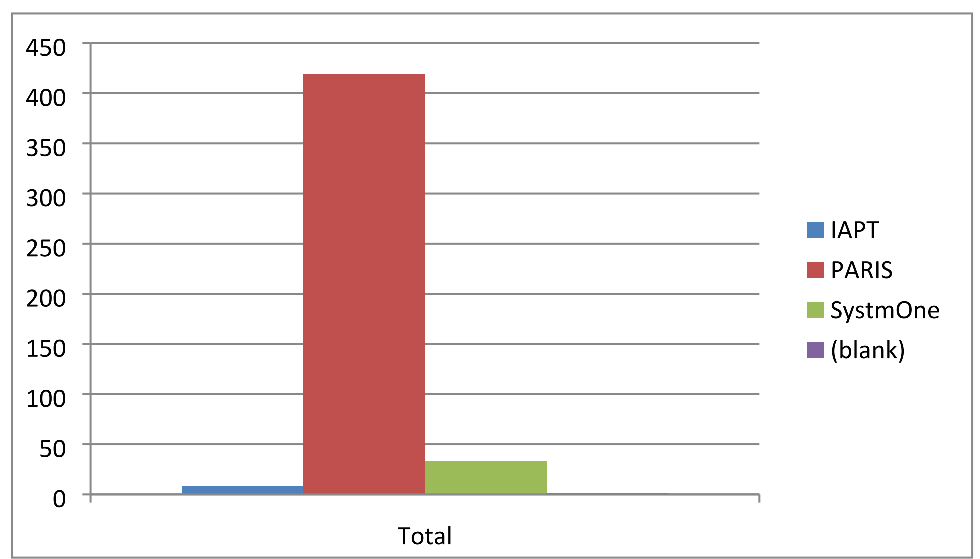
1 April 2019 to 30 June 2019, the Mortality Review Group reviewed 27 deaths. These reviews were undertaken by a multi-disciplinary team and it was established that of the 27 deaths reviewed, 26 have been classed as not due to problems in care. 1 was referred to the Serious Incident Group and is currently under further investigation.

The Mortality Group review the deaths of patients who fall under the following 'red flags' from 28 March 2019:

- Patient taking an Anti-psychotic medication
- Patients whose care plan was not reviewed in the 6 months prior to their death
- Patient whose risk plan and or safety plan was not in place or updated as per policy, prior to death
- Death of a patient with a learning disability

6. Analysis of Data

6.1 Analysis of deaths per notification system since 1 April 2019 to 30 June 2019

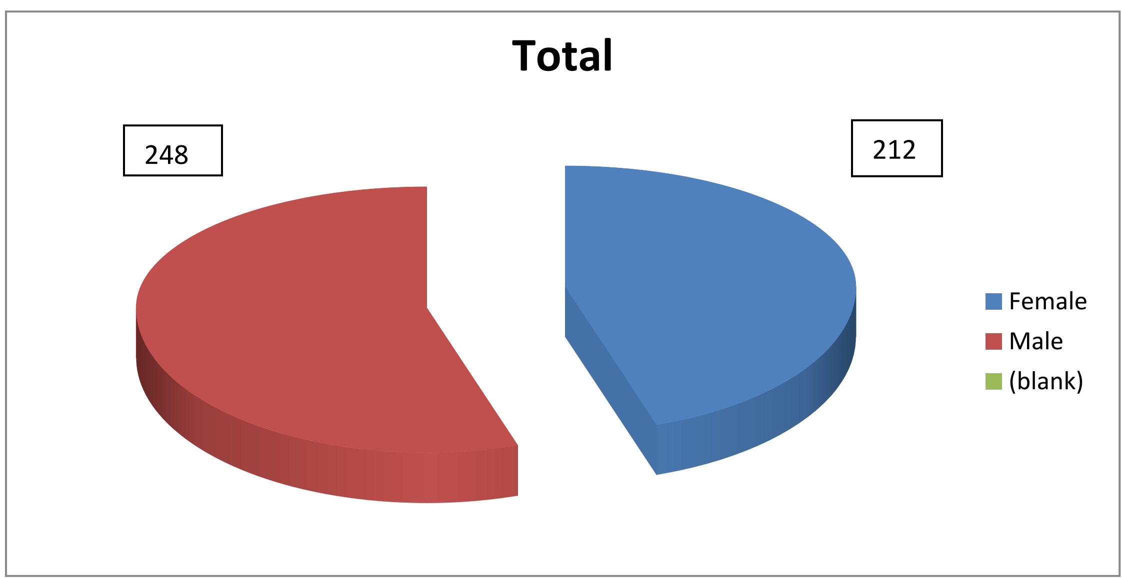


	IAPT	PARIS	SystmOne	Grand Total
Count	8	419	33	460

The data above shows the total number of deaths reported by each notification system. The majority of death notifications were predominately pulled from PARIS. This clinical record system is aligned to our largest population of patients and a population at greatest risk of death due to the proportion of older people in our care. 33 death notifications were extracted from SystmOne and 8 death notifications were extracted from IAPT.

6.2 Deaths by Gender since 1 April 2019 to 30 June 2019

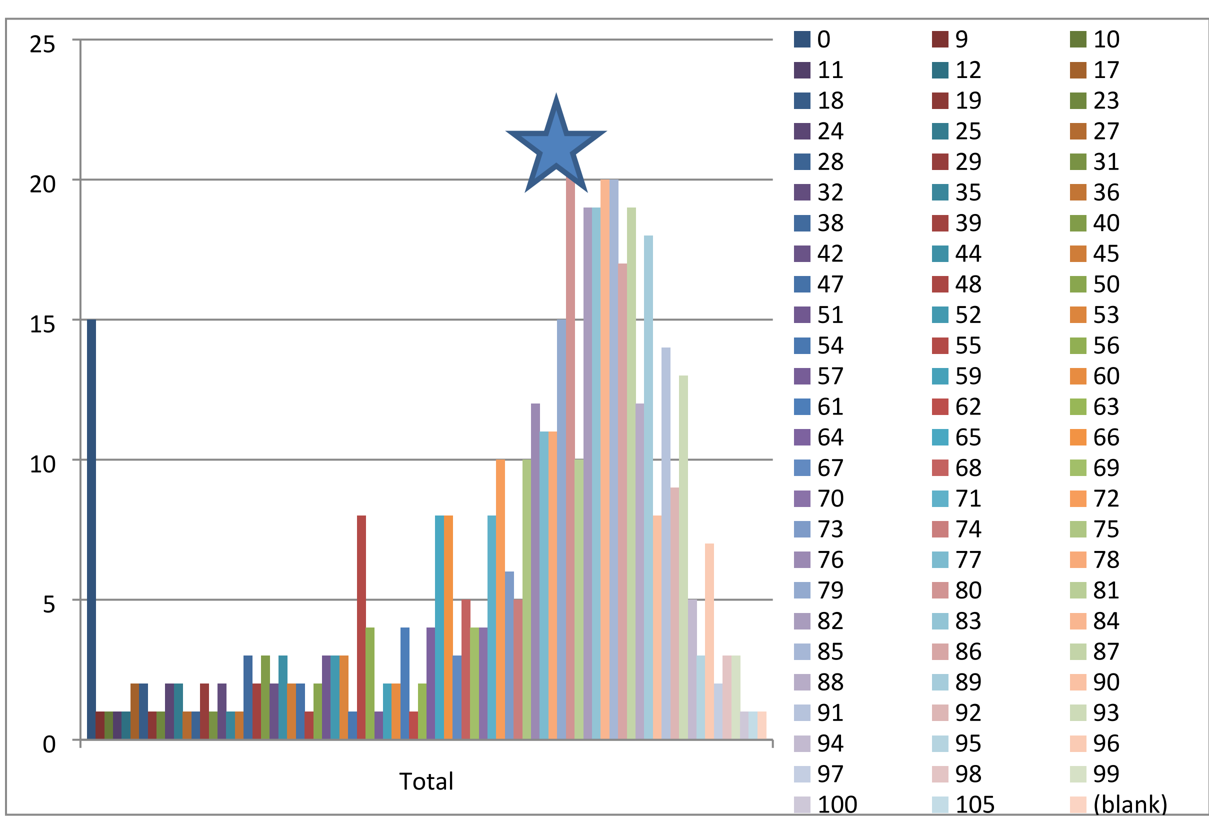
The data below shows the total number of deaths by gender 1 April 2019 to 30 June 2019. There is very little variation between male and female deaths; 248 male deaths were reported compared to 212 female.



	Male	Female	Grand Total
Count	248	212	460

6.3 Death by Age Group since 1 April 2019 to 30 June 2019

The youngest age was classed as 0, and the oldest age was 105 years. Most deaths occur within the 80 - 85 age groups (indicated by the star). In the last report, most deaths occurred between 86 - 91 age groups.



6.4 Learning Disability Deaths since 1 April 2019 to 30 June 2019

	April 2019	May 2019	June 2019
LD Deaths	0	4	4

The Trust reviews all deaths relating to patients diagnosed with a Learning Disability.

The Trust also currently sends all Learning Disability deaths that have been reported through the Datix system to the Learning Disabilities Mortality Review (LeDeR) Programme. However, we are unable to ascertain how many of these deaths have been reviewed through the LeDeR process, as LeDeR only looks at a sample of overall deaths. Currently the Lead Professional for Patient Safety and Experience is working closely with LeDeR so that the Trust can be involved moving forward in the review process. Since the last report, the Trust is now sharing relevant information with LeDeR which is used in their reviews. Since 1 April 2019 to 30 June 2019, the Trust has recorded 8 Learning Disability deaths.

The Trust now receives a quarterly update from LeDeR which highlights good practice and identified learning.

6.5 Death by Ethnicity 1 April 2019 to 30 June 2019

White British is the highest recorded ethnicity group with 369 recorded deaths, 61 deaths had no recorded ethnicity assigned, and two people did not state their ethnicity. The chart below outlines all ethnicity groups.

Ethnicity	Count
White – British	369
Not Known	61
White - Any other White background	12
Other Ethnic Groups - Any other ethnic group	5
Not stated	2
Caribbean	1
White – Irish	4
Asian or Asian British – Pakistani	2
Pakistani	1
Asian or Asian British – Indian	2
Mixed - White and Black Caribbean	1
Grand Total	**460**

6.6 Death by religion 1 April 2019 to 30 June 2019

Christianity is the highest recorded religion group with 85 recorded deaths, 44 deaths had no recorded religion assigned, 10 people refused to state their religion and 212 left this information blank. The chart below outlines all religion groups.

Row Labels	Count of Religion
Christian	85
Church Of England	55
Unknown	44
Not Religious	29
Not Given Patient Refused	10
Roman Catholic	8
Methodist	5
None	2
Muslim	1
Not Religious - Old Code	1
Jehovah's Witness	1
Catholic: Not Roman Catholic	1
Sikh	1
Patient Religion Unknown	1
Atheist movement	1
Pentecostal Christian	1
Spiritualist	1
United Reform	1
(blank)	212
Grand Total	**460**

6.7 Death by sexual orientation 1 April 2019 to 30 June 2019

Heterosexual or straight is the highest recorded sexual orientation group with 133 recorded deaths, 314 people left this information black. The chart below outlines all sexual orientation groups.

Row Labels	Count of Sexual Orientation
Heterosexual Or Straight	120
Heterosexual	13
Bi-Sexual	1
Gay Or Lesbian	1
Not Appropriate To Ask	2
Not Stated (declined)	5
Person Asked And Does Not Know	2
Unknown	2
(blank)	314
Grand Total	**460**

6.8 Death by disability 1 April 2019 to 30 June 2019

Other is the highest recorded disability group with 15 recorded deaths, 13 deaths had a learning disability (dementia) assigned, and 12 people had behaviour and emotional disability assigned. From the 460 deaths only 110 patients' electronic records had a disability assigned. The chart below outlines all disability groups however changes have been made to how the below data will be collated moving forward. During collection of the data it was apparent that if clinicians were choosing 'memory or ability to concentrate learn or understand; this was being categorised as learning disability. Therefore the PARIS team to ensure that it is clearer for clinicians and to improve accuracy of data, the current option of "Learning Disability" will be changed to reflect the fact that it has historically included dementia. This will then be end dated and a new option of "Learning Disability" will be added. A new code has been added specifically to allow clinicians to pick dementia. This change will allow the two disabilities to be independently analysed moving forward.

Row Labels	Count of Disability
Other	15
Learning Disability (Dementia)	13
Behaviour and Emotional	12
Hearing	5
Mobility and Gross Motor	4
Progressive (LT) Conditions	4
Learning Disability (Dementia)	3
Learning Disability (Dementia); Mobility And Gross Motor	3
Behaviour and Emotional; Learning Disability (Dementia); Learning Disability (Dementia); Other; Self Care and Continence	2
Behaviour and Emotional; Mobility and Gross Motor	2
Self-Care and Continence	2
Behaviour and Emotional; Behaviour and Emotional	1
Behaviour and Emotional; Learning Disability (Dementia)	1
Behaviour and Emotional; Learning Disability (Dementia)	1
Behaviour and Emotional; Learning Disability (Dementia); Learning Disability (Dementia); Perception of Physical Danger; Other	1

Row Labels	Count of Disability
Behaviour and Emotional; Learning Disability (Dementia); Mobility and Gross Motor; Self Care and Continence	1
Behaviour and Emotional; Learning Disability (Dementia); Perception of Physical Danger; Self Care And Continence	1
Behaviour and Emotional; Manual Dexterity; Learning Disability (Dementia)	1
Behaviour and Emotional; Manual Dexterity; Mobility and Gross Motor; Speech; Self Care and Continence	1
Behaviour and Emotional; Other; Self Care and Continence	1
Behaviour and Emotional; Other; Self Care And Continence; Sight	1
Behaviour and Emotional; Progressive (LT) Conditions; Other; Mobility and Gross Motor; Other	1
Behaviour and Emotional; Self Care and Continence; Sight; Other	1
Hearing; Learning Disability (Dementia)	1
Hearing; Learning Disability (Dementia); Learning Disability (Dementia)	1
Hearing; Learning Disability (Dementia); Mobility and Gross Motor; Learning Disability (Dementia)	1
Hearing; Learning Disability (Dementia); Mobility And Gross Motor; Self Care And Continence; Sight	1
Hearing; Mobility and Gross Motor	1
Hearing; Mobility and Gross Motor; Other; Self Care and Continence; Other	1
Hearing; Mobility and Gross Motor; Sight; Self Care and Continence	1
Hearing; Other	1
Hearing; Self Care and Continence; Sight; Mobility and Gross Motor	1
Hearing; Self Care And Continence; Speech; Progressive (Lt) Conditions	1
Learning Disability (Dementia); Hearing; Self Care And Continence; Speech	1
Learning Disability (Dementia); Learning Disability (Dementia); Perception of Physical Danger; Progressive (LT) Conditions; Other	1
Learning Disability (Dementia); Mobility and Gross Motor	1
Learning Disability (Dementia); Perception of Physical Danger; Self Care and Continence	1
Learning Disability (Dementia); Self Care and Continence	1
Learning Disability (Dementia); Sight	1
Manual Dexterity	1
Manual Dexterity; Learning Disability (Dementia); Learning Disability (Dementia); Mobility and Gross Motor; Other	1
Manual Dexterity; Mobility and Gross Motor; Self Care and Continence	1
Manual Dexterity; Progressive (LT) Conditions	1
Mobility and Gross Motor; Behaviour and Emotional; Self Care and Continence	1
Mobility and Gross Motor; Behaviour and Emotional; Sight	1
Mobility and Gross Motor; Manual Dexterity; Self Care and Continence	1
Mobility and Gross Motor; Mobility and Gross Motor	1
Mobility and Gross Motor; Speech; Other; Behaviour and Emotional	1
Other; Behaviour and Emotional; Hearing	1
Other; Self Care and Continence; Other	1
Physical Disability	1
Progressive (LT) Conditions; Other; Mobility and Gross Motor; Other	1
Self-Care and Continence; Mobility and Gross Motor	1
Self-Care and Continence; Perception of Physical Danger	1
Self-Care and Continence; Speech; Progressive (LT) Conditions	1
Speech; Learning Disability (Dementia); Other	1
Grand Total	**110**

7. Recommendations and Learning

Below are examples of the recommendations that have been undertaken following the review of deaths either through the *Untoward Incident Reporting and Investigation Policy and Procedure* or *Learning from Deaths Procedure.* These recommendations are monitored by the Patient Safety Team and are allocated to a specific team, and individuals to be completed. This is not an exhaustive list.

7.1 Action Log

Areas of good practice have been identified whilst undertaking the Case Record Reviews, these have included;

- Good regular contact, patient well supported
- Strong link between Community Psychiatric Nurse, General Practitioner and Adult Social Care.
- Recorded Mental Capacity Assessments
- Detailed entries made by the doctor and clinicians
- Well-co-ordinated care and liaison between services
- Safety box contained relevant and helpful detail

Actions recorded from completed Serious Incidents;

- To feedback the requirements for the completion/ updating of Safety Assessments when risks are increasing. Case notes to reflect that any risks have been considered/ reviewed and note any immediate concerns.
- Manager to scope out the teams knowledge and understanding around substance misuse services, assessing and understanding of substance and alcohol misuse, the interventions and support available in the local area.
- Audit required in relation to initial assessments, a sample from all team members.
- Recruitment, sickness and leave to be reviewed and actioned
- To develop a team protocol upon transferring patients to other wards.
- EPR PARIS team clarification needed around current process in relation to death notification
- To improve services for forensic patients with a community setting.
- To improve: Communication regarding serious incidents relating to mental health patients via community forensic services. Information sharing from non-trust forensic providers.
- To scope to possibility of increasing the provision of ED training to adult psychiatric teams
- Scope possibility of enhanced physical health recording on Paris IT system
- Neighbourhood CMHT to review current practice in relation to message taking
- The Service Manager to audit the current processes for the Service against the Operational policy being used.
- Review of the Trust guidelines for the management and treatment of opiate use with consideration to the inclusion of a withdrawal scale assessment tool (i.e. COWS)
- Internal transfer policy and procedure to be reviewed.
- To review current criteria for in-patient admissions for the Hartington Unit.

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 5 November 2019

2019/20 Staff Flu Campaign Update

Purpose of Report

To update the Board on the progress of the 2019 Staff Flu Campaign and provide assurance on the robustness of the campaign as demonstrated by the NHS Improvement (NHSI) flu self-assessment (appendix 1).

Executive Summary

In 2018 the Trust made a small improvement in the staff flu vaccination uptake, reaching 54.5%. National expectations of staff flu uptake are increasing with a key focus on ensuring trusts achieve 80% of frontline staff being vaccinated. A significant Commissioning for Quality Innovation (CQUIN) payment is associated with this.

This paper outlines the plans put in place to ensure achievement of this and our performance against the assessment as we hit one month into the campaign.

Several early successes have been realised, notably the pre-book clinics and the improved data quality of the new e-consent system, however there have also been challenges, including the availability of peer vaccinators.

Plans are in place to ensure these challenges are overcome and that the Trust achieves the targeted threshold, most notably by taking a personalised approach, working through teams and individuals to connect them with their nearest vaccine.

Strategic Considerations	
1) We will deliver **great care** by delivering compassionate, person-centred innovative and safe care	X
2) We will ensure that the Trust is a **great place to work** by attracting colleagues to work with us who we develop, retain and support by excellent management and leadership	X
3) We will make the **best use of our money** by making financially wise decisions and will always strive for best value to make money go further	X

Assurances

- In developing the Staff Flu Campaign for 2019 a thorough review of the 2018 campaign was completed and national best practice consulted.
- The Trust is required to complete an NHSI self-assessment which provides external assurance on its flu plans

Consultation

- Staff had the opportunity to feedback on the approach taken for 2018 with suggestions being included in the 2019 campaign. Most notable was the Unicef partnership which was suggested by a staff member.

Governance or Legal Issues

- There is a CQUIN associated with staff flu vaccine uptake with thresholds set at 60% (minimum) and 80% (maximum).

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

- Equal access to flu vaccinations for all staff is a core component of the campaign. An analysis was carried out to ensure uptake of flu vaccines, amongst protected characteristic groups, was representative in the 2018 campaign. Pleasingly the Trust outperformed other trusts in this area with a representative uptake amongst these staff.

Recommendations

The Board of Directors is requested to:

1) Take assurance on the robustness of the flu campaign plan as demonstrated by the NHSI self-assessment framework (appendix 1)
2) Note the successes of the campaign so far
3) Note the challenges identified so far and the plans in place to address these.

Report presented by: **Amanda Rawlings**
Director of People Services

Report prepared by: **Jamie Broadley**
Staff Wellbeing Lead

2019/20 Staff Flu Campaign Update

Current Position

At time of writing 20.1% of frontline DHCFT staff have been vaccinated. This is compared to 12.9% for the same time point last year. This uptake is broken down by team below:

Staff Due	Target	Consent Yes	Vaccinated	% Vaccinated	% Vaccinated Yes Consent
2035	1628	339	410	20.1 %	120.9 %

Division	Staff Due	Target	Consent Yes	Vaccinated	% Vaccinated	% Vaccinated Yes Consent
383 Adult Care Acute	409	328	60	96	23.5 %	160.0 %
383 Adult Care Community	306	245	43	86	28.1 %	200.0 %
383 Business Improvement + Transformation	1	1	1	0	0.0 %	0.0 %
383 Children's Services	322	258	50	35	10.9 %	70.0 %
383 Clinical Serv Management	9	8	3	5	55.6 %	166.7 %
383 Corporate Central	3	3	2	0	0.0 %	0.0 %
383 Estates + Facilities	32	26	6	8	25.0 %	133.3 %
383 Forensic + MH Rehab	135	108	26	8	5.9 %	30.8 %
383 Med Education & CRD	35	28	4	7	20.0 %	175.0 %
383 Nursing + Quality	25	20	9	15	60.0 %	166.7 %
383 Older Peoples Care	372	298	66	84	22.6 %	127.3 %
383 Ops Support	45	36	7	16	35.6 %	228.6 %
383 People Services	1	1	0	0	0.0 %	0.0 %
383 Psychology	96	77	12	15	15.6 %	125.0 %
383 Specialist Care Services	244	196	50	35	14.3 %	70.0 %

Live data

All staff have the opportunity to view this data, both at trust level and team level by following this link (https://www.theflujab.com/) and clicking on reports in the black bar at the top of the screen.

NHSI self-assessment

We are required to submit a self-assessment framework to NHSI on the campaign plans before December (please see Appendix 1) along with weekly NHSI data on uptake by Health Care Workers. As is evident from the self-assessment our flu plans are robust and comply with best practice guidance.

Key Successes

Through the first month of the campaign the following elements in particular have worked well in increasing staff vaccine numbers:

- **Pre-book clinics** – We built on the success of last year by offering 10 clinics in which staff could book a 5 minute vaccination slot a month in advance. These proved very popular with all clinics ‘selling out’ and ensuring a fast start to the campaign.
- **E-consent system live data** – The new e-consent system gives us live data on both consents and vaccines. This vastly improves our ability to monitor the efficacy of different approaches whilst also identifying hotspots for us to target.

- **Unicef partnership** – Through our partnership with Unicef we have already sponsored 1230 vaccines (for measles, tetanus and polio) across the developing world. This has inspired our ‘share hope not flu’ campaign which has been positively received by staff. This is especially engaging given that the idea came from a member of DHCFT staff.

Key Challenges

The following key challenges have been identified throughout the initial month of the campaign:

- **Clinic availability** – whilst the pre-book clinics were positively received there was frustration at the amount of slots available, especially at key sites such as St Andrew’s House. This is due to the amount of clinic time we have contracted with UHDB as our occupational health provider.
- **Peer vaccinator numbers** – Despite a thorough engagement approach in the run up to the campaign we have struggled to engage all clinical teams to identify peer vaccinators for their service.
- **E-consent system engagement** – As with any new system there are always teething problems and we have had to be patient in a small number of cases with getting staff set up and happily using the new system. We have had the back up of paper forms where necessary to ensure an audit trail and to keep everyone safe. We have now worked through any initial challenges and the system is running well.

Forward Plan

Based on feedback received and the challenges identified above we have the following plans in place going forward:

- **Personalised approach –** The Organisational Effectiveness Team within People Services are now conducting ‘Flu lock ins’ where we work through teams and staff not yet vaccinated, linking them up with their nearest peer vaccinator. These happen on a weekly basis and will maintain campaign momentum and nip any challenges in the bud.
- **Bank staff support** – In areas that are struggling for peer vaccinators we have now recruited several flexible vaccinators via our bank to ensure we can cover sites, meetings or training sessions where there are opportunities to vaccinate staff.
- **Additional Occupational Health clinics** – In response to the feedback around the initial run of clinics we have now procured a further ten clinics from Occupational Health and are currently booking these in at our key sites.

We will continue to collect feedback on the staff flu campaign and, in conjunction with the live data, use this to tailor the approach as we go.

NHS Improvement (NHSI) flu self-assessment (appendix 1)

Trust Self-assessment			RAG
A Committed Leadership			
A1	Board record commitment to achieving the ambition of 100% of front line healthcare workers being vaccinated, and for any healthcare worker who decides on the balance of evidence and personal circumstance against getting the vaccine should anonymously mark their reason for doing so.	Clear message of expectation from board included in initial communications. Consent system designed to capture all staff members' vaccine status.	
A2	Trust has ordered and provided the quadrivalent (QIV) flu vaccine for healthcare workers	Vaccines procured and specific clinics for over 65s staff arranged	
A3	Board receive an evaluation of the flu programme 2018/19, including data, successes, challenges and lessons learnt	Thorough Flu Lessons Learnt and Forward Plan presented at People and Culture Committee	
A4	Agree on a board champion for flu campaign	Carolyn Green leading campaign as chief nurse	
A5	All Board members receive flu vaccination and publicise this	Flu vaccines given at October Board Development Meeting with associated comms	
A6	Flu team formed with representatives from all directorates, staff groups and trade union representatives	Central flu team from Organisational Development, Communications, I,P&C, Chief Nurse, Staff Side & Pharmacy.	
A7	Flu team to meet regularly from September 2019	Bi-weekly flu calls in place since August	
B Communications plan			
B1	Rationale for the flu vaccination programme and facts to be published – sponsored by senior clinical leaders and trades unions	Myth busting and associated comms on vaccine efficacy communicated through initial phase of the campaign.	
B2	Drop in clinics and mobile vaccination schedule to be published electronically, on social media and on paper	Specific intranet page and feature in weekly email on all available clinics, followed up with site specific emails.	
B3	Board and senior managers having their vaccinations to be publicised	Photos and videos at all major clinics being shared through all communication channels, featuring senior and frontline staff.	

Trust Self-assessment			RAG
B4	Flu vaccination programme and access to vaccination on induction programmes	All new starters offered vaccination on day 1 of induction.	
B5	Programme to be publicised on screensavers, posters and social media	All communications channels utilised.	
B6	Weekly feedback on percentage uptake for directorates, teams and professional groups	Live data available to all staff. Published weekly through communications channels	
C Flexible accessibility			
C1	Peer vaccinators, ideally at least one in each clinical area to be identified, trained, released to vaccinate and empowered	80 peer vaccinators identified across clinical teams, training condensed to enable ease of recruitment, incentives for active peer vaccinators.	
C2	Schedule for easy access drop in clinics agreed	Combination of pre-book and drop in clinics available.	
C3	Schedule for 24 hour mobile vaccinations to be agreed	Peer vaccinators able to vaccinate across all shift times.	
D Incentives			
D1	Board to agree on incentives and how	Campaign themed around Unicef 'jabs for jabs' partnership – for every staff member vaccinated, 3 jabs are sponsored via Unicef. Brand of 'share hope not flu' links to incentives at point of vaccination of personalised stickers.	
D2	Success to be celebrated weekly	Live data available 24/7. Weekly figures published through communications channels showing staff vaccines given and Uncief vaccines sponsored. Also feature a team of the week who have increased uptake most in that week.	

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 5 November2019

Workforce Race Equality Standard (WRES) Improvement Action Plan 2019/20

Purpose of Report

This paper presents a revised WRES Improvement Action Plan 2019-20 (based on WRES data 18/19), for approval developed in partnership with the Black & Minority Ethnic (BME) Colleague Network. The WRES action plan and BME Conference Report 2019 are attached as Appendices 1 and 2.

Executive Summary

The Board approved the WRES 2018/19 blue template, associated benchmarking documents, including the introduction of the new 15% BME workforce targets as part of the workforce dashboard on 5 September, 2019. The Board considered and discussed Trust WRES data and journey – organisational performance and improvement actions and requested a revised action plan.

This report presents a revised WRES Improvement Action Plan for consideration and approval which was developed in partnership with BME Colleague Network and senior leaders at their annual Conference which took place on 25 September 2019.

Approximately 130 people attended the event, where the agenda included a thought-provoking and emotive session on ‘Unconscious Bias’ from an external facilitator and speaker, David Shosanya; updates on the 2018-19 Reverse Mentoring programme and their plans for Cohort 2 in 2019; and two action-planning workshops to address key areas in the Workforce Race Equality Standard, focusing on workforce diversity and representation and career development opportunities for BME colleagues. The session was opened by Sharon Rumin, Vice-Chair Elect of the Network and Ifti Majid, Chief Executive and BME Sponsor.

The actions developed by the Network at the conference have been used to develop the WRES Improvement Action Plan 2019-20, which can be found in Appendix 1. The actions include recruiting and developing a workforce that reflects the diverse communities we serve on the basis that increasing our people diversity will improve our performance and patient care. This is in direct response to WRES metrics and feedback from the BME Network in terms of addressing the gap of BME staff in middle and senior management positions through recruitment and progression.

A Diversity Recruitment Action Steering Group for improving workforce equality and diversity using ‘disruptive and non-traditional approaches’ has been established and is headed by Claire Wright, Deputy Chief Executive and Board Equalities Lead. It reports directly to Executive Leadership Team and works with People Services to create more opportunities for BME staff to access training opportunities, progress within the organisation and achieve our greater BME workforce BME diversity target.

Non-Executive Director interview Panel – BME network members invited to be part of shortlisting and full voting interview panel during December 2019.

Strategic Considerations	
1) We will deliver **great care** by delivering compassionate, person-centred innovative and safe care	x
2) We will ensure that the Trust is a **great place to work** by attracting colleagues to work with us who we develop, retain and support by excellent management and leadership	x
3) We will make the **best use of our money** by making financially wise decisions and will always strive for best value to make money go further	x

Assurances

- The Trust will take an organisational development approach to drive change and inclusive leadership through holding leaders to account and tracking performance. Established Diversity Recruitment Action Steering Group reporting directly to Executive Leadership Group.
- WRES Improvement Plan has been refined with BME Network and leaders to address disparities. WRES is performance managed via Equalities Forum which has trust wide membership and is part of the governance structure and sub-group of People & Culture Committee.
- The Trust has signed up to the national WRES expert programme to facilitate best practice and guidance
- Race at Work Charter and Reverse Mentoring Programme.

Consultation

- WRES metrics and Improvement Plan has been shared and developed with the BME Colleague Network & Equality Forum to directly address the WRES indicators to address the inequalities and drive improvement. WRES work streams include representatives from diverse groups of staff, staff network, staff side, governors and Trust Management Team.

Governance or Legal Issues

The WRES is a mandatory part of the NHS Standard Contract and the Trust is required to submit WRES and action plan to commissioners outlining progress on implementing the standard (as part of Schedule 4 Evidence for 2019-20) and then published on our public facing website by the 27th September, 2019

Undertaking the EDS2 demonstrates progress and commitment to understanding of duties towards protected characteristics or REGARDS groups under the Equality Act 2010 & Human Rights Act 1998. The Specific Duties regulations already require all public authorities, listed at the schedules to the regulations, to publish information to demonstrate their compliance under the Public Sector Equality Duty (PSED).

Public Sector Equality Duty & Equality Impact Risk Analysis

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

Differential impact is evidenced via the WRES indicators which capture ethnicity data and identifies the disparities between BME and White colleagues. Moreover the WRES Tracker 2015-2019 establishes a baseline and benchmarking to measure our progress.

The paper encourages leaders to visibly demonstrate living the Trust values in building a 'positively inclusive culture' and using the WRES evidence as an enabler to improve our workforce diversity and person centred and fair/just environment for everyone. It sets out how we will demonstrate visible leadership and driving key actions such as setting targets for ethnic minority representation, recruitment, progression and supporting mentoring and sponsorship.

The Board has signed up to the Race at Work Charter and our WRES action plan has been developed to demonstrate that there is visible commitment from the top to drive change. Making it clear that supporting equality in the workplace is the responsibility of all leaders and managers.

Recommendations

The Board of Directors is requested to:

1) Approve the revised WRES Improvement Action Plan 2019-20
2) Note Diversity Recruitment Steering Group reporting directly to ELT to drive improvement across the WRES metrics and targets
3) Note the BME Network Annual Conference Report 2019.

Report presented by: **Amanda Rawlings**
Director of People & Organisational Effectiveness

Report prepared by: **Harinder Dhaliwal**
Head of Equality, Diversity & Inclusion

Appendix 1: WRES Improvement Action Plan 2019/20
Appendix 2: BME Network Annual Conference Report 2019

Workforce Race Equality Standard (WRES) Improvement Action Plan 2019-20 (Based on WRES 2018/19 data). Produced in partnership with the BME Network at the BME Annual Conference on 25 September 2019.

Indicator	Action(s)	When	Owner	Update/Outcome	Position
Workforce Diversity & Representation	Establish Diversity Recruitment Action Steering Group to achieve greater diversity and improve workforce equality at all levels of the organisation. Introduction of BME Inclusion target of 15% BME representation in each of the AfC paybands across the Trust. Actions identified by two workshops: 1) Disruption of the interview panel with inclusion advocates; 2) Non-traditional interview process to meet diverse needs; 3) Adapting external and internal advertisement of posts to reach out to the local community.	First meeting: 17/10/19. Second meeting scheduled for 12/11/19.	**Diversity Recruitment Action Steering Group:** Suki Khatkar (Chair) Claire Wright (Executive Sponsor) Sandra Bennett Hannah Burton Sara Boulton Harinder Dhaliwal Clare Meredith Nicola Myronko Amanda Rawlings Rubina Reza Sharon Rumin Bal Singh Nadine Thomas David Tucker	Diversity Recruitment Action Steering Group to report to ELT (IM email 26/9/19). Update as of 17/10/19: Steering Group had inaugural meeting on 17/10/19 and agreed key actions, including introducing ‘inclusion advocates’ into the recruitment process for shortlisting and interviewing for (initially) Band 7 and above.	

Indicator	Action(s)	When	Owner	Update/Outcome	Position
Career Development Opportunities	1) Masterclasses from April 2020 to support people to progress in the organisation, to include support with job applications and interview skills. Career coaching in appraisals, even for those who are not sure if they would like to progress. 2) Promotion of development opportunities: Managers and leaders need to know what is available for staff, to include shadowing and secondments to learn about and gain access to other services. 3) Streamline Training Needs Analysis process. Managers need to be asked more disruptive questions before they refuse an application, and must give a reason why it has been refused.	Report to Equality Forum quarterly on progress.	**Faith Sango** **With support from EDI Service and BME Network**		
All	1) Reverse Mentoring for Equality, Diversity and Inclusion (ReMEDI) programme: To be rolled out to wider Trust, especially senior leaders at Band 7 and above, mentored by a second cohort of colleagues from a BME background. 2) WRES Experts Programme, designed to support the organisation to embed best practice with regards to race equality. 3) Review WRES National Report for learning what works in other organisations with improving scores.	Oct 19-Jun 20 When released on WRES England website.	**ReMEDI Steering Group:** Ifti Majid Claire Wright Amanda Rawlings Bal Singh Surinder Khakh Tray Davidson Harinder Dhaliwal **Rubina Reza** **EDI Service**	ReMEDI mentors and mentees identified. To be paired and trained in November 2019. Programme launched 9 October 2019.	

BME Staff Network Conference 2019 Report

Theme: The impact of Unconscious Bias on our everyday decision-making.

Positively inclusive: helping BME colleagues to succeed.

#DHCFTBMEConf

25th September 2019
Conference Room, Research & Development Centre, Kingsway Hospital, Derby

Produced by:
Harinder Dhaliwal - Head of Equality, Diversity and Inclusion
Clare Meredith - Equality, Diversity and Inclusion Advisor
Equality, Diversity and Inclusion Service

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Summary

The purpose of this report is to provide an overview of the 2019 BME Staff Network Conference which took place on 25th September 2019 at Kingsway Hospital in Derby.

Approximately 130 people attended the event, where the agenda included a thought-provoking and emotive session on 'Unconscious Bias' from an external facilitator and speaker, David Shosanya; updates on the 2018-19 Reverse Mentoring programme and their plans for Cohort 2 in 2019; and two action-planning workshops to address key areas in the Workforce Race Equality Standard, focusing on workforce diversity and representation and career development opportunities for BME colleagues.

The session was opened by Sharon Rumin, Vice-Chair Elect of the Network and Ifti Majid, Chief Executive and BME Sponsor.

The actions developed by the Network at the Conference have been used to develop the WRES Improvement Action Plan 2019/20 (based on WRES 18/19 data), which can be found in Appendix 3. The actions include addressing the gap of BME staff in middle and senior management positions through recruitment and progression, overseen by a Diversity Recruitment Action Steering Group headed by Claire Wright, Deputy Chief Executive and Board Equalities Lead, and working with People Development to create more opportunities for BME staff to access training opportunities and progress within the organisation. We received 41 completed evaluation forms and found that 58.5% rated their overall evaluation of the

"I found listening to some of the experiences of my BME colleagues at the BME Conference to be very sobering and extremely thought-provoking.
It frustrates me greatly as Staff-Side Chair that our BME colleagues continue to be disadvantaged and that there was a feeling within the room by some that actions taken were still paying lip service in regards to the bigger issues that need addressing.
I am glad that there is great progress being made and heartened that the BME Network are being listened to and seem to be instrumental in pushing for positive change - this really does need to be done at pace.
I hope everybody in the room like me went home that evening thinking about what they can do to help drive the changes that are needed.
I am looking forward to attending next year's Conference and truly hope that the Trust continues on its journey and cannot emphasize enough how we all have a key role to play in the trust being truly inclusive to all."

'Change will not come if we wait for some other person or some other time. We are the ones we've been waiting for. We are the change that we seek.' - Barack Obama.

- **Lee Fretwell, Staff-Side Chair**

Conference as 'Excellent', and the remaining 41.5% rated it as 'Good'.

Introduction

Welcome address and Opening Remarks: Sharon Rumin, Vice Chair Elect of the BME Network

The conference began with a moving welcome address from Sharon Rumin. Her speech described her own journey as a person from a BME background and the little progress made since Windrush 70 years ago as BME staff members are still underrepresented in senior positions. Her speech set the tone for an open, honest and thought-provoking conference.

Setting the context and journey: Ifti Majid, Chief Executive and Executive Sponsor of the BME Network

Ifti thanked Sharon for a heartfelt and emotional start, and explained that the day was an opportunity for personal reflection and to give ourselves time to think about the impact that each member of staff has on their own environment.

'Today is about what we can do differently tomorrow' – Ifti Majid

The Chief Executive then asked the Conference attendees to participate in an activity based on perceptions in the Trust. Attendees moved between four points in the room (North, East, South and West) to answer the questions, which included how many cases of overt racism had occurred in the Trust over a particular timeframe, and the positioning of BME colleagues in the Trust. Ifti revealed there were 34 BME colleagues at Band 7 and above, but the number drops to just 7 from Band 8a and above.

By looking at the Workforce Race Equality Standard (WRES) data and in anticipation of David Shosanya's presentation on 'Unconscious bias', Ifti invited the attendees to consider the possible reasons why people from a BME background are 2.86 times less likely to be appointed from shortlisting compared to white colleagues.

The Trust has undertaken actions to address the gap over the last year, including:

- Agreed and signed off BME inclusion targets for each AfC band (15% BME)
- Subscribed to the NeXT Director Scheme.
- BME members of staff have taken part in interview panels.
- The Executive team have been challenged by the CEO to each have an equality objective.
- Every new member of staff receives equality, diversity and inclusion training at induction with the Head of Equality, Diversity and Inclusion.

- Introduced a 'stop' in the disciplinary process for any case involving a BME member of staff. Their cases now go through a Director.

Ifti also asked the Conference attendees to write a pledge declaring one thing they will do differently tomorrow as a result of today. The Trust's Communications Team have made the pledges into a poster that will be displayed around the Trust. Please see Appendix 1.

The impact of Unconscious Bias on everyday decision-making

Our guest speaker and facilitator, David Shosanya, delivered a powerful presentation on the impact of unconscious bias, exploring what it means and the strategies each of us can use to reduce unconscious bias.

Truths about unconscious bias:

1) It is natural
2) It is unintended
3) It impacts on decision-making and can have adverse consequences as a result.
4) It can be managed: we have a responsibility to manage our behaviour.

'What voices are missing?'

Key points from David's presentation including always considering what voices are missing from any discussion/decision, and what assumptions you are bringing to the situation. This is applicable to any instance where there is a dominant group i.e. recruitment panel.

The Conference was split into groups to discuss the impact of unconscious bias on different parts of an organisation, including succession planning, networks, performance management, promotion, work allocation and recruitment, and to identify steps that could be used to reduce it.

David also emphasised the power of mentoring and exposure because proximity changes an organisation. Highlighting the Reverse Mentoring for Equality, Diversity and Inclusion (ReMEDI) programme at

Derbyshire Healthcare, he explained that giving people the opportunity to access spaces that they do not traditionally have access to is one of the ways to start these conversations and change the culture: ‘human connection provides us all with the impetus to move forward’.

David gave attendees the opportunity to speak openly about how they were feeling, with a mix of excitement, disappointment and optimism being highlighted. David’s PowerPoint presentation can be found in Appendix 2.

Multi-Cultural Lunch and Networking

The Conference was catered for with a multi-cultural lunch (gluten-free vegetable and halal curries with naan bread) and attendees were given the opportunity to network with colleagues and celebrate Black History Month.

Reverse Mentoring for Equality, Diversity and Inclusion (ReMEDI): Cohort 1

The pairs that participated in the ReMEDI programme shared their experiences and the professional and personal impacts that the programme had had on them. All of the pairs agreed that it had contributed to their personal development, and many pairs have agreed to keep meeting to continue the positive experience. Through a process of establishing boundaries and developing trust between the pairs, they were able to understand more about each other’s worlds, how people might react differently to external factors and how some members of the community might experience barriers and obstacles in areas that are open to most.

Many also recognised the level of courage and bravery it takes to participate in this programme and take initiative, recognising a difference in their confidence and abilities after the reverse mentoring process.

The Reverse Mentoring programme is currently being rolled out to more people in September 2019, with BME mentors being encouraged to mentor managers and leaders in the organisation. Cohort 2 is being overseen by the ReMEDI Steering Group, led by members of Cohort 1.

Workforce Race Equality Standard (WRES) Action Plan Updates

At the BME Annual Conference in 2018, attendees agreed to focus on three key areas in the WRES:

1. Indicator 2: The relative likelihood of staff being appointed from shortlisting across all posts.
2. Indicator 3: The relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation.
3. Indicator 4: The relative likelihood of staff accessing non-mandatory training and CPD.

Nicola Myronko (Head of People Resourcing), Amanda Wildgust (Head of Employee Relations) and Faith Sango (Head of People Development) delivered presentations on the progress made on each of the three WRES indicators above, highlighting the need for radically different actions to make a difference for BME colleagues in the Trust.

Workshops:

The Conference split into two workshops, focusing on developing three key actions required to make an impact for Workforce Diversity and Representation and Career Development Opportunities. The identified actions can be found in Appendix 3.

Workforce Diversity & Representation Workshop, Group 1 (facilitated by Nicola Myronko, Head of People Resourcing and Amanda Rawlings, Director of People and Organisational Effectiveness:

Workforce Diversity & Representation Workshop, Group 2 (facilitated by Claire Wright, Deputy Chief Executive and Director of Finance):

Career Development Opportunities Workshop (facilitated by Faith Sango, Head of People Development):

Evaluation

Approximately 130 people attended the event from all levels of the organisation, including:

- DHCFT BME Network
- Executive Board
- General Managers
- Area Service Managers
- People Services
- Estates & Facilities
- Derby City Council BME Network

We received 41 completed evaluation forms at the end of the Conference (please see Appendix 4 for a full report) and a summary of the key findings is provided below.

Q1: 58.5% rated their overall evaluation of the Conference as ‘Excellent’, and the remaining 41.5% rated it as ‘Good’.

Q2: 78.05% rated the overall effectiveness of the Unconscious Bias session as ‘Excellent’, 19.51% rated it as ‘Good’ and 2.44% rated it as ‘Fair’.

Q3: The word cloud below has been created in response to this question, which asked the attendees to describe the conference in 3 words, with the most recurring words as 'thought-provoking', 'hopeful' and 'educational'.

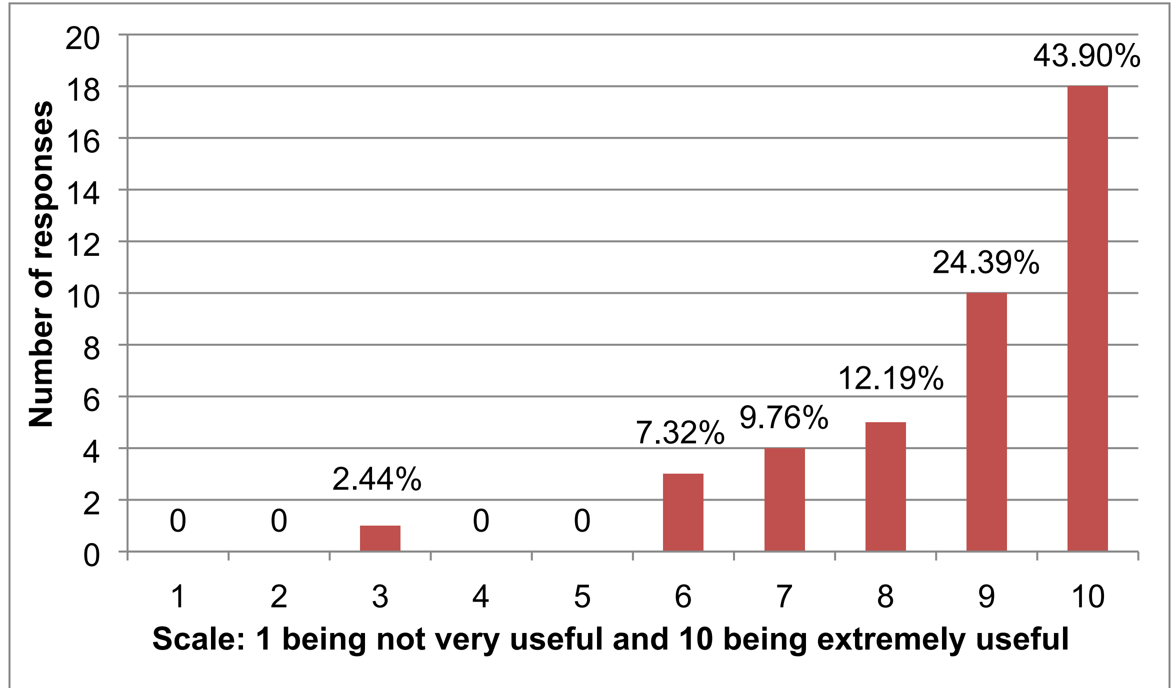
Interesting
Challenging Enlightening
Interactive Saddening
Educational Inclusive
Relevant Heartening
Informative Engaging
Energising
Progressive Change
Honest Hopeful Emotional
Encouraging Enjoyable
Empowering Frank Caring Evocative
Thought-provoking
Helpful Moving
Powerful Inspirational Open
Uplifting Positive
Exciting Eye-opening
Reflective

Q4: 53.65% said that the Unconscious Bias session was the most helpful or of value to them, while 12.19% said it was career progression opportunities. Other information of value was cited the WRES data, networking with colleagues and signposting for the BME Network, among others.

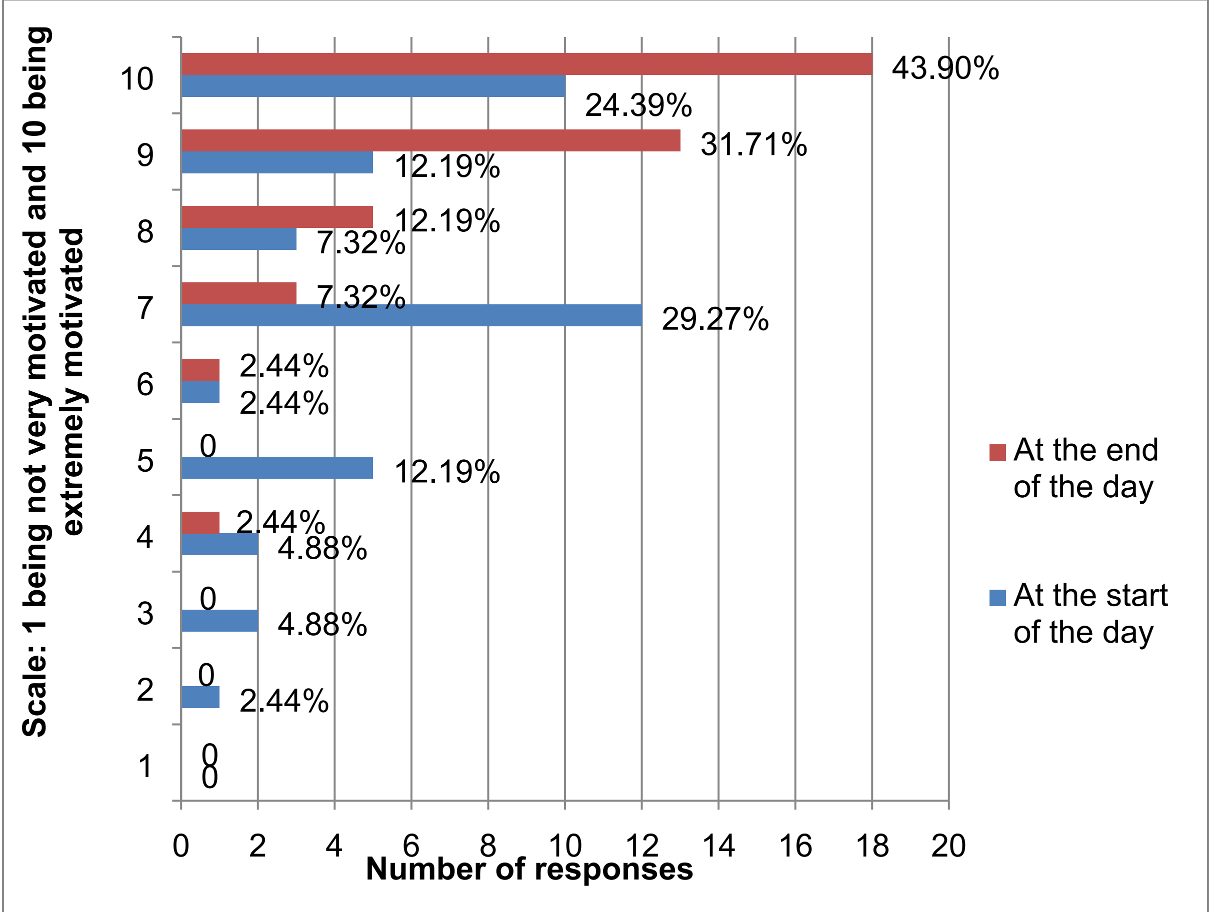
Q5: 12.19% of respondents declared that they would be sharing the 'Inclusive Leadership' questionnaire with their team or managers, another 12.19% said they would be putting the information from it into practice.

Q6: 39.02% of respondents said there was nothing of little value in the Conference. Other responses included too much detail on the statistics on the WRES data and the fact that more BME staff needed to be encouraged/freed to attend the Conference.

Q7: The graph below shows that the majority (43.90%) found the event extremely useful (top of scale) in developing the BME Network and themselves.



Q8: The graph below shows that the majority of responses (29.27%) felt partially motivated at 7/10 at the beginning of the day, while by the end of the day, the level of motivation increased to 10/10 for 43.90% of respondents.

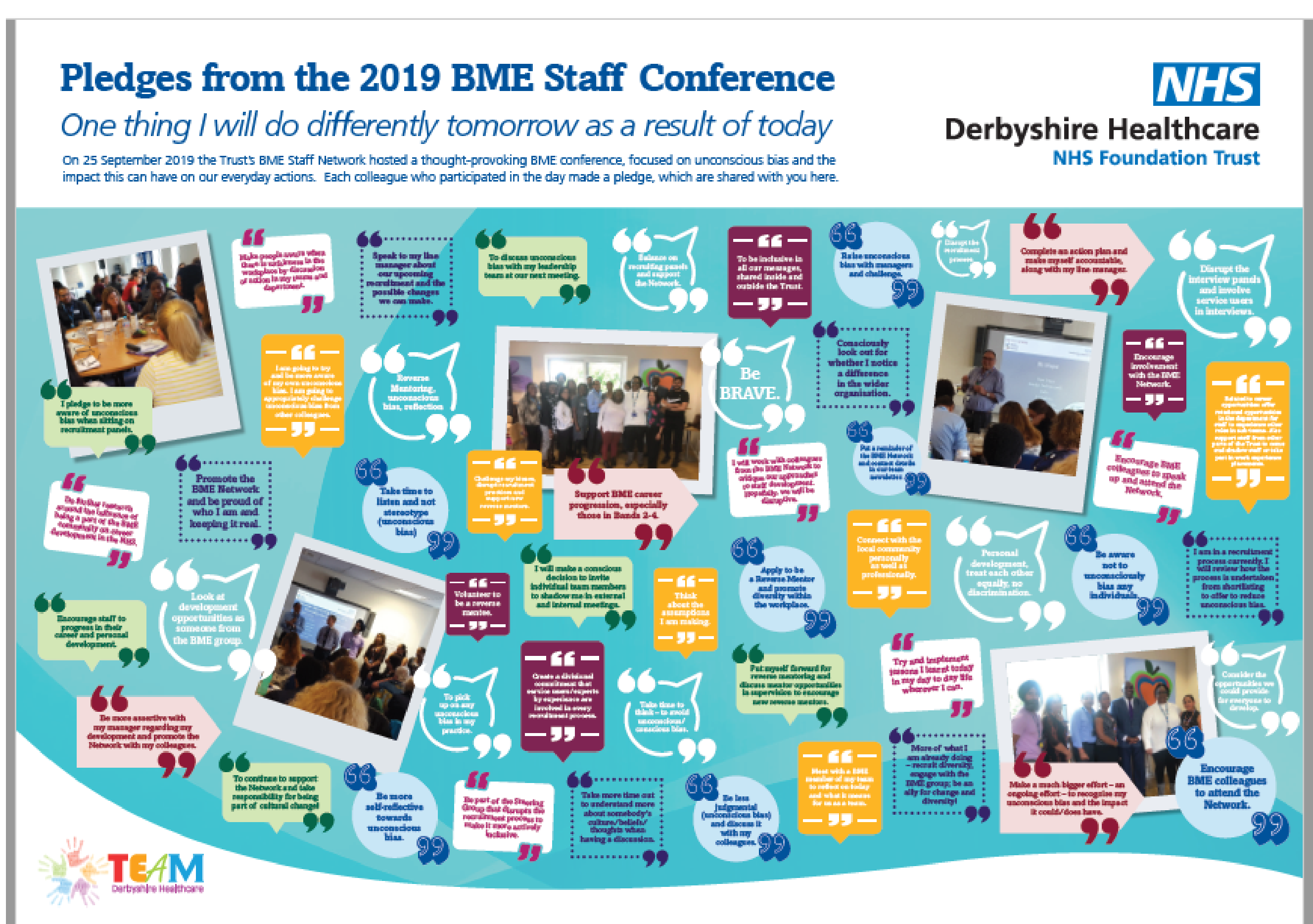


Q9: The majority of respondents believed that developing their understanding of unconscious bias had benefitted them and their work, closely followed by the benefit of having a different perspective and the opportunity to network with other colleagues in the Trust.

Q10: 17.07% of respondents believed the event could be improved by giving more time for the guest speaker and 12.19% would have liked more staff to attend the Conference.

Q11: The majority of responses were themed around thanking the BME Network for the enjoyable day, along with general comments around the need for non-BME staff to have spoken up more.

Appendix 1: Staff Pledges poster



The A1 sheet of this poster will be available and presented in the Ashbourne Centre and circulated to DHCFT leaders.

DHNFT_Staff_Pledges_A1_Poster.pdf

Appendix 2: David Shosanya: The impact of Unconscious Bias on everyday decision-making

Permission was given to share the presentation with attendees of the Conference by David Shosanya. Colleagues can access David Shosanya's slides by requesting a copy from the Equality, Diversity and Inclusion Service.

Appendix 3: WRES Improvement Action Plan 2019/20 (based on WRES 18/19 data)

Action(s)	When	Owner	Update/Outcome	Position
Workforce Diversity & Representation: Establish Diversity Recruitment Action Steering Group to achieve greater diversity and improve workforce equality at all levels of the organisation. Introduction of BME Inclusion target of 15% BME representation in each of the AfC paybands across the Trust. Actions identified by two workshops: 1) Disruption of the interview panel with inclusion advocates; 2) Non-traditional interview process to meet diverse needs; 3) Adapting external and internal advertisement of posts to reach out to the local community.	First meeting met on 17/10/19. Steering Group to report to ELT (IM email 26/9/19).	**Diversity Recruitment Action Steering Group:** Suki Khatkar Claire Wright Sandra Bennett Hannah Burton Sara Boulton Harinder Dhaliwal Clare Meredith Nicola Myronko Amanda Rawlings Rubina Reza Sharon Rumin Bal Singh Nadine Thomas David Tucker	Steering Group met on 17/10/19, and agreed key actions, including introducing 'inclusion advocates' into the recruitment process for shortlisting and interviewing for (initially) Band 7 and above.	Ongoing
Career Development Opportunities: 1) Masterclasses from April 2020 to support people to progress in the organisation, to include support with job applications and interview skills. Career coaching in appraisals, even for those who are not sure if they would like to progress. 2) Promotion of development opportunities:	Report to Equality Forum quarterly on progress.	**Faith Sango** **With support from EDI Service and BME Network**		Ongoing

Managers and leaders need to know what is available for staff, to include shadowing and secondments to learn about and gain access to other services. 3) Streamline Training Needs Analysis process. Managers need to be asked more disruptive questions before they refuse an application, and must give a reason why it has been refused.				
All 1) Reverse Mentoring for Equality, Diversity and Inclusion (ReMEDI) programme: To be rolled out to wider Trust, especially senior leaders at Band 7 and above, mentored by a second cohort of colleagues from a BME background. 2) WRES Experts Programme, designed to support the organisation to embed best practice with regards to race equality. **3)** Review WRES National Report for learning what works in other organisations with improving scores.	Oct 19-Jun 20 When released on WRES England website.	**ReMEDI Steering Group:** Ifti Majid Claire Wright Amanda Rawlings Bal Singh Surinder Khakh Tray Davidson Harinder Dhaliwal **Rubina Reza** **EDI Service**	ReMEDI mentors and mentees identified. To be paired and trained in November 2019. Programme launched on 9th October 2019.	Ongoing

Appendix 4: Evaluation of the Conference

Q1: What is your overall evaluation of the Conference?

Excellent	Good	Fair	Poor
24	17	0	0

Q2: What is your rating of the overall effectiveness of the Unconscious Bias session?

Excellent	Good	Fair	Poor
32	8	1	0

Q3: Please share 3 words to describe the conference:

Word	Number of occurrences	Word	Number of occurrences
Caring	1	Inclusive	3
Challenging	4	Informative	7
Change	1	Inspirational	6
Educational	6	Interactive	1
Emotional	4	Interesting	4
Empowering	1	Moving	2
Encouraging	1	Open	3
Energising	1	Positive	3
Engaging	4	Powerful	4
Enjoyable	2	Progressive	1
Enlightening	3	Reflective	3
Evocative	1	Relevant	1
Exciting	2	Saddening	1
Eye-opening	5	Shared ownership	1
Frank	1	Stimulating	1
Heartening	1	Thought-provoking	8
Helpful	1	Tiring	1
Honest	5	Trust	1
Hopeful	8	Uplifting	1

Q4: As you reflect on the information provided throughout the conference programme, what information was the most helpful or of value to you?

- Unconscious bias session (23)
- Career progression opportunities (5)
- Networking with other colleagues and sharing experiences (4)
- WRES data (3)
- Ideas from the workshops for action (3)
- Signposting for the network (1)
- Knowledge of completed actions towards this goal (1)
- All valuable (1)
- Not sure (1)

Q5: How do you intend to use the 'inclusive leadership' questionnaire shared with you at the Conference to build on your inclusive leadership development needs?

- Share with my team/managers (5)
- To put into practice (5)
- Not sure (4)
- To reflect on my own leadership and use it to identify areas for development (2)
- Did not receive this (2)
- To reflect on the conversations I have with staff (1)
- Invite people to share their views (1)
- None (1)
- Not relevant (1)
- Developing myself (1)
- I challenge the leadership team already. Often this leaves me on the outside (1)
- Add to skill set (1)

Q6: What aspects of the conference were of least value to you?

- None/All beneficial (16)
- Lack of time for discussion/presentations were rushed (3)
- Reverse Mentoring (2)
- Too much detail on the statistics (2)
- Personal stories (1)
- The fact Band 7 leaders were encouraged to attend, not BME staff (1)
- Have not decided yet (1)

Q7: How relevant/useful was this event to develop the BME Network/yourself?

Scale	1 Not Very Useful	2	3	4	5	6	7	8	9	10 Extremely Useful
Number of Responses	0	0	1	0	0	3	4	5	10	18

Q8: How motivated and engaged with the BME Network did/do you feel?

A) At the start of the day:

Scale	1 Not Very Motivated	2	3	4	5	6	7	8	9	10 Extremely Motivated
Number of Responses	0	1	2	2	5	1	12	3	5	10

B) At the end of the day:

Scale	1 Not Very Motivated	2	3	4	5	6	7	8	9	10 Extremely Motivated
Number of Responses	0	0	0	1	0	1	3	5	13	18

Q9: Please say in what ways have you/your work benefited professionally?

- Develop understanding of unconscious bias (6)
- Different perspective (5)
- Networking (4)
- Recognise my own impact (3)
- Make a change (3)
- Develop understanding of BM E issues (2)
- Encouraged to pursue career progression (2)
- I have been educated (2)
- Opportunity to develop (1)
- Develop understanding of cultural diversity (1)
- Challenge my assumptions (1)
- Prioritised BME issues (1)
- Being noticed and heard (1)
- More motivation (1)

Q10: In what ways could the event be improved?

- More time for presentations & guest speakers (7)
- Invite more staff (5)
- Empower BME Network to have more involvement in the day (personal stories) (3)
- Bigger room (3)
- Hold leaders accountable for the actions identified (1)

- Move around the room to sit with different groups throughout the day (1)
- Better outcomes in data next year (1)
- More advertising/promotion (1)
- More bite-sized sessions (1)
- Hear more from non-BME colleagues (1)
- More sharing of ideas (1)
- Not sure (1)
- Nothing (1)

Q11: Please use the space below to share any additional comments and/or suggestions you may have:

- Thank you/Enjoyable day/Glad to be part of it (5)
- Give more time for external speaker (2)
- Voices of non-BME attendees not heard much (2)
- Give more time for workshops (1)
- How do we challenge some of the toxic management that continues to retain toxic culture? (1)
- Looking forward to the implementation of a disruptive approach in addressing the lack of equality for BME staff/service users. (1)
- Enable all staff to attend, especially BME staff (1)
- Should contact all BME staff to ask how they are feeling and what they need i.e. a separate survey as the Staff Survey is not enough (1)

Useful links and further information:

NHS Equality and Diversity Council WRES Report (published in May 2019, covers 2018)

A Model Employer: Increasing black and minority ethnic representation at senior levels across the NHS (January 2019)

Learning Lessons to Improve our People Practices – Baroness Dido Harding (May 2019)

A Fair Experience for All: Closing the ethnicity gap on rates of disciplinary action across the NHS workforce (July 2019)

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 5 November 2019

Revision of the Policy for engagement with the Board of Directors and Council of Governors

Purpose of Report

The Board of Directors, in consultation with the Council of Governors, approved the first version of the Policy for Engagement between the Trust Board and the Council of Governors in 2016. The policy is now due for renewal and requires some minor amendments. These minor amendments were supported by the Governance Committee in October. The Policy continues to reflect the Foundation Trust Code of Governance and compliments the Trust Constitution, Standing Orders and locally agreed protocols developed by the Council of Governors, for example the process for the appointment of the Lead and Deputy Lead Governor.

Executive Summary

The policy covers a range of important areas including:

- Relationship between the Trust Board and the Council of Governors
- Handling of concerns
- Powers & duties, roles and responsibilities of the Trust Board and the Council of Governors
- Role of the Senior Independent Director
- Grounds and procedure for the removal of the Chair or a Non-Executive Director
- Dispute Resolution Procedure

The policy also encompasses those activities which we have developed within the Trust such as the Board/Council of Governor sessions.

The purpose of this policy is therefore to:

- Set out the systems and structures to promote a constructive working relationship between the Council of Governors and the Trust Board
- Set out a process for dealing with problems that may arise, as recommended by NHS Improvement's Code of Governance

Recommended changes in Version 2 (attached) are:

- References to Director of Corporate Affairs and Trust Secretary replaced with Trust Secretary.
- 3.4.1 has been amended to more accurately reflect the frequency and topics for the annual joint Trust Board and Council of Governor meeting.
- 3.8 has been amended so it matches with the changes agreed at the Council of Governors meeting in May 2019 regarding the Lead Governor and Deputy

Lead Governor role.

- Appendix 4 – Dispute Resolution – point 4 - Panel for Advising Governors. In practical terms, although this is still in the statute, NHS Improvement has disbanded the Panel. It is suggested that this is left in the policy but the Trust and the Council of Governor would seek advice from the Regulator should the situation listed in the dispute resolution procedure arise.

Strategic Considerations		
1)	We will provide **great care** by delivering compassionate, person-centred innovative and safe care; ensuring choice, empowerment and shared decision making is the norm.	X
2)	We will ensure that the Trust is a **great place to work** by attracting colleagues to work with us who we develop, retain and support by excellent management and leadership; creating an empowered, compassionate and inclusive culture that actively embraces diversity.	X
3)	We will make the **best use of our money** by making financially-wise decisions every day and avoid wasting resources. We will always strive for best value by finding ways to make our money go further.	X

Strategic considerations and assurances

- This Policy for Engagement clarifies the respective roles and responsibilities of the Board and the Council of Governors.
- This policy outlines the assurance of the Board and the Council of Governors to maintain commitment to the Nolan principles which are a foundation of our roles.

Consultation

This policy was originally developed through the Governance Committee and the revision has also been through this Committee.

Governance or Legal issues

This policy outlines the commitment by the Board of Directors and governors to developing engagement and two-way communication to carry out their respective roles effectively

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

- The Policy includes an EIRA (Equality Impact Risk Analysis) that states that Governors are fully supported by the Trust and reasonable adjustments implemented. Governors are offered on-going support and training to ensure that they can carry out their role. This includes provision of support workers where required and working with individual governors to ensure they have access to information in a preferred format (for example, in hard copy rather than email). Governors are also supported to attend meetings where they have disability and/or access issues.

Recommendations

The Board of Directors is requested to approve the revised policy document.

Report prepared by **Justine Fitzjohn**
Trust Secretary

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

Policy for engagement between the Trust Board and the Council of Governors

See also:	Located in the following policy folder on the Trust Intranet
Trust Constitution	N/A – latest version is available on the NHSI website

Service area	Issue date	Issue no.	Review date	
Trust wide	November 2019	02	Oct 2022	
Ratified by	**Ratification date**	**Responsibility for review:**		
Board of Directors	November 2019	Board of Directors		

Document published on the Trust Intranet under: Corporate Policies and

Did you print this document?

Please be advised that the Trust discourages retention of hard copies of policies and can only guarantee that the Policy on the Trust Intranet site is the most up-to date version

ACCESSIBLE INFORMATION STANDARD

The Accessible Information Standard directs and defines a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of service users.

Ensure you have considered an agreed process for: sending out correspondence in alternative formats and appointments for patients / service users with communication needs, where this is applicable.

Checklist for Policy for engagement between the Trust Board and the Council of Governors

Summary (Plain English) Summarise the main points of the policy below in a style that is clear and easy to understand. Ensure the whole policy is written in plain English, using simple language where possible and avoiding convoluted sentences and obscure words. The resulting policy should be easy to read, understand and use.
The Policy outlines the commitment by the Board of Directors and governors to developing engagement and two-way communication to carry out their respective roles effectively.

Name / Title	Policy for Engagement between the Trust Board and the Council of Governors	
Aim of Policy	To outline the commitment by the Board of Directors and governors to developing engagement and two-way communication to carry out their respective roles effectively.	
Sponsor	Trust Secretary	
Author(s)	Trust Secretary	
Name of policy being replaced	Policy for Engagement between the Trust Board and the Council of Governors	**Version No of previous policy:** **01**

Reason for document production:	GIAP Requirement and best practise
Commissioning individual or group:	Trust Board and Council of Governors

Individuals or groups who have been consulted Issue 1:	**Date:**	**Response**
Governance Committee	6 June and 7 July 2016	Approved
Council of Governors	6 September 2016	Formally agreed subject to Trust Board approval
Board	Oct 2016	Approved
Individuals or groups who have been consulted Issue 2		
Governance Committee	10 October 2019	
Trust Board	5 November 2019	

Name of policy document:	Engagement between the Trust Board and Council of Governors
Issue No:	02

Version control (for minor amendments) - issue 1

Date	Author	Comment
24 January 2018	Assistant Trust Secretary	Addition of Deputy Lead Governor to point 3.3.4. Correction to 3.8.2, bullet point 8, from Nominations and Remuneration Committee to Council of Governors. Amendments approved Trust Board in Development Session on 20 December 2018 and ratified by Council of Governors on 24 January 2018

Version control (for minor amendments) – issue 2

Date	Author	Comment
October 2019	Trust Secretary	• Change from Director of Corporate Affairs and Trust Secretary to Trust Secretary • Amendment to 3.4.1 to allow more flexibility on areas of focus when the Trust Board and Council of Governor meet jointly. • Amendment to 3.8 to match with the changes agreed at the Council of Governors meeting in May 2019 regarding the Lead Governor and Deputy Lead Governor role.

Policy for engagement between the Trust Board and Council of Governors

1. Introduction

2. Purpose

3. Relationship between the Trust Board and Council of Governors

4. Handling of concerns.

5. Associated documents

Appendix A
Powers and duties of the Trust Board and the Council of Governors

Appendix B
Role of the Senior Independent Director

Appendix C
Grounds and procedure for the removal of the Chair or any Non-Executive Director

Appendix D
Disputes Resolution Procedure

Policy for engagement between the Trust Board and the Council of Governors

1. Introduction

The Trust Board is accountable to the community it serves and discharges that responsibility through its relationship with the Council of Governors. The Council of Governors represents the community and its major stakeholders, including staff, through elected and nominated members.

The Board leads the Trust by undertaking four key roles:

- setting strategy
- supervising the work of the executive in the delivery of the strategy and through seeking
- assurance that systems of control are robust and reliable
- setting and leading a positive culture for the board and the organisation
- giving account and answering to key stakeholders, particularly Councils of Governors.

The statutory general duties of the Council of Governors are:

- to hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors, and
- to represent the interests of the members of the corporation as a whole and the interests of the public.

The Trust Board recognises that it needs to enable the Council to hold it to account, in the first instance through the Non-Executive Directors. The Trust Board commits to consult governors on all strategic issues and material service developments before decisions are made, recognising that governor feedback enables a better informed and more effective Board.

Governors provide an important assurance role for the Trust by scrutinising the performance of the Board. The Trust Board and Council of Governors commit to work together constructively, based on openness and transparency, good communication and strong mutual understanding. They respect the different roles of each and the have common aim to work in the best interests of the organisation.

This policy outlines the commitment by the Board of Directors and governors to developing engagement and two-way communication to carry out their respective roles effectively.

Name of policy document:	Engagement between the Trust Board and Council of Governors
Issue No:	02

- The Trust Board and Council of Governors are committed to building and maintaining an open and constructive working relationship. Under-pinning such a relationship is the need for clarity on the respective roles and responsibilities.
- NHS Improvement's Code of Governance (2013) recommends that each Foundation Trust should have a Policy for Engagement between the Trust Board and the Council of Governors, which clearly sets out how the two bodies will interact with one another for the benefit of the Trust.

- This policy for engagement clarifies the respective roles and responsibilities of the Board and the Council of Governors, and describes the information flow between the two groups. The policy describes the involvement of governors in forward planning, and the role they plan in respect of holding the Trust Board to account.

- This policy for engagement also sets out a process should the governors have a concern about the performance of the Board, compliance with the licence or the welfare of the Trust. It also describes the process should the governors have significant concerns about the performance of the Chair or Non-Executive Directors.

- This policy is intended to provide clear guidance and a useful framework for both the Trust Board and Council of Governors and has been approved by each respectively.

The policy also encompasses those activities which we have developed within the Trust such as the yearly Board/Council of Governor sessions and Governor/Non-Executive Director informal sessions.

In developing this policy both the Board and the Council of Governors are keen to maintain commitment to the Nolan principles which are a foundation of our roles:

The Nolan Principles - The Seven Principles of Public Life

Selflessness
Holders of public office should take decisions solely in terms of the public interest. They should not do so in order to gain financial or other material benefits for themselves, their family, or their friends.

Integrity
Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might influence them in the performance of their official duties.

Objectivity

In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit.

Accountability
Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.

Openness
Holders of public office should be as open as possible about all the decisions and actions that they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands.

Honesty
Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.

Leadership
Holders of public office should promote and support these principles by leadership and example.

2. Purpose

2.1 The Board is committed to building and maintaining an open and constructive working relationship with the Council of Governors. The Board believes that it is important that the respective powers and roles of the Trust Board and the Council of Governors are clear, and are followed in practice.

2.2 There may be times where the Council of Governors has concerns about the running of the Trust. NHS Improvement's Code of Governance recommends that the Council of Governors should establish a Policy for Engagement with the Trust Board for those circumstances when they have concerns about the performance of the Trust Board, compliance with its licence or the welfare of the Trust.

2.2 The purpose of this policy is therefore to:

- set out the systems and structures to promote a constructive working relationship between the Council of Governors and the Trust Board
- set out a process for dealing with problems that may arise, as recommended by NHS Improvement's Code of Governance.

2.3 This policy complements the Trust’s arrangements for governor communication with NHS Improvement and the Care Quality Commission (CQC) where governors have concluded that a Trust has failed, or is failing, to act in accordance with its constitution, or Chapter 5 of the Health and Social Care Act (2006) and where it is considered that the intervention of NHS Improvement or the Care Quality Commission may be appropriate. That is, it is the role of the Lead Governor to contact regulators in this instance.

3. Relationship between the Trust Board and the Council of Governors

3.1 Powers and Duties, Roles and Responsibilities

3.1.1 The respective powers and roles of the Trust Board and the Council of Governors are set out in their Standing Orders and the Trust Constitution.

3.1.2 The Trust Board and the Council of Governors should understand their respective roles and seek to follow them in practice. Any concerns or queries should be raised with the Chair, Trust Secretary or Lead Governor.

3.1.3 The Trust will provide induction and ongoing training regarding roles and responsibilities.

3.2 Trust Board and Council of Governors

3.2.1 In order to facilitate communication between the Trust Board and Council of Governors, there will be an opportunity for governors to raise questions linked to the agenda of each public Trust Board meeting. As per established arrangements for questions to the Trust Board, these should be submitted to Board Secretary at least 48 hours prior to the Board meeting.

3.2.2 The Council of Governors will have the opportunity to submit formal questions/concerns to the Trust Board, and will receive a response within seven working days of the meeting.

3.2.3 Governors may, by informing the Chair, request an item to be added to the agenda of the Council of Governors for discussion, or via the Governance Committee, or raise as ‘any other business’ at the Council of Governors meeting.

3.2.4 Governors will have the opportunity to raise questions about the affairs of the Trust with any Director present at a meeting of the Council of Governors. Wherever possible, questions should be submitted to the Chair in advance of

the meeting, to enable a reasonable time to be allocated during the meeting. Where this is not possible, a written response will be provided within seven days of the meeting.

3.2.5 Whilst a confidential part of Board of Director meetings will be held in private the agenda from these meetings will be made available for governors, via the Lead Governor. The public Trust Board papers will be sent to governors electronically and are also available from the Trust website prior to the meeting.

3.3 Role of the Chair

3.3.1 The Chair is responsible for leadership of the Trust Board and the Council of Governors, ensuring their effectiveness on all aspects of the role and setting their agenda. The Chair is responsible for ensuring that the two groups work together effectively, and that they receive the information they require to carry out their duties.

3.3.2 In the Chair's absence meetings of the Council of Governors will be chaired by the Deputy Chair of the Trust Board.

3.3.3 The Chair will ensure that the views of governors and members are communicated to the Trust Board and that the Council of Governors is informed of key Trust Board decisions.

3.3.4 The Chair will meet with the Lead Governor and the Deputy Lead Governor, and will have 1:1 meetings with individual governors as reasonably requested.

3.4 Role of the Trust Board

3.4.1 The Trust Board will formally meet with the Council of Governors at least once a year to discuss areas of mutual benefit.

3.5 Role of Non-Executive Directors and the Senior Independent Director

3.5.1 Non-Executive Directors will be invited to attend meetings of the Council of Governors, make presentations and answer questions as appropriate.

3.5.2 Non-Executive Directors will commit time to build effective relationships with governors and governors and Non-Executive Directors will agree to spend time together to understand each other's perspectives and build good levels of mutual understanding.

3.5.2 The Senior Independent Director will be available to the Council of Governors and individual governors if they have concerns which contact through the normal channels of Chair has failed to resolve or for which such contact is inappropriate. The Senior Independent Director should attend sufficient meetings of the Council of Governors Council to listen to their views in order to help develop a balanced understanding of the issues and concerns of the governors and members.

3.5.3 The role of the Senior Independent Director is set out in Appendix B.

3.5.4 The process to be followed in dealing with concerns is set out in Section 4.

3.6 Role of Executive Directors

3.6.1 Executive directors (including the Chief Executive or deputy) will be invited to attend Council of Governors meetings, and be asked to facilitate discussions and answer questions as appropriate.

3.7 Role of the Governors

3.7.1 Governors are required to meet the statutory duties as set out in Appendix A.

3.8 Role of the Lead Governor and Deputy Lead Governor of the Council of Governors

3.8.1 As Lead Governor:

- Act as a direct link between the governors and NHS Improvement in situations where it would be inappropriate to go through the Chair
- Act as the point of contact between the Council of Governors and the Care Quality Commission
- Prioritise agenda items for the Council of Governors and ensure action plans are followed
- In exceptional circumstances, act as deputy to the Trust Chair in situations relating to CoG, when it is not appropriate for the usual Trust Deputy Chairperson to act into this role
- Maintain regular communication with the Chair, conducting regular reviews of the performance of the Trust
- Member of the Nominations and Remuneration Committee
- Member of the Governance Committee
- Represent concerns that governors may have (either as a body, or individually) to the Chair

- To undertake appropriate action where non-compliance or any misconduct is alleged under the Governors' Code of Conduct, as set out in the Code, which could include, together with the Chair addressing inappropriate action by any Governor and raising the matter at the Governance Committee subject to Nominations and Remuneration Committee approval.
- Lead the appraisal process for the Council of Governors, and facilitate the Council of Governors review of effectiveness
- Maintain a close working relationship with the Senior Independent Director (SID) of the Board of Directors
- Together with the SID carry out the appraisal of the Chair
- Agree the format of regular Council of Governor/Non-Executive Director meetings
- As representative of the Trust's Council of Governors establish and maintain working relationships with NEDs, the Board of Directors and forge links with external bodies such as CQC, Health and Wellbeing Board and Council of Governors of other foundation trusts.
- Together with the Chair, mutually agree with a Governor any formal time away from the role. The Lead Governor will then provide support following return of that governor from a leave of absence.

3.8.2 Deputy Lead Governor

3.8.2.1 The Deputy Lead Governor is not a mandated role. The duties are:

- To deputise for the Lead Governor in their absence through illness or other clashing commitments

- To cover for the Lead Governor, where the Lead Governor may have a conflict of interest in taking part in an activity

- To offer support alongside the Lead Governor in maintaining working relationships with external bodies as detailed in the Lead Governor Role Description.

- To familiarise themselves with the workings of the Trust, NHSI and any other agencies in order to carry out their role.

3.9 Council of Governors involvement in forward planning

3.9.1 When the Trust Board is engaged in strategic planning (e.g. annual planning, strategic direction) governors will be involved in the process so that the views of members can be properly canvassed and fed into the process.

3.10 Accountability

3.10.1 The Council of Governors has a role to hold the Non-Executive Directors individually and collectively to account for the performance of the Trust Board, including ensuring the Trust Board acts so that the Trust does not breach its licence. In order to carry out this role, the Council of Governors will be provided with high quality information that is relevant to the decisions they have to make. The information needs of the Council of Governors will be discussed as part of the induction process and subject to ongoing review, and the governors will be consulted in the planning of agendas of Council of Governors meetings.

3.10.2 NHS Improvement's Code of Governance provides that the Trust Board will notify the Council of Governors of any major new developments or changes to the Trust's financial condition, performance of its business or expectations as to its performance, that if made public would be likely to lead to a substantial change to the financial well-being, healthcare delivery performance or reputational standing of the Trust.

3.10.3 The Health & Social Care Act 2012 places a mandatory duty on the Board of Directors to consult with and seek the agreement of the Council of Governors on 'significant transactions' including mergers, acquisition, dissolution, separation, raising additional services from activities other than via its principal purpose and raising the threshold of funds raised from private patients as outlined in the Trust's Constitution.

3.10.4 The Council of Governors have the powers to call an Executive Director to the Council of Governors for the purpose of obtaining information about the Trust's performance of its functions or the Director's performance of their duties.

4. Handling of Concerns

4.1 A concern, in the meaning of this policy, must be directly related to either:

- The performance of the Trust Board, or
- Compliance with the licence, or
- The welfare of the Trust

Other matters that do not constitute a concern can be raised with the Chair to be discussed at the appropriate forum (see para 3.2.2-3.2.4).

4.2 Stage 1 – Informal

4.2.1 In the event that the Council of Governors has a concern of the type described above, every attempt should be made to resolve the matter firstly by discussion with the Chair. Where it affects financial matters, the Director of Finance should be involved. The Lead Governor should normally represent the Council of Governors in these matters, and they will consider whether additional representation is required.

4.2.2 Every attempt should be made to resolve concerns in an appropriate way, and as quickly as possible. This may involve the Chair convening a meeting with governors, and/or requesting reports from the Chief Executive, Director of Finance or another director or officer of the Trust, or a report from the Audit and Risk Committee or other committee, and providing comments on any proposed remedial action.

4.2.3 The outcome of the matter will be reported to the next formal meeting of the Council of Governors, who will consider whether the matter has been resolved satisfactorily.

4.3 Stage 2 – Formal

4.3.1 This is the formal stage where stage 1 has failed to produce a resolution and the services of an independent person are required. In this case the Senior Independent Director assumes the role of mediator, as recommended by the Code of Governance, and conducts an investigation.

4.3.2 The decision to proceed to Stage 2 and beyond will always be considered by the full Council of Governors, at an extraordinary, private meeting. This is to ensure that any decision is a collective Council of Governors decision. The decision to proceed to Stage 2 must be collectively agreed by a majority of the Council of Governors present at a meeting which is quorate. In the event that the Council of Governors does not agree to proceed to Stage 2, that decision is final.

4.3.3 Evidence requirements

Any concern should be supported by relevant evidence. It cannot be based on hearsay alone, and should meet the following criteria:

- Any written statement must be from an identifiable person(s) who must sign the statement and be willing to be interviewed under either stage of this process.
- Other documentation must originate from a bona fide organisation and the source must be clearly identifiable. Newspaper articles will not be accepted as prima facie evidence but may be admitted as supporting evidence.

- Where the concern includes hearsay, e.g. media reports, the Council of Governors may require the Trust Board to provide explanations and, if necessary, evidence to show that the hearsay reports are untrue.

4.3.4 Investigation and Decision of the Senior Independent Director.

4.3.4.1 The Senior Independent Director's role is to seek to resolve the matter in the best interests of the Trust.

4.3.4.2 The Senior Independent Director will produce a written report of their findings and recommendations and present it to the Council of Governors and Trust Board. The report will address the issues raised by the Council of Governors, and will also consider whether action is required to repair any breakdown in the relationship between the Trust Board and the Council of Governors.

4.3.4.3 The decision of the Senior Independent Director will be final in resolving the matter in the best interests of the Trust.

4.3.4.4 In the event that the Council of Governors' remain dissatisfied with the Senior Independent Director's decision, the options in paragraph 3.4 may be considered.

4.4 Action in event of Stage 2 failing to achieve resolution

4.4.1 If the Council of Governors does not consider that the matter has been adequately resolved, they have four options:

- Accept the failure to reach a resolution of the matter and consider the matter closed; or
- Seek the intervention of another independent mediator (i.e. a Chair or Senior Independent Director from another NHS Foundation Trust) in order to seek resolution of the matter, or
- Inform NHS Improvement if the Trust is at risk of breaching its licence.
- Follow the Dispute Resolution Procedure (as outlined at Appendix D).

- **4.5 Removal of the Chair or any Non-Executive Director**

4.5.1 In relation to concerns raised in accordance with this policy, the Council of Governors should only exercise its power to remove the Chair or any Non-Executive Directors after exhausting all other means of engagement with the Trust Board.

4.5.2 The procedure for removing the Chair or a Non-Executive Director is set out in Appendix C.

Appendix A

Powers and duties of the Trust Board and the Council of Governors

Trust Board:	Council of Governors:
All the powers of the Trust are to be exercised by the Trust Board. The Trust Board may do anything which appears to it to be necessary or desirable for the purposes of or in connection with the functions of the Trust, subject to any restrictions in its licence. The powers of the Trust Board include, but are not limited to, the ability to borrow and invest money, acquire and dispose of property, enter into contracts, accept gifts of property (including property to be held on Trust for the purposes of the Foundation Trust or for any purposes relating to the health service), and employ staff.	The Council of Governors cannot veto decisions made by the Trust Board.
The Trust Board must submit forward planning information and annual reports and accounts to NHS Improvement, after consulting with the Council of Governors and having regard to their views.	The Council of Governors is to be consulted on forward planning by the Trust Board, and the Trust Board must have regard to their views.
The Trust Board will present the annual report and accounts and the auditors report to the Council of Governors and will lay a copy of the annual accounts, and any report of the auditor on them before Parliament, and once it has done so, send copies of these documents to NHS Improvement, along with the annual report.	The Council of Governors is to be presented with the annual report and accounts and the report of the auditor on them, at a general meeting of the Council of Governors.
It is for the Non-Executive Directors to appoint and remove the Chief Executive. The appointment of the Chief Executive requires the approval of the Council of Governors.	The Council of Governors is to approve the appointment of the Chief Executive by the Non-Executive Directors. The appointment requires the approval of a majority of the Council of Governors.

Trust Board:	Council of Governors:
It is for a committee consisting of the Chair, the Chief Executive and the other Non-Executive Directors to appoint or remove the Executive Directors	The Council of Governors is to appoint the chair and other Non-Executive Directors of the NHS Foundation Trust at a general meeting of the Council of Governors. The appointment requires the approval of a majority of the members of the Council of Governors. If the Council of Governors is to remove the Chair or Non-Executive Directors of the NHS Foundation Trust, such removal must occur at a general meeting of the Council of Governors and it requires the approval of three quarters of the members of the Council of Governors.
The Trust Board must establish a committee of Non-Executive Directors to decide the remuneration and allowances, and the other terms and conditions of office, of the Chief Executive and other Executive Directors	The Council of Governors is to decide the remuneration and allowances, and the other terms and conditions of office, of the Non-Executive Directors. The decision requires the approval of a majority of the members of the Council of Governors.
The Trust Board must establish a committee of Non-Executive Directors to act as an Audit Committee	The Council of Governors is to appoint or remove the external auditor at a general meeting of the Council of Governors. The appointment and removal requires the approval of a majority of the members of the Council of Governors.
Provide active leadership of the Trust within a framework of prudent and effective controls which enable risk to be assessed and managed.	Represent the interests of the Trust's members and partner organisations in the local health economy.

Trust Board:	Council of Governors:
Set the Trust's strategic aims, taking into consideration the views of the Council of Governors, ensuring that the financial and human resources are in place for the Trust to meet its objectives, and review management performance.	Regularly feedback information about the Trust, its vision and its performance to the constituencies and the stakeholder organisations that either elected or appointed them.
Ensure compliance by the Trust with its licence, its Constitution, mandatory guidance issued by regulators, relevant statutory requirements and contractual obligations.	Act in the best interests of the Trust and adhere to its values and governor Code of Conduct.
Ensure the quality and safety of healthcare services, education, training and research delivered by the Trust and apply the principles and standards of clinical governance set out by relevant NHS bodies.	Hold the Non-Executive Directors individually and collectively to account for the performance of the Trust Board including ensuring the Trust Board acts so that the Trust does not breach its licence.
Ensure that adequate systems and processes are maintained to measure and monitor the Trust's effectiveness, efficiency and economy as well as the quality of its healthcare delivery.	Acknowledge the overall responsibility of the Trust Board for running the Trust and should not try to use the powers of the Council of Governors to veto decisions of the Trust Board.
Regularly review the performance of the Trust in these areas against regulatory requirements and approved plans and objectives.	Establish a policy for engagement with the Trust Board for those circumstances when they have concerns about the performance of the Trust Board, compliance with its licence or the welfare of the Trust.
Establish the values and standards of conduct for the Trust and its staff in accordance with NHS values and accepted standards of behaviour in public life, and operate a Code of Conduct that builds on the values of the Trust and reflects high standards of probity and responsibility.	Inform the Independent Regulator if the Trust is at risk of breaching its licence if these concerns cannot be resolved at a local level.

Trust Board:	Council of Governors:
Ensure that there is a formal, rigorous and transparent procedure for the appointment or election of new members to the Trust Board, and satisfy itself that plans are in place for orderly succession of appointments to the Trust Board so as to maintain an appropriate balance of skills and experience within the Trust and on the Trust Board, and ensure planned and progressive refreshing of the Trust Board.	Agree a process for the evaluation of the Chair and the Non-Executive Directors, with the Chair and the Non-Executive Directors, and agree the outcomes of the evaluations.
Present a balanced and understandable assessment of the Trust's position and prospects.	Agree with the Audit and Risk Committee of the Trust Board the criteria for appointing, reappointing and removing external auditors.
Maintain a sound system of internal control to safeguard public and private investment, the Trust's assets, patient safety and service quality.	Work with the Trust Board on such other matters for the benefit of the Trust as may be agreed between them.
Establish formal and transparent arrangements for considering how they should apply the financial reporting and internal control principles and for maintaining an appropriate relationship with the Trust's auditors.	Assess its own collective performance and its impact on the Trust, and communicate this to the members of the Trust.
Consult and involve members, patients, clients and the local community, and monitor how representative the Trust's membership is and the level of effectiveness of member engagement.	Liaise with members via membership emails and publications. When appropriate hold meetings with members, which could include constituency meetings to ensure Member's interests are represented and Trust information is fed back.
Ensure that the Trust co-operates with other NHS bodies, local authorities and other relevant organisations with an interest in the local health economy.	

Trust Board:	Council of Governors:
Work with the Council of Governors on such other matters for the benefit of the Trust as may be agreed between them.	Raise issues and matters for discussion: Contact Chair/Membership and Involvement Manager to identify an appropriate forum and to submit items for meetings, eg - Request items to be included in the Council of Governors (or Governance Committee) agenda or raise matters under Any Other Business - Raise formal questions for response by the Trust Board - Ask questions of the Chief Executive at Council of Governors meetings.
Follow the principles of openness and transparency in its proceedings and decision making unless this conflicts with a need to protect the wider interests of the public or the Trust (including commercial in confidence matters) and make clear how potential conflicts of interests are dealt with.	
Undertake a formal and rigorous annual evaluation of its own performance and that of its committees and individual directors.	

Appendix B

Role of the Senior Independent Director

The Senior Independent Director (SID) will be a Non-Executive Director of the Trust Board.

The SID's role will be

- To be available to the Trust Directors if they have concerns which cannot be resolved through the normal channels (or is inappropriate) of the Chair or Chief Executive.

- To support the Chair in resolving disputes between individual Trust Board members in respect of their role as a director of the Trust.

In respect of the Council of Governors

- To be available to members and governors if they have concerns which cannot be resolved through the normal channels (or is inappropriate) of the Chair or Chief Executive. To maintain sufficient contact with governors to understand their issues and concerns, including building an effective relationship with the Lead Governor.

- To help resolving disagreements between the Council of Governors and Trust Board in accordance with the policy setting out the approach to be taken in these circumstances

- To agree a process for evaluating the performance of the Chair and to agree appropriate processes for reporting such evaluation annually to the governor Nominations and Remuneration Committee.

- To work with the Chair to establish a policy for engagement of the Council of Governors with the Trust Board.

APPENDIX C

Grounds and Procedure for the Removal of the Chair or any Non-Executive Director

Introduction

The Council of Governors has the power to remove the Chair and any Non-Executive Director of the Trust. Such removal must occur at a general meeting of the Council of Governors and requires the approval of three quarters of the members of the Council of Governors.

In relation to concerns raised under the Policy for Engagement, the Council of Governors should only exercise its power to remove a Non-Executive Director after exhausting all other means of engagement with the Trust Board, as set out in that policy.

Grounds for removal

The removal of a Non-Executive Director should be based on the following criteria. Grounds for removal can include the following:

a) s/he is not qualified, or is disqualified, from becoming or continuing as a Non-Executive Director under the Constitution
b) s/he has failed to attend meetings of the Trust Board for a period of six months
c) s/he has failed to discharge his/her duties as a Non-Executive Director
d) s/he has knowingly or recklessly made a false declaration for any purpose provided for under the Constitution or in the 2006 Act
e) s/he has knowingly or recklessly failed to declare a conflict of interest
f) his/her continuing as a Non-Executive Director would be likely to:
    I. prejudice the ability of the Trust to fulfil its principal purpose or other of its purposes under the Constitution or otherwise to discharge its duties or functions
    II. harm the Trust’s work with other persons or bodies with whom it is engaged or may be engaged in the provisions of goods or services
    III. adversely affect public confidence in the goods and services provided by the Trust; or otherwise bring the Trust into disrepute
g) s/he has failed or refused to comply with the regulatory framework, the Standing Orders, or any Code of Conduct which the Trust shall have published from time to time
h) s/he has refused without reasonable cause to undertake any training which the Trust requires all Non-Executive Directors to undertake

i) s/he purports to represent the views of any professional body, political party or trade union of which he is a member

j) it is not in the interests of the Trust for the Non-Executive Director to continue to hold office

k) s/he does meet the criteria as outlined in the Trust Fit and Proper Persons Test policy.

The following list provides examples of matters which may indicate to the Council of Governors that it is no longer in the interests of the Trust that a Non-Executive Director continues in office. The list is not intended to be exhaustive or definitive; the Council of Governors will consider each case on its merits, taking account of all relevant factors.

a) If an annual appraisal or sequence of appraisals is unsatisfactory

b) If the Non-Executive Director loses the confidence of the Trust Board

c) If the Non-Executive Director loses the confidence of the public or local community in a substantial way

d) If the Non-Executive Director fails to monitor the performance of the Trust in an effective way

e) If the Non-Executive Director fails to deliver work against pre- agreed targets incorporated within their annual objectives

f) If there is a terminal breakdown in essential relationships, e.g. between a Chair and a Chief Executive or between a Non-Executive Director and the Chair or the rest of the Trust Board.

Procedure

a) Any proposal to remove a Non-Executive Director can be proposed by a Council member, the Chair, or the Trust Board.

b) The Non-Executive Director will be notified in writing of the allegations, and be invited to submit a response.

c) The Non-Executive Director is entitled to address the Council of Governors at the meeting considering the proposal to remove him/her.

d) The Trust Board may make representations to the Council of Governors whether they are for, or against the resolution, or even if they are divided.

e) The Council of Governors may consider any relevant evidence, e.g. appraisal documentation or witness statements.

f) The Council of Governors should take professional advice, via the Trust Secretary, prior to removing a Non-Executive Director.

g) In relation to concerns raised in accordance with the Policy for Engagement, the Council of Governors should only exercise its power to remove a Non-Executive Director after exhausting all other means of engagement with the Trust Board.

Chair of meetings

The Chair may normally express an opinion on the appointment and removal of a Non-Executive Director, but does not have formal voting rights at the Council of Governors in a vote to remove the Non-Executive Director.

The Chair should also consider, however, whether in particular circumstances a conflict of interest arises in dealing with the removal of a Non-Executive Director, and if so, stand aside for that part of the meeting.

For the removal of the Chair, the Senior Independent Director will preside at meetings of the Council of Governors.

Removal and disqualification of governors

The process for the removal and disqualification of governors is covered in Annex 5 of the Trust's constitution.

Appendix D

Dispute Resolution Procedure

In the event of dispute between the Council of Governors and the Trust Board, where the above policy has been followed as appropriate through informal (Stage 1) and formal (Stage 2) procedures at outlined at 4.2 and 4.3, the dispute resolution procedure can be considered as a further option should Stage 2 procedures fail to achieve a resolution:

1. In the first instance the Chair on the advice of the Trust Secretary, and such other advice as the Chair may see fit to obtain, shall seek to resolve the dispute.

2. If the Chair is unable to resolve the dispute he shall appoint a special committee comprising equal numbers of Directors and Governors to consider the circumstances and to make recommendations to the Council of Governors and the Board of Directors with a view to resolving the dispute.

3. If the recommendations (if any) of the special committee are unsuccessful in resolving the dispute, the Chair may refer the dispute back to the Trust Board who shall make the final decision.

4. Under the 2006 Act, as amended, NHS Improvement has appointed a Panel for Advising Governors (the Panel) to which governors of NHS foundation trusts may refer a question concerning whether their trust has failed, or is failing, to act in accordance with its constitution, or Chapter 5 of the 2006 Act.

REGARDS EIRA: Assessing Equality Relevance (Stage 1)

To be completed and attached to any policy document or framework when submitted to the appropriate committee for consideration and approval.

Name of activity/proposal/policy/function	Policy for Engagement between the Trust Board and the Council of Governors
Date screening commenced	October 2019
Name and role of person undertaking this REGARDS EIRA	Justine Fitzjohn, Trust Secretary

Step 1: Give an overview of the aims, objectives, intended outcomes and who will benefit from the activity or proposal (equality relevant and succinct)?
To outline the commitment by the Board of Directors and governors to developing engagement and two-way communication to carry out their respective roles effectively.

Step 2 Evidence & Engagement – What early data or evidence have you used to substantiate your decisions? Please provide details of who you have engaged, dates and add links to research and data

The policy has been developed from reviewing best practice and incorporates comments arising from discussion by governors at the Governance Committee at its 6 June 2016 and 7 July 2016 meeting. The governors subsequently approved the policy at the Council of Governors meeting on 6 September for onward consideration by the Board of Directors. It was approved by the Board of Directors at its meeting on 5 October 2016. The policy was reviewed in October 2019 and a number of minor amendments were presented to the Governance Committee on 10 October 2019. The policy will be reported to the Trust Board for approval on 5 November 2019 and will be reviewed at three year intervals.

Step 3: Impact - What impact does this activity/policy or changes in function have on those within the REGARDS/protected characteristic groups?

Area of potential impact REGARDS Impact Positive or Negative (- or +) Not sufficient to just tick please provide details	Reduce discrimination -/+		Promote/increase equality of opportunity or access -/+		Reduce inequalities -/+		Promote good community relations -/+	
Race (Ethnicity)	+	See below	+	See below	+	See below	+	See below
Economic Disadvantage	+	See below	+	See below	+	See below	+	See below
Gender/Sex & Gender Reassignment	+	See below	+	See below	+	See below	+	See below
Age	+	See below	+	See below	+	See below	+	See below
Religion or Belief	+	See below	+	See below	+	See below	+	See below
Disability	+	See below	+	See below	+	See below	+	See below
Sexual Orientation	+	See below	+	See below	+	See below	+	See below
Pregnancy & Maternity	+	See below	+	See below	+	See below	+	See below
Marriage & Civil Partnership	+	See below	+	See below	+	See below	+	See below
Other equality groups/people e.g. carers, homeless, substance misuse, unemployed, offenders, veterans & sex workers	+	See below	+	See below	+	See below	+	

Governors are fully supported by the Trust and reasonable adjustments implemented. Governors are offered on-going support and training to ensure that they can carry out their role. This includes provision of support workers where required and working with individual governors to ensure they have access to information in a

preferred format (for example, in hard copy rather than email). Governors are also supported to attend meetings where they have disability and/or access issues.			
Step 4 : Risk Assessment			
Does this activity propose major changes in terms of scale or significance for DHCFT? YES: is there a clear indication that, although the policy is minor it is likely to have a major affect for people from REGARDS equality groups e.g. service design, delivery, reoccurring issues of inequality or unequal access. Please tick appropriate box below			
YES		**No**	
High Risk : Complete Full REGARDS EIRA		**No Impact/Low Risk**: Go to step 5	
Step 5 : REGARDS Completion Statement			
If this proposal has <u>No impact/equality neutral/low impact</u> - please spell out/ provide evidence/links and justification for how you reached this decision. Please remember that a REGARDS EIRA can be called upon at any time to justify decision making or asked for as part of audit. This policy's affect in respect of protected characteristics is neutral.			
Sign off that this is low risk and does not require a full EIRA Name Reviewer/Assessor: Justine Fitzjohn Date 29 September 2019			

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 5 November 2019

Board Assurance Framework (BAF)
Fourth Issue for 2019/20

Purpose of Report

To meet the requirement for Boards to produce an Assurance Framework. This report details the fourth issue of the BAF for 2019/20.

Executive Summary

- Due to the timing of Board and Committee meetings, Version 3 of the BAF was last reviewed by Board recently, on 3 September 2019. The risk ratings for all risks remain the same overall, however significant work continues to mitigate the actions against the gaps in controls and assurances identified in the BAF. As in previous versions, changes between versions presented to the Board are highlighted in blue text.
- At Board in September 2019 it was raised that the discussion from the previous Audit and Risk Committee in relation to BAF risk 1a had not been clearly articulated in the version of the BAF presented. The Committee had questioned if the risks associated with the acute care pathway were impacting on community service waiting times and together with the lack of commissioning to deliver a full service, should be articulated in the BAF. Discussion at the Executive Leadership Team (ELT) on 16 September identified that assurances around community waiting times are in place and will be presented via the next deep dive/position statement to the Board on access and responsiveness. In addition waiting time risks for specific services are already articulated in a number of operational risks. ELT noted that while the acute care pathway was a minor contributor to increased community waiting times, the greater impact was increasing demand and this is already noted as a root cause in risk 1a.
- An additional gap in control has been added to the BAF for risk 3a following discussion and challenge at Finance and Performance Committee on17 September The Director of Finance included a gap which describes the need to manage and mitigate emergent cost pressures arising as a result of clinical, quality, operational and strategic requirements.

An expected completion date for each action continues to be shown alongside the action review date, shown in brackets, to enable Board Committees to focus the reports and reviews required to mitigate the risks identified.

One risk continues to remain removed from formal reporting through the BAF due to commercial sensitivities.

The updated BAF deep dive programme is attached. It was proposed to the Audit and Risk Committee that the deep dive for risk 1a be moved to January 2020, due to the Board having received a deep dive on the risk at an extraordinary meeting in August 2019 and the close scrutiny and monitoring of the risk via Quality Committee on a monthly basis. However due to the level of risk identified, the Audit and Risk

Committee requested it be competed sooner. Therefore an additional meeting has been convened after Board on 3 December to allow for this to take place.

Strategic Considerations	
1) We will deliver **great care** by delivering compassionate, person-centred innovative and safe care	x
2) We will ensure that the Trust is a **great place to work** by attracting colleagues to work with us who we develop, retain and support by excellent management and leadership	x
3) We will make the **best use of our money** by making financially wise decisions and will always strive for best value to make money go further	x

Assurances

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

Consultation

- Executive Leadership Team: 16 September 2019
- Audit and Risk Committee: 03 October 2019

Governance or Legal Issues

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

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

- Specific elements within each BAF risk and associated actions are addressed by the relevant lead Executive Director in taking forward. The Audit and Risk Committee in October 2019 requested all Board Committees undertake a mid-year review of agenda items to ensure the Committee was discharging its duties in relation its public sector equality duty.

Recommendations

The Board of Directors is requested to:

1) Approve this fourth issue of the BAF for 2019/20 and the significant assurance the paper provides of the process of the review, scrutiny and update of the BAF in seeking to identify and mitigate risks to achieving the Trust's strategic objectives
2) Agree to continue receive a quarterly update of the 2019/20 BAF risks as outlined in the forward plan.

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

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

Rachel Kempster
Risk and Assurance Manager

Board Assurance Framework

Movement of risks and deep dive programme for Fourth Issue of the BAF for 2019/20

The Board Assurance Framework (BAF) is a high level report which enables the Board of Directors to demonstrate how it has identified and met its assurance needs, focused on the delivery of its objectives and subsequent principal risks. The BAF provides a central basis to support the Board's disclosure requirements with regard to the Annual Governance Statement (AGS), which the Chief Executive signs on behalf of the Board of Directors, as part of the statutory accounts and annual report. This is the fourth formal presentation of the Board Assurance Framework to the Board for 2019/20

1) Overview and movement of risks 2019/20

A summary of all risks currently identified in the 2019/20 BAF is shown below, together with the movement of the risk rating throughout the year.

BAF ID	Risk title	Director Lead	Risk rating Issue 1	Risk rating Issue 2	Risk rating Issue 3	Risk rating Issue 4	Risk rating Issue 5	Direction of movement
19_20 1a	There is a risk that the Trust will fail to provide standards for safety and effectiveness required by our Board	Director of Nursing and Patient Experience/Medical Director	HIGH (4x4)	HIGH (4x4)	EXT (5x4)	EXT (5x4)		⇧
19_20 1b	There is a risk that the Trust estate does not comply with regulatory and legislative requirements	Chief Operating Officer	HIGH (4x4)	HIGH (4x4)	HIGH (4x4)	HIGH (4x4)		⇔
19_20 2a	There is a risk that the Trust will not be able to retain, develop and attract enough staff and protect their wellbeing to deliver high quality care	Director of People and Organisational Effectiveness	EXT (4x5)	EXT (4x5)	EXT (4x5)	EXT (4x5)		⇔
19_20 3a	There is a risk that the Trust fails to deliver its financial plans	Director of Finance	EXT (4x5)	EXT (4x5)	EXT (4x5)	EXT (4x5)		⇔
19_20 3b	There is a risk that the Trust fails to influence external drivers (such as national policy and BREXIT) which could impact on its ability to effectively implement its Strategy	Chief Executive Officer	HIGH (4x4)	HIGH (4x4)	HIGH (4x4)	HIGH (4x4)		⇔

2) Deep dives 2019/20

'Deep dives' remain fully embedded in the BAF process and enable review and challenge of the controls and assurances associated with each risk. A timetable for 2019/20, agreed with Executive Directors, is shown below. The deep dive for risks with a residual risk rating of extreme will be undertaken by the Audit and Risk Committee, the responsible committee for these risks is also shown (in brackets).

The plan for BAF Deep Dives for 2019/20 is shown below.

Risk ID	Subject of risk	Director Lead	Committee
19_20 1a	There is a risk that the Trust will fail to provide standards for safety and effectiveness required by our Board	Carolyn Green / Dr John Sykes	Audit and Risk Committee (Quality Committee) December 2019 (at additional Audit and Risk Committee meeting)
19_20 1b	There is a risk that the Trust estate does not comply with regulatory and legislative requirements	Mark Powell	Finance and Performance Committee November 2019
19_20 2a	There is a risk that the Trust will not be able to retain, develop and attract enough staff and protect their wellbeing to deliver high quality care	Amanda Rawlings	Audit and Risk Committee (People and Culture Committee) July 2019 - completed
19_20 3a	There is a risk that the Trust fails to deliver its financial plans	Claire Wright	Audit and Risk Committee (Finance and Performance Committee) January 2020
19_20 3b	There is a risk that the Trust fails to influence external drivers (such as national policy and BREXIT) which could impact on its ability to effectively implement its Strategy	Ifti Majid	Board Dec 2019

Summary Board Assurance Framework Risks 2019/20. Issue 4.2

Ref	Principal risk	Director Lead	Current rating (Likelihood x Impact)	Responsible Committee
Strategic Objective 1. To provide GREAT care in all services				
19_20 1a	There is a risk that the Trust will fail to provide standards for safety and effectiveness required by our Board	Executive Director of Nursing/Medical Director	EXTREME 5x4	Quality Committee
19_20 1b	There is a risk that the Trust estate does not comply with regulatory and legislative requirements	Chief Operating Officer	HIGH 4x4	Finance and Performance Committee
Strategic Objective 2. To be a GREAT place to work				
19_20 2a	There is a risk that the Trust will not be able to retain, develop and attract enough staff and protect their wellbeing to deliver high quality care	Director of People and Organisational Effectiveness	EXTREME 4x5	People and Culture Committee
Strategic Objective 3. To make BEST use of our money				
19_20 3a	There is a risk that the Trust fails to deliver its financial plans	Executive Director of Finance	EXTREME 4x5	Finance and Performance Committee
19_20 3b	There is a risk that the Trust fails to influence external drivers (such as national policy and BREXIT) which could impact on its ability to effectively implement its Strategy	Chief Executive Officer	HIGH 4x4	Board

Note: In line with the review of the BAF against the Trust Strategy 2018 – 2021 (refreshed April 2019), completion dates for some actions are expected to extend beyond the 2019/20 financial year.

Summary Board Assurance Framework Risks 2019/20. Issue 4.2

Strategic Objective 1. To provide GREAT care in all services

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

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

Root causes:

a) Financial settlement in contracts chronically underfunded
b) Workforce supply and lack of capacity to deliver effective care across all services
c) Substantial increase in clinical demand
d) Increasing patient and family expectations of service
e) Changing demographics of population
f) Lack of stability of clinical leadership at all levels
g) Lack of compliance with CQC standards
h) Lack of embedded outcome measures
i) Known links between SMI and other co-morbidities, and increased risk factors in population
j) Lack of processes for communication between primary and secondary care with respect to physical health monitoring
k) Changes in national requirements to access standards
l) Financial investment in health visiting and school nursing below recommended national level

BAF ref: 1a	**Director Lead**: Executive Director of Nursing/Medical Director	**Responsible Committee**: Quality Committee

Inherent risk rating:			**Current risk rating:**				Target risk rating:			Risk appetite:		
Rating HIGH	Likelihood 4	Impact 4	Rating EXTREME	Likelihood 5	Impact 4	Direction ⇔	Rating MODERATE	Likelihood 3	Impact 4	Accepted	Tolerated	Not accepted

Key controls:

Preventative – Quality governance structures, teams and processes to identify quality related issues; Induction and mandatory training; 'Duty of Candour' processes; clinical audits and research, health and safety audits and risk assessments, physical health care screening and monitoring

Detective – Quality dashboard reporting; Quality visit programme; Incident, complaints and risk investigation; Annual Training Needs Analysis; HoNoS clustering; FSR compliance checks; mortality review process; Physical health care monitoring clinics pilots; Daily assurance safety check log

Directive – Quality Improvement Strategy. Physical Health Care Strategy; Recovery Strategy; Policies and procedures available via Connect; CAS alerts; Clinical Sub Committees of the Quality Committee

Corrective – Board committee structures and processes ensuring escalation of quality issues; Annual skill mix review; CQC action plans; Learning from incidents, complaints and risks; Actions following clinical and compliance audits; Workforce issues escalation procedures; Reporting to commissioner led Quality Assurance Group on compliance with quality standards

Assurances on Controls (internal):	Positive assurances on Controls (external):
Quality and NHSI dashboard Scrutiny of Quality Account (pre-submission) by committees and governors Programme of physical healthcare and other clinical audits and associated plans	National enquiry into suicide and homicide NHLSA Scorecard demonstrating low levels of claims Safety Thermometer identifies positive position against national benchmark Mental Health Benchmarking data identifies higher than average qualified to unqualified staffing ratio on inpatient wards CQC comprehensive review 2018, 11 services area domains improved, 5 deteriorated;

Summary Board Assurance Framework Risks 2019/20. Issue 4.2

		Identified Trust fully compliant with NQB Learning from Deaths guidance. 2018/19 internal audits: Risk Management; Data Quality: RTT (internal audit; Data Security and Protection; IT General Controls; Divisional Governance Schedule 4/6 analysis and scrutiny by commissioners			
Key gaps in control:	**Key actions to close gaps in control:**	**Impact on risk to be measured by:**	**Expected completion date./(Action review date):**	**Summary of progress on action:**	**Action on track:**
Effective plan to ensure acute care is improved to a level that the CQC would assess and rate as at least 'requires improvement' across all domains	Delivery of plan for acute care to meet CQC rating of least 'requires improvement' delivered by May 2019 [ACTION OWNER DON/MD/COO]	Outcome of acute core service CQC inspection. Due May 2019. Superseded by outcome of CQC comprehensive inspection. Due Dec 2019	31/05/2019 Not achieved 31/12/2019 (Revised date)	CQC report published 5/6/19. Trust remains inadequate across acute adult services. Extraordinary meeting with board Aug 2019. Overall BAF risk raised to extreme (in v3). Concern remains in reaching training targets. Investment in inpatient director, clinical lead and range of other clinical posts. Transformation plan co-produced with staff, in delivery. Next comprehensive inspection due Dec 2019.	
Compliance with physical healthcare standards as outlined in the Physical Healthcare Strategy	Develop and agree a Physical Healthcare Strategy Implementation Plan (by June 2019). Completed. [ACTION OWNER MD] Deliver Physical Healthcare Implementation Plan [ACTION OWNER MD]	Implementation of targets as identified within Physical Health Care Strategy/Implementation Plan Physical health care dashboard reporting (specific measurables with respect to % compliance to be identified and added)	31/03/2020 ~~30/09/2019~~ (to be confirmed)	Gap analysis updated for ELT June 2019. 6 month review of progress against the Physical Health Care Strategy took place Sept 2019. Benchmarking standards against other Trusts (June 2019) identify low compliance for the Trust. Progress to improve underway. Implementation plan developed and overseen by PHCC. Plan to include principles of shared care	

				with primary care. Draft physical care dashboard in place, 'go live' date to be confirmed. A&RC requested escalation to QC.	
Effective plan to ensure ability to achieve quality priorities, CQUIN and Non CQUIN targets	Implement CQUIN action plan for 2018/19 (by March 2020) [ACTION OWNER DON]	Delivery of CQUIN targets for 2019/20 Quarterly submissions to Commissioners on achievements to date	31/03/2020 (31/12/2019)	Suicide prevention CQUIN continues to be on track, The design of pathway specific safety planning tools is underway Plan drafted for ELT Jul 2019 to achieve flu vaccination CQUIN for staff. Campaign launched 06/09/19	
Care plans and /or relapse prevention plans effectively involve the patient concerned reducing demand on services	Ensure care and/or relapse prevention plans are person centred and made available to the patient involved (by March 2020) [ACTION OWNER DON] Review preventable admissions to identify where demand on the acute care pathway can be reduced (by March 2020) [ACTION OWNER DON]	85% of care and /or relapse prevention plans are assessed as patient centred and are made available to the patient Decrease in % of patient admitted due to lack of a relapse prevention plan	31/03/2020 (31/12/2019) 31/03/2020	New model for care planning to be embedded through the acute care improvement plan Review to be completed and presented to TMT, with improvement trajectories	
Effective implementation of NICE/best practice guidance	Evidence of individual teams implementation of NICE guidance, evidenced through the Quality Visits (by close of 19/20 Quality Visit programme) [ACTION OWNER DON]	100% of clinical teams can evidence use of NICE guidance	~~31/12/2019~~ 31/12/2020 (31/03/2020)	Completion date revised from 30/09/2019 in line with expected completion Quality Visit Programme, which has been extended until Dec 2020. Mid programme target identified.	
Effectively implemented plan to ensure continuous quality improvement in the Trust in line with NHSI guidance	Identify gaps to delivery of quality improvement against NHSI guidance and implement agreed Quality Improvement Plan (by March 2020) [ACTION OWNER DBI&T] Evidence of individual teams development of a quality initiative, evidenced through the Quality Visits (by close of 19/20 Quality Visit	Achievement of the 19/20 milestones and any 18/19 milestones that have not yet been delivered of the Quality Improvement Implementation plan 100% of clinical teams can evidence implementation of a quality initiative	31/03/2020 (30/11/2019) 31/12/2019	Scheduled bi-annual progress reporting to QC against plan in place Plan in place for stakeholder engagement sessions before rolling programme of Board	

	programme). [ACTION OWNER DON]			decisions on strategies.	
Lack of coherent vision of the purpose of services at pathway level with a clear plan of how services need to adapt to meet changes in the demand	Workshop for clinically led strategy development [ACTION OWNER DBI&T] Strategies agreed by Board (by Sept 2019) [ACTION OWNER DBI&T]	Delivery of outcomes as defined in implementation plan for clinically led strategy development	31/10/2019	Workshops for all clinically led strategies completed, with exception of learning disability which will be undertaken in Sept 2019. First wave to be presented to Board Oct 2019	
Lack of a co-ordinated approach to collecting and acting on patient feedback across all services	Develop and implement a Patient Experience Strategy (by March 2020) [ACTION OWNER DON] Implementation of EQUAL forum (by March 2020) [ACTION OWNER DON]	Agreed Patient Experience Strategy to Board (by July 2019) (specific measurables with respect to impact to be identified and added)	31/03/2020 (31/10/2019) 31/03/2020	Draft Patient Experience Strategy, agreed with Patient Experience Committee Aug 2019. To be presented to Quality Committee Oct 2019 for approval EQUAL forum in place from June 2019	
Key gaps in assurance:	**Key actions to close gaps in assurances:**	**Impact on risk to be measured by:**	**Expected completion date./(Action review date):**	**Summary of progress on action:**	**Action on track:**
Gaps identified in CQC comprehensive assessment of services June 2018 (reported in September 2018) and Mental Health Act focused inspections undertaken throughout year	Completion of CQC action plan following the 2018 CQC comprehensive inspection (by May 2019) [ACTION OWNER DON/MD/COO] Completion of all actions following MHA focused CQC inspections (by timescales agreed in individual reports) [ACTION OWNER DON/MD/COO	Completion of all actions following CQC comprehensive inspection Completion of all actions following MHA focused CQC inspections	31/10/2019 (30/11/2019)	9 actions remain to be completed from previous inspection. 18 actions from the acute care review have been added 77 actions from Jan 2019. As of July 2019 36 remain overdue. Escalation underway Monitored by MHA Ops group.	
Achievement of Royal College of Psychiatrists (RCP) Standards across Acute Services	Complete RCP self-assessment (by 30/09/2019) Develop and implement plan to achieve RCP standards [ACTION OWNER MD/DON/COO]	Achievement of RCP Standards by Jan 2020	31/01/2020	Draft self-assessment completed on target. Ward self-assessment commenced, external review schedules for Jan 2020	

Staff feedback and patient surveys identify that the current policy around smoking on Trust premises is not fit for purpose	Using staff feedback and patient survey results to develop a new smoking policy focusing on harm reduction. [ACTION OWNER DBI&T]	Increased compliance with the Trust smoking policy as measured by: improved feedback from staff and patients and a reduction in levels of smoking in undesignated areas	31/03/2020	Policy agreed by Quality Committee July 2019. To launch revised approach through summer 2019. Monitoring to be overseen by PHCC and COAT. A&RC asked that QC retain a watching brief on relative risk of E cigarettes	

Summary Board Assurance Framework Risks 2019/20. Issue 4.2

Strategic Objective 1. To provide GREAT care in all services

Principal risk: There is a risk that the Trust estate does not comply with regulatory and legislative requirements

Impact: Low quality care environment
Crowded staff environment
Non-compliance with statutory care environments
Non-compliance with legal requirements for asbestos, legionella and electrical compliance

Root causes:

a. Long term under investment in NHS capital projects and estate
b. Limited opportunity for Trust large scale capital investment
c. Increasing expectations in care and working environments
d. National capital funding restrictions expected for 2019/20

BAF ref: 19_20 1b | **Director Lead**: Chief Operating Officer | **Responsible Committee**: Finance and Performance Committee

Inherent risk rating:			Current risk rating:				Target risk rating:			Risk appetite:		
Rating HIGH	Likelihood 4	Impact 4	Rating HIGH	Likelihood 4	Impact 4	Direction ⟺	Rating MODERATE	Likelihood 3	Impact 4	Accepted	Tolerated	Not accepted

Key controls:

Preventative – Routine environmental assessments for legionella and asbestos; Environmental risk assessments reported through Datix;
Detective – Monthly reporting progress against Premises Assurance Model (PAM) to TMT
Directive – Capital Action Team role in scrutiny of capital projects
Corrective – Short term investment agreed to support key risk areas

Assurances on Controls (internal):	Positive assurances on Controls (external):
- Health and Safety Audits - Premises Assurance Management System (PAMS) reporting to TMT providing updates on key priority areas	- 2018/2019 CQC Inspection feedback regarding PLACE regarding quality of Trust environment

Key gaps in control:	Key actions to close gaps in control:	Impact on risk to be measured by:	Expected completion date./(Action review date):	Progress against action:	Action on track:
Board approved Estates Strategy for 5 years, and implementation of 2019/20 plan	Estates strategy engagement event to finalise strategy (by Sept 2019) [ACTION OWNER COO] Present Estates Strategy to Board (by Nov 2019) [ACTION OWNER COO] Implement relevant milestones set out in	Agreed Estates Strategy (by Nov 2019)	30/11/2019	5 day engagement week planned for Sept 2019. Board development session focused on estates strategy Jul 2019. Further session arranged for Oct 2019	

	the 5 year Estates Strategy implementation plan [ACTION OWNER COO]				

Key gaps in assurance:	Key actions to close gaps in assurances:	Impact on risk to be measured by:	Expected completion date./(Action review date):	Progress against action:	Action on track:
Lack of assurance on full cycle of governance for estate compliance with statutory legislation	Completion of self-assessment of premises assurances model (PAM) and plan for annual reassessment (by April 2019) [ACTION OWNER COO]	Achievement of statutory compliance with legionella, electric, asbestos (by March 2020)	31/03/2020	PAM self-assessment completed and ongoing continuous improvement reported to TMT and ELT	
	Development of a Board approved improvement/ action plan, prioritised by level of risk (by April 2019) [ACTION OWNER COO]			Action plan agreed by TMT and ELT in Feb 2019	
	Associated resource plan agreed (April 2019) [ACTION OWNER COO]			Resource plan agreed by TMT and ELT in Feb 2019	
	Review 2019/20 action plan to identify risks to delivery, including implementation of skilled roles to ensure routine regulatory and legislative checks are completed [ACTION OWNER COO]	Compliance reporting to TMT with specific risks identified as part of PAMS reporting (to continue monthly from March 2019)	(31/12/2019)	Report to TMT July 2019 which outlined progress against three highest risks: legionella; asbestos; electrical safety	
Negative feedback from staff regarding their working environment, including buildings, office environments, car parking etc	Develop plans to address immediate estates issues ahead of formalisation of the Trust Estates Strategy [ACTION OWNER COO]	Improvement in feedback from staff via existing engagement routes	31/12/2019	Trust wide Estates and Environmental Group commenced June 2019, to enable focus on key issues. Process for consideration of issues by CAT now in place.	
Lack of adherence to emerging national guidance and policy requiring the elimination of mixed sex wards and dormitory style inpatient facilities.	Deliver a single room development plan (by Aug 2019) [ACTION OWNER COO] Develop a long term Estates Strategy (by Nov 2019) [ACTION OWNER COO]	Achievement of single room development. Board approved long term Estates Strategy	~~31/08/2019~~ 31/10/2019 30/11/2019	Concept mapping undertaken allowing estimation of initial bed number reductions. Fully costed implementation plan to be considered by Board Oct 2019	

Summary Board Assurance Framework Risks 2019/20. Issue 4.2

Strategic Objective 2. To be a GREAT place to work

Principal risk: There is a risk that the Trust will not be able to retain, develop and attract enough staff and protect their wellbeing to deliver high quality care

Impact: Risk to the delivery of high quality clinical care including increased waiting times
Exceeding of budgets allocated for temporary staff
Loss of income

Root causes:

a. National shortage of key occupations
b. Future commissions of key posts insufficient for current and expected demand
c. ~~Trust reputation as a place to work~~
d. Trust seen as small with limited development opportunities
e. Sufficient funding to deliver alterative workforce solutions
f. Retention of staff in some key areas
g. Traditional workforce structure

BAF ref: 19_20 2a	**Director Lead**: Amanda Rawlings, Director of People and Organisational Effectiveness	**Responsible Committee**: People and Culture Committee

Inherent risk rating:			**Current risk rating:**				Target risk rating:			Risk appetite:		
Rating EXTREME	Likelihood 4	Impact 5	Rating EXTREME	Likelihood 4	Impact 5	Direction ⟺	Rating HIGH	Likelihood 3	Impact 5	Accepted	Tolerated	Not accepted

Key controls:

Preventative –Resourcing Plan covering wide range of recruitment channels including targeted campaigns, refresh 'Work For Us' intranet page, leadership development, new role and skill mix changes, leadership development programme, increased well-being support.
Detective – Performance report identifying specific hotspots and interventions to increase recruitment and retention.
Directive – Wellbeing strategy, infrastructure and programmes to support staff health and wellbeing. Workforce plan to grow and develop the workforce.
Corrective – Leadership and Management Strategy and development programmes to build inclusive and engaging leadership and management. Leadership Programme Launch – Core Leaders.

Assurances on Controls (internal):	Positive assurances on Controls (external):
Bi Monthly People Performance Report to Trust Management Team, Executive Leadership Team and People and Culture Committee, includes recruitment tracker Workforce Supply Hot Spot report to Trust Management Team and People and Culture Committee Workforce Plan delivery monitored monthly by the Strategic Workforce Group	Staff survey, high level of participation for 2018 Pulse Checks CQC visits identify caring and engaging staff HEE returns against funding EG for TNA's Safe staffing reports and CHPPD reporting (planned v's actual staff) WRES, WRED and Gender pay gap reporting 2018/19 internal audits: Recruitment; Acting up

Key gaps in control:	**Key actions to close gaps in control:**	**Impact on risk to be measured by:**	**Expected completion date./(Action review date):**	**Progress against action:**	**Action on track:**

Summary Board Assurance Framework Risks 2019/20. Issue 4.2

Effective recruitment and retention plan to fill substantive and bank posts	Monthly tracking of People Performance: turnover and recruitment and retention hot spots (specifically inpatient and health visiting/school nursing), with focused actions [ACTION OWNER DP&OE, COO]	Reduction in vacancies in identified hotspot areas to below 10%. Reduced turnover rate	31/03/2020 (31/12/2019)	Offer introduced specifically to recruit and retain inpatient nurses with 2 year programme to develop from B5 to B6 within 2 years and payment of DBS and professional fees Discussion underway with commissioners re HV/SN practice standards for safeguarding. Implementation of improvement plan by division.	
Fully delivered leadership and management development programme	Roll out of the Leadership Launch and masterclasses (~~by June~~ during 2019) and monitor up take [ACTION OWNER DP&OE]	90% of Leaders attend the Leadership Launch 50% uptake of Management Masterclasses	31/03/2020 (31/12/2019) 31/03/2020] (31/01/2020)	77% of leaders have now attended the leadership sessions. Continuing through 2019. Increasing no of masterclasses being offered	
	Move from Pilot to scale for 360 feedback leadership tool [ACTION OWNER DP&OE]	Attendance at the programme, take up of a coach and 360 appraisal to improve individual performance	~~30/09/2019~~ 30/11/2019	360 feedback tool now in place, pilot completed. Tool is being offered to leaders to use	
	Develop senior, middle and aspiring leaders programme with East Midlands Academy [ACTION OWNER DP&OE]			To be launched by Autumn 2019	
Focus on colleagues health and wellbeing provision and infrastructure	Agree investment wellbeing offer by the Executive Leadership Team (Completed March 2019) [ACTION OWNER DP&OE]	Reduction in sickness absence rates to 5% or below (target date tbc as linked to CIP agreement)	31/03/2020 (31/12/2019)	Well-being offer launched, positive uptake. Sickness absence rate Aug 2019 is 6.34%	
	Review Occupational Health contract to include rapid access to musculo-skeletal services (MSK). Roll out access to counselling service [ACTION OWNER DP&OE]	Reduction in sickness absence rates as a result of MSK issues	01/03/2020	Rapid response to MSK services now in place. 'Resolve' in place with positive uptake. Developing system wide approach to staff health and well-being.	

	Roll out of DHCFT specific flu vaccination plan [ACTION OWNER DP&OE]	Increased uptake of staff flu vaccination to ~~75%~~ 80% (increase in national target)		Campaign launched 06/09/19	
Development of a funded Workforce Plan	Develop and implement 2019/20 of the Workforce Delivery Plan (by March 2020)	Utilisation of the Apprenticeship Levy Use of CPD, DHCFT Investment decisions (by when and how measured to be determined)	31/03/2020	2019/20 Apprenticeship Levy being used for 10 nursing, 2 ACP and a range of other apprenticeship roles 2019/20 Workforce Development Plan agreed by PCC and Board. Includes CPD investment, apprenticeship levy spending and progress with implementation of new roles Pathway focused (3 year) work plan to be developed by Sept 2019, to support the Clinical Pathway Developments	
Staff reporting being disadvantaged due to their protected characteristics	Action plans to be approved and implemented for staff with protected characteristics (by March 2020). To be monitored by Board	Annual publication of Workforce Race Equality Standard data, identifying an improved position Gender pay gap report action plan Workforce Disability Equality Standard reporting to commence in late 2019	31/03/2020 (31/10/2019)	Action plans being developed with staff networking groups around protected characteristics. Reporting PCC and Board.	
Key gaps in assurance:	**Key actions to close gaps in assurances:**	**Impact on risk to be measured by:**	**Expected completion date./(Action review date):**	**Progress against action:**	
Training compliance in key areas below target set by the Trust	Review and simplify mandatory training requirements to align to an individual's role and contract [ACTION OWNER DP&OE, DON, MD] Review E-Learning offer and system improvement requirements in terms of ease of use	90% of staff achieve their mandatory training requirements (by March 2020)	31/03/2020 (tracked monthly)	Acute inpatient 'hotspot' areas monitored weekly. Remains below trajectory. Issues identified with respect to E learning. Reconfiguration of the OLM system is underway to improve user access and	

	[ACTION OWNER DP&OE] Focused action plan in acute care services in relation to: safeguarding; ILS and physical intervention training	 Achievement of training targets for acute care services: safeguarding (70% by 30/09/2019) ILS (80% by 30/09/2019) physical intervention training (70% by 30/09/2019)		experience. Monitored weekly. Additional capacity to deliver training and staff rosta'd to enable attendance	
Evidence of safer staffing levels of suitably qualified staff	Compliance with NHSI Workforce Safeguards requirements (by March 2020) [ACTION OWNER DP&OE, COO/MD/DON]	Full compliance with safer staffing levels in line with the NHSI Workforce Safeguards	~~30/09/2019~~ 30/11/2019	Reporting to PCC Nov 2019.	
Trust tracking of retention of staff who could be impacted by the recent changes to pension taxation rules	NHS Employers have set up a national working group to look at this. Trust has briefed the Remunerations and Appointments Committee and is tracking this with medics at LNC.	Tracking of Executives and Medical staff retention rates as this is the group that is impacted at this time	(31/10/2019)	Six monthly review process in place. Discussion at REMCOM 18/09/2019 following NHS Employers and government announcements re pension schemes and future taxation	

Summary Board Assurance Framework Risks 2019/20. Issue 4.2

Strategic Objective 3. To make BEST use of our money

Principal risk: There is a risk that the Trust fails to deliver its financial plans

Impact: Trust becomes financially unsustainable

Root causes:

a) Non-delivery of internal CIP including back office efficiency
b) 'QIPP' disinvestment by commissioners leaves unfunded stranded costs in Trust
c) Other income loss without equivalent cost reduction (e.g. CQUIN, cost per case activity, commissioner clawback)
d) Costs to deliver services exceed the Trust financial resources available, including contingency reserves.
e) Lack of sufficient cash and working capital or loss due to material fraud or criminal activity
f) Enacting system risk sharing agreement

BAF ref: 19_20 3a	**Director Lead**: Claire Wright, Executive Director of Finance	**Responsible Committee**: Finance and Performance Committee

Inherent risk rating:			**Current risk rating:**				Target risk rating:			Risk appetite:		
Rating EXTREME	Likelihood 4	Impact 5	Rating EXTREME	Likelihood 4	Impact 5	Direction ⟺	Rating MODERATE	Likelihood 2	Impact 5	Accepted	Tolerated	Not accepted

Key controls:

Preventative – Budget training, segregation of duties, contract team to manage with commissioning risk, mandatory counterfraud training and annual counterfraud work programme. Project Vision system controls for CIP/CI

Detective –Audits (internal, external and in-house); Scrutiny of financial delivery, bank reconciliations; Continuous improvement including CIP planning and delivery; Contract performance, Local counterfraud scrutiny

Directive – Standing financial instructions; budget control, delegated limits, 'no-PO no pay' rules; Agency staff approval controls; Approval to appoint process; Business case approval process (e.g. back office); CIP targets issued; Invest to save protocol. Basis of agreement of risk share.

Corrective – Corrective management action; Use of contingency reserve; Disaster recovery plan implementation; TMT performance reviews and associated support/ in-reach in ELT and TMT for CIP delivery. Risk mitigation activity and oversight at STP level.

Assurances on Controls (internal):	Positive assurances on Controls (external):
Delivery of plan, in-year and forecast outturn for overall Trust financial plan Delivery of Continuous improvement including CIP (through appropriate mix of waste reduction and year-on-year actual cost reduction, productivity improvement and successful budget reduction Delivery of Counterfraud and audit work programme with completed and embedded actions for all recommendations Independent assurance via internal auditors, external auditors and counterfraud specialist that the figures reported are valid and systems and processes for financial governance are adequate Use of Resources report to Trust Board meeting November 2018 and Sept 2019 evidences strategic approach to effective use of resources and measurement of	- Internal Audits– significant assurance rating for 2018/19 audit: Integrity of the general ledger and key financial systems; Internal audit review - Sickness Absence review (Counterfraud) - External Audits – strong record of high quality statutory reporting - Grant Thornton audits show good benchmarking for key financial metrics (including liquidity) - NHSI Finance Rating Metrics – shows good performance - National Fraud Initiative – no areas of concern - Local Counterfraud work – Referrals show good counterfraud awareness and reporting in Trust and no material losses have been incurred - Deloitte Well Led review – positive affirmation of the effectiveness of the Finance

progress with ten Use of Resources priorities	and Performance Committee

Key gaps in control:	Key actions to close gaps in control:	Impact on risk to be measured by:	Expected completion date./(Action review date):	Progress against action:	Action on track:
Delivery of a continuous improvement (CI) plan that will meet requirements for financial sustainability and quality improvement to improve productivity and reduce waste, driven by the Use of Resources top ten	2019/20 plans to be finalised [ACTION OWNER DBI&T] Reporting of future continuous improvement and 19/20 CIP schemes – plan and actual delivery throughout year [ACTION OWNER DBI&T]	Achievement during year of planned 19/20 CIP savings totalling £4.6m. Replacement of non-recurrent 2019/20 CIP with recurrent CIP ahead of 1st April 2020 Size of pipeline for continuous improvement plans for future years	31/03/2020	CIP was discussed at an extraordinary F&P in July and schemes were identified to close the gap	(green)
				Non recurrent CIP still needs replacing with recurrent CIP. Progress relating to plan reported to Finance and Performance Committee July 2019. Further plan has been developed, to be considered by ELT end Sept 19	(amber)
				Finance and Performance Committee May 2019 scrutinised progress with 2019/20 and future pipeline Progress reports continue to every F&P meeting (And ELT reporting) Use of Resources update to Trust Board Sept 19 showed slow progress in some areas, particularly a lack of improvement in lost days due to sickness absence	(amber)
Delivery of specific benefits realisation as described in investment cases, including the Mental Health Investment Standard (MHIS)	CCG Contract sign-off including MHIS investments (by April 2019) [ACTION OWNER DBI&T] Collation of summary of expected benefits to be realised from key investments in 2019/20 [ACTION OWNER DBI&T]	Signed contract Measurement and monitoring of impact of E-Roster, E Job planning, new shift pattern and MH Investment Standard by Finance and Performance Committee and MH Service Delivery Board (MHSDB)	31/03/2020 (31/12/2019)	Contract signed	(blue)
				E-Roster, shift pattern and E job planning not yet in place, consultation underway. MHIS monitored at MHSDB New gateway process agreed by ELT in Sept 19 to increase consistency of articulation of benefits – using PDSA via the project office	(amber)
Management of emergent cost pressures that exceed the planned contingency budget . Required due to clinical, quality, operational	Forecast Deep dives in every area undertaken by Director/Deputy Finance. ELT scrutiny of deep dive outcomes resulting in additional management action which will	Reduction/elimination of the forecast gap to achieving the control total.	Achieve by 31/03/20 (Review by 15/11/2020	Forecast deep dives based on month 5 have taken place and reported back to ELT 16/09/19. Additional actions have been agreed to further inform the next	(amber)

and strategic priorities (excluding STP system risk share)	reprioritise forecast spend and seek to maximise achievement of income [ACTION OWNER DOF]		month 7 forecast)	forecasts Forecasts for month 6 and month 7 will be reviewed to ascertain level of confidence at that point of achieving the control total	
Key gaps in assurance:	Key actions to close gaps in assurances:	Impact on risk to be measured by:	Expected completion date./(Action review date):	Progress against action:	Action on track:
Inconsistency of managers' application of appropriate HR policy e.g. secondary employment and working while sick, in order to close practice gaps identified by previous counterfraud referrals	Implementation of group Counterfraud meetings with HR, Finance and LCFS to support targeted training and oversight (meetings in place by end March 2019) [ACTION OWNER DOF]	Reduction in counterfraud findings related to application of relevant HR process Conversion of amber ratings within parts of 2018/19 self-review tool (SRT) to green in next submission	31/03/2020 (31/12/2019)	Regular meetings taking place Self-Review Tool (SRT) for 2018/19 completed and submitted (with green overall rating)	
Lack of sight of detailed and approved schemes to close system gap (risk share)	System sharing group oversight (reporting to CEO/Finance Director group) and JUCD Board [ACTION OWNER DOF]	Size of risk share pot and DHCFT portion	31/03/2020 (31/12/2019)	Joint system oversight process through Systems Savings Group. Developing a Finance Assurance Group to include at all F&P Committee Chairs and DOFs. New section to be added to F&P reporting covering the risk share	

Summary Board Assurance Framework Risks 2019/20. Issue 4.2

Strategic Objective 3. To make BEST use of our money

Principal risk: There is a risk that the Trust fails to influence external drivers (such as national policy and Brexit) which could impact on its ability to effectively implement its Strategy

Impact: If the Trust Strategy is not delivered, it could lead to a deterioration of services available to patients and a negative impact on the Trusts financial position, which could result in regulatory action

Root causes:

a) Priority in other parts of the system i.e. A&E
b) Financial constraints nationally and locally
c) Lack of system wide leadership
d) Lack of engagement with staff from other organisations
e) Suddenly changing national directives out with control of the Trust
f) Regulatory bodies imposing different rules and boundaries
g) Move to system wide working causes tension between loyalty to the system v's sovereign organisation
h) Unresolved political decision making regarding Brexit
i) Political time spent on Brexit taking time from other priorities

BAF ref: 19_20 3b	**Director Lead**: Ifti Majid. Chief Executive Officer	**Responsible Committee**: Board

Inherent risk rating:			**Current risk rating:**				Target risk rating:			Risk appetite:		
Rating HIGH	Likelihood 4	Impact 4	Rating HIGH	Likelihood 4	Impact 4	Direction ⟺	Rating MOD	Likelihood 3	Impact 4	Accepted	Tolerated	Not accepted

Key controls:

Preventative – Maintenance of strong relationships with commissioners particularly mental health and learning disability SRO (Senior Responsible Officer); Close alignment between emerging CCG QIPP plans and STP workstream objectives; Full involvement with appropriate system wide groups; Maintenance of strong relationships with other providers; service receiver engagement; Working openly and honestly with clear line of sight to impacts on sovereign organisation; CEO representation on national Mental Health Network Board

Detective – Scrutiny of national directives; Translation to local action i.e. are national directives being adhered to?

Directive- Agreed contract with CCG and adherence to Mental Health Investment Standard

Corrective- Ongoing discussions with key stakeholders on proposed changes, progress, establishment of partnerships etc. ; Engagement and consultation with patients, carers, public and staff as appropriate; Interrelationships with other STP workstreams; Active CCG membership and participation in STP Mental Health Delivery Board; Fortnightly CEO and DOF meeting across Derbyshire system

Assurances on Controls (internal):	Positive assurances on Controls (external):
- Reports to Board regarding any system wide changes or risks - Regular progress feedback to F&P on system change - Updates and feedback at TMT and ELT in order to update on system change or 'blockers' - Engagement with Governors in order to get feedback and update them on progress - Engagement with staff though managers, staff side, focus groups etc - CEO's Board Report providing strategic scan of national policy landscape	NHSE/I agreement of plans Mental Health Delivery Board and checkpoint meetings with central STP team Bimonthly performance meetings with NHSI

Summary Board Assurance Framework Risks 2019/20. Issue 4.2

Key gaps in control:	Key actions to close gaps in control:	Impact on risk to be measured by:	Expected completion date./(Action review date):	Progress against action:	Action on track:
National policy and local implementation focuses on organisations in deficit and those that provide acute care, leading to the Trust not receiving the focus they deserve	Maintain senior open dialogue with commissioners being prepared to escalate through contract mechanisms any failure to deliver national MHIS contract expectations [ACTION OWNER CEO] Have a strong senior leadership presence in system Board and Executive meetings as well as the emerging provider alliance Boards and acute care strategy forums – this will require re-prioritisation of Executive and next in line capacity [ACTION OWNER CEO] Lead the development of an updated STP mental health system plan ensuring it is approved through Joined Up Care Derbyshire governance [ACTION OWNER CEO]	Maintenance of separate working groups at a system level relating to our core services led by Trust senior leaders Agreed contract in place for 19/20 that does not require external mediation. Delivery of the Mental Health Investment Standard and support to core services within it. Delivery of the STP MH QIPP savings and realise reinvestment of all savings into MH programme spend. Full *Futures in Mind* allocation passed to the Trust by commissioners	31/03/2021 (30/09/2019)	All workstreams currently undertaking review of process in line with STP refresh in Sept 2019. Enhanced focus agreed with learning disability workstream – June 2919 JUCD Board.	
				Contract in place, without need for external medication	
				Contract includes a full MH Investment Standard monitored through the MH Service Delivery Board	
				No MH QIPP savings identified in CCG plan	
				Futures in Mind allocation agreed as part of contract. To monitor throughout year.	
Lack of full understanding as to the impact to the Trust of leaving the EU in relation to essential supplies, impact on research and development, impact on staffing availability and logistics such as petrol	Maintenance of an up to date EU Exit risk assessment until the risk nationally has deemed to have reduced [ACTION OWNER COO] Ensure colleagues within the Organisation are aware of the key risks and mitigating actions [ACTION OWNER COO] Link in with Joined Up Care Derbyshire colleagues to ensure that where actions are needed that can be completed at a system level this is carried out [ACTION OWNER COO] Respond to requests for information from	The lack of major or critical incidents affecting the Trust resulting from risks associated with leaving the EU	31/10/2019	EU Exit Steering Group in Trust reconvened from 17/09/19	
				Two briefings to Trust staff outlining Trust readiness for BREXIT. Risk associated included in leadership development programme	
				Monthly reporting to Joined Up Care Derbyshire on system BREXIT readiness. Currently suspended	
				All escalation reports delivered on time as required	

	the national leadership team as these could inform changes in actions required of our Trust [ACTION OWNER COO]				
Key gaps in assurance:	**Key actions to close gaps in assurances:**	**Impact on risk to be measured by:**	**Expected completion date./(Action review date):**	**Progress against action:**	**Action on track:**
Lack of assurance with respect to the impact of national policy, in particular in relation to the: Long Term Plan; Integrated Care Systems, Revisions to the Mental Health Act; Fit and Proper Persons which may impact on the governance mechanisms and or clinical service delivery within our organisation	Continue to utilise opportunities to influence and lobby at a national level through attending MHN Board national and regional CEO and Chair meetings [ACTION OWNER CEO] Development of a stakeholder register including local MP's to ensure they are briefed on risks to and opportunities for our local population relating to proposed policy change [ACTION OWNER CEO] Attendance at regional events such as Regional CEOs meeting as these feed into NHSI/E at a national level and provide a conduit for influencing policy changes [ACTION OWNER CEO]	Trust maintenance of full compliance with regulatory standards Plans for policy and or legislation changes are developed in a timely way to enable effective implementation	31/03/2021	Quarterly MH Network in place. CEO met national MH Director regarding important of care services Stakeholder management approach agreed by ELT April 2019 Chair and CEO continue to attend events to ensure early notification on planned changes to policy. Three national influential leaders visited Trust during May/June 2019 giving opportunity to discuss national policy	

Summary Board Assurance Framework Risks 2019/20. Issue 4.2

Risk Rating:

The summary score for determining the risk ratings for each risk is shown below. The full Risk Matrix, including descriptors, is shown in the Trusts Risk Management Strategy

Risk Assessment Matrix					
The Risk Score is simply a multiplication of the Consequence Rating x the Likelihood Rating. The Risk Grade is the colour determined from the Risk Assessment Matrix below.					
LIKELIHOOD	**CONSEQUENCE**				
	INSIGNIFICANT 1	**MINOR 2**	**MODERATE 3**	**MAJOR 4**	**CATASTROPHIC 5**
RARE 1	1	2	3	4	5
UNLIKELY 2	2	4	6	8	10
POSSIBLE 3	3	6	9	12	15
LIKELY 4	4	8	12	16	20
ALMOST CERTAIN 5	5	10	15	20	25

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

Action progress:

The colour ratings are based on the following descriptors.

Actions on track for delivery against gaps in controls and assurances:	Colour rating
Action completed	Blue
Action on track to completion within proposed timeframe	Green
Action implemented in part with potential risks to meeting proposed timeframe.	Amber
Action not completed to original or formally agreed revised timeframe. Revised plan of action required.	Red

Action owners:

CEO	Chief Executive Officer	COO	Chief Operating Officer
DOF	Executive Director of Finance	DON	Executive Director of Nursing and Patient Experience
MD	Medical Director	DP&OE	Director of People and Organisational Effectiveness
DBI&T	Director of Business Improvement and Transformation		

Board Committee Assurance Summary Report to Trust Board
People & Culture Committee – Meeting held 24 September 2019

Key items discussed

- **People and Culture Committee Board Assurance Framework (BAF) Risks** – Recruitment enhanced offer for new joiners by paying Disclosure and Barring Service (DBS) and Nursing and Midwifery Council (NMC) validation for first year of service along with implementation of the Band 5/6 framework in acute areas, offer re wellbeing across Derbyshire. Amanda Rawlings is leading this work with Sheffield Hallam University, with Head of Head of People Development regarding the apprenticeship levy, Workforce Race Quality Standard (WRES) and the Workforce Disability Equality Standard (WDES) work. BME Conference held in September will highlight how we change our workforce profile to be more inclusive. Training compliance to be given in the Workforce Development report. Safer Staffing is to be reported in the Combined Performance report at next meeting. Pension taxation was also discussed.
- **Strategic Workforce Report –** this included proposals to reform the NHS Pension Scheme, package of support to train and retain NHS nurses, enabling staff movement between NHS organisations - new toolkit for employers, improving recruitment and retention in Acute Services, "Positive" bulletins going out now as feedback from Staff Forum - updating staff on the changes made.
- **Workforce Performance Report** – report is designed to be aligned to People Strategy. Improvements in reporting were discussed to provide more assurance specific to the Committee. Report is to be more risk focussed and show action taking place to provide assurance. Executive summary is to be developed with areas addressed at Trust Management Team (TMT) meetings and any other key areas. Executive summary is to highlight risk areas contained in the BAF actions that are in place.
- **Acute Care Training Update** – has been to Quality Committee and Board. Action plan in place up to end of November but need to deliver the improvement onwards from November. Challenges around delivering safeguarding training was discussed. Plans are in place in acute areas, concerns regarding course cancellations and trainer unavailability and how we can access training in other Trusts - this is part of the STP workforce plan for training.
- **Update on the Leadership and Management strategy roll out** - The Leadership Development team have been working on establishing the management masterclasses and leadership programmes, good attendance to leadership launch, applicants through "Aspiring to Be" programme is to be tracked.
- **Update on staff engagement activity and 2019/20 staff survey roll out** - An update and feedback on new internal communication mechanisms introduced to engage with staff and plans going forwards. Feedback from the recent Pulse Check results, which show the Trust's current position based on the Q1 all staff survey and the plan for the 2019 NHS Staff Survey. The plans for the 2019/2020 staff survey were noted.
- **Flu Campaign 2019/20 -** huge task to achieve target of 80% for clinical staff. The paper outlines the plans put in place to ensure achievement of this. This includes several key improvements from 2018, a new e-consent system, more pre-book clinic slots, an expansion of the peer vaccinator programme, a new communications approach entitled 'Share Hope Not Flu' - partnership with Unicef to offer a 'jabs for jabs' incentive scheme.
- **Non-Medical Prescribing Evaluation -** In 2018 it was agreed that we would recruit a number of NMP (Non-Medical Prescribing) to support the medical capacity in the CMHTs (Community Mental Health Teams). TMT (Trust Management Team) requested an evaluation of the impact

of this role. Appropriate to recruit an NMP to support medics which is really positive to support the medical workforce. It is helping to manage some of the demand in teams, and is helping to support as an addition to the multi-disciplinary teams' (MDT) positive evolvement, positive message about the impact this is having on our strategic workforce plans. • **Employee Relations Assurance Report** – quarterly update , shows time in days to close cases, worrying trend in BME cases which is now shifting with the check point now introduced, focus is on reducing the time to resolve, using the right decision methodology • **Equalities WRES and WDES** – received by the Trust Board on 3 September. Submitted to the Committee for noting. • **Structure of the People & Culture Committee** – Terms of reference – Chief Executive reserves the right to attend, name of Committee to remain the same, streamline more working with TMT and ELT. • **2019/20 Forward Plan** – to be redeveloped with Chair and Executive Lead. • **Items escalated to the Board or other Committees** – no items were considered necessary for escalation • **Identified risks arising from the meeting for inclusion or updating in the BAF** - nothing added risk rating remains unchanged • **Meeting effectiveness** – good discussions. Reports were of a good standard although executive summaries need strengthening.
Assurance/lack of assurance obtained • Workforce Performance Report - limited due to areas of concern but not about the report itself • Acute Care Training Update - significant assurance against the trajectory of 85% and noting the challenge post November to sustain this improvement • Update on staff engagement activity and 2019/20 staff survey roll out – significant assurance, noted from this positive report. • Flu Campaign 2019/20 - significant assurance that we have everything in place • Employee Relations Assurance Report – quarterly update - Significant assurance on process and tracking but limited assurance by the time to resolve cases
Key risks identified None
Decisions made None
Escalations to Board or other committee None

Committee Chair: Julia Tabreham	**Executive Lead: Amanda Rawlings, Director of People Services & Organisational Effectiveness**

Board Committee Summary Report to Trust Board
Audit & Risk Committee – Meeting held 3 October 2019

Key items discussed

- Board Assurance Framework (BAF)
- Proposed Risk Management Strategy 2019 – 2022, including progress against 2016 – 2019 Strategy
- Implementation of internal and external audit recommendations progress report
- Review of 2018/19 Annual Report and Accounts/Quality Report Production
- Corporate Governance Framework update
- Freedom to Speak Up update – considered with the 360 Assurance report
- Update on 2019/20 objectives for the Audit and Risk Committee
- Data Security and Protection Report
- External Audit Progress Report
- Internal Audit Progress Report
    - Implementation of Freedom to Speak Up Policy and Procedure
    - Audit Committee Maturity Matrix
- Identification of any issues arising from the meeting for inclusion or updating in the Board Assurance Framework
- 2019/20 Forward Plan
- Meeting effectiveness

Assurance/lack of assurance obtained

- The BAF paper provided significant assurance on the process of the review, scrutiny and update of the BAF in seeking to identify and mitigate risks to achieving the Trust's strategic objectives.
- The Committee accepted assurances provided on the progress made against the 2016 – 2019 Risk Management Strategy and the objectives outlined for the next 3 years,
- The internal audit recommendations tracker report gave the Committee assurance on the actions identified as completed and the trajectory for completion of the remaining open actions.
- The Committee acknowledged that the Trust has robust processes in place to effectively deliver the requirements of the Annual Report and Accounts and noted the learning identified from the 2018/19 Annual Report and Accounts, ahead of the process commencing for 2019.
- The limited assurance report was received on Raising Concerns/Speaking up at Work (Whistleblowing). The Committee noted the significant developments made to improve speaking up and was assured that all of the recommendations from the 360 Assurance report were in hand and will be implemented.
- In relation to the Data Security and Protection Report, the Committee received significant assurance on the work towards completion of the 2019/20 toolkit and on the Data Security work plan.
- The Committee was satisfied with the progress against its 2019/20 objectives.

Key risks identified

- An additional gap in control has been proposed for BAF Risk 3a following a discussion and challenge at the Finance and Performance Committee on 17 September. The gap describes the need to manage and mitigate emergent cost pressures arising as a result of clinical, quality, operational and strategic requirements.
- Although the Committee had agreed to defer the Deep Dive on BAF risk 1a, this risk would continue to be closely monitored by the Quality Committee.
- A number of risks were acknowledged around Data Security and Protection but the Committee was satisfied with the controls in place to mitigate the risks.

Decisions made

- Approved the fourth issue of the BAF for 2019/20 and the significant assurance that the paper provides of the process of the review, scrutiny and update of the BAF in seeking to identify and mitigate risks to achieving the Trust's strategic objectives.
- Approved the Risk Management strategy 2019-2022, on behalf of the Board
- Agreed the extension of the completion date to the 7 October 2019 for the two outstanding actions in relation to the Data Quality: KPI Testing, Referral to Treatment Audit.
- Supported the delay to the refresh of the Corporate Governance Framework to allow work on the Board Committee Structure Review to be completed.

Escalations to Board or other Committee

- All other Board Committees will be asked to undertake a mid-year assessment of compliance against the equality, diversity and inclusion objectives and this will be monitored by the Committee was as part of the year-end review of committee effectiveness.
- The Committee had raised a query on the Dashboard for Physical Healthcare and it was noted that updates were fed directly in to the Quality Committee.

Committee Chair: Geoff Lewins **Non-Executive Director**	**Executive Lead: Justine Fitzjohn** **Trust Secretary**

Board Committee Assurance Summary Report to Trust Board
Quality Committee meeting held 8 October 2019

Key items discussed

- **BAF Risks for Quality Committee**
- **Acute Care Monthly Update** - Significant assurance on the progress. Tentatively positive outcome. Monthly report, with exception report
- **Patient Experience Strategy** - Agreed and ratified. Positive feedback on the simplicity. Progress review to take place in six months, Equalities impact to be updated to reflect the impact and adjustments to be in place/made. Strategy to be reviewed against actions within six months.
- **Health Visitor Caseloads** - Review of the caseload skill mix and mitigating actions to reduce the risk the pressure in Children's services. A new model to support families in need outlined a solution to significantly reduce the risk to children in the Trust's geographical area. Discussion took place on the improvement work required to support staff and children. Overall limited assurance.
- **Equality and Diversity 2 (EDS 2) Update - Review of EDS2 goal**. Kedleston Unit is on trajectory to improve this area. Significant assurance was offered on progress.
- **Serious Incidents Bi-monthly report** – the report summary was provided and included a detailed review of serious incident reporting, themes and improvements. Significant assurance received with some minor gaps in controls in reducing actions overdue/plans. Evidence of improvement and learning was seen
- **Learning from Deaths/Mortality Report** (prior to submission to Board in November) the report was offered with significant assurance. Significant improvement was received with compliance with mortality reviews. No significant concerns bar improvement
- **Website Accessibility Statement** – report showed evidence of compliance with the law. Further improvements delegated to Trust Management Team (TMT) to ensure compliance.
- **Issues arising for inclusion or updating in Board Assurance Framework** - Health visitor and improvement areas and mitigation plan are included in BAF. Committee is to review the extreme rating of the acute transformation plan review at the end of November based upon delivery and forward plan. Further exploration of improvements will take place in other areas of other core services.
- **Forward plan** – to be reviewed

Assurance/Lack of Assurance Obtained

- Acute Care Monthly Update - Significant assurance on the progress
- Health Visitor Caseloads – overall limited assurance
- EDS 2 Update - Review of EDS2 goal - significant assurance was offered on progress.
- Serious Incidents Bi-monthly report - significant assurance
- Learning from Deaths/Mortality Report - significant assurance
- Further review of areas of significant assurance areas to improve final areas.

Meeting Effectiveness

- Well chaired and clear meeting.

Decisions made

- Ratified Patient and Carer Strategy and plan
- Reviewed and scrutinised decision making of the BAF
- Health visitor caseload mitigation plans
- Review and scrutiny of the serious incident process and learning
- Review and scrutiny of the mortality review process

Escalations to Board or other Committee

- Executive Leadership Team on improvement areas for Flu inoculations

Committee Chair: Anne Wright on behalf of Margaret Gildea	**Executive Lead: Carolyn Green, Director of Nursing & Patient Experience**

Board Committee Assurance Summary Report to Trust Board
Safeguarding Committee – 15 October 2019

Key items discussed

Matters arising

Richard Wright asked for a brief on key issues with regard to the impact on School Nursing county disinvestment for Joined up care Derbyshire.

Safeguarding strategy

- The strategy has been out to further consultation and as agreed at last Committee an infographic conveying the key messages has been developed
- The executive lead provided the information behind the pillars of the strategy key areas
- Feedback was given to correct a typo in the Infographic red column
- Infographic blue column to be adjusted to show people working in our organisation, rather than staff. This section is to be reworded with communications team
- Strategy agreed subject to revised changes
- Further discussion on wider risks or vulnerable groups. The risks associated with the equalities impact assessment at risk i.e. Autism. Quality Impact Assessment will be shared with the Quality Committee and wider STP.

Mental Health homicides- action and improvement plan

- Mr S revisited the action plan. Now completed and closed
- Mrs Z to continue and make improvement of safety planning and review in February 2020 in the Quality and Safeguarding Committee.

Safeguarding Children Position report

- All levels of training Safeguarding Children has improved. There remains one specific area to reach minimum target level at the end of October 2019 and meeting compliance trajectory in November 2019
- Discussion took place arranging a Board development session for NEDs to achieve required training in December
- Summary of improvement and action
- Significant assurance with one minor gap in control, of training of a 2% gap in minimum Trust compliance to be improved.
- Considered the progress against the Safeguarding Strategy and plans for further improving against the strategic objectives.
- Significant assurance with one minor mitigating action to close the gap. This gap in control had a plan to improve with a fixed timescale.

Special Educational Needs (SEND) report

- The Committee noted the positive good areas of practice associated with Trust practice, recommendations accepted. Co-development of the plan with partners and to improve operational performance of the named improvement areas was noted.
- The Committee requested that the Children's Division confirm that this is on the risk register, and has an effective mitigation plan detailed against the specific recommendations. This is currently in design and is scrutinised by partners.
- Limited assurance. The Committee noted the plan is in design with partners for submission. Follow up paper on improvement requested for the next Safeguarding Committee meeting.

Safeguarding Adults Position statement

- The Committee noted the patterns and allegations of abuse and the origin of the allegations. The Committee requested additional scrutiny and improvement areas to continue in line with the Safeguarding Strategy and improvement work.
- Significant improvement in training, with one minor gap in control, of 2% gap to be improved for one area of Safeguarding adults training, this again had a fixed improvement period.
- Continued improvement in trauma and sexual safety practice was noted and new quality improvement work was discussed.
- Committee noted the significant assurance and complex cases in this area.

Board Assurance Framework (BAF)

- The Committee discussed decisions made and further actions associated with the BAF
- Risk register improvements to the Children's division based upon the SEND feedback
- Chaperone policy, which is at final draft stage will be revised to include learning from a local mental health trust incidents published in October 2019 regarding safety.
- Terms of reference for the Quality and Safeguarding Committee will outline specific areas of practice and any revised outcomes including horizon scanning on any changing legislation.
- Equalities impact on individuals with a disability with autism who may be at risk due to autism. Statutory guidance and evidence of concerns regarding how individual's needs are being met in line with non-Trust high profile Derbyshire cases, the information learnt from Trust incidents and patient complaints, and Trust Board story to the Quality committee.

Reflection on the effectiveness of the meeting

- Equalities issues are improving, to improve the completion of the boxes / ticking the boxes and plan to fully mitigate actions
- Well chaired
- Improved papers and clarity of risks
- Improved performance, including sustained performance on controls and checks re DBS

Any Other Business

Confidential section and briefing by Executive lead and NEDs on complex case and actions to support.

2019/20 Forward Plan

To include new terms of reference, SEND inspection and regular Safeguarding strategy performance updates.

Assurance/lack of assurance obtained

- Significant assurance with small item improvement plan for Safeguarding Children and Adult training.
- Limited assurance on SEND inspection outcome and reassured on the requirement to Trust specific action plan which is in design. To be revisited by operational executive lead to ensure that this is included on /Childrens divisional risk register and the operational team, scrutinise the action plan development and present at the next Safeguarding Committee.

Key risks identified

- Sustained significant increase in county wider domestic violence cases and noted the context of the rural review and the Safeguarding Dashboard in activity in this area.
- Revisited and commissioned additional work on autism and equalities issues with regard to access to effective treatment when not commissioned

Decisions made • Safeguarding strategy agreed, timescales for communications and roll out agreed • Chaperone policy to be revised by executive lead based upon another trust, this is still within timescale and to ensure a learning approach	
Escalations to Board or other committee • Executive Leadership team. Risk register and SEND actions.	
Committee Chair: Anne Wright	**Executive Lead: Carolyn Green, Director of Nursing and Patient Experience**

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 5 November 2019

Use of Emergency Powers

Purpose of Report

To inform the Board of the use of emergency powers by the Chief Executive and the Chair.

Executive Summary

On 24 October 2019, the Chair and Chief Executive, having consulted with two Non-Executive Directors (Richard Wright and Geoff Lewins) approved the submission of the submission of the Improving Access to Psychological Therapies (IAPT) Tender to meet the deadline of 25 October 2019.

Strategic Considerations	
1) We will deliver **great care** by delivering compassionate, person-centred innovative and safe care	X
2) We will ensure that the Trust is a **great place to work** by attracting colleagues to work with us who we develop, retain and support by excellent management and leadership	X
3) We will make the **best use of our money** by making financially wise decisions and will always strive for best value to make money go further	X

Assurances

Information on contractual, financial and service implications were provided in background reports. The emergency use of powers were required in order to meet the submission deadlines.

Consultation

Discussions on the tender submission have been held at the Finance and Performance Committee and the Executive Leadership Team.

Governance or Legal Issues

The powers which the Board has reserved to itself within its Standing Orders may in an emergency be exercised by the Chief Executive and the Chair after having consulted at least two Non-Executive Directors (SO 6.2). The exercise of such powers by the Chief Executive and the Chair shall be reported to the next formal meeting of the Board for noting.

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

There is no direct impact on those with protected characteristics arising from the use of these emergency powers. In relation to the tender, the new tariff system to be operated by the CCG will incentivise providers to ensure the service is being accessed by people with Long-term Conditions and by people from BME backgrounds. It is expected that this will improve access and outcomes for people with these protected characteristics.

The service is available on referral from GP Practices and also by self-referral from individuals. Our service will need to ensure we continue to monitor access from people with protected characteristics to inform our marketing and availability of our services. The tender document will include any relevant equality-related impacts and considerations.

Recommendations

The Board of Directors is requested to note the exercise of emergency powers by the Chief Executive and the Chair to approve the submission of the Improving Access to Psychological Therapies (IAPT) Tender.

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

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

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS

NHS Term / Abbreviation	Terms in Full
A	
A&E	Accident & Emergency
ACCT	Assessment, Care in Custody & Teamwork
ACE	Adverse Childhood Experiences
ACP	Accountable Care Partnership
ACS	Accountable Care System (now known as ICS)
ADHD	Attention Deficit Hyperactivity Disorder
AfC	Agenda for Change
AHP	Allied Health Professional
ALB	Arms-length body such as NHS Improvement (NHSI) and NHS England (NHSE)
AMHP	Approved Mental Health Professional
AO	Accountable Officer
ASD	Autism Spectrum Disorder
ASM	Area Service Manager
B	
BAF	Board Assurance Framework
BMA	British Medical Association
BAME	Black, Asian & Minority Ethnic group
C	
CAMHS	Child and Adolescent Mental Health Services
CASSH	Care & Support Specialised Housing
CBT	Cognitive Behavioural Therapy
CCG	Clinical Commissioning Group
CCT	Community Care Team
CDMI	Clinical Digital Maturity Index
CEO	Chief Executive Officer
CGA	Comprehensive Geriatric Assessment
CIP	Cost Improvement Programme
CMDG	Contract Management Delivery Group
CMHT	Community Mental Health Team
CNST	Clinical Negligence Scheme for Trusts
COAT	Clinical Operational Assurance Team
COF	Commissioning Outcomes Framework
COG	Council of Governors
CPA	Care Programme Approach
CPD	Continuing Professional Development
CPN	Community Psychiatric Nurse
CPR	Child Protection Register
CQC	Care Quality Commission
CQI	Clinical Quality Indicator
CQUIN	Commissioning for Quality Innovation
CRB	Criminal Records Bureau
CRG	Clinical Reference Group
CRS	(NHS) Care Records Service
CRS	Commissioner Requested Services
CSF	Commissioner Sustainability Fund
CTO	Community Treatment Order
CTR	Care and Treatment Review

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Term / Abbreviation	**Terms in Full**
D	
DAT	Drug Action Team
DBS	Disclosure and Barring Service
DfE	Department for Education
DHCFT	Derbyshire Healthcare NHS Foundation Trust
DIT	Dynamic Interpersonal Therapy
DNA	Did Not Attend
DH	Department of Health
DoLS	Deprivation of Liberty Safeguards
DPA	Data Protection Act
DRRT	Dementia Rapid Response Team
DTOC	Delayed Transfer of Care
DVA	Derbyshire Voluntary Action (formerly North Derbyshire Voluntary Action)
DWP	Department for Work and Pensions
E	
ECT	Enhanced Care Team
ECW	Enhanced Care Ward
ED	Emergency Department
EDS2	Equality Delivery System 2
EHIC	European Health Insurance Card
EHR	Electronic Health Record
EI	Early Intervention
EIA	Equality Impact Assessment
EIP	Early intervention in psychosis
ELT	Executive Leadership Team
EMDR	Eye Movement Desensitising & Reprocessing Therapy
EMR	Electronic Medical Record
EPR	Electronic Patient Record
ERIC	Estates Return Information Collection
ESR	Electronic Staff Record
EWTD	European Working Time Directive
F	
FBC	Full Business Case
FOI	Freedom of Information
FFT	Friends and Family Test
FSR	Full Service Record
FT	Foundation Trust
FTN	Foundation Trust Network
F&P	Finance and Performance
5YFV	Five Year Forward View
G	
GDPR	General Data Protection Regulation
GGI	Good Governance Institute
GMC	General Medical Council
GP	General Practitioner
GPFV	General Practice Forward View
H	
HEE	Health Education England

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Term / Abbreviation	**Terms in Full**
HES	Hospital Episode Statistics
HoNOS	Health of the Nation Outcome Scores
HSCIC	Health & Social Care Information Centre
HSE	Health and Safety Executive
HWB	Health and Wellbeing Board
I	
IAPT	Improving Access to Psychological Therapies
ICS	Integrated Care System (formerly ACS)
ICT	Information and Communication Technology
ICU	Intensive Care Unit
IDVAs	Independent Domestic Violence Advisors
IG	Information Governance
IM&T	Information Management and Technology
IPP	Imprisonment for Public Protection
IPR	Individual Performance Review
IPT	Interpersonal Psychotherapy
J	
JNCC	Joint Negotiating Consultative Committee
JTAI	Joint Targeted Area Inspections
JUCB	Joined Up Care Board
JUCD	Joined Up Care Derbyshire
K	
KPI	Key Performance Indicator
KSF	Knowledge and Skills Framework
L	
LA	Local Authority
LCFS	Local Counter Fraud Specialist
LD	Learning Disabilities
LHP	Local Health Plan
LHWB	Local Health and Wellbeing Board
LOS	Length of Stay
M	
MARS	Mutually Agreed Resignation Scheme
MAU	Medical Assessment Unit
MAS	Memory Assessment Service
MAPPA	Multi-agency Public Protection Arrangements
MARAC	Multi-agency Risk Assessment Conference (meeting where information is shared on the highest risk domestic abuse cases between representatives of local police, probation, health, child protection, housing practitioners, Independent Domestic Violence Advisors (IDVAs) and other specialists from the statutory and voluntary sectors.
MASH	Multi-Agency Safeguarding Hub
MCA	Mental Capacity Act
MDA	Medical Device Alert
MDM	Multi-Disciplinary Meeting
MDT	Multi-Disciplinary Team
MFF	Market Forces Factor
MHA	Mental Health Act

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Term / Abbreviation	**Terms in Full**
MHIN	Mental Health Intelligence Network
MHIS	Mental Health Investment Standard
MHRT	Mental Health Review Tribunal
MSC	Medical Staff Committee
N	
NCRS	National Cancer Registration Service
NED	Non-Executive Director
NICE	National Institute for Health and Care Excellence
NHS	National Health Service
NHSI	National Health Service Improvement
O	
OBC	Outline Business Case
ODG	Operational Delivery Group
OP	Out Patient
OSC	Overview and Scrutiny Committee
P	
PAB	Programme Assurance Board
PAG	Programme Advisory Group
PALS	Patient Advice and Liaison Service
PAM	Payment Activity Matrix
PARC	Psychosis and the reduction of cannabis (and other drugs)
PARIS	This is an electronic patient record system
PbR	Payment by Results
PCC	Police & Crime Commissioner
PHE	Public Health England
PICU	Psychiatric Intensive Care Unit
PID	Project Initiation Document
PLIC	Patient Level Information Costs
PMLD	Profound and Multiple Disability
PPT	Partnership and Pathway Team
PREM	Patient Reported Experience Measure
PROMS	Patient Reported Outcome Measure
PSF	Provider Sustainability Fund
Q	
QAG	Quality Assurance Group
QC	Quality Committee
QIA	Quality Impact Assessment
QIPP	Quality, Innovation, Productivity Programme
R	
RAID	Rapid Assessment, Interface and Discharge
RCGP	Royal College of General Practitioners
RCI	Reference Cost Index
REGARDS	Race, Economic disadvantage, Gender, Age, Religion or belief, Disability and Sexual orientation
RTT	Referral to Treatment
S	
SAAF	Safeguarding Adults Assurance Framework
SBARD	Situation, Background, Assessment, Recommendation and Decision (SBARD) tool

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Term / Abbreviation	**Terms in Full**
SBS	Shared Business Services
SEND	Special Educational Needs and Disabilities
SI	Serious Incidents
SIRI	Serious Incident Requiring Investigation
SLA	Service Level Agreement
SLR	Service Line Reporting
SOC	Strategic Options Case
SOF	Single Operating Framework
SPOA	Single Point of Access
SPOE	Single Point of Entry
SPOR	Single Point of Referral
STEIS	Strategic Executive Information System
STF	Sustainability and Transformation Fund
STP	Sustainability and Transformation Partnership
S(U)I	Serious (Untoward) Incident
T	
TARN	Trauma Audit and Research Network
TCP	Transforming Care Partnerships
TCS	Transforming Community Services
TDA	Trust Development Authority
TMT	Trust Management Team
TUPE	Transfer of Undertakings (Protection of Employment) Regulations 1981
TMAC	Trust Medical Advisory Committee
W	
WTE	Whole Time Equivalent

2019-20 Board Annual Forward Plan

Exec Lead	Item	2 Apr 19	7 May 19	4 Jun 19	2 Jul 19	3 Sep 19	1 Oct 19	5 Nov 19	3 Dec 19	4 Feb 20	3 Mar 20
	Paper deadline	26 Mar	29 Apr	28 May	24 Jun	27 Aug	23 Sep	28 Oct	25 Nov	27 Jan	24 Feb
Trust Sec	Declaration of Interests	X	X	X	X	X	X	X	X	X	X
CG	Patient Story	X	X	X	X	X	X	X	X	X	X
CM	Minutes/Matters arising/Action Matrix	X	X	X	X	X	X	X	X	X	X
CM	Board Forward Plan (for information)	X	X	X	X	X	X	X	X	X	X
CM	Board review of effectiveness of meeting	X	X	X	X	X	X	X	X	X	X
STRATEGIC PLANNING AND CORPORATE GOVERNANCE											
CM	Chair's Update	X	X	X	X	X	X	X	X	X	X
IM	Chief Executive's Update	X	X	X	X	X	X	X	X	X	X
MP/CW	NHSI Annual Plan - timing to be confirmed							X			
AR	Staff Survey Results										X
AR	Equality Delivery System2 (EDS2)							X			
AR	Workforce Race Equality Standard (WRES)					X					
AR	Workforce Disability Equality Standard (WDES)					X					
AR	Workforce Standards Formal Submission									X	
AR	Gender Pay Gap Report										X
AR	Public Sector Duty Annual Report									X	
AR	Pulse Check Results and Staff Survey Plan					X					
AR	Flu Campaign for 2019/20							X			X
AR	Workforce Plan			X							
Trust Sec	NHS Improvement Year-End Self-Certification		X								
Trust Sec	Year-End Governance Reporting from Board Committees and approval of ToRs		X								
Trust Sec	Corporate Governance Framework							X			
Trust Sec	Trust Sealings (six monthly)	X					X				
Trust Sec	Annual Review of Register of Interests	X									
Trust Sec	Board Assurance Framework Update	X		X		X		X		X	
IM	Deep Dive BAF Risk 3b - risk that the Trust fails to influence external drivers (such as national policy and BREXIT) which could impact on its ability to effectively implement its strategy								X		

2019-20 Board Annual Forward Plan

Exec Lead	Item	2 Apr 19	7 May 19	4 Jun 19	2 Jul 19	3 Sep 19	1 Oct 19	5 Nov 19	3 Dec 19	4 Feb 20	3 Mar 20
Trust Sec	Freedom to Speak Up Guardian Report (six monthly)					X					X
Trust Sec	Fit and Proper Person Declaration			X							
Trust Sec	Board Effectiveness Survey Report Policy for Engagement between the Board and COG	X							X		
Trust Sec	Report from Council of Governors Meeting (for info)	X		X		X	X		X	X	
Committee Chairs	Board Committee Assurance Summaries (following every meeting) - Audit & Risk, Finance & Performance, Mental Health Act, Quality, People & Culture, Safeguarding Committees	X	X	X	X	X	X	X	X	X	X
MP	Annual Emergency Planning Report (EPPR)								X		
GH	Business Plan Monitoring close down of 2018/19 (May) Proposal for 2019/20 (June) 2019/20 Update (Dec)		X	X					X		
GH	Trust Strategy Review		X		X						
GH	Clinical Strategies 2019-22: Oct: Older Adult, Working Aged Adult - Nov: Eating Disorders, Perinatal - Dec: Forensic and Rehab, Substance Misuse, Children's - Feb: LD						X	X	X		
OPERATIONAL PERFORMANCE											
CG/CW/AR/ MP	Integrated performance and activity report to include Finance, Workforce, performance and Quality Dashboard		X	X	X	X	X	X	X	X	X
CG/JS/AR/ MP	Workforce Standards Formal Submission/Safer Staffing										X
QUALITY GOVERNANCE											
CG/CW/MP/ GH/JS/AR	Quality Report - focus on CQC domains (Well Led CQC & NHSI (Trust Sec) Apr 2020		Responsive MP	Caring CG		Use of Resources CW			Quality & Strategy GH	Safety JS	Effective CG AR
JS	Learning from Deaths Mortality report (quarterly publication of information on death) Apr/Jul/Oct/Feb/Apr	X				A		X		X	
JS	Guardian of Safe Working Report			X					A		X
JS	NHSE Return on Medical Appraisals sign off					X					
CG	Control of Infection Report					A					
JS	Re-validation of Doctors				A						
CG	Annual Review of Recovery Outcomes								X		
CG	Treat Me Well Campaign Update				X						
CG	Annual Looked After Children Report						X				
CG	Outcome of Patient Stories						X				
POLICY REVIEW											
JF	Fit and Proper Person Policy										X